2002 Houston Area
HIV/AIDS Needs Assessment
EXECUTIVE SUMMARY

A COLLABORATIVE PROJECT OF THE:

Ryan White Planning Council
Houston Local Needs Assessment Task Force (LNATF) of the
State of Texas Assembly Group East (STAGE)
Houston Regional HIV/AIDS Resource Group
Harris County Hospital District
Harris County Public Health & Environmental Services - HIV Services
City of Houston Prevention Community Planning Group (CPG)
Housing Opportunities for Persons with AIDS (HOPWA)

ACKNOWLEDGEMENTS

Collaboration is the key to effective planning, especially around an illness as complex as HIV/AIDS. This report could not have been written without the collaborative efforts of the following partners:

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The City of Houston Prevention Community Planning Group (CPG)
Housing Opportunities for People with AIDS (HOPWA)

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But, most of all… heart felt thanks to the 750 people with HIV/AIDS and their caregivers for participating in this important process. The 2002 HIV/AIDS Needs Assessment is dedicated to you.

TABLE OF CONTENTS

HOUSTON EMA/HSDA 2002 COMPREHENSIVE HIV/AIDS NEEDS ASSESSMENT EXECUTIVE SUMMARY

PURPOSE

The purpose of the Houston Area HIV/AIDS Comprehensive Needs Assessment, which is conducted every three years, is to provide accurate and reliable information about the level of use, perception of need, experience of barriers, and analysis of gaps in services to those affected with HIV/AIDS. This information is used by community-based planning bodies to select priorities and recommend allocations of federal and other funds granted to communities to assure a comprehensive continuum of care.

REGION

This Needs Assessment is conducted for the Houston Eligible Metropolitan Area (EMA) and the Houston Health Services Delivery Area (HSDA) designated by the Texas Department of Health (TDH). The EMA is designated by the Health Resources and Services Administration (HRSA), a division of the US Department of Health and Human Services, to receive Ryan White CARE Act funds to provide services to People Living with HIV or AIDS (PLWH/A). The Houston EMA is a six-county area in southeast Texas that consists of Chambers, Fort Bend, Harris, Liberty, Montgomery and Waller counties. The Houston HSDA consists of these same six counties and four others—Austin, Colorado, Walker and Wharton. The land area of the combined EMA/HSDA is 9,415 square miles and the 2000 Census showed the population to be slightly more than 4.3 million.

The Houston EMA receives Ryan White Title I funding, which provides emergency relief to metropolitan areas that are disproportionately affected by HIV/AIDS. This funding is awarded to the Harris County Judge's Office and administered by the HIV Services Division of the Harris County Public Health and Environmental Services Department. As the administrative agency for these Title I funds, $19.3 million in fiscal year 2002, HIV Services subcontracts with more than 30 agencies to provide health and support services to PLWH/A. HIV Services relies on the Ryan White Planning Council, a volunteer collaboration comprised of people affected by HIV, service providers and community leaders, to establish service definitions, set priorities and allocations and to direct long-range planning for Title I funds.

The Houston HSDA is the area designated by HRSA to receive Ryan White Title II and TDH State Services funding, which is intended to improve the quality, availability and organization of health care and support services for PLWH/A, with an emphasis on rural populations. In Texas, Title II and TDH State Services funding is channeled through the Texas Department of Health to the Houston Regional HIV/AIDS Resource Group, Inc. The Resource Group is also the administrative agency for several other funding sources that provide HIV/AIDS services in the area, including Ryan White Title III and IV and some of the funds from Housing Opportunities for Persons with AIDS (HOPWA). The planning body for the HSDA is the State of Texas Assembly Group East (STAGE). The City of Houston administers Centers for Disease Control (CDC) HIV prevention funds as well as the majority of those from HOPWA.

EPIDEMIOLOGY

Texas AIDS Statistics

According to the TDH, through December 31, 2001, there were 24,531 people living with AIDS in Texas. Most of the people with AIDS are male (84%), Anglo (44%) or African American (33%), between the ages of 30 and 39 (48%), and infected through unprotected male-to-male sex (51%).

Local AIDS Statistics

In the 10-county Houston area, there were more than 7,600 people reported to be living with AIDS in 2001. Again, the majority of living AIDS cases is male (81%), between 30 and 39 years old (45%), and attributed to unprotected male-to-male sex (50%). In terms of race/ethnicity, however, most living AIDS cases were among African Americans (41% *vs.* 39% for Anglos).

Trends in AIDS Diagnoses

In the Houston area, the number of AIDS cases diagnosed each year has dropped steadily since 1996, falling from 1,687 that year to 431 in 2001. While that is good news overall, communities of color have seen steady increases in their proportion of the total number of cases diagnosed each year. In 1997, African Americans surpassed Anglos for the first time, accounting for 47% of cases; in 2001, that percentage increased to 54%. The Hispanic population has seen less dramatic, but still steady, increases. In 2001, Hispanics also surpassed the Anglo community, accounting for 23% of the AIDS cases diagnosed (vs. 22% for Anglos). In terms of behavioral risk, the proportion of AIDS diagnoses attributed to unprotected heterosexual contact has increased, accounting for 27% of the total in 2001. By contrast, the proportion attributed to unprotected male-to-male sex has steadily decreased from a high of 75% at the beginning of the epidemic to a low of 33% in 2001. It is also worthy of note that the proportion of cases with an unknown attributable risk behavior has increased steadily to 27% of cases diagnosed in 2001. These are cases for which not enough information regarding sexual partners is known to fit the stringent CDC definition of heterosexual contact. Based on data gathered by the local health department, however, it is thought that many of these cases among females actually can be attributed to unprotected heterosexual contact.

Texas HIV Statistics

When reviewing information about the prevalence of HIV in Texas, it is important to note that physicians and other healthcare providers were not required to report diagnosis of HIV until 1999. Thus, the totals given by the TDH or even the CDC are likely well below the actual number of cases. According to the TDH, through December 31, 2001 there were over 10,500 reported cases of people living with HIV infection. The demographics of HIV infections look a little different than those of people living with AIDS. Most people living with HIV infection are male (71%). About 39% are between the ages of 30 and 39 and 31% are between the ages of 20 and 29. Just over one third of all cases are attributed to unprotected male-to-male sex (36%). Cases attributed to unprotected heterosexual contact and unsafe injection drug use each account for about 16% of the total cases and cases that cannot be attributed to one of the specified behaviors account for 25% of the total. More African Americans (43%) are living with HIV in Texas than any other race/ethnicity. Anglos are next with 36% of the cases, followed by Hispanics with about 20%.

Local HIV Statistics

Through December 2001, the TDH reports just over 3,400 people living with HIV in the Houston area. The profile of people living with HIV differs from that of people living with AIDS. While males still account for the majority of people living with HIV, the difference between the genders is far less dramatic: 64% for males vs. 36% for females. In terms of age, there is an even split between the 20 to 29 and the 30 to 39 groups, each accounting for about 36%. African Americans account for 58% of people living with HIV, more than twice the percentage in the Anglo community (27%). Finally, the number of cases attributed to unprotected sex is almost the same for heterosexual sex as it is for male-to-male sex, at 27% and 33%, respectively.

Pediatric Statistics

For 2001, the TDH reports 69 cases (32 Male and 37 Female) of pediatric AIDS and 149 (78 Male and 71 Female) cases of HIV. Of these HIV cases, 68% are African-American, 13% are Anglo and 12% are Hispanic. The effective treatment of pregnant women has resulted in fewer children being born with HIV.

Estimates of HIV Prevalence

Many sources of data can be used to derive estimates of HIV prevalence (all those with HIV disease in an area). Using these, several different modes and estimates have been made for the total impact of HIV disease in the Houston area. Though estimates range from 14,000 to 25,000, the general consensus is that the most acceptable estimate of total HIV infected individuals in the area is between 18,000 and 22,000.

PROCEDURE

The Needs Assessment project, which was implemented from November 2001 through April 2002, was developed and guided by the Joint Needs Assessment Group (NAG). The NAG is a planning group comprised of individuals affected by HIV/AIDS and providers of medical and other health-related and psychosocial services and includes representatives from programs funded by each of the Ryan White CARE Act Titles I-IV and HOPWA (Housing Opportunities For Persons with AIDS). The tasks of the NAG were distributed among four *working groups* that are referred to as “joint” groups in order to reflect the partnership among these programs. These groups include the:

- Joint Epidemiology Group:
  - Determined sampling frame: i.e., assigning as a goal the number of individuals who should be surveyed in each of the demographic and HIV exposure categories.
- Joint Data Collection Group:
  - Developed the client survey instrument, recommending and approving the populations to be recruited and topics to be included in focus groups, recommending and approving the procedures and locales for the collection of data from hard-to-reach populations.
- Joint Resource Inventory Group:
  - Developed the provider survey instrument and reviewing the data generated by this survey.
- Joint Gaps Analysis Group:
  - Reviewing the overall report for content, accuracy, and presentation documenting the biases and confounders that affect the findings of the study.

Data Collection

Three types of data were gathered for this Needs Assessment: 1) survey data from both clients and service providers; 2) focus groups; and 3) Rapid Assessment, Response & Evaluation (RARE) interviews/surveys. These are referred to in the document as “street interviews.” The following discussion details the instruments, types of participants, and procedures involved in the collection of each of these types of information.

Survey Instrument

Two surveys were administered: a *client survey*, for individuals who are HIV positive and/or their caregivers and a *provider survey* for those agencies that offer medical, health-related and/or psychosocial services to those affected by HIV/AIDS. The survey instrument used in the Needs Assessment was an adaptation of an instrument developed for the State of Texas through the Statewide Coordinated Statement of Need (SCSN). The Houston project was the first large-scale administration of this survey. As is the case with any survey instrument, some limitations were found in this document. Among these were:

- The possibility of selecting contradicting responses
- Leading questions
- Use of terms that may have been unclear or indistinguishable to respondents
- Forced selection of responses without the options of “not applicable” or “do not know”
- Confusing formatting of questions
- The inappropriateness of the document for pediatric and adolescent respondents.

Several measures were undertaken to lessen the effect of these limitations, including:

- The use of facilitators at all survey sites
- Two qualitative data collection methods (focus groups and street interviews) to validate survey data
- Comparison of ambiguous responses in a survey with other questions to clarify meaning
- Analytical methods that address as many of the limitations as possible.

Despite these limitations, a rich resource of information was generated by the survey. It is noteworthy that the SCSN development team has since included several modifications in the instrument based on recommendations from Houston’s working groups. The client survey, which was available in both English and Spanish versions, consisted of 50 questions, several of which were tables or questions with several components.

Survey Administration

Twenty-three sites were chosen for administration of the client survey, which was conducted from December 9 through December 22, 2001. These included institutional providers, community-based organizations, county jails, a state prison and social service agencies. Telephone surveys were carried out for several caregivers of pediatric clients and for young adolescents, in response to requests from the referral sources of these clients and in an attempt to provide the most convenience and minimal discomfort to these respondents. Thirty-four percent (34%) of the respondents were surveyed at one site, which could have potentially introduced a sampling bias in the data. However, the respondents were referred to this site from agencies and organizations throughout the EMA/HSDA and thus the sample was not comprised solely of clients from this provider. Further, analysis of the data confirmed that these respondents received services from the broad range of providers.

Respondents were recruited primarily by flyers posted at major service provider sites. Survey administration was conducted in groups, with facilitators provided to: 1) Assist respondents with the technical aspects of completing the survey; 2) Validate the survey upon completion; and 3) Distribute the $35 gift certificate. Spanish translators were available at each administration site and sign language interpreters were available upon request. Prior to completing surveys, respondents were given consent forms to read (or to have read to them) and acceptance and completion of the survey was interpreted as consent. The surveying process was conducted anonymously and at no time in the processes of consent, survey completion, or data analysis were respondents asked their names.

The respondent population was generally ambulatory and healthy enough to travel to a survey site and complete the one-hour survey. Therefore the survey may not adequately reflect the needs of bed-bound or end-stage AIDS patients.

Focus Groups

A goal of the qualitative (narrative) data collection phase of the Needs Assessment is to better illustrate the meaning of the quantitative (numerical) data as well as to provide greater insight into the actual experiences of PLWH/A as they participate in various care systems. An important source of narrative information was generated by focus groups. Focus groups are meetings in which volunteers, assembled by specific categories, participate in semi-structured group interviews. Two facilitators conducted each of the meetings. Sessions were audio taped and transcribed and, as in the surveying, client identity was kept confidential. Fourteen groups were held for clients and 2 for service providers. Participants received a $25 gift certificate to a grocery store as an acknowledgement for their involvement in the groups. (Please see: *Focus Group Analysis* for details of these groups).

Modified RARE

Among the goals in conducting a Needs Assessment is a means to ensure that the interests of as many clients as possible are included. A particular challenge to this goal is the ability to gain access to individuals who are reluctant or unable to participate in such activities. A data collection program, known as “Rapid Assessment, Response and Evaluation (RARE)” method, has been promoted by HRSA and the CDC to overcome this challenge. RARE consists of 4 techniques: 1) Focus groups; 2) Street interviews; 3) Rapid Assessment Surveys; and 4) Direct Observation. The effectiveness of the RARE model centers on training residents, from the locales where hard-to-reach individuals live and work, to serve as “field researchers.” Three such individuals were recruited and they participated in each of the components except the focus groups, which were facilitated as discussed earlier. The Third Ward and Montrose areas were chosen as RARE sites.

Data Analysis

Quantitative Data

The quantitative (numerical) data consists of counts and percentages calculated from responses to the client survey. From the 50 questions, 938 variables were created and stored in 2 statistical analysis software databases (SPSS and SAS). Data for this study was analyzed using descriptive statistical techniques (i.e., counts, percentages and cross-tabulations). Service use, needs, barriers and gaps reported by survey respondents were calculated at 2 levels: service category and individual services. Tables in Questions 47 and 48 in the client survey asked respondents to report on their use, perceptions of needs, availability and barriers of all HIV services. Services are grouped in 17 service categories, which are segmented into 63 individual services (Please see Appendix 1). These are designations developed by HRSA. The following table illustrates how use, needs, barriers, and gaps were calculated.

Service Status	Analysis	Survey Question
Use	Count of the number of "yes" responses to the statement: "Check the box that indicates if you have used this service."	47
Need	Count of the number of "yes" responses to the statement: "Check the box that indicates if you currently need the service."	47
Barrier	Count of the number of "Hard to get" responses to the statement: "Check the box that describes how easy it was for you to get the service."	47
Gap	Sum of respondents who responded "yes" to need and "no" to the statement: "Check the box that indicates if you believe that this service is available to you."	47

Qualitative Data

Focus group and RARE data were transcribed and analyzed using methods that counted the frequency of the occurrence of responses and methods that sought to determine not only the details of a situation, but also the meaning that clients assign to these situations. For purposes of the Needs Assessment, the content analysis provides central themes in the data as well as lists of client priorities.

Secondary Data Sources

In addition to the quantitative and qualitative data collected during the Needs Assessment, three other sources inform this study: the 2002 Houston Area Epidemiological Profile, the Centralized Patient Care Data Management System (CPCDMS), and the CD4 Online Management and Patient Information System (COMPIS), which are databases used by the respective Administrative Agents to track client information. This profile is a description of the status of the HIV epidemic in the Houston area. In order to provide both data and context, the document includes not only HIV/AIDS data but also general social, economic, and other health-related information that might effect HIV planning. This information is provided for both the EMA and HSDA. The 2002 Epidemiological profile begins on page 1 of this document. Both CPCDMS and COMPIS data reported here represent unduplicated client counts.

REVIEW OF FINDINGS

The following section reviews the findings of the Needs Assessment by Service Category. In each is a listing of the Use, Needs, Barriers and Gaps reported by the survey sample as a whole. The percents represent the proportion of respondents that listed the service as used, needed, etc. The higher the percent, the more respondents cited that service. Ranks compare the Service Categories to each other. The lower the number, the higher the rank. For example, Ambulatory Care was reported by 83.6% of respondents as a service that they used. Since this was the highest percent of reported use, it is ranked as 1. A list of Service Categories and related Individual Services can be found in Appendix 1. The full Needs Assessment includes percents and rankings for all the Service Categories and Individual Services. Appendix 2 lists the Use, Needs, Barriers and Gaps for all Categories. Appendix 3 lists these for all Special Study Populations, which include:

- African-American Men Who Have Sex With Men
- Women of Childbearing Age
- Incarcerated/Recently Released Individuals
- Youth (ages 13-24).

AMBULATORY/OUTPATIENT MEDICAL CARE

HRSA DEFINITION:

Provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient, community-based and/or office-based setting.

CPCDMS/COMPIS Registration Data

CPCDMS and COMPIS data show that 4,732 unduplicated clients used Ryan White Titles I and II funded ambulatory/outpatient medical care services during the one-year period of 3/1/01 through 2/28/02. In addition, 74 unduplicated clients used Title II nutritional counseling services and 79 used Title IV primary care services during the same time period. These numbers represent 21.5% - 44.2% of the estimated 11,051 - 22,706 PLWH/A living in the EMA/HSDA. These data include only those services billed to Titles I, II, IV and State Services. Many services have supplemental funding sources.

All Respondents:

Status	**Percent**	**Rank**
Use	83.6	1
Need	69.9	2
Barrier	18.0	2

Findings

- The primary care provider was consistently referenced as the main source of information for HIV services and clinical information. Clients expected that their primary care provider would provide treatment for comorbidities. They talked about the frequency of primary care provider visitation and the fact that they are overwhelmed with the time and energy demand if they are referred to another provider. Respondents complimented the quality of services provided by their HIV/AIDS clinic providers, with some concerns voiced about the attitude or bureaucratic attitudes of private providers.
- Most concerns about vision care focused on three interrelated issues: 1) access to general optometric care; 2) need for CMV screenings; and 3) limited choice of providers associated with health insurance plans.
- Women respondents cited neither gynecology nor obstetrical care as a significant need unless they were pregnant or recently pregnant. Young women who were currently or recently pregnant were enthusiastic in their praise of obstetrical providers, and linked their emotional attachment to their clinicians with expectations that prenatal care would assure that their children would be HIV negative. Women expected that providers understand HIV and its impact on pregnancy. They indicated that their primary motivator for adherence to HIV treatment regimens was concern for their children.
- Caregivers of HIV+ children indicated that care for PLWH/A is provided by the healthcare clinicians with a Pediatric/Infectious Disease background. Respondents with children who are sero-negative did not specify needs for pediatric care.
- Seventy-seven percent of survey respondents, who indicated use of primary care, also reported use of infectious disease care.

CASE MANAGEMENT

HRSA DEFINITION:

A range of client-centered services that link clients with health care, psychosocial and other services to ensure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate from inpatient facilities.

CPCDMS/COMPIS Registration Data

CPCDMS and COMPIS data show that 2,564 unduplicated clients used Titles I and II and TDH State Services social case management services. COMPIS data shows an additional 118 unduplicated clients used Title IV case management services. This represents 4.0% - 8.3% and 11.8% - 24.3% of the estimated 11,051 - 22,706 PLWH/A in the EMA/HSDA. However, many PLWH/A use case management services not funded by either Title I or Title II.

Social Case Management			Medical Case Management		
All Respondents			**All Respondents**		
Status	**Percent**	**Rank**	**Status**	**Percent**	**Rank**
Use	62.8	5	Use	48.1	6
Need	46.8	6	Need	39.5	9
Barrier	9.0	7	Barrier	6.0	62
Gap	3.3	15	Gap	2.6	32

Findings

- Case management is one of the most widely used services, and relationships with case managers can be among the most interpersonally involving for the client.
- According to providers, the goal of social case management is client independence, but the goal of medical case management is an ongoing relationship with clients to assist them in implementing their medical care plan and to overcome barriers both to receiving care and adhering to treatment regimens.
- In discussing case managers, respondents were more likely to offer comments about level of satisfaction than with any other service. Of note is that every possible level of satisfaction was reported. Many praised their case managers, especially those new to the system or younger clients. Long-term survivors or those experienced in the system stated that they had experienced a significant decline in the quality of case managers with less awareness by many of available services or services for which clients were eligible. Many respondents reported no case manager, with some stating because they did not have need for their services and others because they had trouble being assigned a case manager.

DENTAL CARE

HRSA DEFINITION:

Diagnostic, prophylactic and therapeutic services rendered by dentists, dental hygienists and similar professional practitioners.

CPCDMS/COMPIS Registration Data

CPCDMS data show 1,115 unduplicated clients used Ryan White Titles I & II oral health care services during the **seven-month** period between 8/1/01 through 2/28/02. (The service came online with CPCDMS in 8/01). COMPIS data show that an additional 40 unduplicated clients used Title II oral health care services during the one-year period between 3/1/01 and 2/28/02. These numbers represent 4.9% - 10.1% of the estimated 11,051 - 22,706 PLWH/A in the EMA/HSDA. These data include only those services billed to Titles I, II, IV and State Services. Many services have supplemental funding sources.

All Respondents

Status	Percent	Rank
Use	67.1	4
Need	58.1	3
Barrier	7.0	9
Gap	3.4	14

<u>Findings</u>

- As is evident by the use and need statistics among all survey respondents, special study populations and focus group findings, dental care access is a significant concern. Respondents frequently articulated their understanding of their increased vulnerability to conditions such as thrush (oral candidiasis), cavities (dental caries) and the secondary and systemic effect these conditions have on their general health.
- Populations eligible for Ryan White funding have often been Medicaid clients prior to HIV infection. Many individuals from this group have poor oral health due to continued lack of dental services by Medicaid and thus, have more urgent need for dental care when they enter the HIV continuum of care system.
- The interplay of access to transportation, perception of limited choices of provider and client understanding of scheduling policies were reported by respondents to present a significant barrier to care.

NUTRITIONAL SERVICES

HRSA DEFINITION:

Provision of nutrition education and/or counseling provided by a licensed/registered dietitian outside of a primary care visit. Nutritional counseling provided by other than a licensed/registered dietician should be provided under psychosocial support services. Provision of food, meals or nutritional supplements should be reported as part of the sub-category, Food and Home-Delivered Meals/Nutritional Supplements.

CPCDMS/COMPIS Registration Data

Because nutritional counseling is not a billable activity within primary care it is not tracked as a subcategory in the CPCDMS. Examples of billable subcategories within primary care include ultrasound, biopsy, psychiatry, mammography, CD4 testing, etc. Nutritional counseling is an activity that primary care providers are expected to do as part of a regular office visit, as it is included in the public health service guidelines.

All Respondents

Status	**Percent**	**Rank**
Use	52.3	9
Need	42.5	8
Barrier	6.0	11
Gap	6.2	11

<u>Findings</u>

- Respondents associate nutritional supplements with enhanced physical energy and a lessening of medication side effects among PLWH/A.
- Because of the perceived value of supplements, respondents indicated a preference for a purchasing assistance program similar to those used for purchase of medication.

DRUG REIMBURSEMENT PROGRAM

HRSA DEFINITION:

Ongoing service/program to pay for approved pharmaceuticals/medications for persons with no other payment source. Subcategories include:

State-Administered Drug Reimbursement Program (ADAP): Title II CARE Act-funded and administered program or other state-funded Drug Reimbursement Program;

Local/Consortium Drug Reimbursement Program: A program established, operated and funded locally by a Title I EMA or a consortium to expand the number of covered medications[1] available to low income patients and/or to broaden eligibility beyond that established by a State-operated Title II or other State-funded Drug Reimbursement Program.

CPCDMS/COMPIS Registration Data

CPCDMS and COMPIS data show that 1,941 unduplicated clients used Ryan White Titles I and II drug reimbursement services during the one-year period of 3/1/01 through 2/28/02. This represents 8.5% - 17.6% of the estimated 11,051 - 22,706 PLWH/A in the EMA/HSDA. However, many clients participate in medication reimbursement programs such as the State of Texas AIDS Drug Assistance Program (ADAP). These data include only those services billed to Titles I, II, IV and State Services. Many services have supplemental funding sources.

All Respondents

Status	Percent	Rank
Use	62.6	6
Need	50.1	5
Barrier	8.0	8
Gap	5.9	12

Findings

- Drug Reimbursement was ranked by survey respondents as a high-use, high-need service. This was validated by focus group participants who stressed the importance of access to medication, which they specified to be access to drug reimbursement, in each of the groups.
- Nearly one-half of survey respondents reported using the TDH HIV Medication Program or AIDS Drug Assistance Program (ADAP) (47.5%).
- An anticipated shortfall in funding for programs such as ADAP is expected to adversely impact local communities.

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[1] Medications include prescription drugs provided through an ADAP to prolong life or prevent the deterioration of health. The definition does not include medications that are dispensed or administered during the course of a regular medical visit, that are considered part of the services provided during that visit.

MENTAL HEALTH SERVICES

HRSA DEFINITION:

Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental health professional licensed or authorized within the State, including psychiatrists, psychologists, clinical nurse specialists, social workers and counselors**.**

CPCDMS/COMPIS Registration Data

CPCDMS and COMPIS data show that 458 unduplicated clients used Ryan White Titles I and IV and TDH State Services mental health care services, 207 used Title I support group services and 223 used Title I peer counseling services during the one-year period between 3/1/01 through 2/28/02. This represents 2.0% - 4.1% of the estimated 11,051 - 22,706 PLWH/A in the EMA/HSDA. These data include only those services billed to Titles I, II, IV and State Services. Many services have supplemental funding sources.

All respondents

Status	Percent	Rank
Use	61.9	8
Need	45.4	7
Barrier	8.0	7
Gap	10.2	6

<u>Findings</u>

- PLWH/As in this study consistently recounted experiences where they felt isolated as a result of their diagnosis. Many had not confided their HIV status to even their closest family or friends. As a result, participants frequently cited the need for counseling services and support groups.
- Those who identified the need for support groups expressed a strong preference for groups that were organized by demographics or interest, i.e. groups for Hispanic women, African American MSM, Anglo MSM, etc.
- Providers cited an increase in the number of clients who present with severe mental health disorders. Commonly reported were bipolar disorder, schizophrenia and major depression.
- Substance abuse remains a persistent problem as reported in the client survey (74% prevalence) as well as in focus groups and street interviews. Providers further confirmed this.
- Of individuals who were homeless within the last two (2) years, 71% indicated receiving psychosocial services.

HOSPICE**

HRSA DEFINITION:

Home-Based Hospice Care: Nursing care, counseling, physician services, palliative therapeutics provided by a hospice program in the terminal stages of illness in their home setting.

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

CPCDMS/COMPIS Registration Data

This service came online with the CPCDMS in 8/01. An estimated 10 clients used Ryan White Title I funded hospice care services during the six-month period between 8/1/01 through 2/28/02. COMPIS data show that 39 unduplicated clients used TDH State Services funded hospice care during the one-year period between 3/1/01 through 2/28/02. These 49 clients represent 0.2% - 0.44% of the estimated 11,051 - 22,706 PLWH/A in the EMA/HSDA." These data include only those services billed to Titles I, II, IV and State Services. Many services have supplemental funding sources.

*****NOTE: Interpretation of data for Hospice, Home Health Care and Adult Day Care is limited by 2 factors: 1- the population surveyed was primarily ambulatory and relatively healthy; 2- the questions on the survey were inadequate to accurately assess the need for these services.***

All Respondents

Status	**Percent**	**Rank**
Use	9.7	17
Need	5.9	17
Barrier	7.0	14
Gap	2.0	17

<u>Findings</u>

- The need for hospice has dramatically decreased even since the last Needs Assessment. This is likely due in part, to conversion of HIV/AIDS from an acute, catastrophic illness to a chronic condition with the advent of antiretroviral medication.
- Survey respondents indicated a clear preference for home-based hospice care, rather than residential care. However, women and African American MSM, reported a slightly higher need for residential care.

HOME HEALTH CARE**

HRSA DEFINITION:

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

- Durable medical equipment
- Homemaker or home health aide services and personal care services
- Day treatment or other partial hospitalization services
- Home intravenous and aerosolized drug therapy, including related prescription drugs administered as part of such therapy
- Routine diagnostic testing administered in the home of the individual
- Appropriate mental health, developmental and rehabilitation services

CPCDMS/COMPIS Registration Data

CPCDMS data show that 35 unduplicated clients used Ryan White Title I home health care services during the **four-month** period between 11/1/01 and 2/28/02 (this service came online with CPCDMS in 11/01). COMPIS data show that an additional 28 unduplicated clients used TDH State Services home health care services during the one-year period between 3/1/01 through 2/28/02. While these numbers represent only 0.3% - 0.6% of the estimated 11,051 - 22,706 of the PLWH/A in the EMA/HSDA, it represents 0.8% of the estimated 7,636 PLWA in the EMA/HSDA. Clients with an AIDS diagnosis are more likely to require home healthcare services than are individuals diagnosed with HIV. These data include only those services billed to Titles I, II, IV and State Services. Many services have supplemental funding sources.

*****NOTE: Interpretation of data for Hospice, Home Health Care and Adult Day Care is limited by 2 factors: 1- the population surveyed was primarily ambulatory and relatively healthy; 2- the questions on the survey were inadequate to accurately assess the need for these services.***

All Respondents

Status	**Percent**	**Rank**
Use	27.0	16
Need	19.9	14
Barrier	9.0	7
Gap	9.7	7

Findings

- Although use of these services reported by survey respondents was quite low, 20% indicated a need for the service category, 10% reported a gap and barriers were ranked in the upper third expect for Professional Care.

REHABILITATION**

HRSA DEFINITION:

Services provided by a licensed or authorized professional in accordance with an individualized plan of care that is intended to improve or maintain a client's quality of life and optimal capacity for self-care. This definition includes physical therapy, speech pathology and low-vision training services.

CPCDMS/COMPIS Registration Data

CPCDMS data show 68 unduplicated clients used Ryan White Title I rehabilitation services during the **five-month** period between 10/1/01 through 2/28/02. (This service came online with CPCDMS in 01/01.) This represents 0.29% - 0.61% of the estimated 11,051 - 22,706 PLWH/A in the EMA/HSDA. These data represents only those services billed to Titles I, II, IV and State Services. Many services have supplemental funding sources.

***** Note: Rehabilitation was a term that survey respondents may have found confusing, which may have influenced their response. During the validation process, several told facilitators that they interpreted rehabilitation to refer to such services as substance abuse treatment or post-incarceration services, such as employment training*.**

All Respondents

Status	Percent	Rank
Use	38.3	10
Need	27.2	10
Barrier	11.0	4
Gap	11.6	5

Findings

- Thirty-eight percent (38%) of the survey population reported a disability other than HIV.
- Thirty-eight percent (38.3%) reported use of rehabilitation services, though use of the three individual services ranged from 17% (physical therapy) to 7.9% (speech therapy). Some of the discrepancy may be explained by the possible misunderstanding of the services included in the HRSA definition of the service category. The definitions of the service categories were not included in the survey for participants to reference.
- Increased risk of hypertension, diabetes and cardiac conditions, associated with anti-retroviral therapies may cause an increased need for rehabilitation services.

EARLY INTERVENTION SERVICES

HRSA DEFINITION:

Counseling, testing, and referral services to PLWH who know their status but are not in primary medical care or who are recently diagnosed and are not in primary medical care for the purpose of facilitating access to HIV-related health services.

The survey instruments did not list this service as one where respondents were asked about use, need, barrier or gaps. Referral information is inferred from respondents answer to the question, “When you found out you were HIV positive, were you referred for any of the following services?” (Question 23 of the survey instrument.)

“How soon after finding out you were HIV positive did you get medical care for your HIV? (Question 30c—respondents could indicate more than one answer.)

If you did not seek medical care within 1 year of finding out you were HIV positive, please indicate why. (Question 30d-respondents could indicate more than one answer.)

Findings

- While the 61% of respondents reported receiving treatment within three months, 16.9% did not enter treatment for more than one year, as the following illustrates:
    - 61% received medical care within 3 months of diagnosis
    - 8.6% within six months
    - 6.6% within a year
    - 16.9% over a year

SUPPORT SERVICES

HRSA DEFINITIONS: (relevant categories only)

Adult Day Care or Childcare [2]: Home- or community-based non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of client or client's child.

Buddy/Companion Services: Activities provided by peers or volunteers to assist a client in performing household or personal tasks. Buddies also provide mental and social support to combat loneliness and isolation.

Client Advocacy: Assessment of individual need, provision of advice and assistance obtaining medical, social, community, legal, financial and other needed services. Advocacy does not involve coordination and follow-up on medical treatments.

Emergency Financial Assistance: Provision of short-term payments for transportation, food, essential utilities or medication assistance, which planning councils, Title II grantees and consortia may allocate.

Food Bank/Home Delivered Meals/Nutritional Supplements: Provision of food, meals or nutritional supplements.

Health Education/Risk Reduction: Provision of information, including information dissemination about medical and psychosocial support services and counseling or preparation/distribution of materials in the context of medical and psychosocial support service to educate clients with HIV about methods to reduce the spread of HIV.

Health Insurance Payments: A program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health insurance program, including risk pools.

Housing Assistance/Housing-Related Services: This assistance is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of Titles I, II and IV funds for short-term or emergency housing must be linked to medical and/or health-care services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

Interpreter Services: (TDH definition) Provision of interpreter services for medical and social service appointments for persons living with HIV/AIDS who are deaf/hard-of-hearing or monolingual.

Outreach Services: Programs that have as their principal purpose identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services. Outreach services do not include HIV counseling and testing nor HIV prevention education

Referral: The act of directing a person to a service in person or through telephone, written or other type of communication. Referral may be made formally from one clinical provider to another, within a case management system by professional case managers or informally through support staff or as part of an outreach services program.

Transportation: Conveyance services provided to a client in order to access health care or psychosocial support services. May be provided routinely or on an emergency basis.

Other Support Services: Direct support services not listed above, such as translation/interpretation services.

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[2] NOTE: Interpretation of data for Hospice, Home Health Care and Adult Day Care is limited by 2 factors: 1- the population surveyed was primarily ambulatory and relatively healthy; 2- the questions on the survey were inadequate to accurately assess the need for these services.

All Respondents

Status	Percent	Rank
Use	81	1
Need	74	1
Barrier	34	1
Gap	42.7	1

Findings

- With the increases in the client population of individuals with severe mental illness reported by providers and the increased longevity of clients, it is likely that the need for adult day care may also increase. This service was ranked in the lower half of services in use, need and gap, but in the upper half for barriers. Because survey respondents were primarily young or middle aged ambulatory clients, there may be under-reporting of the need for services such as **Adult Day Care.**
- Across special study populations reported need and gap for **Buddy/Companion Services** is higher than for the entire survey sample, with the greatest need cited by those who are incarcerated or recently released from jail or prison.
- As would be expected, women reported the highest use of **Childcare** services. That Youth indicated the highest need and the highest gap is likely reflective of the fact that the preponderance of that group is young mothers, who may have limited awareness of or resources to secure childcare. Although women in all focus groups discussed childcare as essential for them to access medical and support services as well as employment, many reported that children were being cared for by family members, most often grandmothers and sisters.
- Approximately twenty to twenty-five percent of adult respondents indicated use of **Client Advocacy Services**. Although there were no specific discussions in focus groups or explanations in the survey, experience from the community-at-large and comparable EMAs would suggest that clients would require the service for several possible reasons. Among these: immigration concerns, issues related to incarceration (the survey sample included 17% who reported current or recent incarceration), family law situations, probate issues and permanency planning for children.
- With the exception of Youth, 26.8 - 31.8 percent of respondents noted use of **Direct Emergency Financial Assistance**. In the entire sample and in the special study groups, as many as 45% designated a need for the service. Further, this service was ranked as the primary gap. Throughout each phase of the data collection, respondents raised financial issues directly or in relation to obtaining needed medical or support services, as well as the more basic services such as food, housing and transportation. Respondents were consistent in their linkage of poverty with the potential for compromised health status. Data from survey respondents support the assumption that financial issues are central to those eligible for Ryan White CARE Act funded services. When questioned about household income in the last year, respondents indicated that: a) 73% earned less than $10,000 per year; b) 90% earned less than $20,000 per year.
- Access to **Food/Home-Delivered Meals** was ranked second by survey respondents when asked to indicate from a list of services which ones they required. However, respondents ranked food first when asked to list their 10 most pressing needs. Approximately half of the entire sample (all respondents) and half of the adults in the special study populations cite food as a need. Among PLWH/As who take antiretroviral drugs, concerns were raised about the relationship between nutrition and treatment side effects, especially those related to digestion.

- Respondents indicated the importance of **HIV/AIDS Health and Risk Reduction Education** (HE/RR) to the general community. Specifically mentioned were prevention, risk factors, treatment and resources. Key channels for this education/information are churches, media, and community leaders. For 80% of survey respondents, health care providers were cited as the primary source of information about HIV and services. No other consistent source of information was reported though the Internet is mentioned as a fast-growing source of knowledge. The study indicates that participants want more information from and for physicians about conditions related to antiretroviral therapy and HIV/AIDS, and to potential conditions that are unrelated to either medication or HIV. 34.5% of respondents indicated that they were unable to access the service because they did not know it was available.
- Respondents asserted that a significant barrier to accessing medical care was the progressive increase in required **Health Insurance Payments** and a more rigorous enforcement of collection. Escalating medical costs and termination of commercial and COBRA insurance have caused some populations to experience a more pressing barrier while others are confronted with eligibility changes in payors or services.
- As immigration patterns in the region have continued to shift from primarily Latin nations, so has the range of need for **Interpreter Services**. While the need for Spanish interpreters continues, there is increasing need for interpreters from Asian and African nations who are fluent in Arabic, Swahili, Amharic, Nuer, Dinka and others. To complicate matters even further, other studies[3] indicate that clients are uncomfortable working with native translators from their countries for fear of eventually coming in contact with this same person in a social situation. Youth reported the highest barriers to interpreter services even though use was much more pronounced among females and the incarcerated/recently released.
- Providers indicated that while several agencies offer street **Outreach Services**, they suggested that improvements might include clearer information about which services were available at each agency and what follow-up services could be provided. Despite low use and gap statistics, the survey respondents ranked need at the mid-range and barriers in the top half. Clients report a lack of coordination among providers of Outreach services. Outreach is funded by several sources; in some areas there are many outreach workers but in others there are none.
- **Transportation** was cited in all focus groups as a significant barrier to accessing medical and support services. It was specifically strong in the focus groups with Disabled, Rural, Older Adults and Young Women with Children.

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[3] Sage Associates. *Ryan White Planning Council Focus Group with Immigrant Service Providers,* Houston, TX. July 31, 2001.

TARGETED FINDINGS: HOUSING AND TRANSPORTATION

Housing and Transportation are perennially listed among the top five needs and gaps nationally and in the Houston Area EMA/HSDA by People Living with HIV/AIDS (PLWH/A). Clients responding to the survey with self-ranked write-in responses listed these among their top 3 slots in both need and gaps.

Housing

Housing was an overriding need and barrier across all population segments in the quantitative survey and qualitative research.

Many PLWH/A utilize housing services not funded by Title I and Title II, including:

- Facilities and programs funded by HOPWA
- Programs funded for youth, the elderly, disabled, substance users and/or mentally disabled under local and/or other federal grant programs.

The Housing Opportunities for Persons With AIDS (HOPWA) program provides emergency housing assistance and rental assistance to eligible persons with HIV/AIDS and their families. The primary objective of HOPWA is to provide housing assistance to help PLWH/A continue to live independently.

Most PLWH/A's cannot afford housing due to their disabilities. People on a fixed income experience trouble paying for anything other than seriously substandard housing; a finding corroborated by the client survey and focus group responses.

Living Arrangements

All respondents report the following housing arrangements:

- 53% live by themselves
- 24% lived with family
- 16% lived in a supervised living arrangement
- 6% were homeless
- 1% were in jail

The rate of recidivism is reported by respondents as highly correlated to adequate housing. Many yearn for independent housing in a 'safe' neighborhood in which drug dealing, sex work or other risk factors that weaken their resolve to recover are not present.

Homelessness:

In the client survey, 19% of respondents reported that they had been homeless or lived in a homeless shelter in the past year, with 20% of those indicating that they had been homeless for 12 months or more. This rate is at the upper end of the national report, with most large EMAs reporting ranges between 10% - 20% homelessness. Of these, 14% to 20% are HIV infected, many of whom are unaware of their condition. The highest rates of HIV infection are found in African Americans, both male and female. Complicating diagnosis and treatment is the lack of a stable living situation, which makes adherence to strict medical regimens, transportation to providers and risk of comorbidities either related to HIV or opportunistic to HIV at an even higher probability for this group.

Affordability:

Fourteen percent of all respondents noted a need for housing modifications to address their non-HIV/AIDS disability. Disabilities were commonly reported (38%), especially by the recently released and females. 25% of survey respondents stated that disabilities have been a problem at some time in their disease, with 14% needing a housing modification to address their non-HIV/AIDS disability.

Financial burden responses from client survey:

- 37% pay $200 or less/month
- 28% pay $200 - 400
- 28% pay $400 - 600
- 7% did not complete this section
- 12% reported receiving rent supplements
- 70% have trouble paying rent at some time in the year
- 18% constantly have trouble paying
- 15.9% often have trouble paying
- 29% infrequently (defined as at least once a quarter) have trouble paying
- 27.5% sometime have trouble paying
- 7.5% rarely have trouble paying

Transportation

Given the size and climate of the area, transportation is a significant consideration for HIV planning. Houston is the only city in the area served by an urban public transit system. In 1999, Houston METRO vehicles logged more than 59 million miles and served over 99 million passengers. There are 1,572 buses in the METRO fleet that cover 130 bus routes with 15 transfer centers. Twenty-seven of these routes are “Park and Ride,” where passengers from outside the city limits can drive to the site and then ride the bus into the city. A 7.5-mile rail line is scheduled to be operational in 2004. MetroLift van service offers transportation to people with disabilities, but hours of operation are limited.

CPCDMS data shows that 1,450 unduplicated clients utilized Ryan White Title I transportation services during the one-year period of 3/1/01 and 2/28/02. This represents 6.4% - 13.1% of the estimated 11,051 - 22,706 PLWH/A in the Houston area. Different funding sources cover different geographic areas, which can make it complicated to access services. Many PLWH/A use transportation services not funded by Title I or TDH State Services.

Transportation equaled housing as a persistent need, complicating adherence to treatment regimens, ability to independently function and concerns about distance to services for the medically disabled. METRO was criticized, with 35% - 40% of PLWH/A citing transportation as a factor in missed appointments. Rural residents were more critical of transportation, citing excessive transport times (multiple hours) frequently incurred to access services within the Beltway. Finally, the influence of drivers was cited in a few focus groups as an invaluable resource about the spectrum of services (medical and social) to new clients.

Rural PLWH/A voiced particular difficulty with transportation, experiencing:

- Reduced access to personal and public forms of transportation
- Intersection points with other services such as dental care, medical care and social service appointments.
- Clients reported that it is difficult to get to:
    - Childcare from their house - 25.8%
    - Transportation from their house - 23.9%
    - Basic services - 23%
    - Social services 21%
    - Medical services - 20.8%

(Clients could respond to more than one barrier, so responses add to over 100%)

Transportation limitations impacted access to medical care and HIV services with between 35% - 40% of PLWH/A missing medical or service appointments due to transportation limitations.

FOCUS GROUP ANALYSIS

In order to provide a means to validate the findings of the survey and to gain greater access to the opinions and service recommendations of people affected with HIV/AIDS and providers of services to them, sixteen focus groups were conducted between January 28 and February 1, 2002.

The focus groups were semi-structured interviews with several topics explored in each. Participants were asked about their perceptions of factors and services that supported them in their efforts to maintain health and factors that may inhibit their efforts. The following discussion briefly summarizes the focus groups. A chart of service category gaps, generated by the survey phase of the Needs Assessment, and analyzed by focus group population, accompanies the summaries, as a means of further validation.

African American Men Who Have Sex with Men

The participants in this group were primarily young men, most of who identified as homosexual, and approximately one-third as bisexual. The men were savvy about services and offered generally positive comments about medical and social service providers, with minor complaints about infrastructure issues, such as the burdens of paperwork. The men discussed the importance of education services to the African American community, and especially prevention services to women.

Anglo Men Who Have Sex with Men

Participants in this group were quite familiar with systems of care, and demonstrated great familiarity with Ryan White funded programs. Concerns of the participants were housing, transportation and relationships with case managers. Although at least one participant owned his home *("I'm one of the lucky ones")*, most indicated that they were struggling with finding and maintaining stable housing. One individual reported that he only *"lives well when [he] lives with someone else"* but such situations are short-term and unpredictable.

Interwoven with the concern for housing was a reported need for transportation. The most intensely discussed topic in the group was the relationship with case managers. Participants were conflicted about their perceived dependence on their case managers, simultaneously chiding themselves and restating the crucial role the workers play in their lives from assistance in service access to interpersonal support.

People with Disabilities

Participants in this group of both men and women who self-identified as disabled, reported physical disabilities, substance abuse and mental illness, in addition to HIV. As might be expected, participants were almost unanimous in listing medications and medical providers as 2 of their top 3 needs, with the third a variation of social or spiritual support. As was found in other groups, participants cited transportation and housing as severe needs fraught with barriers to access.

These range from perceptions of overt discrimination to lack of accommodations for physical disabilities. An especially poignant conversation emerged in which participants discussed their experiences of marginalization and loneliness. According to the group, many individuals face increased social isolation because of the combination of HIV and other disabilities. Participants recounted incidents when family members refused to serve them food on the family dinnerware and others of abandonment by friends.

Incarcerated Women

The participants in this group were inmates in a state prison for women. In order to protect their confidentiality, these interviews were conducted individually. Each of the women recounted, without prompting, that they were incarcerated for a drug-related offense. The participants were scheduled for release from one week to 11 months from the time of the interviews. All had children who were currently living with relatives. None of the women indicated that her HIV status was her most pressing concern, as was the case in many of the other groups. Rather, they were most concerned about their ability to structure a lifestyle that allowed them to refrain from drug use.

Affordable, safe, independent housing for themselves and their children was determined to be the core of that lifestyle. Most also anticipated finding adequate employment and some spoke of job training. When pressed about their health concerns, they spoke of concerns that they would be able to afford medications. At least one woman also spoke passionately about the need for prevention education so, *“my daughter doesn’t end up like me.”*

Long Term Survivors

The selection criterion for this group was a diagnosis with HIV prior to 1992. Participants were men and women ranging in age from approximately mid-40s to mid 50s. None indicated a current AIDS diagnosis. Two individuals discussed comorbidities, one man was diabetic and a woman cited a physical disability related to an injury from an automobile accident. Most commonly mentioned needs, in addition to medical care and medications, were for transportation, housing and food pantry services.

Difficulties with transportation service providers and the belief that public transportation offered more options, encouraged several of the participants to try to gain access to bus passes. For a few participants, limited access to safe, affordable housing was classified as a deterrent to medication adherence and medical treatment. This is consistent with the information provided in many of the groups. Three of the participants were Hispanic and stressed the importance of bilingual, bicultural staff in medical and support service agencies.

Northern Rural Residents

Participants in this group were men and women who live primarily in Montgomery County, an area north of Houston. The critical needs reported by the participants were the need for satellite service sites, especially for dental, medical and food pantry services, transportation and community-based information campaigns and prevention education.

According to participants, rural medical and dental providers are not only ill equipped to assist clients in health maintenance and treat them for HIV-related conditions, but also quite reluctant to do so. In contrast, participants expressed much satisfaction with agencies that offer satellite services locally, but they indicated that these are limited. Many, therefore, chose to seek healthcare in Houston. Transportation then becomes a barrier to accessing care. Policies of providers that permit little flexibility in keeping appointment times or who have policies that require appointments to be made to complete paperwork, were noted to be burdensome for rural clients.

The recommendations for community information and prevention education were particularly strident in this group. Participants recounted incidences where they were shunned or directly discriminated against because of their HIV status. They further reported that community awareness of HIV risk and prevention behaviors was lacking and that few venues were available for this information to be presented.

Adults over 45 Years of Age

This group of men and women reported that the most crucial needs related to their healthcare were access to medication, medical providers and financial assistance. The need for medical care was particularly important in this group, all but one participant also reported significant comorbidities that included: bipolar disorder, CMV, diabetes, AIDS-related asthma, hypertension and stroke. One participant had also been diagnosed with AIDS. In their discussion of the need for medical care, they were especially articulate about the necessity for providers to be adequately informed and to treat them in a compassionate and respectful manner.

Participants noted that issues of competence and provider attitude were more likely problematic when they sought care from a provider not accustomed to treating PLWH/A. The group also addressed the importance of social support. One of the participants told of his experiences as an informal mentor to a younger, newly diagnosed patient. He stressed the sense of isolation one feels at the time of diagnosis, which was exacerbated in this case, since the young patient was also monolingual in Spanish. When told he had AIDS, he felt terrible. [Mentor] met him at [provider] and told him *"You might die of something else, this you can live with".* He was better after that.

Currently Pregnant Women

While the women in this group asserted that medical care and access to medications were essential needs, especially as they affected their pregnancies, the central theme of the group was the importance of their relationships with their providers. Participants spoke of the critical importance of case managers and medical staff in assisting them with medication adherence, maintaining emotional health and hope and coping with their fears related to the health status of their children.

The medical concerns of the group were significant. Ranging in age from 39 to 45, their risks associated with pregnancy were higher and all but one reported a comorbidity including: stroke, diabetes and paranoid schizophrenia. Nonetheless, when they spoke of their healthcare needs, they focused exclusively on their hopes and fears for their children.

Southern Rural Residents

All participants indicated that medical care, access to medications and dental care were their most essential needs. Their requests for medical care included not only access to clinics, but equally to medical personnel who are well informed and accessible. Several of the participants were treated in Houston, which is located more than 30 miles from the site of the focus groups and as much as 90 miles from the home of at least one of the participants. Access to medications required, for participants, adequately informed medical personnel and financial assistance to purchase the drugs.

Currently, all participants are under regular medical care, and all expressed general satisfaction with most of their providers, although there was discussion about the "attitudes of some of them." Their dissatisfaction appeared to be much less prominent than it was in the northern counties. Dental care was considered an essential need both because of the paucity of dentists in their hometowns and because of the lack of training about care of HIV+ patients among these providers. All participants found that transportation was quite problematic in the area. As in many other groups, participants stressed the importance of community education and the impact that an informed and compassionate community has on the quality of their lives.

Substance Users

Each of the participants in this group reported use of drugs, most often cocaine, heroin and either marijuana and/or alcohol. Participants discussed limitations of medical services, lack of affordable housing and the particular challenged faced by those with a history of incarceration, especially in finding housing. These participants reported numerous threats to their health, in addition to possible chemical dependency, including episodic or chronic homelessness, repeated incarcerations and difficulties in maintaining medication adherence as well as refraining from HIV risk behaviors.

Adult Women

Comprised of women in their 40s, this group, more than any other, described their HIV status in terms that suggested that their diagnosis reflected on their sense of identity. Though they listed their three highest needs for health maintenance: medical care, case management and housing, they stressed that they wanted to communicate the impact of the diagnosis. That discussion centered on the shame and ostracism that they believed their diagnosis caused them.

Although never asked the question, four of the six participants volunteered that they were infected through blood transfusion, all after 1990, which seemed unlikely, but underscores the fear of judgment that was repeated throughout the Group. Each recounted the story of her diagnosis. Four indicated that they were not told they were HIV positive, but rather were given indirect comments that hinted at the situation. All reported that the quality of care from the private physicians who had treated them prior to diagnosis deteriorated so much so that they transferred to a clinic specializing in HIV care.

The group reported their initial reactions to their diagnosis: depression, alcohol abuse treatment avoidance and passivity. For one woman, the experience was sufficiently disconcerting, that she had not sought care since her diagnosis 6 months prior to the group. At the conclusion of the session, the women concurred that support groups would be very useful to them.

Youth (ages 13-24)

Two groups were held for youth. Although recruiting efforts were targeted toward segregating 13 - 19 years old and 20 - 24 year olds, participants in both groups ranged from 14 - 24. The participants in these groups were African American adolescents and young women, most of whom were also mothers of toddlers or infants. In both groups, the participants adamantly emphasized the need for consistent and persistent prevention efforts directed toward adolescents and young adults, most especially toward females.

The participants detailed that lack of information about HIV risk and naiveté about their sexual partners had placed them in jeopardy. They spoke of their currents efforts within their social networks to inform friends and family about risks and protective factors. Similar to accounts from older women, these participants reported the importance of their health care providers in supporting their adherence to medications regimens and risk reduction. Those with children indicated their perceptions of the importance of maintaining their health in order that they might better care for their children.

PROVIDER SURVEY

In order to better determine the community’s capacity to address the continuum of care and more effectively meet the needs of clients with HIV/AIDS, the Needs Assessment included a survey of providers of services to those clients. The survey, adapted from the Statewide Coordinated Statement of Need (SCSN) Provider Survey (see Procedures) included questions that generated the following types of descriptive information:

- Types of agencies offering HIV-related services
- Demographics of client population
- Range of services offered
- Barriers to service

The survey also polled providers for their recommendations to improve the system of care for clients and to foster collaboration and cooperation among agencies. In addition to the survey, provider input was solicited through two focus groups: one open to all providers of HIV services and one for providers of services to immigrants.

Of the 50 providers that responded to the survey, 19 represented organizations whose services are offered either exclusively or primarily to PLWH/A or are perceived by the community to be ASOs. These were self-reported or later classified as AIDS Service Organizations (ASO). Thirty-one (31) organizations were self-reported or later classified as non-ASO in that their client populations extend beyond PLWH/A. Agencies “later classified” as ASOs target PLWH/A for services, but do not serve only these individuals.

Description of Providers

Non-ASOs have a longer tenure of service than do ASOs. Of ASOs 53% have been in existence for at least 10 years, compared to 63% of non-ASOs. Ryan White CARE Act funding is the predominant source of support for HIV-related services reported by both ASO (84.2%) and non-ASO (58%)respondents. The non-ASOs were more likely to report funding from private insurance (22.6%) and client fees (29%), while ASOs report more foundation support and contributions (57.8% for both). ASOs were also far more likely to receive funding from public sources. According to the respondents, social case management is the most frequently offered service (32%), followed by ambulatory medical care, prevention education and patient education (each 28%). Of the respondent sample, minimal variations exist between ASOs and non-ASOs in the services they offer, with the exception of ambulatory outpatient medical care. Four of 19 ASOs make this service available to clients compared to 10 non-ASO organizations.

Although respondents did not delineate the specific demographics of their clients, several reported efforts to target client populations. Seven agencies targeted female clients, six targeted male, and one targeted transgendered clients. Of those agencies that specified the race and ethnicity of their client populations, 9 indicated African American clients; 3 agencies, American Indian; 2 agencies, Pacific Islander/Hawaiian; two agencies, Anglo, and 1 agency Asian. Six agencies indicated that they focused on services to Hispanic clients. Using age as a criterion, 10 agencies served clients less than 12 years of age, 5 agencies served adolescents; 5 young adults age 20 – 39; and 8 listed clients 40 and older. Providers also categorized their clients using HRSA definitions of populations with special needs.

Findings

Transportation was cited as a barrier by 44% of providers. In each of the client focus groups, transportation was cited as a barrier and often as the most significant barrier in accessing medical and support services. Transportation was also identified as a barrier on the client survey. Limited data sharing is perceived by clients, according to focus group information, as “excess paperwork.” Especially in the groups for Anglo MSM and African American MSM, many clients reported a perception that they were required to supply each new provider to whom they might be referred with information that they had given previous providers. They indicated that they are “already in the system” (referring to either COMPIS or CPCDMS) with this replication reported as burdensome. Other clients reported that the sharing of any data among providers was unacceptable as it might lead to a breach in confidentiality.

Client inability or refusal to adhere to medication regimens was self-reported in focus groups and reiterated in provider groups and in responses to the client survey as a significant barrier to continuing in medical care. Many focus group participants offered anecdotes that medication side effects or the rigors of medication scheduling were significant barriers to seeking or maintaining medical care. Among self-reported out-of-care clients, 46% indicated on the survey that they chose not to seek medical care. In contrast, 33% cited provider advice and 21% access to care as the primary barrier.

Focus group and street interview participants offered additional explanations of the personal choice not to seek care that is consistent with the provider report. Several reported that initially after diagnosis, they were stunned and tended to conceptualize their HIV status as either an indication of immediately impending death or as something of no significance, which could be denied. With these attitudes they indicated that the rigors of treatment were perceived to be useless or of no significance.

For many clients, eventual contact with service providers corrected these notions and treatment began. However, according to both providers and clients, once the physical and emotional stress and side effects of medication adherence is experienced, clients are again at risk of reverting to the more extreme positions. These notions and client reactions are documented throughout the HIV-related professional literature as well as that focusing on other serious, chronic diseases. The inhibiting effect of substance abuse on care-seeking behaviors was also substantiated in all phases of the needs assessment. This factor is significant in that the presence of diagnosed and undiagnosed substance abuse among PLWH/A has been shown to be substantial

Provider Central Themes

Within the 2 provider focus groups several themes emerged. Reviewing these adds context to the survey findings and can be used to support the community’s efforts to enhance the service delivery system.

Service Needs

- Similar to clients, providers expressed the importance of ambulatory outpatient medical care and support services
- Providers rank mental health and preventive services higher than do clients, although both groups list them as essential.
- Focus group participants added that their clients are reporting increasing need for dental and vision care. Dental care needs involved prevention, treatment and prosthodontics. In vision care, needs include preventive care, corrective lenses and CMV screening. This may be related to the disparities between Medicaid coverage and the availability of these services to those in the HIV continuum of care.
- Rural clients indicated a need for satellite service centers in both the northern and southern communities in the EMA/HSDA, which was confirmed by providers.

Service Barriers

- Participants in the focus groups corroborated the survey respondents' description of service barriers.
- The system-related services, transportation and client data sharing are being addressed, by the community according to participants. New transportation options are being created, including increasing the number of providers and developing options to using CARE Act funded transportation services.
- Client data sharing methods will continue to improve as region-wide data systems are upgraded and as the issue is addressed through provider collaborations.
- Providers recognize the special needs that accompany clients with substance use/abuse issues and are attempting to incorporate those needs into care delivery systems
- Providers also stressed the need for multicultural competence in the delivery of services.
- Both clients and providers report that limited access to insurance further compromises access to care for many clients.

Prevention Services

- Providers indicated they are diversifying their prevention efforts to include more targeted populations, more sites and a wider range of methods. Secondary and tertiary prevention efforts were especially noted.
- Clients, especially African American women, were adamant about the need for primary prevention services to women of color.
- Rural clients requested community-wide prevention and general HIV-related information.

Recommendations

Based on the findings of the provider survey and focus groups, the following recommendations are offered:

- Use Standards of Care and contractual negotiations to ensure consistent provider adherence to cultural sensitivity policies.
- Determine balance between client choice of provider and provider capacity.
- Continue to communicate with client base regarding frequently misunderstood services:
  - Substance abuse short-term treatment does not equal housing
  - Dental services and the spectrum of offerings, link to transportation issues
  - Vision care/ Cytomegalo Virus (CMV) testing available at [provider] - clarify payer qualification criteria
  - Housing can be supported using multiple funding sources for client not only HOPWA.
- Focus on expanding the network of agencies and organizations that can serve as points of entry to the HIV continuum of care and provide them with information about the HIV/AIDS system of care.
- Develop and enforce protocols for referrals to the appropriate provider and level of care.

GENERAL RECOMMENDATIONS

Recognize the changing face of the HIV epidemic in the Houston EMA/HSDA and ensure representation, in Needs Assessment and other community research, by females (increased from 17% female in 1999 Needs Assessment to 25% female) and bisexuals (13% gender identification with higher fraction in severe needs population: not-in-care, incarcerated and African American and Anglo Men Who Have Sex with Men groups).

Aggressively educate the community about the need to receive primary medical care.

Specific attention should be paid to the incarcerated (access) and youth/females (provider related) populations.

The importance of client's knowledge of viral load as essential to modern antiretroviral therapy should be stressed to all providers and clients.

The crucial role of non-ASO's as 'portals' or 'points of entry' into the HIV/AIDS system cannot be over-stressed with nearly half the respondents to both qualitative and quantitative surveys reporting their diagnosis when accessing services for reasons other than specific HIV testing. Continued efforts at networking, education and quick referrals are essential.

Continue to work, network and outreach to general providers, especially those who are likely to test potential HIV-positive individuals as they enter the system. (Nearly half determined they were HIV-positive unrelated to HIV testing).

Educate the general community about HIV/AIDS, especially the poorest levels of society.

Include in planning efforts, programs that address the needs of those dually diagnosed with HIV and substance abuse.

Comorbidities were rife throughout the population. Substance abuse, psychiatric disorders and sexually transmitted diseases were expected, but considerable medical comorbidities related or incident to antiretroviral therapy were also listed, key among them hypertension, cardiac issues, and diabetes.

Of concern were the reported psychiatric conditions versus what emerged in qualitative research. Paranoid schizophrenia and bipolar disorders were frequently cited on the quantitative client survey and in focus groups. With little probing, however, situational depression or chronic depression emerged as a much more pervasive issue.

It would be worthwhile to survey for this specific condition at a later date.

Ensure that depression is listed on any checklist for new client evaluation

Service-Specific

Ambulatory/Outpatient Medical Care was ranked high as a service gap with 32% of respondents reporting an issue with use. Some concern was expressed specifically towards non-ASO (AIDS Service Organization) ambulatory services or the lack of coordination between insurance and ambulatory access.

Continue to expand information systems, such as CPCDMS, to ensure system-wide knowledge of client access into the ambulatory system. This is particularly vital as AIDS converts to a chronic disease with ambulatory access the mainstay of treatment.

Another service ranking high as a gap was medical case management, particularly as an individual service. Three (3) issues were reported as themes requiring greater attention. These were:

- Coordination of health care services, particularly inter-agency
- Coordination of health care and support services
- Accessibility and continuity of care with case managers

The last issue was intriguing, as even long-term survivors had a disparaging notion of discontinuing regular contact with case managers, even if they reported increasing lack of knowledge among newer and younger case managers. Many of the long-term survivors (even in focus groups other than long-term survivors - the disabled), reported that they could negotiate the system better than any case manager that they had ever been assigned with the exception of their first case manager upon entry into the system.

Dependence on social case management seems integrated with services that require case manager referral—specifically cited were transportation and housing.

Efforts to psychologically disconnect social case management from dependence and praise those clients, especially long-term survivors, who achieve independence from the system, should be recognized, praised and initiated upon entry to the system as the goal of effective case management. This would also ease burdens on an already strained system.

Increase coordination among agencies to reduce duplication of services and enhance clients ability to navigate through the care system.

Coordination of health and support services would be fostered by the same information system discussed in the first service-specific recommendation.

Dental care ranked as a high service category need with over 50% of respondents listing this service and individual service codes matching this ranking. There was a perception of a gap with this service, related to:

- Location of services
- Block scheduling
- Lack of timely access – interrelated issue with transportation resulting in 35 - 40% of respondents citing delayed or rescheduled service

Dental providers might consider studies to probe further these concerns and to develop additional options to service delivery that address these perceived gaps. A specific recommendation offered by focus group participants was the possible expansion of services in both the North and South rural areas and in Northwest Houston.

Mental Health Services are a significant area for interaction with the HIV service delivery system. Those clients who have been homeless in the past two (2) years ranked these services as essential (71%).

Appreciate the critical nature of mental health services along the spectrum (psychological/psychiatric counseling, mental health, emergency psychiatric services). This is a widely used service (57% used this service) with a high satisfaction rating as a service category (68%), and individual service ranking (7th as priority).

Research the incidence of depression, especially as clients are first diagnosed or enter the system. Many focus group attendees relayed extreme feelings of rage, depression and lingering sadness not only upon learning they were HIV positive, but as they attempted to master system access. Many of the women in these groups were unaware of the importance of treating their depression and the impact that it could have on treatment compliance or progression.

Include community mental health centers in planning, since they are mandated to serve those with severe mental illness, defined as major depression, schizophrenia and bipolar disorder as well as the developmentally delayed.

Disabilities were commonly reported (38%), especially by the incarcerated/recently released and females. 25% of survey respondents stated that disabilities have been a problem at some time in their disease, with 14% needing a housing modification to address their non-HIV/AIDS disability.

Other Service Needs

Housing was an overriding need and barrier throughout all populations. 19% reported being homeless or living in a homeless shelter in the past year. Many live with family or friends, with 25% in supervised or group homes. Many PLWH/A are aware that this is a citywide issue with affordable housing for people on fixed incomes, since many of them live with their parent(s) who are in that category.

Correlated to adequate housing is the rate of recidivism. Many clients yearn for independent housing in a 'safe' neighborhood in which drug dealing, sex work or other risk factors that could weaken their resolve to continue to recover are not present.

Continue to collaborate with housing related services such as HOPWA.

Transportation equaled housing in its listing as a pervasive need complicating adherence to treatment regimens, ability to independently function and even concerns with distance to services for medically disabled. METRO Lift and funded shuttle system was roundly criticized, with 35-40% of PLWH/A citing transportation as a factor in missed appointments.

Rural residents also expressed concerns about transportation with excessive transport times (multiple hours) frequently incurred to access services within the Beltway. Finally, the influence of drivers was cited in a few focus groups as critical resources of the spectrum of services (medical and social) available to those new to the care system.

Continue to work with transportation providers to develop accessible mass transit.

Maintain one system for transportation - shuttle or taxi with vouchers. Considerable confusion still exists with clients about which system is in place and the qualifications to access that system.

- Work with planning bodies to maintain funding to not further stress an already overloaded system.
- Educate shuttle drivers in the resources available to clients, with specific training on spotting those new to care. Provision of brochures, informational materials and other assistance for those entering the system on the shuttles will allow these drivers to further support knowledge of the system. Several focus group participants specifically mentioned their support as vital for them understanding better where to go and what range of services could be accessed.

Economic

Attempt to more effectively transition adolescents (16 - 17), especially young mothers who are HIV positive from Medicaid to other forms of insurance. In the 15 - 24 young mothers focus group, all six participants expressed confusion and anxiety about their insurance status upon turning 18.

Information

Increase public awareness and education through more community-wide media campaigns.

Most respondents in focus groups and some client surveys (25%) specifically compared the information transmission in Houston to other urban areas regarding HIV/AIDS prevention and/or treatment. The Internet is growing as a source of knowledge, but public relations, advertising and public announcements were viewed as underutilized sources of public information.

SPECIAL STUDY FINDINGS

African American Men Who Have Sex with Men

Theme 1: AA MSM are better educated more likely to carry employer-sponsored or private insurance or COBRA and have drug assistance from those payers than all respondents or other special study groups.

Recommendation: This socioeconomic group can better access resources yet is slightly less likely to be 'in care' at 77% than all respondents. This may demonstrate cultural beliefs or misperception or unawareness of providers. Respondents reported that providers advised against aggressive primary care despite a tendency for AA MSM to be unaware of their viral load. This suggests that either the providers for AA MSM need to be educated regarding more aggressive primary care or at a minimum, more proactive education of their clients regarding viral load needs to occur.

Theme 2: AA MSM admitted in both focus groups and the RARE street interviews to hustling with both sexes whether they are truly bisexual or not. They openly express concern about transmission to African American Women.

Recommendation: Proactive and open communication and education among the African American community needs to occur about protection (condoms) and/or education of African American women about rejection or refusal techniques.

Theme 3: Comorbidities are of particular concern for AA MSM due to their ethnic propensity to be at higher risk for high blood pressure and diabetes. The interaction of these two conditions to antiretroviral therapy is most concerning.

Recommendation 3: Ensure that providers to AA MSM are aware of the complications and risks associated with antiretroviral medication and conditions to which African Americans are predisposed. Fully alert all providers, including non-ASO's who may be less aware of these complications than AIDS service organizations.

Youth

Theme 1: Youth consistently demonstrated a desire for more education, information at an earlier age. This extends to risk factors such as unprotected sex and drug use. Early grade school seems premature, but specific comments about sex education not starting until the 6th grade as far too late show the need to start these efforts early.

Recommendation: Continue to provide prevention education at increasingly earlier ages in school systems, churches and day care. Extend patient education programs targeted to young mothers and female teens.

Theme 2: Youth are among the most likely to be uninsured. Many lose coverage when they turn 18 years old.

Recommendation: Further target those PLWH/A Youth who are turning 18 to ensure continuity of care and funding.

Theme 3: Youth are vulnerable to being unconnected to any care system due to their lack of means to pay for care, lack of awareness to find out what services are offered, belief that they are not at high risk and their probability of being uninsured. These vulnerability factors are stressed when many young women have children at an early (under 20 years) age. Lack of employment or under-employment further stresses their situation.

Recommendation: Coordinate AIDS prevention efforts with other social service agencies (schools, after-school programs, youth development programs) that cater to youth. Develop risk profiles to have for agencies to use in assessing and referring those youth most vulnerable to risk of developing HIV. Consider a peer outreach program to inform and educate Youth regarding risk factors and areas for testing/treatment.

Theme 4: 16.7% of Youth stated that they were born HIV positive and of the “out-of-care” youth, 7.2% also stated that they were HIV positive at birth. This may indicate either that they received early aggressive treatment and appropriate medical advice to not receive primary care in the past 6 months or a fatalistic attitude towards the disease.

Recommendation: Continue to assess any difference in the care needs of perinatally infected youth.

Theme 5: Surveillance data suggest that the rate of new infection among youth is increasing and that as many as 25% - 30% of those infected may not know their HIV status.

Recommendation: Expand outreach, testing and early intervention programs to youth. Explore the opportunities for assistance in these efforts from the NIH-funded Adolescent Trial Network, which was created to “develop effective methods of enhanced case finding for Youth living with HIV/AIDS, and to develop and test prevention efforts for the most vulnerable youth.”[4]

Women of Childbearing Age

Theme 1: A high percentage of women (56.6%) were diagnosed as HIV positive incident to other testing (did not seek out direct test to confirm HIV). Women were the special study group least likely to be diagnosed following a visit for HIV testing. Pregnancy testing is a unique means of detection with 13.9% determining their HIV status at this point.

Recommendations:
Communicate with the agencies conducting pregnancy testing about developing protocols for care since this is a frequent locus for HIV diagnosis. Aggressively refer or treat these women. Ensure that sensitive treatment of females occurs in regards to their being informed of their diagnosis.

Theme 2: Females were less likely to use ADAP or other drug reimbursement benefits despite their high use of antiretroviral therapy (expensive medications with co-payment currently averaging $105)

Recommendation: Review females awareness of drug reimbursement benefits, particularly ADAP

Theme 3: Females represented a higher “out-of-care” population than the population (15% vs. 12%) with 41% of the 15% “out-of-care” reporting that they did not seek primary care within the past 6 months due to physician advice.

Recommendation: Further explore the report that providers advise females against actively accessing primary care services. A high percentage of “out-of-care” was reported yet current viral load most resembles highest viral load.

Incarcerated/Recently Released (I/RR)

This was the only group who did not place their HIV/AIDS diagnosis as their most pressing concern. They unanimously stated that staying free of drugs was their #1 mission. Their children tend to live with relatives, with their key concerns being finding housing, employment and basic resources to stay ‘clean’ of drugs.

Theme 1: The Incarcerated/Recently Released were notable in their service category rankings in the higher value placed on substance abuse and mental health services. According to experience reported by providers of substance abuse services, very few individuals receive any substance abuse treatment while incarcerated.

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[4] Ellen, JM. *The Hopkins HIV Report - Adolescents and HIV*. May 2002.

Recommendation: Work to develop more transition programs including those inside prisons to ease the transition of the high (53% self-reported) rate of substance abuse. The Texas Department of Criminal Justice (TDCJ) has established a program of halfway houses for individuals who are identified or who request transition opportunities that incorporate substance abuse treatment.

Theme 2: In prison and transitional HIV medication adherence is a significant issue with recently released often reporting being issued a very limited supply of drugs. Lack of permanent address is a confounding obstacle to being 'in-care' and continuing adherence to a strict medication regimen.

Recommendation: Develop a comprehensive transitional program that allows clinics to 'adopt' recently released, with prior resources provided including a permanent address if none is otherwise available, ongoing medication regimen and basic resources (nutrition and basic medical care).

Theme 3: Transportation is frequently mentioned as a limitation to accessing other needed services. In addition, many individuals, upon release, do not have a valid identification, such as a driver's license, which is also a barrier to accessing transportation and other services.

Recommendation: Incorporate transportation as a resource provided before release.

Theme 4: High disability and low employment rates make this group vulnerable to remain "out-of-care" (19% vs. 12% for all respondents). Among those recently released from prison, there is a high rate of uninsured.

Recommendation: Within the comprehensive transition program, incorporate job retraining, insurance eligibility and other efforts to economically support the recently released. These efforts need to be anticipated well before release (up to 1 year prior).

Theme 5: A substantial percent of I/RR individuals are in care and express concerns about medication availability and service coordination. A smaller, but important, subset of I/RR appears disinterested in care. Several focus group interviews with I/RR revealed that this disinterested population exists and may be difficult to reach. This is true despite the presence of comorbidities disproportionate to the full population (neuropathy, thought/memory disorders, liver disease, pulmonary disease)

Recommendation: More comprehensive screening on intake and release of these individuals from incarceration, both for HIV and comorbidities. From these efforts, a more thorough assessment of treatment needs can be determined.

Theme 6: Releasees with felony drug offenses are not eligible for food stamps leaving them vulnerable and putting a strain on local food banks.

Recommendation: Work with providers to insure access to service.

Out-of-Care

Discuss policy of the planning bodies regarding desired and achievable numbers of "out-of-care" and "never-in-care" to phase in to the service delivery system. Further study of the "out-of-care" (12% of client survey respondents) would help determine which are appropriately not accessing ambulatory primary care services and which should, but are not due to: 1) Lack of access; 2) Lack of awareness; 3) Lack of desire.

Ensure that further outreach to the higher percentage of "out-of-care" will not deteriorate current service to the majority (81% of client survey respondents) of "in-care". Conduct a similar policy decision regarding the resistant "never-in-care" (7%).

Focused efforts can be made with the two highest subgroups, youth and the incarcerated/recently released. Use public media to reach the “never-in-care” with further RARE or street outreach efforts aimed at probing the hard-to-reach, unconnected PLWH/A. With the interviews, conduct testing where permitted so that knowledge of serostatus can convert to action with information provided about free services, locations, etc.

APPENDIX 1

SERVICE CATEGORIES AND INDIVIDUAL SERVICES

- Ambulatory/Outpatient Medical Care
  - *Primary Care*
  - *OB/GYN*
  - *Pediatric*
  - *Vision Care*
  - *Specialty Care*
  - *Infectious Diseases*
  - *Medical Case Management*
- Social Case Management
- Dental Care
- Emergency Medical Services
  - *Primary Care*
  - *OB/GYN*
  - *Pediatric*
  - *Vision Care*
  - *Specialty Care*
  - *Infectious Diseases*
  - *Medications/Pharmacy*
- Home Health Care
  - *Para-Professional Care*
  - *Professional Care*
  - *Specialized Care*
  - *Durable Medical Equipment*
- Hospice
  - *Home-Based Hospice Care*
  - *Residential Hospice Care*
- Inpatient Services
  - *Primary Care*
  - *OB/GYN*
  - *Pediatric*
  - *Vision Care*
  - *Specialty*
  - *Infectious Diseases*
  - *Medications/Pharmacy*
- Long Term Care
  - *Nursing Homes*
  - *Assisted Living Facility*
  - *Hospice Care*
  - *Transitional Facility*
- Medications and Therapeutic
  - *Medications/Pharmacy*
- Research
  - *Clinical Trials*
- Mental Health Therapy/Counseling
  - *Psychological & psychiatric treatment and Counseling Services*
  - *Support Groups*
- Nutritional Services
  - *Education, counseling and/or direct therapeutic nutritional / supplemental food products and/or services*
  - Rehabilitation Care
  - *Physical Therapy*
  - *Speech Pathology*
  - *Low Vision Training Services*
- Substance Abuse Treatment / Counseling
  - *Substance Abuse Counseling*
  - *Substance Abuse Treatment*
- Support Services
  - *Adoption / Foster Care Assistance*
  - *Adult Day or Respite Care*
  - *Alternative Treatment / Therapies (Acupuncture, massage therapy, natural meds)*
  - *Buddy/Companion Services*
  - *Childcare*
  - *Client Advocacy / Legal Services*
  - *Counseling (Other)*
  - *Direct Emergency Financial Assistance*
  - *Food Bank/Home-Delivered Meals*
  - *Health Insurance Payments*
  - *Housing*
  - *Housing Payment*
  - *Mental Health Services (licensed, clinical)*
  - *Transportation (to required services)*
  - *Translation/Interpretation*
  - *Exercise/Fitness/Strength Training*
- Patient Education Services
  - *HAART*
  - *Health Education*
  - *Information Clearinghouse/Library*
  - *Patient Education Center*
- Prevention Education Services
  - *Street Outreach*
  - *Information Clearinghouse/Library*
  - *Prevention/Health Education Services*

APPENDIX 2

USE RANKING:

Use statistics represent the percentage of respondents who indicated on the client survey that they have used the service.

USE RANKING - ALL RESPONDENTS

SERVICE	PERCENT	RANK
Ambulatory/Outpatient Medical Care	83.6	1
Support Services	81.5	2
Emergency Medical Services	78.5	3
Dental Care	67.1	4
Social Case Management	64.8	5
Drug Reimbursement	62.6	6
Inpatient Services	62.1	7
Mental Health Therapy/Counseling	61.9	8
Nutritional Services	52.3	9
Rehabilitation*	38.3	10
Patient Education	37.5	11
Research*	36.8	12
Substance Abuse Treatment/Counseling	36.7	13
Long Term Care*	28.2	14
Prevention Education Services	27.9	15
Home Health Care*	27.0	16
Hospice*	9.8	17

**NOTE: Interpretation of data for Hospice, Home Health Care and Adult Day Care is limited by 2 factors: 1- the population surveyed was primarily ambulatory and relatively healthy; 2- the questions on the survey were inadequate to accurately assess the need for these services.*

Rehabilitation was a term that survey respondents may have found confusing, which may have influenced their response. During the validation process, several told facilitators that they interpreted rehabilitation to refer to such services as substance abuse treatment or post-incarceration services, such as employment training.

NEED RANKING:

Need statistics represent the percentage of respondents who indicated on the client survey that they need the service.

NEED RANKING - ALL RESPONDENTS

SERVICE	PERCENT	RANK
Support Services	74.9	1
Ambulatory/Outpatient Medical Care	69.6	2
Dental Care	58.1	3
Emergency Medical Services	52.6	4
Drug Reimbursement Program	50.1	5
Social Case Management	46.8	6
Mental Health Therapy/Counseling	45.4	7
Nutritional Services	42.5	8
Inpatient Services	36.2	9
Rehabilitation*	27.2	10
Patient Education Services	26.7	11
Prevention Education	22.7	12
Substance Abuse Treatment/Counseling	22.2	13
Home Health Care*	19.9	14
Research*	19.4	15
Long Term Care*	19.3	16
Hospice*	5.9	17

**See NOTE on page 38 regarding these service categories.*

BARRIER RANKING:

Barrier statistics represent the percentage of respondents who indicated on the client survey that they perceived the service as “hard to get.”

BARRIER RANKING - ALL RESPONDENTS

SERVICE	PERCENT	RANK
Support Services	33.7	1
Ambulatory/Outpatient Medical Care	18.4	2
Emergency Medical Services	12.3	3
Rehabilitation Care*	11.3	4
Long Term Care*	10.4	5
Inpatient Services	9.4	6
Social Case Management	9.3	7
Patient Education Services	9.2	8
Home Health Care*	8.4	9
Mental Health Therapy/Counseling	8.2	10
Research*	8	11
Prevention Education Services	7.9	12
Drug Reimbursement Program	7.6	13
Hospice*	7.2	14
Dental Care	6.8	15
Substance Abuse Treatment/Counseling	5.8	16
Nutritional Services	5.7	17

**See NOTE on page 38 regarding these service categories.*

GAP RANKING:

Perceived service gaps were determined based on a respondent indicating on the client survey that the service was “needed” but “not available”.

GAP RANKING - ALL RESPONDENTS

SERVICE	PERCENT	RANK
Support Services	42.7	1
Ambulatory/Outpatient Medical Care	31.9	2
Emergency Medical Services	24.9	3
Inpatient Services	16.4	4
Rehabilitation*	11.6	5
Mental Health Therapy/Counseling	10.2	6
Home Health Care	9.7	7
Long Term Care*	9.2	8
Patient Education Services	8.9	9
Prevention Education Services	8.3	10
Nutritional Services	6.2	11
Drug Reimbursement Program	5.9	12
Research*	4.7	13
Dental Care	3.4	14
Social Case Management	3.3	15
Substance Abuse Treatment/Counseling	2.4	16
Hospice*	2.1	17

**See NOTE on page 38 regarding these service categories.*

APPENDIX 3

SERVICES ANALYSIS FOR ALL RESPONDENTS

% = Percentage of survey respondents who indicated a use, need, or barrier.
Rank for Service Category = Order of importance among 17 service categories; indicated in **bold**.
Rank for Individual Services = Order of importance WITHIN service category. 1 is most important.

SERVICE	Use		Need		Barrier	
	%	Rank	%	Rank	%	Rank
Ambulatory/Outpatient Medical Care	**83.6**	**1**	**69.9**	**2**	**18.0**	**2**
Primary Medical Care	66.9	1	42.5	6	5.9	72
Vision Care	53.6	4	46.9	4	10.3	5
Obstetrics/Gynecology	20.9	35	13.6	70	5.5	67
Pediatric Care	13.0	51	8.9	73	5.0	69
Specialty Care	23.9	29	17.8	39	6.8	24
Infectious Disease	47.8	7	33.2	14	4.6	51
Case Management						
Social Case Management	**62.8**	**5**	**46.8**	**6**	**9.0**	**7**
Medical Case Management	48.1	6	39.5	9	6.0	62
Nutritional Service	**52.3**	**9**	**42.5**	**8**	**6.0**	**11**
Nutritional Education, Counseling, etc	29.4	19	27.6	22	3.8	66
Support Services	**81**	**1**	**74**	**1**	**34**	**1**
Adult Day Care*	8.1	53	7.1	52	6.1	38
Buddy/Companion Services	9.6	55	14.7	47	7.4	15
Child Care	9.7	56	8.1	53	5.9	39
Client Advocacy/Legal Services	17.5	40	20.1	33	7.4	14
Emergency Financial Assistance	24.4	27	39.9	8	14.4	3
Food Bank/Home-delivered Meals	46.2	8	49.2	2	7.7	10
Health Education/Risk Reduction	17.2	41	21.4	31	6.5	28
Health Insurance Payments	15.7	45	24.2	26	12.4	4
Housing Assistance	22.9	31	35.4	12	15.6	2
Housing	23.9	28	32.3	15	16.8	1
Interpreter Services	8.7	80	9.7	80	6.8	26
Outreach Services	10.6	79	15.2	46	6.2	34
Referral	Not Available					
Transportation	29.5	18	35.5	11	9.9	6
Dental Care	**67.1**	**4**	**58.1**	**3**	**7.0**	**9**
Substance Abuse Treatment/Counseling	**36.7**	**13**	**22.2**	**13**	**6.0**	**10**
Drug Reimbursement Program	**62.6**	**6**	**50.1**	**5**	**8.0**	**8**
Medications/Pharmacy	58.4	3	48.4	3	6.8	25
Mental Health Services	**61.9**	**8**	**45.4**	**7**	**8.0**	**7**
Psychological/Psychiatric Treatment, Counseling	34.1	15	29.4	18	5.1	74
Support Groups	37.7	12	34.8	13	4.4	80
Mental Health Services, Licensed, Clinical	28.4	26	26.0	23	5.9	63
Hospice*	**9.7**	**17**	**5.9**	**17**	**7.0**	**14**
Home-Based Hospice	7.9	61	5.0	59	6.1	35
Residential Hospice	8.1	76	4.5	77	5.9	75
Home Health Care*	**27.0**	**16**	**19.9**	**14**	**9.0**	**7**
Paraprofessional Care	10.5	70	9.2	71	6.3	33
Professional Care	13.0	50	12.8	76	5.8	73
Specialized Care	11.8	77	10.5	78	6.6	27
Durable Medical Care	10.4	57	9.5	54	7.3	17
Rehabilitation*	**38.3**	**10**	**27.2**	**10**	**11.0**	**4**
Physical Therapy	17.0	42	21.5	30	7.4	15
Speech Pathology	7.9	28	6.9	79	6.9	19
Low Vision Training Services	11.3	66	10.3	65	5.6	6
Early Intervention	Not Available					

*See note on page 38 regarding these service categories.

SERVICES ANALYSIS FOR AFRICAN-AMERICAN MSM

% = Percentage of survey respondents who indicated a use, need, or barrier.
Rank for Service Category = Order of importance among 17 service categories; indicated in **bold**.
Rank for Individual Services = Order of importance WITHIN service category. 1 is most important.

SERVICE	Use		Need		Barrier	
	%	Rank	%	Rank	%	Rank
Ambulatory/Outpatient Medical Care	**80.0**	**3**	**28.0**	**12**	**17.0**	**2**
Primary Medical Care	62.8	1	36.1	2	6.6	5
Vision Care	56.7	2	46.1	1	11.8	1
Obstetrics/Gynecology	12	5	6.4	5	10.3	2
Pediatric Care	9.5	6	5.6	6	6.3	6
Specialty Care	25.1	4	15.0	4	7.9	3
Infectious Disease	52.3	3	32.7	3	6.9	4
Case Management						
Social Case Management	**63.0**	**9**	**64.0**	**3**	**9.0**	**9**
Medical Case Management	51.0		36.2		7.8	
Nutritional Service	**63.0**	**8**	**47.0**	**4**	**6.0**	**17**
Nutritional Education, Counseling, etc	35.9		37.5		3.9	
Support Services	**84.0**	**1**	**57.0**	**3**	**37.0**	**1**
Adult Day Care*	10.2	11	6.3	11	7.1	6
Buddy/Companion Services	14.8	10	15.3	10	5.6	10
Child Care	8.6	12	5.2	12	4.7	11
Client Advocacy/Legal Services	20.2	8	19.2	8	7.0	7
Emergency Financial Assistance	26.8	5	45.1	2	14.1	3
Food Bank/Home-delivered Meals	49.4	1	52.2	1	3.8	12
Health Education/Risk Reduction	20.9	7	19.4	7	6.3	8
Health Insurance Payments	19.2	9	27.0	6	12.6	4
Housing Assistance	27.7	4	36.1	3	16.1	2
Housing	28.3	3	35.0	4	19.5	1
Interpreter Services	9.0	13	5.1	13	6.3	8
Outreach Services	24.2	6	18.2	9	6.1	9
Referral	Not Available					
Transportation	30.0	2	31.9	5	8.6	5
Dental Care	**73.0**	**4**	**82.0**	**1**	**10.0**	**5**
Substance Abuse Treatment/Counseling	**54.0**	**11**	**29.0**	**11**	**8.0**	**15**
Drug Reimbursement Program	**57.0**	**10**	**47.0**	**5**	**7.0**	**16**
Medications/Pharmacy	58.3		45.9		6.1	
Mental Health Services	**70.0**	**6**	**29.0**	**10**	**9.0**	**12**
Psychological/Psychiatric Treatment, Counseling	42.7	2	32.9	2	5.4	1
Support Groups	43.3	1	37.4	1	4.7	2
Mental Health Services, Licensed, Clinical	30.2	3	30.3	3	3.9	3
Hospice*	**13.0**	**17**	**6.0**	**16**	**10.0**	**7**
Home-Based Hospice	9.2	1	4.7	1	4.7	1
Residential Hospice	9.2	1	5.1	1	4.7	1
Home Health Care*	**71.0**	**5**	**13.0**	**16**	**13.0**	**3**
Paraprofessional Care	11.5	3	7.5	4	9.5	1
Professional Care	15.3	1	13.4	1	7.1	2
Specialized Care	13.2	2	10.6	2	7.1	2
Durable Medical Care	11.5	3	8.3	3	7.1	2
Rehabilitation*	**50.0**	**12**	**20.0**		**11.0**	**4**
Physical Therapy	20.4	1	20.5	1	6.3	3
Speech Pathology	8.9	3	5.9	3	7.1	2
Low Vision Training Services	13.7	2	12.2	2	8.7	1
Early Intervention	Not Available					

*See note on page 38 regarding these service categories.

SERVICES ANALYSIS FOR INCARCERATED/RECENTLY RELEASED INDIVIDUALS

% = Percentage of survey respondents who indicated a use, need, or barrier
Rank for Service Category = Order of importance among 17 service categories; indicated in **bold**.
Rank for Individual Services = Order of importance WITHIN service category. 1 is most important

SERVICE	Use		Need		Barrier	
	%	Rank	%	Rank	%	Rank
Ambulatory/Outpatient Medical Care	**79.0**	**2**	**30.0**	**9**	**20.0**	**2**
Primary Medical Care	59.3	1	38.6	2	7.0	5
Vision Care	54.1	2	39.3	1	12.3	1
Obstetrics/Gynecology	23.4	4	9.6	5	8.8	2
Pediatric Care	10.0	6	4.4	6	7.9	3
Specialty Care	20.9	5	20.2	4	7.9	3
Infectious Disease	35.5	3	34.2	3	1.8	6
Case Management						
Social Case Management	**63.0**	**6**	**63.0**	**2**	**7.0**	**12**
Medical Case Management	49.5		48.2		7.9	
Nutritional Service	**57.0**	**8**	**41.0**	**5**	**6.0**	**16**
Nutritional Education, Counseling, etc	39.9		33.3		5.3	1
Support Services	**81.0**	**1**	**67.0**	**2**	**41.0**	**1**
Adult Day Care*	11.8	10	9.6	10	7.9	7
Buddy/Companion Services	14.5	9	17.5	8	7.0	8
Child Care	11.8	10	7.0	11	7.9	7
Client Advocacy/Legal Services	20.9	7	21.9	7	10.5	5
Emergency Financial Assistance	31.8	4	43.9	3	14.0	3
Food Bank/Home-delivered Meals	50.9	1	52.6	1	4.4	10
Health Education/Risk Reduction	15.5	8	16.7	9	7.0	8
Health Insurance Payments	22.7	6	27.2	5	12.3	4
Housing Assistance	29.4	5	38.6	4	19.3	2
Housing	37.3	2	45.6	2	21.1	1
Interpreter Services	11.8	10	7.0	11	7.0	7
Outreach Services	22.7	6	21.9	7	6.1	9
Referral	Not Available					
Transportation	35.5	3	38.6	4	9.6	6
Dental Care	**59.0**	**7**	**67.0**	**1**	**6.0**	**15**
Substance Abuse Treatment/Counseling	**66.0**	**4**	**32.0**	**7**	**8.0**	**8**
Drug Reimbursement Program	**54.0**	**10**	**50.0**	**3**	**5.0**	**17**
Medications/Pharmacy	50.9		43.9		6.1	
Mental Health Services	**64.0**	**5**	**35.0**	**6**	**9.0**	**7**
Psychological/Psychiatric Treatment, Counseling	39.1	2	33.3	2	6.1	1
Support Groups	49.5	1	34.2	1	6.1	1
Mental Health Svcs, Licensed, Clinical	34.2	3	31.6	3	5.3	2
Hospice*	**7.0**	**17**	**2.0**	**2**	**8.0**	**11**
Home-Based Hospice	10.9	2	4.4	1	7.0	2
Residential Hospice	11.9	1	4.4	1	7.9	1
Home Health Care*	**19.0**	**16**	**15.0**	**15**	**8.0**	**10**
Paraprofessional Care	14.7	2	6.1	3	7.0	4
Professional Care	18.3	1	7.5	2	8.8	1
Specialized Care	11.0	3	7.9	1	8.0	2
Durable Medical Care	10.9	4	4.4	4	7.9	3
Rehabilitation*	**40.0**	**12**	**19.0**		**13.0**	**3**
Physical Therapy	21.8	1	19.3	1	8.8	1
Speech Pathology	13.6	3	5.3	3	8.8	1
Low Vision Training Services	14.5	2	14.0	2	7.9	2
Early Intervention	Not Available					

*See note on page 38 regarding these service categories.

SERVICES ANALYSIS FOR WOMEN OF CHILDBEARING AGE

% = Percentage of survey respondents who indicated a use, need, or barrier
Rank for Service Category = Order of importance among 17 service categories; indicated in **bold**.
Rank for Individual Services = Order of importance WITHIN service category. 1 is most important

SERVICE	Use		Need		Barrier	
	%	Rank	%	Rank	%	Rank
Ambulatory/Outpatient Medical Care	**81.0**	**2**	**37.0**	**6**	**23.0**	**2**
Primary Medical Care	68.4	1	41.1	2	7.9	2
Vision Care	59.5	2	45.4	1	12.8	1
Obstetrics/Gynecology	58.0	3	37.6	3	5.9	5
Pediatric Care	23.1	6	11.7	6	5.6	6
Specialty Care	25.0	5	19.8	5	7.5	3
Infectious Disease	47.3	4	28.5	4	6.4	4
Case Management						
Social Case Management	**66.0**	**5**	**54.0**	**2**	**11.0**	**4**
Medical Case Management	56.3		43.4		6.6	
Nutritional Service	**43.0**	**9**	**42.0**	**4**	**6.0**	**16**
Nutritional Education, Counseling, etc	28.8		24.5		4.6	
Support Services	**82.0**	**1**	**50.0**	**3**	**38.0**	**1**
Adult Day Care*	11.3	12	7.7	13	7.0	11
Buddy/Companion Services	11.4	11	12.1	11	6.1	13
Child Care	19.7	6	11.1	12	6.5	12
Client Advocacy/Legal Services	24.5	5	19.3	7	9.0	7
Emergency Financial Assistance	31.5	3	39.6	4	14.6	4
Food Bank/Home-delivered Meals	47.5	1	50.2	1	7.9	10
Health Education/Risk Reduction	12.9	9	17.0	8	8.2	9
Health Insurance Payments	17.2	7	24.2	5	16.2	3
Housing Assistance	30.9	4	41.1	2	16.9	2
Housing	30.9	4	40.3	3	18.9	1
Interpreter Services	12.8	10	12.6	10	9.5	6
Outreach Services	15.8	8	22.2	6	8.7	8
Referral	Not Available					
Transportation	39.0	2	14.6	9	11.4	5
Dental Care	**64.0**	**6**	**71.0**	**1**	**9.0**	**11**
Substance Abuse Treatment/Counseling	**39.0**	**11**	**7.0**	**13**	**4.0**	**17**
Drug Reimbursement Program	**62.0**	**7**	**40.0**	**5**	**7.0**	**14**
Medications/Pharmacy	59.5		41.1		5.4	
Mental Health Services	**57.0**	**8**	**27.0**	**9**	**9.0**	**10**
Psychological/Psychiatric Treatment, Counseling	33.0	2	24.2	3	5.0	2
Support Groups	44.3	1	32.5	1	3.9	3
Mental Health Services, Licensed, Clinical	29.7	3	25.6	2	7.6	1
Hospice*	**10.0**	**17**	**2.0**	**17**	**8.0**	**17**
Home-Based Hospice	13.5	2	5.3	2	9.6	1
Residential Hospice	14.6	1	6.8	1	9.1	2
Home Health Care*	**31.0**	**14**	**16.0**	**14**	**8.0**	**7**
Paraprofessional Care	15.5	4	7.7	3	6.5	1
Professional Care	21.7	1	8.7	2	6.0	2
Specialized Care	19.7	2	7.2	4	6.0	2
Durable Medical Care	16.1	3	12.6	1	6.0	2
Rehabilitation*	**35.0**	**12**	**12.0**		**11.0**	**6**
Physical Therapy	16.6	1	17.4	1	8.5	2
Speech Pathology	10.9	3	5.8	3	9.7	1
Low Vision Training Services	12.5	2	9.7	2	8.5	2
Early Intervention	Not Available					

*See note on page 38 regarding these service categories.

SERVICES ANALYSIS FOR YOUTH AGES 13 - 24

% = Percentage of survey respondents who indicated a use, need, or barrier
Rank for Service Category = Order of importance among 17 service categories; indicated in **bold**.
Rank for Individual Services = Order of importance WITHIN service category. 1 is most important

SERVICE	Use		Need		Barrier	
	%	Rank	%	Rank	%	Rank
Ambulatory/Outpatient Medical Care	**68.0**	**1**	**40.0**	**2**	**29.0**	**1**
Primary Medical Care	58.3	1	45.8	1	4.2	3
Vision Care	50.0	2	33.3	2	12.5	1
Obstetrics/Gynecology	37.5	4	25.0	3	8.3	2
Pediatric Care	33.3	5	25.0	3	4.2	3
Specialty Care	22.7	6	20.8	5	12.5	1
Infectious Disease	39.1	3	20.8	5	12.5	1
Case Management						
Social Case Management	**14.0**	**5**	**26.0**	**2**	**9.0**	**4**
Medical Case Management	36.4		33.3		12.5	
Nutritional Service	**13.0**	**11**	**10.0**	**10**	**5.0**	**17**
Nutritional Education, Counseling, etc	17.4		4.2		4.2	
Support Services	**48.0**	**4**	**17.0**	**6**	**19.0**	**3**
Adult Day Care*	4.3	6	4.2	6	8.3	4
Buddy/Companion Services	4.3	6	8.3	5	8.3	4
Child Care	13.6	3	20.8	1	8.3	4
Client Advocacy/Legal Services	4.3	6	8.3	5	12.5	2
Emergency Financial Assistance	12.5	4	20.5	2	4.2	5
Food Bank/Home-delivered Meals	25.0	1	20.8	1	8.3	4
Health Education/Risk Reduction	25.0	1	12.5	4	12.5	2
Health Insurance Payments	4.2	7	16.7	3	8.3	4
Housing Assistance	8.3	5	20.8	1	12.5	2
Housing	12.5	4	16.7	3	8.3	4
Interpreter Services	8.3	5	4.2	6	12.4	3
Outreach Services						
Referral	Not Available					
Transportation	16.7	2	25.0	1	16.7	1
Dental Care	**38.0**	**7**	**38.0**	**1**	**9.0**	**6**
Substance Abuse Treatment/Counseling	**7.0**	**13**	**10.0**	**9**	**9.0**	**7**
Drug Reimbursement Program	**49.0**	**3**	**0.0**	**0**	**5.0**	**16**
Medications/Pharmacy	41.7		29.2		8.3	
Mental Health Services	**40.0**	**6**	**14.0**	**9**	**9.0**	**8**
Psychological/Psychiatric Treatment, Counseling	21.7	2	8.3	2	8.3	2
Support Groups	37.5	1	16.7	1	4.2	3
Mental Health Services, Licensed, Clinical	4.2	3	4.2	3	12.5	1
Hospice*	**0.0**	**17**	**0.0**	**0**	**9.0**	**15**
Home-Based Hospice	8.7	1	4.2	1	13.6	1
Residential Hospice	8.7	1	4.2	1	13.6	1
Home Health Care*	**18.0**	**9**	**3.0**	**14**	**9.0**	**11**
Paraprofessional Care	13.0	1	0.0	2	8.3	1
Professional Care	13.0	1	0.0	2	8.3	1
Specialized Care	8.7	2	0.0	2	8.3	1
Durable Medical Care	8.7	2	4.2	1	8.3	1
Rehabilitation*	**0.0**	**16**	**0.0**		**9.0**	**14**
Physical Therapy	16.6	1	17.4	1	8.5	1
Speech Pathology	4.3	2	0.0	2	8.3	2
Low Vision Training Services	4.3	2	0.0	2	8.3	2
Early Intervention	Not Available					

*See note on page 38 regarding these service categories.