HOUSTON EMA & HOUSTON HSDA

IDENTIFICATION AND DESCRIPTION OF THE CONTINUUM OF CARE

Prepared for

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL AND THE HOUSTON HSDA CONSORTIUM

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IDENTIFICATION AND DESCRIPTION OF HOUSTON EMA CONTINUUM OF CARE: INTERIM REPORT

Prepared for the
Houston Area HIV Services Ryan White Planning Council and The Houston Health Services Delivery Area Consortium

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Submitted by the Partnership for Community Health, Inc.

INTRODUCTION

The Houston Area HIV Services Ryan White Planning Council (Council) and the Houston Health Services Delivery Area Consortium (Consortium) have placed a high priority on describing the current continuum of care (COC) for people living with HIV/AIDS (PLWH/A) in the Houston EMA. The Partnership for Community Health (PCH) and the Office of Community Projects (OCP) at the Graduate School of Social Work, University of Houston started this project in January 1999 and completed a community meeting on February 24, 1999. This document is a report of the background research and the outcome of that meeting.

Goal

The overall goal of this project is to provide a framework for a continuum of care that will be used to inform and guide the Council, Consortium, providers, and consumers in establishing priorities and funding HIV/AIDS services. It will provide the information that will enable planners to make the adjustments necessary to meet the continuing and changing needs of PLWH/A.

Objectives

The work plan established by the PCH/OCP project team and approved by the Council and the Houston HSDA Care Consortium is described below.

1. Provide a theoretical framework within which to describe the Houston EMA COC.
2. Identify and gather information from other EMAs around the country.
3. Facilitate a community meeting to present the theoretical framework, describe the types of models from around the country, select a model prototype for the Houston community, and begin to discuss how the full COC should be represented for the Houston EMA.
4. Review the results of this work with the participants at the community forum.

Concurrent with the COC effort, PCH/OCP, as part of the overall needs assessment, will:

1. Gather information from existing resource guides about the number and kinds of services that exist in the Houston EMA related to the provision of HIV services.
2. Through survey instruments, focus groups and provider interviews, suggest how the continuum of care reflects the current service needs, gaps and barriers in the Houston area.

In the final recommendations of the needs assessment, the discussion of the continuum of care will emphasize service needs, gaps and barriers as well as the necessary linking mechanisms to ensure the system works as efficiently and effectively as possible.

FRAMEWORK FOR THE CONTINUUM OF CARE

A continuum of care (COC) is defined by HRSA[1], as "a coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV infection to meet their health care and psychological service needs throughout all stages of illness."

Most Eligible Metropolitan Areas (EMAs) serving PLWH/A include in their system of care:

- primary and secondary prevention of HIV infection
- outreach to the general and at-risk populations to promote prevention and treatment
- the delivery of medical and social services
- the delivery of support services to assure that PLWH/A can access medical and social services.

The COC speaks to several constituencies:

- The general public, whose support is needed for the continued community support of the HIV and AIDS prevention and care systems.
- At-risk populations who are HIV negative and a subset of the general public. They are the targets of prevention efforts.
- PLWH/A who are consumers of the HIV and AIDS services.
- The service providers.
- The administrative agents for the Ryan White Care Act.
- The local, State and Federal funders who require accountability for service systems and provide the resources and governing regulations for the entire system of prevention and care.

[1] Self Assessment Module, JSI, 1998.

These constituencies are in a reciprocal relationship. They plan for the continuum of care, utilize HIV/AIDS services, and monitor the effectiveness of the services.

In addition to these various constituencies, the COC includes the set of services and linking mechanisms that the Ryan White Planning Council, the Consortium, and the community feel should be available to reach their vision for the community.

ELEMENTS OF THE CONTINUUM OF CARE

A continuum of care must take into account several factors in order to truly reflect the needs of the communities infected and affected with HIV and AIDS. These are:

1. The mission and vision statements of the various planning bodies
2. The goals and objectives of the planning bodies
3. The services available in the delivery system
4. The linkages necessary to insure efficiency and effectiveness
5. The coordinating mechanisms that can be utilized to ensure effective linkages are established and maintained

Mission and Vision

Houston is a complex service environment with several different planning bodies, each with their own mission and vision statement. These statements allow the public, staff and governing boards to determine what the focus of service provision will be, what guiding principles will determine how those services are provided and, in a broad sense, what the expected outcomes are for the system. The mission and value states of the Council, Consortium, and Prevention Planning Group are shown in Attachment 1.

System Outcomes

The mission and vision statements note several common system goals that suggest what services should currently be available and what services should be considered in the Houston Area COC. These goals and objectives include:

- Identifying and addressing the needs of unserved and underserved populations.
- Including prevention and treatment services.
- Providing services in an efficient and effective manner.
- Providing services in a seamless manner as a person moves among the different levels of care.
- Providing high quality and culturally appropriate services.
- Advocating for the service needs of PLWH/A.

- Encouraging cooperation necessary for the coordination and delivery of services.
- Assuring that the community in need is aware of available prevention and treatment resources.
- Promoting the dissemination of information to all constituencies.
- Identifying service needs, gaps and barriers.
- Planning capacity to meet needs.
- Improving the quality of life of PLWH/A.
- Assuring that the system is free of discrimination based on race, color, creed, gender, religion, sexual orientation, disability, or age.
- Assuring that PLWH/A, the general public, and providers are included in the process.

Five attributes summarize the system goals and objectives. Referred to as the 5 A's, the delivery system must be:

1. Available
2. Accessible
3. Affordable
4. Appropriate
5. Accountable

The services must be *available* to meet the needs of the PLWH/A and their caregivers, *accessible* to all populations infected or affected by HIV/AIDS, *affordable* to all populations infected or affected by HIV/AIDS, *appropriate* for different cultural and socio-economic populations and care needs, and *accountable* to the funding sources and clients for providing contracted services at high quality.

Client Outcomes

In addition to these system goals and objectives, system and client outcomes can be measured to determine its effectiveness. Several client outcomes can be inferred from the goals and objectives above. These address the needs of all of the consumers within the COC. They include:

- Preventing persons from becoming HIV positive.
- Preventing persons from progressing from HIV to AIDS.
- Improving or maintain health status of PLWA.
- Sustaining or improve the quality of life of PLWA.
- Providing a dignified death to those who are at the end-stage of AIDS.

Linkages

Continuums of Care ideally provide services in a seamless manner as a person moves among the different levels of care. The Houston area has many service providers and in order to provide coordinated services, linkages are critical. According to the HRSA guideline for developing a continuum of care, linkages refer to those inter-entity structures that result in:

- Better client care coordination. Clients with multiple needs or those who move from one intensity level to another should have a well coordinated treatment plan understood by all involved.

- Integrated information systems where one client record that combines financial, clinical and utilization information is available for multiple users, without breaching the confidentiality of the clients.

- Integrated systems of financing that allow for access to all aspects of the system through some mechanism of financial support.

While not all continuums of care will incorporate all of these elements, they are guideposts for improving service integration, efficiency, and effectiveness.

Mechanisms for Providing Inter-entity Linkages

Some of the mechanisms presented in the HRSA guidelines for establishing the necessary linkages include:

1. Participation on councils,
2. Joint planning meetings,
3. Joint prioritization activities,
4. Contractual arrangements,
5. Joint case conferences,
6. Standardized practice procedures,
7. Uniform intake forms,
8. Shared client information,
9. Shared staff arrangements.

The Houston area already engages in several of these activities and the challenge for the Houston area is to develop those mechanisms that will best meet the goals and objectives of the continuum of care.

Summary of the COC Framework

In summary, the COC in the Houston area needs to focus upon the mission and vision of the Council, Consortium, and Prevention Planning Group. It has to have concrete system and client outcomes to the services provided within the system. The COC is more than a list of services, however, it is a plan for maintaining, improving and adding the strategic linkages that promote efficient and effective service delivery.

REVIEW OF THE EXISTING CONTINUUMS OF CARE

In specifying and modifying the Houston Area COC, the project team reviewed and documented lessons learned from the continuum of care of other EMAs.

Methodology

In reviewing the existing COCs throughout the nation, 49 eligible metropolitan areas (EMAs) were found to receive Title I funding. Of those 49, 45 in the contiguous United States were contacted to send the team information about the COC. Multiple attempts were made to contact these EMAs, either through the designated contact person, the Planning Council Chairperson, or other Ryan White personnel. The project team was able to reach 23 of the EMAs. All of the EMAs had comprehensive plans and some kind of description of their service delivery system, but only six provided a visual representation or model of their existing COC.[2] This visual model provides a snapshot of how planners can delineate and arrange services and linkage mechanisms within an HIV/AIDS system of care. These visual models were provided by:

1. Cleveland, Ohio
2. Hudson County/Jersey City, New Jersey
3. Austin, Texas
4. Riverside/San Bernadino, California
5. New York City, New York
6. Orange County, California

Demographics

The demographics related to a number of variables in both these six sites and in the Houston EMA are noted in Tables 1 – 5 at the end of this section.

Table 1, on page 11, summarizes population figures along with growth, projected growth and migration figures for each EMA. The Houston EMA includes six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Walker. Table 1 indicates that:

- Of the seven EMAs reviewed, Houston had the second largest land area, behind Riverside/San Bernadino.
- Houston was second behind New York City in population.

- The Houston EMA is currently ranked eighth in national population, and has experienced a 21.2% population growth between 1990 and 1996. Austin was the only EMA reviewed with a higher percentage of population growth (24.7%).
- Only Houston, Riverside/San Bernadino, and Austin experienced a positive net migration between 1990 and 1996. Houston's population is expected to continue growing, with an anticipated 12.6% projected population growth for 1996 through 2002.

Table 2, on page 12, takes a look at the racial and ethnic make-up of each community included in this study.

- In general, the population of the Houston EMA most resembled that of the New York and Hudson County/Jersey City EMAs in racial breakdown. These three EMAs had a larger percentage of African Americans than the other EMAs. New York had the highest percentage at 21%, followed by Houston with 18% and Hudson County/Jersey City at approximately 16%.
- The Orange County EMA had the highest percentage of Asians/Pacific Islanders, with about 12% of the population, while this racial group only comprised 2.4% of the Houston EMA population.
- All the EMAs had approximately 1% or less of the population American Indian, Eskimo, or Aleut.
- In the breakdown by ethnicity, Hudson County/Jersey City had the highest percentage of the population with Hispanic origin, with 37% of the population. The Austin, Riverside/San Bernadino, and Orange County EMAs had between 25% and 30% of the population of Hispanic origin. The Houston EMA had 13% of the population of Hispanic origin.

Client Profiles

Table 3, on page 13, details client characteristics of recipients of Ryan White CARE Act (RWCA) funding. Approximately 25% of the clients served by the Houston EMA in FY 1996 were female. This gender breakdown is most similar to the Austin EMA, which had about 22% female clients served. Both the New York and the Hudson County/Jersey City EMAs served a higher percentage of female clients, with 43% and 39% female clients, respectively.

With respect to race/ethnicity, both African American and Hispanic clients were disproportionately represented among clients served by the RWCA in the Houston EMA. African Americans comprised approximately 18% of the population in Houston in 1996, but were 43% of clients served. Houston's Hispanic population is also over represented

epidemic. According to the Centers for Disease Control and Prevention (CDC), African Americans have the highest rate of HIV infection: 92.9 per 100,000 in 1995. Hispanics had the second highest rate: 46.2 per 100,000 in 1995 (CDC, 1998).

The breakdown of the age of RWCA clients in the Houston EMA is similar to the other EMAs that were identified for comparison. Approximately 96% of the clients served in the Houston EMA were 20 years of age or older. Only about 2% of the clients were adolescents, and 2.5% were children under age 13. The Hudson County/Jersey City EMA had the largest percentage of children under 13 served, with approximately 8% of clients served. The New York EMA had both the largest percentage of adolescent clients in FY 1996, with about 11% of the clients served, and the largest percentage overall of children and adolescents under age 20, with about 17% of the clients served.

Table 4, on page 14, looks at information related to exposure category. Almost half of the clients served by the RWCA in the Houston EMA were in the category of men who have sex with men (MSM). This percentage is more than double that of both the New York and Hudson County/Jersey City EMAs.

Approximately 17% of Houston clients were in the injection drug use (IDU) exposure category. While this figure is about double that of both the Austin and Riverside/San Bernadino EMAs, it is less than half of the percentage of IDU exposure of the New York and Hudson County, New Jersey EMAs. With approximately 8% of clients in the exposure category of heterosexual contact, Houston also has approximately half as many clients as the New York and Hudson County/Jersey City EMAs in that category. It is significant to note that the Houston EMA had the highest percentage of clients in the combined MSM/IDU exposure category, with 17.5% of clients served.

RWCA Funding[3]

Table 5, the final table at the end of this section, details the Title I and Title II expenditures for several of the EMAs. In FY 1996, the combined Title I and Title II Ryan White CARE Act funding for Houston was $9,706,735. This amount represented 32% of the total funding for HIV services in the community. Therefore, approximately 68% of HIV services in the Houston EMA were funded through other sources. This percentage was comparable to that of the Austin and Hudson EMAs, with 38% and 35% of total funding from Titles I and II, respectively.

[3] Statistical information for Ryan White CARE Act clients and providers was not available for the Cleveland and Orange County EMAs, therefore these two EMAs are not included for comparison in Tables

Both the New York and Riverside/San Bernadino EMAs had a higher percentage of RWCA funding, with approximately 50% of HIV services funded through Titles I and II for both EMAs.

Table 3 indicated that 27,080 clients were served through the RWCA in the Houston EMA in FY 1996. Approximately 39% of these clients, or 10,490 people, were new clients. By contrast, in the other four EMAs, approximately half of the clients served were new clients.

Table 1 EMA Demographics

EMA	Houston TX	Cleveland OH	New York NY	Austin TX	Riverside/ San Bern. CA	Hudson County/ Jersey City NY	Orange County CA
Land Area	5,921 sq. miles	2,708 sq. miles	1,148 sq. miles	4,226 sq. miles	27,270 sq. miles	47 sq. miles	790 sq. miles
Population	3,791,921	2,233,288	8,643,437	1,041,330	3,015,783	550,789	2,636,888
National Population Rank	8	21	2	55	11	88	5
Population Growth 1990-96	21.2 %	4.8 %	2.9 %	24.7 %	16.9 %	-0.4 %	9.4 %
Projected Pop. Growth 1996-2002	12.6%	0.6 %	-0.3 %	14.2 %	14.7 %	-0.4 %	5.3 %
Net Migration 1990-96	+ 36,250	- 59,448	- 976,137	+ 113,773	102,585	- 69,855	- 177,332

Source: American Community Network

Table 2 EMA Population Breakdown by Ethnicity

EMA	Houston TX	Cleveland OH	New York NY	Austin TX	Riverside/ San Bern. CA	Hudson County/ Jersey City NJ	Orange County CA
White*	79.0 %	92.0 %	72.0 %	89.0 %	87.0 %	75.9 %	85.4 %
Black	18.4 %	7.0 %	21.2 %	8.8 %	7.2 %	15.7 %	1.9 %
Asian or Pacific Islander	2.4 %	0.7 %	6.1 %	1.3 %	4.7 %	8.1 %	12.1 %
American Indian, Eskimo, or Aleut	0.3 %	0.2 %	0.3 %	0.4 %	1.2 %	0.3 %	0.6 %
Hispanic	13.0 %	2.0 %	19.1 %	25.7 %	29.8 %	37.0 %	26.1%

Source: American Community Network

*All federal record keeping and data presentation is required to use four race categories (White, Black, American Indian and Alaska Native, Asian and Pacific Islander) and two ethnicity categories (Hispanic and non-Hispanic). Race and ethnicity are treated as separate and independent categories.

Table 3 Ryan White CARE Act Client Statistics

EMA*	Houston TX	New York NY	Austin TX	Riverside/ San Bernadino CA	Hudson County/ Jersey City NJ
Clients served	27,080	101,510	3,260	3,740	9,170
Gender					
Male	20,450 (75.5%)	57,600 (57.6%)	2,540 (77.9%)	3,160 (84.5%)	5,620 (61.3%)
Female	6,630 (24.5%)	43,210 (42.6%)	710 (21.8%)	570 (15.2%)	3,550 (38.7%)
Ethnicity**					
White	10,350 (38.2 %)	15,040 (14.8%)	1,650 (50.6%)	2,210 (59.1%)	1,890 (20.6%)
Black	11,510 (42.5%)	43,570 (42.9%)	910 (27.9%)	580 (15.5%)	4,110 (44.4%)
Hispanic	4,900 (18.1%)	38,250 (37.7%)	620 (19.0%)	800 (21.4%)	3,020 (32.9%)
Asian/PI	100 (0.4%)	1,510 (1.5%)	10 (0.3%)	40 (1.1%)	50 (0.5%)
Native Amer.	220 (0.8%)	380 (0.4%)	20 (0.6%)	50 (1.3%)	6 (0.06%)
Age**					
Under 13 y/o	680 (2.5%)	5,330 (5.3%)	90 (2.8%)	20 (0.5%)	770 (8.4%)
13-19 y/o	480 (1.8%)	11,570 (11.4%)	10 (0.3%)	30 (0.8%)	320 (3.5%)
20 y/o & older	25,910 (95.7%)	83,200 (82.0%)	3,150 (96.6%)	3,680 (98.4%)	8,060 (87.9%)

Source: Health Resources and Services Administration, HIV/AIDS Bureau
* Data unavailable for Cleveland, OH and Orange County, CA
** Percentages may not equal 100 due to missing data

Table 4 Ryan White CARE Act Percentage of Clients by Exposure Category

EMA*	Houston TX	New York NY	Austin TX	Riverside/ San Bernadino CA	Hudson County/Jersey City NJ
MSM	48.2%	18.2%	37.7%	48.1%	13.6%
IDU	16.8%	38.2%	9.3%	7.7%	44.3%
MSM/IDU	17.5%	1.8%	4.8%	5.8%	0.1%
Heterosexual Contact	8.3%	25.9%	6.8%	2.4%	27.8%
Other/Undetermined	9.1%	15.9%	41.5%	36.0%	14.2%

Source: Health Resources and Services Administration, HIV/AIDS Bureau* Data unavailable for Cleveland, OH and Orange County, CA

Table 5 Ryan White CARE Act Provider Statistics

EMA*	Houston TX	New York NY	Austin TX	Riverside/ San Bernadino CA	Hudson County/ Jersey City NJ
# new AIDS cases for 1995 (% national total)	1,158 (1.62%)	10,496 (14.70%)	323 (.45%)	768 (1.08%)	760 (1.06%)
CY 1996 Title I funding	$9,035,644	$66,786,341	$1,709,019	$3,918,274	$5,031,492
CY 1996 Title II funding	$671,091	$6,578,542	$634,130	$632,829	$166,687
% total HIV Service Funding from Titles I & II	32%	50%	38%	47%	35%
Clients served	27,080	101,510	3,260	3,740	9,170
New clients	10,490	52,320	1,500	1,980	4,600
Estimated % with HIV**	35.8%	53.8%	54.1%	46.2%	36.7%
Estimated % with AIDS**	62.3%	37.1%	34.8%	51.9%	57.0%

Source: Health Re sources and Services Administration, HIV/AIDS Bureau
* Data unavailable for Cleveland, OH and Orange County, CA
** Not all providers report HIV status

ASSESSMENT OF CONTINUUMS OF CARE

Types of Continuums of Care

For the purpose of this report, the model COCs received from the six EMAs have been categorized into four basic types. These are the *linear*, the *client-need centered*, the *hierarchical* and the *functional.*[4] Categorizing models into four different types is somewhat arbitrary and there is some overlap between the various models. However, it provides a way to delineate the major characteristics of each model and assist in deciding which model or features of each model are most suitable for the Houston community.

Table 6 summarizes the four types of models. The visual presentations of the COC models are found in Attachment 2.

Table 6 Continuum of Care Model Typology

Type	Definition	Example
Linear	- Straight line - Uses disease trajectory to define service delivery system	Cleveland, OH
Client-need Centered	- Client is focus - Flexible structure - Movement defined by client needs	Hudson County/Jersey City, NJ
Hierarchical	- Relational classification - Organized around core set of services	Austin, TX
Functional	- Represents functional categorization of client needs - Services are placed together because they represent similar functions	Riverside/San Bernadino, CA New York, NY Orange County, CA

Linear Model

The linear model suggests that services travel along a single line from entry into the system to, usually, death. The Cleveland model is an example of this type of representation. The client's entry into the service system is determined by the client's stage of disease, as defined by T-cell count. Movement within the system goes in one

[4] It is important to keep in mind that models assessed are visual representations of much more complex processes and systems. In addition, the snapshot view of the continuum of care as presented in these one-page models does not delineate how planners might go about arranging services and linkage mechanisms to make the model an actuality.

direction only, following the progression of the disease toward death. The client starts with the initial positive test and ends with a T-cell count of 0 to 50. Services are categorized according to this progression. For example, a client may start with referral to care, which becomes primary care in the early stages of infection and then ongoing care, medical care, intermittent disability, and then hospice services as ability for independent living decreases and the need for professional health care increases.

This model has several positive features. It demonstrates that many services are needed throughout the disease process, and that the *character* of the services may change as the disease progresses. For instance, legal issues are generally different at stage one than they are at the final stages.

The biggest drawback to this model is that it presents a dated notion of HIV and AIDS services. Today, the health and well-being of PLWH/A do not usually follow a linear progression from health to death. In addition, as a working model, it presents two particular problems:

1) The model does not emphasize the linkages that might be necessary throughout a system to make it most accessible and flexible to those who need it.
2) The format creates a fair amount of redundancy in the listing of services. For example, transportation is listed four different times.

Client-Need Centered Model

The client-need centered model has the client as its focus. The premise of the model allows for a flexible structure, but the organization of and movement within the model are defined by client needs and characteristics, and it is designed for direct client use.

The Hudson County/Jersey City, NJ, model is a good example of a client-need centered model. Hudson County refers to its model as a Care Map, and it is a step-by-step guide of where to go for HIV/AIDS services. If a client is concerned about getting tested, he or she can find out which services are available by going to Care Map I and following the arrows. It is the client's individual situation and needs that drive the structure of the model. The same is true of Care Map II. Once a test is positive, the client goes in one direction if they are a child or adolescent, another if they are an adult, and another if they are an adult with special needs.

This type of model's greatest strength is in providing the user with a clear entry point into the system and a clear path to the outcomes of care. The Care Maps are also good tools for case managers, giving them a cursory view of how the system works and allowing them to coordinate care and express the direction of care relatively easily to their clients.

However, while it is important for COCs to be responsive to client needs, this particular representation is not as helpful a tool for planners in designing and modifying the system. It does not show the system as a whole and does not demonstrate how the system needs to be designed, evaluated, or modified over time. This is particularly true in relation to portraying the linkages and coordinating mechanisms that are necessary to keep a complex system of care functioning efficiently and effectively.

Hierarchical Model

The hierarchical model is arranged by a relational system of classification organized around a core set of services. The model presumes that until a basic set of needs related to physical health, or survival, are met, the next level of need, which may be more related to quality of life, cannot be realized.[5]

The Austin model is an example of the hierarchical type of model. The core of the model is the basic needs category, or those services a PLWH/A needs for survival. The independence and life skills categories are the successive steps in the hierarchy reaching toward optimum emotional and physical well-being. At the bottom of the model are the resources, infrastructure, case management, and outreach functions that are required to maintain the system. They serve as integrating mechanisms for the delivery of services across all categories. With good resources, a sound infrastructure, and case management and outreach systems in place, a client can move from one service to another and one category to another.

Unlike in the linear model, there is no element of time implied. A client is not held to a particular service at a particular stage of disease. It is organized with the goal of living with HIV/AIDS and is flexible to meet the needs of the individual. The model is also a useful tool for planners because it represents all necessary parts of a well functioning system.

One problem with the model, however, is the relative arbitrary placement of services, which may not reflect the values of the PLWH/A who are using the services. For example, what one client sees as a service to reach a higher level of independence, another may view as a basic need. To the extent that the hierarchical arrangement might determine resource allocation, this placement of services could be a potential problem. It is likely that services needed by smaller target groups will be viewed as less “basic” and possibly under- or un-funded.

[5] It is similar in concept to the model of psychological health and growth articulated by Maslow, in whose schema the primary level relates to safety needs and the highest level encompasses the need for self-actualization and expression.

Functional Model

The functional model represents a planner's best understanding of how a system addresses a client's needs. Services are placed together because they represent like functions or serve similar functions within the overall system. Three of the models in this report fall into the functional category. They are New York, Riverside/San Bernadino, and Orange County, CA.

The Riverside/San Bernadino model organizes services into three categories: core, ancillary, and access. Core services address the basic needs of PLWH/A, that is, food, housing, safety/security, and health care. Beyond that are the ancillary and access services, which support health care and social needs and allow PLWH/A to address barriers to care.

The New York model uses four intersecting circles to describe its system. Each contains its own set of services: targeted, access, physical and life sustaining, and capacity building. This model was developed with the New York Planning Council in mind, referring to specific funding categories and work groups within the system that address the various resource issues and needs within their designated area.

The Orange County, CA, model uses a three-column chart with the following service categories: medical and healthcare, practical, and supportive. Placement of services in each category is defined by actual practice - vision care is a medical service, a food bank is a practical service, and respite care is a supportive service. This is a flat representation with no demonstration of a relationship between the services. What is interesting, however, is the use of italics to show services that are available but not funded by Ryan White.

The functional models serve as good tools for guiding councils and planners. They help to conceptualize the service delivery system and its various aspects, which enables these groups to focus on how to prioritize resource allocation and improve service delivery and integration.

On the other hand, the models are more or less static and they may not anticipate future client needs. The nature of the categories may not allow for the inclusion of new or emerging services that are necessary to the well-being of the client group. While they serve to address individual needs, they may not be very helpful to the everyday lives of PLWH/A because the total context of their need may not be addressed.

A second disadvantage is that the models are not user-friendly in their presentation. The New York model, for example, uses language unfamiliar to the general consumer. In addition, while the inclusion of services geared to specific populations is commendable, the wording and placement leads to a fair amount of redundancy in the listing of services and the uncertainty of where they are most appropriate.

Service Categorizations in the Models

There is little agreement on what should be basic or secondary services within the COCs. In the six models presented, there are over 100 services listed. As shown in Table 7, Riverside/San Bernadino lists 21 services as basic needs. Austin includes some of these but not others, adds some new ones, and comes out with a total of 14 "basic services". New York includes 11 "basic services". Austin, New York, and Riverside agree on three as basic: ambulatory care, dental care, and drug reimbursement. There are over 15 services that only one EMA includes as basic. Whether these categorizations reflect unique needs in each of the EMAs or whether they tend to indicated the somewhat arbitrary nature of categorizations is unknown.

Table 7 Functional Models Service Categories

	EMA		
Services	**Austin**	**New York**	**Riverside/ San Bernadino**
Ambulatory care	X	X	X
Dental care	X	X	X
Drug reimbursement	X	X	X
Adult day care		X	X
Buddy services		X	X
Emergency shelters	X		X
Food bank	X		X
Home care/skilled nursing	X	X	
Home-delivered meals	X		X
Hospice care	X		X
In-patient medical services	X		X
Mental health treatment	X		X
Rental/utility assistance	X		X
Emergency financial assistance	X		
Emergency medical care	X		
Emergency response			X
Food and nutrition		X	
Food – grocery vouchers			X
Housing / Apartments			X
Housing referral coordination		X	
Housing - Single room occupancy units			X
Housing - supportive housing			X
In-home supportive services			X
Skilled nursing facilities			X
Spiritual care			X
Substance abuse treatment	X		X
Supportive counseling		X	
TB services		X	
Treatment education		X	

Additional Continuum of Care Information

In addition to the six models presented above, information related to three additional EMAs has been gathered. In Sacramento, CA, a clearly defined continuum of care exists within the Ryan White Title I application. The system is built around Core Services, or those "essential to the infected person's health, longevity, and quality of life." These are augmented by Primary Linking Services and Support Services, which enable people affected by HIV/AIDS to obtain the core services and stay in care. The entire system is enhanced by Community Capacity Building Services designed to continually improve the system of care.

In New Haven, CT, the continuum has the goal of "sustain[ing] a seamless provision of services to safeguard the quality of life throughout all stages of the life cycle of this disease." The services are grouped into four categories: 1) health care, 2) psychosocial (including case management), 3) social service (food, transportation, etc.), 4) substance abuse treatment, and 5) extended care services. Case management with extensive collaboration and well-developed referral systems among all service providers is a key element.

In the New Haven model, there are three additional notable features: 1) Clinic Coordinators who oversee aspects of the clinic operations, including maintaining relations with clients and linking with case managers, 2) Early Linkage, a program designed to help transition a client from prevention services into the care delivery system and diminish the gap between testing positive and entry into primary care service, and 3) interagency collaboration as a condition of funding through the Planning Council.

Detroit, MI, has developed a booklet that discusses the continuum of care. There are five elements: 1) Coordinating and Integrating Mechanisms, 2) Medical Care, 3) Mental Health Care, 4) Population Concerns, and 5) Social Services. Under each element, they discuss the ideal for different types of services and the plan to reach that ideal. The goal is a functional continuum of care that will allow clients to "directly access care services at any point." Individual (between providers, case managers and clients) and systemic (between payors, policy makers, and public officials) coordination is key to a seamless continuum of care.

DEVELOPING THE HOUSTON CONTINUUM OF CARE

Goals of the Houston Continuum of Care

The goal of the Houston COC is to specify and show the linkages between a full range of client-centered, cost-effective services that unify the prevention and treatment of the HIV epidemic in the greater Houston area.[6]

The objectives discussed within the Houston community have been:

1. To coordinate an innovative, complete continuum of care to meet the needs of the HIV infected and affected communities.

2. To ensure that the service model is client-centered and community supported.
   - 2.1 Develop and implement a system to bring clients into the planning and evaluation process.
   - 2.2 Develop a grievance procedure for clients.
   - 2.3 Develop marketing/communication strategies that ensure community participation.
   - 2.4 Develop reporting methods.
   - 2.5 Provide viable financial and administrative resources for the continuum of care to maximize service dollars.
   - 2.6 Streamline financial and administrative resources.
   - 2.7 Develop and implement strategies to secure ongoing funding.

3. To ensure accountability and quantitative evaluation of the continuum of care.
   - 3.1 Ensure that evaluation recommendations are addressed.
   - 3.2 Implement summative evaluation of the process.
   - 3.3 Implement an outcome-based system of evaluation.
   - 3.4 Disseminate results of evaluation process.

Process Outcomes

The process outcomes for a comprehensive coordinated delivery system include that services be:

1. Client centered: Clients must have input into defining their needs, assessing services, and modifying/changing services to meet their needs. This is achieved by assuring the:
   - 1.1 Participation of PLWH/A in the planning process.
   - 1.2 Feedback from PLWH/A through needs assessment and consumer satisfaction surveys and an accessible grievance procedure.

[6] This goal is based on the synthesis of Houston information.

2. Proactive: The Consortium, Council, Prevention Planning Group, and providers must anticipate the changing needs of PLWH/A and the system has to be flexible to meet new needs.

3. Comprehensive: A comprehensive continuum of care for HIV/AIDS services often includes more than services funded by the Ryan White Care Act. A comprehensive system:
   - 3.1 Encourages the general public to provide continuing support to PLWH/A through supporting public programs that provide services.
   - 3.2 Promotes awareness of HIV status to those at risk so that they can receive early care and protect others from infection.
   - 3.3 Provides prevention services to those who are HIV negative.
   - 3.4 Provides treatment to those who are at all stages of HIV infection.

4. Dynamic: The system should suggest movement of persons from one service to another. Consumers move about in the system depending on their needs.

A New Conceptualization of the Continuum of Care

Several models that have a visual representation have been developed by other EMAs. Their characteristics, strengths, and weaknesses are outlined in the preceding section of this report. Most COCs have lists of services organized in linear, client-centered, and hierarchical or functional systems, as described above. However, none of them suggest outcomes for clients and none clearly delineate the different populations who use the system. In addition, all look relatively static and may be more or less difficult to modify as client needs change along with changing treatment strategies and new advances in care.

PCH/OCP suggests a new way to conceive the continuum that includes these elements. Often times, analogies help in understanding a model. In this instance, conceive of the Continuum of Care as a rail system made up of six rail tracks that move passengers up and down the lines to different stations. As shown in Table 8, the tracks are defined by their starting and ending points.

The tracks represent the general type of services. The qualifications refer to the types of consumers who generally take the different lines. The starting points define the key identifying factor for the passenger. The destination is the outcome for the consumers.

Think of the passengers as being in three classes:

1. Ambassador class: those with private insurance.
2. Business class: those with Medicaid or Medicare.
3. Coach class: those with no insurance or who are uninsured or under-insured.

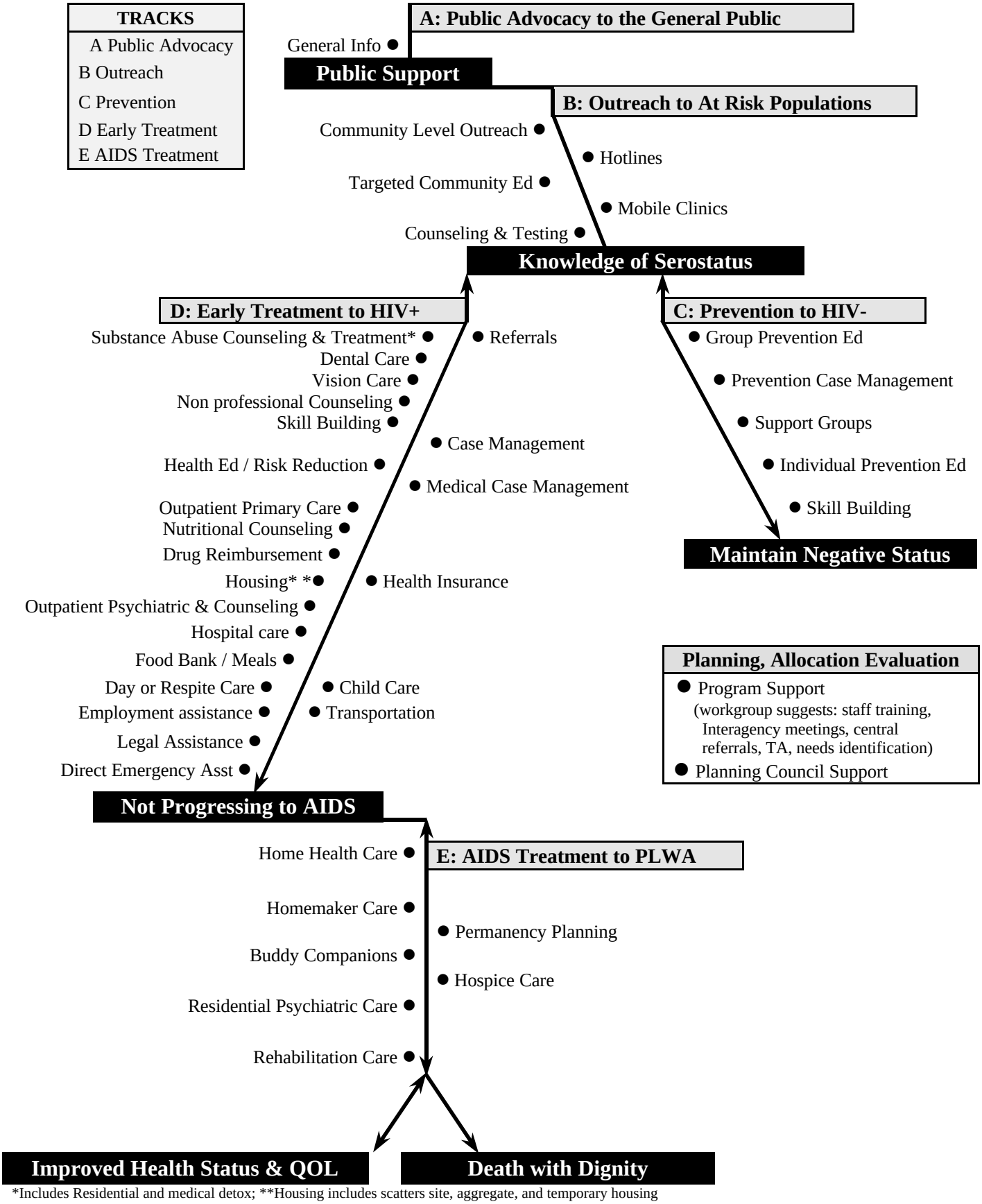
Between the starting point and destinations are several station stops representing services. The consumer can choose to stop or skip that station. They can get on and off at different times and go back and forth on the line. If they have the right qualifications, they can move between lines.

Table 8 Continuum of Care Lines

TRACK	QUALIFICATION	START	DESTINATION
A. Public Advocacy	General public	No awareness of AIDS	Support for HIV/AIDS services
B. Outreach	High risk behaviors	No awareness of serostatus	Awareness of serostatus
C. Prevention	Knowledge of negative status	Aware of negative status	Maintaining negative status
D. Early Treatment	Early knowledge of HIV positive status	Awareness of infection	No progression to AIDS
E. AIDS Treatment	PLWA	AIDS diagnosis	Improved health status & quality of life (QOL) (or) Death with Dignity.

Figure 1, on the following page, shows what that system might look like for Houston. For the HIV positive lines, D-E , the “stations” on the left are those that provide access to the services on the right. The numbers in parentheses present the 1999 priorities. Following the Figure is a more full description of system.

Figure 1 HIV/AIDS CONTINUUM OF CARE



*Includes Residential and medical detox; **Housing includes scatters site, aggregate, and temporary housing

To summarize the features of this system:

- It has several tracks, each defined by its outcomes.
- Consumers can enter the system at any point on the track, provided they are qualified.
- Consumers can travel up or down the line.

Working with the Continuum

At this point, the continuum of care presented in this report is a framework, but it is not the recommended Houston Continuum of Care. Rather, it is a place to start. There are several tasks to be completed, including:

Defining the Services

The first task is reviewing the services and their placement on the system. Are the services on the right track? For Ryan White services, this is particularly relevant for the HIV positive tracks (D-F) that feed into the PLWA1 (initial stages) and PLWA2 (late stages) tracks. The service stops along these tracks are largely predetermined. While some adjustments may be necessary, HRSA and the past history of the Houston EMA have determined the services and the eligibility of the consumers. The largest challenge is to set the terms of eligibility between HIV and AIDS.

Defining the Consumer

The second major task is to review who the consumers are and project who they are likely to be in the future so as to ensure that the system has the capacity to meet their needs. This is done by reviewing the existing and projected profile of consumers in the epidemiological review. For each of the different populations, estimates can be made regarding their utilization and the capacity of the system to serve them.

A well-operating system will not have a lot of excess capacity, but at the same time also will not have huge waiting lines. In addition, a well-operating system will ensure that there are adequate ways for people to feed into the system. Several factors need to be considered and figures will be available after completion of the needs assessment:

1. Knowledge of the potential number of consumers in the system so we can start to determine the capacity of the system. These include:
   1.1. General population
   1.2. Targeted population
   1.3. HIV positive in the system
   1.4. HIV positive out of the system
   1.5. PLWA early stages
   1.6. PLWA late stages

2. Knowledge of the insurance status of the consumer in order to determine how many seats of the different classes to install in the system. How many will be full-paying consumers (How many with insurance)? How many will be subsidized (Medicare, Medicaid, State or Federal drug reimbursement, etc.)? How many will be nonpaying (uninsured)?

3. For those subsidized consumers, it will have to be decided if there are more efficient ways to have them access the system. What services can be provided to those who have Medicaid and Medicare? Will managed care provide the access to needed services? How can those with private insurance best use the system to obtain the best treatment?

4. The planner of the system should have a good profile of the consumers in order to determine if the services will meet their different needs and demands. Consumers might be divided by:
   4.1. Ethnicity
   4.2. Special situation
   4.3. Risk population
   4.4. Sex
   4.5. Co-morbidities

5. The planners of the system should make sure that the consumer has direct input into the systems through the use of needs assessment surveys and participation on the various planning bodies.

Creating the Linkages

When planning the placement of service, and the opening of new services, the linkages between services are equally as important as the services themselves. There are competing objectives:

1. Reduce redundancy of administrative burden and services in the system while ensuring adequate access to those who live in distant areas.

2. Provide adequate input of services through multiple points of access. Think of this as designing a ticketing facility. For HIV and AIDS services, we need not only direct outlets (testing), but adequate links to emergency rooms, drug treatment, STD clinics, and acute care facilities.

3. Facilitate services while not overburdening the staff and capacity of the system.

4. Ensure continuity of services so that consumers find that they are able to move around the system and will not be stuck at any one station.

Training the Providers

Training providers and their staff is key to having a well-running system. Without trained staff and assurances that they have adequate benefits, any system will break down. Is there adequate formal and informal training? What is the benefit structure for the staff?

Informing and Training the Consumers

Informed consumers are the best consumers. What efforts are made to have them informed? Are the efforts coordinated?

Assessing the System

Every system should have standards. They might be divided into two basic areas:

1. How the system provides the services. For example common criteria include:
   1.1. Waiting times
   1.2. Quality of services
   1.3. Consumer satisfaction
   1.4. Ability to spend the allocated funds on the contracted services

2. Did the system have the desired outcomes?
   2.1. Health status: mortality and morbidity
   2.2. Quality of life

INPUT FROM THE COMMUNITY[7]

On February 24th, 1999 the PCH/OCP project team facilitated a community meeting to review the theoretical framework, present the models from other EMAs, and outline a proposed model for the Houston community. As a starting point, the group agreed to use the proposed model for discussion related to how this community would like to see the continuum of care represented.

In discussing the Houston COC, two groups were formed. One centered on prevention services and one on services to those who were infected or affected by HIV. Several questions were posed to the groups. These related to appropriate services, special populations, linkages, and training and support for providers and administrative agents.

The information from these groups will be used in conjunction with data from the consumer surveys, focus groups, and provider surveys in developing the final recommendations for the Continuum of Care.

What Should Be Modified on the Proposed Model Continuum of Care?

General comments from the participants indicated that the concept of viewing the continuum of care as service tracks that served six population groups (defined by their risk, exposure to, or point of HIV disease progression) was well received. There was some concern, however, that the track system as delineated suggests that services are time-linked in a linear fashion with one following the other. While the intent of the system is to show that it is nonlinear (people can get on or off the system at different stops and at any time), this was not clear from the analogy. Some participants also felt that the hierarchical Austin model made more sense for the Houston EMA.

Within the context of the "track" system, some participants felt that a better method would be to show the services grouped together (particularly for D and E) with entry to the universe of services at many different points. This would prevent the model from unintentionally misrepresenting how services are needed by, or available to, consumers who are HIV positive or diagnosed with AIDS. While the level of need may differ with the different diagnoses, the service itself is still required. Others felt that the tracks should only be seen as a reference point and should not be interpreted literally and also pointed out that some services do indeed have eligibility criteria based on severity of illness.

[7] A revised continuum of care reflects comments that the suggested continuum of care was too linear and the lined too "vertical". In addition, The difference between early and late treatment is visually closer. The outcome "death with dignity" was not revised after the Council felt that it best reflected the "end point" of late treatment. The services are limited to those funded under the existing Ryan White. Suggested additional services will be discussed in the forthcoming Needs Assessment.

Several comments noted the linear "look" of the system and suggested more intersecting "stations" and highlighting the major junctions and overlap of the "tracks." This change will be presented in the final recommendation.

There was also some concern expressed with the outcome "Death with Dignity" if the model were to be useful in working directly with clients. The consensus was that this designation should be changed if such use was anticipated. If the model is to be used as a planning tool only, it could be acceptable to leave the outcome as stated.

These issues will be addressed in the final model. Comments related to specific tracks on the model or targeted populations groups were also provided by the two groups. These are categorized according to the Tracks that are affected.

Specific comments regarding the tracks included:

Track A. Public Advocacy/Information: In addition to what is already represented on Track A, the population at large should receive general information through the media and mass marketing, as well as hotlines, that could provide basic information.

Track B. Outreach: In addition to the services mentioned as additions to Track A, the participants mentioned the need for:

1. Mobile clinics
2. Outreach workers and transportation services to allow persons to have post-exposure prophylaxis (PEP)
3. Counseling and testing
4. Health education risk reduction (HERR) services
5. Preventive case management
6. Individual and group preventive education
7. Support groups
8. Skill building opportunities
9. Job training
10. Education and housing assistance
11. Classes offered to couples with sero-discordance so that they may maintain their status and preserve their health
12. Needle exchange programs for high risk groups

Several participants noted that while many of these services were listed on Track C, they should be started earlier.

Track C. Prevention: The new services identified in B (job training, education, housing assistance, PEP, HERR, preventive case management, transportation services, mobile clinics, outreach workers) should be continued on this track. An HIV/AIDS vaccine would be appropriate here.

Track D. Early Treatment, Track E. AIDS Treatment, and Track F. End Stage Treatment: These tracks should be combined with multiple depots for entry into the system.

The services between D and E in particular should not be separated, as they are needed by both groups. In addition, access to services such as child care (infected and affected children) and mobile clinics should be included. Other services to include:

1. HERR
2. Permanency planning
3. Support groups (non professional - peer counseling)
4. Housing assistance (rent, locations)
5. Job training, education and employment assistance
6. Skill building to include empowerment and self advocacy
7. In-house recovery counseling
8. Transitional, scattered-site, congregate, or temporary housing (focus on women with children and consumers outside Harris county)
9. Nursing, social, and family-centered, as well as medical, case management
10. Medical detoxification and stabilization services

What Are the Primary Issues Related to Special Populations?

Prison Population

There is no consistent care in the penal system. Currently, there is no case manager at the Sheriff's Department to meet the needs of the HIV positive prisoners and soon-to-be-released population. Issues relate to mistreatment, being burned out on medicines, treatment complications, and many psychosocial problems. When they are released, there is no continuity of care or transfer of services. A serious gap in the delivery system exists between the time of release and when they are connected to a case manager and can apply to the Thomas Street Clinic.

HIV Negative Children of HIV Positive Adults

As this population is underserved, it is not clear how many children fall into this category. Both the HIV positive adults and the children are affected when there are no

services that can handle the needs of parents with children. This includes providing day care when the parent is in treatment and offering suitable transportation for both the children and the parent. Women often sacrifice their care in the long run in order to meet the needs of their children. These issues go back to the intake/assessment process in that the case manager needs to be able to refer outside of the system to take care of the children - a dual referral process. These children lose services after the death of their parent/s although some programs do have a grace period.

Older Adults

Older adults who have not become eligible for Medicare often cannot access the system. There is a need to have geriatric case managers to support this population group.

Adolescents

Adolescents, particularly those who are homeless, have special needs. Services that should be targeted to this group include peer groups, information on safer coming out and general counseling services regarding HIV status.

Recreational Drug Users

This group is particularly prone to indulging in risky sexual behaviors. They have a need for prevention services, including needle exchange programs, to ensure that they do not become HIV positive, or, if they are already positive, from passing the infection onto others.

Undocumented Persons

This group has been identified as one of three special studies to be included in the needs assessment. There are several major issues that impact this group of persons. First, the language and cultural barriers often preclude someone from seeking services. While Title I does not require documentation of citizenship, some agencies are confused about this. In addition, persons hesitate to approach agencies for fear of losing their anonymity and worry about the confidentiality of the information that they share with the agency. Building trust is a key issue and should be emphasized with all service providers. Providers also need to understand how cultural barriers other than language can impede the provision of services. Cultural competency extends beyond learning a new language.

Gay Males

Special attention should be paid to gay males for prevention services. These should include, prevention case management, skill building for safe behaviors, and relapse prevention services.

MSM/IDU

The Houston EMA, in comparison to the other EMAs described earlier (see Table 4), has a large percentage of clients in the MSM/IDU exposure category. Of particular importance is the need for needle exchange programs.

Sex Workers

Sex workers have special needs related to the frequency of potential risky behaviors. Prevention services are extremely important for this particular group.

Women of Color

This population group often does not seek services for a number of reasons: lack of access, fear of identifying self as HIV positive, limited resources, and all of the issues that impact parents of HIV negative children mentioned earlier.

Persons Returning to Work

Persons who have returned to work as their health status improves will often forego their health care because they do not want to take off work for doctor and/or clinic appointments.

Heterosexual Minority Men

This group may choose not to get services because they do not want to be identified as HIV positive. Special outreach efforts may be required.

How Do Linkages Work within the System?

Prevention Services

In the prevention discussion group, several issues were noted to improve linkages within the system on Tracks A and B. First, there should be transportation services that could get interested individuals to educational events. As clients come into the system, there should be a prevention case management system to ensure services are targeted and appropriate. A mobile outreach service could help identify potential at-risk clients who could benefit from prevention services. In addition, there should be better identification for referral services for the general public and at-risk populations.

Intervention and Treatment Services

The intervention discussion group noted the ***Centralized Patient Care Data Management System (CPCDMS***) as the new database that will facilitate access to integrated client

record management. It was noted that there has been misunderstanding and lack of communication about how the system will work. All Ryan White services will be connected to the system and other entities can purchase the software to become a part of the system. While the protocols for these linkages have not been established, this system is viewed as a potential solution to the ongoing issue of client record keeping. The further development and testing of the system over the next year will be an important step in building effective linkages in the Houston EMA.

A lengthy discussion was held about the advisability of having the client records reside with the client and moving from site to site with that person. However, issues of record loss and replacement make this an inadvisable method of client tracking and reporting.

Cross contracts between service providers have worked well to facilitate collaboration. However, there are several issues. It is often difficult to get like service providers to the table to collaborate. Competition over limited funding can be a barrier. Because of access to funding streams, alliances change from contract year to contract year. In order to do effective collaboration, one must know the agencies well, trust their intentions, and know their various agendas. There needs to be better methods of having this occur in order to facilitate more collaboration and joint case planning.

Single year funding is noted as a strong disincentive to collaboration, case planning, coalition building, and evaluation. Group members noted that multi-year funding is necessary for continuity of service alliances as well as client care. While it was recognized that HRSA mandates the project length, many felt that multi-year funding should be advocated for. There was a recommendation for 5-year funding with an end to the RFP process as it currently exists.

Planning, building effective services and ensuring quality care all require multi-year endeavors. Clients are often hurt as one agency loses funding and another picks up the client base. In competitive funding, when an application is not accepted for renewal, valuable information is often lost and valuable time is spent in reinventing the wheel to recreate the client's service history. Clients are often loyal to case managers, not the agency. Information is lost in the transition to new services. Under current rules, this transition must take place in too short a time frame - the current 30 day Title I time period needs to be extended if multi-year contracts are not a possibility. Clients often abandon the system in these transition periods. It is not appropriate to ask case managers to make up for dysfunctional systems. Rather, these complex linkages must be improved.

There was a recommendation to explore a **voucher system** that would allow money to go to a client who could then purchase services when and where needed rather than having the funds go to the agencies through a competitive bid process. In addition, not enough clients are applying for Medicaid. They are often in the Ryan White system because it is easier to sign them up for those services. There are outside funds and State tax funded services that could be available to clients if they would access them. Better linkages

between all types of services would facilitate more appropriate utilization of both treatment services and funding streams.

One additional issue was noted: There needs to be continued efforts to develop **standards of care** and to ensure that services actually reach these standards. Follow-up and quality of care evaluations are needed to ensure that the service delivery system is working well on behalf of clients - both the individual services within the system as well as the linkages that are developed to integrate the many and varied service categories.

What Services Should the COC Include for Providers and Administrative Agents?

Benefits and Perks

A primary need identified by both discussion groups was a benefits and perks package to include health insurance, retirement, and workmen's compensation. By doing this as a pool of providers, premiums could be reduced and there would be less likelihood that workers would lose benefits as they transferred from one agency to another.

Staff Training

Another area identified by all participants relates to staff training. This is needed in several different areas. First, bereavement training - the cost of caring - to help identify and mitigate the stress of working with a population that often experiences death. There was a recognition that there is a difference between those providers who live with AIDS themselves and those who do not and how they relate to clients and handle client issues and their own mortality.

Additional training should be offered in the area of cultural competency, enhancing the quality of care, fund raising, supervision skills, good management practices, and resource and referral issues, such as using Medicaid and accessing United Way services. It was noted that the Council has just approved an allocation of funds for case management training. In addition, there should be contract requirements to provide ongoing staff development training.

Interagency Meetings

Participants suggested that more meetings among agencies would not only improve linkages for clients, but also provide the opportunity for developing individual and organizational skills through joint in-service training and case collaboration.

Integrated Funding Streams

Individual funding streams often lead to fragmented care as an agency may be covered for one type of service but not another. While some agencies might have the expertise to

provide the additional services, they often do not have the resources or may not wish to assume the liability of taking on the additional work without reimbursement or contractual authority to do so.

Technical Assistance

A technical assistance program that would allow agencies to call for specific help in addressing a time-limited, discrete problem could help improve service delivery and client outcomes.

Central Referral System

When agencies identify a problem or issue with a client that they themselves cannot address, it is not clear who they should call to get the appropriate service for that client. A central referral source that has access to client records and care plans would facilitate effective service provision for both service providers and their clients.

Geographical Coordination of Services

Case management is about more than just race/gender/family type, etc. It is also about community. If services were more geographically coordinated, there would be fewer transportation problems and better linkages. Originally, the service delivery system was developed from an emergency response, and it still does not reflect a client-needs perspective. Resources began as a cluster around a central area and 15 years later it remains the same. Retooling the system could improve quality of care and client access.

Provider Survey

It was noted that a provider survey to identify provider needs would be very helpful in identifying what issues need to be addressed. The surveys that have been done often go to top level management who may not understand the needs of line staff. The survey should be broad based to identify needs at all levels within the service provider system.

NEXT STEPS

This is a working document in the continued development of a Houston Area HIV/AIDS Continuum of Care. This document will be submitted for review to the community for their review and comments.

Comments will be incorporated into the final draft, and if the community is interested in working with the recommended framework, a second community workgroup will be facilitated by the consultants.

The recommended framework will be used as a context for the information being collected in the needs assessment consumer and provider surveys and focus groups. To the degree possible, as suggested in Working with the Continuum, page 26, the service needs, gaps and barriers will be quantified for the continuum of care. The final model will then be developed and presented along with the full needs assessment report.

Attachment 1 Mission and Vision Statements

Missions

The mission of the Ryan White Planning Council is to "improve the quality of life and advocate for those infected and/or affected with HIV/AIDS by taking a leadership role in the planning and assessment of HIV resources."

The Houston HSDA Care Consortium has the following as its preamble: "We, the members of this Consortium, commit to each other that we will endeavor to provide the highest quality services to our patients and clients. We pledge to cooperate together through honest debate and discussion in order to coordinate and deliver the funded services in a most efficient and effective manner. This Consortium does not tolerate prejudice in any form. No member of this Consortium shall discriminate on the basis of one's race, color, creed, gender, religion, sexual orientation, disability, or age."

The Community Planning Group (CPG) Mission: "Our mission is to develop a comprehensive prevention plan (the plan) to present to the Houston Department of Health and Human Services (HDHHS) as a guide for their HIV prevention efforts. Our task is to study the issues surrounding the HIV epidemic and provide input to HDHHS through the development of the plan. The plan addresses specific HIV prevention needs of various populations based on their 'high-risk' sexual and drug using behaviors. The CPG recognizes that BEHAVIORS put people at risk, not their particular race, ethnicity, or sexual orientation."

Visions

The vision of the Ryan White Planning Council is stated thusly: "We envision an educated community where the needs of all HIV/AIDS infected and/or affected individuals are met by accessible, effective, and culturally sensitive health and psychosocial services that are part of a full coordinated system. The community will continue to intervene responsibly until the end of the epidemic."

System Goals and Client Outcomes

In addition to these mission and vision statements, the Ryan White Planning Council has established three goals to direct their efforts. These goals also help to define the COC in the Houston EMA. They are:

1) Collaborate with and utilize information from all constituencies to plan and deliver high quality and cost effective care

2) Identify and provide services to unserved and underserved populations

3) Promote the dissemination of information on HIV prevention, treatment and resources

Attachment 2 Visual Models of Continuums of Care