

Part 1: Unmet Need for Primary Medical Care

The CARE Act requires Title I and Title II grantees and planning bodies to estimate, assess, and address the unmet need for HIV-related primary medical care for persons who know their HIV status but are not receiving such care.

The Newark EMA has prepared estimates of unmet need since 2001 for the FY 2002 Title I grant application. For the FY 2005 Title I grant application submitted in November 2004, all EMAs in the United States were required to prepare an estimate of unmet need using the federal **HRSA/HAB Unmet Need Framework**. This estimate and the methodology are set forth in I-Unmet Need Estimate below. The estimates for FY 2006 are being prepared and will be submitted with the FY 2006 grant application on September 30, 2005.

Another estimate of unmet need is the “unmet need for Title I medical care” within the EMA. This estimate compares the total PLWHA both EMA-wide and by county with the number of PLWHA receiving Title I funded medical care. This shows the gap or unmet need for Title I medical care. This is the best estimate of unmet need for each county, and is a baseline for planning and resource allocation by the Planning Council and its Priority Setting Committee.

I. Unmet Need Estimate

For the FY 2005 Title I grant application, the Newark EMA estimated unmet need using the “Unmet Need Framework” Option 1 provided by HRSA and HIV/AIDS data for both Calendar Year (CY) and Fiscal Year (FY) 2003 as discussed below and shown in Table 4-1.

#1 Population estimates. It is estimated that there are (a) 6,136 people living with HIV/non-AIDS who know their status (PLWH/non-AIDS/aware), and (b) 6,514 people living with AIDS (PLWA) in the Newark EMA as of 12/31/03. This is a total of 12,650 PLWHA.

#2 Estimates of people in care. It is estimated that the number and percent of those in care are: (a) 3,406 (55.5%) PLWH/non-AIDS/aware, and (b) 3,859 (59.2%) PLWA in the Newark EMA who received HIV primary medical care during the 12-month time period of FY 2003, using the Framework definition. This is a total of 7,265 or 57.4% of PLWHA in the Newark EMA who are estimated to be “in care.”

#3 Estimates of unmet need. It is estimated of the number and percent of those not in care or “unmet need” is: (a) 2,730 (44.5%) PLWH/non-AIDS/aware, and (b) 2,655 (40.8%) PLWA in the Newark EMA who did *not* receive HIV primary medical care during FY 2003. The total unmet need is estimated at 5,385 PLWHA or 42.6% of the total population of individuals diagnosed with AIDS and HIV in the Newark EMA.

**Table 4-1: HRSA/HAB Unmet Need Framework – Option 1
Submitted with FY 2005 Title I Grant Application on November 10, 2004**

Input	Value	Data Source
Population Sizes		
A. Number of persons living with AIDS (PLWA), recent time period	6,514	2003 HARS Data from Centers for Disease Control and Prevention (CDC). As of 12/31/03.
B. Number of persons living with HIV (PLWH non-AIDS/aware), recent time period	6,136	2003 HARS Data from Centers for Disease Control and Prevention (CDC). As of 12/31/03.
Care Patterns		
C. Number of PLWA who received the specified HIV primary medical care services in 12-month period	3,859	NJDHSS matched files with HARS, NJ ADAP, Senior Gold, NJPAAD, GA welfare, Medicaid, laboratories. Newark DHHS CHAMP.
D. Number of PLWH (aware, non-AIDS) who received the specified HIV primary medical care services in 12-month period	3,406	NJDHSS matched files with HARS, NJ ADAP, Senior Gold, NJPAAD, GA welfare, Medicaid, laboratories. Newark DHHS CHAMP.
Calculated Results		
E. Number of PLWA who did not receive primary medical services	2,655	6,514 PLWA minus 4,282 PLWA in care
F. Number of PLWH (non-AIDS, aware) who did not receive primary medical services	2,730	6,136 PLWH minus 3,899 PLWH in care
G. Total HIV+/aware not receiving specified primary medical care services (quantified estimate of unmet need)	5,385	Sum of 2,655 and 2,730. Yields unmet need of 42.6% of 12,560.

Data sources. The data sources used are as follows:

#1 Population estimates. The source for People Living with HIV not AIDS and People Living with AIDS as of 12/31/03 is the U.S. Centers for Disease Control and Prevention (CDC). These data are prepared by the CDC from the HIV/AIDS Reporting System (HARS) and distributed to EMAs for use in the Title I grant application. The Newark EMA finds that these data are the best, most current estimate, of PLWHA and therefore has used this source.

#2 Estimates of people in care were derived from the following sources. (1) The Newark EMA Title I CHAMP system reported numbers of PLWHA receiving Title I medical care

during FY 2003. (2) Data from the N.J. Department of Health and Senior Services (NJDHSS) was used to estimate other non-Title I sources of medical care. In 2002-2003, NJDHSS matched its HARS files with other sources of medical care and medications. These included NJ ADAP, NJ Senior Gold, NJPAAD, General Assistance (GA) welfare, Medicaid, data from state laboratories. NJDHSS DHAS shared these data with the Title I EMAs and other planning regions in the state for use in subsequent estimates of unmet need.

Unmet Need Narrative from FY 2005 Title I grant application. The following narrative was included in the Newark EMA's FY 2005 Title I grant application to further clarify the computations on unmet need.

"Table 4-2 below sets forth the computation of unmet need by data source. The "population size" consists of data provided by CDC for FY 2005 - 12,650 individuals in the EMA knew their HIV status as of 12/31/03. Of these, 6,514 (51%) are living with AIDS and 6,136 (49%) living with HIV. Data are consistent with New Jersey State HARS data. New Jersey has been an HIV reporting state since 1992.

"The Newark EMA has been estimating unmet need since 2001 (FY 2002 application). Local Newark EMA data on Title I medical care service utilization, expenditures and client characteristics has been supplemented by data available from state agencies – Title II, ADAP and Medicaid. The source of Newark EMA local data is the Title I Management Information System known as CHAMP – Comprehensive HIV/AIDS Management Program – which operates under the direction of the City of Newark (grantee) with funding from Title I. Measurement of unmet need has been continuously improved via CHAMP through mandatory recording of relevant client data by provider agencies – CD4 count, viral load, source of health insurance - and via the EMA's Quality Management program.

"In September 2003 the Newark EMA, the five other EMAs in New Jersey and NJDHSS began a statewide collaboration to secure state level matched HIV and primary medical care data within each EMA. NJDHSS matched client data from its HIV/AIDS Reporting System (HARS) with patients receiving HIV-specific medical care from New Jersey Medicaid, New Jersey General Assistance (GA) welfare medical program, the NJ AIDS Drug Assistance Program (ADAP), NJ Pharmaceutical Assistance to the Aged (PAAD) and "Senior Gold" prescription programs, and the New Jersey laboratory reporting system for HIV/AIDS. Aggregate statewide and EMA-specific data were provided, showing HIV and AIDS status for PLWH both with and without private insurance. For the Newark EMA, the baseline number of PLWH in care estimated using state-level sources for CY 2002 was roughly equal to the number of PLWH in Title I funded medical care during FY 2002.

"For the FY 2005 grant application, the total PLWH in care were determined primarily using local Newark EMA data from CHAMP and supplemented by state-level data from NJDHSS. The primary reasons were that the state estimate of PLWH in care was not updated for CY 2003 and the Newark EMA experienced a significant increase of 21% (1,014) in the number of PLWH receiving Title I medical care – from 4,853 in FY 2002 to 5,867 in FY 2003. A total of 9,013 PLWH residing in the Newark EMA received Title I funded services in FY 2003 (3/1/03-2/28/04) according to CHAMP records. Of these, 5,867 unduplicated clients received primary medical care funded by Title I, or 51% of the total of 12,650 PLWH. HIV/AIDS status was obtained from each client's most recent CD4 count recorded on CHAMP. Of the clients receiving Title I funded

medical care, 3,094 had a CD4 count of below 200 (AIDS), and 2,773 had CD4 count of 200 or greater (HIV). Viral load data confirmed these diagnoses.

“Additional FY 2003 Title I clients who did not receive Title I medical care but reported other sources of health insurance also had CD4 counts recorded on CHAMP. These were included as being “in care” as follows: Medicaid – 182 (AIDS) and 331 (HIV), and Medicare – 45 (AIDS) and 66 (HIV).

“NJDHSS reported that in CY 2002, 774 or 6.6% PLWH with private insurance were “in care” – 538 (70%) with AIDS and 231 (30%) with HIV. Although receipt of private insurance is reported on CHAMP, the NJDHSS reports were deemed more accurate because the universe included all PLWH versus only those receiving Title I.

**Table 4-2: Computations for Unmet Need in Newark EMA
FY 2005 Title I Grant Application (November 10, 2004)**

	AIDS	HIV	Total
As of 12/31/03 Persons Living with:	6,514	6,136	12,650
HRSA FY 2003 – Newark EMA			
Newark DHHS CHAMP			
Title I 2003 Medical Care	3,094	2,773	5,867
Medicaid No Title I Medical Care	182	331	513
Medicare No Title I Medical Care	45	66	111
Subtotal	3,321	3,170	6,491
NJDHSS Div HIV/AIDS Services			
Private Insurance – 2002	538	236	774
TOTAL “In Care” – Number	3,859	3,406	7,265
Percent	59.2%	55.5%	57.4%
Unmet Need – Number	2,655	2,730	5,385
Percent	40.8%	44.5%	42.6%

II. Unmet Need Estimates within the Newark EMA Title I System

Unmet need estimates using only PLWHA receiving Title I medical care can provide an assessment of the responsiveness of the EMA’s Title I system of care to the epidemic. A relatively low percent of clients receiving Title I medical care can also indicate geographic areas of need for more medical care (and an increased percentage allocation for Title I medical care). It can also indicate the need for Title I case managers in these areas to determine (1) if such clients are receiving medical care, and (2) where and how they are receiving it, e.g., payment

source (Medicaid, Medicare, private insurance, etc.). Table 4-3 below shows these data for PLWHA as of 12/31/04 and Title I CHAMP data for FY 2004 (as of 2/28/05). Because CHAMP data on HIV status (AIDS versus HIV not AIDS) is still being collected, the total PLWHA are reported. The data are presented for the EMA, five counties, and five largest cities.

	PLWHA as of 12/31/04	FY 2004 Title I Medical Care		Not in FY 2004 Title I Medical Care	
		#	%	#	%
Newark EMA	12,569	5,420	43%	7,419	57%
Essex	9,287	4,177	45%	5,110	55%
Morris	619	143	23%	476	77%
Sussex	120	12	10%	108	90%
Union	2,433	808	33%	1,625	67%
Warren	110	10	9%	100	91%
East Orange	1,241	573	46%	668	54%
Elizabeth	1,005	427	42%	578	58%
Irvington	897	311	35%	586	65%
Newark	5,865	3,023	52%	2,842	48%
Plainfield	508	193	38%	315	62%
5 Cities	9,516	4,527	48%	4,989	52%

Source: NJDHSS, DHAS HIV Surveillance Reports 12/31/04.
Newark DHHS. CHAMP FY 2004 (as of 2/28/05).

Figure 4-A shows the “met” need by Title I from Table 4-3. Title I provides medical care for less than half (46%) of total PLWHA in the EMA and nearly half of PLWHA in the five largest cities (48%). By county, Essex County has the highest percent of PLWHA assisted by Title I medical care at 45%. Union is second, with 33% of PLWHA assisted by Title I medical care. Morris is next with 23% of its PLWHA receiving Title I medical care. Only one in 10 PLWHA in Sussex and Warren counties receive Title I medical care.

Among the five cities, more than half of Newark’s PLWHA (52%) receive Title I medical care. This is followed by East Orange (46%) and Elizabeth (42%). More than one third of PLWHA in Plainfield (38%) and Irvington (35%) receive Title I medical care.

It is likely that the targeting of Title I resources had helped to reduce AIDS prevalence among PLWHA by providing access to medical care to low income, uninsured PLWHA who would not otherwise be able to afford expensive and timely medical care for HIV disease.

Figure 4-B shows the “unmet need” for Title I medical care from Table 4-3. This is the gap in medical care, as viewed from the Title I funded medical system.

Unmet need for Title I medical care is 57% for the entire Newark EMA. By county, Essex County has the lowest percentage at 55% of total PLWHA. This is followed by Union County at 67% and the suburban/rural counties at 77% to 90%.

Among the five cities, unmet need for Title I medical care is 52%. That is, Title I pays for half of the medical care of HIV+ residents in these areas. This is largely due to the high usage of Title I medical care by HIV+ Newark residents. By city, unmet need for Title I medical care is the lowest in the City of Newark. Only 48% or 2,842 of 5,865 PLWHA are not receiving medical care from Title I. East Orange follows closely at 54%, as does Elizabeth at 58%. Unmet need for Title I medical care is nearly two-thirds of PLWHA in Plainfield (62%) and Irvington (65%).

The conclusion to be drawn from these data is that the Newark EMA's Title I program continues to effectively target resources to provide medical care for the high number of low income, uninsured PLWHA who have no source of health insurance other than Title I. Data from the 2000 Census on the concentration of poverty within the Newark EMA, which was reported in the Newark EMA HIV Health Services Planning Council 2004 Needs Assessment, confirm this conclusion. Data on current income and poverty from the 2004 American Community Survey of the U.S. Census Bureau, which was released on August 30, 2005, underscore this as well.

Figure 4-A: "Met Need" and the Title I System - Percent of PLWHA Receiving Title I Medical Care in FY 2004

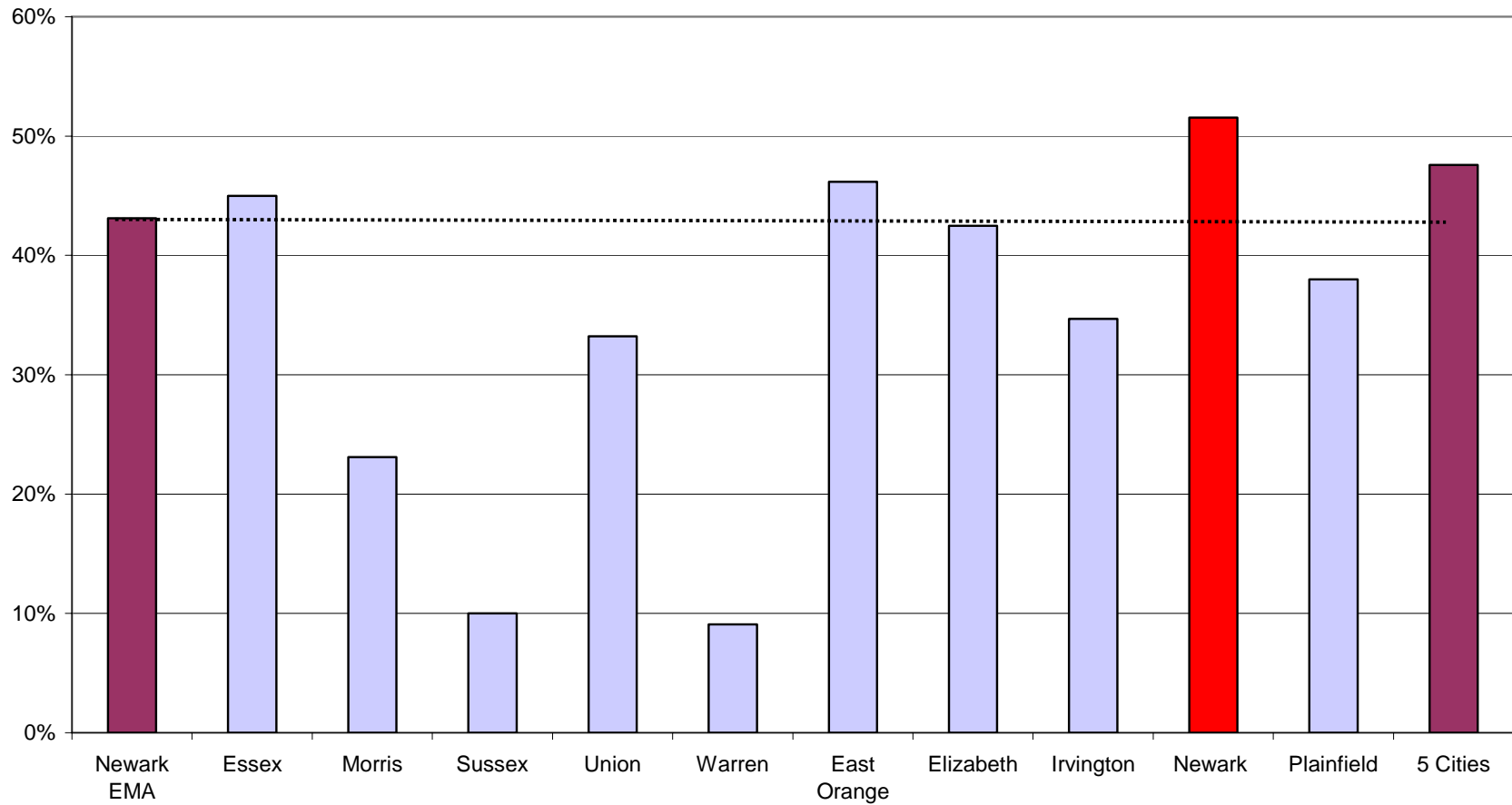
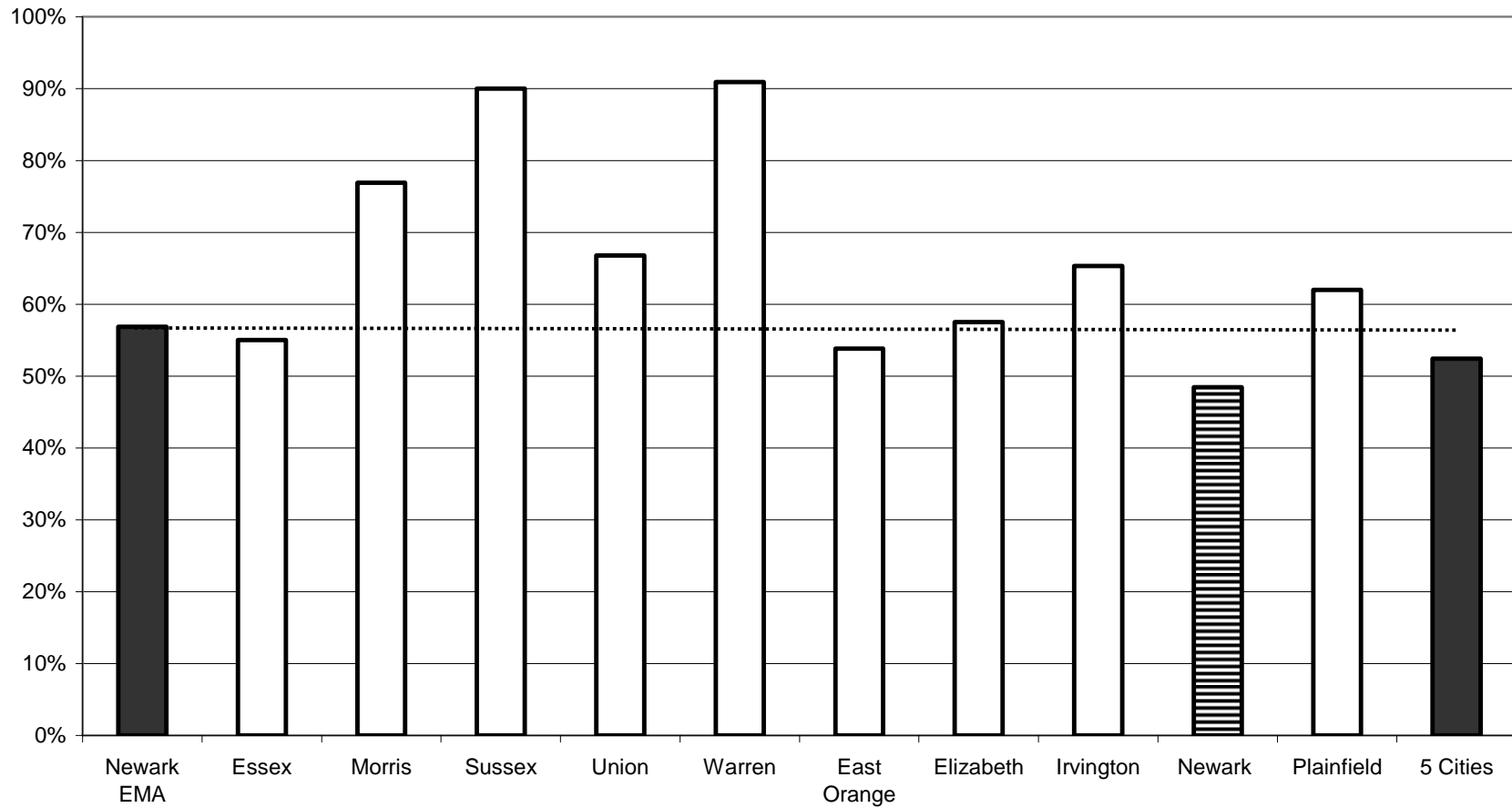


Figure 4-B: "Unmet Need" for Title I Medical Care - Percent of PLWHA Not Receiving Title I Medical Care in FY 2004



III. Issues Regarding Data About Medical Care Utilization

For this 2005 Needs Assessment Update, the Planning Council asked questions regarding issues related to data on medical care utilization among PLWHA. The responses are reported below.

Gaps in data about medical care utilization

The most noticeable gap in data about medical care utilization is the lack of a single source to collect such data for a majority of PLWHA. This is because there is no single payor for medical care for HIV disease. Instead, there are various payment sources for medical care which provide funding to numerous governmental entities (state and local) and directly to provider organizations (mostly nonprofit) and across jurisdictional lines (e.g., EMAs which cover several counties). These funding sources are summarized in Table 4-4 below.

Each funding source has its own limitations. With respect to Ryan White CARE Act (RWCA) programs, data reported to HRSA are aggregate numbers and not client level with unique identifiers. HRSA does not have ability to cross tabulate these data to create an unduplicated client count within its programs. Cross matches of patient data between federal programs (RWCA, Medicare, and Veterans' programs) and agencies such as HRSA, the Centers for Medicare and Medicaid Services (CMS) and Veterans' Administration (VA) are unlikely. Within the State of New Jersey, NJDHSS has already matched state-level data bases in 2003 to help identify met need and unmet need within Medicaid, Title II, GA Medicaid, ADAP, NJPAAD, and Senior Gold. This cross match is not being performed routinely. Furthermore, a cross match with local data such as the Newark EMA's Title I data files have raised issues regarding client identifiers, patient confidentiality and use of the data. At local level, EMAs may have more success in obtaining unduplicated patient count among other RWCA providers within their jurisdiction via informal agreement or cross-title contracting. However, this is not a system which can be utilized regularly.

The following issues are involved with collecting unduplicated data on PLWHA receiving medical care within New Jersey, the Title I EMAs, and localities:

- (1) Data must be reported to single source or two sources who will serve as clearing house and create unduplicated client count;
- (2) Sources must be trusted; and
- (3) Client confidentiality must be maintained. It is unknown if clients sign a release stating that their data may be shared.

Table 4-4: Overview of Sources of Medical Care and Data in Newark EMA

Payment Source for Medical Care	Funding to:	Funding covers	Medical care provided by:	Data collection and reporting
Federal				
RWCA Title I	City of Newark (Chief Elected Official)	EMA	Funded by contract directly to medical providers.	Client level data are maintained by Newark DHHS HIV/AIDS data base (CHAMP). 9,000+ PLWHA. Reported directly to HRSA.
RWCA Title II	NJDHSS, DHAS	Statewide	Individual providers funded by contract with NJDHSS	Unknown. (By provider to NJDHSS who reports directly to HRSA.)
RWCA Title III	Individual medical provider agencies	Providers	Receive contract directly from HRSA	Client level data for each agency. Reported directly to HRSA.
RWCA Title IV	Individual medical provider agencies	Providers	Receive contract directly from HRSA	Client level data for each agency. Reported directly to HRSA.
Medicare	CMS	Providers	Providers via fee for service or MCO contract.	Client level data for entire US Medicare system is maintained by USDHHS, CMS.
Veterans Benefits	Veterans Administration	Nationwide	Physician at VA hospitals, clinics	Client level data for entire US VA medical system is maintained by US Veterans Admin.
Federal/State				
Medicaid	NJDHS, DMAHS	Statewide	Providers via fee for service or MCO contract.	Client level data for entire NJ Medicaid system is maintained by NJDHS, DMAHS
State				
GA Medicaid	NJDHS, DMAHS	Statewide	Providers via fee for service. Bill DMAHS directly	Client level data for entire NJ Medicaid system is maintained by NJDHS, DMAHS
NJ Charity Care	NJDHSS	Statewide	Hospitals bill NJDHSS?	Unknown.
Private				
Private Insurance	Individual insurance companies	Statewide	Physicians under contract bill the insurers.	Patient level data for each insurance company.
HIV Medications				
Title II ADAP (Federal)	NJDHSS, DHAS	Statewide	NJDHSS manages program. Clients apply via medical provider.	Client level data are maintained by NJDHSS, DHAS.
NJPAAD	NJDHSS	Statewide	NJDHSS manages program. Clients apply via medical provider.	Client level data are maintained by NJDHSS, DHAS.
Senior Gold	NJDHSS	Statewide	NJDHSS manages program. Clients apply via medical provider.	Client level data are maintained by NJDHSS, DHAS.

Possible methods to improve collection of information on medical care within the Title I system

Within the Newark EMA, the most likely source to collect data on medical care utilization is the Title I CHAMP system. This is due to the volume of PLWHA served by Title I, the number of medical providers, the number of additional gateway services of case management, and the number of nonmedical Title I providers who can obtain this information.

CHAMP is a single source data repository for over 9,000 unduplicated PLWHA receiving Title I services. This is approximately 75% of the 12,569 PLWHA in the Newark EMA as of 12/31/04. Data on source of health insurance has been collected by CHAMP since 2001 and has been a required field since 2003. Current upgrades to CHAMP have added data fields to collect data on source of health care other than Title I, including the payment source. These new changes will be implemented in 2005-2006. They provide an opportunity to obtain more comprehensive data on medical care utilization other than Title I and the payment source for such care.

Strategies to improve collection of information on medical care within the Title I system are as follows:

- (1) Title I case managers should continue to ask all Title I clients if they are receiving medical care and to document the source of care and payment for health insurance both in the case record/client file and on CHAMP.
- (2) As a condition of receiving any Title I service, every provider should continue to ask every Title I client (1) if they are receiving medical care, (2) the name of the provider, and (3) the source of health insurance reimbursement. Documentation of health insurance should be maintained in the Title I case record/client file.
- (3) When revisions to CHAMP are completed, all providers should record alternate sources of medical care payment and providers, including documentation in the case record/client file. The grantee should regularly review the status of this documentation via summary reports. Ryan White Unit monitors should include this in their provider monitoring protocols.
- (4) The grantee and Council should work with Title I providers who also receive funding from other CARE Act titles, e.g., Title II (Early Intervention services), Title III and Title IV (women and children) to identify methods to obtain an unduplicated count of CARE Act clients across all titles.

Factors affecting access to medical care

As identified in Needs Assessments of the Newark EMA and other studies, factors affecting access to medical care include but are not limited to:

- (1) Ease of linkage and access to medical care upon receipt of an HIV diagnosis,
- (2) Readiness of PLWHA to enter and remain in medical care,

- (3) Availability of medical care near where PLWHA live or work or other geographical access to care (e.g., by transportation),
- (4) Availability of support services needed to help PLWHA remain in care (such as transportation, child care, mental health counseling, substance abuse treatment),
- (5) Capacity of medical providers to serve PLWHA timely,
- (6) Cultural sensitivity of providers to PLWHA, and
- (7) Payment for medical care.

The Newark EMA Title I system, in coordination with other payment sources for medical care, has helped many low income, uninsured PLWHA access and remain in medical care. The data above on unmet need, particularly Newark which has an unmet need of less than 50% of PLWHA, attest to the success of this system. Increasing percentages of PLWHA in Title I medical care shown in the section on Title I Service Utilization further highlight the success of the system.

Part 2 of this Needs Assessment, “Connecting to Care and Reducing Unmet Need – Survey of Title I Medical Providers”, shows the efforts being made by Title I medical providers to ensure that PLWHA keep medical appointments and remain in care. This survey was completed through the Council’s Care and Treatment Committee, to identify how medical providers were attempting to reduce unmet need. The survey also shows the models of care developed by medical providers whose agencies are administering the HIV Rapid Test. These models immediately link newly diagnosed PLWHA to medical care following an HIV positive diagnosis, but are tailored to their particular agency and patient populations. The additional comments by providers in the Part 2 narrative underscore that providers are aware of challenges facing PLWHA and are developing responses to improve retention in care. Providers are experiencing an increase in newly diagnosed PLWHA as a result of the HIV Rapid Test and foresee a continuation of this trend. They are addressing this trend by strengthening linkages between counseling and testing and primary medical care. Additional funding for Title I medical care will be needed for the increased PLWHA. The most likely response would be increased percentage allocations for medical care by the Planning Council.

Evaluating needs of people not in care

There are two categories of PLWHA not in care – those receiving a Title I service other than medical care and those not receiving any Title I services. The needs of the first population have been assessed by the Council in prior needs assessments, through focus groups, key informant interviews and some surveys. Some responses are indicated in the 2005 Substance Abuse Consumer Survey reported in this Needs Assessment Update. Because they have some connection to the Title I system, they have likely been educated by Title I providers about the importance of getting medical care. Barriers to care include current substance abuse and denial of their HIV disease, and the fact that they do not feel sick so they do not perceive the need to get medical care.

The needs of the second population - not receiving any Title I services - have also been estimated in prior Council needs assessments, also by focus groups and key informant interviews. However, these are mostly second hand sources. The 2000 study of PLWHA in

Newark using the Rapid Assessment, Response and Evaluation (RARE) methodology interviewed PLWHA not in Title I or any system of care, and as such was the most accurate report of needs of such PLWHA.

The Council could consider conducting another study using the RARE methodology to evaluate the needs of PLWHA not in care. However, this study is expensive and labor-intensive. It requires considerable planning; utilizes experts in RARE methodology from the federal government; and requires identification of local residents to serve as interviewers, training those interviewers on survey techniques and providing stipends or incentives to participate. Compiling the results of individual interviews, all of which are tape recorded, takes time for transcription, analyzing data and writing the final report. It is unknown if the Council or the EMA will have resources available to pay for this study, given the trend of federal funding for Title I (flat funding and possible decreases).

Also, the focus of HRSA seems to have shifted from broad-based identification of needs toward development of solutions regarding PLWHA who know their status but are not in care. HRSA has defined the “needs” of those PLWHA, regardless of their unique characteristics, to be medical care and support services to ensure access to and retention in such care. Its “Connecting to Care” technical assistance initiative has identified a variety of strategies to reach PLWHA not in care and to bring them into care. Such strategies consider the demographic and cultural characteristics of PLWHA as well as service infrastructure among the 17 participating communities across the United States. All EMAs have received training on “Connecting to Care” and are being encouraged to develop and implement similar targeted strategies for their specific unserved PLWHA. With this federal initiative for all CARE Act programs, it appears that Planning Councils are being advised to balance competing uses for limited Title I funds between further assessment of need versus development of solutions to improve access to and retention in medical care.

There are still pockets of unmet need within the EMA, particularly among immigrant populations in Newark, Union County (Elizabeth), and Morris County (Morristown and Dover). A higher percent of people are living with AIDS (48%) in Union and Morris counties, as opposed to Essex (51% and 50% in Newark). The Council may want to direct resources to these areas to study medical care patterns, and needs for additional medical care. Research activities can include:

- (1) In-depth study of NJDHSS DHAS HIV surveillance data by city and ZIP code to determine characteristics of PLWHA – gender, race/ethnicity, age, and exposure category.
- (2) Study of CHAMP data for same geographic areas regarding utilization of Title I medical care, also by gender, race/ethnicity, age, self-reported exposure category, HIV status (HIV versus AIDS) as reported by the Title I medical providers via CD4 count, and source of health insurance.
- (3) Interviews with case management agencies in those counties who serve immigrant populations and review of case records to determine source of health insurance and receipt of medical care from non-Title I sources.

- (4) Comparison of two data sets and results of interviews and case record reviews, and identification of any gaps between total PLWHA and those served by Title I, as well as obtaining an estimate of unmet need.
- (5) Identification of possible solutions to reduce unmet need and increase the percentage of these PLWHA in medical care.

This type of study could be completed using existing Council resources and CHAMP personnel. If warranted, this study could be followed up by field studies. Although this is often costly, because of the need for culturally and linguistically appropriate interviewers and study team, the study could be cost-effective by targeting it to specific neighborhoods identified as problematic. This approach to studying unmet need would also allow the Council's limited resources to be spent on identifying and recommending strategies to improve linkages to medical care and supportive services for unserved populations.