DRAFT

2017 Comprehensive Plan for HIV Prevention and Care Services

Prevention and Early Identification Workgroup

3:00 p.m., Monday, April 4, 2016
Meeting Location: 2223 W. Loop South, Room #416

AGENDA

I.	Call to Order A. Welcome B. Moment of Reflection C. Adoption of the Agenda D. Approval of the Minutes	Amy Leonard and Ken Malone, Co-Chairs
II.	Review Available Data for PEI	Amber Harbolt, Health Planner, Office of Support
III.	Select PEI Goals for 2017 Plan (Logic Model 1)	
IV.	Next Steps A. Set Next Meeting– 5/2 or 5/9 1. Select PEI Solutions and Benchmarks for 2017 Plan to Complete Logic Model 1 2. Begin work on Logic Model 2	Amy Leonard and Ken Malone, Co-Chairs.
II.	Announcements	
III.	Adjourn	

◆ Meetings hosted by the Ryan White Planning Council 2223 W. Loop South, #240; Houston, TX 77027 ◆
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2017 Comprehensive Plan for HIV Prevention and Care Services

PREVENTION AND EARLY IDENTIFICATION WORKGROUP

3:00 p.m., Monday, March 7, 2016
Meeting Location: 2223 West Loop South, Room 532; Houston, TX 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Amy Leonard, co-chair	Brenda Booker	Camden Hallmark, HHD
Alex C. Moses	Cecilia Ross, excused	Sha'Terra Johnson-Fairley, TRG
Amber Wright	Curtis Bellard, excused	Amber Harbolt, Office of Support
Annette Johnson	Denny Delgado	Diane Beck, Office of Support
Arlene Johnson	Johnny Wilkerson, excused	
Denis Kelly	Kevon Strange	
Ella Collins-Nelson	Maggie White	
Florida Kweekeh	Nancy Miertschin, excused	
Isis Torrente	Rose Haggarty, excused	
Jeff Meyer	Ruth Atkinson, excused	
John Lazo	Teresa Pruitt, excused	
Lorena Arista	Tracy Gorden, excused	
Michael Kennedy	Yvonne Lu	
Rodney Mills	W. Jeffrey Campbell	
Tana Pradia		

Call to order: Amy Leonard, Co-Chair, called the meeting to order at 3:12 p.m.; she welcomed everyone and asked for a moment of reflection.

Adoption of the Agenda: ***Motion #1:*** *It was moved and seconded (Kelly, Bellard) to adopt the agenda.* **Motion Carried.**

Approval of the Minutes: ***Motion #2:*** *It was moved and seconded (Kelly, Lazo) to approve the February 1, 2016 meeting minutes with one correction, Noble was present.* **Motion Carried.** Abstentions: Bellard, Pruitt.

Leonard asked for volunteers/nominations for someone to chair the last part of the meeting because she will have to leave at 4:15 p.m.. ***Motion #3:*** *it was moved and seconded (Kelly, Mills) to nominate Teresa Pruitt to chair the meeting after 4:15 p.m..* **Motion carried.**

2017 Comprehensive Plan Objectives: The workgroup reviewed the objectives that were approved by the Leadership Team on February 3, 2016. See attached.

2012 Special Populations Benchmarks Progress: Harbolt reviewed the Prevention and Early Identification Strategy benchmarks and the progress made for each. See attached.

Development of 2017 Special Populations Activities: Harbolt reviewed the following tools: Logic Model 1 – Goals, Solutions, & Benchmarks, Logic Model 2 – Solution, Focus & Activities, and Logic Model 3 – Action Planning Matrix. See attached.

Next Meeting: April 4, 2016 at 3:00 p.m.; Agenda items include: (1) review of available data; and (2) begin development of 2017 Comprehensive Plan activities.

Announcements: Pradia said there will be a presentation for Women and Girls HIV Awareness day on Thursday, March 10th at 6:00 p.m. at the Legacy Montrose Campus.

Adjourn: The meeting was adjourned at 4:27 p.m.

2017 Comprehensive Planning Process
Available Data for Prevention and
Early Identification Strategy

DRAFT

	1. HIV Diagnosis Rate	2. HIV Diagnosis Proportion	3. HIV/AIDS Prevalence Rate	4. Unaware Estimates	5. Linked Proportion (New Dx Only)	6. Late Diagnosis
Houston EMA	**23.9**	**-**	**430.0**	**5,225**	**80%**	**32%**
Sex						
Male	**37.7**	**78%**	**646.2**	**3,901**	**78%**	**34%**
Female	10.2	22%	216.7	1,325	87%	26%
Race/Ethnicity						
White	9.4	15%	248.1	1,107	83%	**33%**
Black / African American	**65.0**	**48%**	**1183.7**	**2,535**	**75%**	27%
Hispanic	21.6	34%	305.8	1,392	83%	**41%**
Other	6.3	2%	67.2	67	90%	**33%**
Unknown	--	1%	--	125	80%	26%
Age						
0 - 1	0.6	0%	2.9	1	100%	--
2 - 12	0.6	0%	7.3	15	**67%**	2%
13 - 24	**36.4**	26%	137.8	285	**74%**	16%
25 - 34	**50.2**	**32%**	**534.0**	998	81%	21%
35 - 44	**37.0**	22%	**758.7**	1,321	**79%**	30%
45 - 54	23.4	13%	**965.5**	**1,531**	83%	**37%**
55+	7.3	6%	**431.4**	1,075	85%	**42%**
Risk Category						
MSM	[d]	**67%**	[d]	**2,878**	**78%**	**33%**
IDU	[d]	5%	[d]	487	85%	32%
MSM/IDU	[d]	2%	[d]	221	84%	31%
Heterosexual contact	[d]	25%	[d]	1,569	83%	31%
Perinatal. transmission	[d]	1%	[d]	67	**67%**	15%
Adult other risk	[d]	--	[d]	4	--	31%

	1. **HIV Diagnosis Rate**	**2. HIV Diagnosis Proportion**	**3. HIV/AIDS Prevalence Rate**	**4. Unaware Estimates**	**5. Linked Proportion (New Dx Only)**	**6. Late Diagnosis**
Definition of selection criterion	Number of new diagnoses of HIV disease within a population while accounting for population size (rate is the number of newly diagnosed HIV cases per 100,000 population)	Percentage of new diagnoses of HIV disease within each group	Number of cases of HIV disease within a population while accounting for population size (rate is the number of HIV cases per 100,000 population)	Number of people within each group estimated to be HIV+ and unaware of their status	Percent of newly diagnosed cases linked to HIV medical care within 3 months of diagnosis	Percent of persons within each group who are AIDS diagnosed within one year of HIV diagnosis
Data source	DSHS, New diagnosis rates 2014. Released 9/15/15	DSHS, New diagnoses 2014. Released 8/12/15	DSHS, Prevalence rates 2014. Released 8/13/15	DSHS, Undiagnosed infection 2014. Released 8/13/15	DSHS, New diagnosis linkage 2014. Released 8/14/15	DSHS, Late Diagnosis by population 2013. Released 9/15/15
Explanations and additional background	Population data are not available for risk groups; therefore, it is not possible to calculate rate by risk		HIV+AIDS (total HIV disease prevalence) Population data are not available for risk groups; therefore, it is not possible to calculate rate by risk	Estimates have been extrapolated using a national approximation of status unaware (14%) provided in Prevalence of Diagnosed and Undiagnosed HIV Infection - United States, 2008-2012. MMWR Vol. 64, No. 24 June 26, 2015. No local estimates are available.		Late diagnosis proportion not available for age range 0-1

National HIV Behavioral Surveillance (NHBS) - MSM *Risk Behaviors*

NHBS is a surveillance system of the HIV risk behaviors of adults in the United States. Risk behaviors of men who have sex with men (MSM) are explored in the NHBS. To participate in the NHBS-MSM study a screening interview will be used to assess whether each respondent meets inclusion criteria. Respondents are eligible to complete the NHBS-MSM interview if they:

- Have not previously participated in the current NHBS-MSM cycle
- Live in the participating MSA or Division
- Are 18 years of age or older
- Were born male and self-identify as male
- Have ever had oral or anal sex with another man
- Are able to complete the interview in English or Spanish

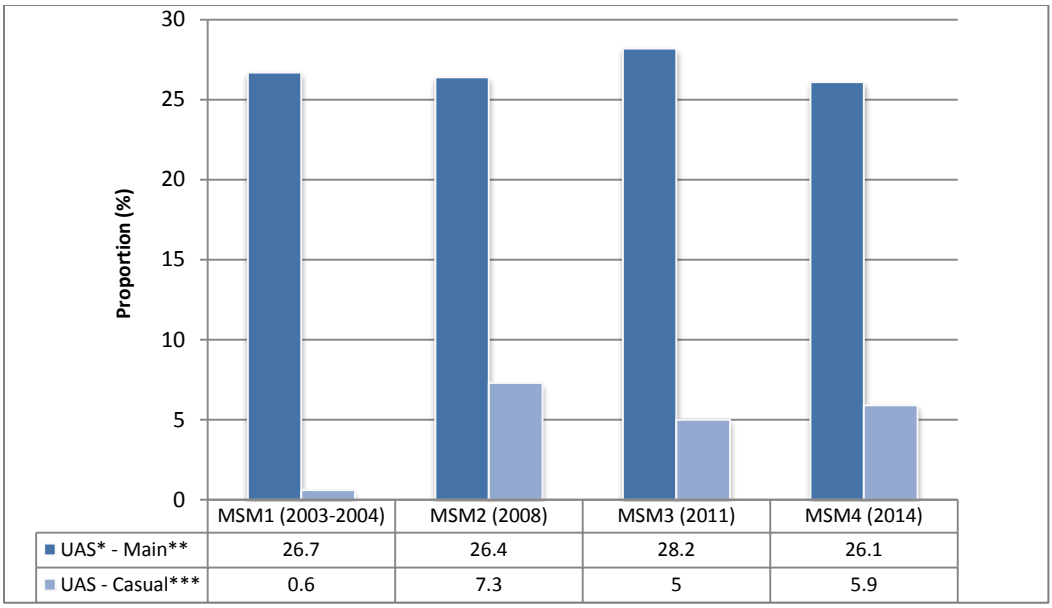
Only those participants meeting the participant inclusion eligibility criteria who also report having had sex with another man in the past 12 months count toward the required NHBS-MSM sample size of 500 current MSM. So far, four cycles of NHBS-MSM have been completed (MSM1 in 2003-2004, MSM2 in 2008, MSM3 in 2011 and MSM4 in 2014) and the MSM5 cycle is anticipated to occur in 2017.

The following risk behavior data reported by MSM during the four cycle periods of NHBS-MSM in Houston was analyzed:

- Unprotected anal sex (UAS) or sex without a condom with a main partner
- Unprotected anal sex (UAS) or sex without a condom with a casual partner
- Condom use during insertive anal sex (IAS) at last sex
- Condom use during receptive anal sex (IAS) at last sex
- Alcohol and/or drugs use at last sex
- Know partner HIV status at last sex
- Ever tested for HIV

A main partner was defined to the participants as a person you have sex with and who you feel committed to above anyone else (girl/boyfriend, wife/husband, significant other, or life partner). A casual partner was defined to the participants as a person you have sex with but do not feel committed to or don't know very well. Other terms explained to the participant were insertive anal sex (IAS) where the participant put his penis in his partners' anus and receptive anal sex (RAS) where the partner put his penis in the participants' anus.

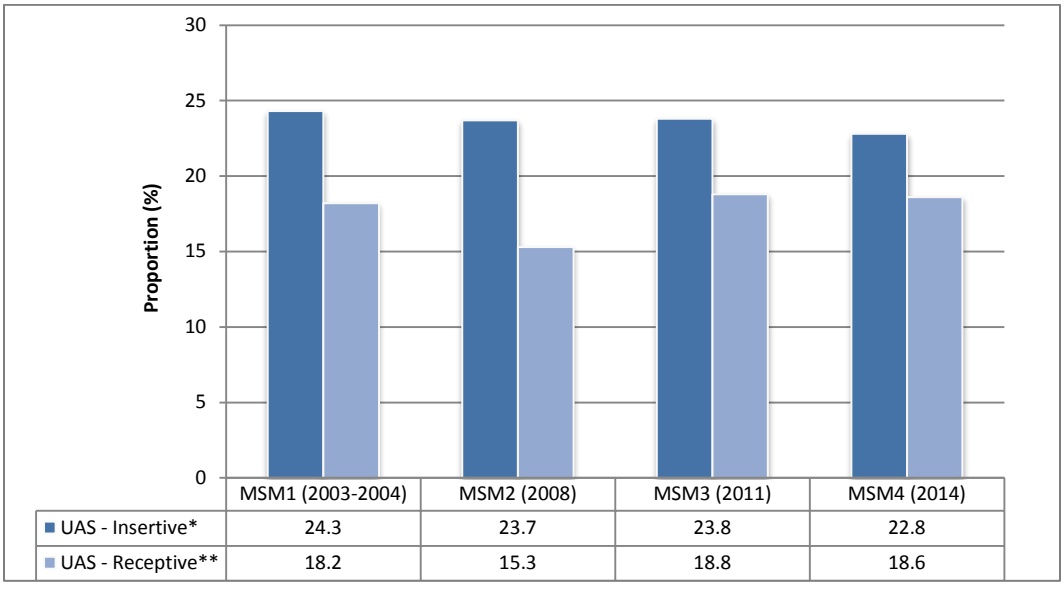
The data showed that more than 25% of MSM had unprotected anal sex with their main partner in the past 12 months in all cycles (Fig. 1). MSM participants showed higher rates of unprotected sex when they engaged in insertive sex when compared to receptive sex (Fig. 2). In general, nearly 30% of MSM were unaware of the HIV status of their last sex partner. Nearly half of the time, the use of alcohol and or drugs occurred during the last sexual encounter in all MSM cycles (Fig. 3). Consistently throughout the years very high rates of ever being tested for HIV have been reported among MSM participants (Fig. 4).



	MSM1 (2003-2004)	MSM2 (2008)	MSM3 (2011)	MSM4 (2014)
UAS* - Main**	26.7	26.4	28.2	26.1
UAS - Casual***	0.6	7.3	5	5.9

***UAS**: Unprotected anal sex*
***Main partner** - a person you have sex with and who you feel committed to above anyone else (girl/boyfriend, wife/husband, significant other, or life partner).*
****Casual partner** - a person you have sex with but do not feel committed to or don't know very well.*

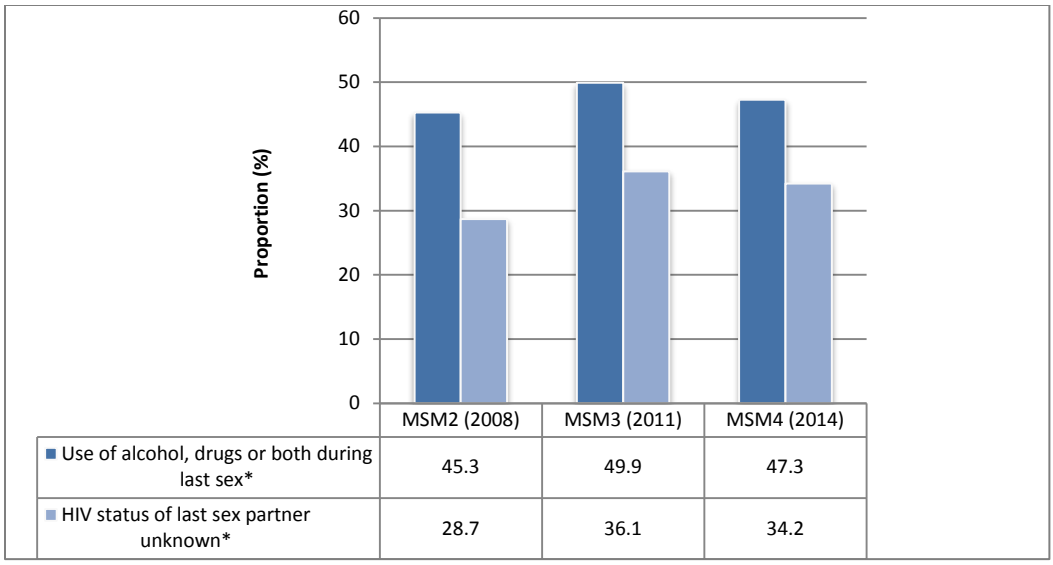
Figure 1: MSM unprotected anal sex by main or casual partner



	MSM1 (2003-2004)	MSM2 (2008)	MSM3 (2011)	MSM4 (2014)
UAS - Insertive*	24.3	23.7	23.8	22.8
UAS - Receptive**	18.2	15.3	18.8	18.6

***Insertive –** anal sex where participant put his penis in his partners' anus.*
****Receptive -** anal sex where partner put his penis in the participants' anus.*

Figure 2: MSM unprotected anal sex, insertive vs receptive



** **MSM1** data was not included because the variables do not exist for last sex or last sex partner in general.*

Figure 3: MSM high risk behaviors during last sex

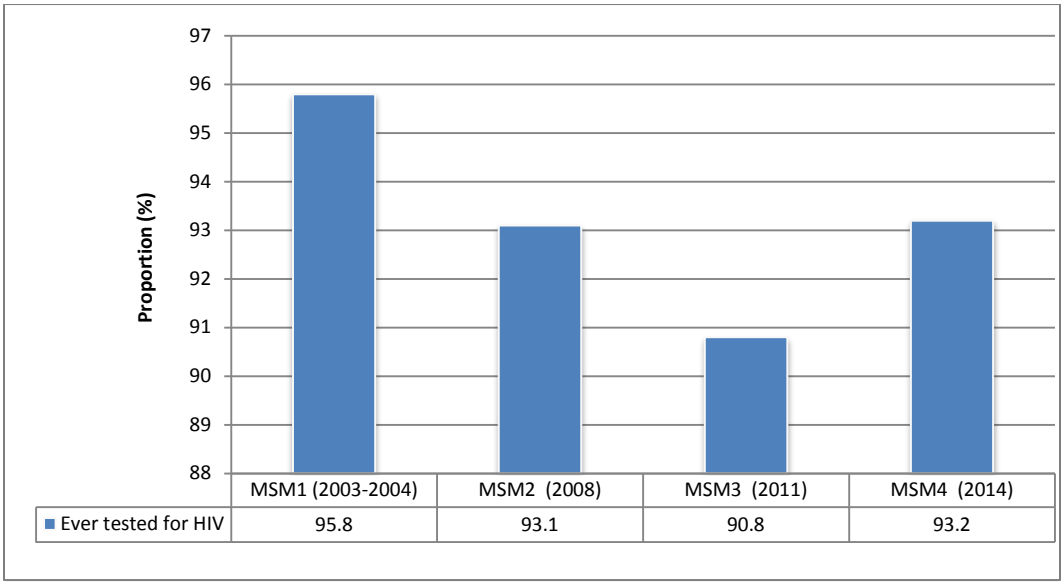


Figure 4: MSM who had ever tested for HIV

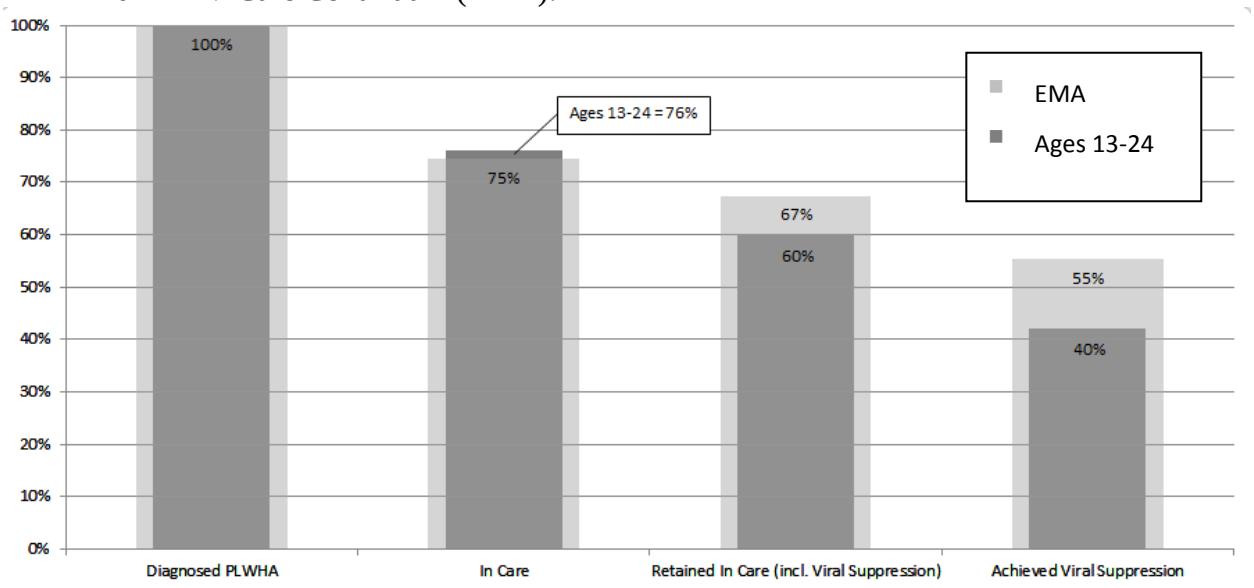
Available Data Handouts on 2012 Comprehensive Plan Special Populations

From 2012 Comprehensive Plan: "Since the beginning of the HIV epidemic, certain populations have born a disproportionate burden of HIV disease.1 "Best practice" in both HIV prevention and care has been to direct resources to the highest-incident populations in response to their greater need.2,3 In the Houston Area, HIV prevention and care services are targeted according to age, sex, race/ethnicity, geography, and risk factors using local epidemiology. However, some populations and communities **may not yet have the greatest burden of disease** in a local area (and/or there is insufficient local data to determine burden), **but have behavioral, socio-economic, or legal circumstances that place them at particularly high-risk for HIV infection and for being out-of-care in ways that other population groups do not.**"

<u>Handout 1:</u> Adolescents
(Aged 13 to 17)

Epidemiologic Summary (age range is 13-24):

- 2014 Prevalence (EMA): 1,364, or 5% of all diagnosed cases
- 2014 New Diagnoses (EMA): 360, or 26% of all new diagnoses
- 2014 Linkage - New Diagnoses (EMA): 239, or 74% linked w/in 3 mos.
- 2013 Late/Concurrent Diagnosis (EMA)[1]: 164, or 2% of all late diagnosis cases
- 2014 HIV Care Continuum (EMA):



From 2013 Epidemiologic Profile: "[As of 2011] a total of 125 adolescents (people age 13 to 17) [were] living with HIV in the Houston EMA. Almost all (92.8%) [were] African American or Hispanic/Latino. The majority were also perinatally infected (79.2%). However, small percentages also reported MSM (12.1%) and heterosexual contact (12.2%) as their primary risk factor. This is divergent from new HIV diagnoses in this age group in the EMA, for which the majority were either MSM or heterosexual (88.8%)."

Service Utilization (age range is 13-24):

- In 2014, the RW program served 815 youth (ages 13-24) were served, or 6.6% of all program clients

Needs Assessment & Special Studies:

- 2014 Needs Assessment: Adolescents (13-17) comprised 1.2% of the total sample surveyed.[2] Compared to the sample as a whole, adolescents experienced more barriers accessing Health Insurance Assistance and Local HIV Medication Assistance. Adolescents also reported difficulty accessing Housing Services.

[1] Late diagnosis cases reflect the diagnosed population, not new diagnoses.
[2] Surveys completed by care takers; 8 surveys completed.

Handout 2: Homeless

(Lack a fixed, regular, and adequate nighttime residence, including those who live in locations not meant for human habitation such as public parks and streets, those who live in or are transitioning from temporary housing or shelters, and those who have persistent housing instability)

Epidemiologic Summary:

- 2014 Homeless Estimate (EMA)[3]: 974, or 3.9% of all diagnosed cases
- 2014 Homeless Unmet Need Estimate (EMA): 248, or 3.9% of all unmet need cases

From 2013 Epidemiologic Profile: "Of those [in 2011 who were] currently homeless in Harris and Fort Bend Counties, it is estimated that 1 out of every 12, or 8.9%, has been diagnosed with HIV. In addition, 1.6% of homeless persons [reported] that they were triggered into homelessness by an HIV diagnosis."[4]

Program Information:

- From the FY15 Part A Grant Application: "[Collaboration] with the Houston EMA public hospital system has revealed the homeless as an emerging population. Harris Health System (HHS) is currently participating in the multi-site Special Projects of National Significance – Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations Initiative. HHS found that most of the project participants were not identified through HHS' routine/opt-out testing program, but rather through one of its clinics out-of-care patient lists and referrals from external agencies. While HHS anticipated providing services primarily to newly-diagnosed homeless PLWH, most of its participants in the project were previously diagnosed. This highlights a challenge in the Houston EMA to effectively retain homeless PLWH and those at-risk of becoming homeless in HIV medical care, and validates the continued need for the RW/A program's close collaboration with City of Houston Housing and Community Development (HCD), the Houston EMA HOPWA grantee."

Needs Assessment & Special Studies:

- 2014 Needs Assessment: Seven percent of respondents met the local definition of homelessness at the time of the survey, which includes residing most often in a shelter, car, street, or an inconsistent combination of various locations. Homeless participants reported having no mental or emotional support for managing HIV at twice the frequency of other participants, and were more likely to be out-of-care. Compared to all participants, more homeless PLWH surveyed reported difficulty accessing Case Management Services, Day Treatment, Early Intervention Services, Food Pantry, Housing, Legal Services, Medical Nutrition Therapy, Mental Health Services, Oral/Dental Care, HIV Primary Care, and Transportation.

[3] State estimate applied locally

[4] Troisi, CL, et al., Perceived Needs of Homeless Persons in Houston/Harris County. Prepared for the Coalition for the Homeless of Houston/Harris County, 2012

<u>Handout 3:</u> Incarcerated or Recently Released (IRR)

(Currently incarcerated in the jail or prison system or have been released from jail or prison within the past 12 months)

Epidemiologic Summary:

- 2014 HIV+ Incarcerated (Harris County, TDCJ): 742, or 34% of all HIV+ incarcerated in Texas
- 2014 Estimated Recently Released (Harris County, TDCJ): 443, or 34% of all HIV+ recently released in Texas[5]

From 2013 Epidemiologic Profile: "In 2011, 65 persons were incarcerated at the time of their HIV diagnosis in Houston/Harris County. This represents 5.2% of all new HIV diagnoses reported in the jurisdiction in that year and 0.7% of the average daily incarcerated population in Houston/Harris County."

Service Utilization:

- In 2014, 897 unduplicated clients received Early Intervention Services (pre-discharge planning).

Needs Assessment & Special Studies:

- 2014 Needs Assessment: Recently released individuals comprised 13.2% of the total sample surveyed. Compared to the sample as a whole, recently released individuals experienced more barriers accessing Case Management Services, Day Treatment, Early Intervention Services, Food Pantry, Health Insurance, Hospice, Housing, Legal Services, Local HIV Medication Assistance, Medical Nutrition Therapy, Mental Health Services, Oral/Dental Care, HIV Primary Care, Substance Abuse Services and Transportation. Twenty percent out-of-care respondents reported being released from incarceration in the past 12 months compared to 13% of the sample as a whole.
- 2013 SIRR Partnership Special Study Evaluating the SIRR Referral Process for HIV Positive Post-Release Offenders: The five highest ranked HIV service needs post-release were HIV primary care, HIV medications, transportation, food, and case management. Barriers to HIV care were: lack of transportation, wait times for ADAP eligibility, lack of targeted social support, and lack of housing.

[5] % of current HIV+ incarcerated in Harris County applied to the total number of HIV+ recently released to estimate the number of HIV+ releases in Harris County.

Handout 4: Injection Drug Users (IDU)

(Inject medications or drugs, including illegal drugs, hormones, and cosmetics)

Epidemiologic Summary[6]:

- 2014 Prevalence (EMA): 2,328, or 9% of all diagnosed cases
- 2014 New Diagnoses (EMA): 66, or 5% of all new diagnoses
- 2014 Linkage - New Diagnoses (EMA): 51, or 85% linked w/in 3 mos.
- 2013 Late/Concurrent Diagnosis (EMA)[7]: 737, or 10% of all late diagnosis cases

From 2013 Epidemiologic Profile: "In 2011, there were 66 cases of new HIV disease and 79 new cases of AIDS diagnosed in individuals with a history of injection drug use (IDU) in Houston/Harris County. When the jurisdiction of analysis is expanded to the Houston EMA, there were an additional 37 new cases of HIV disease in IDUs and an additional 33 new cases of AIDS in IDUs. Individuals with IDU risk were the only group in both jurisdictions with more new cases of AIDS than new cases of HIV diagnosed in 2011. In general, when IDUs were newly diagnosed with HIV in Houston/Harris County and in the EMA in 2011, they were male, African American, and over age 35."

Service Utilization (age range is 13-24):

- In 2014, 17 unduplicated clients used Substance Abuse Treatment (outpatient) services.[8] Additionally 1,266 unduplicated clients received Clinical Case Management, which serves individuals with mental health and/or substance use concerns.

Needs Assessment & Special Studies:

- 2014 Needs Assessment: IDU comprised 1.5% of the total sample surveyed.

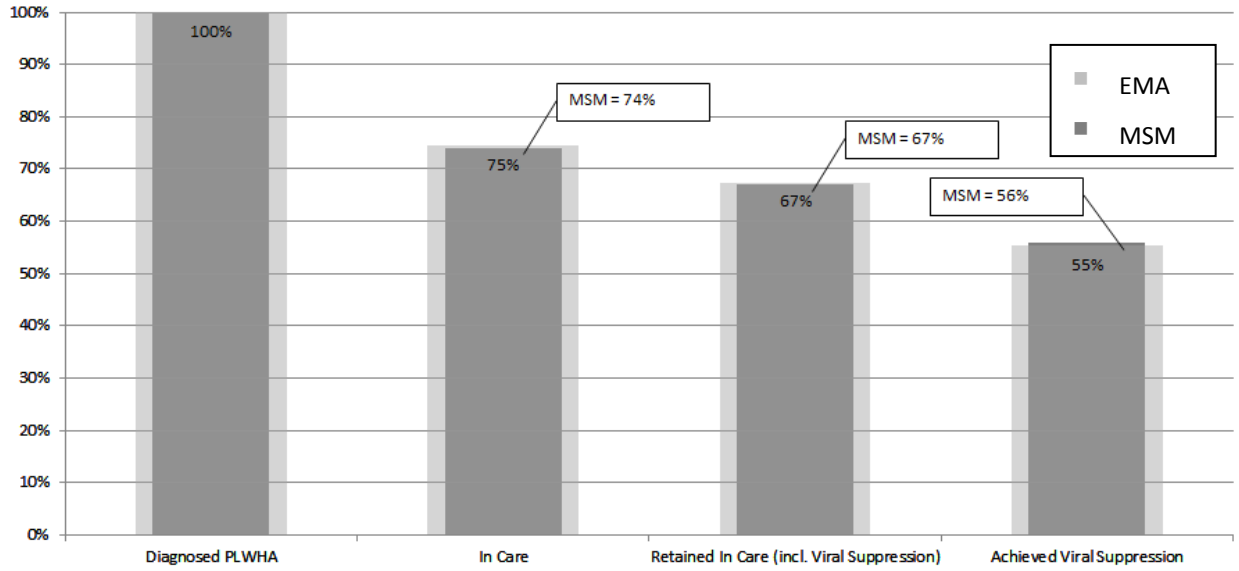
[6] Does not include MSM/IDU risk factor
[7] Late diagnosis cases reflect the diagnosed population, not new diagnoses.
[8] Includes both injection and non-injection drug use

<u>Handout 5:</u> Men who Have Sex with Men (MSM)

(Men who engage in male-to-male sexual practices and identify as gay or bisexual, those who engage in male-to-male sexual practices and do not identify as gay or bisexual, and those who engage in gay or bisexual male culture regardless of gender identity (i.e., male-to-female transgender))

Epidemiologic Summary:[9]

- 2014 Prevalence (EMA): 13,759, or 55% of all diagnosed cases
- 2014 New Diagnoses (EMA): 930, or 67% of all new diagnoses
- 2014 Linkage - New Diagnoses (EMA): 706, or 78% linked w/in 3 mos.
- 2013 Late/Concurrent Diagnosis (EMA)[10]: 4,261, or 56% of all late diagnosis cases
- 2014 HIV Care Continuum (EMA):



From 2013 Epidemiologic Profile: "[From 2002 to 2011], an average of 489 MSM of color (MSMOC) [were] diagnosed with HIV in Houston/Harris County each year compared to an average of 164 White MSM annually. This breaks down to 259 African American MSM and 214 Hispanic/Latino MSM diagnosed each year on average. In addition, the number of African American MSM diagnosed with HIV has increased each year of this ten year period as did the number of Hispanic MSM diagnosed with HIV each year."

"When analyzed by age, the numbers of newly diagnosed MSM in Houston/Harris County in each age range have remained relatively stable over a ten year period, with the exception of young MSM (MSM age 13 to 24) and MSM age 35 to 44. In the case of the former, the numbers of new HIV cases in young MSM have increased each year (from 2003 to 2010) while, in the case of MSM age 35 to 44, the numbers of new HIV cases have declined."

[9] Does not include MSM/IDU risk factor

[10] Late diagnosis cases reflect the diagnosed population, not new diagnoses.

Service Utilization:

- In 2014, males comprised 74% of all RW program clients served, and 75% of new clients served.

Needs Assessment & Special Studies:

- 2014 Needs Assessment: MSM (gay, bisexual, or pansexual self-identified) comprised 37.4% of the total sample surveyed. Fifty percent of out-of-care participants identified as MSM. Compared to the sample as a whole, MSM experienced more barriers accessing Early Intervention Services, Health Insurance Assistance, Housing, Legal Services, Local HIV Medication Assistance, Medical Nutrition Therapy, Oral/Dental Care, and Substance Abuse Services. MSM also reported difficulty accessing Case Management Services, Day Treatment, Food Pantry, Mental Health Services, HIV Primary Care, and Transportation.

Handout 6: Transgender[11]

(Individuals who cross or transcend culturally-defined categories of gender)

Epidemiologic Summary:

Gender identity for transgender and gender non-conforming individuals is generally not reflected in most epidemiologic and surveillance data. This is one of the primary shortcomings of using solely epidemiologic data to identify populations with disproportionate burden. Often transgender and gender non-conforming individuals are categorized by sex at birth, which does not accurately and adequately demonstrate current risks, needs, and barriers.

Service Utilization:

- In 2014, 93 transgender unduplicated clients were served in the RW program. or 0.8% of all clients served. Ninety-one were identified as male-to-female transgender, while two were identified as female-to-male transgender.

Needs Assessment & Special Studies:

- 2014 Needs Assessment: Transgender and gender non-conforming individuals (reporting discordant sex at birth + gender identity or expression today) comprised 3.5% of the total sample surveyed. Transgender individuals reported universal condom use (using condoms every time) in higher proportions than both cisgender men and cisgender women (63% versus 40% and 44%, respectively). Compared to the sample as a whole, transgender individuals experienced more barriers accessing Case Management Services, Food Pantry, Health Insurance Assistance, Local HIV Medication Assistance, and HIV Primary Care. Transgender also reported difficulty accessing Day Treatment, Early Intervention Services, Housing, Medical Nutrition Therapy, Mental Health Services, Oral/Dental Care, and Transportation.\
- 2013 Access to HIV Care among Transgender and Gender Non-Conforming People in Houston: Seventy-six percent of transgender individuals in the study were linked to care within three months of their HIV diagnosis. Those reporting delayed entry most often cited denial about their positive status. When asked what barriers, if any, respondents had encountered since their diagnosis, the most commonly-cited barriers were lack of transportation (44%) poor treatment from staff due to gender variance (29%), lack of funds to pay for services (28%), and denial about being HIV-positive (24%). In addition, 19% of respondents reported lack of provider familiarity with transgender needs as a barrier to care. The five most commonly reported additional needs included housing, including rental assistance and shelters for transgender individuals; transportation services; assistance with basic needs such as food and clothing; support groups for transgender individuals; and employment assistance for individuals. Eighty-four percent of respondents reported being treated differently in public due to gender variance, including 16% who reported being asked to leave a public place. In addition, 60% of respondents reported being harassed or taunted due to their gender variant status, 36% reported being threatened with violence, and 30%, 23%, and 16% reported being the victims of physical assault, sexual assault, and rape, respectively, at some time in their lives.

[11] Here refers to both transgender and gender non-conforming individuals.

Black Women and HIV in Harris County

Texas Department of State Health Services HIV/STD Program

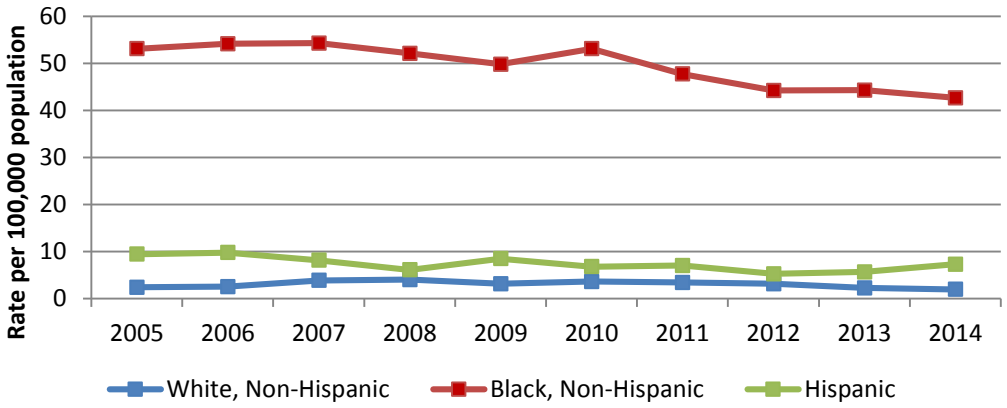
The Big Picture

As of 2014, there were 3,997 Black women living with HIV in Harris County. Black women comprise 67% of women living with HIV in Harris County, but only 20% of the female population in Harris County.

Black Women Living with HIV in Harris County

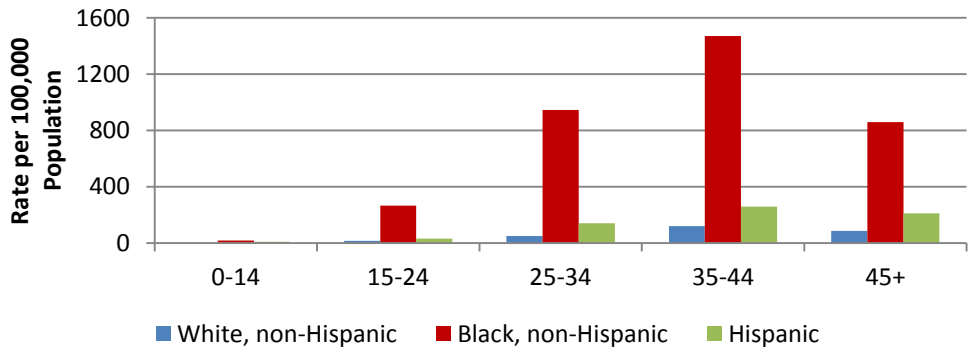
In Harris County, the rate of Black women living with HIV (902.3/100,000 population) is 14 times the rate of white women living with HIV and 7.6 times the rate of Hispanic women living with HIV. Over 2% of Black women age 35-44 in Harris County are living with HIV.

Rate of new HIV Diagnoses in Women by Race/Ethnicity, Harris County, 2005-2014



The most common way that Black women in Harris County get HIV is through unprotected sex with an HIV infected man (88%). Twenty-four (24%) percent of Black women in Harris County were diagnosed with HIV late in the progression of the disease (they received their HIV and AIDS diagnoses within one year).

One in 110 Black Women in Harris County are living with HIV.
Rate of Women Living with HIV by Age and Race/Ethnicity, Harris County, 2014



Black Women without HIV-Related Medical Care in 2014

Advances in medical care enable people with HIV to stay healthy and survive longer than ever before. Some persons living with HIV may not seek care because they do not feel ill. Others may have problems affording or accessing health care. Others may not seek medical care because of substance abuse, mental health issues or HIV-related stigma.

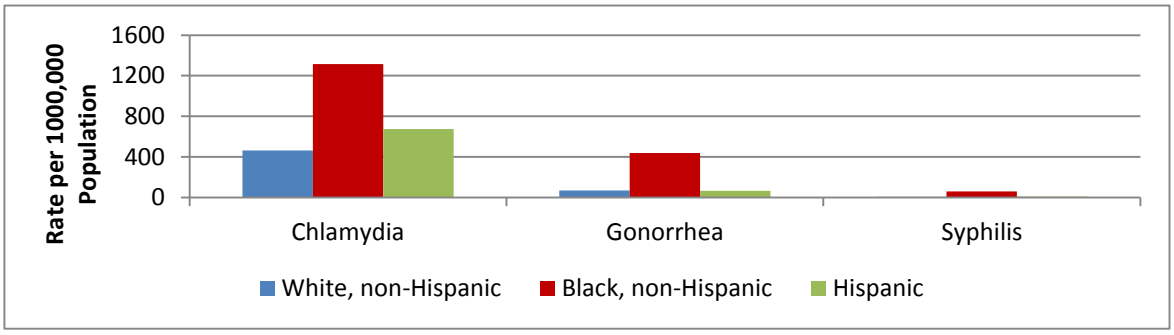
Among the major racial and ethnic groups in Texas, Blacks have the greatest number (7,610, 25%) of their population who do not receive medical care for HIV. In Texas, 1 in 5 Black women with HIV were out of care in 2014. This represents 2,276 (23%) Black women not in care across the state.

In 2014, over 1 in 5 Black women with HIV in Harris County were not receiving medical care for their infection. This represents 879 Black women not in care.

HIV and Other STDs

People infected with STDs are at least two to five times more likely than uninfected people to get HIV if they are exposed to HIV through sexual contact. In addition, if an HIV-infected person is also infected with another STD, that person is more likely to transmit HIV through sexual contact than other HIV-infected persons. Among women, Blacks have the highest rates of chlamydia, gonorrhea and syphilis in Harris County.

Rate of Women with Chlamydia, Gonorrhea, Syphilis by Race/Ethnicity, Harris County, 2014



HIV Prevention for Black Women in Texas

Stigma, biological vulnerabilities, trauma, relationship dynamics and structural factors such as poverty, unemployment and lack of education can contribute to HIV transmission among Black women. For more information on how to get involved in HIV prevention for Black women in Texas, please contact Deborah Carr at Deborah.Carr@dshs.state.tx.us or (512) 533-3088.

FACTS TO CONSIDER	**One in every 336 Texan has HIV, compared to:** **One in 108 Black Texans** **One in 538 White Texans** **One in 423 Hispanic Texans**

- From 2012 to 2014, there were 464 new cases of HIV in women under the age of 25 in Texas. Over 61% of these were young Black women
- The rate of new HIV cases in Black women in Texas is 7 times and 18 times higher than the rates in Hispanic and White women, respectively.
- Black women have the highest case rates for chlamydia, gonorrhea and Primary and Secondary Syphilis in Texas.

TEXAS Department of State Health Services

DSHS HIV/STD Program
PO Box 149347 MC 1873
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www.dshs.state.tx.us/hivstd
Publication No. E13-13493
(Rev. 11/11)

Data in this fact sheet are current through December 31, 2014. For source information, please send an email to hivstd@dshs.state.tx.us.

Table 3: New HIV Diagnoses in Houston/Harris County by Race/Ethnicity, 2014

	White			African American			Hispanic			Total		
	Number	%	Rate*	Number	%	Rate*	Number	%	Rate*	Number	%	Rate*
Total	180	100.0%	13.0	626	100.0%	73.9	441	100.0%	23.8	1293	100.0%	29.1
Sex												
Male	166	92.2%	24.0	436	69.6%	109.9	375	85.0%	39.5	1013	78.3%	45.8
Female	14	7.8%	2.0	190	30.4%	42.2	66	15.0%	7.3	280	21.7%	12.5
Age Group												
15-24 yrs	26	14.4%	17.7	180	28.8%	135.4	113	25.8%	37.2	331	25.7%	52.8
25-34 yrs	58	32.2%	28.2	199	31.9%	144.6	152	34.7%	48.9	426	33.1%	59.3
35-44 yrs	50	27.8%	28.0	121	19.4%	103.0	103	23.5%	36.2	284	22.0%	44.5
45-54 yrs	32	17.8%	15.7	84	13.5%	79.6	54	12.3%	25.8	175	13.6%	31.0
55 yrs and over	14	7.8%	3.2	40	6.4%	24.9	16	3.7%	7.6	72	5.6%	8.2
Mode of Exposure**												
MSM	148	82.2%		353	56.3%		338	76.6%		869	67.2%	
IDU	7	3.7%		41	6.5%		14	3.1%		63	4.8%	
Heterosexual	16	8.8%		217	34.7%		81	18.5%		327	25.3%	
Other	10	5.3%		16	2.5%		8	1.8%		35	2.7%	
%MSM in Male***		89.1%			80.8%			90.1%			85.8%	

Source: Houston/Harris County data were from Texas eHARS, 2015; Texas data were from 2013 Texas STD and HIV Epidemiologic Profile.

**: Population data were from 2014 ACS 1-year estimates. Rate was shown the number of cases per 100,000 population in each subgroup.*

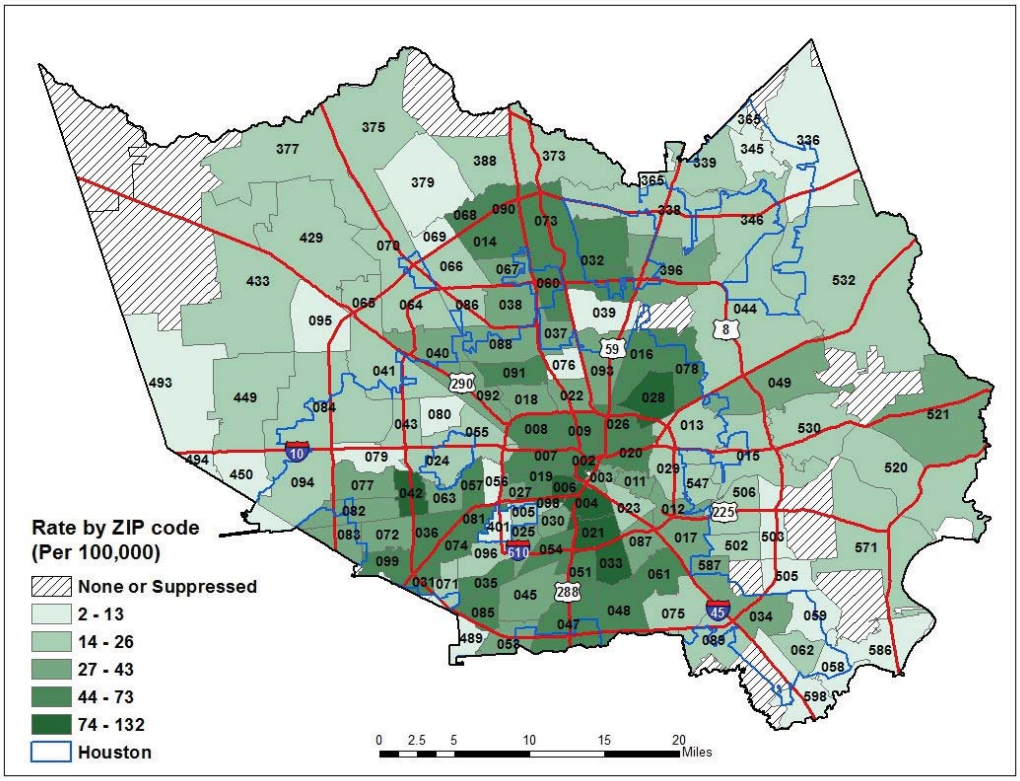
***: Patient with no risk reported were re-categorized into standard categories using CDC's multiple imputation program.*

****: Percentage of MSM within males is shown.*

Geographic Distribution of New HIV Diagnoses

The burden of HIV disease by neighborhood is mapped in Figure 10, which shows rates of new HIV diagnoses by ZIP code in Houston/Harris County for 2014. The ZIP codes with higher rates of new HIV diagnoses were located in central and northern Houston/Harris County.

***Figure 10*: New HIV Diagnoses by ZIP Code in Houston/Harris County, 2014**

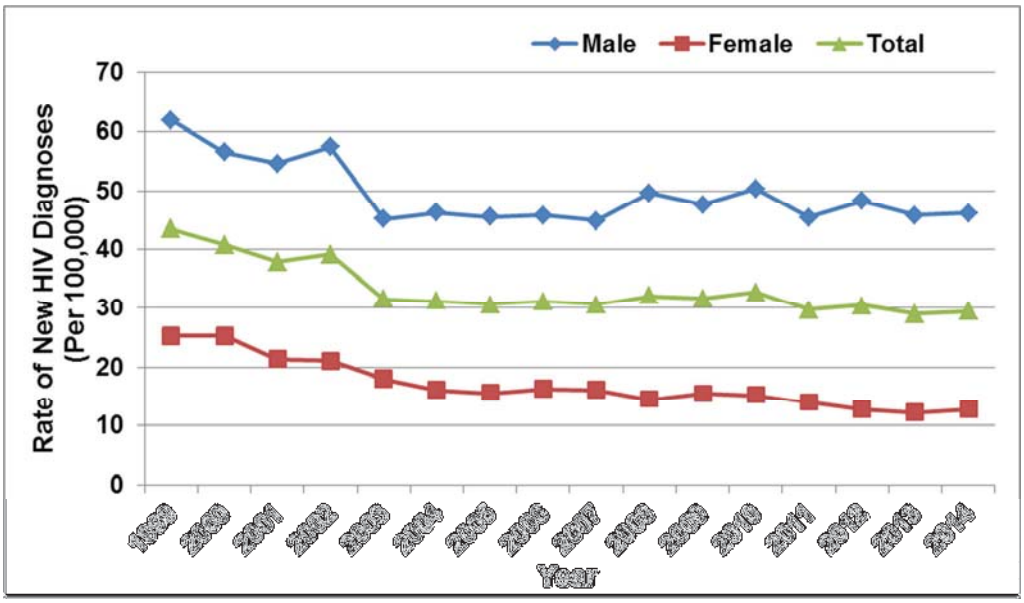


Source: Texas eHARS, 2015. The number of new HIV diagnoses includes all cases diagnosed in 2014 with address at HIV diagnosis within Houston/Harris County and reported to eHARS by 7/26/2015. The population data was based on 2010 US Census. The rates by ZIP code are grouped by quintiles and shown in the map. ZIP codes are labeled using the last three digits only (e.g. 77002 is labeled as "002").

Trends of New HIV Diagnoses by Key Sub-populations

The rate of new HIV diagnoses both in females and males decreased from 1999 to 2003 and kept relatively constant after 2004 in Houston/Harris County, which was consistent with trends in the U.S.[7](Figure 11).

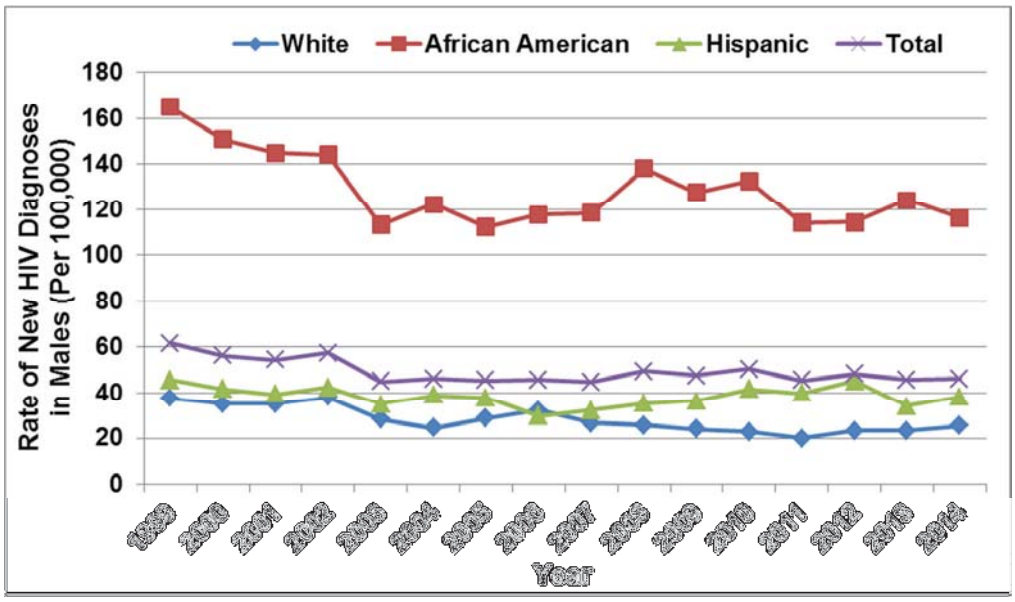
Figure 11: **New HIV Diagnoses by Sex at Birth in Houston/Harris County, 1999-2014**



Source: Texas eHARS, 2015.

The rate of new HIV diagnoses in African American males decreased from 1999 to 2003 and remained relatively constant after that. However, the African American was the group with highest rate of new HIV diagnoses each year. In White, Hispanic and all males, the rate of new diagnoses remained stable from 1999 to 2014 (Figure 12).

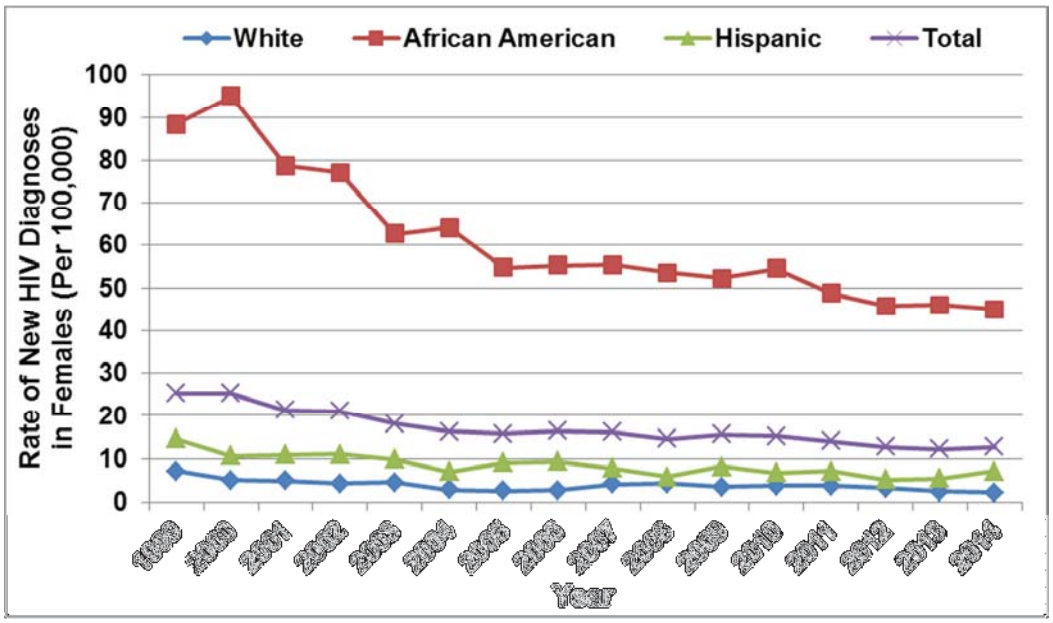
Figure 12: **New HIV Diagnoses by Race/Ethnicity in Males, Houston/Harris County, 1999-2014**



Source: Texas eHARS, 2015.

The rate of new HIV diagnoses in females slightly decreased from 1999 through 2012 (Figure 11). This was driven mostly by a decreasing trend in African American females. The rates in Hispanic and White females were relatively constant (Figure 13).

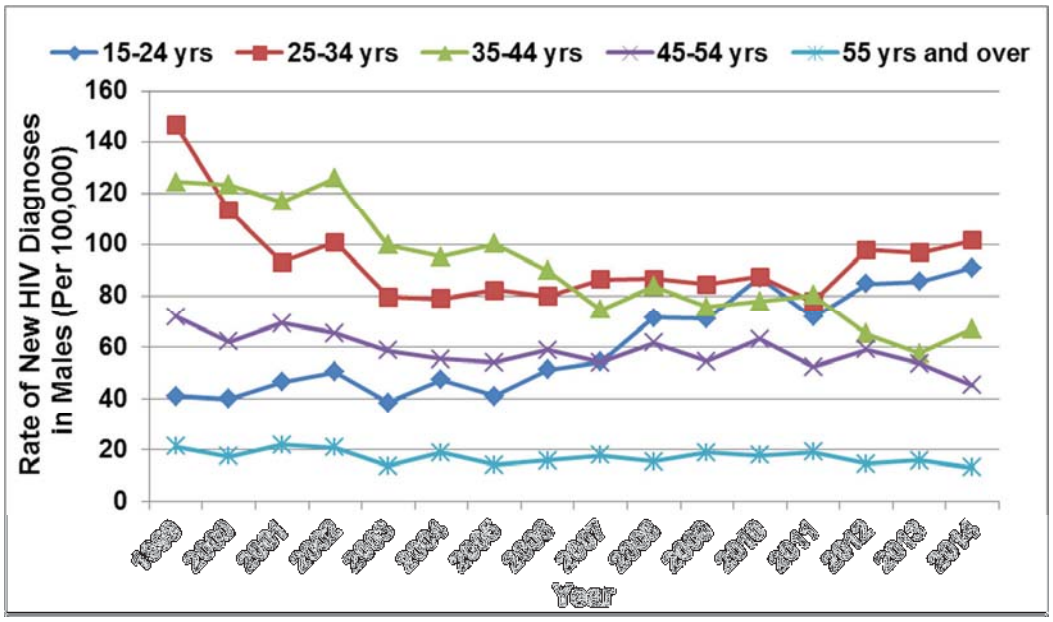
Figure 13: **New HIV Diagnoses by Race/Ethnicity in Females, Houston/Harris County, 1999-2014**



Source: Texas eHARS, 2015.

The rate of new HIV diagnoses among young males 15-24 years increased dramatically from 1999 through 2014 (Figure 14). The rate in age group 25-34 years decreased from 1999 to 2003 and slightly increased from 2004 to 2014. The age group 35-44 years had consistent decreasing rates from 1999 to 2014, while the rate in groups 45 or older remained relatively stable over the years.

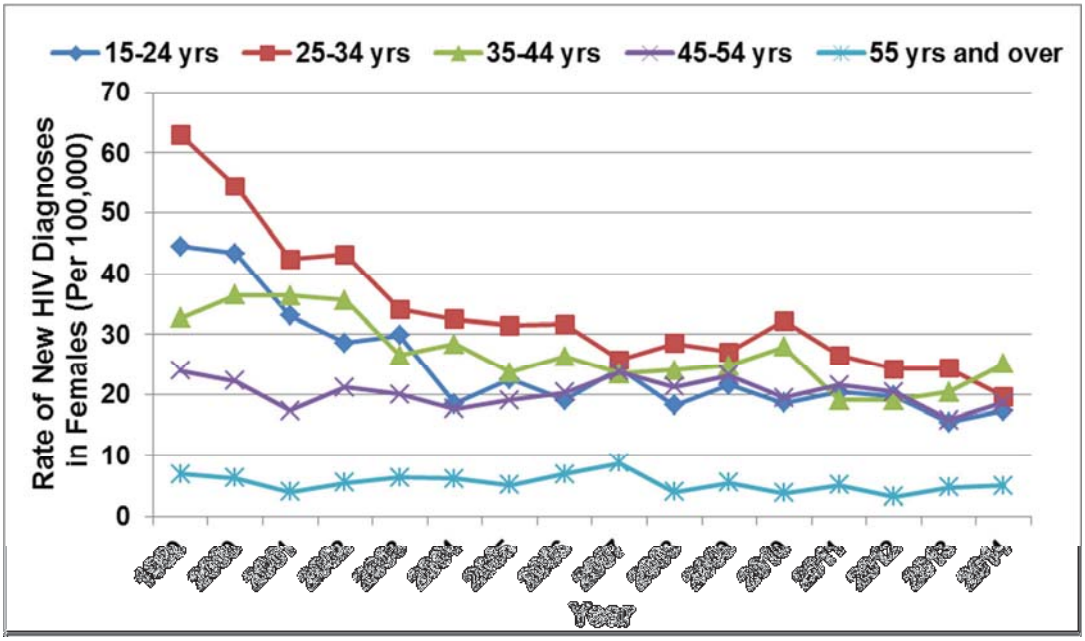
Figure 14: **New HIV Diagnoses by Age Groups in Males, Houston/Harris County, 1999-2014**



Source: Texas eHARS, 2015.

From 1999 to 2014, the rates of new HIV diagnoses in 15-44 year-old females were decreasing, with the greatest decrease in the age group 15-34 years (Figure 15). Age groups of 45 years or older showed a stable trend over the years.

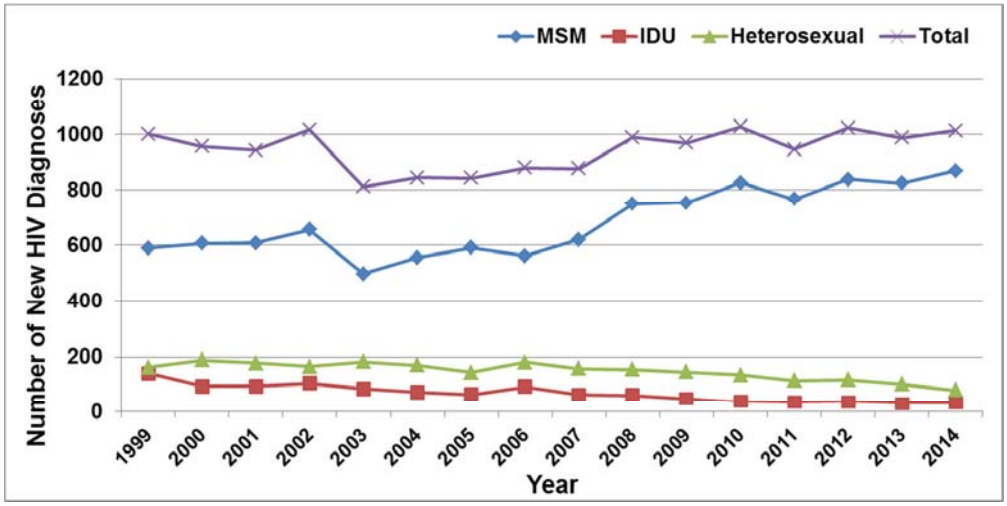
Figure 15: **New HIV Diagnoses by age groups in Females, Houston/Harris County, 1999-2014**



Source: Texas eHARS, 2015.

In males, the number of new HIV diagnoses among MSM increased from 2003 to 2014 in Houston/Harris County, while new diagnoses among IDU and heterosexuals slightly decreased starting in 2006 (Figure 16).

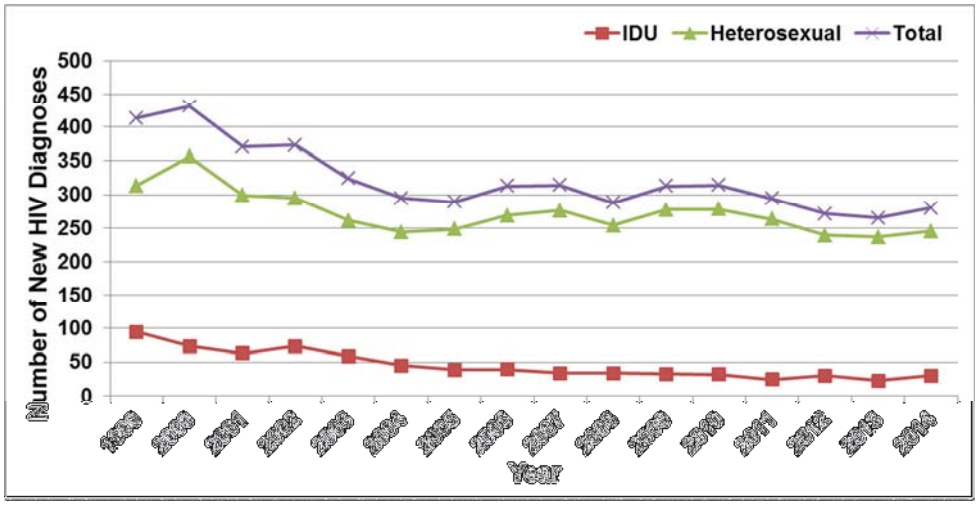
Figure 16: **New HIV Diagnoses in Males by Transmission Risks in Houston/Harris County, 1999-2014**



Source: Texas eHARS, 2015. Patients with no risk reported were not re-categorized by using CDC's multiple imputation or risk program.

Heterosexual contact was the main mode of transmission for women and it showed a decreasing trend along with IDU (Figure 17).

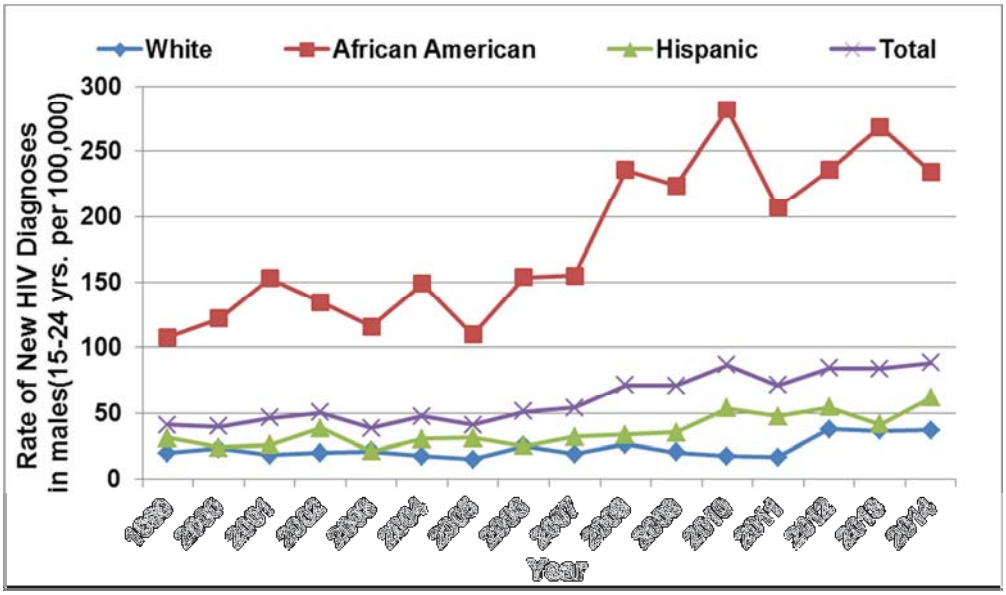
Figure 17: **New HIV Diagnoses in Females by Transmission Risks, Houston/Harris County, 1999-2014**



Source: Texas eHARS, 2015. Patients with no risk reported were not re-categorized by using CDC's multiple imputation or risk program.

In young MSM (13-24 years old), the rate of new HIV diagnoses increased dramatically from 1999 to 2014 in African Americans. In both Hispanic and White groups, the rates increased slightly from 1999 to 2014. Overall, the rate of new HIV diagnoses in young MSM increased from 2003 to 2014 in Houston/Harris County (Figure 18).

Figure 18: **New HIV diagnoses in Young (13-24 years old) Men Who Have Sex with Men by Race, 1999-2014**



Source: Texas eHARS, 2015.

Concurrent/Late Diagnoses, Progression to AIDS

Concurrent/late HIV diagnosis is defined as an AIDS diagnosis within 12 months of an HIV diagnosis. Studies showed that late HIV diagnosis is associated with higher mortality and lower survival outcomes. If diagnosed early, HIV- positive individuals can seek treatment sooner and receive more health benefits from highly-active antiretroviral therapy (HAART) medication. Therefore, late HIV diagnosis can be used as an indicator for HIV prevention program planning and evaluation.

In 2014, 26.2% of newly diagnosed HIV-positive people in Houston/Harris County progressed to AIDS within a year (Table 5). Males had a slightly higher percentage (26.4%) of late diagnosis compared to females (25.7%), and Hispanics had the highest percentage of late HIV diagnoses (34.4%) among all race/ethnicity groups. Compared to younger age groups, older age groups had a higher percentage of late HIV diagnoses. Half of the newly diagnosed people over 55 years old were late diagnoses (50.0%). MSM had a relatively lower percentage of late HIV diagnoses (23.6%) compared to the heterosexual transmission group (30.5%). In summary, males, Hispanics, people over 55 years of age and heterosexual transmission risk had a higher percentage of late HIV diagnoses. HIV prevention programs in Houston/Harris County should target these populations at risk for late HIV diagnosis to encourage HIV testing.

Table 5: **Concurrent/Late HIV Diagnoses in Houston/Harris County, 2013**

	HIV to AIDS ≤ 1 year (Late HIV Diagnosis)		HIV to AIDS > 1 year		Total
	Number	%	Number	%	
Total	328	26.2%	923	73.8%	1251
Sex					
Male	260	26.4%	726	73.6%	986
Female	68	25.7%	197	74.3%	265
Race/Ethnicity					
White	37	22.0%	131	78.0%	168
African American	151	23.2%	501	76.8%	652
Hispanic	128	34.4%	244	65.6%	372
Other/Unknown	12	20.3%	47	79.7%	59
Age at HIV diagnoses					
13-24 yrs	52	16.8%	258	83.2%	310
25-34 yrs	92	21.7%	332	78.3%	424
35-44 yrs	84	35.1%	155	64.9%	239
45-54 yrs	60	31.6%	130	68.4%	190
55 yrs and over	40	50.0%	40	50.0%	80
Mode of Exposure*					
MSM	152	23.6%	491	76.4%	643
Heterosexual	51	30.5%	116	69.5%	167
Other/Unknown	125	28.3%	316	71.7%	441

Source: Texas eHARS, 2015.

**: Patients with no risk reported, or with transmission risk of IDU, MSM/IDU were categorized into Other/Unknown group.*

2017 Comprehensive Plan Prevention and Early Identification (PEI) Goals Selection Table

2012 PEI Goals	Corresponding 2017 Plan Goals	Corresponding NHAS Update for 2020 Goals	Status	2017 Revision (if applicable)
1. Reduce New HIV Infections	2. Prevent and reduce new HIV infections	• Reducing new HIV infections	☐ Keep as Written ☐ Revise ☐ Remove	
2. Increase Awareness of HIV	1. Increase community mobilization around HIV in the Greater Houston Area 6. Increase community knowledge around HIV in the Greater Houston Area	• Reducing new HIV infections • Improving access to care and health outcomes	☐ Keep as Written ☐ Revise ☐ Remove	
3. Increase Awareness of HIV Status	2. Prevent and reduce new HIV infections 3. Ensure that all people living with or at risk for HIV have access to early and continuous HIV prevention and care services	• Reducing new HIV infections • Improving access to care and health outcomes	☐ Keep as Written ☐ Revise ☐ Remove	
4. Ensure Early Entry Into Care	3. Ensure that all people living with or at risk for HIV have access to early and continuous HIV prevention and care services 4. Reduce the effect of co-occurring conditions that hinder HIV prevention behaviors and adherence to care	• Reducing new HIV infections • Improving access to care and health outcomes • Reducing HIV-related health disparities	☐ Keep as Written ☐ Revise ☐ Remove	
5. Maximize Adherence to Antiretroviral Therapy	2. Prevent and reduce new HIV infections 4. Reduce the effect of co-occurring conditions that hinder HIV prevention behaviors and adherence to care	• Reducing new HIV infections • Improving access to care and health outcomes	☐ Keep as Written ☐ Revise ☐ Remove	
6. Address the HIV Prevention Needs of High Incidence Communities	2. Prevent and reduce new HIV infections 5. Reduce disparities in the Houston Area HIV epidemic and address the needs of vulnerable populations 6. Increase community knowledge around HIV in the Greater Houston Area	• Reducing new HIV infections • Improving access to care and health outcomes • Reducing HIV-related health disparities • Achieving a more coordinated national [local] response	☐ Keep as Written ☐ Revise ☐ Remove	
7. Reduce Population Risk Factors for HIV Infection	2. Prevent and reduce new HIV infections 4. Reduce the effect of co-occurring conditions that hinder HIV prevention behaviors and adherence to care 5. Reduce disparities in the Houston Area HIV epidemic and address the needs of vulnerable populations	• Reducing new HIV infections • Improving access to care and health outcomes • Reducing HIV-related health disparities • Achieving a more coordinated national [local] response	☐ Add	
			☐ Add	

Important Questions:

1. Do the goals selected correspond with the NHAS Update for 2020 goals? Are any not addressed?
2. Do the goals selected correspond with 2017 Comprehensive Plan goals? Are any not addressed?
3. Have any issues, policies, therapies, or strategies relevant to effective prevention and early identification emerged since 2011 when the 2012 Plan was developed that are not addressed?
4. Are the goals relevant in light of:
    a. Changes in language or description (appropriate terminology)?
    b. Current funding priorities (both within and outside the HIV prevention and care system)?
    c. Local HIV data?
    d. Other local, state, and national strategies for prevention and early detection?

UPDATED:
03/03/16

All meetings subject to change. Please call in advance to confirm: 713 572-3724.

Unless otherwise noted, meetings are held at:

2223 W. Loop South,
Suite 240
Houston, TX 77027

May 2016

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	**2**	**3**	**4**	**5** 12 noon Steering Committee Room #240	**6** 5:00 pm Deadline for submitting Idea Forms	**7**
8	**9**	**10**	**11**	**12** 12 noon Planning Council Room #532 1:45 pm Speaker's Bureau Workgroup 2:00 pm Comp HIV Planning Room #532	**13**	**14**
15	**16**	**17** 11:00 am HTBMN Wg #4 and Operations Room #240	**18** HIV Vaccine Awareness Day	**19** 11:00 am Quality Improvement Room #101 2:00 pm NAG Room #416 National Asian & Pacific Islander HIV Awareness Day	**20**	**21**
22	**23**	**24** 12:00 pm Affected Community Room #532 7:00 pm Public Hearing 900 Bagby 77002	**25** SIRR	**26** 9:00 am TENTATIVE Quality Improvement 11:00 am Priority & Allocations Room #532	**27**	**28**
29	**30** **Memorial Day** **OFFICE CLOSED**	**31**				