

**2009 CALIFORNIA COMPREHENSIVE CARE PLAN
FOR HIV/AIDS CARE, TREATMENT, AND SUPPORT**

TABLE OF CONTENTS

LETTER OF CONCURRENCE	6
CONTRIBUTORS	7
INTRODUCTION.....	8
EXECUTIVE SUMMARY	8
SECTION 1. WHERE ARE WE NOW?	
WHAT IS OUR CURRENT SYSTEM OF CARE?	9
California Epidemiological Profile	9
<u>A California Overview</u>	
<u>California HIV/AIDS Epidemiology</u>	
Cumulative AIDS and HIV Cases Reported as of September 30, 2008	
Reported HIV and AIDS Cases among Adults and Adolescents Presumed	
Living as of September 30, 2008	
<u>Trends and Emerging Populations</u>	
Current State HIV/AIDS Care System	16
<u>OA</u>	
<u>California Ryan White Part B Programs</u>	
CMP	
ADAP	
CARE/HIPP	
CSP/HIV Care Consortia	
EIP	
Positive Changes	
Bridge Project	
Pathways	
<u>Other OA Care Programs</u>	
MCWP	
HIV Therapeutic Monitoring Program (TMP)	
California Statewide Treatment Education Program (CSTEP)	
HOPWA	
Residential AIDS Licensed Facilities (RALF) Program	
<u>Coordination with Other Ryan White Programs</u>	
Part A-Funded Regions	
Parts C and D	
AIDS Education and Training Centers (AETCs)	
<u>Coordination with HIV Prevention Services</u>	
<u>Integration and Coordination within CDPH</u>	
CDPH Integration Project	

TB Control Branch
STD Control Branch
Coordination with VH

Coordination with other California Departments

Department of Health Care Services (DHCS)
Department of Alcohol and Drug Programs (ADP)
Department of Housing and Community Development (DHCD)
California Department of Corrections and Rehabilitation (CDCR)
California Department of Education (CDE)
Interagency Workgroup

Coordination with Other Federal Programs

Other Opportunities to Enhance Communication, Coordination, and Collaboration

California Conference of Local AIDS Directors (CCLAD)
CCLHO
National Association of State and Territorial AIDS Directors (NASTAD)
CHRP
VCI
Prevention Think Tank
Rural Think Tank
Clinical Meeting
Telemedicine
U.S.-Mexico Border Health Initiatives

Spectrum of Care Services

California Resource Inventory and Profile of Ryan White

Part B-Funded Providers by Service Category..... 39

Assessment of Need 39

Unmet Need Estimate

Need for Primary Medical Care and Other Core Services

Needs of HIV/AIDS-Positive Persons in Care
Needs of HIV/AIDS-Positive Persons Out of Care

Gaps in Care

Gaps in Core Medical Services

Outpatient and Ambulatory Health Services
ADAP Treatments and Pharmaceutical Assistance
Oral Health Care
Home Health- and Community-Based Health Care
Hospice Services
Mental Health Services
Substance Use and Addiction Treatment Services
Medical Case Management Services

Gaps in Supportive Services

Client Advocacy Services
Emergency Financial Assistance
Food and Nutrition Services

- Housing Services
- Legal Services
- Linguistic, Translation, and Interpretation Services
- Medical Transportation Services

Prevention Needs

- Linkage with Counseling and Testing Services
- Prevention with Positives
- PCRS

Barriers to Care 58

Individuals' Barriers to Care

- Access to Services or Knowledge of Services
- Denial and Fear of Illness
- Disclosure and Stigma
- Experiences with Medications
- Homelessness and Marginally Housed
- Immigration and Immigration Status
- Lack of Service Linkage
- Mental Health Issues
- Reluctance to Seek Early Medical Care
- Sensitive, Competent, and Culturally Appropriate Care
- Substance Use Issues

Systemic Barriers to Care

- Awareness of Services
- Complexity of Eligibility and Enrollment Processes
- Culturally Responsive Services
- Data Collection, Evaluation, and Outcomes Tracking
- Integration of Care
- Lack of Key Services
- Lack of Health Insurance
- Lack of Service Linkages
- Medicare Part D
- Poverty
- Providers Knowledge and Experience
- Quality Management
- Service Continuity
- Staff Turnover

**SECTION 2. WHERE DO WE NEED TO GO?
WHAT IS OUR VISION OF AN IDEAL SYSTEM? 70**

OA Goals 70

Guiding Principles and Values 71

SECTION 3. HOW WILL WE GET THERE?	
HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF, AND ACCESSIBILITY TO, CORE SERVICES?.....	72
Long-Term (Three-Year) Goals and Objectives	72
<u>Service Delivery System Goals</u>	
<u>Administrative System Goals</u>	
Short-Term (Annual) Goals and Objectives	75
SECTION 4. HOW WILL WE MONITOR OUR PROGRESS?	
HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR SHORT- AND LONG-TERM GOALS?	81
Improving Client-Level Data (CLD)	81
Using Data for Evaluation.....	81
Measuring Clinical Outcomes	82
CONCLUSION	87
APPENDIX 1: Resource Inventory and Profile of Ryan White Part B-Funded Providers by Service Category	88
APPENDIX 2: Estimating the Number of HIV/Non-AIDS Individuals Aware of their Status in California	153
REFERENCES.....	155

LETTER OF CONCURRENCE

California HIV Planning Group

Karen Ingvaldstad, Project Officer
HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 7A-55
Rockville, MD 20857-0001

Dear Ms. Ingvaldstad:

This letter is written to demonstrate our concurrence with the 2009 California Comprehensive Plan for HIV/AIDS Care, Treatment, and Support (Comprehensive Plan), which has been developed by the California Department of Public Health, Center for Infectious Diseases, Office of AIDS (OA).

California's statewide planning group for HIV care and prevention, the California HIV Planning Group (CHPG), has been involved in, and has supported the development of, the 2009 Statewide Coordinated Statement of Need and related Comprehensive Plan. These documents clearly illustrate the enormity of the impact of the HIV/AIDS epidemic in California, outline the related care and treatment needs of persons living with HIV in California, and offer OA's short- and long-term goals for addressing these issues.

As Co-Chairs of CHPG, we are signing this Letter of Concurrence to show our support for the submittal of this Comprehensive Plan.

Sincerely,

Signed by Liz Voelkert on behalf of:

Ellen Swedberg
Co-Chair
California HIV Planning Group

Ricki Rosales
Co-Chair
California HIV Planning Group

CONTRIBUTORS

The 2009 California Comprehensive Care Plan for HIV/AIDS Care, Treatment, and Support and the related 2009 Statewide Coordinated Statement of Need were developed with input and thoughtful guidance from a number of participants representing clinics, public health departments, Ryan White Care Program grantees, persons living with HIV/AIDS, community-based organizations, affordable housing organizations, local and statewide planning groups, academic institutions, and other service agencies and providers that directly, or indirectly, help meet the myriad care, treatment, support, and prevention needs of persons with HIV/AIDS in California.

INTRODUCTION

The 2009 California Comprehensive Care Plan for HIV/AIDS Care, Treatment, and Support (Comprehensive Plan), which is based on knowledge of the existing care system as well as the needs and gaps outlined in California's 2009 Statewide Coordinated Statement of Need (SCSN), provides an update on the evolving epidemic and the health care needs of those who are and are not currently in care. The Comprehensive Plan will outline strategies and approaches to achieve the following Health Resources and Services Administration (HRSA) expectations:

- Ensure the availability and quality of all core medical services within the state;
- Eliminate disparities in access to core medical services and support services for individuals among disproportionately affected subpopulations and historically underserved communities;
- Specify strategies for identifying individuals who know their HIV status but are not in care, informing them about available treatment and services, and assisting them in accessing and engaging in those services;
- Include a discussion of clinical quality measures;
- Include strategies that address the primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system;
- Provide goals, objectives, timelines, and appropriate allocation of funds;
- Include strategies to coordinate the provision of services and programs for HIV prevention, including outreach and early intervention services;
- Include strategies for the prevention and treatment of substance abuse, and
- Include strategies for the treatment of mental health disorders.

EXECUTIVE SUMMARY

The Comprehensive Plan identifies multiple issues and challenges confronting the delivery of HIV-related services in California, in addition to describing the state's current publicly funded HIV care system. The Comprehensive Plan was developed in conjunction with the SCSN using shared knowledge and experiences, a review of available data, and in-depth discussions of policy and service delivery issues that emerged through the comprehensive planning process. This document presents a framework for the continued development and improvement of California's comprehensive service delivery model for HIV/AIDS care, treatment, and support. Recommended strategies seek to build upon the existing spectrum of HIV care and treatment. The Comprehensive Plan is intended to be a useful plan that can be an ongoing reference and guide. It will be periodically monitored to ensure effective implementation and updated or modified as needed to reflect emerging issues, budgetary constraints, and trends.

SECTION 1. WHERE ARE WE NOW? WHAT IS OUR CURRENT SYSTEM OF CARE?

California Epidemiological Profile

A California Overview

Like the nation, California is now facing some of its greatest economic challenges in recent history. Huge budget shortfalls, reduced revenues, high unemployment, and a lack of adequate housing, education, and health care are just a few of the many issues that Californians will wrestle with in the coming years. The California network of HIV/AIDS care, treatment, support, and prevention services must remain intact and responsive in this environment in order to maintain the health and productivity of HIV-infected persons in California, to avoid the more expensive HIV care that results from inadequate primary and preventive care, and to help prevent the further transmission of HIV. The HIV care system, like all health care services, is already encountering the effects of a weakening economy, including budget cuts, loss of staff through layoffs or unfilled vacancies, and increased demand as unemployment increases. Maintaining access to, and excellence of, the HIV care service delivery system when faced with reduced resources coupled with increasing demand, including for safety net services, will be a challenging task.

Forged through community action and compassion, the existing California HIV/AIDS care system is a unique model for responding to life-threatening illness. When operating optimally, the system supports people with HIV throughout their lives, providing a tailored, coordinated range of services to meet the full spectrum of medical, support, and prevention needs generated as a result of disease progression and other life changes. In the past, the California HIV care system has been capable of responding to rapid changes in scientific knowledge and treatment of the disease, as well as societal factors that influence the availability and accessibility of essential care, treatment, support, and prevention services. Continued funding via the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Care Act), via the State General Fund, and by leveraging other private and public funding sources, will be critical to California's ability to continue to provide services that are adaptable and responsive to the economic and societal context as well as to the changing demographics of those infected with HIV and to the many settings in which HIV/AIDS services are provided.

As described in the SCSN, California has the world's eighth largest economy and is home to 12 percent of the population of the United States. It is the third largest state by geographic area and the largest by population. It is a diverse state, encompassing major cities, extensive suburban stretches, rural frontier counties, beautiful natural environments, and an agricultural industry that feeds much of the nation. Some of the poorest and some of the wealthiest Americans live in California, as well as a large transient population, including tourists, migrant workers, and the homeless. California's cultural diversity is unmatched by any other state, with the majority of the population determined by the 2000 Census to be people of color. California is home to two of the

first epicenters of the AIDS epidemic, San Francisco and Los Angeles, and 15 percent of all people living with HIV/AIDS (PLWH/A) in the United States reside in California.

Nine of the country's Part A Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) are in California. Coordination among the California Department of Public Health (CDPH), Center for Infectious Diseases (CID), Office of AIDS (OA) Part B-funded programs and the numerous Part A jurisdictions has proven to be a critical component of the overall statewide plan for delivery of HIV/AIDS services. California's SCSN described how the size and diversity of the state of California, as well as cross-jurisdictional coordination, presents unique, complex challenges to planners of HIV care, treatment, support, and prevention services. In addition, as described in previous SCSNs, HIV/AIDS programs in California must include targeted programs specially designed to serve exceptionally varied groups and communities, while reaching both large populations in urban and suburban areas and remote populations in rural and frontier communities. At the same time, these tailored services must link and integrate in a wide variety of public and private sector provider settings.

The high level of poverty in which many HIV-infected Californians live, combined with the widespread lack of health insurance, further complicates the effort to deliver effective, comprehensive services. The weakening of the California economy in the last few years has left cities, counties, and towns with fewer resources. All of these factors have resulted in an increased reliance on publicly funded health and other safety net services. Now, even more seriously, California's current budget deficit is the largest in the state's history, further reducing the state's ability to increase, or even maintain, existing services for the ever increasing numbers of persons now living with HIV/AIDS due to the success of antiretroviral medications.

In the past, California has successfully met and overcome many of these challenges by creating a series of comprehensive care systems throughout the state that regionally and locally meet many of the basic health and psychosocial needs of PLWH/A. Community-based organizations (CBOs) and local health departments form the backbone of this service delivery system. California has made significant progress in ensuring that access to basic medical services and antiretroviral drug therapies are available to all Californians who need and request them, and that basic medical services are linked to a network of supportive services that help meet the physical, emotional, and practical needs of PLWH/A. Emphasis has also been placed on providing prevention services within clinical care settings in order to lessen the transmission of HIV from infected persons to others. Also central to program planning and operations has been ensuring greater access to services for emerging populations impacted by HIV. California has successfully implemented and expanded health outreach to bring newly diagnosed and out-of-care individuals into treatment earlier.

Maintaining this effective network of HIV care, treatment, and prevention services in the current fiscal climate will be a daunting task. Even without a state budget deficit of approximately \$42 billion, the state still has a long way to go in guaranteeing full access to appropriate services for all Californians infected with HIV. Additionally, much work

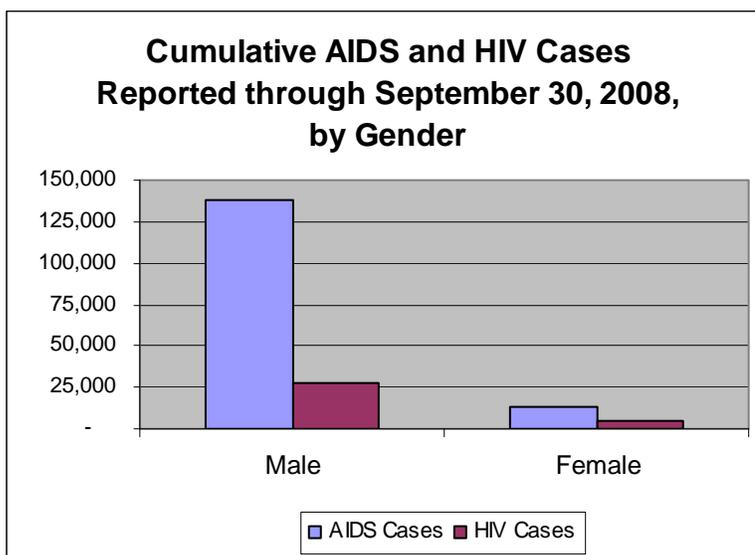
must be completed to ensure that all residents have access to quality services that meet their cultural, linguistic, and lifestyle needs. Gaps remain in the system of care, despite best efforts, and much work must be done to develop new and complete approaches to integrating services, maximizing resources, bringing people with HIV who are aware and unaware of their serostatus into care, and meeting HRSA's goals.

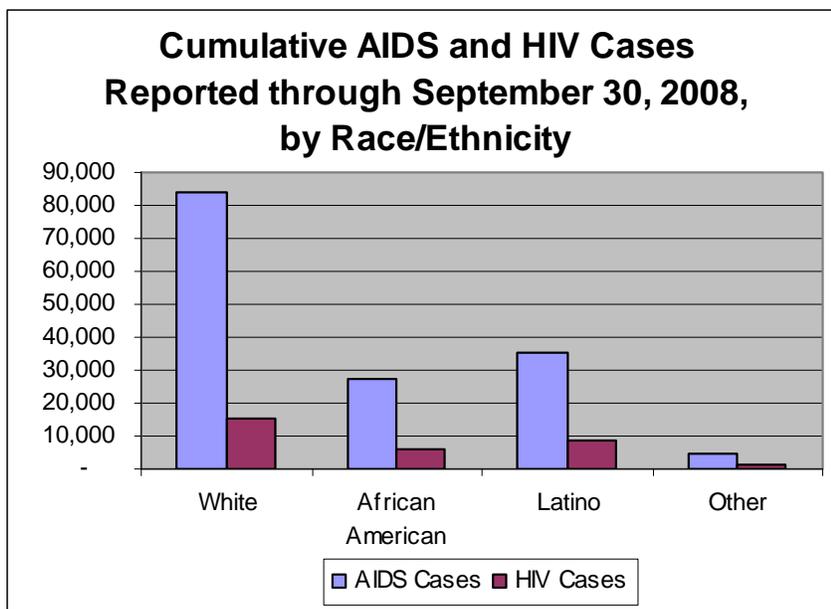
California HIV/AIDS Epidemiology

California began reporting AIDS cases by name to the Centers for Disease Control and Prevention (CDC) in March 1983. In July 2002, California began reporting HIV cases by non-name code; this code-based reporting system was in place through April 16, 2006, and generated 41,155 HIV case reports. On April 17, 2006, Governor Arnold Schwarzenegger signed legislation requiring that HIV cases be reported by name, rather than by code, effective immediately. This change was designed to improve and strengthen how California tracks HIV infections and to ensure continued federal funding for programs and services to Californians affected by HIV/AIDS. However, as part of the implementation of the name-based HIV reporting system, CDC required California to remove all code-based HIV data from the statewide HIV/AIDS Reporting System (HARS) database. Thus, the data and information contained herein reflect AIDS cases reported to the HIV/AIDS Case Registry from March 1983 through September 30, 2008, and HIV cases reported by name from April 16, 2006 through September 30, 2008.

Cumulative AIDS and HIV Cases Reported as of September 30, 2008

As of September 30, 2008, California has received case reports for 150,835 AIDS diagnoses and 31,386 HIV infections. White males, age 25 or older at diagnosis, account for most AIDS (N=77,671) and HIV (N=12,985) cases reported to date. Fifty-seven percent of individuals reported with AIDS are known to be deceased.



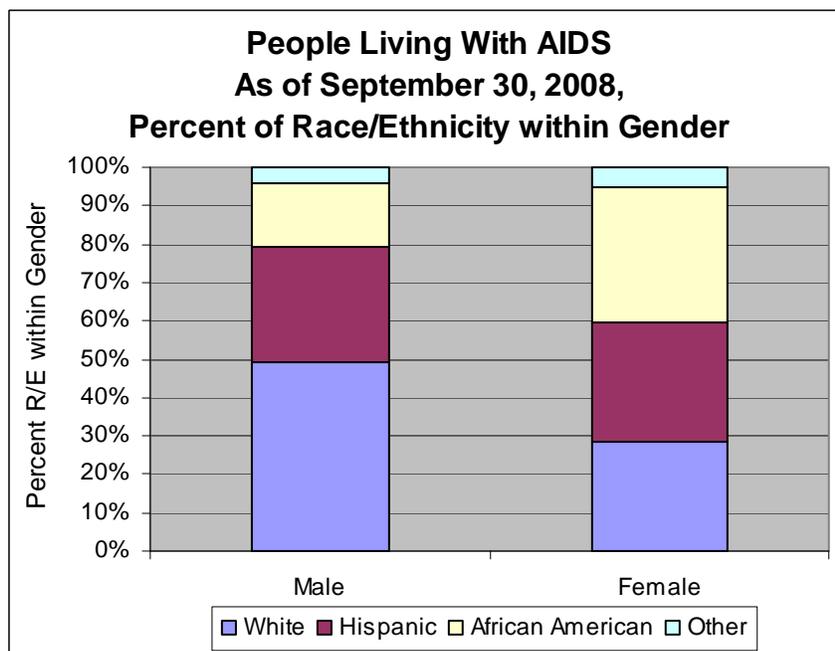


Reported HIV and AIDS Cases among Adults and Adolescents Presumed Living as of September 30, 2008

AIDS:

The number of individuals diagnosed and reported with AIDS, who are presumed to be living, has increased steadily across all demographic groups since 1990. As of September 30, 2008, 65,373 adults diagnosed and reported with AIDS are presumed living in California. Of these, 88 percent are men, 11 percent are women, and 1 percent are transgender.

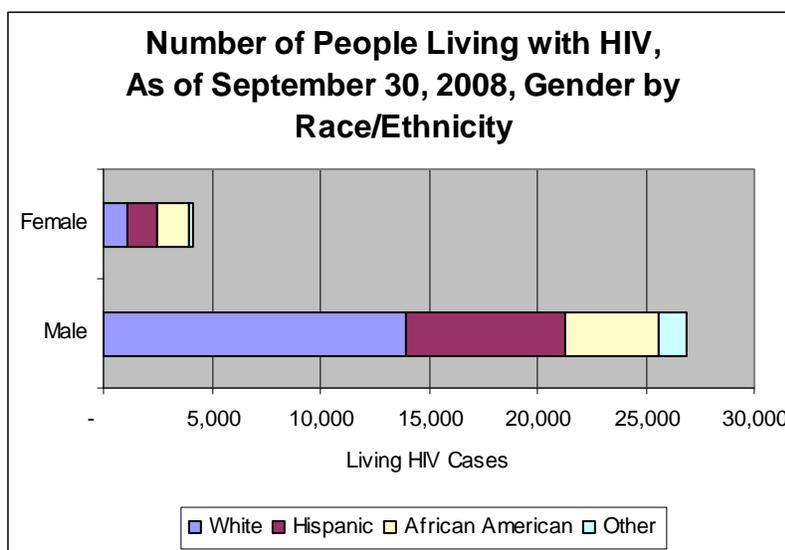
The racial/ethnic breakdowns differ by sex. Whites (50 percent) and Hispanics (30 percent) account for the majority of adult/adolescent men presumed to be living with AIDS in California. Women presumed to be living with AIDS in California are mainly African American (35 percent), Hispanic (31 percent), or White (29 percent).



The majority of individuals presumed to be living with AIDS were between the ages of 30 and 50 when diagnosed (73 percent for men and 64 percent for women). Forty-four percent of males and 38 percent of females were diagnosed in their 30s. A smaller percentage, 15 percent of males and 20 percent of females, were diagnosed with AIDS during their 20s. Men who have sex with men (MSM) account for most of the reported individuals presumed living with AIDS in California. Of the 57,492 men, 82 percent are MSM, including MSM who are also injection drug users (MSM/IDUs). Among women living with AIDS, 53 percent were exposed through heterosexual contact, and 28 percent through injection drug use.

HIV:

In total, 30,485 adults and adolescents have been reported by name and are presumed living with HIV in California. The majority (86 percent) is male and most are White (53 percent) or Hispanic (27 percent). The racial/ethnic breakdown of women diagnosed and reported with HIV, who are presumed living, is 34 percent African American, 33 percent Hispanic, and 28 percent White.

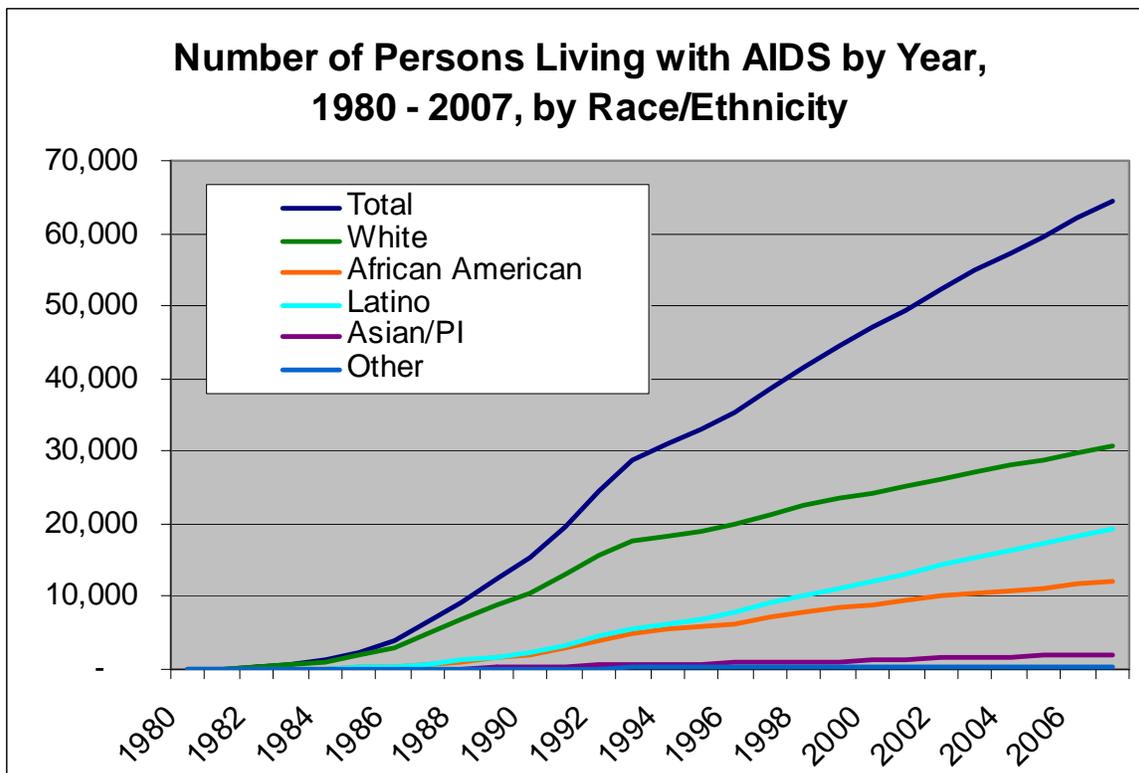
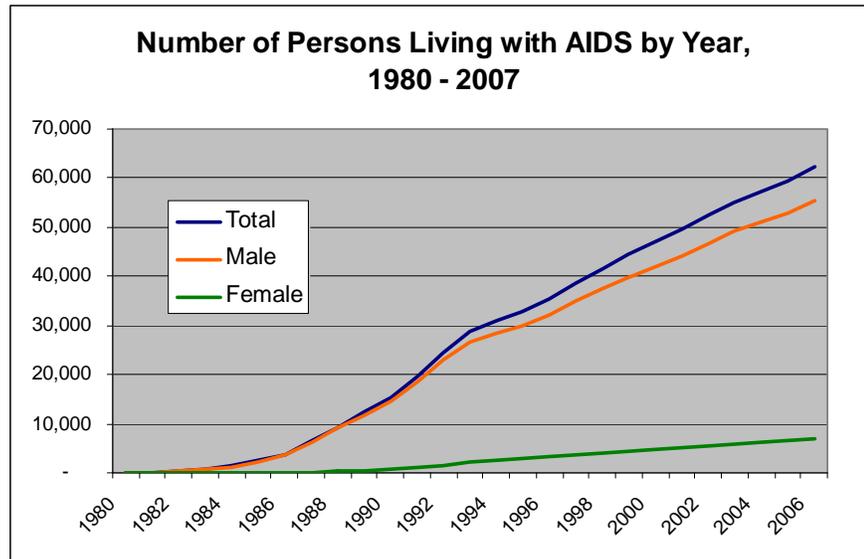


The majority of individuals, 39 percent of males and 32 percent of females, diagnosed and reported with HIV and presumed living were diagnosed in their 30s. Twenty-eight percent of both men and women presumed living were diagnosed with HIV in their 20s.

HIV exposure by risk, among those presumed living in California, is similar to that of AIDS. Among men, MSM and MSM/IDUs account for 86 percent of cases. Women who are presumed living were exposed primarily through heterosexual contact (52 percent) or injection drug use (21 percent).¹

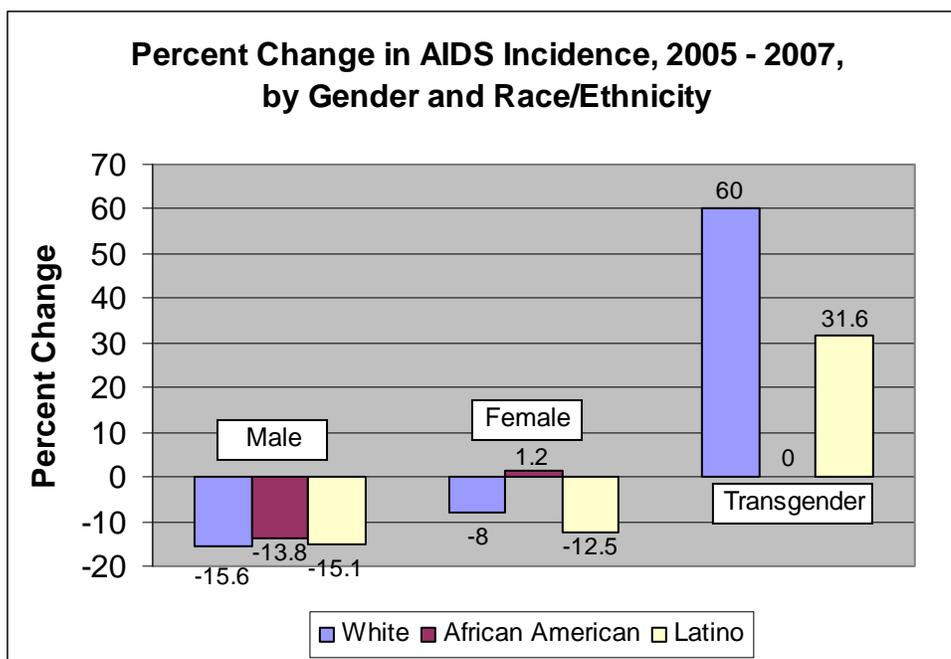
Trends and Emerging Populations

With the success of antiretroviral treatment and relatively constant incidence, the number of people living with HIV and AIDS continues to increase every year. Between 2001 and 2007, the number of people living with AIDS increased by 30 percent; males increased by 30 percent while women increased by 37 percent. By race/ethnicity, Whites increased by 22 percent, followed by African Americans with a 30 percent increase, Latinos by 45 percent, Asian/Pacific Islanders by 55 percent, and all others by 18 percent. (Because California's HIV reporting system is not yet mature, percent change statistics for HIV were not calculated.)



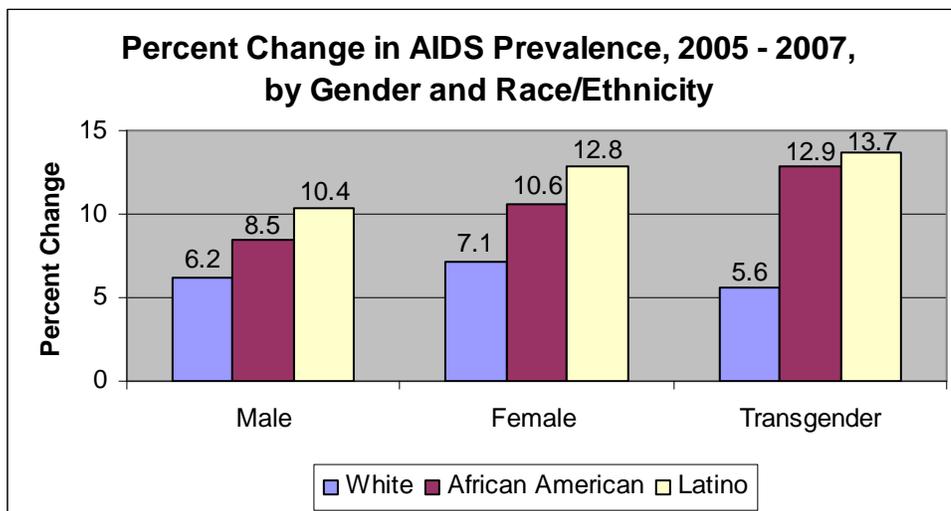
While African Americans are disproportionately impacted by HIV and AIDS, which necessitates targeted prevention and care services, the increasing Asian/Pacific Islander population also deserves attention. While the overall numbers are still relatively small (1,351 living AIDS cases in 2001 compared to 2,098 living cases by the end of 2007, for an additional 747 cases), several research studies based in San Francisco suggest that young Asian/Pacific Islander MSM are increasingly engaged in high-risk behaviors.² Although one-half of California’s Asian population is of Chinese or Filipino origins,³ the culturally and linguistically diverse Asian/Pacific Islander population provides challenges for developing appropriate prevention messages and ensuring access to culturally sensitive care and treatment services.

The number of new AIDS cases diagnosed in 2005 compared to the number in 2007 decreased in total by almost 13 percent. By gender and race/ethnicity, all demographic groups experienced a decrease in the number of diagnosed AIDS cases over this two year time-frame, except for African American women (1.2 percent increase) and transgenders. Overall, the number of new AIDS cases diagnosed among people identifying as transgender increased by 15.9 percent. Although the numbers are very small, 44 in 2005 and 51 AIDS cases in 2007, the increase in new AIDS diagnoses relative to the decrease for most other populations merits attention.



The number of transgenders living with HIV/AIDS continues to increase each year. As of September 30, 2008, 564 transgender cases were living with AIDS, with another 306 estimated to be living with HIV. Furthermore, the transgender numbers are more than likely underrepresented, with many transgenders miscategorized as MSM.⁴ Between 2005 and 2007, the number of African American and Latino transgenders living with

AIDS increased more than men and women of the same race/ethnicity (i.e., 8.5 percent increase for African American men, 10.6 percent increase for African American women, and 12.9 percent increase for African American transgenders).



Current State HIV/AIDS Care System

OA

As designated by California Health and Safety Code Section 131019, OA has lead responsibility for coordinating state programs, services, and activities relating to HIV/AIDS. OA is thus uniquely positioned to provide leadership in California, through both direct funding and through collaboration, facilitation, and influencing, to meet our primary goals (i.e., to minimize new HIV infections and to maximize the number of people with HIV infection who are accessing, and receiving, appropriate care, treatment, support, and prevention services). OA's responsibilities and opportunities for impact lie at both the individual level, through health services functions, and at the population level, through public health functions. Given its unique position, OA has the opportunity and the responsibility to develop the broadest possible vision of the individual and public health needs associated with HIV prevention, care, treatment, and support in California. OA also has the responsibility to identify and leverage all resources directly and indirectly available to OA. By doing this, in addition to allocating funds, implementing, and administering programs, and ensuring excellence and accountability, OA aims to ensure the most impactful use of every resource within the state.

OA has a state fiscal year 2008-09 budget of approximately \$492 million and is funded by State General Fund, CDC, HRSA, U.S. Department of Housing and Urban Development (HUD) funds and other sources. OA's staff of approximately 160 is organized into HIV Care, HIV Education and Prevention Services, and HIV/AIDS Epidemiology Branches and Administrative and the AIDS Drug Assistance Program (ADAP) Sections.

OA is the state grantee for funding provided through Part B of the Care Act. OA, through its HIV Care Branch (comprised of the CARE, Community Based Care (CBC), and Early Intervention Sections) and the ADAP Section is responsible for all OA-funded care and treatment programs and services and for overseeing administration of the Care Act's Part B grant.

OA programs that receive full- or partial- Part B funding include ADAP, Care Services Program (CSP), Comprehensive AIDS Resources Emergency/Health Insurance Premium Program (CARE/HIPP), AIDS Case Management Program (CMP), Early Intervention Program (EIP), Positive Changes, Pathways, and Bridge Project. The HIV Care Branch also administers a number of other care and treatment programs that receive no Ryan White Part B funding. These programs are detailed below.

California Ryan White Part B Programs

Programs funded through OA that receive full- or partial-Ryan White Part B-funding include:

CMP

CMP provides comprehensive, home- and community-based care services for persons with AIDS or symptomatic HIV infection who would otherwise utilize hospitals, emergency rooms, and nursing homes. The program maintains clients in their homes and avoids the need for more costly institutional care in a nursing facility or hospital. In addition to Part B funding, CMP utilizes State General Funds to provide services CMP is administered in the CBC Section and works in close association with the AIDS Medi-Cal AIDS Waiver Program (MCWP), also administered within CBC. MCWP, funded by State/Federal Medicaid funds, is described in the Non-Ryan White Part B-Funded Programs section, below.

ADAP

ADAP provides medication coverage to individuals with HIV infection who could not otherwise afford them. Drugs on the ADAP formulary slow the progression of HIV disease, effectively prevent and treat opportunistic infections and HIV related co-morbidities among people with HIV/AIDS, and treat some of the symptoms associated with antiretroviral therapy. ADAP funding is composed of Ryan White Part B funds, State General Funds, and statutorily mandated drug manufacturer rebates. ADAP is intended as a program of last resort for people who have no other means to pay for their HIV drugs. ADAP coordinates with other payers of HIV health care to ensure ADAP is the payer of last resort.

CARE/HIPP

CARE/HIPP helps people with HIV/AIDS maintain their private health insurance coverage and continue their access to primary medical care. Because participants'

health insurance policies must cover outpatient prescription drugs, the program also helps ensure that CARE/HIPP clients have access to AIDS drugs and preserves ADAP access for clients with no other method of obtaining drug coverage. CARE/HIPP seeks to increase awareness of the program throughout the state of the availability of CARE/HIPP. CARE/HIPP helps HIV-positive persons acquire quality medical care by the continuation of their own comprehensive health insurance coverage.

CSP/HIV Care Consortia

CSP provides Part B funding to local health jurisdictions (LHJs) and CBOs throughout California for the provision of care, treatment, support, and prevention services for PLWH/A. CSP provides funding to address the needs of the 43 non-EMA counties, while the HIV Care Consortia component of the program provides Part B funding to the remaining 15 counties in the three EMAs and six TGAs in California.

Local planning bodies, such as Part A Planning Councils and HIV Care Planning Groups, make decisions regarding the priorities of specific service needs. These planning bodies are responsible for conducting and/or updating an assessment of HIV/AIDS service needs in their geographic service areas. In addition to providing funding to support the provision of medical care, treatment, and support services, CSP increases access to medical care to include vulnerable populations, those who know their status but are not accessing care, and to those living in geographically underserved areas. The program increases linkages to culturally appropriate points of entry into the medical system.

EIP

First implemented in 1987 with CDC funds in the Long Beach and Santa Clara health jurisdictions, EIP is a comprehensive, multidisciplinary program that provides HIV care and prevention services to HIV-infected persons and their at-risk HIV-negative partners at 36 clinics throughout the state. The goals of EIP are to prolong the health and productivity of those living with HIV and to interrupt the transmission of HIV to others. Services include comprehensive HIV medical care, psychosocial services, transmission risk-reduction interventions, health and treatment education, treatment adherence, case management, and benefits counseling. EIP is funded with a combination of Ryan White Part B, CDC, and State General Fund dollars.

Positive Changes

Positive Changes provides prevention interventions for HIV-infected persons who are assessed as being at high risk for transmitting HIV. The program is located at 19 EIP clinic sites statewide. Risk-reduction specialists, who are licensed mental health professionals (e.g., licensed clinical social workers or marriage and family therapists), work with clients to initiate, support, and sustain behavior changes that lower or eliminate HIV transmission risk. Highly individualized, specific behavior change plans are developed in partnership with clients and emphasize gradual, incremental,

achievable goals. Although based in EIP clinic sites, high-risk HIV-infected persons may be referred to the program from any agency providing services to HIV-infected persons. Positive Changes is funded with Ryan White Part B, CDC, and State General Fund dollars.

Bridge Project

The Bridge Project is funded by a combination of Ryan White Part B, Minority AIDS Initiative, CDC, and State General Funds targeted for communities of color. The project is a specific response to research indicating that many persons of color do not seek treatment until advanced stages of disease progression, have lower rates of retention in treatment programs, and have lower adherence to medication regimes. The project funds clinic-based “Bridge workers” who are peers and members of the community they serve. The Bridge workers identify out-of-care, HIV-infected persons and facilitate their access to HIV services. They also facilitate re-entry into care, or help to maintain in care those clients who are only marginally engaged in treatment. Another goal of the project is to prevent further transmission of HIV in communities of color that are disproportionately impacted by HIV infection by increasing the number of HIV-infected individuals successfully enrolled in clinic-based prevention interventions. The Bridge Project is located in all 36 EIP clinics statewide. Though located in the 36 EIP clinics, Bridge workers are charged with linking and engaging out-of-care HIV-infected persons into care at the service location that is most suited to their clients needs, not limited to EIP sites.

Pathways

Pathways is a program that integrates substance abuse and mental health treatment services within the EIP care model at 17 of the 36 EIP clinic sites statewide. Pathways integrates treatment for substance abuse and mental health disorders into EIP’s multidisciplinary HIV services, thus helping clients receive treatment for both in one setting and ensuring that dual-diagnosis services are fully coordinated with every aspect of HIV care. Pathways counselors are licensed mental health professionals and are an integral part of the EIP multidisciplinary treatment team. EIP clients who have been diagnosed with one or more disorder(s) related to the use of alcohol or other drugs and/or one or more mental health disorder(s) are eligible for Pathways services. Pathways is funded with a combination of Ryan White Part B and State General Fund dollars.

Other OA Care Programs

Non-Ryan White Part B-Funds are made available through a variety of funding sources, such as State General Fund, CDC, HUD, and Medi-Cal (California’s Medicaid). These funds are allocated via the HIV Care Branch to LHJs, community clinics, and CBOs that provide HIV medical and supportive services throughout California. These non-Ryan White Part B-funded programs are closely linked with Ryan White Part B-funded programs. For instance, local Housing Opportunities for Persons with AIDS (HOPWA)

programs are usually coordinated with CSP to allow PLWH/A to obtain or remain in affordable housing while receiving support services and medical care.

Programs administered by the OA's HIV Care Branch that are not funded with Ryan White Part B funds include:

MCWP

MCWP provides services that allow persons with mid- to late-stage HIV/AIDS to remain in their homes through their continuum of care, stabilize and maintain an optimal level of health, improve quality of life, and provide an alternative to more expensive and non-community-based institutional care in hospitals or nursing facilities. The waiver's goals are to provide high-quality care, a broad range of services which are non-duplicative of other programs, and services which are targeted to the specific needs of each client. Emphasis is given to those populations which are institutionalized and/or disproportionately affected by HIV/AIDS. MCWP is administered in the CBC Section and works in close association with CMP, also administered within CBC. CMP is described in the Ryan White Part B-Funded Programs section, above.

HIV Therapeutic Monitoring Program (TMP)

TMP provides viral load and antiretroviral drug resistance laboratory tests for low-income, HIV-infected Californians who do not have other third-party coverage. The program utilizes a voucher-based system at approximately 131 service locations statewide in 37 California counties. To be eligible to utilize program vouchers, a client must be HIV infected, have no medical insurance or third-party coverage, not be Medi-Cal eligible, and have an annual federal adjusted gross income below \$50,000. Viral load testing is used by clinicians to monitor indications to initiate or response to antiretroviral therapy. Resistance testing (genotypic and phenotypic) measures the degree to which an individual's HIV has become resistant, or less sensitive, to antiretroviral drugs. The program is funded 100 percent with State General Fund dollars.

California Statewide Treatment Education Program (CSTEP)

CSTEP was established to provide comprehensive treatment education training, certification, and periodic recertification to HIV service providers. CSTEP training is intended to reduce the documented disparities in access to medical care in communities of color, and to improve adherence to optimum HIV treatments in line with medical research developments. CSTEP training is offered to HIV service providers on four levels and includes topics such as: introduction to the field of HIV care, sexually transmitted diseases (STDs), wellness education and principles, how HIV is transmitted, available treatments, what treatment side effects can be anticipated, the importance of patient adherence, how to enroll clients in investigational new drug trials, how to develop client treatment plans, how to support clients through group sessions and other means of support, new and emerging HIV treatment issues, and medical developments. CSTEP training, certification, and recertification is offered in both English and Spanish.

HOPWA

HOPWA provides housing assistance designed to alleviate or prevent homelessness for PLWH/A and to improve access to HIV/AIDS care, treatment, and support. OA receives a HOPWA grant annually through HUD. On an annual basis, OA allocates HOPWA funds to counties outside the HUD Eligible Metropolitan Statistical Areas through a formula process. The funds are used for short-term emergency rent, mortgage, and utility payments to prevent homelessness as well as tenant-based or project-based rental assistance, facility operating costs, housing information, permanent housing placement assistance, and support services. A portion of the funds have been used for the development of housing units.

Residential AIDS Licensed Facilities (RALF) Program

The intent of the RALF Program is to address the ongoing operational subsidy needs of residential facilities currently licensed as Residential Care Facilities for the Chronically Ill (RCFCI). These RCFCIs provide a high level of residential care for PLWH/A. RALF funds provide an added emphasis on serving persons with HIV who are homeless or are in jeopardy of homelessness.

Coordination with Other Ryan White Programs

Part A-Funded Regions

California's three EMAs are Los Angeles, San Francisco, and San Diego. The six TGAs are Orange, San Bernardino/Riverside, Sacramento, Santa Clara, Sonoma, and Alameda/Contra Costa. OA continues to work with the three EMAs and six TGAs to coordinate Parts A and B and other state-funded programs. Part B funding is provided to Part A areas through ADAP, CSP, CMP, EIP, Bridge Project, Positive Changes, Pathways, and CARE/HIPP programs. OA will continue to coordinate with EMAs by appointing OA management and health specialist staff as voting members on all Part A Planning Councils and requiring that CMP projects located in Part A areas participate on Part A planning bodies in order to be fully aware of Part A-specific resources available to their clients in those communities. Additionally, Part A fiscal agents and service providers actively participate on OA planning groups convened to help address statewide fiscal and policy issues.

Parts C and D

OA continues to have numerous state-funded EIP sites and CMP/MCWP projects co-located with Part C sites. Parts C and D sites very often receive Part B funding. These jointly funded Part C funded grantees provide a broad spectrum of coordinated care and services to a greater number of persons living with HIV (PLWH). Additionally, representatives from Part C and D grantees participate in the local planning groups in

the development of integrated planning documents through CSP and are well-represented in the SCSN process.

Listed below are the Part C Recipients in California and the OA-funded programs that are co-located in these Part C agencies or health departments:

<u>Name of Agency</u>	<u>LHJ</u>	<u>CSP / CMP / MCWP/ EIP</u>			
Contra Costa County Health Services Dept	Contra Costa	x	x	x	x
Del Norte Clinics, Inc	Butte	x			
Fresno Community Hospital and Medical Center DBA University Medical Center	Fresno	x	x	x	
Open Door Community Health Centers	Humboldt	x			
Clinica Sierra Vista	Kern	x			
AltaMed Health Services Corporation	Los Angeles	x	x	x	
Catholic Healthcare West/St. Mary Medical Center	Los Angeles	x	x	x	
Charles R. Drew University of Medicine and Science	Los Angeles	x	x		x
Tarzana Treatment Centers, Inc	Los Angeles	x	x	x	
Northeast Valley Health Corporation	Los Angeles	x			
Mendocino Community Health Clinic, Inc.	Mendocino	x			
Natividad Medical Center	Monterey	x	x	x	x
Orange County Health Care Department	Orange	x			x
Plumas County Public Health Agency	Plumas	x	x		x
San Bernardino County Public Health Dept	San Bernardino	x			x
Center for AIDS Research Education and Services	Sacramento	x			x
North County Health Services	San Diego	x	x		
University of California, San Diego	San Diego				x
Santa Barbara County Health Department	Santa Barbara	x			x
Santa Clara County Health Department	Santa Clara	x			x
Santa Cruz County Health Services Agency	Santa Cruz	x	x	x	x
Solano County Health and Social Services	Solano	x	x	x	
Sonoma County Health Services Department	Sonoma	x			x
Ventura County Health Department	Ventura	x	x	x	x

Pacific AIDS Education Training Center (PAETC)

OA has collaborative working relationships with 11 AIDS Education Training Center (AETC) Local Performance Sites (LPS) throughout California. In addition, OA contracts directly with PAETC at the University of California, San Francisco to provide medical consultation, training, information, and referrals for OA and both OA-funded and non-OA-funded HIV service providers.

OA funds PAETC to provide information and consultation to physicians and health care providers through an HIV Warmline. The Warmline, via a widely publicized toll-free number, offers up-to-the-minute HIV clinical information and individualized expert consultation across the broad range of clinical HIV/AIDS problems. The Warmline is staffed by a multidisciplinary team of physicians and other clinicians who are experienced in HIV care and treatment. They help to provide the best possible care for HIV-positive patients. The Warmline includes HIV Resistance Testing Consultation and support for HIV/AIDS clinicians. This is a free service for clinicians who have patient-specific questions about antiretroviral therapy and resistance testing.

PAETC assists the HIV Care Branch and ADAP Section with medical policies and procedures, implementation of staff in-service training plans and medical treatment updates and assists OA's quality management efforts by providing expert guidance in the development, collection, analysis, and interpretation of medical indicators. In addition, through a special program called Chart Review and Targeted Education Project, PAETC physicians provide assistance with chart reviews at local clinics and identify and gaps or opportunities for improvement. Local AETC LPS staff then follow up, if necessary, by providing targeted technical assistance and training to local clinic or program staff.

Coordination with HIV Prevention Services

OA values the continued coordination, collaboration, and co-location of local, state, and federally funded care, treatment, and support services with prevention services. The coordination of efforts is focused primarily, but not exclusively, on: 1) linking newly diagnosed HIV-infected individuals immediately into care; 2) identifying individuals or populations who are HIV positive but not in care and engaging or re-engaging them in care; 3) prevention programs/strategies for HIV-infected persons; 4) Partner Counseling and Referral Services (PCRS), now known as Partner Services (PS); and 5) integrated and/or complementary state and local planning for recipients of state, CDC, and/or HRSA funding for HIV.

The state has created and implemented policy over the years to enhance and support integration and coordination efforts. HIV Care Consortia in the nine EMAs and TGAs in California have been melded into the existing planning councils to provide an integrated approach to service delivery planning. Additionally, the state has transitioned the HIV Care Consortia model in non-EMA/TGA counties as an approach to achieving a more inclusive and comprehensive planning model that includes the local HIV prevention

planning groups (i.e., prevention's local implementation groups). Local care planning groups are structured to support inclusiveness, and are charged with developing local comprehensive planning documents that address the needs of persons with HIV/AIDS, including those not in care, and developing an integrated approach to the delivery of HIV care and prevention services. The inclusion of local agencies and CBOs that represent the mentally ill, homeless, the formerly incarcerated population, substance abusers, etc., will foster a coordinated continuum of care and prevention interventions and services available through a multitude of funding sources and agencies in all communities.

Other examples of integrated care/prevention efforts include the following:

- Since 1987, EIP has provided clients with multidisciplinary care and prevention services. All EIP sites coordinate their services with Part A- and/or B-funded services, and many are also Ryan White Part C recipients. All sites also coordinate with CDC-funded prevention services, and EIP receives CDC funding at the state level. Since its inception, EIP has been mandated to provide HIV transmission risk assessments and prevention interventions for its HIV-infected clients and, when applicable, their at-risk partners within the clinical care setting.
- In 19 EIP sites, Positive Changes (formerly known as the HIV Transmission Prevention Project), a "prevention with positives" program that provides individual, intensive HIV transmission prevention interventions for HIV-infected persons that have been assessed as being at very high risk for transmitting HIV within the clinical care setting. Data from Positive Changes has been demonstrated to show sustained behavior change and cost effectiveness.⁵
- The Bridge Project, targeted for communities of color, prevents HIV transmission in communities of color that are disproportionately affected by HIV by increasing the numbers of HIV-infected persons successfully engaged in HIV care, treatment, and prevention services. Bridge workers focus on out-of-care and lost-to-care individuals and use street outreach techniques to facilitate entry and engagement into care.
- The HIV Education and Prevention Services Branch, in collaboration with the HIV Care Branch, OA Joint Task Force on Prevention for Positives, and the statewide California HIV Planning Group (CHPG) helped California counties implement up to a 25 percent redirection of HIV prevention funding to prevention for positives. The HIV Care Branch and HIV Education and Prevention Services Branch staff and its contractors continue to provide technical assistance and training to LHJs and CBOs about prevention for positives models that are currently being implemented and that have demonstrated effectiveness. These trainings also encourage collaboration between the HIV prevention and HIV care providers at the county and agency levels.
- The OA Joint Task Force on Prevention for Positives, in collaboration with CHPG, also produced the California OA Guidelines for Prevention for Positives, first published in April 2004. The guide was updated and revised in October 2006 and is currently under revision.

- The HIV Care Branch partners with the HIV Education and Prevention Services Branch in overseeing the CHPG statewide planning group. Specific focus points have included coordination of state planning efforts, care and treatment strategies for targeted populations, and development of population-based care, treatment, support, prevention strategies, and interventions.
- CSP of the HIV Care Branch is actively collaborating with the HIV Education and Prevention Services Branch to integrate and/or coordinate the local planning activities for HRSA and CDC-funded services.
- The care and prevention branches are also collaborating to integrate disclosure support for HIV-infected persons, disclosure training for HIV providers, and PS into HIV care and treatment services throughout the state. The HIV Education and Prevention Services Branch, via the California HIV/STD Prevention Training Center, provides training on disclosure and PS for both prevention and care service providers.

HIV disclosure counseling, partner elicitation, partner notification, and follow-up services are offered to HIV-infected persons throughout the continuum of care with prioritization of both the newly diagnosed and clients in HIV care settings such as EIP or CMP. State and local partners work as a team to implement PS, follow up with other PS, and, when requested, conduct anonymous partner notification.

- The CBC Section has revised its CMP protocols to require that nurses and social workers consistently discuss prevention efforts with all clients. In addition, the CBC Section included the provision of prevention services for all CMP clients as part of their program funding processes.

Integration and Coordination within CDPH

CDPH Integration Project

CDPH has undertaken a process to integrate client services delivered by coordinated programs at state, local, and service agency levels. In California this effort, originally framed by CDC in 2007, has included a monthly meeting of a group comprised of representatives from all related programs within CDPH/CID, including OA, Viral Hepatitis (VH), Tuberculosis (TB) Control Branch, Immunization Branch, and Sexually Transmitted Disease (STD) Control Branch. Representatives from LHJs have been included in parts of this process. The 2008 Integration Objectives for all programs include:

- Improving data systems to inform programs;
- Enhancing prevention interventions;
- Addressing and responding to racial disparities; and
- Strengthening workforce capacity and program infrastructure.

Anticipated long-term benefits of this ongoing process of service integration are better access to care; improved quality of care; more streamlined care; better control of infectious disease; more cross-trained, knowledgeable staff; and programmatic and fiscal efficiencies.

In addition to these broad CDPH integration efforts, OA continues to collaborate on specific projects within CDPH, including:

TB Control Branch

OA collaborates with CDPH/TB Control Branch to develop and sustain coordinated TB and HIV/AIDS policies at state and local levels. Of importance is the coordination of policies with agencies administering programs for people at high risk for TB and HIV/AIDS, including substance abuse treatment programs and correctional facilities. The TB Control Branch provides TB prevention guidelines to HIV service agencies and HIV residential facilities, and OA provides technical assistance on HIV counseling and testing for TB patients statewide.

STD Control Branch

OA's HIV Education and Prevention Services Branch and HIV Care Branch and CDPH/STD Control Branch have collaborated to provide CDC-funded PS activities in California. These activities are made available via a venue- or provider-based model, including settings such as counseling and test sites, HIV education and prevention service sites, STD clinics, EIP clinics, and via CMP. The STD Control Branch provides a two-day training entitled: HIV Disclosure and PS that is geared towards any provider who works with PLWH. They also provide technical assistance to support local HIV programs to establish an HIV PS program.

CDPH's HIV/STD Prevention Training Center offers a related course, Supporting Self Disclosure of HIV Status, for HIV care providers statewide. This disclosure training was developed by the STD/HIV Prevention Training Center as the result of a need identified by OA's HIV Care Branch for care providers to develop the skills necessary to guide and support all client disclosure efforts, including disclosing to friends, family members, employers, and/or potential sexual or needle-sharing partners.

VH Program

OA staff participated in a recent initial State Viral Hepatitis Strategic Planning meeting where the framework for a state plan was redeveloped. These same staff members agreed to participate on advancing specific initiatives as part of the Strategic Plan. The state VH coordinator and OA chiefs meet and collaborate monthly at CDPH integration meetings.

Training on VH has been provided by the state VH coordinator for local program staff and OA staff at annual regional and state-wide conferences. Compliance with program screening standards is monitored during program site visits in both EIP and CMP/MCWP. Programs within the HIV Care Branch currently integrate hepatitis testing and, when appropriate, immunization into HIV care and treatment services.

Coordination with other California Departments

As designated in California Health and Safety Code Section 131019, OA has lead responsibility for coordinating state programs, services and activities related to HIV/AIDS. OA is responsible for envisioning and coordinating a cross-departmental response to the HIV/AIDS epidemic that operates at the individual level through health care services and at the population level through public health functions. A number of other state departments and offices provide, or supplement, care, treatment, support, and/or prevention activities related to HIV/AIDS, including the following:

Department of Health Care Services (DHCS)

Senate Bill 162 established a CDPH within the existing California Health and Human Services Agency and statutorily transferred certain responsibilities from the former California Department of Health Services (CDHS) to the new CDPH, effective July 1, 2007. At the same time, CDHS was renamed DHCS. DHCS serves as the Medicaid single state agency in exercising administrative authority over the HIV/AIDS waiver and serves as the primary liaison with the Federal Center for Medicare and Medicaid Services. CDPH operates and administers the HIV/AIDS waiver under DHCS monitoring, oversight, and administrative discretion, and according to federal and state statutes and regulations, the HIV/AIDS waiver, and an Interagency Agreement.

Department of Alcohol and Drug Programs (ADP)

Federal law requires that 5 percent of the total award under the Substance Abuse Prevention and Treatment (SAPT) Block Grant be expended on HIV early intervention services. These funds are utilized to provide early intervention, testing, and counseling services for clients in drug treatment programs. ADP administers this program by contracting with counties, and has defined the use of these funds as “those activities involved in the prevention and delay of the progression of HIV by encouraging HIV counseling, testing, and assessment of the progression of the disease and the provision of prophylactic and anti-viral prescription drugs.” SAPT HIV is allocated to counties on a needs-based methodology. Counties are required to develop plans for spending their allocation and must comply with ADP guidelines. Typically, counties provide a wide range of services, including pre- and post-test counseling and referrals for related medical and social services.

In selected counties, OA provides support services for the ADP HIV testing program for persons enrolled in alcohol and other drug (AOD) treatment programs. These services

include training ADP counselors to conduct risk assessment and disclosure sessions for in-treatment clients.

OA and ADP have developed a working relationship through active participation on planning and advisory bodies and through collaboration on initiatives such as syringe exchange and methamphetamine prevention. OA and ADP are planning to meet to formulate approaches for better utilizing the HIV set-aside funding to provide for a more appropriately targeted delivery of services.

Additionally, the local planning component of CSP requires local fiscal agents to prepare local comprehensive service delivery plans, and stresses the importance of consulting with HIV and non-HIV service agencies. Local planning groups are mandated to create linkages with county AOD departments, as well as treatment sites and other CBOs that target the substance-using population. The creation of linkages between state departments, local government, HIV service agencies, AOD offices, and treatment sites is fundamental to providing effective services and can be especially helpful when serving the HIV-positive injection drug using population. OA's strategy is to continue creating and strengthening these linkages through providing technical assistance, and creating opportunities for departments to focus on issues in a collaborative manner.

Finally, ADP has an appointed representative on CHPG, which advises OA. This representative assists in identifying issues and programs on which ADP and OA can collaborate.

Department of Housing and Community Development (DHCD)

In accordance with Title 24, Code of Federal Regulations, Part 91, HOPWA, the Emergency Shelter Grant Program, Community Development Block Grant Program, the HOME Investments Partnership Program, and the Lead Hazard Control Program must submit a Consolidated Annual Plan and a Consolidated Annual Performance and Evaluation Report (CAPER) to HUD each year. DHCD is the lead agency for preparing the Annual Plan and CAPER for submittal to HUD. OA coordinates with DHCD to ensure HOPWA Program and HIV/AIDS housing need information is included in the Consolidated Plan and CAPER. Additionally, OA has been successful in recruiting housing specialists from DHCD to work at OA on HIV housing programs, policy development, and in providing technical assistance.

California Department of Corrections and Rehabilitation (CDCR)

OA has established a Corrections Working Group which meets monthly to further communication and coordination efforts with CDCR. The CDCR Parole and Community Services Division now participates in these meetings with OA staff in order to facilitate the provision of services to HIV-infected inmates as they are discharged back to their home communities. The CDCR Transitional Case Management Program (TCMP) develops pre-release social services and health care case management and treatment

plans for inmates, and OA is working with CDCR and TCMP contractors to ensure that inmates are connected with EIP clinics and other HIV service providers at the earliest opportunity.

The Corrections Working Group also reviews current and ongoing research on incarcerated populations, examines how existing OA and CDCR databases can be utilized to inform service delivery for inmates while incarcerated and post-release, and designs and implements new research proposals. At the current time, a member of the Corrections Working Group serves as the lead investigator for the CDCR-OA Prisoner Condom Access Pilot Program (authorized by California law) which permits a non-profit or health agency to provide “sexual barrier protection devices” to state prisoners. This pilot program is now being implemented within the Solano State Prison, with wall-mounted dispensing machines used for condom distribution.

California Department of Education (CDE)

CDE also has an appointed representative on CHPG. One of the key roles performed by this liaison staff person is to identify areas where OA and CDE can coordinate and collaborate.

The Adolescent Sexual Health Working Group (ASHWG), operating under the California Adolescent Health Cooperative, is one such collaborative effort. Together, OA, CDE, the Office of Family Planning, the Maternal and Child Health Branch and key non-governmental agencies have joined to develop a set of core competencies for adolescent sexual and reproductive health education. These core competencies have been published on the California Teen Health Web site and are intended to facilitate consistent health outcomes for adolescents receiving such education or services. They do not constitute a training curriculum but rather serve as a set of guidelines to improve the consistency and continuity of information used by those in the field. An intended outcome is a reduction in the transmission of STDs, as well as HIV. The core competencies for adolescent sexual and reproductive health can be found on the California Teen Health Web site: www.californiateenhealth.org.

ASHWG also identified the absence of a common format in data reported by HIV, STD, and teen pregnancy prevention programs as a barrier to a successful integrated approach to HIV, STD, and teen pregnancy prevention. To establish a common format, ASHWG formed a data integration subcommittee. The intended outcome is strengthened communication and increased collaboration among prevention programs.

Interagency Workgroup

OA Chief, Michelle Roland, MD, chairs an interagency work group that is advisory to the Visioning Change Initiative (VCI), a project of AIDS Partnership California (APC) and California HIV/AIDS Research Program (CHRP). For more information on VCI, see the Other Opportunities to Enhance Communication, Coordination, and Collaboration section, below.

The Interagency Workgroup provides a structure to facilitate statewide communication, coordination, planning, and mutual decision-making regarding critical and emerging issues in HIV-related prevention, care, and support services.

Current work group tasks are: 1) reviewing and advising a project that is mapping HIV funding and services; and 2) furthering the development of communication, collaboration, and coordination across California state agencies. In addition to OA, the participant list includes:

- DHCS;
- ADP;
- CDPH's Division of Communicable Disease Control, Office of Women's Health, Office of Family Planning, and Office of Multicultural Health;
- CDCR;
- Department of Mental Health;
- Department of Managed Health Care;
- Department of Social Services;
- CDE;
- Office of Patient Advocate;
- Office of Statewide Health Planning and Development;
- DHCD;
- Department of Aging; and
- Employment Development Department.

Coordination with Other Federal Programs

Gathering and disseminating information regarding other federal programs and providing this information to our partners in the form of technical assistance is supported by OA. Focus groups and other information-gathering processes revealed a gap between CARE-funded programs and the variety of other federally funded clinics, particularly in the rural regions of California. CSP is working with HRSA staff to educate, provide technical assistance, and disseminate information regarding Federally Qualified Health Centers such as community health centers, migrant health clinics, health care for the homeless programs, and other federally funded programs.

Additionally, to support the creation of linkages among these agencies, CSP has developed relationships with community organizations that directly or indirectly serve or have contact with HIV-infected and -affected populations. This includes federal, state, and local agencies, as well as community-based and faith-based organizations that would likely have contact with individuals who are infected but not receiving care, or are unaware of their HIV status.

Other Opportunities to Enhance Communication, Coordination, and Collaboration,

OA is fortunate to have the opportunity to work with and support many organizations and projects dedicated to ending the suffering caused by HIV. These include:

California Conference of Local AIDS Directors (CCLAD)

CCLAD's vision is: A California Free of HIV. Their mission is to improve the quality and scope of health programs for HIV prevention and HIV-positive persons by promoting standards of excellence throughout the state of California. CCLAD, in partnership with OA, achieves this mission by providing input and support in the development of sound HIV/AIDS policy, by enhancing partnerships with the California Conference of Local Health Officers (CCLHO); and by creating bridges between LHJs, state wide coalitions, CBOs, and other affiliate organizations.

CCLHO

The membership of CCLHO includes the 61 legally appointed physician health officers in California, one from each of the 58 counties and the three cities of Berkeley, Long Beach, and Pasadena. CCLHO provides a state/local forum for the discussion of significant health issues in order to develop recommendations for appropriate health policy. This includes legislative and regulatory review. CCLHO meets semiannually and its Board of Directors meets monthly. Its various program committees consider technical and policy issues in communicable disease control and prevention; health promotion and chronic disease prevention; environmental health; emergency, disaster and terrorism preparedness; and health surveillance and data. The Communicable Disease sub-committee, on which OA actively participates, meets monthly.

National Alliance of State and Territorial AIDS Directors (NASTAD)

NASTAD represents the nation's state health agency directors who have programmatic responsibility for administering HIV/AIDS health care, prevention, education, and supportive service programs funded by state and federal governments. NASTAD is dedicated to reducing the incidence of HIV/AIDS infection in the United States and its territories, providing comprehensive, compassionate, and high-quality care to all PLWH/As, and ensuring responsible public policies. NASTAD provides national leadership to achieve these goals, and to educate about, and advocate for, the necessary federal funding to achieve them. NASTAD also promotes communication between state and local health departments and HIV/AIDS care, support, and treatment programs. NASTAD supports and encourages the use of applied scientific knowledge and input from affected communities to guide the development of effective policies and programs. NASTAD strengthens state and territory-based leadership, expertise, and advocacy and brings them to bear in reducing the incidence of HIV infection and in providing care and support to all who live with HIV/AIDS. NASTAD's vision is a world free of HIV/AIDS.

Dr. Roland is a member of the NASTAD Executive Committee and Peg Taylor, Chief of the HIV Care Branch, is a member of NASTAD's newly formed Care Advisory Committee (CAC). CAC will include a diverse representation of Part B programs across the nation and assist NASTAD in improving communications with HRSA's HIV/AIDS Bureau (HAB).

NASTAD's African American Advisory Committee, comprised of African American AIDS directors and senior African American HIV program staff, assists NASTAD's staff in developing activities and initiatives in African American communities aimed at reducing rates of HIV/AIDS and increasing access to care for those living with HIV/AIDS. Clarissa Poole-Simms, CARE Section Chief, is a member of this committee. The committee is developing the plan to address the strategies listed ensuring that the mission of the NASTAD AAAC, which is to maintain an integral leadership role in fighting the HIV/AIDS and viral hepatitis epidemics among African Americans in the United States, is implemented nationwide.

CHRP

CHRP, formerly known as Universitywide AIDS Research Program, was established by the University of California in 1983 at the request of the state Legislature. It provides funding for scientific research on AIDS at the university, funds innovative basic, clinical, social, behavioral, and policy research, and provides scientific leadership by convening California stakeholders from diverse backgrounds with expertise in ending the human suffering caused by HIV disease. CHRP's collaborations with OA include OA's Clinical Quality Management Program and the development of the AIDS Regional Information and Evaluation System (ARIES), a comprehensive data system containing demographic, behavioral, clinical and service utilization data.

Dr. Roland serves as a member of the CHRP Advisory Council. As a result of a two-year collaborative planning process, the Advisory Council and representative program staff developed a Strategic Plan which was the driving force behind the new Call for Applications released in September 2008. New award types in the Call for Applications reflect input from stakeholders that CHRP grant funds need to be strategically targeted to have a greater impact in areas where there is a critical need for research in California.

VCI

Established in 2007, VCI is a statewide leadership group, composed of invited representatives from state and local health agencies, consumers, community organizations, research institutions, funders, and other stakeholders, that works to build statewide consensus on developing strategies and policies to ensure ongoing and improved integrated prevention and care services for HIV/AIDS in a context of growing demand and shrinking resources. VCI grew out of an earlier three-year project called "Managing Scarcity." Managing Scarcity was initiated by APC, a public/private collaboration whose purpose is to arrest the escalating rate of HIV in California, inform

sound policy decisions, and strengthen the systems of HIV prevention and care and treatment.

Managing Scarcity played a part in supporting California's role in the Federal Ryan White Care Act Reauthorization process in 2007. As a result of this process, the need to make a continuing commitment to visioning new policies and strategies to meet the state needs was identified. VCI will help to fill this identified need for a continuing, high-level statewide planning process that can enhance statewide HIV planning and decision-making, shape new local and statewide responses to the epidemic, increase planning and coordination with non-HIV-specific entities, and expand and enhance California's national HIV leadership role. The goal of VCI is to create a more sustainable, effective, integrated and responsive HIV health care, prevention and support system for people living with, or at risk for, HIV in California.

Visioning Change receives support from private and public funders including the Evelyn and Walter Hass, Jr. Fund, Sutter Health, and OA. Current activities include the development of a statewide consensus statement/response to federal policy proposals that may be put forth to reauthorize or replace the Ryan White Care Act in 2009 and to develop new integrated models of prevention and care for HIV that maximize services for Californians at risk for infection, or already infected with HIV. Dr. Roland is the state liaison to VCI and in this role leads an interagency work group on HIV/AIDS prevention, care, and support systems. This work group is described above in the section, Interagency Workgroup.

Prevention Think Tank

On May 13 and 14, 2008, OA hosted an initial Prevention Think Tank meeting. Invited stakeholders included: CHRP; San Francisco AIDS Foundation; Center for HIV Prevention and Care; CDC; National Center for HIV, Hepatitis, STD and TB Prevention; University of California, Los Angeles Program in Global Health; California STD/HIV Prevention Training Center; AIDS National Institutes of Mental Health; San Francisco General Hospital; Los Angeles County Department of Public Health; Center for Community Health NPI Semel Institute for Neuroscience; University of California, San Diego, Antiviral Research Center; Center for AIDS Prevention Studies; East Bay AIDS Center; Los Angeles Gay and Lesbian Center; and Alameda County Medical Center.

The purpose of the Prevention Think Tank was to consider whether the evidence to support several HIV prevention strategies for which there are CDC's guidelines or ongoing studies is compelling enough to warrant scale up at the local level in California. For each intervention, participants discussed successful implementation efforts, barriers to implementation, and suggestions for how to scale-up interventions in a coordinated and efficient manner. Finally, they considered how to evaluate the implementation and expansion of these programs as well as capacity building and technical assistance needs.

The topics that were addressed at the meeting include current OA-supported programs including Prevention with Positives, PS, and behavioral interventions (including diffuse effective behavior-based interventions) of which many have not yet reached their potential; new pilot efforts such as HIV screening in medical settings and acute HIV screening; and programs that have not yet been implemented through OA such as non-occupational post-exposure prophylaxis.

The process initiated by the Prevention Think Tank will continue through 2009. OA will continue active discussions within the office; may conduct focus groups and/or key informant interviews with representatives of local health departments, CBOs, clients, advocates, and academics as well as out advisory and other community input groups.

Rural Think Tank

California is made up of urban areas and thousands of square miles of areas that are considered rural in nature. The Rural Think Tank launched by OA, in collaboration with rural health jurisdictions and urban health jurisdictions that include rural areas, will consider successful programs and strategies for delivering services in the context of rural California, as well as barriers and obstacles, and suggest potential policy and program changes for OA.

This meeting will focus on three goals:

1. Identify policy and program changes for OA that are likely to facilitate appropriate and high-quality HIV surveillance, education and prevention, and care and treatment activities in rural LHJs and urban LHJs containing rural areas;
2. Facilitate access to relevant non-OA training, consultation and other resources; and
3. Facilitate collaboration within and between LHJs.

The initial meeting will have multiple, focused, concurrent break-out sessions with time for very succinct report backs and full-group discussion. Breakout topics include:

- Reducing OA administrative burden and increasing flexibility at LHJ level;
- Enhancing training and technical assistance and focusing training requirements;
- Maximizing prevention with minimal resources;
- Correctional issues;
- Enhancing specialty HIV/AIDS medical care;
- IDU, Non-IDU substance use, and hepatitis C virus (HCV); and
- Increasing appropriate HIV testing: in medical settings and testing partners and social networks of those in care.

Clinical Meeting

OA hosted a clinical meeting, Supporting California's HIV Care Needs: An Initial Meeting of Training, Consultation, and Professional Organization Partners. Participating organizations included: PAETC, California STD/HIV Prevention Training

Center, International AIDS Society-USA, the American Academy of HIV Medicine, HIV Medicine Association, Association of Nurses in AIDS Care, California Medical Association, CDCR, Veterans Affairs Administration, Kaiser Permanente, and CCLAD.

Discussion focused on three areas: 1) how OA can facilitate and support increased coordination and collaboration among partner groups to maximize the impact of our work to provide high-quality care and support to people with HIV through the state; 2) creating an Emergency Response Network for HIV care and support; and 3) other professional organizations with a focus on HIV care and/or clinical training and consultation in California (e.g., professional organizations representing HIV clinical pharmacists, family medicine, internal medicine, physician's assistants, etc.). Additional discussions will continue with expanded collaboration between training, consultation, and professional organization partners.

Telemedicine

OA is stepping up its focus on telemedicine and web-based avenues for medical consultation in order to provide rural area providers access to a broad range of technology-enhanced services to improve the quality of health care services. As one of several strategies to achieve this, OA will be exploring possible collaboration with the University of California, Davis, which is establishing a statewide broadband telehealth network aimed at improving the rural health care infrastructure throughout California. This project will connect more than 300 rural sites with each other and with a network of specialty providers at academic medical centers and other nonprofit and for-profit health providers statewide. Another possible strategy is to link Warmline inquiries with telemedicine or Web-based consultation opportunities.

U.S.-Mexico Border Health Initiatives

OA is working on several border health initiatives that include:

- **U.S.-Mexico Border Epidemiologic Profile:** OA in collaboration with NASTAD and other U.S. border states (Texas, Arkansas, and New Mexico) is working to develop an epidemiologic profile to increase our understanding of the burden of HIV/AIDS and modes of transmission in order to better plan for appropriate prevention and care interventions within this geographical region.
- **HIV/AIDS Behavioral Surveillance among MSM, IDUs, and Heterosexuals:** In collaboration with CDC, San Ysidro Health Center, and the MAAC Program, this study involves the development and implementation of a surveillance system to monitor behaviors that place people at risk for HIV infection in San Diego County. A comprehensive epidemiologic survey is utilized to assess risk and preventative behaviors and access to prevention services, HIV testing, counseling, and referral services.
- **San Diego Hospice and Palliative Care:** The primary objectives of this program are to assist clients in living an independent lifestyle; to decrease transmission of HIV through education/harm reduction techniques; to coordinate efficient use of

community resources; to foster continuity of services; to promote an understanding of HIV/AIDS process, and to maintain quality health care. Through community outreach and assessments, the program helps HIV-positive individuals gain comfort with accessing community resources and gain independence while improving their quality of life.

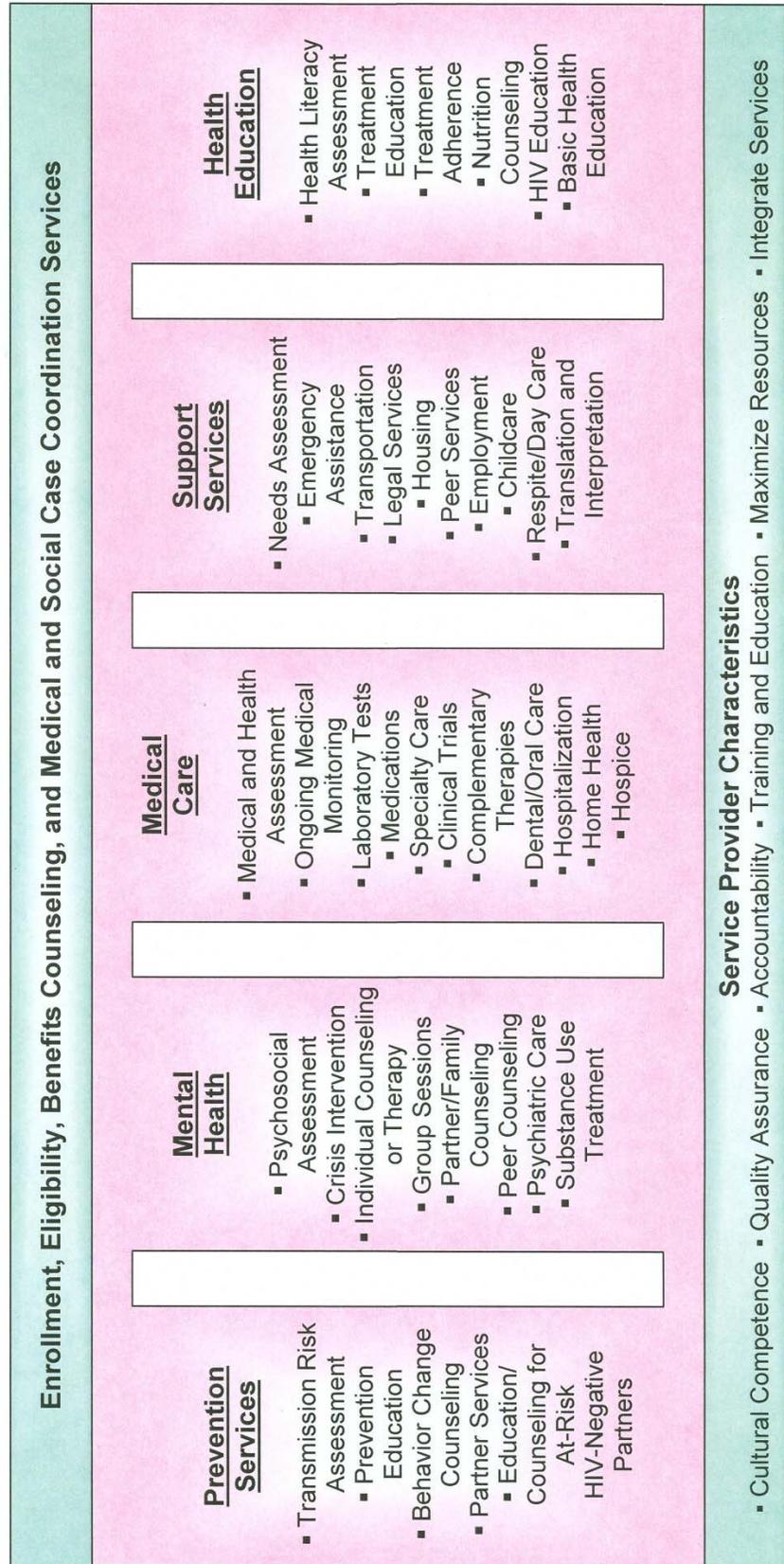
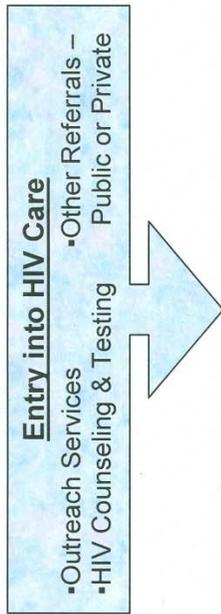
- Imperial County Public Health Department: This program aims to keep HIV/AIDS-diagnosed clients in care. To do so, Imperial County works closely with Programa Amigo, which is affiliated with the medical university, Universidad de Baja California in Mexicali. Program activities are comparable to those provided through the San Diego Hospice and Palliative Care Program noted above.
- Spanish Curriculum for HIV Counseling and Testing Workshops: In collaboration with Universidad de Baja California, this program aimed to fulfill the mutual goal of reducing HIV transmission on both sides of the border by providing our public health counterparts in Mexico with methodology and tools to provide effective prevention services, specifically HIV counselor training. In order to do so, the project team worked to replicate the California Basic 1 HIV test counselor training to ensure a high-quality and effective training consistent with the U.S. curriculum and to provide counselors with the tools required to offer and provide client-centered risk-reduction counseling and HIV antibody testing.

Spectrum of Care Services

The spectrum of California HIV/AIDS services includes a comprehensive array of care, treatment, support, and prevention services designed to enhance the quality and length of life for PLWH/A and to prevent or reduce HIV transmission. The array of HIV/AIDS services in California has not changed substantially since the 2003 Comprehensive Plan, but the spectrum of care services now puts a greater emphasis on transmission reduction and prevention with positives, treatment adherence, benefits counseling, and services to help PLWH/A adjust to lower levels of publicly funded assistance.

The chart on the following page, Spectrum of California HIV/AIDS Care, has been modified from the 2003 spectrum so that it is simpler and focused primarily on types of services. The interrelationship of the major service categories, whether funded by Part B or non-Part B sources, is shown, with the medical services category being central. Enrollment, eligibility, benefits counseling, and case coordination are shown as services that are related to all service categories. However, third party payors, such as ADAP, Medi-Cal, county indigent programs, and insurance continuation programs, to which these services are the essential portal, are not shown. Similarly, case coordination, whether medical or social, includes such programs as the CMP/MCWP or TCMP, but these specific types of case coordination are not shown. Referrals into care are also simplified and do not show the rich variety of sources, such as from private physicians, the correctional system, or as a result of partner notification services. In this way, the chart on the following page depicts, simply and directly, the range of the California HIV/AIDS service spectrum, and the interrelationships of those services.

Spectrum of California HIV/AIDS Care



California Resource Inventory and Profile of Ryan White Part B-Funded Providers by Service Category

California is home to 61 LHJs located in 58 counties. Funding for the full spectrum of HIV services is provided through numerous federal, state, local, and private agencies and has created an intricate network of HIV care, treatment, support, and prevention service providers throughout California. HIV service providers include community based organizations, county health departments, county and private hospitals, community clinics, private physicians and clinicians, housing agencies, mental health providers, substance abuse treatment sites, laboratories, and other supportive service agencies that target populations of PLWH/A as well as agencies that target the general population in need of services. Appendix 1 shows both an inventory of resources in California as well as a profile of providers, including those that are Part B-funded, by service category.

Assessment of Need

This section of the plan addresses a number of important topics related to the needs of individuals in and out of care and their access to care, including the following topics:

- Unmet need estimate;
- Need for primary care and other core services;
- Need for support services;
- Gaps in care; and
- Prevention needs.

The 2009 SCSN process was used to assess the overall needs of PLWH/A in California. Needs assessments and comprehensive plans from all regions of the state were analyzed, including the detailed needs assessments developed by the nine Part A-funded EMAs and TGAs in California that represent over 90 percent of PLWH/As in the state. Additionally, needs were identified with the assistance of CHPG, a summit of participants representing all titles of Care Act, consumers, and other persons representing underserved populations.

Unmet Need Estimate

OA estimated California's unmet need for HIV primary medical care, following the Unmet Need Framework guidance from HRSA. The Framework estimated that 44 percent of PLWA and 43 percent of PLWH, for a total of 43.5 percent of all PLWH/A, had an unmet need for HIV medical care.

An individual with AIDS or HIV (PLWH/non-AIDS and aware of HIV status) was considered to have an unmet need for HIV primary care medical when there was no evidence of any of the following three components of HIV primary medical care in a 12-month period (July 2006–June 2007): viral load testing, CD4 count, or antiretroviral

therapy. HRSA's Unmet Need Framework assumes that receipt of one or more of these three services represents met need for HIV primary medical care.

Each year OA develops the Statewide Estimate of Unmet Need, working in conjunction with California's nine EMAs and TGAs. This collaboration assists the Part A grantees in developing their local estimate of unmet need, and enables OA to refine its statewide estimate through access to local care data provided by the nine Part A grantees and other privately and publicly funded resources.

The focus on PLWH/A-positive individuals aware of their status but not in care has a legislative basis. The 2000 Amendments to the Ryan White Care Act required each Part A and B grantee (at that time, referred to as Title I and II) to:

- “determine the size and demographics of the population of individuals with HIV disease,” and
- “determine the needs of such populations, with particular attention to both individuals with HIV disease who know their HIV status are not receiving HIV-related services” and “disparities in access and services among affected subpopulations and historically underserved communities.”

To develop the statewide estimate of unmet need, OA used the following data sources and methodologies to estimate the population size and care patterns:

Population estimates: The AIDS population (63,006) is the number of reported cases of AIDS diagnosed through June 30, 2007, and reported into the AIDS surveillance system by September 30, 2008. The PLWH/non-AIDS/aware population (58,091) for California was estimated using information published by CDC as well as the limited information within named HIV data collected to date. Additional technical information on the estimation process is found in Appendix 2.

Care Pattern Data: Representatives of the state's nine Part A EMAs and TGAs participated in a statewide unmet need working group. OA took the lead in development of the data for the Part A and Part B estimates. OA created a matched data set using ADAP, ARIES, Medi-Cal (Medicaid), HARS, and Kaiser Permanente Northern California client information records. To ensure that no individual was counted more than once, the program data were merged into one data file. This was done using the client demographic variables date of birth and gender, and a soundex variable created from the individual's first and last name. Each data file was processed to identify care patterns for the one-year time period of July 1, 2006 through June 30, 2007. If an individual received HIV medical care as defined above, during this time period, the met need variable indicated a “YES.” Every Part A EMA/TGA then received region-specific data from this OA master data file. Each EMA/TGA matched with its local HARS data and other local provider data to develop its Part A unmet need estimate; upon completion each EMA/TGA sent back to OA an updated dataset with additional care information and also additional client records not found in the master data

file. This allowed OA to develop a more complete Part B estimate due to the EMAs/TGAs data inclusion of information from their local HARS and provider data files. OA was unable to obtain client-level data from the Federal Veteran's Administration (VA). Therefore, OA used the aggregate data provided on the VA Web site. The data are for calendar year 2003 and in order to separate PLWA and PLWH/non-AIDS/aware, OA applied the same proportion found for the linked and unduplicated data files.

The statewide estimate of unmet need for California (included in the 2009 HRSA Application) is shown in Table 1, below. However, due to the limitation of the data sources, primarily lack of data on HIV/AIDS clients receiving primary medical care from private insurance companies other than Kaiser Permanente Northern California and MediCare, the final unmet need percentages overestimate the number of AIDS and HIV-aware with unmet need in California.

Table 1: 2009 Unmet Need Framework

Population Sizes		Value		Data Source(s)
Row A	Number of PLWA, as of date June 30, 2007.	63,006		OA surveillance system.
Row B	Number of PLWH/non-AIDS/aware, as of June 30, 2007.	58,091		CDC national estimate adjusted for California.
Care Patterns		Value		Data Source(s)
Row C	Number of PLWA who received the specified HIV primary medical services during the 12-month period July 1, 2006 to June 30, 2007	35,214		HARS, Medi-Cal, ADAP, Kaiser Northern California, ARIES, and VA.
Row D	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical services during the 12-month period July 1, 2006 to June 30, 2007.	33,150		HARS, Medi-Cal, ADAP, Kaiser Northern California, ARIES, and VA.
Calculated Results		Value	Percent	Calculation
Row E	Number and percent of PLWA who did not receive specified HIV primary medical services.	27,792	44.1%	Value = Row A. - Row C., Percent =Row E. / Row A.
Row F	Number and percent of PLWH/non-AIDS/aware who did not receive specified HIV primary medical services.	24,941	42.9%	Value = Row B. - Row D., Percent =Row F./ Row B.
Row G	Total HIV-positive/aware not receiving specified HIV primary medical care services (quantified estimate of unmet need).	52,733	43.5%	Value = Row E. + Row F., Percent =Row G./ (Row A. + Row B.)

OA further analyzed the unmet need data, and estimated the percent of unmet need by gender and race/ethnicity. This analysis can be used to identify subpopulations with higher unmet need, allowing for the focusing of outreach activities and both supportive and medical care services. These data are shown in Table 2.

In general, while a focus should be on decreasing the percent of all subpopulations with unmet need, when examining the data within gender we see that males are less likely to be receiving care than females, with 47.9 percent of the male population in need of HIV medical care compared to 37.5 percent of the female HIV/AIDS population. The fact that men account for 89.9 percent of all positive individuals with unmet need emphasizes that in California the epidemic is still more prevalent among men than women. However, the lack of private insurance data probably overemphasizes the unmet need of the male subpopulation more than any other. When examining race/ethnicity, the percent of unmet need for Whites, African Americans, and Latinos are relatively similar (50.7, 49.5, and 48.4 percents, respectively). Again, the lack of additional private insurance data probably overemphasizes the percent of Whites with unmet need more than the other two groups.

Table 2: Estimate of Unmet Need and Subpopulation Analysis

	(a)	(a / 121,097)	(b)	(c)	(c / a)	(c / 56,381)
	PLWA and PLWH/non-AIDS	Percent of Total	Number with Met Need	Number with Unmet Need*	Percent of Population with Unmet Need*	Percent of Unmet Need
Total	121,097		64,716	56,381	46.6%	
PLWA	63,006	52.0%	33,997	29,009	46.0%	51.5%
PLWH/ non-AIDS	58,091	48.0%	30,719	27,372	47.1%	48.5%
Gender						
Male	105,880	87.4%	55,204	50,676	47.9%	89.9%
Female	15,217	12.6%	9,512	5,705	37.5%	10.1%
Race/ Ethnicity						
White	58,010	47.9%	28,587	29,423	50.7%	52.2%
African American	22,688	18.7%	11,454	11,234	49.5%	19.9%
Latino	34,993	28.9%	18,052	16,941	48.4%	30.0%

*VA numbers are not included in the subpopulation analysis; only aggregate VA data were available and thus could not be distributed by gender and race/ethnicity. The framework total for those receiving care is 3,648 higher than the number shown above for those with met need, and the percent of unmet need is higher in this table (46.6 percent compared to 43.5 percent) because of the absence of VA data.

Need for Primary Medical Care and Other Core Services

The service needs of PLWH/A were fully developed in the 2009 SCSN and therefore this document contains only a brief overview and summary of those needs. As part of needs assessment efforts, clients in most of the California EMAs and TGAs were asked to select the services that were “most important” to them and then, secondly, to identify their unmet needs (i.e., services they may have needed over a set period in the recent past but were unable to obtain or unable to obtain in sufficient amounts). This section summarizes the results related to the first category, the “most important” services as perceived by clients. A later section on “Gaps in Care” will briefly address current priorities in relationship to perceived service gaps (unmet client needs).

An overriding concern among California's HIV/AIDS service providers is to make certain that Ryan White Care Act services are available, accessible, and culturally and linguistically appropriate across all populations and service categories, and that they meet HRSA's goal of access to quality HIV care for all. This is both increasingly important and increasingly challenging as the population of Ryan White Care Act-supported individuals living with HIV/AIDS in California is more likely than in the past to be poor, homeless, or marginally housed, and multiply diagnosed. It is especially important to recognize that many EMAs in California are now working with reduced or inadequate funding levels, making it an increasing challenge to meet the needs of PLWH/A.

Needs of HIV/AIDS-Positive Persons in Care

The following discussion addresses the needs of PLWH/A who are enrolled in care and treatment. A later section will address the specific needs of individuals who are out of care.

By far the most critical life-extending services offered to PLWH/A are primary medical care and HIV medications. Primary medical care was identified by overall needs assessment respondents as the top priority service need in almost every EMA and TGA in California. In some rural areas there is a need for additional HIV medical specialists and physician training. Help in obtaining medications was a close second priority to primary medical care among PLWH/A, almost always appearing in the top three priorities as identified by clients. Other core services that commonly rated in the top five needs in recent needs assessments include case management and oral health care. The results for the majority of needs assessments done throughout California noted that these services were critical to PLWH/A and rarely provided by other publicly funded programs. Additionally, advanced or specialty dental care was also mentioned as a very important need by many survey respondents, focus group members, and providers. The Inland Empire TGA reports that 90 to 100 percent of PLWH/A need the following core services: primary medical care, AIDS drugs, dental care, and medical nutrition therapy.

In terms of support services, the services most commonly rated in the top five needs among clients include housing, transportation, financial assistance (especially with rent or utility payments), and food and nutrition-related needs. Housing, while almost always being rated below primary care and medications, was identified as a very critical need by many individuals. For example, the highest rated support service reported by the Inland Empire TGA was housing (72 percent of clients) and non-medical case management (63 percent). Housing in California tends to be extremely expensive, as are other basic needs such as food, transportation, and professional services (including medical and dental). In some areas of the state, low-cost housing is in short supply, which further drives up the cost for single occupancy hotel rooms and other living accommodations. Other non-core services that were mentioned in the top priorities by clients included assistance in obtaining health insurance and information and education on managing HIV disease. Interestingly, homeless individuals and young people tended to rate information and referral services as one of their top priority needs.

The top rated core medical service needs for communities of color were similar to the top priorities for all clients surveyed. Individuals identified medical care, HIV medications, dental care, and case management as their most critical needs. This same set of core services were typically identified by women of childbearing age and MSM, when data was separately analyzed. Women also identified the need for mental health counseling and home health services as other core services which they needed and utilized. African Americans rated food and nutrition-related services highly in several EMAs. African Americans identified a broad array of other needed core and support services including transportation, housing, dental care, and financial assistance. The Orange County TGA noted that African American clients in care tend to access supportive services such as food, housing, and transportation services at a significantly higher rate than other clients. The most critical support services identified by Latinos include benefits counseling, financial assistance (including payments for medications), transportation, and housing. Latino MSMs identified the need for more Spanish speaking services or services with interpretation and translation capacity as part of such services as primary medical care, dental services, mental health services, substance use services, legal assistance, employment assistance, as well as support groups. MSMs as well as women in Los Angeles included transportation and food in their top five service needs.

For inmates or recently incarcerated individuals, the top rated core services are somewhat different than for other groups. Survey results included a broader range of responses. Similar to other groups, medical care, dental care, and case management were highly rated needs. Not surprisingly, however, alcohol and drug treatment, mental health services, and specialty medical care were also highly rated core services. HIV medications were rated by this group to be in their top five service needs in only one EMA. Other highly rated support services included: housing (especially emergency housing), transportation, assistance with benefits and health insurance, as well as food and nutrition-related assistance. Emergency housing was identified as a very high priority for these individuals. The services that were rated in the top five support

services were very similar for substance users as for inmates or recently incarcerated individuals.

California faces both the promises and the challenges of a population of PLWH/A who are living longer. While this is a very welcome challenge, it puts added pressure on the system of care to adapt to meet the needs of an aging population of long-term survivors. Some clients need care for age-related diseases. Needs assessment results show that special support services, such as mental health counseling, housing (including long-term residential care); and social opportunities designed for older adults are important to this population. EMAs report that PLWH/A with improved health are looking for education, jobs, training, volunteer work, and sometimes new career paths. It is important to help them reduce their reliance on the public health care system, and to ensure that they maintain or improve their benefits and income in the process. PLWH/A are also thinking about having children, going back to school, or making other important life changes. The system of care must be able to help people transition to appropriate Ryan White Care Act-funded services when no longer needed, just as it helps people access care.

As the epidemic changes, one of the factors identified by providers throughout the state is the need to address co-morbidities related to HIV/AIDS. California faces large and sometimes expanding numbers of cases for many of the co-morbidities related to HIV/AIDS, a situation that will exacerbate the challenges of bringing new individuals into care as well as the ongoing care and treatment for those already in care. Addressing the needs of PLWH/A includes simultaneously addressing these other serious and complex needs for treatment of substance use problems, other STDs, TB, and HCV infection.

According to ADP, methamphetamine is now the most commonly reported primary drug problem in California, surpassing alcohol and heroin.⁶ The percentage of Hispanic clients and young MSM with a primary methamphetamine problem has steadily increased in recent years.⁷ California also has a large immigrant population and is one of seven states with the highest prevalence of tuberculosis. According to CDC, HIV contributes to the TB pandemic because “immune suppression increases the likelihood of rapid progression from TB infection to TB disease.”⁸ The prevalence of STDs in California is also on the rise, indicating high-risk behaviors that may translate into more HIV cases. The rates per 100,000 population have increased for most STDs between 2002 and 2006; up 29.4 percent for gonorrhea, 63 percent for primary and secondary syphilis, 20.9 percent for latent syphilis, and 3.9 percent for Chlamydia.⁹ There are an estimated 500,000 to 600,000 Californians currently infected with HCV with an estimated 5,000 new infections annually.

Needs of HIV/AIDS-Positive Persons Out of Care

The most recent results show that there are an estimated 121,047 PLWH/A (who are aware of their status) in California. Of those, 68,364, or 56 percent are in primary medical care, as measured using the criteria established by HRSA (i.e., receipt of one

or more of the following three components of HIV primary medical care in a 12-month period: viral load testing, CD4 count, or antiretroviral therapy). That leaves 52,733 out of care, or 44 percent for the state. Approximately one-half of these are PLWA and one-half living with HIV (non-AIDS).

Approximately one-half of the out-of-care populations in California are those from communities of color, especially Latino and African American individuals (Table 2). These findings suggest a need for more efforts focused on bringing all HIV-positive individuals, including historically underserved populations into care in order to prevent disease progression, improve health outcomes, reduce disparities, and prevent further transmissions.

Out-of-care individuals need the full spectrum of services. One study, conducted in the Sacramento TGA, asked individuals to rank order their service needs. The top five (from first to fifth priority) were nutrition, transportation, medications, specialty medical care, and housing. The most significant perceived gaps in service for these individuals were food, dental care, help with holistic or alternative therapies, vision care, and housing.¹⁰ Food/nutrition and housing services were priority needs but perceived to be unavailable or not available in sufficient amounts. The other priority needs were generally perceived to be available in the current system of care. The San Diego EMA found that the greatest service gaps for out-of-care individuals were medical care, dental care, housing, transportation, psychiatric medications, and HIV medications.¹¹

Women often prioritize the needs of their families over their own and family responsibilities can prevent HIV-positive women who know their status from getting care. Support services, such as stable housing, transportation, and childcare, are especially important for this group of individuals. Similarly, some active substance users and/or recently incarcerated individuals who know their HIV status prioritize basic needs such as housing and food over medical care.

Gaps in Care

An examination of services that are available and provided in California combined with an understanding of the changing demographics of the epidemic now allows for state health planners to focus on gaps in the service delivery system for HIV/AIDS clients. This section describes gaps in services for PLWH/A in California as described by state partners, such as EMAs, TGAs, and others familiar with service availability. Gaps are missing or inadequate services, and are experienced by those who are not in primary medical care for their HIV, those who are not accessing any services at all, and those living with HIV who are getting most but not all of their needs met.

Increased resources could address nearly all of the service gaps that will be identified, but the fact that they have not yet been addressed speaks to the unavailability of the very resources needed. Reduced funding resulting from the economic downturn has eroded local and state budgets. Services that PLWH/A need in many aspects of their lives have been cut and the stress on other services continues to evolve. Among these

are support for health care and substance abuse treatment, public transit, housing, employment, and public benefits.

The most frequently identified gaps are for housing (including housing information and temporary or transitional housing), dental care, and financial assistance with rent and utilities. It is important to note that housing was also identified by clients as one of the top needed support services (without regard to the availability of the service in their community). Similarly, dental care, including specialty care, was identified by clients as one of the top needed support services. Emergency financial assistance, especially to assist with rent and utility payments, was another top priority support service that was perceived by clients to be in insufficient supply or inaccessible. Additionally, substance use treatment and transportation are services quick to be identified by providers as critical client needs and ones that are also viewed by clients as a common gap. We can therefore conclude that, from the perspective of clients in treatment and their providers, housing, dental care, financial assistance, substance use treatment, and transportation are the most critical as well as most commonly unmet needs throughout California. However, it is important to be cautious in making generalized conclusions about unmet client needs because needs vary by client population and geographic area of the state.

In addition to those mentioned above, other common gaps that were identified by clients include food and nutrition services, legal services, as well as complementary care. Providers also identified mental health, health insurance, alternative therapies, and nutrition programs as service areas being challenged. It is interesting to note that in Los Angeles, one of the regions with the largest HIV and AIDS populations, housing and food were the largest gaps for all individuals surveyed, reflecting a shift in the epidemic to more disenfranchised and lower income populations.

The following presentation begins by addressing gaps in core medical services followed by gaps in support services. The discussion includes gaps in services for current clients as well as gaps in services for out-of-care individuals.

Gaps in Core Medical Services

Outpatient and Ambulatory Health Services

Along with appropriate medications, primary medical care is the most critical life-extending service offered to PLWH/A. Primary medical care was identified by overall needs assessment respondents as the top priority service need in almost every EMA and TGA in California. While primary medical care was not a service that was identified by in-care clients as an unmet need on an aggregate level for the state, the lack of availability of an HIV specialist physicians in some rural areas means that some people with HIV will not be assured the most up-to-date treatments or that critical health conditions may not be diagnosed and treated in a timely manner.

Providers as well as staff from PAETC have noted the need for additional HIV General Practitioner training, especially in areas removed from the major epicenters of the

epidemic in California. Throughout the state, there is a need for provider training related to the implementation of recent CDC recommendations on routine HIV testing in health care settings.¹² There is also a need for more programs that offer primary medical care integrated with mental health and substance use treatment services.

Insufficient funding for medical care, high rates of PLWH/A who are uninsured, and differences in the availability of supportive services that create access and maintenance in health care all contribute to the complexity of providing care to all PLWH/A throughout California. With increased use of antiretroviral therapy, many PLWH/As are living healthier lives. The decline in HIV/AIDS deaths, with the resulting complexities in providing care for an aging HIV/AIDS population, and ongoing new infections creates pressures on the care system throughout the state.

There remains a need to better integrate support services and prevention services with primary medical care. In addition, the integration of primary care, mental health, and substance use treatment services will help to effectively address complex patient needs, while ensuring treatment compliance, coordinated care, strong communication, and joint planning among providers.

By definition, out-of-care individuals are experiencing a gap in primary medical care, the most critical service related to their survival and health. For those individuals who have been in care but have dropped out, appointment reminder calls, transportation, and careful “no show” tracking and follow up can help to ensure that service gaps, especially primary medical care, are closed.

ADAP Treatments and Pharmaceutical Assistance

Most PLWH/As in California have better access to HIV medications when compared with many other states, due in part to the state’s support to provide needed resources to this program and the centralized model for administration. Eligible individuals have access to a comprehensive ADAP formulary (181 drugs, as of January 2009) that includes all medications necessary to treat HIV/AIDS and related opportunistic infections in accordance with the Federal Public Health Service treatment guidelines for. Those who are covered under the state’s Medi-Cal program have access to *all* Food and Drug Administration-approved drugs, including these treatments.

More private insurers, however, are placing a larger burden on the insured including higher co-payments and limitations. ADAP can assist with premiums, co-payments, deductibles, and coverage gaps for eligible individuals with private health insurance, but this is not a complete solution to the increased burden now being placed on insured PLWH/A.

Oral Health Care

The lack of oral health care services remains a significant gap in HIV services in California. Needs assessments from Part A areas throughout the state, identified dental

care as a top unmet need for PLWH/A. Advanced or specialty dental care was described as a very important need by many in-care survey respondents, focus group members, and providers. Similarly, dental care was a highly rated need by individuals out-of-care in California. There are only four Part F Dental Reimbursement Programs in California,¹³ concentrated principally in the largest urban areas of the state. Many PLWH/As live outside these catchment areas. Denti-Cal, the Medicaid dental coverage in California, has extremely limited coverage for adults.

There is a continuing need for high-quality dental and oral services throughout the state. It has been widely reported by PLWH/A throughout California that some dentists are still unwilling to treat people with HIV. Other issues that affect the accessibility of these services include the lack of publicly funded dental benefits and the low reimbursement rates dentists receive as payment for those individuals who do have benefits. Private dental insurance policies that finance dental services under a reimbursement model in which patients must pay for dental services and then wait for reimbursement by an insurance company may also limit access to expensive dental services for many patients. Further, dental reimbursement rates are often inadequate and annual expenditure caps too low to cover all dental needs. Preventive dental care is extremely important, yet is available to very few HIV-infected persons.

The Sacramento EMA conducted a special needs assessment of out-of-care individuals in 2006 and reported that dental care was perceived as an unavailable service. Lack of funding was perceived as the main reason for these services not being available.

Home Health- and Community-Based Health Care

In some California regions, reduced HIV funding has led to the reduction or elimination of home-based services for PLWA, including home health, attendant, and nursing care; hospice care; and respite care for family members and other caregivers. The only licensed adult day health care program for PLWH/A in California closed several years ago because of funding cuts. Neither Medi-Cal nor Medicare cover the full array of home health and hospice services needed, sometimes creating a gap in service. Because of the special needs of many AIDS-diagnosed populations, including multiple diagnoses, dementia, and other factors, it is often difficult to identify providers for these services from other non-HIV-specific agencies and programs.

Day care for those with AIDS-related dementia continues to be a service that many communities are not able to provide. As PLWH/A age, there will be increasing needs for HIV-competent senior services, whether that means senior programs welcoming PLWH/A, or HIV agencies acquiring geriatric expertise.

Hospice Services

Due to the reduced demand for hospice services in recent years, there is not a gap in this particular service in most California communities. However, residential care for

those with AIDS-related dementia continues to be a service that many communities are not able to provide.

Mental Health Services

Throughout the state, there is a shortage of long-term counseling and therapeutic services and psychiatric care for PLWH/A. In recent needs assessments, mental health care was frequently identified by women and inmates or recently incarcerated individuals, as well as other in-care populations, as needed services. The lack of mental health services (which can help with depression, anxiety, as well as refer clients into care) was identified as a key gap in service for out-of-care individuals by providers and local needs assessment initiatives in California.

Gaps in service related to mental health include the availability of psychiatric services (including the provision of psychotropic medications) and mental health counseling services, especially individual treatment, as well as the need for additional training on HIV-related issues for mental health program staff. Additionally, there is a need for additional programs that integrate primary medical care, mental health, substance abuse programs, and housing services.

In California, individuals on Medi-Cal are given a specific number of total allowable service “units” each month which they can utilize. Therefore, individuals on Medi-Cal sometimes must choose between mental health, complementary therapy such as acupuncture, and other types of similarly classified health services each month because these services are categorized together. Other HIV funding streams help to fill in this mental health service gap but some LHJs, such as the San Jose/Santa Clara area, report reduced or eliminated funding for mental health programs. Reduced overall HIV funding levels, as well as a downturn in state and local economies, has resulted in reduced levels of support for mental health and other support services for PLWH/A. These reductions may have a future impact on client access to care, HIV treatment adherence, quality of life, and the likelihood of engaging in high-risk behaviors that can transmit the disease.

Mental health services must be culturally appropriate, as cultures have different understandings and expectations of mental health services. Increased availability of and access to psychiatric consultation is essential in providing effective care and support to mentally ill PLWH/A.

Substance Use and Addiction Treatment Services

There are wait lists for substance abuse treatment programs throughout California. That is true regardless of the community, region, drug of choice, or treatment modality. In some cases, there is no treatment locally available, no publically funded treatment, or no treatment to meet critical needs, such as residential treatment for women with children, or programs for monolingual Spanish speakers. Opiate addiction remains a major problem among IDUs in California, yet wait lists continue for methadone

replacement programs, a well-researched, effective treatment option, and many regions of California have no local methadone replacement programs. Buprenorphine, a newer opiate replacement therapy that is subject to fewer regulatory restrictions than methadone maintenance therapy, is not yet widely available in the state. In recent needs assessments, alcohol and drug treatment services were highly rated core services for inmates or recently incarcerated individuals.

According to ADP, methamphetamine is now the most commonly reported primary drug problem in California, surpassing alcohol and heroin.¹⁴ Methamphetamine and amphetamine use is a long standing problem in California, and its use is prevalent in the gay male community. It is now getting increased attention throughout the country. Successful methamphetamine treatment is a fairly new development, and there is a small but growing body of clinical research on what comprises effective treatment. Programs in San Francisco and Los Angeles report good outcomes, but also report that successful treatment for stimulant abuse may take longer than that for opiate or alcohol abuse. PLWH/As who want treatment for their methamphetamine addiction face significant gaps in treatment availability. Like all substance abuse treatment programs, methamphetamine treatment must be culturally appropriate to be successful.

Despite some progress, the goal of “drug treatment on demand” for PLWH remains unrealized. Extensive work remains to be done to ensure adequate access to drug treatment services for people with HIV, a problem that is not unique to the HIV care system. Drug treatment capacity is inadequate, and appropriate and effective treatment modalities are not always available. New treatment technologies and policies such as buprenorphine or office-based methadone treatment is currently underutilized and can help expand treatment capacity and offer more treatment options to PLWH/A.

The lack of sanctioned syringe exchange programs in some areas decreases the ability of providers to offer this valuable harm reduction service. Syringe exchange has been demonstrated as an effective means for reducing transmission of blood-borne pathogens including HCV and HIV, yet syringe exchange programs are not funded or sanctioned in most counties. Legal barriers continue to limit resources for syringe exchange. Recent legislation signed into law by Governor Arnold Schwarzenegger has increased access to sterile syringes through pharmacy sales. This statute provides some legal access to clean needles and syringes and is a significant step forward in California’s HIV prevention efforts. However, access to sterile syringes remains severely limited in California’s vast Central Valley, where methamphetamine use is among the highest in the nation. No pharmacies are authorized to sell syringes without a prescription in the region; one syringe exchange program was recently authorized to operate in Fresno County.

Linkage to drug and alcohol programs and additional residential treatment beds were identified as key gaps in service for out-of-care individuals by providers and local needs assessment initiatives in California. In recent needs assessments, alcohol and drug treatment services were highly rated core services for inmates or recently incarcerated individuals.

Medical Case Management Services

Recent needs assessment data from Part A areas has clearly shown that case management remains a critical and highly ranked service by PLWH/A. Fortunately, with the exception of a few rural areas with limited access, case management is available to PLWH/As throughout the state.

The primary case management service gaps are related to ensuring adequate case management service for each client, cultural and linguistic competency, availability of specialized case management, quality assurance, and enhanced coordination. Inadequate amounts of case management per client is identified as an important gap by individuals from communities of color, women, MSM, as well as inmates or the recently incarcerated. The complexity of service systems coupled with an increase in serving individuals with more complex issues, such as those who are multiply diagnosed, has created a greater burden on case management systems resulting in an increased need for this service.

Although case management is commonly available for PLWH/A, it is not always culturally appropriate or accessible for all. Successful case management relies on a relationship of trust and respect between the social worker or case manager and the client. That trust and respect are easier to build if there is a common language and a shared understanding of the cultural context in which the client lives. PLWH/A who do not speak English need case management in their own language, and case management in other languages, including: Spanish, Tagalog, Vietnamese, Cantonese, and Thai, remains a major gap in many areas of the state.

Funding has been inadequate for the specialized case management programs that support the intensive care and support needs of special populations such as youth or recently incarcerated individuals. While excellent examples of these programs exist in some regions, they are non-existent or under funded in others.

Nursing case management is particularly needed by PLWH/A with advanced HIV disease and other chronic health conditions. As the population of PLWH/A ages, nursing case management will become a greater need and a larger gap. Transitional case management for PLWH/A being released from correctional facilities is vital to linking people with services in the community, but is sporadic across the state, despite PLWH/A being released to all counties.

Some individuals need intensive case management, while others need little or none. Ensuring that clients receive the appropriate level of care could be achieved through the greater use of acuity assessments. Excessive caseloads can lead to a lack of adequate attention to clients' needs and can delay access to needed services. Fluctuating caseloads and inadequate staff training may also result in case management services of an uneven quality. More fluid case management models are needed to better respond to fluctuating client conditions and needs over time.

In some areas of the state, improved coordination between case management and medical and other support services is needed. Integrated service programs, including a strong case management component, are valuable models of care that ensure better communication, joint case planning, cross-training of staff, and other benefits.

Information and referral, typically one of the components of a CMP, was identified as one of the key gaps in service for out-of-care individuals by providers and local needs assessment initiatives in California. This would indicate a gap in services that might bring more out-of-care individuals into treatment.

Gaps in Supportive Services

The following section describes gaps in supportive services. These services are defined by HRSA to include: client advocacy, emergency financial assistance, food bank/home-delivered meals, housing services, legal services, linguistic services, and medical transportation.

Client Advocacy Services

Client or peer advocacy services are funded to provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services. They offer HIV-positive individuals empowerment, training and development, and self-help opportunities. These services can help overcome the isolation and loneliness that often affects client health, while serving as a vital link to services and socialization. Many programs throughout California have developed peer mentoring or advocacy services, incorporating HIV-positive individuals into the fabric of the service delivery system. The primary gap for this service is the lack of funding in some areas of California to provide adequate levels of this service.

Outreach is another important service, as well as information and referral, that is typically provided by client or peer advocates. Peer outreach services are critical methods to ensure that out-of-care individuals are connected (or reconnected) to care.

Emergency Financial Assistance

In recent needs assessments throughout California, emergency financial assistance (especially with rent or utility payments) was most commonly rated in the top five support service needs among clients. These programs differ among LHJs. The lack of available resources has been reported as a gap in care and as a barrier to accessing and maintaining persons in care. Direct emergency financial assistance helps prevent homelessness, facilitates continuity of drug treatment, and access to food, which in turn helps improve the health and well-being of PLWH/A.

Food and Nutrition Services

Ensuring access to high-quality food, including nutritional supplements, home-delivered meals, vitamins, and packaged and prepared foods is essential for maintaining and prolonging health and life expectancy for PLWH/A. Several LHJs report coordination with existing food banks while others have struggled to do so. Nutritional needs of PLWH/As are specific and some local food bank providers do not have the capacity or reliable inventory to meet these needs.

In terms of support services, food and nutrition-related needs were most commonly rated in the top five needs among clients who participated in needs assessment surveys. African Americans, inmates/recently incarcerated, and out-of-care individuals highly rated food and nutrition-related services in several EMAs. The principle gap related to this service is lack of resources on the local level to provide sufficient amounts of groceries and home-delivered meals to clients. This service is of particular importance to individuals with lower-incomes and underserved populations, such as African Americans and women.

The Sacramento EMA conducted a special needs assessment of out-of-care individuals in 2006 and reported that food was perceived as an unavailable service. Lack of funding was perceived as the main reason for these services not being available.

Housing Services

Housing continues to be a major need by PLWH/A in California. Housing is a bottleneck service: if PLWH/A do not have housing, it is more difficult for them to access all other services and to get the full benefit from medical care and medication. There is a lack of affordable, safe housing units for all low-income groups in California. This major gap in service includes information and referral for housing resources as well as temporary (emergency), transitional, and permanent housing.

In some areas of the state, there is a housing crisis that creates serious problems for PLWH/A. For example, affordable housing in San Francisco is often not available for PLWH/A as well as other residents. Orange County determined that housing was a very highly ranked service by African American and Latino clients. Housing, including emergency housing, was identified by inmates and recently incarcerated individuals from several parts of the state as a most critical service. A study specifically designed to survey out-of-care individuals with HIV infection in Sacramento County found that housing was a major need by these respondents. Other EMAs, including San Diego, found similar results.

The lack of affordable housing is a major problem for PLWH/A with low incomes throughout California. Even in communities that have effective housing programs for people with HIV, these programs are frequently inadequate or inappropriate for certain populations such as large families with children. In some areas of the state, low-cost housing is in short supply, which further drives up the cost for single occupancy hotel

rooms and other living accommodations. There is a shortage of approaches to help people with HIV overcome hurdles to obtaining long-term housing such as a poor credit record and a lack of residency history. Housing programs in rural regions are under-supported in general. Housing is a significant unmet need within the homeless HIV/AIDS population in California. These individuals often experience additional barriers to care such as extreme poverty, substance abuse problems, mental health diagnoses, other physical impairments, lack of information about available resources, and a lack of insurance.

Legal Services

Access to legal services for PLWH/A remains a critical component in the continuum of care. Several LHJs report a reduction in funding for this service in recent years due to reduced funding levels.

Linguistic, Translation, and Interpretation Services

As with other support services, as funding decreases and expenses increase, support for linguistic, translation, and interpretation services becomes threatened by spending cuts. The provision of service to the large and increasing number of monolingual Spanish speaking individuals in California constitutes a special challenge related to this service category. In recent needs assessments conducted in California, Latino MSMs especially identified the need for more Spanish speaking services or services with interpretation and translation capacity such as primary medical care, dental services, mental health services, substance use services, legal assistance, employment assistance, as well as support groups.

In addition to Spanish, there are many other languages that are spoken by monolingual persons in California. Service providers struggle to provide the necessary oral and written linguistic services required by the state's diverse population. In addition, deaf individuals living with HIV/AIDS need to continue to receive American Sign Language interpretation and access to interpretation technology.

Medical Transportation Services

Ensuring full access to comprehensive transportation services remains a central need for persons with HIV/AIDS. In recent needs assessments from California areas, transportation was most commonly rated in the top five support service needs. This was particularly true for some underserved populations like the recently incarcerated and African Americans individuals. A study specifically designed to survey out-of-care individuals with HIV infection in Sacramento County found that transportation was a major need by these respondents. Other EMAs, including San Diego, found similar results.

Lack of consistent access to transportation remains a barrier to accessing HIV services for some people. This problem exists in both rural and urban settings. In rural areas,

those without public transit, and areas with widely dispersed services, transportation is a service gap that leads directly to other service gaps for PLWH/A. Finding practical solutions to the problem would contribute toward ending HIV service disparities across the state, while improving treatment adherence, and improving access to health and social services for clients. As with childcare and other services, the inability to access this supportive service creates a systemic barrier to accessing medical and social services. Enhancement of transportation services must include both access to a full range of transportation options, and subsidization of transportation costs, including transportation suitable and accessible to persons with disabilities other than HIV.

Transportation is a critical component of the overall continuum of care whose costs continue to accelerate on an ongoing basis. As the HIV/AIDS service system strives to create expanded and enhanced services to meet the demand for comprehensive systems of care, the demand for expanded transportation services also increases, placing greater cost demands on the system as a whole. These service repercussions must be taken into account both when planning for and mandating new services within LHJs or regions of California.

Transportation was identified as one of the key gaps in service for out-of-care individuals by providers and local needs assessment initiatives in California. This was particularly true for out-of-care women, including a large percentage of African American women.

Prevention Needs

Linkages with Counseling and Testing Services

Strong linkages are needed between counseling and testing services and HIV care services. A strong linkage helps to ensure that out-of-care individuals are connected to, and engaged in, care and treatment services without delays thus avoiding the decline in health that can result when HIV-infected persons come late to care. For example, some counseling and testing programs use same day referrals into primary medical care to ease the transition into medical and other care. Also, some co-located test sites introduce the newly diagnosed HIV-positive client to a member of the care team when the diagnosis is given. Still other test sites arrange for a Bridge Project worker to come to the test site to be introduced to the newly diagnosed person at the time the test results are given. When a member of the care team or a Bridge worker has been personally introduced to the client at the test site, follow up on the client is facilitated and permissible.

Prevention with Positives

The development of effective HIV treatments has had a profound impact on every aspect of HIV services. The life-extending benefits of antiretroviral therapies has meant that the number of PLWH continues to increase. Those who respond well to treatment are able to enjoy more active lives, and for some, this means an increase in activities

associated with increased risk of HIV transmission. The impact of antiretroviral therapies, as well as the steady level of HIV incidence in communities of color, points to the need for interventions specifically designed to meet the prevention needs of HIV-positive persons.

Creating and sustaining behavior change to reduce HIV transmission is difficult and requires approaches that are highly individualized and that take culture and context into account. Providers and funders must recognize that transmission prevention often requires long-term interventions and support and is rarely adequately addressed via basic prevention messages and traditional HIV education. When considering implementation of prevention with positives programs, it is essential to remember that little is known about strategies to maintain behavior change across time. Most studies focus on behavior change only over the first 6 to 12 months post-intervention, but given the general success of HIV treatments, PLWH have to contend with the issue of risk for many years. In addition, many prevention programs fail to acknowledge the importance of anticipating and working with relapses into risky behavior. Even individuals who possess a strong commitment, good support systems, and the best of intentions can suffer a lapse, reflecting the simple reality that it is very difficult to maintain behavior change over time. The lack of both individualized, long-term support strategies and a straightforward, compassionate discussion of how to contend with relapses may limit the effectiveness of HIV prevention with HIV-positive persons.

While the central role of HIV prevention services with HIV-positive people is now widely recognized, published research about successful model programs is still limited. As more information becomes available on appropriate and effective transmission prevention services with HIV-positive people, including services provided directly by PLWH, it is essential that this information be made available. Lack of dissemination and effective implementation may result in inadequate, ineffective, or hastily constructed programs.

Effective prevention for positives interventions may require that significant resources be devoted to staff training in topics such as motivational interviewing, harm reduction theory, sexual compulsivity, information about the dynamics of specific categories of drug use, and multiple other topics that may not have been previously addressed (or at least not addressed from the perspective of prevention with positives work). Some prevention with positives programs do not include training and support for staff and volunteers, especially as needed to counter unrealistic expectations they may have for their own and their clients' success. Unreasonable expectations for behavior change can contribute to client anxiety and create an environment in which it is difficult for clients to disclose the challenges they face in trying to achieve lower risk behaviors.

PS

PS services are an essential component in preventing HIV and in identifying those who may be unaware of their positive serostatus or aware but out of care. Although significant progress has been made in training HIV service providers in the provision of

PS, many providers, both public and private, remain to be trained and/or informed of the availability of PS. The HIV Education and Prevention Services Branch, via the California HIV/STD Prevention Training Center, provides training on disclosure and PS for both prevention and care service providers. Trained staff who are able to provide anonymous notification of identified partners should also be available throughout the state, in rural as well as more populated areas.

Barriers to Care

Barriers relate to unique circumstances or challenges which prevent individuals from accessing care and may also affect the quality of care. The following discussion addresses barriers to care for individuals both in and out of care, as well as systemic barriers. Because of the extensive discussion of barriers to care for underserved population in the 2009 SCSN, this presentation will address broad and overarching barriers that affect multiple populations. The conclusions are drawn from comprehensive planning documents from LHJs, past input from members of planning groups in California (including CHPG), and from experts in outreach to PLWH/A (such as the Bridge Project staff members).

The barriers discussed below are not all-inclusive and are not listed in any priority order. Not all of these issues affect care to the same degree and not all apply to all populations. It is important to note that many of these barriers overlap and are inter-related to one another, profoundly exacerbating problems in accessing care and treatment. The initial discussion concerns client-centered barriers to care followed by systemic barriers to care.

Individuals' Barriers to Care

To help define the full range of reasons that people do not enter HIV care or drop out of HIV care, OA gathered input from members of planning groups, including CHPG, and from experts in outreach to this population, such as the staff of the Bridge Project. These groups offered information regarding out-of-care populations based on their personal experience and professional knowledge. Information was gathered from each group regarding the factors that keep people out of care, the factors that cause people to drop out of care, and the strategies that are effective in bringing people back to care. The results were not dissimilar from earlier research regarding the out-of-care population.

Of particular interest was the perspective of the staff members of the Bridge Project, a program multi-funded by HRSA, Minority AIDS Initiative, CDC, and the State General Fund. The Bridge Project's goal is to prevent further transmission of HIV in disproportionately affected communities of color by increasing the number of people with HIV who are successfully enrolled in comprehensive HIV treatment and prevention services. As a program dedicated to bringing impoverished and disenfranchised people of color directly into the system of care, Bridge Project staff have a close working

knowledge of the reasons why the hardest-to-reach populations do not seek care, and of what may ultimately assist to bring them into care.

The persons living in California who know their HIV-positive status but do not access HIV-specific services do so for a variety of reasons. In some cases, the system has failed to inform these individuals of the availability of HIV-specific programs. In other cases, individuals are dealing with a complex range of life issues and complications that act as barriers to accessing care. In still other cases, people are afraid to confront the reality of their diagnosis, or are fearful that seeking care will cause their HIV status to be revealed to others.

Whatever the specific individual reasons, there is extensive evidence to suggest that a significant percentage of the out-of-care population consists of poor and disenfranchised populations, who often do not access health care except in emergencies. In 2000, a total of 6.2 million Californians had no health insurance of any kind, a fifth of the state's population under age 65. While publicly funded services are available to help these individuals access treatment and medications, their lack of regular contact with the health care system in general may act as a barrier to seeking HIV services.

Other populations do not have regular contact with the health care system. Young people may not access preventive health services, particularly when they are living away from home. Homeless populations have little or no access to basic, consistent health care. As noted earlier, some ethnic minority populations may have a deep-seated mistrust and suspicion of the health care system that keeps them from seeking regular care. For these and other groups, such as women, sex industry workers, incarcerated populations, and undocumented immigrants, a lack of familiarity and comfort with the health care system may contribute to an unwillingness or reluctance to enter care.

This section summarizes some of the most common reasons identified by clients and supportive service providers/outreach workers for remaining out of care in California. For purposes of discussion, these factors are grouped below into categories and are presented alphabetically, rather than in a prioritized order.

Access to Services or Knowledge of Services

PLWH, particularly if they are poor, disabled, or in rural communities, may not have a way to access services even when they are available. These individuals may lack access to viable transportation options, may not have the support of an individual to help get them to a medical appointment, or may not be able to attend service facilities during regular business hours. In other cases, services needed to get an individual into care may not be available in a given region, services such as substance abuse treatment, specialty medical care, or services in languages other than English. Individuals from some populations, such as Latinos and African Americans, report that they knew very little about HIV disease before they were infected. Therefore, their knowledge of the disease and available services may be extremely limited.

Undocumented persons may believe that they are not eligible for HIV services due to their immigration status since, in most other cases, they would not be eligible for health care services. However, in many infectious disease programs, like HIV and TB control, services are provided without regard to immigration status

Additionally, the unavailability of easily accessed care can present a barrier. Clients who have never sought services before, particularly members of stigmatized populations, may spend weeks working up the courage to make an appointment or walk into a clinic, and then lose heart when the phone access is too difficult to navigate, the wait time for an appointment is too long, there are no walk-in services, clinic staff are unwelcoming or impolite, or the enrollment process is too overwhelming. These individuals may not seek another appointment for some time.

Denial and Fear of Illness

Many PLWH, often in early stages of coming to terms with the disease, undergo a period of denial that can keep them out of care for weeks, months, or even years. Some people recently diagnosed with HIV refuse to believe they have the virus, and others choose to believe the virus will not affect them. Often it takes either a negative health experience or a need for assistance with a basic support service such as food or housing to bring a person into care for the first time.

Disclosure and Stigma

Some populations are not only dealing with HIV as a disease, but are trying to address internal and external stigma regarding HIV itself. Stigma of living with HIV/AIDS appears to be a very strong influence restricting PLWH/A from seeking HIV medical care. In focus groups, many participants indicated that their particular community was scared, they did not want to be identified as having HIV or being gay, and felt a strong sense of shame in being labeled as HIV positive.

For undocumented populations, fear of disclosure of non-resident status, or of their disease, keeps many people out of care each year. Victims of domestic violence may be unwilling to disclose their HIV status to a partner because of fear of retaliation. Some individuals who receive an HIV diagnosis feel that HIV is a shameful condition that lessens the individual and subjects him or her to humiliation or rejection by family and friends, while others fear that they will lose their job if their employer learns they have HIV. These individuals may fear that by seeking services, they will expose their HIV status, and they avoid services in order to keep their condition a secret.

The number of MSM living with HIV/AIDS in California remains enormous in number. Stigma and homophobia remain barriers to care for many MSM, especially those in rural areas, those in communities of color, and those who do not identify as gay or bisexual.

Experiences with Medications

Many people with HIV have been taking medications for years, and at some point may become exhausted or exasperated with the presence of medications and doctor's visits in their day-to-day lives. These individuals may tire of the constant need to watch their regimens, and of structuring their lives around their medications. Others "burn out" on the emotional ups and downs of living with the illness, and the constant struggle of dealing with the HIV service and health care systems. Still others may become fed up with the negative or painful side effects of certain medications.

Some individuals have very different experiences that lead to the same outcome of dropping out of care. After starting medication regimens for the first time, some people drop out of care because they begin to feel well. In other words, because they no longer feel sick, they do not feel they need to remain on medication or in medical care. But others have the opposite experience and have immediate negative problems with side effects, and they also drop out of care, but because they feel worse. Others simply "take a break" from medications, fail to re-enter treatment, and ultimately become individuals who are out of care.

Homelessness and Marginal Housing

Homelessness is a clear barrier to health care in California. The high cost of real estate and, therefore, affordable housing opportunities in California have created a housing crisis, particularly for the most disenfranchised populations. Because of mental illness, alcoholism, substance abuse, past incarceration, or disability, some homeless people are unable to become employed or to care for themselves, and do not know how to, or cannot access, medical or supportive services. Some homeless people are dealing with severe mental illness and require extensive intervention and support in order to attain stability prior to beginning HIV medical care. Transportation is another prevalent problem among the homeless that limits access.

If PLWH/A do not have safe, stable, affordable housing, it is difficult for them to access and maintain other services, including primary care, substance abuse treatment, and mental health therapy. Lack of housing is one of the most significant barriers to care in several EMA needs assessments.

Immigration and Immigration Status

Immigration status can pose a barrier to care as individuals may fear deportation, discrimination, or loss of employment. In California, the number of undocumented Latino immigrants is significantly large and includes individuals from Mexico, South American, Central America, as well as the Caribbean. Along the border, many Latinos travel back and forth for work, family, or personal reasons. Many people making these crossings are traveling back and forth across the border several times in one year or even in the same month. There are minimal health services along the border, leaving many local residents without access to primary medical care. Health care services are

not well-coordinated across the border, resulting in people receiving varying levels of care and contradictory medical advice. Staying in medical care is even more of a challenge for migrant workers, especially those who travel between Mexico and the United States.

The Asian/Pacific Islander group of immigrant to California has typically included a diverse group of Japanese, Vietnamese, Laotian, Cambodian, and other Southeast Asian immigrants, as well as Pacific Islanders. Increasingly, California is home to newer groups of Asian immigrant populations including Eastern European and Middle Eastern, especially Iraqi, Iranian, some Russian groups, Pakistani, and Indian. These individuals face special barriers to care due to language, immigration status, and cultural norms.

Lack of Service Linkage

Many providers and people with HIV believe that the moments immediately after an individual has first received an HIV diagnosis represents a critical opportunity, which, if missed, can result in people being lost to care. For most people, the moments following receipt of an HIV diagnosis are traumatic, particularly if the individual has not expected the diagnosis. Newly-diagnosed individuals can be lost to the care system for an extended period of time if this critical opportunity to link them to care is missed.

In California's approximately 800 state-funded test sites, most HIV tests now utilized are rapid tests. Those individuals receiving a preliminary HIV-positive rapid test result are immediately given a conventional HIV test as a confirmatory test. Currently, approximately 50 percent of those with a preliminary positive test result do not return to obtain the result of the confirmatory HIV test. It is unclear what percent of those who do not return for their confirmatory test results have not been linked to care services since individuals may proceed to obtain care services, private or public, after the preliminary result.

Mental Health Issues

Mental illness, whether chronic and severe or relatively minor, is a critical factor underlying people's inability to enter care, to remain in care, or to begin and maintain antiretroviral therapies. Among all HIV-positive persons, the prevalence of mood and anxiety disorders and substance use disorders is significantly higher than in the general population. Stress, depression, and anxiety make it difficult for an HIV-infected person to cope with life in general, much less with the demands of an HIV diagnosis. More serious mental disorders contribute to stigma and disenfranchisement, and compromise individuals' ability to successfully engage in care. The poor judgment, difficulty forming relationships, and impulsivity associated with personality disorders can contribute to inability to remain in care and to access vital support systems.

Persons with HIV infection may be contending with chronic mental and/or addiction disorders that were present before the onset of HIV infection. Others may develop

transient symptoms of mental disorder as a response to HIV diagnosis. These symptoms may actually be a reasonable response to the shock and stress of diagnosis (e.g., depressive or anxiety-based symptoms) and may need no intervention other than supportive counseling. Conversely, they may represent the onset of more serious disorders that will require more intensive monitoring and intervention. Finally, some HIV-infected persons may develop serious symptoms related to HIV infection itself (e.g., HIV-Associated Dementia or Minor Motor-Cognitive Disorder).

Staff at some health facilities may be uncomfortable dealing with mental health issues or may lack the needed expertise to offer appropriate services. As a result, people with mental health problems often have difficulty accessing ongoing medical care at county or community-based medical clinics, often the only place that these individuals can receive medical services because if they lack medical insurance. Discrimination against the mentally ill can be a barrier to care. Such discrimination may not result from a conscious rejection of mentally ill people by the medical care system, but through a general lack of resources or skills to provide adequate medical care. This problem is closely related to the problem of a lack of culturally appropriate mental health services for mentally ill PLWH.

Reluctance to Seek Early Medical Care

Some cultures and families believe that one need not seek medical care until one is very ill, and other individuals may seek the assistance of a healer in their own traditional culture rather than a Western medicine practitioner. Prophylactic treatment may never have been experienced and, therefore, may be a concept not easily accepted in some cultures or families.

Latino and African American populations often report that they do not go to the doctor unless they are very ill and thereby enter the system late with more needs. The “late-to-care” pattern is also reported for IDUs, other substance users, and incarcerated or recently incarcerated individuals.

Sensitive, Competent, and Culturally Appropriate Care

In a region as culturally diverse as California, it is vital that providers offer services that respond to the specific cultural needs and backgrounds of their service populations. Lack of access to sensitive, competent, and culturally appropriate service providers is a serious problem facing all health services providers in California, including providers of HIV services. The lack of availability of sufficient numbers of knowledgeable, culturally competent HIV providers makes it difficult for PLWH to find providers that they consider to be sensitive, understanding, and empathetic. This can create disillusionment with the system and may contribute to people dropping permanently out of care.

Many of these problems stem from the lack of services that respond to and reflect specific cultural backgrounds and orientations. For example, Native Americans experience high rates of poverty, unemployment, drug and alcohol use, STDs, and

violence, and are sometimes unwilling to utilize service programs identified as targeting gay White men. Cultural sensitivity is defined not only from an ethnic standpoint, but also in the sense of lifestyle and life choices. Individuals need to receive both medical and psychosocial services that directly reflect their cultural, ethnic, religious, and linguistic background as much as possible. This includes the availability of services in their own language and services by multicultural staff members that reflect the communities they serve. Cultural sensitivity also includes the availability of providers who are respectful toward often-marginalized populations, such as gay and bisexual men, transgender individuals, IDUs, youth, and women.

Populations such as the homeless, IDUs, the mentally ill, transgender persons, and persons who speak a language other than English report experiencing problems with provider rejection, an issue of particular concern given that these are all groups increasingly affected by HIV. Rejection or mistreatment by a medical provider can be an extremely hurtful experience for the patient, often leading to a resistance to seek care on a future occasion, or necessitating the building up of trust “from scratch” in the hope that the next service provider will be respectful and compassionate.

Perhaps because of their smaller numbers, a comprehensive continuum of care is less readily and regularly available for women than for men. A comprehensive continuum of women's HIV services must include women-focused and women-friendly primary and specialty medical care, especially in obstetrics and gynecology; family planning and prenatal care; mental health services; women-only support groups; childcare; transportation; housing; food; and access to public benefits programs.

Problems also occur when PLWH are unable to locate primary care physicians, counselors, or other support personnel in their region who have a strong background in HIV. This can be a particular problem in rural and underserved communities. As with other provider issues, this can lead to disillusionment, a lack of satisfaction with care, and a fully grounded fear that services may be detrimental, rather than helpful, to one's health and well being.

A critical gap in HIV services that may lead to being out of care is the lack of other PLWH in supportive peer positions within health and social service agencies. Such services can be extremely helpful in helping a newly diagnosed individual come to terms with his or her HIV status, learn the rudiments of the HIV service system, and share fears and process emotional responses with an individual who has already been through a similar experience. This peer support can be particularly beneficial if provided by trained, competent peer support staff who share the ethnic, cultural, linguistic, gender, sexual, and other characteristics of the populations with whom they work.

Substance Use Issues

Substance use is an underlying factor within the complex network of circumstances that prevent people from seeking or actively engaging in HIV care and prevention services. Active substance users often try to avoid contact with medical systems for fear of having

their substance use challenged, fears about interactions between street drugs and HIV medications, legal repercussions, child custody issues, or prior experiences with health care providers who treated the user with disdain or hostility.

Substance users in the advanced stages of addiction or who are suffering from personality disorders or other mental illness may present with erratic behaviors or be otherwise difficult for staff to contend with; this can create challenges for service agencies.

Active substance users may not be welcome in some health care settings. Some providers view them as inherently manipulative and unable to take responsibility for their own care. These beliefs, while partially grounded in the reality that addiction-related behaviors present many challenges for providers, may create barriers that make health care inaccessible to substance users.

Barriers to treatment include requirements of sobriety or abstinence from drugs as a prerequisite of enrollment, and the assumption that an active user is an inappropriate candidate for antiretroviral medications. Because of the ongoing shortage of available drug treatment program slots, even users who are ready to enter treatment may not be able to do so within a reasonable time span. Others lack access to suitable or culturally appropriate drug treatment programs, or to long-term support to help them change their life circumstances effectively.

Systemic Barriers to Care

Achieving a comprehensive, flexible spectrum of HIV services, particularly in a manner that makes essential services accessible to everyone and distributes resources fairly among the HIV-infected population, is in many ways the ultimate goal of Ryan White Care Act-funded services. As part of local planning activities, Ryan White Care Act groups are charged with developing continuums that prioritize or categorize services based on the nature of the local epidemic, and on the region-specific service gaps or barriers that are most prevalent for underserved people with HIV. Though informative and useful, the plans typically do not account for all resources available to address the needs of PLWH/A.

For a region as large and complex as California, however, there are several critical systemic barriers to developing a single continuum of care that can be generalized for the full range of the state's diverse HIV-affected population. Service needs and resources differ from region to region, and needs differ widely from individual to individual and may change over time.

The following section lists systemic issues that may affect the quality and availability of care. These issues are listed alphabetically and are not in priority order. Not all of the issues below affect care to the same degree, and not all apply to every region of California.

Awareness of Services

In many areas, people with HIV may not access HIV services because they do not know that services are available to meet their needs. People with HIV may be unaware of how or where to access or obtain services, and because they do not know that services may be available to them for low or no cost. To ensure full access to care, it is vital that HIV service providers publicize their programs both within the health and social service community and to the general public at large. However, these outreach efforts require additional resources that HIV programs often lack.

Complexity of Eligibility and Enrollment Processes

As in other public service systems, there are often duplicative intake processes and forms to be completed when people are entering and using the system of care. Clients may also be required to re-apply for public benefits or to re-establish eligibility for benefits or services on a monthly or quarterly basis. While these processes are part of any complex system of care, they increase the difficulty of accessing and maintaining care. For some persons seeking HIV services, these processes are barriers.

Culturally Responsive Services

In a region as culturally diverse as California, it is vital that providers offer services that respond to the specific cultural needs and backgrounds of their service populations. A lack of service providers who reflect or understand the ethnic, cultural, or lifestyle background of the individuals they serve, or who do not have staff available who speak a client's language, can result in miscommunication, misunderstanding, or a lack of trust between provider and patient. The lack of culturally responsive services can contribute to the hesitance on the part of some people living with HIV to seek services or support. In California, ensuring linguistic competence increasingly means not only providing services in English and Spanish, but also translation for the hearing impaired and for individuals who speak other languages, including the more than 100 Asian dialects and languages spoken in California.

This category encompasses significant gaps and disparities facing the HIV care system. In some parts of the state, services tailored to the needs of specific groups such as communities of color, women, transgender people, and young people are not available. There is sometimes an absence or shortage of service staff who relate to and understand the particular lifestyles, needs, or cultural backgrounds of their HIV-infected patients. Lack of culturally appropriate care can increase patients' reluctance to visit providers or to disclose personal information and can lead to inappropriate or substandard service and support. It is, therefore, important that HIV providers strive to understand and respond appropriately to the varying needs of diverse populations.

Data Collection, Evaluation, and Outcomes Tracking

One of the overriding needs within the California HIV care system as a whole is related to data collection and evaluation. Data collection systems and evaluation efforts are critical to the capacity of LHJs to adapt their ways of doing business and effectively address the emerging needs and increasing complexity of care for the expanding HIV-affected populations. The capacity for enhanced evaluation across the entire system of care must be expanded throughout the state of California. Consistent, standardized, reliable, and expanded data collection systems are needed to track such things as service utilization, wait lists, unmet client needs, service quality indicators, and outcomes. Enhanced or expanded data collection systems would allow agencies and LHJs to more quickly and accurately identify service gaps and deficiencies, to produce meaningful data that allows for effective assessment of the quality, impact, and outcomes of services, and to allocate resources more strategically. Because of the continuum of services offered and the sometimes integrated approaches to providing care, the existing system of HIV/AIDS care in California may provide a model for the provision of community-based care in other health and social service areas. To effectively demonstrate this, service outcomes must be further measured and evaluated. Evaluation efforts should also be expanded to include reliable means of identifying and quantifying the number and nature of persons with HIV/AIDS who are not in care.

The lack of good data systems can prevent care providers from identifying successes, disseminating successful models, accurately demonstrating need, and being fully accountable to funders. Coordinated data collection, program evaluation, and targeted research can help identify emerging issues, identify service gaps and disparities, maintain quality care, and improve client outcomes.

In response to some of these issues, California has implemented ARIES, which is a custom, Web-based, centralized HIV/AIDS client management system. It provides a single point of entry for clients, allows for coordination of client services among providers, meets both HRSA and other treatment reporting requirements, and provides comprehensive data for program monitoring, quality assessments, and scientific evaluations. ARIES enhances services for clients with HIV by helping providers automate, plan, manage, and report on client data.

Integration of Care

PLWH/A with concurrent medical, mental health, and substance use conditions need coordinated care to produce the best health outcomes. Case conferences, shared client records, or cross-training can help integrate care. There are good models of integrated care for multiply diagnosed PLWH/A in the state which could be replicated in other areas, and best practices shared with other providers.

The quality, scope, and coordination of care for PLWH/A in California is affected by the ability of providers to plan and develop collaborative, multidisciplinary approaches to

HIV service and care, especially in light of the changing, complex needs of those affected by the epidemic. Opportunities and incentives must be developed for increased interaction and service integration among providers and consumers, Care Act grantees, HIV/AIDS and non-HIV/AIDS-specific agencies, regional and LHJs, medical and psychosocial providers, public and private funders, private and governmental bodies, local and national agencies, rural and urban providers, and local and regional consortia and planning groups. Infrastructure support should be provided for coordination. Agency mergers and collaborations should be supported by planners, funders, and policy makers.

Lack of Key Services

Individuals who are out of care identify the lack of key services as a major barrier to care. Examples of services that are needed but perceived to be unavailable or inadequate include transportation services in rural areas; lack of stabilization services such as housing for the homeless or those at risk of homelessness; and, in some areas, a shortage of physicians who are knowledgeable regarding HIV treatment and the Public Health Service (PHS) standards of care.

Lack of Health Insurance

Whatever the specific individual reasons, there is extensive evidence to suggest that a significant percentage of the out-of-care populations consists of poor and disenfranchised populations, who often do not access health care except in emergencies. California has the fifth highest percentage of residents without health insurance coverage in the country (almost 19 percent).¹⁵ While publicly funded services are available to help these individuals access treatment and medications, their lack of regular contact with the health care system in general may act as a barrier to seeking HIV services.

Lack of Service Linkages

Many providers and people with HIV believe that the moments immediately after an individual has first received an HIV diagnosis represents a critical opportunity, which, if missed, can result in people being lost to care. For most people, the moments following receipt of an HIV diagnosis are traumatic, particularly if the individual has not expected the diagnosis. In some cases, if no one is present to help the person make an immediate linkage to care, that individual can be lost to the system for an extended period of time.

Medicare Part D

The introduction of Medicare Part D has challenged those responsible for assisting PLWH/As throughout California with access to medication assistance. Fortunately, ADAP has been able to provide wrap-around services to help prevent the loss of necessary medications and the disruption of treatments. Many LHJs throughout the

state are still able to assist individuals through pharmaceutical assistance programs to cover medications not available on ADAP's formulary or for those needing assistance while eligibility to other programs is determined. However, as the economic pressures in California continue to mount, the ability of LHJs and HIV/AIDS planning councils to maintain these programs will decrease in the coming years.

Poverty

Poverty has a significant impact on many PLWH/A. It is one of the most basic barriers to care, quality of life, and good health outcomes. People living in poverty must not only face the burden of having insufficient resources for basic necessities, but they are often the individuals who are least likely to be familiar with the health care system, who have the most distrust of traditional health care services, and who are most in need of support in order to access basic medical care. Poverty is a consuming condition that often draws focus and attention away from health preservation and life improvement. Poverty creates barriers to accessing services, and creates additional needs for basic survival services such as food and housing. Poverty is an independent predictor of worse health outcomes in multiple health studies. In California, the African American population has the largest percentage of individuals living below 100 percent of the Federal Poverty Level¹⁶ and this population also has a significant level of homelessness.

Providers Knowledge and Experience

It is critical that HIV service systems be able to provide access to medical specialists and psychosocial providers who are trained and experienced in providing HIV care. Access to such care can sometimes mean the difference between an individual receiving adequate or inadequate care.

Quality Management

The effectiveness or appropriateness of HIV services can sometimes be compromised where there are no quality measures to assess whether or not services are being provided according to established standards of care, or if they are being provided in a manner that is appropriate to each individual's condition. Disparities in service can also occur if there are no systems to ensure comparable service quality or availability across regional systems of care. Data collection and analysis is needed to support quality management, including electronic medical records, and systems to minimize medical errors. Information technology is available to improve quality of services for PLWH/A and should be funded and incorporated into best practices.

Service Continuity

An ongoing reason for people leaving care is the lack of service continuity both within individual service regions, and across areas inside and outside of California. It is reported that individuals drop out of care when their physician or case manager leaves

the area or moves to another agency. Others exit the system due to administrative issues, such as being shifted to another health maintenance organization by an employer, when a physician group drops off a preferred provider list, or when the clients lose their private medical insurance. Still others drop out of care when an agency or service in an accessible location closes down and they can no longer easily access care in an alternative service location.

Some of these same issues apply when individuals move from region to region within California. Often, people with HIV cannot find suitable or comfortable services that match those available in their previous location, and must either travel back to their original community to access care, or receive inadequate or unsatisfactory care. Others enter California from out of state, and lack an easy means to identify services in their new community.

For individuals entering or being released from jail or prison, an interruption in HIV care often results. Significant barriers to care for inmates being returned to the community or transferred to another correctional facility relate to problems in ensuring that prisoners are released or transferred with a supply of prescribed medications and with appropriate linkages to internal or outside services.

Staff Turnover

Many HIV service organizations have problems in retaining staff members over long periods of time, and they have difficulties in filling or re-filling key positions. Staff turnover disrupts trusting relationships developed over time between clients and staff members and creates ongoing training needs. Factors contributing to this problem can include low pay, long hours, the emotionally draining nature of the work, job instability caused by a lack of multiyear funding commitments, and competition in certain professional fields such as nursing and social work.

SECTION 2. WHERE DO WE NEED TO GO? WHAT IS OUR VISION OF AN IDEAL SYSTEM?

Those Californians who have worked to end HIV, those with HIV, and those affected by HIV continue to envision an integrated comprehensive system of high-quality HIV care, treatment, support, and prevention services that is accessible and that contributes to ending HIV. Although operational short- or long-term goals may vary with social, political, and economic realities, the broadest goals, mission statements, values, and guiding principles have remained hauntingly familiar through the decades.

OA Goals

The goals of OA are to:

- Minimize new HIV infections; and

- Maximize the number of persons with HIV/AIDS in California who access and receive HIV/AIDS care, treatment, support, and prevention services.

The shared mission of the HIV Care Branch and ADAP Section is:

- To ensure a responsive and sustainable system of HIV/AIDS care, treatment, support, and prevention services;
- To ensure equitable access to, and provision of comprehensive, high-quality, and effective HIV/AIDS health care, treatment, and supportive services throughout California for all PLWH/As;
- To ensure equitable access to, and provision of, high-quality, effective HIV transmission prevention services throughout California for PLWH/As who are at risk for transmitting HIV;
- To ensure the efficient, responsible, and ethical use of fiscal resources for HIV/AIDS service delivery and program administration; and
- To ensure and demonstrate positive outcomes through effective program oversight, accountability, quality management, and research and evaluation.

Guiding Principles and Values

The principles and values that guide the HIV Care Branch and ADAP Section are:

- All people with HIV must be provided appropriate quality care, treatment, and support services that improve health outcomes, enhance quality of life, and reduce health disparities;
- In order to slow the epidemic, all people with HIV who are at risk for transmitting HIV must have access to effective HIV prevention services, including appropriate medications and treatment adherence support;
- All people with HIV must have access to HIV services regardless of geographic region, age, race, national origin, religion or sect, sexual orientation or identity, income, veteran status, immigration status, disability, ethnicity, or citizenship;
- The care system is enhanced through the significant involvement of people with HIV in the planning, implementation, management, and evaluation of the HIV care system;
- Valuing and supporting HIV staff and providers through ongoing technical assistance, dissemination of information, training, and self-care strategies is essential to maintaining a high-quality and sustainable HIV service delivery system;

- Outreach to people with HIV who are not in care is a critical element of the HIV service system, especially within communities that are underserved, vulnerable, or disproportionately impacted;
- The provision of HIV services must be linguistically and culturally appropriate to, and synchronous with, the diverse populations in California;
- Integrating services related to HIV, STD, VH, and TB facilitates detection, access, and effective treatment;
- Collaboration and coordination with local partners is essential to the development and maintenance of a comprehensive, sustainable HIV service delivery system;
- Collaboration and coordination among public and private partners are essential to planning, developing, funding, managing, and evaluating a comprehensive, sustainable system of HIV services;
- Informed, evidence-based policy development and programmatic decision making are essential for achieving effective service delivery and successful outcomes;
- Integrity and accountability are essential to the responsible management of public dollars; and
- Flexibility and creativity are key components of a care service system that is responsive to changes in the HIV epidemic as well as to its societal, political, and fiscal context.

SECTION 3. HOW WILL WE GET THERE?

HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF, AND ACCESSIBILITY TO, CORE SERVICES?

The HIV Care Branch and ADAP Section developed short- and long-term goals to further their efforts to accomplish the OA mission and HIV Care Branch purpose. These short- and long-term goals are consistent with the HIV Care Branch guiding principles and goals, as well as with HRSA's policies and expectations for administration and oversight of Ryan White Part B-funded programs.

Long-Term (Three-Year) Goals and Objectives

Service Delivery System Goals

- To increase access and reduce health disparities, especially in the disproportionately-impacted, vulnerable, and underserved populations most often served with public funds;

- To improve or maintain the quality of HIV care, treatment, support, and prevention services for persons with HIV/AIDS in California through quality management and outcomes measurement;
- To encourage and support proactive actions by HIV care providers to coordinate with the follow-up efforts of existing and developing HIV test sites within and outside of medical settings to link newly diagnosed HIV-infected persons into HIV care sites;
- To maximize the use of the services and resources available to PLWH/A in California through the development and support of benefits counseling expertise throughout the state, including services that promote independence and self-sufficiency;
- To respond to fiscal challenges by developing policies and guidelines that support service delivery efficiencies without lessening quality care, treatment, or prevention services.
- To minimize preventable future HIV/AIDS costs by identifying and filling those gaps in care, treatment, and prevention services that significantly contribute to the development of more serious, and more expensive, health conditions and increased HIV transmission;
- To expand and improve transitional case management services to maintain HIV treatment for recently incarcerated or soon to be released HIV-infected persons; and
- To integrate mental health and substance abuse treatment services within HIV care settings.
- To leverage training and consultation resources, including in person, by phone, by telemedicine, and by Web-based systems, to increase access to appropriate care in all relevant settings.
- To increase our understanding of, and programmatic focus on, lost-to-care/never-in-care HIV-infected individuals.

Administrative System Goals

- To respond to fiscal challenges by coordinating with local partners to assess administrative and contractual functions and identify opportunities for streamlining processes and developing efficiencies;
- To support, improve, or enhance planning and evaluation activities to respond to changes in the epidemic and its societal, political, and fiscal context;

- To assess, and modify as necessary, current HIV/AIDS program allocations to ensure the most equitable, effective, and efficient use of resources; and
- To develop effective and efficient methods of blending funding streams without reducing accountability or increasing administrative burden.
- To maximize program resources through enforcement of payor-of-last-resort policies and requirements.

Short-Term (Annual) Goals and Objectives

1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit to be provided	3. Quantity		4. Time Frame: Indicate the estimated duration of activity relating to the objective listed.	5. Funds: Provide the approximate amount of funds to be used to provide this service.
		3a) Number of people to be served	3b) Total Number of service units to be provided		
Service Priority Name: ADAP		Total Priority Allocation: \$86,745,592			
Service Goal: To ensure access to HIV/AIDS treatments					
a. Provide all drugs within the PHS Guidelines for the treatment of HIV	One prescription	35,234	1,050,611 prescriptions average 29.8 prescriptions per client	4/1/09 - 3/31/10	\$86,745,592
b. Provide all PHS A-1 recommended medications for the prevention and treatment of opportunistic infections.					
c. Provide a comprehensive drug formulary to eligible ADAP clients.					
6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:					
a. & b. 90% of ADAP clients with CD4+ T-cell count less than 350 are prescribed highly active antiretroviral therapy.					
Service Priority Name: CMP		Total Priority Allocation: \$5,426,517			
Service Goal: To provide comprehensive nurse and social work case management to persons with HIV/AIDS to allow these individuals to remain in their homes, stabilize their health, improve their quality of life, and avoid costly institutional care.					
a. Provide ongoing, face-to-face case management contacts with CMP clients.	Six face-to-face contacts during the fiscal year	1,107	6,642	4/1/09 - 3/31/10	\$4,341,214
b. Provide ongoing face-to-face case management contacts with women, infants, children and youth.	Six face-to-face contacts during the fiscal year	276	1,656	4/1/09 - 3/31/10	\$1,085,303
6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:					
Appropriateness of care: staff-to-client ratios meet CMP requirements and reassessments are conducted every 60 days to ensure client health and welfare. By the end of the fiscal year, 90% of all contractors will meet the staffing requirements and 80% of all clients charts sampled will reflect timely reassessments.					
Access to care: a comprehensive service plan that includes long-term goals, identified problems or needs, stated goals and objectives, and services and interventions are developed and reviewed at least every 60 days (or when client's condition changes). By the end of the fiscal year, 80% of all client charts reviewed will document that the service plan has been reviewed, with client input, at least every 60 days.					
Service Priority Name: CARE/HIPP		Total Priority Allocation: \$1,700,000			
Service Goal: Provide premium payments on behalf of clients with insurance coverage.					
a. Ensure eligible clients with continued private health insurance coverage have access to the program.	Quarterly private insurance premium payments for up to 36 months with recertification of eligibility.	400	552	4/1/09 - 3/31/10	\$1,700,000

1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit to be provided	3. Quantity		4. Time Frame: Indicate the estimated duration of activity relating to the objective listed.	5. Funds: Provide the approximate amount of funds to be used to provide this service.
		3a) Number of people to be served	3b) Total Number of service units to be provided		
b. Prompt premium payments to ensure continued coverage.	Quarterly private insurance premium payments for up to 36 months with recertification of eligibility.	400	552	4/1/09 - 3/31/10	Included in a.
6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:					
a. Quarterly communication with benefits counselors to ensure that clients meet eligibility requirements. b. Quarterly determination of third-party payers (i.e., Medicaid and/or Medicare) via the Medi-Cal Eligibility Data Systems to ensure transition to appropriate payer.					
Service Priority Name: EIP			Total Priority Allocation: \$6,092,535		
Service Goal: To provide comprehensive multidisciplinary HIV care, treatment, and prevention services to PLWH/A in order to maintain their health and productivity and to reduce the transmission of HIV.					
a. Assist never-in-care HIV-positive, including the post-incarcerated, to engage in HIV care, treatment, and prevention services.*	1 client contact = 5 service units	310	1,550	4/1/09 - 3/31/10	\$221,001
b. Assist lost-to-care HIV-positive persons, including the post-incarcerated, to engage in HIV care, treatment, and prevention services.*	1 client contact = 5 service units	310	1,550	4/1/09 - 3/31/10	\$221,001
c. To provide comprehensive early intervention services including, but not limited to, confirmatory testing, laboratory tests, periodic medical evaluation and follow up, provision of therapeutic measures, referrals, and other related services.	1 visit 4 times per year	2,100	8,400	4/1/09 - 3/31/10	\$3,169,150
d. To provide comprehensive health and treatment education and transmission risk-reduction services.	1 visit 2 times per year	2,100	4,200	4/1/09 - 3/31/10	\$1,562,883
e. To identify EIP clients at very high risk for HIV transmission and to provide intensive, individualized counseling interventions.	1 visit/contact 20 times per year	250	5,000	4/1/09 - 3/31/10	\$459,250
f. To provide integrated mental health services and counseling services to individuals with a diagnosed mental illness, conducted in a group or individual setting.*	1 visit/contact 20 times per year	120	2,400	4/1/09 - 3/31/10	\$459,250
6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:					
Appropriateness of care: staff-to-client ratios meet CMP requirements and reassessments are conducted every 60 days to ensure client health and welfare. By the end of the fiscal year, 90% of all contractors will meet the staffing requirements and 80% of all clients charts sampled will reflect timely reassessments.					
c. and d. Indicator/CD4 T-cell count (HAB OPR #2) 75% of clients with HIV infection will have 2 or more CD4 T-cell counts performed in the measurement year.					

* Services that address objectives 1a, 1b, and 1f will be increased if supplemental funding is approved.					
Service Priority Name: Direct Services			Total Priority Allocation: \$2,655,467		
Service Goal: To ensure PLWH/A have access to on-going health care and supportive services in order to improve their health status and quality of life.					
a. To provide comprehensive, accessible, and equitable health care services in accordance with PHS Treatment Guidelines for HIV-positive individuals	One office visit or test	1,078	14,316	4/1/09 - 3/31/10	\$366,047
b. To ensure uninterrupted access to life saving medications necessary to effectively treat HIV disease for eligible PLWH/A.	Once script filled	100	1,032	4/1/09 - 3/31/10	\$5,600
c. To provide quality mental health treatment to eligible PLWH/A to promote their mental stability and capacity to attend to health care needs related to HIV disease.	One session (group or individual)	200	1,443	4/1/09 - 3/31/10	\$52,965
d. To provide substance abuse treatment to eligible PLWH/A to address chemical dependency in an effort to improve their quality of life and to enhance their capacity to adhere to HIV treatment regimens.	One group or individual visit or bed night	35	774	4/1/09 - 3/31/10	\$13,500
e. To provide quality oral health care to eligible PLWH/A through reimbursement to qualified dentists.	One office visit or test	97	2,357	4/1/09 - 3/31/10	\$52,292
f. To link eligible PLWH/A with timely, coordinated, and continuous access to medically-appropriate levels of health, treatment adherence, and support services through case management and on-going assessment of client's needs and personal support systems, in a medical setting	One office/home visit	1,523	53,729	4/1/09 - 3/31/10	\$784,387
g. To link eligible PLWH/A with timely, coordinated, and continuous access to medically-appropriate levels of health and support services through case management and on-going assessment of client's needs and personal support systems in a non-medical setting.	One office/home visit	1,523	53,729	4/1/09 - 3/31/10	\$601,364
h. To link eligible PLWH/A with available home health care including professional services and high tech therapies.	One home visit	140	2,084	4/1/09 - 3/31/10	\$18,945
i. To provide financial assistance to eligible PLWH/A to maintain continuity of health insurance or medical benefits under a health insurance program.	One month of premium paid	337	1,200	4/1/09 - 3/31/10	\$713,975
j. To provide nutritional education and counseling with a registered or licensed dietician.	One office visit or test	92	25	4/1/09 - 3/31/10	\$17,147
k. To provide room/board, nursing care, counseling, and physician services to those in the terminal stages of illness.	Encounter	22	7,832	4/1/09 - 3/31/10	\$1,532
l. To ensure necessary transportation for client to maintain access to health care and supportive services.	One roundtrip	1,903	4,806	4/1/09 - 3/31/10	\$188,012

m. To provide early intervention counseling, outreach, testing, and referral to those infected and affected by HIV/AIDS as it relates to drug exposure and other factors. To coordinate supportive services to bring individuals into the continuum of care.	Encounter	20	243	4/1/09 - 3/31/10	\$10,270
n. To provide services that educate clients with HIV and HIV transmission and how to reduce the risk of HIV transmission.	Encounter	1,500	18,275	4/1/09 - 3/31/10	\$75,108
o. To provide emergency financial assistance to eligible clients for utilities and medication assistance when no other options are available.	One payment	375	42,872	4/1/09 - 3/31/10	\$67,430
p. To provide food and necessary household supplies to eligible clients through the use of vouchers and/or food banks.	One voucher or meal	1,208	57,419	4/1/09 - 3/31/10	\$179,309
q. To provide short-term or emergency housing and housing-related services to eligible clients and their families to assist them in gaining or maintaining medical care.	Monthly payment	275	125	4/1/09 - 3/31/10	\$79,115
r. To provide educational services to high-risk clients to reduce the risk of HIV transmission in identified populations.	Encounter	298	2,357	4/1/09 - 3/31/10	\$75,408
s. Provide resources to contracted agents to provide psychosocial support services to PLWH/A to combat the negative effects of loneliness and isolation and grief caused by HIV than can impair their ability to maintain good health.	Encounter	203	3,350	4/1/09 - 3/31/10	\$44,212
t. To provide resources to agencies that deliver legal services to PLWH/A as defined under the Ryan White Part B Program.	Consultation	7	15	4/1/09 - 3/31/10	\$600
u. To direct clients to a service in person, by telephone, written or any other form of communication.	One session	5	65	4/1/09 - 3/31/10	\$224
v. To relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.	One session	4	50	4/1/09 - 3/31/10	\$200
w. To identify people with unknown HIV disease so they may become aware of, and enrolled in care and treatment services.	Encounter	10	25	4/1/09 - 3/31/10	\$4,300
x. To provide interpretation and translation services.	Occurrence	40	59	4/1/09 - 3/31/10	\$3,125
y. To provide individualized care to improve/maintain clients' quality of life and optimal capacity for self care.	Encounter	4	152	4/1/09 - 3/31/10	\$500
6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:					
a. Ensure that 75% of all client charts reviewed for CSP in a medical setting have CD4 counts noted in the files. f. 80% of client files reviewed of clients receiving CSP-funded case management services will have a comprehensive, individualized service plan on record.					

Service Priority Name: Consortia EMA/TGA			Total Priority Allocation: \$9,965,197		
Service Goal: To ensure PLWH/A have access to ongoing health care and supportive services in order to improve their health status and quality of life.					
a. To provide comprehensive, accessible, and equitable health care services in accordance with PHS treatment guidelines for HIV-positive individuals.	One office visit, test or durable goods item	9,113	48,097	4/1/09 - 3/31/10	\$4,004,339
b. To ensure uninterrupted access to life saving medications necessary to effectively treat HIV disease for eligible PLWH/A.	One script filled	625	4,453	4/1/09 - 3/31/10	\$294,956
c. To provide emergency financial assistance to eligible clients for utilities and medication assistance when no other options are available.	One payment	64	1,880	4/1/09 - 3/31/10	\$14,515
d. To provide substance abuse treatment to eligible PLWH/A to address chemical dependency in an effort to improve their quality of life and to enhance their capacity to adhere to HIV treatment regimens in a residential setting.	One group or individual visit or bed night	12	3,752	4/1/09 - 3/31/10	\$4,000
e. To provide quality oral health care to eligible PLWH/A through reimbursement to qualified dentists.	One visit	11	3	4/1/09 - 3/31/10	\$1,200
f. To link eligible PLWH/A with timely, coordinated, and continuous access to medically appropriate levels of health and support services through case management and ongoing assessment of client's needs and personal support systems in a medical setting.	One office/home visit	3,180	8,298	4/1/09 - 3/31/10	\$3,186,063
g. To provide room and board, nursing care, counseling, physician services, and palliative therapeutics services to clients in the terminal states of illness in a residential setting.	One bed night	4,127	84,379	4/1/09 - 3/31/10	\$349,293
h. To ensure necessary transportation for client to maintain access to health care and supportive services.	One roundtrip	378	1,023	4/1/09 - 3/31/10	\$98,577
i. Provide food and necessary household supplies to eligible clients through the use of vouchers and/or food banks.	One voucher or meal	198	604	4/1/09 - 3/31/10	\$8,252
j. To provide short-term or emergency housing assistance to eligible clients and their families to assist them in gaining or maintaining medical care.	Monthly payment	10	30	4/1/09 - 3/31/10	\$2,800
k. Provide resources to contracted agents to provide psychosocial support services to PLWH/A to combat the negative effects of loneliness, isolation and grief caused by HIV that can impair their ability to maintain good health.	Encounter	667	2,002	4/1/09 - 3/31/10	\$480,000

l. To link eligible PLWH/A with timely, coordinated, and continuous access to medically appropriate levels of health and support services through case management and ongoing assessment of client's needs and personal support systems in a non-medical setting.	One office/home visit	1,420	4,260	4/1/09 - 3/31/10	\$1,494,779
m. To provide skilled health services in the client's home based on a written plan of care.	One home visit	10	120	4/1/09 - 3/31/10	\$1,782
n. To provide services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission	Encounter	423	4,260	4/1/09 - 3/31/10	\$24,641
o. Provide financial assistance to maintain continuity of health insurance	One month premium	800	4,800	4/1/09 - 3/31/10	\$1,000,000
6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:					
a. Ensure that 75% of all client charts reviewed for CSP in a medical setting have CD4 counts noted in the files. f. 80% of client files reviewed of clients receiving CSP-funded case management services will have a comprehensive, individualized service plan on record.					

SECTION 4. HOW WILL WE MONITOR OUR PROGRESS? HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR SHORT- AND LONG-TERM GOALS?

Improving Client-Level Data (CLD)

The ability to collect relevant data is critical to ensure that eligible clients receive necessary medical and support services, to monitor the quality of those services, and to evaluate the effectiveness of those services in improving clients' health and quality of life. While some data can be collected from contracts, progress reports, site visits, and chart reviews, access to a comprehensive data system containing client demographic, behavioral, clinical, and service utilization data allows for a complete and systematic evaluation. OA's HIV client case management system, ARIES, is the primary data system for clients receiving services from CSP, EIP, CMP, MCWP, and CARE/HIPP. Bridge Project, Pathways, and Positive Changes will transition to ARIES in the coming year. ADAP has a separate, robust data reporting system that contains client demographic and drug utilization information.

ARIES is a Web-based HIV/AIDS client case management system that OA developed in partnership with the San Bernardino/Riverside and San Diego Part A Grantees, along with the Texas Part B Grantee. Statewide implementation began in July 2006, with the final OA-funded providers scheduled to be trained and using ARIES no later than June 2009. OA-funded providers that choose to not use ARIES (this option is only available for providers in EMA/TGA regions that are not using ARIES as their primary HIV data collection system) are responsible for importing its state- and federal-mandated data into ARIES. Once ARIES implementation is complete, OA will have statewide, unduplicated client and service data, providing the opportunity for improved program monitoring, quality management activities, and evaluation projects. Additionally, clients in both ARIES and ADAP data systems can be linked for robust reporting and evaluation activities.

ARIES is currently undergoing minor modifications to ensure it meets HAB's CLD reporting requirements. OA also participated in the CLD pilot and is working closely with HAB contractors to ensure our providers have the capability to electronically upload data from ARIES to HAB. By January 1, 2009, ARIES will be configured to collect all the necessary CLD, and the reporting capability will be available by June 2009 (for the reporting cycle beginning in July 2009).

The ARIES partners and users are continuously enhancing ARIES to meet new reporting requirements, and to better meet the needs of HIV/AIDS clients and the agencies that serve those clients.

Using Data for Evaluation

The short- and long-term goals and objectives for achieving California's vision for care and treatment will be monitored and evaluated on an ongoing basis. Performance

measurements have been established and will be evaluated utilizing the data collected through the ARIES or ADAP data reporting systems, or other data sources as appropriate, including qualitative data. Program objectives not met will be evaluated and, in line with existing quality management processes (such as the plan-do-study-act cycle) incremental changes will be made as necessary.

With the full implementation of ARIES, OA plans to improve its monitoring of the clients served and services utilized by developing and distributing cross-program reports, both for internal use and external distribution. Additionally, as ARIES implementation work decreases, staff will be developing proposals for HIV care and treatment program evaluation activities. In particular, OA is developing its strategic plan, with the two primary goals of: 1) minimizing the number of people acquiring HIV infection; and 2) maximizing the number of people with HIV infection who are accessing appropriate care, treatment, and support services. New evaluation activities will be developed to support and respond to these two primary goals.

Measuring Clinical Outcomes

As required by HRSA, OA's HIV Care Branch has established a Clinical Quality Management (CQM) Committee which includes staff from all the care and treatment programs (including ADAP and CARE/HIPP), as well as staff from the Care Research and Evaluation Section of the HIV/AIDS Epidemiology Branch. The committee operates with an approved CQM plan, which includes the following mission, purpose, and goals:

Mission: Use continuous quality improvement methodologies to systematically evaluate client care and services to ensure equitable access to and provision of comprehensive quality health care and supportive services in California for PLWH/A.

Purpose: The purpose of OA's CQM Program is to:

- Ensure that limited resources are used effectively and efficiently;
- Identify problems, barriers, and program deficiencies and use the results to improve services;
- Support medical providers' efforts to assure that services adhere to HIV clinical practice standards and PHS guidelines; and
- Improve the quality of HIV health and supportive services and increase the probability of desired patient outcomes.

Major Goals:

- Enhance CQM activities and CQM awareness through the following activities new for 2009:
 - i. Ensure new CQM Committee staff are trained regarding CQM principles; attend monthly CQM Technical Assistance Webinars; complete the National Quality Center online tutorials;

- ii. Monitor the selected HAB Group 1 core clinical performance measures that each care and treatment program adopted;
 - iii. Review HAB Group 2 clinical performance measures and recommend to management that one or more measures be adopted by each program;
 - iv. Review HAB Group 3 draft clinical performance measures, update OA management and make possible recommendations for adoption; and
 - v. Establish a plan to evaluate our CQM process and structure, begin implementation of evaluation plan.
- Improve data collection methods and accessibility to perform CQM activities by:
 - i. Continuing to update ARIES to calculate and report on HAB clinical performance measures (if appropriate); and
 - ii. Reviewing and supporting the care and treatment programs as they revise and update their chart review tools to ensure that modifications improve their ability to monitor the quality of services provided by their contractors.

OA has also been working more closely with PAETC to enhance our CQM activities. A PAETC physician now sits on OA's CQM Committee and provides additional clinical guidance and experience. Additionally, PAETC provides clinical consultation, information, referral, and training to medical providers. PAETC assists the HIV Care Branch and ADAP with medical policy/procedures, implementation of staff in-service training plans, chart reviews, and medical treatment updates and assists OA's quality management efforts by providing expert guidance in the development, collection, analysis, and interpretation of medical indicators.

Each care and treatment program develops and monitors two categories of indicators: 1) those that assess how appropriately and effectively the OA program is conducting its business and to identify and evaluate ways to improve programmatic and fiscal administration; and 2) those that assess and monitor the quality of services provided by an OA-funded provider to ensure the delivery of quality services to clients in accordance to programmatic standards of care or PHS treatment guidelines. Over the past year, OA care and treatment programs have increased their ability to monitor the provider-based indicators, which are primarily clinical outcome measures. HAB's development of HIV core clinical performance measures for adults and adolescents provided a structure for improving our monitoring of clinical outcome measures.

Once HAB released its Group 1 HIV Core Clinical Performance Measures, OA's CQM Committee evaluated the feasibility and utility of adopting each measure. Additionally, the data collection requirements of each indicator were evaluated by the ARIES partnership. It was determined that only a few changes were necessary to incorporate the five Group 1 measures into ARIES; in October 2008 these indicators became available in ARIES. With this enhancement, every provider using ARIES can now, at a click of a button, determine the percentage of its eligible clients that meet each of those five quality indicators.

In late 2008, the ARIES partners completed its feasibility analysis of incorporating the HAB Group 2 indicators, and determined that, with some modifications, all but one of the indicators can be supported by ARIES (the exception is the lipid screening indicator, which will be supported once ARIES undergoes a medical module enhancement). The Group 2 indicators will be available in ARIES by mid-2009.

The majority of OA’s care and treatment programs adopted at least one of the Group 1 indicators; monitoring will begin in January 2009, giving programs time to inform and train its providers, and acknowledging that all OA-funded providers will be entering data into ARIES by June 2009.

Below is a table describing the performance measures each care and treatment program plans to monitor for calendar year 2009, with new goals noted by **NEW** in the indicator type cell:

Program	Program or Provider Focus	Indicator Type	Indicator	Performance Measure	Data Sources
CBC	Provider	Administrative Accountability (HRSA Goal #7)	Number of contractors submitting timely data	65% of CMP/MCWP contractors	ARIES/ CAREbase
	Provider	Accessibility of Care (HRSA Goal #1)	Number of client charts reflecting appropriate program eligibility	80% of all CMP/MCWP charts	Site Visit Tool
	Program	Program Education/Training (HRSA Goal #5, #6, #7)	Number of new and existing projects or staff trained	--80% of requested TA provided --80% of requested orientations provided --100% of new providers trained all within 60 days	-- Site visit reports -- Progress reports
	Program	Administrative Accountability (HRSA Goal #7)	Number of contractors actually reviewed and Compliance Review Reports issued within required time period	--80% of contractors reviewed within 18-month standard --80% of reports issued after the Compliance Review within 90 days	Site visit log
	Provider	HAB Group 1 PCP Prophylaxis - OPR #3 NEW	Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm ³ who were prescribed PCP prophylaxis	70% of eligible clients will have documented PCP prophylaxis	ARIES
	Provider	HAB Group 2 TB Screening NEW	Percentage of clients with HIV infection who received testing with results documented for LTBI since HIV diagnosis	70% of eligible clients will have documented LTBI testing results	ARIES

2009 California Comprehensive Care Plan for HIV/AIDS Care, Treatment, and Support

Program	Program or Provider Focus	Indicator Type	Indicator	Performance Measure	Data Sources
	Provider	HAB Group 1 OPR #2 - CD4 T-Cell count NEW	Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year	75% of eligible clients will have 2 or more CD4 T-cell counts	ARIES
CARE/HIPP	Provider	Accessibility of Care (HRSA Goal #1)	Number of clients who access outpatient medical care and prescription drugs by continuing their private health insurance coverage. Expanded Program Eligibility Limit to 36 months	400 clients will be served annually. Potentially 50 clients will continue to receive C/H services	ARIES
	Program	Program Education/Training (HRSA Goal #5, #6, #7)	100% of five major enrollment areas.	100% of five major enrollment areas.	Tracking Log
	Program	Administrative Accountability; Accessibility of Care (HRSA Goal #1, #7)	Balance of funds in account	100% accuracy in reconciliation with Accounting and State Controllers Office	-- Access database -- CORE expenditure report
CSP	Program	Administrative Accountability (HRSA Goal #7)	Number of Fiscal Agents who will have a Monitoring Site Visit at least once within reporting period	Annually 33% of fiscal agents will have one Monitoring Site Visit (our goal is to perform a minimum of one monitoring site visit at each fiscal agent per contract period)	Monitoring Site Visit Tool
	Provider	Accessibility of Care; Appropriateness of Care; Continuity of Care; Efficacy of Care; Efficiency of Care; Patient Perspective Issues (HRSA Goal #1,2,4)	Number of clients receiving CSP-funded case management services who have a comprehensive, individualized service plan on record	80% of client files reviewed that receive CSP-funded case management services will have a comprehensive, individualized service plan on record	-- Fiscal Agent Monitoring Site Visit Tool -- Subcontractor Survey
	Provider	HAB Group 1 CD4 T-Cell count - OPR #2 NEW	Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year	75% of eligible clients will have 2 or more CD4 T-cell counts	ARIES
	Provider	HAB Group 1 PCP Prophylaxis - OPR #3 NEW	Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm ³ who were prescribed PCP prophylaxis	70% of eligible clients will be prescribed PCP prophylaxis	ARIES

2009 California Comprehensive Care Plan for HIV/AIDS Care, Treatment, and Support

Program	Program or Provider Focus	Indicator Type	Indicator	Performance Measure	Data Sources
	Provider	HAB Group 1 Medical Visits - OPR #1 NEW	Percentage of clients with HIV infection who had 2 or more medical visits in an HIV care setting in the measurement year	75% of eligible clients will have 2 or more medical visits in an HIV care setting	-- ARIES (primary source) -- Monitoring Site Visit Tool
	Provider	HAB Group 2 TB Screening NEW	Percentage of clients with HIV infection who received testing results documented for LTBI since HIV infections	70% of eligible clients will have documented LTBI testing results	ARIES
EIP, Bridge Project, Positive Changes	Program	Administrative Accountability (HRSA Goal #7)	Number of program sites visited during FY	33% of sites will be visited by EIS staff during the current FY for project assessment purposes. Thirty-four sites of which 8% - 20% do not need to be visited	Project tracking tool
	Program	Administrative Accountability (HRSA Goal #7) NEW	Number of program sites needing assistance that received follow-up activity	75% of sites with problems or issues identified by EIS staff during a monitoring visit will receive training, technical assistance or other follow-up activity	-- Project tracking tool -- Program files -- Quarterly reports -- Site visit reports -- Site correspondence
EIP	Provider	HAB Group 2 HIV Risk Counseling NEW	Percentage of clients with HIV infection who received HIV risk counseling as part of their primary care	50% of clients will receive HIV risk counseling as part of their HIV care services	-- ARIES (primary source) -- CRaTE (secondary source) -- Monitoring Site Visit tool
	Provider	HAB Group 1 CD4 T-Cell count - OPR #2 NEW	Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year	75% of eligible clients will have 2 or more CD4 T-cell counts	-- ARIES -- Chart reviews
	Provider	HAB Group 1 Medical Visits - OPR #1 NEW	Percentage of clients with HIV infection who had 2 or more medical visits in an HIV care setting in the measurement year	75% of eligible clients will have 2 or more medical visits in an HIV care setting	--ARIES --Chart reviews
TMP	Provider	Accessibility of Care (HRSA Goal #1)	Number of vouchers utilized each year	70% of vouchers issued are used before they expire	Monthly tracking and usage form
Bridge Project	Provider	Accessibility of Care (HRSA Goal #1)	Number of Bridge clients previously out-of-care that enroll in care	75% of Bridge clients previously out-of-care enroll in HIV care	Bridge Project database/ARIES
	Provider	Continuity of Care (HRSA Goal #1)	Number of Bridge clients previously lost-to-care that re-enroll in care	75% of Bridge clients previously lost-to-care enroll in HIV care	Bridge Project database/ARIES

Program	Program or Provider Focus	Indicator Type	Indicator	Performance Measure	Data Sources
ADAP	Provider	Accessibility of Care (HRSA Goal #1)	Number of complete applications processed within 24 hours	80% of complete enrollment applications are processed within 24 hours	Ramsell quarterly QA report
	Provider	Patient Perspective Issues (HRSA Goal #5)	Number of clients satisfied with pharmacy services	75% of client surveys will contain positive responses on pharmacy services	OA/ADAP Client Satisfaction survey
	Provider	Accessibility of Care (HRSA Goal #1)	Number of complete requests processed within 24 hours	50% of completed Prior Authorization requests are processed within 24 hours	Ramsell quarterly QA report
	Provider	HAB Group 1 HAART	Number of clients that are prescribed HAART	90% of ADAP clients who AIDS are prescribed HAART	Quarterly prescription/client data submitted to OA from Ramsell

CONCLUSION

In the past, California has had great success in overcoming the many challenges to providing HIV services for many different populations throughout the varied regions of the state. CBOs and local health departments have formed the backbone of the service delivery system, supported by a strong local planning and advocacy component. Significant progress has been made in ensuring that access to basic medical services and medications are available to all HIV-infected persons, and that basic medical services are linked to a network of prevention and support services that reduce HIV transmission as well as help meet the psychosocial, physical, educational, and practical needs of PLWH/A. Much progress has also been made in ensuring greater access to services for disproportionately affected, vulnerable, and emerging populations, and expanded outreach has brought individuals into treatment earlier.

However, past success will mean little if we are unable to maintain comprehensive, accessible, quality, affordable HIV services in this era of shrinking resources and increased demand for services. The current economic crises in the state and the nation have already begun to erode the health care system, including HIV services. The foremost challenge for California will be to closely examine the existing service delivery system in an effort to identify opportunities to economize or prioritize without adversely affecting health outcomes or increasing HIV transmission, both of which have the potential to increase, rather than avoid, future HIV/AIDS costs.

Since the beginning of the epidemic, HIV service providers, advocates, administrators, public servants, scientists, researchers, and persons affected and infected by HIV have formed an effective coalition to meet the challenges of HIV. Current economic conditions will again require a strong coalition to meet this most recent obstacle to conquering HIV.

Resource Inventory and Profile of Ryan White Part B-Funded Providers by Service Category

County Name Counties Served	Contractor (Subcontractors)	Program	Core Medical Services										Support Services																			
			Outpatient/ Ambulatory Medical Care	ADAP Treatments	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premiums	Home Health Care	Home and Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services	Case Management (Non- Medical)	Child Care Services	Emergency Financial Assistance	Food Bank	Home Delivered Meals	Health Education Risk Reductions	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services Residential	Treatment Adherence Counseling
Alameda Contra Costa	Bay Area Consortium for Quality Health Care, Inc.	CMP										X			X										X							
		MCWP						X				X					X						X		X							
		EIP				X													X													
		Br																							X							
		Pthwys									X		X							X												
		TMP	X																													
		PC									X		X							X												
	Berkeley Primary Care Access Clinic	TMP	X																													
	Casa Segura	TMP	X																													
	East Bay AIDS Center	TMP	X																													
		CSP	X									X																				
	Contra Costa County Health Services Department Public Health	CSP	X			X	X								X	X							X									
		CMP							X			X																				
		MCWP							X			X					X															
		EIP				X													X													
		Br																							X							
	Highland Hospital	TMP	X																													
Tri City Health Center	TMP	X																														

Resource Inventory and Profile of Ryan White Part B-Funded Providers by Service Category

County Name Counties Served	Contractor (Subcontractors)	Program	Core Medical Services										Support Services																							
			Outpatient/ Ambulatory Medical Care	ADAP Treatments	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services Health Insurance Premiums	Home Health Care	Home and Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services	Case Management (Non- Medical)	Child Care Services	Emergency Financial Assistance	Food Bank	Home Delivered Meals	Health Education Risk Reductions	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services Residential	Treatment Adherence Counseling					
San Francisco Marin San Mateo	San Mateo County Health Services	CMP	X					X			X					X		X			X		X													
		MCWP						X			X						X					X														
		EIP				X												X																		
		TMP	X																																	
		PC								X		X						X																		
		Br																						X												
	Walden House	CSP																											X							
	San Mateo AIDS Clinic/Edison Program	CSP	X								X											X									X					
	Hospice by the Bay	CMP							X			X																								
		MCWP							X			X																								
San Joaquin																																				
San Joaquin	San Joaquin County Public Health Services	CMP						X			X					X		X			X															
		MCWP							X			X																								
		HOPWA											X			X		X				X														
		TMP	X																																	
		EIP				X												X																		
		Br																							X											
		CSP												X			X						X													
		Pthwys									X		X						X																	

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
FAIRMONT HOSPITAL	15400 FOOTHILL BLVD	SAN LEANDRO	94578	510-895-4353	510-895-4359	01-Sep-97	30-Jun-09	GARCIA, ALEJANDRA	AGARCIA@ACMEDCTR.ORG	Alameda	555
HIGHLAND HOSPITAL	1411 E. 31ST STREET	OAKLAND	94602	510-437-4355	510-437-4947	01-Sep-97	30-Jun-09	QUIJANO, BILLIE		Alameda	1,235
AIDS PROJECT EAST BAY	1320 WEBSTER STREET	Oakland	94612	510-663-7979	510-663-7980	01-Sep-97	30-Jun-09	ADAIR, DONISE	dadair@apeb.org	Alameda	340
Santa Rita Jail	5325 Broder Blvd.	Dublin	94568	510-551-6748	510-551-6609	01-Sep-97	30-Jun-09	Martin, Chew		Alameda	792
Tri-City Health Center	39184 State Street	Fremont	94538	510-713-6690	510-739-1239	01-Sep-97	30-Jun-09	Arroyo, Elias	Eliasarroyo94538@yahoo.com	Alameda	232
Tri-City Health Center	3311 Pacific Avenue #14	Livermore	94550	925-606-1451	925-606-1468	01-Sep-97	30-Jun-09	Arroyo, Elias	Eliasarroyo94538@yahoo.com	Alameda	65
KAISER-OAKLAND	280 W. MAC ARTHUR BLVD	OAKLAND	94611	510-752-6344	510-752-1639	01-Sep-97	30-Jun-09	KEY, JENNIFER	Pager # 510-805-2736	Alameda	551

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
KAISER - HAYWARD	27400 HESPERIAN BLVD.	HAYWARD	94545	510-784-4829	510-784-4990	01-Sep-97	30-Jun-09	LOSSOW, LYN		Alameda	188
LA CLINICA DE LA RAZA	1515 FRUITVALE AVE	OAKLAND	94601	510-535-4000	510-535-4291	01-Sep-97	30-Jun-09	TAYLOR, SCOTT	STAYLOR@LACLINICA.ORG	Alameda	52
TRI-CITY HAYWARD	770 "A" STREET	HAYWARD	94541	510-727-9233	510-727-9232	25-Sep-98	30-Jun-09	ELIAS ARROYO		Alameda	118
AIDS MINORITY HEALTH INITIATIVE	5709 MARKET ST	OAKLAND	94607	510-652-3300	510-763-3132	27-Apr-99	30-Jun-09	SISSON, PATRICIA	PSISSON2001@yahoo.COM	Alameda	138
AIDS HEALTH CARE FOUNDATION	411 30TH ST	Oakland	94609	510-628-0949	415-552-2909	08-Aug-00	30-Jun-09	AIELLO, JOSEPH		Alameda	312
VITAL LIFE SERVICES	5836 SAN PABLO AVE	OAKLAND	94608	510-655-3435	510-655-2543	01-Mar-05	30-Jun-09	ESPIRITU, MONICA	MONICA@VITALCALIFORNIA.ORG	Alameda	16
EAST BAY AIDS CENTER	3100 SUMMIT STREET 2ND FLOOR	OAKLAND	94609	510-869-8400	510-869-8774	22-Dec-05	30-Jun-09	DELGADO, JOSEPH		Alameda	485

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
BUTTE COUNTY PUBLIC HEALTH DEPARTMENT	202 MIRA LOMA DR	OROVILLE	95965	530-538-6109	530-538-6221	08-Feb-00	30-Jun-09	LORNA ANDREATTA		Butte	149
HOME HEALTH CARE MANAGEMENT, INC	1398 RIDGEWOOD DRIVE	RICHARDSON SPRINGS	95973	530-343-0727	530-895-1703	08-Feb-00	30-Jun-09	LOOFBOURROW, MARILYN		Butte	90
SIERRA HOPE	P.O. BOX 159	ANGELS CAMP	95222	209-736-6792	209-736-6836	01-Sep-97	30-Jun-09	WILLIS, SHARON	SWILLIS@SIERRAHPE.ORG	Calaveras	84
HOME HEALTH CARE MANAGEMENT, INC	1018 LIVE OAK BLVD, STE C	YUBA CITY	95991	530-673-4657	530-673-5649	13-Dec-04	30-Jun-09	LOOFBOURROW, MARILYN		Colusa	1
CONTRA COSTA COUNTY HEALTH SERVICES	597 CENTER AVE. #200	MARTINEZ	94553	925-313-6771	925-313-6798	01-Sep-97	30-Jun-09	STURR, JOHN	JSTURR@HSD.CCCOUNTY.US	Contra Costa	668
MARTINEZ DETENTION FACILITY	1000 WARD ST	Martinez	94553	925-646-1642	925-646-4272	06-Jul-00	30-Jun-09	TIMOTHY TAM		Contra Costa	133
WEST CO. DETENTION FACILITY PHARMACY	5555 GIANT HWY	San Pablo	94806	510-262-4378	510-262-4399	26-Sep-00	30-Jun-09	IMOGEN CHAN		Contra Costa	15

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
DEL NORTE COMMUNITY HEALTH CENTER	200 "A" STREET	CRESCENT CITY	95531	707-465-6925	707-465-6070	01-Sep-97	30-Jun-09	BENZON, PATRICIA	patbenzon@yahoo.com	Del Norte	32
DEL NORTE AREA RED CROSS	1672 NORTHCREST DRIVE	CRESCENT CITY	95531	707-464-2277	707-464-4199	28-Mar-01	30-Jun-09	HARTWICK, CHARLES	chartwick@delnorteredcross.org	Del Norte	2
SIERRA FOOTHILLS AIDS FOUNDATION	530 MAIN ST STE 2E	Diamond Springs	95619	530-622-1923	530-344-0685	01-Sep-97	30-Jun-09	FUQUAY, JOAN	joan@sierrafoothillsaids.org	El Dorado	71
SIERRA FOOTHILLS AIDS FOUNDATION	PO BOX 14003	SOUTH LAKE TAHOE	96150	530-542-2991	530-541-7658	01-Sep-97	30-Jun-09	ALPER, MAXINE		El Dorado	80
FRESNO CITY HEALTH SERVICE AGENCY	1221 FULTON MALL -CD DIVISION	FRESNO	93775	559-445-3434	559-445-3459	01-Sep-97	30-Jun-09	BALDOVINOS, MARIA	MBALDOVINOS@CO.FRESNO.CA.	Fresno	466
UNIVERSITY MEDICAL CENTER-SPECIAL SERVICES	455 S.CEDAR AVE	FRESNO	93702	559-459-5109	559-459-5102	18-Nov-02	30-Jun-09	DELGADO, MARGARITA	MDELGADO@COMMUNITYMEDICAL	Fresno	473
BUTTE COUNTY PUBLIC HEALTH DEPARTMENT	202 MIRA LOMA DRIVE	OROVILLE	95965	530-538-6220	800-641-0015	06-Mar-04	30-Jun-09	SHERRY BLOKER		Glenn	0

Appendix 1

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
HOME HEALTH CARE MANAGEMENT	1398 RIDGEWOOD DRIVE	RICHARDSON SPRINGS	95973	530-343-0727	530-895-1703	13-Dec-04	30-Jun-09	LOOFBOURRO W, MARILYN		Glenn	4
HUMBOLDT COUNTY HEALTH DEPARTMENT	529 "I" STREET	EUREKA	95501	707-268-2174	707-445-7346	01-Sep-97	30-Jun-09	GEOFFREY BARRETT		Humboldt	231
IMPERIAL COUNTY HEALTH DEPT.	935 BROADWAY	EL CENTRO	92243	760-482-4299	760-482-4753	01-Sep-97	30-Jun-09	GIL, ROSENDO	RGIL@IMPERIALCOUNTY.NET	Imperial	156
CLINICAS DE SALUD	900 MAIN ST.	Brawley	92227	760-344-6471	760-344-8410	31-Oct-00	30-Jun-09	ROBLES, ESMERALDA	esmeraldar@clinicadesalud.org	Imperial	92
INYO COUNTY HEALTH SERVICES	207 "A" WEST SOUTH STREET	BISHOP	93514	760-873-3914	760-873-7800	01-Sep-97	30-Jun-09	STOUTENBURG, SUZANNE		Inyo	18
KERN COUNTY DEPT OF PUBLIC HEALTH	1800 MT. VERNON AVE. 2ND FLOOR	BAKERSFIELD	93306	661-868-0527	661-868-0173	18-Feb-00	30-Jun-09	CASTELLANOS, HILDA	CASTELLANOS@CD.KERN.CA.US	Kern	549
KINGS COUNTY DEPT. OF HEALTH	330 N. CAMPUS	HANFORD	93230	559-584-1401	559-582-0065	01-Sep-97	30-Jun-09	WILSON, SUZANNE	swilson@co.kings.ca.us	Kings	79

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
CO.LAKE DHS PH DIV. NORTHSHORE	922 BEVINS CT.	LAKEPORT	95453	707-263-1090	707-262-4280	01-Sep-97	30-Jun-09	PAULET, MICHELE	PAULETM@CO.LAKE.CA.US	Lake	132
CO. LAKE DHS PH DIV SOUTHSORE	922 BEVINS CT	Lakeport	95453	707-994-9433	707-994-6739	28-Jun-99	30-Jun-09	KAMMERER, JOAN	JOANK@CO.LAKE.CA.US	Lake	78
LASSEN COUNTY PUBLIC HEALTH	1445 PAUL BUNYAN RD SUITE B	SUSANVILLE	96130	530-251-8183	530-251-4871	01-Sep-97	30-Jun-09	ZIMMERMANN, JOANNA	JZIMMERMAN@CO.LASSEN.CA.	Lassen	13
HARBOR- UCLA MEDICAL CENTER	1000 WEST CARSON ST	TORRANCE	90509	310-222-5472	310-533-0447	01-Sep-97	30-Jun-09	LOPEZ, YOLANDA	ylopez@ladhs.org	Los Angeles	1,381
JEFFREY GOODMAN SPECIALTY CARE	1625 NORTH SCHRADER BLVD 3R	LOS ANGELES	90028	323-993-7587	323-860-4041	09-Mar-00	30-Jun-09	HERNANDEZ, GEORGE		Los Angeles	6,640
H. CLAUDE HUDSON CHC	2829 S.GRAND AVE.	LOS ANGELES	90007	213-744-3919	213-744-3763	01-Sep-97	30-Jun-09	PALMER, LORETTA		Los Angeles	140
LAC & USC MATERNAL CHILD & ADOLESCENT CLINIC	1640 N MARENGO ST RM 200	LOS ANGELES	90033	323-226-2030	323-226-3971	01-Sep-97	30-Jun-09	PAMPFLIN, CYNTHIA		Los Angeles	3,501

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
LONG BEACH COMP HEALTH CENTR	1333 CHESTNUT AVE	LONG BEACH	90813	562-599-8696	562-218-0853	01-Sep-97	30-Jun-09	SERNA, PATRICIA	P SERNA@LA DHS.ORG	Los Angeles	493
OLIVE VIEW MEDICAL CENTER	14445 OLIVE VIEW DRIVE	SYLMAR	91342	818-364-4202	818-364-4263	01-Sep-97	30-Jun-09	EUSTAQUIO, MARIA /CHRISTIE		Los Angeles	716
NORTHEAST VALLEY HEALTH CORP	6551 VAN NUYS BLVD, #201	VAN NUYS	91401	818-988-6335	818-988-2140	01-Sep-97	30-Jun-09	SALGUERO, MIRIAM	MSALGUERO NEVHC.ORG	Los Angeles	1,043
EAST VALLEY COMMUNITY HEALTH CENTER	680 FAIRPLEX DRIVE	Pomona	91768	909-620-8088	909-623-4861	01-Sep-97	30-Jun-09	MUNOZ, VIRGINIA		Los Angeles	464
ST. MARY MEDICAL CENTER C.A.R.E CLINIC	1043 ELM AVE #300	LONG BEACH	90813	562-624-4944	562-624-4975	01-Sep-97	30-Jun-09	LOVELY, PAUL	PAUL.LOVELY@CHW.EDU	Los Angeles	1,696
KAISER PERMANENTE SUNSET	1505 NORTH EDMONT 1ST FLOOR	LOS ANGELES	90027	323-783-4148	323-783-5694	01-Sep-97	30-Jun-09	CHANG, JOSEPH		Los Angeles	921
HIGH DESERT HOSPITAL	44900 N.60TH ST. WEST	LANCASTER	93536	661-945-8508	661-945-8536	25-Feb-99	30-Jun-09	CECENA, BARBARA	BCECENA@LADHS.ORG	Los Angeles	215

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
SHERIFF CENTRAL JAIL HOSPITAL	441 BAUCHET ST. RM #6024	LOS ANGELES	90012	323-526-5579	323-415-6391	01-Sep-97	30-Jun-09	JENNIE WONG		Los Angeles	4,581
AHF HOLLYWOOD CLINIC	1300 N. VERMONT AVE #407	LOS ANGELES	90027	323-662-0492	323-662-1913	01-Sep-97	30-Jun-09	BAMISH, JENNIFER	JENNIFER.BA MISH@AIDS HEALT	Los Angeles	4,100
ALTAMED-EAST LOS ANGELES-HIV CLINIC	5427 EAST WHITTIER BLVD	LOS ANGELES	90022	323-869-5401	323-869-5457	01-Sep-97	30-Jun-09	CAMPOS, MONICA	mocampos@a ltamed.org	Los Angeles	1,698
AIDS HEALTH FOUNDATION WESTSIDE CLINIC	99 NO LA CIENEGA BLVD STE 200	BEVERLY HILLS	90211	310-657-9353	310-657-9367	01-Sep-97	30-Jun-09	BRADLEY, DAMIAN		Los Angeles	2,818
AIDS HEALTH FOUNDATION DOWNTOWN CLINIC	1414 SOUTH GRAND AVE #400	LOS ANGELES	90015	213-741-9727	213-741-0867	01-Sep-97	30-Jun-09	TRUJILLO, SILVIA	SILVIA.TRUJI LLO@AIDHE ALTH	Los Angeles	1,951
AIDS HEALTH FOUNDATION VALLEY CLINIC	4835 VAN NUYS BLVD., SUITE 200	Sherman Oaks	91403	818-380-2626	818-380-2620	25-Feb-00	30-Jun-09	JOHNSON, TANIESHA		Los Angeles	1,355
ALTAMED HEALTH SERVICES CORPORATION	9436 EAST SLAWSON AVE	PICO RIVERA	90660	562-949-8717	562-801-0129	29-Feb-00	30-Jun-09	CAMPOS, MONICA		Los Angeles	315

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
MARTIN LUTHER KING JR. HOSPITAL/OASIS CLINIC	12021 SOUTH WILMINGTON AVE	LOS ANGELES	90059	310-668-3176	310-223-0094	16-Mar-00	30-Jun-09	CRAIG, JESSE MAE		Los Angeles	1,359
DREW UNIVERSITY EARLY INTERVENTION PROGRAM	3209 NORTH ALAMEDA STE."K"	COMPTON	90222	310-761-8444	310-761-8448	01-Sep-97	30-Jun-09	PIRES, SECILIA	seciliapires@c drewu.edu	Los Angeles	209
CHILDRENS HOSPITAL LOS ANGELES	5000 W SUNSET BLVD 4TH FLOOR	LOS ANGELES	90027	323-669-2390	323-913-3614	01-Sep-97	30-Jun-09	LEAVELL, JEFF	JLEAVELL@CHLA.USC.EDU	Los Angeles	161
CATALYST FOUNDATION	44758 ELM AVE	LANCASTER	93534	661-948-8559	661-942-0738	01-Sep-97	30-Jun-09	BARNES, ROBIN	ROBINBARNES@QNETCOM	Los Angeles	142
TARZANA TREATMENT CENTER	18646 OXNARD ST	TARZANA	91356	818-996-1051	818-996-2490	01-Sep-97	30-Jun-09	GONZALEZ, CARMEN		Los Angeles	385
VENICE FAMILY CLINIC	604 ROSE AVE	VENICE	90291	310-664-7607	310-664-7676	08-Dec-98	30-Jun-09	LAZARO, JORGE	JAZARO@UC LA.EDU	Los Angeles	67
KAISER WOODLAND HILLS	5601 DE SOTO AVE	WOODLAND HILLS	91365	818-719-2460	818-719-2477	14-May-99	30-Jun-09	VI SESSMITH, SIVINEE	SIVINEE.X.VI SESSMITH@KP.O	Los Angeles	112

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
KAISER WEST LOS ANGELES	6041 CADILLAC AVE MOD 2C - W	LOS ANGELES	90034	323-857-2165	323-587-3941	14-May-99	30-Jun-09	JOHNSON, RAPHAEL		Los Angeles	176
KAISER HARBOR CITY	25975 S NORMANDIE AVE	HARBOR CITY	90710	310-517-2935	310-517-4103	24-May-99	30-Jun-09	KADAH, JENNIFER	JENKADAH@YAHOO.COM	Los Angeles	145
KAISER PANORAMA CITY	13652 CANTERA ST	PANORAMA CITY	91402	818-375-2977	818-375-3852	24-May-99	30-Jun-09	ED PLATEO		Los Angeles	152
KAISER BELLFLOWER	9400 ROSECRANS	BELLEFLOWER	90706	562-461-6525	562-461-4910	14-May-99	30-Jun-09	POHL, OLIVIA		Los Angeles	123
KAISER BALDWIN PARK	1011 BALDWIN PARK BLVD	BALDWIN PARK	91706	626-851-7044	626-851-7041	14-May-99	30-Jun-09	SAROSSY, STEVEN	steven.s.sarosy@kp.org	Los Angeles	9
EL PROYECTO DEL BARRIO	8902 WOODMAN AVE 3RD FLOOR	ARLETA	91331	818-830-7181	818-830-7280	27-Jan-00	30-Jun-09	SANCHEZ, NATALIE		Los Angeles	238
VALLEY COMMUNITY CLINIC	6801 COLDWATER CANYON AVE	NORTH HOLLYWOOD	91605	818-763-1718	818-763-7231	20-Mar-00	30-Jun-09	MENA, MARTHA	mmena@valleyclinic.org	Los Angeles	240

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
WATTS HEALTH CENTER	10300 S COMPTON AVE	Los Angeles	90002	323-568-3013	323-568-1512	06-Jul-00	30-Jun-09	CHAVEZ, ALICIA	alicia.Chavez@wattshealth.org	Los Angeles	148
TARZANA TREATMENT CENTER	7101 BAIRD AVE #101	Reseda	91335	818-342-5897	818-881-5376	12-Jul-00	30-Jun-09	RIVERA, JUAN	jriviera@tarzana.tc.org	Los Angeles	259
COMMON GROUND	2012 LINCOLN BLVD.	SANTA MONICA	90405	310-314-5480	310-314-5488	14-Aug-00	30-Jun-09	FERNANDEZROXANA	rfernandez@commongroundwestside.org	Los Angeles	312
AIDS HEALTHCARE FOUNDATION	9200 COLIMA ROAD, SUITE 106	Whittier	90603	562-693-2654	562-693-1595	19-Oct-00	30-Jun-09	VALDES, CARMEN		Los Angeles	443
T.H.E. CLINIC	3834 S WESTERN AVE	Los Angeles	90062	323-730-1920	323-295-6577	29-Dec-00	30-Jun-09	OMORUYI, CARSHAWA	comoruyi@theclinicinc.org	Los Angeles	260
ASIAN PACIFIC HEALTHCARE VENTURE	1530 HILLHURST AVE., SUITE 200	Los Angeles	90027	323-644-3880	323-644-3892	25-Feb-01	30-Jun-09	MA, ANDREW	ADWMA@APHEV.ORG	Los Angeles	11
HUBERT H. HUMPHREY	5850 SOUTH MAIN ST.	Los Angeles	90003	323-846-4219	323-238-0210	19-Mar-01	30-Jun-09	GUITRON, ROSA		Los Angeles	281

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
AIDS HEALTHCARE FOUNDATION	2146 WEST ADAMS BLVD.	Los Angeles	90018	323-766-2162	323-730-8244	09-Apr-01	30-Jun-09	TRUJILLO, SILVIA	silvia.trujillo@aidhealth.org	Los Angeles	217
UCLA CARE CLINIC	1399 SOUTH ROXBURY DR SUITE 10	Los Angeles	90035	310-557-9062	310-557-3450	05-Sep-01	30-Jun-09	CLAIBORNE, DEON		Los Angeles	226
OFFICE OF AIDS PROGRAM & POLICY	600 S.COMMONWEALTH AVE 6TH FL	Los Angeles	90005	213-637-8431	213-387-0912	01-Oct-01	30-Jun-09	KNIGHT, LARRY	laknight@ladhs.org	Los Angeles	0
AIDS PROJECT LOS ANGELES	611 S. KINGSLEY DR.	LOS ANGELES	90005	213-201-1659	213-201-1665	01-Dec-01	30-Jun-09	RILEY, JOHN	JRILEY@APLA.ORG	Los Angeles	921
UCLA MEDICAL CENTER (MATERNAL CHILD PROGRAM)	10833 LECONTE AVE 22-442 MDCC	LOS ANGELES	90095	310-206-3536	310-825-9175	18-Jun-02	30-Jun-09	SAYAMA, TERRI	TSAYAMA@MEDNET.UCLA.EDU	Los Angeles	29
REDONDO BEACH HEALTHCARE CENTER	520 N PROSPECT AVE SUITE 209	REDONDO BEACH	90277	310-374-5475	310-374-5625	25-Sep-02	30-Jun-09	GONZALEZ, NANCY	Nancy.Gonzalez@AidsHealth.org	Los Angeles	223
AIDS HEALTHCARE FOUNDATION/ EL MONTE	3131 SANTA ANITA AVE # 109	EL MONTE	91733	626-444-9453	626-444-9256	29-Oct-02	30-Jun-09	VALDES, CARMEN		Los Angeles	101

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
ALTA MED HEALTH SERVICE CORPORATION	10454 E. VALLEY BLVD	EL MONTE	91731	626-582-1432	626-453-8465	18-Feb-03	30-Jun-09	CAMPOS, MONICA		Los Angeles	55
AHF-ANTELOPE VALLEY SATELLITE CLINIC	1669 WEST AVENUE J, SUITE 301	LANCASTER	93534	661-723-3244	661-723-3504	31-Mar-03	30-Jun-09	GALAN, JESSE		Los Angeles	40
LAC-USC MEDICAL CENTER-RAND SCHRADER 5P-21	1300 N MISSION ROAD	LOS ANGELES	90033	323-343-8203	323-226-8339	01-Sep-97	30-Jun-09	PUPO, AURORA		Los Angeles	2,019
MADERA COUNTY PUBLIC HEALTH	14215 RD 28	MADERA	93638	559-675-7627	559-675-4943	01-Sep-97	30-Jun-09	HARRIS, ANNE	AHARRIS@MADERA-COUNTY.COM	Madera	81
HHS CLINICS	3260 KERNER BLVD	San Rafael	94901	415-473-4128	415-473-4114	01-Sep-97	30-Jun-09	BOTSON, JONATHAN	JBOTSON@CO.MARIN.CA.US	Marin	175
MARIN AIDS PROJECT	910 IRWIN ST	San Rafael	94901	415-457-2487	415-457-5687	01-Sep-97	30-Jun-09	CRONIN, KEVIN	KEVIN@MARINAIDSPROJECT.ORG	Marin	213
MARIN COUNTY JAIL	13 PETER BEHR DRIVE	SAN RAFAEL	94903	415-499-6651	415-499-7505	01-Sep-97	30-Jun-09	GRANT, MARSHA		Marin	45

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
CPS D.B.A. Y & S PHARMACY	13 PETER BEHR DRIVE	San Rafael	94903	800-782-4696	267-487-8911	09-Mar-00	30-Jun-09	BORELL, ANN L.		Marin	14
MENDOCINO COUNTY PUBLIC HEALTH	221B SOUTH LENORE AVE	WILLITS	95490	707-456-3806	707-456-3808	01-Sep-97	30-Jun-09	ANCHORDOGRUY, ROSALIE	ANCHRODR@MENDOCINO.CA.US	Mendocino	83
MENDOCINO COUNTY HEALTH & HUMAN SERVICES ANGE	1120 S DORA STREET	Ukiah	95482	707-472-2698	707-472-2665	26-Nov-07	30-Jun-09	ANCHORDOGRUY, ROSALIE		Mendocino	15
MERCED COUNTY HEALTH DEPT.	260 E.15TH STREET	MERCED	95340	209-381-1047	209-381-1034	01-Sep-97	30-Jun-09	TILSTON, LOUISE	LTILSTON@COMERCED.CA.US	Merced	105
MODOC COUNTY HEALTH DEPARTMENT	441 NORTH MAIN STREET	Alturas	96101	530-233-6311	530-233-6332	17-Jun-99	30-Jun-09	DEBRA CHAPMAN		Modoc	3
MONO COUNTY HEALTH DEPARTMENT	P.O. BOX 3329	MAMMOTH LAKES	93546	760-924-5410	760-924-5415	01-Sep-97	30-Jun-09	PEARCE, SANDRA	spearce@mono.ca.gov	Mono	5
MONTEREY COUNTY AIDS PROJECT	780 HAMILTON	SEASIDE	93955	831-394-4747	831-393-3453	01-Sep-97	30-Jun-09	PACHECO, SONIA	SONIA@MCA.P.ORG	Monterey	345

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
MONTEREY COUNTY AIDS PROJECT	1441 CONSTITUTION BL 760	SALINAS	93906	831-796-1770	831-393-3453	18-Apr-00	30-Jun-09	PACHECO, SONIA		Monterey	277
JOHN XXIII AIDS MINISTRY	1121 BALDWIN STREET	SALINAS	93906	831-442-3959	831-442-3985	25-Jul-05	30-Jun-09	ERIC VOGELGESAN G		Monterey	88
NAPA COUNTY H & H SERVICES	2261 ELM ST	NAPA	94559	707-253-4161	707-253-4815	01-Sep-97	30-Jun-09	CACERES, SALVADOR	SCACERES@CO.NAPA.CA.US	Napa	93
NEVADA COUNTY HEALTH DEPARTMENT	500 CROWN POINT CIRCLE SUITE 1	GRASS VALLEY	95945	530-265-1731	530-271-0879	01-Sep-97	30-Jun-09	MCSEVENEY, CAMILLE	SFAFCAMILLE@ONEMAIN.COM	Nevada	114
ORANGE COUNTY HEALTH CARE CLINIC RM 103 F	1725 WEST 17TH STREET	SANTA ANA	92706	714-834-8175	714-834-8655	01-Sep-97	30-Jun-09	DIANA MENDOZA		Orange	3,878
ORANGE COUNTY JAIL	550 NORTH FLOWER ST	SANTA ANA	92703	714-647-4183	714-647-4660	04-Mar-99	30-Jun-09	MARILYN CORLEY		Orange	585
SIERRA FOOTHILLS AIDS FNDN	12183 LOCKSLEY LANE, SUITE 205	AUBURN	95602	530-889-2437	530-889-2443	01-Sep-97	30-Jun-09	LIGHTFOOT, JENNY	JENNY@SIERRAFOOTHILLSAIDS.ORG	Placer	162

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
PLUMAS COUNTY PUBLIC HEALTH AGENCY	P.O. BOX 3140	QUINCY	95971	530-283-6584	530-283-6425	01-Sep-97	30-Jun-09	BOK, DOTTI		Plumas	21
COUNTY REGIONAL MEDICAL CENTER (RCRMC)	PO BOX 9610	MORENO VALLEY	92552	951-486-4633	951-486-4635	10-Feb-99	30-Jun-09	HOSKINS, SUE		Riverside	2,074
DESERT AIDS PROJECT	1695 NORTH SUNRISE WAY	PALM SPRINGS	92262	760-323-2118	760-320-4635	03-Feb-00	30-Jun-09	HOSKINS, SUE		Riverside	3,139
ROBERT PRESLEY DETENTION CENTER	4000 ORANGE STREET FLOOR 7	RIVERSIDE	92501	951-275-4476	951-275-4479	01-Sep-97	30-Jun-09	CRAGER, WALTER		Riverside	21
SACRAMENTO COUNTY	4600 BROADWAY SUITE 2600	SACRAMENTO	95820	916-874-9583	916-874-9328	01-Sep-97	30-Jun-09	ROXANNE HARRISON	harrisonr@sac county.net	Sacramento	1,900
KAISER PERMANENTE	6600 BRUCEVILLE RD.	Sacramento	95823	916-688-2389	916-688-2752	02-Oct-00	30-Jun-09	ROBERTSON, DONNA	DONNA.M.ROBERTSON@K P.ORG	Sacramento	178
KAISER	2025 MORSE AVE	Sacramento	95825	916-973-6904	916-973-5637	07-Jun-01	30-Jun-09	DORENFELD, SUSAN	SUSAN.DORENFELD@KP .ORG	Sacramento	259

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
CARES PRACTICE MANAGER	1500 21ST STREET	Sacramento	95814	916-914-6213	- -	13-May-08	30-Jun-09	MAUREEN PONGYAN	mpongyan@caresclinic.org	Sacramento	250
HEALTH & HUMAN SERVICES AGENCY	1111 SAN FELIPE ROAD, SUITE 10	HOLLISTER	95023	831-636-4011	831-636-4037	01-Sep-97	30-Jun-09	MORALES, PATRICIA	patricia@sanbenitoco.org	San Benito	31
SAN BERNARDINO COUNTY CLINIC	799 E. RIALTO AVENUE	SAN BERNARDINO	92415	909-383-3060	909-383-3212	01-Sep-97	30-Jun-09	ALVEREZ-RAMIREZ, LORRAINE		San Bernardino	1,711
WEST VALLEY DETENTION CTR.	9500 ETIWANDA AVENUE	RANCHO CUCUMONGA	91739	909-463-5085	909-463-5217	01-May-99	30-Jun-09	KEVIN CONNOR, RN		San Bernardino	293
AHF UPLAND CLINIC	8263 GROVE AVENUE, SUITE 201	Rancho Cucamonga	91730	909-579-0708	909-579-0778	04-Jan-01	30-Jun-09	JOHNSON, TANIESHA		San Bernardino	591
COUNTY OF SAN DIEGO	PO BOX 88524 (MS P501C)	San Diego	92110	619-296-3400	619-296-2688	01-Sep-97	30-Jun-09	PROCTOR, SONJA	sonjaproctor@sdcounty.ca.gov	San Diego	1,167
UCSD DISCHARGE PHARMACY/OUT PATIENT	200 WEST ARBOR DR DEPT 8765	SAN DIEGO	92103	619-471-0396	619-471-0392	01-Sep-97	30-Jun-09	GARCIA, LETICIA	L1GARCIA@UCSD.EDU	San Diego	351

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
SAN YSIDRO HEALTH CENTER/CASA	3045 BEYER BLVD	SAN YSIDRO	92154	619-662-4161	619-662-4109	01-Sep-97	30-Jun-09	MAGANA, ANA	AMAGANA@SYHC.ORG	San Diego	646
NORTH PARK FAMILY HEALTH CENTER	3544 30TH STREET	SAN DIEGO	92104	619-515-2581	619-683-7588	01-Sep-97	30-Jun-09	MARQUEZ, CORINA	corinam@fhcsd.org	San Diego	1,642
NORTH COUNTY HEALTH SERVICES/ SAN MARCOS	150 VALPREDAR D, STE.211	SAN MARCOS	92069	760-736-8617	760-736-3210	01-Sep-97	30-Jun-09	MCGOLDRICK, VICTORIA	VICTORIA.MCGOLDRICK@NCHS-HEALTH.ORG	San Diego	1,132
NEIGHBORHOOD HEALTHCARE	1001 EAST GRAND AVE	ESCONDIDO	92025	760-737-7896	760-737-7898	01-Sep-97	30-Jun-09	SAMAR HIREISH		San Diego	115
AMERICAN INDIAN HEALTH CENTER (DOWN TOWN)	2630 FIRST AVE.	San Diego	92103	619-234-2158	619-234-1525	01-Sep-97	30-Jun-09	GUILLEN, FRANKO	FGUILLEN@CA.IHS.GOV	San Diego	225
BEING ALIVE PEER ADVOCACY	4070 CENTRE STREET	SAN DIEGO	92103	619-291-1400	619-291-1491	01-Sep-97	30-Jun-09	KEASLER, JOHN	JCKSD@SBCGLOBAL.NET	San Diego	935
VISTA COMMUNITY CLINIC/ TRI-CITY BRANCH	161 THUNDER DR #212	VISTA	92083	760-631-5030	760-941-2641	01-Sep-97	30-Jun-09	ROBLES, MARIA	ROBLES@VISTA COMMUNITY CL	San Diego	155

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
COMPREHENSIVE HEALTH CENTER (DOWN TOWN)	120 ELM STREET	SAN DIEGO	92101	619-235-4211	619-235-4517	30-Nov-98	30-Jun-09	WILLIAM GRIMES (BILL)		San Diego	891
KAISER PERMANENTE/ CONTINUING CARE SERVICE	4647 ZION AVE ROOM 2002	SAN DIEGO	92120	619-528-2564	619-528-6917	09-Apr-99	30-Jun-09	ELLEN LANDELLS		San Diego	477
SAN DIEGO COUNTY SHERRIFF	8525 GIBBS STREET STE 101	SAN DIEGO	92123	858-974-5977	858-974-5827	04-Mar-99	30-Jun-09	CLARK, ASHLEY	ASHLEY.CLARK@SDSHERIFF.ORG	San Diego	832
UCSD TREATMENT CENTER (CLINICAL TRIALS)	150 W.WASHINGTON STREET	SAN DIEGO	92103	619-543-8080	619-298-0177	09-Apr-99	30-Jun-09	AIEM, HEIDI	HAIEM@UCSD.EDU	San Diego	610
CHRISTIES PLACE	2440 THIRD AVENUE	SAN DIEGO	92101	619-702-4186	619-702-5924	21-Jul-99	30-Jun-09	SCHOONOVER, KIMBERLY	kim@christiesplace.org	San Diego	131
NEIGHBORHOOD HOUSE ASSOCIATION/ CBS MANAGEMEN	286 EUCLID AVE STE 110	San Diego	92114	619-266-9400	619-263-6398	21-Jul-99	30-Jun-09	STOVELL, SR, ELTON		San Diego	83
UCSD OWEN CLINIC	4168 FRONT ST., 3RD FLOOR	San Diego	92103	619-543-3700	619-543-7841	20-Apr-01	30-Jun-09	ESTRADA, CARLOS	cfeestrada@ucsd.edu	San Diego	1,925

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
COMPREHENSIVE HEALTH CENTER COORDINATED SVCS	286 EUCLID AVE. SUITE 308	SAN DIEGO	92114	619-527-7390	619-527-7394	01-May-03	30-Jun-09	RICARDO ZELAYA		San Diego	109
SAN DIEGO HOSPICE & PALLIATIVE CARE	4311 THIRD AVENUE	SAN DIEGO	92103	619-278-6400	619-278-6499	09-Aug-06	30-Jun-09	WALKUP, CINDI	cwalkup@sdhospice.org	San Diego	84
TRANSACTIONAL CASE MANAGEMENT PROGRAM	565 PEARL STREET STE 200	LA JOLLA	92037	619-666-9719	858-551-2956	16-Mar-07	30-Jun-09	LYDIA CUEVA	lydia.cueva@dcr.ca.gov	San Diego	6
SAN YSIDRO HEALTH CENTER/CASA	4004 BEYER BLVD	SAN DIEGO	92173	619-662-4161	619-662-4109	13-May-08	30-Jun-09	ANA MAGANA		San Diego	0
HEALTH CENTER #1 CASTRO MISSION HEALTH CENTER	3850 - 17TH STREET	SAN FRANCISCO	94114	415-487-7524	415-431-8039	01-Sep-97	30-Jun-09	ALVARADO, ROGER		San Francisco	1,371
HEALTH CENTER #2 MAXINE HALL	1301 PIERCE STREET	SAN FRANCISCO	94115	415-292-1355	415-928-6487	20-Jan-00	30-Jun-09	PEARSE, BILL		San Francisco	128
HEALTH CENTER #3 SILVER AVENUE	1525 SILVER AVENUE	SAN FRANCISCO	94134	415-715-0315	415-467-3320	20-Jan-00	30-Jun-09	QUEVEDO, MARIA		San Francisco	46

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
HEALTH CENTER #4 CHINA TOWN	1490 MASON STREET	SAN FRANCISCO	94133	415-705-8508	415-705-8505	20-Jan-00	30-Jun-09	KONG, SHARON	SKARON.KO NG@SFDPH. ORG	San Francisco	30
HEALTH CENTER #5 OCEAN PARK	1351 - 24TH AVENUE	SAN FRANCISCO	94122	415-682-1904	415-753-8134	20-Jan-00	30-Jun-09	LUM, NOREEN	NOREEN.LU M@SFDPH.O RG	San Francisco	141
TOM WADDELL CLINIC	50 IVY STREET	SAN FRANCISCO	94102	415-355-7515	415-554-2577	21-Jan-00	30-Jun-09	KUAN, JACK		San Francisco	1,213
POTRERO HILL HEALTH CENTER	1050 WISCONSIN STREET	SAN FRANCISCO	94107	415-648-3022	415-550-1639	21-Jan-00	30-Jun-09	SMITH, PAM		San Francisco	272
SOUTHEAST HEALTH CENTER	2401 KEITH STREET	SAN FRANCISCO	94124	415-671-7000	415-822-3620	21-Jan-00	30-Jun-09	FISHER, MAE		San Francisco	181
CITY CLINIC HEALTH CENTER	356 7TH STREET	SAN FRANCISCO	94103	415-487-5526	415-437-9231	14-Jul-99	30-Jun-09	HERNANDEZ, LUIS		San Francisco	274
KAISER HOSPITAL	2425 GEARY BLVD	San Francisco	94115	415-833-3475	415-833-3475	20-Jan-00	30-Jun-09	LIEUW, GABRIEL	GABRIEL.LIE UW@KP.ORG	San Francisco	1,637

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
UCSF/ STANFORD HEALTHCARE	400 PARNASSUS, ACC BLDG	SAN FRANCISCO	94143	415-353-2417	415-353-2406	01-Sep-97	30-Jun-09	GAYFIELD, DONNIE	donnie.gayfield@ucsfmedctr.org	San Francisco	241
ST MARYS HOSPITAL HIV SERV	2235 HAYES ST 5TH FLOOR	SAN FRANCISCO	94117	415-750-4852	415-750-4835	01-Sep-97	30-Jun-09	SOMERS, ERNEST	esomers@chw.edu	San Francisco	1,159
MISSION NEIGHBORHOOD HEALTH	240 SHOTWELL STREET	SAN FRANCISCO	94110	415-552-1013	415-552-0529	01-Sep-97	30-Jun-09	RODRIGUEZ, LAURA		San Francisco	584
BLACK COALITION ON AIDS	2800 THRID STREET	San Francisco	94107	415-615-9945	415-615-9943	08-Jul-08	30-Jun-11			San Francisco	7
SAN FRANCISCO AIDS FOUNDATION	995 MARKET ST. #200	SAN FRANCISCO	94103	415-487-8006	415-487-8079	21-Jan-00	30-Jun-09	NOVOGRODSKY, ELLEN	ENOVGRODSKY@SFAF.ORG	San Francisco	805
HAIGHT ASHBURY FREE CLINIC	558 CLAYTON ST	SAN FRANCISCO	94117	415-487-5638	415-431-9909	01-Sep-97	30-Jun-09	CRONIN, SHARON	SCRONIN@HAFCL.ORG	San Francisco	428
CA PACIFIC MEDICAL CENTER	CASTRO & DUBOCE	SAN FRANCISCO	94114	415-600-5045	415-565-6018	21-Jan-00	30-Jun-09	HINKLE, LAILA	HINKLEL@SUTTERHEALTH.ORG	San Francisco	886

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
TENDERLOIN AIDS RESOURCE CENTE	187 GOLDEN GATE ST	SAN FRANCISCO	94102	415-241-2525	415-431-3959	05-Jul-99	30-Jun-09	SAMPAYO PEREZ, CELIA		San Francisco	48
FORENSIC AIDS HEALTH PROJECT	798 BRANNAN	San Francisco	94103	415-863-8237	415-863-3975	30-Sep-99	30-Jun-09	LOPEZ, SALVADOR		San Francisco	217
CONTINUUM & SPRINGBOARD	255 GOLDEN GATE AVENUE	SAN FRANCISCO	94102	415-437-2900	415-437-2550	09-Mar-00	30-Jun-09	WOTKE, DANIELA		San Francisco	209
SAN FRANCISCO CITY AND COUNTY JAIL	650 5TH SUITE #309	San Francisco	94103	415-995-1700	415-348-8604	13-Jan-00	30-Jun-09	CHANG, DORA	DCHANG@SFGH.ORG	San Francisco	1,548
HEALTH AT HOME	45 ONONDAGA	San Francisco	94112	415-452-2115	415-452-2164	31-May-00	30-Jun-09	GROENINGER, MARGIE	MARGIE.GROENINGER@CHNSF.ORG	San Francisco	27
URBIN INDIAN HEALTH CENTER	160 CAP ST	San Francisco	94110	415-621-8051	415-621-3985	08-Jun-00	30-Jun-09	KEBA, ANNA	annak@nativehealth.org	San Francisco	39
ASIAN & PACIFIC ISLANDER	730 POLK STREET 4TH FLOOR	San Francisco	94109	415-292-3400	415-292-3404	15-Dec-00	30-Jun-09	VALDEZ, MALOU	MALOU@APIWELLNESS.ORG	San Francisco	148

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
SAINT FRANCIS MEMORIAL HOSPITAL	900 HYDE ST.	SAN FRANCISCO	94109	415-353-6215	415-353-6594	29-Jan-02	30-Jun-09	CENKO, DIANE	DCENKO@C HW.EDU	San Francisco	113
ERVIN MAGIC JOHNSON HIV CLINIC	1025 HOWARD ST.	SAN FRANCISCO	94103	415-552-2814	415-552-2909	04-Apr-02	30-Jun-09	AIELLO, JOSEPH		San Francisco	418
S.F.G.H. WARD 86	995 POTRERO AVE, BLDG80 WARD86	SAN FRANCISCO	94110	415-206-3154	415-206-4141	01-Sep-97	30-Jun-09	CHRIS GANDEZA 861027		San Francisco	2,741
SAN JOAQUIN PUBLIC HEALTH SERVICES	1601 E. HAZELTON AVENUE	STOCKTON	95205	209-468-3820	209-468-3495	05-Jul-00	30-Jun-09	HOLGUIN, ANGELICA	aholguin@sjc phs.com	San Joaquin	457
SAN JOAQUIN CTY CORRECTIONAL	7000 MICHAEL N. CANLIS BLVD	FRENCH CAMP	95231	209-468-4486	209-468-4772	23-Jun-99	30-Jun-09	GUERRERO, JAVIER		San Joaquin	17
CHANNEL MEDICAL CENTER	PO BOX 779	Stockton	95202	209-940-7232	209-940-7239	20-Jan-00	30-Jun-09	CASILLAS, CECILIA	CCASILLAS@ COMMUNITY MEDICA	San Joaquin	86
SAN JOAQUIN AIDS FOUNDATION	4330 NORTH PERSHING	Stockton	95207	209-476-8533	209-476-8142	20-Jan-00	30-Jun-09	WAYNE MOCK		San Joaquin	121

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
AIDS SUPPORT NETWORK	P.O. BOX 12158	SAN LUIS OBISPO	93406	805-781-3660	805-781-3664	01-Sep-97	30-Jun-09	MENDOZA, CONRAD	CMENDOZA@SLOHEPC.ORG	San Luis Obispo	180
SAN MATEO COUNTY AIDS PROGRAM	222 WEST 39TH AVE	SAN MATEO	94403	650-573-2385	650-573-2474	15-Jan-00	30-Jun-09	O'BRIEN, ROSE	ROBRIEN@CO.SANMATEO.CA.US	San Mateo	981
WILLOW CLINIC	795 WILLOW ROAD BLDG 334	MENLO PARK	94025	650-599-3899	650-599-3673	01-Sep-97	30-Jun-09	ROSE O'BRIEN EXT 6180		San Mateo	89
SMC NORTH COUNTY HEALTH CENTER	375 89TH STREET	DALY CITY	94015	650-301-8600	650-573-2474	01-Sep-97	30-Jun-09	O'BRIEN, ROSE	robrien@co.sanmateo.ca.us	San Mateo	0
SAN MATEO COUNTY JAIL	300 BRADFORD STREET	REDWOOD CITY	94063	650-599-7340	650-599-1082	01-Sep-97	30-Jun-09	MICHAEL GRIFFIN		San Mateo	48
SANTA BARBARA COUNTY CLINIC	345 CAMINO DEL REMEDIO	SANTA BARBARA	93110	805-681-5120	805-681-5436	01-Sep-97	30-Jun-09	ALSTOTT, CHERIE	CHERIE.ALSTOTT@SBCPHD.ORG	Santa Barbara	303
SANTA BARBARA COUNTY PUBLIC HEALTH DEPT.	301 NORTH "R" STREET	Lompoc	93436	805-737-6400	805-737-6458	08-May-00	30-Jun-09	CAMPOS, BARBARA	barbara.camp@sbcpd.org	Santa Barbara	8

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
COUNTY CLINIC SANTA MARIA	2115 S. CENTERPOINT PARKWAY	SANTA MARIA	93455	805-346-8240	805-346-8449	01-Sep-97	30-Jun-09	HUACUJA, ISABEL	ISABEL.HUA CUJA@SBCP HD.ORG	Santa Barbara	94
PUBLIC HEALTH PHARMACY	976 LENZEN AVE.	SAN JOSE	95126	408-792-5174	408-947-8730	31-May-00	30-Jun-09	GIRON - KLEIN, SILVIA	silvia.klein@H HS.CO.SANT A-CLARA.CA.U S	Santa Clara	220
POSITIVE PACE CLINIC	2400 MOORPARK AVE STE 316B	SAN JOSE	95128	408-885-4088	408-885-6872	31-May-00	30-Jun-09	CARREJO, ROXANNA	roxanna.carrej o@hhs.cp.san ta-clara.ca.us	Santa Clara	1,601
HEALTH TRUST AIDS SERVICES	1400 PARKMOOR AVE SUITE 230	SAN JOSE	95126	408-961-9850	408-961-9856	02-Jun-00	30-Jun-09	DOMINICK, SARA	sarad@healtht rust.org	Santa Clara	655
KAISER - HARC DEPT	710 LAWRENCE EXWY	SANTA CLARA	95051	408-851-4244	408-236-4249	31-May-00	30-Jun-09	LUU, TYE		Santa Clara	255
TB CLINIC	976 LENZEN AVE	SAN JOSE	95126	408-792-5586	408-947-8778	21-Oct-98	30-Jun-09	NING S DECENA		Santa Clara	6
MAIN JAIL PHARMACY	2221 ENBORG LANE	San Jose	95128	408-793-6144	408-995-5126	19-Aug-99	30-Jun-09	DENNIS DWYER		Santa Clara	332

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
ELMWOOD PHARMACY JAIL SITE	2221 ENBORG LANE	San Jose	95128	408-793-6144	408-995-5126	19-Aug-99	30-Jun-09	DENNIS DWYER		Santa Clara	155
HEALTH SERVICES AGENCY	1080 EMELINE AVE.	SANTA CRUZ	95065	831-454-4070	831-454-4896	31-Mar-00	30-Jun-09	JOHNSON, ROD		Santa Cruz	291
HEALTH SERVICES AGENCY	9 CRESTVIEW DR.	WATSONVILLE	95076	831-454-4070	831-763-8237	31-Mar-00	30-Jun-09	ROD JOHNSON		Santa Cruz	37
SHASTA COUNTY JAIL	1655 WEST ST.	REDDING	96001	530-245-6127	530-225-5599	07-Jul-99	30-Jun-09	BERGER, ART		Shasta	569
HOME HEALTH CARE MANAGEMENT, INC	1620 CYPRESS AVE, SUITE 1	REDDING	96002	530-226-0120	530-224-7186	13-Dec-04	30-Jun-09	LOOFBOURROW, MARILYN		Shasta	79
SIERRA COUNTY HEALTH DEPARTMENT	P.O.BOX 7	LOYALTON	96118	530-993-6700	530-993-6741	01-Sep-97	30-Jun-09	MILLER, JILL		Sierra	1
SISKIYOU COUNTY HIV/AIDS FOUNDATION	PO BOX 407	Mount Shasta	96067	530-918-9007	530-926-3953	29-Jan-99	30-Jun-09	STAN DRUCKER		Siskiyou	38

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
SOLANO COUNTY HEALTH SERVICES	355 TUOLUMNE STREET	VALLEJO	94590	707-553-5117	707-553-5649	01-Sep-97	30-Jun-09	MCARTHUR, ESTHER	EMCARTHUR@SOLANOCOUNTY.CO	Solano	296
KAISER HOSPITAL	975 SERENO DRIVE	VALLEJO	94589	707-651-2330	707-651-5135	01-Mar-98	30-Jun-09	BEAL, SUSAN		Solano	158
COMMUNITY MEDICAL CENTERS	131 WEST "A" STREET	DIXON	95620	707-635-1673	707-635-1670	31-Aug-98	30-Jun-09	MATA, VERONICA	vmata@communitymedicalcenters.org	Solano	26
PLANNED PARENTHOOD (HOPWA)	3467 SONOMA #10	VALLEJO	94590	707-642-2039	707-258-8712	01-Sep-97	30-Jun-09	SHEPARD CREER, MONICA	SHEPCREER@AOL.COM	Solano	10
SOLANO COUNTY SHERIFF OFFICE	530 UNION AVE.	FAIRFIELD	94533	707-421-7154	707-421-6674	01-Sep-97	30-Jun-09	NORRIS, TOM		Solano	23
SOLANO COUNTY HEALTH & SOCIAL SERVICES	2101 COURAGE DR	FAIRFIELD	94533	707-784-2062	707-784-2033	13-Jul-05	30-Jun-09	MARCANO, RACHEL	rfmarcano@solanocounty.com	Solano	17
CENTER FOR HIV PREVENTION/CARE	499 HUMBOLDT ST	SANTA ROSA	95404	707-565-7402	707-565-7620	01-Sep-97	30-Jun-09	BEAVER, DANNY	DBEAVER@SONOMA-COUNTY.ORG	Sonoma	870

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
KAISER PERMANETE MEDICAL CENTER	401 BICENTENNIAL WAY MOB EAST	SANTA ROSA	95403	707-571-4000	707-571-4604	15-Sep-98	30-Jun-09	MEADE, SUSAN	susan.meade@kp.org	Sonoma	238
RUSSIAN RIVER HEALTH CENTER	3RD AND CHURCH	GUERNEVILLE	95446	707-869-2849	707-869-1477	05-May-03	30-Jun-09	DANNY BEAVER		Sonoma	0
STANISLAUS PUBLIC HEALTH DEPT	820 SCENIC DRIVE	MODESTO	95350	209-558-8938	209-558-4905	01-Sep-97	30-Jun-09	HOLBERT, JEROME	JHOLBERT@SCHSA.ORG	Stanislaus	390
HOME HEALTH CARE MANAGEMENT, INC	1018 LIVE OAK BLVD, STE C	YUBA CITY	95991	530-673-4657	530-673-5649	13-Dec-04	30-Jun-09	LOOFBOURROW, MARILYN		Sutter	20
BUTTE COUNTY PUBLIC HEALTH DEPARTMENT	202 MIRA LOMA DRIVE	OROVILLE	95965	530-538-6109	530-538-6221	06-Mar-04	30-Jun-09	SHERRY BLOKER		Tehama	0
HOME HEALTH CARE MANAGEMENT, INC	1620 CYPRESS AVE, SUITE 1	REDDING	96002	530-226-0120	530-224-7186	13-Dec-04	30-Jun-09	LOOFBOURROW, MARILYN		Tehama	3
TRINITY CITY HEALTH & HUMAN SERVICES	P.O. BOX 1470	WEAVERVILLE	96093	530-623-8209	530-623-1297	11-Jan-99	30-Jun-09	HUANG, CAROL		Trinity	3

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
HOME HEALTH CARE MANAGEMENT, INC	1620 CYPRESS AVE, SUITE 1	REDDING	96002	530-222-3371	530-226-5032	13-Dec-04	30-Jun-09	LOOFBOURROW, MARILYN		Trinity	6
HILLMAN HEALTH CENTER	1150 S KST	Tulare	93274	559-685-2535	559-685-2661	09-Sep-99	30-Jun-09	VAUGHAN, RON	ronvaughan@prodigy.net	Tulare	235
VENTURA PUBLIC HEALTH	600 E LOS ANGELES AVE	Simi Valley	93065	805-652-6649	805-652-6298	01-Sep-97	30-Jun-09	WINTERS, SHEILA	SHEILA.WINTERS@VENTURA.ORG	Ventura	106
VENTURA COUNTY PUBLIC HEALTH	3147 LOMA VISTA RD	VENTURA	93003	805-652-3302	805-652-6298	01-Sep-97	30-Jun-09	WENDLING, VALERIE	valerie.wendling@ventura.org	Ventura	591
COMMUNICARE HEALTH CENTER	500 B JEFFERSON BL #195	WEST SACRAMENTO	95605	916-403-2970	916-403-2971	26-Aug-99	30-Jun-09	LILLIEDOLL, TINA		Yolo	106
COMMON CARE HEALTH CENTERS	804 COURT ST	WOODLAND	95695	530-668-2400	530-668-3434	22-Jan-03	30-Jun-09	BRENT WILDER		Yolo	19
HOME HEALTH CARE MANAGEMENT, INC	1018 LIVE OAK BLVD, SUITE C	YUBA CITY	95991	530-673-4657	530-673-5649	13-Dec-04	30-Jun-09	LOOFBOURROW, MARILYN		Yuba	24

**Resource Inventory and Profile of Ryan
White Part B-Funded Providers by
Service Category
AIDS Drug Assistance Program (ADAP)
Sites**

Site Name	Address	City	Zip	Phone	Fax	Start Date	End Date	Contact	Email	LHJ	Clients
CITY OF LONG BEACH	2525 GRAND AVE.# 106	LONG BEACH	90815	562-570-4316	562-570-4033	09-Nov-98	30-Jun-09	GUTIERREZ, ROSIE	ROSIE_GUTIERREZ@LONGBEACH	Long Beach	928
ANDREW ESCAJEDA CLINIC	1845 NORTH FAIR OAKS AVE G-151	PASADENA	91103	626-744-6098	626-744-6148	01-Sep-97	30-Jun-09	OLIVAS, SANDRA	SOLIVAS@CITYOFPASADENA.NE	Pasadena	783
CITY OF BERKELEY PH NURSING	830 UNIVERSITY AVE	Berkeley	94702	510-981-5358	510-981-5345	01-Sep-97	30-Jun-09	BLEA, LEROY		Berkeley	82
BERKELEY PRIMARY ACCESS CLINIC	2001 DWIGHT WAY	BERKELEY	94703	510-204-6514	510-204-5304	01-Sep-97	30-Jun-09	HUANG, MAIA	mhuang@lifelongmedical.org	Berkeley	160
CALIFORNIA STATE OFFICE OF AIDS	PO BOX 997426	Sacramento	95899	916-449-5949	916-449-5959	04-Feb-99	30-Jun-09	CLEVELAND, KELLY		Office of AIDS	4
RAMSELL CORPORATION	200 WEBSTER STREET STE 300	OAKLAND	94607	888-311-7632	510-587-2790	15-Jun-00	30-Jun-09	FLOWERS, ERIC	ERIC@RAMSELLCORP.COM	PMDC	186

Estimating the Number of HIV/Non-AIDS Individuals Aware of their Status in California

HIV prevalence for California was estimated using information published by CDC as well as the limited information within HIV data collected to date. CDC published the following national estimates for PLWH (CDC. HIV prevalence estimates – United States, 2006. Morbidity and Mortality Weekly Report 2008;57(39):1073-1076):

- At the end of 2006, there were an estimated 1,106,400 (95 percent confidence intervals: 1,039,000 to 1,185,000) HIV-infected adults/adolescents (13 years or older) living in the United States (including PLWA); and
- An estimated 232,700 (21 percent) were undiagnosed and unaware of their infection.

Using this information, the number of HIV-infected adults/adolescents in the United States who are aware of their infection was taken as:

$$1,106,400 - 232,700 = 873,700$$

Then the number of adult/adolescent PLWA in the United States at the end of 2006 as reported by CDC was subtracted (CDC. HIV/AIDS surveillance report, 2006. Vol. 18. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2008.):

$$873,700 - 435,621 = 438,079$$

This was used as the estimated number of adult/adolescent PLWH (non-AIDS) who were aware of their HIV infection, which is the national HIV (non-AIDS) prevalence estimate as defined in this grant application. Adult/adolescent HIV prevalence for California at the end of 2006 was estimated by taking 13 percent of this total ($0.13 \times 438,079 = 56,951$). The 13 percent was derived as the weighted average of 14 percent (the percentage of PLWA in the United States who live in California, per the aforementioned CDC HIV/AIDS surveillance report) and 11 percent (the approximate percentage of new national HIV infections occurring in California), with more weight given to PLWA because that population is larger. To arrive at adult/adolescent HIV prevalence in California at the end of 2007, an additional 1,631 cases were added (obtained by subtracting AIDS incidence between January 1, 2007 and December 31, 2007, from the 5,000 new HIV infections assumed diagnosed during that time). The final HIV (non-AIDS) prevalence estimate for California at the end of 2007 was obtained by adding the estimated number of pediatric HIV (non-AIDS) cases. This was taken as 0.8 percent of estimated adult/adolescent HIV prevalence (this percentage was estimated using available HIV and AIDS surveillance data), or $0.008 \times (56,951 + 1,631) = 469$. The final estimate is thus:

$$56,951 + 1,631 + 469 = 59,051$$

Demographic distributions of estimated HIV prevalence were determined by using both names-based HIV data ($n=32,794$) and HIV cases reported in California via non-name code ($n=41,155$). Because of its larger size, the code-based data were

**Estimating the Number of HIV/Non-AIDS Individuals
Aware of their Status in California**

used to determine all demographic distributions except race/ethnicity, which used the names-based data because these data had much more complete information pertaining to race/ethnicity.

The final estimate of 59,051 was adjusted down to **58,091** for the unmet need framework in order to account for two different ending dates (June 2007 for the unmet need framework and December 2007 for complete year population estimates).

REFERENCES

-
- ¹ For almost one-fourth of women presumed living with HIV in California, exposure falls into the Other/Undetermined category (21 percent). For the majority of these cases, the only known risk is heterosexual contact without the sexual partner's risk information.
- ² CDC. HIV/AIDS among Asians and Pacific Islanders. August 2008. Available at: www.cdc.gov/hiv/resources/factsheets/API.htm. Accessed January 20, 2009.
- ³ U.S. Census Bureau. "Table 4: Estimates of Population by Race and Hispanic Origin for the United States and States: July 1, 2007 (SC-EST2007-04)." Available at: www.census.gov/popest/states/asrh/SC-EST2007-04.html. Accessed December 12, 2008.
- ⁴ Sevelius, J., Keatley, J., Rouse Iñiguez, J., Reyes, EM. (2008). *Serving Transgender People in California: Assessing Progress, Advancing Excellence*. University of California, San Francisco: The Center of Excellence for Transgender HIV Prevention. Available at: <http://transhealth.ucsf.edu/pdf/serving-trans-ca.pdf>. Accessed January 20, 2009.
- ⁵ California Department of Health Services/OA, Economic Evaluation of California's Prevention Case Management Intervention for HIV-Positive and HIV-Negative Persons: The HIV Transmission Prevention Project (HTPP), November 2006.
- ⁶ ADP, "Meth Facts," 2008. Available online: www.ADP.ca.gov/Meth/facts.shtml. Accessed December 8, 2008.
- ⁷ CDHS/STD Control Branch, Provisional Data Tables, 2006. Available online: www.dhs.ca.gov/dcdc/STD/stdindex.htm. Accessed December 8, 2008.
- ⁸ Morbidity and Mortality Weekly Report from CDC, March 2007. Available online: www.cdc.gov/mmwr/preview/mmwrhtml/mm5611a2.htm.
- ⁹ CDHS/STD Control Branch, Provisional Data Tables, 2006. Available online: www.dhs.ca.gov/dcdc/STD/stdindex.htm. Accessed December 8, 2008.
- ¹⁰ 2006 Sacramento Out of Care Needs Assessment.
- ¹¹ 2008 San Diego, CA "HIV/AIDS Needs Assessment Survey of People Living with HIV/AIDS," Page 130.
- ¹² Personal communication from PAETC, January 2009.

-
- ¹³ HRSA Web site at <http://hab.hrsa.gov/treatmentmodernization/dentalrosters2008.htm>. Accessed December 31, 2008.
- ¹⁴ ADP, “Meth Facts,” 2008 at www.adp.ca.gov/Meth/facts.shtml.
- ¹⁵ U.S. Census Bureau. “Current Population Reports, P60-231, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*”, Table 10. U.S. Government Printing Office, Washington, DC, 2006.
- ¹⁶ CDPH/OA, Integrated Epidemiologic Profile of HIV/AIDS for California, November 2008, page 23.