2006-2009 Comprehensive HIV Services Plan

Ryan White CARE Act
Riverside/San Bernardino, California
Eligible Metropolitan Area

Final Plan
Adopted November 2005
Inland Empire HIV Planning Council
Riverside/San Bernardino, CA EMA
2006-2009 Comprehensive HIV Services Plan

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October 24, 2005

Letter of Concurrence

Dear Friends,

It is with great pride that we present this public review draft of the Inland Empire HIV Planning Council’s three-year Comprehensive HIV Services Plan for persons living with HIV/AIDS and those affected, in the Riverside/San Bernardino, California Eligible Metropolitan Area (EMA). Of particular concern are communities of color and other traditionally underserved populations. Many people, including individuals living with HIV/AIDS, service providers, the two public health departments’ staff, and others have participated in creating this plan. We want to express our deep thanks to all of these people for their dedication and commitment to working together to strengthen and improve our systems of prevention and care.

The Comprehensive Plan Subcommittee of the Planning Committee has coordinated the Development of this plan for FY 2006-2009 including:

1. Review of the Comprehensive Plan guidance and care system expectations from the Health Resources and Services Administration which administers the Ryan White CARE Act.
2. Development and implementation of a Comprehensive Needs Assessment including a major consumer survey and focus groups to determine unmet need, service gaps, barriers to care, and disparities of care.
3. Facilitating the Planning Council’s decision-making for the establishment of priority services and the allocation of funds for direct core and support services and Planning Council Support.
4. Recommending long-term and short-term goals, objectives, service unit definition, number of people to be served, total number of service units to be provided, time frame and proposed FY 2006 funds for each core priority service funded with Ryan White CARE Act Title I and Minority AIDS Initiative as well as Title II.
Please join us in reviewing this important plan. This public review draft will be released October 27, 2005 and the deadline for feedback is November 23, 2005. Four Public Community Forums have been scheduled throughout the two County EMA (See attached schedule). The plan will also be available on the IEHPC website www.iehpc.org.

Respectfully,

Eric Frykman, MD
Co-Chair

Joe Acosta
Co-Chair
Inland Empire HIV Planning Council

The Inland Empire HIV Planning Council is pleased to release the Public Review Draft of the

2006-2009 Comprehensive HIV Services Plan for the Riverside/San Bernardino, CA Eligible Metropolitan Area

The Public Review Draft will be presented at each of the following Community Forum:

CATHEDRAL CITY LIBRARY
33-520 Date Palm Drive
Cathedral City, CA 92234
Tuesday, October 25, 2005, from 2:00pm – 4:00pm

RIVERSIDE COUNTY DEPT. OF PUBLIC HEALTH
4065 County Circle Drive, Auditorium Room 101
Riverside, CA 92503
Tuesday, November 8, 2005, from 2:00pm – 4:00pm

HOOK COMMUNITY CENTER
14973 Joshua Street, Game Room
Victorville, CA 92394
Tuesday, November 9, 2005, from 2:00pm – 4:00pm

GENERAL SERVICES GROUP (GSG) BUILDING
777 E. Rialto Avenue, Conference Room A
San Bernardino, CA 92415
Tuesday, November 15, 2005, from 2:00pm – 4:00pm

If you are living with HIV/AIDS, a provider of HIV/AIDS services, or just a community member that cares your comments are wanted!

For information on where public review hard copies and CD-ROM versions are available, please contact Joe Acosta, Co-Chair c/o Planning Council Support Staff:

Check our website at www.iehpc.org
Contact Planning Council Support Staff at (951) 358-6269
e-mail: dangulo@co.riverside.ca.us

This plan was supported by funding through Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, as amended by the Ryan White CARE Act in 1996 and 2000.
As of October 2005:

Riverside County

Bob Buster, Vice Chairman
First District Supervisor

John F. Tavaglione
Second District Supervisor

Jeff Stone
Third District Supervisor

Roy Wilson
Fourth District Supervisor

Marion Ashley, Chairman
Fifth District Supervisor

San Bernardino County

Bill Postmus, Chairman
First District Supervisor

Paul Biane, Vice Chairman
Second District Supervisor

Dennis Hansberberger
Third District Supervisor

Gary Ovitt
Fourth District Supervisor

Josie Gonzales
Fifth District Supervisor

Inland Empire HIV Planning Council
Riverside/San Bernardino, CA EMA

As of October 2005:

Joe Acosta, Co-Chair

John L. Brown

Jeffrey A. Byers

Ed Cueto

Faith Davis-Bolton

Darlene DeBayona

Steven A. English

Warner Engdahl

Fred Flotho

Gregory French

Eric Frykman, M.D., Co-Chair

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Victoria Jauregui Burns

Charles Johnson

Susan MacKintosh, DO

Kris Mazure

Debbie McCray

Benita Ramsey

Joan Thirtkettle

Evelyn Valentino

Dorla Williams

Alan Ziven
Contributors

This document is the result of countless hours of participation and effort by members of our community who are committed to improving the HIV prevention and care delivery system. Individuals who contributed their expertise including people living with HIV (PLWH), people who provide services to PLWH, and staff from the two County Public Health Departments who provide direct services and support, planning and administrative functions.

The diversity of our community in terms of geography, race, ethnicity, sexual orientation and gender is well reflected among this list of contributors – some participated in the Comprehensive Plan Subcommittee of the Planning Committee. Most of the individuals here volunteered their time while some were paid to provide additional expertise or support. Contributors also included people familiar with needs assessment methodology, health services planning, and evaluation.

Contributors also included individuals with first-hand knowledge of unmet needs and services gaps in our system. All should be acknowledged for their contributions. 512 persons living with HIV/AIDS participated in the 2005 Comprehensive Needs Assessment, on an anonymous basis.

This plan could not have been developed without the collaborative efforts and guidance of the following Comprehensive Plan Subcommittee Members and community volunteers and their contribution to the success of this process and commitment to persons living with HIV/AIDS in the Riverside/San Bernardino, CA EMA:

Joe Acosta, Planning Council Co-Chair
Charles Johnson, Comprehensive Plan Subcommittee Chair
Daniel Brown, Inland AIDS Project, Vice President Client Services
Ed Cueto, Bienestar, Executive Director (PC Member)
Steve English, PC Member
Bonnie Flippin, San Bernardino County, RWCA Grantee Staff
Fred Flotho, PC Member
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Victoria Jauregui Burns, Riverside County, Chief HIV/AIDS Division (PC Member)
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Thi Pham, Riverside County, PC Support Manager
Travette Smith, Riverside County, PC Support Staff
Kola Sofeso, Riverside County, PC Support Staff
Maritza Tona, Foothill AIDS Project, Executive Director
Janet Velez, Consultant
Alan Ziven, PC Member
Many thanks to all of the consumers and service providers whose input, commitment and inspiration contributed to the success of the 2005 Comprehensive Needs Assessment!

This plan was supported by funding provided through Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, as amended by the Ryan White CARE Act in 1996 and 2000.

Those who use this document are welcome to reproduce or quote this document in whole or in part provided acknowledgement is given. Suggested Citation: Inland Empire HIV Planning Council 2006-2009 Comprehensive HIV Services Plan, Riverside County Department of Public Health, Riverside, California, November 2005.

This plan will also be available at the IEHPC website:  www.iehpc.org

Inquiries regarding this report should be directed to:

Riverside County
Department of Public Health
HIV/AIDS Division
6370 Magnolia Avenue, Suite # 200
Riverside, CA 92506
951.358.5307
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INTRODUCTION

Comprehensive HIV services planning is a central focus of the Ryan White CARE Act (RWCA) legislation and an essential component of Title I programs. Comprehensive Planning is necessary to achieve the goals of the RWCA: to develop, organize, coordinate, and implement more effective and cost efficient systems of essential services to individuals and families living with HIV/AIDS.

Comprehensive HIV Services Planning helps Planning Council address four basic questions:

1. Where are we now?
2. Where should we be going?
3. How will we get there?
4. How will we monitor our progress?

The Inland Empire HIV Planning Council (IEHPC) 2006-2009 Comprehensive HIV Services Plan (CHSP) is a collaborative document that provides a roadmap and a course of action to guide the Riverside/San Bernardino, CA Eligible Metropolitan Area (EMA) and service delivery for persons living with HIV/AIDS (PLWH/A) for the next three years. The plan was developed through a 10-month process that involved the Inland Empire HIV Planning Council Comprehensive Plan Subcommittee of the Planning Committee.

The Plan is intended to be a dynamic and informative document, continually monitored to ensure effective implementation and modified as needed to reflect consumer needs, emerging issues, and budgetary constraints, and trends. Recommended strategies in the Plan seek to sustain the existing spectrum of care for HIV care and treatment, while proposing new strategies that increase the quality, cultural competency, and cost-effectiveness of care in the EMA.

The overarching vision of the Inland Empire HIV Planning Council is to promote access and improve the quality of culturally and linguistically appropriate services to PLWH/A in the EMA. Particular attention and focus is on communities of color not in HIV medical care.

The development of the Plan was a collaborative effort that included consumers, providers, Planning Council members, Planning Council Support staff, Grantee staff, and community. The process was consumer focused and consumers participated in all aspects of the Comprehensive HIV Services Plan.

Title I of the Ryan White CARE Act is a central component in the nation’s response to providing access to care and treatment to people living with HIV/AIDS. Over 70 percent of reported cases of people living with AIDS live within the 51 eligible metropolitan areas (EMAs) receiving Title I funds, where many must depend on lifesaving primary medical care, prescription drugs and supportive services supported by the Ryan White CARE Act. RWCA Title I funds are disbursed to those metropolitan areas hardest hit by the HIV/AIDS epidemic such as the Riverside/San Bernardino, CA (EMA). Title I funds serve as payer of last resort.
for underinsured and uninsured persons living with HIV/AIDS (PLWH) who cannot pay for the care they need.

This document satisfies the requirement of the CARE Act that each Title I Planning Council develop a comprehensive plan for the organization and delivery of health services for people with HIV disease. The Comprehensive Plan was developed in response to the 2005 Comprehensive Needs Assessment identified unmet needs, service gaps, disparities in care, and barriers to services for PLWH/A in the EMA.

Figure A-1 demonstrates how needs assessments are linked with all planning tasks, including priority setting and resource allocation, because they provide a foundation of information for making sound planning decisions.

Figure A-1  Needs Assessment Interlinking with all Planning Activities

Linking Needs Assessment and Planning

Executive Summary

SECTION ONE – WHERE ARE WE NOW: WHAT IS OUR CURRENT SYSTEM OF CARE?

Chapter 1: Description of the Eligible Metropolitan Area (EMA)

Chapter 1 provides a description of the Riverside/San Bernardino Eligible Metropolitan Area (EMA). Key points include:

- The Riverside/San Bernardino, CA EMA is comprised geographically of the largest and fourth largest counties in the state of California.
- It is the largest Eligible Metropolitan Area in the United States.
- The population of California is increasing; and the population of the EMA is growing at over double the State’s rate.
- The EMA is projected to experience substantial shifts in racial and ethnic composition in the coming decade.

Chapter 2: Epidemiological Profile

Chapter 2 provides an epidemiological profile HIV/AIDS in the Riverside/San Bernardino EMA including trends and future projects. Key points include:

- Incidence of diagnosed AIDS cases peaked in 1992 with over 800 cases and has decreases steadily since then to 305 AIDS cases in 2003.
- As of December 31, 2004, a total of 6,533 people are living with HIV disease in the EMA; 4095 people living with AIDS and 2,438 living with HIV. 64% of the prevalent AIDS cases reside in Riverside County and 36% in San Bernardino County.
- When looking at living cases only, which is the present-day burden of the disease, clearly the African American community and White Non-Hispanic population are disproportionately affected.
- African Americans have the highest HIV/AIDS prevalence rates of all of the race/ethnic groups.
- AIDS incidence rates are highest for African Americans, which are on average twice the rate of White Non-Hispanic and three to four times the rate of Hispanics, depending on the year of analysis.

Chapter 3: Historical Response to the Epidemic

Chapter 3 provides a historical overview of Riverside and San Bernardino Counties’ response to the HIV/AIDS epidemic from 1983 – 2005. Key highlights of the last two years include:

- In 2004 contract monitoring oversight and activities of RWCA Title I contracts were transferred from subcontractor Riverside County Department of Public Health to San Bernardino County Department of Public Health.
Planning Council management and support activities were transitioned from the Office of the Grantee in San Bernardino County to Riverside County Department of Public Health.

Service Category SAFE-T-Net was created to assist PLWH/A that are out of care get into HIV medical care.

Rapid testing was implemented in Riverside County in 2004.

The EMA collaborated with the state of California and nine other EMA’s in the State to develop and implement a methodology for estimating unmet needs.

A 2005 Comprehensive Needs Assessment was conducted to identify unmet need and service gaps for PLWH/A in the EMA.

Chapter 4: Assessment of Need

Chapter 4 provides an assessment of need for persons living with HIV/AIDS (PLWH/A) based on various data sources including the 2005 Comprehensive Needs Assessment. Key highlights include:

- An examination of core services (Ambulatory Outpatient Medical Care, Pharmaceutical Assistance, Case Management, Oral Health Services, Mental Health Services and Substance Abuse Services) identified disparities based on the RWCA 04-05 Year-end Utilization Report.
- Across the five core services, for the most part, African Americans and/or Latinos underutilize services. Females are significantly underutilizing some services, such as pharmaceutical assistance.
- In the 2005 Comprehensive Needs Assessment, the EMA identified six special needs populations; Youth (aged 13-24 years), Adult Women (aged 25 years and older), Latinos/as, African Americans, Men who have sex with men (MSM), Substance users (injection and non-injection users).

Chapter 5: Current Continuum of Care

Chapter 5 describes the current continuum of health care and supportive services available for PLWH/A in the Riverside/San Bernardino EMA’s. Key highlights include:

- Through extensive technical assistance and in response to recommendations from HRSA during FY 2005, the EMA will complete the transition from a social service case management model to a medical model of care based on the Chronic Care Model.
- Helping PLWH/A gain access to and engage in medical care is the primary focus of the EMA’s HIV continuum of care.
- As part of the priority setting and resource allocation processes for FY 05/06, IEHPC recommended that 100% of the Minority AIDS Initiative (MAI) funding be utilized for ambulatory medical care. This marked a significant change from previous years, but recognizes and supports primary medical care as the center of the system of care.
- In the Chronic Care Model, HIV Ambulatory Medical Care is the centerpiece of the HIV service delivery system. In this model, case management exists as a core service and support function to HIV medical care focused on increasing access to care.
Chapter 6: Resource Inventory

Chapter 6 presents an overview of the distribution of services throughout the Riverside/San Bernardino EMA and the different funding streams available to support the continuum of health care and support services.

- As of June 30, 2005, there were nine RWCA funded providers in the EMA with a total of twenty service delivery sites. There are four HIV medical providers in the EMA.
- In spite of the cost of providing services which continues to increase, the HIV service delivery system has continued to experience deeper funding restrictions.
- During the priority setting and resource allocation process the Inland Empire HIV Planning Council has developed a plan to maintain a core set of essential services that would be available to all eligible PLWH/A.

Chapter 7: Profile of RWCA Providers

Chapter 7 provides a summary of Part B of the RWCA Title I Resource Inventory Provider Surveys. Information on provider profile and client data is provided. Key highlights include:

- HIV medical care and a variety of support services are provided at twenty RWCA funded service delivery sites throughout the EMA.
- HIV Education and Prevention services are provided at 80% of the RWCA funded sites.
- Sixty percent of the RWCA funded sites self-reported they do not have the capacity to offer additional units of service with existing funding.
- Fifteen percent of service delivery sites have plans to decrease services or hours.
- Ninety-five percent of sites have formal agreements, commitment letters, MOU’s or verbal agreements with other agencies in order to maximize resources and coordinate services for PLWH/A in the EMA.

Chapter 8: Barriers to Care

Chapter 8 provides factors that deter clients from care and client and provider perspectives on barriers to care that may affect the quality and availability of care. These include:

- Homelessness contributes to deteriorating health and compromised nutritional status. This population is hard-to-reach and difficult to engage in primary medical care.
- PLWH/A who lack insurance may defer care. When care is deferred, the cost and complexity of treatment increases because PLWH/A are often further along the HIV disease continuum.
- Poverty impacts the cost and complexity of service delivery in several ways. First the very poor frequently defer primary medical care until they are seriously ill often due to fear or denial of service and financial uncertainty.
- Both substance abuse and chronic mental illness create challenges for PLWH/A to accessing primary medical care and adherence to HIV treatment.
- According to the 2005 Comprehensive Needs Assessment, RWCA providers identified the top three barriers to services as lack of transportation, lack of adequate providers and resources, and homelessness and poverty.
- Consumer surveys from the Needs Assessment report identified stigma of living with HIV/AIDS as the greatest influence restricting PLWH from seeking HIV medical care.
SECTION TWO – WHERE DO WE NEED TO GO: WHAT SYSTEM OF CARE DO WE WANT?

Chapter 9: Continuum of Care for High Quality Core Services

Chapter 9 discusses the shared values, vision, and guiding principles of the members of the Planning Council’s vision for the future system of care. It also describes how the plan will provide increased access to the HIV Continuum of Care and how it will promote parity of HIV services throughout the EMA and how it will encourage PLWH retention in care and treatment adherence.

SECTION THREE – HOW WE WILL GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF AND ACCESSIBILITY TO CORE SERVICES?

Chapter 10: Short-term and Long-term Goals and Objectives

Chapter 10 describes the short-term and long-term goals and objectives, related to the provision of services, changes in the service-delivery and improvements in the planning process.

SECTION FOUR – HOW WE WILL MONITOR OUR PROGRESS: HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR SHORT AND LONG-TERM GOALS?

Chapter 11: Monitoring and Evaluation of Plan

Chapter 11 discusses the monitoring and evaluation processes and procedures utilized in the EMA in monitoring progress with short and long-term goals and objectives.
Chapter 1: Description of the EMA

Geographics
The Riverside/San Bernardino, California, Eligible Metropolitan Area (EMA) is comprised geographically of the largest and fourth largest counties in the state of California (Figure 1-1). With 27,460 square miles, it is the largest EMA in the United States. It is larger than the combined landmasses of several eastern states and is divided into six service areas. Diverse terrain, including mountains and deserts, presents significant challenges to the delivery of medical care and support services. These challenges are exacerbated by the rising need for reliable and efficient transportation while facing the 5th worst traffic in the United States (USA Today, 9/12/04).

Figure 1-1  Map of the Riverside/San Bernardino, California EMA Service Areas

The EMA is divided into six Service Areas, three in each county (Table 1-1). The EMA contains urban centers, suburban, rural, and remote communities, as well as internationally recognized resort cities. The East County Service Area in Riverside County and the East Valley Service Area in San Bernardino County have the highest levels of prevalent HIV/AIDS cases, respectively.
As noted above, the EMA has been divided into six service areas for the purposes of health planning. The east, mid, and west county service areas of Riverside County roughly divides the population area of the county into equal thirds. However, this is not the case in San Bernardino County, where the east valley and west valley service areas are located in the extreme southwest corner of the county while the desert region constitutes the remainder. Table 1-1 presents the cities/communities within the EMA by county and service area. It is noteworthy that, with the exception of the west valley region of San Bernardino County, all service areas have numerous unincorporated areas.

Table 1-1. Cities/Communities by County and Service Areas

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<th>Service Areas:</th>
<th>Riverside County</th>
<th>San Bernardino County</th>
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<td># 1</td>
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<td></td>
<td>West County</td>
<td>Mid County</td>
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<td>Belltown</td>
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<td>Bermuda Dunes</td>
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<td>El Cerrito</td>
<td>Banning</td>
<td>Cathedral City</td>
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Demographics
The latest demographic data are from the 2003 American Community Survey (ACS), which is administered by the US Census Bureau. According to the 2003 ACS, the median age is 31.6 years, nearly 70% are over 18 years old, and 49.5% of the EMA are male. By race and ethnicity, the 2003 ACS estimates 41% of the population is of Hispanic ethnicity; 44% are White race only, 7% are African American race only, 5% are Asian/Pacific Islander race only, <1% are American Indian or Alaska Native race only, and roughly 2% are another race only or multi-race (Figure 1-2). The 2003 ACS estimates nearly 21% of the EMA population was foreign born, with a majority immigrating from Latin America. According to the 2003 ACS, 64% of the foreign born residents are not citizens. Thus, an estimated 513,838 persons (13.4% of the total population in the EMA) are possibly undocumented residents.

Figure 1-2 Proportion of the Riverside/San Bernardino, California EMA Population by Race/Ethnicity: 2003 American Community Survey


The population of California is increasing; and the population of the EMA is growing at over double the State’s rate. From January 2000 to January 2005, the population of California expanded by 8.7 percent according to the California Department of Finance estimates. During the same period, the population of the EMA has grown 17.4% (State of California, Department of Finance, E-4 Population Estimates for Cities, Counties and the State, 2001-2005, with 2000 DRU Benchmark. Sacramento, California, May 2005).
The EMA is projected to experience substantial shifts in racial and ethnic composition in the coming decade (Figure 1-3). According to estimates by the California Department of Finance, by 2010, the Hispanic population is projected to increase over 2000 census counts and will become the majority race/ethnic group.

The proportion of the population that is Hispanic is projected to increase from 38% in 2000 to 52% by 2010. Over the same time period the White Non-Hispanic population is projected to decrease. The percentages of Asian/Pacific Islander, African American Non-Hispanic, and American Indian groups are also projected to increase between 2000 and 2010. Although much smaller in total, the Asian /Pacific Islander populations will close to double in number during this time period (State of California, Department of Finance, Population Projections by Race/Ethnicity, Gender and Age for California and Its Counties 2000-2050, Sacramento, California, May 2004).

Figure 1-3 California Department of Finance Population Projections for the Riverside//San Bernardino, California EMA: 2000-2050


Figure 1-3 represents the anticipated demographic shift in race/ethnicity within the population of the EMA. These projections from the California Department of Finance are based on a model that incorporates natality, mortality and migration in the projection. Therefore, many factors affect the accuracy of this projection. If the Hispanic birth rate decreases, for example, the projection may overestimate the increase in the Hispanic population.
Figure 1-4 represents the proportion of the EMA population by age groups for the population of the EMA. Although only 29% of the population is between 25 and 44 years old, this same group accounts for over 63% of the persons living with HIV/AIDS.

**EMA Administration and Management**

As a result of technical assistance received from federal Health Resources Services Administration (HRSA) project officer, recommendations were made to reorganize the Riverside/San Bernardino, CA EMA. In 2004, Planning Council support oversight and activities were transitioned from the San Bernardino County Department of Public Health Office of the Grantee to subcontractor Riverside County Department of Public Health, HIV/AIDS Division and contract monitoring oversight of Ryan White CARE Act contracts was transferred to the Office of the Grantee from Riverside County.

RWCA funds are administered by San Bernardino County, Department of Public Health the Grantee of Record. Figure1-5 is an organizational chart for how RWCA funds are administered.

**Reorganization of Planning Council**

Figure 1-6 is an organizational chart of Planning Council Committees and Subcommittees after the restructuring. The revision of PC committee structure reflects PC mandates for the CARE Act. IEHPC reorganized its committees and their functions in order to improve Grantee and Planning Council communication based on recommended modifications on committee structure made by HRSA consultant. Table 1-2 lists all of the PC committee and subcommittee charges.
Figure 1-5: Riverside/San Bernardino EMA Organizational Chart

Ryan White CARE Act Title I Program

San Bernardino County
Board of Supervisors (BOS)
(Grantee of Record)

BOS Chairman
1st District Supervisor
Bill Postmus

BOS Vice-Chairman
2nd District Supervisor
Paul Biane

3rd District Supervisor
Dennis Hansberger

4th District Supervisor
Gary Ovitt

5th District Supervisor
Josie Gonzales

San Bernardino County
Department of Public Health

Jim Felten
Public Health Director

Div of Admin Services
Bea Valdez

Div of Environmental Health/Animal Control
Dan Avera

Div of Child Adolescent & Family Health Svcs
Jim Felten, Interim

Div of Disease Control & Prevention
Eric Frykman

Fiscal Administrative Svcs
Mary Peluffo – P.H. Manager

Statistics & Vital Records
Kathie Pelletier – P.H. Manager

Information Services
Jerry Sharp – Supervising ASA III

RWCA, Title I
RWCA, Title II
HOPWA
Daniel Perez
PH Program Coordinator
Inland Empire HIV Planning Council

Committee Structure Organizational Chart

- Honorary Advisors
- Consultants
- PLANNING COUNCIL
  - Executive Committee
    - Bylaws Subcommittee
    - EAM Subcommittee
  - Planning Committee
    - Needs Assessment Subcommittee
    - Comprehensive Plan Subcommittee
    - Priority Setting & Allocations
  - Council Development Committee
  - Empowerment Committee
    - Community Access Subcommittee
  - QM Committee
    - Standards Subcommittee
    - Evaluation Subcommittee

LEGEND
- Planning Council Committee/Subcommittee
- Ancillary Advisors & Consultants
Table 1-2 Inland Empire HIV Planning Council – Committee and Subcommittee Charges

Planning Council Charges:

The mission of the Inland Empire HIV Planning Council is to identify the health and support service needs of persons living with HIV disease in the Riverside/San Bernardino, CA Eligible Metropolitan Area and to assure that those services are available. The establishment, maintenance, expansion or reduction of HIV-related services is to be informed by the guiding principles, shared values and shared vision statements developed by persons living with HIV disease and the Planning Council. A common goal is to develop a continuum of high quality of care that is client-centered, client-collaborative, culturally competent, cost effective, efficient and accessible to all eligible persons living with HIV disease and their affected families. The Planning Council is mandated to establish priorities for the allocation of funds based on local needs assessments; develop a comprehensive plan for the organization and delivery of health and support services; and assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need. The Planning Council recognizes that these mandates are best addressed through collaboration among clients, service providers, public health officials and other members of the community.

In addition, members of the Planning Council will

- Foster awareness in the communities of the EMA concerning HIV/AIDS, and the role/mission of the Planning Council
- Foster support for programs to prevent the spread of HIV and programs that provide support and care services for people living with HIV/AIDS
- Promote consumer education as to the services available through Planning Council-funded priorities.

Executive Committee Charges:

- Within the parameters established by the PC, the Executive Committee acts on behalf of the Council on matters deemed by the Executive Committee to require action prior to the next regularly scheduled Council meeting
- Coordinate committee work
- Coordinate with other HIV consortia and planning bodies
- Coordinate and oversee activities of all committees, subcommittees, and working groups
- Develop procedures for Council record keeping and other administrative functions
- Coordinate/oversight of Council support staff
- Enforce code of respect between members and staff
- Set agenda for Council meetings
- Review and take action on grievances against the Planning Council
- On behalf of the Council, review and act upon allegations against members for violations of the Council Code of Conduct, including disciplinary actions short of termination and recommendation of termination to the Council, and other governance matters.
### Bylaws Subcommittee Charges:
- Coordinate with Planning Council to create and amend bylaws to meet the council's needs
- Working through the Executive Committee, coordinate the development of Council bylaws in accordance with Ryan White legislation and HRSA guidelines
- Recommend changes to bylaws, policies and procedures as needed
- Present for Council approval recommended changes to bylaws

### Evaluation of Administrative Mechanism Subcommittee Charges:
- Develop procedures and assess the efficiency of the administrative mechanism of both the Grantee (e.g., procurement and contract management) and the Planning Council Support Staff (e.g., assisting the Planning Council in establishing and carrying out process) for timely and appropriate activities within the EMA

### Council Development Committee Charges:
- Develop and implement ongoing recruitment process
- Recommend candidates for Planning Council appointment
- Ensure membership representation that reflects the epidemic on the Planning Council
- Develop process to orient, educate and train Council members at scheduled Membership Training meetings and/or events
- Recommend members for assignment to committees
- Monitor member participation, attendance, and committee assignment(s)
- Assure representative participation of people living with HIV that meets or exceeds federal standards
- Suggest ways to streamline the operation of the Planning Council and its committee to accomplish the committee mission more easily, efficiently and economize on staff resources; and
- Develop and coordinate activities that may enhance the future progress of the EMA
- The chair of this committee has representation at the Executive Committee

### Empowerment Committee Charges:
- Develop and promote consumer education about the Planning Council and its role in provision of health and support services to PLWH
- Foster awareness in the communities of the EMA concerning HIV/AIDS, and the role/mission of the Planning Council
- Foster support for programs to prevent the spread of HIV and programs that provide support and care services for people living with HIV/AIDS
- Promote consumer education as to the services available through Planning Council-funded priorities
- Gather information about and create awareness of services generally available to consumers provided by sources other than those funded by this EMA/Planning Council.
• Support the recruitment of qualified members for the Planning Council, and facilitate participation of consumers at all levels
• Develop funding sources to promote increased consumer participation HIV related activities
• Oversee and monitor the Planning Council’s Consumer Grievance procedures and their relationship to the provision of health and support services to PLWH that are funded through the Ryan White CARE Act
• Work cooperatively with the Grantee to administer effective processes to resolve grievances of persons being served by the EMA concerning problems related to access to and quality of service. Refer to IEHPC Policies & Procedures regarding the grievance process.
• With the advice of the Grantee’s County Counsel, make determinations concerning conflicts of interest related to Planning Council business
• Coordinate and oversee activities of the Community Access Subcommittee
• The chair of this committee has representation at the Executive Committee

**Community Access Subcommittee Charges:**

• Guide and make recommendations toward the EMA’s efforts to achieve equitable delivery of high quality culturally competent services to all eligible residents of the EMA
• Serve as a sounding board and line of communications between the EMA and populations historically and newly identified in the EMA as being underserved
• Guide and make recommendations toward the EMA’s effectiveness at identifying and bringing into care persons who are aware they are HIV infected but who are not in care
• Recommend programs and techniques to be adopted in the EMA to improve outreach and services to underserved populations
• Participate in the coordination of the annual Priority Setting and Resource Allocation “Data” Summit to ensure minority access to services within the EMA
• The chair of this subcommittee has representation at the Empowerment Committee

**Planning Committee Charges:**

• Coordinate, facilitate and oversee activities of the Needs Assessment Subcommittee, the Comprehensive Plan Subcommittee, and the Priority Setting and Resource Allocation Subcommittee to ensure a coordinated effort for a comprehensive planning process within the EMA
• Participate in the development of, and ensure that Council actions are consistent with, the Statewide Coordinated Statement of Need
• The chair of this committee has representation at the Executive Committee
Needs Assessment Subcommittee Charges:

- Conduct needs assessment to identify what services are needed and what populations need care
- Determine the size and demographics of the population of individuals with HIV disease
- Identify barriers to care and access among affected subpopulations and historically underserved communities
- Determine the needs with particular attention to individuals with HIV disease who do not know their HIV status and are not receiving HIV-related services, and disparities in access and services among affected subpopulations and historically underserved communities
- Gather information about and create awareness of services generally available to consumers provided by sources other than those funded by this EMA/Planning Council
- Establish methods for obtaining input on community needs and priorities
- The chair of this subcommittee has representation at the Planning Committee

Comprehensive Plan Subcommittee Charges:

- Based upon the results of the needs assessment, develop, review, and revise a Comprehensive HIV Services Plan for the delivery of health and support services that includes strategies for identifying those not in care, strategies for resolving barriers to care, and the coordination and compatibility of services within the EMA
- The chair of this subcommittee has representation at the Planning Committee

Priority Setting & Resource Allocation Subcommittee Charges:

- Based upon the results of the needs assessment, the Comprehensive HIV Services Plan, and other information, develop recommendation to Planning Council for priorities and allocation of funds within the EMA, including how best to meet each priority; plan and coordinate the annual Data Summit
- Evaluate, plan, and make recommendations to the Council with respect to the service priorities and/or resource allocations to be delivered within each service area in the EMA
- The chair of this subcommittee has representation at the Planning Committee

Quality Management Committee Charges:

- Guide, coordinate, facilitate and oversee the development of the EMA’s continuum of care, service category definitions, and standards of care for each service category
- Coordinate and facilitate the standards and evaluation activities within the EMA for continuous quality improvement through the activities of two subcommittees - the Standards Subcommittee and the Evaluation Subcommittee
- Implement special projects related to standards and evaluations activities
- The chair of this committee has representation at the Executive Committee
Standards Subcommittee Charges:

- Develop, monitor and revise as needed the following: Standards of Care, Client Eligibility Criteria, and Output and Outcome Indicators to be consistent with HRSA Policy and to meet the changing needs of PLWH in the EMA
- Convene, as needed, specialized working groups to include experts from specific fields (e.g., Primary Medical Care, Mental Health, HIV Medical Care, Substance Abuse, Dental Care, etc.) to inform standards development
- The chair of this subcommittee has representation at the Quality Management Committee

Evaluation Subcommittee Charges:

- Monitor and evaluate the Comprehensive HIV Services Plan; determine what impact services are having on client health outcomes
- Examine the cost-effectiveness of the services delivered as a quarterly check with the Grantee
- Review service category expenditures and program performance and compare them to Planning Council goals and objectives
- Assess aggregate performance of services
- Assist in developing units of service and cost analysis
- Assess capacity of services in the EMA
- Provide input for the comprehensive plan in relation to support services
- Assist in the development of a quality assurance mechanism for funded services based upon performance standards of care established by the Council
- Consult with Standards Subcommittee, as needed, to inform evaluation mechanism
- The chair of this subcommittee has representation at the Quality Management Committee
Chapter 2: Epidemiological Profile

HIV infection was made reportable in California on July 1, 2002. The EMA now has sufficient code-based HIV data, managed in the State of California’s HIV/AIDS Reporting System (HARS), to report actual HIV prevalence. The HIV prevalence, AIDS prevalence, and AIDS incidence data are derived from the HARS databases maintained locally by Riverside and San Bernardino Counties. Local data from the counties’ HARS databases mirror the CDC data provided to the EMA. The following chapter presents data on the incidence rate, prevalence rates, current epidemiological trends and projections, and co-morbidity data.

Incidence by Year of Diagnosis

Incidence of diagnosed AIDS cases peaked in 1992 with over 800 cases and has decreased steadily since then to 305 AIDS cases in 2003 (Figure 2-1). Due to the reporting lag, 2004 data are considered provisional at this time. Although HIV reporting did not begin until mid-2002, cases submitted from that point on might have a prior diagnosis date.

Figure 2-1 Number of AIDS Cases by Year of Diagnosis, Riverside/San Bernardino, California EMA, 1981-2004
No-names HIV reporting began in June 2002 and is too recently implemented to produce reliable trends. Also, because there is no case investigation, it may never be possible to confirm the date of diagnosis. It is questionable why there is a doubling of the HIV incidence by year of diagnosis during the year reporting began (Figure 2-2). One could speculate that some existing cases with an unknown or ambiguous date of diagnosis were assigned the date of reporting as the date of diagnosis by the reporting agency.

Prevalence

Tables 2-1 shows the prevalent (living) cases of HIV and AIDS as of December 31, 2004. A total of 6,533 people are living with HIV disease; 4095 people living with AIDS and 2,438 living with HIV. 64% of the prevalent AIDS cases reside in Riverside County and 36% in San Bernardino County. 88% of the prevalent AIDS cases are male.
When looking at living cases only, which is the present-day burden of the disease, clearly the African American community and White Non-Hispanic population are disproportionately affected. The proportion of the EMA’s general population that is African American is 7%, while the proportion of African American persons living with HIV/AIDS is 15.7% (Table 2-1). The proportion of the population that is White Non-Hispanic (Figure 2.3) is 44%, while the proportion of White Non-Hispanic persons living with HIV/AIDS is 59% (Table 2-1).

As demonstrated in Figure 2-3 both the White Non-Hispanic and African American populations bear a disproportionate burden of the cumulative reported HIV and AIDS cases. African American AIDS cases are double that of their proportion in the general population. The opposite is true for the Hispanic/Latino population.
African Americans have the highest HIV/AIDS prevalence rates of all the race/ethnic groups (Figure 2-4). With a rate of nearly 200 per 100,000 persons in the population, it is more than three times higher than the Hispanic/Latino population. The White Non-Hispanic population has a prevalence rate of nearly 180 AIDS cases per 100,000 (second highest overall). Although the Native American/Alaskan Native AIDS rate appears high, the rate is based on small numbers and is considered unstable.

The AIDS prevalence rate for the White Non-Hispanic population varies greatly between the two counties of the EMA. The AIDS rate for White Non-Hispanics is more than twice as high in Riverside County as it is in San Bernardino County.
Chapter 2: Epidemiological Profile

Trends of the Epidemic

5-Year Trend of Number of AIDS Cases by Race/Ethnicity

Over the last four years (2004 is provisional and should not be included for trend analysis) the incidence trend of AIDS cases by year of diagnosis is slightly different by race/ethnicity (Figure 2-5). The White Non-Hispanic population has had the most diagnosed AIDS cases and is experiencing a slight increase in number of cases per year. The number of incident cases for both the Hispanic and African American populations has been relatively flat at about two-thirds the number of incident cases of the White Non-Hispanics. These trends are in contrast to the incidence in Los Angeles County (see graph below). Since 1997, Hispanics have had the highest numbers of incident AIDS cases. Also, the number of incident AIDS cases per year is roughly equal to the number for the White Non-Hispanic population.
Figure 2-5 Number of AIDS Cases as of December 31, 2004 by Race/Ethnicity, Riverside/San Bernardino, California EMA, 2000-2004

LA County provided for comparison.

Source:
County of Los Angeles Department of Health Services, Public Health Semi-Annual HIV/AIDS Surveillance Summary, January 2005
5 Year Trend of Percent of AIDS Cases by Race/Ethnicity

Figure 2-6 Percent of AIDS Cases as of December 31, 2004 by Race/Ethnicity, Riverside/San Bernardino, California EMA, 2000-2004

The same relatively flat trend is seen when looking at the percent of incident AIDS cases by year of diagnosis and race/ethnicity (Figure 2-6). Since 2000, depending on the year, between 50% and 60% of the cases have been White Non-Hispanic, 25% to 30% of the cases have been Hispanic, and 10% to 20% of the cases have been African American. This is in sharp contrast to the percent of incident cases by race/ethnicity in Los Angeles County, where, since 1997 the majority of the cases have been Hispanic (see graph below).

LA County provided for comparison.

Source:
County of Los Angeles Department of Health Services, Public Health Semi-Annual HIV/AIDS Surveillance Summary, January 2005
Breakdown of the Epidemic by Race/Ethnicity and Gender

5-Year Trend of Incidence Rates by Race/Ethnicity and Gender

AIDS incidence rates are highest for African Americans, which are on average twice the rate of White Non-Hispanic and three to four times the rate of Hispanics, depending on the year of analysis (Figure 2-7). These differences are even more pronounced when looking at the incidence rates by gender and race/ethnicity (Figures 2-8 and 2-9).

Figure 2-7  AIDS Incidence Rates as of December 31, 2004 by Race/Ethnicity, Riverside/San Bernardino, California EMA, 2000-2004

Figure 2-8  AIDS Incidence Rates for Males as of December 31, 2004 by Race/Ethnicity, Riverside/San Bernardino, California EMA, 2000-2004
African American females have an average AIDS incidence rate that is five times higher than Hispanic or White Non-Hispanic females (Figure 2-8). In contrast to the rate of males (Figure 2-7), the rates for Hispanic and White Non-Hispanic females are the same.

Figure 2-9  AIDS Incidence Rates for Females as of December 31, 2004 by Race/Ethnicity, Riverside/San Bernardino, California EMA, 2000-2004

Epidemiological Projections

AIDS Incidence Forecast

Based on a model applied by the City of Las Vegas, Nevada, Eligible Metropolitan Area, Figure 2-10 forecasts the number of AIDS cases by year using a log linear trend line. The trend is based on reported AIDS cases by diagnosis year from 1993 to 2004 and projects the AIDS incidence to 2010. The results by applying standard statistical methods find the predictive power of the projection strong, supporting the model’s suggestion that the number of individuals diagnosed with AIDS per year will continue to decrease. As mentioned before, since HAART became available, the time interval between diagnosis of HIV and progression to AIDS has lengthened for HIV positive persons, thereby reducing the number of AIDS diagnoses.
This forecast model is based on an established trend of diagnosed cases per year. Since AIDS reporting has been long established, spanning a period of over twenty years, a reliable trend is achievable. HIV reporting, on the other hand, is relatively new. As mentioned before, the data are not reliable, thus a predictive model for HIV incidence using a trend line cannot be determined.

With the decline in deaths outpacing the decline in new cases (Figure 2-11), the number of prevalent cases will continue to increase. Thus, the HIV care system will need to continuously expand to meet the care and treatment needs of people living with HIV/AIDS. Furthermore, this does not reflect the trends for those individuals who do not know they are HIV positive.
Figure 2-11  Estimated Number Living with HIV/AIDS, Number of New HIV/AIDS Cases, Estimated Number of HIV/AIDS Deaths, by Year of Diagnosis as of December 31, 2004, Riverside/San Bernardino, California EMA, 1982-2004

AIDS/HIV Deaths, New Cases, and People Living with HIV/AIDS
Riverside/San Bernardino EMA 1982-2004
By Year of Diagnosis

For a more detailed epidemiological profile of the Riverside/San Bernardino, California Eligible Metropolitan Area (EMA), please refer to the Inland Empire HIV Planning Council 2005 Comprehensive Needs Assessment Report.
### Chapter 3: Historical Response to the Epidemic in the EMA Highlights (1983 – 2005)

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<td>1983</td>
<td>Departments of Public Health in Riverside &amp; San Bernardino Counties received their first reports of AIDS.</td>
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<td>1984</td>
<td>Community Counseling &amp; Consultation Center, now known as Desert AIDS Project (DAP), began to serve PLWH infection residing in the Coachella Valley of Eastern Riverside County. A group of concerned volunteers initiated educational programs; STOP AIDS and Buddies program in response to increasing problems experienced by PLWH in what became the EMA. Group became founding members of Inland AIDS Project (IAP).</td>
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<td>1985</td>
<td>Inland Counties Health Systems Agency established a 50-member, multi-disciplinary task force to identify AIDS education and services coordination needs in its four county service areas. HIV antibody counseling &amp; testing and prevention education were developed and implemented in both counties. By Dec. 31st – 67 cases of AIDS had been reported in EMA.</td>
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<td>1986</td>
<td>Riverside General Hospital initiated HIV outpatient services in its Infectious Disease Clinic.</td>
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<td>1987</td>
<td>Riverside County Department of Public Health established a categorical HIV/AIDS unit within its Disease Control Program. California Institution for Men in Chino opened its Del Norte facility to HIV infected inmates. Foothill AIDS Project (FAP) was established in the City of Pomona in eastern Los Angeles County. Riverside and San Bernardino Counties began to participate in the California Department of Health Services, Office of AIDS, AIDS Drug Assistance Program.</td>
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<td>1988</td>
<td>San Bernardino County Department of Public Health established a categorical AIDS program within its Disease Control Section. The Inland Empire Chapter of the American Red Cross began providing prevention education to women of childbearing age and at-risk youth. A number of AIDS service providers within the East County service areas of Riverside County formed the Coachella Valley AIDS consortium with a grant from the James Irvine Foundation.</td>
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### Chapter 3: History of the EMA Response to the Epidemic

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<td>1989</td>
<td>With funds from the California Department of Health Services, Early Intervention Program (EIP), the County of Riverside, Department of Public Health added outpatient primary medical care services for persons living with HIV. By Dec. 31st – 787 cases of AIDS had been reported within the EMA.</td>
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<td>1990</td>
<td>San Bernardino County Department of Public Health opened an HIV outpatient clinic in the City of San Bernardino.</td>
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<td>1991</td>
<td>The HIV advisory committees became the founding members of the Riverside County Consortium on AIDS and the San Bernardino County HIV Care Consortium under Title II of the CARE Act, administered by the State Office of AIDS. DAP opened an outpatient primary care clinic in the City of Palm Springs.</td>
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<td>1992</td>
<td>The San Bernardino County, Department of Public Health added dental care to its consortium of care in the City of San Bernardino. Dental care also became available as a Ryan White CARE Act, Title II funded service in Riverside County. San Bernardino County formed a coalition of providers to compete for California Department of Health Services, Office on AIDS and U.S. Conference of Mayors funding to expand prevention education throughout the county.</td>
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<td>1993</td>
<td>Riverside/San Bernardino EMA became eligible for U.S. Department of Housing and Urban Development, Housing Opportunities for Persons with AIDS program formula funding through the City of Riverside. Riverside/San Bernardino counties became eligible for federal fiscal year 1994 funding under Title I of the CARE Act. An intergovernmental agreement specifying the planning council size, co-chairs and method for the allocation of resources was reported between the two counties. Inland Empire HIV Planning Council was established.</td>
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<td>1994</td>
<td>The Planning Council improved its effectiveness through the implementation of a mentoring process for new council members.</td>
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**Chapter 3: History of the EMA Response to the Epidemic**

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<td>• San Bernardino &amp; Riverside Counties determined that the Inland Empire HIV community prevention planning councils would provide direction to prevention efforts throughout the region.</td>
<td>• RWCA was reauthorized and significant increases in funds were appropriated by U.S. Congress. Protease inhibitors taken in combination with nucleoside analogues became widely available for PLWH. Enrollment in Medical Managed Care for some recipients of AFDC was initiated. Amendments to the Social Security Act and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 were signed into law; state implementing legislation was passed. By Dec. 31, 5,291 cases of AIDS had been reported within the EMA.</td>
<td>• A non-governmental community co-chair was elected to the Planning Council. DAP established a wellness program and re-employment program in response to its clients. IAP was awarded a three-year HIV prevention demonstration project grant from the Centers for Disease Control and Prevention.</td>
<td>• Development of a strategic plan was initiated by the Planning Council. Title I local drug reimbursement program funds were used to purchase the combination therapy drugs prior to their addition to the State of California ADAP formulary. Case Management standards were developed and adopted. The cumulative AIDS case fatality rate continued to decline in the EMA. As a result of co-morbidity data, the service category substance abuse counseling and treatment was added to the list of services to be delivered.</td>
<td>• The California Department of Health Services, Office of AIDS convened a steering committee to supervise &amp; monitor the preparation of the first California Statewide Coordinated Statement of Need. Both counties established mobile test sites through the California Department of Health Services’ Neighborhood Intervention Geared to High Risk Testing (NIGHT) Program.</td>
<td>• S.B. County expanded services to include evening clinic to serve those entering or re-entering work force due to successes of highly active anti-retroviral therapy. Implementation of the Congressional Black Caucus Initiative supports outreach to African Americans living with HIV in the EMA. Inland Empire HIV Planning Council 1999-2000 Strategic Plan was developed. The Grantee contracted Support Center/Executive Services Corps to provide T.A. on client satisfaction surveys, retrospective audits, quality assurance, and training on the concepts and process of TQM.</td>
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### Chapter 3: Historical Response to the Epidemic

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<td>- The AIDS Healthcare Foundation opened a primary care clinic in the City of Rancho Cucamonga.</td>
<td>- The ad hoc Underserved Populations/Community Linkages Committee sponsored workshops for outreach to the African American and Hispanic communities. The workshops were titled “Inter-Faith, Stakeholders and Gatekeepers Workshop.”</td>
<td>- The San Bernardino County established a support group for monolingual, Spanish speaking women.</td>
<td>- A Comprehensive Needs Assessment was conducted throughout the EMA to determine the needs of PLWH.</td>
<td>- A Specialized Needs Assessment was conducted to identify needs of African American and the barriers keeping PLWH out of care.</td>
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<td>- The State-funded Bridge Project was started to prevent further transmission of HIV in communities of color through increasing the number of HIV-infected individuals successfully enrolled in comprehensive HIV treatment and prevention services.</td>
<td>- A major system-related change is underway as providers convert to a new MIS system called CAMINAR.</td>
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<td>- The San Bernardino County Department of Public Health began to provide food and transportation for its clients.</td>
<td>- The passage of State Proposition 36 caused the Planning Council to more than double the allocation for substance abuse counseling and treatment.</td>
<td>- The Planning Council By-laws were revised for consistency with FY 2000 reauthorization of the CARE Act and to give consumers a greater role and responsibilities in process.</td>
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<td>- PC members and support staff created a “Contract Monitoring and Evaluation” tool for use in site visits.</td>
<td>- The Center for Health Research, Loma Linda University contracted with Riverside/San Bernardino EMA, Title I Grantee to conduct a variety of Capacity Building activities.</td>
<td>- Proposal for a Community-based Dental Partnership Program submitted by the Loma Linda University School of Dentistry funded with CARE Act Part F monies was approved in the amount of $300,000 per year for three years.</td>
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<tr>
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<td>- The San Bernardino County Department of Public Health began to provide food and transportation for its clients.</td>
<td>- PC initiated development of a new comprehensive plan.</td>
<td>- Governor Davis signed AB 2197 (Koreta). This legislation establishes a pilot program to expand Medi-Cal benefits to low-income, non-disabled HIV positive patients.</td>
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<td>- Bienestar, Title I Grantee to conduct a variety of Capacity Building activities.</td>
<td>- The revised and updated SCSN was released.</td>
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<td>- A Comprehensive Needs Assessment was conducted throughout the EMA to determine the needs of PLWH.</td>
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<td>- The State began the process to review its 1998 SCSN with participation from EMA’s and Title II Consortia.</td>
<td>- Grantee standardized client satisfaction survey and analysis for RWCA providers in the EMA.</td>
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<td>- Two new services (Early Intervention Services and Emergency Financial Assist.) were added to the service categories.</td>
<td>- Bylaws Committee revised Planning Bylaws for approval by IEHPC.</td>
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<td>- The IEHPC and the African American Health Initiative presented a series of Mini Summits on Women and HIV Issues in May, for Youth in June and for African American men in July.</td>
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<td>- ARIES Project implementation Kick-off Architier Site Visit provided by the Grantee.</td>
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HRSA Project Officer conducted a site visit in EMA and made recommendations on Planning Council and Grantee roles and responsibilities and provided technical assistance on MAI Plan.

Loma Linda University Center for Health Research completed a resource inventory and needs assessment of current MAI providers and of potential providers and identified targeted areas for capacity development.

Grantee hired a full-time Q.M. Coordinator responsible for coordination of all quality management activities.

Contract Monitoring oversight and activities of RWCA Title I contracts were transferred from subcontractor Riverside County Department of Public Health to the Office of the Grantee in San Bernardino County.

PC Management and Support activities were transitioned from the Office of the Grantee to Riverside County Department of Public Health.

A Specialized Need Assessment was conducted to identify the needs of the Monolingual Spanish speaking community.

T.A. was provided to Grantee on developing and integrating QM program across the EMA.

Service Category SAFE-T-Net was created to get all PLWH out of care into HIV medical care.

HRSA Consultant provided training and technical assistance to EMA on a data driven Priority Setting and Resource Allocation process.

The first two-day Summit was presented for the Annual Priority Setting and Resource Allocation process designed to engage all PC members.

A Consumer Training was provided to IEHPC.

Rapid HIV Testing was implemented in Riverside County.

The San Bernardino County RWCA Title I Program and The National Minority AIDS Education and Training Center signed an MOU to provide capacity building assistance activities to MAI providers.

The EMA collaborated with the State and nine other EMA’s in California to develop and implement a methodology for estimating unmet needs.

A two day retreat was provided to Planning Council members.

Implementation of the shift from a Social Service Case Management Model to the Chronic Care Model system of care occurred.

Disaster preparedness planning was initiated.

Inland AIDS Project expanded the provision of Case Management services in Sun City, service area # 2 of Riverside County.

Riverside County Department of Public Health is the first county in Southern California to provide the Medical Marijuana Program to PLWH/A.
Chapter 4: Assessment of Need

Various data sources are utilized to assess need in the Riverside/San Bernardino EMA. In order to capture unmet needs and gaps in services that exist among PLWH/A, a comprehensive needs assessment was conducted in 2005 by the Inland Empire HIV Planning Council. Methodology consisted of consumer surveys, consumer focus groups, and provider surveys. In addition, utilization data were gathered by the Office of the Grantee in an effort to identify disparities in HIV medical care. The following chapter presents data on special need populations, service gaps and potential disparities in care in core services.

**PLWH in the EMA that are Underrepresented in the System of Care:** As part of the fiscal year FY 05/06 priority setting and resource allocation process, the Title I Grantee gathered service utilization information by demographic group and HIV/AIDS prevalence to identify disparities in care. When examining core services, the following disparities emerged based on the RWCA 04-05 Year-end Utilization report. This may signal service gaps.

1. **Ambulatory Outpatient Medical Care:** African Americans are utilizing only 10.8% of services, yet they represent 15.9% of PLWH/A; females are underutilizing services (11.4%) as compared to their representation among PLWH/A (13.5%); PLWH/A residing in Service Areas 4, 5, and 6 (San Bernardino County) are underrepresented among PLWH/A receiving RWCA-funded medical care.

2. **Pharmaceutical Assistance:** African Americans, Latinos, females, and PLWH/A who reside in Service Areas 1, 2, and 4 are underutilizing pharmaceutical assistance relative to their representation among PLWH/A.

3. **Case Management:** PLWH/A who are residents of Service Area 4 (West Valley San Bernardino County) are underutilizing case management services.

4. **Oral Health Services:** PLWH/A ages 25 to 44 years and PLWH/A who reside in Service Area 3 (East Riverside County) are underutilizing oral health services.

5. **Mental Health Services:** African American and Latino PLWH/A, and PLWH/A aged 25 to 44 years are underutilizing mental health services.

6. **Substance Abuse Services:** African American, Latino, female PLWH/A and PLWH/A ages 25-44 years or those who are residents of Service Area 4 are underutilizing substance abuse services relative to their representation.

**Level of Service Gaps in the EMA:** Although it is difficult to assess the level of service gaps, particularly due to multiple, non-RWCA-funded services (e.g. services funded by Medicaid), the clear underutilization of services by specific sub-groups mentioned above may suggest potential disparities. Most disturbing is the significant underutilization (i.e. ≥5%) of services as compared to representation among all PLWH/A of medical care services by African Americans and residents of San Bernardino County’s Service Areas 4 and 5. With primary medical care as the centerpiece of the EMA’s Chronic Care Model system of care, this potential gap needs to be examined more carefully to understand any contributing factors. Data gathered from the EMA’s early intervention services program (locally referred to as “SAFE-T Net”) and its Bridge Project will contribute to this analysis.
Across the other five core services, certain trends emerge. For the most part, African Americans and/or Latinos underutilize services. Females are significantly underutilizing some services, such as pharmaceutical assistance. This could be due to the fact that females may be more likely than males to be enrolled in Medicaid, of which a significant portion pays for drugs. In terms of age, PLWH/A ages 25-44 underutilize services the most. Lastly, PLWH/A who reside in San Bernardino County are more likely to underutilize services. This could point to potential service gaps as a result of the geographic expanse of the county.

**Assessment of Populations with Special Needs:** The Title I Grantee and the IEHPC engage in an ongoing process to assess service needs and gaps of current and emerging special needs populations. This process includes but is not limited to quantitative and qualitative data analysis of HIV and AIDS prevalence, service utilization, and consumer surveys and focus groups. In its *2005 Comprehensive Needs Assessment*, the EMA identifies six special needs populations:

1. Youth (aged 13-24 years)
2. Adult Women (aged 25 years and older)
3. Latinos/as
4. African Americans
5. Men who have sex with men (MSM)
6. Substance Users (injection and non-injection users)

The following narrative describes the unique challenges, service gaps, and estimated costs associated with delivering services for each population.

- **Youth (13-24 years of age)**

PLWH/A youth (13-24 years) comprise 6.5% of all PLWH/A in the EMA. Developmentally, youth are at a very different stage in their lives than adults. HIV positive youth may have a sense of invulnerability that “it” cannot happen to them. Youth require age-appropriate services, tailored to meet their specific needs. In the EMA’s *2005 Comprehensive Needs Assessment (CNA)*, youth identified medical care as their top service priority. They also included dental, emergency financial, housing assistance, home health, and case management among their service priorities. These priorities contrast with actual utilization of services. The top three services utilized by Youth include case management, food services, and dental care. As previously discussed, there is no current underutilization of services.

- **Adult Women (25 years of age and older)**

Females comprise a growing segment of the EMA’s PLWH/A; there are 874 PLWH/A who are female, representing 13.4% of the EMA’s total PLWH/A. Female respondents from the *2005 Consumer Survey* did not identify medical care as one of their top five priorities. Instead, they identified case management, dental care, food, housing, and transportation services as priorities. Female PLWH/A utilization of services reflects this pattern. Females are underrepresented in their utilization of medical care, pharmaceutical assistance, and substance abuse services.

Adult women face a host of challenges that are different from males. Pregnancy; potential perinatal HIV transmission; child care; domestic violence concerns; and legal issues related
to divorce, domestic violence, and immigration are only some of the unique issues facing women. In addition the medical management of HIV in women is different than that in men. Women who avoid the health care system and/or defer their own health care to ensure access to medical care for their children, can present additional medical conditions that impact access to and utilization of services. This is particularly true for women with dysplasia and other abnormal Pap results. The costs and complexity of care for women is different due to treatment needs related to cervical and other female-specific illnesses.

- **African Americans/Blacks**

African Americans are disproportionately impacted by HIV/AIDS (15.7% of PLWH vs. 8% of the general population). There are 1,026 African American PLWH/A in the EMA. Case management ranks as the top service priority for African American PLWH/A. This is followed by dental care, food, housing assistance, and transportation. These service priorities are reflected in the underutilization of four core services by African Americans noted earlier: ambulatory medical care, pharmacy assistance, mental health services and substance abuse services.

The EMA needs to gather additional information to determine whether or not the underutilization of core services is related to barriers to access. This underutilization will certainly negatively impact health care outcomes creating disparities in care. When asked about medical and case management provider sensitivity concerning race/ethnicity, 16% of African American consumer survey respondents voiced disagreement to a statement that providers were sensitive to their race/ethnicity. The EMA needs to continue its work with contracted service providers to implement its cultural competency guidelines that are expected to be completed in FY 2005.

As part of the EMA’s 2005 CNA, the IEHPC conducted three focus groups targeting African Americans to supplement the consumer survey information. Several issues unique to African Americans emerged. The 2005 CNA notes that African Americans participated in the health care system less than any other racial/ethnic group due to stigma and other cultural factors. This leads “to a higher rate of failed appointments, more treatment adherence issues, and unstable living conditions. African Americans also tend to enter the service delivery system late.” Interestingly, although focus group participants identified medical care as a key service need, 2005 Consumer Survey respondents did not rank medical care as one of their top five priorities.

Finally, ‘men on the down low’ generally refers to African American men who engage in male-to-male sexual contact but do not necessarily identify as gay or bisexual. The needs of this population have implications for both HIV prevention and care, as well as contribute to the growing number of HIV positive women in the EMA. This has critical implications for HIV care costs as some African American men may delay seeking treatment in order to hide their HIV status from family and female sexual partners. This may also be a contributing factor as to why African Americans enter the HIV care system later in their disease progression.

- **Latinos/Hispanics**

Latinos represent a growing number and proportion of the EMA’s population (about 42% of the general population) as well as their number of the EMA’s PLWH/A (1,464 Latino PLWH/A). HIV medical care, followed by dental care, food, and housing assistance are the
top service priorities for Latino PLWH/A. As noted earlier, Latinos are underutilizing three core services: pharmacy assistance, mental health services, and substance abuse services.

As with African Americans, the EMA needs to investigate further the cause for this underutilization, to determine if there are barriers to accessing services that will likely result in poorer health outcomes. When asked about provider (medical and case management providers) sensitivity concerning race/ethnicity, 14.5% of Latino respondents stated that they disagreed or strongly disagreed that providers were sensitive to their race/ethnicity.

The IEHPC also conducted a focus group targeting Latinos. Like African Americans, Latinos also tend to enter the care system late. Latinos also have a high rate of missed appointments and have a higher rate of issues related to treatment adherence. Focus group participants noted that transportation assistance is needed to facilitate access to all services, not just medical care. Other unique needs are related to immigration issues, language barriers for monolingual Spanish speaking individuals, issues related to stigma and discrimination, fear of disclosing one’s HIV status, and other cultural factors keep Latino PLWH/A from accessing care.

- Men who have sex with men (MSM)

The two modes of transmission categories of MSM and MSM/IDU together constitute 70.2% or 4,564, of all PLWH/A in the EMA. MSM prioritize HIV medical care as their top priority. This is followed by dental care, food, and case management services. This prioritization fairly well reflects utilization of services by MSM. The 2005 CNA notes that the top five utilized services by MSM are: HIV medical care, case management, food, pharmacy assistance, and dental care.

More than other populations, MSM are typically very well informed about the care system and, therefore, require less outreach in comparison to underrepresented populations. However, MSM tend to be more susceptible to depression and substance abuse, thereby requiring more access to mental health and substance abuse counseling and treatment services. The high rate of syphilis among MSM provides evidence of unsafe sexual practices that place other MSM at risk for HIV. Thus, continued ‘prevention for positive’ efforts targeting MSM are necessary to stem further transmission. MSM also must deal with stigma and discrimination related to their sexual orientation. Encouraging is the fact that only 10% of MSM respondents to the 2005 Consumer Survey noted that they ‘disagreed’ or ‘strongly disagreed’ with the statements that medical professionals and case managers are sensitive towards their sexual orientation. Also as noted earlier, the popular use of methamphetamines among MSM can contribute to unsafe sexual behavior as well as to added service delivery costs related to a highly addictive drug.

- Substance Users (injecting and non-injecting)

IDUs comprise 11.5%, or 748, of all PLWH/A in the EMA. IDUs represent only a portion of the total substance using population. The EMA includes both injecting and non-injecting substance users as a joint special needs population. Substance Users prioritize HIV medical care and food as their top service priorities. This priority is reflected in their utilization of services; the top three utilized services are HIV medical care, case management, and food.
Riverside and San Bernardino Counties are generally considered to be “methamphetamine drug production capitals” of the nation with more methamphetamine labs than any state in the nation except for Washington and Tennessee. Thus, the relative availability of methamphetamine combined with its lower cost makes this a serious concern within the EMA.

Several unique issues face substance users. First, like HIV, substance abuse and particularly injection drug use, carries its own stigma and discrimination. In addition, substance users are more likely than other populations to have co-morbidity related to hepatitis B and C, experience homelessness, or be dually-diagnosed with a mental disorder. When in active addiction, treatment adherence and making scheduled medical appointments can be challenging.

**Determining Unmet Need**

HRSA requires each EMA to estimate the level of unmet need in the EMA utilizing the “HRSA/HAB Unmet Need Framework.” Unmet need is defined as individuals who are living with HIV, are aware of their status, and are not receiving regular primary medical care. In 2004, the Riverside/San Bernardino, California, EMA participated in the statewide effort to estimate unmet need. A methodology was created by the California Department of Health, Office of AIDS, which combines data from Medi-Cal, AIDS Drug Assistance Program (ADAP), HIV/AIDS Reporting System (HARS), Veterans Affairs (VA), and Kaiser Permanente. Using this methodology, it was estimated that, of the 6,531 people estimated to be living with HIV/AIDS in the jurisdiction, as of December 31, 2004, 4,596 (or 70%) received HIV primary medical care during the specified time period, while 1,135 (or 28%) demonstrated unmet need for HIV primary medical care. Although the private insurance data could not be separated into distinct HIV and AIDS data, it is estimated from the public data that approximately 30% of those with AIDS had unmet need, and 33% of those with HIV (non-AIDS) had unmet need.

Chapter 5: Current Continuum of Care

FY 2005 marks a significant change in the EMA’s current Continuum of Care. Through extensive technical assistance and in response to recommendations from HRSA during FY 2005, the EMA will complete the transition from a social service case management model to a medical model of care based on the Chronic Care Model.

Within this system, HIV primary care and specialty services become the primary point of entry and include but are not limited to: county public health departments; mental health programs; local and regional hospitals (16 in Riverside County and 19 in San Bernardino County), including their emergency services departments; Health Maintenance Organizations and managed care plans (e.g. Kaiser Permanente, Health Net, and Medicaid Managed Care, [Inland Empire Health Plan, and Blue Cross]; various private and non-profit medical, family practice and special provider groups; Federally qualified health centers, and hemophilia diagnostic and treatment centers. In addition to these medical care avenues, PLWH/A can enter the continuum of care through HIV counseling and testing sites; early intervention services programs; substance abuse programs; detoxification programs; homeless centers; adult and juvenile detention facilities; prisons and jails. It is important to note that all Title I-funded physicians and nurses are required to be members of the American Academy of HIV Medicine and Association of Nurses in AIDS Care, respectively.

Mechanisms that Enable PLWH/A to Access and Remain in Primary Care: Helping PLWH/A gain access to and engage in medical care is the primary focus of the EMA’s HIV continuum of care. With this at the forefront, identifying gaps in service, individuals with unmet need, and potential disparities in access is integral to the Chronic Care Model. The Title I Grantee and the IEHPC have implemented several mechanisms across the continuum to enable PLWH/A to access and remain in primary care. These mechanisms include, but are not limited to:

1. Awarding contracts to primary care providers that ensures geographically accessible services across the EMA’s huge expanse;
2. Actively identifying and encouraging minority-serving organizations to apply for competitive funds;
3. Conducting a formal needs assessment, which includes consumer surveys and focus groups, to obtain input from underserved communities to identify specific service priorities and barriers to care;
4. Establishing Medical Care Client Advisory Groups for all Title-I funded medical care providers with appropriate African American and Latino representation;
5. Encouraging and supporting co-location of HIV counseling and testing at medical care provider sites;
6. Delivering early intervention services to target underserved communities, particularly African Americans, Latinos, and women;
7. Utilizing formalized linkage agreements between contracted service providers and county officials that establish the process for referrals and follow-up on referrals;
8. Implementing the ARIES MIS that will allow for tracking of unduplicated clients to identify those clients who “fall out of care” and follow-up with clients through case management; and

9. Collaborating with publicly funded-health systems in Riverside and San Bernardino Counties to develop a new system of health service delivery that reduces duplication of services and provides a single point of entry for clients.

Use of Title I and Minority AIDS Initiative Funds to Decrease Disparities: As part of the priority setting and resource allocation processes for FY 05/06, the IEHPC recommended that 100% of Minority AIDS Initiative (MAI) funding be utilized for ambulatory medical care services. This marked a significant change from previous years, but recognizes and supports primary medical care as the center of the system of care. The intent of the IEHPC was to have dedicated funding available for underserved communities of color, particularly African Americans and Latinos, within the EMA. The IEHPC determined that there was significant unmet need within these underserved populations and that focusing funding on specialized, culturally and linguistically appropriate primary medical care would help reduce health outcome disparities and increase access to care.

Additionally, the IEHPC has drafted general directives to the Title I Grantee to require that primary medical care providers have Medical Care Clinic Client Advisory Groups with both African American and Latino representation. They are also currently modifying cultural competency guidelines to further ensure that medical care and other primary care providers offer culturally sensitive and linguistically appropriate services. These efforts will help the EMA reduce barriers to care for African Americans and Latinos, thereby increasing access.

EMA’s Case Management System: In the Chronic Care Model, HIV ambulatory Medical care is the centerpiece of the HIV service delivery system. In this model, case management exists as a core service and support function to HIV medical care focused on increasing access to care. The role of the case manager is to work with the PLWH/A to identify and remove barriers to care, assist PLWH/A who know their status but are not in care in gaining access to care (i.e. unmet need), and to partner with the medical care provider to help PLWH/A obtain other needed core (e.g. dental care, mental health counseling, substance abuse counseling) and supportive services (e.g. transportation, housing) to ensure that PLWH/A remain in care. Case managers link newly affected and underserved PLWH/A to primary medical care and assure that they remain in care through screening, intake and assessment, development of individualized service plans, telephone contacts, face-to-face visits, case conferences, periodic reassessments, and crisis intervention.

Some case managers are co-located with HIV counseling and testing sites (at three service provider locations) and are able to work immediately with newly-identified HIV positive individuals to link them to care. Other case managers are co-located with the EMA’s early intervention services program, locally referred to as the Support Advocacy For Entry and Transition Program (SAFE-T Net), to link into care both newly identified HIV positive individuals and those PLWH/A who know their status but are not currently in care.

Lastly, case managers help to ensure that PLWH/A remain in care once they have entered into primary medical care. Proactively, case managers follow-up with clients on a regular basis to make sure that they do not miss their medical appointments as well as to identify and address any new barriers that may be limiting access to care. The EMA’s new web-based management information system (MIS), known as ARIES (AIDS Regional Information...
and Evaluation System) will facilitate tracking PLWH/A within the continuum of care. Through ARIES, the EMA will be able to track individuals who have left the EMA’s system of care. With this information, case managers will be able to target strategically their follow-up activities to those PLWH/A who have fallen out of care and work to get them back into care.

**Coordination of resources among other federal and local programs**

Currently the EMA receives Ryan White CARE Act (RWCA) funding from 5 sources:

1. Title I (including Minority AIDS Initiative) as an eligible EMA;
2. Title II funds through the State of California Office of AIDS;
3. Title III Early Intervention Services (San Bernardino County Health Department);
4. Title III Capacity Building (San Bernardino County Health Department); and
5. Title IV Part F (Community-based Dental Partnership) through the Loma Linda University School of Dentistry.

During the FY 2006 priority setting and resource allocation process, IEHPC members reviewed the data reports to inform their deliberations, particularly regarding resource allocations. For example, for the second year in a row, the IEHPC recommended that 100% of Minority AIDS Initiative (MAI) funds ($315,224) be utilized for ambulatory medical care services. The intent of the planning council is to increase access to culturally and linguistically appropriate primary care services and decrease disparities in health outcomes, particularly for African American and Latino PLWH/A. Also, through the priorities of the State of California Office of AIDS, the EMA utilizes 100% of Title II funding ($830,321) for HIV primary medical care. Since Primary Medical Care Services is the top ranking priority within the EMA, funding comes from multiple sources, including Title I, MAI, and Title II. The IEHPC members reviewed the level of total available resources when making final recommendations for use of Title I funds. The EMA’s Office of the RWCA Grantee is responsible for the administration of both Title I (including MAI) and Title II funds. This ensures coordination of funding to maximize accessibility and number of services available throughout the EMA.

The EMA directly receives a Title III: Early Intervention Services (EIS) award ($516,298). The EMA’s EIS program plays an integral part in helping to identify newly diagnosed HIV positive individuals, as well as those individuals who know their HIV status but are not in care (i.e. unmet need), and bring them into medical care. Through its EIS program, the EMA specifically targets underserved populations -- including African Americans, Latinos, and women -- where there may be barriers to accessing services that result in disparities in care. As a result, the IEHPC has internally designated EIS as the 7th “protected” service within the EMA. This status ensures greater funding stability should there be a decrease in Title I or other leveraged funds. Thus, Title I funds augment Title III funds available for EIS services. The Office of the RWCA Grantee works with the San Bernardino County Department of Public Health (Title III recipient) to coordinate and not duplicate EIS services within the EMA. A small portion of the EMA’s Title III funding supports a medical provider-based *Prevention for Positives Program*.

The IEHPC allocates only a very small amount of Title I funds for pharmaceutical assistance ($110,000 requested for FY 2006). ADAP is the primary source of funding for pharmaceuticals within the EMA, totaling $15,190,243. The ADAP program in California is generous and has relatively high-income thresholds – up to 400% federal poverty level. However, the IEHPC allocates a limited amount of Title I funds for pharmaceutical...
assistance for two purposes. First, as new PLWH/AIDS are enrolled into primary medical care, Title I-funded pharmaceutical assistance provides a bridge to ADAP, while ADAP-eligibility and enrollment occurs. Second, the ADAP formulary or that of other private health insurers does not cover 100% of possible prescribed HIV-related medications. Thus, Title I-funded pharmaceutical assistance serves as a “stop-gap” for the provision of medications not funded through other available resources.

Although the EMA does receive limited funding from Title IV Part F (Community-based Dental Partnership) the resource inventory indicates that these funds are used for training and not for direct oral health services to PLWH/AIDS. Thus, as the need for dental care has increased within the EMA, as evidenced by utilization trends and information from the EMA’s 2005 Comprehensive Needs Assessment, the IEHPC recommended a 70.5% increase in funding from $281,791 in FY 05 to $480,546 in FY 06 to this core service. This is an increase of $198,755.

Other Funding Sources for HIV/AIDS Services – Implications for Planning

For planning the comprehensive continuum of care, the IEHPC assesses available resources external to Title I funds, assesses the unmet need for services, and then identifies gaps. For the most part, Title I funds are prioritized to fill gaps in specific services or to target underserved populations (e.g. African Americans and Latinos). The EMA Resource and Capacity Inventory informs the IEHPC’s decision-making during the priority setting and resource allocation process. This inventory provides a map for both RWCA and non-RWCA funding available within the EMA. By incorporating available information on other-funded HIV/AIDS services into their priority setting and resource allocation decisions, the IEHPC is able to minimize and eliminate duplication of services and ensure that RWCA funds are utilized as the payer of last resort.

Having a thorough understanding of other funding sources’ eligibility requirements, what they pay for, what they do not pay for, assists the IEHPC in identifying gaps in care for specific populations. For example, Medicaid (i.e. Medi-Cal) and Medicare are the two largest public sources of funds for PLWH/AIDS in the U.S. and the EMA. However, both have very specific eligibility requirements based on income for Medi-Cal and based on age or permanent disability status for Medicare. Thus, if a PLWH/AIDS within the EMA does not meet eligibility requirements or is waiting enrollment, then Title I and other RWCA-funded services fill the gap. The Title I Grantee and IEHPC require and monitor providers to ensure that all clients are screened for Medi-Cal, Medicare, and other insurance eligibility prior to utilizing Title I funds for services.

The impact of implementation of Medicare Part D Prescription Drug Program, effective 1-1-06, is unknown at this time. During the FY 2006 priority setting, when considering allocating Title I funds for Home Health Services, the IEHPC took into consideration key pieces of information. First, the utilization and average cost per person was too high to warrant the use of funds for this service category. Also, in 2004, Medi-Cal covered $62,797 for home health services for HIV positive beneficiaries in the EMA. Recognizing that there are other sources of funding for home health services to ensure a continuity of service to PLWH/AIDS, the IEHPC recommended that the Title I resource allocation for home health services be reduced by $220,000 (45%).

Other publicly-funded medical care benefit programs in the EMA include the State Child Health Insurance and Healthy Families Programs in California, which targets “working poor” families with children and the Jerry L. Pettis Memorial Veterans Medical Center, which
provides inpatient and outpatient medical care and pharmacy assistance for veterans. Leveraging the SCHIP and Healthy Families programs are an additional vital resource in providing medical care services to the EMA’s 97 infants and children (ages 0-19 years). Although those eligible for Department of Veterans Affairs services primarily access primary care and pharmaceutical services through the EMA’s VA medical center, they do access other Title I-funded supportive services such as transportation and housing that are not provided by the VA.

Currently within the EMA, HOPWA funds support costs for housing and utility assistance; tenant-based rental assistance; housing acquisition and rehabilitation; and home health care. Other services for women, infants, children and youth include the Federal Supplemental Nutrition Education and Food Supplement Program.

The EMA receives SAMHSA funding to provide substance abuse counseling and treatment, primary medical care, and HIV antibody counseling and testing in drug treatment centers. Title I-funded case managers screen and enroll eligible clients for services and benefits with the California Education Development Department, Federal Supplemental Security Income, and Social Security Disability Insurance programs.

With its Advancing HIV Prevention initiative, the Centers for Disease Control and Prevention (CDC) place an increased emphasis on identifying new HIV positive individuals and linking them to care through HIV counseling and testing and preventing transmission of HIV by targeting HIV prevention programs to HIV positive individuals. The intent of the CDC’s Prevention for Positives efforts is to stem the epidemic at its source. Through partner counseling and referral services, the CDC hopes to encourage known partners of HIV positive individuals to seek HIV antibody testing. Finally, the CDC also recognizes that HIV positive individuals who are engaged in primary medical care are more likely to practice safer sexual and/or needle-sharing behaviors than those who are not linked to care. With this paradigm shift within the CDC, the gap between HIV prevention and care disappears as HIV prevention and care become complementary components of the comprehensive continuum of care.
Chapter 6: Resource Inventory

Distribution of Services
The Riverside/San Bernardino, CA Eligible Metropolitan Area covers 27,460 square miles and is geographically the largest EMA in the United States. The vast area and diverse terrain of the EMA present significant challenges to the provision of a seamless continuum of care. The EMA is comprised of two unique counties, Riverside County and San Bernardino County with six service areas (three in each county).

Despite this, the EMA has managed to develop a continuum of care accessible to persons living with HIV with service locations as far East as the Coachella Valley, Sun City in the South, Barstow in the North and Rancho Cucamonga in the west. Our reach provides access to both individuals living with HIV/AIDS in our urban and suburban areas as well as individuals living in remote and rural areas.

Table 6-1 is an inventory of service delivery by provider and services rendered. It also includes the amounts awarded by the Grantee for the current year (FY 05-06).

As of June 30, 2005, there were nine Ryan White CARE Act Title I providers, with a total of 20 service delivery sites throughout the two-county EMA that participated in a Provider Survey. These providers were: AIDS Healthcare Foundation (1 site), Bienestar Human Services, Inc. (1 site), Central City Lutheran Mission (1 site), Desert AIDS Project (2 sites), Inland AIDS Project (6 sites), Foothill AIDS Project (3 sites), Riverside County Department of Public Health (2 sites), SAC Health Systems (1 site) and San Bernardino County Department of Public Health (3 sites).

For a complete illustration of the distribution of services per service area in the Riverside/San Bernardino, California EMA, refer to the Resource Inventory Map on page 6-4. This map identifies the various services provided in the EMA, which sites provide bilingual staffing, and which sites provide support groups for hard-to-reach communities such as Monolingual Spanish-speaking clients, African Americans and women. A wide range of services is offered in most service areas with the exception of the Mid County of Riverside County (Service Area 2) which currently only offers case management services once a week. The Riverside County Department of Public Health is currently in its planning stages of offering Ambulatory Outpatient Medical Services in this service area as well.
## Table 6-1 Resource Inventory for FY 2005/2006

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<tr>
<th>Provider</th>
<th>County/Service Areas</th>
<th>Funding FY 05/06</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Healthcare Foundation</td>
<td>San Bernardino Service Area #4</td>
<td>$209,630</td>
<td>• Ambulatory/Outpatient Medical Care&lt;br&gt;• Ambulatory/Outpatient Medical Care (MAI)</td>
</tr>
<tr>
<td>Bienestar Human Services</td>
<td>San Bernardino Service Area #5</td>
<td>$149,021</td>
<td>• Case Management Services&lt;br&gt;• Early Intervention Services (SAFE-T-Net)&lt;br&gt;• Transportation Services</td>
</tr>
<tr>
<td>Central City Lutheran Mission</td>
<td>San Bernardino Service Area #5</td>
<td>$39,200</td>
<td>• Case Management Services</td>
</tr>
<tr>
<td>Desert AIDS Project</td>
<td>Riverside Service Area #3</td>
<td>$2,026,319</td>
<td>• Ambulatory/Outpatient Medical Care&lt;br&gt;• Ambulatory/Outpatient Medical Care (MAI)&lt;br&gt;• Local Drug Reimbursement&lt;br&gt;• Case Management Services&lt;br&gt;• Early Intervention Services (SAFE-T-Net)&lt;br&gt;• Food Services&lt;br&gt;• Mental Health Services&lt;br&gt;• Oral Health/Dental Care Services&lt;br&gt;• Substance Abuse Services&lt;br&gt;• Transportation&lt;br&gt;• Home Health Care&lt;br&gt;• Legal Services</td>
</tr>
<tr>
<td>Foothill AIDS Project</td>
<td>San Bernardino Service Areas 4, 5</td>
<td>$245,592</td>
<td>• Case Management Services&lt;br&gt;• Early Intervention Services (SAFE-T-Net)&lt;br&gt;• Food Services&lt;br&gt;• Mental Health Services&lt;br&gt;• Transportation Services</td>
</tr>
<tr>
<td>Inland AIDS Project</td>
<td>Riverside/ San Bernardino Counties Service Areas 1, 2, 5, &amp; 6</td>
<td>$1,369,126</td>
<td>• Case Management Services&lt;br&gt;• Early Intervention Services (SAFE-T-Net)&lt;br&gt;• Food Services&lt;br&gt;• Mental Health Services</td>
</tr>
<tr>
<td>Provider</td>
<td>County/Service Areas</td>
<td>Funding FY 05/06</td>
<td>Services Provided</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------</td>
<td>------------------</td>
<td>--------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Riverside County Dept of Public Health       | Riverside Service Area # 1        | $440,499         |  • Substance Abuse Services  
  • Transportation Services  
  • Home Health Care Services  
  • Legal Services |
| Riverside County Medically Indigent Services Program (MISP) | Riverside Service Area # 1    | $36,633          |  • Oral Health/Dental Care |
| Riverside County Regional Medical Center     | Riverside Service Area # 1        | $22,540          |  • Local Drug Reimbursement |
| Social Action Community Health Systems       | San Bernardino Service Area # 5   | $138,078         |  • Oral Health/Dental Care |
| San Bernardino County Dept. of Public Health | San Bernardino Service Areas 4, 5, & 6 | $584,405         |  • Ambulatory/Outpatient Medical Care  
  • Ambulatory/Outpatient Medical Care (MAI)  
  • Local Drug Reimbursement |
Red text indicates bilingual personnel are available.

* Support Groups for Monolingual Spanish Speaking Clients Available
+ Support Groups for African Americans Available
# Support Groups for Females Available
Fiscal Resources Available for PLWH in EMA

In spite of the cost of providing services which continues to increase, the HIV service delivery system has continued to experience deeper funding restrictions. To address this dilemma, the Inland Empire HIV Planning Council has developed a plan to maintain a core set of essential services that would be available to all eligible PLWH/A. That decision may result in the loss of significant support services on which many PLWH/A have come to rely. To sustain core services at this present level, the allocation of funds to these services must increase at the expense of funding for other programs. The Planning Council is currently dealing with difficult decisions concerning what services may no longer be funded using RWCA dollars in order to preserve core services.

A fiscal survey was e-mailed to all Ryan White CARE Act (RWCA) providers in the Riverside/San Bernardino, CA Eligible Metropolitan Area (EMA) to identify resources available for persons living with HIV. Program Years 2004 and 2005 were compared to identify variances between all sources of funding, both public and private, for various service categories. The following Table 6-2 and 6-3 are key findings based on the self-reported information provided by the RWCA providers in the EMA. Table 6-4 provides information on the availability of funds for services for PLWH/A.

Table 6-2 Decreases in Funding from Program Year 2004/05 to Program Year 2005/06

<table>
<thead>
<tr>
<th>Service</th>
<th>2004 Total</th>
<th>2005 Total</th>
<th>Variance</th>
<th>% Decreased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Care Services</td>
<td>$15,000</td>
<td>-0-</td>
<td>-$15,000</td>
<td>100%</td>
</tr>
<tr>
<td>Client/Peer Advocacy</td>
<td>$25,000</td>
<td>-0-</td>
<td>-$25,000</td>
<td>100%</td>
</tr>
<tr>
<td>Referral Hotline</td>
<td>$13,989</td>
<td>-0-</td>
<td>-$13,989</td>
<td>100%</td>
</tr>
<tr>
<td>Dental/Oral Health</td>
<td>$787,273</td>
<td>$611,014</td>
<td>-$176,259</td>
<td>22%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>$80,000</td>
<td>$67,254</td>
<td>-$12,746</td>
<td>16%</td>
</tr>
<tr>
<td>Local Drug Reimburse.</td>
<td>$158,886</td>
<td>$136,886</td>
<td>-$22,000</td>
<td>14%</td>
</tr>
<tr>
<td>Transportation</td>
<td>$403,000</td>
<td>$353,814</td>
<td>-$49,186</td>
<td>12%</td>
</tr>
<tr>
<td>Housing/Supportive</td>
<td>$2,154,645</td>
<td>$1,937,191</td>
<td>-$217,454</td>
<td>10%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>$519,071</td>
<td>$473,340</td>
<td>-$45,731</td>
<td>9%</td>
</tr>
<tr>
<td>Food Services</td>
<td>$387,500</td>
<td>$362,458</td>
<td>-$25,042</td>
<td>6%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>$737,699</td>
<td>$695,552</td>
<td>-$42,147</td>
<td>6%</td>
</tr>
</tbody>
</table>

Table 6-3 Increases in Funding from Program Year 2004/05 to Program Year 2005/06

<table>
<thead>
<tr>
<th>Service</th>
<th>2004 Total</th>
<th>2005 Total</th>
<th>Variance</th>
<th>% Increased</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFE-T-Net (EIS)</td>
<td>$296,527</td>
<td>$470,400</td>
<td>$173,873</td>
<td>59%</td>
</tr>
<tr>
<td>Prevention Services</td>
<td>$3,379,042</td>
<td>$4,120,612</td>
<td>$741,570</td>
<td>22%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>$405,878</td>
<td>$461,198</td>
<td>$55,320</td>
<td>14%</td>
</tr>
<tr>
<td>Case Management</td>
<td>$1,667,191</td>
<td>$1,871,019</td>
<td>$203,828</td>
<td>12%</td>
</tr>
<tr>
<td>HIV Medical Care</td>
<td>$3,912,142</td>
<td>$3,946,137</td>
<td>$33,995</td>
<td>1%</td>
</tr>
</tbody>
</table>
### Table 6-4: Availability of Other Public Funding

<table>
<thead>
<tr>
<th>Categories</th>
<th>Ryan White Title I</th>
<th>%</th>
<th>Other Federal Funds</th>
<th>%</th>
<th>State Funds</th>
<th>%</th>
<th>Local Funds</th>
<th>%</th>
<th>Total Funds</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory/Outpatient Medical Care</td>
<td>2,030,584</td>
<td>56.5%</td>
<td>1,346,619</td>
<td>13.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3,377,203</td>
<td>11.7%</td>
</tr>
<tr>
<td>State AIDS Drug Assistance Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15,190,243</td>
<td>100.0%</td>
<td></td>
<td></td>
<td>15,190,243</td>
<td>52.8%</td>
</tr>
<tr>
<td>Home/Community-Based Support Services</td>
<td>581,908</td>
<td>16.2%</td>
<td>315,998</td>
<td>3.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>897,906</td>
<td>3.1%</td>
</tr>
<tr>
<td>Other Outpatient/Community-based Primary Medical Care Services</td>
<td>983,000</td>
<td>27.3%</td>
<td>2,306,256</td>
<td>23.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3,289,256</td>
<td>11.4%</td>
</tr>
<tr>
<td>Inpatient Medical Care Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5,627,449</td>
<td>56.3%</td>
<td></td>
<td></td>
<td>5,627,449</td>
<td>19.5%</td>
</tr>
<tr>
<td>Prevention with Positives</td>
<td>403,808</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>403,808</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>TOTAL FUNDS</strong></td>
<td>3,595,492</td>
<td>100%</td>
<td>10,000,130</td>
<td>100%</td>
<td>15,190,243</td>
<td>100%</td>
<td></td>
<td></td>
<td>28,785,865</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Riverside/San Bernardino, California EMA 2006 Title I HRSA Grant Application
Chapter 7: Profile of RWCA Providers

Provider Profile and Client Data
Collecting information from the provider’s point of view is an important part of a comprehensive needs assessment. Provider surveys were conducted in 2005 with providers who receive Ryan White CARE Act funding.

Part B of the Provider survey addressed the following: descriptive data about the providers, information on who the providers served; what services are provided; the provider’s perception and ideas on how service provision could be improved; transportation accessibility; barriers to services; capacity to increase units of service with existing funding; interagency collaboration and cooperation; and ways in which the IEHPC and Office of the Grantee can assist in improving collaboration and cooperation at each service delivery site throughout the EMA’s six service areas.

Table 7-1 Number of HIV Clients Served

<table>
<thead>
<tr>
<th>Estimated HIV+ Client Population</th>
<th>% HIV+ Population treated in all provider sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>7,364</td>
<td>65.8%</td>
</tr>
</tbody>
</table>

Table 7-2 Number of Monolingual Spanish Speaking HIV Positive Clients Served

<table>
<thead>
<tr>
<th>Estimated HIV+ clients served on a yearly basis are Monolingual Spanish Speaking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated HIV+ Monolingual Population</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>7,364</td>
</tr>
</tbody>
</table>

A variety of support services is provided at 70% of the Title I service delivery sites that are not Ryan White CARE Act funded to non-HIV clients (such as partners, children and other family members). These support services include: case management, co-dependent couples counseling, substance abuse, bereavement counseling, HIV negative support group, testing for syphilis and HIV, testing and family counseling, education to partners/family members as needed, family gatherings; Back to School Picnic, Christmas Party, Easter Party; family therapy, child therapy, couples therapy; health education and prevention for family members; dental services; prevention education, HIV counseling and testing, substance abuse prevention and HIV education, housing for family members of HIV+ clients, substance abuse counseling for family members of the HIV+ clients, and other counseling services.

HIV Education and Prevention services are provided at 80% of the RWCA funded sites in the EMA. Interventions provided include: Outreach (Targeted Prevention), Prevention Case Management, Individual Intervention, Group Level Intervention, Health Education Sessions, Prevention for Positives Group Sessions, Health Communications/Public Information, and the Peer Training Program.

Provider Capacity and Capability
Sixty percent of the RWCA funded sites reported they do not have the capacity to offer additional units of service with existing funding. Reasons provided varied, but most indicated the need for additional funding to expand staffing and hours of operation.

Fifteen percent of service delivery sites have plans to decrease services or hours. Food services will be decreased due to cuts in RWCA Title I funding. Some of the mental health support groups and substance abuse groups have also been cancelled due to diminished funding for these services.

Accessibility

<table>
<thead>
<tr>
<th>Table 7-3  Number of Service Delivery Sites Accessible to Public Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is your Service Delivery site accessible to public transportation?</strong></td>
</tr>
<tr>
<td>Yes = 20</td>
</tr>
<tr>
<td>No = 0</td>
</tr>
<tr>
<td>No Response = 0</td>
</tr>
</tbody>
</table>

All sites are in proximity to some type of public transportation and all indicate they are within 0 to 5 miles from the nearest bus stop.

<table>
<thead>
<tr>
<th>Table 7-4  Distance from Service Delivery Site to Bus Stop</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How far is the bus stop from your Service Delivery Site?</strong></td>
</tr>
<tr>
<td>0 to 5 miles</td>
</tr>
<tr>
<td>#</td>
</tr>
<tr>
<td>n=20</td>
</tr>
</tbody>
</table>

Sites are also in close proximity to a freeway/highway; 55% indicate they are located within 0 to 5 miles and 45% indicate anywhere from 6 to 10 miles.

<table>
<thead>
<tr>
<th>Table 7-5  Distance from Service Delivery Site to Closest Freeway/Highway</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How far is the closest freeway/highway exit from your Service Delivery Site?</strong></td>
</tr>
<tr>
<td>0 to 5 miles</td>
</tr>
<tr>
<td>#</td>
</tr>
<tr>
<td>n=11</td>
</tr>
</tbody>
</table>

Although accessibility to sites looks favorable, this survey did not capture the lack of resources for bus vouchers or gas cards for clients. Even though all sites are within five miles or less to a bus stop, many clients take multiple buses for a lengthy period of time to arrive at sites. This is especially true of Service Areas 2 and 6 which are the Mid County of Riverside County and High Desert of San Bernardino County, respectively, where transportation is very limited. It is important to note that RWCA Title I transportation funds were also cut this program year, reducing this service for clients in the EMA.
Collaboration

Table 7-6  Number of Service Delivery Sites That Have Formal Agreements with Collaborators

<table>
<thead>
<tr>
<th>(6a) Does your agency have any HIV specific verbal agreements etc., with other agencies?</th>
<th>95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes = 19</td>
<td>95%</td>
</tr>
<tr>
<td>No = 1</td>
<td>5%</td>
</tr>
</tbody>
</table>

Ninety-five percent of sites have formal agreements, commitment letters, MOU’s, or verbal agreements with other agencies in order to maximize resources and coordinate services for PLWH in the EMA.

Thirteen of the sites are collaborating and coordinating services with other providers not in the RWCA system of care. Some of the providers that are in the Continuum of Care for PLWH in the EMA are:

- Catholic Charities, Hospice and Loma Linda University
- Private Physicians
- Visiting Nurse Association (VNA), Hospice of the Valley, Salvation Army, Western Eagle
- Home Health Organizations, AIDS Assistance Program, FISH, Inland AIDS Project, Desert Regional Medical Center, Eisenhower Medical Center, JFK Hospital; Riverside County Dept. of Mental Health, Riverside County DPSS, Desert Regional Pharmacy, the Rancho Recovery Center, US Department of Veterans Affairs, and private physicians, therapists and optometrists.
- Several Recovery Centers – American Recovery, Olive Vista
- River Community, Sober Living Facilities, Inland Valley Drug and Alcohol Recovery Services, Sierra Vista; Housing Authority of San Bernardino; Project Angel Food; Pomona Valley Hospital; Indian Valley Infectious Diseases; HIV/AIDS Legal Services Agency; Behavioral Health
- Minority AIDS Project
- Loma Linda University School of Dentistry
- In-Home Supportive Services; Social Security Administration, State Office of AIDS
- Lutheran Mission
- California State University San Bernardino
- St. John of God (Drug Rehab); High Desert Homeless Shelter; Samaritan Helping Hands; Desert Mana

Table 7-7  Number of Service Delivery Sites That Actively Follow-Up with Referrals

<table>
<thead>
<tr>
<th>Does your site actively follow-up and track outcomes of referrals with these agencies?</th>
<th>55%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes = 11</td>
<td>55%</td>
</tr>
<tr>
<td>No = 8</td>
<td>40%</td>
</tr>
<tr>
<td>No Response = 1</td>
<td>5%</td>
</tr>
</tbody>
</table>

The majority (55%) of sites do follow-up and track outcomes of referrals with the agencies they are in collaboration with.

Improve Service Coordination

When asked what could be done to improve service coordination and collaboration among providers to expand and improve services to PLWH, many of the providers felt that a centralized database (such as the ARIES Management Information System that is currently being implemented EMA-wide), consistent quarterly provider network meetings, and other trainings for providers would improve coordination and collaboration.
The following is a list of suggestions for both the IEHPC and the Office of the Grantee to assist agencies to better coordinate services with other providers at their respective delivery sites:

Table 7-8 Suggestions on how IEHPC and RWCA Grantee can Assist Providers

<table>
<thead>
<tr>
<th>Grantee</th>
<th>IEHPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Technical assistance to enhance programs and services targeting monolingual Spanish-speaking, youth and women.</td>
<td>• Increase visibility of the Planning Council and Grantee at this service area.</td>
</tr>
<tr>
<td>• Increase visibility of the Planning Council and Grantee at this service area.</td>
<td>• Increase the role of HIV providers to improve the quality of HIV Care.</td>
</tr>
<tr>
<td>• Negotiate agency-to-agency MOU’s for all Title I services.</td>
<td>• Support the necessary changes to improve collaboration among HIV providers and other service providers.</td>
</tr>
<tr>
<td>• Improve data management technology.</td>
<td>• Support implementation of quality initiatives in HIV Programs.</td>
</tr>
<tr>
<td>• Restructure Provider Network Meetings</td>
<td>• Improve comprehensiveness of services available.</td>
</tr>
<tr>
<td>• Provide training to other HIV Agencies in collaboration and coordination of services.</td>
<td>• Make decisions that reflect the needs of persons infected with HIV especially from minority communities.</td>
</tr>
<tr>
<td>• Facilitate communication with other service providers about patients.</td>
<td>• Improve response to changes in the epidemic.</td>
</tr>
<tr>
<td>• Usage of standardized forms for HIV services for all providers.</td>
<td>• Restructure Committees to more useful ones.</td>
</tr>
<tr>
<td>• Increase the pool of funding</td>
<td>• Understand that the client’s individual dental needs require a comprehensive treatment plan which cannot be attained successfully with the cap in place for dental services.</td>
</tr>
<tr>
<td>• Encourage more collaboration between agencies on a regular basis and keep agencies aware of changes to existing services and of all available services.</td>
<td>• Providing information on the IEHPC website in Spanish.</td>
</tr>
<tr>
<td>• Facilitate staff training on cultural, linguistic, diversity and sensitivity at collaborating provider’s sites.</td>
<td></td>
</tr>
<tr>
<td>• A comprehensive resource guide with names of specific contact persons would be very helpful.</td>
<td></td>
</tr>
<tr>
<td>• Increase funding for service delivery sites to improve used office equipment and furniture.</td>
<td></td>
</tr>
<tr>
<td>• Provide technical assistance for collaboration with other providers.</td>
<td></td>
</tr>
<tr>
<td>• Provide training to private medical providers for sensitivity towards HIV+ community.</td>
<td></td>
</tr>
</tbody>
</table>

Table 7-9 Number of Service Delivery Sites With Waiting List for Services

<table>
<thead>
<tr>
<th>Do you currently have a waiting list for HIV-related services at this Service delivery Site?</th>
<th>30% of service delivery sites have waiting lists for food services, housing services, case management services, bus tickets and the residential care facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes = 6</td>
<td>30%</td>
</tr>
<tr>
<td>No = 14</td>
<td>70%</td>
</tr>
</tbody>
</table>

RWCA Title I food services were cut this program year, and no RWCA Title I funds were allocated for housing services.
Table 7-10 Listing of Services with Current Waiting List by Service Areas

<table>
<thead>
<tr>
<th>Services with a Waiting List</th>
<th>Number of People on waiting list</th>
<th>Expected time of wait</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Vouchers</td>
<td>200</td>
<td>2 weeks</td>
<td>Service Area 1</td>
</tr>
<tr>
<td>Case Management</td>
<td>5</td>
<td>15 days</td>
<td>Service Area 1</td>
</tr>
<tr>
<td>Food Services</td>
<td>40</td>
<td>30 days</td>
<td>Service Area 4</td>
</tr>
<tr>
<td>Food Services</td>
<td>35</td>
<td>1 Month</td>
<td>Service Area 5</td>
</tr>
<tr>
<td>Bus Tickets</td>
<td>35</td>
<td>1 Month</td>
<td>Service Area 5</td>
</tr>
<tr>
<td>Housing</td>
<td>6</td>
<td>2 weeks</td>
<td>Service Area 5</td>
</tr>
<tr>
<td>Case Management</td>
<td>5</td>
<td>15 days</td>
<td>Service Area 5</td>
</tr>
<tr>
<td>Food Services</td>
<td>40</td>
<td>30 days</td>
<td>Service Area 5</td>
</tr>
<tr>
<td>Adult Residential Facility</td>
<td>6</td>
<td>90-180 days</td>
<td>Service Area 6</td>
</tr>
</tbody>
</table>

For more detailed information on provider survey results, please refer to the Inland Empire HIV Planning Council 2005 Comprehensive Needs Assessment Report.
Chapter 8:  Barriers to Care

The following chapter provides information on factors that deter clients from care and other barriers that may affect the quality and availability of care. It also provides client and provider perspectives on identified barriers that exist for PLWH/A in the EMA.

Homelessness: According to combined data from the San Bernardino County 2003 Homeless Census & Survey and the County of Riverside 2004 Homeless Census Project, the mid-point rate of homelessness in the EMA is approximately 334 per 100,000 on any given day. Nearly one-third of homeless individuals use or have used various forms of illicit drugs. Twenty percent (20%) indicated that they had been diagnosed with depression and almost 10% with other mental illnesses. Another 27% indicated that at some point in the previous year they were in need of health care, but did not receive it.

Approximately 8.7% of PLWH/A respondents to the 2005 Consumer Survey reported that they had been homeless for more than seven days within the past 12 months; 78% of whom were substance users. Another 6.5% of PLWH/A reported that they had been homeless for less than seven days within the past 12 months; 60.8% were substance users. From this data, the estimated rate of homelessness for PLWH/A within the EMA is 15,000 per 100,000 population, significantly higher than in the general EMA population.

Homelessness contributes to deteriorating health and compromised nutritional status. Many homeless PLWH/A lack transportation, apartment-hunting skills, and have poor credit histories that hinder their ability to obtain suitable housing. This population is hard-to-reach and difficult to engage in primary medical care, particularly those with substance abuse and/or mental health problems. Homeless PLWH/A require significant outreach and case management services to address their needs, including advocacy and follow-up.

Lack of Insurance: The UCLA Center for Health Policy reports that approximately 16% of residents in San Bernardino County and 16.5% of residents in Riverside County lacked health insurance in 2001. This dramatically increased to 22.7% (San Bernardino County) and 24.8% (Riverside County) in 2003. This translates to an uninsured rate of 16,000 per 100,000 population. Based upon self-reported insurance status, only 9.7% of PLWH/A responding to the 2005 consumer survey reported that they had no health insurance (rate of 10,000 per 100,000). This significant difference between the EMA’s general population and PLWH/A may be largely due to the success of providers in screening PLWH/A for Medicaid eligibility (Medi-Cal in California) and other 3rd party payers as a required component of service delivery within the EMA, ensuring that Title I funds are used as payer of last resort.

PLWH/A who lack insurance may defer care. When any care is deferred, the cost and complexity of treatment increases because PLWH/A are often further along the HIV disease continuum. Because they require more intensive and frequent treatment at an estimated cost of $136-$150 per visit (EMA service cost analysis FY 04), this increases Title I costs. When compared to the average cost per ordinary primary medical visit funded by Medi-Cal, at $153 per visit (2004 CA State MediCal Report), the EMA’s care infrastructure continues to provide primary medical and HIV specialty care at a competitive rate. This increases the EMA’s potential to reach the greatest number of clients and provide needed specialized care.

Poverty: According to the Advanced American Community Survey Profile 2004 of the U.S. Census, approximately 14.7% of residents in San Bernardino County and 14.2% in
Riverside County live at or below 100% of the federal poverty level (FPL). This compares to 13.3% of Californians and 13.1% of Americans living in poverty. The 2005 Consumer Survey found that 35% of PLWH respondents were living at or below 100% FPL. Within the general EMA population, the rate per 100,000 population of individuals living at or below 300% of the FPL is 53,000 per 100,000. This escalates to 81,000 per 100,000 population for PLWH/A within the EMA. In addition, the median household income for the general population in the EMA is $47,497. The median annual income for 69% of 2005 Consumer Survey PLWH/A respondents was $9,720.

The 2005 Consumer Survey reveals a higher rate of poverty among African American, Adult Women, Youth, and Substance User respondents. For each sub-population, more than 80% of respondents lived at or below 200% of the FPL. Poverty impacts the cost and complexity of service delivery in several ways. First, the very poor frequently defer primary medical care until they are seriously ill often due to fear of denial of service and financial uncertainty. As their HIV disease progresses, in the absence of care, the cost for medication and laboratory support increases as does the complexity of their primary medical management, case management, and other needed primary care and support services.

**Substance Use:** The rate of injection drug use is 34 times greater in a PLWH/A and the rate of other (non-injecting) drug use is nearly three times higher among PLWH/A than the general population.

The rise in methamphetamine use is becoming a hot topic across the country both in the popular media as well as in the substance abuse and HIV literature. In January 2005, the Los Angeles Times headline reads: “Gays’ Rising Meth Use Tied to New HIV Cases.” The Kaiser Family Foundation Reports in July 2005, “Crystal Meth Use Fuels Rise in HIV Cases Among White MSM.” Finally, the August 8, 2005 cover of Newsweek magazine reads, “The Meth Epidemic: Inside America’s New Drug Crisis.”

Crystal methamphetamine is inexpensive to produce and is quickly becoming the drug of choice across all socio-economic groups. Although methamphetamine use has become rampant among MSM, it is quickly spreading among all populations.

Fueling this local methamphetamine epidemic, San Bernardino and Riverside Counties have among the highest number of methamphetamine laboratories in the nation, according to the Inland Narcotics Clearing House’s 2002 Hammer Report. The rate of methamphetamine use in the general population of the EMA is twice that of California, 32% and 16% respectively.

About 17.4% of the 2005 Consumer Survey respondents self-reported having used illicit substances other than injection drugs in the past 12 months. Ten percent (10%) reported that they had used alcohol (>2 drinks per day) in the past 12 months. Providing primary medical care and other support services to this population can be challenging. Individuals in active addiction may find adherence to treatment regimens difficult, requiring more frequent follow-up. As noted earlier, substance users are more likely to experience homelessness than other populations. As such, they are likely to require additional resources, such as food, housing assistance, transportation, referral for treatment, and some may be multiply-diagnosed with other mental health disorders, further escalating the complexity and cost of care. According to Healthy People 2010, “Substance abuse and its related problems are among society’s most pervasive health and social concerns.” Each year, about 100,000 deaths in the United States are related to alcohol consumption.
Chronic Mental Illness: The prevalence of chronic mental illness in the EMA’s general population is 3,310 per 100,000 population compared to 42,500 among PLWH/A. This represents a PLWH/A rate that is nearly 13 times greater than in the general population. Chronic mental illness may include depression, schizophrenia, bipolar or other disorder. Many PLWH/A with mental illness may find HIV treatment adherence challenging and have difficulty accessing medical and support services. Chronic mental illness among PLWH requires more costly and complex types of assistance due to their challenges in processing information, keeping appointments, and completing paperwork necessary to obtain benefits. The need for psychotropic drugs, as well as additional staff time required to help PLWH/A manage treatment regimens contribute to the increased costs to serve this population.

Unique Service Delivery Challenges
Over the past three years, the EMA has had to provide the same or increased level of quality services in the face of consecutive Title I funding cuts (totaling 16.7%), while during the same period, experiencing a 30.1% increase in AIDS prevalence. The Title I Grantee and the IEHPC have worked closely with HRSA’s HAB Technical Assistance team to develop a streamlined approach to service delivery, adopt the Chronic Care Model, and improve its management information systems in order to maximize efficiencies in the system of care delivery. By the end of FY 2005, all of these efforts are expected to be fully in place. It will be difficult for the EMA to sustain further cuts in funding while being expected to provide the same or higher level of care. An analysis completed by the Communities Advocating Emergency AIDS Relief (CAEAR) Coalition of Title I Awards and funds per capita revealed that the Riverside/San Bernardino EMA has the lowest allocation per PLWH/A among all EMAs in California. Although the EMA’s unmet need is estimated to be 1,935 individuals, without additional resources, the EMA has little financial capacity to provide for the care of these individuals. Applying the estimated annual average cost of care for adults ($18,896) based upon average 2004 Medi-Cal PLWH/A expenditures, the EMA would require an additional $36.6 million of additional or leveraged resources to bring this population into the care system.

As noted earlier, the huge geographic expanse of this EMA creates real challenges to service delivery. Although large concentrations of PLWH/A reside in specific urban areas, some PLWH/A are remotely located in more rural, desert regions of the EMA. Ensuring access to all needed services across this expanse, with its intervening mountain ranges, is difficult. Continued collection of service utilization data by service area, as well as geographic allocation of resources is essential for increasing access. Finally, the exponential population growth, including an ever-increasing number of undocumented immigrants, in the EMA will continue to strain public resources. The need for language appropriate and culturally competent services will increase accordingly. Concurrently, increasing housing and rental costs have an impact on an individual’s income. The EMA anticipates that over time, an increasing proportion of the general population will be living at or below the federal poverty level (FPL), certainly within 300% of the FPL.

In addition to the existing service delivery challenges the EMA is facing, the EMA may be called upon to provide services to PLWHA who may have been displaced by Hurricane Katrina. Acknowledging the importance of this need, the Planning Council and the Grantee have given providers relevant directives and the EMA will maintain documentation in the event that the expenditures incurred by the EMA may be reimbursed. Initial reports indicate that approximately 400 evacuees are moving into the EMA. It is reasonable to assume that the PLWH/A included would be eligible for Title I services and require extensive support.
Barriers to Services
In the 2005 Comprehensive Needs Assessment RWCA providers completed a two-part Resource Inventory survey. One of the questions presented to providers was what they identified as barriers for their clients to access services at their service delivery sites. Many of the providers had multiple sites throughout the two county EMA. Each site were unique in terms of geography, rural vs. urban. Figure 8-1 is the result of the barriers as identified by providers. The top three barriers identified by providers for clients accessing services at their sites were: lack of transportation, lack of provider resources, and homelessness and poverty.

Figure 8-1  Barriers to Services as Identified by Providers

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<td>Transportation</td>
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<td>Poor communication or coordination</td>
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<td>Lack of nutritious food</td>
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<td>Stigma</td>
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<td>Food services</td>
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<td>No direct phone line</td>
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<td>Employment</td>
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<td>Language</td>
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<td>Staff travel requirements</td>
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Consumer Surveys: Top 10 reasons PLWH identified for not receiving care

In the consumer surveys there were many reasons given why individuals were not in care. Figure 8-2 identifies these reasons by consumers not currently receiving primary HIV medical care. None of these categories were mutually exclusive, thus individuals were permitted to mark any and all reasons they were not receiving care.
Key findings:

- Stigma of living with HIV/AIDS still appears to be the greatest influence restricting PLWH from seeking HIV medical care. This assumption is made from the 22.9% who mentioned fear that HIV/AIDS would be known, as well as the 17.1% who said that they do not want to deal with their HIV/AIDS.

- Among the other choices for barriers, no other barrier was selected more than 6% of the time. Both “experienced side effects from meds” and “went to jail or prison” received 5.7%. The remaining choices all were selected less than 3% of the time and were “fear that sexual preference would be known”, “worried about eligibility”, “unhappy with the medical staff” or “did not have a reason”. Additional issues not indicated as keeping individuals from care were their “visual impairment”, “hearing impairment”, “distrust of the medical staff”, “lack of child care”, or “feeling of discrimination”.

Consumer Focus Groups: Common Themes Identified

When focus group participants were asked why they thought people who are living with HIV are not receiving medical care, many of the participants indicated that their particular community was scared, and they didn’t want to be identified as having HIV or being gay. Also, being labeled if they are HIV positive, the shame of being HIV, side effects of meds, and denial. This information confirms data from the consumer surveys.
SECTION TWO
WHERE DO WE NEED TO GO: WHAT SYSTEM OF CARE DO WE WANT?

Chapter 9: Continuum of Care for High Quality Core Services

Mission, Vision, Guiding Principles and Shared Values
The following Mission, Vision, Guiding Principles and Shared Values were adapted from the statements, principles, used in the comprehensive HIV services plan developed in 1998. They were subsequently reviewed and revised with relatively minor modification in 2002. In early CY 2005, the Mission, Vision, Principles and Values were reviewed by the following Planning Council groups: Empowerment Committee and Community Access Subcommittee; Planning Committee and Subcommittees; Quality Management and Subcommittees; Council Development Committee and Executive Committee. The Planning Council had initially reviewed proposed changes at its January 2005 meeting and adopted them at the April Planning Council meeting. A 30-day review and comment period for the draft 2006-2009 Comprehensive HIV Services Plan will provide consumers and members of the general public another opportunity to offer their comments and propose additional changes.

Mission Statement
To maintain the optimum health of all those living with HIV/AIDS in Riverside and San Bernardino Counties through the development and implementation of a comprehensive, consumer-centered continuum of care.

Vision Statement
There is a stable funding base to support the full continuum of HIV-related medical care and support services within the Riverside/San Bernardino, California EMA. There are no significant gaps in service. Services are available regardless of the ability to pay and are consumer centered, user friendly, culturally competent, well publicized and geographically accessible. These accomplishments will be achieved through strong public/private partnerships, and will enhance the quality of life and sense of well being among people living with HIV/AIDS in the EMA. There is no stigma associated with HIV/AIDS.

Guiding Principles and Shared Values
The Inland Empire HIV Planning Council members want to continually keep consumers in the forefront of everyone’s minds. Therefore, the Guiding Principles developed by the Planning Council stress a consumer-centered continuum of care.

Guiding Principles
To improve health outcomes:
- There is a concerted effort to identify, bring into, and maintain in care all persons living with HIV/AIDS who may or may not know their status.
- Consumers are to be treated with dignity, compassion and respect.
- There must be reliable and easily accessible information about treatment, service options and resources.
- There must be streamlined, equitable access to a comprehensive system of quality services.
The system will be driven by consumers and advocate for consumer needs.
Care systems will be revised to meet emerging needs.
Consumers must receive help with needs that extend beyond those that are specifically HIV-related.
Services will be structured to encourage consumers to share in the responsibility for their health care.
There must be outreach to those least able to access care.
Consumers must be afforded the opportunity to contribute to the planning and delivery of services.
CARE Act funds will be the funds of last resort.
The impact of CARE Act funds must be evaluated and improvements to quality of service made as needed.

**Shared Values**
The shared values are divided into five categories: 1) How services are provided, 2) Where services are provided, 3) What services are provided, 4) For whom services are provided, and 5) By whom services are provided.

**How Services Provided**
- Preserves clients’ right to confidentiality
- Compassionate, dignified, respectful, empowering
- Cost-effective
- High quality
- Equitable
- Culturally and linguistically competent
- Holistic
- Timely
- Logical
- According to established standards
- Safe, supportive and barrier free environment
- Consumer centered

**Where Services Provided**
- Accessible from all geographic areas
- Facilitate access with improved transportation and emerging communications technology
- Information on where services are provided should be available using multiple modalities
- Services are located in areas of greatest need

**What Services Provided**
- Services that prolong and enhance quality of life
- Services that reduce spread of HIV
- Services that promote maximizing health

**For Whom Services Provided**
- People infected and affected by HIV/AIDS in our community

**By Whom**
- Qualified providers
- Providers who are representative of the communities they serve
• By a balance of public sector organizations and Community-Based Organizations (CBOs):
  • Services will be coordinated with other health-care and social service delivery systems

**How the Plan will provide increased access to the HIV continuum of care.**

The EMA has received extensive technical assistance from the HRSA's HIV AIDS Bureau (HAB) to increase access to and improve the coordination of services along the EMA's HIV/AIDS continuum of care as seen in Figure 9-1. The IEHPC is committed to creating a system of care that is client-centered and responsive to those clients identified as having the most severe needs such as African Americans, Hispanics, MSM, Youth, Adult Women, and Substance Users. To best address unmet need, strong linkages exist between outreach programs, HIV counseling and testing sites, other entry points, and support service providers, and the EMA’s early intervention services program (locally referred to as “SAFE-T-Net”). SAFE-T-Net targets PLWH/A with unmet need (i.e. who know their HIV status, but are not in care).

**Figure 9-1  Riverside/San Bernardino, CA EMA HIV/AIDS Continuum of Care**

As part of the IEHPC’s community planning process they established seven “protected” core services during the **Priority Setting & Resource Allocation Summit 2005**. These include in IEHPC Priority order: (1) Ambulatory Medical care, (2) Pharmaceutical assistance (i.e. HIV related medications), (3) Case management, (4) Oral health, (5) Mental health services, (6) Substance abuse services, and (7) early intervention services (locally referred to as SAFE-T-Net).

The first six services reflect the six core services recommended. These six services are addressed in the FY 2006 Implementation Plan (Chapter 10, Section A). Within each implementation plan objective, the EMA includes numbers targeting “new” clients to be served in addition to “current” clients. The purpose is to increase access to services thereby beginning to address the EMA’s unmet need (i.e. PLWH who know their status but are not engaged in regular HIV primary care). The IEHPC included SAFE-T-Net as a protected...
Ambulatory Medical Care: Ambulatory Medical and HIV specialty care are central to the EMA’s comprehensive continuum of care and FY 2006 Implementation Plan. Since adopting the Chronic Care Model of disease management, the EMA strongly encourages that HIV positive clients be in medical care (either in the RWCA system or externally). Other RWCA-funded support services such as, transportation, and food, among others exist to help PLWH/A to access and remain in primary medical care.

Pharmaceutical Assistance: It is well documented that the role of Highly Active Antiretroviral Therapy (HAART) is improving health outcomes for PLWH/A. Title I-funded pharmaceutical assistance provides a stop-gap for EMA eligible PLWH/A prior to enrollment in ADAP. It is also used to provide assistance to PLWH who are not eligible for other drug assistance programs. Lastly, it helps pay for prescribed medications that are not on the formulary of a specific insurance (e.g. ADAP, Medi-Cal, Part D – Medicare’s prescription drug program or other private insurance).

Case Management (Chronic Care Model): Through HRSA’s technical assistance, the EMA has embarked on a process to transition from a social case management model to a medical management model of case management (i.e. Chronic Care Model). This transition will be completed in FY 2005. The FY 2006 Implementation Plan therefore reflects a fully transitioned EMA. The primary difference in approach is that the Social Case Management Model provides services based upon a plan of care (locally known as an Individualized Service Plan-ISP), while in the Chronic Care Model, the medical professional determines the appropriate level of case management. As noted earlier, this places ambulatory primary medical care at the hub of the service system. Enrollment in medical care (RWCA-funded or other funded) is strongly encouraged. Other Title I-funded core and support services are available to maintain PLWH in HIV primary medical care.

Oral Health Care: Preventative and regular dental care is essential to the general health and well-being of everyone, particularly people with compromised immune systems such as those living with HIV and AIDS. In the Surgeon General’s report on oral health, he notes that “a silent epidemic” of oral diseases is affecting our most vulnerable citizens including many people of color. The report further states that “immuno-compromised patients, such as those with HIV infection, are at higher risk for oral problems such as candidiasis.”

Eating properly is necessary for nutrition and overall general health. Many of the HIV/AIDS treatment protocols require that medications be taken with food. Oral health problems that hinder this may negatively impact a person’s ability to be compliant to his/her treatment regimen. Thus, increasing the availability of and access to dental services is a core component of the EMA’s continuum of care.

Mental Health Services: Healthy People 2010 states that approximately 22% of the U.S. population aged 18-64 years has had a diagnosis of a mental disorder alone. Mental illness does not discriminate and affects people from all socio-economic backgrounds and races/ethnicities. Healthy People 2010 further states: “Major health issues for gay men are HIV/AIDS and other sexually transmitted diseases, substance abuse, depression, and suicide.” It is therefore critical that the EMA include mental health services as a core component of its continuum of care, particularly given the significant number of PLWH who are MSM.
Substance Abuse Services: Substance abuse is a significant problem in the EMA. As noted in the Severe Need section, the EMA has a higher proportion of PLWH who became infected through injection drug use (IDU) than in California. The EMA also has a higher proportion of PLWH whose mode of transmission risk was MSM and IDU. Additionally, with the growing popularity of crystal methamphetamine use, particularly among MSM along with the popularity of Palm Springs, California as a gay resort community, substance abuse -- injecting and non-injecting -- continues to be a significant problem as evidenced by data from the EMA’s largest community-based HIV/AIDS service organization - Desert AIDS Project. Substance abuse deteriorates overall health status and impairs an individual’s adherence to HIV treatment regimens, which is essential for improved health outcomes. As a result, outpatient substance abuse treatment is an important core service within the EMA’s continuum of care.

How the plan will address the needs of special populations
In its 2005 CNA, the IEHPC and Title I Grantee made tremendous efforts to gather qualitative consumer survey and focus group data from the EMA’s six designated special populations. These include youth, adult women, African Americans, Latinos, MSM, and substance users. The IEHPC utilized data from the 2005 CNA to inform the priority setting and resource allocation process. This process laid the foundation for the proposed FY 2006 Implementation Plan.

Table 9-1 outlines how each core service addresses the needs of the six special populations. The IEHPC also developed key service directives and cultural competency guidelines to assist the Title I Grantee when implementing services targeting special needs populations, also presented below.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Response to Special Needs Populations</th>
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<tbody>
<tr>
<td>Ambulatory Medical Care</td>
<td>• Specific measurable objectives developed for services targeting women, infants, children, and youth (WICY).</td>
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<tr>
<td><strong>IEHPC Directive</strong></td>
<td>• MAI-funded ambulatory medical care has measurable objectives targeting underserved communities, particularly African Americans and Latinos/as.</td>
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<td>• Require all Medical Care Clinic Client Advisory groups to increase to a minimum of five clients with both Black and Hispanic representation.</td>
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<tr>
<td>Pharmaceutical Assistance</td>
<td>• Specific measurable objectives developed for WICY.</td>
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<td>Case Management</td>
<td>• Specific measurable objectives developed for WICY.</td>
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<tr>
<td>Oral Health Care</td>
<td>• Specific measurable objectives developed for WICY.</td>
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<tr>
<td>Mental Health</td>
<td>• Specific measurable objectives developed for WICY.</td>
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<tr>
<td>Substance Abuse - Outpatient</td>
<td>• Specific measurable objectives developed for WICY.</td>
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<td>• The category itself targets the “substance user” special needs population, including MSM/IDU, women, African Americans, Latinos, and youth.</td>
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<tr>
<td><strong>IEHPC General Directive for all Services</strong></td>
<td>• Direct all contractors to tailor all services provided to be culturally sensitive and linguistically appropriate. Implement Cultural Competency Guidelines being developed by the Planning Council as the basis for development of provider programs to improve access and reduce barriers to service.</td>
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Core Service | Response to Special Needs Populations
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• Ensure that providers of core services target service provision to include underserved groups as shown in the 2005 Needs Assessment by using agencies that primarily target minority and WICY clients.

While MSM are a “special need” population, they also represent the single largest group of consumers of Title I services in the EMA. The Title I Grantee will continue to monitor utilization of services to ensure that MSM receive their proportionate share of services.

**How the plan will promote parity of HIV services throughout the EMA**
As noted earlier, the EMA is divided into six service areas to facilitate program planning. Because of the EMA’s huge expanse, it is vital that Title I services are available in a broad number of settings to ensure geographic parity and accessibility for PLWH/A. The FY 2006 Implementation Plan states within each objective that services are available across the six service areas. The EMA’s currently funded service providers are spread across the six service areas. Both the Riverside and San Bernardino County Health Departments deliver services at multiple sites as do other community-based organizations (CBOs). However, due to its size and the inadequate and disjointed public transportation system, the EMA also provides transportation assistance through its Title I funds as a vital service to help PLWH/A get to and from medical and other primary care appointments.

Other funded services (e.g. early intervention services, food bank, home health services, housing services, and legal services) are part of the EMA’s comprehensive continuum of care. For all services constituting the complete FY 2006 Implementation Plan the IEHPC is developing cultural competency guidelines for service providers to ensure equal access to quality HIV care by diverse populations. These guidelines ensure that providers not only have culturally sensitive services but that they have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

The FY 2006 Implementation Plan explicitly calls attention, within the goal statement under “Ambulatory/Outpatient Medical Care”, to the importance of providing medical care that is consistent with Public Health Service Treatment Guidelines. Case management needs to be “client-centered” and “consistent with the implementation of the Chronic Care Model.” Likewise, substance abuse treatment should be in accordance with SAMHSA best practice models. Each of these goal statements addresses the need for quality of care for all services for all PLWH. Although not explicitly stated in the FY 2006 Implementation Plan, the IEHPC’s revised Standards of Care document further spells out quality standards for each service category and adherence to the Standards of Care is contractually mandated for all RWCA providers. The Title I Grantee monitors adherence through its annual monitoring process.

**How plan will encourage PLWH retention in care and treatment adherence**
In HRSA’s Chronic Care Model, considered a “best practice,” the HIV medical care provider is at the hub of the HIV care continuum. The medical provider and not a case manager determines the appropriate level of service for the PLWH/A. By the end of FY 2005/06, the EMA will have completed its transition to this model of care and is reflected in the FY 2006 Implementation Plan. Central to the model, the primary care provider plays the key role in helping PLWH to remain engaged in care and adhere to treatments. To receive Title I funding, the Title I Grantee requires that all service providers adopt this new framework. In order to receive referrals for other primary care or Ryan White-funded services, a PLWH/A

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Chapter 9: Continuum of Care High Quality Core Services 9-6
will be encouraged to enrolled in primary medical care. The primary care provider works with the client as an active participant in the process to identify needed support services to help facilitate treatment adherence and retention in care.

Built into the goal statements for core services is reference to the intent of the goal to help PLWH/A remain in care and adhere to HIV treatment regimens. For example, the goal for case management states: “To provide client-centered case management services to persons living with HIV/AIDS in the EMA that are consistent with implementation of the Chronic Care Model in order to facilitate access to and retention in primary medical care and support services.” Mental health, substance abuse, and oral health services incorporate similar language. The shift to SAMHSA’s best practice of the simultaneous treatment of HIV, mental illness and substance abuse will also encourage PLWH retention in care and in treatment adherence.

Coordination with Prevention Education

The dynamics of the HIV/AIDS epidemic have dramatically challenged the way HIV prevention and care planning processes are conducted by government and private organizations. Both prevention and care plans must coordinate efforts to address the needs of PLWH/A in the EMA. Strategies and interventions for prevention efforts should be comprehensive, incorporating different proven strategies addressing the varied populations in a culturally and linguistically appropriate manner.

Riverside and San Bernardino counties local prevention efforts include a wide range of strategies used effectively in HIV prevention programs. Based on each county’s epidemiology and needs, specific populations are targeted from a variety of venues. Both counties are in the process of developing their HIV Prevention Plans. Table 9-2 provides an overview of the prevention plans of both Riverside and San Bernardino counties.

### Table 9-2 Prevention Plans of Riverside and San Bernardino Counties

<table>
<thead>
<tr>
<th>Riverside County</th>
<th>San Bernardino County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategies:</strong></td>
<td><strong>Strategies:</strong></td>
</tr>
<tr>
<td>- Targeted prevention education (street-based outreach)</td>
<td>- Targeted prevention education (street based outreach)</td>
</tr>
<tr>
<td>- HIV prevention education group presentations</td>
<td>- HIV prevention education group presentations</td>
</tr>
<tr>
<td>- Confidential and anonymous HIV antibody counseling and testing</td>
<td>- Confidential and Anonymous HIV antibody counseling and testing</td>
</tr>
<tr>
<td>- Positives Change Program.</td>
<td>- Risk reduction focusing on Prevention with Positives (for example, treatment adherence education and partner notification).</td>
</tr>
<tr>
<td><strong>Target populations:</strong></td>
<td><strong>Target populations:</strong></td>
</tr>
<tr>
<td>- Men who have sex with men (MSM)</td>
<td>- Men who have sex with men</td>
</tr>
<tr>
<td>- Injection Drug Users (IDU) and/or their sexual partners</td>
<td>- Injection drug users (IDU) and/or their sexual partners</td>
</tr>
<tr>
<td>- Persons of color</td>
<td>- Persons of color</td>
</tr>
<tr>
<td>- Substance users</td>
<td>- Medi-Cal eligible women</td>
</tr>
<tr>
<td>- Men who have sex with men over 55</td>
<td>- Substance users</td>
</tr>
</tbody>
</table>
### Chapter 9: Continuum of Care High Quality Core Services

#### Target Venues:
- Substance abuse recovery centers
- Local gay bars
- Public and alternative high schools
- Public park settings
- Community health fairs

#### Target Venues:
- West Valley Detention Center
- Central Juvenile Hall
- Substance Abuser Recovery Center
- Local Gay Bars
- Adult Bookstores
- Youth Drop-in Centers
- Local Educational Institutions-Community College and Universities
- Community Day Schools
- Public and Alternative High Schools
- Public Park Settings
- Community Health Fairs

**Currently Rapid HIV Testing** is available in Riverside County at three public health centers. Rapid testing improves access to care.

San Bernardino County is currently in the process of initiating the application process to provide Rapid HIV Testing.

Riverside County is currently developing a local survey of prevention needs, affected populations, co-factors, and local interventions demonstrating effectiveness. In addition to surveys, key informants will be interviewed in order to test perceptions of epidemiological data, effectiveness of interventions, alternative/complementary resources for prevention programs, and perceived needs of the community.

The Inland Empire HIV Planning Council is dedicated to the expectation of integrating the prevention education and care and treatment services in order to address the needs of culturally diverse, underserved communities. In the effort to make this a reality, both councils will represent one another and participate in the local planning efforts and decision making for services for PLWH/A in the EMA. This will ensure that HIV prevention community planning and CARE act planning work in effective partnerships. These bodies will share information so that HIV prevention and HIV/AIDS care programs work together in planning and implementing effective strategies to reduce the number of HIV infections and enhance access to care for those living with HIV disease.

Figure 9-2 provides an illustration on how prevention and treatment coordinate services to meet the needs of the PLWH/A in the Riverside/San Bernardino EMA.
How the EMA will use MAI funding to enhance the quality of care and health outcomes in communities of color.

Beginning March 1, 2005 (FY 05-06), the IEHPC shifted the use of 100% of MAI funds from early intervention services to ambulatory medical care. The intent was to improve health outcomes and reduce disparities in care among communities of color more directly by increasing access to and delivering culturally responsive and linguistically appropriate HIV primary medical care.

Utilizing 100% of MAI funding for ambulatory medical care ensures that the EMA consistently collects and tracks MAI mandated health outcome indicators over time. Health outcome indicators collected during FY 04-05 will serve as a baseline for future years. As seen in Table 9-3 below, 70% of MAI clients experienced improvement in two of three health outcome indicators. The IEHPC and Title I Grantee expect to see dramatic improvements with the shift in funding from early intervention services to ambulatory medical care services.

<table>
<thead>
<tr>
<th>Health Outcome Indicator</th>
<th># of MAI Clients with Test Results</th>
<th># Improved or Maintained</th>
<th>% Improved or Maintained in FY 04-05</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4 Count</td>
<td>513</td>
<td>378</td>
<td>74%</td>
</tr>
<tr>
<td>CD4 %</td>
<td>507</td>
<td>354</td>
<td>70%</td>
</tr>
<tr>
<td>Viral Load</td>
<td>513</td>
<td>240</td>
<td>47%</td>
</tr>
</tbody>
</table>

Table 9-3 FY 04-05 Baseline Health Outcome Indicators for MAI Clients

a) The federal-state planned shift of fee-for-service Medi-Cal recipients to Medi-Cal Managed Care has been delayed from January 1, 2006. The impacts of this delay and other potential reforms such as changes in eligibility are unknown at this time, but the situations will require monitoring.
Disaster Preparedness Planning

The Riverside/San Bernardino, California EMA is subject to various natural and manmade disasters including major earthquakes, wildfires, flash floods, landslides, and terrorism incidents due to the EMA’s proximity to the Long Beach/Los Angeles Ports and the San Onofre Nuclear Power Plant in North San Diego County. The EMA also contains numerous large capacity water-storage facilities with dams, one of which is Lake Perris, the terminus of the California Water Project. In July 2005, weaknesses in its dam were identified. Subsequently, water levels were significantly reduced and engineering plans developed to address seismic safety concerns about the dam which is located in Service Area 1, an urban area.

Any of these potential disasters can subject PLWH/A, their families and Ryan White CARE Act service providers to interruptions in care. Based on the challenges experienced as a result of Hurricanes Katrina and Rita, improvements in this EMA’s disaster preparedness planning by PLWH/A and their providers are necessary.
Chapter 10: Short-term and Long-term Goals and Objectives

The Comprehensive HIV Services Plan provides a roadmap for the development and implementation of activities by the Inland Empire HIV Planning Council and the Ryan White CARE Act Office of the Title I & II Grantee to enhance the delivery and effectiveness of services to PLWH/A in the EMA for the next three years. The long-term, short-term goals and objectives detailed here will serve as a foundation for the priorities to be implemented by the Grantee, as part of its 2006 Annual Implementation Plan, in efforts to enhance the delivery and effectiveness of the continuum of care.

Existing linkages will be enhanced between the Planning Council, RWCA Office of the Title I & II Grantee, public health, mental health, and social service agencies, the affected and infected communities, service providers and others involved in the HIV continuum of care as a result of the implementation of these activities. It is anticipated that opportunities will emerge as well for the creation of additional community and organizational linkages that will enhance the delivery of effective and comprehensive HIV services in the Riverside/San Bernardino, CA EMA.

The EMA goals and objectives presented in this chapter are incorporated into the framework of Health Resources Services Administration (HRSA) goals and objectives. These affect parts of the system of care or address pervasive problems or issues. They reflect the philosophical vision of the Planning Council and their projection of what changes will occur over the next three years. These changes will increase access to core and support services; address unmet need and gaps in services; and reduce disparities in care for the underserved. Since the epidemiology of HIV, treatment for HIV, and the social services and health care programs used by PLWH are changing rapidly, goals and objectives covering a longer period of time would most likely be outdated before they could be implemented. Therefore, it is expected that the goals and objectives will be reviewed and revised annually to address emerging needs, reflect updated health and service outcomes, utilization information, and changes in federal and state policies.

A total of $7,061,251 in Ryan White CARE Act funding was budgeted to accomplish Year 1 (FY 06/07) goals and objectives presented in this plan. As of October 24, 2005, Congress had not completed work on the reauthorization of the CARE Act which technically expired September 30, 2005 nor had Congress completed the Appropriations Bill which includes CARE Act funding for FY 2006. Therefore, these goals and objectives were developed prior to the Reauthorization of the Ryan White Care Act and are subject to change pending the reauthorization. There may also be changes in Year 1 Implementation Plan (i.e., specific core services provided and numbers of clients to be served and units of services provided) required by March 1, 2006 based on actual award amount. In addition, goals and objectives for each funded support service will be developed.
Short-term and Long-term Goals and Objectives

### HRSA GOAL 1: Improve Access to Health Care.

#### EMA GOAL 1.1: To provide and increase access to comprehensive, client-centered, culturally competent and linguistically appropriate primary medical care consistent with the Public Health Service Treatment Guidelines and Institute for Healthcare Improvement/HIV/AIDS Bureau (IHI/HAB) Collaborative Chronic Care Model for persons living with HIV/AIDS (PLWH/A) in the Riverside/San Bernardino, CA EMA (R/SB EMA).

**Core Service #1: Ambulatory/Outpatient Medical Care**

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1a By 2/28/07, provide geographically accessible, culturally competent and linguistically appropriate Primary Medical Care services to a minimum of 1,884 current and 120 new HIV positive clients for a total of 2,004 clients ensuring that primary medical care services are available in the R/SB EMA’s six service areas.</td>
<td>1.1c By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Primary Medical Care services are available in the R/SB EMA’s six service areas.</td>
<td>1.1e By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Primary Medical Care services are available in the R/SB EMA’s six service areas.</td>
</tr>
<tr>
<td>1.1b By 2/28/07, provide geographically accessible, culturally competent and linguistically appropriate Primary Medical Care services to a minimum of 184 current and 12 new HIV positive women, infants, children, and youth for a total of 206 clients in the EMA’s six service areas.</td>
<td>1.1d By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Primary Medical Care services are available to HIV positive women, children, and youth in the EMA’s six service areas.</td>
<td>1.1f By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Primary Medical Care services are available to HIV positive women, children, and youth in the EMA’s six service areas.</td>
</tr>
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</table>

#### EMA GOAL 1.2: To reduce disparities in HIV/AIDS-related health outcomes among disproportionately impacted, marginalized and underserved populations, primarily African Americans/Blacks and Latinos/as (Hispanics).

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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<tbody>
<tr>
<td>1.2a By 2/28/07, through Minority AIDS Initiative (MAI) funding, provide geographically accessible, culturally competent and linguistically appropriate Primary Medical Care services to a</td>
<td>1.2b By 2/28/08, maintain current service levels or increase service levels depending on Minority AIDS Initiative (MAI) funding, to provide geographically accessible, culturally competent and</td>
<td>1.2c By 2/28/09, maintain current service levels or increase service levels depending on Minority AIDS Initiative (MAI) funding, to provide geographically accessible, culturally competent and</td>
</tr>
</tbody>
</table>
### EMA GOAL 1.3: To provide HIV related medications for PLWH/A in the R/SB EMA who are not eligible for other funding sources or for whom the prescribed pharmaceutical is not on the formulary of their specific funding source and who meet EMA eligibility criteria. [Core Service #2: Pharmaceutical Assistance (HIV Related Medications)]

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<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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<tbody>
<tr>
<td>1.3a By 2/28/07, provide Pharmaceutical Assistance to a minimum of 290 current and 19 new HIV positive clients for a total of 309 clients living in each of the R/SB EMA’s six service areas.</td>
<td>1.3c By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that Pharmaceutical Assistance is available to HIV positive clients living in each of the R/SB EMA’s six service areas.</td>
<td>1.3e By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that Pharmaceutical Assistance is available to HIV positive clients living in each of the R/SB EMA’s six service areas.</td>
</tr>
<tr>
<td>1.3b By 2/28/07, provide Pharmaceutical Assistance to 38 current and 3 new HIV positive women, infants, children and youth, for a total of 41 clients in the EMA’s six service areas.</td>
<td>1.3d By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that Pharmaceutical Assistance is available to HIV positive women, children, and youth in the EMA’s six service areas.</td>
<td>1.3f By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that Pharmaceutical Assistance is available to HIV positive women, children, and youth in the EMA’s six service areas.</td>
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</table>

### EMA GOAL 1.4: To provide client-centered, culturally competent and linguistically appropriate case management services to PLWH/A in the R/SB EMA that are consistent with implementation of the Chronic Care Model in order to facilitate access to and retention in primary medical care and support services (e.g., SAFE-T-Net Program). [Core Service #3: Case Management]

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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</thead>
<tbody>
<tr>
<td>1.4a By 2/28/07, provide culturally competent and linguistically appropriate Case Management services to a minimum of 2,293 current and 146 new HIV positive</td>
<td>1.4c By 2/28/07, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and</td>
<td>1.4e By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and</td>
</tr>
</tbody>
</table>

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**Chapter 10: Goals and Objectives**  
10-3
## Chapter 10: Goals and Objectives

### Comprehensive HIV Services Plan

#### EMA GOAL 1.5: To provide access to culturally competent and linguistically appropriate dental and/or periodontal care (e.g., diagnostic, therapeutic, or prophylactic services) for PLWH/A in the R/SB EMA in order to maintain oral health, thereby sustaining proper nutrition and improving health outcomes.

**Core Service #4: Oral Health Care**

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.5a</strong> By 2/28/07, provide culturally competent and linguistically appropriate Oral Health Care services to a minimum of 512 current and 33 new HIV positive clients for a total of 545 clients in the EMA’s six service areas.</td>
<td><strong>1.5c</strong> By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Oral Health Care services are available to HIV positive clients in the EMA’s six service areas.</td>
<td><strong>1.5e</strong> By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Oral Health Care services are available to HIV positive clients in the EMA’s six service areas.</td>
</tr>
<tr>
<td><strong>1.5b</strong> By 2/28/07, provide culturally competent and linguistically appropriate Oral Health Care services to 67 current and 4 new HIV positive women, children and youth, for a total of 71 clients in the EMA’s six service areas.</td>
<td><strong>1.5d</strong> By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Oral Health Care services are available to HIV positive women, children, and youth in the EMA’s six service areas.</td>
<td><strong>1.5f</strong> By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Oral Health Care services are available to HIV positive women, children, and youth in the EMA’s six service areas.</td>
</tr>
</tbody>
</table>
### EMA GOAL 1.6: To provide access to culturally competent and linguistically appropriate Mental Health Services by licensed or authorized mental health professionals, including psychological and psychiatric treatment, for PLWH/A in the R/SB EMA in order to improve retention in primary medical care services. *(Core Service #5: Mental Health Services)*

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6a By 2/28/07, provide culturally competent and linguistically appropriate Mental Health Services (individual sessions) to 392 current and 25 new HIV positive clients for a total of 417 clients in the EMA’s six service areas.</td>
<td>1.6e By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Mental Health Services (individual sessions) are available to HIV positive clients in the EMA’s six service areas.</td>
<td>1.6i By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Mental Health Services (individual sessions) are available to HIV positive clients in the EMA’s six service areas.</td>
</tr>
<tr>
<td>1.6b By 2/28/07, provide culturally competent and linguistically appropriate Mental Health Services (individual sessions) to 50 current and 3 new HIV positive women and youth, for a total of 54 clients in the EMA’s six service areas.</td>
<td>1.6f By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Mental Health Services (individual sessions) are available to HIV positive women and youth, in the EMA’s six service areas.</td>
<td>1.6j By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Mental Health Services (individual sessions) are available to HIV positive women and youth, in the EMA’s six service areas.</td>
</tr>
<tr>
<td>1.6c By 2/28/07, provide culturally competent and linguistically appropriate Mental Health Services (group sessions) to 586 current and 37 new HIV positive clients for a total of 623 clients in the EMA’s six service areas.</td>
<td>1.6g By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Mental Health Services (group sessions) are available to HIV positive clients in the EMA’s six service areas.</td>
<td>1.6k By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Mental Health Services (group sessions) are available to HIV positive clients in the EMA’s six service areas.</td>
</tr>
<tr>
<td>1.6d By 2/28/07, provide culturally competent and linguistically appropriate Mental Health Services (group sessions) to 77 current and 5 new HIV positive women, children and youth, for a total of 29 clients in the EMA’s six service areas.</td>
<td>1.6h By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Mental Health Services (group sessions) are available to HIV positive clients in the EMA’s six service areas.</td>
<td>1.6l By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Mental Health Services (group sessions) are available to HIV positive clients in the EMA’s six service areas.</td>
</tr>
</tbody>
</table>
EMA GOAL 1.7: To provide access to culturally competent and linguistically appropriate outpatient Substance Abuse treatment in accordance with Substance Abuse and Mental Health Services Administration best practice models for PLWH/A that have substance use issues in the R/SB EMA in order to improve retention in HIV/AIDS Primary Medical Care and improve HIV treatment adherence.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.7a  By 2/28/07, provide culturally competent and linguistically appropriate Outpatient Substance Abuse Services (Individual) to 91 current and 6 new HIV positive clients for a total of 97 clients in the EMA’s six service areas.</td>
<td>1.7e  By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Outpatient Substance Abuse Services (Individual) are available to HIV positive clients in the EMA’s six service areas.</td>
<td>1.7i  By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Outpatient Substance Abuse Services are available to HIV positive clients in the EMA’s six service areas.</td>
</tr>
<tr>
<td>1.7b  By 2/28/07, provide culturally competent and linguistically appropriate Outpatient Substance Abuse Services (Individual) to 13 current and 1 new HIV positive women and youth, for a total of 14 clients in the EMA’s six service areas.</td>
<td>1.7f  By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Outpatient Substance Abuse Services are available to HIV positive women and youth in the EMA’s six service areas.</td>
<td>1.7j  By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Outpatient Substance Abuse Services are available to HIV positive women and youth in the EMA’s six service areas.</td>
</tr>
<tr>
<td>1.7c  By 2/28/07, provide culturally competent and linguistically appropriate Outpatient Substance Abuse Services (Group) to 211 current and 13 new HIV positive clients for a total of 224 clients in the EMA’s six service areas.</td>
<td>1.7g  By 2/28/08, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Outpatient Substance Abuse Services (Group) are available to HIV positive clients in the EMA’s six service areas.</td>
<td>1.7k  By 2/28/09, maintain current service levels or increase service levels depending on subsequent funding to ensure that culturally competent and linguistically appropriate Outpatient Substance Abuse Services (Group) are available to HIV positive clients in the EMA’s six service areas.</td>
</tr>
<tr>
<td>1.7d  By 2/28/07, provide culturally competent and linguistically appropriate Outpatient Substance Abuse Services (Group) to 27 current and 2 new HIV positive women, and youth, for a total of 29 clients in the EMA’s six service areas.</td>
<td></td>
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</tr>
</tbody>
</table>
## Chapter 10: Goals and Objectives

<table>
<thead>
<tr>
<th>EMA GOAL 1.8: Address the barrier of stigma among PLWH/A from communities of color.</th>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.8a</strong> By February 28, 2007, HIV services will be mainstreamed by promoting a culturally and linguistically appropriate social marketing campaign EMA-wide that will decrease stigma by increasing public education and awareness among African Americans and Latinos (including monolingual).</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>1.8b</strong> By February 28, 2007, collaboration will be developed between HIV services, faith-based, and other community organizations, stakeholders and gatekeepers that have established trust with the community to build a network of services.</td>
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<td></td>
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</tr>
<tr>
<td><strong>1.8c</strong> By February 28, 2007, consumers will be educated on patient rights, the grievance policy process, and how to find an advocate or learn to be a self-advocate.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.8d</strong> By February 28, 2008, HIV providers will continue to promote a culturally and linguistically appropriate social marketing campaign EMA-wide that will decrease stigma by increasing public education and awareness among African Americans and Latinos (including monolingual).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.8e</strong> By February 28, 2008, collaboration will continue between HIV services, faith-based, and other community organizations stakeholders and gatekeepers.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>1.8f</strong> By February 28, 2008, consumers will continue to be educated on how to find their way through the system, their rights as consumes, how to advocate and how to become a self-advocate.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.8g</strong> By February 28, 2009, HIV providers will continue to promote a culturally and linguistically appropriate social marketing campaign EMA-wide that will decrease stigma by increasing public education and awareness among African Americans and Latinos (including monolingual).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.8h</strong> By February 28, 2009, collaboration will continue between HIV services, faith-based, and other community organizations stakeholders and gatekeepers.</td>
<td></td>
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</tr>
<tr>
<td><strong>1.8i</strong> By February 28, 2009, consumers will continue to be educated on how to find their way through the system, their rights as consumes, how to advocate and how to become a self-advocate.</td>
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</tbody>
</table>
**EMA GOAL 1.9:** Increase awareness of information on HIV medical care and other support services in the EMA among providers and PLWH/A and the general community.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.9a By February 28, 2007, IEHPC website will be revised to include user-friendly information on provider services, how to access these services (English and Spanish) and links in English and Spanish.</td>
<td>1.9e By February 28, 2008, IEHPC website will be maintained and updated as needed.</td>
<td>1.9h By February 28, 2009, IEHPC website will be maintained and updated as needed.</td>
</tr>
<tr>
<td>1.9b By February 28, 2007, a social marketing campaign plan targeting hard-to-reach communities will be developed to provide educational messages that are culturally and linguistically appropriate.</td>
<td>1.9f By February 28, 2008, social marketing campaign will be implemented EMA-wide.</td>
<td>1.9i By February 28, 2009, social marketing campaign results will be reviewed and evaluated.</td>
</tr>
<tr>
<td>1.9c By February 28, 2007, Riverside County Department of Public Health will continue to provide Rapid HIV Testing.</td>
<td>1.9g By February 28, 2008, Riverside and San Bernardino Counties will continue to provide Rapid HIV Testing.</td>
<td>1.9j By February 28, 2009, Riverside and San Bernardino Counties will continue to provide Rapid HIV Testing.</td>
</tr>
<tr>
<td>1.9d By February 28, 2007, San Bernardino County Department of Public Health will begin providing Rapid HIV Testing.</td>
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**HRSA GOAL 2: Improve Health Outcomes.**

**EMA GOAL 2.1:** Bring people with HIV/AIDS who know their status and are not in care into care.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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<tbody>
<tr>
<td>2.1a By February 28, 2007, CARE Act-funded providers will have implemented EMA-wide SAFE-T-Net Program targeting unmet need population to link with care services.</td>
<td>2.1e By February 28, 2008, CARE Act-funded providers will continue to implement EMA-wide SAFE-T-Net Program targeting unmet need population to link with care services.</td>
<td>2.1i By February 28, 2009, CARE Act-funded providers will continue to implement EMA-wide SAFE-T-Net Program targeting unmet need population to link with care services.</td>
</tr>
<tr>
<td>2.1b By February 28, 2007, CARE Act-funded providers will Identify PLWH aware of</td>
<td>2.1f By February 28, 2008, CARE Act-funded providers will Identify PLWH aware of</td>
<td>2.1j By February 28, 2009, CARE Act-funded providers will Identify PLWH aware of</td>
</tr>
</tbody>
</table>
## HRSA GOAL 3: Improve the Quality of Health Care.

**EMA GOAL 3.1:** Assure the highest quality of services in all service categories.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1a By February 28, 2007, Planning Council, Grantee, and CARE Act-funded providers will continue to support the Quality Management Plan.</td>
<td>3.1d By February 28, 2008, Planning Council, Grantee and CARE Act-funded providers will continue to support the Quality Management Plan.</td>
<td>3.1g By February 28, 2009, Planning Council, Grantee and CARE Act-funded providers will continue to support the Quality Management Plan.</td>
</tr>
<tr>
<td>3.1b By February 28, 2007, Standards of Care for all service categories will be reviewed and revised as necessary.</td>
<td>3.1e By February 28, 2008, Standards of Care will be reviewed and revised as needed.</td>
<td>3.1h By February 28, 2009, Standards of Care will be reviewed and revised as needed.</td>
</tr>
<tr>
<td>3.1c By February 28, 2007, the Quality Management Committee will review and revise performance indicators, which are linked to optimal measurable outcomes for all service categories.</td>
<td>3.1f By February 28, 2008, the Quality Management Committee will continue to review and revise performance indicators as needed.</td>
<td>3.1i By February 28, 2008, the Quality Management Committee will continue to review and revise performance indicators as needed.</td>
</tr>
</tbody>
</table>
### HRSA GOAL 4: Eliminate Health Disparities.

#### EMA GOAL 4.1: Ensure services are targeting people with the most severe needs.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
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<th>Objectives FY 08</th>
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</thead>
<tbody>
<tr>
<td><strong>4.1a</strong> By February 28, 2006, Planning Council will review updated Federal Poverty Guidelines and revise as needed eligibility criteria for CARE Act-funded services as needed.</td>
<td><strong>4.1c</strong> By February 28, 2007, Planning Council will evaluate the impact of revised criteria and modify as needed.</td>
<td><strong>4.1e</strong> By February 2008, Planning Council will evaluate the impact of revised criteria and modify as needed.</td>
</tr>
<tr>
<td><strong>4.1b</strong> By February 28, 2007, Planning Council will review epidemiological, utilization, and outcomes data to identify severe need populations.</td>
<td><strong>4.1d</strong> By February 28, 2008, Planning Council will continue to review epidemiological, utilization, and outcomes data to identify severe need populations.</td>
<td><strong>4.1f</strong> By February 28, 2009, Planning Council will review epidemiological, utilization, and outcomes data to identify severe need populations.</td>
</tr>
</tbody>
</table>

#### EMA GOAL 4.2: Improve health status of people of color, especially in view of the disproportionate prevalence rate of African Americans who are living with HIV/AIDS and are not in care in the EMA.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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</thead>
<tbody>
<tr>
<td><strong>4.2a</strong> By February 28, 2007, Planning Council Support staff will review the literature and produce a report for the Planning Council on successful service models and strategies addressing African American PLWH/A not in care.</td>
<td><strong>4.2c</strong> By February 28, 2008, Successful models will be adapted and implemented to increase access to culturally competent services.</td>
<td><strong>4.2f</strong> By February 28, 2009, the models will be evaluated; training will be revised and continued as needed.</td>
</tr>
<tr>
<td><strong>4.2b</strong> By February 28, 2007, Planning Council will develop guidelines and performance measures for providers on how to address cultural competency for staff and programming.</td>
<td><strong>4.2d</strong> By February 28, 2008, the Grantee will incorporate in RFP and contract language CARE Act-funded providers will develop culturally competency plans that will address the cultural and linguistic needs of clients and work with the Council on addressing identified gaps in, and barriers to, services.</td>
<td><strong>4.2g</strong> By February 28, 2009, Grantee will continue to assess required cultural competency plans from CARE Act-funded providers.</td>
</tr>
<tr>
<td><strong>4.2e</strong> By February 28, 2008, Grantee will provide a summary of plans from providers to Planning Council.</td>
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</table>
### HRSA GOAL 5: Improve the Public Health and Health Care Systems.

#### EMA GOAL 5.1: Move towards a more integrated system of care.

<table>
<thead>
<tr>
<th>Goals FY 06</th>
<th>Goals FY 07</th>
<th>Goals FY 08</th>
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</thead>
<tbody>
<tr>
<td><strong>5.1a</strong> By February 28, 2007, Planning Council will identify agencies within the EMA that are currently involved and others that should be involved in the HIV/AIDS service delivery system.</td>
<td><strong>5.1c</strong> By February 28, 2008, Objectives will be developed to increase collaboration and interagency cooperation and service integration.</td>
<td><strong>5.1e</strong> By February 28, 2009, Formal agreements and linkages will be established among HIV service providers and other agencies to increase cooperation and service integration.</td>
</tr>
<tr>
<td><strong>5.1b</strong> By February 28, 2007, Planning Council will review and revise IEHPC’s plan to engage participation and dialogue among agencies outside of HIV/AIDS service system.</td>
<td><strong>5.1d</strong> By February 28, 2008, Recommendations will be provided to Planning Council for service integration activities.</td>
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</tr>
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</table>

#### EMA GOAL 5.2: Continue development of the EMA’s “client centered” system of care.

<table>
<thead>
<tr>
<th>Goals FY 06</th>
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<th>Goals FY 08</th>
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<tbody>
<tr>
<td><strong>5.2a</strong> By February 28, 2007, Planning Council will ensure people living with HIV are central to the continued planning, development, and evaluation of the system of care.</td>
<td><strong>5.2d</strong> By February 218, 2008, Planning Council will continue to ensure people living with HIV are central to the continued planning, development, and evaluation of the system of care.</td>
<td><strong>5.2f</strong> By February 218, 2009, Planning Council will continue to ensure people living with HIV are central to the continued planning, development, and evaluation of the system of care.</td>
</tr>
<tr>
<td><strong>5.2b</strong> By February 28, 2007, Planning Council will develop a plan to recruit and retain consumer membership and involvement in Planning Council.</td>
<td><strong>5.2e</strong> By February 28, 2008, Planning Council will have increased its consumer membership by a minimum of 30% (3 additional seats).</td>
<td><strong>5.2g</strong> By February 28, 2009, Planning Council will have increased its consumer membership by a minimum of 30% (3 additional seats).</td>
</tr>
<tr>
<td><strong>5.2c</strong> By February 28, 2007, Planning Council will have increased its consumer membership by a minimum of 30% (3 additional seats).</td>
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</table>
### EMA GOAL 5.3: Prevent transmission of HIV by HIV+ individuals who know their status.

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<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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</thead>
<tbody>
<tr>
<td>5.3a By February 28, 2007, Planning Council will meet on a periodic basis with local prevention planning groups in both Riverside and San Bernardino Counties to coordinate prevention efforts, strategies, and resources.</td>
<td>5.3c By February 28, 2008, Joint workgroup will continue to meet to identify overlapping goals and target populations and design and implement joint services.</td>
<td>5.3d By February 28, 2009, Joint workgroup will continue to meet to identify overlapping goals and target populations and design and implement joint services.</td>
</tr>
<tr>
<td>5.3b By February 28, 2007, representation from both prevention planning and care and treatment will develop a joint workgroup to identify overlapping goals and target populations and design joint services.</td>
<td>5.3c By February 28, 2008, Joint workgroup will continue to meet to identify overlapping goals and target populations and design and implement joint services.</td>
<td>5.3d By February 28, 2009, Joint workgroup will continue to meet to identify overlapping goals and target populations and design and implement joint services.</td>
</tr>
</tbody>
</table>

### EMA GOAL 5.4: Maximize access to health and financial benefits for people with HIV/AIDS.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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</thead>
<tbody>
<tr>
<td>5.4a By February 28, 2007, Grantee will ensure all clients are screened for benefit eligibility and referred to appropriate providers.</td>
<td>5.4d By February 28, 2008, Grantee will continue to monitor providers on client eligibility screening; provide technical assistance to agencies to ensure compliance with eligibility requirements.</td>
<td>5.4g By February 28, 2009, Grantee will continue to monitor providers on client eligibility screening; provide technical assistance to agencies to ensure compliance with eligibility requirements.</td>
</tr>
<tr>
<td>5.4b By February 28, 2007, Grantee will ensure clients have access to benefits counseling and assistance in obtaining any benefits for which they are eligible, including financial and health benefits.</td>
<td>5.4c By February 28, 2008, continual funding for benefits counseling and legal assistance programs will be available.</td>
<td>5.4h By February 28, 2009, continual funding for benefits counseling and legal assistance programs will be available.</td>
</tr>
<tr>
<td>5.4c By February 28, 2007, Grantee and Planning Council will design and implement a study to identify impact of implementation of Medicare Part D Prescription Drug Program on HIV/AIDS clients and CARE Act-funded services especially pharmaceutical assistance.</td>
<td>5.4d By February 28, 2008, Grantee will continue to monitor providers on client eligibility screening; provide technical assistance to agencies to ensure compliance with eligibility requirements.</td>
<td>5.4g By February 28, 2009, Grantee will continue to monitor providers on client eligibility screening; provide technical assistance to agencies to ensure compliance with eligibility requirements.</td>
</tr>
<tr>
<td>EMA GOAL 5.5: Coordinate resources among other federal, state, and local programs.</td>
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<tr>
<td><strong>Objectives FY 06</strong></td>
<td><strong>Objectives FY 07</strong></td>
<td><strong>Objectives FY 08</strong></td>
</tr>
<tr>
<td>5.5a By February 28, 2007, IEHPC and Prevention planning groups will meet quarterly to review shared goals and objectives and to coordinate programs with local prevention planners and providers.</td>
<td>5.5g By February 28, 2008, IEHPC and Prevention planning groups will continue to meet quarterly to review shared goals and objectives and to coordinate programs with local prevention planners and providers.</td>
<td>5.5m By February 28, 2009, IEHPC and Prevention planning groups will continue to meet quarterly to review shared goals and objectives and to coordinate programs with local prevention planners and providers.</td>
</tr>
<tr>
<td>5.5b By February 28, 2007, Planning Council representatives will meet twice a year with local substance abuse planners and providers to provide education on HIV client sensitivity and discuss shared issues and challenges and coordinate services.</td>
<td>5.5h By February 28, 2008, Planning Council will continue to meet twice a year with local substance abuse planners and providers to provide education on HIV client sensitivity and discuss shared issues and challenges and coordinate services.</td>
<td>5.5n By February 28, 2009, Planning Council will continue to meet twice a year with local substance abuse planners and providers to provide education on HIV client sensitivity and discuss shared issues and challenges and coordinate services.</td>
</tr>
<tr>
<td>5.5c By February 28, 2007, Planning Council’s Planning Committee will identify issues and appropriate mechanisms for Council to support advocacy for alternative resources for services, including primary care, housing, mental health, and substance abuse, in order to offset any future reductions in funding,</td>
<td>5.5i By February 28, 2008, Planning Council’s Planning Committee will continue to identify issues and appropriate mechanisms for Council to support advocacy for alternative resources for services, including primary care, housing, mental health, and substance abuse, in order to offset any future reductions in funding.</td>
<td>5.5o By February 28, 2009, Planning Council’s Planning Committee will continue to identify issues and appropriate mechanisms for Council to support advocacy for alternative resources for services, including primary care, housing, mental health, and substance abuse, in order to offset any future reductions in funding.</td>
</tr>
<tr>
<td>5.5d By February 28, 2007, Planning Council representatives will attend meetings of local Mental Health and Behavioral Health Departments at least once a year to coordinate services.</td>
<td>5.5j By February 28, 2008, Planning Council representatives will continue to attend meetings of local Mental Health and Behavioral Health Departments at least once a year to coordinate services.</td>
<td>5.5p By February 28, 2009, Planning Council representatives will continue to attend meetings of local Mental Health and Behavioral Health Departments at least once a year to coordinate services.</td>
</tr>
<tr>
<td>5.5e By February 28, 2007, Council staff will identify relevant organizations and schedule meetings to support linkages to organizations providing services to PLWH/A going into or coming out of treatment.</td>
<td>5.5k By February 28, 2008, Council staff will continue to identify relevant organizations and continue to schedule meetings to support linkages to organizations providing services to PLWH/A going into or coming out of treatment.</td>
<td>5.5q By February 28, 2009, Council staff will identify relevant organizations and continue to schedule meetings to support linkages to organizations providing services to PLWH/A going into or coming out of treatment.</td>
</tr>
</tbody>
</table>
### EMA GOAL 5.6: To increase coordination and collaboration with existing service systems.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.6a By February 28, 2007, Formal collaborations will be developed between HIV service providers and existing agencies serving communities of color and children, youth and families.</td>
<td>5.6d By February 28, 2008, Formal collaborations will be maintained between HIV service providers and existing agencies serving communities of color and children, youth and families.</td>
<td>5.6g By February 28, 2009, Formal collaborations will be maintained between HIV service providers and existing agencies serving communities of color and children, youth and families.</td>
</tr>
<tr>
<td>5.6b By February 28, 2007, Formal collaborations will be developed with existing mental health and substance abuse providers and HIV service providers.</td>
<td>5.6e By February 28, 2008, Formal collaborations will be maintained with existing mental health and substance abuse providers and HIV service providers.</td>
<td>5.6h By February 28, 2009, Formal collaborations will be maintained with existing mental health and substance abuse providers and HIV service providers.</td>
</tr>
<tr>
<td>5.6c By February 28, 2007, Grantee will provide opportunities for inter-agency cooperation and information sharing to improve service integration during regularly scheduled Provider Network meetings.</td>
<td>5.6f By February 28, 2008, Grantee will continue to provide opportunities for inter-agency cooperation and information sharing to improve service integration during regularly scheduled Provider Network meetings.</td>
<td>5.6i By February 28, 2009, Grantee will continue to provide opportunities for inter-agency cooperation and information sharing to improve service integration during regularly scheduled Provider Network meetings.</td>
</tr>
</tbody>
</table>
**HRSA GOAL 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies.**

**EMA GOAL 6.1:** PLWH/A and their Ryan White CARE Act-funded providers in the EMA will be better prepared to survive natural or manmade disasters.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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</thead>
<tbody>
<tr>
<td>6.1a By November 30, 2006, IEHPC, through its Planning Committee and with input from the Grantee’s Provider Network, will obtain, review, identify policy changes required (e.g., pharmaceutical refill policies that do not allow a 7-day supply to be maintained), and modify as needed current disaster preparedness information appropriate for PLWH/A, their families and providers and appropriate agencies (e.g. local, state, federal disaster planning) in case of major earthquakes, wildfires, floods, landslides or terrorist incidents.</td>
<td>6.1b By November 30, 2007, the IEHPC, with input from the Provider Network, will review and update disaster preparedness information.</td>
<td>6.1c By November 30, 2008, the IEHPC, with input from the Provider Network, will review and update disaster preparedness information.</td>
</tr>
</tbody>
</table>

**HRSA GOAL 7: Achieve Excellence in Management Practices**

**EMA GOAL 7.1:** Ensure CARE Act funds are used as the payer of last resort.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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</thead>
<tbody>
<tr>
<td>7.1a By February 28, 2007, Grantee will ensure all CARE Act-funded agencies providing Medi-Cal eligible services are certified to bill Medi-Cal.</td>
<td>7.1e By February 28, 2008, Grantee will continue to ensure certification will be monitored and evaluated.</td>
<td>7.1g By February 28, 2009, Grantee will continue to ensure certification will be monitored and evaluated.</td>
</tr>
<tr>
<td>7.1b By February 28, 2007, agencies not yet certified will become certified and technical assistance will be provided as needed.</td>
<td>7.1f By February 28, 2008, Grantee will continue to ensure monitoring of CARE Act-funded providers’ policy on third party reimbursement.</td>
<td>7.1h By February 28, 2009, Grantee will continue to ensure continual monitoring of CARE-Act funded providers’ policy on third party reimbursement.</td>
</tr>
</tbody>
</table>
Final Plan

Comprehensive HIV Services Plan  
Riverside/San Bernardino, CA EMA

<table>
<thead>
<tr>
<th>EMA GOAL 7.2: To improve data management within the EMA.</th>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2a By February 28, 2006, Grantee will ensure continued implementation of the AIDS Regional Information and Evaluation System (ARIES) Management Information System (MIS) EMA-wide.</td>
<td>7.2d By February 28, 2007, Grantee will evaluate the implementation of the ARIES Management Information System EMA-wide and develop recommendations for modifications and enhancements.</td>
<td>7.2g By February 28, 2008, Grantee will evaluate the implementation of the ARIES Management Information System EMA-wide and develop recommendations for modifications and enhancements.</td>
<td></td>
</tr>
<tr>
<td>7.2b By February 28, 2007, Grantee will continue to assess training needs and facilitate ongoing training for providers and Grantee staff as ARIES is implemented and enhanced.</td>
<td>7.2e By February 28, 2008, Grantee will continue to assess training needs and facilitate ongoing training for providers and Grantee staff.</td>
<td>7.2h By February 28, 2009, Grantee will continue to assess training needs and facilitate ongoing training for providers and Grantee staff.</td>
<td></td>
</tr>
<tr>
<td>7.2c By February 28, 2007, Grantee will analyze data collected and make recommendations for improvement of services for Year 2.</td>
<td>7.2f By February 28, 2008, Grantee will continue to analyze data collected and make recommendations for improvement of services for Year 3.</td>
<td>7.2i By February 28, 2009, Grantee will continue to analyze data collected and make recommendations for improvement of services for Year 4.</td>
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<table>
<thead>
<tr>
<th>EMA GOAL 7.3: Planning Council will conduct its activities efficiently and effectively and fulfill all mandated roles and responsibilities.</th>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3a By February 28, 2007, Planning Council will conduct a minimum of 11 monthly full council meetings and will ensure that council meetings are publicly accessible, scheduled, and agenda is mailed and</td>
<td>7.3c By February 28, 2008, The Planning Council will conduct monthly full council meetings and will ensure that council meetings are publicly accessible, scheduled, and agenda is mailed and</td>
<td>7.3e By February 28, 2009, The Planning Council will conduct monthly full council meetings and will ensure that council meetings are publicly accessible, scheduled, and agenda is mailed and</td>
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</table>
Final Plan

Comprehensive HIV Services Plan
Riverside/San Bernardino, CA EMA

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<tr>
<th>Objectives FY 06</th>
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</thead>
<tbody>
<tr>
<td>7.4a By February 28, 2007, the Council Development Committee will oversee the Council’s recruitment, retention, and training activities.</td>
<td>7.4j By February 28, 2008, The Council Development Committee oversees the Council’s recruitment, retention, and training activities.</td>
<td>7.4q By February 28, 2009, The Council Development Committee oversees the Council’s recruitment, retention, and training activities.</td>
</tr>
<tr>
<td>7.4b By February 28, 2007, Planning Council will assess member attendance quarterly and address as needed and identify gaps for recruitment efforts.</td>
<td>7.4k By February 28, 2008, Planning Council will assess member attendance quarterly and address as needed and identify gaps for recruitment efforts.</td>
<td>7.4r By February 28, 2009, Planning Council will assess member attendance quarterly and address as needed and identify gaps for recruitment efforts.</td>
</tr>
<tr>
<td>7.4c By February 28, 2007, Planning Council membership will be reflective of the EMA’s epidemic profile.</td>
<td>7.4l By February 28, 2008, Planning Council membership will be reflective of the EMA’s epidemic profile.</td>
<td>7.4s By February 28, 2009, Planning Council membership will be reflective of the EMA’s epidemic profile.</td>
</tr>
<tr>
<td>7.4d By February 28, 2007, Planning Council Development Committee will review applications and make recommendations for membership at least quarterly.</td>
<td>7.4m By February 28, 2008, Planning Council will continue to assess member attendance quarterly and address as needed.</td>
<td>7.4t By February 28, 2009, Planning Council will continue to assess member attendance quarterly and address as needed.</td>
</tr>
<tr>
<td>7.4e By February 28, 2007, Planning Council will assess member attendance quarterly and address as needed.</td>
<td>7.4n By February 28, 2008, Planning Council will continuously review and revise Council Bylaws, as needed.</td>
<td>7.4u By February 28, 2009, Planning Council will continuously review and revise Council Bylaws, as needed.</td>
</tr>
<tr>
<td>7.4f By February 28, 2007, Planning Council will review and revise Council Bylaws, as needed.</td>
<td>7.4o By February 28, 2008, new Planning Council members are oriented and</td>
<td>7.4v By February 28, 2009, new Planning Council members are oriented and</td>
</tr>
</tbody>
</table>
### EMA GOAL 7.5: The Planning Council conducts needs assessments on a regular basis.

<table>
<thead>
<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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<tbody>
<tr>
<td>7.5a By May 30, 2006, Planning Council will conduct a specialized needs assessment on substance abuse service gaps among PLWH/A.</td>
<td>7.5c By May 30, 2007, Council will conduct a specialized needs assessment on mental health service gaps among PLWH/A.</td>
<td>7.5e By May 30, 2008, Council will conduct a Comprehensive Needs Assessment to identify unmet needs, gaps and barriers to care in services among PLWH/A in the EMA.</td>
</tr>
<tr>
<td>7.5b By February 28, 2007, the Needs Assessment Subcommittee will continue to oversee all needs assessment activities.</td>
<td>7.5d By February 28, 2008, the Needs Assessment Subcommittee will continue to oversee all needs assessment activities.</td>
<td>7.5f By February 28, 2009, the Needs Assessment Subcommittee will continue to oversee all needs assessment activities.</td>
</tr>
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</table>

### EMA GOAL 7.6: The Planning Council reviews and revises its Comprehensive HIV Services Plan on an annual basis.

<table>
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<tr>
<th>Objectives FY 06</th>
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<th>Objectives FY 08</th>
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<tbody>
<tr>
<td>7.6a By February 28, 2007, the Evaluation Subcommittee will oversee implementation of current three-year Comprehensive HIV Services Plan goals and objectives.</td>
<td>7.6d By February 28, 2008, the Evaluation Subcommittee will continue to oversee implementation of current three-year Comprehensive HIV Services Plan goals and objectives.</td>
<td>7.6g By February 28, 2009, the Evaluation Subcommittee will continue to oversee implementation of current three-year Comprehensive HIV Services Plan goals and objectives.</td>
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</table>
### EMA GOAL 7.7: The Council prioritizes services and allocates funds in an efficient and well informed process each year.

<table>
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<tr>
<th>Objectives FY 06</th>
<th>Objectives FY 07</th>
<th>Objectives FY 08</th>
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</thead>
<tbody>
<tr>
<td>7.7a By February 28, 2007, Planning Council will establish service priorities and allocate funds at the Annual Priority Setting and Resource Allocation Summit based on epidemiological data, needs assessment, service utilization data, and other available information.</td>
<td>7.7b By February 28, 2008, Planning Council will establish service priorities and allocate funds at the Annual Priority Setting and Resource Allocation Summit based on epidemiological data, needs assessment, service utilization data, and other available information.</td>
<td>7.7c By February 28, 2009, Planning Council will establish service priorities and allocate funds at the Annual Priority Setting and Resource Allocation Summit based on epidemiological data, needs assessment, service utilization data, and other available information.</td>
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</table>

### EMA GOAL 7.8: The Council reviews the effectiveness of the evaluative administrative mechanism on a regular basis.

<table>
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<tr>
<th>Objectives FY 06</th>
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<th>Objectives FY 08</th>
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</thead>
<tbody>
<tr>
<td>7.8a By February 28, 2007, the EAM Subcommittee will oversee all grantee assessment activities.</td>
<td>7.8c By February 28, 2008, the EAM Subcommittee will continue to oversee all grantee assessment activities.</td>
<td>7.8e By February 28, 2009, the EAM Subcommittee will continue to oversee all grantee assessment activities.</td>
</tr>
<tr>
<td>7.8b By February 28, 2007, Planning Council will identify successes in meeting recommendations from existing grantee assessment activities.</td>
<td>7.8d By February 28, 2008, Planning Council will identify successes in meeting recommendations from existing grantee assessment activities.</td>
<td>7.8f By February 28, 2009, Planning Council will identify successes in meeting recommendations from existing grantee assessment activities.</td>
</tr>
</tbody>
</table>
Chapter 11: Monitoring and Evaluation of Plan

Monitoring and Evaluation of the Comprehensive HIV Services Plan

The Evaluation Subcommittee of the Quality Management Committee will assume responsibility for monitoring and updating the Comprehensive HIV Services Plan on an annual basis. Short-term and long-term goals will be reviewed and monitored and changes made in the Plan will be based on changes in the epidemic, service needs, provider capacity, and resources in the EMA. The annual review will also take into account the legislative, regulatory, health service delivery, and treatment changes that will affect the system of care.

Assessment of the compliance of the Planning Council with HRSA requirements is also part of the evaluation responsibilities. The Council support staff, in collaboration with the Evaluation Subcommittee will develop an evaluation template that will be used to monitor the Council’s accomplishment of the tasks required to perform, such as timely posting of minutes on the web site, evaluating the grantee, and adequately training new council members on core competencies. Accomplishments of these objectives will be documented and reported to the Evaluation Subcommittee.

The IEHPC 3-year Comprehensive HIV Services Plan includes specific objectives for each of the next three years that support the goals developed through the EMA’s community planning process. Evaluating the implementation process and outcomes that result from these objectives is a collaborative process that involves the PC & the RWCA Grantee.

The Council will continuously monitor the implementation of the EMA’s priorities through the activities of the Evaluation Subcommittee. In order to effectively assess the system of care in the Riverside/San Bernardino EMA, the Council relies on the work of the Grantee, as well as information gathered during the Council’s needs assessment process and the involvement of community members.

These reports will come from the Grantee, the Planning Council support staff, and committees of the Council, allowing the council to track and assess progress in providing optimal services for PLWH/A.

System-wide goals and objectives will be revisited and revised as needed each year during the PC Priority Setting and Resource Allocation Annual Summit. The Evaluation Subcommittee will be responsible for the evaluation of the system-wide goals and conduct a semi-annual review of progress towards the system-wide goals and objectives; and will report to the full council on progress towards the goals.

Evaluating the implementation of the service category goals and objectives is primarily the responsibility of the Grantee. The grantee develops the implementation plans that actualize the service category goals the Council approves, through the procurement process for new services, and the review and renewal of service contracts from ongoing programs. The Grantee has a monitoring process that ensure that subcontractors are utilizing funds.
appropriately and documenting and reporting accurately the units of service they are providing for people for PLWH/A in the EMA.

The Grantee will provide reports at least quarterly to the full Council on the implementation of program objectives, the contract monitoring process, the effect of reduced funding on the service system, and progress towards utilization data and analysis. During the 2005 Priority Setting and Resource Allocation Summit, the Grantee provided utilization data, potential identified disparities in services, and expenditure data about each service category. Updated service category information will be provided each year to the Council during PS&RA Summit, so that multi-year analysis of trends within and among service categories can be conducted.

The Planning Council and the Grantee have been involved in development, periodic review and revision of Standards of Care for specific service categories. These standards are developed through a cooperative process that includes service providers, representatives of the Grantee, and consumers. The Standards Subcommittee of the Quality Management Committee in the development of the standards have examined best practices in each field, and determined strategies for service delivery that are congruent with the overall goals and shared values and vision of the council. Standards of care have been developed for Ambulatory/Outpatient Medical Care, Social Case Management, Early Intervention Services: SAFE-T-Net, Mental Health Services, Substance Abuse, Oral Health, and Health Education/Risk Reduction for Positives. In addition, a Common Standard was developed to include those topics which applied to every service and the current financial eligibility criteria matrix.

The periodically reviewed and revised standards of care are an integral part of the Quality Management Plan being implemented by the Grantee, and are integrated into service provider contracts.

The health outcomes that result from participating in the system of care services, such as improved health status and reduced morbidity and mortality are evaluated as part of the EMA’s ongoing QM plan. This QM plan will continue to address individualized client-level outcomes, as well as provide population-based analysis so that the Council can determine whether we are successfully eliminating disparities in health outcomes between different populations. This will allow the Council to evaluate some of the system-wide goals, such as improving the health status of people of color in the EMA.

**EMA’s Overall Quality Management Program**

The EMA is committed to implementing its quality management (QM) activities in collaboration with PLWH consumers, service providers, the Inland Empire HIV Planning Council (IEHPC), and the Office of the RWCA-Title I/II Grantee. The mission of the QM Program is: to ensure that all RWCA eligible people living with HIV/AIDS (PLWHA) in the Riverside/San Bernardino, CA Eligible Metropolitan Area (EMA) receive high quality medical care and support services to maintain them in care.

Figure 11-1 depicts the collaborative structure of staff and key stakeholders that oversee the EMA’s quality activities. This collaboration includes processes to assess the Title I Grantee on the progress of the QM Plan. Within this structure, each major entity has a key role.
Inland Empire HIV Planning Council (IEHPC)
The IEHPC oversees the work of the Quality Management Committee that is comprised of various stakeholders. The IEHPC reviews and provides feedback on implementation of the QM Plan and is responsible for the development and review of the Standards of Care and outcome indicators in accordance with USPHS Guidelines. Monthly, the IEHPC receives updates on QM activities through the EMA’s Grantee Report.

Quality Management Committee
As noted earlier, the Title I Grantee through the Office of the RWCA Program has collaborated with the IEHPC in developing a Quality Management Committee (QMC), which in conjunction with its two sub-committees (Evaluation and Standards) is the primary body to help determine measurement priorities and methods on an ongoing basis. The QMC facilitates cross-Title coordination by collaborating with consumers, representatives from Title I/II, MAI and Part F providers, and other consultants and/or experts as appropriate.

The QMC provides oversight by monitoring the QM Program’s progress in meeting the goals outlined in the QM Plan. The QMC also provides input to the EMA’s Quality Management Program. The Committee meets monthly, or as needed to fulfill committee responsibilities and the committee includes a representative from the Office of the RWCA Title I/II Grantee, Quality Management Program. The Committee reviews and updates the QM Plan annually and establishes quality assurance and evaluation activities.

The QMC determines program priorities, performance measures, and identifies indicators to assess and improve performance. The Committee makes recommendations to the Grantee for appropriate education relating to quality improvement concepts and techniques. The Committee reports cumulative service (process) and health outcome results to the Executive Committee and Planning Council. Recommendations of the QMC are made directly to the Planning Council and the Title I/II Grantee via the monthly committee report process.

RWCA Title I & II Grantee
The QM Coordinator facilitates the development, implementation, and review of the EMA’s
QM Plan. This plan assesses quality management activities throughout the year. The QM Coordinator also oversees the ongoing development and implementation of continuous quality improvement (CQI) mechanisms and measures for service providers. The QM Coordinator provides technical assistance to agencies to facilitate ongoing improvement of services. The QM Coordinator is part of the Grantee’s Program Auditing Team to ensure providers are in compliance of the IEHPC’s Standards of Care (QA).

**RWCA TITLE I & TITLE II Funded Service Providers**

Quality touches the lives of PLWH at the point of service. Service providers work collaboratively with the Title I Grantee and the IEHPC to ensure high quality programs and services. In FY 04-05, all Title I-funded agencies developed QM plans that included a process for integrating the new chronic care model into their service delivery. The plans include how the agency will track service indicators and health outcomes, document, and report them to the Title I Grantee. All Title I-funded agencies have implemented the FOCUS PDSA (Plan, Do, Study, Act) CQI model for process improvement. Finally, service providers participate in the EMA’s annual, standardized, Client Satisfaction Survey as part of their contract requirements.
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Appendix A

Inland Empire HIV Planning Council

The Inland Empire HIV Planning Council is pleased to release the Public Review Draft of the

2006-2009 Comprehensive HIV Services Plan 
for the Riverside/San Bernardino, CA 
Eligible Metropolitan Area

The Public Review Draft will be presented at each of the following Community Forum:

CATHEDRAL CITY LIBRARY
33-520 Date Palm Drive
Cathedral City, CA  92234
Tuesday, October 25, 2005, from 2:00pm – 4:00pm

RIVERSIDE COUNTY DEPT. OF PUBLIC HEALTH
4065 County Circle Drive, Auditorium Room 101
Riverside, CA  92503
Tuesday, November 8, 2005, from 2:00pm – 4:00pm

HOOK COMMUNITY CENTER
14973 Joshua Street, Game Room
Victorville, CA  92394
Tuesday, November 9, 2005, from 2:00pm – 4:00pm

GENERAL SERVICES GROUP (GSG) BUILDING
777 E. Rialto Avenue, Conference Room A
San Bernardino, CA  92415
Tuesday, November 15, 2005, from 2:00pm – 4:00pm

If you are living with HIV/AIDS, a provider of HIV/AIDS services, or just a community member that cares your comments are wanted!

For information on where public review hard copies and CD-ROM versions are available, please contact Joe Acosta, Co-Chair c/o Planning Council Support Staff:

Check our website at www.iehpc.org

Contact Planning Council Support Staff at (951) 358-6269 or e-mail: dangulo@co.riverside.ca.us

This plan was supported by funding through Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, as amended by the Ryan White CARE Act in 1996 and 2000.
Community Forums

A thirty-day review period was provided for public review and comments of the 2006-2009 Comprehensive HIV Services Plan. The Inland Empire HIV Planning Council also arranged for five community forums to be presented in the Riverside/San Bernardino, California EMA. The Comprehensive Plan Subcommittee of the Planning Committee identified five service areas targeted to present the Comprehensive Plan community forums. These service areas included; Cathedral City & Indio (Service Area 3); San Bernardino (Service Area 4); Riverside (Service Area 1); and Victorville (Service Area 6). The forum in San Bernardino was provided in Spanish for the monolingual community.

The forums were established to gather information and comments from the infected and affected communities and the general community on the 2006-2009 Comprehensive HIV Services Plan. Public Service Announcements were sent to fifty local and grassroots newspapers and publications throughout the six services areas of the EMA.

A total of four planning Council members, six provider representatives, and six PLWH/A and General Community attended the forums.

Community Forum Comments:

- “Target faith-based organizations may “open the door” for disparities in health care.”

- HIV testing has not been mentioned in new outreach program based in Coachella Valley.

- Riverside County Dept. of Public Health, HIV/AIDS Program has the goal to branch out further east in the desert with a mobile van team starting up soon, hopefully within the first couple of months.

- Suggestions for “social marketing” were made, i.e.; billboards advertising for HIV/AIDS.

- Suggestion to possibly add HIV testing to STD testing for syphilis outbreak.

- Riverside County Neighborhood Clinic is collaborating with Inland AIDS Project due to the need for more services and transportation to clients. This will hopefully diminish disparities because without transportation clients cannot receive services.

- A suggestion was made for the Inland Empire HIV Planning Council to coordinate a large, EMA-wide, prevention program/event.
• “HIV Rapid Testing is a blessing!”

• “Positive Change” program is available through Riverside County Neighborhood Clinic with a high majority of substance abusers. Substance abuser choice of drugs, methamphetamines.

• Pharmaceutical services have a problem with liability issues as mental drugs conflicts with people admitting that they will not stop their substance abuse.

• “Positive Change” program will go out and seek clients since their attention span is limited, as long as it is a safe environment.

• Provider expressed the need for better transportation for clients in Victorville, recommending full month bus passes and possibly a bus system to San Bernardino. Also expressed the need for another infectious physician in Victorville.

• “The ideas presented in the plan were good but how are you going to bring this to the community?” “You might want to consider having individuals living with HIV in the community bring these messages to their own community.”

• “The social marketing plan is good because it will bring information to all people about HIV/AIDS.”

• “Many people from our community just are in denial about being HIV positive.”

• “Using a peer advocacy to help others that are HIV+ would be good.”