

LOS ANGELES COORDINATED HIV NEEDS ASSESSMENT (LACHNA) 2016

Final Report



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EXECUTIVE SUMMARY

This report presents data from the 2016 Los Angeles Coordinated HIV Needs Assessment (LACHNA 2016). Interview data were collected from a representative sample of 277 respondents from 35,276 persons living with HIV who were in medical care in 2014. Respondents were asked about their use of, need for, and access to 16 selected HIV-related care and support services in the previous 12 months. Respondents were also asked whether they experienced any change in accessing needed HIV care and support services following implementation of the Affordable Care Act (ACA). The intent of this report is to describe the utilization of HIV medical and support services, to highlight gaps and barriers to needed services, and to evaluate the impact of ACA on service access. These data can be used to inform planning bodies and service organizations of the service needs of persons living with HIV in LAC. Major findings include:

- **Utilization of Services:** Overall, service utilization was high among survey respondents, with nearly all respondents utilizing at least one service in the past 12 months (99.7%). Service categories with the highest utilization were medical outpatient (99.3%), oral health care (58.8%), AIDS pharmaceutical assistance (53.8%), vision services (48.4%) and clinic-based case management (39.7%).
- **Need for Services:** All respondents reported a need for at least one of the 16 services. Need was greatest for health-related services that included medical outpatient (99.6%), oral health care (88.1%) and vision services (71.5%) followed by clinic and community-based case management (56.0%).
- **Gaps in Services (Needed but did not receive service):** Nearly two-thirds of the respondents (63.2%) reported at least one gap in service. Service gaps were greatest for oral health care (33.2%), vision (32.3%), housing services (58.5%), medical nutrition therapy (35.7%), and case management (all forms; 20.6%).
- **Barriers to Needed Services:** Among the 175 respondents reporting service gaps, all reported experiencing at least one barrier to needed services. Respondents with gaps in oral health care reported the most barriers (n=149) to services followed by housing services (n=136) and vision services (n=89). The most common barrier across the top service gaps was “Didn’t know where to go or whom to call” followed by “Service cost too much/lack of insurance.”
- **Impact of ACA on HIV Service Access:** Fifty-nine percent of respondents experienced some change in their insurance from 2012 to 2015. Respondents who experienced changes to their insurance had more service gaps compared to those who did not (69.1% vs 54.8%), with significant differences seen for oral health and mental health services. One in four respondents reported increases in premiums and copays, however, the majority of respondents reported no financial impact.

In spite of the relatively low response rate (24.8%), the surveillance-based random sampling methodology used for this assessment -- a newer and more complex study method -- yielded a representative sample of HIV-positive persons that is generalizable or can be applied to all adult PLWH in care in LAC. These data can be used to inform policy decisions regarding the delivery of HIV prevention and treatment services and to more fully understand the impact of ACA changes on those services.

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INTRODUCTION

The Health Resources and Services Administration (HRSA), the federal funder of HIV care for low-income persons in the United States, requires that each jurisdiction receiving Ryan White Program (RWP) funding conduct a needs assessment to inform data-driven priority setting and resource allocation activities as part of the planning process.[1] To meet this requirement, the Los Angeles County (LAC) Commission on HIV (COH) and the LAC Department of Public Health Division of HIV and STD Programs (DHSP) collaborated to conduct a needs assessment of HIV-positive adults living in Los Angeles County. The COH is the federally mandated, local RWP HIV planning body, comprised of community stakeholders, charged with the planning and allocation of federal funds for prevention and treatment services for HIV in LAC. DHSP is the governmental body responsible for developing and maintaining a comprehensive continuum of prevention, care and treatment programs for people at risk for or living with HIV and STDs in LAC.

According to guidelines from the HRSA HIV/AIDS Bureau, the needs assessment should describe: 1) HIV care and prevention service need; 2) gaps in accessing needed services; and, 3) barriers that impede access to needed services.[2] This information is obtained through the systematic collection of data from PLWH and includes individual and social characteristics that may impact service access. These data are then analyzed to identify what services are being provided, what services are needed, and what service gaps remain for PLWH in LAC.

Background

In 2011, there were an estimated 1 million persons in the United States diagnosed and living with HIV.[3] Of these, approximately 50% were retained in HIV care and 35% were virally suppressed.[4] At that time, the Centers for Disease Control and Prevention estimated that PLWH who attended a medical care visit in the past year accounted for 61% of HIV transmissions while PLWH who attended a medical care visit in the past year and had suppressed viral load accounted for only 2.5% of transmissions. [5]

Early and consistent treatment of HIV with antiretroviral therapy (ART) suppresses the amount of virus in a person's body and reduces HIV-related morbidity and mortality as well as risk of transmission to others.[6-8] Despite the availability of effective treatment, the individual and public health benefits of achieving viral suppression among people living with HIV (PLWH) in the US and in LAC have not yet been fully attained.

To improve HIV health outcomes and reduce HIV transmission, the White House issued the first-ever National HIV/AIDS Strategy (NHAS) in 2010 with recent updates in 2015.[9] This strategic plan outlined three primary goals: 1) reduce new HIV infections; 2) increase access to care and improve health outcomes for people living with HIV; and 3) reduce HIV-related health disparities and health inequities. National targets were established to meet these goals by 2015 and recently updated for 2020, and include: 1) increasing the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90 percent; and 2)

increasing the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80 percent.[9]

In 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law to make quality healthcare more accessible and affordable.[10] At the end of 2012, in preparation for the expansion of Medi-Cal, LAC started to transition the funding of medical care for low-income PLWH from the RWP to HealthyWay LA (the local low-income Medicaid expansion program) through the LAC Department of Health Services. As a result, from 2013 to 2015, the number of PLWH receiving medical care paid for by the RWP declined, however the number of PLWH receiving RWP support services during that same period, regardless of payment source for medical care, remained stable.[11]

Taking these current HIV challenges and HRSA requirements into account, COH and DHSP collaborated to conduct the sixth quantitative needs assessment since 2002. Historically, LACHNA has focused on PLWH in the RWP care system. RWP has been the largest funding source for HIV care and treatment services in LAC and is considered the “funder of last resort” for all low-income HIV infected persons and their families. Given the changes in the health care landscape following the implementation of the Patient Protection and Affordable Care Act (ACA), it was imperative that this cycle of LACHNA expand its scope to include all PLWH in LAC in order to understand more fully, access to, utilization of and need for medical and support services across all systems of care, including the RWP.

The current needs assessment focused on care and support services utilized by PLWH and was designed to provide a comprehensive profile of service needs and gaps for PLWH in LAC following ACA implementation. This report provides data to support planning bodies and stakeholders as they prioritize diverse demands to ensure that PLWH in the RWP and other systems of care in LAC can access appropriate, comprehensive and holistic care to improve health outcomes and achieve the 2020 National HIV/AIDS Strategy targets.

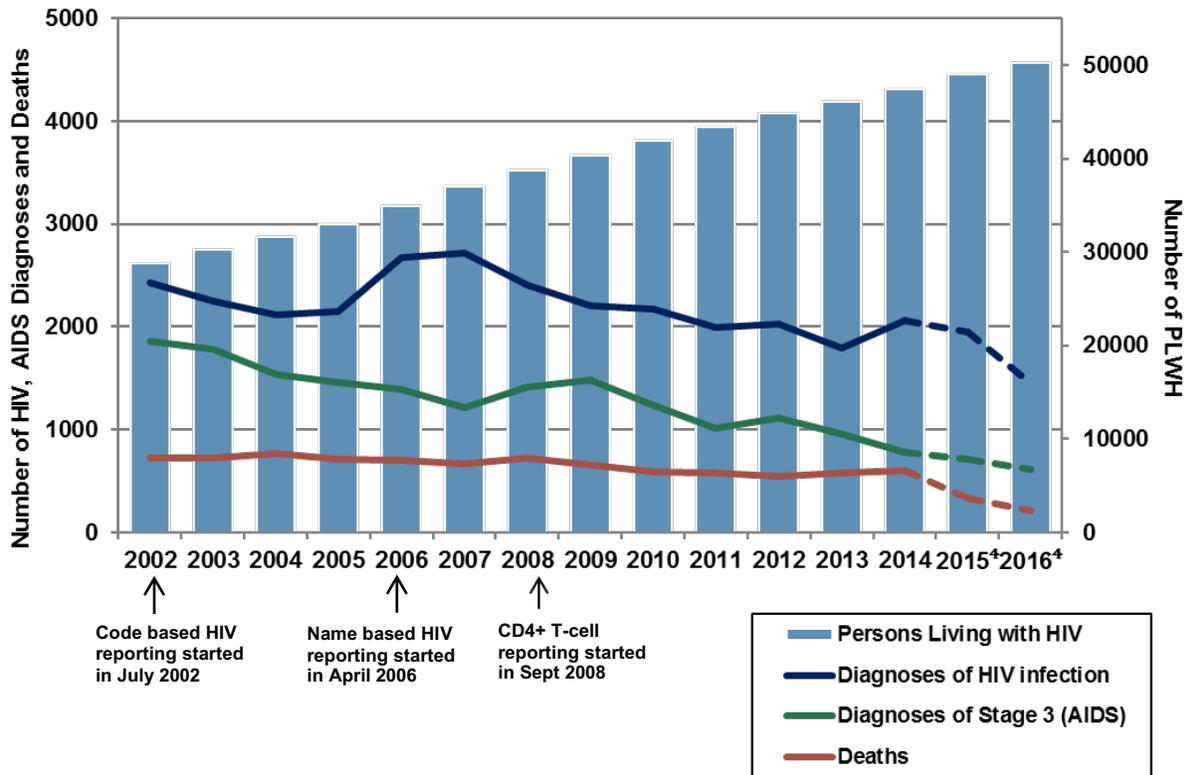
Overview of HIV in LAC

In 1981, the first HIV infections were identified in LAC among five homosexual men. Since then LAC has remained a focal point in the epidemic and is the jurisdiction with the second largest number of diagnosed HIV infections in the country.[12] In 2014, LAC accounted for approximately 40% of the newly diagnosed HIV infections in the state of California[13] and 3.5% of new diagnoses nationally.[12]

Figure 1 provides an overview of HIV in LAC from 2002 through 2016. Due to the increased availability of HIV treatments and better HIV reporting practices (e.g. name-based HIV reporting, CD4/T-cell reporting), the number of PLWH has gradually increased from nearly 30,000 infections in 2002 to approximately 50,000 HIV infections in 2016. In addition, the

number of new HIV diagnoses, Stage 3 (AIDS) diagnoses, and deaths have slowly decreased since 2002.

Figure 1. Annual Diagnoses of HIV Infection¹, Stage 3 HIV Infection (AIDS), Persons Living with HIV², and Deaths³ among Persons Diagnosed with HIV Infection, Los Angeles County, 2002-2016



¹ Based on named reports for persons with a diagnosis of HIV infection regardless of the disease stage at time of diagnosis.

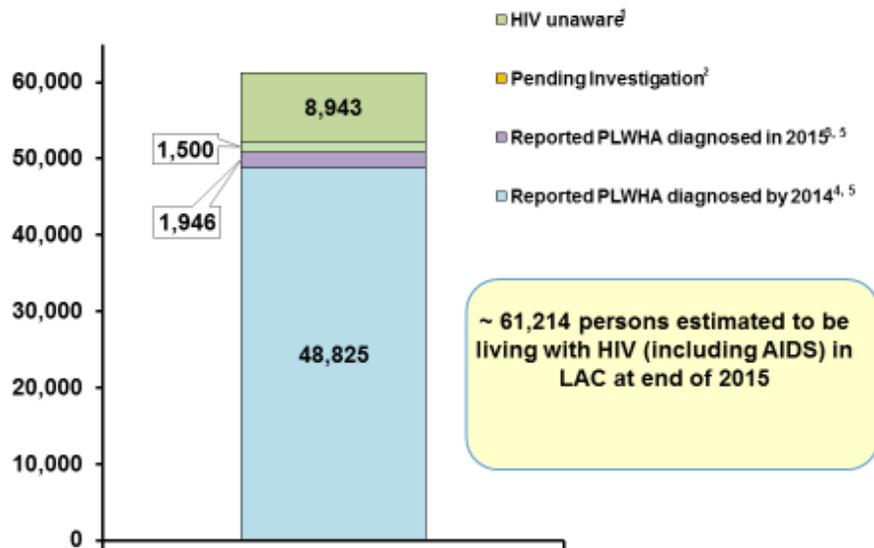
² Includes persons whose most recent known address as of 2016 was in Los Angeles County (LAC).

³ Includes persons whose residence at death was in LAC or whose most recent known address before death was in LAC, when residence at death is missing.

⁴ Data are provisional due to reporting delay (as indicated by the dashed lines).

At the end of 2015, over 61,000 persons were estimated to be living with HIV in LAC, of which approximately 8,943 were unaware of their HIV infection, that is, they had not yet had an HIV test or received their HIV test results (see Figure 2).[14] Among the 50,771 persons diagnosed and living with HIV in LAC, at the end of 2015, the majority were male (89%), Latino (42%) or White (32%), and over 40 years of age (74%). Most reported being exposed to HIV through male-to-male sexual contact (78% MSM; 6% MSM/IDU), and an increasing percentage reported heterosexual contact (10%).[14]

Figure 2. Estimated Number of Persons Living with HIV and AIDS in LAC at End of 2015



¹ It was estimated that 14.6% of PLWH were unaware of their infection in 2015. This was projected from 2014 estimate of 15.0% for California according to CDC’s new methods using HIV case surveillance data and CD4 test results (see CROI Abstract #899: Johnson, AS; Song, R; Hall, HI. State-Level Estimates of HIV Incidence, Prevalence, and Undiagnosed Infections. Conference on Retroviruses and Opportunistic Infections (CROI); 2017 Feb 13-16; Seattle, WA)

² Total estimated 1,500 lab reports pending investigation likely to result in unduplicated cases.

³ Includes persons diagnosed with HIV infection in 2015, living as of 12/31/2015, and reported through 12/31/2016.

⁴ Includes persons diagnosed with HIV infection by 12/31/2014 and living as of 12/31/2015.

⁵ Data are based on most recent known address at the end of 2015 in Los Angeles County.

Source: LAC Division of HIV and STD Programs, reported as of 12/31/16.

In 2015, nearly 2,000 persons were newly diagnosed with HIV. The majority were male (90%), Latino (47%), and 20-39 years of age (65%).^[15] In 2015, rates of HIV diagnoses were highest among American Indian/Alaskan Native men, African American men and women, and males 20-29 years of age.^[16]

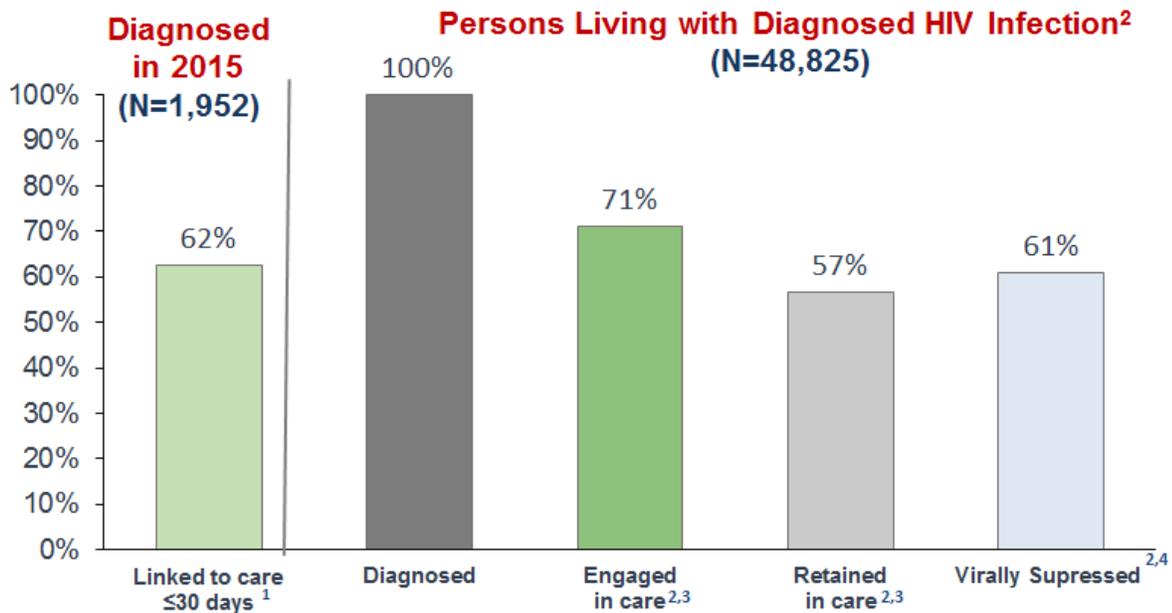
Figure 3 shows the proportion of PLWH in LAC at each stage of the HIV treatment cascade. Among the nearly 2,000 individuals diagnosed with HIV in 2015, 62% were linked to care within 1 month of diagnosis. Of the nearly 49,000 PLWH, 71% were engaged in care, 57% were retained in care, and 61% were virally suppressed.

Certain populations in LAC are disproportionately impacted along steps in the HIV Cascade. Table 1 highlights the significant disparities by key demographic characteristics within each stage of the HIV continuum of care in LAC in 2015:

- African Americans and Latinos were less likely to be linked to care within 1 month of HIV diagnosis compared to Whites.

- Compared to persons aged 50 and older, persons aged 30-49 were less likely to be linked to care within 1 month of HIV infection.
- Compared to Whites, Latinos, Asians/Pacific Islanders, and multi-race individuals were more likely to be engaged or retained in care, while African Americans were less likely to be engaged or retained in care.
- Persons 18-29 and 30-49 years of age were less likely to be engaged or retained in care compared to persons 50 years of age and older.
- Compared to MSM, persons who inject drugs (PWID) and high-risk heterosexuals were less likely to be engaged in care compared to MSM, and PWID were less likely to be retained in care compared to MSM.
- Compared to Whites, Asians/Pacific Islanders were more likely to be virally suppressed, while African Americans and American Indians/Alaskan Natives were less likely to be virally suppressed.
- Persons 18-29 and 30-49 years were less likely to be virally suppressed compared to persons 50 years of age and older.
- Persons who inject drugs and MSM/PWID were less likely to be virally suppressed compared to MSM. [17]

Figure 3. HIV Care Continuum, Los Angeles County, 2015*



¹ Denominator includes persons who were diagnosed with HIV infection in 2015; numerator includes persons reported with diagnosed HIV infection in 2015 who linked to care within 30 days of HIV diagnosis.

² Denominator includes persons with diagnosed HIV infection through 2014 and living with diagnosed HIV infection in LAC as of 12/31/2015 based on most recent residence; excludes persons who no longer live in LAC and includes persons who moved to LAC after their initial HIV diagnosis.

³ Engaged in care: ≥ 1 CD4/VL/Genotype tests in 2015; retained in care: ≥ 2 CD4/VL/Genotype tests at least 91 days apart in 2015.

⁴ Viral suppression defined as < 200 copies/ml.

*2015 data are provisional due to reporting delay.

Source: Division of HIV and STD Programs, HIV Surveillance data as of December 31, 2016.

Table 1. Summary of Disparities in the Continuum of Care by Key Characteristics in Los Angeles County, 2015

Demographic Characteristic	HIV CASCADE STAGES			
	Linkage to Care \leq 1 month ¹	Engagement in Care ²	Retention in Care ³	Viral Suppression ⁴
Race/Ethnicity	African Americans	African Americans	African Americans	African Americans
	Latinos			American Indians/Alaska Natives
Age		18-29 years	18-29 years	18-29 years
		30-49 years	30-49 years	30-49 years
Transmission Category		People who Inject Drugs	People who Inject Drugs	People who Inject Drugs
		High-risk Heterosexuals		MSM/PWID

¹ Based on adjusted prevalence ratios and 95% confidence interval estimates from a Poisson generalized linear regression model adjusted for age, race, gender, HIV transmission category, county of birth, type of diagnostic facility (public, federal or private), and lifetime homelessness

² Based on adjusted prevalence ratios and 95% confidence interval estimates from a log binomial generalized linear regression model adjusted for age, race, gender, HIV transmission category, county of birth, type of diagnostic facility (public, federal or private) and number of years living with HIV

³ Based on adjusted prevalence ratios and 95% confidence interval estimates from a log binomial generalized linear regression model adjusted for age, race, gender, HIV transmission category, county of birth, type of diagnostic facility (public, federal or private), lifetime homelessness and number of years living with HIV

⁴ Based on adjusted prevalence ratios and 95% confidence interval estimates from a log binomial generalized linear regression model adjusted for age, race, gender, HIV transmission category, county of birth, type of diagnostic facility (public, federal or private), lifetime homelessness and number of years living with HIV

In FY 2015, to meet the needs of PLWH along the various stages of the cascade, DHSP funded over 150 service contracts with over 50 community-based organizations and County departments in LAC that included:

- Core medical services (ambulatory outpatient medical services, medical specialty, oral health care, medical nutrition therapy, nPEP),
- Care services (linkage case management, transitional case management (youth), psychiatric mental health, mental health-psychotherapy, medical care coordination),
- Support services (residential care facilities for chronically ill, transitional residential care facilities, home-based case management, transitional case management (incarcerated), substance abuse residential rehabilitation, substance abuse residential detox, substance abuse transitional housing, substance abuse day treatment, food/nutrition, language services, transportation, medical transportation), and benefits specialty services.

A total of \$46,552,283 was allocated for services for PLWH in FY2015-2016. The majority of funds were allocated for outpatient/ambulatory medical care (34.2%) and case management

services (31.3%). Table 2 provides an overview of the services funded through DHSP, the funding source, the percent of total funded allocated to the service in 2015-2016, and the stage of the HIV care continuum which was impacted by these services.

Table 2. DHSP Actual 2015-2016 Allocations by Service.

Type of Services	Funding Source	Actual 2015-2016 Allocations (\$46,552,283)	Stage of HIV Care Continuum
Outpatient/Ambulatory Medical Care	RW Part A, NCC, State	34.2%	Engaged, retained in care, virally suppressed
Case Management (all types)*	RW Part A, MAI, NCC, CDC	31.3%	Diagnosed, engaged, retained in care, virally suppressed
Housing	RW Part A, RW Part B, MAI,	10.5%	Engaged, retained in care, virally suppressed
Mental Health	RW Part A	6.0%	Engaged, retained in care, virally suppressed
Home and Community Based Health Services	RW Part B, NCC	6.0%	Engaged, retained in care, virally suppressed
Outreach	MAI	3.6%	HIV+ unaware, diagnosed
Substance Abuse (Residential)	RW Part A, RW Part B, State	2.3%	Engaged, retained in care, virally suppressed
Oral Health Care	RW Part A, Part B	2.0%	Engaged, retained in care, virally suppressed
Medical Transportation	RW Part A	1.7%	Engaged, retained in care, virally suppressed
Referrals for Health Care/Support Services	RW Part A	1.0%	Diagnosed, engaged, retained in care, virally suppressed
Food Bank/Home-Delivered Meals	RW Part A	0.7%	Engaged, retained in care, virally suppressed
Linguistics	MAI	0.6%	HIV+ unaware, diagnosed, engaged, retained in care, virally suppressed
Medical Nutrition Therapy	RW Part A	0.1%	Engaged, retained in care, virally suppressed

*Includes medical and non-medical case management.

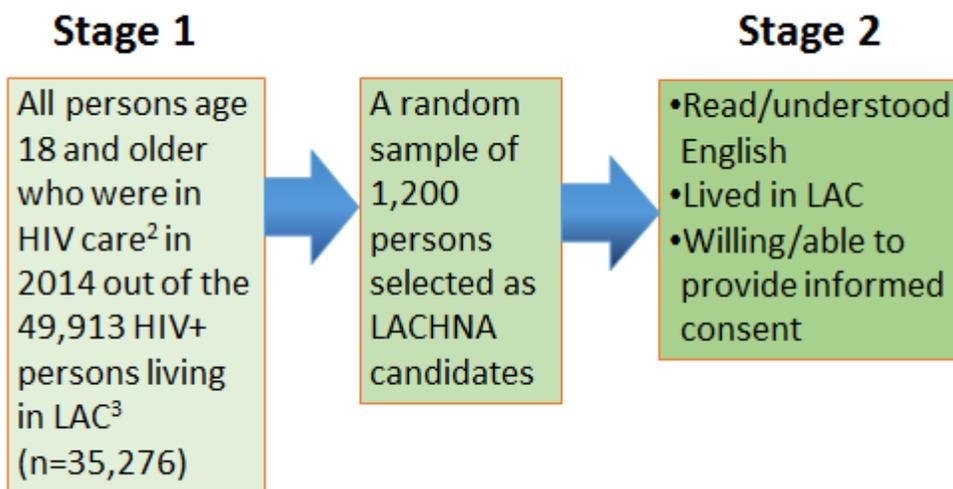
The majority of funds allocated for services for PLWH were from the RWP. Approximately 17,064 PLWH in LAC (34.6% of all PLWH in the county) utilized at least one service from a RWP-funded agency in FY 2015-2016 and 8,103 (47.5%) had at least one HIV medical care visit paid for by the RWP. Among the 17,064 RWP clients, 73.4% were linked to care in less than 30 days compared to 69.5% of all PLWH, 82.7% were retained in care compared to 56.8%, and 80.0% were virally suppressed compared to 60.5%. These data demonstrate better retention and viral suppression among RWP clients compared to LAC overall. Similar patterns have also been seen in comparisons using national data and are attributed to the additional wrap-around services available to RWP clients.[18]

SURVEY METHODOLOGY

Participant Selection

Respondents for LACHNA were selected using a two-stage random sampling strategy to ensure a representative sample, meaning a sample for which results could be generalized, or applied, to all adult PLWH in medical care in LAC, regardless of the system of care accessed. A similar method is currently used by the Centers for Disease Control and Prevention (CDC) for local and national HIV surveillance-based studies to construct representative samples of HIV-positive persons in HIV care.[19] Figure 4 illustrates the process of the two-stage sampling strategy.

Figure 4. LACHNA 2016 Two-Stage Sampling Strategy¹



¹ CDC methodology

² In HIV care defined as evidence of at least one HIV laboratory test (viral load, CD4, or genotype) performed in LAC and reported in HARS between 01/01/14 and 12/31/14

³ HIV-positive defined as having an HIV case report in the LAC HIV/AIDS Reporting System (HARS) as of December 31, 2014

In the first stage, a sample of PLWH (n=1200) were randomly selected from 35,276 cases in the LAC HIV/AIDS Reporting System (HARS), a database of all reported HIV and AIDS cases in LAC, who:

1. Were age 18 years and older;
2. Were HIV-positive as evidenced by a case report in HARS as of December 31, 2014; and,
3. Had at least one HIV laboratory test performed in LAC and reported in HARS from January 1 – December 31, 2014.

In the second stage, potential respondents who were not currently incarcerated or deceased and could be contacted were scheduled for an in-person meeting to complete the survey if they were:

1. Able to read and understand either English or Spanish;
2. Currently living in LAC; and,
3. Willing and able to provide written informed consent and participate in the survey.

Survey Design

The 2016 LACHNA survey used a cross-sectional study design to assess HIV care and support service access and need among PLWH in medical care in LAC. This design is appropriate to better understand how common or prevalent an issue or characteristic is and how that issue impacts the study population. For these reasons, this design is often used to collect data for the purposes of describing service need and utilization and allocating resources.[20]

Sample Size

Calculating the sample size, or the number of participants, is critical to ensure that a large enough sample is selected to detect meaningful differences. For LACHNA, the key difference of interest was service gap. We estimated that a minimum sample of 350 PLWH would be enough to detect the largest gap identified in the previous 2011 LACHNA data.

Due to a low response from the first round of sampling (141 out of 600 PLWH), the two-stage sampling was repeated to provide an additional pool of eligible PLWH to meet the targeted sample size. The second round excluded those selected in the first round. The overall study response from the two rounds of sampling was 24.8% (n=277).

For more information on sample size, see Appendix B.

Recruitment

Potential respondents were recruited using protocols from other DHSP research studies and demonstration projects, including the Medical Monitoring Project and Navigation programs that were designed to ensure respondent confidentiality and to protect the safety of both

potential respondents and the study staff. The study staff used a number of internal and public record databases to obtain current HIV care facility and contact information for potential respondents that included:

- The LAC HIV/AIDS Reporting System (HARS);
- HIV and STD Casewatch Databases;
- Lexis-Nexis; and,
- The LAC Sheriff's Department Inmate Information Center

Study staff attempted to contact potential respondents using both indirect and direct methods. For indirect contact, research staff worked with a partner agency (clinic staff or medical provider) to contact the potential respondent. For direct contact, study staff used information obtained in the database search to contact potential respondents via telephone, text message and letter following approved scripts specific for each type of communication. Up to three contact attempts were made for each type of communication.

Figure 5 below provides the final results of the recruitment efforts. Out of the overall sample of 1,200 possible respondents, 31 were excluded because they were deceased or incarcerated and 52 were ineligible. Among the remaining 1,117 possible respondents, 10% declined to participate in the survey, 65% could not be reached with the available contact information, and 25% were interviewed.

For more information on recruitment methods, see Appendix B.

Non-Participation

Overall, 23% of all 1,200 sampled persons (25% of eligible 1,117 PLWH) who were approached to participate consented to be interviewed. The majority of sampled persons who did not participate could not be contacted with the available contact information (n=727; 65%) or declined to participate (n=113; 10%). To determine if there were differences between those who did and did not participate in LACHNA, we used basic demographic information reported in the HARS data system. This information included: age, gender, race/ethnicity, and Service Planning Area (SPA) of residence. There were no significant differences in demographic characteristics between sampled persons who did not participate (excluding ineligible PLWH) and those who did participate.

Enrollment

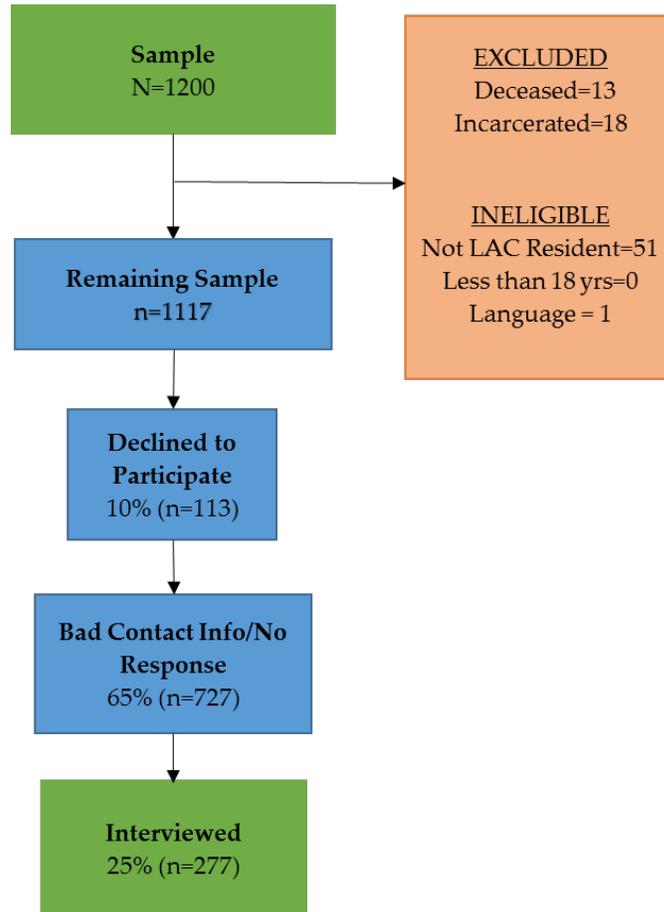
Study staff met with willing potential respondents at a mutually agreed upon location to obtain informed consent and administer the survey. These locations included the respondent's clinic, providers' office or medical home, coffee shop, library, or DHSP offices. Care was taken by the research staff to ensure that whatever location was agreed upon, it was secure and semi-private due to the sensitive nature of some of the survey questions. Each respondent was compensated for their time with \$50 in gift cards to local stores (e.g., Target, Ralph's).

All study procedures were reviewed and approved by the institutional review boards of the participating organizations to ensure human subjects protections. To further protect study

respondents, a certificate of confidentiality was obtained from HRSA to ensure respondent identities were protected to the fullest extent of the law.

For more information on enrollment methods, see Appendix B.

Figure 5. Results of LACHNA 2016 Recruitment Efforts



Survey Instrument

The survey was administered by study staff in either English or Spanish on password-protected tablet computers using a computer-assisted survey instrument and took approximately 45 minutes to complete. Surveys were conducted from December 2015 through June 2016. Table 3 briefly describes the key survey domains.

The selection of the survey domains was guided by the previous work of the COH in collaboration with Roger Andersen to adapt his model of Health Services Use to the LAC HIV care continuum.[21-24]

For more information on how the selected survey domains relate to service utilization and outcomes for the assessment of need in LAC, and for detailed information on the survey instrument, see Appendix C.

Table 3. LACHNA 2016 Survey Domain Descriptions

Domain	Description of Domain
Socio-Demographics	<ul style="list-style-type: none"> • Race/ethnicity • Gender • Age • Language • Country of origin • Residency status • Sexual orientation • Education • Employment • Housing status/homelessness • Economic status • Incarceration history
HIV Testing and Care History	<ul style="list-style-type: none"> • HIV testing history pre-HIV diagnosis • Length of time HIV positive • Linkage, engagement and retention in primary medical care
General Health	<ul style="list-style-type: none"> • Perceived overall health
Health care utilization and insurance coverage	<ul style="list-style-type: none"> • Past (pre-ACA) insurance coverage • Current (post-ACA) insurance coverage • Health literacy (understanding of provided medical information)
Needs assessment	<ul style="list-style-type: none"> • Utilization of HIV-related medical and social services • Need for services • Gaps in services • Barriers to needed services
Medication Adherence	<ul style="list-style-type: none"> • Prescription for HIV medications • Current adherence
Mental Health	<ul style="list-style-type: none"> • Assessment of depression, anxiety, somatic symptoms, psychosis and repetitive thoughts or behaviors, • Inpatient treatment
Sexual Risk Behavior	<ul style="list-style-type: none"> • Brief assessment of risk behaviors and recent STD diagnosis
Substance Use	<ul style="list-style-type: none"> • Alcohol • Illicit substances • Inpatient treatment
HIV Prevention Activities	<ul style="list-style-type: none"> • PEP/PrEP awareness • Current HIV prevention activities and sexual practices • HIV prevention activities and sexual practices prior to HIV diagnosis
Other Determinants	<ul style="list-style-type: none"> • Trauma • Internalized HIV stigma • HIV discrimination

Selected Service Categories

In 2015, DHSP contracted with agencies throughout LAC to provide 15 different services for PLWH, and an additional 8 services were funded directly through other sources for a total of 23 funded services in LAC. Survey respondents were asked about 16 specific HRSA defined HIV service categories within the survey. These categories were selected based on high service utilization. For each service category, respondents were asked whether they utilized the service in the past 12 months, whether they needed the service, and reasons they were unable to access the service. See Tables 4a and 4b for a description of the specific language used in the survey and Appendix D for a description of each service category.

Table 4a. Service Categories and Survey Language, LACHNA 2016 Survey

	HRSA Service Category	COH Service Category	Survey Language
1	Outpatient/Ambulatory Medical Care	Ambulatory Outpatient Medical Services, Medical Subspecialty Services, Therapeutic Monitoring Program	...ongoing medical care from a doctor to treat your HIV...
2	ADAP	Local AIDS Pharmaceutical Assistance	...ADAP, a program that helps you pay for HIV medications...
3	Oral Health Care	Oral Health Services	...dental care...
4	Skilled Nursing*	Skilled Nursing	...or been in a nursing facility...
5	Mental Health Services	Psychiatry, Psychotherapy	...any therapy or are seeing a psychiatrist or psychologist...
6	Medical Nutrition Therapy	Medical Nutrition Therapy	...any nutritional support provided by a nutritionist who evaluates your diet, provides nutritional counseling and/or recommends supplements to improve your health...
7	Case Management (all forms)	Medical Care Coordination, Linkage Case Management, Benefits Specialty, Benefits Navigation, Transitional Case Management, Housing Case Management	...or do you have a case manager... Where do or did you receive case management from?
8	Emergency Financial Assistance	Direct Emergency Financial Assistance, Hotel/Motel/Meal Vouchers	...assistance from programs that help pay for services when you have an emergency. These include things like hotel/motel vouchers for shelter or individual meal vouchers...

Table 4b. Service Categories and Survey Language, LACHNA 2016 Survey

	HRSA Service Category	COH Service Category	Survey Language
9	Food Bank/Home-Delivered Meals	Nutrition Support	...any food banks/grocery services or home delivered meals (such as meals on wheels)...
10	Housing Services	Residential Care Facilities for the Chronically Ill, Transitional Residential Care Facilities, Emergency Shelters, Transitional Housing, Permanent Supportive Housing	...Section 8 Housing services or other supportive housing assistance ...Did these services help you to maintain your housing or to improve your housing situation? ...Were these services helpful in referring you to the medical care, insurance coverage, and other services you need?
11	Medical Transportation Services	Medical Transportation	...transportation services like a bus passes/tokens or taxi services to and from your doctor's appointments...what types of transportation assistance did you receive?
12	Psychosocial Support Services (Support Groups)	Psychosocial Support Services	...or attend any support groups, programs or workshops sponsored by your doctor/clinic or a social services agency...
13	Referrals for Health Care/Support Services	Referrals	...any referrals from a doctor, nurse, social worker or case manager for other HIV-related services that they could not provide...
14	Rehabilitation Services	Rehabilitation Services	...any physical rehabilitation services such as speech therapy or physical therapy to improve a medical condition...
15	Substance Abuse Treatment Services	Substance Abuse Treatment: Day Treatment, Residential Detoxification, Residential Rehab	...any substance abuse treatment services such as outpatient, detox or inpatient at a substance abuse recovery center...
16	Vision Services	Ophthalmic and Optometric services	...or have you gone to an eye doctor, or received prescription glasses or contacts...

RESULTS

Respondent Characteristics

Tables 5a and 5b provide an overview of the demographic characteristics of respondents who completed the LACHNA 2016 survey. In addition, it provides a comparison of some key characteristics to our target population, which is a subset of PLWH that met the eligibility criteria from the 2015 HARS data. Overall, the demographic characteristics of the LACHNA 2016 respondents were comparable to the target population. Therefore, given the study design, we can assume that other characteristics of the study sample are comparable to those in the targeted population (e.g. insurance status, type of insurance).

Table 5a. Demographic Characteristics of LACHNA 2016 Respondents and Target Population

Characteristics	LACHNA 2016 N=277		Target Population ¹ N=35,276	
	No.	%	No.	%
Gender				
Male	238	85.9	30,966	87.8
Female	34	12.3	3,812	10.8
Transgender (M-F)	5	1.8	498	1.4
Age Group				
18-29 years	17	6.1	2,828	8.0
30-39 years	43	15.5	6,210	17.6
40-49 years	78	28.2	10,014	28.4
50-59 years	88	31.8	11,287	32.0
60+ years	51	18.4	4,937	14.0
Race/Ethnicity²				
Latino/Hispanic	130	46.9	14,556	41.3
African-American/Black	64	23.1	6,994	19.8
Asian/Pacific Islander	4	1.4	1,248	3.5
Native American/Alaska Native	0	-	180	0.5
White/Caucasian	76	27.4	11,602	32.9
Mixed/Other race or ethnicity	3	1.1	696	1.1
Sexual Orientation				
Homosexual, Gay/Lesbian	171	61.7	n/a	-
Heterosexual/Straight	74	26.7	n/a	-
Bisexual	26	9.4	n/a	-
Other/Don't Know/ Refused to Answer	6	2.2	n/a	-

¹ Source: 2015 HIV Surveillance Data as of 06/30/2015. Includes a subset of PLWH that met the eligibility criteria.

² Unable to locate and interview Native Americans/Alaska Natives in our sample. Asians and Pacific Islanders are also under-represented.

'-' = Data not reported in HARS.

Table 5b. Demographic Characteristics of LACHNA 2016 Respondents and Target Population

Characteristics	LACHNA 2016 N=277		Target Population ¹ N=35,276	
	No.	%	No.	%
HIV Transmission Category				
MSM	194	70.0	24,607	69.8
IDU	12	4.3	1,201	3.4
MSM/IDU	17	6.1	2,066	5.9
Heterosexual Contact	17	6.1	2,243	6.4
Other/Undetermined	37	13.4	5,159	14.7
Country of Birth				
US Born	176	63.5	n/a	-
Foreign Born	101	36.5	n/a	-
Years Living in US (n=100)				
<10 Years	8	8.0	n/a	-
≥ 10 Years	92	92.0	n/a	-
Survey Language				
English	212	76.5	n/a	-
Spanish	65	23.5	n/a	-

¹ Source: 2015 HIV Surveillance Data as of 06/30/2015. Includes a subset of PLWH that met the eligibility criteria.

'-' = Data not reported in HARS.

The majority of LACHNA respondents were male (86%), 50 years of age and older (50%), Black or Latino/a (70%), identified as Homosexual, Gay or Lesbian (71%), and reported male-to-male sexual contact (70%) as their HIV transmission category. Nearly two-thirds (63.5%) of respondents were born in the US, however, among foreign-born, 92% had lived in the US for 10 or more years and the majority of respondents completed the surveys in English (77%).

Tables 6a and 6b highlight the social and economic characteristics of LACHNA respondents. While only 31% of respondents reported having full-time employment, 67% reported having some college, a bachelor's degree or any post-graduate studies, and 97% reported a stable current housing status. Reported annual household income was less than \$20,000 for nearly half the sample (48%) with 37% at or below the Federal Poverty Guidelines, yet the majority of respondents (83%) had health insurance at the time of the interview. Over a third of respondents reported having a history of incarceration; however, only 4% reported being recently incarcerated (past 2 years).

Table 6a. Social and Economic Factors among LACHNA 2016 Respondents (N=277)

Factors	Respondents	
	No.	%
Highest Level of Education Completed		
Never Attended School	2	0.7
Grades 1 to 8	24	8.7
Grades 9 to 11	27	9.7
High School Graduate/GED	40	14.4
Some college, associate or technical degree	116	41.9
Bachelor's degree	43	15.5
Any Post-Graduate studies	25	9.0
Current Employment Status		
Full-time (≥32 hours)	85	30.7
Part-time (<32 hours)	43	15.5
Unemployed	44	15.9
Retired/Homemaker/ Disabled/ Student/SSI	93	33.6
Other	12	4.3
Annual Household Income (2014)		
<\$10,000	67	24.2
\$10,000-\$19,999	66	23.8
\$20,000-\$29,999	45	16.2
\$30,000-\$39,999	20	7.2
\$40,000-\$49,999	13	4.7
≥\$50,000	52	18.8
Don't Know/Refused to Answer	14	5.1
2014 Federal Poverty Guidelines (FPG)		
At or Below FPG	101	36.5
101-200% of FPG	70	25.3
201-300% of FPG	27	9.7
301-400% of FPG	18	6.5
>400% of FPG	47	17.0
Unknown	14	5.1
Current Housing Status*		
Stable housing	268	96.8
Temporary housing	3	1.1
Homeless	6	2.2
Homeless in the Past 12 Months		
Yes	20	7.2
No	257	92.8

* Stable housing defined as living in own home, in a rental unit alone, with a friend (pay rent), with family, or with partner or spouse; Temporary housing defined as living in a group or foster home, residential care facility (nursing home), supportive housing, transitional housing, hotel/motel/SRO, or temporarily with friends or family; Homeless defined as living in a car, outside, on the street, in a shelter or in an abandoned or vacant building.

Table 6b. Social and Economic Factors among LACHNA 2016 Respondents (N=277)

Factors	Respondents	
	No.	%
Insurance Status		
Insured	231	83.4
Not Insured*	44	15.9
Ever Incarcerated		
Yes	102	36.8
No	174	62.8
Recently Incarcerated (Past 2 years)		
Yes	12	4.3
No	264	95.3

* Respondents who reported having ADAP or Ryan White as source of their sole source of health care coverage (6.5%, n=18) were also included in this category.

Table 7 provides data on the geographic distribution of LACHNA respondents. Geographic data, such as zip codes and census tracts, can help us better understand how geographic factors may impact access to services, retention in care, and viral suppression. We used respondents' zip codes to identify the Service Planning Area (SPA) of residence. Similar to our sampled population, the largest proportion of respondents (37.9%) lived in the Metro area (SPA 4) followed by South Bay (SPA 8 - 14.8%), San Fernando Valley (SPA 2 – 12.3%) and South (SPA 6 – 12.3%; see Table 3).

Table 7. Geographic Factors for LACHNA 2016 Respondents and Target Population

Geographic Factors	Respondents		Target Population ¹	
	N=277		N=35,276	
	No.	%	No.	%
Service Planning Area				
Antelope Valley(1)	4	1.4	718	2.0
San Fernando(2)	34	12.3	5,263	14.9
San Gabriel(3)	22	7.9	2,654	7.5
Metro(4)	105	37.9	12,534	33.5
West(5)	11	4.0	1,763	5.0
South(6)	34	12.3	4,079	11.6
East(7)	24	8.7	2,512	7.1
South Bay(8)	41	14.8	5,477	15.5
Unknown	2	0.7	276	0.8

¹ Source: 2015 HIV Surveillance Data as of 06/30/2015. Includes a subset of PLWH that met the eligibility criteria.

Table 8 provides information regarding the HIV care status and history of respondents. More than two-third of respondents had been diagnosed and living with HIV for 10 or more years (67.9%) and almost all reported being in HIV care (97.5%). The majority reported having 2 or more doctor visits in the past 12 months (94.6%) and 82.3% reported their last doctor visit

was in the last 3 months. Though 22.7% of respondents reported being ever out of care for more than 12 months, respondents who reported being ever out of care were more likely to have been living with HIV for 10 years or more. The majority of respondents had current prescriptions to ART (96.0%) and 98.5% reported being adherent to their medications in the past 30 days. Overall, 84.1% were virally suppressed and of the 262 who were adherent, 86% were virally suppressed.

Table 8. HIV Care Related Factors for LACHNA 2016 Respondents (N=277)

Factors	Respondents	
	No.	%
Years Since Diagnosis¹		
1-5 Years	37	13.4
6-10 Years	48	17.3
>10 Years	188	67.9
In Care		
Yes	270	97.5
No	7	2.5
Number of clinic visits in the past 12 months		
≥2	262	94.6
<2	15	5.4
Time since last HIV care provider visit		
≤3 months	228	82.3
>3 months	49	17.7
Ever Out of Care for >1 year		
Yes	63	22.7
No	214	77.3
Current Prescription to ART		
Yes	266	96.0
No	9	3.3
Not in Care	2	0.7
ART Adherence (n=266)		
Yes	262	98.5
No	4	1.5
Virally Suppressed²		
Yes	233	84.1
No	44	15.9

¹Missing=4

²Viral suppression data was extracted from eHARS. Persons were considered virally suppressed when viral load test was ≤ 200 copies/ml. of blood.

There are a number of factors related to mental health that can impact how and whether PLWH access medical and support services.[25, 26] In the LACHNA survey we assessed whether respondents' had a history of a mental health diagnosis, whether they were currently experiencing symptoms of a mental health issue, exposure to trauma, stigma related to their HIV status, and perceived discrimination from healthcare providers. As shown in Table 9, the

majority of respondents reported no history of a mental health diagnosis (53.4%). The most common reported mental health diagnoses were depressive disorder (40.4%) and anxiety disorder (25.3%).

Table 9. Mental Health Related Factors for LACHNA 2016 Respondents (N=277)

Factors	Respondents	
	No.	%
MH Diagnosis (Ever)¹		
No	148	53.4
Yes	127	45.9
Depression	112	40.4
Anxiety Disorder	70	25.3
Bipolar Disorder	22	7.9
Schizophrenia	8	2.9
MH Symptoms (further MH assessment needed)²		
No	123	44.4
Yes	154	55.6
Depression	85	30.7
Anxiety	109	39.4
Somatic Symptoms	78	28.2
Psychosis	21	7.6
Repetitive Thoughts	36	13.0
Exposure to Trauma (Ever)³		
Yes	232	83.8
No	45	16.3
HIV Stigma⁴		
No Stigma	86	33.5
Low Levels of Stigma	108	42.0
High Levels of Stigma	63	24.5
Any Healthcare Discrimination since HIV Diagnosis		
Yes	77	27.8
No	200	72.2

¹ Data not mutually exclusive. Don't Know/Refused to Answer=2.

² DSM-5 Level 1 Cross-Cutting Symptom Measure tool. This tool screens respondents and identifies those who require additional inquiry for further detailed mental health evaluation.

³ Brief Trauma Questionnaire (BTQ) - assesses traumatic exposure according to *DSM-IV* but specifically asks about life threat and/or serious injury.

⁴ Internalized HIV Stigma Scale.

To assess symptoms of certain underlying mental health conditions, we used the DSM-5 Level 1 Cross-Cutting Symptom Measure tool.[27] Of the 277 respondents, 55.6% were currently experiencing symptoms indicative of an underlying mental health condition and 44.4% were not. Among the 154 respondents experiencing symptoms, 39.4% reported symptoms of anxiety, 30.7% reported depressive symptoms, and 28.2% reported somatic symptoms. Though 53.4% of respondents reported no mental health diagnosis, 55.6% of respondents reported experiencing

symptoms, which infers some respondents may have undiagnosed or under-diagnosed mental health conditions.

In addition, we assessed respondents' lifetime exposure to trauma (e.g. life threat or serious injury) using the Brief Trauma Questionnaire (BTQ)[28] and found 83.8% of respondents reported ever having a traumatic experience. HIV-related stigma was assessed using an abbreviated version of an internalized HIV stigma scale [29] and one in four respondents was found to have experienced high levels of HIV stigma. We also asked respondents questions to identify whether they had experienced any discrimination from the healthcare system since their HIV diagnosis (e.g. hostility/lack of respect, less attention, refused service). Overall, 27.8% reported experiencing any discrimination from the healthcare system with 20% reporting someone had exhibited hostility or a lack of respect towards them, 16% reporting they received less attention than other patients, and 8% said they were refused service. Among those who reported healthcare discrimination, 24% reported it was because of their HIV status, and 12% reported it was due to their gender, gender identity or gender expression.

The sexual and substance use risk factors among LACHNA respondents are presented in Tables 10a and 10b. To assess respondent's sexual risk for HIV transmission, respondents were asked about the likelihood of condom use in various scenarios. The majority of respondents stated that it would not affect their decision to use a condom if they had an undetectable viral load (55.6%), taken their HIV medication correctly (63.9%), knew that their sex partner was also HIV positive (52.7%), or knew that their sex partner was taking PrEP (56.7%). However, nearly 20% of respondents reported that they would be less likely to use condoms if they had an undetectable viral load (19.9%), knew their sex partner was on PrEP (19.1%) or knew partner was HIV positive (18.1%). Respondents who reported they would not use condoms in these specific situations may or may not use condoms regularly. However, we were unable to further analyze these responses because we did not ask about current condom use in our survey.

Diagnosis of a sexually transmitted disease (STD) in the past 6 months was reported by 13% of respondents. Syphilis was the most commonly reported STD (7%) followed by Gonorrhea (5%) and Chlamydia (5%). Though not included in Table 10a, 89% of recent STD diagnoses were among MSM.

Use of alcohol or substances has been shown to be associated with high risk sexual behaviors [30] and can impact one's ability to access and utilize services as well as reach viral suppression.[31, 32] We used the AUDIT-C tool[33] to assess whether respondents' drinking behaviors exceeded the recommended limits for men and women. The majority (57%) of respondents had drinking behaviors below the recommended limits according to our assessment tool; however, 31% had drinking behaviors above the limits, and 10% had drinking behaviors so severe that treatment would be encouraged.

Using the NIDA-modified ASSIST tool[34], we looked at respondents' level of substance use risk (low, moderate, high; cannabis not included), based on their history of recent use, and level

of involvement (e.g. frequency of use, ability to stop use, failure to function, and health, social, legal and/or financial consequences). Overall, 38% of respondents reported no risk, 39% reported low risk and 22% reported moderate risk. Few respondents (<5) were considered to be high-risk. Self-reported substance use in the past 3 months was reported by 37.9% of respondents. Nearly one-third reported recent Cannabis use (29%) and 9% reported recent methamphetamine use (9%). Lifetime and recent injection substance use was reported by 13% and 2% of respondents, respectively. While not included in Table 10b, injection substance use was highest among those using methamphetamines, with almost 12% of respondents reporting ever injecting methamphetamine and 2% recently injecting methamphetamine.

Table 10a. Sexual Risk Factors among LACHNA 2016 Respondents

Risk Factors	Respondents	
	N=277	
Condom Use If...	No.	%
Viral Load Undetectable ¹		
More Likely	51	18.4
Less Likely	55	19.9
No Difference	154	55.6
HIV Medication Taken Correctly ²		
More Likely	44	15.9
Less Likely	40	14.4
No Difference	177	63.9
Sex Partner also HIV ³		
More Likely	67	24.2
Less Likely	50	18.1
No Difference	146	52.7
Sex Partner taking PrEP ¹		
More Likely	50	18.1
Less Likely	53	19.1
No Difference	157	56.7
Sexually Transmitted Diseases (STD)		
Any STD diagnosis in the past 6 months ⁴		
No	239	86.3
Yes	36	13.0
Syphilis	19	6.9
Gonorrhea	15	5.4
Chlamydia	15	5.4
Herpes Simplex 1 or 2	<5	-

¹ Seventeen respondents answered “Don’t know”, refused to answer or were not asked this question.

² Sixteen respondents answered “Don’t know”, refused to answer or were not asked this question.

³ Fourteen respondents answered “Don’t know”, refused to answer or were not asked this question.

⁴ Don’t Know/Refused to answer=2.

Table 10b. Substance and Alcohol Use Risk Factors among LACHNA 2016 Respondents

Risk Factors	Respondents N=277	
	No.	%
Self-Reported Substance Use (Past 3 Months)		
Cannabis	79	28.5
Cocaine	19	6.9
Prescription Stimulants	5	1.8
Methamphetamine	25	9.0
Inhalants	5	1.8
Sedatives or Sleeping Pills	17	6.1
Hallucinogens	3	1.1
Street Opioids	1	0.4
Prescription Opioids	10	3.6
Any Injection Substance Use		
Lifetime Use	36	13.0
Recent Use	6	2.2
Level of Substance Use Risk¹		
No Risk	105	37.9
Lower Risk	108	39.0
Moderate Risk	60	21.7
High Risk	4	1.4
Alcohol Use²		
Below Recommended Limits	157	56.7
Above Recommended Limits	115	41.5

¹Substance use risk measured utilizing NIDA-ASSIST instrument. Includes use of cocaine, prescription stimulants, methamphetamine, sedatives or sleeping pills, hallucinogens and prescription opioids. Cannabis was not included in this assessment of risk.

²Alcohol use measured utilizing AUDIT-C tool. Number of respondents under “Treatment encouraged” category may be underestimated as the AUDIT-C tool also recommends treatment for all individuals with above recommended alcohol consumption who have a history of prior alcohol treatment (LACHNA-2016 survey did not ask questions about prior alcohol treatment). Missing=5.

The LACHNA needs assessment included several questions to better understand PrEP/PEP awareness among PLWH and communication with their partners about PrEP/PEP. While the majority of respondents were aware of PrEP (66.1%), only 40.8% were aware of PEP. Nearly half of the 183 respondents reported ever talking to their partner about PrEP (43.7%), and one-third of respondents reported a partner ever told them they were taking PrEP (32.2% - see Table 11). Though not reported in Table 11, a small proportion of respondents reported ever taking PrEP or PEP themselves (<1% and 1% respectively).

Table 11. Knowledge of PrEP/PEP among LACHNA 2016 Respondents

	Respondents N=277	
	No.	%
Aware of PrEP	183	66.1
Aware of PEP	113	40.8
Ever Talked to Sex Partner about PrEP (n=183) ¹	80	43.7
Partner Ever Told you They Were Taking PrEP (n=183) ¹	59	32.2

¹Missing=5.

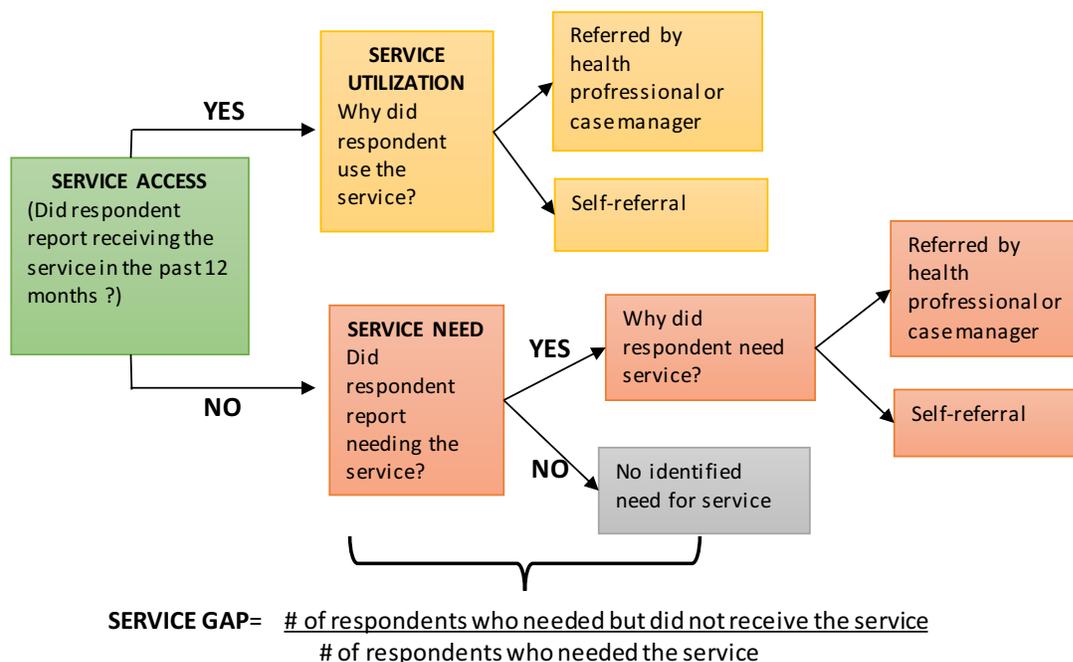
Key Findings: Respondent Characteristics

- The demographic characteristics of respondents are comparable to the target population sampled and therefore the results of this assessment are generalizable, or applicable, to all adult PLWH in medical care and living in LAC.
- Nearly half of respondents (48%) reported an annual household income of less than \$20,000 and only a third were employed full-time (31%) but the majority reported stable housing (97%) and insurance coverage (83%).
- Similar to our target population of adult PLWH in medical care in LAC, the largest proportion of respondents (37.9%) lived in the Metro area (SPA 4).
- The majority of respondents were virally suppressed in the past year (84%) and had a current prescription for ART (96%).
- Nearly half of respondents (46%) reported being previously diagnosed with a mental health condition, while 56% reported experiencing current symptoms of a mental health condition suggesting underdiagnosed mental health conditions.
- The majority of respondents reported a history of trauma (84%).
- One quarter of respondents reported a history of HIV stigma.
- Twenty-eight percent of respondents reported experiencing discrimination in a healthcare setting following their HIV diagnosis.
- Nearly one-third (31%) of respondents had drinking behaviors above the recommended limits, and 10% had drinking behaviors so severe that treatment would be encouraged.
- Nine percent of respondents reported recent methamphetamine use.
- Thirteen percent of respondents reported a recent STI.
- The majority of respondents reported that their decision to use condoms would not be affected by:
 - Their viral load or ART adherence
 - Their partner taking PrEP or being HIV-positive

The following section describes how LACHNA respondents reported utilizing HIV-related care and support services, their need for those services and whether they experienced any gaps in or barriers to accessing needed services. These data are intended to inform the COH, DHSP, and HIV prevention, care and support service providers about access to HIV-related services for all populations, as well as to improve health outcomes, and move toward achieving the 2020 National HIV/AIDS Strategy (NHAS) targets.

Figure 6 provides a schematic of how service utilization, need and gaps were assessed through LACHNA. Need was also differentiated by professionally-identified (e.g. by medical provider, a case manager or other professional) and self-identified need.

Figure 6. Schematic of Assessment of Need



HIV Service Utilization

Respondents were asked whether they had utilized each of the 16 selected care and support services in the past 12 months. The self-reported utilization of services is presented in Table 12. Nearly all respondents (99.6%) reported utilizing at least one service in the 12 months prior to enrollment in LACHNA. The top 5 utilized services were Outpatient/Ambulatory Medical Care (99.3%), Oral Health Care (58.8%), Local AIDS

Pharmaceutical Assistance (53.8%), Vision Services (48.4%), and Case Management (Clinic-based – 39.7%). Similarly, the top utilized service in LACHNA 2011 was Medical Outpatient (90.2%). The least utilized service among respondents was Substance Abuse Services (1.8%).

Though all respondents had to have been in medical care in 2014 to participate in LACHNA, this data suggests that nearly all patients were still in care when they completed the LACHNA survey (December 2015 – June 2016). While the annual NHAS 2020 target is to increase the proportion of persons diagnosed with HIV and retained in HIV care to 90%^[35], we were unable to make a direct comparison with the LACHNA sample since the respondents reflected only PLWH in HIV medical care. However, in FY 2015/2016, 82.7% of RWP clients were retained in care compared to 56.8% of all PLWH in LAC. Thus, additional support may be needed to retain RW and specifically non-RWP clients in HIV medical care.

Table 12. LACHNA 2016: Self-Reported HIV Service Utilization in the Past 12 Months (n=277)

Service Category Utilized	Rank	n	%
At Least One Service	-	276	99.6
Outpatient/Ambulatory Medical Care	1	275	99.3
Oral Health Care	2	163	58.8
ADAP	3	149	53.8
Vision Services	4	134	48.4
Case Management (Clinic-based) ¹	5	110	39.7
Mental Health Services	6	92	33.2
Medical Transportation Services	7	79	28.5
Medical Nutritional Therapy	8	63	22.7
Referrals for Health Care/Support Services	9	49	17.7
Housing Services	10	44	15.9
Support Groups	11	40	14.4
Food Bank/Home-Delivered Meals	12	35	12.6
Rehabilitation Services	13	22	7.9
Emergency Financial Services	14	18	6.5
Case Management (Community-based) ¹	15	13	4.7
Skilled Nursing	16	11	4.0
Substance Abuse Services	17	5	1.8

¹ Case Management included as two categories in this table.

HIV Service Needs

Table 13 presents identified need for specific HIV services and type of identified need. Service need in the past 12 months was ranked by the most needed service to least needed service reported by total need. All respondents reported needing at least one service (100%) outside of medical care. The proportion of respondents who reported needing a service ranged from 99.6% (Outpatient/Ambulatory Medical Care) to 3.6% (Substance Abuse Services). The

top 5 most needed services were Outpatient/Ambulatory Medical Care (99.6%), Oral Health Care (88.1%), Vision Services (71.5%), ADAP (58.5%) and clinic-based Case Management (56.0%). The least needed services reported were Rehabilitation Services (11.2%), Skilled Nursing (4.7%), and Substance Abuse Services (3.6%). These findings are similar to LACHNA 2011 and Medical Monitoring Project (MMP) data. MMP, like LACHNA 2011, was a clinic-based sample of PLWH in HIV medical care in LAC. In LACHNA 2011 data, Outpatient/Ambulatory Medical Care and Oral Health Care services were found to be the most needed services. Similarly, dental and vision care were the most needed services according to MMP data. Vision Services was not included in LACHNA 2011 as it was not a HRSA-funded service category.

Services referred by a medical provider, a case manager or other professional were defined as professionally-identified need. Self-identified need was determined by respondents themselves. While respondents could report that need for a service was both professionally-identified and self-identified, for the purposes of this report, service needs that were both professionally- and self-identified were categorized as professionally-identified.

Table 13. LACHNA 2016: HIV Service Need (n=277)

Needed Service	Total Need			Identified Need by Type			
	Rank	n	%	Professional ¹		Self	
				n	%	n	%
Needed at least one service	-	277	100.0	-	-	-	-
Outpatient/Ambulatory Medical Care	1	276	99.6	251	90.9	25	9.1†
Oral Health Care ²	2	244	88.1	97	39.8	145	59.4†
Vision Services	3	198	71.5	87	43.9	111	56.1
ADAP	4	162	58.5	139	85.8	23	14.2†
Case Management (all forms)	5	155	56.0	110	71.0	45	29.0†
Mental Health Services ³	6	123	44.4	64	52.0	58	47.2
Medical Transportation Services	7	106	38.3	58	54.7	48	45.3
Housing Services	7	106	38.3	26	24.5	80	75.5†
Medical Nutritional Therapy	8	98	35.4	60	61.2	38	38.8†
Food Bank/Home-Delivered Meals	9	64	23.1	13	20.3	51	79.7†
Support Groups	10	63	22.7	30	47.6	33	52.4
Referrals for Health Care/Support Services	11	61	22.0	49	80.3	12	19.7†
Emergency Financial Services ³	12	41	14.8	15	36.6	25	61.0
Rehabilitation Services	13	31	11.2	22	71.0	9	29.0†
Skilled Nursing	14	13	4.7	10	76.9	3	23.1
Substance Abuse Services	15	10	3.6	2	20.0	8	80.0

¹ Services that were both professionally- and self-identified were categorized as a professionally identified need.

² Missing identified need for 2 respondents.

³ Missing identified need for 1 respondent.

†p<.05

For 3 of the 16 service categories, the proportion of respondents reporting self-identified service need was significantly higher than the proportion reporting professionally-identified

need. These services included Oral Health Care, Housing Services, and Food Bank/Home-delivered Meals. The proportion of respondents reporting professionally-identified need for 6 of the 16 service categories was significantly higher than the proportion of those reporting self-identified need. These services included Outpatient/Ambulatory Medical Care, ADAP, Case Management (all forms), Medical Nutritional Therapy, Referrals for Health Care/Support Services, and Rehabilitation Services. Note that need for housing was asked of all respondents regardless of housing status (e.g. housing need was not specific to homeless respondents), so respondents who were not homeless might still have housing needs (e.g. need to improve housing conditions).

Presented in Table 14 below are HIV Service Need, Utilization and Gaps among LACHNA respondents. Among those respondents who identified a need for Oral Health Care (88.1%) and Vision Services (71.5%), nearly one third did not receive these services or had a service gap. For those in need of Housing (38.3%), Emergency Financial Services (14.8%), and Substance Abuse Services (3.6%), at least half did not receive these services.

Table 14. HIV Service Need, Utilization and Gaps among LACHNA 2016 Respondents (n=277)

Service Category	Service Needed ¹		Services Utilized		Service Gap ²	
	n	%	n	%	n	%
Outpatient/Ambulatory Medical Care	276	99.6	275	99.6	1	0.4
Oral Health Care	244	88.1	163	66.8	81	33.2
Vision Services	198	71.5	134	67.7	64	32.3
ADAP	162	58.5	149	92.0	13	8.0
Case Management (all forms)	155	56.0	123	79.4	32	20.6
Mental Health Services	123	44.4	92	74.8	31	25.2
Medical Transportation Services	106	38.3	79	74.5	27	25.5
Housing Services	106	38.3	44	41.5	62	58.5
Medical Nutritional Therapy	98	35.4	63	64.3	35	35.7
Food Bank/Home-Delivered Meals	64	23.1	35	54.7	29	45.3
Support Groups	63	22.7	40	63.5	23	36.5
Referrals for Health Care/Support Services	61	22.0	49	80.3	12	19.7
Emergency Financial Services	41	14.8	18	43.9	23	56.1
Rehabilitation Services	31	11.2	22	71.0	9	29.0
Skilled Nursing	13	4.7	11	84.6	2	15.4
Substance Abuse Services	10	3.6	5	50.0	5	50.0

¹ Includes professionally- and self-identified need.

² Service gaps are defined as the proportion of respondents who needed but did not receive a service among those who needed that service.

A gap in service occurs when a service is needed but is not received. Overall, 63% of respondents reported experiencing at least one service gap. Table 15 ranks the service categories from those with the largest number of respondents who reported a service gap to those with the smallest number of respondents with a service gap. Nearly one third of respondents who needed Oral Health Care (33.2%; n=81), Vision Services (32.3%; n=64), and Medical Nutrition Therapy (35.7%; n=35) did not receive these services, and over half of the 106 respondents who needed housing did not receive these service (58.5%). These findings are similar to the previous needs assessment (LACHNA 2011) in which Oral Health Care and Rental Assistance were ranked as the services with the top service gaps. Vision Services was not included in the previous needs assessment, as it is not a HRSA-funded service category. Similarly, MMP data show Oral Health and Vision Services having the largest unmet need, with housing ranked at #4. The Outpatient/Ambulatory Medical Care service category had the least number of gaps, which could be attributed to the sampling methods used for this LACHNA cycle; however, gaps in Medical Outpatient services in the LACHNA 2011 survey were also low with only 4% reporting they needed but did not receive these services.

Table 15. LACHNA 2016: HIV Service Gaps (n=277)

Service Category	Total		
	Rank	%	% Gap ¹
Any Gap	-	175	63.2
Oral Health Care	1	81	33.2
Vision Services	2	64	32.3
Housing Services	3	62	58.5
Medical Nutritional Therapy	4	35	35.7
Case Management (all forms)	5	32	20.6
Mental Health Services	6	31	25.2
Food Bank/Home-Delivered Meals	7	29	45.3
Medical Transportation Services	8	27	25.5
Emergency Financial Services	9	23	56.1
Support Groups	9	23	36.5
ADAP	10	13	8.0
Referrals for Health Care/Support Services	11	12	19.7
Rehabilitation Services	12	9	29.0
Substance Abuse Services	13	5	50.0
Skilled Nursing	14	2	15.4
Outpatient/Ambulatory Medical Care	15	1	0.4

¹ Service gaps are defined as the proportion of respondents who needed but did not receive a service among those who needed that service.

To better understand gaps in oral health and vision services, we looked at gaps in these services by age (18-49 years vs. 50+ years). There were no differences in utilization, need or gaps

by age for oral health, and no differences in gaps for vision services; however, there were significant differences in utilization of vision services with respondents 50 years and older utilizing more services, which was most likely linked to increased vision issues that occur with age.

Service gaps were also examined by whether the need for these services were professionally- or self-identified. With the exception of Outpatient/Ambulatory Medical Care, all gaps were among services that had a high proportion of self-identified need (58.3% to 100.0%) and 9 of the 16 services had a significantly higher proportion of self-identified need (see Table 16). These disparities may reflect inadequate assessment or definition of client need by providers, inadequate disclosure of need or understanding of eligibility for service by clients, or some combination.

Table 16. LACHNA 2016: HIV Service Gaps by Identified Need (n= 277)

Service Category	Total Gap ¹		Type of Need			
			Professionally-Identified ²		Self-Identified ²	
	n	%	n	%	n	%
Oral Health Care	81	33.2	31 ³	38.3	48 ³	59.3
Vision Services	64	32.3	22	34.4	42	65.6†
Housing Services	62	58.5	12	19.4	50	80.6†
Medical Nutritional Therapy	35	35.7	7	20.0	28	80.0†
Case Management (all forms)	32	20.6	6	18.8	26	81.3†
Mental Health Services	31	25.2	9	29.0	22	71.0†
Food Bank/Home-Delivered Meals	29	45.3	3	10.3	26	89.7†
Medical Transportation Services	27	25.5	5	18.5	22	81.5†
Emergency Financial Services	23	56.1	3 ³	13.0	19 ³	82.6†
Support Groups	23	36.5	6	26.1	17	73.9†
ADAP	13	8.0	3	23.1	10	76.9
Referrals for Health Care/Support	12	19.7	5	41.7	7	58.3
Rehabilitation Services	9	29.0	3	33.3	6	66.7
Substance Abuse Services	5	50.0	1	20.0	4	80.0
Skilled Nursing	2	15.4	0	0.0	2	100.0
Outpatient/Ambulatory Medical Care	1	0.4	1	100.0	0	0.0

¹ Service gaps are defined as the proportion of respondents who needed but did not receive a service among those who needed that service.

² Services that were both professionally- and self-identified were categorized as a professionally-identified need

³ Some respondents did not answer question about type of service need, for oral health care (n=2) and emergency financial services (n=1).

†p<.05

Some populations may be disproportionately impacted by service gaps which may affect their ability to access or maintain medical care. Tables 17a and 17b highlight respondents who reported any service gap by socio-demographic characteristics. Race/ethnicity was the only demographic characteristic with significant differences. The proportion of Latino and African

American respondents with any service gap was significantly higher than the proportion of Whites with any service gap.

Table 17a. LACHNA 2016: HIV Service Gaps by Socio-Demographic Characteristics¹

Characteristic	Total Sample	Any Gap
	N=277	n=175
	N	%
Gender		
Male ²	238	61.3
Female	34	70.6
Transgender (M-F)	5	100
Age Group		
18-29 years	17	82.4
30-39 years	43	79.1
40-49 years	78	59.0
50-59 years ²	88	64.8
60+ years	51	47.1
Race/Ethnicity		
Latino/Hispanic	130	66.2+
African-American/Black	64	71.9+
Asian/Pacific Islander	4	75.0
White/Caucasian ²	76	50.0
Mixed/Other race or ethnicity	3	66.7
Sexual Orientation		
Homosexual, Gay/Lesbian ²	171	59.1
Heterosexual/Straight	74	71.6
Bisexual	26	73.1
Other	5	40.0
Don't Know/Refused to Answer	1	0.0
Service Planning Area		
Antelope Valley(1)	4	50.0
San Fernando(2)	34	64.7
San Gabriel(3)	22	59.1
Metro(4) ²	105	65.7
West(5)	11	54.6
South(6)	34	64.7
East(7)	24	54.2
South Bay(8)	41	63.4
Unknown	2	100.0

¹ Service gaps are defined as the proportion of respondents who needed but did not receive a service among those who needed that service.

² Reference group.

†p<.05

In addition to demographic characteristics, we looked at gaps by type of clinic. Respondents who reported receiving their medical care at a RWP-funded clinic reported significantly more overall gaps than respondents at non-RWP-funded clinics (68.4% vs. 50.6%, respectively), which could be associated with a difference in income between patients of RWP-funded and non-RWP funded clinics; however, more complex analysis is needed to better understand the reasons for this finding (see Table 17b).

We also looked at whether recent substance use or mental health symptoms were associated with any gaps in services. Respondents who reported recent substance use reported significantly more gaps in services compared to those who did not report recent substance use (76.7% versus 59.5%, respectively), and respondents who reported experiencing any mental health symptoms reported significantly more service gaps compared to those who did not report experiencing any mental health symptoms (72.1% vs. 52.0% - see Table 17b).

Table 17b. LACHNA 2016: HIV Service Gaps by Socio-Demographic Characteristics¹

Characteristic	Total Sample	Any Gap
	N=277	n=175
	N	%
Medical Clinic		
Ryan White	196	68.4†
Non-Ryan White ²	81	50.6
Alcohol Use		
Above Recommended Limits	115	66.1
Below Recommended Limits	157	61.2
Recent substance use (3 months)³		
Yes	60	76.7†
No	217	59.5
Lifetime Trauma		
Yes	232	64.2
No	45	57.8
Any Mental Health Symptoms		
Yes	154	72.1†
No	123	52.0
History of Mental Health Diagnosis		
Yes	127	69.3
No	150	58.0

¹ Service gaps are defined as the proportion of respondents who needed but did not receive a service among those who needed that service.

² Reference group.

†p<.05

HIV Service Barriers

All 175 respondents who reported a service gap also reported experiencing at least one barrier to needed services. As shown in Table 18, among respondents who reported experiencing service gaps in the past 12 months by service category, 81 respondents with gaps in Oral Health Care reported the most barriers to accessing services (n=133) followed by 119 barriers to Housing Services experienced by 62 respondents. On average, respondents with service gaps experienced 1.6 barriers to Oral Health Care and 1.9 for Housing Services. The

average number of service barriers per respondent ranged from 1.0 (Outpatient/Ambulatory Medical Care Services) to 2.8 (Substance Abuse Services).

Table 18. LACHNA 2016: HIV Service Gaps and Barriers

Service Category	Total Gaps ¹			Total Barriers ²	
	Rank	No.	%	No.	Avg. No. Barriers
Oral Health Care	1	81	33.2	133	1.6
Vision Services	2	64	32.3	78	1.2
Housing Services	3	62	58.5	119	1.9
Medical Nutritional Therapy	4	35	35.7	57	1.6
Case Management (all forms)	5	32	20.6	55	1.7
Mental Health Services	6	31	25.2	54	1.7
Food Bank/Home-Delivered Meals	7	29	45.3	42	1.4
Medical Transportation Services	8	27	25.5	30	1.1
Emergency Financial Services	9	23	56.1	37	1.6
Support Groups	9	23	36.5	30	1.3
ADAP	10	13	8.0	15	1.2
Referrals for Health Care/Support	11	12	19.7	18	1.5
Rehabilitation Services	12	9	29.0	12	1.3
Substance Abuse Services	13	5	50.0	14	2.8
Skilled Nursing	14	2	15.4	4	2.0
Outpatient/Ambulatory Medical Care	15	1	0.4	1	1.0

¹ Service gaps are defined as the proportion of respondents who needed but did not receive a service among those who needed that service.

² Respondents may have more than one barrier to accessing a service.

Among the six service categories with the most service gaps, we looked at the specific barriers to receiving those services. The barriers identified by respondents were similar across service categories and were often the result of a lack of information on how to access the services. Tables 19 to 24 list the top main barriers and the most common barrier for the six service categories with the highest ranked service gaps.

Oral Health Care was ranked as the service category with the greatest gaps (33.2%, n=81). As shown in Table 19, the top main barrier to accessing Oral Health Care was “Service costs too much/lack of insurance” (23.5%) and the most common barrier reported was “Didn’t know where to go or whom to call” (44.4%). This is consistent with the LACHNA-2011 results, where the largest service gap observed was for Oral Health Care and respondents reported the main barriers were at the individual level which included lack of awareness about service availability, location of the service and whom to ask for help.

Table 19. LACHNA 2016: Barriers to Oral Health Care (n=81)

Service Barrier	Main Barrier		All Barriers	
	No.	%	N	%
Service costs too much/lack of insurance	19	23.5	20	24.7
Didn't know where to go or whom to call	18	22.2	36	44.4
Did not follow up (with referral or appointment)	13	16.1	15	18.5
Too many rules, regulations, paperwork or red tape	12	14.8	16	19.8
In process of getting the service	8	9.9	11	13.6
Service isn't available in my area	3	3.7	9	11.1
Not eligible or denied services	2	2.5	7	8.6
Other life priorities (child care/work)	2	2.5	2	2.5
Service hours are inconvenient	2	2.5	2	2.5
Stigma (Concern people would think badly of me)	1	1.2	3	3.7
Waiting list is too long	1	1.2	8	9.9

Vision Services, presented in Table 20, ranked second for service gaps with 32.3% (n=64) of respondents who needed this service reporting they did not receive it. The top main and the most common barrier was “Didn't know where to go or whom to call” (37.5% and 39.1%, respectively). Vision Services was not included in the previous LACHNA survey because the service category was not funded by HRSA.

Table 20. LACHNA 2016: Barriers to Vision Services (n=64)

Service Barrier	Main Barrier		All Barriers	
	No.	%	No.	%
Didn't know where to go or whom to call	24	37.5	25	39.1
Did not follow up (with referral or appointment)	10	15.6	12	18.8
Service costs too much/lack of insurance	7	10.9	8	12.5
Not eligible or denied services	6	9.4	7	10.9
In process of getting the service	6	9.4	11	17.2
Other life priorities (child care/work)	3	4.7	3	4.7
Service isn't available in my area	3	4.7	4	6.3
Service hours are inconvenient	2	3.1	3	4.7
Too many rules, regulations, paperwork or red tape	2	3.1	2	3.1
Waiting list is too long	1	1.6	2	3.1

Housing Services ranked high in service gaps at #3 with 58.5% (n=62) of respondents reporting that they did not receive this needed service. The top main and the most common barrier to Housing Services was “Didn't know where to go or whom to call” (35.5% and 50.0%, respectively - see Table 21). These findings were similar to LACHNA-2011, in which rental assistance and short term rent/mortgage ranked #2 and #3. Previous barriers were similar and included both individual (not aware service was available, not aware of location or did not know whom to ask for help) and organizational (service provider insensitive to concerns, wait time too long, provided wrong referrals) barriers.

Table 21. LACHNA 2016: Barriers to Housing Services (n=62)

Service Barrier	Main Barrier		All Barriers	
	No.	%	No.	%
Didn't know where to go or whom to call	22	35.5	31	50.0
Waiting list is too long	12	19.4	29	46.8
In process of getting the service	10	16.1	15	24.2
Too many rules, regulations, paperwork or red tape	7	11.3	15	24.2
Not eligible or denied services	4	6.5	10	16.1
Other life priorities (child care/work)	2	3.2	2	3.2
Concern about immigration status	1	1.6	1	1.6
Did not follow up (with referral or appointment)	1	1.6	3	4.8
Homelessness	1	1.6	2	3.2
Service isn't available in my area	1	1.6	7	11.3
Transportation problems	1	1.6	1	1.6

As in LACHNA 2011, Medical Nutritional Therapy continued to be ranked in the top 5 service gaps. Ranked #4 in the current LACHNA, 35.7% (n=35) of respondents reported they needed but did not receive Medical Nutritional Therapy. The top main and the most common barrier was "Didn't know where to go or whom to call" (51.4% and 62.9%, respectively - see Table 22). Similarly, in LACHNA 2011, 68.6% of respondents reported individual barriers (not aware service was available, not aware of location or did not know whom to ask for help) to Medical Nutrition Therapy.

Table 22. LACHNA 2016: Barriers to Medical Nutritional Therapy (n=35)

Service Barrier	Main Barrier		All Barriers	
	No.	%	No.	%
Didn't know where to go or whom to call	18	51.4	22	62.9
Did not follow up (with referral or appointment)	4	11.4	4	11.4
In process of getting the service	3	8.6	3	8.6
Not eligible or denied services	2	5.7	2	5.7
Service costs too much/lack of insurance	2	5.7	3	8.6
Homelessness	1	2.9	1	2.9
Service hours are inconvenient	1	2.9	2	5.7
Service isn't available in my area	1	2.9	3	8.6
Transportation problems	1	2.9	4	11.4
Waiting list is too long	1	2.9	3	8.6
Was drinking or using drugs	1	2.9	1	2.9

Almost 21% of respondents reported they needed and did not receive Case Management Services. The data in Table 23 includes Clinic-, Community-, and Jail-based Case Management; however, they were not asked about separately, thus further detail cannot be provided. The top main and the most common barrier for Case Management was "Didn't know where to go or whom to call" (59.4% and 78.1%, respectively - see Table 23). In LACHNA 2011, only Housing Case Management was ranked in the top 10 service gaps and the majority (62.9%) reported

individual barriers to Housing Case Management which included not aware service was available, not aware of location or did not know whom to ask for help.

Table 23. LACHNA 2016: Barriers to Case Management¹ (all forms) (n=32)

Service Barrier	Main Barrier		All Barriers	
	No.	%	No.	%
Didn't know where to go or whom to call	19	59.4	25	78.1
Service isn't available in my area	6	18.8	10	31.3
Not eligible or denied services	2	6.3	2	6.3
Did not follow up (with referral or appointment)	1	3.1	3	9.4
Homelessness	1	3.1	1	3.1
In process of getting the service	1	3.1	2	6.3
Other life priorities (child care/work)	1	3.1	1	3.1
Service costs too much/lack of insurance	1	3.1	1	3.1

¹ Includes Clinic-based, Community-based, and Jail-based Case Management. Data not available by type.

While Mental Health Services was not ranked as one of the top 5 services with service gaps, mental health issues are an important barrier to accessing medical care[25, 26], so it is important to understand the barriers to mental health services. One in four respondents reported they needed but did not receive Mental Health Services in the past 12 months. The top main and the most common barrier was "Didn't know where to go or whom to call" (29.0% and 48.4%, respectively – see Table 24).

Table 24. LACHNA 2016: Barriers to Mental Health Services (n=31)

Service Barrier	Main Barrier		All Barriers	
	No.	%	No.	%
Didn't know where to go or whom to call	9	29.0	15	48.4
Service costs too much/lack of insurance	6	19.4	9	29.0
Did not follow up (with referral or appointment)	4	12.9	4	12.9
Other life priorities (child care/work)	4	12.9	5	16.1
Service isn't available in my area	2	6.5	3	9.7
Waiting list is too long	2	6.5	5	16.1
In process of getting the service	1	3.2	4	12.9
Stigma (Concern people would think badly of me)	1	3.2	1	3.2
Too many rules, regulations, paperwork or red tape	1	3.2	4	12.9
Was drinking or using drugs	1	3.2	1	3.2

Key Findings: Needs Assessment

- Patterns of service utilization, needs and gaps were similar to previous LACHNA and other needs assessment data for LAC (MMP).
 - Almost all LACHNA 2016 respondents reported accessing medical care in the past 12 months (99.3%) – similarly 90.2% accessed medical care in LACHNA 2011.
 - Service need was highest for Outpatient/Ambulatory Medical Care (99.6%) – consistent with previous LACHNA data (93.8%).
 - Oral Health Care was reported as the second highest need (88.1%) – consistent with previous LACHNA data (82.9%) - and top need among MMP respondents.
 - Vision Services (71.5%), which was not included in the previous assessment, ranked as the third most needed service – consistent with MMP data.
 - Substance Abuse Services was the least needed service with 3.6% reporting a need.
 - 63% of respondents reported experiencing at least one service gap.
 - Nearly one third (33.2%) of respondents who needed Oral Health Care, Vision Services (32.3%), and Medical Nutrition Therapy (35.7%) did not receive these services - similarly Oral Health Care was ranked as top service gap in LACHNA 2011 and Oral Health and Vision Services had the largest unmet need in MMP.
 - Ranked #3, over half of respondents needing housing did not receive these services (58.5%) – similarly, Rental Assistance had the second highest service gap in LACHNA 2011 and Housing was ranked #4 in unmet need for MMP.
 - Proportion of respondents with any service gap was higher among Latino and African American respondents when compared to their White counterparts.
 - Higher proportions of respondents with recent substance use and mental health symptoms reported service gaps compared to those without recent substance use or mental health symptoms.
 - Respondents who reported receiving their medical care at a RW clinic reported significantly more gaps in services than respondents at non-RW clinics (68.4% vs. 50.6%, respectively) which could be associated with a difference in income between patients of RWP-funded and non-RWP funded clinics.
 - Among the 175 respondents reporting any service gaps, all respondents reported experiencing at least one barrier to needed services.
 - Respondents with gaps in Oral Health Care reported the most barriers (n=133) to services followed by Housing Services (n=119).
 - The top main barrier and most common barrier was “Didn’t know where to go or whom to call” to access service, which was consistent with the LACHNA 2011 findings (lack of awareness about the service was reported as the most common barrier).
 - Cost was cited as the main barrier for oral health services.

The following section evaluates changes in insurance coverage that respondents may have experienced after ACA implementation, and whether those changes impacted access to HIV care for PLWH in LAC. This section was developed based on a Kaiser Family Foundation report, which looked at access to healthcare after the implementation of the ACA among insured and uninsured.[36] The majority of LACHNA respondents reported having insurance coverage at the time of the survey, so similar comparisons could not be made. Therefore, this section focused on changes in respondent’s insurance coverage, access to care, views of insurance coverage and the impact of the ACA on respondent’s finances.

Current Insurance Coverage

At the time of the interview, the majority of LACHNA respondents (83.4%) reported having current insurance coverage, while 15.9% reported no coverage, and less than 1% were waiting for their coverage to begin (see Table 25). Among the 231 respondents who reported having current insurance coverage, 61.0% reported having Medi-Cal (Medicaid), 36.4% reported having private insurance or an HMO, and 29.0% reported having Medicare.

Table 25. LACHNA 2016: Insurance Coverage (n=277)

	No.	%
Covered by health insurance¹	231	83.4
Medi-Cal	141	61.0 ⁴
Private health insurance or HMO	84	36.4 ⁴
Medicare	67	29.0 ⁴
My Health LA	10	4.3 ⁴
Other health insurance ²	14	6.1 ⁴
Not covered by health insurance³	44	15.9
Waiting for insurance coverage to start	2	0.7

¹Not mutually exclusive. Respondents may be covered by more than one form of health insurance.

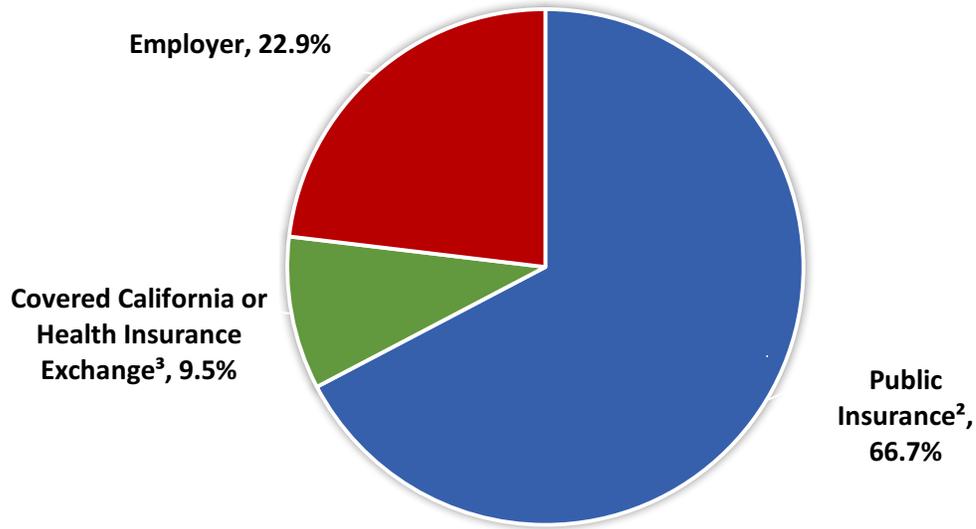
²Includes Veteran’s Administration, OA-HIPP and other health insurance.

³Respondents who reported having ADAP or Ryan White only (6.5%) were also included in this category. Reasons for lack of health insurance included: Can’t afford it/too expensive (2.5%), Concerned about immigration status (2.5%), I don’t know how to get it or whom to ask (1.8%), I was told I was ineligible (2.5%), and Too much red tape, process is too confusing (1.1%).

⁴Percent among currently insured PLWH (n=231).

Figure 7 provides the source of payment for respondents who reported having current insurance coverage. The majority of respondents reported having public insurance (e.g. Medicare, Medi-Cal; 66.7%), while one in five (22.9%) reported employer-covered insurance, and 9.5% reported purchasing their own health insurance through a health exchange.

Figure 7. LACHNA 2016: Payment Source for Insurance Coverage (n=231)¹



¹Don't Know/Refused=2.

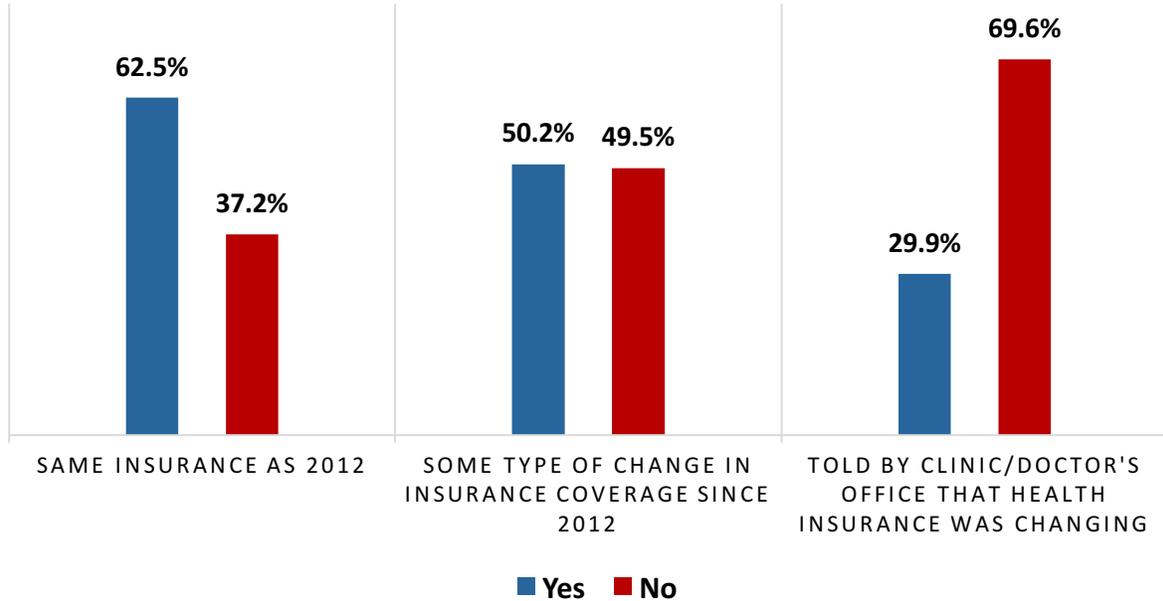
²Does not pay for coverage. Includes Medicare, Medi-Cal, and OA-HIPP.

³Self-purchased plan.

Changes in Insurance Coverage Since 2012

LACHNA respondents were asked several questions to determine if they had experienced any changes in their insurance coverage since 2012. Approximately 58.5% of respondents reported experiencing any changes in their insurance coverage since 2012. As shown in Figure 8, among the 277 respondents who were asked if they had the same coverage as they did in 2012, 37.2% reported they did not. All respondents were asked if they had some type of change in their insurance coverage; half (50.2%) reported having some type of change, such as enrollment in Medi-Cal or a loss of health insurance. Finally, among the 277 respondents, 29.9% reported that they had been told by the clinic or doctor's office that their health insurance was changing (see Figure 8).

Figure 8. LACHNA 2016: Changes in Insurance Coverage n=277¹



¹Missing=1.

Of the 139 respondents who reported some type of change in their insurance coverage since 2012 (Figure 8 – blue middle bar), 35.3% reported enrolling in Medi-Cal, 20.9% reported enrolling in a health plan via Covered California, and 20.9% reported a new private health plan due to new employment. Others experienced a loss in insurance (15.7%), a change to their doctor (13.7%), lost services (e.g. dental/vision), saw an increase in out of pocket expenses (8.6%), or changed from one plan to another (4.3% - see Table 26).

Table 26. LACHNA 2016: Types of Change to Insurance Coverage (n=139)

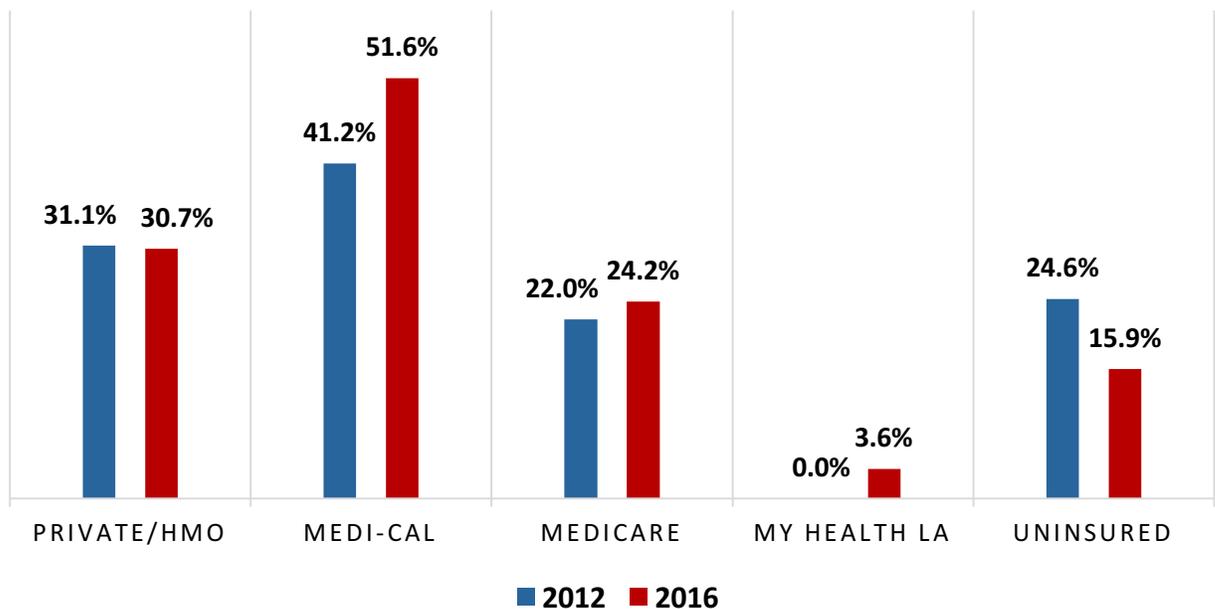
Type of Change ¹	No.	%
Enrolled in Medi-Cal	49	35.3
Enrolled in Private Health Plan because of new job	29	20.9
Enrolled in Covered California	29	20.9
Lost health insurance coverage	22	15.8
Changed doctor or clinic because of a change in coverage	19	13.7
Enrolled in Medicare	17	12.2
Lost service/increased out of pocket expenses	12	8.6
Changed from one plan to another	6	4.3
Other ²	8	5.8

¹Not mutually exclusive. Respondents may have experienced more than one change in coverage.

²Other types of changes included: changes to plan coverage, moved to other county, changed plan to keep doctor, and long referral process.

Figure 9 compares the insurance coverage of respondents at the time of their interview to the coverage they reported having in 2012. As expected, there were increases in the proportion of respondents enrolled in Medi-Cal from 41.2% in 2012 to 51.6% in 2016, with smaller increases in the proportion of those enrolled in Medicare from 22.0% in 2012 to 24.2%. In addition, the proportion of uninsured respondents decreased from 24.6% in 2012 to 15.9% in 2016. Respondents who reported having ADAP or Ryan White only (6.5%) were also included in this category, as these programs were not considered insurance plans. The main reasons respondents reported a lack of insurance were: could not afford it/too expensive (2.5%), concerns about immigration status (2.5%), did not know how to get it or whom to ask (1.8%), I was told I was ineligible (2.5%), and too much red tape, process is too confusing (1.1%).

Figure 9. LACHNA 2016: Types of Insurance Coverage in 2012 and 2016 (n=277)



In Table 27 below the HIV service gaps are presented by changes in insurance coverage. Respondents who reported any changes in coverage reported significantly more overall service gaps than those who reported no changes (69.1% vs. 54.8%; $p < 0.05$). In addition, significant differences in service gaps between respondents with changes in coverage compared with those without changes were reported for Oral Health (38.5% versus 25.0%), Housing (67.8% versus 46.8%) and Mental Health services (29.3% versus 17.1%).

Table 27. LACHNA 2016: HIV Service Gaps by Changes in Coverage (n= 277)

Service Category	Total Gap ¹		Experienced No Changes in Coverage n=115		Experienced Changes in Coverage n=162	
	n	%	n	%	n	%
	Any Service Gap	175	63.2	63	54.8	112
Oral Health Care	81	33.2	24	25.0	57	38.5†
Vision Services	64	32.3	23	26.7	41	36.6
Housing Services	62	58.5	22	46.8	40	67.8†
Medical Nutrition Therapy	35	35.7	12	35.3	23	35.9
Case Management (all forms)	32	20.6	10	18.5	22	21.8
Mental Health Services	31	25.2	7	17.1	24	29.3†
Food Bank/Home-Delivered Meals	29	45.3	12	52.2	17	41.5
Medical Transportation Services	27	25.5	14	31.1	13	21.3
Emergency Financial Services	23	56.1	6	50.0	17	58.6
Support Groups	23	36.5	9	40.9	14	34.2
Local AIDS Pharmaceutical Assistance	13	8.0	2	3.0	11	11.5
Referrals for Health Care/Support Services	12	19.7	4	26.7	8	17.4
Rehabilitation Services	9	29.0	2	20.0	7	33.3
Substance Abuse Services	5	50.0	1	50.0	4	50.0
Skilled Nursing	2	15.4	1	14.3	1	16.7
Outpatient/Ambulatory Medical Care	1	0.4	1	0.9	0	0.0

¹Service gaps are the absolute difference between the proportion of respondents reporting a need for a service and the proportion of respondents who utilized that service.

† p<.05

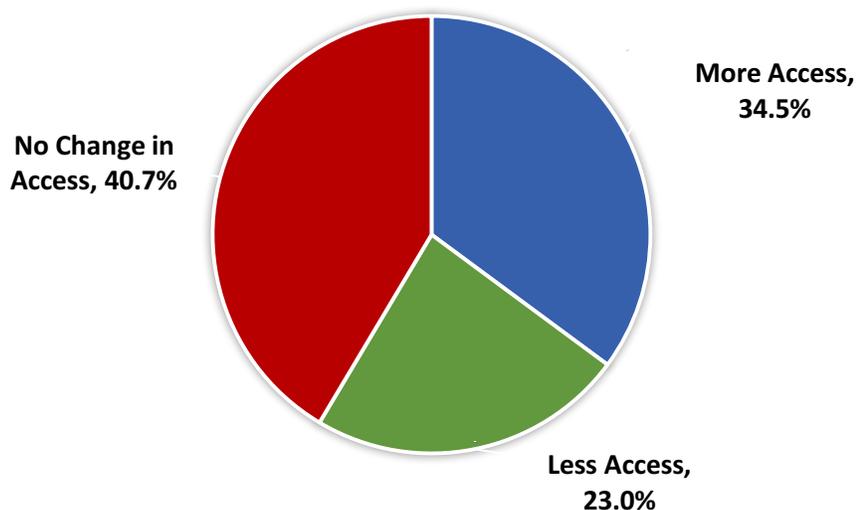
Access to Care

The majority of respondents (56.0%) reported a public health clinic or health center as their main source of medical care, while 32.9% reported a private doctor or HMO. Almost all respondents (93.0%) reported having an individual at their main source of care that they thought of as their HIV doctor, nurse or provider. Twenty-one percent (n=57) of respondents reported having a primary care provider who was not an HIV specialist. Among the 57 respondents who had a non-HIV specialist primary provider, 68% reported relying on their HIV doctor for the majority of their medical care, and 19.3% (n=11) reported needing a referral to see their HIV doctor.

Overall, there were 162 (58.5%) respondents that reported any type of change to their insurance coverage from 2012 to 2016. For that subset of respondents, additional questions were asked regarding how those changes may have impacted their access to services. Forty-one percent of the 162 respondents reported no change in access to services, while 34.5% reported more access, and 23.0% reported less access from 2012 to 2016 (see Figure 10). However, when asked if they had lost a health service, 75.2% reported they had lost at least one health service

they used or needed. Note that as a result of a coding error in the survey, not all respondents with changes in coverage were asked the additional questions regarding access to services (n=49).

Figure 10. LACHNA 2016: Changes in Access to Services (n=113)^{1,2}



¹ As a result of a coding error in the survey, 49 respondents were not asked the additional access to services questions. ² Don't know=2.

Overall, respondents felt they had access to the medical care they needed. The majority *strongly/somewhat agreed* that if they needed hospital care, they could get admitted without trouble (77.6%), that they had easy access to specialists that they needed (83.0%), that medical care was conveniently located (81.6%), and that they were able to get medical care whenever they needed it (88.1%). Similarly, the majority *strongly/somewhat disagreed* that it was hard to get medical care in an emergency (65.0%), and that they went without medical care they needed because it was too expensive (78.0%; see Table 28).

In addition to the 16 service categories above, respondents were asked about general medical care and whether they had any gap in utilization within the last 12 months. We also looked at this gap by whether respondents reported any changes in insurance coverage from 2012 to 2016 (Table 29). Overall, 41.9% (n=116) reported at least one gap in utilization, with 17.7% reporting a gap for prescription medications, and 17.3% reporting they did not receive treatment or follow up for a specific health problem. As shown earlier in Table 15, only 0.4% of respondents who needed HIV-specific Outpatient/Ambulatory Medical Care reported a gap in this service. However, in Table 29, 15.9% of respondents reported they were unable to access general routine medical care or a check-up. Similar to Table 15, few gaps were reported for substance abuse treatment. For those who experienced a gap in utilization, the majority (68.2% to 81.3%) experienced a change in coverage, with significant differences in the proportion of respondents who experienced change in coverage compared to those who did not for prescription medications, specialist referrals and routine medical care.

Table 28. LACHNA 2016 Respondents Perceptions about Access to Medical Care (n=277)

	Strongly Agree/Somewhat Agree	Neither Agree or Disagree	Strongly Disagree/Somewhat Disagree
	%	%	%
If I need hospital care, I can get admitted without any trouble ¹	77.6	12.6	8.0
It is hard for me to get medical care in an emergency ²	19.1	12.6	65.0
Sometimes I go without the medical care I need because it is too expensive	18.0	4.0	78.0
I have easy access to the medical specialists that I need	83.0	5.8	11.2
Places where I can get medical care are very conveniently located ³	81.6	3.6	14.4
I am able to get medical care whenever I need it ³	88.1	2.5	9.1

¹Don't know=5, ²Don't know=9, ³Don't know=1.

Table 29. LACHNA 2016: Gap in Utilization (n=277)

Service	Gap in Utilization		Experienced No Changes in Coverage n=115		Experienced Changes in Coverage n=162	
	n	%	n	%	n	%
Prescription medications	49	17.7	12	24.5	37	75.5†
Treatment/Follow-up for a specific health problem	48	17.3	9	18.8	39	81.3
A referral to a specialist	46	16.6	11	23.9	35	76.1†
Routine Medical Care/Check-Up	44	15.9	14	31.8	30	68.2†
Mental health care/Counseling	40	14.4	10	25.0	30	75.0
Treatment for a substance abuse problem	5	1.8	<5	-	<5	-

†p<.05

The most common reasons reported for gaps in utilization were having other life priorities and being unable to afford costs. Among the 49 respondents who experienced a gap for prescription medications, 38.8% reported they were unable to afford the costs and 18.4% reported a change in their insurance or provider. Among the 44 respondents who did not get their routine medical care or check-up, 40.9% reported they had other life priorities, and 15.9% reported office times were not convenient. Among the 46 respondents who did not get a referral to a specialist, one in five reported they were unable to afford the costs (21.3%) or had other life priorities (21.3%). Reasons for not receiving Mental Health Counseling included: other life priorities (25%), office times not convenient (20.0%), and other reasons (22.5%). Among those who did not get treatment or follow-up for a specific health problem, 25% reported they were unable to afford the cost and 25% had other life priorities (see Table 30).

Table 30. LACHNA 2016: Reason for Gap in Utilization

Reason	Prescription Medication n=49	Routine Medical Care/ Check-Up n=44	Referral to a Specialist n=46	Mental Health Care/ Counseling n=40	Treatment/ Follow-up for Special Health Problem n=48
Unable to Afford Costs	38.8	11.4	21.3	10.0	25.0
Office Times Not Convenient	12.2	15.9	14.9	20.0	14.6
Transportation Problems	4.1	2.3	2.1	2.5	8.3
Other Life Priorities	10.2	40.9	21.3	25.0	25.0
Change in Insurance/ Provider	18.4	11.4	14.9	10.0	14.6
Provider-related Issue	4.1	6.8	6.4	10.0	2.1
Other	12.2	11.4	19.2	22.5	10.4

Respondents reported that not receiving a needed service often caused increased stress and their condition to worsen. Among the 49 respondents who needed but did not receive prescription medication, 53.1% reported increased stress, and 26.5% reported their condition got worse. Of the 41 respondents who did not get routine medical care or a check-up, 39% said they experienced an increase in stress, and of the 43 respondents who did not get a referral to a specialist, 34.9% reported increased stress, and 25.6% reported that their condition got worse. Forty respondents reported being unable to access mental health care/counseling, and of these 62.5% reported an increase in stress as a result of not getting the service. Of the 47 respondents who reported not getting treatment or not following up for a specific health problem, 40.4% of

respondents said their condition got worse, and 31.9% said they had an increase in stress (see Table 31).

Table 31. LACHNA 2016: Impact of Gap in Utilization

Reason	Prescription Medication n=49	Routine Medical Care/ Check-Up n=41	Referral to a Specialist n=43	Mental Health Care/ Counseling n=40	Treatment/ Follow-up for Special Health Problem n=47
Condition Got Worse	26.5	12.2	25.6	15.0	40.4
Loss of Time from Work/ Other Activities	6.1	14.6	11.6	5.0	10.6
Increase in Stress	53.1	39.0	34.9	62.5	31.9
Other	8.2	22.0	20.9	5.0	12.8
No Impact	6.1	12.2	7.0	12.5	4.3

Views of Insurance Coverage

Respondents with insurance were asked several questions to assess their perceptions of their insurance coverage. Table 32 highlights respondents' rating of their insurance coverage at the time of the interview by whether they had changes in insurance coverage. The majority of respondents rated their insurance coverage at the time of the interview as either good (45.8%) or excellent (45.8%). A significantly lower proportion of respondents with changes in insurance coverage reported their insurance was excellent (37.4%) compared to those who had no changes in insurance coverage (60.9%). These data suggest that respondents who reported changes in their insurance coverage were less "satisfied" with their care than those who did not report changes.

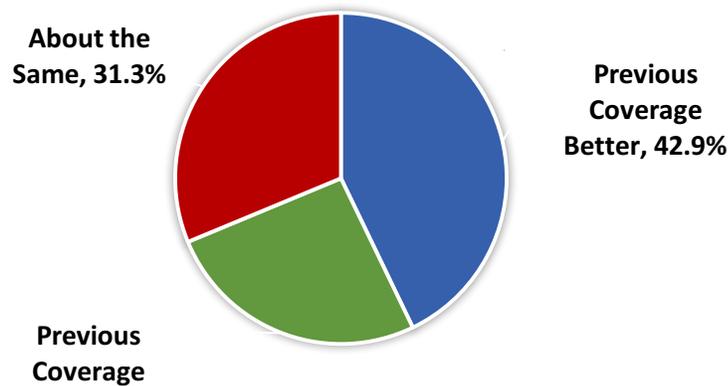
Table 32. LACHNA 2016: Rating of Current Insurance among Insured Respondents (n=231)

Rating	Rating of Current Insurance		No Changes in Coverage N=92		Changes in Coverage N=139	
	n	%	n	%	n	%
Excellent	108	46.8	56	60.9	52	37.4†
Good	103	44.6	32	34.8	71	51.1†
Not So Good/Poor	20	8.7	4	4.4	16	11.5

† p<.05

Insured respondents who reported experiencing changes in their insurance coverage were asked to compare their new coverage with their previous coverage. Forty-three percent of respondents reported that their previous coverage was better, while 31.3% reported it was about the same, and 25.9% reported the previous coverage was worse (see Figure 11). Again, note that as a result of a coding error in the survey, not all respondents with changes in coverage were asked the additional questions regarding access to services (n=49).

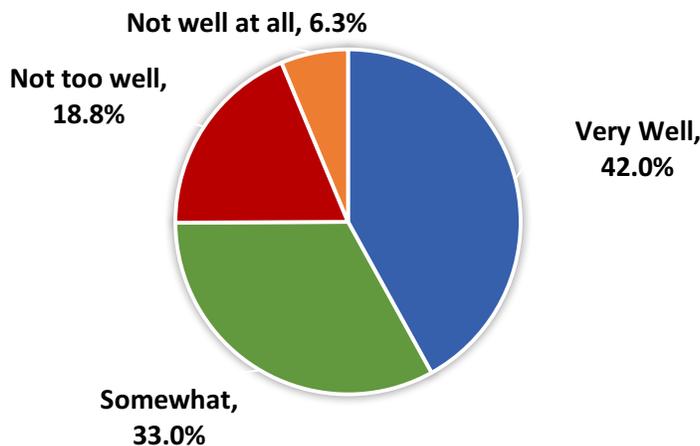
Figure 11: LACHNA 2016: Comparison of New Insurance Coverage to Previous Insurance Coverage (n=112)¹⁻²



¹ 49 respondents were not asked additional access questions due to a coding error in the survey. ² Missing=1.

Insured respondents who reported changes in insurance coverage were also asked how well they understood what healthcare services their new plan covered. Forty-two percent reported they understood their plans very well, while 58% reported they understood somewhat, not too well or not well at all (see Figure 12). This may be explained by the fact that individuals whose medical care was previously funded by RWP had shifted to insurance plans, which may have been a new experience, and their health insurance literacy may have been lower.

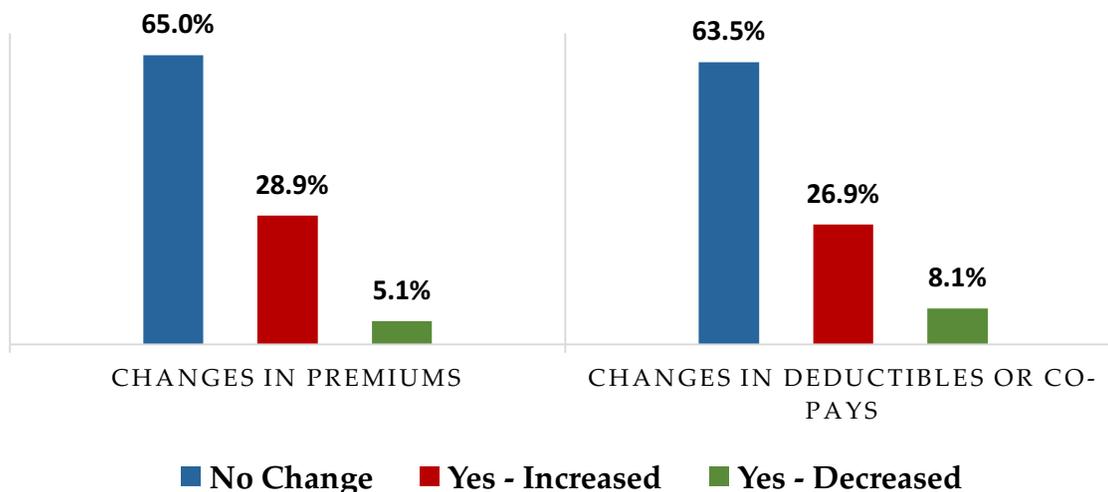
Figure 12. LACHNA 2016: Understand Healthcare Services Covered (n=112)¹⁻²



¹ 49 respondents were not asked additional access questions due to a coding error in the survey. ² Missing=1

The financial impact of changes in insurance coverage as a result of ACA was assessed among those respondents with insurance (see Figures 13 and 14). Figure 13 shows that the majority of respondents did not report any changes in the cost of deductibles/copays (63.5%) or premiums (65.0%).

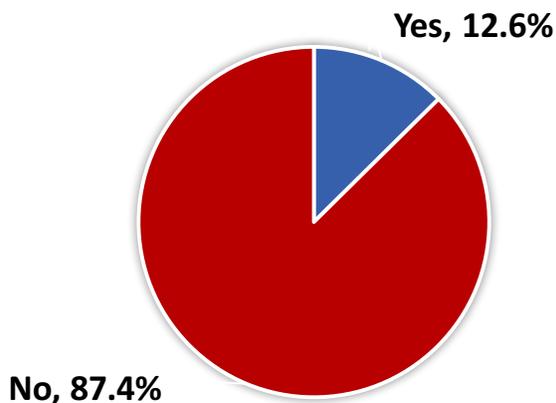
Figure 13. LACHNA 2016: Impact of ACA on Insurance Premiums and Co-pay¹ (n=197)



¹ Includes only those respondents who had health insurance coverage in 2012 and 2016.

In Figure 14, the majority (87.4%) of respondents reported that they had not needed to start paying share of cost expenses for Medi-Cal or Medicare as a result of changes to their insurance coverage.

Figure 14. LACHNA 2016: Had to Start Paying Medi-Cal or Medicare Share-of-Cost Expenses (n=119)^{1,2}



¹ Includes only those respondents who had Medi-Cal or Medicare coverage in 2012 and 2016.

² Don't know/refused=4.

Key Findings: Impact of ACA

- The majority of respondents were insured at time of interview (83%) with 61% Medi-Cal, 34% Private/HMO, and 29% Medicare.
- Overall, 59% (n=162) of all respondents reported any changes in insurance coverage from 2012 compared to 2016 that included:
 - Different type of insurance coverage in 2012 (n=103),
 - Changes to plan or coverage (n=139), or
 - Provider reported changes to respondent's insurance coverage (n=83).
- Among respondents who reported any changes in plan or coverage (n=139):
 - 35% reported enrolling in Medi-Cal.
 - 21% reported enrolling in Covered California.
- The proportion of uninsured respondents decreased from 25% in 2012 to 16% in 2016.
- Among all respondents, a higher proportion with changes to their insurance reported service gaps compared to those who did not (69% vs 55%).
 - Service gaps for oral health and mental health services were significantly higher among respondents with changes to their insurance compared to those with no change in insurance.
- The majority of respondents (64-65%) reported no change in medical expenses as a result of changes to their insurance. Among insured respondents:
 - 29% reported an increase in premiums.
 - 27% reported an increase in deductibles and/or co-pays.

LACHNA Strengths

- The initial sample of 1200 was simple to obtain through the use of existing resources (HARS).
- Using a novel sampling method, we were able to obtain a representative sample of patients with HIV in care – generalizable, or applicable, to adult PLWH in medical care and living in LAC.
- Because we sampled from eHARS, the sample included persons with multiple insurance types and in different systems of care to capture post-ACA migration patterns.

LACHNA Limitations

- Small sample size limited analysis by subgroups:
 - Transgender persons
 - Native Americans/Alaska Natives, Asians and Pacific Islanders
 - Unlike previous needs assessment, oversampling was not conducted.
- Majority of LACHNA respondents were in HIV care, so we cannot evaluate unmet need for medical care; however, this issue is addressed using multiple data sources in the 2015 Unmet Need Report.[37]
- Because the sample was selected from HARS, HIV-negative persons were not included; thus their prevention service utilization, needs, and gaps are not reflected here. Other data sources, including the National HIV Behavioral Surveillance, are more applicable to address these issues.
- Comparatively low response rate (24.8%)
 - Challenging and novel recruitment strategy using surveillance data
- Susceptible to recall bias
 - Responses based on respondent's recall of service utilization and need
- Needs Assessments are cross-sectional surveys
 - Difficult to determine cause and effect/temporality (e.g. does being uninsured result in poor mental health or does poor mental health result in being unable to enroll in or access health insurance.)

SUMMARY OF KEY FINDINGS

Overall, the demographic characteristics of LACHNA respondents were comparable to the target population. The majority of respondents were male (86%), 50 years of age and older (50%), Black or Latino/a (70%), identified as Homosexual, Gay or Lesbian (71%), and reported male-to-male sexual contact (70%) as their HIV transmission category. The largest proportion of respondents (37.9%) lived in the Metro area (SPA 4) and nearly half of respondents (48%) reported an annual household income of less than \$20,000. A third of respondents (31%) were employed full-time, and the majority reported stable housing (97%). Eighty-three percent of respondents reported having insurance coverage at the time of the interview, 96% had a current prescription to ART, and 84% were virally suppressed.

Patterns of utilization, need and gaps were similar to the previous LACHNA survey as well as other needs assessment data for LAC such as that found in the Medical Monitoring Project (MMP). Almost all respondents reported accessing medical care in the past 12 months (99.3%), and need was highest for Outpatient/Ambulatory Medical Care (99.6%), Oral Health Care (88.1%), and Vision Services (71.5%). Nearly one third (33.2%) of respondents who needed Oral Health Care, Vision Services (32.3%), and Medical Nutrition Therapy (35.7%) did not receive these services, and over half of respondents needing housing did not receive these services (58.5%). Latino and African American respondents had significantly higher service gaps compared to White respondents, and respondents who reported receiving their medical care at a RW clinic reported significantly more gaps in services than respondents at non-RW clinics (68.4% vs. 50.6%, respectively). Oral health continued to be the service with the most gaps, and respondents with gaps in Oral Health Care reported the most barriers (n=133) to services followed by respondents with gaps in Housing Services (n=119). The top main barrier and most common barrier was “Didn’t know where to go or whom to call” to access services.

To understand the impact of ACA, respondents were asked several questions. Overall, 59% (n=162) of respondents reported any changes in insurance/coverage from 2012-2016. Of the 162 respondents, 103 reported a different type of insurance in 2012 (n=103), 139 experienced any changes in plan or coverage, and 83 reported their provider told them about changes to their insurance coverage. Of the 139 respondents who reported any changes in plan or coverage, 35.3% reported enrolling in Medi-Cal and 20.9% reported enrolling in Covered California. Uninsured respondents decreased from 25% in 2012 to 16% in 2016, and a higher proportion of respondents with changes to their insurance reported service gaps compared to those who did not (69% vs 55%). The majority of respondents reported no change in expenses as a result of changes to their insurance; however, 29% of insured respondents reported an increase in premiums, and 27% of insured respondents reported an increase in deductibles and/or co-pays.

RECOMMENDATIONS

- LACHNA Respondents reported lack of awareness as the main barrier to accessing services for 5 out of the 6 services with the largest gaps.
 - Recommendation:
 - Increase consumer awareness of the availability of HIV support services within the RW.
 - Identify strategies to expand awareness of and access to HIV support services for PLWH outside of the RWP system.
 - Increase provider education to strengthen assessment of patient need to reduce service gaps.

- Approximately 16% of respondents were uninsured at time of interview. Among those insured over one-quarter reported an increase in premiums (29%) and/or deductibles or co-pays (27%) from 2012 to 2016.
 - Recommendation:
 - Increase provider and consumer education to maximize insurance benefits for PLWH in order to:
 - Reduce costs of premiums/deductibles/copays as a service barrier
 - Ensure all PLWH are receiving insurance coverage and services for which they are eligible.

- Although lack of awareness was the most commonly reported main barrier to accessing housing services (36%), almost half of respondents with a gap in this service (47%) reported “Waiting list is too long”, “In process of getting the service” or “Too many rules, regulations, paperwork or red tape” as the main barrier to accessing housing services.
 - Recommendation:
 - Consider innovative strategies to increase housing options to reduce wait time for needed services.

- Nearly 20% of respondents reported that they would be less likely to use condoms if they had an undetectable viral load (19.9%), knew their sex partner was on PrEP (19.1%), or knew partner was HIV positive (18.1%).
 - Recommendation:
 - Consider brief health education interventions for PLWH on HIV transmission risk related to viral suppression, PrEP use and condom use.

- The current assessment targeted in-care adult PLWH and focused on general LAC PLWH population. Persons at risk for HIV and PLWH who are out of medical care are not represented.
 - Recommendation:
 - Leverage existing surveillance studies in LAC to inform future needs assessment to include:

- Persons at risk for HIV in LAC who include MSM, persons who inject drugs and high-risk heterosexuals interviewed through the National HIV Behavioral Surveillance project to better inform HIV testing and prevention activities.
 - PLWH in LAC, including those who are out of medical care, interviewed through the Medical Monitoring Project.
- Small sample sizes among certain subgroups (e.g. Transgender persons, Native Americans/Alaska Natives, Asians and Pacific Islanders) limited our ability to conduct a comprehensive needs assessment within these populations.
 - Recommendation:
 - Address gaps in data with directed studies that target populations and/or service categories of interest.
 - Oral health services had the largest service gap and was identified as second most needed service after Outpatient/Ambulatory Medical Care.
 - Recommendation:
 - Strengthen provider capacity to assess of oral health needs of patients.
 - Provide targeted messaging to PLWH on how to better access to oral health services.
 - Consider an in-depth needs assessment specific to oral health.
 - Viral suppression is the most important outcome for PLWH, and a multitude of factors such as adherence to ART, engagement in HIV care, and determinants of health, can impact whether viral suppression is achieved. In addition, gaps in accessing needed services may also impact viral suppression.
 - Recommendation:
 - More complex analyses of LACHNA and other survey data are needed to better understand the impact of service gaps on viral suppression.

APPENDICES

Appendix A: Glossary of Terms

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
Adherence	Taking HIV medications as prescribed
ART	Anti-retroviral Therapy
CASI	Computer-Assisted Self Interview
Commission/COH	Los Angeles County Commission on HIV
Covered California	California’s official health care marketplace where individuals, families and small businesses can find low cost health insurance. [38]
Cross-sectional Study	Data collected from a population, or a representative subset, at one specific point in time
Disproportionate	Being out of proportion; too large or too small in relation to something.
DHSP	Division of HIV and STD Programs
eHARS	electronic HIV/AIDS Reporting System
FPG	Federal Poverty Guidelines
FY	Fiscal Year
HIPAA	Health Insurance Portability Authorization Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization. An organization that provides comprehensive health care to voluntarily enrolled individuals and families in a particular geographic area by member physicians with limited referral to outside specialists. [39]
HRSA	Health Resources and Services Administration
IRB	Institutional Review Board

LAC	Los Angeles County
LACHNA	Los Angeles Coordinated HIV Needs Assessment
Medi-Cal	California’s Medicaid program. Free or low-cost health coverage for children and adults with limited income and resources. [40]
MSM	Men who have sex with men
MSM/IDU	Men who have sex with men/Injection drug users
NHAS	National HIV/AIDS Strategy
nPEP	Non-occupational post-exposure prophylaxis
OA-HIPP	Program that pays monthly health, dental and vision insurance premiums for eligible clients and their family members.
PEP	Post-exposure prophylaxis. Taking anti-retroviral medicines after being potentially exposed to HIV to prevent becoming infected. [41]
PLWH	Persons living with HIV
PrEP	Pre-exposure prophylaxis. When people at very high risk for HIV take HIV medicines daily to lower their chances of getting infected. [42]
Representative Sample	When a small number of people accurately reflect the members of the larger population or sample.
RWP	Ryan White HIV/AIDS Program. Provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured.
Service Barrier	An obstacle to receiving a service.
Service Gap	When a service is needed but is not received.
SPA	Service Planning Area
STD	Sexually Transmitted Disease
Transgender	Term used to describe people whose gender identity differs from the sex the doctor marked on their birth certificate. [43]

Viral suppression

Viral suppression is a main goal of HIV treatment. Viral suppression occurs when viral load (amount of HIV in the blood) is less than 200 copies per milliliter of blood. [44]

Appendix B: Survey Methods

Sampling Methods

Study Design

The 2016 LACHNA survey used a cross-sectional study design to assess HIV care and prevention access and need among adult PLWH in HIV medical care in LAC.

Sampling and Eligibility

Respondents for LACHNA were selected using a two-stage sampling strategy to ensure a representative sample, meaning a sample for which results could be generalized, or applied, to all adult PLWH in HIV medical care in LAC, regardless of the system of care accessed.

The first stage involved identifying a representative sample of 1200 randomly selected PLWH in LAC from the 35,276 persons reported in HARS who: 1) were HIV-positive with a case report in the LAC HIV/AIDS Reporting System (HARS); 2) were age 18 years and older; and, 3) had at least one HIV laboratory test performed in LAC and reported in HARS from January 1 – December 31, 2014.

The second stage involved contacting potential respondents from the 1200 PLWH selected who were: 1) able to read and understand either English or Spanish; 2) currently living in LAC; and, 3) willing participate in the survey and able to provide written informed consent.

Recruitment Methods

The study staff used a number of internal and public record databases to obtain current HIV care facility and contact information for potential respondents that included: HARS, HIV Casewatch, STD Casewatch, Lexis-Nexis and the LAC Sheriff's Department Inmate Information Center. Potential respondents were recruited indirectly through HIV care or support service providers or directly with available contact information.

Enrollment

Study staff met with willing potential respondents at a mutually agreed upon location such as the respondent's clinic, providers' office or respondent's home, coffee shop, library, or DHSP offices, to obtain informed consent and administer the survey. Care was taken by the study staff to ensure that whatever location was agreed upon, it was secure and semi-private due to the sensitive nature of some survey questions. Respondents were compensated \$50 in gift cards to local stores (e.g., Ralph's, Target) for their time.

Sample Size

Power calculations were performed to determine a sample size sufficient to detect meaningful differences in service gaps. Results from the previous LACHNA study (2011) reported that among the 47 services assessed, the proportion of respondents reporting gaps for any individual service ranged between <1%-34%. Thus, using a maximum of 35% response distribution and given a recommended precision of $\pm 5\%$ and a 95% confidence level, a sample size of 350 would be sufficient to detect the largest gap identified in the LACHNA 2011 data.[45]

Based on findings from previous demonstration projects and research studies using this two-staged sampling methodology, it was estimated that we may be unable to locate and or/enroll up to 40% of sampled persons as a result of: 1) having invalid or outdated locator information; 2) the person having moved from the jurisdiction; 3) the person being deceased; or, 4) the person refusing to participate. To account for this, we oversampled by increasing the total initial sample drawn from 350 to 600 eligible persons which might yield a sample of 360. However, after attempting to reach the first sample of 600, we had a lower than expected response (n=141). Thus, a second sample of 600 was drawn, excluding those in the initial sample, to meet the target sample size of 350. The final sample was 277 which represented a precision of $\pm 5.7\%$ (margin of error), and a 95% confidence level at a response distribution of 35%. That is, the largest service gap we expected to see was 35% however the largest gap we observed in the data was 33%.

Informed Consent

All respondents signed an informed consent and Health Insurance Portability Authorization Act (HIPAA) authorization form approved by the institutional review boards (IRBs) at the participating service sites to ensure human subjects protections. Additionally, a certificate of confidentiality was obtained from HRSA to ensure respondent identities were protected to the fullest extent of the law.

Survey Instrument

Surveys were administered by trained interviewers in either English or Spanish on password-protected tablet computers using a computer-assisted survey instrument. The survey took approximately 45 minutes to complete and included: socio-demographics, HIV testing and care history, a general health assessment, health care utilization, insurance coverage, needs assessment (utilization, need, gaps, barriers), medication adherence, mental health, sexual behaviors, substance use, HIV prevention activities (e.g. PrEP, assessment of prevention activities), and social determinants.

Sampling Bias and Generalizability:

Several steps were taken to minimize potential sources of bias when possible. First, a random sample of PLWH was generated to ensure that an unbiased and representative sample of PLWH in care was selected. However, as was suggested in previous studies, the use of two-stage sampling yielded a low response (24.8%) which could have increased the likelihood of non-responder bias. Table 33 shows that our interviewed sample did not differ significantly from our target population and therefore yielded a representative sample. However, to evaluate whether any non-responder bias was introduced, we analyzed the demographic characteristics of non-participants (e.g. chose not to participate, unable to contact) and participants, and found non-participants did not differ significantly from those who did participate except among white respondents who declined significantly more than other races. As a result, these findings are generalizable or can be applied to all adult PLWH in HIV medical care in LAC.

To reduce interviewer bias, the survey was interviewer-administered using trained interviewers. While some interviewer bias may have been introduced, respondents completed the survey and encountered few problems as compared to our previous experiences with computer assisted self-interviews.

Study Sample Comparison

Table 33: LACHNA 2016 Study Sample Comparison

Variables	All PLWH in LAC ¹ N = 49,913		Target Population ² n = 35,276		Sample n = 1200		Interviewed n = 277	
	N	%	n	%	n	%	n	n
Gender								
Male	43,659	87.5	30,966	87.8	1,051	87.6	238	85.9
Female	5,575	11.2	3,812	10.8	128	10.7	34	12.3
Transgender	679	1.4	498	1.4	21	1.8	5	1.8
Age Group								
<18 years	79	0.2	N/A	N/A	N/A	N/A	N/A	N/A
18-29 years	4,223	8.5	2,828	8.0	105	8.8	17	6.1
30-39 years	9,056	18.1	6,210	17.6	214	17.8	43	15.5
40-49 years	14,223	28.5	10,014	28.4	341	28.4	78	28.2
50-59 years	15,462	31.0	11,287	32.0	371	30.9	88	31.8
60+ years	6,870	13.8	4,937	14.0	169	14.1	51	18.4
Race/Ethnicity								
Asian	1,695	3.4	1,248	3.5	35	2.9	4	1.4
White	15,786	31.6	11,602	32.9	386	32.2	76	27.4
African American	10,327	20.7	6,994	19.8	250	20.8	64	23.1
Latino	20,972	42.0	14,556	41.3	501	41.8	130	46.9
American Indian/ Alaska Native	262	0.5	180	0.5	6	0.5	0	-
Multi-race/ Unknown	871	1.8	696	1.1	22	1.8	3	1.1
Transmission Category								
MSM	38,513	77.2	24,607	69.8	845	70.4	194	70.0
IDU	2,712	5.4	1,201	3.4	37	3.1	12	4.3
MSM/IDU	3,105	6.2	2,066	5.9	68	5.7	17	6.1
Heterosexual Contact	5,162	10.3	2,243	6.4	71	5.9	17	6.1
Other	421	0.8	5,159	14.7	179	14.8	37	13.4
SPA								
Antelope Valley(1)	991	2.0	718	2.0	31	2.6	4	1.4
San Fernando(2)	7,103	14.2	5,263	14.9	190	15.8	34	12.3
San Gabriel(3)	3,525	7.1	2,654	7.5	90	7.5	22	7.9
Metro(4)	18,395	36.9	12,534	33.5	423	35.3	105	37.9
West(5)	2,541	5.1	1,763	5.0	57	4.8	11	4.0
South(6)	5,670	11.4	4,079	11.6	128	10.7	34	12.3
East(7)	3,369	6.8	2,512	7.1	86	7.2	24	8.7
South Bay(8)	7,848	15.7	5,477	15.5	183	15.3	41	14.8
Unknown(9)	471	0.9	276	0.8	13	1.0	2	0.7

¹ Source: 2015 HIV Surveillance Data as of 06/30/2015.

² Source: 2015 HIV Surveillance Data as of 06/30/2015. Includes a subset of PLWH that met the eligibility criteria.

Appendix C: Survey Instrument

The selection of the survey domains was guided by the previous work by the COH in collaboration with Roger Andersen to adapt his model of Health Services Use to the LAC HIV care continuum.[21-24]. The adapted model illustrates how individual and contextual determinants grouped as predisposing, enabling and need-based factors influence health behaviors ultimately impacting individual- and population-level key outcomes. Figure 15 below lists the selected survey domains and how they relate to service utilization and outcomes for the assessment of need in LAC.

Figure 15: Justification of Survey Domains

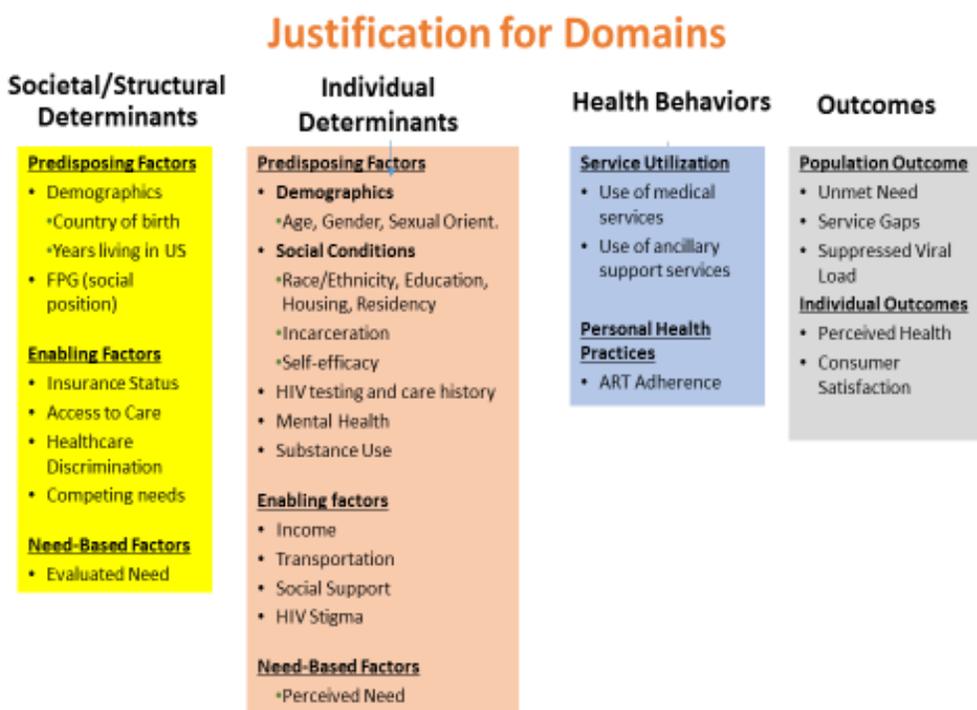


Table 34 provides data sources for questions utilized in each of the survey domains.

Table 34. LACHNA 2016 Survey Domains and Sources

Survey Domain	Source(s)
HIV Testing and Care History	<p>A. <u>HIV Testing and Care History</u></p> <ol style="list-style-type: none"> 1. Gardner, E.M., et al. The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. <i>Clin Infect Dis</i>. 2011; 52:793-800. 2. Centers for Disease Control and Prevention. Vital signs: HIV prevention through care and treatment--United States. <i>MMWR Morb Mortal Wkly Rep</i>. 2011; 60(47):1618-23.
Health Care Utilization	<p>A. <u>Current/Past Coverage</u></p> <ol style="list-style-type: none"> 1. The Henry J. Kaiser Family Foundation. Coverage Expansion and the Remaining Uninsured: A Look at California During Year One of ACA Implementation. 2015. Retrieved on July 9, 2015 from: http://files.kff.org/attachment/report-coverage-expansions-and-the-remaining-uninsured-a-look-at-california-during-year-one-of-aca-implementation. 2. Cunningham, W.E., et al. The prospective effect of access to medical care on health-related quality-of-life outcomes in patients with symptomatic HIV disease. <i>Med Care</i>. 1998; 36(3):295-306. (Access to Care Scale) <p>B. <u>Health Literacy</u></p> <ol style="list-style-type: none"> 1. Glass, T.R., et al. Longitudinal analysis of patterns and predictors of changes in self-reported adherence to antiretroviral therapy: Swiss HIV Cohort Study. <i>J Acquir Immune Defic Syndr</i>. 2010 Jun;54(2):197-203. 2. Katz, I.T., et al. Factors associated with lack of viral suppression at delivery among highly active antiretroviral therapy-naive women with HIV: a cohort study. <i>Ann Intern Med</i>. 2015 Jan 20;162(2):90-99.
Needs Assessment	<p>A. <u>Needs Assessment</u></p> <ol style="list-style-type: none"> 1. Division of HIV and STD Programs, Los Angeles County Department of Public Health and the Los Angeles County Commission on HIV. Los Angeles Coordinated HIV Needs Assessment-Care (LACHNA-Care): 2011 Final Report. December 2011:1-153. Retrieved on June 9, 2015 from: http://hivcommission-la.info/cms1_173837.pdf. 2. Dierst-Davies R, Wohl AR, Pinney G, Johnson CH, Vincent-Jones C & Pérez MJ. Methods to Obtain a Representative Sample of Ryan White-Funded Patients for a Needs Assessment in Los Angeles County: Results from a Replicable Approach. <i>J Int Assoc Provid AIDS Care</i>. 2015. [Epub ahead of print]
Medication Adherence	<p>A. <u>Medication Adherence</u></p> <ol style="list-style-type: none"> 1. Dieffenbach CW, Fauci AS. Thirty years of HIV and AIDS: future challenges and opportunities. <i>Ann Intern Med</i> 2011;154:766-771. (Adapted)

Survey Domain	Source(s)
	<ol style="list-style-type: none"> 2. Palella FJ Jr, Delaney KM, Moorman AC, Loveless MO, Fuhrer J, Satten GA, et al.; for the HIV Outpatient Study investigators. Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. <i>N Engl J Med</i> 1998; 338:853-860. (Adapted) 3. Jia Z, Ruan Y, Li Q, et al. Antiretroviral therapy to prevent HIV transmission in serodiscordant couples in China (2003-11): a national observational cohort study. <i>Lancet</i> 2012 Dec 1. 4. Conway B, Tossonian H. Comprehensive approaches to the diagnosis and treatment of HIV infection in the community: can ‘seek and treat’ really deliver? <i>Curr Infect Dis Rep</i> 2011;13:68-74. 5. CDC. Achievements in public health: reduction in perinatal transmission of HIV infection—United States, 1985–2005. <i>MMWR</i> 2006;55:592-597. 6. Townsend CL, Cortina-Borja M, Peckham CS, de Ruiter A, Lyall H, Tookey, PA. Low rates of mother-to-child transmission of HIV following effective pregnancy interventions in the United Kingdom and Ireland, 2000- 2006. <i>AIDS</i> 2008;22:973-981.
Sexual Risk Behaviors	<p>A. <u>Sexual Risk Behaviors</u> Survey questions were adopted and adapted from the last LACHNA survey and the MCC assessment.</p>
Mental Health	<p>A. <u>Mental Health</u> <ol style="list-style-type: none"> 1. Narrow, W. E., Clarke, D. E., Kuramoto, S. J., Kraemer, H. C., Kupfer, D. J., Greiner, L., & Regier, D. A. DSM-5 field trials in the United States and Canada, Part III: development and reliability testing of a cross-cutting symptom assessment for DSM-5. <i>American Journal of Psychiatry</i>, 2013;170(1):71-82. (23-item DSM-V Cross Cutting Symptom) </p>
Substance Use	<p>A. <u>Substance Use</u> <ol style="list-style-type: none"> 1. Wechsler, H., Nelson & T.F. Binge drinking and the American college students: What’s five drinks? <i>Psychology of Addictive Behaviors</i>. 2001;15(4):287-91. 2. Mdege, N.D., & Lang, J. Screening instruments for detecting illicit drug use/abuse that could be useful in general hospital wards: a systematic review. <i>Addict Behav</i>. 2011;36(12):1111-19. (Adapted - modified NIDA-ASSIST instrument) </p>
HIV Prevention Activities	<p>A. <u>PrEP and PEP Awareness</u> <ol style="list-style-type: none"> 1. Bauermeister, J.A., Meanley, S., Pingel, E., Soler, J.H. & Harper, G.W. PrEP awareness and perceived barriers among single young men who have sex with men. <i>Curr HIV Res</i>. 2013;11(7):520-7. 2. Liu, A.Y., Kittredge, P.V., Vittinghoff, E., Raymond, H.F., Ahrens, K., Matheson, T., Hecht, J., Klausner, J.D.& Buchbinder, S.P. Limited knowledge and use of HIV post- and pre-exposure prophylaxis among gay and bisexual men. <i>J Acquir Immune Defic Syndr</i>. 2008;47(2):241-7. </p>

Survey Domain	Source(s)
	<p>B. <u>HIV Prevention</u> Items from this section were adopted or adapted from the CDC funded Medical Monitoring Project.</p>
Social Determinants	<p>A. <u>Trauma</u></p> <ol style="list-style-type: none"> Schnurr, P.P., Spiro, A. III, Vielhauer, M.J., Findler, M.N., & Hamblen, J.L. Trauma in the lives of older men: findings from the Normative Aging Study. <i>J Clin Geropsychol.</i> 2002;8:175-187. (Brief Trauma Questionnaire) <p>B. <u>12-Item Internalized HIV Stigma Scale:</u></p> <ol style="list-style-type: none"> Sayles, J.N., et al. Development and psychometric assessment of a multidimensional measure of internalized HIV stigma in a sample of HIV-positive adults. <i>AIDS Behav.</i> 2008;12(5):748-758. <p>C. <u>HIV Discrimination Items</u></p> <ol style="list-style-type: none"> Katz, M.H., Cunningham, W.E., Mor, V., Andersen, R.M., Kellogg, T., Zierler, S. (2000). Prevalence and predictors of unmet need for supportive services among HIV-infected persons: impact of case management. <i>Medical Care</i>, 2000;38(1), 58-69. (Adapted - HCSUS study) Schuster MA, Collins R, Cunningham WE, Morton SC, Zierler S, Wong M, Tu W, Kanouse DE. Perceived discrimination in clinical care in a nationally representative sample of HIV-infected adults receiving health care. <i>J Gen Intern Med.</i> 2005;20(9):807-13. (HCSUS study)

Appendix D: Service Categories

Table 35 provides a description for each of the 16 service categories asked about within this survey.

Table 35. HRSA Service Category Descriptions

HRSA Service Category	Service Category Description*
Outpatient/Ambulatory Medical Care	<p>Diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting</p> <p>Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings</p>
Local AIDS Pharmaceutical Assistance	<p>Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or sub-recipient</p> <p>A supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria</p>

HRSA Service Category	Service Category Description*
Oral Health Care	Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.
Skilled Nursing**	<p>Skilled nursing facility services provide culturally competent nursing care to people living with HIV/AIDS who need 24-hour care in a residential home (non-institutional, home-like environment).</p> <p>Skilled nursing facility service care includes:</p> <ul style="list-style-type: none"> Residential services Medical supervision 24-hour skilled nursing and supportive care Pharmacy Dietary care Social/recreational services
Mental Health Services	Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.
Medical Nutrition Therapy	<p>Nutrition assessment and screening</p> <p>Dietary/nutritional evaluation</p> <p>Food and/or nutritional supplements per medical provider's recommendation</p> <p>Nutrition education and/or counseling</p>
Case Management (all forms)	<p>Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).</p> <p>Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face,</p>

HRSA Service Category	Service Category Description*
	phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient.
Emergency Financial Assistance	Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Food Bank/Home-Delivered Meals	Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following: <ul style="list-style-type: none"> Personal hygiene products Household cleaning supplies Water filtration/purification systems in communities where issues of water safety exist
Housing Services	Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services.
Medical Transportation Services	Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.
Psychosocial Support Services	Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include: <ul style="list-style-type: none"> Bereavement counseling Caregiver/respite support (RWHAP Part D) Child abuse and neglect counseling HIV support groups
Referrals for Health Care/Support Services	Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).
Rehabilitation Services	Rehabilitation Services are provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client’s quality of life and optimal capacity for self-care.

HRSA Service Category	Service Category Description*
Substance Abuse Treatment Services	<p>Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:</p> <ul style="list-style-type: none"> Screening Assessment Diagnosis, and/or treatment of substance use disorder, including: <ul style="list-style-type: none"> Pretreatment/recovery readiness programs Harm reduction Behavioral health counseling associated with substance use disorder Outpatient drug-free treatment and counseling Medication assisted therapy Neuro-psychiatric pharmaceuticals Relapse prevention <p>Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes:</p> <ul style="list-style-type: none"> Pretreatment/recovery readiness programs Harm reduction Behavioral health counseling associated with substance use disorder Medication assisted therapy Neuro-psychiatric pharmaceuticals Relapse prevention Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)
Vision Services	Core medical service that includes specialty ophthalmic and optometric services rendered by licensed providers.

*Source: Health Resources and Services Administration. Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds. http://hab.hrsa.gov/affordablecareact/service_category_pcn_16-02_final.pdf

** COH category. Not a HRSA Category.

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