

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee

2:00 p.m., Thursday, March 14, 2019

Meeting Location: 2223 W. Loop South, Room 532
Houston, Texas 77027

AGENDA

I. Call to Order

- A. Welcome
- B. Moment of Reflection
- C. Adoption of the Agenda
- D. Approval of the Minutes (February 14, 2019)

Ted Artiaga and
Daphne L. Jones, Co-Chairs

II. Public Comment and Announcements

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization.

III. Epidemiological Profile

- A. Chapter 1 Revision
- B. Chapter 2 (EMA Data Only)
- C. Update from HHD

Amber Harbolt, Health Planner
Office of Support

Dr. Imran Shaikh,
Houston Health Department

IV. FY2020 EIIHA Workgroup

- A. Motion to Council

V. Needs Assessment Progress

- A. Updated Timeline
- B. 2019 Needs Assessment Key Concepts

VI. Announcements

Ted Artiaga and
Daphne L. Jones, Co-Chairs

VII. Adjourn

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee

2:00 p.m., Thursday, February 14, 2019

Meeting Location: 2223 West Loop South, Room 101; Houston, Texas 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Daphne L. Jones, Co-Chair	Imran Shaikh, excused	Sha'Terra Johnson-Fairley, TRG
Ted Artiaga, Co-Chair	Isis Torrente, excused	Crystal Townsend, TRG
Dawn Jenkins	Elizabeth Drayden	Samantha Bowen, RWGA
Denis Kelly		Amber Harbolt, Office of Support
Holly McLean		Diane Beck, Office of Support
Rodney Mills		
Matilda Padilla		
Shital Patel		
Faye Robinson		
Dominique Brewster		
Ryan Clark		
Nancy Miertschin		
Steven Nazareus		
Steven Vargas		
Anthony Williams		
Larry Woods		

Call to Order: Daphne L. Jones, Co-Chair, called the meeting to order at 2:05 p.m. and asked for a moment of reflection. She then asked everyone to introduce themselves.

Adoption of Agenda: **Motion #1:** *it was moved and seconded (Vargas, Mills) to adopt the agenda.* **Motion carried.**

Approval of the Minutes: **Motion #2:** *it was moved and seconded (Kelly, Vargas) to approve the November 8, 2018 minutes.* **Motion carried.** Abstentions: Brewster, McLean, Miertschin, Padilla, Patel, Williams, Woods.

Public Comment: None.

Nuts and Bolts for Committee Members: Harbolt reviewed the Nuts and Bolts for Committee Members, Petty Cash deadlines, Conflict of Interest, Open Meetings Act Training, Timeline of Critical 2019 Council Activities, Purpose of the Committee, Committee Meeting Schedule, memo re, Open and the 2019 Committee Goals, see attached. **Motion #3:** *it was moved and seconded (Padilla, Jenkins) to accept the 2019 committee goals as presented.* **Motion Carried.**

NAG Overview and 2019 Needs Assessment Timeline: Harbolt reviewed the attached Needs Assessment Structure and Proposed Needs Assessment Group Activities Timeline. She

described the role of the committee, NAG, workgroups and partners in the process. She said that she has acquired six tablets to use for surveys this year. Kelly and others suggested allowing the survey to be conducted online without an administrator. Harbolt said that we are unable to do that. Johnson-Fairley suggested sharing the link to the online survey with DIS workers who could share when they find individuals who are out of care.

Select a Committee Vice Chair: Vargas nominated Mills for vice chair; Mills accepted the nomination.

Announcements: Harbolt said there is an FYI in the meeting packet which is Ryan White Program data from HRSA. While it is not local data, it is good information. Kelly said he would be attending HIV advocacy day and health care advocacy day in Austin next week. Vargas added that if anyone would like to attend HIV advocacy day they can sign up at Legacy, and tomorrow at Bering, Positive Women's Network will hold a legislative training for those attending advocacy day.

Adjournment: The meeting was adjourned at 3:33 p.m.

Submitted by:

Approved by:

Amber Harbolt, Office of Support Date

Chair of Committee Date

JA = Just arrived at meeting
 LR = Left room temporarily
 LM = Left the meeting
 C = Chaired the meeting

2019 Voting Record for Meeting Date February 14, 2019

MEMBERS	Motion #1: Agenda				Motion #2: Minutes				Motion #3: 2019 Committee Goals			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Ted Artiaga, Co-Chair				C				C				C
Daphne L. Jones, Co-Chair		X				X				X		
Dawn Jenkins		X				X				X		
Denis Kelly		X				X				X		
Holly McLean		X						X		X		
Rodney Mills		X				X				X		
Matilda Padilla		X						X		X		
Shital Patel		X						X		X		
Faye Robinson		X				X				X		
Imran Shaikh	X				X				X			
Isis Torrente	X				X				X			
Dominique Brewster		X						X		X		
Ryan Clark		X				X				X		
Elizabeth Drayden	X				X				X			
Nancy Miertschin		X						X		X		
Steven Nazareus ja 2:36 pm	X				X					X		
Steven Vargas		X				X				X		
Anthony Williams		X						X		X		
Larry Woods		X						X		X		



Chapter 1: The Houston Area Population

What are the sociodemographic characteristics of the general population in the Houston Area?

“The Houston metro area is now the single most ethnically diverse urban region in the country [.]”

~ Kinder Institute for Urban Research, *The Kinder Houston Area Survey: Thirty-Six Years of Measuring Responses to a Changing America*
May 2017

Distribution of Total Population By County

(Table 1.1) The Houston Eligible Metropolitan Area (**EMA**) consists of six counties in Southeast Texas: Chambers, Fort Bend, Harris (including the City of Houston), Liberty, Montgomery, and Waller. The Houston Health Service Delivery Area (**HSDA**) includes these and four additional counties: Wharton, Colorado, Austin, and Walker. In 2016, the total population of the EMA was 5,800,581, or 22% of the Texas population. Harris County remains the population center of the EMA with 76.4% of the population, though the EMA other counties' shares have increased, particularly in Fort Bend and Montgomery Counties. As a whole, the Houston EMA represents a larger proportion of the total Texas population today than in 2010.

TABLE 1-Distribution of Total Population in the Houston EMA by County, 2010 and 2016				
County	Total Population-2010 ^a	Total Population-2016 ^b	County Percent of EMA-2010 ^a	County Percent of EMA-2016 ^b
Chambers	32,371	38,072	0.6%	0.7%
Fort Bend	541,983	683,756	10.7%	11.8%
Harris (incl. Houston)	3,950,999	4,434,257	77.9%	76.4%
Liberty	74,922	78,598	1.5%	1.4%
Montgomery	427,717	518,849	8.4%	8.9%
Waller	40,831	47,049	0.8%	0.8%
EMA Total	5,068,823	5,800,581	100.0%	100.0%
			EMA Percent of State-2010 ^a	EMA Percent of State-2016 ^b
Texas Total	24,311,891	26,956,435	20.8%	21.5%

^aSource: U.S. Census Bureau, 2006-2010 American Community Survey. Retrieved on 02/16/2018

^bSource: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

Population Change

(Table 2) Since 2010, the population of the Houston EMA has grown by a higher percentage than the state of Texas as a whole. Over 730,000 more people live in the EMA today than in 2010. The largest percent change in population occurred in Fort Bend and Montgomery Counties, with 26.2% and 21.3% more people, respectively, in 2016 than in 2010. Liberty County experienced the least growth with a 4.9% increase over six years. The population size within the rural Houston EMA counties grew by 22.2%, acquiring almost a quarter of a million people between 2010 and 2016.

TABLE 2-Total Population Change in the Houston EMA by County, 2010 and 2016				
County	Total-2010 ^a	Total-2016 ^b	Change in Population	
			#	%
Chambers	32,371	38,072	5,701	+17.6%
Fort Bend	541,983	683,756	141,773	+26.2%
Harris (incl. Houston)	3,950,999	4,434,257	483,258	+12.2%
Liberty	74,922	78,598	3,676	+4.9%
Montgomery	427,717	518,849	91,132	+21.3%
Waller	40,831	47,049	6,218	+15.2%
EMA	5,068,823	5,800,581	731,758	+14.4%
Rural EMA	1,117,824	1,366,324	248,500	+22.2%
Texas	24,311,891	26,956,435	2,644,544	+10.9%

^aSource: U.S. Census Bureau, 2006-2010 American Community Survey. Retrieved on 02/16/2018

^bSource: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

Demographics By Total Population and County

(**Table 3**) In 2016, the population of the Houston EMA was 37.5% Hispanic, 35.8% White (non-Hispanic), 17.7% African American, and 9.0% all other race/ethnicities. This makes the Houston EMA a “minority majority” area, in which people of color (**POC**) comprise the majority of the population. Together, Hispanic, African American, and other race/ethnicity individuals comprise 64.2% of the total Houston EMA population.

TABLE 3-Distribution of Total Population in the Houston EMA by Sex, Race/Ethnicity, and Age, 2016

	Number	Percent of Total Population
Total EMA Population^a	5,800,581	100.0%
Sex (at birth)^a		
Male	2,879,519	49.6%
Female	2,921,062	50.4%
Transgender-Identified Estimate^b	38,284	0.66%
Race/Ethnicity^a		
White	2,076,659	35.8%
African American	1,027,467	17.7%
Hispanic/Latino	2,174,084	37.5%
Other	522,371	9.0%
Age^c		
Under 2	187,060	3.1%
2 - 12	1,005,199	16.6%
13 - 24	1,010,682	16.7%
25 - 34	927,940	15.3%
35 - 44	860,924	14.2%
45 - 54	779,393	12.9%
55 - 64	634,456	10.5%
65+	559,554	9.2%

^aSource: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

^bEstimated proportion of transgender-identified people in Texas in using data from CDC's Behavioral Risk Factor Surveillance System (BRFSS), applied to local total population. See Suggested citation:

Flores, A.R., Herman, J.L., Gates, G.J., & Brown, T.N.T. (2016).

How Many Adults Identify as

Transgender in the United States?

Los Angeles, CA: The Williams Institute for more details on methodology

^cSource: Texas Department of State Health Services, 2016 Houston EMA Population Denominators. Received on 09/14/2017

(Table 4) Several counties within the Houston EMA are also “minority majority” areas. People of color comprise the majority of the population in Fort Bend, Harris, and Waller Counties. In fact, Hispanic individuals comprise the largest single population group in Harris County today at 37.5% population. The Houston EMA is also more ethnically diverse than Texas as a whole, with smaller proportion White (non-Hispanic) individuals and a larger proportion of African American and Asian/Pacific Islander individuals than Texas. Within in the EMA, the largest proportion of African American individuals reside in Waller, and the largest proportion of Asian/Pacific Islander individuals reside in Fort Bend.

TABLE 4-Distribution of Total Population in the Houston EMA by County and Race/Ethnicity, 2016						
County	Total Population	Percent of Total Population by Race/Ethnicity				
		White	African American	Hispanic/Latino	Asian/Pacific Islander	Other Race
Chambers	38,072	68.1%	8.0%	21.1%	1.4%	1.3%
Fort Bend	683,756	34.9%	20.8%	24.0%	18.8%	1.6%
Harris	4,434,257	31.2%	18.9%	41.8%	6.7%	1.4%
Liberty	78,598	66.9%	10.3%	20.7%	0.7%	1.4%
Montgomery	518,849	68.7%	4.4%	22.4%	2.6%	1.8%
Waller	47,049	43.2%	25.4%	29.0%	0.9%	1.6%
EMA Total	5,800,581	35.8%	17.7%	37.5%	7.6%	1.4%
Texas Total	26,956,435	43.4%	11.9%	38.6%	4.4%	1.6%

Source: U.S. Census Bureau, 2006-2010 American Community Survey. Retrieved on 02/16/2018

(Table 5) Differences regarding age also occur between the Houston EMA and the state. Overall, the Houston EMA is younger than Texas, with a larger proportion of residents below age 65. Waller County has the largest proportion of people under 25 in the EMA, and Liberty County has the largest proportion of people age 65 and over.

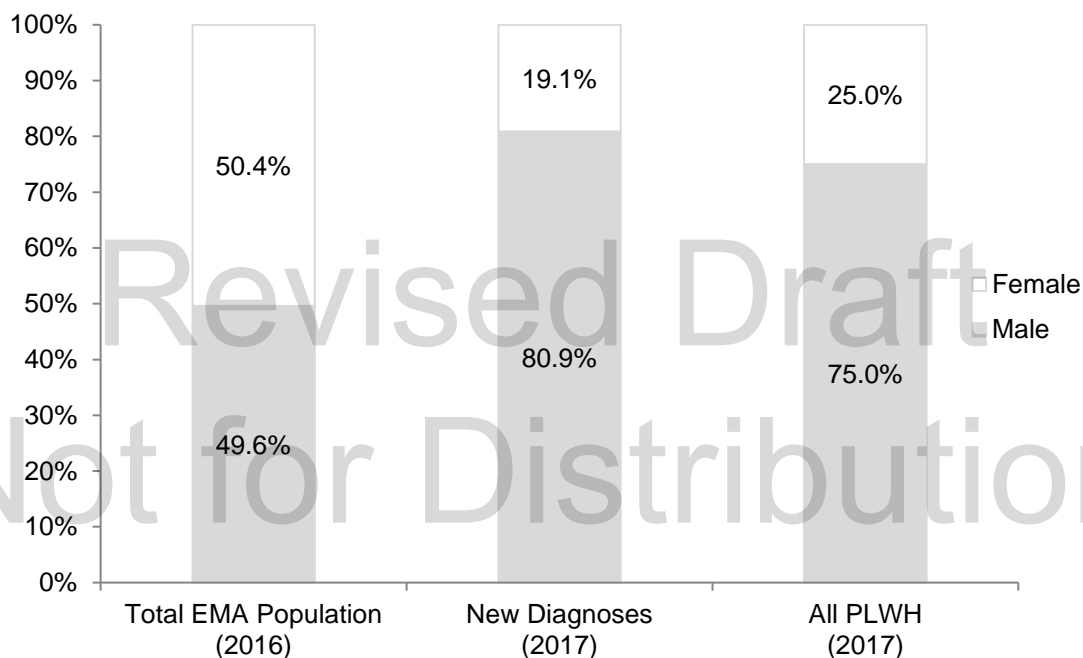
TABLE 5-Distribution of Total Population in the Houston EMA by County and Age, 2016				
County	Total Population	Percent of Total Population by Age		
		Under 25	25 - 65	65+
Chambers	38,072	36.4%	53.0%	10.4%
Fort Bend	683,756	36.3%	53.9%	9.5%
Harris	4,434,257	37.0%	53.8%	9.3%
Liberty	78,598	34.6%	52.4%	12.8%
Montgomery	518,849	35.1%	52.7%	12.1%
Waller	47,049	46.1%	42.4%	11.5%
EMA Total	5,800,581	36.8%	53.6%	9.6%
Texas Total	25,145,561	36.6%	51.8%	11.5%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

Comparison of Total Population to the Population Living with HIV

(Graph 1) The Houston EMA population is evenly divided by sex assigned at birth between males at birth and females at birth at 49.6% and 50.4%, respectively. However, a larger proportion of males at birth than females at birth were newly diagnosed with HIV in 2017 (80.9% vs. 19.1%), and more males at birth than females at birth comprised all diagnosed people living with HIV (**PLWH**) (75.0% vs. 25.0%). The distribution of newly diagnosed PLWH and all PLWH by sex assigned at birth shifted toward males at birth between 2011 and 2017, with decreases in new diagnoses (20.8% decrease from 24.1% in 2011) and HIV prevalence (4.94% decrease from 26.3% in 2011) among females at birth.

GRAPH 1-Comparison of Total Population^a in the Houston EMA to PLWH^b by Sex (at birth)



^aSource: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

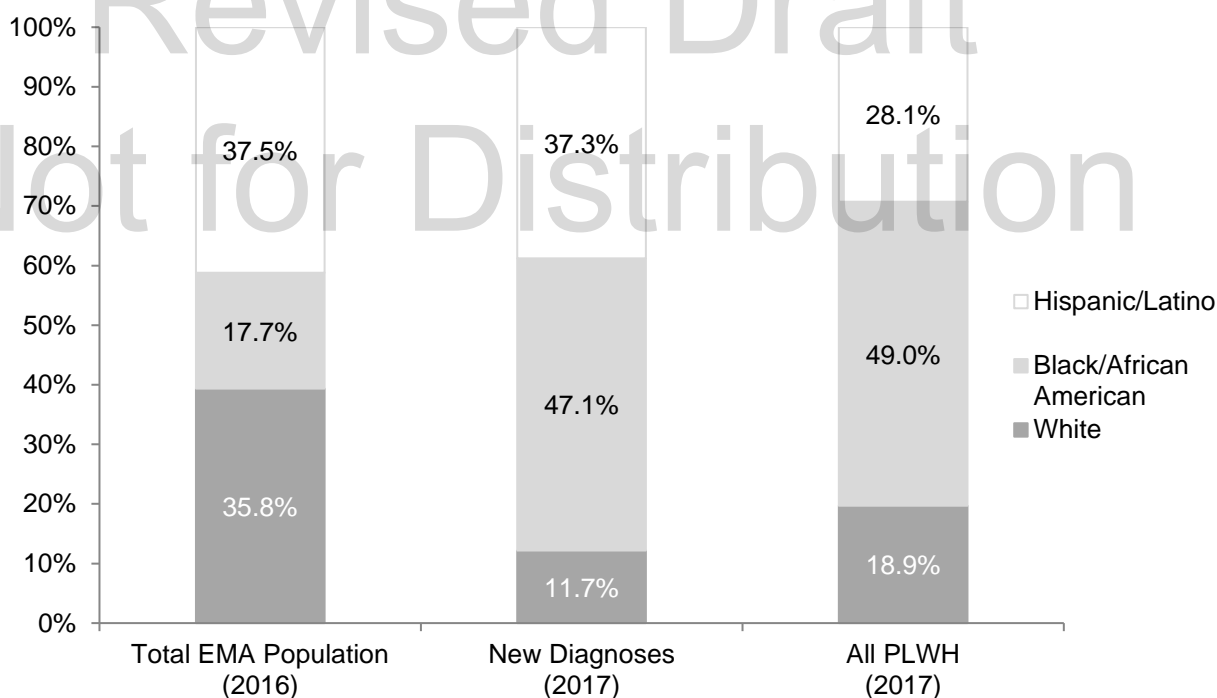
^bSource: Texas eHARS. New HIV Diagnoses and diagnosed PLWH as of 12/31/17

(Graph 2) Newly diagnosed and PLWH populations in the Houston EMA are more racially diverse than the general population, with POC experiencing higher proportions of new diagnoses and HIV prevalence. While African American and Hispanic individuals account for 55.2% of the total Houston EMA population, these groups constitute 84.4% of all new HIV diagnoses and 77.1% of all PLWH. Notably, African American individuals account for only 17.7% of the total Houston EMA population, but comprise a disproportionate amount of all new HIV diagnoses (47.1%) and nearly half of all PLWH (49.0%) in the region.

Trends in HIV among African American communities is somewhat smaller in the epidemic statewide. According to the Texas Department of State Health Services, HIV is more evenly distributed in Texas with African American individuals comprising 37% of all PLWH and 38% of new diagnoses.¹ Regardless, POC in both the Houston EMA and Texas as a whole share a disproportionate burden of new diagnoses and HIV prevalence relative to each race/ethnicity's size within the general population.

Between 2011 and 2017, new diagnoses among Hispanic individuals in the Houston EMA increased by 21.5% (from 30.7%), as did overall HIV prevalence by 20.1% (from 23.4%).

GRAPH 2- Comparison of Total Population^a in the Houston EMA to the PLWH^b by Race/Ethnicity



^aSource: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

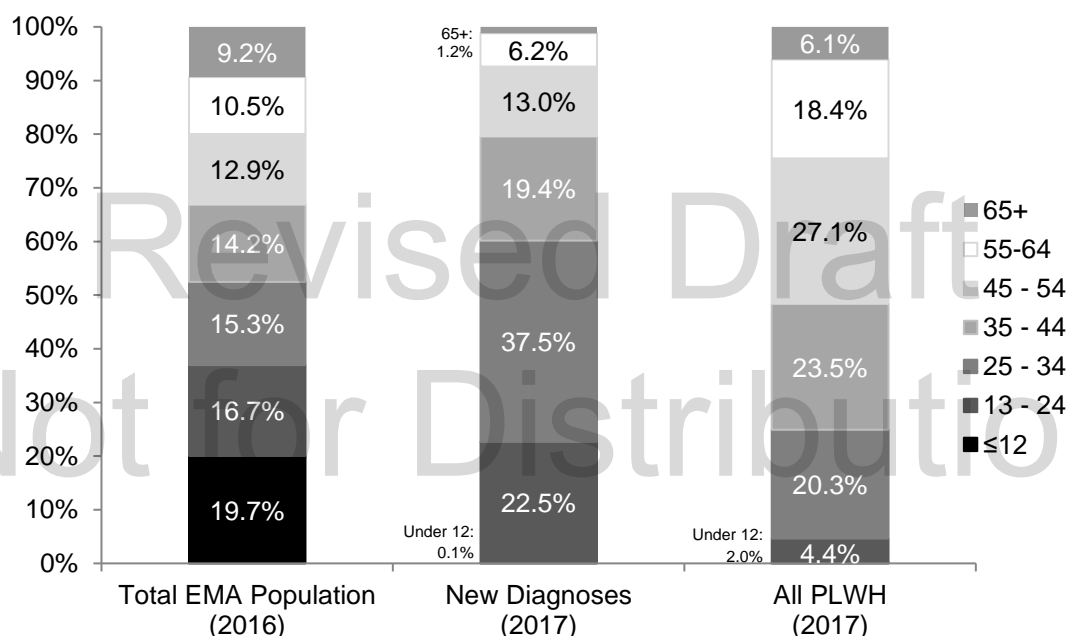
^bSource: Texas eHARS. New HIV Diagnoses and diagnosed PLWH as of 12/31/16

¹Texas Department of State Health Services. 2017-2021 Texas HIV Plan. Reporting Period: January 1 to December 31, 2014. The Texas HIV Plan is available at <https://txhivsyndicate.org/texas-hiv-plan/>

(Graph 3) When analyzed by age, people age 25 to 34 account for a larger proportion of new HIV diagnoses (37.5%) than their proportion within the general Houston EMA population in the Houston EMA (15.3%). Similarly, people age 45 to 54 account for a larger proportion of those living with HIV (27.1%) than their proportion within the general Houston EMA population in the Houston EMA (12.9%).

Trends reflect a shift toward more PLWH age 55 and over represented in overall HIV prevalence within the Houston EMA. Between 2011 and 2016, new diagnoses decreased by 11.5% (from 7.8% in 2011) among PLWH age 55 and over, while HIV prevalence increased by 36.9% (from 16.8% in 2011). Beginning for 2017, an upper age limit of 65 and over was added to reflect the population aging with HIV.

GRAPH 3- Comparison of Total Population^a in the Houston EMA to the PLWH^b by Age (Descending)



^aSource: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates. Retrieved on 02/16/2018

^bSource: Texas eHARS. New HIV Diagnoses and diagnosed PLWH as of 12/31/16

Socioeconomic Characteristics

Socioeconomic conditions such as access to resources, educational attainment, and healthcare coverage can affect health, functioning, and quality of life outcomes,² including risk for HIV transmission and access to HIV prevention and care services.

Employment

(**Table 6**) In 2016, the percent of the eligible population unemployed in Texas was 9.0%, compared to an average of 7.1% for counties in the Houston EMA. Overall, unemployment has decreased in the EMA since 2011 by 11.5%. Within the EMA's counties, Liberty has the highest percentage of people unemployed at 9.2%, followed by Waller at 9.0%, while Fort Bend has the lowest unemployment rate at 5.4%. Between 2011 and 2016, the unemployment rate decreased for every county in the Houston EMA except Waller, which experienced an increase in the unemployment rate by 25.0%.

TABLE 6-Employment Status in the Houston EMA by County, 2016 ^a			
County	Percent of Eligible ^b Population Employed-2016	Percent of Eligible ^b Population Unemployed-2016	Change in Percent Unemployed 2011
Chambers	55.4%	6.4%	-11.1%
Fort Bend	63.2%	5.4%	-1.8%
Harris	63.5%	7.0%	-20.5%
Liberty	46.6%	9.2%	-32.8%
Montgomery	60.2%	5.4%	-28.0%
Waller	55.1%	9.0%	25.0%
EMA Average	57.3%	7.1%	-11.5%
Texas	60.1%	9.0%	5.9%

^aSource: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S2301: EMPLOYMENT STATUS. Retrieved on 3/27/2018

^bPopulation over the age of 16 and in the labor force

²U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020: Determinants of Health*. Located at: <http://www.healthypeople.gov/2020/about/DOHAbout.aspx>

Household Income and Poverty Measures

(Table 7) The average median household income in the Houston EMA continues to be higher than in Texas as a whole, though Texas experienced slightly higher household income growth between 2011 and 2016. On average, households in the EMA earn about \$10,500 more per year compared to households statewide. Fort Bend County has the highest median household income at \$91,152, while Liberty County has the lowest at \$49,655 followed by Waller County at \$53,508. Regardless, median household income growth occurred in all Houston EMA counties except Chambers. Fort Bend County experienced the highest median household income growth at 13.0% between 2011 and 2016, while Chambers County experienced a decrease of 1.2%.

Comparison in supplemental income between the Houston EMA and Texas is variable. As a whole, fewer households in the Houston EMA receive cash public assistance and food stamp/Supplemental Nutrition Assistance Program (**SNAP**) benefits than statewide, while a greater proportion of Houston EMA households receive Social Security and Supplemental Security Income (**SSI**). Liberty County, which has the lowest median household income in the EMA, also has a larger percentage of households receiving Social Security (31.3% vs. 25.2%), SSI (7.5% vs. 5.0%), cash public assistance (1.9% vs. 1.2%), and food stamp/SNAP benefits (16.8% vs. 11.2%). Additionally, Waller County has highest proportion of households receiving food stamp/SNAP benefits at 17.5% of households.

Between 2011 and 2016, the Houston EMA experienced an increase in the proportion of households receiving supplemental income across Social Security (11.5% increase from 22.6%), SSI (38.9% increase from 3.6%), and food stamp/SNAP benefits (9.8% increase from 10.2%).

County	Median Household Income-2016a	Percent Change from 2011	Percent of Households Receiving Each Type of Supplemental Income			
			Social Security	Supplemental Security Income (SSI)	Cash Public Assistance	Food Stamp/SNAP Assistance
Chambers	\$70,396	-1.2%	25.8%	3.7%	0.9%	5.6%
Fort Bend	\$91,152	13.0%	19.8%	3.0%	1.1%	7.4%
Harris	\$55,584	7.7%	19.6%	4.3%	1.5%	13.2%
Liberty	\$49,655	6.4%	31.3%	7.5%	1.9%	16.8%
Montgomery	\$70,805	8.6%	25.8%	3.9%	1.1%	6.7%
Waller	\$53,508	6.7%	28.7%	7.3%	0.9%	17.5%
EMA Average	\$65,183	7.0%	25.2%	5.0%	1.2%	11.2%
Texas	\$54,727	8.9%	25.0%	4.9%	1.6%	13.1%

aSource: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. DP03: SELECTED ECONOMIC CHARACTERISTICS. Retrieved on 3/27/2018

(**Table 8**) The percentage of households earning less than \$15,000 per year can indicate low socioeconomic status within a particular area. In 2016 in the Houston EMA, 10.2% of households met this threshold compared to 11.9% of households statewide, an 11.3% decrease from 11.5% in 2011. Counties that exceed the Houston EMA and statewide percentages of households earning less than \$15,000 annually are Liberty at 13.2% and Waller at 12.3%. However, between 2011 and 2016 both Liberty and Waller counties experienced decreases in this measure by 11.4% from 14.9%, and 16.3% from 14.7%, respectively.

TABLE 8-Percent of Total Households in the Houston EMA Earning Less than \$15,000 Per Year by County, 2011 and 2016		
County	Percent of Households	
	2011 ^a	2016 ^b
Chambers	9.1%	10.7%
Fort Bend	6.0%	5.3%
Harris	12.5%	11.1%
Liberty	14.9%	13.2%
Montgomery	9.0%	7.4%
Waller	14.7%	12.3%
EMA	11.5%	10.2%
Texas	13.4%	11.9%

^aSource: U.S. Census. 2009-2011 American Community Survey 3-Year Estimates. S2301: EMPLOYMENT STATUS. Retrieved on 1/31/13

^bSource: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S2301: EMPLOYMENT STATUS. Retrieved on 3/27/2018

TABLE 8-Percent of Total Households in the Houston EMA Earning Less than \$15,000 Per Year by County, 2011 and 2016	
County	Percent of Households
	2011 ^a
Chambers	9.1%
Fort Bend	6.0%
Harris	12.5%
Liberty	14.9%
Montgomery	9.0%
Waller	14.7%
EMA	11.5%
Texas	13.4%

Individual Poverty

(**Table 9**) In 2016, the Houston EMA had a lower percentage of its population living below the federal poverty level (15.5%) compared to the state as a whole (16.7%). All counties in the Houston EMA except Chambers and Waller saw decreases between 2011 and 2016 in the percentage of the population living in poverty. Waller County had the highest level of poverty in the EMA at 19.0%, followed closely by Harris at 17.4% and Liberty at 17.3%, while Fort Bend had the lowest level of poverty at 8.2%. In 2016, 14.0% of males at birth and 17.0% of females at birth in the EMA live below the federal poverty level. One-fifth of females at birth in Waller (21.1%) and Liberty (20.2%) counties lived below the federal poverty level in 2016.

County	Percent Below Federal Poverty Level	Percent Change from 2011	Percent Below Poverty Level by Sex at Birth ^b	
			Male at Birth	Female at Birth
Chambers	11.7%	9.3%	11.0%	12.3%
Fort Bend	8.2%	-1.2%	7.5%	8.8%
Harris	17.4%	-5.9%	15.7%	19.1%
Liberty	17.3%	-6.0%	14.6%	20.2%
Montgomery	11.0%	-13.4%	10.1%	12.0%
Waller	19.0%	1.1%	17.1%	21.1%
EMA	15.5%	-8.3%	14.0%	17.0%
Texas	16.7%	-6.2%	15.2%	18.2%

^aSource: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S1701: POVERTY STATUS IN THE PAST 12 MONTHS. Retrieved on 3/27/2018

^bRepresents the percent of males/females at birth in the geographic area that is living in poverty; and not the male/female at birth distribution of people living in poverty in the geographic region.

(**Table 10**) Analysis of poverty by race/ethnicity reveals that, in general, more POC are living below the federal poverty level in the Houston EMA than are Whites. In 2016, 22.6% of African American and 23.0% of Hispanics individuals in the Houston EMA were living in poverty, compared to 14.1% of Whites. Across every county in the Houston EMA except Waller, Hispanic individuals experienced greater proportions of poverty than did White or African American individuals. A third of African American individuals (33.3%) in Waller County lived under the federal poverty level, as did nearly a third (31.6%) of Hispanic individuals.

TABLE 10-Percent of Populationa Living Below Federal Poverty Level in the Houston EMA by Race/Ethnicity, 2016			
County	White	African American	Hispanicb
Chambers	10.5%	12.5%	19.8%
Fort Bend	7.4%	9.2%	15.3%
Harris	15.5%	22.6%	23.6%
Liberty	16.8%	18.8%	31.6%
Montgomery	10.3%	16.1%	23.5%
Waller	14.8%	33.3%	27.6%
EMA	14.1%	20.6%	23.0%
Texas	15.5%	22.6%	24.2%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S1701: POVERTY STATUS IN THE PAST 12 MONTHS. Retrieved on 3/27/2018

^aRepresents the percent of each race/ethnicity in the geographic area that is living in poverty; and not the racial distribution of people living in poverty in the geographic region.

^bHispanic is not mutually exclusive from the races presented in this table. Other races are not included because the sample case size by County is too small.

(**Table 11**) Analysis of poverty by age reveals that, in general, more minors (individuals under 18 years old) are living below the federal poverty level in the Houston EMA than are adults (individuals over age 18). In 2016, 23.0% of people under age 18 were living in poverty, compared to 13.4% of people age 18 to 64, and 10.4% of people age 65 and over. Larger proportions of minors in Harris (26.0%) and Waller (25.1%) counties were living in poverty compared to all minors, all adults 18 to 64, all seniors in the EMA and the state. However, the proportions of minors living below the federal poverty level in Harris and Waller counties decreased between 2011 and 2016 by 5.8% (from 27.6%) and 7.0% (from 27.0%), respectively.

TABLE 11-Percent of Population^a Living Below Federal Poverty Level in the Houston EMA by Age, 2016			
County	Under 18 years	18 to 64 years	65 years and older
Chambers	13.7%	10.7%	12.1%
Fort Bend	11.2%	7.0%	6.9%
Harris	26.0%	14.6%	11.3%
Liberty	23.3%	16.2%	10.6%
Montgomery	14.8%	10.0%	7.7%
Waller	25.1%	19.4%	10.1%
EMA	23.0%	13.4%	10.4%
Texas	23.9%	14.7%	10.8%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S1701: POVERTY STATUS IN THE PAST 12 MONTHS. Retrieved on 3/27/2018

^aRepresents the percent of each age group in the geographic area that is living in poverty; and not the age distribution of people living in poverty in the geographic region.

Educational Attainment

(Table 12) Educational attainment in the Houston EMA skews slightly toward higher education levels in most counties. In 2016, 23.0% of Houston EMA residents attained a high school diploma or equivalency, 27.2% attended some college or attained an Associate's degree, and 31.6% attained a bachelor's degree or higher. The county with the highest educational attainment is Fort Bend, where 44.6% of residents had a bachelor's degree or higher, a 9.3% increase from 40.8% in 2011. The county with the lowest educational attainment was Liberty, where 23.8% of residents had less than a high school diploma or equivalency, though this was a 5.3% increase from 22.6% in 2011. Waller County followed with 21.6% of residents having less than a high school diploma or equivalency, a 24% increase from 17.4% in 2011. Overall, the Houston EMA displays a greater disparity in educational attainment through larger proportion of residents at both ends of the educational spectrum than Texas as a whole. In 2016, 18.2% of EMA residents had less than a high school diploma or equivalency (compared to 17.7% for the state), and 31.6% have a bachelor's degree or higher (compared to 28.1% of the state).

TABLE 12-Educational Attainment in the Houston EMA by County, 2016				
County	Percent of Total Population ^a			
	Less than high school diploma	High school diploma or GED	Some college or Associate's degree	Bachelor's degree or higher
Chambers	16.2%	29.2%	33.5%	21.1%
Fort Bend	10.8%	17.5%	27.0%	44.6%
Harris	19.8%	23.3%	26.8%	30.1%
Liberty	23.8%	39.1%	27.1%	10.0%
Montgomery	13.2%	24.1%	29.7%	33.0%
Waller	21.6%	30.5%	29.1%	18.7%
EMA	18.2%	23.0%	27.2%	31.6%
Texas	17.7%	25.1%	29.2%	28.1%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S1501: Educational Attainment. Retrieved on 3/27/2018

^aPopulation aged 25 and over in the geographic region

Health Insurance Coverage

(**Table 13**) The Houston EMA has a slightly higher proportion of residents who are uninsured compared to the state as a whole (20.4% vs. 19.3%). The EMA experienced a 19.2% drop in the proportion of uninsured residents from 25.3% in 2011. As of 2016, nearly 1.2 million people in the Houston EMA lack any kind of health insurance coverage. Harris County has the largest proportion of uninsured at 22.2% (higher than both the EMA and state), while Montgomery County has the lowest proportion of uninsured at 15.3%. All counties, the EMA, and Texas saw decreases in the percent of the population uninsured between 2011 and 2016. Within the EMA, Fort Bend experienced the greatest decrease in percent uninsured from 17.8% to 13.1%. Of the total Houston EMA population, more have private insurance than public. The county with the largest proportion of privately insured is Fort Bend (75.1%), while the county with the largest proportion of publicly insured is Liberty (33.2%), followed by Waller (29.6%).

TABLE 13-Health Insurance Coverage in the Total Population in the Houston EMA by County, 2016^a						
County	Percent with Health Insurance	Type of Health Insurance ^b		Number of People Without Insurance	Percent Without Health Insurance	Change in Percent Uninsured from 2011
		Private	Public			
Chambers	83.5%	66.3%	24.9%	6,247	16.5%	-0.6%
Fort Bend	86.9%	75.1%	17.9%	89,121	13.1%	-26.2%
Harris	77.8%	55.9%	27.9%	978,821	22.2%	-18.2%
Liberty	79.0%	53.8%	33.2%	15,121	21.0%	-15.6%
Montgomery	84.7%	69.9%	23.2%	78,770	15.3%	-21.3%
Waller	79.0%	57.2%	29.6%	9,824	21.0%	-25.6%
EMA	79.6%	59.5%	26.3%	1,177,904	20.4%	-19.2%
Texas	80.7%	60.5%	28.6%	5,114,811	19.3%	-17.5%

^aSource: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. DP03: SELECTED ECONOMIC CHARACTERISTICS. Retrieved on 3/27/2018

^bDenominator for type of health insurance is civilian noninstitutionalized population regardless of coverage status; type of health insurance reflects the proportion among this population, not the proportion among those with coverage

Foreign Born and Linguistic Isolation

(Table 14) As anticipated given the ethnic diversity in the Houston EMA, in 2016 a larger proportion of the Houston EMA population was foreign-born than for Texas as a whole (24.3% vs. 16.7%). In Fort Bend and Harris counties, over a quarter of the population was born in another country. Chambers County experienced a substantial demographic shift between 2011 and 2016 as the percent of foreign-born residents increased by 66.0% to 10.5% from 6.30%. Liberty County closely followed with a 10.5% increase in foreign-born residents (from 6.9% to 7.6%).

In 2016, the majority of foreign-born individuals in the EMA were born in Latin America. This was true for all counties in the EMA, with the exception of Fort Bend County (50.3% foreign-born in Asia). The EMA as a whole had a population of individuals born in Asia that was a larger proportion in the EMA than in Texas (24.8% vs. 20.4%). The majority of foreign-born residents in the EMA are not naturalized citizens, though this percent is slightly lower than for the state as a whole.

County	Percent Foreign-Born	Percent Change from 2011	Citizenship ^b		Birth Place Among Foreign-Born ^b			
			Percent Naturalized Citizen	Not U.S. Citizen	Europe	Asia	Africa	Latin America
Chambers	10.5%	66.0%	19.5%	80.5%	6.0%	14.1%	5.5%	73.0%
Fort Bend	27.1%	7.0%	54.3%	45.7%	4.6%	50.3%	8.5%	34.4%
Harris	25.7%	2.2%	34.1%	65.9%	4.1%	21.4%	4.9%	68.5%
Liberty	7.6%	10.5%	22.9%	77.1%	3.4%	7.8%	--	87.3%
Montgomery	12.9%	2.5%	32.7%	67.3%	9.3%	15.4%	--	69.6%
Waller	14.4%	8.1%	23.7%	76.3%	3.8%	4.0%	--	89.3%
EMA	24.3%	2.8%	36.6%	63.4%	4.4%	24.8%	5.2%	64.3%
Texas	16.7%	2.3%	35.4%	64.6%	4.2%	20.4%	4.3%	69.8%

^aSource: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. DP02: SELECTED SOCIAL CHARACTERISTICS IN THE UNITED STATES. Retrieved on 3/27/18. Dashes indicate data for this geographic area cannot be reported because the sample size is too small.

^bDenominator is foreign-born population in Houston EMA

(**Table 15**) According to available data, a larger proportion of the population in the Houston EMA is both non-English speaking and linguistically isolated (**LI**) than statewide.

TABLE 15-Percent of Non-English Speaking Population that is Linguistically Isolated in the Houston EMA by County, 2016		
County	Percent non-English Speaking at Home	Percent Linguistically Isolated (LI) ^a
Chambers	19.1%	10.4%
Fort Bend	38.4%	12.9%
Harris	43.4%	20.3%
Liberty	18.5%	6.9%
Montgomery	20.0%	7.7%
Waller	24.6%	11.6%
EMA	40.0%	18.0%
Texas	35.2%	14.1%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. DP02: SELECTED SOCIAL CHARACTERISTICS IN THE UNITED STATES. Retrieved on 3/27/2018.

^aLinguistically isolated is defined as someone who reports speaking English less than "very well."

(**Table 16**) According to available data, 30.4% of the population in the Houston EMA speaks Spanish, 3.4% speak another non-English/Indo-European language, and 4.8% speak an Asian/Pacific Islander language. Of these, 14.5%, 0.9%, and 2.2% are also LI. Proportions of LI are higher in the EMA than statewide across all languages.

TABLE 16-Percent of Non-English Speaking Population that is Linguistically Isolated^a in the Houston EMA by Language and County, 2016						
County	Spanish		Other Indo-European		Asian or Pacific Islander	
	Percent Speaking Language	Percent Linguistically Isolated	Percent Speaking Language	Percent Linguistically Isolated	Percent Speaking Language	Percent Linguistically Isolated
Chambers	15.8%	9.2%	1.8%	0.6%	0.9%	0.5%
Fort Bend	18.2%	6.3%	7.8%	2.0%	10.1%	4.2%
Harris	34.4%	16.9%	3.1%	0.9%	4.5%	2.2%
Liberty	17.0%	6.4%	0.8%	--	0.6%	--
Montgomery	16.8%	7.0%	1.5%	--	1.4%	0.5%
Waller	23.2%	11.5%	0.6%	--	0.6%	--
EMA	30.4%	14.5%	3.4%	0.9%	4.8%	2.2%
Texas	29.5%	12.1%	2.1%	0.5%	2.8%	1.2%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. DP02: SELECTED SOCIAL CHARACTERISTICS IN THE UNITED STATES. Retrieved on 3/27/2018. Dashes indicate data for this geographic area cannot be reported because the sample size is too small.

^aLinguistically isolated is defined as someone who reports speaking English less than "very well."

Community Health Indicators

Data related to preventable disease, disability, and death help measure population health in a specific geographic area. Rankings of specific communities within each of these types of measures can provide valuable information about the population's overall health status, which may negatively or positively influence specific health conditions such as HIV. Taken together, these types of measures can help illustrate each community's overall health.³

Fertility and Mortality Rates

(**Table 17**) Tracking fertility and mortality in a specific geographic area provides information about potential population growth. Comparing these rates between areas, they can also reveal information about quality of life and life expectancy. In 2013, all but one county (Harris) had fertility lower than the statewide fertility rate. The rate in Harris County was 71.5 per 1,000 women of childbearing age (a 7.98% decrease from 77.7 births in 2009), compared to 69.8 statewide (a 7.0% decrease from 75.1 births in 2009). Fertility rates in all counties within the Houston EMA and statewide have declined since 2009. Chambers and Liberty counties have mortality rates that are higher than state mortality rates. Taken together, these rates suggest that the EMA has fewer births and more deaths compared to Texas as a whole.

County	Fertility Rate ^a		Mortality Rate ^b	
	2009	2013	2009	2013
Chambers	71.4	61.3	866.2	874.1
Fort Bend	68.2	62.4	676.2	599.6
Harris	77.7	71.5	788.5	737.8
Liberty	65.9	66.4	1007.6	1027.1
Montgomery	71.2	67.1	822.8	693.3
Waller	67.4	60.0	944.5	748.5
Texas	75.1	69.8	781.2	749.2

Source: Texas Department of State Health Services. Center for Health Statistics. Health Facts Profiles, 2009 and 2013

^aFertility rates are per 1,000 women ages 15 - 50.

^bReflects deaths from all causes. Rates are age adjusted to the 2000 standard per 100,000 population. No age-adjusted rates were calculated if based on 20 or fewer deaths.

³Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. County Health Rankings and Roadmaps. Located at :<http://www.countyhealthrankings.org/>.

Selected Causes of Death

(**Table 18**) Tracking the leading causes of death in a defined geographic area provides information about the specific health conditions facing the population and can indicate needed preventive or acute health care interventions. In 2013, the highest rates of death in the Houston EMA occurred from cardiovascular disease (heart disease), cerebrovascular disease (stroke), and cancer. With the exception of Fort Bend County, all counties in the Houston EMA had rates of cancer mortality that exceeded the state.

TABLE 18-Rates^a of Selected Causes of Death in the Houston EMA by County, 2013								
County	Heart Disease	Stroke	Cancer	Lung Disease	Accidents	Diabetes	Suicide	Liver Disease
Chambers	175.3	--	218.9	--	--	--	--	--
Fort Bend	134.3	34.0	133.1	28.4	26.3	13.4	8.3	8.3
Harris	166.3	40.6	159.9	32.0	36.8	20.0	9.8	11.0
Liberty	302.5	45.5	197.7	80.8	61.3	--	--	--
Montgomery	154.1	29.6	160.6	50.3	30.3	11.8	15.5	8.9
Waller	201.7	--	170.4	--	58.9	--	--	--
Texas	170.7	40.1	156.1	42.3	36.8	21.6	11.6	12.8

Source: Texas Department of State Health Services. Center for Health Statistics. Health Facts Profiles 2013. Dashes indicate frequency too low to calculate rate.

^aRates are age adjusted per 100,000 population. No age-adjusted rates were calculated if based on 20 or fewer deaths.

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Disability

(**Table 19**) Tracking the level of disability in a specific geographic area provides information about the population's vulnerability to hearing, vision, cognitive, ambulatory, self-care, and independent living difficulty or impairment, all of which can affect access to resources and increase need for service assistance. In 2016, a smaller proportion of people living with a disability were in the Houston EMA (9.4%) than in the population of Texas as whole (11.6%). The proportion of people living with a disability in the Houston EMA has increased by 20.5% from 7.8% in 2011. Fort Bend County has the lowest percentage of people living with a disability at 7.8%, while Liberty County has the highest percentage at 17.8%.

TABLE 19-Percent Population Living with a Disability in the Houston EMA by County, 2016

County	Percent Living with a Disability
Chambers	13.0%
Fort Bend	7.8%
Harris	9.3%
Liberty	17.8%
Montgomery	10.5%
Waller	14.2%
EMA	9.4%
Texas	11.6%

Source: U.S. Census. 2012-2016 American Community Survey 5-Year Estimates. S1810: DISABILITY CHARACTERISTICS. Retrieved on 3/27/2018.

Additional Selected Community Health Indicators

(Table 20) The remaining indicators presented here are a selection of some of the most commonly used measures of vulnerability to poor health outcomes. These measures provide information about the behaviors of the population that may lead to health challenges over time, and reveal opportunities where preventive or acute health care interventions may reverse risk and improve long-term health outcomes. In 2016, most counties in the Houston EMA, with the exception of Waller County, experienced levels of risk comparable to the state of Texas as a whole. Compared to the rest of the state, the population in Waller County experienced higher proportions of poor to fair health, smoking, obesity, physical inactivity, and limited access to healthy foods. Chambers and Montgomery counties exceeded the state in excessive alcohol use. Slightly higher proportions of low birth weight, an indicator of risk for infant mortality and other health associations, occurred in Fort Bend, Harris, and Liberty counties compared to the rest of the state.

County	In Poor or Fair Health	Low Birth Weight	Smoking	Obesity	Physical Inactivity	Limited Access to Healthy Foods	Excessive Alcohol Use
Chambers	15.0%	8.0%	15.0%	27.0%	31.0%	5.0%	21.0%
Fort Bend	14.0%	9.0%	12.0%	25.0%	22.0%	7.0%	18.0%
Harris	18.0%	9.0%	13.0%	27.0%	24.0%	6.0%	18.0%
Liberty	18.0%	9.0%	17.0%	28.0%	29.0%	8.0%	19.0%
Montgomery	14.0%	7.0%	14.0%	26.0%	26.0%	6.0%	21.0%
Waller	19.0%	8.0%	18.0%	36.0%	30.0%	11.0%	20.0%
Texas	18.0%	8.0%	14.0%	28.0%	24.0%	9.0%	19.0%

Source: County Health Rankings & Roadmaps. A project of the Robert Wood Johnson Foundation (RWJF) and the University of Wisconsin Population Health Institute. 2016. Retrieved on 3/27/18

^aPercentage of the total population in each geographic region reporting the selected condition.



Chapter 2: HIV in the Houston Area

What is the scope of the HIV epidemic in the Houston Area?

The Centers for Disease Control and Prevention (**CDC**) report that, as of 2017, the Houston – The Woodlands – Sugar Land metropolitan statistical area ranks 11th in the nation for rate of new HIV transmissions.

➤ Source: CDC HIV Surveillance Report Volume 29: Diagnoses of HIV Infection in the United States and Dependent Areas, 2017

The data presented in this chapter are organized according to two geographic service jurisdictions in the Houston Area: (1) Houston/Harris County (**H/HC**) and (2) the Houston Eligible Metropolitan Area (**EMA**), which includes Houston/Harris County. The separation of jurisdictions in the data presentation is intended to enhance the utility of this document as a tool for planning both HIV prevention and HIV care services. Data for the third geographic service jurisdiction in the Houston Area, the Houston Health Services Delivery Area (**HSDA**), are presented in Chapter 6: Special Topics in HIV Epidemiology in the Houston Area under the Rural population. Data for the HSDA are not presented here due to the overlap of data and data sources with the EMA, which makes the data virtually identical.

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Houston/Harris County

HIV Incidence

Incidence is an epidemiological term used to refer to the total number of new transmissions of a disease (both diagnosed and undiagnosed) in a population during a specific period. Colloquially, new HIV diagnoses based on positive test events are used interchangeably with HIV incidence. This is because more timely testing technology has only recently become available that can offer a more precise estimate HIV incidence in a jurisdiction. Houston/Harris County is unique in that it operates an HIV Incidence Surveillance Program, which creates estimates of HIV incidence. This allows for analysis true new transmissions of HIV for Houston/Harris County in addition to new HIV diagnoses.

*** [Data pending HHD Approval] ***

New HIV Diagnoses

Stage 3 HIV (formerly AIDS) has been a reportable disease in Texas since March 1983. In January 1999, all positive HIV tests became reportable to the State. Texas law requires physicians, dentists, hospitals, clinical laboratories, and certain school officials to report the results of all diagnostic HIV tests to the health authority in their reporting jurisdiction. For epidemiological purposes, HIV reporting laws allow communities to summarize, analyze, and address trends in all new HIV diagnoses made and reported during a specific period. While the year in which a positive HIV test result is reported is not necessarily the

year in which the transmission occurred, reports of new HIV diagnoses provide the most complete representation of trends in HIV transmission.

*** [Data pending HHD Approval] ***

Stage 3 HIV Progression and Late/Concurrent Diagnoses

The time elapsed between when a person is newly diagnosed with HIV and progression to Stage 3 HIV (if such progression occurs) is used to indicate late diagnosis. The term late diagnosis means that an individual progressed to Stage 3 HIV within 12 months of being diagnosed. When an individual is diagnosed with HIV for the first time at Stage 3, this is referred to as concurrent diagnosis. Late/concurrent diagnosis is an indicator of delayed testing, and is of particular importance to identifying populations with higher need for early testing and linkage to care.

*** [Data pending HHD Approval] ***

People Living with HIV (PLWH)

Prevalence is an epidemiological term for the total number of people living with a particular condition during a specific period. Prevalence does not indicate how long a person has been living with the condition, but reveals a point-in-time landscape of the condition. For HIV surveillance, prevalence refers to living people who have been diagnosed with HIV, regardless of time of transmission or date of diagnosis.

*** [Data pending HHD Approval] ***

Mapping of New Diagnoses and People Living with HIV by Zip Code

Using Geographic Information System (**GIS**) software, local jurisdictions can map new HIV diagnoses and HIV prevalence by zip code. This helps jurisdictions identify patterns in the impact of HIV at the neighborhood level. It is also possible to identify similarities and differences in residential patterns between all PLWH and those who are newly diagnosed.

*** [Data pending HHD Approval] ***

HIV and Mortality

Mortality is an epidemiological marker used to measure the effect of a condition on the population as a whole. HIV mortality data reflects the number of PLWH who died in a specific period. It is important to note that HIV mortality data reflects all causes of death, not exclusively those medically related to HIV.

*** [Data pending HHD Approval] ***

New Diagnoses, Prevalence, and Mortality, Five-Year Trend

HIV epidemiology in states and counties across the U.S. show a similar trend over time. Due to advances in HIV testing and treatment, HIV-related mortality has steadily declined

while the number of PLWH has steadily increased. Concurrently, the number of newly reported HIV diagnoses has remained stable for the last decade.

*** [Data pending HHD Approval] ***

The Houston Eligible Metropolitan Area (EMA)

The Houston EMA includes the six counties of Chambers, Fort Bend, Harris (including the City of Houston), Liberty, Montgomery, and Waller. The data presented below are for the Houston EMA as a whole and are not county-specific.

New HIV Diagnoses

See Houston/Harris County for an explanation of this data point

(Table 6) In 2017, 1,234 individuals were newly diagnosed with HIV in the Houston EMA. This is a rate of 20 new HIV diagnoses for every 100,000 people in the EMA. Over 80% of new diagnoses were among males (at birth). African Americans had the highest rate of both new HIV diagnoses with 54 new diagnoses per 100,000 African Americans in the Houston EMA. This is nearly eight times the rate among Whites and triple the rate among Hispanic/Latinos. African Americans account for close to half of the new diagnoses of HIV in the EMA, and people of color (**POC**) account for 88% of new diagnoses. The age ranges of new diagnoses follow a normal distribution that peaks with 25 to 34 year olds for HIV (38% of new diagnoses). Male-male sexual contact (**MSM**) was the most commonly reported transmission risk factor among new diagnoses in the Houston EMA in 2017 at 71%, followed by sex with male/sex with female at 24%.

TABLE 6-New HIV Diagnoses in the Houston EMA by Sex at Birth, Race/Ethnicity, Age, and Transmission Risk, 2017^a				
		New Diagnoses	%	Rate ^b
Total		1,234	100%	20.0
Sex at Birth				
	Male	998	80.9%	32.6
	Female	238	19.1%	7.6
Race/Ethnicity				
	White	144	11.7%	6.8
	African American	581	47.1%	54.1
	Hispanic/Latino	460	37.3%	19.4
	Other	26	2.1%	5.0
	Multiracial	23	1.9%	26.4
Age				
	0 - 12	N	N	N
	13 - 24	278	22.5%	27.3
	25 - 34	463	37.5%	49.3
	35 - 44	240	19.4%	27.3
	45 - 54	161	13.0%	20.4
	55 - 64	76	6.2%	11.1
	65+	15	1.2%	2.3
Transmission Risk^c				
	Male-Male Sexual Contact (MSM)	870	70.5%	*
	People with Injection Drug Use (PWIDU)	46	3.7%	*
	MSM/PWIDU	24	1.9%	*
	Sex with Male/Sex with Female	291	23.6%	*
	Perinatal transmission	N	N	*
	Adult other risk	0	0.0%	*

^aSource: Texas eHARS. New HIV diagnoses as of 12/31/17

^bSource: Texas Department of State Health Services, 2017 Houston EMA Population Denominators. Received on 07/20/2018

^cCases with unknown risk were redistributed based on historical patterns of risk ascertainment and reclassification

*Population data are not available for risk groups; therefore, it is not possible to calculate rate by risk

^NData has been suppressed to meet cell size limit of 5

People Living with HIV (Prevalence)

See Houston/Harris County for an explanation of this data point

(Table 7) At the end of 2017, there were 28,225 people living with HIV in the Houston EMA. This means that, for every 100,000 people residing in the EMA, 458 were people diagnosed with HIV. Seventy-five percent (75%) of all people living with HIV in the EMA were male (sex at birth). African Americans had the highest HIV prevalence rate with 1,265 African American PLWH for every 100,000 African Americans in the jurisdiction. This is just over five times the HIV prevalence rate among Whites and roughly four times the rate among Hispanic/Latino individuals. People aged 45 to 54 had the highest HIV prevalence rate of all age groups (966.9 per 100,000 population) and accounted for 27% of all diagnosed PLWH. Male-male sexual contact (**MSM**) was the most commonly reported transmission risk factor diagnosed PLWH in the Houston EMA in 2017 at 57%, followed by sex with male/sex with female at 29%.

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TABLE 7-People Living with HIV in the Houston EMA by Sex at Birth, Race/Ethnicity, Age, and Transmission Risk, 2017^a				
		Prevalence	%	Rate ^b
Total		28,225	100%	457.8
Sex at Birth				
	Male	21,178	75.0%	692.0
	Female	7,047	25.0%	227.0
Race/Ethnicity				
	White	5,321	18.9%	245.8
	African American	13,830	49.0%	1265.1
	Hispanic/Latino	7,926	28.1%	334.6
	Other	389	1.4%	72.2
	Multiracial	759	2.7%	-
Age				
	0 - 1	N	N	N
	2 - 12	58	0.2%	5.7
	13 - 24	1,230	4.4%	120.7
	25 - 34	5,738	20.3%	611.5
	35 - 44	6,632	23.5%	754.3
	45 - 54	7,649	27.1%	966.9
	55-64	5,186	18.4%	758.9
	65+	1,730	6.1%	797.6
Transmission Risk^c				
	Male-Male Sexual Contact (MSM)	16,133	57.2%	*
	People with Injection Drug Use (PWIDU)	2,368	8.4%	*
	MSM/IDU	1,099	3.9%	*
	Sex with Male/Sex with Female	8,264	29.3%	*
	Perinatal transmission	343	1.2%	*
	Adult other risk	18	10.0%	*

^aSource: Texas eHARS. All diagnosed PLWH as of 12/31/17

^bSource: Texas Department of State Health Services, 2017 Houston EMA Population Denominators. Received on 07/20/2018. Denominator for Multiracial not available.

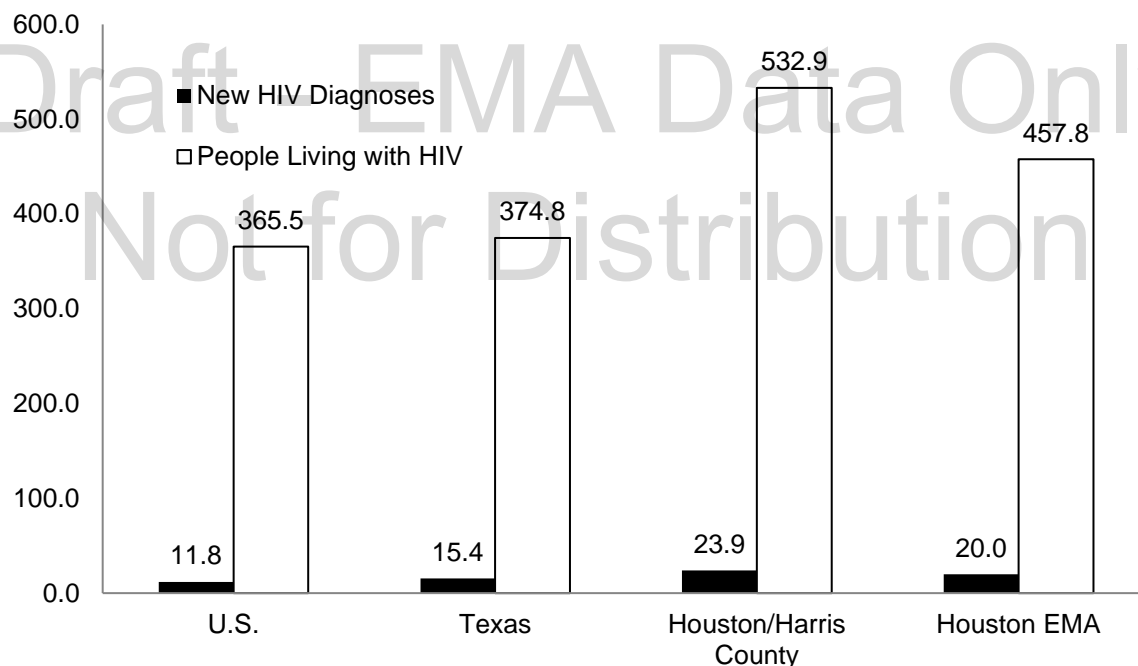
^cCases with unknown risk were redistributed based on historical patterns of risk ascertainment and reclassification

Summary of HIV Epidemiology by Jurisdiction and the U.S.

A comparison of core HIV epidemiological indicators between the two Houston Area jurisdictions, Texas, and the U.S. provides context for the local HIV impact data presented in this Chapter.

(Graph 2) Overall, Texas has comparable prevalence and higher HIV diagnosis rate compared to the U.S. Both Houston/Harris County and the Houston EMA have higher HIV diagnosis and prevalence rates. Rates of new HIV diagnoses in both Houston/Harris County and the Houston EMA are approximately double that of the U.S. The HIV prevalence rate in Houston/Harris County is 1.4 times higher than the Texas and U.S. HIV prevalence rates. The prevalence rate in the Houston EMA is 1.2 times higher than the rate in Texas and 1.3 times higher than the U.S. rate.

GRAPH 2-Rates of New HIV Diagnoses and Persons Living with HIV by Local, State, and National Jurisdiction



^aU.S. Source: CDC HIV Surveillance Report Volume 29: Diagnoses of HIV Infection in the United States and Dependent Areas, 2017. Prevalence is 2016.

^bTexas Source: CDC HIV Surveillance Report Volume 29: Diagnoses of HIV Infection in the United States and Dependent Areas, 2017. Prevalence is 2016.

^cHouston/Harris County Sources: Houston/Harris County eHARS. Diagnoses, 2017; Prevalence, 2016

^dSource: Texas eHARS. All data, 2017

*All rates per 100,000 population

FY 2020 EIIHA Plan

For the past few years, the Council approved the following motion regarding the EIIHA Strategy. Staff suggests that the Comprehensive HIV Planning Committee recommend an updated version of this same motion in 2019 for the FY 2020 EIIHA Plan.

Item: FY 2020 EIIHA* Plan

Recommended Action: Motion: In order to meet HRSA grant application deadlines, request the Planning Council to allow the Comprehensive HIV Planning Committee to have final approval of the FY 2020 EIIHA Plan target populations, provided that:

- The FY 2020 EIIHA Plan is developed through a collaborative process that includes stakeholders from prevention and care, community members, and consumers; and
- The recommended FY 2020 EIIHA Plan target populations are distributed to Planning Council members for input prior to final approval from the Comprehensive HIV Planning Committee.

**The Early Identification of Individuals with HIV/AIDS, or EIIHA, is a national HRSA initiative to increase the number of individuals who are aware of their HIV positive status and link them to medical care. Each year, the Ryan White Planning Council hosts a collaborative process of HIV prevention and care strategies and stakeholders to develop an EIIHA plan for the Houston Area.*

Proposed Needs Assessment Group Activities Timeline
February 2019 – March 2020

Draft
Updated 03-06-19

Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019
Needs Assessment Group (NAG) meets to design Needs Assessment (NA) process ✓	Survey Workgroup creates survey tool – 3/18/19, 11a – 1p	NAG approves survey tool and sampling plan – 4/15/19, 1p – 3p	Analysis Workgroup adopts principles for data analysis (May meet in April)	NA data collection and entry continues	NA data collection and entry continues NAG update – 7/15/19, 1p – 3p	NA data collection and entry continues
	Epi Workgroup convenes to create sampling plan – 3/18/19, 2p – 4p	NA data collection and entry begins	NA data collection and entry continues	Focus Group: Case Mgmt Staff – 6/19/19	Focus Group: Outreach Staff – 7/10/19	Focus Group: Prevention / Linkage Staff
Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
NA data collection and entry ends, cleaning and analysis begins	Analysis WG convenes to review preliminary findings	Analysis concludes, staff write report	Committee approves NA report	No activities	Steering and Council approve NA report	Report findings prepared for HTBMN and priority setting processes
Focus Group: HSDA/Rural consumers	Focus Group: EMA/Urban consumers	NAG reviews/approves NA report – 11/18/19, 1p – 3p				

Houston Area HIV Services Ryan White Planning Council (RWPC)

2019 Needs Assessment

Key Concepts for Primary Data Collection

Streamlined – prune any questions that are redundant or for which data have not been used; focus on service utilization, needs, accessibility and barriers; qualitative & quantitative data collection on barriers; continued effort to survey Out of Care population, including electronic surveying and expanding sites beyond primary care locations; focus groups with case managers, prevention/linkage/outreach staff, rural consumers, and urban consumers

Concept 1: Demographics

- 1.1 – Expand nationality/nation of origin question from Hispanic/Latino participants (2014) to all race/ethnicity categories

Concept 2: HIV Care Service Needs

- 2.1 – Needs of long-term survivors and aging PLWH
- 2.2 – Assess need for all fundable service categories, with clarification on which services are currently funded to avoid confusion.

Concept 3: HIV Care Service Accessibility

Concept 4: HIV Care Service Barriers

- 4.1 – Assess communication with care providers (types of communication, and barriers including language barriers)

Concept 5: Social Determinants of Health – Include questions to assess knowledge gaps identified through the 2018 Social Determinants of Health Special Study:

- 5.1 – **Economic Stability** (unreported employment; persistent food insecurity)
- 5.2 – **Education** (types of higher education and completion/reasons for not completing; consider changes in methodology/questions to accommodate non-English/Spanish languages; linguistic isolation)
- 5.3 – **Social and Community Context** (fuller picture of other types civic participation like volunteering and engaging in collective activities; in-depth linkage, retention, and service navigation following release from incarceration (possibly save for a Special Study); aspects of social cohesion such as resource sharing and navigation, shared social identity)
- 5.4 – **Health and Health Care** (reasons for lapses in health care coverage; health literacy)
- 5.5 – **Neighborhood and Built Environment** (access to foods that support healthy eating patterns; community crime and violence/safety; environmental conditions; quality of housing, including overcrowding)

HRSA supports Trump Administration's Plan to End the HIV Epidemic

U.S. Department of Health & Human Services
Health Resources and Services Administration

HRSA NEWS ROOM
<http://newsroom.hrsa.gov>

FOR IMMEDIATE RELEASE
Wednesday, February 6

CONTACT: HRSA PRESS OFFICE 301-443-3376
Press@hrsa.gov

The Health Resources and Services Administration (HRSA) fully supports the Trump Administration's initiative: *Ending the HIV Epidemic: A Plan for America*.

Through HRSA's Ryan White HIV/AIDS Program and the HRSA-funded Health Center Program, the agency will play a leading role in helping to diagnose, treat, protect and respond to end the HIV epidemic.

"We have an unprecedented opportunity to end the HIV epidemic in America. Through this initiative, in 2020, HRSA would work with program recipients to expand evidence-informed interventions proven to increase engagement and retention in care, reduce stigma, and improve viral suppression for the hardest to reach individuals," said HRSA Administrator George Sigounas, MS, Ph.D. "HRSA's Health Center Program will play a major expanded role in providing Pre Exposure Prophylaxis (PrEP) to those populations at the greatest risk of acquiring HIV infection."

HRSA will target resources to the 48 highest burden counties, Washington, D.C., San Juan, Puerto Rico, and seven states with a substantial rural HIV burden.

The HRSA-funded Health Center Program will expand PrEP services to selected health centers in the focus jurisdictions where over half of all new HIV infections occur.

HRSA's Ryan White HIV/AIDS Program will increase HIV care and treatment efforts in the focus jurisdictions.

The Ryan White HIV/AIDS Program has a track record of success. Of all the patients that had at least one medical visit in the program in 2017, 86% were virally suppressed, significantly higher than the national average of 60% among all those living with diagnosed HIV.

The Ryan White HIV/AIDS Program will continue to provide key services such as case management, behavioral health, medications, and medical care as well as support services such as transportation and housing — all of which are critical for engaging people living with HIV in medical care and ensuring improved health outcomes.

HRSA's Health Center Program supports 12,000 service delivery sites across the country, providing affordable, accessible, high quality, and cost-effective preventive and primary health care to more than 27 million people annually.

Health centers provide a model of coordinated, comprehensive, and patient-centered primary health care, integrating a wide range of medical, dental, mental health, substance use disorder, and patient services.

Health centers are also a key point of entry for people undiagnosed with HIV. Nearly two million patients receive a HIV test at a health center annually.

Many health centers provide HIV care services, including PrEP. And within the *Ending the HIV Epidemic initiative*, HRSA's Health Center Program will play a major expanded role in providing PrEP to those populations at the greatest risk of acquiring HIV infection.

For more information on *Ending the HIV Epidemic: a Plan for America*, please visit: <https://www.hiv.gov/ending-hiv-epidemic>.

For more information on the Ryan White HIV/AIDS Program, please visit: <https://hab.hrsa.gov>.

For more information on HRSA's Health Center Program, please visit: <https://bphc.hrsa.gov>.

Date Last Reviewed: February 2019

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:

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

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



Diagnose all people with HIV as early as possible after infection.

Treat the infection rapidly and effectively to achieve sustained viral suppression.



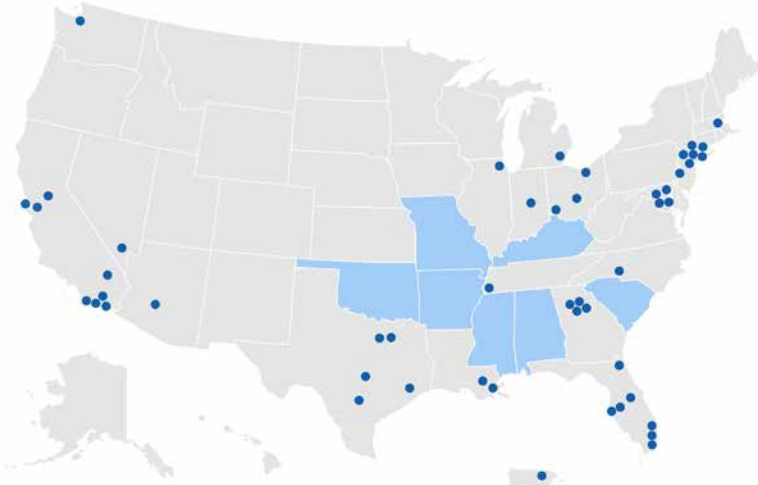
Protect people at risk for HIV using potent and proven prevention interventions, including PrEP, a medication that can prevent HIV infections.

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.



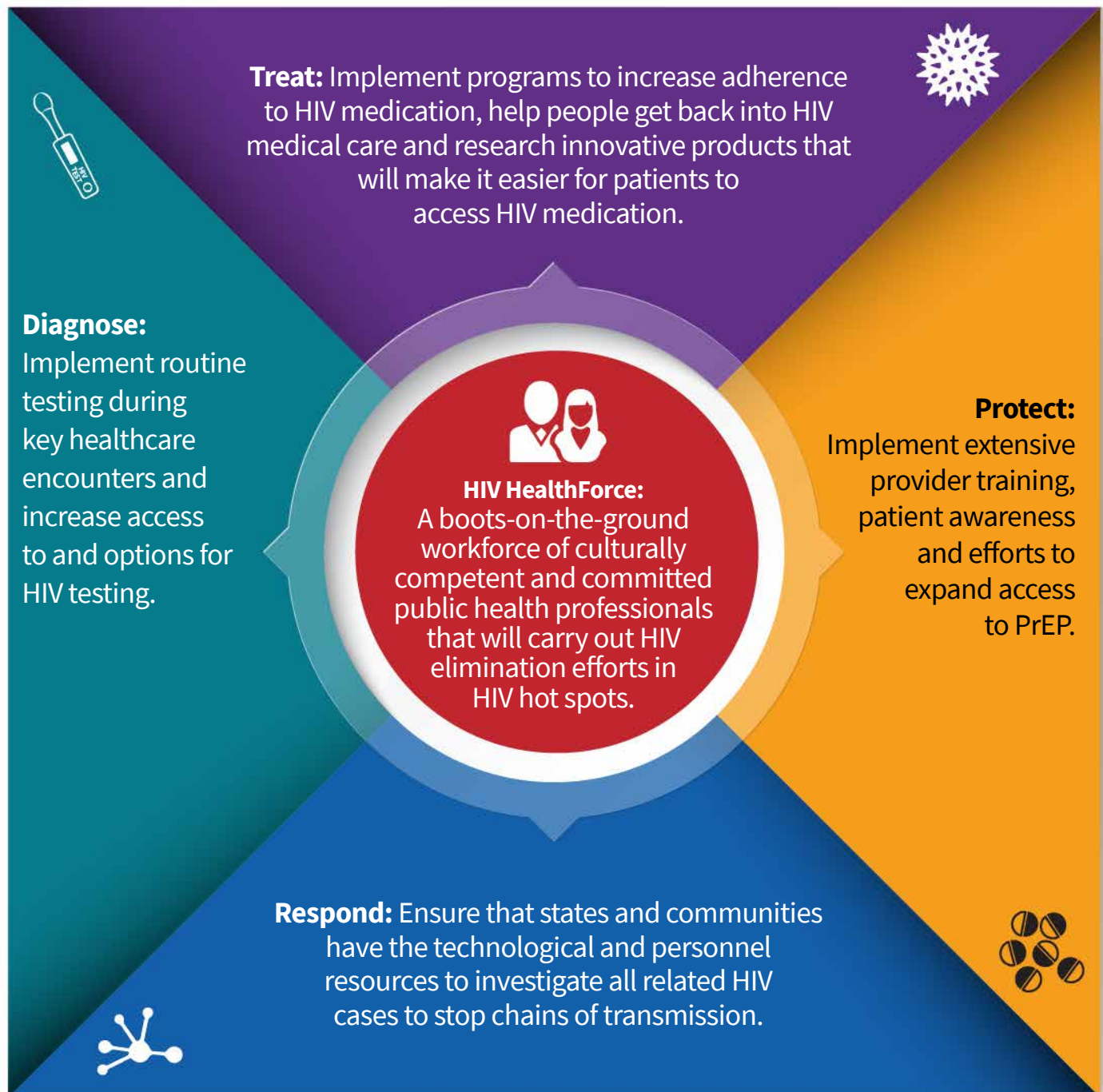
Geographical Selection:

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 – 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:



The New York Times

San Francisco Is Beating H.I.V. Why Can't Houston?

We know how to fight the epidemic, but patients in the South still aren't getting the treatment they need.

By Charlene Flash

Dr. Flash is a specialist in infectious diseases.

March 1, 2019

HOUSTON — In his State of the Union address, President Trump surprised Congress by asking for a “commitment to eliminate the H.I.V. epidemic in the United States within 10 years.” I’m a physician who specializes in H.I.V. and AIDS prevention in a city with one of the highest infection rates in the country, so that’s music to my ears. But the president needs to know that we’re going to fail if we don’t start working much harder.

After nearly 40 years, we finally have the biomedical tools and the public health strategies to end the H.I.V. epidemic in America. The winning strategy goes like this: Increase the number of people who get tested for H.I.V., and start those who test positive on antiretroviral therapy as soon as possible, which helps prevent transmission of the virus. Those who test negative but are vulnerable to infection because of sexual activity should take pre-exposure prophylaxis, or PrEP, the daily drug regimen that reduces the risk of getting H.I.V.

The tragedy is that those tools are sitting on the shelf in many parts of the country, especially the South, where H.I.V. rates are still rising among some groups and where AIDS disproportionately afflicts African-Americans. Just this week the Centers for Disease Control and Prevention reported that the “progress in H.I.V. prevention has stalled.”

Big cities on both coasts — where AIDS was concentrated when it was officially recognized as a health condition in the early 1980s — have deftly managed the disease. San Francisco was once ground zero, yet in 2017 new H.I.V. diagnoses there fell to 221, a record low. The city’s Department of Public Health credits PrEP and a rapid-start program that gets those who test positive for H.I.V. into care within five days.

Other urban areas have made similar strides. In New York City, new H.I.V. infections dropped 26 percent from 2012 to 2016. In the city’s clinics, people are offered treatment as soon as the virus is diagnosed. Demetre Daskalakis, the deputy health commissioner for disease control, said this program is working with “staggering success.”

The H.I.V. epicenter in the United States has instead shifted to the South, which now accounts for more than half of new infections and nearly half of deaths directly related to H.I.V. Eight of the 10 states and all of the 10 metropolitan areas with the highest rates of new H.I.V. diagnoses are in the South. The region had 20,000 new cases in 2017, compared with 6,000 cases in the Northeast.

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Even after learning they have the disease, Southerners face serious hurdles to getting care. A lack of public transportation, in both big cities and rural areas, makes going to the doctor more difficult. The cost of medications can be prohibitive, especially in a state like Texas, which has the highest uninsured rate in the nation. Not enough H.I.V. -positive patients are beginning treatment within a month of diagnosis, even though research shows that doing so improves health

and reduces the risk of transmission. Far too few people who could benefit are taking PrEP.

And of course, there is lingering stigma that keeps people who need help on the margins.

Over the past few years there has also been a demographic shift. African-Americans now represent 44 percent of all people infected with H.I.V., nearly four times their proportion of the population; Hispanics, 18 percent of the population, account for 26 percent of infections. Houston's population is 44 percent Hispanic and 23 percent black, and H.I.V. rates among young people of color here are rising. H.I.V. rates among black women are 17 percent higher than among white women.

We are making slow, steady progress. The Joint United Nations Program on H.I.V./AIDS last year honored the Ponce De Leon Center in Atlanta, which serves more than 6,000 people a year, most of them living in poverty and uninsured or underinsured. The center provides not only H.I.V. diagnosis and treatment but also financial counseling and nutrition.

And nationwide, while we don't yet have a cure, the medical breakthroughs around H.I.V. are impressive. Thousands of Americans are living happy, successful, long lives with the infection.

But this makes some of the cases I see all the more distressing. I had a patient who died last year of an AIDS-related cancer at age 31. Another woman, who has been infected with H.I.V. for 15 years, is 41 years old and unable to get out of bed. Little can be done for these women, the infection having been diagnosed late in their illness.

So, yes, we can meet the president's goal of ending AIDS in a decade, but only if we race to get our new tools more efficiently and equitably to those who need them.

Charlene Flash is an infectious-disease doctor and associate chief medical officer at Legacy Community Health, and a clinical assistant professor at Baylor College of Medicine.

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A version of this article appears in print on March 1, 2019, on Page A19 of the New York edition with the headline: H.I.V. Is Thriving in the South

READ 129 COMMENTS

- Description of the proposed pilot project, including, but not limited to, the goals, objectives, processes that will be studied, and evaluation methods

E. Initiation and Duration of Pilot Projects

The selected participants should be ready to start their pilot project within 4 months of receiving a letter of acceptance from FDA into the program. The duration of a pilot project should not exceed 6 months. FDA may consider a pilot project with a later start date or longer duration depending on the proposed goal(s) and objective(s). Each pilot project is expected to be completed within the proposed duration time period. This time period does not include an additional 30 days for completion of a final report (see Section II.G. Reports).

F. Participation in Pilot Projects

Each participant that is selected into the program will be responsible for conducting its pilot project. A group of entities (e.g., members of the pharmaceutical distribution supply chain or other stakeholders, including trade associations) that partners to conduct a pilot project will be considered a single participant for purposes of the DSCSA Pilot Project Program. The participant will be responsible for the funding and resources necessary to conduct the pilot project, and for determining each partner's role and responsibility in its pilot project.

Prior to launch of a pilot project, FDA intends to hold a design strategy meeting with the selected pilot participant(s) to review the goal(s) and objective(s) for the pilot project and discuss the project plans and other pertinent details. FDA also expects pilot project participants to submit reports on the progress of their pilot projects to FDA (see Section II.G. Reports). Participants should evaluate their pilot projects using the evaluation methods they identified during the pilot project design process.

G. Reports

Each pilot project is expected to be completed within the proposed duration time period, and FDA asks that all participants submit periodic progress reports to FDA while the pilot project is being conducted, in addition to submitting a final report after completing the pilot project. These reports will provide insight into the systems and process needed to comply with certain DSCSA requirements for enhanced drug distribution security.

1. Progress Report(s)

Each pilot project program participant is expected to provide reports on the progress of its pilot project to FDA. The progress reports are intended to capture the ongoing work during the pilot project, including but not limited to, status or results, changes, challenges, and/or lessons learned. FDA will work with participants to develop an appropriate schedule for the submission of progress reports based on the design and duration of the pilot project. Because the duration of a pilot project should not exceed 6 months, the frequency of progress reports will vary based on the length of the individual pilot project. Pilot projects of relatively shorter duration may result in shorter time intervals between progress reports. For example, FDA may ask for monthly progress reports for a 6-month pilot project, however for a 1-month pilot project, FDA may ask for weekly progress reports.

2. Final Report

Within 30 to 45 business days of completing a pilot project, each participant is expected to provide a final report to FDA that captures the description, objectives, methods, evaluation, costs and key findings, and lessons learned from the project. Timely completion of pilot projects and the final report will support FDA's DSCSA implementation, including the statutory requirements under section 582(j) of the FD&C Act to consider information from pilot projects in the development of guidances for unit-level tracing and standards for the interoperable data exchange in section 582(h)(3) and (4) of the FD&C Act. FDA may also request that the participants meet with the Agency upon the completion of their pilot project or the final report.

H. Final DSCSA Pilot Project Program Report

To ensure that all supply chain members benefit from the information generated by the DSCSA Pilot Project Program, FDA intends to make the following information about each pilot project of the program available to the public in a final program report: (1) The names and industry sector(s) of the pilot project participant(s); (2) the pilot project's objectives and evaluation methods; (3) the duration of the pilot project; and (4) the key findings and lessons learned from the pilot project. FDA intends to post the information related to the DSCSA Pilot Project Program and the final program report on FDA's website.

I. Recordkeeping

Any records generated by a participant while conducting a pilot project should be maintained in accordance with the participant's normal recordkeeping practices. For pilot projects that involve partnering entities, the partnering entities should decide who is responsible for the records generated in the course of conducting the pilot project. FDA recommends that participants maintain the progress reports and final report for its pilot project for at least 1 year after completion of the pilot project.

III. Paperwork Reduction Act of 1995

This notice contains information collection provisions that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). The collection of information in this notice was approved under OMB control number 0910–0859.

Dated: February 4, 2019.

Lowell J. Schiller,

Acting Associate Commissioner for Policy.

[FR Doc. 2019–01561 Filed 2–7–19; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Information (RFI): Improving Efficiency, Effectiveness, Coordination, and Accountability of HIV and Viral Hepatitis Prevention, Care, and Treatment Programs

AGENCY: Office of HIV/AIDS and Infectious Disease Policy, Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services.

ACTION: Notice.

SUMMARY: Both the *National HIV/AIDS Strategy* (NHAS) and the *National Viral Hepatitis Action Plan* (NVHAP) expire in 2020. The Department of Health and Human Services (HHS) Office of HIV/AIDS and Infectious Disease Policy (OHAIDP), in collaboration with federal partners, is leading development of the next iterations of these two separate and distinct national strategies. To help inform the next iterations of the NHAS and NVHAP, HHS seeks input from external stakeholders for improving efficiency, effectiveness, coordination, and accountability of HIV and viral hepatitis prevention, care, treatment, and cure policies, services, and programs.

DATES: To be assured consideration, comments must be received at the

address provided below, no later than 5:00 p.m. ET on March 11, 2019.

ADDRESSES: Electronic responses are strongly preferred and may be addressed to HepHIVStrategies@hhs.gov. Written responses should be addressed to: U.S. Department of Health and Human Services, Room L001, 330 C Street SW, Washington, DC 20024. Attention HIV/ Viral Hepatitis RFI.

FOR FURTHER INFORMATION CONTACT: Nathan Fecik, MPH regarding HIV or Corinna Dan, RN, MPH regarding viral hepatitis, in the Office of HIV/AIDS and Infectious Disease Policy, (202) 795-7697.

SUPPLEMENTARY INFORMATION: The NHAS and NVHAP have served as roadmaps for the national response to HIV and viral hepatitis in the United States. They have been of great value in establishing and monitoring indicators of progress toward important national public health goals, setting expectations, identifying opportunities for stakeholder engagement across sectors, and improving transparency and accountability. As a nation, we have made significant progress toward achieving the goals for both strategies, but ongoing challenges and disparities remain.

The NHAS and the NVHAP were developed with input from nonfederal stakeholders who are committed to working toward shared national goals and aligning efforts across sectors. The strategies allow flexibility to adapt to: Scientific advances; changes in the needs of people with and at-risk for these infections; emerging threats to our progress toward eliminating HIV and viral hepatitis, such as the opioid crisis; and other factors including social determinants of health and stigma that affect the health of people with and at risk for these infections.

This request for information seeks public input on improving efficiency, effectiveness, coordination, and accountability of HIV and viral hepatitis prevention, care, treatment, and cure policies, services, and programs at all levels and for all types of stakeholders. The feedback received will inform the next edition of two separate strategies: (1) The National HIV/AIDS Strategy; and (2) the National Viral Hepatitis Action Plan. Please indicate the national strategy to which each comment applies. If submitting comments for both strategies please submit two separate responses. Topics of interest include, but are not limited to, the following:

(1a) What components of the NHAS do you think should be maintained? What changes should be made to the NHAS? This may include changes to the

structure, goals, and indicators, key areas of focus and/or populations, and annual reporting processes by federal agencies. This may also include areas of the current strategy that should be scaled back or areas of the current strategy that should be expanded or scaled up.

(1b) What components of the NVHAP do you think should be maintained? What changes should be made to the NVHAP? This may include changes to the structure, goals, and indicators, key areas of focus and/or populations, and annual reporting processes by federal agencies. This may also include areas of the current strategy that should be scaled back or areas of the current strategy that should be expanded or scaled up.

(2a) Specific recommendations you think will improve the efficiency, effectiveness, accountability, and impact of the national response to HIV.

(2b) Specific recommendations you think will improve the efficiency, effectiveness, accountability, and impact of the national response to viral hepatitis.

(3a) What specific actions should the federal government and others take to improve the coordination of funding and delivery of HIV services?

(3b) What specific actions should the federal government and others take to improve the coordination of funding and delivery of viral hepatitis services?

(4a) What monitoring and evaluation strategies would further improve HIV prevention, care, and treatment?

(4b) What monitoring and evaluation strategies would further improve viral hepatitis prevention, care, and treatment?

Dated: January 29, 2019.

Tammy R. Beckham,

Director, Office of HIV/AIDS and Infectious Disease Policy.

[FR Doc. 2019-01695 Filed 2-7-19; 8:45 am]

BILLING CODE 4150-28-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Document Identifier: OS-0937-New]

Agency Information Collection Request: 30-Day Public Comment Request

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: In compliance with the requirement of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the

following summary of a proposed collection for public comment.

DATES: Comments on the ICR must be received on or before March 11, 2019.

ADDRESSES: Submit your comments to OIRA_submission@omb.eop.gov or via facsimile to (202) 395-5806.

FOR FURTHER INFORMATION CONTACT: Sherrette Funn, Sherrette.Funn@hhs.gov or (202) 795-7714. When submitting comments or requesting information, please include the document identifier 0937-New-30D and project title for reference.

SUPPLEMENTARY INFORMATION: Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Title of the Collection: SMARTool Pilot Replication Project.

Type of Collection: OMB No. 0937-NEW—Office of the Assistant Secretary for Health (OASH).

Abstract: The Office of the Assistant Secretary for Health (OASH), U.S. Department of Health and Human Services (HHS), is requesting approval by OMB of a new information collection request. OASH is updating the Center for Relationship Education's Systematic Method for Assessing Risk-Avoidance Tool (SMARTool), a tool for sexual risk avoidance (SRA) curriculum developers and implementing organizations (IOs) to ensure that their SRA curricula are grounded in evidence. In an effort to assess the SMARTool's impact, OASH aims to conduct a formative evaluation to (1) provide preliminary evidence on the effectiveness of SRA curricula that are aligned with the SMARTool, (2) derive lessons learned to improve the implementation of SRA curricula, and (3) develop and test baseline and follow-up questionnaires that assess SRA program effects on the key SMARTool constructs. The evaluation will be conducted with an estimated four IOs. The evaluation will use quantitative and qualitative methods and will include both a process evaluation and an outcome evaluation.

Need and Proposed Use of the Information: To enhance the rigor of the evaluation, a comparison group will be identified for each IO, if possible. This