DALLAS EMA, HSDA, EMSA

COMPREHENSIVE HIV SERVICES PLAN

Prepared for

Dallas County Health and Human Services, Ryan White Planning Council of the Dallas Area and the Ryan White Consortium of North Texas

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[1] B. Cabrera, R. Holcomb, J. Jordan, H. Lacy, W. Longoria, S. Moreno, L. Parhams, J. Schield, E. Webb, and G. Willett.

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ACROYNMS

ADAP	AIDS Drug Assistance Program
AETC	AIDS Education Training Center
ASOs	AIDS Service Organizations
CDC	Centers for Disease Control and Prevention
COC	Continuum of Care
Consortium	Ryan White Consortium of North Texas
RWPC	Ryan White Planning of the Dallas Area
DHHS	Department of Health and Human Services
DCHHS	Dallas County Health and Human Services
EFA	Emergency Financial Assistance
EMA	Dallas Eligible Metropolitan Area
HIPAA	Health Insurance Portability and Accountability Act
HIV-HOPE	HIV Health Options to Promote Employment Project
HMP	Health Maintenance Plan
HOPWA	Housing Opportunities for People with AIDS
HPSA	Health Personnel Shortage Area
HRSA	Health Resources and Services Administration
HSDA	Health Services Delivery Area
HUD	Housing and Urban Development
IDU	Injection Drug Users
MHI	Median Household Income
MOU	Memorandum of Understanding
MPP	Medication Plus Project
MRI	Medication Reimbursement Initiative
MSM	Men-who-have-sex-with-men
MUA	Medically Underserved Area
OI	Opportunistic Infection
PHS	Public Health Service
PLWA	Person(s) Living with AIDS
PLWH/A	Person(s) Living with HIV and AIDS
PPG	Prevention Planning Group
PTSD	Post-traumatic Stress Disorder
RW	Ryan White
RWCA	Ryan White Care Act
SAMHSA	Substance Abuse and Mental Health Services Administration
SRO	Single Room Occupancy
STD	Sexually Transmitted Disease
TB	Tuberculosis
TDH	Texas Department of Health

INTRODUCTION

How to Use This Plan – What is Included

The Plan is about what, why, and how changes are made to the service system to improve the health and quality of life of PLWH/A.

This Comprehensive Services Plan presents a set of decisions about what, why, and how changes are made in HIV/AIDS care services to achieve the vision and values of the RWPC/Consortium. It is about what is important in improving the health status and quality of life of people living with HIV and AIDS (PLWH/A). The April 2001 version is an update to the Plan first developed in 1998. It updates information in the previous plan and adds a contextual framework for estimating unmet need.

The Plan is flexible and responsive It should be re-assessed and updated annually.

The Plan provided information needed to assess and modify the Continuum of Care (COC) for HIV/AIDS services to meet the continuing, new, and unmet needs and barriers to services. It is like a road map with suggested routes to desired outcomes. It is not a detailed set of specifications to be followed; rather, it is a flexible and responsive approach to addressing key questions and must be assessed annually relative to changes in the medical/clinical, financial and legislative environment, the epidemic, and the needs of PLWH/A.

In the accompanying 2001 Needs Assessment among PLWH/A, a framework for measuring unmet needs is detailed. The key elements are shown below:

Service need or absolute need	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.
Perceived need and demand	Perceived need and demand of PLWH/A for services based on qualitative and quantitative data is highly correlated.
Fulfilled need	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.
Service capacity	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.

Unmet absolute need	This refers to a need-capacity gap and is the difference between the number needing a service and the capacity of the system.
Unmet perceived need	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.
Unmet demand or perceived excess capacity	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.
Need-demand gap	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.

The Needs Assessment survey estimated the perceived need and demand and the service section presented estimates of service need and fulfilled need.

This Plan further details those estimates based on a review of the epidemiology and advances the process of estimating capacity, in order to better determine what services have unmet needs.

Over time, it is expected that the RWPC/Consortium will continue to modify the Plan based on their experience or on changes in the epidemic that suggest new or altered routes to achieve their overall mission.

The Plan is organized into three chapters that respond to three major planning questions that provide information on estimating need and unmet need.

Chapter I: Where are we now?
Chapter II: Where should we be going?
Chapter III: How will we monitor and evaluate our results?

The Plan is a series of questions and answers about the epidemic in the Dallas EMA.

Within each chapter there are a series of detailed questions that are addressed. Taken together, these responses form the basis for the critical success factors that lead to the fulfillment of the RWPC/Consortium's vision and values. Each critical success factor is accompanied by an action plan that states the desired outcomes, objectives, actions, and indicators for outcomes.

Chapter I answers "Where are we now?"

The five sections in Chapter I build a foundation for assessing the need for different services.

Section A outlines the existing COC. This is the referent for the services that are being provided to PLWH/A.

Sections B and C of Chapter I focus on the epidemiology of HIV and AIDS in the Dallas EMA. They answer:

- Who has HIV and AIDS in the Dallas EMA and what have been past trends?
- How can we characterize PLWH/A now and in the future?

Together these provide the information to estimate theoretical need.

Section D specifically addresses those out-of-care. It reports the results of interviews and focus groups with out-of-care PLWH/A and suggests some strategies moving PLWH/A into care.

Section E provides a resource inventory. It answers, "What services and resources are currently available in the Dallas area?" It provides the information for estimating capacity.

Section F answers, "What are the unmet needs and service delivery barriers that are creating gaps in services?" This section summarizes the perceived needs, unmet needs, and barriers. It provides a service-by-service review of unmet need.

In summary, Chapter I contributes to the process of identifying several types of needs:

1. The number, type, and location of people who need a service (service need);
2. The capacity of the system to service clients (service capacity);
3. The profile of needed services and the number of people who use those services (demand);
4. Estimates of people needing care and the capacity of the system to serve them (unmet need);
5. Estimates of the number demanding services and the ability of the system to serve them (unmet demand);
6. Estimates of the people not seeking care and the number needing care (need-demand gap).

Chapter II discusses "Where should we be going?"

Chapter II discusses Dallas EMA's response to the question, "Where should we be going?"

Section A states the RWPC/Consortium's shared vision. Section B states the RWPC/Consortium's values for the way in which PLWH/A should experience the service system.

Section C answers, "How will we develop short term (annual) and long term service objectives, service priorities and allocated resources?" The RWPC/Consortium had identified the core competencies and weaknesses of the existing service system in 1999 and they were reviewed and updated for this Plan. Based on the epidemiology and needs assessment, success factors are identified which are considered critical to making responsive changes in the service delivery system and achieving the vision.

Chapter III puts forth "How will we monitor our progress and results?"

Chapter III answers, "How will we monitor our progress and results?" It suggests measures and methods to assess the accomplishments of the critical success factors and suggests a timetable for the delivery of the activities that will result in improving the health status and quality of life of PLWH/A.

What is Not Included in the Plan

The Plan does not make future decisions

The plan does not attempt to make future decisions. While it involves anticipating the future environment, the decisions are made in the context of the present. The Plan provides a wealth of information and highlights trends, but it does not replace the exercise of judgment by leaders; it does facilitate creative and sensible decision-making based on factual qualitative and quantitative information.

I. WHERE ARE WE NOW?

A. What Is The Existing COC In Our Community?

A shift from acute and end-stage care to chronic care.

AIDS has evolved from an acute and fatal disease to a severe chronic disease that has difficult medication adherence requirements and expensive medical regimens.

Before protease inhibitors and combination therapies, the goal of AIDS care services was to prolong the lives of persons living with AIDS (PLWA) while sustaining a reasonable quality of life. Resources were allocated to manage opportunistic infections (OIs) and prepare PLWA and their families for the fatal consequences of AIDS. Services were funded to educate PLWA about, and provide them with, prophylactic medication to reduce the number of OIs and medication to cure or control OIs and to suppress HIV. Support services were provided to assure that treatment was accessible and effective.

Care goals:

Education about treatment options;

Providing treatment;

Monitoring outcomes;

Modifying, sustaining and enhancing support systems;

Maintaining quality of life;

Preparing those who don't respond to medication for death.

Today, the majority of the resources are allocated to sustain the lives of PLWH/A, and the HIV/AIDS service COC emphasizes:

- Educating PLWH/A and their providers about the treatment of a serious chronic disease that requires complex medical regimens;
- Providing coordinated ongoing treatment;
- Monitoring the effectiveness of treatments and changing them when necessary;
- Modifying, sustaining, and enhancing support systems that provide access to care;
- Maintaining a reasonable quality of life that provides PLWH/A with basic health care and social services;
- Providing those who do not respond to medication with services that prepare them and their families for the debilitating and, often, fatal consequences of AIDS.[2]

Treatment must be available, accessible, affordable and appropriate.

To achieve these outcomes, there is a need to make treatment appropriate, available, accessible, and affordable.

Today the care system will have to accommodate more than double the number of clients seen in 1994.

In the past, the vast majority of care has focused on PLWA, and as shown in the Epidemiological Profile & Trends, they will increase from about 2500 in 1994 to over 6000 in 2003. Today there is also an increasing need to provide care to those persons who are infected with HIV and need early treatment and care. The result is that the care system will have to accommodate more than double the number of PLWA seen in 1996, and, depending on outreach, up to 8,000 PLWH/A in 2001.

[2] Because not everyone tolerates the new treatments, and even those on medication are vulnerable to OIs, there is a continuing need for services to be provided to those who will die from AIDS.

HIV/AIDS COC In Dallas

Table I-1 shows the HIV/AIDS COC in Dallas.

Table I-1 HIV/AIDS COC in Dallas

Medical Services	Support Services	Access Services
Medical Care	Housing Facility Operations	Short/Long Term Rental
Medical Case Management	Food Pantry	Transportation
Drug Reimbursement	Congregate Meals	Case Management
Transportation of Medicines	Home-Delivered Meals	Client Advocacy
Dental Care	Legal Services	Insurance Assistance
Home Health Care	Day/Respite Care for Adults	Information and Referral
Hospice Care	Day/Respite Care for Children	Access for Underserved
Mental Health Counseling	Buddy/Companion Services	Interpretation Services
Substance Abuse Treatment		

At the center of the COC are core services which are vital to the health and well-being of PLWH/A.

The HIV/AIDS service COC provides essential services that sustain the health, life, and well-being of PLWH/A. Core services are considered medical services. Given the increasingly complex treatment regimens, there is also a central need for medical case management, referrals, and treatment education/access. The services of medical care, medical case management, dental care, mental health counseling, home health, hospice, substance abuse counseling, drug reimbursement, and transportation of medicine provide treatment for HIV infection, and AIDS-related conditions.

Targeted services to special populations are part of the COC.

Selected services that are targeted to special populations are also a part of core services. While proportionately there are relatively few IDU, pediatric, adolescent, mentally ill, and (with the effectiveness of the new medication) acutely ill PLWH/A, services for these individuals are critical to maintain and improve their quality of life. Services such as substance abuse treatment, mental health counseling, hospice care, home health care, and pediatric care are targeted services within the COC for these special populations.

Other services central to the stability and quality of life of PLWA are housing and food. Without stable housing or adequate nutrition, PLWH/A will be unable to sustain treatment regimens and they will have a poor quality of life.

Support services serve to assure that a person has their basic needs met and overcome barriers that allow PLWH/A to access the core services.

Support Services serve to assure that a person has their basic needs met and overcome barriers that allow PLWH/A to access the core services. The services of adult day care, services for children and adolescents, food pantry, congregate meals, delivered meals, volunteer support, legal, and housing (HOPWA funded) provide for basic needs of daily living, which

if unmet, complicate the lives of PLWH/A, and function as barriers to accessing and remaining in health care services.

Ensuring access to services is a component of every COC framework.

An essential part of providing non-prejudicial services is the accessibility of services to everyone who is entitled to them. These include services such as case management, transportation, and legal services. Outreach and follow-up for the un-served and under-served should have an outcome of improving accessibility to services.

Access services ensure that PLWH/a have the information and ability to access care.

Access Services ensure that PLWH/A have the information and ability to access appropriate service. Information and referral, comprehensive case management, client advocacy, transportation of people, access for underserved populations, interpretation, insurance assistance, and emergency financial assistance services have the primary function of resolving other barriers which preclude clients from accessing core services. They provide needed information, health insurance, a means of referral for needed psychosocial services, or transportation to sources of other services.

To date, the COC has been built by adding services onto the original core set.

This COC framework developed by the RWPC/ Consortium has largely evolved over time by adding services that were increasingly needed by PLWH/A. The Dallas EMA's COC is designed to meet the needs of PLWH/A including those that are unable to afford them, or that cannot be met by use of other available resources.

The existing continuum does not suggest the process by which PLWH/A access services nor the complementary relationships between services.

Coordination, collaboration and data sharing require capacity-building, and some infrastructure.

Criteria for the continuum of care should be that it improves the health status and quality of life of PLWH/A.

Coordination, collaboration, assessment, and data sharing require the development of infrastructure among service providers. Understanding the most current protocols and ramifications for coordinated services will be facilitated by improved provider access to the latest treatment information through on-line technologies, and the ability of providers to monitor and track clients and share information. Sharing information will be facilitated by the successful implementation of a common data collection system. The success of collaborations can be assessed through the evaluation of referrals and health status outcomes.

The success of the COC can be measured.

Several outcomes can be used to measure the success of the COC including:

- Physiological indicators of health status such as mortality and morbidity;
- Psychosocial indicators, including quality of life measures;
- Quality assurance indicators to assure that a high and equal standard of service is provided to all PLWH/A;
- Organizational indicators to track cooperation and collaboration

and the level of expertise between and among DCHHS and providers;
- Efficiency indicators such as unit costs for services;
- Process indicators to assure that services are being obtained by targeted populations throughout the Dallas EMA.

Not all outcomes are quantifiable. The COC provides a guide for the RWPC/Consortium in providing services. Indicators of success are the usefulness of the COC in guiding decisions by the RWPC/Consortium, and the degree to which it is used as a referent to meeting the shared vision and values of the RWPC/Consortium.

The utility of the COC is also seen in the way in which PLWH/A understand the services provided. A consensus in continuum of care often leads to more complementary services and less competition and divisiveness among providers and PLWH/A.

The COC is evolving from meeting the needs of an end-stage illness to meeting the needs of those with a chronic disease.

The SCSN has recommended a new way to describe the COC that provides for more explicit outcomes and included prevention. This may be an appropriate revision for the next year as the continuum moves from an end-stage illness system to a chronic disease system. In addition HRSA has required that the COC reflect greater coordination with prevention services, reaching those out-of-care, and provided coordinated services for substance abuse.

B. Who has HIV infection & AIDS in the Dallas EMA/HSDA and what have past trends been?

The majority of PLWH/A in the Dallas EMA reside in Dallas County

The Dallas EMA/HSDA[3] covers a 4,000 square mile area of north central Texas. The EMA, as defined for eligibility by Ryan White Care Act (RWCA) Title I, has expanded to include four additional counties, three north of Dallas, and one South of Dallas. The complete list of counties that now make up the Dallas EMA/HSDA are: Collin, Cooke, Dallas, Denton, Ellis, Fannin, Grayson, Henderson, Hunt, Kaufman, Navarro and Rockwall. As of July, 1999 at least fifty-nine percent of the EMA's total population resided in Dallas County, the heart of the EMA. As shown in Figure I-1, 93% of all People Living with AIDS (PLWA) reside in Dallas County and, as might be expected, the greatest amount of 1998-1999 RWCA funds were specifically allocated to agencies located in Dallas County, many of them serving the larger EMA.

[3] The Dallas EMA is a Health Resources and Service Administration (HRSA) designation and covers the same area as the Dallas EMSA (Eligible Metropolitan Statistical Area), a Census Bureau designation.

Dallas was among the first wave of EMAs to receive RWCA funds

The Dallas EMA was among the first generation of EMAs to receive Title I funding in 1991 and reflects a disproportionate share of AIDS cases compared to other metropolitan areas in the United States.

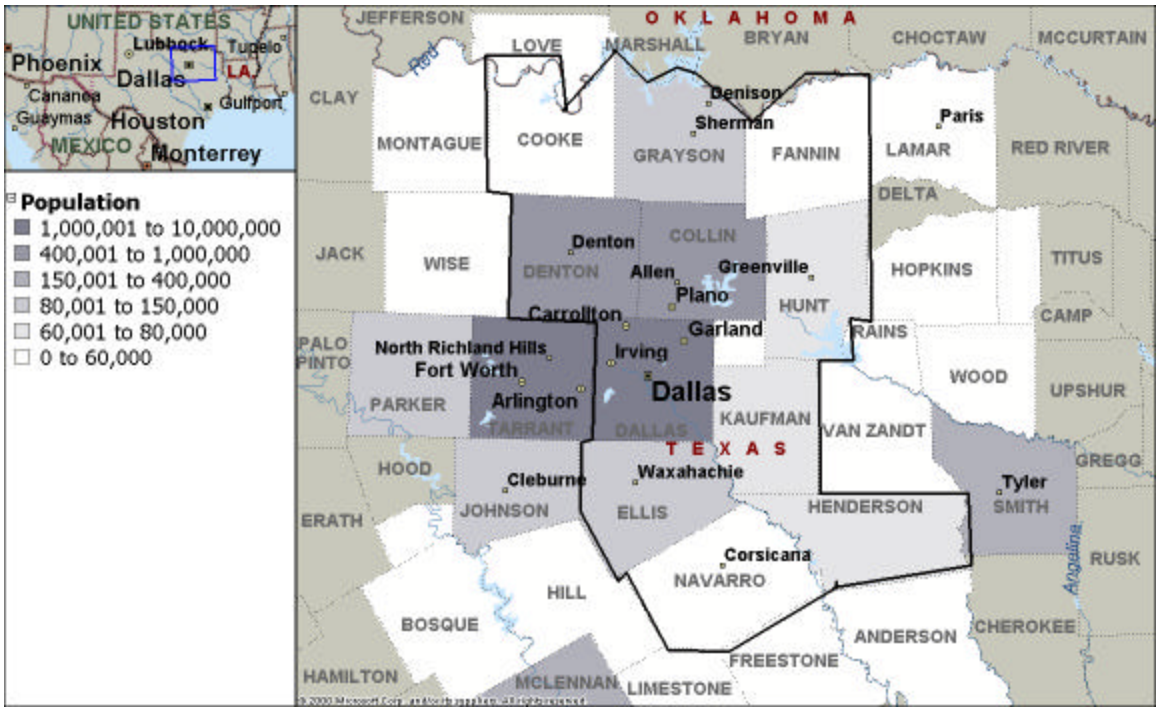
Before a description of those living with AIDS is provided, a general demographic profile for each county provides contextual information, especially as it relates to their availability of health care resources.

The county descriptions include several State and Federal designations that are defined below.

A Health Personnel Shortage Area (HPSA) includes a geographic area, population groups and facilities recognized by the United States Department of Health and Human Services (DHHS) as having an acute shortage of three professions that are recognized by this program:

- Primary medical care professionals;
- Primary care dentists – general and general pediatric specialists;
- Mental health professionals.

Figure I-1 Map of Dallas Area



There are three major components of a HPSA:

1. A rational service area that is usually a county or a subcounty area;
2. The population to physician ratio;
3. Access to primary care resources in surrounding areas.

A Medically Underserved Area (MUA) is a designated area that has a shortage of personal health services for either the entire area population or a specific population group in the area. Criteria are based on the percentage of elderly people (65 and older), poverty rates, infant mortality rates, and the ratio of primary care physicians per population (1000).

A subcounty area is used as a designation when there are gaps in availability and access to services, but not for an entire county. For example, there may be enough physicians in a county to serve the whole population, but some sub-populations do not have appropriate access or availability of services. A subcounty area can be a population or a facility that is serving a population. For example, a prison can be designated as a subcounty area.

The profiles are based on 1998 data provided by the Texas Department of Health (TDH).[4]

County Profiles:

County Profiles

Collin County

Collin County has sizable Medicaid and Anglo populations.

The overall population of Collin County is now estimated at 429,414. This figure represents a change of 19.1%, or an additional 81,991 residents in the county since 1995. Anglos now represent 83.8%; Latino's represent 8.0%; African Americans represent 3.9%, and 4.3% were represented by "other" ethnicity. In terms of changes in population, Latino and "other" ethnicity had the largest increases in their proportional representation of the overall county population. Collin County has a relatively low unemployment rate of 2.1%, which is a decrease from the county's 3.3% level in 1997. The rate is also lower than the state rate of 4.8%, which has dropped from 6.0% in 1995. Total Medicaid expenditures have increased from $36.9 million in 1997 to $40.2 million in 1998. About 11,913 Collin residents were unduplicated Medicaid eligibles in 1998, a drop of 20% from 1995 levels. There were 500 direct patient care physicians in 2000 (a ratio of 1 per 795 residents), an increase of three from 1995. There are currently 103 participating Medicaid physicians in the county, an increase of 17 from 1995. Acute care hospitals have increased from four to six as of 1998.

[4] 1998 was the last year for which this type of information was available.

Cooke County

Cooke County is one of four rural counties added to the Dallas HSDA in 2000.

Cooke County is one of four counties that have been added to the Dallas EMA in 2000. It ranks 76th in size compared to other Dallas counties. It has a total population of 33,780. The County demographic profile is 88.1% Anglo, 6.7% Latino, 3.8% African American and 1.4% other race/ethnicity. Cooke County's unemployment rate of 3.3% is at a level consistent with that of other counties in the HSDA and is lower than the statewide rate of 4.8%. Total Medicaid expenditures are $12.5 million, approximately 0.2% of the statewide total. There are 4,001 Medicaid eligible in the county, with 14 Medicaid participating physicians out of 21 direct patient care physicians, a ratio of one physician per 1,609 county residents. The County has two acute care hospitals and five nursing homes. No areas/populations in Cooke County were designated as a HPSA as of 2000, although all of the county was designated as a MUA.

Dallas County

Dallas County, by far the epicenter of the EMA's AIDS epidemic, has the largest population and resources of all counties in the EMA.

According to 1998 estimates, Dallas County now has a population of 2,052,457, a 3.5% increase from 1995. Dallas is by far the largest county in the EMA and the second largest county in Texas. In contrast to more rural Collin County, in 1998, 56.9% of Dallas residents were Anglo, 19.7% African American, 20.1% Latino, and 3.3% other race/ethnicity. As in Collin County, the greatest increase in Dallas residents was among Latinos, with the largest decrease among Anglos. The unemployment rate continues to decrease in the county, falling from 5.0% in 1995 to 3.6% in 1998. Total Medicaid expenditures in Dallas were $544.4 million of the state total of $7.1 billion. On average, Dallas' monthly food stamp recipients accounted for about 7.0% of the statewide monthly average, a decrease from the 8.6% average in 1995. There are now 222,327 people who are Medicaid eligible in the County, a 16% decrease from the 1995 level of 263,386. Direct care physicians have increased from 3,742 in 1995 to 4,133, comprising approximately 14% of the total statewide. That is about one physician per 497 Dallas residents. There is an abundance of acute care hospitals, 34 in total, and 62 nursing homes. Some subcounty areas are designated as HPSAs and MUAs.

Denton County

Denton is the second largest county in the EMA with a poverty population that is designated as Medically Underserved.

Denton County has a smaller population of 390,951 residents. Since 1995, the population of Denton County has increased by 14.2%, or an additional 55,657 residents. Overall, 83.6% of residents were Anglo, 8.2% Latino, 4.7% African American, and 3.5% other ethnicity. Keeping with the trend in population changes seen in other Dallas

EMA counties, Denton's Latino population has increased more than any other group over the period 1995 to 1998. The unemployment rate fell from 3.5% in 1995 to 2.0% in 1998. Total Medicaid expenditures were $102.8 million, about 1.4% of the statewide total, and a 12.5% increase over 1995 levels. In Denton County, 14,114 people were eligible for Medicaid, a decrease of 27.5%; there was one direct care physician for every 1,265 residents. In total, there were 309 direct care physicians, an increase from 1995 of 58; four acute care hospitals, and 13 nursing homes. Subcounty areas or populations in Denton are designated as HPSAs, and the poverty population is designated as a MUA.

Ellis County

Ellis County has a small population, and has MUAs, but no Health Professional Shortages.

With an estimated population of 103,900 residents in 1998, Ellis County is ranked 32nd in size in Texas. Since 1995, it is estimated that Ellis County's overall population has increased by 11.6% or an additional 12,063 residents. Of the population, 74.8% were Anglo, 15.5% Latino, 8.8% African American, and less than 1% other. The unemployment rate of 3.6% was lower than the statewide average of 4.8%, and continues the trend of lower unemployment figures seen in other counties in the EMA. Medicaid expenditures were approximately $32.7 million and 10,030 unduplicated Medicaid eligibles were reported. Overall, there were 66 direct care physicians, and increase of nine over 1995 levels, representing one for every 1,574 residents. While there is only one acute care hospital in the county, there were seven nursing homes. These figures have not changed since 1995. Ellis County had sub county areas that were designated as MUAs, but no HPSAs.

Fannin County

Fannin county was recently added to the HSDA and is the smallest in terms of population of any County in the HSDA.

Fannin County is the smallest county in the HSDA in terms of population size, with only 28,088 residents as of 1998. It is also a recent addition to the EMA. The unemployment rate, as in several other counties in the HSDA, is the same as the statewide rate of 4.8%. The county makes up 0.2% of statewide Medicaid expenditures at $15.3 million. There are 3,627 individuals eligible for Medicaid in the county; 11 direct patient-care physicians, and the county has the highest ratio of population per physician of any county in the HSDA with one per 2,553. There is only one acute care hospital in Fannin County and six nursing homes. All of Fannin County was designated as a HPSA and as a MUA.

Grayson County

Grayson County is a recent addition to the HSDA and ranks 33rd overall in size statewide.

Grayson County, a third addition to the HSDA, is ranked 33rd in the state with a population of 103,444. The county's population is 83.6% Anglo, 7.7% African American, 6.1% Latino, and 2.6% other ethnicity. The county's unemployment rate matches that of the state at 4.8%. Medicaid expenditures were $50.4 million and a total of 12,750 residents were Medicaid eligible with 81 Medicaid participating physicians available. Overall, the county has 158 direct care physicians, a ratio of one per 655 residents. There are four acute care hospitals and 14 nursing homes in the county. No areas/populations in Grayson County were designated as a HPSA. Some subcounty areas/populations are considered MUAs.

Henderson County

Henderson County is ranked 46th in size in Texas with an average unemployment rate. It is designated as "Medically Underserved".

With a 1998 estimated population of 68,296, Henderson County has seen a 6.4% increase in its population since 1995. Overall, Henderson County is ranked 46th in size of all Texas counties. Of the population, 86.4% was Anglo, a slight decrease from 1995 estimates, 7.2% were African American, 5.8% were Latino, a 1% increase and the largest increase in any population in this county since 1995, and less than 1% were another race/ethnicity. The unemployment rate of 4.1% is lower than 1995 levels, and nearly matches the statewide average. There has been a slight increase of total Medicaid expenditures from $28.4 million in 1995 to $30.8 million in 1998. The number of Medicaid eligibles dropped, as in most counties, from 10,342 residents in 1995 to 9,549 residents in 1998. There is only one acute care hospital, and 46 direct care physicians, one per 1,485 residents and an increase of eight physicians over 1995 levels. Henderson County has subcounty areas or populations which were designated as HPSAs, and the County is no longer a MUA, as it was in 1995.

Hunt County

Hunt County is similar to Henderson County, in profile.

Hunt County has dropped from 43rd to 44th in size of all Texas counties, even though its population increased 3.2% to 70,308. Demographics for Hunt County are fairly consistent with those for Henderson. The overwhelming majority (82.5%) of residents were Anglo, followed by African Americans (10.7%), Latinos (5.8%), and then other race/ethnicity (less than 1%). Unemployment has dropped from 6% in 1995 to 3.9% in 1998. Medicaid expenditures increased from $25 million to $28.9 million over the period 1995 to 1998, and represents 0.4% of the statewide total. Medicaid eligible persons dropped from 10,077 in 1995 to 9,131 in 1998. The County's participating Medicaid physicians decreased from 30 to 21 out of a

total of 46, providing one physician for every 1,528 residents. While there were two acute care hospitals, there were also seven nursing homes. Hunt County is a designated MUA and a HPSA.

Kaufman County

Kaufman County has a very small population, with a lower than average unemployment rate, no medical professional shortage, but some areas are medically underserved.

Kaufman County is now ranked 48th in the state, due to a 10.6% increase in population to 65,002 in 1998. The majority was Anglo (78.3%), followed by 12.4% African American and 8.3% Latino. Since 1995, the African American population has decreased in size, while the Latino population has increased. The unemployment rate in 1998 was 4.3%, only a slight decrease from the 1995 level of 4.4%, one of the smallest decreases in any of the EMA's counties. Of the residents, 7,318 were Medicaid eligible, and there were 29 Medicaid participating physicians out of 63 direct patient care physicians, providing one medical doctor for every 1,032 Kaufman residents. The County has subcounty areas that are designated as MUAs but has no HPSAs.

Navarro County

Navarro County has the highest unemployment rate of any of the counties in the Dallas HSDA.

Navarro County, another recent addition to the Dallas HSDA, has a population of 42,836, ranking it 64th in the state. The majority of residents are Anglo (70.4%), followed by African Americans (18.7%), Latinos (9.7%) and other race/ethnicity (1.2%). The unemployment rate in the county is one of the highest of all the counties in the HSDA, at 5.2% and is the only county whose unemployment rate is higher than the statewide rate of 4.8%. As of 1998, there were 7,246 Medicaid eligible persons in Navarro County. There are 52 direct care physicians, of which 34 are Medicaid participating. The county has one acute care hospital and seven nursing homes. All of the county was designated a MUA, although no areas/populations are HPSAs.

Rockwall County

Rockwall County ranks very low in Texas in population size, while its unemployment is low, and it is not MUA or HPSA.

Rockwall County is now ranked 68th in Texas, as opposed to its 1995 ranking of 76. It continues to have a relatively small population of 38,420, a slight increase over 1995 levels. Of these, in 1998, 88.4% were Anglo, 7.6% were Latino, and 2.7% were African American. About 1% was other race/ethnicity. Their unemployment rate continues to be approximately half the statewide average at 2.1%. Slightly over 5% of county residents are Medicaid eligible (2,083). Rockwall County has 74 direct care physicians, of which 21 are Medicaid participating. There is one acute care hospital, and three nursing homes. Despite these small numbers, the County does not have a HPSA and has no MUAs.

Income and Poverty: Planning Area[5]

There is great disparity of wealth within the Dallas EMA.

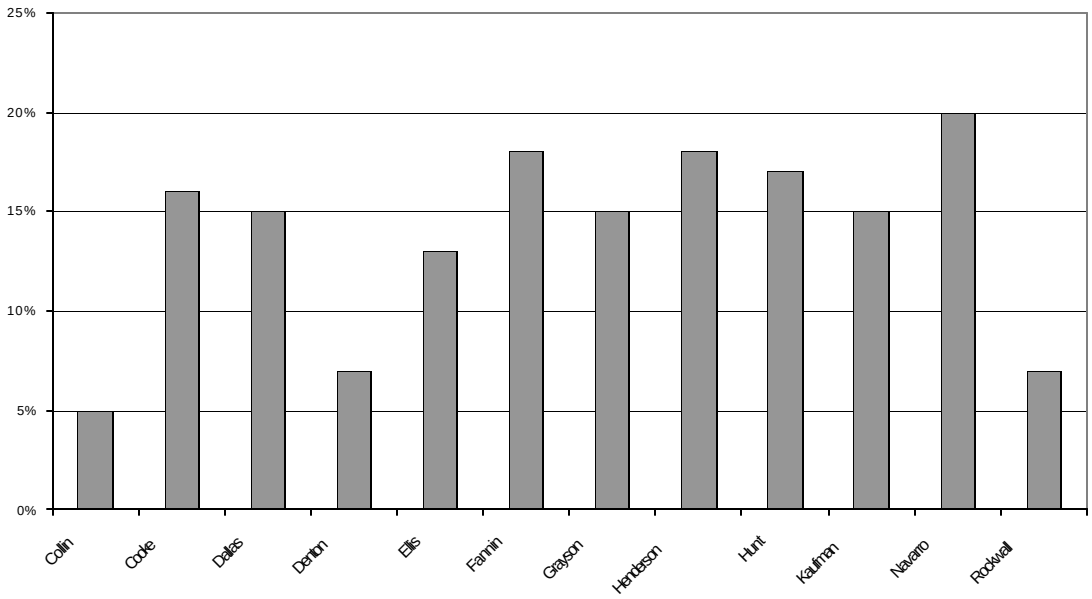
Median household income (MHI)—the amount which divides the income distribution into two equal groups, half having incomes above that amount and the other half having incomes below that amount—varied significantly between counties in the Planning Area. In 1997, the most recent year for which MHI by county was available, MHI spanned from Navarro County ($28,217) to Collin County ($65,814). The MHI for Dallas County in 1997 was $40,960

Dallas Co. has the most residents living in poverty. Fannin, Henderson, Hunt, and Navarro Co. had the highest % living in poverty.

Dallas County had the most residents living in poverty in 1995, while Fannin, Henderson, Hunt, and Navarro Counties had the highest percent of people living in poverty. Of note is that these same four counties—Fannin, Henderson, Hunt, and Navarro—had the four lowest MHIs.

Figure I-2 compares the percent of residents living in poverty, by county, for 1995.

Figure I-2 Percent of Residents Living in Poverty, by County (1995)



Source: U.S. Census Bureau. Available online: www.census.gov/hhes/www/saipe.html

[5] This section was first presented in the "Dallas Planning Area HIV/AIDS Housing Plan" by AIDS Housing of Washington, 2001.

C. How Can We Characterize PLWH/A Now and in the Future?

Epidemiological Profile & Trends

This section profiles PLWH/A.

The purpose of this section is to highlight the population in need of services. For estimating needs and unmet need, the number and profile of people living with HIV (PLWH) is the most useful information. However, HIV reporting has only been mandatory in Texas since 1998, and there is no accurate count of PLWH/A. Consequently, this epidemiology section presents trends of PLWA and, in the past year, the demographics of PLWH are presented. Unless otherwise noted, the figures used are from 1999[6], the last full year of data reported in the latest Epidemiological Review of the Dallas Area.[7]

The epidemiology of AIDS is changing, services should anticipate the changes.

The epidemiology of HIV and AIDS in the Dallas Eligible Metropolitan Area (EMA), like other EMAs, is changing dramatically due to the success of medical treatment efforts. The basic statistics through 1999 for the twelve county's included in the Dallas EMA and HSDA are shown in Table I-2.

Table I-2 AIDS Statistics for Dallas

Cumulative Dallas 12 counties in the HSDA and EMA through 1999	12,230
Cumulative Dallas 8 county EMA AIDS Cases through 1999	12,049[1]
Living with AIDS in the 12 counties in the HSDA and EMA in 1999	5,203
Living with AIDS in the Dallas EMA in 1999	5,112
Projected number living with AIDS in 2003 in Dallas EMA	6,000 - 6,500
Living with HIV (not AIDS) in 1999 in the Dallas EMA through 1999	4,533 - 5,497
Living with HIV/AIDS in Dallas EMA in 1999	9,645 - 10,845
Projected number of HIV infected in 2003 in Dallas EMA	10,500 - 11,900
1. Texas Department of Health	

Positive Outcomes of Care System: Declining Death Rates

Death rates due to AIDS is rapidly declining.

A declining mortality rate is evidence of a continuum of care (COC) that works. Figure I-3 and Figure I-4 indicates that deaths related to AIDS are rapidly declining.

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[6] In 1999 the HSDA added Cooke, Grayson, Fannin and Navarro Counties. For purposes of comparison, the trends from 1992 include these counties that were not part of the HSDA in 1992. The HSDA includes all counties except Henderson.

7 Dallas EMA Epidemiological Report, Prepared for Dallas County Health And Human Services by the Partnership for Community Health, December, 2000.

Death rates are substantially higher among African Americans than Anglos or Latinos.

However, the decline in death rates is not equal among all ethnic groups. As shown in Figure I-3 the death rate (defined by the crude death rate per 100,000)[8] is substantially higher among the African American population, and while it has declined faster than that of the Anglo and Latino populations, it continues to be between three or five times the rate of the Anglo and Latino death rate.

Case fatality rates are expected to decline for more recently diagnosed cases because of improved care and shorter periods of time with AIDS

This large discrepancy between African Americans and other ethnic populations is somewhat moderated by the fatality rates shown in Figure I-4. This "fatality rate" measures the death rate among a cohort diagnosed with AIDS during a certain calendar year and tracked by TDH.[9] Unlike the rate per 100,000, these PLWA have entered the care system and are tracked by TDH. Case fatality rates are expected to decline for more recently diagnosed cases because of improved care and shorter periods of time with AIDS, but they are useful for comparing between groups how lethal it was over time to be diagnosed with AIDS.

Fatality rates have leveled off for African Americans and Anglos.

Fatality rates have declined among all ethnic groups at about the same pace. In 1998, Anglos have the lowest fatality rates, followed by Latinos and African Americans, but in 1999 Anglos had the highest fatality rate. Latinos, fatality rates took an upward turn in 1996, and in 1998 and 1999, were about the same as African Americans. Also, while the differences among the ethnic groups widened between 1996 and 1997, by 1999 the differences are much smaller, with a fatality rate of 5.6% among African Americans, 6.6% among Latinos and 9.5% 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.

African Americans who have entered the system of care appear to have about the same fatality rate as Anglos or Latinos.

The small difference in fatality rates among ethnic populations in the cohort suggest that African Americans who access the care system earlier in their infection are surviving at the same rate as Anglos and Latino persons living with AIDS.

[8] The mortality rate, or rate of death per 100,000 reflects everyone who was recorded by a doctor on the death certificate as dying of AIDS-related disease for a specific year. The mortality rate captures trends in current deaths due to AIDS whether or not they were ever reported to TDH as a person with AIDS and regardless of when they were diagnosed.

[9] TDH notes that the PLWA tracked is a cohort in the sense that it applies to people diagnosed with AIDS during a certain calendar year. They actively pursue death reports on reported AIDS cases, doing matching with Bureau of Vital Statistics death certificates and receiving reports of deaths from our local sites. Each AIDS case is not actively followed.

Figure I-3 HIV/AIDS Deaths by Ethnicity per 100,000 of Dallas EMA Population

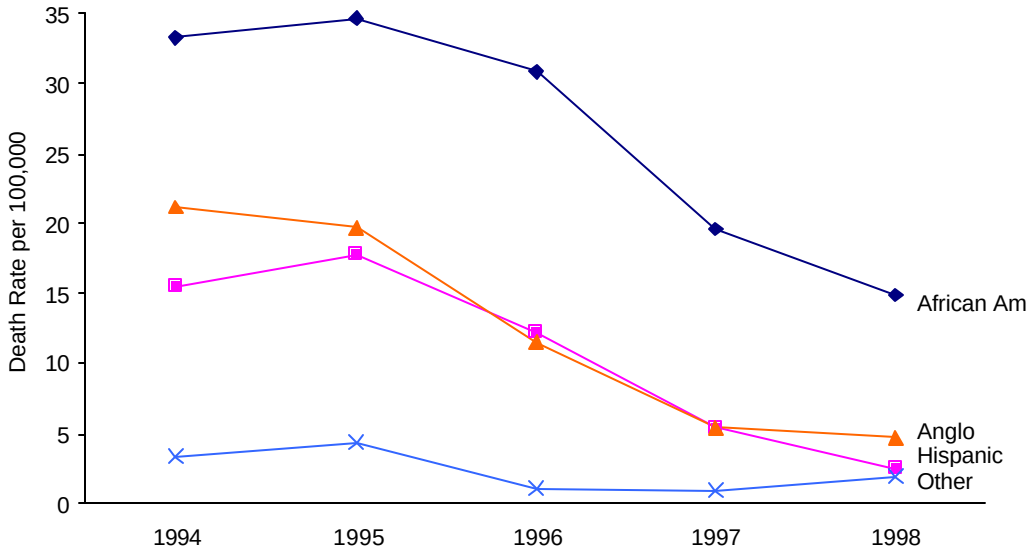
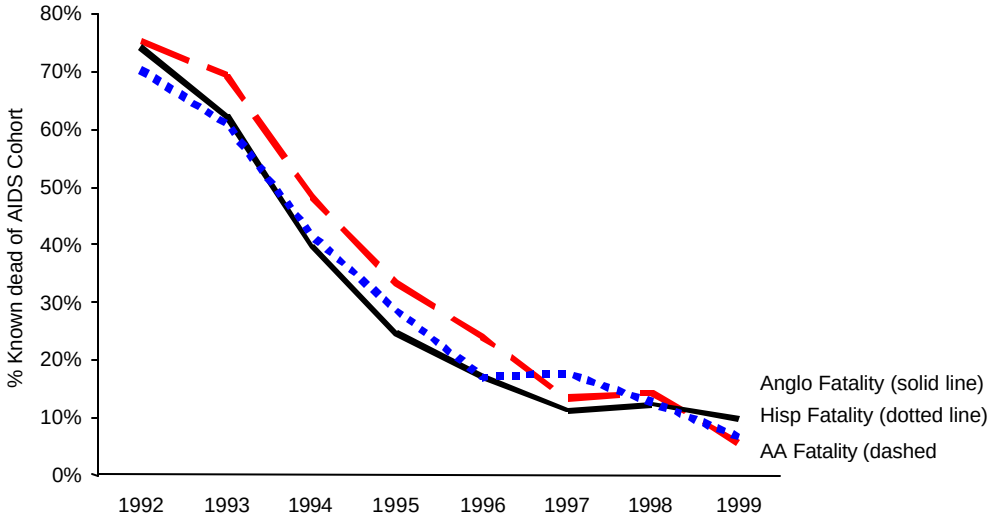


Figure I-4 AIDS Fatality Rates 1992-1999



Newly Diagnosed Cases

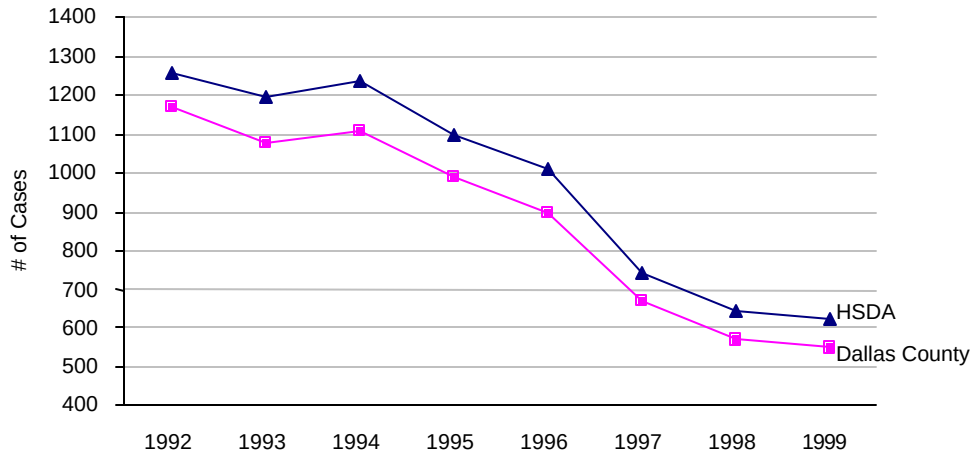
From 1992 to 1999, there was a 50% drop in the number of persons diagnosed with AIDS yearly.

In addition to declining death rates, another outcome of a care system that works is many HIV infected persons are not progressing to AIDS as rapidly as in the past. In 1992, 1,258 persons were diagnosed with AIDS in the Dallas EMA, while in 1999, less than half of that amount, 623 persons were diagnosed, representing a decline of about 50%. Figure I-5 displays the decline in AIDS cases reported yearly in the 12-county Dallas EMA/HSDA and Dallas County. Dallas County accounted for the vast majority of all AIDS cases in the Dallas EMA.

In Dallas County, 1,169 AIDS cases were diagnosed in 1992 and 550 in 1999. The slower rate of decline between 1998 and 1999 suggest that drug regimens may be less effective than in the past and/or outreach is bringing in persons who are in later stages of HIV/AIDS disease.

As seen in Figure I-5, between 1993 and 1994, there was an increase in newly diagnosed AIDS cases. However, it should be noted that one reason for the increase between 1993 and 1994 was due to the change in the AIDS surveillance case definition in 1993.[10] The downward trend resumed after 1994, with a steep decrease of about 26% noted between 1996 and 1997, and then leveling off to a decrease of about 13% between 1997 and 1998.

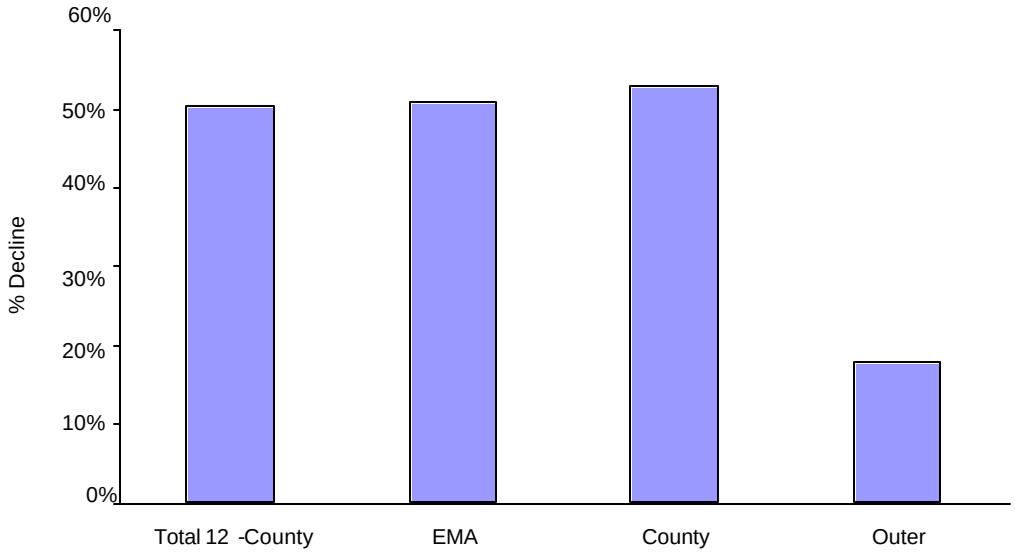
Figure I-5 AIDS Cases by Year of Diagnosis: Dallas HSDA and Dallas County



Compared to Dallas County, the outer counties saw a much smaller decline from 1992 to 1999, but that is in part due to the few number of cases reported in the outer counties in 1992. As seen in Figure I-6, the change from 1992 to 1999 was about 50% compared to a decline of less than 20% for the outer counties. Overall, the number of rural cases remains quite small. Out of 623 cases diagnosed with AIDS in 1999, the outer counties account for 73 or slightly over 10% of the cases.

[10] Effective January 1, 1993, the AIDS case definition expanded and included HIV-infected persons who had severely impaired immune function based on having a CD4+ cell count under 200, pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer.

Figure I-6 Percentage Change in Number of AIDS Cases 1992-1999



As of 1998 there has been a slight increase in Anglo AIDS cases.

Figure I-7 shows that there is a decline in newly diagnosed cases from 1992 to 1999 among all ethnic populations, with a particularly large drop among Anglos through 1997. African Americans and Latinos, while having considerably fewer new cases of AIDS diagnosed each year, have never shown a dramatic decline. In terms of absolute numbers, African Americans closely followed the number of newly diagnosed Anglos starting in 1997. In the past year the number of Anglo new infections has increased. This trend, if it continues, could suggest increasing need for more intense outpatient care. The inserted box, "PLWA-1999" - indicates that, despite the significant drop in newly diagnosed cases, Anglos continue to make up the majority of PLWA cases in 1999 (Anglo 57% or 2945 cases) followed by African Americans (30% or 1557 cases), and Latinos (12% or 645 cases). There were also 33 Asian Pacific Islanders and 22 Native American PLWA.

MSM show the greatest decline in number of new AIDS cases reported.

Figure I-8 shows an unequal decline in diagnosed AIDS cases for exposure groups. MSM show a significant decline in number of AIDS cases diagnosed yearly through 1998, although since 1997 the rate of decline has leveled off, and between 1998 and 1999 the number of newly diagnosed cases fell only slightly from 395 to 388. IDUs and MSM/IDUs have shown a consistent decline of newly diagnosed AIDS cases since 1994. Heterosexuals have an inconsistent pattern but have nearly doubled from 47 newly diagnosed cases in 1998 to 86 in 1999. Those with no risk group classified also have an inconsistent pattern, but the overall pattern shows a slight increase in newly diagnosed cases.

In 1999, MSM constitute about 70% of all PLWA.

Despite the large drop of newly diagnosed MSM AIDS cases, as shown in the framed pie chart in Figure I-8, in 1999 MSM continue to be the majority (70%) of all PLWA.

Figure I-7 AIDS Cases by Year of Diagnosis by Race

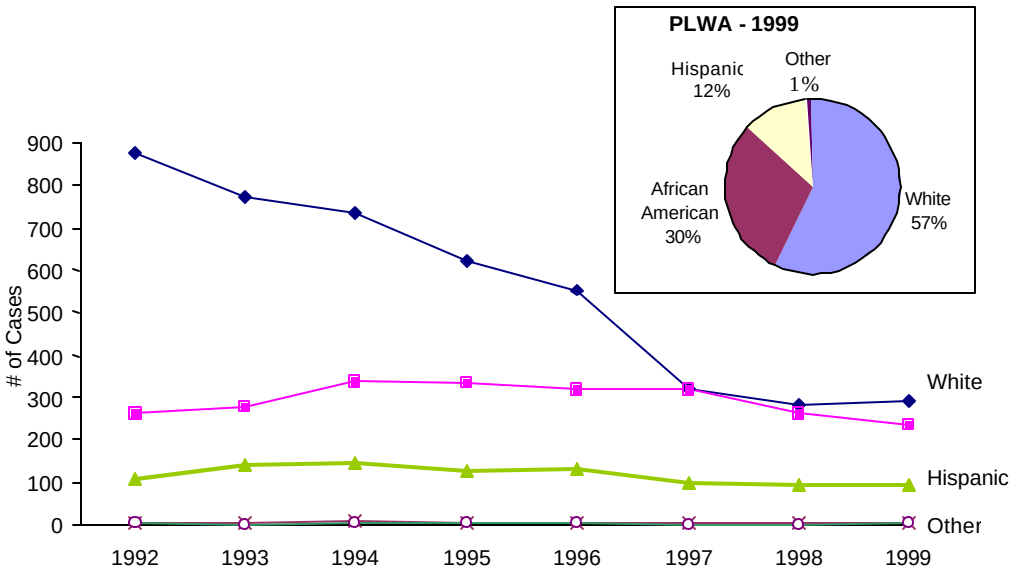
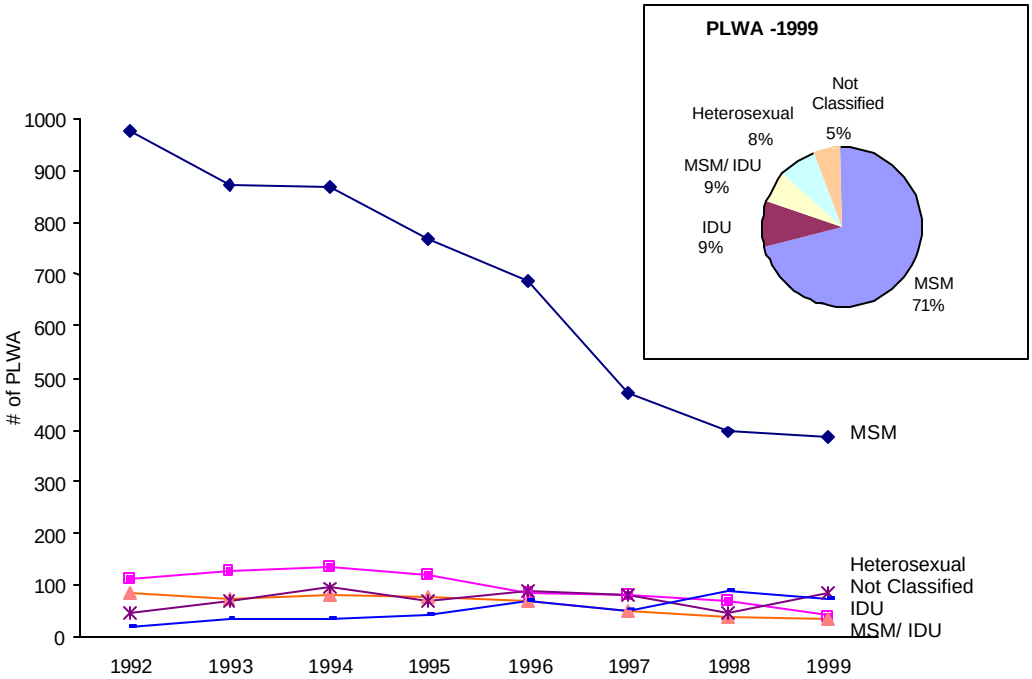


Figure I-8 Cases by Year of Diagnosis by Risk Group



Persons Living With AIDS

The number of PLWA is dramatically increasing.

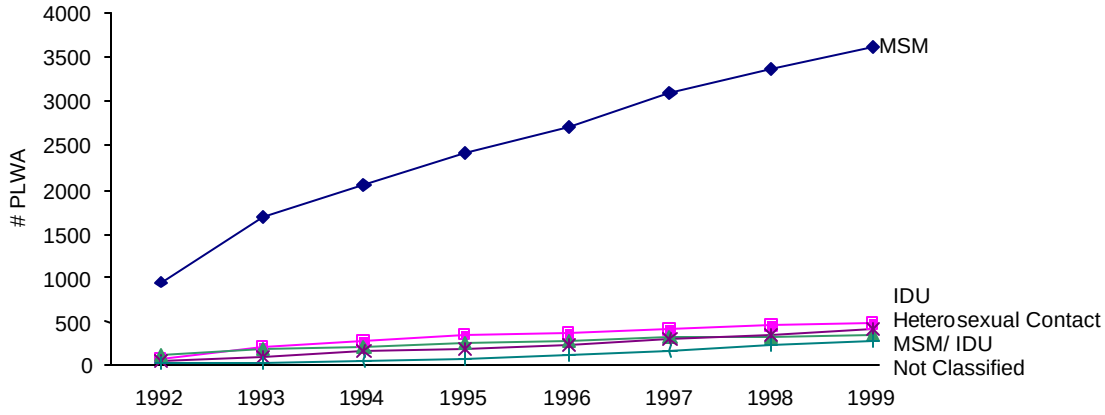
With declining death rates and fewer persons progressing from HIV to AIDS, there has been a dramatic increase in the number of PLWA since 1992. The number of PLWA in the Dallas EMA/HSDA has more than quadrupled since 1992, and has grown from 3,758 in 1996, the time of the last plan, to 5,203 in 1999.

Demographic Profile of PLWA

At the end of 1999, of the 5,203 PLWA, 69.5% are MSM, although they now make up a smaller proportion than in 1996.

As shown in Figure I-9, although the percentage MSM living with AIDS has decreased from 78% to 70%, the vast majority continue to be MSM (including MSM/IDUs), suggesting a shift in demographics to other risk groups, as detailed below. Given their large number, MSM will continue to comprise the vast majority of PLWA for the foreseeable future. Of all MSM living with AIDS in 1999, approximately 65% are Anglo, 21% are African American, and 13% are Latino.

Figure I-9 Living with AIDS by Risk Group



Of PLWA, 9% are IDU. Latino IDUs have increased from less than 6% to 7% of all IDU PLWA.

The number of exclusively IDU has increased, from 6% to 9% of all PLWA from 1992 to 1999. In 1999, of the approximately 477 PLWA who are exclusively IDUs 55% are African American, 38% are Anglo, and 7% are Latino.

Heterosexuals have the largest increase in PLWA of any group over the past three years.

There are 411, or about 8%, of the PLWA who are heterosexuals. Since 1992, this number represents an eleven fold increase from the 35 cases reported in 1992, and is one of the largest increases in PLWA of any risk group over the past three years. Fifty-four percent (54%) of the heterosexual PLWA are African American, 28% are Anglo, and 16% are Latino.

There are 581 females living with AIDS in the Dallas EMA/HSDA. Approximately 44% of these were infected through heterosexual sex, and most are women of color.

As shown in Figure I-10, females living with AIDS have increased over ten times since 1992, and by 174% since 1996. They account for a large majority of those infected through heterosexual sex, and represent slightly over a quarter of the IDUs. The proportion of females that are PLWA has increased from about 5% in 1992 to 11% in 1999, a significant increase.

Figure I-10 PLWA by Gender

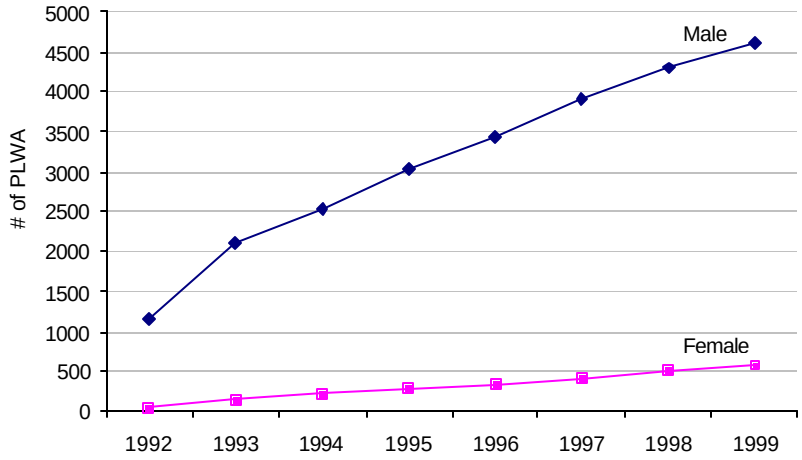


Figure I-11 shows the increase in PLWA by ethnicity. Anglos continue to have the greatest number of PLWA, and they have increased from 886 to 2945, an increase of about 230%. African Americans have increased from 207 to 1557, a 650% increase, and Latinos have increased from 113 to 645, a 470% increase. Together, Asian Pacific Islanders and Native American/Alaskans (noted in graphic as Other) compose less than 1% of PLWA and are mostly MSM.

Figure I-11 Living with AIDS by Ethnicity

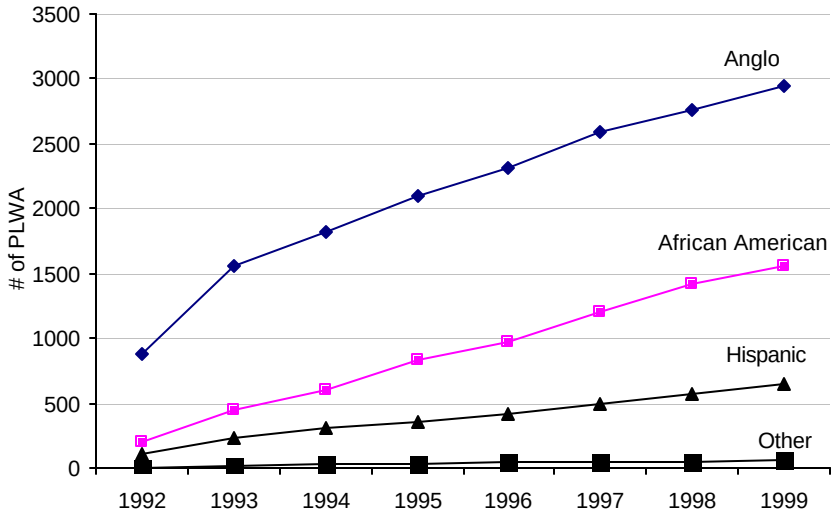
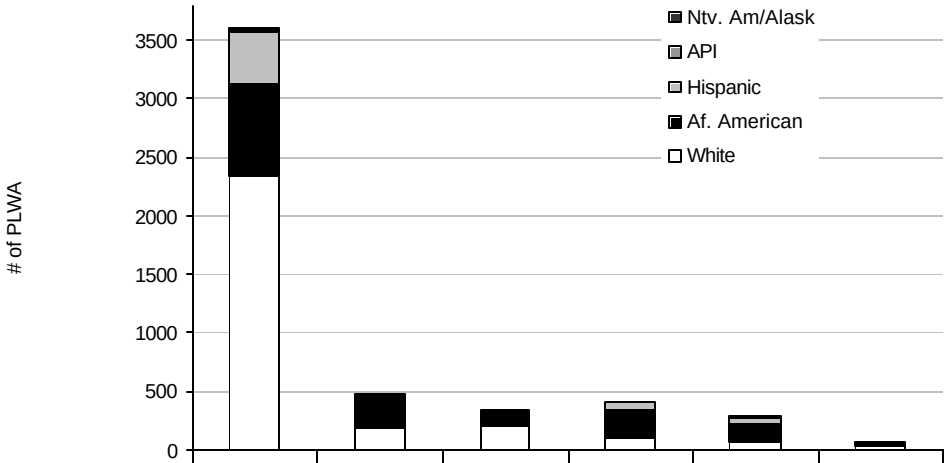


Figure I-12 shows the proportion of PLWA in the Dallas area in 1999. Although people of color are increasingly becoming infected and progressing to AIDS, the Dallas area epidemic continues to severely impact Anglo MSM. Out of the 5,112 PLWA in 1999, just under half are Anglo MSM males.

Figure I-12 PLWA - 1999



	MSM	IDU	MSM - IDU	Hetero-sexual	Not -Clas-sified	Adult Bl./ Bl. Product/ Hem
Ntv. Am/Alask	15	2	5	0	0	0
API	19	2	1	3	5	3
Hispanic	457	33	26	68	49	10
Af. American	776	260	103	223	166	19
White	2350	180	204	117	58	28

Geographic Profile

89% of PLWA are in Dallas County.

Over 89% of those living with AIDS reside in Dallas County, a slight decrease from the 92% residing in the County in 1996. The trend for counties with largest number of AIDS cases is shown in Figure I-13. The other two most populous counties are north of Dallas and have the most cases of PLWA outside of Dallas. Denton, with 162 cases has 3% of all AIDS cases and Collin has 2%. Next, Grayson has 2% and each of the other counties in the Dallas HSDA have less than 1% of the PLWA.

In 1999 there were less than 10 AIDS cases in the four rural counties of Cooke, Fannin, Grayson, and Navarro.

Table I-14 shows the trend in newly diagnosed cases in the four rural counties of Cooke, Fannin, Grayson, and Navarro. The AIDS cases in these counties remained mostly below ten. However, in 1993 the newly diagnosed AIDS cases rose from five to 20 in the county of Grayson. The variation is likely to be due to immigration, suggesting there are few new cases being diagnosed in these counties. Overall, the number of rural cases remains quite small. Out of 623 cases diagnosed with AIDS in 1999, the outer counties account for 73 or slightly over 10% of the cases.

Figure I-13 Living with AIDS by EMA Counties
(Note: Dallas County is not included in this graph)

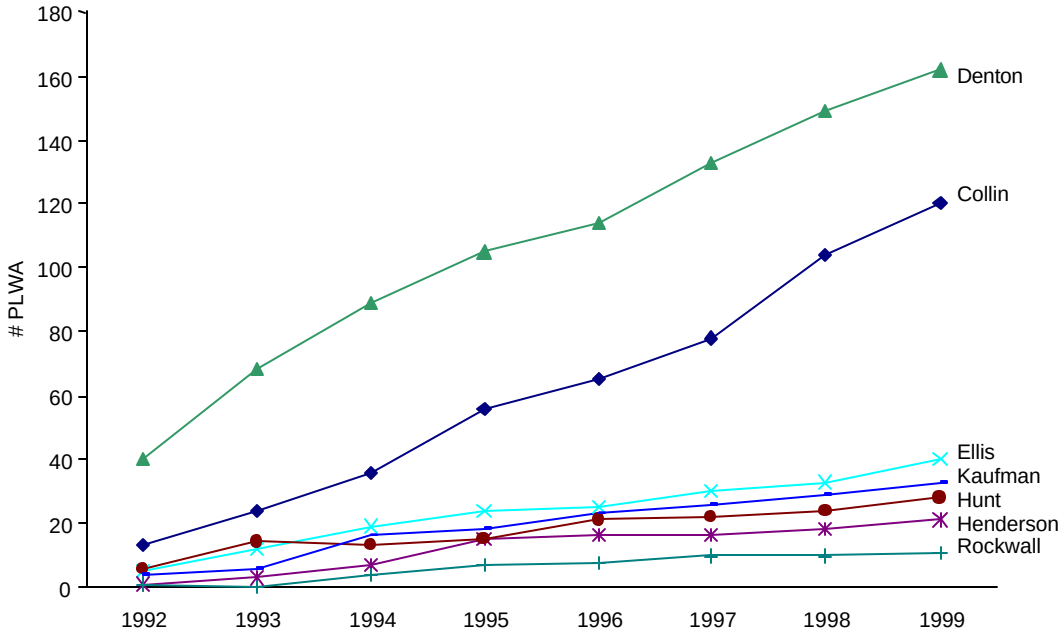
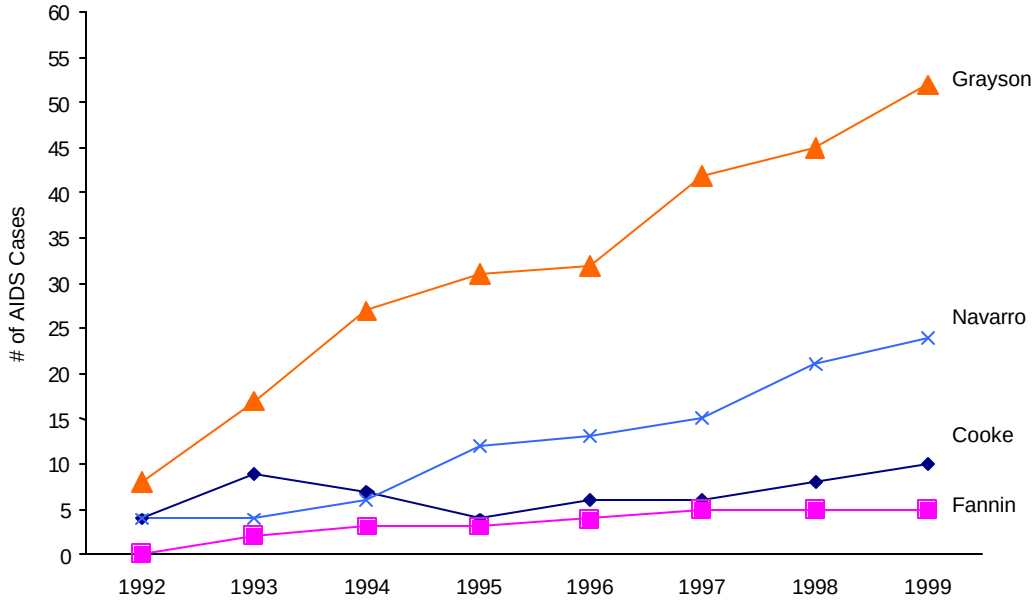


Figure I-14 Living with AIDS by New HSDA Counties



Within Dallas Co. there are distinct communities that can be identified geographically.

Oak Lawn has a higher proportion of gay residents.

Within Dallas County, however, there are distinct communities of people who require targeted services. Some communities live in different parts of Dallas and can be identified within geographic areas. For example, Oak Lawn, a neighborhood in central Dallas with zip code 75219, has a higher proportion of gay residents than other areas, and South Dallas has a higher proportion of African Americans than other areas. In terms of geographic divisions, for the purposes of this report, "outlying counties" refers to all of the above listed counties other than Dallas County (see Figure I-1) and Dallas County is divided into North and South along Route 80 as shown in Table I-15.

Communities of color are more likely to live in South Dallas.

The HIV epidemic in the EMA was initially concentrated in and around portions of Oak Lawn and the vast majority of cases were among the gay male population. By the late 1980s, HIV had begun to spread into communities of color within central Dallas, and by the mid 1990s, community members of other parts of Dallas County and in the outlying suburban and rural counties of the EMA were infected and affected.

Given the transmission rates among African Americans, zip codes 75241, 75217, 75227, and 75210 are at greatest risk of HIV infection and those infected are at greatest risk of progressing to AIDS.

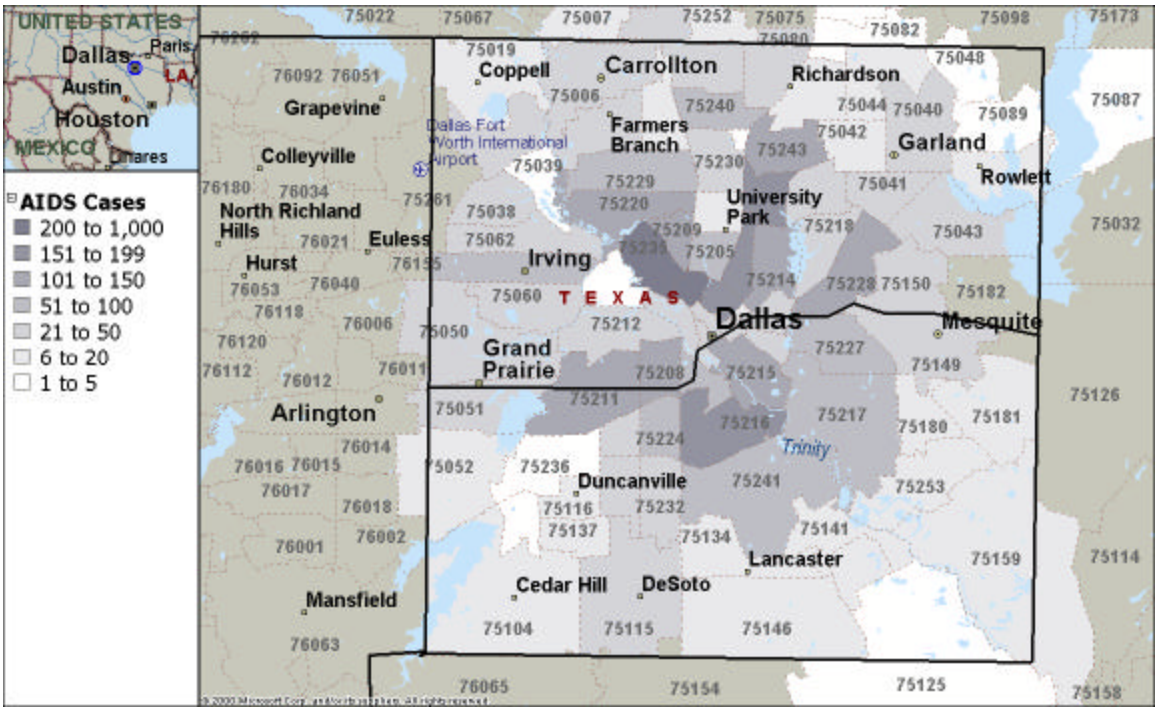
In 1999, as shown in Table I-15, the two areas with the largest number of AIDS cases are zip code areas 75219 and 75235 (both in central Dallas), followed by zip codes areas 75206 and 75231 in northern Dallas. As noted above, the areas more known for gay residents continue to have the largest number of MSM. In southern Dallas, 75216 is the area with the highest concentration of AIDS. There is a relatively high number of African Americans in zip code are 75216 and 75231 (in the north). Given the higher transmission rates among African Americans, the data suggest that zip code areas 75241, 75217,

75227, and 75210 are at greater risk of HIV infection and progression to AIDS than other areas. In the north, zip codes 75231 and 75220 are likely to have significant numbers of African Americans at relatively high risk of HIV infection and progression to AIDS.

Other groups highly vulnerable to HIV and AIDS such as recently incarcerated, IDUs, out-of-care, are distributed throughout the Dallas EMA.

Common traits, behaviors, and lifestyle are other ways to define populations at risk for HIV. Adolescents, recently incarcerated, gay men, injection drug users, out-of-care, and others are groups by a common demographic or lifestyle, but may not be easily definable by zip codes or geography.

Figure I-15 Dallas County AIDS by North & South



Subpopulations with Small Numbers of PLWA

In 1999, 33 Asian Pacific Islanders were living with AIDS, up from 26 in 1996. Most were MSM and over 25 years old.

While there are few PLWA who are adolescents or Asian Pacific Islanders, they have special needs, which include the provision of culturally appropriate services. For adolescents, providers must take into consideration legal or emotional issues of minors and those with gay, bisexual and transgender sexual orientation. In 1999, of the 33 Asian Pacific Islanders living with AIDS, all were over 25, with the largest proportion (58%) being MSM. The 22 Native American/Alaskans were also over 25 and 68% were MSM.

In 1999, 94 persons under age 24 were living with AIDS. They had a wide range of risk factors.

The number of persons ages 13-24 living with AIDS has decreased dramatically since 1996, from 179 persons to 84 persons, a 53% drop in cases, mostly among the 20-24 age group. From the 1996 report we know that the majority of PLWA in this age range were clustered in

the 20-24 range, thus making it likely that many simply moved into the next age category of 25-29 over the past three years. Young adults had a wide range of risk factors. They were most likely to be MSM; however, about 12% reported IDU and 17% reported heterosexual transmission. A larger percentage than in other age groups remained unclassified.

Projecting the Number of PLWA

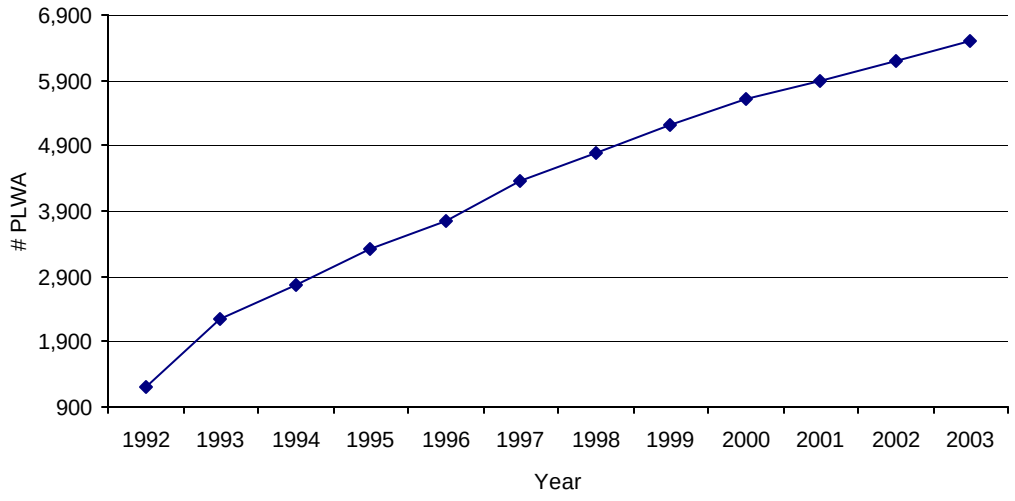
Between 6,000 and 6,5000 people will be living with AIDS by 2003.

In the 1998 Epidemiological Profile, PCH projected that by 2003 there is likely to be between 6,000 and 6,500 PLWA in the Dallas area.

The projections assume continued effective treatment.

One of three models in the 1998 Epidemiological Profile is shown in Figure I-16. It assumes that 92% of those living with AIDS will continue to live in 2000 and then 95% will live each year until 2003. Given the fewer number of persons projected to progress to AIDS, this model projects that cumulative PLWA will increase from 1,731 persons in 1992 to about 6,500 in 2003. Although African Americans will increase proportionately to Anglos, Anglos will continue to be the majority of PLWA for the foreseeable future.

Figure I-16 Trend for PLWA in Service Area Revised Model



HIV Estimates

There is no accurate measure of HIV infections.

In making HIV projections, the warning that was written in the 1998 Epidemiological Profile is still valid: *"There is no measure of HIV infections and any methods used here can only be as accurate as the assumptions made in calculating HIV."*

In the 1998 Plan, PCH estimated that in 1996 there were between 8,213 and 13,495 PLWH/A living in the Dallas EMA. The lower estimate was based on a method used by Holmberg[11], updated for current demographic and migration trends. The higher estimate was based on the Prevention Planning Group (PPG) HIV prevalence estimates reported in 1996.

2001 Epi Profile predicted that there would be between 9,645 to 10,845 PLWH/A.

In the 2001 Epidemiological Profile, PCH refined and lowered the range of the estimate, and predicted that in the year 2000 there would be between 9,645 - 10,845 PLWH/A in the Dallas area, and that by 2003 there would be about 12,000 PLWH/A in the Dallas area.

By 2003 there may be as many as 12,000 PLWH/A.

In that estimate the Holmberg figures were updated to allow for more recent populations estimates. For the estimates of gender and ethnicity for each risk group, in 1998 the distribution of PLWA was used. This year, with HIV data reported, the 1999 distribution of PLWH was used. Unlike 1998, this report does not present the estimate of the PPG, consequently the higher estimate for HIV that was presented in 1998 is not included.

The 2001 Epidemiological Profile also included the CDC estimate of 5,497 PLWH in the Dallas area for 1998. Combined with the reported 4,797 PLWA, there would be 10,294 PLWH/A in 1998, which is in the same range as the PCH estimate.

Current HIV reporting provides information about the distribution of HIV, but it is too early to provide an accurate picture of the cumulative HIV prevalence in the EMA.

CDC provides a breakdown of their estimate by sex, risk group and ethnicity. Table I-3 compares this to the actual 1999 HIV reports. While one year of HIV data is not an accurate picture of cumulative cases of HIV infection in the Dallas area, the HIV data does provide information about the distribution of HIV among the populations who are becoming infected. When comparing these, HIV serostatus shows significantly more women, heterosexuals, and Latinos. This may reflect the emphasis of testing these populations, and they will likely decline as a proportion in the following years. Still they confirm the change in the demographics of the epidemic.

[11] The Holmberg method is described in the American Journal of Public Health, May 1996 (Vol. 86, No. 5). See the Dallas EMA AIDS Epidemiology Report for a more complete description of how his methods were used and modified.

Females, African Americans and heterosexuals have over twice as many HIV cases reported as new cases of AIDS.

Despite these increases the overall profile of HIV/Aids will change slowly.

When comparing new HIV cases reported in 1999 to new AIDS cases reported in 1999, not surprisingly, females, African Americans, and heterosexuals (all of which represent many of the same individuals), have over twice as many HIV cases reported as new cases of AIDS diagnosed, indicating that these populations are increasing faster than males, Anglos, and MSM. Still, as reported earlier, the differences are fairly small and the overall profile of the HIV epidemic will change slowly.

Table I-3 HIV Subpopulations Estimates

TOTAL HIV	CDC Estimate		1999 HIV report	
	Number	Percent	Number	Percent
Sex (Total)	5,497	100.00%	641	100.00%
Male	4,730	86.00%	502	78.32%
Female	767	14.00%	139	21.68%
Risk Group (Total)	5498	100.00%	545	100.00%
MSM	3,805	69.20%	336	61.65%
IDU	592	10.80%	43	7.89%
MSM/IDU	317	5.80%	47	8.62%
Heterosexual	716	13.00%	115	21.10%
Hemo/Trans	68	1.20%	4	0.73%
Race (Total)	5,498	100.00%	536	100.00%
Anglo	2,940	53.50%	228	42.54%
African American	2,027	36.90%	227	42.35%
Latino	478	8.70%	76	14.18%
Asian	34	0.60%	3	0.56%
Native American	19	0.30%	2	0.37%

Co-Morbidities: STDs, Substance Abuse, Psychiatric Need, Homelessness, And Tuberculosis

Sexually Transmitted Diseases (STDs)

High STD rates are an indicator that risk of HIV infection is high.

Gonorrhea and syphilis rates indicate the level of unprotected sexual contact, and, in theory, should provide an early warning system for increased HIV infection. It is also known that individuals who have a history of STDs are more vulnerable to HIV infection.

STD rates are not a good predictor of AIDS.

Empirically, the relationship between STDs and AIDS is less clear. Given the latency period of AIDS, at best, increases in STDs may indicate an increase in AIDS over several years in the future. Other factors such as treatment of HIV and other medical factors make establishing a clear relationship difficult. After a few years of HIV reporting, a clearer pattern may be seen.

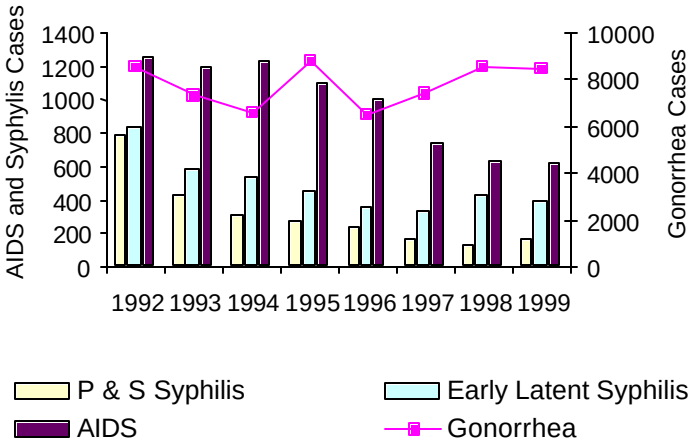
Even with increased HIV rates, it is not clear if these cases will progress to AIDS with the current medication.

Table I-17 plots the incidence of STDs and AIDS from 1992 to 1999. Given the lag between infection and AIDS diagnosis, the decline in newly diagnosed AIDS in 1994 and 1995 may reflect the 1992-1994

decrease in gonorrhea and syphilis. If there is a relationship, a continuous drop in newly diagnosed AIDS will be seen for three more years.

The increase in the rate of syphilis and gonorrhea rates between 1997 and 1998 send a warning that there may be more unprotected sex that could result in a rise of HIV. Given the current treatment alternatives, it is uncertain whether individuals diagnosed with HIV will progress to a diagnosis of AIDS. There is some evidence in the 2000 Young Gay Men's Study that infection rates among this sexually active cohort is increasing.

Figure I-17 STDs and AIDS



Drug Use and IDU

By the end of 1999, 15.7% of PLWA were either IDU or MSM/IDU.

At the end of 1999, 16% (816) of the PLWA were either IDU or MSM/IDU, a slight increase over the 15% reported in 1998. Since 1992 the number of IDU and MSM/IDU have increased from 185 to 816. Of the IDU and MSM/IDU, 47% were Anglo, 44% were African American, and 7% were Latino.

In the 2001 survey of consumers, 16% of the participants noted that they had a history of injecting non-prescribed substances, and 14% identified themselves as chemically dependent. As expected, when asked to report on alcohol and substance use in the last six months, the rates are fairly low. This may be reflective of the drug-free requirement of some of the housing facilities in which the respondents reside and some inclination to give "socially desirable" answers. When asked if they ever used substances:

Cocaine is the third most frequent substance used.

- Cocaine is the third most frequent substance used among most of the subpopulations, with over 60% of the recently incarcerated, IDUs and Anglo heterosexuals reporting use of this substance. Cocaine is the number one substance used among the IDU.

Youth have high rates of current marijuana use.

Crystal meth is used most recently by youth, out-of-care, and African American heterosexuals.

Out-of-care and HIV+ report higher rates of chemical dependency.

- As expected, IDUs have the highest rates of ever using both alcohol and marijuana. Youth, however, have the highest rates of current marijuana use, with 67% reporting weekly use.
- Youth, out-of-care, and African American heterosexuals have the highest use of crystal methamphetamine in the past six months. HIV symptomatic individuals report the highest use of this substance in the past week, suggesting that self medication for the commonly reported symptom of fatigue.
- PLWH/A who are out-of-care report the highest rates of chemical dependency, followed by African American MSM and African American heterosexuals.
- Symptomatic HIV positive respondents report higher rates of chemical dependency than those who are asymptomatic, and higher rates than AIDS diagnosed individuals.

Psychiatric Need

Mental illness can negatively impact adherence to medical regimens and significantly reduce the quality of life for PLWH/A.

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.

Some mental health indicators have increased compared to findings from the 1998 needs assessment.

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 2001 study has seen an increase to over 50% for some populations such as MSM and PLWA. Further findings from the present study indicate that:

8% of PLWH/A reported mental impairment in the 2001 consumer survey. IDUs are more likely to report mental disability.

34% of PLWH/A report anxiety.
50% report depression.

- 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.
- PLWA report a very high rate of diagnosable disorders, including anxiety (34%) and depression (50%). Over 50% of IDUs and 46% of MSM report having been diagnosed with depression. IDUs report higher rates of dementia than any other group, with 11 percent saying they had been diagnosed in the past two years.

74% of PLWH/A report individual counseling.

- Individual counseling is the most common treatment method for all groups, with 74% of all PLWH/A seeking this type of counseling, and 60% report receiving it in an outpatient care setting by a doctor or therapist. Half the PLWH/A report group sessions. Latinos are much less likely to seek counseling.

Homeless and Nearly Homeless

The City of Dallas Continuum of Care 1999 Single Point Homeless Count found more than 3,000 people in homeless shelters and 82 living on the streets.

Unlike the 1998-99 Needs Assessment, there is a wealth of information on housing.[12] The results of the 2000 housing study 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. An updated survey in 2001 found 2909 persons homeless.

As seen in Table I-4, 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 I-4 Demographic Profile of Homeless in City of Dallas[13] (1999)

Demographic Category		Number	Percent
Total Counted		**3,098**	**100%**
Individuals		2,200	71%
Children in families		600	19%
Adults in families		298	10%
Race / Ethnicity	African American	1,810	58%
	Anglo	898	29%
	Latino	380	12%
	American Indian/Alaskan Native	10	<1%
Sex	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	250	8%

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

[12] For more information see "Dallas Planning Area HIV/AIDS Housing Plan" by AIDS Housing of WA, 2000.
[13] Dallas Planning Area HIV/AIDS Housing Plan, AIDS Housing of Washington, 2000.

A recent survey of 613 HIV/AIDS consumers in the Dallas EMA found that 4% were currently homeless.

In the 2001 Needs Assessment consumer survey about 3% of PLWH/A were homeless or near homeless.

5% of those out-of-care indicated they were homeless; 19% said they were in a homeless shelter.

In Table I-5, 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, 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 findings may be unreliable due to small sample size.

Table I-5 Current Housing Situation of Survey Respondents

Current Housing Situation	2000 Housing Study %	2001 Needs Assessment %
Homeless (on the streets)	*4%*	*1.5%*
Crashing for free (temporarily)	*2%*	*(not asked)*
Staying in a shelter	*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%	

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.

*

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

Nearly 30% of IDUs and those out-of-care have been homeless for some period in the last 2 yrs. 10% - 13% of MSM and heterosexuals say they have been homeless.

- 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 I-6 Homeless by Risk Group and Ethnicity

	Total	MSM	IDU	HET	PLWA	Af Am	Latino	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

14% of participants of the 2001 Needs Assessment have lived in transitional housing over the past 2 yrs.

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.

Up to 33%of Latino and 30% of African Americans living with HIV and AIDS have lived in assisted 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 Latino population and 30% of the African Americans say they have lived in an assisted living facility in the past two years.

Dallas Planning Area HIV/AIDS Housing Plan

A housing needs assessment and planning process was completed for the Dallas EMA/HSDA in 2000 by AIDS Housing of Washington.

Dallas County Health and Human Services (DCHHS) contracted with AIDS Housing of Washington to facilitate a community-based HIV/AIDS housing needs assessment and planning process in 2000. Highlights from the final report[14] are presented in this section. A complete report can be obtained from DCHHS.

According to the report, in the Dallas/Fort Worth rental housing market, apartment occupancy was at 95 percent as of August 1999. The lack of affordable housing is aggravated by the rise of the number of Americans living in extreme poverty, which, combined with a shortage of affordable rental housing, has resulted in a housing crisis for many residents with low incomes living in the Dallas Planning Area.

It is estimated that 34 percent of renters in the EMSA cannot afford the Fair Market Rent (FMR) for a one-bedroom apartment without incurring a cost burden.

Residents of the Dallas Planning Area with low incomes often incur a housing cost burden (spending more than 30 percent of their income on housing and related expenses). In fact, it is estimated that 34 percent of renters in the EMSA cannot afford the Fair Market Rent (FMR) for a one-bedroom apartment ($560) without incurring a cost burden. In Collin, Denton, Hunt, and Kaufman Counties, more than 38 percent of

[14] Dallas Planning Area HIV/AIDS Housing Plan, AIDS Housing of Washington, 2000.

renters cannot afford the FMR for a one-bedroom unit without incurring a cost burden.

Tuberculosis

In 1998 there were 253 new cases of TB.

Tuberculosis (TB) is much more likely to be contracted by persons with compromised immune systems. In Dallas County, there were 253 new cases of TB in 1998. State records show that 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.

The 2001 Needs Assessment survey found that 12% of the PLWH/A reported having either active TB or inactive TB. The majority of active and inactive TB cases reported were in the Latino (15%) and African American (14%) communities with a high percentage among recently incarcerated (20%)

D. Out-of-care

Estimating the number of those out-of-care

It is estimated that there may be up over 1,250 PLWH/A who are out-of-care.

HRSA, DCHHS, and providers of HIV and AIDS care in Dallas suspect that there is a sizeable population of PLWH/A who are not receiving medical care. This suspicion is supported by the recent epidemiological review combined with a review of COMPIS data. The epidemiological review estimated that over 10,500 persons are living with HIV and AIDS in the Dallas area in 2001. COMPIS data shows that about 5,300 PLHW/A received case management and about 4,000 persons received out-patient care. Based on survey and secondary data, 40% to 50% may receive medical services that are not funded by Ryan White, and therefore are not reflected in the COMPIS figures. Assuming the higher end of this estimate, 1,250 PLWH/A would be out-of-care.

Who are the out-of-care, where do they reside, and what are their reasons for not accessing care?

Several strategies were used to find the out-of-care.

Several strategies were used to include the out-of-care in the 2001 needs assessment consumer survey, including:

- Providers funded through prevention and 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, reported that over 100 clients had not accesses care 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.

- Non-medical care providers in the EMA were asked to refer clients who were known to be receiving non-medical care services only
- All respondents were asked in the survey if they received different types of care in the last year, and how many times they received it.

Identifying those out-of-care is difficult – suggesting that the majority of those out-of-care do not know their status. 21 of the 378 PLWH/A interviewed were out-of-care.

These methods yielded few out-of-care respondents. The few clients referred by outreach and non-medical care providers proved not to be truly out-of-care. Out of the 100 Amelia Court clients who had not sought care in the last year and not kept appointments, caseworkers at Amelia Court were able to track only two participants who were out-of-care. The majority could not be found, and of those tracked most were in care or had moved.

Interviewers reported identifying 64 out-of-care respondents from the different sources. However, on further analysis several of the 64 reported the name of a clinic or doctor where they received services. Twenty-one participants, however, claimed that they were not currently seeking medical care, and these were the participants that most unambiguously fit the out-of-care criteria. Notably, of those 21, ten reported having received medical care sometime in the past.

PLWH/A who have contact with the care system are likely to maintain some contact with the system.

It remains possible that there are a significant number of PLWH/A who know they are positive and who have dropped out of care after contact with the system. However, based on the methods used in this needs assessment, the number of out-of-care who know their status is smaller than expected. It is more likely that those out-of-care do not know their HIV status or have never had contact with providers.

Once in contact, most PLWH/A who participated in the needs assessment tended to maintain some contact with care providers. In tracking the 100 Amelia Court clients who had not returned there for care in the past year, most have not stopped care, but rather changed providers, moved to a private physician or another clinic, and/or are seeking care outside of the Ryan White funded providers. Estimates of the numbers who fall into these categories requires further research.

Qualitative data was used to supplement the small sample of out-of-care.

To supplement and add depth to the quantitative findings, qualitative data in the form of focus groups and key informant interviews were conducted to ascertain reasons why PLWH/A had not sought medical care in the previous year. One focus group was designed exclusively for out-of-care PLWH/A, and eleven other groups had questions related

to seeking care, such as reasons why care was not sought after discovering a positive test result.

Defining out-of-care

A significant number of those out-of-care may continue treating their HIV infection.

Out-of-care were initially defined as those who had not sought traditional medical treatment for more than a year. The survey analysis demonstrated how difficult it was to operationalize that definition because of people's inability to track time of last visit and their lack of clear understanding about "primary care" or "outpatient care."

While the 21 persons defined as not accessing care are true out-of-care individuals, they present a somewhat complex set of care behaviors. For example, several said they continued to report receiving treatments.

About ¼ of those out-of-care continue to take drugs for their HIV infection.

About a quarter of the out-of-care say they continue to take drugs for their HIV, and about 20% say they are continuing antiretroviral or protease inhibitors. While proportion of out-of-care taking HIV/AIDS drugs is significantly lower than the overall survey sample (83% saying they take medication and 70% are taking some type of cocktail), it suggests that many out-of-care continue a drug regimen even when they stop seeing a primary care provider. The question that remains is how are those out-of-care filling their prescriptions and whether they are reporting accurately.

Those out-of-care find it hard to maintain their medical regimen.

When asked why they stopped taking medication, significantly more out-of-care say they ran out of supplies (43%) than all PLWH/A (33%). This is not surprising, since 100% of out-of-care survey respondents are not currently receiving medical care, and therefore have limited access to prescriptions for HIV/AIDS medications.

Profile of the Out-of-Care

Demographic characteristics of the 21 out-of-care survey participants

Out-of-care are disproportionately Latino, and African Americans.

Communities of color, particularly Latinos, are disproportionately represented among those out-of-care. Thirty-eight percent of the 21 out-of-care are Latino, in contrast to the 13% of the overall sample. African Americans represent a slightly greater 43% of the out-of-care, but that is in contrast to 32% in the overall sample or PLWH/A. Anglos represent 14% of the out-of care in contrast to representing 54% of the overall sample of PLWH/A.

Females much more likely to be out-of-care.

Because females represent a significant proportion of Latinos and African Americans living with HIV and AIDS, it is not surprising that a

disproportionate number of out-of-care are female. While 48% of the 21 out-of-care are female, in the overall needs assessment sample, females represent less than 15%.

The out-of-care are more likely to be looking for work than those in-care.

A higher proportion of out-of-care PLWH/A are looking for work but are currently unemployed (48%) than that of the total survey sample (12%). This may be related to the higher proportion of HIV positive out-of-care who experience no clinical symptoms, and therefore may be more likely to seek employment.

Those out-of-care are much more likely to have unstable housing or be homeless.

Unstable housing appears to be related to being out-of-care. About a third of those out-of-care have been homeless in the past two years compared to fewer than 20% of all PLWH/A. About 20% are currently living in a shelter or group home, and this is much higher than the slightly more than 1% of PLWH/A who are living in temporary shelters.

Because of the non-random sampling and small sample size of those out-of-care, the above quantitative estimates may not be valid. However, they do suggest that people of color, particularly Latinos women, appear to have a greater set of challenges to accessing care or remaining in care consistently than do White/Caucasian respondents.

Barrier to care

Survey participants ranked 41 different barriers and out-of-care participants had substantial differences on 21 of those barriers compare to the overall survey sample.

Participants in the survey were asked to rank 41 different barriers to care. Figure I-18 shows 21 barriers that were ranked highest by those out-of-care or had the largest difference between those out-of-care and all PLWH/A. In reading the figure, the largest barriers are at the bottom of the chart, and the difference score is shown in parentheses by the name of the barrier. For example, “no health insurance” is perceived of as the highest barrier, between a moderate barrier and a high barrier, and those out-of-care perceive it as a substantially higher barrier (.7) than all PLWH/A.

As noted earlier, there are three types of barriers, individual, organizational, and structural. Individual barriers are those like lack of knowledge that are held by the individual and that he or she has some level of control. Organizational barriers are those like “lack of on-site child care”, and are in the domain of the providers. Structural barriers are those like “no health insurance” and are a reflection of eligibility or availability of services.

Out-of-care PLWH/A have higher individual, organizational, and structural barriers.

Figure I-18 indicates that:

- Those out-of-care have higher individual, organizational, and structural barriers than all PLWH/A.

Affordability and cost of care is a major barrier to care for those out-of-care.

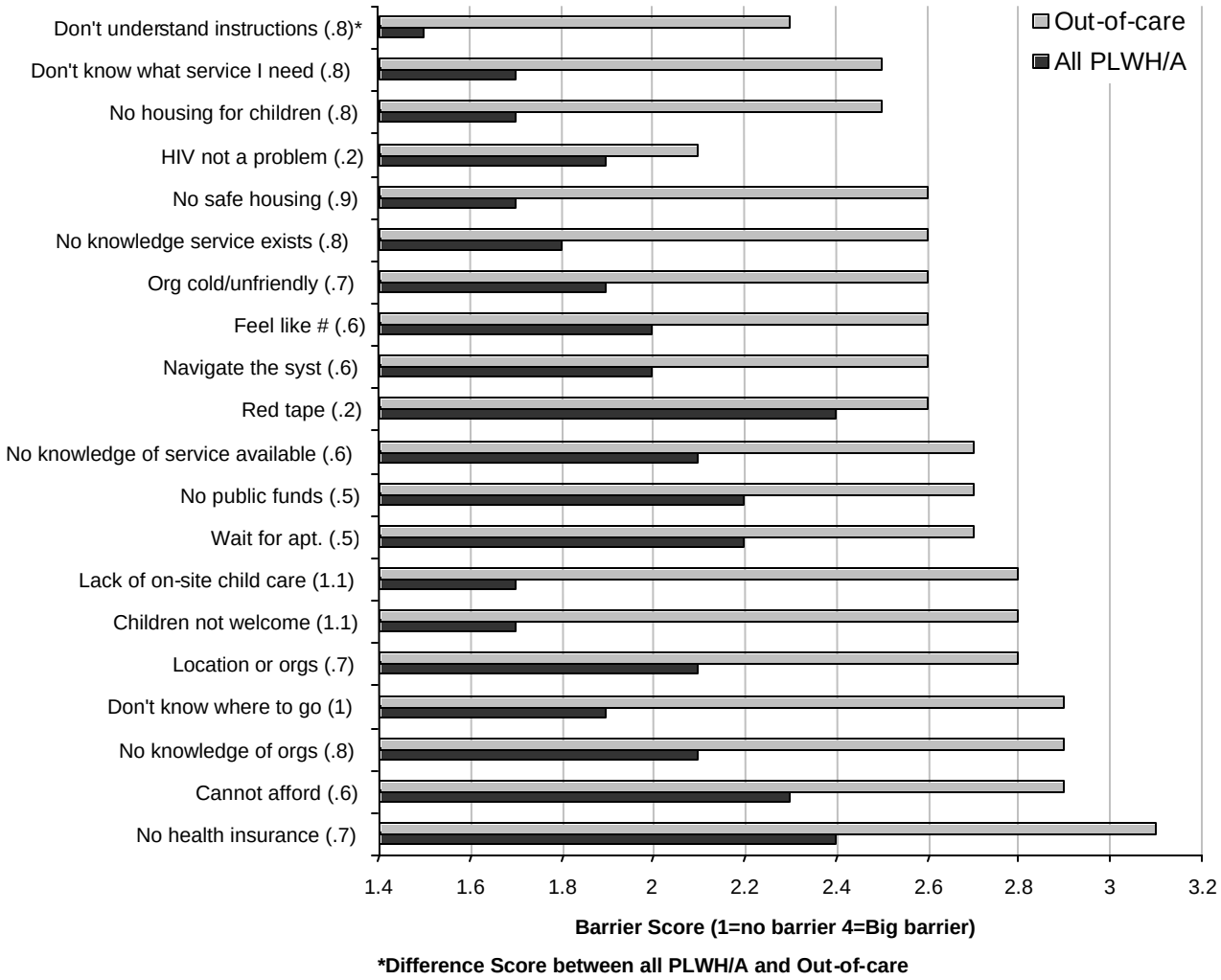
Other barriers include:
- Lack of knowledge
- Inadequate child care
- No safe housing for battered women
- Red tape.

- Structural barrier, like "affordability" and "cost" are the highest barriers for those out-of-care, and while there are considerably higher for those out-of-care than all PLWH/A, they are not the barriers with the greatest difference.
- Barriers with the greatest difference between those out-of-care and all PLWH/A relate to the issue of childcare. "Children are not welcome" and "lack of on-site child care" are moderately high barriers for those out-of-care, and are much higher barriers of the out-of-care living with HIV and AIDS than all PLWH/A.
- "No safe housing" ranks as a moderately high barrier for those out-of-care, but is of considerably greater concern to those out-of-care than for all PLWH/A.
- Individual barriers, particularly lack of knowledge about organizations, location, and services, rank as relatively high barriers for those out-of-care. Not understanding instructions ranks as a moderately high barrier, but it is a much higher barrier for those out-of-care than all PLWH/A.
- Red tape is considered an equally high barrier for those in and out-of-care.

Findings from focus groups and key informant interviews support the survey results for out-of-care PLWH/A.

The focus groups and key informant interviews supported these findings. Both women who were key informants noted that lack of child care and their children's need for "full-time" parents as a barrier for them accessing and maintaining care. They also noted cost and length of time it takes to get into medical care. One woman said she couldn't afford the medications and the blood tests, which is an indication of lack of knowledge about different no- and low-cost insurance options for low-income families.

Figure I-18 Barriers to Care



***Difference Score between all PLWH/A and Out-of-care**

No Symptoms

Not perceiving a need for care is one reason often cited by PLWH/A for not seeking primary care services.

In a study of the out-of-care in Seattle, a main reason for being out-of-care was that participants felt care was not needed. This is supported by the Dallas data, but was not highlighted in the ranking of barriers, where "HIV was not a problem" was ranked as a small barrier. Over 60% of those out-of-care were HIV positive with no symptoms. This is in contrast to 39% in the overall sample. This was further supported in key informant interviews and focus groups where those out-of-care often cited that they did not perceive a need for care because they had no symptoms severe enough to seek care.

Out-of-care perceive a lower need for primary medical care and drug reimbursement.

Out-of-care perceive a lower need for several services. Given their stage of HIV disease, out-of-care perceive a lower need for **primary medical care** (40%) compared to the total sample (57%). Those out-of-care also expressed a very low need (15%) for **drug reimbursement**

compared to about 43% of the total sample of PLWH/A.

For example, one rural male interviewed felt he didn't need to see a doctor because he hadn't experienced any symptoms for his HIV. He also doesn't generally trust doctor's opinions on how to maintain a healthy life with HIV and without medications.

A female participant reported that after 10 years she still doesn't understand HIV and the symptoms that could or would show. She had asked a doctor about symptoms but hasn't really understood his responses. Currently she doesn't feel she has any symptoms from HIV but is dealing with a great deal of depression and body weakness.

Lack of knowledge

Out-of-care survey participants cite lack of knowledge about existing services and programs as a barrier to seeking care.

Another reason for lack of perceived need and access to care may be lack of knowledge about existing services and programs. Out-of-care have the highest knowledge gap in several important service areas: 85% are unaware of **drug reimbursement** services, compared to 47% of the total sample; 52% are unaware of **case management** services, compared to 20% of the total sample; and 71% are unaware of **mortgage/rent assistance** services, compared to 42% of the sample.

Out-of-care recognize a need for treatment outreach.

While there are lower levels of knowledge about services among those out-of-care, there is a sense that they would like more information. Forty-percent of the out-of-care say they need **treatment outreach** compared to just over a quarter of to the total sample of PLWH/A reporting that they need outreach.

Focus group participants confirm that insufficient knowledge about services is a barrier to seeking care.

The focus groups confirmed that the reason for not seeking care was insufficient knowledge about the continuum of care and how to access the vast array of services available to PLWH/A in the Dallas area. Several participants also had a lack of understanding about how to access care and the eligibility criteria.

For example one male indicated that he was not really aware of case management as a service and does not believe he has a case manager assigned to him. He feels that there is not enough information to get a person involved in the continuum of care. He only knows of it through the experiences his partner has gone through.

Latino/Latino respondents have a much harder time accessing care services than other sub-populations.

As highlighted in the general 2001 Needs Assessment, Latino respondents indicate a much harder time accessing care services due to limited knowledge of the service system in general and unfamiliarity with resources available to assist in negotiating the continuum of care. Since Latinos are disproportionately represented in the out-of-care, this emphasizes the need to increase knowledge and information about care in this population.

Transportation

Inadequate transportation contributes to keeping PLWH/A out-of-care; it is not a large barrier.

Although transportation was not among the top ranked barriers by those out-of-care (a score of 2.4 out of 4), it was mentioned by several focus group participants as a barrier to receiving care.

Discrimination

Perceived discrimination was a small to moderate barrier cited by the out-of-care group.

In the consumer survey, several items related to perceived discrimination based on race/ethnicity. The out-of-care group, however, did not rank sexual identity and orientation among their highest barriers. The item "I do not feel valued as a person by the agency" was perceived as a small to moderate barrier by the out-of-care group compared to a small barrier by all PLWH/A. "The discrimination I felt from people at the agency" was ranked as a small barrier by those out-of-care, although they ranked it higher than the total sample.

The focus group participants were vocal about discrimination. For example, a male Latino participant said "I do believe Doctors just drop people at times. I think it could be because I am Latino or because I didn't fall in the right ethnicity category that they needed. I am proof that a lot of that happens here. I don't think they need more one ethnicity or another. I just think they have their numbers that they need and you either fall into them at the time or you don't."

Organizational Insensitivity

Organizational barriers don't rank high as a barrier for out-of-care, but it is mentioned in the focus groups.

While felling like a number and lack of knowledge by providers ranked low in the quantitative rating, some focus group participants did mention organizational barriers. For example, One African American male said, "It took me three months to find out that [my] case manager could write a referral. They usually refer you to [one organization] and [another organization] has the ability to write referrals. I didn't know this. I instead went direct to [a third organization]. They shove you around instead of having you deal with the one agency that you need."

Language

Evan among Latinos, lack of adequate translation services did not rank on their list of barriers.

Given the disproportionate number of Latinos among the out-of-care, it was expected that lack of Spanish speaking staff would be a high barrier. However, the out-of-care ranked "Service provider did not speak my language" as only a small barrier – although still higher than the all PLWH/A.

Summary for out-of-care

Latinos and African Americans are much more likely to be out-of-care than Anglos.

Latinos and African Americans are much more likely to be out-of-care than Anglos, and Latinos appear to be far more disproportionately out-of-care considering their representation among all PLWH/A. Among all PLWH/A women are more likely to African American or Latino, and women are also much more likely to be out-of-care than men. Those with unstable housing are also much more likely to be out-of-care.

The main reasons for PLWH/A being out-of-care include: 1) cost and perceived inability to pay, 2) perceived lack of need, 3) lack of knowledge, 4) lack of child-care, and 5) perceived discrimination. For some PLWH/A who are out-of-care lack of trust in providers was a barrier to seeking care.

Education on ways to qualify for care and pay for care would help lower perceived barriers for PLWH/A who are out-of-care.

Educating PLWH/A and case managers who serve them of the different ways that PLWH/A can qualify for care and pay for care would help lower a perceived barrier. This is particularly true for those in earlier stages of infection who may not be aware of the benefits of early treatment or their eligibility for treatment.

Because many more of the out-of-care say they are asymptomatic and looking for jobs, there may be an opportunity to provide information about HIV infection and care with unemployment benefits.

Family care services would motivate persons out-of-care to stay in care.

Another strategy to motivate persons out-of-care to stay in care is providing family care. The higher proportion of women and the need for child care is considerably higher among those out-of-care than for all PLWH/A.

Referral to safe places where battered women can go for HIV care would contribute to more women seeking care.

An unexpected finding was that the barrier “there is no safe housing for battered persons available” was much more important for those out-of-care than those in care. In part that may be due the disproportionate number of women who are out-of-care, but it may also reflect the fact that women need to perceive a safe place where they can receive care that would not put them in danger if their partner found out their status or put their relationship in jeopardy.

Careful interpretation of these finding must be observed due to the small sample size and difficulty operationalizing out-of-care.

Due to the small sample size and difficulty operationalizing out-of-care, the above findings may not be valid estimates of the profile for those out-of-care or the ranking of barriers. However, they do suggest some major themes and barriers and they can be further quantified in future needs assessments.

E. What services and resources are currently available in the Dallas area?

Resources Available In The Dallas EMA/HSDA

Shifting Profile of Care [15]

Increasing numbers of PLWA, and changes in treatment demand a shift in the profile of care.

With the changes in treatment, the profile of care needed by the increasing number of PLWH/A is shifting from acute care to chronic care. Indicators of services providers are the number of units of service provided and the number of persons who received each service. Table I-7 shows the number of units of service reported in 1997, 1999, and 2000 funded through Title I, Title II, CBC, State HIV and City AIDS funding. Table I-8 shows the number of unduplicated clients. Together they indicate both capacity and differing levels of demand for services. Figure I-19 shows the percentage increase or decrease of units of service between 1999 and 2000.

Medical care, adult day care, and legal services show a mixed pattern of the number of units of service provided, with a decrease between 1997 and 2000, but an increase from 1999 to 2000. However, the number of clients seen in outpatient care and legal services has consistently increased, suggesting that visits may be less frequent. Still, if the estimate of PLWA is 6,000 and PLWH/A about 10,000 it suggests that many infected persons are not accessing Ryan White (RW) funded providers or not accessing care.

Hospice care has increased, though the number of clients is very small.

A steady increase in the number of units of service was reported for case management/client advocacy, housing, and information and referral services. From 1999 to 2000 case management/client advocacy increased 37%, housing 7%, and information and referral 65%. Somewhat surprising, is the number of units of hospice care also showed a steady increase (40%), perhaps reflecting longer stays by clients in hospice facilities.

Unduplicated clients receiving case management has steadily increased.

Case management also had an 18% increase in unduplicated clients from 4,516 clients to 5,312 between 1999 and 2000. The emphasis in case management shifted from a comprehensive psychosocial focus to case management with a medical focus in 1995, causing a drop in the number of unduplicated clients served that year, but, since that time, the number of clients seeking case management services has steadily increased.

Housing has provided more units of service but to fewer clients between 1999 and 2000.

Housing, on the other hand, reported an increase in units but a 13% decrease in unduplicated clients, possibly indicating fewer turnovers as death rates decline. If a shortage in housing existed when there was a high rate of turnover due to deaths, it is likely it will increase in the future

[15] The source of the data for this analysis is COMPIS and not every service provider accurately reported data, consequently the findings should be viewed as trends and not as exact counts of services or unduplicated clients.

as PLWH/A live longer and as the average person infected has greater economic needs.

Several services reported a steady decline in the total number of units of service provided. They include: home health care (-26% decline from 1999 to 2000), prepared meals (-22%), food pantry (-25%), dental care (-21%), and RN visits (-35%). Many of these declines in units of service are expected to reflect a decline in the number of clients as the health status of PLWH/A improves. Predictably, RN home visits showed a 17% decline in unduplicated clients served, paralleling their decline in units of service provided. Prepared meals also showed a decline in unduplicated clients served (-9%), as did food pantry (-4%), but not at the same rate as the decline in their units provided.

In contrast to a declining number of units of service, home health care, showed a slight increase in the number of clients served between 1999 and 2000 after a large decline from 1997 to 1999. The reason is unclear.

Dental showed a 20% decline in clients serviced. Given the high consumer demand for dental care, it is surprising that fewer units of service are being provided to fewer clients.

Medical case management has seen a decrease in demand at the same time that prescriptions have increased.

Medical case management, transportation, outreach, substance use, volunteers, and legal services reflect a mixed pattern of units of service provided between 1997 and 2000. Medical case management is the most surprising because, after a marked increase from 1997 to 1999, it has shown a significant 22% decrease between 1999 and 2000 in units of service, and a 59% decrease in unduplicated clients. The reason may be the difficulty Amelia Court had replacing medical case managers who left, resulting in considerably less medical case management capacity.

Transportation, outreach, substance use, and volunteers showed a large increase in both units of service provided between 1997 and 1999. However transportation showed only a small increase in unduplicated clients, and outreach, and volunteers showed a significant decline in units of service between 1999 and 2000.

The pattern of substance abuse visits and the substance abuse needs of PLWH/A need to be further examined.

The decline in substance abuse services has continued, though there has been a 6% increase in the number of unduplicated clients served. This may be explained by the increase in non-RW funding to the Greater Dallas Council on Alcohol and Drug Abuse, but given the increase in PLWA who are substance users, this pattern of service requires some further consideration.

Mental health and medication reimbursement also have a mixed pattern of units of service provided between 1997 and 2000. Medication is the most

puzzling because of the 56% drop in reported units of service but 12% increase in unduplicated clients. This suggests some form of measurement error and has to be further investigated. Mental health services showed a substantial increase between 1997 and 1999, but then had a 16% decline in number of units provided between 1999 and 2000. This corresponded to a 9% decrease in unduplicated clients.

The majority of services have seen a decrease in units of service reported.

The majority of services increased their units of service from 1999 to 2000. Given the decreasing mortality, improvements in medical markers and level of functioning due to successful treatments, this decrease might be expected. It may also be a result of changes in data reporting and monitoring. Additional trend analysis should be conducted at the end of the 2001/02 fiscal year (FY2000) to confirm the trends reported here.

Table I-7 Number of Service Units 1997 – 2000

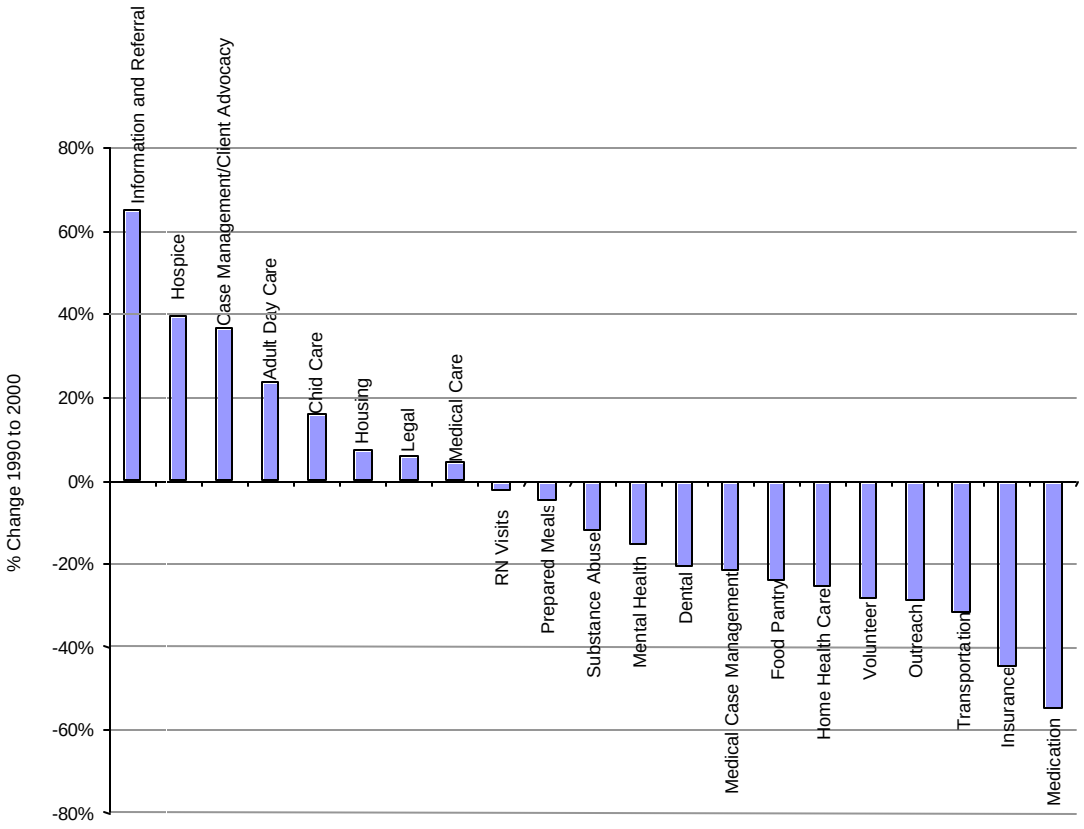
Units of Service	97 Actual	99 Actual	00 Actual	99-00 Increase/ Decrease
Case Management/Client Advocacy	119,255	124,323	170,240	37%
Housing	56,481	7,629	77,758	7%
Prepared Meals	61,638	59,613	56,634	-5%
Medical Case Management	9,699	72,684	56,544	-22%
Transportation	23,490	77,421	52,893	-32%
Outreach	30,282	72,211	51,230	-29%
Information and Referral	19,218	28,624	47,232	65%
Food Pantry	86,610	33,227	25,059	-25%
Medical Care	19,480	17,891	18,632	4%
Mental Health	8,078	11,135	9,386	-16%
Substance Abuse	3,695	9,001	7,920	-12%
Volunteer	867	8,392	5,980	-29%
Medication	5,066	11,857	5,275	-56%
Dental	6,961	5,132	4,048	-21%
Adult Day Care	5,841	3,139	3,881	24%
Child Care	--	2,980	3,456	16%
RN Visits	2,778	2,930	2,851	-3%
Insurance	--	5,160	2,845	-45%
Legal	2,282	1,206	1,279	6%
Home Health Care	1,991	1,068	795	-26%
Hospice	283	307	429	40%

Table I-8 Number of Unduplicated Clients 1997 - 2000

Unduplicated Clients	97 Actual	99 Actual	00 Actual	99-00 Increase/ Decrease
Case Management/Client Advocacy	3,064	4,516	5,312	18%
Outpatient Visits	2,958	3,313	3,595	9%
Food Pantry	543	1,894	1,821	-4%
Food: Prepared Meals	--	1,574	1,439	-9%
Transportation	503	1,060	1,126	6%
Mental Health	937	1,234	1,119	-9%
Dental	1,022	1,293	1,033	-20%
Medical Case Management	83	2,229	914	-59%
Legal	378	502	581	16%
Housing	267	543	475	-13%
Medications	402	323	363	12%
Insurance	--	299	334	12%
Volunteer	1,173	338	270	-20%
Substance Abuse	123	219	234	7%
Adult Day Care	122	246	216	-12%
Child Care	199*	100	120	20%
RN Home Visits	--	139	115	-17%
Home Health Care	325	21	28	33%
Hospice	9	8	6	-25%

* Services for Children

Figure I-19 Percentage Change in Units of Service 1999-2000



Available Funding

$25,260,487 was allocated in FY2000-01 for services from Federal, State, and City funding sources in the Dallas EMA.

In FY2000 approximately $25,260,000 in Federal, State and City funds were available under all Titles of the RW Comprehensive AIDS Resources Emergency Act of 1990, HOPWA, Texas HIV and Social Services Grants, City AIDS Grants and State ADAP. This section describes how those resources have been allocated by service category.

Table I-9 shown below presents the funding sources for various services. The services are ordered by the year 2001-2002 priorities, (indicated by the number in the far left-hand column). The RWPC/ Consortium subtotal column indicates the funds allocated by the RWPC and Consortium. The overall Total column includes those funds allocated by other RWCA Titles, HOPWA, State HIV, State ADAP, City AIDS, and the Congressional Black Caucus (CBC).

31% of RW TI & II funds are allocated for primary care. 9% are allocated to case management and client advocacy. 6% is allocated to medicine.

As expected the largest allocation by the RWPC and Consortium, 31% of the Title I and Title II funds, has been allocated for primary care, which accounts for outpatient care and medical case management services. Next is case management and client advocacy with an allocation of 9%, followed by insurance assistance that received 7% of the Title I and Title II funds. That is followed by medical reimbursement, including transportation for medicine, which represents 6% of the Title I and Title II funds. Dental care is next with less than 6%, followed by Minority Access with 5%.

Primary care funds are intended as funds of last resort for those without other means to pay for outpatient care.

Primary care funds are intended as funds of last resort for those without Medicaid or Medicare, private insurance, or other ways to pay for primary care. Notably, the role of medical case management is seen as very important, with the second largest allocation.

About one third of those accessing care are uninsured.

From the 2001 Needs Assessment survey, it is estimated that about a third of the PLWH/A who are accessing care are uninsured and their dependence on Ryan White, HOPWA, State HIV, Sate ADAP, CDC, and City AIDS to provide services will be great.

Insurance assistance to maintain insurance is an effective use of Ryan White Care Act funds.

Insurance is the preferable payer for care, and it has been shown in other States than Ryan White funds used to pay for insurance is more efficient than funds that pay for direct care. While Texas legislation limits the ability to use Ryan White Funds to purchase insurance, the high allocation for insurance assistance reflects the growing need to supplement insurance for PLWH/A. As more PLWH do not progress to AIDS and do not qualify for disability, and with few other sources for insurance assistance, this category

could take on increasing importance.

Trends in Funding

RWPC/Consortium allocated funds have increased from $11.7 million to $16.1 million from 1996 to 2001.

Primary care, medical case management, and prescription reimbursement have substantially larger portions of the budget.

Housing has shown a steady and substantial decline.

Case management and client advocacy has more funds, but a lower percentage of the overall budget.

The trends in funding from 1996 through the allocations in FY2000, shown in Table I-10, display the evolution of the HIV and AIDS care system. The total amount available from RWCA Title I and II, HOPWA, and Texas HIV and Social Service Grants have increased from about $11.7 million to $16.1 million from 1996 to 2001. Table I-10 does not include funding through Title III, Title IV and Part F of the CARE Act, State ADAP funding or City AIDS funds. The trends, as measured by percentage of overall budget, reflect the growing number of PLWH/A and the growing emphasis on medical care. Medical case management and prescription reimbursement having had substantially more funds allocated each year from 1996 through 2001 and have a larger percentage of the budget. Housing has showed a steady and substantial decline, and both home health care and emergency financial assistance have shown an overall drop in funding since 1996. Case management has had an increase in funding, but represents a slightly smaller proportion of the overall budget.

Counseling, volunteer support, and mental health services has shown a decline since 1996.

Among the less funded services, substance abuse services showed an increase from 1996 through 2000, but a substantial decline in the past year. Counseling, volunteer support, and mental health counseling has shown an overall decline in funding since 1996.

Grant funding is only part of the AIDS funding story.

In assessing the appropriate funding levels, RWCA, HOPWA and Texas HIV and Social Services grants should not be considered in a vacuum. They are part of a larger HIV/AIDS care system and the components of that system are discussed in the following sections.

Table I-9 Allocations for Dallas EMA Services 2000 – 2001 Ranked by FY2000 Priorities

	Service	Title I	Title II	RWPC/ Consortium Subtotal	%	Title III, Title IV, Part F	HOPWA	State HIV	State ADAP	City AIDS	CBC	Overall Total
1.1	Primary Care	$2,131,152	$800,662	$2,931,814	24.1%	$354,862					$138,484	$3,425,160
1.2	Medical Case Management	$803,174	$80,240	$883,414	7.3%			$47,250			$57,100	$987,764
2.1	Medication Reimbursement	$541,817	$87,338	$629,155	5.2%			$75,600				$704,755
2.2	Transportation of Medicine	$76,352		$76,352	0.6%							$76,352
2.2	Transportation	$474,183	$10,968	$485,151	4.0%			$75,600				$560,751
3	Dental Care	$635,041	$40,642	$675,683	5.5%	$89,000						$764,683
4.2	Long Term Housing			$0	0.0%		$859,346					$859,346
4.9	Emergency Financial Asst.			$0	0.0%		$478,342					$478,342
4.9	Housing Operations			$0	0.0%		$1,068,000	$198,450				$1,266,450
5.1	Food Pantry	$326,914	$13,819	$340,733	2.8%			$70,875				$411,608
5.2	Prepared Meals	$411,266	$22,340	$433,606	3.6%			$28,350				$461,956
5.3	Home Delivered Meals	$43,261		$43,261	0.4%							$43,261
7.1	Case Management	$653,054	$14,075	$667,129	5.5%			$91,375		$113,000	$93,690	$965,194
7.2	Client Advocacy	$437,370	$6,003	$443,373	3.6%			$24,570			$110,725	$578,668
8.1	Home Health Care	$361,341		$361,341	3.0%							$361,341
8.2	Hospice	$38,482	$3,508	$41,990	0.3%							$41,990
9	Mental Health	$429,438		$429,438	3.5%			$24,570			$83,980	$537,988
10	Insurance Assistance	$746,000	$59,714	$805,714	6.6%							$805,714
11	Substance Abuse	$233,030	$10,985	$244,015	2.0%							$244,015
12	Information & Referral/HERR	$224,835	$6,683	$231,518	1.9%					$167,000		$398,518
13.1	Minority Access	$589,570	$33,480	$623,050	5.1%			$24,570				$647,620
13.2	Sign Language Interpretation	$51,303		$51,303	0.4%							$51,303
14	Legal Services	$111,600		$111,600	0.9%			$39,959				$151,559
15	Adult Day Care	$83,672		$83,672	0.7%			$34,965				$118,637
16.9	Services for Children	$210,000	$12,647	$222,647	1.8%	$800,000		$80,325		$39,000		$1,141,972
17	Volunteer Support	$274,956	$21,000	$295,956	2.4%			$47,250				$343,206
99	ADAP		$245,000	$245,000	2.0%				$7,578,110			$7,823,110
99	Program Supp.	$9,000		$9,000	0.1%							$9,000
99	HSPC Support	$121,000		$121,000	1.0%							$121,000
99	Administration	$540,250	$118,657	$658,907	5.4%		$71,350	$95,967				$826,224
99	Needs Assess.	$35,000		$35,000	0.3%		$18,000					$53,000
	TOTAL	$10,593,020	$1,587,762	$12,180,782	100.0%	$1,243,862	$2,495,038	$959,676	$7,578,110	$319,000	$483,980	$25,260,487

Table I-10 Dallas EMA Service Priorities: % Of Total Amount Spent From 96 to 00 & Allocated in FY2000 for Title I, II, HOPWA, Texas HIV and Social Services Grants

SERVICE CATEGORIES	EXPENDED								AWARDED	
	1996-97		1997-98		1998-99		1999-00		2000-01	
	$	%	$	%	$	%	$	%	$	%
Outpatient Medical Care	**$2,091,451**	**17.9**	**$2,525,200**	**21.0**	**$3,203,781**	**24.2**	**$3,586,756**	**25.3**	**$4,762,817**	**29.5**
Medical Care	$1,849,485	15.8	$2,140,124	17.8	$2,169,652	16.4	$2,216,652	15.6	$3,070,298	19.0
Prescription Drug Reimbursement	$157,466	1.4	$309,514	2.6	$401,675	3	$656,374	4.6	$704,755	4.4
Medical Case Management	$84,500	0.7	$75,562	0.6	$632,454	4.8	$713,730	5	$987,764	6.1
Access For Targeted Pop.	**$533,623**	**4.6**	**$682,588**	**5.7**	**$617,810**	**4.7**	**$749,686**	**5.3**	**$698,923**	**4.3**
Minority Access	$495,623	4.2	$598,588	5	$500,552	3.8	$672,570	4.7	$647,620	4.0
Regional Access	$0	0	$50,000	0.4	$50,374	0.4	NA		NA	
Sign Language and Intp. Svs.	$38,000	0.3	$34,000	0.3	$66,884	0.5	$77,116	0.5	$51,303	0.3
Information & Referral	**$60,000**	**0.5**	**$190,000**	**1.6**	**$224,835**	**1.7**	**$224,835**	**1.6**	**$231,518**	**1.4**
Food	**$557,683**	**4.8**	**$561,327**	**4.7**	**$811,440**	**6.1**	**$812,355**	**5.7**	**$916,825**	**5.7**
Food Pantry	NA		NA		$403,563	3	$403,563	2.8	$411,608	2.6
Home Delivered Meals	NA		NA		$20,085	0.2	$21,000	0.1	$43,261	0.3
Prepared Meals	NA		NA		$387,792	2.9	$387,792	2.7	$461,956	2.9
Emergency Assistance	**$1,314,868**	**11.2**	**$1,220,843**	**10.2**	**$1,622,679**	**12.2**	**$1,024,620**	**7.2**	**$1,284,056**	**8.0**
Emergency Financial Assistance	$718,768	6.1	$568,843	4.7	$838,992	6.3	$304,620	2.1	$478,342	3.0
Insurance Assistance	$596,100	5.1	$652,000	5.4	$783,687	5.9	$720,000	5.1	$805,714	5.0
Transportation	**$523,606**	**4.5**	**$610,933**	**5.1**	**$633,495**	**4.8**	**$675,309**	**4.8**	**$637,103**	**4.0**
Transportation (Medication)	$80,000	0.7	$77,216	0.6	$80,000	0.6	$80,000	0.6	$76,352	0.5
Transportation (People)	$443,606	3.8	$533,717	4.4	$553,495	4.2	$595,309	4.2	$560,751	3.5
Case Management	**$1,138,519**	**9.7**	**$1,080,613**	**9**	**$1,160,901**	**8.8**	**$1,142,402**	**8.1**	**$1,430,862**	**8.9**
Case Management	$770,019	6.6	$817,971	6.8	$727,861	5.5	$707,861	5	$852,194	5.3
Client Advocacy	$368,500	3.2	$262,642	2.2	$433,040	3.3	$434,541	3.1	$578,668	3.6
Housing Facility Operation	**$1,648,242**	**14.1**	**$1,536,821**	**12.8**	**$1,327,731**	**10**	**$1,327,731**	**9.4**	**$1,266,450**	**7.9**
Professional Home Health Svs.	**$669,093**	**5.7**	**$331,548**	**2.8**	**$296,564**	**2.2**	**$273,189**	**1.9**	**$403,331**	**2.5**
Home Health Care	$560,160	4.8	$261,548	2.2	$237,189	1.8	$237,189	1.7	$361,341	2.2
Hospice Care	$108,933	0.9	$70,000	0.6	$59,375	0.5	$36,000	0.2	$41,990	0.3
Dental Care	**$453,270**	**3.9**	**$530,667**	**4.4**	**$562,910**	**4.2**	**$566,115**	**4**	**$675,683**	**4.2**
Mental Health	**$901,532**	**6.3**	**$710,017**	**4.7**	**$715,740**	**4.3**	**$652,464**	**4.6**	**$537,988**	**3.3**
Mental Health Counseling	$599,638	5.1	$459,021	3.8	$564,240	4.3	$652,464	4.6	$537,988	3.3
Counseling (Other)	$141,894	1.2	$111,784	0.9	$0	0	NA		NA	
Legal Services	**$160,000**	**1.4**	**$139,212**	**1.2**	**$151,500**	**1.1**	**$151,500**	**1.1**	**$151,559**	**0.9**
Substance Abuse	**$254,914**	**2.2**	**$313,211**	**2.6**	**$404,723**	**3.1**	**$404,723**	**2.8**	**$244,015**	**1.5**
Volunteer Support	**$446,837**	**3.8**	**$466,952**	**3.9**	**$397,072**	**3**	**$397,072**	**2.8**	**$343,206**	**2.1**
Services For Children	**$274,650**	**2.4**	**$281,669**	**2.3**	**$260,920**	**2**	**$260,325**	**1.8**	**$302,972**	**1.9**
Daycare/Respite Care	$274,650	2.4	$281,669	2.3	$260,920	2	$260,325	1.8	$302,972	1.9
Adult Day Care/Respite Care	**$210,565**	**1.8**	**$206,337**	**1.7**	**$149,119**	**1.1**	**$142,965**	**1**	**$116,844**	**0.7**
ADAP	**NA**		**$60,661**	**0.5**	**NA**		**$447,448**	**3.2**	**$245,000**	**1.5**
Administration	**$563,805**	**4.8**	**$614,998**	**5.1**	**$595,441**	**4.5**	**$804,076**	**5.7**	**$826,224**	**5.1**
RWPC/Consortium	**$62,114**	**0.5**	**$111,360**	**0.9**	**$135,889**	**1**	**$150,000**	**1.1**	**$121,000**	**0.8**
Needs Assessment	**NA**		**NA**		**$155,655**	**1.2**	**$18,000**	**0.1**	**$53,000**	**0.3**
TOTAL	**$11,704,772**	**100**	**$12,035,745**	**100.0**	**$13,276,705**	**100.1**	**$14,180,510**	**97.5**	**$16,119,476**	**100.0**

Non-RWCA Funding Sources

By far, Medicaid / Medicare are the largest payer for HIV/AIDS care.

RWCA, HOPWA, Texas HIV and Social Services Grants, and City Grants are only part of the story. The largest funders of HIV/AIDS primary health care services are Medicaid and Medicare, and for PLWH/A there are a number of other sources that work in conjunction with RWCA funded services to provide a full continuum of care. A complete picture of AIDS services in the Dallas EMA should be developed that accounts for non-CARE Act sources of funding for HIV and AIDS care services, including funds spent across all service categories, total number of clients served, and total units of service provided by funding source, including numbers of unduplicated clients per service category.

Non-RW funding sources include:

- Insurance paid for out of wages and benefits or out-of-pocket by PLWH/A (private insurance, including HMO, PPO, individual and group policies, COBRA, and the Texas Health insurance risk pool);
- TDH health insurance assistance programs (Texas HIV Health Insurance Options and HIV Health Option Promote Employment);
- Veterans Administration;
- Local Health Care District;
- Medicaid and Medicaid Managed Care
- Medicare (Part A and Part B)
- SSDI
- Children's Health Insurance Program (CHIP)

Below some of these sources of funding are discussed, but the inventory of resources and data presented below only reports on information that was available to Dallas County Health and Human Services. A distinct resource inventory initiative was not undertaken at this time, as it was not under the scope of this project.

Private Insurance and COBRA

Private insurance includes individual and group policies paid for out of wages, employee benefits, and out-of-pocket by the PLWH/A and/or their place of employment. Providers of private individual or group insurance are Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPOs), or insurance companies.

Those covered by COBRA[16] or have purchased insurance from the Texas Health insurance risk pool (Pool) are included in those who have private insurance.

12% of the PLWH/A report having private insurance paid through work. 3% had COBRA, 2% had private insurance not through work.

5% of PLWH/A may have a need for insurance reimbursement.

In the 2001 Needs Assessment, about 12% of the participants reported having private insurance paid for through work. Another 3% had COBRA, and 2% had private insurance not through work. Those with COBRA and private insurance not through work may be eligible for insurance reimbursement with CARE Act funds. Assuming 5% might have a need for such reimbursement, about 350 persons would be eligible. COMPIS indicates that in 2000, 334 PLWH/A received insurance reimbursement.

Due to Texas legislative restrictions, providers cannot purchase Pool insurance for PLWH/A. Consequently, unless there is some change in legislation, it is unlikely that the need for insurance reimbursement will increase substantially from RWCA funds.

Texas Health Insurance Risk Pool

The Health Insurance Risk Pool provides eligible PLWH/A with coverage for major hospital, medical, and surgical expenses, who are unable to obtain health insurance.

The Pool was created by the Texas legislature to provide eligible residents with coverage for major hospital, medical, and surgical expenses. The Pool serves residents who are unable to obtain health insurance due to a medical condition, or who are considered federally eligible individuals as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

While general eligibility is fairly restrictive, a diagnosis of HIV and AIDS is determined as a condition for automatic eligibility. Eligibility coverage can be denied if PLWH/A:

- have other health insurance in effect;
- are eligible for other health insurance, including eligibility for continuation of coverage under state or federal law, except for: coverage or plans that limit preexisting conditions, or medical condition waivers, or for which a higher premium rate than the current Pool premium rate is charged.

Due to high premiums and deductibles, and the inability of RW funds to provide insurance reimbursement, the high risk pool is not a viable option for most persons living with HIV and AIDS.

Veterans Administration Medical Center

PLWH/A who have been honorably discharged from the military can access the Veterans Administration Medical Center. The Dallas Veterans

[16] COBRA refers to those who have left work and continue to be insured under their company's plan by providing premiums to the employer.

Administration Medical Center is a 480 bed hospital, which provides comprehensive care to veterans. The facility includes a new Clinical Addition, which contains the intensive care units, outpatient clinics, radiology, pharmacy, laboratories, and other support services. Their Infectious Disease Clinic meets two half days per week plus an additional half day research clinic. The patient mix includes PLWH/A.

Just under 3% of PLWH/A use the VA facilities.

Based on the 2001 Needs Assessment, just under 3% of the PLWH/A report using the VA facilities.

Social Security Disability Insurance (SSDI)

42% of the PLWH/A report being on SSDI. That is probably an over-estimate.

Social Security Disability Insurance (SSDI) is a federal program funded by employment taxes. To qualify a PLWH/A has to have paid employment taxes for a certain period of time[17] and, based on an application, be designated as disabled by the Social Security Administration (SSA). After the applicant has received disability benefits for 24 months, he/she is eligible to receive Medicare benefits. Based on the 2001 Needs Assessment, about 42% of the PLWH/A report being on SSDI.

Medicare

Medicare is a federal health insurance program for those over 65 and those with disabilities, including AIDS. Part A covers hospitalization. Part B covers outpatient care and related expenses. It does not cover medication.

Medicare is a federal health insurance program for people 65 years of age and older and certain younger disabled people including those living with AIDS. Like SSDI, it is funded from employment taxes, and, if a person has AIDS or is disabled, he or she must have received SSDI for 24 months before qualifying for Medicare. Medicare has two parts, A and B. Part A covers hospitalization and is provided to all Medicare recipients at no cost. Medication is provided during in-hospital stays. Part B covers doctors' visits and related expenses. It does not cover medication. Medication is available through purchased "Medigap" insurance, or through enrollment in a Medicare managed care program. There is a monthly premium (deducted from the SSDI check) with additional co-payments.

There are programs to pay for premiums, co-insurance and deductibles.

If a person on Medicare A is determined to be financially needy (low income and limited assets [$4,000 per individual or $6,000 per couple], he or she can also be designated as a qualified Medicare beneficiary (QMB), qualify for the specified low-income Medicare beneficiary (SLMB) program, or qualifying individual (QI) program. These state programs cover part or all of out-of-pocket expenses such as premiums (Medicare Part B), coinsurance, and deductibles. Some States have programs that will pay for Medicare premiums, co-payments and deductibles for Part B.

17 If in your mid-thirties, you must have paid in for at least five of the ten years before you became disabled; if younger, fewer years of pay-in are required; if older, more than five years.

37% of PLWH/A report receiving Medicare benefits.

Based on the 2001 Needs Assessment survey, 37% of the PLWH/A report receiving Medicare benefits and 8% report enrolling in a Medicare HMO.

Medicaid and Social Security Income (SSI)

Medicaid coverage in the state of Texas has eligibility requirements that are among the most restrictive in the US.

Medicaid coverage in Texas has some of the most restrictive eligibility requirements in the U.S. This creates a barrier to care for PLWA, particularly for those in the EMA already removed from easy access to services, such as those living outside Dallas County and, in particular, those in rural areas.

Medicaid accompanies SSI, TANF and food stamps.

Medicaid is the health benefit that accompanies Supplemental Security Income (SSI), Temporary Assistance to Needy Families (TANF), and food stamps. To be eligible for SSI, a person must meet the following criteria:

- The applicant must be a citizen of the U.S. or a qualified alien.
- The applicant must verify that he/she has low income (usually under $532 per month).
- The applicant must verify that he/she has limited assets (under $2000 for individual, under $3000 for couple, not counting the value of a home or non-luxury automobile).

SSI qualifications is based on income and disability.

The qualification for SSI is based on the income and the disability determination of the applicant. If determined to be disabled and granted SSI, the applicant can remain on SSI and Medicaid indefinitely. If an individual has earned enough quarters to qualify for SSDI but the SSDI payments are low (less than $532 per month), SSI is provided in addition to the SSDI up to $532. Medicaid also covers anyone who receives $1 or more in SSI benefits.

If an applicant's income is low, again under $532 per month, he/she might be eligible to receive some SSI during the time it takes to determine disability status. If SSI is granted, Medicaid continues as the primary medical coverage for 24 months, after which time Medicare becomes the primary insurance provider and Medicaid covers long-term care only. If the applicant does not qualify for disability, the SSI and Medicaid are discontinued.

Roughly, about 27% of PLWH/A have Medicaid coverage. 8.5% report enrolling in a Medicaid managed care program.

A very rough estimate of the number of PLWH/A who have Medicaid can be made using the 2001 Needs Assessment Survey of PLWH/A. About 27% of the participants reported they had Medicaid coverage. Of those, 8.5% said they had enrolled in a Medicaid Managed Care Program. Provided there are about 6,900 eligible PLWH/A, roughly 1,863 Medicaid recipients living with HIV and AIDS would be covered.

Medicaid managed care will present the EMA with new challenges.

Coordination of benefits and continued eligibility for services are key.

Additional uncertainty lies in the introduction of Medicaid managed care in the EMA. PLWH/A in Dallas can access two Medicaid Waiver programs, but they are not well subscribed. The waivers are only mandatory for TANF and related persons, although there is voluntary enrollment of SSI recipients. Since Texas' traditional Medicaid program still restricts prescription coverage to three prescriptions per month, there is an incentive for beneficiaries to enroll in Medicaid managed care. It is too early to assess the impact of Medicaid managed care on the effectiveness of the COC, but it has the potential of extending benefits. The quality of the care, however, will have to be closely monitored.

Those enrolled in the standard Medicaid program will probably continue to access RW funded care because of co-payment requirements and the restriction to three medicines under its prescription coverage.

Dallas County has the lion's share of Medicaid eligible residents and expenditures in the EMA.

While data on PLWH/A who are Medicaid eligible and receive services in the Dallas EMA are not available, a portrait of the volume of Medicaid services, eligible residents, and expenditures in the EMA overall can be made for all residents. As Table I-11 below shows, the majority of Medicaid expenditures and services in the EMA are provided in Dallas County, with more than one quarter million eligible residents and Medicaid recipients. This compares with Rockwall County with about 2,000 Medicaid eligible clients and recipients. Total Statewide expenditures are $7.1 billion and the bulk of services are provided on an outpatient basis and through private offices across all counties.

Table I-11 Medicaid In The Dallas EMA (1998)

County	Medicaid Eligibles (unduplicated)	Medicaid Recipients	Physician services	In-patient	Out-patient	Expenditures in the County
Collin	11,913	10,311	8,247	2,603	4,984	$40,237,765
Cooke	4,001	3,532	2,459	700	1,842	$12,470,705
Dallas	222,327	189,063	157,811	43,377	95,467	$544,449,162
Denton	14,114	11,678	5,863	1,864	3,078	$102,859,034
Ellis	10,030	8,662	7,083	2,015	4,749	$32,672,047
Fannin	3,627	3,263	2,321	785	1,707	$15,323,380
Grayson	12,750	11,243	9,167	2,489	5,661	$50,408,873
Henderson	9,549	8,311	6,773	2,052	4,231	$30,839,210
Hunt	9,131	7,919	5,391	1,771	4,260	$28,882,241
Kaufman	7,318	6,467	5,408	1,533	3,355	$23,993,273
Navarro	7,246	6,345	5,023	1,150	3,249	$25,497,600
Rockwall	2,083	1,796	1,496	458	853	$8,434,200

Dual Eligibility for Medicaid/Medicaid

About 11% of PLWH/A report having dual Medicare/Medicaid coverage.

When an individual who receives SSI is awarded SSDI, Medicare becomes his/her primary medical benefit provider. However, if the amount of the SSDI benefit does not meet the current federal poverty guidelines (approximately $532 per month), SSI will be paid to supplement the SSDI amount up to a combined total of $532. If a client receives $1 or more of SSI, he maintains Medicaid coverage in addition to Medicare. Normally, in the case of dual eligibility, Medicaid becomes the payor of last resort and covers long-term and/or nursing home care only. Medicare continues to cover hospitalization (Part A), doctor's visits, and associated costs (Part B). Medicaid coverage then reverts to its traditional prescription benefit of three per month. Based on the 2001 Needs Assessment survey, about 11% have dual Medicare and Medicaid coverage.

Temporary Assistance to Needy Families (TANF)

TANF is a program for women and children who cannot qualify for SSI.

TANF is a federal insurance program targeted to women and children under 18 years old. This program covers women who cannot qualify for SSI.

Women and children under 18 years old who qualify for TANF and/or food stamps are also eligible for Medicaid coverage even though they may make more money (between 100% and 200% of the Federal Poverty Level) than the limits set for SSI eligibility. The income and asset criteria for TANF is complex and dependent on a number of factors including: whether a woman is pregnant, if the woman is able to work or has recently worked, who a child lives with, if a child has been "deprived" of the support of a legal parent, and whether the responsible relative cooperates with the state child support program. Assets and resources are considered in a TANF determination but a number of resources are exempt such as the home and surrounding property, burial plots, personal possessions, resources not available to the family, and resources of SSI recipients.

The Children's Health Insurance Program (CHIP)

CHIP is an insurance program specifically for children of families with incomes too high to qualify for Medicaid, but less than 200% FPL. Care is provided through the Medicaid system.

CHIP is an insurance program specifically for children of families with incomes that are too high to qualify for other benefits like Medicaid, but still are less that 200% of the federal poverty level (FPL). Premiums are low, ranging from $15 a year with no monthly premiums for those making less than 150% FPL, to $15 enrollment with monthly premiums of $18 for families with an income of 200% FPL. Care is provided through the Medicaid system.

Non-Insured

RWCA funds both supplement care for persons with other forms of insurance and ensures that those with no insurance receive care. The extensive service delivery provided through Parkland Hospital, the County's public hospital in Central Dallas, which serves the entire HSDA provides care to people in the EMA regardless of insurance coverage or income. Most of these services are paid for through the RWCA.

Both non-insured and insured may be eligible for medical reimbursement and other benefits provided by RWCA funds.

About 25% of PLWH/A are estimated to have no insurance coverage.

Although about a third of the PLWH/A reported having no health insurance in the 2001 Needs Assessment survey, this is likely to be an over-estimate because about 6% also reported receiving SSDI. It is estimated that roughly 25% of the PLWH/A do not have any type of coverage in the Dallas area.

AIDS Drug Assistance Program

ADAP provides medications, assists with deductibles and co-payments, extends income eligibility, and purchases medications for PLWH/A who need assistance.

The AIDS Drug Assistance Program (ADAP), previously referred to as the HIV Medication Program, provides medications, assists with deductibles and co-payments, extends income eligibility through HIV-HOPE, and purchases medications for Consortia at Public Health Service (PHS) prices through Medication Plus Project (MPP). Both HIV-Hope and MPP are described below.

ADAP is funded through a blend of Title I funds, Title II funds, and State general revenues. In general, during State FY1998, $19 million was contributed from Title II funds, $3 million from General State Revenue, and $1 million from Title I contributions. In 2000, RW Title II contributed $245,000 to ADAP.

PLWH/A who live in the Dallas EMA received nearly $7.6 million worth of treatment in assistance last year.

ADAP fills prescription orders for PLWH/A who need assistance with the costs of treatment, and who meet certain eligibility criteria. PLWH/A who live in the Dallas EMA received nearly $7.6 million worth of assistance with treatments between January 1, 2000 and December 31, 2000. Table I-12 show the unduplicated clients, their county of residence at the time the data were generated (not at the time of service), and the amount spent. All enrolled clients in the Dallas EMA are included.

Over 85% of ADAP services are used in Dallas County.

With over 90% of the PLWA residing in Dallas County, not surprisingly, over 85% of ADAP funded services were used by Dallas county residents.

Table I-12 ADAP Clients and Expenditures 2000

COUNTY	CY 2000	AMOUNTS
Collin	50	$242,392
Cooke	6	44,565
Dallas	1,723	6,501,605
Denton	59	241,410
Ellis	20	63,068
Fannin	0	0
Grayson	32	115,859
Henderson	19	111,204
Hunt	26	80,810
Kaufman	27	57,399
Navarro	10	51,866
Rockwall	15	67,932
Total Dallas EMA	1,987	$7,578,110

* Texas Department of Health (TDH), July 1998.

ADAP is further comprised of the following projects and initiatives.

The Medication Plus Project (MPP)

MPP will purchase drugs on the state formulary at PHS prices.

The Medication Plus Project (MPP) is a new initiative begun on April 1, 1998. MPP will allow contractors that designate RW Title II, State Services, or Early Intervention funds to purchase medications for their clients through ADAP. This means that medications will be available at the Public Health Service (PHS) price. The medications purchased through the MPP will be paid for through contractor accounts set up through the Bureau of HIV and STD Prevention.

Additional drugs can be added to the purchase list over time,

While the medications that can be bought may be limited at first, some of the more expensive and frequently ordered medications not on the ADAP formulary can be added to the list. This will be established through discussions with the contractors wishing to participate.

Contractors must establish relationships to enact eligibility.

To be eligible to participate in the program, the contractor must:

- designate funds to purchase medications through their existing TDH contracts (RW Title II, State Services, Early Intervention);
- establish a Memorandum of Understanding (MOU) with a pharmacy currently participating in the Health Maintenance Plan (HMP - like an HMO);
- complete an application and have it approved by designated TDH staff;
- have clients be currently enrolled in ADAP to be eligible for MPP.

To be eligible to participate in the program, a pharmacy must:

- be a participating pharmacy in the HMP;
- have an established MOU with a contractor participating in the MPP
- include a copy of the MOU with the application to participate in the MPP.

The HIV Medication Reimbursement Initiative

MRI provides continued health insurance coverage for PLWH/A who otherwise could not afford it.

In 1998, the Texas Department of Health (TDH) received funding to help maintain a continuum of health insurance coverage for individuals with HIV disease who otherwise could not afford to pay the deductible and co-insurance payments required by their health insurance providers.

TDH is currently operating the Medication Reimbursement Initiative (MRI) to help meet the needs of those individuals. The program is available to eligible Texas residents who have active health insurance benefits covering prescription medications. MRI works as a high-risk pool for PLWH/A with an income level 200% of the federal poverty guidelines. No assistance can be given by any government agency for premiums, only for medications.

In order to be eligible for the MRI, the following criteria requires that each applicant:

- has a diagnosis of HIV;
- is under the care of a Texas-licensed physician who prescribes the medication(s);
- meets the financial eligibility criteria of the program, and;
- have active health insurance benefits, which provide coverage for prescription medications.

MRI covers those whose income is less than 200% of the federal poverty level.

A person is financially eligible if he or she has an income, when combined with the income of his/her spouse, that does not exceed 200% of the current Federal Poverty Income Guidelines. TDH will determine if the person satisfies this criterion. The following are the TDH (April, 1998) income guidelines for the program:

Size of family unit	Family income may not exceed:
1	$15,480
2	$20,720
3	$25,960
4	$31,200
5	$36,440

Comparison of TDH Programs

Table I-12 on the following page compares purpose, eligibility criteria and some program specific information on the two existing programs: ADAP and MRI. The HIV Health Options to Promote Employment (HIV-HOPE) program, described in the 1998 Plan, is no longer in operation.

The progress and implementation of the program should be monitored, especially the efficiency of enrollment of clients and the ease of access and use. These resources are complementary to Medicaid, State ADAP, and Title I, therefore providing an important component within the evolving continuum of care.

Table I-13 Comparison of TDH Programs

Program Name	Purpose/Background	Client Eligibility/Criteria	Financial Eligibility	Program Specific Information
AIDS Drug Assistance Program (ADAP)	To offset the cost of FDA-approved HIV medications according to the TDH established drug formulary.	1. Texas Resident 2. HIV+ 3. Under MD Care 4. Financially Eligible	1. Medicaid does not include drugs or it is exhausted 2. No 3rd party payor 3. Gross family income <-200% of poverty	Medications on the formulary are listed by priority status. If the demand for the priority 1 drugs increases beyond budget capacity to continue to furnish all the medication on the formulary, the program will begin to eliminate the medication in priority 3 and then priority 2, as necessary. The program will not abruptly cease purchasing priority 2 and 3. The process will be gradual.
Texas Medication Plus program (MPP)	Allow TDH contractors that purchase HIV medications with Title II and State Service grants to purchase drugs at Public Health Service price. Medication purchases through the MPP will be paid for through contractor accounts set up through TDH.	1. Enrolled in HMP	Contractor specific	TDH Contractor Requirements 1. Contractor must designate grant funds to purchase medications. 2. Contractor must establish a MOU with an HMP pharmacy. 3. Application must be completed by contractor and approved by TDH. Pharmacy requirements 1. Must be a HMP participating pharmacy 2. MOU established with contractor 3. MOU included with contractor's application

Housing Opportunities for People with AIDS (HOPWA)

HOPWA addresses the housing and housing-related needs of PLWH/A and is administered by the City of Dallas.

Housing Opportunities for People with AIDS (HOPWA) is a federal grant program that addresses the housing and housing-related needs of PLWH/A in the Dallas HSDA. The City of Dallas has oversight responsibility for this HUD funded program. The City specifically administers that portion of HOPWA that can be used for capital construction. Dallas County Health and Human Services (DCHHS) operates the emergency short-term rental and long-term rental assistance programs and has primary monitoring responsibility for the housing facility operations component of grant administration. DCHHS oversees a range of HOPWA funded supportive services. They also monitor the administration and operations of all program activities in conjunction with several non-profit service providers.

HOPWA planning is based on a housing and homeless needs assessment.

HOPWA planning is based on a housing and homeless needs assessment of Dallas' extremely low, low to moderate, and middle-income households. Cost burdens are defined as the extent to which gross housing costs, including utility costs, exceed 30% of gross income. Severe cost burden is defined as the extent to which gross housing costs, including utilities exceed 50% of gross income. Overcrowding refers to a housing unit containing more than one person per room. Physical defects refer to a housing unit lacking complete kitchen or bathroom.

HOPWA Funding

HOPWA funding years (cycles) can overlap, and extend for three years of contracting, to allow for capital construction. The City of Dallas oversees the portion of the grant allocations that can be used towards capital construction and related costs for PLWH/A.

HOPWA funds a broad range of supportive services.

Table I-14 provides the allocations and percentage breakdown for HOPWA '97 – HOPWA '00 and recommendations for HOPWA '01. In the table:

Allocation of funds has changed significantly over the years 1997-2001.

Since 1997, the amount of HOPWA funds allocated to a range of services has varied considerably. Of particular interest is the significant decrease in the amount allocated to support services, which dropped from 24% of total allocations in 1997 to just 4% in 2001. Congregate housing allocations, however, have increased over the same period. In 1997, 20% of funds were allocated to this service, while in 2001 nearly 50% of total allocations are recommended to support congregate housing. Long and short-term financial assistance has remained relatively constant over the period.

Table I-14 Allocations for HOPWA '97 - '00 and Recommendations for HOPWA '01

Service Category	HOPWA '97	HOPWA '98	HOPWA '99	HOPWA '00	HOPWA '01
Dallas County Pass Through					
Support Services	$639,672	$568,640	$0	$0	$115,194
Congregate Housing	535,656	554,660	1,139,000	1,139,000	1,348,615
Long Term Assistance	421,872	359,280	788,346	895,790	980,748
Short Term Assistance	417,120	304,620	478,342		
Administration	70,488	65,000	71,350	71,350	106,023
Needs Assessment	0	18,000	18,000	0	0
Sub Total (DCHHS)	2,084,808	1,870,200	2,495,038	2,106,140	2,550,580
City of Dallas					
Support Services	0	0	139,000	79,000	79,000
Rental Assistance	0	0	100,000	100,000	100,000
Housing Acquisition	475,992	469,800	400,000	200,000	0
Administration	79,200	0	75,150	76,860	84,420
Sub Total (City of Dallas)	555,192	469,800	714,150	455,860	263,420
GRAND TOTAL	**$2,640,000**	**$2,340,000**	**$3,209,188**	**$2,562,000**	**$2,814,000**

Housing Resources Dedicated to PLWH/A

A range of housing resources is available to PLWH/A..

In the Dallas Planning Area, a range of housing resources is available to PLWH/A. This section provides an overview of those resources that are dedicated solely to PLWH/A. Resources include housing for PLWH/A seeking substance use treatment, end-of-life care, housing information services, independent housing linked with support services, and other housing types. These housing types constitute a "continuum" of housing services dedicated to PLWH/A. A full, effective, continuum of HIV/AIDS housing includes emergency, transitional, permanent, and specialized care facilities and services in addition to a range of support services.

The HIV/AIDS system cannot by itself address the wide range of housing and housing-related needs of PLWH/A.

In addition to housing dedicated to PLWH/A, other housing resources exist that may be accessed by PLWH/A in need of housing assistance, such as emergency shelters and Section 8 vouchers. The HIV/AIDS system cannot by itself address the wide range of housing and housing-related needs of PLWH/A. Therefore, it is essential that wider community resources, including service systems that address homelessness, crisis assistance, mental health, and medical care, be accessed to meet these growing needs.

Emergency, transitional, and permanent housing resources dedicated for PLWH/A in the Dallas Planning Area are summarized in Table I-15.

Table I-15 HIV/AIDS-Dedicated Housing Resources for Dallas Planning Area

Type/Program	Daily Capacity	Clients Served in 1999	Type of Client Served
Emergency Housing Assistance			
City of Dallas EHS	N/A	70	All
DCHHS	N/A	232	All
ARCOT	4	9	All
ARRT	N/A	N/A	All
ASNT	N/A	24	All
Transitional Housing Assistance			
Welcome House, Inc.	16	52	SA
Johnnie's Manor, Inc.	21	110	SA
Permanent Housing Assistance			
AIDS Services of Dallas*	225	248	All**
ARCOT	16	18	All
DCHHS (HOPWA rental assistance)	N/A	166	All
ASNT (HOPWA rental assistance)	N/A	41	All
Other Housing Programs			
Bryan's House	17	47	Children
Legacy Founder's Cottage	4	22	dvanced illness
Total Current Resources	**303**		**1,039**

*In addition to permanent housing, AIDS Services of Dallas provides its tenants with specialized care if they were to become sicker. They do not have a specific number of units set aside for specialized care.
**Hillcrest House houses formerly homeless individuals; Spencer Gardens houses families.

Housing Consumer Survey Results[18]

PLWH/A throughout the Dallas Planning Area were surveyed regarding their current and previous living situations, housing needs, and housing preferences.

PLWH/A throughout the Dallas Planning Area were surveyed regarding their current and previous living situations, housing needs, and housing preferences. More than 1,500 surveys were distributed and 613 were returned. Survey respondents indicated that there were many factors other than their HIV status that affected their daily lives and their ability to maintain stable housing.

Survey respondents indicated that there were many factors other than their HIV status that affected their daily lives and their ability to maintain stable housing

Many PLWH/A had substance use and/or mental health issues, homelessness and criminal histories, and disabilities in addition to HIV/AIDS. These factors influenced their ability to earn an income and afford rent. The vast majority of respondents earned less than $1,000 a month, and the average amount they spent on their housing cost was 46 percent, leaving little money for other expenses. Very few respondents were receiving job-training services, despite indications that many respondents were not working and faced significant barriers to gaining employment.

[18] Executive Summary, Dallas Planning Area HIV/AIDS Housing Plan. AIDS Housing of Washington, 2000.

The majority of respondents indicated that they preferred to live in a housing situation that enabled them to mix with the general community. In addition, many respondents preferred to live alone and/or stay where they were currently living, although, if they were to get sicker, many preferred to live in a supportive housing program or to stay with family or friends. Safe, drug-free neighborhoods and clean and sober living environments were important to respondents, as were living near support services, medical care, and public transportation.

Critical Housing Issues[19]

The following is a summary of the Dallas Planning Area's HIV/AIDS housing systems' critical issues, as determined during the HIV/AIDS housing needs assessment and planning process.

There are needs at every stage of the HIV/AIDS housing continuum.

- There are needs at every stage of the HIV/AIDS housing continuum included transitional and permanent housing options, especially for those with diagnoses in addition to HIV/AIDS, such as mental illness and substance use, and for those with other special needs, such as individuals with criminal histories, women and families, and immigrants who remain undocumented.

Existing housing resources are not sufficient to meet growing need.

- Existing housing resources are not sufficient to meet growing need, while some housing programs are not meeting licensure and standards of care requirements. In addition, the community perception is that the HOPWA rental assistance program is not operating efficiently. The impact of this is that fewer housing opportunities are available for PLWH/A in the area.

There is a lack of mainstream, non-AIDS specific affordable housing throughout the Dallas Planning Area.

- There is a lack of mainstream, non-AIDS specific affordable housing throughout the Dallas Planning Area. PLWH/A are one of several marginalized populations in the Dallas Planning Area, where all people with low incomes face a shortage of available, quality, and affordable housing options.

Service and housing providers are facing many challenges serving people with unique needs.

- Service and housing providers are facing many challenges serving people with unique needs, including serving clients with poor or non-existent credit or rental history, criminal history, mental health and substance use issues, and lack of documentation. Enhanced and expanded support services are needed to assist these people to maintain housing, address substance use or mental health issues, re-enter the work force, and meet the needs of their children. Focus groups, key informant interviews, and consumer surveys consistently indicated a need for more resources for job and life skills training, transportation, and finance and benefits counseling.

[19] Dallas Planning Area HIV/AIDS Housing Plan, AIDS Housing of Washington, 2000.

There is inadequate collaboration and communication among systems that serve PLWH/A, among HIV/AIDS housing providers, and between HIV/AIDS housing providers and local funders.

- There is inadequate collaboration and communication among systems that serve PLWH/A, among HIV/AIDS housing providers, and between HIV/AIDS housing providers and local funders. Critical issues include:
  - Improved collaboration among all the systems and housing providers serving individuals and families with low incomes is needed in order to successfully address the problems of clients with multiple diagnoses.
  - Improved, ongoing communication between HIV/AIDS housing providers and HIV/AIDS housing funders is needed. This includes communication among providers, who should continue to meet regularly, and communication between funders, notably at the City and County of Dallas, especially regarding HOPWA funding decisions.

There is a need to **build the capacity** of current HIV/AIDS housing providers in order to adequately respond to the overwhelming need for affordable housing.

- There is a need to build the capacity of current HIV/AIDS housing providers in order to adequately respond to the overwhelming need for affordable housing for PLWH/A in the Dallas Planning Area. In addition, existing mainstream community-based housing providers need to be encouraged to develop housing opportunities for PLWH/A, as there are too few HIV/AIDS housing providers.
- There is a need for increased HIV/AIDS housing education and advocacy within both the HIV/AIDS-dedicated service system and the mainstream community-based service system.

Texas Department of Health designated DCHHS to serve as pilot for the State in the development of unit costs.

Unit Costs

TDH asked DCHHS to serve as pilot for the State in the development of unit costs. DCHHS will require that proposals for funding contain budgets that are based on the specific cost of a unit of service, multiplied by the number of units the service provider proposes to deliver during the year.

To calculate original unit costs (UC) for each service, all expenditures of all service providers for the 1998-99 grant year, within a given service category, were totaled. The sum was then divided by the total number of units of service that they provided, within that service category. This produced an average UC for each of the service categories, which was then compared to reimbursement rates by other third party payers, such as Medicaid and private insurance. Unit rates for mental health and substance abuse were adjusted to approximate the amounts of current Medicaid reimbursement levels. From the UC, DCHHS then created cost corridors for each service category by multiplying the UC by both 90% and 110%.

It is recommended that proposals for funding contain budgets based on these corridors; however, agencies may submit budgets above the corridors if they provide adequate justification for their higher costs.

Table I-16 illustrates how calculations were made to determine unit costs and unit cost corridors. Table I-17 outlines the recommended unit cost corridors for selected service categories.

Table I-16 Example of Unit Cost and Unit Cost Corridor Calculations

Service Category/ Provider	Expenditures X	Units Provided Y	Unit Cost X/y	Average Cost	Cost Corridor
Agency A	$200,000	400	$500	$486	10% above
Agency B	$100,000	300	$333		10% below
Agency C	$250,000	400	$625		total unit cost
Total	*$550,000*	*1100*	*$500*		*$450-$550*

Table I-17 FY2000 Title I, II, and HOPWA Phase I Recommended UC Corridors

Service Category	Average Unit Cost	Cost Corridor
OUT PATIENT MEDICAL CARE		
Medical Care	$228.93 per visit	$206.04 - $251.82
Drug Reimbursement	----------	----------
Medical Case Management	$11.32 per 15 min increment	$10.19 - $12.45
Transportation of Medicine	$5.03 per one-way trip	$4.53 - $5.53
FOOD		
Food Bank	$20.58 per visit	$18.52 - $22.64
Congregate Meals	$5.39 per meal	$4.85 – $5.93
Home Delivered Meals	$2.66 per meal	$2.39 – 2$2.93
DENTAL CARE	$82.56 per visit	$74.30 - $90.82
CASE MANAGEMENT		
Comprehensive Case Management	$10.78 per 15 min increment	$9.70 - $11.86
Client Advocacy	$10.78 per 15 min increment	$9.70 - $11.86
FINANCIAL ASSISTANCE		
Emergency Financial Assistance	----------	----------
Insurance Assistance	----------	----------
HOUSING		
Housing Facility Operations	$21.06 per day	$18.95 - $23.16
Long Term Rent	----------	----------
ACCESS FOR TARGETED POPULATIONS		
Access for Underserved Populations	$11.19 per contact	$10.07 - $12.31
Interpretation Services and Sign Language	$31.73 per hour	$28.56 - $34.90
TRANSPORTATION	$13.00 per one way van visit	$11.70 - $14.30
	$10.00 per bus pass	$9.00 - $11.00
	$15.00 per taxi voucher	$13.50 - $16.50
MENTAL HEALTH COUNSELING		
Individual session	$50.00 per 45 minute individual session	$45 - $55
Group session	$13.00 per client, per 60 minute group session	$11.70 - $14.30
INFORMATION AND REFERRAL	$4.81 per contact	$4.33 – $5.29
SUBSTANCE ABUSE TREATMENT		
Individual session	$50 per 45 minute individual session	$45 - $55
Group session	$16 per client, per 60 minute session	$14.40 - $17.60
LEGAL SERVICES	$23.07 per 15 minute increment	$20.76 - $25.38
PROFESSIONAL HOME HEALTH SERVICES		
Home Health Services (RN)	$91.27 per visit	$82.14 - $100.40
Home Health Services (HHA)	$59.56 per visit	$53.60 - $65.52
Hospice Care	$93.09 per 24hrs (day)	$83.78 - $102.40
SERVICES FOR CHILDREN AND ADOLESCENTS	$7.15 per hour	$6.43 - $7.87
VOLUNTEER SUPPORT	$4.78 per hour	$4.30 - $5.26
ADULT DAY CARE	$7.81 per hour	$7.03 - $8.59
The cost for certain services within the Dallas service delivery area may exceed the unit cost rates specified by DCHHS. In such cases, specific and reasonable justification for the higher rates must be provided.		

Geographic Location of Service Providers and Funding Amounts

Dallas County is divided into northern and southern halves and the EMA is divided into Dallas County and "outlying" Counties.

For reference purposes, this document divides the county of Dallas in a northern and southern half, and the Dallas EMA into Dallas County and "Outlying" counties. These definitions have been discussed earlier under PLWA, "geographic profile" where the boundaries were shown in map 1 and map 2.

Where Title I Services Are Located

Matching location specific needs to the residence of PLWH/A is a useful planning tool for the geographic allocation of services. Table I-18 indicates that all services supported by Title I funds in the current fiscal year and prioritized by the RWPC are available in the Dallas EMA. Table I-18 provides the name and locations of service providers, and except for the two providers who serve rural areas in the North and West, their locations are mapped in Figure I-20.

The majority of available service providers are headquartered in the northern half of Dallas County, but serve residents from all parts of the EMA.

The majority of available service providers are headquartered in the northern half of Dallas County, which has historically had the vast majority of AIDS cases, and many of the organizations serve the southern half of the County and Outlying Counties.

In assessing the effectiveness of this distribution, the distribution of services provided, rather than location of services funded, would provide more accurate information for the assessment of unmet needs in different geographic areas. The provider survey was designed to capture site specific service information, including multiple sites used by a single agency in providing an array of services. Due to the poor response to the provider survey, the geographic distribution of specific services is not available.

AIDS cases and funds track by geography.

Overall, funds and AIDS cases track proportionally, by geographic area. There has been some movement of providers to Southern Dallas, and the Clinic in South Dallas is become revitalized after a period of organizational difficulties. Future adjustments in funding based on location should depend on a number of factors including:

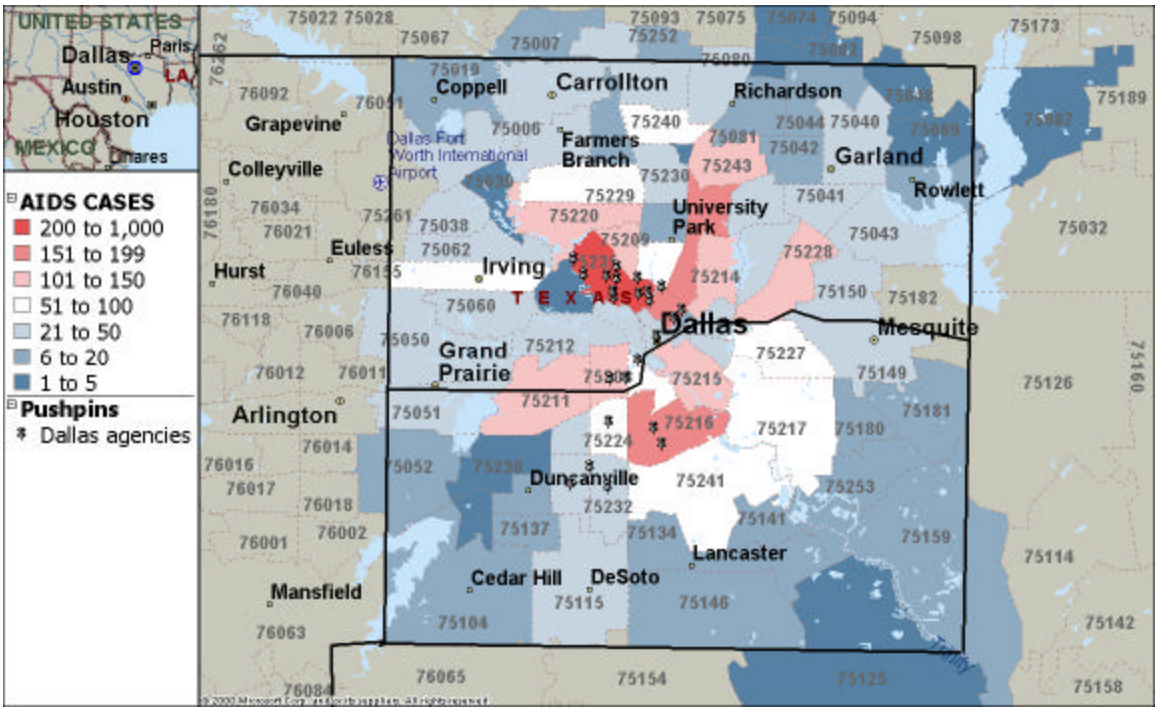
People's individual needs should be taken into account when planning for placement of services and distribution.

- The preference of people seeking services. For example, some PLWA choose to travel to services because of notions of quality and anonymity;
- The availability of culturally appropriate and high quality services;
- Convenience for populations returning to work, people with children and others with special needs.

Table I-18 Name and Location of RW TI and TII Providers

Agency Name	Address	City	State	Zip
AIDS Resource Center of Texoma	222 W. Brockett	Sherman	TX	75090
Environmental Health Services	1500 Marilla	Dallas	TX	75201
Home Health Services of Dallas, Inc.	2929 Carlisle	Dallas	TX	75204
Legacy Counseling Center, Inc.	4054 McKinney Avenue	Dallas	TX	75204
Welcome House	921 N. Peak Street	Dallas	TX	75204
Dallas County Health Division	2377 N. Stemmons Freeway	Dallas	TX	75207
DCHHS HOPWA	2377 N Stemmons Freeway	Dallas	TX	75207
AIDS Arms, Inc.	219 Sunset	Dallas	TX	75208
AIDS Interfaith Network, Inc.	1005 W. Jefferson Blvd., #301	Dallas	TX	75208
AIDS Services of Dallas	800 N. Lancaster	Dallas	TX	75208
C.A.D.A.P.	Lancaster Kiest Shpg. Ctr.	Dallas	TX	75216
Dallas VA Medical Center	4500 S. Lancaster	Dallas	TX	75216
South Dallas Health Access	5787 S. Hampton Road	Dallas	TX	75216
AIDS Resource Center of Dallas	2701 Reagan Street	Dallas	TX	75219
Dallas Legal Hospice	3626 N. Hall	Dallas	TX	75219
Greater Dallas Council on Alcohol and Drug Abuse	4525 Lemmon Avenue	Dallas	TX	75219
La Sima Foundation, Inc.	401 Wynnewood Professional Bldg.	Dallas	TX	75224
Bethlehem Foundation	1159 W. Camp Wisdom	Dallas	TX	75232
Johnnie's Manor	1705-C Martin Luther King Jr. Blvd.	Dallas	TX	75232
Cathedral of Hope	5910 Cedar Springs Road	Dallas	TX	75235
Children's Medical Center of Dallas	1935 Motor Street	Dallas	TX	75235
Dallas County Hospital District - Parkland	1936 Amelia Court	Dallas	TX	75235
Dental Health Programs, Inc.	8625 King George Drive	Dallas	TX	75235
Holistic Services, Inc.	5415 Maple Avenue	Dallas	TX	75235
Open Arms	5940 Forest Park Road	Dallas	TX	75235
Human Services Network, Inc.	6969 Boulder Drive	Dallas	TX	75237
Renaissance III	2606 Martin Luther King Jr. Blvd.	Dallas	TX	75239
Visiting Nurse Association of Texas	1440 W. Mockingbird Lane	Dallas	TX	75247
Baylor College of Dentistry	3302 Gaston Avenue	Dallas	TX	75266
AIDS Resources of Rural Texas	111 North Main	Weatherford	TX	76088
AIDS Services of North Texas	616 Fort Worth Drive	Denton	TX	76201

Figure I-20 Distribution of AIDS Service Providers - North and South Dallas



The delivery and transportation infrastructure should be taken into account when assessing the geographic distribution of funded services.

In planning for the distribution of services in the future, the delivery and transportation infrastructure should be assessed in light of the greater mobility of PLWA, and the increasing number of PLWH/A expected in Dallas County. For example a more cost and outcome effective solution might be to provide transportation for rural PLWH/A to provide outpatient and specialty care combined with enhanced case management to track and address any barriers that might impede access to care.

Transportation is not reported as a large barrier.

The 2001 Needs Assessment summarized in the following section examines some of these issues. It suggests that transportation is not perceived as a large barrier for most PLWA. Still, other barriers, such as waiting lines and red tape, might be addressed by improving access.

Data from the 1998 Needs Assessment, combined with COMPIS data would allow a more detailed analysis of where people who use services live and what their satisfaction is with existing services. When an improved data collection system is established, information on residential and transportation patterns can be better documented over time, and trends can be identified.

Capacity

Capacity of services in the COC is a critical component of measuring unmet need. It includes both RW and non-RW funded services.

An accurate assessment of capacity is critical in determining unmet need and the subsequent priorities and levels of funding for different services. The goal of the allocation process is to assure that the continuum of care (COC) has the capacity to meet unmet need.

A goal of the COC is to assure that there sufficient capacity to meet demand.

At the basic level, unmet need is the need that has not been met after accounting for Ryan White and non-Ryan White funded services. Unmet need for any service can be met by reallocating resources from services where there is excess capacity, by adding capacity through increasing efficiency, or by changing protocols to require less utilization, or adding resources.

Capacity in the continuum of care includes both Ryan White funded services and non-Ryan White Funded services. Further, for the RWPC and Consortium, only Title I, Title II, and CBC funded services and related capacity are within their sphere of influence. Because RW funds are funding of last resort, before allocating funds for services, it is necessary to determine what proportion of the each service category can be provided by non-RW funds. In addition, the RWPC and Consortium should coordinate Title III, IV and part F funds to assure that there is no unintended overlap in funding services.

In the Dallas area there is no effective means to measure capacity.

There is no effective means to measure total capacity for the COC in the Dallas area. The 2001 needs assessment included a provider survey, but this was limited to Ryan White Care providers, and response rate on that survey was poor making the data used for estimating capacity incomplete.

Estimating the RW funded service capacity will become more precise with the implementation of unit costs and tracking of units delivered. Using this measure, the number of units provided by Title I, Title II, and CBC funds, and the units provided by other Ryan White Titles can be accurately reported. In addition an effort has to be made to accurately estimate of percentage of units provided by other sources.

Estimates of capacity are possible based on COMPIS data and survey data.

Still, based on available COMPIS data and contract reports some estimates of capacity are possible based on a number of assumptions regarding average unit costs, accuracy of reporting, and rough estimates of non-Ryan White funded services based on survey data.

Table I-19 extrapolates the units provided from the total funding levels of Ryan White, HOPWA, City, and State grants. It also provides a rough estimate of the percentage of units provided by Non Ryan White providers. The estimates are made for each service by dividing the funds allocated by the average unit cost provided by the cost corridors. Because

These estimates depend on reliable report of units of service delivered.

each organization has different administrative expenses, this will not be a precise estimate of capacity.

Notably this is a very rough estimate and depends on the accuracy of the average unit cost and use of all funds allocated. For services like outpatient care, the number of services reported delivered is greater than those reported funded, indicating that providers are being more efficient or providing units at lower costs. The medical case management figures are suspicious. The number of units funded is a fraction of the units reported delivered, and is likely to indicate some reporting error in the unit of measurement, as

On the other hand several services show that the number of units delivered are below those funded. For example food pantry and legal services show delivering fewer services than funding indicating a smaller than expected demand or inadequate infrastructure.

The non Ryan White estimates are based on survey data reports of insurance and benefit coverage. They should be considered guesses and while useful for planning purposes, efforts should be made to quantify them in future needs assessments.

The ramifications of these estimates on establishing priorities and funding levels are discussed in Developing Service Priorities and Allocations, page I-88.

Another method to estimate capacity is to based on the number of line staff personnel multiplied by the average number of units each line staff is able to provide. The 2001 provider survey asked staff composition but the low response rate did not allow this method.

Table I-19 Capacity of the Care System

Units of Service (order of 00/01 priority)	Service Unit	Reported Units 2000	Funded 2000 RW TI & II & CBC*	Funded TIII, IV, f, HOPWA, State & City*	% RW T I, II, CBC	Est % ** Insurance, Medicaid, Medicaid, other	Est. System Capacity
Outpatient Medical Care	visit	18,632	13,412	1,550	89.6%	60%	37,405
Medication	dose	5,275	NA	NA	NA	50%	NA
Medical Case Management	15 minutes	56,544	8,449	424	95.2%	5%	9,340
Food Pantry	visit	25,059	16,557	3,444	82.8%	10%	22,223
Prepared Meals	meals	56,634	80,446	5,260	93.9%	10%	95,229
Dental	visit	4,048	8,184	1,078	88.4%	20%	11,578
Case Management/Client Advocacy	15 minutes	170,240	143,215	21,238	87.1%	5%	17,3108
Insurance	payment	2,845	NA	NA	NA	8%	NA
Housing	Nights	77,758	NA	NA	NA	NA	NA
Outreach	1 hour	51,230	NA	NA	NA	50%	NA
Transportation	1 way trip	52,893	37,319	5,815	86.5%	80%	215,670
Mental Health	session	9,386	10,268	491	95.4%	50%	21,518
Information and Referral	contacts	47,232	48,133	34,719	58.1%	50%	165,704
Substance Abuse	session	7,920	4,880	---	---	60%	NA
Legal	15 minutes	1,279	4,837	1,732	73.6%	60%	16,423
RN Visits	visit	2,851	6,067	0	100.0%	5%	6,386
Home Health Care	visit	795			---	5%	0
Hospice	day	429	451	0	100.0%	5%	475
Child Care	day	3,456	31,139	128,577	19.5%	80%	798,580
Volunteer	hours	5,980	NA	NA	NA	NA	NA
Adult Day Care	day	3,881	10,713	4,477	70.5%	5%	15,989

F. What are the unmet needs & service delivery barriers?

2001 Needs Assessment Methodology

Needs were determined by a survey of 387 PLWH/A in 2001 and 12 focus groups.

In the winter of 2000/01, the RWPC/Consortium conducted a series of focus groups and a representative survey of PLWH/A.[20] Three hundred and eighty-seven (387) interviews were completed. Women, communities of color, heterosexual, and rural PLWA were purposely oversampled to assure sufficient cell sizes. In addition, efforts were made to identify and survey out-of-care. After intensive out-reach efforts, 21 out-of-care were identified. As shown in Table I-20 the overall intent of the over-sampling of difficult to reach populations was achieved. For analysis, any analysis of the "total population of PLWH/A" the over samples were weighed back to their population estimates. Subgroup analysis on risk groups was also weighted to show relative differences. Analysis of sex and ethnicity were unweighted to take advantage of the oversamples in these communities. Greater detail of the sampling methods can be found in the 2001 Needs Assessment Report.

Table I-20 Needs Assessment Sample

TOTAL[1] SAMPLE	N	%
	387	**100**
MSM	284	73%
IDU	70	18%
Heterosexual	95	25%
Females	95	25%
African American	169	44%
Latino	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

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 I-21.

[20] The Partnership for Community Health, a nonprofit New York Based TA organization, was awarded the contract to do the epidemiology review, needs assessment and comprehensive services` plan based on an RFP process.

Table I-21 Focus Group and Key Informant Interviews

Focus Groups/Key Informant Interviews	Participants
1 focus group with Af Am Male Heterosexuals and IDUs	(6) Dallas Co.
1 focus group with Af Am Female Heterosexuals and IDUs	(4) Dallas Co.
1 focus group with Latino Male Heterosexuals and IDUs	(8) Dallas Co.
1 focus group with Latino Female Heterosexuals and IDUs	(6) Dallas Co.
1 focus group with Out-of-Care	(2) Dallas Co.
2 focus groups with Af Am MSM	(10) & (11) Dallas Co.
1 focus group with Latino 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

Most Needed Services

Top Rated Needs Compared to 1998

The top five services needed the most in 2001 are food bank, nutritional supplements, dental care, medication reimbursement, and case management.

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 I-21, 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 I-22 Ranking of Top Service 2001 vs. 1998

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

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, housing, and transportation;
- More persons are living with HIV and not progressing to AIDS, thus unable to qualify for disability but able to work and obtain 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 terms 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.

Table I-20 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 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.

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, rent/mortgage assistance, and transportation are in the top ten service needs and this confirms comments heard throughout the focus groups.

There is a high perceived need to obtain drug 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 PLWH/A where the majority of those infected are maintaining their health through successful drug treatment. Dental care continues to be ranked highly because it is a service that PLWH/A would not be able to get without RW assistance, and it is clearly viewed by PLWH/A as improving their quality of life.

Figure I-21 Top Ranked Needs by PLWH/A

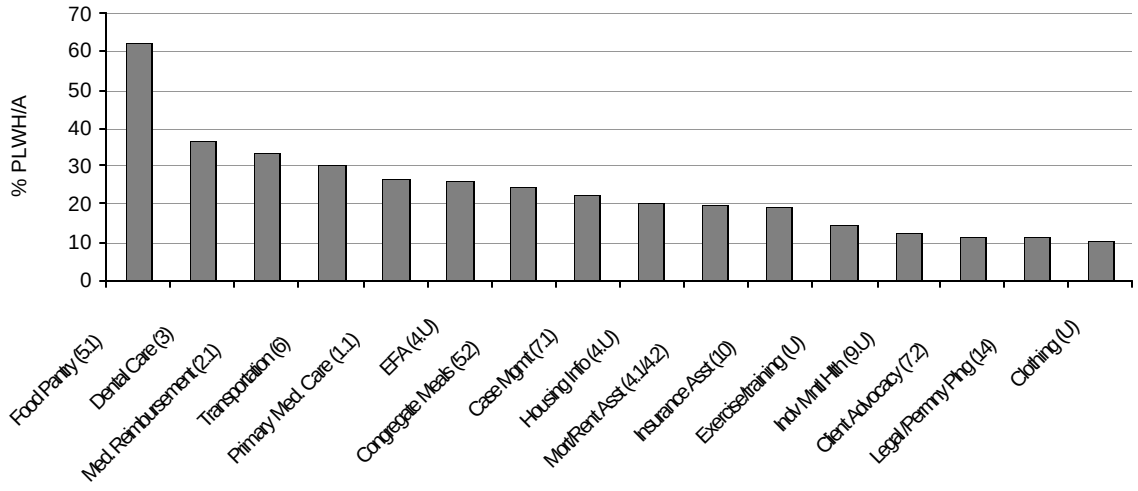
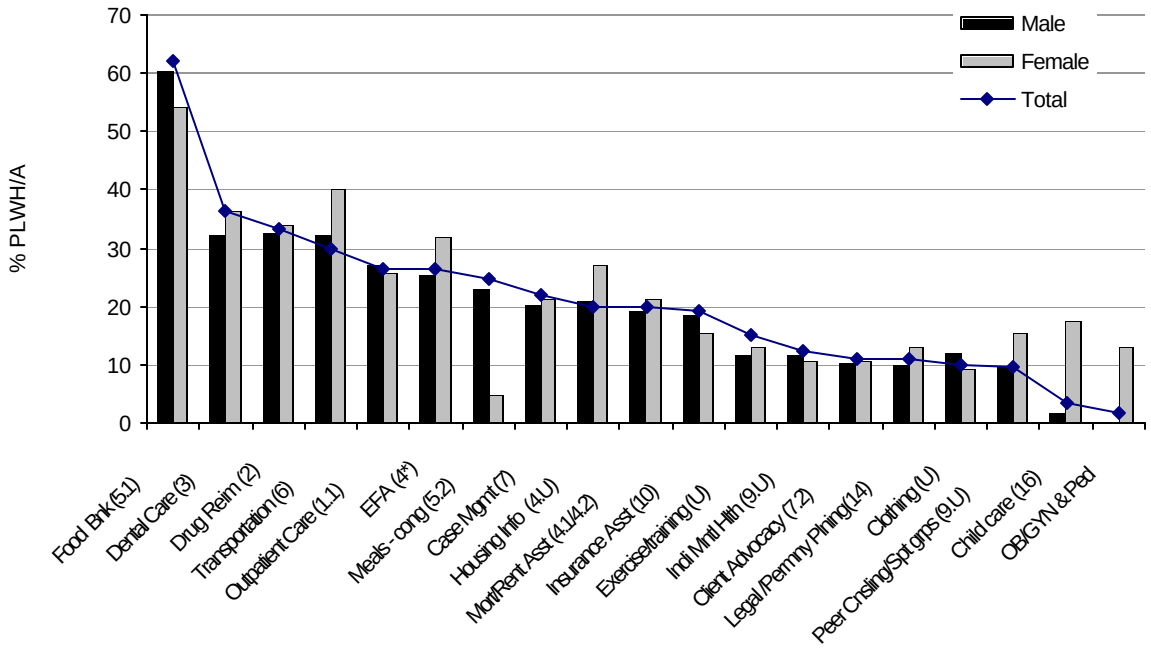


Table I-21 shows the services that males and females report needing the most. The line in the figure shows the "total" population need. Notably, among the general services, females are more likely than men to report needing transportation, financial assistance, housing and peer counseling. Not surprisingly, women are also much more likely to need child care and seek care by an OBGYN. Men are more likely to report needing meals and insurance assistance.

Figure I-22 Top Ranked Needs by Gender



African Americans and Latinos say they have a greater need than Anglos for transportation, housing information, congregate hosing and childcare.

When the top ranked needs are reviewed by ethnicity, as shown in Table I-22, 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 Latinos say they have a greater need than Anglos for transportation, housing information, congregate hosing and childcare. Latinos, report a greater need for housing, insurance assistance, peer counseling, vocational counseling, and translations services.

IDUs report reporting needing case management, peer counseling and support, vocational counseling, outpatient substance abuse treatment, and congregate housing.

Table I-23 shows the top ranked needs by risk group. MSM, who are disproportionately 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 congregate housing. Heterosexuals, disproportionately represented by African American females, say they are more likely to need emergency financial assistance and childcare.

Figure I-23 Top Ranked Need by Race

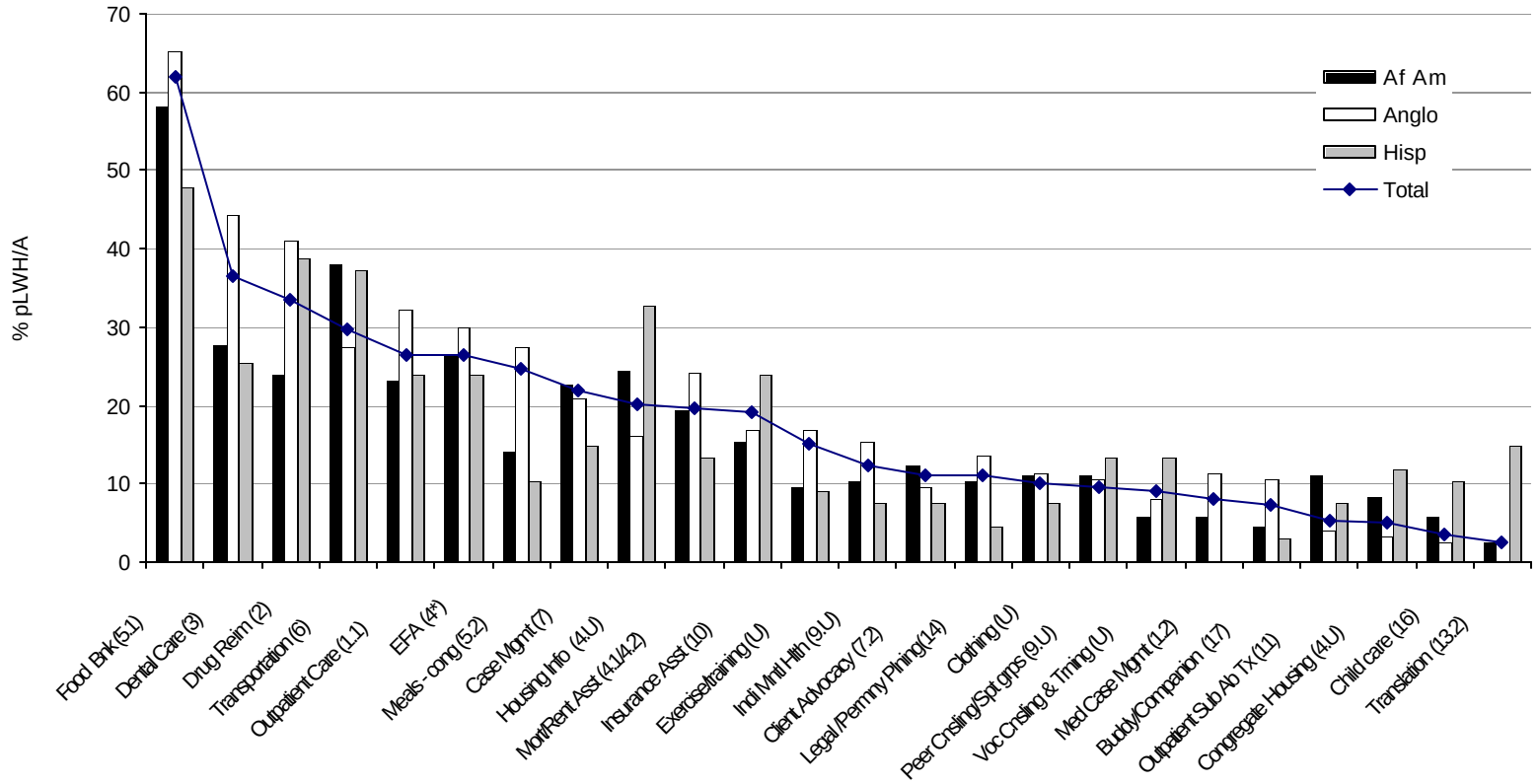
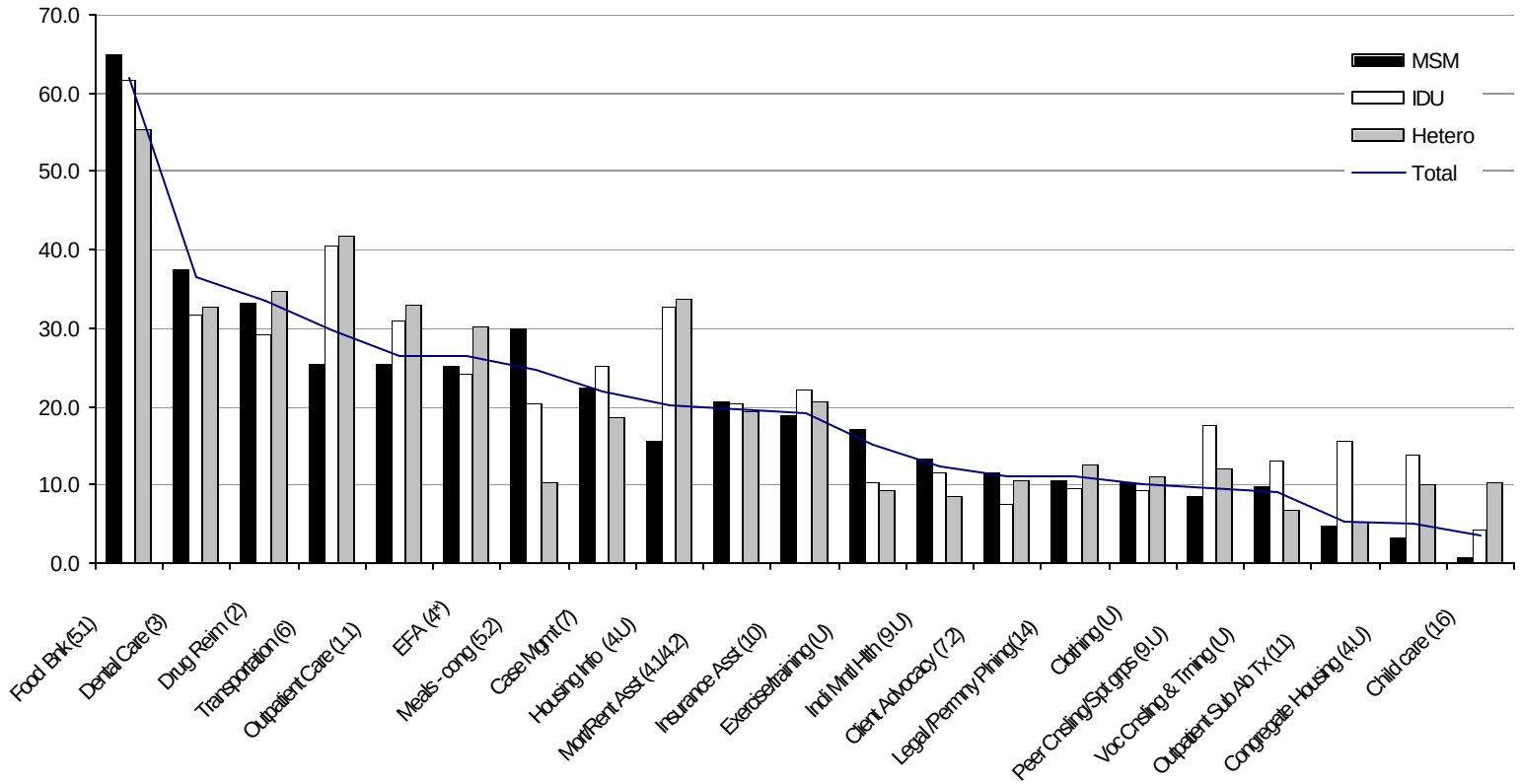


Figure I-24 Top Ranked Needs by Risk Group



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

For each of top fifteen services that most participants reported they needed, Table I-23 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".

Current use is reported to be under 40% for EFA, housing info, and mortgage and rent assistance.

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, core services are reported to adequately meet the needs of PLWH/A.

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

PLWH/A expect to need more housing services.

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 I-23 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
Drug 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 Heath	48.8%	2.1	3.6
Client Advocacy	45.9%	2.1	3.5
Legal Services / Permanency Planning	40.5%	2.3	3.3

*

Gap measure were constructed:

The 2001 Needs Assessment Survey measured the knowledge, perceived need, demand, and utilization for the 17 service categories and 35 subcategory classifications. In order to determine gaps in services several gap measure were constructed.

Knowledge gap is based on the assumption that everyone eligible should know about the service.

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.

Unmet perceived need is the difference between those asking for a service and receiving it.

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.

Need-receive gap is the difference between those saying they need the service and those receiving it.

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.

Table I-24 shows how each service ranks on these need and gap measures. The order of services reflects the RWPC/Consortium's priority ranking for 2000-2001.

There was very high awareness of food, dental, case management, and outpatient care.

There was lower awareness of insurance, information services, volunteer services, counseling, children's services, substance abuse, and congregate housing.

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 for a number of services. These included 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 largest need-receive gap was among the services PWLH/A say they needed the most – EFA,

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

health insurance, legal services, and transportation.

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 Latinos, there was a gap for translation services.

Notably there was no reported gap for the RWPC 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.

Health insurance and EFA stood out as having particularly large "need-receive" gaps.

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

Several needs were higher in the communities of color. Those are shown in the bullets on the right.

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 Latinos have relatively high need-receive gaps, with 22% to 23% reporting a need for **emergency financial assistance** and not receiving it.
- African Americans and Latinos 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 Latinos, 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 had a number of very high needs and they are shown in the right.

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 needs are bulleted on the right.

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 s**ubstance 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 needs are bulleted on the right.

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**.

Table I-24 Service Knowledge, Need, Demand,& Utilization

	Service	% Knowing	% Needing	% Asking	% Receiving	Knowledge Gap	Unmet perceived need	Need-Receive Gap
1.0	Outpatient Medical Care	76%	57%	55%	98%	24%	-43%	-41%
1.2	Medical CM	60%	34%	36%	33%	40%	3%	1%
1.U	Med Specialists (not OB/GYN)	59%	38%	38%	33%	41%	5%	5%
1.U	OB/GYN	71%	51%	47%	60%	29%	-13%	-9%
2.1	Drug Reimbursement	53%	43%	37%	87%	47%	-50%	-44%
2.2	Med. Delivery	52%	29%	25%	27%	48%	-2%	2%
3.0	Dental Care	82%	77%	71%	71%	18%	0%	6%
4.0	Housing	60%	34%	35%	23%	40%	12%	11%
4.1	Mortgage/Rent Assistance	58%	43%	41%	40%	42%	1%	3%
4.U	Congregate Housing	47%	19%	20%	19%	53%	1%	0%
4.U	Emergency Medical Services	77%	25%	50%	58%	23%	-8%	-33%
5.0	Food Services	89%	73%	72%	74%	11%	-2%	-1%
5.2	Congregate Meals	69%	46%	43%	51%	31%	-8%	-5%
5.3	Home Delivered Meals	43%	19%	16%	7%	57%	9%	12%
6.0	Transportation	60%	39%	39%	33%	40%	6%	6%
7.0	Case Management	80%	60%	66%	74%	20%	-8%	-14%
8.1	Para-Professional Home Health Care	48%	14%	18%	10%	52%	8%	4%
8.1	Professional Home Health Care	47%	11%	15%	16%	53%	-1%	-5%
8.2	Hospice Care	41%	6%	6%	4%	59%	2%	2%
9.U	Peer Counseling	49%	24%	22%	18%	51%	4%	6%
9.U	Group Mental Health	60%	27%	29%	37%	40%	-8%	-10%
9.U	Individual Mental Health	65%	40%	42%	51%	35%	-9%	-11%
10.0	Health Insurance	50%	45%	38%	27%	50%	11%	18%
11.0	Substance Abuse Treatment	50%	16%	17%	18%	50%	-1%	-2%
11.U	Residential Substance Abuse	42%	9%	10%	11%	58%	-1%	-2%
12.0	Information and Referral	70%	23%	28%	30%	30%	-2%	-7%
12.U	Hotline	59%	19%	19%	13%	41%	6%	6%
12.U	Information Clearinghouse	42%	21%	17%	15%	58%	2%	6%
12.U	Nutrition	69%	32%	35%	37%	31%	-2%	-5%
12.U	Resource Directory	68%	43%	39%	51%	32%	-12%	-8%
13.0	Access for Targeted Pops.	49%	27%	24%	20%	51%	4%	7%
13.2	Translation	36%	11%	9%	5%	64%	4%	6%
14.0	Emergency Financial Assistance	59%	45%	41%	29%	41%	12%	16%
14.0	Legal Services	66%	36%	38%	26%	34%	12%	10%
15.0	Adult Day Care	31%	9%	6%	4%	69%	2%	5%
16.U	Child Care	27%	8%	6%	5%	73%	1%	3%
16.U	Services for Children	20%	3%	2%	2%	80%	0%	1%
17.0	Volunteer Services	47%	20%	16%	14%	53%	2%	6%

Barriers are grouped into four types: individual, organizational, structural, and special needs.

Barriers

Forty-two barriers grouped into four general types: 1) individual, 2) organizational, 3) structural and 4) special needs are ranked by PLWH/A in the 2001 Needs Assessment Survey and focus groups. The barriers ranked by participants are shown in Table I-25. In the survey each barrier was rated as a "big", "moderate", "small" or "no barrier at all."

The determination of the types of barriers was based on a statistical technique called factor analysis.[21] 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.

Total Population Ranking of Barriers

Figure I-25 Highest Barriers, presents the "overall" barrier score for the top barriers identified by PLWH/A. 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 I-25 Highest Barriers. 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."

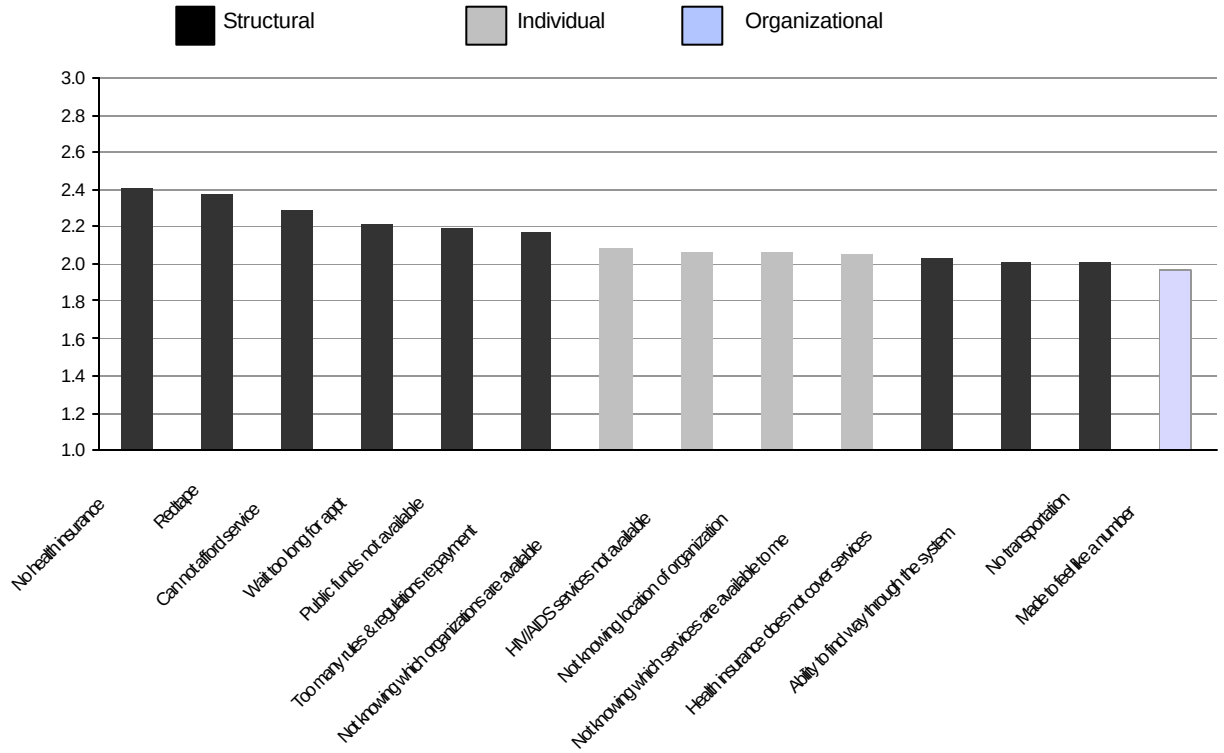
[21] A pairwise Pearsons correlation matrix was used as input. A varimax option was selected to better discriminate the factors.

Table I-25 Types of Barriers

Structural *Rules and Regulations* 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 *Access* 9. No transportation 10. No access to HIV care treatment specialist **Organizational** *Provider Sensitivity* 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	*Provider Expertise* 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 he/she was doing 25. Provider did not speak consumer's language **Individual** *Knowledge* 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 *Well-Being* 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 **Special Needs** 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

Figure I-25 Highest Barriers

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



Out of the top 14 barriers, nine are structural barriers, four are individual and one organizational.

As seen in Figure I-25, 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:

- No health insurance
- Red tape
- Cannot afford service
- Wait too long for appt
- Public funds not available
- Too many rules & regulations regarding payment
- Not knowing which organizations are available
- HIV/AIDS services not available
- Not knowing location of organization
- Not knowing which services are available to me
- Health insurance does not cover services
- Ability to find way through the system
- No transportation
- Made to feel like a number.

Summary of Barriers

In this section, a summary of findings related to barriers is discussed. Rankings and discussion for each of the 42 barriers studied can be found in the 2001 Needs Assessment Report.

Of the 42 barriers ranked by PLWH/A, none was perceived as “high.”

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 dimensions fell in one group more than the other and therefore presented separately.

The highest barriers were structural barriers, accounting for nine of the top fourteen.

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 prevent them from accessing services.

Women, African Americans, IDUs, recently incarcerated and those out-of-care face higher barriers than other groups.

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.

PLWH/A complained about the amount of paperwork they needed to fill out.

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.

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 that 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 PLWA was reported to keep persons from seeking services.

Developing Service Priorities and Allocations

Each year the RWPC/Consortium applies the information gained in needs assessments, epidemiological data, and its experience to set priorities for different service categories.

The number of PLWA is a rough estimate.

The number of persons infected with HIV is an imprecise estimate.

In developing the priorities and allocation of funds for services, the number of clients likely to need services is an important consideration. However, as indicated in the epidemiological section, the recent advances in medication have resulted in a decline in mortality due to AIDS, and with improved medication, the number of persons progressing from HIV to AIDS will decline. The extent to which decreased mortality and fewer persons progressing to AIDS will impact the number of PLWA is, at best, a rough estimate. In addition, because HIV has been reportable in Texas for only one year, the number of persons infected with HIV is an even more imprecise estimate.

A number of factors are taken into consideration in estimating priorities and allocating funding to services.

In estimating priorities and allocating funding to services, a number of factors are taken into consideration including the:

- History of rankings by the RWPC/Consortium;
- Number of persons likely to need the service;
- Priority ranking of the consumers;
- Number of persons receiving the service;
- Unmet demand;
- The importance of Title I, II, CBC and State/City grants in the overall funding;
- Capacity of the system to provide the service;
- Potential barriers to accessing the service; and
- Unit costs.

Many of these cannot be precisely quantified, but the information summarized above in this comprehensive plan allows estimates of these factors.

Rankings and percentage allocations should not match one-to-one, in order to allow for lower and higher unit costs, and needs between services.

In Table I-26, the left-hand columns summarized the history of funding priorities by the RWPC and Consortium. It includes only Ryan White Title I and II, HOPWA, CBC and Texas HIV and Social Services Grants ($16,119,476). It does not include Ryan White Title III, IV, Part F ($1.2 million for service to children, primary and dental care), State ADAP ($.7.6 million), or City Grants ($319,000). As noted in Table I-9 this would raise the total to about $25.3 million. The percentage of amount allocated, shown on the right, and the priority rankings do not reflect a one-to-one relationship with priorities. This is expected; services such as congregate housing, medical care, and intensive counseling and prescription drug therapy have high unit costs, while information and referral and access for

targeted populations have lower unit costs. Notably in Table I-26, the second ranked category in the 2000/2001 allocations, medications (transportation and reimbursement), have been included in outpatient medical care for purposes of comparison. Alone, they would account for 4.9% of the amount allocated.

Outpatient medical care has the highest priority.

The priorities indicate that outpatient medical care continues to be the number one priority, as it was from 1997 through 1999. Notably, in 1996, case management was considered the highest priority. Food and Dental Care have moved up in priority to second and third, confirming the importance of these services found in the 2001 Needs Assessment.

Food services and Dental Care are the second and third ranked priorities.

Case management and housing have increased in rank, reflecting their relative need.

The next tier of priorities includes services that assist PLWH/A to navigate the system and services that support stable housing. Information and Referral services has dropped from 9th to 10th, though as indicated earlier, there has been a substantial increase in demand for this service.

Mental health and Substance abuse service are ranked in the middle.

Mental Health and Substance Abuse services have remained in the middle tier of priorities, ranking 9th and 11th respectively. The bottom tier of service priorities is those specialized services that are important, but to selected populations, or have majority funding outside of Ryan White Care. ADAP is at the bottom of the list because the majority of funding for ADAP comes from the State program, and contributions from the RWPC/Consortium funds are generally unnecessary or small.

Lower tier services are those targeted to special populations or receive majority funding from non-Ryan White sources.

Available Funding and Service Utilization

This section summarized the available information for services.

The 2001 Needs Assessment provides detailed information on the number of units of service provided, cost of service, and allocation of funds for some, but not all, service categories. This section summarizes the available information for services. Comparisons are made to the amount of funding that was allocated to a service category, the number of units of service that level of funding could theoretically support, and the actual number of units of service delivered. In some cases, it appears that services are over-funded compared to the amount of service utilized by PLWH/A, and in other instances, funding is less than the demand being placed on certain services. In these instances, reported numbers are suspect and it suggests further investigation into the reporting procedures before any generalization can be made.

Table I-26 Dallas Area Service Priorities and % of Total Amount Spent in FY1999 & Allocated in FY2000

PRIORITY RANKINGS 99	PRIORITY RANKINGS 00/01	SERVICES	99/00 Expended $14,180,51 %	00/01 Allocated $16,119,476 %
1	1	Outpatient Medical Care	25.3	30.0
-	2	Medications (added as separate category in 00/01 and including medication transportation and reimbursement – 4.9%)		
3	3	Dental Care	4.0	4.2
7	4	Housing	9.4	13.2
5 (Tie)	-	Financial Assistance (in housing in 00/01)	7.2	8.0
2	5	Food	5.7	5.7
8	6	Transportation	4.8	3.5
5 (Tie)	7	Case Management	8.1	8.9
13	8	Professional Home Health Services	1.9	2.5
10	9	Mental Health Counseling	4.6	3.3
--	10	Insurance assistance (part of EFA in 99)	5.1	5.0
11 (Tie)	11	Substance Abuse Treatment	2.8	1.5
9	12	Information and Referral	1.6	1.4
4	13	Access for Targeted Populations	5.3	4.3
11 (Tie)	14	Legal Services	1.1	0.9
16	15	Adult Day Care	1.0	0.7
14	16	Services for Children and Adolescents	1.8	1.9
15	17	Buddy/Volunteer Support	2.8	2.1
		ADAP	3.2	1.5
		Program Support	-	0.1
		Administration	5.7	5.1
		RWPC/Consortium	1.1	0.8
		Needs Assessment	0.1	0.3

The RWPC would benefit from a more detailed study that analyzes cost of service and utilization patterns.

The services are listed in the order of the RWPC/Consortium 2000/01 priorities. No final conclusions can be drawn from this preliminary data. The RWPC would benefit from a more detailed study that analyzes cost of service and utilization patterns, which in turn, would provide useful information for a more efficient allocation of resources. This was started with the distribution of the provider information form in 2001, but data was not received for analysis in time of this Plan.

Outpatient Medical Care

Outpatient Medical Care receives 30% of total funding.

Predictably, outpatient medical care received the highest proportion of funds and has increased from 25% of total funding to 30% based on the increased number of clients and the rise in medical costs. It is estimated that Ryan White Title I, II, CBC, State, and Social Service Grants provide between 40% and 60% of all funding for outpatient care, with the other costs paid by insurance and other benefits.

Needs Assessment participants ranked outpatient care fifth in importance. It is not ranked higher because there is no reported unmet need.

Outpatient care, however, is ranked fifth in importance out of all funded services by PLWH/A surveyed as part of the 2001 needs assessment. As noted earlier, this is likely to reflect that the perceived need for outpatient care is being satisfied. In fact, fewer persons demand outpatient care than report receiving it.

Outpatient care at the current level will require greater capacity as more PLWH/A enter the system.

Title I and Title II provide about $3,070,299 for outpatient care service with an additional $138,484 provided by the Congressional Black Caucus and $354,862 through Title III of the CARE Act. The average unit cost for an outpatient medical care visit is $228.93. In the 2000/01 fiscal year, 13,412 units of service were funded, with 18,632 units actually provided, suggesting that continued outpatient care at the current level will require greater capacity.

Current protocols that call for medical appointments as a condition to receive medication or to maintain disability benefits may need to be reconsidered.

If current levels of utilization continue, there is a need to increase capacity. However, consumers are asking for fewer visits. This suggests that current protocols that call for appointments with a medical provider as a condition to receive medication or to maintain disability benefits might be reconsidered. For many these may be perceived as too frequent, and could indicate an area where outpatient care could be reduced for those who have few symptoms and medical needs.

A more realistic estimate of need for medical case management is one-third of PLWH/A who have adherence problems. There appears to be little unmet need.

Medical case management is included under outpatient medical care, and the reported data indicates that about 87,100 units were funded, and 56,544 received. In theory, if all those who were eligible asked for medical case management there would be a need for over 171,000 units, but a more realistic estimate of need would be to provide medical case management to about the third of the PLWH/A who have adherence problems (see 2001 Needs Assessment). Thus about a third of those eligible would need medical case management. This corresponds to the number provided. The adequacy of the number of case management units allocated is further suggested by the very low need-receive gap of 1%.

Most need for medication delivery is met. Female and rural PLWH/A expressed an unmet need for medication delivery.

There are no units of measurement reported on medication delivery. From the consumer side, it appears that there is no overall unmet need, but, in the Needs Assessment report, rural and women express a greater need than other populations.

Dental Services

Dental services are ranked third in priority.

Dental services are in 3rd place in overall rankings, reflecting the importance of dental care in improving the quality of life of PLWH/A.

Although PLWH/A, in general, reported no unmet need for Dental Care, Hispanics indicate an unmet need.

The data indicates that the funding allocated to dental services would purchase more units than demanded. There are over 8,000 units funded and about 4,000 units reported received. This could reflect a reporting error, suggest that the category is over-funded, or that consumers are not fully aware of the service. Overall PLWH/A reported no unmet

demand. Hispanics indicate small levels of unmet need. If all those eligible demanded services over twice as many units would have to be allocated.

Under-utilization of dental services needs to be investigated.

As one of the top ranked service categories in terms of need, it would be helpful to determine why dental services appear to be under utilized in relation to the level of funding being provided, and to develop a program of informing and bringing into dental care those in need, but unaware of the service.

Ryan White funding is the major source of dental care coverage for PLWH/A.

In calculating the allocation for dental care, Ryan White funds are likely to be the only funds allocated for dental care. While PLWH/A can pay for dental care out-of-pocket, the level set for dental care is most likely to reflect the vast majority of dental care services subsidized in the COC.

Housing

Unit costs for housing is very high. Less costly alternatives should be investigated.

Housing, the fourth ranked service by the RWPC and Consortium, received the second highest allocations (13%). This increase from FY 1999 levels reflects its higher ranking and the continued importance of housing for PLWH/A. However, unit costs are very high for congregate housing, and while housing is critical for PLWH/A, less costly alternatives, such as scattered sites, may be more economical in the future as PLWH/A have improved health status.

HOPWA provides a majority of the funding for housing services.

HOPWA allocates $2.5 million of the housing services. This is supplemented by about $263,000 by State and City grants. HOPWA provides all funds, about $478,000, for emergency financial assistance and a little over a million dollars for housing operations. State HIV provides funds support services, rental assistance, and housing acquisition and administration. In addition to HOPWA, other housing resources exist such as emergency shelters and Section 8.

HOPWA and Section 8 housing resources may be able to be maximized through effective coordination by case management and client advocacy.

Twelve percent of the PLWH/A ask but do not receive housing, and 16% ask but do not receive emergency financial assistance. As noted in the AIDS Housing Needs Assessment, there is a clear need to build capacity. However, given that the largest burden on housing falls on HOPWA, the challenge for the RWPC and Consortium is how to assist PLWH/A to maximize the HOPWA and Section 8 housing resources through effective case management and client advocacy. In addition, greater efforts to coordinate and collaborate with non-Ryan White sources may expand other funding opportunities for developing housing and providing financial assistance.

Food Services

The consumer ranks food services first in service needs and RWPC ranks it fifth for funding.

Proper nutrition is critical to assist adherence to medical treatments and to maintain overall health. In addition, food supplements play a vital role for the most underserved populations, such as the homeless. The RWPC/Consortium ranks food fifth in priority and PLWH/A rank it first. It received the fifth largest amount of funding. The difference in ranking between the consumer and RWPC reflect the changing profile of PLWH/A who have increasing needs of basic human services due to their economic and family situations.

Lesser need for home-delivered meals.

Some trends can be predicted. As PLWH/A become healthier, there will be less need for home delivered meals for people unable to live independently.

Congregate meals plays a valuable role in the overall service structure.

Prepared meals present a relatively low cost opportunity to reach different community of PLWH/A and provide support. This service provides a vehicle for information distribution and advice and appears to play a valuable role in the overall service structure.

The majority of funding for food services is likely to come from Ryan White.

Food services are widely used, and there is an estimated theoretical need of about 19,000 units of service. According to DDHS records, about 20,000 units of food pantry service were funded; COMPIS, however shows that only 5,275 units of the food pantry service were served. Although the health department units of service reported for only Title I and Title II, and not for funds provided by the state or through private funding sources, the funding that is reportable most likely accounts for the majority of food pantry funds. Information on delivered meals and congregate meals were not available to estimate need.

The gap in the number of units reported versus the number funded may be due to a miscalculation in the dollar support required to meet the need in the Dallas EMA, or it may reflect a reporting error. Further research into this apparent gap in funding and utilization should be undertaken to determine whether funds currently allocated to food pantry services should be re-directed to services where the need is greater and the funding is unable to support it.

In the 2001 Needs Assessment estimated that approximately the number asking and number receiving for food pantry services are about the same, suggesting that current supply meets demand. Though the qualitative data suggests that several PLWH/A find the amount of food they are allowed to take is too small and the quality of food is uneven. There is reported demand for more home delivered meals largely by African Americans and women. This may reflect a general need for food rather than an inability to prepare meal due to disability.

Transportation

The location of providers and the timing/coordination of appointments are to be considered for allocations.

The funding level for transportation dropped from nearly 5% in 1999 to 3.5% in 2000/01. Allocations decisions related to transportation service have several critical considerations including the location of providers and the timing and coordination of appointments.

Transportation includes cab rides, one-way trips, and mass transit vouchers.

Funding levels for services are difficult to assess because it involved relatively expensive cab rides and one-way trips, and less expensive mass transit vouchers. Without further categorization in reporting and consumer surveys, only demand and past history provides guidance on allocations.

The overall need-receive gap is small. Women and African Americans tended to express more of a need for transportation than other PLWH/A.

The overall need-receive gap is small, with 6% more saying they need it than receive it. It is largest among women and African Americans. From a logical perspective, there are two countervailing forces. On one hand persons are becoming healthier and thus in less need for transportation. On the other hand, more persons without the means or access to private transportation are becoming infected and progressing to AIDS. Consequently, there is likely to be greater need for transportation services among communities of color. An additional study could be undertaken to model the transportation needs of PLWH/A.

Case Management/ Client Advocacy

Third largest allocation is Case management.

Case management is ranked 7th in priority by both the RWPC/Consortium and PLWH/A, and client advocacy is ranked 14th by PLWH/A. Case management is the third largest recipient of funds at 8.9%, which is a slight increase over the 1999 allocation.

There is a growing need for case management with a medical emphasis, but there is also an expanded need to help PLWH/A receive entitlements.

Case management is evolving and consumer needs reflect a greater need for case management with a medical emphasis, seen in the greater funding of medical case management. However the need for case to assist PLWH/A gain entitlements and access the system is also likely to increase as more PLWH/A enter the system. At the same time, the need for assistance in adhering to medical regimens will increase. A professional level of case managers with enhanced training will become critical resources as the mix of services provided and the costs associated with case management services become more complex.

Case management is highly utilized and shows little unmet need.

Case management services have one of the highest utilization rates of any service category, but are ranked the seventh most needed services by PLWH/A. Title I and Title II, State HIV funds, City AIDS funds, and Congressional Black Caucus funds provide $965,194 for case management/client advocacy. With an average unit cost of $10.78 for a 15-minute increment of time, total service units funded in 2000/01 were

estimated to be 80,000. A total of 170,240 units were actually provided, far surpassing the amount funded through public sources, suggesting some adjustment might be made in unit costs or reporting procedures. Theoretical need for case management is about 111,000 units.

More people are receiving case management than report needing it.

As with outpatient medical care, more people are receiving the service than report needing it. According to the needs assessment, 74% of survey respondents reported receiving case management services with only 60% reporting a need for it. Since case managers are the referral point to many services across the system, it is not surprising to see PLWH/A utilizing this service in order to gain entry to other needed services, and this may explain the gap between needing and receiving.

RWPC/Consortium may want to assure that case managers provide a wider range of referrals and cross-provider utilization.

To create a better fit between demand and utilization and to more adequately meet expected demand, protocols could be changed to reflect lower demand. On the other hand, qualitative data suggested that many PLWH/A find that case managers are somewhat narrow in their view. The RWPC/Consortium may want to provide standards for training that assure that case managers provide a wider range of referrals and cross-provider utilization. If case managers were viewed as more helpful, it would be valued higher.

The system of providing short term client advocates may better address the issues of PLWH/A. From the qualitative data, additional effort has to be made to distinguish the difference and use of case managers and client advocates.

There is almost no information on the number and success of referrals.

There is little information on the number and success of referrals. Anecdotal information from the focus groups that are reported later in this document suggests it occurs between complementary services, but varies in effectiveness. The process of referrals could be more systematic and referrals could be tracked and monitored to facilitate evaluation.

Home Health Services

Professional home health services are not ranked high by PLWH/A. Still there is an expressed unmet need.

Professional home health services from an RN or other trained person is ranked 8th by the RWPC/Consortium and near the bottom of the list by all PLWH/A. This might be expected, because PLWH/A only access professional care when they are ill or disabled and that is increasingly unlikely.

As the Anglo MSM populations is at a more advanced stage of infection than other communities, the need is greater among this population. However, there is demand-receive gap among communities of color and females.

Title I is the main funding source of home health care among the different Ryan White titles and State and City grants. However, Medicaid and insurance may cover some home health care. Independent agencies have long established a history of providing home health care, and the need will be highly related to more advanced stages of HIV disease.

Mental Health Counseling

PLWH/A rank mental health services moderately high in need.

Mental health services are essential for many PLWA who have co-morbidities of drug use and mental illness. They are ranked 9th by the RWPC. Individual and group counseling are ranked 13th and 17th respectively by PLWH/A. There are few good estimates on the number of clients in need of mental health services because of the multiple funding sources.

PLWH/A report receiving more mental health services than they ask for.

As seen in above in Table I-8 there has been a significant decline in number of clients served and Table I-26 shows a relatively small decline in funding. In the survey, consumers noted that they received more mental health services than they asked for.

More recently diagnosed may benefit from mental health services.

While current trends suggest a continued declining need in individual and group mental health services, in considering priority and allocations, the qualitative data suggests the need for those more recently diagnosed to access mental health services. Provided the services are culturally appropriate and access is encouraged, there is likely to be an increase in demand among communities of color. This may be an opportunity to prepare clients for issues of denial and disclosure that present barriers to accessing care.

Insurance Assistance

Not having insurance is a top barrier to accessing care.

Not having insurance is a top barrier to accessing care. It is ranked as the 10th priority by the RWPC and 11th by PLWH/A. The scope of insurance assistance is limited to premiums and related co-pays and deductibles for eligible PLWH to ensure continuation of insurance coverage. Consequently the relatively small number, 334 PLWH/A corresponds to about the 5% of the PLWH/A who reported COBRA or private insurance that is not work related.

A high demand-receive gap for insurance assistance.

Still, the demand-receive gap is among the highest of all services suggesting there is a considerable perceived need, and many of those asking may not be eligible given the current service definition.

The newly infected may have less adequate or no health insurance.

In the future, insurance assistance will become much more important. With fewer persons disabled, SSDI and Medicaid will cover fewer persons unless a Medicaid waiver for HIV positive persons is accepted. Given that demographic profile of the newly infected, they are less

likely to have adequate, if any, insurance. Insurance Assistance can play a significant role in paying co-pays and deductible for those insured at work or through COBRA.

The RWPC/Consortium might also consider educational efforts at the State Legislature to permit the purchase and payment of insurance premiums in the Texas high risk pool for PLWH/A.

Substance Abuse Treatment

Substance abuse is a major gateway to HIV transmission.

Women and African Americans report a higher unmet need for substance abuse services.

Substance abuse treatment services are ranked 11th out of 17th by the RWPC/Consortium and in the bottom fourth of services by PLWH/A. The relatively low rank reflects the low percentages of PLWA who are classified as substance users. However, substance use is a major gateway for heterosexual transmission. Non-IDU substance abuse affects significantly more PLWH/A than injection drug use. From the epidemiology and survey, the need for these services among drug users is great. There is little unmet need noted by consumers in general. African Americans and women tend to say they need it the most.

Title I allocated $233,030 for substance abuse treatment, and $10,985 comes from the state through Title II. One unit of substance abuse services is defined as a 45 minute counseling session at an estimated cost of $50 per session, suggesting that 4,880 units of service were funded in the 2000/01 fiscal year by Ryan White and State Grants. A total of 7,920 units of service were actually provided, suggesting that other sources of funds such as TCADA and SAMSA also fund services.

An explicit program of coordination between Ryan White and other sources of drug abuse services will be developed.

As drug abuse services tend to be offered through several different channels, the RWPC/Consortium might make a more extensive study to determine whether current allocations are sufficient to meet the apparent demand in services.

Information and Referral

Information and referrals include several subservices including HERR, nutrition education and counseling, hotline or telephone information, resource directories, and information clearinghouse. It is ranked 12th by the RWPC/Consortium and most of the services in information and referrals were not in the top half of the most needed services.

PLWH/A report receiving more health information than they ask for.

In total, the information and referral services receive nearly $400,000. PLWH/A typically say they receive more health information than they ask for, however African Americans and females are the exception and generally they ask for more information than they receive.

African Americans and women express unmet information needs.

The information service with the largest unmet need is the information center and library. In general, PLWH/A report asking for this service more often than they receive it. Again, African Americans and females

express the largest unmet need. Hispanics, notably, have a relatively large unmet need for information, particularly the resource guide.

Reflecting the small unmet need expressed by PLWH/A and the multiple other sources of revenue for information services, as shown in Table I-26, the RWPC/Consortium allocated slightly less to information and referrals in 2000-2001 than in 1999-2000. In considering allocations the unmet needs of African Americans and women must be considered as well as the interface between prevention and care information.

There is an increasing demand for synthesized and targeted information that is culturally competent.

In addition, the qualitative information suggests that there is an increasing demand for synthesized and targeted information to address the needs of different populations in a culturally competent manner. As the information and referral services are reconsidered, alternative distribution sources, easier and targeted access, and more preparation and synthesis of information could potentially meet a greater need.

Access for Targeted Populations

Access for Targeted Populations has dropped in funding priorities.

The fourth ranked priority in 1999, Access for Targeted Populations, dropped to 13th place in 2000. This service recognizes the need to improve access for un- and under-served populations, and the evidence suggests that this it particularly needed among African Americans.

Over 1000 persons may be out-of-care.

The epidemiology suggests that there may about 10,500 PLWH/A in the Dallas area. It is estimated that about two-thirds, or 6,930 know their serostatus (see the 2001 Needs Assessment Report for details of estimates). COMPIS shows that over 5,000 persons are receiving care, suggesting that about 2,000 persons are not receiving care by providers funded by Ryan White, and over 1,000 persons are out-of-care.

The task for access to targeted populations will be to coordinate with prevention to increase the number of at-risk persons to be tested and to bring them into care. This is particularly critical among the communities of color. The second challenge is to find and bring those out-of-care into care by improving access, providing child care, increasing knowledge about affordable care and assisting persons with obtaining entitlements.

Translation Services

Translation services would assist in reducing the need-receive gap of services in the Hispanic communities.

As part of access to targeted populations, translation services should help close the need-receive gap for the Hispanic population. As more monolingual and Spanish speaking are brought into the COC through outreach, there will be an increasing need for translation services.

Legal Services

There is little unmet need for legal services.

Legal services dropped from 11th to 13th in RWPC/Consortium priorities from 1999 to 2001. In the 2000/01 fiscal year, funding levels for legal services reached $151,559 through a combination of sources including Title I and State HIV funds. About 6,570 units, or 15 minute time increments were funded and about 5,275 units were actually provided, indicating a good match between funding and capacity.

PLWH/A report asking for legal services more than receiving it.

However, PLWH/A indicate a substantial unmet need and say they ask for more services than they receive. While women and African Americans have the largest unmet need, there is an unmet need among all ethnic communities and risk populations. As living AIDS cases continue to increase in the Dallas EMA, it is likely that the demand for legal services could increase as with most other services.

Improving access to legal services is likely to increase demand.

The qualitative data provides clues to providing legal services that better meet the needs of PLWH/A. Increasing hours, creating more rapid response, and providing more experienced legal advice will help consumer and should substantially increase access to legal services.

Adult Day Care

Adult day care is a service for those adults living with HIV and AIDS who are no longer capable of independent living, are in recovery and need assistance to resume independent living, or have a need to improve their quality of life and provide respite to their caregivers.

Adult day care is essential for those with significant disabilities.

Because of the small number of persons who need to access this service, it is low on both the RWPC/Consortium's and consumers priority. Still, it is an essential service for those with significant disabilities such as dementia or other end-state illnesses.

From data reports it appears that more units were funded than accessed, but there continues to be an unmet demand. For those insured by Medicaid or other insurance there is likely to be some coverage for adult health care. If the reports are accurate, to increase demand there is a need to increase education about adult day care among caregivers who provide support for PLWH/A.

Services for Children and Adolescents

Services to children are appropriately funded.

With the declining number of infants and small number of adolescents, services for children have a low priority ranking, and with over $1.1 million in funding, there is an excess of units of service budgeted to meet expected need. Title IV provided $800,000 in 2000/2001 and Title I and II provided about $222,647. State HIV and City AIDS also

provided funding. Other funding such as insurance programs targeted to young poor families (Medicaid, CHIP) and TANF also provide potential funds for services to needy families.

There is a knowledge gap about available child services.

The survey and focus groups suggested that there is a significant knowledge gap about available services and for those out-of-care childcare is perceived as a barrier. This would suggest renewed resources to link families in need with available resources.

Buddy Companion

A knowledge gap may be connected to low demand for Buddy Companion services.

As PLWH/A become healthier the need for buddy companion services will decrease. If reporting is correct, there are more units funded currently than delivered. However, there is also a perceived unmet need. Lack of knowledge may contribute to the unmet need, as under 50% of all populations know about buddy/companion services.

The greatest expressed need is among females and recently incarcerated (31%), rural (28%) and families (27%). Need is lowest among males (17%).

Currently, Buddy Companion services may best serve rural and recently incarcerated consumers.

Initially buddy services were helpful among gay men as a way of providing companionship to those disabled by of AIDS. Today its purpose has changed, and it might be targeted to rural and recently incarcerated as a way of supplementing and supporting care. This suggests, however, the need to arrange transportation or expand services to phone or other types of support. It is also harder to find buddies and volunteers to work with communities with no intrinsic ties. Thus recruitment and training for buddies becomes a greater challenge.

Funding should follow demand, suggesting continued declines in funding, but providers may re-conceptualize the service so that it responds to unmet need among different population.

Conclusions for Planning

Who?

In 2001, the service system will be providing services for over 5,500 PLWH/A.

The trend of decreasing mortality and increasing number of PLWH/A continues in the Dallas area. From a caseload of about 3,850 PLWA in 1996, the service system will have to provide services for over 5,500 PLWH/A in 2001.

There will be at least the same number of HIV infected individuals who have not progressed to AIDS.

There will be at least the same number, and probably more, HIV infected persons who have not progressed to AIDS by 2000. Up to 2,000 are likely to be out-of-care and another 3,500 who are positive but do not know their status. Those out-of-care and with unknown

status will be predominately among communities of color. Those out-of-care are most likely to be African American, while those with unknown status are likely to most represented among the Hispanic and African American communities.

The vast majority will be MSM and Anglo. About a fifth will be African American and about 11% will be Hispanic.

Of those living with AIDS, the vast majority will be MSM and about 70% will be Anglo, 19% African American and 11% Hispanic. There will be a minor shift toward more African Americans and proportionately fewer Hispanics. However, the majority of Hispanics with AIDS will continue to be MSM.

Of PLWA, IDUs will continue to be 9% - 12%. The majority of IDUs will be African American.

IDUs will continue to be between 9% and 12% of those living with AIDS. In 1999, roughly 450 IDUs living with AIDS will need care. The majority will be African American, and over a third will be Anglo. Less than 10% will be Hispanic. About a quarter of the IDUs will be female.

Non-injection drug use is a serious co-morbidity.

Non-injection drug use is a serious co-morbidity with HIV and may interfere with adherence to treatment regimens, and/or interact negatively with medications. Substance abuse, recreational and habitual, continues to be a major challenge for HIV care services.

There will be fewer than 300 heterosexuals with AIDS.

Between 200 and 275 PLWH/A will be heterosexuals. Over half will be female; the majority of those will be African American.

The morbidity rates indicate African Americans are accessing the continuum of care at a later stage of HIV disease.

The mortality and fatality rates, plus recent seroprevalence studies point to African Americans as being of particularly high risk of complications due to AIDS and of becoming infected by HIV. This would suggest a greater focus on effective programs to improve the access to care for African Americans.

Fewer than 10% of PLWA will be in outlying counties.

Over 90% of those living with AIDS and infected by HIV will be in Dallas County. This percentage is likely to increase. Of the roughly 350 PLWH/A residing in outlying counties, the majority will be physically able to travel for services. The challenge will be in arranging effective and efficient transportation and easy access to centralized services.

For HIV positive persons, early medical monitoring is recommended. Adherence will be a challenge.

Early medical monitoring for HIV positive persons who have not progressed to AIDS will be needed and a system of case management and adherence assistance will have to evolve to assure that all non-Ryan White entitlements are accessed, with an improved coordination among services, particularly housing.

The low number of PLWH/A among populations such as infants, adolescents, those co-infected with TB, and the homeless does not allow for the support of organizations that provide only AIDS services

to each of these populations. The challenge will be to integrate AIDS services into existing services targeted to these populations, or to expand AIDS services organizations to meet their special needs.

There is little data on the co-morbidity of mental illness.

There is a need for improved data on individuals living with HIV and mental illness, and providing mental health services to those in early stages of infection.

The COC is shifting to meet the needs and demands of PLWH/A, and the need for services are likely to change. There are key environmental changes that will result in considerably different demand on the COC.

First, treatments have been very successful. That will have four consequences effecting services.

1. There will be significant increase in the number of PLWH/A who will need care and 2) the much slower progression of HIV to AIDS, as early treatment will sustain low viral load and high t-cell counts.
2. As PLWH don't progress to AIDS, they will not be eligible for disability and consequently coverage under SSDI, SSI, and Medicaid will greatly decrease.
3. There is a significant shift in new HIV cases into the African American communities who are traditionally under-insured.
4. Because of low morbidity, Anglo MSM will continue to represent the vast majority of PLWA.

There is a growing in-migration of Hispanics.

Second, there is a growing in-migration of Hispanics. This is both an opportunity for coordination between prevention and care around testing, and it is a warning that HIV may disproportionately affect Hispanics in the near future.

Third is the expansion of the EMA to cover additional rural counties and the necessity to provide coordination between providers and provide services to those communities.

Resources

Shift in resources to core needs of medication and medical care.

Ryan White, HOPWA, State HIV, ADAP, CBC, and City AIDS contribute about $25.2 million to the services in the continuum of care (COC). This does not include Medicaid or Medicare, private insurance, out-of-pocket expenses, other publicly and privately supported service providers, or pharmaceutical clinical trial or compassionate care programs that distributes drugs. About $16,000 are under the direct control of the RWPC/Consortium, and it provides the majority of care services to those who are under- and un-insured, with four important exceptions: 1) medication funded through ADAP, 2) services targeted to children and families funded under Title IV, and 3) housing and

emergency financial assistance, largely funded through HOPWA, and 4) substance abuse services which are provided through TCACA and SAMSA. The interface with these services exists through some supplementary funding for enhanced services or programs and through referral services, including case management and client advocacy.

Resources expended on prescription medications and outpatient medical care have been increasing. Assuring that PLWH/A have access to these critical services takes priority and there will be increasing demands on the system because fewer PLWH/A will be insured.

Along with need, resources on food services, housing, and case management have also been increasing and case load increases. The profile of these services is likely to change as PLWH/A become healthier, as is discussed below.

Balancing support services with medical care will be a challenge as the numbers of persons eligible for medical care increase.

Given finite resources, the RWPC/Consortium will have to make difficult decisions about the support they provide to stabilize PLWH/A and to enable them to adhere to their medical regimen and maintain a reasonable quality of life.

Resources for substance abuse services appear to be declining faster than the epidemic would suggest.

Of particular interest is the decrease in funding for substance abuse services and level funding of insurance. While funding outside RW may fill this gap, an assessment of the capacity to serve substance abuse services and insurance in the Dallas EMA would provide essential information for planning.

What Needs and Barriers?

The HIV/AIDS system is doing an excellent job meeting the outpatient, medication, and case management needs of PLWH/A who are in care, and the primary emphasis of the COC is to assure that all PLWH/A have affordable and culturally appropriate access to these services.

MSM have the highest overall awareness, utilization, and satisfaction as well as the lowest barriers to care.

Although there might be a need for improvement in awareness of outpatient care, medication delivery, and case management, Anglo MSM generally report high awareness and utilization of relevant services, high access, and high satisfaction with services. Overall MSM have the lowest barriers to care and, like most other populations surveyed, find insurance and red tape among their highest barriers. Because the system tends to serve these PLWH/A relatively well and they have a strong advocacy voice, there are few significant gaps in their services. Greater access to information is one area that has an unmet need.

Insurance reimbursement is a service that is likely to rapidly grow among those with work histories who are HIV positive or have AIDS.

	For those at work with low paying wages, there is likely to be a demand for co-pays or deductibles. For those leaving work due to HIV illness there will be a demand for insurance continuation. There is an opportunity for the RWPC/Consortium to further promote the ability to pay for co-payments and deductibles for those returning to work in an effort to maximize the insurance coverage of PLWH/A.
Future challenge: available, accessible, affordable and appropriate medication.	The challenge is to continue needed services for MSM while improving efficiency of coordination of services to communities of color and women. The needs assessment particularly showed high unmet need among African Americans and women across most services.
There will be an increase in the proportion of African American and Latino MSM. Stigmatization from community and friends continues to be a barrier for men-of-color.	The percentage of men-of-color who have sex with men will increase, and they are likely to have particular needs. The survey and focus groups highlight their reluctance to seek care because they fear stigmatization from their community. Utilization of services is relatively high for all Latinos and men-of-color. While they have greater awareness and utilize AIDS services more than heterosexuals with AIDS, they are not as aware of services as Anglo MSM.
Young MSM are at particular risk for HIV infection and appear to access services less than adult populations.	Young MSM appear to be at particularly high risk for contracting HIV, suggesting greater coordination with prevention and testing for these young men. They appear to access services considerably less suggesting a need for both outreach and training for service providers to identify and be sensitive to the needs of youth.
Men-of-color and Latinos report above-average needs for basic services such as housing and food services. Still, utilization and satisfaction is relatively high.	African Americans and Latino men and women have greater needs in basic housing and food services, which may be attributed to lower socio-economic status. Latinos, like MSM, have relatively high satisfaction and report good access to services. Based on fatality rates and focus group data, it appears that Latinos are more likely than African Americans to access care and receive ongoing care.
IDU are aware of referrals, so coordinating services and referrals can be particularly effective.	As drug users often have multiple needs. They are disproportionately represented among the homeless and mentally ill. Providing coordinated care for drug users should be a high priority, and suggests efforts to coordinate with TCADA and SAMHSA programs would be beneficial. IDU report relatively high needs for almost all services and they report among the highest barriers to care.
IDU are aware of and utilize AIDS services. IDU have relatively high rules and regulations and organizational barriers.	As expected, they have higher needs for substance abuse programs, but they also express high needs for basic services. They feel that they rules and regulations are relatively high barriers. This is likely to be due to rules requiring abstinence and the presentation of paperwork that they may not be able to maintain.

Women's service needs and barriers parallel those of men. They are generally heavier users of outpatient medical services, but less aware of medication delivery.

The majority of the heterosexual AIDS cases are women of color who have contracted AIDS through sex with drug users or bisexual partners. Most of their needs parallel the needs of men infected with HIV. However, the survey reveals that they tend to be less aware of medication delivery and emergency financial assistance and they have a much greater need for childcare. While there are adequate resources for child care and services, there is inadequate knowledge among women about how to access these services.

Confidentiality and appropriate referrals are significant barriers to care for women.

Confidentiality and referrals stand out as barriers for women. Confidentiality is an issue because of the immigrant and migrant status of some of the women infected and, among women of color, there is significant stigmatization of PLWA in their communities. Referrals are an issue because it is likely that many of the women who are receiving care are accessing sustained health care for the first time and have multiple health care needs.

Recently incarcerated PLWA are less likely to access information than other populations. Housing placement is a high need and red tape and insurance eligibility are relatively high barriers.

Recently incarcerated PLWH/A have relatively high awareness of services, but are much less likely to utilize information services. Housing placement is among their greatest needs and, like other groups, insurance and red tape present their highest barriers. Sensitivity to their issues also is a top barrier for the recently incarcerated.

The focus groups suggested that recently incarcerated PLWH/A face discrimination and lack of consistent care. This suggests greater training for the correctional officers and medical providers and the establishment of procedures for PLWH/A while incarcerated. Recently incarcerated with a felony conviction within the last three years are ineligible for HOPWA funds and this may reduce the options for funding services targeted to the recently incarcerated.

The shift of emergency funding to HOPWA and seeking other non-emergency funding is a goal of the RWPC/Consortium.

There is considerable unmet need for housing and the related emergency financial assistance. Because the majority of funds are committed through HOPWA, the major goal of the RWPC/Consortium should be to provide improved coordination and advocacy for PLWH/A to HOPWA and section 8 housing.

Current Challenge

The future challenge is a shift to a chronic care system. Effective and coordinated care will become increasingly vital.

Over the past few years the RWPC/Consortium has been adjusting the COC from an end-care system to a chronic care system. That has meant the shift from end-stage services such as hospice care, to ongoing medical treatment, medical case management, and medication reimbursement. Planning can improve the efficiency of the system by cutting red tape and reducing client burden by sharing information and improving referrals.

The next generation of COC will be to shift from a system that is a major provider of services to coordinating services and providing necessary supplementary care. That will require improved coordination with other funding sources for basic services such as housing and food, as well as coordination with insurance carriers and employers.

As chronic care becomes the norm, there will have to be a shift from emergency funding to more sustainable Medicare, Medicaid, and private insurance. Planning for that shift is essential. Part of that process is providing the systems for sharing information and preparing for managed care. They system has already adopted unit costing, and the perfection of that system will make the transition to managed care easier.

Overall, the priorities of the RWPC/Consortium have anticipated the needs of the different populations affected by AIDS.

The evolution of the COC will also require that systems be developed to effectively bring persons into care through: 1) testing and the subsequent awareness among individuals of their positive status, and 2) assuring that those in care continue treatment and those out-of-care return to care. This will require coordination with prevention services and work with community organizations that have a track record of working within the African American, Latino, and immigrant communities.

The transition from acute to chronic care and from grant funded to managed care will be difficult for CBOs and other organizations with little infrastructure for tracking clients, billing, or monitoring services.

The RWPC/Consortium recognizes the need to develop dependable tracking and patient care systems and to develop a continuing database that measures system capacity. Without these systems, the priority and allocation process will continue to be a very imprecise process. These will be particularly important as the managed care model becomes the standard for organizations serving PLWA.

For underserved populations, sustaining comprehensive services will present a substantial challenge.

Last, the infrastructure that has allowed for the provision of care to the most underserved and disadvantaged populations should be continued. For many PLWH/A, AIDS care has been the first time that they have experienced any type of sustainable care, and its positive impact on their health is evident.

II. WHERE SHOULD WE BE GOING?

Shared vision and values are the touchstones for all action.

The question, "Where should we be going?" was asked in order to determine the course in which the service system should be taking to meet the changing needs of PLWH/A, the epidemic and the environment. In 1998, the RWPC/Consortium mutually defined its vision and values, and these are the referent for all actions. All activity should be directed to achieving the vision of the RWPC/Consortium, and should embody their values.

A. What is the shared vision for a COC for PLWH/A in the community?

Three years ago, the RWPC/Consortium developed a shared vision statement that would guide their service delivery and planning. The 1998 shared vision statement was reviewed in 2001 by an ad-hoc strategic planning group to determine its continued relevance and representation. Although most members agreed that the 1998 statement was still an accurate representation of the vision of the current RWPC, modifications were suggested and approved that broadened the scope of the statement to encompass clients out-of-care, clients who are new to the system, as well as issues of access to services and clarification of the meaning of prevention in the context of a COC. The following revised vision statement reflects the commitment of the RWPC/Consortium to continuing to strive for a comprehensive and responsive service system:

The vision of the Dallas EMA embodies its shared values and sets direction.

By the year 2004, there will be an accessible, comprehensive, non-prejudicial, and coordinated continuum of high quality, cost and outcome effective prevention, health, access, and support services for PLWH/A in the Dallas EMA and HSDA.

By "accessible", the vision reflects that today the HIV/AIDS care systems appear less accessible for some groups like African Americans and drug users than other populations affected by AIDS.

"Comprehensive" suggests that the continuum of care must meet basic medical as well as support needs of PLWH/A, and must be prepared to provide services from point of infection through to the stabilization of the infection or death of the PLWA.

"High quality" suggests that there is a standard of care that is measurable and that it achieves improved health status and quality of life.

"Cost and outcome effective prevention, health, access and support services" means that effectiveness and efficiency are monitored and that outcomes have been specified for services throughout the COC and have been achieved.

B. What are our shared values about services for PLWH/A?

The values statement that was initially adopted for the 1998 plan was also revisited by the ad-hoc strategic planning group. The intent of the values statement was to ensure that PLWH/A were able to access services with dignity and were empowered to make choices about their treatment. This statement was expanded by the 2001 strategic planning group to explicitly address PLWH/A who were not currently in care, emphasizing the RWPC's commitment to an inclusive and responsive service system.

Values include respect, cultural competence, dignity, and empowerment for PLWH/A in a changing environment.

The values of the RWPC/Consortium encompass the compassionate, ethical, respectful, client-focused, and culturally competent delivery of care to PLWH/A currently receiving services and those not yet in the system of care.

The values speak to the need to have a core of service providers who are responsive to PLWH/A and sensitive to their medical and social needs, and who will take steps to ensure that all PLWH/A have access to services.

C. How will we develop short (annual) and long-term service objectives, service priorities, & allocated resources?

Core competencies, strengths, and weaknesses were examined before developing actions.

To develop activities that enhance and modify the service system to achieve the vision of the RWPC/Consortium, an internal assessment was conducted in late 1997 and early 1998. Core competencies (or strengths and weaknesses) of the service system, services provided, and the support structures were examined. The support structures include administration of the grants, contract administration & planning, RWPC/Consortium support, and planning & evaluation.

Conceptual Framework

Planning Schema

In reviewing the core competencies, core weaknesses, and critical success factors specified by the RWPC/Consortium, Table II-1 provides an overall schema.

Table II-1 Planning Schema

SYSTEM-WIDE	ADMINISTRATIVE	SERVICE DELIVERY / IMPLEMENTATION
Collaboration	RWPC Functions	Service priorities and delivery.
Continuum of Care	Contract Administration	
	Planning & Evaluation	

System-wide concerns include: collaboration and continuum of care.

System-wide concerns, such as collaboration and continuum of care, are those that affect the way in which services add up to affect the health and well being of PLWH/A.

Administrative functions address the RWPC/ Consortium and its support mechanism-DCHHS.

Administrative functions are the domain of the RWPC/Consortium and DCHHS. They provide for the planning and execution of services, develop RFPs based on service priorities, allocate funds, award and review contracts, and evaluate outcomes.

Service delivery and implementation.

Service delivery involves developing the service priorities and implementing the plan based on the needs of PLWH/A and the mandates of State and Federal agencies.

Core Competencies & Weaknesses of Dallas EMA HIV/AIDS Care System

In developing the 1998 Comprehensive Plan, the RWPC/Consortium created an Advisory Panel to work with planning consultants to review core competencies and weaknesses.

Table II-2 Core Competencies and Strengths indicates that:

- Cooperation, coordination and volunteer support are core strengths of the service delivery system.
- Targeted services, especially those for children, are strengths of the COC.
- The administrative process efficiently allocates and distributes funds.
- Planning & Evaluation are moving toward unit costs.
- Many Title I service priorities were identified as core competencies.

CORE WEAKNESSES

Table II-3 Core Weaknesses of the HIV/AIDS care system indicates that:

- System-wide collaboration is weakest for special target populations like incarcerated, multiple diagnosed, and drug users. Collaboration for obtaining financial assistance is weak.
- COC weaknesses suggest access problems which require targeted actions.
- Other COC weaknesses suggest lack of sensitivity on the part of some providers.

- Administrative weaknesses indicate the need to broaden the base of participation through translation services and encouraging more diversified participation on the RWPC/Consortium, including input from clients who feel they can make grievances.
- Another administrative weakness identified was obtaining evaluation and assessment results.
- Service delivery and implementation weaknesses include providing greater access to services through transportation, increased risk reduction activity, employment and vocational programs, and housing options.

Table II-2 Core Competencies and Strengths

SYSTEM-WIDE CORE COMPETENCIES **Collaboration** • Levels of cooperation between agencies • Coordination of care • Charitable support and volunteers **Continuum of Care** • Targeting populations • Services for children – daycare, medical, managed care
ADMINISTRATION CORE COMPETENCIES **Contract Administration** • Working relationship between Title I, II, HOPWA, and State Services, Administrative Agency, and Planning • RFP process • Administrative process is efficient (allocation and distribution of RWCA $ to client is rapid and smooth) • Long term personnel with long term providers **Planning & Evaluation** • Administrative structure – unit cost work and planning • Unit cost system movement • RWPC
SERVICE DELIVERY / IMPLEMENTATION COMPETENCIES **Service Priorities** • Outpatient Medical Care – Parkland, VA, M.K. Wright Clinic • Housing services – ASD, Welcome House, Legacy, Johnnie's Manor, Bryan's House • HOPWA • Long term assistance (needs exposure) • Food services • Counseling – one on one and group • Dental services • Substance abuse counseling • Mental health services • Legal assistance • Case management/client advocacy/network

Table II-3 Core Weaknesses

SYSTEM-WIDE **Collaboration** • Prevention-treatment collaboration • Drug abuse awareness education for providers • Penal system services • Multiple diagnoses • Financial assistance
Continuum of Care • Late entry of clients into service • Accessibility of services – rural and South Dallas • Many clients have no insurance • Adolescent services • Gender specific services for women with HIV • Perception of care - some clients do not feel that they are treated with compassion and respect • Lack of respect/tolerance for persons with HIV/AIDS • Sensitivity to needs of women • Sensitivity to needs of parents and children
ADMINISTRATION **Contract Administration** • Translation services – lack of bilingual staff • Clients' fear of registering complaints or making grievances **Planning & Evaluation** • Evaluation and assessment of results • RWPC appointment process • Cooperation – HRSA needs more visibility
SERVICE DELIVERY / IMPLEMENTATION • Transportation in outlying counties • Need for housing options • Reemployment/employment programs • Transportation • Burial assistance - lack of corporate support for burial needs • Drug rehabilitation • No needle exchange program • Information and referral

Critical Success Factors - 2001

The RWPC/Consortium, who considered them in developing critical success factors in 1998, identified the above core competencies and weaknesses. The Advisory Group revisited these for the 1998 Plan in two Strategic Planning sessions held in April and May of 1998.

The 2001 ad-hoc strategic planning group revisited the 1998 critical success factors and established a new set of critical success factors, marking a new course of action for the next three years.

System Wide: Critical Success Factors

Real Time Data Collection System

Objective:

- To create a real time data collection system that makes client information available to all RWCA- funded providers across the Dallas EMA/HSDA.

Desired Outcome:

A real time data collection system will:

1. Improved access and use of data for client tracking and decision-making.
2. Enable on-going referral tracking to ensure client access to needed services.
3. Provides the information required to identify and measure system wide outcomes.
4. Collects comprehensive client level data elements.
5. Provides information on changes in client status, such as health-status, service use, and selected demographics including living situation in a timely manner.
6. Greater provider and consumer understanding of information.

How?/Action	Who	Process Measure	Data (Data Needed)	When
1. Ensure modules for referral and outcomes (etc.) are a part of the system.	RWPC to mandate. DCHHS to provide referral and outcome fields.	Development of outcome indicators.		3rd quarter 2001
2. Ensure all necessary data elements are included that can satisfy multiple reporting and monitoring requirements.	DCHHS, working with providers, to provide monitoring fields.	List of all requirements. Development of standardized reports. Database that includes mandatory elements.		3rd quarter 2001

How?/Action	Who	Process Measure	Data (Data Needed)	When
3. Install data collection system.	RWPC to select system. DCHHS to contract and monitor. Vendor to install. Consultant to supervise.	Selection of vendor. Monitoring reports Meeting timeline for implementation. Job descriptions. Hiring.		March 2002
4. Consumer / provider workshops on uses of data	DCHHS	Schedule of workshops. Attendance lists.		1st quarter 2002
5. Focus groups, adhoc committee meetings, surveys, key informant interviews	DCHHS to RFP. Vendor to conduct and analyze.	RFP. Contract.		3rd quarter 2002.

Collaboration and Coordination

Objectives:
A COC that maximizes available service capacity through collaborations and partnerships between CARE Act and non-CARE Act funded service providers and includes the following features:

- A coordinated referral system.
- A real-time data system to share client information.
- Coordination of services among RWCA funded services and between RW and non-RWCA funded services.
- Regular updates on all policy and program initiatives of all Titles of the CARE Act, the Substance Abuse and Mental Health Services Administration (SAMHSA), and HCFA.
- Ongoing monitoring of quality of care to ensure that the standards of care are met throughout the COC..

Desired Outcomes:

1. HIV/AIDS service system that strives for 100% access to service, 0% disparity in health outcomes for all PLWH/A in the Dallas EMA/HSDA.
2. Greater efficiency and cost effective use of RW funds by maximizing other funding sources for care.
3. Updated directory indicating linkages among providers for services in the COC.
4. Improved service planning, coordination, and delivery of services by the DCHHS and providers of care services.
5. Increased number of collaborative agreements / MOUs among providers of care services.
6. Increased number of referrals by collaborative agencies to PLWH/A.
7. Improved understanding by PLWH/A of the providers and services within the COC.
8. Increased utilization by PLWH/A of referrals.
9. Greater client satisfaction with coordination of services.
10. Improved collection of clinical and physiological indicators of health and ongoing treatment outcome studies that measure the impact of collaboration.

11. Reduction in client complaints and civil rights issues, increases in reports of fair and ethical treatment of clients. through Ombudsman of care coordination system.

How?/Action	Who	Process Measure	Data (Data Needed)	When
1. Complete implementation of the care coordination system.	DCHHS oversight Providers to use	Progress reports	Report from System	2001-2002 2002
2. Track number of unduplicated clients receiving care	DCHHS	Operational client tracking system (update or replacement of COMPIS)	Client database	2002-ongoing
3. Establish standards for collaboration and referrals	RWPC, DCHHS	RWPC meetings		2002-2003
4. Develop memorandums of understanding (MOU) for formalizing collaborations and implement	DCHHS develop MOUs. Providers to complete MOUs.	MOU format accepted, # of MOUs		2001
5. Identify community resources that would increase services, capacity, or access by collaboration through provider information forms and secondary data analysis.	RWPC to fund. Contractor collects provider and secondary data. DCHHS to contract and monitor. Providers to compete info.	Contract specifications, contract., I&R Directory	Minutes, Database of resources and capacity	2001 - Ongoing
6. Schedule biannual meetings that provide a forum for provider interaction where collaborations can be initiated and strengthened. Mandatory attendance.	DCHHS to schedule and coordinate.	Attendance lists, Minutes	Survey of providers at biannual meeting	Start 3rd quarter 2001, then biannual
7. Through improved data collection, perform outcome evaluation studies that document the effectiveness and impact of system-wide collaborations on clinical health indicators.	RWPC to fund. DCHHS to RFP and monitor study. Contractor to develop data collection tools and procedures. PLWH/A to complete surveys/focus groups.	Contract outcome evaluation studies, Number of interviews completed.	Ongoing client assessment data	2002-2003

How?/Action	Who	Process Measure	Data (Data Needed)	When
8. Ensure that consumers understand eligibility for services at RW and non-RW providers through the Resource Guide and over the Web. Promotion of services.	RWPC to fund. DCHHS to monitor contractor to complete guide and web information.	Survey of client knowledge of linkages. Design and implementation of public information campaign. Production and distribution of guide. Completion of web page.	Qualitative and quantitative assessment study.	Ongoing updates of Resource Guide; web development 2002. Public Info campaign 2002.
9. Measure client satisfaction.	DCHHS/consultant to develop protocol and institute standardize client satisfaction measures. Ombudsman	Standardized client satisfaction protocol. Ombudsman report.	Satisfaction database	2003-3304

Standardized Eligibility Requirements Within Service Categories

Objective:

- Standardized eligibility requirements.
- Reduced abuse and duplication of services.

Desired Outcome:

1. Equal access to services throughout the EMA.
2. Improved access to services.
3. Ease monitoring of contractual requirements.
4. Improve cost effectiveness.

How?/Action	Who	Process Measure	Data (Data Needed)	When
1. Development of draft client eligibility requirements for provider	RWPC / consultant to draft. DCHHS to provide TA. DCHHS and Community review. Approval RWPC to fund.	Schedule for standards. Draft standards	Review of existing Dallas and other EMA standards.	By March 2002
2. Develop standardized forms to specify eligibility.	DCHHS	Drafts of forms		2001
3. Technical assistance training for providers on how to implement client eligibility requirements.	DCHHS	Operational client tracking system with expenditure fields for other sources.	Expenditure	2002-2003

Administration: Critical Success Factors

Monitoring RW as Payer of Last Resort

Objective:
RW funds are used to pay for services that are unavailable through other means. To ensure that Ryan CARE Act funds are used to pay for services that are not covered through reimbursement or other programs, the following are recommended:

- Identification of services provided by non-RW funding in order to ensure that the CARE Act is the payer of last resort.
- Regular updates on all non-RW policy and program initiatives that provide services on the COC. These include Medicare, Medicaid, the Substance Abuse and Mental Health Services Administration (SAMHSA), HCFA, and other reimbursement channels.
- Providing technical assistance to agencies that need additional infrastructure to apply for reimbursements for services.

Desired Outcome
1. Reduce dependency on CARE Act funded services by identifying non CARE Act funded resources for providing services to Dallas EMA and HSDA clients.
2. The non redundant use of RWCA funds.

How?/Action	Who	Process Measure	Data (Data Needed)	When
1. Encourage and provide technical assistance to service providers to seek alternative funding sources.	RWPC to fund. DCHHS to provide TA.	TA contracts	Database of funding sources.	2002 – 2003

How?/Action	Who	Process Measure	Data (Data Needed)	When
2. Monitor provider expenditure of RW Funds to ensure providers are applying for Medicaid, Medicare, and other reimbursements prior to using RW funds.	DCHHS	Operational client tracking system with expenditure fields for other sources.	Expenditure	2002 – 2003
3. Monitoring and oversight by DCHHS to ensure providers are applying for Medicaid, Medicare, and other reimbursements prior to using RW funds.	DCHHS	Report of % of reimbursement for different sources by funder	Client database	202-2003

Integration of New Counties into RW Consortium of North Texas

Objective:
To expand the RW Consortium of North Texas and create a more efficient service delivery system through integration of Cooke, Fannin, Grayson, and Navarro Counties.

Desired Outcome:
1. Adoption of a standardized COC that ensures access to services throughout the RW Consortium of North Texas.
2. Integration of a uniform reporting system.
3. Integration of service standards and outcomes measures.

How?/Action	Who	Process Measure	Data (Data Needed)	When
1. Collaboration between planning bodies.	RW Consortium of North Texas RWPC	Schedule of meetings. Minutes.	COC. Standards.	April 2001
2. Technical assistance to additional four counties on reporting standards and outcomes.	RWPC. Vendor.	Schedule of TA. Vendor RFP & contract. Vendor report of TA.	Outcome measures. Standardized reporting	December 2001
3. PLWH/A information campaign	RW Consortium of North Texas RWPC	FG and Survey repot		February 2002.

Enhance Recruitment & Retention of HIV/AIDS Service Providers
(emphasis on minority providers)

Objective:

To enhance the capacity, quantity, quality and diversity of service providers in the RW Consortium of North Texas.

Desired Outcome:

1. Increase the number of proposals submitted in response to Title I RFPs by providers who serve communities of color.
2. Improve the quality of submitted proposals in response to RFPs.
3. Improved quality of care to clients.
4. Increased financial stability of providers.

How?/Action	Who	Process Measure	Data (Data Needed)	When
1. Identify potential providers who are not currently funded for HIV/AIDS services.	DCHHS	Increased number of potential respondents to RFPs.		Oct 2001
2. Provide grant writing technical assistance to potential providers	DCHHS Potential providers to accept	TA Schedule. Increased number of service providers at technical assistance.		Ongoing

Service Delivery / Implementation

Client Retention to Medical Services and Care

Objective:

Client adherence to medical care including visits, medications, and treatments.

Desired Outcome:

1. Increased adherence to HIV therapies.
2. Reduced number of canceled and missed medical appointments.
3. Reduced number of clients lost to follow-up.
4. Better quality of life and longevity for clients.

How?/Action	Who	Process Measure	Data (Data Needed)	When
1. Educational program for providers:- - - Standards related to staff training. - Clinical education RWCA providers.	RWPC to encourage DCHHS Providers to hold/sponsor clinical education.	Education curriculum. Schedule of education plan. Attendance at trainings. Assessment of education.	Exiting curriculums.	Oct 2001
2. Clinical trials access program.	DCHHS to fund provider to distribute clinical trial alerts	Distribution of clinical trials. Monitoring clinical trial enrollment.	National database of clinical trials	Dec 2001
3. Adherence study	RWPC to specify. DCHHS to RFP and monitor. Vendor to conduct.	Contract. Questionnaire. Results of the study.		1st quarter 2002.

Service Sensitivity to Targeted Populations

Objective:

Increased sensitivity to targeted populations by all RW funded providers during service delivery.

Desired Outcome:

1. Broadening the concept of minority access (people of color, women, bilingual, gay and bisexual men, homeless).
2. Increased number of people of color and women to care.
3. Increased sensitivity to targeted populations by providers.
4. Increased accessible to service sites for communities of color and women.

How?/Action	Who	Process Measure	Data (Data Needed)	When
1. Service sensitivity to targeted populations.	RWPC to fund development of protocols notes for specific populations. Vendor to develop notes.	Development of protocol notes.		Oct 2001
2. Refocus role of Minority Access Committee to become more inclusive of target populations.	Minority Access Committee DCHH	Minority Access Committee project reflects expanded focus.		Oct 2001
3. Perform survey and needs assessment for service delivery for women, youth, and families.	RWPC to fund. DCHHS to RFP and contract. Vendor	Women, youth, family survey created.		2002/2003 (non-comprehensive year task).

III. HOW WILL WE MONITOR OUR PROGRESS AND RESULTS

A. How will we monitor our progress and results

Each of the action templates suggests indicators and methods to monitor progress.

The critical factor templates in Chapter II indicate several activities. On each template the indicators of progress, measures, and data sources are listed. These recommend the tools and measures needed to monitor the progress of the plan. They suggest both quantitative and qualitative data be collected for monitoring and assessment of the plan.

The indicators require quantitative and qualitative data collection. They will be more successful if they minimize data collection burden on the provider and provide usable feedback on services.

The indicators of progress necessitate that several data sources be tapped and several new tools be created. A key element in the success of the plan is that PLWH/A, providers, and DCHHS remain committed to the process of monitoring and assessment and that the tools be designed to facilitate data collection and provide rapid feedback on services without placing too much burden on service providers. Table III-1 provides some of the observations of the consultant team on selected tools. There are no comments on meetings and forums as these are organized and executed on a regular basis in the Dallas EMA.

New Types of Information and Challenges

Environmental impact and performance evaluation will provide needed indicators to the RWPC/Consortium.

The RWPC/Consortium does not currently have systematic information on environmental changes nor performance evaluation.

The Changing Environment

Systematic assessment of the environment will help determine whether change is being appropriately anticipated and the real and potential impact on the lives of PLWH/A. Areas to assess include not only medical/clinical treatment advances, but also legislative/regulatory; e.g., welfare reform and immigration law changes as well as health care financing, and the introduction of Medicaid managed care. These will alert the RWPC/Consortium to the changes that impact priorities, allocations, and services.

Table III-1 Indicator Comments

INDICATORS	COMMENT
Waiting lists	Currently waiting list data appears inaccurate and suggest that there be more uniform standards set for reporting as part of the contract monitoring system.
Annual Needs Assessment	The Needs Assessment be done every other year with selected updates on priority populations. The new information system be designed to provide ongoing information and that Provider Information Forms be an ongoing process. Special populations may be surveyed if data is needed.
Annual Epidemiological Review	TDH can be an excellent partner in the epidemiological review. Working with them to review key questions and format data will make the collaboration effective.
Collaboration and linkage	Collaborations and linkages are not systematically monitored. They should be specified as part of the contract procedures and monitored as part of the contract review. Providers might do systematic follow-ups to determine the efficacy of collaborations.
Client complaints	This can be captured by a uniform consumer satisfaction survey and also through consumer feedback phone numbers and other procedures established by the RWPC/Consortium to encourage the reporting of complaints.
Unit cost information, unduplicated client counts, number of services	These unit costs established in the cost corridors will need refinement over the next year. Quality assurance is a critical element of this process. COMPIS reporting will be essential until the new data collection is established and working. An important element in unit cost that is sometimes overlooked is the tracking of actual staff time spent, and not reporting pre-determined percentages of time allocated to an activity.
I & R directory	I & R directories can take many forms. The AID Resource Center paper and on-line directory plus Hotline are valuable resources. The Information form, when collected and updated on a regular basis can provide input into the directory and enhance the information. Highlighting eligibility and linkages would be useful and noting client feedback could provide a form of quality assurance.
Clients knowledge of service	Knowledge and utilization of service are collected in the Need Assessment.
Data collection	The completion of accurate COMPIS data will be a major element in the assessment of services until the new system is in place. Agencies will need adequate TA to make sure the data is complete and timely. The new data collection system should be easier for data entry and have flexible report writing capacity
Standard of care monitoring	As standards of care are set, tools and training have to be in place to assure services are monitored and actions are taken when standards are found lagging.

Performance Evaluation

Outcome measures are necessary to determine whether services are producing improved health and quality of life for PLWH/A.

Asking about whether the services that are provided produce measurable health and quality of life benefits for PLWH/A is one way to measure performance. Measures that are selected need to be tied to performance expectations and to outcomes. This is a difficult and time intensive process, which requires a change in the ways of thinking and

training for providers and planners and PLWH/A. Training includes understanding the continuum of care, the ways in which services are delivered, and the value in assessing results.

Outcome results require the measurement of base-line indicators and require trend data.

Outcome-oriented results cannot be expected to be measurable in a short time frame. As with any new data system, start-up is filled with kinks, which need to be massaged out of the system over time. The costs of collecting, analyzing and synthesizing these data, including opportunity costs, need to be analyzed in relation to the usefulness of these data.

Overall, the indicators and measures will allow system-wide assessment.

The plan challenges the RWPC/Consortium to define and measure system-wide objectives, and system-wide impact. While progress has been made towards starting to identify outcomes and collecting unit cost data, the focus of monitoring and evaluation has been on counting whether the number of inputs contracted for met the number of outputs produced. The recommended indicators measure system-wide impact with the goal of determining the impact on the lives of PLWH/A who have engaged elements of the continuum of care. Being able to and actually answering this question with measures that are tied to performance expectations will instill the planning process with enhanced accountability. This accountability is an implicit agreement between PLWH/A, providers, and planners. Once the infrastructure is present and the tools are in place, the plan can move forward.

Critical Success Factor Action Plan Timeline

The Critical Success Factor Action Plan Timeline establishes timeframes for the activities related to the nine critical success factors.

This chapter lays out a schedule of activities to monitor and evaluate the implementation of the nine critical success factors. For the remainder of 2001 through 2004, the fiscal quarter in which the activity takes place is specified. For 2004, activities are noted for the year, but not for each quarter. The templates and the "comments" section of the plan indicate that the products and tools should be available at key points in the planning and evaluation cycle for decision-making.

The Plan needs to be flexible and responsive to changes.

The plan needs to be flexible and responsive. The dates are suggested targets, but may shift as priorities change or problems are encountered with implementation.

The capacity of the system to respond to changes needs to be considered, as well as the time it takes to implement them.

Equally likely, the environment, epidemic, and/or PLWH/A needs may change over the course of the plan. The regular monitoring of needs, barriers, and the epidemiology of the epidemic will suggest where the plan needs adjustment. Adjustments and shifts should be encouraged and welcomed, in response to environmental changes.

CRITICAL SUCCESS FACTORS ACTION PLAN TIMELINE																					
ACTIONS	**DATE**										**WHO**										**COMMENTS**
	Fall 01	**Wnt 02**	**Spr 02**	**Sum 02**	**Fall 02**	**Wnt 03**	**Spr 03**	**Sum 03**	**Fall 03**	**2004**	**C/C**	**DCHHS**	**P&P**	**MAC**	**Eval**	**PROVIDER**	**TDH**	**PLWH/A**	**Other**	**Conslt**	Key: C/C=RWPC/Consortium P&P=Planning & Priorities MAC=Minority Access Eval=Evaluation ASO AIDS Service Organization
SYSTEMWIDE																					
Real time Data Collection System																					
1. Ensure modules for referral and outcomes (etc.) are a part of the system.	O										X	X	X		X					X	Consultant to RWPC to help develop outcomes.
2. Ensure all necessary data elements are included that can satisfy multiple reporting and monitoring requirements.	O										X	X	X	X	X			X		X	Need to assure that all data fields needed for reports and planning are in the database.
3. Install data collection system.			O									X				X				X	Allow adequate time for testing and training.
4. Consumer / provider workshops on uses of data		O									X	X								X	Start the process of adoption early, obtain buy-in from providers and consumers.
5. Focus groups, adhoc committee meetings, surveys, key informant interviews					O						X	X			X			X		X	RFP & contract for consultant to produce report

CRITICAL SUCCESS FACTORS ACTION PLAN TIMELINE																					
ACTIONS	**DATE**										**WHO**										**COMMENTS**
	Fall 01	**Wnt 02**	**Spr 02**	**Sum 02**	**Fall 02**	**Wnt 03**	**Spr 03**	**Sum 03**	**Fall 03**	**2004**	**C/C**	**DCHHS**	**P&P**	**MAC**	**Eval**	**PROVIDER**	**TDH**	**PLWH/A**	**Other**	**Conslt**	Key: C/C=RWPC/Consortium P&P=Planning & Priorities MAC=Minority Access Eval=Evaluation ASO AIDS Service Organization
Collaboration & Coordination																					
1. Complete implementation of the care coordination system.	O	O	O	O							X	X				X					Requires cooperation between C/C, HOPWA, HSDA funded agencies and administrators
2. Track number of unduplicated clients receiving care		O	O	O	O	O	O	O	O	O		X				X					Through COMPIS reports and reports from new data system. Requires accurate input from providers.
3. Establish standards for collaboration and referrals		O	O	O	O	O	O	O	O		X	X								X	Continue to establish and measure standards for collaboration & referral.
4. Develop memorandums of understanding (MOU) for formalizing collaborations and implement			O									X									
5. Identify community resources that would increase services, capacity, or access by collaboration through provider information forms and secondary data analysis.		O	O	O	O	O	O	O	O	O	X	X	X			X				X	Lack of success in obtaining provider information in the past suggests that the forms be required as part of the contract requirement and data collection be ongoing.
6. Schedule biannual meetings that provide a forum for provider interaction where collaborations can be initiated and strengthened. Mandatory attendance.			O		O		O		O		X					X					

CRITICAL SUCCESS FACTORS ACTION PLAN TIMELINE

ACTIONS	DATE										WHO										COMMENTS
	Fall 01	Wnt 02	Spr 02	Sum 02	Fall 02	Wnt 03	Spr 03	Sum 03	Fall 03	2004	C/C	DCHHS	P&P	MAC	Eval	PROVIDER	TDH	PLWH/A	Other	Conslt	Key: C/C=RWPC/Consortium P&P=Planning & Priorities MAC=Minority Access Eval=Evaluation ASO AIDS Service Organization
7. Through improved data collection, perform outcome evaluation studies that document the effectiveness and impact of system-wide collaborations on clinical health indicators.		O			O			O			X	X						X		X	DCHHS to develop RFP. PLWH/A to be respondents to surveys.
8. Ensure that consumers understand eligibility for services at RW and non-RW providers through the Resource Guide and over the Web. Promotion of services.		O	O	O	O	O	O	O	O	O	X	X				X				X	Survey of client knowledge of linkages. Design and implementation of public information campaign. Enhancement of ARC web page.
9. Measure client satisfaction.						O				O		X			X					X	Standardize client satisfaction measures. Yearly survey.

CRITICAL SUCCESS FACTORS ACTION PLAN TIMELINE																						
ACTIONS	**DATE**										**WHO**										**COMMENTS**	
	Fall 01	**Wnt 02**	**Spr 02**	**Sum 02**	**Fall 02**	**Wnt 03**	**Spr 03**	**Sum 03**	**Fall 03**	**2004**	**C/C**	**DCHHS**	**P&P**	**MAC**	**Eval**	**PROVIDER**	**TDH**	**PLWH/A**	**Other**	**Conslt**	Key: C/C=RWPC/Consortium P&P=Planning & Priorities MAC=Minority Access Eval=Evaluation ASO AIDS Service Organization	
Standard Eligibility Requirements within Service Categories																						
1. Development of draft client eligibility requirements for provider			O								X	X	X	X						X	Standards should have public comment period.	
2. Develop standardized forms to specify eligibility.	O											X										
3. Technical assistance training for providers on how to implement client eligibility requirements.		O	O	O	O	O	O	O	O	O		X									Allow for training and start-up with providers	

CRITICAL SUCCESS FACTORS ACTION PLAN TIMELINE																						
ACTIONS	**DATE**										**WHO**										**COMMENTS**
	Fall 01	**Wnt 02**	**Spr 02**	**Sum 02**	**Fall 02**	**Wnt 03**	**Spr 03**	**Sum 03**	**Fall 03**	**2004**	**C/C**	**DCHHS**	**P&P**	**MAC**	**Eval**	**PROVIDER**	**TDH**	**PLWH/A**	**Other**	**Conslt**	Key: C/C=RWPC/Consortium P&P=Planning & Priorities MAC=Minority Access Eval=Evaluation ASO AIDS Service Organization
ADMINISTRATION																					
Monitoring RW as Payer of Last Resort																					
1. Encourage and provide technical assistance to service providers to seek alternative funding sources.		O	O			O	O					X				X					TA contracts. Database of funding sources needed.
2. Monitor provider expenditure of RW Funds to ensure providers are applying for Medicaid, Medicare, and other reimbursements prior to using RW funds.		O	O			O	O					X			X	X	X				Operational client tracking system with expenditure fields for other sources. Expenditure data needed.
3. Monitoring and oversight by DCHHS to ensure providers are applying for Medicaid, Medicare, and other reimbursements prior to using RW funds.		O	O			O	O					X				X					Ensure that providers know proper codes to use for each different non-RW funding source. Report of % of reimbursement for different sources by funder. Client database needs to capture appropriate fields for Medicaid Medicare and might include a module for reimbursement.
Integration of New Counties into RW Consortium of North Texas																					
1. Collaboration between planning bodies.			O								X	X				X					Meeting should be scheduled and minutes maintained. COCs and Standards of Care for each agency working with the agencies serving the new added counties.

CRITICAL SUCCESS FACTORS ACTION PLAN TIMELINE																					
ACTIONS	**DATE**										**WHO**										**COMMENTS**
	Fall 01	**Wnt 02**	**Spr 02**	**Sum 02**	**Fall 02**	**Wnt 03**	**Spr 03**	**Sum 03**	**Fall 03**	**2004**	**C/C**	**DCHHS**	**P&P**	**MAC**	**Eval**	**PROVIDER**	**TDH**	**PLWH/A**	**Other**	**Conslt**	Key: C/C=RWPC/Consortium P&P=Planning & Priorities MAC=Minority Access Eval=Evaluation ASO AIDS Service Organization
2. Technical assistance to additional four counties on reporting standards and outcomes.		O									X					X					Schedule date for technical assistance. Vendor RFP and contract needed. Vendor will provide report of TA's value.
3. PLWH/A information campaign		O									X					X					Focus groups conducted to understand the awareness of services in the area. Training of case managers to be able to refer clients to services.
Enhance Recruitment & Retention of HIV/AIDS Service Providers (emphasis on minority providers)																					
1. Identify potential providers who are not currently funded for HIV/AIDS services.	O											X									Increase number of potential respondents to RFPs. PLWH/A can be referred to newly identified providers of various services.
2. Provide grant writing technical assistance to potential providers		O				O						X							X		Relationship is between DCHHS and potential providers.

CRITICAL SUCCESS FACTORS ACTION PLAN TIMELINE																					
ACTIONS	**DATE**										**WHO**										**COMMENTS**
	Fall 01	**Wnt 02**	**Spr 02**	**Sum 02**	**Fall 02**	**Wnt 03**	**Spr 03**	**Sum 03**	**Fall 03**	**2004**	**C/C**	**DCHHS**	**P&P**	**MAC**	**Eval**	**PROVIDER**	**TDH**	**PLWH/A**	**Other**	**Conslt**	Key: C/C=RWPC/Consortium P&P=Planning & Priorities MAC=Minority Access Eval=Evaluation ASO AIDS Service Organization
SERVICE DELIVERY / IMPLEMENTATION																					
Client Retention to Medical Services and Care																					
1. Educational program for providers:																					
a. Standards related to staff training.	O										X	X				X					Medical care standards and education curriculum created.
b. Clinical education RWCA providers.	O										X	X				X					Education training sessions scheduled with attendance maintained. Assessment of sessions necessary. Exiting curriculums needed.
2. Clinical trials access program.		O										X				X					Clinical trial data/research distributed to medical providers.
3. Adherence study		O									X	X				X				X	RWPC will specify needs for study. DCHHS will RFP for evaluation. Medical care providers will participate and refer clients for study.
Service Sensitivity to Targeted Populations																					
1. Service sensitivity to targeted populations.	O										X					X		X			RWPC will fund development of protocol notes for various targeted populations. Vendor will develop notes based on various interactions with clients from those populations.
2. Refocus role of Minority Access Committee to become more inclusive of target populations.	O											X		X							Re-evaluate current targeted populations and include new ones to expand MAC's focus.
3. Perform survey and needs assessment for service delivery for women, youth, and families.					O	O	O	O			X	X				X		X		X	RWPC will fund project. DCHHS will create RFP and contract. Providers to those populations will assist in project.

Updating the Comprehensive Services Plan

Monitoring progress of the Plan involves three categories of activities:

1. Reviewing progress on meeting objectives and achieving outcomes by reviewing indicators of progress and assessing measures.
2. Updating the information on which the Plan was based
   2.1. Needs Assessment, Epidemiological information, Changing Environment, and Resource Inventory
3. Revising the Plan based upon feedback about what is working and what is not.

Updating the Plan should become part of the regular planning & evaluation cycle conducted by the RWPC/Consortium.

The responsibility for monitoring progress on the Plan lies with the RWPC/Consortium. Appropriate work groups, with a broad representation from PLWH/A and the communities infected need to be identified to continue the detailed work of further elaborating the critical success factors, and of prioritizing them. The Planning & Priorities Committee should approve this work, if completed by work groups or the Panel, before it goes to the full RWPC/Consortium. Once agreed upon, the Allocations Committee should be charged with identifying and making resources available that are consistent with the priority of the critical success factor.

IV. ATTACHMENTS

Attachment 1 References

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