



Ryan White Planning Council of the Dallas Area Interim Needs Assessment August 2021

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In collaboration with Dallas County Health and Human Services and the Ryan White Planning Council of the Dallas Area.

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Collaborating Partners

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Dallas County Ryan White Needs Assessment Committee
Dallas County Ryan White Planning Council
People Living with HIV in the greater Dallas area and Ryan White HIV/AIDS Program Consumers

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Background and Purpose

In 2020 Susan Wolfe and Associates, LLC (SWA) in collaboration with Dr. Kyrach Brown from the University of Texas at Arlington presented the report with the results of the 2019 Dallas EMA Ryan White Needs Assessment. Since the report was presented, the Ryan White Planning Council (RWPC) prepared a plan to respond to the findings and began implementing the plan. Shortly after the needs assessment findings were shared, the COVID-19 epidemic disrupted the operations of systems providing health and supportive care for people living with HIV/AIDS (PLWHA) and providers were forced to develop alternative ways to conduct outreach and deliver care.

In 2021 as COVID-19 rates decline and vaccination rates increase, there are expectations that providers and PLWHA will be able to return to providing and receiving services with the same methods used pre-COVID-19. However, COVID-19 era adaptations led to innovations and new ways of doing things that may be retained. This interim needs assessment offers an opportunity to capture not only the impact of COVID-19 on providers and consumers, but also the lessons learned.

The purpose of this mini-needs assessment is to:

1. Identify how COVID-19 impacted the care delivery system and outreach, especially for underserved populations and populations with special needs.
2. Determine the extent to which COVID-19 impacted individuals from identified underserved populations and their ability to access prevention and care services.

Methods

SWA gathered the information needed through key informant interviews with providers and focus groups with previously identified underserved populations. Each of these methods are described in more detail below.

Provider Interviews

Key informant interviews using a semi-structured interview protocol were conducted with 14 prevention and care providers in the Dallas EMA Service area representing 11 different organizations.

Dallas County Health and Human Services provided a list of 20 Ryan White service providers representing 12 different organizations to SWA. An email was sent to each provider on the list with an invitation to participate and a link to SignUpGenius, an online scheduling system. Many dates and time slots were presented to provide options for different days of the week and times of day. Invited participants were also provided an opportunity to email the SWA team if none of the days and time slots worked for them.

Two of the individuals on the list provided contact information for alternative respondents, both of whom participated in the interview. Four of the prospective interviewees actively declined participation as they felt the other representative from their organization that we had contacted would be better suited to provide the answers to the questions. Two passively declined and never responded to any of the emails that were sent. Interviews were conducted by Dr. Susan Wolfe, CEO and Community Consultant from SWA or one of her associates, Jenn Ballentine.

The interview questions were developed by SWA in collaboration with members of the RWPC. The interview protocol that was used is presented in Appendix A.

Focus Groups with Identified Underserved Populations

Five focus groups were conducted with populations that were identified as underserved and having unique needs:

- Black Men (9 participants)
- Black women (5 participants)
- Hispanic/Latino men¹ (7 participants)
- Two focus groups with transgender men and women (5 participants total).

A Spanish language interpreter was provided for the focus groups with Hispanic/Latino men. Each focus group took approximately one hour to complete, and participants were each given a \$15 gift card as compensation for their time.

All focus groups were conducted by Dr. Susan Wolfe. Four of the five groups were conducted via Zoom and all sessions were recorded with verbal consent from the participants. One group was conducted in person with appropriate social distancing and all participants wearing masks in compliance with public health recommendations. The session was audio-recorded with verbal consent from the participants.

The initial plan included one focus group each with Hispanic/Latina women, youth living with HIV/AIDS, and youth who are not living with HIV/AIDS. Efforts were made to organize these groups, but attempts were unsuccessful.

The focus group protocol and questions were developed by SWA in collaboration with members of the RWPC. The focus group protocol that was used is presented in Appendix B.

¹ This focus group included one transgender woman.

Findings

Changes Made Resulting from the 2019 Needs Assessment

The 2019 needs assessment report was delivered in March 2020, just before Dallas County begin to experience the impact of COVID-19. This left little opportunity for providers and the RWPC to give it adequate attention as they have been busy since that time managing the impact of the pandemic on their organizations and consumers. Nonetheless, the interviews and focus groups asked questions to determine whether providers and consumers had seen or heard of the results from the 2019 needs assessment. They also asked about changes made by providers and consumers’ observation of changes.

Did providers and consumers hear or see the results?

Consumers who participated in the focus groups reported they were not aware of the results. Among providers, more than half had seen the report, or at least browsed parts that were relevant to them.

What changes did providers make?

Providers described some changes they had made after they read the results of the needs assessments. Others had made changes that were unrelated to the results, but consistent with the recommendations, nonetheless. One provider remarked that they engage in continuous improvement whereby when they see something that needs to be improved, they just do it. Some changes that were planned had to be put on a back burner due to COVID-19.

Rural providers outside of the Dallas EMA did not find the needs assessment to be helpful because it focuses primarily on the needs of populations they do not serve.

Reported changes based on the needs assessment are listed below.



Including clients more often in decisions about how services are provided. Involving them in decisions about grant applications.



Using the data to support grant writing. Shifting grants to specifically support *medical* case management.



Integrating primary care with management of HIV in a clinic to improve access and reduce stigma of visiting an HIV services only clinic.



Working across the EMA to reduce the eligibility burden with each agency having its own eligibility and clients having to do the same things multiple times creating undue burden. This is still a work in progress.



Increasing access and the number of new patients seen.



Doing research about transgender issues. Engaging in work on cultural humility and awareness. Changing forms to be more inclusive and include preferred name, as they are required to enroll people based on their legal names.



Providing full wraparound services with pharmacy and a full medical clinic. This includes Spanish-speaking services, including transcription services for others.



Implementing a Rapid Start Clinic. They were already considering it, but the needs assessment influenced them to move forward.



Adding an additional bilingual therapist.

What changes did consumers observe?

Consumers reported they have seen some changes since the 2019 needs assessment was completed, although they are not sure that they were related, or expressed that they were unrelated.



One clinic is open on some Saturdays and has evening hours.



Another clinic opened and there is more access in different parts of the city, including the southern sector and Fair Park area.



The Amelia Court clinic moved to the new professional building at Parkland. Staff have more resources and room to provide care.



The Community Health Center for Health Empowerment PREP clinic started HIV care because they were seeing so many come in for testing who were not getting into care.



Mobile testing units were out by nightclub locations in the Design District and Cedar Springs areas. They noticed a lot of people out and about participating in the mobile units.

How COVID-19 Affected Service Delivery

Changes made because of COVID-19

Some providers reported they did not miss a beat in transitioning to services during COVID-19. They mainly provided resources rather than clinical services and were able to continue providing meals, transportation, and other resources without shutting down for even one day. They did need to make modifications to how services were provided. One provider described a process where their consumers held their ID up to the glass door and bus passes were distributed through the mail slot in the door. They plan to soon replace this with a prescription window.

Clinics reported they limited their service capacity during the pandemic. The need for social distancing required that patients not sit in waiting rooms. Wellness screenings for staff and visitors were implemented, including contactless temperature taking. Patients were not allowed to come in unless they had appointments. Clinic staff reported that some patients who did not have access to technology wanted to come in for services. Others reported they still had people coming in for HIV testing. Saturday clinics were discontinued. In some instances, patients came in to give blood for testing, but follow-up visits were done via telemedicine. Clinics also used at home testing for sexually transmitted infections so they could continue to provide the service.

Many providers shared that they were forced to either close their doors at first, or throughout the pandemic. Administrative services especially transitioned to working from home. Resource centers were closed. Some services that were suspended temporarily were able to make needed adaptations and soon reopened and continued to provide services. A service provider reported that their consumers were still coming to the door, so they installed an intercom so they could talk to them safely.

Meal programs were forced to adapt as well. They transitioned from serving in-person, community meals to providing meals-to-go whereby consumers could come by and pick up their meals. Demand for meal services reportedly increased during the pandemic. Housing programs delivered meals to residents and whatever staff were on site pitched in and helped out.

Physical workplace adaptations were necessary to ensure social distancing and other precautions. Windows needed to be sealed and signs put up. One provider had patients go into the exam room where the doctor met with them virtually. Other adaptations included a time clock that measures temperature, new furniture that could be cleaned and spaced out better, desk shields and glass barriers, new air filters, and touch free light switches. Water fountains and snacks were removed. Van drivers were provided with Tyvek suits to cover them

completely, plexiglass dividers between driver and rider, and face shields and masks for themselves and masks to provide to their riders.

Dental services were forced to shut down completely until they could obtain proper PPE and other needed safety measures. Even after they opened, services were slowed. Dental providers saw some patients via telehealth. Although they were unable to receive reimbursement for those services, they continued to provide them.

Organizations that provide housing had many considerations. They were challenged with making changes to protect all residents. This required looking at all their policies and procedures, ensuring that residents adhered to public safety protocols such as mask requirements and visitation restrictions. There were challenges with residents visiting neighbors in their rooms in some instances. At the same time these providers continued to provide meals and other services. They did not have the option to close even temporarily or to allow staff to work from home. COVID-19 testing was performed regularly for residents and staff. If a resident tested positive, one provider reported they moved them to a hotel and delivered food to them to keep other residents safe.

Legal services transitioned to providing services over the phone. Legal papers such as wills still had to be signed in person with witnesses, so attorneys met with their clients and witnesses in outdoor settings like porches as a safer practice.

Telemedicine and Technology Solutions

The health care providers who participated in the interviews reported they were engaging in telemedicine. For some providers, little effort was required to make the change as they were already providing some services via telemedicine. These organizations had already started the transition before COVID-19 and it was one of their goals to make this change. Even though they were ready, they still reporting having some challenges along the way. This was especially true for their patients who did not have easy access to Internet or telephones.

Other health care providers who were not set up for telemedicine had to shut down as they took the necessary steps to plan and implement the services. Providers reported it did not take very long, two weeks in some instances, to prepare and change their service protocols. There were also expenses involved in making the change. In some instances, staff required training to implement telemedicine. It is difficult to provide services without headsets, and for some they were still on back order at the time they were interviewed in the summer of 2021.

Case management and behavioral health services also used telehealth services to deliver care and meet with their clients. For many, COVID-19 was very isolating, and they needed to meet face-to-face to the extent it was possible. Telehealth provided that opportunity. Ultimately, case management and behavioral health providers found that the ability to deliver services via technology was somewhat dependent on where their clients were and their individual needs. Legal services also found they were able to use technology to continue to provide services throughout the pandemic.

Telemedicine services allowed providers to bring services to patients in rural areas and in shelters. One challenge was that there are rural areas, and even areas in Dallas County where there are problems with cell phone reception and broadband access. Even providing wireless hot spots did not help if there was no broadband access. Another challenge was ensuring that the services they were using were compliance with the Health Insurance Portability and Accountability Act (HIPAA) federal law that was passed to protect sensitive patient health information.

An additional benefit for providers was that telemedicine did not require having staff on premises, which allows for infinite capacity as providers do not need to maintain or pay for office space for them. However, it should be noted that in some instances, providers needed to provide their staff with resources such as laptops and headsets so they could work remotely. There were also challenges when staff needed to scan and upload documents as all did not have access to the needed equipment.

Dental services set up phone banks with dentists on call 24 hours a day, seven days a week for their patients and for patients throughout the State of Texas. They were not allowed to bill for the services but provided them anyways. Medical providers reported lost revenues as they were not reimbursed at the same rates as they are for in-person visits. One reported losing 40% of their revenue due to providing services via telemedicine.

Providers cited benefits for consumers as being less stigmatizing as they will not be seen seeking care at HIV clinics. It is also more convenient, they do not need transportation, and can seek counseling more discretely if needed. The downside is the lack of technology capabilities and having to spend time educating patients. Some data plans do not support video calls. During the pandemic it allowed mental health services to continue as therapists were able to work from home to make virtual visits.

Consumers expressed mixed opinions about receiving care via telemedicine. Some consumers viewed it as a positive change to be able to visit with their doctors on the telephone or through their computer. Even those who expressed positive opinions still expressed that sometimes they liked or felt a need for an in-person visit with their doctor, but they liked the telemedicine option. Mostly, those who preferred telemedicine did so because of the convenience and time savings it offered them.

Others expressed they felt that virtual visits were forced upon them. Others missed seeing their doctors face to face. Some found telemedicine to be distracting as there was activity going around them as they tried to engage with their doctors. Others complained of longer wait times for when they had to wait for a callback. They felt the visits were shorter and they got less time with their doctors. They also felt the visits were less thorough and the level of care was not the same. They also found it hard to communicate without physical or eye contact.

Some were concerned that they had fewer blood draws. Others preferred in person in case there was a need for testing at the time of their visit. They could go straight to the labs or x-ray

when they visited in person. Telemedicine visits were difficult for newly diagnosed individuals as they were unable to get the support needed. Telemedicine was viewed by some as one more form of isolation that affected people mentally.

Perhaps the greatest challenge with telemedicine was for those who did not have access to the technology needed to access care online. Sometimes the visits were dropped if Internet connections were not good. There was more potential for miscommunication. Consumers who were not tech savvy had to learn to use features such as Zoom and MyChart to get access to their records and health information and it was challenging for some.

Some consumers who were less positive about telemedicine still saw some benefits. They enjoyed being able to talk to someone and having prescriptions filled more quickly. They also enjoyed not having to drive in traffic. They felt it should be retained as an option.

While telemedicine was the most prevalent technology solution applied, other technologies were also used. There was more use of electronic medical records noted both before and during the pandemic. Patients appreciated this because it gave them easier access to their medical records and allowed them to check for drug interactions. They felt their records were kept better. Medical providers are able to access their records across facilities. It reduced testing as doctors could see test results from prior tests.

One provider used an app whereby consumers could use it to click and send pictures of documentation they needed to submit. Then the provider could simply call or text to let the consumer know that the information was received. DocuSign was another frequently used technology solution to obtain signatures. Digitizing records made it much easier for audits as they no longer required the use of multiple large binders to share records.

Communications included email, telephones, and online conference platforms such as Zoom, Microsoft Teams and WebEx. Providers were able to provide support groups and continue Community Advisory Board meetings virtually each week. One provider stressed the importance of having cameras on during meetings and replicating the experience of being in-person where you can read body language.

Intake and Recertification

Intake and recertification were consistently described as problematic during the 2019 Needs Assessment. The amount of paperwork and requirements were described as barriers to care. The paperwork demands were described as burdensome by both providers and consumers. Intake information is not centralized, and recertifications are required on the consumers' birthdays and then every six months, including having consumers present paperwork and documentation. Individuals who are not housed or who have mental health challenges sometimes lose their paperwork. This not only burdens consumers but adds to the administrative burden on providers.

The pandemic required greater flexibility regarding intake and recertification processes. Providers were able to utilize emergency applications from the state and Dallas County for Ryan White and the state administered Part B AIDS Drug Assistance Program (ADAP). Providers relied on document pickup and drop-off or email procedures where they received documents curbside or at the front desk. Assessments were done over the telephone rather than in-person. Some providers used technological solutions for signatures such as DocuSign, others were able to allow verbal signatures. One medical provider is working to develop the recertification process through MyChart where patients due for recertification will be able to answer questions and upload information.

The timelines were extended, and the six-month eligibility requirement was extended. Consumers who were eligible in March of 2020 were eligible through December. There was more flexibility on paperwork due dates as well. Despite the easing of restrictions, providers struggled to get paperwork from some consumers who were noncompliant, which hurts them when they are audited.

As the intake and recertification process returns to pre-pandemic requirements, providers are feeling the burden. Some providers became more proactive with recertification processes. They called consumers who were due to renew to ensure they did so before their eligibility expired, and they lost access to services. Prior to COVID-19 the responsibility was on the consumer to keep track.

Consumers commented on how much simpler the easing of these procedures were for them. They liked being able to report their information over the phone and email pictures of documentation or copies of emails with information such as their electricity bills. They suggested that these procedures be retained as an option. Other consumers reported delays in recertification and people being taken off the rolls, causing multiple problems.

Policies and Processes Changes

Providers changed policies and practices to shift to allowing staff to work from home all the time, or at least part of the time. Some offices reported having rotating schedules for staff to reduce the number that were in their offices at the same time. This was especially important for a time when N95 protective masks were in short supply. Providers also reported taking turns coming into the office to scan documents.

Some providers reported a need to examine many of their policies and procedures and to write new ones. These included how to do verbal consent, notations, telehealth clinical documentation, signs that had to be posted, contingency plans, COVID-19 materials, messages to clients, state guidelines, COVID-19 testing, sexually transmitted infection testing, vaccine access, operational changes for safety, the use of PPE, human resources policies regarding illnesses, and an educational plan for vaccines. Providers in some instances described doing complete rewrites of former policies and writing all new policies to support necessary practice changes.

As new information came in, procedures and policies had to be changed. One provider described that “things were changing by the minute.” At the same time, providers were working to comply with requirements from funders. One provider created a COVID-19 guidance plan that was broken down by department. They also surveyed residents to find out how they felt about the regular testing and other changes and held virtual town halls so residents could question leadership and share information.

Providers adapted existing services to provide deliveries, bundle services so they were more coordinated. They created tracking mechanisms whereby they could determine changes in eligibility and track when recertification was due for clients.

How changes affected Service Providers

Changes impacted service providers’ staff positively and negatively. Administration, case managers and other staff were either put on rotation or shifted to remote work responsibilities. While many staff were positive about these changes, others experienced challenges. Staff who had children in the home were balancing the needs of home and family at the same time they were caring for consumers and meeting their work obligations. Some staff were forced to work remotely because of exposure to COVID-19 or family member exposure, others were forced to deplete their paid leave. There were also instances where staff lost family members during COVID-19.

Positive Effects

One positive effect that was described was that COVID-19 and the changes required made them look more closely at how they did everything, and question whether some things were necessary, such as required documents. As they revert to business as usual, they are continuing to re-examine the efficiency and effectiveness of process, and the necessity of some requirements. Providers expressed this as an opportunity for improvement.

Some providers viewed the need to innovate to manage during the pandemic as a positive impact. Some of the changes included drive through service delivery options whereby consumers did not have to leave their car to receive food. Tables were set up outdoors for people who did not have cars so they could walk up and pick up what they needed.

Some providers were able to add new staff that were needed on-site for services providing housing during the pandemic. One added a physician specialist to provide psychiatric services for residents with mental health needs when there are crises. The doctor meets patients in their rooms, so they do not need to go anywhere to receive services.

Organizations received funding to invest in newer technologies and processes that will be beneficial if something like this occurs again in the future. One provider was forced to digitize paper files and viewed that as an opportunity as they will move forward fully digital.

Providers saw fewer no-shows for telemedicine and telephone appointments compared with in-person clinical services.

One provider reported that Dallas County was helpful when they called on them. They provided guidelines and helped them to understand them.

Staff were forced to work remotely in many instances and found that they were able to work effectively from home when necessary. The result was even as services were reopening, many decided to maintain flexible and remote work schedules. This has had added benefits such as addition of new workstations and more parking availability. There is increased capacity to add more staff. There were still some challenges as staff at some provider organizations needed to set up systems to take turns so they could safely come into the office to scan and upload paper files and documentation.

The demands of adapting to the pandemic provided a learning experience for providers. Some were surprised that they were able to pivot as quickly as they did to accommodate needed changes. Providers were pleased with the extent to which their staff stepped up to meet the moment and do what needed to be done.

Negative Effects

Providers described negative effects of the changes they made during COVID-19 as well. In some instances, before COVID-19, providers served as sources of social support for consumers. While they were unable to provide in-person services, they were also unable to provide the level of support some consumers needed. They could not provide refuge to those who needed a safe space to visit when they were feeling lonely or experiencing mental health challenges.

Providers also lost some staff who were afraid to come to work during the pandemic and decided to leave employment and stay home. They have since been challenged with seeking new staff to fill positions, including clinical staff for medical and psychological services. Some providers lost a substantial number of staff who were burned out and rethinking work/life balance. Volunteer pools shrunk considerably during COVID, leaving providers with even fewer human resources. Staff training reduced as staff were working remotely and sitting at computer screens all day.

Clinics were not able to close all gaps in terms of patient care and quality of care as they cannot do everything over the Internet. Because of this, some patients discontinued care and they are working to get them back. Although, they are concerned that the resurgence from the Delta variant may once again force them to roll back services. Likewise, flexibility needed to manage during the pandemic meant daily huddles and regular meetings were discontinued.

While one service provider reported leaning on Dallas County, another expressed they felt Dallas County was not very proactive. They did not receive technical assistance or information about best practices. The county was late to respond to some of their requests and they

perceived the agency as inefficient. They felt the county should have met with every agency and assessed their needs. They felt the county failed them.

Safety precautions especially affected providers' ability to conduct outreach services, including presentations and testing throughout the community. Others who had contact with the public during this time were challenged by patients or others who did not want to wear masks.

Some providers lost funding from some sources during this time as well, although they continued to pay staff. Providers who receive funding on a fee for service basis lost substantial revenue as they were forced to cut back on the number of individuals served.

There were also expenses involved in preparing to meet safety requirements for re-opening. In the absence of mask mandates, providers needed to install safety shields, purchase masks, sanitizers, and face shields for staff and clients, and make other structural adaptations in order to ensure staff and consumer safety. They had to expand janitorial services to provide daily sanitation of the entire facilities.

Providers also noted that the work toward implementing changes from the 2019 needs assessment had to take a back seat to COVID-19. It still is as the pandemic was resurging with the Delta variant at the time of this report.

Dental services experienced negative effects from the COVID-19 pandemic. They were forced to close for a substantial amount of time by the State of Texas Dental Board and CDC guidance. They experienced a backup of new patients and slow down in completing treatment plans. They are still working to catch up on referrals as they receive at least a dozen new referrals per day. They may be unable to accommodate them for months. Even after reopening, CDC, ADA, and clinical leadership allowed them to only do certain types of treatment. They underspent their grant funds in 2020 and this year are still advocating to get the funding back as they are increasing services once again. Some providers have not been able to accept any new patients at all. They have unused space but are unable to hire staff to use it. This was true before COVID-19 to some extent and is a greater problem with increased demand for services.

Some providers reported that some of their clients died during COVID-19, and some lost staff members. Some lost as many as 30 clients that they were aware of and suspected there were more. They were unsure if PLWHA were disproportionately impacted by the pandemic and were curious to know whether that had been examined. It created additional stress on staff who had relationships with those who were lost.

How changes affected consumers

Consumers described many changes that worked well for them during COVID-19. One was the requirement to remain at least six feet apart. This required limited access and resulted in less crowded waiting rooms and shorter wait times. Clinics stopped walk-ins as well, relying on an Urgent Care line whereby a nurse assessed the urgency of their need and scheduled a same-

day appointment only if it was necessary. Additionally, once things started opening again some consumers found that getting most care and surgeries done was easier.

Some of the consumers generally liked the virtual visits and hoped they will continue. They determined that they like being able to decide for themselves if their needs require an in-person visit. A consumer shared that some doctors required a negative COVID-19 test before they would allow for an in-person visit. They saw this safety measure as positive given that if medical staff became sick from COVID-19 they would be shorter of staff. Patients who tested positive for COVID-19 were told to go to the emergency room where they were equipped to handle it.

Consumers commented on how helpful and supportive many services and individuals were throughout the pandemic. One consumer who volunteered some time with an agency reported that the agency has asked them to become more involved. Another described how a service provider reached out to them every month to see if they were mentally okay and taking their medications. Not only were services helpful, but in some cases, consumers commented on how helpful other individuals were during this time. A consumer commented on how they reached out to another individual who told them about Abounding Prosperity and how helpful that was.² Another commented on how the pandemic provided an opportunity to meet many phenomenal sisters and brothers.

Consumers described some ways that services during COVID-19 could have been improved. Updating websites with current information would have been helpful. Consumers often start their search for information by using search engines such as Google or Bing, and they provide links to websites. They also go to social media such as Facebook to seek information about hours, services available, and how to access clinics. When information was not current, consumers remarked that they were unsure whether to go for their medical care or not, having to call in or rely on word of mouth from other consumers.

When consumers did call in, they were often confronted with a series of recordings asking them to push buttons, and then were put on hold. This was true for all service providers and compounded the stress of seeking information. They recommended some Ryan White money be used to hire staff to answer phones in person. If this is not a possibility, if consumers are placed on hold, they shared that it would be useful to know the hold time, or to be able to leave their name and number for a callback.

Consumers also cited problems with services during COVID-19. Some felt they were put off as they were scheduled for appointments and then cancelled. They commented about customer service not being as good as they would have liked. One consumer who was hospitalized complained that a nurse treated them rudely and then left the door open when the individual was cleaning themselves, violating their privacy.

² Consumers cited Naomi Green and Helen Turner as two individuals who were especially helpful to others throughout the pandemic.

Some consumers described a need for more health care services availability during COVID-19. They described situations where they felt sick yet had to wait to get an appointment. Access to medical services was limited, and some found it upsetting that they were sent home if they showed up at a clinic with a cough or fever since that is where they should be getting medical treatment for it. One visited their HIV doctor in person for an hour and a half, only to inadvertently find out later that the doctor had COVID-19. Notably, this doctor was not a Ryan White provider.

Some consumers who used telemedicine services expressed that they spent much of the time talking with nursing assistants and did not feel they had adequate time with their doctors who know them and their medical needs better. They felt like they have the relationship with their doctors, but the nurses and medical assistants only know them on paper.

While consumers who resided in an apartment complex specifically for PLWHA were homebound due to COVID-19 precautions, a large storm occurred, and they were left without electricity and water for days. They felt there is a need to prioritize community housing such as theirs for restoration of basic services given their medical vulnerabilities.

Service Delivery Models that will be Retained

The most frequently cited new service delivery model that providers reported they would adopt and retain is telehealth for both clinical and case management services. One provider will be giving patients tablets so they will be able to participate in telehealth. They reported being able to see more patients and higher show rates. They will also explore the potential of additional virtual services, such as social support groups and behavioral health. Virtual services save patients transportation time and addresses transportation barriers.

Providers reported they will continue to hold some meetings virtually. One provider that transitioned to digitizing all documentation and calendars plans to continue the practice and further develop digital content management and other systems. Phone appointments and telephone case management will also be continued as needed. Residential services will continue to provide workstations for residents who lack access to computers and tablets.

More flexible work options such as remote work and flexible hours will be retained by some providers.

Drive through services may be continued in some instances, especially for those who remain uncomfortable entering buildings and having closer interactions. Providers also received funding to purchase gift cards and hand them out to consumers to help with needs during this time. They plan to continue the practice for as long as they are able.

Not all providers reported they will be maintaining COVID-19 practices. Some expressed eagerness to return to providing services as they did before the pandemic.

Lessons Learned about Service Delivery from Managing COVID-19

Providers shared a number of lessons they learned from managing their responses to the COVID-19 pandemic. A provider shared that they learned that the things that were on their wish list with reasons why they could not do them could, in fact, be done. They merely required the right person in the organization to say “yes,” and the mind shift COVID-19 forced them to have. They questioned why consumers were required to come in person twice a year to recertify their eligibility. They now do not understand why this is considered necessary. The same was true for Ryan White billing procedures as they appreciated the ability to email a spreadsheet. Providers are hopeful that change will be retained.

Being open to change was also cited as a lesson learned. Being more flexible and understanding the importance of communication with everyone was also stressed. With prior change efforts there was constant evaluation of options and resources and adoption and implementation of the changes never moved forward. COVID-19 forced the changes. Communication modes among staff have increased to incorporate technology, more cell phone communication.

Providers learned that when they put their mind to accomplishing something they can find a way to make it happen. COVID-19 improved service delivery models, created more options, allowed providers to serve more people. Providers learned that they are adaptable.

The importance of in-person socialization and human interactions was recognized. Providers recognized how important services such as community meals and provision of spaces where consumers can rest, play, get hugs as needed, and gather is for their well-being.

Trust between administration and staff and between providers and consumers is important. Administrators found that staff will be productive if they work remotely. During the period when staff worked remotely they completed their work and delivered services. Additionally, traffic and smog and other environmental effects of commuting were reduced. On the other hand, the extensive screen time from using Zoom and other online technologies can be draining. Patients will also do what is needed and are deserving of trust as well.

Unit and cost-based services do not always work well. Providers are paid if clients or patients show up, but are not paid if they don't, even though they have allocated the time. No-shows result in lost revenues creating budgeting challenges.

Engaging in more technology-based services will require hybrid models to accommodate those without access to Internet and required devices, and those who are not technologically savvy. Many clients have embraced changes to doing what is needed by technological means as they are able, and others have not.

How COVID-19 Affected Access to Medications

Impact on timelines and access

The transition to telemedicine created some delays for consumers to get prescriptions filled and medication changes, but nothing substantial. Bureaucratic processes sometimes compromised patients' access to life-saving medications. One consumer reported needing an inhaler, but because their prescription had expired, they had to wait and make an appointment at a time when they were experiencing substantial breathing problems.

Some consumers found it burdensome when they went to get medications and were asked for identification before they could receive them. Others felt that it is becoming more and more difficult to get their medications, and it sometimes took too long. They were denied their medications if there was an error. Since the clinic moved from Amelia Court to the professional building at Parkland, patients found they have to walk further and endure more complications to get their medications filled. Consumers commented on the long wait times to get prescriptions filled at Parkland. Sometimes when consumers went to get medications (from Parkland and other sources), the medications were not available, and they had to make a second trip.

Providers also reported challenges with the "patchwork" system through which some PLWHA get their medications. In these cases, they may get HIV medications through the ADAP program, but other medications from Parkland and other sources. Getting all of the medications they needed was challenging, especially in regard to them getting a 90-day supply.

Others expressed that some people were not getting medications at all during the pandemic, including needed medications for mental health care. One of the consequences was that consumers reported knowing individuals who were sharing their prescription medications with others or obtaining medications through the black market. In one instance, a consumer was able to receive needed medications only after a provider intervened on their behalf.

Access is also limited in instances where certification or insurance preauthorization is delayed. Ryan White took longer to confirm eligibility through Austin sometimes which complicated the process. Providers reported backlogs at ADAP. There have been changes regarding access for some medications. Some medications were dropped from the Texas Department of State Health Services formulary, including medications for breathing and high blood pressure. Consumers were told it was so that they could concentrate on them receiving their HIV medications, without considering that not having those medications available will exacerbate their HIV care needs.

There were some positive experiences with obtaining needed medications. Consumers reported in some instances that they were able to have medications delivered at no added charge. However, one consumer reported that their family was picking up their medications for them during the pandemic and they were never told about delivery services. Too often information

was shared via word of mouth among consumers as providers did not pass the knowledge on routinely. Deliveries were also difficult to access for individuals who live where the entrance is gated. Medications sent through the mail were sometimes delayed or never received. Consumers commented on how much easier it was when they were able to get a 90-day supply of their medications.

Some consumers commented that COVID-19 had no impact on their ability to get their medications. Some providers also did not perceive any impact from their perspectives. In some instances, patients had clearly not shared their challenges with them. In other instances, they did not provide services relevant to access to medications. One provider reported having worked closely with their patients who were on the ADAP program to ensure there were no medication delays through the emergency application process and time extensions.

Impact on adherence to protocols

Inability to access medications when they were needed sometimes interfered with adherence to protocols. Consumers reported they missed some doses, which could potentially have negative impact on their health.

Transgender men and women reported having challenges with accessing hormone therapy. As a result, they went without them for some time and suffered ill effects. They commented on how the bouncing back and forth can potentially endanger their health. They also commented that obtaining needed hormones is easier in Dallas County compared with some other urban areas throughout the state. Transgender individuals residing in rural areas are especially challenged with getting the medications they need.

Impact on Underserved Populations

Providers reported some challenges that persist across all underserved populations, especially among individual with lower incomes. Some were COVID-19 related, others persisted since before COVID-19. Perhaps most challenging for providers was their inability to conduct outreach to underserved populations during the COVID-19 pandemic. They networked among themselves and were able to refer existing consumers, but they were not able to reach individuals who were not yet diagnosed or newly diagnosed. Some outreach during COVID-19 was conducted virtually, but underserved populations often lack technology needed to interact in this manner.

Access to services for all underserved populations proved to be a challenge before and during COVID-19 for many reasons. Multiple factors can affect access, including geography, employment requirements, family obligations, availability, and finances.

Transportation was a major challenge for PLWHA before the pandemic as identified as a barrier to care during the 2019 Needs Assessment, and then the need was exacerbated during COVID-19. Those who do not have private vehicles must rely on public transportation such as the bus

or the DART Rail. These options are often crowded, and other riders may not take proper safety precautions such as distancing or wearing masks. Being in an enclosed space close to unmasked individuals posed a major health risk for everyone, but especially those who are immunocompromised. For many PLWHA, this meant they were unable to travel freely to reach services to meet their needs.

Those with transportation challenges were also limited in accessing childcare services. Although they may have been available, they were unable to safely travel to drop their children off. Transportation safety concerns also created challenges for maintaining employment as for many, public transportation is their only way to get to their workplace. Many underserved PLWHA are already challenged with maintaining employment if they are not healthy because of the need to more frequently take time off to seek care.

Underserved populations often lack access to technology or the Internet. Many rely on public spaces, such as the library, when they need to use a computer or go online. With libraries closed their access was cut off. While some were able to transition to use smart phones, there were still many others who did not have phones that would accommodate telehealth visits or other virtual services. For example, one provider reported that government-issued phones are flip phones and do not accommodate video calls. Even individuals with smart phones were not always able to use their email to send documents or do other tasks that require a tablet or computer.

Many Ryan White recipients work hourly wage jobs and as service workers. Their hours were cut during COVID-19 which had a negative impact on their finances. Individuals with lesser incomes generally do not have access to credit cards, which are necessary for having food delivered, which meant they were forced to leave their homes and enter public spaces to get food and other basic needs met. Grocery delivery and Amazon, which so many individuals who have adequate resources relied on during the pandemic, were not options for them.

PLWHA were high risk during COVID-19 which forced some to leave their jobs. Others were concerned about sharing their diagnosis with their employers so they could more easily take care of their health needs during this vulnerable time. There was a reported increase in employment discrimination during this time as employers tried to force them back to work while they were high risk.

Affordable housing was identified as a need in the 2019 Needs Assessment and continues to be a challenge for all underserved populations. They were challenged with maintaining housing and meeting other basic needs before COVID-19, and even more as their income fell after COVID-19. While there was a moratorium on evictions, rent assistance and other help available during the pandemic, as the pandemic assistance is coming to an end many are behind in their rent payments and at risk of being evicted.

COVID-19 restricted in-person connections and isolated individuals. Many of the elderly who have been aging through the system were especially affected as they were "locked in" and unable to engage in social interactions that were important for their well-being. They were most

vulnerable given both their age and being immunocompromised. Loneliness is associated with poorer health and well-being. Providers expressed concern about consumers being re-traumatized with the stigma of the COVID-19 virus and memories of the stigma of HIV.

Black Men who Have Sex with Men (MSM)

Black MSM reported some of the same issues that were identified during the 2019 Needs Assessment. These included access to services and negative provider interactions. Their issues were less COVID-19 related than they were ongoing from before the pandemic.

One prevalent theme was a sense that they were not being provided access to the same types of services. They commented about differential referrals whereby they see others sent to the higher quality “Neiman Marcus” services and they are referred to the “K-Mart” services by the same referral systems.

There is also the perception that as people of color they do not get the same access to health care services, even if they have insurance. The services are often not offered to them. One focus group participant described an incident where he showed up in the Emergency Room of a local hospital without identification and was treated as indigent. Once they found his insurance, they started doing more to care for his needs.

They described the racial disparities with HIV services as “alive and well.” The level of service they receive depends on who they talk to, who is at the front desk, who answers the phone, or just who is there when they walk through the door. Too often the staff at the HIV services organizations, case manager, and people in management positions are not people of color and/or do not have HIV, so they have no idea what their lives are like.

Providers expressed challenges in Black and Latino communities where stigma is highest. It continued to create problems with getting people to be tested and getting HIV positive individuals into care. This is especially true if they are receiving services at places where there is a risk of being identified as HIV positive from being seen there.

Providers reported they had more challenges reaching young Black men. They did not connect or remain engaged virtually. Their program is built around personal interactions and social support. Another provider noted that their services are not located in an area close to where many of the Black PLWHA reside, which requires them to use public transportation to reach them. They did not see many Black PLWHA during the pandemic because of this. Alternatively, another provider who has a site focusing on young Black MSM maintained a peer navigator, case manager, and client advocate and reported that they were able to keep their participants engaged.

Black Women

Black women reported that they have not seen many changes since 2019. Some things were described as having gotten a little better, but the structural inequities continue, and were exacerbated by COVID-19 when everything stopped. There are still issues with the systems of care as described in the prior needs assessment. They felt that not enough was being done. Staff and clinicians still require more education and training (as was identified in 2019). They were described as “not knowing the difference between cultural humility and cultural competency.” There is a need for better communication and true transparency among providers.

The need for representation with more Black women at the table when policies are developed was reiterated by this group. They requested that not only should Black people be at the table, but they should be “effectively” at the table where they are being heard. Too often policies are developed and then presented to consumers to authenticate, and then the policy makers claim they sought input. They are not seeking input throughout the development process where they should be bringing people into the talks during formation. Staff, community members, and everyone should be provided training so they can more effectively engage in these processes.

Black women also described problems with being able to trust some of the doctors they have seen. This was particularly true with some of the clinics as compared to having their own private doctor. They described instances where they have found important health information was withheld from them, including their diagnosis. They also described being given medications for mental illness and sleep problems by physicians who did not even discuss the medications, their purpose, or why they were prescribing them. Policy for the services they receive allows for virtual visits after one in-person visit per year. The women who participated in this focus group expressed that this policy did not always provide them with opportunities for in-person visits when they felt they were necessary. They described the clinics as being like musical chairs – if the music stops some are left out. Black women described a need for improved peer support and social systems that they could rely upon to share information with one another.

Transgender Men and Women

Challenges identified in the 2019 Needs Assessment persisted and were amplified in some ways by COVID-19. Transgender individuals in both focus groups shared that they still encounter disrespect from service providers. Members of one group expressed feelings of disenfranchisement among the LGBTQ community and feelings that even they are unable to relate to their needs and challenges.

Maintaining employment is challenging for many transgender individuals due to discrimination. Some transgender consumers described having their hours cut back and enduring disparaging comments from supervisors. Discriminatory behavior and disrespect were described as especially problematic for those who transition while they are at a workplace as co-workers failed to understand or accept their change.

Transgender men described getting little attention in comparison to transgender women. They felt a need for more attention to their issues as well as more visibility. There is little representation of transgender men, and they have little opportunity to meet or socialize with other transgender men, thus, they and their specific needs are relatively invisible. They expressed interest in someone providing groups where they could safely gather. They have observed instances where transgender men get their hormones from others because they do not feel comfortable or safe seeking them from other sources.

Transgender women expressed continued fear of speaking out given the number of transgender women who have been murdered. They are being killed simply for being themselves which has pushed many transgender women into hiding. Dating can put them in precarious situations and one consumer expressed the importance of letting men know she is transgender up front so there are no questions later, and no chance of a misunderstanding that can later put her in danger.

Transgender consumers noted that for any transgender woman or man, unless they can pass without any questions, that they are transgender is the first thing many people see. They described being "looked at by genitals rather than who they are."

Another challenge they confront is with their names. Many who have not yet had their names legally changed face discomfort when attending events where their government name, rather than their chosen name, is placed on name tags or used to identify them. They are often put in the position of explaining their names and chosen pronouns. Some people continue to call them by their government name or the wrong pronouns, which they view as clearly and purposefully disrespectful.

Some providers have services specifically for transgender consumers, including a transgender clinic. Others reported they are working to improve in this area and offer more specialized services, including affinity groups. Legal services reported an increase in transgender individuals coming forth for name changes and they are offering that service.

The individuals participating in the focus group for transgender men and women were asked for input regarding how the Ryan White Planning Council could encourage and obtain more engagement with representatives of the transgender community. Suggestions were:

- Get into the community and meet with small groups. Ask members to tell a friend, and then another friend, and use word of mouth. Provide food and hold sessions in the evening. Or consider sponsoring lunch or brunch.
- Promote a sense of safety among participants.
- Host mini-conferences with topics of interest.
- When people engage, make sure they are honestly engaged and participating. And when people engage and participate, continue to make them feel welcome and valued.
- Go to where transgender men and women gather rather than asking them to come to where you are. Meet them where they are.

- Host meetings via Zoom whereby transgender individuals can talk, vent, ask questions. Really listen to their frustrations. Ensure their voices are genuinely and completely heard.

Hispanic and Latino/a Men and Women

Concerns described in the focus group with Hispanic/Latino men were generalizable to the entire Hispanic and Latino/a population or the larger population of underserved PLWHA. They described transportation and other problems consistent with those other groups are facing as well. Many of the challenges that were present before COVID-19 continued and were exacerbated by the pandemic.

For Hispanic and Latino/a PLWHA, language barriers continue as there are still too few Spanish speaking case managers and other providers. Focus group participants reported one Spanish speaking case manager available to them and insufficient Latino/a representation among services. They also stated that the providers have acknowledged the problem and are working on it.

Service providers admitted to difficulties keeping the Latino/a community engaged because so many were essential workers and continued to work. It was difficult to engage them virtually while they were at work. Many did not have access to the technology needed to engage virtually, which affected services to them.

Language barriers were challenges for service providers. They often used language lines to translate for telemedicine appointments. Some have Spanish speaking staff, others described difficulties finding bilingual service providers given the rate they can afford to pay. Spanish speaking professionals are often in demand so they are able to choose higher paying jobs.

One provider whose center holds groups for Latina women was challenged as they were unable to continue meeting. They were also unable to continue outreach to the Latino/a communities.

Youth

While we were unable to gather information directly from youth via the focus groups, providers provided some insights into challenges experienced by youth. One provider reported that they have youth who visit multiple times per week for peer support and interaction. When they closed the doors during COVID-19 that option was no longer available to them.

Another youth services provider experienced a decline in retention. To date, they have not been able to bring the youth back, as they perceived they were taking advantage of restrictions against leaving their homes. This was reinforced by another provider who reported they did not see many newly diagnosed consumers and youth. They are challenged with where to go to give them needed information.

Other Underserved Populations that were Identified

Providers mentioned other populations that were underserved in addition to those identified in the prior needs assessment and for this interim project. Further information is provided about them below.

Rural Populations

Rural populations were described as having challenges as well, especially access to services and medications. One provider requested tablets for their consumers living in rural areas so they would be able to engage in telehealth on a regular basis. Transgender individuals residing in rural areas face additional challenges as they often do not have access to needed hormones.

Uninsured

Sometimes uninsured individuals are challenged when seeking health care services outside of the Ryan White system, such as emergency medical services. There is the perception that when they are in an emergency room or similar situation the medical providers slow down what they are doing and offer less care depending on the ability to pay.

Incarcerated Individuals

There was little opportunity for outreach to incarcerated individuals during the pandemic. Providers were unable to reach them with education and resources.

Unhoused PLWHA

Several providers mentioned challenges serving the unhoused population during COVID. Outreach services were curtailed during this time, and many individuals who are unhoused lack technology or even basic telephones. One provider developed a relationship with the police to help to find them. They dropped off food and other needed supplies, including hygiene packs, to shelters where they knew their unhoused participants were staying.

Unhoused individuals were challenged during COVID-19 as shelters were forced to cut their capacity to meet public health recommendations. More unhoused individuals were referred for permanent housing during this time.

Current Unmet Needs

Consumers and service providers described many continuing and new unmet needs. Many PLWHA still have problems getting their most basic needs met. Clothing is a need for many women. They described a need for a clothing store where they would be able to obtain what they need. Access to healthy food is problematic for those who are living in food deserts. They expressed a desire to be able to eat better to help control cholesterol and diabetes. Resources

for exercise are also inaccessible for many PLWHA, which has made it difficult for them to maintain a healthy weight. As long as COVID-19 continues to threaten health, money for effective masks and other personal protective equipment is needed.

Many PLWHA are challenged with finding jobs or getting better jobs. Some lack job search knowledge and skills and others need more education. Getting a job sometimes requires having enough money to prepare a professional resume, dress for interviews, and pay for other self-presentation related needs to be more competitive in the employment market such as a good haircuts, makeup, and dental care. Many were denied unemployment and needed help with appeals. Others needed assistance with accessing other funds that were available through the stimulus packages. During COVID-19 many consumers left their jobs that required them to interact with the public. It was too high risk for them, especially prior to the availability of vaccines. Some also felt uncomfortable disclosing their status to employers to be able to take extra precautions needed.

While Ryan White provides funding for dental services, there is still not enough dental care available. The services that are available are often overloaded. Providers described a need for payment and arrangements with private dentists to treat patients. Limitations on the ability to provide dental services throughout the pandemic and added precautions has resulted in delays and appointments being pushed back.

Housing continues to be a challenge, especially with the current housing market whereby prices and rents are continuing to rise. Housing for individuals and families with moderate or low incomes has long been in short supply. Now it is becoming in even shorter supply and making it increasingly difficult for many to find or maintain housing. Housing assistance has been available during the pandemic, however individuals whose incomes exceed guidelines but have expenses from medical care and other needs are unable to access it.

COVID-19 was of such urgency that other medical problems took a back seat throughout the pandemic. Primary care physicians did not always provide enough quality time to get questions answered. They felt a need for better communication between themselves and medical staff, with added focus on their quality of life.

The isolation and fear of contracting or transmitting COVID-19 left some consumers with mental health problems, such as anxiety and depression. Consumers described the period as very stressful as they had to make so many adaptations. Providers also noticed increased stress and mental health concerns among those they served. The isolation was especially harmful for those who already had mental health challenges. One provider noted having to do three mental health warrants for consumers who were in a psychotic state.

Transportation continues to be a problem, especially for those who do not reside or work in areas where public transportation is available. They are forced to rely on private modes such as Uber, Lyft, or cab fare which can be expensive. Even simple errands such as trips to the grocery store or pharmacy became expensive. As many whose incomes are near or below poverty levels or those who have experienced credit problems from mounting medical bills or other financial

challenges lack access to credit cards, delivery was not an option. Those who reside in areas where public transportation is available found it risked their health given crowded conditions and the number of riders who did not wear masks. Consumers requested they be allowed gas money in lieu of bus tickets.

Transportation challenges also persist for PLWHA who have disabilities, such as those who are unable to walk. Providers were reported to recommend transportation services that are not accessible even after they are told about the disabilities. In addition to providing transportation, there is a need for assistance with tasks such as shopping, such as someone to help carry everything back to their homes.

Learning about what services and assistance is available is still challenging for many PLWHA. Information is seldom volunteered and obtaining complete and accurate information is often challenging. Many currently rely on knowledge being passed from others, which is an entirely random process. Consumers recommended a centralized resource guide that continues to provide current information. Consumers voiced a need for resources available in a single location where they would be able to get all their needs met. This would reduce the need to provide transportation to multiple sites and would make it easier for those who need information about services.

Experience with Vaccinations

Successes with Vaccinating PLWHA

Providers made many efforts to ensure patients were vaccinated. PLWHA were considered priority. The providers reported having much success with the populations they served. They provided on-site vaccination clinics, transportation to vaccination clinics, and providers also connected them with appointments, accurate information, and ample encouragement. Some attended special training to learn how to encourage people and get past hesitancy. Most reported all or nearly all their staff were vaccinated. Many reported higher than average vaccination rates among those they serve. Nearly all the consumers who participated in the focus groups were vaccinated.

Challenges with Vaccinating PLWHA

Providers reported that challenges with vaccinating PLWHA were no different than those being reported for the general population. These include mistrust, misinformation, hesitancy as they wait to see how others react, and questions about safety and efficacy. There are especially challenges with individuals with mental health problems. Providers reported they are promoting vaccinations, and even giving gift cards to staff to ensure they are fully vaccinated.

Some consumers expressed vaccine hesitancy. One consumer was hesitant to get vaccinated until they decided to get it so they could access services. Others expressed a need for more accurate information to be spread. They described many people they knew who were afraid of

the vaccine or feared the side effects. They heard stories of people who fainted or died from it. Consumers in one group admitted they knew more people who died from COVID-19 and reported they lost many friends, acquaintances, and family members to it.

Impact of the Vaccination on Consumers

Many consumers reported that receiving the vaccination gave them some peace of mind. It increased their comfort level with going to more crowded places, although they still wear masks and socially distance from others. It has allowed them to reduce their isolation. Consumers reported they are still avoiding unvaccinated friends and family members, even with the vaccine.

Some are still hesitant to go places and wear masks near all people, reporting they are still as afraid of COVID-19 as they were when it first came out. They feel that having HIV makes them much more vulnerable, even with the vaccine.

Some consumers reported they experienced side effects, such as a sore arm or tiredness from the vaccine but were still fine. Consumers who reported they had COVID-19 described much more discomfort from the disease such as pain and chills compared with getting the vaccine.

COVID-19 Impact on Other Vaccinations

Some providers expressed that COVID-19 had taken over and they heard little about any other vaccines. Others reported that their clients received all the needed vaccines. Medical providers reported they administered a high number of flu vaccines and had no challenges convincing people to get it.

Suggestions

Providers and consumers reported that access to services remains a challenge for all underserved populations. Consolidation of more services is needed (clinics, pharmacy, food, dental, housing assistance) so that underserved populations can go to only one provider instead of several. Also, if someone has multiple appointments at multiple organizations, that can interfere with their ability to obtain and maintain employment. More flexible services with after hours and weekend availability are needed.

In addition to time and geography, access to some services is limited culturally. Some consumers expressed they have received poor service and others feel the services are not culturally accessible having experienced microaggressions from staff. Cultural humility training and creating a culture that is accepting and comfortable for all individuals is important, especially when serving vulnerable populations such as PLWHA.

Consider exploring transportation alternatives to public transportation that is crowded and unregulated for safety precautions in the event there is another pandemic or similar threat posed to PLWHA.

More case managers who have HIV and are persons of color are needed. More efforts need to be made to recruit more case managers to resemble the population they are serving. If there are too few qualified individuals available, consider investing in supporting individuals to obtain their Community Health Worker certification. This minimal investment would go far to increase the pool of available workers.

Future Needs Assessments

When asking questions about housing needs, be sure to ask if they are already in a program funded by HOPWA or Ryan White. This is important because it substantiates the continued need for housing support. If a disproportionate number of individuals who are housed through these services respond to the needs assessment survey and report they have no needs for housing, the result may be interpreted as less need for these programs, although there is clearly still a high need.

Consider expanding the focal populations for future needs assessments to include representation from rural populations. In the 2019 Needs Assessment and for this one, large portions of the EMA were not represented. Also, it is important to more fully incorporate the Sherman-Dennison EMA which also represents a large, mostly rural population.

Finally, begin conducting outreach to underrepresented populations as soon as possible to prepare for the 2022 needs assessment. Work to engage the consultant who will conduct the assessment soon to provide sufficient time for outreach and relationship building ahead of time. This will ensure a more participatory process by more individuals and more underrepresented populations for more accurate and representative results. The Request for Applications should go out no later than October 2021 to complete the needs assessment by the end of January 2023.

Appendix A: Key Informant Interview Protocol

RWNA-Mini Key Informant Interview Protocol

Introduction

Thank you for agreeing to talk with us today about your experience with providing Ryan White services. My name is Dr. Susan Wolfe and I have been asked by The Ryan White Planning to speak with you about your experience.

This interview is part of a mini-needs assessment. The Ryan White Planning Council's Needs Assessment Committee will use this information to inform future work and for quality improvement.

Before we get started, I want to let you know that:

- ✓ We appreciate your time and honest opinions about these topics.
- ✓ You do not have to answer any questions that make you feel uncomfortable, and you can stop or even leave the call any time you want.
- ✓ The information you provide today will be confidential. The information will be shared with The committee, but you will not be personally identified.
- ✓ I would like to record the conversation today just so I can go back and make sure I have captured your thoughts accurately. I will erase it as soon as I write a summary of the main points from today's talk.

Do I have your permission to record this conversation?

Do you have any questions before we begin?

Let's start by talking about the 2019 Needs Assessment.

1. Did you have an opportunity to read or hear about the results of the needs assessment?
 - a. (If yes) Did you make any changes in your organization or to your services based on the findings?

Now I would like to learn more about how COVID has affected your organization and services you provide.

2. How did COVID affect your service delivery?
 - a. What changes did you need to make because of COVID?

- b. How did COVID impact your organization and services. Please share both good and bad effects.
 - c. How did COVID impact your service delivery processes, or how your services are delivered? Specifically:
 - i. Did you engage in telehealth or telemedicine?
 - ii. Was there any impact on timelines for medications?
 - iii. Did you change intake processes?
 - iv. Was the recertification process changed?
 - v. What other processes changed?
 - vi. What policies were changed?
 - d. Did you adopt new service delivery models?
 - i. (if yes) Please describe them.
 - ii. (if yes) What features of the new service delivery models do you plan to retain when you are able to return to business as usual (if any)?
 - e. What did you learn about service delivery from your experience managing COVID that can be useful for you or for others to know as you move forward?
3. How did COVID affect your ability to respond to needs and conduct outreach to each of the groups that I will name?
- a. Black men who have sex with men (MSM)
 - b. Transgender individuals
 - c. Hispanic/Latinx women
 - d. Hispanic/Latinx men
 - e. Black women
 - f. Youth
4. Based on your observations and experience, what challenges have you seen among the underserved populations I described? (*probe for each of the groups if they are relevant*)
- a. Please share challenges that have persisted since before COVID?
 - b. Now please share challenges that were specifically related to COVID?
5. Based on your observations and experience, what successes have you seen or heard of in regard to vaccinating PLWHA?
6. Based on your observations and experience, what challenges have you seen or heard of in regard to vaccinating PLWHA?
- a. Has there been COVID related impact on other vaccinations, i.e., pneumonia and flu).

Thank you for taking time to talk with me today and sharing this information. Is there anything else you would like to talk about or share before we end the interview?

Appendix B: Focus Group Protocol

RWNA-Mini Focus Groups Protocol

Introduction

Hello. My name is Susan Wolfe and I am working to gather information for an interim Ryan White Needs Assessment. As part of the information gathering, we are doing a series of focus groups like this one to gather information from people living with or affected by HIV/AIDS. It is important for you to know that whatever you say in this space is confidential. We will not be reporting on who participated in the focus groups, nor will we be sharing any information that will identify you. Your responses will be analyzed with the responses from all groups and used to identify and report on service needs. Before we start, it would be helpful to get to know each other a little. Can you each please tell me the name that you want to be known by here?

Now, I would like to ask if I have permission to record this session. These recordings will be heard only by me and they will be protected on my secure drive.

Do I have your permission to record this conversation?

Do you have any questions before we begin?

- 1. What changes did you see in prevention and care that can be attributed to the needs assessment findings (if any)?**
- 2. How did COVID affect your access to prevention services and care, or access of people who know?**
 - a. How did it affect access to medications?**
 - b. How did it affect adherence to medication protocols?**
- 3. How did you or people you know experience changes providers made to adapt to COVID?**
 - a. What worked well?**
 - b. What could be done differently?**
- 4. Have you received a vaccination, or do you plan to receive one?**
 - a. (If yes) How has this affected your life?**
 - b. (If no) Why not?**

5. What needs do you still have that are not being met? (*probe specific to each group, based on needs and challenges identified from the last needs assessment*)

Questions to ask both youth groups

6. What are their concerns as young people?
 - a. The Ryan White Planning Council would like more involvement of youth (ages 13-24). What do you think might be a good way to get youth interested in participating?

Questions to ask high-risk youth not living with HIV

7. What ideas do you have to reach out and encourage more youth to be tested for HIV?
 - a. What do you think keeps them from being tested?
8. How much do you know about PEP and PREP?
 - a. Where do you usually get your information about sexual health?
 - i. Do you feel like you know all you need to know, or would you like resources for more information?

Questions to ask Transgender group

9. The Ryan White Planning Council would like more involvement from the Transgender community. What do you think would be a good way to engage with Transgender individuals and bring them to the table?
 - a. What are the barriers to engagement?

Thank you for taking time to talk with me today and share this information. Is there anything else you would like to talk about or share before we end the focus group?