

IV. General Findings from the Consumer and Provider Surveys

A. Distribution and Response

Consumer Surveys: The Planning Council delivered a total of 2,575 surveys (including 216 Spanish language surveys) to various sites throughout King County. Distribution sites included service agencies, offices of private medical care providers and private dentists. In addition, some surveys were distributed in various social venues and groups for PLWH in the broader community. The Planning Council received a total of 456 responses, for a return rate of 17.7% of surveys distributed to agencies. These surveys represent 7.7% of the estimated 5,900 PLWH in the county who are presumed to be aware of their serostatus. Twenty surveys were from respondents residing outside of King County and therefore considered invalid (not included in analysis). The return rate for Spanish language surveys (28/216; 13.0%) was lower than for English language surveys (428/2359; 18.1%).

Data from previous years suggests that approximately 60% of surveys distributed to agencies and providers were actually distributed to consumers. Considering the actual number of surveys distributed, the survey return rate for consumer surveys in 2005 would be 29.5% (456/1545).

In order to track return rates, the surveys were coded by distribution site. Table 3 shows a breakdown of survey returns by type of distribution site.

Table 3. Consumer Survey Returns by Distribution Site (N=456)

Type of Site	# Returned	% of Total
AIDS organizations/agencies	229	50%
Medical center or hospital clinics	93	20%
AIDS residential or care facilities	56	12%
Council member outreach	23	5%
Other social service agencies	15	3%
Public Health- Seattle & King County	11	2%
Private doctors' offices	11	2%
Community health center or clinics	9	2%
Substance use recovery programs	8	2%
Private dentists' offices	1	<1%
TOTAL	456	100%

Provider Surveys: The Planning Council delivered a total of 382 surveys to a wide spectrum of HIV/AIDS care providers throughout the county including: primary care providers, case managers, mental health and substance use treatment professionals,

private dentists and other social service providers. The Planning Council received a total of 188 valid responses, for a return rate of 49.2%.

Providers were asked to indicate the nature of the specific service(s) that they provided to persons living with HIV/AIDS. Table 4 shows a breakdown of surveys received from different types of service providers (note: 12 providers indicated providing multiple care services).

Table 4. Provider Survey Returns by Types of Services Provided

Service Provided	# Providers	% of Total
Western medical care	65	34.95%
Mental health therapy	31	16.67%
Case Management	26	13.98%
Housing assistance and/or services	17	9.14%
Emotional support programs	14	7.53%
Substance abuse/treatment counseling	14	7.53%
Adult day health programs	13	6.99%
Dental care	11	5.91%
Support services	8	4.30%
Client advocacy	5	2.69%
Treatment/adherence	5	2.69%
Alternative, non-Western therapies	2	1.08%
Other	12	6.45%
Multiple Services	12	6.45%
No answer	2	1.12%
	N=188	

B. Consumer Survey: General Demographics

Demographics of survey responses were compared to PLWH demographic estimates generated by Public Health’s HIV/AIDS Epidemiology Program in order to compare respondents with the overall population of PLWH in King County (Table 6).

While most demographic indicators were fairly representative of PLWH estimates in King County, there were higher percentages of our respondents that were persons of color. This is aligned with the project’s goal to over-sample traditionally under-served populations. Higher numbers of responses from smaller populations improve the representation of that respective group in analysis. The largest single response group was white MSM (53% of total) even though this population was under-sampled in comparison to King County estimates. However, there was a higher proportion of consumer respondents compared to King County estimates of PLWH that were Black/African American, Latino/Latina, Women, MSM/IDU, non-MSM IDU, and non-Seattle King County residents. Over the last four years there has also been a steady increase in age of respondents.

Sex: Males accounted for 86% of the survey responses, females for 13% and transgendered persons for 2% (all male-to-female). There was slightly less female representation in responses than when the same survey was conducted in 2003, but still a higher percentage than King County estimates of female PLWH. The overall prevalence estimates in King County are 90% male and 10% female. Females were significantly more likely to be Black/African American (35%), than Latino/Latina (5%), and White (5%).

Race: The survey asked respondents to check all applicable racial and ethnic categories. Black/African American and Latino categories were inclusive of both US and foreign born respondents. Response rates indicate that the survey effectively over-sampled persons of color as compared to the estimated King County PLWH population. The representation of those who identified themselves as non-White or mixed race is similar to the response in 2003, with a slightly lower Asian/Pacific Islander representation and a 4% increase in Black/African American respondents. Seventeen percent of the respondents identified as Black/African American (versus 16% of estimated PLWH), 13% Latino/Latina (9% of estimated PLWH), 3% American Indian/Alaska Native (2% of estimated PLWH), and 2% Asian/Pacific Islander (2% of estimated PLWH). Sixty-one percent of the respondents identified as white PLWH, compared to 71% of PLWH estimated in King County.

Black/African American respondents were significantly more likely to be recently incarcerated (30%), and recently homeless (28%). This may be a reflection of the over-representation of people of color (especially African Americans), incarcerated. Male respondents were significantly more likely to be White/Caucasian (66%) than were female respondents (27%). Female respondents were significantly more likely to be Black/African American (53%) than were male respondents (13%).

Place of residence: From the total sample (456 surveys) 20 consumers reported living outside of King County and were therefore excluded from analysis. 84% of survey respondents listed Seattle as their place of residence, up from 80% in 2003. Three percent live in East King County, 10% live in South King County, 4% live in North King County. Epidemiologic data estimates that 85% of reported King County PLWH were Seattle residents at the time of their diagnosis with 15% residing in other areas of the county. Again, the smaller populations residing outside of Seattle have been over-sampled.

Both injection drug users (82%), and those who use drugs but did not inject (88%) were significantly more likely to reside in Seattle than non-drug users (72%). Black/African American respondents were significantly less likely to reside in Seattle (68%) than Latino/Latina (80%) and White (82%). Black/African American respondents were significantly more likely to live in South King County (20%), than Latino/Latina (9%), and White (7%). Male respondents were significantly more likely to reside in Seattle (82%), than women respondents (62%). Women were significantly more likely to reside in South King County (26%), than male respondents (7%).

Age: The average survey respondent was older than the King County estimates of PLWH. Thirty-two percent of PLWH in the county were estimated to be between the ages of 14 and 29 at time of diagnosis, compared to only 6% of the survey respondents. Conversely, 25% of respondents were 30-39 as compared to 44% estimated in the county at time of diagnosis. 69% (42% ages 40-49, 27% ages 50 and over) of consumer respondents indicated an age of 40 or older compared to 24% (19% 40-49, 5% 50 and over) of the same age group estimated in King County at time of diagnosis. This reflects the aging Ryan White consumer population compared to the overall King County epidemiological data, which notes age at diagnosis. The age difference of the surveyed population is likely due to the fact that King County estimates of age reflect the age at diagnosis and with lowered mortality rates the population of PLWH is aging. Also, this difference may be due to the fact that younger persons living with HIV are generally less likely than older individuals to be aware of their serostatus, and thus would not have completed the survey. There have been very few pediatric (age 13 and under) cases reported locally. The project did not meet its goal to over-sample younger PLWH.

The aging trend can be seen through consumer demographics of the last three needs assessments conducted in 2001, 2003, and 2005 (Table 5). The percentage of respondents who did not indicate their age increased dramatically in 2005 (22%). With one in four respondents not indicating their age, the actual representation of the respondent's age for the consumer survey may vary considerably.

Table 5: Age of Consumer Respondents Over Time

Age of consumer respondents	2001%	2003%	2005%
13 and under	0	0	0
14-24	4%	3%	3%
25-29	6%	6%	3%
30-39	36%	31%	25%
40-49	32%	38%	42%
50 and over	15%	23%	27%
No answer	7%	2%	22%

Recently homeless respondents were significantly more likely to be younger. Twenty percent of the homeless respondents were either between the ages of 14-24, or 25-29 compared to only 3% of non-homeless respondents. Black/African American respondents were significantly more likely to be young (17%) between the ages of 14-29 than were Latino/Latina (4%) and White (3%) respondents. Women were significantly more likely to be between the ages of 25-29 (8%), than men (2%).

Exposure category: The consumer survey asked respondents to check all the potential modes of transmission that they believe might have been responsible for their HIV infection. Reflective of the epidemic pattern in King County, survey respondents were most likely to report HIV transmission due to male/male (MSM) sexual activity (59%).

While this was less than the estimate for King County (70%), there was an over-sample of MSM/IDU respondents (17%) compared to county estimates (9%), non-MSM Injection drug users (8% response compared to 6% county estimate), and heterosexual non-IDU respondents (12%) compared to county estimates (7%).

Primary language: Eighty-eight percent of consumer survey respondents reported English as their primary language, similar to 2003 (87%). Of the remaining 12% of the respondents in 2005, 8% were primarily Spanish speakers. The most common languages mentioned include a variety of African languages, including Swahili and Amharic. This is aligned with the overall increase in the epidemic among foreign-born black populations in Seattle/King County.

MSM of color respondents were significantly less likely to indicate English as their primary language (67%) than White MSM (99%). Latino/Latina respondents were significantly less likely to identify English as their primary language (34%), than were White (99%) and were Black/African American respondents (85%).

Born in the United States: Eighty-six percent of consumer survey respondents reported that they were born in the US and 14% were born in other countries. This was a higher representation of US born respondents than in 2003 (82%). In 2003, before “African born” was a racial category in this survey, there was some concern that African Americans checked this by mistake. Of the respondents who reported that they were not native to the US, 9% have lived in the US for less than two years, and 73% have lived in the US over 6 years.

MSM of color respondents were significantly more likely to be born outside of the US (35%) than White MSM (2%). Latino/Latina were significantly more likely to be born outside of the US (73%), than were Black (16%), and White (2%) respondents.

Ryan White CARE Act (RWCA) Service Eligibility: The consumer survey asked respondents to indicate their income level based on the most recent federal poverty level (FPL) income categories. With consideration of the number of dependents that lived with the respondent, 95% of the respondents indicated their household income was at or below 200% of the FPL (the eligibility criteria for RWCA services). This was an increase from the 68% of respondents in 2003. While non-RWCA eligible respondents were considered invalid responses, there was little (+/- 1%) to no variation in results with or without the inclusion of these cases and therefore they were included in the sample.

Nineteen percent of the respondents indicated that they had dependents living with them. This was almost double the percentage of respondents in 2003 (10%). This increase is likely a result from the change in the question being asked. In 2003, respondents indicated the “number of dependent children” living with them while in 2005 respondents indicated the “number of dependents” living with them (not exclusively children).

Recently homeless respondents were significantly more likely to have an income below \$19,140 (95%), than were not-homeless (76%) respondents. Injection drug users were significantly more likely to have an income below \$19,140 (88%), than were non-drug users (78%).

Other demographic indicators:

- Forty-eight percent of respondents reported having ever been diagnosed with a mental illness.
- Seventeen percent of respondents reported being homeless with no permanent place of residence within the past year (same as in 2003 and a 6% increase from 2001).
- Ten percent reported being in jail or prison in the past year (about what was found among respondents in 2003 and 2001).

Significant sub-population differences between the above indicators included:

- Injection drug users (61%) and drug users who do not inject (50%) are significantly more likely to be diagnosed with a mental illness than non-drug users (39%).
- Recently incarcerated respondents were significantly more likely to be homeless in the past year (51%) than non-incarcerated (14%).
- Both injection drug users (27%), and drug users who do not inject (22%) are significantly more likely to have been homeless in the past year than non-drug users (7%).
- Recently homeless respondents were significantly more likely to have been incarcerated in the past year (28%) than not-homeless respondents (6%).

The findings above illustrate the interaction and relationship between the most common co-morbidities for low-income PLWH struggling to navigate the HIV care system.

Table 6. Demographic Comparison of 2005 Consumer Survey Respondents and King County PLWH (Estimates)

Characteristics	Survey Respondents (N=436)20 invalid		KC PLWH Estimates (N=8,400)
	N	%	%
SEX (n=436)			
Male	373	86%	90%
Female	55	13%	10%
Transgendered (M-to-F)	8	2%	N/A
Transgendered (F-to-M)	0	----	N/A
RACE (n=436)			
American Indian/Alaska Native	14	3%	2%
Asian/Pacific Islander	7	2%	2%
Black/African-American	76	17%	16%
Latino/Latina	55	13%	9%
White/Caucasian	265	61%	71%
Other	1	<1%	N/A
Mixed race	18	4%	<1%
EXPOSURE CATEGORY (n=432)			
Male/male sex (non-IDU)	258	59%	70%
Injection drug use (non-MSM)	34	8%	6%
MSM and IDU	72	17%	9%
Heterosexual contact (non-IDU)	54	12%	7%
Transfusion/blood products	9	2%	1%
Don't know	31	7%	
Other	6	1%	7%
AGE (n=335)			
13 and under	0	----	----
14-24	10	3%	15-19: 2%
25-29	10	3%	72
30-39	85	25%	72
40-49	140	42%	72
50 and over	89	27%	72

SEXUAL ORIENTATION (n=432)			
Straight/heterosexual	98	23%	N/A
Gay or Lesbian	280	65%	N/A
Bisexual	42	10%	N/A
Other	12	3%	N/A
CLIENT INCOME (n=433)			
Less than \$19,140	346	80%	N/A
\$19,141 to \$25,660	36	8%	N/A
\$25,661 to \$32,180	19	4%	N/A
Greater than \$32,181	32	7%	N/A
RESIDENCE (n=436)			
Seattle	364	84%	86%
East King County	14	3%	
South King County	42	10%	15% Other
North King County	16	4%	
Other (20 other → excluded)	0	0%	
PRIMARY LANGUAGE (n=435)			
English	384	88%	N/A
Spanish	33	8%	
Other	19	4%	
BORN IN THE UNITED STATES (n=434)			
Yes	374	86%	84%
No	60	14%	11%
More than 10 years	25	57%	Unknown:
OTHER DEMOGRAPHIC CHARACTERISTICS (n=436)			
Diagnosed with mental illness	205	48%	N/A
Have dependents (n=380)	74	19%	N/A
Homeless (current or past year)	75	17%	N/A
In jail or prison (current or past	42	10%	N/A

C. Consumer Survey: Medical and Health Indicators

The consumer survey asked respondents about a variety of HIV-related medical and other health indicators including mental health and substance use (Table 7). This information offers additional insights about the HIV health status of the consumers who responded to the survey, as well as providing information about the extent of other co-morbidities in the cohort that may impact their overall health.

TABLE 7

2005 CONSUMER SURVEY: MEDICAL AND HEALTH INDICATORS		
	N	%
DOCTOR CERTIFIED AS AIDS DISABLED (n=432)		
Yes	232	54%
No	148	34%
Don't know	52	12%
LAST T-CELL COUNT (n=411)		
Under 200	69	17%
201 – 500	134	33%
Over 500	105	26%
Don't know	104	24%
LAST VIRAL LOAD (n=409)		
Undetectable/below 70	165	40%
Between 70 – 1000	35	9%
1001 – 10,000	33	9%
10,001 – 100,000	34	9%
Over 100,000	6	2%
Don't know	134	31%
HIV MEDICATIONS (n=435)		
Taking antiviral medications	323	74%
Taking meds to treat or prevent OI's	123	28%
Taking meds to manage HIV side	124	28%
FREQUENCY OF PROVIDER VISITS (n=435)		
Never	5	1%
Once a year	7	2%
Twice a year	32	7%
Three or more times a year	385	89%
Satisfied with provider visits (n=327)	306	94%

INJECTION DRUG USE HISTORY (n=436)				
Injection drug use in past 12 months		49	11%	
<i>INJECTION VERSUS NON-INJECTION DRUG USE (n=436)</i>				
DRUG NAME		% INJ	%NON-	%BOT
Cocaine	15%	3%	11%	1%
Heroin	7%	5%	2%	<1%
Methamphetamine	19%	7%	10%	3%
GHB/K/Party drugs	6%	1%	4%	<1%
Downers	2%	NA	2%	NA
Poppers/inhalants	13%	NA	13%	NA
Ecstasy	5%	NA	5%	NA
Marijuana	30%	NA	30%	NA

AIDS disability: The consumer survey asked respondents to indicate if their doctor certified them as AIDS disabled. Fifty-four percent of respondents reported being certified as AIDS disabled, a decrease from the 61% of respondents that indicated certification in 2003. Thirty-four percent of respondents reported they were not certified as AIDS disabled, similar to the 31% in 2003. In 2005, 12% of respondents did not know if they had been certified as AIDS disabled, an increase from the 8% of respondents in 2003. AIDS disability certification is required for some types of housing.

Unlike previous years, race was a significant factor in relation to AIDS disability. MSM of color respondents were significantly more likely to not know if they were disabled by AIDS (17%) than White MSM (10%) and non-MSM (10%). Black/African American respondents were significantly less likely to know if they were disabled with AIDS (21%) than Latino/Latina (11%) and White (9%) respondents. By contrast, White respondents were significantly more likely to be disabled by AIDS (58%), than Black/African American (35%), and Latino/Latina (26%) respondents. This may be due to the significantly higher percentage of White consumer respondents that knew of their AIDS disability certification, and/or the demographic changes in the epidemic over time.

Latest T-cell counts: With regards to T-cell counts, race, gender, incarceration, and homelessness were all significant demographic correlates. MSM of color respondents were significantly less likely to know their T-cell count (34% did not know), than White MSM (17% did not know). Recently incarcerated respondents were significantly more likely to have a T-cell count of less than 200 (46%) than non-incarcerated respondents (20%). Recently incarcerated respondents were significantly less likely to know their T-cell count (37% did not know) than non-incarcerated respondents (23% did not know). Recently homeless respondents were significantly more likely to have a T-cell count under 200 (34%) than not-homeless respondents (17%). Female respondents were significantly more likely to *not* know their T-cell count (44%), than male respondents (23%).

Seventeen percent of consumer respondents reported having a T-cell count under 200, a decrease from the 25% of respondents in 2003. A T-cell count under 200 is the clinical marker for AIDS diagnoses. Thirty-three percent reported having T-cell counts between 201-500, and 25% with T-cell counts over 500. Both of these percentages represent an improvement from 2003 when 45% of respondents reported having T-cell counts in the 201-500 range, and 19% over 500. However, similar to the findings of AIDS disability status, 24% of consumers did not know the results of their most recent T-cell test, a significant increase from the 11% that indicated the same in 2003.

Latest viral loads: Just as with T-cell counts, incarceration and homelessness were significant factors for viral load status. Recently incarcerated respondents were significantly less likely to know their viral load (52% did not know) than non-incarcerated respondents (28% did not know). Recently incarcerated respondents were significantly more likely to have a viral load greater than 10,000 (25%), and significantly less likely to have a viral load that was undetectable (45%) than non-incarcerated respondents (13%, and 61% respectively). Recently homeless respondents were significantly more likely to not know their viral load (43%) than not-homeless respondents (28%). Recently homeless respondents were also significantly less likely to have an undetectable viral load (42%) than not-homeless (63%), and significantly more likely to have a viral load above 10,000 (29%) than not-homeless respondents (13%). Unlike t-cell counts, women were as likely to know their viral load as men.

Forty percent of consumer respondents reported having undetectable viral loads. Nine percent reported having viral loads between 70-1000; 9% reported viral loads between 1001-10,000. Nine percent had viral loads of 10,001-100,000 and 2% reported having viral loads above 100,000. Just as with the other medical indicators (T-cell count, and AIDS disability certification), there was a significant increase in the numbers of respondents who did not know their viral loads; 11% in 2003 to 31% in 2005.

HIV medications: Seventy-four percent of respondents indicated taking some form of antiviral medication, similar to the 72% of respondents in 2003. In contrast, the percentage of respondents taking drugs to treat or prevent opportunistic infections decreased from 37% in 2003 to 28% in 2005 and the percentage of respondents taking drugs to manage HIV side effects decreased from 38% in 2003 to 28% in 2005. Over the past six years the percentage of consumer respondents taking antiretroviral medications has remained on average between 70-74%. However, other types of HIV-related medications show a decreasing trend over time (Table 8). With the exception of 2001 (when “hit hard, hit early” was the catch phrase) use of antiviral medications has slowly and steadily increased over time.

Table 8: Consumer Medication Status Over Time

Type of HIV-Related Medication	1999	2001	2003	2005
Antiretroviral medications	69%	79%	72%	74%
Medications to treat/prevent OI	54%	43%	37%	28%
Medication to manage side-effects	51%	---*	38%	28%

*Note: in 2001 medication to manage side-effects was not assessed on the consumer survey.

Significant consumer demographic characteristics relating to differences in taking HIV medications included incarceration, homelessness, race, and drug use. Recently incarcerated respondents were significantly less likely to be taking antiviral medications (58%) and were more likely to be taking meds for opportunistic infections than non-incarcerated individuals (35%). MSM of Color respondents were significantly less likely to be taking medications for side-effects (25%), than White MSM (35%). Recently homeless respondents are significantly less likely to be taking antivirals (57%) and medication for opportunistic infections (19%) than not-homeless (78% and 31% respectively). Injection drug users were significantly less likely to be taking antiviral medications (63%) than both drug users who do not inject (74%), and non-drug users (81%).

D. Provider Survey: Client Demographics

The survey asked providers about the total number of clients with HIV/AIDS on their active caseload and asked them to characterize their HIV/AIDS clientele by several demographic indicators. Averaging valid responses from all returned surveys derived percentages for each of the demographic characteristics. Based on response to these demographic questions, the client population served by provider survey respondents is fairly representative of PLWH in King County (Table 9). Efforts to over-sample among providers who serve women, persons of color, MSM/IDU, and non-MSM were successful based on demographic frequencies. It is important to note that King County estimates only include those who are diagnosed in King County, and do not account for in and out migration.

Total caseload: The average caseload reported by all types of providers is 115 clients, with a range of one to 1,052. Among the most common provider types, primary medical care providers (n=65) reported an average caseload of 99 (range 5 to 500), mental health providers (n=31) reported an average caseload of 33, and case managers (n=26) reported an average caseload of 137. While the average caseloads for medical providers and mental health providers decreased from 2003, there was a dramatic increase in the average caseloads reported by case managers, from 78 in 2003 to 137 in 2005 (76% increase).

Sex: The average client caseload among provider respondents was 82% male, 16% female, and 1% transgendered. These figures are similar to those reported by providers in 2001, and 2003.

Race: The racial breakdown of the average provider caseload was 64% White and 36% persons of color, as compared to King County PLWH estimates of 71% and 29% respectively, thus the provider respondents over-sampled clients that were People of Color. This is about the same percentage of providers' clients that were persons of color in 2003 (35%).

Age: Similar to consumer survey percentages, providers were more likely to be serving clients over the age of 40 and less likely to be serving those 39 and younger. The aging trend found in the consumer survey was also apparent in provider's average caseloads from 2003 when 42% of clients were over the age of 40, to 53% of clients in 2005. Once again, King County estimates of age are reflective of age at diagnosis which may also account for the age variation in our sample.

Exposure category: The survey asked providers to classify their clients by primary modes of HIV exposure. Providers reported that 51% of their clients were exposed through male/male sex, with an additional 18% of clients dually exposed through MSM contact and injection drug use. King County estimates for these populations are 70% and 9% respectively. Not only are providers serving a disproportionate number of MSM/IDU compared to King County estimates, there has been an increasing trend in the average caseloads of MSM/IDU: 2001 (9%); 2003 (13%); 2005 (18%). It is important to note that King County estimates refer to mode of HIV exposure at diagnosis, while providers are indicating current or recent behavior of clients in their caseloads.

Similar to 2003, 12% of provider caseloads were reported as primarily exposed through injection drug use (KC estimate: 6%). Providers reported a substantially higher percentage of clients exposed through heterosexual contact (15%). Not only is this double the King County estimate (7%), but also an increase from 2003 in which providers reported 9% of their clients were exposed to HIV through heterosexual contact.

Place of residence: Providers reported seeing a higher percentage of clients from the areas of King County which are outside of Seattle than appear in King County PLWH estimates. This trend has been apparent over the last four years from provider surveys. The percent of clients reported living outside of Seattle has increased from 23% in 2001 and 29% in 2003, to 36% in 2005. The non-Seattle residence of provider caseloads include 5% from East King County, 9% from South King County, and 6% from North King County. The most significant difference in residence over the past two years is King County providers reporting that 15% of their caseloads are consumers who live outside of King County. This is an increase from 6% in 2003.

Primary Language: Providers reported that 91% of their clients are primarily English speaking, with 8% Spanish-speaking and 2% being primary speakers of other languages. This represents a slight decrease in non-English speaking clients reported in 2003 (11%). The most common other languages spoken by clients were various African languages including Amharic, and Swahili. There is an increasing trend of the number of providers that report seeing one or more clients who were primary speakers of languages other than

English or Spanish: 2001(17% of providers), 2003 (23% of providers), to 2005 (28% of providers).

Other demographic indicators: On average, providers reported no significant changes in the percentages of clients who were homeless, diagnosed with mental illness, and/or had a history of chemical dependency. The provider interviews emphasized the severity of these co-morbidities beyond the percentages noted below.

Table 9: Demographic Comparison of 2005 Provider Survey Client Demographics and King County PLWH Estimates

Characteristics	Client Demographics From Provider Surveys(N=188)	KC PLWH Estimates (N=8,400)
Average client caseload = 115 (range 1 to 1052)		
SEX (N~180)		
Male	82%	90%
Female	16%	10%
Transgendered (M-to-F)	1%	
Transgendered (F-to-M)	<1%	
RACE (N~174)		
Black/African American	17%	16%
American Indian/Alaska Native	3%	2%
Asian	3%	2%
Latino/Latina	11%	9%
White/Caucasian	64%	71%
Other	3%	
AGE (N~178)		
<13	<1%	0%
13-24	4%	12%
25-29	13%	20%
30-39	30%	44%
40-49	38%	19%
50 and over	15%	5%

Characteristics	Client Demographics From Provider Surveys(N=188)	KC PLWH Estimates (N=8,400)
EXPOSURE CATEGORY (N~160)		
MSM	51%	70%
Injection drug use (non-MSM)	12%	6%
IDU and MSM	18%	9%
Heterosexual contact (non-IDU)	15%	7%
Perinatal/Blood/Other	4%	1%
PLACE OF RESIDENCE (N~180)		
Seattle	64%	86%
East King County	5%	Other KC: 15%
South King County	9%	
North King County	6%	
Outside King County	13%	
PRIMARY LANGUAGE (N~180)		
English	91%	N/A
Spanish	8%	N/A
Other	2%	N/A
OTHER DEMOGRAPHIC CHARACTERISTICS (N~169)		
Homeless (in past year)	17%	N/A
In jail or prison (in past year)	8%	N/A
Hx. Of chemical dependency	39%	N/A
Diagnosed w/mental illness	35%	N/A

E. Service Priorities

Consumer-identified priorities: The consumer survey included a one-page list of the 28 types of HIV/AIDS-related services offered in the King County Continuum of Care. The survey asked consumers to identify up to seven services that they considered most important in helping them cope with HIV/AIDS-related health issues (“service priorities”). Responses were collapsed into the 20 Planning Council-identified RWCA service categories shown below, and ranked by overall percentage of response. Table 10 includes cumulative responses of service priorities.

TABLE 10 CONSUMER SERVICE PRIORITIES RANK (N=436, 20 invalid cases)		
Rank	Ryan White Funding Category	%
1	Case Management	69%
2	Ambulatory/outpatient medical care	64%
3	AIDS Drug Assistance Program	63%
4	Oral health care	62%
5	Food bank/home delivered meals	55%
6	Housing assistance/related services	47%
7	Mental Health Services	34%
8	Psychosocial support	30%
9	Alternative, non-Western therapies	28%
10	Treatment adherence support	22%
11	Transportation	21%
12	Emergency financial assistance	18%
13	Legal services	17%
14	Day/respite care for adults	14%
15(tie)	Referral for health care services	12%
15(tie)	Substance abuse services	12%
17	Client advocacy	11%
18(tie)	Home health care	9%
18(tie)	Health education/risk reduction	9%
20	Child care	4%

HRSA currently defines core services to be: ambulatory/outpatient medical care, oral healthcare, case management, mental health services, substance abuse services, and AIDS Drug Assistance Program. Consumers ranked four core services in the top five service priorities in 2005. Case management was the highest service priority, with 69% of respondents indicating that it was a priority for them. Case management was followed by ambulatory/outpatient medical care, AIDS Drug Assistance Program (ADAP), oral health care and food bank/home delivered meals. Among the component services within the food/bank home delivered meals category, consumers were much more likely to prioritize bags of groceries (42%), than emergency grocery vouchers (21%) or prepared meals (21%).

Sub-population differences for consumer service priorities: There was a lot of variation by sub-populations in ranking service priorities. Table 10 lists the sub-populations that indicated significantly higher priorities for care services.

When consumer data are viewed by exposure category, there were significantly different priorities for IDU and MSM than for the sample as a whole. IDU (non-MSM) were significantly more likely to prioritize client advocacy and housing assistance/related services. Among MSM respondents, there were three sub-population differences in priorities:

- White MSM were significantly more likely to prioritize ambulatory/outpatient medical care, and mental health services.
- MSM/IDU were significantly more likely to prioritize food bank/home-delivered meals, housing assistance/related services, day/respice care for adults, and client advocacy.
- MSM of Color were significantly more likely to prioritize housing assistance/related services, and substance abuse services.

In addition to race being a differential factor for MSM, there were also overall consumer racial differences in setting priorities:

- Black/African American respondents were significantly more likely to prioritize food bank/home-delivered meals, housing assistance/related services, treatment adherence support, emergency financial assistance, legal services, and child care.
- Latino/Latina respondents were significantly more likely to prioritize client advocacy, and emergency financial assistance.
- Respondents that were not born in the US, of which 92% were non-White, were significantly more likely to prioritize legal services and substance abuse services.

Gender differences in priorities were also apparent. Women were significantly more likely than men to prioritize psychosocial support, emergency financial assistance, home health care, and child care.

Description of some of the potential sub-population differences is provided in each of the chapters in Part V that highlight survey comments and consumer focus group responses to all service categories and HRSA defined core services for PLWH.

Table 11: Consumer Service Priority Rankings With Significant Sub-Population Differences (Collapsed into Ryan White funding categories, N=436)

Rank	Service	#	%	Significantly HIGHER priority for...
1	Case management	310	69%	
2	Ambulatory/outpatient medical care	290	64%	White MSM (72%)
3	AIDS Drug Assistance Program	285	63%	
4	Oral health care	280	62%	
5	Food bank/home-delivered meals	250	55%	MSM/IDU (66%), Black (65%)
6	Housing assistance/related services	210	47%	Homeless (72%), Incarcerated (65%), MSM/IDU (64%), IDU (59%), MSM of Color (58%), Black (68%)
7	Mental health services	156	34%	White MSM (42%)
8	Psychosocial support	139	30%	Women (42%)
9	Alternative, non-Western therapies	130	28%	
10	Treatment adherence support	105	22%	Black (34%)
11	Transportation	98	21%	
12	Emergency financial assistance	84	18%	Incarcerated (30%), Women (31%), Black (29%), Latino/a (29%)
13	Legal services	79	17%	Foreign Born (29%), Black (31%)
14	Day/respice care for adults	66	14%	MSM/IDU (23%)
15(tie)	Referral for health care services	57	12%	
15(tie)	Substance abuse services	55	12%	Foreign Born (21%), MSM of Color (17%)
17	Client Advocacy	53	11%	Incarcerated (23%), MSM/IDU (30%), IDU (27%), Latino/a (25%)
18(tie)	Home health care	39	9%	Women (16%)
18(tie)	Health education/risk reduction	39	9%	
20	Child care	17	4%	Women (22%), Black (13%)

In addition to the sub-population differences listed above, AIDS-related disability status was also a significant variable to consumer priorities. Respondents who indicated that their doctor certified them as AIDS disabled, were significantly more likely than non-AIDS disabled respondents to prioritize case management, ambulatory/outpatient medical care, adult day healthcare, transportation, home health care, and prepared meals (a subcategory within food bank/home-delivered meals).

Comparison between 2003 and 2005 consumer service priorities: Table 12 illustrates the change in percentages of consumers prioritizing RWCA services from 2003 to 2005. There were quite a few small percentage changes (+/- 5%), and only two of the twenty service categories had significant increases or decreases in priority (bolded in Table 12). Case management has the most significant increase in priority (up 3 in rank and 11%) from 2003 and has increased in consumer priority over the past four years (50% in 2001; 57% in 2003; and 69% in 2005). Treatment adherence support tied for the second highest percentage increase (+5%) along with Alternative, non-Western therapies, Food bank/home delivered meals, and Substance abuse services. Conversely, emergency financial assistance was the only service category with a significant decrease (a 10% decrease and a drop of 2 in rank).

TABLE 12: CONSUMER SERVICE PRIORITIES CHANGE 2003 → 2005 (N=436, 20 invalid cases)			
Ryan White Funding Category	2003% (N=467)	2005% (N=436)	% Change
Case Management	57%	69%	+11%
Treatment adherence support	17%	22%	+5%
Alternative, non-Western therapies	23%	28%	+5%
Food bank/home delivered meals	50%	55%	+5%
Substance abuse services	7%	12%	+5%
Mental Health Services	30%	34%	+4%
AIDS Drug Assistance Program	59%	63%	+4%
Home health care	5%	9%	+4%
Health education/risk reduction	5%	9%	+4%
Day/respite care for adults	11%	14%	+3%
Transportation	18%	21%	+3%
Referral for health care services	10%	12%	+2%
Oral health care	61%	62%	+1%
Client advocacy	11%	11%	0%
Child care	4%	4%	0%
Psychosocial support	32%	30%	-2%
Ambulatory/outpatient medical care	66%	64%	-2%
Legal services	20%	17%	-3%
Housing assistance/related services	50%	47%	-3%
Emergency financial assistance	28%	18%	-10%

Provider-identified service priorities: The provider survey included the same one-page list of 28 types of HIV/AIDS-related services as was included in the consumer version. The survey asked each responding provider to identify up to seven services that they considered most important in helping their clients cope with HIV/AIDS-related health issues. Responses were collapsed into the 20 Planning Council-identified Ryan White service categories for analysis and reporting purposes. Table 13 reports cumulative responses of provider priorities.

Table 13		
2005 Provider Service Priorities Ranking		
(N=187; 1 invalid case)		
Rank	Ryan White Funding Category	%
1	Case management	83%
2	Ambulatory/outpatient medical care	71%
3	Mental health services	66%
4	AIDS drug assistance program	65%
5	Substance abuse services	62%
6	Housing assistance/related services	46%
7	Treatment adherence support	37%
8	Day/respite care for adults	30%
9	Psychosocial support	29%
10(tie)	Transportation	28%
10(tie)	Oral Healthcare	28%
12	Food bank/home delivered meals	18%
13	Health education/risk reduction	12%
14	Alternative, non-Western therapies	11%
15	Client advocacy	7%
16	Referral for health care services	5%
17	Home health care	4%
18	Legal services	4%
19(tie)	Childcare	2%
19(tie)	Emergency financial assistance	2%

In order to ensure that provider-identified priorities were not biased by over-sampling certain types of providers, additional analysis was conducted controlling for provider type. Analysis of provider respondents revealed that seven service provider types were significantly more likely to prioritize a service which they provided (conflict of interest).

However, there is not a significant variation in the results for service priorities based on conflict of interest for the providers mentioned above because of the smaller numbers of these providers out of the total sample. The largest variation occurs with mental health providers because they were a substantial portion of the total sample. Even when corrected for potential conflict, mental health services showed no significant change in priority from 2003.

Just like consumer respondents, providers ranked case management as the highest service priority for their clients, followed by ambulatory/outpatient medical care, mental health services, ADAP/insurance, and substance abuse services. Among the components of the ADAP service category, AIDS Drug Assistance Program was prioritized much higher (60% of providers) than health insurance (28% of providers). Among the components of substance abuse services, drug/alcohol counseling and treatment was prioritized by a significantly greater proportion of providers (59%) than methadone vouchers (11%).

Comparison between 2003 and 2005 provider-identified service priorities: Provider priority rankings and percentages only reflected significant changes to two service categories over the past two years (table 14). Substance abuse services had the most significant increase in percentage (up 28% from 2003), making it a top five service priority for providers. Similar to consumers, treatment adherence support reflected the second highest percentage increase (+9%). Health education/risk reduction had a 4% increase in priority and the largest rank increase (up 4 in rank from 2003). Transportation (+7%) and oral health care (+5%) also reflected an increase in priority for providers.

ADAP was the only service category with a significant decrease in priority for providers (down 11% from 2003). However, even with this decrease in percentage of providers who prioritized this service, ADAP was still ranked as a top five service priority.

TABLE 14: PROVIDER SERVICE PRIORITIES CHANGE 2003 → 2005			
Ryan White Funding Category	2003%\ (N=178)	2005%\ (N=187)	%CHANGE
Substance abuse services	34%	62%	+28%
Treatment adherence support	28%	37%	+9%
Transportation	21%	28%	+7%
Oral Healthcare	23%	28%	+5%
Psychosocial support	25%	29%	+4%
Health education/risk reduction	8%	12%	+4%
Case management	81%	83%	+2%
Food bank/home delivered meals	17%	18%	+1%
Referral for health care services	5%	5%	0
Home health care	4%	4%	0
Legal services	4%	4%	0
Childcare	2%	2%	0
Ambulatory/outpatient medical care	72%	71%	-1%
Mental health services	67%	66%	-1%
Day/respite care for adults	31%	30%	-1%
Alternative, non-Western therapies	12%	11%	-1%
Housing assistance/related services	47%	46%	-1%
Client advocacy	8%	7%	-1%
Emergency financial assistance	4%	2%	-2%
AIDS drug assistance program	76%	65%	-11%

Comparison between 2005 consumer and provider service priorities: Comparisons between percentages of consumer and provider responses yield significant differences for ten RWCA service categories in service priorities (Table 15). Nine service categories also reflect a difference in rank between providers and consumers of greater than three.

**Table 15: Comparison Between 2005
Consumer and Provider-Identified Service Priorities**

Service	Consumer (N=436)		Providers (N=187)	
	Rank	%	Rank	%
Case management	1	69%	1	83%
Ambulatory/outpatient medical care	2	64%	2	71%
AIDS Drug Assistance Program	3	63%	4	65%
Oral health care	4	62%	10 (tie)	28%
Food bank/home-delivered meals	5	55%	12	18%
Housing assistance/related services	6	47%	6	46%
Mental health services	7	34%	3	66%
Psychosocial support	8	30%	9	29%
Alternative, non-Western therapies	9	28%	14	11%
Treatment adherence support	10	22%	7	37%
Transportation	11	21%	10 (tie)	28%
Emergency financial assistance	12	18%	19 (tie)	2%
Legal services	13	17%	18	4%
Day/respite care for adults	14	14%	8	30%
Referral for health care services	15(tie)	12%	16	5%
Substance abuse services	15(tie)	12%	5	62%
Client Advocacy	17	11%	15	7%
Home health care	18 (tie)	9%	17	4%
Health education/risk reduction	18 (tie)	9%	13	12%
Child care	20	4%	19(tie)	2%

Providers were significantly more likely than consumers to prioritize substance abuse services (50% more and 10 higher in rank), mental health services (32% more and 4 higher in rank), day/respite care for adults (16% more and 6 higher in rank), case management (14% more and same rank), and treatment adherence support (15% more

and 3 higher in rank). Consumers were significantly more likely than providers to prioritize food bank/home delivered meals (37% more and 7 higher in rank), oral health care (34% more and 6 higher in rank), emergency financial assistance (16% more and 7 higher in rank), and alternative therapies (17% more and 5 higher in rank),

Since the inception of the comprehensive assessment process in 1995, providers have been far more likely than consumers to identify substance use treatment and mental health counseling as service priorities. This trend continues over the past two years. Both in 2003 and 2005, providers were more than five times more likely to prioritize substance abuse services (62% versus 12%) and almost twice as likely to prioritize mental health counseling (66% versus 34%). While the disparity has been consistent for these core services, both providers and consumers increased mental health and substance abuse services as a priority by both percentage and rank since the 2003 needs assessment. Many providers in key informant interviews reported increased severity of mental health and/or chemical dependency among their dually and triply diagnosed clients. They also reported client resistance to and/or lack of access to these services (more description in Part V).

F. Service Gaps

Consumer-identified service gaps: The consumer survey asked respondents to identify each of the 28 services offered in the King County Continuum of Care as ones that they need and use, did not need, or needed but could not get. Each service that a consumer identified as “need, but cannot get” is considered a service gap. Unlike service priorities, where consumers and providers were limited to seven, consumer respondents could list as many gaps as they wanted to. These responses were collapsed into the 20 Planning Council-identified RWCA service categories for analysis and reporting purposes. Table 16 illustrates these gaps in services.

As in 2003, consumers did not identify any gross deficiencies or inaccessibility of the services available in the Seattle-King County Continuum of Care. There was a lot of variation, however, when comparing responses among specific sub-populations (discussed later).

Housing services have been a top six service gap among RWCA services in Seattle/King County for consumers since 1999. In 2005 housing services emerged as the number one service gap for consumers, increasing both in rank order and percentage from both 2001 and 2003. Almost two-fifths of consumer respondents noted this gap. Comparing the three services within this service category, emergency assistance paying rent showed the largest gap (26%), followed by assistance finding housing/transitional housing (20%), and emergency hotel vouchers (16%).

Other top ranked consumer service gaps include: food bank/home-delivered meals (31% of respondents); alternative non-Western therapies (30% of respondents); Oral health care, a core service (28%); emergency financial assistance (27%); and psychosocial support (25%).

<p style="text-align: center;">TABLE 16 CONSUMER GAPS TO SERVICES “Need, but can’t get” RANK (N=436, 20 invalid cases)</p>		
Rank	Ryan White Funding Category	%
1	Housing assistance/related services	38%
2	Food bank/home-delivered meals	31%
3	Alternative, non-Western therapies	30%
4	Oral health care	28%
5	Emergency financial assistance	27%
6	Psychosocial support	25%
7	Legal services	21%
8	AIDS Drug Assistance Program	19%
9	Client advocacy	19%
10	Referral for healthcare services	17%
11	Mental health services	17%
12	Treatment adherence support	14%
13	Transportation	14%
14	Home health care	11%
15	Substance abuse services	9%
16	Day/respite care for adults	8%
17	Case management	6%
18	Child care	6%
19	Health education/risk reduction	5%
20	Ambulatory/outpatient medical care	4%

Sub-population differences of consumer service gaps: There was a lot of variation by sub-populations in identifying service gaps. Table 17 indicates the sub-populations that indicated significantly higher gaps for the various care services.

In terms of exposure category, significantly different service gaps were identified for IDU and MSM. IDU (non-MSM) were significantly more likely to identify gaps to referral for health care services, client advocacy and home health care. Among MSM respondents, race and injection drug use were significant factors associated with self-identified service gaps:

- MSM of Color were significantly more likely to have gaps to housing services, alternative non-Western therapies, food bank/home-delivered meals, emergency financial assistance, legal services, transportation, substance abuse services, and day/respite care for adults. In the continuum of care, MSM of Color had significantly higher gaps in services than any other subpopulation (8 of 20 service categories).

- MSM/IDU were significantly more likely to identify gaps in housing assistance/related services, alternative non-Western therapies, food bank/home-delivered meals, client advocacy, referral for health care services, mental health services, transportation, and substance abuse services.

Demographically, race, gender and foreign-born status were variables related to significantly higher identified gaps to services. In addition to the differences in MSM of Color noted above, race was, overall, a major factor in defining differences with service gaps. People of color were significantly more likely to identify gaps to half of the current RWCA services:

- Black/African American respondents were significantly more likely to prioritize transportation and child care.
- Latino/Latina respondents were significantly more likely to prioritize emergency financial assistance, legal services, transportation, and day/respite care for adults.
- Foreign-born respondents were significantly more likely to identify gaps in housing services, food bank/home-delivered meals, emergency financial assistance, legal services, transportation, home health care, day/respite care for adults, and child care.
- Women were significantly more likely to identify gaps to home health care and child care.

Other complicating factors including homelessness and incarceration were significant indicators of identifying more service gaps.

- Respondents who are currently or have been homeless within the past year were significantly more likely to identify gaps to housing services (as one might expect), and oral health care.
- Respondents who had been incarcerated in the past year were significantly more likely to identify gaps to alternative, non-Western therapies, and mental health services.

Few significant differences emerged in service gap identification based on disability status. Persons who were not disabled by HIV/AIDS indicated significantly greater gaps for Ambulatory/outpatient medical care, and oral health care, than those respondents that reported having AIDS disability certification.

A description of some of the potential issues accounting for sub-population differences is provided in each of the chapters in Part V that highlight survey comments and consumer focus group responses to gaps with core medical services and vital support services.

Table 17. Consumer Service Gap Rankings with Significant Sub-Population Differences (Collapsed into Ryan White funding categories, N=436)

Rank	Service (core services bolded)	#	%	Significantly HIGHER gap identified by...
1	Housing assistance/related services	174	38%	MSM of Color (48%), Foreign Born (53%), Homeless (60%), MSM/IDU (52%)
2	Alternative, non-Western therapies	140	31%	MSM of Color (40%), Recently incarcerated (47%), MSM/IDU (46%)
3	Food bank/home-delivered meals	140	30%	MSM of Color (41%), Foreign Born (47%), MSM/IDU (40%)
4	Oral health care	129	28%	Homeless (38%), Non-disabled PLWH (33%)
5	Emergency financial assistance	124	27%	MSM of Color (38%), Foreign Born (42%), Latinos (43%)
6	Psychosocial support	111	25%	
7	Legal services	94	21%	MSM of Color (37%), Foreign Born (40%), Latinos (43%)
8	AIDS Drug Assistance Program	91	19%	
9	Client advocacy	87	19%	IDU (26%), MSM/IDU (29%)
10	Referral for health care services	78	17%	IDU (23%), MSM/IDU (27%)
11	Mental health services	77	17%	Recently incarcerated (33%), MSM/IDU (25%)
12	Treatment adherence support	66	14%	
13	Transportation	61	14%	MSM of Color (24%), Foreign Born (23%), MSM/IDU (24%), Black (25%), Latinos (24%)
14	Home health care	51	11%	IDU (21%), MSM of Color (16%), Foreign Born (19%), Women (20%)
15	Substance abuse services	41	9%	MSM of Color (15%), MSM/IDU (29%)
16	Day/respite care for adults	35	8%	MSM of Color (14%), Foreign Born (18%), Latinos (18%)
17	Case management	29	6%	
18(tie)	Child care	28	6%	Foreign Born (15%), Women (25%), Black (18%)
18(tie)	Health education/risk reduction	24	5%	
20	Ambulatory/outpatient medical care	20	4%	Non-disabled PLWH (6%)

Comparison between 2003 and 2005 consumer-identified service gaps: Just as from 2001 to 2003, the percent of consumers who identified service gaps rose in seventeen of the twenty categories from 2003 to 2005 (Table 18). What is even more noteworthy is the significance of service gap increases over the past two years compared to 2001 and 2003. Most gap increases were not significant from 2001 to 2003, but twelve service categories reflected a significant increase in consumer gaps from 2003 to 2005.

TABLE 18			
CONSUMER GAPS TO SERVICES			
“Need, but can’t get”			
CHANGE 2003→ 2005			
Ryan White Funding Category	2003% (N=483)	2005% (N=436)	% Change
Housing assistance/related services	24%	38%	+14%
Alternative, non-Western therapies	18%	30%	+12%
AIDS Drug Assistance Program	8%	19%	+11%
Oral health care	17%	28%	+11%
Referral for health care services	10%	17%	+7%
Transportation	7%	14%	+7%
Client advocacy	12%	19%	+7%
Treatment adherence support	8%	14%	+6%
Emergency financial assistance	21%	27%	+6%
Home health care	5%	11%	+6%
Substance abuse services	4%	9%	+5%
Day/respice care for adults	4%	8%	+4%
Psychosocial support	21%	24%	+3%
Mental health services	14%	17%	+3%
Legal services	18%	21%	+3%
Ambulatory/outpatient medical care	2%	4%	+2%
Health education/risk reduction	4%	5%	+1%
Food bank/home-delivered meals	31%	31%	0
Case management	6%	6%	0
Child care	7%	6%	-1%

**Bolted: significant increases in service gaps*

The housing assistance/related services category showed the largest percentage increase in consumer identified gaps to services and was the number one service gap in 2005 for consumers. Among the most significant increases in service gaps, housing services was followed by alternative non-western therapies, ADAP, oral health care, treatment adherence support, referral for health care services, transportation, client advocacy, emergency financial assistance, home health care, substance abuse services, and day/respice care for adults. Both in 2001 and 2003, emergency financial assistance was ranked as the highest consumer-identified service gap with a 10% increase in service gap between those years. In 2005, emergency financial assistance also reflected a significant gap increase (+6%), however, seven other services reflected higher percentage increases for gaps.

Provider-identified service gaps: The provider survey asked respondents to identify service gaps for the clients they served using the same list of 28 HIV/AIDS-related services from which priorities were identified. Each responding provider was asked to check any of the services which a substantial number of their clients needed, but had difficulty accessing. Responses were also collapsed into the 20 Planning Council-identified Ryan White service categories for analysis and reporting purposes. Table 19 includes the cumulative responses of provider-identified service gaps. Since providers were identifying gaps for their overall caseload in the past year (average of 115 clients) they were more likely to indicate gaps to services than consumers who were responding for themselves alone, hence the higher percentages of identified gaps by providers than consumers. Provider-identified service gaps are useful as a reflection of provider opinions about the Continuum of Care, rather than in determining a quantitative measure of service gaps for the population of PLWH in King County.

Almost half of HIV-related care providers indicated mental health services, oral health care, and substance abuse services as the top three service gaps in 2005. Providers did not rank housing assistance/ related services as high as consumers did and also significantly fewer providers ranked this is a service gap than in the past. However, housing assistance/ related services was still ranked as a top five service gap by providers. Supporting the fact that providers are seeing more and more clients who are residing in King County outside of Seattle, for the first time in six years transportation rose to the top five service gaps for providers in 2005.

In order to ensure that provider-identified service gaps were not biased by over-sampling certain types of providers, additional analyses were conducted controlling for provider type. There were no statistically significant differences in gap rankings when data were controlled for provider type.

Table 19		
2005 Provider Service Gaps Ranking		
(N=165; 23 invalid cases)		
Rank	Ryan White Funding Category	%
1	Mental health services	49%
2	Oral health care	48%
3	Substance abuse services	44%
4	Housing assistance/related services	43%
5	Transportation	27%
6	Psychosocial support	25%
7	AIDS Drug assistance program	24%
8 (tie)	Treatment adherence support	18%
8(tie)	Alternative, non-Western therapies	18%
10	Home health care	16%
11	Food bank/home delivered meals	13%
12	Legal services	13%
13	Childcare	13%
14	Emergency financial assistance	12%
15	Case management	12%
16	Client Advocacy	10%
17(tie)	Health education/risk reduction	7%
17(tie)	Ambulatory/outpatient medical care	7%
19	Referral for health care services	6%
20	Day/respite care for adults	4%

Comparison between 2003 and 2005 provider-identified service gaps: There were far fewer significant changes over the past two years with provider-identified service gaps than there were for consumer-identified service gaps (Table 20). Providers indicated that two service categories had increased significantly as gaps while three service categories significantly decreased. The largest service gap increase reported by providers was in transportation (+11% and up five in rank). Just as for consumers, the ADAP service category which includes assistance paying for medical insurance premiums, also showed a significant increase in the percentage of providers who identified that their clients needed but could not get the service.

TABLE 20
PROVIDER GAPS TO SERVICES
“Need, but can’t get”
CHANGE 2003→ 2005

Ryan White Funding Category	2003% (N=182)	2005% (N=167)	%CHANGE
Transportation	16%	27%	+11%
AIDS drug assistance program	16%	24%	+8%
Case management	7%	12%	+5%
Mental health services	45%	49%	+4%
Oral health care	44%	48%	+4%
Referral for health care services	2%	6%	+4%
Home health care	13%	16%	+3%
Childcare	10%	13%	+3%
Legal services	11%	13%	+2%
Ambulatory/outpatient medical care	5%	7%	+2%
Alternative, non-Western therapies	17%	18%	+1%
Psychosocial support	24%	25%	+1%
Health education/risk reduction	6%	7%	+1%
Health education/risk reduction	6%	7%	+1%
Food bank/home delivered meals	14%	13%	-1%
Treatment adherence support	22%	18%	-4%
Client Advocacy	14%	10%	-4%
Substance abuse services	49%	44%	-5%
Day/respite care for adults	14%	4%	-10%
Emergency financial assistance	25%	12%	-13%
Housing assistance/related services	58%	43%	-15%

Comparison between consumer and provider gap rankings: In 2005, significant differences emerged between consumer and provider-identified gaps in 11 of the 20 service categories, compared to significant differences in 13 service categories in 2003. Consumers identified significant increases in service gaps for twelve service categories compared to only two significant service gap increases by providers. Providers were more likely than consumers to identify gaps with all of the core services (medical care, oral health care, case management, ADAP, substance abuse services, and mental health services).

It is difficult to determine if this disparity represents actual differences in consumer versus provider perceptions of service gaps, or a methodological limitation (since consumers were asked to identify personal gaps while providers were asked to identify service gaps across their entire caseload.) In some cases because of variances in caseload size, provider aggregate response may have over-stated gaps by inflating gaps for small numbers of consumers into system-wide problems.

The largest disparities in percentages of consumer and provider-identified service gaps emerged in the service categories of substance abuse services (44% providers versus 9% consumers), mental health services (49% providers versus 17% consumers), and food bank/home-delivered meals (31% consumers versus 13% providers). Although housing assistance/related services was a higher ranking gap for consumers by percentage, more providers (43% compared to 38%) indicated this category to be a service gap. Although similar in rank, 20% more providers than consumers identified oral health care as a service gap. Three times as many consumers as providers indicated a service gap to referral for health care services.

From 2003 to 2005, the disparity between provider and consumer-identified gaps diminished most dramatically for housing assistance/related services, treatment adherence support, and substance abuse services. The disparity between provider and consumer-identified gaps increased most for food bank/home-delivered meals, emergency financial assistance, and alternative/non-Western therapies.

TABLE 21
Comparison Between 2005
Consumer and Provider-Identified Service Gaps

Service	Consumer (N=436)		Providers (N=165)	
	Rank	%	Rank	%
Housing assistance/related services	1	38%	4	43%
Alternative, non-Western therapies	2	31%	8 (tie)	18%
Food bank/home-delivered meals	3	30%	11	13%
Oral health care	4	28%	2	48%
Emergency financial assistance	5	27%	14	12%
Psychosocial support	6	25%	6	25%
Legal services	7	21%	12	13%
AIDS Drug Assistance Program	8	19%	7	24%
Client advocacy	9	19%	16	10%
Referral for health care services	10	17%	19	6%
Mental health services	11	17%	1	49%
Treatment adherence support	12	14%	8 (tie)	18%
Transportation	13	14%	5	27%
Home health care	14	11%	10	16%
Substance abuse services	15	9%	3	44%
Day/respite care for adults	16	8%	20	4%
Case management	17	6%	15	12%
Child care	18	6%	13	13%
Health education/risk reduction	19	5%	17 (tie)	7%
Ambulatory/outpatient medical care	20	4%	17 (tie)	7%

G. Consumer-identified service priorities as compared to service gaps

Comparing service gaps with service priorities helps determine the magnitude of potential system inadequacies and supports strategic planning and resource allocation decisions. Table 22 lists the top ten consumer-identified service priorities in comparison with the gap ranking for each service. Six of the top ten consumer priorities also ranked among the top ten gaps.

Unlike previous years, the service that consumers reported as having the highest priority-to-gap ratio was *not* emergency financial assistance (18% of consumers rating the service as a priority and 27% identifying it as a gap). In 2005, the highest service priority-to-gap ratio for consumers in order were alternative/non-Western therapies, housing assistance/related services, and psychosocial support.

Case management and outpatient medical care (identified among the top service priorities across almost all sub-populations were rarely identified as gaps. Only 6% of consumers (same as 2003) identified case management as a service gap. Four percent of consumers identified outpatient medical care as a service gap, a slight increase from the 2% in 2003. Part V examines in more detail unmet need for medical care.

TABLE 22
2005 SERVICE PRIORITIES AS COMPARED TO SERVICE GAPS
FROM CONSUMER SURVEYS (N=436, 20 invalid cases)

Service	PRIORITY		GAP	
	Rank	% of Resp.	Rank	% of Resp.
Case management	1	69%	18	6%
Ambulatory/outpatient medical care	2	64%	20	4%
AIDS Drug Assistance Program	3	63%	8	19%
Oral health care	4	62%	4	28%
Food bank/home-delivered meals	5	55%	2	31%
Housing assistance/related services	6	47%	1	38%
Mental health services	7	34%	11	17%
Psychosocial support	8	30%	6	25%
Alternative/non-Western therapies	9	28%	3	30%
Treatment adherence support	10	22%	12	14%