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1) Demonstrated need

(1.a) HIV/AIDS Epidemiology

HIV (Not AIDS) prevalence and AIDS prevalence increased in the Oakland Transitional Grant Area (TGA) by just over 9% from the year ending 12/31/2006. The TGA's rates for AIDS incidence, AIDS prevalence and HIV /Not AIDS prevalence by demographic group and exposure category as of December 31, 2007 are shown in Attachment Three, Table 1, "HIV/AIDS Epidemiology". Our discussion of Unmet Need describes how local health officials used HARS data and other electronic databases to estimate that just under half of the TGA's PLWH/A population have documented unmet need.

The data in Table One is from the local HIV/AIDS Reporting Systems (HARS) maintained by Alameda County and Contra Costa County (CCC). Until a recent amendment of the California Health and Safety Code, HIV data from California was not recognized by the CDC because of non-names reporting. Nonetheless, California Health Jurisdictions collected, reviewed, investigated, and maintained HIV data on individuals diagnosed within the jurisdiction as required by state law.

On April 17, 2006, California law amended the Health and Safety Code to require health care providers and laboratories to report cases of HIV infection by name to local health departments (LHDs) and require LHDs to report cases of HIV infection by name to the California Department of Public Health. Health authorities in Alameda and Contra Costa Counties and the City of Berkeley's Public Health Department expect that the name-based HIV reporting system will enhance the TGA's ability to track the HIV epidemic, monitor emerging trends in HIV transmission and efficiently allocate education, prevention and treatment resources.

The Oakland TGA is a tri-jurisdictional entity comprising the health departments of Alameda and Contra Costa counties and the City of Berkeley in Alameda County. Although most epidemiologic trends reported in this application pertain to the TGA as a whole, there are important differences in the demographic characteristics and exposure categories of the PLWH/A populations among the three jurisdictions that arise in part from differences in the ethnic and racial composition of the two counties. These differences, described below, combined with differences between the two counties in funding and delivery of public health services have necessitated different approaches to service delivery to insure parity of services, effective outreach and treatment across the TGA. (The City of Berkley in Alameda County operates an independent health jurisdiction, but collaborates with the two counties in TGA-wide planning. Most data pertaining to Berkeley has been included in discussion of either Alameda County or the TGA as a whole.).

i) Demographic Characteristics and Exposure Categories

Although there has been a downward trend in the number of new infections and AIDS diagnosis since the height of the epidemic in 1992/1993, HIV now has a disproportionate effect on the TGA's vulnerable, low income communities of color, especially heterosexual African American women. Men who have sex with men (MSM) still constitute the highest prevalence and incidence. However; heterosexuals comprise an increasingly larger proportion of both incidence and prevalence.

Demographics

There were 6,997 PLWH/A in the TGA as of December 31, 2007. HIV (Not AIDS) Prevalence was 2,738; AIDS Prevalence was 4,259 and AIDS Incidence was 548. In Contra Costa County Whites make up just

under half of HIV (Not AIDS) Prevalence and AIDS prevalence and just under a third of AIDS incidence in the two year period 2006-2007. African Americans constitute approximately 30% of HIV Not AIDS prevalence and AIDS prevalence and over 44% of AIDS incidence.

In Alameda County Blacks constitute 46% of both HIV (Not AIDS) prevalence and AIDS prevalence, and over half of AIDS incidence. Whites in Alameda County represent a third of both HIV Not AIDS prevalence and AIDS prevalence and just under a quarter of AIDS incidence.

Exposure

In both Counties, MSM is the highest exposure category. Although the proportion of AIDS among MSM has decreased since the height of the epidemic, AIDS incidence, exposure and HIV (not AIDS) prevalence in this exposure category have risen since the last reporting period. In Alameda County MSM were 56% of HIV Not AIDS prevalence, 57% of AIDS prevalence and nearly 52% of AIDS incidence in the 2006-2007 period. In CCC MSM were approximately 61% of HIV (Not AIDS) prevalence, 56% of AIDS prevalence and nearly 59% of AIDS incidence.

Heterosexual contact was the second highest exposure category in both counties. In Alameda County heterosexuals were about a fifth of HIV (Not AIDS) prevalence and AIDS prevalence and 26% of AIDS incidence.

Injection Drug Use (IDU) is the third highest exposure category in both counties. In Alameda County IDU account for slightly more than ten percent of HIV Not AIDS prevalence and AIDS prevalence and just under ten percent of AIDS incidence. In CCC, IDU are 13% of HIV Not AIDS prevalence, 18% of AIDS prevalence and 12.5% of AIDS incidence.

ii) Disproportionate Impact on Certain Populations

With increases in the HIV incidence among African Americans, Latinos, heterosexuals and intravenous drug users, and a steady decrease in the number of new AIDS diagnosis among MSM, the HIV/AIDS epidemic in the Oakland TGA has begun to resemble the epidemic in the urban Northeast of the United States: The Oakland TGA clients are medically indigent people –increasingly people of color – with substance use and mental health problems and few resources. For most clients, failure to adequately treat HIV disease is only one of many poor health outcomes.

HIV/AIDS incidence and prevalence are concentrated in the low income, minority neighborhoods in the City of Oakland in Alameda County and the cities of Richmond, San Pablo and Pittsburg in Western and East CCC. Oakland, with roughly one third of Alameda County's population is the city of residence of approximately half the county's AIDS cases. Richmond and San Pablo in CCC have the highest cumulative incidence of AIDS in CCC at six per thousand and five per thousand respectively.
In the TGA as a whole, AIDS incidence, prevalence and HIV (not AIDS) prevalence is highest for African Americans followed by Whites, Latinos and Asian Pacific Islanders (API). Although African Americans are only 11% of the general population, they represent the greatest proportion of prevalent cases (43%) of AIDS incidence (50%) -- up two percent from the two year period ending in 12/31/2006-- and of HIV (not AIDS) prevalence (42.25%).

Table A: Disproportionate Impact of HIV/AIDS				
Ethnicity	% of TGA Population[1]	AIDS Incidence[2]	AIDS Prevalence	HIV Not AIDS Prevalence
Black	11.64	50%	43%	42.25%
White	52	25%	37.4%	37.6%
Hispanic	21	16%	14.6%	13.4%
API	20	6.75%	4.1%	3.6%

In both Alameda County and CCC, African Americans have the largest cumulative total of AIDS diagnosis of any ethnic group. Although they are only 9% of the population in CCC, African Americans account for 32% of cumulative AIDS cases to date as well as 32% of those currently living with AIDS[3]. In Alameda County, African Americans were 44% of all AIDS diagnosis to date but only 29% of the population with a case rate of 56 per 100,000 compared to a white case rate of 8 per 100,000. The 2007 HIV/AIDS case rate for African Americans was four to twenty times that of other ethnic groups.[4] In CCC African Americans are approximately 9% of the population but 32% of the AIDS cases reported through April 1, 2007[5], 44% of AIDS incidence in the last two calendar years (up nearly 3 percent from the last two year reporting period) and 32% of the HIV (Not AIDS) prevalence as of the end of 2007.

Increasing numbers of Hispanics have also been diagnosed and are living with HIV in both counties. Hispanics are approximately 20% of the population in each county. Rates of infection among Hispanics are of concern to local health authorities. In an unpublished State of California Office of AIDS study of HIV testing of Latinos in the Bay Area, 1.5% of men and 4.3% of transgender Latinos tested positive. [6] The proportion of total cases for which Latinos accounted in the TGA 2005-2006 has doubled from ten years ago.

TGA-wide, Hispanics account for 16% of AIDS incidence (up 1% from the previous two year reporting period), 14% of prevalence and 13.4% of HIV not AIDS prevalence. Incidence, prevalence, and HIV not AIDS rates for Hispanics is higher in Contra Costa than Alameda County. However, in Alameda County, Hispanics are 12.4% of HIV not AIDS, 14.2% of AIDS prevalence and 15.3% of AIDS Incidence, while in CCC they are 16.2% of HIV Not AIDS prevalence, 16% of AIDS prevalence and 18.5% of AIDS incidence.

Disproportionate Impact: An Overview of Sexual Contact Exposure

Although, MSM continue to comprise the largest proportion of cumulative AIDS cases (61% in Alameda County and 63% in CCC) and account for the largest proportion of annual AIDS cases in the last two years (51.7% in Alameda and 58% in CCC), the proportion of HIV infection attributable to heterosexual exposure and injection drug use (IDU) continues to rise in both counties. The female proportion of PLWH/A in the TGA has increased substantially since the height of the epidemic. Approximately 18% of PLWA in the TGA are women and nearly a quarter of African Americans living with AIDS are women. 30% of all new AIDS cases diagnosed in calendar year 2007 in the TGA were women[7]. Women of color and particularly African American women have suffered the greatest impact.

[1] U.S. Census Quick Facts Tables at Census.gov
[2] State of California HARS
[3] Contra Costa health Services; HIV/AIDS Epidemiology Report; July 2007; Juan Reardon, M.D.
[4] AIDS Epidemiology Report Alameda County, California 1980-2006; The Alameda County Public Health Department: Community Assessment Planning And Education (Cape) Unit, And The Division Of Communicable Disease Control And Prevention HIV AIDS Cases in Alameda County, Presentation for the Community Collaborative Planning Council, April 4, 2008
[5] Contra Costa Health Services HIV/AIDS Epidemiology Report, July 2007
[6] State Office of AIDS HIV Testing in Hispanic/Latinos in the Bay Area Counties; preliminary unpublished data
[7] Elaine Bautista, Alameda County Public Health Department special data run

Heterosexual contact with an injection drug user is the predominant mode of infection for TGA residents infected through heterosexual contact (40%) in Contra Costa. In Alameda County heterosexual contact accounted for a quarter of all new infections in 2007. Half of the cumulative AIDS cases among women in Alameda County have been attributed to heterosexual contact, and injection drug use accounts for another 34%[8]. Women constitute 58% of heterosexual AIDS cases in CCC. In both counties, men are the majority in all other exposure categories.

In CCC women are 28% of all IDUs diagnosed with AIDS. 74% are African American. Additionally, women comprise the majority (58%) of heterosexual contact AIDS cases in CCC are women. Of the cumulative total of 595 women diagnosed with HIV or AIDS in CCC between 1982 and 2007, 43% (258) were infected through heterosexual contact[9].

There are important differences between the two counties in sexual exposure mode for HIV transmission that have implications for service delivery. In both Alameda and CCC, heterosexual exposure and IDU are the second and third most frequent exposure categories. However in Alameda heterosexual exposure accounted for 26% of new AIDS cases diagnosed in the last two calendar years while in CCC heterosexual exposure accounted for 14% of the total of AIDS incidence. In both counties IDU exposures has risen as the proportion of AIDS cases attributable to MSM has declined. IDU is higher in CCC at 12.5% of AIDS incidence in 2006-2007, than in Alameda where it was 9.6.

There are also important differences between the two counties in the ethnic make up of the MSM exposure category. In CCC white men are (67%) of MSM ever diagnosed with AIDS. In Alameda County, the cumulative total of MSM diagnosed with AIDS is more evenly divided between men of color (48%) and white men (52%). African American men constitute 34.1% of MSM ever diagnosed with AIDS in Alameda County vs. 17% in CCC. In Alameda County, African American MSM were 23% of **all** new infections in the last two years and 22% of **all** new AIDS diagnosis in the same period

Disproportionate Impact: Minorities, Women of Color, and Recently Incarcerated

Although AIDS cases and case rates have declined significantly among every race/ethic group since the height of the epidemic in the early 1990s, the African American rates for both men and women continue to be higher than those for any other race/ethnic group.

Table B: Rates by Race/Ethnicity in Alameda County			
Race	2005-07 cases	Average Annual Rate[10]	Ratio
Blacks	305	54	--
Latinos	99	9.7	5.6
Asian	42	3.8	14.1
Whites	148	8.6	6.3
Other	7	n/a	--
Total	601	13.3	4.1

Women of Color

The majority of women ever diagnosed with AIDS or living with HIV are women of color, and most are African American. Approximately 67% of all women living with AIDS in Alameda County and 58% of all women living with AIDS in CCC are African American. Latinas made up 10% of all women living with AIDS in Alameda County and 12% of all women living with AIDS in CCC[11].

[8] AIDS Epidemiology Report; Alameda County California 1980-2006 July 2007
[9] Contra Costa Health Services HIV/AIDS Epidemiology Report, July 2007 pages 8 & 9 and "The Public's Health; HIV AIDS 1982-2007
[10] Per 100,000; Alameda County Public Health Department
[11] Alameda County AIDS Epi Report July 2007 and CCC AIDS Epi Report July 2007

The Formerly Incarcerated

Non whites (predominantly African Americans and Latinos) comprise 70% of California's prison population[i]. The impact of incarceration and HIV prevalence among inmates on their families and the communities in the TGA to which inmates return is enormous. San Quentin State Prison near San Francisco, California paroles thousands of prisoners annually to low income neighborhoods in Oakland in Alameda County and Richmond and San Pablo in CCC.[12] 8,800 prisoners were paroled to the TGA in calendar year 2007[13]. The most recently available statistics on seroprevalence of the California prisoner populations is 3%, which is ten times the rate for the general population and about the same as California Emergency rooms. 25% Of All HIV infected will spend time in prison each year.

iii) Populations of PLWH in the TGA that are underrepresented in CARE Act

A study of the "Service Needs of People with HIV/AIDS in the Oakland Eligible Metropolitan Area[14]" found that approximately 75% of PLWH/A in both Alameda and CCC were not served by Care Act Titles I and II (Parts A and B). Of course, not all of these individuals would be eligible for Ryan White funds of last resort if they were insured, but they might have been eligible for other services. The study found that 80% of the unserved were men and 75% were young adults. Approximately 35% of the unserved were White half of the unserved were African Americans and 15% were Latino.

Table Two provides details on the large portion of Oakland TGA clients with substance use mental illness and other co-morbidities. Table Two also details the high proportion of individuals who have other markers correlated with difficulty accessing and staying in care, such as lack of insurance and homelessness. Many of our clients have low literacy rates, and mistrust health care providers. These medical and psychosocial deficits contribute to delayed entry, poor retention and poor prognosis for current and potential clients. Many low income people in both counties are under-insured or noninsured, make poor use of preventive care and receive emergency care at crisis points. Due in part to group norms, health-seeking behaviors such as use of emergency rooms at crisis points, competing necessities for daily living, and poor access to information and resources, many individuals and families do not receive regular medical care for prevention, diagnosis or treatment of **any** illness, including HIV/AIDS.

AIDS Diagnosis at First HIV Test

Two measures strongly associated with delayed care are an AIDS diagnosis with an HIV test and rapid progression to AIDS after a positive test. In Alameda and CCC counties during the last eight years, 323 and 588 people respectively were diagnosed with AIDS at the time of their first HIV test. In CCC in 2007, 16 individuals converted to AIDS within a year of their first HIV test, and in Alameda County in the period 2000-2008, 984 individuals or approximately 58% of testers progressed to AIDS within a year of their first test indicating either a lack of treatment, late entry to care or both. Since 2000 late testers in CCC have represented over 50% of the newly diagnosed cases of AIDS. A reduction in the number of late testers in CCC in 2005-2007 may be an indication that fewer HIV infected persons are becoming late testers.[15] These measures of delayed care again reveal the difference in the demographic profile of the epidemic in the two counties. Although many more men than women were diagnosed with AIDS at the time of their first test in both counties, In Alameda County, African Americans were diagnosed with AIDS in greater numbers

[12] Jessica Anne Clarke, MD, PhD; Chief Medical Officer (A) San Quentin Prison California Department of Corrections and Rehabilitation; Pacific AIDS Education and Training Center; Asilomar September 2005

[13] California Department of Corrections; California Prisoners and Parolees 2007

[14] The Center for Applied Local Research; DeSondra Ward; 2002

[15] Contra Costa County Public Health; "The Public's Health"; Alameda County and Contra Costa County Public Health Departments, Special Data Runs

than any other ethnic group. According to surveillance data, late testers in Alameda County (progression to AIDS within a year and AIDS at first diagnosis) are about 30% White and 70% people of Color. Approximately half of the late testers are African American. Over 80% of late testers are men. CCC, whites were the majority of people with an AIDS diagnosis at first test, in CCC, a third of people with AIDS at first test were White MSM.

Based on the data, a reasonable yet conservative estimate is that about a third of Ryan White clients enter treatment late in the progression of HIV disease. This means that as many as 2,300 of the approximately 7,000 people currently living with HIV or AIDS (according to HARS data) in the Oakland TGA are individuals who may have delayed their access to care and treatment.

Even among those who know their status, care is often delayed or intermittent. In the Oakland TGA's 2007 Need Assessment, 16% of the Consumer Survey respondents said they were diagnosed with AIDS at the time that they tested positive. 20% of respondents said that they waited for more than a year after testing positive before seeing a doctor. The same percentage said that at some period in the past, they had gone for more than a year without seeing a doctor after having initially entered care. 23% reported that they had gone for more than six months without seeing a doctor or going to a clinic. For those that delayed care or sought care sporadically, almost all said that getting sicker was what prompted them to seek medical attention. Our Implementation Plan includes goals and objectives designed to reach underserved and disproportionately effected populations and retain them in care.

Latinos

Many in the Latino community are monolingual Spanish speakers for whom limited English language ability is a barrier to accessing public services. In the 2007 Needs Assessment, 25% of Latino respondents reported waiting for between one to four years before seeing a doctor after testing positive. 32% reported that they were diagnosed with AIDS at their first HIV test. 80% of Latinos diagnosed with AIDS recently have been MSM. Many MSM of color, especially youth and young adults, avoid the stigma associated with being known as gay nor do they feel that they are culturally a part of that community, and do not benefit from the targeting of services to the gay community.

IDU

In CCC, 68% of IDUs over the last five years have had multiple treatment episodes. The drug use and relapse that are common among recovering substance users mean that their care is often interrupted placing additional strains on the public HIV health care system. In focus groups and surveys conducted as part of the "Alameda/CCC Out of Care Summit" report, IDUs were more likely than other consumers to report an unmet need for Primary Care.[16] Chaotic lifestyles are among the many environmental influences strongly correlated with inconsistent access to and adherence with care and treatment recommendations. Twenty four percent of IDUs in the TGA's 2007 Needs Assessment reported waiting one to four years after testing positive before seeing a doctor. Forty-four percent reported going for more than six months without seeing a doctor or visiting a clinic. 23% reported not having any health insurance at all.

[16] Widening the Circle of Care: Service Needs of People with HIV/AIDS in the Oakland TGA

Adolescents (13-19)
According to Alameda and CCC HARS data, only 97 adolescent AIDS cases (less than 1% of cumulative AIDS diagnoses) were identified between 1980 and 2007 in the Oakland TGA. Nonetheless, local public health officials believe that higher rates of HIV infection exist in this population based on markers for HIV risk, such as the high rates of STIs among young people, especially Chlamydia among young women of color in West Contra Costa where nearly 71% of cases are in young people under 25 years of age. While these rates indicate that youth are being tested for STIs when symptomatic, there is no information that indicates they seek preventive primary care services or that they seek follow up medical care once the initial infection is diagnosed and treated.

27% of youth and young adult Ryan White clients surveyed in the 2007 Needs Assessment reported that they had gone for more than 6 months without seeing a doctor or visiting a clinic. 42% did not know their CD4 count. Both measures indicate that youth delay or seek care only sporadically.

Transgender
Due to limited health system capacity to meet the needs of transgender individuals, gathering data on rates of infection and the number of transgender people out of care has been difficult. County health officials, case managers and community based organizations that work with transgender individuals in Alameda and Contra Costa believe that AIDS incidence and HIV infection rates among transgender people are probably underreported. As of December 31, 2007, HARS data indicated that there were cumulatively 65 transgender individuals diagnosed with AIDS in Alameda and CCC[17]. These cases are predominantly African American (92%) and most often reported as MSM exposure (81%).[18]

In a recent study by Tri-Cities, a community based Ryan White funded clinic in southern Alameda County, 104 transgender women were interviewed and 58% reported being HIV positive. Only 38% stated that they have an HIV medical provider, and of these, less than half visit that medical provider on a regular basis.

In another Social network-based HIV testing campaign, Tri-Cities outreach workers tested 13 transgender individuals, and 11 tested positive. Two of the nine had known of their status prior to testing but were out of care. Reasons given for being out-of-care included intense concern about confidentiality, lack of transgender sensitive care, and past negative experiences with HIV agencies, such as being turned away due to lack of valid ID.

iv) Estimated level of service gaps among PLWH/A in the TGA

The 2007 Needs Assessment including a Consumer Survey component, 2007 Client Satisfaction Survey, 2006 Client Satisfaction Survey in CCC, service utilization and chart review data, and analysis of public comment at Planning Council meetings, provide data on services requested by clients, client satisfaction with services received and gaps in those services.

Primary Medical Care
Despite the difficulty in serving a client population with large numbers of people with substance use, mental health and other issues that cause personal instability and the potential for interruption of medical care, available data indicate no significant service gaps in the provision of primary care services. The Needs Assessment did not reveal a service gap in this category, and 80 percent of respondents to the Consumer

[17] Alameda and Contra Costa County Public Health Departments; Special data runs
[18] Alameda County AIDS Epidemiology Report; July 2007

Survey reported being satisfied with the level of primary care services they received. In a sample of 82 patient charts in Alameda County, 91% received a minimum of two primary care visits in the last Ryan White fiscal year. 79% of clients received CD4 tests twice during the period and 76% had viral load testing twice during the period. In a sample of chart reviews, 80% of clients were compliant with their HAART regimen. Nonetheless, 25% of the charts had documented a history of non conformance at some time in the past.

Medical Case Management

Medical case management is an especially important service category for the Oakland TGA's client population because many clients have difficulty keeping appointments and drug adherence. Although the Needs Assessment's found a surplus of medical case management services, 23% of survey respondents reported intervals longer than six months without medical care and 20% reported going for more than a year. But only 6% said that it had been more than 12 months since they had seen a doctor.

Chart reviews indicate that 91% of clients successfully kept primary medical appointments consistent with their care plans and were able to develop self management goal setting. Eighty percent completed at least half of their individual care plan objectives. As we have noted elsewhere in this application, CCC uses the bulk of its Ryan White Part A funding for case management to assist clients to navigate the medical care system and to remain in care. 76% of *Contra Costa Client Satisfaction Survey* respondents reported being very satisfied with medical case management services.

Oral Health

The Needs Assessment' indicates a nine percentage point gap between need for dental care and dental care received. Clients reported long waiting times for appointments indicating it takes months to get an appointment. Some respondents indicated that they were not aware that they were eligible for dental services. This constraint on availability of service combined with lack of information and client reluctance to seek care means that in many instances expensive specialty care is necessary by the time clients seek care. The Planning Council increased funding for Oral Care to expand availability of service.

Mental Health Therapy and Counseling

The Needs Assessment found no significant gap in availability of mental health services. Still, Isolation, loneliness, stress, emotional distress and the need for more support with these issues were the most frequently mentioned issues in response to the Needs Assessment's open ended question pertaining to problems respondents faced in managing HIV. 63% of survey respondents indicated that they were satisfied with the mental health services that they had received.

Home Health Care

Utilization data show that 22 individuals used home health care services in the last Ryan White fiscal year. The Needs Assessment found a ten point gap between the amounts of the service needed and received for skilled health services at home based on a written plan of care. The gap was especially high for Latinos at 25 points. Despite competing service needs in both core service and support service categories, the Planning Council will search for strategies to fill this gap as it develops a new Comprehensive Plan.

Substance Abuse Treatment

20% of respondents to the Consumer Survey reported having been treated for substance use in the last calendar year. Although the Needs Assessment did not find a gap in this service category, it is apparent from the TGA-wide utilization data that completion of substance abuse treatment programs is problematic

for Ryan White clients as it is for other substance using populations: Only 7% of 249 individuals were found to have completed treatment and only 6% reported a reduction in drug use. Failure to achieve these goals does not necessarily reflect limited access or a gap in service, but may be an indication of the difficulty of achieving successful substance abuse treatment results generally.

Food

The Needs Assessment found the largest unmet support service need in the food and nutrition categories with a 10 point difference between need and services received for prepared and delivered meals. There was a 6 point gap between services needed and received for nutrition services provided by a registered dietitian. The TGA's clientele is overwhelmingly poor and frequently unable to afford basic necessities including food. Intravenous drug users have difficulty prioritizing nutrition and frequently rely on the TGA-supported food services for basic nutrition.

Housing

Ten out of 12 case managers surveyed at Alameda County HIV service agencies listed housing assistance among their client's top three unmet service needs. The Needs Assessment found an eight percentage point gap in emergency hotel vouchers needed and received. There was also a seven percentage point gap in the need for assistance paying rent, and a 3.6% gap in assistance finding temporary and/or transitional housing. Over 70% of Consumer Survey respondents reported having been homeless for periods ranging from one month to a year. Our clients have particular difficulty maintaining housing stability because safe, low cost housing in Alameda and Contra Costa counties is limited. The median house price in Alameda and Contra Costa Counties has risen by 60% and 90% respectively since 2001 and is an indication of the generally high cost of housing including rental housing. This lack of access to stable housing increases the likelihood that our clients, especially the mentally ill and substance users, will abandon their medical care or seek care only sporadically.

Medical Transportation

Alameda and CCC are large geographic areas of 700 and 734 square miles respectively with limited, and in some areas, non existent public transportation. Transportation vouchers are especially important in light of record high gas prices that approached $5.00 a gallon in some areas of the TGA. Additionally, Contra Costa hospitals and clinics were forced to cut transportation and voucher support for the medically indigent several years ago which left Ryan White funding as a transportation safety net. The Planning Council prioritized and allocated 3% of funding for medical transportation including van service for medical transportation of clients living in the northern part of the county.

Vision Care

Only 18% of Client Satisfaction survey respondents reported receiving vision care services and only 57% of those were very satisfied with the service they received. Lack of information was the most frequently identified barrier to adequate vision care. It is anticipated that increased funding for medical case management will increase access to vision care. Additionally the Planning Council and Office of AIDS managers are working with Ryan White funded vision care service providers to increase outreach to eligible clients.

(1.b) Impact of Co-morbidities on the Cost and Complexity of Providing Care

Attachment 5 summarizes the impact of co-morbidities on the cost and complexity of providing care. As explored in further detail, below, the co-occurrence with HIV of mental illness, substance use, STIs, and

other infectious diseases, complicated by poverty, homelessness, and lack of insurance, characterizes a large portion of the Ryan White clientele in the Oakland TGA. In Alameda County, 67% of Ryan White clients were unemployed, compared with unemployment rates of approximately 5% for the general population. Approximately 17% of the TGA's client population is medically indigent with no health insurance whatsoever compared to between 9 and 11 percent in Contra Costa and Alameda respectively for the general population.[19]

Because the Contra Costa County's public health system provides health care for uninsured county residents through its Basic Health Care (BHC) program, and since HRSA instructed the County not to supplant this funding with Part A funds, CCC uses the bulk of its Ryan White Part A funding for medical case management which is crucial to treatment adherence for a population that includes a large number of IDUs with co-occurring mental illnesses and other health problems that impair a client's ability to remain in medical care. All of the TGA's Ryan White clients, but especially clients in CCC, depend to a large degree on case management to help them navigate health and social service delivery systems, adhere to drug regimens, locate and travel to medical care, keep medical appointments and develop health literacy related to HIV disease. Without this network of supportive services, a significant percentage of low income individuals with HIV who are eligible for primary care services would simply not obtain those services.

Complexity of Care: HIV infection is typically only one of many health problems facing our Ryan White clients. High rates of intravenous drug use, poverty and unemployment, as well as low levels of education and health literacy, combined with unstable housing, mean that many of our clients do not make health care a high priority. The public health apparatus is confronted with a clientele with complex health problems that frequently involve complex drug regimens. Reaching these clients and helping them to sustain positive health outcomes are complicated by the chaotic lives that many low income, substance using individuals lead.

i) STIs[20] and other medical co-morbidities

High rates of gonorrhea and other STIs -- surrogate markers for HIV risk-- indicate a continuing and costly health crisis within minority communities in the Oakland TGA.

Table C	Gonorrhea in the Oakland TGA 2007		
	Alameda	**CCC**	**CA**
Number	2,369	969	
Rate per 100,000	155	92.8	**90**
Female Rate	155	106.7	
Male Rate	155	77	
%Male	49	42%	
%Female	51	58%	

Gonorrhea: Gonorrhea infection has been concentrated overwhelming in low income communities of color. In CCC, 64% of female cases were among young women and girls between the ages of 15 and 24. 58% of male cases and 54% percent of female cases were among boys and young men between the ages of 15 and 24. Half of both male and female cases were African American. In Alameda County 73% of female cases were among girls and women 15 to 24 years old. 50% of male cases were in this age range. 53% of female cases and 62% of male cases in Alameda County were African American. In both counties, 80% of male and female cases were among people of color.

[19] California Health Interview Survey (CHIS)

[20] California Local Health Jurisdiction STD Data Summaries, 2006 Provisional Data (July 2008)

Table D	Chlamydia in the Oakland TGA 2007		
	Alameda	CCC	CA
Number	7,085	3,439	
Rate per 100,000	462	329	
Female Rate	663	474	537
Male Rate	259	169	215
% Male			
% Female			

Chlamydia infections in Contra Costa, particularly among young African American women, have risen steadily since 1996. In 2004, 1,175 cases of Chlamydia in the low income, minority neighborhoods of West Contra Costa accounted for 43% of all infections in the county (2754). Nearly 71% of the West Contra Costa cases are in young people under 25 years of age.[21] 73% and 57% percent of the female and male cases respectively were between the ages of 15 and 24. Over 70% of all cases were African American or Latino.

In 2007 reported cases of Chlamydia in Alameda County increased by 15% from the preceding year. Approximately 73% of female cases were among girls and young women 15 to 24, and 55% of the male cases were in this age range. 53% of the female cases were African American and 26.7% were Latina. 62% of the male cases were African American and 18.5% were Latino.

Syphilis: There were 73 cases of infectious syphilis (primary, secondary, and early latent syphilis) reported in 2007 in Alameda County and 40 reported in CCC. [22] 94% of Alameda's P&S syphilis cases and 92% of the early latent syphilis cases were men. In CCC all of the 27 P&S cases were men and 69% of the early latent cases were men.

From 2004 to 2006, 211 early syphilis cases in Alameda County were contacted for follow up interview. Of these, 79.6% were MSM. Half of the MSM were co-infected with HIV compared to one in five (21.4%) of all others (females and heterosexual males).[23]

In 2007 primary and secondary cases of syphilis in CCC doubled to 32 cases of which 21 were in MSM. Ten of these were co-infected with HIV. In Contra Costa County 5 (3%) of the 179 Ryan White Part C clients in 2007 were diagnosed with syphilis.

Cost and Complexity of Treating STIs for co-infected PLWH/A

Chlamydia requires a lab and physician visit for initial diagnosis, antibiotic treatment and follow-up visits to determine the success of treatment, as well as gynecological specialty care, all of which increase the cost and complexity of care. Treatment for gonorrhea requires an initial diagnostic visit involving urine testing followed by antibiotic treatment for those who test positive, and follow-up visits to determine the effectiveness of the treatment and six-month follow-up visits including lab tests. Syphilis is an extremely costly and complex STI to treat. Initial diagnosis requires a blood test, rather than urine test, and after initial prophylaxis treatment, monthly visits with accompanying lab tests are required for up to six months.

The rate for STIs other than Syphilis among Ryan White clients in the Oakland TGA is approximately 3% or about 145 Ryan White Clients in fiscal year 2007-2008.[24] Although the exact cost of treating STIs for

[21] Contra Costa Health Services Department, Sexually Transmitted Disease Program special data run. Also see data links at ccpublichealth.org

[22] California Department of Health Services STD Control Branch. "Chlamydia, Cases and Rates, California Counties & Selected City Health Jurisdictions, July 2008.

[23] Alameda County 2007 Sexually Transmitted Disease Morbidity Report

patients co-infected with HIV in the TGA is unavailable, we have estimated the cost of treatment by assuming a 3% co-infection rate and applying it to available estimates of treatment costs for each STI. The number of syphilis cases used in the estimate below is based on CCC Ryan White Part C and Alameda County CADR data indicating a 3% co-infection rate.

Table E: Estimated Annual Cost of Treating STIs			
STI	**Cost per person[25]**	**# of clients**	**Total Cost**
Chlamydia	$244		
Gonorrhea	$160		
Average cost of treatment Chlamydia and Gonorrhea	$200	145	$29,000
Syphilis	$444	90	$40,000
Total			**$69,000**

ii) Other Medical Co-morbidities

Hepatitis C in the General Population: Due to high rates of injection drug use, Hepatitis C remains a significant health concern in Contra Costa where local estimates indicate that more than 28,000 individuals may be infected. In 2005, 37% of the 531 newly reported cases of Hepatitis C carriers were in low income, predominately African American neighborhoods of West Contra Costa. In 2006, there were 665 reported cases of Hepatitis C in the entire County.[26]

A 2001 study conducted at the Alameda County Medical Center/Highland Hospital showed 36% of all Adult Immunology Clinic patients were co-infected with HCV. A recent Hepatitis B and C prevalence survey of injection drug users in the Oakland TGA found approximately 89% tested positive for the Hepatitis C Virus antibody and 75% were antibody positive for hepatitis B.[27] The Alameda County Department of Behavioral Health Care Services estimates that 26,000 to 32,000 persons are infected with HCV based on estimates of the number of injection drug users in the county and CDC estimates of the rate of HCV infection among those exposed.[28] More than 3,000 HCV tests were conducted throughout the County at selected alcohol and drug treatment sites between 2000 and 2005. Of those tested in this five year period, 1,129 tested positive for HCV, an average of 225 positive tests per year.[29]

Cost and complexity of Treating PLWH/A co infected with HIV-Hepatitis C

The potential for contraindications and complications of HCV therapy and HIV antiretroviral medications requires more intense monitoring by the HIV specialist and increases the cost and complexity of treating both diseases. There are 281 PLWH/A who received services in Alameda County and presented with Hepatitis C in the last Ryan White fiscal year. There are 242 IDU PLWH/A in CCC[30]. Using CDC estimates of HIV-Hepatitis C co-infection rates of 50% to 90%, we estimate that there are at a minimum 400 PLWH/A with hepatitis C. in the Oakland TGA 319 Ryan White clients in the last fiscal year were infected with

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[24] HIV/AIDS Client Services Intake Summary Reports Alameda and Contra Costa Counties 3/1/2007 2/28/2008

[25] Perspectives on Sexual and Reproductive Health; Volume 36, Number 1, January/February 2004 "The Estimated Direct Medical Cost of Sexually Transmitted Diseases Among American Youth, 2000". Chesson, Blandford, Gift, Tao and Irwin

[26] Other Reportable Communicable Diseases; Contra Costa Health Services March 2007

[27] Extracts from the Urban Health Study of the University of California at San Francisco web pages ucsf.edu/uhs/program/htm.

[28] Alameda County Health Department, Division of AIDS and Communicable Disease, *Memo to Hepatitis C Task Force*, 2001.

[29] Alameda County Public Health Department, Division of Communicable Disease Control and Prevention.

[30] CCC Health Services HIV/AIDS Epi Report July 2007

hepatitis C. Cost for treatment for Hepatitis C ranges between $8,000 and $15,000 a person.[31] We estimate the cost for co-infected RW patients at between $2,552,000 and $4,785,000 annually. Because so few RW clients have sufficient medical insurance, these costs are largely born by the TGA's three Health Departments.

TB in the General Population: 51 residents of CCC were diagnosed with active TB in 2007, a reduction of 14% since 2005 (58 cases), and 39% since 2003 (82 cases). The county's TB rate in 2007 was 4.8 per 100,000, 35% less than for California as a whole (7.4 per 100,000). [32] The improvement in the rate is due largely to aggressive targeting of outreach and treatment in West Contra Costa, where approximately 45% of all TB cases in 2002 resided. Although epidemiological data revealed no new cases in persons diagnosed in the county with HIV infection, service data shows six clients co infected with HIV and TB.

In 2007, there were 155 cases of TB in Alameda County (excluding the city of Berkeley). This is an increase of 6% from 2006. Alameda County's case rate in 2007 was 10.2 per 100,000 residents, higher than the state rate. This rate is higher than in CCC and the city of Berkeley, but is lower than in San Francisco. [33] There were 51 TB case in CCC in 2007 for a case rate of 4.9 per 100,000.

Cost and Complexity of Treating TB among PLWH/A

Service data indicates 27 Ryan White clients served in the last fiscal year were co-infected with TB and HIV.[34] The treatment for TB is both costly and lengthy. HIV+ patients with active TB need an initial chest x-ray, prophylactic treatment, and must be followed daily until the disease is controlled. Once symptoms respond to medication, patients must be seen monthly for a year, with a chest x-ray. Officials of the health departments of Contra Costa and Alameda County estimate the cost of treatment at approximately $5,000 per person including $800 in drug charges resulting in a total cost of approximately $135,000 to treat TB in co-infected Ryan White clients.[35]

Cost and Complexity of Treating Substance Use: Approximately 20% of the TGA's Ryan White clients presented with substance abuse issues in the last Ryan White fiscal year. Nearly 17% were injection drug users. (The percentage is nearly 23% in CCC.)[36] Tri City Health Center, a community based medical care provider in south Alameda County, has reported that 57% of clients who identified as MSM stated that they engage in substance use and/or experience depression, anxiety or mental illness; 41% of Latino clients reported these problems.

There are 288 IDU PLWH/A cases in CCC[37] and 590 in Alameda County. Outpatient methadone maintenance treatment costs approximately $12.00 daily. Residential Treatment for men ranges from $52 to $85 a day and for women from $49 to $55 a day. Detoxification treatment typically lasts from 21 days to six months. However methadone maintenance can last up to two years. Perinatal treatment costs between $66 to $122/day and lasts an average of 90 days for those who test negative for drugs upon admission or show low signs of withdrawal. Treatment can last much longer and cost much more for clients who test positive and or are undergoing a "hard" withdrawal.

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[31] http://www.cdc.gov/hiv/resources/factsheets/coinfection.htm
[32] TB Epi Report; Contra Costa Health Services; March 2007
[33] TB in Alameda County, 2006; Alameda County Public Health Department
[34] Intake Summary Reort March 2007 – Feb 2008; Alameda County Office of AIDS
[35] www.cchealth.org/groups/epidemiology/tb
[36] HIV/AIDS Client Services Summary Intake Report 06/07
[37] Contra Costa Health Services HI/AIDS Epidemiology Report July 2007

A conservative estimate that 500 individuals receive 21 days of outpatient methadone treatment results in a cost of about $900,000. However, because most IDUs have multiple treatment episodes (Data from Contra Costa Health Services indicates that 85% of all IDU admissions in CCC are served more than once in substance abuse treatment programs) and because treatment can last much longer than three weeks, public health officials believe the combined total annual costs for methadone treatment and detoxification is substantially higher.

Mental Illness: About a third of all Oakland TGA Ryan White clients served in the last fiscal year presented mental health issues. The most commonly reported mental health problem in the 2007 Needs Assessment was depression with 40% of Needs Assessment Consumer Survey respondents reported being diagnosed and treated for depression within the past twelve months. Transgender women and women of color reported being diagnosed and treated more frequently than other groups with 66% of transgender women and 48% of women of color reporting diagnosis and treatment for depression. 8.5% of Needs Assessment respondents reported being diagnosed with bipolar disease, with women of color (16%) and IDU (9.5%) being diagnosed more than other groups.

The average cost per client for mental health services per client in the Oakland TGA last fiscal year was $1,800[38]. The State of California reports estimated cost of mental health services of $66,000,000 for Contra Costa and $106,816,579 for Alameda County in FY 99-2000, the most recent year for which these figures are available.[39]

iii) *Prevalence of Homelessness and Poverty Rates*

The high rates of homelessness and poverty that our clients endure compared to poverty and homelessness in the general population, illustrated in Attachment 4, clearly place our clients at a greater risk for relatively more negative health outcomes than the risk for poor outcomes in general public. County databases indicate that 29% of Ryan White clients in CCC and 20% in Alameda County had a period of homelessness or unstable housing.[40] 28% of all Needs Assessment respondents reported that they were either homeless or in unstable housing. 37% and 34% respectively reported that they had lived on the street or in homeless shelters for periods ranging from a month to a year.

The Oakland TGA's Ryan White clients are far less likely to attend to basic healthcare needs, and often present at emergency rooms with advanced ailments such as abscesses, blood poisoning, and AIDS diagnosis in late stages of HIV infection which mean increased costs of medical care and limited benefits from the anti-retroviral drug therapies. The average cost per client for short term and emergency housing assistance was $1,485 according to utilization data.

iv) Estimated Number of Uninsured Individuals

Almost 12% of Alameda County residents were uninsured in 2005, the last year that uninsurance statistics were available.[41] Another 147,000 received MediCal (Medicaid) benefits. In CCC, 89,000 (8.8%) of residents were uninsured in 2005[42]. By comparison in 2007 approximately 20% of Ryan White clients in

[38] CADR
[39] California Department of Mental Health; Estimated Cost of Service, by County and Service Type
[40] Intake Summary Report 3-2007 to 2-2008 and CCC HIV Epi Report July 2007
[41] California Health Interview Survey, 2005. Data request, http://www.chis.ucla.edu/main/DQ2/ default.asp, cited in Alameda County Access to Care Collaborative, "Addressing Racial and Ethnic Health Disparities in Alameda
[42] U.S. Census Bureau (2005) Population Estimates Table T1

Alameda and 34% of clients in CCC were uninsured.[43] In both counties, Latinos are much less likely to be insured than other ethnic groups. In 2005, 22.6% of Latinos were uninsured, by far the largest group of uninsured people in the TGA.[44] This finding was confirmed by the Needs Assessment in which 18% of Latino respondents reported that they had no insurance including Medicaid or Medicare. 19% of IDUs also had no insurance.

The Needs Assessment, found a 14% gap between need and assistance received in paying for medical insurance premiums, co payments and deductibles. Lack of health insurance reduces access to regular care and early intervention both of which are critical to survival for HIV positive patients. In one study the mean costs for late presenters (a CD4 count <200 cells/μL) were more than twice as high as those for early presenters ($18,448 vs. $8455, respectively). Most costs were attributable to HIV-related hospital care costs and the immediate initiation of antiretroviral therapy.[45]

v) People Living At Or Below 300% Of Poverty

Almost all Ryan White clients in both counties live at or below 300% of the federal poverty line. (Enrollees in Contra Costa's Basic Health Care must have incomes no greater than 300 percent of the federal poverty line.) By comparison 31% of Contra Costa's population and 39% of Alameda County residents live at or below 300 percent of poverty.[46]

vi) Impact Of Individuals Who Were Formerly Incarcerated

65,000 prisoners from state prison and local jails have been released to Alameda and Contra Costa counties over the last three years. Local county jails in Alameda and Contra Costa County have released 41,000 of these prisoners,[47] and the California Department of Corrections has released the other 24,000. About 75 percent of the parolees from state prison return to Alameda County. Most return to the low income neighborhoods in either Oakland in Alameda County or Richmond and San Pablo in CCC. Most state prisoners returning to the TGA have been incarcerated in San Quentin State Prison, a large, medium security prison near San Francisco in Marin County, California.

The most recent statistics on HIV seroprevalence in the California prisoner populations is 3%,[48]. In a randomized prerelease interview conducted by a northern Californian community based organization, 10% of informants self-reported as HIV positive. Assuming a seropositivty rate of 3%, we estimate approximately 2,000 individuals with HIV AIDS have been released to the TGA over the last three years.

As is the case with the TGA's Ryan White client population generally, HIV positive prisoners reentering the TGA from state, federal and local jails deal with a wide variety of health problems in addition to HIV. A California Department of Health Services study reveals that the prevalence of hepatitis C in California

[43] Contra Costa Client Data Report & Alameda County Intake Summary
[44] California Health Interview Survey 2005
[45] The high cost of medical care for patients who present late (CD4<200 cells/μL) with HIV infection; HIV Medicine Volume 5 Page 93 - March 2004
[46] U.S. Census Bureau (2005). American Community Survey, Table B17002 and 2005 California Health Interview Survey.
[47] Dr. Harold Orr, Medical Director, Alameda County Jails
[48] Jessica Anne Clarke, MD, PhD; Chief Medical Officer (A) San Quentin Prison California Department of Corrections and Rehabilitation; Pacific AIDS Education and Training Center; Asilomar September 2005 and National Commission on Correctional Health Care.(2002). "The health status of soon-to-be-released inmates: A report to Congress". Chicago: National Commission on Correctional Health Care

prisons is 34% and hepatitis B is 28%. Estimates of prisoners with serious mental illness are as high as 20%. Alcohol and other Drug abuse rates are estimated to be 85%.[49]

California's 70% recidivism rate is nearly twice the national average.[50] This high rate of recidivism means that many parolees reenter prison several times, which can subject an HIV positive reentrant's treatment to delays or interruption if the individual refuses medication in prison to avoid revealing that he is HIV positive.

The TGA estimates the annual cost of care for Ryan White clients at approximately $2,000 including a minimum of two medical visits, diagnostic and laboratory costs and other costs of core services. Given the complexity of service to the recently incarcerated such as outreach, mental health services, substance use services, and the effects of late entry to care and intermittent care, the TGA estimates costs are increased by a factor of 2.5 for an annual cost per client of $5,000. Assuming an in care rate of .5, we calculate the cost of serving this population at $5,000,000 over the last three years.

(1.c) Impact of Part A Funding: Funding Mechanisms and the Impact of the Decline in Ryan White Formula Funding

i) Report on the Availability of Other Funding

See Attachment 5 for the TGA's table of public funding for HIV-related care services from federal, state and local sources expected in FY 2008.

ii) Coordination of Services and Funding Streams

Other CARE Act Parts Considered During Part A Priority Setting

During the allocations and priority setting meetings, grantee staff provided the Planning Council an update on expected HIV funding from other public sources including current and expected funding for Parts B through D. The Alameda County and CCC Health Departments manage the distribution of all RWCA funding, coordinating a network of health and psychosocial support which also includes Housing Opportunities for People With AIDS (HOPWA), State Office of AIDS Nurse Case Management funds, State HIV Education and Prevention services, HIV Testing and Surveillance funds, and MediCal Waiver reimbursements.

Alameda County, the grantee of record for RWCA Part A and B funds for the TGA, also receives RWCA Parts C and D funding for services in Alameda County. Contra Costa, the grantee of record for Contra Costa's RWCA Part C program, has an MOU with the Alameda County Part C provider to prevent duplication of services. The Pacific AIDS Education Training Center (AETC), located in Oakland, provides training support across the TGA.

Part B

ADAP is managed by the State Office of AIDS. To prevent duplication of services, the Planning Council provides very limited resources for medications. Each jurisdiction has trained individuals, including MSW case mangers in CCC, who certify eligibility and enroll individuals in the ADAP program. Additionally, Part

[49] Outline of Alameda County's Health Care System for the Medically Indigent, Dr. Tony Iton, Alameda County Public Health Director and County Health Officer

[50] Parole in California in the Los Angeles Times, April 23, 2006; Fischer, Ryan D, Are California's Recidivism Rates Really the Highest in the Nation in The Bulletin, Center for Evidenced-Based Corrections, University of California, Irvine.

B funds an array of health and support services in the TGA. The Council considers all Part A and B funds in setting priorities and allocations.

Part C
HRSA has advised Contra Costa that it may not displace its current HIV primary care funding with HRSA funds. Therefore Contra Costa uses Part A funds mainly to support case management. The Planning Council took this into consideration during allocation and priority setting. Contra Costa uses Part C funds for HIV Early Intervention Service targeting the County's poorest neighborhoods. In Alameda County Ryan White CARE Act Part C provides comprehensive HIV-specific outpatient Early Intervention Services to a population of impoverished individuals and families living with HIV.

Part D
The Part D-funded Family Care Network (FCN) is the primary source of care for HIV-infected women, infants, children, and young people in both Counties. It is an integrated collaborative of multidisciplinary providers that provide a comprehensive range of HIV care and support services. Approximately 75% of the FCN service population consists of low-income persons of color, including African American, Hispanic/Latino, and API.

Services Funded By Other Federal And Local Sources Considered In Planning the Continuum Of Care And During Priority Setting And Allocation.

SAMHSA
In CCC, the Department of Alcohol and Other Drugs applies for and administers SAMHSA funding. In Alameda County SAMHSA funds are administered by the county's Behavioral Health Care Services Agency. The TGA also partners in SAMHSA-funded grants with HIV components: In CCC, one SAMHSA funded project provides HIV testing and partner counseling services for the homeless population while another seeks to expand testing and counseling services for substance users in the criminal justice system. In Alameda County SAMHSA funded programs offer HIV prevention, counseling and education and medical care services for HIV-AIDS targeting Native Americans and Latinos, and Alcohol and other Drug use treatment as part of services offered to prisoners reentering the community.

HOPWA
HOPWA funds awarded to the TGA are received by the City of Oakland and distributed in accordance with an Intergovernmental Agreement (IGA). In Contra Costa, CARE Act funds are generally not used for housing services as HOPWA funds both housing advocacy services and short term housing assistance in addition to the development and rehabilitation of housing. In Alameda County, HOPWA funds are administered by the County's Department of Housing and Community Development which facilitates use of these funds in planning the continuum of HIV care. HOPWA program management staff made presentations to the Planning Council during the priority setting and allocation processes on how HOPWA funds are used in the TGA.

Medicaid/Medicare
Each county administers MediCal (Medicaid) and Medicare programs as required by state and federal law. Case management and client benefits advocates aggressively enroll individuals in MediCal. Ryan White funding fills the gap created when MediCal is denied or when MediCal payments is capped out. MediCal provides limited funding for home health care for individuals enrolled in the Medi-Cal waiver program.

The Contra Costa Health Services Department (CCHSD) annual budget is about $678,000,000 - 87% from third party reimbursements and grants and the remaining 13% in local support. As the largest provider of uncompensated care for the medically indigent in Contra Costa, CCHSD participates in the 340 (B) Drug Discounting Program and has FQHC status for several clinics.

Rather than using CARE Act funds to support the identification of HIV positive individuals enrolled in Alcohol and Other Drug Services (AODS) treatment sites, Contra Costa uses HIV set aside funds under the AODS block grant to test and refer positive individuals to the HIV system of care. Additionally, this year AODS staff training will strengthen staff ability to identify high risk individuals and refer them for services.

Veterans Affairs

The VA HIV Clinic in Oakland serves approximately 100 patients from Alameda and Contra Costa Counties. Approximately 30% of the caseload has an AIDS diagnosis.

(1.d) Assessment of Populations with Special Needs

Alcohol and other drug use disorders, mental illness, and poverty have a profound impact on the HIV infected population in the Oakland TGA. These co-morbid health or mental health conditions combined with poverty influence the ability of our clients to access and remain in medical care, and to achieve positive health outcomes. These problems manifest in broken health care appointments, inattention to medication regimens, non-compliance with medical provider care and treatment orders, and disregard for risk of transmission or for further deterioration of health status. Ensuring the availability of appropriate and high quality primary care is simply not enough to provide comprehensive care for this population. Without the provision of significant supportive assistance, individuals in greatest need and at the highest risk for transmission of HIV simply do not stay in care.

The Planning Council has identified six populations with special needs: African American MSM, Latino MSM, IDUs, Women of Color, Youth 13-24 years of age, and Transgender women.

We have derived cost estimates for providing services to each special population from the AIDS Healthcare Foundation's estimate of $325 per visit for two visits. Laboratory, diagnostic and other core service costs are estimated at an additional $1,350 annually per patient for an average cost of $2,000 per patient.

i) African American and Latino MSM

***Unique Challenges and Service gaps*:** HIV/AIDS has impacted MSM more than any other exposure category in the Oakland TGA. African American and Latino MSM constitute 70% of **all** new HIV infections in the two year period ending 12/212007 and a third of new AIDS diagnosis in the same period. As we noted in our discussion of delayed access to care, 70 % of those who were diagnosed with AIDS at their first HIV test in Contra Costa were MSM. This is a strong indication that many MSM delay entry into care which raises the cost of care and diminishes the likelihood of positive health outcomes.

Many MSM of color in the Oakland TGA are not gay identified. Focus groups conducted as part of the Oakland TGA's 2002 Out of Care Summit and the 2007 Needs Assessment reveal that MSM of color feel stigmatized by both the larger community of color and the gay community. It is widely understood that stigma fuels the unwillingness of men of color to test or seek care after a positive result. In Alameda County, about one third of African American MSM have never tested to determine their HIV status, and a significant proportion of those who have been tested have not been tested recently, despite continued high

–risk behavior. Large numbers of those tested never receive their results.[51] Non-Gay Identified MSM pose a significant challenge for care providers since they are frequently unresponsive to care or testing messages aimed at bisexual or gay men. Moreover, unemployment, homelessness and poverty lead many African American men not to prioritize health care and to focus instead on basic survival needs.

Methamphetamine Use by MSM: A collaborative study involving the University of California AIDS Research Program, the grantee and Tri Cities community clinic found a notable diversity in the ethnic background of methamphetamine using HIV positive MSM in Alameda County. Investigators conducted ethnographic mapping, field observations and qualitative interviews, and found that after learning about their positive status many MSM engaged in a period of accelerated meth use and suffered deteriorating health.[52]

Estimated Costs Associated with Complexity of Care to African American and Latino MSM
MSM generally are increasingly encountering antiretroviral drug resistance as well as complications from long periods of time on these drugs. Genotyping is needed more frequently. Patients with AIDS should be seen four times a year while someone with HIV (Not AIDS) may only need one to two visits annually. Treatment of these complications and drug resistance are costly. Among the service needs cited by African American MSM in the TGA's Needs Assessment were dental care, home health care, and nutrition services. As we have noted elsewhere, dental services are especially costly because many clients delay oral health care to the point that they need expensive specialty care.

Latinos in both counties are uninsured and diagnosed with AIDS at their initial HIV test at rates disproportionate to their percentage of the population. These two factors indicate that many in this population enter care late in the course of HIV disease, and clearly show an unmet need for primary HIV care. Late entry into care results in increased cost of treatment.[53] By some estimates, direct care costs in the year following HIV diagnosis are more than 200% higher for patients who present late. The mean costs for late presenters are as much as twice as high ($18 448 vs. $8,455, respectively) [54] as for those who seek care soon after infection. Some of this isolation is related to language barriers. The most recent census data shows that approximately 26% of all CCC residents speak a language other than English at home. The percentage is higher in West CCC where 36.2% of residents speak a language other than English at home, and 19.4% indicate that they speak English "less than very well

Additional services required by Latino MSM therefore include translation and interpreting services, intensive case management involving outreach targeting Latino and African American clients as well as additional medical services related to late entry into care.

Local health officials estimate that the additional clinical, diagnostic/laboratory costs as well as substance abuse treatment and mental health services associated with treating this population raise the average cost per client by a factor of 2 to approximately $4,000 per patient for a total cost of treating older MSM clients, provision of specialty oral health services, additional cost of $3,330,000 as illustrated in the table below.

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[51] HIV / AIDS Prevention and Education for AAMSM: A Gap Analysis; HIRE Center Research Brief; California State University, East Bay
[52] Countering a Hidden Risk: Initiating Change Among Methamphetamine-Using MSM, Center for AIDS Prevention Studies Research Portfolio Spring 2008
[53] US Census Bureau: Profile of Selected Economic Characteristics: 2000 http://factfinder.census.gov
[54] The high cost of medical care for patients who present late (CD4<200 cells/μL) with HIV infection: HIV Medicine Volume 5 Page 93 - March 2004

Total AA and Latino MSM PLWH/A	% in care	Total AA and Latino MSM in care	Annual Cost per client	Total estimated cost associated
1,850	.6	1110	$4,000	$4,440,000

ii) IDUs

Unique Challenges and Service Gaps

IDUs typically require multiple substance use treatment episodes. Medical care challenges include treatment of abscesses and treatment of Hepatitis C and other blood borne diseases. Typically IDUs have great difficulty remaining in care for extended periods of time. 25% of IDU respondents to the Needs Assessment Consumer Survey reported waiting for one to four years after testing positive to see a doctor. 5% of respondents waited more than five years. Inconsistent medication adherence makes them especially vulnerable to HIV strain mutations. They require prevention services to address risk behavior including survival sex and poor compliance with care and treatment. The loss of California Department of Alcohol and other Drugs treatment slots further compounding the difficulty of serving this population.

Estimated Costs Associated with Complexity of Care to IDUs

As we have noted above, outpatient methadone maintenance treatment costs approximately $12.00 daily on a sliding scale. Residential Treatment for men ranges from $52 to $85 a day and for women from $49 to $55 a day. Detoxification treatment typically lasts between 21 days and six months, however methadone maintenance can last for many years. Perinatal treatment costs between $66 to $122/day and lasts an average of 90 days for those who test negative for drugs upon admission or show low signs of withdrawal.

Local health officials estimate that the additional detoxification, residential treatment, methadone maintenance, specialty oral health services, clinic visits and mental health services associated with treating this population raise the average cost per client by a factor of 2.5 to approximately $5,000 per patient for a total cost of treating IDU clients of $2,650,000 as illustrated in the table below.

Total IDU/HIV PLWH/A	% in care	Total IDU/HIV in care	Annual Cost per client	Total estimated cost associated with delivering care
881	.6	530	$3,750	$2,650,000

iii) Women of Color

Unique Challenges and Service Gaps

The number of heterosexual women who become infected through intravenous drug use or by unprotected sexual intercourse with their IDU partners has increased over the course of the epidemic. Almost half of women ever diagnosed with AIDS in CCC are intravenous drug users. Many of the female clients seeking RW funded services have been pregnant women living in poverty who seek prenatal care late or not at all and discover their HIV status during pregnancy or labor. Many providers report that a large percentage of their female clients are domestic violence victims. Due to the threat of violence and out of a general fear of the stigma associated with HIV or an AIDS diagnosis, many women avoid treatment. Women often fail to prioritize their HIV care because of competing survival needs, such as child care.

Estimated Costs Associated with Complexity of Care to Women of Color

Women tend to be unemployed at higher rates than men in the Oakland TGA which causes them to rely more heavily than men on emergency financial assistance for such things as utilities. In the 2007 Needs

Assessment women indicated a substantial gap in need for assistance with housing services including emergency hotel vouchers and emergency rent assistance.

Preventing perinatal transmission represents added costs for medical care of some women as do the increasing number of female IDU who require substance abuse treatment. Although Alameda County's teen birth rates are on the decline, from 58.2 per 100,000 in 1991 to 28.0 in 2002, for 15 – 19 year olds, for Latinas it is substantially higher (76.1) as well as for African Americans (58.2). High rates of Chlamydia and other sexually transmitted disease also add to the cost of care. As we noted in our discussion of STIs, the proportion of infections occurring in women of color in Alameda and CCC is as high as 80%.

The additional housing services, perinatal transmission prevention, STI treatment, substance abuse treatment, training and use of Spanish speaking "promotoras" (patient navigators who conduct outreach targeting Latinas in an effort to keep them in care) are estimated to increase the cost of serving this population by a factor of 2 for an annual cost per client of $4,000 and a total cost of $2,632,000.

Total Women of Color PLWH/A	% in care	Total Women of Color in care	Annual Cost per client	Total estimated cost associated with delivering care
1,096	.6	658	$4,000	$2,632,000

iv) Youth 13-24

Unique Challenges and Service Gaps

Young people within our target population fit the same demographic profile as adult Ryan White clients. They are typically youth of color, low income and they frequently present with a number of co-morbidities including STIs, chronic illnesses and alcohol and other drug use disorders. Within this population, MSM are frequently reluctant to seek care in a timely manner because of the fear of stigma. 26% of youth respondents to the Needs Assessment reported being diagnosed and treated for substance abuse within the 12 month period preceding the survey. A large percentage reported using a variety of substances including alcohol, meth and ecstasy.

Young adolescents have typically not developed the cognitive thinking skills necessary to manage their own care effectively. Many have personal or mental health problems that act as barriers to accessing care and complying with care plans. For example, 28% of youth Needs Assessment survey respondents reported skipping medication once or twice a month usually due to side effects, and 40% reported being diagnosed with depression.

Clinics and medical facilities that primarily treat adult HIV patients are often not appropriately staffed or structurally and organizationally designed to serve young people effectively. Cultural competence in the instance of HIV medical care for youth must include flexibility in scheduling processes and procedures such as drop-in and same day appointments with staff and clinicians who have the knowledge, skills and abilities that enable them to correctly identify the developmental stage of young clients in order to provide effective HIV health care.

Other barriers to care for this population include: legal issues such as parental consent and immigration status; lack of transportation or a reliance on inadequate public transportation; cultural barriers including language and/or literacy; situational barriers such as school and employment commitments or restrictive parental authority.

Estimated Costs Associated with Complexity of Care

There are very high rates of STIs among youth, especially youth of color. In CCC the case rates (per 100,000 people) for Chlamydia among women aged 20-24 was 712. Repeated infections, delayed access to care and treatment, and aggravation of other conditions due to untreated Chlamydia and other STIs increase the cost of care for this vulnerable population and place them at heightened risk for transmission of HIV and other sexually transmitted diseases.

The specialized youth services, STI treatment, and substance abuse treatment required by this population increase the costs of serving this population by a factor of 2.5 for an annual cost per client of $5,000 and a total cost of $1,410,000.

Total Youth 13-24 PLWH/A	% in care	Total Youth 13-24 in care	Annual Cost per client	Total estimated cost associated with delivering care
470	.6	282	$5,000	$1,410,000

v) Transgender (MTF)

Unique Challenges and Service Gaps

The combination of enormous stigma and poverty has led to a high degree of social isolation for this community. There is no centralized agency or gathering place for the LGBT community and MTF transgender individuals have few opportunities to receive health care services specifically designed for them. Because many young, low income transgender women of color in Alameda County especially do not trust health care providers and are unwilling to identify as transgender at clinics and laboratories, HARS data regarding transgender women in the TGA is limited. Available information indicates an extremely high HIV infection rate with seroprevalence rates as high as 11%. The majority of infections occur in African Americans.[55]

Tri Cities Clinic, a Ryan White funded primary care clinic, recently conducted an anonymous interview of 104 transgender women in Alameda County in order to fill this information gap. Findings suggest that infection rates and numbers of people out of care are higher than HARS data indicates. 58% of respondents reported being HIV positive and over 60% reported mental health issues including suicidal ideation and depression. In a social network-based HIV testing campaign conducted by this same organization, 11 out of thirteen test results were positive and two of the nine were known positive but out of care.

The survey also measured service needs. The services needed the most were primary health care (45%), support groups (43%), housing (38%), mental health services (28%) and HIV care services (16%). When asked whether they had access to these services, 69% knew where to go for services, but 81% were not accessing them. Barriers to care included concerns about confidentiality, drug use, and prioritizing economic survival over health care.

Estimated Costs Associated with Complexity of Care

Isolation and the low priority that many transgender women (MTF) give to health care mean that outreach and case management are costly and time consuming. Typically street outreach through one-on-one encounters is the only effective, albeit sometimes dangerous, way to reach this population. Effective care requires specially trained clinicians and retraining of existing staff and clinicians to increase awareness and

[55] Alameda County Office of AIDS EPI Report; 2006

sensitivity to the needs of this community. Crime and violence tend to permeate the areas in which many transgender women live and work which has a negative impact on the ability to provide care.

TGA health officials estimate that the additional costs of street outreach, staff training, as well as the additional time required for case management for this population increases the costs of HIV services by a factor of 2.75 for an annual cost per client of $5,500 and a total cost of $176,000.

Total Transgender PLWH/A	% in care	Total Transgender in care	Annual Cost per client	Total estimated cost associated with delivering care
54	.6	32	$5,500	$ 176,000

(1.e) Unique Service Delivery Challenges

The Oakland TGA is home to a number of large health care systems spread across a large area. This has limited integration of the public health care services which in turn has made it difficult to identify out-of-care populations and individuals or to measure the full extent of the epidemic -- including treatment cost. Additionally, the Alameda County Behavioral Health Care Services agency does not track HIV status of its mental health and substance abuse clients.

Because so many of our clients lead chaotic lives as a result of poverty, mental illness and alcohol and other drug use, service providers must contend with high rates of broken appointments which increase costs and complicates care delivery. In CCC's Infectious Disease Clinics, the broken appointment rate in past years has varied between 30% and 46% depending on the season. Aggressive outreach has raised the kept appointment rate in some of CCC's regional health clinics to 80%. Broken appointments remain a problem in other CCC clinics. In Alameda County, HIV primary care contractors report that broken appointment rates can range from 10% to 50% depending on the time of year and clinic location.

(1.f) Impact of decline in Ryan White Formula Funding

Part A funding for the Oakland TGA has decreased since FY 03 by $1 million dollars from a high of $6.5 million to $5.4 million in 08. Formula and supplemental funding were combined in a single award in fiscal years 01-05. Therefore, we are reporting on the decline in funding in general terms from FY03 through the current year.

In Alameda County in FY03, Ryan White funded 28 agencies providing services in 29 categories. By the 08 fiscal year, Ryan White funded agencies and categories had been reduced to 19 and 16 respectively. The largest reductions in funding have been in food services, housing (reduced by over $600,000) and Emergency Financial Assistance which was reduced from $600,000 in FY03 to less than $140,000 in FY07. Funding was also reduced or eliminated for alternative and complimentary medical services, peer advocacy, treatment adherence services, vision, and translation and interpretation, day and respite care, housing related services, psychosocial support and client advocacy. In Contra Costa County, reductions were made in Emergency Financial Assistance, Food and Home Health Care, and RW funding for Benefits Counselling was eliminated.

For the most recent round of reductions, the grantee provided the Council data estimating that reductions would impact approximately 700 clients. Agencies dealt with the impact of the reductions by referring clients to other sources of assistance, or by making internal adjustments to absorb the cuts and continue

services without Part A funding. Alameda County general funds were used to restore day and respite care services for adult PLWH/A.

The Needs Assessment, Client Satisfaction Survey, public comment at Planning Council meetings and feedback from case managers all indicate that housing assistance presents one of the biggest service gaps for PLWH/A in the TGA. In order to meet the housing and housing relate needs of PLWH/AIDS in Alameda County, HOPWA and the Planning Council are in the process of drafting a Memorandum of Understanding to increase and enhance coordination between RW funded services and HOPWA funded services. The first step in this effort was a Council decision to maintain the Housing Assistance category at the 2007-2008 level and to absorb HOPWA funded housing related case management, substance abuse and mental health services that meet Ryan White Modernization Act criteria. In turn, HOPWA now partially funds Housing Assistance formerly funded by RW.

(1.g) Unmet Need

In response to the federal legislative directive to develop an estimate of unmet need, the California Department of Health Services (DHS) and each of California's Part A EMAs and TGAs collaborated to estimate the number of persons residing in each jurisdiction not receiving primary medical care. California and its local health jurisdictions based their approach to estimating unmet need on the "Unmet Need Framework" developed by the University of California, San Francisco. Unmet need was defined as individuals who were living with HIV or AIDS in FY 2006-2007, aware of their status, and who had **no** evidence of receiving HIV primary care. HIV primary care (met need) was operationalized as receipt of viral load (VL), CD4 count, or anti-retroviral therapy (ART) during the time period of 07/2006 – 06/2007.

It is estimated that 9,756 people living with HIV/AIDS in the Oakland TGA jurisdiction in FY 2006-2007, 4665 (47.8%) were persons living with AIDS (PLWA), and 5091 (52.2%) were persons living with HIV (PLWH). It was found that of these cases, 2719 (51.5%) of PLWA and 2558 (48.5%) received HIV primary medical care during the specified time period, while 1946 (43.4) of PLWA and 2533 (56.6%) of PLWH demonstrated an unmet need for HIV primary medical care. Of the 9756 cases in the Oakland TGA, 4259 were AIDS cases reported in HARS, and 2738 were HIV cases known to HARS. The balance of records were PLWA and PLWH cases identified in one of the datasets other than HARS as reporting residence in the Oakland TGA jurisdiction during the time period. Of the 9756 records, 1109 (20%) of cases that were previously categorized as Need Unmet in the data from DHS had been found to have received primary medical care through matches to our local HARS and laboratory data.

Methods: The Oakland TGA, in collaboration with the DHS Office of AIDS, took the following approach to constructing the unmet need estimate:

1. DHS matched HIV and AIDS cases from HIV/AIDS Reporting System (HARS) with electronic data from the California AIDS Drug Assistance Program (ADAP), Medi-Cal claims records, DHS HIV/AIDS client management system, ARIES, and Kaiser Permanente – Northern California Medical Group data sets using a unique ID derived from a soundex, date of birth, and gender. The datasets were merged, unduplicated and each case examined for evidence of primary care during the time period as detailed above. If documentation of primary care was indicated in any of the databases, the case was considered "in care" and their need "met". Conversely, if no suggestion of HIV primary care was determined, the case was considered "out of care" and need "unmet".
2. Data subsets created by DHS were distributed to the respective EMAs and TGAs containing a) alive cases diagnosed with HIV/AIDS and reported within the EMA, and b) cases identified as residing in the EMA at the time of receipt of ADAP, Medi-Cal, ARIES or Kaiser services. Datasets included client level

information allowing the LHJs within the EMA to link the cases back to programs where they had obtained services. Alameda County and Contra Costa County jurisdictions were able to match the subset for the Oakland EMA against local HARS surveillance and laboratory data to further identify individuals "in care"/ "out of care", individuals not captured in the matching process by DHS and to characterize demographic characteristics of both in and out of care populations.

3. The subset was matched to lab data locally reported under HIV/AIDS surveillance activities, which captures viral load, and cases were updated as appropriate. Updated subsets from Contra Costa and Alameda counties were merged.
4. Population size of PLWA and PLWH for the Oakland TGA was derived from the HARS data matched to HIV/AIDS cases identified from the match to MediCal, ADAP, ARIES and Kaiser North datasets. Population size includes any case reported to HARS as living within the TGA at time of diagnosis, as well as cases who may have been reported in another jurisdiction outside the Oakland TGA, but identified as residing in Alameda or Contra Costa during receipt of care covered by Medi-Cal, ADAP or Kaiser.

Caveats and Limitations

1. Initial assignments of cases to TGA/EMA subsets by DHS were based on county of residence from the five databases (HARS, ADAP, ARIES, Medi-Cal and Kaiser). County of residence identified from ADAP, Medi-Cal and Kaiser were not necessarily the same as the counties of HIV or AIDS diagnosis, reflecting migration into and out of the Oakland TGA. Subsets received from the state DHS therefore includes cases diagnosed in the TGA, as well as out of jurisdiction cases who have recently moved to or sought care within the TGA, emphasizing the fact that the Oakland TGA provides services to not only it's residents, but to individuals diagnosed outside the jurisdiction who seek services within the TGA jurisdictions. The linked dataset thus provides a partial view of in- and out-migration from the TGA. From the linked data, we found that 2,758 cases, or 28.3% of the affected population, are believed to have been diagnosed outside of the jurisdiction and migrated into the Oakland EMA for care. Conversely, approximately 708 (483 AIDS, 225 HIV) cases were diagnosed in the Oakland EMA and migrated out during care over the FY 04-05 period. Information on migration across state lines was not known; therefore we were left to assume that in-migration equals out-migration.
2. Client level Ryan White Part A service utilization data is not readily available in Alameda County. The client level data that is available could not be matched due to an inability to replicate the unique code on which the datasets were matched.
3. The Oakland TGA is limited in its ability to obtain information on individuals in private care. Only information on Kaiser – Northern CA patients is available. This limited ability to match to private care records may overestimate the number of individuals who are out of care. Additional funding would allow further investigations of patients in private care.
4. Age of the cases reviewed for the Unmet Need estimate was calculated as age at Jan 1, 2007, the midpoint of the 12 month period. This differs from the surveillance data where the age at time of diagnosis is recorded; therefore it is difficult to make age comparisons.

Findings:

The PLWA and PLWH(non-AIDS) with unmet need are predominantly male (65.6%), over 45 years of age (54.3%), and primarily Black (41.7%) or White (31.9%). However, PLWH (49.8%) are more likely than PLWA (41.7%) to have unmet need. Women comprise a larger percent of out of care (31.4%) than in care

(24.0%), particularly female HIV (non-AIDS) cases, where 43% of these women are out of care. Blacks are the greatest racial/ethnic proportion (41.7%) among individuals with Unmet Need, and there are a substantial number of White AIDS cases out of care (31.9%).
Demographic characteristics for all of the identified cases in and out of care are displayed along with AIDS surveillance data in Table F.

Table F Characteristics of HIV and AIDS Cases In- and Out of Care and PLWA/H in the Oakland TGA

	Out of Care (Unmet Need)			In Care (Unmet Need)			Surveillance		
	AIDS	HIV (nonAIDS)	Total	AIDS	HIV (nonAIDS)	Total	PLWA	PLWH	Total
Total	**1946**	**2533**	**4479**	**2719**	**2558**	**5277**	**4259**	**2738**	
Gender									
Female	16.4%	42.9%	31.4%	18.9%	24.0%	21.4%	18.5%	21.0%	19.5%
Male	83.4%	57.1%	65.6%	81.17	76.0%	78.6%	815%	79.0%	80.5%
Age Group									
0-12 yrs	<1%	2.7%	1.6%	<1%	1.3%	<1%	<1%	1.7%	0.9%
13-19 yrs	<1%	3.6%	2.2%	<1%	1.1%	<1%	<1%	2.0%	1.2%
20-44 yrs	32.0%	49.4%	42.0%	36.5%	49.2%	42.6%	71.6%	75.7%	73.2%
45 & over	67.6%	44.3%	54.3%	63.0%	48.3%	55.9%	27.1%	20.6%	24.6%
Race/Ethnicity									
Asian/PI	3.5%	5.5%	4.7%	4.0%	4.7%	4.3%	3.5%	3.7%	4.0%
Black	43.2%	40.5%	41.7%	40.9%	41.1%	41.0%	43.1%	42.3%	42.8%
Hispanic	12.5%	12.0%	12.2%	16.0%	13.3%	14.7%	14.6%	13.4%	14.1%
NativeAm/Alaskan	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%
White	39.8%	25.8%	31.9%	38.3%	33.4%	36.0%	37.5%	37.6%	37.5%
Multi/Other//Unk	<1%	6.7%	4.0%	<1%	7.1%	3.7%	<1%	2.6%	1.3%

Assessment of Unmet Need:

Because the information to complete the unmet needs framework for this application was not yet available, results of last year's assessment of unmet needs were shared with the planning council and integrated into the planning and prioritization process for FY 07 – 08. The Planning Council noted the large number of women Latinos and Blacks out of care and used this information in conjunction with the Needs Assessment and other data sources in designating Latino and Black MSM and women of color as special populations.

Given that the data set contains information on clients receiving services from Medi-Cal, ADAP and Kaiser, further analysis will be done on the demographics of clients enrolled in these services. The information will allow us to assess gaps in services reviewing variances between clients being served by one system versus another.

The Office of AIDS is currently in negotiation with the Parts C and D funded entities to expand the database created to capture client level data for the Alameda County Part A funded services. The system, HIV/AIDS Client Services (HACS) system currently includes information on Parts A,B and MAI recipients in Alameda County. The added information will allow us to get a more complete picture of clients being served across the four Parts, service patterns for distinct populations, and service gaps.

2) Access to HIV AIDS Care and the Plan for FY 2009

(2.a) The TGA Established Continuum of HIV/AIDS Care and Access to Care

Access and support services are critical to treatment adherence for our clients many of whom have substance use and mental health problems which when combined with the effects of poverty, impede their ability to keep doctors' appointments and to adhere to care and treatment plans.

The involvement of three jurisdictions -- Alameda and Contra Costa Counties and the City of Berkeley-- with their distinct funding mechanisms and public health systems - has given rise to different approaches to HIV primary care delivery across the region. The approaches to care delivery are coordinated to insure parity of services and broad access to care across the entire TGA through a common Comprehensive Plan which includes TGA-wide System of Care standards, Quality Management principles, standards and outcome measures, and case management objectives.

Support for early entry to care has been further strengthened by merging the care and prevention planning functions within the Community Collaborative Planning Council (The Planning Council) which focuses on the shared goals of care and prevention and seeks to identify innovative and integrated ways to improve access to care and reduce the risk of transmission.

The following describes HIV health care delivery in the three jurisdictions in the TGA.

Alameda County

Alameda County Health Department does not provide services directly, but instead contracts with and monitors health care providers and community-based service organizations that provide ambulatory care, medical case management and other Ryan White funded services. The contracted providers must demonstrate cultural competence (including multilingualism in order to serve the target population's large Latino community). They are also chosen based on geographic location. Most are based in the City of Oakland where 58% of people ever diagnosed with AIDS in Alameda County lived at the time of diagnosis and where 54 to 65 percent of the cases diagnosed each year to the present live.

Ryan White funds are used to fund HIV primary care services at the county's two largest public medical facilities: The East Bay AIDS Center at Alta Bates Summit Medical Center and the Alameda County Health Center in Oakland. Funds are also used to provide primary care services in 4 community clinics located in north and south County. In addition to medical care, agencies are under contract to provide social support and access services including: psychosocial support, housing services, substance abuse treatment and counseling, food and nutrition services, emergency financial assistance, transportation and legal services.

Contra Costa County

An important feature that distinguishes CCC is its policy of universal access to health care for county residents below 300% of poverty through a formal HMO style program called "the Basic Health Care Program," (BHC). BHC has been in place for thirty years and currently has an enrollment of 65,000. An essential component of the registration and eligibility verification process for BHC is that each individual applying for this assistance must complete a Medicaid application to ensure that no other health care coverage is available. Individuals are then certified for a six month period and must recertify at the end of the six months in order to continue receiving BHC coverage.

The City of Berkeley

Although Berkeley residents are eligible for the TGA's Part A services provided through Alameda County medical centers and service providers, the City of Berkeley Public Health Department also provides medical case management; community based mental health services and HIV testing and counseling services for Berkeley residents. The City of Berkeley employs a network of public health medical case managers who operate within a family care model. When a case manager is informed that an individual is HIV positive, the case manager refers him or her for treatment and enrolls the individual in AIDS Drug Assistance Program. Case managers also confer with primary care providers.

i) Mechanisms Enable Communities Of Color To Access And Remain In Care

The HIV epidemic in both Alameda and Contra Costa counties has evolved over the last 25 years from one largely affecting white MSM to one whose impact increasingly and disproportionately affects low income communities of color. The TGA has responded to this change by combining the previously separate prevention and treatment planning functions within one Community Collaborative Planning Council to use diminished funding more efficiently and to exploit more efficiently the nexus between prevention, testing and treatment in order to improve service to hard to reach populations such as IDUs, African American and Latino MSM and transgender individuals.

Mechanisms used to reach the target population include case management processes designed specifically for people who have difficulty adhering to care plans and treatment; multiple points of entry into the care system, co-location of testing and primary care services; field case management; and standardized processes to locate clients who have dropped out of care.

Multiple Points of Entry to the Continuum of Care

The Oakland TGA's continuum of care consists of a variety of service providers situated throughout the TGA, although most are located in the urban centers where our clientele are concentrated, namely the Cities of Oakland and Hayward in the northern and southern areas respectively of Alameda County, and the Cities of Richmond and San Pablo in CCC. This ensures that clients have numerous support services, hospitals and community based clinics through which they may enter care.

In Alameda County, most Ryan White clients enter the continuum through traditional ambulatory care provided at the County Medical Center's Highland and Fairmont Campuses. Clients may also enter care through Emergency Room visits at Highland Hospital, or the AIDS Health Care Foundation, as well as via primary care referrals made when an individual requests Emergency Financial Assistance at one of the Continuum of Care's support service providers. All service providers, regardless of the specific service they provide, are contractually obligated to maintain a referral service to link their clients to primary care.

In CCC, BHC provides multiple points of entry into care for HIV positive individuals by serving clients at the Contra Costa Regional Medical Center (CCRMC) and at 13 clinics throughout the county. Infectious Disease /HIV Specialty clinics operate in 3 regions and augment CCC Regional Medical Center's Family Practice healthcare model. Social workers staff the Family Practice and Infectious Disease clinics and HIV specialists provide the ambulatory care services.

Mobile Testing in CCC

People who test positive at the CCC's mobile testing van are linked directly with a case manager and with an HIV social worker. They may also be directly linked to a Prevention with Positives (PwP) team member, the Part C nurse or an outreach worker depending on need.

Co-location of Testing and Care

An important outgrowth of the merger of care and prevention activities is the policy of encouraging co-location of testing and primary care referral efforts in order to incorporate HIV prevention into the medical care of HIV positive clients. All county funded testing sites must provide referrals to primary care.

An example of this policy is Alameda County's Prevention with Positives Program which provides links to care for HIV positive people and aims to enable them to avoid infecting others with HIV or exposing themselves to other strains of HIV or sexually transmitted diseases and other blood-borne illness such as hepatitis.

In CCC patients who test positive at the county's health clinics or at any of its mobile testing sites are immediately assigned a case worker and referred to primary care. HIV counseling and testing (C&T) services are available through the Contra Costa Regional Medical Center, at clinical service sites and through mobile testing. These combined resources allow clients to select the venue most suited to their needs. Both Anonymous and Confidential testing services are available. Over the past year, the mobile HIV testing program has increased the number of rapid test venues to improve early access to care and treatment. At this time, more than 90% of all field testing is rapid test. Individuals with a preliminary positive result are linked directly to the Medical Social Worker to arrange a follow up appointment for confirmatory lab work. Those who are confirmed HIV positive are then scheduled to see the physician. HIV test counselors also provide Prevention with Positive services and have been trained to assist with partner disclosures.

Most women receiving prenatal services enter the care delivery system through the Healthy Start program. California law requires that all pregnant women be counseled and offered an HIV test. The Healthy Start Program policies require that all women complete a risk assessment for HIV, receive counseling information and be offered an HIV test. Those women who test positive are immediately referred to an HIV specialist for follow up care. The Medical Social Worker generally meets with the client at an early medical visit. Follow-up medical appointments are arranged and risk reduction service referrals are offered on a regular basis including Prevention with Positives, Partner Counseling Referral, disclosure assistance, and support for medication adherence.

Other Entry and Retention Mechanisms:

- Community based clinics located in every region of Alameda County offer neighborhood HIV treatment as an alternative to the county's large public hospitals.
- Alameda County's two needle exchange sites located in East and South County provide a strong connection to primary care for HIV positive participants. Needle exchange operates in four areas of CCC. The County Health Department conducts HIV testing at the sites, and individuals who test positive are referred into care at the nearest county infectious disease clinic.
- Comprehensive risk counseling (CRSC) links prevention to care through partner notification.
- Alameda and CCC coordinate with the CDC funded "Bridge Project" in which community members link people who test positive with treatment and support services by reducing racial, cultural, or other barriers that prevent PLWH/A from seeking and obtaining treatment. Bridge workers engage in one-on one encounters with PLWH/A through home or field visits, where they provide supportive counseling, information, education, assistance with referrals, and assessment of the clients' readiness to engage additional services. Bridge Workers and peer advocates are currently working at the Alameda County Medical Center, the East Bay Aids Center (EBAC) in Oakland and at the Tri-Cities Health Center in South County.

- Although all doctors in Part A funded primary care facilities have always been HIV specialists, a more recent response to difficulties in enrolling people in HIV treatment services has been to place medical case managers in *all* community clinics that receive Part A funding.
- The TGA's MAI funding will continue to target Alameda County's large parolee population with intense case management, mental health and substance abuse services and housing. CCC's MAI funding through Part C supports outreach to lost to care populations.
- Highland Hospital of the Alameda County Medical Center (ACMC) was the first hospital in California to offer point of care rapid testing in labor and delivery. This practice has since been expanded to the Alta Bates campus, and Eden Medical Center in Southern Alameda County. HRSA funded AETC training is underway to prepare providers to conduct routinized testing with a special focus on prenatal clinics.
- ***Get Screened Oakland*** is a response to the HIV state of emergency in the City of Oakland. The project's goals are to routinize HIV testing, increase the number of city residents who know their status and to increase the number of city residents in appropriate early care / treatment. The project seeks to ensure that all community and faith-based organizations and health care facilities offer HIV rapid tests to all of their clients. OAA is collaborating with Get Screened Oakland to ensure immediate referrals to treatment for those who test positive.
- Legal services and client advocacy aimed specifically at HIV positive African Americans and women of color including home and hospital visits by legal professionals and interns.
- Computer tracking: One Alameda County service provider implemented a computer appointment tracking system that alerts case managers to search for out of care clients.
- ACMC's Highland Hospital Emergency Department HIV testing Program tested 10, 363 people in 2007. 52 people tested positive. To date in 2008, 6,528 tested people have been tested in the ED, with 33 positive results. ED patients who test positive after hours and on weekends are given intake appointments in the Adult Immunology Clinic. A staff member is assigned to follow up with any patient that does not show up for their intake appointment to help transition them into care. ACMC has also implemented social networking for the ED positives, offering incentives for social contacts of new positives to come in for testing.
- The ACMC HIV Testing department conducts active surveillance of hospital patients, reviewing charts to identify potential high-risk patients and offer testing and counseling. Clients testing positive during the day are walked to the HIV Specialty clinic to schedule their intake appointments.

Locating Out of Care Clients Care

All contractors in the TGA are required to have a plan to locate and bring back into care PLWH/A who have fallen out of care or who access care sporadically. In both counties, a client is "out of care" if he or she misses consecutive medical appointments or has not had lab work done in six months.

In the City of Berkeley, HIV and STD testing is done at locations throughout the city and at sex venues. Field workers identify people at these venues who know they are positive but out of care (estimated by Berkeley public health officials at 25%) and refer them to care. There are plans to provide basic case management services at sex venues to identify and support MSM clients who have fallen out of care or seek care sporadically.

In April 2007 the City of Berkeley Public Health Department conducted a "Walk the Walk" program, delivering information on available public HIV services to every address in census blocks with the highest AIDS/HIV prevalence. Staff followed the mailing with a door to door campaign to personally describe to residents the City's care services and resources. Using available data, the campaign sought to contact

PLWH/A who are most likely to be out of care, typically African Americans in the city's low income, southwestern neighborhoods. Another "Walk the Walk" campaign was held in the 07/08 fiscal year.

(2.b) Table: FY 2009 Implementation Plan

The TGA's Implementation Plan is found in Attachment 7.

(2.c) Implementation Plan Narrative

The TGA's four core medical service areas and two support service categories to which the Planning Council allocated the largest amounts of Part A funding reflect the principle finding of the recent Needs Assessment, client satisfaction survey, and CCC's Client Satisfaction Surveys that the typical Oakland TGA Ryan White client suffers from some combination of poverty, homelessness, substance use and mental illness, which impede access and retention in medical care.

i) How the Planning Council connects Needs Assessment, Comprehensive Plan and Service Priorities

Our highest funded services implement the goals of the Oakland TGA's 2006-2009 Comprehensive Plan outlined below. They were developed after assessing, epidemiological (demographic and risk behavior) trends, and differences in the epidemiology of HIV/AIDs between the two counties.

1. To maintain and support access to a comprehensive coordinated TGA-wide continuum of HIV primary health care that incorporates HIV prevention activities and targets low income and underserved populations. Medical case management services within a chronic care model will be deployed to ensure access and promote self management among the out of care, hard to reach and severe need clients because substance use, mental health and related conditions obstruct their access to and retention in care.

2. To ensure parity of HIV service access throughout the Oakland TGA, service providers will be contractually obliged to achieve and exercise cultural competence as follows:.

   A practice model which incorporates culture in the delivery of services; procedures for staff recruitment, hiring and retention that will achieve the goal of a diverse and culturally competent workforce; resources to support the professional development of awareness, knowledge and skills in the area of cultural and linguistic competence.

3. To ensure that persons with HIV have access to a high quality evidence-based system of care that measures health outcomes and incorporates continual assessment and planning.

The following are examples of the links between the Needs Assessment, Unmet Need Framework, Comprehensive Plan, the highest funded Service Priorities and the Implementation Plan.

Ambulatory Care: The Needs Assessment revealed a large degree of satisfaction with the primary medical care they received (81 percent said they were satisfied). Nonetheless, 20% of respondents to the Consumer Survey said that they had gone for a period of more than 12 months since first testing positive without seeing a doctor or visiting a clinic, and 23% said that they had gone for more than six months. Over 40% of transgender people surveyed said that they had gone for a period of 12 months without seeing

a doctor. However at the time of the Survey only 6.5% of all respondents had not been to a doctor for a year or more.

Although many factors contribute to a client's health status, these results are an indication that regular primary care is an essential component to positive health outcomes for our client population. 20% of respondents reported co infections of Hepatitis A, B or C. The Unmet Need Framework in Attachment 8 indicates that 4,479 people were out of care in 2006-2007 Ryan White fiscal year. The Planning Council's ranking Primary Care first and maintaining its allocation at 21.25% responded to the ongoing need for primary care.

The TGA expects an increase in the number of people seeking HIV care with the launch of the "Get Screened Oakland" project. The Alameda County Office of AIDS is working with a variety of other stakeholders in establishing routine testing in a number of venues including emergency rooms, labor and delivery services. Collaborating with Get Screened Oakland to routinize HIV testing is the primary example of the Comprehensive Plan's first goal to ensure access to HIV care that incorporates HIV prevention activities. The Implementation Plan's objective of improved patient outcome is linked to the Comprehensive Plan and Needs Assessment by stipulating a minimum of two annual visits to a doctor, increased CD4 counts, and decreases in viral load.

The link between Needs Assessment and priority setting is also seen in CCC's recommended allocation to medical case management and ambulatory care. More respondents in CCC than in Alameda County said they needed ambulatory care and received it (74% vs. 64%). Fewer respondents in CCC said that they needed more of this service than they received (12% vs. 24%). In light of these survey results and given that CCC provides ambulatory care for residents at 300% of the federal poverty level, the Contra Costa Consortium recommended the Planning Council allocate substantially more funding in Contra Costa to case management than to primary care. The Planning Council took this action to support the ability of Contra Costa clients in obtaining HIV health care, complying with medical instructions and adhering to drug therapy.

***Medical Case Management*:**
The high rate of AIDS diagnosis with a first test is one of many factors that indicate that medical case management and treatment adherence services are crucial components to maintaining positive health outcomes for our population. 20% of Needs Assessment survey respondents indicated that they had gone 12 months or m more without seeing a doctor and 23.6% said they had gone six months or more without seeing a doctor. 90% of these individuals said they were motivated to seek medical care only when they got sicker. Many of our clients are co diagnosed or co infected. 20% of Needs Assessment survey respondents said they were taking anti depressants. 24% said they were taking herbal medication or other non prescription supplements 44 % of respondents said that they had had skipped taking medication once or twice a month; 14% said they had skipped medication once or more a week and 6% said that they had stopped taking their medication all together. The most commonly sighted reasons were forgetting, side effects and difficulty scheduling their medication.

Given the low education levels, frequency of depression diagnosis, high rates of substance use (40% and 20% of respondents according to the Needs Assessment) and large IDU component of the target population, medical case management is an important means of increasing health literacy and providing the treatment adherence service/support that are essential to positive health outcomes.

CCC, where IDU and co-addicted clients present an acute problem, allocated 59% of its funding to Medical Case Management. CCC Client Satisfaction Surveys show high levels of satisfaction with case management; 94% of respondents stated that they were able to make appointments with case managers soon enough for their needs all of the time. 90% of Surveyed clients said they were able to get the services that case managers referred them to most or all of the time and 91% said they felt supported by their case managers all of the time.

For the first time since the start of the CARE program all six Ryan White funded primary care providers in Alameda County, including four community clinics, have medical case management services on site. Behavioral Health Care, the county's mental health service provider employs state funded medical case managers.

The link between the Needs Assessment finding and priorities is seen in the high ranking given to Case Management in both counties where it was ranked second. The link to the Comprehensive Plan and Implementation Plan, can be seen in the emphasis placed on access to coordinated services and parity of services. The link to the Implementation Plan is seen in the outcome objectives of clients adhering to their care plan goals; remaining in medical care; and completing substance abuse or mental health treatment

Mental Health: The prioritization of mental health care reinforces the Comprehensive Plan's Objective to improve service to severe need populations, including multiply diagnosed people. OAA QM staff found Ryan White mental health services for PLWH/A clients compared favorably with results from a National Quality Center survey of satisfaction with mental health services. 87% of respondents strongly agreed with the statement "overall I am satisfied with the mental health treatment I have received over the last 12 months." 86% said that they were able to see their mental health provider soon enough for their needs all or most of the time.

More survey participants in Alameda county than in the national survey found that (a) mental health providers knew how HIV affected mental health all or most of the time (b) rarely or never found it hard to talk to their providers (c) patient interactions were favorable (d) that providers explained the possible interactions between HIV medications and psychiatric medications, and (e) felt better as a result of their treatment over the last 12 months.

Prioritization of mental health is connected to the Implementation Plan outcome objectives of reduction in social isolation, retention in medical care, reduction in crisis and psychiatric hospitalization and retention in mental health counseling services. In CCC the prioritization of mental health was related to client date indicating a strong need for mental health coordinators to provide referrals for clients to receive ongoing treatment and to ensure that clients are motivated to participate in medical and other care services.

Substance Abuse: Substance abuse services are an element in the Comprehensive Plans first goal of providing a comprehensive and integrated continuum of care, and goal two ensuring parity of services by reaching all eligible clients especially the isolated and hard to reach. We have noted that intravenous drug use is one of the principle modes of infection for our population, especially among African American women.

Support Services

The Planning Council ranked food and housing as the services most important to positive health outcomes for local PLWH/A. This prioritization reinforces the second goal of the Comprehensive Plan to ensure parity

of HIV service access the Oakland TGA through culturally competent services that strive to reach all HIV infected people in our region. The Oakland TGS is an extremely expensive area. The second goal of the Comprehensive Plan acknowledges that poverty and low health literacy are impediments to maintaining optimal health. Many of our clients must prioritize food and other daily needs ahead of their HIV care and treatment. The Implementation Plan corresponds with the Comprehensive Plan, allocations and priorities, and findings of the Unmet Need Framework by establishing the objectives of increased health literacy (increased knowledge about nutrition and HIV disease), an increase in the number of clients who are able to meet their nutritional needs, an increase in the number who remain connected to ambulatory care and who acquire and maintain stable housing placement.

ii) All Core Medical Services Were Prioritized and Allocated Funding

The Planning Council prioritized and allocated funding to each of the 6 core medical services. .

iii) How the Plan Will Provide Increased Access to the HIV Continuum of Care for Minority Communities

The Plan mandates cultural competence training for all case managers to be delivered by Clinical Quality Management staff and consultants as needed. Effective and culturally competent case management in both counties has been and will continue to be the primary means of reducing access barriers to care for minority communities, for populations where HIV prevalence is increasing and for people who know their status but are not in care.

The objectives of the four highest ranked core services especially case management and substance abuse and mental health services as well as the food, legal and housing support service categories are to reduce personal and situational barriers to accessing care and to strengthen access to care for a clientele that is made up principally of poor people of color, many of whom are chronic substance users with mental health problems who need treatment for their substance use and mental illness. Access to adequate food, legal assistance and affordable housing is critical to our client population's ability to prioritize health care, mental health care and substance use treatment by enabling them to eat healthfully, keep medical and mental health appointments and access social support and counseling services.

The Core services will increase their access by increasing the number of minority clients who meet their care plan goals, maintain a connection to primary care, complete substance abuse and mental health interventions. Contractual language in service contracts used in both counties require providers to meet minimal standards of cultural competence. QM staff members provide technical assistance to medical case managers throughout the TGA to strengthen contractors' cultural competence in medical case management services for disenfranchised populations. Finally the Plan calls on the TGA to provide integrated care and prevention services to PLWH/A to promote adoption of risk reduction strategies and expediting access to needed medical care..

iv) How the Plan Will Address the Needs of Emerging Populations

Based on the Needs Assessment, epidemiological data presented by the Alameda and CCC Health Departments, patient chart reviews conducted by Alameda County Office of AIDS QM staff and public comment during a series of Planning Council meetings, the Planning Council identified six special populations: African American MSM, Latino MSM; IDUs; Women of Color; Youth ages 13-24; and transgender women.

MSM continues to be the most frequent mode of exposure in both counties and is still the highest prevalence of HIV (Not AIDS), AIDS incidence and AIDS prevalence in both counties. In Alameda County, MSM continued to account for the majority (61%) of cumulative AIDS cases. Although there was a decline in the proportion of annual AIDS cases attributed to MSM during the 1990s, increases were observed in 2002 and 2003, and again in 2005 thru 2006. In both counties the majority of MSM living with HIV are men of color, predominantly African American men and increasingly African American men of color over forty, the a result of increased survival rates due to ART drug therapies.

In CCC MSM accounted for 64% of all men diagnosed with AIDS in the five year period 2002 through 2006. There are currently 662 persons 50 years old or older living with HIV or AIDS in CCC of which MSM account for 56%. To reach this population effective and culturally competent case management is essential. Case managers must be able to identify barriers specific to MSM of color and be able to reach and communicate with MSM who are not gay identified. These requirements are reflected in case management service goal 3: Ensure PLWH/A achieve and maintain optimal health through comprehensive case management, and in the objective regarding case management cultural competence training Additionally the Plan's Ambulatory/Outpatient Medical Care outcome objectives seek to ensure that MSM receive adequate medical care, complete lab work and adhere to treatment.

Latinos, especially monolingual Spanish speakers, are a large and growing population in the TGA. Language can be a major barrier to care for this population. Latino clients require culturally and linguistically appropriate medical, support and case management services. The continuum of care must employ sufficient case managers to serve Latino clients who speak English but are more comfortable speaking Spanish as well as those who speak limited or no English. Case managers must be aware of and able to identify barriers to care that are rooted in culture and tradition specific to their Latino clientele.

Women of Color

Since the beginning of the epidemic, we have seen HIV and AIDS increase dramatically among women in the Oakland TGA. The great majority are women of color who need a variety of culturally appropriate medical case management and support services in order to access care and to adhere to treatment and care plans. The needs of this population are addressed by the Medical Case Management service priority objective that requires the provision of culturally competent medical case management.

Youth (13-24)

The Needs Assessment identified a need for culturally competent medical case managers, mental health services and medical care providers knowledgeable in adolescent development issues. The Needs Assessment also identified a need for support groups for youth and easier access to counselors. These needs are addressed in the Implementation Plan's Ambulatory Care Service Priority goal of increasing the number of clients who meet their care plan goals and an increase in the number clients who maintain a connection to primary care as defined by a minimum of 2 visits.

Injection Drug Users (IDU)

The Needs Assessment identified barriers to support services necessary for the personal stability that intravenous drug users -- especially those who are homeless or have criminal records -- need to access and maintain a connection to primary care. The assessment found that both outpatient and residential treatment are needed by a larger percentage of out-of-care survey respondents than those in the care system. The survey also identified a need in Alameda County for programs specifically designed for HIV+ IDUs. The needs of this population are addressed by the objectives of Service Priority 2, Case

Management, pertaining to self management skills and decreases in high risk behavior, and by Support Service Priorities 1 and 2 (food and housing) whose objectives aim to stabilize housing and improve nutrition in order to enable clients to participate in the management of their own care.

Transgender

Stigma and confidentiality concerns are the most significant barriers to adequate health care for HIV infected transgender women and indicate a need for more in-depth cultural competence training regarding their specific needs. This training, which is reflected in the Case Management Service objectives and objectives of the ambulatory care service priority pertaining to referral to care for mental health and substance abuse treatment, and regular visits to doctors. Cultural competence training will involve technical assistance to enable agencies to adopt non-traditional strategies, such as flexible appointment hours, private appointments and evening and weekend clinics, social network and peer based outreach. Given the high rates of high risk sexual behavior reported by HIV positive transgender women, it is expected that targeted and culturally competent services will not only benefit the women, but may assist in preventing further infections.

Peer education and social network-based groups are powerful tools to encourage transgender women to begin to feel welcome and to use services. Community building activities encourage safer sex practices. Peer-based activities led by transgender women can also play a strong role in changing social norms that act as barriers to accessing HIV services.

v) Plan Encourages PLWH to Remain Engaged in Medical Care

Both Alameda County and CCC have established that adherence to HIV treatment and HIV medical care is the top priority in caring for PLWH/A in the Oakland TGA. TGA Standards of Care require all contracted support service providers (housing, food, respite care etc.) to determine whether clients have a primary care provider and to refer clients who do not have a physician of record to a doctor or clinic. This requirement is reflected in the medical case management service priority which stresses integrated care and prevention services and expedited access to medical care, and the fifth goal of the substance abuse services priority which pertains to strengthening case management capacity.

One of CCC Health Services' Quality Management goals is to achieve a minimum of 50% compliance with care plans. Focusing resources on medical case management is essential to keeping clients in CCC engaged in care since the county's PLWH/A population includes large numbers of impoverished people who are alcohol and other drug dependent.

As an example of efforts to keep these individuals engaged in care, Contra Costa officials noticed an increase in the number of Part C Early Intervention Service enrollees failing to complete at least one CD 4 count in a year. Realizing that homelessness and intravenous drug use were the root causes of the broken appointments, they focused substantial time and effort on stabilizing primary care attendance for the homeless HIV positive population. The number of homeless enrollees completing a CD 4 count during the three year interval increased. However, since the total number of enrollees, regardless of housing status, without a CD 4 count in the year, rose from 11.5% to 16.3%, it is believed that poverty as much as homeless may be the cause. A goal for the coming year will be to increase the number of clients with at least one CD 4 count completed in the year.

vi) How the Plan Will Promote Parity of HIV Services

Alameda County and CCC have adopted Standards of Care for Ryan White funded services which all contracted service providers are required to follow. In addition to the Standards of Care, the TGA has taken measures to ensure geographic parity of service. Geographic parity is accomplished by allocating resources to ensure services are available in high impact regions of the TGA, especially along the I-80 corridor which stretches through some of the poorest and heavily impacted parts of the TGA. Contra has thirteen Costa County public health clinics located throughout the county. Van service is available in both counties to take clients to medical and laboratory appointments.

a. How service goals and objectives relate to Health People 2010 Initiative

Table F below summarizes how the Health People 2010 goals and objectives from chapter 13 of Healthy People 2010 correspond to the Oakland TGA's Implementation Plan

Table F: Healthy People 2010 Goals and FY 2007 Implementation Plan	
Healthy People 2010 Goals	**Oakland TGA's FY 2008 Implementation Plan Goals and Objectives**
Reduce the number of: 1) New AIDS Cases 2) AIDS cases among adolescent and adult MSM 3) New AIDS cases among IDU 4) New AIDS cases among MSM / IDU Extend the interval of time between an initial diagnosis of HIV infection and AIDS diagnosis in order to increase years of life of an individual infected with HIV. Increase years of life of an HIV-infected person by extending the interval of time between an AIDS diagnosis and death. Reduce deaths from HIV infection.	By providing timely access to medical care and expanding access to populations heretofore unconnected to care including AAMSM, the growing number of IDU cases of HIV infection, transgender women and youth, the Plan is designed to reduce the number of new AIDS diagnosis. Outcome Objectives for Service Priority 1 (Ambulatory Care) seek to ensure that clients are quickly and permanently connected to high quality HIV medical care • % of clients will maintain a connection to primary care as defined by a minimum of 3 visits per year. • % of clients w/ substance abuse and/or mental health issues will be referred for treatment • % of clients with increased self-management skills. • % of clients who see an HIV specialist ever six months
Reduce the number of cases of HIV infection among adolescents and adults Increase the proportion of sexually active persons who use condoms. Increase the number of HIV-positive persons who know their serostatus	• Case Management Goal: Reduce transmission of HIV through education and prevention. • The Case Management objective of decreasing high risk behavior
Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support	Substance Abuse Priority Goal: Increase the percentage of clients screened and referred for mental health and substance abuse treatment
Increase the proportion of adults with TB who have been tested for HIV	Case management Objectives • Percent of out of care clients connected to primary care • Percent of clients with a Care Plan.
Increase the proportion of HIV-infected adolescents	Ambulatory Care Goal

Table F: Healthy People 2010 Goals and FY 2007 Implementation Plan	
and adults who receive testing, treatment, and prophylaxis consistent with current Public Health Service treatment guidelines.	• Ensure PLWH/A are connected to and retained in medical care • Increase the number of people who are retained in care.

b. Ensure That Resource Allocations For WICY Services Are In Proportion To The Percentage Of The TGA's AIDS Cases Represented By Each Population.

Approximately 22% of PLWA in the TGA are women. AIDS services to women were about 31% of total expenditures. There were no infant AIDS cases in the reporting period. AIDS services for infants were .32% of total expenditures. Children accounted for .49% of PLWA; AIDS services for children were 1.51% of total expenditures. Youth were 1.96% of PLWA and accounted for 2.01 percent of total AIDS service expenditures.

The TGA is committed to 1) serving women, infants, children and youth in their proportion of the AIDS population within the TGA and 2) ensure parity of HIV service access throughout the Oakland TGA continuum of care. Case management service priority seeks to provide services to disenfranchised populations. Additionally, the ongoing case management redesign will disseminate specific requirements for case managers and program design that will specify minimal expectations from all contractors as regards proportional service to women, infants and children.

We will continue to coordinate services with other funding streams in order to maximize the quality and quantity of services to the TGA's WICY population including the following:

- State Child Health Insurance Program (CHIP)
- Services for Women, Infants, and Children, such as the WIC program and the Substance Abuse Treatment Program for Pregnant Women;
- The program for HIV positive youth at the East Bay AIDS Center;
- Children's Hospital Oakland, Pediatric AIDS Program which offers medical care for infected and exposed children

c. **The TGA Will Use MAI Funding To Enhance Quality Of Care And Health Outcomes In Communities Of Color Disproportionately Impacted By The HIV Epidemic**

Contra Costa receives MAI funds through the Part C program and uses those funds to locate individuals lost to medical care, help them return to care, and support them in navigating the health care delivery system. MAI funds will also be used for a program for recently released prisoners in Alameda County. The program provides clients with short-term housing, case management and substance abuse counseling that are critical for successful reentry.

MAI funding supports HIV ACCESS a program in Alameda County that serves low-income HIV positive people. Outreach is conducted by street outreach programs operated by HIV ACCESS member agencies within the neighborhoods where the target populations live and socialize thus maximizing accessibility to primary health care.

Finally, specialized programs designed to meet the needs of the MAI targeted populations such as a very popular Latino support group at ACMC Highland and AIDS Project East Bay's specialized programs for

African American MSM, transgender populations and youth also encourage retention in care and help the county to diminish disparities in health status.

3) Grantee Administration

a) Program Organization

The Alameda County Public Health Department administers all parts of the HIV Emergency Relief Grant Program for the Oakland TGA as the Grantee and Fiscal Agent. Dr. Anthony Iton, M.D. is the Director of the Department and the County's Health Officer. The Ryan White Part A program in the Oakland TGA is administered by the Alameda County Public Health Department's Office of AIDS Administration (OAA), which employs a total of 17 FTE. The Office does not provide direct services, but instead contracts with local providers of HIV medical, behavioral healthcare and supportive services. Lori Williams, Director of Care and Prevention, has primary responsibility for program management and oversight. She is supervised by Ronald Kabir Hypolite, Director of the Office of AIDS Administration. Ms. Williams manages a staff of five FTE care and prevention Program Specialists who monitor implementation of treatment and prevention service program contracts with community based care and prevention providers. She also supervises one FTE Quality Management program manager (currently vacant), an information systems specialist and a data input clerk.

OAA has recently hired a bilingual (Spanish /English) community liaison senior program specialist to work closely with the TGA's Latino population. This position was created in response to the Office of AIDS and Planning Council concern with high positive test rates for Bay Area Latinos especially transgender Latinos. The community liaison officer also manages programs serving other disproportionately affected groups funded through the Minority Aids Initiative.

A Fiscal and Contracts Director who reports to the Director of the Office of AIDS monitors the Office's contracts with service providers. Two accounting specialists report to her.

The administrative and programmatic integration of the care and prevention functions was undertaken in order to simplify program administration and to encourage providers to use the natural links between testing, counseling, partner notification and treatment to identify eligible clients and direct them to treatment services. Combining both services under one director and staff also streamlines the administrative processes within the office and reduces the administrative burden on community based providers by simplifying forms and removing duplicate reporting requirements.

The Oakland TGA Collaborative Community Planning Council was established in 2006 to determine and address both the treatment and prevention needs in Alameda and Contra Costa Counties. The integration of care and prevention functions within one planning body mirrors the grantee's administrative and programmatic integration of care and prevention functions. As was the case for the Office of AIDS, the impetus for the combination of both functions was to use limited and diminishing resources optimally in order to best serve the affected population, and to benefit from the inherent link between prevention, testing and treatment. The CCPC is a 26 member planning body made up of volunteer community members as well as Office of AIDS staff, a HOPWA representative. Members are appointed by the Director of the Office of AIDS to two year terms.

The Council elects two Co-chairs to one year terms. There are six standing Council committees as follow: Quality Data and Service Committee, Policy and Education Review Committee, People Living with HIV/AIDS Committee, Membership and Community Involvement Committee, Prevention Committee, and Executive Committee.

Each Committee elects its own Co-Chairs. Initially when the prospective members go through mandated Orientation they select a committee they want to participate in if they get approved to be on the planning council. Otherwise the individual planning council member select what committee they wish to serve on. The co-chairs select members to chair each of the five Council committees and assign members to work on one or more committees.

PLWHA represent 39% of the Planning Council membership. There are 6 male PLWHA, 2 female PLWH/A and two who identify as transgender. The Council is12% Hispanic, 42% African American and 39% Non Hispanic White.

b) Grantee Accountability

i. The Process To Separately Track Formula, Supplemental, Unobligated And Carry Over Funds

Upon receipt of the Part A award, the OAA calculates a ratio/percentage of formula to supplemental funds. This ratio is applied in calculating formula and supplemental expenditures. The same ratio is applied to any unobligated funds at the end of the grant period. Carry over funds are tracked separately from formula and supplemental funds based on budgets that service providers submit with requests to carry over funds. A spreadsheet linked to the carry over budget is maintained to track carry over expenditures.

ii. Redistribution of unexpended funds

The grantee makes every effort to avoid the need for substantial reallocation of funds by monitoring the previous years funding distribution and expenditures. For the current fiscal year the grantee needed to redistribute only $70,000 or % of the total 2008 award. If needed redistribution occurs in September at the halfway point of the Ryan White fiscal year. OAA staff determines which agencies have and have not expended 50% of their funds. Staff also reviews spending patterns, service utilization data including numbers of clients served to date. For agencies with low service utilization and/or low client numbers, funds are reallocated immediately within the same service categories to other agencies. Agencies that have over expended may receive supplemental funding during this process. The grantee seeks Planning Council approval prior to reallocating funding to a different service category. The grantee provides quarterly fiscal reports to the Planning Council with recommendations on reallocation.

iii. Fiscal and Program Monitoring Process and Technical Assistance

Fiscal and program monitoring verifies contractual compliance, provides technical assistance when needed and supports collaboration and coordination of services. Each service provider must submit to the Office of AIDS a composite budget detailing all HIV/AIDS and non-HIV/AIDS specific funding. Each agency must also submit a mid year progress report that describes progress toward meeting each of the agencies' outcome objectives. The report also requires providers to document success or barriers, needs for technical assistance, and action plans as they pertain to each of the following areas: Reducing barriers to care, Strategies for bringing PLWHA who know their status into care, Increasing client access to care,

Maintaining clients in care, Reducing barriers/disparities to care, Improving quality of care, and Ensuring fiscal accountability.

Agencies must submit monthly invoices which indicate the number of unduplicated clients served and units of service provided. OAA staff enters monthly service utilization data into the HIV/AIDS computer system (HACS). At the end of the fiscal year, each agency submits a copy of its General Ledger. All expenditures must match all invoiced expenditures.

iv. Frequency of Fiscal and Programmatic Site Visits

Site visits allow OAA staff to develop or continue a relationship with the contractor's staff, gain insight and a better understanding of how the agency delivers services, experience first hand the operations of the program, make sure funding is spent appropriately, ensure that services meet QM standards, and is culturally competent.

OAA staff review contract deliverables, including objectives, units of service, major activities, timelines, and evaluation strategies to ensure thorough understanding of service delivery and to assess each agency's readiness to deliver service. At site visits, grantee staff explains the content, format and purpose of required reports, invoices, budget revision, and timelines.

During the second annual site visit, staff reviews the administrative, programmatic (client services) and fiscal functioning of the agency to date. The visit includes a thorough review of the agency's administrative functioning, fiscal systems and client services. OAA Staff reviews with the agency's management and staff data entry to date, compliance with contract requirements, submitted reports, expenditure reports, client satisfaction reports, and quality assurance reports. OAA staff provides the agency with an assessment of the agency's progress and whether the agency is meeting identified objectives and achieving HRSA goals.

v. Process for Corrective Action

When grantee staff members identify irregularities or programmatic-related concerns, the responsible Program Manager raises the issue immediately with agency staff and with the OAA Director of Care and Prevention. The nature and extent of the concern is documented and shared with the agency administration. The Program Manager directs the agency to develop a Corrective Action Plan detailing precise steps to remedy the matter. The agency must develop a Corrective Action Plan.

Agencies that fail to respond with an adequate plan may be placed on probation. Probation consists of monthly visits, submission of monthly reports by the agency, participation in specified trainings and or technical assistance activities. If at the end of the probationary period efforts to resolve the problem have failed, the contract can be terminated.

vi. The number of contractors funded in FY 2008

There were 19 agencies contractors funded in FY 2009. All agencies contracted to provide Ryan White services received a minimum of two site visits in 2008. Some agencies received additional site visits upon request or at the instigation of the OAA. Therefore the average number of site visits was three.

vii. Improper Charges

There were no findings of improper charges in FY 2008. The Corrective Action for improper charges follows:

Questioned Costs are costs that are not properly supported by accounting records, are related to a violation of law, regulation or contract, or appear unreasonable. The contractor must provide supporting documentation or an explanation within 30 days. If the contractor fails to comply with this requirement, the costs are disallowed and reimbursable to the Department.

Disallowed costs are costs that are clearly unallowable or reimbursements in excess of allowed costs. To resolve disallowed costs, the contractor repays the disallowed amount in full within 30 days of notification of disallowance. The County may enforce repayment by deducting the amount owed from any outstanding balance due to the contractor, or by other legal means.

viii. Technical Assistance

Technical assistance is provided during the two mandatory site visits and additionally upon request. Technical assistance typically involves budget preparation and assistance with accounting and reporting. QM staff provides QM technical assistance on standards and other measures of quality management.

ix. Fiscal Audits and Contractor Compliance

All agencies are currently compliant with OMB Circular A-133. Fiscal monitoring consists of a fiscal interview and completion of the fiscal questionnaire during a site visit. Once completed the questionnaire is forwarded to the Fiscal and Contracts Director for review. If the Director identifies problems, she conducts a phone interview with the agency to gather more information. If this process proves unsatisfactory, the Fiscal Director conducts a Technical Assistance visit. In those situations where more intense intervention is required, a private consultant is hired to work directly with the agency. The consultant's task is to resolve the identified problem, to assess the agency's financial system and make recommendations to improve the financial system.

All agencies are required to submit an annual audit report six months after the end of the contract. County auditors recommend acceptance or rejection of the report. If it is rejected, the agency is required to submit a corrected report.

c) Third Party Reimbursement

i. Process to ensure contractors monitor third party reimbursement

All service providers are contractually required either to conduct an assessment of each client's eligibility for public entitlements and insurance benefits or to refer the client to an entitlements advocate for this assessment. This assessment and/or referral must be done during the initial intake. Pending approval for public or private benefits, clients may be provided services covered solely with Ryan White funds. Service providers that are third party certified (e.g. MediCal or Medicare) are obliged by contract to bill the relevant third parties. Additionally, clients are required to provide a recent verification of income, verification of residency, verification of HIV status, and verification of insurance coverage to determine eligibility for Ryan White funded services.

ii. How subcontractors document that clients have been screened for an enrolled in eligible programs

The grantee conducts fiscal monitoring during each fiscal year to ensure expenditures are accurate and CARE Act funds are the payer of last resort. During the contract negotiations process and in contracts language, contractors are informed of their obligation to access CARE Act funds only when other resources are not available. Subcontractors for services that are third party reimbursable are also required to submit a comprehensive budget to the grantee reflecting all third party funds available for billing.

The Alameda County Office of AIDS Administration requires all of its contracted service providers to complete this Midyear Progress Report. This report is intended to help the OAA assess the progress service providers are making toward their objectives to satisfy HRSA's overall goal to provide quality services to PLWHA in the Oakland TGA. This report covers the funding period from March 1st through August 31, 2008, for Part A, April 1st through September 30, 2008 for Part B and July 1st through December 31st for County funds.

The Public Health Departments in both counties received a federal waiver of certain Medicaid requirements enabling the MediCal program to cover home and community-based services for persons, with a diagnosis of symptomatic HIV disease or AIDS, and with symptoms related to HIV disease, as an alternative to institutionalized care. The waiver program allows subcontractors to bill MediCal for a range of services ensuring that CARE Act funds are the payer of last resort.

d) Administrative Assessment

The Administrative Assessment was done using a written questionnaire distributed to grantee staff, service providers and Planning Council members. A review of the Council Members responses revealed general satisfaction with the Grantee's performance with managing and distributing Care Funds. However, the Council voiced concern that the merger of care and prevention rolls was proving problematic, and requested technical assistance. The OAA has responded by contacting the Center for Disease Control and arranging for training on the implementation of the merger.

All respondents were given the option to respond to the questionnaires by email, phone interview, fax or in person. Follow up telephone calls and emails were sent to Planning Council members and Service providers who did not respond to the initial contact. The survey instruments for grantee, providers and council members consisted questions respectively that were designed to assess:

- Fiscal monitoring and reimbursement
- The RFP process
- Response to and Provision of Training and Technical Assistance
- The Relationship between the Council and Administrative Agent
- Response to the Planning Council's request for data to use in planning

The survey's findings are as follows:

Planning Council Responsibilities

Finding 1: Planning Council members and members of the public have found it difficult to understand the abundance of data that is used in the priority setting and allocation process. Some Council members noted that the data is not previewed and analyzed sufficiently so that is understandable by all members of the public and Planning Council.

Recommendations: Distribution and analysis of data used in the priority setting and allocation process needs to be completed earlier in the grant cycle to give the Council time to allocate effectively diminishing resources. The Office of AIDS should provide outcome data to the Council for its planning process and should assist the full Council and relevant Council Committees by previewing and presenting a full analysis of all data used in priority setting and allocations. The Office of AIDS should provide detailed specific reports on the outcomes of each funded category, in order to ensure agencies accountability The Office of AIDS should assist the Council to develop and identify technical assistance that will increase cohesiveness of planning activities for the Council's combined prevention and care responsibilities.

Current Status: The Office of AIDS will present a comprehensive data report to the Council within six weeks after the end of the current Ryan White fiscal year. The report will include an analysis of epidemiology, QM, cost, needs assessment, gap analysis, utilization data, and other sources of funding. Grantee staff will base recommendations for allocations and priorities on an analysis of this information which will also be made available to the Council and public.

Finding 2: CCPC and Service Providers perceived insufficient community input in the Ryan White program.

Recommendations: Grantee should collaborate with the Council to better educate and inform the public of the Council's role, and ensure that women with children are represented on the Council. The grantee in collaboration with the Council should inform and educate the public about the Council's composition; Request regular presentations on funded service categories. Where permissible make performance outcomes for funded agencies available to the public.

Current Status: The Office of AIDS is currently collaborating with interested Council Members in recording a series of PSAs as part of a media campaign which also includes updating of the Office of AIDS website. The Office of AIDS will review with the Council other means to conduct outreach and increase public attendance at Planning Council meetings.

Organizational Issues

Finding 3: Some providers and grantee staff reported that site visits were either administratively cumbersome or that technical assistance, although available, was untimely.

Recommendations: The administrative requirements of Ryan White service provides should be kept at a minimum to the extent that such reductions to not negatively impact QM and effective allocation of resources and continue to allow for adequate fiscal monitoring. Additionally technical assistance should be provided within a well delimited time frame.
Current Status: In order to improve communication and minimize the administrative burden on providers, Office of AIDS staff has implemented a one week maximum response time for delivery of technical assistance requested by providers. Additionally, the Office of AIDS in conjunction with service providers will, by the beginning of the next Ryan White fiscal year, review all site visit protocols currently in use to make certain that they do not include any unnecessary administrative procedures. The practice of mandatory two site visits is currently under administrative review.

4) Planning and Resource Allocation

a) The letter of assurance from our Planning Council chairs is included in Attachment 2.

b) Description of Priority Setting and Resource Allocation Process

The Alameda County Community Collaborative Planning Council (the Planning Council) and the Contra County Consortium act in concert to set priorities and allocations for the Oakland TGA. The Planning Council establishes regional plans and processes for the two counties while the Consortium sets local plans and processes for CCC. The Consortium is an umbrella network of clients, providers and interested community members that addresses the issues of HIV and AIDS in CCC and recommends how HIV/AIDS

funds should be used in CCC. The Planning Council is a 35 member body with representatives from CCC and the City of Berkeley Public Health Departments as well as other stakeholders from across the TGA.

As we have noted, a HRSA fiscal review of Contra Costa's system of care indicated that Ryan White CARE Act funds should not be used to supplant funding of services provided by the county's Basic Health Care plan (BHC). In accordance with this directive, Contra Costa HIV/AIDS Consortium recommended that the Planning Council allocate only a small amount of funding to Contra Costa primary care. The focus of the Consortium's efforts has been to direct CARE Act resources (including Parts A, B and MAI) towards strengthening case management capacity to better assist clients in navigating the County's health care delivery system, including completing the enrollment process and keeping health care appointments.

Over a period of three months, the Consortium's Recommendations Committee met and heard public comment and CCC staff presentations on demographic and epidemiological trends and recommendations.

As has been the case for the last several years, the Consortium ranked service categories in four tiers. Lower ranked services will be reduced or eliminated in the case of a funding reduction to ensure that the services essential to positive health outcomes remain adequately funded.

Primary Care and Case Management were ranked in the first tier as "essential to positive health outcomes". The second tier included services that were "very important" because they reduced critical barriers to care; Third tier services were those that were "important" and fourth tier were services that "enabled access to care". The Consortium decided to flat fund all services except transportation which was increased by 1% due to consistent demand, and Health Education Risk Reduction services, which as increased by 2.6%. Increased funding in these two categories was made possible by elimination of funding for respite care. The respite care category was eliminated because CCC was not in a position to provide the service with the contest of the new HRSA definition.

The Planning Council adopted the Consortium's priorities and allocations unanimously during the course of its priority setting and allocation process described below.

i) PLWH/A Are Involved And Their Priorities Are Considered

PLWH/A have participated directly in the formulation of this grant application and in setting the priorities and funding allocations established by the TGA. All Planning Council meetings are public, and public comment is solicited at the beginning of each meeting. A PLWH/A subcommittee of the Council regularly solicits input from PLWH/A in the TGA and advises the Council of particular concerns of PLWH/A. Throughout the priority and allocation process, the Council heard input from members of the public as well as its PLWH/A members. The Council's Membership Committee make a special focus to assure that PLWA community members participated in the priority setting and allocation processes.

The Council funded a 2007 Needs Assessment conducted by faculty and staff at California State University Hayward who measured client satisfaction and the unmet service needs of PLWH/A, and identified the extent to which medical and support services are available, accessible, and appropriate for persons living with HIV/AIDS in the Oakland TGA. The consultant interviewed a sample of consumers and reported to the Council on demographic trends of the epidemic and out of care population including age, gender, income and employment, health insurance status, and HIV-related primary care and ancillary service utilization. PLWH/A also responded to open ended questions that encouraged them to provide qualitative information concerning barriers to care and the quality of care and support services.

ii. Data Were Used To Increase Access To Core Medical Services And Reduce Disparities In Access

The Planning Council's Data Committee held preliminary discussions with epidemiology staff on epidemiological trends, reviewed utilization data before it was brought to the full Council, and coordinated data presentations to the Council. In the Priority Setting meetings, Council listened to public comment, discussed epidemiologic trends, reviewed several service delivery issues, reviewed information on out of care populations, established service categories and allocations and chose six Special Populations. Additionally, the Needs Assessment consultant briefed the Council on his findings including client satisfaction data, barriers to care and unmet service needs.

In setting priorities and making allocations, the Planning Council sought to increase access to core medical services and reduce disparities in access for hard to reach populations identified in the data review. These data indicated a tendency among MSM of color, transgender women, youth, IDUs and women of color to delay or forgo HIV medical care due to lack of transportation, housing instability, stigma, substance use and mental health issues or competing survival needs.

For example in designating transgender individuals a special population, the Council noted the Tri Cities survey in which over half of 104 transgender women were HIV positive and out of care and that over 60% reported mental health issues including suicidal ideation, suicide attempts, and depression. The Council also noted the number of individuals reporting substance use and mental health problems in both the Needs Assessment and in service utilization databases for the two counties.

In designating youth a special population, the Council noted the high rates of STIs among youth of color. The Council considered the overwhelming response in the TGA's latest Needs Assessment that oral health was one of the top unmet service needs, and increased funding for this service by over one and a half percent. .

The Needs Assessment indicated a gap in oral health services; a pervasive need for emergency assistance with housing and food among support services needed most by almost all Needs Assessment respondents; high utilization of ambulatory care and case management services, with use in both categories surpassing the predicted units of service. The primary strategy that the Council adopted to achieve this goal was to increase funding for case management by two percent.

The Planning Council's PLWH/A Committee, held an open forum for members of the HIV community to help it decide on recommendations for the Council's priority and allocation meetings. The PLWH//A Committee also reviewed information from the 2007 Needs Assessment. The PLWH/A was especially concerned with indications that sexually active youth, especially MSM of color were engaging in high risk behaviors and not getting tested or delaying entry into care into late adolescence or early adulthood. This contributed to the Council's designation of youth as a special population.

The Council also took into consideration waiting lists for Home Health Care and mental health services. It was also noted that providers have consistently reported poorer outcomes for clients with mental health and substance abuse issues.

iii. How Changes And Trends In HIV/AIDS Epidemiology Data Were Used.

The principle changes and trends in HIV epidemiology that the Council used were: the emergence of significant rates of infection among Latinos (especially Latino MSM); the continuing high prevalence of HIV

infection among African Americans and especially African American MSM; and evidence that an increasing proportion of PLWH/A are heterosexual, a trend that disproportionately effects African American women. These changes and trends led the Council in their designation of the special populations we have noted. These trends also reinforced the need to maintain a relatively high level of funding for case management services in order to reach these hard to serve populations and retain them in care.

iv. Cost data Used by the Planning Council in Making Funding Decisions

The Council made its allocation decisions after presentations on utilization trends, consumer patterns and the availability of other public funding sources. The information on which the Council based its decisions included data supporting a decrease in allocation to transportation by elimination of van service in Alameda County because not all funds were used last year and because the service was not cost effective. The Council determined that clients are adequately served with transportation vouchers at considerable savings to the program. (This reduction did not include Contra Costa's local van services since that service was found to increase access to primary care.) It was also found that clients needed increased access to oral health care and that specialty oral health care was crucial for the TGA's client base. It was determined that an increase in case management allocation to support cultural competence training for medical case managers and increased service levels would be a cost effective way of retaining hard to reach clients.

The TGA undergoes a midyear reallocation process in which staff presents information on service utilization and expenditures in individual service categories along with recommendations for reallocation of funds. This process ensures that funds are allocated where they are used and needed the most.

The Council is continuing an arrangement reached last year with HOPWA in which Ryan White and HOPWA funding streams were realigned to more coherently fund housing related case management, substance abuse and mental health services, which had been funded by HOPWA. The Council has implemented an MOU with HOPWA to work collaboratively to maximize housing stability for PLWH/A.

v. Unmet Need Data were used by the Planning Council in making priority and allocation decisions.

There has been an increase in eligible clients due to limits on Medical Coverage; increases in the client population in south and east Alameda County and an increase in clients needing a variety of specialty care; The Needs Assessment found a 13 percent gap in need for mental health service vs. services received and a 13 percent gap in need for food services vs. services received.

The Unmet Needs Framework data gathering and analysis process had not been concluded when the Planning Council began its priority setting and allocation processes. In lieu of this year's data, the Council reviewed data on the populations with greatest unmet need from last year's process. The Council noted the estimate of clients who were not accessing care on a regular basis. The Council also noted that the majority of people with unmet need were African American men leading the Planning Council to prioritize and allocate funds to the mental health services, primary care and case management categories. This finding led the Council to designate African American MSM as a special population. The Council will use final data analysis from the 2006 Unmet Needs process to shape the updated Comprehensive Plan.

vi. The Council's Process Addresses Prospective Funding Decreases

The Contra Costa Consortium reached a set of recommendations for allocation of Part A and B funds in CCC. The process configured services in tiers, placing essential core services in tiers one and two, and support services in tiers two, three, and four. The Consortium decided to maintain full flat funding of core

services, agreed to eliminate support services in tiers two and three in the event of a funding reduction in order to maintain funding at current levels for core services. The Council and Consortium took this approach to ensure that services that directly improve health extend life and improve the quality of life would be preserved, in the event of funding decreases.

The Planning Council also agreed to maintain funding of highest ranked core services and reduce funding in support services as needed to achieve this in the event of a reduction in funds.

c) Allocation Table

: CORE SERVICES	Contra Costa %	Alameda %
Ambulatory/Outpatient Medical Care	0.00%	18.48%
Case Management - Medical	60.37%	24.51%
Mental Health Services	10.35%	14.27%
Oral Health	0.00%	6.25%
Substance Abuse	10.32%	5.61%
Home Health Care	0.00%	5.90%
Sub-total	81.04%	75.02%
SUPPORT SERVICES:		
Housing Assistance	0.00%	5.19%
Food	7.35%	4.73%
Emergency Financial Assistance (Food, Utilities)	0.00%	3.37%
Medical Transportation	4.04%	1.85%
Legal Service	4.59%	3.37%
Psychosocial Support	0.00%	4.50%
Health Education/Risk Reduction	2.99%	0.00%
Linguistic	0.00%	0.56%
Child Care	0.00%	1.40%
Sub-total	18.96%	24.98%
Grand Total	**100.00%**	**100.00%**

5. Budget and Maintenance of Effort

Alameda and Contra Costa Counties

MOE funds are tracked separately using each County's accounting system. These systems itemize and track funding sources by distinct codes which allow MOE and Ryan white funds to be tracked completely separately. Ryan White and MOE documentation is also kept in separate filing areas. The chart below demonstrates that the overall level of HIV-related expenditures have been maintained year-to-year for the last two complete fiscal years.

.	Item	County	FY 06 – 07	FY 07– 08
1	General Fund Administration – includes education and prevention, care and treatment, testing, and surveillance	Alameda	$1,501,499	$1,404,533
2	Care and Treatment Services	Alameda	$ 44,807	$ 75,000
3	Education and Prevention Services	Alameda	$ 586,062	$657,528
4	County Medical Services Program – HIV/AIDS Related	Alameda	0	0
5	AIDS General Fund	Contra Costa	$ 400,000	$334,432
6	AIDS Testing	Contra Costa	0	$104,333
7	AIDS Enhanced Surveillance Services	Contra Costa	$38,071	$ 41,361
8	AIDS Case Management	Contra Costa	$23,096	$ 1,264
9	AIDS Education and Prevention	Contra Costa	0	$ 5,293
10	AIDS Street Outreach	Contra Costa	$93,538	$ 33,940
11	AIDS Medi-Cal Waiver Case Management Services	Contra Costa	$200,000	$ 244,785
12	AIDS CARE Act Services CARE I and II	Contra Costa	$282,292	$ 288,403
13	AIDS Women's Early Intervention Services	Contra Costa	$33,361	$ 11,854
		TOTALS	$3,202,726	$ 3,202,726

6) Clinical Quality Management

a) Structure, Mission and Goals

The mission of the Oakland TGA's Quality Management Program is to provide high quality, culturally sensitive primary medical care and support services to people living with HIV/AIDS in Alameda and Contra Costa counties. This mission applies to both Ryan White programs and county funded HIV treatment services. In order to ensure that high quality services are provided consistently across the TGA, the QM staff in both counties has increased collaboration on clinical QM activities over the course of the last Ryan White fiscal year. The coordinated aspects of QM activities are described in this section.

The goals of our clinical Quality Management Program are:

- To improve health outcomes, reduce health disparities, and increase access and retention in care for PLWH/A.
- To continually improve clinical Quality Management activities that are in place.
- To identify best practices QM strategies from other health jurisdictions and implement them in the Oakland TGA.

The TGA's Quality Goals for 2007-2008 Ryan White fiscal year are to:

- Improve service delivery in the Oakland Transitional Grant Area

- Increase awareness of QI principles and knowledge about quality management among contracted service providers
- Improve the effectiveness of the Council's decision-making process for establishing priorities and making allocations.
- Improve access and retention in substance abuse and mental health treatment services
- Improve the efficiency of the HIV/AIDS Administrative programs

(b) Roles of staff or committees responsible for quality management activities

As the grantee, the Alameda County Office of AIDS Administration oversees the TGA's Clinical Quality Management Program. Staff members from both counties collaborate to design and implement a range of QM activities in their respective counties. These jointly developed activities include measuring client satisfaction through surveys and other tools, coordinating QM trainings for grantee staff and contracted service providers, conducting assessments of service providers QM activities, conducting chart reviews, updating and finalizing standards of care which includes establishing appropriate and measurable health indicators and presenting QM findings and utilization data to the Planning Council as part of the priority setting and allocation processes.

The TGA has worked to improve inter-county cooperation and implementation of all QM tasks and functions across county borders to ensure parity of services. Staff members from both Counties meet regularly to discuss regional issues. In addition to this intercounty QM activity, Office of AIDS staff participates regularly in the Central California Quality Committee, a committee of QM coordinators from Central California that meet quarterly to exchange information on quality management.

(c) Internal quality processes

The following internal quality processes are all related to the TGA's five annual quality goals:

- QM staff from both counties developed and adopted the Oakland TGA Quality Management Plan and workplan.
- At our request, the National Quality Center (HRSA's technical assistance consultant) provided an evaluation of our current QM plan, and made recommendations for improvement of the plan and strengthening of the QI infrastructure and activities.
- Staff members in both counties conduct chart reviews at service provider sites to ensure that core services are being provided adequately and that they meet QM standards. Twice yearly, QM staff members analyze contractor progress reports and compile outcome data. The results of chart reviews and progress reports are discussed with the providers, the CQI committee and the Planning Council.
- QM staff members provide technical assistance to contractors to help them develop QM plans and to measure and report outcomes and quality activities. Technical assistance is provided on site, and includes a review of QI principles, data collection and analysis methodologies, and how to conduct improvement projects. For example, an analysis of current Ryan White fiscal year utilization data revealed a rise in the use of oral health services. Moreover, oral health exams, prevention and hygiene instructions are used as indicators.
- QM staff developed standardized forms for progress notes, care and treatment plans, and disclosures to be used by all providers.
- All agencies under contract to provide Ryan White services in the Oakland TGA have completed the "Quality Management 101" training.

- Because a large proportion of our clientele are co-diagnosed with substance dependence and mental illness in addition to HIV infection, we have begun to place special focus on quality improvement in the areas of substance abuse and mental health treatment. Medical case management and primary care service providers are required to develop workplans that include assessing the substance abuse and mental health needs of their clients, and make referrals and conduct follow up. Subsequent chart reviews assessed compliance with this requirement, as well as disparities in use and access patterns. In a sample of 138 clients receiving case management services the following rates of compliance with the assessment requirement was observed:
- All contractors who provide core services must participate in a TGA-wide annual National Quality Center standardized Client Satisfaction Survey. The survey tool is used in both counties and across Ryan White programs A-D.
- QM staff members participate in web cast quality management technical assistance trainings offered by the National Quality Center.

(d) Indicators monitored for primary medical care and case management.

The TGA has adopted indicators for primary care, case management, substance abuse treatment mental health and oral health, home care and support services. The following are the specific indicators that are monitored for primary medical care and case management. Staff gathered findings from chart reviews, care plans, progress notes, reassessment forms, referral log charts, and case conference notes that document type and number of referrals.

Ambulatory Care Indicators	**Date collection and findings**
• All clients will have a minimum of 2 primary care visits within each fiscal year. (TGA-wide) • Percentage of clients who have viral loads every 4 months • Percentage of clients who have CD_4 cell counts performed every 4 months	• 84% reported 2 visits a year in 2006 • 73% on ART at last visit of the year • 82% documented as having received adherence counseling • 59% had a Viral Load every 4 months • CD4 count every 4 months-60%; • Mental Health Screening 75%
Case Management Indicators	
• Increase in percentage of clients who keep primary medical care appointments consistent with signed care plans within the fiscal year • Increase in the number and percent of HIV+ clients who access community referral sources • Increase in the number of clients with self-management goal setting. • Increase in the number of clients who complete at least half of their individual care plan objectives	• 85% kept primary medical care appointments • 75% accessed community referral sources • 60% had developed self-management goals • 71% had completed at least half of their individual care plan objectives. • Primary care visit within the last 6 months • 82% assessed for mental health and substance abuse • 33% assessed for treatment/ appointment and medication adherence

6 (b) Data Collection and Results

(i) What data has been collected

Both Alameda and CCC collect and maintain client level data. The HIV Client Services System (HACS) in Alameda County and CCC's ARIES database facilitate data collection by:

- Identifying disparities in outcome related to race, gender and language.

- Eliminating or significantly reducing duplication of intake activities so that clients are not forced to complete the same forms at each provider agency.
- Efficiently gathering service delivery data from the provider agencies.
- Assisting providers in unduplicating client numbers for reporting and planning purposes.
- Automating the production of the CARE Act Data Report (CADR)

Information on each client is collected at intake and over the course of medical care and support service delivery. This information includes biographical and demographic data, exposure category, insurance status, primary health care source, other presenting health issues, income level and employment, and the specific primary care or support services that each client accesses. HACS and ARIES data systems gather service utilization data, and more extensive screening data for the primary care services in accord with HRSA's annual CARE Act Data Report (CADR).

(ii) How data are used to improve service delivery

TGA staff measure core service outcomes (primary care, case management, oral health, home care, substance abuse and mental health) and service provider compliance with quality goals and contractual requirements. This data is collected using chart reviews and progress reports for a sample of the Ryan White Part A population. For primary care, data collection seeks to measure whether clients are adequately screened for such co-morbidities as mental illness, substance use, STIs, and hepatitis. The substance abuse and medical case management outcomes that are measured pertain to adequate documentation of progress notes, statement of client's rights and responsibilities, description of treatment plans and assessments for tobacco use, and mental health and substance abuse screenings.

(iii) Quality efforts have been used in priority setting and resource allocation

During the 2007 priority and allocations process, QM staff presented the results of chart reviews and other data on patient outcome in core service categories and client satisfaction. The data confirmed that prioritizing core services was essential to the health and well being of Part A clients in the Oakland TGA. The data validated the level of tests and screenings that providers are responsible for including TB, STIs, and gynecological screenings for female clients. In response to these findings the Planning Council maintained ambulatory care's priority ranking of one.

(iv) Quality improvement projects that improve service delivery.

The following projects and activities have (1) enabled the TGA to improve coordination and understanding of TGA quality efforts among Planning Council members, staff and service providers; (2) increased use of data in making informed decisions for improved client care; (3) established shared goals and objectives; and (4) created a multidisciplinary approach to quality improvement.

- ***Quality Management Assessment***: The assessment was conducted at all care sites in Alameda and CCC throughout calendar year 2003 QM staff used the results to develop quality trainings for care providers which were conducted in January and February 2006 and 2007. Training on health disparities and cultural competency was held in January 2008.
- **Improvements:** The assessment led to the development of a user friendly sample agency quality management plan and checklist for contractors; QM staff held "Quality Management 101" trainings for all care and prevention contractors; and A "Got Data, Now What" training was held in January of 2006-2007. All providers have an agency HIV specific QM plan.

- ***Training on CQI principles***: This training was provided to the Planning Council during retreats and orientations in March, April and August 2007 and during individual service provider site visits in 2007.
- **Improvement:** Council members have increased their knowledge of quality improvement principles, how data are used to improve health outcomes, and what health outcomes are measured in the TGA and the next steps for improvement; Council members used the cross TGA outcome report, service utilization and the client satisfaction survey results in setting priorities and making allocations;

- ***Standardized self management criteria***: QM staff standardized the criteria that agencies must use to determine whether self management and other outcome goals are being achieved**.** QM staff conduct a Client Satisfaction survey for the core services. The survey includes cultural competence questions added by consumers and staff. Consumers will help with the distribution, collection and analysis of the results.
- **Improvement**: Standardization has resulted in increased accuracy in data collection across the TGA; improvement in client satisfaction, better health outcomes and a greater understanding of how results can be used to improve care. After review of last year's data, the QM staff in both counties decided to propose that a pharmacist work with primary care clients to improve adherence and understanding of HIV medications

- ***QM staff identified a need for continuous assessment of the mental health and substance abuse needs of clients*** because substance use and mental health problems are the strongest indicators of people dropping out of care and because the Oakland TGA has a high proportion of clients diagnosed with substance use and mental health problems.

- **Improvement**: the TGA's Part C provider shared a depression tool with non Part C providers in order to improve their ability to assess and refer clients for mental health treatment. 93% of clients received mental health assessments, and 84% were assessed for use of illegal drugs

- ***OA staff worked with the dental providers to develop a health maintenance screening tool for use by dentist, similar to the one used by some primary care sites.***
- Improvement: It is expected that this tool will facilitate outcome reporting and documentation of services. The focus on oral health services (required contract indicator for primary care) will increase the number of clients receiving dental visits, improve access and increase the number of specialty dentists available to PLWH/A.

[i] California Department of Corrections; Data Analysis Unit; April 30, 2003