Central Texas HIV/AIDS Client Needs Assessment

Center for Community Health Development

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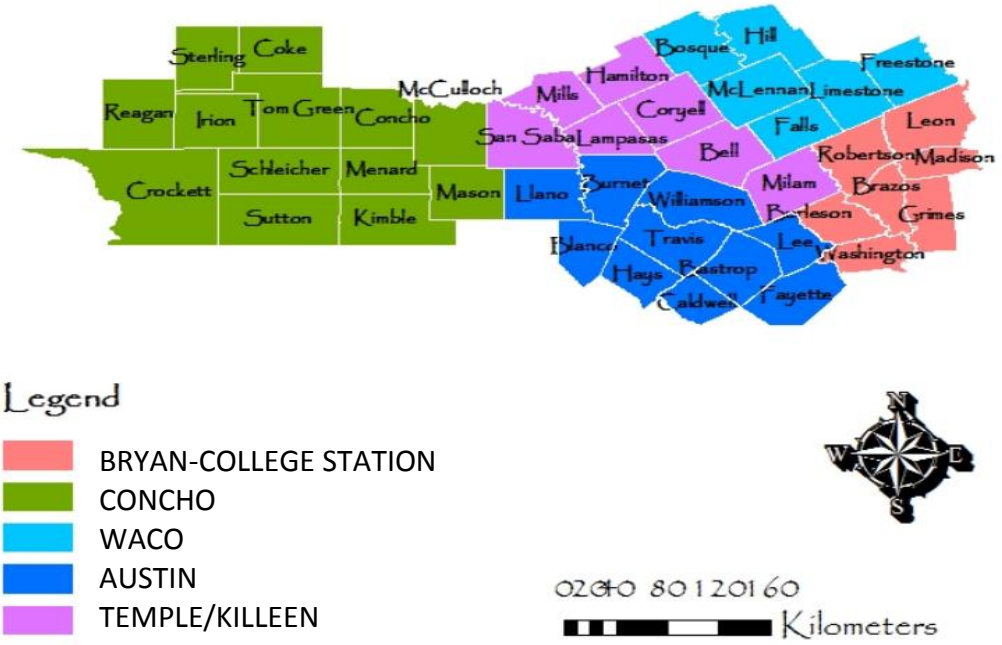
Central Texas HIV/AIDS Client Needs Assessment: 2013

Introduction

The Brazos Valley Council of Governments (BVCOG) serves as the administrative agency for HIV services funded by the Texas Department of State Health Services, through Part B of the Ryan White Treatment Extension Act of 2009, to provide services to people living with HIV/AIDS (PLWHA) in the Central Texas region. As such, BVCOG facilitates the planning of medical and support services for PLWHA in the Central Texas HIV/AIDS Service Area (CTHASA). The CTHASA (see Figure 1 below) is comprised of five health service delivery areas (HSDAs) and contains 43 counties in Central Texas, each with a metropolitan hub:

Austin HSDA:	Austin
Bryan/College Station HSDA:	Bryan/College Station
Concho Plateau HSDA:	San Angelo
Temple/Killeen HSDA:	Temple
Waco HSDA:	Waco

Figure 1: Map of Central Texas HIV/AIDS Service Area



In order to plan and set funding priorities for such a large area of Texas, information regarding both current users of HIV services as well as those who are not receiving services is needed. First, planning requires the identification of priority needs (a set of priority target populations and interventions for each identified target population). Proper planning ensures that HIV resources target priority

populations and their service needs as determined by a comprehensive needs assessment. Using an adaptation of the *Statewide Coordinated Statement of Need (SCSN) Needs Assessment Client Survey,* the BVCOG gathered client data in order to capture information regarding client service needs, current use, availability, barriers to use, and perceived importance of such services.

To assist further in the planning process, BVCOG requested input from those providing services to PLWHA. BVCOG gathered information from case managers, case manager supervisors, program managers, and program coordinators regarding HSDA organizational processes, services, client care, and perceptions of the Ryan White Care (RWC) System. This information complemented the data gathered through the client survey.

Methodology

The BVCOG HIV Administrative Services contracted with the Center for Community Health Development (CCHD) to collect data using a revised SCSN Needs Assessment Client Survey for PLWHA in the five HSDAs of the Central Texas HIV Administrative Service Area (CTHASA): Austin, Bryan/College Station, Concho Plateau, Temple/Killeen, and Waco. CCHD collected usable survey data from 199 participants and interview data from nine service providers in five HSDAs, completed data entry, and conducted analysis of both survey and interview responses.

Participant Recruitment for Survey

Possible participants were identified by BVCOG through the AIDS Regional Information and Evaluation System (ARIES), the statewide database used to collect information on HIV/AIDS clients and services. All PLWHA who received at least one service within the past 24 months, who consented to be contacted via mail by their service provider, and were at least 18 years old were queried to be contacted by an initial mailing. Initial recruitment packets contained a letter from the client's case management agency encouraging them to participate in the survey, a consent form with contact information, and a self-addressed stamped envelope to return the completed form (See Appendix A).

Reminder letters from the clients' case management agency were mailed to the same possible participant list at eight weeks following the initial mailing. The total number of eligible participants identified by ARIES for recruitment was 700 individuals; Table 1 provides a breakdown of how many letters of recruitment were mailed to each HSDA. The initial survey response rate was 41% - 289 possible participants returned survey packets indicating interest in completing the survey. Only 201 clients ultimately completed the survey, for a total response rate of 29%.

Table 1: Survey Recruitment by Health Service Delivery Area

Health Service Delivery Area	English In Care	English Out of Care	Spanish In Care	Spanish Out of Care
Austin	103	58	13	1
Bryan/College Station	146	28	0	1
Concho Plateau	43	19	2	0
Temple/Killeen	102	51	0	0
Waco	102	27	2	2

Survey Administration & Participant Compensation

Due to the large geographic area the Central Texas HDSA covers, client interviews were conducted by phone. Clients were provided two options for participation:

1. A telephone interview where survey staff called a telephone number provided by the participant on a date and time specified by the participant; or,
2. A telephone interview via a toll-free number for the client to call during specified hours.

Project staff from the Texas A&M School of Rural Public Health handled all aspects of survey administration. Following training, staff members were required to demonstrate proficiency in administering the survey and handling a variety of situations that may have occurred during calls.

Participants completing the survey received a $40 Wal-Mart gift card if they were considered out-of-care and a $25 Wal-Mart gift card if they were in-care.

Survey Design

The survey utilized for this project was an adaption of the survey used in the 2009 Central Texas HIV/AIDS Client Needs Assessment. The survey included questions about local information and questions on those clients who are out-of-care, recently released, and substance/injecting drug users, including:

- Screening of PLWHA to determine whether they were in-care or out-of-care;
- Open-ended questions identifying reasons for being out-of-care and/or for dropping out-of-care (among in-care), as well as barriers to care identified by out-of-care participants;
- General barriers to care for all respondents;
- Substance abuse treatment service needs, asked of substance users;
- Detailed questions for people recently released from incarceration about receipt of medical care while incarcerated and support provided at the time of release; and
- Ranking of services considered important and rating of the importance of services in maintaining/accessing HIV medical care.

In order to gather current information that is comparable to previous iterations of the survey, the BVCOG used an amended version of a survey first used in 2006. This version of the survey allows for comparison to previous surveys for possible changes occurring in the PLWHA population in Central Texas as well as continuing using a survey with validated questions. Further information on the validation of the 2006 iteration of the survey can be found in the *2005 Austin Area Comprehensive HIV Needs Assessment*.

A survey was also available in Spanish for clients who were not comfortable taking the survey in English. The English survey was translated by a CCHD staff member fluent in the local Spanish dialect. All Spanish surveys were conducted by the same CCHD employee who translated the survey. English and Spanish versions of the survey used can be found in Appendix B.

Case Manager Interviews

Nine service providers, including case managers, case manager supervisors, program managers, and program coordinators, were identified by the BVCOG to complete interviews regarding service delivery. At least one representative from each HSDA completed an interview: one representative from Temple/Killeen, and two representatives from each of the other HSDAs. Interviews were conducted by phone and lasted between 15 and 30 minutes. Questions were developed and revised by BVCOG and CCHD; the topics of discussion were related to organizational processes, services, client care, and perceptions of the RWC System. All interview responses were captured through notes taken by project staff, with the permission of those being interviewed.

Data Analysis

Survey responses were recorded in the Qualtrics Research Suite software package. Data from completed surveys was imported into SPSS 22.0 by two graduate students trained by a CCHD staff member to reduce error. Surveys were checked for completion, assigned an ID number, and coded directly into SPSS entry. CCHD staff members validated the surveys entered to ensure accurate coding and minimal data entry error.

Tables in this document will use valid percents when referring to data; valid percents take into account any missing data from variables calculating percentages with a smaller number than the total number of surveys conducted. For example, if 115 people participated in a survey and on a specific question only 100 people responded, there is missing data for 15 cases. So, if 85 responded yes and 15 responded no, the calculations for percentages would not be 85/115, but 85/100 to take into account the missing data (valid percent).

Data from the interview responses were recorded for each respondent. The content of the responses was analyzed thematically and themes were identified as they emerged through examination.

Assessment and Survey Instrument Limitations

All information collected is self-reported data, which is susceptible to respondent bias. Exaggeration, memory lapses, and wanting to provide a socially acceptable answer are just a few of the possible factors that could influence participant answers.

Every effort was made to include as many survey participants as possible. Data presented within this report will contain descriptive statistics such as frequencies, percentages, and cross tabulations.
The survey design had several unavoidable limitations, one of the most formidable being the length of the survey. The survey took an average of 30 minutes to complete; thus, participant fatigue may have biased answers in an attempt to simply finish the survey. Survey instructions included an option for respondents to withdraw from the survey at any time and still receive an incentive, or to stop the survey and complete it on a different date in order to reduce participant fatigue. Additionally, at the beginning of the services component of the survey, survey administrators provided participants with information on what was left to complete in the survey.

The most significant amendment to the survey was a reconstruction of the services matrix from the 2009 survey. Despite decreasing the number of services included in the survey, the final section was still long, with the same set of questions that had to be repeated for each service category.

Another limitation relates to many questions lacking possible responses such as *not applicable*, *don't know* or *refused*. Participants may have skipped questions as a result, leading to missing data.

Finally, some participants were confused by some of the survey questions and project administrators attempted to explain questions in a manner that would not influence the participant's responses. The survey administrators utilized a paraphrased version of the DSHS Glossary of HIV Services (Appendix C) that incorporated lay terminology into the survey to explain service names such as permanent housing placement and HIV/AIDS medication assistance. The final version of the survey was reviewed and approved by BVCOG and CCHD project administrators.

Regional Findings

This section will begin with an overview of findings from the case management interviews, and then discuss findings from the client surveys.

Case Management Interviews

Each case management interview covered a range of topics. Responses were grouped broadly into the categories of organizational processes, services and client care, and the Ryan White Care System.

Organizational Processes

Each service provider interviewed was asked to discuss his/her organization's definition of *adherence*; a definition used by all organizations considered a client "adherent" if he or she is taking medication 95% of the time and completing required lab work (e.g., viral loads and CD4 counts). While adherence was primarily defined by whether or not a client is compliant to taking their medication and having labs done, there were program compliance regulations required of clients that went beyond this definition, and these varied by agency. Some agencies mentioned treatment plans and treatment goals in which clients must participate, while other agencies discussed the specifics of program compliance, such as attending required clinical appointments, keeping in contact with case managers regularly (this varies based on client's acuity level), following through on resource referrals, and keeping agencies up-to-date with client contact information. The most common way clients are trained on adherence and program compliance regulations is through education. Clients are informed and reminded of expectations upon intake, and then continually throughout their time in the program.

Service providers were also asked to discuss how their agency communicates with other service organizations utilized by clients. This communication is important to ensure a continuum of care. Three themes emerged from responses to this question: following up with the service organization; following up with the client; and following up with both the client and service organization. Among service providers who prioritized following up with service organizations, a contractual agreement with other service organizations was highlighted as an effective way to ensure continuum of care. Several case managers stated that in this way, they are able to contact the organization directly to see if a client kept an appointment. Because clients can be difficult to follow up with in a timely manner, this direct organizational communication is an important method of service coordination. In contrast, other respondents emphasized following up with the client as their means of ensuring continuum of care.

These service providers stated that their clients generally follow up after appointments, so contacting the service organization is not necessary. The relationship between service providers and clients represents the best way to ensure the client receives the full continuum of care. Others said that they prefer to follow up with clients because if the client did miss a scheduled appointment, the reason for that can be discussed. If the client is experiencing a barrier to care, it can be identified and addressed as well. Lastly, those who mentioned contacting both client and service organization said that they do so because it is the most thorough way to ensure continuum of care.

When asked if their organization has case management meetings, all respondents answered *yes*. The frequency of these meetings varied between agencies from once a week to once a month. In addition, meetings can and do occur as often as needed outside of scheduled times. In general, case managers and support staff attend the meetings; a couple of agencies mentioned occasionally inviting others to attend, such as bereavement or suicide counselors or new community organizations that could potentially be a source for referral. One purpose of case management meetings mentioned by service providers is to serve as a brainstorming session. During this time, service providers discuss how to keep clients in care and healthy. Some said that the brainstorming sessions are good for addressing issues. For example, if a case manager is dealing with a particular problem, they can bring it up and discuss as a group the best way to address that problem. Another commonly mentioned purpose for these meetings is to provide support to case managers. Many mentioned that the meetings provide a supportive environment in which service providers can vent frustrations, talk about what is working and what is not working, and build relationships among one another. Lastly, case management meetings were said to be a means of keeping everyone on the same page and of one accord with expectations; everyone attending is updated on what is going on within their department and/or agency. Respondents said these meetings were an overall good growing opportunity and necessary for optimal care of clients.

Frequently mentioned topics of discussion for case management meetings included client cases, program logistics, and community resources. Of these topics, client cases were said to be the primary focus of discussion during case management meetings. Some agencies mentioned that they review their list of clients and each case manager gives an update on what is going on with each of their clients. Another agency mentioned that they discuss their client load during every meeting. Every time there is an intake, the agency staff get together and discuss the client's assessment, figure out their acuity level, and create a treatment plan. An alternative strategy, used by another agency for discussing client cases, is for each case manager to bring a specific number of client cases to the meeting for review. In this model, case managers discuss the client's viral load, doctor's visits, medication adherence, insurance, referrals, and ways to get clients to be more adherent. Program logistics are also discussed; internal processes are reviewed and organizational updates that affect the functioning of the program, department, or agency are shared as needed. The third most common topic of discussion is community resources: service providers update one another on any new community resources, such as health education or support group opportunites, that are available to clients.

Services and Client Care

Service providers were asked how they help their clients understand the RWC System and how it works; the unanimous response was through education. Case managers are responsible for describing the federal program, why it exists, what services are available to clients, and what clients can expect from participating in the program. Respondents described this educational process as ongoing, stating that much of the information is reiterated during client update meetings or as needed based on a client's level of understanding. After the information is initially conveyed to clients during intake, some

agencies give the clients written material (e.g., handbook, brochure) to take with them that lists the services available. Some agencies provide information on their websites as well.

Service providers were then asked a set of questions about how they determine where to refer clients, how they avoid duplication of services, and how they stay current with sources for referral in their communities. All respondents stated that clients are referred to other service organizations based on the client's needs and available community resources. The referral process begins when clients fill out a needs assessment. Then, based on those needs and the resources available, case managers link the client to needed services. To avoid duplication of services, many respondents said that they primarily refer clients out for services before using the services offered through the RWC System. Since the RWC System is a payer of last resort, this prioritization makes sense. Other respondents also said that they simply talk to clients and ask them what services they have already accessed or are currently receiving before offering RWC services, while still other service providers have contacts at other community organizations that they can ask whether clients are eligible for, or have already accessed, services from that organization. Many case managers discussed the importance of staying abreast of community organizations and what they offer. In this way, they can easily refer clients when clients come in with specific needs. Service providers also use databases such as ARIES and the 2-1-1 system to find services for clients before providing the service. Respondents said that the best ways to stay current on resources for referral in the community are to attend community events and meetings, maintain relationships with community agencies, look in the local paper, talk with other case managers, and access websites, such as the 2-1-1 website, if possible.

The last set of questions related to keeping clients in care, barriers to care, and ways to bring out of care clients back into care. Respondents stated that the best ways to keep clients in care are by building relationships and constantly communicating with them. Many case managers discussed the need to "go beyond what is required." This was described as being their client's support system, being their advocate, and making the case management service a "one stop shop" for all the needs of the client. They stated that creating an environment of trust and genuine care helps to keep clients engaged. There was also a consensus among respondents that communication is key. Some employ routine phone calls to clients even if they do not have an appointment scheduled, just to check to see how they are doing. Others stated that it is important to communicate with clients based on the acuity scale and level of care; some clients need more contact than others and case managers generally know their clients and how often they need to be contacted.

Some of the major barriers identified by case managers included confidentiality, personal issues, program logistics, and transportation. Though clients are informed that everything is confidential, there is still a fear of being seen seeking this type of service. Some said that to address this barrier, their organizations provide reassurance as often as possible; one particular agency mentioned "back door access" which allows clients to enter through a back door rather that the front. This same agency also has case managers that will meet clients off-site to keep them engaged in treatment; this is a part of the "go beyond what is required" mentality. The next major barrier discussed was client personal issues. These were described in terms of prioritization, mental health, and substance abuse. It was mentioned that clients dealing with these type of personal issues are the ones that tend to fall out of care. Some service providers said that their clients are living on the edge and have so many other concerns that taking care of their HIV is not prioritized. Other service providers discussed mental health and substance abuse as problems that generally co-exist among their clients, and that these personal issues keep clients from prioritizing or staying consistant with their HIV needs. Program logistics were also mentioned as a barrier to clients staying in care. Case managers stated that the re-application process is

tedious, and sometimes clients fall out of care for this reason. For example, every six months clients have to complete new paperwork even if nothing has changed. Clients also have to meet with their case managers to review the same information they reviewed six months prior, which can take between 30 minutes to one hour, and some clients choose not to re-apply. Another issue related to program logistics is changing physicians in the clinics. Clients have discussed with case managers that they sometimes feel uncomfortable speaking with a new physician about their HIV-related issues. Some respondents stated that changing physicians can be difficult for clients once they have developed trust with a particular physician, and sometimes the lack of knowledge about or experience with HIV-related issues can impede a new physician's ability to break down barriers and build client trust.

When discussing strategies used to bring out of care clients back into care, the unanimous response was that there is no mechanism in place to accomplish this. Some case managers said that physicians and clinics refer clients back to agencies when they appear in the emergency room due to HIV-related illnesses. Interventions tried by different agencies include home visits, calling clients, and going out into the community to promote and deliver HIV testing. Again, these were mentioned as attempts to reach out to clients and are not always successful. Many stated that their focus has to remain on the clients that are in care, and once a client is out of care, there is nothing more they feel they can do. Respondents further stated that to bring out of care clients back into care is not only beyond the scope of work for case managers, but it also impedes the confidentiality rights of the client. While there is concern and desire to address this issue, there is also a consensus that it is almost impossible.

Ryan White Care System

Service providers were asked about their perceptions of the RWC System. Specifically, they were asked what services were most valuable in their opinion, what services were most utilized, and what gaps they believe exist in the current services offered.

According to respondents, the most valuable service provided by the RWC System is case management. Many stated that case management is what links clients to care, and without this service, clients would not know how to navigate the system and would miss out on all of what is available to them. Furthermore, many mentioned that case managers are instrumental in keeping clients in care by continually following up with them to ensure clients have what they need. Financial services were also mentioned as extremely valuable to clients. Respondents stated that many of the clients who utilize the RWC System have financial hardships that inhibit their ability to afford the necessary care. Another service said to be valuable is medical care; clients need the treatment in order to stay healthy and would otherwise become ill. The services case managers mentioned as most utilized by clients were case management, medical care, food vouchers, and transportation. This aligns with the findings from the client survey, described in detail in the following section.

The greatest gap in services, identified by service providers, is a lack of coverage for specialized medical care. For the most thorough care, some clients require specialized testing (e.g., genotype testing for drug resistance), that if received, would place a burden on the budgets of agencies. Physicians are aware of the financial burden and generally will not order the test. However, regardless of cost, clients are still in need of the service for optimal care. Some service providers stated that many of their clients have non-HIV related illnesses that agencies cannot assist with; this is also seen as a gap in services. Other identified gaps in services include a lack of drug rehabilitation services and assistance with costs associated with eyeglasses. Respondents mentioned that RWC covers the exam but does not cover the cost of the eyeglasses. Housing and dental services were also discussed, and though these services are covered by RWC, agencies mentioned that the need for these services outstrips available funding.

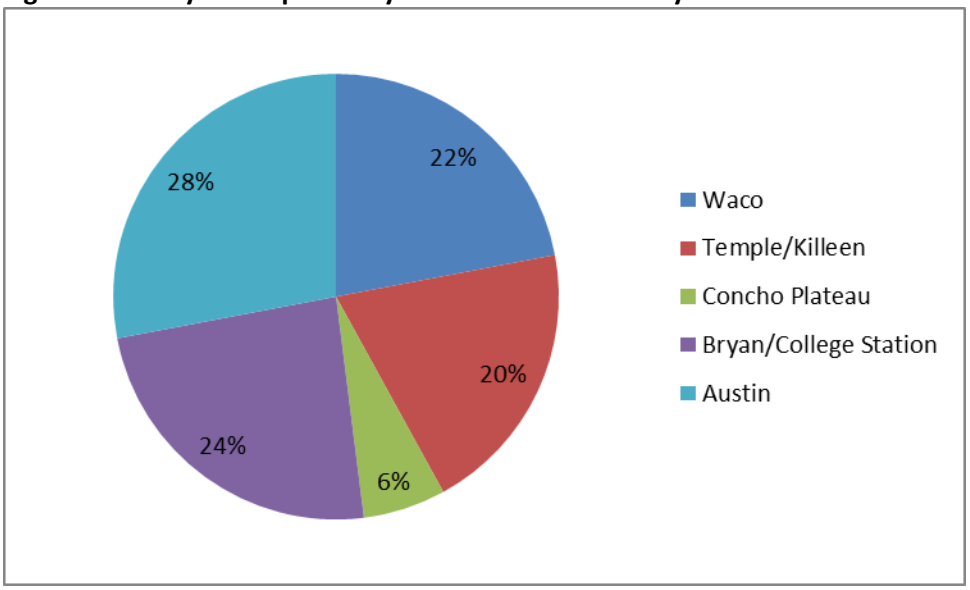
Client Survey

Two hundred and eighty-nine possible participants responded to the recruitment packets; however, only a total of 201 surveys were conducted by CCHD project staff for a final survey response rate of 70%. A software glitch resulted in two completed surveys being lost, for a total of 199 usable survey responses. Of those participants not surveyed, some were unable to be contacted due to wrong numbers, others refused the survey upon contact by survey administrators, and the remainder either were unable to be reached or did not use the toll-free call-in number provided despite repeated attempts, reminder letters, and an extended time period to take the survey. Seven surveys were administered in Spanish and translated prior to data entry. The data described here is a summary of the 199 usable responses from survey participants.

Health Service Delivery Area

When analyzed by HSDA, the largest percentage of respondents (28%) was from the Austin HSDA, which also houses the largest number of clients. As seen in Figure 2 below, a similar percentage of the respondents lived in the Bryan/College Station, Waco, and Temple/Killeen HSDAs (24%, 22%, and 20% respectively). Only 6% of the respondents were from the Concho Plateau HSDA.

Figure 2: Survey Participation by Health Service Delivery Area



The geographic area that comprises the HASA is comprised of 43 counties, however in the past year only 30 counties contained active clients. Survey respondents represented 27 of the 30 counties and 48% of respondents reported living in one of three counties: 18% of the survey participants lived in McLennan County, part of the Waco HSDA, while 16% of participants reported living in Bell County, part of the Temple/Killeen HSDA; 14% reported living in Brazos County, part of the Bryan-College Station HSDA.

Demographics

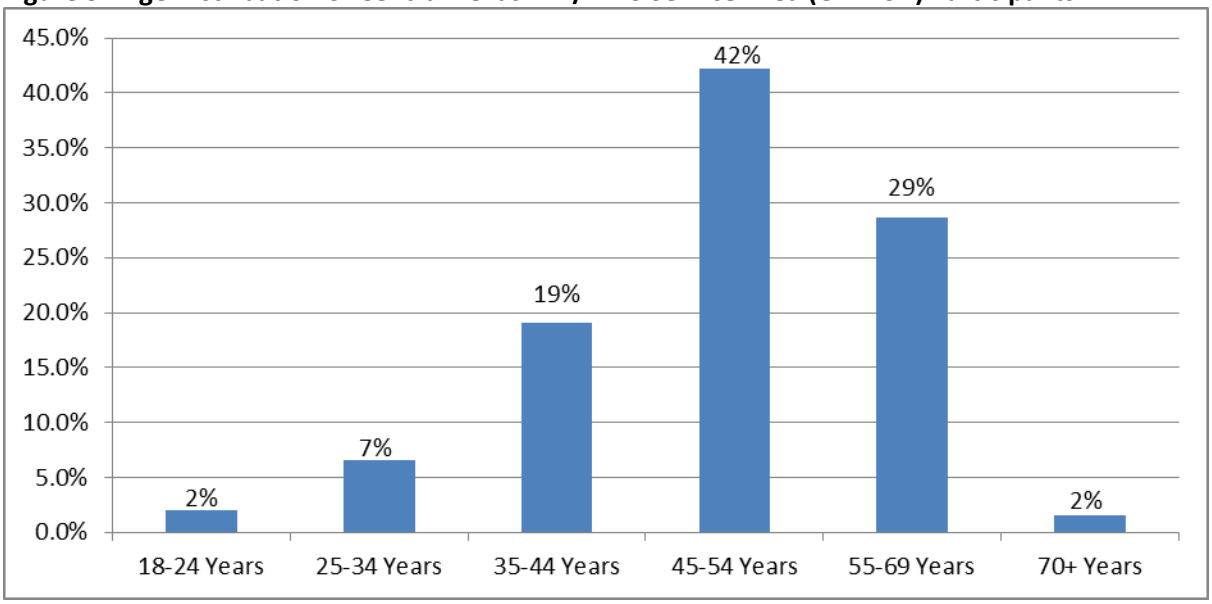
Gender

Fifty-two percent of participants indicated their gender as male, while 47% said they were female. Less than 1% of the respondents reported being transgendered.

Age

Few respondents were under 34 years of age. Nineteen percent of the respondents were between 35 and 44 years of age while 42% were between 45 and 54 years old. The remaining 31% of respondents were older than 55 years. The age distribution of the participants is depicted in Figure 3 below.

Figure 3: Age Distribution of Central Texas HIV/AIDS Service Area (CTHASA) Participants

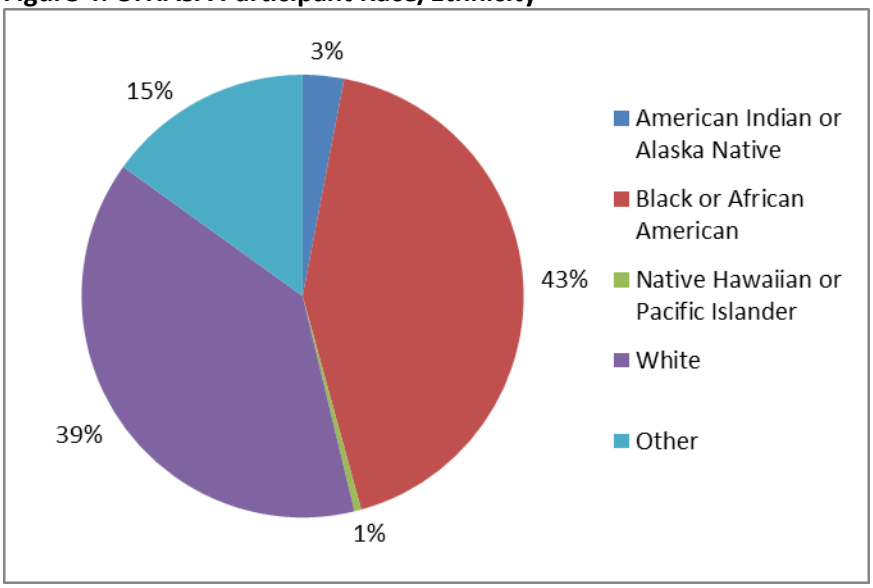


Race/Ethnicity

When asked about their ethnic background, 18 percent of respondents indicated they were Hispanic or Latino.

Each participant was also asked to identify their racial background. As Figure 4 illustrates, 43% of the participants indicated their racial background as Black or African-American and 39% indicated their race as White. Three percent of participants reported their race as American Indian or Alaskan Native. The remaining 15% of respondents indicated their race as *other*. Among these respondents, 48% specified their race to be Hispanic or Mexican. Other notable origins included in the *other* category were biracial and Mexican-American.

Figure 4: CTHASA Participant Race/Ethnicity



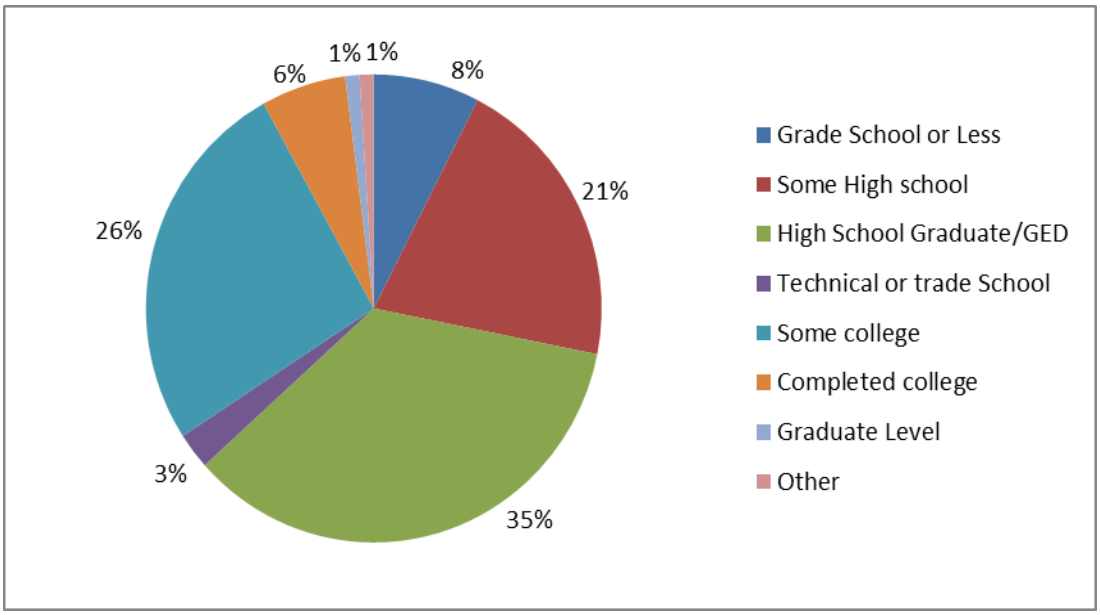
Language

Survey participants were asked to indicate their primary language. Ninety-four percent of the participants said their primary language was English, while 6% reported their primary language was Spanish. Less than 1% indicated that their primary language was something other than English or Spanish.

Educational level

Participants were also asked about the highest level of education they completed. Less than 30% of participants have less than a high school education, while 35% are high school graduates or have their GED. Three percent of participants went to technical school or trade school and 26% of the respondents have some college education. Six percent of respondents reported completing college and an additional 1% of participants indicated they have a graduate level education. The remaining respondents selected *other* as their educational attainment level. When these responses were analyzed, 50% of the respondents said they have an Associate's degree, while the remaining half did not attend school. The educational attainment of the survey participants is depicted in Figure 5 on the following page.

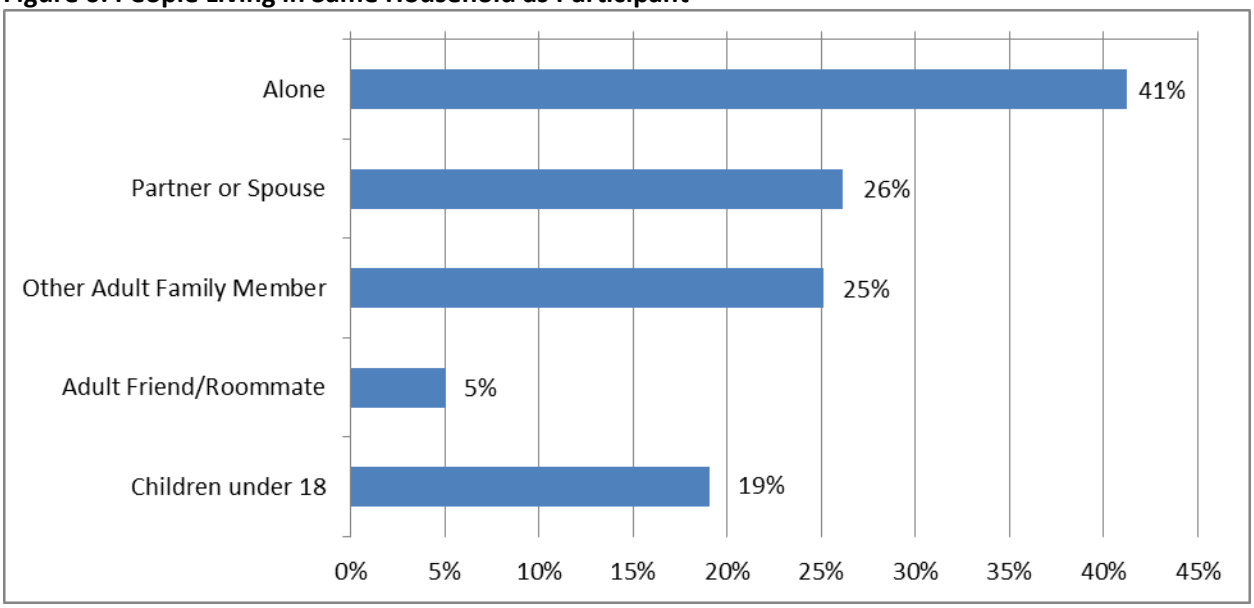
Figure 5: Educational Attainment of Participants Living in the CTHASA



Housing

When asked about the people that live in their household, 41% of survey participants indicated that they live alone. Twenty-six percent of participants said they live with a partner or spouse, while 25% live with another adult family member, and 5% live with an adult friend or roommate. Nineteen percent of survey participants reported having children under the age of 18 years living in their household. Figure 6 below further illustrates the participants' housing situation.

Figure 6: People Living in Same Household as Participant



Among the respondents who reported having dependent children (under the age of 18 years) living in their household, 50% reported having only one child in the home. Twenty-nine percent reported having two children living in their home, while 16% said they had three dependent children in their household. The remaining 5% of respondents reported having four or more children under the age of 18 years living in their household.

Participants who reported not living alone were asked about the status of the other individuals living within their household. Twenty-three percent of participants said that someone in their household other than themselves was currently living with HIV, while 1% of survey participants said they did not know the status of the other individuals living in their home.

Those participants who indicated having children under the age of 18 years living in their home were also asked to report on the status of the children. None of the participants indicated that any children living in their home had been diagnosed with HIV, and 2% of participants did not know the status of the children living in their home.

Seventy-five percent of survey participants reported living in an apartment or house that they own or rent, while 14% of participants said they lived at a parent's or relative's apartment or home. An additional 10% of participants reported their current housing situation as *other*, which included living in a trailer or mobile home.

Survey participants were also asked to identify any other places they have lived within the past year. Sixty-one percent of participants who lived somewhere other than their current home within the past 12 months reported living in an apartment or home that they owned or rented, 11% of participants reported living at their parent's or relative's apartment or home, and 9% of participants said that they lived in other places during the past year such as a trailer or mobile home. Table 2 below compares the participants' current living situation with other places survey participants reported living within the past year.

Table 2: Current Housing and Housing within the Past Year*

Type of Housing	Current	Within the Past Year
Apartment/ House You Own/Rent	75%	61%
At your Parent's/Relative's Apartment/House	14%	11%
Someone Else's Apartment/House	1%	1%
Homeless shelter	1%	0%
In a halfway house, transitional housing, or treatment facility	0%	1%
Skilled Nursing Home	0%	1%
Battered Men's Shelter	0%	1%
Other	10%	9%
***column totals may not add to 100% because participants were allowed to report multiple housing locations in the past year**		

Ten percent of survey participants indicated that they have had trouble getting or maintaining housing within the past year. As seen in Table 3 below, 50% of those who said they have had trouble securing housing reported not making enough money to pay rent and 30% said they did not have enough money for a security deposit. An additional 40% of the participants reported the reason they had trouble getting or maintaining housing as other, which included financial instability, deciding which county to live in, being rejected from or losing Section 8 housing benefits, and physical health problems.

Table 3: Reasons for Trouble Securing Housing

Reason for Trouble Securing Housing	% Participants Reporting Reason
Do Not Make Enough Money to Pay Rent	50%
Not Enough Money for Security Deposit	30%
No Transportation to Search for Housing	30%
Criminal record	25%
Bad credit	20%
Mental Health Issues	15%
Alcohol or Drug Abuse	10%
Other	40%
***column totals may not add to 100% because participants were allowed to report multiple reasons for housing problems**	

An individual's housing situation can have an impact on his/her ability to care for their HIV, and survey participants were asked to report on any barriers related to their housing situation that might prevent them from taking care of their HIV. A majority of participants (70%) reported that nothing about their housing situation prevented them from taking care of their HIV. Of those with perceived barriers, the following were listed most frequently: being afraid that others would know their HIV status (17%), not having enough money for rent (9%), and not having enough food to eat (8%). Responses in the *other* category included financial issues such as not having enough money to pay for rent, lack of transportation to get to medical appointments, and mental health problems. A complete breakdown of responses is provided in Table 4 below.

Table 4: Housing Situations that Prevent Participants from Caring for their HIV

Housing Situation	% Participants Reporting Barriers
Afraid of Others Knowing You Are HIV Positive	17%
Do Not Have Money to Pay for Rent	9%
Do Not Have Enough Food to Eat	8%
Do Not Have A Bed to Sleep In	3%
Cannot Get Away From Drugs (in the Neighborhood)	3%
Do Not Have a Safe/Private Room	2%
Do Not Have Heat/Air Conditioning	2%
Do Not Have A Place to Store Your Medications	2%
Do Not Have Running Water	2%
Do Not Have A Telephone Where Someone Can Call	1%
Do Not Have A Bathroom	1%
Other	6%
***column totals may not add to 100% because participants were allowed to report multiple housing situations**	

Personal Health & Wellness

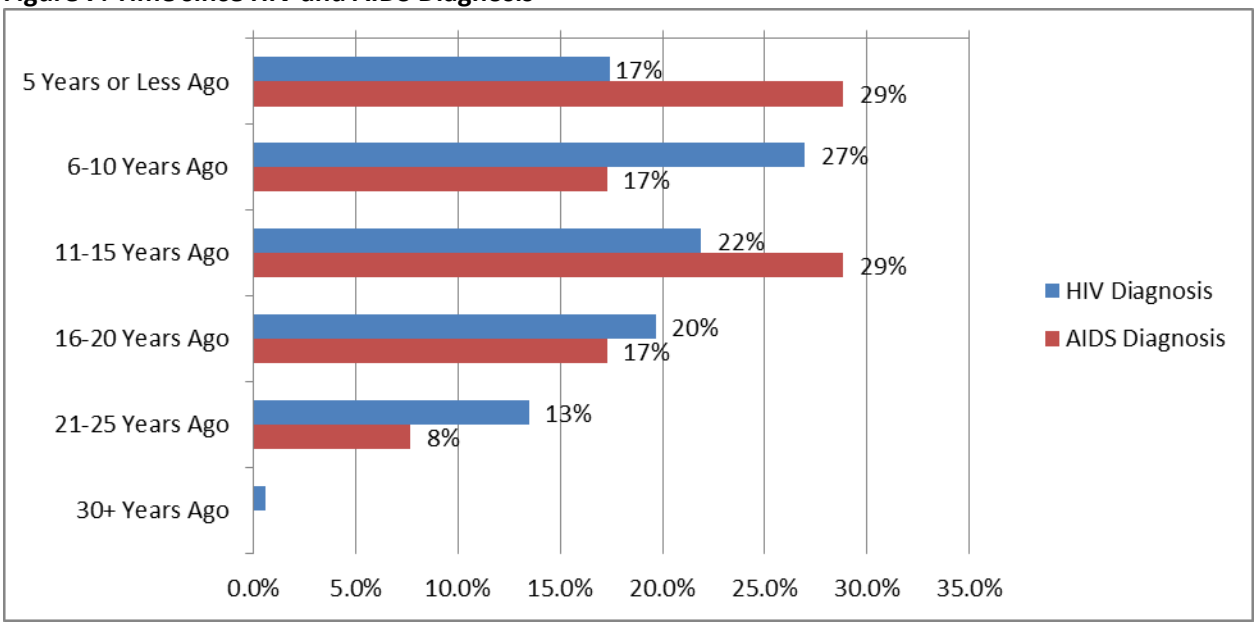
HIV Diagnosis

All (100%) of the survey participants said that they were HIV positive. When asked to report the year in which they were first diagnosed, over half reported being diagnosed between 11 and 25 years ago: 14% of participants reported being diagnosed with HIV 21 to 25 years ago, 20% of participants first tested positive for HIV between 16 and 20 years ago, while another 22% tested positive for the first time between 11 and 15 years ago. Twenty-seven percent of participants tested positive for the first time six to 10 years ago, and an additional 17% first tested positive for HIV less than five years ago.

AIDS Diagnosis

More than one-fourth of respondents (28%) reported being told by a doctor, nurse, or other medical practitioner that they have AIDS. Eight percent of these participants indicated that they were diagnosed 21 or more years ago and another 17% said they were diagnosed with AIDS between 16 and 20 years ago. Twenty-nine percent of participants diagnosed with AIDS said their diagnosis occurred between 11 and 15 years ago, while an additional 17% said they were diagnosed between six and 10 years ago. Twenty-nine percent of survey participants with AIDS reported being diagnosed less than five years ago. An illustration of the time since HIV and AIDS diagnosis for survey participants is provided in Figure 7 below.

Figure 7: Time since HIV and AIDS Diagnosis

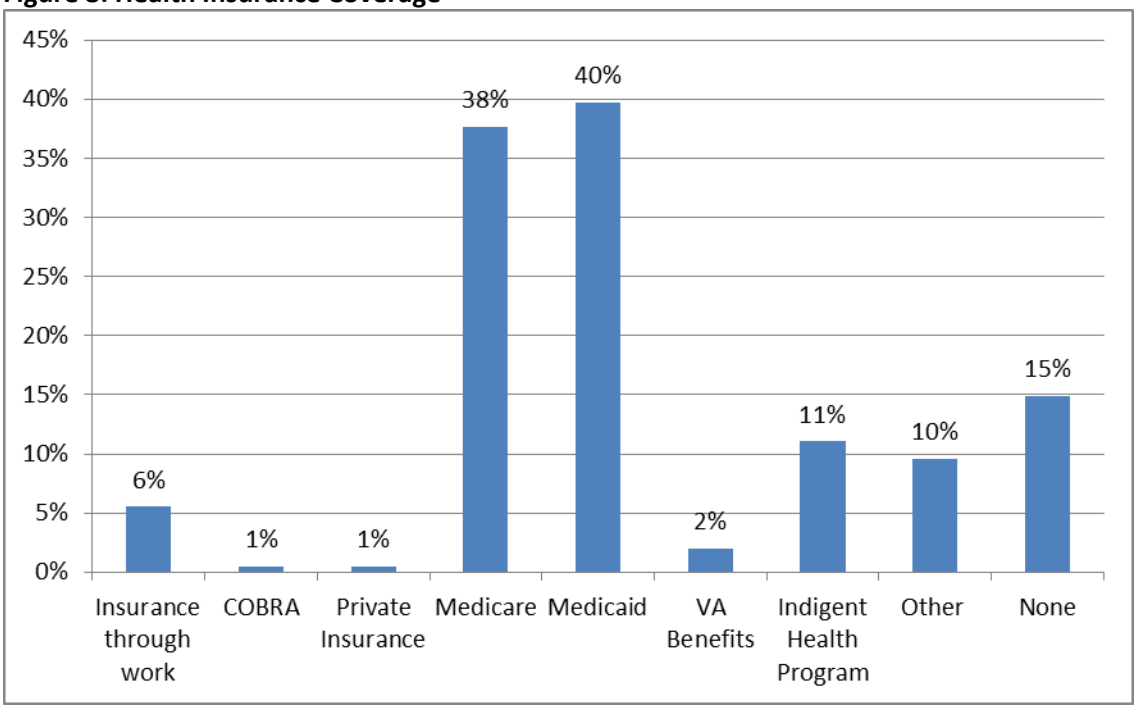


Health Insurance

Respondents were asked to identify the primary form of insurance they had, but several participants still identified two sources (e.g. Medicare and Medicaid). For this reason, percentages will add to more than 100%. When asked about health insurance coverage, 15% of participants said they did not have any health insurance. Forty percent of participants reported having Medicaid and 38% reported having Medicare. Eleven percent of participants received their health insurance through a county indigent health program or other assistance program. A small portion of the survey participants reported having

insurance through work (6%), Veteran's Affairs (2%), COBRA (1%), or private insurance (1%). Ten percent of participants reported other sources of coverage. Health insurance coverage among survey participants is represented in Figure 8.

Figure 8: Health Insurance Coverage



HIV/AIDS Medications

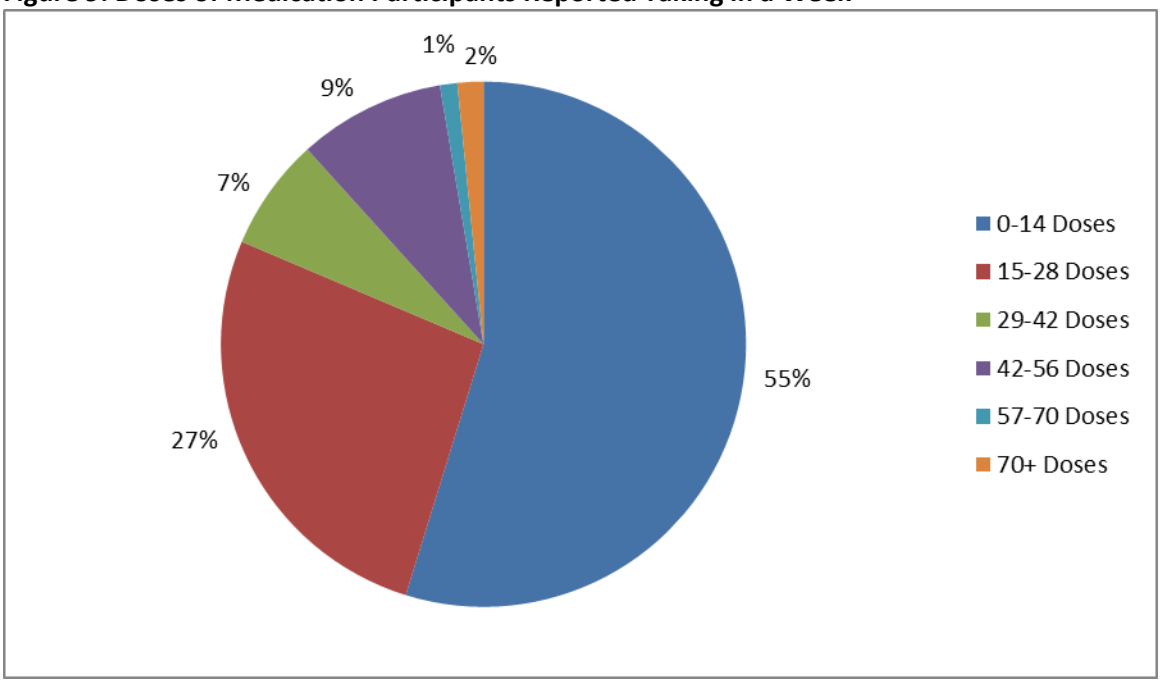
The majority of survey participants (91%) said that they were taking some kind of medications. Eighty-nine percent of participants said they were taking antiretrovirals and/or protease inhibitors. Additionally, 25% reported taking anti-depressants for depression or anxiety, 17% reported taking nutritional supplements, and 14% of participants indicated that they were taking antibiotics to fight infections. Among the answers provided under *other* were medications for high blood pressure and pain medication, medications for mental health issues (Seroquil, Trazadone, Resperidone, Doxipan, Lexipro), asthma medications, sleeping medications, medication to help control HIV (Stribild, Isentress, Viread) and medications for other conditions such as acid reflux, infection, and testosterone boosters. As seen in Table 5 on the following page, nutritional supplements, herbal treatments, and steroids to help with appetite or build weight were also included in the list of medications. It is important to note that the table percentages do not add to 100% because many survey participants take more than one medication.

Table 5: Medications Participants Reported Currently Taking

Medication	% Participant Currently Taking Medications
Antiretroviral	89%
Antidepressants	25%
Nutritional Supplements	17%
Antibiotics	14%
Antifungals	4%
Antivirals	3%
Steroids	3%
Herbal Treatments	3%
Alternative Therapies/Home Remedies	2%

While discussing their medications, participants were also asked to indicate the number of doses of their prescribed HIV medications they were supposed to take in a week. The majority of participants reported taking four or fewer pills per day; more than half (55%) of the participants said they were supposed to take between one and 14 doses of their prescribed HIV medications in a week, while 27% said they were supposed to take between 15 and 28 doses each week. Figure 9 below illustrates the number of doses survey participants reported being prescribed to take in a week.

Figure 9: Doses of Medication Participants Reported Taking in a Week



Survey participants who reported currently taking any HIV medications were then asked about the number of doses they missed within the past seven days. More than three-fourths of participants (77%) said they had not missed a single dose within the past week, while 21%said they missed between one and three doses, and 2% of participants said they missed four or more doses within the past seven days. When asked about the reasons why they are not taking their prescribed medications as directed, 23% of

survey participants said they simply forget to take them. Five percent of participants indicated that side effects keep them from taking their medication as directed.

Among those participants who answered *other* when asked about their reasons for not taking their medication as prescribed, 18% indicated having trouble getting their prescriptions filled, usually because the pharmacy was out of their medications or because they ran out of refills. Fourteen percent said their depression prevented them from taking their medication. Eleven percent of participants said that a lack of transportation to the pharmacy to pick up their medications was the reason why they were not taking their medication as prescribed. Eleven percent of participants reported lacking food kept them from taking their medication as prescribed because they cannot take their medications on an empty stomach. An additional 11% reported traveling or not having their medications with them as a reason. Other reasons participants listed included drinking or drugs interfered with taking their medication (7%), problems with their insurance or not being able to afford the medication (7%), and feeling too tired or falling asleep before they could take it (7%).

Other Conditions or Infections

Seventeen percent of participants reported being diagnosed with other conditions or infections, along with HIV, within the past year. The most common condition reported was Hepatitis C (5%). Since the participants were asked about new diagnoses, responses did not reflect conditions that were diagnosed outside the 12 month window. As a result, the responses do not include all participants who potentially experienced these conditions or infections in the past year, only those who received a new diagnosis.

Disabilities

Survey participants were asked if any physical or mental disabilities hindered them from getting needed HIV services. Thirteen percent of the survey participants reported being unable to get needed HIV services because of a physical or mental disability, and the greatest percentage of participants reported conditions outside of the listed disabilities. Some of the responses included under *other* were chronic back pain, post-traumatic stress disorder (PTSD)/anxiety, use of a cane, or being bedridden.

Mental Health

The majority of survey respondents reported they were currently experiencing one or more mental health conditions (60%). Among these participants, 40% indicated they were currently experiencing depression, 33% said they were currently experiencing anxiety, and 19% were currently experiencing bipolar disorder. Nine percent of participants said they were experiencing a personality disorder, 7% said they were experiencing attention deficit hyperactivity disorder (ADHD), and 3% reported experiencing psychosis. An additional 8% of participants said they were experiencing another mental health condition. These conditions include obsessive compulsive disorder, PTSD, panic attacks, claustrophobia, mood swings, suicidal and disorientation.

While 60% of participants said they were currently experiencing a mental health condition, 62% reported ever receiving a formal diagnosis of a mental health condition. Forty-six percent of participants indicated they had been diagnosed with depression and 24% said they had been diagnosed with anxiety. Seventeen percent of participants said they had ever been diagnosed with bipolar disorder, while diagnoses of ADHD, psychosis, and a personality disorder were reported by 4% of participants. Another 7% of participants indicated they were currently experiencing other mental health conditions.

Table 6 below compares the proportion of participants who reported a formal diagnosis with those who indicated currently experiencing the listed mental health conditions. With the exception of psychosis and depression, more participants reported currently experiencing mental health conditions compared to those who reported a formal diagnosis for each condition.

Table 6: Mental Health Conditions Experienced and Diagnosed

Mental Health Condition	% Participants Formally Diagnosed with Condition	% Participants Currently Experiencing Condition
Depression	46%	40%
Anxiety	24%	33%
Bipolar	17%	19%
Personality Disorder	4%	9%
ADHD	4%	7%
Psychosis	4%	3%
Other Mental Disorder	7%	8%
***column totals may not add to 100% because participants were allowed to report multiple mental health conditions**		

One of the ways that mental health conditions are treated or monitored is through mental health counseling. Twenty-eight percent of survey participants reported that they had been in mental health counseling or another type of counseling within the last two years. In comparison to the percentage of respondents reporting mental health conditions, this utilization rate is lower than expected, possibly indicating a service need.

Substance Abuse

Survey participants were also asked about a history of, or current, substance abuse. Forty-three percent of participants indicated they had a history of using any street drugs (cocaine, inhalants, marijuana, etc.) and 10% of participants reported currently using street drugs. When asked about injecting drugs for non-prescription use, 13% of participants said they had done this in the past, but less than 1% of the participants reported currently injecting drugs for non-prescription use.

Ten percent of survey participants indicated that using drugs or drinking alcohol negatively affects their ability to take care of their HIV, but the wording of the question confused many respondents. Several participants reported that using drugs or drinking alcohol would have a negative impact, or those actions had a negative impact in the past, on their ability to take care of their HIV. However, since these respondents were not currently using drugs or drinking alcohol, they were unsure how to respond to this question. This ambiguity may have affected the quality of responses.

While 65% of participants who reported current drug or alcohol use indicated they were not interested in any type of treatment program and did not need to improve, other participants expressed an interest in information and free treatment. Twenty percent of participants said they wanted information about what services are available, and 10% said they were interested in information about where to go for treatment. Fifteen percent of participants also said they would be interested in free treatment. Table 7 provides a breakdown of the types of substance abuse treatment the survey participants indicated as being of interest.

Table 7: Types of Substance Abuse Treatment or Information Participants Indicated Interest In

Type of Substance Abuse Treatment or Information	% Participants Interested in Type of Treatment or Information
None, Do Not Need to Improve	65%
Information About What Services Are Available	20%
Free treatment	15%
Information About Where To Go or Treatment	10%
Inpatient Detox Program	5%
Outpatient Substance Abuse Treatment Program	5%
Immediate Admission to A Program When Ready	5%
Transportation to Treatment	5%
Treatment Program Only for HIV Positive People	5%
***column totals may not add to 100% because participants were allowed to report on any of the possible responses**	

Special Populations

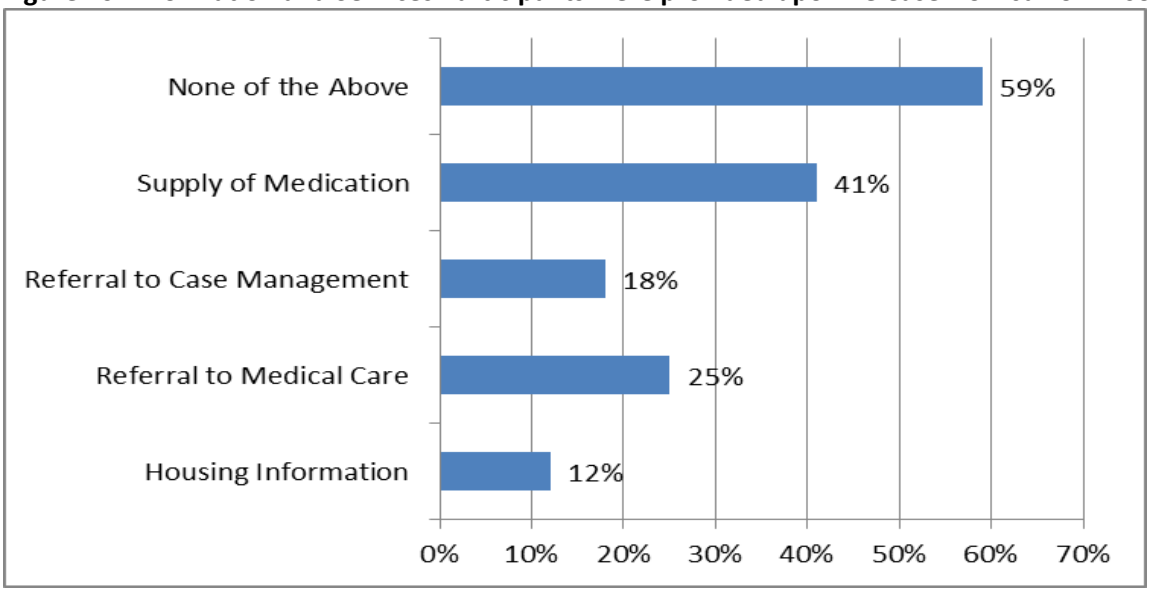
Incarcerated

Fifteen percent of the survey participants reported being in jail or prison in Texas within the past year. Eighty-two percent of these participants said the incarceration facility was a county jail, 12% said they were incarcerated in a state jail, and 6% reported being incarcerated in a state prison.

Eighty-eight percent of the participants who reported being in jail or prison within the past year also reported being diagnosed with HIV before incarceration. However, when asked about being tested for HIV while incarcerated, only 2% of participants said they were tested while in jail or prison, and all of these participants tested positive. Seventy percent of the participants that had been in jail or prison within the past year reported that the jail/prison staff knew they were HIV positive; yet only 53% of clients indicated that they received HIV related medical care while incarcerated. Notably, the clients who reported that prison/jail staff did not know their HIV status were all in county jails. Ryan White service providers across the state are beginning to recognize the importance of partnering with local incarceration facilities to improve the quality of care provided to HIV positive individuals.

Survey participants were also asked about the information and services they received upon being released from jail or prison. Forty-four percent of the participants reported that they were given a supply of HIV medication to take with them when released, while less than 2% of participants said they were given information about how to find housing, a referral to medical care upon release from jail or prison, and a referral to case management. More than half (59%) of participants said they did not receive any of the above mentioned services. Figure 10 on the following page illustrates the information and services participants were provided with upon their release from jail or prison.

Figure 10: Information and Services Participants were provided upon Release from Jail or Prison



Among those participants who reported receiving a supply of HIV medication upon release from jail or prison, 75% said they were given enough medication to last until they were able to obtain more after release.

Participants also discussed the barriers that kept them from getting HIV services after they were released. Twelve percent of participants who had been in jail or prison within the past year reported barriers relating to a lack of financial resources, and an equal number reported that not knowing where to go to obtain HIV services kept them from getting needed services. More than half of participants (53%) listed *other* as a barrier to getting needed HIV services upon release from jail or prison. Responses were too varied to discuss without potentially violating participant confidentiality.

Pregnant

Female survey participants were asked if they were currently pregnant or if they had been pregnant within the past year. Among the 47% of survey participants who reported their gender as female, only 3% said they were either currently pregnant or had been within the past year. Two-thirds (67%) of the female participants who were currently pregnant or had been pregnant within the past 12 months reported receiving medication to prevent transmission of HIV from mother to baby.

Out of Care

Through a series of questions, survey administrators were able to determine if participants were in care or out of care. The ARIES database produced a list of individuals who were considered out of care according to the ARIES system. Officially, individuals are considered to be out of care if they met these four conditions: not having a viral load test, CD4 count, medical prescription, or medical visit.
For the purposes of the survey, individuals were considered out of care if they reported: not having a CD4 count in the past year, not having a viral load test done in the past year, and not taking antiretroviral medications within the past year. The survey did not ask directly about medical visits. Among the 199 survey participants, only 4% (n=7) did not report being in care according to any of the listed methods. A table describing the different ways participants could be categorized as out of care can be found below.

Table 8: Patients Categorized as Out of Care

Method of Classification	Number of Patients Out of Care
ARIES	26
No CD4	19
No Viral Load	23
No Antiretrovirals	22

The participants who were out of care were asked about the reasons why they had not received medical care within the past year. Thirty-seven percent of the participants indicated they had not sought care because they do not believe they currently need medical care, while 42% of participants reported *other* reasons for not receiving medical care. When asked to specify these other reasons, participants indicated they were told they did not need medical care. They also reported that they didn't know they were HIV positive or they did not qualify for services because their income was too high.

Survey participants who reported being out of care were asked about what might help them get back in to care. Participants listed obtaining employment with insurance, getting into a program to help pay their medical expenses, receiving transportation assistance, and having a better case worker as potential reasons they would return to care.

All of the survey participants (n=199) were asked if they had ever stopped getting medical care for more than six months in a row since they first tested positive for HIV. Almost one-fifth (19%) of participants said this was true for them. When asked about why they stopped getting medical care for more than six months, 15% of participants said they did not believe that they needed medical care because they were not sick. Twelve percent of participants said financial reasons kept them from getting medical care for more than six months, while another 12% said that they were actively using alcohol or drugs (or relapsed) which kept them from seeking medical care for more than six months. A breakdown of the reasons participants quit getting medical care for more than six months since they first tested positive for HIV is provided in Table 9 below.

Table 9: Reasons why Participants Quit Getting Medical Care for More Than Six Months

Reason Why Quitting Getting Care for 6+ Months	% Participants Citing Reason for not Getting Medical Care for 6+ Months
Did Not Believe You Needed Medical Care Because You Were Not Sick	15%
Financial reasons	12%
You Were Actively Using Alcohol or Drugs (or Relapsed)	12%
Did Not Want To Take Medication	9%
Medication Had Too Many Side Effects	6%
It was hard to keep appointments	6%
Worried That Someone Might Find Out About HIV Status	3%
Other	36%

Responses in the *other* category include: being in jail or prison, depression, not understanding the severity of their diagnoses, and being unable able to get the care they needed. Some participants said

they quit getting medical care for six months or more because they did not qualify or had to wait for their insurance to come into effect, while others stated that there was not HIV treatment available when they were diagnosed, or that they moved and had a difficult time finding out what was available and where to go for services.

The participants who reported ever being out of medical care for six months or longer were asked about the things that helped them get back into care. The majority of the participants said that getting sick and the prospect of dying motivated them to get back into HIV medical care, while others said that encouragement from friends and support groups helped them. Participants also reported moving back to Texas as a reason they got back into care, indicating the perceived quality of CTHASA service delivery. Other reasons participants credited for their return to medical care included that they wanted to start feeling better and felt it was time to start taking care of themselves, they qualified for health insurance or an HIV program, and they could not work anymore.

Assessment and Ranking of Services

The client needs assessment asked survey respondents about the use, availability, need, and importance of specific HIV medical and social services, as well as barriers to accessing services and their personal opinion of anything that might be missing within each service. Interviews with case managers also asked about the provision of HIV medical and social services.

In the 2006 Central Texas HIV/AIDS Client Needs Assessment, a service matrix asked clients to provide information on their experience with over 30 service categories. A modified version of this matrix was used in the 2009 survey, and further revisions occurred in 2013. All services in the 2013 survey were identified as priorities based on BVCOG staff input and participant responses in earlier surveys. Respondents were provided a definition of each service which was paraphrased by CCHD staff (Appendix D) based on the Texas Department of State Health Services (DSHS) Glossary of HIV Services. Following a discussion of each service, participants were asked to rank the services in order of importance - "Tell me which of those services (previously discussed) are most important to you with the first one you list being the most important." Table 10 lists these service categories in order of importance as ranked by participants. The table below also contains the percentage of survey participants who reported that they were currently using a service or had used a service in the past, as well as the percentage of participants who reported never using the service, but said they needed the service. The services that were ranked as the five most important by respondents were HIV/AIDS medication assistance, case management, transportation, dental care, and food bank services.

Table 10: HIV/AIDS Services Summary

Service	Ranking	% of Participants reporting current or past use	% of Participants never using the service but reporting a need for the service
Medication Assistance	1	63%	21%
Case Management	2	98%	83%
Transportation	3	71%	49%
Dental Care	4	79%	65%
Food Bank	5	77%	48%

Rental Assistance	6	24%	33%
Short Term Housing	7	33%	37%
Permanent Housing Placement	8	15%	31%
Psychosocial Support	9	35%	12%
Mental Health Services	10	36%	10%
Health Insurance	11	12%	36%

Survey participants were asked if they had ever used the service with possible responses (a) *yes, I am currently using this service*, (b) *yes, I have used it in the past, but do not currently need this*, (c) *no*, and (d) *unsure*. Those responding no or unsure were asked if they needed the service and if the service was available to them. The participants who did not report using the service were also asked if there was anything that kept them from getting the service. A list of possible barriers were provided, as well as an *other* category in which participants could provide other reasons not listed. All participants were then asked to rate how important the service was to them staying in or getting back into HIV medical care on a scale of *very important*, *somewhat important*, *neutral/unsure*, *not very important*, *not at all important*. Finally, the survey asked participants if there was anything that they felt was missing from the service under discussion that was not being provided. This question was open-ended, allowing the respondents to say anything.

A critical component of service delivery, accessibility, and usage relates to how well clients' needs are met. Participants were asked about services they needed but were not receiving, and case managers were also asked to identify any gaps in service delivery they observed. A participant was determined to have an unmet need if they responded to survey questions in the following manner: (a) *they had never used the service*, (b) *they needed the service*, and (c) *the service was not available*. Unmet needs for each of the different service categories are addressed in the sections below.

A discussion of survey responses to each service category follows. Each service is discussed separately, in order of importance, as ranked by survey participants.

HIV/AIDS Medication Assistance

This service includes assistance with HIV/AIDS medications for clients without insurance. This service includes the Texas HIV Medication Program. This is not for clients with insurance and is not for medications for high blood pressure or diabetes. Over 60% of survey respondents had used medication assistance – 37% reported current use of the service and 26% reported having used the service in the past, but did not currently need these services. Thirty-one percent had not used the service and another 6% responded that they were unsure whether or not they had used the service.

Of the respondents who had never used HIV/AIDS medication assistance, 80% reported they did not need the service. Of the same group of respondents who had never used the service, 56% reported the service was *available* to them, 10% said it was *not available*, and 34% were *unsure* if medication assistance was available to them. Table 11 illustrates the differences in each HSDA of those respondents who reported they did not need the service. Very few respondents were calculated to have their need for this service as not met – 13% of participants who had not used medication assistance reported that they needed the service and that it was not available.

Table 11: Need Distribution of Participants Reporting No Current or Past Use of HIV/AIDS Medication Assistance Services, by HSDA

	Austin	Bryan/College Station	Concho Plateau	Temple/Killeen	Waco	Total Region
Yes	26%	16%	25%	22%	11%	21%
No	74%	84%	75%	78%	89%	80%

The survey inquired about barriers present that may prevent those who are not using HIV/AIDS medication assistance from accessing the service. Twenty-one percent of those not using HIV/AIDS medication assistance services reported not doing so because they simply did not need or want the service. Commonly reported barriers to using this service reported were that respondents did not know about the service, they needed transportation to pick up prescriptions, they did not qualify for the program or they could not afford the medication. Participants also stated that they have their own insurance or are covered by Medicaid or Medicare.

Despite barriers listed, nearly all respondents reported HIV/AIDS medication assistance as a critical service with 99% of all respondents rating it as *very important*. When asked about whether anything additional should be included in this service the most common response was *nothing* or *no*, indicating a satisfaction with the service as it is currently provided. However, some respondents voiced that they would like for the program to include financial assistance for doctor visits, they needed transportation to pick up prescriptions, and they would prefer better communication with the pharmacy and automatic refills. Participants also stated that they would like for the program to cover other medication and would like more information about medications' side effects.

Case Management

Case management services involve a case manager who evaluates client needs, develops a care plan, and helps clients access HIV medical care and other needed services. A case manager may help clients get to a doctor's appointment, pay for HIV medications, help with housing, or refer clients to a food bank. Ninety-eight percent of survey participants reported either current (86%) or past (12%) use of case management services; 95% reported case management as a *very important* or *somewhat important* service. Fewer than 5% indicated they were *neutral/unsure* (1%) or that the service was *not very important* (4%).

Only 3% of participants indicated they had *never used* case management services and less than 10 participants overall reported an unmet need in regards to accessing case management services. Among those reporting never using case management services, there were no reasons given for not accessing the service.

Some participants reported the need for additional services to be included with case management such as transportation to service, and financial assistance with housing and utilities. Also, better communication among case managers and between case managers and clients was mentioned frequently by survey respondents, as was the need for more compassionate case managers, and case managers that didn't bring their personal beliefs into their jobs. These results are not surprising as both

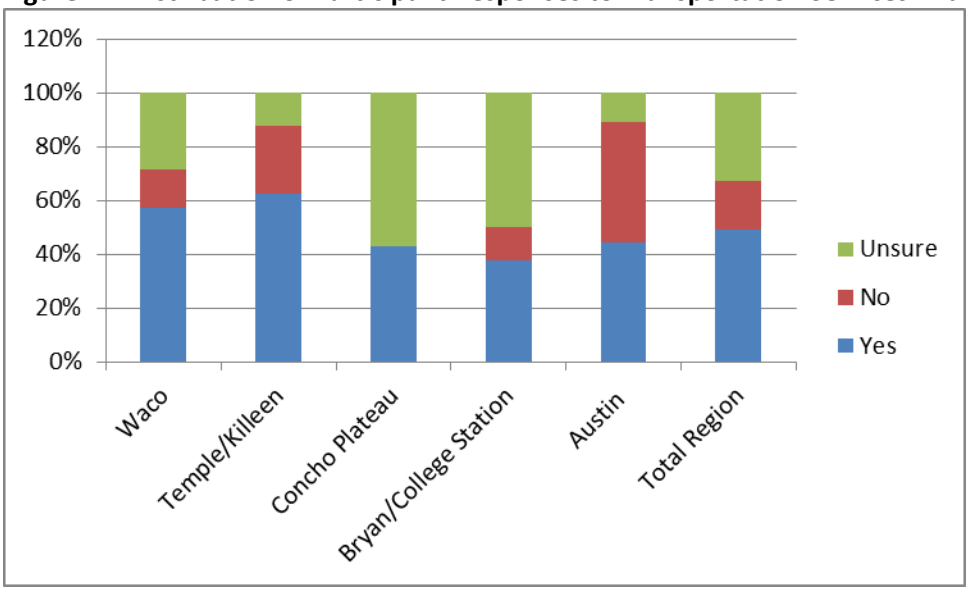
medication assistance and case management services ranked as the most important services by survey participants.

Transportation

Nearly three-fourths of survey participants reported current use (49%) or past use (23%) of transportation services. Transportation services include services provided directly or through a voucher to a client so he/she may access medical or support services such as gas cards, bus passes, gas tokens, etc. This service was rated by nearly all survey participants as *very important* (89%) or *somewhat important* (9%). Despite the significant level of importance, two HSDAs had 40% or greater report *never* using this service – Waco HSDA (46%) and the Concho Plateau HSDA (63%).

Among the participants who had not used transportation services (29%), half of those reported *no need* for the service. Interestingly, 49% of all respondents reported that they needed transportation services, and the same percentage of those never using the service stated that the service was available. Fourteen percent of the respondents who had never used the service reported they had not used the service because they did not need or want it. The availability of the service, as reported by respondents that had previously never used the service is displayed in Figure 11 (next page) based on the respondent's HSDA.

Figure 11: Distribution of Participant Responses to Transportation Services Availability, by HSDA



Eleven percent of all participants with a need for transportation assistance reported that the service was not available to them, or an unmet need. Reasons for not using the service identified by these participants included: they use Medicaid transportation or they have their own vehicle. Other barriers that prevented survey participants from using transportation services were that the service is not available in their area or they lacked information about the service.

A majority of all survey participants responded *no* or *none* to the question asking what else should be added to transportation services. Participants responding with other answers reported the need for more frequent transportation pick up and drop off times, and providing transportation that did not

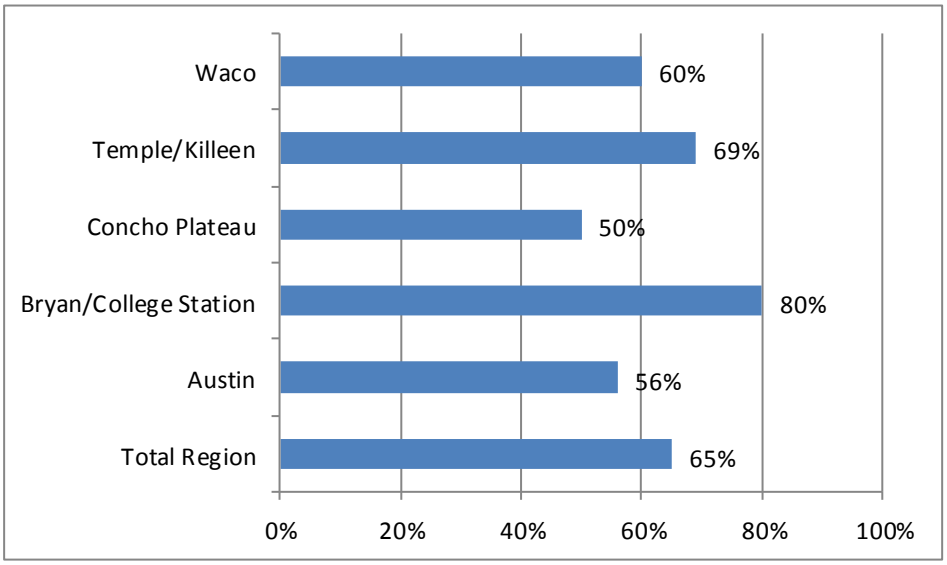
include the local bus system (i.e. taxis). Also, participants suggested improving the transportation system to include the provision of rides to more places than only a doctor's appointment/office. Those survey respondents using gas vouchers reported the need for more than two vouchers per month, vouchers with a greater value, and the ability to use vouchers for more than just medical appointments (i.e. going to the food bank, shopping, etc.). Also, participants suggested that there be more handicap options and that eligibility for the service should include Medicaid recipients.

Dental Care

Dental care includes diagnostic, preventive, and therapeutic services provided by a dentist or other trained provider of dental care. A majority of survey respondents (79%) indicated current or past use of dental services. Fifty-four percent reported current use of the service and 25% reported using the service in the past. Only 20% of respondents had not used this service. Overall, the service was considered either *very important* (84%) or *somewhat important* (12%) by survey respondents.

Among those who reported not using dental care services, 65% reported needing the service and more than half of those never receiving services (55%) reported the service was available to them. Twenty-three percent of this group was unsure if dental care services were available. An unmet need was calculated for 29% of participants - PLWHA who reported they needed dental care but that it was unavailable. Figure 12 illustrates the reported need for dental care services, in each HSDA and the overall region, by respondents who had never used dental services.

Figure 12: Percentages of respondents reporting a need for dental care services, by HSDA[1]



Several barriers were documented from survey participants including lack of insurance coverage, transportation challenges, and not knowing the service was available. Participants expressed a need for dentures/partials, oral surgery and cosmetic dentistry to be added to the current coverage of dental care services. Issues experienced by participants relating to dental care services included problems with determining how to access the service and difficulty keeping appointments.

[1] Need for the service was only asked of participants responding *no* or *unsure* to the previous question of *"Have you ever used this service?"*

Food Bank

Food bank services include provisions of actual food or vouchers but does not include finances to purchase food or meals, though vouchers to purchase food are acceptable. The provision of essential household supplies such as hygiene items and household cleaning supplies is also allowed. Survey participants almost unanimously declared this service as important – 82% reported the food bank as *very important* and 14% reported it as *somewhat important*. Another 2% were *neutral/unsure* about the food bank's importance and 2% felt it was *not very important* or *not at all important*. Seventy-seven percent of survey participants reported current or past use of the service. Despite having 23% of respondents report *never* using the service, 96% reported this service as vital; this information only underscores the potential impact this service has for persons living with HIV/AIDS.

The need for this service was split by those who reported *never* using food bank services – 48% of those who had not used it needed food bank services, 46% did not. Overall, for the participants who expressed a need for food bank assistance, over half said the service was unavailable or they were not sure if it was. This breakdown is illustrated in Table 12. Within the HSDAs, two areas had more than one-quarter of clients who needed the service report they were *unsure* if a food bank was available to them, indicating an opportunity for better communication about available services.

Table 12: Distribution of Participant Responses to Food Bank Service Availability, by HSDA

Is this service available to you?	Austin	Bryan/College Station	Concho-Plateau	Temple/ Killeen	Waco	Total Region
Yes	67%	63%	100%	44%	60%	46%
No	17%	0%	0%	25%	20%	23%
Unsure	17%	38%	0%	31%	20%	32%

Barriers identified by participants included hours of operation, information regarding services were not in their language and other barriers such as not knowing about the program, no transportation to the food bank, and confusion over eligibility requirements. Few participants reported the need for additional services to be included with food bank services; however, the following improvements to the program were suggested by many:

- **increasing access** to food pantry via food delivery, providing the service to more individuals, and providing transportation;
- **providing a better selection** of items including fresh fruit and vegetables, more protein sources, personal hygiene supplies, and childcare items such as diapers;
- **increasing the amounts/frequency** of food vouchers and/or trips to the pantry;
- including **supplements**; and,
- **better communication** with clients that such a service is available.

Rental Assistance

Almost one-quarter (24%) of survey respondents reported current or past use of rental assistance. This service includes assistance to income eligible clients and their families with rent and utilities until they are able to secure affordable, stable housing, or long-term HOPWA.

Very few survey respondents reported currently using this service (8%), even though 96% reported the service as *very* or *somewhat important*. Sixteen percent of participants reported using rental assistance

services in the past, but did not currently use it, leaving more than 75% of survey participants who had never utilized rental assistance services.

Among the survey respondents who had never used the service, 33% reported needing this service; however, 48% reported being unsure if the service was offered and 10% said that it was not available to them. Twelve percent of respondents who needed the service reported rental assistance as unavailable to them, representing an unmet need. Table 14 illustrates the disparities between current use, need for, and availability of rental assistance services.

Table 14 Distribution of Participant Responses for Use, Need, and Availability of Rental Assistance Services, by HSDA[2]

	Austin	Bryan/ College Station	Concho Plateau	Temple/ Killeen	Waco	Total Region
Have you ever used this service?						
Yes, I am currently using this service	4%	11%	0%	5%	16%	8%
Yes, I have used it in the past, but do not currently need this	16%	15%	18%	15%	18%	16%
No	80%	74%	82%	78%	66%	75%
Unsure	0%	0%	0%	3%	0%	1%
Do you need this service?						
Yes	22%	46%	22%	29%	45%	33%
No	73%	54%	78	65%	52%	63%
Is this service available to you?						
Yes	49%	49%	44%	29%	34%	42%
No	4%	9%	0%	21%	14%	10%
Unsure	47%	43%	56%	50%	52%	48%

Barriers to using rental assistance services reported by respondents who had never used the service included not knowing whether the service was available to them, not qualifying for the service, or being too proud to use the service. When asked about what else could be included with this service, respondents gave suggestions for improvement as opposed to additional things to be included. Common suggestions for improvement regarding this service included a need for better and clearer communication about the rental assistance program, including financial planning assistance, increasing the program's privacy and confidentiality, and allowing for housing rental locations in safer areas.

Short-Term Housing and Utility Assistance

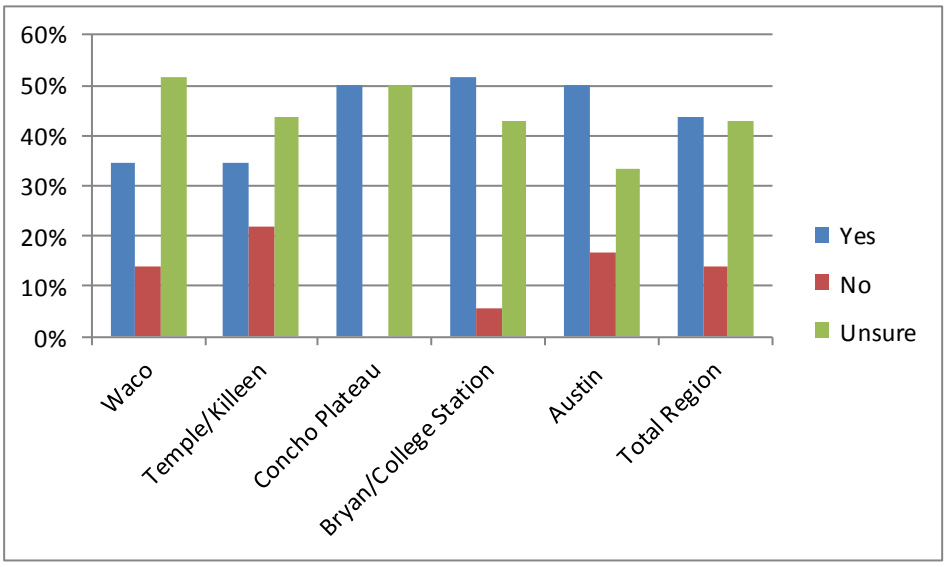
The short-term housing and utility assistance program (short-term HOPWA) is housing subsidy for short-term rent, mortgage, and utility payments. This service is limited to a period not to exceed 21 weeks' worth of assistance in any 52 week period.

Few survey participants utilized this service – 8% were currently using the assistance program and another 25% had used it in the past but did not currently need it. Two-thirds of participants reported

[2] HSDA totals may not add to 100% due to rounding.

never using the service. Of those not using the service, 58% indicated they did not need the service. Availability of short-term housing and utility assistance across the five HSDAs is presented in Figure 13. Forty-four percent of those who have never used the service reported that short-term housing and utility assistance was *available* to them; however, a similar number of participants (43%) were *unsure* if the service was available. Twenty percent of participants who had never used this service reported an unmet need (needed the service, but it was not available) regarding short-term housing and utility assistance.

Figure 13: Availability of Short-Term Housing and Utility Assistance across the five HSDAs



When asked about the barriers to accessing short term housing and utility assistance, among the respondents who had never used the service, 30% responded that they *did not need it or want it*. The most frequent response for those providing a response of *other* were lack of awareness of the program's availability. Despite the apparent lack of use and need for this service by a large portion of the survey participants, a majority still rated short term housing and utility assistance as *very important* (85%) and *somewhat important* (11%) to stay in or get someone back into HIV medical care.

Many participants shared ideas for improvements in the program such as better communication about the service, removing the cash penalty for late payments, and including coverage for propane and internet connections.

Permanent Housing Placement

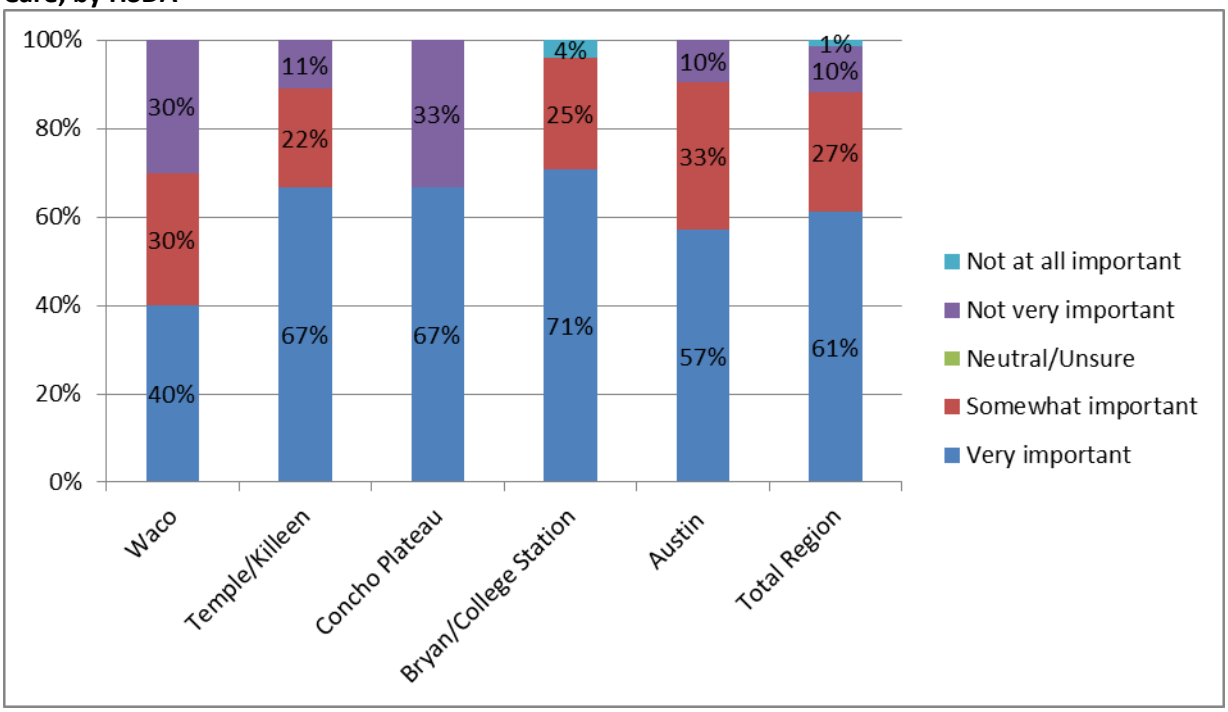
Permanent housing placement, another service rated by over 90% of survey respondents as *very important* (65%) or *somewhat important* (26%) to staying in or getting back in medical care, provides clients with assistance with reasonable security deposits, not to exceed the amount equal to two months of rent, and related application fees and credit checks. Despite its importance rating, permanent housing assistance was reported as *never used* by 85% of survey respondents; however, among those who never used it 31% reported that they needed the service. Unfortunately, 42% were *unsure* if the service was available. Twenty-four percent of participants that had never used permanent housing assistance reported a need for permanent housing assistance that was not met; and 45% of participants who reported never using the service did not know whether the service was available.

When asked about what additional services should be included within the permanent housing assistance program, participants did not respond with services but made suggestions for improvement to the current program. Suggestions included: making the program more accessible (i.e. expand eligibility, decrease time on waiting lists, reduce the amount of paperwork), and providing better communication about the service (e.g. general information), and increase funding.

Psychosocial Support

Psychosocial support includes the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Thirty-five percent of survey respondents reported current or past use of psychosocial support services. Close to 90% of survey respondents reported this service as *very important* (61%) or *somewhat important* (27%). Among the five HSDAs, however, importance of the service varied with as few as 40% of Waco HSDA respondents reporting the service as *very important*, compared to 57% in the Austin HSDA, 67% in the Concho Plateau HSDA, 67% in the Temple/Killeen HSDA and 71%t of Bryan/College Station HSDA survey respondents (see also Figure 14).

Figure 14: Participant Rating of Psychosocial Support Importance to Getting or Staying In HIV Medical Care, by HSDA



Among the 65% of survey respondents who have never used the service, 83% reported they did not need psychosocial support services. More than half of the survey respondents who needed psychosocial support services said the services were unavailable (38%) or they were not sure (25%). In general, a substantial portion of participants were unsure whether psychosocial services were available within each HSDA; the percentage of participants who were unsure of the service's availability ranged from 14% in the Bryan/College Station HSDA to 27% in the Temple HSDA.

Lack of transportation, not knowing about the service and its availability, and inconvenient meeting times were the primary barriers reported for accessing psychosocial support services. Psychosocial support services were one of the few services for which many participants had opinions for additional

services or products they felt should be included. Participants expressed a desire for services to be available at more frequent times and tailored for different participant groups. Suggestions for improvement from survey participants included better consistency in service provision, transportation to and from psychosocial support events.

Mental Health Services

Persons living with HIV/AIDS may be eligible for psychological and psychiatric treatment and counseling services. These services are provided by a licensed mental health professional to individuals with a diagnosed mental illness and may be conducted in a group or individual setting. Ninety-three percent reported this service as *very important* or *somewhat important*. Less than 2% were *neutral or unsure* regarding the importance of counseling services and 6% felt this service was *not very important*. Service use is further displayed in Table 15.

Table 15: Distribution of Participant Responses to Mental Health Services Use, by HSDA

Have you ever used this service?	Austin	Bryan/ College Station	Concho Plateau	Temple/ Killeen	Waco	Total Region
Yes, I am currently using this service	21%	15%	27%	28%	14%	20%
Yes, I have used it in the past, but do not currently need this	21%	21%	18%	8%	14%	17%
No	57%	64%	45%	65%	73%	63%

Thirty-six percent of the participants reported current or past use of mental health services. Among those who had never used the service, 90% reported they did not need the service. Participant reporting on the availability of mental health services was mixed; 74% said the service was *available*, 9% reported it was *not available*, and 18% were *unsure* if counseling services were available. Availability of mental health services also varied among HSDAs; 66% reported availability in the Austin and Temple HSDAs compared to 38% of Concho Plateau and Bryan/College Stationparticipants who reported mental health services as available. Seventy-seven percent of Waco HSDA participants said mental health services were available. Only 8% of participants reported an unmet need for this service.

Nearly 90% of participants who had never used mental health services reported that they did not need or want it. Participants did describe challenges and suggestions for improvement in the service. Respondents suggested increasing access to this service by providing free or reduced cost counseling services, transportation (including transportation from rural areas), and issuing reminder cards to participants.

Health Insurance Assistance

This service includes financial assistance in order to keep health insurance (including COBRA) or to get medical benefits through purchasing a health insurance policy. It can be used to pay premiums, co-payments, and deductibles and can be used with Medicare and Medicaid. Only a small percentage of survey participants reported using this service – four percent said they were currently using the service, and only eight percent had used the service in the past.

Eighty-seven percent of participants reported never using the service, and among this group 36% reported they *needed* the service. However, responses from participants who had not used health insurance assistance showed that only 31% reported the service as available and 55% were *unsure* of

the service's availability. Twelve percent of the participants who had never used the service had an unmet need – needed the service but it was not available to them.

Health insurance assistance was rated as *very important* by 75% of survey respondents. Seventeen percent said it was *not very important* or *not at all important*. Despite the overall rating as *very important*, importance varied across HSDAs, as seen in Table 13. Participants listed barriers to accessing health insurance assistance, primarily having no way to pay for it and a lack of information about the service.

Table 13: Participant Rating of Health Insurance Assistance Importance to Getting or Staying In HIV Medical Care, by HSDA

How important is/was this service for you to stay in or get you to use HIV medical care?	Austin	Bryan/College Station	Concho Plateau	Temple/ Killeen	Waco	Total Region
Very Important	86%	75%	100%	83%	50%	75%
Somewhat Important	14%	0%	0%	0%	17%	8%
Neutral/Unsure	0%					0%
Not Very Important	0%	25%	0%	17%	17%	13%
Not at all Important	0%	0%	0%	0%	17%	4%

Few survey participants reported other things they thought should be included in the current service. Of those who provided a response, participants reported needing additional assistance understanding health insurance coverage options and the need for more services (such as medications, dental insurance, and equipment such as walkers and LifeAlert) to be included.

Other Information Regarding Services

Throughout the service related questions in the survey, many participants reported service needs not specific to the services listed in the questionnaire. These additional requests included:

- greater access to specialty care;
- more pharmacies in rural areas;
- increased number of HIV specialist healthcare providers; and
- 24-hour hotline or crisis line for PLWHA.

A general observation about responses to the service-related questions was the need for better communication regarding available services and a need to make access easier. Problems with access to all services included transportation, too much or too complicated paperwork and a lack of consistency in service provision (cancellations, infrequent visits, not returning phone calls, etc.).

Inherent in any survey, limitations to the data will exist. Following data analysis of the service-related questions, some specific concerns arose and are presented here. The concerns are applicable to few cases or only to a few specific questions out of many, but important to mention regardless. The service-related question limitations are:

- The survey asks participants who had never used a specific service if the service was available to them. Respondents could answer *yes*, *no*, or *unsure*; no additional clarification was provided.

For six of the 11 services (medication assistance, health insurance assistance, permanent housing, short term housing, rental assistance, and transportation) more than one-third reported they were unsure if the service was available. One concern is if those responding to the question as unsure were unsure if the service was available through their organization or unsure if they qualified for it. Further, many respondents knew they received some type of assistance, only they were not sure of the name of the service. For instance, some participants knew they received assistance for their apartment; however, they did not know if it was short term housing assistance, permanent housing assistance, or rental assistance. Therefore, this type of confusion over the name of the services likely resulted in some erroneous reporting over whether or not a client had used the service and or if the service was available to them.

- Another limitation within the service-related questions is the question asked within each service related to barriers - "Is there anything that keeps you from getting this specific service?" The barriers defined by this question under each service are only reported by participants who had earlier identified that they had never used the current service under discussion. This helps local organizations and planners learn more about barriers for those who need the service but are not accessing it, but it does provide any information for clients currently using the service who most likely also have barriers to accessing the service. It is logical to assume that some of the barriers listed such as agency hours of operation and limited access for those in rural areas are the same for those who have used the services. However, it is important to note that all barriers discussed in the service section of this report are only for survey respondents who had never used or were unsure if they had used the service.

- Another limitation of the survey is the difficulty in reaching out of care clients and vice versa, the ease of reaching in care clients. The survey sample was selected from a database of individuals more likely to be in care than out of care. Clients not currently receiving care, or ever receiving care, are much more difficult to contact and interview about what might assist them in returning to HIV medical care. Thus it is not surprising that few out of care clients were surveyed.

Overview of Health Service Delivery Area Reports

Each area of the Central Texas HIV/AIDS Service Area is unique, therefore specific Health Service Delivery Area (HSDA) reports were written to provide information on data for that delivery area. The supplemental reports that follow, when appropriate, make relevant comparisons to the Central Texas service delivery area. An overview of the needs assessment process, methodology and comprehensive analysis of the Central Texas HIV/AIDS Service Area is contained in the full report CTHASA report.

HSDA Supplemental Reports

Austin HSDA
Bryan/College Station HSDA
Concho Plateau HSDA
Temple/Killeen HSDA
Waco HSDA