

DALLAS EMA & HSDA NEEDS ASSESSMENT REPORT

Prepared for

Dallas County Health and Human Services

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Abbreviations

ADAP	AIDS Drug Assistance Program
ASO	AIDS Service Organization
Consortium	Ryan White Consortium of North Texas
DCHHS	Dallas County Health and Human Services
EMA	Eligible Metropolitan Area
HET	Heterosexual



HSDA
HSPC
IDU
MSM
OI
PCH
STD

HIV Service Delivery Area
Dallas HIV Health Services Planning Council
Injecting drug user
Men-who-have-sex-with-men
Opportunistic infection
Partnership for Community Health
Sexually transmitted diseases



1. INTRODUCTION

Dallas County Health and Human Services (DCHHS), the Dallas HIV Health Services Planning Council (HSPC) and the Ryan White Consortium of North Texas (Consortium) have contracted with the Partnership for Community Health (PCH) to conduct a comprehensive HIV/AIDS Care Needs Assessment in the Dallas Eligible Metropolitan Area (EMA). The goal of the needs assessment is to provide the RWPC of the Dallas Area, the Consortium and DCHHS with data on HIV/AIDS that is necessary for effective services planning.

The full needs assessment has three reports. The first is an epidemiology report that provides an estimate of who will need services. The epidemiological report has been produced and submitted to DCHHS.

This is the second report, and it describes the findings of the needs assessment and presents information obtained through a survey of 387 PLWH/A and ten focus groups with African Americans, Hispanics, heterosexual men and women, injecting drug users (IDU), and people out-of-care. To supplement findings key informants interviews were completed with several consumers and providers.

The conceptual framework for the needs assessment is shown in Table 1-1. To facilitate the measurement of service needs, unmet needs and gaps and barriers, a list of relevant services and barriers was created that was used throughout this needs assessment and are described in greater detail in the following Methods section.

Table 1-1 Definition of Needs and Gaps

<i>Service need or absolute need</i>	Theoretical estimate based on a policy protocol and standards / model of care. It is an estimate of the number of people who would benefit from a service, regardless of whether they are actually receiving it.
<i>Perceived need and demand</i>	Perceived need and demand of PLWH/A for services based on qualitative and quantitative data is highly correlated.
<i>Fulfilled need</i>	Actual utilization of services measured by surveys or other non-direct counts by source of funding. It is expressed by the fact that an HIV-infected individual has actually received a service that is paid for by a multitude of sources.
<i>Service capacity</i>	Number of clients who can be served and the number of slots available for a particular service, by funding source (RW, insurance, public assistance, grant-funded, compassionate drug programs, etc.)

From these four “raw” calculations, four gap measures are calculated.

<i>Unmet absolute need</i>	This refers to a need-capacity gap and is the difference between the number needing a service and the capacity of the system.
<i>Unmet perceived need</i>	This refers to the difference between the perceived need/demand and utilization. It is the services that PLWH/A say they need and what services they actually sought.
<i>Unmet demand or perceived excess capacity</i>	This refers to a demand-capacity gap and is the difference between the number seeking service and the capacity of the system. It is the difference between the units of service utilized and the number of units of service that are available.
<i>Need-demand gap</i>	This refers to individuals needing, but not perceiving they need, services and is the difference between the number who in theory should receive services and the number perceiving they need services.



This Needs Assessment Report specifically addresses the absolute service needs, the perceived needs or demand, fulfilled need, unmet absolute need, unmet perceived need, and barriers to care reported by PLWH/A and providers.

The third and final report is an update of the Comprehensive HIV Services Plan for the Dallas EMA and HIV Service Delivery Area (HSDA) and will be produced and submitted separately from the needs assessment report. It will result from the provider survey analysis including gaps based upon capacity information analyzed from the provider survey.



2. METHODS

Introduction

The Partnership for Community Health conducted the needs assessment for the Dallas EMA and HSDA in 1998, and this needs assessment builds on the foundation of that project. As in 1998, a Project Advisory Group (PAG) was formed to provide oversight to the execution of the needs assessment. The consumer survey and focus group outlines were part of a highly participatory process involving members of the PAG. All decisions regarding content and length were approved by the PAG and they continued to be consultant throughout the project. The names of those on the project advisory list are shown in Attachment 1.

Four different methods of data collection are utilized for this needs assessment:

- A review of secondary information, including epidemiological data from the HIV and AIDS Reporting System (HARS) provided by TDH and aggregate client data from COMPIS and contract monitoring sources. This information was used to estimate the prevalence of HIV, the sampling frame, and the number of units of service provided by the care system.
- A survey among a representative sample of PLWH/A drawn from providers and from outreach to find those out-of-care. The survey allowed updated estimates of the demographics of PLWH/A, including co-morbidities, and current estimates awareness of services and perceived knowledge, need, demand, utilization, and barriers related to services.
- A series of ten focus groups among target populations and key informant interviews. They permit an in-depth view of needs and barriers to services and allow a greater depth of analysis by providing support and exceptions to findings from the survey.
- A provider survey. The purpose of the provider survey is to provide information on the services provided, all funding for services, and provider perception of service needs.

The consumer and provider focus group outlines are shown in Attachment 2 and Attachment 3. The key informant interviews were based on a condensed version of the focus group protocols and separate documents were not created. The consumer survey is shown in Attachment 4. The Needs Assessment Client Survey recommended by the Statewide Coordinated Statement of Need (SCSN) was used as guidance during the design of the instrument. The list of services developed by PCH was derived from the list of funded services and were approved by DCHHS as representing services that were funded, or of interest to, the Council and Consortium. They are shown in question 46 of the consumer survey (see Attachment 4). The list of barriers was developed based on prior needs assessments conducted by PCH using a multidimensional schema discussed in the Barriers Section below. The questions related to barriers appear as question 47 of the consumer survey. Respondents were also asked about “other” barriers using an open end format and these were coded.

The consumer survey was an interviewer-assisted questionnaire, with trained interviewers available at all sites where the survey was administered to provide guidance and assistance to participants. Participants for the focus groups received a \$15 cash incentive and participants of



the consumer survey received a \$10 cash incentive. Anyone unable to complete the entire consumer survey for reasons such as illness or fatigue still received the cash incentive. Another incentive for participants to complete the survey was their inclusion in a lottery with grand prize being a computer and smaller prizes consisting of gift certificates to local grocery stores, movie theatres, and shopping centers.

For analysis purposes the consumer survey captured demographic information, including stages of HIV infection, mode of transmission, socioeconomic indicators, and location of residence. Location was analyzed by Dallas County (urban) and non-Dallas County (rural). The EMA and HSDA include Collin, Cooke, Dallas, Denton, Ellis, Fannin, Grayson, Henderson, Hunt, Kaufman, Navarro, and Rockwall counties. The survey also measured co-morbidities of HIV with mental illness, sexually transmitted diseases (STDs) and tuberculosis (TB). In addition, the survey included questions related to HIV prevention and behavior. The consumer surveys were completed between December of 1999 and March of 2001.

Quantitative Survey

Sample Design

The focus group and survey recruitment strategies were based on an overall sampling plan designed to draw a representative sample of clients from AIDS service organizations and clinics and in assure that there were sufficient numbers of women, Hispanic, heterosexual and IDU PLWH/A to analyze. For this needs assessment, several groups of PLWH/A were the focus of recruitment efforts, including people out-of-care, people from rural counties, and people of color across all risk groups. The stratified sample design is shown in Table 2-1.

Table 2-1 Stratified Sample Plan

Risk Group	MSM	Heterosexual & Substance Users		TOTAL
	Men	Men	Women	
African American	30	30	30	90
Latinos	30	30	30	90
Anglo	30	30	30	90
Asian Pacific Islander & other ethnicity				15
Not in Care				40
Rural				
MSM				15
HET/Substance Users				30
	90	90	90	370

Three parallel strategies were used to obtain a sample of in-care and out-of-care participants. For those in-service, a stratified random sampling plan for each of the 30 AIDS service organization (ASO) based on the proportion of the of client served by that agency. The stratified populations included MSM, MSM/IDU, IDU, heterosexual, females, African American, Hispanic, Anglo, other ethnicities, and rural. In order to preserve the confidentiality of the client, the sample was drawn using the unique identifier in COMPIS. Clients served by more than one agency were assigned to one of the agencies they served.



To further maintain client confidentiality, service providers were asked to contact the client and invite them to participate in the survey. Clients who consented to completing the survey were scheduled to meet with trained interviewers at several sites throughout the EMA to complete the survey and receive the incentive. For hard to reach populations and populations that were the focus of special recruitment efforts, such as those in rural areas where transportation was a barrier to completing an in-person survey, telephone interviews were conducted. The incentive was then mailed to the participant.

Two other parallel methods used by PCH were a non-random intercept method where interviewers went to providers and interviewed selected respondents based on target demographics and a snowball method where clients referred other difficult-to-reach PLWH/A. These methods were used to identify and recruit PLWH/A who were out-of-care, Hispanic, and Anglo heterosexuals.

Out-of-care participants were defined as those who had not received medical care in the past year. While there was general agreement among providers and DCHHS staff that there is a sizeable population of PLWH/A who are not receiving medical care, they are dispersed throughout the system and not easily identified. Providers funded through Title I for outreach services were contacted and asked to refer those PLWH/A who were not receiving medical care to the study. Amelia Court, the HIV clinic that is part of Parkland Health and Hospital System and the largest provider of medical care to PLWH/A in the Dallas EMA, provided the study with a list of 100 clients that had been lost to follow-up over the past year and had not returned to the clinic for their scheduled appointments. Staff at the clinic contacted these individuals on behalf of the study to invite them to participate in the consumer survey. Out of the 100 clients listed as lost to follow-up and not receiving medical care, Amelia Court staff was able to identify only two possible participants. Finally, non-medical care providers in the EMA were asked to refer clients who were known to be receiving non-medical care services only.

Unfortunately, these efforts did not produce the number of out-of-care clients designated in the sample design. Based on an analysis of the data for who had not seen a medical provider in the past year, prior to verification, 51 participants were identified as out-of-care. Later, when the data was verified, that number was reduced to 21 persons who were truly out of medical for at least a year.

Because unique identifier codes were assigned to each survey that included letter in the participants name, and specific codes, it was possible to screen for duplicate participants. When this was done 30 duplicate interviews were found and omitted.

Quantitative Sample Obtained

Three hundred and eighty-seven (387) interviews were completed. Quotas were not reached among heterosexuals, women, Hispanics, and “other ethnicities.” Still, as shown in Table 2-2 the overall intent of the over-sampling difficult to reach populations was achieved.



Table 2-2 Needs Assessment Sample

TOTAL SAMPLE		
	N	%
TOTAL¹	387	100
MSM	284	73%
IDU	70	18%
Heterosexual	95	25%
Females	95	25%
African American	169	44%
Hispanic	75	19%
Anglo	131	46%
Other ethnicities ²	12	3%
Rural	56	14%
Out-of-care	21	5%
PLWA	207	53%
¹ The population groups are not mutually exclusive		
² Includes Asian-Pacific Islanders, Native Americans, mixed and other ethnicities		

Qualitative Component

Focus Groups and Key Informant Interviews

To supplement the quantitative findings of the consumer survey and to gain greater insight into the providers' perception of needs, gaps and barriers, twelve focus groups were held with consumers and providers. In addition, interviews were conducted with key informants of special populations. The types of groups are shown in Table 2-3.¹

Table 2-3 Focus Group and Key Informant Interviews

Focus Groups/Key Informant Interviews	Participants
1 focus group with African American male heterosexuals and IDUs	(6) Dallas Co.
1 focus group with African American female heterosexuals and IDUs	(4) Dallas Co.
1 focus group with Hispanic male heterosexuals and IDUs	(8) Dallas Co.
1 focus group with Hispanic female heterosexuals and IDUs	(6) Dallas Co.
1 focus group with Out-of-Care	(2) Dallas Co.
2 focus groups with African American MSM	(10) & (11) Dallas Co.
1 focus group with Hispanic MSM	(10) Dallas Co.
2 focus group with male and female rural residents	(9) Grayson Co., (5) Ellis Co.
2 focus groups with medical and social service providers	(12) & (12)
1 key informant interview with an out-of-care client	(1) Collin Co.
2 key informant interviews with medical providers	(1) Administrator, Amelia Court Clinic; (1) Acting ED, FW Empowerment
1 key informant interview with social service agency	(1) Legacy Counseling, Dallas

¹ The actual configuration differed somewhat from the proposed design. The initial design specified 10 focus group and 10 key informant interviews be conducted. In practice, 12 focus groups were conducted and 4 key informant interviews were recorded. Several providers and consumers were also interviewed as part of the data collection process.



Recruitment for the focus groups was done simultaneously with recruitment for the consumer survey. Before the focus group sessions began, interviewers were available to assist the focus group participants with completing the consumer survey. Dr. Mitchell Cohen, Mr. Michael DeMayo, and Mr. Basil Reyes conducted all consumer and provider groups. Spanish language translators were used for all groups among Hispanic participants. All groups were both audio and video taped, were transcribed professionally, and were coded by PCH staff for qualitative analysis. All focus group participants were informed about the purpose and use of the audio and video equipment, and the confidentiality of all participants was assured.

In addition to the focus groups, key informant interviews were conducted with medical and social service providers. Two key informant interviews were conducted with an out-of-care client. Interviews were conducted in several sessions over a one month period. All sessions were completed by telephone. Key informants were asked to comment on key issues raised by the Council/Consortium.

Analysis

The survey was analyzed using the statistical package Statistical Program for Social Sciences (SPSS).

Analysis of the data was done by the “total sample” and key demographic groups shown in Table 2-4 below:

Table 2-4 Analysis Populations

<ul style="list-style-type: none"> 1. Total (Weighted sample) 2. Gender <ul style="list-style-type: none"> 2.1. Male 2.2. Female 3. Risk Group <ul style="list-style-type: none"> 3.1. MSM <ul style="list-style-type: none"> 3.1.1. Total 3.1.2. African American 3.1.3. Hispanic 3.1.4. Anglo 3.2. Heterosexual transmission <ul style="list-style-type: none"> 3.2.1. Total 3.2.2. African American 3.2.3. Hispanic 3.2.4. Anglo 3.3. IDU – Injecting drug user <ul style="list-style-type: none"> 3.3.1. Total 3.3.2. African American 3.3.3. Hispanic 3.3.4. Anglo 	<ul style="list-style-type: none"> 4. Ethnicity <ul style="list-style-type: none"> 4.1. African American <ul style="list-style-type: none"> 4.1.1. Total 4.1.2. Male 4.1.3. Female 4.2. Anglo <ul style="list-style-type: none"> 4.2.1. Total 4.2.2. Male 4.2.3. Female 4.3. Hispanic <ul style="list-style-type: none"> 4.3.1. Total 4.3.2. Male 4.3.3. Female 5. Special Pop <ul style="list-style-type: none"> 5.1. Recently Incarcerated 5.2. Out-of-Care 5.3. Youth (12-24) 5.4. Family 5.5. Geographic <ul style="list-style-type: none"> 5.5.1. Urban (Dallas Co.) 5.5.2. Rural (outside of Dallas Co.) 5.6. Stage of Infection <ul style="list-style-type: none"> 5.6.1. AIDS 5.7. HIV + symptomatic 5.8. HIV + asymptomatic
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As noted above, selected populations were over-sampled to assure adequate sample sizes for analysis. Consequently, sex, and ethnicity categories are analyzed using unweighted data in order to reflect their disproportionate numbers in the sample.

For the Total sample analysis and risk group analysis, the subpopulations were weighted back to their proportion in the estimated HIV population. The population estimates are based on the Epidemiological information, and are shown in Table 2-5. The unweighted sample shows the over-sampled populations, while the weighted sample is very close to the projected population estimates of PLWH/A.

Table 2-5 Sample Frame

Risk Group		% Total Pop	Weighted Sample	Unweighted Sample	
IDU	Total	9.9%	10.1%	12.4%	
	Gender	Male	6.2%	6.1%	6.2%
		Female	3.3%	4.0%	6.2%
	Ethnicity	African American	5.1%	5.3%	6.2
		Latino	0.6%	1.9%	2.6
		Anglo	3.6%	2.8%	3.4%
Other		0.5%	0.1%	0.3%	
MSM	Total	65.0%	65.4%	43.7%	
	Ethnicity	African American	13.9%	14.3%	18.1%
		Latino	8.2%	7.4%	6.7%
		Anglo	42.0%	43.1%	17.1%
		Other	0.8%	0.7%	1.8%
Hetero	Total	16.8%	16.7%	30.5%	
	Gender	Male	6.2%	6.2%	12.4%
		Female	10.6%	10.5%	18.3%
	Ethnicity	African American	9.1%	8.7%	13.4%
		Latino	2.8%	3.2%	9.0%
		Anglo	4.8%	4.7%	7.8%
		Other	0.2%	0.1%	0.3%
	MSM/IDU	Total	7.4%	7.8%	13.4%
Ethnicity		African American	2.2%	3.5%	5.9%
		Latino	0.5%	0.6%	1.0%
		Anglo	4.2%	3.3%	5.7%
		Other	0.4%	0.4%	0.8%

The basic demographic, services and barriers cross tabulations are shown in Attachment 6 through Attachment 13. Selected analysis is shown in graphic and table form in the text. The barrier analysis was based on a factor analysis of the items asked in question 48 of the consumer survey (Attachment 4). The analysis is further discussed in the barrier chapter of this report.

Top of mind service and aggregate barrier scores are discussed in their respective sections. After each of these aggregate level analysis, a template is prepared for each service and each barrier, and their meaning is discussed in each section.

Focus groups were transcribed and coded using the coding scheme shown in Attachment 5. Each comment was coded by relevant demographic group, service and barrier. Comments are used throughout the report to add depth, reinforce, or emphasize minority positions of PLWH/A.



3. DEMOGRAPHIC PROFILE OF PLWH/A

The Demographic Profile describes all PLWH/A who completed the survey across several key demographic characteristics. Complete demographic data for all survey respondents is listed in Attachment 6. The “total” column in this attachment shows the “weighted” sample, so that it is representative of the total population of PLWH/A.

In order to make Attachment 6 more accessible, many of the demographic characteristics that describe the sample are described in this section. For those seeking complete information, Attachment 6 has more detailed demographic descriptions.

Basic Demographics

The majority of the following figures show the basic demographics of the four primary risk categories: men who have sex with men (MSM), MSM who inject drugs (MSM/IDU), injecting drug users (IDU) and heterosexuals who report no injection drug use (HET). The demographic section also includes information on stage of infection (PLWH and PLWA) and rural and urban respondents. Wherever possible, individuals who are out-of-care are included in the demographic description.

Table 3-1 shows the total weighted survey sample of the 387 PLWH/A that participated in the consumer survey. In this demographic analysis, the weighted sample is used because it is representative of the proportion of the PLWH/A in each demographic category. Below are some highlights of the demographic analysis:

- The majority of the sample is Anglo (54%), followed by African American (32%), Hispanic (13%) and other (1%). The “other” category includes Native Americans and Asian/Pacific Islanders. Due to the extremely small sample size, the “other” category will not be included as a separate category in the demographic analysis.
- People of color as a group, including African Americans, Hispanics, Native Americans, and Asian/Pacific Islanders, represent 46% of the sample.
- MSM represent the largest proportion of PLWH/A at 63%, followed by heterosexuals at 17%, IDUs at 10% and MSM/IDUs at 8%.
- Eighty-three percent (83%) of PLWH/A completing the survey live in Dallas County, which is considered the “urban” area of the Dallas EMA/HSDA. Participants of the other 11 counties that comprise the Dallas EMA/HSDA, represents about 16% of the survey sample.
- PLWA represent 56% of the sample, and PLWH account for 44% of the sample.
- The total weighted sample consists of 85% males and 15% females.



Table 3-1 Number of Survey Respondents (N=387)

	TOTAL SAMPLE		African American		Hispanic		Anglo		Other ²	
	N	% wt.	N	% tot sample	N	% tot sample	N	% tot sample	N	% tot sample
TOTAL¹ N=	387	100.0	123	31.8	50	12.9	209	54.0	5	1.3
MSM	253	63.4	55	14.2	29	7.5	167	43.1	3	0.8
MSM/IDU	30	7.7	13	3.4	2	0.5	13	3.4	2	0.5
IDU	39	10.1	21	5.4	7	1.8	11	2.8	0	0.0
Hetero	65	16.8	34	8.8	12	3.1	18	4.6	0	0.0
TOTAL	387	100.0	123	31.8	51	13.2	208	53.7	5	1.3
Rural	64	16.5	5	1.3	8	2.1	51	13.2	0	0.0
Urban	323	83.5	118	30.5	43	11.1	157	40.6	5	1.3
TOTAL	386	100.0	122	31.7	51	13.2	208	54.0	5	1.3
PLWA	218	56.5	58	15.0	29	7.5	127	32.9	4	1.0
PLWH	168	43.5	64	16.6	22	5.7	81	20.9	1	0.3
TOTAL	387	100.0	123	31.8	51	13.2	208	53.7	5	1.3
Male	331	85.5	93	24.0	41	10.6	192	49.6	5	1.3
Female	56	14.5	30	7.7	10	2.6	16	4.1	0	0.0

¹The population groups are not mutually exclusive
²Includes Asian/Pacific Islanders, Native Americans, mixed and other ethnicities

Gender by Risk Group

Figure 3-1 shows PLWH/A by risk group and gender. As noted in the figure:

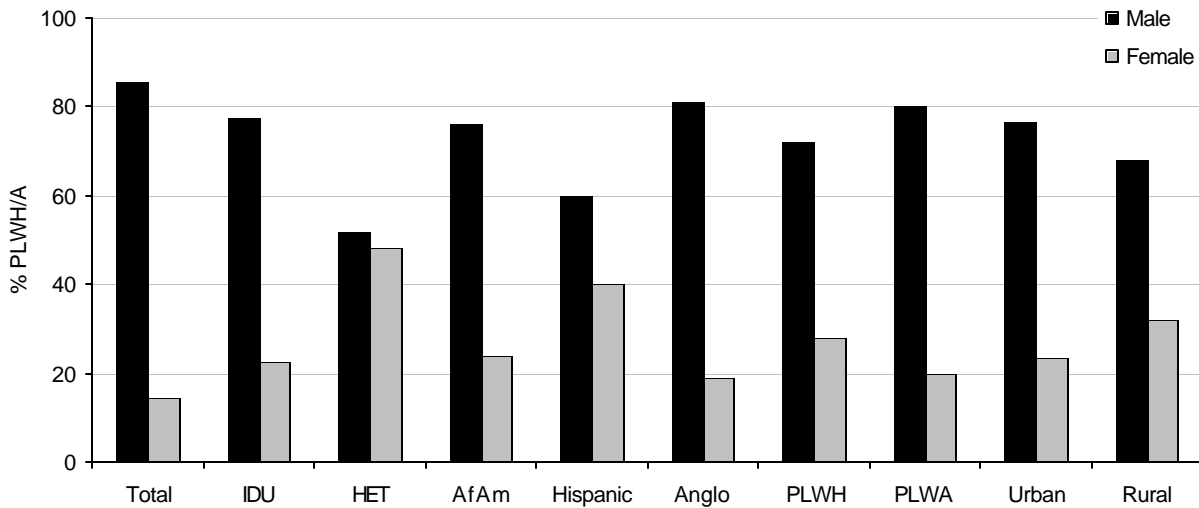
- Males represent the vast majority of all risk groups except heterosexuals, where there is a slight majority of women.
- Among the Hispanic population the vast majority of infected persons in care are male.

Findings not shown in the figure:

- African American women account for over 50% of all women surveyed, and approximately 8% of the total survey sample.
- The majority of males are AIDS diagnosed (58%), while the majority of females are not (53%).
- Seventy-two percent of all heterosexual survey respondents are female, though heterosexual females make up just 10% of the total survey sample.



Figure 3-1 Gender by Risk Group



Education: Risk Category and Ethnicity

Table 3-2 and Table 3-3 show the different levels of education for each of the risk categories and racial/ethnic groups.

- Forty-five percent of all PLWH/A in the study have some college experience, including graduate level studies, 24% have not completed high school, and 25% are high school graduates.
- Over 55% of MSM have some level of college education compared to 23% of heterosexuals.
- Injecting drug users, heterosexuals and people out-of-care (not shown) have the lowest level of education with 43%-44% not completing high school.
- Anglos have the highest education level, with 61% having some college experience. This compares to 42% for African Americans and 24% for Hispanics.
- Over 40% of Hispanics have not completed high school, a much higher rate than the overall sample.



Table 3-2 Risk Group Education Levels

	Total	MSM	MSM/ IDU	IDU	HET
Education Level	%	%	%	%	%
Grade school or less	5.5	2.3	3.9	21.9	9.2
Some high school	18.6	14.9	12.8	22.3	34.0
Graduated High School/GED	24.9	20.7	36.8	36.3	29.1
Technical or Trade School	5.7	6.8	5.8		4.8
Some college	26.9	30.8	25.2	16.7	18.0
Completed college	14.7	19.8	9.7	2.7	4.2
Graduate level	3.7	4.7	5.8		0.8

Table 3-3 Ethnicity by Education Levels

	Total	African American	Hispanic	Anglo
Education Level	%	%	%	%
Grade school or less	5.5	6.3	19.6	1.8
Some high school	18.6	24.0	21.5	14.5
Graduated High School/GED	24.9	27.2	29.7	22.8
Technical or Trade School	5.7	7.8	5.2	4.6
Some college	26.9	24.9	17.4	29.6
Completed college	14.7	8.1	6.6	20.9
Graduate level	3.7	1.7	0	5.8

Ethnicity and Risk Group

Table 3-4 shows the ethnic/racial composition of each of the major risk categories. It indicates that:

- Among the total weighted sample, the majority of PLWH/A are MSM (65%), 17% are heterosexual, 10% are non-MSM IDU, and 8% are MSM/IDU.
- African Americans (32%) and Anglos (54%) make up the largest proportion of ethnicities in the survey sample.
- Within the MSM group, 22% are African American, 11% Hispanic, 66% are Anglo, and 1% are Other ethnicities.
- The MSM/IDU group is comprised of 45% African Americans, 8% Hispanics, 43% Anglos, and 5% Other ethnicities.
- Within the heterosexual group, African Americans make up 52%, Hispanics 19%, and Anglos 30%.



Table 3-4 Ethnicity by Risk Group

	Total	MSM	MSM/ IDU	IDU	HET
Ethnicity	%	%	%	%	%
African American	31.8	14.2	3.4	5.4	8.8
Hispanic	13.2	7.5	<1%	2.0	3.1
Anglo	53.7	43.1	3.4	2.8	4.6
Other	1.3	<1%	<1%	-	<1%

Income

In order to receive Ryan White and state supported benefits, the current HIV/AIDS care system has income restrictions depending on the service provided. In order to qualify for the AIDS Drug Assistance Program (ADAP) or other state-funded medication reimbursement programs, PLWH/A are eligible up to 200% of poverty (about \$17,000 a year for a single person). In general, those receiving Ryan White Services have low incomes. Table 3-5 shows income levels for each risk group and Table 3-6 shows income levels for racial/ethnic groups.

Table 3-5 Income and risk group

	Total	MSM	MSM/ IDU	IDU	HET
Household income	%	%	%	%	%
\$8,500 or less	51.0	41.1	61.3	76.0	69.3
\$8,501 - \$11,500	15.2	20.0	15.5	-	5.5
\$11,501 - \$15,000	10.5	12.2	1.9	14.6	5.6
\$15,001 - \$27,000	8.5	7.8	7.7	4.3	14.3
\$27,001 - \$36,500	4.6	5.8	-	5.1	2.1
\$36,501 - \$50,100	6.9	9.6	3.9	-	1.7
Greater than \$50,101	3.3	3.6	9.7	-	1.6

Table 3-5 indicates that:

- Within the overall sample, over half of survey respondents have incomes at or below \$8,500 per year and three quarters of the full sample have incomes at or below \$15,000 per year.
- In all risk categories, the majority of respondents have incomes less than \$8,500 per year. Injecting drug users (IDUs) and heterosexuals report the highest proportion of low incomes than other risk groups.
- MSM and MSM/IDU have the highest proportion of incomes above \$36,000 per year compared to other risk groups, though the proportion of all MSM and MSM/IDU within this income category is relatively small (14%).



Table 3-6 Income and Ethnicity

	Total	African American	Hispanic	Anglo
Household Income	%	%	%	%
\$8,500 or less	51.0	70.8	64.2	35.6
\$8,501 - \$11,500	15.2	10.1	12.6	19.1
\$11,501 - \$15,000	10.5	5.3	7.2	14.5
\$15,001 - \$27,000	8.5	7.7	10.8	8.6
\$27,001 - \$36,500	4.6	2.4	1.3	6.9
\$36,501 - \$50,100	6.9	2.6	3.9	10.0
Greater than \$50,101	3.3	1.1	-	5.4

Table 3-6 indicates:

- African Americans (71%) and Hispanics (64%) have the highest proportion of respondents earning less than \$8,500 per year, while Anglos have the lowest proportion (36%).
- For incomes at or below \$15,000 per year, African Americans and Hispanics again have the highest proportion of survey respondents falling into this range with 86% for African Americans and 84% for Hispanics.
- 15% of Anglos have incomes over \$36,501 per year, the highest proportion of any racial/ethnic group.

Table 3-7 shows income by urban/rural and stage of infection. While the vast majority of PLWH/A live in Dallas County, the table indicates that:

- Participants living in urban areas have the highest proportion of income less than \$8,500 at 64%, and the lowest proportion earning \$36,501 or more, at 6%.
- The income distribution for PLWA and PLWH is very similar, with the highest proportions falling into the lowest income range.

Table 3-7 Income by Urban/Rural and PLWH/A

	\$8,500 or less	\$8,501-\$11,500	\$11,501-\$15,000	\$15,001-\$27,000	\$27,001-\$36,500	\$36,501-\$50,000	> \$50,001	Total
	%	%	%	%	%	%	%	%
Urban	64.2	11.6	7.0	8.9	2.4	3.7	2.1	100.0
Rural	42.9	10.7	14.3	8.9	7.1	7.1	8.9	100.0
PLWA	48.8	19.2	11.2	7.5	4.1	6.6	2.5	100.0
PLWH	53.5	10.2	9.8	9.5	5.4	7.2	4.4	100.0

Insurance

Figure 3-2 and Table 3-8 show the percentage of PLWH/A who are insured and the types of insurance used. They indicate that:



- Health insurance coverage for populations in the Dallas EMA/HSDA is relatively high. As shown in Figure 3-2, over 70% of PLWA and 62% of PLWH report health insurance coverage.
- Among racial/ethnic groups, African Americans report the highest coverage at 71%, which is also higher than the overall survey sample proportion of 68%. Anglos follow with 69% reporting some form of insurance, and finally Hispanics, with the lowest proportion of coverage at 56%.
- Among risk categories, MSM and MSM/IDU (not shown in graph) report the highest proportion of insurance coverage, with 68% and 75% respectively.

Figure 3-2 Health Insurance

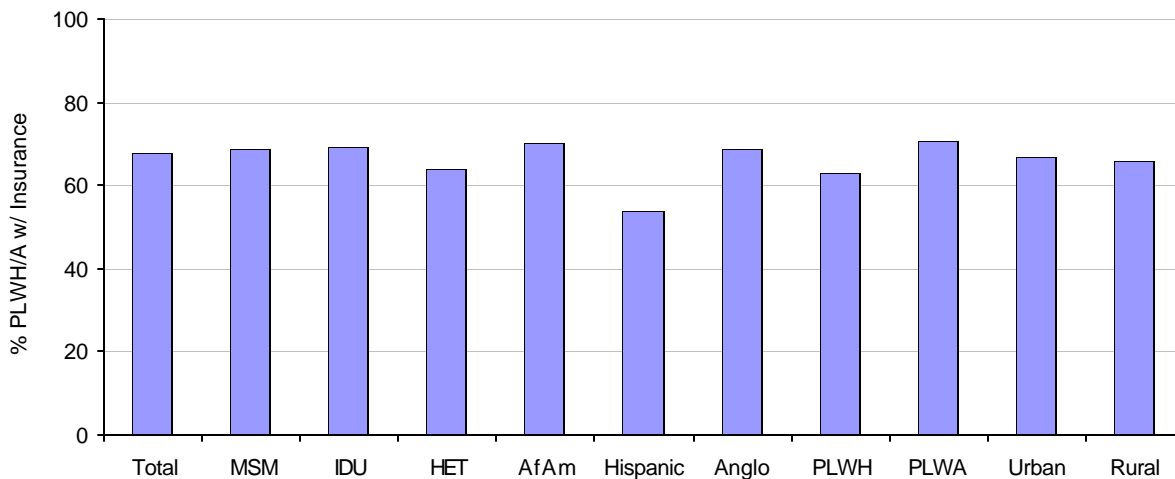


Table 3-8 Types of Insurance for Ethnicity and PLWA and PLWH

	Total Sample	African American	Hispanic	Anglo	PLWA	PLWH
Type of Insurance	%	%	%	%	%	%
No health insurance	32.3	29.6	45.9	31.3	27.7	38.3
Insurance through work	9.8	8.7	6.7	10.5	9.9	9.8
COBRA	2.9	1.9	2.7	4.0	3.7	1.9
Private insurance not through work	2.2	5.6	1.3	0.8	2.5	1.8
Veterans Administration	3.6	5.0	0.0	3.3	4.8	2.0
MEDICARE	37.1	28.1	23.0	44.1	43.7	27.6
MEDICARE - managed by an HMO	8.2	9.3	7.5	6.5	9.5	6.5
MEDICAID	26.9	35.2	24.3	23.4	25.2	29.4
MEDICAID - managed by an HMO	8.5	14.8	8.6	2.9	8.2	9.1
Other health insurance	6.8	6.7	6.2	6.4	8.5	4.6



As shown in Table 3-8:

- Medicare and Medicaid are the most common sources of insurance, with nearly 30% reporting coverage through Medicaid and 28% through Medicare. Nearly 70% of PLWA receive their insurance through these sources, and over 60% of African Americans and Anglos.
- Hispanics have the highest uninsured rates at 46%, much higher than the 32% rate for all PLWH/A.
- Private insurance not through work was the insurance source least used by both PLWA and PLWH.

Not shown in Table, but indicated in Attachment 6:

- Fifty-seven percent of individuals out-of-care report having no health insurance. For those out-of-care with insurance, most are covered by either Medicare (19%) or Medicaid (19%).
- PLWA who are asymptomatic have a higher rate of uninsured (41%) than those who are symptomatic (24%).
- One third of both men and women are uninsured. Women are more likely to receive Medicaid (37%) than men (25%). Women are also more likely to receive their health insurance through work (12%) than any other group.

Entitlements and Benefits

PLWH/A in the Dallas EMA/HSDA received a variety of entitlements and benefits in addition to health insurance coverage. Approximately 66% receive assistance paying for their HIV medications. Medication reimbursement comes from ADAP, Ryan White Title I, Medicaid, and private insurance.

Other benefits, such as long and short-term disability, food stamps, and rental assistance are often more difficult to obtain than drug benefits. They are necessary because of the large number of PLWH/A who are living near or at poverty levels.

- The three most common forms of benefits received are Social Security Disability Income (SSDI), long-term disability, and short-term disability.
- More than 47% of the MSM participants reported receiving SSDI.
- More African American participants report receiving food stamps (26%) than any other racial/ethnic group.

Employment Status

As shown in Table 3-9, over 30% of PLWH are employed in some capacity, while only 20% of PLWA are so employed. As might be expected, PLWA are much more likely to be on full-time



disability (52%) than PLWH (37%), and PLWH are more likely to be unemployed and looking for work (14%) than PLWA (9%).

Table 3-9 Employment status: Ethnicity and PLWH/A

	Total Sample	African American	Hispanic	Anglo	PLWA	PLWH
Employment Status	%	%	%	%	%	%
Employed full-time	11.8	13.9	13.6	10.1	8.4	16.5
Employed part-time	10.0	6.4	25.7	8.3	8.9	11.4
Working part-time and on disability	3.4	2.3	5.2	3.3	3.0	3.5
Not working - on full disability	46.0	44.4	31.6	50.6	52.5	37.4
Not working - applied for disability	10.5	12.1	6.5	10.8	10.0	11.2
Not working - looking for work	11.6	17.4	14.1	7.7	9.7	14.3
Not working - student	1.6	2.2	0.6	1.5	1.6	1.7
Retired	2.7	0.7	2.7	3.7	3.3	2.0
Other	2.4	0.7	0.0	4.0	2.7	2.0

- The majority of all groups are not working and are on full time disability. Anglos are the largest group not working and on full disability at 51%.
- Hispanics make up the largest racial group employed part-time at 26%, far higher than the number of African Americans (6%) and Anglos (8%).
- African Americans report not working and looking for work more than the other racial/ethnic groups (17%).
- More than 40% of Hispanics are employed in some capacity, a much higher proportion than that of African Americans (27%) and Anglos (22%).

Not shown in Table 3-9:

- Only 19% of individuals out-of-care are unemployed and on full disability, while the largest percent (48%) are unemployed and looking for work.
- Twenty-two percent of women are employed full-time, compared to 11% for the whole sample and 10% for men. Women have the smallest percent unemployed and on full disability (31%) compared to men (48%) and all PLWH/A (46%).

Age Distribution

The collected data (Attachment 6) of the consumer survey further indicate that:

- The mean age for the total weighted sample is 41 years with a range of 16 to 69. The majority of the participants (74%) are over 37 years of age.
- Two adolescents completed the survey.
- Sixteen participants are 60 years or older.



Relationships

Table 3-10 indicates that respondents are involved in many different types of relationships.

- Approximately 48% of the overall sample is single, and 7% are widowed or have lost their partner.
- Fifty percent of MSM are single. Twenty-eight percent report being partnered. Four percent are legally married and nearly 13% are divorced or have lost their partner.
- Thirty-eight percent of heterosexuals are either married, partnered, or in a common law relationship, while 36% are single.
- Nearly half (48%) of the IDUs have never been partnered or married. More MSM/IDUs report having had a partner die (14%) than any other risk group.

Table 3-10 Relationship status and risk category

	Total Sample	MSM	MSM/ IDU	IDU	HET	PLWA	PLWH
Relationship Status	%	%	%	%	%	%	%
Single	48.2	50.0	59.3	47.6	36.0	50.7	44.9
Legally Married	7.3	4.0	1.9	13.9	19.0	8.1	6.5
Common Law	3.7	2.3	0.0	6.7	8.9	1.4	6.7
Partnered	21.9	27.8	19.4	4.3	10.6	20.9	23.1
Separated	4.7	2.7	1.9	9.6	10.9	2.2	8.0
Divorced	7.1	5.6	3.9	15.4	9.0	7.9	6.0
Widowed or partner died	6.9	7.1	13.6	2.6	5.7	8.3	4.8

Living Arrangements

Table 3-11 shows the different profiles of living arrangements for the participants of the survey.

- The majority (59%) of all survey respondents live in their own house or apartment and 35% live alone.
- Eight percent are homeless and on the street, homeless and living in a shelter, living in a transitional housing facility, or living in housing provided by the city or state.
- IDUs are more likely to be homeless (8%) than any other risk category. Ten percent live in a halfway house or treatment facility.
- Among MSM, 65% live in their own house or apartment and nearly two-thirds live alone.
- Over two percent of PLWA are homeless and living on the street or in a car. The majority, however, live in stable housing (60% in their own house or apartment).

Not shown in Table 3-11:



- Women are more likely to be living in a homeless shelter (5%) than men (0.6%) or the overall sample (1.3).
- Individuals out-of-care have the highest rates of homelessness with 19% living in a homeless shelter and 5% homeless and living on the street or in a car, suggesting an unstable living situation may be related to care seeking.

Table 3-11 Living situation by Risk Category and PLWH/A

	MSM	MSM/ IDU	IDU	HET	PLWA	PLWH
Living Situation	%	%	%	%	%	%
Own house or apartment	64.4	40.7	52.6	50.7	60.8	56.4
Parent's/relative's apt./house	12.6	11.6	4.3	21.0	14.0	12.2
Someone else's apt./house	9.5	12.8	-	-	8.3	9.3
Rooming or boarding house	2.5	1.9	2.6	3.6	2.0	3.5
"Supportive living" facility	3.7	5.8	11.2	3.7	5.3	3.7
Group home or residence	2.8	3.9	7.7	3.0	1.7	5.7
Half-way house, transitional housing, or treatment facility.	1.9	15.5	9.6	3.0	3.1	5.1

Stages of Disease

Diagnosed with AIDS

Approximately 56% of PLWH/A reported that they were told by their doctor that they have AIDS. MSM are more likely to be diagnosed with AIDS than any other risk group at 60%. African Americans were least likely to report living with AIDS than any of the other ethnic subpopulations.

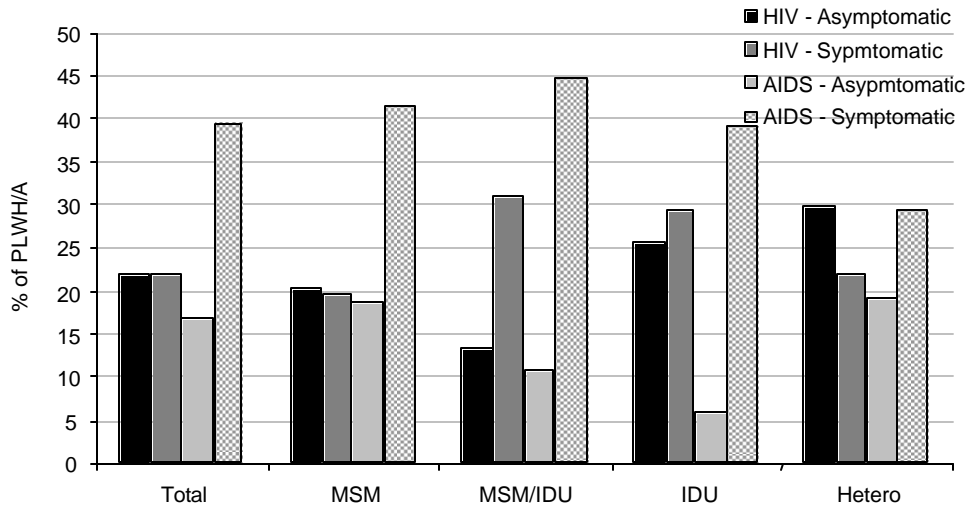
Symptomatic

The findings indicate that over 60% of the survey sample currently have symptoms associated with their HIV infection. Of those diagnosed with AIDS, over 70% report being symptomatic. Among HIV+, non-AIDS diagnosed respondents, 50% report symptoms. Figure 3-3 shows the percentage reporting symptoms by risk category.

- IDUs and MSM/IDUs are the most symptomatic among the participants.
- Close to 50% of the heterosexuals are asymptomatic, and 40% of the MSM report no symptoms.



Figure 3-3 Percentage with and without symptoms by risk category



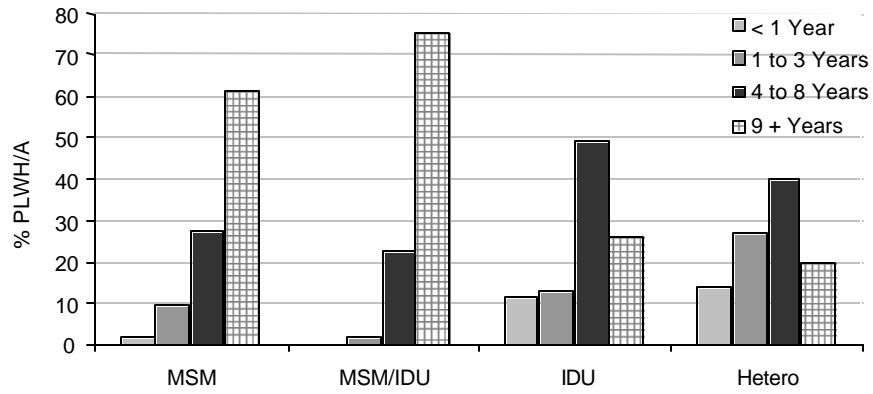
Length of Time of Infection

Figure 3-4 shows the length of time that people have been living with HIV.

- MSM and MSM/IDU are more likely to be diagnosed with HIV infection longer than other risk categories. Over 60% of MSM have been diagnosed for nine years or longer and over 75% of MSM/IDUs.
- Over 50% of all survey respondents have been HIV infected for nine years or longer. Seventy-five percent or more of the MSM, MSM/IDU, and IDU groups have been infected for at least four years.
- Heterosexuals report the most recent infections, with 14% reporting HIV infection of less than one year.



Figure 3-4 Length of Time Known HIV Positive by Risk Group





4. MEDICATION AND ADHERENCE

Medication and Adherence

The use of combination therapy and prophylactics to prevent opportunistic infections has greatly improved the length and quality of life of PLWH/A. Continued and improved health status outcomes will depend, in part, on the availability, access and adherence to properly prescribed medical regimens.

- The vast majority of respondents (80%) are currently taking medicines to treat their HIV infection. Seventy percent of all survey respondents report being currently on a drug cocktail, consisting of two or more HIV/AIDS medications.
- Only 6% of PLWH/A taking medications have stopped and 31% report never skipping a dose. Over 50%, however, have missed their medication schedule anywhere from once or twice a month (31%) to more than twice a week (12%).
- Over 90% of PLWA report taking HIV medications, and 85% are on combination drug therapy. One-third have never skipped their meds, though over 60% report having interrupted their medication schedule from once or twice a month to more than twice a week. Only 5% of PLWA have stopped taking their meds altogether.
- Figure 4-1 shows that IDUs have stopped taking their medications more than any other group (13%), in contrast to 7% of heterosexuals and 6% of MSM.
- Heterosexuals reported higher adherence to medications than other risk categories with close to 45% reporting never skipping their medications.

Not shown in Figure 4-1:

- PLWA participants who are symptomatic report higher medication use (90%) than asymptomatic PLWA and all HIV infected.
- Rural respondents, like those in urban areas, have high rates of medication taking, including combination drug therapy.



Figure 4-1 Medications and Adherence by Risk Category

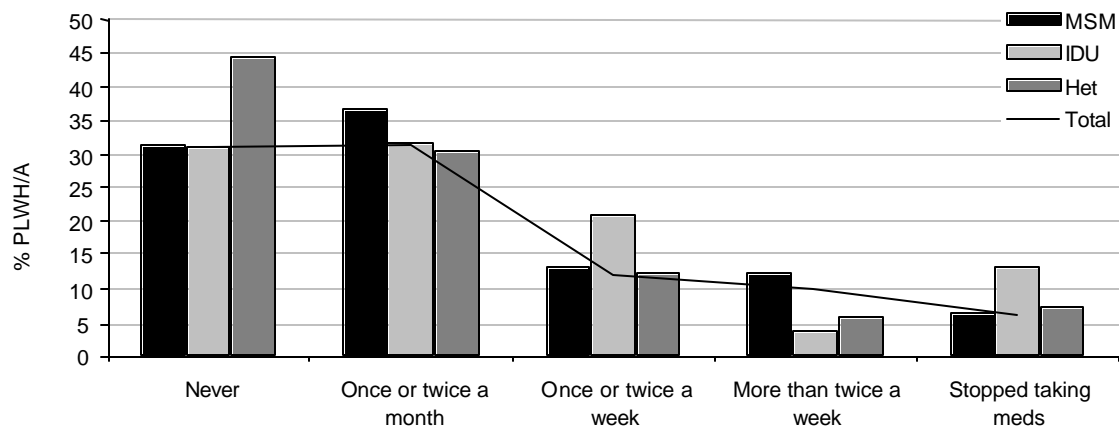


Figure 4-2 indicates the top three reasons for discontinuing medications for all PLWH/A were:

1. forgetting to take them (60%),
2. the side effects associated with the use of the medications (42%), and
3. the difficulty of the schedule and requirements (37%).

IDUs were more likely than other groups to cite homelessness and not wanting to take them as reasons for stopping medications. Heterosexuals and IDUs were more likely than MSM to run out of medications, while MSM cited side effects at a higher proportion than other groups for stopping meds.

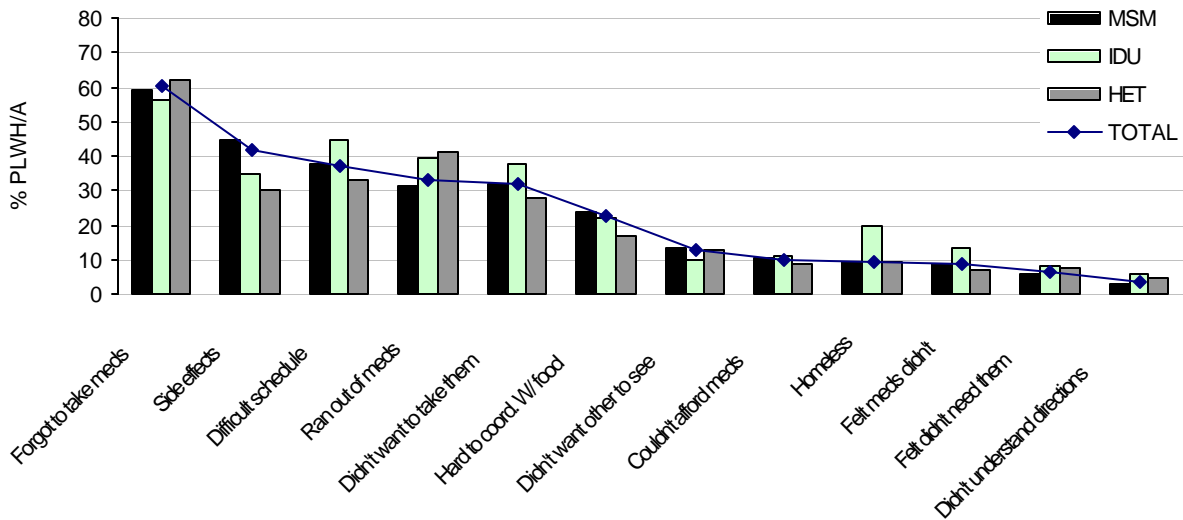
For PLWH/A, reasons for skipping meds match those for the overall sample and for risk categories. Over 60% have skipped due to forgetting to take their dose, and over 40% have skipped because of side effects or because of the difficulty of the schedule and requirements.

Not shown in Figure 4-2:

- The overwhelming majority of all PLWH/A who did stop taking their medications made the decision without the advice of their doctor.



Figure 4-2 Reasons for Stopping Medications by Risk Category



Summary of Medication and Adherence

The overwhelming majority of all PLWH/A surveyed report being on combination therapy (78%), though a large proportion have skipped their meds at some point (60%). A smaller percentage report stopping their meds altogether (7%). IDUs showed higher proportions of discontinuing medications and of intermittent use, compared to other groups. The vast majority of those who skip or stop their medication do so without the knowledge and consent of their physician.

The most common reason for lack of adherence is that PLWH/A forgot. This suggests a more concerted effort to incorporate different kinds of reminders like participation of family members and partners, beeping pill boxes, etc., as a strategy to help PLWH/A remember to take medications. The second most frequently reported reason is side effects which suggests more communication between PLWH/A and their physician to determine the best ways to minimize side effects.

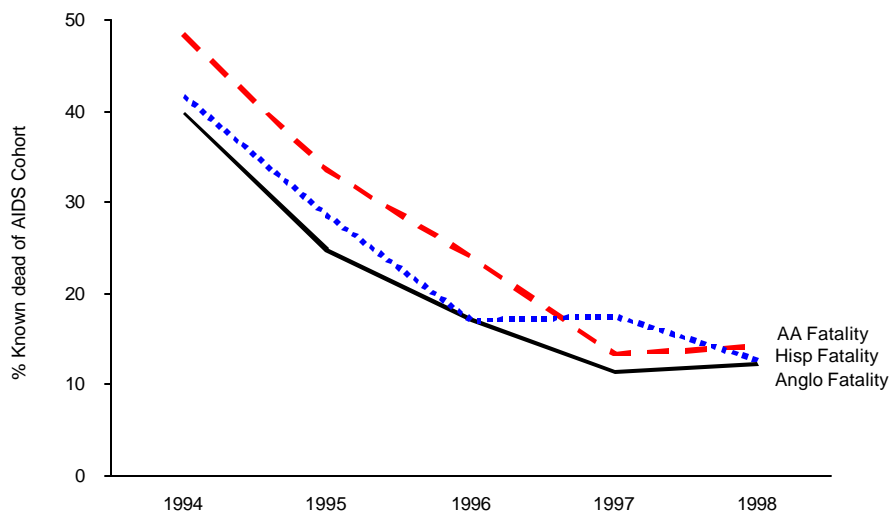


5. OUTCOMES

Mortality

Fewer people dying of AIDS and improved quality of life for those living with HIV and AIDS are two outcomes measured in this needs assessment. Figure 5-1 indicates that fatality rates have declined among all ethnic groups at about the same pace. In 1998, Anglos have the lowest fatality rates, followed by Hispanics and African Americans. Hispanics, taking an upward turn in 1996, dropped below the African American fatality rate in 1998. Also, while the differences among the ethnic groups widened between 1996 and 1997, in 1998 the differences are much smaller, with a fatality rate of 14% among African Americans, 13% among Hispanics and 12% among Anglos. The precipitous decline that was noted in the mid 90s has more recently leveled off with the three ethnic groups displaying similar patterns.

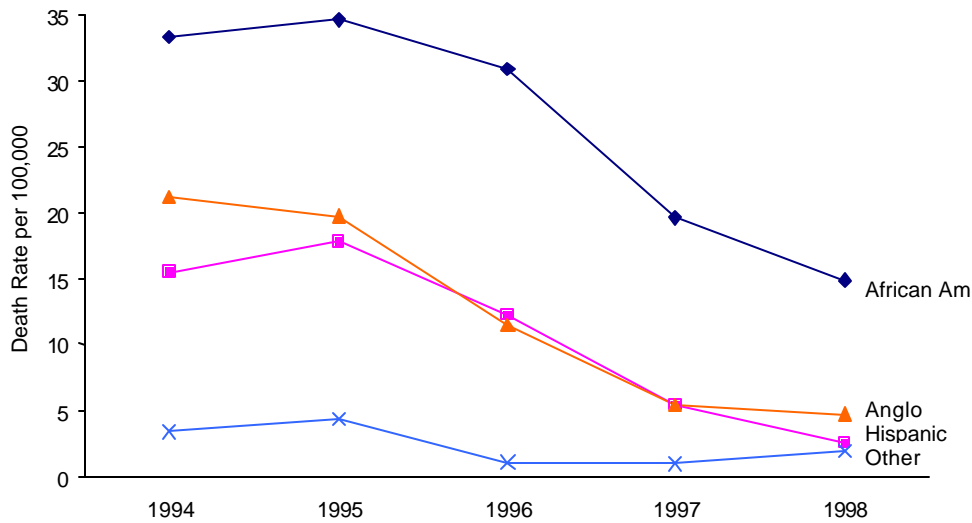
Figure 5-1 % Deceased by Year of People with AIDS in a Cohort Tracked by TDH



Unfortunately, as shown in Figure 5-2 for all deaths, the death rate is substantially higher among the African American population, and while it has declined faster than that of the Anglo and Hispanic populations, it continues to be between three or five times the rate of the Anglo and Hispanic death rate.



Figure 5-2 HIV/AIDS Deaths by Ethnicity per 100,000 of Dallas EMA Population



Quality of Life

The second outcome measure for the system of care is improved physical and mental health. While no baseline physical or mental health measures are available for PLWH/A, survey participants rated their current physical and emotional health and then compared it to “when they first sought treatment for their HIV infection.” The assumption is that access to care, and in particular to new HIV drug therapies, have had a positive impact on the physical and mental health of PLWH/A seeking care. Consequently, improved physical or emotional health after seeking treatment would suggest the system is meeting its major objective.

Drug therapies, however, may not have the same beneficial affect across all populations, and some PLWH/A may experience severe side-effects that compromise both physical and mental health. Additionally, there are disparities in access to care and treatment that may also impact quality of life. As a result of these factors, it is expected that some of the survey respondents will report decreasing physical and emotional health regardless of the quality of the treatment.

Figure 5-3 reports the current and perceived change in physical health. It is divided by three stages of HIV infection. The first two stages of HIV infection, symptomatic and asymptomatic are mutually exclusive. The third is whether the survey participant said he or she was diagnosed with AIDS. While the majority of those said they were symptomatic, about 38% said they were asymptomatic.

As expected, those with no symptoms are more likely to report excellent (25%) or good (57%) physical health, and about 5% report poor physical health. Unanticipated is that more persons with AIDS say their health is excellent or good (57%) than those who are HIV positive with symptoms (42%). Ten percent or less of those who are symptomatic or those diagnosed with AIDS report being in poor physical health. The majority of those who are symptomatic report that their health is “fair”, with close to half of those living with AIDS say their health is good.



Just over half of those living with AIDS who are symptomatic or asymptomatic say their physical health status has improved. HIV positive persons with symptoms are more likely to say that their health status is worse (33%) compared to asymptomatic persons living with HIV.

Figure 5-4 reports the current perceived change in emotional health. Very little difference can be found between those who are symptomatic (10%) and those with an AIDS diagnosis (9%) who report poor emotional health. Over 55% of PLWH/A in all stages report their emotional health is very good or excellent.

Asymptomatic participants report the greatest improvements in emotional health (60%), with better than half of the symptomatic (54%) and PLWA (58%) reporting emotional health improvements.

Participants across all stages of HIV infection have reported improvements in physical and emotional health and a majority does not report poor physical or poor emotional health, suggesting the system is having a positive impact on the lives of PLWH/A.



Figure 5-3 Quality of Life – Physical Health

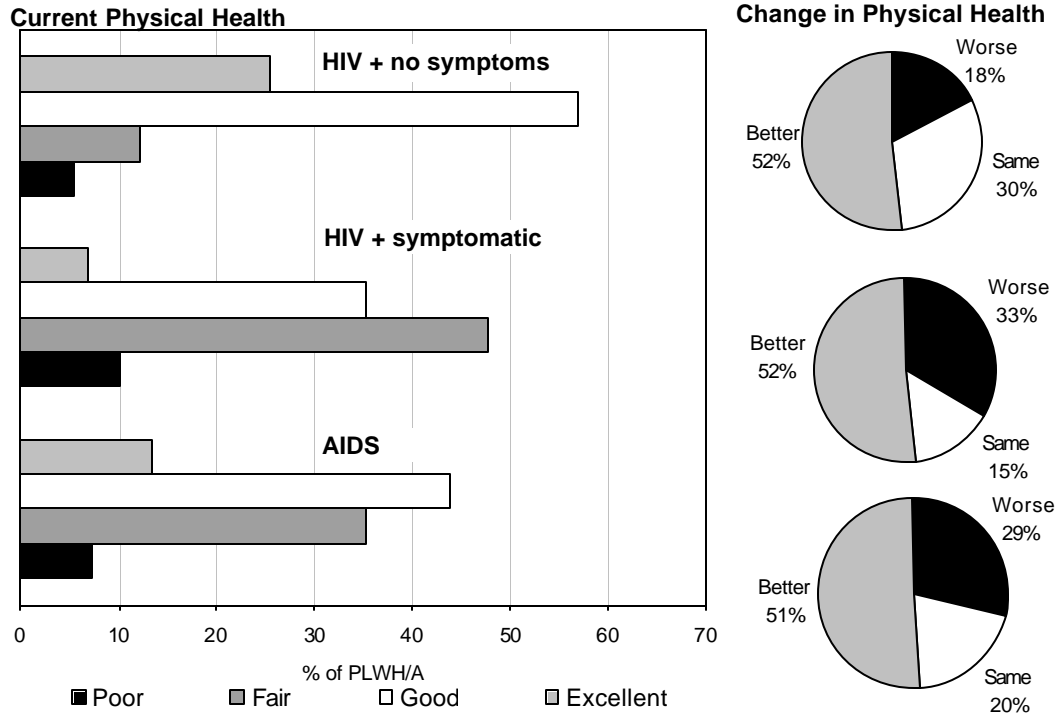
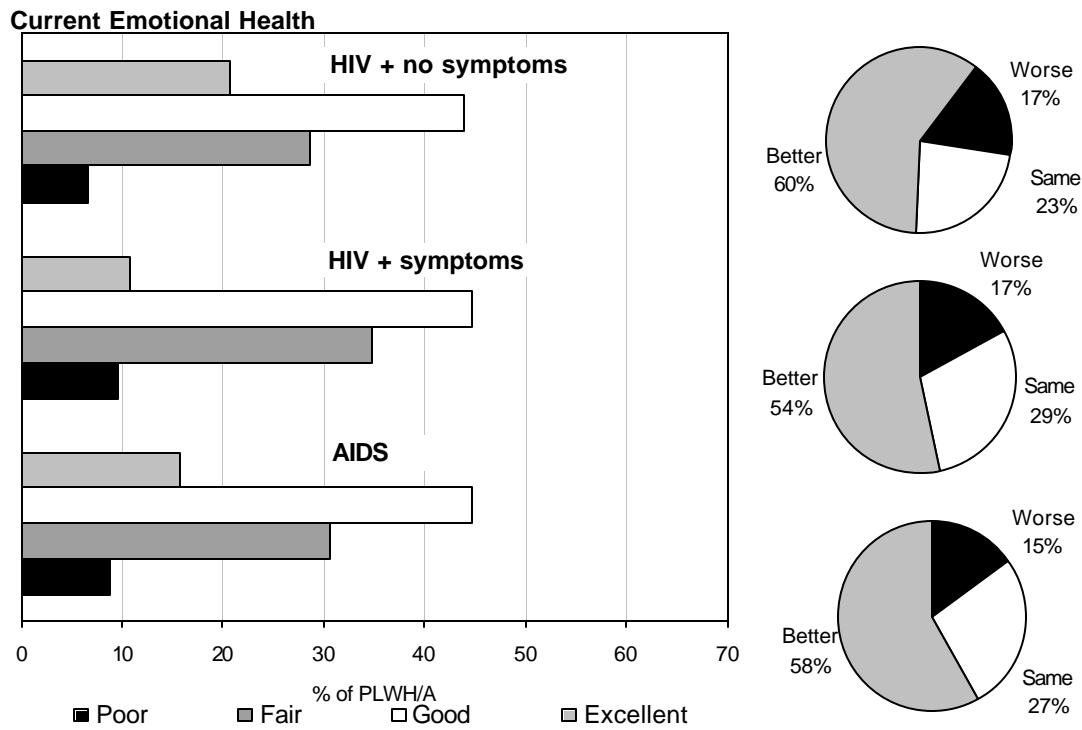


Figure 5-4 Quality of Life – Emotional Health





6. CO-MORBIDITIES

Substance Abuse

The co-morbidity of substance use and HIV includes IDUs, but also extends to the use of other substances, including non-injecting forms of crystal methamphetamine and ecstasy. The survey results show a relatively high level of substance use among respondents which, due to common under-reporting of risk behaviors, may be an under representation of total use. Patterns of substance use found in the 2001 needs assessment are very similar to those reported in the 1998 analysis.

Figure 6-1 Substance Use Among PLWH/A

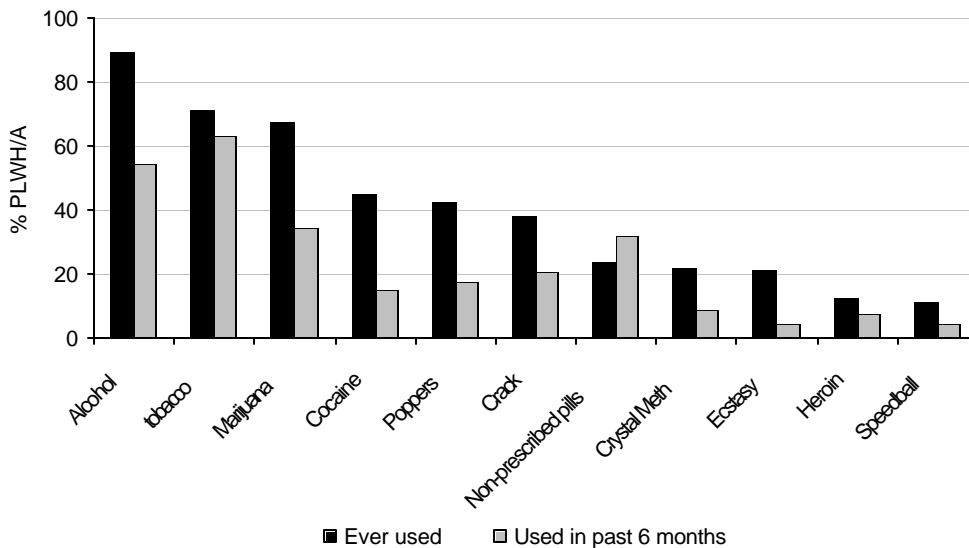


Figure 6-1 indicates that:

- Not surprisingly, alcohol and tobacco are used by most participants, with over 50% reporting having used them in the last 6 months.
- Marijuana is the third most frequent substance used, with nearly 70% of participants reporting ever having used it and over 30% having used in the past 6 months.
- Cocaine, poppers, and crack are the next most used substances, with a range of use over the past six months from just over 15% of the sample to 20%.
- Over 30% of PLWH/A have used pills not prescribed by their doctor in the past 6 months, about the same percent that have used marijuana.
- Crystal methamphetamine and the party drug, ecstasy, have ever been used by over 20% of PLWH/A, with recent use at approximately 5%.



Not shown in graph:

- PLWH/A who are out-of-care report the highest rates of chemical dependency, followed by African American MSM and African American heterosexuals.
- HIV positive, symptomatic respondents report higher rates of chemical dependency than those who are asymptomatic, and higher rates than AIDS diagnosed individuals.

Sexually Transmitted Diseases, Hepatitis, and Yeast Infection

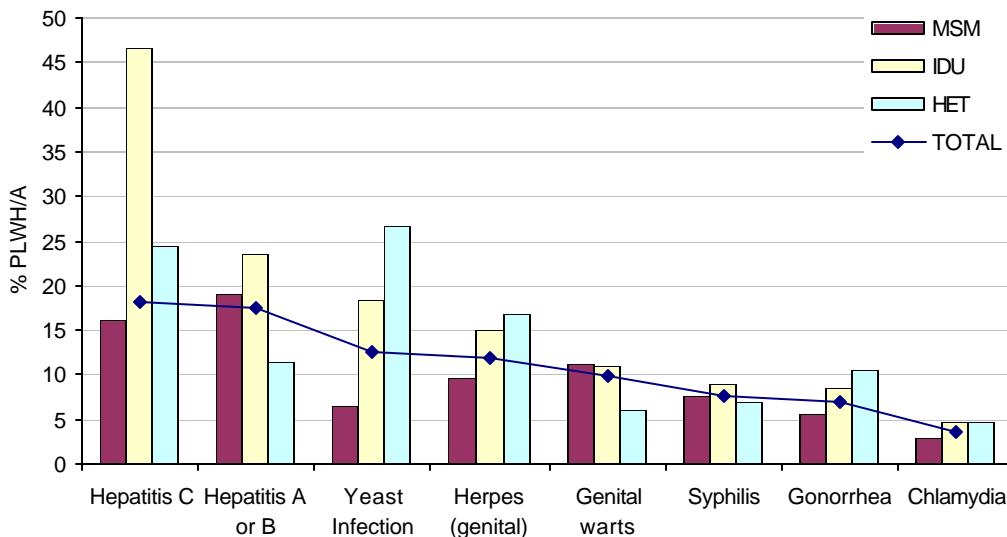
STDs have a dual impact on PLWH/A and those at risk for HIV infection. Individuals with a history of STDs are likely to have a compromised immune system and more likely to contract opportunistic infections (OIs). Also, manifestations of STDs such as open sores and genital ulcers make a person more vulnerable to HIV infection or re-infection. From an epidemiological perspective, a rise in STD rates, particularly gonorrhea and syphilis, indicate a rise in unprotected sexual intercourse that can lead to higher infection rates. Hepatitis, particularly Hepatitis C, is associated with needle sharing and is an indication of risk of HIV infection among IDUs.

Figure 6-2 indicates an alarming proportion of all groups reporting infection with Hepatitis A or B and Hepatitis C. Over 45% of IDUs report Hepatitis C infection, far higher than any other group, indicating that needle sharing continues to be a problem for this population. Since the heterosexual and IDU group are not mutually exclusive, the high rate of Hepatitis C among the heterosexual group may be due to the large percent of IDUs (over 35%) in the heterosexual risk category.

Among MSM, genital warts, genital herpes and syphilis are the other most common STDs reported, though compared to rates of Hepatitis, the figures are much lower. In general, MSM report the lowest rates of all STDs among the risk categories.



Figure 6-2 STDs among PLWH/A



Mental Illness

Mental illness covers a wide range of diseases including major depression, bipolar depression, post-traumatic stress disorder (PTSD), anxiety disorders, schizophrenia or psychotic disorders, and dementia. It may include people who are severely and persistently mentally ill or those who are less debilitated by depression and anxiety. Still, even a less severe and persistent mental illness can negatively impact adherence to medical regimens and significantly reduce the quality of life for PLWH/A.

Compared to some findings from the 1998 needs assessment, some mental health indicators appear to have increased over time. For example, the previous study found 30% of respondents reporting psychiatric counseling post HIV infection, while the current study has seen an increase to over 50% for some populations such as MSM and PLWA. Further findings from the present study indicate that:

- About 8% of all survey respondents reported being mentally impaired, with IDUs reporting the highest rates at 14%. Ten percent of HIV symptomatic and AIDS symptomatic participants report being mentally impaired.
- Post HIV infection counseling is common among all participants, with MSM (57%) and PLWA (53%) reporting the highest rates.
- PLWA have very high rates of diagnosable disorders, including anxiety (34%) and depression (50%). Over 50% of IDUs have been diagnosed with depression and 46% of MSM. IDUs have higher rates of dementia than any other group, with 11 percent being diagnosed in the past two years.
- Individual counseling is the most common treatment method for all groups, with 74% of all PLWH/A seeking this type of counseling.



Homeless and Nearly Homeless

Unlike the 1998-99 Needs Assessment, there is a wealth of information on housing.² The results of the 2000 Housing Plan Survey found that there was a considerable need to increase housing, particularly independent living. The 2001 Needs Assessment data confirms that there is a perceived need by consumers, particularly for African Americans and females.

The City of Dallas Continuum of Care 1999 Single Point Homeless Count conducted on January 19, 1999, with the participation of over 30 agencies, found more than 3,000 people were counted in homeless shelters and 82 people were counted that were living on the streets.

As seen in Table 6-1, 11% of the 3000 homeless persons self-identified as living with HIV or AIDS. This figure is likely to be low, given the high number of homeless with co-factors associated with HIV. Like those infected by HIV, homeless are disproportionately African American, including chronic substance abusers, ex-offenders, and individuals with mental illness.

Table 6-1 Demographic Profile of Homeless in City of Dallas³

(January 1999)

Demographic Category	N	Percent
Total Counted	3,098	100%
Individuals	2,200	71%
Children in families	600	19%
Adults in families	298	10%
Race/Ethnicity		
African American/Black	1,810	58%
Caucasian/White	898	29%
Hispanic/Latino	380	12%
American Indian/Alaskan Native	10	<1%
Gender*		
Male	1,496	48%
Female	1,002	32%
Special Populations (self-reported)		
Persons living with AIDS	335	11%
Chronic substance users	500	16%
Ex-offenders	200	6%
Seriously mentally ill	375	12%
Domestic violence victims	175	6%
Dual diagnosis**	160	5%
Unaccompanied youth	75	2%
Veterans		8%
<small>Note: Percentages may add up to more than 100 due to rounding. *The gender of the 600 children counted was not available. **Dual diagnosis indicates persons living with AIDS who are seriously mentally ill and/or are chronic substance user</small>		

² For more detailed housing information see “Dallas Planning Area HIV/AIDS Housing Plan” by AIDS Housing of Washington, 2000.

³ Dallas Planning Area HIV/AIDS Housing Plan, AIDS Housing of Washington, 2000.



In Table 6-2, the findings of the 2000 Housing Plan Survey of 613 consumers and the 2001 Needs Assessment survey of 387 PLWH/A are compared. In the housing survey, seven percent were on the streets, in shelters, in residential hotel/motels, or “crashing for free” when they completed the survey. Notably, survey participants were not randomly selected and represent a larger number of homeless and PWLH/A who reside in institutional and supportive housing than in the general population of PLWH/A. In the 2001 Needs Assessment survey, about 3% of the participants were homeless or near homelessness. The sample for this survey was more representative and weighted to the known populations of PLWH/A. Five percent of those out-of-care indicated they were homeless and 19% said they were in a homeless shelter, although these finding may be unreliable due to small sample size.

Table 6-2 Current Housing Situation of Survey Respondents

Current Housing Situation	2000 Housing Study	2001 Needs Assessment
	%	%
<i>Homeless (on the streets)</i>	4%	1.5%
<i>Crashing for free (temporarily)</i>	2%	(not asked)
<i>Staying in a shelter</i>	1%	1.3%
Social service agency housing program (drug/alcohol treatment center, halfway house, etc.)	2%	15.3*
HIV/AIDS housing facility	22%	
Live in a residential hotel/motel	1%	
<small>Italicized text indicates that people living in these situations are considered homeless or at risk of homelessness. *Halfway house, transitional housing, treatment facility, “supportive living facility”, group home or residence, rooming or boarding house, other housing provided by City or State.</small>		

The 2001 Needs Assessment Survey found that the use of housing varied greatly by risk group and ethnicity. Table 6-3 indicates that:

- Nearly 30% of IDUs and those out-of-care and 25% of African Americans have been homeless for some period of time in the last two years.
- Between 10% and 13% of MSM and heterosexuals, respectively, say they have been homeless.



Table 6-3 Homeless by Risk Group and Ethnicity

	Total	MSM	IDU	HET	PLWA	African American	Hispanic	Anglo
Length of Time	%	%	%	%	%	%	%	%
Never	87.3	89.4	71.2	82.5	85.1	74.9	91.9	90.6
Less than a month	4.4	3.3	10.8	6.4	5.9	4.2	2.7	2.3
1-3 months	1.6	1.4	3.9	2.2	2.5	7.8	2.7	2.3
4 months to 1 year	5.5	5.2	10.7	5.8	5.0	10.2	0	3.1
More than 1 year	1.2	0.6	3.5	3.2	1.5	3.0	2.7	1.6

The Needs Assessment survey further indicated that 10% of the sample of PLWH/A said they currently lived in a halfway house or transitional housing facility, and 14% of the participants have lived in transitional housing over the past two years. IDU, African Americans, and recently incarcerated are much more likely to have lived in transitional housing.

Five percent of the sample of PLWH/A currently lives in an assisted living facility, and about 20% have lived in an assisted living facility in the past two years. Up to 33% of the Hispanic population and 30% of the African Americans say they have lived in an assisted living facility in the past two years.

Tuberculosis

The survey found that 12% of the PLWH/A reported having either active TB or inactive TB. The majority TB cases reported were in the Latino (15%) and African American (14%) communities with a high percentage amongst recently incarcerated (20%).

Newly diagnosed cases for TB among those living with HIV and AIDS have been declining since 1997 in Dallas County. In 1993, there were 25 new TB/AIDS co-infected cases. In 1997, there were nine new TB/AIDS co-infected cases and in 2000 there were five new TB/AIDS co-infected cases.



7. SERVICES

Introduction

The Council and Consortium fund the seventeen service categories shown in Table 7-1. The list in Table 7-1 is in order of the 2001-2002 priorities.

Table 7-1 Service Categories 2001-2002 Priorities

<p>1. OUTPATIENT MEDICAL CARE 1.1 Primary care (medical care) 1.2 Medical case management U. Appointments for OB/GYN and/or pediatric care U. Medical specialists (not OB/GYN) U. Rehabilitative Services</p> <p>2. MEDICATIONS 2.1 Medication reimbursement 2.2. Prescription medication delivery</p> <p>3. DENTAL CARE</p> <p>4. HOUSING* 4.1 Mortgage or rent assistance (short term) 4.2 Mortgage or rent assistance (long term) U. Living in Congregate Housing U. Emergency Financial Assistance</p> <p>5. FOOD 5.1 Food pantry 5.2 Meals in a group setting 5.3 Home-delivered meals</p> <p>6. TRANSPORTATION (people)</p> <p>7. CASE MANAGEMENT 7.1 Case management 7.2 Client advocacy</p> <p>8. HOME HEALTH SERVICES 8.1a Home Health Care. professional 8.1b Home Health Care. para-professional 8.2 Hospice Care U. Nursing Home Long-Term Care</p>	<p>9. MENTAL HEALTH COUNSELING U. Individual mental health U. Group mental health U. Peer counseling</p> <p>10. INSURANCE ASSISTANCE</p> <p>11. SUBSTANCE ABUSE TREATMENT U. Outpatient substance abuse tx U. Residential hour a day substance abuse tx</p> <p>12. INFORMATION AND REFERRAL U. HERR U. Nutrition education and counseling U. Hotline or telephone info U. Resource directory U. Information clearinghouse. Library</p> <p>13. ACCESS FOR TARGETED POP 13.1 Access to underserved pop (Treatment outreach) 13.2 Interpretation services</p> <p>14. LEGAL SERVICES</p> <p>15. ADULT DAY CARE – RESPITE</p> <p>16. DAY RESPITE CARE FOR CHILDREN & ADOL. U. Children and family services U. Adoption/foster care U. Child care</p> <p>17. BUDDY/COMPANION U. Emergency medical services U. Complementary Care U. Employment Assistance U. Exercise/Fitness/Strength/Training</p>
<p>U = no subcategory priority *Housing facility operations is ranked, but is not a consumer service and is not shown here</p>	

Over time the priorities have shifted and new sub-categories of services have been added as care for HIV and AIDS moves from end stage to chronic treatment and the demand of PLWH/A have been assessed. While outpatient care has remained the top priority, medical case management was moved from a subcategory of outpatient care to its own category in 1999 to assist PLWH/A coordinate access to care and information concerning medical care, medication, and adhere to their medical regimen. In 2001 “medications” was added as its own category as medication reimbursement and access to drugs took on added significance in maintaining the health status of PLWH/A.

Food and dental care increased in priority from 1999-2000 (FY1999) to 2000-2001 (FY2000), but then decreased in priority from FY2000 to 2001-2002 (FY2001). In response to consumer demand, unmet needs, and the shift to unit costing, between FY2000 and FY2001, “medication” and “insurance assistance” became their own categories, reflecting the need to maintain a person



on a medical regimen by ensuring for its payment and delivery. Dental services remained the third ranked priority as consumer demand remains high, and dental monitoring can provide early detection of compromised immune systems and ensure that dental problems are not a barrier to proper nutrition. Food moved from second to fifth priority, case management moved from fourth to seventh priority, and access for targeted populations moved from seventh to thirteenth priority. Housing moved up for sixth to fourth, transportation from eighth to sixth, and home health care from thirteenth to eighth. Financial assistance was moved from a major category into subcategories of housing. Information services moved from tenth to twelfth.

At the lower end of the priorities, services for children and adolescents were modified, resulting in the category day/respite care for children and adolescents. Volunteer support was changed to buddy/companion services and placed as the lowest priority.

Most Needed Services

Top Rated Needs Compared to 1998

The top five services PLWH/A said they needed the most in 2001 are the same as those reported in 1998, but the rankings are different. As shown in Table 7-2, food bank and nutritional supplements have become the highest ranked need in 2001 compared to the fourth ranked need in 1998. Dental care is the second ranked need, up one from 1998. Medication reimbursement has moved down a bit, and outpatient care has moved from second highest reported need to fifth. The lower emphasis on medical care probably indicates the improved health status of PLWH/A and is the result of the successful medication and services that ensure access to care. Case management has moved into the top 10 service needs from 1998.

Table 7-2 Ranking of Top Service 2001 vs. 1998

Service # in () is the 2001-02 priority; some services may be subservices of major categories	2001 Consumer Rank	1998 Consumer Rank
Food (5)	1	4
Dental (3)	2	3
Medication Reimbursement (2)	3	1
Transportation (6)	4	5
Outpatient Care (1)	5	2
Emergency Financial Asst (4)	6	5
Meals (5)	7	-
Case Management (7)	8	13
Housing (4)	9	8
Mortgage Assistance (4)	10	11

The trends in the prioritization and consumer demand for services reflect the continuing shift in the profile of persons becoming infected and living with HIV and AIDS. These trends include:

- The populations infected are poorer and in growing need of basic services such as food and housing;



- More persons are living with HIV and not progressing to AIDS, thus unable to qualify for disability but able to work and qualify for insurance;
- Many PLWH/A have been infected for more than five years and they have gained basic information about the disease and services. Information needs shift for those managing long term HIV infection, and it includes information on how to control chronic HIV disease, obtain benefits, and navigate the care system.

Services PLWH/A Report Needing Most

In the 2001 survey, the consumers were asked to list the top ten services they needed. Figure 7-1 shows services that are needed by at least 10% of the PLWH/A. The number following the service in parentheses is the 2001-2002 priority ranking, as noted in Table 7-1.

From the perspective of the PLWH/A the shift in demand reflects the trends in the epidemic. As traditionally poorer populations are represented among PLWH/A, and as those infected live longer and have become poor due to prolonged disability, there is a greater need for basic services. Food, emergency assistance, and rent/mortgage assistance are in the top ten service needs and this confirms comments heard throughout the focus groups. There is a high perceived need to obtain medication reimbursement, reflecting the 80% of PLWH/A who are on medication. Outpatient care continues to be perceived as important, although not the most important service. This reflects the improved and stable health status of people living with HIV and AIDS where the majority of those infected are maintaining their health through successful drug treatment. (See the section earlier on OUTCOMES) Dental care continues to be ranked highly because it is a service that PLWH/A would not be able to get without Ryan White assistance, and it is clearly viewed by PLWH/A as improving their quality of life.

The lowest ranked services, shown in Table 7-3, are end-stage services or services targeted to special populations such as women and children. As shown in Figure 7-1 to Figure 7-4, when needs for women or families are ranked by gender, they show a much higher rating.



Figure 7-1 Top Ranked Needs by PLWH/A

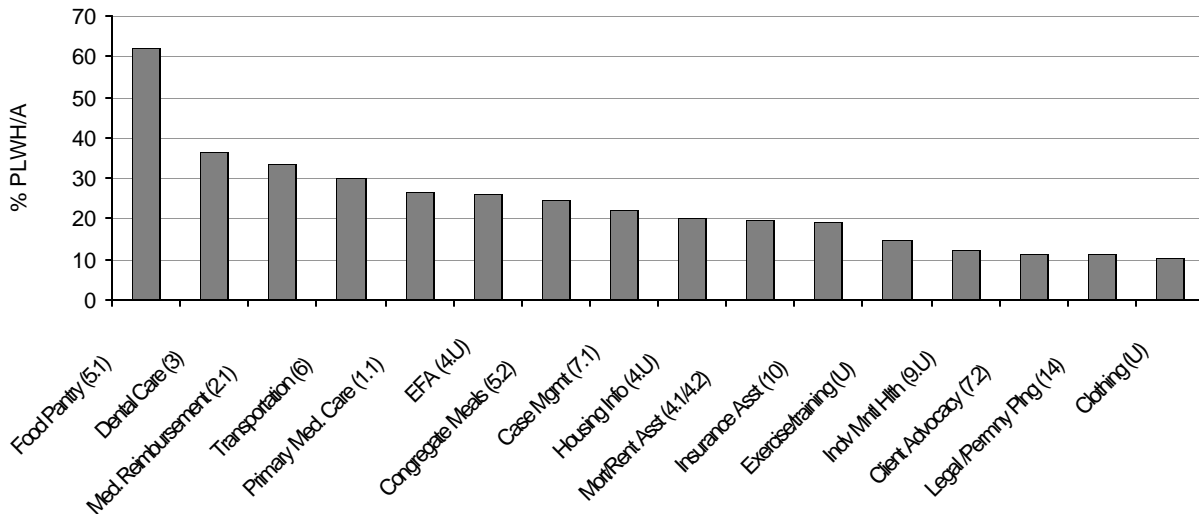


Table 7-3 Top Ranked Needs

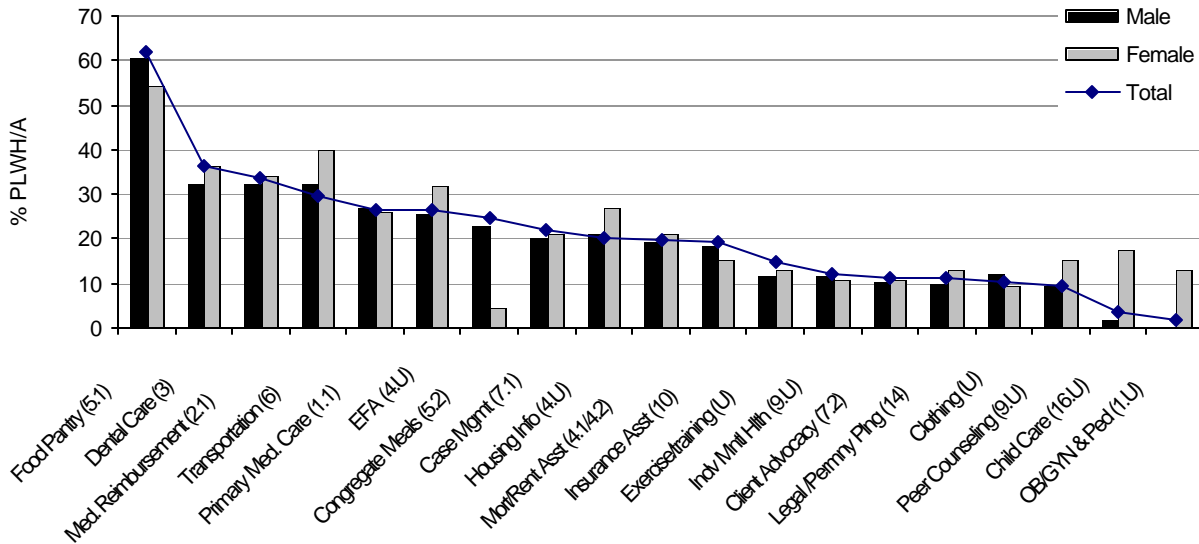
SERVICES	%
<i>Number in () represent 2001-2002 ranking</i>	<i>Wt.</i>
Food Pantry (5.1)	62.0
Dental Care (3)	36.5
Drug Reimbursement (2)	33.5
Transportation (6)	29.8
Outpatient Care (1.1)	26.6
EFA (4*)	26.4
Meals - cong (5.2)	24.7
Case Mgmt (7)	21.9
Housing Info (4.U)	20.0
Mort/Rent Asst (4.1/4.2)	19.7
Insurance Asst (10)	19.3
Exercise/training (U)	15.0
Individual Mental Health (9.U)	12.2
Client Advocacy (7.2)	11.1
Legal /Permanency Planning(14)	11.1
Clothing (U)	10.1
Peer Counseling/Support groups (9.U)	9.5
Voc Counseling & Training (U)	9.0
Med Case Mgmt (1.2)	8.1
Nutrition Ed& Counseling (12)	7.5
Buddy/Companion (17)	7.2
Visits to Medical Specialists (U)	6.0
Toiletries & Household Goods (including furniture)	5.9
Emergency Med (U)	5.7
Outpatient Sub Abuse Treatment (11)	5.2
Med Delivery (2.2)	5.1
Holistic or Complementary Care	5.0
Congregate Housing (4.U)	5.0

Adult Day/ Respite (15)	4.8
Treatment Outreach (13)	4.2
HERR (12.U)	4.0
Resource Directory (12.U)	3.7
Home-del Meals (5.3)	3.5
Child care (16)	3.5
Rehabilitative (U)	3.2
Hotline/Tele Info (12.U)	2.5
Vision Care for eyeglasses	2.5
Translation (13.2)	2.5
Group MH (9.U)	2.3
HHC - para-professional (8.U)	2.1
Info Clearinghouse/Library (12.U)	2.0
OB/GYN & Pediatrics	1.8
Hospice Care (8.2)	1.4
Church	1.4
Pet Services	1.4
Residential Substance Abuse Tx (11.U)	1.2
HHC - professional (8.1)	0.9
Roommate Service	0.7
Universal Confidential Intake Form	0.7
Volunteer Work Program	0.7
Emergency Transportation	0.5
Car Insurance Assistance	0.3
Adoption/foster care (U)	0.3
Nursing home - Long term care (U)	0.2
Taxi Services	0.2
Haircut Coupons	0.2
Prophylactics	0.2
Medical Research Program	0.1



Figure 7-2 shows the services that males and females report needing the most. The line in the figure shows the “total” population need. Notably, among the general services, females are more likely than men to report needing transportation, financial assistance, housing and peer counseling. Not surprisingly, women are also much more likely to need child care and seek care by an OB/GYN. Men are more likely to report needing meals and insurance assistance.

Figure 7-2 Top Ranked Needs by Gender



When the top ranked needs are reviewed by ethnicity, as shown in Figure 7-3, Anglos express a greater need than other racial populations for food, dental, outpatient care, meals, mortgage/rent assistance, exercise training, individual mental health, medical case management, and buddy companion services. African Americans express a greater need for client advocacy and outpatient substance abuse treatment. African Americans and Hispanics say they have a greater need than Anglos for transportation, housing information, congregational housing and childcare. Hispanics, report a greater need for housing, insurance assistance, peer counseling, vocational counseling, and translations services.

Figure 7-4 shows the top ranked needs by risk group. MSM, who are more likely Anglo, show a greater need than other risk groups for food, dental care, meals, and exercise and training. IDUs report that they are more likely than other risk groups to need case management, peer counseling and support, vocational counseling, outpatient substance abuse treatment, and congregational housing. Heterosexuals, who are more likely represented by African American females, say they are more likely to need emergency financial assistance and childcare.



Figure 7-3 Top Ranked Need by Ethnicity

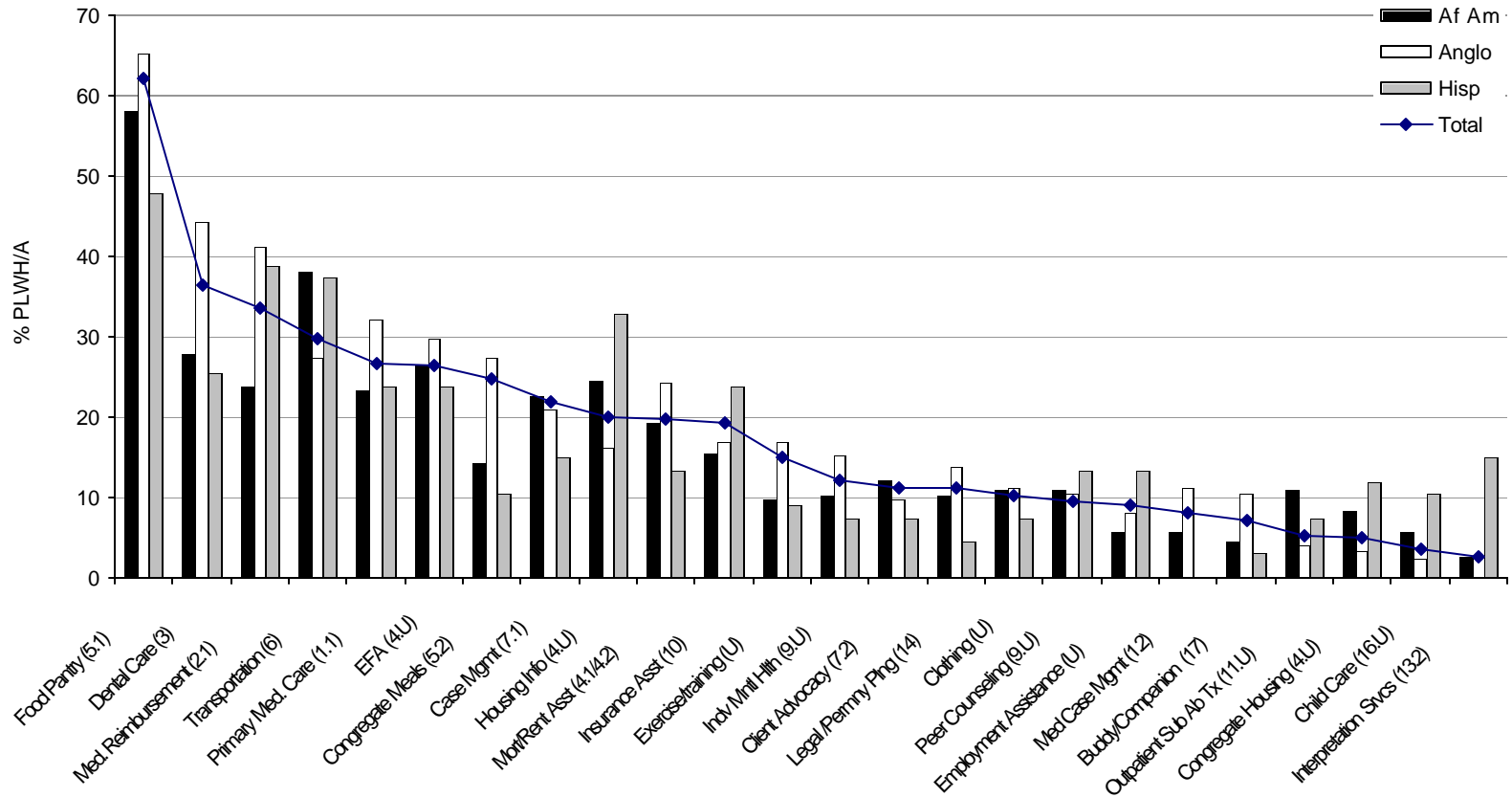
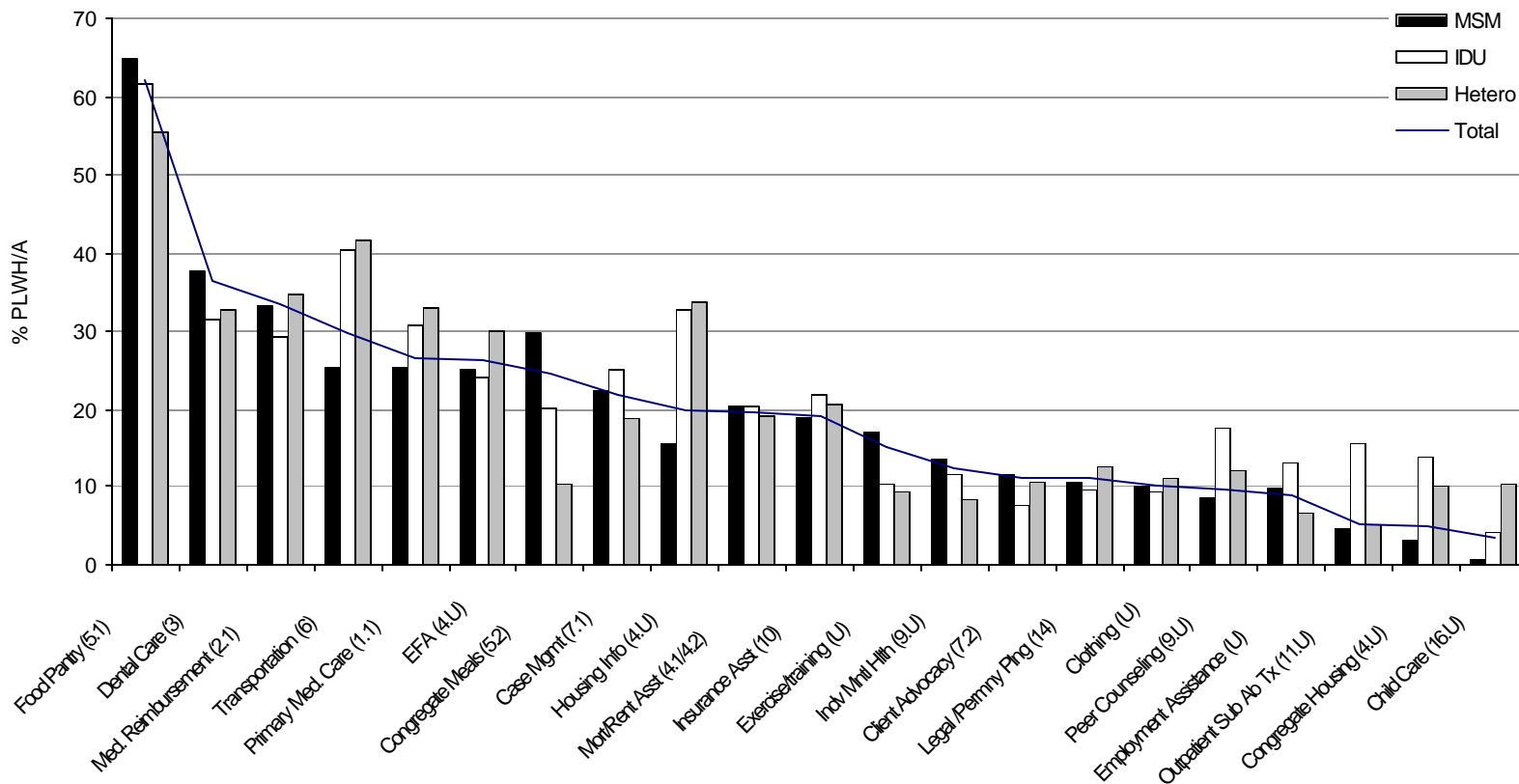




Figure 7-4 Top Ranked Needs by Risk Group





Use, Meeting Needs, and Future Needs Among Top Rated Needs

For each of top fifteen services that most participants reported they needed, Table 7-4 indicates the percentage of those who currently say they use each service, and ranks how well each service meets their needs and their future need. The first column shows the percentage of PLWH/A using the service. The second and third column present the mean score for how well the need is met and future need, respectively. For example a 2.5 in the second column indicates that the need was between very well and adequately met. A score of 3.5 in the 3rd column corresponds to the future need and indicates that it is between “need more” and “about the same.”

Notably, current use is reported to be under 40% for emergency financial assistance, housing information, mortgage or rent assistance and exercise and strength training. It is between 40% and 50% for individual mental health, client advocacy, and legal services. For those noting them as top needs, utilization is above 85% for meals in a group setting, and food bank.

In general, the services that are most needed are reported to adequately meet the needs of the participants. Those services which poorly to adequately meet their needs include emergency financial assistance, mortgage or rent assistance, and housing information.

Among these top ranked services, there is a perception that more services are needed. The greatest expanded future need is reported for housing information and mortgage assistance.

Table 7-4 Current Use and Meeting Need, and Future Need

	Currently Using	Meets Need 3=very well 2=Adequately 1=Poorly	Future Need 4=Need more 3=About same 2=Need less 1=Won't need
Food Bank, Supplements, Vouchers	86.7%	2.5	3.5
Dental Care	65.2%	2.3	3.4
Medication reimbursement	79.5%	2.6	3.3
Transportation to access HIV -related Services	70.6%	2.5	3.5
Primary Outpatient Care	81.9%	2.6	3.4
Emergency Financial Assistance	26.3%	1.7	3.6
Meals in a Group Setting	92.4%	2.7	3.4
Case Manager	75.0%	2.5	3.4
Housing Information Services	39.7%	1.8	3.7
Mortgage or Rent Assistance	36.2%	1.7	3.7
Health Insurance Assistance	53.3%	2.0	3.5
Exercise/fitness/strength/training	18.6%	1.9	3.7
Individual Mental Health	48.8%	2.1	3.6
Client Advocacy	45.9%	2.1	3.5
Legal Services / Permanency Planning	40.5%	2.3	3.3



Service Knowledge, Perceive Need, Demand, and Utilization

In the following section, service knowledge, perceived need, demand, and utilization is presented for each service and subservices shown in Table 7-1. They are presented by the priority 2001-2002 priority ranking.

Each service has the same format that provides systematic access to a wealth of information about each service. Once the reader masters how to read the information for one service, the knowledge can be applied to each of the following services.

Epidemiological, Service Units, and Funding

As shown in Figure 7-5 at the top of the service template is the definition for each service followed by concise statement of the service unit, eligibility criteria, and average unit of service. Where definitions have been stated by the Council, this section is left blank. For the most part eligibility is defined by income. For Title I the PLWH/A has to be within the EMA and for Title II within the HSDA. For end stage services there is usually an advanced acuity requirement.

Figure 7-5 Service Template – Definition, Units, Eligibility, & Average Units

<i>Definition</i>	
General management of acute and chronic medical conditions or prevention of such conditions through initial visit and intake, complete history and physical examination, lab tests necessary for evaluation and treatment, immunizations, follow-up visits and maintenance, appointments as indicated on the basis of clinical status, and referrals to other medical specialists, as necessary.	
Service Unit, Eligibility, and Funding	
Unit:	DCHHS defined service unit
Eligibility:	Council/Consortium defined eligibility
Average unit:	Based on the units of service recorded in COMPIS divided by the number of unduplicated clients.

The three boxes following the definition is the next set of information shown in the service template. As shown in Figure 7-6, the boxes show basic epidemiological information and monitoring information, service units provided in 2000, and funding levels.

Figure 7-6 Service Template - Epi, Units, & Funding

EST. PLWH/A		SERVICE UNITS 2000		FUNDING 2000-2001	
TOTAL	10,500	Number of Units Funded	From DCHHS	RW Care Title I & CBC	From DCHHS
Know HIV	6,930 (2/3 of PLWH/A)	Unduplicated Count	From DCHHS	RW Care Title II	From DCHHS
In Service	From COMPIS	Theoretical Need	Av. unit * # elig	Other	From DCHHS
Est. # Elig	Set by Council/Consortium	Number Reported Received	From DCHHS	Total Allocated	Sum of above

Estimated PLWH/A is based on the 2001 Epidemiological Review prepared by PCH. The estimate of 10,500 PLWH/A is the lower range of the estimate PLWH/A. The estimate of persons knowing their HIV status is made based on the CDC estimate that about two-thirds of those living with HIV know their status. The CDC national estimate is used because there is no better estimate available specifically for the Dallas EMA.

The estimate of those in-service is based on information provided by DCHHS, and was derived from COMPIS data. There may be a lag on reported COMPIS information and some clients may



not be reported. That would tend to under-count the number of clients. At the same time, there may be duplicates if a PLWH/A in service provided a different name. The degree of each error is unknown. However, DCHHS has confidence that it is a reasonable estimate of PLWH/A who access services funded by Title I and II. These estimates are important because they are used in determining the information provided in the Service Unit box and the gap indicators.

Under “Service Units 2000”, the number of units funded and “unduplicated count” is based on DCHHS data (derived from COMPIS). The “Theoretical Need” is based on the average units of service provided times the number of eligible PLWH/A. Dividing the total units provided by the unduplicated count results in an estimate of the average number of units provided to each client. Eligibility criteria, the number of units provided, and the unduplicated client count were provided by DCHHS. The raw data and calculation are shown in Attachment 7.

The third box on the top of the service template shows the funding for the service by Ryan White Title I and Congressional Black Caucus, Title II, and other funding sources that include TDH grants.

Taken together these three top boxes of data provide a snapshot of the service provided, demand for the service, and resources allocated for providing the service.

Perceived Needs

The graphs following the top box and the box labeled “Reported in 2001” display summarized data from the 2001 Consumer Needs Assessment Survey. (See page 7-21.) They present the percentage of PLWH/A who report knowing, needing, asking for, receiving, and accessing the service. The full set of data can be seen in Attachment 8 through Attachment 12.

When interpreting the graphs, the solid line going through each graph shows the total estimate for all PLWH/A. It is based on an analysis of the weighted data. The data graphed is presented to the right of the graphs, where the exact percentage can be seen. For example, in outpatient care, 76% of all PLWH/A know about outpatient medical care, slightly over 57% say they need outpatient medical care, 55% say they asked for outpatient medical care, and 98% say they received care. The reason for the large gap between needing, asking, and receiving is discussed in the bullet points on the bottom of the case management sheet.

In the top graph the bars show the estimated knowledge, need, demand (asked), and utilization (received) for males and females, and for the risk groups men-who-have-sex-with men (MSM), injecting drug users (IDU) and heterosexuals. For example, as seen in the graphs and in the box on the right, 74% of the men and 71% of the females know about outpatient care. More females (66%) say the need outpatient care than males (51%).

The second set of graphs shows the knowledge, need, demand, and utilization by racial populations: African Americans, Hispanic, and Anglos. Notably there are too few Asian/Pacific Islanders and other ethnicities to show reliable data, but they are represented in the focus group comments and the numbers can be seen in the Attachment at the end of the report.



The last set of graphs shows knowledge, need, demand, and utilization for those out-of-care (OC), recently incarcerated (RI), PLWH/A with children (family), and rural PLWH/A. Rural is defined as those living outside of Dallas County.

Not all the groups shown are independent; some MSM might be drug users and visa versa, some heterosexuals are drug users and visa versa, some rural are out-of care, etc.

Gaps

The box marked “gaps” provides summary indicators of unmet need. These gaps are shown for the total population, and by gender and ethnicity. The knowledge gap is based on the assumption that all PLWH/A, with the exception of clearly targeted services such as OB/GYN and hospice services, should know about each service. Thus it usually is everyone living with HIV/AIDS minus the percent who know about the service. A large knowledge gap indicates a need for information and referrals about the service to PLWH/A.

The unmet perceived need is the difference between those asking for a service and those receiving it. Ideally everyone asking and eligible for a service should receive it. If there is a large gap, it indicates that barriers are high and/or service capacity is low. If capacity is low, it suggests adding capacity through additional funding or increased efficiency. Where there are more services provided than asked for the gap is shown as a negative number. For example, for outpatient care the “unmet perceive need” is a -43%. That indicates that 43% more persons received outpatient care than asked for it. The reason is discussed in the bullet points at the end of the service template. If barriers are present they are noted in the focus group comments at the end of each section and in the following chapter on barriers.

The Need-Receive gap is the difference between those saying they need the service and those saying they receive it. A large number here indicates that more PLWH/A say they need a service than received it. A large negative number indicates that more persons receive care than say they need it.

Summary Gap Indicators

The last box on the page reports summary gap indicators for the entire population. There are three summary measures. The “Units received / Units funded” gap is the units received for 2000 divided by the units funded during that period. It shows whether the units funded are likely to meet the existing demand. A number over 100% indicates that more units are reported received than funded. In this example of outpatient care, there was 39% more units received than funded, indicating that the system is working above capacity (or that the reporting system is incorrect). This suggests that persons in the cost corridor may be too high, or that the system is overtaxed and working beyond its capacity.

The “Reported / Theoretical Need” gap is the number of units reported divided by the theoretically need. A number over 1 means that there are more units being reported than being funded. In the example of outpatient care, the 142% suggests that more persons are getting



outpatient care than say they need it, and it confirms the sentiment of the consumer that they receive outpatient care more often than they need or want it.

The last gap measure, the “Eligibility Gap” refers to those who are eligible minus those who ask for the service. The closer to zero, the more likely those eligible for services receive them. A large positive number means that more people are eligible than ask for the service. That finding suggests there is need for outreach so those who are eligible can request services. A negative score indicates that more people ask than are eligible. In the instance of outpatient care, the 19% indicates that there are more persons eligible than asking for the service.

Where all the gap indicators point to unmet needs, then there is a strong argument for increasing the capacity of the system. Where indicators show that there is a disparity between subpopulations, some resources might be allocated to those services that reach that population. Where there are negative gaps, it may indicate that capacity is greater than needed, that it may appropriate to look to other existing funding streams to provided services, or that there is some problem in the measurement and monitoring tools.

The last section for each of the seventeen main service areas is focus group comments. The focus group comments add depth to the qualitative findings by demonstrating trends using participants own words. Comments both support majority views and emphasize minority positions.



Outpatient Medical Care

Primary Care

Definition

General management of acute and chronic medical conditions or prevention of such conditions through initial visit and intake, complete history and physical examination, lab tests necessary for evaluation and treatment, immunizations, follow-up visits and maintenance, appointments as indicated on the basis of clinical status, and referrals to other medical specialists, as necessary.

Service Unit, Eligibility, and Funding

Unit: One (1) outpatient visit provided to a patient.

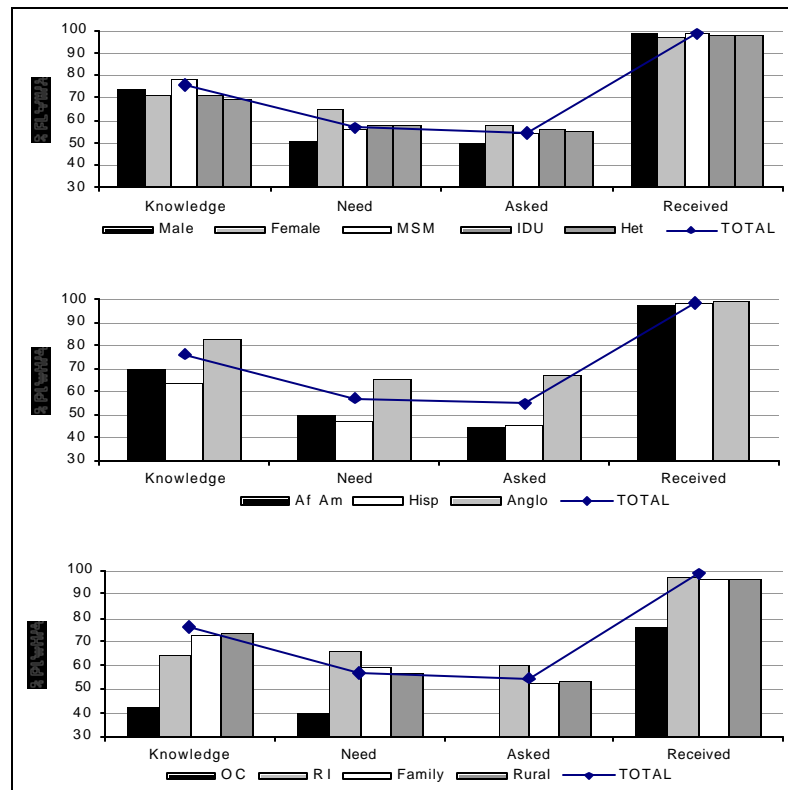
Eligibility: 91% eligible based on Income at 300% poverty and residence of Dallas EMA/HSDA.

Average unit: 5.2 visits

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	3,595
Est # Elig	2,523

SERVICE UNITS 2000	
Number of Units Funded	13,412
Theoretical Need	13,063
Number Reported Received	18,632

FUNDING 2000-2001	
RW Care Title I & CBC	\$2,269,637
RW Care Title I	\$800,662
Other	0
Total Allocated	\$3,070,299



REPORTED in 2001			
	Total	Male	Female
% Knowing	76%	74%	71%
% Needing	57%	51%	66%
% Asking	55%	50%	59%
% Receiving	98%	99%	97%
Af Am Hisp Anglo			
% Knowing	70%	64%	83%
% Needing	50%	47%	66%
% Asking	45%	45%	67%
% Receiving	98%	99%	99%

GAPS (a "-" indicates that more service was provided than was asked for or needed.)			
	Total	Male	Female
Knowledge Gap	24%	26%	29%
Unmet perceived need	-43%	-49%	-38%
Need-Receive Gap	-41%	-48%	-31%
Af Am Hisp Anglo			
Knowledge Gap	30%	36%	17%
Unmet perceived need	-53%	-54%	-32%
Need-Receive Gap	-48%	-52%	-33%

SUMMARY GAP INDICATORS	
Units received / Units funded	139%
Reported / Theoretical Need	142%
Eligibility Gap	19%

- Knowledge of outpatient medical care ranges from 60% to 85%. Assuming 100% of PLWH/A should know about outpatient medical care, there is a knowledge gap ranging from 17% for Anglos to 36% for Hispanics. African Americans also have a high knowledge gap of 30%.



- The percent of PLWH/A asking for outpatient medical care is surprisingly low, considering the importance of this service. There is a large gap, however between those receiving the service and those asking for it. The largest gap is among African Americans and Hispanics with over 50% more individuals receiving outpatient medical care than asking for it. It is likely that there are both substantive and methodological reasons for this gap. Substantively, PLWH/A are sent to clinics as part of their standard care – they don't have to ask. The size of this gap may also be due to the late placement of outpatient care in the list of services rated by participants. Those service later in the list had a tendency to be skipped or answered with a "no."⁴
- Thirty-nine percent (39%) more units of service have been delivered than have been funded according to the average cost for outpatient medical care. It may be that the average cost is underestimated for this service category or that the system provides more service units than they are funded to provide.
- The eligibility gap indicates that there are 19% more PLWH/A asking for services than are eligible for services. This may be a result of a too strict definition of eligibility based on insurance, and it is also a reflection that there may be greater opportunity to utilize third party payers without paying from Ryan White Care Act funds.

⁴ The number receiving care was adjusted up based on responses to other questions asking about primary care in the questionnaire.



OB/GYN and/or Pediatric Care

Definition

OB/GYN – General management of obstetrician and gynecological medical conditions or prevention of such conditions through initial visit and intake, complete history, and physical examination, lab tests necessary for evaluation and treatment, follow-up visits and maintenance, appointments as indicated on the basis of clinical status, and referrals to other medical specialists, as necessary.

Pediatric Care – Same definition as above but for children with the addition of immunizations.

Service Unit, Eligibility, and Funding

Unit:

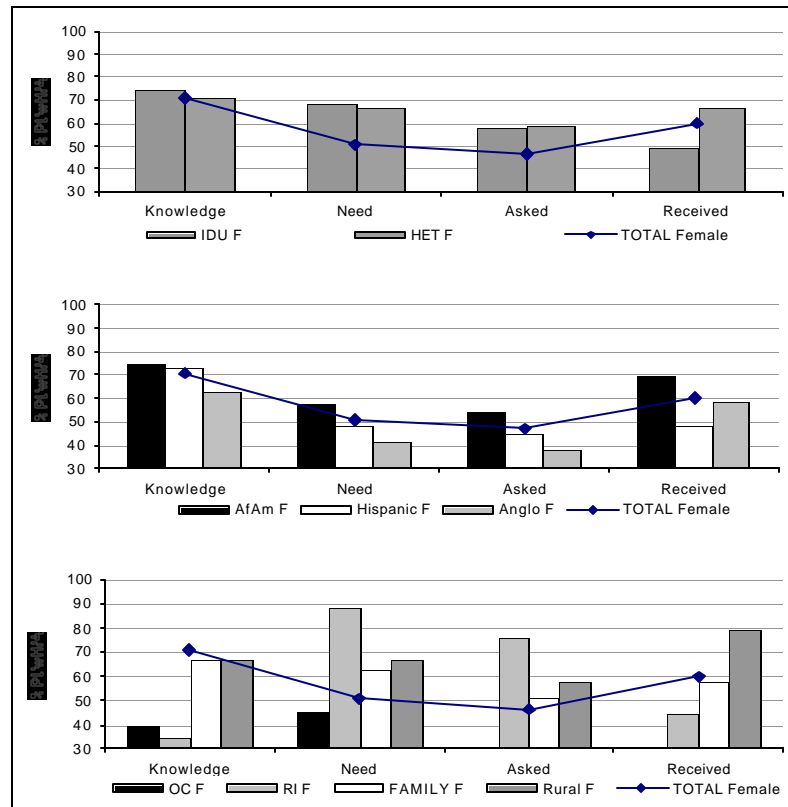
Eligibility:

Average unit:

EST. PLWH/A
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001			
	Total F	IDU F	HET F
% Knowing	71%	75%	71%
% Needing	51%	68%	67%
% Asking	47%	57%	58%
% Receiving	60%	50%	66%
	Af Am F	Hisp F	Anglo F
% Knowing	74%	73%	63%
% Needing	58%	48%	42%
% Asking	54%	45%	38%
% Receiving	69%	48%	58%

GAPS			
	Total F	IDUF	HET F
Knowledge Gap	29%	25%	29%
Unmet perceived need	-13%	7%	-8%
Need-Receive Gap	-9%	18%	1%
	Af Am F	Hisp F	Anglo F
Knowledge Gap	26%	27%	37%
Unmet perceived need	-15%	-3%	-20%
Need-Receive Gap	-11%	0%	-16%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	

- Knowledge of OB/GYN services is high among all female subpopulations in care. Forty percent of women out-of-care and 35% of those women recently incarcerated do not know



about OB/GYN services. Among racial/ethnic groups, Anglo women have the largest knowledge gap at 37%. African American females are the best informed, with a knowledge gap of 26%.

- In general, need for OB/GYN services is high, with about half of all female PLWH/A and about two-thirds of the IDU and heterosexual females reporting a need. The recently incarcerated female group reports the highest need of all groups (89%), although the number of women in this subpopulation is fairly small (n=8) and the findings may not be generalizable.
- The number of female PLWH/A asking for this service is also high, though not as high as perceived need, with a general demand ranging between 38% and 58%.
- IDU females are the only group reporting an unmet perceived need at 7%, and 18% of the IDU females report needing but not receiving OB/GYN services. All other groups are receiving more services than they report needing or have asked for.
- Because this sub-service has not been clearly defined, and units of service have not been tracked, summary gap indicators are not available.



Medical Case Management

Definition

Coordination of patient health care for persons living with HIV/AIDS (PLWH). This includes coordinating with primary care physicians, home health care providers, emergency medical providers, and other community-based service providers including those who provide access and support services, as needed, to ensure that patients receive appropriate medical care.

Service Unit, Eligibility, and Funding

Unit: One (1) documented fifteen (15) minute, face-to-face encounter with a patient, or One (1) documented fifteen (15) minute, other specifically defined activity on behalf of a patient (e.g., telephone contact with patient, care giver, social service agency, or health care provider.)

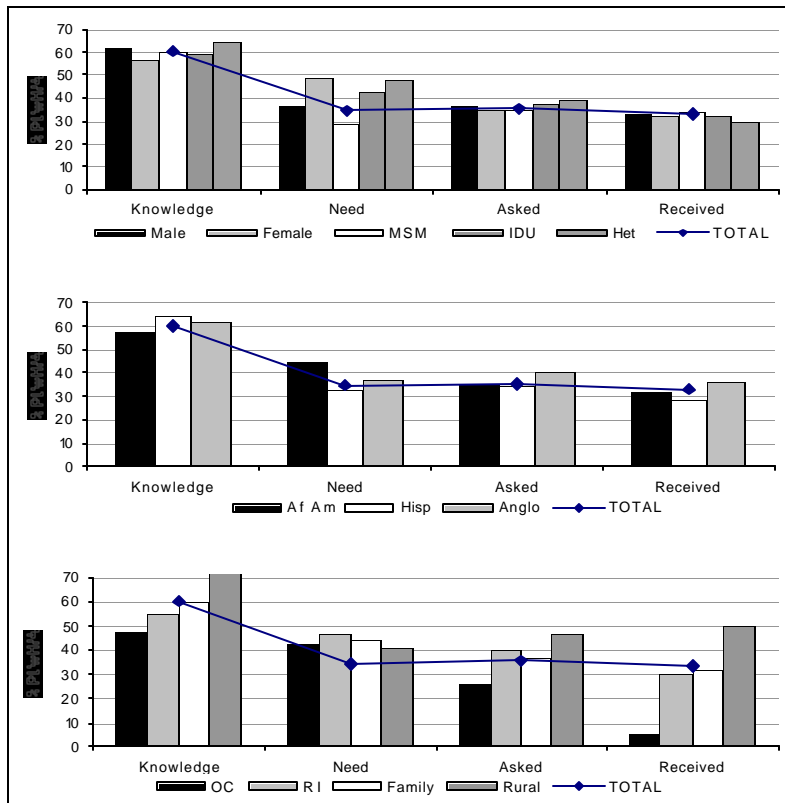
Eligibility: 36% eligible based on 91% (of the PLWH/A in the EMA/HSDA at 300% poverty) of the 80% taking medications and 50% of them reporting adherence problems.

Average unit: 61.9 visits

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	914
Est # Elig	2,523

SERVICE UNITS 2000	
Number of Units Funded	87,050
Theoretical Need	156,054
Number Reported Received	56,544

FUNDING 2000-2001	
RW Care Title I & CBC	\$860,276
RW Care Title I	\$80,240
Other	\$44,888
Total Allocated	\$985,404



REPORTED in 2001			
	Total	Male	Female
% Knowing	60%	62%	57%
% Needing	34%	39%	49%
% Asking	36%	37%	34%
% Receiving	33%	33%	32%
Af Am Hisp Anglo			
% Knowing	58%	64%	62%
% Needing	45%	33%	37%
% Asking	36%	34%	40%
% Receiving	31%	28%	36%

GAPS			
	Total	Male	Female
Knowledge Gap	40%	38%	43%
Unmet perceived need	3%	4%	2%
Need-Receive Gap	1%	6%	17%
Af Am Hisp Anglo			
Knowledge Gap	42%	36%	38%
Unmet perceived need	5%	6%	4%
Need-Receive Gap	14%	5%	1%

SUMMARY GAP INDICATORS	
Units received/ Units funded	65%
Reported / Theoretical Need	36%
Eligibility Gap	-4%

- Knowledge of Medical Case Management ranges from 57% to 64%. The knowledge gap is about 40% for all groups, with females and African Americans indicating a slightly higher



knowledge gap than other sub-populations. Heterosexuals report the highest knowledge (approximately 65%) than other risk categories.

- The knowledge gap is relatively high for most populations while the unmet perceived need, that is the proportion of PLWH/A asking for the service and receiving it, is very low. That indicates the need for improved awareness and increased knowledge among PLWH/A about primary care, issues of adherence, and appropriate and coordinated care and medication. Hispanics report the highest unmet perceived need, with 6% not receiving services that they asked for and females reporting the lowest unmet perceived need at 2%.
- Females report the highest need for this service (49%) and have the highest need-receive gap (17%).
- Fourteen percent of African Americans report needing medical case management but not receiving it, the second highest need-receive gap of all groups.
- Sixty-five percent of funded units have been delivered. Thirty-three percent of those who, in theory, could use the service do not ask for it. However, on a more practical basis there is only a small gap between those who are eligible and those who ask for the service.



Medical Specialists (not OB/GYN)

Definition

Provision of office-based medical services, and specialized health services focusing on the prevention of illness and the ongoing management of chronic conditions and acute health problems. Usual providers of medical care are: physicians, advanced practice nurses (e.g., nurse practitioners, certified nurse midwives, and clinical nurse specialists), physician assistants, and specialists (e.g., immunologists, cardiologists, ophthalmologists, oncologists, neurologists, etc.).

Service Unit, Eligibility, and Funding

Unit:

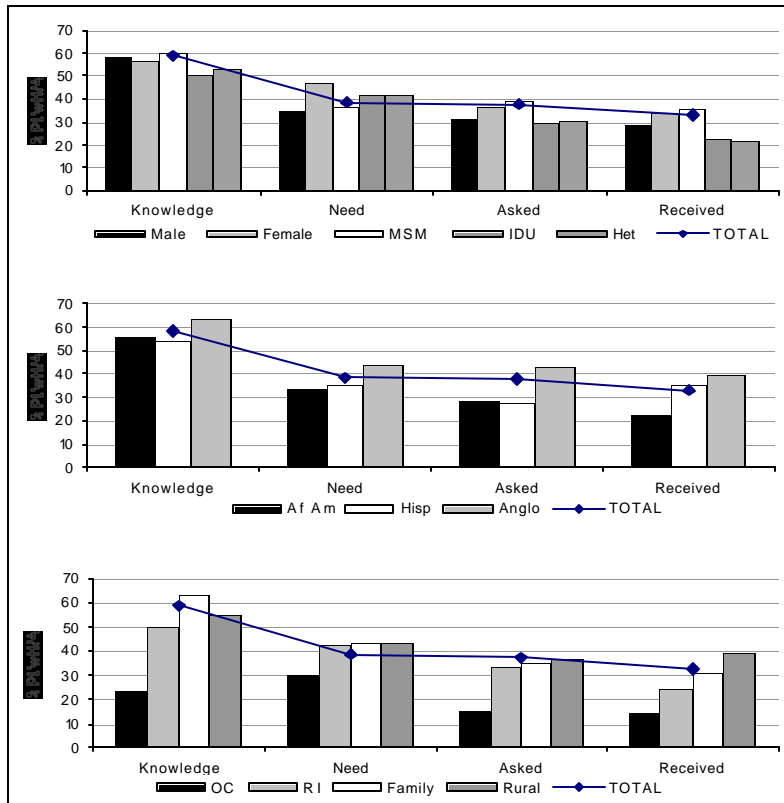
Eligibility:

Average unit:

EST. PLWHA
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported
Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	59%	58%	57%
% Needing	38%	34%	47%
% Asking	38%	32%	37%
% Receiving	33%	29%	34%
	Af Am	Hisp	Anglo
% Knowing	55%	54%	63%
% Needing	34%	35%	44%
% Asking	28%	29%	43%
% Receiving	22%	35%	39%

GAPS	Total	Male	Female
Knowledge Gap	41%	42%	43%
Unmet perceived need	5%	3%	3%
Need-Receive Gap	5%	5%	13%
	Af Am	Hisp	Anglo
Knowledge Gap	45%	46%	37%
Unmet perceived need	6%	-6%	4%
Need-Receive Gap	12%	0%	5%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- Knowledge of medical specialists is highest among families and lowest among individuals out-of-care. MSM have asked for this service more than heterosexuals or IDUs.
- Need for medical specialists is highest among females (47%) with the lowest need reported by males (34%).



- In general there are small gaps between those asking and receiving services, with most populations asking for slightly more specialist services than they receive. Hispanics are the only group who are receiving more services than have asked for, and this may be due to the Hispanic population being more reluctant to ask for services than other sub-populations.
- Females and African Americans have the highest need-receive gap. Thirteen percent of females report needing medical specialist services and have not received them, and 12% of African Americans report needing but not receiving the service.

Focus Group Comments – Outpatient Medical Care

Primary care

Several focus group participants indicated that they were satisfied with outpatient care. However several others had critical comments regarding the difficulty in getting appointments and the cost of services. There is also some sentiment that doctors in rural lack the expertise of doctors specializing in HIV/AIDS.

On the positive side, one Latina female said that she has been very happy with the services especially with her doctor who has been “real understanding.” She noted that her job is very important and that when she has appointments at certain times, instead of having to wait she will get her in right away and discharged so she could go on to work.

An African American heterosexual IDU male expressed his satisfaction with the medical care in Dallas. He said, *“I had a multiple diagnosis when I was diagnosed with HIV in 1999. I found out I had syphilis in the spine, hepatitis C, borderline diabetic and anemic. Thank God I was in Dallas - that's where I needed to be because we don't have these services in Memphis. Since I was diagnosed with that, I wanted to make a positive thing about it. I want to live with this disease instead of die of it, I immediately picked up education about it.”*

A Latino MSM said, *“Everything is different at the [hospital clinic]. At the main building [of the hospital], I had to fight to have a surgery done. The team here at this clinic had to fight for me with the doctors over there because they didn't want to do it because I have AIDS. Luckily I had these good people at this Clinic fighting for me. This [hospital clinic] is a whole different world from the main hospital.”*

A few participants noted the reason why they did not seek care. An Anglo MSM, noting his good health status said, *“I haven't needed a doctor or hospital for several years.”*

Women did not tend to focus their comments on OB/GYN services. Usually women talked about more basic needs. One rural Anglo female noted, *“Women with HIV have other needs. Dealing with life is stressful. Our healthcare should not add to the stress. Also the government says our income is below poverty level, but we still make too much to get some of the services.”*



Those participants that did mention OB/GYN tended to complain that they were limited to the HIV/AIDS clinic for care. One Anglo female noted, *“OB/GYN situation irritates me very bad here in Dallas. Most OB/GYNs do not want to see you because of your HIV and that is an extreme hassle. I don't have one now but I wish I did. I have a very bad need for that - I have not seen one in awhile. .”*

A rural Latina said she goes to a large hospital facility to receive care. Still, she notes, *“The OB/GYN does not check me out. I don't feel a need to go see a doctor for myself. If I need to see a doctor I will go to the emergency room.”* She adds that her options are limited because of Medicare. *“The thing stopping me from going to a doctor now is that they don't take Medicare. I am currently taking HIV/AIDS meds. I am getting them from a doctor in the Valley who I had when I was there a year ago. I can call down there when my drugs run out and they will call the pharmacy here to refill the meds. Medicaid is paying for the medications.”*

The lack of expertise of rural physicians was noted a few times. For example, one rural participant noted, that, *“When [I] reach a certain point, [my doctor] has to hand me over to another doctor because she isn't an infectious disease doctor.”* Another rural participant, a Hispanic man, noted that care was often linked to insurance. He said, *“I ended up with a doctor in North Dallas. They did pick me up but she made it very clear that “when your insurance runs out and you have to go to Medicare, I am going to have to drop you.” In that one year, I was dropped and that's how I ended up at [a large hospital facility].”*

The quality of rural care was noted several times. A rural Anglo female noted, *“We don't get good attention from our doctor. There seems to be only one infectious disease doctor to check our HIV in the area. I use her but don't like her. In the past I had a doctor that gave you one on one time and gave you more information. It seems you're in, you do blood work, see the doctor and then you are out.”*

Not many participants dwelled on medical specialist in the focus groups. When prompted a number of persons mentioned specific problems including neuropathy, hemorrhoid, and some skin and dermatology problems.

Surprisingly, cancer and other manifestations of HIV and side effects of medication were not mentioned, and prompting for a need for specialist resulted in few comments.

One veteran, however, did note, *“Seeing a specialist is difficult through the VA system. I've had severe rashes for 6 months and I still am waiting for my 9 month appointment. My rash is a product of my CMV so I am worried that the CMV will come back.”*

A few participants compared Dallas services with other places they received services. Their comparisons were not positive. One Anglo MSM noted, *“I have lived in Houston and Los Angeles, and Dallas has the worst healthcare of all. This one person had the power to deny me access to a doctor and my meds because she didn't want to work me in and there was only one person to do that job. In Houston, at the HIV clinic, there is not so much paperwork, and there*



are usually 3 people to do that intake job. And there are doctors that see you--not nurse practitioners."

The cost of care was another theme that was mentioned by several participants. One out-of-care person noted, *"The main thing is being able to afford it. Like the medication and stuff, because most of the time you have to see the doctors and like draw blood and stuff and things like that, and I don't have the money for it."*

Medical Case Management

Participants of the focus groups were not very clear about the services offered by a medical case manager. For example, in the Latino MSM focus group only one of the nine participants had an idea of a medical case manager's role in the continuum of care. And all participants said they did not currently have a medical case manager. The one male said, *"To me, the medical case management is about when the medical situation is going on and they are connected to the hospital or one of these referral services and they are the liaison between you and the providers. They all decide whether or not you are going to need home health care. That's from the medical case management involvement or maybe your medications. You all are having problems getting your prescriptions filled or whatever, if you call on the medical case manager, that's when they get involved. Where with the other just plain case manager, those are basically how to get bills paid or transportation."*

Another African American male IDU said that his medical case manager, *"gave me a list of papers with the medication names on it with side effects & what dose I am supposed to take."*

A rural male participant said his medical case manager, *"gave me a list of what to take and what not to take and information about the side effects and stuff like that. She ran that off for me. I am not currently taking supplements. I've got to get some, because I want to try it. I was asking her about the detoxifiers and she was telling me about the ones that I could use to where it wouldn't take the build up of the medication that I have in my body out of my body to where I would have to start all over again. That's what I've been asking for, you know, which ones I could take where it wouldn't bother the resistance I've already built up. I'm not worried about the costs of the supplements. If I've got the money I'll get it, if I don't I won't."*



Medications

Medication reimbursement

Definition

The provision of prescription medications as prescribed or ordered by a physician to prolong life, to improve health, or to prevent deterioration of health for low-income PLWH who do not have prescription drug coverage, to expand the number of covered medications available to them, and/or to broaden eligibility, within guidelines set by the Ryan White Planning Council of the Dallas Area and the Ryan White Consortium of North Texas, beyond that established by a state-operated Title II (Texas Medication Program) or other state-funded medication reimbursement program.

Service Unit, Eligibility, and Funding

Unit: One (1) specific, prescribed dose of medication provided to a specific client.

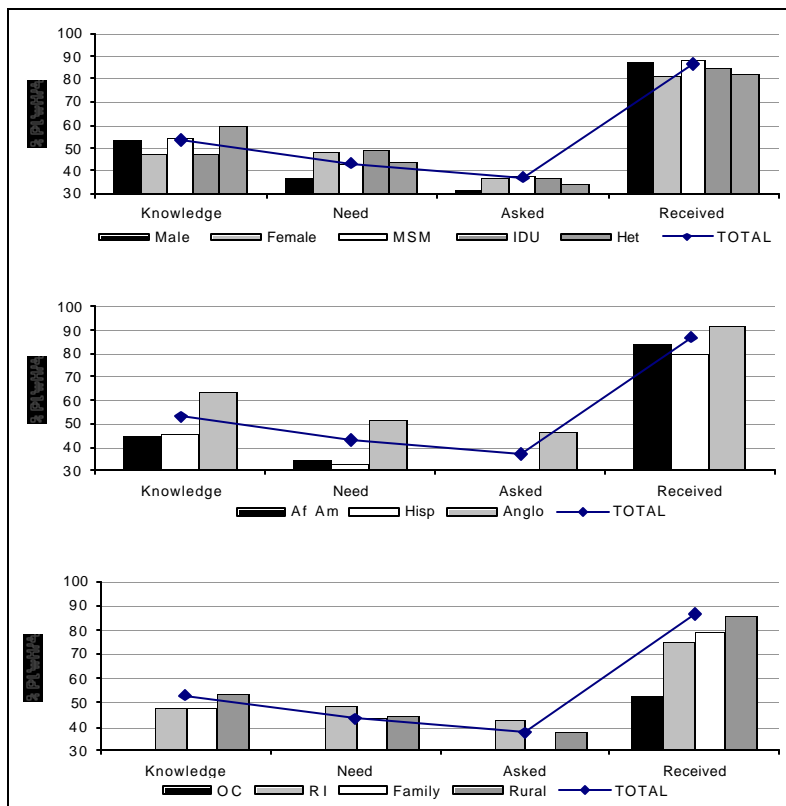
Eligibility:

Average unit: 14.5 doses

EST. PLWHA	
TOTAL	10,500
Know HIV	6,930
In Service	363
Est # Elig	

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported Received	5,275

FUNDING 2000-2001	
RW Care Title I & CBC	\$541,817
RW Care Title II	\$87,338
Other	\$75,600
Total Allocated	\$704,755



REPORTED in 2001			
	Total	Male	Female
% Knowing	53%	53%	47%
% Needing	43%	37%	48%
% Asking	37%	32%	37%
% Receiving	87%	87%	81%
Af Am Hisp Anglo			
% Knowing	44%	45%	64%
% Needing	34%	32%	52%
% Asking	26%	24%	47%
% Receiving	84%	80%	92%

GAPS			
	Total	Male	Female
Knowledge Gap	47%	47%	53%
Unmet perceived need	-50%	-55%	-44%
Need-Receive Gap	-44%	-50%	-33%
Af Am Hisp Anglo			
Knowledge Gap	56%	55%	36%
Unmet perceived need	-58%	-56%	-45%
Need-Receive Gap	-50%	-48%	-40%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	



- In general, over half the PLWH/A know about medication reimbursement. Anglos report the highest knowledge of medication reimbursement services (64%) and African Americans report the lowest knowledge (44%). Heterosexuals knowledge level is highest (60%) among risk categories.
- There is a wide range of reported need for this service, with 32% of Hispanics indicating a need for medication reimbursement and 52% of Anglos.
- In general, more services are being provided than are being asked for or perceived are needed. For all groups, the number receiving drug reimbursement is greater than the number asking or saying they need this service. This gap is somewhat inflated because the number receiving drug reimbursement was adjusted upward based on responses to other questions in the survey. The number asking or needing was not adjusted, and the result is an inflated gap index.
- As expected, those out-of-care are much less likely to know, ask, or say they need drug reimbursement.
- While the summary gap measures are not available, the data indicate that those who know about, and are eligible for drug reimbursement, usually get the service. The system works to provide drugs to those who do not ask for the service. The challenge is to coordinate and maximize drug reimbursement with the several different programs and agencies that provide some reimbursement. As indicated in the focus group comments, another challenge is to assure the continuity of drug therapies.



Prescription Medication Delivery

Definition

Services provided for the redistribution of medications in bulk quantity to community-based, residential agencies, and in small, prescribed quantities to residential sites.

Service Unit, Eligibility, and Funding

Unit: One (1) one-way medication prescription trip (pickup or delivery).

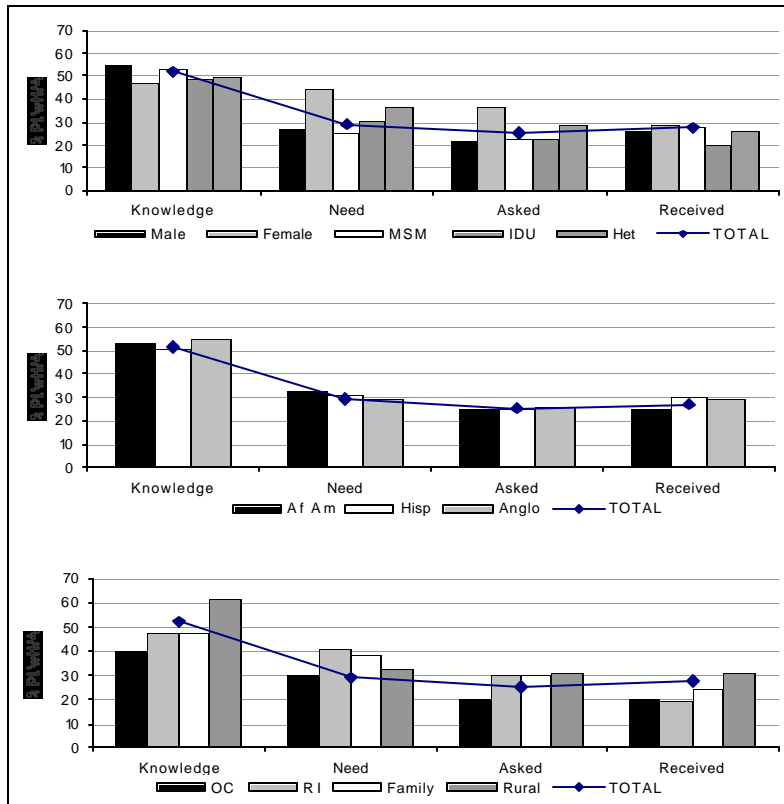
Eligibility: 86% eligible based on income at 300% poverty and residence of Dallas EMA.

Average unit:

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	
Est # Elig	5,991

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported Received	

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	



REPORTED in 2001			
	Total	Male	Female
% Knowing	52%	55%	47%
% Needing	29%	27%	45%
% Asking	25%	22%	37%
% Receiving	27%	26%	28%
Af Am			
% Knowing	53%	51%	55%
% Needing	32%	31%	30%
% Asking	26%	25%	26%
% Receiving	25%	30%	29%

GAPS			
	Total	Male	Female
Knowledge Gap	48%	45%	53%
Unmet perceived need	-2%	-4%	9%
Need-Receive Gap	2%	1%	17%
Af Am			
Knowledge Gap	47%	49%	45%
Unmet perceived need	1%	-5%	-3%
Need-Receive Gap	7%	1%	1%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	

- About half the PLWH/A know about prescription medication delivery. Females have relatively low levels of knowledge (47%), although with families they may need the service the most. For special populations, knowledge of prescription medication delivery ranges from over 60% for recently incarcerated PLWH/A to just under 40% for individuals who are out-of-care.
- In general, about 30% say they need prescription delivery services. More females (45%) than other subpopulations report needing prescription medication delivery.



- Overall, about the same percent of PLWH/A say they need and receive this service, but females have the highest need-receive gap, with 17% reporting a need for the service but not receiving it.
- For the special populations, rural PLWH/A have a higher knowledge and they receive it more than other special populations, reflecting their high level of need.

Focus Group Comments – Medications

Medication reimbursement

For the most part participants in the focus groups received their medications, but they frequently mention the cost of the medication and the limited number of drugs they can access with Medicaid. Many participants did not demonstrate knowledge of the different funding sources for medication reimbursement. Many relied on their case manager or provider to figure out the sources for accessing medication.

A Latino MSM said, “I was flatly denied because the medication was too expensive. It is on their medication list because I had picked up the same prescription before. This time they wouldn't give it to me. I guess they just expect me to put up with it. I tell them that it is painful to be without the medication. They just say, “We know it's painful, but we are not responsible for this.”

There is a fear that funds to cover medication are not adequate and may be not be available. An Anglo MSM said that medication reimbursement funds had been totally expended. He said, *“I'm not currently using (prescription assistance) because they ran out of damn money and no one knows what's going on at the [large AIDS service organization].”*

A number of participants mentioned problems with meeting the co-pay of \$5.00 per prescription. However a male Hispanic said, *“The last co-pay was \$5 for the pharmacy but if they don't have it, they still get their medications. They don't pay but they still stamp it that the medication has been received. So there is no problem with that although they are trying to charge \$5 per medication.”*

Prescription Delivery

In general participants appreciated the drug delivery service. For example an African American heterosexual noted, *“Recently I started with a prescription where they pick up my meds for me. That's pretty good. I am over at [an ASO] and so I signed up there. That's where I go get my medicine. They bring it to the building and I go right then and pick it up. That helps me financially because I mean it was just \$5 per prescription but sometimes I didn't have it. So when I was able to sign up with that, that really helped me.”*

As noted above, about half the participants did not know about medicine delivery services. In some instances the extent of the service was not known. For example, a Latina said, *“I didn't*



know they would take it to your home but then I don't think they would take it all the way out to Mesquite. I have a car that's just an old (inaudible) and so it doesn't get me around that good but it does get me to some places. If I wasn't able to pick up my medications and if they do go out there. I did not know that they did deliver your medications to you.”

One participant noted that the delivery system needed some lead time to work. A Latina noted, *“Sometimes [using the delivery service is] hard because I have to give them 3 day advance notification for refills and if I miss them I have to wait another 3 days. I usually take care of it myself.”*

A Latino MSM noted that he was frustrated by the system until he found out that he needed to complete an application. He told how he could not get his medication, then noted, *“I have been waiting for my medication for longer than a month. The doctor switched me to a new medication and he told me it was going to be about 6 or 7 days to wait for this medication. I ordered my medication and I have been waiting. I never have picked up my medications at the pharmacy here because they ask me for a co-pay. So I wait for the delivery service to pick up for me because they don't charge. I've been checking with an agency and they don't have the medication. Last Thursday the lady at the agency asked me to come to [the hospital clinic] and speak to someone to see what's going on. I speak with [that person] who told me the medication is at the pharmacy but the problem is that no one ever told me that I need to fill out an application. I filled an application and they say that in this week it will be ready. So I don't know when.”*

A female Hispanic IDU also pointed out that it may be a disadvantage not to have direct contact with the pharmacist. She said, *“They had sent me my meds by delivery service. The meds I received were different looking than the meds I had taken previously. There was no note or information included so I was afraid to take them. I didn't take them for 3 months and I didn't feel sick. Actually I felt better with more energy.”*



Dental Care

Definition

Provides preventive, diagnostic, and therapeutic care by/under the direction of a licensed dentist, (I.e., dentist, dental student hygienist, and student hygienist).

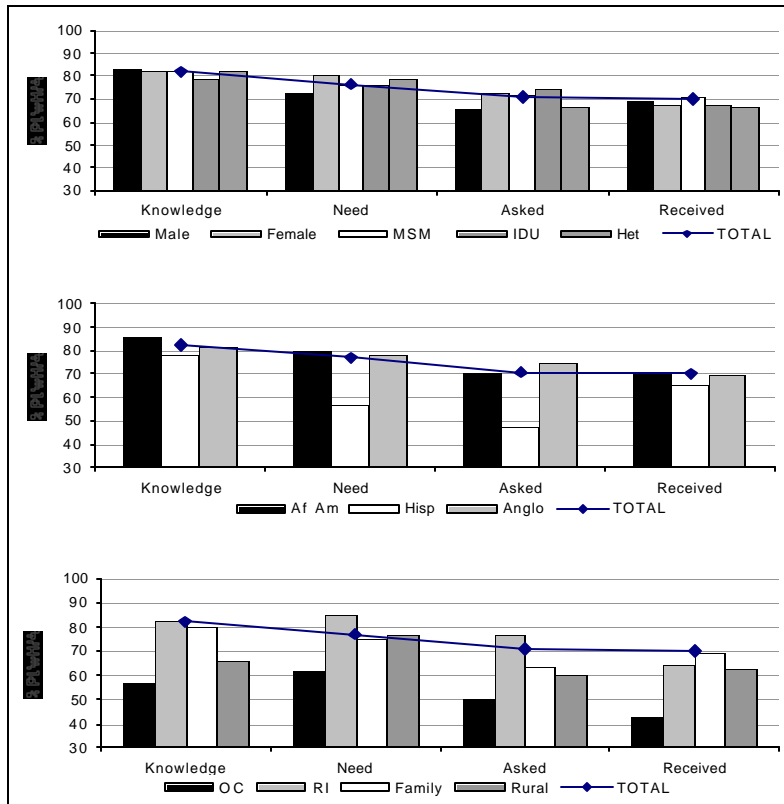
Service Unit, Eligibility, and Funding

Unit: One (1) dental visit by a patient to obtain services.
 Eligibility: 91% eligibility based on 300% of poverty and residence of Dallas EMA/HSDA.
 Average unit: 3.9 visits

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	1,033
Est # Elig	6,306

SERVICE UNITS 2000	
Number of Units Funded	8,184
Theoretical Need	24,720
Number Reported Received	4,048

FUNDING 2000-2001	
RW Care Title I & CBC	\$635,041
RW Care Title II	\$40,642
Other	
Total Allocated	\$675,683



REPORTED in 2001			
	Total	Male	Female
% Knowing	82%	83%	82%
% Needing	77%	72%	81%
% Asking	71%	66%	73%
% Receiving	71%	70%	68%
Af Am Hisp Anglo			
% Knowing	86%	79%	82%
% Needing	80%	57%	78%
% Asking	71%	47%	74%
% Receiving	70%	66%	70%

GAPS			
	Total	Male	Female
Knowledge Gap	18%	17%	18%
Unmet perceived need	0%	-4%	5%
Need-Receive Gap	6%	2%	13%
Af Am Hisp Anglo			
Knowledge Gap	14%	21%	18%
Unmet perceived need	1%	-19%	4%
Need-Receive Gap	10%	-9%	8%

SUMMARY GAP INDICATORS	
Units received/ Units funded	49%
Reported / Theoretical Need	16%
Eligibility Gap	-20%

- Knowledge of dental services is relatively high, with over 80% of most groups including the total population reporting knowledge of the service. Among ethnic groups, Hispanics have the largest knowledge gap of 21% and African Americans the smallest gap at 14%. Among the special populations, the out-of-care have the lowest knowledge, followed by the rural PLWH/A.
- For all PLWH/A, the unmet perceived gap is small. For example, females report a 5% unmet perceived need, and Anglos a 4% unmet need. Hispanics report receiving more service than



being asked for by 19%, reflecting a continued trend that this population asks for less and expects fewer services.

- Recently incarcerated PLWH/A report the highest need for dental services of all special populations, with nearly 85% needing dental care.
- The need-receive gap is highest for females (13%) and African Americans (10%).
- Nearly 80% of those eligible for dental care have asked for it.
- Forty-nine percent (49%) of the number of units funded has been delivered. Given the relatively large eligibility gap (% asking minus % eligible) of -20, this suggests that there may be too little capacity or other factors that limit the systems ability to provide dental care.

Focus Group Comments – Dental Care

Dental services are fairly well known in the Dallas EMA and HSDA, but there is uncertainty about the scope and continuation of services. An Anglo rural participant noted, *“We don't know exactly what is available to us. Like the dental program, we had that and I was getting my teeth pulled and all the bottom was out and then the program was cut. The funding is gone.”*

Several other participants were under the impression that funding had been cut. A rural Anglo male complained, *“My dental work was stopped in the middle of a procedure because of a lack of funds”*

A Hispanic MSM said, *“They have a number of places you can go for dental care but they don't always provide the services that you need.”*

Several times participants noted that if they had serious or specialized need they had a hard time obtaining the amount of dental care they needed. A Hispanic MSM said, *“I've been using dental work for a couple of years now. They've got four different places that are great for dental. Well, the one here (at the hospital clinic), the problem with it is they will only see you for 15 minutes. They've got everybody scheduled at 15 minute intervals. So if you can't get it done in 15 minutes, too bad. You know. I know what I need isn't going to be done in 15 minutes. The one I would like to go is [at an ASO]. For that I have to pay \$25 per visit. With a dentist you know you are not going to go in with just one visit. It's going to be one, two or three visits the first month. So I am kind of in a catch-22 situation. I can come here to [the hospital clinic] where they won't do the work I need or I can go to the other place where I can't afford it. What I would like to do is dental without that sliding scale stuff. At least if you are under a certain amount like 200% poverty level.”*



Housing

Housing Information

Definition

The provision of assistance in locating and obtaining suitable, on-going or transitional shelter. This can include costs associated with finding a residence and/or subsidized rent; and, residential housing services, which are the provision of housing assistance in a group home setting.

Service Unit, Eligibility, and Funding

Unit:

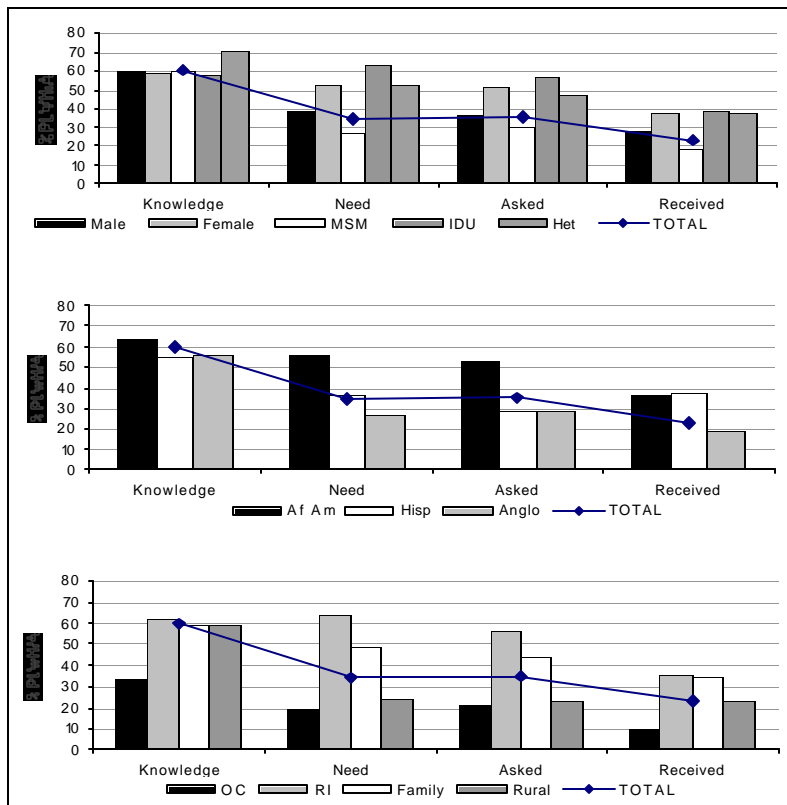
Eligibility:

Average unit:

EST. PLWHA
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported
Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	60%	60%	59%
% Needing	34%	38%	52%
% Asking	35%	36%	51%
% Receiving	23%	27%	37%
	Af Am	Hisp	Anglo
% Knowing	63%	55%	57%
% Needing	56%	36%	27%
% Asking	53%	29%	28%
% Receiving	36%	37%	18%

GAPS	Total	Male	Female
Knowledge Gap	40%	40%	41%
Unmet perceived need	12%	9%	14%
Need-Receive Gap	11%	11%	15%
	Af Am	Hisp	Anglo
Knowledge Gap	37%	45%	43%
Unmet perceived need	17%	-8%	10%
Need-Receive Gap	20%	-1%	9%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- Overall trends indicate that African Americans and recently incarcerated report greatest needs and gaps for housing when compared to other subpopulations.



- Knowledge for all PLWH/A is fairly high at 60%, but has a wide range with about 30% of the out-of-care knowing about housing, over 60% of the males and African Americans and 71% and heterosexuals saying they know about housing services.
- IDUs and recently released report a high need for housing information (62%). Among ethnic populations, the African Americans have the highest need-receive gap, with 20% more African Americans living with HIV and AIDS saying they need services but do not receive them. There is also a 9% need-receive gap for Anglos. Hispanics are the only group to report receiving more services than asked for or needed, indicating a trend in the data that, as a group, Hispanics have lower expectations than other subpopulations.



Congregate Housing

Definition

Provides housing in assisted living facilities that includes a range of services such as: food services, comprehensive case management, home health care, medical case management, maintenance, furnishings, etc. Funded congregate housing services in Dallas County are licensed by the Texas Department of Human Services as an Assisted Living Facility, or by the Texas Department of Health as a Special Care Facility.

Service Unit, Eligibility, and Funding

Unit:

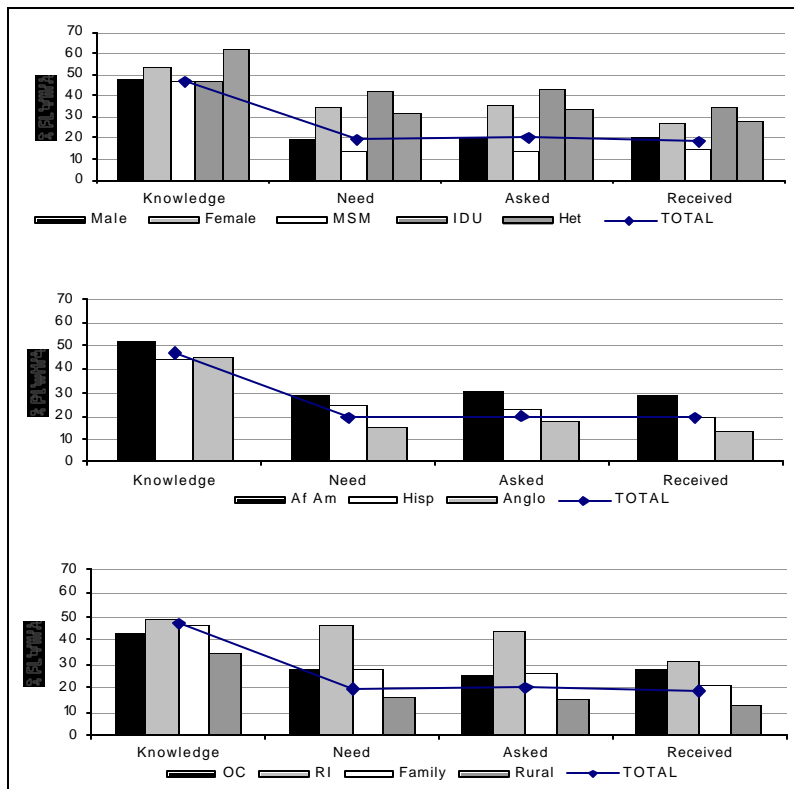
Eligibility: Must reside in Dallas EMA/HSDA. The maximum co-pay of 30% of income.

Average unit:

EST. PLWH/A
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	47%	48%	54%
% Needing	19%	19%	34%
% Asking	20%	21%	36%
% Receiving	19%	20%	27%
	Af Am	Hisp	Anglo
% Knowing	52%	44%	46%
% Needing	29%	24%	16%
% Asking	31%	23%	18%
% Receiving	29%	19%	14%

GAPS	Total	Male	Female
Knowledge Gap	53%	52%	46%
Unmet perceived need	1%	1%	9%
Need-Receive Gap	0%	-1%	7%
	Af Am	Hisp	Anglo
Knowledge Gap	48%	56%	54%
Unmet perceived need	2%	4%	4%
Need-Receive Gap	0%	5%	2%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- Less than half of all PLWH/A know about congregate housing. Females and African Americans report the greatest knowledge and greatest need for congregate housing. The knowledge gap ranges from a high of 56% among Hispanics to a low of 39% for heterosexuals.



- Need for congregate housing is highest among recently incarcerated PLWH/A (45%) followed by IDUs (41%) and females (34%).
- Unmet perceived need is low for all groups, suggesting most PLWH/A asking for congregate housing say they receive services.
- The need-receive gap is also extremely low, ranging from 2% to 7%.

Emergency Financial Assistance

Definition

Provision of short-term payments to agencies, or establishment of voucher programs to assist with emergency expenses related to food, rent, utilities, medications or other critical personal needs.

Service Unit, Eligibility, and Funding

Unit:

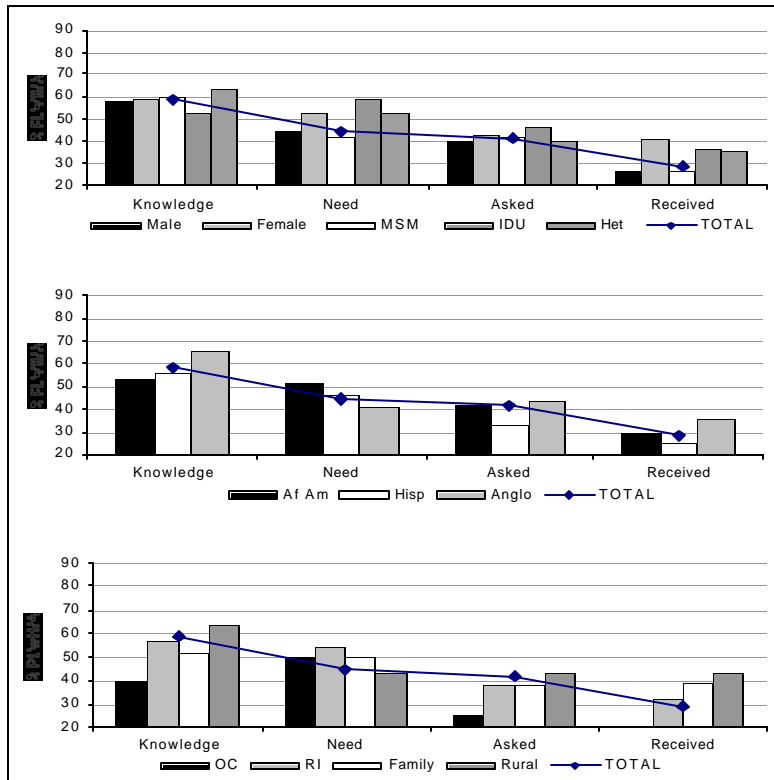
Eligibility:

Average unit:

EST. PLWH/A
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported
Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001			
	Total	Male	Female
% Knowing	59%	58%	59%
% Needing	45%	44%	53%
% Asking	41%	41%	43%
% Receiving	29%	27%	41%
	Af Am	Hisp	Anglo
% Knowing	53%	56%	66%
% Needing	52%	47%	41%
% Asking	41%	33%	44%
% Receiving	29%	25%	35%

GAPS			
	Total	Male	Female
Knowledge Gap	41%	42%	41%
Unmet perceived need	12%	14%	2%
Need-Receive Gap	16%	17%	12%
	Af Am	Hisp	Anglo
Knowledge Gap	47%	44%	34%
Unmet perceived need	12%	8%	9%
Need-Receive Gap	23%	22%	6%

SUMMARY GAP INDICATORS	
Units received/	Units funded
Reported /	Theoretical Need
Eligibility	Gap



- Overall, the greatest need reported for emergency financial assistance is among IDUs and females, but the largest need gaps are among males and African Americans.
- Generally, about 60% of PLWH/A know about emergency financial assistance. There is little difference in knowledge among males and females. African Americans report the lowest level of knowledge (53%) while Anglos report the highest (66%). For special populations, the out-of-care have significantly less knowledge about emergency financial assistance (40%). PLWH/A out-of-care (60%) and African Americans (47%) have the largest knowledge gaps.
- Approximately one-third to one-half of most groups report a need for emergency financial assistance. Females (53%), IDUs (59%), and recently incarcerated (53%) report the highest need. Unmet perceived need ranges from a low of 2% for females to a high of 14% for males, indicating that males who ask for emergency financial assistance are less likely to receive it.
- African Americans and Hispanics have a relatively high need-receive gap, with 22% to 23% reporting a need for emergency financial assistance and not receiving it.
- Rural populations tend to report receiving better than average emergency financial assistance.



Mortgage or Rent Assistance

Definition

Provision of short-term payments to agencies, or establishment of voucher programs to assist with emergency expenses housing including rent or mortgage payments.

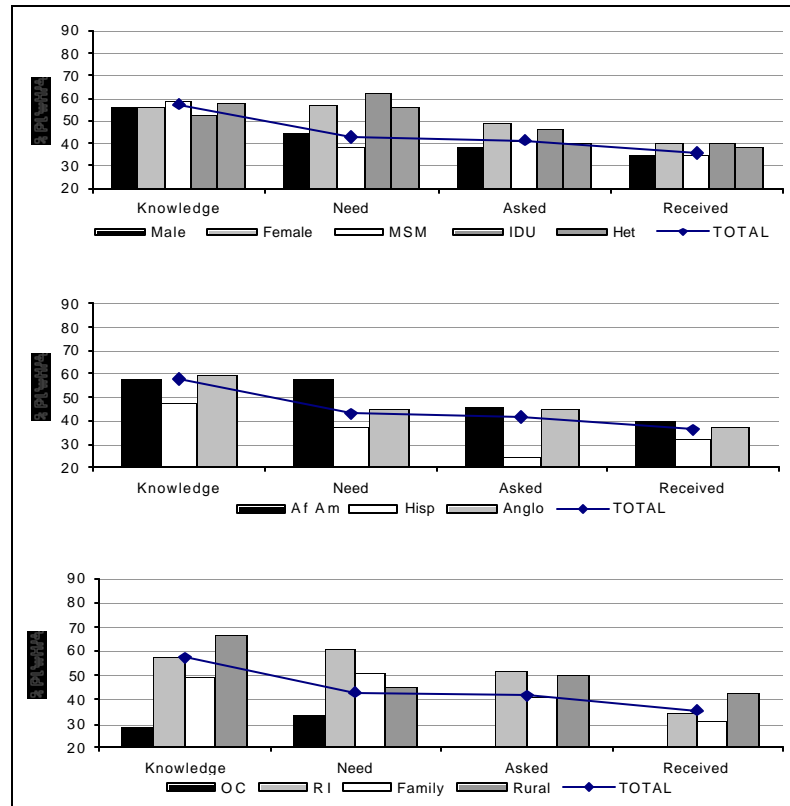
Service Unit, Eligibility, and Funding

Unit: One (1) payment of rent or mortgage payment to maintain housing.
 Eligibility: 82% eligibility based on 200% of poverty and residence of Dallas EMA/HSDA.
 Average unit:

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	
Est # Elig	5,683

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported Received	

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	



REPORTED in 2001			
	Total	Male	Female
% Knowing	58%	56%	57%
% Needing	43%	45%	58%
% Asking	41%	39%	50%
% Receiving	40%	35%	41%
Ethnicity Breakdown			
	Af Am	Hisp	Anglo
% Knowing	57%	48%	59%
% Needing	57%	37%	44%
% Asking	46%	25%	45%
% Receiving	40%	32%	37%

GAPS			
	Total	Male	Female
Knowledge Gap	42%	44%	43%
Unmet perceived need	1%	4%	9%
Need-Receive Gap	3%	10%	17%
Ethnicity Breakdown			
	Af Am	Hisp	Anglo
Knowledge Gap	43%	56%	57%
Unmet perceived need	6%	-7%	8%
Need-Receive Gap	17%	5%	7%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	-41%

- Overall about 6 out of 10 PWLH/A know about mortgage and rent assistance. There is little difference among males and females. Hispanics are less knowledgeable than other ethnic populations, and have the highest knowledge gap. Among special populations, rural PLWH/A report the highest level of knowledge (67%), while those out-of-care report the lowest overall knowledge (30%).



- Forty-three percent of all PLWH/A report a need for mortgage or rent assistance. Females (58%) and IDUs (62%) report the highest need for this service. African Americans and females have a relatively high need-receive gap.
- Females also report the highest demand for mortgage or rent assistance (58%), followed by African Americans (57%). Hispanics report the lowest demand at 25%. IDUs report the largest need-receive gap at 20%, followed by African Americans and females (17%).

Focus Group Comments

Housing was expressed by a variety of individuals in the focus groups as a major need for their living with HIV successfully. An African American male said, *“Housing assistance is what is needed. Light bills and food costs can be covered under housing - but first you have to get into housing.”*

Although food, rent and utility bills are different subcategories of emergency assistance, for PLWH/A who can't pay their bills they are trade-offs that have to be made. A Hispanic heterosexual said, *“I need help with house repair and better quality food. I'm very grateful for the financial help with mortgage and utility...”* He added, *“[It] will be great if we have it more than five times a year.”* A Latino MSM said, *“In terms of priorities, what is important to us, to me, is my long term rental assistance. That helps me. Although it only pays for half of my rent, with that half of my rent, I buy my groceries and pay my drug co-payments.”* An African American heterosexual male expressed his need, *“I'm on a fixed income with SSI and that only covers my rent. I have light bills, my phone's off now, because I don't have enough to cover it...I need financial assistance.”*

In some instances the most needy also are confronting many other personal or life crisis, and may not, under existing eligibility rules, qualify for assistance. A MSM/IDU showed how related the needs are and how quickly situations change. He said, *“I lived with parents until today. Today I became homeless. Skipped medications due to drug use. Kicked me out of program. Research study program no longer provided meds. Need housing, food, clothing, help with car repair bill. Need help with mortgage or rent assistance. Need individual mental health counseling. I need help as soon as possible. I can't pay for car repair to get car out of shop to get to services.”*

There is obviously a link between SSDI and SSI and the need for financial assistance. Several participants noted how difficult it was to live on SSDI, and the difficult they have navigating the disability system. This Anglo MSM has dropped out of SSDI, but falls through the cracks. He said, *“ I am Not working, SSDI has stopped. Working odd jobs. Not able to get a regular job because of my meds and side effects.”*

An African American female noted, *“I never was getting income in my house... It's hard because I have a light bill, a telephone bill and my rent is \$535 a month and my check is only \$530 and it's kind of hard with one income. Then when we went to Dallas County to get some help they turned us down the first time because somebody else had helped us in November and*



December. Then we came out here and the chick over there, she sent us back up there.... "We can't help you but one time, only one time." But it seems like to me they should be able to help us all of the time because it's only one income. I can't afford all of that by myself and [my husband] can't work. So it's hard. Seems to me they should have more financial assistance for rent and stuff like that for people with HIV.

Others note financial assistance is not sufficient. A Hispanic male noted that rental assistance paid for only half his rent. When his therapist changed and sessions became more expensive, he had to decide to pay rent or continue therapy.



Food Services

Food Pantry

Definition:

Provision of food (not finances to purchase food) and related grocery items to include personal hygiene, paper products, and cleaning supplies (e.g. bleach, laundry detergent, disinfectant) in a food pantry setting. Regulations and guidelines for the food pantry should be followed as addressed in the additional assurances listed in the Continuum of Care: Definitions, Units of Service, and Scope of Work.

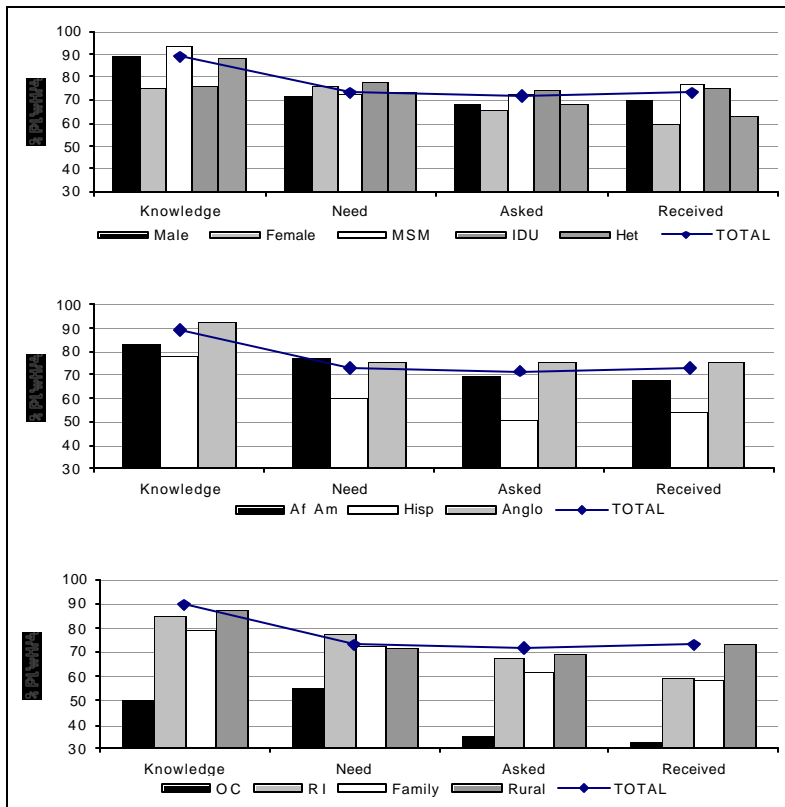
Service Unit, Eligibility, and Funding

Unit: One (1) visit per client, for up to a seven (7) day supply of food and related grocery items.
 Eligibility: 91% eligibility based on 300% of poverty and residence of Dallas EMA/HSDA.
 Average unit: 2.9 visits

EST. PLWHA	
TOTAL	10,500
Know HIV	6,930
In Service	1,821
Est # Elig	6,306

SERVICE UNITS 2000	
Number of Units Funded	20,000
Theoretical Need	18,287
Number Reported Received	5,275

FUNDING 2000-2001	
RW Care Title I & CBC	\$326,914
RW Care Title II	\$13,819
Other	\$70,875
Total Allocated	\$411,608



REPORTED in 2001			
	Total	Male	Female
% Knowing	89%	89%	76%
% Needing	73%	72%	76%
% Asking	72%	69%	66%
% Receiving	74%	70%	60%
Af Am Hisp Anglo			
% Knowing	83%	78%	92%
% Needing	77%	60%	76%
% Asking	69%	51%	75%
% Receiving	68%	54%	76%

GAPS			
	Total	Male	Female
Knowledge Gap	11%	11%	24%
Unmet perceived need	-2%	-1%	6%
Need-Receive Gap	-1%	2%	16%
Af Am Hisp Anglo			
Knowledge Gap	17%	22%	8%
Unmet perceived need	1%	-3%	-1%
Need-Receive Gap	9%	6%	0%

SUMMARY GAP INDICATORS	
Units received/ Units funded	26%
Reported / Theoretical Need	29%
Eligibility Gap	-19%

- Overall the knowledge of food pantry is 89%. Females (76%) are less knowledgeable about the service than males (89%). Among ethnic organizations there are significant differences



in knowledge with Hispanics (78%) the lowest, African Americans next (83%) and Anglos with the highest knowledge (92%). Among special populations, those out-of-care know far less than those in care.

- Overall, about three-quarters of the PLWH/A say they need the food pantry, and about the same number receive the services, leaving a negligible need-receive gap. Sixteen percent (16%) of the females and 9% of the African Americans, however, say they receive less than they need.
- Similarly, females have a greater unmet perceived need, while Hispanics, males, and Anglos report receiving more services than they have asked for.
- People out-of-care report the lowest need and have asked for food pantry services less than any other group.
- Based on the average cost, there are 26% more units funded than received, and the theoretical need is 29% greater than units received. The eligibility gap for food pantry is 19%, suggesting that a greater percentage of PLWH/A are eligible than ask for food services. These gap measures suggest that the high perceived need is being funded, but that the system lacks the infrastructure or capacity to meet demand.



Congregate Meals

Definition

Provision of actual meals, not finances to purchase food or meals. Regulations and guidelines for a congregate meal program should be followed as addressed in the additional assurances listed in the Continuum of Care: Definitions, Units of Service, and Scope of Work.

Service Unit, Eligibility, and Funding

Unit: One (1) prepared meal provided to a client in a congregate setting.

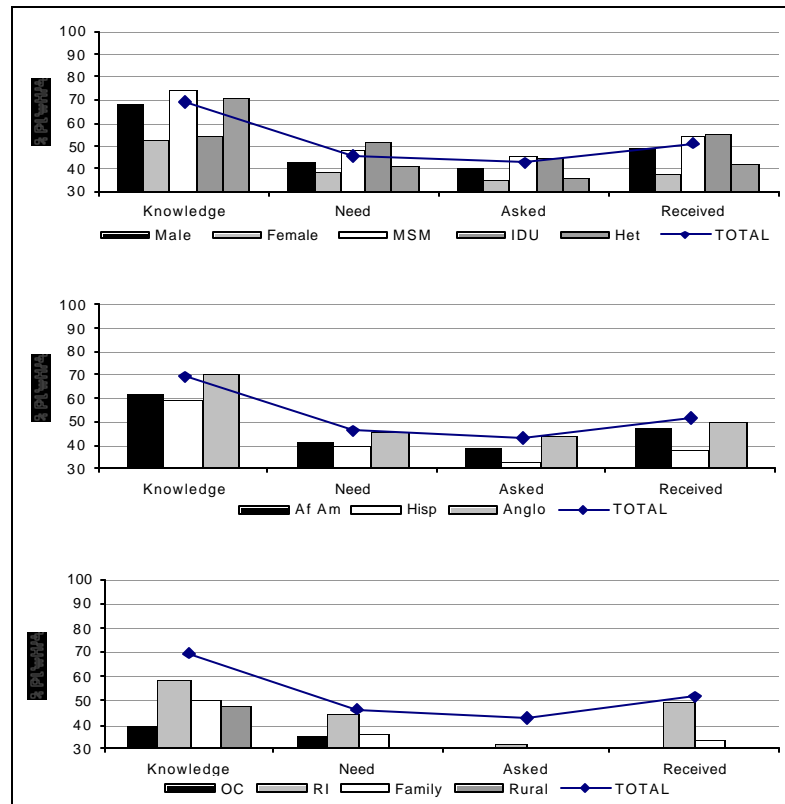
Eligibility: 91% eligibility based on 300% of poverty and residence of Dallas EMA/HSDA.

Average unit:

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	
Est # Elig	

SERVICE UNITS 2000	
Number of Units Funded	85,706
Theoretical Need	
Number Reported Received	

FUNDING 2000-2001	
RW Care Title I & CBC	\$411,266
RW Care Title II	\$22,340
Other	\$28,350
Total Allocated	\$461,956



REPORTED in 2001			
	Total	Male	Female
% Knowing	69%	69%	53%
% Needing	46%	44%	39%
% Asking	43%	40%	35%
% Receiving	51%	49%	38%
Af Am Hisp Anglo			
% Knowing	62%	59%	71%
% Needing	42%	39%	45%
% Asking	38%	32%	44%
% Receiving	47%	37%	50%

GAPS			
	Total	Male	Female
Knowledge Gap	31%	31%	47%
Unmet perceived need	-8%	-9%	-3%
Need-Receive Gap	-5%	-5%	1%
Af Am Hisp Anglo			
Knowledge Gap	38%	41%	29%
Unmet perceived need	-9%	-5%	-6%
Need-Receive Gap	-5%	2%	-5%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	

- About 62% of all PLWH/A know about congregate meals. More males (69%) know about congregate meals than females (53%). Hispanics (59%) and African Americans are less likely to know about meals than Anglos (71%). Among the risk groups, IDUs are less likely to know about meals.
- Females have the largest knowledge gap (47%) followed by Hispanics (41%).



- In general, more people report receiving congregate meals than have asked for them (the unmet perceived need gap is -8%).
- Hispanics report a lower need for congregate meals (39%) than African Americans (42%) or Anglos (45%) and there is no need-received gap.

Home-delivered Meals

Definition

Cost-effective provision of nutritionally-balanced home-delivered meals and/or nutritional supplements, not finances to purchase food or meals. Regulations and guidelines for home-delivered meals should be followed as addressed in the additional assurances listed in the Continuum of Care: Definitions, Units of Service, and Scope of Work.

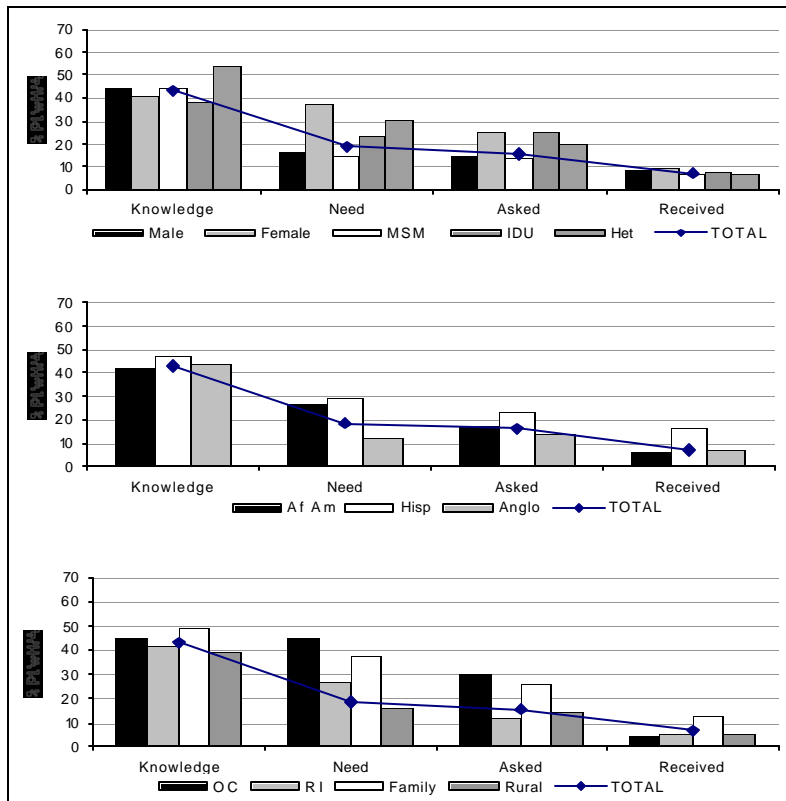
Service Unit, Eligibility, and Funding

Unit: One (1) prepared meal provided to a client in a congregate setting.
 Eligibility: 82% eligibility based on 300% of poverty and residence of Dallas County.
 Average unit:

EST. PLWHA	
TOTAL	10,500
Know HIV	6,930
In Service	
Est # Elig	5,676

SERVICE UNITS 2000	
Number of Units Funded	16,264
Theoretical Need	
Number Reported Received	

FUNDING 2000-2001	
RW Care Title I & CBC	\$43,261
RW Care Title II	
Other	
Total Allocated	\$43,261



REPORTED in 2001			
	Total	Male	Female
% Knowing	43%	45%	42%
% Needing	19%	17%	38%
% Asking	16%	15%	26%
% Receiving	7%	8%	10%
Ethnicity Breakdown			
	Af Am	Hisp	Anglo
% Knowing	42%	47%	44%
% Needing	27%	29%	12%
% Asking	18%	23%	14%
% Receiving	7%	16%	7%

GAPS			
	Total	Male	Female
Knowledge Gap	57%	55%	58%
Unmet perceived need	9%	7%	16%
Need-Receive Gap	12%	9%	28%
Ethnicity Breakdown			
	Af Am	Hisp	Anglo
Knowledge Gap	58%	53%	56%
Unmet perceived need	11%	7%	7%
Need-Receive Gap	20%	13%	5%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	-66%



- Overall, less than half (43%) of PLWH/A reported knowing about home-delivered meals. There is little difference between males and females. Among ethnic populations, knowledge is highest among Hispanics (47%), and lowest among African Americans.
- In general, there is a low demand for this service. Only 15% of males have asked for it, 14% of Anglos and 18% of African Americans. Females and IDUs report the highest demand of approximately 26%.
- Among all PLWH/A, about one in five say they need meal delivery. It is much higher among women (38%) and those out-of-care (45%).
- Reported need for home-delivered meals is slightly higher than demand. Overall, 19% of PLWH/A report a need for home delivered meals compared to 16% that asked for it. The need-receive gap is greatest among females (28%) and African Americans (20%).

Focus Group Comments – Food

Several focus group participants said the food pantry service was an essential service. With the low monthly disability payment, the services offered provided the difference between feeding themselves and their families and going hungry.

Access to food pantry was an issue for some rural participants. One MSM noted, “[*There is] Not a food pantry here for people like me here where I live. The closest thing to me is WIC but I am not allowed to go there.*” But he echoed the problem many rural persons had with confidentiality. He said, “[*But also I am wary about going to social agencies to get services because people are very funny here and I don’t want to express that I am positive.*”

A few participants noted the lack of meat and milk products. For example, one Hispanic MSM said, “[*Food pantry -- great people -- no meat, cheese, or butter.*” Another African American noted, “[*Food Pantry: Not enough meats.*”

Some participants, such as this female Anglo IDU, did not have full knowledge of the services offered. For example, she said, “[*Food pantry is easy to access but the vouchers are very hard because I only heard about them this morning.*”

Few other services had such extreme differences of opinion as the congregate meal program. When the comments were analyzed, it appears the eligibility rules and the inability of some to access the program caused considerable resentment.

It was not uncommon to receive comments like those of an Anglo MSM said, “[*I think the lunch program is one of the best services offered to me. A decent meal means all the world to me.*”

On the other hand some participants said the threshold based on stage of disease was too high. An Anglo MSM said, “[*The agency I have gone to is the worst agency I’ve encountered. Because my T-cells are too high, I can’t access the food pantry. I’m on permanent disability with HIV and coronary heart disease. I live on a fixed income that often leaves me with no funds to buy food, so I have to skip paying a bill every other month or so to be able to afford food.*”



Transportation

Definition

Timely curb-to-curb, and as needed, door-to-door conveyance services provided to persons living with HIV/AIDS who are unable to use personal or public transportation. May be provided routinely, or on an emergency basis. Services will be provided with a priority to access health care, followed by psycho-social support services. Regulations and guidelines for transportation should be followed as addressed in the assurances listed in the Continuum of Care: Definitions, Units of Service, and Scope of Work are in the local transportation agreement.

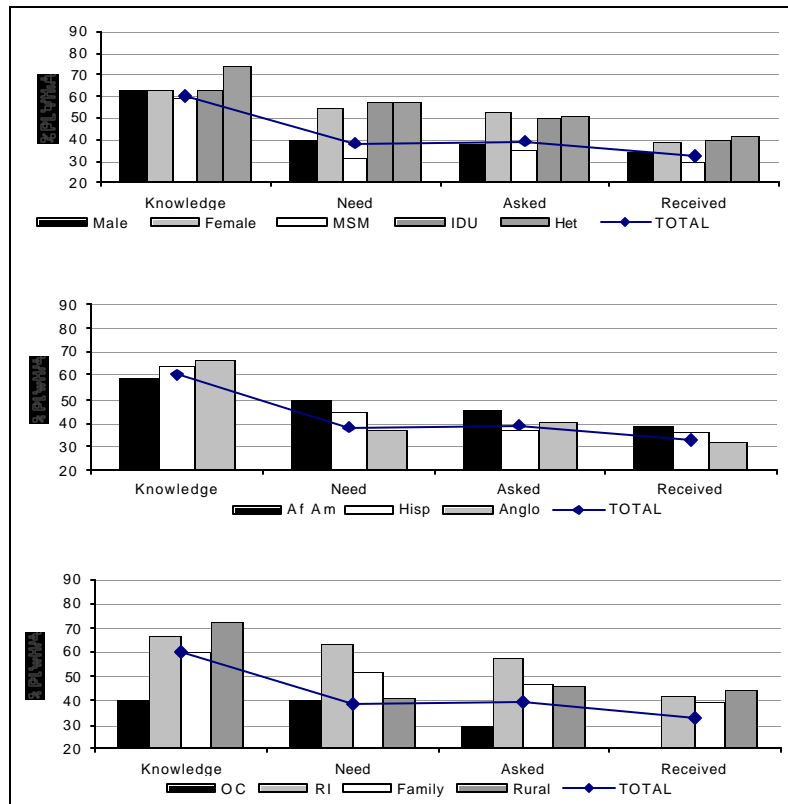
Service Unit, Eligibility, and Funding

Unit: One (1) health-related, child-transported, or other (support service) one-way van trip, or One (1) booklet of bus passes, or One (1) taxi voucher.
 Eligibility: 91% eligibility based on 300% of poverty and residence of Dallas EMA/HSDA.
 Average unit:

EST. PLWHA	
TOTAL	10,500
Know HIV	6,930
In Service	1,126
Est # Elig	6,306

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported Received	52,893

FUNDING 2000-2001	
RW Care Title I & CBC	\$474,183
RW Care Title II	\$10,968
Other	\$84,528
Total Allocated	\$569,679



REPORTED in 2001			
	Total	Male	Female
% Knowing	60%	63%	62%
% Needing	39%	40%	54%
% Asking	39%	38%	52%
% Receiving	33%	34%	39%
Af Am Hisp Anglo			
% Knowing	59%	64%	66%
% Needing	49%	44%	37%
% Asking	45%	37%	41%
% Receiving	39%	36%	32%

GAPS			
	Total	Male	Female
Knowledge Gap	40%	37%	38%
Unmet perceived need	6%	4%	13%
Need-Receive Gap	6%	6%	15%
Af Am Hisp Anglo			
Knowledge Gap	41%	36%	34%
Unmet perceived need	6%	1%	9%
Need-Receive Gap	10%	8%	5%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	-52%

- In general, 60% of the PLWH/A know about transportation services, and there are small differences between gender and ethnic populations. Among the special populations, those out-of-care (40%) are much likely to know about transportation services, while recently



incarcerated are more likely to know (73%) about transportation services. The knowledge gap is highest among Hispanics, Anglos, and PLWH who are out-of-care.

- Reported need varies for transportation, with females, families, heterosexuals, IDUs, and recently incarcerated indicating the highest need – all over 50%. Males and Anglos report the lowest need, approximately 40% for each group.
- In general, about four in ten PLWH/A ask for transportation services. As expected those out-of-care are much less likely to ask for transportation services (40%). Among all PLWH/A 6% say they ask for but do not receive services. This rate is much higher among females (13%) and Anglos (9%).
- The need-receive gap falls in approximately the same range, with females (15%) and African Americans (10%) reporting the largest gap between needing transportation and receiving it.

Focus Group Comments - Transportation:

Transportation was viewed as an essential service by some participants. A rural Anglo MSM said, *“Transportation services is a lifesaver up here. My agency drove me around for 10 months while I was disabled. It was very needed. I do drive my own car, but I have hard days and driving can be a challenge especially when it is an hour drive to the VA. It's important for me to get to those appointments.”*

A Latino MSM said, *“We don't have transportation. Sometimes when I need transportation, they say I am outside the limits of the city.”* Another Latino MSM followed by discussing his travels for services by saying, *“They consider me rural. I do have to come in. My sister drives me in from Carrollton to the Park and Ride to catch one of the Express buses and then I have to try and catch another bus and then transfer off that bus to catch a bus to get over here to Dallas.”*

The rural residents interviewed in AIDS Resources of Rural Texas' Waxahachie County satellite office lived in Navarro County. They were use to traveling to Tarrant County (61 miles away from Corsicana Texas in Navarro Co.) They all seemed content with living a distance from the nearest care agency as long as transportation was provided to them by their agency. Currently the client load in Ellis and Navarro Counties is so small that the care agency is capable of transporting the clients to their HIV related service appointments. A rural Anglo heterosexual IDU male said, *“The Tarrant County Health Department sent me a package telling me where to go. There isn't an office in Corsicana, so they gave me this package with a booklet. Tarrant Co. is sixty miles away from my home. They provide transportation. They will organize it with other people who need to go at the same time.”*

Complaints about the transportation system tended to be with scheduling. For example, a rural Anglo female IDU said, *“I think we needed a specified time so that we could go and get our doctor appointments. I know a lot of people who don't have the means to get to those appointments in Dallas. We should have a monthly time that this area goes to [the large hospital facility] and people can catch rides down there. It'd have to be that once or twice a month the ARCOT van could go down there and back - but it's an all day event.”*



A rural Anglo MSM mentioned that the local transportation service does not work well. He said, *“They have a new van but the program hasn't gotten off. We don't have volunteers here to do the driving. There are many individuals here that don't have transportation to get meds or make their doctors appointments. If you don't have a family member or a friend to do it then you miss your appointments because you didn't know how else to get there.”*

One African American IDU male brought up his concern about transportation by saying, *“I am getting bus passes but they don't give out month passes anymore. Only 22 roundtrips a month. They stopped at the first of the year. And since I am signed up with [one agency] then I can't go to any other agency for more transportation because they see that as double-servicing.”*

Even with taxi vouchers, some still find getting a cab a difficult. An Anglo female IDU said, *“Regarding transportation for HIV services, it is hard to get a cab. There are companies that have the service during the day but not at night & using their services is an all day affair.”*



Case Management

Case Management

Definition

A client-centered service addressing a comprehensive range of needs, including health care, that connects clients and their family or significant others with all appropriate resources and services. Through on-going follow-up and contacts, case management provides assistance to clients through the entire spectrum of disease of HIV/AIDS from early intervention to death. These services must encompass a responsibility for effective management and coordination of community resources.

Service Unit, Eligibility, and Funding

Unit: One (1) documented fifteen (15) minute face-to-face encounter with a client, or one (1) documented, fifteen (15) minute, specifically-defined "other" encounter with another service entity on behalf of a client.

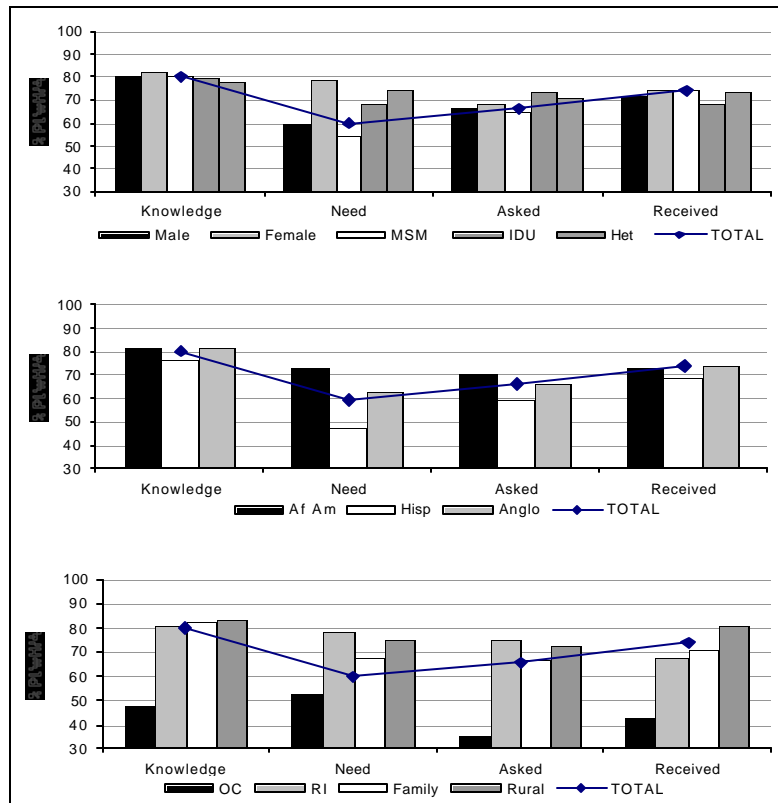
Eligibility: 100% eligibility.

Average unit: 47.3 visits

EST. PLWHA	
TOTAL	10,500
Know HIV	6,390
In Service	3,595
Est # Elig	6,390

SERVICE UNITS 2000	
Number of Units Funded	79,669
Number Recommended	110,880
Number Reported Received	170,240

FUNDING 2000-2001	
RW Care Title I & CBC	\$746,744
RW Care Title II	\$14,075
Other	\$98,016
Total Allocated	\$858,835



REPORTED in 2001			
	Total	Male	Female
% Knowing	80%	81%	82%
% Needing	60%	60%	79%
% Asking	66%	67%	69%
% Receiving	74%	72%	75%
Af Am Hisp Anglo			
% Know ing	82%	76%	82%
% Needing	73%	48%	62%
% Asking	71%	59%	66%
% Receiving	73%	69%	74%

GAPS			
	Total	Male	Female
Knowledge Gap	20%	19%	18%
Unmet perceived need	-8%	-5%	-6%
Need-Receive Gap	-14%	-12%	4%
Af Am Hisp Anglo			
Knowledge Gap	19%	24%	18%
Unmet perceived need	-2%	-10%	-8%
Need-Receive Gap	0%	-21%	-12%

SUMMARY GAP INDICATORS	
Units received/ Units funded	149%
Reported / Theoretical Need	153%
Eligibility Gap	-34%



- In general, about 80% of PLWH/A know about case management. Assuming 100% of PLWH/A should know about case management, there is a gap of about 20% among most populations. There is little difference in knowledge by gender or ethnicity. As expected, those out-of-care have significantly less awareness of case management.
- Reported need varies for case management, with females (75%) and heterosexuals (80%) indicating the highest need, and MSM (45%) and Hispanics (55%) expressing the lowest need. Recently incarcerated (79%) and rural (75%) express a greater than average need for case management.
- In general, two-thirds of PLWH/A ask for case management. Slightly more African Americans (71%) and slightly less Hispanics (59%) ask for it. Usually more PLWH/A receive it than ask for it and there is no unmet perceived need gap.
- Although the standard is for everyone HIV positive to receive case management, all PLWH/A report receiving 14% more case management than they report needing. The perceived need is significantly less than the standard of everyone receiving case management, particularly among MSM and Hispanics. Only females report having a slightly greater need for case management than they receive.



Client Advocacy

Definition

A service that assesses the presenting problem/need of the client. Client advocates make appropriate referrals and provide short-term monitoring and follow-up in the process of connecting the client with comprehensive case management (This may not be the goal in all cases.). Follow-up consists of an additional contact with the client to assure resolution of the presenting problem/need, or to address a new problem/need that has been identified.

Service Unit, Eligibility, and Funding

Unit: One (1) documented, fifteen (15) minute face-to-face encounter with a client, or one (1) documented fifteen (15) minute, specifically defined, "other" encounter with another service provider on behalf of a client.

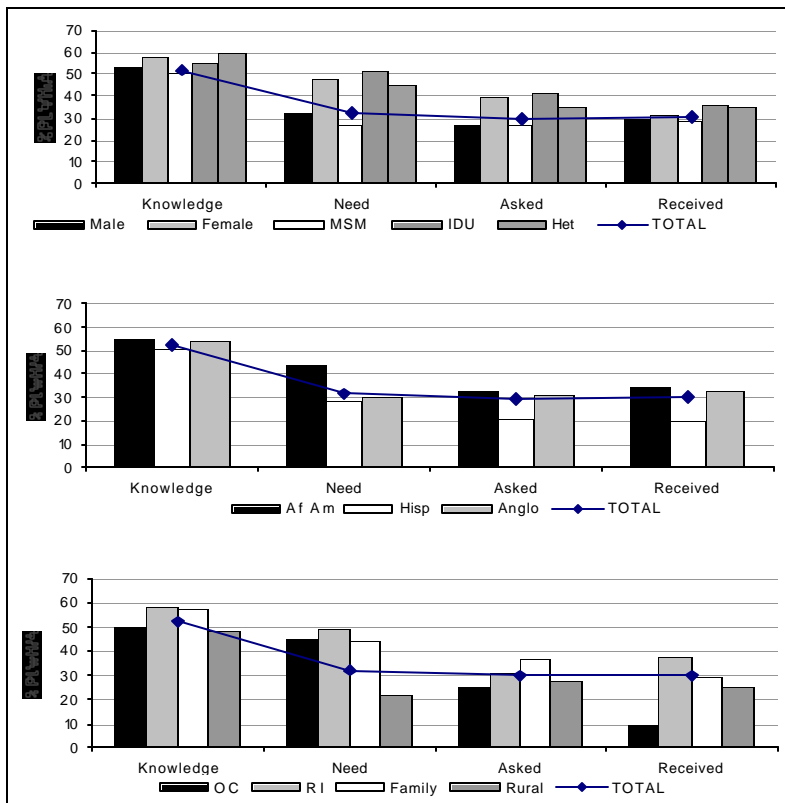
Eligibility: 91% eligible based on income at 300% poverty and residence of Dallas EMA/HSDA.

Average unit:

EST. PLWHA	
TOTAL	10,500
Know HIV	6,930
In Service	3,595
Est # Elig	6,306

SERVICE UNITS 2000	
Number of Units Funded	
Number Recommended	
Number Reported Received	

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	



REPORTED in 2001			
	Total	Male	Female
% Knowing	52%	53%	58%
% Needing	32%	32%	48%
% Asking	30%	27%	39%
% Receiving	30%	30%	32%
Af Am Hisp Anglo			
% Knowing	55%	51%	54%
% Needing	44%	28%	30%
% Asking	33%	21%	31%
% Receiving	34%	20%	32%

GAPS			
	Total	Male	Female
Knowledge Gap			
Unmet perceived need			
Need-Receive Gap			
Af Am Hisp Anglo			
Knowledge Gap			
Unmet perceived need			
Need-Receive Gap			

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	-61%

- In general, 52% of PLWH/A report knowledge of client advocacy. Heterosexuals (60%), females (58%) and recently incarcerated (58%) report the highest awareness of the service.
- IDUs (51%) and recently incarcerated (50%) report the highest need for client advocacy.



- Recently incarcerated received client advocacy the most (38%) suggesting a service that is part of the discharge program for recently incarcerated.

Focus Group Comments

Many participants found that their case managers were competent and useful. A female, Anglo heterosexual said, *“I am very happy with the treatment and respect I have received. I feel very comfortable with my case manager and have no problems asking her questions.”* A male Anglo heterosexual noted, *“My case manager gave so much of himself that it's unreal. He's made it a whole lot easier.”* An African American heterosexual male said, *“With case management, they give you referrals to a variety of services. When I found my case manager, it seemed that my confusion was resolved.”*

Case managers sometimes travel to the infected person's residence and that is appreciated. A rural female said, *“It's easy because she comes to my house. Otherwise I would not be able to see her.”*

On the other hand, some participants were critical, a male African American heterosexual said, *“I do not feel services are being provided for me. My case manager does not help me at all.”*

A female Hispanic participant noted, *“I have a case manager. I don't remember who it is because it's like they call you one time and say, ‘Okay, I'm the worker. Is all of your information the same or have you changed anything?’ and I don't hear from them anymore. I think they should get in touch with you at least, I know I realize they have a lot of clients and stuff but at least once a month they should call you and say, “Do you need anything? Are you doing okay?.” But they don't. It's been so long I don't even remember who the person is.”*

To some degree participant complaints appear to be based on factors outside of their case managers control. A Hispanic female complains, *“I have completed a HOPWA application dated in July 1998. To date, I have not received a reply and can no longer afford my current house without rental assistance.”* She added, *“My case manager has contacted HOPWA representative and left messages to which no reply has been made. The income bracket that my family and I may fall slightly over the guideline amount making us ineligible to receive additional assistance, but our living situation warrants action from our community agencies.”*

There is a feeling among participants that case managers have too large a caseload. An Anglo, MSM, for example, said, *“Patients need a case manager/patient advocate to assist and inform of services/benefits not known to patients. They say they have case managers but for 400 patients they only have 2 to 3 case managers.”*

Particularly rural participants say they are inadequately served. An Anglo rural male said, *“They don't have enough funds for case managers. The one case manager here is overloaded. One caseworker for all of the clients.”* Another rural participant noted, *“I live in my parents home. A case manager is assigned but he is 75 miles away from me.”*



While the majority of participants said they had adequate amounts of information, a few participants, like this male Hispanic MSM wanted more. He said, *“I just need more info regarding areas that I had problems with. I need more literature about HIV and need to know who to talk to for referrals. I don't know why I don't think of my CM to be in that position.”*

From comments in the focus groups it is unclear if participants distinguished between case management and client advocacy. The participants in the African American heterosexual/IDU male focus group did not know of client advocacy as a service. Several participants of various backgrounds and risk groups expressed the need for a client advocate to assist in getting food stamps, SSDI, SSI, and/or health insurance (including Medicaid).

Others expressed their recognition that they have to be their own “advocate”, but it is unlikely that they meant short term assistance. An African American MSM suggested that he often served as his own “advocate.” He said, *“There are services everywhere. You just have to get information and look in there and read what's in there and what they want to help you with, and take time to call them and do something for yourself. If you don't do it for yourself nobody else is going to do it for you.”* Another African American MSM echoed the thought by saying, *“You have to go in and talk to people about their problems. If you've got a problem go to somebody with it. That's what they are there for. But if you go down there and sit there and say, ‘I just want some bus tickets. Bye, I'll see you later’ - you are not going to get anything. That's all they are going to give you.”*



Home Health Services

Professional Home Health Care

Definition

Provision of homemaker/health aide services, therapeutic, nursing, supportive or compensatory health service provided by a licensed/certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a physician.

Service Unit, Eligibility, and Funding

Unit: One (1) skilled nursing visit, or One (1) home health aide visit, or One (1) unit of durable medical equipment delivered to a patient.

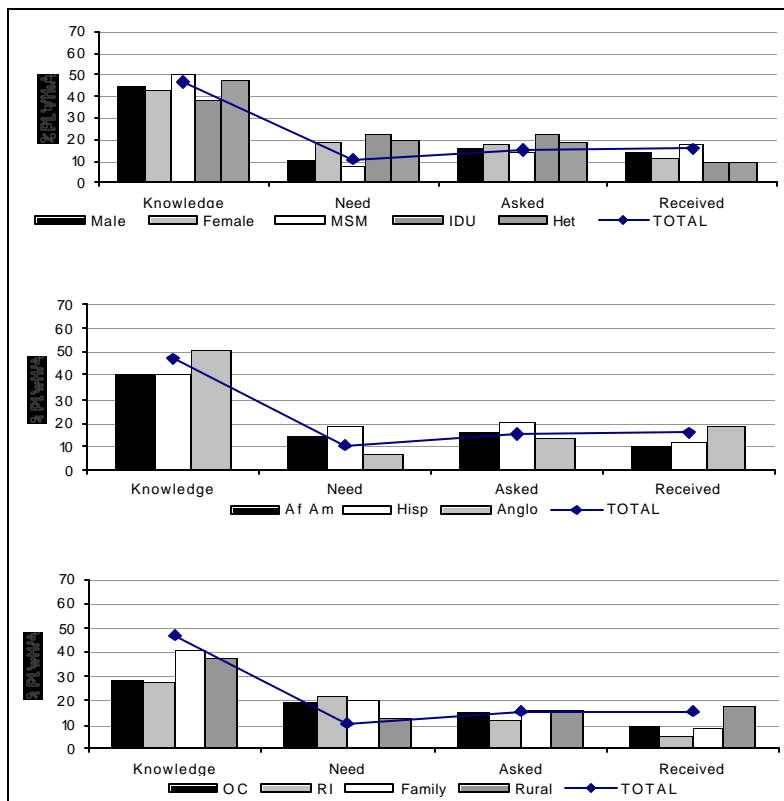
Eligibility: 47% eligible based on PLWA with residence in Dallas County.

Average unit:

EST. PLWHA	
TOTAL	10,500
In Service	
Est # Elig	3,222

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported	
Received	

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	



REPORTED in 2001			
	Total	Male	Female
% Knowing	47%	45%	43%
% Needing	11%	11%	19%
% Asking	15%	16%	17%
% Receiving	16%	14%	12%
Af Am Hisp Anglo			
% Knowing	40%	41%	51%
% Needing	15%	19%	7%
% Asking	16%	20%	14%
% Receiving	11%	12%	19%

GAPS			
	Total	Male	Female
Knowledge Gap	53%	55%	57%
Unmet perceived need	-1%	2%	5%
Need-Receive Gap	-5%	-3%	7%
Af Am Hisp Anglo			
Knowledge Gap	60%	59%	49%
Unmet perceived need	5%	8%	-5%
Need-Receive Gap	4%	7%	-12%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	-32

- Overall, less than half of PLWH/A surveyed know about professional home health services. African Americans (40%) and Hispanics (41%) are less knowledgeable about home health services than Anglos (51%). Assuming everyone should know about health home care, the



largest knowledge gaps are among PLWH/A out-of-care (28%), recently incarcerated (26%) and African Americans (60%).

- Need for this service is under 20% for all groups, with the lowest need among Anglos (7%) and the highest need among Hispanics and heterosexuals (about 20%). For special populations, those out-of-care and those PLWH/A with families have a higher need than other subpopulations.
- In general, 15% of PLWH/A have asked for this service. Hispanics (20%) are more likely to ask for it, while Anglos are least likely to ask for it (14%).
- The unmet perceived gap indicates that, except Anglos, more PLWH/A ask for services than receive them.



Para-Professional Home Health Care

Definition

Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that includes appropriate health care professionals. Includes homemaker, home health aide, personal care, and attendant care services.

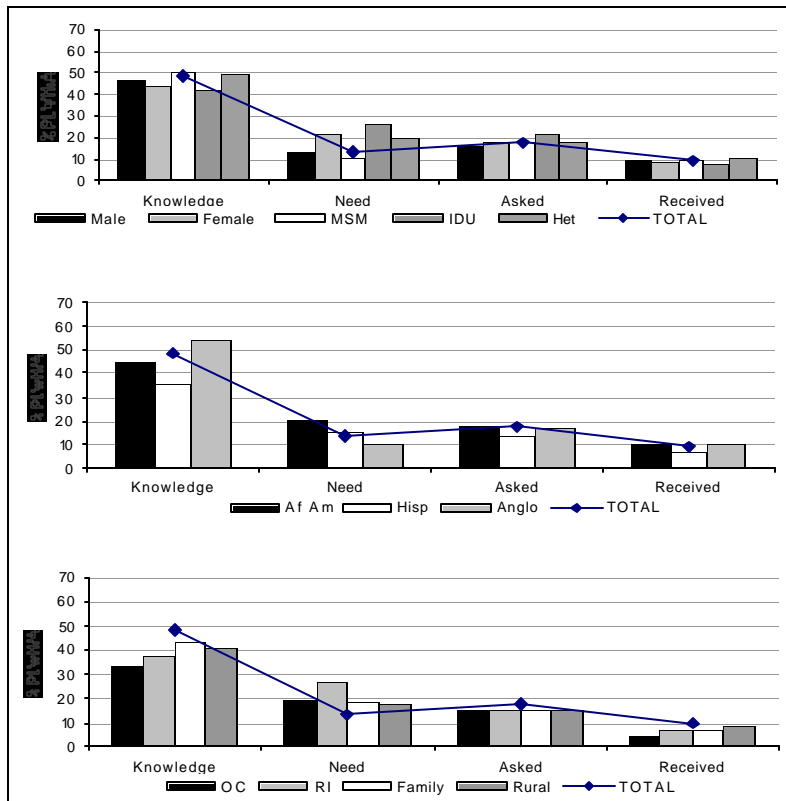
Service Unit, Eligibility, and Funding

Unit: One (1) home health aide visit, or One (1) unit of durable medical equipment delivered to a patient.
 Eligibility: 47% eligible based on PLWA with residence in Dallas County.
 Average unit:

EST. PLWHA	
TOTAL	10,500
In Service	
Est # Elig	3,222

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported	
Received	

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title I	
Other	
Total Allocated	



REPORTED in 2001			
	Total	Male	Female
% Knowing	48%	46%	44%
% Needing	14%	14%	22%
% Asking	18%	16%	17%
% Receiving	10%	10%	8%
Af Am Hisp Anglo			
% Knowing	45%	36%	54%
% Needing	20%	15%	11%
% Asking	18%	14%	17%
% Receiving	11%	7%	11%

GAPS			
	Total	Male	Female
Knowledge Gap	52%	54%	56%
Unmet perceived need	8%	6%	9%
Need-Receive Gap	4%	4%	14%
Af Am Hisp Anglo			
Knowledge Gap	55%	64%	46%
Unmet perceived need	7%	7%	6%
Need-Receive Gap	9%	8%	0%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	-29%

- In general, knowledge of para-professional home health care services is about 50%, with the highest knowledge among Anglos (54%). Hispanics report knowing about it the least (36%).



- Average need for this service was 11%. Females (19%) needed it more than males (11%), and IDUs (25%) needed it more than other risk groups. Among special populations, recently incarcerated and families had an above average need for para professional home health services. The need-receive gap for para-professional home health care services is highest among females (14%).
- IDUs indicate the highest demand for this service with approximately 20% asking for it. Unmet need among gender and risk groups was small. Hispanic had the largest unmet perceived need with 8% more person asking for the para-professional home health care than receiving it.



Hospice Care

Definition

Nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting. Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

Service Unit, Eligibility, and Funding

Unit: One (1) twenty-four (24) hour period of hospice services delivered to a patient in the patient's home, or One (1) twenty-four (24) hour period of room and board, and hospice services provided to a patient in the terminal stages of illness, in a residential facility.

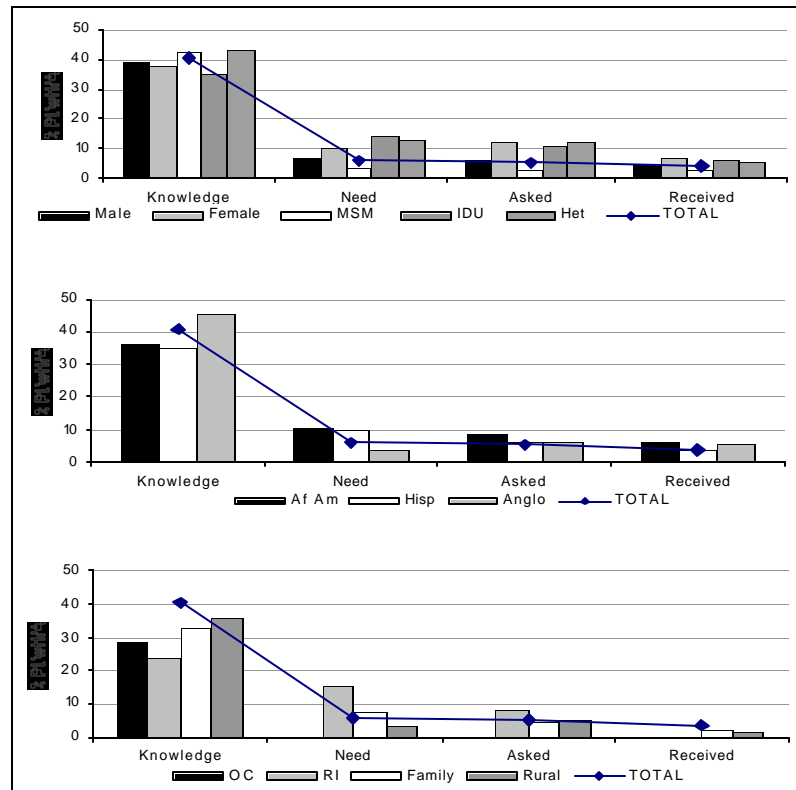
Eligibility: 48% eligible based on PLWA (50%) residing in the Visiting Nurse Assoc. service area (EMA)

Average unit:

EST. PLWHA	
TOTAL	10,500
Know HIV	6,930
In Service	
Est # Elig	3,292

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported	
Received	

FUNDING 2000-2001	
RW Care Title I & CBC	\$34,482
RW Care Title II	
Other	\$3,508
Total Allocated	\$37,990



REPORTED in 2001			
	Total	Male	Female
% Knowing	41%	40%	37%
% Needing	6%	7%	10%
% Asking	6%	6%	12%
% Receiving	4%	5%	6%
Af Am Hisp Anglo			
% Knowing	36%	35%	45%
% Needing	11%	10%	4%
% Asking	9%	7%	6%
% Receiving	6%	4%	5%

GAPS			
	Total	Male	Female
Knowledge Gap	59%	60%	63%
Unmet perceived need	2%	1%	6%
Need-Receive Gap	2%	2%	4%
Af Am Hisp Anglo			
Knowledge Gap	64%	65%	55%
Unmet perceived need	3%	3%	1%
Need-Receive Gap	5%	6%	-1%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	-42%

- Hospice care is for PLWA who need continuous and intensive care. Given that fewer people enter this stage of HIV disease, it is not surprising that the knowledge of hospice care is about 4 and 10.



- Need is quite low with only 6% of the PLWH/A surveyed reporting a need for hospice care. Recently incarcerated (17%), IDUs (14%) and heterosexuals (12%) have a somewhat higher need. This may be due to their late entry into the care system.
- There are more persons saying they ask for hospice care than receive it, with the highest unmet perceived need gap is highest among females (6%).
- Females, heterosexuals and IDUs have asked for hospice care more than other groups with a range of 6% to 12%.
- The need-receive gap is highest among African Americans (5%) and Hispanics (6%).

Focus Group Comments – Home Health Care

The need for home health care was clear for some of the participants. For example, a rural Anglo MSM caregiver feels his HIV symptomatic partner should get home visits from his physician or better transportation services for appointments. He said, *“With his eyesight disappearing he can have two or three appointments in a week. It became difficult for me to get him down there those two times. We live 35 miles away. But when you are dealing with the rush hour in Dallas which will mean at times a two hour commute. And with it being the County Hospital system, you are there all day no matter what the procedure is. Literally, every doctor appointment is a full day that his caretaker has to take off from work to take care of it. That's been a problem. And you can't get that kind of medical treatment from any hospital out here in Collin Co. You have to travel to Dallas for it.”*

Another MSM from Henderson County noted the trade off between transportation services and home health care. He said, *“A home health care professional would be nice to have here because I don't drive.”*

Qualifications to have home health care were a barrier. A rural Anglo MSM needs the service because he is losing his vision but does not qualify. He said, *“I need someone to come over and help me clean. I can cook but I can't clean the house. My eyes are going down hill. I drop things and am afraid of breaking things. I don't qualify because I don't need six hours of help a week.”*

The challenge of providing home health care services to the homeless was suggested by an Anglo female IDU. She said, *“It is hard to inject the drugs (steroids) with a past IV usage but my doctor wants me to take them. I had to stop medications because I was on illegal drug usage. Being homeless at times I didn't sleep for days at a time. There is no good hospice environment for non-terminal here in Dallas.”*



Mental Health Counseling

Individual Mental Health

Definition

Psychological and psychiatric treatment and counseling services through individual process to be provided to patients and caregivers by or under the direction of a mental health professional who is licensed or authorized within the State of Texas. This includes psychiatrists, psychologists, social workers, and counselors. Crisis counseling should be available to patients and care givers.

Service Unit, Eligibility, and Funding

Unit: One (1) forty-five (45) minute level I individual session, or One (1) forty-five (45) minute level II individual session.

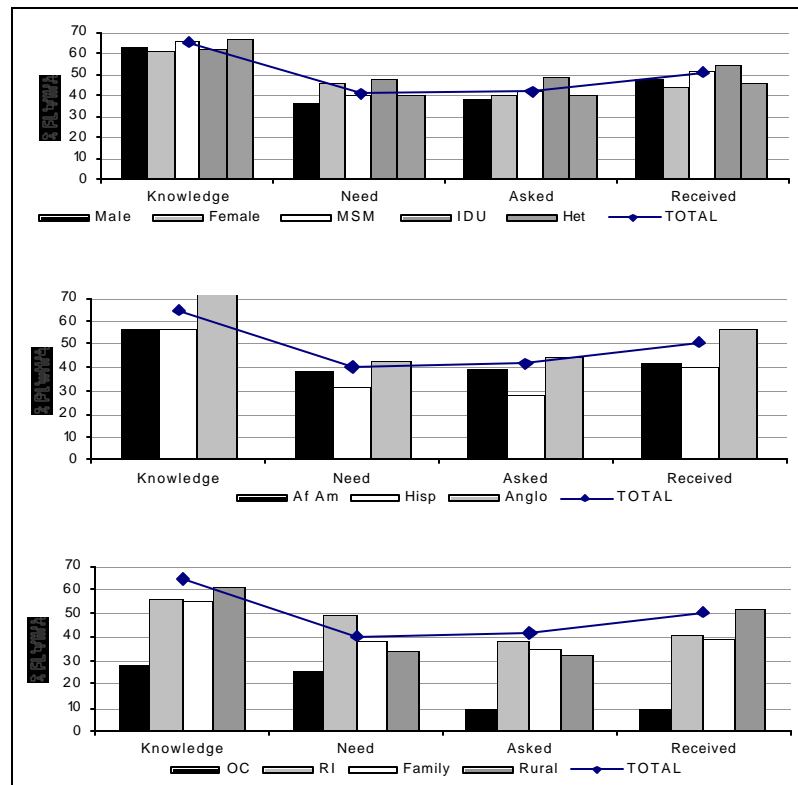
Eligibility: 91% of eligibility based on 300% poverty and residence of Dallas EMA/HSDA.

Average unit:

EST. PLWHA	
TOTAL	10,500
Know HIV	6,930
In Service	
Est # Elig	6,306

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported Received	

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	



REPORTED in 2001			
	Total	Male	Female
% Knowing	65%	63%	61%
% Needing	40%	36%	46%
% Asking	42%	38%	40%
% Receiving	51%	48%	44%
Af Am Hisp Anglo			
% Knowing	57%	56%	73%
% Needing	39%	32%	43%
% Asking	39%	28%	45%
% Receiving	42%	40%	57%

GAPS			
	Total	Male	Female
Knowledge Gap	35%	37%	39%
Unmet perceived need	-9%	-10%	-4%
Need-Receive Gap	-11%	-12%	2%
Af Am Hisp Anglo			
Knowledge Gap	43%	44%	27%
Unmet perceived need	-3%	-12%	-12%
Need-Receive Gap	-3%	-8%	-14%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	-49%

- Knowledge of individual mental health counseling amongst the surveyed PLWH/A is generally high (65%). African Americans (57%) and Hispanics (56%) report lower knowledge of individual mental health services than Anglos (73%). Least knowledgeable are



PLWH/A out-of-care(30%). The knowledge gap is highest among African Americans (43%) and Hispanics (44%).

- Overall need is approximately 40%. Females (46%) say they need mental health services more than males (36%), and among risk groups IDUs are the most likely to need individual mental health services. Among the special populations almost 50% of the recently incarcerated say they need individual mental health services.
- In general, 42% of PLWH/A ask for individual mental health counseling. There is little difference between males and females. Hispanics (28%) ask for it considerably less than African Americans (39%) and they ask for it less than Anglos (45%).
- All populations report receiving more services than they ask for, with over 50% of Anglos, IDUs, and rural residents report receiving this service. There is not an “unmet perceived need” gap.
- The need-receive gap for all groups also indicates that service use is higher than reported need.



Group Mental Health

Definition

Psychological and psychiatric treatment and counseling services through family and group sessions to be provided to patients and caregivers by or under the direction of a mental health professional who is licensed or authorized within the State of Texas. This includes psychiatrists, psychologists, social workers, and counselors. Crisis counseling should be available to patients and care givers.

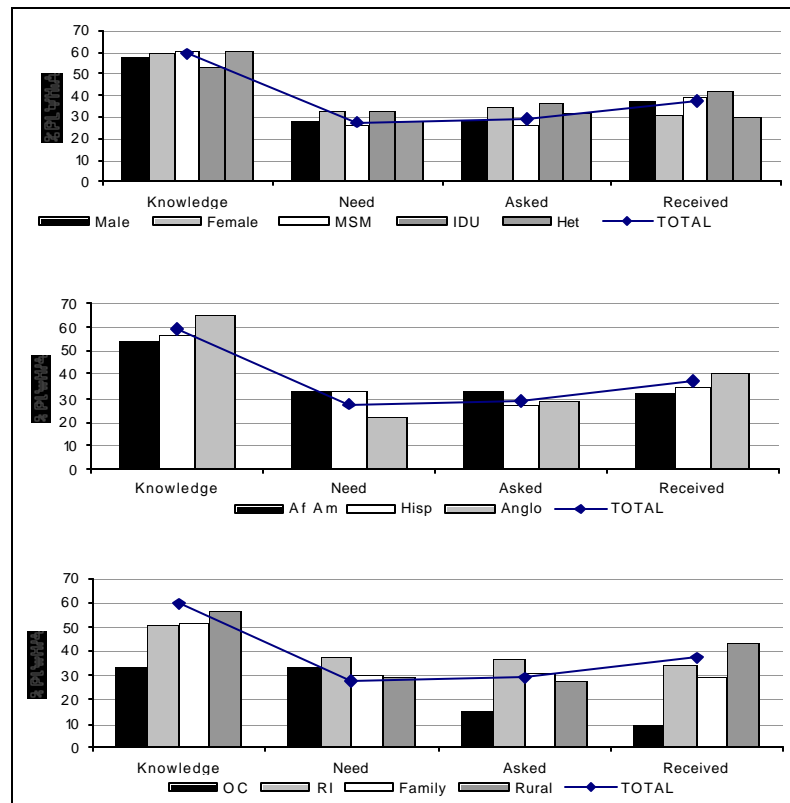
Service Unit, Eligibility, and Funding

Unit: One (1) patient participating in a sixty (60) minute level I group session, or One (1) patient participating in a sixty (60) minute level II group session.
 Eligibility: 91% of eligibility based on 300% poverty and residence of Dallas EMA/HSDA.
 Average unit:

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	
Est # Elig	6,306

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported	
Received	

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	



REPORTED in 2001			
	Total	Male	Female
% Knowing	60%	57%	60%
% Needing	27%	28%	33%
% Asking	29%	28%	35%
% Receiving	37%	38%	31%
Af Am Hisp Anglo			
% Knowing	54%	57%	65%
% Needing	34%	32%	22%
% Asking	33%	27%	29%
% Receiving	32%	35%	41%

GAPS			
	Total	Male	Female
Knowledge Gap	40%	43%	40%
Unmet perceived need	-8%	-10%	4%
Need-Receive Gap	-10%	-10%	2%
Af Am Hisp Anglo			
Knowledge Gap	46%	43%	35%
Unmet perceived need	1%	-8%	-12%
Need-Receive Gap	2%	-3%	-19%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	-62%

- Knowledge of group mental health counseling is also high, with the general PLWH/A population reporting 60% knowledge of this service. African Americans know about it less



than other ethnic groups and have the highest knowledge gap. Males and Hispanics also both have a relatively high knowledge gap of 43%)

- Approximately one-third of most groups report a need for group mental health counseling. The highest need. Like individual counseling females say they need it more than males. African Americans (34%) and Hispanics (32%) say they need group mental health services more than Anglos(22%). Among the special populations, recently incarcerated (38%) have a relatively high need for this service.
- On average a third of PLWH/A ask for this service. IDUs (38%) and African Americans (33%) report asking for this service more than Anglos, and IDUs ask for more than other risk groups.
- Generally, more group mental health service is being provided than is either being asked for or needed. Rural residents report receiving it the most (43%).
- African Americans and females have report needing and asking for group mental health services more than they receive it.



Peer Counseling and Support

Definition

Individual and/or group counseling services, other than mental health counseling, provided to clients (according to DHS guidelines) by non-licensed counselors. May include psycho-social, caregiver support, bereavement counseling, drop-in counseling, benefits counseling, other support group activities, and/or nutritional services.

Service Unit, Eligibility, and Funding

Unit:

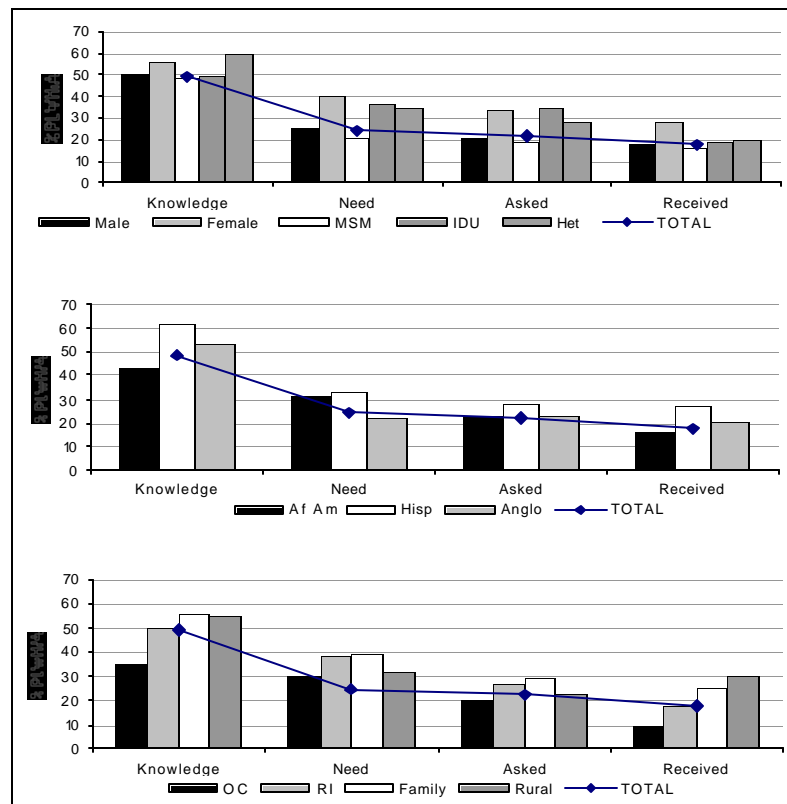
Eligibility:

Average unit:

EST. PLWHA
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001			
	Total	Male	Female
% Knowing	49%	50%	56%
% Needing	24%	25%	40%
% Asking	22%	21%	33%
% Receiving	18%	17%	29%
	Af Am	Hisp	Anglo
% Knowing	44%	62%	53%
% Needing	31%	33%	22%
% Asking	23%	28%	23%
% Receiving	16%	27%	21%

GAPS			
	Total	Male	Female
Knowledge Gap	51%	50%	44%
Unmet perceived need	4%	4%	4%
Need-Receive Gap	6%	8%	11%
	Af Am	Hisp	Anglo
Knowledge Gap	56%	38%	47%
Unmet perceived need	7%	1%	2%
Need-Receive Gap	15%	6%	1%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- In general, knowledge of peer counseling and support is about 50% among PLWH/A. Females (56%) know more about peer counseling than males (50%), and Hispanics report the highest knowledge (62%) followed by Anglos (53%) and African Americans (44%). Among the special populations, those out-of-care report the lowest level of knowledge about peer support (32%).



- Reported need averages 24% with over 30% if the females and IDUs saying they need peer support. Among special populations, over 30% of PLWH/A who have families, rural participants, and recently incarcerated report a need of over 30%.
- About a quarter of all PLWH/A ask for peer counseling, and 18% receive it. Females ask for peer counseling the most, and receive it the most. There are small unmet perceived need gaps.
- Fifteen percent (15%) of the African Americans and 12% of the males say they need but do not receive peer counseling services.

Focus Group Comments:

Many of the participants felt they were receiving good mental health services. A rural Anglo MSM said, *“The care agency is a real nice space to go to--very supportive like a family. They keep you informed and active in re: to the different events in the community.”*

The value of peer counseling was also noted. A heterosexual Latina said, *“When I found out in '91, I went to a few support groups which helped a lot but then I kind of went into isolation for a couple of years and then I started going again. The support groups help a lot.”*

For many PLWH/A mental health counseling is needed for other issues than HIV. A rural female IDU reported, *“It's partly needed because of the HIV, but it also has to do with personal problems with other family members and their health matters.”*

One problem noted was the lack of transportation of mental health appointment. An Anglo MSM from Henderson County said, *“Transportation is very badly needed here to get to HIV services. The closest thing here is the Medicaid van that takes me to [the large hospital facility] for doctor appointments but they don't help you get other things done.”*

This was confirmed by an Anglo female IDU who said, *“Peer counseling/support is very hard to access without transportation especially when they are at night. Here in Dallas you have to be very sick to get transportation services.”*

Participants in the survey noted that there was a larger gap for peer counseling and support that either individual or group session. Many focus group participants confirmed that observation. A rural Anglo MSM said, *“One thing that I would like to bring up is that there is a big need for peer group counseling. You can't go to just one therapist. One barrier is that the therapist is seen as a doctor. And you may not click with that therapist. And they may not have the knowledge to know what you are dealing with. We had groups here that was being facilitated by a drug and alcohol rehabilitation counselor. That kind of treatment wouldn't do me any good. But we don't have the capability of having the group. I can't get out at 6 o'clock at night and drive twenty miles for a group meeting. I would be fatigued at the end of the night.”*

An African American MSM expressed his desired need from peer support. He said, *“The given fact is motivation. The people to need something to be empowered so they can move on.”*



Another African American MSM expressed his thought that peer counseling can be used as a way to network. He particularly found it useful to learn how to navigate through the system. Regarding peer counseling he said, *“It’s an unmet need, especially as an African American gay man in recovery. And not so much than just like some drop-in place. Just a place where you can just be yourself and there’s not all of these rules and restrictions and not always somebody trying to pound down on you about medications, but just somewhere where people can come and be sociable. For me, that’s the best way that information is gotten and that I can retain.”*



Health Insurance Assistance

Definition

Payment of insurance premiums and related co-pays and deductibles for eligible PLWH to ensure continuation of insurance coverage.

Service Unit, Eligibility, and Funding

Unit: One (1) monthly payment (i.e., premium, related co-pay, or deductible paid on behalf of a client.)

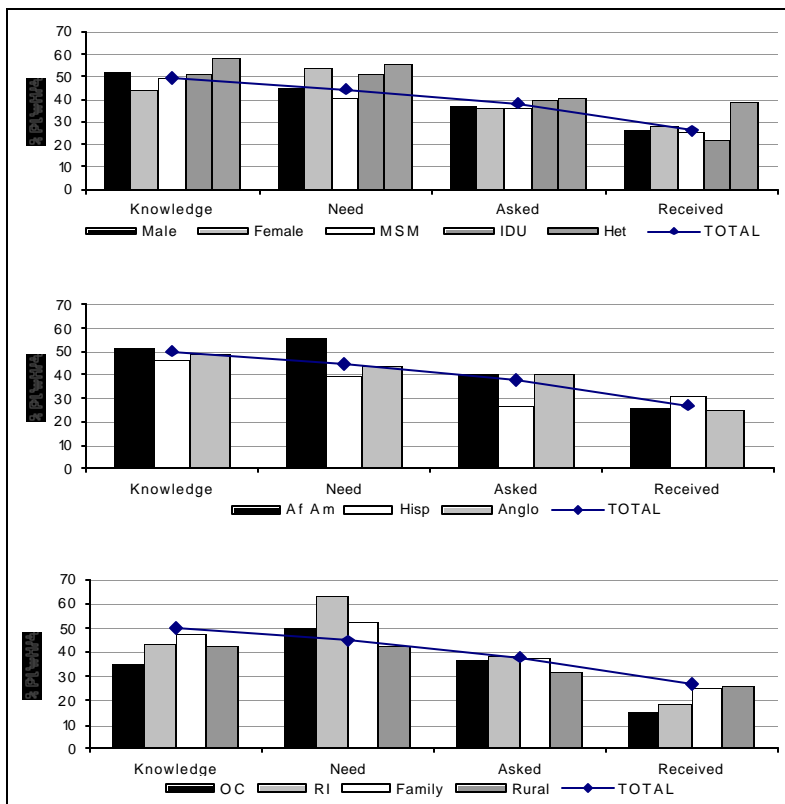
Eligibility: 300% of poverty and residence of Dallas EMA/HSDA.

Average unit: 8.5 payments

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	334

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported Received	2,845

FUNDING 2000-2001	
RW Care Title I & CBC	\$746,000
RW Care Title II	\$59,714
Other	
Total Allocated	\$805,714



REPORTED in 2001			
	Total	Male	Female
% Knowing	50%	52%	44%
% Needing	45%	45%	54%
% Asking	38%	38%	36%
% Receiving	27%	26%	28%
Af Am Hisp Anglo			
% Knowing	51%	46%	49%
% Needing	56%	39%	44%
% Asking	41%	27%	40%
% Receiving	26%	31%	25%

GAPS			
	Total	Male	Female
Knowledge Gap	50%	48%	56%
Unmet perceived need	11%	12%	8%
Need-Receive Gap	18%	19%	26%
Af Am Hisp Anglo			
Knowledge Gap	49%	54%	51%
Unmet perceived need	15%	-4%	15%
Need-Receive Gap	30%	8%	19%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	

- Half of all PLWH/A report knowledge of health insurance assistance. Females (44%) are less likely to know about health insurance continuation than males (52%). Between risk groups, heterosexuals indicate the highest knowledge (59%). As expected, PLWH/A out-of-care have the largest knowledge gap related to health insurance assistance.



- Females (54%) report greater needs than males (45%), and among risk groups, IDUs (50%) and heterosexuals (57%) indicate the greatest need. Among ethnic groups, African Americans (56%) the highest need (63%), while Hispanics note the lowest (39%). Among the special populations, recently incarcerated (63%) and families (52%) show the greatest need.
- Among risk groups, heterosexuals report receiving the service the most (40%). Between ethnic populations, Hispanics (31%) say they are most likely to receive insurance reimbursement. As expected those out-of-care receive insurance reimbursement the least, followed by recently incarcerated.
- 30% more African American perceive they need health insurance reimbursement than receive it

Focus Group Comments – Insurance Reimbursement

Health insurance continuation is only available to those that have insurance. Often when a person becomes unemployed there is a small window of opportunity. An Anglo MSM notes, *“I have had it for periods of time when I was employed by a different employer. When I was self-employed, I couldn't get it. With my current employer, I missed the window of opportunity to enroll but the next time it comes around I will be able to enroll for sure.”*

The need for health insurance for families was confirmed in the focus groups discussions. For example, an African American heterosexual female said, *“I don't have any insurance for my children. I'd like to have assistance for my children, including dental.”*

An Anglo MSM said, *“I have a moderate barrier with not having health insurance because I will be losing my private insurance in a couple of months.”*

From the cumulative comments in the focus groups about insurance, it appeared that many persons were unaware of what insurance continuation meant and were unaware of the windows of opportunity they may have if they become unemployed or need insurance assistance.



Substance Abuse Treatment

Outpatient Substance Abuse Treatment

Definition

Substance abuse services (including alcohol) assessment, treatment, and counseling by an agency with appropriate license or authority in a residential health services setting. Follow-up and aftercare services or placement must also be addressed.

Service Unit, Eligibility, and Funding

Unit: One (1) forty-five (45) minute individual counseling session, or One (1) patient participating in a sixty (60) minute group session (not to exceed ten (10) grant-funded patients per group).

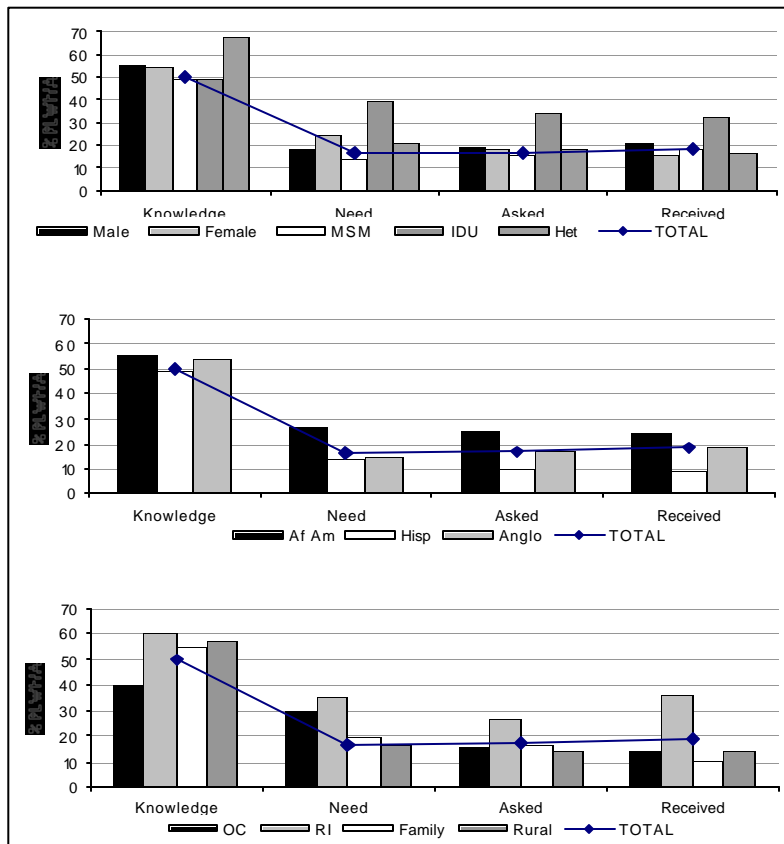
Eligibility: 12% eligible based on: the percent of PLWH/A that report chemical dependency and meet the income requirement of 300% of poverty and are residents of the Dallas EMA/HSDA.

Average unit: 33.8 sessions

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	234
Est # Elig	819

SERVICE UNITS 2000	
Number of Units Funded	4,880
Theoretical Need	29,890
Number Reported Received	7,920

FUNDING 2000-2001	
RW Care Title I & CBC	\$233,030
RW Care Title II	
Other	\$10,985
Total Allocated	\$244,015



REPORTED in 2001			
	Total	Male	Female
% Knowing	50%	55%	54%
% Needing	16%	18%	25%
% Asking	17%	19%	18%
% Receiving	18%	21%	16%
Af Am Hisp Anglo			
% Knowing	55%	49%	54%
% Needing	27%	14%	15%
% Asking	29%	9%	17%
% Receiving	24%	9%	19%

GAPS			
	Total	Male	Female
Knowledge Gap	50%	45%	46%
Unmet perceived need	-1%	-2%	2%
Need-Receive Gap	-2%	-3%	9%
Af Am Hisp Anglo			
Knowledge Gap	45%	51%	46%
Unmet perceived need	5%	0%	-2%
Need-Receive Gap	3%	5%	-4%

SUMMARY GAP INDICATORS	
Units received/ Units funded	162%
Reported / Theoretical Need	29%
Eligibility Gap	5%



- In general, about half the PLWH/A know about outpatient drug abuse treatment. Among risk groups, heterosexuals reporting the highest knowledge (68%). Among the special populations, PLWH/A who are out-of-care report the lowest knowledge the lowest (40%).
- Females (25%) say they have a greater need than males (18%). Between risk groups, as expected, IDUs (40%) have a substantially greater need than other risk groups. Between the special populations, recently incarcerated (35%), IDUs (40%), and PLWH/A who are out-of-care (27%) report the highest need for substance abuse treatment. MSM, Hispanics, and Anglos report the lowest need at approximately 15%.
- Those populations most effected by intravenous drug use have asked for substance abuse treatment the most. IDUs have asked for this service more than any other population (33%), followed by recently incarcerated and African Americans (both at approximately 29%).
- Among risk groups, the highest utilization (30%) is reported among IDUs. Among ethnic populations, African Americans report the highest usage (24%).
- The need-receive gap is highest among females (9%).
- The summary gap indicates that 62% more services were delivered than were funded, based on the unit cost measure.



Residential Substance Abuse Treatment

Definition

Substance abuse services (including alcohol) assessment, treatment, and counseling by an agency with appropriate license or authority in an office-based health service setting. Follow-up and aftercare services or placement must also be addressed.

Service Unit, Eligibility, and Funding

Unit:

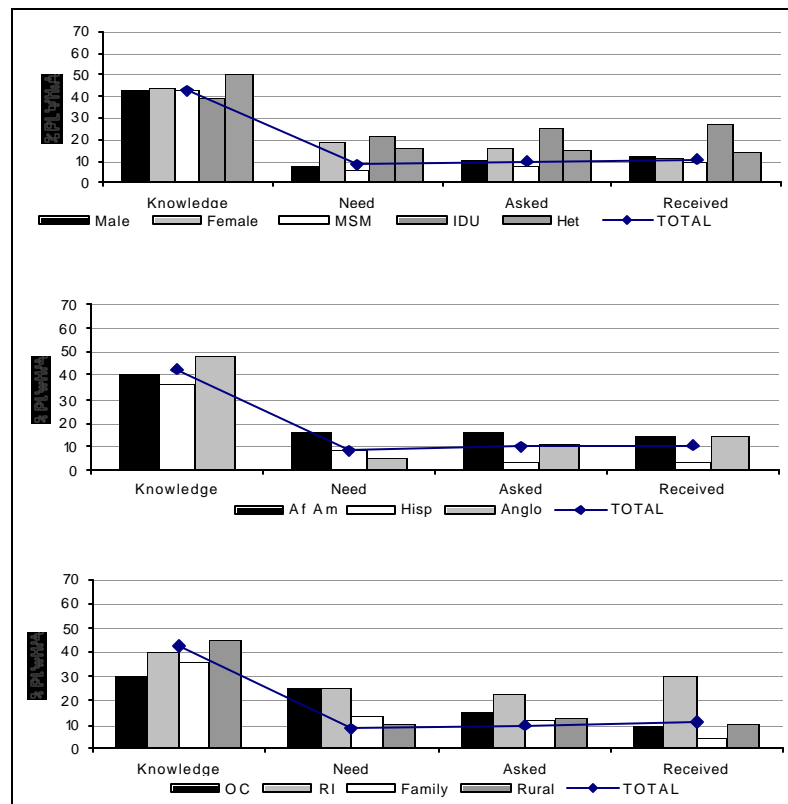
Eligibility: 12% eligible based on: the percent of PLWH/A that report chemical dependency and meet the income requirement of 300% of poverty and are residents of the Dallas EMA/HSDA.

Average unit:

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	234
Est # Elig	819

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported	
Received	

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title II	
Other	
Total Allocated	



REPORTED in 2001			
	Total	Male	Female
% Knowing	42%	43%	44%
% Needing	9%	8%	19%
% Asking	10%	11%	16%
% Receiving	11%	13%	12%
Af Am Hisp Anglo			
% Knowing	41%	37%	48%
% Needing	16%	8%	5%
% Asking	16%	3%	12%
% Receiving	15%	4%	15%

GAPS			
	Total	Male	Female
Knowledge Gap	58%	57%	56%
Unmet perceived need	-1%	-2%	4%
Need-Receive Gap	-2%	-5%	7%
Af Am Hisp Anglo			
Knowledge Gap	59%	63%	52%
Unmet perceived need	1%	-1%	-3%
Need-Receive Gap	1%	4%	-10%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	-2%

- In general, 42% of PLWH/A have knowledge of residential substance abuse treatment. Among risk groups, the knowledge is greatest among heterosexuals (50%), and among ethnic populations, the knowledge is greatest among Anglos (48%) and least among Hispanics (37%). The largest knowledge gap is among Hispanics (63%). Almost 70% of those PLWH/A out-of-care do not know about residential drug treatment.



- In general the perceived need for residential drug treatment is low (9%). It is highest among IDUs (20%) and African Americans (16%). Despite low knowledge, those out-of-care report relatively high levels of need (24%).
- In general about 10% of PLWH/A say they have asked for this service. Females (16%) and African Americans (16%) and IDUs (25%) are most likely to have asked for this service.
- IDUs (29%) and recently incarcerated (30%) report the highest usage. The unmet perceived need is very small, indicating that most person who ask for the service receive it. The need-receive gap is highest (7%) among females and those out-of-care.

Focus Group Comments Substance Abuse Treatment

Participants who use substance abuse treatment find it helpful. An African American MSM said, *“Let me tell you what's working for me today and working very well is [a treatment center] for recovery. I had been there before, but they are working in stuff real well. It is working really, really well. I just do one-on-one counseling, but they have offered me to stay with them. When I first started accessing services they were in effect immediately.”*

Another African American said, “The [substance abuse treatment] service has been supportive and helpful. It gave me a roof over my head. At least I'm not out on the streets. They have helped me with my chemical dependency problem.”

The success of rehab was again noted by another African American. He said, *“I'm becoming responsible again. As a matter of fact, I just recently opened a bank account, which I hadn't in 20 years. I'm able to accept responsibilities now. I'm learning how to deal with my feelings without drugs and alcohol. I'm in therapy, individual therapy and group therapy. I'm learning instruction again. My medical needs are being met.*

Another African American said, “I went to [a treatment center] and that was the best thing for me, but I messed around I relapsed and they discharged me. I got my head back on straight, you know, because it was on crooked. I just got out of prison, which isn't an excuse. I eventually made it to another treatment center. It is good for a person going through detox. You need a place to be for 30 or 90 days doing this detox and getting away from everything, so it is the place to go. They will detox you.”

The need for a variety of types of counseling services is suggested by this African American MSM. He said, *“After I came out of a private treatment facility I sought counseling at a care agency, and then my counselor left because of funding issues. Then I was stuck. But in the process of that I would stop by another care agency (that services substance users) and they would allow me to sit in on the group, not being declined, not paying anything. Anytime I needed support, they were always there. It acts, which we don't have at this care agency, somewhat as a drop-in place where I can drop-in for emotional support, and it helped me during that time that I needed it. I still feel that I can go there. For anybody, it's a very untraditional type of place. I guess they've got structure, but as far as just dropping in and saying, ‘Hey, I need to talk to somebody,’ there is no structure with that. That really helped me.”*



The lack of knowledge served as a barrier to some substance abusers. One participant said, *“I just talked to a female friend of mine, and she's been to one or two places but all of these other places, she didn't have a clue. She is struggling because she is not aware of what services are available to her. She's HIV positive and she is staying in a housing facility for substance abuse but it has nothing to do with HIV. She wants to know where to go.”*

A common theme in residential substance abuse treatment facilities is lack of independence. An African American MSM noted, for example, said, *“I've been going back and forth to the same treatment center. I wanted to spend my 90 days at that center and seek housing where I could motivate myself. Because at the treatment center, you are stuck there. I feel like if I can move somewhere like [another treatment center] I would still be getting my drug treatment, still be getting my counseling, be getting my meetings in, and be on my own to advance.”*

One African American MSM has found the balance between independent living and substance abuse that works for him. He said, *“I'm affiliated with a totally different type of program that's designed to hopefully do what I think your program is designed to do but doesn't sound like it is. The program that I'm with allows you to live independently in a community living setting where you take care of yourself, you spend your money on you. This doesn't work for everybody but it works for the people I see around me. ...Today I have the opportunity to assimilate back into the mainstream of society and know for myself what I can and can't do that's detrimental to me, my physical and mental and my HIV.”*

The link between housing and independent living and substance abuse treatment programs is clear from participants. An African American MSM said, *“I've been [at a treatment site] for about 4 months now. I recently got awarded my benefits from Social Security and I want access to housing. I want to live independently. I don't want to go leave one treatment center to go to another treatment center. It's mind boggling and stressful. I want my own stove.”*

Finding and making a transition to independent housing is difficult. An African American MSM noted, *“The main thing I've been struggling with is housing, and trying to get up on my feet, which I've been kind of stumbling with that. Right now I've got two months clean time and I'm working on my recovery, and trying to get everything together. I'm limited to certain things. Being on parole I just can't go out there and get an apartment. Because of my record, they deny you on certain things. So I'm stuck. There are only so many doors that are open for me, and I'm just trying to find the best thing for me. I want my own place. I don't want to be dependent on substance abuse treatment centers. I don't want to have to stay at the same treatment facility. I've been there for four months, I sure don't want to stay there another six months or a year waiting on the housing authority to help me.”*

An African American MSM said, *“I've been in the program for about 5 months, and it's hard because I get myself to a level and I expect to go out there and start getting my life back together but I feel like I'm held back. I can't just up and leave the program because I have no sources of income and no housing. So if I was to leave I would be out on the street. In some ways you feel trapped. Sometimes when you try to seek outside help, it's highly difficult. That's true with any program, it seems like.”*



Information and Referral

Health Education/Risk Reduction (HERR)

Definition

Provides basic information about available medical and psychosocial support services throughout the Dallas service delivery area and offers appropriate referrals based on each client's situation. May also include specific information about treatment education and reducing the risk of transmitting HIV.

Service Unit, Eligibility, and Funding

Unit:

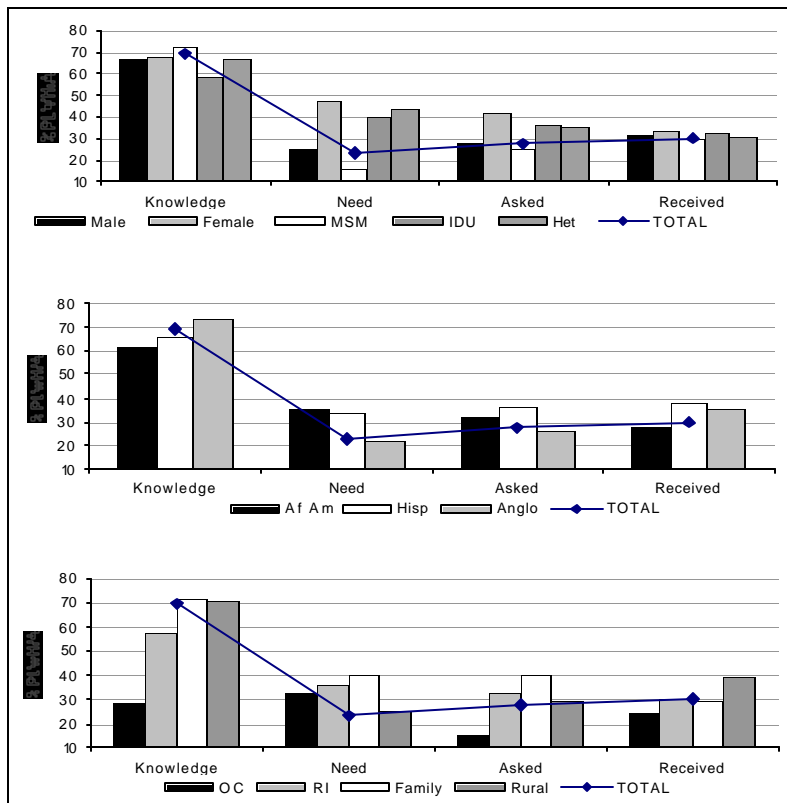
Eligibility:

Average unit:

EST. PLWHA
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	70%	67%	67%
% Needing	23%	25%	47%
% Asking	28%	28%	41%
% Receiving	30%	32%	33%
	Af Am	Hisp	Anglo
% Knowing	62%	67%	73%
% Needing	35%	34%	22%
% Asking	32%	37%	26%
% Receiving	27%	38%	35%

GAPS	Total	Male	Female
Knowledge Gap	30%	33%	33%
Unmet perceived need	-2%	-4%	8%
Need-Receive Gap	-7%	-7%	14%
	Af Am	Hisp	Anglo
Knowledge Gap	38%	33%	27%
Unmet perceived need	5%	-1%	-9%
Need-Receive Gap	8%	-4%	-13%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- In general, 70% PLWH/A report knowledge for health education and risk reduction counseling. African Americans (62%) know least about HERR. PLWH/A who are out-of-care report very low awareness of HERR (28%).



- Among risk groups, MSM report the lowest need (15%). Men (25%) report less need than females (47%).
- Most subpopulations receive more information than they ask for, however, females (8%) and African Americans (5%) reporting an asking for more services than they receive.
- More service is being provided than is being asked for among males, MSM, and IDUs. However, 14% of the females and 8% of the African Americans say they need more services than they receive.



Nutrition Education and Counseling

Definition

A program that allows for clients to meet with a Registered or Licensed Dietician or Nutritionist with specific HIV/AIDS experience. The one-on-one consultation allows for the client with HIV/AIDS to have their nutritional situation assessed by a professional, who explains the importance of proper nutrition to the client and offers recommendations for improving or meeting their daily nutritional needs. This may include specific diet suggestions, resources for assistance, shopping and cooking tips, information on supplements, and questions to ask their primary care provider.

Service Unit, Eligibility, and Funding

Unit:

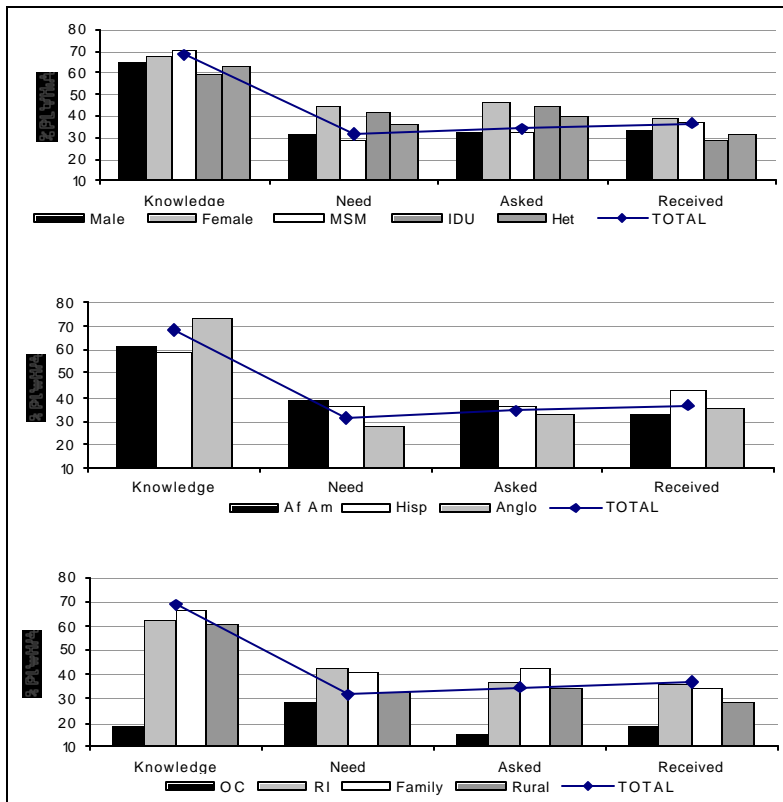
Eligibility:

Average unit:

EST. PLWHA
TOTAL
Know HIV
In Service

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	69%	65%	67%
% Needing	32%	32%	44%
% Asking	35%	33%	47%
% Receiving	37%	34%	39%
	Af Am	Hisp	Anglo
% Knowing	62%	60%	74%
% Needing	39%	37%	29%
% Asking	39%	39%	33%
% Receiving	33%	43%	35%

GAPS	Total	Male	Female
Knowledge Gap	31%	35%	33%
Unmet perceived need	-2%	-1%	8%
Need-Receive Gap	-5%	-2%	5%
	Af Am	Hisp	Anglo
Knowledge Gap	38%	40%	26%
Unmet perceived need	6%	-4%	-2%
Need-Receive Gap	6%	-6%	-6%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- The general 69% of the PLWH/A report having knowledge of nutrition education and counseling services. There is little difference between gender and risk groups, with the



exception that Anglos who report having a higher level of knowledge (74%) than other subpopulations. Among special populations, the lowest knowledge of the service is among PLWH/A out-of-care (20%). knowledge of this service.

- Perceived need for nutrition education and counseling is higher among females (44%) than males (32%). Among ethnic populations, it is higher among African Americans (39%) and Hispanics (37%) than Anglos (29%).
- Most PLWH/A who report a need for this service receive it, with females and African Americans reporting an unmet perceived need gap in the range of 5% to 6%.
- About a third of all PLWH/A ask for nutrition education and counseling. Females (47%) ask for it significantly more than males (33%). Among ethnic populations Hispanics and African Americans (both 39%), ask for it more than Anglos (33%).
- Among ethnic populations, Latinos report the highest usage (44%).
- Females and African Americans say they need and ask for more nutritional education and counseling than they receive.



Hotline or Telephone Info

Definition

A 1-800 number that serves the Dallas service area with information and referrals for anyone infected with or impacted by HIV/AIDS.

Service Unit, Eligibility, and Funding

Unit:

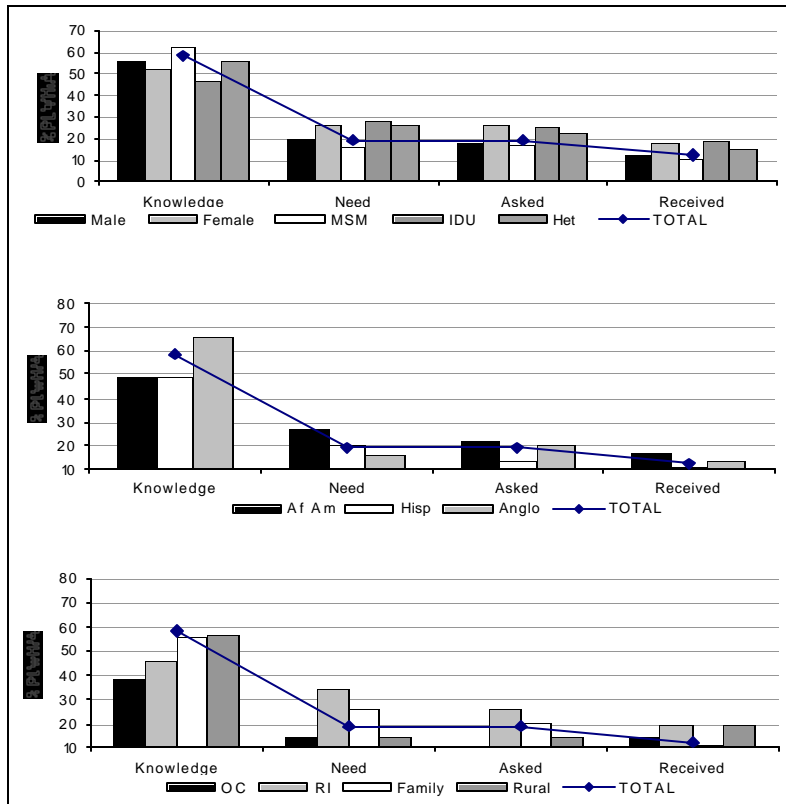
Eligibility:

Average unit:

EST. PLWHA
TOTAL
Know HIV
In Service

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported
Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title I
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	59%	56%	53%
% Needing	19%	20%	27%
% Asking	19%	18%	26%
% Receiving	13%	13%	18%

	Af Am	Hisp	Anglo
% Knowing	49%	49%	65%
% Needing	27%	21%	16%
% Asking	22%	14%	20%
% Receiving	17%	11%	14%

GAPS	Total	Male	Female
Knowledge Gap	41%	44%	47%
Unmet perceived need	6%	5%	8%
Need-Receive Gap	6%	7%	9%

	Af Am	Hisp	Anglo
Knowledge Gap	51%	51%	35%
Unmet perceived need	5%	3%	6%
Need-Receive Gap	10%	10%	2%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- About 60% of the PLWH/A know about hotline or telephone information. Anglos report the highest knowledge (65%), with African and Hispanics saying they know the least (49%). Among special populations, PLWH/A out-of-care report the lowest knowledge of hotline and telephone information (40%).
- Need for this service is fairly low, with an average of 19% of PLWH/A reporting a need. Women (27%) are more likely to need this service than men (20%). African Americans



(27%) report needing hotline or telephone information the most, and about 27% of the IDUs say they need this service.

- Reflecting their needs, females and IDUs and recently incarcerated are more likely to ask for this service more than other groups.
- There is a small, but consistent, unmet perceived need gap, indicating that more PLWH/A are asking for hotline and telephone services than receiving it.
- The largest need-receive gap for this service is among African Americans and Hispanics (10% each).



Resource Directory

Definition

A resource directory for the Dallas service area which includes all Ryan White funded agencies in the Dallas service area as well as additional non-funded agencies that provide services to PWA. It is designed to be distributed and used by clients. Most ASOs give the resource directory to clients at their initial intake for services. It is also used by caseworkers, social workers, counselors, etc., across a broad spectrum of community based and medical organizations to assist in getting clients into services.

Service Unit, Eligibility, and Funding

Unit:

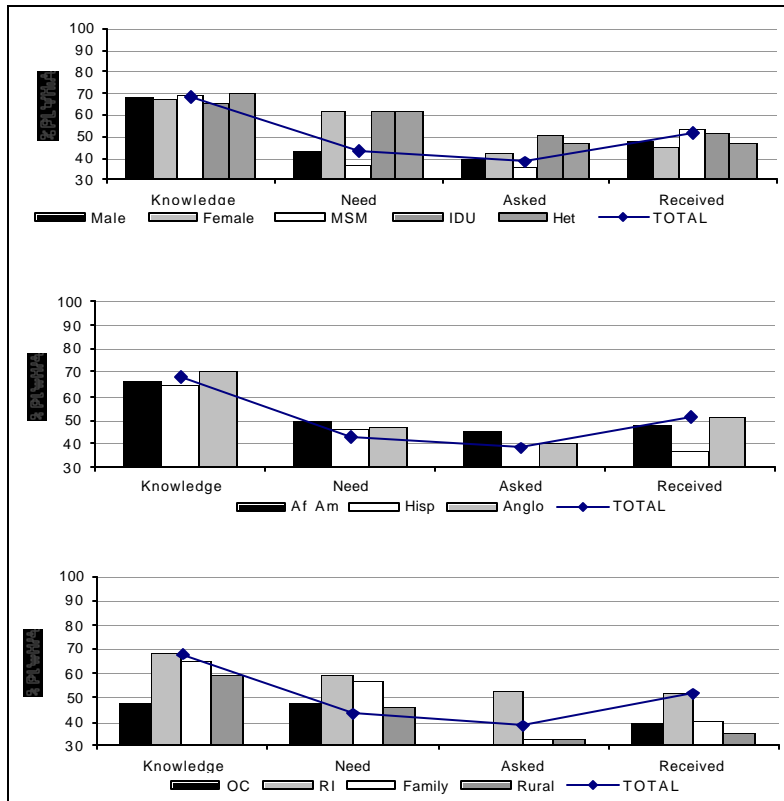
Eligibility:

Average unit:

EST. PLWHA
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported
Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	68%	69%	67%
% Needing	43%	43%	61%
% Asking	39%	40%	43%
% Receiving	51%	48%	45%

	Af Am	Hisp	Anglo
% Knowing	67%	65%	70%
% Needing	50%	46%	47%
% Asking	46%	29%	40%
% Receiving	49%	37%	52%

GAPS	Total	Male	Female
Knowledge Gap	32%	31%	33%
Unmet perceived need	-12%	-8%	-2%
Need-Receive Gap	-8%	-5%	16%

	Af Am	Hisp	Anglo
Knowledge Gap	33%	35%	30%
Unmet perceived need	-3%	-8%	-12%
Need-Receive Gap	1%	9%	-5%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- In general, 68% of the PLWH/A report knowledge of the resource directory. There are few differences in knowledge by gender, ethnicity, or risk group. Among special populations, only PLWH/A out-of-care have a relatively low knowledge level (47%).



- Among ethnic populations, Hispanics significantly less likely to ask for a resource guide than Anglos (40%) or African Americans (46%).
- On average about 43% report needing the resource directory. Females (61%) have a high need, and 16% say they need it but don't receive it. Nine percent (9%) of the Hispanic PLWH/A also say they need it but do not receive a resource directory.
- There is no unmet perceived need – nobody asking for a resource directory said they did not receive one.



Information Clearinghouse, Library

Definition

Maintains the complete database of referral information and serves as the clearinghouse for the Dallas EMA by maintaining and distributing any changes or updates to ASO contact information. The library also maintains educational literature, brochures, videos, and Internet access for clients to find more information about living with HIV/AIDS.

Service Unit, Eligibility, and Funding

Unit:

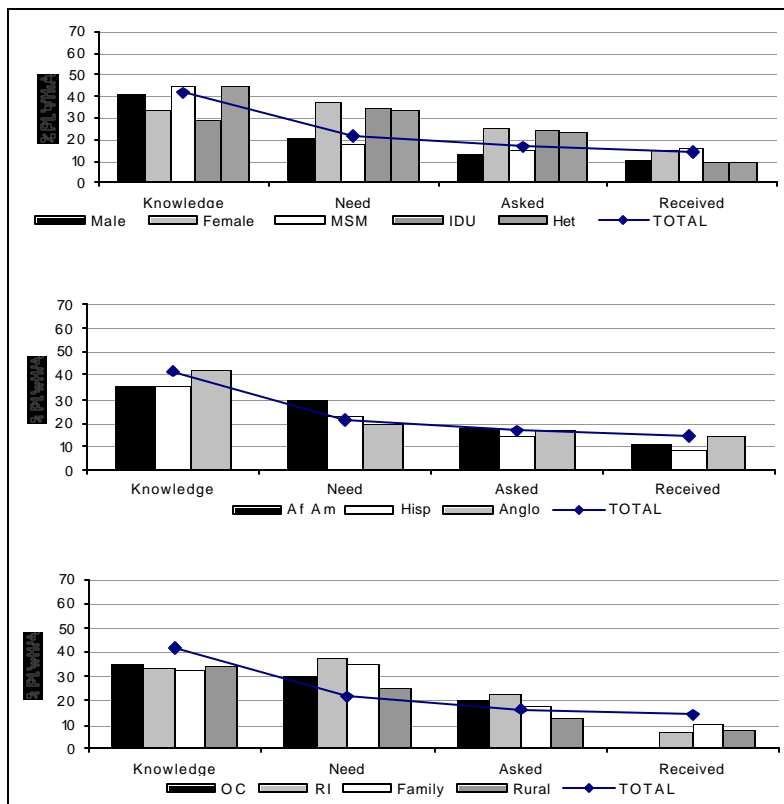
Eligibility:

Average unit:

EST. PLWH/A
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported
Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	42%	41%	33%
% Needing	21%	21%	38%
% Asking	17%	13%	25%
% Receiving	15%	11%	15%
Af Am Hisp Anglo			
% Knowing	36%	36%	43%
% Needing	30%	23%	20%
% Asking	18%	14%	17%
% Receiving	11%	8%	15%

GAPS	Total	Male	Female
Knowledge Gap	58%	59%	67%
Unmet perceived need	2%	2%	10%
Need-Receive Gap	6%	10%	23%
Af Am Hisp Anglo			
Knowledge Gap	64%	64%	57%
Unmet perceived need	7%	6%	2%
Need-Receive Gap	19%	15%	5%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- In general, 42% of PLWH/A report knowing about an information clearinghouse library service. Females (33%) say they know about it less than males (41%), but females (25%) ask for it more frequently than males (13%). The largest knowledge gap among females (67%), African Americans (64%) and Hispanics (64%).



- Given it is an information center, perceived need is moderate. On average 30% of PLWH/A say they need an information clearinghouse and library. Females (38%) report needing it more than males (21%), African Americans (30%) say they need it the more than other ethnic populations, and MSM (19%) much less than other risk groups.
- The unmet perceived need indicates that there is a gap between those asking and receiving information, but it is much higher among females and African Americans. The gap between perceived need and services received information is particularly high among African Americans (18%). The need-receive gap is largest for females (23%) and African Americans (19%).

Focus Group Comments Information and Referral

Many focus groups participants mentioned seeking information. For example a Latina IDU said, *“I need to be more informed of the services that are available to me. And I need to look more into it, to get more information for myself.”*

One African American MSM brought up how the resource directory allows him to be his own advocate. He said, *“I’ve been here for four months and I have learned it very, very well. Anything in that book that I want I am going to go and get, and I’ve only been here for four months.”*

Although the overall level of knowledge about care was high, some participants highlighted the fact that there continues to be a need for information services. One African American woman said, *“What are all of the symptoms of HIV, because I don’t even know. I mean I have had HIV for ten years, and I don’t even know what the symptoms are.”* An African American MSM said, *“I feel that the agencies need to spend more time teaching about risky behaviors on the street.”*

A theme among focus group participants is that providers do not provided easy access to information. For many, interpersonal channels of information remain the best resource. An Anglo MSM out of care said the following, *“If my partner hadn’t gone through this, the answer would be yes I would not know what to do. The reason I do know is not because of publicity or awareness in the community, it’s only because I have gone through it with my partner’s condition. I wouldn’t know where to start if it hadn’t been going through with it with my partner. And I don’t know if my partner would have known where to start if he didn’t have his brother who knew about all these things. Like now, I am very aware of these things but as a general rule if this hadn’t happened to someone close to me I wouldn’t have known where to turn.”*

The need for correct medication information was suggested by some participants who clearly had the wrong information about the need to maintain their drug regimen. One African American heterosexual female said, *“I’m not on any protease inhibitors now because I haven’t felt bad. But, like I said, I don’t have no symptoms. The only thing is like my head hurts, the headaches.”*



Participants confirmed that nutritional information is part of their overall care. *A rural African American IDU male said, “You get nutritional information every time you are in the hospital for my care. They would talk to me on how to eat & take care of myself.”*

A rural African American heterosexual male said, “At Tarrant County, the woman makes sure that your diet is right and stuff like that. If you've got questions, like I asked my doctor the other day about herbal supplements. She gave me a list of what to take and what not to take and information about the side effects and stuff like that.”

A Latino MSM said, “There needs to be more outreach at the agencies when people are there going and getting services. Kind of like a meals on wheels, you would catch people when they are actively receiving care. Also needed is nutrition education. Some food may be high in calories, low in sodium, high in fat - we don't really know what we need for our diet.”

A number of participants noted the resource directory. However, some also referred to the challenge of keeping it up to date. An Anglo MSM said, *“A resource guide I always get is frequently wrong in listing of services, phone numbers and physical locations.”* Others said they needed one. For example, a rural Latina IDU said, *“I haven't seen one [resource directory] in awhile. I don't know if I'm supposed to ask for it or will they provide it.”*



Access for Targeted Populations

Access for Targeted Populations (Treatment Outreach)

Programs which have as their principal purpose identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services, not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached, and be designed with quantified program reporting which will accommodate local effectiveness evaluation.

Service Unit, Eligibility, and Funding

Unit:

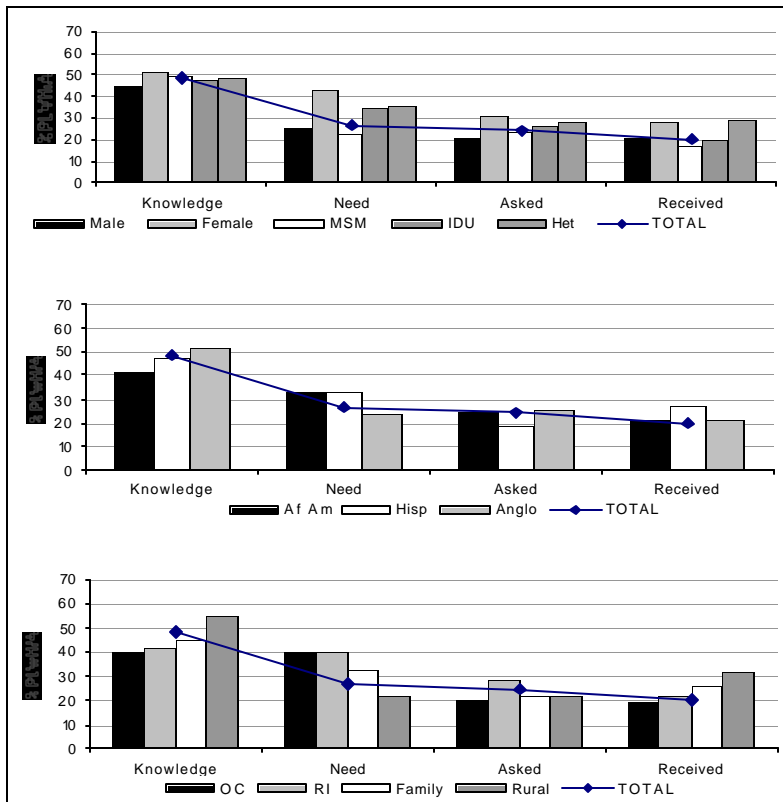
Eligibility: PLWH/A must reside in Dallas EMA/HSDA.

Average unit:

EST. PLWH/A
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	49%	45%	52%
% Needing	27%	25%	43%
% Asking	24%	21%	31%
% Receiving	20%	21%	29%
	Af Am	Hisp	Anglo
% Knowing	42%	47%	52%
% Needing	33%	33%	24%
% Asking	24%	19%	25%
% Receiving	21%	27%	21%

GAPS	Total	Male	Female
Knowledge Gap	51%	55%	48%
Unmet perceived need	4%	0%	2%
Need-Receive Gap	7%	4%	14%
	Af Am	Hisp	Anglo
Knowledge Gap	58%	53%	48%
Unmet perceived need	3%	-8%	4%
Need-Receive Gap	12%	6%	3%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap



- About half of PLWH/A report some knowledge of treatment outreach services. There are small differences among gender and ethnic populations. Among the special populations, rural PLWH/A (55%) have the highest awareness and out-of-care (40%).the lowest awareness.
- Over a quarter of the PLWH/A say they need treatment outreach. Need is much higher among females (43%) than males (25%). Among ethnic populations, Anglos (24%) report the lowest need.
- Approximately one-quarter of all PLWH/A have asked for treatment outreach services. Females (31%) tend to ask for treatment outreach a little more, and, among ethnic populations, Hispanics (19%) ask a little less.
- Reflecting their greater demand, females and Hispanics also receive treatment outreach more than other subpopulations.
- Unmet perceived need is fairly low (4%). Most PLWH/A asking for treatment outreach have received services, with Hispanics as the only group receiving more services than asked for (-8%).
- Females and African Americans have the largest need-receive gap, ranging from 12% to 14%.



Translation or Interpretation Services

Definition

Interpretation, sign language, or translation services provided to clients and care givers who do not use spoken or written English.

Service Unit, Eligibility, and Funding

Unit: One (1) hour of interpretation/ sign language/translation services to a client who, through the efforts of an interpretation /sign language/ translation service worker, is engaged in HIV/AIDS-related services, or One (1) hour of translating written documents for other Dallas County pass-through grant-funded agencies in the Dallas service delivery area.

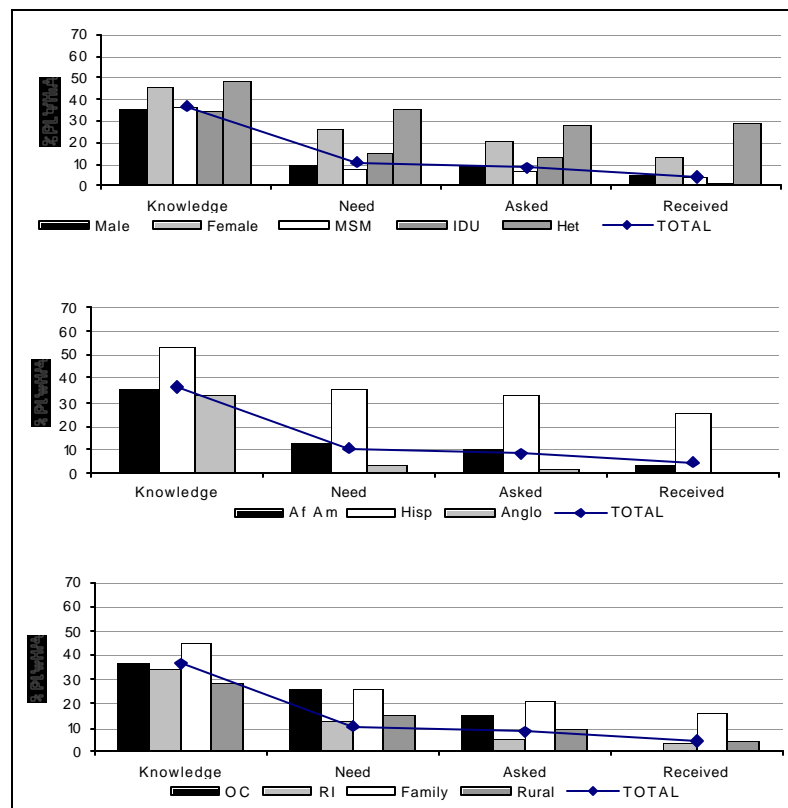
Eligibility: PLWH/A living in Dallas EMA/HSDA with a 300% poverty level.

Average unit:

EST. PLWH/A
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	36%	36%	46%
% Needing	11%	10%	27%
% Asking	9%	9%	21%
% Receiving	5%	5%	14%
	Af Am	Hisp	Anglo
% Knowing	36%	54%	33%
% Needing	13%	36%	4%
% Asking	11%	32%	2%
% Receiving	4%	26%	0%

GAPS	Total	Male	Female
Knowledge Gap	64%	64%	54%
Unmet perceived need	4%	4%	7%
Need-Receive Gap	6%	5%	13%
	Af Am	Hisp	Anglo
Knowledge Gap	64%	46%	67%
Unmet perceived need	7%	6%	2%
Need-Receive Gap	9%	10%	4%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- Among Hispanics, the population most likely to need translation services, about half (47%) know about translation services.
- About a third of the Hispanics need translation services. It would be expected that need among other ethnic populations would be lower, but it is not. This finding may be due to the



feeling that other populations feel that information in English also has to be “interpreted” for PLWH/A to understand it.

- Among Hispanics, everyone who asks for services say they receive it, but more Hispanics say they need it than receive it.

Focus Group Comments – Access for Targeted Populations

The need for treatment outreach was referred to by some participants. For example, a female IDU said, *“Attention needs to be given to Hispanics because a lot of the women are scared to come out.”*

Regarding translation, Hispanics had different experiences with interpretation services. A recently diagnosed Latino MSM said, *“I don't see any problems. Every agency I have been to has someone that does speak Spanish.”* While another Latino MSM responded by saying, *“I know that applies to the small medical clinics - you can get Spanish translation here. But in the main building of the hospital, no you wait hours and hours for a translator to come. But here, we have a few Hispanics working here.”*



Legal Services

Definition

Civil legal assistance provided to PLWH/A through attorney consultation, legal advocacy, or paraprofessional advocacy.

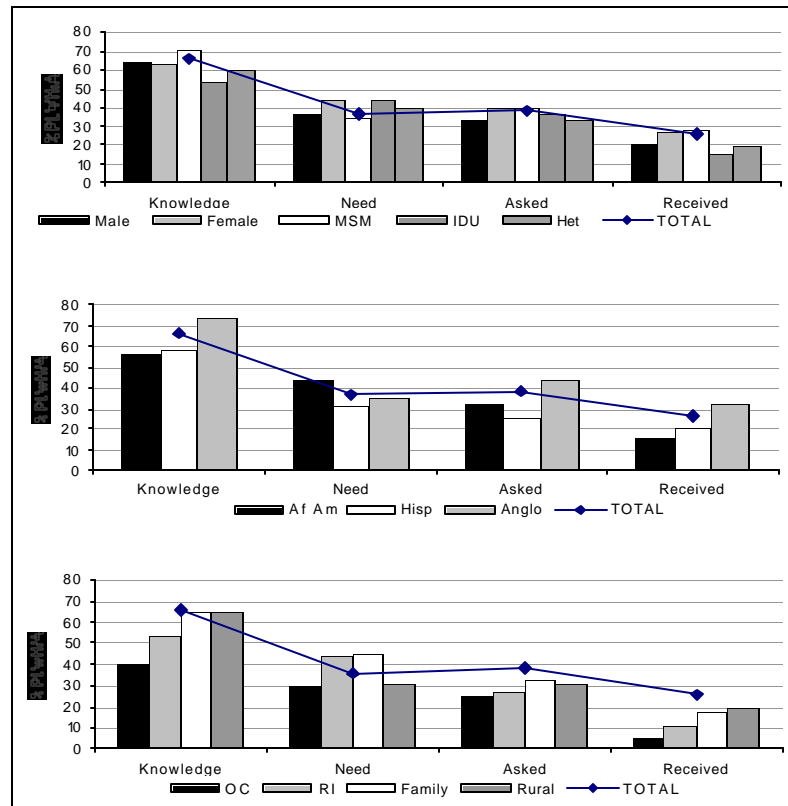
Service Unit, Eligibility, and Funding

Unit: One (1) documented, fifteen (15) minute period of consultation or legal advocacy by an attorney. One (1) documented, fifteen (15) minute period of advocacy by a paraprofessional.
 Eligibility: 91% eligible based on 360% of poverty and residence of Dallas EMA/HSDA.
 Average unit: 9.1 15 minute visits

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	581
Est # Elig	6,303

SERVICE UNITS 2000	
Number of Units Funded	6,570
Theoretical Need	56,005
Number Reported Received	5,275

FUNDING 2000-2001	
RW Care Title I & CBC	\$111,600
RW Care Title II	
Other	\$39,959
Total Allocated	\$151,559



REPORTED in 2001			
	Total	Male	Female
% Knowing	66%	64%	63%
% Needing	36%	36%	44%
% Asking	38%	34%	39%
% Receiving	26%	21%	26%
Ethnic Groups			
	Af Am	Hisp	Anglo
% Knowing	56%	58%	74%
% Needing	43%	31%	35%
% Asking	32%	25%	43%
% Receiving	16%	20%	32%

GAPS			
	Total	Male	Female
Knowledge Gap	34%	36%	37%
Unmet perceived need	12%	13%	13%
Need-Receive Gap	10%	15%	18%
Ethnic Groups			
	Af Am	Hisp	Anglo
Knowledge Gap	44%	42%	26%
Unmet perceived need	16%	5%	11%
Need-Receive Gap	27%	11%	3%

SUMMARY GAP INDICATORS	
Units received/ Units funded	80%
Reported / Theoretical Need	9%
Eligibility Gap	-53%

- In general, 66% PLWH/A report knowing that legal services are available to them. Males and females had the same level of knowledge about legal services. Among ethnic groups, knowledge of legal services is highest among Anglos (74%). Among risk groups it was highest among MSM (71%). Among the special populations it was lowest among PLWH/A out-of-care (40%), but not as low as for other services.



- Among gender, ethnic, and risk group populations, females (44%), IDUs (43%), and African Americans (43%) reported the highest need for legal services. Among the special populations, families (43%) and recently incarcerated (42%) said they had the greatest need.
- In general, between 30% and 45% of PLWH/A ask for this service. The unmet perceived need gap is fairly high, particularly among special populations with recently incarcerated and families reporting the largest gaps.
- Anglos report the highest usage of legal services (32%). MSM (29%) use legal services more than other subpopulations. All subpopulations report asking for more legal services than they receive.
- Except for Anglos, the need-receive gap is greater than the unmet perceived need, indicating that more persons say they need the service than ask for it, and many that ask for it don't get it. African Americans have the largest need-receive gap of 27%.
- In general, there is a problem getting this service to all PLWH/A who either report needing it or who have asked for it.
- The summary gap indicator shows that 80% of funded services were received, 9% of the theoretical need was met, and 53% of all PLWH/A that are eligible for legal services did not ask for those services.

Focus Group Comments – Legal Services

Legal services were not brought up frequently by the focus group participants. In most instances it was mentioned in relation to illegal immigrant status.

A few participants mentioned discrimination. For example, a Spanish speaking heterosexual Latina discussed her legal concerns. *“I was a baby sitter for a lady who had a newborn that I was taking care of all the time. The woman found out about my HIV and asked that I no longer take care of the baby. She had me sign a release because she is concerned that the baby might have been infected. I am wondering if anything should happen like if I should file any kind of legal charges against her. I feel like legally I did not have to disclose my status to her. So I am wanting to know if legally there is anywhere if I needed to have any legal recourse.”*



Adult Day Care and Respite Care

Definition

Program may include health or support services from a licensed health care professional. Day/respite care may be continuing (licensed or registered provider), or informal on a limited basis. Activities should provide an opportunity for caregivers to participate in meaningful and gainful life activities, which are designed to reduce isolation and loneliness and enhance their quality of life.

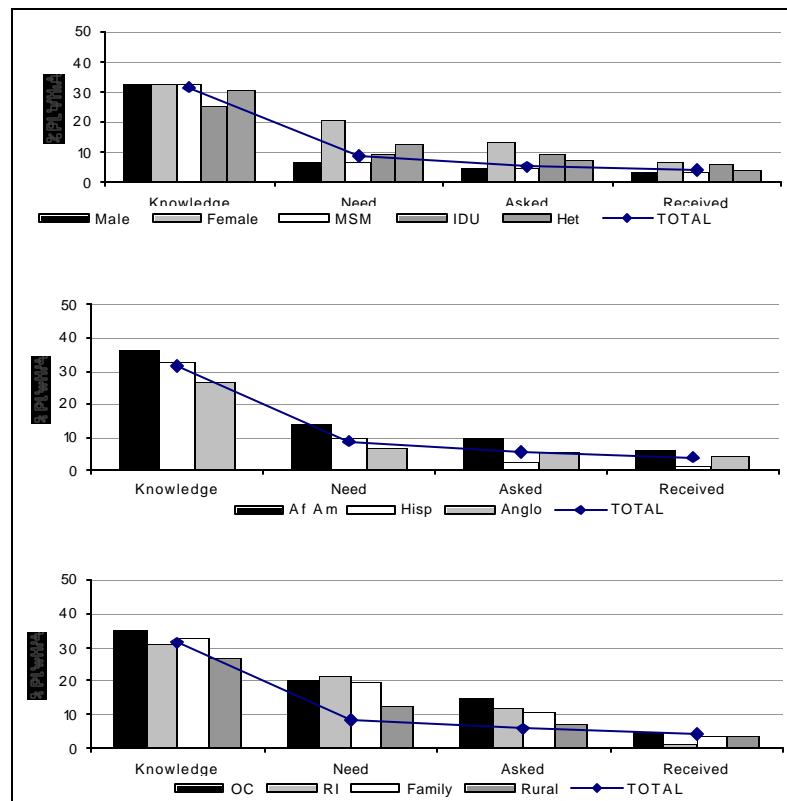
Service Unit, Eligibility, and Funding

Unit: One (1) hour of day/respite care to an HIV+ adult.
 Eligibility: 90% eligibility based on: Adult over 13 years, 300% of poverty and residence of Dallas EMA/HSDA.
 Average unit: 18 one hour visits

EST. PLWHA	
TOTAL	10,500
Know HIV	6,930
In Service	216
Est # Elig	6,237

SERVICE UNITS 2000	
Number of Units Funded	31,244
Theoretical Need	112,064
Number Reported Received	3,881

FUNDING 2000-2001	
RW Care Title I & CBC	\$233,030
RW Care Title II	
Other	\$10,985
Total Allocated	\$244,015



REPORTED in 2001			
	Total	Male	Female
% Knowing	31%	32%	33%
% Needing	9%	7%	21%
% Asking	6%	5%	14%
% Receiving	4%	4%	7%
Af Am Hisp Anglo			
% Knowing	36%	32%	27%
% Needing	14%	10%	6%
% Asking	10%	3%	6%
% Receiving	6%	1%	5%

GAPS			
	Total	Male	Female
Knowledge Gap	69%	68%	67%
Unmet perceived need	2%	1%	7%
Need-Receive Gap	5%	3%	14%
GAPS (continued)			
Knowledge Gap	64%	68%	73%
Unmet perceived need	4%	2%	1%
Need-Receive Gap	8%	9%	1%

SUMMARY GAP INDICATORS	
Units received / Units funded	12%
Reported / Theoretical Need	3%
Eligibility Gap	-84%

- Adult day care is for those adults living with HIV and AIDS who are not able to care for themselves and need supervision. For the vast majority of those in care, this is not relevant. It is not surprising that knowledge of adult day care and respite care is low, ranging from 25% to 40%, and the need is under 10%.



- Females (14%) are more likely to ask for adult day care and respite care than other populations. This observation is likely to reflect their need for relief from child care – and it may be a misinterpretation of this category. PLWH/A out-of-care also are more likely to ask for this service, suggesting the need for these persons to have a stable environment that provides care.
- It appears that either the measurement of units funded is in error, or that most of the units funded have not been delivered. This finding requires further investigation.

Focus Group Comments – Adult Day Care / Respite Care

A reason that women seek respite care was confirmed in a few comments in focus groups. An Anglo heterosexual female said, *“I have three kids but they took them a long time ago. They are with me again. There are times where I have, it is like I have to take care of myself, see what I am saying? And then it is like I go to work, I work at night. There is a daycare I occasionally use, but besides that, there it is just same routine, work, take care of the kids, so I don't have any time for like myself to just relax or whatever.”*



Services for Children and Adolescents

Adoption and/or Foster Care

Definition

Service Unit, Eligibility, and Funding

Unit:

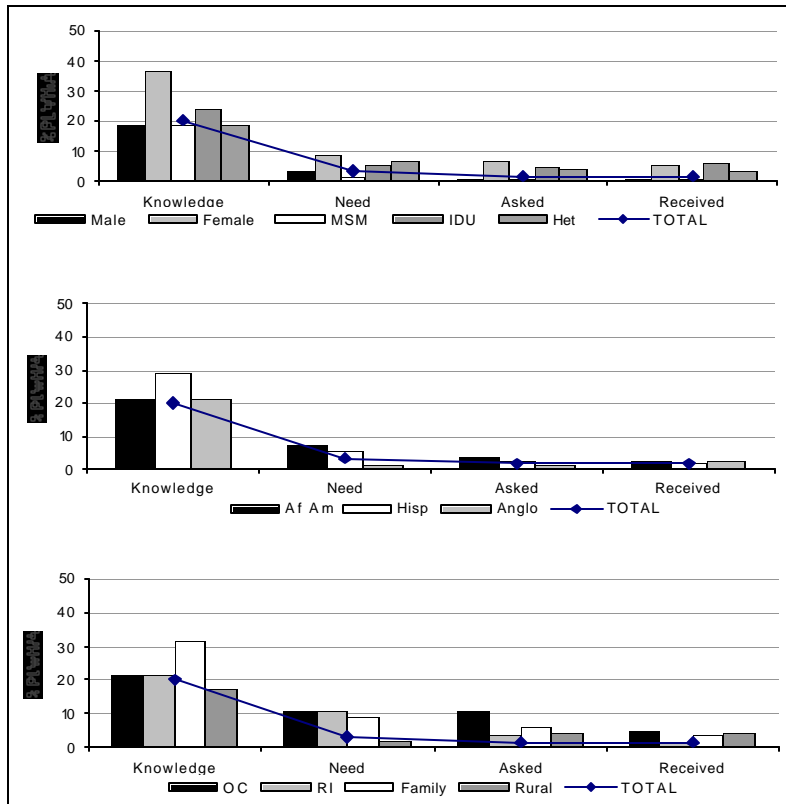
Eligibility:

Average unit:

EST. PLWH/A
TOTAL
Know HIV
In Service
Est # Elig

SERVICE UNITS 2000
Number of Units Funded
Theoretical Need
Number Reported Received

FUNDING 2000-2001
RW Care Title I & CBC
RW Care Title II
Other
Total Allocated



REPORTED in 2001	Total	Male	Female
% Knowing	20%	19%	36%
% Needing	3%	3%	9%
% Asking	2%	1%	7%
% Receiving	2%	1%	6%
	Af Am	Hisp	Anglo
% Knowing	21%	29%	21%
% Needing	8%	6%	1%
% Asking	4%	3%	1%
% Receiving	3%	1%	2%

GAPS	Total	Male	Female
Knowledge Gap	80%	91%	64%
Unmet perceived need	0%	0%	1%
Need-Receive Gap	1%	2%	3%
	Af Am	Hisp	Anglo
Knowledge Gap	79%	71%	79%
Unmet perceived need	1%	2%	-1%
Need-Receive Gap	5%	5%	-1%

SUMMARY GAP INDICATORS
Units received/ Units funded
Reported / Theoretical Need
Eligibility Gap

- This service is relevant for very few PLWH/A and it is not surprising that knowledge is extremely low for adoption and/or foster care services. Only 19% of all PLWH/A have children and the need to be aware of these services is a small subset of those. In general, knowledge ranges between 20% and 40%, and is highest among females (36%).
- Need for this service is below 10% for most groups, and is highest among females at 9%.
- The unmet perceived need gap and the need-receive gap is also very low, suggesting most PLWH/A who need or ask for this service are receiving it.



Child Care

Definition

Home or center-based medically managed child/adolescent day or respite care to HIV+ children/adolescents or children/adolescents of HIV+ guardians. Programs should include health or support services from a licensed health care professional. Pre-school/ developmental activities should be a part of the child care program. Adolescent care programs should include opportunities for adolescents to participate in meaningful and gainful life activities, which are designed to reduce isolation and loneliness and enhance their quality of life. Child/adolescent care may be continuing (licensed or registered provider), or informal on a limited basis.

Service Unit, Eligibility, and Funding

Unit: One (1) hour of medically managed day or respite care to an HIV+ child, or One (1) hour of day or respite care to an affected child, or One (1) hour of medically managed day or respite care to an HIV+ adolescent, or One (1) hour of day or respite care to an affected adolescent.

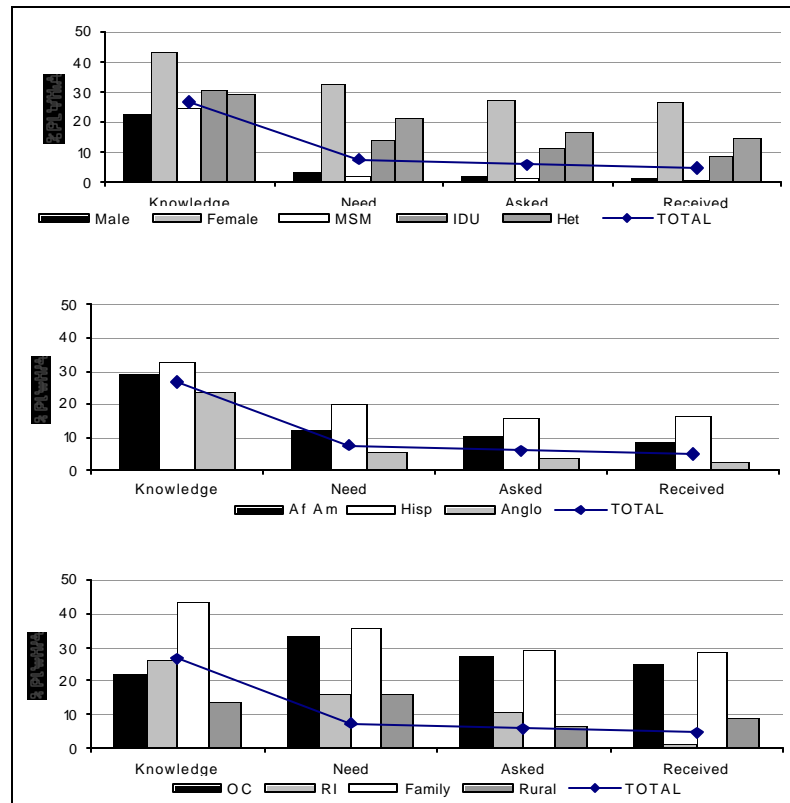
Eligibility: 16% eligibility based on: Percent of PLWH/A living with children (18%), 300% of poverty and residence of Dallas EMA.

Average unit: 28.8 units

EST. PLWHA	
TOTAL	10,500
Know HIV	6,930
In Service	120
Est # Elig	1,138

SERVICE UNITS 2000	
Number of Units Funded	42,374
Theoretical Need	32,783
Number Reported Received	3,456

FUNDING 2000-2001	
RW Care Title I & CBC	\$210,000
RW Care Title II	\$12,647
Other	\$80,325
Total Allocated	\$302,972



REPORTED in 2001			
	Total	Male	Female
% Knowing	27%	23%	43%
% Needing	8%	4%	33%
% Asking	6%	3%	27%
% Receiving	5%	2%	27%
Af Am Hisp Anglo			
% Knowing	29%	32%	23%
% Needing	12%	20%	5%
% Asking	10%	16%	4%
% Receiving	9%	16%	3%

GAPS			
	Total	Male	Female
Knowledge Gap	73%	77%	57%
Unmet perceived need	1%	1%	0%
Need-Receive Gap	3%	2%	6%
Af Am Hisp Anglo			
Knowledge Gap	71%	68%	77%
Unmet perceived need	1%	0%	1%
Need-Receive Gap	3%	4%	2%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	10%
Eligibility Gap	-10%



- Knowledge of child-care services is low, though only 19% of PLWH/A have children and would possibly need this service. Knowledge, not surprisingly, is highest among females (43%) and lowest among males (23%). IDUs also have high knowledge (43%) and this may be due to the large number of female IDUs in the system.
- As expected the need for child-care services is very high for females (33%). Because over half the heterosexuals are women, the need is also high among heterosexuals (21%). Slightly less than half of the IDUs are females, so the need is also relatively high among IDUs (14%).
- There is no unmet perceived need gap for females, suggesting all women who have reported a need for this service have received it.
- Females, heterosexuals, and IDUs have asked for child care services more than any other group.
- The need-receive gap is also very low, indicating that most PLWH/A who ask for child care services are getting the service.
- The proportion of units received to units funded is extremely low, indicating that funding for child care far surpasses the need for the service.
- The eligibility gap for this service indicates that 13% of those eligible have not asked for the service.

Focus Group Comments:

Focus group participants, even women, did not discuss child care very extensively. The one topic that did appear a few times was the lack of transportation to bring children to child care. From reviewing the focus group discussions, there is a sense that women did not know the full extent of the services offered..



Volunteer Services – Buddy/Companion

Definition

Activities provided by volunteers/peers to assist an HIV+ individual in performing personal or household tasks, and providing mental and social support.

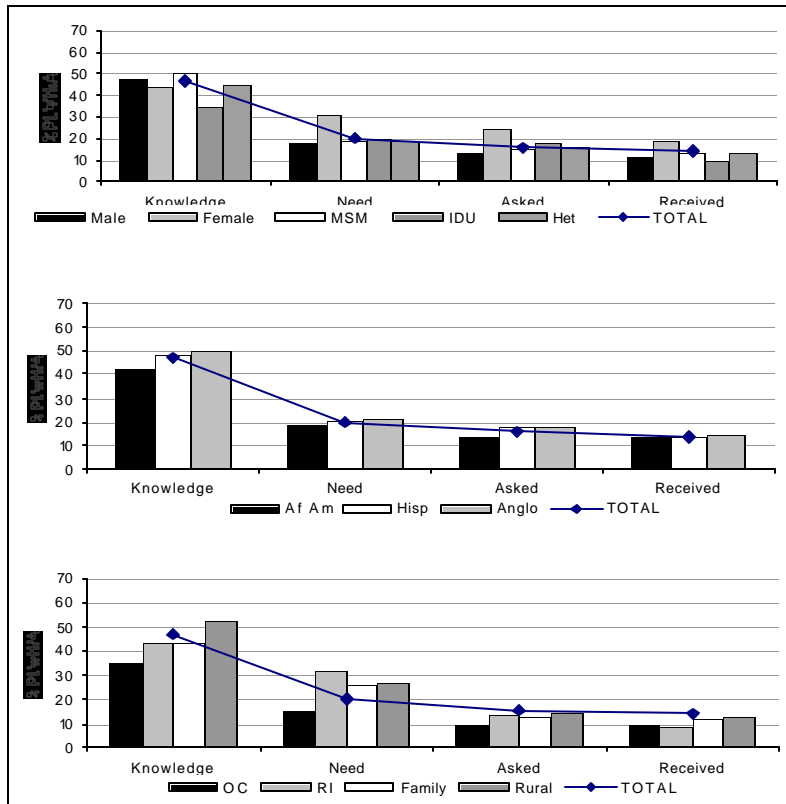
Service Unit, Eligibility, and Funding

Unit: One (1) hour of services to an HIV+ individual.
 Eligibility: 91% eligibility based on: 300% of poverty and residence of Dallas EMA/HSDA.
 Average unit: 22.1 one hour visits

EST. PLWH/A	
TOTAL	10,500
Know HIV	6,930
In Service	270
Est # Elig	6,306

SERVICE UNITS 2000	
Number of Units Funded	71,306
Theoretical Need	139,678
Number Reported Received	5,980

FUNDING 2000-2001	
RW Care Title I & CBC	\$274,956
RW Care Title II	\$21,000
Other	\$44,888
Total Allocated	\$340,844



REPORTED in 2001			
	Total	Male	Female
% Knowing	47%	48%	44%
% Needing	20%	17%	31%
% Asking	16%	14%	25%
% Receiving	14%	12%	19%
Af Am Hisp Anglo			
% Knowing	42%	49%	50%
% Needing	19%	21%	22%
% Asking	14%	18%	18%
% Receiving	14%	13%	15%

GAPS			
	Total	Male	Female
Knowledge Gap	53%	52%	56%
Unmet perceived need	2%	2%	6%
Need-Receive Gap	6%	5%	12%
Af Am Hisp Anglo			
Knowledge Gap	58%	51%	50%
Unmet perceived need	0%	5%	3%
Need-Receive Gap	5%	8%	7%

SUMMARY GAP INDICATORS	
Units received/ Units funded	8%
Reported / Theoretical Need	4%
Eligibility Gap	-75%

- Knowledge of buddy/companion services is at or under 50% for all subpopulations. There is little difference by gender. Among risk groups IDUs (35%) have significantly less awareness. Among ethnic populations, African Americans (42%) are less likely to know about this service. Among the special populations, over 50% of the rural population knows about buddy/companion services.
- Need for buddy/companion services are highest among females and recently incarcerated (31%), rural (28%) and families (27%). Need is lowest among males (17%).



- Females have asked for this service most (25%), followed by IDUs (19%) and heterosexuals (17%).
- Almost all PLWH/A who ask for the service receive it.
- The need-receive gap is highest for females at 12%. Almost all groups have reported some gap between their reported need for this service and receiving it.
- Funding for this service appears much higher than the amount of service being provided. Only 8% of funded units were actually provided last year. This observation may be due to measurement error and needs further investigation.

Focus Group Comments – Buddy / Companion Services

This service was not a main topic of the focus groups, and was not introduced very often by participants. The few comments that were made were very complementary.

For example, a heterosexual Latina said, *“The buddy program I am in is pretty good.”*

A rural African American heterosexual male said, *“It’s very helpful to have them to talk to once a week. It’s important since I have been diagnosed disabled since 1999.”*

There were a few comments regarding the need for volunteers to provide transportation.



Emergency Medical Services

Definition

Medical care for acute conditions requiring immediate care usually provided in a hospital emergency room.

Service Unit, Eligibility, and Funding

Unit:

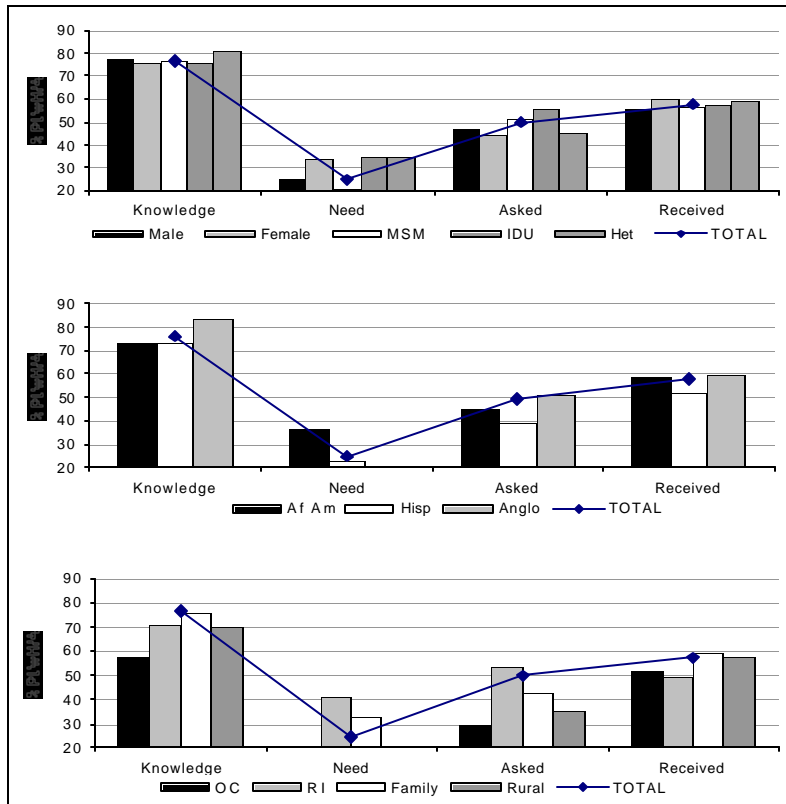
Eligibility:

Average unit:

EST. PLWHA	
TOTAL	
Know HIV	
In Service	

SERVICE UNITS 2000	
Number of Units Funded	
Theoretical Need	
Number Reported Received	

FUNDING 2000-2001	
RW Care Title I & CBC	
RW Care Title I	
Other	
Total Allocated	



REPORTED in 2001			
	Total	Male	Female
% Knowing	77%	77%	76%
% Needing	25%	25%	34%
% Asking	50%	47%	45%
% Receiving	58%	56%	60%
Af Am Hisp Anglo			
% Knowing	73%	73%	83%
% Needing	36%	23%	18%
% Asking	46%	39%	51%
% Receiving	59%	51%	60%

GAPS			
	Total	Male	Female
Knowledge Gap	23%	23%	24%
Unmet perceived need	-8%	-9%	-15%
Need-Receive Gap	-33%	-31%	-26%
Af Am Hisp Anglo			
Knowledge Gap	27%	27%	26%
Unmet perceived need	-13%	-12%	-9%
Need-Receive Gap	-23%	-28%	-42%

SUMMARY GAP INDICATORS	
Units received/ Units funded	
Reported / Theoretical Need	
Eligibility Gap	

- Knowledge of emergency medical services is generally high (77% for all PLWH/A). African Americans and Hispanics have the largest knowledge gap at 27%.
- Reported need for services is much lower than the amount of service being provided.
- Demand for emergency medical services is generally higher than reported need. Females (45%), males (47%), Anglos (51%), and IDUs (55%) report the highest demand for this service.



Focus Group Comments – Emergency Medical Services

Emergency payments of medical services were not mentioned by focus group participants. There were a number of statements, however, that indicated lack of awareness and need.

For example, an Anglo heterosexual man said, “[My] medical bills want immediate payment. They are not willing to work with you. Particularly with professional healthcare through [professional home health care] and its pharmacy. The pharmacy didn’t bill me for 6 months and then a bill came in for \$10,000. We were able to settle at \$200 a month. I think they can build a better system, especially with me who doesn't have a bad payment record.”

Several participants also noted that the co-payments for medication meant that at times they would go without medication.



8. BARRIERS

The sample of PLWH/A and the focus group respondents reported that the system of HIV/AIDS care is pretty easy to access. On average, PLWH/A ranked barriers as "small" to "moderately" high. Still, several barriers were identified that could be lowered in order to improve the access and quality of services provided. In the survey, the highest barriers were "system" related, and PLWH/A were less likely to say that agency staff makes it difficult for them to access care.

Overall PLWH/A Score for Barriers

On the questionnaire, PLWH/A rated and discussed forty-two barriers. They rated the barriers on a four-point scale ranging from a "big barrier" to "no barrier at all."⁵ The forty-two barriers can be grouped into four general types of barriers: 1) individual, 2) organizational, 3) structural and 4) special needs.

The determination of the types of barriers was based on a statistical technique called factor analysis.⁶ This technique indicates which barriers were most likely to be sorted into the same group by the PLWH/A survey participants. It is as though the PLWH/A were given a deck of cards with each barrier printed on it and asked to sort them in stacks, with each stack reflecting a common underlying theme. The types of barriers include:

- Individual barriers. These refer to the individual's knowledge, physical and mental health.
- Organizational barriers. These are further divided into three types: 1) access, 2) sensitivity, and 3) expertise. Access barriers have to do with lack of transportation and access to specialists. Sensitivity barriers are related to sensitivity that providers have to their clients. Expertise barriers reflect the expertise of the provider and quality of care.
- Structural barriers are related to insurance, cost, red tape, rules and regulations, and problems navigating the system of care.
- Special needs barriers affect families with children and PLWH/A who have been victims of domestic violence.

Before discussing these different types of barriers, an overall barrier score is shown in Attachment 13 for gender, risk group, ethnicity, and special populations.

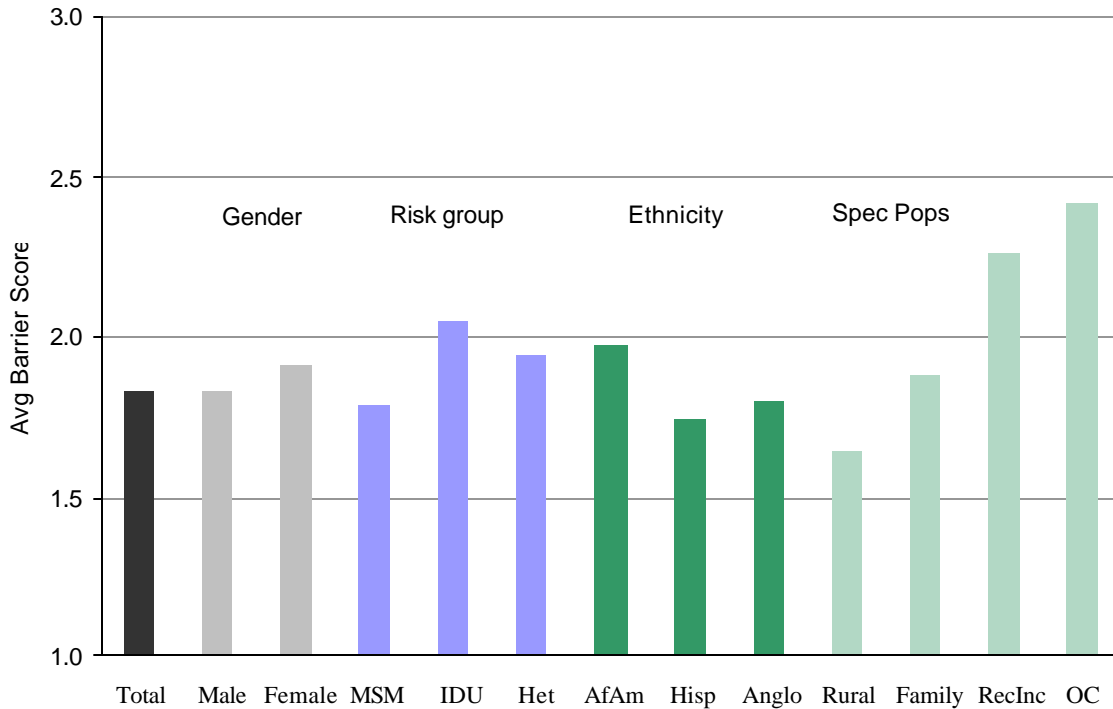
⁵ For exact wording see question 48 in the questionnaire, Attachment 4, and the Barrier section in the focus group outline, Attachment 2.

⁶ A pairwise Pearson's correlation matrix was used as input. A varimax option was selected to better discriminate the factors.



Figure 8-1 Average Barrier Scores by Risk Group

1=no barrier at all, 2=small barrier, 3=moderate barrier, 4=big barrier



Overall, when the ratings of all of the barriers are averaged, none of the risk groups or ethnic populations reported a big barrier. As shown in Figure 8-1, the highest overall barrier score is less than 2.5 - or a rating of between a "small barrier" (score of 2) and "moderate barrier" (score of 3.0).

As seen in Figure 8-1, females have slightly higher barriers than men; African Americans reported slightly higher barriers than other ethnicities. Not surprisingly, PLWH/A out-of-care reported the highest barriers among all the participants, with an average overall barrier of 2.4. On the other hand, rural PLWH/A reported the lowest barrier score (1.6).

Categorizing Individual Barriers Reported by PLWH/A

Table 8-1 groups each of the forty-two barriers into the more general categories of organizational, structural, individual or special needs barriers. In total, both the focus group respondents and survey respondents rated 12 individual level barriers, 15 organizational barriers, 11 structural barriers, and four special needs barriers. They are shown in Table 8-1.



Table 8-1 Types of Barriers

Structural	Individual
<p><i>Rules and Regulations</i></p> <ol style="list-style-type: none"> 1. No health insurance 2. Red tape 3. Cannot afford service 4. Wait too long for appointment 5. Public funds not available for service 6. Too many rules and regulations regarding payment 7. Health insurance does not cover the services 8. Ability to navigate system <p><i>Access</i></p> <ol style="list-style-type: none"> 9. No transportation 10. No access to HIV care treatment specialist <p>Organizational</p> <p><i>Provider Sensitivity</i></p> <ol style="list-style-type: none"> 11. Made to feel like a number 12. No referrals 13. Cold atmosphere 14. Not valued as a person 15. Questions not answered 16. Discrimination 17. Lack of sensitivity to beliefs and spiritual concerns 18. Afraid of being reported to authorities 19. Fear breach of confidentiality 20. Not getting along with providers <p><i>Provider Expertise</i></p> <ol style="list-style-type: none"> 21. Providers are not helpful 22. Those prescribing meds do not understand adherence issues 23. Providers do not understand what is needed 24. Medical provider did not know what he/she was doing 25. Provider did not speak consumer's language 	<p><i>Knowledge</i></p> <ol style="list-style-type: none"> 26. Not knowing organizations available to provide service 27. HIV/AIDS services needed not available 28. Not knowing location of organizations providing services 29. Not knowing available services 30. Not knowing where to go for help 31. Not knowing that services exist to treat HIV infection 32. Not knowing medical services needed for treating HIV infection 33. Not knowing organizations available to provide service <p><i>Well-Being</i></p> <ol style="list-style-type: none"> 34. HIV is really a problem 35. Worried that someone would find out HIV status (lack of confidentiality) 36. Too upset to think about services/ treatment 37. Physical health 38. Do not understand the treatment instructions <p>Special Needs</p> <ol style="list-style-type: none"> 39. Children are not welcomed at agencies 40. No housing is available that allows children 41. No safe housing for battered persons 42. Lack of on-site child care

Ranking of Specific Barriers

Attachment 13 shows the average score for barriers for the total populations, gender, risk group, ethnicity, and special populations.

How to Read the Barrier Attachment

Attachment 13 can be read down the column to determine the magnitude of the barrier for the total population and each subpopulation. They are ranked from highest to lowest barrier for the general population. As seen looking down the "Total" column, the top five barriers fall in the range of small to moderate barriers. The remainder falls in the range of "no barrier at all" to a "small barrier." The rank orders tend to be similar, but not the same, for all subpopulations. For example, females rank "red tape" as their top barrier.

Barrier scores can also be compared across columns to determine different perceptions of each barrier among the different subpopulations. Comparison can be made to the "Total" population or another subpopulation. For example, looking across the row for "public funds not available," the recently incarcerated PLWH/A rate this barrier higher than most other groups.



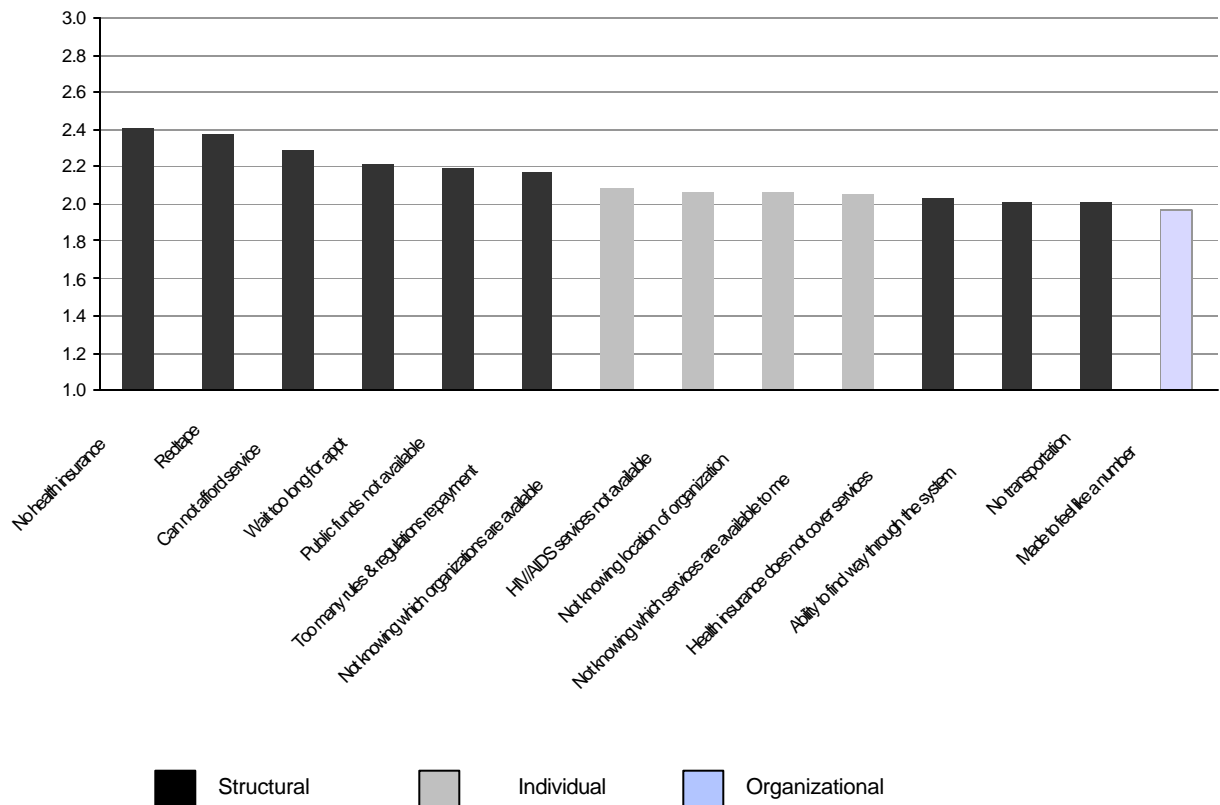
Total Population Ranking of Barriers

Before reviewing the barrier scores for the seven dimensions identified in Table 8-1, the next section presents the “overall” barrier score shown in the first column. The “total” score is the cumulative average for the 42 different barriers.

The rank order for the total population for each barrier is shown in Figure 8-2. As indicated in the overall barrier scores, no single barrier is ranked as a “big barrier.” For everyone, “having no insurance” is the highest barrier, considered between a “moderate barrier” and a “small barrier.”

Figure 8-2 Highest Barriers

4=big barrier 3=moderate barrier 2=small barrier 1=no barrier at all



As seen in Figure 8-2, out of the top fourteen barriers, with a barrier score of 2.0 or higher mentioned, nine are structural barriers, four are individual and one organizational.

The top barriers were:

- I do not have health insurance.
- There is too much paperwork and/or red tape.
- I cannot afford the service.
- I had to wait too long to get an appointment or see someone.
- Public funds were not available to offer the service.



- There are too many rules & regulations regarding payment for services.
- Not knowing which organization(s) are available to me to provide services that I need.
- The HIV/AIDS services I need are not available.
- Not knowing the location of organization(s) providing services.
- Not knowing which services are available to me.
- My health insurance does not cover service(s) I need.
- My ability to find way through the system.
- I do not have transportation to get from my home to the place where the service is provided.
- The organizations providing the services to me make me feel like a number.

How to Read the Barrier Ranking Tables and Figures

The following section presents the seven dimensions of barriers. The 42 barriers are discussed within its corresponding dimension. A table with the barrier rankings is shown which represents the ranking held by each barrier among the list of forty-two. The rankings range from one to four, where one represents the barriers rated among the top ten, a two represents barriers ratings which fell within the ten to 20 top barriers, a ranking of three included barriers rating from 20 to 30 and a ranking of four represents all barriers rated above 30. For instance, the specific barriers that fall within the structural dimension of barriers are shown in Table 8-2. The barrier item of “no health insurance: is shown to have a rank score of one, indicating that this barrier was among the top ten barriers rated by PLWH/A. The solid bold border surrounding the cell for the different populations indicates that this was in fact the number one barrier identified by that population.

The graphs following each of the tables present the total average barrier score for each gender, risk group, and special populations for each. Each graph also shows the average barrier score for the total population.

Following the graphs are bulleted points highlighting the differences by each of the subgroups. Focus group comments are also included on the second page of each of the dimensions to add the voice and perspective of the participating PLWH/A.



Structural - Rules and Regulations

Definition

Structural barriers are factors perceived to be external to an individual. They include barriers resulting from rules and regulations and lack of access to needed services. The following nine items are related to structural elements which present barriers for PLWH/A:

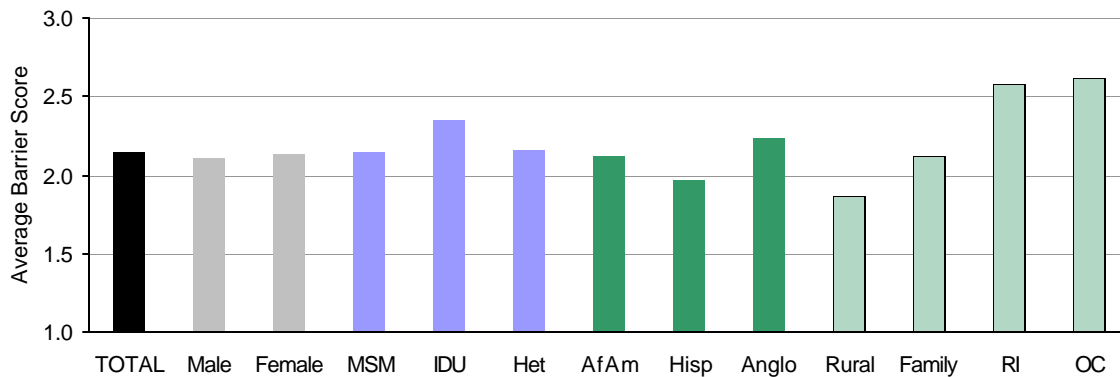
- I do not have health insurance.
- There is too much paperwork and/or red tape.
- I cannot afford the service.
- I had to wait too long to get an appointment or see someone.
- Public funds were not available to offer the service.
- There are too many rules and regulations regarding payment for services.
- My health insurance does not cover the service(s) I need.
- My ability to find my way through the system.
- My income is too high to get certain HIV/AIDS services.

Table 8-2 Barrier Ranking – Structural

Barrier	Total	Male	Female	MSM	IDU	Het	AA	Hisp	Ang	OC	RI	Fam	Rural
No health insurance	1*	1*	1	1*	1*	1	1*	1*	1*	1*	1*	1	1*
Red tape	1	1	1*	1	1	1	1	1	1	2	1	1	1
Cannot afford service	1	1	1	1	1	1	1	1	1	1	1	1	1
Wait too long for appointment	1	1	1	1	1	1	2	1	1	1	1	2	2
Public funds not available for service	1	1	1	1	1	1	1	1	1	1	1	1	1
Too many rules and regulations regarding payment	1	1	1	1	1	2	2	1	1	2	1	1	2
Health insurance does not cover the services	2	1	2	1	1	2	1	2	1	2	1	1	2
Ability to navigate system	2	2	1	2	2	1	2	2	1	2	2	2	1
Income too high	4	4	4	3	4	4	4	4	3	4	4	2	4



Figure 8-3 Structural Barriers



- Among the top ten barriers for all groups with an average barrier score of 2.3.
- The total sample's score indicated a small barrier.
- Men and women report about equal structural barriers.
- IDUs experience greater structural barriers than MSM or heterosexuals.
- Anglos report higher structural barriers than African Americans or Hispanics.
- Rural PLWH/A report the lowest rating for structural barriers.
- The recently incarcerated and out-of-care report the highest structural barriers.

Focus Group Comments:

The difficulties of qualifying for services due to the rules and regulations regarding eligibility were discussed by several focus group participants. An African American MSM discussed how having a high t-cell count resulted in decreased access to services. He explained, *“Because of my health status I have not had to access a lot of services and for some my T-cell count is too high. I’ve just need help with the basics like mortgage assistance. I’m basically self-sufficient.”*

A Latino MSM said, *“I’ve been HIV positive since 1987. I’ve been disabled since 1992. I ask how money is distributed to the agencies because there are people that are living by themselves and they don’t have the extra money they need for existence. When I need money for my bills I will go to the County but I don’t qualify. And then I go to other agencies, and I don’t qualify. So I ask how the money is distributed. I know that there are housing programs which I don’t qualify for. I qualify for drug reimbursement from TDH but I don’t qualify for other services - I don’t know why. I don’t have money to pay my medical bills. Sometimes I see people who do qualify for services and they are wearing new clothes and I wonder ‘Hey, what about me?’”*

An African American heterosexual IDU male brought up the problems that occur when public funds are not available to offer a service. He said, *“I am finding out that these agencies still want referrals for their services. But some of the agencies won’t take all*



referrals if they don't have the funding. You can refer to organizations all day long but they ain't gonna straighten out and tell other organizations that they have these funds."

The amount of red tape and paperwork required to obtain services is often a deterrent for many PLWH/A. A heterosexual Anglo man expressed, *"Some people get tired of going through all the bullshit. When a person goes into an interview that person should get some kind of help instead of having to go back three or four times."* A Latino MSM offered a suggestion by saying, *"I would resolve the red tape by having all the agencies figure out what information is needed per agency that you are going to access instead of having them do the intake at each agency that you go to. You know, there goes the whole day right there, not literally, but almost."*

A Latino MSM brought up his previous trouble in navigating through the care system. He said, *"Don't make the mistake of going to one place thinking that maybe this place will be nice and then you go here too. Because they will blackball you and nobody will help you. If they found out and you go to one and they tell you no and you go to another that's in the network and if you are not in the network, they don't get burned. If you want to do AIDS business in Dallas, you've got to be part of the network. I think it's very bad. They justify it by saying that it saves them money but if you've got a problem with an individual, to me, you focus on that individual and get them assistance they need. What they fear is that the people with substance abuse problems, are going from one to another. But if they got a substance abuse problem, get them into substance abuse treatment. Don't just lock them out of everything. That's not taking care of the solution. That's not taking care of anything. Those who simply really do not know, like myself when I went to get help from one and thought, "Wow, this is just a cold person. I'll come over here and try". I get black balled for a year because I didn't know any better. To me, if you would just at least educate the people that this is going to happen, you know if you go from one place to another. But they won't do that either."*



Structural - Access

Definition

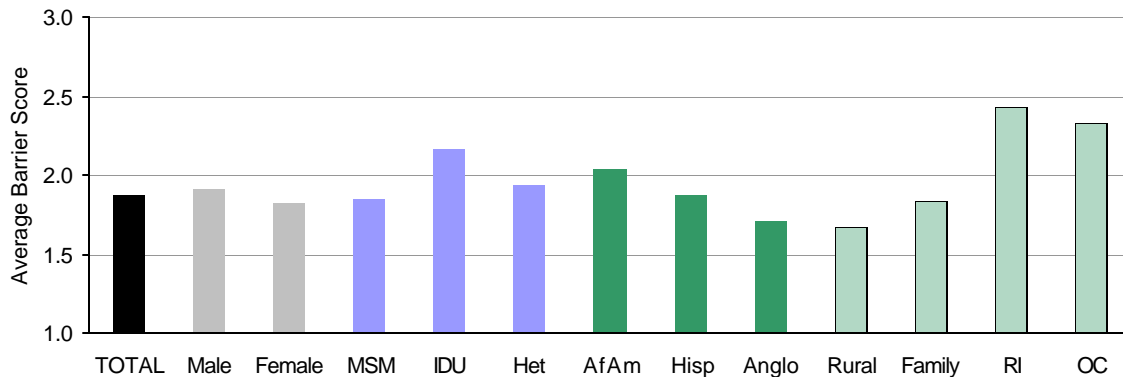
Access barriers are also structural factors which affect a PLWH/A's ability to receive the care or services they need. In the survey and focus groups, PLWH/A were asked to rate the following two access items:

- I do not have transportation to get from my home to the place where the service is provided.
- I do not have access to an HIV care treatment specialist.

Table 8-3 Barrier Ranking -Access

Barrier	Total	Male	Female	MSM	IDU	Het	AA	Hisp	Ang	OC	RI	Fam	Rural
No transportation	2	2	2	1	1	2	2	1	2	3	1	2	2
No access to HIV care treatment specialist	3	3	4	3	3	3	3	3	4	3	3	4	3

Figure 8-4 Access Barriers



- The total sample of PLWH/A felt that lack of transportation and lack of access to HIV specialists were less than small barriers.
- Access is the only barrier for which men rated a slightly higher score than women. For men, not having access to HIV specialists presented a small barrier.
- For IDUs not having transportation represented a small to moderate barrier.
- Recently incarcerated and out-of-care PLWH/A rated lack of access as a small to moderate barrier.

Focus Group Comments:

The lack of transportation was a recurring theme throughout the focus group discussions. A rural Latina IDU summarized the transportation barrier as follows. She said, “*Very easy to access the service, but lack of transportation inhibits me from getting there.*”



Individual - Knowledge

Definition

Knowledge is an individual barrier and is an indicator of the level of knowledge and awareness held by the PLWH/A. It includes the following seven specific items:

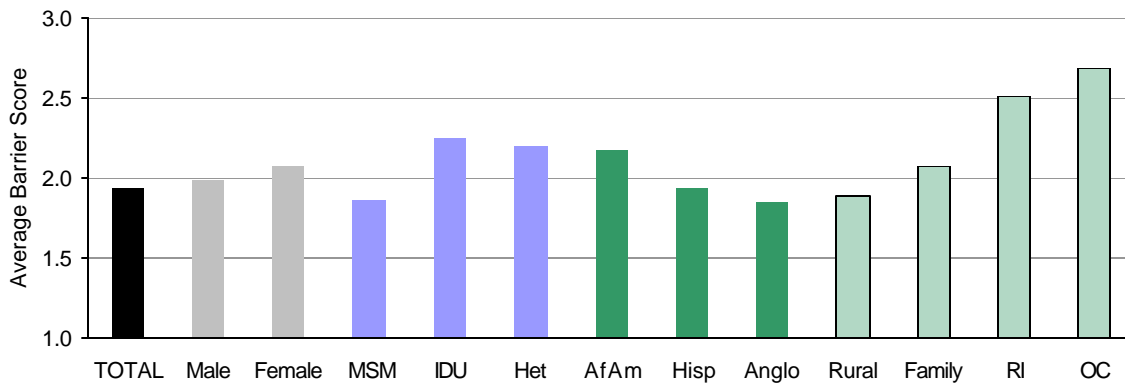
- Not knowing which organization(s) are available to me to provide service that I need.
- The HIV/AIDS services I need are not available.
- Not know the location of the organization(s) providing services.
- Not knowing which services are available to me.
- I do know where to go or who to ask for help.
- Not knowing that services exist to treat my HIV infection.
- Not knowing which medical services I need for treating my HIV infection.

Table 8-4 Barrier Ranking - Knowledge

Barrier	Total	Male	Female	MSM	IDU	Het	AA	Hisp	Ang	OC	RI	Fam	Rural
Not knowing organizations available to provide service	1	1	1	2	1	1*	1	1	1	1	1	1	1
HIV/AIDS services needed not available	1	2	2	1	2	2	1	2	2	3	2	3	2
Not knowing location of organizations providing services	1	1	1	2	2	1	1	1	2	1	1	1	1
Not knowing available services	1	1	1	2	1	1	1	1	1	1	2	1*	1
Not knowing where to go for help	2	2	2	2	2	1	1	2	2	1	2	1	1
Not knowing that services exist to treat HIV infection	3	2	2	3	2	3	2	2	3	2	2	3	2
Not knowing medical services needed for treating HIV infection	3	3	3	4	3	2	3	3	4	2	2	2	3



Figure 8-5 Individual Barriers - Knowledge



- Overall, the total sample of PLWH/A rated their own knowledge as one of the top barriers, second only to rules and regulations.
- For women, their own lack of knowledge about treatment and services was more than a small barrier.
- IDU and heterosexuals also report their lack of knowledge as a small to moderate barrier.
- African Americans reported that not knowing the organizations nor services that were available to them represented a small to moderate barrier.
- For the out-of-care and the recently incarcerated, not knowing where to go for help or the locations of the organizations represented close to a moderate barrier for them.

Focus Group Comments:

For some focus group participants their own lack of awareness about the location and or type of services that existed for HIV limited their ability to seek care. For instance, an Anglo MSM felt that information was not always readily made available. He described his situation as follows, “*After becoming HIV+ and living with it and going through financial problems, looking for the services is very overwhelming. I think in our community information should be given freely. If the info is made available then it could prevent peoples' worlds from falling apart. A lot of information is not freely given. You sometimes have to ‘pull’ the info out of some workers/volunteers.*”

Similarly an African American heterosexual IDU male said, “*I don't know what exists because I don't have a counselor. I don't know who to get into contact with. I have not received any referrals from my medical provider.*”



Individual - Well-Being

Definition

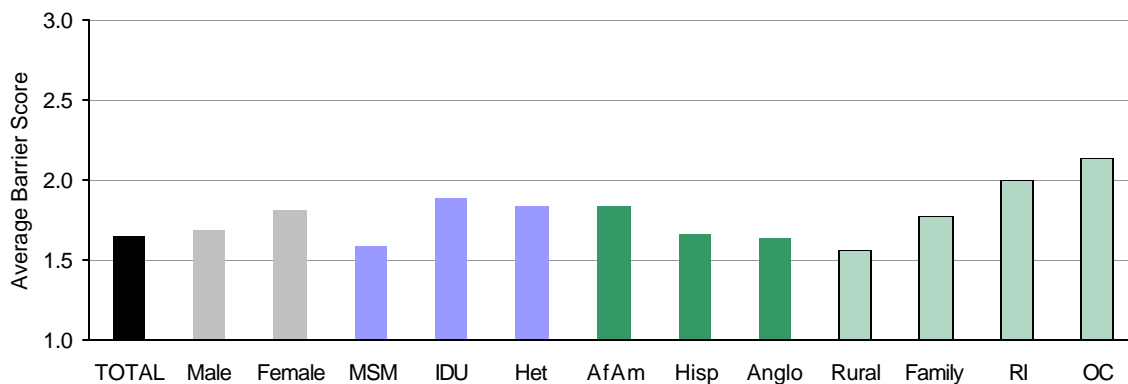
An individual's well-being, both mental and physical may affect his/her ability to access care. The following five items refer to the individual's assessment of their own state of mind and physical health.

- I do not believe HIV is really a problem for me.
- I was worried that someone would find out I am HIV positive (lack of confidentiality).
- I am too upset to think about services and/or treatment.
- My physical health has not allowed me to get to the place where the services are provided.
- I do not understand the instructions about treatment.

Table 8-5 Barrier Ranking - Individual Well-Being

Barrier	Total	Male	Female	MSM	IDU	Het	AA	Hisp	Ang	OC	RI	Fam	Rural
HIV is really a problem	2	2	2	2	2	2	2	2	2	4	4	3	1
Worried that someone would find out HIV status (lack of confidentiality)	2	2	2	3	2	2	2	2	3	4	3	2	2
Too upset to think about services/ treatment	4	4	3	4	4	3	4	3	3	4	3	3	4
Physical health	4	4	4	4	4	4	4	4	4	4	4	4	4
Do not understand the treatment instructions	4	4	4	4	4	4	4	4	4	3	4	4	4

Figure 8-6 Individual Barriers - Well-Being





- Overall, the total sample felt this was less than a small barrier (1.7).
- Women's higher rating for denial and fear that others may find out about their HIV status contribute to a slightly higher individual barrier score than men's rating.
- Fear of others finding out was also a small barrier for IDUs resulting in a higher overall barrier score than the one reported by MSM and heterosexuals.
- For the rural and recently incarcerated PLWH/A fears of others finding out and being too upset to think about services were the main individual barriers related to their own well-being.

Focus Group Comments:

While not among the top ten ranked barriers, denial and the individual's state of mind were often mentioned by participants as reasons for not seeking care or postponing care.

A rural Anglo woman discussed how she dealt with her denial. She said, "I was in denial for a long time at first. When I got to know the people and doctors and clinic, I felt very comfortable. I don't feel like they wouldn't be confidential of my disease. My family does not want to know and it's fine for me to tell them in my own time."

Another Anglo woman also talked about her state of mind. She described as follows, *"I am still in denial. I cannot believe I am HIV positive. Please find a cure for me. I wish this disease would go away."* A Latino MSM exposed a different type of individual barrier which relates to Latinos hesitance to seek external assistance. He said, *"The main problem is that we don't get too much help for ourselves. If a problem comes up, we can fix it ourselves."*

A rural Hispanic woman discussed how her substance use interfered with her getting care. She said, *"It took me a month to go because I didn't want to go, but I was doing drugs... I would just get overdosed all of the time. This was during my pregnancy. My baby is healthy. During that month after my diagnosis my mom kept trying to talk me into getting help telling me it would be good for my baby."*

The concern that others may find out their HIV status and the stigma attached to being positive also keeps some people from seeking services. A rural Anglo MSM felt that the signs identifying the agencies may discourage some PLWH/A from going to the agency. He felt that *"the sign outside of service place should not have the word AIDS on it. I believe people would be more likely to use service without it."*



Organizational - Sensitivity

Definition

Organizational barriers are also factors perceived to be external to the individual. However, unlike structural or systematic factors, organizational factors are considered to be inherent of the particular functioning and operation of provider agencies. Organizational sensitivity barriers reflect the PLWH/A's assessment of the organizational climate, staff's interpersonal skills and level of discrimination felt by the PLWH/A.

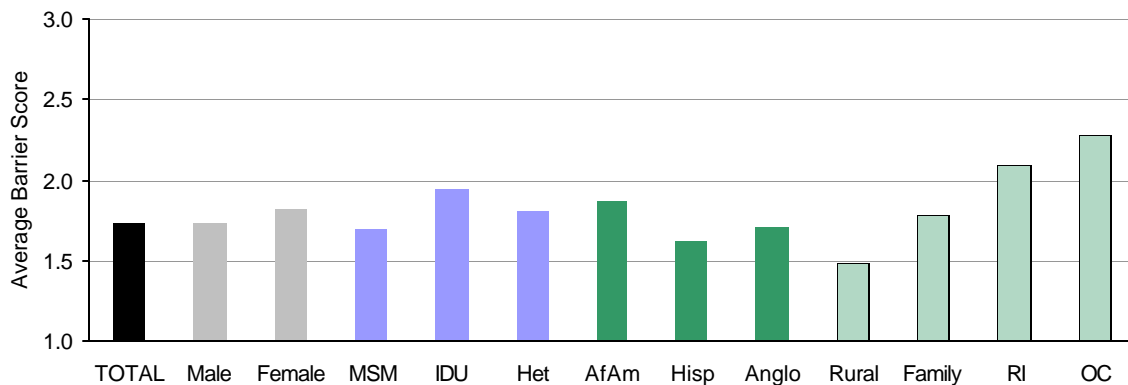
- The organization(s) providing the services to me make me feel like a number.
- The organization(s) providing services to me do not give me referrals for the services I need.
- The atmosphere at the organization(s) providing services is cold and unfriendly.
- I do not feel valued as a person by the people providing services to treat my HIV infection.
- The organization(s) providing services do not answer my questions.
- The discrimination I felt from people providing service(s) to me.
- The organization(s) providing services to me lack sensitivity to my beliefs and spiritual concerns.
- I have been afraid of being reported to the authorities by the organization(s) that provide services to me.
- The organization(s) that provide service care will breach my confidentiality.
- I do not get along with people providing the service.

Table 8-6 Barrier Ranking - Organizational

Barrier	Total	Male	Female	MSM	IDU	Het	AA	Hisp	Ang	OC	RI	Fam	Rural
Made to feel like a number	2	2	3	1	3	2	2	3	2	2	2	2	2
No referrals	2	2	2	2	2	2	2	2	2	2	2	2	2
Cold atmosphere	2	2	2	2	2	3	3	2	2	2	3	3	3
Not valued as a person	2	3	3	2	2	3	3	2	2	3	3	3	3
Questions not answered	3	3	3	3	3	3	3	3	2	3	3	3	3
Discrimination	3	3	3	3	3	3	3	4	2	4	3	3	4
Lack of sensitivity to beliefs and spiritual concerns	3	3	3	3	3	3	3	3	3	3	3	4	4
Afraid of being reported to authorities	4	3	4	3	4	4	4	4	4	4	4	4	3
Fear breach of confidentiality	4	4	4	4	4	4	4	4	4	4	4	4	4
Not getting along with providers	4	4	4	4	4	4	4	4	4	4	4	4	4



Figure 8-7 Organizational Barrier - Sensitivity



- Overall, the total sample felt that this was less than a small barrier
- Women report a slightly higher organizational barrier related to provider’s sensitivity than do men.
- Among the risk groups, IDUs report a slightly higher organizational barrier than MSM or heterosexuals.
- While still considered a less than small barrier, African Americans rate organizational sensitivity slightly higher than Anglos or Hispanics.
- Persons out-of-care experience the greatest organizational sensitivity barrier among all the populations.
- Recently incarcerated feel that lack of organizational sensitivity is a small barrier.

Focus Group Comments

The organizational culture and staff’s personalities greatly affect PLWH/A’s willingness or readiness to seek care. An African American MSM described this as follows, *“I feel that some agencies providing services are not really concerned about the clients - just making money.”* This opinion was evident to him in the hours of operation, attitude of workers, and their unwillingness to assist.

An African American IDU male said, *“Before you get any services, you have to sign up in order for them to get paid. I feel like I am a statistic. A number. One counselor said she needed to get so many clients to get paid - to get by. If we stop signing these things, perhaps they will get back to work.”*

A Hispanic MSM talked about the need to seek out specific providers by name. It rests on the consumer to be informed. For example, he said, *“There is a hospital liaison and unless you know her name, you don't get help. You have to kind of like know you're going, and know the liaison and what her name is going to be for that weekend or week and if you know her name then she will call and start pushing. She will push you through. But if you don't know what that liaison's name is, you are out there like the rest of them.”*



Another Hispanic MSM brought up the need for referrals. In regards to approaching an agency for rental assistance, he said, *“You've got to have a referral to get in there. Someone has to refer you to be able to get in there and it would help if it was someone that speaks Spanish. At [a particular agency], especially, you would need to bring your own translator because they don't have one full time.”*

Discrimination was among one of the lower ranked needs, however, focus groups comments highlighted some bias against members of specific populations. For instance, in discussing the barriers to services felt by the general Latino MSM community, the mistreatment towards transgender individuals was brought up. One Latino MSM said, *“I think there are a lot of transgender that aren't getting help because of the way they are being treated by others. They don't go to any of the agencies because they are discriminated against. At any of the agencies, any of the services, they have no one there that represents them. The people here don't know how to treat them. At the emergency room, they really don't know how to treat them because they come in with female problems. Or urinary problems. The people there really freak out. The one biggest advocate that they had passed away about two months ago. She was a client advocate and it's left a big hole. They are trying to get a transgender on the planning council.”*

A heterosexual Latino male also felt the effect of discrimination. In his opinion, it was not specific to a racial group but instead to having AIDS. He related his friend's experience, *“It's a lack of respect whether you are white, black or brown. X says that he had a similar incident happen to him at [the large hospital facility] where they said, ‘You have AIDS.’ Basically what they were telling him was we are separating people with AIDS from everybody else. Which again, he does have a big gripe about that, it's still lack of respect. I guess he is saying that whether it is a policy of theirs that they separate you from everything, that's discrimination, bottom line. That's what he felt at the time.”*

A Latino MSM also discussed the insensitivity of a service provider. He said, *“I believe people are starting to forget that we are still sick. We may be in the public and able to move around and appear not to be sick. But when we go back to our homes, we know we are sick. And a lot of people are forgetting that. And they will think, “Ah, he can work.” At the complex where we are staying at, they are trying to force people to go back to work. Not forcing directly because they can't do that, but indirectly they are passing out note slips. So that gives me the idea that if they are working for people with HIV, they are trying to force us back to work.”*

An African American heterosexual IDU male discussed the lack of insensitivity he felt from a local provider. He said, *“I've been on that list for housing nine months. To have a felon on your record, DCHHS takes their time about approving the forms. It's the DCHHS part of it. Because I'm from another state. After nine months they finally tell me that [a housing facility] has accepted me but I have to fill out the forms again. So [the housing facility] had to put me back down on the list until I had all the proper paperwork. So you can go through another year waiting. I have an income of \$1333 a month, I'm working - I don't mind paying, but I still can't get in. I went back into society, I went through my drug program, I done got myself prepared to live with this disease,*



and I can't move forward. I'm still giving my money back to the people who are paying me.”

Over burdened staff also presented barriers for PLWH/A. A rural Anglo MSM described the problem. *“One of the problems here is that the case manager is overloaded. It's hard to take care of everyone's needs when there is only one of you and several calls coming in everyday. There's no way that you can keep up with all that.”*

A rural Anglo woman felt that the lack of communication by the organizations represented a barrier. She said, *“We don't know exactly what is available to us. Like the dental program, we had that and I was getting my teeth pulled and all the bottom was out and then the program was cut. The funding is gone. I believe once we had an obstetrician and now that's gone. We don't know what is going on here. Now the rumor is that Dallas is taking us over. We are uninformed here. The board meetings of this agency used to be open and I understand now they are closed. So you just don't know. They used to encourage the clients to attend the meetings and now they don't. It depends on who you are and who you know.”*



Organizational - Provider Expertise

Definition

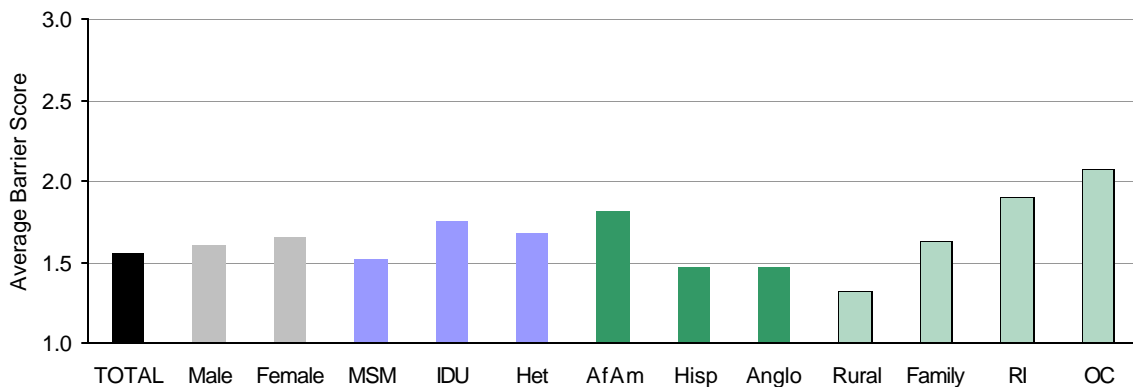
The provider expertise further qualifies the organizational culture. It relates to the PLWH/A's perceived level of provider knowledge and training. It also includes the providers' ability to communicate effectively with the consumer. The following five items refer to an assessment of the providers' expertise:

- The people are not helpful who work at the organization(s) providing services.
- Those prescribing and counseling me on medication do not understand why I have trouble taking them.
- The people providing the services did not understand what I needed.
- The medical person providing services to me did not know he/she was doing.
- The person providing services to me did not speak my language.

Table 8-7 Barrier Ranking - Provider Expertise

Barrier	Total	Male	Female	MSM	IDU	Het	AA	Hisp	Ang	OC	RI	Fam	Rural
Providers are not helpful	3	3	4	3	3	4	3	3	3	3	3	4	4
Those prescribing meds do not understand adherence issues	4	4	3	4	4	4	4	4	4	4	4	4	3
Providers do not understand what is needed	4	4	4	4	4	4	3	3	4	3	4	3	3
Medical provider did not know he/she was doing	4	4	4	4	4	4	4	4	4	4	4	4	4
Provider did not consumer's language	4	4	4	4	4	4	4	4	4	4	4	4	4

Figure 8-8 Organizational Barrier - Provider Sensitivity





- Overall, this barrier is among one of the lowest ranked barriers. PLWH/A do not feel the level of knowledge or training that the providers possess represent a barrier to care.
- The out-of-care PLWH/A are the only ones to report a small barrier related to providers' expertise, providers not understanding what they needed or not being very helpful being the biggest barriers for them.
- The recently incarcerated also felt that providers not being helpful, not knowing what they needed and providers not knowing what they were doing were small barriers. This may reflect their HIV care while in prison.

Focus Group Comments:

An African American heterosexual IDU male discussed the barrier he has experienced with service providers that are not helpful. He said, *"I have asked for a referral from my medical provider but they only refer me to a case worker within [the hospital clinic] and they don't tell you much. I told her that I needed bus passes and I am told that you have to go through this and that you have to go through that. And that they count how many times you use services. They don't want to hear about what is on your mind because they aren't social workers."*

The lack of provider expertise referred to staff at all levels. PLWH/A spoke about the poor training of case managers, receptionists, and doctors alike. For instance, an Anglo woman described her inability to see a doctor for her HIV infection. She said, *"I haven't gone to see a doctor. I am here at [this hospital clinic], but it is like there are so many people that have HIV that they don't have time to see you individually. So you get a licensed worker, you tell her what you need, what your complaints are and if she doesn't have the answers to help you, because she doesn't know, so she sets you up a doctor's appointment and you have to go to another doctor and then you miss that doctor's appointment because you have got other things to do. So you don't get the help that you really need."*

Similarly, a Latino MSM said, *"I'm not sure what the problems are but I believe that the case managers don't have the adequate information. They are given a little book and that is their training. Really, that's why I was saying clients gets more information from other clients."*

An African American heterosexual male discussed the lack of response he has received regarding his loss of appetite. He said, *"I told my doctor that something is affecting my appetite. I don't want nothing. It smells great but I don't want to eat it. I have been asking them to give me something, they won't give me anything. The only way I can get an appetite is to smoke marijuana. It gives me the appetite to eat. They said I hadn't lost enough weight - I guess I don't qualify, I don't know."*

The lack of bilingual staff was also a barrier raised by Hispanic PLWH/A in some of the focus groups. A heterosexual Hispanic woman spoke about her experience with one of



the organizations serving Hispanics. A translator assisting with the focus groups described her problem as follows, *“For example the [multi-service organization] has a bilingual staff. They have Spanish people and she will be calling and the receptionist answers in English but she can just mention the name of the person that she needs and they will connect her. But she said they were given referrals in their charts and they told her to call other agencies. She would call those agencies and of course English speaking people would answer and they could not speak Spanish. She said that's the problem she has had so she has not been able to receive services.”*

In the Latino MSM focus group, the difference between the various Spanish dialects were brought up which makes it difficult for a general Spanish translator to fully assist the monolingual Spanish speaker to understand. One male said, *“I translate at a local agency. Sometimes the words can be given to the client in Spanish the same way it comes in English. Sometimes they are giving the wrong directions. Something does need a little translation most of the time [from dictionary Spanish]. Communication is an area of problems.”*

A rural Anglo man feels his doctor's training and interpersonal skills are inadequate. He says, *“My doctor is bad. At one point she told me that I only had eight months to live. She immediately wanted me to take AZT and I didn't want to take it. She basically told me to leave her office because she felt there was nothing else she could do. But I told her that I wanted to be part of my health care. It's where she comes from. She attempts to have power over the men.”*



Special Needs

Definition

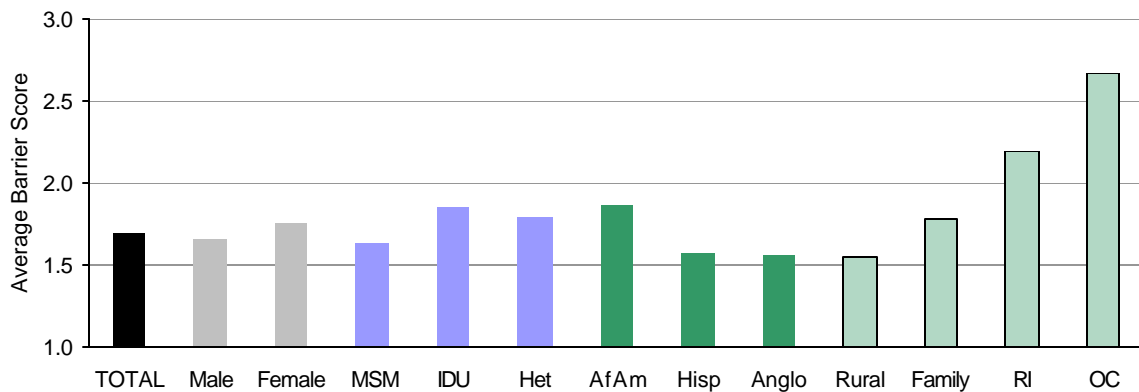
Special needs barriers affect about one third of the participating PLWH/A. They relate to specific services for families and children. They also include the need for housing for battered persons. The following four items were classified as special needs barriers.

- My children are not welcome at the agency where I go to get services.
- No housing that allows children is available to me.
- There is no safe housing for battered persons available to me.
- The lack of on-site child care where I go to for services.

Table 8-8 Barrier Ranking - Special Needs

Barrier	Total	Male	Female	MSM	IDU	Het	AA	Hisp	Ang	OC	RI	Fam	Rural
Children are not welcome at agencies	3	4	2	4	3	2	2	4	3	1	2	2	2
No housing is available that allows children	3	3	3	3	4	3	3	3	4	2	3	3	3
No safe housing for battered persons	3	3	4	2	3	4	4	3	3	2	4	4	4
Lack of on-site childcare	4	4	3	4	3	3	4	4	3	1	2	2	3

Figure 8-9 Special Needs Barriers





- The need for services for women and families and or battered people was rated as a barrier by less than one third the total sample. Among those PLWH/A, the lack of these services represented less than a small barrier.
- However, for the recently incarcerated and for the out-of-care, the lack of on-site childcare and feeling like their children were not welcomed at the agencies were small to moderate barriers. This may reflect only their perception and not their actual experience as women and PLWH/A with children feel these are less than small barriers for them.

Focus Group Comments

A rural African American woman expressed the need to find an appropriate place for her and her children. Having used substances she faced the risk of losing her children and not having a proper place to live. She related her story, “ *After I got pregnant they wanted to give my baby away and I wouldn't do it. I had to move back home. I'm trying to find a place that I can go to with me and my kids out of Corsicana. I don't like living in Corsicana. It's too small. I don't like living there.*”

For a heterosexual African American woman her children were also a concern. She explains, “*You do things different if you are HIV positive, you try to find a decent place to live but it's not just you and your partner or you by yourself, it's you and the kids. Once you let them know that you are HIV positive or have AIDS you are [discriminated against]. As long as you keep it a secret, everything is fine but once you let it out, it's different with or without kids.*”



Summary of Barriers

Overall, none of the 42 barriers ranked by PLWH/A was perceived as "high." The 42 barriers were categorized into four general categories by the PLWH/A: 1) organizational, 2) individual, 3) structural, and 4) special needs. Notably, while there was some overlap in the organizational and structural barriers, when analyzed, the specific barriers discussed within each dimension fell in one group more than the other and therefore presented separately.

The highest barriers were structural. Out of the top fourteen barriers mentioned, nine are structural barriers, four are individual and one organizational. The lowest barriers tended to be those regarding provider expertise and sensitivity, suggesting that these are not perceived as large obstacles for obtaining HIV/AIDS services. Also, while PLWH/A recognize their own lack of knowledge about services and treatment as a barrier, they don't feel their mental nor physical health prevents them from accessing services.

The top barriers were:

- I do not have health insurance.
- There is too much paperwork and/or red tape.
- I cannot afford the service.
- I had to wait too long to get an appointment or see someone.
- Public funds were not available to offer the service.
- There are too many rules & regulations regarding payment for services.
- Not knowing which organization(s) are available to me to provide services that I need.
- The HIV/AIDS services I need are not available.
- Not knowing the location of organization(s) providing services.
- Not knowing which services are available to me.
- My health insurance does not cover service(s) I need.
- My ability to find way through the system.
- I do not have transportation to get from my home to the place where the service is provided.
- The organizations providing the services to me make me feel like a number.

Among the subpopulations, women, African Americans, IDUs, recently incarcerated and those out-of-care face higher barriers than other groups. Women, African Americans and heterosexuals rate not knowing about the organizations available to provide services as a higher barrier than other subpopulations. Notably, child care and family services are rated higher among the recently incarcerated and the out-of-care.



The relationship between red tape and eligibility was clear in the focus groups. PLWH/A complained about the amount of paperwork they needed to fill out, even though the result was that they were not eligible for services like housing or financial services. In the focus groups there were several comments on the need to address the staff's attitudes and poor interpersonal skills. It was suggested that language and sensitivity barriers cause persons to not seek services and thus would not be represented in the sample.

While not perceived as a high barrier in the survey, the focus groups highlighted the need for higher levels of expertise among providers.

Provider sensitivity to personal beliefs and treatment issues were rated among the lowest barriers. Denial, concern about confidentiality, and family special needs are also perceived as very small barriers among the group of PLWH/A as a whole. Yet focus group comments revealed these barriers are higher in rural communities and among substance users and recently incarcerated. In these communities, AIDS and homosexuality tend to be more highly stigmatized than in openly gay communities. The chance of being identified as a PLWH/A was reported to keep persons from seeking services.



9. CONCLUSION

The epidemiology of HIV and AIDS in the Dallas area predicts that over 5,200 are living with AIDS and over twice that number are living with HIV and AIDS. For purposes of calculating unmet need, 6,930 PLWH/A are estimated to currently reside in the Dallas area. Because of a relatively effective continuum of care, these PLWH/A can expect a longer and a better quality of life than those living with HIV and AIDS only a few years ago.

Improved Outcomes

Since 1994, fatality rates for all ethnic communities have decreased from over 40 per hundred thousand to less than 15 per hundred thousand persons with AIDS who are in care. There is some indication that the rapid decline between 1994 and 1997 is leveling off, indicating a lower but continuing need for acute medical care among those for whom medical therapies are ineffective, or those who are experiencing serious side effects of prolonged medication. The data also shows that African Americans are less likely than other ethnic groups to get into care early, and those out-of-care are much more likely to die than those in care.

In 2001, 56% of the PLWH/A report being diagnosed with AIDS, and about 60% say they have some symptoms. For both asymptomatic and symptomatic, over 60% report that their physical health is good or excellent, and almost 70% say their physical health is the same or better now compared to when they first sought treatment for HIV.

Fewer, but still over half, of PLWH/A say their emotional health is good or excellent with over 80% saying their emotional health is better now than when they first sought HIV treatment.

One counter-intuitive finding is that those who are HIV positive and symptomatic often report a worse health status than those living with AIDS, suggesting the continued need for early treatment.

Top Needs

From the perspective of the PLWH/A the shift in demand reflects the trends in the epidemic. As traditionally poorer populations are represented among PLWH/A, and as those infected live longer and have become poor due to prolonged disability, there is a greater need for basic services. Food, emergency assistance, and rent/mortgage assistance are in the top ten service needs and this confirms comments heard throughout the focus groups.

There is a high perceived need to obtain medication reimbursement, reflecting the 80% of PLWH/A who are on medication. Outpatient care continues to be perceived as important, although not the most important service. This reflects the improved and stable health status of people living with HIV and AIDS where the majority of those infected are maintaining their health through successful monitoring and medication. Dental care continues to be ranked high because it is a service that PLWH/A would not be able to get without Ryan White assistance, and it is clearly viewed by PLWH/A as improving their quality of life.



Although most of the top 10 needed services reported in 2001 are the same as those reported in the previous needs assessment completed in 1998, the emphasis is clearly more on meeting basic needs than obtaining medical care. The top perceived needs also differ from the priorities ranking of the Council and Consortium, with food and transportation ranked very high in top-of-mind needs.

There are some differences by sex and ethnicity among top needs. Females say they need transportation, financial assistance, housing, and peer counseling more than men. They emphasize the need for child care and OB/GYN services.

People of color have a higher need for transportation, housing, and childcare than Anglo PLWH/A. African Americans express a greater need for outpatient substance abuse treatment and client advocacy than other ethnic communities, and Hispanics report a greater need for insurance assistance, peer counseling, vocational counseling and translation services.

In general, PLWH/A said the medical related services that they needed most met their needs. However, support services like emergency financial assistance, housing information, and mortgage and rent assistance were much less likely to meet their needs.

In terms of future need, it was anticipated that most services would be needed more, and there was a particularly high future need for more housing, emergency financial assistance, and mental health services.

Services

For the 17 service categories and 35 subcategory classifications, the participants of the survey indicated their level of knowledge, how much they needed it, if they asked for it, and if they received it.

There was very high awareness of food services, dental care, case management, and outpatient care. However, over 50% of the participants said they did not know about several services for which they were eligible, suggesting a need to improve awareness of services including health insurance, information clearinghouse, volunteer services, peer counseling, services for children, residential substance abuse programs, and congregate housing. Surprisingly, more than 45% said they did not know about medication delivery or drug reimbursement.

While knowledge about OB/GYN was high among all females, 40% of the women out of care and 35% of the women recently incarcerated did not know about OB/GYN.

The gap between those that said they asked for and those that said they received services are generally small, and in many instances services are provided in the normal course of care and are not specifically asked for. The largest gaps are among the services that PLWH/A said they needed the most, including emergency financial assistance, health insurance, legal services, and transportation. Particularly among Hispanics, there was a gap for translation services.



Notably there was no reported gap for the Council and Consortium's top priority services of medical care, including drug reimbursement and outpatient care, and dental care. There was also no gap reported for case management and food services.

While the gap between those who said they needed services and received services generally followed the gap between those asking and receiving services, health insurance and emergency financial assistance stood out as having particularly large "need-receive" gaps, suggesting that many PLWH/A understand they need insurance but are aware that they are not eligible and don't ask for it. There were significant differences between sexes, ethnic communities, and risk groups.

Communities of Color

- Overall trends indicate that African Americans and recently incarcerated report greatest needs and gaps for **housing** when compared to other subpopulations.
- Thirty percent more African Americans perceive they need **health insurance reimbursement** than receive it, and 15% more ask for it than receive it.
- African Americans and Hispanics have relatively high need-receive gaps, with 22% to 23% reporting a need for **emergency financial assistance** and not receiving it.
- African Americans and Hispanics have the largest knowledge gap at 27% knowledge of **emergency medical services**.
- African Americans have the largest need-receive gap of 27% for **legal services**.
- African Americans (10%) report the second largest gap between needing **transportation** and receiving it.
- African Americans report needing and asking for **group mental health services** more than they receive it. Specifically, 15% of the African Americans say they need but do not receive **peer counseling services**.
- Among Hispanics, the population most likely to need **translation services**, 47% know about translation services, suggesting a need for greater awareness. Everyone who asks for **translation services** say they receive it.

Women

- While knowledge of **OB/GYN services** is high among most female subpopulations in care, forty percent of women out-of-care and 35% of those women recently incarcerated do not know about OB/GYN services.
- Females report the highest need for **medical case management** (49%) and have the highest relative need-receive gap for medical case management (17%).
- Females (53%) report a high need for **emergency financial assistance**.



- Females have a relatively greater need-receive gap for **food pantry services** and for **home delivered meals**.
- Only females report having a slightly greater need for **case management** than they receive.

IDU

- IDUs and recently released report a high need for **housing information** (62%).
- IDUs (51%) report the highest need for **client advocacy**.
- Between risk groups, as expected, IDUs (40%) have a substantially greater need than other risk groups for **substance abuse treatment**.
- IDUs (59%) report a high need for **emergency financial assistance**.
- IDUs report the highest need-receive gap of 20% for **mortgage/rent assistance**.

Recently Incarcerated

- Recently incarcerated PLWH/A report the highest need for **dental services** of all special populations, with nearly 85% needing dental care.
- Recently incarcerated (53%) report a high need for **emergency financial assistance**.
- Recently incarcerated (50%) report the second highest need for **client advocacy**.

Funded and Delivered Services

The number of units received and funded is not available for several services, suggesting a need for tracking subservices and a uniform data entry system. For services where figures are available, providers delivered more units of care for case management, outpatient care, and substance abuse programs than were funded. On the other hand, less units of care were delivered than funded by providers of medical case management, food services, and dental care.

Barriers

As in 1998, overall barrier scores ranged from moderate to small barriers to no barrier at all. They were slightly lower than they were in 1998. Two of the special populations, those out-of-care and the recently released, reported the highest barriers. Among the ethnic communities, African Americans reported the highest barriers, and among the risk groups IDUs (which are disproportionately African American) had the highest barriers. Females had slightly higher overall barrier scores than men.

The top two barriers remained the same as in 1998, insurance coverage and red tape. Females tended to rank red tape higher than males. The other top barriers were structural: affordability, waiting too long to get an appointment, and public funds not being available. Lack of knowledge about services was the next tier of barriers reported, including not knowing the location of the organization and not knowing which services were available. Heterosexuals and particularly



PLWH/A with families tended to rate lack of knowledge about which organizations provided services higher than other subpopulations. Access barriers such as no transportation were particularly high among the recently released and those out-of-care.

Organizational barriers that ranked highest tended to deal with the difficulty navigating the system and organizations that depersonalized the individual. Overall they were rated lower than structural or individual barriers. Barriers such as lack of sensitivity and discrimination and fear of being reported to authorities were ranked low by all ethnicities and risk groups.

There have been several advances reflected in the data since the 1998 Needs Assessment. Barrier scores are lower and there is more information available to determine gaps. The outcomes of mortality continue to be low and reported quality of life is high. There is some concern about the leveling off of mortality, suggesting that medications may have reached their maximum effect, or that side effects and long term impact of medication may be resulting in deaths.

Consumers report receiving the top priorities of the Council and Consortium of outpatient care and medication. As more persons are living with HIV and not progressing to AIDS, there will be fewer PLWH/A eligible for disability and consequently there will be a substantial impact on the ability of Medicaid and Medicare to contribute to the cost of medication. This will result in an increasing need for RWCA funds to contribute to medication reimbursement.

Also with fewer persons qualifying for disability combined with extended life expectancy of PLWH, there will be a need to move persons from Ryan White Care Act funded services to more sustainable Medicare, Medicaid, or other private insurance. Enrolling persons in the Medicaid managed care programs and assuring quality of care are important steps in the near future. One possibility is investigating a Medicaid waiver for HIV infected persons to become eligible for Medicaid. For those in poverty, making sure that all available federal and state programs are used to access care will be important to sustaining care.

Medical case management has yet to find a clearly defined space in the minds of consumers. Most troubling is that the need is perceived to be great by the Council and Consortium, but the infrastructure to deliver it, and demand for it, does not reflect its high priority. The continuing challenge of adherence, plus the need to further coordinate care suggests a growing need for medical case management, but it must be able to effectively help consumers resolve these issues and increase in perceived value. The role of case management continues to need refinement and with the shift to non-RWCA funding channels, there is a growing need for case managers to become familiar with the services provided by non-RWCA funded providers. Establishing effective referrals remain a top priority.

Dental care, the third ranked priority of the council and second most perceived need of consumers presents a contradiction in terms in of utilization, which appears to be falling. The reasons are unknown but should be investigated.

As the need for primary care and medication reimbursement grows, the ability to provide support services may be reduced. Yet food, transportation , and housing are among the top ranked needs



of the consumer. There appears to be a need to assess the food pantry and congregate meal programs. There is substantial demand on a service that was designed to supplement nutrition and now may have taken on a role as a main provider of food. Clearly coordination with existing nutrition and food programs should be a high priority.

Housing continues to be a need that cannot be met adequately through RWCA funds. As the health status of PLWH/A improves and the vast majority fall under 300% of the federal poverty level, there will be growing demand for independent housing. While it will be essential for those with co-morbidities of homelessness, chronic and persistent mental illness, and substance use to have access to stable housing in order to receive effective treatment, the cost of housing will far exceed the RWCA funds appropriations. This suggests greater coordination with TACADA and HUD, and continued coordination with HOPWA. Several concrete suggestions are made in the 2000 Housing Plan.

HRSA has pointed out that the reauthorization of the Care Act requires greater effort to identify the needs of those who know their status but are not in care. This needs assessment found few people who knew their status out of care, and suggests both a more concerted effort to track persons from counseling and testing and to track persons who are diagnosed later in their infection from acute hospital visits. Based on those interviewed, those out of care are much more likely to have low knowledge levels, be homeless, and have mental disabilities. All suggest a need for aggressive and persistent case management.

There is overwhelming evidence that communities of color have greater barriers and have greater levels of need for many care services. The epidemic in the African American community continues and is becoming a heterosexual epidemic. Although women represent a small minority of PLWH/A, the majority of them are African American. All infected African Americans have high needs for care, drug reimbursement, legal services, housing, emergency financial assistance, food, and transportation. African American women have a particularly high need for child care and OB/GYN services. Hopefully the new management in the South Dallas Clinic will improve the level of care. The evidence of high infection rates among young gay African Americans is alarming, and suggests a need for active follow-up and care in this community and close coordination with prevention efforts.

Hispanics, a growing community in Dallas, remain an enigma. They are more likely to report lower care needs and lower barriers than other ethnic groups. The most likely explanation is that Hispanics, as a group, have lower expectations of care and services. Many are illegal immigrants and many others do not understand entitlements. Focused outreach efforts to these communities with persistent case management may be a way to insure their inclusion in the continuum of care.

Last, is the recognition that for Dallas the majority of the PLWH/A continue to be Anglo MSM. They are more likely to have AIDS and have a need for acute care services. Maintaining services and care for this population must remain a high priority for the Council and Consortium. Assisting them return to work and assuring their benefits will continue to improve the outcomes in the HIV care system.



10. ATTACHMENTS

Attachment 1 Project Advisory Group Roster

Attachment 2 Focus Group Outline for PLWH/A

Attachment 3 Focus Group Outline for Providers

Attachment 4 Dallas 12-County Needs Assessment Survey of PLWH/A

Attachment 5 Focus Group Coding Scheme

Attachment 6 PLWH/A Demographics

Attachment 7 Eligibility Requirements

Attachment 8 Service Knowledge

Attachment 9 Service Need

Attachment 10 Services Asked

Attachment 11 Service Received

Attachment 12 Service Accessibility

Attachment 13 Barriers by Total Population and Subpopulations