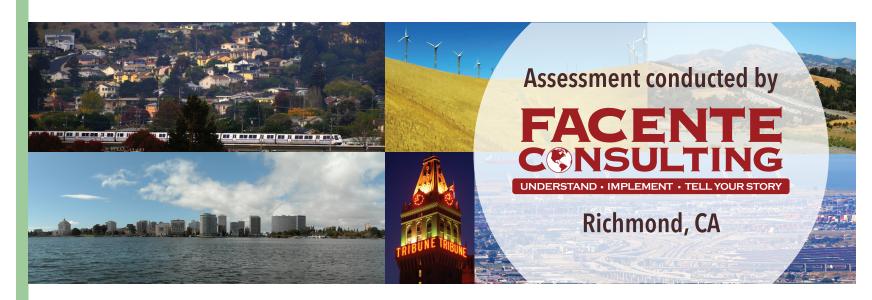
Oakland Transitional Grant Area (TGA) 2013 HIV/AIDS Needs Assessment

Encompassing
Alameda and Contra Costa Counties, California



Report prepared by Shelley N. Facente, MPH

December, 2013

Acknowledgements

VaShone Huff, Denisha DeLane, Arly Flores for their knowledge and rapport with HIV/AIDS providers and consumers within the Oakland TGA and their work in gathering the qualitative data used for this assessment

Julia Marcus for her epidemiological expertise and assistance

Jillian Banks-Kong for her design and formatting expertise and assistance

Staff at the Alameda and Contra Costa health departments, especially Dr. Neena Murgai and those who generated data, graphs, and maps to illustrate the information presented in this report

Members of the Oakland TGA Collaborative Community Planning Council

Members of the Contra/Costa HIV/AIDS Consortium

All of the service providers and consumers who gave their time and insights in order to help all of us better understand the needs of people at risk for or living with HIV in the Oakland Transitional Grant Area in 2013

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CHAPTER ONE

Introduction & Methods

Background

In January of 2013, the Office of AIDS Administration of the Alameda County Public Health Department released a Request for Proposals on behalf of the Oakland Transitional Grant Area (TGA). Under the Part A funding category of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, areas of the United States that are disproportionately affected by the HIV epidemic can be designated as "Transitional Grant Areas" and can receive emergency relief grants to provide community-based HIV-related services.¹ The Oakland TGA encompasses both Alameda and Contra Costa Counties, a region that is 1623.15 square miles with a population of approximately 2.6 million people.² Under the regulations of the Health Resources and Services Administration (HRSA) TGAs are required to use a community planning process, and are encouraged to establish a planning council that is representative of the community and assists in setting priorities for HIV services in the TGA, as well as allocating resources to address these priorities.1 In the Oakland TGA, this group is the Collaborative Community Planning Council (CCPC), a 20-member body that meets monthly in entirety, in addition to smaller committee meetings.3 The Request for Proposals released in early 2013 sought a qualified contractor to conduct a 2013 HIV/AIDS Needs Assessment in the Oakland TGA, and to produce a written report that could be used to guide the CCPC in determining HIV service priorities and allocations for Ryan White Program funds beginning March 1, 2014. In Spring of 2013, Facente Consulting was hired to conduct this assessment.

Focus of the Assessment

The 2013 HIV/AIDS Needs Assessment had 4 stated areas of focus:

- 1. Mapping service locations, and investigating the distance clients must travel to access HIV services
- 2. Examining the impact of the Low Income Health Plan on consumers of HIV services and the consumer awareness of the healthcare changes resulting from the Affordable Healthcare Act of 2012

- 3. Assessing the needs of HIV-positive heterosexual men in Alameda and Contra Costa Counties, including identifying disparities in accessing services, and
- 4. The incidence of intimate partner violence and the impact on HIV incidence, prevalence, and outcomes.

Methods

In order to have findings available in time to inform resource allocation decisions for 2014, there was an extremely short timeline for this assessment. For this reason, and given the limited resources available to conduct data collection, this assessment was designed as a primarily qualitative effort to quickly examine needs and underlying factors impacting these four topics. Qualitative research involves the exploration of chosen topics through unstructured data collection: primarily focus groups, in-depth interviews, facilitated group meetings, and analysis of existing written content (i.e. reports or published literature). Data are usually gathered through a combination of audio recordings, notes that were taken during discussions using loosely structured interview guides, and written observations recorded by the person responsible for data collection immediately after the close of each session. In this project, data were gathered in this way from service providers, community stakeholders, health department staff, and directly from consumers to elicit stories and obtain a well-rounded perspective on the topic areas of the needs assessment. Data were then analyzed through a common process called immersion/ crystallization,4 whereby researchers immerse themselves in the data they've collected, reflect on the overall picture until the ideas crystallize and they can identify and describe meaningful themes and patterns in the data.

In this assessment, the qualitative research was paired with two quantitative surveys, comprised of mostly closed-ended questions which, when responses were taken together, could be summarized and counted in a way that was useful for the assessment. Overall, a team of five people worked on the assessment team, together offering a comprehensive set of necessary skills, knowledge, and relationships within the TGA in order to successfully conduct this assessment.

Extensive efforts were made to solicit input from agencies, stakeholders, and individuals throughout the TGA. In all, data were collected from the following sources:

3 REGIONAL STAKEHOLDER MEETINGS

open to anyone in the region who wanted to discuss the issues of focus for the Needs Assessment. These meetings were held in Fremont, Concord, and Oakland.

6 AGENCY-FOCUSED GROUP MEETINGS OR ONE-ON-ONE INTERVIEWS

held with a subset of service providers in key agencies at their service location.

6 CLIENT/CONSUMER FOCUS GROUPS

held in partnership with various agencies throughout the region with specific target populations relevant to the Needs Assessment areas of focus. Focus groups were held with:

- Latinos (held in Spanish)
- Women
- Youth
- People who inject drugs
- HIV-positive men of color
- Black men

Partner Agencies who supported recruitment and hosting of focus groups include Highland Hospital, AIDS Health-care Foundation, East Bay AIDS Center, Women Organized to Respond to Life-Threatening Diseases (WORLD), HIV Education and Prevention Project of Alameda County (HEPPAC), the MOCHA Men's Group and Youth Group at The Rainbow Community Center of Contra Costa County, Grupo Fremont VIP, Black Treatment Advocates Network (BTAN) / The Bay Area Regional African-American AIDS State of Emergency Coalition (BARAASEC), La Clínica de La Raza, Bay Cares and Get Screened Oakland.

52 PROVIDER SURVEYS FROM 38 AGENCIES

these surveys were collected online via SurveyMonkey[†] and were quantitatively analyzed. Responding agencies were:

- Abode Services
- AIDS Healthcare Foundation
- AIDS Project of the East Bay
- Alameda County Public Health Department
- Alameda Health Consortium

- Alameda Health Systems
- Allen Temple Baptist Church
- Anthony Jones MD
- Berkeley Builds Capacity
- California Department of Health

†SurveyMonkey is a free or paid online survey service, available at www.surveymonkey.com.

52 provider surveys from 38 agencies (cont.)

- Centerforce
- Children's Hospital & Research Center Oakland
- Community Care Services Inc.
- Contra Costa Health Services, HIV/AIDS
 & STD Program
- Contra Costa Interfaith Housing
- East Oakland Community Project
- Eden I&R
- Family Support Services of the Bay Area
- Food Bank of Contra Costa and Solano
- Grupo Fremont VIP
- HIV ACCESS, Asian Health Services
- HFPPAC.
- Housing Consortium of the East Bay
- Imani Community Church

- La Clínica de La Raza
- Lifelong Medical Care
- Neighborhood House of North Richmond
- Options Recovery Services
- Planned Parenthood Mar Monte
- Project Open Hand
- Providence House
- Rainbow Community Center of Contra Costa County
- Resources for Community Development
- Rubicon Legal Services
- The Yvette A. Flunder Foundation
- Tri-City Health Center
- WORLD
- YWCA Contra Costa / Sacramento

97 CONSUMER SURVEYS COLLECTED FROM 14 AGENCIES AND SEVERAL COMMUNITY EVENTS THROUGHOUT THE TGA

these surveys were distributed on paper and collected from participating agencies after at least a 2-week period. Participating agencies were chosen to have a varied spread according to geography, service type, and target population. Consumer surveys are a small semi-representative sample of the larger population of People Living with HIV or AIDS (PLWHA) in the TGA and were not intended to be all-inclusive due to resource limitations. They were collected with the support of:

- AIDS Healthcare Foundation
- AIDS Project East Bay
- BTAN / BAARASEC
- La Clínica de La Raza
- Community Care Services
- East Bay AIDS Center
- East Bay AIDS Advocacy Foundation / East Bay AIDS Walk

- Grupo Fremont VIP
- HEPPAC
- Highland Hospital
- Lifelong Medical Care
- Options Recovery Services
- Rainbow Community Center of Contra Costa County
- WORLD

Data Collection and Analysis

All qualitative sessions followed a loosely structured interview guide which changed slightly through the course of the assessment to focus on emerging themes or clarify discrepancies. Individual and group sessions were recorded when participants consented; if anyone objected, the recording was not made. Audio recordings were only used for transcription purposes and were not shared outside the assessment team. Team members took notes during sessions, and immediately afterward recorded observational notes of the session – i.e. what themes arose, what was challenging, what should be changed before the next session. The combination of assessment team member observations, session notes, and transcripts from each of the group and individual sessions was then analyzed and coded to identify themes, key quotations, and other information that informed the findings and recommendations presented in Chapters III – VI of this report.

The provider surveys were conducted online in English via SurveyMonkey. Emails were sent to as many providers as possible, and email recipients were encouraged to forward the invitation to colleagues throughout the TGA. Responses were collected throughout May, June, and July, and were exported from the SurveyMonkey system for detailed analysis. The consumer surveys were distributed on paper to 14 service agencies chosen for their diversity of location, services provided, and target populations. Surveys were distributed by hand in bulk to each agency, in both English and Spanish, with a request to have all HIV-related clients complete a survey for a two-week period. At the close of this period an assessment team member returned to the agency to pick up the surveys. Data from survey responses were entered into Microsoft Access and then analyzed for this report.

Structure of this Report

Chapter II of this report provides a summary of the epidemiology of HIV/AIDS in the Oakland TGA. This is not intended to be a comprehensive epidemiological profile; rather, it is a summary intended to highlight the most relevant pieces of data recently analyzed and presented by staff at the Alameda and Contra Costa County health departments. This summary helps to set the stage for the findings and recommendations described in the following chapters of the report.

Chapters III – VI each focus on one of the four topic areas of focus identified for this assessment. Each chapter presents any available data to describe the scope of the problem, highlights the findings of the assessment relevant to that topic, and presents a series of concrete recommendations.

Chapter VII presents a final summary of overarching themes regarding HIV/AIDS needs and service gaps in the Oakland TGA, and presents a series of recommendations for future work in this area.

Limitations

This Needs Assessment was commissioned with limited resources and extremely limited time; as a result the decision was made to focus primarily on service providers, with the assumption that those providers would be willing and able to speak as advocates for the needs of their clients. This information was then verified and supplemented through direct consumer assessment via focus groups and surveys. Despite structural challenges, the team succeeded in gathering a wealth of information that tells the story of needs and service gaps for the Oakland TGA in four broad topics. However, this 2013 HIV/AIDS Needs Assessment, as with other similar types of needs assessments, has a number of limitations that should be kept in mind while reviewing and interpreting the findings and recommendations presented in this report.

- This Needs Assessment was designed to be largely qualitative. Qualitative research is very well suited to provide information about human behavior, emotions, rationale, and contextual factors. However, because the numbers of people sampled in qualitative research tend to be small (as they were here), the data collected cannot be summarized quantitatively. Additionally, although those surveyed for this Needs Assessment were chosen to reflect the diversity of the TGA, this was not a random sample and responses may not represent the experiences of everyone in the TGA.
- For the consumer surveys and focus groups, the team experienced great difficulty in recruiting consumers who were not already clients at a participating service provider. As a result, there is limited information available in this report about the needs and service gaps for HIV-positive consumers who are not already engaged with HIV-related services within the TGA.
- Epidemiological and surveillance data related to HIV/AIDS is under strict confidentiality
 restrictions for obvious reasons. The combination of data security regulations and minimal
 staffing of both county health departments meant that epidemiological analysis was limited
 to key aspects of the local epidemics. The data presented here are the most comprehensive
 and updated information available at the time of writing.

CHAPTER TWO A Summary of Epidemiology of HIV/AIDS in the Oakland TGA

The Oakland TGA is a multi-jurisdictional area encompassing a demographically diverse population across Contra Costa and Alameda Counties. Given such diversity, it is vital to understand the nuances of the epidemic within the TGA. Factors such as geographic sprawl of an area, density of the overall population in that particular location, and prevalence of HIV among those residents help to paint a very detailed picture of potential HIV need for the region. Layered upon that foundation is the greater detail about exactly who seems to be most at-risk for HIV infection in the TGA: in which groups is the disease spreading the fastest (what groups have higher incidence rates), and which people seem to be most disproportionately affected (what groups make up a greater proportion of HIV cases than their proportion of total people in the TGA). These epidemiological realities raise important questions about why certain people are more impacted by HIV, and offer critical information that should be used to fairly set priorities and determine funding allocations.

This chapter will first describe the HIV/AIDS epidemic in Contra Costa County and then provide an overview of the epidemic in Alameda County. The data summarized in this chapter were provided by the Alameda County and Contra Costa County health departments.

Contra Costa County

Contra Costa County is a 732.6-square-mile area north of Alameda County, abutted by the San Francisco and San Pablo Bays on the west. Geographically, it is the ninth smallest county in California; however, in terms of population it is the ninth largest county in the state, with the US Census Bureau estimating 1,049,025 residents in the County in 2010.

Contra Costa County is generally divided into three zones for planning purposes: West County, Central County, and East County. The chart below shows the breakdown of towns, cities, and unincorporated areas within those zones.⁵

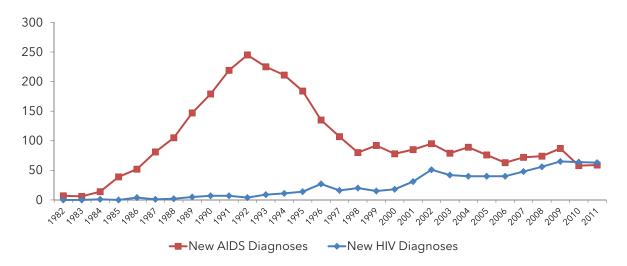
Figure 2.1
Contra Costa County Cities and Unincorporated Areas

West County		Central (Central County		East County	
Incorporated	2006	Incorporated	2006	Incorporated	2006	
Areas	Population	Areas	Population	Areas	Population	
Richmond	103,469	Concord	124,436	Antioch	100,945	
San Pablo	31,216	Walnut	66,111	Pittsburg	62,979	
		Creek				
Hercules	28,834	San Ramon	53,137	Brentwood	45,892	
El Cerrito	23,472	Danville	43,052	Oakley	29,074	
Pinole	19,465	Martinez	36,582	TOTAL	238,890	
TOTAL	206,455	Pleasant Hill	33,462	Unincorporated Areas:		
Unincorporated A	Unincorporated Areas:		24,191	Bay Point	Bay Point	
Bayview-Mont	Bayview-Montalvin		17,693	Bethel Island		
Crockett		Moraga	16,338	Byron		
East Richmond Heights		Clayton	10,924	Discovery Bay		
El Sobrante		TOTAL	425,926	Knightsen		
Kensington		Unincorporated Areas:				
North Richmond		Alamo				
Port Costa	Port Costa		Blackhawk-Camino			
Rodeo	Rodeo Tassajara					
Rollingwood		Canyon				
Tara Hills		Clyde				
Diablo						
Mountain View		1				
		Pacheco				
		Vine Hill				
		Waldon				

As of December 31, 2012, an estimated 1,270 people were living with AIDS diagnoses in Contra Costa County. An additional 688 individuals had been diagnosed with HIV infection that had not progressed to AIDS. Thus, through the end of 2012 a total of 1,958 people were living with HIV or AIDS in the county. New AIDS diagnoses peaked at 245 in 1992, decreased over the subsequent five years, and have been gradually decreasing since 1997. However, new HIV diagnoses have increased gradually over time since the beginning of the epidemic, with incidence at its highest – 63-65 cases per year – during 2009-2011.

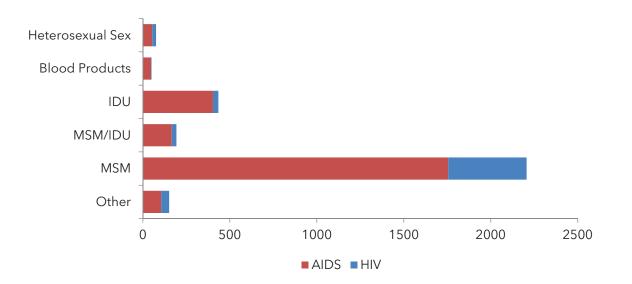
It is important to note that mandatory reporting of HIV infection (as opposed to AIDS, which has been a reportable disease since the early 80s) began in California in 2002. This had significant impact on the way HIV non-AIDS cases were counted and tracked in both Contra Costa and Alameda Counties before and after that date.

Figure 2.2
New HIV/AIDS Diagnoses (N=3,744), Contra Costa County, 1982-2011



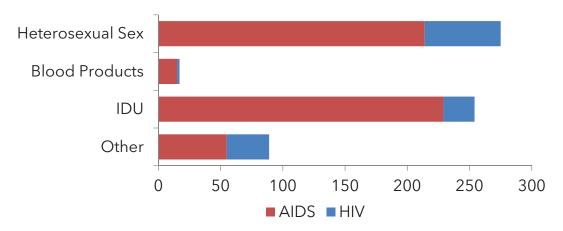
Historically, both HIV and AIDS cases among males in Contra Costa County have been concentrated among men who have sex with men (MSM), which reflects the profile of the wider HIV/AIDS epidemic in the western United States. However, unlike other areas of California, injection drug use (IDU) is a relatively common risk factor among males diagnosed with HIV/AIDS in Contra Costa County, contributing to 14% of diagnoses. Heterosexual sex accounts for less than 3% of HIV/AIDS diagnoses in the county.

Figure 2.3
Risk Factors for Males Diagnosed with HIV/AIDS (N=3,110), Contra Costa County, 1982-2011



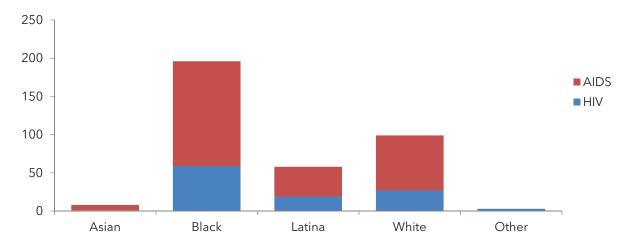
Of the total PLWHA in Contra Costa County as of December 31, 2012, 19% were women. Among women diagnosed with HIV/AIDS in the county during 1982-2011, the primary risk factors were heterosexual contact and IDU, accounting for 43% and 40% of cases, respectively.

Figure 2.4
Risk Factors for Females Diagnosed with HIV/AIDS (N=635), Contra Costa County, 1982-2011



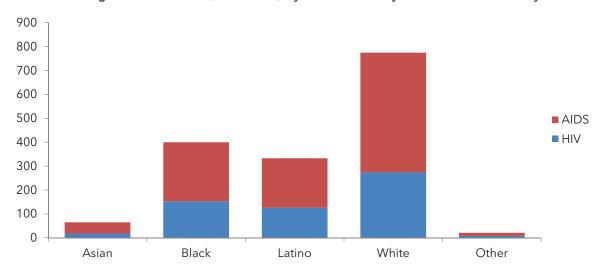
Among women, African Americans are disproportionately affected by HIV/AIDS in Contra Costa County. As of December 31, 2012, over half (54%) of female PLWHA were African American, compared to an overall 10% of county residents who are African American. There are half as many White women (27%) living with HIV/AIDS in the county.

Figure 2.5
Females Living with HIV/AIDS (N=364) by Race/Ethnicity, Contra Costa County, 2012



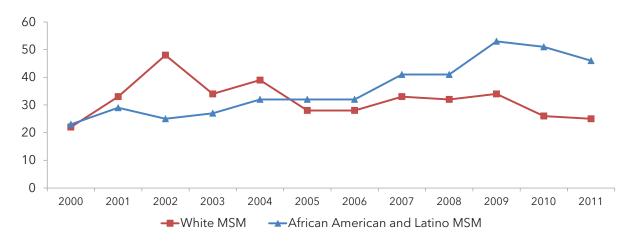
Among males in Contra Costa County, the epidemic also disproportionately affects African Americans. African Americans account for 25% of HIV/AIDS cases among males, compared to the overall 10% of county residents who are African American. On the other hand, 68% of county residents are White, while only 49% of male PLWHA in the county are White.

Figure 2.6
Males Living with HIV/AIDS (N=1,594) by Race/Ethnicity, Contra Costa County, 2012



As of 2000, there were no differences in HIV/AIDS diagnoses among White MSM compared to African American and Latino MSM in Contra Costa County. However, in the subsequent decade, HIV and AIDS diagnoses may have increased among African American and Latino MSM while decreasing among White MSM. In 2011, there were 46 new HIV/AIDS diagnoses among African American and Latino MSM, compared to only 25 among White MSM.

Figure 2.7
HIV/AIDS Diagnoses Among MSM by Race/Ethnicity (N=814), Contra Costa County, 2000-2011



Alameda County

Alameda County is a 738-square-mile area bordered by Contra Costa County in the north, the San Francisco Bay on the west, Santa Clara County on the south, and San Joaquin County on the east. The 2010 population was estimated to be 1,510,271, making Alameda County the seventh most populated county in the State of California.

Alameda County is generally divided into two zones for planning purposes: West County and East County (formerly known as the Livermore-Amador Valley), with running hills dividing the county in two.⁶ The chart below shows the breakdown of towns, cities, and unincorporated areas within those zones.^{7,8}

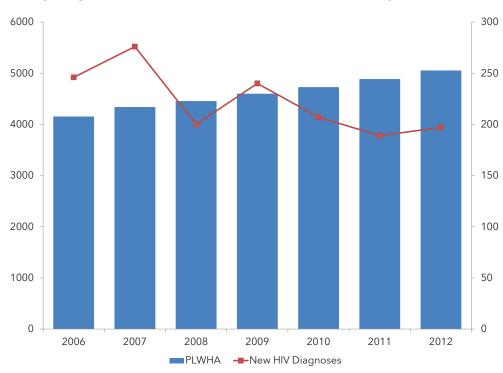
Figure 2.8
Alameda County Cities and Unincorporated Areas

Coasta	ıl Plain	Livermore-Amador Valley		
Incorporated Areas	2010 Population	Incorporated Areas	2010 Population	
Alameda	73,812	Dublin	46,036	
Albany	18,539	Livermore	80,968	
Berkeley	112,580	Pleasanton	70,285	
Emeryville	10,080	TOTAL	197,289	
Fremont	214,089	Unincorporated Areas:		
Hayward	144,186	Sunol		
Newark	42,573			
Oakland	390,724			
Piedmont	10,667			
San Leandro	84,950			
Union City	69,516			
TOTAL	1,171,716			
Unincorporated Areas:				
Ashland				
Castro Valley				
Cherryland				
Fairview				
San Lorenzo				

As of December 31, 2012, 3,522 people were living with AIDS diagnoses in Alameda County – an epidemic approximately 3 times the size of that in Contra Costa County. An additional 1,532 individuals had been diagnosed with HIV infection but had not progressed to AIDS. Through 2012, the total number of PLWHA in the county was 5,054, with 197 people being newly diagnosed with HIV in that year.

As seen in Contra Costa County, AIDS diagnoses peaked in Alameda County in 1992 and have steadily decreased since that year. The number of PLWHA overall has increased, and the number of deaths from AIDS decreased, with improvements in antiretroviral therapy. The number of new HIV cases declined slightly from 2006 through 2012.

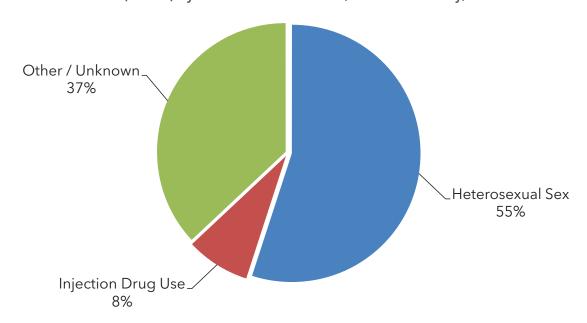
Figure 2.9
Newly Diagnosed HIV Cases and PLWHA, Alameda County, 2006-2012



Demographically, the Alameda County epidemic largely parallels that of Contra Costa County. Among individuals newly diagnosed with HIV during 2010-2012 in Alameda County 14% were female, compared to 19% female in Contra Costa County. Also similar to Contra Costa County, the primary risk factor for newly diagnosed HIV cases for women in Alameda County was heterosexual contact, accounting for 55% of cases.

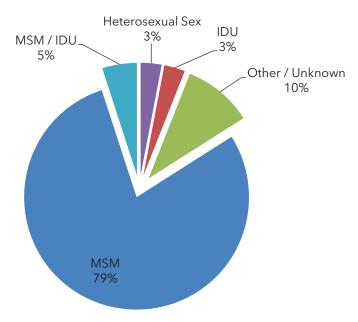
However, IDU is five times more prevalent as a risk factor for female HIV/AIDS cases in Contra Costa County compared to female HIV cases in Alameda County. Only 8% of female HIV cases during 2010-2012 in Alameda County were attributable to IDU, compared to 40% of female HIV/AIDS cases in Contra Costa County through 2011.

Figure 2.10
Female HIV Cases (N=84) by Mode of Transmission, Alameda County, 2010-2012



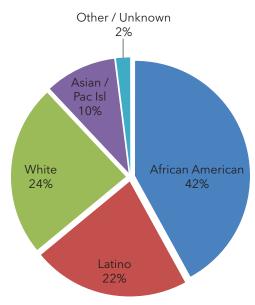
As reflected in the wider HIV/AIDS epidemic in the State of California, the burden of the epidemic in Alameda County lies among men. Of the males newly diagnosed with HIV during 2010-2012, the majority (79%) were MSM, with IDU and heterosexual sex each only contributing 3% of the cases.

Figure 2.11
Male HIV Cases (N=509) by Mode of Transmission, Alameda County, 2010-2012



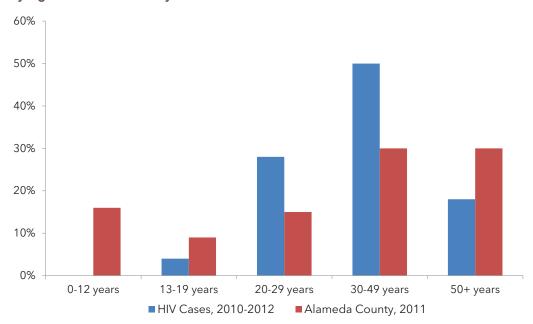
As seen in Contra Costa County, new HIV diagnoses in Alameda County in both males and females are disproportionately concentrated in African Americans. Overall, 42% of new HIV cases during 2010-2012 were among African Americans, while African Americans make up only 12% of the county population.

Figure 2.12
Newly Diagnosed HIV Cases (N=593) by Race/Ethnicity, Alameda County, 2010-2012



Compared to the overall age distribution in Alameda County, newly diagnosed HIV cases in the county are disproportionately concentrated in younger adults. The majority (78%) of HIV cases are diagnosed among individuals between the ages of 20 and 49, while adults aged 20-49 are only 45% of the total county population.

Figure 2.13
Comparison of Newly Diagnosed HIV Cases (N=593) and County Residents (N=1,525,655) by Age, Alameda County, 2010-2012



Overall, the HIV/AIDS epidemic in both Contra Costa and Alameda Counties is concentrated in males, African Americans, MSM, and young adults. Males account for the vast majority of new HIV diagnoses in both counties, with MSM contributing to the majority of those cases. In both males and females, African Americans are disproportionately affected by HIV/AIDS compared to the overall demographic profile of these counties. Adults aged 20-49 also carry a disproportionate burden of the epidemic. Finally, IDU is far more prevalent among female HIV/AIDS cases in Contra Costa County compared to those in Alameda County.

In the following chapters, this Needs Assessment focuses on four specific topic areas of concern. Although this HIV/AIDS overview is not comprehensive, having a broad understanding of the overall demographic profile of the epidemic in these counties provides a context for these topic areas and findings of this assessment.

CHAPTER THREE Proximity of Services to PLWHA

Literature Regarding Proximity of Services and Accessibility

The literature is clear that people who are located more geographically distant to necessary health and social services are less likely to access them, even when in serious need.⁹⁻¹¹ Similarly, research has shown that – especially when patients or clients must travel an inconvenient distance to reach services – co-location of health care and social services is beneficial, both in terms of increased service access and improved patient outcomes.¹²⁻¹⁴ This is only logical, as anyone would prefer a comprehensive "one-stop shop" that meets most of their needs without requiring travel, over a necessity to make multiple stops in multiple places to obtain the same services.

However, actual distance or travel time to services is not the only critical issue. The ability to trust providers and feel comfortable in the service location is at least as important. Much research has demonstrated that development of client-provider trust is instrumental to improved outcomes of the client or patient, ¹⁵⁻¹⁸ and in fact some have suggested that interventions that improve patient or client-provider trust may reduce health disparities. ¹⁹ More importantly, actual or perceived poor treatment, insensitivity, or discrimination by a service provider can do damage to clients or patients – worsening outcomes or even traumatizing those who were expecting to find a supportive environment. ²⁰⁻²²

The point, then, is that living nearby to HIV-related services is not sufficient; PLWHA must live near HIV-related service organizations that offer services relevant to their personal needs and are linguistically and culturally competent. This chapter looks at both the geographic proximity and appropriateness of services for PLWHA in Alameda and Contra Costa Counties.

Overview of Proximity of Services to PLWHA in the Oakland TGA

Because the Oakland TGA spans such a wide geographic area, it is important to understand whether HIV services are located in areas that are easily accessible to residents living with HIV infection and/or AIDS diagnoses. This chapter will first describe the geographic distribution of the HIV/AIDS epidemic in Contra Costa and Alameda Counties, and will then describe the distribution of available HIV/AIDS services in each county with respect to where PLWHA live.

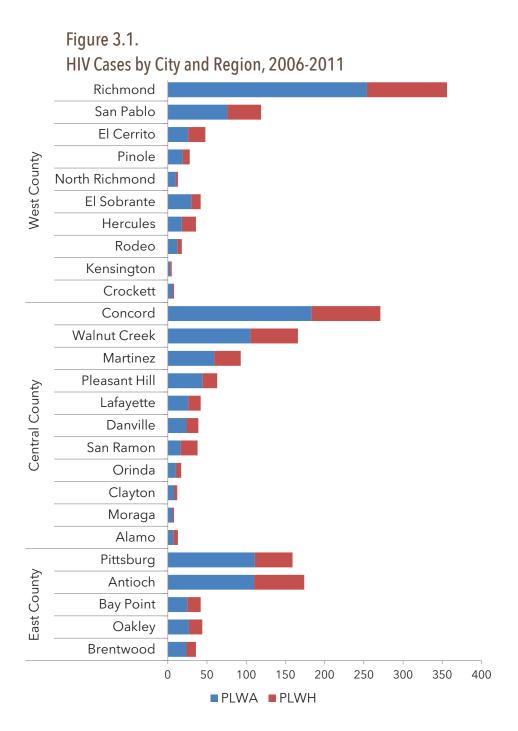
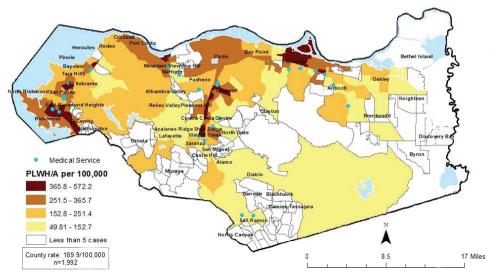


Figure 3.2 (on the following page) shows a map of Contra Costa County, with the shading representing the distribution of PLWHA in the county by current residence; darker areas represent a higher density of PLWHA in a particular census tract. Each blue dot represents the location of an HIV/AIDS-related medical service.

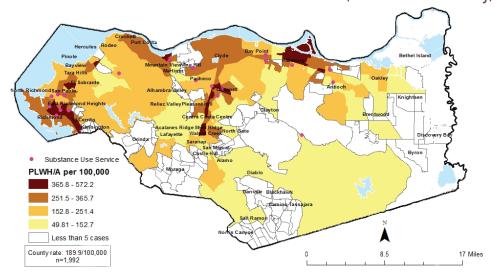
Figure 3.2
Distribution of PLWHA and Medical HIV/AIDS Services, Contra Costa County, 2013



Overall, the location of HIV/AIDS-related medical services roughly corresponds to the areas of the county with the highest concentrations of PLWHA. However, there are some shaded areas, such as Oakley and Crockett, where PLWHA may have to travel further for medical services. Few HIV-related medical services are available in the eastern, and especially southeastern, regions of the county, where PLWHA may need to travel furthest to access such services.

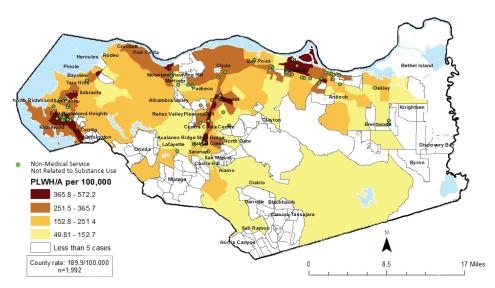
Figure 3.3 depicts the same map of Contra Costa County, with the pink dots representing the location of HIV/AIDS-related substance use services. Again, these services are generally located in the areas of the county with the highest prevalence of PLWHA. However, there are several areas with a high density of PLWHA, such as Walnut Creek, that have no HIV/AIDS-related substance use services.

Figure 3.3
Distribution of PLWHA and Substance Use Services, Contra Costa County, 2013



And finally, Figure 3.4 shows the same distribution of HIV/AIDS cases in the county, but this time with green dots representing the locations of HIV/AIDS-related services that are neither medical nor related to substance use (i.e., psychosocial services such as mental health counseling, food, housing, case management, support groups, syringe exchange, etc.).

Figure 3.4
Distribution of PLWHA and Medical HIV/AIDS Services, Contra Costa County, 2013

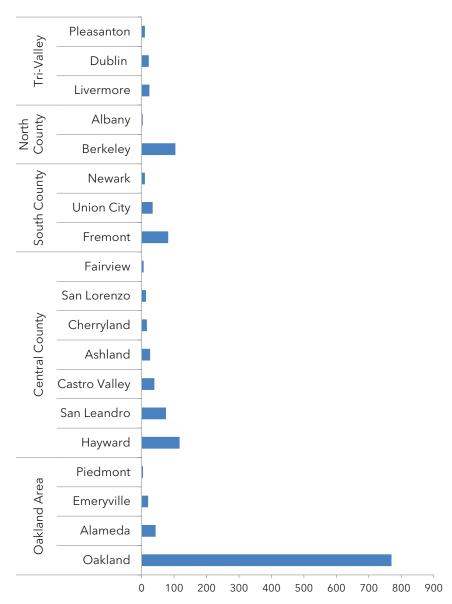


These non-medical and non-substance use HIV/AIDS-related services follow a similar pattern to medical services, in that they are generally located in the areas with the highest density of PLWHA. Again, however, there are few services available in the eastern, and particularly southeastern, areas of the county. Furthermore, each of these dots may represent a different type of service provider, suggesting that some PLWHA may need to travel some distance to access a specific type of service that is needed.

In general, Contra Costa County is a more rural county than Alameda County, with fewer PLWHA. Yet proportionately, there are many more services available per PLWHA than is true in Alameda County, as can be seen by comparing these maps with those on the following pages. The biggest challenge related to distance to services – in both counties – is for those people who happen to be living with HIV while residing in outlying areas of their county. They may be one of the only PLWHA around, and as a result will need to travel farther for HIV-related services than others in the county who live in areas with a higher density of PLWHA.

In **Alameda County**, the greatest burden of HIV cases is in Oakland. During 2006-2012, Oakland accounted for over half (54%) of new HIV diagnoses in Alameda County. Similar to the geographic distribution of cases in Contra Costa County, Oakland is characterized by a high prevalence of individuals living below the poverty line compared to the larger State of California (20% vs. 14% during 2007-2011).

Figure 3.5
City of Residence at Diagnosis for HIV Cases (N=1,555), Alameda County, 2006-2012



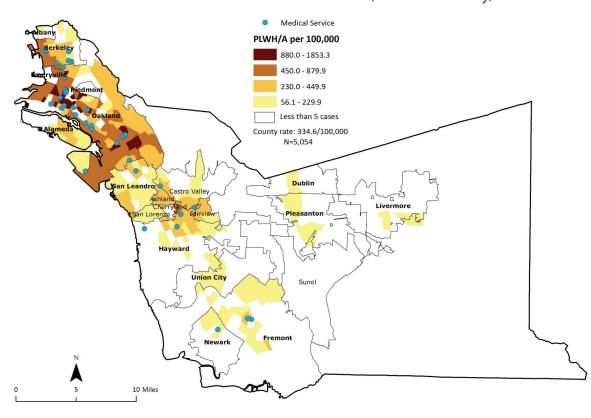


Figure 3.6
Distribution of PLWHA and Medical HIV/AIDS Services, Alameda County, 2013

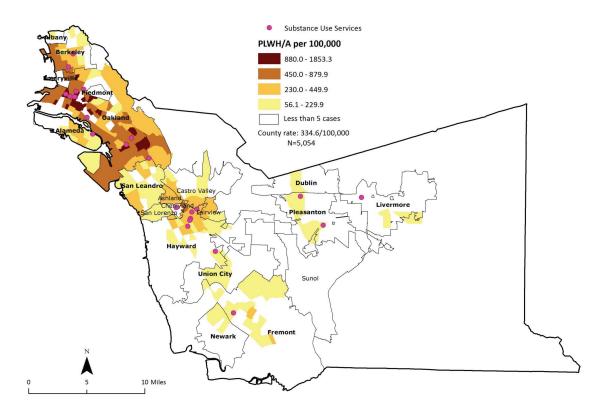
Source: CAPE (Community Assessment, Planning, Education, and Evaluation), with data from eHARS.

Figure 3.6 shows a map of Alameda County, with all HIV/AIDS-related medical services locations represented by a blue dot. Behind those dots appears the distribution of PLWHA in the county by current residence. As can be seen by the map legend, the darker the shading of a particular census tract, the greater the concentration of PLWHA there.

It is clear from this map that, overall, HIV/AIDS-related medical services are generally located in the areas of the county with highest prevalence of HIV and AIDS. However, there are a few notable darkly shaded areas with no nearby blue dot, especially in Oakland. It is also important to recognize that in the eastern parts of the county, few HIV specialty medical services are available, including none in Union City, Dublin, Pleasanton, or Livermore. While the burden of HIV disease is much lighter in these areas, there are still PLWHA living there and those people must travel great distances, often with few transportation options, for medical care.

Figure 3.7 presents a nearly identical map of the county, except instead of HIV/AIDS-related medical services, the pink dots on this map denote substance use services.

Figure 3.7
Distribution of PLWHA and Substance Use Services, Alameda County, 2013



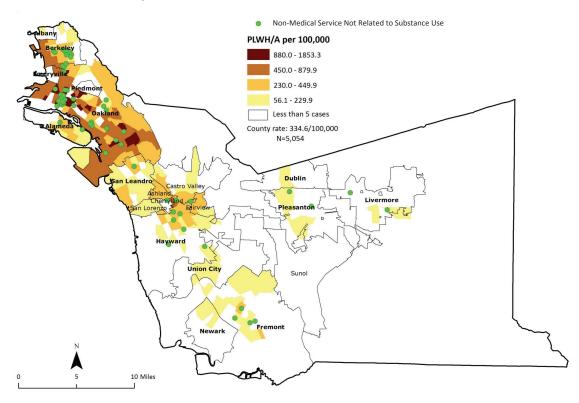
Source: CAPE (Community Assessment, Planning, Education, and Evaluation), with data from eHARS.

From this map, it is clear that there is wider distribution of substance use services throughout the county, particularly into the east. However, it is also more noticeable that there are large sections of Oakland that have significant burden of disease and yet few or no substance use service organizations located nearby.

Finally, Figure 3.8 shows the same distribution of HIV/AIDS cases in the county, but this time with green dots denoting organizations that offer HIV-related services other than medical or substance use services (i.e. psychosocial services such as mental health counseling, food, housing, case management, support groups, syringe exchange, etc.).

Figure 3.8

Distribution of PLWHA and Non-Medical HIV/AIDS Services Not Related to Substance
Use, Alameda County, 2013



Source: CAPE (Community Assessment, Planning, Education, and Evaluation), with data from eHARS.

Similar to with substance use services, other non-medical HIV-related services are pretty widely distributed throughout the county, and with the exception of some of the same regions of Oakland are located roughly near the areas of highest prevalence. However, in this case it is very important to remember that the green dots on this map represent a very wide variety of services. The dots are not interchangeable; someone who specifically needs housing assistance, for example, will only be able to find services at a few dots on this map, regardless of where they live.

Consumer Distance Traveled for Services

44 (47%) of the consumers who responded to the consumer survey during this assessment said they traveled less than 5 miles for services that day. 31 (33%) said they traveled 6-15 miles, 14 (15%) said they traveled 16-30 miles, and 4 (4%) said they traveled more than 30 miles for services. It is important to note that this is self-reported distance traveled, and may or may not be an accurate measure of the distance actually traveled. It is also not a measure of time traveled, which may have been a more useful indicator to measure and should be studied in future assessments.

Figures 3.9 and 3.10 display the distance traveled by age and by length of time living with HIV.

Figure 3.9 Self-Reported Distance Traveled to Service Agency, by Age of Consumer

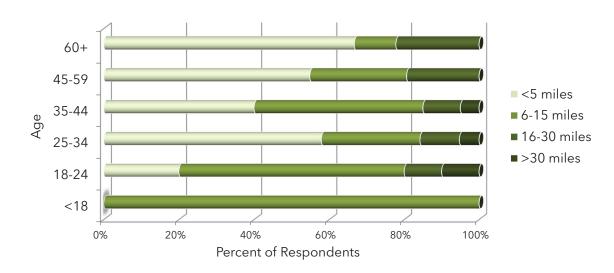
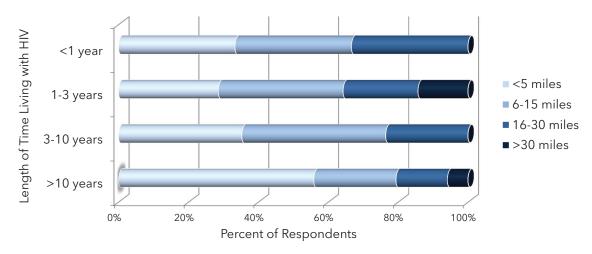


Figure 3.10
Self-Reported Distance Traveled to Service Agency, by Length of Time Living with HIV

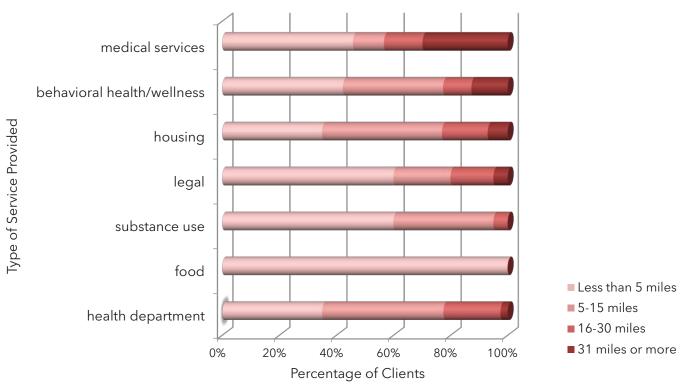


While some differences are visible regarding distance traveled for HIV-related services among these categories of age and length of time living with HIV, ultimately there are no significant patterns that appear. (Note that only one respondent was under age 18, which skewed the bottom bar of Figure 3.9.)

Providers responding to the SurveyMonkey survey were asked the percentage of their clients who traveled less than 5 miles, 5-15 miles, 16-30 miles, and 31 miles or more for services at their agency.

The figure below shows the average distance traveled by clients as reported by service providers, grouped into service type.

Figure 3.11
Provider-Reported Distance Clients Travel to Services, by Service Type



From this figure it is clear that consumers seem to travel much further for medical services, and next furthest for behavioral health/wellness services. Some explanations for this are that medical services often have strict eligibility requirements, and once people establish a relationship with medical providers in one location they tend to stay there even if it is far away from home. Behavioral health/wellness programs tend to be specialized for a certain group of people, and/or require heightened sensitivity and cultural competence on the part of staff. Therefore, it is logical that people are willing to travel farther to seek services at an agency that is a good match for them. Housing and legal support services are special cases because they don't often require a visit to the service location, at least on an ongoing basis. Most of all, people did not report traveling far for food, which makes sense largely because it is not logistically feasible to transport food a long way.

Reasons for Large-Distance Travel

1 out of 3 consumers who took the consumer survey said they traveled less than 10 minutes for services. Of those who traveled more than 10 minutes, 21 (34%) said they did so because there were no HIV-related services available closer to their home. 22 (34%) and 13 (21%) said they traveled so far because they didn't feel comfortable at agencies that were closer, or didn't like the way they were treated at agencies that were closer, respectively. (Note that categories are not mutually exclusive; consumers were asked to check all options that applied.) Only 2 (2%) of people said they traveled so far because they couldn't get an appointment at an agency that was closer. 15 (16%) said they liked being farther away so they won't run into anyone they know.

These responses were similar to the themes that arose from the qualitative sessions. Staff and consumers interviewed for this assessment frequently described that consumers would travel great distances for services if they felt those services were high-quality, and if they were able to receive comprehensive or unique services there; this was especially true for consumers who needed food access or syringe exchange, who did not speak English, or who were especially concerned about confidentiality in service locations closer to home. One respondent offered,

"I don't care how far the location is, to be honest, as long as they provide good service and it's easy to get to."

Another spoke similarly:

"Distance does not matter to me. Living with HIV is challenging enough. I want to have an experienced doctor that can support me and provide quality medical care that is culturally sensitive and without judgment."

Once clients had a very positive experience at a particular agency, they were likely to return regardless of inconvenience – highlighting the importance of developing trust, progress, and shared experiences between service providers and consumers. In fact, some staff described clients traveling as far away as Gilroy, Santa Cruz, and Modesto. Along the same lines, once clients had a negative experience at a particular agency, they were often willing to travel much farther to alternative agencies where they believed they received better treatment.

There are two other factors that arose during the assessment that influenced consumers' need and willingness to travel longer distances for services. The first was eligibility requirements. Some people described needing to travel farther from home to find agencies that provide services for

which they specifically are eligible based on income, risk behavior, or other factors. Secondly, a number of consumers described being willing to travel farther for services that are incentivized or offer greater financial support than agencies that are closer.

Cultural Competency Challenges Regarding Service Proximity

It was a major theme of the assessment that the simple geographic proximity of services to the homes of consumers was not a sufficient measure of service accessibility. While consumers who did not live near any HIV-related services clearly felt that burden, many consumers who lived very close to service providers also felt a need to travel great distances for services. In these cases, it was almost always due to issues of cultural competence. This includes whether people felt that staff at an agency were sensitive and competent to deal with their unique issues – whether related to their race or ethnicity, sexual orientation, gender identity, faith tradition, immigrant status, language(s) spoken, age, or other factors. Stories of experiences with racism, sexism, homophobia, transphobia, and being turned away for undocumented status were just some of the examples that arose during this assessment. As stated earlier, once a person has a bad experience with a culturally incompetent service provider, they are far less likely to return to that service location, even if other more suitable locations require them to travel great distances.

According to the consumer survey data from this assessment, Latinos were more likely to travel a longer distance for services than other groups: 66% of Latinos traveled 6 miles or more for services, compared to 39% of African Americans and 36% of Whites, respectively. Figure 3.12 shows the percent of respondents who selected each category of travel distance broken down by ethnicity.

African Americans

Whites

Whites

African Americans

Whites

Whites

African Americans

Percent of Respondents

Figure 3.12
Self-Reported Distance Traveled to Service Agency, by Ethnicity

It is possible that much of the difference in distance traveled for Latinos can be attributed to language issues. In the qualitative focus groups, however, Latinos repeatedly discussed their experiences with race-based discrimination while seeking services within the TGA. Numerous specific cases of alleged racial discrimination were enumerated in detail by consumers in the Spanish-language focus group. A full 50% of consumer survey respondents who said they traveled more than 10 minutes for services due to poor treatment at closer agencies were Latino.

One suggestion by respondents during the assessment that could help increase documentation of problems and result in improved treatment was greater information about patient/client rights and grievance procedures. Visibly advertising these rights and procedures and encouraging patients or clients to file grievances when they are mistreated could reduce the feeling that some consumers have that they are unable to effectively advocate for themselves in these situations.

RECOMMENDATION: Create a TGA-wide poster (or set of posters) highlighting patient/client rights and briefly spelling out options consumers have if they wish to file a grievance. Require that these posters be visibly present in all waiting areas and/or clinical offices of HIV-related service providers in the TGA.

There were numerous instances where consumers described continuing to seek services at agencies where they felt they were treated poorly, because better options simply didn't exist. A respondent from the Latino focus group explained:

"For example, I have friends who go to [an agency where they are treated very well], and they only give them \$250 per year for rent...At [another agency where they feel they are treated very poorly], they give you \$500, \$600, or even \$800. That's why we go [to the second agency], because they help you more. Yet there's discrimination [there]. At [the first agency] they treat you well, with respect and good manners, but they don't give you enough funds."

There are many factors that play into the amount of money or services any one agency can provide to a single consumer (including eligibility requirements, overall agency funding, etc.). The problem arises when consumers must choose between quantity of service or quality of treatment. This is clearly a serious issue within the TGA that warrants further study.

RECOMMENDATION: A Task Force should be convened to determine the validity of claims of racial discrimination and take specific steps to address these concerns and ensure safe and fair treatment for all HIV-positive people throughout the TGA regardless of race, ethnicity, sexual orientation, gender identity, faith tradition, immigrant status, language(s) spoken, age, or similar factors.

In addition to experiences of discrimination, another major theme that impacted distance to services in this assessment was language. Only 5 (8%) of respondents to the consumer survey said they traveled more than 10 minutes for services because no one speaks their language at agencies that are closer; however, as this was not a representative sample these data should be interpreted with caution. 27 of the 97 surveys (28%) were from respondents who chose to take the Spanish-language version of the survey. During the qualitative focus groups and staff interviews this issue arose quite frequently. Consumers spoke about friends or family members going without services simply because they didn't understand where they could seek services that would be appropriate for them. They were often solution-oriented, requesting various resources that would help monolingual Spanish-speaking people better identify services and access them in a language they understand. As one service provider explained,

"When English is not your first language it is hard to navigate within the system and access services especially when you are living with AIDS. [The Alameda County Office of AIDS Administration] need[s] to make sure that we have systems in place to support the needs of the Spanish speaking community and others who don't speak English as their first language."

Service providers who responded to the SurveyMonkey survey generally reported Spanish-speaking staff within their agency. Of the 31 agencies who answered the question, only 4 reported no Spanish-speaking staff members; the rest ranged from 1 to all staff members being bilingual. However, an additional 8 agencies noted that most or all of their bilingual staff only worked part-time or were volunteers, and therefore were unlikely to be regularly available. 3 of the 4 agencies who reported no Spanish-speaking staff members did also report that their agency served bilingual and/or non-English speaking monolingual clients. Of those, 2 reported a significant portion of clients who were in fact monolingual with a language other than English (20% and 17%, respectively).

RECOMMENDATION: Require that all HIV-related service providers within the TGA have at least one bilingual staff member who can speak Spanish, and is available for service provision or translation assistance during the majority of service hours. Allow for an exemption process for agencies that have reasonable need to be excluded from this requirement (i.e. they provide highly specialized services or are extremely unlikely to have Spanish-speaking clientele).

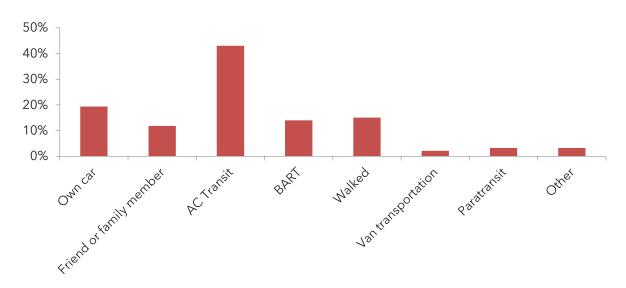
RECOMMENDATION: Have a physical location (i.e. information booth or office) where non-English speakers can learn about resources and HIV-related services that are available to them, especially if they are available in Spanish. In addition to (or in lieu of) a physical location, a free hotline (similar to 411) and period publication like a newsletter (produced on paper and electronically) should be made available to Spanish-speaking residents of the TGA that will assist monolingual speakers in learning about and accessing HIV-related services.

Transportation

No significant differences were seen between men and women in the distance traveled. However, the qualitative data showed that transportation was a key issue for access to services, regardless of gender.

Figure 3.13 shows the methods that consumer survey respondents said they used to get to their service agency.

Figure 3.13
Self-Reported Method of Transport to Service Agency



Of those who walked to the service location where they took the consumer survey, 12 traveled less than 5 miles but 2 reported traveling 6-15 miles (both of these combined walking with some other form of public transportation).

Of those who used AC Transit, 12 traveled less than 5 miles, 12 traveled 6-15 miles, and 11 traveled 16-30 miles. Importantly, all of the people who traveled more than 30 miles reported doing so via AC transit.

The need to use public transportation is a very important issue, because public transit means that sometimes even people who live in close physical proximity to a service location spend a long time to reach that location. As one consumer described,

"To get to the hospital [where I get my medical services] I take two buses, and I spend an hour and a half, or two hours to be on time. It's difficult."

This sentiment was echoed by some staff members who were interviewed, who described some of their clients traveling 45 minutes to one and a half hours each way on public transportation to reach them for services, even if they lived relatively nearby.

Of particular issue is the availability of public transportation for people living in unincorporated areas of the TGA. Residents who live in areas of Alameda County such as Castro Valley, San Lorenzo, Fairview, and Sunol, or areas of Contra Costa County such as Bay Point, Bethel Island, or North Richmond usually find they have limited and sometimes no access to public transportation from their residences. Without access to a private vehicle, people in this area must pay for expensive taxis, use county-sponsored van transportation or Paratransit, or spend long parts of their day traveling to and from service providers with whatever public transportation is available. This concern was highlighted by one consumer, who said,

"There are not many services available to me living Castro Valley. I have to travel to Oakland or Fremont for most of my medical services. [The Alameda County Office of AIDS Administration] need[s] to figure out how we can make it easier for the people in unincorporated areas to access quality services."

Overall, accessibility of a service seemed more important to most respondents in this assessment than physical distance. The most ideal service locations were in close proximity to easily-accessed public transit stops (minimizing the need for transfers or lengthy, rambling bus rides) and/or had free parking available for those who were able to drive. In other situations, alternate transportation methods were sometimes needed, such as taxis or van transportation, and those can be quite costly. A number of people spoke to increasing challenges with accessing care in the TGA as reduced funding was leading to cuts in support for client transportation.

Two specific solutions to transportation challenges were offered by consumers or staff. The first is to increase mobile services, such as the mobile pharmacy run by AIDS Healthcare Foundation, the mobile syringe exchange van run by HEPPAC, the mobile care van run by the Rainbow Community Center of Contra Costa County to support clients with mobility issues, or the mobile HIV testing van run by Berkeley Building Capacity. Instead of requiring consumers to travel to services, mobile programs allow agencies to bring services to the consumer.

especially in regions where clients are located physically far from services and/or are particularly disadvantaged with regard to transportation options – especially in unincorporated areas. Also investigate the possibility of having pop-up or satellite clinics on rotating days in these areas that would provide nearby access to HIV specialty clinicians and other wrap-around services.

The second solution is to concentrate multiple services within one agency, or co-locate agencies in an area. One of the main complaints heard from some consumers in the focus groups was the need to travel from one agency to another to access the various services they required. One respondent likened his vision of this to be "like a mall."

"In transportation, you can save. If you can go to the dentist, the [eye doctor], pick up food, everything in the same place."

While of course there are advantages to spreading service locations widely throughout the TGA, there is also benefit to increasing the amount of services offered at key agencies in "one-stop" fashion, and/or encouraging agencies to co-locate when possible. The need to travel to agencies is inevitable for many consumers. However, their travel time and money is far better spent if they are able to meet most of their HIV-related needs in just one location.

RECOMMENDATION: Prioritize comprehensive, rather than single-specialty, services at agencies whenever possible, to minimize the amount of travel required for consumers with multiple needs. Also encourage service providers to locate their agencies in the same or very nearby locations, to allow for a more "mall-style" one-stop service opportunity.

It is worth noting that a number of focus group respondents emphasized the importance of systems for creating or referring consumers to resources that would improve their chances for stable employment. Employment support is critical, because many of the consumers who are forced to travel to multiple locations throughout the TGA to meet their HIV-related needs must do so largely due to financial insecurity. Food and housing assistance, for example, are services least likely to be co-located with other medical or psychosocial HIV-related services. If consumers struggling with finances could be supported in employment, they could eliminate one, two, or even more trips from their set of regular HIV-related service visits.

Special Populations

Finally, there are two populations not yet mentioned that require special note when it comes to the travel distance required to access needed services. The first is people who inject drugs, since syringe exchange is still illegal in so many counties. Although syringe exchange is not a service funded by the Ryan White CARE Act, Alameda and Contra Costa Counties both permit syringe exchange services. However, many syringe exchange providers in the TGA see clients who travel

very far distances (such as from the San Joaquin Valley) because they are unable to access syringe exchange in their home counties. In order to ensure that the greatest number of injection drug users are able to access their syringe exchange services, HEPPAC offers mobile syringe exchange services on a rotating basis. Consumers know the van schedule and are able to come to a location near them on a regular basis.

RECOMMENDATION: Prioritize expansion of syringe exchange services throughout the TGA, as it is one of the few harm reduction interventions that has been proven to reduce the spread of HIV. This may require the addition of funding for more vans to provide increased mobile services through HEPPAC or other agencies.

The second special population is formerly incarcerated individuals. After release from Santa Rita county jail, San Quentin, or other jails/prisons, many consumers who found health services while inside find themselves disconnected from services on the outside. Knowledge of available services and the financial stability to pay for transportation to access those services are substantial challenges for many people after release from jail. And while formerly incarcerated people are certainly able to take advantage of the variety of medical and psychosocial services that exist for the general population, their psychosocial needs are sometimes unique, and the TGA lacks any services specifically geared toward meeting the needs of this population. Even more importantly, access to services may be limited or even outright denied to formerly incarcerated people as a result of their conviction, especially for drug offenders and sex offenders. As a result, many travel long distances to reach agencies which they've heard will provide acceptable and/or specialized services.

PECOMMENDATION: Develop resource guides and other tools to support appropriate referrals for formerly incarcerated individuals re-entering community throughout the TGA. Work with agency partners to identify the best resources for formerly incarcerated people in service categories including but not limited to medical care and treatment, housing, substance abuse services, and job/training services (note that job/training services are not funded by the Ryan White CARE Act).

CHAPTER FOUR Knowledge and Impact of the Low Income Health Plan (LIHP)

Background and Information about LIHP and the Affordable Care Act The 2010 passage of the Patient Protection and Affordable Care Act (ACA)²³ was a landmark event for healthcare in the United States. In 2014 the ACA will extend health insurance coverage to more than 30 million currently uninsured persons,²⁴ helping them gain access to reliable medical care that previously seemed out of reach. While this is a significant increase in health insurance coverage for Americans, the ACA does not result in universal healthcare access.²⁵ According to estimates from the United States Congressional Budget Office, the ACA will raise the percentage of US citizens and legal residents under the age of 65 who have health insurance from 83% to 95%.²⁶ This means that approximately 23 million persons will remain uncovered, including undocumented immigrants and those who choose not to purchase health insurance.²⁴

In the short term, states and counties have been challenged to find ways to help their residents transition from old healthcare systems (pre-2010) to full Healthcare Reform (2014) and meet the needs of all residents in the meantime. To this end, the US Centers for Medicare and Medicaid Services approved California's Section 1115 Waiver, California Bridge to Health Reform, which authorized the state to operate an insurance coverage expansion program known as the Low Income Health Plan, or LIHP²⁷ (pronounced, "lip"). Each county in California is responsible for rolling out this optional program for their own uninsured residents. Patients eligible for LIHP must be:

- Between 19-64 years of age, and
- Be a United States citizen or legal permanent resident who has resided in the US continuously for 5 or more years.

Residents can enroll in LIHP under two different programs:

- 1. **The Medi-Cal Expansion Program (MCE):** This program covers adults whose household gross in The Medi-Cal Expansion Program (MCE): This program covers adults whose household gross income is at or below 133% of the Federal Poverty Level.
- 2. The Health Care Coverage Initiative Program (HCCI): This program covers adults whose household gross income is between 134 200% of the Federal Poverty Level.* Residents who wish to enroll in HCCI must not be eligible for Medi-Cal or any other health insurance.

Clients who were previously enrolled in the AIDS Drug Assistance Program (ADAP) but are eligible for LIHP are required to apply for LIHP, and when enrolled begin receiving their HIV medications at a LIHP pharmacy. ADAP can cover medication costs for LIHP-eligible PLWHA during the grace period between LIHP application and enrollment; for Alameda County this is 90 days and for Contra Costa County it is 45 days.²⁸ Clients who are not eligible for LIHP but are eligible for ADAP may continue to receive medications through ADAP.

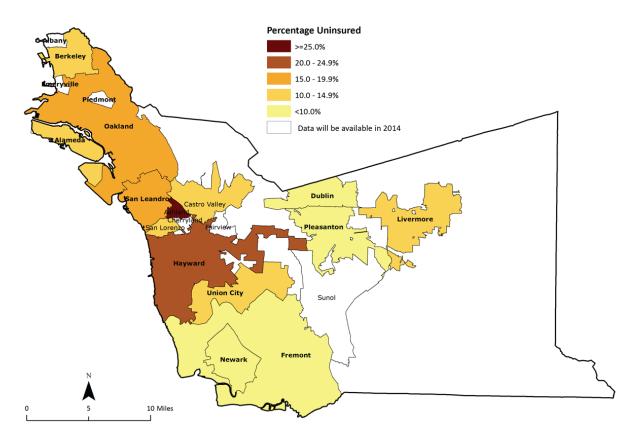
Residents of Contra Costa County can apply for LIHP by calling toll-free, 1-800-771-4270. PLWHA can request a medical case manager to assist with the enrollment process and accessing medical care by calling the Contra Costa HIV/AIDS & STD Program at 925-313-6771. Residents enrolled in LIHP can seek medical services at the Contra Costa Regional Medical Center, other health department-run health centers, and (with prior authorization) La Clínica de La Raza or Brookside Community Health Center.

Alameda County administers LIHP through the Health Program of Alameda County (HealthPAC). To enroll, residents can contact any of the providers who are certified screening and enrollment sites, available at http://achealthcare.org/health-insurance-info/low-income-coverage-options/screeningenrollment/. Residents enrolled in HealthPAC/LIHP can seek medical services at the Alameda County Medical Center, the AIDS Healthcare Foundation Health Care Clinic, Asian Medical Center, East Bay AIDS Center (EBAC), La Clínica de La Raza (Transit Village), LifeLong Medical Care (the Berkeley Primary Care Access Clinic, the East Oakland Clinic, or the West Berkeley Family Practice), and Tri-City Health Center (State Street).

^{*} For information about the current Federal Poverty Level standards, please visit http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html.

Both counties in the TGA have already spent significant time analyzing the geographic distribution of uninsured residents, and planning the roll-out of LIHP accordingly. For Alameda County, Figure 4.1 details the map of uninsured residents in the county as of 2011:

Figure 4.1
Map of Percentage Uninsured, Alameda County, 2011

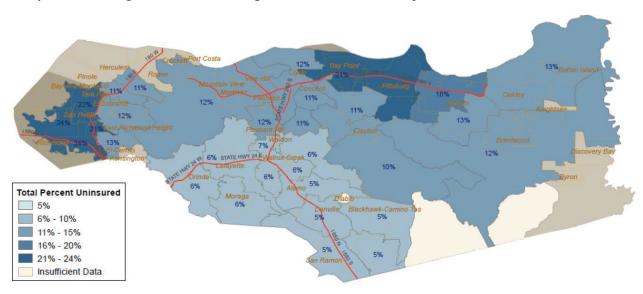


Source: CAPE (Community Assessment, Planning, Education, and Evaluation), with data from American Community Survey 2008-2010.

This map demonstrates that the areas in Alameda County with a high burden of HIV/AIDS as seen in Chapter II, such as Hayward and Oakland, also have a high proportion of uninsured residents who may benefit from the ACA and/or LIHP enrollment.

In Contra Costa County, a consulting firm was hired and produced a report in 2011 that presented the findings of a sustainability audit of the county's regional medical center and health centers.²⁹ In this report, a map of the percentage of uninsured residents in the county in 2009 was presented:

Figure 4.2
Map of Percentage Uninsured, All Ages, Contra Costa County, 2009



Source: IPUMS ACS Sample. Steven Ruggles, Matthew Sobek, Trent Alexander, Catherine A. Fitch, Ronald Goeken, Patricia Kelly Hall, Miriam King, and Chad Ronnander. Integrated Public Use Microdata Series: Version 4.0 [Machine-readable database]. Minneapolis, MN: Minnesota Population Center [producer and distributor], 2010.

This report also presented a map displaying a projection of the remaining uninsured residents in 2014, assuming an 85% uptake for LIHP and other programs related to Health Reform:

Figure 4.3
Map of Projected Percentage Uninsured Assuming 85% Uptake of Health Reform Programs,
All Ages, Contra Costa County, 2014



Source: IPUMS ACS Sample. Steven Ruggles, Matthew Sobek, Trent Alexander, Catherine A. Fitch, Ronald Goeken, Patricia Kelly Hall, Miriam King, and Chad Ronnander. Integrated Public Use Microdata Series: Version 4.0 [Machine-readable database]. Minneapolis, MN: Minnesota Population Center [producer and distributor], 2010.

It is clear from these images that the distribution of uninsured residents in Contra Costa County is not expected to change, but the overall percentage of uninsured patients in each region decreases dramatically. Similar to Alameda County, in Contra Costa County it is the areas that have highest rates of HIV/AIDS (Richmond, San Pablo, Pittsburg, and Bay Point) that also have the greatest proportion of uninsured residents and may stand to benefit most from the Affordable Care Act.

It is important to touch on the impact that the ACA will have on undocumented immigrants, who make up a whopping one-fifth of the currently uninsured population in the state of California.³⁰ Undocumented immigrants are specifically excluded from eligibility for LIHP and other ACA-related programs. They are not allowed to purchase private health insurance as part of state insurance exchanges, are not eligible for premium tax credits or lower co-payments on any private insurance they do purchase, and are not eligible for Medicare, the Children's Health Insurance Program (CHIP), or non-emergency Medicaid – although they remain eligible for emergency Medicaid if low-income. Undocumented immigrants may continue to seek non-emergency health services at community health centers or safety-net hospitals, although health centers may have varying policies on eligibility for service.³¹

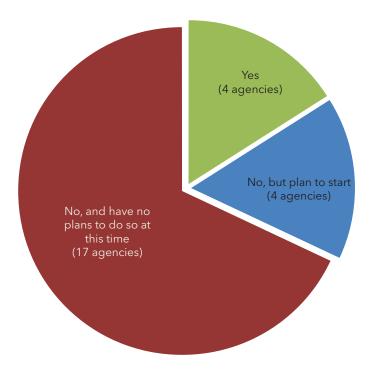
There are potential benefits to undocumented immigrants as a result of the ACA, however. The ACA provides more money to community clinics to expand their services, which can potentially lead to an increase in healthcare options for undocumented people. Those who are able to purchase a private health plan can no longer be denied coverage due to pre-existing conditions (as of 2014), the same as US citizens or legal residents. Additionally, for families where some members are undocumented but some members are US citizens or legal residents (such as one parent, or one or more children), those family members may be able to qualify for more affordable health coverage as a result of the ACA, possibly lessening the strain of healthcare costs on the family budget overall.³²

RECOMMENDATION: Determine the overall impact of the ACA on undocumented immigrants in the Oakland TGA, and take concrete steps to mind the gaps created and offer no-cost or low-cost services to undocumented people who need non-emergency health care.

Agency Support and Training Around LIHP and the ACA

Not all agencies enroll clients in LIHP or other ACA-related programs. When asked whether this was a service their agency provided, only 8 of the 25 agencies who answered the question said that their agency either already enrolled clients in LIHP or planned to start enrolling clients soon, as seen in Figure 4.4:

Figure 4.4 "Does your agency enroll clients in LIHP or other ACA-related programs?"



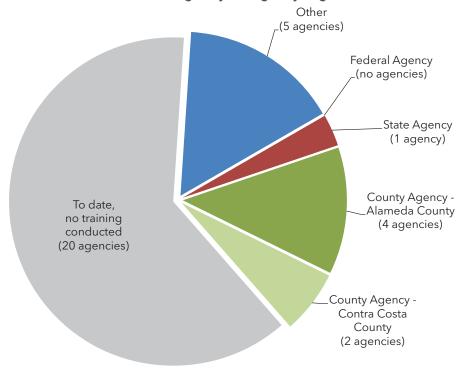
For many agencies, enrolling clients in LIHP is simply not relevant for their service type or target population. However, even agencies who serve people who would be ineligible for LIHP would benefit from increased staff knowledge about how LIHP works or the ways that the ACA will affect their clients' healthcare options. For example, agencies who focus on pediatric patients may still want to be able to answer questions that their client's parents or guardians may have about the ACA. Agencies who provide housing support and no medical services may still want to be able to redirect their homeless clients who are eligible for LIHP toward agencies who can enroll them in the service. Specifically, a number of agencies who did not enroll clients in LIHP spoke to the need to improve relationships with enrolling agencies and enable more concrete referrals and what is known as "warm handoffs" of clients who are eligible to enroll.

Contra Costa County began enrollment of PLWHA into LIHP in 2012, and has nearly completed LIHP enrollment of eligible clients. The general sense among providers was that great strides had been made toward implementation of healthcare reform overall. Many in Alameda County related a strong desire to learn more and be better trained about the ACA and LIHP so they can improve

support for their clients, but explained that they felt the resources and opportunities for training were limited since county staff were still determining the impact and actual implementation of the ACA. Repeatedly staff used phrases like "I'm not exactly sure how it will work," "Most staff are not aware much less the clients," and "Our clients are not aware of the changes that are coming especially since agencies are not clear yet how they will implement the changes."

Unfortunately, the ACA is a complex law that is poorly understood by most Americans, including public health and medical care providers.^{33,34} All HIV-related service providers could likely benefit from training about the ACA for this reason, yet to date very little training has been completed for service providers in the TGA. This is highlighted in Figure 4.5, with responses to a survey question on the provider survey.

Figure 4.5 "Who conducted the ACA training for your agency/organization?"



This information was strongly corroborated in the qualitative sessions, where those within Alameda County who had received trainings mostly described webinars or brief meetings, but continuously commented on the lack of clear information that service providers have about LIHP and the ACA, which trickles down to clients who are uninformed and unsure how to enroll.

One client summarized the words of many when he said,

"I am not sure how it is going to work, but I am happy to have medical care. I get my meds through ADAP but I need more coverage. Obamacare is the answer to my prayers."

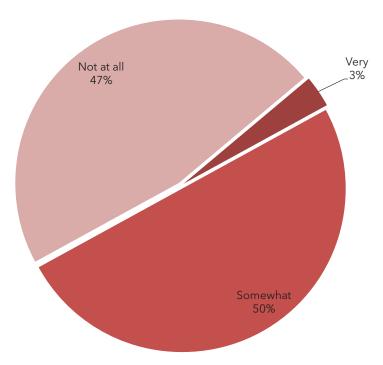
The reality is that this assessment made clear the following: In Contra Costa County, client enrollment in LIHP is essentially complete. In Alameda County, clients are ready and excited to enroll, but largely don't know how to determine eligibility or how to proceed with enrollment. Agencies need to be ready to support their clients in becoming better informed and in linking to an enrollment site, but most providers in Alameda County say they are waiting for concrete direction and training from health department staff before this can happen.

PECOMMENDATION: Roll out more widespread ACA training as soon as possible in Alameda County. Make training easily accessible in multiple formats, then require training for representatives and key staff of all HIV-related service providers in the county. Be sure to have at least one version of the training that is geared for medical providers and case managers, and one version of the training that is geared toward service providers who are unlikely to ever enroll clients into LIHP or another ACA-related program.

Consumer Understanding of LIHP, the ACA, and their Healthcare

In the SurveyMonkey survey, service providers were also asked about their perception of client understanding of the ACA or LIHP. Figure 4.6 shows the breakdown of provider responses regarding client information level overall – which reflects a general feeling of client misinformation or lack of information regarding this major, complex healthcare shift.

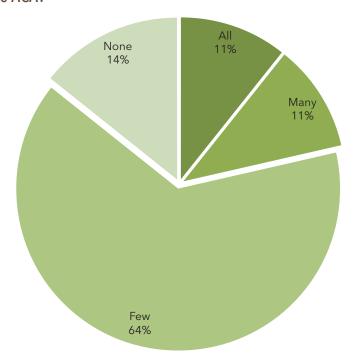
Figure 4.6
"How confident are you that the clients served at your agency are well-informed about the impacts of the Affordable Care Act?"



Next, providers were asked about their own agency's role in informing their clients about LIHP or the ACA. For some responding organizations this was irrelevant, as their target population and/ or services provided were not impacted by the passage of the ACA. However, for the remaining respondents, Figure 4.7 shows the breakdown of their responses to this question:

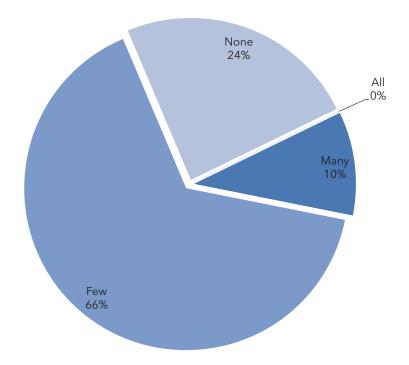
Figure 4.7

"What proportion of your clients have been informed by your organization about LIHP or the ACA?"



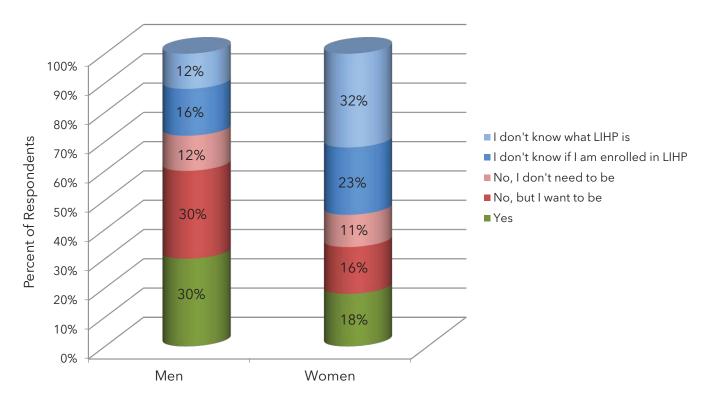
Finally, providers were asked more specifically how many of their clients they thought had a good understanding of the ways that their personal healthcare would change as a result of the ACA. None of the providers thought that all of their clients had a good understanding of this shift. The vast majority believed that few or none of their clients had a good understanding of the changes that they would experience.

Figure 4.8
"How many of your clients have a good understanding of the changes to their healthcare as a result of the ACA?"



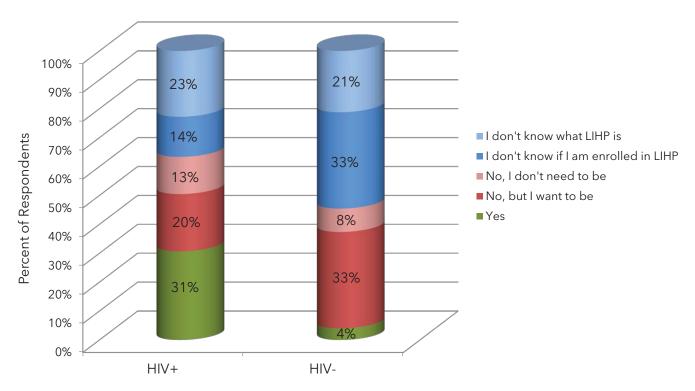
These provider responses were right in line with the consumer responses received through the consumer survey. Consumers were asked whether they were enrolled in the Low Income Health Program and the responses showed a high level of uncertainty about the program, as evidenced in Figure 4.9. Significant differences were seen in responses by men and women:

Figure 4.9 "Are you enrolled in the Low Income Health Program (LIHP)?", By Gender of Respondent



When looking at the same responses by HIV status instead of gender, significant differences can also be seen; these are to be expected given that these consumer surveys were collected at HIV-related service organizations, which are more likely to be focusing LIHP services and information on their HIV-positive clients. In fact, many of the providers who participated in qualitative sessions said that the only real impacts of the ACA that they had seen for their clients so far was the transition of some clients from ADAP to LIHP.

Figure 4.10 "Are you enrolled in the Low Income Health Program (LIHP)?", By HIV Status of Respondent



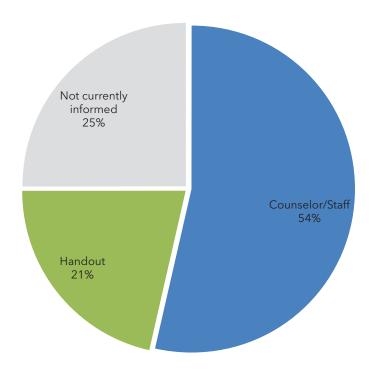
It is important to note that confusion about healthcare options, insurance coverage, or program eligibility is not a new issue since the advent of the ACA. When asked about current insurance coverage and expectations about how it may change, multiple consumers in the qualitative sessions described uncertainty about the processes that led to them being insured or uninsured in the past. When asked what they knew about the ACA or changes that would come to their healthcare, it was a general theme among consumers that they were unsure of the impacts it would have, how to enroll, or where to go from here – but they were excited about the potential, were eager to enroll, and believed that it would have a positive impact overall on them and their network or family.

In fact, a number of the service providers interviewed during the qualitative sessions were under the impression that clients eligible for Medi-Cal were automatically ineligible for LIHP, and that if many of their clients were on Medi-Cal the LIHP program was largely irrelevant to their agency. In fact, it is true that anyone who is eligible for Medi-Cal is not eligible for the Health Care Coverage Initiative (HCCI) program of LIHP. However, adults whose gross income is at or below 133% of the Federal Poverty Level – as of 2013 this was \$31,322 for a family of 4 – are still eligible for the Medi-

Cal Expansion Program (MCE) of LIHP, even if they are currently enrolled in Medi-Cal. This is just one example of the clear and urgent need for more readily available provider training about LIHP, even for staff in agencies that will not be enrolling clients in the program.

Relevant to these findings, service providers were also asked via the SurveyMonkey survey to identify how their clients are informed of changes to their healthcare based on the ACA. 25% of agencies that answered the question responded that their clients were not currently informed by their agency (any method). More than half of the respondents said that a counselor or other staff member was responsible for informing clients. No respondents said that client trainings or other methods were used to inform clients.

Figure 4.11 "How are clients informed of the changes to their healthcare based on the ACA?"

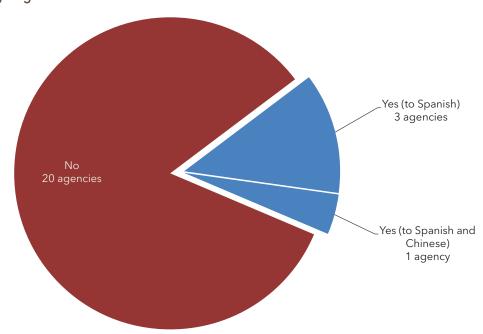


A majority of service providers who participated in the qualitative assessment said that informational handouts (i.e. fact sheets, brochures, and flyers) in lay language for clients would be a major improvement in their ability to inform clients about LIHP and the impacts that the ACA would have on their healthcare.

RECOMMENDATION: Develop a TGA-wide set of informational materials intended for clients – both HIV-positive and HIV-negative – to inform them about LIHP and/ or the ACA. Ensure that these materials are printed in multiple languages, and distribute them widely to service agencies.

Importantly, agency representatives were asked on the SurveyMonkey survey whether they had any materials about ACA that were available in languages other than English, and only 4 of the agencies that responded to the question replied that this was in fact true.

Figure 4.12 "Are there any materials about the ACA translated to other languages in your agency/organization?"



This is important because clients who do not speak English still, of course, need access to information about the ACA. In fact, monolingual non-English speakers are actually more likely to be uninsured and in need of LIHP or other ACA-related assistance. According to data by the Centers for Medicare and Medicaid Services, in 2011 approximately 263,743 people in Alameda and Contra Costa Counties had no health insurance; 67,163 (25%) of those do not speak English "very well" or better.³⁵ In contrast, in the two counties in 2011, only an estimated 17% of residents spoke English less than "very well."³⁶

In addition to monolingual non-English speakers, another group that will require special attention during the ACA transition period is formerly incarcerated people. Prior to the ACA and at this current time, there are already substantial challenges that exist for accessing care and follow-up on HIV treatment received in jail or prison, for those residents of the TGA who are released back into the community. Staff of Santa Rita jail who were interviewed for this assessment stressed that information will need to be provided to clients as part of their exit plan, with customized information about how their healthcare is best addressed under LIHP or other changes put in place by the ACA.

In addition to written informational materials for clients in multiple languages, the other suggestion made with high frequency in the qualitative sessions was to develop and hold in-person informational sessions for clients at various agencies. This could be done through training agency staff to hold such sessions, or – better yet – could be done with a roving team of individuals who have been specially trained to speak with clients in the Oakland TGA to provide information and answer their questions about LIHP and the ACA. These highly trained staff could then work with HIV-related service agencies throughout the TGA to schedule information sessions for clients at their site. These sessions should also be offered in Spanish, and in county jails if possible, for inmates who are preparing for release.

RECOMMENDATION: Design and train a small team of staff from within the TGA who can move around from agency to agency providing informational sessions for clients about LIHP and the ACA, including in Spanish.

Finally, more than one qualitative session included a staff person who suggested additional strategies for increasing LIHP enrollment for eligible clients within the TGA, including utilizing mobile vans to bring enrollment sites to clients (rather than expecting them to travel to health centers that may be unfamiliar) and/or holding special enrollment events that can be advertised to the community.

RECOMMENDATION: Explore alternate methods for boosting LIHP enrollment for eligible clients, including the use of mobile vans or publicizing "enrollment events" in various locations.

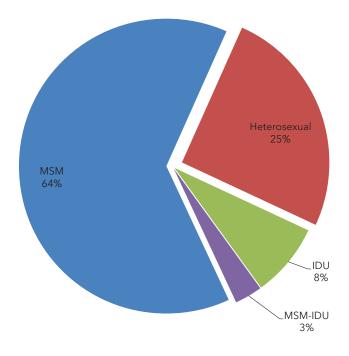
CHAPTER FIVE

The Needs of Heterosexual HIV-Positive Men

Literature and Background About Heterosexual Men Living with HIV

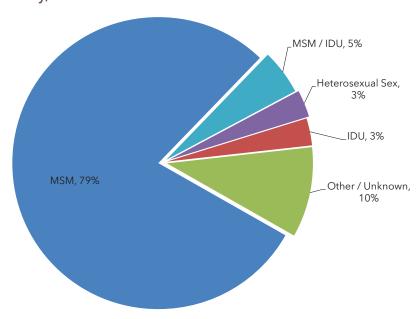
The needs of heterosexual men who are living with HIV in the United States are complex. While many other countries have substantial heterosexually-transmitted HIV epidemics, in the US infections transmitted through heterosexual sex are still in the minority. That, however, is changing. In 2010, the Centers for Disease Control and Prevention estimated that 1 in 4 new infections in the US (about 12,100 infections total) occurred through heterosexual sex (See Figure 5.1 below). Yet 2 out of 3 of those heterosexual infections were among women, meaning that only approximately 8,000 of 47,500 people infected overall in 2010 (17%) were men who were infected through heterosexual contact, compared to 29,925 (63%) who were MSM who do not inject drugs.

Figure 5.1
Estimated New HIV Infections, 2010, by Transmission Category³⁷



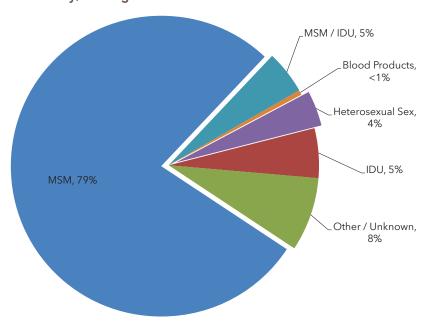
In Alameda County, 3% of newly diagnosed HIV cases among males during 2010-2012 were attributable to heterosexual contact.

Figure 5.2 Males Newly Diagnosed with HIV (N=509) by Mode of Transmission, Alameda County, 2010-2012



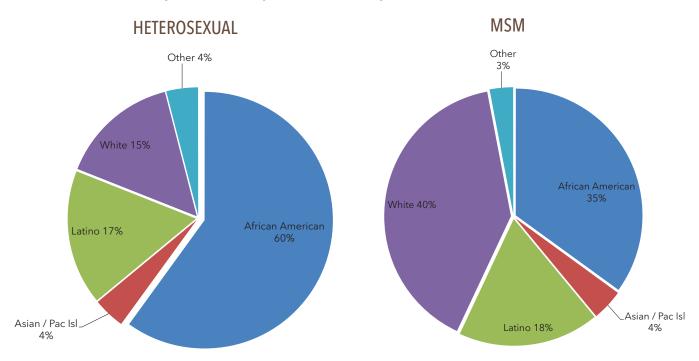
Similarly, in Contra Costa County 4% of newly diagnosed HIV cases among males through 2011 were attributable to heterosexual contact.

Figure 5.3
Males Newly Diagnosed with HIV (N=580) by Mode of Transmission,
Contra Costa County, Through 2011



The situation becomes clearer when these data are investigated by race/ethnicity. In Alameda County, almost 2 out of 3 of HIV-positive heterosexual men are African American.

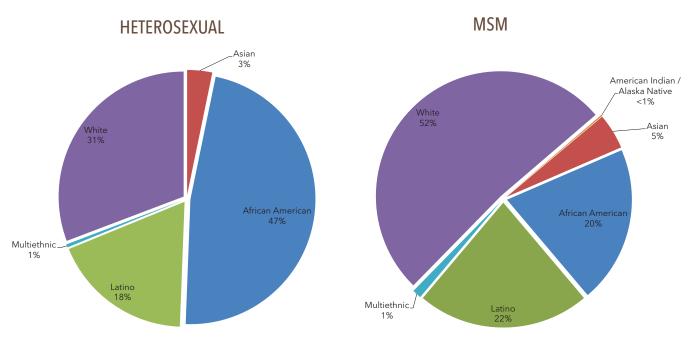
Figure 5.4
Male PLWHA by Race/Ethnicity, Alameda County, 2012



By contrast, African Americans comprise approximately 1 out of 3 of PLWHA MSM in Alameda County, with Whites being the largest racial/ethnic group represented among MSM.

A similar pattern is evident in Contra Costa County. Among heterosexual male PLWHA, nearly half are African American; among MSM PLWHA, only 20% are African American, with whites comprising the majority of that group.

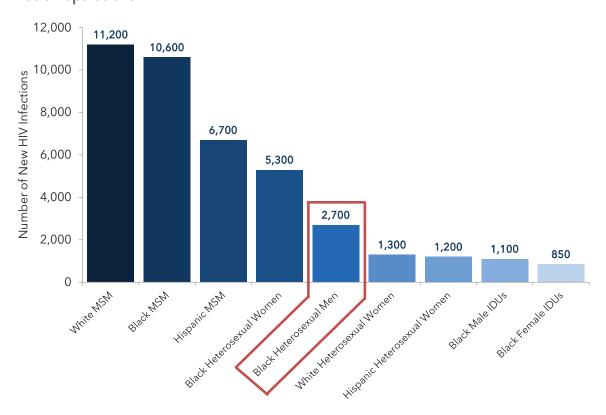
Figure 5.5
Male PLWHA by Race/Ethnicity, Contra Costa County, 2012



It is important to point out that modes of transmission are imperfect categories, as many people who become infected with HIV in fact had multiple, simultaneous types of risk. For example, a person who injects drugs may be counted in the "IDU" category, while in fact they became infected with HIV through unprotected sex. However, these categories are useful for broad statistical analyses and the study of trends overall.

Nationally, when ranking sub-populations of ethnicity and mode of transmission by greatest number of new HIV infections, Black heterosexual men rank 5th highest of all groups, well above White and Hispanic heterosexual women and all injection drug users.

Figure 5.6
Estimated New HIV Infections in the United States, 2010, for the Most-Affected Sub-Populations³⁷



And yet, it is very important to recognize that a great number of people who were infected with HIV through injection drug use are also heterosexual. The category of HIV-positive heterosexual men does not just include men who became infected through heterosexual contact. Instead, "heterosexual" is a term based on sexual orientation. Sexual orientation is a self-chosen identity, whether straight (heterosexual), gay (homosexual), or bisexual. People can identify as heterosexual and still have same-sex sexual contact.^{38,39} Some studies have shown that men who identify as gay are more than twice as likely to use condoms when having sex with men than heterosexually-identified MSM.⁴⁰

So, then, HIV-positive heterosexual men could be non-injecting men who were infected through heterosexual contact, heterosexual men who were infected through injection drug use, men

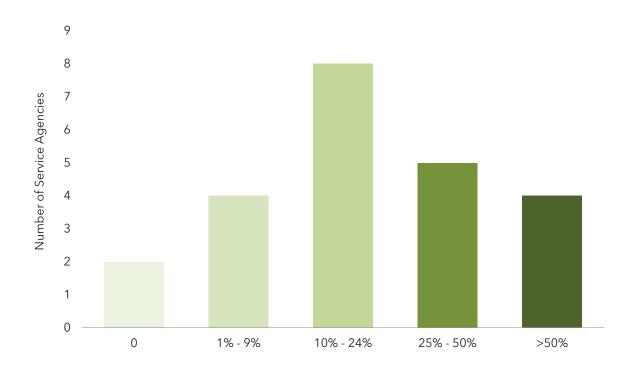
who identify as straight but have had regular same-sex sexual encounters, and men who identify as straight and only have had same-sex sexual encounters under special circumstances, such as in prison or in exchange for drugs, money, housing, or services. In truth, they could be a combination of any of these, and may or may not be aware of the relative risk for HIV transmission that has resulted from their behavior.

All this creates a unique challenge when trying to address the needs of HIV-positive heterosexual men, as they are so varied. For those heterosexual men who inject drugs, there is a history of HIV-related services for injection drug users, and they are likely to be able to find and access those services. But to some extent, the very existence of non-injecting HIV-positive heterosexual men as a population is defined by "not" being something within the world of HIV – which makes them largely invisible and difficult to identify and target for services. Most HIV-related resources are focused on specific target populations: primarily gay men or other identifiable MSM, injection drug users, or women. As these are the populations most affected according to the epidemiology of the local epidemic, these are the groups reflected in funding priorities. No funding in the TGA has been designated specifically for HIV-related services for heterosexual men. Many service providers believe that their services are targeting all people regardless of gender, sexual orientation, or substance use – but in most cases, consumers have developed a sense of whether an organization is a "gay" organization or one geared toward people who use drugs, or focuses on anything that is "other" from their own identity and experience.

As an example, 21 of the 23 agencies who responded to the SurveyMonkey question "Does your agency serve HIV-positive heterosexual men?" answered yes. Yet in the qualitative sessions of this assessment, service providers and consumers alike spoke repeatedly about the lack of services geared toward and/or comfortable for HIV-positive heterosexual men.

When asked to identify the percentage of agency clients who are heterosexual men (whether HIV-positive or HIV-negative), providers at various agencies answered in quite a range, from "zero" to "99%". Figure 5.7 shows the spread of answers given to this SurveyMonkey question.

Figure 5.7 "What percentage of your clients are heterosexual men (regardless of HIV status)?"



Perspectives on Modes of HIV Transmission for Heterosexual Men

In each of the qualitative sessions – stakeholder meetings, agency meetings, consumer focus groups, and one-on-one interviews – participants in this assessment were asked how they thought the majority of HIV-positive heterosexual men contracted HIV. As predicted, the answers varied widely: injection drug use, sex with men, sex work, and heterosexual sex. Some went further, to explain why they thought what they thought:

"Follow the epidemiology! Women of color are positive and having heterosexual sex. This is a big issue....most of the men [who infected them] have homosexual contact."

"Some people are back and forth to jail; they may not be gay, but may have had a homosexual encounter or been a man who had sex with men at one time."

A group of service providers who work almost exclusively with injection drug users, as well as the IDU consumer focus group members, both strongly believed that almost every man who is

heterosexual and HIV-positive is also an injection drug user – whether they contracted the virus through injection drug use, through sex work related to poverty or substance use, or through sexual behavior. A number of respondents went on to describe their observation that many injection drug users go to great lengths to obtain clean needles, but then don't use condoms when they have sex whether they are HIV-positive or HIV-negative.

In the end, the wide variation in answers to this question serves to underscore the most fundamental problem for HIV-positive heterosexual men: they are not a uniform group, and many people have strong ideas based on their own assumptions about how heterosexual men contracted HIV and what their behavior or interests may be today. This challenge creates invisibility and silence for a population that is difficult to characterize and therefore difficult to target for outreach and services.

Barriers to Service for HIV-Positive Heterosexual Men

Unlike the responses to the question about modes of transmission for HIV-positive heterosexual men, when asked about barriers that these men face when seeking HIV-related services in the TGA answers were surprisingly consistent.

The first theme was stigma, isolation, and invisibility for this group. Many echoed the words of one respondent,

"There is an assumption that all HIV-positive men are homosexual."

This assumption has many implications, according to those who discussed this issue. First, some men are afraid or unwilling to be associated with what they (and others) see as a "gay disease," and would rather suffer without services than allow this association to be made. This can lead to feelings of isolation and alienation from peers and from other people living with HIV, who could otherwise be a source of support, comfort, and information. Even for those who are not homophobic, a fear of being "outed" as having had some kind of same-sex sexual contact may be another reason to stay disengaged from services. And finally, HIV-positive heterosexual men, like all people, often look for a place to go for services where they will see peers and feel at home. Given the small numbers of heterosexual men living with HIV in the Oakland TGA, that simply doesn't happen.

The second theme was a related one: there are not a lot of straight men who work as HIV-related service providers in the Oakland TGA, and there are not a lot of straight men who are advocates or spokespeople for health promotion or HIV prevention campaigns. There simply is not a voice of leadership for this group of people, and this only stands to exacerbate feelings of isolation and invisibility.

The third theme centered around data. Many service providers spoke to this issue, explaining that HIV-positive heterosexual men are so invisible at service agencies because "we don't ask the right questions," or that "sexual orientation is not required at intake." A majority of providers questioned whether there were any data in the TGA about heterosexual men. It is generally accepted that the elimination of health disparities requires consistent, quality data collection, particularly about underserved populations.41 Very minimal data exist in the Oakland TGA about this group and if disparities among HIV-positive heterosexual men are a concern one easy step to take is to begin collecting high-quality data on them.

RECOMMENDATION: Identify some simple but useful data points to collect system-wide about HIV-positive heterosexual men, and require them to be collected in as many service providers as possible throughout the TGA. Prioritize inclusion of these and any other data about heterosexual men in epidemiological reports or presentations about HIV within the TGA.

The final theme had to do with male behavior in general: men are less likely than women to go to the doctor or seek social services.⁴²⁻⁴⁶ As numerous respondents pointed out, men are more likely to be private, stoic, to want to handle their own problems, or to resist asking for help. This is true medically and with other psychosocial services. As one male consumer said,

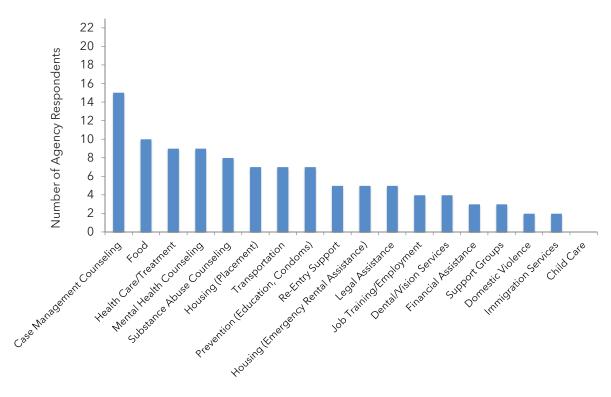
"It is challenging for men to go to the doctor anyway, whether gay or straight or positive. We need encouragement and support to properly care for ourselves."

Regardless of their HIV status or sexual orientation, men are simply less likely to seek HIV-related services in the TGA overall. This, combined with the specific challenges already discussed that increase isolation and invisibility among HIV-positive heterosexual men, means that these men are far less likely to access services than others.

Needs and Service Gaps for HIV-positive Heterosexual Men

Given the themes above, it is relevant to present the answers that service providers gave via SurveyMonkey to the question, "What types of services at your agency are most likely to be accessed by HIV-positive heterosexual male clients?"

Figure 5.8
Provider Report of Types of Services at their Agency Most Likely to be Accessed by HIV-Positive Heterosexual Male Clients



In concordance with the qualitative responses of service providers and consumers, many of the 23 providers who said their agency served HIV-positive heterosexual men did not think they were likely to access prevention services, mental health counseling, or health care and treatment. In fact, the only service category that more than half of the service providers thought HIV-positive heterosexual men were likely to access was case management. Too often, heterosexual men may wait until they are facing a health or psychosocial crisis before they reach out for help.

Ultimately, however, for this topic participants in the qualitative sessions were very oriented toward solutions for improving services and better meeting the needs of HIV-positive heterosexual men in the TGA. It is critical to reiterate that this is not a homogenous population. To successfully

meet the needs of this group of people, safe spaces must be created that will allow them to gain support and seek services. Because they are not homogenous, then, this requires utilizing multiple different types of safe spaces using multiple, overlapping strategies. Here are some solutions that multiple respondents suggested during this assessment, each of which would target and support one aspect of the overall population of HIV-positive heterosexual men in the TGA.

1. Establish multiple support groups for HIV-positive heterosexual men, in order to account for geographic spread and language differences. Support groups are supposed to be places where people can open up about their inner thoughts and insecurities, and it can be difficult for heterosexual men to do this in mixed groups. Some described the best solution as not only having a group specifically for heterosexual men (as opposed to gay men) but also creating a comfortable space without women or children present, too. It is worth noting the warning of one respondent, though, who said:

"The challenge will be getting straight men to discuss sexuality and behavior [with other straight men in a support group] without calling the conversation sexual."

Yet others described the importance of offering family-oriented support groups, as another route through which heterosexual men may feel more comfortable engaging in HIV-related services. Women and families have a very influential role in the lives of many heterosexual men, as one respondent noted:

"Men will listen to female partners or wives, or even friends who encourage them to get care [for their HIV]."

In addition to being thoughtful about the makeup of support groups, many respondents suggested the use of incentives that will speak to non-injection drug using heterosexual men, such as free haircuts, tickets to games and events, food or gas vouchers, hot meals at the groups, etc. Incentives have been shown to draw individuals who need services but otherwise may not make the effort to attend,⁴⁷⁻⁵⁰ and may be useful in this case to increase participation in support groups for this particular target group.

RECOMMENDATION: Establish support groups both specifically for HIV-positive heterosexual men and for families; ensure that they are located in various regions throughout the TGA and are offered in English and Spanish, to improve accessibility.

2. Improve education campaigns, cultural competence among service providers, and overall services specifically geared toward injection drug users. Since a large portion of HIV-positive heterosexual men inject drugs, to have a positive effect on this group requires attention to the needs of injection drug users as a whole.

FECOMMENDATION: Develop a plan to improve services in the TGA for injection drug users, including provider awareness and sensitivity. This would include an integrated approach to awareness, prevention, and intervention that includes harm reduction approaches (such as a combination of free condoms, HIV and HCV testing, and provision of clean needles and works). It also includes a commitment to investigating "wet" housing support – housing that does not require abstinence from alcohol or drugs to be eligible, as this is impossible for many injection drug users who nonetheless have significant housing support needs.

3. Develop and implement a series of awareness campaigns designed to raise visibility and reduce stigma for HIV-positive heterosexual men. As one person explained:

"You need real stories from straight men to reach other straight men."

Through PSAs, social media, and other venues, finding straight male spokespeople who are leaders in their communities – such as ministers, athletes, and others – to promote HIV testing and encourage other heterosexual men to speak up about HIV will have a big impact, according to many of the people who participated in this assessment.

As important as it is to involve straight spokesmen in these campaigns, however, it is again valuable to remember the central role that women and families can have for some heterosexual men. A campaign that capitalizes on these relationships could also be quite strong with this population, especially if used as part of a combination approach.

RECOMMENDATION: Develop and implement a series of awareness campaigns designed to raise visibility and reduce stigma for HIV-positive heterosexual men. Recruit straight spokesmen who are leaders in their communities to help promote the campaign. Get Screened Oakland did a campaign similar to this a few years ago called "Are you man enough?" that was targeted to Black men. Lessons learned from that campaign can be incorporated into new campaign efforts.

4. In addition to improving the visibility of heterosexual men as part of public awareness campaigns, it is also important to increase the roles of heterosexual men as service providers. This can be done by prioritizing the hiring of heterosexual men in service agencies, encouraging more straight men to work as peer health advocates, and promoting job opportunities within networks of heterosexual men. Doing so will help reduce barriers that currently exist for HIV-positive heterosexual men in seeking services, as they will no longer feel that "there is no one there who understands me," as respondents described that so many heterosexual men may feel today.

men as service providers within HIV organizations. Encourage HIV-positive heterosexual men to work as peer health advocates, utilizing those advocates for both outreach and service provision, and promote relevant job opportunities within straight male networks.

5. Explore the use of non-traditional locations for outreach, which will increase the likelihood that HIV-positive heterosexual men are diagnosed and engaged in services. Venues were suggested by multiple participants, including barbershops, YMCAs, basketball courts, churches, gyms, and sporting events. Reaching out to men in these venues will have the potential to not only increase rates of HIV testing and diagnosis, but reduce stigma through normalizing HIV and raising awareness that HIV is truly not a "gay disease."

RECOMMENDATION: Explore the use of non-traditional locations frequented by heterosexual men for HIV outreach. Some good examples of these locations are barbershops, YMCAs, basketball courts, churches, gyms, and sporting events.

6. Finally, two groups of respondents in the qualitative interviews discussed their vision for a clinic or health center that specializes in men's health issues. This would encompass a range of men's health issues, not just HIV, and would be a major step toward encouraging men in the region to take charge of their health and develop relationships with medical providers. Establishing something like this is likely outside the scope of the Alameda County Office of AIDS Administration, the HIV/AIDS & STD Program of Contra Costa Health Services, or the TGA's Collaborative Community Planning Council. However, working toward this goal through collaborations with service providers who could make it a reality is something concrete that can be done within the HIV service community.

CHAPTER SIX Intimate Partner Violence and its Relationship to HIV

Literature Regarding IPV and its Relationship to HIV

Intimate partner violence (IPV), also sometimes referred to as domestic violence, is a major public health issue in the United States. According to the 2010 National Intimate Partner and Sexual Violence Survey (NIPSVS), approximately 1 in 3 women and 1 in 4 men in the United States have experienced physical violence, rape, and/or stalking by an intimate partner in their lifetime.⁵¹

These simple statistics contradict the conventional wisdom that domestic violence occurs solely within heterosexual couples, with men acting as perpetrators and women as victims. While research specifically focused on IPV within same-sex couples has been limited, the 2010 NIPSVS investigated this issue and found that lesbian, gay, and bisexual people reported levels of intimate partner violence at rates equal to or higher than those of heterosexuals, as seen in Figure 6.1 below:

Figure 6.1
Lifetime Prevalence of Rape, Physical Violence, and/or Stalking by an Intimate Partner⁵²

Women		Men	
Lesbian	44%	Gay	26%
Bisexual	61%	Bisexual	37%
Heterosexual	35%	Heterosexual	29%

According to this survey, the majority of female IPV survivors report that their perpetrators were male, regardless of whether they experienced rape, physical violence, and/or stalking. Males who survived rape and non-contact unwanted sexual experiences also reported mostly male perpetrators, and nearly half of men who reported stalking by an intimate partner identified the perpetrator as male. However, the majority of perpetrators of physical violence and approximately half of the perpetrators of stalking male intimate partners were women.⁵¹

Of particular importance to this assessment is the association between IPV and HIV infection. A national study in 2009 surveyed nearly 14,000 women and found that 12% of HIV infections among the women in intimate relationships were due to IPV.⁵³ Other studies have shown that HIV-positive MSM may be at least as likely to be survivors of IPV as HIV-positive women,⁵⁴ and that HIV-positive MSM are more likely than HIV-negative MSM to report both physical and psychological abuse by a partner in the past 5 years.⁵⁵

This association between IPV and HIV is so strong for a variety of reasons. Survivors of IPV are often unable to practice safer sex because sex is coerced or forced, ^{56,57} because they are less able to negotiate condom use with their partner, ^{58,59} and/or they are fearful of violence as a result of requests to use condoms. ^{60,61} Additionally, men who perpetrate IPV have been found to be more likely to engage in behaviors that put them at risk for HIV, ⁶² including inconsistent condom use. ⁶³

At least as important to this assessment is the literature that is beginning to show that IPV negatively impacts HIV outcomes and engagement in care for PLWHA. One recent study by Shafer and colleagues⁶⁴ found that both the experience of IPV and threats from a partner resulted in a statistically significant increased risk of having a CD4 count below 200 and a detectable viral load. In Shafer's analysis, the relationship between experiencing IPV and having worse HIV outcomes remained independent of age, race, education, sexual orientation, socioeconomic status, post-traumatic stress disorder, depression, and substance abuse.

There is some evidence to suggest that people who are survivors of IPV may have altered cortisol responses and inappropriate T-cell activation, leading to worse HIV outcomes. 65,66 However, Shafer's study also showed that all participants who were experiencing IPV had significantly poorer engagement in care (i.e. more missed clinic visits or poorer medication adherence), and that the risk for poor engagement in care was particularly high in men who have experienced abuse. 64

Prevalence of IPV within the Oakland TGA

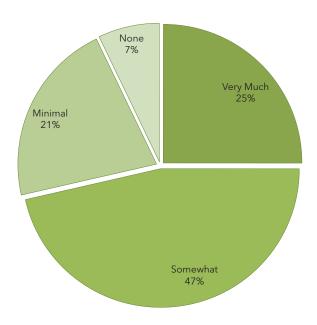
Very little data exist about IPV within Alameda and Contra Costa Counties. According to data from the California Department of Justice, in 2010 there were 6,730 calls made to report domestic violence to law enforcement in Alameda County (44.6 calls per 10,000 persons) and 3,687 such calls made in Contra Costa County (35.2 calls per 10,000 persons) in 2010.⁶⁷ Yet according to the National Coalition Against Domestic Violence, a full 75% of all physical assaults and 80% of all rapes actually go unreported.⁶⁸

Among the 97 consumers who completed the consumer survey for this assessment, 26 (more than 1 in 4) reported being survivors of IPV. Overall, 75% of the people who completed the survey were PLWHA, and yet 92% of the IPV survivors were HIV-positive. Of those who were IPV survivors and PLWHA, more than half said that they thought their experience with IPV affected whether they became HIV-positive or had an impact on their health as a PLWHA.

38% of the 26 survey respondents who identified themselves as IPV survivors were men (n=10) and 62% were women (n=16). 20% of Whites (3 of 15), 27% of African Americans (12 of 44), and 28% of Latinos (10 of 36) who responded to the survey reported being survivors of IPV.

In addition to asking consumers about IPV as part of the quantitative part of the assessment, service providers were also asked about this issue through the SurveyMonkey survey. First, they were asked how prominent of an issue they thought IPV (identified in the SurveyMonkey as "domestic violence") was for clients within their organization, with a 4-point Likert scale, as can be seen in Figure 6.2.

Figure 6.2 "How prominent of an issue do you think domestic violence is among your agency's clients?"



The qualitative data mostly supported these quantitative findings, although when presented with an open-ended question instead of a Likert scale, respondents generally stressed the great importance and impact that IPV has on their clients. Both consumers and service providers who participated in group meetings or focus groups talked about the extensiveness of IPV among their clients and networks. The only exceptions to this were representatives from two agencies whose small clientele did not seem heavily affected, and the participants of the Latino focus group, where only one member had directly experienced or witnessed IPV and participants were generally unable or unwilling to discuss the issue in depth. In a majority of the groups the point was raised that IPV is often a big issue whether or not individual clients realize it to be. There were a number of statements about the need to raise awareness about IPV, such as this one:

"Many people do not understand or recognize that they are in fact in abusive situations."

Multiple respondents explained that a lot of people don't realize they are victims of IPV, and alternatively many do not know they are perpetrators of IPV – their behavior is learned from family members in their own households growing up, or from other past trauma they have experienced. In other cases, respondents spoke about IPV occurring as a result of poor anger management; that

in fact men who have had stressful or otherwise traumatic experiences with foster care, prison, and/or residence in communities riddled with violence (as examples) can sometimes experience anger that results in unexpected violence toward their intimate partners. However, a respondent in one stakeholders' meeting did point out that many times men who are perpetrators do recognize their role in IPV even while it continues to happen, and they are actively dealing with stigma and shame around this issue.

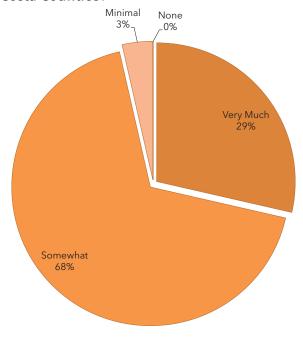
RECOMMENDATION: Increase the existence and availability of mental health services and other psychosocial and clinical supports for perpetrators of IPV (both men and women), to help them recognize and deal with their behaviors in order to heal themselves, gain new skills to handle triggers and reduce violence, and have healthier relationships overall.

Stigma and shame around IPV was a major theme that surfaced repeatedly during the qualitative data collection. Some respondents explained that IPV was a big issue in their community overall regardless of gender, but that it wasn't talked about much. "People don't want to be victimized," said one respondent; stigma and shame impact all survivors of IPV, regardless of gender. However, invisibility of IPV support services for men as well as homophobia or fear of being seen as "less than a man" are added reasons that male survivors of IPV may be even less likely to actively seek services or disclose their need for support around IPV. For these reasons, a number of respondents throughout this assessment strongly recommended increased social awareness campaigns in order to help people recognize the signs of IPV, become aware of existing resources to support survivors and perpetrators of IPV, and reduce shame and stigma about IPV overall. Specifically, one group of male consumers talked about the need for men to speak out about IPV and be recruited by service providers to serve in such roles, since "men will listen to other men and their families."

RECOMMENDATION: Raise visibility about how to identify IPV for one-self or others, promote IPV resources, and reduce shame and stigma about IPV through a social marketing and/or social media campaign within the Oakland TGA. Do this in partnership with IPV service agencies (such as the Alameda County Family Justice Center or STAND! For Families Free of Violence) to maximize resources, increase collaborations and improve cohesiveness of services. These strategies should target both men and women.

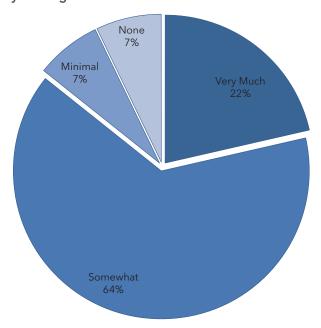
Perceptions of the Impact that IPV has on HIV Incidence and Outcomes Through SurveyMonkey, service providers were also asked about the impact that they thought IPV had on HIV incidence throughout the TGA as a whole, and on the HIV-related outcomes for clients in their organization. Responses were again requested on a 4-point Likert scale, as shown in

Figure 6.3
"How much of an impact do you think domestic violence has on HIV incidence in Alameda and Contra Costa Counties?"



Figures 6.3 and 6.4.

Figure 6.4
"How much of an impact do you think domestic violence has on HIV-related outcomes for clients in your organization?"



In the qualitative sessions, both providers and consumers were far more emphatic about the large impact that IPV had on HIV incidence and outcomes, for both men and women. Some of the major themes were that IPV impacts self-esteem, increases stress, and reduces an individual's control over both the physical and financial aspects of their lives; all of these issues increase a person's risk for HIV infection, missed medical appointments, or poor medication adherence. Respondents also felt this increased the likelihood of extensive substance use as a form of self-medication, especially for those who have a history of substance abuse or are in recovery.

In general, reliable access to medications was a major issue. Multiple respondents across many groups in the assessment described that people who are dependent on medications for their HIV and are experiencing IPV are often challenged because part of the IPV relationship involves withholding meds and/or refusing to provide access to medical care (such as denying transportation, insurance coverage, or the ability to attend appointments). They explained that sometimes perpetrating partners actively destroy or discard medications, but other times IPV survivors simply flee quickly and leave medications behind, as this consumer retold:

"I had to leave in the middle of the night. I was scared for my life and I had nothing. No money. No place to go. Didn't even think about my meds."

Finally, respondents said that a major impact that IPV can have on HIV incidence and outcomes is unstable housing that can result, especially if they decide to leave their IPV relationship. A sudden decision to flee a violent home frequently results in a need for emergency shelter, but also often leads to a need for housing support over a longer term, especially if the IPV survivor does not yet have financial independence. Although a need for housing support is not new for the Oakland TGA as a whole, it may be a very new, alien, and isolating experience for the IPV survivors who find themselves homeless – all while needing to continue adhering to their HIV regimen or keeping medical appointments.

Critical Referrals for IPV Survivors or Perpetrators

One very important point made by multiple respondents during the qualitative sessions is that supportive services and referrals are needed for both survivors and perpetrators of IPV, and for both women and men. In fact, many people bemoaned the dearth of IPV-specific services available to and comfortable for men, and a few went out of their way to remind those around them that survivors were not the only ones who needed attention, like this service provider who said,

"With quality psychosocial and clinical supports, men and women who are perpetrators of violence can learn new was to deal with their issues and triggers. Make them aware of their behavior and provide new ways to deal with the triggers of stress and anger to break the cycle."

Services for men – both survivors and perpetrators. Prioritize the establishment of these services where needed, and promote the existence of these services to agencies throughout the TGA so that agency staff will be better able to support their male clients.

It is true that, as one respondent pointed out, many times a person dealing with IPV is not open to taking referrals, even if they would be helpful. Nevertheless, many people experiencing IPV are anxious for anyone to notice their situation and offer information about supportive services – even if it means traveling quite a distance to meet their needs, as one agency staffperson explained in a group session. The reality is that while efforts to change the behavior of perpetrators are critical, they take time and have varying levels of success. Many times, survivors of IPV are in life-threatening situations and need services immediately, without question.

RECOMMENDATION: Work to increase awareness of emergency services, including housing protections and legal services, available to survivors of IPV. Increasing provider awareness will improve the opportunity for survivors of IPV to quickly access life-saving support in times of great need.

During most of the qualitative sessions in this assessment, consumers and providers were asked about the referrals or services that they believed were critical for IPV survivors or perpetrators, especially those living with HIV. Participants offered the following list, with many people reiterating the same themes over and over again, including the need for these services to be available in Spanish as well as in English:

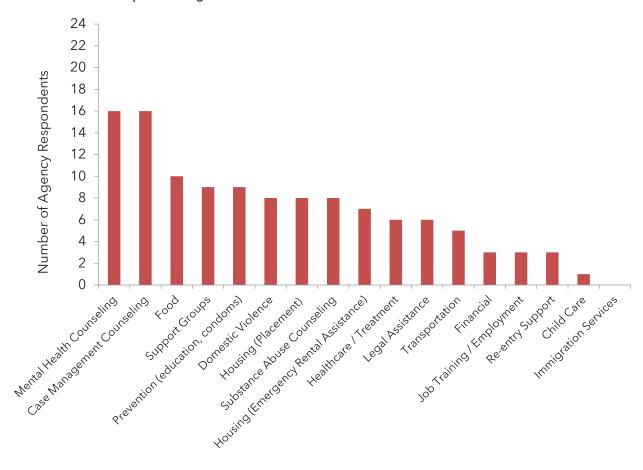
- Housing Support. This includes emergency shelter as well as assistance in finding a safe
 and affordable place to live in the longer term. A number of people pointed out that safe
 and suitable housing is often extra-challenging for clients who inject drugs, as they are not
 welcomed or supported in many shelters or supportive housing sites.
- Assistance with Protective Custody. This also included helping to facilitate restraining orders, completing police reports, or handling other legal proceedings required to protect the health and welfare of IPV survivors and their families.
- **Substance Use Treatment.** This includes abstinence-based treatment as well as harm reduction services; as stated earlier worsening or relapsing substance use is a significant problem for many in IPV relationships.
- Mental Health Support / Counseling. This one is likely obvious most people who are survivors or perpetrators of IPV will require counseling to help them break the cycle of violence and move forward in their lives. Mental health referrals to people or agencies who have expertise in IPV issues is imperative.

- Emergency Medical Services. Survivors of IPV often experience physical or sexual trauma and should be seen by emergency medical services, even if shame and stigma makes them resistant to seek these services. Support in obtaining emergency medical services may mean accompanying a client to the hospital and staying with them until admission or discharge.
- **Employment Assistance.** As stated earlier, financial independence is often a significant challenge for survivors of IPV, especially during an abusive relationship or shortly after leaving it. Assistance to succeed in obtaining employment and the resulting financial freedom is critical.
- **Childcare.** Survivors of IPV who have children often need support with childcare in order to seek mental health or substance use treatment, attend to legal issues, or search for employment.
- Assistance to enroll in ADAP, LIHP, and other needed government programs (i.e. food stamps/food pantry, etc). Similar to the need for employment assistance, many people who have recently left an IPV relationship will need immediate help enrolling in a variety of government assistance programs that previously were unnecessary. This may be very unfamiliar terrain for some consumers.
- **Help with Developing a Safety Plan.** This is important both for IPV survivors who are still in an IPV relationship, and those who have left that relationship but could still potentially be in danger from an angry ex-partner. Helping a client walk through a realistic safety plan can be one of the most important things that any provider can do.
- **Anger Management Classes.** Breaking the cycle of violence is of utmost importance in efforts to address IPV, and assisting clients in accessing anger management classes when appropriate can be a vital step in helping this to become reality.

Screening for IPV

In addition to asking providers about their perceptions regarding the prevalance and impact of IPV on HIV, service providers were also asked via SurveyMonkey to identify the services at their agency that they thought were most likely to be accessed by clients experiencing IPV, as is detailed in Figure 6.5. The variation in responses is important, because it points to the need for systems that screen IPV in a variety of settings, as well as an awareness among agency staff and volunteers that a client in almost any arena within their agency may be a survivor of past or current IPV.

Figure 6.5
Provider Report of Types of Services at their Agency Most Likely to be Accessed by Clients Experiencing IPV



The need for widespread IPV screening within a variety of service types was heavily reinforced during the qualitative sessions. Some themes that arose related to this were that in general it is usually easier for women to come forward for IPV help than men – largely due to shame and stigma – and that in fact, most men may not ever go directly to an IPV services agency for help without someone directly linking them. This could be due to lack of knowledge of what services exist and how to access them, or due to a doubt that they would be welcomed or supported there as a man. Yet even for women, reaching out for help around IPV can be extremely difficult. As one respondent explained, if and when a survivor of IPV chooses to leave their relationship, that is typically the only time s/he will reach out to someone for assistance. While they're hiding what's

happening, they are not going to ask someone to help them.

All of this means that service providers must be keenly aware of the signs and symptoms of IPV, and prepared to act in a sensitive manner to see if a client who is dealing with IPV may be willing and able to accept support and referrals. People experiencing IPV are in almost every setting, but are invisible in many of them – and regular processes for screening are often the only way to recognize and support these individuals.

Along these lines, throughout the assessment there were repeated calls for widespread implementation of IPV screening during agency intake; this was true across many types of agencies and

RECOMMENDATION: Encourage widespread IPV screening during intake at all HIV-related agencies throughout the TGA. If possible, develop a centralized, standard procedure (i.e. a standard set of questions that could be added to any agency intake form) and make this template available to all agencies in the TGA for use if desired. Include training for intake staff at all agencies about how to properly screen for IPV.

service categories.

A related issue is data collection related to IPV, as even those providers who did have IPV screening protocols for intake explained that the data were not systematically collected or shared because it was not required for any grants or monitoring processes. Similar to the challenges inherent with lack of data around HIV-positive heterosexual men, without concrete data on IPV in the Oakland TGA, it is difficult to appropriately design or prioritize IPV-related interventions.

RECOMMENDATION: Require reporting of IPV intake screening data throughout the TGA. Collect and analyze those data at the health department level and share findings on a regular basis in order to assist in the prioritization and modification of IPV-related services as needed.

Provider Training

Although not asked via SurveyMonkey, in the qualitative settings providers were asked about the kinds of trainings that their agency staff receive related to IPV. Answers ranged from "not much – the basics, although all staff are encouraged to seek out more training," to one agency that listed a plethora of trainings that were regularly provided to staff agency-wide in areas as varied as trainings on the cycle of trauma for children to trainings through the Stand in Pride project (a collaboration between the Rainbow Community Center of Contra Costa County, STAND! For Families Free of Violence and Community Violence Solutions, which is intended to improve services for lesbian, gay, bisexual, transgender, and queer survivors of IPV). In general, though, the most common response was that clinical social workers and other counselors have specialized training and expertise, and other agency staff are taught to identify signs of IPV and to make referrals to crisis hotlines, shelters, and/or IPV-focused agencies.

FECOMMENDATION: In addition to developing and providing training for intake staff at all HIV-related agencies in the TGA about how to properly screen for IPV, brief trainings about IPV should be developed and made available to all service providers as well as consumers and the wider community. These trainings should focus on how to identify IPV, what to do if you suspect IPV, and what community resources are available to support people who are in or were previously in IPV relationships. This will also encourage service providers to develop relationships that will allow for "warm handoffs" of clients who have IPV-related needs.

CHAPTER SEVEN Summary & Final Recommendations

This work represents countless hours of contemplation and sharing of information on the part of PLWHA and other consumers in the Oakland TGA, service providers, and members of the assessment team. The assessment focused on four main topics that had been pre-selected by the CCPC; this is not a comprehensive look at needs related to HIV/AIDS overall.

Future assessments should be carefully planned to maximize the use of limited resources within the TGA for this type of endeavor. Above all, this requires thoughtful selection of topics of focus in order to ensure that findings are relevant and likely to result in actual changes within the jurisdiction. Ultimately, priorities need to be formed within the TGA through reviewing the epidemiological profile of the HIV/AIDS epidemic, and matching the relative money and attention that various target populations receive to that hard data. In addition, it is a reality that the standards and priorities of HRSA and the Centers for Disease Control and Prevention influence sustainable practice within state and local jurisdictions. This Needs Assessment has the potential to be a valuable tool in deeply exploring the nuances of high-priority populations and intervention strategies; this also means that the findings are more likely to be used to influence funding allocations and fulfill obligations to funders.

Other topics to consider for future needs assessments include, among other things:

- further exploration of the impact of healthcare reform, especially with regard to who is falling through the cracks of reform in the Oakland TGA, and whether PLWHA have continuing access to high-quality HIV medications without restriction or interruption
- 2. further examination of the *time* it takes consumers to travel to their HIV-related service providers, as opposed to distance, which was the focus of this assessment, and
- 3. the ongoing needs of MSM, who continue to bear the greatest burden of the epidemic in this TGA according to the epidemiology.

Because access to HIV and AIDS data is – with great reason – highly restricted, any needs assessments of this nature should in the future be linked with a representative from each county health

department who can provide timely, custom (if simple) analyses of recent data. This is truly the only way to ensure that the assessment is based on accurate information and targeted in the correct places as it unfolds.

Finally, timing of future assessments should be discussed before launch. In this case, a deadline for funding allocations existed on one end, and a series of slow bureaucratic processes squeezed from the other end, rapidly shrinking the data collection and analysis period of this assessment into less than 3 months. For a TGA as geographically large and demographically varied as this one, this is simply not a reasonable period of time for a high-quality, comprehensive assessment without restricting the topics of focus to one or two. This, combined with that data collection period straddling the end of the fiscal year, contract monitoring obligations, and agency understaffing due to summer vacation, meant that involvement was very difficult or even impossible for some of the most interested service providers.

For ease of use moving forward, the following is a restatement of the recommendations that were included throughout this document. Recommendations were intended to be concrete and feasible, if prioritized by the CCPC and county health departments.

Recommendations Related to the Proximity of Services to PLWHA

- ☐ Create a TGA-wide poster (or set of posters) highlighting patient/client rights and briefly spelling out options consumers have if they wish to file a grievance. Require that these posters be visibly present in all waiting areas and/or clinical offices of HIV-related service providers in the TGA.
- ☐ A Task Force should be convened to determine the validity of claims of racial discrimination and take specific steps to address these concerns and ensure safe and fair treatment for all HIV-positive people throughout the TGA regardless of race, ethnicity, sexual orientation, gender identity, faith tradition, immigrant status, language(s) spoken, age, or similar factors.
- ☐ Require that all HIV-related service providers within the TGA have at least one bilingual staff member who can speak Spanish, and is available for service provision or translation assistance during the majority of service hours. Allow for an exemption process for agencies that have reasonable need to be excluded from this requirement (i.e. they provide highly specialized services or are extremely unlikely to have Spanish-speaking clientele).

☐ Have a physical location (i.e. information booth or office) where non-English speakers can learn about resources and HIV-related services that are available to them, especially if they are available in Spanish. In addition to (or in lieu of) a physical location, a free hotline (similar to 411) should be made available to Spanish-speaking residents of the TGA that will assist monolingual speakers in learning about and accessing HIV-related services. ☐ Prioritize mobile services whenever feasible, especially in regions where clients are located physically far from services and/or are particularly disadvantaged with regard to transportation options – especially in unincorporated areas. Also investigate the possibility of having pop-up or satellite clinics on rotating days in these areas that would provide nearby access to HIV specialty clinicians and other wrap-around services. ☐ Prioritize comprehensive, rather than single-specialty, services at agencies whenever possible, to minimize the amount of travel required for consumers with multiple needs. Also encourage service providers to locate their agencies in the same or very nearby locations, to allow for a more "mall-style" one-stop service opportunity. ☐ Prioritize expansion of syringe exchange services throughout the TGA, as it is one of the few harm reduction interventions that has been proven to reduce the spread of HIV. This may require the addition of funding for more vans to provide increased mobile services through HEPPAC or other agencies. ☐ Develop resource guides and other tools to support appropriate referrals for formerly incarcerated individuals re-entering community throughout the TGA. Work with agency partners to identify the best resources for formerly incarcerated people in service categories including but not limited to medical care and treatment, housing, job/training services, and substance abuse services.

Recommendations Related to Knowledge and Impact of the Low Income Health Plan

□ Determine the overall impact of the ACA on undocumented immigrants in the Oakland TGA, and take concrete steps to mind the gaps created and offer no-cost or low-cost services to undocumented people who need non-emergency health care.

☐ Roll out more widespread ACA training as soon as possible in Alameda County. Make training easily accessible in multiple formats, then require training for representatives and key staff of all HIV-related service providers in the county. Be sure to have at least one version of the training that is geared for medical providers and case managers, and one version of the training that is geared toward service providers who are unlikely to ever enroll clients into LIHP or another ACA-related program. ☐ Develop a TGA-wide set of informational materials intended for clients – both HIV-positive and HIV-negative – to inform them about LIHP and/or the ACA. Ensure that these materials are printed in multiple languages, and distribute them widely to service agencies. ☐ Design and train a small team of staff from within the TGA who can move around from agency to agency providing informational sessions for clients about LIHP and the ACA, including in Spanish. ☐ Explore alternate methods for boosting LIHP enrollment for eligible clients, including the use of mobile vans or publicizing "enrollment events" in various locations. Recommendations Related to the Needs of Heterosexual HIV-positive Men ☐ Identify some simple but useful data points to collect system-wide about HIV-positive heterosexual men, and require them to be collected in as many service providers as possible throughout the TGA. Prioritize inclusion of these and any other data about heterosexual men in epidemiological reports or presentations about HIV within the TGA. ☐ Establish support groups both specifically for HIV-positive heterosexual men and for families; ensure that they are located in various regions throughout the TGA and are offered in English and Spanish, to improve accessibility. Develop a plan to improve services in the TGA for injection drug users, including provider awareness and sensitivity. This would include an integrated approach to awareness, prevention, and intervention that includes harm reduction approaches (such as a combination of free condoms, HIV and HCV testing, and provision of clean needles and works). It also includes a commitment to investigating "wet" housing support – housing that does not require abstinence from alcohol or drugs to be eligible, as this is impossible for many

injection drug users who nonetheless have significant housing support needs.

Develop and implement a series of awareness campaigns designed to raise visibility and reduce stigma for HIV-positive heterosexual men. Recruit straight spokesmen who are leaders in their communities to help promote the campaign. Get Screened Oakland did a campaign similar to this a few years ago called "Are you man enough?" that was targeted to Black men. Lessons learned from that campaign can be incorporated into new campaign efforts.
 Take steps to increase the roles of heterosexual men as service providers within HIV organizations. Encourage HIV-positive heterosexual men to work as peer health advocates, utilizing those advocates for both outreach and service provision, and promote relevant job opportunities within straight male networks.
 Explore the use of non-traditional locations frequented by heterosexual men for HIV outreach. Some good examples of these locations are barbershops, YMCAs, basketball courts, churches, gyms, and sporting events.

Recommendations Related to Intimate Partner Violence and its Relationship to HIV

- Increase the existence and availability of mental health services and other psychosocial and clinical supports for perpetrators of IPV (both men and women), to help them recognize and deal with their behaviors in order to heal themselves, gain new skills to handle triggers and reduce violence, and have healthier relationships overall.
- □ Raise visibility about how to identify IPV for oneself or others, promote IPV resources, and reduce shame and stigma about IPV through a social marketing and/or social media campaign within the Oakland TGA. Do this in partnership with IPV service agencies (such as the Alameda County Family Justice Center or STAND! For Families Free of Violence) to maximize resources, increase collaborations and improve cohesiveness of services. These strategies should target both men and women.
- ☐ Ensure the existence and appropriateness of IPV services for men both survivors and perpetrators. Prioritize the establishment of these services where needed, and promote the existence of these services to agencies throughout the TGA so that agency staff will be better able to support their male clients.

☐ Work to increase awareness of emergency services, including housing protections and legal services, available to survivors of IPV. Increasing provider awareness will improve the opportunity for survivors of IPV to quickly access life-saving support in times of great need. ☐ Encourage widespread IPV screening during intake at all HIV-related agencies throughout the TGA. If possible, develop a centralized, standard procedure (i.e. a standard set of questions that could be added to any agency intake form) and make this template available to all agencies in the TGA for use if desired. Include training for intake staff at all agencies about how to properly screen for IPV. ☐ Require reporting of IPV intake screening data throughout the TGA. Collect and analyze those data at the health department level and share findings on a regular basis in order to assist in the prioritization and modification of IPV-related services as needed. ☐ In addition to developing and providing training for intake staff at all HIV-related agencies in the TGA about how to properly screen for IPV, brief trainings about IPV should be developed and made available to all service providers as well as consumers and the wider community. These trainings should focus on how to identify IPV, what to do if you suspect IPV, and what community resources are available to support people who are in or were previously in IPV relationships. This will also encourage service providers to develop

relationships that will allow for "warm handoffs" of clients who have IPV-related needs.

Appendix A

References

- 1. Health Resources and Services Administration. (2013). Part A Grants to Emerging Metropolitan & Transitional Grant Areas [Website]. Retrieved from http://hab.hrsa.gov/abouthab/parta.html.
- 2. United States Census Bureau. (2013). State & County QuickFacts [Website]. Retrieved from http://quickfacts.census.gov/qfd/states/06/06001.html (Alameda) and http://quickfacts.census.gov/qfd/states/06/06013.html (Contra Costa).
- 3. Collaborative Community Planning Council. (2013). Welcome to the Collaborative Community Planning Council (CCPC) [Website]. Retrieved from http://www.hivccpc.org/.
- 4. Borkan J. (1999). Immersion/Crystallization. In Crabtree BF and Miller WL (Eds.) Doing Qualitative Research (2nd Edition). Thousand Oaks, CA: Sage Publications. pp. 179-194
- 5. Contra Costa Health Services AIDS Program. (2008). Contra Costa County, California Comprehensive HIV Prevention Plan, 2008 2013. Martinez, CA: Contra Costa Health Services.
- 6. Superior Court of California, County of Alameda. (2013). About Alameda County [Website]. Retrieved from http://www.alameda.courts.ca.gov/pages.aspx/about-alameda-county.
- 7. Alameda County, CA. (2013). Cities of Alameda County [Website]. Retrieved from http://www.acgov.org/about/cities.htm.
- 8. United States Census Bureau. (2013). State & County QuickFacts [Website]. Retrieved by searching individual cities from http://quickfacts.census.gov/qfd/states/06000.html.
- 9. St-Jacques S, Philibert MD, Langlois A, Daigle JM, Pelletier E, et. al. (2003). Geographic access to mammography screening centre and participation of women in the Quebec Breast Cancer Screening Programme. Journal of Epidemiology and Community Health. doi:10.1136/jech-2013-202614.
- 10. Slinin Y, Guo H, Li S, Liu J, Morgan B, Ensrud K, Gilbertson DT, et al. (2013). Predictors of provider-patient visit frequency during hemodialysis. American Journal of Nephrology, 38(2), 91-98.
- 11. Raknes G, Hansen EH, Hunskaar S. (2013). Distance and utilisation of out-of-hours services in a Norwegian urban/rural district: an ecological study. BMC Health Services Research, 13(1), 222.
- 12. Blue-Howells J, McGuire J, Nakashima J. (2008). Co-location of health care services for homeless veterans: a case study of innovation in program implementation. Social Work in Health Care, 47(3), 219-231.
- 13. Grzybowski S, Stoll K, Kornelsen J. (2011). Distance matters: a population based study examining access to maternity services for rural women. BMC Health Services Research, 11, 147.
- 14. Gunn RA, Lee MA, Callahan DB, Gonzales P, Murray PJ, Margolis HS. (2005). Integrating hepatitis, STD, and HIV services into a drug rehabilitation program. American Journal of Preventive Medicine, 29(1), 27-33.

- 15. Boya C, Route PS, Fennie K, Ettinger W, Manchester GW, Weinstein B. (2012). Measuring patient-provider trust in a primary care population: refinement of the health care relationship trust scale. Research & Nursing in Health, 35(4), 397-408.
- 16. Kim SS, Chung T, Perry MJ, Kawachi I, Subramanian SV. (2012). Association between interpersonal trust, reciprocity, and depression in South Korea: A prospective analysis. PLoS ONE, 7(1), 1-8.
- 17. Manuco JM. (2010). Impact of health literacy and patient trust on glycemic control in an urban USA population. Nursing and Health Sciences, 12, 94-104.
- 18. Nguyen GC, LaVeist TA, Harris M, Datta LW, Bayless TM, Brant SR. (2009). Patient trust in physician and race are predictors of adherence in medical management in inflammatory bowel disease. Inflammatory Bowel Diseases, 15, 1233-1239.
- 19. Thom, DH, Hall MA, Pawlson G. (2004). Measuring patients' trust in physicians when assessing quality of care. Health Affairs, 23, 124-132.
- 20. Ashton CM, Haidet P, Paterniti DA, Collins TC, Gordon HS, et. al. (2003). Racial and ethnic disparities in the use of health services: bias, preferences, or poor communication? Journal of General Internal Medicine, 18(2), 146-152.
- 21. Magnus M, Herwehe J, Murtaza-Rossini M, Reine P, Cuffie D, Gruber D, Kaiser M. (2013). Linking and retaining HIV patients in care: the importance of provider attitudes and behaviors. AIDS Patient Care and STDs, 27(5), 297-303.
- 22. Campbell R, Raja S. (1999). Secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. Violence & Victims, 14, 261-275.
- 23. Patient Protection and Affordable Care Act, Pub. L. No. 111-148. Retrieved from http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.
- 24. Gabow P, Katz M, Rosenbaum S, Siegel B, panelists. (2011). Proceeding from Impact of the Affordable Care Act on the Safety Net. Washington, DC: Academy Health.
- 25. Marco CA, Moskop JC, Schears RM, et al. (2012). The ethics of health care reform: impact on emergency medicine. Academy of Emergency Medicine, 19(4), 461-468.
- 26. United States Congressional Budget Office. (2011). CBO's March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act(Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Retrieved from https://www.cbo.gov/sites/default/files/cbofiles/attachments/HealthInsuranceProvisions.pdf.
- 27. California Department of Health Services. (2013). Low Income Health Program (LIHP) [Website]. Retrieved from http://www.dhcs.ca.gov/provgovpart/Pages/lihp.aspx.

- 28. California Department of Public Health. (2013). LIHP Screening During ADAP Enrollment and Recertification in Counties Currently Screening ADAP Clients for LIHP. Retrieved from http://www.cdph.ca.gov/programs/aids/Documents/ADAPMMLIHPFlowchart.pdf
- 29. Health Management Associates. (2011). Sustainability Audit of the Contra Costa County Regional Medical Center and Health Centers: Stage 1 Information Memorandum Final Report. Retrieved from http://ca-contracostacounty.civicplus.com/DocumentCenter/Home/View/6523.
- 30. Long P, Gruber J. (2011). Projecting the impact of the Affordable Care Act on California. Health Affairs, 30(1), 63-70.
- 31. National Immigration Law Center (2013). Immigrants and the Affordable Care Act (ACA). Retrieved from http://www.nilc.org/document.html?id=157%20.
- 32. Southeast Asia Research Action Center (SEARAC). (2013). How the Affordable Care Act Helps Undocumented Immigrants. Retrieved from http://www.searac.org/sites/default/files/How%20 ACA%20helps%20undocumented%20immigrants.pdf.
- 33. Huntoon KM, McCluney CJ, Scannell CA, Wiley EA, Bruno R, et al. (2011). Healthcare reform and the next generation: United States medical student attitudes toward the Patient Protection and Affordable Care Act. PLoS One, 6(9), e23557.
- 34. The Henry J. Kaiser Family Foundation. (2013). Kaiser Health Tracking Poll: April 2013. Retrieved from http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-april-2013.
- 35. Centers for Medicare & Medicaid Services. (2013). Census Data to Target the Uninsured [Website]. Retrieved from http://cms.gov/Outreach-and-Education/Outreach/HIMarketplace/Census-Data-. html?no_redirect=true.
- 36. United States Census Bureau. (2013). Language spoken at home by ability to speak English for the population 5 years and over. 2011 American Community Survey 1-year estimates [Dataset]. Retrieved from http://Factfinder2.census.gov.
- 37. Centers for Disease Control and Prevention. (2012). New HIV Infections in the United States [Fact Sheet]. Retrieved from http://www.cdc.gov/nchhstp/newsroom/docs/2012/hiv-infections-2007-2010. pdf.
- 38. Doll LS, Peterson LR, White CR, Johnson ES, Ward JW. (1992). The Blood Donor Study Group. Homosexuality and nonhomosexually identified men who have sex with men: A behavioral comparison. Journal of Sex Research, 29, 1-14.
- 39. Ross MW, Essien EJ, Williams ML, Fernandez-Esquer ME. (2003). Concordance between sexual behavior and sexual identity in street outreach samples of four racial/ethnic groups. Sexually Transmitted Diseases, 30(2), 416-425.
- 40. Pathela P, Hajat A, Schillinger J, Blank S, Sell R, Mostashari F. (2006). Discordance between sexual behavior and self-reported sexual identity: a population-based survey of New York City men. Annals of Internal Medicine, 145(6), 416-425.

- 41. Dankwa-Mullan I, Rhee KB, Williams K, Sanchez I, Sy FS, Stinson N, Ruffin J. (2010). The science of eliminating health disparities: Summary and analysis of the NIH Summit recommendations. American Journal of Public Health, 100(Suppl 1), S12-S18.
- 42. Tudiver F, Talbot Y. (1999). Why don't men seek help? Family physicians' perspectives on help-seeking behavior in men. Journal of Family Practice, 13(1), 47-52.
- 43. Addis ME, Mahalik JR. (2003). Men, masculinity, and the contexts of help seeking. American Psychology, 13(1), 5-14.
- 44. O'Brien R, Hunt K, Hart G. (2005). "It's caveman stuff, but that is to a certain extent how guys still operate": Men's accounts of masculinity and help seeking. Social Science & Medicine, 61, 503-516.
- 45. Galdas P, Cheater F, Marshall P. (2005). Men and health help-seeking behaviour: Literature review. Journal of Advanced Nursing, 49, 616-623.
- 46. White A, Banks I. (2004). Help seeking in men and the problems of late diagnosis. In: Kirby R, Carson C, Kirby M, Farah R, editor. Men's Health. London: Martin Dunitz.
- 47. Kouides RW, Bennett NM, Lewis B, Cappuccio JD, Barker WH, LaForce FM. (1998). Performance-based physician reimbursement and influenza immunization rates in the elderly: The Primary-Care Physicians of Monroe County. American Journal of Preventive Medicine, 14(2), 89-95.
- 48. Centers for Disease Control and Prevention. (2005). Use of social networks to identify persons with undiagnosed HIV infection --- Seven U.S. cities, October 2003–September 2004. Morbidity and Mortality Weekly Report, 54(24), 601-605.
- 49. Marteau TM, Ashcroft RE, Oliver A. (2009). Using financial incentives to achieve healthy behaviour. British Medical Journal, 338, 338:983-985.
- 50. Zenner D, Molinar D, Nichols T, Riha J, Macintosh M, Nardone A. (2012). Should you people be paid for getting tested? A national comparative study to evaluate patient financial incentives for chlamydia screening. BMC Public Health, 12, 261.
- 51. Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, et al. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Retrieved from http://www.cdc.gov/violenceprevention/nisvs/.
- 52. Centers for Disease Control and Prevention (2011).NISVS: An Overview of 2010 Findings on Victimization by Sexual Orientation. Retrieved from http://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_victimization_final-a.pdf.
- 53. Sareen J, Pagura J, Grant B. (2009). Is intimate partner violence associated with HIV infection among women in the United States? General Hospital Psychiatry, 31 (3), 274–278.
- 54. Pantalone DW, Schneider KL, Valentine SE, Simoni JM. (2012). Investigating partner abuse among HIV-positive men who have sex with men. AIDS Behavior, 16(4), 1031-1043.

- 55. Greenwood GL, Relf MV, Huang B, Pollack LM, Canchola JA, Catania JA. (2002). Battering victimization among a probability-based sample of men who have sex with men. American Journal of Public Health, 92(12), 1964–9.
- 56. Garcia-Moreno, C. (2000). Violence against women: International perspectives [Review]. American Journal of Preventive Medicine, 19(4), 330–333.
- 57. Molitor F, Ruiz JD, Klausner JD, McFarland W. (2000). History of forced sex in association with drug use and sexual HIV risk behaviors, infection with STDs, and diagnostic medical care: Results from the young women survey. Journal of Interpersonal Violence, 15 (3), 262-278.
- 58. Silverman JG. (2011). Adolescent female sex workers: invisibility, violence and HIV [Review]. Archives of Disease in Childhood, 96(5), 478-481.
- 59. El-Bassel N, Gilbert L, Rajah V, Foleno A, Frye V. (2000). Fear and violence: Raising the HIV stakes. AIDS Education and Prevention, 12(2), 154-170.
- 60. Mittal M, Senn TE, Carey MP. (2011). Mediators of the relation between partner violence and sexual risk behavior among women attending a sexually transmitted disease clinic. Sexually Transmitted Diseases, 38(6), 510–515.
- 61. Seth P, Raiford JL, Robinson LS, Wingood GM, DiClemete RJ. (2010). Intimate partner violence and other partner-related factors: Correlates of sexually transmissible infections and risky sexual behaviours among young adult African American women. Sexual Health, 7(1), 25-3.
- 62. El-Bassel N, Fontdevila J, Gilbert L, Voisin D, Richman BL, Pitchell P. (2001). HIV risks of men in methadone maintenance treatment programs who abuse their intimate partners: A forgotten issue. Journal of Substance Abuse, 13 (1-2), 29-43.
- 63. Frye V, Ompad D, Chan C, Koblin B, Galea S, Vlahov D. (2011). Intimate partner violence perpetration and condom use-related factors: Associations with heterosexual men's consistent condom use. AIDS and Behavior, 15(1), 153-162.
- 64. Schafer KR, Brant J, Gupta S, Thorpe J, Winstead-Derlega C, Pinkerton R, et al. (2012). Intimate partner violence: A predictor of worse HIV outcomes and engagement in care. AIDS Patient Care and STDs, 26(6), 356-365.
- 65. Griffin MG, Resick PA, Yehuda R. (2005). Enhanced cortisol suppression following dexamethasone administration in domestic violence survivors. American Journal of Psychiatry, 162, 1992-1199.
- 66. Constantino RE, Sekula LK, Rabin B, Stone C. (2000). Negative life experiences, depression, and immune function in abused and nonabused women. Biological Research for Nursing, 1, 190-198.
- 67. RAND California. Domestic Violence Number of Crimes [Database]. Retrieved from http://ca.rand.org/stats/community/domvio.html.
- 68. National Coalition Against Domestic Violence. (2007). Domestic Violence Facts [Fact Sheet]. Retrieved from http://www.ncadv.org/files/DomesticViolenceFactSheet(National).pdf.

Appendix B

ALAMEDA

Alameda Alliance for Health

1240 N Loop Rd Alameda 94502

Alameda Emergency Food Bank

1900 Thau Way Alameda 94501

Alameda Family Services

2325 Clement Ave Alameda 94501

ANTIOCH

Bay Area Addiction, Research, and Treatment (BAART)

3707 Sunset Lane Antioch 94509

YWCA Contra Costa / Sacramento

931 Cavallo Road Antioch 94509

BERKELEY

Affordable Housing Associates

1250 Addison St Berkeley 94702

Alta Bates Summit Medical Center -

Alta Bates Campus

2450 Ashby Ave Berkeley 94705

Berkeley Addiction Treatment Services

2975 Sacramento St Berkeley 94702

Berkeley Builds Capacity

2222 Bancroft Way Berkeley 94720 Berkeley Food & Housing Project - Men's Housing Program

1931 Center St Berkeley 94704

Berkeley Food & Housing Project -

Multi Service Center

2362 Bancroft Way Berkeley 94705

Berkeley Food & Housing Project - North County

Women's Center

2140 Dwight Way Berkeley 94704

Berkeley Free Clinic

2339 Durant Ave Berkeley 94704

Berkeley Health Center for Women and Men

2908 Ellsworth St Berkeley 94705

Building Opportunities for Self-Suffiency (BOSS)

2065 Kittredge Street Berkeley 94704

Center for Independent Living

2539 Telegraph Ave Berkeley 94705

City of Berkeley Public Health Clinic

830 University Ave Berkeley 94710

Coalition for Alternatives in Mental Health -

Berkeley Drop-in Center

3234 Adeline Street Berkeley 94703

East Bay Community Law Center

3130 Shattuck Ave Berkeley 94705

Homeless Action Center

3126 Shattuck Ave Berkeley 94705

Options Recovery Services

1931 Center St Berkeley 94704

Pacific Center for Human Growth

2712 Telegraph Ave Berkeley 94705

Resources for Community Development

2220 Oxford St Berkeley 94704

William Byron Rumford Medical Clinic

2960 Sacramento Street Berkeley 94710

Women's Daytime Drop-In Center

2218 Acton St Berkeley 94702

CONCORD

Catholic Charities of the East Bay - HIV/AIDS Services

3540 Chestnut Ave Concord 94519

Food Bank of Contra Costa and Solano

4010 Nelson Ave Concord 94520

Rainbow Community Center of Contra Costa County

2118 Willow Pass Rd #500 Concord 94520

FREMONT

Abode Services

40849 Fremont Blvd Fremont 94538

Bay Area Community Services Adult

Day Care Services

40963 Grimmer Blvd Fremont 94538

Carnales Unidos Reformando Adictos (CURA)

37437 Glenmoor Drive Fremont 94536

Grupo Fremont VIP

4766 Serra Avenue Fremont 94538

Tri-City Health Center

39500 Liberty St Fremont 94538

Tri-City Health Center

39184 State Street Fremont 94538

HAYWARD

AAlameda County Housing Authority

22941 Atherton St Hayward 94541

Community Resources for Independent Living (CRIL)

439 A St Hayward 94541

Concord House

20373 Concord Ave Hayward 94541 Appendix B Hayward (cont.)

Crescent Healthcare, Inc.

2547 Barrington Ct Hayward 94545

East Bay Community Recovery Project Health Division

22971 Sutro Street Hayward 94541

Hayward Wellness Clinic at Winton

24100 Amador Street Hayward 94544

Horizon Services, Inc.

1558 B St #291 Hayward 94541

Horizon Services, Inc.

1151 A St Hayward 94541

La Familia Counseling Service

26081 Mocine Ave Hayward 94544

Planned Parenthood Mar Monte

1866 B Street Hayward 94541

Second Chance Hayward Recovery Center

107 Jackson Street Hayward 94544

Spectrum Community Services

2747 Oliver Drive Hayward 94545

Spectrum Community Services

1435 Grove Way Hayward 94546

Terra Firma Diversion Educational Services

30086 Mission Blvd Hayward 94544

Tiburcio Vasquez Health Center

22331 Mission Blvd Hayward 94541

Women on the Way Recovery Center

20424 Haviland Ave Hayward 94541

LIVERMORE

Axis Community Health

446 Lindbergh Ave Livermore 94551

Community Resources for Independent Living

3311 Pacific Ave Livermore 94550

MARTINEZ

Contra Costa Health Services HIV/AIDS & STD Program

597 Center Avenue #200 Martinez 94553

YWCA Contra Costa / Sacramento

1320 Arnold Ave #170 Martinez 94533

NEWARK

Newark Wellness Clinic

6066 Civic Terrace Ave Newark 94560

OAKLAND

A Friendly Place

2298 San Pablo Ave Oakland 94612

Adult Medical Services at Hotel Oakland

275 14th Street Oakland 94612

AIDS Healthcare Foundation

238 E 18th Street Oakland 94606

AIDS Healthcare Foundation

400 30th St #300 Oakland 94609

AIDS Project East Bay

1320 Webster Street Oakland 94612

Alameda County Community Food Bank

7900 Edgewater Dr Oakland 94621

Alameda County Public Health Department

1000 Broadway, Suite 310 Oakland 94607

Albert J. Thomas Medical Clinic

10615 International Blvd Oakland 94603

Allen Temple Baptist Church

8501 International Blvd. Oakland 94621

Anthony Jones MD

400 29th St., Suite 501 Oakland 94619

Asian Health Services

818 Webster Street Oakland 94607

Bay Area Addiction, Research, and Treatment (BAART)

1124 International Blvd Oakland 94606

Bay Area Community Services Adult Day Care Services

5714 Martin Luther King Jr Way Oakland 94609

Berkeley Adult Day Health Center

1890 Alcatraz Ave Oakland 94703

California Prevention and Education Project (Cal-PEP)

2811 Adeline St Oakland 94608

Catholic Charities of the East Bay - HIV/AIDS Services

433 Jefferson St Oakland 94607

Center for Independent Living

1470 Fruitvale Ave Oakland 94601

Center for Independent Living

610 16th St #419 Oakland 94612

Children's Hospital & Research Center Oakland

747 52nd Street Oakland 94609

Circle of Care

2540 Charleston Street Oakland 94602

Community Care Services Inc.

3317 Elm St #202 Oakland 94609

Community Recovery Center East

7501 International Blvd Oakland 94621

Community Recovery Center West

451 28th Street Oakland 94612

Dept. of Veterans Affairs - Infectious Disease Clinic

2221 Martin Luther King Jr Way Oakland 94612 Appendix B
Oakland (cont.)

East Bay AIDS Center (EBAC)

3100 Summit St Oakland 94609

East Bay Community Recovery Project Health Division

2579 San Pablo Ave Oakland 94607

East Bay Community Recovery Project Health Division

2730 Adeline St Oakland 94607

East Bay Perinatal Medical Associates

350 30th St #208 Oakland 94609

East Oakland Community Project

7515 International Blvd Oakland 94621

East Oakland Health Center

7450 International Blvd Oakland 94621

East Oakland Recovery Center

7200 Bancroft Ave Oakland 94605

Eastmont Wellness Clinic

6955 Foothill Blvd #200 Oakland 94605

Family Support Services of the Bay Area

401 Grand Avenue #200 Oakland 94610

Fred Finch Youth Center

3800 Coolidge Ave Oakland 94602

Health Initiatives for Youth - QTY Treehouse

1924 Franklin St, 3rd floor Oakland 94612

Henry Robinson Multi-Service Center

559 16th St Oakland 94612

Highland Hospital

1411 E 31st Street Oakland 94602

HIV Education and Prevention Project of Alameda County (HEPPAC)

5323 Foothill Blvd Oakland 94603

Homeless Action Center

1432 Franklin St Oakland 94612

Horizon Services, Inc.

3485 Telegraph Ave Oakland 94609

Humanistic Alternatives to Addiction, Research, and Treatment (HAART)

10850 Macarthur Blvd Oakland 94605

Imani Community Church

3300 MacArthur Blvd Oakland 94602

La Cheim Adult Behavioral Services

3031 Telegraph Ave Oakland 94609

La Clinica de la Raza - Casa del Sol

1501 Fruitvale Ave Oakland 94601

La Clinica de la Raza - Clinica Alta Vista

1515 Fruitvale Ave Oakland 94601

La Clinica de la Raza - Fruitvale Dental

3050 East 16th Street Oakland 94601

La Clinica de la Raza - Fruitvale Village

3451 E. 12th Street Oakland 94601

La Clinica de la Raza - San Antonio Neighborhood Health Center

1030 International Blvd Oakland 94606

Native American Health Center

3124 International Blvd Oakland 94601

Organization to Achieve Solutions in Substance Abuse (OASIS)

520 27th Street Oakland 94612

Planned Parenthood Eastmont Health Center

7200 Bancroft Ave Oakland 94605

Project Open Hand

1921 San Pablo Ave Oakland 94612

Providence House

540 23rd St Oakland 94612

Street Level Health Project

2501 International Blvd Oakland 94601

The Yvette A. Flunder Foundation

8501 International Blvd. Oakland 94621

Volunteers of America Bay Area - Prevention and Health Services Division

672 13th Street, Suite 100 Oakland 94612

West Oakland Health Center

700 Adeline Street Oakland 94607

Women Organizing to Respond to Life-Threatening Diseases (WORLD)

449 15th Street, Suite 303 Oakland 94612

PITTSBURG

La Clinica de La Raza

333 East Leland Rd Pittsburg 94565

PLEASANTON

Axis Community Health

1991 Santa Rita Blvd, Suite H Pleasanton 94566

Axis Community Health

6666 Owens Drive Pleasanton 94588

Valley Community Health Center

4361 Railroad Ave, Suite I Pleasanton 94566

RICHMOND

Bay Area Addiction, Research, and Treatment (BAART)

1313 Cutting Blvd Richmond 94804

California Department of Health

850 Marina Bay Parkway Richmond 94804

Catholic Charities of the East Bay - HIV/AIDS Services

2369 Barrett Ave Richmond 94804 Appendix B
Richmond (cont.)

Greater Richmond Interfaith Program (GRIP)

165 22nd Street Richmond 94801

LifeLong Medical Care

2400 Nevin Ave Richmond 94801

Native American Health Center

260 23rd Street Richmond 94804

Neighborhood House of North Richmond

820 23rd Street Richmond 94804

SAN LEANDRO

Fairmont Hospital

15400 Foothill Blvd San Leandro 94578

HIV ACCESS, Asian Health Services

101 Callan Ave, Suite 300 San Leandro 94577

SAN PABLO

LifeLong Brookside Community Health Center

2023 Vale Road San Pablo 94806

West County Health Center

13601 San Pablo Ave San Pablo 94806

WALNUT CREEK

Contra Costa Interfaith Housing

3164 Putnam Blvd Walnut Creek 94597

AGENCIES THAT RARELY REQUIRE CLIENT VISITS TO THE SERVICE LOCATION

A Safe Place

Oakland

AGUILAS

San Francisco

AIDS Community Research Consortium

Redwood City

AIDS Emergency Fund

San Francisco

AIDS Legal Referral Panel

San Francisco

Alameda County Bar Association Volunteer Legal Services Corporation

Oakland

Asian Law Alliance

San Jose

Bay Area Perinatal AIDS Clinic

San Francisco

Bay Cares

Oakland

Clinica Esperanza

San Francisco

Clinicas para los Derechos del Trabajador (The Legal Aid Society Employment Law Center)

San Francisco

Day Worker Center of Mountain View

Mountain View

Eden I&R - AIDS Housing & Information Project

Hayward

Edin Council for Hope & Opportunity (ECHO) Housing

Oakland

Fremont Fair Housing Services

Fremont

GELAAM

Burlingame

Get Screened Oakland

Oakland

Grupo Pro Latino De San Jose

San Jose

Health Trust

San Jose

Hope Hospice, Inc.

Dublin

Housing Rights, Inc.

Berkeley

Instituto Familiar de la Raza

San Francisco

La Raza Centro Legal

San Francisco

La Raza Community Resource Center

San Francisco

Marin AIDS Project

San Rafael

Pace Clinic

San Jose

Positive Resource Center

San Francisco

Project Inform

San Francisco

Project Sentinel (Fair Housing)

Fremont

Protection and Advocacy, Inc.

Oakland

Rubicon Legal Services

Richmond

San Francisco AIDS Foundation

San Francisco

Season of Sharing (Alameda Social Services)

Oakland

Shanti

San Francisco

Sutter Visiting Nurses Association and Hospice

San Mateo