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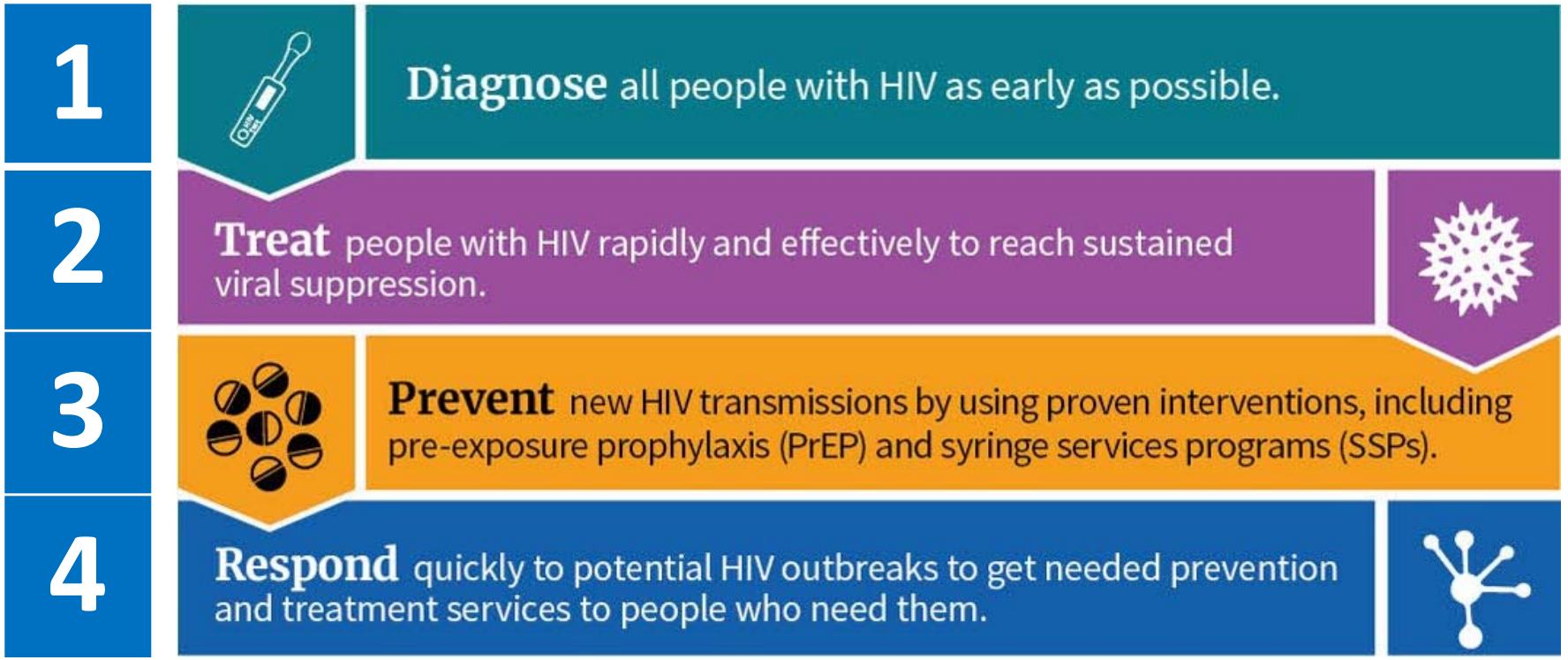
# FY 2021
# How to Best Meet The Need
# Special Workgroup

Report Prepared by:

Ryan White Grant Administration

# ENDING THE HIV EPIDEMIC 2020 TREATMENT WORKPLAN

# Ending the HIV Epidemic – Pillar 2



# Community Feedback

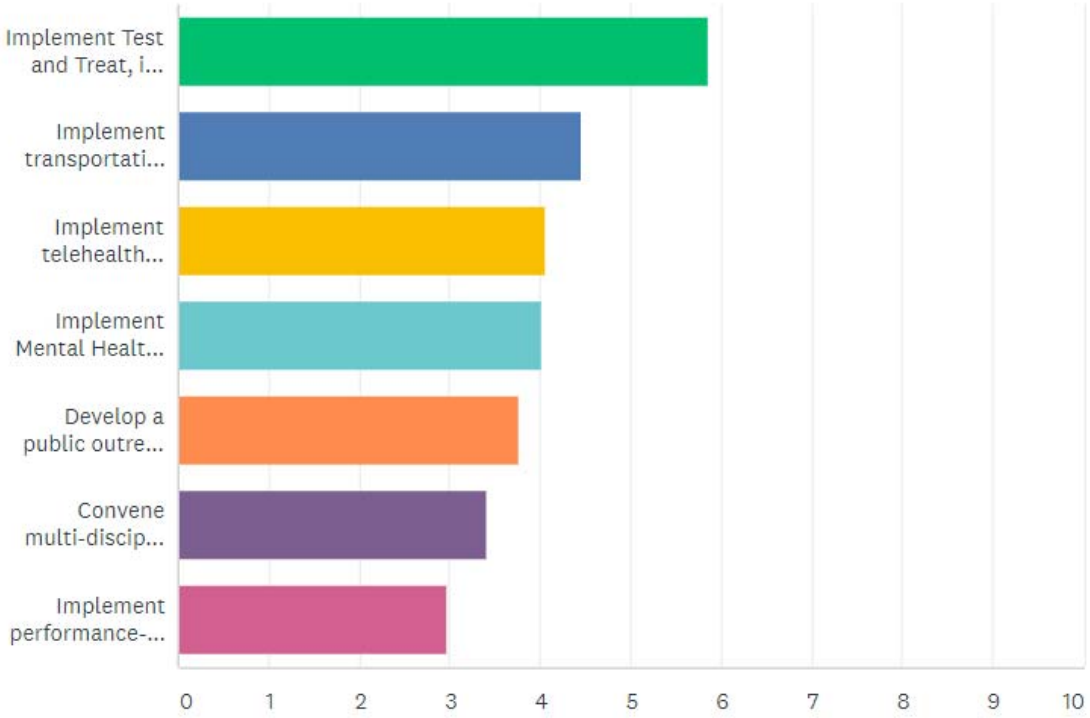
1. Please rank the following activities, with 1 being the activity you would most like to see implemented.

- Implement transportation program that utilizes ride sharing providers such as Uber and Lyft for newly diagnosed and return to care people living with HIV (PLWH).
- Implement telehealth mobile app that facilitates treatment adherence and reduces stigma designed specifically for newly diagnosed and return to care PLWH.
- Implement Mental Health Medical Case Management services for those newly diagnosed with HIV or returning to care.
- Implement Test and Treat, i.e. the initiation of HIV medications within 72 hours of HIV diagnosis, at current Ryan White Part A Primary Care providers for newly diagnosed and return to care patients.
- Develop a public outreach campaign to educate PLWH on accessing treatment services and de-stigmatize HIV.
- Convene multi-disciplinary Case Review Team to examine service delivery gaps and opportunities in vulnerable populations where linkage and viral suppression goals are unmet.
- Implement performance-based HIV treatment contracts for Ryan White service provider subrecipients

# Community Feedback Results

Please rank the following activities, with 1 being the activity you would most like to see implemented.

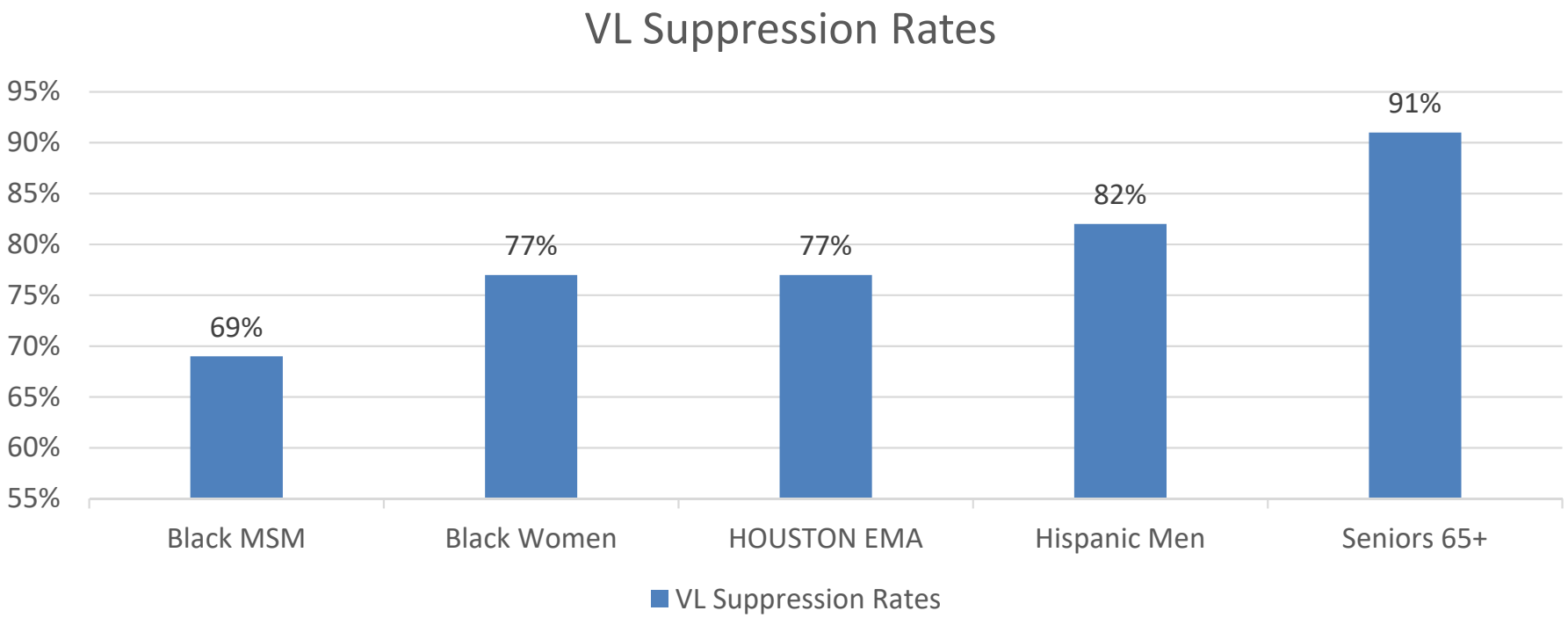
Answered: 56 Skipped: 0



# Test and Treat

- Rapid ART initiation should be offered to all people living with HIV following a confirmed HIV diagnosis and clinical assessment.
- Rapid initiation is defined as within seven days from the day of HIV diagnosis; people with advanced HIV disease should be given priority for assessment and initiation.
- Guidelines for Managing Advanced HIV Disease and Rapid Initiation of Antiretroviral Therapy. Geneva: World Health Organization; 2017. 3, RECOMMENDATION FOR RAPID INITIATION OF ART. Available from: https://www.ncbi.nlm.nih.gov/books/NBK475972/

# Ending the HIV Epidemic –Challenges



# Next Steps

- Encourage initiation of rapid HIV care and treatment to achieve viral suppression and stop transmission.
- Develop opportunities to sustain improvement momentum gained in increasing viral suppression rates and decreasing disparities.
- Engage with a community population that reflects the current Houston epidemic to implement tailored interventions for care and treatment service delivery.

# EMERGENCY FINANCIAL ASSISTANCE

# HRSA SERVICE DEFINITIONS

# Emergency Financial Assistance

***Description:***

- Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

***Program Guidance:***

- Direct cash payments to clients are not permitted.
- It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

# Food Bank/Home Delivered Meals

***Description:***

- Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:
  - Personal hygiene products
  - Household cleaning supplies
  - Water filtration/purification systems in communities where issues of water safety exist

***Program Guidance:***

- Unallowable costs include household appliances, pet foods, and other non-essential products.

# Housing

***Description:***

- Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services.
- Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation.
- Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

***Program Guidance:***

- RWHAP Part recipients must have mechanisms in place to allow newly identified clients access to housing services. Upon request, RWHAP recipients must provide HAB with an individualized written housing plan, consistent with RWHAP Housing **HIV/AIDS BUREAU POLICY 16-02**

# Core Medical vs Support Services

- The Ryan White Care Act requires that grantees expend not less than 75 percent of their grant funds on core medical services.
- Per applicable Ryan White Policy Clarification Notices, Emergency Financial Assistance, Food Bank, and Housing are Support Services restricted to no more than 25% of EMA expenditures.
- FY 18 Houston EMA Core Expenditures were 86%

# Ryan White is Payer of Last Resort

- Some Area Emergency Financial Assistance Programs
  - Memorial Assistance Ministries
  - Gulf Coast Community Services
  - My Brother's Keeper
  - BakerRipley
  - City of Houston – HOPWA Program

# The Housing Opportunities for Persons With AIDS (HOPWA)

- Administer through U.S. Department of Housing and Urban Development (HUD)

- The HOPWA program is the only federal housing program solely dedicated to providing rental housing assistance for persons and their families living with HIV/AIDS. The program provides states and localities with resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of low-income persons living with HIV/AIDS. HOPWA housing support enables these special-needs households to establish or maintain stable housing, reduce their risks of homelessness, and improve their access to healthcare and other support.

- Grants may be used to provide a variety of forms of rental housing assistance, including emergency and transitional housing, shared housing arrangements, community residences, and single room occupancy dwellings (SROs). Appropriate supportive services are provided as part of any assisted housing. **Eligible grant activities include housing information, resource identification, and permanent housing placement; acquisition, rehabilitation, conversion, lease, and repair of facilities to provide short-term shelter and services; new construction (for SROs and community residences only); project- or tenant-based rental assistance, including assistance for shared housing arrangements; short-term rent, mortgage, and utility payments; operating costs; technical assistance for community residences; administrative expenses; and supportive services, including case management.**

# Estimated City of Houston HOPWA FY20 Funding

- FY20 Formula: $10,315,585
- FY20 Coronavirus Aid, Relief, and Economic Security Act (CARES): $1,501,211
  - Source: https://www.hud.gov/program_offices/comm_planning/budget/fy20/

# CARES Act Supplemental Award Information for HOPWA Grantees

**Use of Grant Funds**

The supplemental funds provided under the CARES Act are to be used by HOPWA grantees as additional funding to maintain operations and for rental assistance, supportive services, and other necessary actions, in order to prevent, prepare for, and respond to coronavirus. The supplemental award may be used to reimburse allowable costs incurred prior to the receipt of the award provided such costs were used to prevent, prepare for, or respond to COVID-19.

Activities for which grantees may use the supplemental grant funds include, for example:

- Assisting HOPWA eligible households in accessing essential services and supplies such as food, water, medications, medical care, and information
- Educating assisted households on ways to reduce the risk of getting sick or spreading infectious diseases such as COVID-19 to others
- Providing transportation services for eligible households, including costs for privately-owned vehicle transportation when needed, to access medical care, supplies, and food or to commute to places of employment
- Providing nutrition services for eligible households in the form of food banks, groceries, and meal deliveries
- Providing lodging at hotels, motels, or other locations to quarantine HOPWA-eligible persons or their household members
- Providing short-term rent, mortgage, and utility (STRMU) assistance payments to prevent homelessness of a tenant or mortgagor of a dwelling for a period of up to 24 months

# Ending the HIV Epidemic: A Plan for America

**HHS is proposing a once-in-a-generation opportunity to eliminate new HIV infections in our nation. The multi-year program will infuse 48 counties, Washington, D.C., San Juan, Puerto Rico, as well as 7 states that have a substantial rural HIV burden with the additional expertise, technology, and resources needed to end the HIV epidemic in the United States. Our four strategies – diagnose, treat, protect, and respond – will be implemented across the entire U.S. within 10 years.**

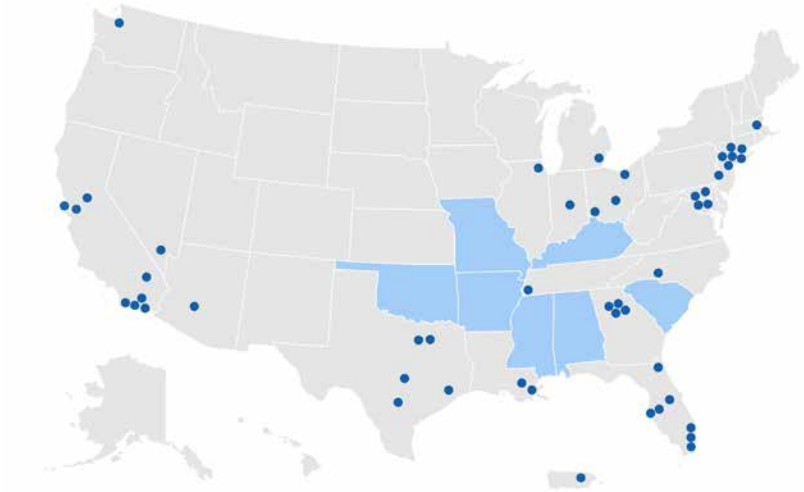
## GOAL:

**75%** reduction in new HIV infections in 5 years and at least **90%** reduction in 10 years.

Our goal is ambitious and the pathway is clear – employ strategic practices in the *places* focused on the right *people* to:

- **Diagnose** all people with HIV as early as possible after infection.
- **Treat** the infection rapidly and effectively to achieve sustained viral suppression.
- **Protect** people at risk for HIV using potent and proven prevention interventions, including PrEP, a medication that can prevent HIV infections.
- **Respond** rapidly to detect and respond to growing HIV clusters and prevent new HIV infections.
- **HIV HealthForce** will establish local teams committed to the success of the Initiative in each jurisdiction.

## The Initiative will target our resources to the 48 highest burden counties, Washington, D.C., San Juan, Puerto Rico, and 7 states with a substantial rural HIV burden.



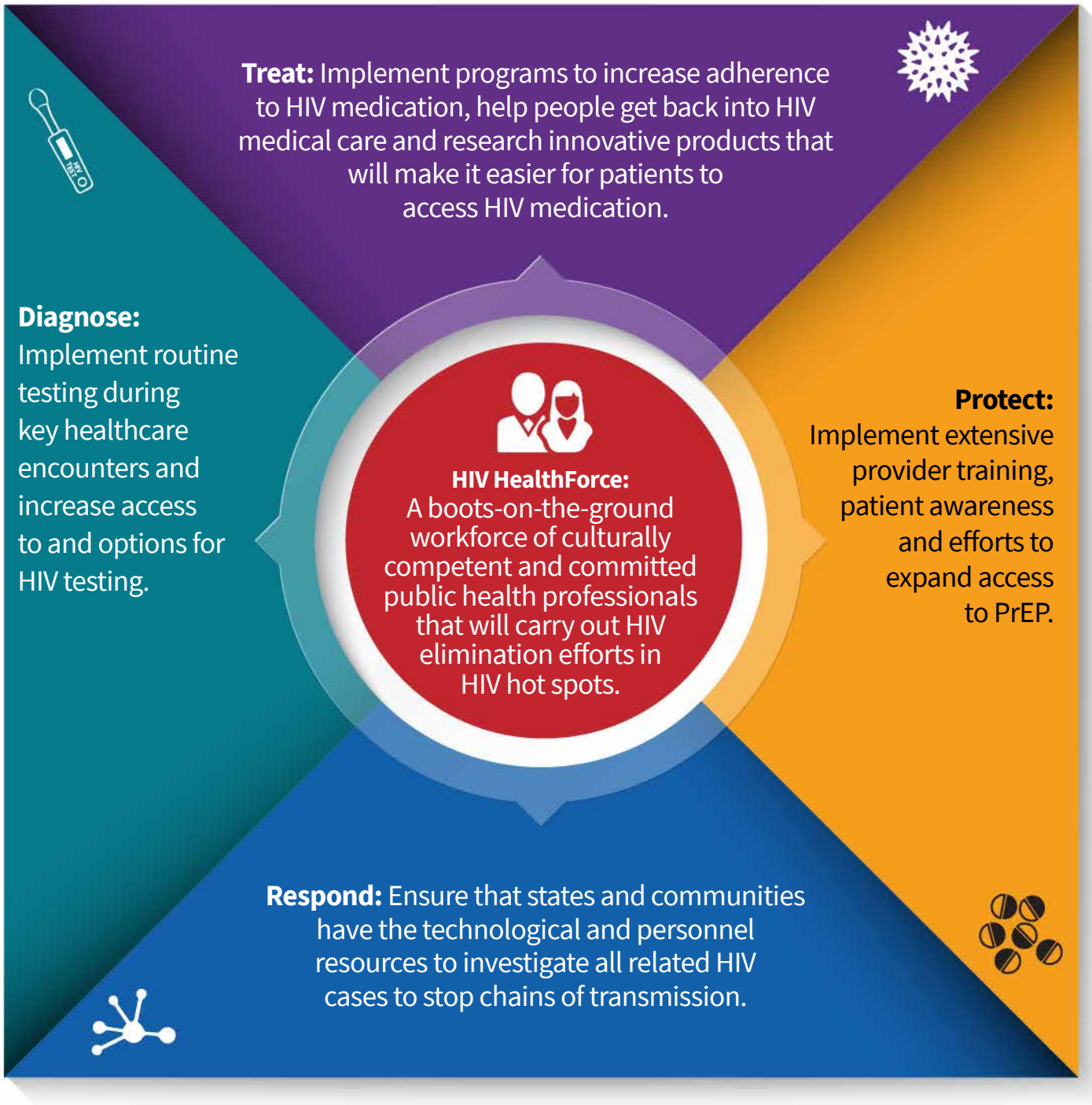
**Geographical Selection:**
Data on burden of HIV in the US shows areas where HIV transmission occurs more frequently. More than 50% of new HIV diagnoses* occurred in only 48 counties, Washington, D.C., and San Juan, Puerto Rico. In addition, 7 states have a substantial rural burden – with over 75 cases and 10% or more of their diagnoses in rural areas.

*2016-2017 data

Ending the HIV Epidemic | www.HIV.gov

# Ending the HIV Epidemic – Key Strategies:

**Achieving elimination will require an infusion of resources to employ strategic practices in the right places targeted to the right people to maximize impact and end the HIV epidemic in America. Key strategies of the initiative include:**



EDITORIAL

# Ending the HIV Epidemic
## A Plan for the United States

Anthony S. Fauci, MD; Robert R. Redfield, MD; George Sigounas, MS, PhD; Michael D. Weahkee, MHA, MBA; Brett P. Giroir, MD

**In the State of the Union Address** on February 5, 2019, President Donald J. Trump announced his administration's goal to end the HIV epidemic in the United States within 10 years. The president's budget will ask Republicans and Democrats to make the needed commitment to support a concrete plan to achieve this goal. While landmark biomedical and scientific research advances have led to the development of many successful HIV treatment regimens, prevention strategies, and improved care for persons with HIV, the HIV pandemic remains a public health crisis in the United States and globally.

Supplemental content

In the United States, more than 700 000 people have died as a result of HIV/AIDS since the disease was first recognized in 1981, and the Centers for Disease Control and Prevention (CDC) estimates that 1.1 million people are currently living with HIV, about 15% of whom are unaware of their HIV infection.[1] Approximately 23% of new infections are transmitted by individuals who are unaware of their infection and approximately 69% of new infections are transmitted by those who are diagnosed with HIV infection but who are not in care.[2] In 2017, more than 38 000 people were diagnosed with HIV in the United States. The majority of these cases were among young black/African American and Hispanic/Latino men who have sex with men (MSM). In addition, there was high incidence of HIV among transgender individuals, high-risk heterosexuals, and persons who inject drugs.[1] This public health issue is also connected to the broader opioid crisis: 2015 marked the first time in 2 decades that the number of HIV cases attributed to drug injection increased.[3] Of particular note, more than half of the new HIV diagnoses were reported in southern states and Washington, DC. During 2016 and 2017, of the 3007 counties in the United States, half of new HIV diagnoses were concentrated in 48 "hotspot" counties, Washington, DC, and Puerto Rico.[4]

The US Department of Health and Human Services (HHS) has proposed a new initiative to address this ongoing public health crisis with the goals of first reducing numbers of incident infections in the United States by 75% within 5 years, and then by 90% within 10 years. This initiative will leverage critical scientific advances in HIV prevention, diagnosis, treatment, and care by coordinating the highly successful programs, resources, and infrastructure of the CDC, the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Indian Health Service (IHS). The initial phase, coordinated by the HHS Office of the Assistant Secretary of Health, will focus on geographic and demographic hotspots in 19 states, Washington, DC, and Puerto Rico, where the majority of the new HIV cases are reported, as well as in 7 states with a disproportionate occurrence of HIV in rural areas (eFigure in the Supplement).

The strategic initiative includes 4 pillars:

1. diagnose all individuals with HIV as early as possible after infection;
2. treat HIV infection rapidly and effectively to achieve sustained viral suppression;
3. prevent at-risk individuals from acquiring HIV infection, including the use of pre-exposure prophylaxis (PrEP); and
4. rapidly detect and respond to emerging clusters of HIV infection to further reduce new transmissions.

A key component for the success of this initiative is active partnerships with city, county, and state public health departments, local and regional clinics and health care facilities, clinicians, providers of medication-assisted treatment for opioid use disorder, and community- and faith-based organizations.

The implementation of advances in HIV research achieved over 4 decades will be essential to achieving the goals of the initiative. Clinical studies serve as the scientific basis for strategies to prevent HIV transmission/acquisition. In this regard, as reviewed in a recent Viewpoint in *JAMA*,[5] large clinical studies have recently proven the concept of undetectable = untransmittable (U = U), which has broad public health implications for HIV prevention and treatment at both the individual and societal level. U = U means that individuals with HIV who receive antiretroviral therapy (ART) and achieve and maintain an undetectable viral load do not sexually transmit HIV to others.[5] U = U will be invaluable in helping to counteract the stigma associated with HIV, and this initiative will create environments in which all people, no matter their cultural background or risk profile, feel welcome for prevention and treatment services.

Results from numerous clinical trials have led to significant advances in the treatment of HIV infection, such that a person living with HIV who is properly treated and adherent with therapy can expect to achieve a nearly normal lifespan. This progress is due to antiviral drug combinations drawn from more than 30 agents approved by the US Food and Drug Administration (FDA), as well as medications for the prevention and treatment regimens of HIV-associated coinfections and comorbidities. Furthermore, PrEP with a daily regimen of 2 oral antiretroviral drugs in a single pill has proven to be highly effective in preventing HIV infection for individuals at high risk. In addition, postexposure prophylaxis provides a highly ef-

fective means of preventing transmission from a high-risk exposure and can serve as a bridge to PrEP.

Collectively, these advances suggest that, theoretically, the HIV epidemic in this country could be ended quickly by expanding access to treatment to all persons with HIV and PrEP to all those at high risk. The administration has developed a practical, achievable plan to focus on hotspots of HIV infection, both demographic and geographic. Lessons learned and effective strategies emanating from this initiative would ultimately be applied to profoundly reduce HIV incidence nationwide through federal, state, and local health departments and nongovernmental organizations.

In the developing world, particularly in Africa, the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria have helped close gaps in HIV treatment and prevention implementation and have addressed disparities between resource-rich and resource-limited nations. PEPFAR has brought the HIV global pandemic from crisis toward control and replaced death and despair with hope and life. The latest results achieved by US leadership and partnerships through PEPFAR, the Global Fund, and other organizations are estimated to have saved more than 21.7 million lives. PEPFAR alone is supporting more than 14.6 million people with lifesaving ART, when just 50 000 people were receiving ART in Africa at the start of the PEPFAR program in 2003.[6]

Demographic and geographic hotspots of HIV infection need a particular focus to interrupt or disrupt the kinetics of HIV spread in the United States. The coordinated multi-HHS agency initiative will provide this focus. The HRSA Ryan White HIV/AIDS Program (RWHAP) has achieved remarkable success in implementing quality HIV treatment and care. For 2017, the program reports that 85% of individuals who had at least 1 medical visit had achieved viral suppression, far exceeding the national average of 60% of HIV-diagnosed adults and adolescents. The RWHAP has significantly increased the rate of viral suppression among key populations including women, transgender individuals, black/African American individuals, adolescents and young adults, and those with unstable housing.[7]

Using this experience, HRSA will accelerate its efforts working with state and county health departments and community and faith-based organizations to play a major role in the HHS initiative to end the US HIV epidemic. The RWHAP provides the infrastructure, personnel, and expertise for effective treatment and medical intervention strategies. The CDC will be critical for this initiative by amplifying its existing programs and working in communities along with state and local health authorities to bring HIV testing to all who need it, to diagnose infections as early as possible, to conduct epidemiologic investigations of new HIV clusters, and to promote rapid linkage to comprehensive care in the RWHAP. The HRSA Health Centers Program will provide PrEP services to those identified at high risk for HIV acquisition and care for those with HIV. The IHS will focus on urban and rural tribal communities, ensuring that emerging threats are addressed and effective programs and services are marshaled in these communities to address the 4 pillars of the strategic initiative. To expand access to treating HIV, the IHS has published PrEP guidelines for local use and customization and developed electronic health record clinical reminders to assist clinical staff.

The NIH's Centers for AIDS Research will inform HHS partners in this initiative on best practices, based on state-of-the-art biomedical research findings, and by collecting and disseminating data on the effectiveness of approaches used in this initiative. In addition to syringe services programs, access to FDA-approved medication-assisted treatment for substance use disorders, in concert with counseling/behavioral services, is critically important. SAMHSA's efforts to increase providers of medication-assisted treatment, particularly in the hotspots, will help control the spread of HIV, providing access for intravenous drug users with substance use disorder and HIV to receive the treatment they need.

The president, the secretary of HHS, and members of the department are committed to ending the HIV epidemic in the United States. The president's budget will propose a way forward on this bold initiative to achieve this goal.

## ARTICLE INFORMATION

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**Conflict of Interest Disclosures:** None reported.

## REFERENCES

1. Department of Health and Human Services, Centers for Disease Control and Prevention. HIV in the United States and dependent areas. https://www.cdc.gov/hiv/statistics/overview/ataglance.html. Updated January 29, 2019. Accessed February 5, 2019.

2. Frieden TR, Foti KE, Mermin J. Applying public health principles to the HIV epidemic: how are we doing? *N Engl J Med*. 2015;373(23):2281-2287. doi:10.1056/NEJMms1513641

3. Department of Health and Human Services, Centers for Disease Control and Prevention. NCHHSTP AtlasPlus. https://www.cdc.gov/nchhstp/atlas/index.htm. Published August 30, 2017. Accessed February 4, 2019.

4. Department of Health and Human Services, Centers for Disease Control and Prevention. HIV Surveillance Report 2017. https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

5. Eisinger RW, Dieffenbach CW, Fauci AS. HIV viral load and transmissibility of HIV infection: undetectable equals untransmittable. *JAMA*. 2019;321(5):451-452. doi:10.1001/jama.2018.21167

6. Joint United Nations Programme on HIV and AIDS. Global HIV & AIDS Statistics—2018 Fact Sheet. http://www.unaids.org/en/resources/fact-sheet. Accessed February 5, 2019.

7. Mandsager P, Marier A, Cohen S, Fanning M, Hauck H, Cheever LW. Reducing HIV-related health disparities in the Health Resources and Services Administration's Ryan White HIV/AIDS Program. *Am J Public Health*. 2018;108(S4):S246-S250. doi:10.2105/AJPH.2018.304689

# ★ ROADMAP ★

# TO ENDING THE HIV EPIDEMIC IN HOUSTON

~December 2016~

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## ACCESS TO CARE

*The vision of the access to care work group is to ensure all residents of the Houston Area receive proactive and timely access to comprehensive and non-discriminatory care to prevent new diagnoses, and for those living with HIV/AIDS to achieve and maintain viral suppression.*

### Recommendation 1: Enhance the health care system to better respond to the HIV/AIDS epidemic

The ability of the local health care system to appropriately respond to the HIV/AIDS epidemic is a crucial component to ending the epidemic in Houston. FQHCs, in particular, represent a front line for providing comprehensive and appropriate access to care for people living with HIV/AIDS. While we acknowledge the commitment of many medical providers to provide competent care, ending the epidemic will require a more coordinated and focused response.

**Ending the epidemic will require a more coordinated and focused response.**

Some specific actions include:

- Develop a more coordinated and standard level of HIV prevention services and referrals for treatment, so that patients receive the same type and quality of services no matter where care is accessed.
- Integrate a women-centered care model approach to increase access to sexual and reproductive health services. Women-centered care meets the unique needs of women living with HIV and provides care that is non-stigmatizing, holistic, integrated, and gender-sensitive.
- Train more medical providers on the Ryan White care system.
- Explore feasibility of implementing a pilot rapid test and treat model, in which treatment would start immediately upon receipt of a positive HIV test.
- Better equip medical providers and case managers with training on best practices, latest developments in care and treatment, and opportunities for continuing education credits.
- Increase use of METRO Q® Fare Cards, telemedicine, mobile units, and other solutions to transportation barriers.
- Develop performance measures to improve community viral load as a means to improve health outcomes and decrease HIV transmission.
- Integrate access to support services such as Women, Infants and Children (WIC), food stamps, Children's Health Insurance Program (CHIP), and health literacy resources in medical settings.

**Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.**

### Recommendation 2: Improve cultural competency for better access to care

Lack of understanding of the social and cultural norms of the community is one of the most cited barriers to care. These issues include race, culture, ethnicity, religion, language, poverty, sexual orientation and gender identity. Issues related to the lack of cultural competency are more often experienced by members of the very communities most impacted by HIV. Medical providers must improve their cultural understanding of the communities they serve in order to put the "care" back in health care. Individuals will not seek services in facilities they do not feel are designed for them or where they receive insensitive treatment from staff.

Some specific actions include:

- Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.
- Include training on interventions for trauma-informed care and gender-based violence. This type of care is a treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma that contribute to mental health issues including substance abuse, domestic violence, and child abuse.
- Establish measures to evaluate effectiveness of training.
- Revise employment applications to include questions regarding an applicant's familiarity with the community being served. New hires with lack of experience working with certain communities should receive training prior to interacting with the community.

### Recommendation 3: Increase access to mental health services and substance abuse treatment

Access to behavioral health and substance abuse treatment are two of the most critical unmet needs in the community. Individuals have difficulty staying in care and adhering to medication without access to mental health and substance abuse treatment. Comprehensive HIV/AIDS care must address the prevalence of these conditions.

**Increase the availability of mental health services and substance abuse treatment.**

Some specific actions include:

- Perform mental health assessments on newly diagnosed persons to determine readiness for treatment, the existence of an untreated mental health disorders, and need for substance abuse treatment.
- Increase the availability of mental health services and substance abuse treatment, including support groups and peer advocacy programs.
- Implement trauma-informed care in health care settings to respond to depression and post-traumatic stress disorders.

## Recommendation 4: Improve health outcomes for people living with HIV/AIDS with co-morbidities

Because of recent scientific advances, people living with HIV/AIDS, who have access to antiretroviral therapy, are living long and healthy lives. HIV/AIDS is now treated as a manageable chronic illness and is no longer considered a death sentence. However, these individuals are developing other serious health conditions that may cause more complications than the virus. Some of these other conditions include Hepatitis C, hypertension, diabetes, and certain types of cancer. When coupled with an HIV diagnosis, these additional conditions are known as co-morbidities. HIV treatment must address the impact of co-morbidities on treatment of HIV/AIDS.

Some specific actions include:

- Utilize a multi-disciplinary approach to ensure that treatment for HIV/AIDS is integrated with treatment for other health conditions.
- Develop treatment literacy programs and medication adherence support programs for people living with HIV/AIDS to address co-morbidities.

## Recommendation 5: Develop and publicize complete and accurate data for transgender people and those recently released from incarceration

There is insufficient data to accurately measure the prevalence and incidence of HIV among transgender individuals. In addition, there appears to be a lack of data on those recently released from incarceration. We need to develop data collection protocols to improve our ability to define the impact of the epidemic on these communities.

## Recommendation 6: Streamline the Ryan White eligibility process for special circumstances

The Ryan White program is an important mechanism for delivering services to individuals living with HIV/AIDS. In order to increase access to this program, we must remove barriers to enrollment for qualified individuals experiencing special situations. We recommend creating a fast track process for Ryan White eligibility determinations for special circumstances, such as when an individual has recently relocated to Houston and/or has fallen out of care.

## Recommendation 7: Increase access to care for diverse populations

According to the 2016 Kinder Houston Area Survey, the Houston metropolitan area has become "the single most ethnically and culturally diverse urban region in the entire country." Between 1990 and 2010, the Hispanic population grew from 23% to 41%, and Asians and others from 4% to 8%. It is imperative that we meet the needs of an increasingly diverse populace.[10]

Some specific actions include:

- Train staff and providers on culturally competent care.
- Hire staff who represent the communities they serve.
- Increase access to interpreter services.
- Develop culturally and linguistically appropriate education materials.
- Market available services directly to immigrant communities.

[10] https://kinder.rice.edu/uploadedFiles/Center_for_the_Study_of_Houston/53067_Rice_HoustonAreaSurvey2016_Lowres.pdf

# ROADMAP
## TO ENDING THE HIV EPIDEMIC IN HOUSTON

-December 2016-

endhivhouston.org

Houston Area Comprehensive HIV Prevention and Care Services Plan

2017 - 2021

*Capturing the community's vision for an ideal system of HIV prevention and care for the Houston Area*

# HOUSTON EMA HIV CARE CONTINUUM

## What is the Care Continuum?

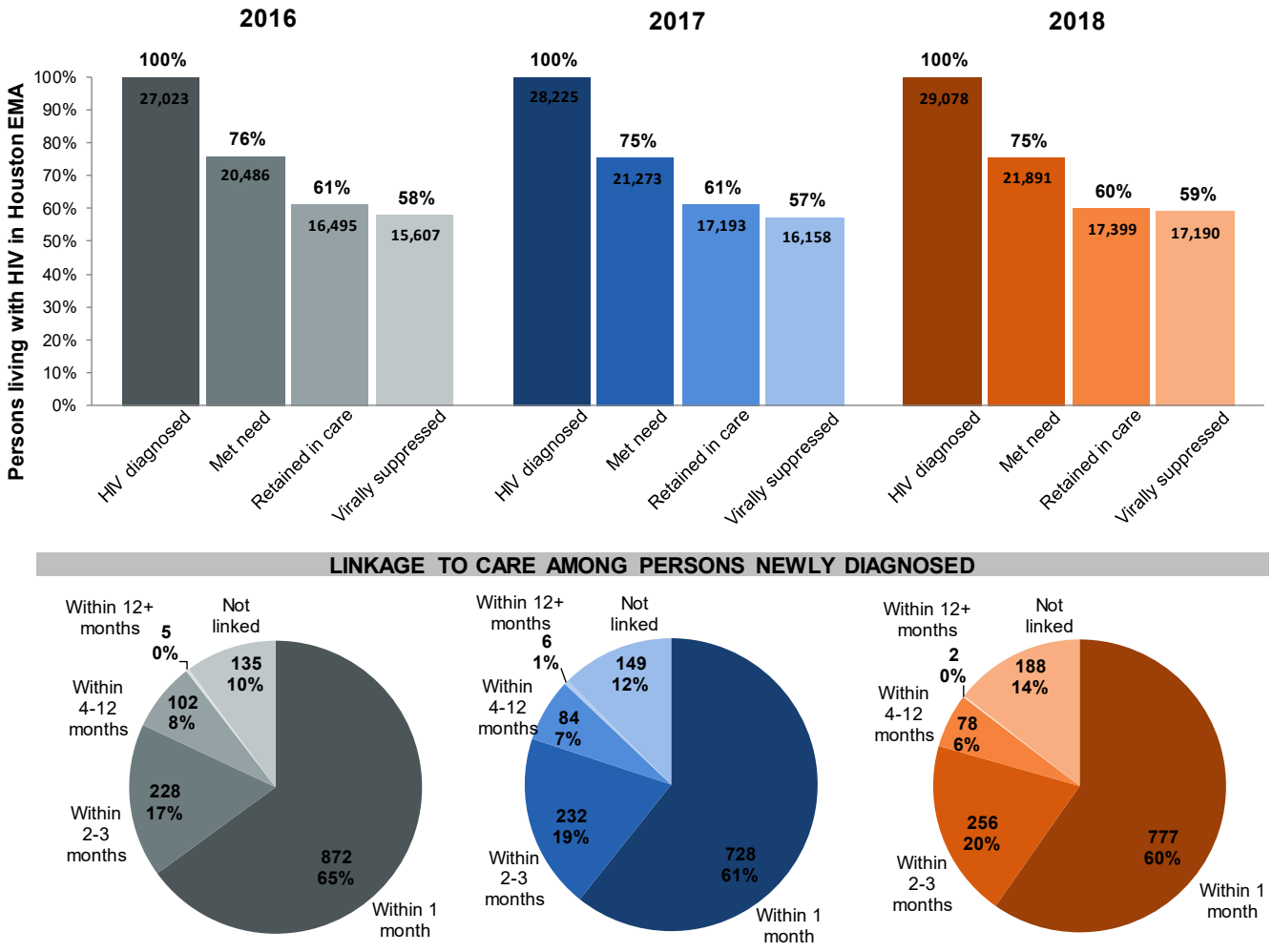
The HIV Care Continuum, previously known as a Treatment Cascade, was first released in 2012 by the Centers for Disease Control and Prevention (CDC). It represents the sequential stages of HIV care, from being diagnosed with HIV to suppressing the HIV virus through treatment. Ideally, the Care Continuum describes a seamless system of HIV prevention and care services, in which people living with HIV (PLWH) receive the full benefit of HIV treatment by being diagnosed, linked to care, retained in care, and taking HIV medications as prescribed to achieve viral suppression.

## The Houston Care Continuum (HCC)

The HCC is a diagnosis-based continuum. The HCC reflects the number of PLWH who have been diagnosed ("HIV diagnosed"); and among the diagnosed, the numbers and proportions of PLWH with records of engagement in HIV care ("Met Need"), retention in care ("Retained in Care"), and viral suppression ("Virally Suppressed") within a calendar year. Although retention in care is a significant factor for PLWH to achieve viral suppression, 'Virally Suppressed' also includes those PLWH in the Houston EMA whose most recent viral load test of the calendar year was <200 copies/mL but who did not have evidence of retention in care.

Linking newly diagnosed individuals into HIV medical care as quickly as possible following initial diagnosis is an essential step to improved health outcomes. In the HCC, initial linkage to HIV medical care ("Linkage to Care") is presented separately as the proportion of *newly* diagnosed PLWH in the Houston EMA who were successfully linked to medical care within one month, three months or within one year after diagnosis.

## *Figure 1:* Houston EMA HIV Care Continuum, 2016-2018**




*Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020*

| Measure | Description | Data source |
|---|---|---|
| HIV diagnosed | No. of persons living with HIV (PLWH) residing in Houston EMA through end of year (alive) | Texas eHARS data |
| Met need | No. (%) of PLWH in Houston EMA with met need (at least one: medical visit, ART prescription, or CD4/VL test) in year | Texas DSHS HIV Unmet Need Project (incl. eHARS, ELR, ARIES, ADAP, Medicaid, private payer data) |
| Linked to care (pie chart) | No. (%) of **newly diagnosed** PLWH in Houston EMA who were linked to medical care ("Met need") within N months of their HIV diagnosis | |
| Retained in care | No. (%) of PLWH in Houston EMA with at least 2 medical visits, ART prescriptions, or CD4/VL tests in year, at least 3 months apart | |
| Virally suppressed | No. (%) of PLWH in Houston EMA whose last viral load test of the year was ≤200 copies/mL | Texas ELRs, ARIES labs, ADAP labs |

From 2016-2018, the total number of persons diagnosed with HIV increased each year and the percentage of those with met need, retention, and viral suppression remained relatively constant.

- The percentage of newly diagnosed PLWH linked to care within one month of diagnosis decreased from 65% to 60% from 2016 to 2018.

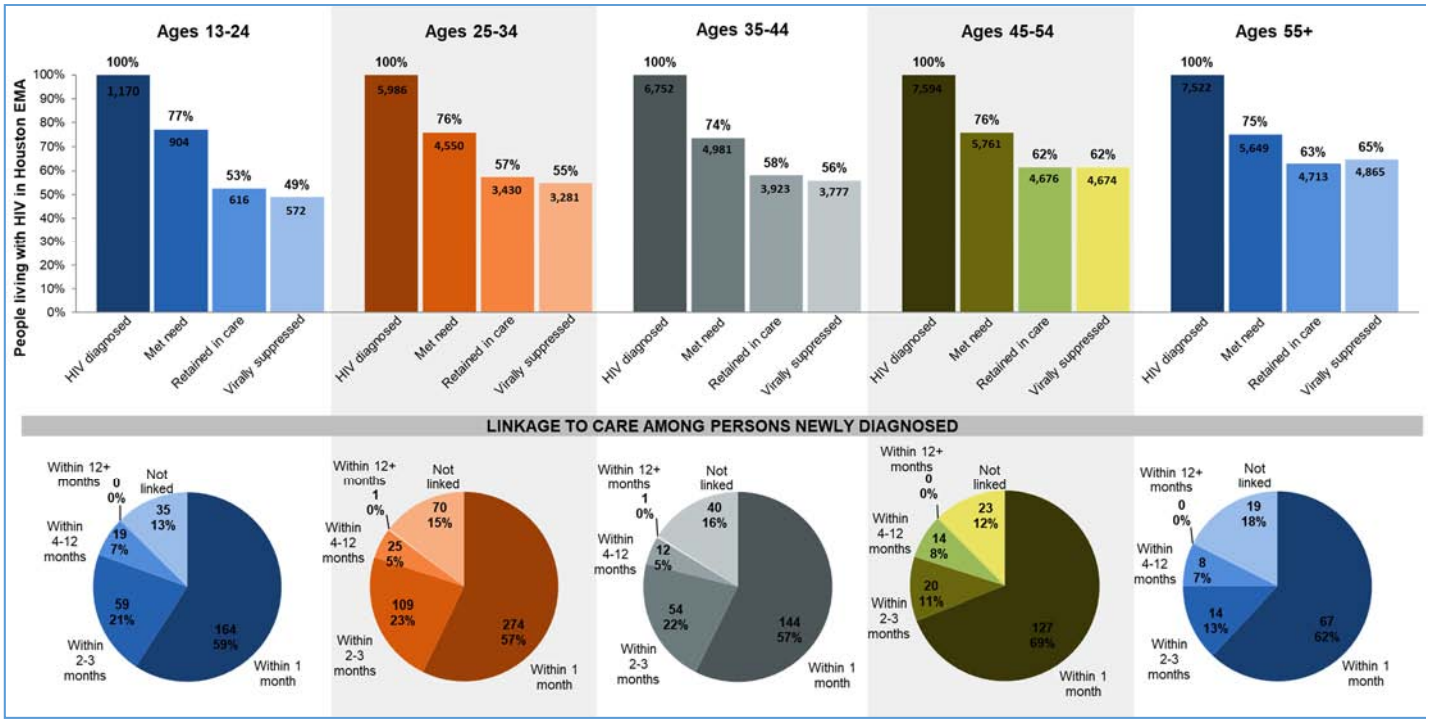
## Disparities in Engagement among Key Populations

Multiple versions of the HCC have been created to illustrate engagement disparities and service gaps that key populations encounter in the Houston EMA.

It is important to note that available data used to construct each version of the Houston HCC do not portray the need for activities to increase testing, linkage, retention, ART access, and viral suppression among many other at-risk key populations, such as those who are intersex, experiencing homelessness, or those recently released from incarceration.

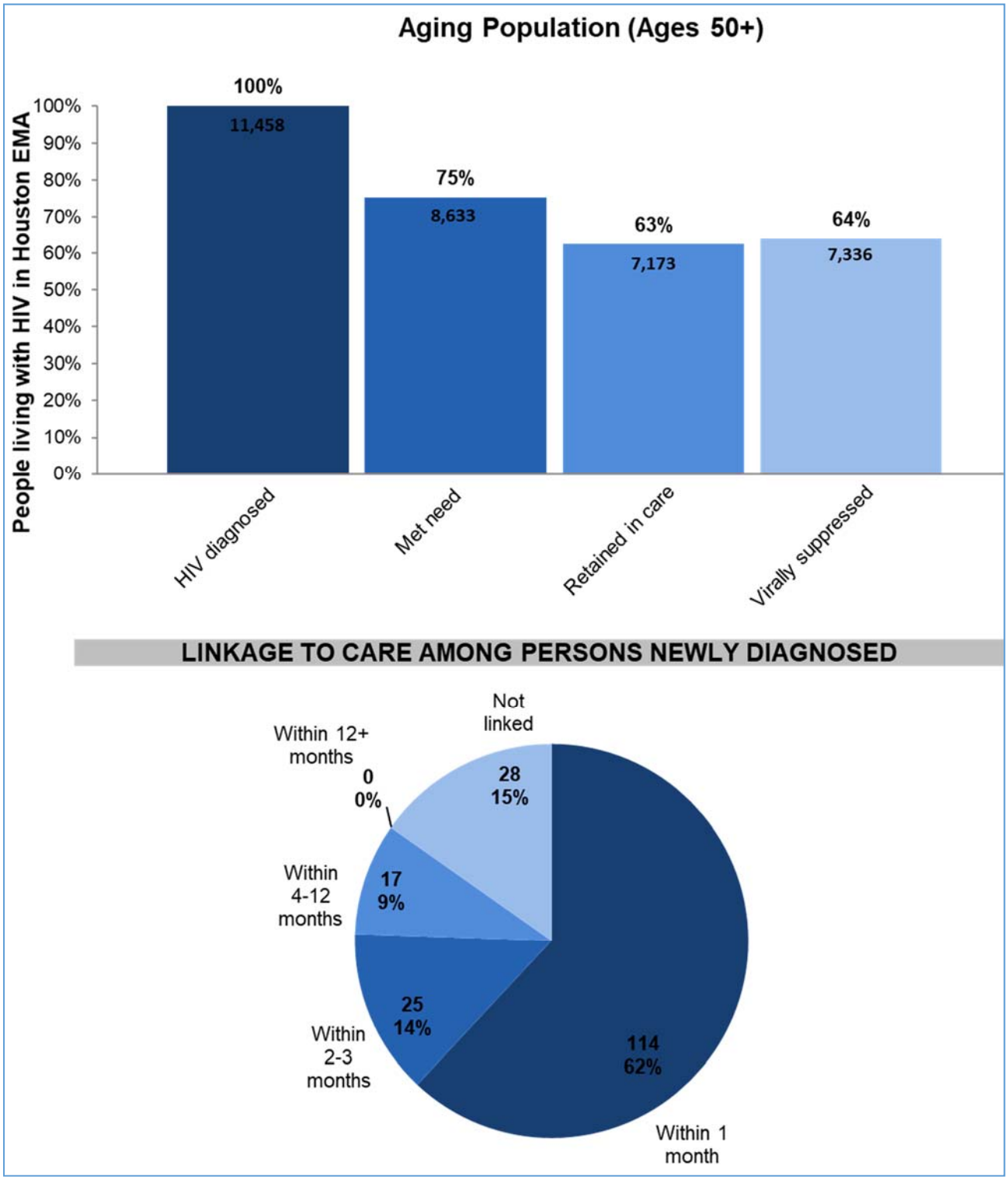
## The Houston EMA Care Continuum, by Age

***Figure 2:*** **Houston EMA HIV Care Continuum by Age Group, 2018****




*Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020*

***Figure 3:*** **Houston EMA HIV Care Continuum by Age Group, 2018****

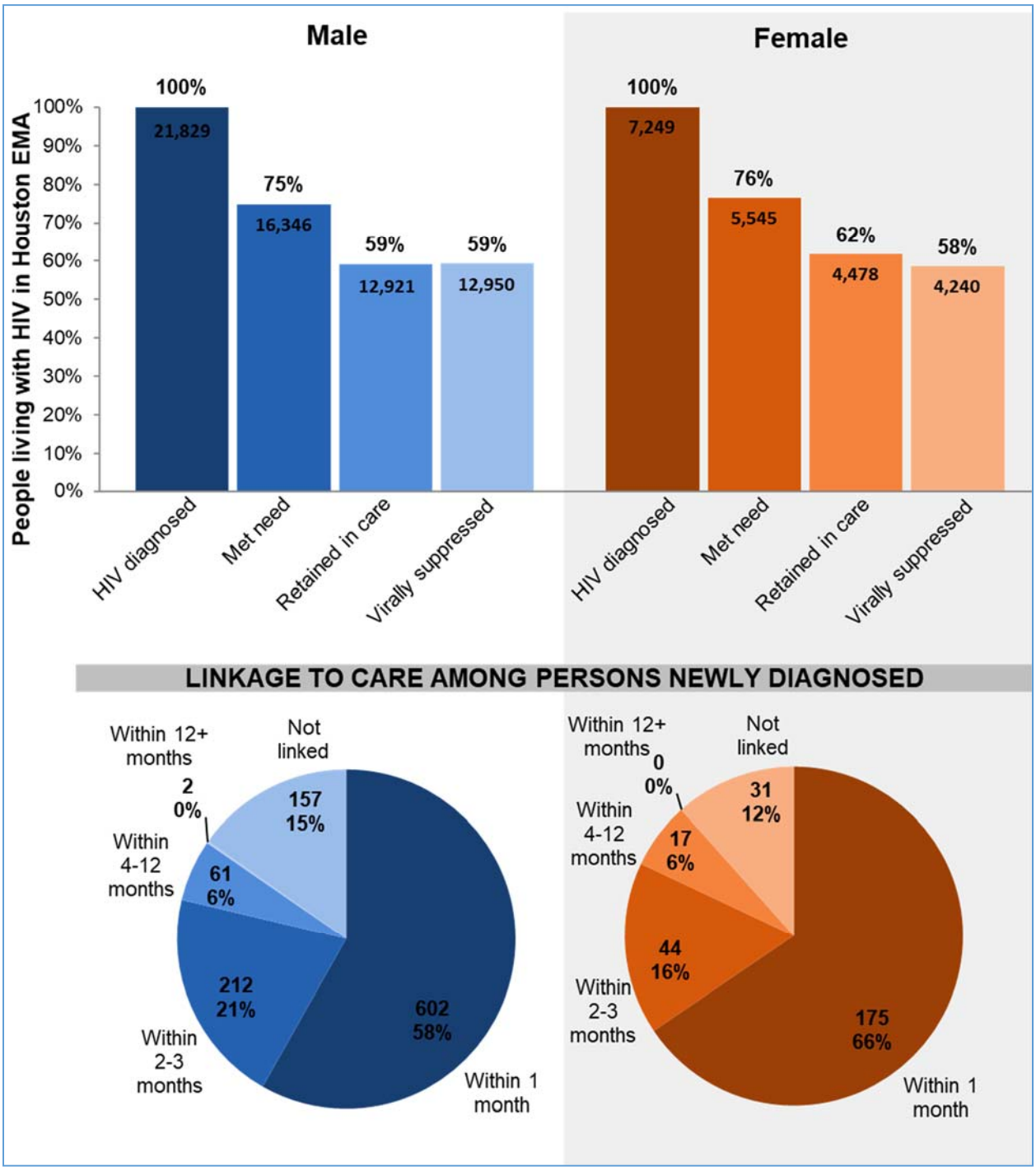



*Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020*

- Younger adults had lower percentages of retention and viral suppression compared to older adults.
- Middle age adults (25-44 years old) had the lowest proportion of newly diagnosed PLWH who were linked to care within one month of diagnosis when compared to other age groups.

## The Houston EMA Care Continuum, by Sex Assigned at Birth/Current Gender

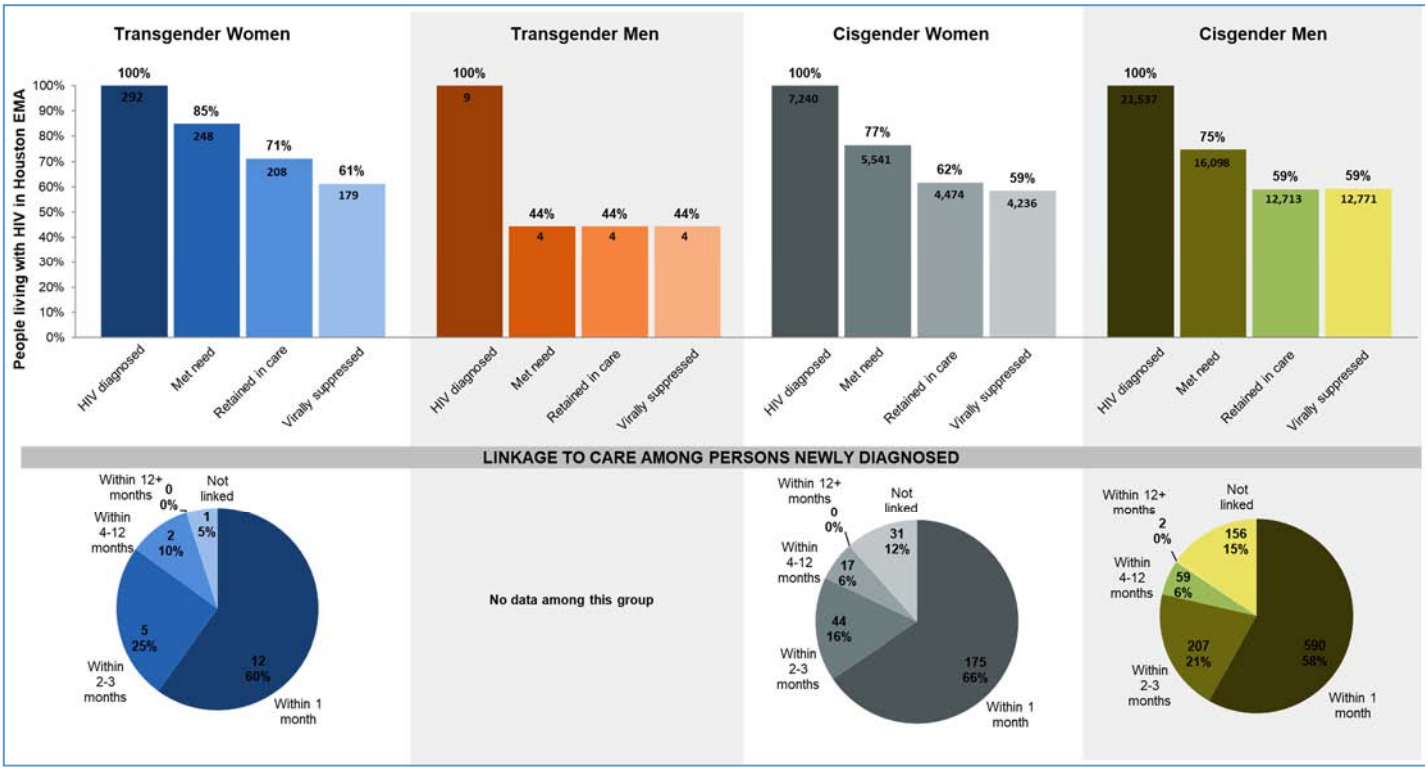
### *Figure 4:* Houston EMA HIV Care Continuum by Sex Assigned at Birth, 2018**




*Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020*

- Females living with HIV in the Houston EMA in 2018 had a slightly higher proportion of individuals with met need and retention in care than males living with HIV, although females had a slightly smaller proportion of viral suppression.
- The proportion of newly diagnosed females linked to care within the first month after diagnosis was higher than males (66% vs. 58%).

## *Figure 5:* Houston EMA HIV Care Continuum by Current Gender, 2018**

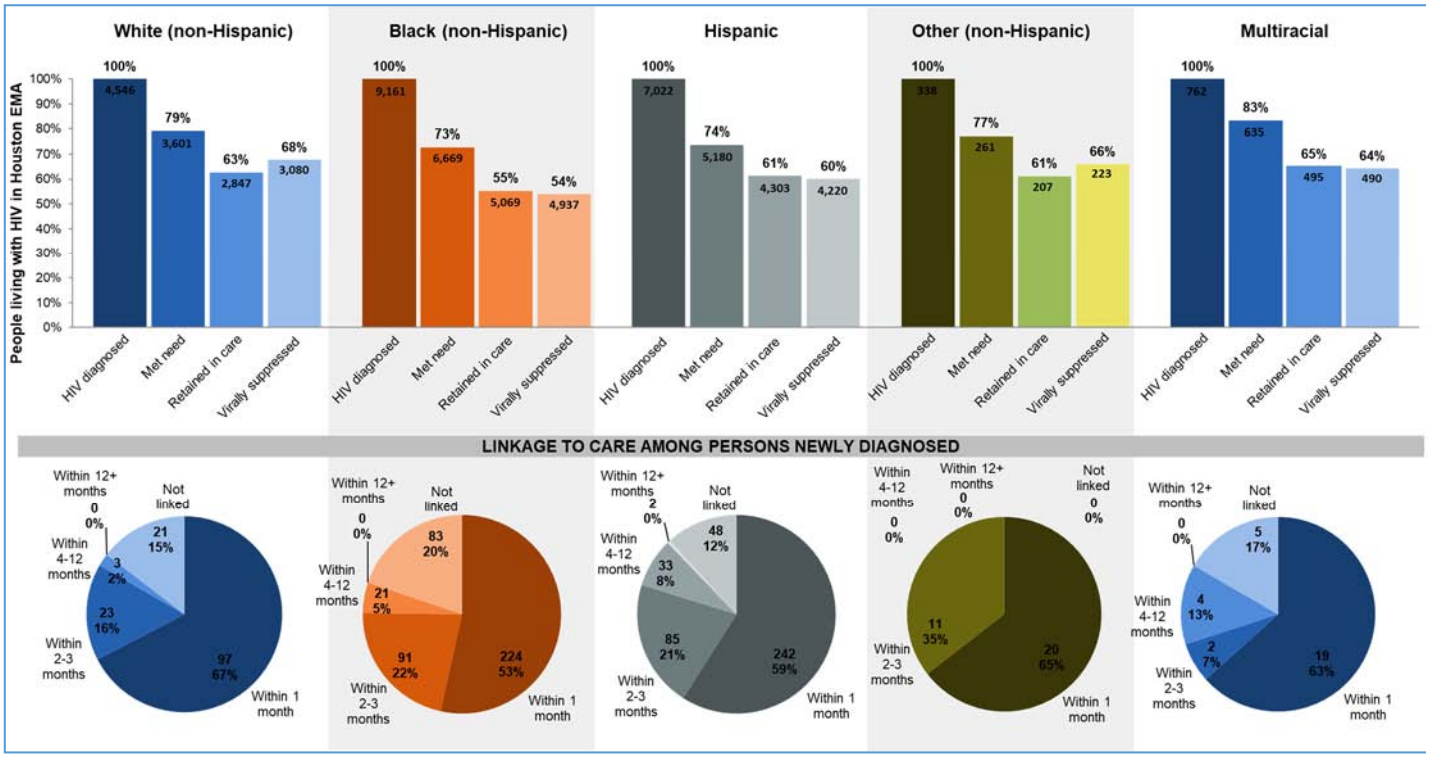



*Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020*

- Transgender women living with HIV in the Houston EMA in 2018 had the highest proportion of individuals with met need, retention in care, and viral suppression.
- Transgender men living with HIV in the Houston EMA in 2018 had the lowest proportion of individuals with met need, retention in care, and viral suppression. Extreme caution should be exercised in interpretation, however, due to the very small numbers of transgender men represented in this data.
- The proportion of newly diagnosed people linked to care within the first month after diagnosis was lower for transgender women compared to cisgender women. However, there were few transgender individuals represented in the data and percentages can vary widely with small increases/decreases.

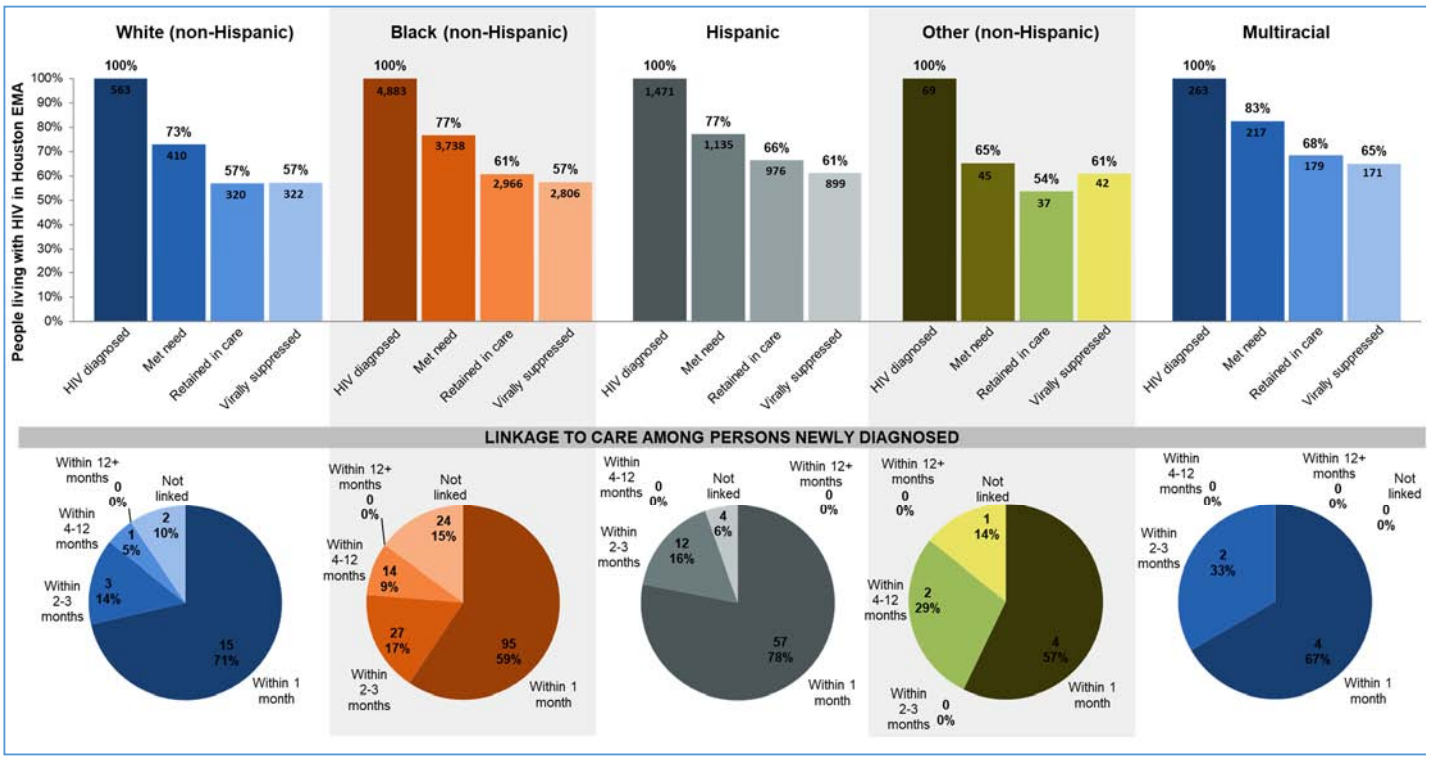
## The Houston EMA Care Continuum, by Sex Assigned at Birth and Race/Ethnicity

### *Figure 6:* Houston EMA HIV Care Continuum by Sex Assigned at Birth = Male and Race/Ethnicity, 2018**




*Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020*

### *Figure 7:* Houston EMA HIV Care Continuum by Sex Assigned at Birth = Female and Race/Ethnicity, 2018**



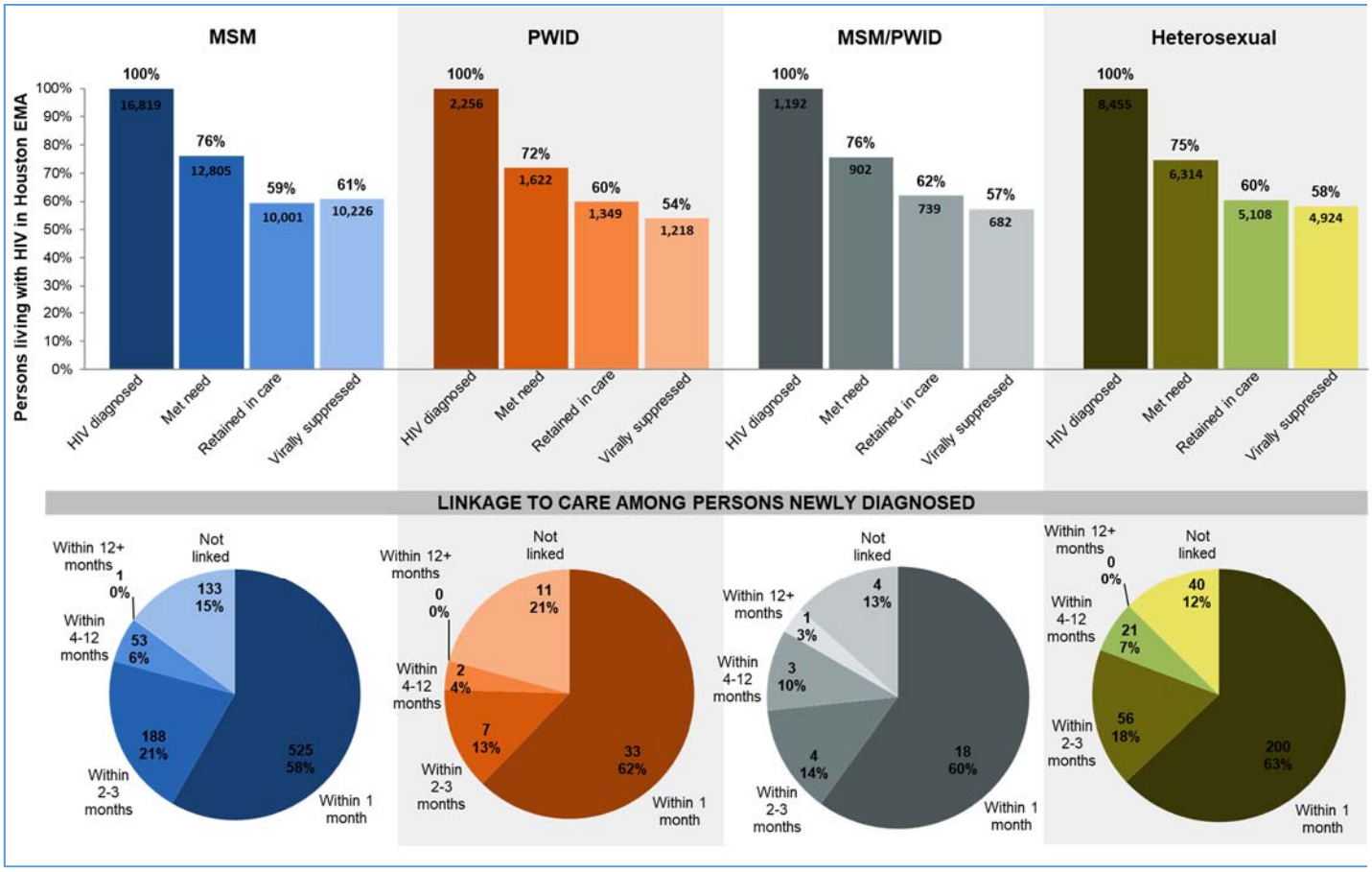

*Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020*

- Compared to White (non-Hispanic) and multiracial males, all other males living with HIV had lower proportions of met need, retention in care, and viral suppression in 2018.
- Among females, Other (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of met need and retention in care while Black and White (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of viral suppression.
- Among those newly diagnosed with HIV, Hispanic females and White (non-Hispanic) males had the highest proportion linked to care within 1 month of diagnosis.
- Overall, Other (non-Hispanic) females living with HIV had the lowest proportion of individuals with met need across all birth sex and race/ethnicity groups. However, this group had few individuals and percentages can vary widely with small increases/decreases. White (non-Hispanic) females and Black (non-Hispanic) males living with HIV had the next lowest proportion of individuals with met need.
- Overall, Other (non-Hispanic) females living with HIV had the lowest proportion of individuals retained in care across all birth sex and race/ethnicity groups. However, this group had few individuals and percentages can vary widely with small increases/decreases. Black (non-Hispanic) males living with HIV had the next lowest proportion of individuals retained in care.
- Overall, Black (non-Hispanic) males living with HIV had the lowest proportion of individuals virally suppressed across all birth sex and race/ethnicity groups. White (non-Hispanic) males living with HIV had the highest proportion of individuals virally suppressed.

## The Houston EMA Care Continuum, by Transmission Risk Factor*

**Transmission risk factors that are associated with increased risk of HIV exposure and transmission include men who have sex with men (MSM), people who inject drugs (PWID), MSM who also inject drugs (MSM/PWID), and heterosexual exposure.*

### *Figure 8:* Houston EMA HIV Care Continuum by Transmission Risk, 2018**




*Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020*

- Although MSM have a higher number of PLWH than the other risk groups, the proportion of diagnosed MSM living with HIV with evidence of met need and retention in care is similar to those observed for other risk groups.
- MSM have a higher proportion of diagnosed PLWH who are virally suppressed but a lower proportion of newly diagnosed PLWH who were successfully linked to care within one month of initial diagnosis. Those with a transmission risk factor of heterosexual contact had the highest proportion of people linked to care within one month of initial diagnosis.
- Overall, PWID as a primary transmission risk factor exhibited the lowest proportions of individuals with met need and viral suppression.

*** 2018 data should be used with caution -- it may be underrepresented due to unforeseen data importing issues at Texas DSHS. Updates to 2018 data will occur in the future.*

Questions about the Houston EMA HIV Care Continuum can be directed to: Amber Harbolt, Health Planner in the Office of Support.

National Institutes of Health
Turning Discovery Into Health



NEWS RELEASES

Media Advisory Thursday, October 24, 2019

# Ending HIV will require optimizing treatment and prevention tools, say NIH experts

*Commentary emphasizes need to optimally implement current tools and develop new interventions.*

## What

Optimal implementation of existing HIV prevention and treatment tools and continued development of new interventions are essential to ending the HIV pandemic, National Institutes of Health experts write in a commentary in Clinical Infectious Diseases.


Unprecedented biomedical research advances over the past four decades have led to development of "toolkits" of highly effective interventions for preventing and treating HIV. *NIAID*

Today, many highly effective HIV treatment and prevention interventions are available. Antiretroviral therapy (ART) not only improves the health and prolongs the lives of people with HIV but also plays an important role in HIV prevention. People living with HIV whose virus is durably suppressed to undetectable levels by ART cannot sexually transmit HIV to others, a concept known as Undetectable=Untransmittable, or U=U. Antiretroviral drugs taken by people without HIV as pre-exposure prophylaxis (PrEP) are highly effective at preventing acquisition of HIV.

Theoretically, the widespread provision of ART and PrEP could end the HIV pandemic. However, a gap exists between theory and reality, write Anthony S. Fauci, M.D., director of

### Institute/Center

National Institute of Allergy and Infectious Diseases (NIAID)

### Contact

Hillary Hoffman
301-402-1663

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NIH's National Institute of Allergy and Infectious Diseases (NIAID), and colleagues. Implementation gaps exist at all stages of the HIV care continuum. Progress in cities like San Francisco, which has dramatically reduced new HIV cases by deploying ART, PrEP and other tools, suggests that these gaps can be overcome. Such examples offer lessons for optimizing implementation strategies.

Even with the availability of simplified HIV drug regimens, medication adherence remains a challenge for many. Thus, there is a need to develop new treatment and prevention strategies and products that can be efficiently taken up by people from diverse communities. Potentially, these new tools will have improved efficacy and broader uptake due to better acceptability and usability.

Researchers are pursuing multiple approaches to achieve durable control of HIV without daily ART, including pursuing a cure that would eradicate HIV from the body or keep it at very low levels, and developing long-acting ART and broadly neutralizing antibodies (bNAbs) that could be dosed once every few months or less often. Approaches to optimizing HIV prevention include long-acting injectables and implants, bNAbs, multi-purpose tools for HIV prevention and contraception, and other innovative strategies. Scientists also are working toward development of a safe and effective preventive HIV vaccine. Currently, three large HIV vaccine efficacy clinical trials are under way globally.

## Article

RW Eisinger, GK Folkers, and AS Fauci. Ending the HIV pandemic: optimizing the prevention and treatment toolkits. *Clinical Infectious Diseases* DOI: 10.1093/cid/ciz998 (2019).

## Who

NIAID Director Anthony S. Fauci, M.D., is available for comment.

NIAID conducts and supports research—at NIH, throughout the United States, and worldwide—to study the causes of infectious and immune-mediated diseases, and to develop better means of preventing, diagnosing and treating these illnesses. News releases, fact sheets and other NIAID-related materials are available on the NIAID website.

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###

# HIV programs get big money in stimulus deal to fight coronavirus

*Chris Johnson*


Lawmakers have reached agreement on a stimulus deal to fight the coronavirus that includes major funds for HIV programs. (Washington Blade file photo by Michael Key)

The record-setting $2 trillion deal Congress reached on Wednesday to stimulate the economy amid the devastation of the coronavirus pandemic contains $155 million to bolster HIV programs serving the nexus of communities affected by both diseases.

For the Ryan White HIV/AIDS Program, the deal includes $90 million for existing contracts under the law and the Public Health Service Act. At the same time, the deal appropriates $65 million for the Housing Opportunities for Persons with AIDS, or HOPWA, to maintain operations and provide rental assistance amid the coronavirus crisis.

In both cases, the money must be used by Sept. 30, 2022, although appropriations for HOPWA afford some additional flexibility. The money is on top of the $330 million Congress appropriated in December 2019 for Ryan White and other initiatives in fiscal year 2020 as part of the Trump administration's initiative to beat HIV by 2030.

The money for the HIV programs is geared toward ensuring recipients — which

include cities, states and community health centers — can continue and expand those services as the coronavirus pandemic complicates efforts to address HIV.

Rachel Klein, deputy executive director of the AIDS Institute, said the additional money for Ryan White programs, which provides care to low income people with HIV, is essential for HIV-positive people trying to obtain services amid the coronavirus pandemic.

"The program itself needs to be able to adapt to provide care in different ways," Klein said. "People are trying to avoid sitting in public meeting rooms unnecessarily right because they don't want to be exposing themselves potentially to a new virus. The programs are going to need to be able to be flexible, to find creative ways to ensure that people are able to still get the care that they need, and that's going to come with some costs."

There are mixed opinions about whether people with HIV are more at risk for COVID-19. On one hand, HIV if left untreated will depress a patient's immune system and make them more susceptible to disease, but Dr. Susan Henn, chief medical officer for the D.C.-based Whitman-Walker Health, has told the Blade for people with well-managed HIV, the increased risk would only be "very slight."

Lauren Killelea, director of public policy of the National AIDS Housing Coalition, said money for HOPWA is needed because people with HIV without access to housing "are less likely to be virally suppressed and therefore more susceptible to COVID-19."

"HOPWA is uniquely situated to be a great, flexible resource for low-income people living with HIV during the coronavirus pandemic," Killelea said. "HOPWA can not only provide permanent housing but also short-term assistance as well as critical supports like access to transportation and nutrition services."

After failed votes in the U.S. Senate and negotiations throughout the week, congressional leaders had announced Wednesday morning they had reached a deal on Stage 3 for congressional action in response to the coronavirus crisis.

A vote was expected earlier Wednesday after the Senate returned from recess, but proceedings were halted over objections from a small cadre of Republicans — including Sens. Tim Scott (S.C.), Ben Sasse (Neb.) and Lindsey Graham (S.C.) — over language they say could lead to the exploitation of unemployment benefits. After leaders agreed to an amendment to appease these lawmakers, the Senate voted to approve the measure 96-0.

The next step is House approval for the stimulus package and President Trump signing the package into law, both of which were expected to happen expeditiously.

A number of parties had pressed Congress for the HIV funds in the stimulus package. Last week, AIDS United and a coalition of 90 HIV/AIDS and LGBTQ groups, including GLAAD, the Human Rights Campaign, Whitman-Walker Health, NMAC, NASTAD, NCSD and the AIDS Institute, sent a letter to every member of Congress urging them to consider people with HIV and "craft a relief package that takes the unique needs of this population into account."

In a letter to Congress dated March 17 and obtained by the Blade, the White House Office of Management & Budget sought money in the stimulus package for Ryan

White and other health programs to the tune of $1.336 billion. An attached request from Health Resources & Services Administration makes that request for “health centers to expand triage and treatment capacity and telehealth, rural hospital technical assistance and the Ryan White HIV/AIDS Program, in response to coronavirus.”

The request, however, makes no mention of HOPWA funds, which the Trump administration sought to cut earlier this month in its budget request for fiscal year 2021. OMB didn’t respond to the Blade’s request to comment on whether it welcomes the HIV money appropriated in the stimulus package.

Killelea said the HOPWA money was inserted by the Transportation and Housing & Urban Development Act appropriations staff headed by Sens. Susan Collins (R-Maine) and Jack Reed (D-R.I.) and Reps. David Price (D-N.C.) and Mario Diaz-Balart (R-Fla.). (Diaz-Balart was the first member of Congress confirmed to test positive for the coronavirus.)

Congress makes the appropriations at the same time the Trump administration has made a pledge to beat HIV in the United States with a PrEP-centric plan that aims at reducing new infections by 75 percent in five years and 90 percent by 2030.

Carl Schmid, executive director of the HIV & Hepatitis Policy Institute and co-chair of Presidential Advisory Council on HIV/AIDS, told the Blade the extra money is needed because the coronavirus threw a “monkey wrench” in the HIV plan.

“I was just talking today to someone at the CDC that several people from the center for that are working on HIV are being used to address COVID-19, and it’s a significant amount of their staff, because they all have the expertise in infectious diseases, and the doctors, too, in the field,” Schmid said. “That’s why I can see a lot of this 90 million being used to, for the doctors in the workforce.”

As Congress advances the deal, the Health Resources & Services Administration’s HIV/AIDS Bureau was set to have a phone conference with grant recipients and stakeholders across the country on Thursday at 3:30 p.m., according to a notice shared with the Washington Blade.

## FROM HRSA

# Coronavirus 2019 (COVID-19) Frequently Asked Questions

*Updated 3/31/2020*

HRSA recognizes the important work Ryan White HIV/AIDS Program recipients, subrecipients, and stakeholders are doing in response to the coronavirus 2019 (COVID-19) public health emergency. HRSA's Ryan White HIV/AIDS Program recipients provide a comprehensive system of HIV primary medical care, medication, and essential support services to the most vulnerable people with HIV, and many play an important role in delivering critical services and assisting local communities during an emergency. HRSA understands Ryan White HIV/AIDS Program recipients are coordinating with existing partners at the state, regional, and local level, while also maintaining ongoing access to HIV care and treatment services and medication to their patients. We are updating this page regularly as information becomes available.

**Are RWHAP recipients allowed to use RWHAP funds to purchase pre-paid cell phones for clients who may need them to support remote service provision? *(Added: 3/25/2020)***

Emergency Financial Assistance (EFA) is the RWHAP service category that may be used to provide pre-paid cell phones for RWHAP clients. To leverage scarce resources, the recipient should also coordinate with existing partners at the state, regional, and local level in advance to identify and define appropriate roles and responsibilities in the event of an emergency. This includes establishing relationships with local hospitals, health departments, and other large community health care providers.

NEW **We've heard from several Ryan White HIV/AIDS Program providers that food on shelves at grocery stores is low, and they would like to be able to support clients' meals using RWHAP emergency financial assistance (EFA) funding. Would our case management agency in eastern Idaho be allowed to use EFA to support meals through Grub Hub and local restaurants that are offering take out options? *(Added 3/31/2020)***

PCN #16-02 (PDF - 173 KB) allows for Emergency Financial Assistance to be used as one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a

voucher program. Standards are determined by RWHAP recipients, however, they must be equitably applied.

NEW **Can Ryan White HIV/AIDS Program Part A Planning Councils (PC) buy phones, electronic devices help PC members with connectivity during this emergency so members can attend meetings? Also, can consumers who are not voting members of the PC, but on the consumer committee be provided with electronic devices so they will be able to fully participate in meetings?** ***(Added 3/31/2020)***

Emergency Financial Assistance (EFA) is the RWHAP service category that may be used to provide pre-paid cell phones for RWHAP clients. To leverage scarce resources, the recipient should also coordinate with existing partners at the state, regional, and local level in advance to identify and define appropriate roles and responsibilities in the event of an emergency. This includes establishing relationships with local hospitals, health departments, and other large community health care providers.

NEW **Can a Ryan White HIV/AIDS Program Part A funded Food Bank Program pay for grocery delivery? Prior to the COVID-19 emergency, this provider had done distributed food vouchers, which they plan to go back to after the emergency is over.** ***(Added 3/31/2020)***

HRSA HAB encourages promoting access to and continuity of care in a safe way during social distancing PCN #16-02 (PDF - 173 KB) allows for Emergency Financial Assistance to be used as one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program. Standards are determined by RWHAP recipients, however, they must be equitably applied.

# 2020 Houston HIV Care Services Needs Assessment

*A collaboration of:*
Houston Area HIV Services Ryan White Planning Council
Houston HIV Prevention Community Planning Group
Harris County Public Health, Ryan White Grant Administration
Houston Health Department, Bureau of HIV/STD and Viral Hepatitis Prevention
Houston Regional HIV/AIDS Resource Group, Inc.
Harris Health System
People Living with HIV in the Houston Area and Ryan White HIV/AIDS Program Consumers

Approval: Pending

# INTRODUCTION

## What is an HIV needs assessment?

An HIV needs assessment is a process of collecting information about the needs of people living with HIV (**PLWH**) in a specific geographic area. The process involves gathering data *from multiple sources* on the number of HIV cases, the number of PLWH who are not in care, the needs and service barriers of PLWH, and current resources available to meet those needs. This information is then analyzed to identify what services are needed, what barriers to services exist, and what service gaps remain.

Special emphasis is placed on gathering information about the need for services funded by the Ryan White HIV/AIDS Program and on the socio-economic and behavioral conditions experienced by PLWH that may influence their need for and access to services both today and in the future.

In the Houston Area, data collected directly from PLWH in the form of a *survey* are the principal source of information for the HIV needs assessment process. Surveys are administered every three years to a representative sample of PLWH residing in the Houston Area.

## How are HIV needs assessment data used?

Needs assessment data are integral to the information base for HIV services planning, and they are used in almost every decision-making process of the Ryan White Planning Council (**RWPC**), including setting priorities for the allocation of funds, designing services that fit the needs of local PLWH, developing the comprehensive plan, and crafting the annual implementation plan. The community also uses needs assessment data for a variety of *non*-Council purposes, such as in writing funding applications, evaluation and monitoring, and the improvement of services by individual providers.

In the Houston Area, HIV needs assessment data are used for the following purposes:

- Ensuring the consumer point-of-view is infused into all of the data-driven decision-making activities of the Houston Area RWPC.
- Revising local service definitions for HIV care, treatment, and support services in order to best meet the needs of PLWH in the Houston Area.
- Setting priorities for the allocation of Ryan White HIV/AIDS Program funds to specific services.
- Establishing goals for and then monitoring the impact of the Houston Area's comprehensive plan for improving the HIV prevention and care system.
- Determining if there is a need to target services by analyzing the needs of particular groups of PLWH.
- Determining the need for special studies of service gaps or subpopulations that may be otherwise underrepresented in data sources.
- By the Planning Council, other Planning Bodies, specific Ryan White HIV/AIDS Program Parts, providers, or community partners to assess needs for services.

Needs assessment data are specifically mandated for use during the Planning Council's *How to Best Meet the Need*, Priority & Allocations, and Comprehensive HIV Planning processes.

Because surveys are administered every three years, results are used in RWPC activities for a three year period. Other data sources produced during interim years of the cycle, such as epidemiologic data and estimates of unmet need, are used to provide additional context for and to better understand survey results.

*Sources:*

2020 Houston Area HIV Needs Assessment Group (NAG), Analysis Workgroup, Principles for the 2020 Needs Assessment Analysis. Approved 08-19-19.

U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Ryan White HIV/AIDS Program Part A Manual Revised 2013. Section XI, Ch 3: Needs Assessment.

## METHODOLOGY

### Needs Assessment Planning

Planning the 2020 Houston Area HIV Care Services Needs Assessment was a collaborative process between HIV prevention and care stakeholders, the Houston Area planning bodies for HIV prevention and care, all Ryan White HIV/AIDS Program Parts, and individual providers and consumers of HIV services. To guide the overall process and provide specific subject matter expertise, a series of Needs Assessment-related Workgroups reconvened under the auspices of the Ryan White Planning Council (**RWPC**):

- The Needs Assessment Group (**NAG**) provided overall direction to the needs assessment process. As such, the NAG consisted of voting members from each collaborating partner and from the following workgroups.
- The Epidemiology Workgroup developed the consumer survey sampling plan, which aimed at producing a representative sample of surveys.
- The Survey Workgroup developed the survey instrument and consent language.
- The Analysis Workgroup determined how survey data should be analyzed and reported in order to serve as an effective tool for HIV planning.

In total, 38 individuals in addition to staff participated in the planning process, of which at least 45% were people living with HIV (**PLWH**).

### Survey Sampling Plan

Staff calculated the 2020 Houston Area HIV Care Services Needs Assessment sample size based on current total HIV prevalence for the Houston Eligible Metropolitan Area (**EMA**) (2017), with a 95% confidence interval, at both 3% and 4% margin of error. Respondent composition goals were proportional to demographic and geographic representation in total prevalence. Desired sample sizes for funded-agency representation were proportional to total client share for the most recent complete calendar year (2018). Efforts were also taken to over-sample out-of-care consumers and members of special populations. Regular reports of select respondent characteristics were provided to NAG, the Comprehensive HIV Planning Committee, and RWPC during survey administration to assess real-time progress toward attainment of sampling goals and to make sampling adjustments when necessary.

### Survey Tool

Data for the 2020 Houston Area HIV Care Services Needs Assessment were collected using a 54-question paper or electronic survey of open-ended, multiple choice, and scaled questions addressing nine topic areas (in order):

- HIV services, needs, and barriers to care
- Communication with HIV medical providers
- HIV diagnosis history
- HIV care history including linkage to care
- Non-HIV co-occurring health concerns (incl. mental health)
- Substance use
- Housing, transportation, and social support
- Financial resources
- Demographics
- HIV prevention activities

The Survey Workgroup determined topics and questions, restructuring and expanding the 45-question 2016 needs assessment survey. Subject matter experts were also engaged to review specific questions. Consistency with the federally-mandated HIV prevention needs assessment for the Houston Area was assured through participation of Houston Health Department staff during the survey development process and alignment of pertinent questions such as those designed to gather demographic information and HIV prevention knowledge and behaviors. A cover sheet explained the purpose of the survey, risks and benefits, planned data uses, and consent. A double-sided tear-sheet of emergency resources and HIV service grievance/complaint process information was also attached, and liability language was integrated within the survey.

### Data Collection

Surveys for the 2020 Houston Area HIV Care Services Needs Assessment were administered (1) in pre-scheduled group sessions at Ryan White HIV/AIDS Program providers, HIV Prevention providers, housing facilities, support groups, Harris County community centers, and specific community locations and organizations serving special populations; and (1) online via word of mouth, print, and social media advertising. Staff contacts at each physical location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through flyers, word of mouth, print advertisement, and staff promotion.

Inclusion criteria were an HIV diagnosis and residency in counties in the greater Houston Area. Participants were self-selected and self-identified according to these criteria. Surveys were self-administered in English, Spanish, and large-print formats, with staff and bilingual interpreters available for verbal interviewing.

Participation was voluntary, anonymous, and monetarily incentivized; and respondents were advised of these conditions verbally and in writing. Most surveys were completed in 30 to 40 minutes. Surveys were reviewed on-site by trained staff, interns, and interpreters for completion and translation of written comments; completed surveys were also logged in a centralized tracking database.

In total, 589 consumer surveys were collected from April 2019 to February 2020 during 47 survey sessions at 27 survey sites and online.

**Data Management**

Data entry for the current Houston Area HIV Care Services Needs Assessment was performed by trained staff and contractors at the RWPC Office of Support using simple numerical coding. Skip-logic questions were entered based on first-order responses; and affirmative responses only were entered for "check-all" questions. Additional variables were recoded during data entry and data cleaning. Surveys that could not be accurately entered by staff ere eliminated. Data are periodically reviewed for quality assurance, and a line-list level data cleaning protocol was applied prior to analysis. When data entry and cleaning are complete, a data weighting syntax will be created and applied to the sample for: sex at birth, primary race/ethnicity, and age group based on a three-level stratification of current HIV prevalence for the Houston EMA (2018). Missing or invalid survey entries will be excluded from analysis per variable; therefore, denominators vary across results. Also, proportions will not calculated with a denominator of the total number of completed surveys for every variable due to missing or "check-all" responses. Data entry for the 2020 Houston Area HIV Care Services Needs Assessment was performed by trained staff and contractors at the RWPC Office of Support using simple numerical coding. Skip-logic questions were entered based on first-order responses; and affirmative responses only were entered for "check-all" questions. Additional variables were recoded during data entry and data cleaning. Surveys that could not be accurately entered by staff or that were found to be duplicates were eliminated (n=11). Data were periodically reviewed for quality assurance, and a line-list level data cleaning protocol was applied prior to analysis. In addition, a data weighting syntax was created and applied to the sample for: sex at birth, primary race/ethnicity, and age group based on a three-level stratification of current HIV prevalence for the Houston EMA (2018), producing a total weighted sample size of 589 (8% in Spanish). Missing or invalid survey entries are excluded from analysis per variable; therefore, denominators vary across results. Also, proportions are not calculated with a denominator of 589 surveys for every variable due to missing or "check-all" responses. All data management and analysis was performed in IBM© SPSS© Statistics (v. 22) and QSR International© NVivo 10.

**Limitations**

The 2020 Houston Area HIV Care Services Needs Assessment produced data that are unique because they reflect the first-hand perspectives and lived experiences of PLWH in the Houston Area. However, there are limitations to the generalizability, reliability, and accuracy of the results that should be considered during their interpretation and use. These limitations are summarized below:

- *Convenience Sampling*. Multiple administrative methods were used to survey a representative sample of PLWH in the Houston Area proportional to geographic, demographic, transmission risk, and other characteristics. Despite extensive efforts, respondents were not randomly selected, and the resulting sample is not proportional to current HIV prevalence. To mitigate this bias, data were statistically weighted for sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2018). Results presented from Chapters 2 through the end of this report are proportional for these three demographic categories only. Similarly, the majority of respondents were Ryan White HIV/AIDS Program clients at the time of data collection, but may have received services outside the program that are similar to those currently funded. Therefore, it not possible to determine if results reflect non-Ryan White systems.
- *Margin of Error*. Staff met the minimum sampling plan goal of at least 588 valid surveys for a margin of error of 4.00%, based on a 95% confidence interval. This indicates that 95% of the time, the quantitative results reported this document are anticipated to be correct by a margin of 4 percentage points. For this reason, results reported in this document are statistically significant, generalizable, and are suitable for planning purposes to draw general conclusions about the overall needs and experiences of people living with HIV in the Houston area.
- *Reporting Bias*. Survey participants were self-selected and self-identified, and the answers they provided to survey questions were self-reported. Since the survey tool was anonymous, data could not be corroborated with medical or other records. Consequently, results

should not be used as empirical evidence of reported health or treatment outcomes. Other data sources should be used if confirmation of results is needed.

- *Instrumentation*. Full data accuracy cannot be assured due to variability in comprehension and completeness of surveys by individual respondents. Though trained staff performed real-time quality reviews of each survey, there were missing data as well as indications of misinterpretation of survey questions. It is possible that literacy and language barriers contributed to this limitation as well.
- *Data management*. The use of both staff and contractors to enter survey data could have produced transcription and transposition errors in the dataset. A line-list level data cleaning protocol was applied to help mitigate errors.

Data presented here represent the most current repository of *primary* data on PLWH in the Houston Area. With these caveats in mind, the results can be used to describe the experiences of PLWH in the Houston Area and to draw conclusions on how to best meet the HIV service needs of this population.

*Sources:*

Houston Area HIV Needs Assessment Group (NAG), Epidemiology Workgroup, 2019 Survey Sampling Principles and Plan, Approved 03-18-19.

Texas Department of State Health Services (DSHS) eHARS data through 12-31-2018, extracted as of spring 2020.

University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPPS Statistics 20, Post-stratification weights, 2009.

## BACKGROUND

### The Houston Area

Houston is the fourth largest city in the U.S., the largest city in the State of Texas, and as well as one of the most racially and ethnically diverse major American metropolitan area. Spanning 600 square miles, Houston is also the least densely populated major metropolitan area. Houston is the seat of Harris County, the most populous county in the State of Texas and the third most populous in the country. The United States Census Bureau estimates that Harris County has almost 4.7 million residents, around half of which live in the city of Houston.

Beyond Houston and Harris County, local HIV service planning extends to four geographic service areas in the greater Houston Area:

- *Houston/Harris County* is the geographic service area defined by the Centers for Disease Control and Prevention (**CDC**) for HIV prevention. It is also the local reporting jurisdiction for HIV surveillance, which mandates all laboratory evidence related to HIV/AIDS performed in Houston/Harris County be reported to the local health authority.
- The *Houston Eligible Metropolitan Area* (**EMA**) is the geographic service area defined by the Health Resources and Services Administration (**HRSA**) for the Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (**MAI**). The Houston EMA includes six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.
- The *Houston Health Services Delivery Area* (**HSDA**) is the geographic service area defined by the Texas Department of State Health Services (**TDSHS**) for the Ryan White HIV/AIDS Program Part B and the Houston Area's HIV service funds from the State of Texas. The HSDA includes the six counties in the EMA listed above plus four additional counties: Austin, Colorado, Walker, and Wharton.
- The *Houston Eligible Metropolitan Statistical Area* (**EMSA**) is the geographic service area defined by U.S. Department of Housing and Urban Development (**HUD**) for the Housing Opportunities for People with AIDS (**HOPWA**) program. The EMSA consists of the six counties in the EMA listed above plus Austin, Brazoria, Galveston, and San Jacinto Counties.

Together, these geographic service areas encompass 13 counties in southeast Texas, spanning from the Gulf of Mexico into the Texas Piney Woods.

### HIV in the Houston Area

In keeping with national new HIV diagnosis trends, the number of new cases of HIV in the Houston Area has remained relatively stable; HIV-related mortality has steadily declined, and the number of people living with HIV has steadily increased. According to current disease surveillance data, there are 29,078 diagnosed people living with HIV in the Houston EMA (**Table 1**). The majority are male (75%), over the age of 45 (52%), and have MSM transmission risk (58%), while almost half are Black/African American (48%).

**TABLE 1-Diagnosed People Living with HIV in the Houston EMA, 2018[a]**

| | # | % |
|---|---|---|
| **Total** | 29,078 | 100.0% |
| **Sex at Birth** | | |
| Male | 21,829 | 75.1% |
| Female | 7,249 | 24.9% |
| **Race/Ethnicity** | | |
| White | 5,109 | 17.6% |
| Black/African American | 14,044 | 48.3% |
| Hispanic/Latino | 8,493 | 29.2% |
| Other/Multiracial | 1432 | 4.9% |
| **Age** | | |
| 0 - 12 | 54 | 0.2% |
| 13 - 24 | 1,170 | 4.0% |
| 25 - 34 | 5,986 | 20.6% |
| 35 - 44 | 6,752 | 23.2% |
| 45 - 54 | 7,594 | 26.1% |
| 55 - 64 | 5,580 | 19.2% |
| 65+ | 1,942 | 6.7% |
| **Transmission Risk[b]** | | |
| Male-male sexual contact (MSM) | 16,818 | 57.8% |
| Person who injects drugs (PWID) | 2,256 | 7.8% |
| MSM/PWID | 1,192 | 4.1% |
| Sex with Male/Sex with Female | 8,455 | 29.1% |
| Perinatal transmission | 340 | 1.2% |
| Adult other | 17 | 0.1% |

[a]Source: Texas eHARS, Diagnosed PLWH in the Houston EMA between 1/1/2018 and 12/31/2018

[b]Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification.

The CDC ranks the Houston Area (specifically, the Houston-Baytown-Sugarland, TX statistical area) 10th highest in the nation for new HIV diagnoses and 11th in cases of progressed/Stage 3 HIV (formerly known as AIDS). In February 2019, the U.S. Department of Health and Human Services (**HHS**) launched the cross-agency initiative *Ending the HIV Epidemic: A Plan for America* with an overarching goal to reduce new HIV transmission in the U.S. by 90% by 2030. This initiative identified Harris County as a priority county due to the high rate and number of new HIV diagnoses, and plans to introduce additional resources, technology, and technical assistance to support local HIV prevention and treatment activities. Of the 29,078 diagnosed PLWH in the Houston Area, 75% are in medical care for HIV, but only 59% have a suppressed viral load.

**HIV Services in the Houston Area**

Both governmental agencies and non-profit organizations provide HIV services in the Houston Area through direct HIV services provision and/or function as Administrative Agents which contract to direct service providers. The goal of HIV care in the Houston Area is to create a seamless system that supports people at risk for or living with HIV with a full array of educational, clinical, mental, social, and support services to prevent new infections and support PLWH with high-quality, life-extending care. In addition, two local HIV Planning Bodies provide mechanisms for those living with and affected by HIV to design prevention and care services. Each of the primary sources in the Houston Area HIV service delivery system is described below:

- Comprehensive HIV prevention activities in the Houston Area are provided by the Houston Health Department (**HHD**), a directly-funded CDC grantee, and the Texas Department of State Health Services (**DSHS**). Prevention activities include health education and risk reduction, HIV testing, disease investigation and partner services, linkage to care for newly diagnoses and out of care PLWH. The Houston Area HIV Prevention Community Planning Group provides feedback and to HHD in its design and implementation of HIV prevention activities.
- The Ryan White HIV/AIDS Program Part A and MAI provide core medical and support services for HIV-diagnosed residents of the Houston EMA. These funds are administered by the Ryan White Grant Administration of Harris County Public Health. The Houston Area Ryan White Planning Council designs Part A and MAI funded services for the Houston EMA.
- The Ryan White HIV/AIDS Program Parts B, C, D, and State Services provide core medical and support services for HIV-diagnosed residents of the Houston HSDA, with special funding provided to meet the needs of women, infants, children, and youth. The Houston Regional HIV/AIDS Resource Group (**TRG**) administers these funds. The Ryan White Planning Council also designs Part B and State Services for the Houston HSDA. Additional programs supported by TRG include reentry housing through HOPWA funds and support of the grassroots END HIV Houston coalition.
- HOPWA provides grants to community organizations to meet the housing needs of low-income persons living with HIV. HOPWA services include assistance with rent, mortgage, and utility payments, case management, and supportive housing. These funds are administered by the City of Houston Housing and Community Development for the Houston EMSA.

Together, these key agencies, the direct service providers that they fund, and the two local Planning Bodies ensure the greater Houston Area has a seamless system of prevention, care, treatment, and support services that best meets the needs of people at risk for or living with HIV.

*Sources:*

Centers for Disease Control and Prevention, *Diagnoses of HIV Infection in the United States and Dependent Areas, 2018*; vol. 30. Published November 2015. Accessed 03/06/2020. Available at: www.cdc.gov/hiv/topics/surveillance/resources/reports/.

U.S. Census Bureau, American FactFinder. Houston (city), Texas and Harris (county), Texas Accessed: 03/03/2020. Available at: https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

U.S. Department of Health and Human Services, *Ending the HIV Epidemic: A Plan for America*. February 2019.

# Chapter 1: Demographics

## PARTICIPANT COMPOSITION

The following summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2020 Houston HIV Care Services Needs Assessment provides both a "snapshot" of who is living with HIV in the Houston Area today as well as context for other needs assessment results.

(**Table 1**) Overall, 95% of needs assessment participants resided in Harris County at the time of data collection. The majority of participants were male (66%), African American/Black (63%), and heterosexual (57%). Over half (60%) were age 50 or over, with a median age of 50-54.

The average unweighted household income of participants was $13,493 annually, with the majority living below 100% of federal poverty (**FPL**). A majority of participants (63%) was not working at the time of survey, with 39% collecting disability benefits and 16% unemployed and seeking employment, and 9% retired. Most participants paid for healthcare using Medicaid/Medicare or assistance through Harris Health System (Gold Card).

**TABLE 1-Select Participant Characteristics, Houston Area HIV Needs Assessment, 2020**

| | No. | % | | No. | % | | No. | % |
|---|---|---|---|---|---|---|---|---|
| County of residence | | | Age range (median: 50-54) | | | Sex at birth | | |
| Harris | 545 | 94.9% | 13 to 17 | 0 | - | Male | 384 | 65.8% |
| Fort Bend | 10 | 41.7% | 18 to 24 | 17 | 2.9% | Female | 200 | 34.2% |
| Liberty | 3 | 0.5% | 25 to 34 | 50 | 8.6% | Intersex | 0 | - |
| Montgomery | 7 | 1.2% | 35 to 49 | 160 | 27.6% | Transgender | 22 | 3.9% |
| Other | 9 | 1.6% | 50 to 54 | 105 | 18.1% | Non-binary / gender fluid | 8 | 1.4% |
| | | | 55 to 64 | 161 | 27.8% | Currently pregnant* | 4 | 2.0% |
| | | | 65 to 74 | 79 | 13.6% | *All currently pregnant respondents reported being in care. The denominator is all respondents reporting female sex at birth | | |
| | | | 75+ | 8 | 1.4% | | | |
| | | | Youth (13 to 27) | 17 | 2.9% | | | |
| | | | Seniors (≥50) | 353 | 59.9% | | | |
| Primary race/ethnicity | | | Sexual orientation | | | Health insurance | | |
| White | 78 | 13.6% | Heterosexual | 329 | 56.8% | Private insurance | 53 | 9.1% |
| African American/Black | 343 | 59.8% | Gay/Lesbian | 176 | 30.4% | Medicaid/Medicare | 388 | 66.7% |
| Hispanic/Latino | 122 | 21.3% | Bisexual/Pansexual | 52 | 9.0% | Harris Health System | 168 | 30.1% |
| Asian American | 4 | 0.7% | Other | 22 | 3.8% | Ryan White Only | 138 | 23.7% |
| Other/Multiracial | 27 | 4.7% | MSM | 238 | 40.5% | None | 11 | 1.9% |
| Residency | | | Yearly income (average: $13,493) | | | Employment | | |
| Born in the U.S. | 511 | 87.8% | Federal Poverty Level (FPL) | | | Disabled | 263 | 38.9% |
| Lived in U.S. > 5 years | 58 | 10.0% | Below 100% | 191 | 67.3% | Unemployed and seeking work | 105 | 15.5% |
| Lived in U.S. < 5 years | 8 | 1.4% | 100% | 54 | 19.0% | Employed (PT) | 59 | 8.7% |
| In U.S. on visa | 1 | 0.2% | 150% | 16 | 5.6% | Retired | 59 | 8.7% |
| Prefer not to answer | 4 | 0.7% | 200% | 15 | 5.3% | Employed (FT) | 53 | 7.8% |
| | | | 250% | 2 | 0.7% | Self Employed | 19 | 2.8% |
| | | | ≥300% | 6 | 2.1% | Other | 118 | 17.5% |

(**Table 2**) Certain subgroups of PLWH have been historically underrepresented in HIV data collection, thereby limiting the ability of local communities to address their needs in the data-driven decision-making processes of HIV planning. To help mitigate underrepresentation in Houston Area data collection, efforts were made during the 2020 needs assessment process to *oversample* PLWH who were also members of groups designated as "special populations" due to socio-economic circumstances or other sources of disparity in the HIV service delivery system.

The results of these efforts are summarized in Table 2.

**TABLE 2-Representation of Special Populations, Houston Area HIV Needs Assessment, 2020**

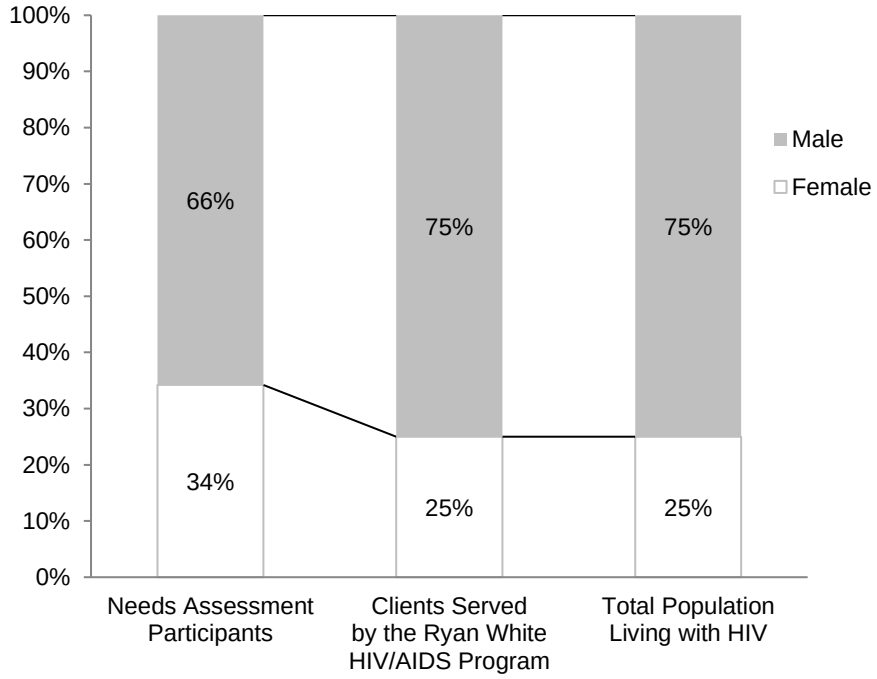
| | No. | % |
|---|---|---|
| Young adult (18-24 years) | 17 | 2.9% |
| Adult age 50+ years | 353 | 59.9% |
| Homeless | 65 | 11.1% |
| Unstably Housed | 159 | 29.0% |
| People who inject drugs (PWID)* | 47 | 8.2% |
| Male-male sexual contact (MSM) | 238 | 40.5% |
| Out of care (last 12 months) | 24 | 4.3% |
| Recently released from incarceration | 65 | 11.6% |
| Rural (non-Harris County resident) | 29 | 5.1% |
| Women of color | 194 | 33.2% |
| Transgender | 22 | 3.8% |

*Includes self-administered medications, insulin, steroids, hormones, silicone, or drugs.

## COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

HIV needs assessments generate information about the needs and service barriers of persons living with HIV (**PLWH**) in a specific geographic area to assist planning bodies and other stakeholders with designing HIV services that best meet those needs. As it is not be feasible to survey every PLWH in the Houston area, multiple administrative and statistical methods are used to generate a sample of PLWH that are reliably representative of *all* PLWH in the area. The same is true in regards to assessing the needs of clients of the Ryan White HIV/AIDS Program.

**GRAPH 1-Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Sex at Birth, 2018**



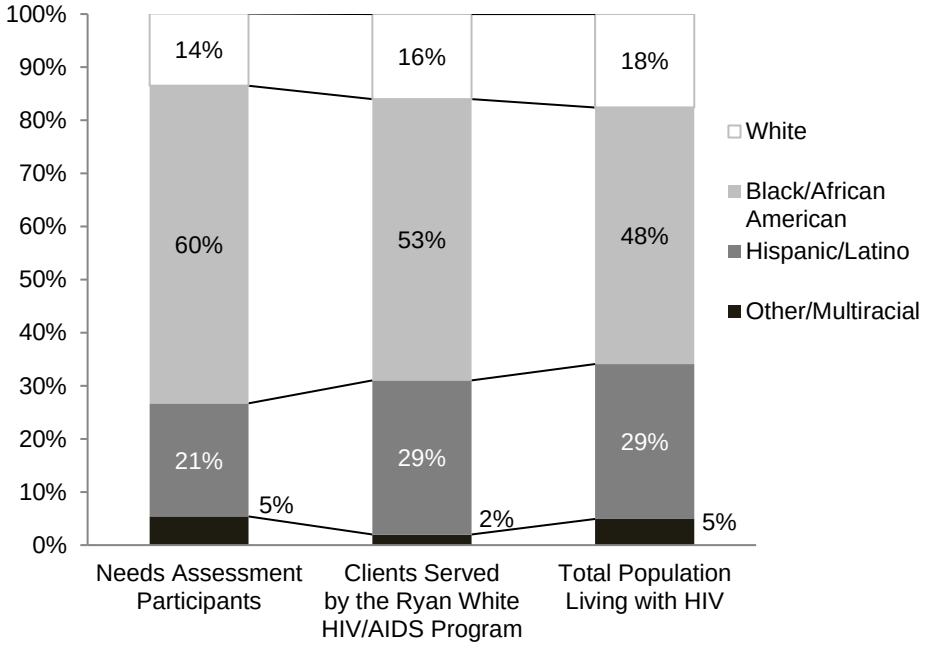

[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18.

As such, awareness of participant representation compared to the composition of both Ryan White HIV/AIDS Program clients and the total HIV diagnosed population is beneficial when reviewing needs assessment results to document actions taken to mitigate any disproportional results.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment males (sex at birth) comprised 66% of participants but 75% of all Ryan White clients, and all PLWH in the Houston Eligible Metropolitan Area (**EMA**). This indicates that male PLWH were underrepresented in the needs assessment sample, while female PLWH were overrepresented.

(**Graph 2**) Analysis of race/ethnicity composition also shows disproportionate representation between participants, all Ryan White clients, and all PLWH in the Houston EMA. Black/African American participants were overrepresented at 60% of participants when compared to the proportions of Black/African American Ryan White clients and PLWH. Conversely, White PLWH and Hispanic/Latino PLWH were slighly underrepresented in the needs assessment.

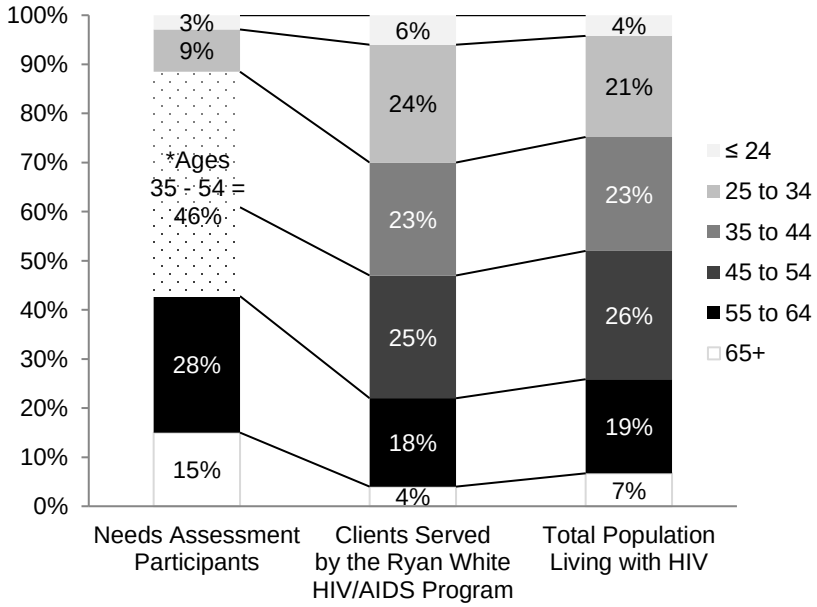
**GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Race/Ethnicity, 2018**




[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18

(**Graph 3**) As referenced in Table 1, 60% of the total needs assessment sample was comprised of individuals age 50 and over. An analysis of age range shows that more needs assessment participants were older than Ryan White clients and PLWH in the Houston EMA. Among needs assessment participants, 28% were ages 55 to 64 and 15% age 65 years and over. Compared to Ryan White clients, 18% were ages 55 to 64 and 4% were 65 and over. Among all PLWH 19% and 7% were in these age groups, respectively. No adolescents (those age 13 to 17) were surveyed. This suggests that youth and young adult PLWH (those age 13 to 24) are generally underrepresented in the needs assessment, while older adults (those age 55 and above) are overrepresented.

**GRAPH 3- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Age[c], 2018**




[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18
[c]Excludes ages0-12
*Age ranges 35-44 and 45-54 combined due to differences in question structuring.

**Weighting the Sample**

Needs assessment data were statistically weighted by sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2018) *prior to* the analysis of results related to service needs and barriers. This was done because the demographic composition of 2020 Houston HIV Care Services Needs Assessment participants was *not* comparable to the composition of all PLWH in the Houston EMA. As such, the results presented in the remaining Chapters of this document are proportional for these three demographic categories only. Appropriate statistical methods were applied throughout the process in order to produce an accurately weighted sample, including a three-level stratification of prevalence data and subsequent data weighting syntax. Voluntary completion on the survey and non-applicable answers comprise the missing or invalid survey entries and are excluded in the statistical analysis; therefore, denominators will further vary across results. All data management and quantitative analysis, including weighting, was performed in IBM© SPSS© Statistics (v. 22). Qualitative analysis was performed in QSR International© NVivo 10.

*Sources:*

Texas Department of State Health Services (TDSHS) eHARS data through 12-31-2018.

University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPPS Statistics 20, Post-stratification weights, 2009.

# Chapter 2:
# Service Needs and Barriers

## OVERALL SERVICE NEEDS AND BARRIERS

As payer of last resort, the Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to people living with HIV (**PLWH**) who may not have sufficient resources for managing HIV. The Houston Area HIV Services Ryan White Planning Council identifies, designs, and allocates funding to locally-provided HIV care services. Housing services for PLWH are provided through the federal Housing Opportunities for People with AIDS (**HOPWA**) program through the City of Houston Housing and Community Development Department and for PLWH recently released from incarceration through the Houston Regional HIV/AIDS Resource Group (**TRG**). The primary function of HIV needs assessment activities is to gather information about the need for and barriers to services funded by the local Houston Ryan White HIV/AIDS Program, as well as other HIV-related programs like HOPWA and the Houston Health Department's (**HHD**) prevention program.

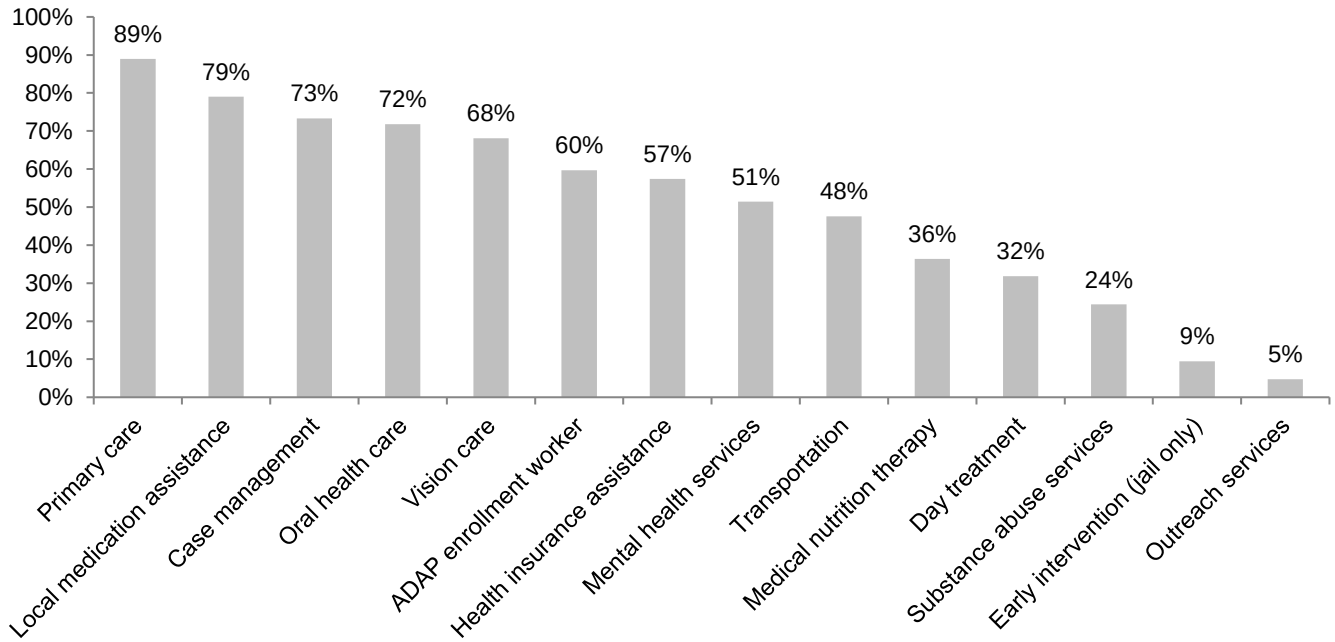
### Overall Ranking of Funded Services, by Need

At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 1**) All funded services except hospice and linguistics were analyzed and received a ranking of need. Emergency financial assistance was merged with local medication assistance, and non-medical case management was merged with medical case management. At 89%, primary care was the most needed funded service in the Houston Area, followed by local medication assistance at 79%, case management at 73%, oral health care at 72%, and vision care at 68%. Primary care had the highest need ranking of any core medical service, while ADAP enrollment worker received the highest need ranking of any support service. Compared to the last Houston Area HIV needs assessment conducted in 2016, need ranking decreased for most services. The percent of needs assessment participants reporting need for a particular service decreased the most for case management and primary care, while the percent of those indicating a need for local medication assistance and early intervention services increased from 2016.

**GRAPH 1-Ranking of HIV Services in the Houston Area, By Need, 2020**

*Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.*
*Denominator: 569-573 participants, varying between service categories*



**Overall Ranking of Funded Services, by Accessibility**

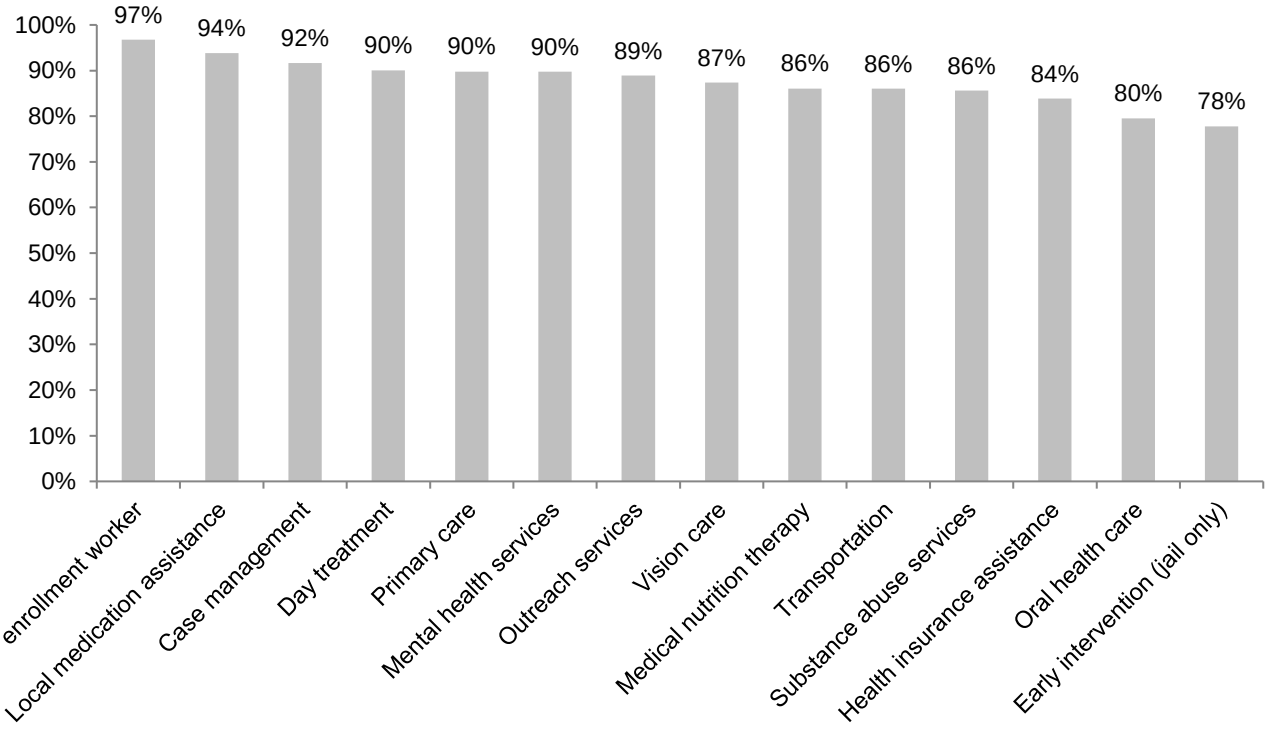
Participants were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both topics are presented below.

(**Graph 2**) All funded services except hospice and linguistics were analyzed and received a ranking of accessibility. The most accessible service was ADAP enrollment worker at 97% ease of access, followed by local medication assistance at 94% and case management at 92%. Local medication assistance had the highest accessibility ranking of any core medical service, while ADAP enrollment worker received the highest accessibility ranking of any support service. Compared 2016 needs assessment, reported accessibility on remained stable on average. The greatest increase in percent of participants reporting ease of access was observed in local medication assistance, while the greatest decrease in accessibility was reported for early intervention services.

**GRAPH 2-Ranking of HIV Services in the Houston Area, By Accessibility, 2020**

*Definition: Of needs assessment participants stating they needed the service in the past 12 months, the percent stating it was easy to access the service.*

*Denominator: 569-573 participants, varying between service categories*



**Overall Ranking of Barriers Types Experienced by Consumers**

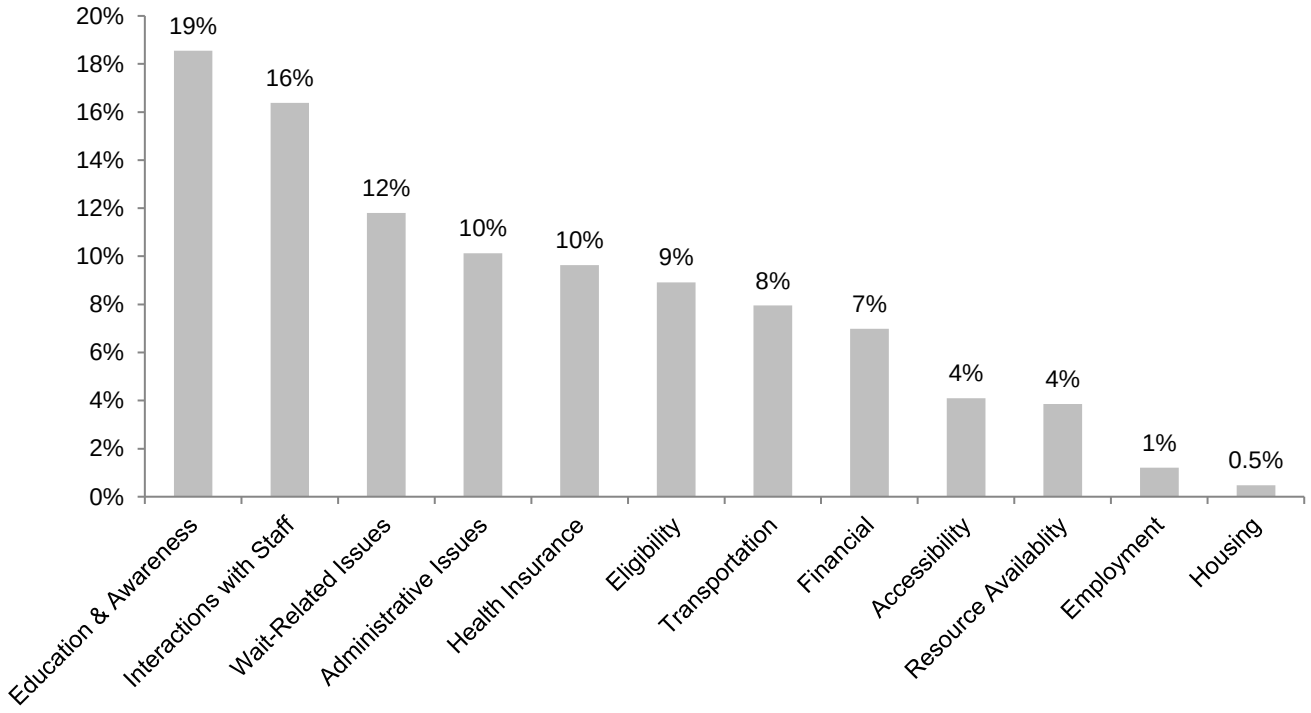
Since the 2016 Houston Area HIV Needs Assessment, participants who reported *difficulty* accessing needed services have been asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. In 2016, staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers, then grouped together into 12 nodes, or barrier types. This categorization schema was applied to reported barriers in the 2020 survey.

(**Graph 3**) Overall, fewer barriers were reported in 2020 (415 barrier reports) than in previous 2016 needs assessment (501 barrier reports), despite the increase in sample size in 2020. Across all funded services, the barrier types reported most often related to service education and awareness issues (19% of all reported barriers); interactions with staff (16%), wait-related issues (12%); administrative issues (10%); and issues relating to health insurance coverage (10%). Housing issues (homelessness or intimate partner violence) were reported least often as barriers to funded services (1%). Between the 2016 and 2020 HIV needs assessments, the percentage of barriers relating to interactions with staff increased by 3 percentage points, while wait-related issues decreased by 3 percentage points.

For more information on barrier types reported most often by service category, please see the Service-Specific Fact Sheets.

**GRAPH 3-Ranking of Types of Barriers to HIV Services in the Houston Area, 2018**

*Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.*
*Denominator: 415 barrier reports*



**Descriptions of Barriers Encountered**

All funded services were reported to have barriers, with an average of 35 reports of barriers per service. Participants reported the least barriers for Linguistic Services (one barrier) and the most barriers for Oral Health Care (90 barriers). In total, 415 reports of barriers across all services were indicated in the sample.

(**Table 1**) Within education and awareness, knowledge of the availability of the service and where to go to access the service accounted for 81% of barriers reported. Being put on a waitlist accounted for a majority (56%) of wait-related barriers. Poor communication and/or follow up from staff members when contacting participants comprised a majority (53%) of barriers related to staff interactions. Forty-five percent (45%) of eligibility barriers related to participants being told they did not meet eligibly requirements to receive the service while redundant or complex processes for renewing eligibility accounted for an additional 39% of eligibility barriers. Among administrative issues, long or complex processes required to obtain services sufficient to create a burden to access comprised most (57%) of the barriers reported.

A majority of health insurance-related barriers occurred because the participant was under-insured or experiencing coverage gaps for needed services or medications (55%) or they were uninsured (25%). The largest proportion (91%) of transportation-related barriers occurred when participants had no access to transportation. Inability to afford the service accounted for all barriers relating to participant financial resources. Services being offered at an inaccessible distance accounted for most (76%) of accessibility-related barriers, though it is noteworthy that low or no literacy accounted for 12% of accessibility-related barriers. Receiving resources that were insufficient to meet participant needs accounted for most resource availability barriers. Intimate partner violence accounted for both reports of housing-related barriers. Instances in which the participant's employer did not provide sufficient sick/wellness leave for attend appointments comprised most (80%) employment-related barriers.

| TABLE 1-Barrier Proportions within Each Barrier Type, 2020 | | | | | |
|---|---|---|---|---|---|
| Education & Awareness | % | Wait-Related Issues | % | Interactions with Staff | % |
| **Availability** (Didn't know the service was available) | 51% | **Waitlist** (Put on a waitlist) | 56% | **Communication** (Poor correspondence/ Follow up from staff) | 53% |
| **Definition** (Didn't know what service entails) | 2% | **Unavailable** (Waitlist full/not available resulting in client not being placed on waitlist) | 22% | **Poor Treatment** (Staff insensitive to clients) | 13% |
| **Location** (Didn't know where to go [location or location w/in agency]) | 30% | **Wait at Appointment** (Appointment visits take long) | 12% | **Resistance** (Staff refusal/ resistance to assist clients) | 6% |
| **Contact** (Didn't know who to contact for service) | 16% | **Approval** (Long durations between application and approval) | 10% | **Staff Knowledge** (Staff has no/ limited knowledge of service) | 19% |
| | | | | **Referral** (Received service referral to provider that did not meet client needs) | 10% |
| Eligibility | % | Administrative Issues | % | Health Insurance | % |
| **Ineligible** (Did not meet eligibility requirements) | 45% | **Staff Changes** (Change in staff w/o notice) | 10% | **Uninsured** (Client has no insurance) | 25% |
| **Eligibility Process** (Redundant process for renewing eligibility) | 39% | **Understaffing** (Shortage of staff) | 7% | **Coverage Gaps** (Certain services/medications not covered) | 55% |
| **Documentation** (Problems obtaining documentation needed for eligibility) | 16% | **Service Change** (Change in service w/o notice) | 7% | **Locating Provider** (Difficulty locating provider that takes insurance) | 18% |
| | | **Complex Process** (Burden of long complex process for accessing services) | 57% | **ACA** (Problems with ACA enrollment process) | 3% |
| | | **Dismissal** (Client dismissal from agency) | 7% | | |
| | | **Hours** (Problem with agency hours of operation) | 12% | | |
| Transportation | | Financial | % | Accessibility | % |
| **No Transportation** (No or limited transportation options) | 91% | **Financial Resources** (Could not afford service) | 100% | **Literacy** (Cannot read/difficulty reading) | 12% |
| **Providers** (Problems with special transportation providers such as Metrolift or Medicaid transportation) | 9% | | | **Spanish Services** (Services not made available in Spanish) | 0% |
| | | | | **Released from Incarceration** (Restricted from services due to probation, parole, or felon status) | 12% |
| | | | | **Distance** (Service not offered within accessible distance) | 76% |
| Resource Availability | % | Housing | % | Employment | % |
| **Insufficient** (Resources offered insufficient for meeting need) | 81% | **Homeless** (Client is without stable housing) | 0% | **Unemployed** (Client is unemployed) | 20% |
| **Quality** (Resource quality was poor) | 19% | **IPV** (Interpersonal domestic issues make housing situation unsafe) | 100% | **Leave** (Employer does not provide sick/wellness leave for appointments) | 80% |

## NEEDS AND ACCESSIBILITY FOR UNFUNDED SERVICES

The Ryan White HIV/AIDS Program allows funding of 13 core medical services and 15 support services, though only 17 of these services were funded in the Houston area at the time of survey. For this first time, the 2020 Houston Area HIV Needs Assessment collected data on the need for and accessibility to services that are allowable under Ryan White, but not currently funded in the Houston area. While these services are not funded under Ryan White, other funding sources in the community may offer them.

### Overall Ranking of Unfunded Services, by Need

Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of allowable but currently unfunded services they needed in the past 12 months.

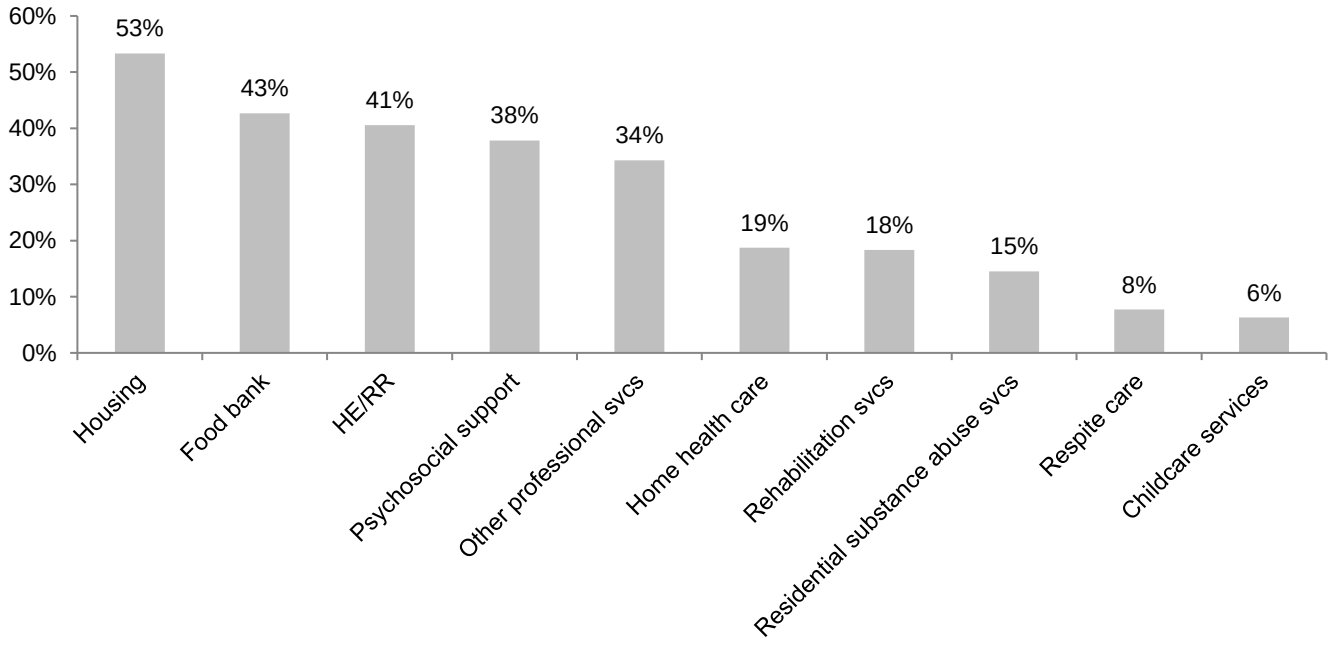
(**Graph 4**) At 53%, housing was the most needed unfunded service in the Houston Area, followed by food bank at 43%, health education/risk reduction at 41%, psychosocial support services at 38%, and other professional services at 34%. Of participants indicating a need for food bank, 69% reported needing services from a food bank, 6% reported needing home delivered meals, and 25% indicated need for both types of food bank service. Among participants indicating a need for psychosocial support services, 89% reported needing an in-person support group, 3% reported needing an online support group, and 8% indicated need for both types of psychosocial support.

Home health care had the highest need ranking of any unfunded core medical service, while housing received the highest need ranking of any unfunded support service.

**GRAPH 4-Ranking of Unfunded HIV Services in the Houston Area, By Need, 2020**

*Definition: Percent of needs assessment participants stating they needed the unfunded service in the past 12 months, regardless of service accessibility.*

*Denominator: 569-572 participants, varying between service categories*



**Overall Ranking of Unfunded Services, by Accessibility**

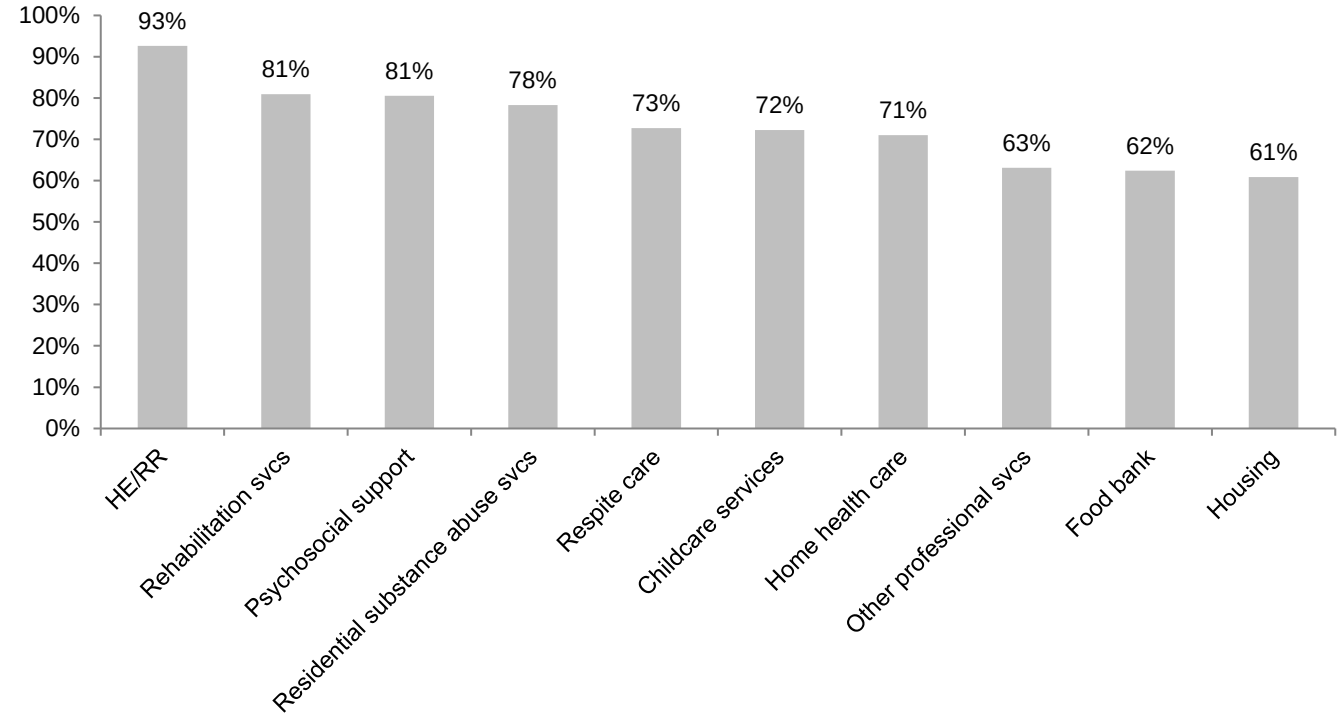
Participants were asked to indicate if each of the unfunded HIV services they needed in the past 12 months was easy or difficult for them to access.

(**Graph 5**) The most accessible unfunded service was health education/risk reduction at 93% ease of access, followed by rehabilitation services at 81%, psychosocial support services at 81%, residential substance abuse services at 78%, and respite care at 73%. The least accessible needed unfunded services was housing at 61%. Home health care had the highest accessibility ranking of any core medical service, while rehabilitation services received the highest accessibility ranking of any support service.

**GRAPH 5-Ranking of Unfunded HIV Services in the Houston Area, By Accessibility, 2020**

*Definition: Of needs assessment participants stating they needed the unfunded service in the past 12 months, the percent stating it was easy to access the service.*

*Denominator: 569-572 participants, varying between service categories*



**Other Identified Needs**

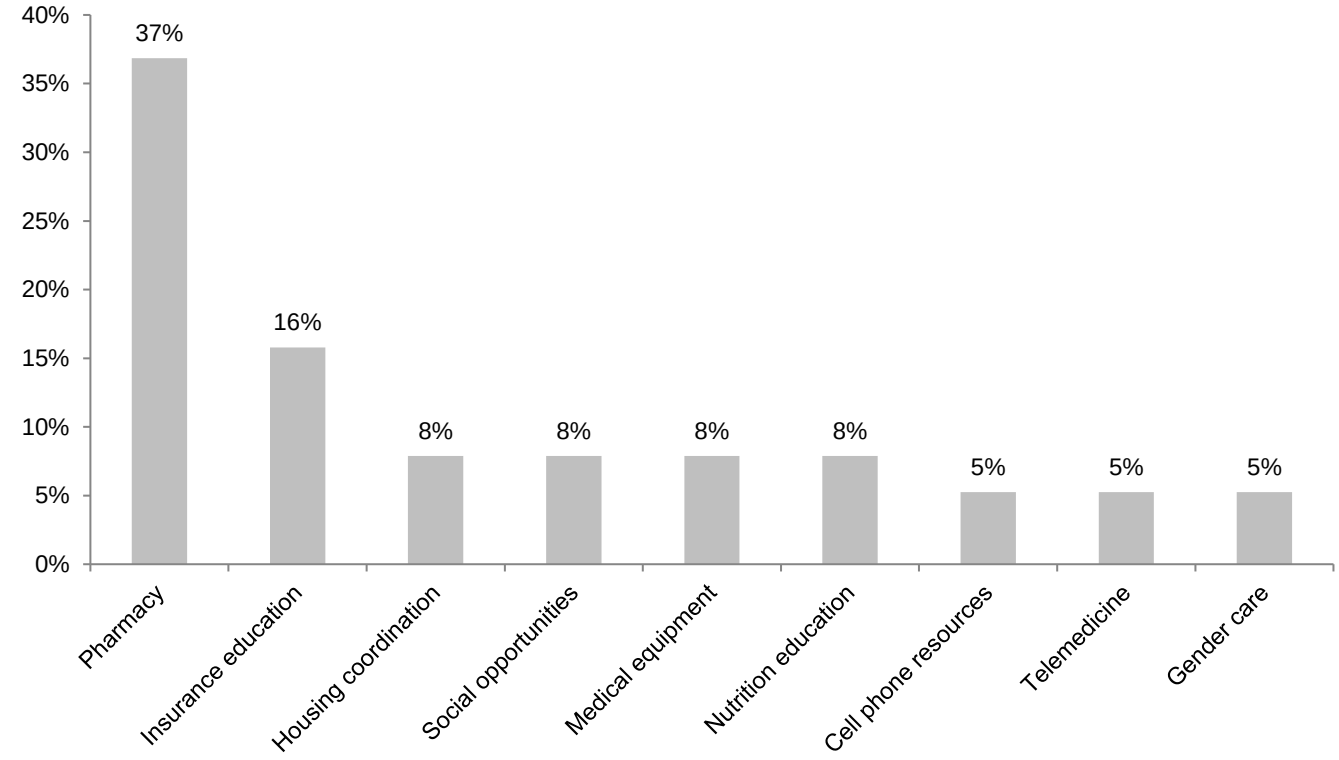
In addition to the allowable HIV services listed above, participants were also encouraged to write-in other types of needed services to gauge any new or emerging service needs in the community.

(**Graph 6**) Participants identified nine additional needs not otherwise described in funded and unfunded services above. The most common identified needs related to pharmacy, such as having medications delivered and automatic refills, at 37%. This was followed by insurance education at 16%, and housing coordination, social opportunities, coverage for medical equipment, and nutrition education, each at 8%.

**GRAPH 6-Other Needs for HIV Services in the Houston Area, 2020**

*Definition: Percent of write-in responses by type for the survey question, "What other kinds of services do you need to help you get your HIV medical care?"*

*Denominator: 38 write-in responses*



# Housing Profile

# 2020 Houston HIV Care Services Needs Assessment

**Disclaimer:**
This Housing Profile uses data from the 2020 Houston Area HIV Care Services Needs Assessment (approval pending). The 2020 Needs Assessment summarizes primary data collected from April 2019 to February 2020 from 589 self-selected, self-identified people living with HIV (PLWH) using either a self-administered written or electronic survey, or verbal interview. Most respondents resided in Houston/Harris County at the time of data collection. Data were statistically weighted for sex at birth, primary race/ethnicity, and age range based on a three-level stratification of HIV prevalence in the Houston EMA (2018). Though quality control measures were applied, limitations to the raw data and data analysis exist, and other data sources should be used to provide context for and to better understand the results. Data collected through this process represent the most current *primary* data source on PLWH in the Houston Area. Census, surveillance, and other data presented here reflect the most current data available at the time of publication.

**Funding acknowledgment:**
The 2020 Houston Area HIV Care Services Needs Assessment is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $24,272,961 and was not financed with nongovernmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government."

Incentives were provided by the Houston Regional HIV/AIDS Resource Group, Inc.

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Approved: PENDING. Primary Author: Amber Lynn Harbolt, MA, Health Planner, Ryan White Planning Council Office of Support.

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## HOUSING SERVICE NEEDS AND BARRIERS

As payer of last resort, the Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to people living with HIV (**PLWH**) who may not have sufficient resources for managing HIV. The Houston Area HIV Services Ryan White Planning Council identifies, designs, and allocates funding to locally-provided HIV care services. Housing services for PLWH are provided through the federal Housing Opportunities for People with AIDS (**HOPWA**) program through the City of Houston Housing and Community Development Department and for PLWH recently released from incarceration through the Houston Regional HIV/AIDS Resource Group (**TRG**). The primary function of HIV needs assessment activities is to gather information about the need for and barriers to services funded by the local Houston Ryan White HIV/AIDS Program, as well as other HIV-related programs like HOPWA and the Houston Health Department's (**HHD**) prevention program. This Profile assesses the need, accessibility, and barriers to housing for PLWH in the Houston area.

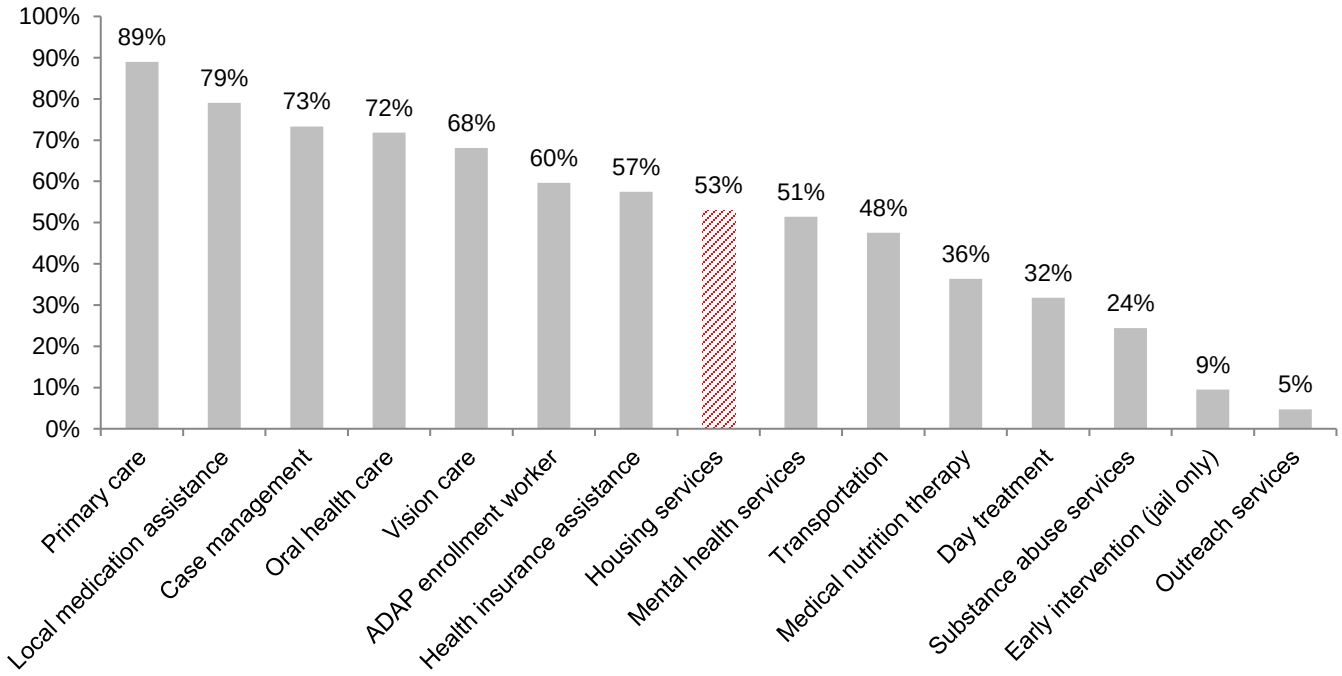
### Overall Ranking of Housing and Funded Services, by Need

At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. For the first time, the 2020 Houston Area HIV Needs Assessment also collected data on the need for and accessibility to 10 additional services that are allowable under Ryan White, but not currently funded through Ryan White in the Houston area, such as housing services. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded and unfunded services they needed in the past 12 months.

(**Graph 1**) All funded and unfunded services except hospice and linguistics were analyzed and received a ranking of need. Housing services was identified as the most commonly needed unfunded service at 53% of survey participants indicating need. When ranked with currently funded services, housing was the 8th highest ranked for need. This places the need ranking for housing services before mental health services, transportation, medical nutrition therapy, adult day treatment, substance abuse services, early intervention services, and outreach services.

**GRAPH 1-Ranking of Housing and Funded HIV Services in the Houston Area, By Need, 2020**

*Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.*
*Denominator: 569-573 participants, varying between service categories*



**Overall Ranking of Housing and Funded Services, by Accessibility**

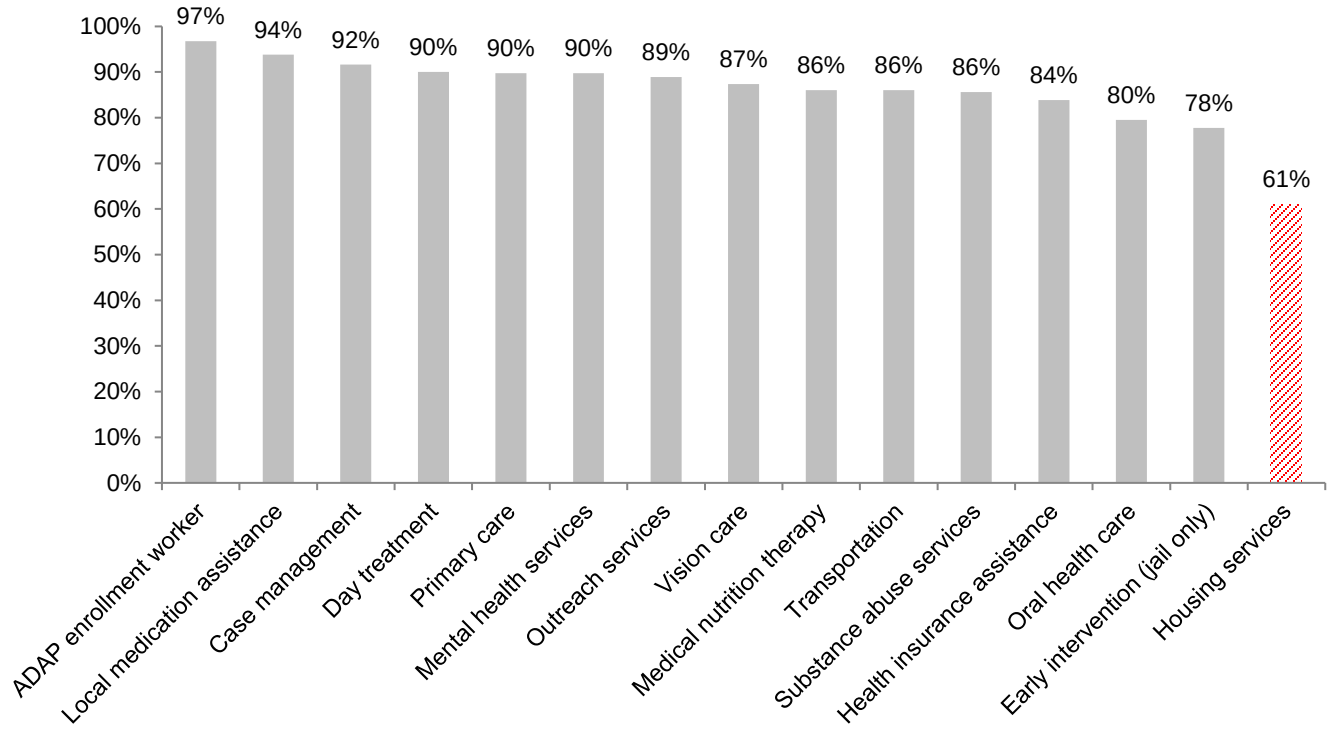
Participants were asked to indicate whether each of the funded and unfunded services they needed in the past 12 months was easy or difficult for them to access.

(**Graph 2**) All funded and unfunded services except hospice and linguistics were analyzed and received a ranking of accessibility. Housing was identified as the least accessible unfunded service as only 61% of the participants who needed housing services found it easy to access. When ranked with currently funded services, housing the lowest ranked for accessibility. This places the accessibility ranking for housing services below every funded and unfunded service.

**GRAPH 2-Ranking of Housing and Funded HIV Services in the Houston Area, By Accessibility, 2020**

*Definition: Of needs assessment participants stating they needed the service in the past 12 months, the percent stating it was easy to access the service.*

*Denominator: 569-573 participants, varying between service categories*



### Housing Services Need and Accessibility by Demographic Categories and Select Special Populations

(**Table 1 and Table 2**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For housing services, this analysis shows the following:

- More females than males found the service accessible.
- More Black/African American PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.

In addition, more transgender, homeless, and MSM PLWH found the housing difficult to access when compared to all participants.

**TABLE 1-Housing Services, by Demographic Categories, 2020**

| | Sex (at birth) | | Race/ethnicity | | | | Age | | |
|---|---|---|---|---|---|---|---|---|---|
| Experience with the Service | Male | Female | White | Black | Hispanic | Other | 18-24 | 25-49 | 50+ |
| Did not need service | 48% | 42% | 53% | 40% | 55% | 29% | 70% | 41% | 53% |
| Needed, easy to access | 31% | 38% | 24% | 41% | 24% | 38% | 30% | 35% | 28% |
| Needed, difficult to access | 22% | 19% | 24% | 19% | 20% | 33% | 0% | 24% | 19% |

**TABLE 2-Housing Services, by Selected Special Populations, 2020**

| Experience with the Service | Homeless[a] | MSM[b] | Out of Care[c] | Recently Released[d] | Rural[e] | Transgender[f] |
|---|---|---|---|---|---|---|
| Did not need service | 23% | 52% | 52% | 22% | 80% | 28% |
| Needed, easy to access | 35% | 25% | 32% | 8% | 3% | 28% |
| Needed, difficult to access | 42% | 23% | 16% | 9% | 17% | 44% |

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

**Barriers to Accessing Housing Services**

Since the 2016 Houston Area HIV Needs Assessment, participants who reported *difficulty* accessing needed services have been asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. In 2016, staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers, then grouped together into 12 nodes, or barrier types. This categorization schema was applied to reported barriers in the 2020 survey.

(**Table 3**) When barriers to housing services were reported, the most common barrier type was wait-related issues at 28% of reports, followed by education and awareness issues (24%), interactions with staff (13%), administrative issues (9%) and eligibility issues (6%). Wait-related issues most commonly experienced were being placed on a housing waitlist (often in excess of 2 years) or being told a waitlist for housing was unavailable. Education and awareness issues were most often lack of knowledge about housing service availability or where to go to access housing services. Barriers regarding interactions with staff were most often poor or no communication from staff and staff who were not knowledgeable about area housing resources. Administrative issues were almost exclusively long, complex, or confusing processes required for accessing housing services. Barriers related to eligibility were most often having difficulty obtaining documentation needed for housing eligibility.

**TABLE 3-Top 5 Reported Barrier Types for Housing Services, 2020**

| | No. | % |
|---|---|---|
| 1. Wait-related (W) | 31 | 28% |
| 2. Education and Awareness (EA) | 27 | 24% |
| 3. Interactions with Staff (S) | 14 | 13% |
| 4. Administrative (AD) | 10 | 9% |
| 5. Eligibility (EL) | 7 | 6% |

## ADDITIONAL HOUSING DATA

The 2020 Houston Area HIV Needs Assessment collected additional data relevant to housing needs, homelessness, housing instability, and housing quality. These additional data are presented below.

### Housing Type, Homelessness, and Housing Instability

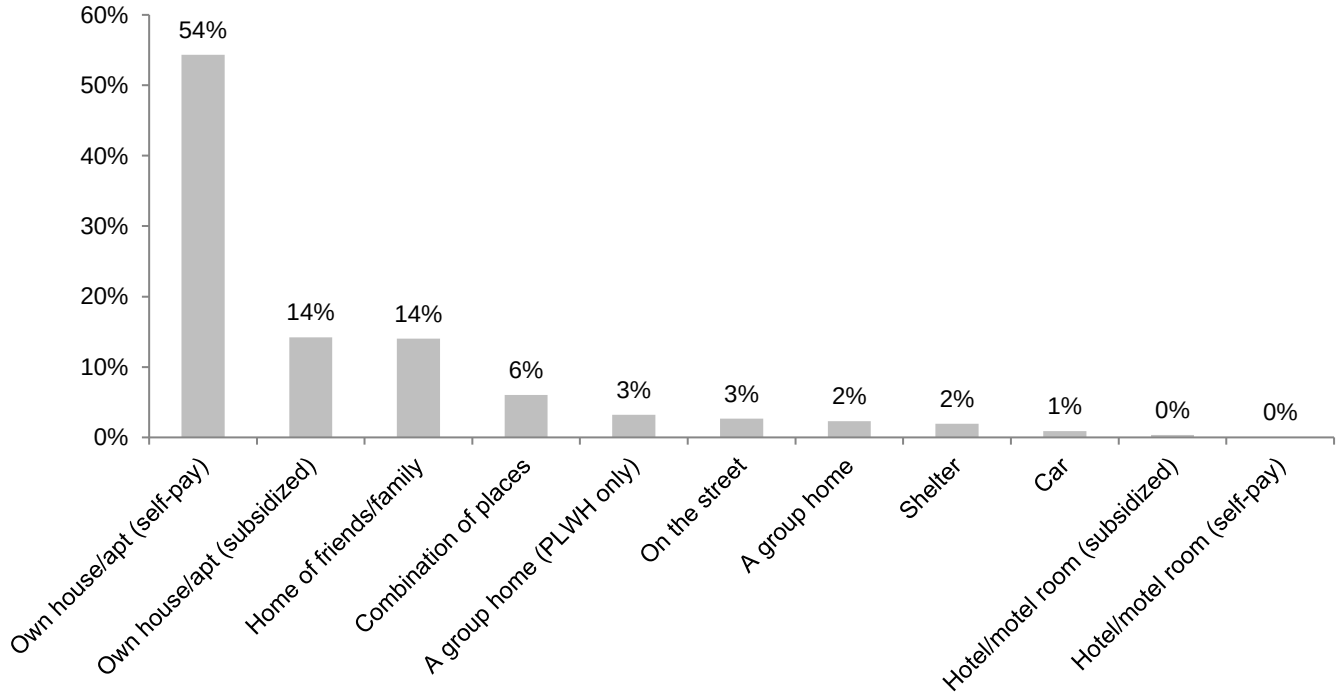
Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to select on response for where they sleep most often from a list of 11 possible housing types. Participants were also encouraged to write in where they sleep most often if they did not see it listed among the housing type options. Another question asked they felt their current housing situation was stable.

(**Graph 3**) A majority of participants slept most often in a house or apartment that they paid for (54%). This was followed by sleeping most often in a subsidized house or apartment (14%), staying with friends or family (14%), sleeping in a combination of places (6%) staying in a group home for PLWH (3%), or sleeping on the street (3%).

Participants who indicated they slept most often at a shelter, in a car, on the street, or in a combination of places that changes were identified as experiencing homelessness. By this metric, 11% of participants were experiencing homelessness as the time of survey. Regardless of housing type, 32% of participants indicated that they felt their current housing situation was unstable.

**GRAPH 3 -Ranking of Housing Types for PLWH in the Houston Area, 2020**

*Definition: Percent of needs assessment participants stating they slept most often at each housing type.*
*Denominator: 563 participants*



**Current Housing Problems**

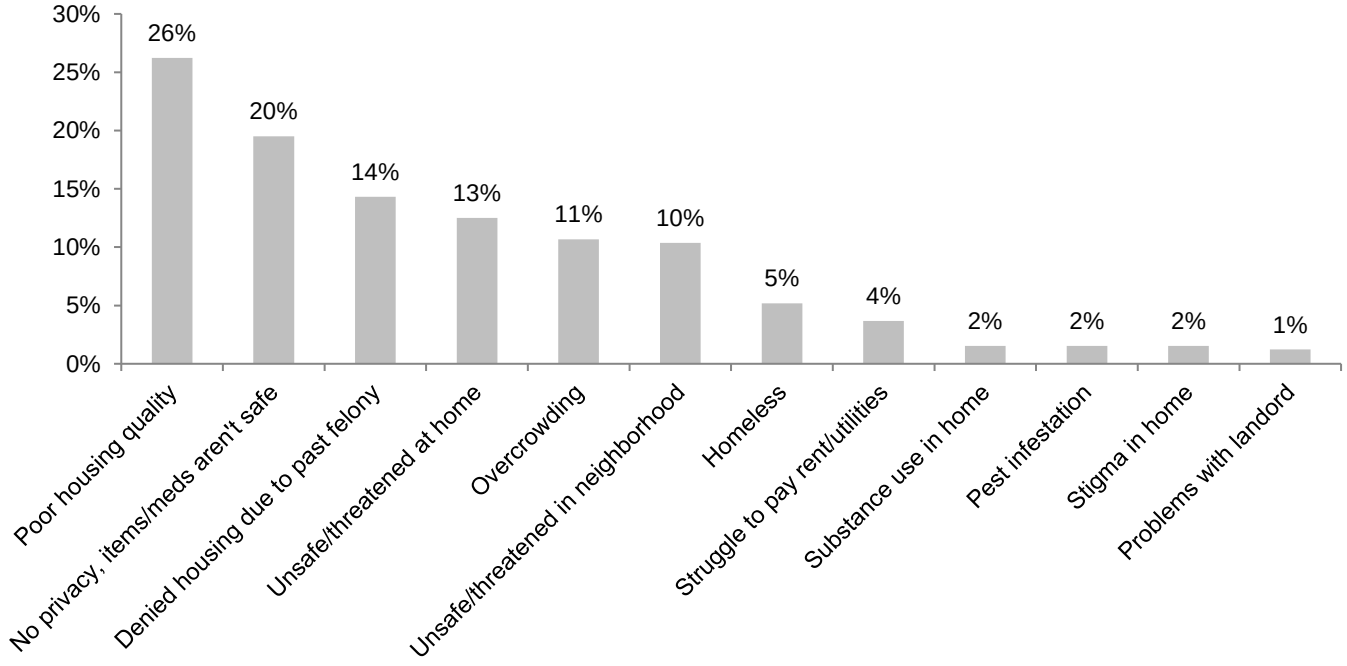
Regardless of housing status and stability, other housing-related issues may present barriers to access and retention in care. Twelve-percent (12%) of participants indicated that their housing situation has interfered with them getting HIV medical care.

Participants were asked to indicate whether they were currently experiencing any of a list of housing quality, safety, or access issues. Participants were also encouraged to write-in any current housing problems, which at analysis were added to the list or condensed into existing options. Forty-percent (40%) of survey participants indicated they were currently experiencing housing quality, safety, or access issues.

(**Graph 4**) The most common housing problem participants were experiencing at the time of survey was poor housing quality at 26%. Examples given in the survey for poor housing quality were presence of mold or asbestos, exposed wires, broken windows, leaks, poor insulation, broken plumbing, or broken appliances. This was followed by having no privacy and feeling that possessions and medications were not safe (20%), being denied housing due to a past felony (14%), feeling unsafe or threatened at home (13%), and overcrowding (11%). Write-in responses with enough cases to justify inclusion in the list currently experiencing homelessness, struggling to pay rent/utilities, substance use in the home, pest infestation, stigma at home, and difficulties with landlords.

**GRAPH 4-Current Housing Problems Experienced by PLWH, 2020**

*Definition: Of needs assessment participants stating they were currently experiencing problems with housing quality, safety, or access, the percent stating they were experiencing each problem.*
*Denominator: 328 participants*



# HIV and African Americans

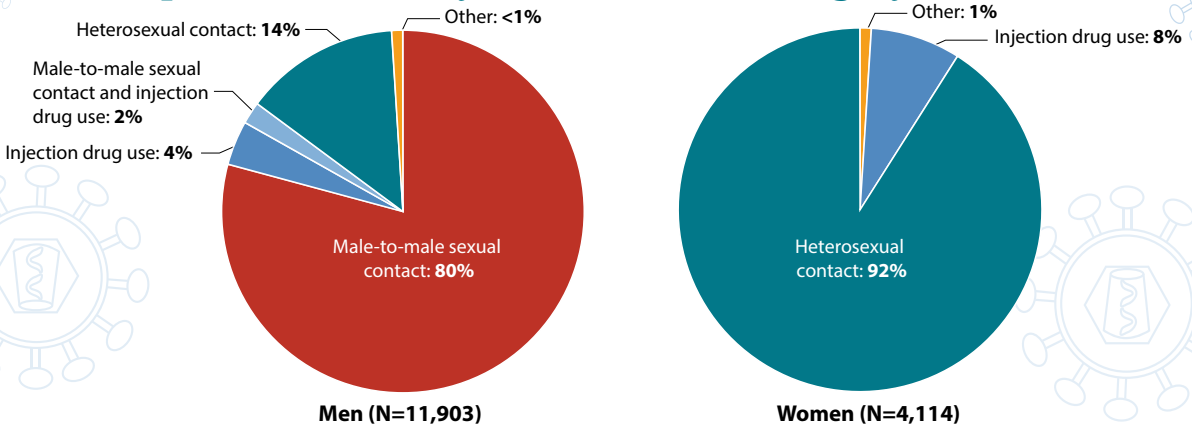
## OF THE 37,832 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2018:

**42% WERE AMONG ADULT AND ADOLESCENT BLACKS/ AFRICAN AMERICANS†**

**31% WERE AMONG BLACK/ AFRICAN AMERICAN MEN**

**11% WERE AMONG BLACK/ AFRICAN AMERICAN WOMEN**

## New HIV Diagnoses Among Blacks/African Americans in the US and Dependent Areas by Transmission Category and Sex, 2018




**Men (N=11,903)** **Women (N=4,114)**

Totals may not equal 100% due to rounding.

## From 2010 to 2017, HIV diagnoses decreased 15% among blacks/African Americans overall.‡ But trends varied for different groups of blacks/African Americans:

Women: **down 27%**

Heterosexual men: **down 32%**

Gay and bisexual men overall:** †† **remained stable**

Gay and bisexual men by age:††

- 13 to 24: **down 11%**
- 25 to 34: **up 42%**
- 35 to 44: **down 21%**
- 45 to 54: **down 36%**
- 55 and older: **remained stable**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

† *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether. This fact sheet uses *African American*, unless referencing surveillance data.

‡ In 50 states and the District of Columbia.

** This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who have sex with men.

†† Includes infections attributed to male-to-male sexual contact and injection drug use (men who reported both risk factors).

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around **1.1 million people** are living with HIV in the US.‡ People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

AT THE END OF 2016, AN ESTIMATED
**476,100**
**BLACKS/AFRICAN AMERICANS HAD HIV.**

**6 in 7**
**KNEW THEY HAD THE VIRUS.‡**

## For every 100 blacks/African Americans with HIV in 2016:‡

- **61** received some HIV care
- **47** were retained in care
- **48** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

## What places some African Americans at higher risk for HIV?

### Knowledge of HIV Status

Some African Americans do not know their HIV status. People who do not know they have HIV can't get the care they need and may transmit HIV to others without knowing it.

### Sexually Transmitted Diseases (STDs)

African Americans have higher rates of some STDs. Having another STD can increase a person's chance of getting or transmitting HIV.

### Socioeconomic Issues

The poverty rate is high among African Americans. The issues associated with poverty, including limited access to HIV prevention and care services, may increase the risk for HIV.

### Stigma and Discrimination


Stigma, fear, discrimination, and homophobia may place some African Americans at higher risk for HIV.

## How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Conducting prevention research and providing guidance to those working in HIV prevention.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

Supporting community organizations that increase access to HIV testing and care.


Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

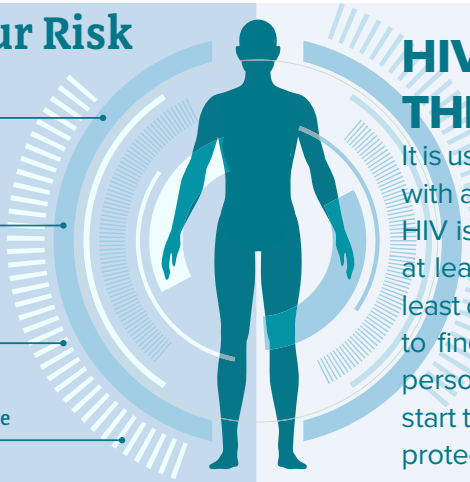
## Reduce Your Risk

Not having sex

Using condoms

Not sharing syringes

Taking medicine to prevent or treat HIV



## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

**For More Information**
Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in January 2020.

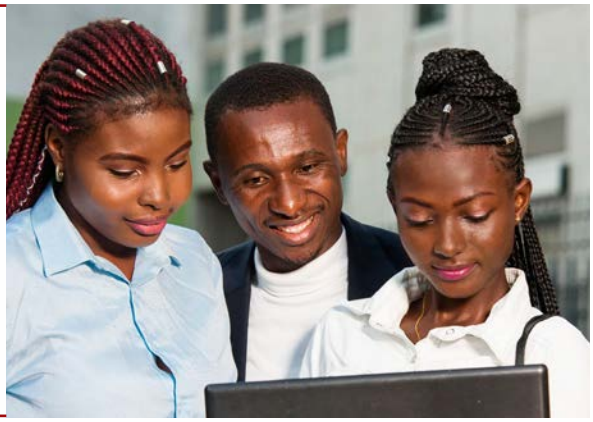
HRSA
Ryan White & Global HIV/AIDS Programs

# HRSA's Ryan White HIV/AIDS Program

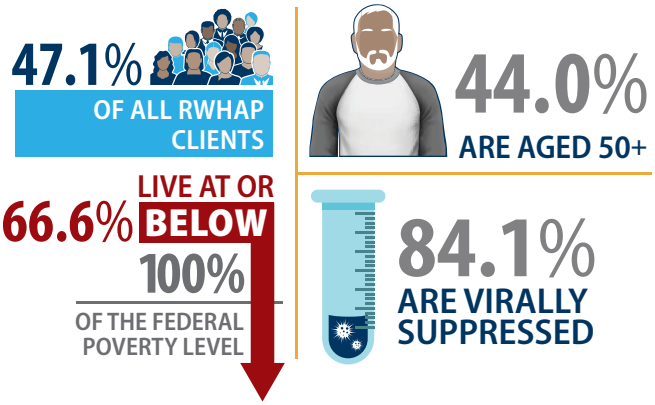
## Black/African American Clients: Ryan White HIV/AIDS Program, 2018

### Population Fact Sheet | January 2020

**The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.**



## Ryan White HIV/AIDS Program Fast Facts: Black/African American Clients




Of the more than half a million clients served by RWHAP, 73.7 percent are from racial/ethnic minority populations, with 47.1 percent of all RWHAP clients identifying as black/African American.

More details about this RWHAP client population are outlined below:

- The majority of black/African American clients served by RWHAP are low income. Data show that 66.6 percent of black/African American clients are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (61.3 percent).
- The majority of black/African American clients served by RWHAP are male. Data show that 62.9 percent of clients are male, 35.0 percent of clients are female, and 2.2 percent of clients are transgender. The proportion of black/African American males is lower than the national RWHAP average (72.0 percent), whereas the proportion of black/African American females is higher than the national RWHAP average (26.1 percent).
- One in seven black/African American clients served by RWHAP has temporary or unstable housing. Among black/African American clients served by RWHAP, 8.3 percent have temporary housing, and 5.9 percent have unstable housing.
- The black/African American RWHAP client population is aging. Black/African American clients aged 50 years and older account for 44.0 percent of all black/African American RWHAP clients.
- Among black/African American male RWHAP clients, 56.3 percent are men who have sex with men (MSM). Among all males served by RWHAP, MSM account for 65.7 percent.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, approximately 84.1 percent of black/African American clients receiving RWHAP HIV medical care are virally suppressed,* which is lower than the national RWHAP average (87.1 percent).

- 83.3 percent of black/African American men receiving RWHAP HIV medical care are virally suppressed.
- 85.7 percent of black/African American women receiving RWHAP HIV medical care are virally suppressed.

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

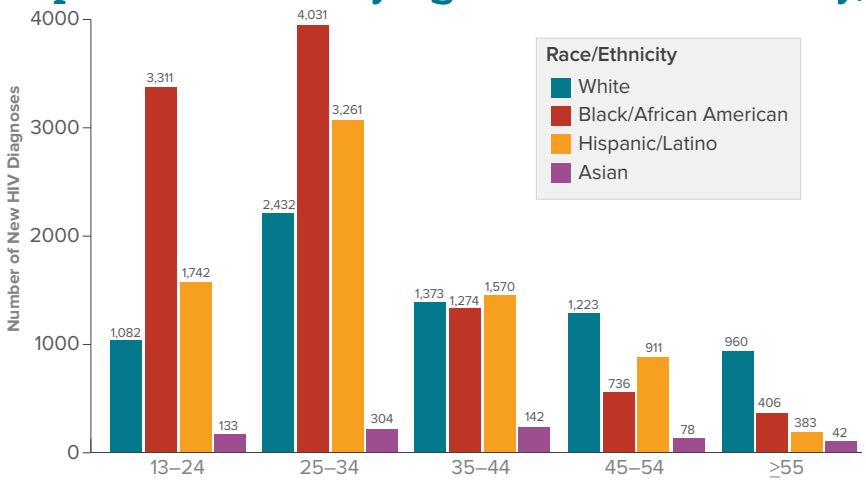
# HIV and African American Gay and Bisexual Men

**OF THE 37,832 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2018,**
**9,756 WERE AMONG ADULT AND ADOLESCENT BLACK/AFRICAN AMERICAN† GAY AND BISEXUAL MEN.‡ ****

**BLACK/AFRICAN AMERICAN GAY AND BISEXUAL MEN MADE UP 37% OF HIV DIAGNOSES AMONG ALL GAY AND BISEXUAL MEN**

**3 OUT OF 4 BLACK/AFRICAN AMERICAN GAY AND BISEXUAL MEN WHO RECEIVED AN HIV DIAGNOSIS WERE AGED 13 TO 34**

## New HIV Diagnoses Among Gay and Bisexual Men in the US and Dependent Areas By Age and Race/Ethnicity, 2018




Subpopulations representing 2% or less of HIV diagnoses among gay and bisexual men are not reflected in this chart. Hispanics/Latinos can be of any race.

## From 2010 to 2017, HIV diagnoses remained stable overall among black/African American gay and bisexual men.†† But trends varied by age:

### Black/African American gay and bisexual men by age‡

- 13 to 24: **down 11%**
- 25 to 34: **up 42%**
- 35 to 44: **down 21%**
- 45 to 54: **down 36%**
- 55 and older: **stable**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether. This fact sheet uses *African American*, unless referencing surveillance data.
‡ Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).
** This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who have sex with men.
†† In 50 states and the District of Columbia.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around **1.1 million people** are living with HIV in the US.†† People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

AT THE END OF 2016, AN ESTIMATED

**225,200**

**BLACK/AFRICAN AMERICAN GAY AND BISEXUAL MEN HAD HIV.**

**8 in 10**

**KNEW THEY HAD THE VIRUS.‡‡**

## For every 100 black/African American gay and bisexual men with HIV in 2016:***

- **75** received some HIV care
- **59** were retained in care
- **57** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

## What places some African American gay and bisexual men at higher risk?

### Delay in Linkage to HIV Medical Care

Not all African American gay and bisexual men with newly and previously diagnosed HIV are linked to care within 90 days of the diagnosis.

### Lower Viral Suppression Percentages

African American gay and bisexual men have lower percentages of viral suppression than gay and bisexual men of other races/ethnicities.

### Socioeconomic Factors

Issues such as limited access to quality health care, lower income, and education may place some African American gay and bisexual men at higher risk for HIV.

### Stigma


Stigma, homophobia, and discrimination may affect whether African American gay and bisexual men seek or receive high-quality health services.

## How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Supporting community organizations that increase access to HIV testing and care.

Conducting prevention research and providing guidance to those working in HIV prevention.


Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

‡‡ Includes infections attributed male-to-male sexual contact only. Among black/African American men with HIV infection attributed to male-to-male sexual contact and injection drug use, 94% knew they had HIV.
*** In 41 states and the District of Columbia.

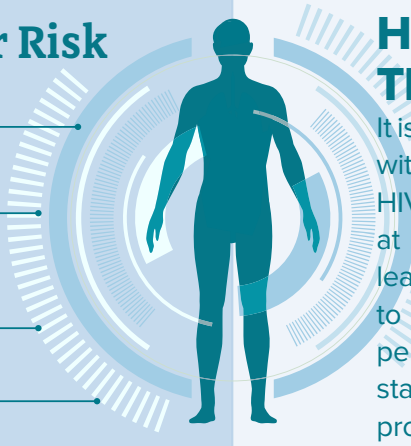
## Reduce Your Risk

Not having sex

Using condoms

Not sharing syringes

Taking medicine to prevent or treat HIV



## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

**For More Information**

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

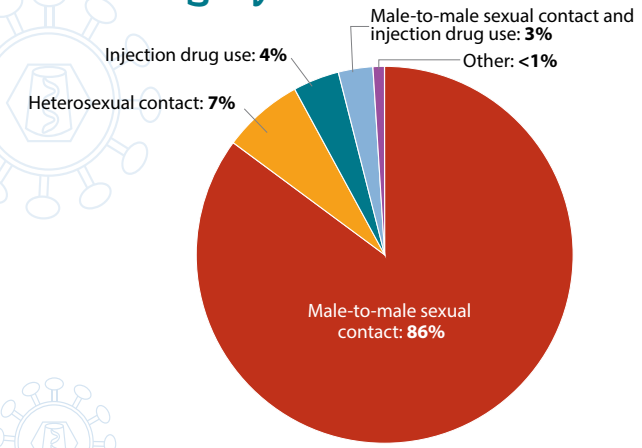
All content is based on the most recent data available in January 2020.

# HIV and Hispanics/Latinos

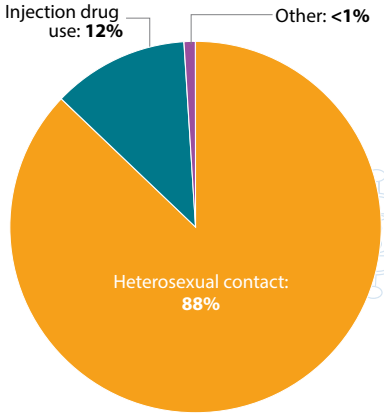
## OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017:

- 26% WERE AMONG ADULT AND ADOLESCENT HISPANICS/ LATINOS†
- 22% WERE AMONG HISPANIC/ LATINO MEN
- 3% WERE AMONG HISPANIC WOMEN/LATINAS

## New HIV Diagnoses Among Hispanics/Latinos by Transmission Category and Sex in the US and Dependent Areas, 2017




**Hispanic/Latino Men** (N= 8,686)




**Hispanic Women/Latinas** (N=1,203)

## From 2010 to 2016, HIV diagnoses increased 6% among Hispanics/Latinos overall.‡ But trends varied by transmission category:

| Hispanic/Latino men by transmission category: | Hispanic women/Latinas by transmission category: |
|---|---|
| Male-to-male sexual contact: **up 21%** | Heterosexual contact: **down 20%** |
| Injection drug use: **down 39%** | Injection drug use: **down 25%** |
| Male-to-male sexual contact and injection drug use: **down 21%** | |
| Heterosexual contact: **down 17%** | |

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Hispanics/Latinos can be of any race.
‡ In 50 states and the District of Columbia.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around **1.1 million people** are living with HIV in the US.‡ People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

AT THE END OF 2016, AN ESTIMATED **254,600** HISPANICS/LATINOS HAD HIV.‡

**5 in 6** KNEW THEY HAD THE VIRUS.

## For every 100 Hispanics/Latinos with HIV in 2016:‡

- **60** received some HIV care
- **49** were retained in care
- **51** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

## What places some Hispanics/Latinos at higher risk?

### Knowledge of HIV Status

Many Hispanics/Latinos do not know their HIV status. People who do not know they have HIV can't get the care they need and may pass HIV to others without knowing it.

### Stigma and Discrimination

Stigma, fear, discrimination, and homophobia may impact the lives of some Hispanics/Latinos. These issues may put some Hispanics/Latinos at higher risk for HIV.

### Sexually Transmitted Diseases (STDs)

Hispanics/Latinos have higher rates of some STDs. Having another STD can increase a person's chance of getting or transmitting HIV.

### Access to HIV Prevention and Care

Immigration status, poverty, migration patterns, lower educational level, and language barriers may make it harder for some Hispanics/Latinos to get HIV testing and care.

## How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

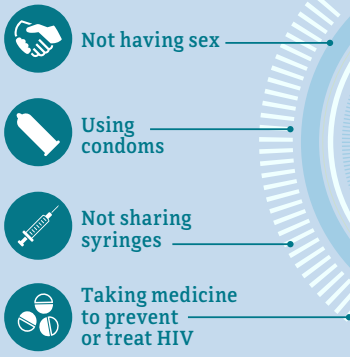
Supporting community organizations that increase access to HIV testing and care.

Conducting prevention research and providing guidance to those working in HIV prevention.


Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

## Reduce Your Risk




## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

**For More Information**

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in October 2019.

HRSA
Ryan White & Global HIV/AIDS Programs

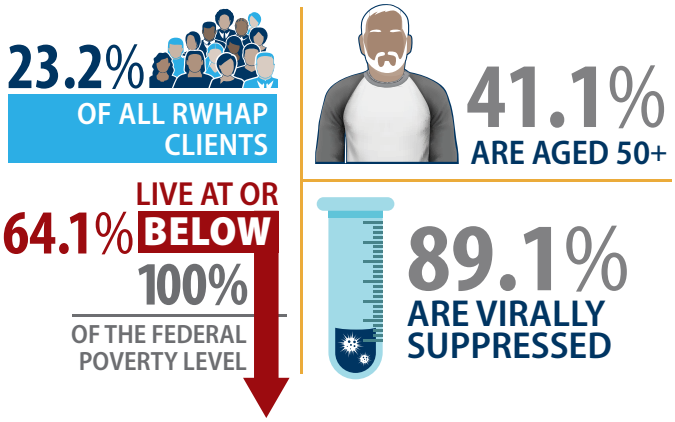
# HRSA's Ryan White HIV/AIDS Program

## Hispanic/Latino Clients: Ryan White HIV/AIDS Program, 2018

### Population Fact Sheet | January 2020

**The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.**

## Ryan White HIV/AIDS Program Fast Facts: Hispanic/Latino Clients




Of the more than half a million clients served by RWHAP, 73.7 percent are from racial/ethnic minority populations, with 23.2 percent of all RWHAP clients identifying as Hispanic/Latino. Below are more details about this RWHAP client population:

- The majority of Hispanic/Latino clients served by RWHAP are low income. Data show that 64.1 percent of Hispanic/Latino clients are living at or below 100 percent of the federal poverty level, which is slightly higher than the national RWHAP average (61.3 percent).
- The majority of Hispanic/Latino clients served by RWHAP are male. Data show that 75.9 percent of clients are male, 21.7 percent are female, and 2.4 percent are transgender.
- Data show that 4.7 percent of Hispanic/Latino RWHAP clients have unstable housing. This percentage is slightly lower than the national RWHAP average (5.3 percent).
- The Hispanic/Latino RWHAP client population is aging. Hispanic/Latino clients aged 50 years and older account for 41.1 percent of all Hispanic/Latino RWHAP clients.
- Among Hispanic/Latino male RWHAP clients, 65.8 percent are men who have sex with men (MSM). This percentage is consistent with the RWHAP national average (65.7 percent).

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, approximately 89.1 percent of Hispanic/Latino RWHAP clients receiving HIV medical care are virally suppressed,* which is slightly higher than the national RWHAP average (87.1 percent).

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

# HIV and Hispanic/Latino Gay and Bisexual Men

## OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017:

**7,722 WERE AMONG ADULT AND ADOLESCENT HISPANIC/LATINO† GAY AND BISEXUAL MEN‡ ****

**ABOUT 2 OUT OF 3 HISPANIC/LATINO GAY AND BISEXUAL MEN WHO RECEIVED AN HIV DIAGNOSIS WERE AGED 13 TO 34**

## New HIV Diagnoses Among Gay and Bisexual Men in the US and Dependent Areas By Age and Race/Ethnicity, 2017


Subpopulations representing 2% or less of HIV diagnoses among gay and bisexual men are not reflected in this chart.

## From 2010 to 2016, HIV diagnoses increased 18% among Hispanic/Latino gay and bisexual men overall.†† But trends varied by age:

**Hispanic/Latino gay and bisexual men by age**

- 13 to 24: **up 17%**
- 25 to 34: **up 34%**
- 35 to 44: **stable**
- 45 to 54: **up 14%**
- 55 and older: **up 10%**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Hispanics/Latinos can be of any race.
‡ Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).
** This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who have sex with men.
†† In 50 states and the District of Columbia.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around **1.1 million people** are living with HIV in the US.†† People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

AT THE END OF 2016, AN ESTIMATED

**168,400**

**HISPANIC/LATINO GAY AND BISEXUAL MEN HAD HIV.††**

**4 in 5**

**KNEW THEY HAD THE VIRUS.‡‡**

## For every 100 Hispanic/Latino gay and bisexual men with HIV in 2016:***

- **76** received some HIV care
- **62** were retained in care
- **61** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

## What places some Hispanic/Latino gay and bisexual men at higher risk?

### Knowledge of HIV Status

People who don't know they have HIV can't get the care they need and may pass HIV to others without knowing it.

### Low PrEP Use


A small number of Hispanic/Latino gay and bisexual men reported using using pre-exposure prophylaxis (PrEP). If taken daily, PrEP is highly effective for preventing HIV.

### Older Sex Partners

Hispanic/Latino gay and bisexual men are more likely to report that their last sex partner was older. Having older partners may increase the likelihood of being exposed to HIV.

### Access to HIV Prevention and Treatment Services

Immigration status, poverty, migration patterns, lower educational level, and language barriers may make it harder for some Hispanic/Latino gay and bisexual men to access HIV services.

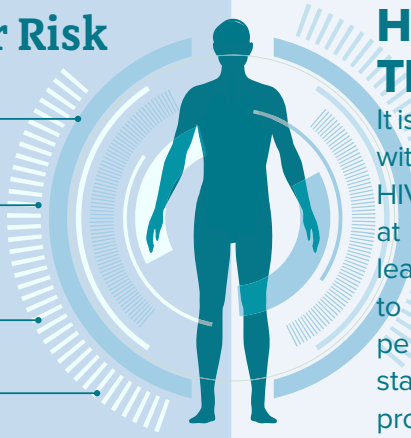
## How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends.
- Supporting community organizations that increase access to HIV testing and care.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.
- Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

‡‡ Includes infections attributed to male-to-male sexual contact only. Among Hispanic/Latino men with HIV infection attributed to male-to-male sexual contact *and* injection drug use, 91% knew they had HIV.
*** In 41 states and the District of Columbia.

## Reduce Your Risk

- Not having sex
- Using condoms
- Not sharing syringes
- Taking medicine to prevent or treat HIV



## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

**For More Information**

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

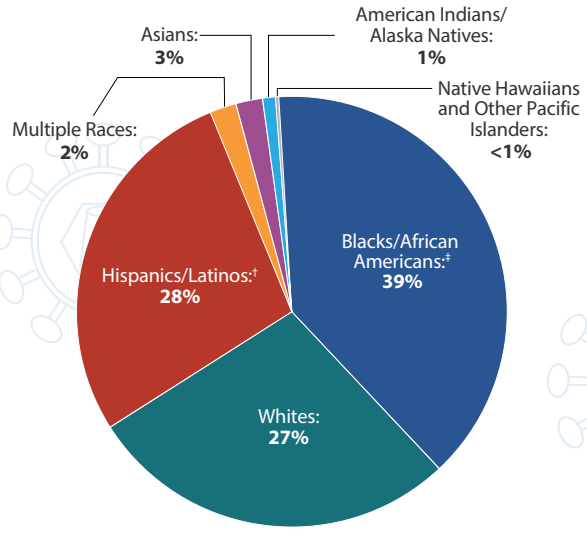
All content is based on the most recent data available in September 2019.

# HIV and Men

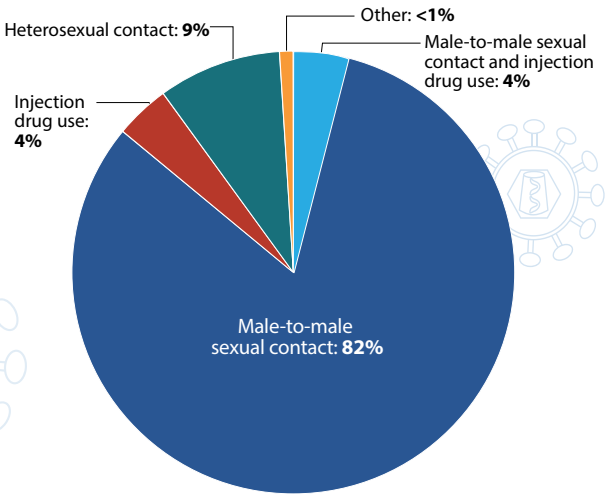
OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017,

## 31,239 (81%) WERE AMONG MEN.

### New HIV Diagnoses Among Men by Race/Ethnicity in the US and Dependent Areas, 2017




### New HIV Diagnoses Among Men by Transmission Category in the US and Dependent Areas, 2017




### From 2010 to 2016, HIV diagnoses decreased 6% among men overall.** But trends varied for different groups of men:

- **Black/African American:** down 7%
- **Hispanic/Latino:** up 11%
- **Asian:** up 45%
- **White:** down 15%
- **Other Races/ Ethnicities:** down 31%

**Men by transmission category**

- Male-to-male sexual contact: **stable**
- Injection drug use: **down 37%**
- Male-to-male sexual contact and injection drug use: **down 23%**
- Heterosexual contact: **down 21%**

**Men by age**

- 13 to 24: **stable**
- 25 to 34: **up 23%**
- 35 to 44: **down 27%**
- 45 to 54: **down 28%**
- 55 and older: **down 5%**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Hispanics/Latinos can be of any race.
‡ *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether.
** In 50 states and the District of Columbia.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around **1.1 million people** are living with HIV in the US.** People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

AT THE END OF 2016, AN ESTIMATED **882,300** **MEN** HAD HIV.**

**6 in 7** KNEW THEY HAD THE VIRUS.

## For every 100 men with HIV in 2016:

- **63** received some HIV care
- **49** were retained in care
- **53** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

## What places some men at higher risk?

### Knowledge of HIV Status

People who don't know they have HIV can't get the care they need and may pass HIV to others without knowing it.

### Sexual Behaviors

Most men get HIV through sexual contact, especially anal sex. Anal sex is the riskiest type of sex for getting or transmitting HIV.

### Sexually Transmitted Diseases (STDs)

Having another STD can greatly increase the chance of getting or transmitting HIV.

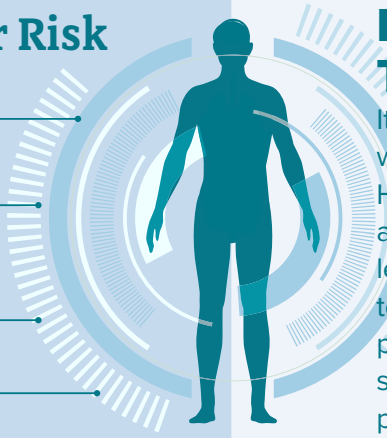
### Injection Drug Use

Sharing needles, syringes, and other injection drug equipment puts people at risk for HIV.

## How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends.
- Supporting community organizations that increase access to HIV testing and care.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.
- Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

## Reduce Your Risk



- Not having sex
- Using condoms
- Not sharing syringes
- Taking medicine to prevent or treat HIV

## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

**For More Information**

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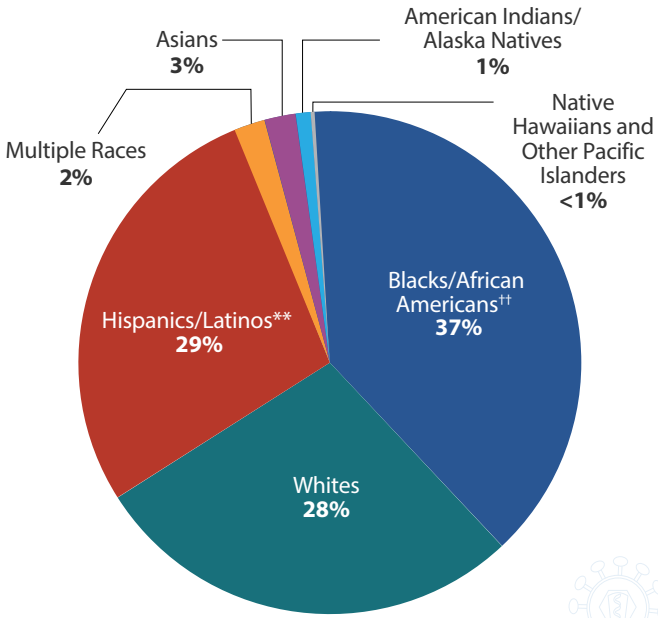
Visit www.cdc.gov/hiv

All content is based on the most recent data available in September 2019.

# HIV and Gay and Bisexual Men

OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017,
**27,000 (70%) WERE AMONG ADULT AND ADOLESCENT GAY AND BISEXUAL MEN.† ‡**

## New HIV Diagnoses Among Gay and Bisexual Men in the US and Dependent Areas By Race/Ethnicity, 2017




## From 2010 to 2016, HIV diagnoses remained stable among gay and bisexual men overall.⌗ But trends varied for different groups of gay and bisexual men:

**Gay and bisexual men by race/ethnicity**

- Black/African American: **stable**
- Hispanic/Latino: **up 18%**
- Asian: **up 52%**
- White: **down 16%**

**Gay and bisexual men by age**

- 13 to 24: **stable**
- 25 to 34: **up 26%**
- 35 to 44: **down 24%**
- 45 to 54: **down 23%**
- 55 and older: **up 5%**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).
‡ This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who have sex with men.
** Hispanics/Latinos can be of any race.
†† *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether.
⌗ In 50 states and the District of Columbia.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around **1.1 million people** are living with HIV in the US.‡‡ People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

AT THE END OF 2016, AN ESTIMATED

**707,100**

**GAY AND BISEXUAL MEN HAD HIV.‡‡**

**5 in 6**

**KNEW THEY HAD THE VIRUS.*****

## For every 100 gay and bisexual men with HIV in 2016:‡‡

- **72** received some HIV care
- **57** were retained in care
- **58** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

## What places some gay and bisexual men at higher risk?

### Knowledge of HIV Status

People who don't know they have HIV can't get the care they need and may pass HIV to others without knowing it.

### Sexual Behaviors

Most gay and bisexual men get HIV from having anal sex without a condom or taking medicine to prevent or treat HIV.

### Sexually Transmitted Diseases (STDs)

Having another STD can greatly increase the chance of getting or transmitting HIV.

### Stigma

Stigma, homophobia, and discrimination may affect whether gay and bisexual men seek or receive high-quality health services.

## How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Supporting community organizations that increase access to HIV testing and care.

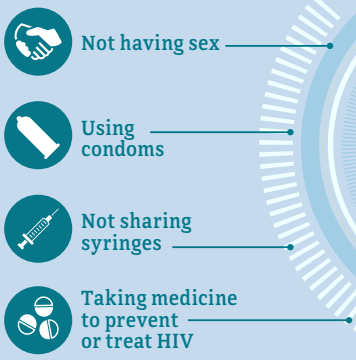
Conducting prevention research and providing guidance to those working in HIV prevention.


Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

*** Includes infections attributed to male-to-male sexual contact *only*. Among men with HIV infection attributed to male-to-male sexual contact *and* injection drug use, 92% knew they had HIV.

## Reduce Your Risk




## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

**For More Information**

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in September 2019.

Ryan White & Global HIV/AIDS Programs

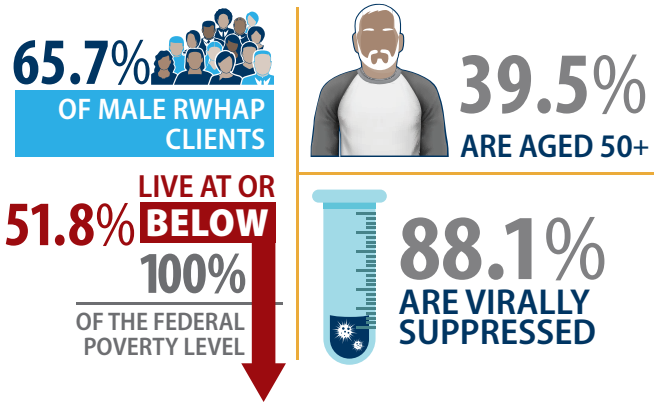
# HRSA's Ryan White HIV/AIDS Program

## Gay, Bisexual, and Other Men Who Have Sex with Men (MSM) Clients: Ryan White HIV/AIDS Program, 2018

### Population Fact Sheet | January 2020

**The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.**

## Ryan White HIV/AIDS Program Fast Facts: Gay, Bisexual, and Other Men Who Have Sex with Men (MSM) Clients




A significant proportion of RWHAP clients are men who have sex with men (MSM). Of the more than half a million clients served by RWHAP, 47.3 percent are MSM. Of male clients served by RWHAP, 65.7 percent are MSM. More details about this RWHAP client population are outlined below:

- The majority of MSM clients served by RWHAP are from racial/ethnic minority populations. Data show that 63.7 percent of MSM RWHAP clients served are from racial/ethnic minority populations. Among MSM, 36.3 percent identify as white, 35.0 percent identify as black/African American, and 25.2 percent identify as Hispanic/Latino.
- More than half of MSM clients served by RWHAP are low income. Of the MSM RWHAP clients served, 51.8 percent are living at or below 100 percent of the federal poverty level, which is lower than the national RWHAP average (61.3 percent).
- Among the MSM RWHAP clients, 4.6 percent have unstable housing. This percentage is slightly lower than the national RWHAP average (5.3 percent).
- The MSM RWHAP client population is aging. MSM clients aged 50 years and older account for 39.5 percent of all RWHAP MSM clients. This percentage is lower than the national RWHAP average (46.1 percent).

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, approximately 88.1 percent of MSM receiving RWHAP HIV medical care are virally suppressed,* which is slightly higher than the national RWHAP average (87.1 percent).

- 78.3 percent of young MSM (aged 13–24) receiving RWHAP HIV medical care are virally suppressed.
- 74.8 percent of young black/African American MSM (aged 13–24) receiving RWHAP HIV medical care are virally suppressed.

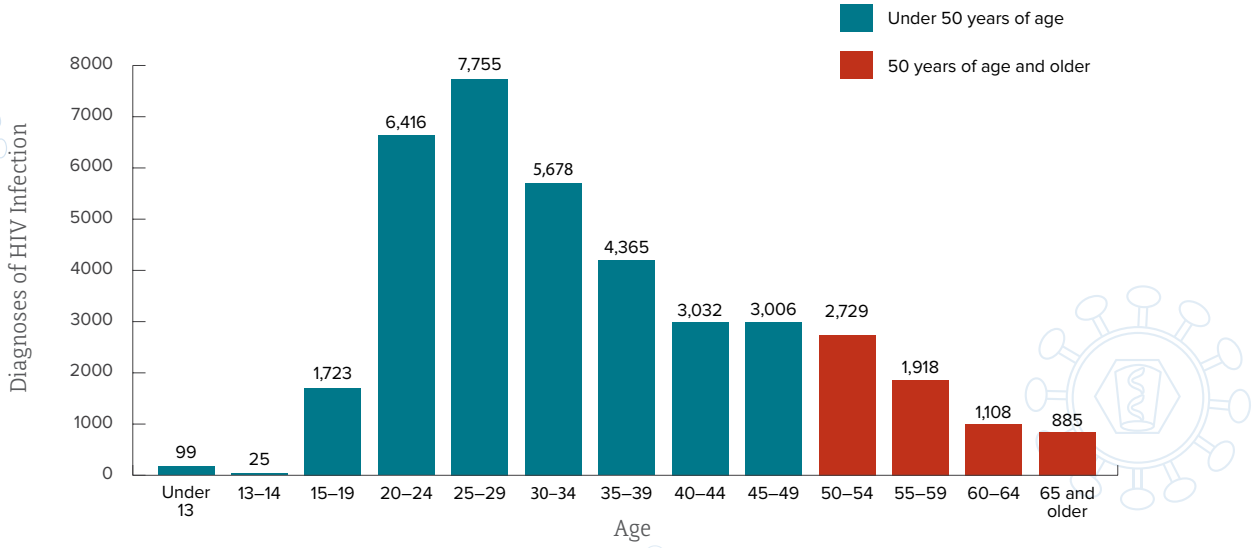
* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

# HIV and Older Americans

**OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017, 6,640 WERE AMONG PEOPLE AGED 50 AND OLDER. OF THESE:**

**2,731 WERE AMONG BLACKS/AFRICAN AMERICANS†** | **2,343 WERE AMONG WHITES** | **1,288 WERE AMONG HISPANICS/LATINOS‡**

## New HIV Diagnoses in the US and Dependent Areas by Age, 2017




**From 2012 to 2016, HIV diagnoses remained stable overall among people aged 50 and older.****
**But trends varied by transmission category:**

**All people aged 50 and older: stable**

| Men by transmission category: | Women by transmission category: |
|---|---|
| Male-to-male sexual contact: **stable** | Heterosexual contact: **down 8%** |
| Injection drug use: **down 17%** | Injection drug use: **down 18%** |
| Male-to-male sexual contact and injection drug use: **down 12%** | |
| Heterosexual contact: **down 9%** | |

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America.
‡ Hispanics/Latinos can be of any race.
** In 50 states and the District of Columbia.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around **1.1 million people** are living with HIV in the US.** People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

AT THE END OF 2016, AN ESTIMATED **327,000** PEOPLE AGED 55 AND OLDER HAD HIV.

**9 in 10** KNEW THEY HAD THE VIRUS.**

## For every 100 people aged 55 and older with HIV in 2016:**

- **69** received some HIV care
- **56** were retained in care
- **60** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

Aging with HIV infection presents special challenges for preventing other diseases because both age and HIV increase risk for heart disease, bone loss, and certain cancers.

## What places some older Americans at higher risk?

### Delayed Treatment

Older people in the US are more likely to have late-stage HIV when diagnosed, start treatment late, and suffer more immune system damage.

### Knowledge of HIV Prevention

Older people may not be as knowledgeable about prevention and sexual risk including having multiple sex partners.

### Stigma

Older people may already face isolation due to illness or loss of family and friends.

### Fewer Discussions with Doctors

Older people may visit their doctors more often, but are less likely to discuss sexual and drug use behaviors.

## How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Supporting community organizations that increase access to HIV testing and care.

Conducting prevention research and providing guidance to those working in HIV prevention.


Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

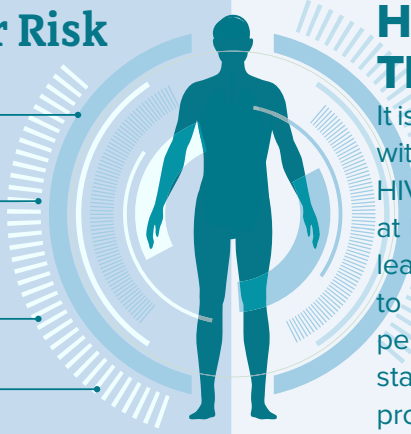
## Reduce Your Risk

Not having sex

Using condoms

Not sharing syringes

Taking medicine to prevent or treat HIV



## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

**For More Information**

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in September 2019.

HRSA
Ryan White & Global HIV/AIDS Programs

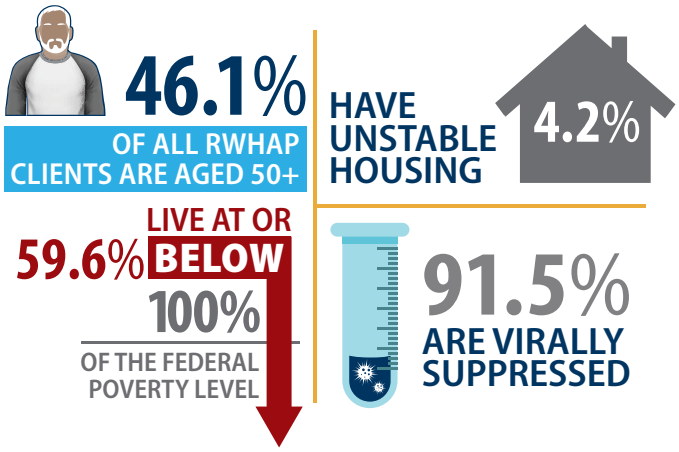
# HRSA's Ryan White HIV/AIDS Program

## Older Adult Clients: Ryan White HIV/AIDS Program, 2018

### Population Fact Sheet | January 2020

**The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.**

## Ryan White HIV/AIDS Program Fast Facts: Older Adult Clients




The RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older. Below are more details about this RWHAP client population:

- The majority of RWHAP clients aged 50 years and older are from racial/ethnic minority populations. Among RWHAP clients aged 50 years and older, 68.2 percent are from racial/ethnic minority populations; 44.9 percent of RWHAP clients in this age group identify as black/African American, which is slightly lower than the national RWHAP average (47.1 percent). Additionally, 20.6 percent of RWHAP clients in this age group identify as Hispanic/Latino, which is slightly lower than the national RWHAP average (23.2 percent).
- The majority of RWHAP clients aged 50 years and older are male. Data show approximately 71.3 percent of clients aged 50 years and older are male, 27.7 percent are female, and 1.0 percent are transgender.
- The majority of RWHAP clients aged 50 years and older are low income. Among RWHAP clients aged 50 years and older, 59.6 percent are living at or below 100 percent of the federal poverty level, which is lower than the national RWHAP average (61.3 percent).
- Data show 4.2 percent of RWHAP clients aged 50 years and older have unstable housing. This percentage is slightly lower than the national RWHAP average (5.3 percent).

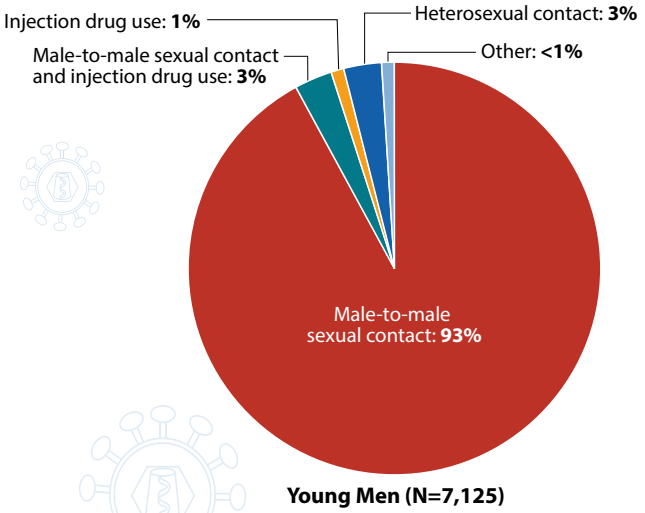
Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, 91.5 percent of clients aged 50 years and older receiving RWHAP HIV medical care are virally suppressed,* which is higher than the national RWHAP average (87.1 percent).

* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

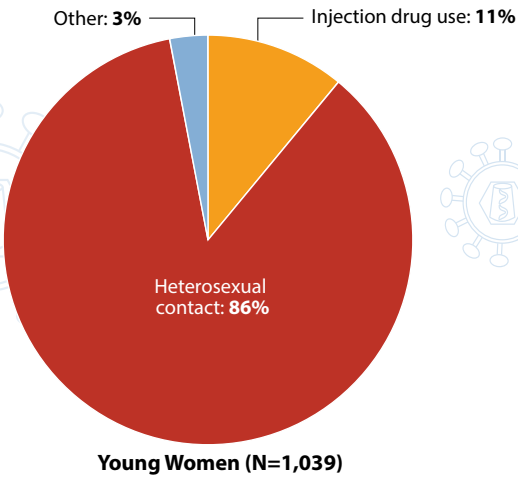
# HIV and Youth

OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017,
**8,164 (21%) WERE AMONG YOUTH AGED 13 TO 24.†**

## New HIV Diagnoses Among Youth by Transmission Category and Sex in the US and Dependent Areas, 2017




**Young Men (N=7,125)**




**Young Women (N=1,039)**

## From 2010 to 2016, HIV diagnoses decreased 6% among youth overall.‡ But trends varied for different groups of youth.

**Youth overall: down 6%**

**Young women: down 32%**

**Young men: remained stable**

**Young gay and bisexual men** by race/ethnicity:**

- **Black/African American: down 5%††**
- **Hispanic/Latino: up 17%‡‡**
- **White: down 6%**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Unless otherwise noted, persons aged 13 to 24 are referred to as *youth* or *young* in this fact sheet.
‡ In 50 states and District of Columbia.
** Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).
†† *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether.
‡‡ Hispanics/Latinos can be of any race.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around 1.1 million people are living with HIV in the US.‡ People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

AT THE END OF 2016, AN ESTIMATED **50,900** **YOUTH** HAD HIV.‡

**ONLY 56%** KNEW THEY HAD THE VIRUS.

## What places some young people at higher risk?

- Many students are not getting the sexual health education they need, and sex education is not starting early enough.
- Certain health-related behaviors put youth at higher risk for HIV, including low HIV testing rates, substance use, low rates of condom use, and multiple sex partners. Research has also shown that young gay and bisexual men who have sex with older partners are at a greater risk for HIV infection.
- Youth aged 20 to 24, especially youth of color, have some of the highest STD rates. Having another STD can significantly increase a person's chance of getting or transmitting HIV.
- Young people may be uninsured or on their parent's insurance making it difficult to access or use medicines to prevent or treat HIV due to cost, perceived stigma, and privacy concerns.
- Stigma, fear, homophobia, isolation, and lack of support may also place many youth at higher risk for HIV.

## How is CDC making a difference?

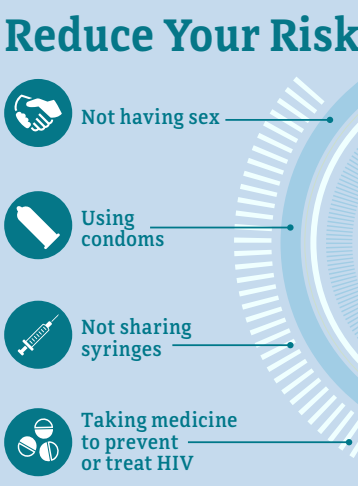
- Collecting and analyzing data and monitoring HIV trends among youth.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments, education agencies, and community organizations by funding HIV prevention work for youth and providing technical assistance.
- Promoting testing, prevention, and treatment through campaigns like *Let's Stop HIV Together* (formerly *Act Against AIDS*).

Visit **www.cdc.gov/hiv** and **www.cdc.gov/healthyyouth** for more information about CDC's HIV prevention activities among youth.

## FOR EVERY 100 YOUTH WITH HIV IN 2015:‡

- **36** received some HIV care
- **27** were retained in care
- **25** were virally suppressed

## Reduce Your Risk




## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

**For More Information**

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Visit www.cdc.gov/hiv

All content is based on the most recent data available in April 2019.

HRSA
Ryan White & Global HIV/AIDS Programs

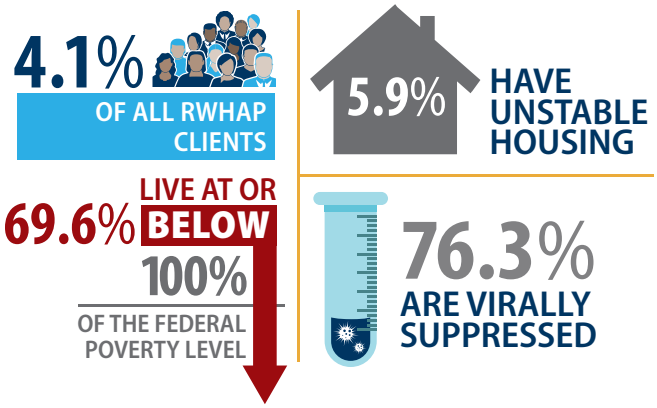
# HRSA's Ryan White HIV/AIDS Program

## Youth and Young Adult Clients: Ryan White HIV/AIDS Program, 2018

### Population Fact Sheet | January 2020

**The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.**

## Ryan White HIV/AIDS Program Fast Facts: Youth and Young Adult Clients




Youth and young adults aged 13–24 years represent 4.1 percent (nearly 22,000 clients) of the more than half a million RWHAP clients. Below are more details about this RWHAP client population:

- The majority of RWHAP clients aged 13–24 years are from racial/ethnic minority populations. Among clients in this age group, 87.1 percent are from racial/ethnic minority populations. Nearly two-thirds (61.4 percent) of youth and young adult clients identify as black/African American, which is higher than the national RWHAP average (47.1 percent). Hispanics/Latinos represent 21.6 percent of youth and young adult RWHAP clients, which is slightly lower than the national RWHAP average (23.2 percent).
- The majority of RWHAP clients aged 13–24 years are male. Data show that 73.6 percent of clients aged 13–24 years are male, 23.3 percent are female, and 3.1 percent are transgender.
- The majority of RWHAP clients aged 13–24 years are low income. Of youth and young adult RWHAP clients, 69.6 percent are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (61.3 percent).
- Data show that 5.9 percent of RWHAP clients aged 13–24 years have unstable housing. This percentage is slightly higher than the national RWHAP average (5.3 percent).

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, 76.3 percent of clients aged 13–24 years receiving RWHAP HIV medical care are virally suppressed,* which is significantly lower than the national RWHAP average (87.1 percent).

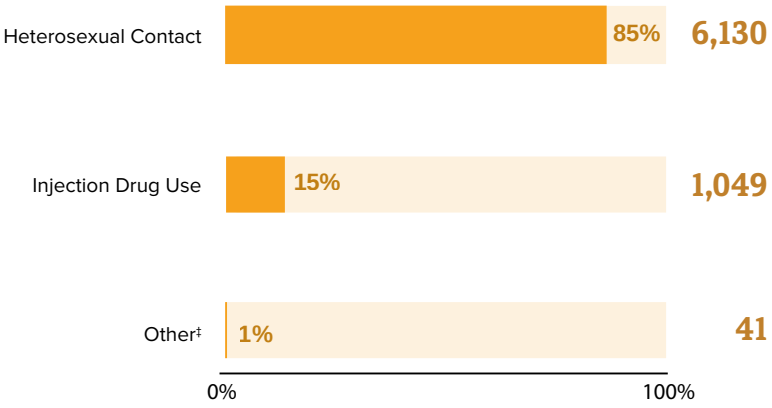
- 78.3 percent of young men who have sex with men (MSM) receiving RWHAP HIV medical care are virally suppressed.
- 74.8 percent of young black/African American MSM receiving RWHAP HIV medical care are virally suppressed.
- 72.1 percent of young black/African American women receiving RWHAP HIV medical care are virally suppressed.
- 68.0 percent of transgender youth and young adults receiving RWHAP HIV medical care are virally suppressed.

* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

# HIV and Women

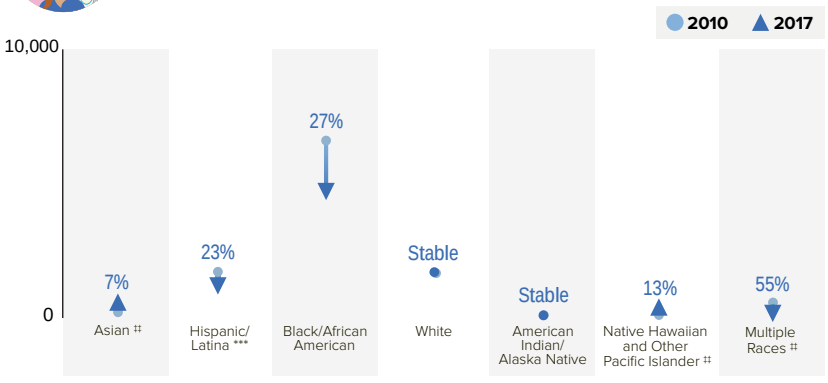

Of the **37,832 NEW HIV DIAGNOSES** in the US and dependent areas* in 2018, 19% were among women.†

## Most of the new HIV diagnoses among women were attributed to heterosexual contact.

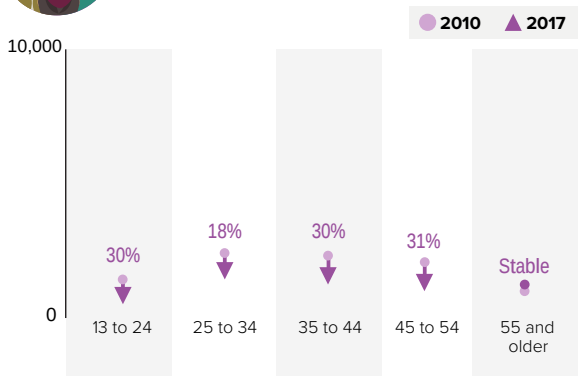



## HIV diagnoses declined 23% among women overall from 2010 to 2017. ** Although trends varied for different groups of women, HIV diagnoses declined for groups most affected by HIV, including black/African American†† women and women aged 25 to 34.

### Trends by Race and Ethnicity




### Trends by Age




* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Adult and adolescent women aged 13 and older.
‡ Includes hemophilia, blood transfusion, perinatal exposure, and risk factors not reported or not identified.
** In 50 states and the District of Columbia.
†† *Black* refers to people having origins in any of the black racial groups of Africa. *African American* is a term often used for Americans of African descent with ancestry in North America.
⌗ Changes in subpopulations with fewer HIV diagnoses can lead to a large percentage increase or decrease.
*** Hispanic women/Latinas can be of any race.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

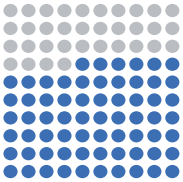
# Women who don't know they have HIV cannot get the care and treatment they need to stay healthy.

At the end of 2016, an estimated **1.1 MILLION PEOPLE** had HIV.** Of those, 258,000 were women.

**8 in 9** women knew they had the virus.

It is important for women to know their HIV status so they can take medicine to treat HIV if they have the virus. Taking HIV medicine every day can make the viral load undetectable. Women who get and keep an undetectable viral load (or stay virally suppressed) have effectively no risk of transmitting HIV to HIV-negative sex partners.

When compared to people overall with HIV, women have about the same viral suppression rates. But more work is needed to increase these rates. In 2016, for **every 100 women with HIV**: **



**66** received some HIV care

**51** were retained in care

**53** were virally suppressed

For comparison, for every **100 people overall** with HIV, **64 received some HIV care**, **49 were retained in care**, and **53 were virally suppressed**.

## There are several challenges that place women at higher risk for HIV.

### Other Sexually Transmitted Diseases (STDs)

Having another STD, such as gonorrhea and syphilis, can increase the chance of getting or transmitting HIV.

### Unaware of Partner's Risk Factors

Some women don't know their male partner's risk factors for HIV (such as injection drug use or having sex with men) and may not use protection (like condoms or medicine to prevent HIV).

### Risk of Exposure

Because receptive sex is riskier than insertive sex, women have a higher risk of getting HIV during vaginal or anal sex than their sex partner.

### History of Sexual Abuse

Women who have been sexually abused are more likely to engage in risky behaviors like exchanging sex for drugs or having multiple sex partners.

## How is CDC making a difference for women?

- Collecting and analyzing data and monitoring HIV trends.
- Supporting community organizations that increase access to HIV testing and care.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.
- Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.
- Strengthening successful HIV prevention programs and supporting new efforts funded through the *Ending the HIV Epidemic* initiative.

For more information about HIV surveillance data and how it is used, read the "Technical Notes" in the HIV surveillance reports at www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

**For more information visit www.cdc.gov/hiv**

All content is based on the most recent data available in March 2020.

HRSA
Ryan White & Global HIV/AIDS Programs

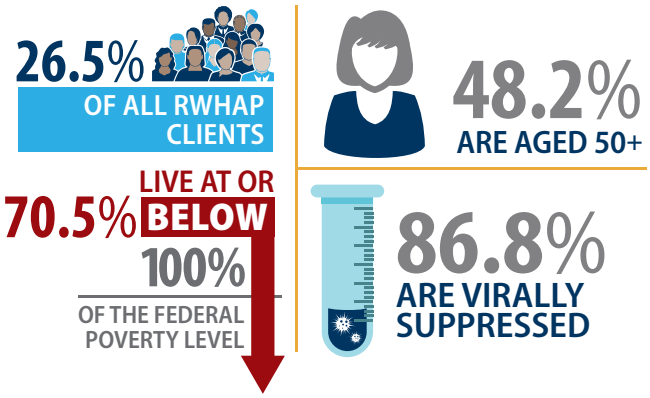
# HRSA's Ryan White HIV/AIDS Program

## Female Clients: Ryan White HIV/AIDS Program, 2018

### Population Fact Sheet | January 2020

**The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.**

## Ryan White HIV/AIDS Program Fast Facts: Female Clients




Females comprise a substantial proportion of RWHAP clients. Of the more than half a million clients served by RWHAP, 26.5 percent are female.

More details about this RWHAP client population are outlined below:

- The majority of female clients served by RWHAP are from racial/ethnic minority populations. The data show that 84.0 percent of female clients are from racial/ethnic minority populations. 62.1 percent of female clients identify as black/African American, which is higher than the national RWHAP average (47.1 percent), and 19.0 percent of female clients identify as Hispanic/Latino, which is lower than the national RWHAP average (23.2 percent).
- The majority of female clients served by RWHAP are low income. Among female clients served, 70.5 percent are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (61.3 percent).
- The data show that 4.2 percent of female RWHAP clients have unstable housing. This is slightly lower than the national RWHAP average (5.3 percent).
- The RWHAP female client population is aging. Among female RWHAP clients served, 48.2 percent are aged 50 years and older, whereas only 3.6 percent of female RWHAP clients are aged 13–24 years.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, approximately 86.8 percent of female clients receiving RWHAP HIV medical care are virally suppressed,* which is slightly lower than the national RWHAP average (87.1 percent).

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

# HIV and Pregnant Women, Infants, and Children

HIV can be passed from mother to child anytime during pregnancy, childbirth, and breastfeeding. This is called *perinatal* transmission.

## BUT THERE IS GOOD NEWS:

For a woman with HIV, the risk of transmitting HIV to her baby can be **1% OR LESS** if she:

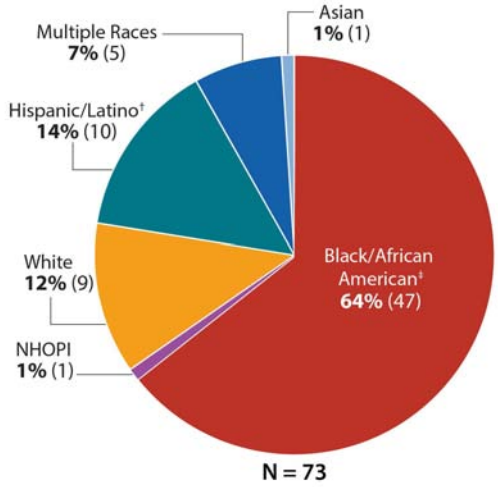
- **Takes HIV medicine daily as prescribed throughout pregnancy and childbirth.**
- **Gives HIV medicine to her baby for 4-6 weeks after giving birth.**
- **Does NOT breastfeed or pre-chew her baby's food.**

If you are pregnant or planning to get pregnant, **get tested for HIV** as soon as possible. If you have HIV, the sooner you start treatment the better—for your health and your baby's health and to prevent transmitting HIV to your sexual partner.

## 73 diagnoses of perinatal HIV in the US in 2017*

From 2012 to 2016, perinatal diagnoses: **decreased 41%**

## Diagnoses of Perinatal HIV Infections in the US and Dependent Areas by Race/Ethnicity, 2017




* Unless otherwise noted, the term *United States* (US) includes the 50 states, the District of Columbia, and the 6 dependent areas of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

† Hispanics/Latinos can be of any race.

‡ *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether.

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Women who are pregnant or trying to get pregnant should encourage their partner to get tested for HIV also. If either partner has HIV, that partner should take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

**A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.**

HIV-negative women who have a partner with HIV should ask their doctor about taking HIV medicine daily, called pre-exposure prophylaxis (PrEP), to protect themselves and their baby.

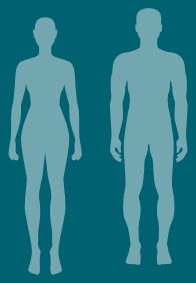
## Why are pregnant women and their babies at risk?

- Preconception care and family planning services are often not provided in HIV care settings.
- Women with HIV may not know they are pregnant, how to prevent or safely plan a pregnancy, or what they can do to reduce the risk of transmitting HIV to their baby.
- The risk of transmitting HIV to the baby is much higher if the mother does not stay on HIV treatment throughout pregnancy and childbirth, or if HIV medicine is not provided to her baby. The risk is also higher if she gets HIV during pregnancy.
- Social and economic factors, especially poverty, may make it harder for some women with HIV to access health care and stay on treatment.

## How is CDC making a difference?

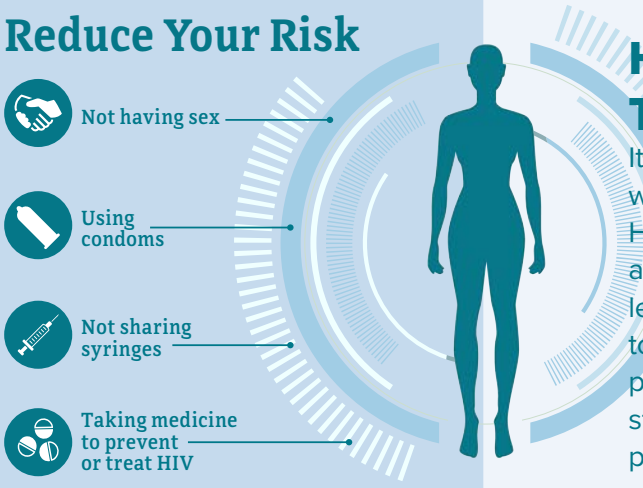
- CDC created a framework (www.cdc.gov/hiv/group/gender/pregnantwomen/emct.html) to help federal agencies and other groups lower the rate of perinatal HIV transmission to less than 1% and reduce the number of cases of perinatal HIV to less than one per 100,000 live births.
- CDC helps lead the Elimination of Mother-to-Child HIV Transmission Stakeholders Group, a group that develops and implements strategies to advance the elimination of perinatal HIV.
- CDC collaborated with and funded partners to develop a continuous quality improvement method that helps local health systems address missed prevention and treatment opportunities for pregnant women with HIV.
- CDC funds perinatal HIV prevention through Integrated Human Immunodeficiency Virus Surveillance and Prevention Programs for Health Departments (www.cdc.gov/hiv/funding/announcements/ps18-1802), and promotes HIV testing and treatment for pregnant women.

**By the end of 2016 in the US, 11,915 people were living with HIV they got through perinatal transmission.**



**1,814 of them were children under the age of 13.**

## Reduce Your Risk




## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

**For More Information**

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in March 2019.

# HIV and Transgender People

## HIV Diagnoses in the US, 2009-2014

**2,351 TRANSGENDER PEOPLE RECEIVED AN HIV DIAGNOSIS. OF THESE:**

**84% WERE TRANSGENDER WOMEN**

**15% WERE TRANSGENDER MEN***

**ABOUT HALF LIVED IN THE SOUTH**

***Transgender:*** people whose gender identity or expression is different from their sex assigned at birth.

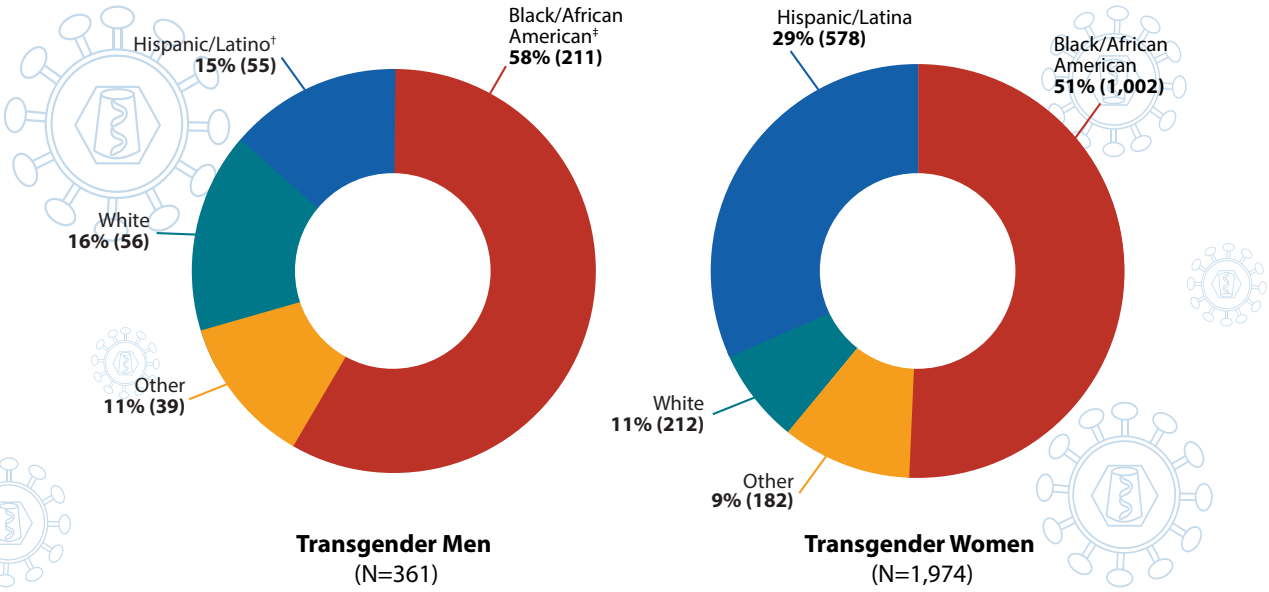
***Gender identity:*** person's internal understanding of their own gender.

***Gender expression:*** person's outward presentation of their gender (example, how they dress).

***Transgender women:*** people who were assigned the male sex at birth but identify as women.

***Transgender men:*** people who were assigned the female sex at birth but identify as men.

## HIV Diagnoses Among Transgender People in the United States by Race/Ethnicity, 2009-2014




* Less than 1% had another gender identity.

† Hispanics/Latinos can be of any race.

‡ *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether.

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Division of HIV/AIDS Prevention

Around 1.1 million people are living with HIV in the US. People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

**A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.**

## Why are transgender people at higher risk?

- Some things that may put transgender people at higher risk for getting or transmitting HIV include multiple sexual partners, having anal or vaginal sex without protection** (like a condom or medicine to prevent or treat HIV), and sharing needles, syringes, or other equipment to inject hormones or drugs. Other factors may include commercial sex work, mental health issues, high levels of substance misuse, homelessness, and unemployment.
- Many transgender people face stigma, discrimination, social rejection, and exclusion. These factors may affect their well-being and put them at increased risk for HIV.
- HIV prevention programs designed for other at-risk groups may not address all the needs of transgender people.
- When health care providers are not knowledgeable about transgender issues, this can be a barrier for transgender people with HIV who are looking for treatment and care.
- Due to certain barriers transgender men and women face, current testing programs may not reach enough people in this population.
- The sexual health of transgender men and transgender and gender minority youth has not been well studied. More research is needed to understand their HIV risk behaviors.
- Transgender women and men might not fully engage in medical care.

## How is CDC making a difference?

- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for transgender people and providing technical assistance.
- Helping health care providers improve care for transgender people with HIV.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS.*

Visit **www.cdc.gov/hiv** for more information about CDC's HIV prevention activities among transgender people.

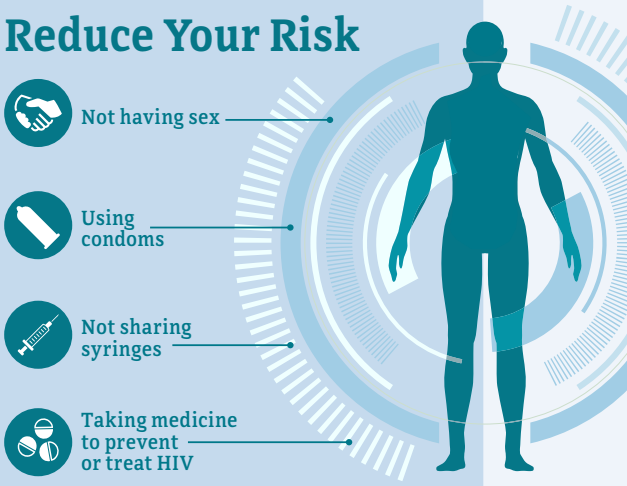
**According to current estimates, about 14% of transgender women in the US have HIV.**

**An estimated 44% of black/African American transgender women have HIV—the highest percentage among all transgender women.††**

** It is important to avoid assumptions regarding the types of sexual activity that transgender people engage in or how they may refer to their body parts.

†† Estimate for transgender women overall includes laboratory-confirmed infections only. Estimates by race/ethnicity include laboratory-confirmed and self-reported infections.

## Reduce Your Risk




## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

**For More Information**

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All content is based on the most recent data available in April 2019.

HRSA
Ryan White & Global HIV/AIDS Programs

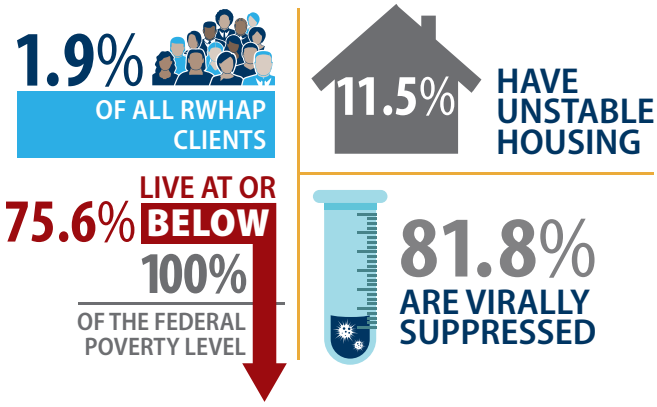
# HRSA's Ryan White HIV/AIDS Program

## Transgender Clients: Ryan White HIV/AIDS Program, 2018

### Population Fact Sheet | January 2020

**The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.**

## Ryan White HIV/AIDS Program Fast Facts: Transgender Clients




Of the more than half a million clients served by RWHAP, 1.9 percent are transgender, representing approximately 10,200 clients. Below are more details about this RWHAP client population:

- The majority of transgender clients served by RWHAP are from racial/ethnic minority populations. Among the transgender clients served, 88.1 percent are from racial/ethnic minority populations; 54.0 percent of transgender clients identify as black/African American and 29.4 percent identify as Hispanic/Latino, both of which are higher than the national RWHAP averages (47.1 percent and 23.2 percent, respectively).
- The majority of transgender clients served by RWHAP are low income. Among transgender RWHAP clients served, 75.6 percent live at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (61.3 percent).
- Data show that 11.5 percent of transgender RWHAP clients have unstable housing. This percentage is substantially higher than the national RWHAP average (5.3 percent).
- The transgender client population is younger than the average for RWHAP clients. Approximately 25.1 percent of RWHAP transgender clients are aged 50 years and older.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. Among the transgender clients receiving RWHAP HIV medical care in 2018, 81.8 percent are virally suppressed,* which is lower than the national RWHAP average (87.1 percent).

* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

# HIV and People Who Inject Drugs

People who inject drugs (PWID) are at high risk for getting HIV if they use needles, syringes, or other injection equipment–for example, cookers–that someone with HIV has used.

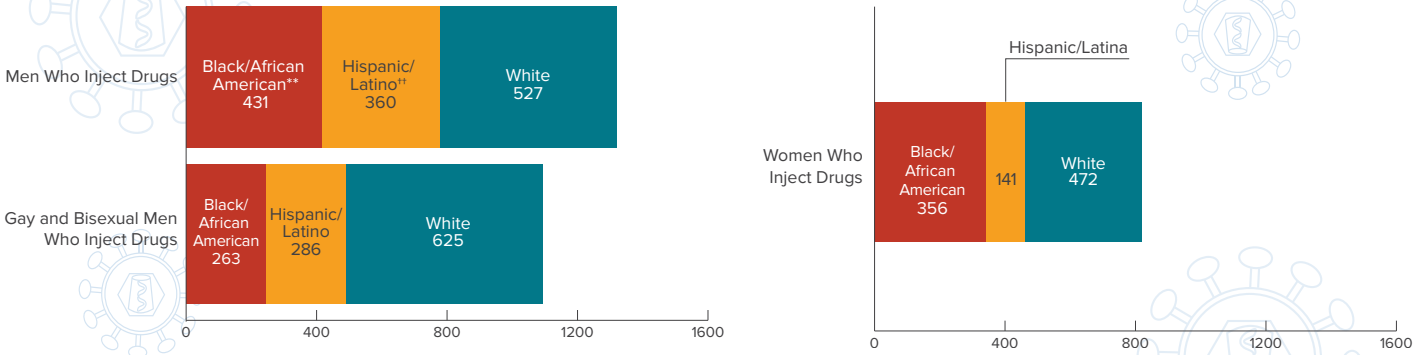
## OF THE 38,739 HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017:

**1 IN 10 (3,641) WERE AMONG PWID**

**2,625 WERE AMONG MEN WHO INJECT DRUGS†**

**1,016 WERE AMONG WOMEN WHO INJECT DRUGS**

## New HIV Diagnoses Among People Who Inject Drugs in the US and Dependent Areas, 2017




This chart does not include subpopulations representing 2% or less of all PWID who received an HIV diagnosis in 2017.

## From 2010 to 2016, HIV diagnoses decreased 31% among PWID overall.† ‡ But trends varied by race/ethnicity.

**PWID overall: down 31%**

**By race/ethnicity:**

- **Black/African American: down 52%**
- **Hispanic/Latino: down 30%**
- **White: remained stable**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

† Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).

** *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether.

†† Hispanics/Latinos can be of any race.

‡ In 50 states and the District of Columbia.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around 1.1 million people have HIV in the US.‡ People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

People with HIV who take HIV medicine as prescribed and get and keep an undetectable viral load (or stay virally supressed) have effectively no risk of transmitting HIV to their HIV-negative sexual partners.

Keeping an undetectable viral load likely reduces the risk of transmitting HIV through shared syringes or other injection equipment. But we don't know how much it reduces the risk.

At the end of 2016, an estimated **189,600 PWID had HIV**.‡ Of these, **93%** knew they had the virus.

## What places some PWID at higher risk?

### Opioid Crisis

Prescription opioid and heroin crisis in nonurban areas leading to more people injecting and new populations being at risk. These areas have limited access to HIV services and substance use disorder treatment.

### Socioeconomic Factors

Social and economic factors like homelessness or not having health insurance. These make it harder for some PWID to access HIV services.

### Lack of Sterile Equipment

Low access to sterile injection equipment in the US.

### Lack of Treatment

Lack of access to treatment for drug addiction or substance use disorder, including medication-assisted treatment (MAT).

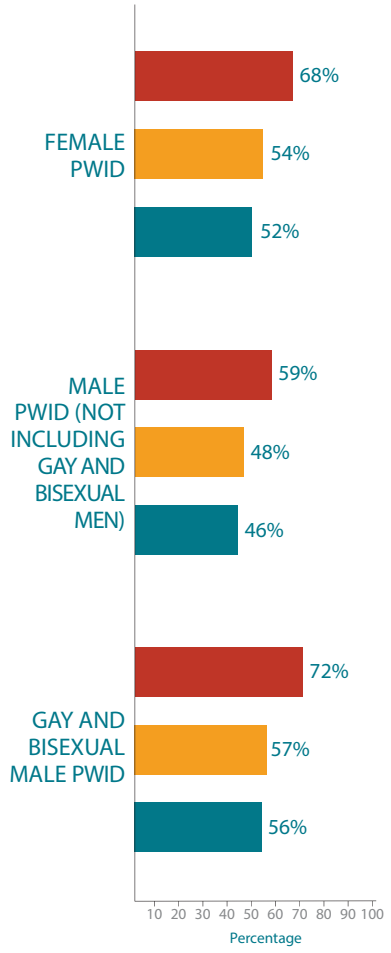
### Other Diseases

Blood-borne diseases such as viral hepatitis and other sexually transmitted diseases (STDs). Having another STD can greatly increase the chance of getting or transmitting HIV through sex.

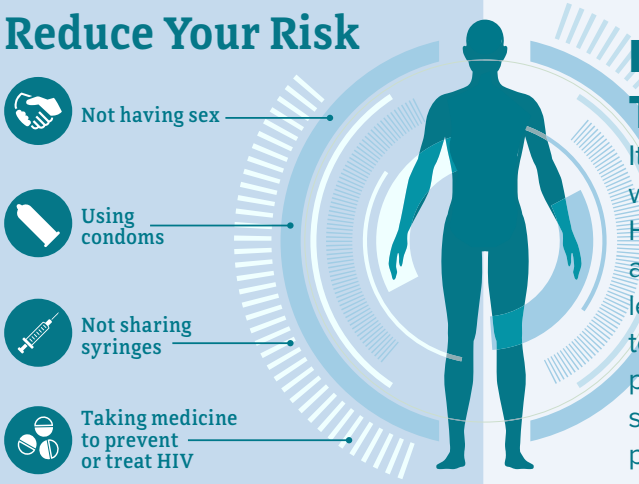
## How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends.
- Supporting responses for HIV outbreaks traced to injection drug use.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Providing guidance and technical assistance to programs on how CDC funding supports implementation of syringe service programs.
- Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.
- Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

## HIV Care for PWID With HIV (2015)‡




## Reduce Your Risk

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**For More Information**

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