5/24/11

FINAL COMPLETE RESULTS: San Diego County 2011 Health and Social Services Provider Survey

(105 Survey Respondents)

Prepared by
HIV, STD and Hepatitis Branch
Public Health Services, Health and Human Services Agency
County of San Diego
May 2011

For more information, or to obtain a copy of related documents which include information from the survey including the Care Treatment Provider Resource Inventory
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San Diego County
2011 Health and Social Services Provider Survey

A. Background and Process

This 67-question survey was developed by the Needs Assessment Subcommittee of the Continuum of Care Committee, a joint committee of the San Diego HIV Health Services Planning Council and the San Diego HIV Prevention Community Planning Board. The committee's charge is to address the local continuum of HIV and related services, including HIV care and treatment, HIV counseling and testing, HIV prevention, HIV/AIDS surveillance, HIV/AIDS research, STD and hepatitis services, behavioral health services and housing services, through the following activities:

1. Provide guidance and support for the community planning process for HIV prevention. This will be accomplished, as feasible, through participation of Prevention Group members on the committee and inclusion of prevention issues as appropriate.
2. Address the local continuum of HIV and related services, encompassing sexual health as appropriate. This includes HIV care and treatment, HIV counseling and testing, HIV prevention, partner services, HIV/AIDS surveillance, HIV/AIDS research, STD and hepatitis services, alcohol and drug services, mental health and housing services.
3. Facilitate coordinated efforts, as defined and required by Health Services and Resources Administration (HRSA) to develop and update:
   - Estimate of unmet need for HIV Primary Care
   - Estimate of people unaware of their status
   - Assessment of subpopulation with unmet need

   Consider methods to address unmet needs. Coordinate Test and Link to Care (TLC) initiative efforts for the Early Identification of Individuals with HIV and AIDS (EIIHA) through testing, notification of results and facilitated linkages to care.
4. Oversee the needs assessment of HIV/AIDS services including people living with HIV/AIDS and service providers.
5. Maintain and periodically update and assess an inventory encompassing all HIV related resources and services.
6. Consider coordination and integration of planning and services where feasible to maximize resources and provide guidance for population specific action plans.

The provider survey is part of an ongoing Needs Assessment process, which included three components: (1) survey of people living with HIV/AIDS; (2) provider survey; and (3) five regional community planning group meetings held throughout the county. The provider survey was intended not only to assist in gathering information from providers about HIV care and prevention needs, but also to augment information for a resource inventory on the range of community services available to HIV-positive and high-risk HIV-negative individuals.

Survey Instrument: The first page of the online survey included the following additional background information:

Welcome to the 2011 San Diego County Social Services Provider Survey. This survey is designed to identify the location, types and coordination of HIV-related services offered in San Diego County, as well as other related support services for People Living with HIV/AIDS (PLWH/A). The results of this survey will be used to help make decisions about additional services needed, and help to better understand the prevention, treatment and testing needs of the San Diego community as well as the met and unmet needs for PLWH/A.

We are requesting information on all services provided by your agency, whether or not you provide HIV-specific services or programs, and whether or not your agency specifically targets clients with HIV/AIDS. If you are not the best person to answer these questions on behalf of your entire agency, please share this survey with the appropriate staff.

This survey should take you about 15-30 minutes. Thank you for taking the time to participate in this important survey. At the end of the survey, you will be directed to a list of resources including who to contact if you have any questions or would like a copy of the survey results.

This survey is co-sponsored by: San Diego HIV Planning Council; HIV Prevention Community Planning Group; County HIV, STD & Hepatitis Branch; County Behavioral Health Services (Alcohol and Drug Services and Mental Health Services); HIV Care Partnership for Women, Children, Adolescents, and Families; Coalition of Latino AIDS Service Providers; HIV Youth Council; and Kemet Coalition.

Data Collection: The County of San Diego HIV, STD and Hepatitis Branch (HSHB) of Public Health Services and Behavioral Health Services (BHS), the HIV Health Services Planning Council (PC), the HIV Prevention Community Planning Group (PG) distributed and collected surveys between April 27 and May 6, 2011. A link to the online survey was distributed through various email distribution lists including HSHB, BHS, PC, PG and Housing Opportunities for People Living with AIDS (HOPWA) program. All advisory group to the PG including the Coalition of Latino AIDS Service Providers (CLASP), the HIV Care Partnership, Kemet, Transgender Advocacy and Service Center (TASC) and the Youth Council and 2-1-1 were requested to distribute the survey and link. A link was posted on the PC website. A letter requesting participation from Terry Cunningham, HSHB Chief was also distributed with the surveys and links. A total of one hundred five (105) surveys were completed on-line.

B. Survey Results

1. Agencies Responding (N=105 Total Responses)

211 San Diego
Alpha Project
Being Alive San Diego HIV/AIDS Services
Borrego Community Health Foundation
Catholic Charities
Chicano Federation of San Diego County, Inc.
Choices in Recovery (2)
Christie's Place
Community Housing Works
Community Research Foundation
County of San Diego
County of San Diego HSHB (2)
County of San Diego HHSA (2)
CRASH Inc. (3)
Crossroads Foundation
Discovery Clubhouse
Family Health Centers of San Diego
Fraternity House, Inc.
Heritage Clinic
Kaiser Permanente (2)
Karibu Center for Social Support and Education
Kemet Coalition/Faith Based Working Group
MAAC Project (2)
Mama's Kitchen
Mental Health Systems, Inc. (5)
Mira Coast College
Mountain Health
NAMI San Diego (3)
Neighborhood Healthcare (2)
Neighborhood House Association (3)
North County Health Services, Inc.
North County Serenity House
Occupational Health Services
Operation Samahan (2)
Pathfinders of San Diego
Phoenix House San Diego, Inc.
Prime Healthcare Inc.
Providence Community Services (2)
Ramona Food and Clothes Closet
Recovery Innovations of California
Regional Task Force on the Homeless
San Diego American Indian Health Center
San Diego Family Care - mid city
San Diego Freedom Ranch
San Diego Hospice & the Institute for Palliative Medicine
San Diego LGBT Community Center
San Diego Volunteer Lawyer Program, Inc.
San Diego Youth Services
San Ysidro Health Center (4)
South Bay Community Services
St Vincent de Paul Village
Stepping Stone Of San Diego (3)
Sycuan Medical/Dental Center
Telecare
The Friends of AIDS Foundation
The Palavra Tree, Inc
The Twelfth Step House Of San Diego, Inc.
The Way Back, Inc.
Townspeople (2)
Tradition One, Inc.
Transitional Case Management Program (TCMP)
UCSD AVRC
UCSD Bridge to Recovery Program
UCSD HIV Neurobehavioral Research Center
UCSD Medical Center, Owen Clinic (2)
UCSD Mother Child & Adolescent HIV Program
UCSD Moores Cancer Center
UCSD Outpatient Psychiatry
UCSD Outpatient Services
United African American Ministerial
Unknown (2)
VA San Diego Healthcare System
Vista Community Clinic (3)
Vista Hill
Walgreens

2. Agency Information: Type, Service Area, Target Populations and Coordination

Which of these best describes your agency? (check one) (n=104 respondents)

Response	n	%
Substance abuse treatment provider	21	(20%)
Community based organization (not AIDS-specific)	17	(16%)
Health clinic	13	(13%)
Mental health treatment provider	11	(11%)
HIV/AIDS service organization	10	(10%)
Multi-service agency with targeted HIV/AIDS services	7	(7%)
Hospital	3	(3%)
Housing services provider	2	(2%)
Multi-service agency with no targeted HIV/AIDS services	2	(2%)
Pharmacy	1	(1%)
Physician/private doctor	1	(1%)
Other	16	(15%)

Non profit outreach, advocacy; Short-term intensive case management program; Information and referral; Legal services with targeted HIV/AIDS legal service; HIV/AIDS housing; Hospital based clinic; Local health jurisdiction – County; Recovery model mental health clubhouse; County mental health case management; Cancer center; Dept. of Vocational Rehabilitation cooperative program contractor; Not for profit HMO; Peer run mental health services; Prevention and early intervention of Schizophrenia and other psychotic disorders; Integrated mental health and substance abuse Tx provider; DUI Program

In which particular region(s)/area(s) of San Diego County do you focus services? (n=104 respondents)

Region	n	%
Central San Diego *(Downtown, East San Diego, Kearny Mesa, Mira Mesa, Scripps Ranch, San Carlos, Tierrasanta)*	61	(59%)
Southeast San Diego *(Alta Vista, Encanto, Golden Hill, Lincoln Park, Logan Heights, Paradise Hills, Sherman Heights)*	41	(39%)
South Bay *(Bonita, Chula Vista, Coronado, Imperial Beach, National City, Otay, San Ysidro)*	37	(36%)
East County *(El Cajon, Jamul, Lakeside, La Mesa, Lemon Grove, Santee, Spring Valley)*	36	(35%)
North County Coastal *(Encinitas, Oceanside, Solana Beach, Vista)*	36	(35%)
North County Inland *(Escondido, Fallbrook, Poway, San Marcos, Valley Center)*	35	(34%)
North Central San Diego *(Bay Park, Beach communities, Clairemont, La Jolla, Linda Vista, Mission Valley, Point Loma, Serra Mesa, University City)*	34	(33%)
Rural Northeast County *(Part of East County: Alpine, Borrego Springs, Julian, Ramona, and the mountain and desert areas in the far eastern part of the county)*	23	(22%)
Other	8	(8%)

SD county (7); Various locations w/ mobile testing unit

Do you target services to people living with HIV/AIDS and/or their affected families? (n=104 respondents)

Response	n	%
Yes	42	(40%)
No	62	(60%)

Do you target services to people at risk of acquiring HIV?(n= 103 respondents)

Response	n	%
Yes	40	(39%)
No	63	(61%)

Do you specifically target services to a particular population? (n=103 respondents)

Response	n	%
Yes	81	(79%)
No	22	(21%)

If yes, specify: *Parolee; Latinos(3), African-American, women, MSM; African Americans(people of African descent); Adolescents/Youth(2); Black; HIV/AIDS clients with higher acuity; Multiple populations in the community clinic setting (including homeless and migrant workers); Formerly incarcerated; Homeless males; Veterans; Substance abusers, inmates in county jails; Women, children and youth 13-24; South Bay ages 12-24; HIV positive clients(3);Poor/low-income individuals/ families; Affordable housing/housing information/referral to all in need of our services especially PLWA.; Newly diagnosed with no insurance and with limited other medical complications; African Americans and others who have HIV/AIDS; African American and Latinos; Kaiser members; Low-income people, especially HIV/AIDS community; Mental health; Low-income/ needy households; Co-morbidity-- HIV, Drug Abuse, Mental health Dx (2).; Native American(2); People affected by AIDS who are vulnerable to hunger because physically ill; People in mental health system and their friends/ family; Low income San Diego County residents with specific legal needs; Parolees diagnosed HIV/AIDS and Mental illness; HIV positive homeless single adults; For prevention and testing- women & for HIV social services- women, children and families; Persons living with mental illness and their family members (2); Youth, seniors, families, those living with and at risk for HIV, Latino MSM's and their families; Male residents; Adult males; Serious mental illness, institutionalized, high- users of psychiatric acute services, homeless, vulnerable; Persons living with/ affected by HIV/AIDS; Adults with history of severe/ persistent mental illness(4); Older adults; People with cancer; Adult citizens receiving mental health services with County/ contractors; People of color; Individuals with SMI, children with SED, and co-occurring mental health and substance disorders; Mentally ill adults; People who receive County Mental Health Services; Female alcohol and drug users(2);Ages 10-25 exhibiting early warning signs of Schizophrenia/other Psychotic disorders; Severe mentally ill(2);Homeless, mentally ill; Those with co-occurring disorders; DUI offenders; Female adult; Bilingual; Transition Age Youth with severe mental illness; LGBT Community, Alcohol and other drug addicts, homeless population; LGBT, HIV/AIDS; Latinas in central region. Beehive targets MSM, IDU, and heterosexuals at increased risk; Substance abusers(9);Pregnant/parenting teen moms*

How do you coordinate services with other agencies serving your clients/patients? (n=102)

Response	n	%
Networking	83	(81%)
Phone referrals	80	(78%)
Collaborative meetings	71	(70%)
MOUs or MOAs	71	(70%)
In-person referrals	60	(59%)
Contracts or subcontracts	47	(46%)
Verbal Agreements	34	(33%)
Co-location of services	29	(28%)
Out-stationing staff/services at other agencies	26	(26%)
Commitment Letters	24	(24%)
Other	9	(9%)

Other Specify: *Housing another agency out-stationed staff; clients referred to program by referring agencies and also complete the necessary referrals paperwork; Community outreach events; Referrals from community-based HIV Medical Case Managers (primarily from Ryan-White funded programs); onsite training and testing for male residents; Contracts/subcontracts do not include financial reimbursement to the agency to defray costs we may choose to only have agreements where our agency is reimbursed in the near future; faxed/mailed referrals; Healthcare appointments; Due to state regulations we are only able to give the referral to the participant, we cannot require they use the referral*

3. BARRIERS AND SUGGESTIONS FOR HIV/AIDS SERVICES

What barriers have your organization faced when providing services to people living with or at risk of acquiring HIV/AIDS?(check top three; n=96)

Response	n	%
Inadequate funding, resources	43	(45%)
Substance abuse and mental health issues and resource needs	39	(41%)
Knowledge of HIV status, disclosure issues and/or stigma	32	(33%)
Housing needs	30	(31%)
Location of services/Transportation needs	28	(29%)
Client issues and expectations	25	(26%)
Service and staff limitations	24	(25%)
Information about services	14	(15%)
Staff training needs	12	(13%)
Cultural/language issues	11	(12%)
Other	11	(12%)
Interagency coordination	6	(6%)

N/A(2);Funding(2); We do not provide services to people living with/at risk of acquiring HIV/AIDS (2); Lack of client contact due to housing/phone number changes; Financial; Services that are cut (i.e. transportation services);Employment; We really haven't come across any specific barriers

What barriers have your clients living with HIV/AIDS faced when accessing services?(check top three) (n=93)

Response	n	%
Inadequate funding, resources	41	(44%)
Substance abuse and mental health issues and resource needs	37	(40%)
Housing needs	35	(38%)
Knowledge of HIV status, disclosure issues and/or stigma	31	(33%)
Location of services/Transportation needs	29	(31%)
Client issues and expectations	22	(24%)
Information about services	18	(19%)
Cultural/language issues	10	(11%)
Other	9	(10%)
Service and staff limitations	7	(8%)
Interagency coordination	5	(5%)
Staff training needs	3	(3%)

Unknown(2); We do not have any clients living with HIV/AIDS; Information material about services in Spanish; Psychiatric sx are too severe to tolerate health care setting; Stigma from independent providers, such as being forced to use disposable plates, silverware and cups; Stigma; Since we do not target this population we don't really have specific data to rate this area

Which of the following trainings would help you to better serve clients/patients living with or at risk of acquiring HIV/AIDS? (check all that apply; n=95 respondents)

Response	n	%
Housing Programs	43	(45%)
Mental health services	41	(43%)
HIV and Co-morbidities	35	(37%)
Alcohol and drug services	34	(36%)
Case management/peer advocacy for PLWH/A	33	(35%)
Services for people with HIV	31	(33%)
Clinical/medical information for HIV/AIDS	30	(32%)
Aging with HIV	29	(31%)
Psychosocial manifestations specific to PLWH/A	29	(31%)
How to better advocate for clients/patients	28	(30%)
Cultural competency	27	(28%)
Networking opportunities about HIV/AIDS care, prevention, and available resources	26	(27%)
Sensitivity to the needs of people with HIV	26	(27%)
Effective interventions for HIV prevention	24	(25%)
HIV 101	20	(21%)
HIV care (antiretroviral tx, dealing w/opportunistic infections, monitoring, explaining status)	19	(20%)
Service planning and priority setting	17	(18%)
Confidentiality for HIV/AIDS	15	(16%)
HIV Partner Services	14	(15%)
HIV Partner Services forms	10	(11%)
Other training……	8	(8%)
None	4	(4%)

Other training: LGBT issues; Brochure/referral options; Referrals; HOPWA, Shelter plus care referral criteria; More funding; How to deal w/transition to being bed-ridden; List of providers

4. Services Provided by Agencies/Programs

HIV Counseling and Testing Services 49 (47%)

HIV Partner Services 36 (34%)

Medical Care Services 25 (24%)

- Adult Day Care/Respite Services..2 (2%)
- Ambulatory/Outpatient Medical Care...............................19 (18%)
- Clinical Trials 7 (7%)
- Clinic-based HIV Treatment Education and Adherence....18 (17%)
- Community-based HIV Treatment Education 7 (7%)
- Dental Care 15 (14%)
- Durable Medical Equipment and Supplies...........................4 (4%)
- Early Intervention Services..15 (14%)
- Health Insurance Payment Assistance 7 (7%)
- Health Screening/Diagnostic Services 16 (15%)
- HIV/AIDS Medications/Medicines....................................15 (14%)
- Home Health Care 4 (4%)
- Hospice Care: Facility-based residential..............................3 (3%)
- Hospice Care: Home-based..3 (3%)
- Inpatient Care..6 (6%)
- Medical specialist other than HIV specialist........................7 (7%)
- Prescription Drug Reimbursement/Assistance.....................8 (8%)
- Primary HIV Medical Care...19 (18%)
- Rehabilitation Services 3 (3%)
- Skilled Nursing/Long-Term Care 1 (1%)
- Training for Health Care Professionals on HIV Treatment .5 (5%)
- Other Medical Care Service...3 (3%)

General nursing/physician visits w/client as needed; reproductive, prenatal, pediatrics, adolescent, mental health (Medi-Cal), holistic healthcare (reiki, yoga,etc.); Services that meet criteria for member coverage under Kaiser benefits, varies by plan

HIV Case Management, Client & Peer Advocacy...........33 (31%)

- Clinic-Based Medical CM for PLWH/A 16 (15%)
- Community-Based Medical CM for PLWH/A 17 (16%)
- Non-medical Case Management or Client Advocacy 20 (19%)
- Peer Advocacy 14 (13%)
- Other Case Management 3 (3%)

CM for permanent supportive housing; Job development; Mental health; Prevention CM

Drug and Alcohol (Substance Abuse) Services.............54 (51%)

- Court-Mandated Treatment... 23 (22%)
- Detoxification Service 5 (5%)
- Environmental Prevention 8 (8%)
- Inpatient (Hospital) Treatment... 4 (4%)
- Intervention and Education 35 (33%)
- Methadone Treatment, LAAM and Naltrexone 0 (0%)
- Outpatient Treatment 24 (23%)
- Recovery Maintenance/After Care................................. 32 (30%)
- Residential Treatment 22 (21%)
- Risk and Harm Reduction... 27 (26%)
- Screening and Assessment..48 46%)
- Services for Co-occurring Disorders.............................. 35 (33%)
- Sober Living/Transitional Housing................................ 20 (19%)
- Support Groups 37 (35%)
- Other Drug and Alcohol Services 4 (4%)

Services are voluntary. Addiction medicine department members referred out to peer counseling services; Referrals; Transitional housing treatment beds; CM

Mental Health Services.. 63 (60%)

- Counseling/Therapy (by a professional)......................... 47 (45%)
- Crisis Intervention 40 (38%)
- Harm Reduction... 32 (30%)
- Inpatient Psychiatric Care.. 4 (4%)
- Medication Monitoring... 22 (21%)
- Mental Health Case Management.................................. 18 (17%)
- Mental Health Outreach.. 19 (18%)
- Outpatient Treatment Services 26 (25%)
- Psychiatric Services.. 23 (22%)
- Psychosocial Rehabilitation Services 15 (14%)
- Residential (board and care)... 4 (4%)
- Screening and Assessment.. 40 (38%)
- Services for Co-occurring Disorders 32 (30%)
- Support groups... 30 (29%)
- Other mental health service 13 (12%)

Prevention/early intervention; All above by CMs trained in mental health care/tx; Partner w/TACHS/CRF for services to residents; Non-clinical education, support services & advocacy; Referrals; Do not offer mental health svcs but CMs are located in the parole office that do have social workers and a psychiatrist; Couple and family counseling; Peer/family education, referrals/support; Peer run recovery based activities w/ focus on work/education goals. No formal therapeutic groups; Employment readiness/ job development/ coaching, short term crisis residential, Transitional residential program, Assertive Community Treatment (ACT) teams, peer-run clubhouses, child youth and family programs (clinic and school based); Recovery support, education, advocacy & peer support; Evidence-based supported employment services

Other Health-Related Services 43 (41%)

- Co-Factor Counseling...10 (10%)
- Complementary or Alternative Therapies........................6 (6%)
- Health Education and Risk Reduction............................35 (33%)
- Nutrition Counseling 23 (22%)
- Other Health-Related Service...14 (13%)

Tx adherence counseling; Assessment/ referral for other medical conditions; Hospice; Refugee services and women's center have clinics; Health navigation line including medical/healthy families applications, prescription assistance applications, and appointment setting; Internship/service hours, staff trainings, educational classes/events; Help to better understand HIV medications/ functions; Hepatitis clinic, women's clinic, lipodystrophy clinic, high resolution anoscopy clinic; Referrals; Yoga, fitness classes/ groups; STD screening; TB and Hepatitis; Job retention strategies; Residential care, assistance with medication regimens, activities of daily living, meal prep

Food Services.. 22 (21%)

- Congregate Meals 5 (5%)
- Emergency Food Services 8 (8%)
- Food Banks/Pantries/Commodities Distribution 9 (9%)
- Home-Delivered Meals... 3 (3%)
- Nutritional Supplements 2 (2%)
- Other Food Service... 8 (8%)

Information/referral/assistance in obtaining home delivered meals; Referrals; Kitchens stocked with food; Food pantry, holiday family meals, etc.; Meals provided for residents(3); Preschool meals

Social and Support Services	66	(63%)
Benefits Counseling	27	(26%)
Buddy/Companion Services	6	(6%)
Case Management: Long Term	28	(27%)
Case Management: Transitional	30	(29%)
Child Welfare Services	4	(4%)
Childhood Developmental/Early Intervention	7	(7%)
Domestic Violence Counseling	14	(13%)
Educational Groups	46	(44%)
Financial Planning Assistance	18	(17%)
In-Home Respite (non-medical)	2	(2%)
Job Placement/Vocational Rehab/Return to Work	15	(14%)
Legal Services	6	(6%)
Parenting Training/Classes	12	(11%)
Permanency Planning	5	(5%)
Personal Care Services	7	(7%)
Pet Support for People with Disabilities	1	(1%)
Practical Support	6	(6%)
Recreation/Social Activities	32	(30%)
Representative payee	10	(10%)
Spiritual Support	11	(11%)
Support Groups	44	(42%)
Other Social or Support Service	11	(11%)

Teen center (free computer/ internet access), movie lounge, volunteer programs; In-office confidential HIV testing and counseling; Active referral; Referrals; Residential services coordination; Out-patient substance abuse tx; Peer mentor program, peer navigation; Programs based on history of severe/persistent mental illness; AA meetings; Assistance w/ adhering to medication regimens, meal preparation/ nutrition adherence, assistance with activities of daily living (bathing, toileting, laundry); HIV prev groups for Latinas

Referral, Access, Outreach, Coordination Services	82	(78%)
Coordinated Services Center/Early Intervention Center	28	(27%)
Field Outreach	43	(41%)
Field Outreach Targeted to People with HIV/AIDS	22	(21%)
Online Outreach	22	(21%)
Information and Referral: Dedicated phone line(s)	23	(22%)
Information and Referral: Internet	27	(26%)
Information and Referral: Written guide/materials	41	(39%)
Other Referral, Access, Outreach, Coordination	14	(13%)

Legal, mental health, substance abuse; In-person assessments, medical sick call, and telephone access for inmates in county jails; Text messaging info/ referrals; CM/ referral for Housing Commission HPRP, Winter Shelter, Veneralbilty Index clients and Vets; Sign up for Ryan White and ADAP; Primary care providers/ OB/GYN/ Addiction medicine/ Psychiatry provided consultation as needed by ID; Outreach to local churches/ faith based orgs. Community events (HIV Testing Day , World AIDS Day, Week of Prayer, Praise Fest; Josue staff refer clients to community-based services based on needs/availability of services; Information/ referral, computer lab, resource library at EIS center, etc.; Housing, transportation assistance; Case-by-case peer referrals to housing/resources needed; Access identified in a resident's plan of care (at time of admission or on-going basis; Resource information; On a case- by-case basis to meet needs of the client

Housing and Shelter Services	33	(31%)
Emergency/Short-term Housing/Shelter	11	(10%)
Housing Information and Referral	24	(23%)
Moving Assistance	5	(5%)
Permanent Independent Housing	10	(10%)
Residential Care Facility for Chronically Ill	2	(2%)
Subsidized Housing	11	(10%)
Supportive Independent Housing	7	(7%)
Tenant-Based Rental Assistance	8	(8%)
Transitional Group Housing	6	(6%)
Transitional Shallow-Rent Subsidy	6	(6%)
Transitional Short-Term Shelter	4	(4%)
Other Housing or Shelter Service	11	(10%)

Assistance to obtain PARS, transitional/emergency housing; Inpatient housing during SA tx, clean/ sober supportive housing post completion of inpt tx; Licensed transitional residential tx facility; Homeless patient's leaving KP hospital receive services and referral/ information services; Affordable housing units; Transitional housing substance-abuse tx beds; Transitional long- term housing; Subsidized practice apartments; Sponsor based Section 8 housing; Sober living; Licensed group homes

Other Basic Needs Services	38	(36%)
Clothing/Furnishings	27	(26%)
Personal Hygiene or Household Items	23	(22%)
Emergency Financial Assistance	8	(8%)
Childcare: Licensed Day Care	3	(3%)
Childcare: Babysitting (unlicensed)	3	(3%)
Transportation-Unassisted	17	(16%)
Transportation-Assisted	12	(11%)
Laundry	11	(10%)
Other Basic Needs Service	7	(7%)

Some of this category is based upon services delivered while in inpt SA tx; As funds are available/as eligible; Shelter - ISN and EFSP Shelter Vouchers and w/EFSP rent and Senior loan fund; Referrals; Transportation to clients to core medical services (in staff vehicles); Emotional support; Supplemental CM services

Other Services	16	(15%)

Bridge services to newly diagnosed clients and re-link lost to care patients; Case finding within county jail population; Advocacy/ advocacy training; Help obtaining discounted CID; vision screening and glasses; Research; HIV prevention talks (around county; We manage a shared Homeless Management Information System (HMIS), a secure countywide database that enables service providers to track persons served and to refer individuals and families to critical resources; Referral/placement into residential tx; Legal services; Educational workshops/ trainings; STD field investigations which includes partner notification, testing, preventative treatment; Learning center; Computer lab; Employment preparation/coaching for adults w/ mental illness open to local Dept of Voc. Rehab; Multifamily groups; Individual placement/support - Evidence-based supported employment; theatre group, art group; intervention with legal system for jail inmates for alternative sentencing; Participant evaluation outcomes; Empowerment and leadership development trainings for HIV+ women; Resource library

5. BARRIERS AND SUGGESTIONS FOR IDENTIFYING HIV POSITIVE INDIVIDUALS UNAWARE OF THEIR STATUS

What are the barriers to finding people with HIV/AIDS who are unaware of their status? (Check all; n=85)

Clients are afraid of disclosure or stigma....74 (87%)
Clients not ready to receive result/address healthcare56 (66%)
Clients do not believe they are at risk....55 (65%)
Cultural barriers....51 (60%)
Clients disenfranchised from medical care....46 (54%)
Clients distrustful of the medical system....44 (52%)
Clients have impaired ability to recognize HIV risk and need for testing/medical care due to substance use/abuse....43 (51%)
Clients do not understand HIV testing....35 (41%)
Limited resources for substance abuse treatment....29 (34%)
Substance abuse pervasive/often socially accepted....27 (32%)
Difficulty in identifying MSM....21 (25%)
Difficulty identifying behaviorally bisexual men....20 (24%)
Clients tired of hearing about HIV....19 (22%)
Limited resources for HIV testing....19 (22%)
Partner Services are underutilized....15 (18%)
Lack of understanding of testing technology....12 (14%)
Location of HIV testing....12 (14%)
Lack of coordination of HIV testing....10 (12%)
Other....7 (8%)

substance abusers are not interested in hiv status; medical staff not trained in integration of hiv testing with routine visit; More sensitivity/confidentiality and culturally appropriate education is needed among employees in the HIV field; limited resources for substance abuse treatment for the GLBT community; lack of emphasis to test WOMEN, women don't perceive themselves to be "at risk"; no barriers currently at clubhouse; Unknown

What provider outreach strategies would be effective in finding PLWH/A unaware of their status? (Check all; n=84)

Conduct outreach and mobile testing at consistent times and locations where high risk groups congregate....59 (70%)
Consistently offer information on HIV testing....53 (63%)
Consistently offer harm/risk-reduction education....51 (61%)
Identify and track locations where high risk groups congregate....48 (57%)
Conduct education groups in detention facilities....48 (57%)
Focus outreach efforts on venues where sex and drug use are prevalent....46 (55%)
Utilize motivational interviewing/stages of change to identify when individuals are ready to test....46 (55%)
Field (street or venue-based) outreach to identify individuals at high risk and refer to testing....45 (54%)
Online outreach....45 (54%)
Ensure HIV Partner Services is offered to every PLWH accessing services....45 (54%)
Provide assisted referrals to testing when feasible 44 (52%)
Social marketing campaigns (billboards, posters, advertisements)....44 (52%)
Post information about testing and safer sex practices at venues where sex and drug use are prevalent....40 (48%)
Website promoting testing and/or disclosure....35 (42%)
Track referrals during outreach....33 (39%)
Increase utilization and tracking of HIV PS....26 (31%)
Other……....4 (5%)

We need to come out of the box and focus in all communities, I am tired of hearing the same strategies drugs-prostitution-gay in my experience in HIV Testing I find most human beings have sex with more than one partner straight or gay; Social marketing campaigns for women; This lies outside our area of expertise. We do not recruit based upon any factor other than history of mental Illness; we do not actively seek people with HIV/AIDS

What HIV testing strategies would assist with finding PLWH/A who are unaware of their status? (Check all; n=86)

Offer free testing at outreach venues....63 (73%)
Test individuals at high risk for HIV....60 (70%)
Collaborate w/substance abuse tx providers that target high-risk individuals to test clients....60 (70%)
Encourage confidential testing....59 (69%)
Build rapport w/client so receptive to follow-up....58 (67%)
Test individuals in jails or prisons....58 (67%)
Coordinate testing with outreach activities....55 (64%)
Offer testing to clients on waitlists for substance abuse tx....52 (61%)
Provide education/support to clients to increase their likelihood of accepting confirmatory test....51 (59%)
Stress the importance/availability of PS....42 (49%)
Transition clients from anonymous to confidential confirmatory testing....28 (33%)
Other strategies....10 (12%)

Alleviate client fears around PS; Build trust with the client so they are better able to understand PS; Discussion about home situation; Discussion about personal/emotional relationship with partner(s); Motivational interviewing; Non judgmental approach; Offer support/help to disclose; Offer to meet with partners to educate/facilitate getting HIV testing; We address it individually w/clients in counseling, helping them to disclose w/ or w/out our help; Continued support, contact person, one person to be able to call when someone needs help; Refer out to appropriate agency; Show the new video; Education for staff; On site staff training; Ongoing PS trainings; Every person that sees clients should offer PS; Offer PS frequently/consistently; PS is offered multiple times to a client at various stages of their services; PS PP was a great project that increased PS utilization

What strategies have you used or do you believe would successfully identify people with HIV/AIDS who are unaware of their status? (n=44 respondents)

Outreach (22) Brochures about agencies; Communicate with consumers at health fairs/other venues; Condom/educational handouts at trolley stops; Consistent field outreach; Improved outreach; Info lines listed at phones where high risk folks congregate; Online outreach (2); Outreach/testing activities in at-risk venues/areas; Outreach at venues/health fairs; Outreach in places where individuals who are high-risk congregate, i.e. bathhouse; Outreach testing; Outreach to target populations w/ event testing; Peer outreach at high-risk spots; Provide flyers/brochures to individuals at community events, i.e. Pride; Provide information; Provide more outreach/education to individuals that are at higher-risk; Social marketing; Social marketing campaigns, including those that combat stigma; Social media campaigns; Social networking; Targeted outreach

Education/Information (16) Educate about health benefits of early detection and benefits of treatment (2); Educate about high-risk activities; Educate about viral load and the risk of assuming negative tests make a partner "safe"; Education (3); Education about HIV/AIDS; Education for clients engaging in high risk behaviors; Education on substance use should include HIV information-how, where, why to test; More awareness; Presenting basic info on STD/HIV and where to go for services; Provide educational groups/classes on the subject; Provide information and education about risk for HIV infection and identify at least three ways s/he can protect themselves; Provide information on HIV/STD's; We bring in people from outside our program to educate our residents; Letting them know where free testing is offered

Testing Availability (14) Conduct testing events in observance of HIV awareness days; Education and testing for residential males in treatment; Mandatory testing upon entry into treatment; Provide coordinated screening and testing service to include county agencies and non-profits; Testing at our facility; Testing at substance abuse treatment centers; Testing in community based orgs/clients distrust medical or county facility; Testing outside of a clinical or hospital environment, clients much more receptive; Easy access to free testing for partners of our patients; Free testing (2); Increase availability of testing; More testing; Testing at bathhouses; Offer free rapid HIV testing

Routine Testing (12) Consistent testing visibility in these areas; Educate providers about CDC recommendations to test yearly; HIV testing becomes routine, especially for women (per CDC guidelines/recommendations); HIV testing should be a part of everyone's yearly physical; Integration of HIV testing into regular dr. visits; Make HIV testing a routine part of every health exam, thereby increasing the numbers of those identified, and reducing the stigma surrounding the test; Offer testing at every visit; Routine testing; Test every patient every year; Test everyone; Test pregnant women receiving services; Universal protocol for testing (i.e. age 14+); Always encourage getting tested, no matter what, it is a repetitive message

Other Counseling and Testing (11) Free access to rapid screening tests for health clinics; HIV Testing during STD clinic hours; Our outside people offer HIV testing if desired; Provide supportive counseling before and after testing; Referral to early identification testing for high risk testers (i.e. early test); Working to have HIV testing automatically given to all patients being tested for any STD; Encourage individuals to get tested; Encouraged client to test; Encouragement; Promotion of testing; Referral to testing at clinics or mobile testing units

Building Rapport (8) Build rapport with clients and keep information confidential; Ensure confidentiality within the limits that are possible; I share my story/experience and talk to them attempting to make the individual more comfortable with the process of getting tested and acquiring medical care; Become part of the community, someone people trust because they know you; Be very careful in not passing judgment and breaking down stereotypes associated with HIV in my presentations, one-on-one or in massive setting; Get to know the community/neighborhood before talk about testing; Honesty/confidence in what I say, always keeping in mind our diverse population (Being culturally aware helps in making less mistakes)

Targeting Communities (2) Constant visibility in hard to reach neighborhoods i.e. Southeast, East County, Imperial Beach, etc.; Increase services in targeted communities; Non-threatening open casual conversations/presentations out in the communities but not limited to LGBT venues. Leaving my contact information for them to feel free in contacting me when they feel comfortable to do so

Other (12) Provide a screening tool with questions regarding sexual history; Provide pre-release services to incarcerated persons; Tracking; We don't pressure residents to disclose; Partner Services (3); Partner Services across the spectrum of HIV care; Incentives (3); Greater coordination amongst providers; Ongoing consultation and education for all Kaiser providers

6. HIV PARTNER SERVICES

Are you aware there are services available to assist PLWH with notifying sex and needle sharing partners of their possible exposure to HIV? (n=88)

Response	n	%
Yes	69	(78%)
No	19	(22%)

HIV Partner Services your agency provides (n=67)

Service	n	%
Coaching for self disclosure	26	(39%)
Dual disclosure	19	(28%)
Elicitation for 3rd party notification by health advisor	18	(27%)
None	39	(58%)

When do you complete a Partner Information Form (PIF)? (n=20 respondents)

Response	n	%
After elicitation of partner information for anonymous third party notification by a health advisor	13	(65%)
After dual disclosure	6	(30%)
After coaching for self disclosure	5	(25%)
Other	5	(25%)

Unable to access partner information counseling provider, we test partners if they are members or not and then notify the health dept of all positive clients; We have been successful at getting patients to self-disclose; After eliciting info and refusal to disclose; We've requested this form and have yet to receive it; Don't know, not part of what I do/not in my department; We do not complete this form

At your agency, who provides Partner Services? (Check all that apply; n=29 respondents)

Provider	n	%
Case Manager	16	(55%)
HIV Counseling and Testing Staff	16	(55%)
HIV Education and Prevention Staff	12	(41%)
Health Educator	11	(38%)
Mental Health Provider	9	(31%)
Peer Advocate	7	(24%)
Alcohol and Drug Counselor	6	(21%)
Doctor	6	(21%)
Nurse	5	(17%)
Nurse Practitioner/Medical Assistant	5	(17%)
Other Medical Professional	1	(3%)
Other	3	(10%)

HIV Support Services Specialist; STD Field Services Staff - Health Advisors - Program Manager; Services from an outside agency

Do you need assistance developing a policy/protocol for when/how to offer Partner Services? (n=21)

Response	n	%
Yes	7	(33%)
No	14	(67%)

Do you know who to contact for information about Partner Services? (n=26 respondents)

Response	n	%
Yes	21	(81%)
No	5	(19%)

What barriers prevent clients from accepting PS? (Check all that apply; n=27 respondents)

Barrier	n	%
Concerns regarding stigma/discrimination	24	(89%)
Fear of rejection/abandonment	23	(85%)
Shame	20	(74%)
They have anonymous partners	20	(74%)
Concerns regarding confidentiality	19	(70%)
Concerns regarding violence	17	(63%)
Concerns regarding loss of economic support	15	(56%)
Fear of accusations of infidelity	15	(56%)
Distrust of public health/medical system	12	(44%)
Lack of trust in HIV care providers	8	(30%)
Previous negative experience w/PS	3	(11%)
Other client related barriers	0	(0%)

What barriers prevent you from offering HIV Partner Services to your clients? (check all that apply; n=15)

Barrier	n	%
Too little time	4	(27%)
Not my job	3	(20%)
Believe clients don't want it	2	(13%)
Believe someone else will do it	2	(13%)
Concerns regarding client confidentiality	2	(13%)
Don't understand how to access Partner Services	2	(13%)
Don't understand what Partner Services is	2	(13%)
Difficulty discussing sex/drug use with clients	1	(7%)
Previous negative experience /Partner Services	1	(7%)
Other provider-related barriers	4	(27%)

With current staffing limits I refer to Agencies focusing on HIV/AIDs population; providers not interested in or are uncomfortable with the subject; we aggressively offer these services no agency barriers; Have not received training

7. LINKAGES TO HIV PRIMARY MEDICAL CARE

What are the reasons some people with HIV/AIDS are not getting HIV medical care? (n=83)

Check all that apply	Rank	Number (%) selected
Using drugs or alcohol	1	66 (80%)
Not ready to deal with having HIV	2	63 (76%)
Mental health problems	3	62 (75%)
Afraid people will find out HIV status	4	61 (74%)
Homeless	5	59 (71%)
Stigma	6	56 (68%)
Feel healthy	7	50 (60%)
Afraid people will think they are gay	8	48 (58%)
Don't know about Ryan White Care and Treatment Services	9	46 (55%)
Not enough money or insurance	10	41 (49%)
Undocumented	10	41 (49%)
Don't understand risk of waiting to get care	12	39 (47%)
Transportation or service location	14	38 (46%)
Don't know where to find the service	14	38 (46%)
Need emotional support	15	37 (45%)
Don't trust doctors or clinics	16	36 (43%)
Don't think they are eligible for services	17	34 (41%)
Need to talk to someone who understands HIV	18	33 (40%)
Don't understand how to get care	19	31 (37%)
Side effects of medications	20	29 (35%)
Children, family or childcare needs	21	28 (34%)
Don't think medical care will help	22	23 (28%)
Services not available in his/her language	23	19 (23%)
Difficulty getting an appointment	24	17 (21%)
Physical disability	25	14 (17%)
Other: *Probably all or most of the above; 100% of our HIV positive clients are in treatment; Better training for ADAP enrollment and Ryan White employees (sensitivity and confidence in what their getting pay to do); Don't know*	26	4 (5%)

What prompts people with HIV/AIDS who know their status to decide to get HIV medical care? (n=81)

Check all that apply	Rank	Number (%) selected
Help from a case manager or peer advocate	1	60 (74%)
Got sick/started having symptoms of HIV	2	58 (72%)
Accepted test results	3	51 (63%)
Help for or addressed his/her mental health problem	3	51 (63%)
Got counseling or support	5	50 (62%)
Help for or addressed his/her alcohol or drug problem	5	50 (62%)
Afraid of getting sick	7	49 (61%)
Got hospitalized	8	47 (58%)
Life became more stable	9	43 (53%)
Help from an outreach worker	10	42 (52%)
Help with housing	11	37 (46%)
Got information s/he needed	12	36 (44%)
Jail or prison system	13	32 (40%)
Got insurance to pay for care	14	31 (38%)
Got HIV prevention services	15	27 (33%)
Coordinated Services Center	16	24 (30%)
Other: *Supportive partner; They meet and trust someone, working in the HIV field; family support*	17	3 (4%)

Which of these services are MOST important to get and keep people with HIV/AIDS in HIV medical care? (n=82 respondents)

Check the Top 5	Rank #	Number (%) ranking among top 5
Alcohol/Drug Recovery Services/Treatment	1	53 (65%)
Case Management	2	51 (62%)
Mental Health Services	3	50 (61%)
Housing Services	4	49 (60%)
Coordinated Services Center	5	34 (42%)
Information and Referral Services	6	30 (37%)
Early Intervention Services	16	28 (34%)
Alcohol/Drug Detoxification	8	25 (31%)
Transportation (bus pass, van)	8	25 (31%)
Outreach Services	10	24 (29%)
Peer Advocacy or Client Advocacy	10	24 (29%)
Support Groups	10	24 (29%)
Health Education	13	23 (28%)
Risk and Harm Reduction Services	14	20 (24%)
HIV Prevention Services	15	19 (23%)
Emergency Financial Assistance	16	18 (22%)
Treatment Education/Adherence	16	18 (22%)
Dental Care	18	12 (15%)
Food Services	18	12 (15%)
Legal Services	20	11 (13%)
Childcare (day care or babysitting)	21	9 (11%)
Representative Payee	22	8 (10%)
Other: *Medication Assistance Programs / ability to get medication; this question should be directed toward clients who will not responsibly continue to access med care*	23	2 (2%)

Which describes your working relationship with HIV primary care provider(s), including how you refer and link your clients to them? (n=81 respondents)

Networking 40 (49%)
Develop and maintain positive relationships with HIV primary care providers to assure access to medical care for clients and follow-up as needed 39 (48%)
Phone referrals 38 (47%)
Develop rapport with clients to obtain *Release of Information* or consent to follow-up on referrals to medical care...31 (38%)
Collaborative meetings 30 (37%)
Consultation with HIV medical providers 25 (31%)
MOUs or MOAs...23 (28%)
In person referrals 22 (27%)
My agency provides HIV medical services........18 (22%)
Co-location of services....................................... 12 (15%)
Contracts or subcontracts................................... 11 (14%)
Verbal agreements...11 (14%)
Commitment letters...9 (11%)
Out-stationing staff or services at medical provider site(s) 7 (9%)
Other 5 (6%)
Referrals to our housing services from Medical Case Managers; We provide services directly through Case Managers; We are used as a resource by every clinical/hospital setting providing HIV care. We are not reimbursed by any of these contracts and we are considering discontinuing the practice of MOU's without financial reimbursement for services; Fraternity House, Inc. works directly with residents' healthcare providers, as well as schedules and coordinates transportation to all healthcare related appointments; Very few clients test positive for the first time with us, we give clients 3 options for secondary/confidential testing
None 14 (17%)

8. OTHER

Is there anything else you would like to add about any of the services your agency provides? (n=8 respondents)

-- Sorry, but this was too long (even though I helped design it) I intentionally left blank questions that had no appropriate answer

--Our housing program allows the participant to find his/her own housing anywhere within the San Diego city limits.

--We provide services to individuals who use meth because we provide services to individuals who may be actively using any drug. We do not collect any information regarding drug use.

--Survey a bit difficult since some questions were answered regarding the specific program I work in while other questions were relevant to my overall organization (ie, specialty clinic within a large medical facility providing comprehensive care).

--Josue homes has begun to collect outcome data on the relationship between stable housing and risk-reduction.

--We see an increase in client participation every year. We are spending far too much time raising funds to keep the doors open. There is little or no funding for HIV/AIDS support services and these services keep clients connected to medical care. Without these support services clients DO NOT care if they are HIV+, if they take medications or show up for medical appointments - without support services clients simply do not care to live in poverty and show up for medical appointments. Clients would rather have no care if medical only is the best we can do.

--We have a very specific service model based upon history of mental illness. We neither discriminate against nor recruit persons based upon any other co-occurring condition, and it would violate our policy as an organization to do so.

--The need for residential care, as well as long term/skilled care for people living with HIV/AIDS will increase as the targeted population ages, and skilled nursing facilities continue to be hesitant to admit people with HIV/AIDS