

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee

2:00 p.m., Thursday, June 11, 2020

*Meeting Location: Online or via phone – **Please do not come in person***

Join Zoom Meeting by clicking on this link: <https://us02web.zoom.us/j/81035711790>

Meeting ID: 810 3571 1790

To join via telephone call: (346) 248-7799

AGENDA

I. Call to Order

A. Welcome

B. Moment of Reflection

C. Adoption of the Agenda

D. Approval of the Minutes (March 26, 2020)

Daphne L. Jones and
Steven Vargas, 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. Review Data Necessary for How to Best Meet the Need

A. Review data from remaining sections of the Needs Assessment
(Chapters 3, 4, and 5)

B. Approve the 2020 Needs Assessment report

Amber Harbolt, Health Planner
Office of Support

IV. Old Business

A. Quarterly Committee Report

V. Announcements

Daphne L. Jones and
Steven Vargas, Co-Chairs

VI. Adjourn

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee
2:00 p.m., Thursday, March 26, 2020
Meeting Location: Zoom teleconference

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Daphne L. Jones, Co-Chair	Bianca Burley	Tana Pradia, RWPC Chair
Steven Vargas, Co-Chair	Ryan Clark	Cynthia Deverson, BCM
Dawn Jenkins	Denis Kelly	Josh Mica
Rodney Mills	Matilda Padilla	Miyase Koksal-Ayhan, HHD
Deondre Moore	Faye Robinson	Crystal Townsend, TRG
Shital Patel	Imran Shaikh	Kim Kirchner, TRG intern
Dominique Brewster	Larry Woods	Mayra Ramirez, TRG intern
Datonye Charles		Tori Williams, Office of Support
Esther Ogunjimi		Amber Harbolt, Office of Support
Anthony Williams		Diane Beck, Office of Support

Call to Order: Daphne L. Jones, Co-Chair, called the meeting to order at 2:13 p.m. and asked for a moment of reflection.

Adoption of Agenda: Motion #1: *it was moved and seconded (Vargas, Jenkins) to adopt the agenda with one change: Add the EIIHA motion after Adoption of 2020 Committee Goals. Motion carried.*

Approval of the Minutes: Motion #2: *it was moved and seconded (Vargas, Ogunjimi) to approve the February 13, 2020 minutes. Motion carried.* Abstentions: Charles, Moore.

Public Comment: None.

Adopt the 2020 Committee Goals: Motion #3: *it was moved and seconded (Vargas, Patel) to adopt the 2020 Committee Goals with one change: add at the end of 1 – in collaboration as much as possible with the development of one local ending the HIV epidemic plan.. Motion carried.*

2020 EIIHA Workgroup: Harbolt reviewed the FY 2020 EIIHA Approval Motion, see attached. **Motion #3:** *it was moved and seconded (McLean, Vargas) to approve the following 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 2021 EIIHA Plan, provided that:*

- *The FY 2021 EIIHA Plan is developed through a collaborative process that includes stakeholders from prevention and care, community members, and consumers; and*
- *The recommended FY 2021 EIIHA Plan is distributed to Planning Council members for input prior to final approval from the Comprehensive HIV Planning Committee.*

Motion carried.

Review Data Necessary for How to Best Meet the Need: Harbolt presented the attached PowerPoint slides reviewing the Introduction, Chapters 1-2 and Service-Specific Fact Sheets needed for the How to Best Meet the Need process. **Motion #4:** *it was moved and seconded (Vargas, Mills) to approve the Introduction, Chapters 1-2 and Service-Specific Fact Sheets for use in the How to Best Meet the Need process.* **Motion Carried.**

Announcements: None.

Adjournment: **Motion #5:** *it was moved and seconded (Vargas, Jenkins) to adjourn the meeting at 3:31 p.m.* **Motion carried.**

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

2020 Voting Record for Meeting Date March 26, 2020

MEMBERS	Motion #1: Agenda				Motion #2: Minutes				Motion #3: 2020 committee goals				Motion #4: EIIHA				Motion #5: 2019 NA for HTBMN			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Daphne L. Jones, Co-Chair				C				C				C				C				C
Steven Vargas, Co-Chair		X				X				X				X				X		
Dawn Jenkins		X				X				X				X				X		
Denis Kelly	X				X				X				X				X			
Rodney Mills		X				X				X				X				X		
Matilda Padilla	X				X				X				X				X			
Shital Patel		X				X				X				X				X		
Faye Robinson	X				X				X				X				X			
Imran Shaikh	X				X				X				X				X			
Dominique Brewster		X				X				X				X				X		
Bianca Burley	X				X				X				X				X			
Datonye Charles		X				X				X				X				X		
Ryan Clark	X				X				X				X				X			
Deondre Moore		X				X				X				X				X		
Esther Ogunjimi lm 3:15pm		X				X				X				X				X		
Anthony Williams ja 2:32pm	X				X				X					X				X		
Larry Woods	X				X				X				X				X			

DRAFT

06/03/20



2020 Houston HIV Care Services Needs Assessment

A collaboration of:

Houston Area HIV Services Ryan White Planning Council

Houston HIV Prevention Community Planning Group

Harris County Public Health, Ryan White Grant Administration

Houston Health Department, Bureau of HIV/STD and Viral Hepatitis
Prevention

Houston Regional HIV/AIDS Resource Group, Inc.

Harris Health System

People Living with HIV in the Houston Area and Ryan White HIV/AIDS
Program Consumers

Approval: Pending

Disclaimer:

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

Funding acknowledgment:

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

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

Suggested citation:

2020 Houston Area HIV Care Services Needs Assessment.

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

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ACKNOWLEDGMENTS

Collaborating Partners:

The 2020 Houston Area HIV Care Services Needs Assessment is a collaboration of the following partners:

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

Contributors:

The 2020 Houston Area HIV Care Services Needs Assessment was made possible by the following individuals who served as NAG and Workgroup members and as points of contact for consumer survey administration:

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Leadership:

The following individuals provided oversight and guidance to the 2020 Houston Area HIV Care Services Needs Assessment process, including survey design, data administration, and the review and approval of this document:

- Needs Assessment Group (NAG) Co-Chairs: W. Jeffrey Campbell, Jon-Michael Gillispie, Eric James, and Steven Vargas
- Epidemiology Workgroup Co-Chairs: Cynthia Deverson and Isis Torrente
- Survey Workgroup Co-Chairs: Ardry Skeet Boyle, Ricardo Mora, and Cecilia Oshingbade
- Analysis Workgroup Co-Chairs: Angela F. Hawkins and Nancy Miertschin

Houston Health Department, Division of Disease Prevention and Control

- Marlene McNeese, Assistant Director
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- Camden J. Hallmark, Senior Analyst
- Kellie Watkins, Staff Analyst

EXECUTIVE SUMMARY

The 2020 Houston Area HIV Care Services Needs Assessment presents data on HIV service needs, barriers, and other factors influencing access to care for people living with HIV (PLWH) in the Houston Area as determined through a consumer survey. Needs assessments ensure consumer experiences and perspectives are included in the data-driven decision-making processes of local HIV planning. Data are used to help set priorities for the allocation of HIV care services funding, in the development of the comprehensive HIV plan, and in designing annual service implementation plans. The last Needs Assessment was conducted in 2016.

HIV Service Needs in the Houston Area

According to the Houston Area HIV Care Services Needs Assessment, all currently funded HIV services in the Houston Area are needed by consumers. The top five most needed services are:

1. Primary care
2. Local medication assistance
3. Case management
4. Oral health care, and
5. Vision care

For the first time in 2020, need for currently unfunded services was analyzed, which revealed substantial need for housing services for PLWH in the Houston area.

Accessibility of HIV Services in the Houston Area

In addition to revealing the most needed HIV services in the Houston Area, the Houston Area HIV Care Services Needs Assessment provides information about access to those services, which helps communities better understand where barriers to services may exist.

In 2020, at least 78% of the PLWH who said they needed each HIV funded service *also* said the service was easily accessible to them. There were some funded services, however, that were less accessible than others: early intervention services, oral health care, and health insurance assistance *least* accessible services according to 2020 Houston Area HIV Care Services Needs Assessment. ADAP enrollment workers and local medication assistance were the most accessible services in 2020.

Barriers to HIV Services in the Houston Area

To improve understanding of barriers to HIV services, the 2020 Houston Area HIV Care Services Needs Assessment also gathers information about the types of

difficulties consumers experience when services are not easily accessible. The most common types of barriers encountered are:

1. Education and awareness issues
2. Interactions with staff
3. Wait-related issues
4. Administrative issues, and
5. Health insurance/coverage issues

In addition to the above results, the 2020 Needs Assessment includes detailed information about a variety of issues that affect access to care, including:

- Service needs and barriers at each stage of the HIV care continuum, from HIV testing and initial diagnosis to treatment to support viral load suppression
- The social, economic, health (both physical and mental), and behavioral characteristics of PLWH that may help or hinder HIV prevention and access to HIV care
- A brief profile on the service needs and barriers of people who are out of care
- Service-Specific Fact Sheets detailing the needs and barriers for each HIV core medical, support, and housing service

Together, these data are used to better understand the HIV care needs and patterns of PLWH in the Houston Area, to identify new and emerging areas of need, and to ultimately improve the system of HIV services so that it best meets the needs of PLWH.

The 2020 Houston Area HIV Care Services Needs Assessment is a collaboration between the Ryan White Planning Council, HIV Prevention Community Planning Group, Ryan White Grant Administration, Houston Health Department Bureau of HIV/STD and Viral Hepatitis Prevention, The Resource Group, Harris Health System, and Housing Opportunities for Persons with AIDS (HOPWA). A total of 38 individuals assisted in the planning and implementation of the needs assessment, of whom 45% were self-disclosed PLWH.

For more information about the 2016 Houston Area HIV Care Services Needs Assessment, contact the Office of Support at (832) 927-7926 or visit www.rvpchouston.org.

What is an HIV needs assessment?

INTRODUCTION

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

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

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

How are HIV needs assessment data used?

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

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

- Ensuring the consumer point-of-view is infused into all of the data-driven decision-making activities of the Houston Area RWPC.
- Revising local service definitions for HIV care, treatment, and support services in order to best meet the needs of PLWH in the Houston Area.
- Setting priorities for the allocation of Ryan White HIV/AIDS Program funds to specific services.

- Establishing goals for and then monitoring the impact of the Houston Area's comprehensive plan for improving the HIV prevention and care system.
- Determining if there is a need to target services by analyzing the needs of particular groups of PLWH.
- Determining the need for special studies of service gaps or subpopulations that may be otherwise underrepresented in data sources.
- By the Planning Council, other Planning Bodies, specific Ryan White HIV/AIDS Program Parts, providers, or community partners to assess needs for services.

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

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

Sources:

- 2020 Houston Area HIV Needs Assessment Group (NAG), Analysis Workgroup, Principles for the 2020 Needs Assessment Analysis. Approved 08-19-19.
- U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Ryan White HIV/AIDS Program Part A Manual Revised 2013. Section XI, Ch 3: Needs Assessment.

METHODOLOGY

Needs Assessment Planning

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

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

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

Survey Sampling Plan

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

Survey Tool

Data for the 2020 Houston Area HIV Care Services Needs Assessment were collected using a 54-question paper or electronic survey of open-ended, multiple

choice, and scaled questions addressing nine topic areas (in order):

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

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

Data Collection

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

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

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

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

Data Management

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

survey entries are excluded from analysis per variable; therefore, denominators vary across results. In addition, proportions are not calculated with a denominator of 589 surveys for every variable due to missing or “check-all” responses. All data management and analysis was performed in IBM® SPSS® Statistics (v. 22) and QSR International® NVivo 10.

Limitations

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

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

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

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

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

Sources:

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

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

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

BACKGROUND

The Houston Area

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

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

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

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

HIV in the Houston Area

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

TABLE 1-Diagnosed People Living with HIV in the Houston EMA, 2018^a

	#	%
Total	29,078	100.0%
Sex at Birth		
Male	21,829	75.1%
Female	7,249	24.9%
Race/Ethnicity		
White	5,109	17.6%
Black/African American	14,044	48.3%
Hispanic/Latino	8,493	29.2%
Other/Multiracial	1,432	4.9%
Age		
0 - 12	54	0.2%
13 - 24	1,170	4.0%
25 - 34	5,986	20.6%
35 - 44	6,752	23.2%
45 - 54	7,594	26.1%
55 - 64	5,580	19.2%
65+	1,942	6.7%
Transmission Risk^b		
Male-male sexual contact (MSM)	16,818	57.8%
Person who injects drugs (PWID)	2,256	7.8%
MSM/PWID	1,192	4.1%
Sex with Male/Sex with Female	8,455	29.1%
Perinatal transmission	340	1.2%
Adult other	17	0.1%

^aSource: Texas eHARS, Diagnosed PLWH in the Houston EMA between 1/1/2018 and 12/31/2018

^bCases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification.

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

HIV Services in the Houston Area

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

- Comprehensive HIV prevention activities in the Houston Area are provided by the Houston Health Department (**HHD**), a directly funded CDC grantee, and the Texas Department of State Health Services (**DSHS**). Prevention activities include health education and risk reduction, HIV testing, disease investigation and partner services, linkage to care for newly diagnoses and out of care PLWH. The Houston Area HIV Prevention Community Planning Group provides feedback and to HHD in its design and implementation of HIV prevention activities.
- The Ryan White HIV/AIDS Program Part A and MAI provide core medical and support services for

HIV-diagnosed residents of the Houston EMA. These funds are administered by the Ryan White Grant Administration of Harris County Public Health. The Houston Area Ryan White Planning Council designs Part A and MAI funded services for the Houston EMA.

- The Ryan White HIV/AIDS Program Parts B, C, D, and State Services provide core medical and support services for HIV-diagnosed residents of the Houston HSDA, with special funding provided to meet the needs of women, infants, children, and youth. The Houston Regional HIV/AIDS Resource Group (**TRG**) administers these funds. The Ryan White Planning Council also designs Part B and State Services for the Houston HSDA. Additional programs supported by TRG include reentry housing through HOPWA funds and support of the grassroots END HIV Houston coalition.
- HOPWA provides grants to community organizations to meet the housing needs of low-income persons living with HIV. HOPWA services include assistance with rent, mortgage, and utility payments, case management, and supportive housing. These funds are administered by the City of Houston Housing and Community Development for the Houston EMSA.

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

Sources:

- Centers for Disease Control and Prevention, *Diagnoses of HIV Infection in the United States and Dependent Areas, 2018*; vol. 30. Published November 2015. Accessed 03/06/2020. Available at: www.cdc.gov/hiv/topics/surveillance/resources/reports/.
- U.S. Census Bureau, American FactFinder. Houston (city), Texas and Harris (county), Texas Accessed: 03/03/2020. Available at: <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>
- U.S. Department of Health and Human Services, *Ending the HIV Epidemic: A Plan for America*. February 2019.



Chapter 1: Demographics

PARTICIPANT COMPOSITION

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

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

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

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

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

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

The results of these efforts are summarized in Table 2.

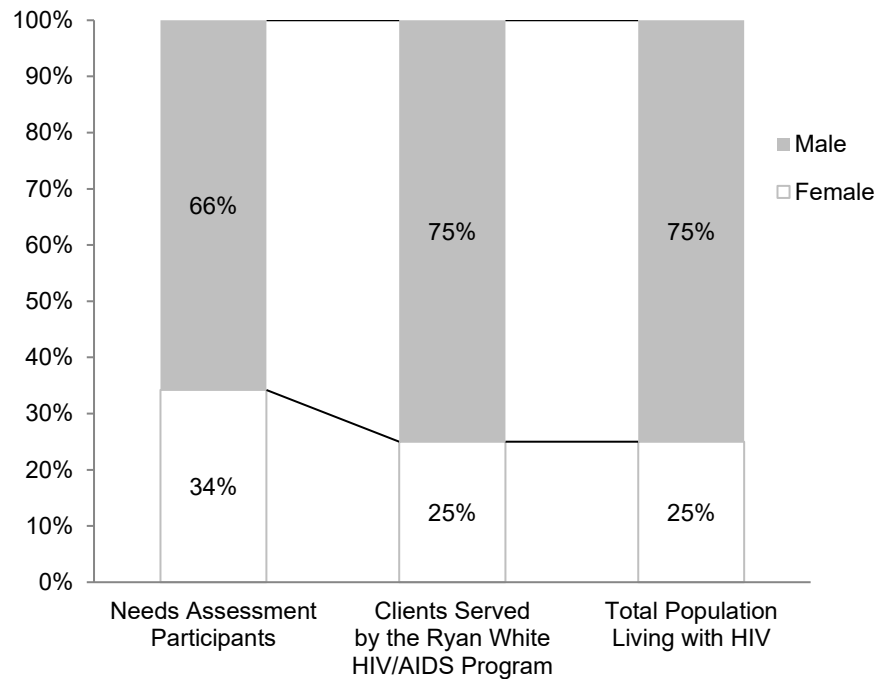
	No.	%
Young adult (18-24 years)	17	2.9%
Adult age 50+ years	353	59.9%
Homeless	65	11.1%
Unstably Housed	159	29.0%
People who inject drugs (PWID)*	47	8.2%
Male-male sexual contact (MSM)	238	40.5%
Out of care (last 12 months)	24	4.3%
Recently released from incarceration	65	11.6%
Rural (non-Harris County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

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

COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

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

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



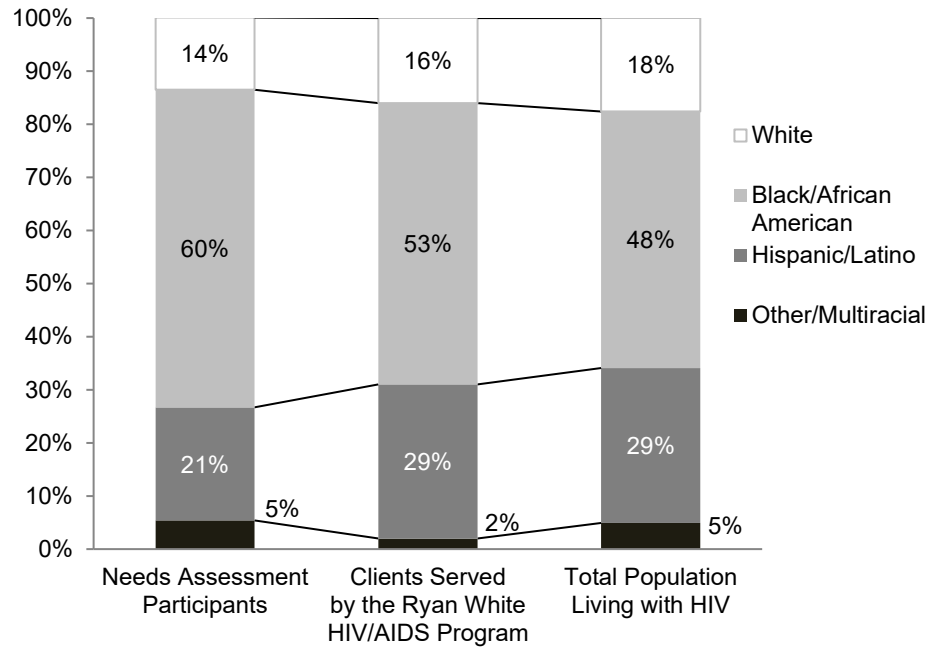
^aSource: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
^bSource: Texas eHARS. Living HIV cases as of 12/31/18.

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

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

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

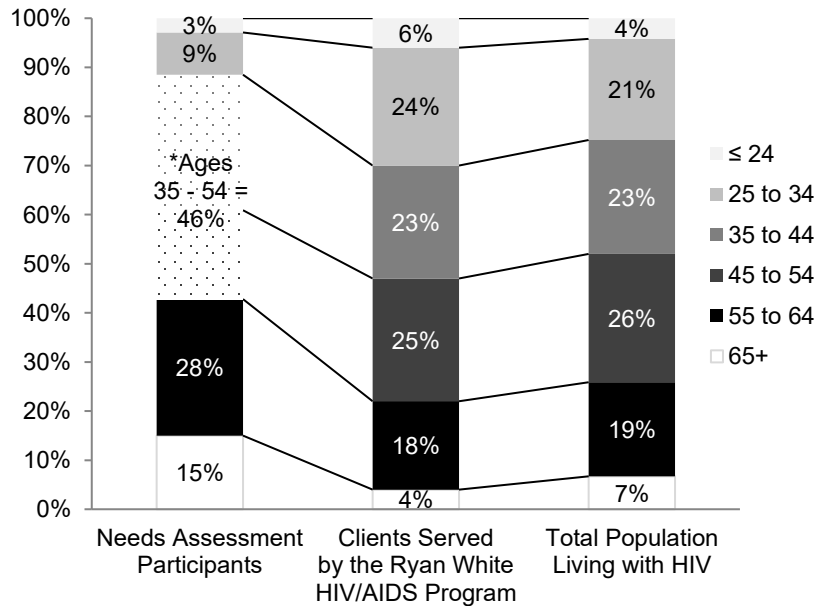
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients^a and Total HIV Diagnosed Population^b in the Houston EMA, by Race/Ethnicity, 2018



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

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

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



^aSource: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
^bSource: Texas eHARS. Living HIV cases as of 12/31/18
^cExcludes ages 0-12
 *Age ranges 35-44 and 45-54 combined due to differences in question structuring.

Weighting the Sample

Needs assessment data were statistically weighted by sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2018) *prior to* the analysis of results related to service needs and barriers. This was done because the demographic composition of 2020 Houston HIV Care Services Needs Assessment participants was *not* comparable to the composition of all PLWH in the Houston EMA. As such, the results presented in the remaining Chapters of this document are proportional for these three demographic categories only. Appropriate statistical methods were applied throughout the process in order to produce an accurately weighted sample, including a three-level stratification of prevalence data and subsequent data

weighting syntax. Voluntary completion on the survey and non-applicable answers comprise the missing or invalid survey entries and are excluded in the statistical analysis; therefore, denominators will further vary across results. All data management and quantitative analysis, including weighting, was performed in IBM© SPSS© Statistics (v. 22). Qualitative analysis was performed in QSR International© NVivo 10.

Sources:

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

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



Chapter 2: Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

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

Overall Ranking of Funded Services, by Need

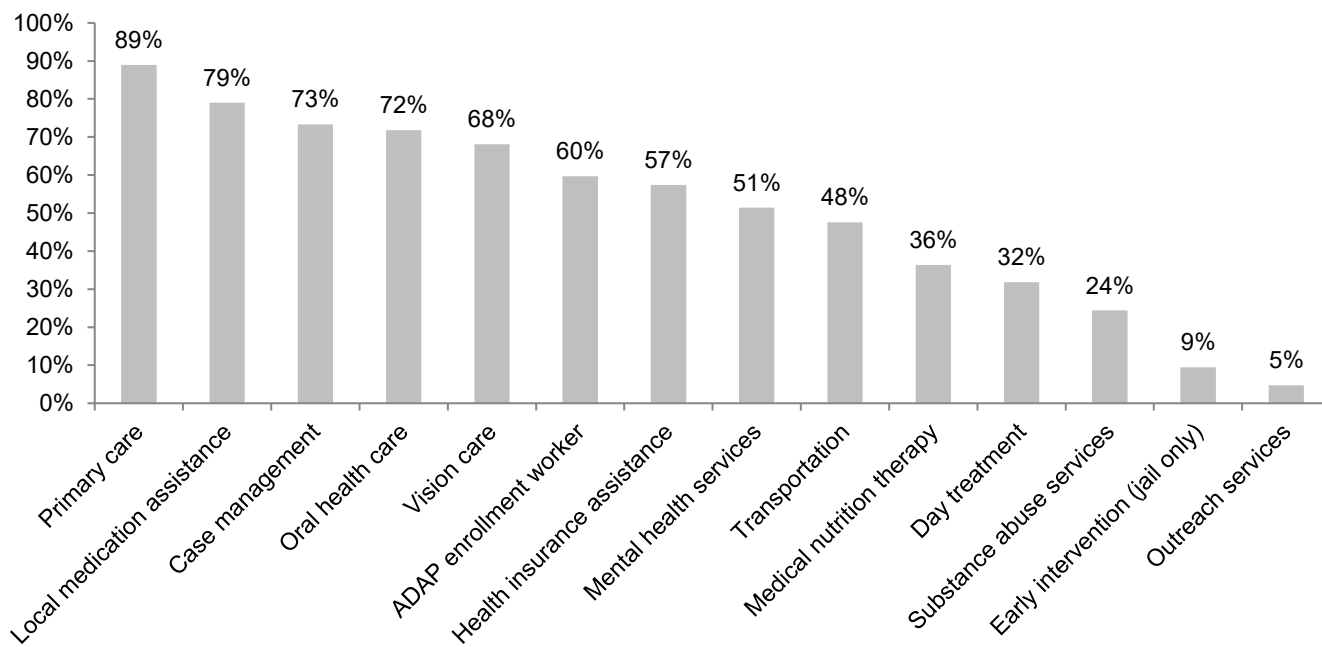
At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. Participants of

the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

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

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

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



Overall Ranking of Funded Services, by Accessibility

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

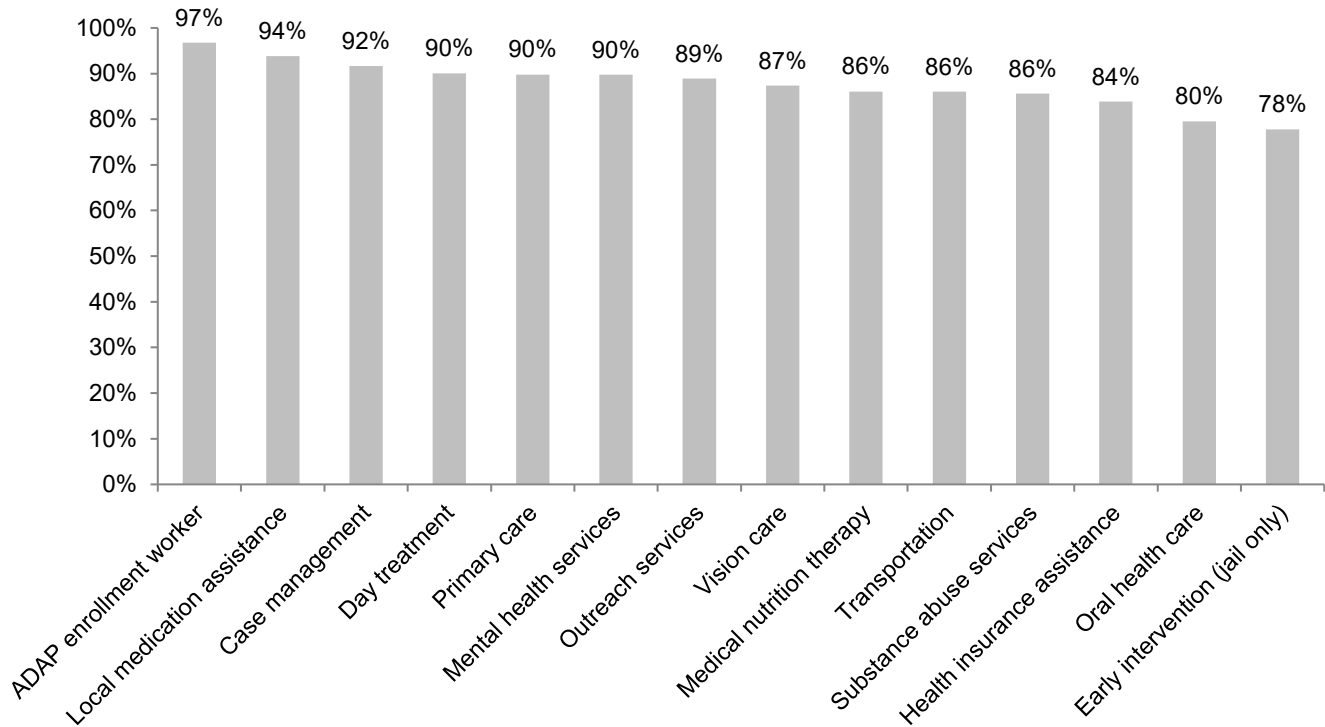
(**Graph 2**) All funded services except hospice and linguistics were analyzed and received a ranking of accessibility. The most accessible service was ADAP enrollment worker at 97% ease of access, followed by

local medication assistance at 94% and case management at 92%. Local medication assistance had the highest accessibility ranking of any core medical service, while ADAP enrollment worker received the highest accessibility ranking of any support service. Compared 2016 needs assessment, reported accessibility on remained stable on average. The greatest increase in percent of participants reporting ease of access was observed in local medication assistance, while the greatest decrease in accessibility was reported for early intervention services.

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

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

Denominator: 569-573 participants, varying between service categories



Overall Ranking of Barriers Types Experienced by Consumers

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

(Graph 3) Overall, fewer barriers were reported in 2020 (415 barrier reports) than in previous 2016 needs assessment (501 barrier reports), despite the increase in sample size in 2020. Across all funded services, the

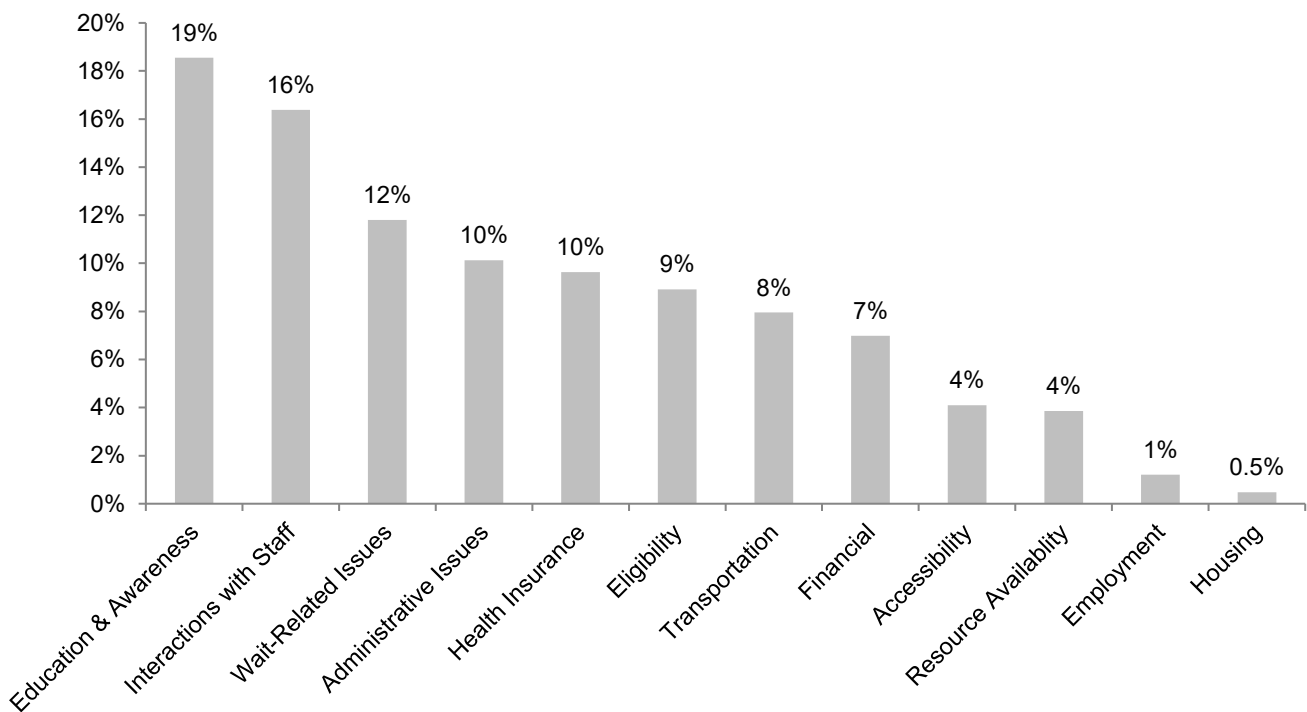
barrier types reported most often related to service education and awareness issues (19% of all reported barriers); interactions with staff (16%), wait-related issues (12%); administrative issues (10%); and issues relating to health insurance coverage (10%). Housing issues (homelessness or intimate partner violence) were reported least often as barriers to funded services (1%). Between the 2016 and 2020 HIV needs assessments, the percentage of barriers relating to interactions with staff increased by 3 percentage points, while wait-related issues decreased by 3 percentage points.

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

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

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

Denominator: 415 barrier reports



Descriptions of Barriers Encountered

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

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

to access comprised most (57%) of the barriers reported.

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

TABLE 1-Barrier Proportions within Each Barrier Type, 2020

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

NEED AND ACCESSIBILITY FOR UNFUNDED SERVICES

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

Overall Ranking of Unfunded Services, by Need

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

(Graph 4) At 53%, housing was the most needed unfunded service in the Houston Area, followed by

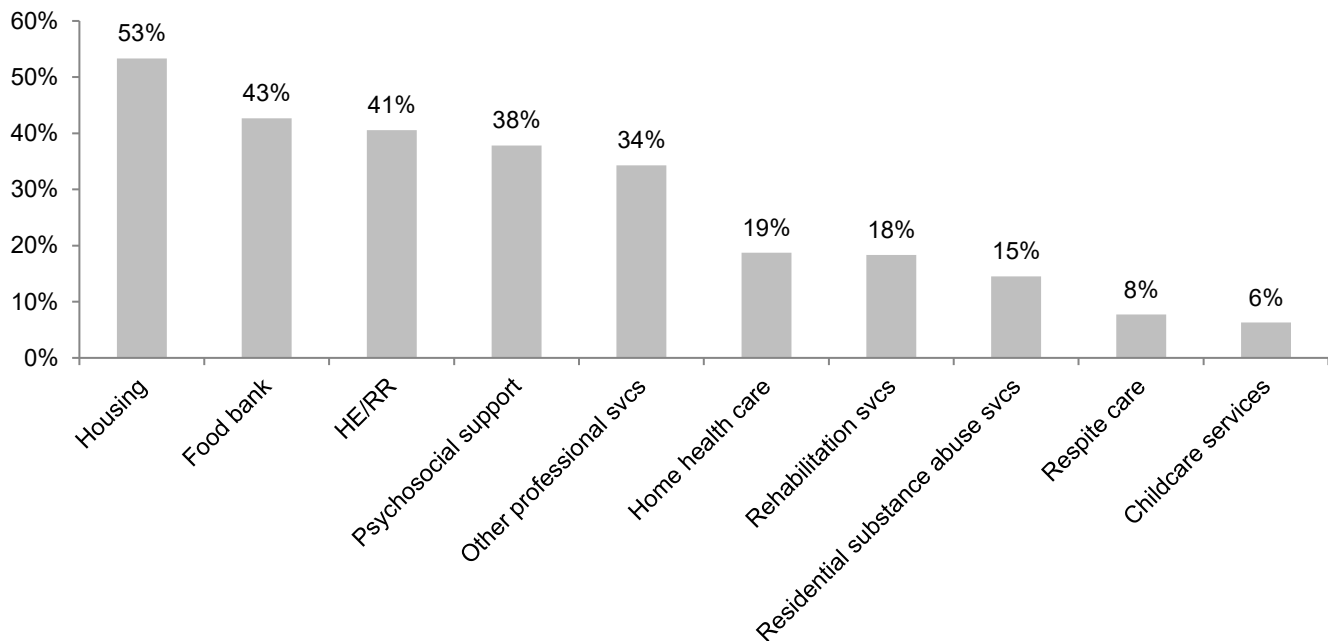
food bank at 43%, health education/risk reduction at 41%, psychosocial support services at 38%, and other professional services at 34%. Of participants indicating a need for food bank, 69% reported needing services from a food bank, 6% reported needing home delivered meals, and 25% indicated need for both types of food bank service. Among participants indicating a need for psychosocial support services, 89% reported needing an in-person support group, 3% reported needing an online support group, and 8% indicated need for both types of psychosocial support.

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

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

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

Denominator: 569-572 participants, varying between service categories



Overall Ranking of Unfunded Services, by Accessibility

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

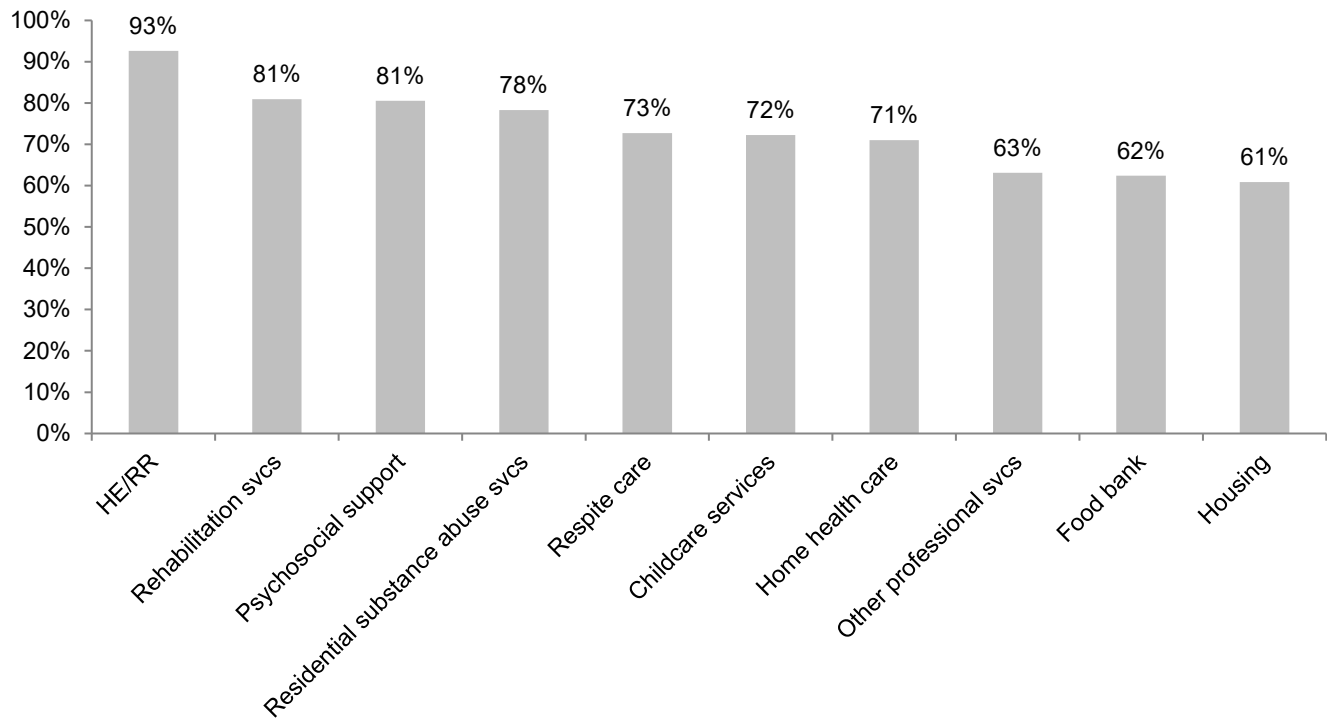
(Graph 5) The most accessible unfunded service was health education/risk reduction at 93% ease of access, followed by rehabilitation services at 81%,

psychosocial support services at 81%, residential substance abuse services at 78%, and respite care at 73%. The least accessible needed unfunded services was housing at 61%. Home health care had the highest accessibility ranking of any core medical service, while rehabilitation services received the highest accessibility ranking of any support service.

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

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

Denominator: 569-572 participants, varying between service categories



Other Identified Needs

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

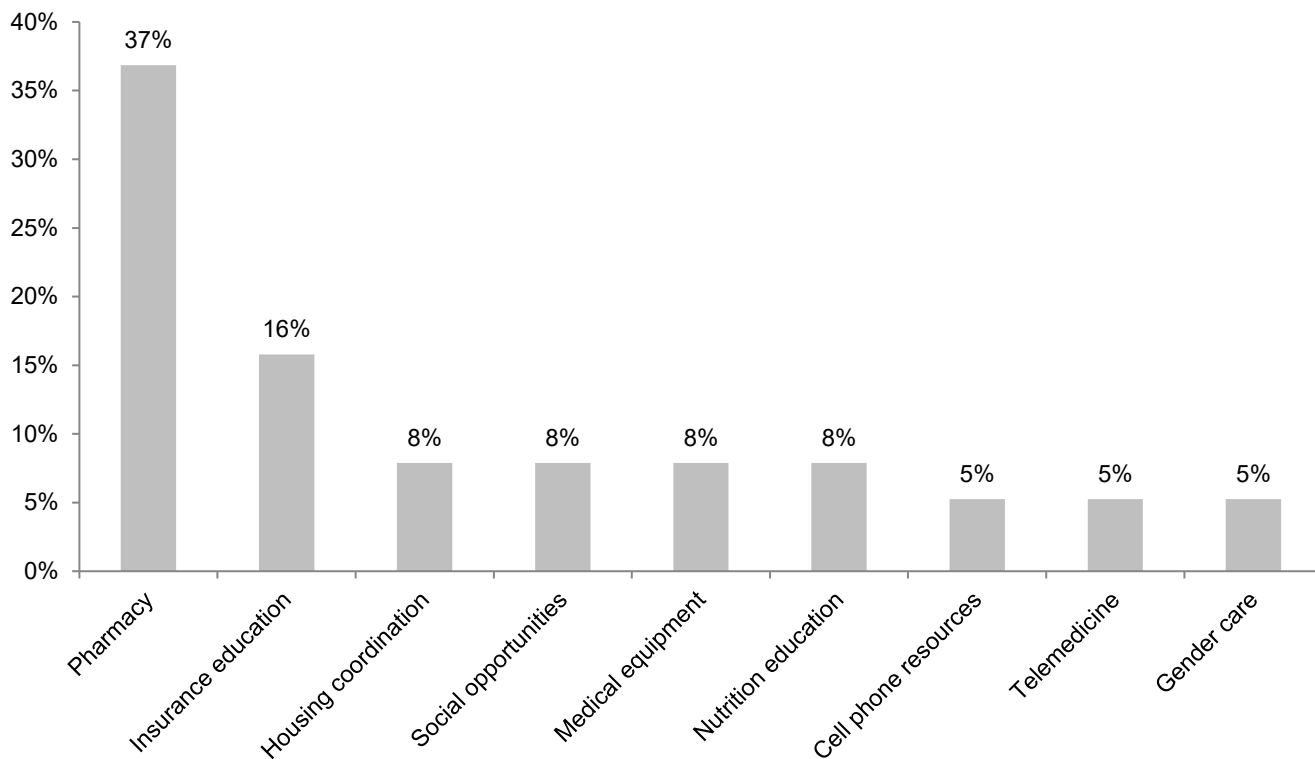
(Graph 6) Participants identified nine additional needs not otherwise described in funded and unfunded

services above. The most common identified needs related to pharmacy, such as having medications delivered and automatic refills, at 37%. This was followed by insurance education at 16%, and housing coordination, social opportunities, coverage for medical equipment, and nutrition education, each at 8%.

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

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

Denominator: 38 write-in responses





Chapter 3: Needs Across the HIV Care Continuum

HIV CARE CONTINUUM

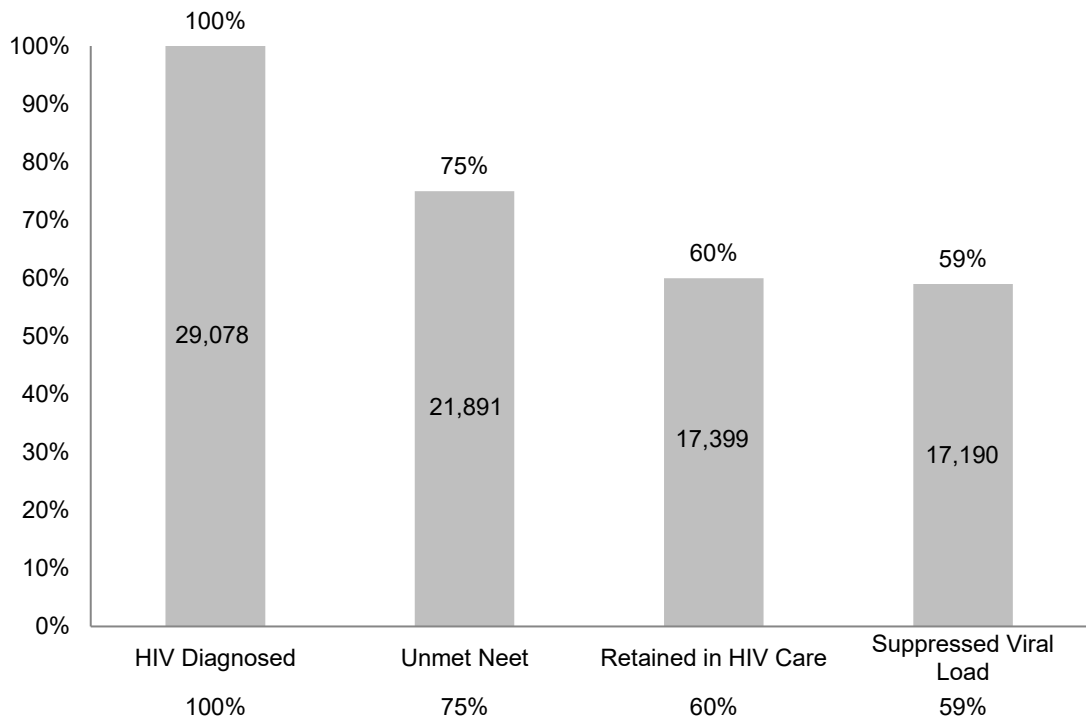
In July 2012, the Centers for Disease Control and Prevention (CDC) released an analysis of the number and percentage of people in the U.S. at each stage of the HIV care continuum originally developed by Gardner et al (2011). The continuum represents the sequential stages of HIV care – from being diagnosed to suppressing the virus through treatment. This analysis is now commonly referred to as the *HIV care continuum* and, in July 2013, the White House launched a national initiative to expand and accelerate efforts along each stage of the continuum.

HIV care continua that incorporate local data allow communities to evaluate the extent to which national and local goals related to increasing HIV awareness, linkage to care, and viral load suppression are being met or exceeded. This model is also useful for identifying local prevention and care service gaps, and targeting efforts to bridge each stage of the continuum.

Engagement in Care in the Houston Area

(Graph 1) Each year, the Houston Area HIV Care Continuum (HCC) is updated using local epidemiological data. Several questions included in the 2020 Houston HIV Care Services Needs Assessment assess barriers to engagement at certain points along the HIV care continuum. The first stage of the HCC was explored in the needs assessment through analysis of diagnosis locations and years. Linkage to care and met need were evaluated through services and materials provided at diagnosis, as well as encountered barriers to timely linkage. Retention was addressed through investigating causes for lost to care and falling out of care. As the defining component of achieving viral suppression, motivations among participants not currently taking antiretroviral medication are assessed at the end of this chapter. Findings from two focus groups conducted with service linkage and outreach workers are presented in this chapter to contextualize issues surrounding timely linkage and effective retention in HIV care.

GRAPH 1-Houston Area HIV Care Continuum, 2018
Denominator: 29,078 diagnosed PLWH in the Houston EMA



Data represented for PLWH in the Houston EMA between 1/1/2018 and 12/31/2018.
HIV Diagnosed: No. of HIV-diagnosed people, and residing in the Houston EMA, 2018. Source: Texas eHARS
Met Need: No. (%) of PLWH in Houston EMA with met need (at least one: medical visit, ART prescription, or CD4/VL test) in year. Source: Texas DSHS HIV Unmet Need Project (incl. eHARS, ELR, ARIES, ADAP, Medicaid, private payer data)
Retained in HIV Care: No. (%) of PLWH in Houston EMA with at least 2 medical visits, ART prescriptions, or CD4/VL tests in year, at least 3 months apart
Suppressed Viral Load: No. (%) of PLWH in Houston EMA whose last viral load test of the year was ≤ 200 copies/mL. Source: Texas ELRs, ARIES labs, ADAP labs

TESTING AND DIAGNOSIS

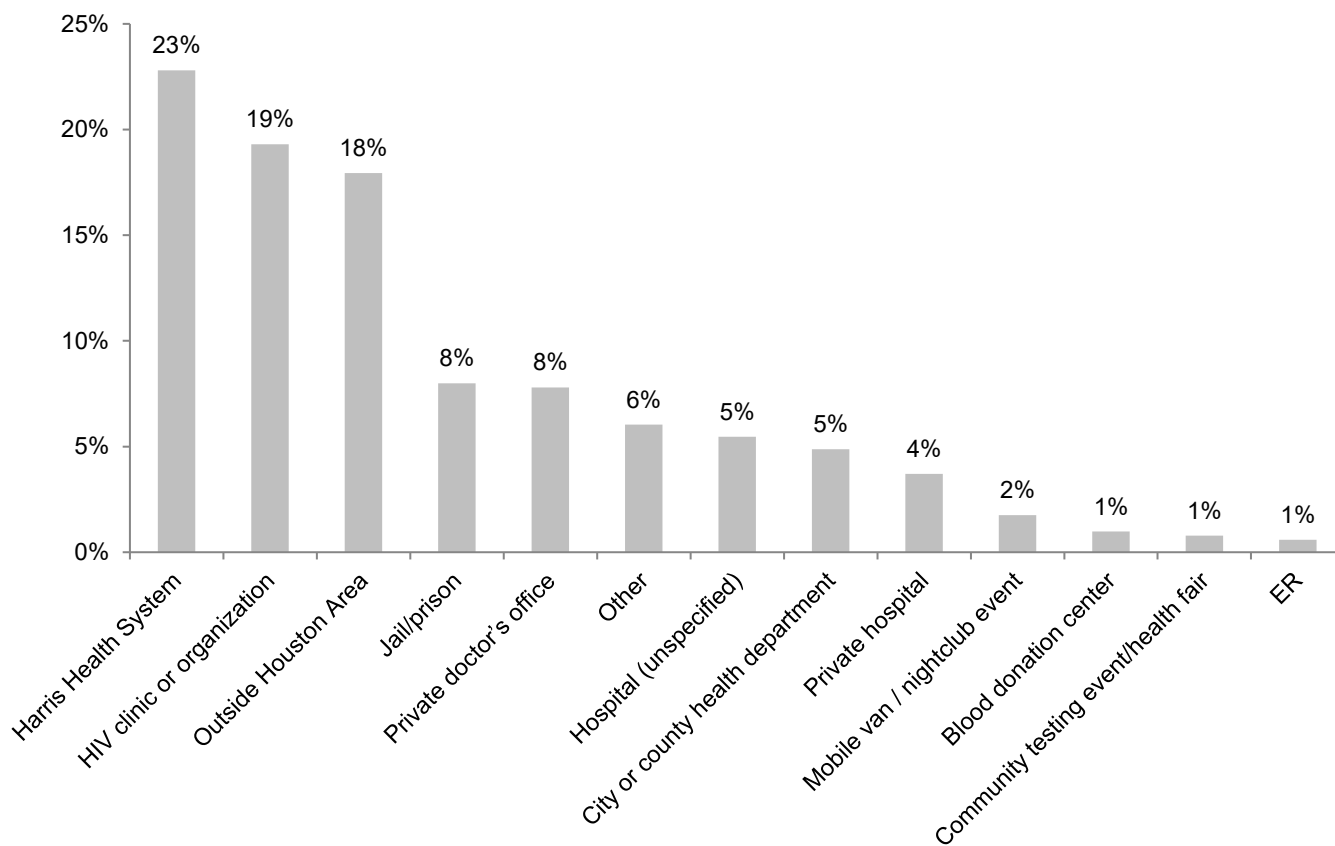
The 2020 Houston HIV Care Services Needs Assessment asked participants to share information from when they were first diagnosed, including when and where they were diagnosed. This information helps identify effective locations for HIV testing in the Houston Area toward the goal of increasing the proportion of PLWH who are aware of their status.

HIV Testing Location

(**Graph 2**) The most common location for being diagnosed with HIV was a Harris Health System facility at 23%, followed by receipt of diagnosis at an HIV clinic or organization (19%), outside the Houston area (18%), jail or prison (8%), or a private doctor's office or clinic (8%). At 1% each, blood donation centers, community testing events/health fairs, and emergency rooms were cited least often.

GRAPH 2-Locations of HIV Diagnosis for PLWH in the Houston Area, 2020

Definition: Percent of times each type of location was reported as the location where participants were first diagnosed with HIV. Denominator: 513 participants



Year HIV Diagnosed

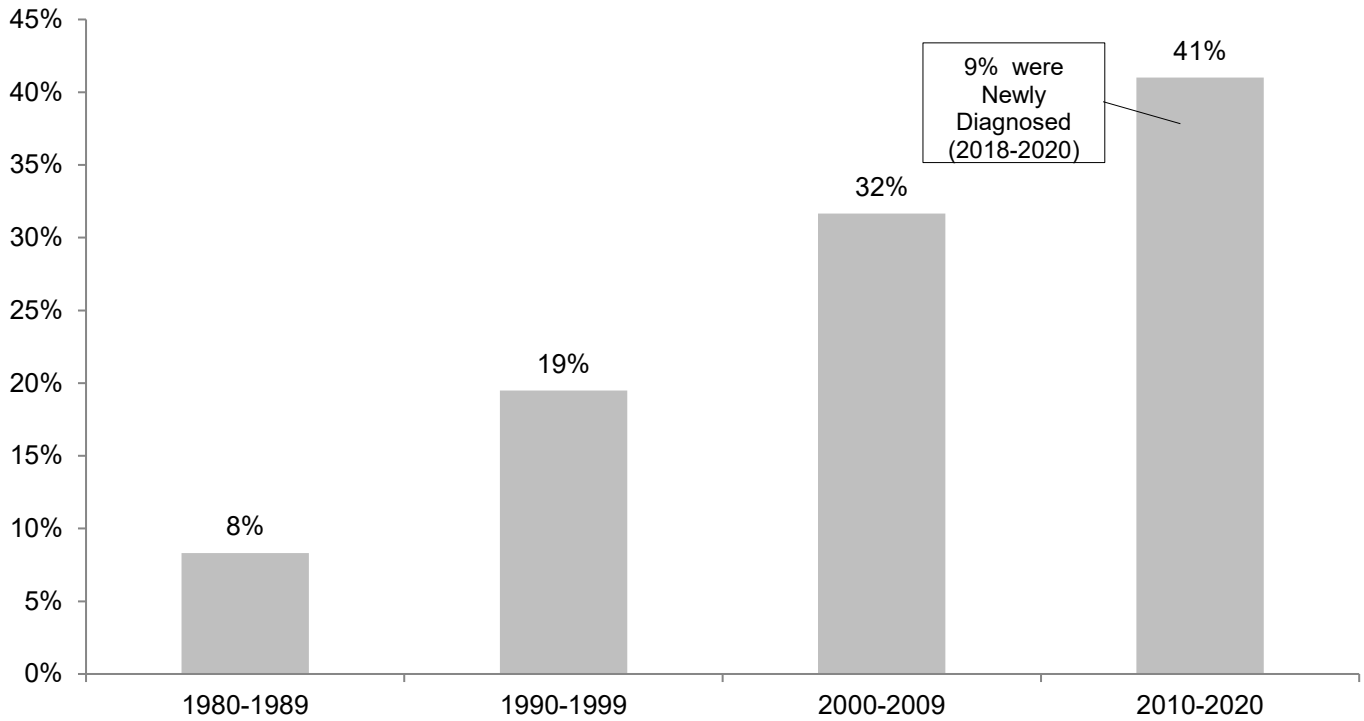
(Graph 3) The average length of time since HIV diagnosis among needs assessment participants was 13 years. More participants were diagnosed between 2010 and 2020 than any other period. Newly diagnosed

participants (diagnosed 2018-2020) comprised 9% of the sample, while recently diagnosed participants (diagnosed 2014-2020) made up 24% of the sample.

GRAPH 3-Year of HIV Diagnosis for PWLH in the Houston Area, 2020

Definition: Percent of participants who were first diagnosed with HIV in each time period.

Denominator: 562 participants



LINKAGE TO CARE

The 2020 Houston HIV Care Services Needs Assessment asked participants about initial entry into HIV care following diagnosis. Information on linkage to care for newly diagnosed individuals can help communities identify strategies to make linkage to HIV care timely and effective for promoting retention in care and viral suppression. Linkage to care information also helps communities identify gaps that result in delayed entry into care as well as potential solutions for bridging linkage gaps with HIV services.

Notes: Most (59%) participants were diagnosed prior to 2010 and the introduction of proactive service linkage efforts such as Service Linkage Workers. Service linkage activities and barriers to timely linkage are discussed for recently diagnosed participants (diagnosed 2014-2020) only in **Graph 4** and **Graph 5**.

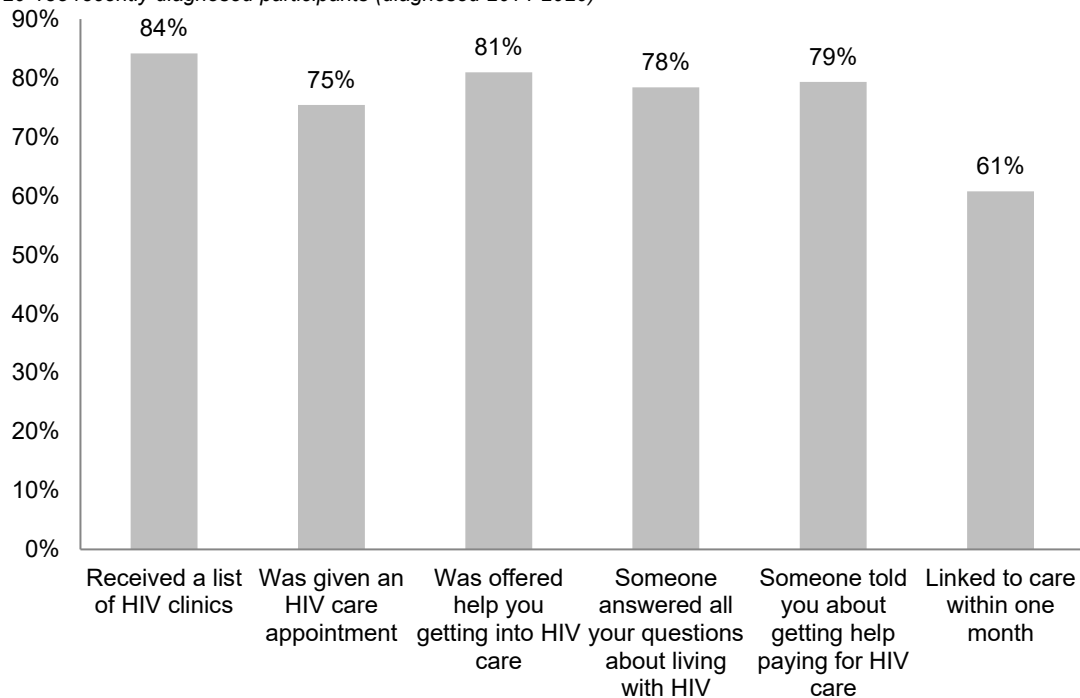
Linkage Services at Diagnosis

(**Graph 4**) 61% of recently diagnosed needs assessment participants reported linkage to care within 1 month of diagnosis. For passive referral, 84% received a list of HIV clinics at the time of diagnoses, while 75% were given their first HIV care appointment. For active linkage to HIV care, 81% of recently diagnosed participants were offered help getting into HIV medical care, 78% has someone answer all of their questions about living with HIV, and 79% had someone inform them about resources to help pay for their HIV medical care. Reported linkage to care mirrors epidemiological data show for the Houston EMA. According to those data (generated by the Texas Department of State Health Services), 60% of persons in the Houston EMA were linked to care within 1 months of diagnosis (2018).

GRAPH 4-Service Linkage Activities Received at the Time of HIV Diagnosis in the Houston Area, 2020

Definition: Percent of recently diagnosed needs assessment participants who received each of type of linkage service at the time of diagnosis.

Denominator: 120-135 recently diagnosed participants (diagnosed 2014-2020)

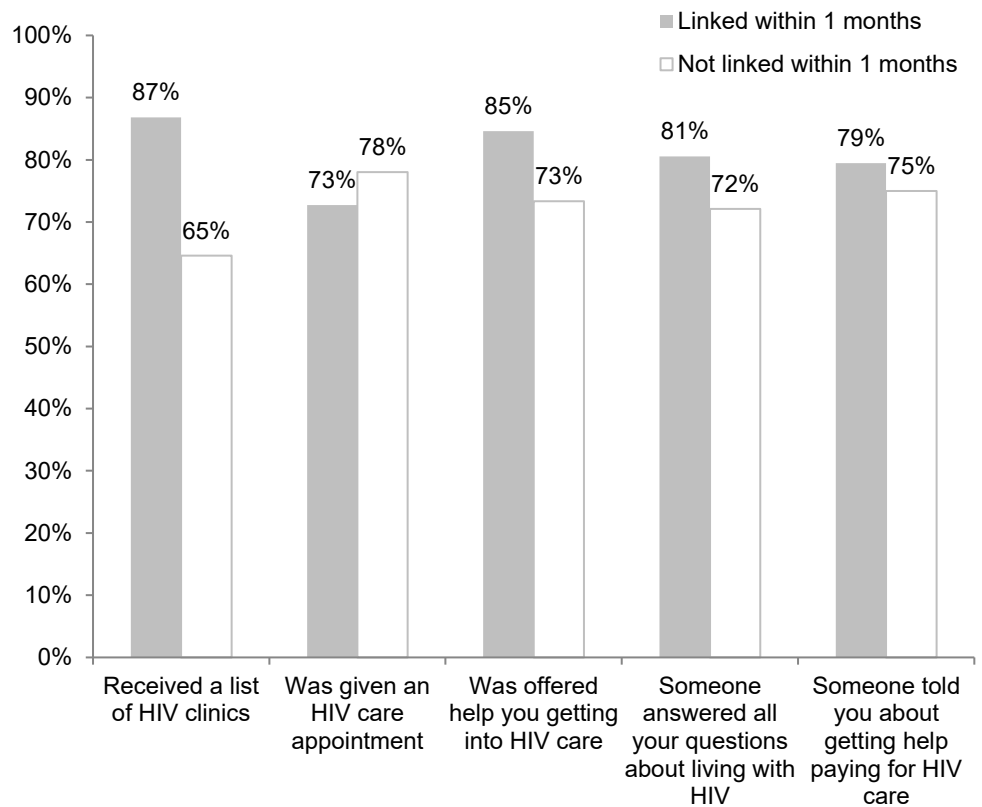


(Graph 5) Receipt of passive referral and active linkage activities appears to be positively associated with early linkage to care: 87% of those who linked to care within 1 month received a list of HIV clinics at the time of diagnosis, compared to only 65% of those not linked to care within 1 month. This association was also observed for being offered help getting into HIV care (85% v. 73%), having someone answer questions about living with HIV (81% v. 72%) and having someone mention resources to help pay for HIV care (79% v. 75%).

GRAPH 5-Service Linkage Activities Received at the Time of HIV Diagnosis in the Houston Area, by Linkage Timeframe, 2020

Definition: Percent of linked and non-linked recently diagnosed needs assessment participants who received each type of linkage service at the time of diagnosis.

Denominator: 82 participants linked within 1 month; 53 participants not linked within 1 month



Barriers to Early Linkage

(Graph 6) All participants who delayed entry into HIV care for more than 1 month after diagnosis were asked the reasons for delayed entry. Thirteen commonly reported barriers were provided as options in the survey, participants could select multiple reasons for delayed entry, and participants could write in their reasons.

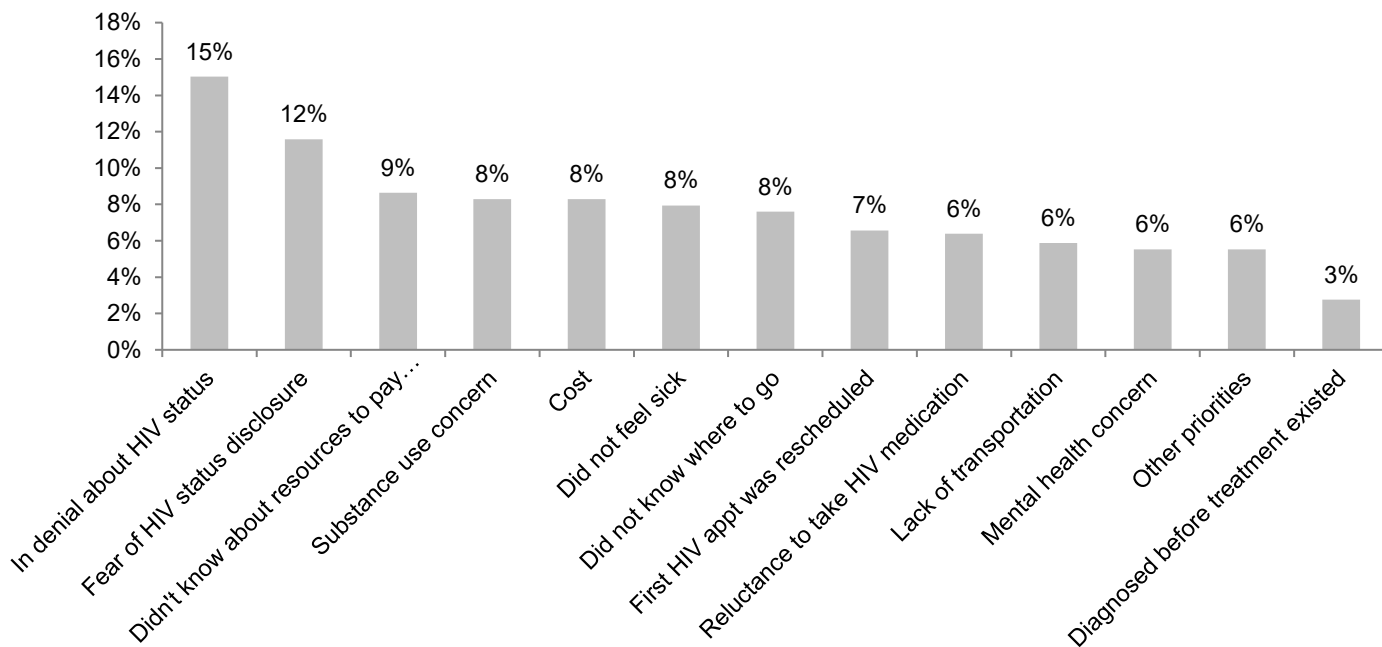
Of the 13 options provided, denial about HIV status was selected most often at 15% of all reasons reported.

This was closely followed by fear of HIV status disclosure (12%), and not knowing about available resources to pay for HIV medical care (19%). The most common write-in reason for delayed entry was incarceration at time of diagnosis. One participant mentioned that they were diagnosed while incarcerated, but had to wait longer than one month after diagnosis to see a doctor for HIV.

GRAPH 6-Reasons for Delayed Linkage to HIV Care in the Houston Area, 2020

Definition: Percent of times each item was reported by needs assessment participants as the reason they were not linked to HIV care within 1 months of diagnosis.

Denominator: 579 reports of reasons for delayed linkage to care



Awareness of Available Services

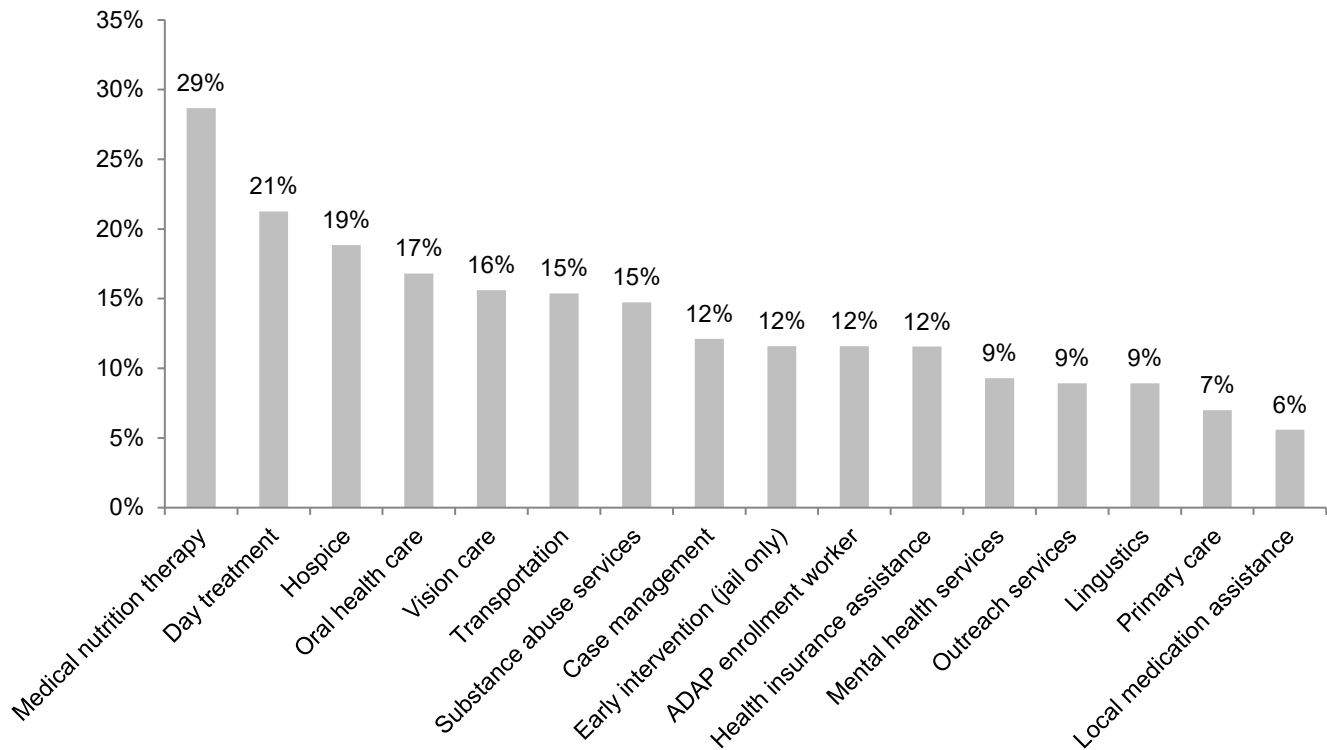
Education and awareness issues present a longstanding barrier to timely linkage to care in the Houston EMA. In particular, lack of awareness that a service exists or is available remains one of the most commonly cited reasons PLWH in the Houston Area do not access a needed service. The 2020 Houston HIV Care Services Needs Assessment survey asked participants to indicate if they did not know a funded

service was available at the time of survey. Results for this question are discussed below.

(**Graph 7**) Medical nutrition therapy had the highest proportion of participants who were unaware that it was an available service at 29% of participants surveyed. This was followed by day treatment (21%), hospice (19%), oral health care (17%), and vision care (16%).

GRAPH 7-Ranking of HIV Services in the Houston Area, By Service Unawareness, 2020

*Definition: Percent of needs assessment participants stating they did not know the service was available.
Denominator: 569-573 participants, varying between service categories*



Findings from Service Linkage Worker

Focus Group

The role of service linkage workers per the Houston EMA Ryan White Part A service category definition is to “assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated” when clients do not require the intensity of Medical Case Management interventions.¹ The ultimate goal of service linkage is to successfully link new and out of care clients to HIV medical care, and provide referrals to needed services to help facilitate this linkage. In June 2019, staff conducted a focus group with five service linkage workers and case managers providing service linkage to provide context for the service linkage process. On average, the focus group participants carried a 30 client caseload, though some service linkage workers reported serving up to 45 clients at any given time. The results of this focus group are examined below by prompt.

“Which services do service linkage clients need most? Are there any needed services that do not currently exist in the Houston area?”

- Immediate housing according to the Housing First approach
- Mental health and re-entry support groups
- Adult Day treatment
- Staff that resemble clients demographically to build trust. [Public clinic] clients have difficulty accessing services only offered at [Federally-Qualified Health Centers and mental health providers] because the staff do not resemble them.
- Phone cards to refill minutes and/or pre-paid phones to help establish in care. It is very challenging to link to care someone with no phone or no minutes
- A more user-friendly statement of income process

“Why do clients have trouble linking to care or fall out of care? What facilitates clients returning to care?”

- Reasons for not linking or falling out of care
 - Lack of transportation
 - Substance use disorder
 - Feeling well
 - Moving/relocating
 - Becoming undetectable (“Clients return to care when they begin to feel sick again.”)

- Having to choose between work or getting care
- ADAP and Ryan White renewal processes are too burdensome for clients
- Frequent phone number changes
- Concerns that using Ryan White or other services will negatively impact the immigration process
- Young MSM have a particularly tough time linking or staying in care; consider redefining young adult services to include up to 28 or 30 years of age
- Reasons for linking or returning to care:
 - Feeling sick or getting sick more often
 - Release from incarceration
 - Acceptance of positive HIV status
 - Having a history or established relationship with their doctor

“What are some of the biggest barriers to care for clients?”

- When providers do not fully understand or have regard for social situations/issues. Service linkage and case management staff end up providing counseling they are not equipped for and cannot bill for.
- Cultural humility/cultural competency issues and the need to learn from/accommodate a variety of clients
- Transportation issues
 - Need an option of Uber/Lyft. People under 25 are reluctant to ride Metro and trips are typically cheaper than taxi rides. This would also reduce missed appointments. Concierge/Healthcare services with ridesharing companies could help.
 - Mobile clinics for clients experiencing homelessness to receive labs and care
 - Wider availability of telemedicine/telehealth appointments

¹ Source: FY 2020 Houston EMA Ryan White Part A/MAI Service Definitions

RETENTION IN CARE

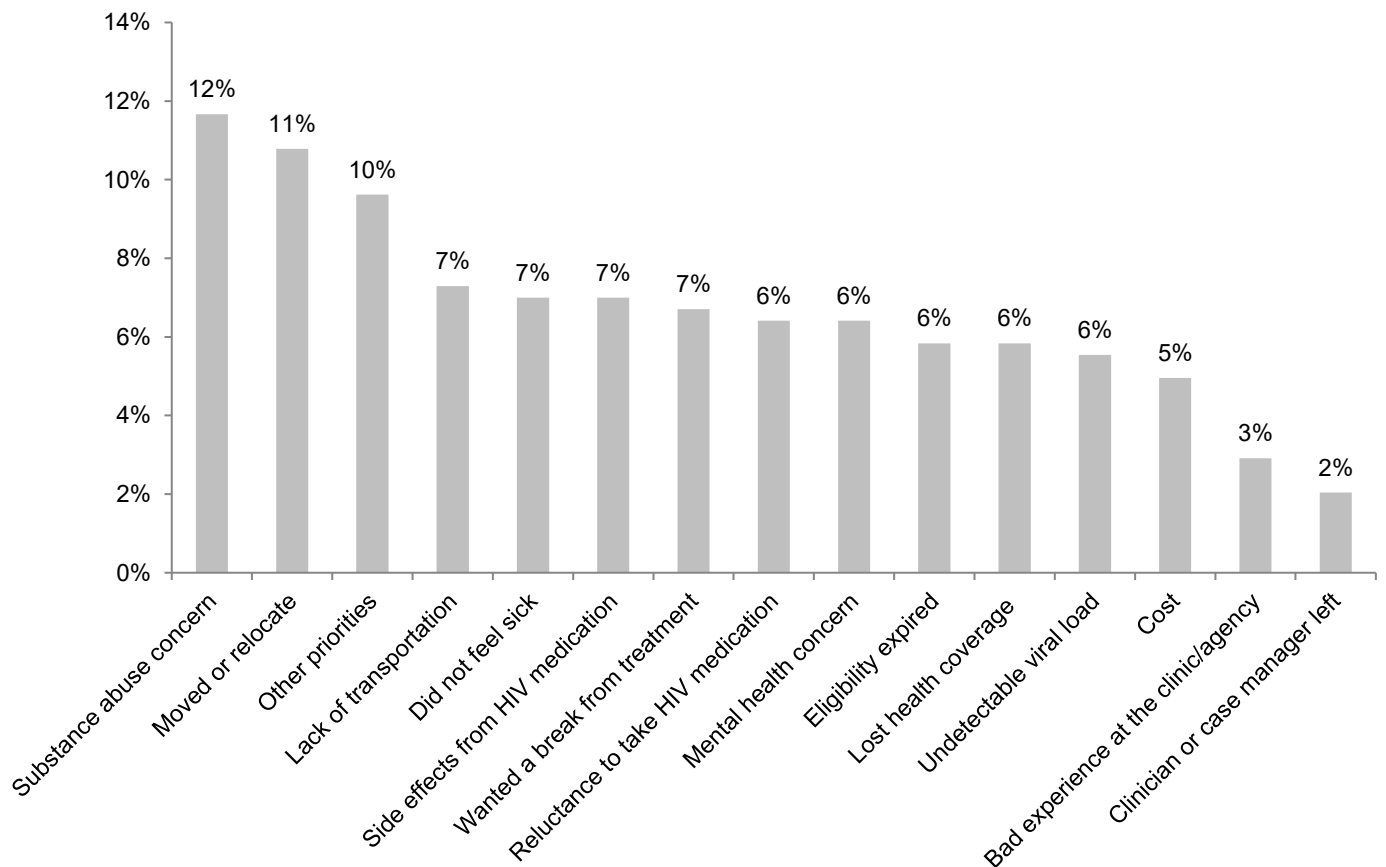
The 2020 Houston HIV Care Services Needs Assessment explored history of HIV care continuity since diagnosis to gather information about barriers to retention. These results help communities identify assets and effective strategies for increasing retention in care in the Houston Area. According to local epidemiological data (generated by the Texas Department of State Health Services), 75% of all diagnosed PLWH in the Houston EMA were in HIV care in the past 12 months, and 60% were retained in care throughout the year (2018). In contrast, 94% of survey participants had met need and 86% were retained in care. A more detailed profile of the 6% of PLWH who were out of HIV medical care at the time of survey is available in Chapter 5 of this document.

Barriers to Retention in Care

(Graph 8) 32% of needs assessment participants reported at least one interruption in their HIV care for 12 months or more since their diagnosis. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Fifteen commonly reported reasons were included as options in the consumer survey. Participants could also write-in their reasons. As in the 2016 Needs Assessment cycle, substance abuse concerns selected most often at 12% of all reasons reported. This was followed by moving or relocating (11%), and having other priorities at the time. The most common write-in reason for falling out of care were fear or stigma, and inability to take time of work to attend appointments.

GRAPH 8-Reasons for Falling Out of HIV Care in the Houston Area, 2020

Definition: Percent of times each item was reported by needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.
Denominator: 343 reasons for falling out of care reported



Communication with HIV Medical Providers

The 2020 Houston HIV Care Services Needs Assessment survey included several new questions to evaluate communication with medical providers as potential supports for or barriers to retention in care. These questions addressed preferred method of communication compared to communication with medical providers, use of plain language when communicating healthcare information, and provider communication quality.

(Graph 9) Participants were asked to name their preferred methods of communication, and select any the ways in which their current HIV medical provider communicates with them from a list of six options provided. Participants also had the option to write in their own response if they did not see it listed, which yielded mail as a seventh communication method.

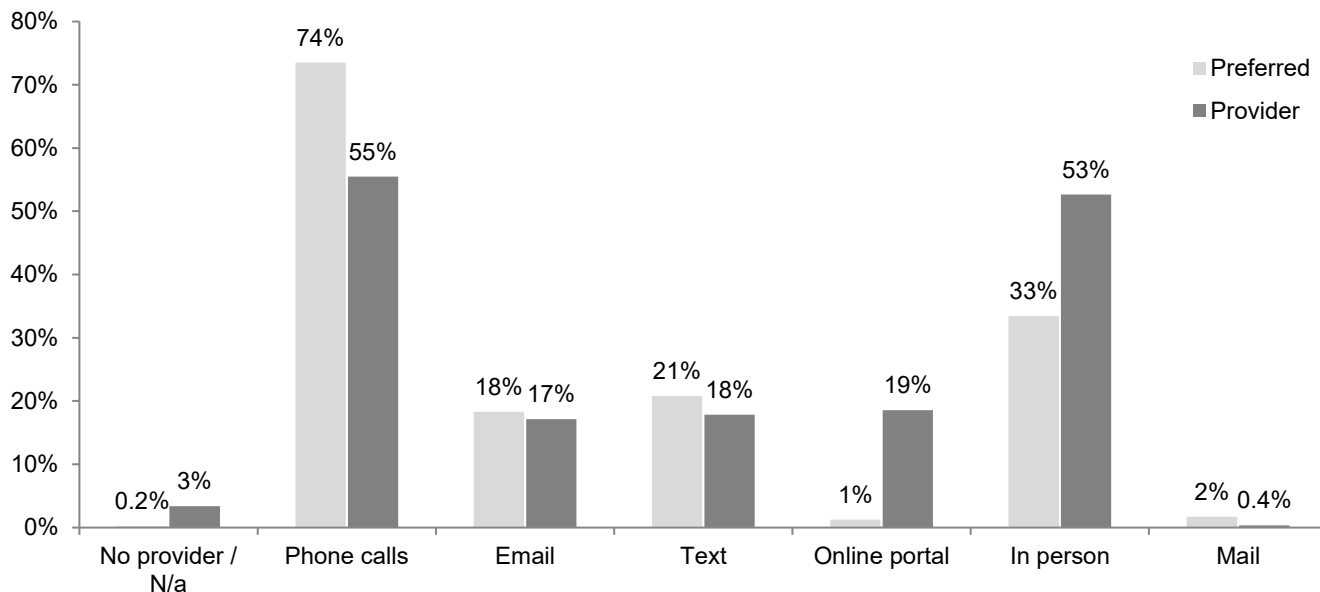
The most commonly reported preferred methods of communication were via phone call (74%), in person (33%), and via text message (21%). The most commonly reported methods of communication used by current medical providers were via phone call (55%), in person (53%), and via an online portal such as MyChart (19%).

The greatest variance between preferred methods of communication and those used by providers occurred among phone calls, in person communication, and online portals. Participants indicated preference for communicating via phone calls at 18 percentage points higher than their current provider’s communication via phone calls. Provider communication in person and via an online portal were reported at higher proportions than participant preferences (19 percentage points and 17 percentage points, respectively).

GRAPH 9-Comparison of Participant’s Preferred Method of Communication to Method Used by HIV Medical Providers, 2020

Definition: Percent of participants who indicated each preferred method of communication and each method used by their current medical provider.

Denominators: 404 participants for preferred method; 566 participants for provider method



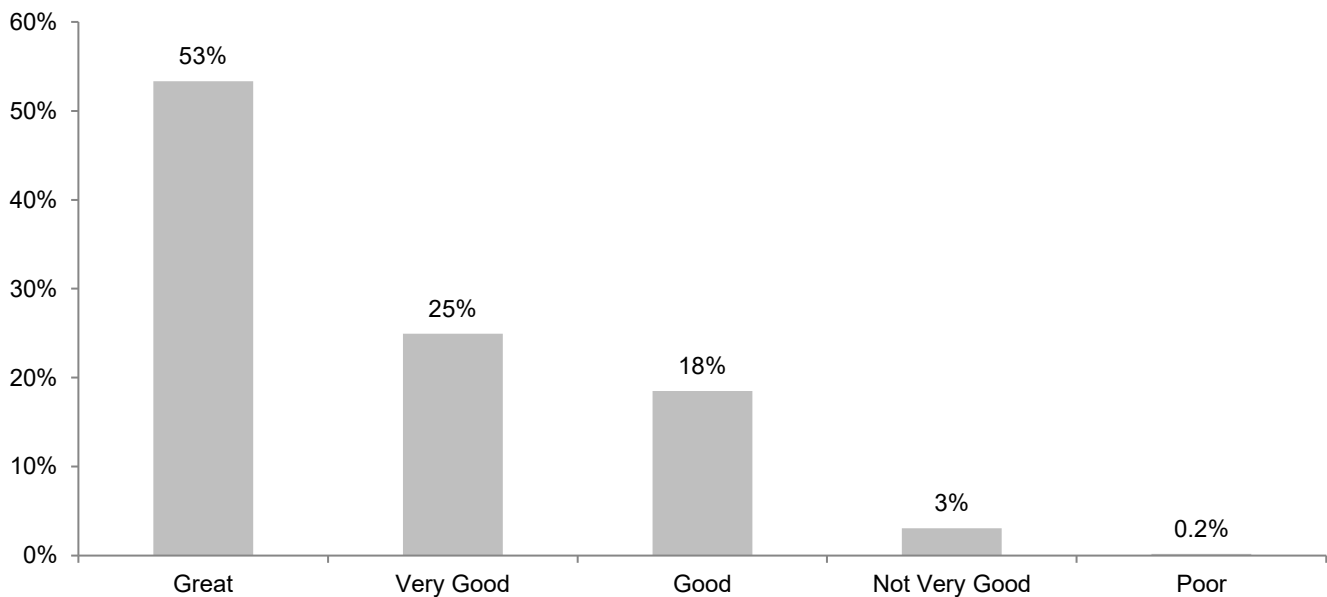
Participants were asked whether their HIV medical provider communicates information about their health in a way that is straightforward and easy to understand. Only 3% of participants (17 individuals) reported that their HIV medical provider does not communicate health information in a way that is straightforward and easy to understand.

(Graph 10) When asked to rate the overall quality of communication with their HIV medical provider on a 5-point scale from Poor/1 to Great/5, 53% of participants rated the communication as Great/5. The

average quality rating of communication with their HIV medical provider was Very Good/4. When communication was Poor/1, Not Very Good/2, or Good/3, participants were asked what could be changed to make communication with their HIV medical provider better. The most common suggestions for improving communication were for HIV medical providers to slow down and use plain language, listen to patient views and concerns, make online/telehealth options easier to use, and improve availability and consistency of provider schedule.

GRAPH 10-Rating of Communication Quality HIV Medical Provider, 2020

*Definition: Percent of participants who indicated each level of quality for communication with their current HIV medical provider.
Denominators: 557 participants*



Findings from Outreach Worker Focus Group

The role of outreach workers per the Houston EMA Ryan White Part A service category definition is to assist PLWH “who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies.”² Outreach services differs from service linkage and case management as the ultimate goal is to facilitate retention in care for PLWH who are out of care or identified as at-risk for falling out of care, as opposed to serving newly diagnosed or in care PLWH. In July 2019, staff conducted a focus group with eight outreach workers and outreach services managers to provide context for the outreach services process. On average, the focus group participants carried a 21 client caseload, though some outreach workers reported serving up to 30 clients at any given time. The results of this focus group are examined below by prompt.

“Which services do outreach services clients need most? Are there any needed services that do not currently exist in the Houston area?”

- Housing (especially for individuals with prior felonies or sexual offenses)
- Expanded access to mental health services for regular/maintenance counseling
- Gas cards for rural clients
- Grocery cards as clients miss medical appointments to attend food bank/meal resource dates
- Cell phones and cell phone minute cards

“Why do clients have fall out of care?”

- Transportation
 - Medicaid transportation is not timely (pick-ups arriving much earlier/later than stated)
 - Lack of awareness about Ryan White van-based transportation

- Clients have additional transportation needs and may use up Ryan White-issued bus cards before their appointment for survival. Outreach workers noted that for \$5 more a year, bus cards could provide unlimited rides and greatly increase retention in care.
- Issues establishing eligibility (ADAP/Ryan White/clinic-level) snowball into inability to receive services
- Difficulties with untreated substance use or mental health disorders can greatly reduce success with establishing and retaining eligibility.
- Panic/other priorities when there is a loss of housing or job. Outreach workers observed that out of care clients with this concern typically return to care when housing and employment are secure.
- Overall lack of information/communication
 - Frontline/eligibility staff turning people away with incorrect information
 - Communication difficulties within organizations
 - Lack of knowledge of Ryan White services not provided at other sites
 - Need for better/more regular communication between case managers, service linkage workers, and outreach staff

“What facilitates or motivates clients returning to care?”

- Establishing housing and/or employment
- Feeling ill makes care more urgent
- Having a strong and sustained support system
- Desired improvements in immigration status
- Establishing health insurance
- Need for other/non-HIV services
- Around August and September when children return to school and parents’ schedules become more flexible
 - Outreach workers observed this along with a drop off in care in November through January for holidays
- Seeking treatment for substance use disorder

² Source: FY 2020 Houston EMA Ryan White Part A/MAI Service Definitions

HIV MEDICATION

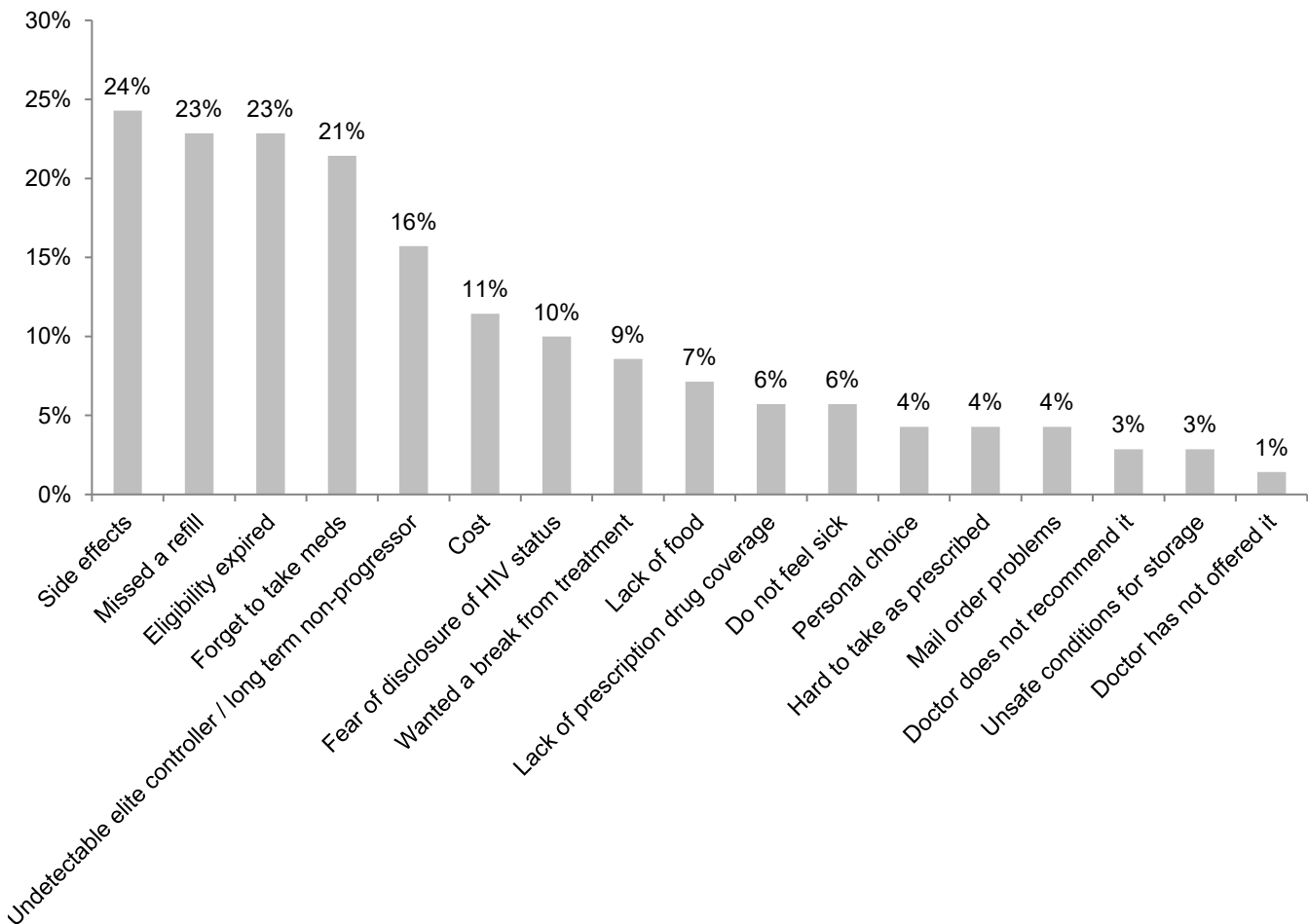
Barriers to HIV Medication

(Graph 11) Information on barriers to medication adherence helps communities design services to ensure HIV medication is available, accessible, and support viral suppression. Thirteen percent (13%) of participants reported they were not taking HIV medications at the time of survey. These participants were asked identify the reason they were not taking medication from a list of 17 commonly reported reasons for difficulty with medication adherence. Participants could also write in their response if they did not see it listed.

Of the 17 options provided, the reason selected most often at 24% of all reasons reported was experiencing medication side effects. This was closely followed by missing a refill (23%), expired eligibility (23%), forgetting to take medications (21%), and being undetectable as an elite controller or long-term non-progressor. The most common write-in reason for not taking HIV medications was difficulty swallowing or taking the medication.

GRAPH 11- Barriers to HIV Medication in the Houston Area, 2020

Definition: Percent of times each item was reported by needs assessment participants not taking HIV medication as the time of survey
Denominator: 70 participants who indicate not taking HIV medication at the time of survey





Chapter 4: Determinants of HIV Care

DETERMINANTS OF HIV CARE

The Social Determinants of Health Framework (**Figure 1**) serves as a place-based model for evaluating socioeconomic factors that influence health and health outcomes in a particular geographic area, such as a neighborhood, city, or service jurisdiction such as the Houston Eligible Metropolitan Area (**EMA**). Beginning at the top and moving clockwise, the five domains of this model are neighborhood and built environment, health and health care, social and community context, education, and economic stability. Each domain is comprised of a series related of social determinants of health. Per the U.S. Department of health and Human Services Office of Disease Prevention and Health Promotion's Healthy People 2020 goals, these social determinants are as follows.

Neighborhood and Built Environment – access to foods that support healthy eating patterns, crime and violence, environmental conditions, and quality of housing.

Health and Health Care – access to health care, access to primary care, and health literacy.

Social and Community Context – civic participation, discrimination, incarceration, and social cohesion.

Education - early childhood education and development, enrollment in higher education, high school graduation, and language and literacy.

Economic Stability – employment, food insecurity, housing instability, and poverty.

The 2020 Houston HIV Care Services Needs Assessment evaluated the ways in which participant experiences with health determinants like those referenced above influence participant health, risks, resources, and access to HIV services. The details of these conditions and experiences are described in the rest of this Chapter. These data help communities better understand the HIV care needs and patterns of PLWH in the Houston Area, as well as identify new or emerging areas of need related to HIV care.

FIGURE 1-The Social Determinants of Health Framework



Source: U.S. Dept of Health and Human Services
– Office of Disease Prevention and Health
Promotion – Healthy People 2020

CO-OCCURRING HEALTH CONDITIONS

The 2020 Houston HIV Care Services Needs Assessment asked participants if they had a current diagnosis of a physical health condition *in addition to* HIV. Options provided included common chronic diseases, age-related conditions, autoimmune disorders, and infectious diseases. Participants were also encouraged write in other conditions not listed. Overall, 76% needs assessment participants reported a current diagnosis of *at least one* co-occurring physical health condition, a 12 percent increase from the 68% of needs assessment participants reporting co-occurring conditions in 2016. This proportion was also positively associated with participant age, with 87% of participants age 50 and over reporting at least one co-occurring physical health condition, compared to 32% of participants age 18 to 24.

Notes: Mental health conditions were addressed separately from physical health conditions in the

survey, and those results are presented in the *Behavioral Health* section of this Chapter. Additionally, non-HIV sexually transmitted diseases (STDs) testing, diagnosis, and treatment are discussed in the *HIV Prevention Behaviors and Vulnerability* section of this Chapter.

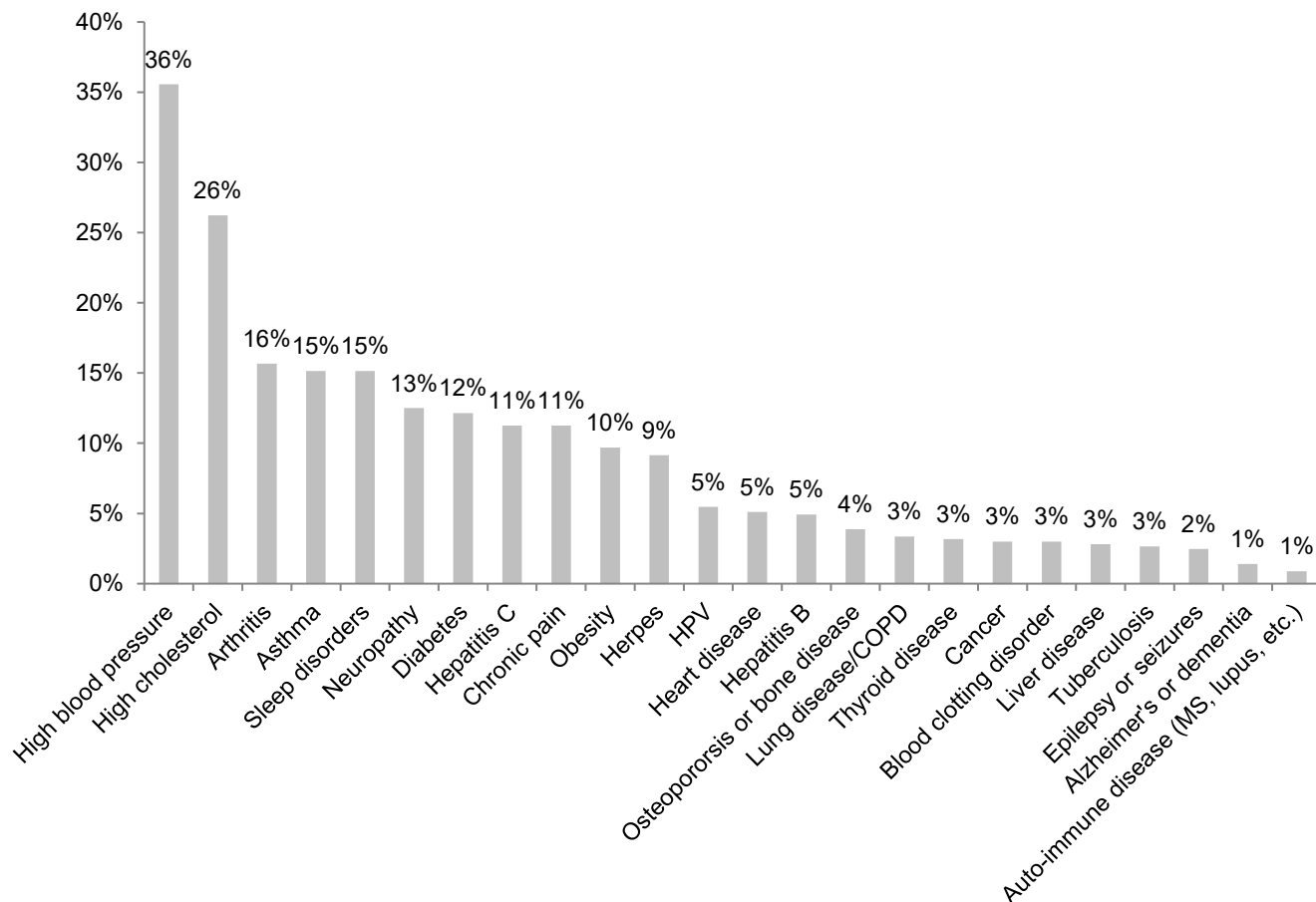
Chronic and Co-Occurring Conditions

(**Graph 1**) The most frequently reported chronic and/or co-occurring health condition was hypertension (36% of participants), followed by high cholesterol (26%), arthritis (16%) asthma (15%), and sleep disorders (15%). Among the 11% of participants with hepatitis C, 71% were receiving treatment. Among the 3% of participants with tuberculosis, 91% reported this as latent tuberculosis. The most common write-in chronic conditions included heart murmurs and degenerative joint disorders.

GRAPH 1-Chronic and Co-Occurring Disease among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants reporting a current diagnosis from a health professional of each medical condition in addition to HIV.

Denominator: 568 participants



BEHAVIORAL HEALTH

Behavioral health refers to the range of conditions related to or affecting mental or emotional well-being. It includes both diagnosed mental illness, indications of psychological distress, and substance use and misuse. The 2020 Houston HIV Care Services Needs Assessment asked participants about each of these behavioral health concerns including current mental health diagnoses, mental/emotional distress symptoms, and substance abuse. Each type is discussed in detail in this Chapter.

Mental Health Diagnoses

(**Graph 2**) Over half of needs assessment participants (54%) reported having a current *diagnosis* of at least

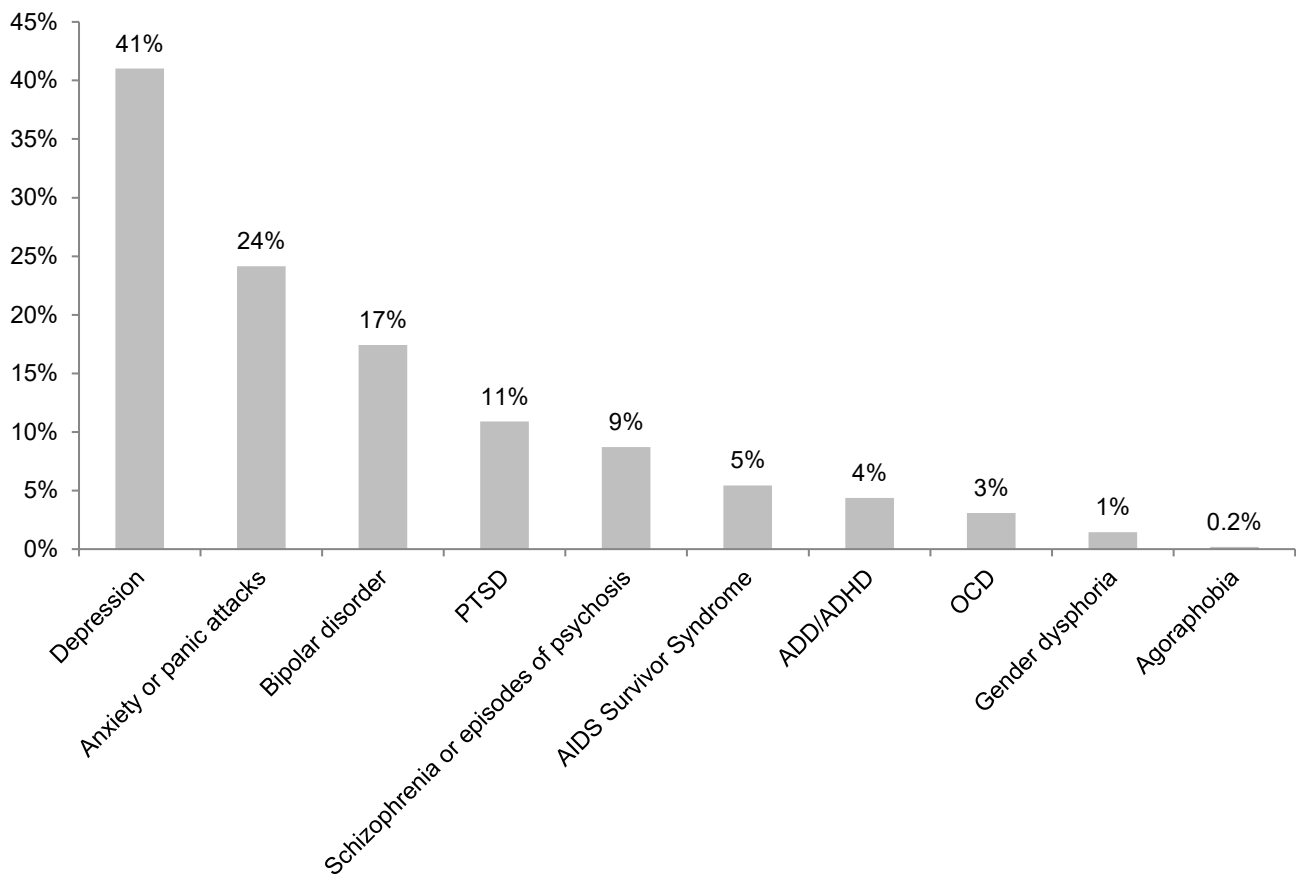
one mental health condition from among a provided list of common conditions, a 5% decrease from the 2016 needs assessment. By comparison, the National Institute of Mental Health reports that 19% of adults in the U.S. have a mental health diagnosis.³

The most frequently reported diagnosis was for depression at 41% of participants, followed by anxiety disorder or panic attacks (24%), bipolar disorder (17%), PTSD (11%), and schizophrenia or episodes of psychosis (9%). The most common write-in mental health diagnosis was borderline personality disorder.

GRAPH 2-Mental Health Diagnoses among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants reporting a current diagnosis from a health professional of each medical condition in addition to HIV.

Denominator: 551 participants



³ <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#>

Mental/Emotional Distress

(Graph 3) In addition to mental health diagnoses, participants were also asked if they had experienced any symptoms of mental/emotional distress in the past 12 months to such an extent that they desired professional help.

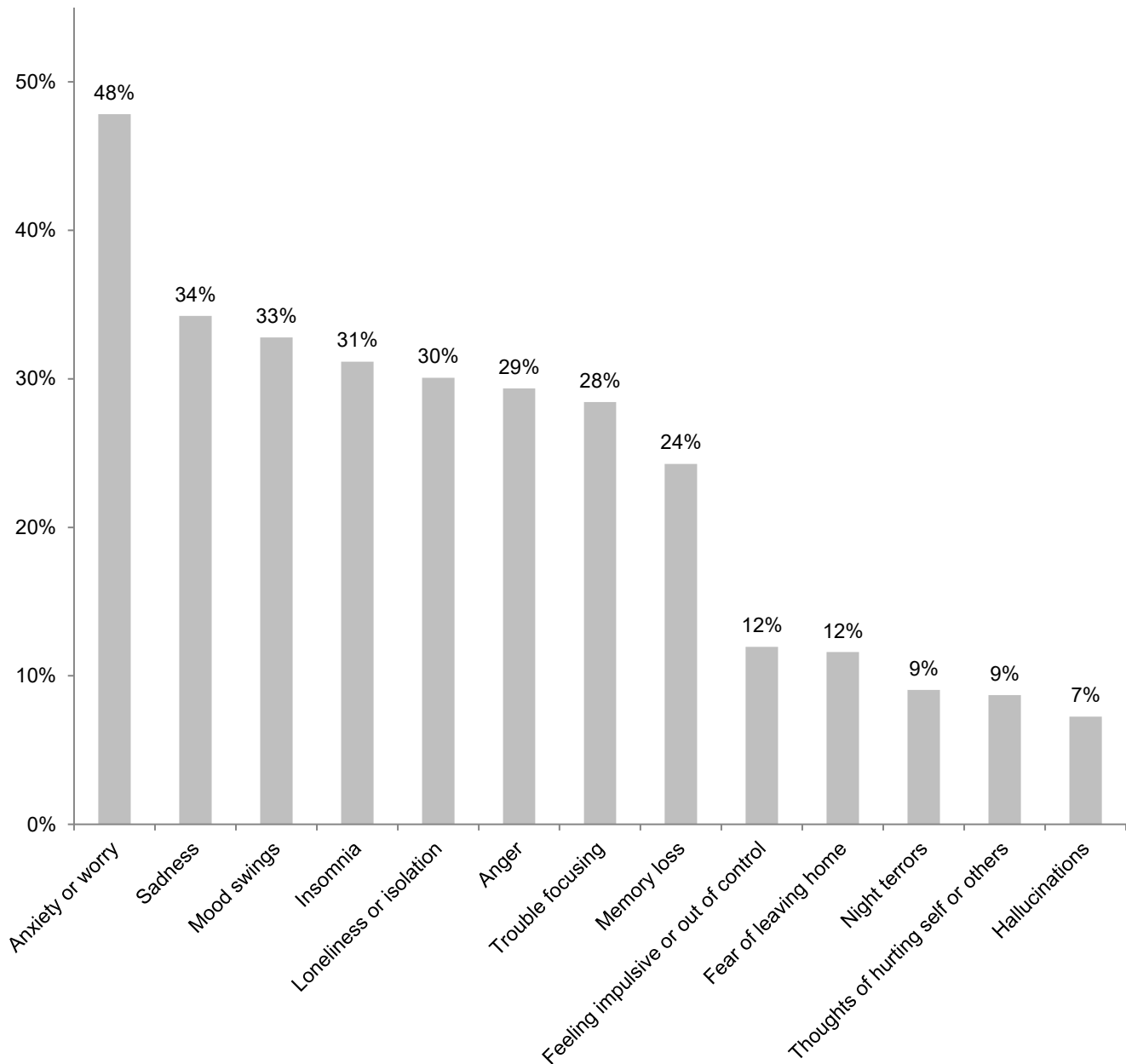
Overall, 69% of participants reported at least one such symptom, an increase of 6% from the 2020 needs

assessment. Of those listed, the most frequently reported was anxiety or worry (48% of participants), followed by sadness (34%), mood swings (33%), insomnia (31%), and loneliness or isolation (30%). No participants provided write-in mental/emotional distress symptoms.

GRAPH 3-Mental/Emotional Distress Symptoms among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants reporting having each of the following symptoms in the past 12 months to such an extent that they desired professional help.

Denominator: 552 participants



Social Support

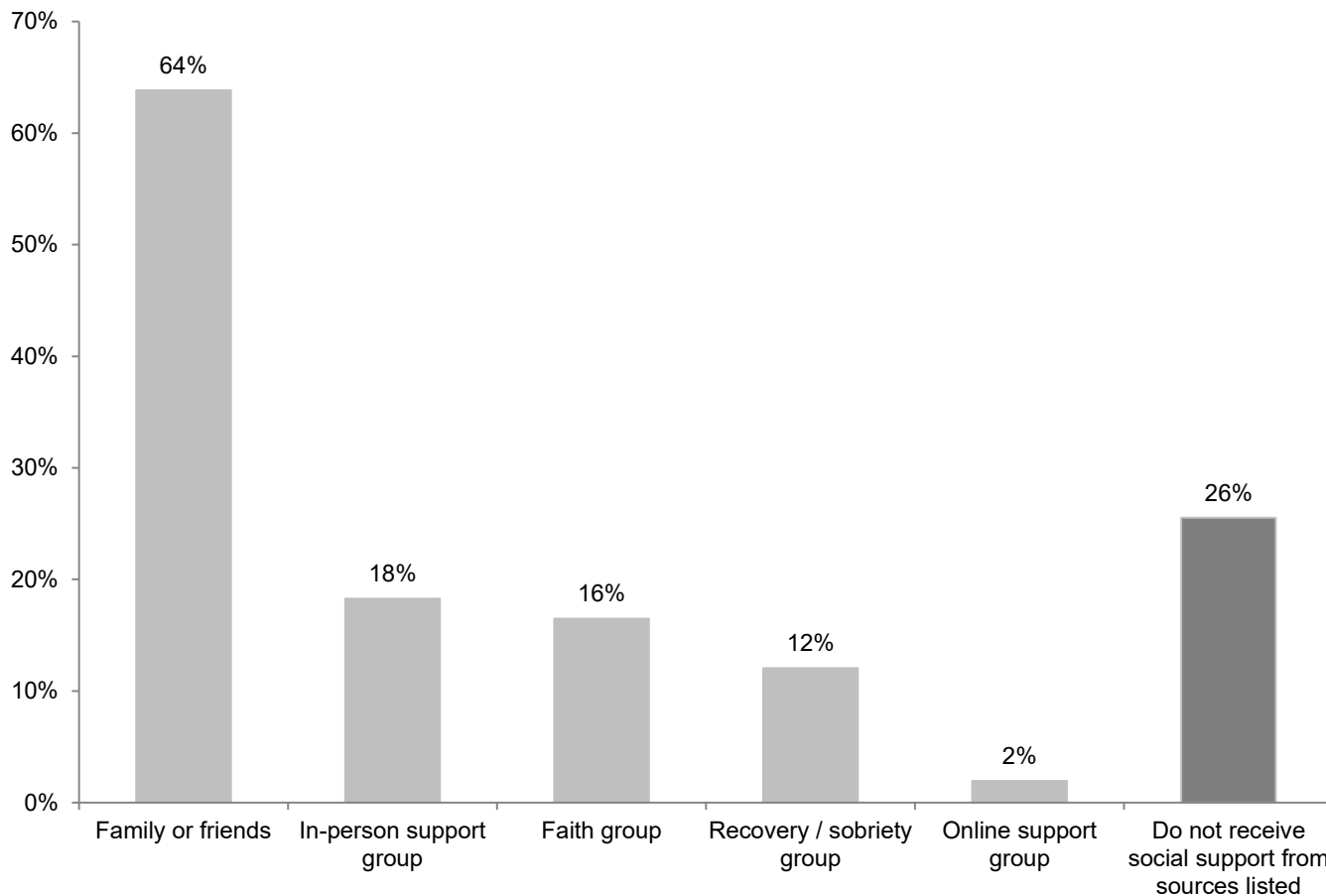
Participants were asked the sources of about social support they receive, described as, “when people or groups in your life provide emotional support, assistance, advice, and/or companionship.” Participants were asked to select from a list of five common sources of social support, or indicate that they did not currently receive any of the sources of social support listed.

(**Graph 4**) The most common source of social support was family or friends at 64% of participants. This was followed by in-person support groups (18%), faith groups (16%), recovery or sobriety groups (12%), and online support groups (2%). When asked to specify the types of online support groups used, the most common write-in responses were Facebook groups and The Posse Meetup group. An additional 26% of participants indicated that they did not receive social support from any of the sources listed.

GRAPH 4-Sources of Social Support among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants, who reported having various sources of social support.

Denominator: 564 participants



Substance Use

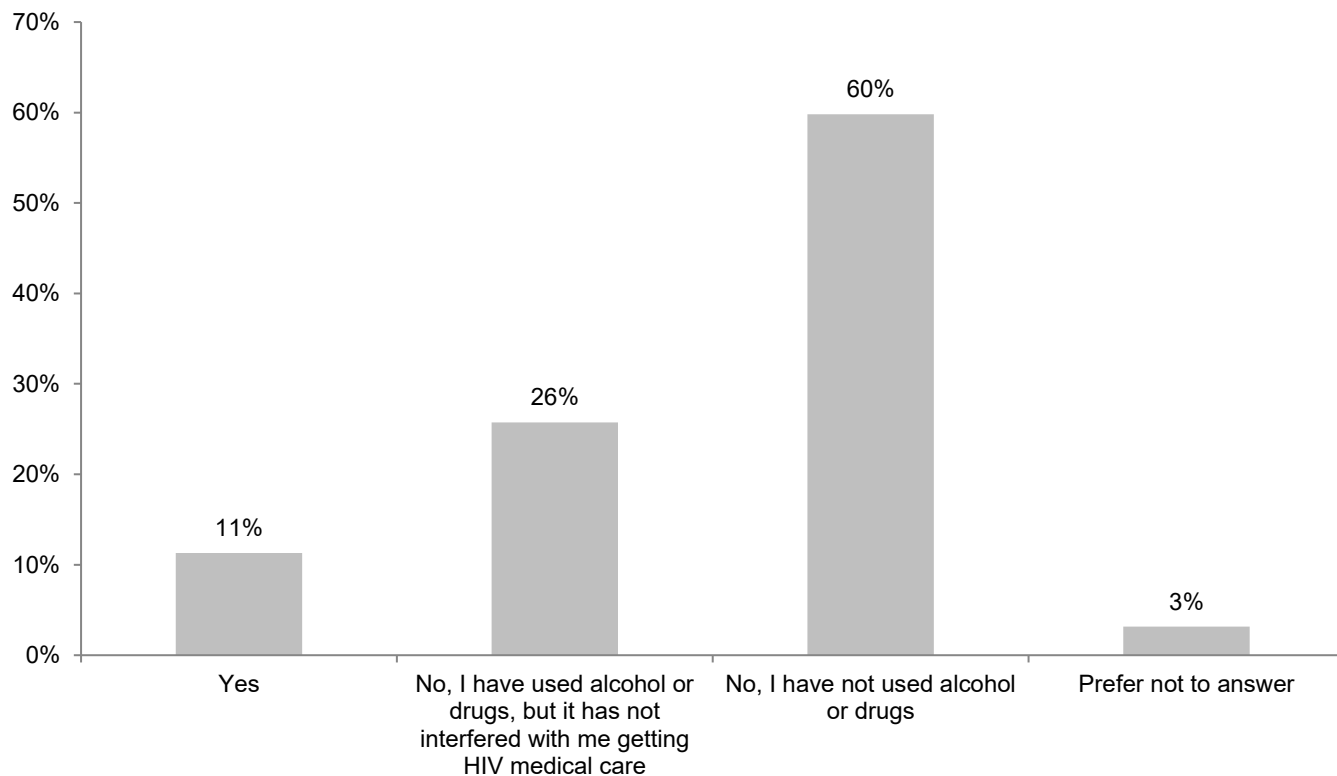
Participants were asked to indicate whether alcohol or drug use had interfered with the participant getting HIV medical care at any point in the past 12 months. Examples provided included alcohol or drug use that led to missing HIV medical appointments, having trouble taking HIV medications as prescribed, avoiding medical care for fear of legal issues, or fear telling an HIV doctor about alcohol or drug use. Those who indicated an alcohol or drug use barrier to care were then asked to select or write in the substance(s) that contributed to the barrier.

(Graph 5) A majority of participants (60%) reported no alcohol or drug use in the past 12 months. This was followed by 26% of participants who reported alcohol or drug use that did not interfere with accessing HIV medical care, and 11% who reported alcohol or drug use that interfered with HIV medical care. Of the 37% of participants who indicate some form of recent alcohol or drug use, nearly a third (30%) had alcohol or drug use that interfered with accessing HIV medical care.

GRAPH 5-Substance Use as a Barrier to Care among PLWH in the Houston Area, 2020

Definition: Percent of participants reporting substance use as a barrier to HIV Care in the past 12 months.

Denominator: 567 participants

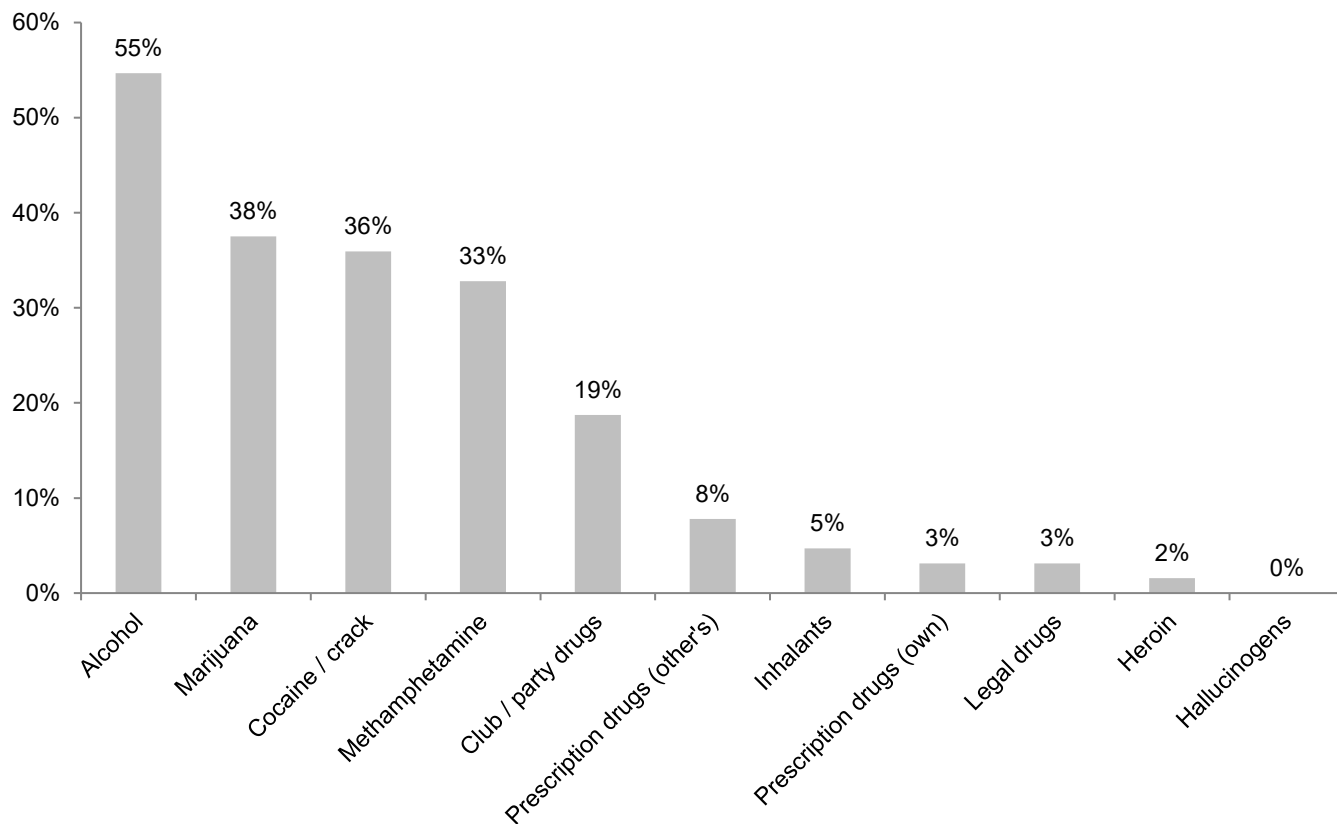


(**Graph 6**) Participants who indicated alcohol or drug use prevented access to HIV medical care in the past 12 months were asked to select which types of substances the participants used. Participants could select as many substances as applicable, and were encouraged to write in any substances used but not provided in the list. The most common substance

type used was alcohol among 55% of participants reporting substance use as a barrier to HIV medical care. This was followed by marijuana (38%), cocaine/crack (36%), methamphetamine (33%), and club or party drugs. No participants indicated hallucinogens as a barrier to care, and there were no substances written in.

GRAPH 6-Types of Substances Used as a Barrier to Care among PLWH in the Houston Area, 2020

Definition: Percent of participants reporting use of each type substance when use presented a barrier to HIV Care in the past 12 months. Denominator: 64 participants



SOCIO-ECONOMIC DETERMINANTS OF HEALTH

The social and economic circumstances of individuals can directly influence their health status and access to care. Factors such as employment, income, food insecurity, medical coverage, housing, and transportation may serve as gateways or barriers to health. These factors are often the underlying causes for health disparities in certain populations. The 2020 Houston HIV Care Services Needs Assessment asked participants about these social and economic circumstances.

Employment

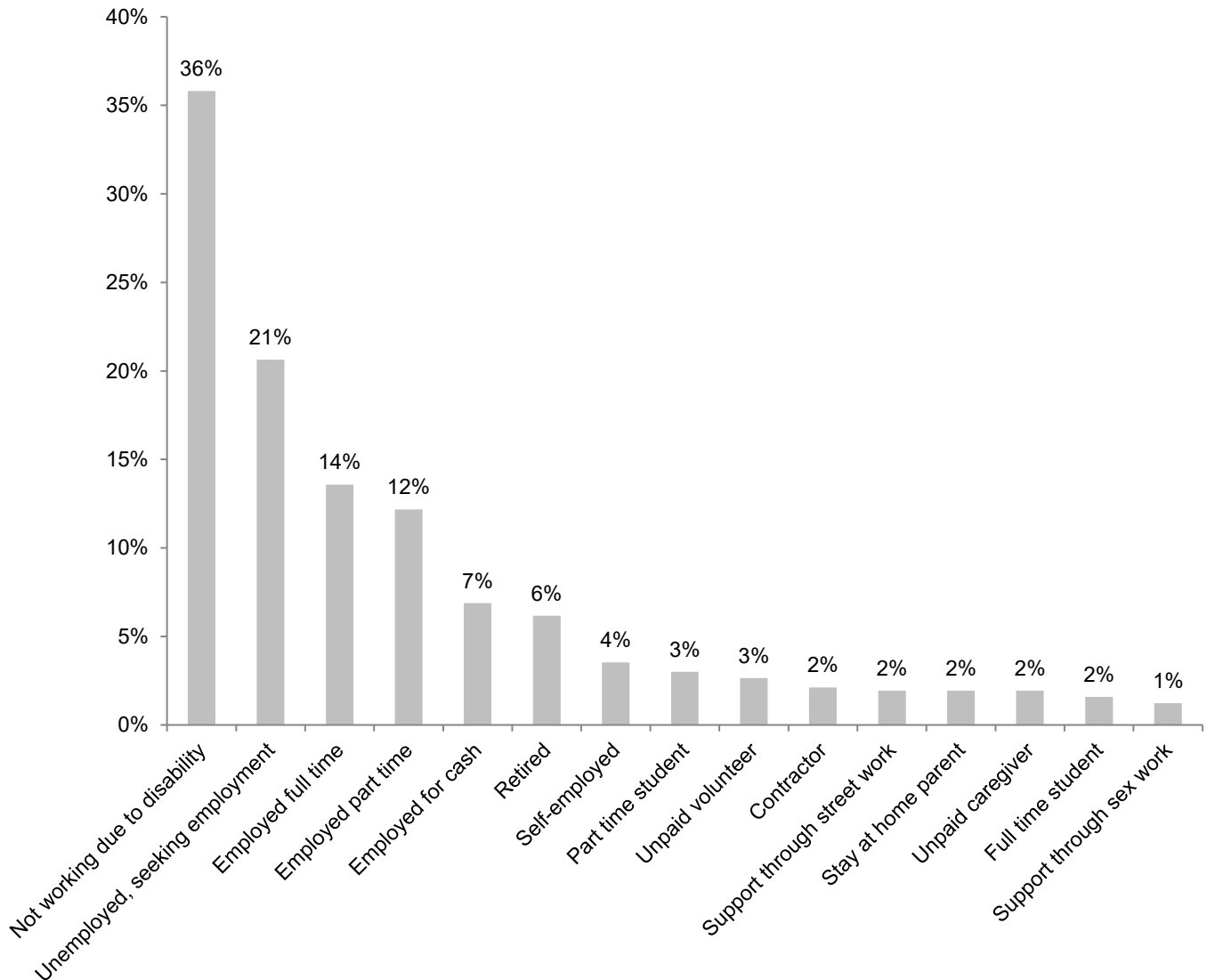
(Graph 7) Participants were asked to identify their current employment situation from a list of options

provided. Participants were asked to select as many types of employment as applicable, and could write in their employment situation if they did not see it listed. The most common employment situation was not working due to disability at 36%. This was followed by participants who were currently unemployed but seeking employment (21%), employed full time (14%) employed part time (12%) and working for cash/under the table payment (7%). The most common types of unpaid work were unpaid volunteer (3%), stay at home parent (2%), and unpaid caregiver to a family member or friend (2%). The most common write-in employment situation was being financially supported by a family member's employment or benefits.

GRAPH 7-Current Employment Situations among PLWH in the Houston Area, 2020

Definition: Percent of participants reporting each type of current employment situation.

Denominator: 567 participants



Household Income and Federal Poverty Level

(Table 1) Participants were asked to estimate their current monthly household income, regardless of source. The average annual household income reported was \$14,420, or \$1,202 per month, a 37% increase in average household income reported in the 2016 Needs Assessment. However, this average annual is four times lower than the average median household income of the general population in the Houston HSDA, and four and a half times lower than the average household

income of the general population in the Houston EMA in 2016. Among participants reporting income, 60% reported incomes below 100% of the Federal Poverty Level (FPL). This was a 15% decrease from 71% of participants reporting annual household incomes below 100% FPL in 2016. Comparatively, the average percentage below 100% FPL was 15% for the general population in Houston HSDA and 14% in the Houston EMA in 2016.

TABLE 1-Average Annual Household Income and Federal Poverty Level among PLWH in the Houston Area, 2020

	Mean Annual Household Income	Percentage Below 100% of Federal Poverty Level
PLWH (2020)	\$14,420	60%
HSDA Average (2016) ^a	\$57,971	15%
EMA Average (2016) ^a	\$65,183	14%

^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

Food Insecurity

Participants were asked whether they regularly had difficulty accessing healthy food. Those reporting regular food insecurity were then asked to select from a list of commonly cited reasons for food insecurity. Participants could also write-in reasons for food insecurity if they did not see an applicable reason listed. In total, 40% of participants reported regular food insecurity.

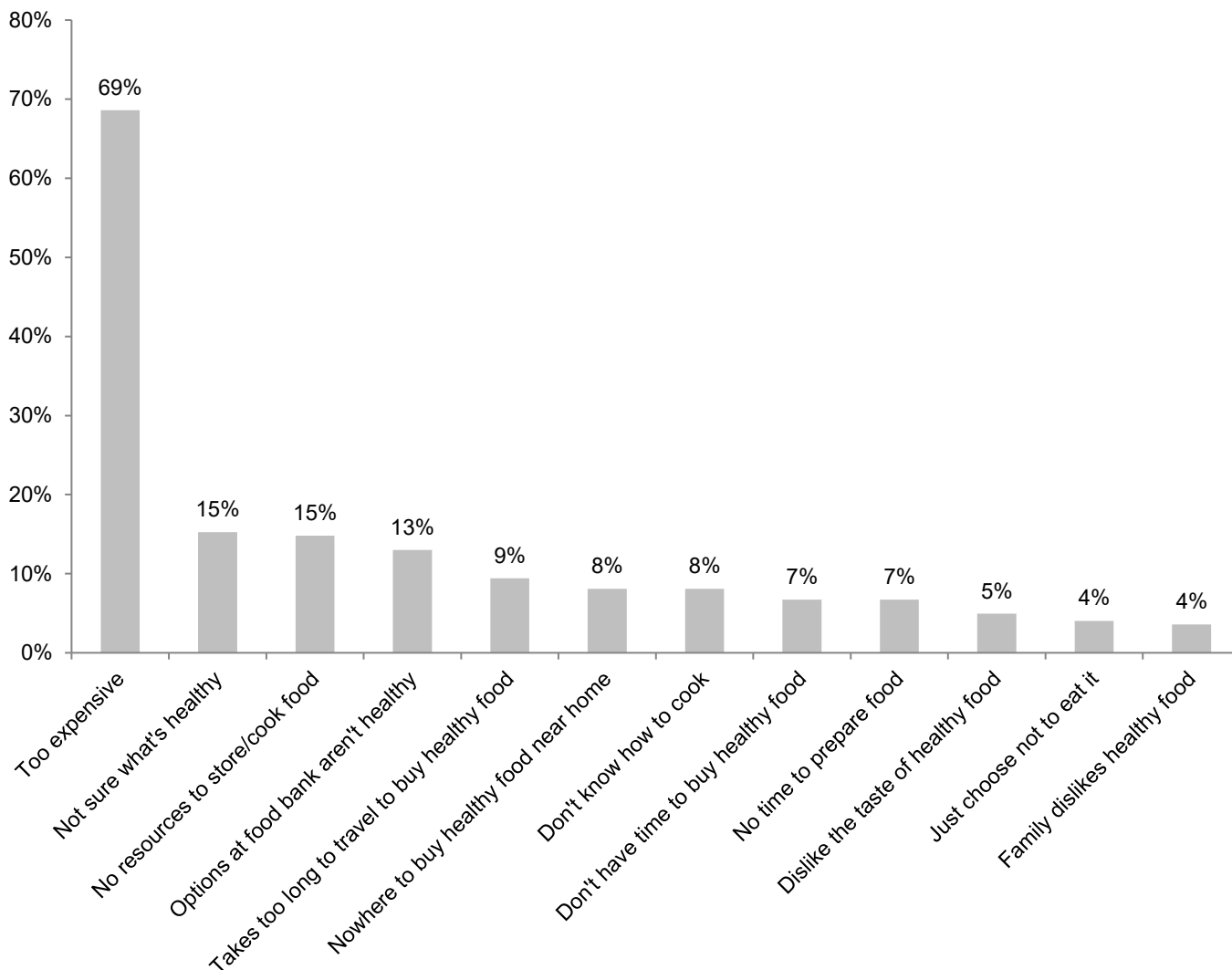
(**Graph 8**) The most common cause reported for regular food insecurity was healthy food being too

expensive for 69% of food insecure participants. This was followed by not knowing what foods were healthy (15%), having no resources to store or cook food (15%), having few healthy options at the food bank, and travel time to buy healthy food was too long (9%). The most common write-in responses were having difficulty transporting food home (particularly when walking or using public transportation) and experiencing homelessness.

GRAPH 8-Causes of Food Insecurity among PLWH in the Houston Area, 2020

Definition: Percent of food insecure needs assessment participants reporting each cause of food insecurity.

Denominator: 223 participants



Medical Care Coverage

Participants were asked details about their medical care coverage for themselves and their families, including how they cover general medical costs; if they experience difficulty covering HIV medication, non-HIV related medications, and medications for mental health conditions; and when difficulty was reported, whether assistance was received to pay for the medications.

(**Graph 9**) Of the 36% of participants with no medical coverage, 32% of participants stated they receive medical care *only* for HIV through the Ryan White Program, 3% stated they did not receive medical care due to inability to pay, and 2% stated that they pay for all medical care for themselves or their family out-of-pocket with no assistance. This means that the

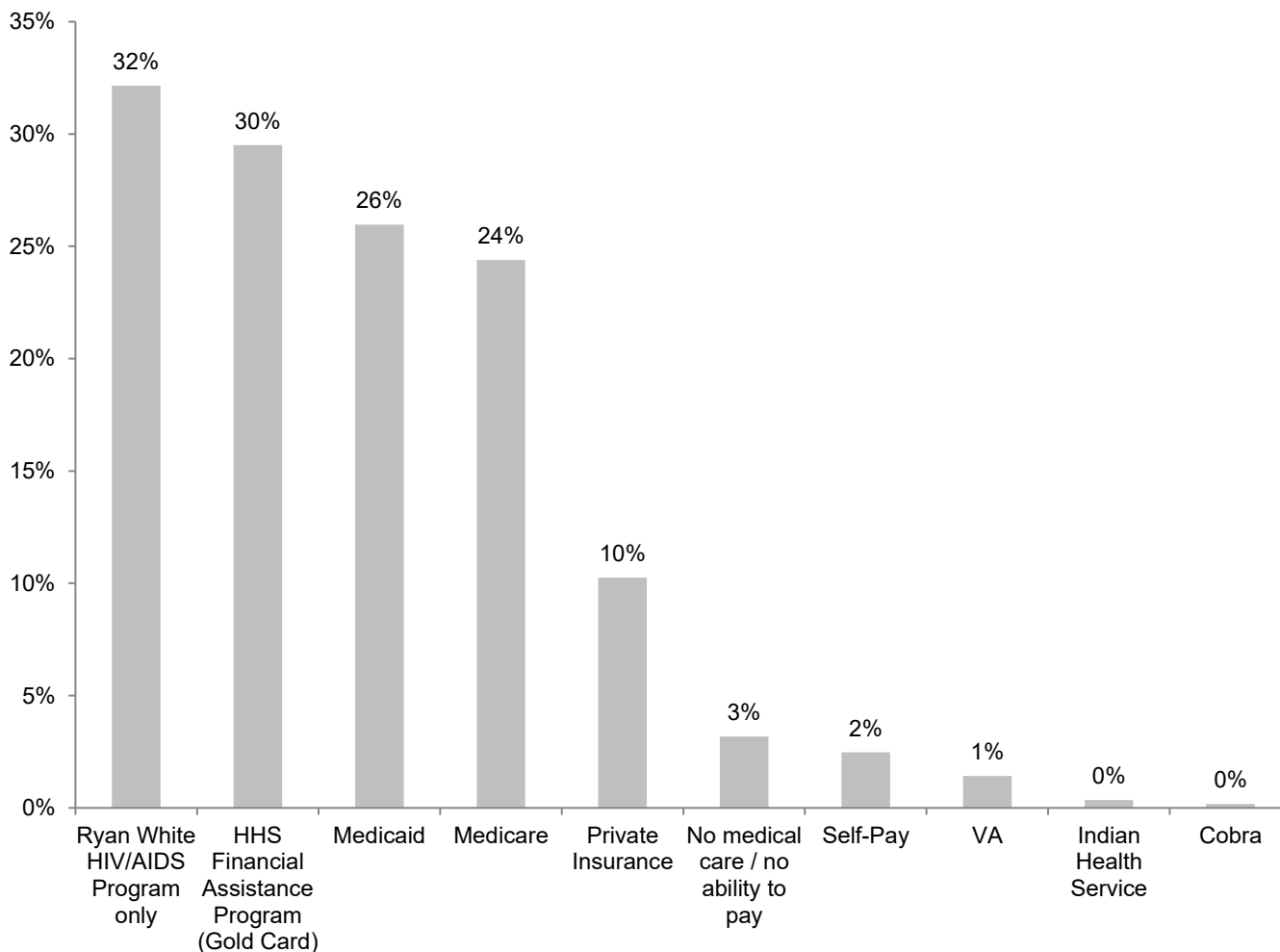
remaining participants (or 68%) reported *some form* of medical coverage, including public health insurance such as Medicaid or Medicare, private health insurance, or health care via programs for specific populations such as veterans or American Indians/Alaska Natives.

Of these specific sources for coverage, 30% of participants were in Harris Health Financial Assistance Program (formerly Gold Card), 26% said they had Medicaid, and 24% had Medicare. Additionally, 10% had private health insurance. This is a slight decrease from the 10% of participants who reported having private insurance in the 2016 Needs Assessment. The most common private insurance carriers for participants were Blue Cross/Blue Shield and Cigna.

GRAPH 9-Sources of Medical Care Coverage among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated having each source of health care coverage, including if their only health care is for HIV through the Ryan White Program and if they did not receive medical care due to inability to pay.

Denominator: 566 participants



(Graph 10, Graph 11, and Graph 12) Participants were asked if they had experienced difficulty paying for prescription medications for HIV, other co-occurring physical conditions, or mental health conditions. 37% of participants reported having difficulty paying for any medication. Results are as follows (*in order*):

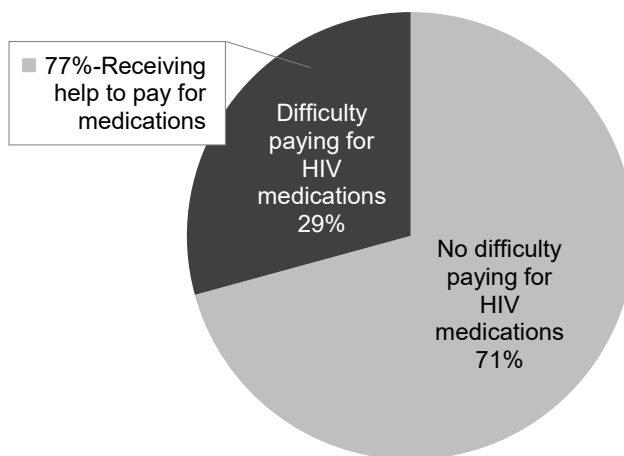
- 29% of participants on HIV medications reported difficulty paying for their prescriptions and, of those reporting difficulty, 77% were receiving financial assistance.

- 33% of participants taking medication for a co-occurring physical health conditions (other than HIV) reported difficulty paying for their prescriptions and, of those reporting difficulty, 63% were receiving financial assistance.

- 25% of participants taking medication for a mental health condition reported difficulty paying for their prescriptions and, of those reporting difficulty, 64% were receiving financial assistance.

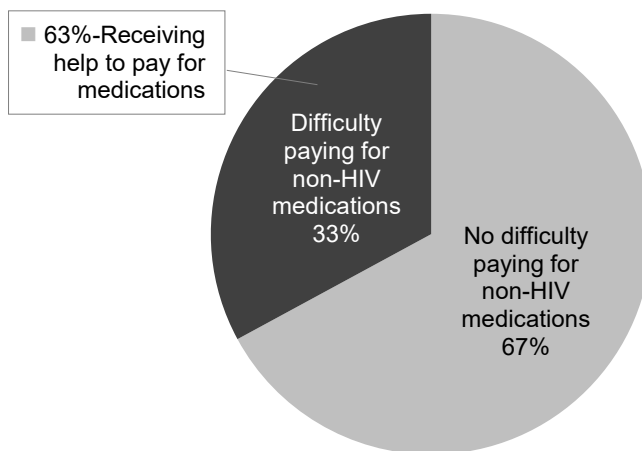
GRAPH 10-Difficulty Paying for HIV Medications among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated difficulty paying for HIV medications and, of those, the percent receiving help.
Denominator: 547 participants



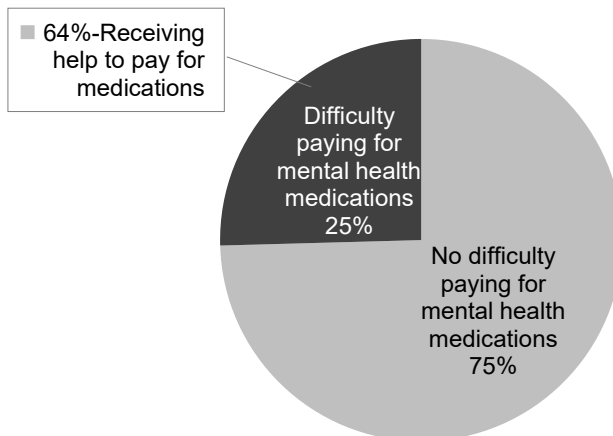
GRAPH 11-Difficulty Paying for Non-HIV Medications among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated difficulty paying for medications for non-HIV health conditions and, of those, the percent receiving help.
Denominator: 468 participants



GRAPH 12-Difficulty Paying for Mental Health Medications among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated difficulty paying for medications for a mental health condition and, of those, the percent receiving help.
Denominator: 348 participants



Transportation

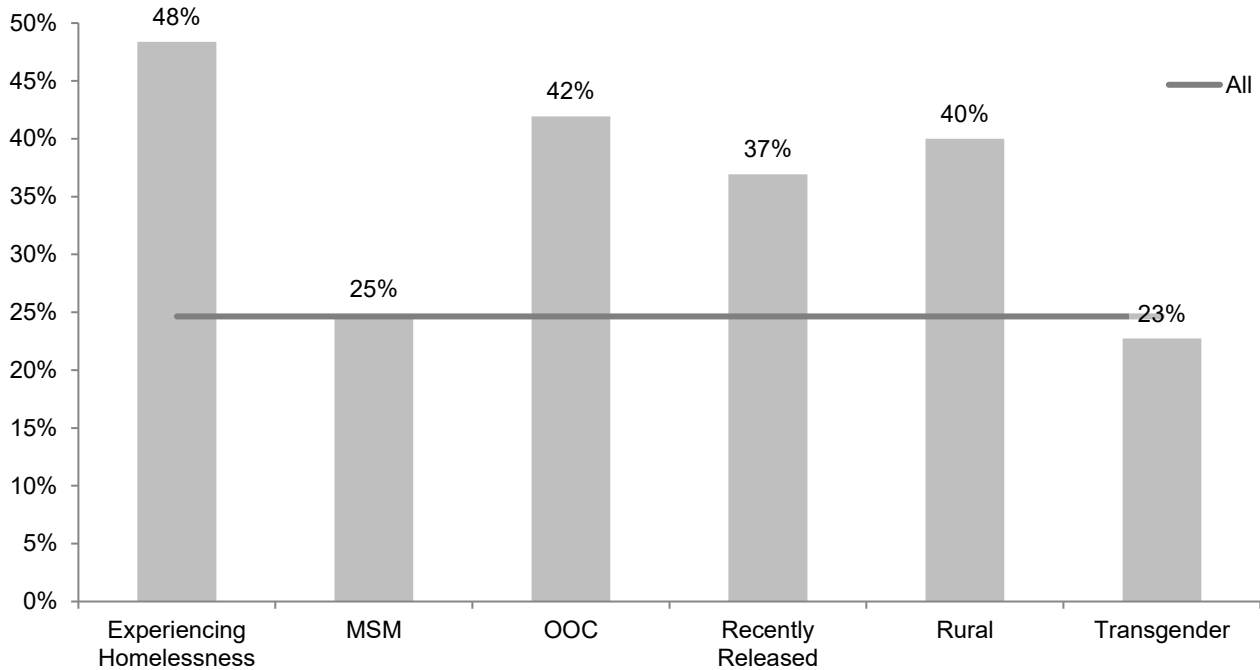
(Graph 13) When asked whether their transportation situation has ever interfered with getting HIV medical care, 25% of participants indicated transportation as a barrier to care. Among select special populations, this proportion was highest for people experiencing homelessness at 48% reporting transportation as a

barrier to HIV medical care. This was followed by the out of care population (42%), rural participants (40%), and those released from incarceration in the past 12 months (37%).

GRAPH 13-Transportation as a Barrier to HIV Medical Care among All PLWH and Select Special Populations in the Houston Area, 2020

Definition: Percent of needs assessment participants (total and by select special population) who reported a transportation situation that interfered with HIV medical care

Denominators: 560 total participants; 62 participants experiencing homelessness; 298 MSM participants; 31 OOC participants; 65 recently released participants; 5 rural participants; and 22 transgender participants



Housing Type, Homelessness, and Housing Instability

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

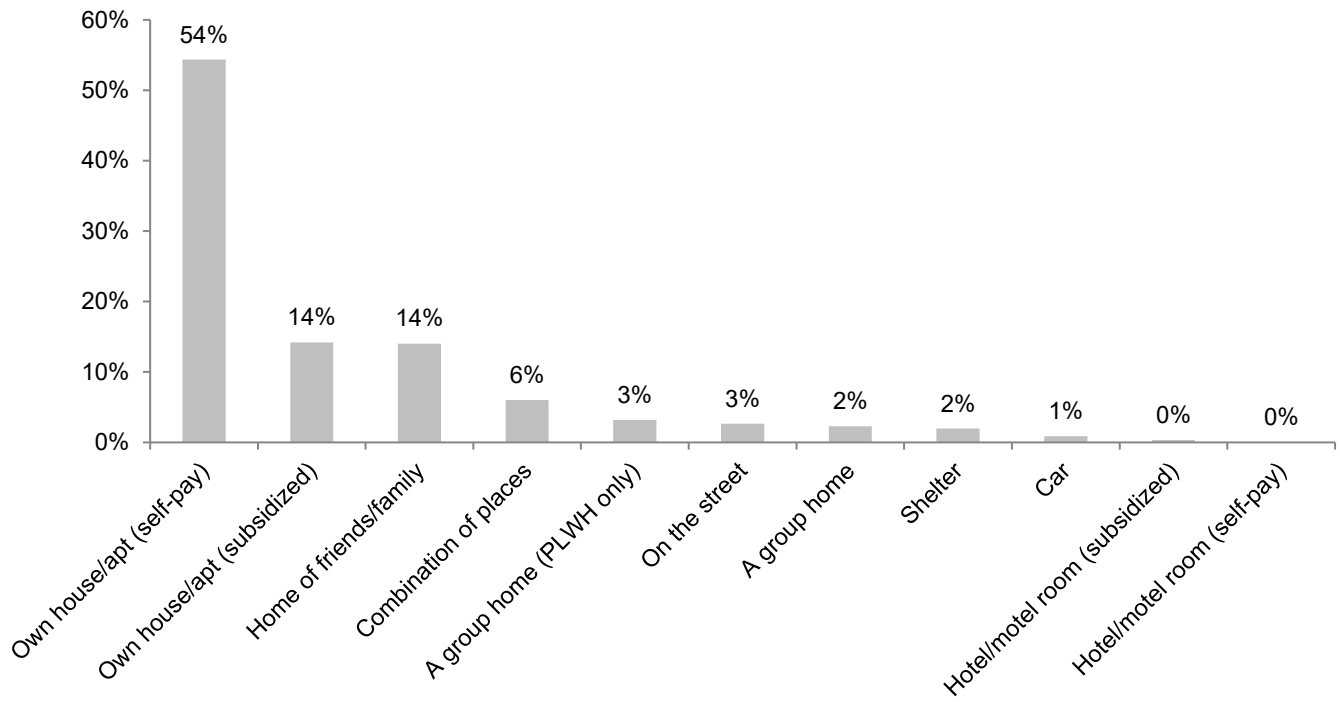
(Graph 14) A majority of participants slept most often in a house or apartment that they paid for (54%). This was followed by sleeping most often in a subsidized house or apartment (14%), staying with friends or family (14%), sleeping in a combination of places (6%), staying in a group home for PLWH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

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

GRAPH 14 -Ranking of Housing Types for PLWH in the Houston Area, 2020

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

Denominator: 563 participants



Current Housing Problems

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

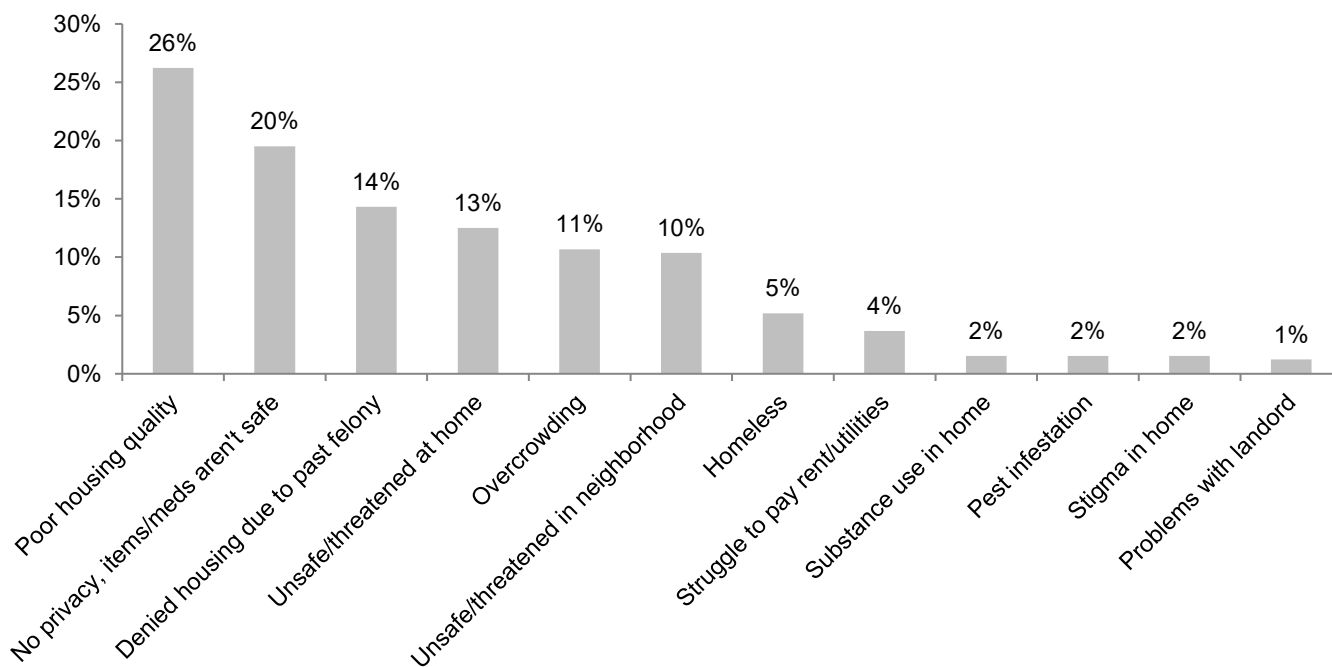
Participants were asked to indicate whether they were currently experiencing any of a list of housing quality, safety, or access issues. Participants were also encouraged to write-in any current housing problems, which at analysis were added to the list or condensed into existing options. Forty-percent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

(Graph 15) The most common housing problem participants were experiencing at the time of survey was poor housing quality at 26%. Examples given in the survey for poor housing quality were presence of mold or asbestos, exposed wires, broken windows, leaks, poor insulation, broken plumbing, or broken appliances. This was followed by having no privacy and feeling that possessions and medications were not safe (20%), being denied housing due to a past felony (14%), feeling unsafe or threatened at home (13%), and overcrowding (11%). Write-in responses with enough cases to justify inclusion in the list were: currently experiencing homelessness, struggling to pay rent/utilities, substance use in the home, pest infestation, stigma at home, and difficulties with landlords.

GRAPH 15-Current Housing Problems Experienced by PLWH, 2020

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

Denominator: 328 participants



EXPERIENCE WITH DISCRIMINATION AND VIOLENCE

Despite the widespread presence of HIV in the U.S., PLWH can encounter discrimination and stigma due to their HIV status. Research also suggests a link between HIV and violence, including intimate partner violence.⁴ The physical and emotional effects of experiencing discrimination and violence can affect the health of PLWH as well as their ability to access HIV care and other needed resources. The 2020 Houston HIV Care Services Needs Assessment explored participant experiences with discrimination, physical violence, and psychological violence.

HIV-Related Discrimination

(**Graph 16**) Twenty-six percent (26%) of participants reported experiencing some form of discrimination in the past 12 months, up from 20% in 2016. Most often this was discrimination in the form of being treated differently because of their positive status (25%), though less often this resulted in being denied services (5%) or being asked to leave a public place (3%).

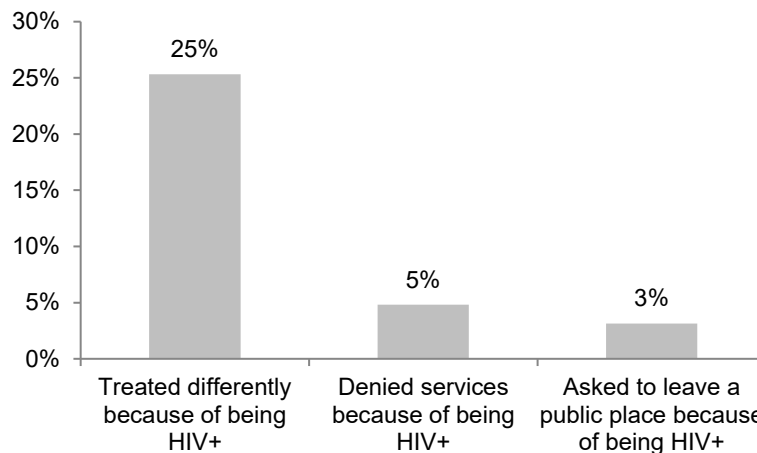
Experience with Violence

(**Graph 17**) Another 16% reported being threatened in the past 12 months, up from 13% in 2016. These were most often verbal harassment (11%) or threats of violence (10%) from someone the participant knew. Nine percent (9%) had been physically assaulted (most often by someone they knew), and 6% had been sexually assaulted. Reports of sexual assaults occurred in equal proportions with individuals known to the participants and strangers. Among transgender or gender non-conforming participants, reports of physical assault (13%) or sexual assault (21%) were higher. Five percent (5%) of participants reported current intimate partner violence.

GRAPH 16-HIV-Related Discrimination in the Houston Area, 2020

Definition: Percent of needs assessment participants reporting each of the following experiences in the past 12 months.

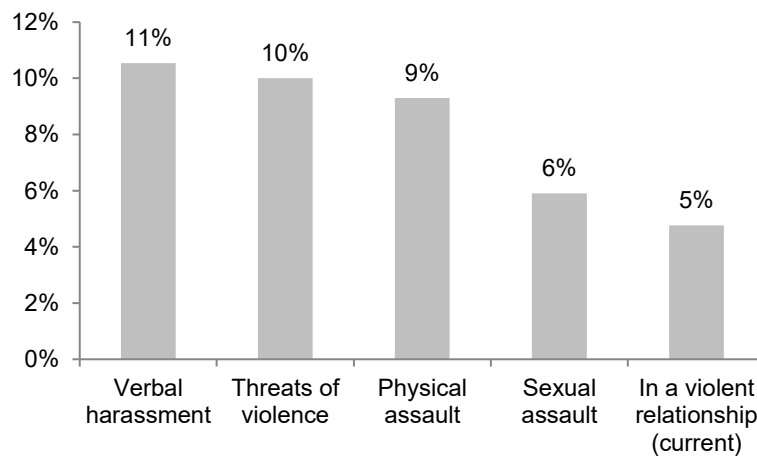
Denominator: 559 participants



GRAPH 17-Violence Experienced by PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants reporting each of the following experiences in the past 12 months.

Denominator: 558 participants



⁴ Dawson, Lindsey; Kates, Jennifer; and Ramaswamy, Amrutha. *HIV, Intimate Partner Violence (IPV), and Women: An Emerging Policy Landscape* (KFF, December 2, 2019) <https://www.kff.org/hiv/aids/issue-brief/hiv-intimate-partner-violence-ipv-and-women-an-emerging-policy-landscape>

HIV PREVENTION BEHAVIORS AND RISKS

Prevention knowledge and behaviors lower the risk of HIV transmission to others, as well as acquisition of other sexually transmitted diseases (**STDs**) or blood-borne conditions. (Source: Health Resources and Services Administration, HIV/AIDS Bureau, Guide for HIV/AIDS Clinical Care, *Preventing HIV Transmission/Prevention with Positives*, January 2011). Moreover, awareness of interventions like pre-

exposure prophylaxis (**PrEP**) and post-exposure prophylaxis (**PeP**) as well as PrEP and PeP resources can empower people living with HIV (**PLWH**) and the community to help those who are HIV-negative decrease their risk. The 2020 Houston HIV Care Services Needs Assessment asked participants about their needs related to HIV prevention information, safer sex and injection behaviors, and PrEP awareness

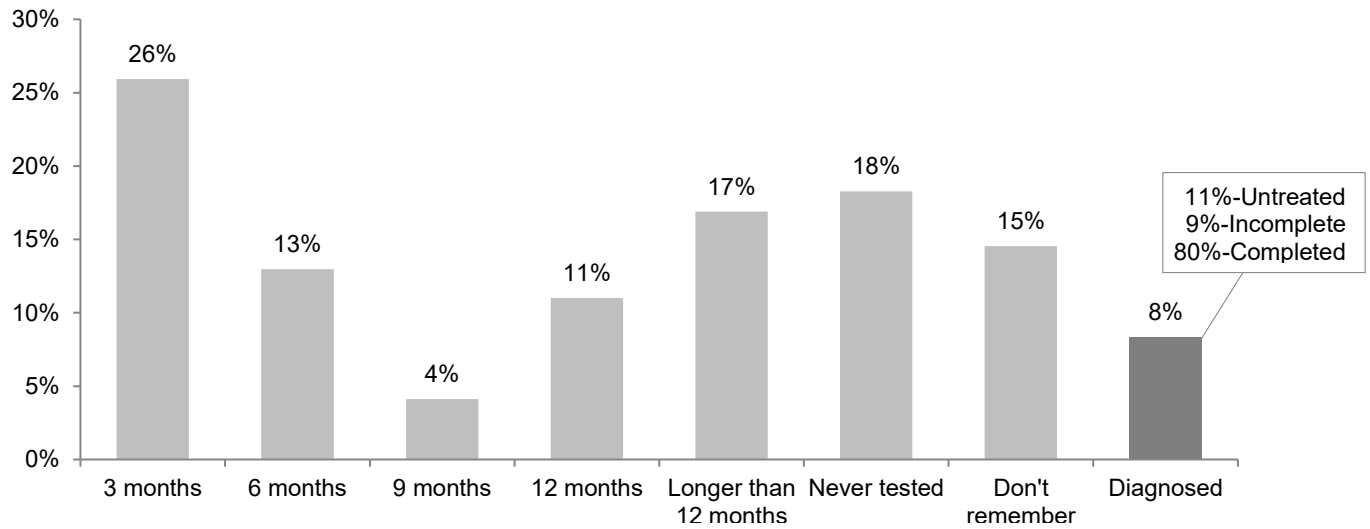
STD Testing and Treatment

(Graph 18, Graph 19, and Graph 20) Participants were asked if they had been tested, diagnosed, and/or treated for chlamydia, gonorrhea, and syphilis in the past 3, 6, 9, and/or 12 months. Twenty percent (20%) of participants (110 individuals) indicated they were tested and diagnosed one or more of these conditions in the past 12 months. Results for each STD are as follows (*in order*):

Twenty-six percent (26%) of participants were tested for chlamydia in the past 3 months, and 11% were tested in the past 12 months. 17% participants had their last chlamydia test longer than 12 months ago, and 18% had never been tested for chlamydia. 8% of participants who were tested for chlamydia in the past 12 months were diagnosed. Of those diagnosed with chlamydia in the past 12 months, 11% were never treated, 9% began but did not complete treatment, and 80% completed treatment of chlamydia.

GRAPH 18-Chlamydia Testing, Diagnosis, and Treatment among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated they were tested, diagnosed, and/or treated for chlamydia in the past 12 months. Denominator: 509 participants

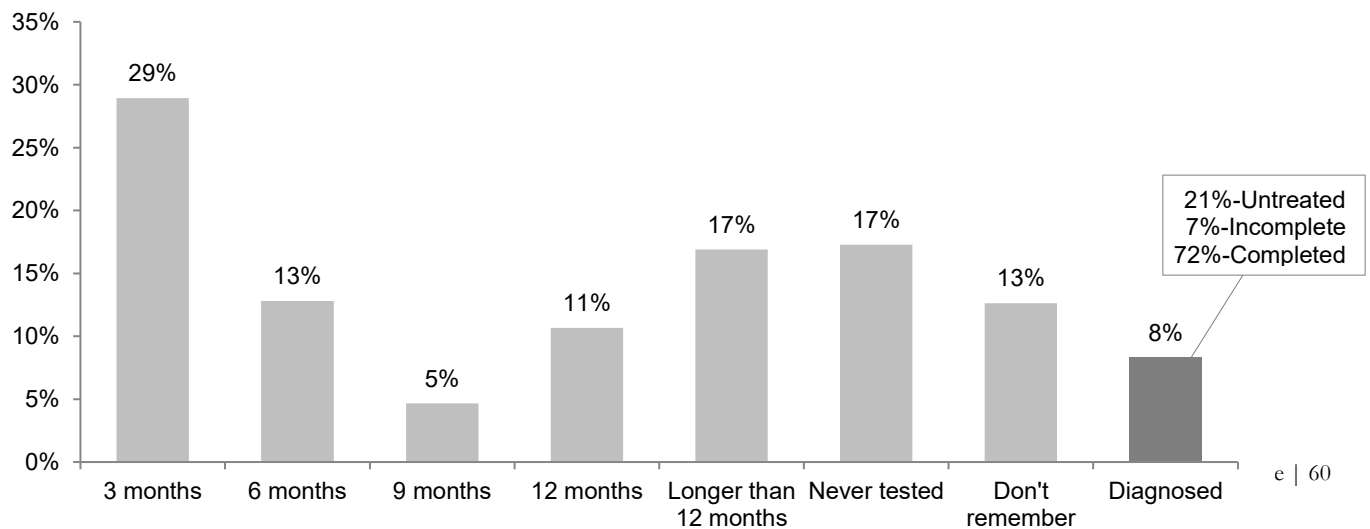


Twenty-nine percent (29%) of participants were tested for gonorrhea in the past 3 months, and 11% were tested in the past 12 months. 17% participants had their last gonorrhea test longer than 12 months ago, and 17% had never been tested for gonorrhea. 8% of

participants who were tested for gonorrhea in the past 12 months were diagnosed. Of those diagnosed with gonorrhea in the past 12 months, 11% were never treated, 9% began but did not complete treatment, and 80% completed treatment of gonorrhea.

GRAPH X19-Gonorrhea Testing, Diagnosis, and Treatment among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated they were tested, diagnosed, and/or treated for gonorrhea in the past 12 months. Denominator: 515 participants

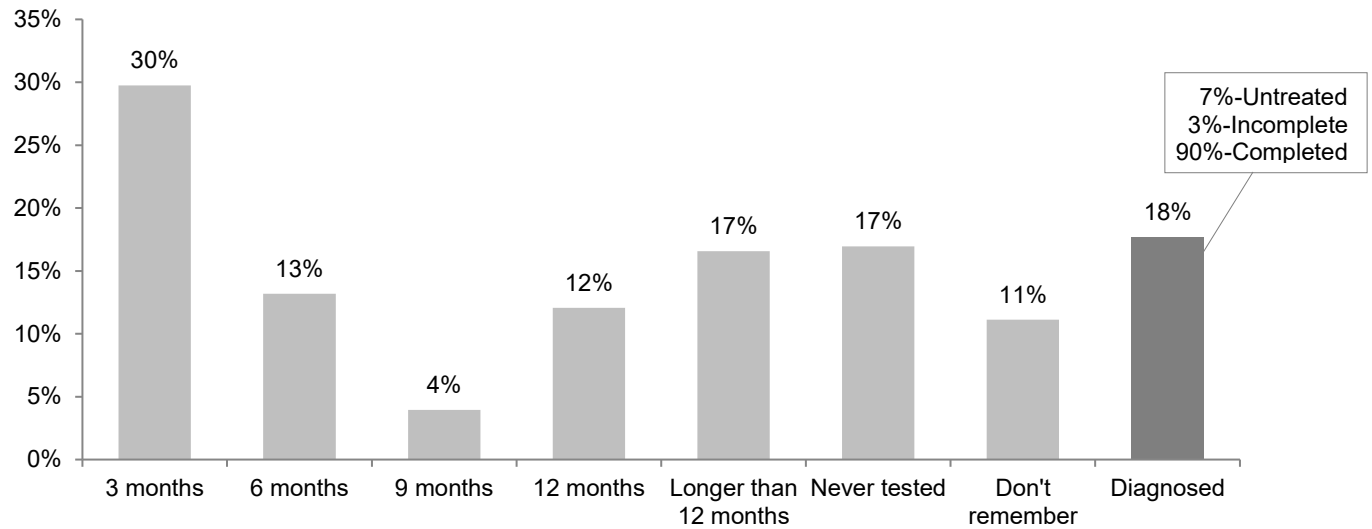


Thirty percent (30%) of participants were tested for syphilis in the past 3 months, and 12% were tested in the past 12 months. 17% participants had their last syphilis test longer than 12 months ago, and 17% had never been tested for syphilis. 18% of participants who

were tested for syphilis in the past 12 months were diagnosed. Of those diagnosed with syphilis in the past 12 months, 7% were never treated, 3% began but did not complete treatment, and 90% completed treatment of syphilis.

GRAPH 20-Syphilis Testing, Diagnosis, and Treatment among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated they were tested, diagnosed, and/or treated for syphilis in the past 12 months. Denominator: 531 participants



Access to HIV Prevention Information

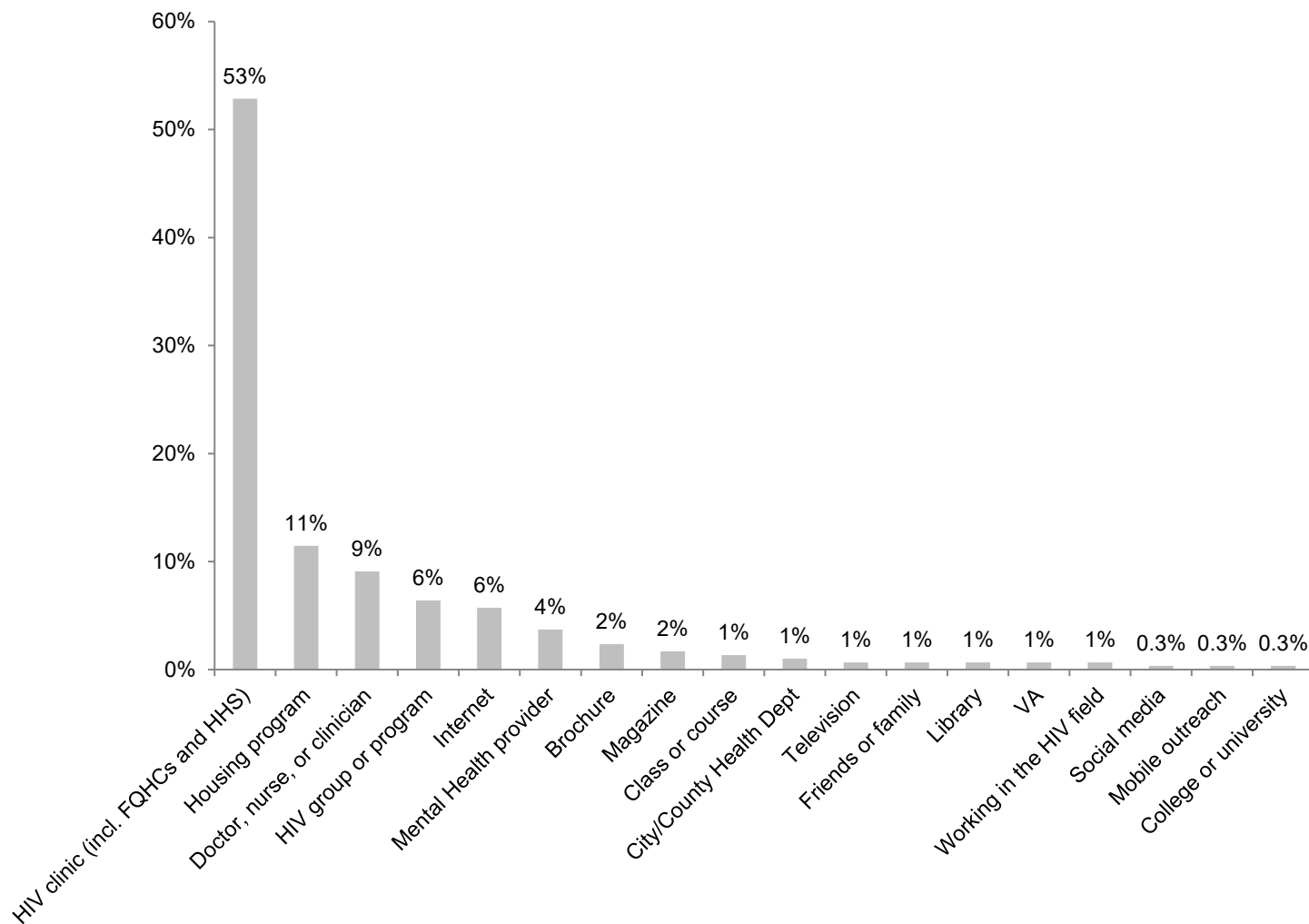
Needs Assessment participants were asked if they had received any information about HIV prevention in the past 12 months. Overall, 57% of participants said they *had* received information in the past year, a 15% decrease from 67% in 2016. Those who had received information were then asked to identify the source of this information and the types of prevention information received

(Graph 21) The source of HIV prevention information cited most often was an HIV clinic, including Federally Qualified Health Centers (**FQHCs**) and Harris Health System (**HHS**) at 53% of all reported sources. This was followed by housing programs (11%); doctors, nurses, or clinicians (9%); an HIV group or program (6%); and the internet (6%). At less than 1%, social media, mobile outreach, and colleges or universities were reported least.

GRAPH 21-Sources of HIV Prevention Information for PLWH in the Houston Area, 2020

Definition: Percent of times each source was reported by needs assessment participants as the source from which HIV prevention education the past 12 months was received.

Denominator: 297 source reports



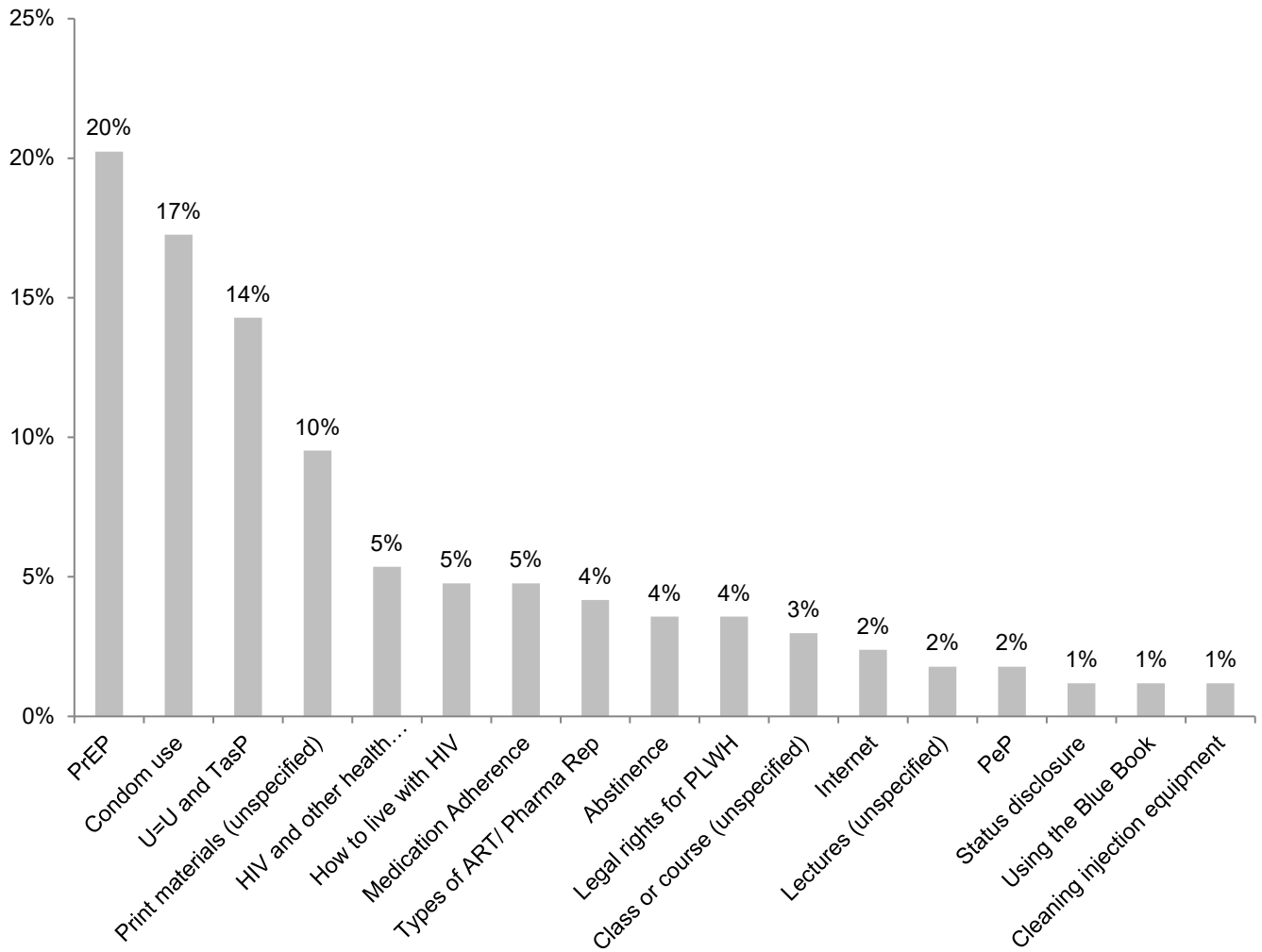
(**Graph 22**) The topic of the HIV prevention information provided most often pre-exposure prophylaxis, or **PrEP**, and 20% of topics reported. This was followed by condom use (17%), undetectable = untransmittable (**U=U**) or treatment as prevention

(**TasP**) (14%), unspecified information from print materials (10%), and HIV and other health conditions (5%). At 1% each, status disclosure, use of the Blue Book resource Guide, and information on cleaning injection equipment were reported least.

GRAPH 22-Topics of HIV Prevention Information Provided to PLWH in the Houston Area, 2020

Definition: Percent of times each topic or information type was reported by needs assessment participants.

Denominator: 297 topic reports



**Prevention through Medication
U=U, PrEP, and PeP Awareness**

Undetectable = untransmittable (U=U), and TasP both refer to the use of anti-retroviral therapy (ART) medications to achieve a consistently undetectable viral load thereby preventing HIV transmission through sex. When asked whether they were aware of U=U before the day of survey, 76% of participants reported that they were aware. Awareness of PrEP, post-exposure prophylaxis (PeP), and resources for both are reported below.

(Table 2) When asked if they had ever heard of PrEP, 80% of participants were PrEP aware, a 43% increase from 56% PrEP aware participants in 2016. Awareness among PLWH of PrEP resources also increased substantially between 2016 and 2020. Whereas 34% of participants knew where to refer someone for PrEP resources in 2016, the proportion of PrEP resource aware participants grew to 58% in 2020, a 71% increase.

TABLE 2- Crosstabulation of PrEP Awareness with PrEP Resource Awareness among PLWH in the Houston Area, 2020

		"Do you know where a person who does not have HIV can go to get on PrEP?"		Total
		Yes	No	
"Have you heard about PrEP before?"	Yes	55%	24%	80%
	No	2%	13%	15%
	Don't Remember	1%	5%	6%
	Total	58%	42%	

Denominator: 562 participants

(Table 3) Post-exposure prophylaxis (PeP) is a method for people who do not have HIV to prevent acquiring HIV if they think they may have been exposed through sex or needle sharing in the last 72 hours. For the first time, the 2020 Needs Assessment measured awareness of PeP and resources to access PeP among PLWH.

When asked if they had ever heard of PeP, 60% of participants were PeP aware. Awareness among PLWH of PeP resources was lower at 52% of participants reporting awareness of where to refer someone to access PeP.

TABLE 3- Crosstabulation of PeP Awareness with PeP Resource Awareness among PLWH in the Houston Area, 2020

		"Do you know where a person who does not have HIV can go to get on PeP?"		Total
		Yes	No	
"Have you heard about PeP before?"	Yes	44%	16%	60%
	No	6%	27%	33%
	Don't Remember	1%	6%	7%
	Total	52%	48%	

Denominator: 560 participants

Sexual Activity and Condom Use

Participants were asked details regarding current sexual activity and use of safer sex practices, in particular, condom use, barriers to consistent condom use, and disclosure of HIV status to potential sex partners. Forty-five percent (45%) of participants reported having no oral, vaginal, or anal sex in the 6 months preceding survey, and were excluded from the following analysis.

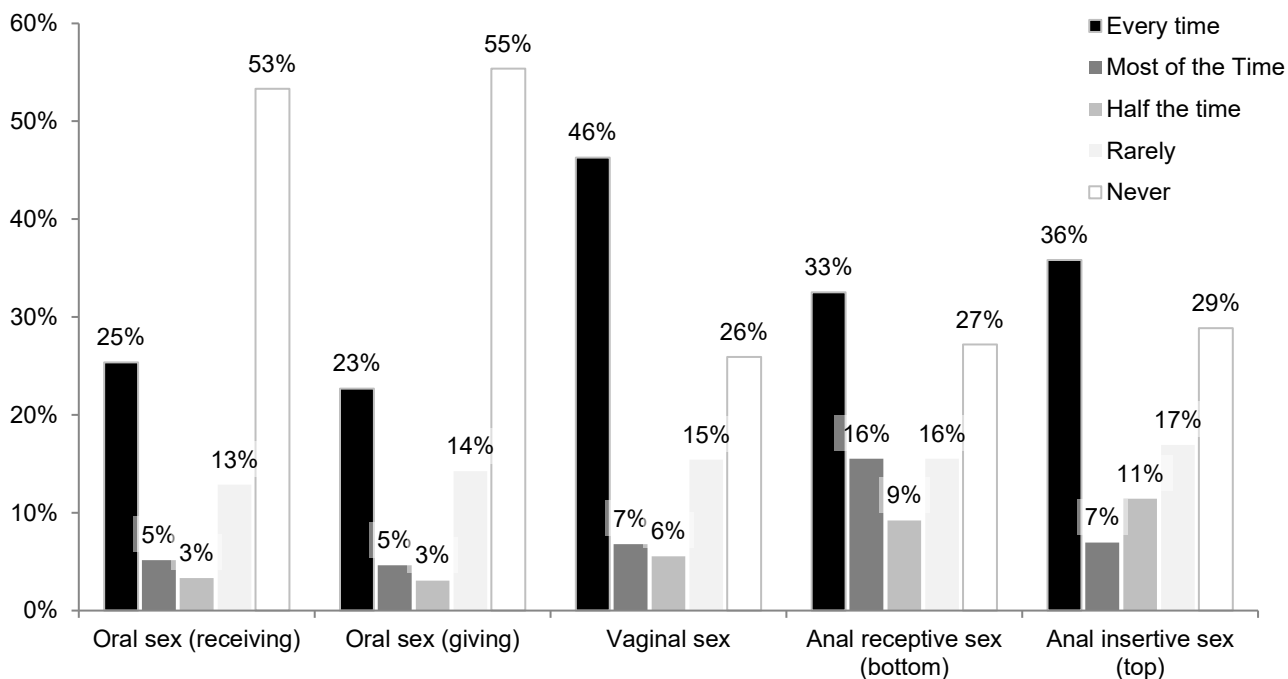
When asked about partner HIV status, 47% of sexually active participants indicated that they had at least one sexual partner who was also living with HIV. Thirteen percent (13%) of participants reported that they had at least one sexual partner who was presumably HIV negative and taking PrEP, while 26% reported having at least one presumably HIV negative partner who was

not taking PrEP. Sixteen percent (16%) reported that they did not know the HIV status of at least one sexual partner.

(**Graph 23**) Forty-four (44%) of sexually active participants said they *always* use condoms during at least one type of sexual activity. Least frequent condom use was reported for oral sex with 55% of participants reporting no condom use for giving oral sex and 53% reporting no condom use for receiving oral sex. The most frequent consistent condom use was observed for vaginal sex, with 46% of participants reporting using a condom for every encounter. Moderate consistent condom use was reported for anal sex, with 36% of participant reporting condom use for anal insertive sex, and 33% reporting condom use for anal receptive sex.

GRAPH 23-Frequency of Condom Use among PLWH in the Houston Area, by Type of Sexual Activity, 2020

Definition: Percent of needs assessment participants reporting condom use frequency by type of sexual activity
Denominator: 162-272 sexually active participants, varying by type of sexual activity

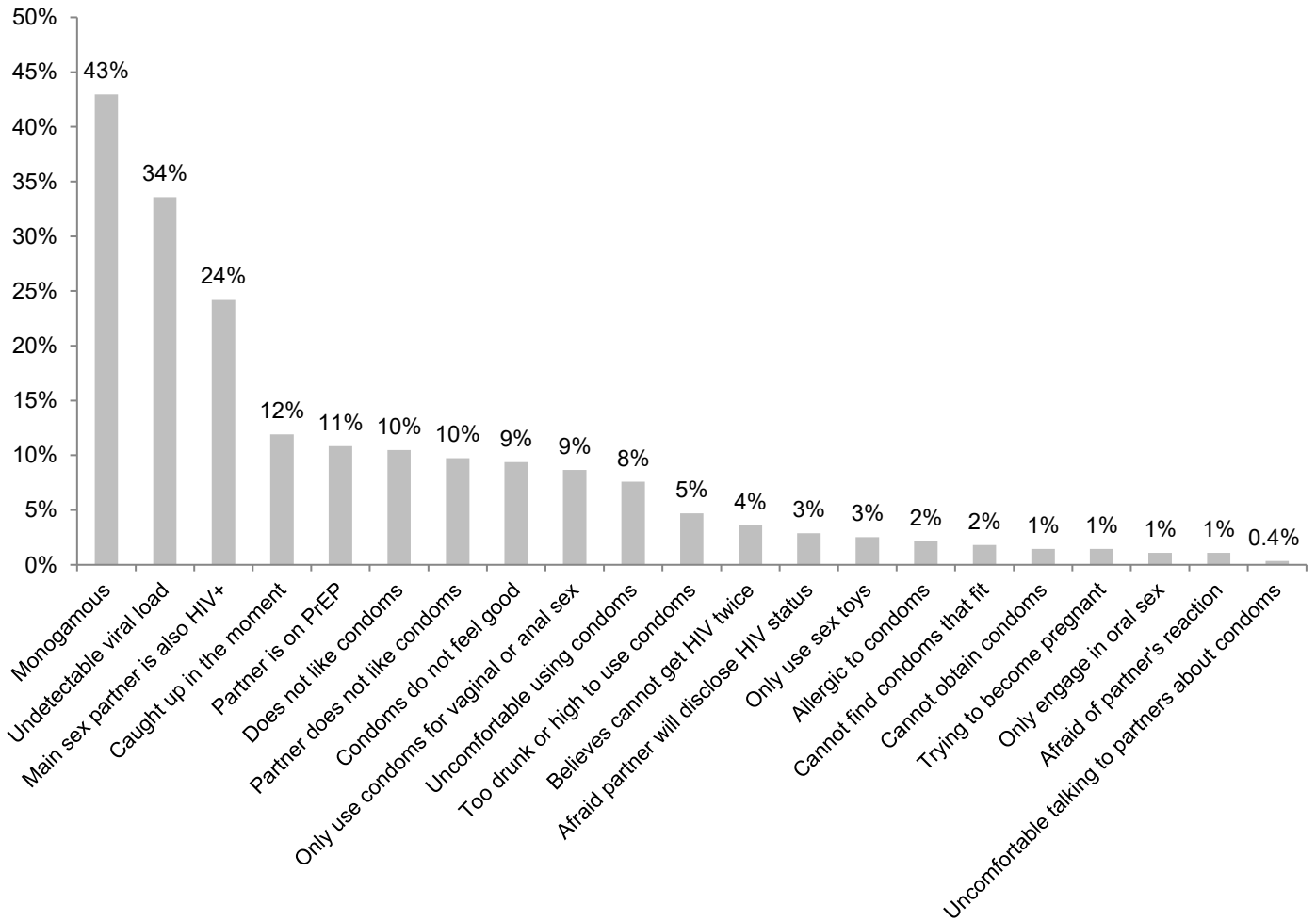


(Graph 24) When inconsistent condom use was reported, participants were asked about their reason for not using a condom. Participants were provided with a list of 21 common reasons for not using condoms, and could write in their reasons. The most frequently selected reasons participants for not using condoms were only having one sexual partner (43%),

having an undetectable viral load (34%), having a sexual partner who was HIV positive as well (24%), getting caught up in the moment (12%), and having a partner on PrEP (11%). The most common write-in reason for inconsistent condom use was the participant’s partner refuses to use a condom or removes the condom during sex.

GRAPH 24-Barriers to Condom Use among PLWH in the Houston Area, 2020

Definition: Percent sexually active needs assessment participants reported each reason for inconsistent condom use
Denominator: 277 sexually active needs assessment participants reporting inconsistent condom use



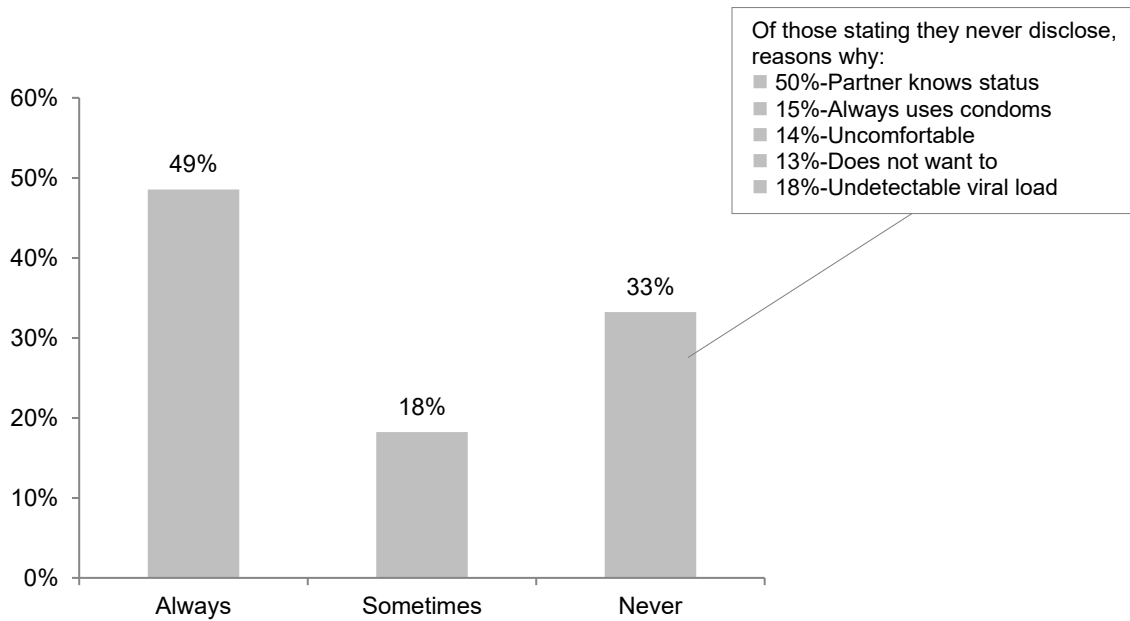
(Graph 25) Participants were asked how frequently they disclose their HIV status to new sex partners. Overall, 49% stated they always disclose their HIV status with every partner, while 33% stated they never

disclose their HIV status. Of those stating they never, the most common reason given was that their main sex partner already knows their HIV status.

GRAPH 25-Disclosure of HIV Status among PLWH in the Houston Area, 2020

Definition: Percent of sexually active needs assessment participants selecting each answer in response to the survey question, "How often do you talk about your HIV status with new sex partners?"

Denominator: 313 sexually active participants



Injection Use

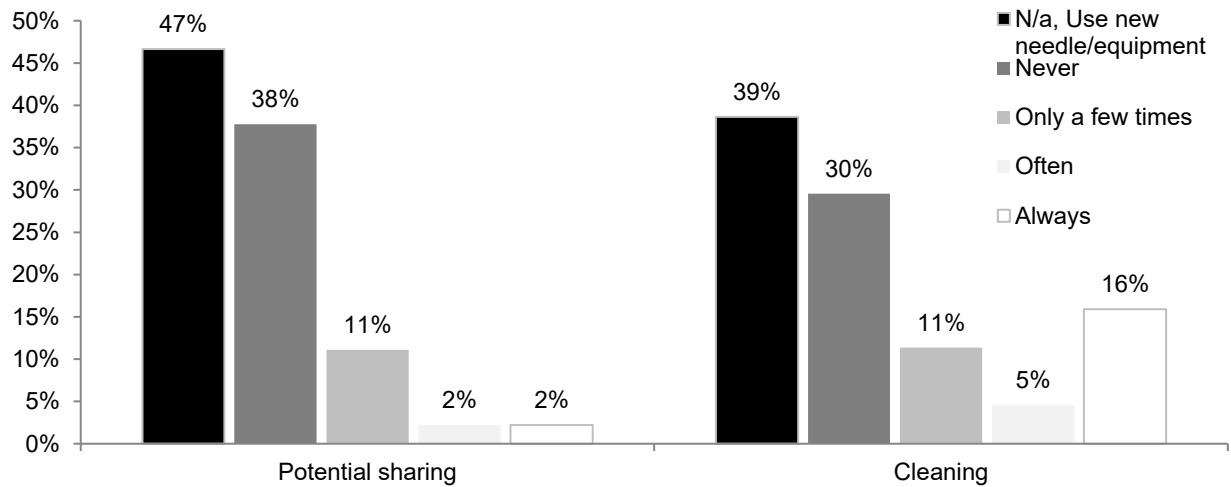
(Graph 26) Participants were asked if they used a needle to inject any substance in the past 12 months. Substance was defined broadly to include medications, insulin, steroids, hormones, silicone, or drugs. Nine percent (9%) of participants reporting using a needle to inject a substance in the past 12 months. Those reporting injection use in the past months were asked how frequently they shared or used needles or injection equipment that somebody else may have

used, and how frequently clean they cleaned needles or injection equipment with bleach. A majority found both questions not applicable. For potential needle/equipment sharing, 47% only use new needles/equipment, and an additional 38% never share used needles/equipment. For needle/equipment cleaning, 39% only use new needles/equipment, and an additional 16% always clean their used needles/equipment with bleach.

GRAPH 26-Frequency of Needle/Equipment Sharing and Cleaning Among PLWH in the Houston Area, 2020

Definition: Percent of participants with injection use in the past 12 indicating needle/injection equipment sharing and cleaning

Denominator: 44-45 participants with injection use in the past 12 months





Chapter 5: Out of Care Profile

OUT OF CARE PROFILE

Details about people living with HIV (**PLWH**) who are *not* in HIV care are of particular importance to local HIV planning. This information helps communities design HIV services to prevent delays or interruptions in care. Continuous HIV care is a national goal for both HIV prevention and care stakeholders, as it can lead to improved health outcomes for individuals as well as reduced transmission of HIV.

Proactive efforts were made to include out of care (**OOO**) PLWH in the 2014 Houston Area HIV/AIDS needs assessment (See: *Methodology*, page 7), and results presented throughout this document include OOC PLWH. This Chapter highlights results *only* for OOC participants and as their results compare to the total needs assessment sample.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 24 participants in the 2020 Houston HIV Care Services Needs Assessment met all criteria for being defined as OOC. This is 7% of the entire needs assessment sample. As with the overall sample, 95% of OOC needs assessment participants resided in Harris County at the time of data collection. While the overall majority of needs assessment participants were male (66%), African American/Black (63%), and heterosexual (57%). However, while the majority of OOC participants were male (79%) OOC participants were more often Hispanic/Latino (54%) and equally identified as heterosexual and MSM (50% respectively). Sixty-one percent (61%) of OOC participants were between the ages of 39 and 54.

The average unweighted household income of OOC participants was \$13,493 annually, \$2,133 lower than the total sample, with the majority living below 100% of federal poverty (**FPL**). A majority of participants (46%) was not formally employed at the time of survey, with 18% collecting disability benefits, 18% unemployed and seeking employment, and 11% retired. However, 28% of OOC participants gained financial support through informal employment such as working for cash, sex work, and street work. Most participants paid for healthcare using

Notes: “Out of care/OOC” is defined in this analysis as a PLWH who indicated in their survey that they had not received any of the following in the past 12 months: an HIV primary care visit, a prescription for HIV medication, or an HIV monitoring test (viral load or CD-4). This definition is consistent with national and state OOC criteria.

Medicaid/Medicare or assistance through Harris Health System (Gold Card).

Characteristics of the OOC (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- Hispanic/Latino
- Adults between the ages of 39 and 54
- Equally heterosexual and MSM
- With lower income, formal employment, and private health insurance

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Chapter were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, page 7).

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

No.		%		No.		%		No.		%	
County of residence			Age range (median: 50-54)			Sex at birth					
Harris	21	95.5%	13 to 17	0	-	Male	19	79.2%			
Fort Bend	0	-	18 to 24	1	4.3%	Female	5	20.8%			
Liberty	0	-	25 to 34	3	13.0%	Intersex	0	-			
Montgomery	1	4.5%	35 to 49	7	30.4%	Transgender	0	3.9%			
Other	0	-	50 to 54	7	30.4%	Non-binary / gender fluid	0	-			
			55 to 64	4	17.4%	Currently pregnant*	0	-			
			65 to 74	1	4.3%	*All currently pregnant respondents					
			75+	0	-	reported being in care. The					
			Youth (13 to 24)	1	4.2%	denominator is all respondents					
			Seniors (≥50)	12	50.0%	reporting female sex at birth					
Primary race/ethnicity			Sexual orientation			Health insurance					
White	2	8.3%	Heterosexual	12	50.0%	Private insurance	0	-			
African American/Black	7	29.2%	Gay/Lesbian	12	50.0%	Medicaid/Medicare	6	30.0%			
Hispanic/Latino	13	54.2%	Bisexual/Pansexual	0	-	Harris Health System	7	35.0%			
Asian American	0	-	Other	0	-	Ryan White Only	5	25.0%			
Other/Multiracial	2	8.3%	MSM	12	50.0%	None	2	10.0%			
Residency			Yearly income (average: \$11,360)			Employment					
Born in the U.S.	15	65.2%	Federal Poverty Level (FPL)			Disabled	5	17.9%			
Lived in U.S. > 5 years	7	30.4%	Below 100%	6	85.7%	Unemployed and seeking work	5	17.9%			
Lived in U.S. < 5 years	1	4.3%	100%	0	-	Employed (PT)	3	10.7%			
In U.S. on visa	0	-	150%	1	14.3%	Retired	3	10.7%			
Prefer not to answer	0	-	200%	0	-	Employed (FT)	3	10.7%			
			250%	0	-	Self Employed	1	3.6%			
			≥300%	0	-	Other	8	28.6%			

BARRIERS TO RETENTION IN CARE

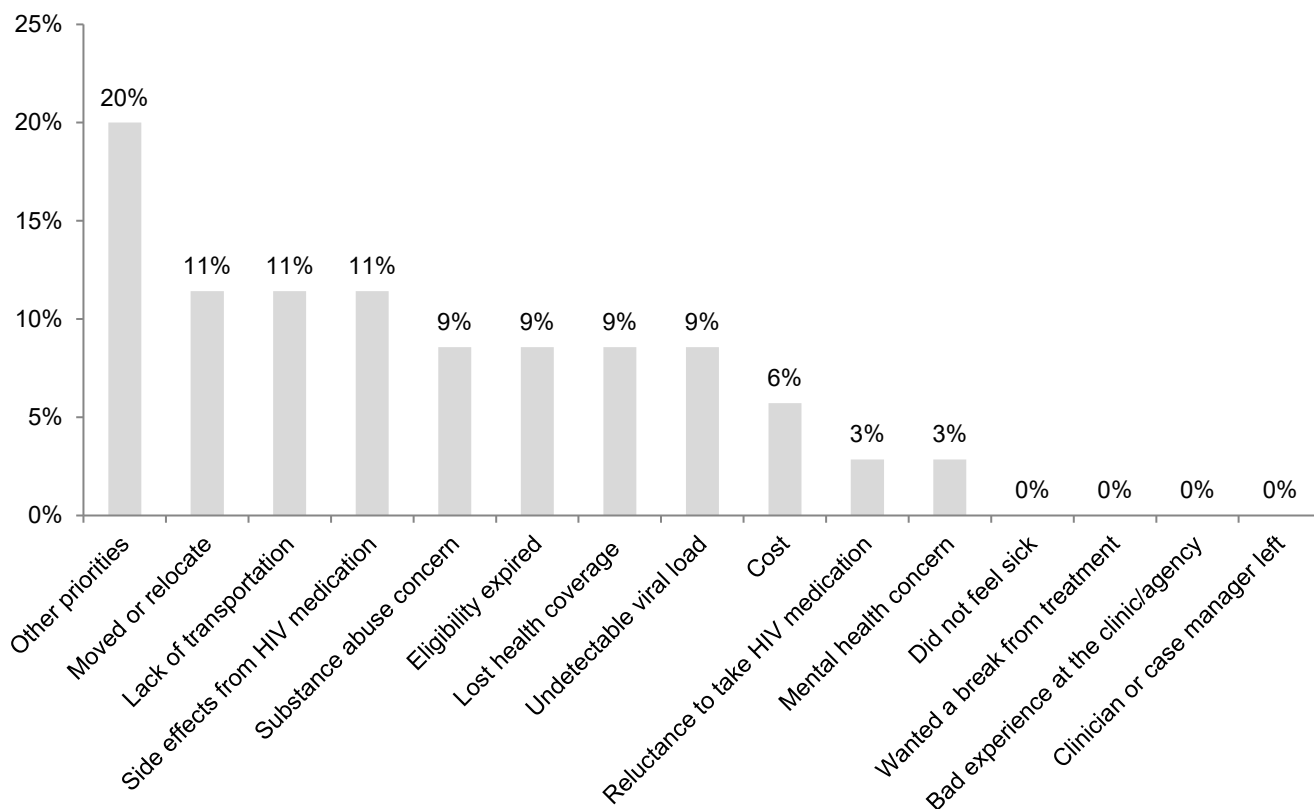
All participants in the 2020 Needs Assessment who reported a break in HIV care for 12 months or more were asked to identify the reasons for the interruption in care, selecting from a preset list of 15 commonly reported reasons. Among the total sample, substance abuse concerns were selected most often, followed by moving or relocating and having other priorities at the time.

(**Graph 1**) Among OOC participants, having priorities other than HIV was cited most often as the reason for an interruption in HIV care (at 20% of reported reasons), followed by moving or relocation (11%), lack of transportation (11%), and experiencing side effects from the medication (11%). There was no trend in write-in reasons for falling out of care.

GRAPH 1-Reasons for Falling Out of HIV Care among OOC PLHW in the Houston Area, 2020

Definition: Percent of times each item was reported by OOC needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.

Denominator: 35 reasons for falling out of care reported



RANKING OF NEED FOR HIV SERVICES

Funded Services

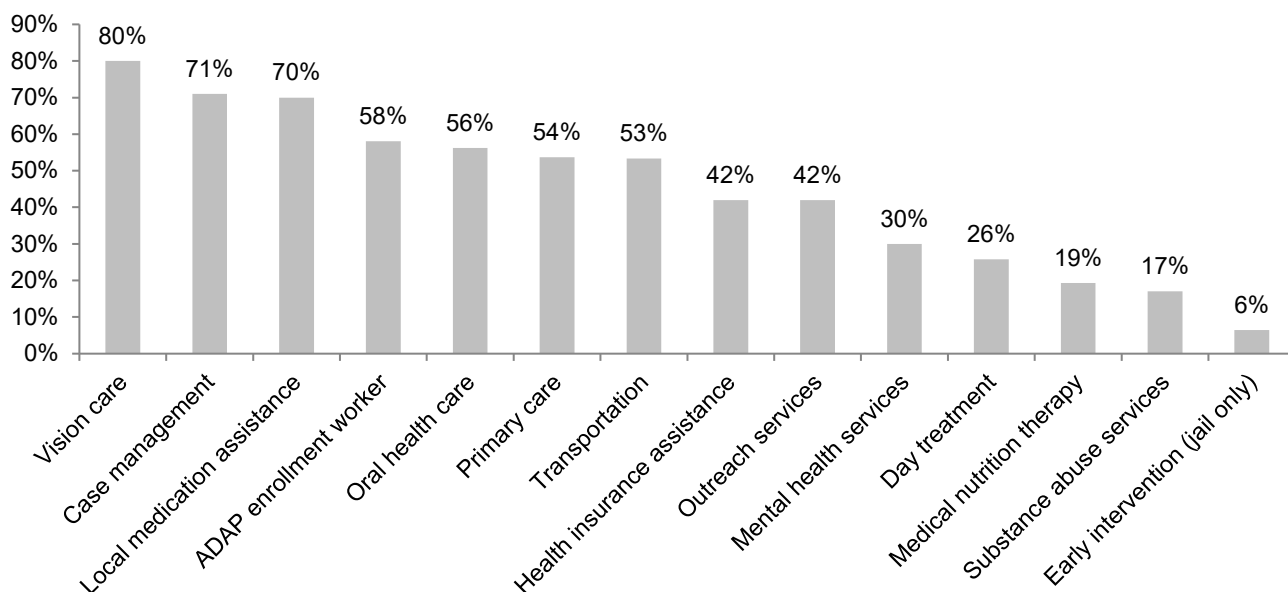
At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months. Among the total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

by local HIV medication assistance, case management, oral health care, and vision care.

(Graph 2) Among OOC participants, vision care was the most needed funded service at 72%, followed by case management (71%), local medication assistance (70%), ADAP enrollment worker (58%), and oral health care (56%)

GRAPH 2-Ranking of HIV Services among OOC PLWH in the Houston Area, By Need, 2020

*Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.
Denominator: 31 OOC participants*



Awareness of Available Services

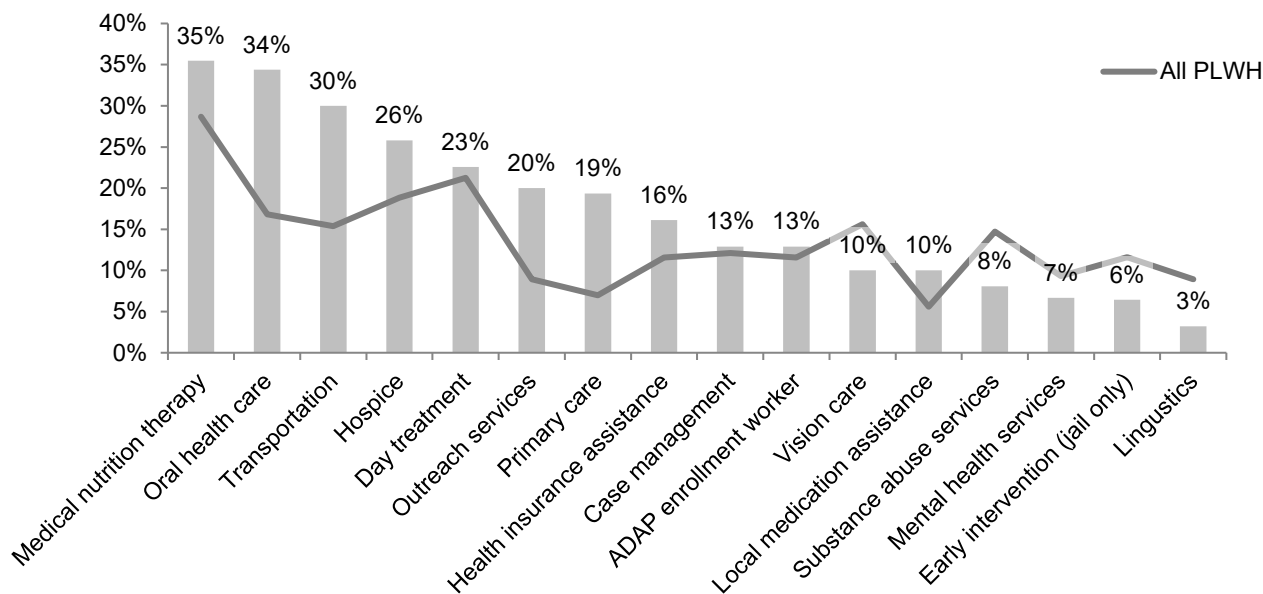
Education and awareness issues present a longstanding barrier to timely linkage to care in the Houston EMA, especially among OOC PLWH. Lack of awareness that a service exists or is available remains one of the most commonly cited reasons PLWH in the Houston Area do not access a needed service. The 2020 Houston HIV Care Services Needs Assessment survey asked participants to indicate if they did not know a funded service was available at the time of survey. Among the total sample, medical nutrition therapy had the highest proportion of participants who were unaware that it was an available service, followed by day treatment, hospice, oral health care, and vision care.

(Graph 3) In general, OOC participants had lower awareness of service availability than the sample as a whole. As with the total sample, medical nutrition therapy had the highest proportion of OOC participants who were unaware that it was an available service at 35% of OOC participants surveyed. This was followed by oral health care (34%), transportation (30%) hospice (26%), and day treatment (23%). The greatest variance in service awareness between the total sample and OOC participants was observed for oral health care, transportation, primary care, and outreach services.

GRAPH 3-Ranking of HIV Services among OOC PLWH and PLWH in the Houston Area, By Service Unawareness, 2020

Definition: Percent of OOC needs assessment participants stating they did not know the service was available.

Denominator: 31 participants





Service-Specific Fact Sheets

ADAP ENROLLMENT WORKER

AIDS Drug Assistance Program (ADAP) enrollment worker, technically referred to as *referral for health care and support*, describes a service that helps people living with HIV (PLWH) access medication coverage by ensuring the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). ADAP enrollment workers meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, assist clients with the submission of complete, accurate ADAP applications, and submit annual re-certifications.

(Graph 1) In the 2020 Houston HIV Care Services Needs Assessment, 60% of participants indicated a need for *ADAP enrollment worker* in the past 12 months. 58% reported the service was easy to access, and 2% reported difficulty. 12% stated they did not know the service was available.

(Table 1) When barriers to *ADAP enrollment worker* were reported, the most common barrier type was education and awareness (30%). Education and awareness barriers reported include lack of knowledge about service availability and who to contact to access the service.

GRAPH 1-ADAP Enrollment Worker, 2020

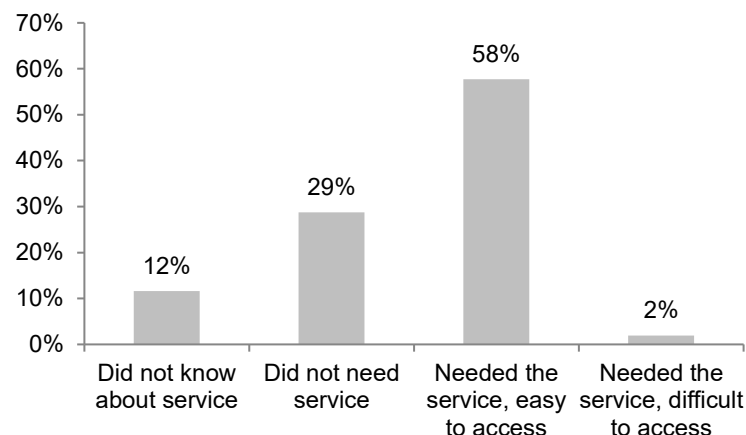


TABLE 1-Top 3 Reported Barrier Types for ADAP Enrollment Worker, 2020

	No.	%
1. Education and Awareness (EA)	3	30%
2. Administrative (AD)	2	20%
3. Eligibility (EL)	2	20%

(Table 2 and Table 3) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *ADAP enrollment worker*, this analysis shows the following:

- More females than males found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.

In addition, more out of care, rural, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-ADAP Enrollment Worker, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	9%	8%	13%	12%	4%	12%	9%	8%
Did not need service	28%	31%	32%	36%	20%	12%	28%	31%	32%
Needed, easy to access	57%	58%	57%	50%	66%	77%	57%	58%	57%
Needed, difficult to access	2%	1%	3%	2%	1%	8%	2%	1%	3%

TABLE 3-ADAP Enrollment Worker, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	8%	6%	0%	5%	0%	18%
Did not need service	7%	12%	0%	0%	3%	9%
Needed, easy to access	76%	71%	100%	89%	91%	64%
Needed, difficult to access	10%	11%	0%	5%	6%	9%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

CASE MANAGEMENT

Case management, technically referred to as *medical case management*, *clinical case management*, or *service linkage*, describes a range of services that help connect persons living with HIV (PLWH) to HIV care, treatment, and support services and to retain them in care. Case managers assess client needs, develop service plans, and facilitate access to services through referrals and care coordination. Case management also includes treatment readiness and adherence counseling.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 73% of participants indicated a need for *case management* in the past 12 months. 67% reported the service was easy to access, and 6% reported difficulty. 12% stated they did not know the service was available.

(**Table 1**) When barriers to *case management* were reported, the most common barrier type was interactions with staff (37%). Staff interaction barriers reported include poor correspondence or follow up, poor treatment, limited staff knowledge of services, and service referral to provider that did not meet client needs.

GRAPH 1-Case Management, 2020

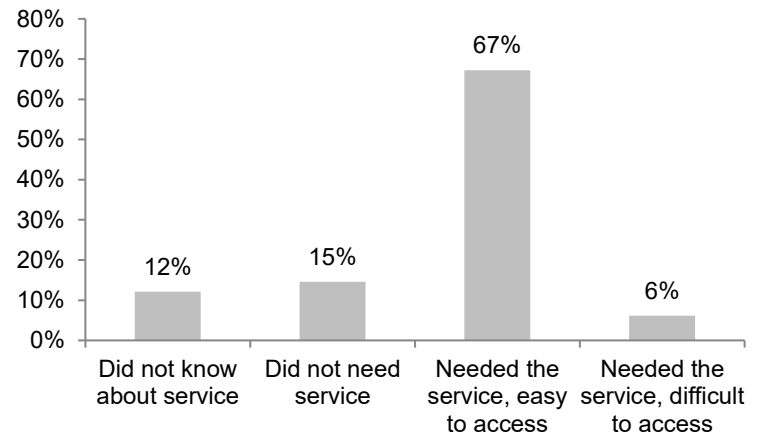


TABLE 1-Top 4 Reported Barrier Types for Case Management, 2020

	No.	%
1. Interactions with Staff (S)	13	37%
2. Education and Awareness (EA)	8	8%
3. Administrative (AD)	6	8%
4. Wait (4)	2	2%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *case management*, this analysis shows the following:

- More females than males found the service accessible.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.

In addition, more out of care, transgender, recently released from incarceration, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Case Management, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	7%	10%	11%	15%	4%	5%	15%	9%
Did not need service	59%	68%	22%	14%	13%	8%	29%	12%	17%
Needed, easy to access	20%	23%	64%	68%	66%	81%	52%	67%	69%
Needed, difficult to access	4%	3%	4%	7%	6%	8%	14%	6%	5%

TABLE 3-Case Management, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	10%	13%	13%	11%	37%	17%
Did not need service	13%	18%	16%	8%	9%	13%
Needed, easy to access	68%	63%	58%	71%	51%	58%
Needed, difficult to access	10%	6%	13%	11%	3%	13%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

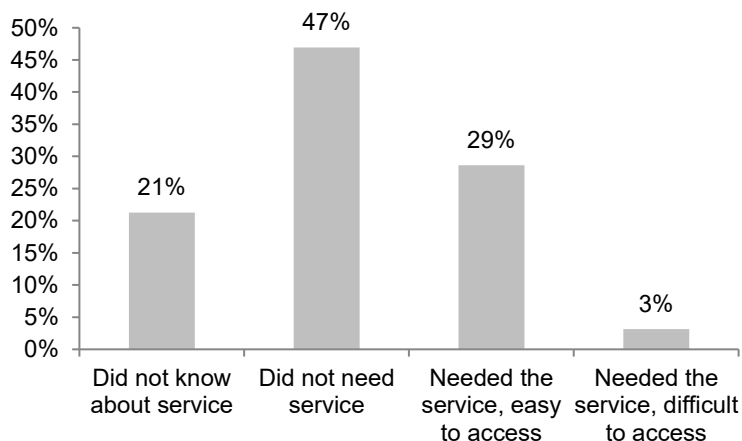
^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

DAY TREATMENT

Day treatment, technically referred to as *home and community-based health services*, provides therapeutic nursing, support services, and activities for persons living with HIV (PLWH) at a community-based location. This service does not currently include in-home health care, in-patient hospitalizations, or long-term nursing facilities.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 32% of participants indicated a need for *day treatment* in the past 12 months. 29% reported the service was easy to access, and 3% reported difficulty. 21% stated that they did not know the service was available.

GRAPH 1-Day Treatment, 2020



(**Table 1**) When barriers to *day treatment* were reported, the most common barrier type was education and awareness (25%). Education and awareness barriers reported include lack of knowledge about service availability and where to access the service.

TABLE 1-Top 3 Reported Barrier Types for Day Treatment, 2020

	No.	%
1. Education and Awareness (EA)	3	25%
2. Administrative (AD)	2	17%
3. Wait (W)	2	17%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *day treatment*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more transgender and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2- Day Treatment, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	22%	18%	18%	24%	20%	19%	14%	26%	15%
Did not need service	46%	50%	69%	49%	40%	42%	38%	45%	51%
Needed, easy to access	28%	29%	12%	24%	38%	31%	52%	25%	32%
Needed, difficult to access	3%	2%	1%	3%	2%	4%	0%	4%	1%

TABLE 3- Day Treatment, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	27%	24%	23%	31%	26%	28%
Did not need service	29%	49%	52%	30%	66%	36%
Needed, easy to access	35%	24%	26%	38%	9%	20%
Needed, difficult to access	8%	3%	0%	2%	0%	16%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

EARLY INTERVENTION (JAIL ONLY)

Early intervention services (EIS) refers to the provision of HIV testing, counseling, and referral in the Ryan White HIV/AIDS Program setting. In the Houston Area, the Ryan White HIV/AIDS Program funds EIS to persons living with HIV (PLWH) who are incarcerated in the Harris County Jail. Services focus on post-incarceration care coordination to ensure continuity of primary care and medication adherence post-release.

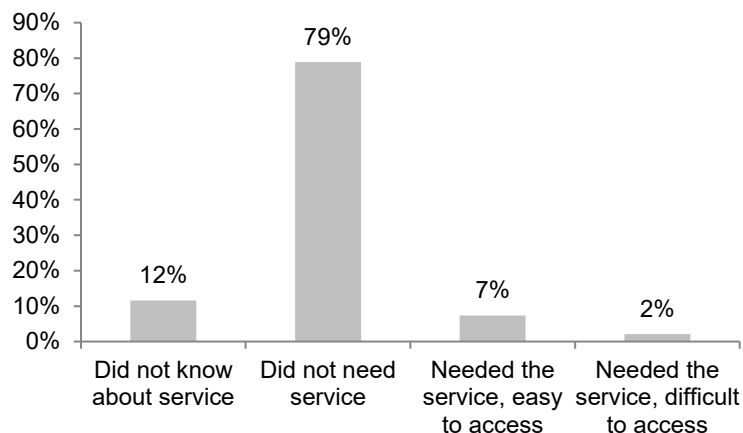
(**Graph 1**) In the 2020 Houston Area HIV needs assessment, 9% of participants indicated a need for *early intervention services* in the past 12 months. 7% reported the service was easy to access, and 2% reported difficulty. 12% stated that they did not know the service was available.

(**Table 1**) When barriers to *early intervention services* were reported, the most common barrier type was interactions with staff (67%). Interactions with staff barriers reported include poor correspondence or follow up, poor treatment, and service referral to provider that did not meet client needs.

TABLE 1-Top 4 Reported Barrier Types for Early Intervention (Jail Only), 2020

	No.	%
1. Interactions with Staff (S)	6	67%
2. Education and Awareness (EA)	3	33%

GRAPH 1-Early Intervention (Jail Only), 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *early intervention services*, this analysis shows the following:

- More females than males found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more recently released, homeless, transgender, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Early Intervention (Jail Only), by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	13%	8%	5%	12%	12%	12%	5%	12%	11%
Did not need service	77%	84%	83%	78%	81%	31%	86%	77%	82%
Needed, easy to access	8%	7%	8%	9%	5%	38%	5%	9%	6%
Needed, difficult to access	2%	1%	4%	2%	1%	19%	0%	3%	1%

TABLE 3-Early Intervention (Jail Only), by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	13%	14%	6%	15%	14%	4%
Did not need service	66%	79%	87%	43%	80%	83%
Needed, easy to access	16%	5%	6%	31%	6%	8%
Needed, difficult to access	5%	3%	0%	11%	0%	4%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

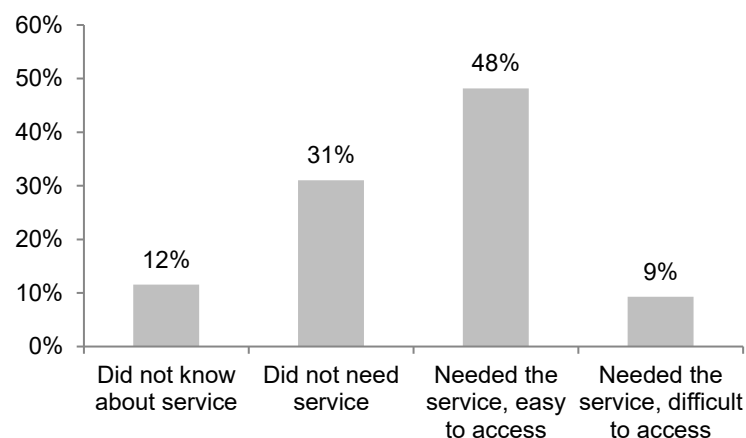
^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

HEALTH INSURANCE ASSISTANCE

Health insurance assistance, also referred to as *health insurance premium and cost-sharing assistance*, provides financial assistance to persons living with HIV (PLWH) with third-party health insurance coverage (such as private insurance, ACA Qualified Health Plans, COBRA, or Medicare) so they can obtain or maintain health care benefits. This includes funding for premiums, deductibles, Advanced Premium Tax Credit liability, and co-pays for both medical visits and medication.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 57% of participants indicated a need for *health insurance assistance* in the past 12 months. 48% reported the service was easy to access, and 9% reported difficulty. 12% stated that they did not know the service was available.

GRAPH 1-Health Insurance Assistance, 2020



(**Table 1**) When barriers to *health insurance assistance* were reported, the most common barrier types were eligibility and financial (each 23%). Eligibility barriers reported include not meeting eligibility requirements, and redundant or complex processes for meeting/renewing eligibility, while financial barriers reported include inability to afford the service.

TABLE 1-Top 5 Reported Barrier Types for Health Insurance Assistance, 2020

	No.	%
1. Eligibility (EL)	9	23%
2. Financial (F)	9	23%
3. Health Insurance Coverage (I)	7	18%
4. Administrative (AD)	5	13%
5. Education and Awareness (EA)	4	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *health insurance assistance*, this analysis shows the following:

- No difference in service accessibility by sex at birth.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more transgender, homeless, MSM, and rural PLWH found the service difficult to access when compared to all participants.

TABLE 2-Health Insurance Assistance, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	9%	15%	13%	8%	12%	0%	12%	11%
Did not need service	30%	34%	43%	29%	32%	12%	14%	30%	34%
Needed, easy to access	48%	48%	40%	48%	50%	58%	81%	47%	49%
Needed, difficult to access	9%	9%	3%	9%	10%	15%	5%	12%	6%

TABLE 3-Health Insurance Assistance, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	21%	11%	16%	25%	17%	13%
Did not need service	32%	30%	42%	25%	23%	25%
Needed, easy to access	34%	47%	42%	43%	49%	33%
Needed, difficult to access	13%	12%	0%	8%	11%	29%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

HOSPICE

Hospice is end-of-life care for persons living with HIV (PLWH) who are in a terminal stage of illness (defined as a life expectancy of 6 months or less). This includes room, board, nursing care, mental health counseling, physician services, and palliative care.

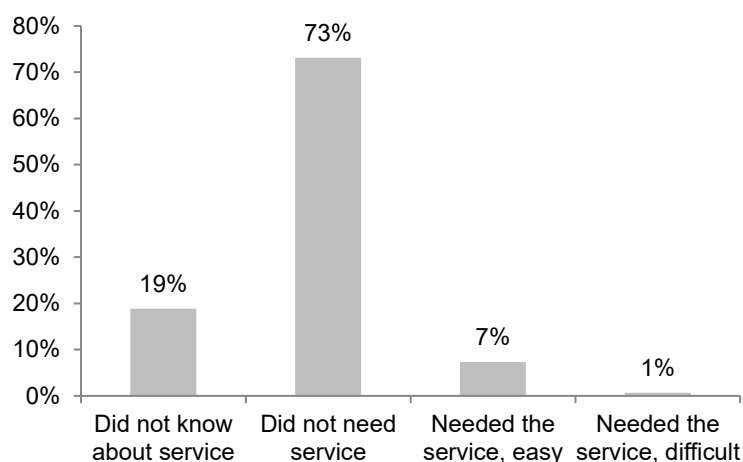
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 8% of participants indicated a need for *hospice* in the past 12 months. 7% reported the service was easy to access, and 1% reported difficulty. 17% stated that they did not know the service was available.

(**Table 1**) Only two barriers were reported for hospice. This number is too small to detect any pattern in service barriers for hospice.

TABLE 1- Reported Barrier Types for Hospice, 2020

	No.	%
1. Health Insurance Coverage (I)	1	50%
2. Transportation (T)	1	50%

GRAPH 1-Hospice, 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *hospice*, this analysis shows the following:

- More females than males found the service accessible.
- More White, Hispanic/Latino, and other/multiracial PLWH found the service accessible than Black/African American PLWH.
- More PLWH age 50+ found the service accessible than other PLWH age 25 to 49.
- In addition, more MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Hospice, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	20%	15%	10%	18%	23%	23%	10%	23%	13%
Did not need service	72%	78%	87%	76%	65%	65%	95%	67%	80%
Needed, easy to access	8%	5%	3%	5%	11%	12%	0%	9%	6%
Needed, difficult to access	0%	1%	0%	1%	0%	0%	0%	1%	0%

TABLE 3- Hospice, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	19%	8%	26%	27%	11%	36%
Did not need service	68%	54%	61%	63%	83%	64%
Needed, easy to access	13%	33%	13%	11%	6%	0%
Needed, difficult to access	0%	1%	0%	0%	0%	0%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

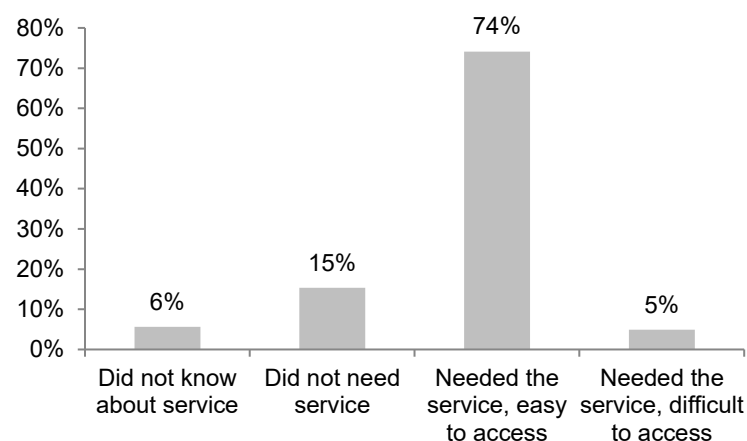
LOCAL HIV MEDICATION ASSISTANCE

Local HIV medication assistance, technically referred to as the *Local Pharmacy Assistance Program (LPAP)*, provides HIV-related pharmaceuticals to persons living with HIV (PLWH) who are not eligible for medications through other payer sources, including the state AIDS Drug Assistance Program (ADAP).

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 79% of participants indicated a need for *local HIV medication assistance* in the past 12 months. 74% reported the service was easy to access, and 5% reported difficulty. 6% stated that they did not know the service was available.

(**Table 1**) When barriers to *local HIV medication assistance* were reported, the most common barrier type was eligibility (25%). Eligibility barriers reported include redundant or complex processes for meeting/renewing eligibility, problems obtaining documentation needed for eligibility and not meeting eligibility requirements.

GRAPH 1-Local HIV Medication Assistance, 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *local HIV medication assistance*, this analysis shows the following:

- More males than females found the service accessible.
- More White PLWH than other race/ethnicities found the service accessible.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, homeless, MSM, rural, and transgender PLWH found the service difficult to access when compared to all participants.

TABLE 1-Top 5 Reported Barrier Types for Local HIV Medication Assistance, 2020

	No.	%
1. Eligibility (EL)	7	25%
2. Administrative (AD)	4	14%
3. Education and Awareness (EA)	4	14%
4. Health Insurance Coverage (I)	4	14%
5. Interactions with Staff (S)	3	11%

TABLE 2-Local HIV Medication Assistance, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	7%	2%	1%	5%	7%	8%	0%	6%	6%
Did not need service	16%	12%	29%	17%	10%	4%	14%	15%	16%
Needed, easy to access	73%	79%	69%	72%	76%	88%	81%	73%	75%
Needed, difficult to access	4%	7%	1%	5%	6%	4%	5%	6%	3%

TABLE 3-Local HIV Medication Assistance, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	11%	6%	10%	6%	6%	8%
Did not need service	15%	17%	20%	8%	17%	46%
Needed, easy to access	68%	71%	70%	83%	71%	42%
Needed, difficult to access	6%	6%	0%	3%	6%	4%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

MEDICAL NUTRITION THERAPY

Medical nutrition therapy provides nutrition supplements and nutritional counseling to persons living with HIV (PLWH) outside of a primary care visit by a licensed registered dietician based on physician recommendation and a nutrition plan. The purpose of such services can be to address HIV-associated nutritional deficiencies or dietary needs as well as to mitigate medication side effects.

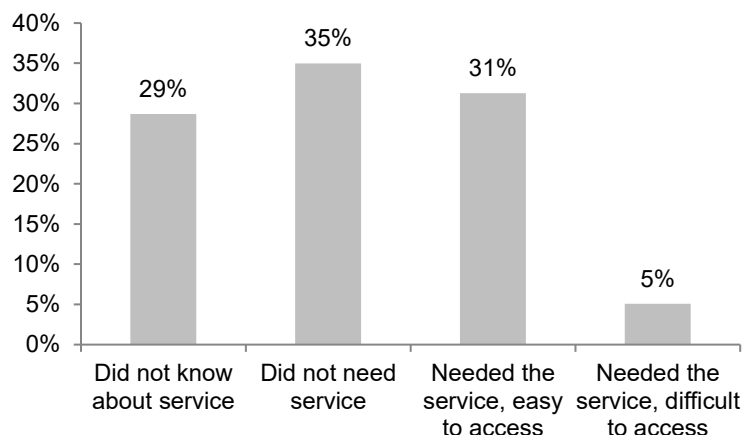
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 36% of participants indicated a need for *medical nutrition therapy* in the past 12 months. 31% reported the service was easy to access, and 5% reported difficulty. 29% stated that they did not know the service was available.

(**Table 1**) When barriers to *medical nutrition therapy* were reported, the most common barrier type was education and awareness (35%) Education and awareness barriers reported include lack of knowledge about service availability, what the service entails, and who to contact to access the service.

TABLE 1-Top 3 Reported Barrier Types for Medical Nutrition Therapy, 2020

	No.	%
1. Education and Awareness (EA)	8	35%
2. Eligibility (EL)	6	26%
3. Interactions with Staff (S)	4	17%

GRAPH 1-Medical Nutrition Therapy, 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *medical nutrition therapy*, this analysis shows the following:

- More female than males found the service accessible.
- More Hispanic/Latino PLWH than other race/ethnicities found the service accessible.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Medical Nutrition Therapy, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	29%	28%	24%	28%	31%	27%	19%	35%	20%
Did not need service	35%	33%	36%	35%	36%	27%	71%	30%	39%
Needed, easy to access	31%	33%	36%	31%	31%	38%	10%	29%	37%
Needed, difficult to access	5%	6%	4%	6%	2%	12%	0%	6%	4%

TABLE 3-Medical Nutrition Therapy, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	29%	31%	35%	41%	43%	17%
Did not need service	37%	36%	45%	28%	40%	54%
Needed, easy to access	24%	29%	16%	30%	17%	29%
Needed, difficult to access	10%	4%	3%	2%	0%	0%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

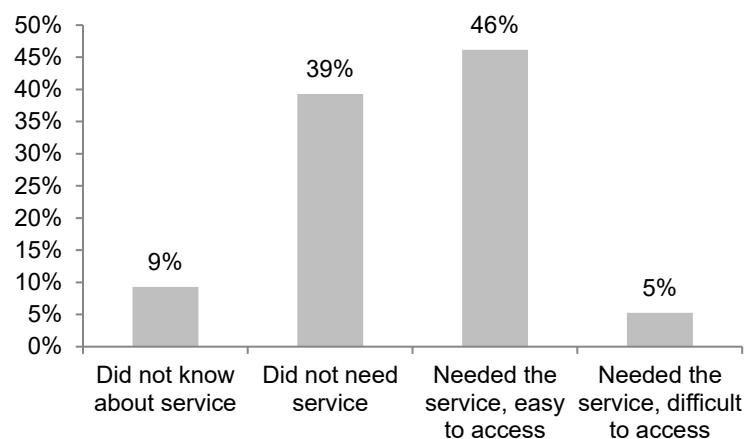
MENTAL HEALTH SERVICES

Mental health services, also referred to as *professional mental health counseling*, provides psychological counseling services for persons living with HIV (PLWH) who have a diagnosed mental illness. This includes group or individual counseling by a licensed mental health professional in accordance with state licensing guidelines.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 51% of participants indicated a need for *mental health services* in the past 12 months. 46% reported the service was easy to access, and 5% reported difficulty. 9% stated that they did not know the service was available.

(**Table 1**) When barriers to *mental health services* were reported, the most common barrier types were administrative, and education and awareness (each 22%). Administrative barriers reported include staff changes, hours of operation, client dismissal from the agency, and understaffing. Education and awareness barriers reported include lack of knowledge about service availability, where to go to access the service, and who to contact to access the service.

GRAPH 1-Mental Health Services, 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *mental health services*, this analysis shows the following:

- More males than females found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more recently released, rural, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 1-Top 5 Reported Barrier Types for Mental Health Services, 2020

	No.	%
1. Administrative (AD)	7	22%
2. Education and Awareness (EA)	7	22%
3. Health Insurance Coverage (I)	4	13%
4. Interactions with Staff (S)	3	9%
5. Transportation (T)	3	9%

TABLE 2-Mental Health Services, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	11%	5%	6%	10%	11%	12%	5%	12%	6%
Did not need service	39%	39%	35%	40%	42%	19%	43%	36%	44%
Needed, easy to access	46%	47%	47%	45%	45%	54%	52%	46%	45%
Needed, difficult to access	4%	8%	12%	5%	2%	12%	0%	5%	5%

TABLE 3-Mental Health Services, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	16%	9%	7%	11%	11%	8%
Did not need service	38%	38%	63%	25%	57%	54%
Needed, easy to access	39%	48%	30%	49%	17%	33%
Needed, difficult to access	7%	5%	0%	14%	11%	4%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

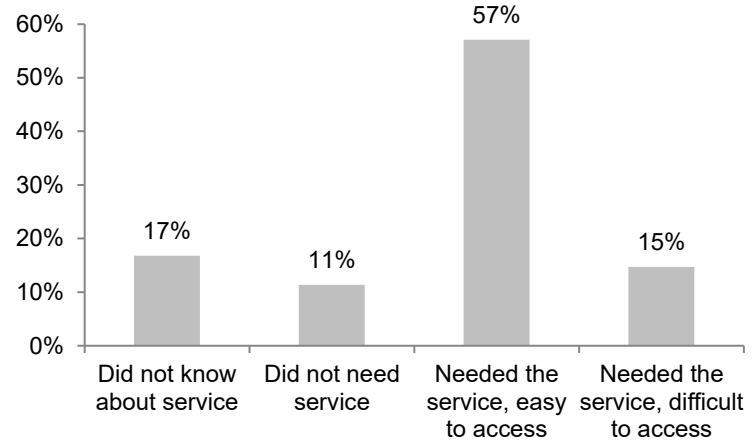
ORAL HEALTH CARE

Oral health care, or dental services, refers to the diagnostic, preventative, and therapeutic services provided to persons living with HIV (PLWH) by a dental health care professional (such as a dentist or hygienist). This includes examinations, periodontal services (such as cleanings and fillings), extractions and other oral surgeries, restorative dental procedures, and prosthodontics (or dentures).

(Graph 1) In the 2020 Houston HIV Care Services Needs Assessment, 72% of participants indicated a need for *oral health care* in the past 12 months. 57% reported the service was easy to access, and 15% reported difficulty. 17% stated that they did not know the service was available.

(Table 1) When barriers to *oral health care* were reported, the most common barrier type was wait-related issues (35%). Wait-related barriers reported include placement on a waitlist, long waits at appointments, and being told to call back as a wait list was full/unavailable. Of note, at least seven participants reported unprompted that their provider stated Ryan White does not cover prosthodontics, and that the participants would need to pay several hundred dollars out of pocket for treatment. Administrative agent and agency staff were notified immediately to resolve this issue.

GRAPH 1-Oral Health Care, 2020



(Table 2 and Table 3) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *oral health care*, this analysis shows the following:

- More males than females found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 18 to 24 found the service accessible than other age groups.
- In addition, more out of care, recently released, and MSM found the service difficult to access when compared to all participants.

TABLE 1-Top 5 Reported Barrier Types for Oral Health Care, 2020

	No.	%
1. Wait (W)	20	22%
2. Interactions with Staff (S)	16	18%
3. Health Insurance Coverage (I)	12	13%
4. Education and Awareness (EA)	11	12%
5. Administrative (AD)	9	10%

TABLE 2-Oral Health Care, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	18%	12%	6%	19%	19%	15%	24%	22%	8%
Did not need service	11%	12%	22%	12%	8%	4%	14%	9%	14%
Needed, easy to access	57%	59%	49%	55%	63%	54%	52%	52%	65%
Needed, difficult to access	14%	17%	22%	14%	10%	27%	10%	17%	12%

TABLE 3-Oral Health Care, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	34%	15%	34%	20%	9%	8%
Did not need service	6%	10%	9%	11%	20%	13%
Needed, easy to access	45%	59%	34%	50%	69%	67%
Needed, difficult to access	15%	16%	22%	19%	3%	13%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

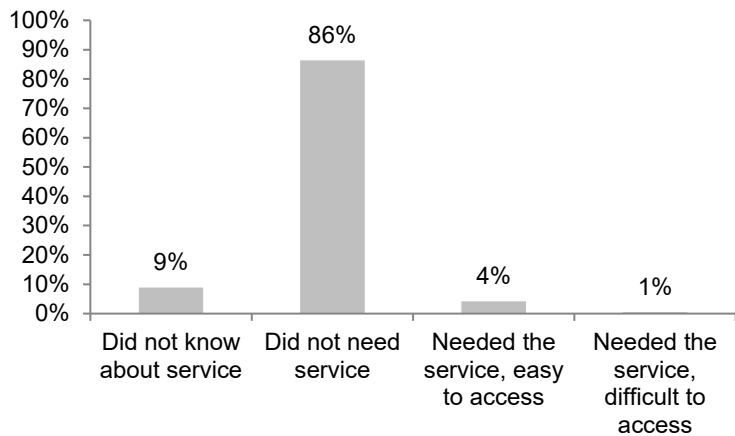
^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

OUTREACH SERVICES

Outreach services are provided for people living with HIV (PLWH) who have missed primary medical care appointments without rescheduling, and who may have other risk factors for falling out of care. The goal of *outreach services* is to support retention in care. Services are field-based, and include assistance with medical appointment setting and accessing supportive services, advocating on behalf of clients to decrease service gaps and remove barriers to services, and helping clients develop and utilize independent living skills and strategies.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 5% of participants indicated a need for *outreach services* in the past 12 months. 4% reported the service was easy to access, and 1% reported difficulty. 9% stated that they did not know the service was available.

GRAPH 1-Outreach Services, 2020



(**Table 1**) When barriers to *outreach services* were reported, the most common barrier type was interactions with staff (71%). Interactions with staff barriers reported include poor correspondence or follow up.

TABLE 1-Top Reported Barrier Type for Outreach Services, 2020

	No.	%
1. Interactions with Staff (S)	5	71%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *outreach services*, this analysis shows the following:

- More males than females found the service accessible.
- More Black/African American and Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more homeless, MSM, recently released, and transgender PLWH found the service difficult to access when compared to all participants.

TABLE 2-Outreach Services, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	22%	17%	22%	19%	22%	23%	57%	25%	11%
Did not need service	42%	40%	57%	45%	33%	38%	24%	34%	53%
Needed, easy to access	34%	40%	17%	34%	42%	38%	19%	37%	34%
Needed, difficult to access	3%	2%	4%	2%	2%	0%	5%	3%	1%

TABLE 3-Outreach Services, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	23%	23%	20%	28%	26%	21%
Did not need service	28%	42%	37%	30%	37%	42%
Needed, easy to access	37%	32%	43%	39%	37%	35%
Needed, difficult to access	12%	3%	0%	3%	0%	2%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

PRIMARY HIV MEDICAL CARE

Primary HIV medical care, technically referred to as *outpatient/ambulatory medical care*, refers to the diagnostic and therapeutic services provided to persons living with HIV (PLWH) by a physician or physician extender in an outpatient setting. This includes physical examinations, diagnosis and treatment of common physical and mental health conditions, preventative care, education, laboratory services, and specialty services as indicated.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 89% of participants indicated a need for *primary HIV medical care* in the past 12 months. 80% reported the service was easy to access, and 90% reported difficulty. 7% stated that they did not know the service was available.

(**Table 1**) When barriers to *primary HIV medical care* were reported, the most common barrier type was transportation (26%). Transportation barriers reported include having no or limited transportation options, and having problems with special transportation providers such as Metrolift or Medicaid transportation

GRAPH 1-Primary HIV Medical Care, 2020

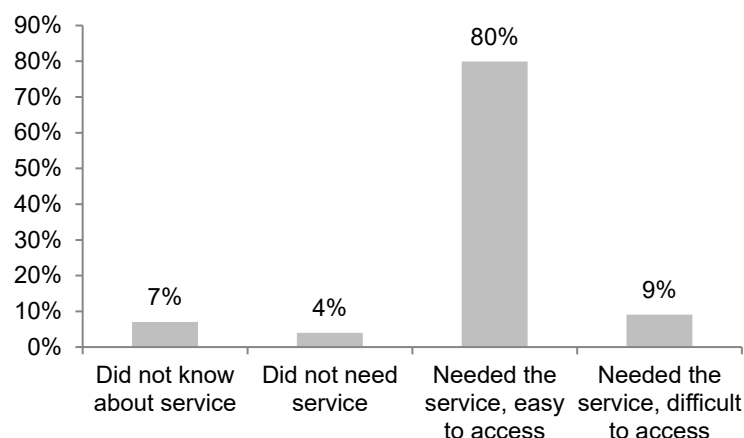


TABLE 1-Top 5 Reported Barrier Types for Primary HIV Medical Care, 2020

	No.	%
1. Transportation (T)	11	26%
2. Education and Awareness (EA)	8	19%
3. Interactions with Staff (S)	8	19%
4. Eligibility	4	9%
5. Wait (W)	4	9%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *primary HIV medical care*, this analysis shows the following:

- More females than males found the service accessible.
- More White PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more rural, out of care, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Primary HIV Medical Care, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	8%	4%	1%	5%	12%	0%	0%	9%	5%
Did not need service	4%	4%	9%	3%	3%	0%	0%	2%	8%
Needed, easy to access	92%	85%	86%	83%	74%	92%	76%	79%	83%
Needed, difficult to access	9%	8%	4%	8%	12%	8%	24%	11%	5%

TABLE 3-Primary HIV Medical Care, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	10%	9%	19%	9%	3%	13%
Did not need service	2%	5%	10%	2%	0%	13%
Needed, easy to access	82%	77%	55%	83%	71%	75%
Needed, difficult to access	6%	10%	16%	6%	26%	0%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

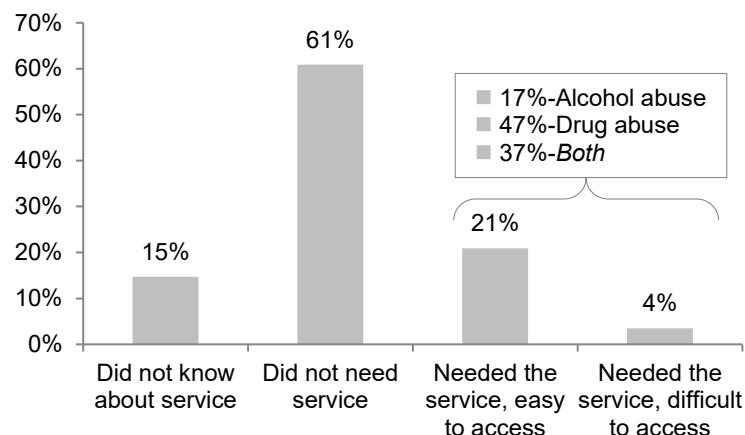
^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

SUBSTANCE ABUSE SERVICES

Substance abuse services, also referred to as *outpatient alcohol or drug abuse treatment*, provides counseling and/or other treatment modalities to persons living with HIV (PLWH) who have a substance use disorder concern in an outpatient setting and in accordance with state licensing guidelines. This includes services for alcohol use and/or use of legal or illegal drugs.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 24% of participants indicated a need for *substance abuse services* in the past 12 months. 21% reported the service was easy to access, and 4% reported difficulty. 15% stated they did not know the service was available. When analyzed by type of substance concern, 17% of participants cited alcohol, 47% cited drugs, and 37% cited both.

GRAPH 1-Substance Abuse Services, 2020



(**Table 1**) When barriers to *substance use services* were reported, the most common barrier type was education and awareness (46%). Education and awareness barriers reported include lack of knowledge about service availability

TABLE 1-Top 2 Reported Barrier Types for Substance Abuse Services, 2020

	No.	%
1. Education and Awareness (EA)	4	46%
2. Transportation (T)	2	18%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *substance abuse services*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more recently released and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Substance Abuse Services, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	7%	12%	12%	18%	19%	43%	15%	12%
Did not need service	59%	68%	69%	63%	58%	58%	43%	59%	65%
Needed, easy to access	20%	23%	16%	21%	21%	23%	10%	22%	21%
Needed, difficult to access	4%	3%	3%	5%	2%	0%	5%	4%	2%

TABLE 3-Substance Abuse Services, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	13%	18%	16%	15%	23%	8%
Did not need service	55%	60%	61%	44%	71%	71%
Needed, easy to access	20%	18%	23%	24%	6%	17%
Needed, difficult to access	12%	3%	0%	18%	0%	4%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

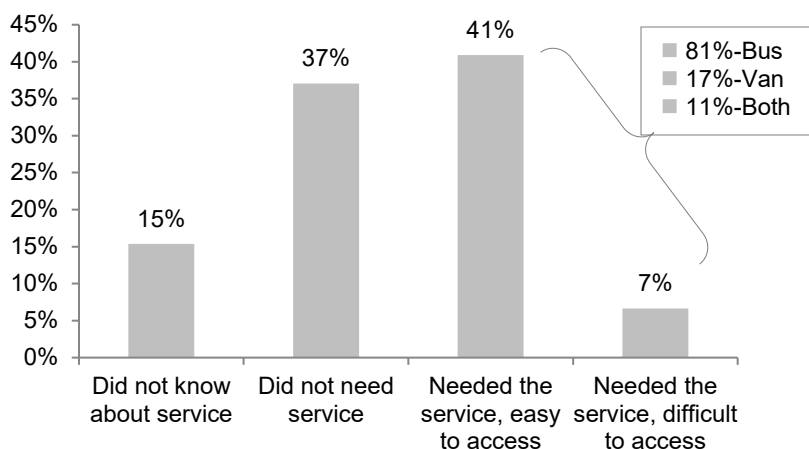
^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

TRANSPORTATION

Transportation services provides transportation to persons living with HIV (PLWH) to locations where HIV-related care is received, including pharmacies, mental health services, and substance abuse services. The service can be provided in the form of public transportation vouchers (bus passes), gas vouchers (for rural clients), taxi vouchers (for emergency purposes), and van-based services as medically indicated.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 48% of participants indicated a need for *transportation services* in the past 12 months. 41% reported the service was easy to access, and 7% reported difficulty. 15% stated they did not know the service was available. When analyzed by type transportation assistance sought, 81% of participants needed bus passes, 17% needed van services, and 11% needed both forms of assistance.

GRAPH 1-Transportation Services, 2020



(**Table 1**) When barriers to *transportation services* were reported, the most common barrier type was education and awareness (24%). Education and awareness barriers reported include lack of knowledge about service availability and where to go to access the service.

TABLE 1-Top 5 Reported Barrier Types for Transportation Services, 2020

	No.	%
1. Education and Awareness (EA)	7	24%
2. Resource Availability (R)	5	17%
3. Transportation (T)	5	17%
4. Eligibility (EL)	3	10%
5. Financial (F)	3	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *transportation services*, this analysis shows the following:

- More males than females found the service accessible..
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more homeless, out of care, and recently released PLWH found the service difficult to access when compared to all participants.

TABLE 2-Transportation Services, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	10%	5%	14%	8%	12%	43%	20%	7%
Did not need service	38%	35%	51%	32%	81%	31%	14%	38%	37%
Needed, easy to access	39%	47%	36%	49%	9%	38%	43%	35%	50%
Needed, difficult to access	6%	8%	8%	5%	1%	19%	5%	7%	7%

TABLE 3-Transportation Services, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	7%	19%	30%	12%	14%	8%
Did not need service	28%	38%	17%	21%	71%	32%
Needed, easy to access	51%	37%	40%	59%	14%	16%
Needed, difficult to access	15%	6%	13%	8%	0%	4%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

VISION CARE

Vision care, technically a subcategory of primary HIV medical care, provides optometric/ophthalmologic treatment, vision screening, and glasses to people living with HIV (PLWH). This does not include fitting of contact lenses.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 68% of participants indicated a need for *vision care* in the past 12 months. 59% reported the service was easy to access, and 9% reported difficulty. 16% stated they did not know the service was available.

(**Table 1**) When barriers to *vision care* were reported, the most common barrier type was wait-related issues. Wait-related barriers reported include scheduling appointments 2-3 months out, placement on a waitlist, being told to call back as a wait list was full/unavailable, and long waits at appointments.

GRAPH 1-Vision Care, 2020

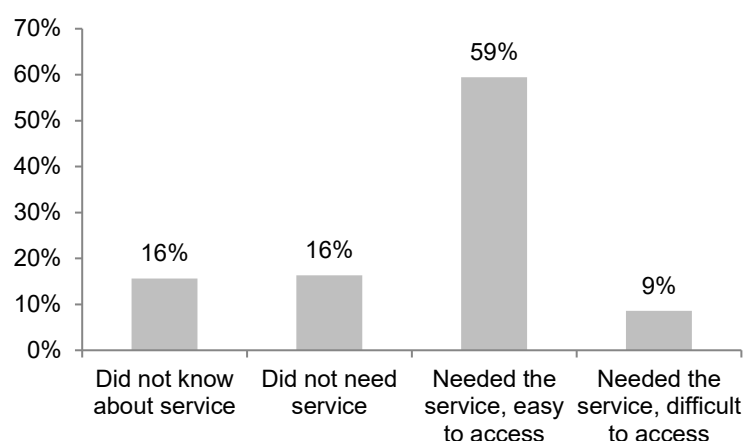


TABLE 1-Top 5 Reported Barrier Types for Vision Care, 2020

	No.	%
1. Wait (W)	15	34%
2. Health Insurance Coverage (I)	8	18%
3. Education and Awareness (EA)	6	14%
4. Financial (F)	4	9%
5. Interactions with Staff (S)	3	7%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *vision care*, this analysis shows the following:

- More males than females found the service accessible.
- More Black/African American PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more homeless and out of care PLWH found the service difficult to access when compared to all participants.

TABLE 2-Vision Care, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	10%	12%	15%	15%	15%	14%	21%	8%
Did not need service	16%	18%	19%	21%	11%	4%	62%	15%	15%
Needed, easy to access	60%	58%	60%	56%	65%	69%	14%	56%	69%
Needed, difficult to access	7%	14%	9%	8%	9%	15%	14%	9%	8%

TABLE 3-Vision Care, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	20%	17%	10%	28%	6%	20%
Did not need service	16%	13%	10%	16%	20%	24%
Needed, easy to access	51%	63%	70%	47%	66%	56%
Needed, difficult to access	13%	7%	10%	9%	6%	0%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender



**2020 Houston Area HIV Care Services Needs Assessment
Approved: PENDING**

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DRAFT

06/03/20



2020 Houston HIV Care Services Needs Assessment

A collaboration of:

Houston Area HIV Services Ryan White Planning Council

Houston HIV Prevention Community Planning Group

Harris County Public Health, Ryan White Grant Administration

Houston Health Department, Bureau of HIV/STD and Viral Hepatitis
Prevention

Houston Regional HIV/AIDS Resource Group, Inc.

Harris Health System

People Living with HIV in the Houston Area and Ryan White HIV/AIDS
Program Consumers

Approval: Pending

Disclaimer:

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

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

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The following individuals provided oversight and guidance to the 2020 Houston Area HIV Care Services Needs Assessment process, including survey design, data administration, and the review and approval of this document:

- Needs Assessment Group (NAG) Co-Chairs: W. Jeffrey Campbell, Jon-Michael Gillispie, Eric James, and Steven Vargas
- Epidemiology Workgroup Co-Chairs: Cynthia Deverson and Isis Torrente
- Survey Workgroup Co-Chairs: Ardry Skeet Boyle, Ricardo Mora, and Cecilia Oshingbade
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EXECUTIVE SUMMARY

The 2020 Houston Area HIV Care Services Needs Assessment presents data on HIV service needs, barriers, and other factors influencing access to care for people living with HIV (PLWH) in the Houston Area as determined through a consumer survey. Needs assessments ensure consumer experiences and perspectives are included in the data-driven decision-making processes of local HIV planning. Data are used to help set priorities for the allocation of HIV care services funding, in the development of the comprehensive HIV plan, and in designing annual service implementation plans. The last Needs Assessment was conducted in 2016.

HIV Service Needs in the Houston Area

According to the Houston Area HIV Care Services Needs Assessment, all currently funded HIV services in the Houston Area are needed by consumers. The top five most needed services are:

1. Primary care
2. Local medication assistance
3. Case management
4. Oral health care, and
5. Vision care

For the first time in 2020, need for currently unfunded services was analyzed, which revealed substantial need for housing services for PLWH in the Houston area.

Accessibility of HIV Services in the Houston Area

In addition to revealing the most needed HIV services in the Houston Area, the Houston Area HIV Care Services Needs Assessment provides information about access to those services, which helps communities better understand where barriers to services may exist.

In 2020, at least 78% of the PLWH who said they needed each HIV funded service *also* said the service was easily accessible to them. There were some funded services, however, that were less accessible than others: early intervention services, oral health care, and health insurance assistance *least* accessible services according to 2020 Houston Area HIV Care Services Needs Assessment. ADAP enrollment workers and local medication assistance were the most accessible services in 2020.

Barriers to HIV Services in the Houston Area

To improve understanding of barriers to HIV services, the 2020 Houston Area HIV Care Services Needs Assessment also gathers information about the types of difficulties consumers experience when services are not

easily accessible. The most common types of barriers encountered are:

1. Education and awareness issues
2. Interactions with staff
3. Wait-related issues
4. Administrative issues, and
5. Health insurance/coverage issues

In addition to the above results, the 2020 Needs Assessment includes detailed information about a variety of issues that affect access to care, including:

- Service needs and barriers at each stage of the HIV care continuum, from HIV testing and initial diagnosis to treatment to support viral load suppression
- The social, economic, health (both physical and mental), and behavioral characteristics of PLWH that may help or hinder HIV prevention and access to HIV care
- A brief profile on the service needs and barriers of people who are out of care
- Service-Specific Fact Sheets detailing the needs and barriers for each HIV core medical, support, and housing service

Together, these data are used to better understand the HIV care needs and patterns of PLWH in the Houston Area, to identify new and emerging areas of need, and to ultimately improve the system of HIV services so that it best meets the needs of PLWH.

The 2020 Houston Area HIV Care Services Needs Assessment is a collaboration between the Ryan White Planning Council, HIV Prevention Community Planning Group, Ryan White Grant Administration, Houston Health Department Bureau of HIV/STD and Viral Hepatitis Prevention, The Resource Group, Harris Health System, and Housing Opportunities for Persons with AIDS (HOPWA). A total of 38 individuals assisted in the planning and implementation of the needs assessment, of whom 45% were self-disclosed PLWH.

For more information about the 2016 Houston Area HIV Care Services Needs Assessment, contact the Office of Support at (832) 927-7926 or visit www.rwphouston.org.

INTRODUCTION

What is an HIV needs assessment?

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

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

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

How are HIV needs assessment data used?

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

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

- Ensuring the consumer point-of-view is infused into all of the data-driven decision-making activities of the Houston Area RWPC.
- Revising local service definitions for HIV care, treatment, and support services in order to best meet the needs of PLWH in the Houston Area.
- Setting priorities for the allocation of Ryan White HIV/AIDS Program funds to specific services.

- Establishing goals for and then monitoring the impact of the Houston Area's comprehensive plan for improving the HIV prevention and care system.
- Determining if there is a need to target services by analyzing the needs of particular groups of PLWH.
- Determining the need for special studies of service gaps or subpopulations that may be otherwise underrepresented in data sources.
- By the Planning Council, other Planning Bodies, specific Ryan White HIV/AIDS Program Parts, providers, or community partners to assess needs for services.

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

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

Sources:

- 2020 Houston Area HIV Needs Assessment Group (NAG), Analysis Workgroup, Principles for the 2020 Needs Assessment Analysis. Approved 08-19-19.
- U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Ryan White HIV/AIDS Program Part A Manual Revised 2013. Section XI, Ch 3: Needs Assessment.

METHODOLOGY

Needs Assessment Planning

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

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

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

Survey Sampling Plan

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

Survey Tool

Data for the 2020 Houston Area HIV Care Services Needs Assessment were collected using a 54-question paper or electronic survey of open-ended, multiple

choice, and scaled questions addressing nine topic areas (in order):

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

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

Data Collection

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

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

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

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

Data Management

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

survey entries are excluded from analysis per variable; therefore, denominators vary across results. In addition, proportions are not calculated with a denominator of 589 surveys for every variable due to missing or “check-all” responses. All data management and analysis was performed in IBM® SPSS® Statistics (v. 22) and QSR International® NVivo 10.

Limitations

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

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

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

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

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

Sources:

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

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

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

BACKGROUND

The Houston Area

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

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

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

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

HIV in the Houston Area

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

TABLE 1-Diagnosed People Living with HIV in the Houston EMA, 2018^a

	#	%
Total	29,078	100.0%
Sex at Birth		
Male	21,829	75.1%
Female	7,249	24.9%
Race/Ethnicity		
White	5,109	17.6%
Black/African American	14,044	48.3%
Hispanic/Latino	8,493	29.2%
Other/Multiracial	1,432	4.9%
Age		
0 - 12	54	0.2%
13 - 24	1,170	4.0%
25 - 34	5,986	20.6%
35 - 44	6,752	23.2%
45 - 54	7,594	26.1%
55 - 64	5,580	19.2%
65+	1,942	6.7%
Transmission Risk^b		
Male-male sexual contact (MSM)	16,818	57.8%
Person who injects drugs (PWID)	2,256	7.8%
MSM/PWID	1,192	4.1%
Sex with Male/Sex with Female	8,455	29.1%
Perinatal transmission	340	1.2%
Adult other	17	0.1%

^aSource: Texas eHARS, Diagnosed PLWH in the Houston EMA between 1/1/2018 and 12/31/2018

^bCases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification.

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

HIV Services in the Houston Area

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

- Comprehensive HIV prevention activities in the Houston Area are provided by the Houston Health Department (**HHD**), a directly funded CDC grantee, and the Texas Department of State Health Services (**DSHS**). Prevention activities include health education and risk reduction, HIV testing, disease investigation and partner services, linkage to care for newly diagnoses and out of care PLWH. The Houston Area HIV Prevention Community Planning Group provides feedback and to HHD in its design and implementation of HIV prevention activities.
- The Ryan White HIV/AIDS Program Part A and MAI provide core medical and support services for

HIV-diagnosed residents of the Houston EMA. These funds are administered by the Ryan White Grant Administration of Harris County Public Health. The Houston Area Ryan White Planning Council designs Part A and MAI funded services for the Houston EMA.

- The Ryan White HIV/AIDS Program Parts B, C, D, and State Services provide core medical and support services for HIV-diagnosed residents of the Houston HSDA, with special funding provided to meet the needs of women, infants, children, and youth. The Houston Regional HIV/AIDS Resource Group (**TRG**) administers these funds. The Ryan White Planning Council also designs Part B and State Services for the Houston HSDA. Additional programs supported by TRG include reentry housing through HOPWA funds and support of the grassroots END HIV Houston coalition.
- HOPWA provides grants to community organizations to meet the housing needs of low-income persons living with HIV. HOPWA services include assistance with rent, mortgage, and utility payments, case management, and supportive housing. These funds are administered by the City of Houston Housing and Community Development for the Houston EMSA.

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

Sources:

- Centers for Disease Control and Prevention, *Diagnoses of HIV Infection in the United States and Dependent Areas, 2018*; vol. 30. Published November 2015. Accessed 03/06/2020. Available at: www.cdc.gov/hiv/topics/surveillance/resources/reports/.
- U.S. Census Bureau, American FactFinder. Houston (city), Texas and Harris (county), Texas Accessed: 03/03/2020. Available at: <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>
- U.S. Department of Health and Human Services, *Ending the HIV Epidemic: A Plan for America*. February 2019.



Chapter 1: Demographics

PARTICIPANT COMPOSITION

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

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

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

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

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

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

The results of these efforts are summarized in Table 2.

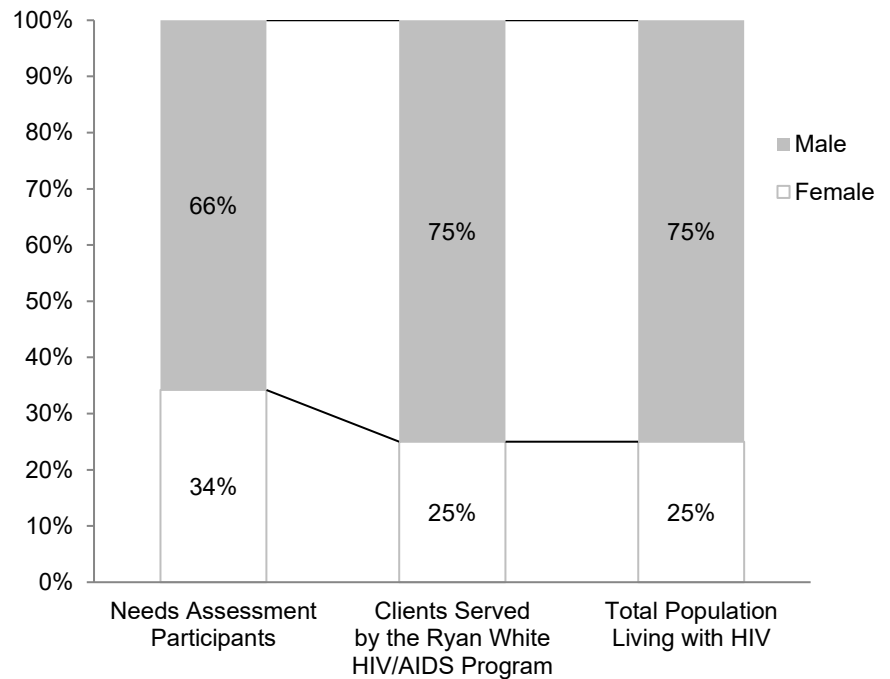
	No.	%
Young adult (18-24 years)	17	2.9%
Adult age 50+ years	353	59.9%
Homeless	65	11.1%
Unstably Housed	159	29.0%
People who inject drugs (PWID)*	47	8.2%
Male-male sexual contact (MSM)	238	40.5%
Out of care (last 12 months)	24	4.3%
Recently released from incarceration	65	11.6%
Rural (non-Harris County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

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

COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

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

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



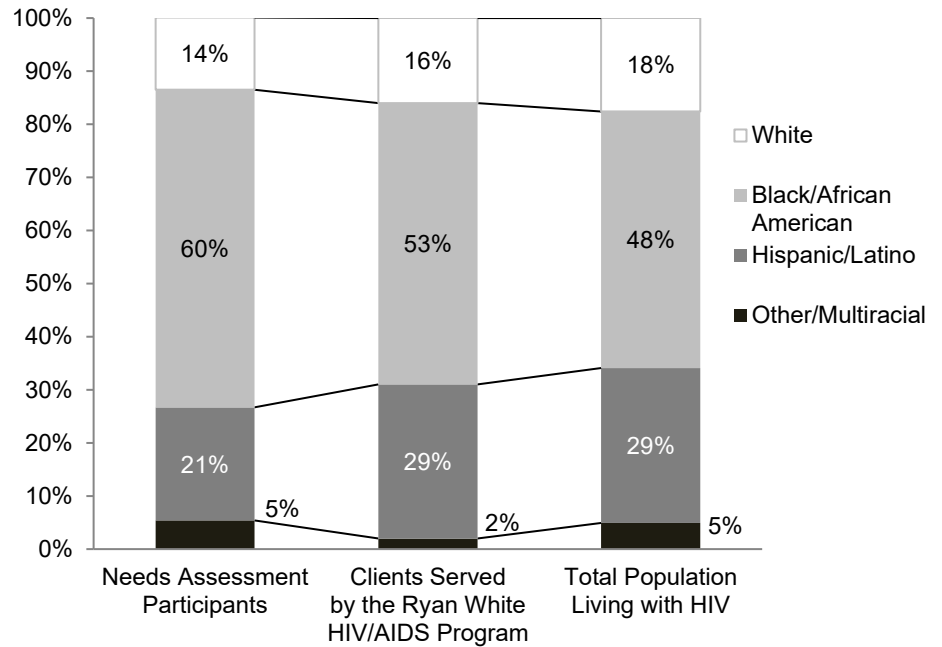
^aSource: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
^bSource: Texas eHARS. Living HIV cases as of 12/31/18.

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

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

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

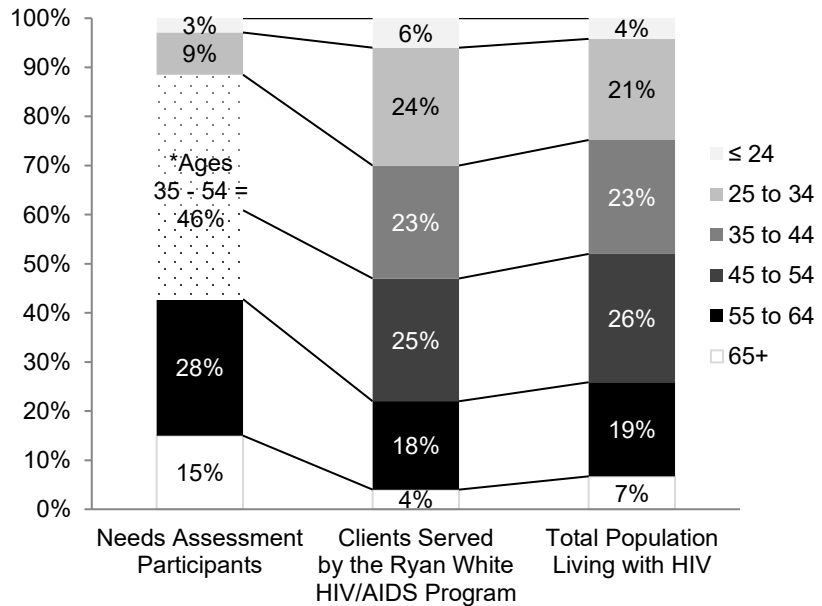
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients^a and Total HIV Diagnosed Population^b in the Houston EMA, by Race/Ethnicity, 2018



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

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

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



^aSource: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
^bSource: Texas eHARS. Living HIV cases as of 12/31/18
^cExcludes ages 0-12
 *Age ranges 35-44 and 45-54 combined due to differences in question structuring.

Weighting the Sample

Needs assessment data were statistically weighted by sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2018) *prior to* the analysis of results related to service needs and barriers. This was done because the demographic composition of 2020 Houston HIV Care Services Needs Assessment participants was *not* comparable to the composition of all PLWH in the Houston EMA. As such, the results presented in the remaining Chapters of this document are proportional for these three demographic categories only. Appropriate statistical methods were applied throughout the process in order to produce an accurately weighted sample, including a three-level stratification of prevalence data and subsequent data

weighting syntax. Voluntary completion on the survey and non-applicable answers comprise the missing or invalid survey entries and are excluded in the statistical analysis; therefore, denominators will further vary across results. All data management and quantitative analysis, including weighting, was performed in IBM© SPSS© Statistics (v. 22). Qualitative analysis was performed in QSR International© NVivo 10.

Sources:

Texas Department of State Health Services (TDSHS) eHARS data through 12-31-2018.
University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPSS Statistics 20, Post-stratification weights, 2009.



Chapter 2: Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

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

Overall Ranking of Funded Services, by Need

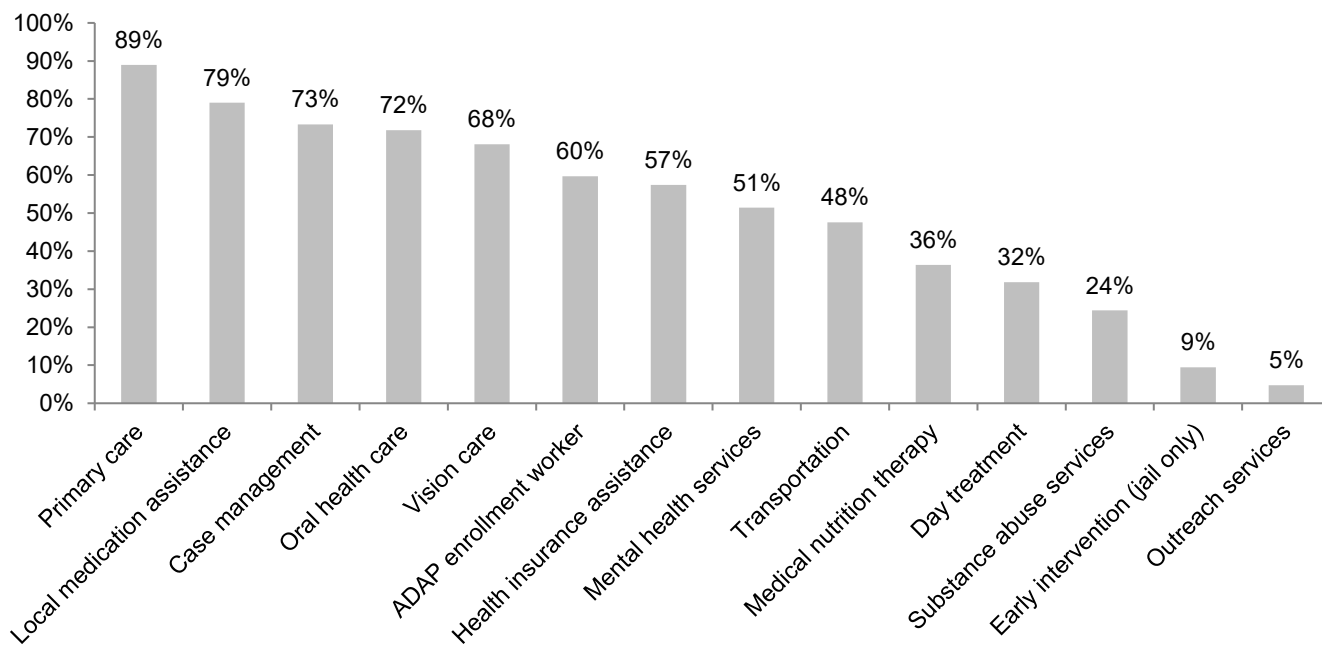
At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. Participants of

the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

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

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

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



Overall Ranking of Funded Services, by Accessibility

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

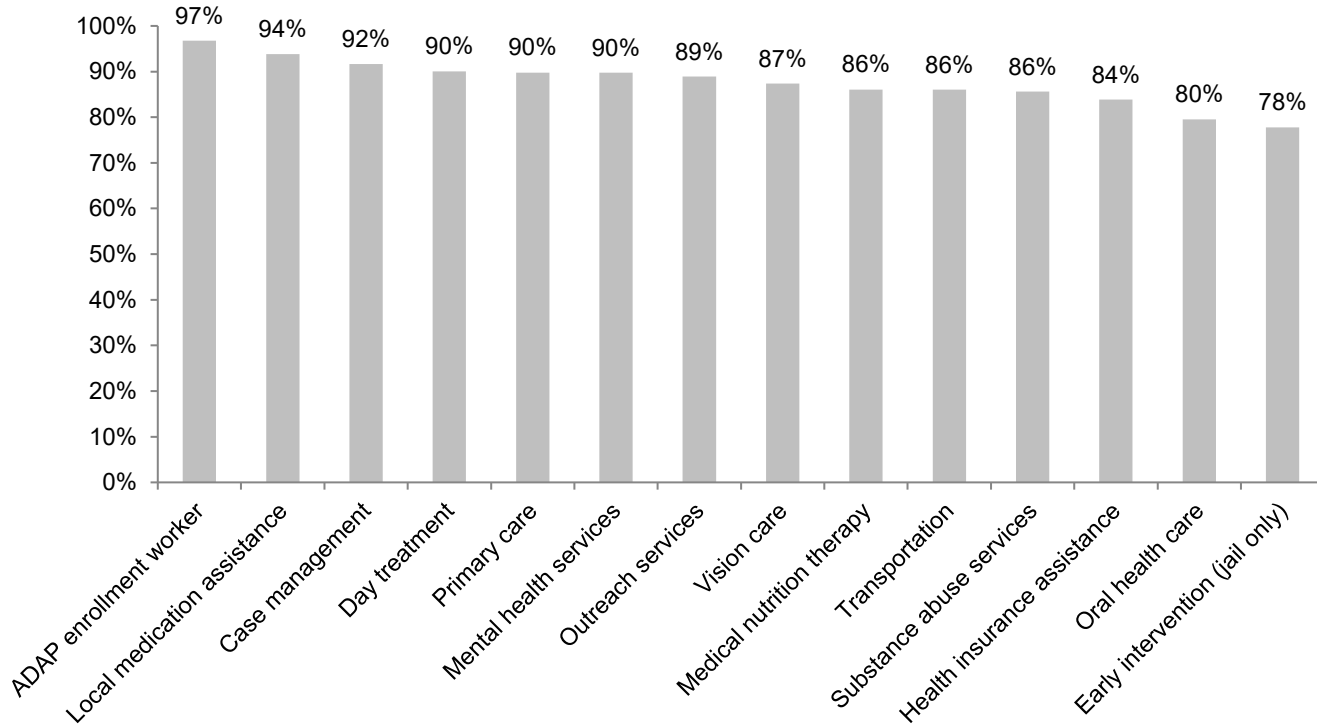
(**Graph 2**) All funded services except hospice and linguistics were analyzed and received a ranking of accessibility. The most accessible service was ADAP enrollment worker at 97% ease of access, followed by

local medication assistance at 94% and case management at 92%. Local medication assistance had the highest accessibility ranking of any core medical service, while ADAP enrollment worker received the highest accessibility ranking of any support service. Compared 2016 needs assessment, reported accessibility on remained stable on average. The greatest increase in percent of participants reporting ease of access was observed in local medication assistance, while the greatest decrease in accessibility was reported for early intervention services.

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

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

Denominator: 569-573 participants, varying between service categories



Overall Ranking of Barriers Types Experienced by Consumers

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

(**Graph 3**) Overall, fewer barriers were reported in 2020 (415 barrier reports) than in previous 2016 needs assessment (501 barrier reports), despite the increase in sample size in 2020. Across all funded services, the

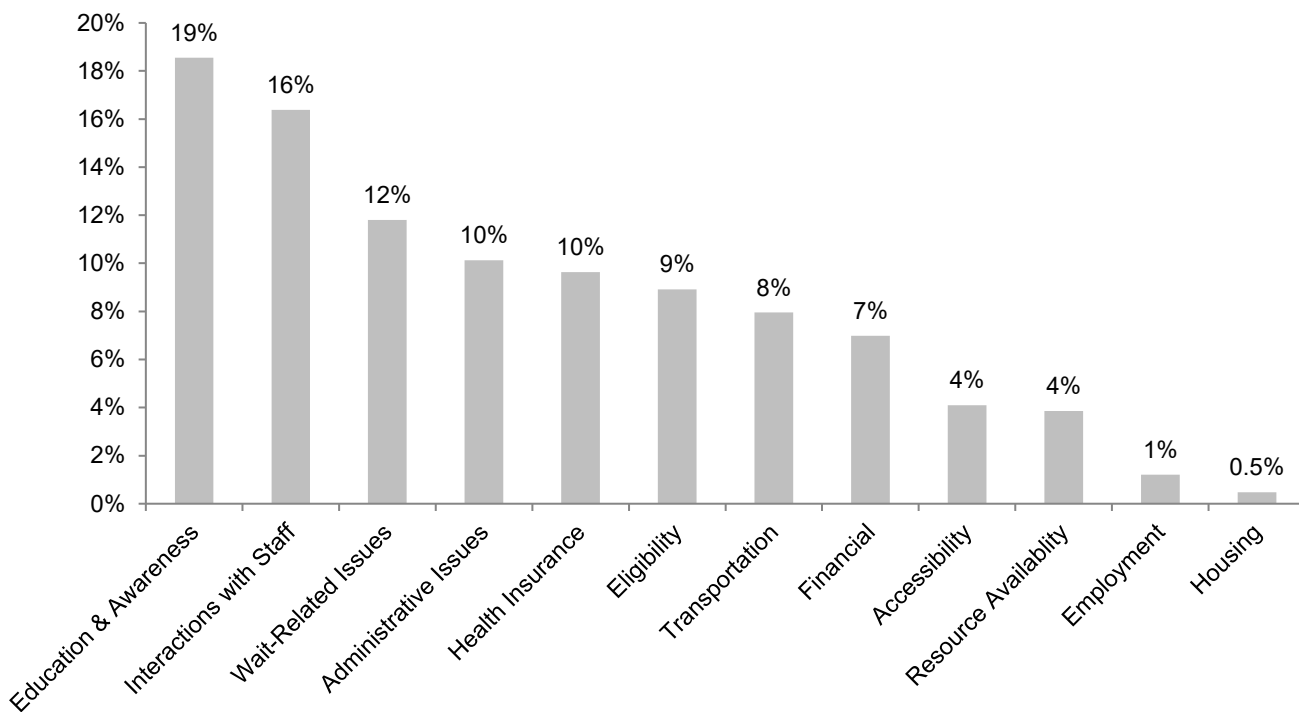
barrier types reported most often related to service education and awareness issues (19% of all reported barriers); interactions with staff (16%), wait-related issues (12%); administrative issues (10%); and issues relating to health insurance coverage (10%). Housing issues (homelessness or intimate partner violence) were reported least often as barriers to funded services (1%). Between the 2016 and 2020 HIV needs assessments, the percentage of barriers relating to interactions with staff increased by 3 percentage points, while wait-related issues decreased by 3 percentage points.

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

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

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

Denominator: 415 barrier reports



Descriptions of Barriers Encountered

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

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

to access comprised most (57%) of the barriers reported.

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

TABLE 1-Barrier Proportions within Each Barrier Type, 2020

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

NEED AND ACCESSIBILITY FOR UNFUNDED SERVICES

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

Overall Ranking of Unfunded Services, by Need

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

(Graph 4) At 53%, housing was the most needed unfunded service in the Houston Area, followed by

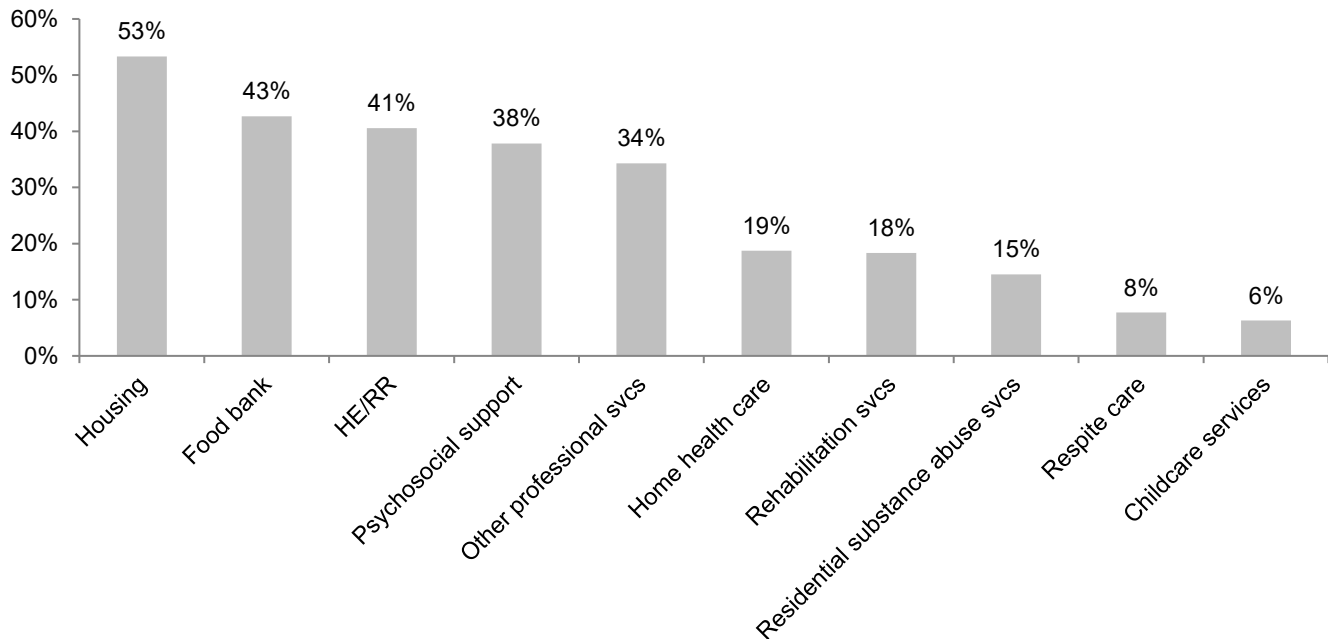
food bank at 43%, health education/risk reduction at 41%, psychosocial support services at 38%, and other professional services at 34%. Of participants indicating a need for food bank, 69% reported needing services from a food bank, 6% reported needing home delivered meals, and 25% indicated need for both types of food bank service. Among participants indicating a need for psychosocial support services, 89% reported needing an in-person support group, 3% reported needing an online support group, and 8% indicated need for both types of psychosocial support.

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

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

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

Denominator: 569-572 participants, varying between service categories



Overall Ranking of Unfunded Services, by Accessibility

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

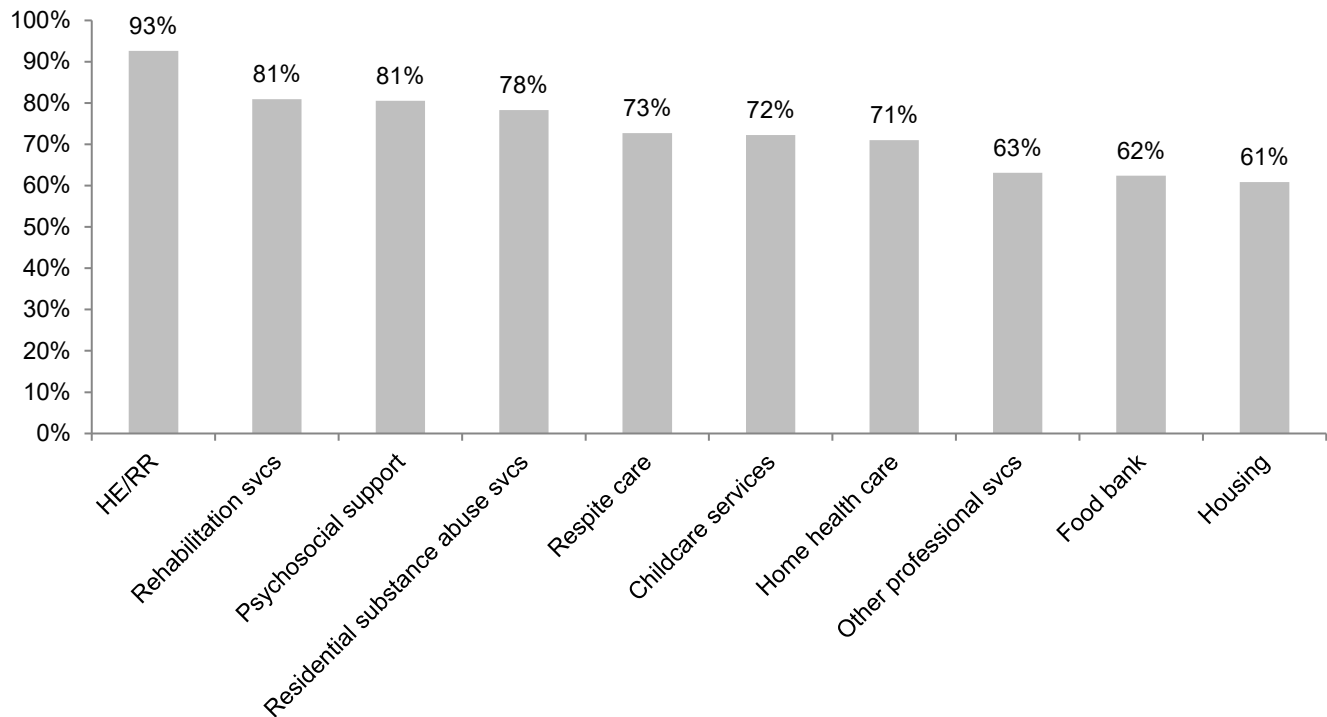
(Graph 5) The most accessible unfunded service was health education/risk reduction at 93% ease of access, followed by rehabilitation services at 81%,

psychosocial support services at 81%, residential substance abuse services at 78%, and respite care at 73%. The least accessible needed unfunded services was housing at 61%. Home health care had the highest accessibility ranking of any core medical service, while rehabilitation services received the highest accessibility ranking of any support service.

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

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

Denominator: 569-572 participants, varying between service categories



Other Identified Needs

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

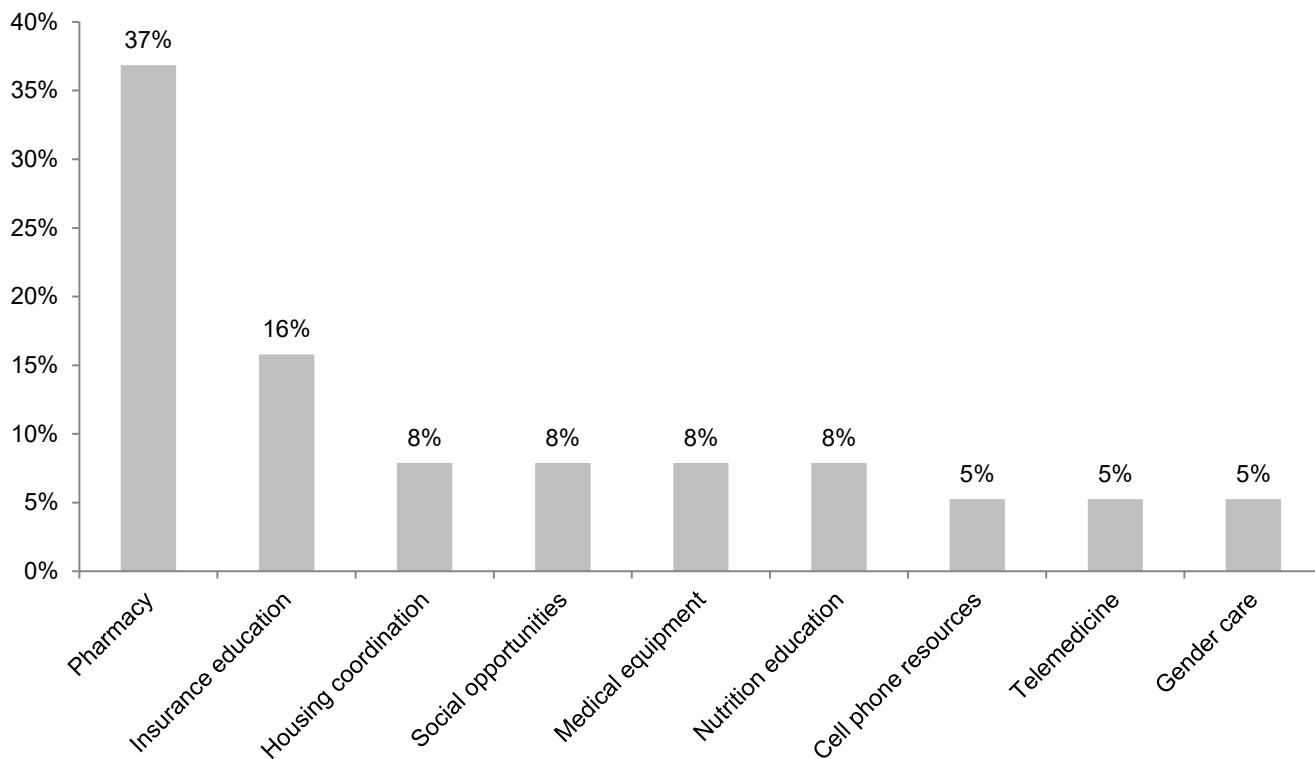
(Graph 6) Participants identified nine additional needs not otherwise described in funded and unfunded

services above. The most common identified needs related to pharmacy, such as having medications delivered and automatic refills, at 37%. This was followed by insurance education at 16%, and housing coordination, social opportunities, coverage for medical equipment, and nutrition education, each at 8%.

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

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

Denominator: 38 write-in responses





Chapter 3: Needs Across the HIV Care Continuum

HIV CARE CONTINUUM

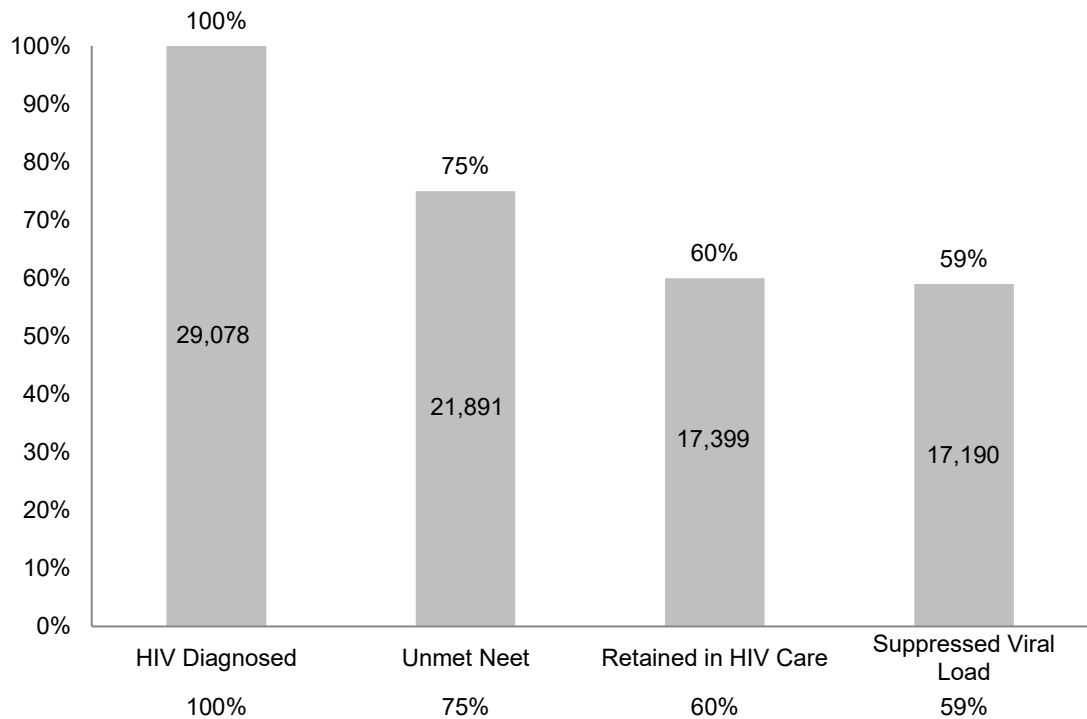
In July 2012, the Centers for Disease Control and Prevention (CDC) released an analysis of the number and percentage of people in the U.S. at each stage of the HIV care continuum originally developed by Gardner et al (2011). The continuum represents the sequential stages of HIV care – from being diagnosed to suppressing the virus through treatment. This analysis is now commonly referred to as the *HIV care continuum* and, in July 2013, the White House launched a national initiative to expand and accelerate efforts along each stage of the continuum.

HIV care continua that incorporate local data allow communities to evaluate the extent to which national and local goals related to increasing HIV awareness, linkage to care, and viral load suppression are being met or exceeded. This model is also useful for identifying local prevention and care service gaps, and targeting efforts to bridge each stage of the continuum.

Engagement in Care in the Houston Area

(Graph 1) Each year, the Houston Area HIV Care Continuum (HCC) is updated using local epidemiological data. Several questions included in the 2020 Houston HIV Care Services Needs Assessment assess barriers to engagement at certain points along the HIV care continuum. The first stage of the HCC was explored in the needs assessment through analysis of diagnosis locations and years. Linkage to care and met need were evaluated through services and materials provided at diagnosis, as well as encountered barriers to timely linkage. Retention was addressed through investigating causes for lost to care and falling out of care. As the defining component of achieving viral suppression, motivations among participants not currently taking antiretroviral medication are assessed at the end of this chapter. Findings from two focus groups conducted with service linkage and outreach workers are presented in this chapter to contextualize issues surrounding timely linkage and effective retention in HIV care.

GRAPH 1-Houston Area HIV Care Continuum, 2018
Denominator: 29,078 diagnosed PLWH in the Houston EMA



Data represented for PLWH in the Houston EMA between 1/1/2018 and 12/31/2018.
HIV Diagnosed: No. of HIV-diagnosed people, and residing in the Houston EMA, 2018. Source: Texas eHARS
Met Need: No. (%) of PLWH in Houston EMA with met need (at least one: medical visit, ART prescription, or CD4/VL test) in year. Source: Texas DSHS HIV Unmet Need Project (incl. eHARS, ELR, ARIES, ADAP, Medicaid, private payer data)
Retained in HIV Care: No. (%) of PLWH in Houston EMA with at least 2 medical visits, ART prescriptions, or CD4/VL tests in year, at least 3 months apart
Suppressed Viral Load: No. (%) of PLWH in Houston EMA whose last viral load test of the year was ≤ 200 copies/mL. Source: Texas ELRs, ARIES labs, ADAP labs

TESTING AND DIAGNOSIS

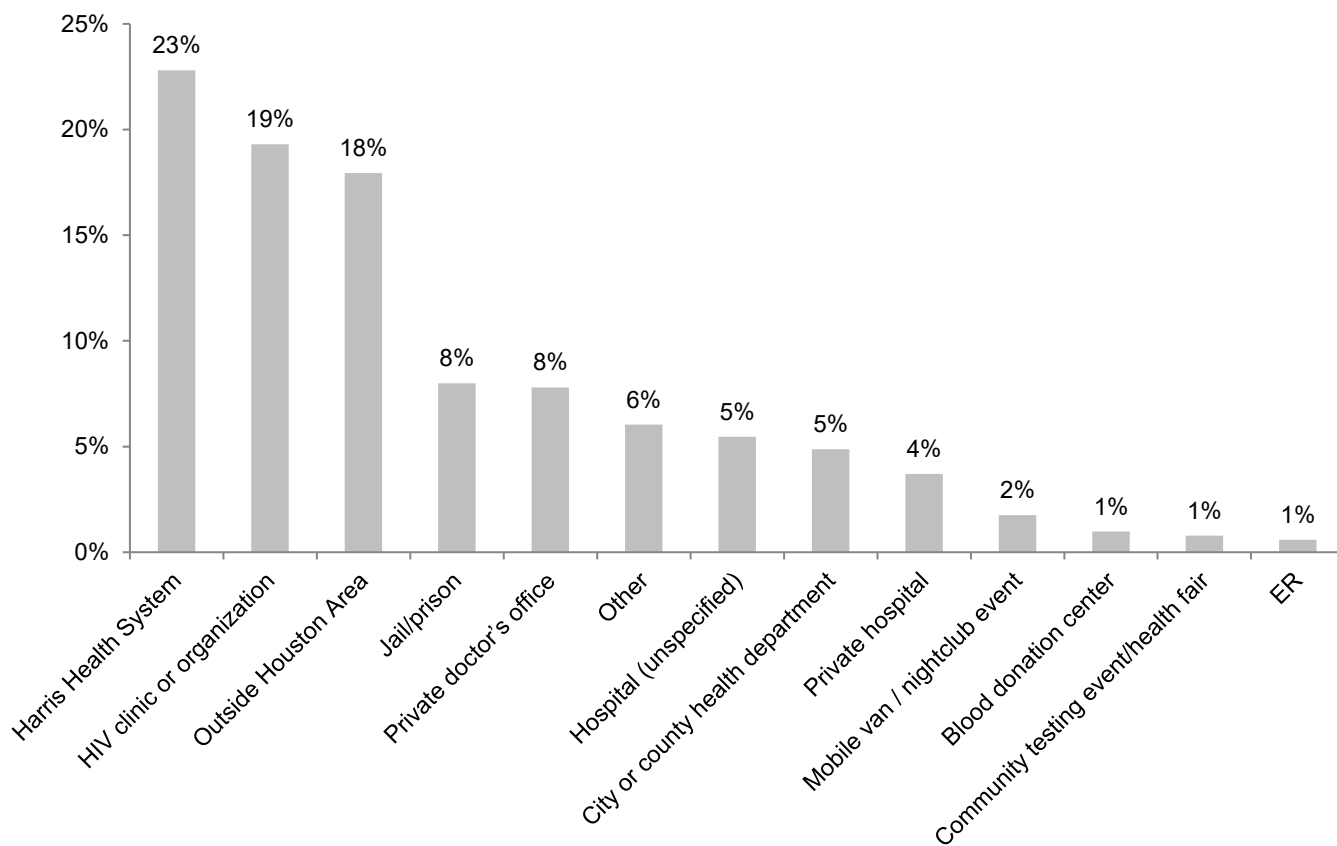
The 2020 Houston HIV Care Services Needs Assessment asked participants to share information from when they were first diagnosed, including when and where they were diagnosed. This information helps identify effective locations for HIV testing in the Houston Area toward the goal of increasing the proportion of PLWH who are aware of their status.

HIV Testing Location

(**Graph 2**) The most common location for being diagnosed with HIV was a Harris Health System facility at 23%, followed by receipt of diagnosis at an HIV clinic or organization (19%), outside the Houston area (18%), jail or prison (8%), or a private doctor's office or clinic (8%). At 1% each, blood donation centers, community testing events/health fairs, and emergency rooms were cited least often.

GRAPH 2-Locations of HIV Diagnosis for PLWH in the Houston Area, 2020

Definition: Percent of times each type of location was reported as the location where participants were first diagnosed with HIV. Denominator: 513 participants



Year HIV Diagnosed

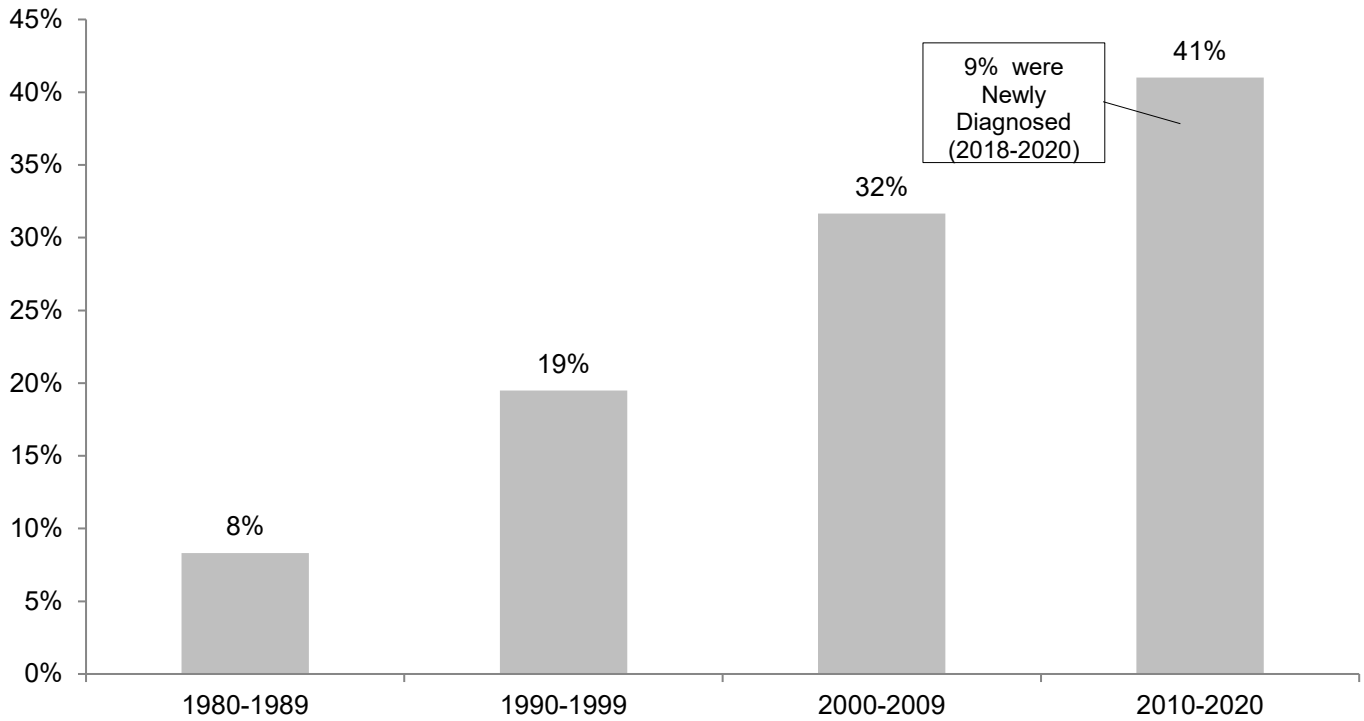
(Graph 3) The average length of time since HIV diagnosis among needs assessment participants was 13 years. More participants were diagnosed between 2010 and 2020 than any other period. Newly diagnosed

participants (diagnosed 2018-2020) comprised 9% of the sample, while recently diagnosed participants (diagnosed 2014-2020) made up 24% of the sample.

GRAPH 3-Year of HIV Diagnosis for PWLH in the Houston Area, 2020

Definition: Percent of participants who were first diagnosed with HIV in each time period.

Denominator: 562 participants



LINKAGE TO CARE

The 2020 Houston HIV Care Services Needs Assessment asked participants about initial entry into HIV care following diagnosis. Information on linkage to care for newly diagnosed individuals can help communities identify strategies to make linkage to HIV care timely and effective for promoting retention in care and viral suppression. Linkage to care information also helps communities identify gaps that result in delayed entry into care as well as potential solutions for bridging linkage gaps with HIV services.

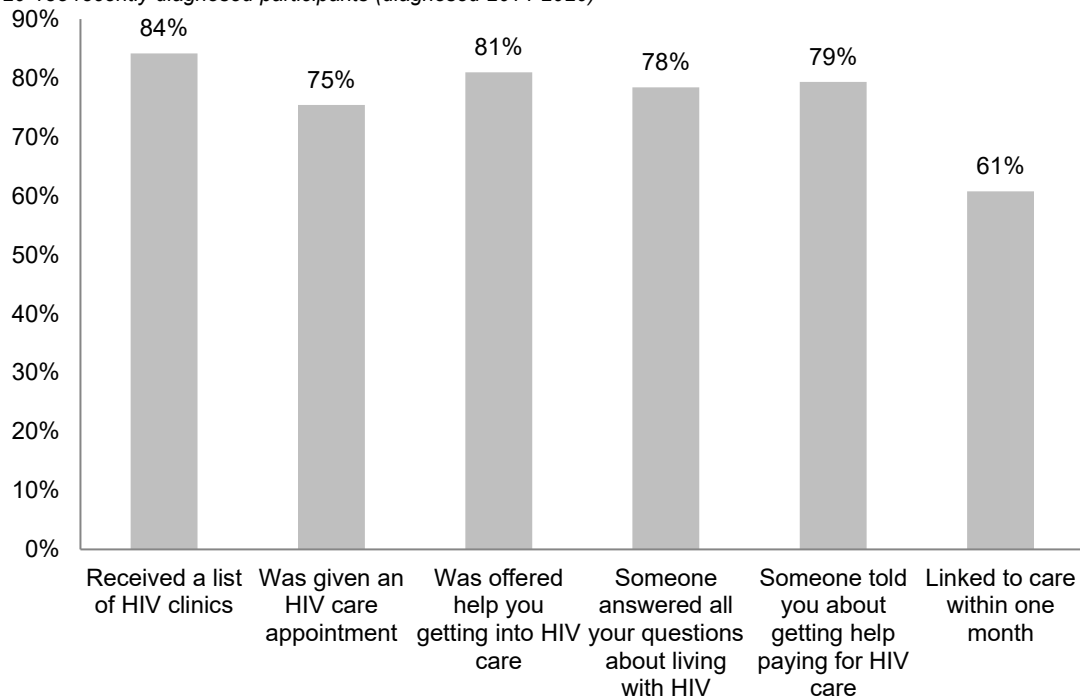
Notes: Most (59%) participants were diagnosed prior to 2010 and the introduction of proactive service linkage efforts such as Service Linkage Workers. Service linkage activities and barriers to timely linkage are discussed for recently diagnosed participants (diagnosed 2014-2020) only in **Graph 4** and **Graph 5**.

Linkage Services at Diagnosis

(**Graph 4**) 61% of recently diagnosed needs assessment participants reported linkage to care within 1 month of diagnosis. For passive referral, 84% received a list of HIV clinics at the time of diagnoses, while 75% were given their first HIV care appointment. For active linkage to HIV care, 81% of recently diagnosed participants were offered help getting into HIV medical care, 78% has someone answer all of their questions about living with HIV, and 79% had someone inform them about resources to help pay for their HIV medical care. Reported linkage to care mirrors epidemiological data show for the Houston EMA. According to those data (generated by the Texas Department of State Health Services), 60% of persons in the Houston EMA were linked to care within 1 months of diagnosis (2018).

GRAPH 4-Service Linkage Activities Received at the Time of HIV Diagnosis in the Houston Area, 2020

Definition: Percent of recently diagnosed needs assessment participants who received each of type of linkage service at the time of diagnosis.
Denominator: 120-135 recently diagnosed participants (diagnosed 2014-2020)

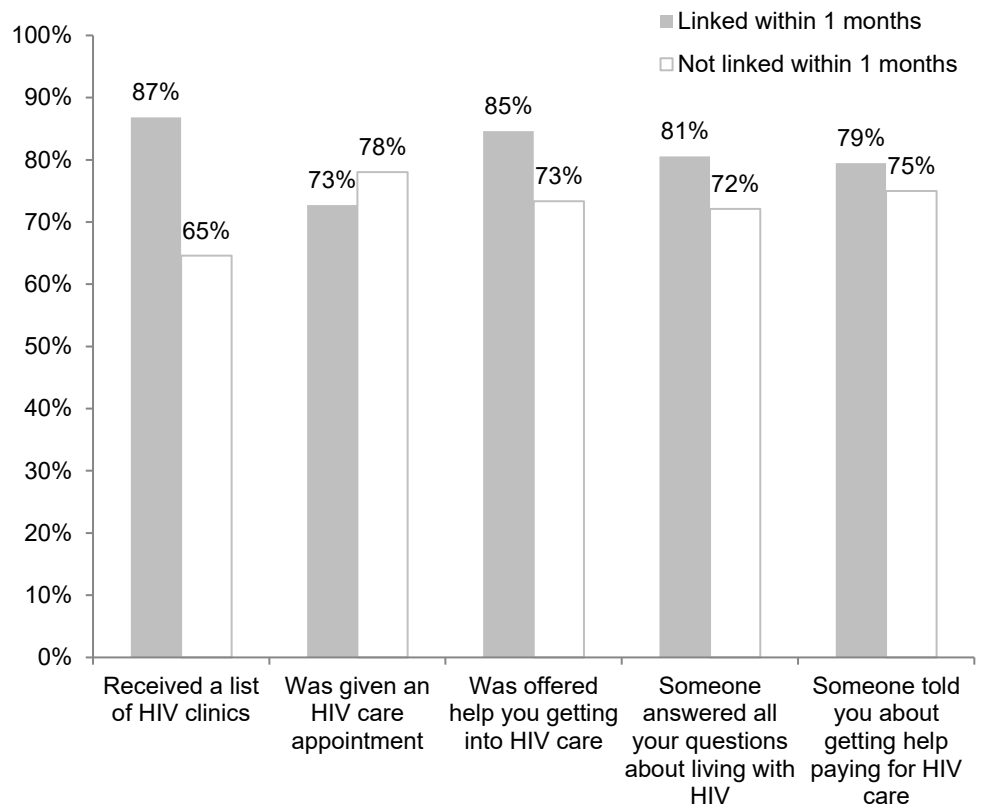


(Graph 5) Receipt of passive referral and active linkage activities appears to be positively associated with early linkage to care: 87% of those who linked to care within 1 month received a list of HIV clinics at the time of diagnosis, compared to only 65% of those not linked to care within 1 month. This association was also observed for being offered help getting into HIV care (85% v. 73%), having someone answer questions about living with HIV (81% v. 72%) and having someone mention resources to help pay for HIV care (79% v. 75%).

GRAPH 5-Service Linkage Activities Received at the Time of HIV Diagnosis in the Houston Area, by Linkage Timeframe, 2020

Definition: Percent of linked and non-linked recently diagnosed needs assessment participants who received each type of linkage service at the time of diagnosis.

Denominator: 82 participants linked within 1 month; 53 participants not linked within 1 month



Barriers to Early Linkage

(Graph 6) All participants who delayed entry into HIV care for more than 1 month after diagnosis were asked the reasons for delayed entry. Thirteen commonly reported barriers were provided as options in the survey, participants could select multiple reasons for delayed entry, and participants could write in their reasons.

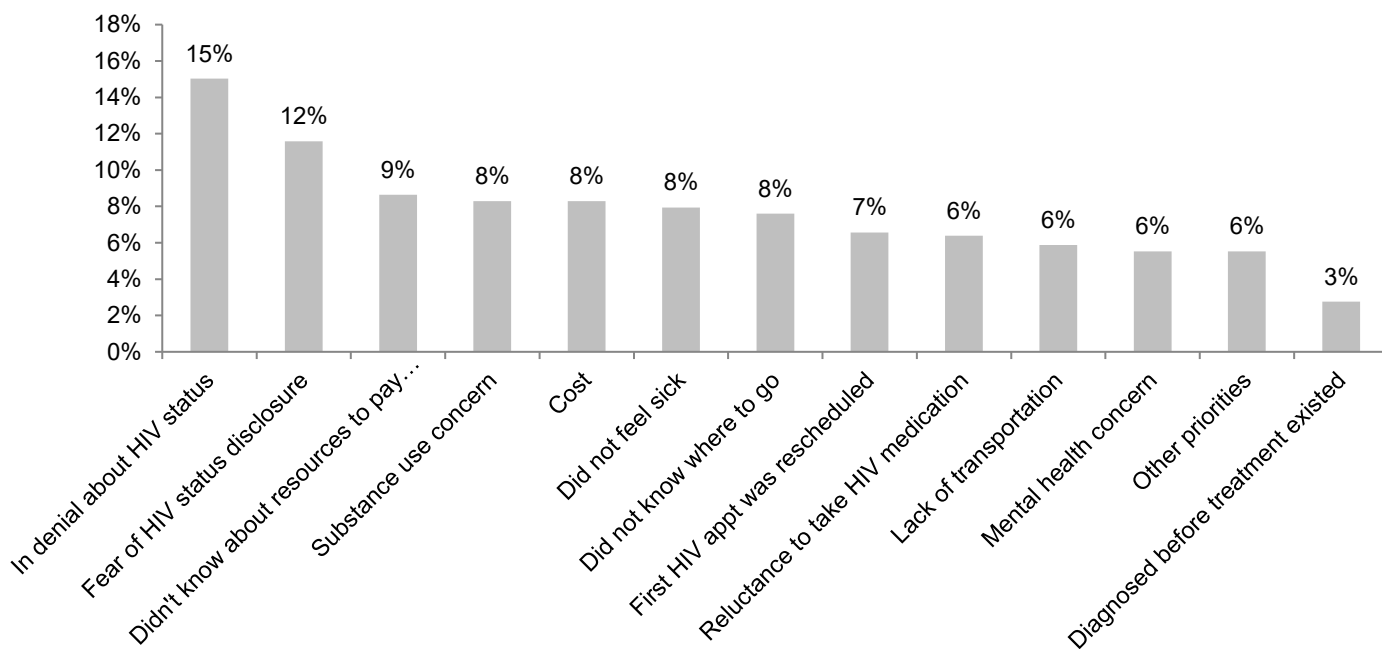
Of the 13 options provided, denial about HIV status was selected most often at 15% of all reasons reported.

This was closely followed by fear of HIV status disclosure (12%), and not knowing about available resources to pay for HIV medical care (19%). The most common write-in reason for delayed entry was incarceration at time of diagnosis. One participant mentioned that they were diagnosed while incarcerated, but had to wait longer than one month after diagnosis to see a doctor for HIV.

GRAPH 6-Reasons for Delayed Linkage to HIV Care in the Houston Area, 2020

Definition: Percent of times each item was reported by needs assessment participants as the reason they were not linked to HIV care within 1 months of diagnosis.

Denominator: 579 reports of reasons for delayed linkage to care



Awareness of Available Services

Education and awareness issues present a longstanding barrier to timely linkage to care in the Houston EMA. In particular, lack of awareness that a service exists or is available remains one of the most commonly cited reasons PLWH in the Houston Area do not access a needed service. The 2020 Houston HIV Care Services Needs Assessment survey asked participants to indicate if they did not know a funded

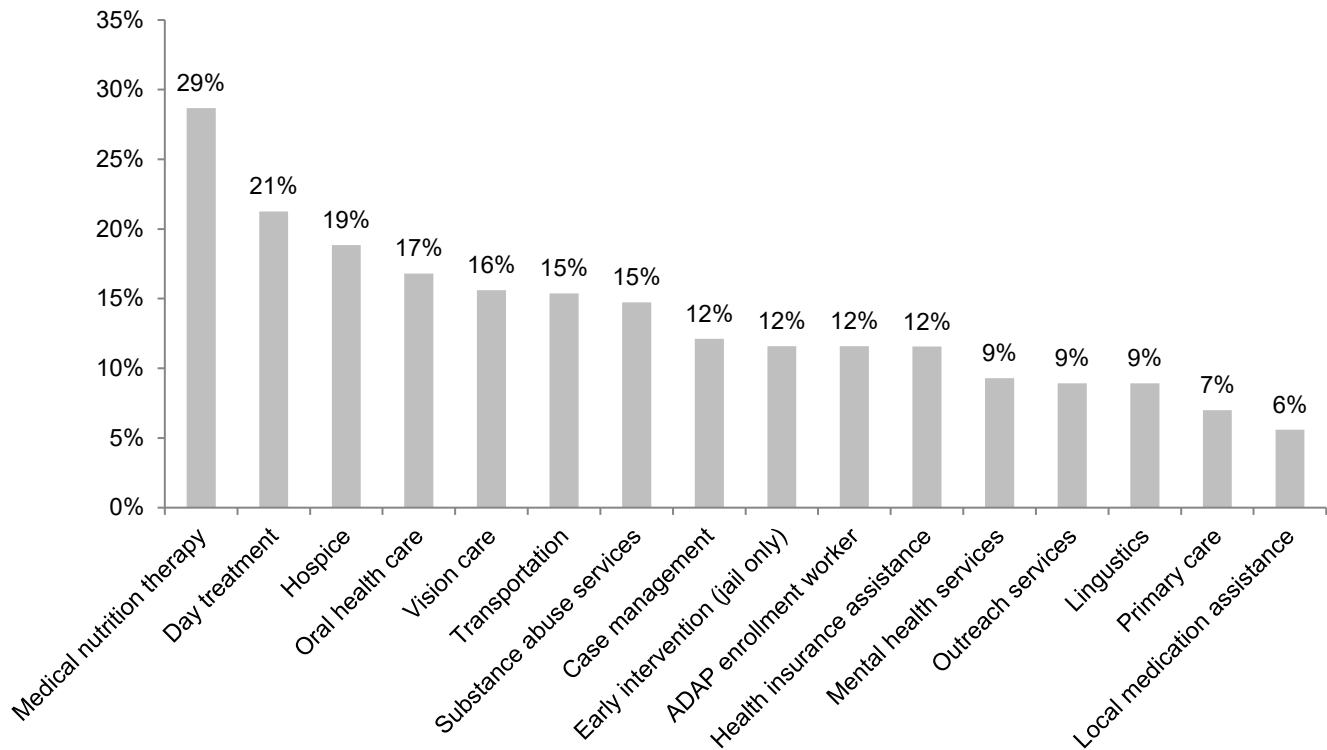
service was available at the time of survey. Results for this question are discussed below.

(**Graph 7**) Medical nutrition therapy had the highest proportion of participants who were unaware that it was an available service at 29% of participants surveyed. This was followed by day treatment (21%), hospice (19%), oral health care (17%), and vision care (16%).

GRAPH 7-Ranking of HIV Services in the Houston Area, By Service Unawareness, 2020

Definition: Percent of needs assessment participants stating they did not know the service was available.

Denominator: 569-573 participants, varying between service categories



Findings from Service Linkage Worker

Focus Group

The role of service linkage workers per the Houston EMA Ryan White Part A service category definition is to “assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated” when clients do not require the intensity of Medical Case Management interventions.¹ The ultimate goal of service linkage is to successfully link new and out of care clients to HIV medical care, and provide referrals to needed services to help facilitate this linkage. In June 2019, staff conducted a focus group with five service linkage workers and case managers providing service linkage to provide context for the service linkage process. On average, the focus group participants carried a 30 client caseload, though some service linkage workers reported serving up to 45 clients at any given time. The results of this focus group are examined below by prompt.

“Which services do service linkage clients need most? Are there any needed services that do not currently exist in the Houston area?”

- Immediate housing according to the Housing First approach
- Mental health and re-entry support groups
- Adult Day treatment
- Staff that resemble clients demographically to build trust. [Public clinic] clients have difficulty accessing services only offered at [Federally-Qualified Health Centers and mental health providers] because the staff do not resemble them.
- Phone cards to refill minutes and/or pre-paid phones to help establish in care. It is very challenging to link to care someone with no phone or no minutes
- A more user-friendly statement of income process

“Why do clients have trouble linking to care or fall out of care? What facilitates clients returning to care?”

- Reasons for not linking or falling out of care
 - Lack of transportation
 - Substance use disorder
 - Feeling well
 - Moving/relocating
 - Becoming undetectable (“Clients return to care when they begin to feel sick again.”)

- Having to choose between work or getting care
- ADAP and Ryan White renewal processes are too burdensome for clients
- Frequent phone number changes
- Concerns that using Ryan White or other services will negatively impact the immigration process
- Young MSM have a particularly tough time linking or staying in care; consider redefining young adult services to include up to 28 or 30 years of age
- Reasons for linking or returning to care:
 - Feeling sick or getting sick more often
 - Release from incarceration
 - Acceptance of positive HIV status
 - Having a history or established relationship with their doctor

“What are some of the biggest barriers to care for clients?”

- When providers do not fully understand or have regard for social situations/issues. Service linkage and case management staff end up providing counseling they are not equipped for and cannot bill for.
- Cultural humility/cultural competency issues and the need to learn from/accommodate a variety of clients
- Transportation issues
 - Need an option of Uber/Lyft. People under 25 are reluctant to ride Metro and trips are typically cheaper than taxi rides. This would also reduce missed appointments. Concierge/Healthcare services with ridesharing companies could help.
 - Mobile clinics for clients experiencing homelessness to receive labs and care
 - Wider availability of telemedicine/telehealth appointments

¹ Source: FY 2020 Houston EMA Ryan White Part A/MAI Service Definitions

RETENTION IN CARE

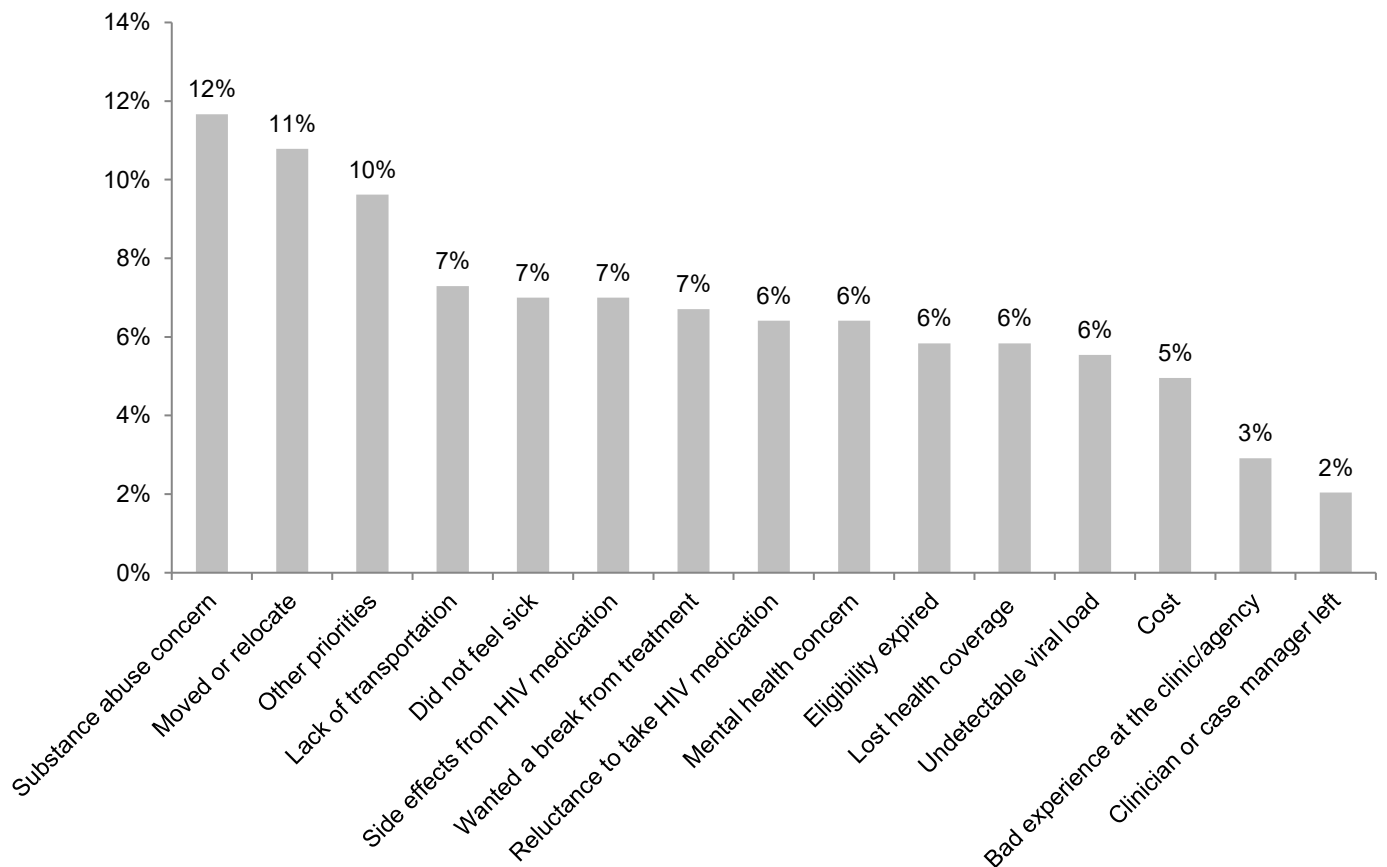
The 2020 Houston HIV Care Services Needs Assessment explored history of HIV care continuity since diagnosis to gather information about barriers to retention. These results help communities identify assets and effective strategies for increasing retention in care in the Houston Area. According to local epidemiological data (generated by the Texas Department of State Health Services), 75% of all diagnosed PLWH in the Houston EMA were in HIV care in the past 12 months, and 60% were retained in care throughout the year (2018). In contrast, 94% of survey participants had met need and 86% were retained in care. A more detailed profile of the 6% of PLWH who were out of HIV medical care at the time of survey is available in Chapter 5 of this document.

Barriers to Retention in Care

(Graph 8) 32% of needs assessment participants reported at least one interruption in their HIV care for 12 months or more since their diagnosis. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Fifteen commonly reported reasons were included as options in the consumer survey. Participants could also write-in their reasons. As in the 2016 Needs Assessment cycle, substance abuse concerns selected most often at 12% of all reasons reported. This was followed by moving or relocating (11%), and having other priorities at the time. The most common write-in reason for falling out of care were fear or stigma, and inability to take time of work to attend appointments.

GRAPH 8-Reasons for Falling Out of HIV Care in the Houston Area, 2020

Definition: Percent of times each item was reported by needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.
Denominator: 343 reasons for falling out of care reported



Communication with HIV Medical Providers

The 2020 Houston HIV Care Services Needs Assessment survey included several new questions to evaluate communication with medical providers as potential supports for or barriers to retention in care. These questions addressed preferred method of communication compared to communication with medical providers, use of plain language when communicating healthcare information, and provider communication quality.

(Graph 9) Participants were asked to name their preferred methods of communication, and select any the ways in which their current HIV medical provider communicates with them from a list of six options provided. Participants also had the option to write in their own response if they did not see it listed, which yielded mail as a seventh communication method.

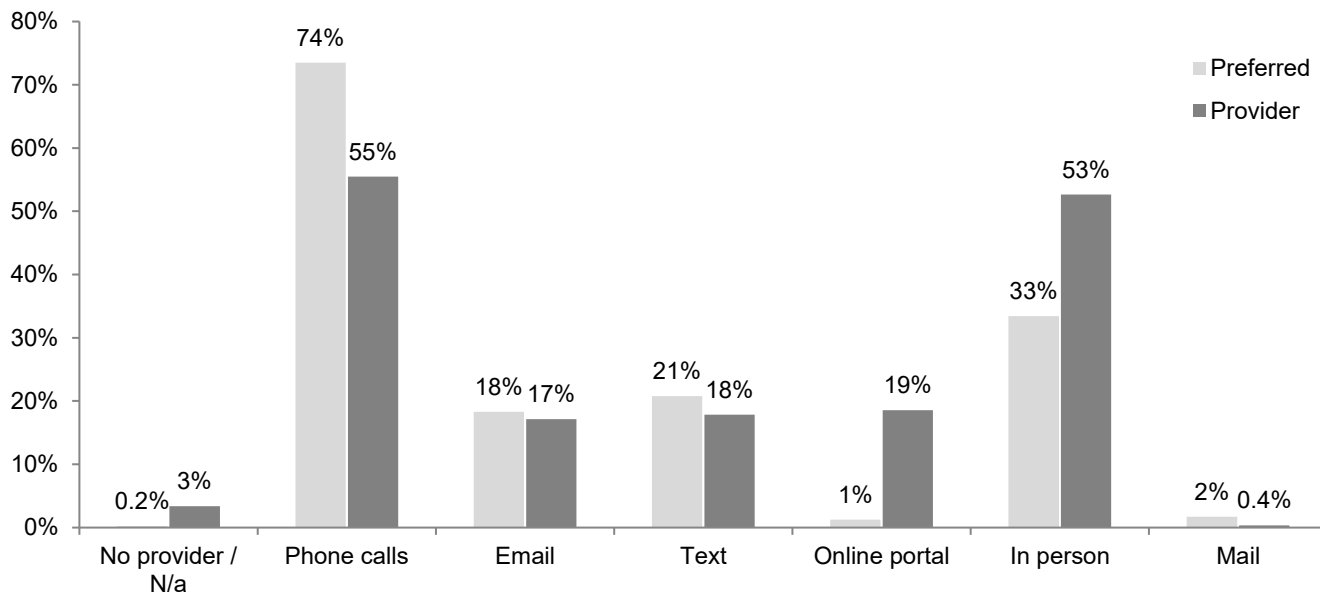
The most commonly reported preferred methods of communication were via phone call (74%), in person (33%), and via text message (21%). The most commonly reported methods of communication used by current medical providers were via phone call (55%), in person (53%), and via an online portal such as MyChart (19%).

The greatest variance between preferred methods of communication and those used by providers occurred among phone calls, in person communication, and online portals. Participants indicated preference for communicating via phone calls at 18 percentage points higher than their current provider’s communication via phone calls. Provider communication in person and via an online portal were reported at higher proportions than participant preferences (19 percentage points and 17 percentage points, respectively).

GRAPH 9-Comparison of Participant’s Preferred Method of Communication to Method Used by HIV Medical Providers, 2020

Definition: Percent of participants who indicated each preferred method of communication and each method used by their current medical provider.

Denominators: 404 participants for preferred method; 566 participants for provider method



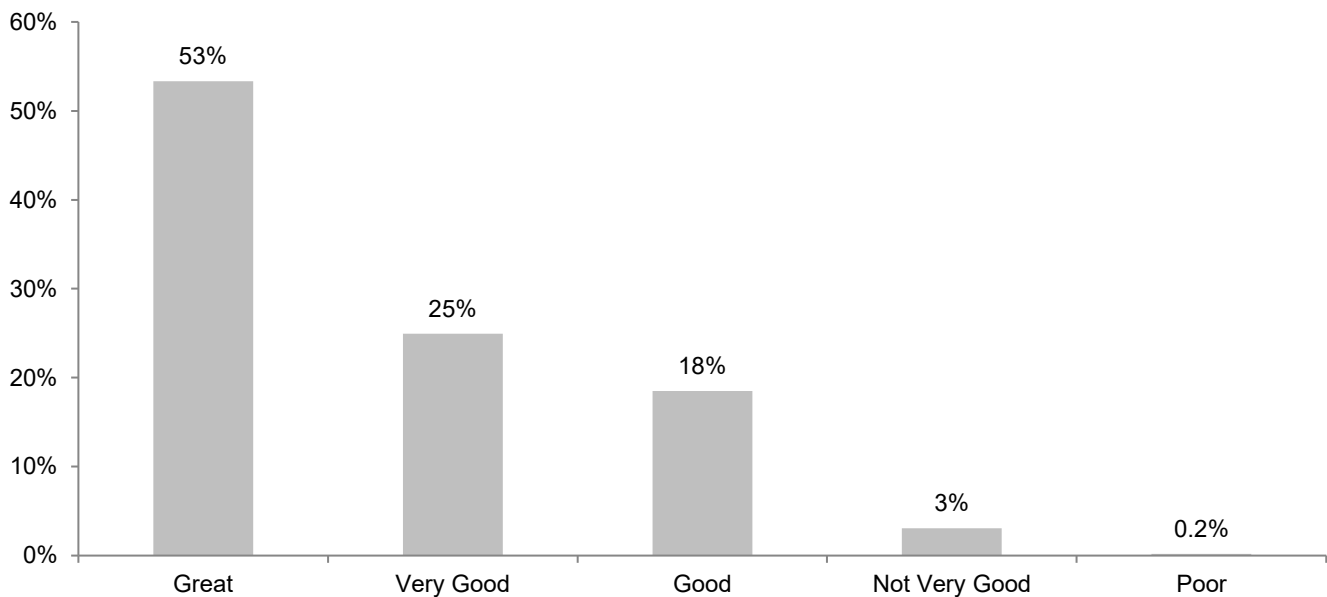
Participants were asked whether their HIV medical provider communicates information about their health in a way that is straightforward and easy to understand. Only 3% of participants (17 individuals) reported that their HIV medical provider does not communicate health information in a way that is straightforward and easy to understand.

(**Graph 10**) When asked to rate the overall quality of communication with their HIV medical provider on a 5-point scale from Poor/1 to Great/5, 53% of participants rated the communication as Great/5. The

average quality rating of communication with their HIV medical provider was Very Good/4. When communication was Poor/1, Not Very Good/2, or Good/3, participants were asked what could be changed to make communication with their HIV medical provider better. The most common suggestions for improving communication were for HIV medical providers to slow down and use plain language, listen to patient views and concerns, make online/telehealth options easier to use, and improve availability and consistency of provider schedule.

GRAPH 10-Rating of Communication Quality HIV Medical Provider, 2020

*Definition: Percent of participants who indicated each level of quality for communication with their current HIV medical provider.
Denominators: 557 participants*



Findings from Outreach Worker Focus Group

The role of outreach workers per the Houston EMA Ryan White Part A service category definition is to assist PLWH “who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies.”² Outreach services differs from service linkage and case management as the ultimate goal is to facilitate retention in care for PLWH who are out of care or identified as at-risk for falling out of care, as opposed to serving newly diagnosed or in care PLWH. In July 2019, staff conducted a focus group with eight outreach workers and outreach services managers to provide context for the outreach services process. On average, the focus group participants carried a 21 client caseload, though some outreach workers reported serving up to 30 clients at any given time. The results of this focus group are examined below by prompt.

“Which services do outreach services clients need most? Are there any needed services that do not currently exist in the Houston area?”

- Housing (especially for individuals with prior felonies or sexual offenses)
- Expanded access to mental health services for regular/maintenance counseling
- Gas cards for rural clients
- Grocery cards as clients miss medical appointments to attend food bank/meal resource dates
- Cell phones and cell phone minute cards

“Why do clients have fall out of care?”

- Transportation
 - Medicaid transportation is not timely (pick-ups arriving much earlier/later than stated)
 - Lack of awareness about Ryan White van-based transportation

- Clients have additional transportation needs and may use up Ryan White-issued bus cards before their appointment for survival. Outreach workers noted that for \$5 more a year, bus cards could provide unlimited rides and greatly increase retention in care.
- Issues establishing eligibility (ADAP/Ryan White/clinic-level) snowball into inability to receive services
- Difficulties with untreated substance use or mental health disorders can greatly reduce success with establishing and retaining eligibility.
- Panic/other priorities when there is a loss of housing or job. Outreach workers observed that out of care clients with this concern typically return to care when housing and employment are secure.
- Overall lack of information/communication
 - Frontline/eligibility staff turning people away with incorrect information
 - Communication difficulties within organizations
 - Lack of knowledge of Ryan White services not provided at other sites
 - Need for better/more regular communication between case managers, service linkage workers, and outreach staff

“What facilitates or motivates clients returning to care?”

- Establishing housing and/or employment
- Feeling ill makes care more urgent
- Having a strong and sustained support system
- Desired improvements in immigration status
- Establishing health insurance
- Need for other/non-HIV services
- Around August and September when children return to school and parents’ schedules become more flexible
 - Outreach workers observed this along with a drop off in care in November through January for holidays
- Seeking treatment for substance use disorder

² Source: FY 2020 Houston EMA Ryan White Part A/MAI Service Definitions

HIV MEDICATION

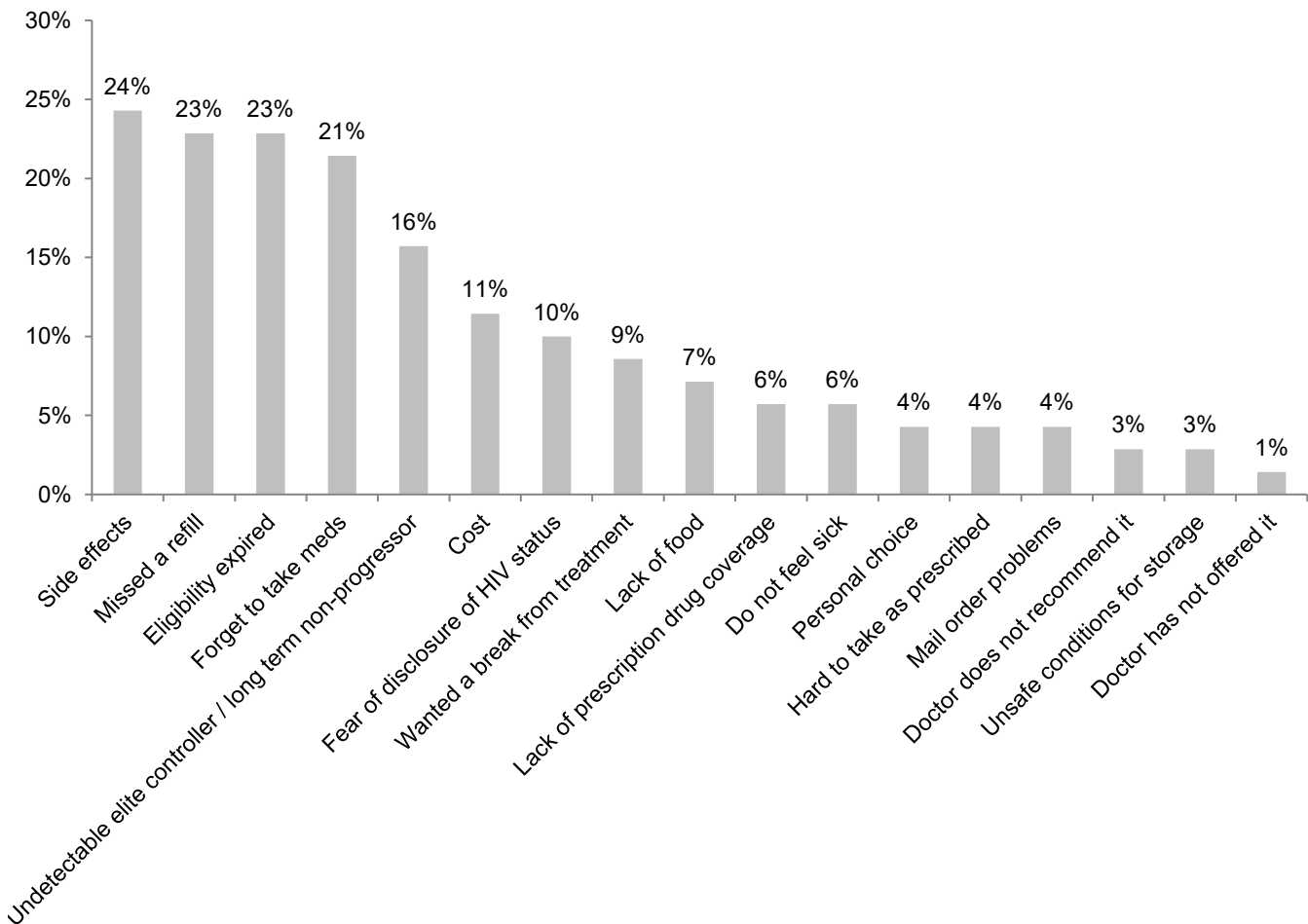
Barriers to HIV Medication

(Graph 11) Information on barriers to medication adherence helps communities design services to ensure HIV medication is available, accessible, and support viral suppression. Thirteen percent (13%) of participants reported they were not taking HIV medications at the time of survey. These participants were asked identify the reason they were not taking medication from a list of 17 commonly reported reasons for difficulty with medication adherence. Participants could also write in their response if they did not see it listed.

Of the 17 options provided, the reason selected most often at 24% of all reasons reported was experiencing medication side effects. This was closely followed by missing a refill (23%), expired eligibility (23%), forgetting to take medications (21%), and being undetectable as an elite controller or long-term non-progressor. The most common write-in reason for not taking HIV medications was difficulty swallowing or taking the medication.

GRAPH 11- Barriers to HIV Medication in the Houston Area, 2020

Definition: Percent of times each item was reported by needs assessment participants not taking HIV medication as the time of survey
Denominator: 70 participants who indicate not taking HIV medication at the time of survey





Chapter 4: Determinants of HIV Care

DETERMINANTS OF HIV CARE

The Social Determinants of Health Framework (**Figure 1**) serves as a place-based model for evaluating socioeconomic factors that influence health and health outcomes in a particular geographic area, such as a neighborhood, city, or service jurisdiction such as the Houston Eligible Metropolitan Area (**EMA**). Beginning at the top and moving clockwise, the five domains of this model are neighborhood and built environment, health and health care, social and community context, education, and economic stability. Each domain is comprised of a series related of social determinants of health. Per the U.S. Department of health and Human Services Office of Disease Prevention and Health Promotion's Healthy People 2020 goals, these social determinants are as follows.

Neighborhood and Built Environment – access to foods that support healthy eating patterns, crime and violence, environmental conditions, and quality of housing.

Health and Health Care – access to health care, access to primary care, and health literacy.

Social and Community Context – civic participation, discrimination, incarceration, and social cohesion.

Education - early childhood education and development, enrollment in higher education, high school graduation, and language and literacy.

Economic Stability – employment, food insecurity, housing instability, and poverty.

The 2020 Houston HIV Care Services Needs Assessment evaluated the ways in which participant experiences with health determinants like those referenced above influence participant health, risks, resources, and access to HIV services. The details of these conditions and experiences are described in the rest of this Chapter. These data help communities better understand the HIV care needs and patterns of PLWH in the Houston Area, as well as identify new or emerging areas of need related to HIV care.

FIGURE 1-The Social Determinants of Health Framework



Source: U.S. Dept of Health and Human Services
– Office of Disease Prevention and Health
Promotion – Healthy People 2020

CO-OCCURRING HEALTH CONDITIONS

The 2020 Houston HIV Care Services Needs Assessment asked participants if they had a current diagnosis of a physical health condition *in addition to* HIV. Options provided included common chronic diseases, age-related conditions, autoimmune disorders, and infectious diseases. Participants were also encouraged write in other conditions not listed. Overall, 76% needs assessment participants reported a current diagnosis of *at least one* co-occurring physical health condition, a 12 percent increase from the 68% of needs assessment participants reporting co-occurring conditions in 2016. This proportion was also positively associated with participant age, with 87% of participants age 50 and over reporting at least one co-occurring physical health condition, compared to 32% of participants age 18 to 24.

Notes: Mental health conditions were addressed separately from physical health conditions in the

survey, and those results are presented in the *Behavioral Health* section of this Chapter. Additionally, non-HIV sexually transmitted diseases (STDs) testing, diagnosis, and treatment are discussed in the *HIV Prevention Behaviors and Vulnerability* section of this Chapter.

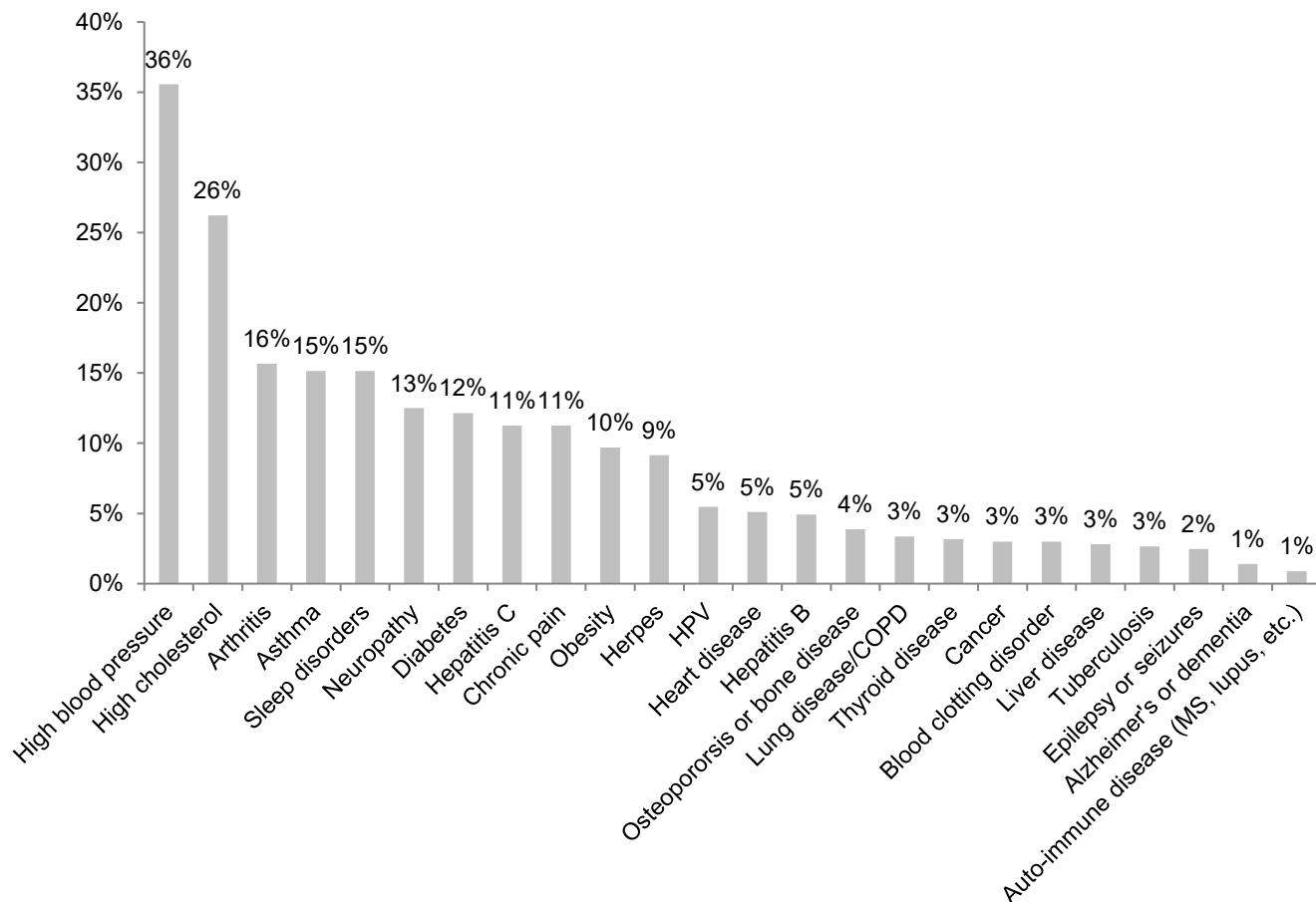
Chronic and Co-Occurring Conditions

(**Graph 1**) The most frequently reported chronic and/or co-occurring health condition was hypertension (36% of participants), followed by high cholesterol (26%), arthritis (16%) asthma (15%), and sleep disorders (15%). Among the 11% of participants with hepatitis C, 71% were receiving treatment. Among the 3% of participants with tuberculosis, 91% reported this as latent tuberculosis. The most common write-in chronic conditions included heart murmurs and degenerative joint disorders.

GRAPH 1-Chronic and Co-Occurring Disease among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants reporting a current diagnosis from a health professional of each medical condition in addition to HIV.

Denominator: 568 participants



BEHAVIORAL HEALTH

Behavioral health refers to the range of conditions related to or affecting mental or emotional well-being. It includes both diagnosed mental illness, indications of psychological distress, and substance use and misuse. The 2020 Houston HIV Care Services Needs Assessment asked participants about each of these behavioral health concerns including current mental health diagnoses, mental/emotional distress symptoms, and substance abuse. Each type is discussed in detail in this Chapter.

Mental Health Diagnoses

(Graph 2) Over half of needs assessment participants (54%) reported having a current *diagnosis* of at least

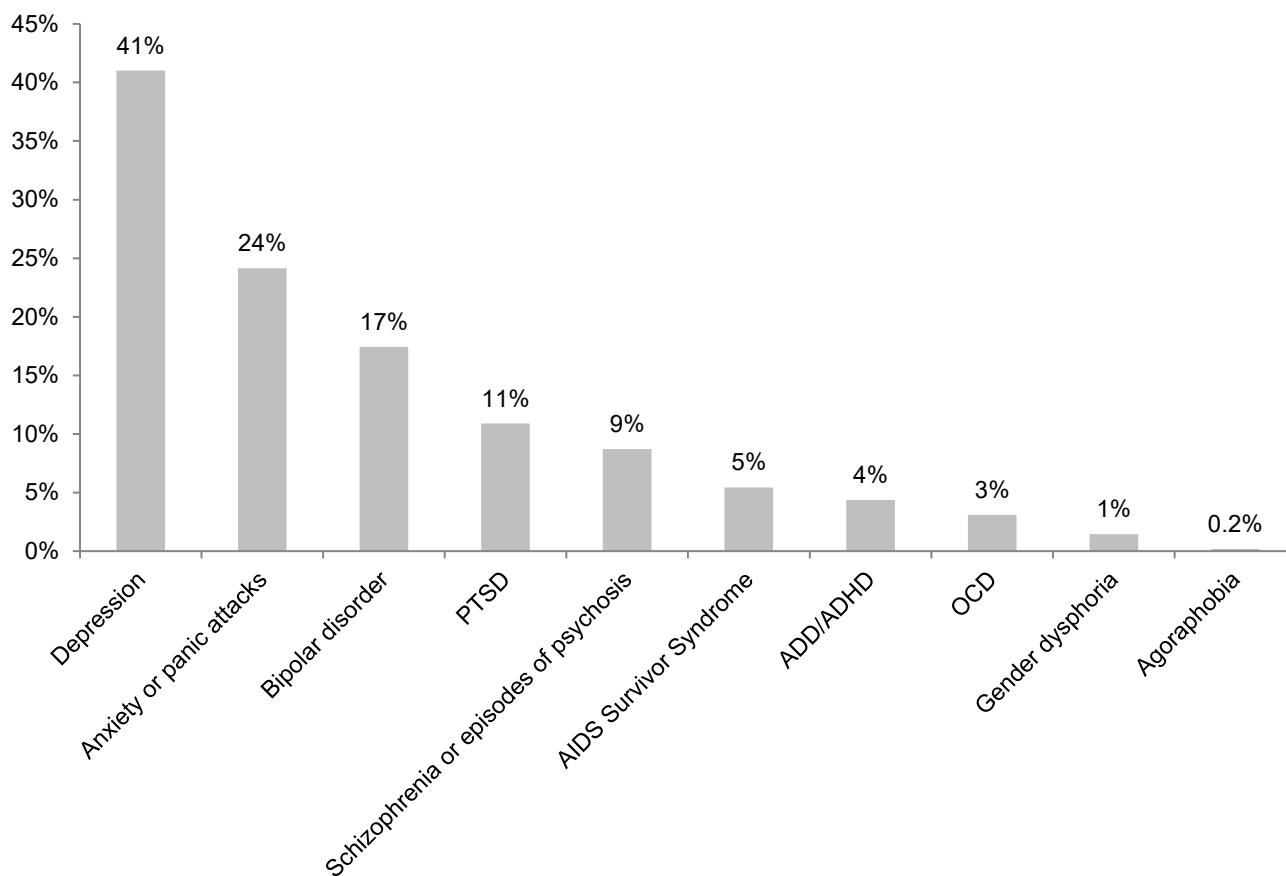
one mental health condition from among a provided list of common conditions, a 5% decrease from the 2016 needs assessment. By comparison, the National Institute of Mental Health reports that 19% of adults in the U.S. have a mental health diagnosis.³

The most frequently reported diagnosis was for depression at 41% of participants, followed by anxiety disorder or panic attacks (24%), bipolar disorder (17%), PTSD (11%), and schizophrenia or episodes of psychosis (9%). The most common write-in mental health diagnosis was borderline personality disorder.

GRAPH 2-Mental Health Diagnoses among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants reporting a current diagnosis from a health professional of each medical condition in addition to HIV.

Denominator: 551 participants



³ <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#>

Mental/Emotional Distress

(Graph 3) In addition to mental health diagnoses, participants were also asked if they had experienced any symptoms of mental/emotional distress in the past 12 months to such an extent that they desired professional help.

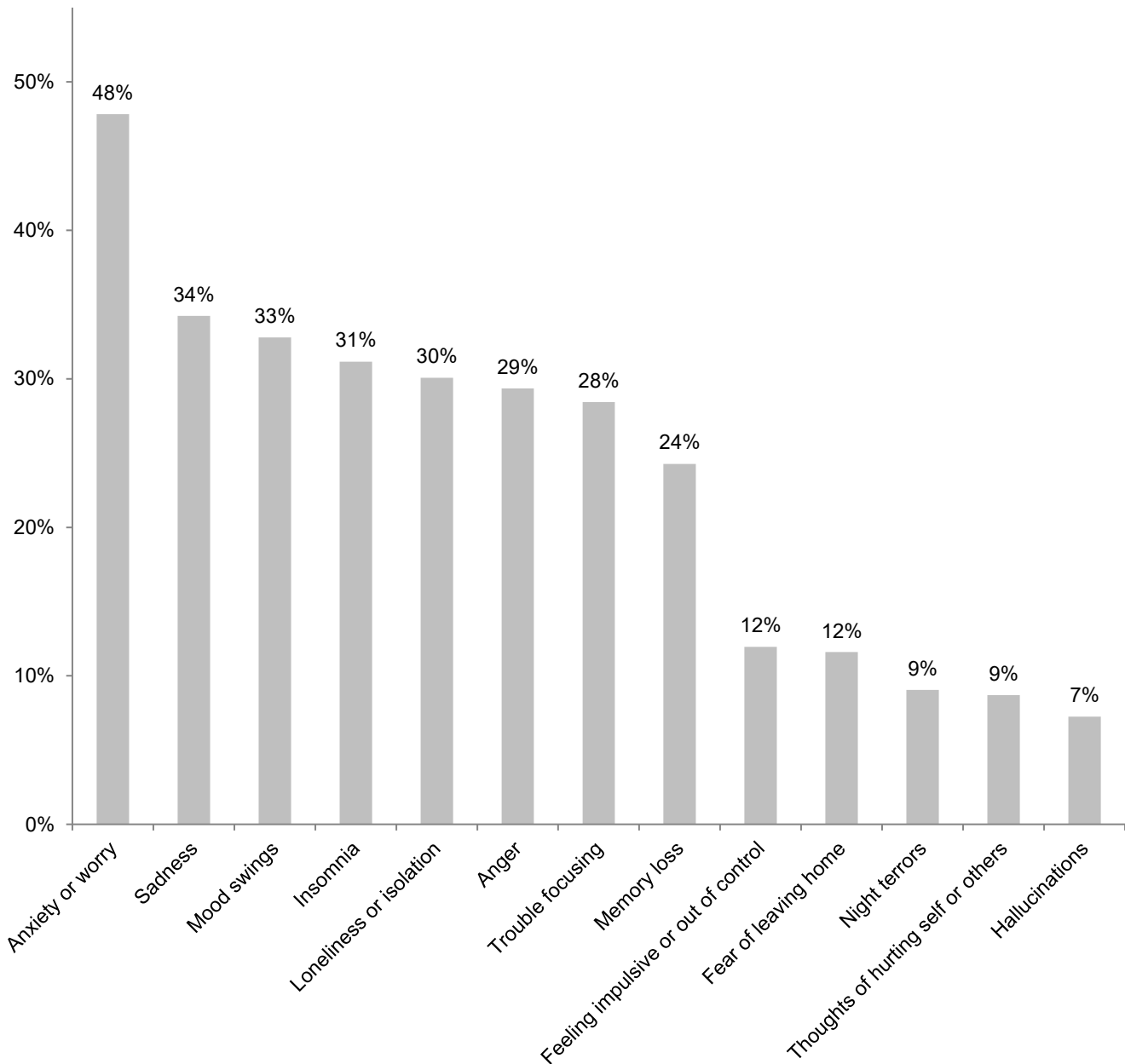
Overall, 69% of participants reported at least one such symptom, an increase of 6% from the 2020 needs

assessment. Of those listed, the most frequently reported was anxiety or worry (48% of participants), followed by sadness (34%), mood swings (33%), insomnia (31%), and loneliness or isolation (30%). No participants provided write-in mental/emotional distress symptoms.

GRAPH 3-Mental/Emotional Distress Symptoms among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants reporting having each of the following symptoms in the past 12 months to such an extent that they desired professional help.

Denominator: 552 participants



Social Support

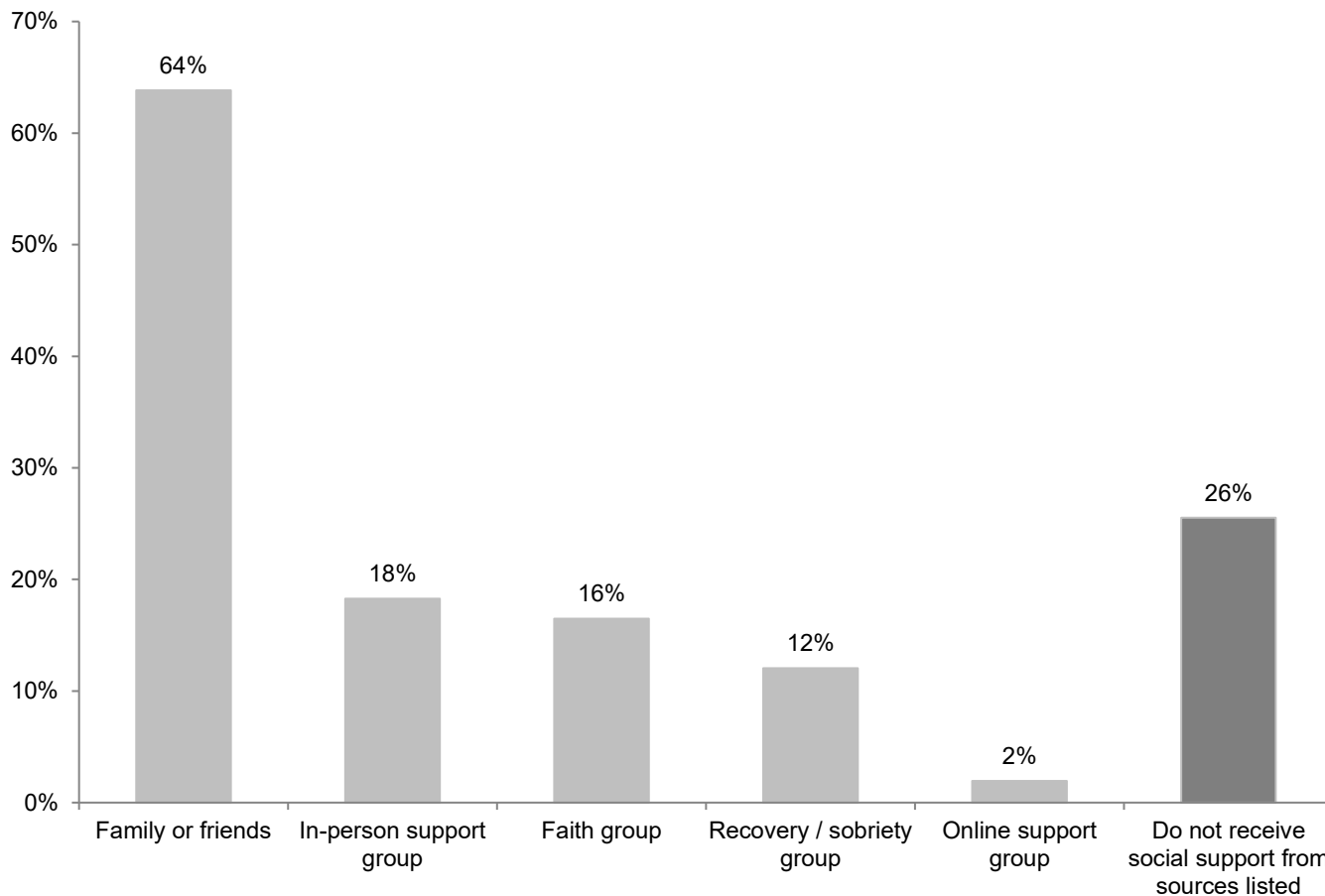
Participants were asked the sources of about social support they receive, described as, “when people or groups in your life provide emotional support, assistance, advice, and/or companionship.” Participants were asked to select from a list of five common sources of social support, or indicate that they did not currently receive any of the sources of social support listed.

(**Graph 4**) The most common source of social support was family or friends at 64% of participants. This was followed by in-person support groups (18%), faith groups (16%), recovery or sobriety groups (12%), and online support groups (2%). When asked to specify the types of online support groups used, the most common write-in responses were Facebook groups and The Posse Meetup group. An additional 26% of participants indicated that they did not receive social support from any of the sources listed.

GRAPH 4-Sources of Social Support among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants, who reported having various sources of social support.

Denominator: 564 participants



Substance Use

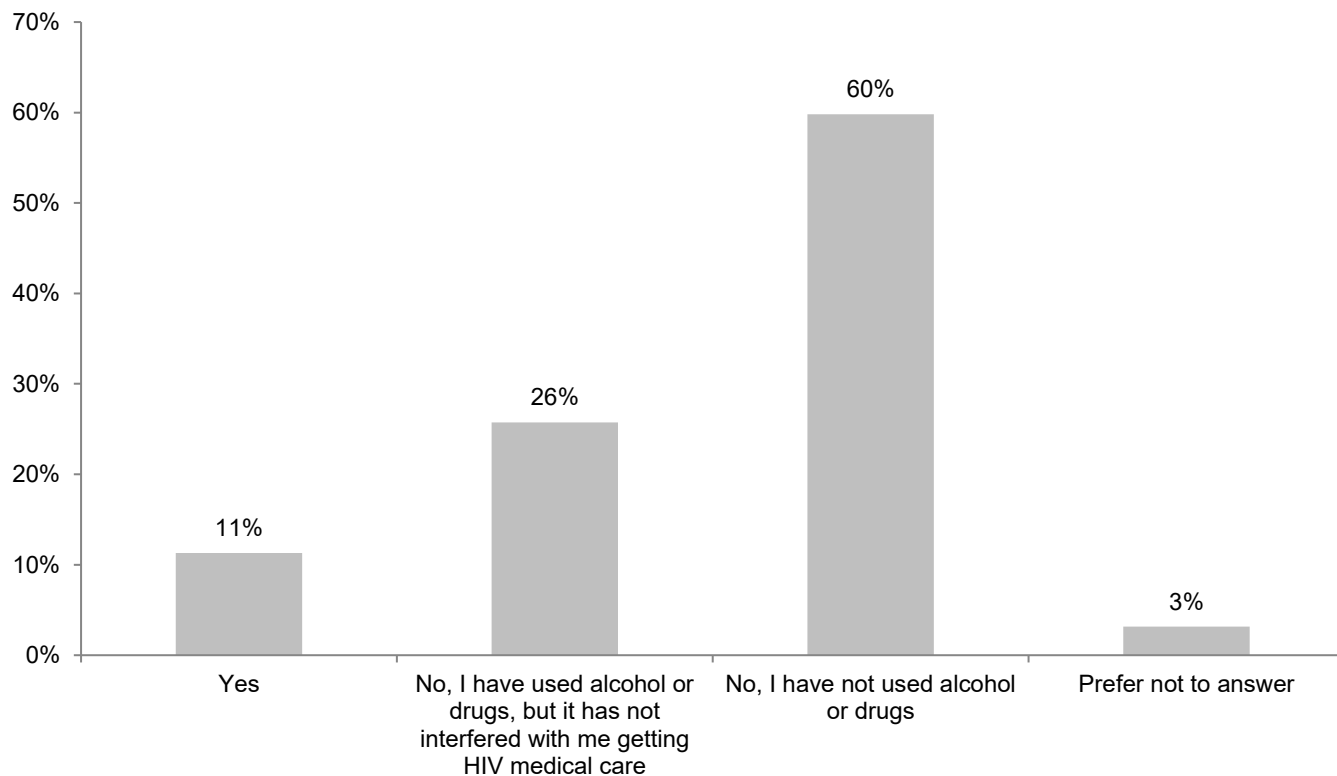
Participants were asked to indicate whether alcohol or drug use had interfered with the participant getting HIV medical care at any point in the past 12 months. Examples provided included alcohol or drug use that led to missing HIV medical appointments, having trouble taking HIV medications as prescribed, avoiding medical care for fear of legal issues, or fear telling an HIV doctor about alcohol or drug use. Those who indicated an alcohol or drug use barrier to care were then asked to select or write in the substance(s) that contributed to the barrier.

(Graph 5) A majority of participants (60%) reported no alcohol or drug use in the past 12 months. This was followed by 26% of participants who reported alcohol or drug use that did not interfere with accessing HIV medical care, and 11% who reported alcohol or drug use that interfered with HIV medical care. Of the 37% of participants who indicate some form of recent alcohol or drug use, nearly a third (30%) had alcohol or drug use that interfered with accessing HIV medical care.

GRAPH 5-Substance Use as a Barrier to Care among PLWH in the Houston Area, 2020

Definition: Percent of participants reporting substance use as a barrier to HIV Care in the past 12 months.

Denominator: 567 participants

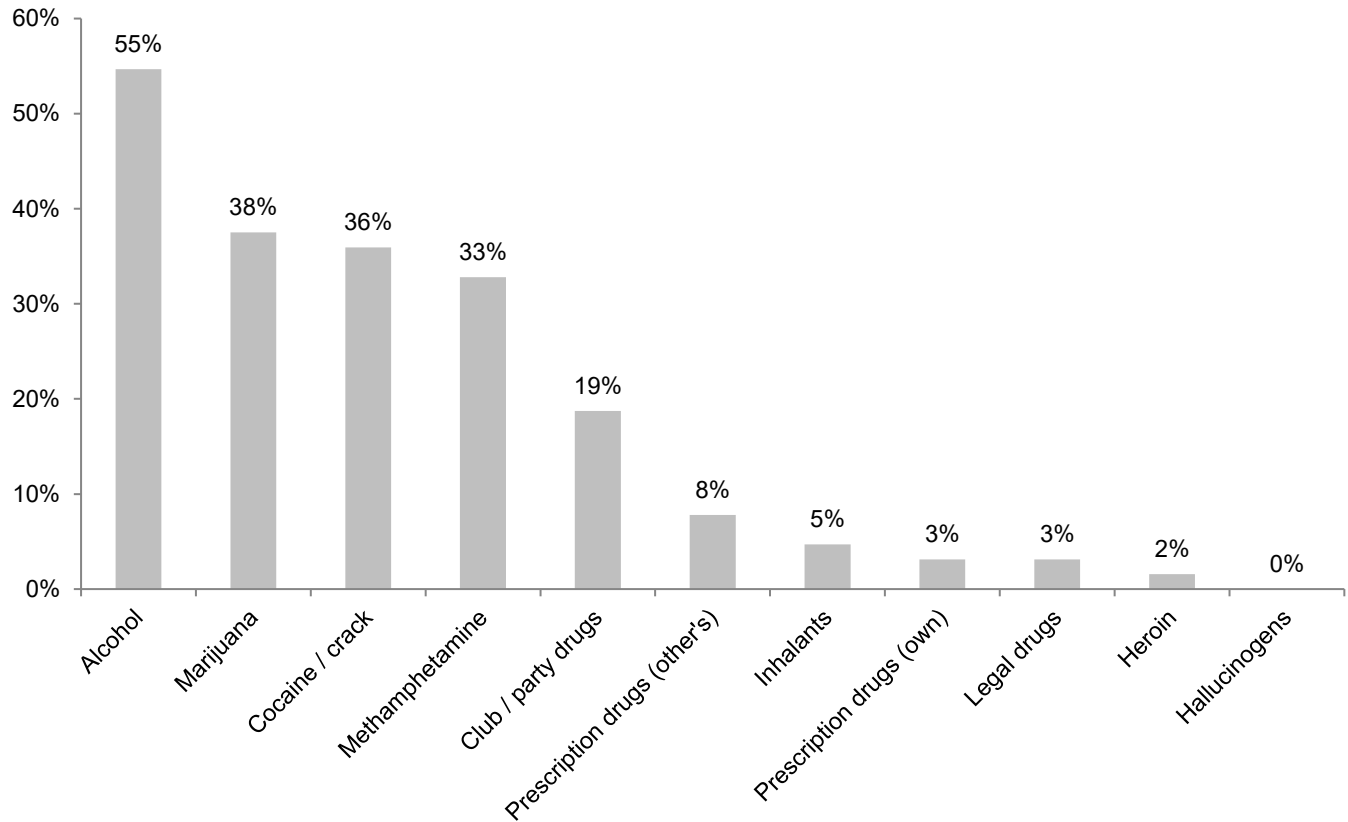


(**Graph 6**) Participants who indicated alcohol or drug use prevented access to HIV medical care in the past 12 months were asked to select which types of substances the participants used. Participants could select as many substances as applicable, and were encouraged to write in any substances used but not provided in the list. The most common substance

type used was alcohol among 55% of participants reporting substance use as a barrier to HIV medical care. This was followed by marijuana (38%), cocaine/crack (36%), methamphetamine (33%), and club or party drugs. No participants indicated hallucinogens as a barrier to care, and there were no substances written in.

GRAPH 6-Types of Substances Used as a Barrier to Care among PLWH in the Houston Area, 2020

Definition: Percent of participants reporting use of each type substance when use presented a barrier to HIV Care in the past 12 months. Denominator: 64 participants



SOCIO-ECONOMIC DETERMINANTS OF HEALTH

The social and economic circumstances of individuals can directly influence their health status and access to care. Factors such as employment, income, food insecurity, medical coverage, housing, and transportation may serve as gateways or barriers to health. These factors are often the underlying causes for health disparities in certain populations. The 2020 Houston HIV Care Services Needs Assessment asked participants about these social and economic circumstances.

Employment

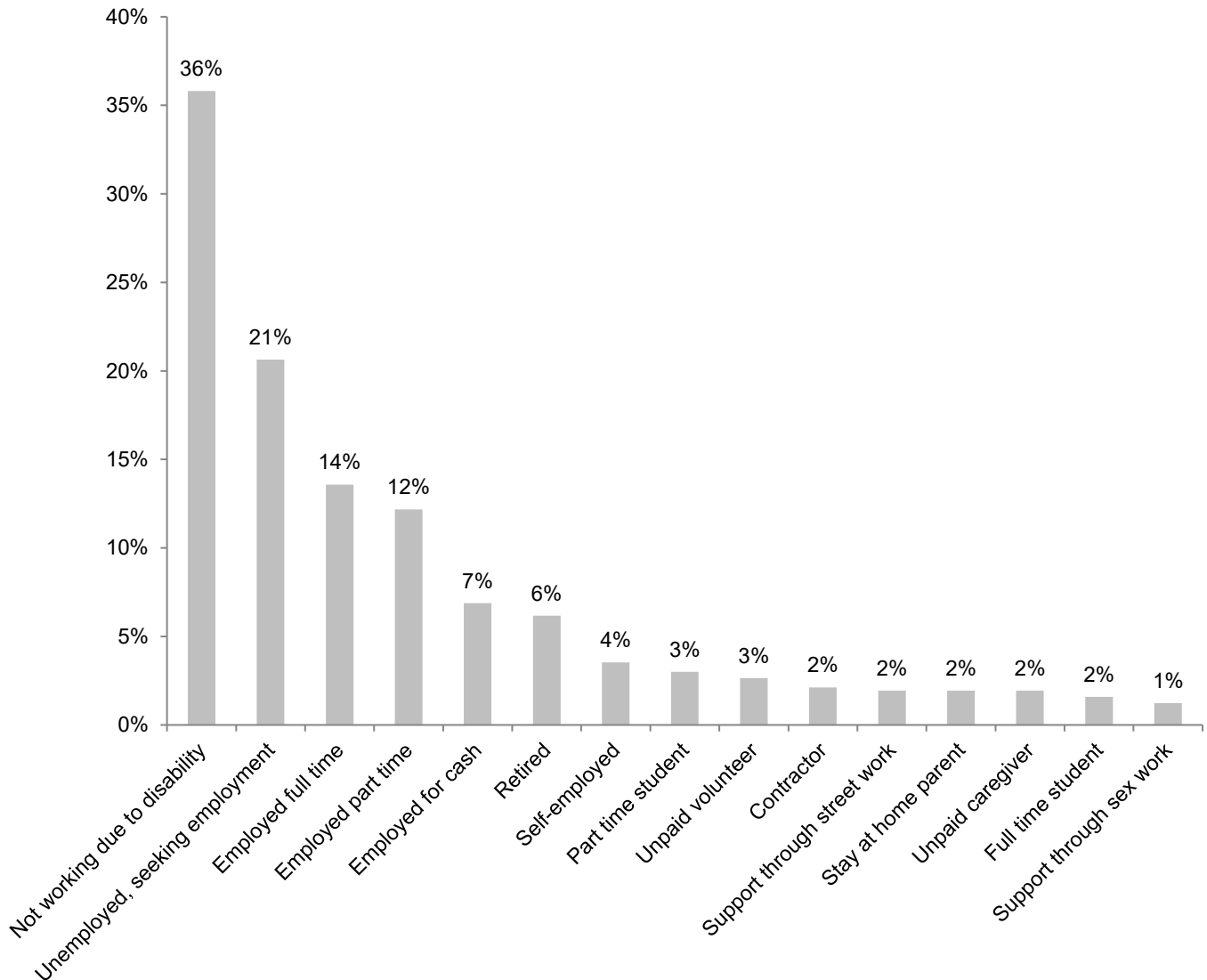
(Graph 7) Participants were asked to identify their current employment situation from a list of options

provided. Participants were asked to select as many types of employment as applicable, and could write in their employment situation if they did not see it listed. The most common employment situation was not working due to disability at 36%. This was followed by participants who were currently unemployed but seeking employment (21%), employed full time (14%) employed part time (12%) and working for cash/under the table payment (7%). The most common types of unpaid work were unpaid volunteer (3%), stay at home parent (2%), and unpaid caregiver to a family member or friend (2%). The most common write-in employment situation was being financially supported by a family member's employment or benefits.

GRAPH 7-Current Employment Situations among PLWH in the Houston Area, 2020

Definition: Percent of participants reporting each type of current employment situation.

Denominator: 567 participants



Household Income and Federal Poverty Level

(Table 1) Participants were asked to estimate their current monthly household income, regardless of source. The average annual household income reported was \$14,420, or \$1,202 per month, a 37% increase in average household income reported in the 2016 Needs Assessment. However, this average annual is four times lower than the average median household income of the general population in the Houston HSDA, and four and a half times lower than the average household

income of the general population in the Houston EMA in 2016. Among participants reporting income, 60% reported incomes below 100% of the Federal Poverty Level (FPL). This was a 15% decrease from 71% of participants reporting annual household incomes below 100% FPL in 2016. Comparatively, the average percentage below 100% FPL was 15% for the general population in Houston HSDA and 14% in the Houston EMA in 2016.

TABLE 1-Average Annual Household Income and Federal Poverty Level among PLWH in the Houston Area, 2020

	Mean Annual Household Income	Percentage Below 100% of Federal Poverty Level
PLWH (2020)	\$14,420	60%
HSDA Average (2016) ^a	\$57,971	15%
EMA Average (2016) ^a	\$65,183	14%

^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

Food Insecurity

Participants were asked whether they regularly had difficulty accessing healthy food. Those reporting regular food insecurity were then asked to select from a list of commonly cited reasons for food insecurity. Participants could also write-in reasons for food insecurity if they did not see an applicable reason listed. In total, 40% of participants reported regular food insecurity.

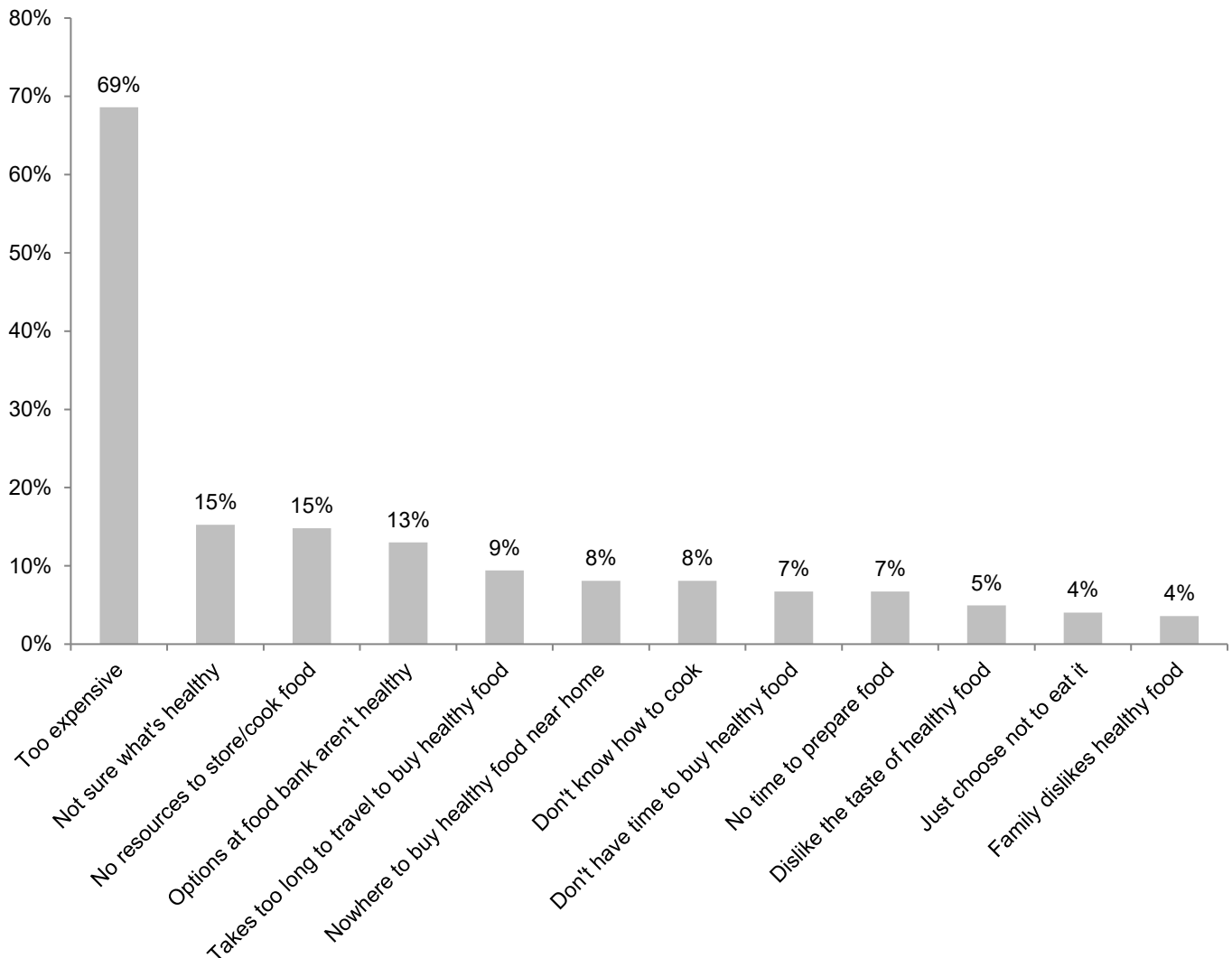
expensive for 69% of food insecure participants. This was followed by not knowing what foods were healthy (15%), having no resources to store or cook food (15%), having few healthy options at the food bank, and travel time to buy healthy food was too long (9%). The most common write-in responses were having difficulty transporting food home (particularly when walking or using public transportation) and experiencing homelessness.

(**Graph 8**) The most common cause reported for regular food insecurity was healthy food being too

GRAPH 8-Causes of Food Insecurity among PLWH in the Houston Area, 2020

Definition: Percent of food insecure needs assessment participants reporting each cause of food insecurity.

Denominator: 223 participants



Medical Care Coverage

Participants were asked details about their medical care coverage for themselves and their families, including how they cover general medical costs; if they experience difficulty covering HIV medication, non-HIV related medications, and medications for mental health conditions; and when difficulty was reported, whether assistance was received to pay for the medications.

(**Graph 9**) Of the 36% of participants with no medical coverage, 32% of participants stated they receive medical care *only* for HIV through the Ryan White Program, 3% stated they did not receive medical care due to inability to pay, and 2% stated that they pay for all medical care for themselves or their family out-of-pocket with no assistance. This means that the

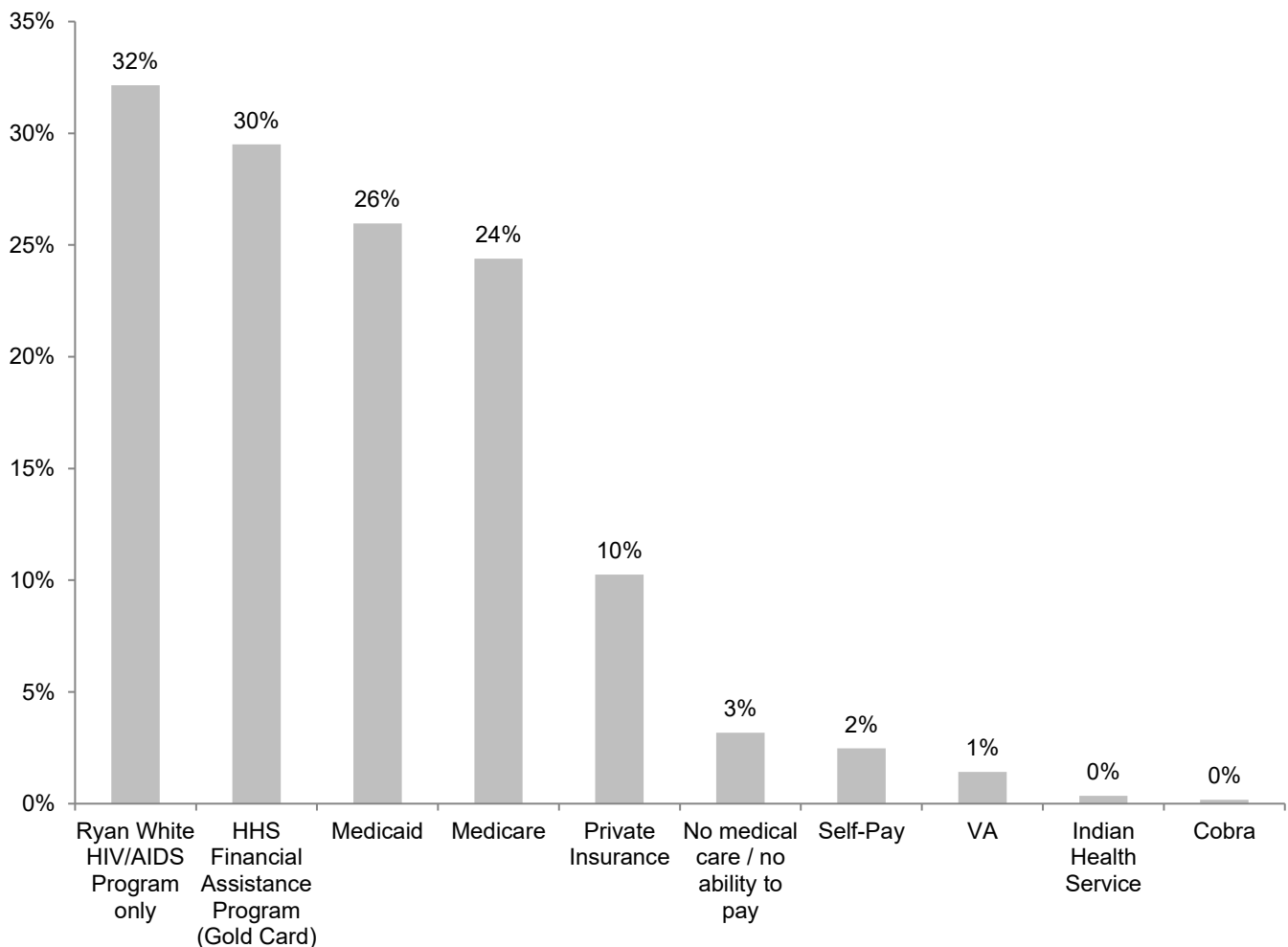
remaining participants (or 68%) reported *some form* of medical coverage, including public health insurance such as Medicaid or Medicare, private health insurance, or health care via programs for specific populations such as veterans or American Indians/Alaska Natives.

Of these specific sources for coverage, 30% of participants were in Harris Health Financial Assistance Program (formerly Gold Card), 26% said they had Medicaid, and 24% had Medicare. Additionally, 10% had private health insurance. This is a slight decrease from the 10% of participants who reported having private insurance in the 2016 Needs Assessment. The most common private insurance carriers for participants were Blue Cross/Blue Shield and Cigna.

GRAPH 9-Sources of Medical Care Coverage among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated having each source of health care coverage, including if their only health care is for HIV through the Ryan White Program and if they did not receive medical care due to inability to pay.

Denominator: 566 participants



(Graph 10, Graph 11, and Graph 12) Participants were asked if they had experienced difficulty paying for prescription medications for HIV, other co-occurring physical conditions, or mental health conditions. 37% of participants reported having difficulty paying for any medication. Results are as follows (*in order*):

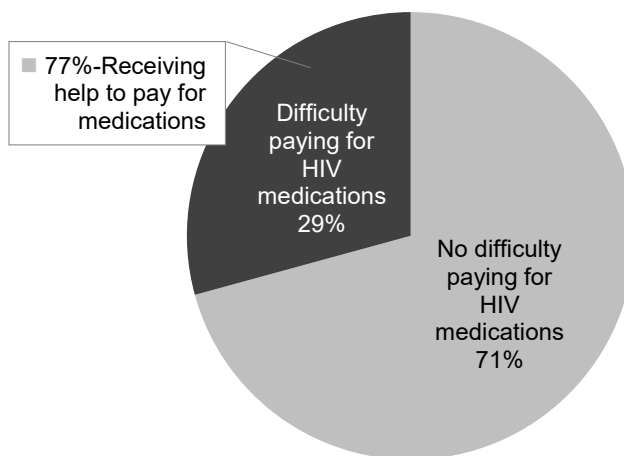
- 29% of participants on HIV medications reported difficulty paying for their prescriptions and, of those reporting difficulty, 77% were receiving financial assistance.

- 33% of participants taking medication for a co-occurring physical health conditions (other than HIV) reported difficulty paying for their prescriptions and, of those reporting difficulty, 63% were receiving financial assistance.

- 25% of participants taking medication for a mental health condition reported difficulty paying for their prescriptions and, of those reporting difficulty, 64% were receiving financial assistance.

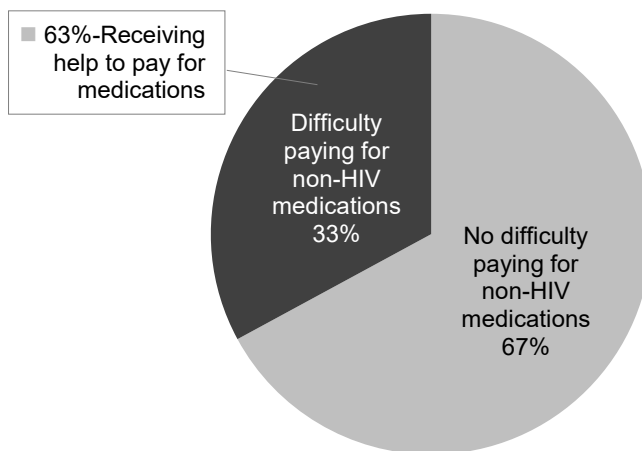
GRAPH 10-Difficulty Paying for HIV Medications among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated difficulty paying for HIV medications and, of those, the percent receiving help.
Denominator: 547 participants



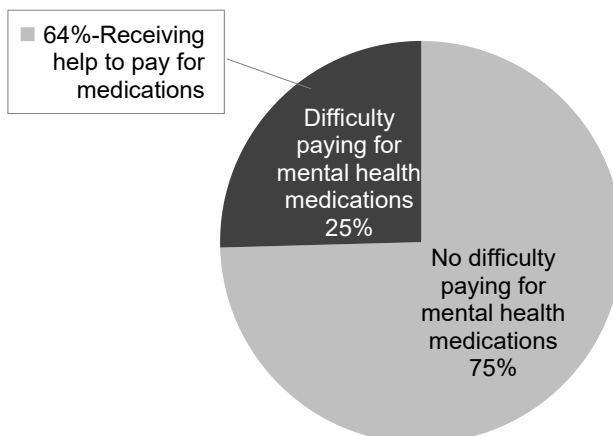
GRAPH 11-Difficulty Paying for Non-HIV Medications among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated difficulty paying for medications for non-HIV health conditions and, of those, the percent receiving help.
Denominator: 468 participants



GRAPH 12-Difficulty Paying for Mental Health Medications among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated difficulty paying for medications for a mental health condition and, of those, the percent receiving help.
Denominator: 348 participants



Transportation

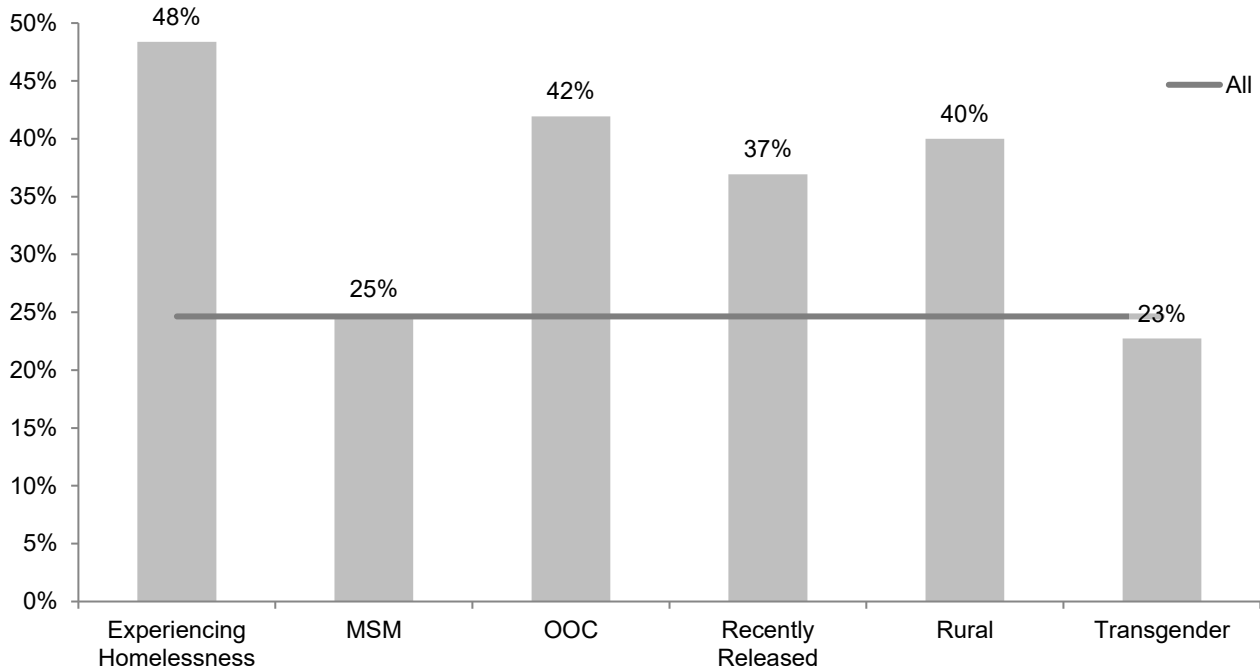
(Graph 13) When asked whether their transportation situation has ever interfered with getting HIV medical care, 25% of participants indicated transportation as a barrier to care. Among select special populations, this proportion was highest for people experiencing homelessness at 48% reporting transportation as a

barrier to HIV medical care. This was followed by the out of care population (42%), rural participants (40%), and those released from incarceration in the past 12 months (37%).

GRAPH 13-Transportation as a Barrier to HIV Medical Care among All PLWH and Select Special Populations in the Houston Area, 2020

Definition: Percent of needs assessment participants (total and by select special population) who reported a transportation situation that interfered with HIV medical care

Denominators: 560 total participants; 62 participants experiencing homelessness; 298 MSM participants; 31 OOC participants; 65 recently released participants; 5 rural participants; and 22 transgender participants



Housing Type, Homelessness, and Housing Instability

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

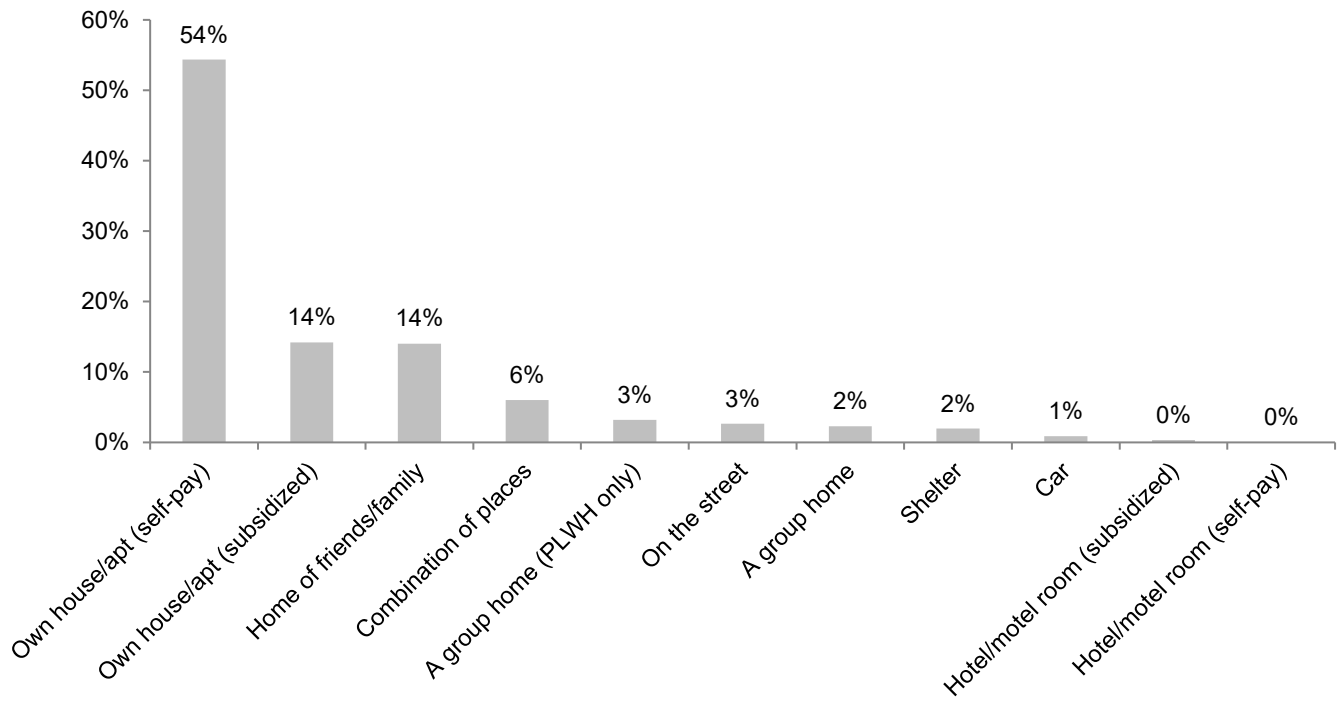
(Graph 14) A majority of participants slept most often in a house or apartment that they paid for (54%). This was followed by sleeping most often in a subsidized house or apartment (14%), staying with friends or family (14%), sleeping in a combination of places (6%), staying in a group home for PLWH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

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

GRAPH 14 -Ranking of Housing Types for PLWH in the Houston Area, 2020

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

Denominator: 563 participants



Current Housing Problems

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

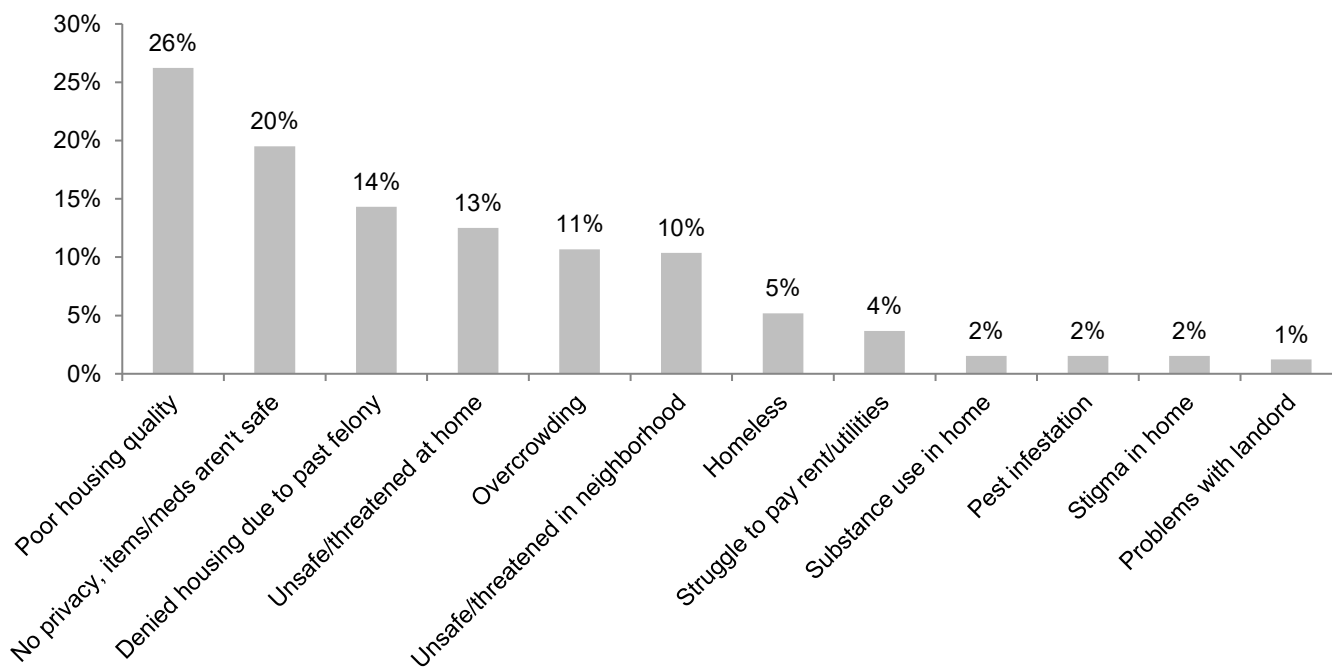
Participants were asked to indicate whether they were currently experiencing any of a list of housing quality, safety, or access issues. Participants were also encouraged to write-in any current housing problems, which at analysis were added to the list or condensed into existing options. Forty-percent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

(Graph 15) The most common housing problem participants were experiencing at the time of survey was poor housing quality at 26%. Examples given in the survey for poor housing quality were presence of mold or asbestos, exposed wires, broken windows, leaks, poor insulation, broken plumbing, or broken appliances. This was followed by having no privacy and feeling that possessions and medications were not safe (20%), being denied housing due to a past felony (14%), feeling unsafe or threatened at home (13%), and overcrowding (11%). Write-in responses with enough cases to justify inclusion in the list were: currently experiencing homelessness, struggling to pay rent/utilities, substance use in the home, pest infestation, stigma at home, and difficulties with landlords.

GRAPH 15-Current Housing Problems Experienced by PLWH, 2020

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

Denominator: 328 participants



EXPERIENCE WITH DISCRIMINATION AND VIOLENCE

Despite the widespread presence of HIV in the U.S., PLWH can encounter discrimination and stigma due to their HIV status. Research also suggests a link between HIV and violence, including intimate partner violence.⁴ The physical and emotional effects of experiencing discrimination and violence can affect the health of PLWH as well as their ability to access HIV care and other needed resources. The 2020 Houston HIV Care Services Needs Assessment explored participant experiences with discrimination, physical violence, and psychological violence.

HIV-Related Discrimination

(Graph 16) Twenty-six percent (26%) of participants reported experiencing some form of discrimination in the past 12 months, up from 20% in 2016. Most often this was discrimination in the form of being treated differently because of their positive status (25%), though less often this resulted in being denied services (5%) or being asked to leave a public place (3%).

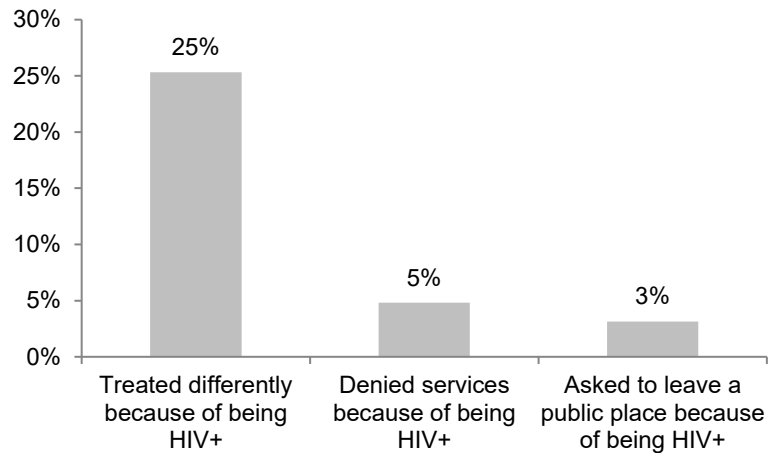
Experience with Violence

(Graph 17) Another 16% reported being threatened in the past 12 months, up from 13% in 2016. These were most often verbal harassment (11%) or threats of violence (10%) from someone the participant knew. Nine percent (9%) had been physically assaulted (most often by someone they knew), and 6% had been sexually assaulted. Reports of sexual assaults occurred in equal proportions with individuals known to the participants and strangers. Among transgender or gender non-conforming participants, reports of physical assault (13%) or sexual assault (21%) were higher. Five percent (5%) of participants reported current intimate partner violence.

GRAPH 16-HIV-Related Discrimination in the Houston Area, 2020

Definition: Percent of needs assessment participants reporting each of the following experiences in the past 12 months.

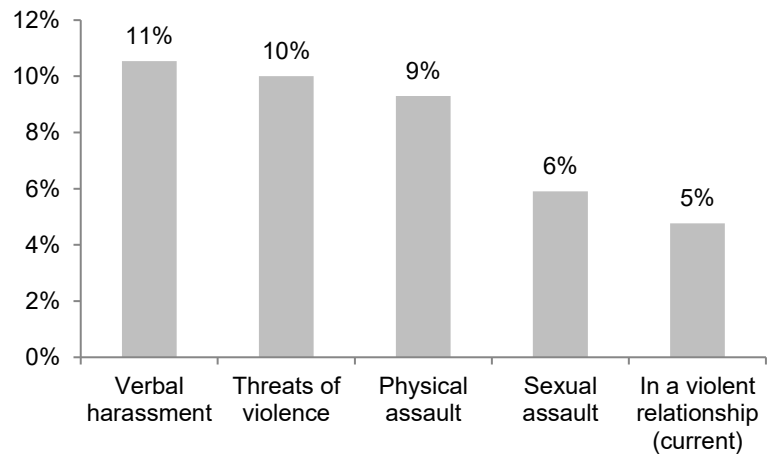
Denominator: 559 participants



GRAPH 17-Violence Experienced by PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants reporting each of the following experiences in the past 12 months.

Denominator: 558 participants



⁴ Dawson, Lindsey; Kates, Jennifer; and Ramaswamy, Amrutha. *HIV, Intimate Partner Violence (IPV), and Women: An Emerging Policy Landscape* (KFF, December 2, 2019) <https://www.kff.org/hiv/aids/issue-brief/hiv-intimate-partner-violence-ipv-and-women-an-emerging-policy-landscape>

HIV PREVENTION BEHAVIORS AND RISKS

Prevention knowledge and behaviors lower the risk of HIV transmission to others, as well as acquisition of other sexually transmitted diseases (**STDs**) or blood-borne conditions. (Source: Health Resources and Services Administration, HIV/AIDS Bureau, Guide for HIV/AIDS Clinical Care, *Preventing HIV Transmission/Prevention with Positives*, January 2011). Moreover, awareness of interventions like pre-

exposure prophylaxis (**PrEP**) and post-exposure prophylaxis (**PeP**) as well as PrEP and PeP resources can empower people living with HIV (**PLWH**) and the community to help those who are HIV-negative decrease their risk. The 2020 Houston HIV Care Services Needs Assessment asked participants about their needs related to HIV prevention information, safer sex and injection behaviors, and PrEP awareness

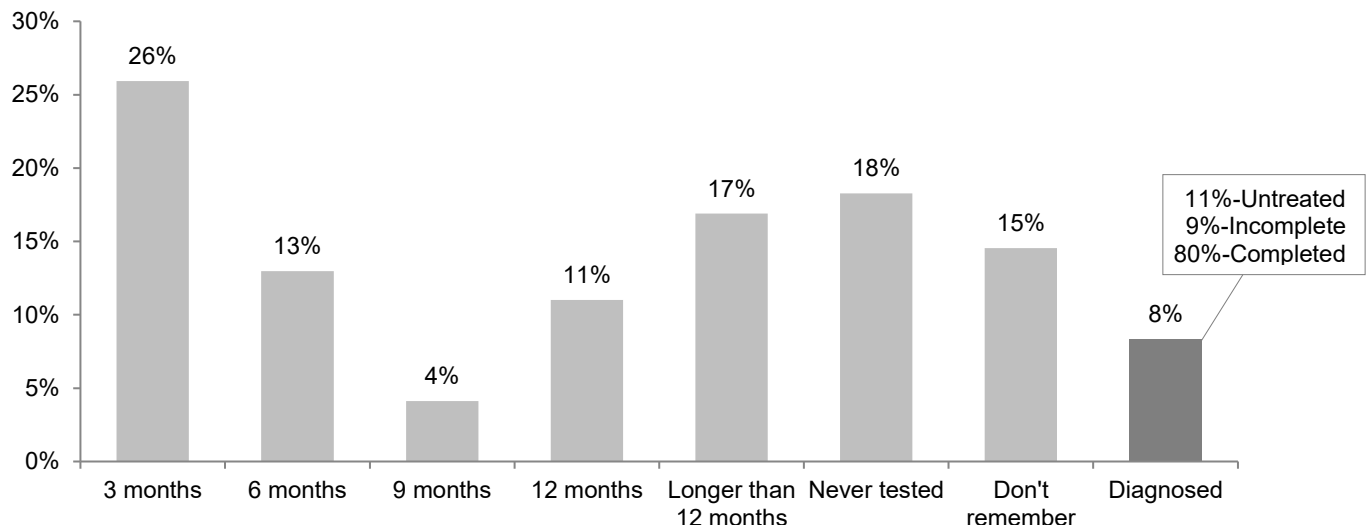
STD Testing and Treatment

(Graph 18, Graph 19, and Graph 20) Participants were asked if they had been tested, diagnosed, and/or treated for chlamydia, gonorrhea, and syphilis in the past 3, 6, 9, and/or 12 months. Twenty percent (20%) of participants (110 individuals) indicated they were tested and diagnosed one or more of these conditions in the past 12 months. Results for each STD are as follows (*in order*):

Twenty-six percent (26%) of participants were tested for chlamydia in the past 3 months, and 11% were tested in the past 12 months. 17% participants had their last chlamydia test longer than 12 months ago, and 18% had never been tested for chlamydia. 8% of participants who were tested for chlamydia in the past 12 months were diagnosed. Of those diagnosed with chlamydia in the past 12 months, 11% were never treated, 9% began but did not complete treatment, and 80% completed treatment of chlamydia.

GRAPH 18-Chlamydia Testing, Diagnosis, and Treatment among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated they were tested, diagnosed, and/or treated for chlamydia in the past 12 months. Denominator: 509 participants

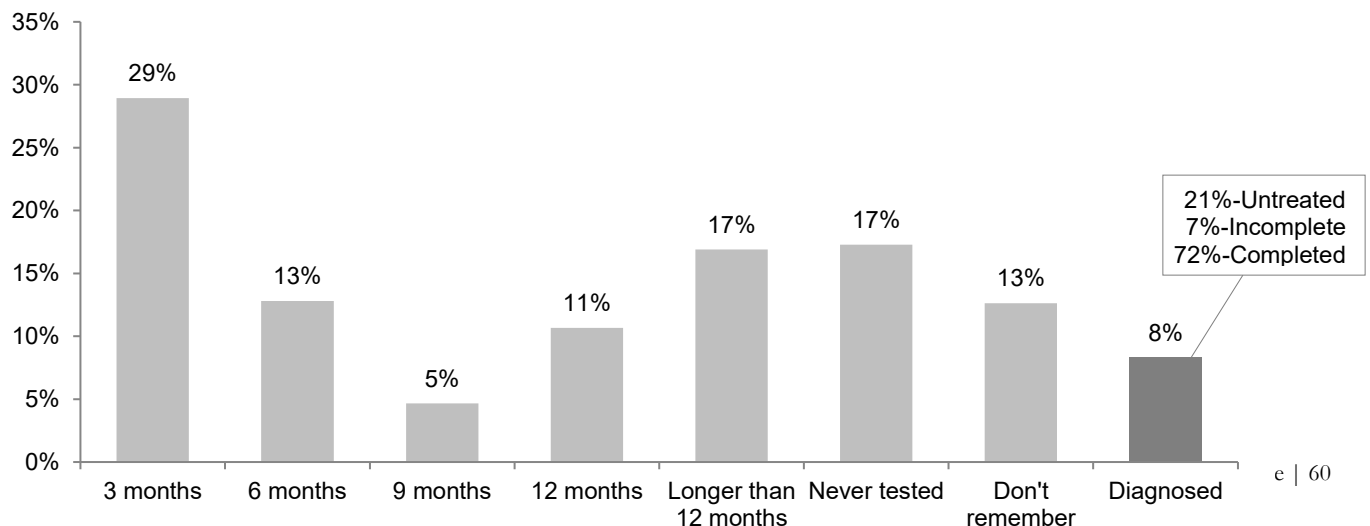


Twenty-nine percent (29%) of participants were tested for gonorrhea in the past 3 months, and 11% were tested in the past 12 months. 17% participants had their last gonorrhea test longer than 12 months ago, and 17% had never been tested for gonorrhea. 8% of

participants who were tested for gonorrhea in the past 12 months were diagnosed. Of those diagnosed with gonorrhea in the past 12 months, 11% were never treated, 9% began but did not complete treatment, and 80% completed treatment of gonorrhea.

GRAPH X19-Gonorrhea Testing, Diagnosis, and Treatment among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated they were tested, diagnosed, and/or treated for gonorrhea in the past 12 months. Denominator: 515 participants

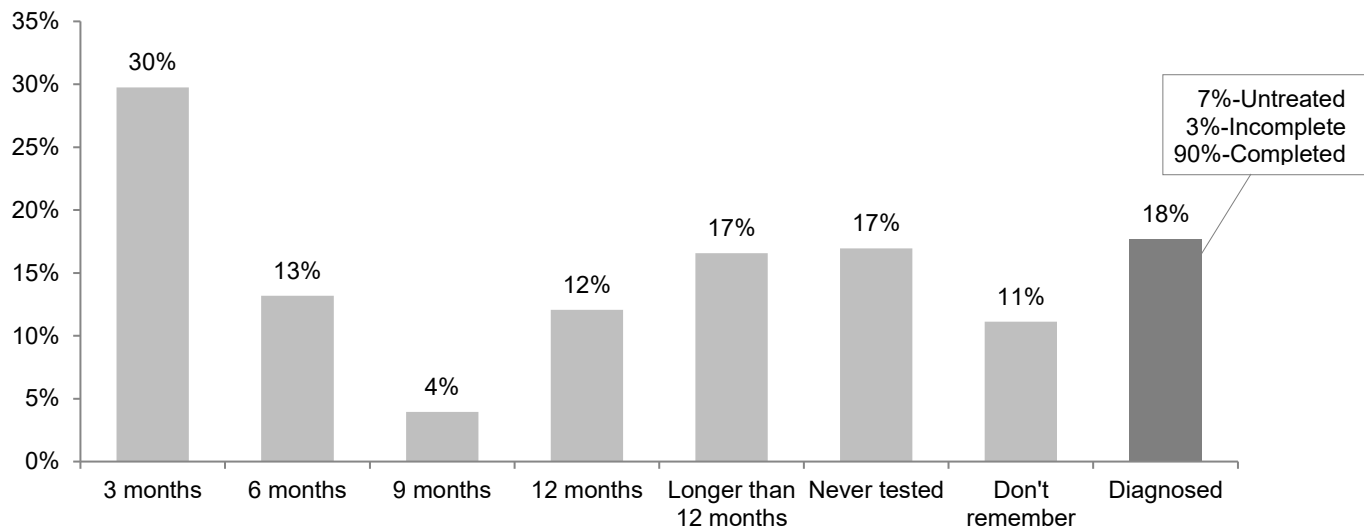


Thirty percent (30%) of participants were tested for syphilis in the past 3 months, and 12% were tested in the past 12 months. 17% participants had their last syphilis test longer than 12 months ago, and 17% had never been tested for syphilis. 18% of participants who

were tested for syphilis in the past 12 months were diagnosed. Of those diagnosed with syphilis in the past 12 months, 7% were never treated, 3% began but did not complete treatment, and 90% completed treatment of syphilis.

GRAPH 20-Syphilis Testing, Diagnosis, and Treatment among PLWH in the Houston Area, 2020

Definition: Percent of needs assessment participants who indicated they were tested, diagnosed, and/or treated for syphilis in the past 12 months. Denominator: 531 participants



Access to HIV Prevention Information

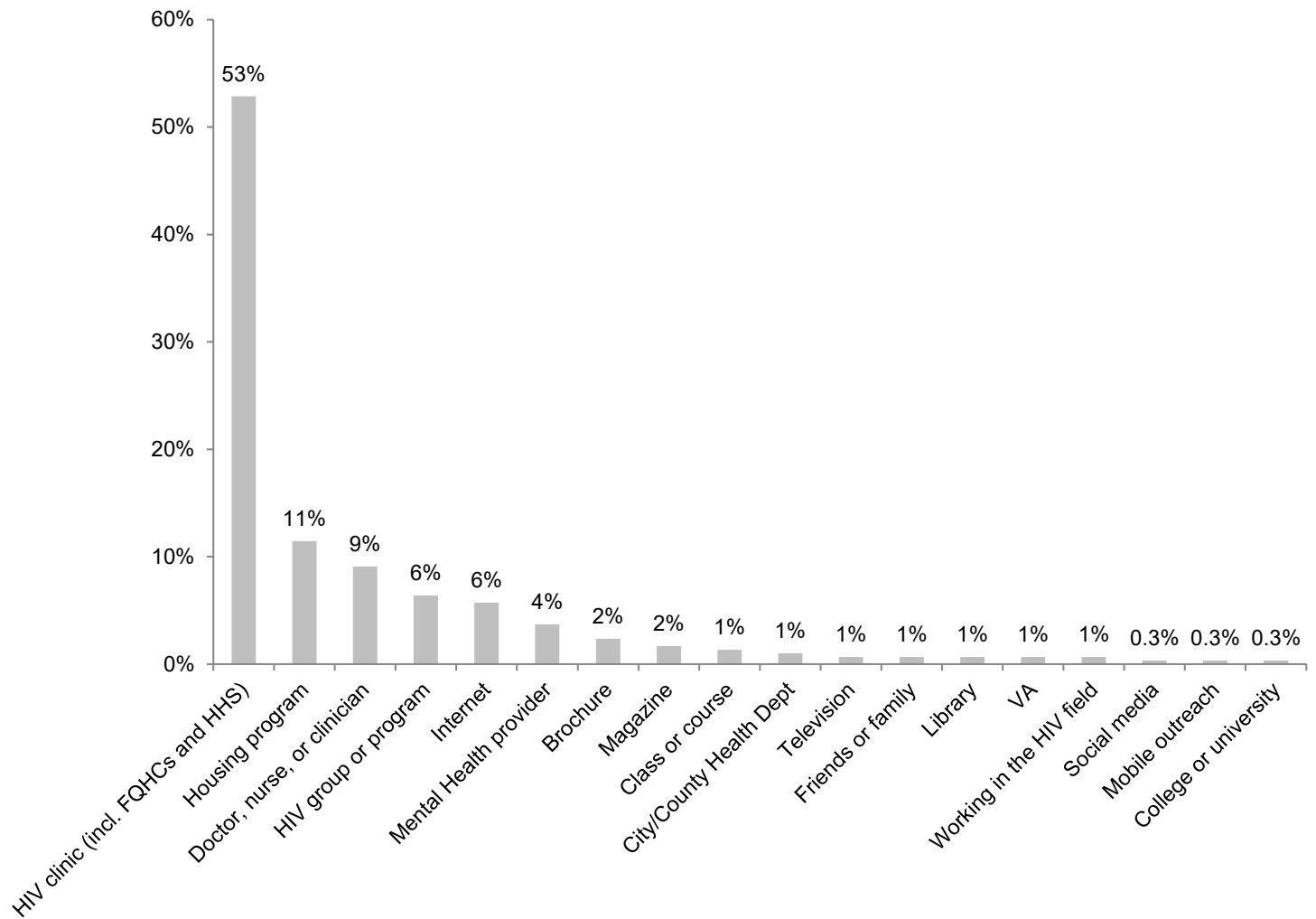
Needs Assessment participants were asked if they had received any information about HIV prevention in the past 12 months. Overall, 57% of participants said they *had* received information in the past year, a 15% decrease from 67% in 2016. Those who had received information were then asked to identify the source of this information and the types of prevention information received

(Graph 21) The source of HIV prevention information cited most often was an HIV clinic, including Federally Qualified Health Centers (**FQHCs**) and Harris Health System (**HHS**) at 53% of all reported sources. This was followed by housing programs (11%); doctors, nurses, or clinicians (9%); an HIV group or program (6%); and the internet (6%). At less than 1%, social media, mobile outreach, and colleges or universities were reported least.

GRAPH 21-Sources of HIV Prevention Information for PLWH in the Houston Area, 2020

Definition: Percent of times each source was reported by needs assessment participants as the source from which HIV prevention education the past 12 months was received.

Denominator: 297 source reports



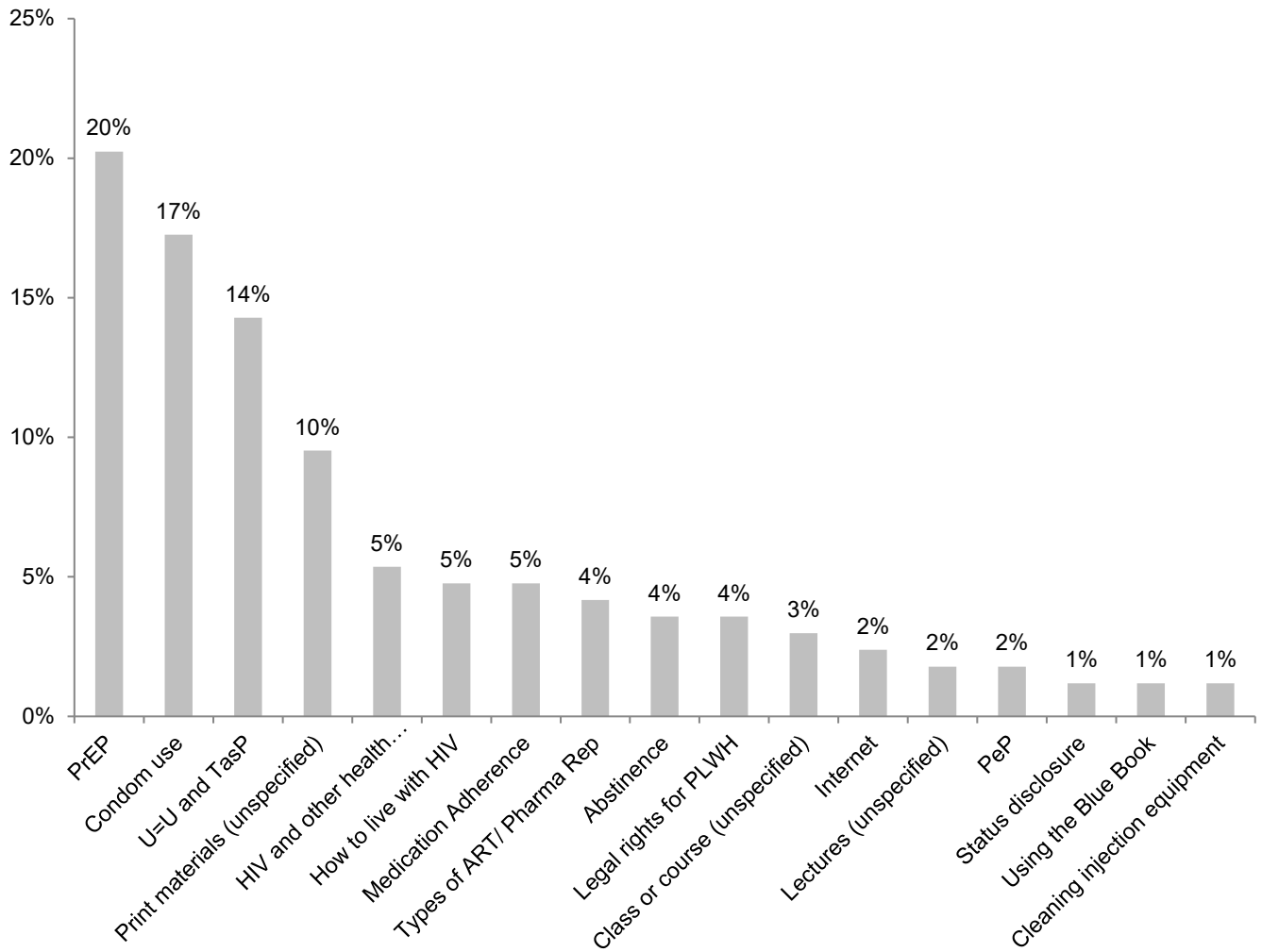
(**Graph 22**) The topic of the HIV prevention information provided most often pre-exposure prophylaxis, or **PrEP**, and 20% of topics reported. This was followed by condom use (17%), undetectable = untransmittable (**U=U**) or treatment as prevention

(**TasP**) (14%), unspecified information from print materials (10%), and HIV and other health conditions (5%). At 1% each, status disclosure, use of the Blue Book resource Guide, and information on cleaning injection equipment were reported least.

GRAPH 22-Topics of HIV Prevention Information Provided to PLWH in the Houston Area, 2020

Definition: Percent of times each topic or information type was reported by needs assessment participants.

Denominator: 297 topic reports



**Prevention through Medication
U=U, PrEP, and PeP Awareness**

Undetectable = untransmittable (U=U), and TasP both refer to the use of anti-retroviral therapy (ART) medications to achieve a consistently undetectable viral load thereby preventing HIV transmission through sex. When asked whether they were aware of U=U before the day of survey, 76% of participants reported that they were aware. Awareness of PrEP, post-exposure prophylaxis (PeP), and resources for both are reported below.

(Table 2) When asked if they had ever heard of PrEP, 80% of participants were PrEP aware, a 43% increase from 56% PrEP aware participants in 2016. Awareness among PLWH of PrEP resources also increased substantially between 2016 and 2020. Whereas 34% of participants knew where to refer someone for PrEP resources in 2016, the proportion of PrEP resource aware participants grew to 58% in 2020, a 71% increase.

TABLE 2- Crosstabulation of PrEP Awareness with PrEP Resource Awareness among PLWH in the Houston Area, 2020

		"Do you know where a person who does not have HIV can go to get on PrEP?"		Total
		Yes	No	
"Have you heard about PrEP before?"	Yes	55%	24%	80%
	No	2%	13%	15%
	Don't Remember	1%	5%	6%
	Total	58%	42%	

Denominator: 562 participants

(Table 3) Post-exposure prophylaxis (PeP) is a method for people who do not have HIV to prevent acquiring HIV if they think they may have been exposed through sex or needle sharing in the last 72 hours. For the first time, the 2020 Needs Assessment measured awareness of PeP and resources to access PeP among PLWH.

When asked if they had ever heard of PeP, 60% of participants were PeP aware. Awareness among PLWH of PeP resources was lower at 52% of participants reporting awareness of where to refer someone to access PeP.

TABLE 3- Crosstabulation of PeP Awareness with PeP Resource Awareness among PLWH in the Houston Area, 2020

		"Do you know where a person who does not have HIV can go to get on PeP?"		Total
		Yes	No	
"Have you heard about PeP before?"	Yes	44%	16%	60%
	No	6%	27%	33%
	Don't Remember	1%	6%	7%
	Total	52%	48%	

Denominator: 560 participants

Sexual Activity and Condom Use

Participants were asked details regarding current sexual activity and use of safer sex practices, in particular, condom use, barriers to consistent condom use, and disclosure of HIV status to potential sex partners. Forty-five percent (45%) of participants reported having no oral, vaginal, or anal sex in the 6 months preceding survey, and were excluded from the following analysis.

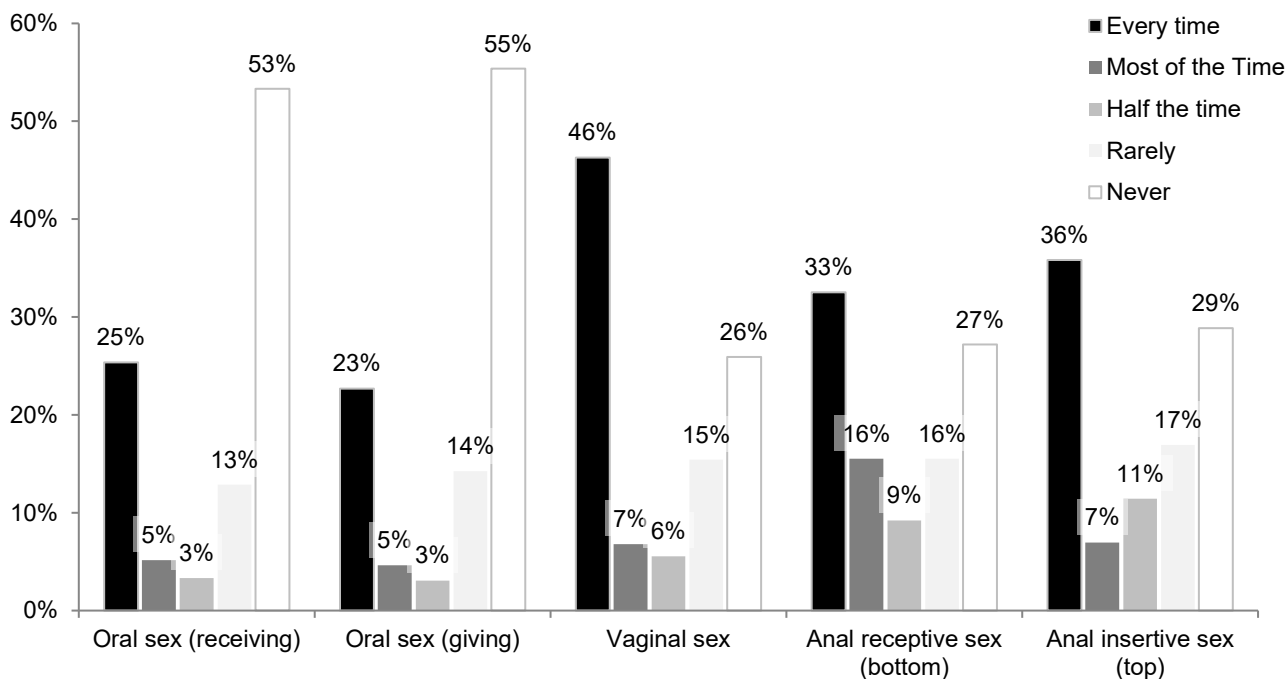
When asked about partner HIV status, 47% of sexually active participants indicated that they had at least one sexual partner who was also living with HIV. Thirteen percent (13%) of participants reported that they had at least one sexual partner who was presumably HIV negative and taking PrEP, while 26% reported having at least one presumably HIV negative partner who was

not taking PrEP. Sixteen percent (16%) reported that they did not know the HIV status of at least one sexual partner.

(**Graph 23**) Forty-four (44%) of sexually active participants said they *always* use condoms during at least one type of sexual activity. Least frequent condom use was reported for oral sex with 55% of participants reporting no condom use for giving oral sex and 53% reporting no condom use for receiving oral sex. The most frequent consistent condom use was observed for vaginal sex, with 46% of participants reporting using a condom for every encounter. Moderate consistent condom use was reported for anal sex, with 36% of participant reporting condom use for anal insertive sex, and 33% reporting condom use for anal receptive sex.

GRAPH 23-Frequency of Condom Use among PLWH in the Houston Area, by Type of Sexual Activity, 2020

Definition: Percent of needs assessment participants reporting condom use frequency by type of sexual activity
Denominator: 162-272 sexually active participants, varying by type of sexual activity

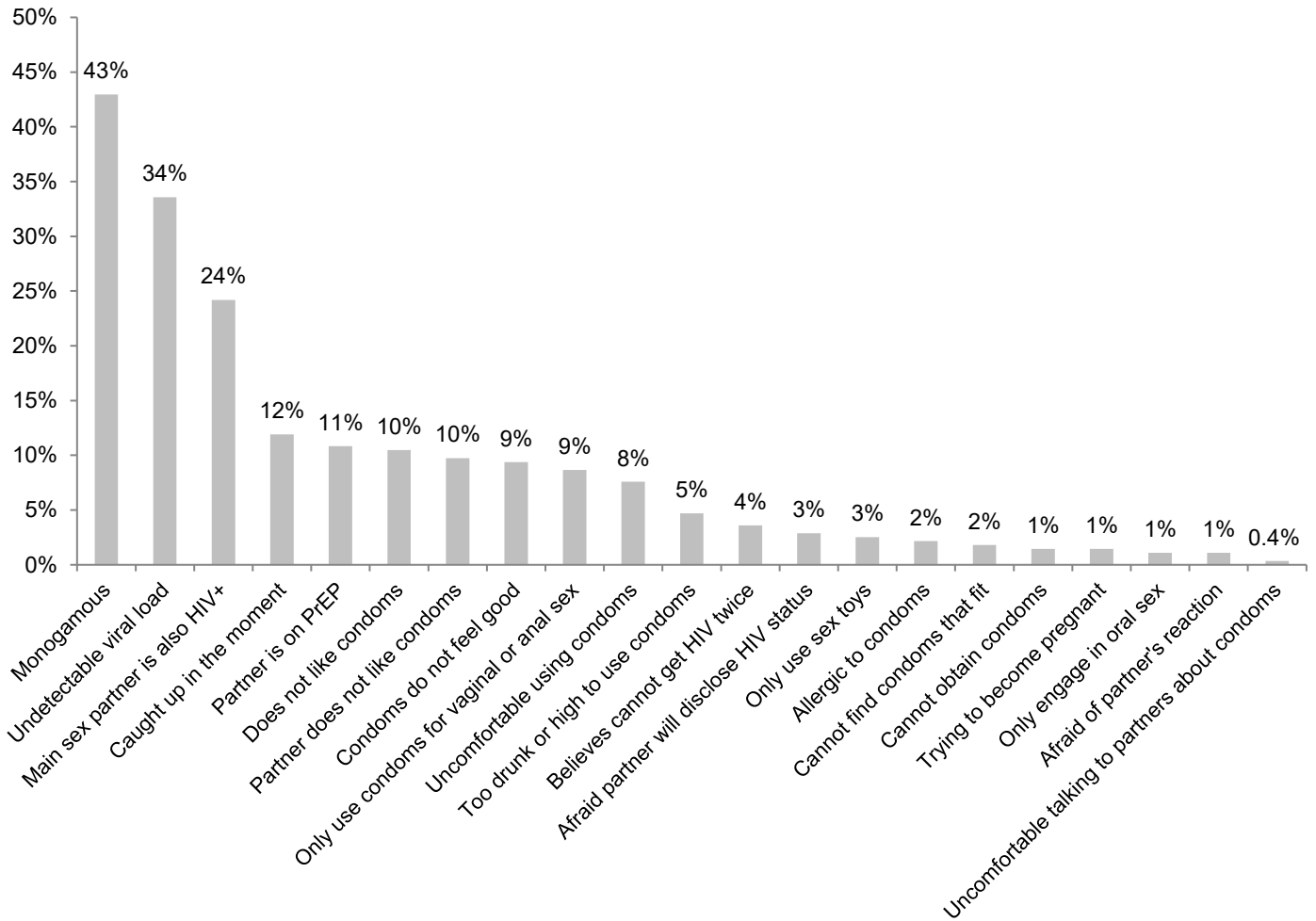


(Graph 24) When inconsistent condom use was reported, participants were asked about their reason for not using a condom. Participants were provided with a list of 21 common reasons for not using condoms, and could write in their reasons. The most frequently selected reasons participants for not using condoms were only having one sexual partner (43%),

having an undetectable viral load (34%), having a sexual partner who was HIV positive as well (24%), getting caught up in the moment (12%), and having a partner on PrEP (11%). The most common write-in reason for inconsistent condom use was the participant’s partner refuses to use a condom or removes the condom during sex.

GRAPH 24-Barriers to Condom Use among PLWH in the Houston Area, 2020

Definition: Percent sexually active needs assessment participants reported each reason for inconsistent condom use
 Denominator: 277 sexually active needs assessment participants reporting inconsistent condom use



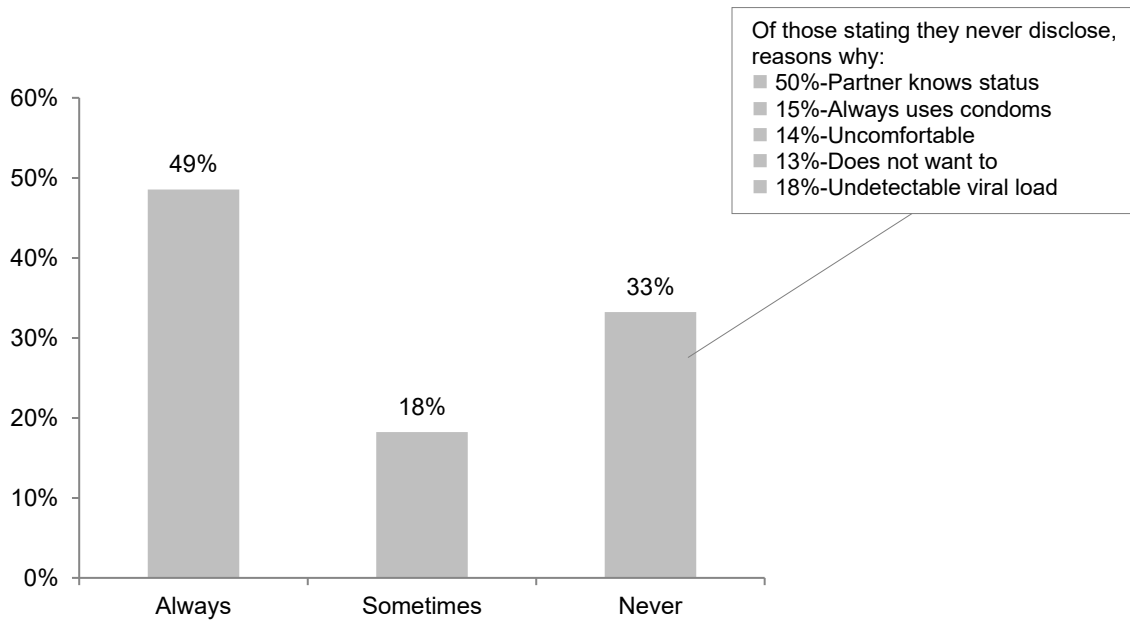
(Graph 25) Participants were asked how frequently they disclose their HIV status to new sex partners. Overall, 49% stated they always disclose their HIV status with every partner, while 33% stated they never

disclose their HIV status. Of those stating they never, the most common reason given was that their main sex partner already knows their HIV status.

GRAPH 25-Disclosure of HIV Status among PLWH in the Houston Area, 2020

Definition: Percent of sexually active needs assessment participants selecting each answer in response to the survey question, "How often do you talk about your HIV status with new sex partners?"

Denominator: 313 sexually active participants



Injection Use

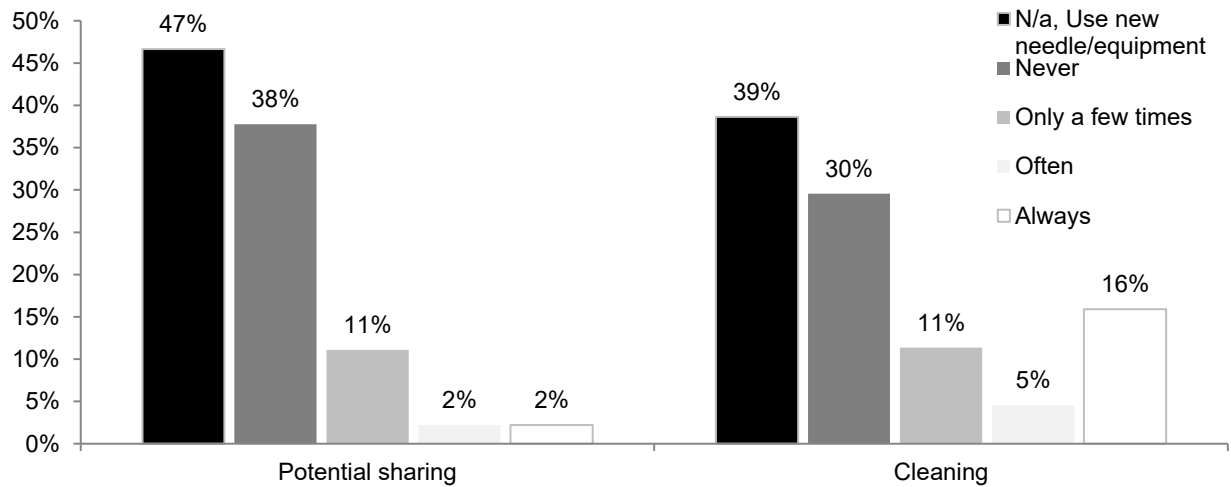
(**Graph 26**) Participants were asked if they used a needle to inject any substance in the past 12 months. Substance was defined broadly to include medications, insulin, steroids, hormones, silicone, or drugs. Nine percent (9%) of participants reporting using a needle to inject a substance in the past 12 months. Those reporting injection use in the past months were asked how frequently they shared or used needles or injection equipment that somebody else may have

used, and how frequently clean they cleaned needles or injection equipment with bleach. A majority found both questions not applicable. For potential needle/equipment sharing, 47% only use new needles/equipment, and an additional 38% never share used needles/equipment. For needle/equipment cleaning, 39% only use new needles/equipment, and an additional 16% always clean their used needles/equipment with bleach.

GRAPH 26-Frequency of Needle/Equipment Sharing and Cleaning Among PLWH in the Houston Area, 2020

Definition: Percent of participants with injection use in the past 12 indicating needle/injection equipment sharing and cleaning

Denominator: 44-45 participants with injection use in the past 12 months





Chapter 5: Out of Care Profile

OUT OF CARE PROFILE

Details about people living with HIV (**PLWH**) who are *not* in HIV care are of particular importance to local HIV planning. This information helps communities design HIV services to prevent delays or interruptions in care. Continuous HIV care is a national goal for both HIV prevention and care stakeholders, as it can lead to improved health outcomes for individuals as well as reduced transmission of HIV.

Proactive efforts were made to include out of care (**OOO**) PLWH in the 2014 Houston Area HIV/AIDS needs assessment (See: *Methodology*, page 7), and results presented throughout this document include OOC PLWH. This Chapter highlights results *only* for OOC participants and as their results compare to the total needs assessment sample.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 24 participants in the 2020 Houston HIV Care Services Needs Assessment met all criteria for being defined as OOC. This is 7% of the entire needs assessment sample. As with the overall sample, 95% of OOC needs assessment participants resided in Harris County at the time of data collection. While the overall majority of needs assessment participants were male (66%), African American/Black (63%), and heterosexual (57%). However, while the majority of OOC participants were male (79%) OOC participants were more often Hispanic/Latino (54%) and equally identified as heterosexual and MSM (50% respectively). Sixty-one percent (61%) of OOC participants were between the ages of 39 and 54.

The average unweighted household income of OOC participants was \$13,493 annually, \$2,133 lower than the total sample, with the majority living below 100% of federal poverty (**FPL**). A majority of participants (46%) was not formally employed at the time of survey, with 18% collecting disability benefits, 18% unemployed and seeking employment, and 11% retired. However, 28% of OOC participants gained financial support through informal employment such as working for cash, sex work, and street work. Most participants paid for healthcare using

Notes: “Out of care/OOC” is defined in this analysis as a PLWH who indicated in their survey that they had not received any of the following in the past 12 months: an HIV primary care visit, a prescription for HIV medication, or an HIV monitoring test (viral load or CD-4). This definition is consistent with national and state OOC criteria.

Medicaid/Medicare or assistance through Harris Health System (Gold Card).

Characteristics of the OOC (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- Hispanic/Latino
- Adults between the ages of 39 and 54
- Equally heterosexual and MSM
- With lower income, formal employment, and private health insurance

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Chapter were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, page 7).

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

No.		%		No.		%		No.		%	
County of residence			Age range (median: 50-54)			Sex at birth					
Harris	21	95.5%	13 to 17	0	-	Male	19	79.2%			
Fort Bend	0	-	18 to 24	1	4.3%	Female	5	20.8%			
Liberty	0	-	25 to 34	3	13.0%	Intersex	0	-			
Montgomery	1	4.5%	35 to 49	7	30.4%	Transgender	0	3.9%			
Other	0	-	50 to 54	7	30.4%	Non-binary / gender fluid	0	-			
			55 to 64	4	17.4%	Currently pregnant*	0	-			
			65 to 74	1	4.3%	*All currently pregnant respondents reported being in care. The denominator is all respondents reporting female sex at birth					
			75+	0	-						
			Youth (13 to 24)	1	4.2%						
			Seniors (≥50)	12	50.0%						
Primary race/ethnicity			Sexual orientation			Health insurance					
White	2	8.3%	Heterosexual	12	50.0%	Private insurance	0	-			
African American/Black	7	29.2%	Gay/Lesbian	12	50.0%	Medicaid/Medicare	6	30.0%			
Hispanic/Latino	13	54.2%	Bisexual/Pansexual	0	-	Harris Health System	7	35.0%			
Asian American	0	-	Other	0	-	Ryan White Only	5	25.0%			
Other/Multiracial	2	8.3%	MSM	12	50.0%	None	2	10.0%			
Residency			Yearly income (average: \$11,360)			Employment					
Born in the U.S.	15	65.2%	Federal Poverty Level (FPL)			Disabled	5	17.9%			
Lived in U.S. > 5 years	7	30.4%	Below 100%	6	85.7%	Unemployed and seeking work	5	17.9%			
Lived in U.S. < 5 years	1	4.3%	100%	0	-	Employed (PT)	3	10.7%			
In U.S. on visa	0	-	150%	1	14.3%	Retired	3	10.7%			
Prefer not to answer	0	-	200%	0	-	Employed (FT)	3	10.7%			
			250%	0	-	Self Employed	1	3.6%			
			≥300%	0	-	Other	8	28.6%			

BARRIERS TO RETENTION IN CARE

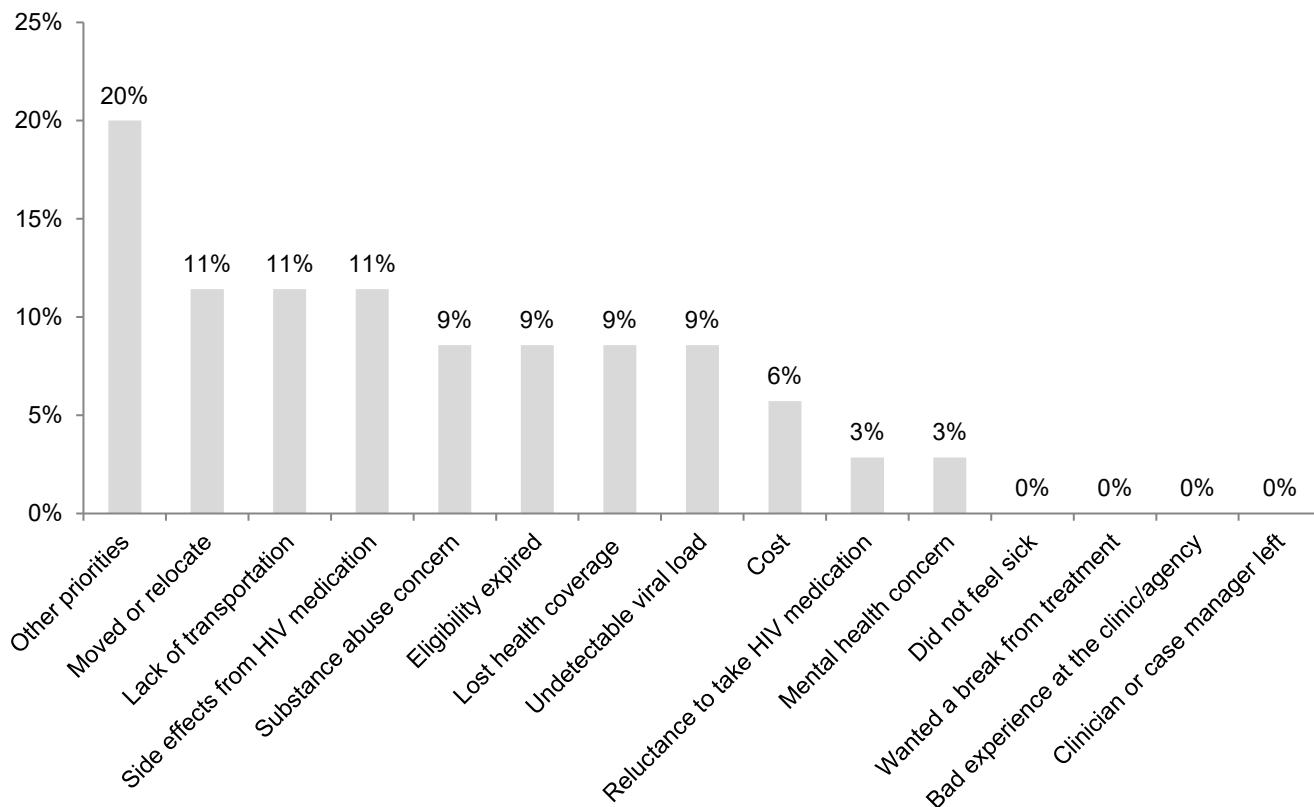
All participants in the 2020 Needs Assessment who reported a break in HIV care for 12 months or more were asked to identify the reasons for the interruption in care, selecting from a preset list of 15 commonly reported reasons. Among the total sample, substance abuse concerns were selected most often, followed by moving or relocating and having other priorities at the time.

(**Graph 1**) Among OOC participants, having priorities other than HIV was cited most often as the reason for an interruption in HIV care (at 20% of reported reasons), followed by moving or relocation (11%), lack of transportation (11%), and experiencing side effects from the medication (11%). There was no trend in write-in reasons for falling out of care.

GRAPH 1-Reasons for Falling Out of HIV Care among OOC PLHW in the Houston Area, 2020

Definition: Percent of times each item was reported by OOC needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.

Denominator: 35 reasons for falling out of care reported



RANKING OF NEED FOR HIV SERVICES

Funded Services

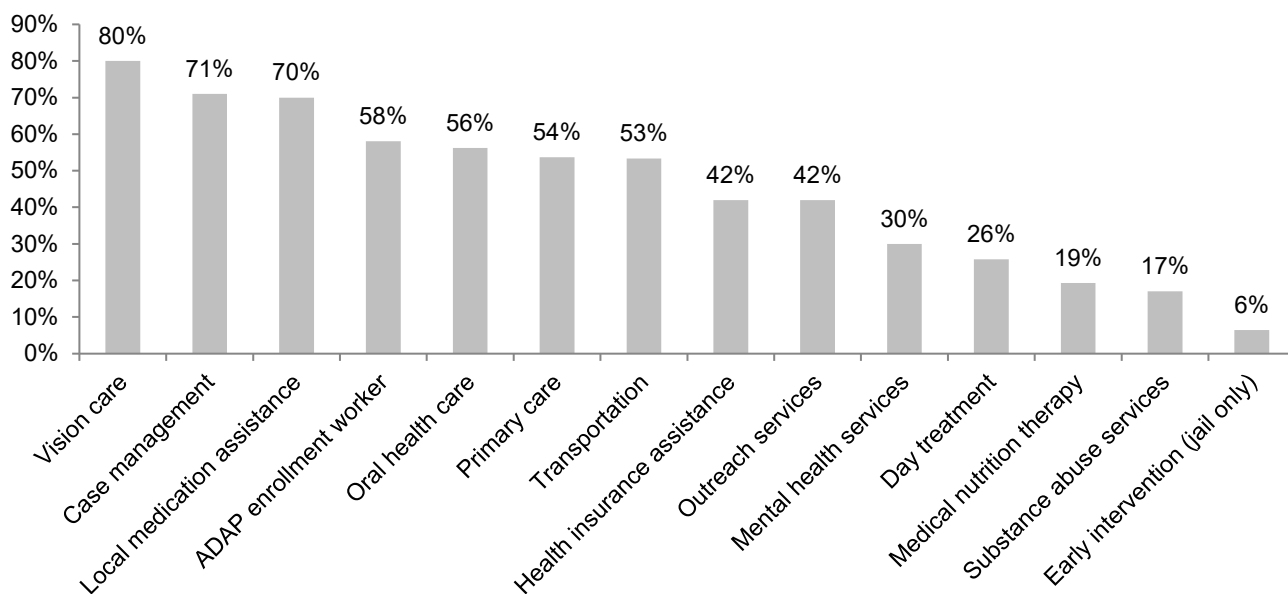
At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months. Among the total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

by local HIV medication assistance, case management, oral health care, and vision care.

(Graph 2) Among OOC participants, vision care was the most needed funded service at 72%, followed by case management (71%), local medication assistance (70%), ADAP enrollment worker (58%), and oral health care (56%)

GRAPH 2-Ranking of HIV Services among OOC PLWH in the Houston Area, By Need, 2020

*Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.
Denominator: 31 OOC participants*



Awareness of Available Services

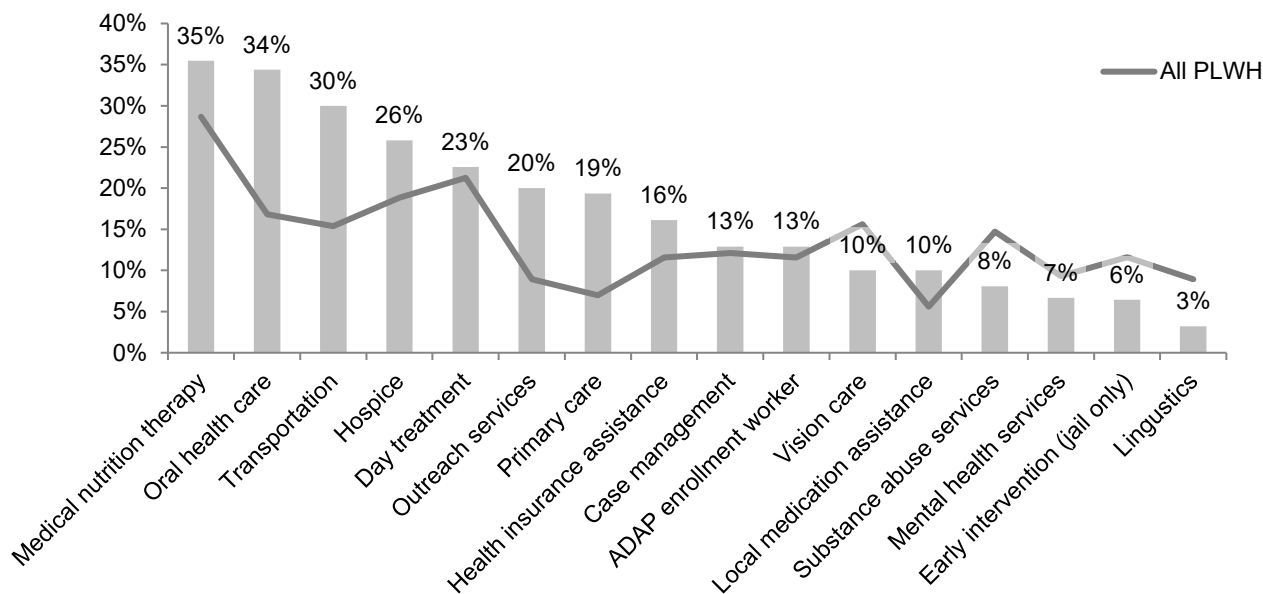
Education and awareness issues present a longstanding barrier to timely linkage to care in the Houston EMA, especially among OOC PLWH. Lack of awareness that a service exists or is available remains one of the most commonly cited reasons PLWH in the Houston Area do not access a needed service. The 2020 Houston HIV Care Services Needs Assessment survey asked participants to indicate if they did not know a funded service was available at the time of survey. Among the total sample, medical nutrition therapy had the highest proportion of participants who were unaware that it was an available service, followed by day treatment, hospice, oral health care, and vision care.

(Graph 3) In general, OOC participants had lower awareness of service availability than the sample as a whole. As with the total sample, medical nutrition therapy had the highest proportion of OOC participants who were unaware that it was an available service at 35% of OOC participants surveyed. This was followed by oral health care (34%), transportation (30%) hospice (26%), and day treatment (23%). The greatest variance in service awareness between the total sample and OOC participants was observed for oral health care, transportation, primary care, and outreach services.

GRAPH 3-Ranking of HIV Services among OOC PLWH and PLWH in the Houston Area, By Service Unawareness, 2020

Definition: Percent of OOC needs assessment participants stating they did not know the service was available.

Denominator: 31 participants





Service-Specific Fact Sheets

ADAP ENROLLMENT WORKER

AIDS Drug Assistance Program (ADAP) enrollment worker, technically referred to as *referral for health care and support*, describes a service that helps people living with HIV (PLWH) access medication coverage by ensuring the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). ADAP enrollment workers meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, assist clients with the submission of complete, accurate ADAP applications, and submit annual re-certifications.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 60% of participants indicated a need for *ADAP enrollment worker* in the past 12 months. 58% reported the service was easy to access, and 2% reported difficulty. 12% stated they did not know the service was available.

(**Table 1**) When barriers to *ADAP enrollment worker* were reported, the most common barrier type was education and awareness (30%). Education and awareness barriers reported include lack of knowledge about service availability and who to contact to access the service.

GRAPH 1-ADAP Enrollment Worker, 2020

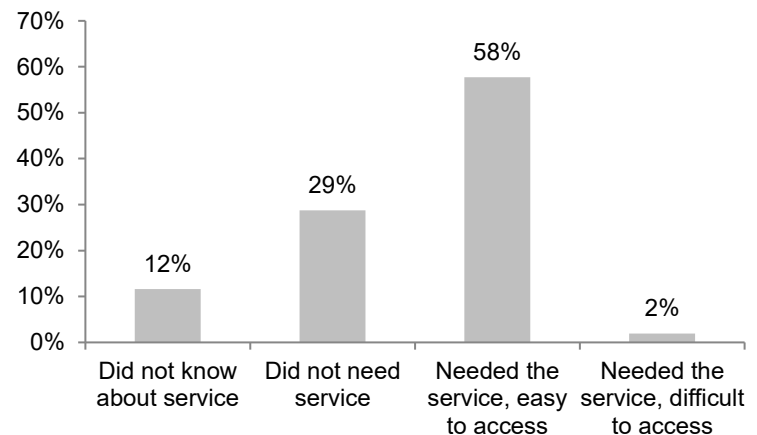


TABLE 1-Top 3 Reported Barrier Types for ADAP Enrollment Worker, 2020

	No.	%
1. Education and Awareness (EA)	3	30%
2. Administrative (AD)	2	20%
3. Eligibility (EL)	2	20%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *ADAP enrollment worker*, this analysis shows the following:

- More females than males found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.

In addition, more out of care, rural, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-ADAP Enrollment Worker, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	9%	8%	13%	12%	4%	12%	9%	8%
Did not need service	28%	31%	32%	36%	20%	12%	28%	31%	32%
Needed, easy to access	57%	58%	57%	50%	66%	77%	57%	58%	57%
Needed, difficult to access	2%	1%	3%	2%	1%	8%	2%	1%	3%

TABLE 3-ADAP Enrollment Worker, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	8%	6%	0%	5%	0%	18%
Did not need service	7%	12%	0%	0%	3%	9%
Needed, easy to access	76%	71%	100%	89%	91%	64%
Needed, difficult to access	10%	11%	0%	5%	6%	9%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

CASE MANAGEMENT

Case management, technically referred to as *medical case management*, *clinical case management*, or *service linkage*, describes a range of services that help connect persons living with HIV (PLWH) to HIV care, treatment, and support services and to retain them in care. Case managers assess client needs, develop service plans, and facilitate access to services through referrals and care coordination. Case management also includes treatment readiness and adherence counseling.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 73% of participants indicated a need for *case management* in the past 12 months. 67% reported the service was easy to access, and 6% reported difficulty. 12% stated they did not know the service was available.

(**Table 1**) When barriers to *case management* were reported, the most common barrier type was interactions with staff (37%). Staff interaction barriers reported include poor correspondence or follow up, poor treatment, limited staff knowledge of services, and service referral to provider that did not meet client needs.

GRAPH 1-Case Management, 2020

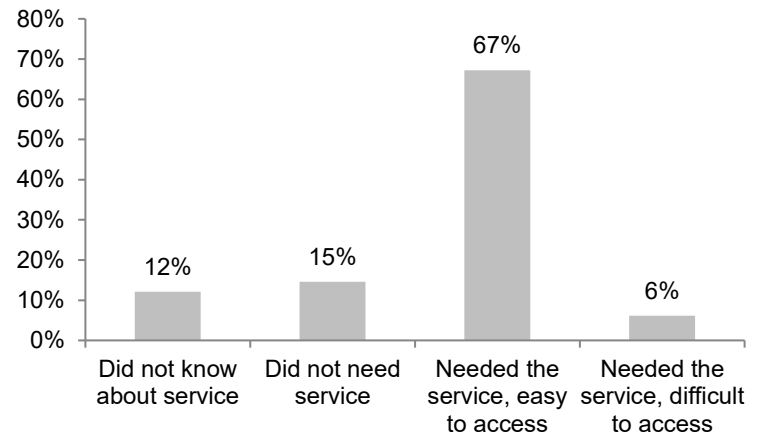


TABLE 1-Top 4 Reported Barrier Types for Case Management, 2020

	No.	%
1. Interactions with Staff (S)	13	37%
2. Education and Awareness (EA)	8	8%
3. Administrative (AD)	6	8%
4. Wait (4)	2	2%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *case management*, this analysis shows the following:

- More females than males found the service accessible.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.

In addition, more out of care, transgender, recently released from incarceration, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Case Management, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	7%	10%	11%	15%	4%	5%	15%	9%
Did not need service	59%	68%	22%	14%	13%	8%	29%	12%	17%
Needed, easy to access	20%	23%	64%	68%	66%	81%	52%	67%	69%
Needed, difficult to access	4%	3%	4%	7%	6%	8%	14%	6%	5%

TABLE 3-Case Management, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	10%	13%	13%	11%	37%	17%
Did not need service	13%	18%	16%	8%	9%	13%
Needed, easy to access	68%	63%	58%	71%	51%	58%
Needed, difficult to access	10%	6%	13%	11%	3%	13%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

DAY TREATMENT

Day treatment, technically referred to as *home and community-based health services*, provides therapeutic nursing, support services, and activities for persons living with HIV (PLWH) at a community-based location. This service does not currently include in-home health care, in-patient hospitalizations, or long-term nursing facilities.

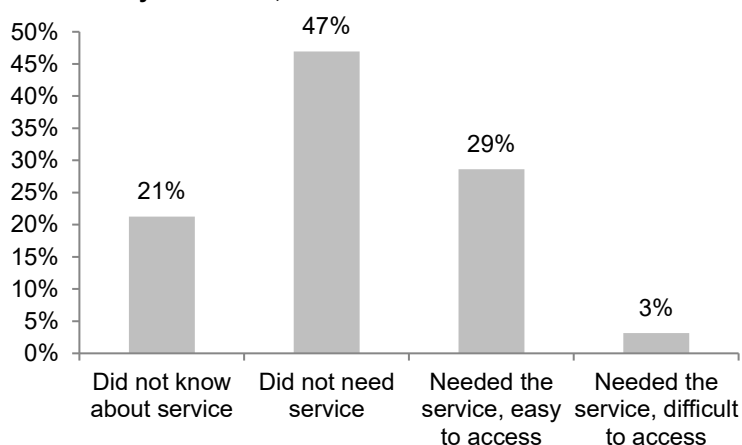
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 32% of participants indicated a need for *day treatment* in the past 12 months. 29% reported the service was easy to access, and 3% reported difficulty. 21% stated that they did not know the service was available.

(**Table 1**) When barriers to *day treatment* were reported, the most common barrier type was education and awareness (25%). Education and awareness barriers reported include lack of knowledge about service availability and where to access the service.

TABLE 1-Top 3 Reported Barrier Types for Day Treatment, 2020

	No.	%
1. Education and Awareness (EA)	3	25%
2. Administrative (AD)	2	17%
3. Wait (W)	2	17%

GRAPH 1-Day Treatment, 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *day treatment*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more transgender and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2- Day Treatment, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	22%	18%	18%	24%	20%	19%	14%	26%	15%
Did not need service	46%	50%	69%	49%	40%	42%	38%	45%	51%
Needed, easy to access	28%	29%	12%	24%	38%	31%	52%	25%	32%
Needed, difficult to access	3%	2%	1%	3%	2%	4%	0%	4%	1%

TABLE 3- Day Treatment, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	27%	24%	23%	31%	26%	28%
Did not need service	29%	49%	52%	30%	66%	36%
Needed, easy to access	35%	24%	26%	38%	9%	20%
Needed, difficult to access	8%	3%	0%	2%	0%	16%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

EARLY INTERVENTION (JAIL ONLY)

Early intervention services (EIS) refers to the provision of HIV testing, counseling, and referral in the Ryan White HIV/AIDS Program setting. In the Houston Area, the Ryan White HIV/AIDS Program funds EIS to persons living with HIV (PLWH) who are incarcerated in the Harris County Jail. Services focus on post-incarceration care coordination to ensure continuity of primary care and medication adherence post-release.

(**Graph 1**) In the 2020 Houston Area HIV needs assessment, 9% of participants indicated a need for *early intervention services* in the past 12 months. 7% reported the service was easy to access, and 2% reported difficulty. 12% stated that they did not know the service was available.

(**Table 1**) When barriers to *early intervention services* were reported, the most common barrier type was interactions with staff (67%). Interactions with staff barriers reported include poor correspondence or follow up, poor treatment, and service referral to provider that did not meet client needs.

GRAPH 1-Early Intervention (Jail Only), 2020

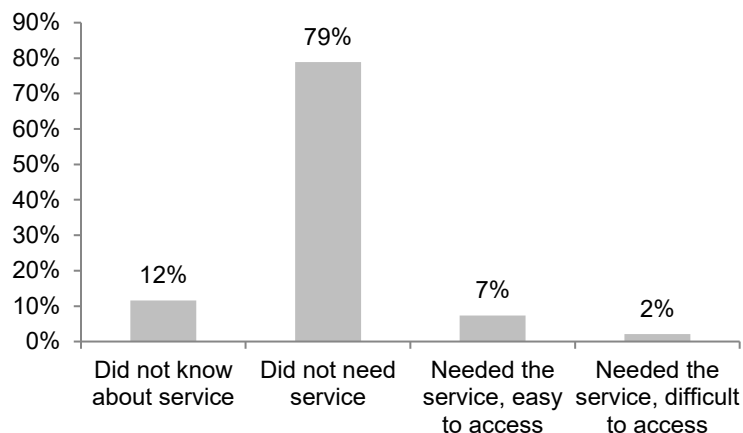


TABLE 1-Top 4 Reported Barrier Types for Early Intervention (Jail Only), 2020

	No.	%
1. Interactions with Staff (S)	6	67%
2. Education and Awareness (EA)	3	33%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *early intervention services*, this analysis shows the following:

- More females than males found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more recently released, homeless, transgender, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Early Intervention (Jail Only), by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	13%	8%	5%	12%	12%	12%	5%	12%	11%
Did not need service	77%	84%	83%	78%	81%	31%	86%	77%	82%
Needed, easy to access	8%	7%	8%	9%	5%	38%	5%	9%	6%
Needed, difficult to access	2%	1%	4%	2%	1%	19%	0%	3%	1%

TABLE 3-Early Intervention (Jail Only), by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	13%	14%	6%	15%	14%	4%
Did not need service	66%	79%	87%	43%	80%	83%
Needed, easy to access	16%	5%	6%	31%	6%	8%
Needed, difficult to access	5%	3%	0%	11%	0%	4%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

HEALTH INSURANCE ASSISTANCE

Health insurance assistance, also referred to as *health insurance premium and cost-sharing assistance*, provides financial assistance to persons living with HIV (PLWH) with third-party health insurance coverage (such as private insurance, ACA Qualified Health Plans, COBRA, or Medicare) so they can obtain or maintain health care benefits. This includes funding for premiums, deductibles, Advanced Premium Tax Credit liability, and co-pays for both medical visits and medication.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 57% of participants indicated a need for *health insurance assistance* in the past 12 months. 48% reported the service was easy to access, and 9% reported difficulty. 12% stated that they did not know the service was available.

(**Table 1**) When barriers to *health insurance assistance* were reported, the most common barrier types were eligibility and financial (each 23%). Eligibility barriers reported include not meeting eligibility requirements, and redundant or complex processes for meeting/renewing eligibility, while financial barriers reported include inability to afford the service.

GRAPH 1-Health Insurance Assistance, 2020

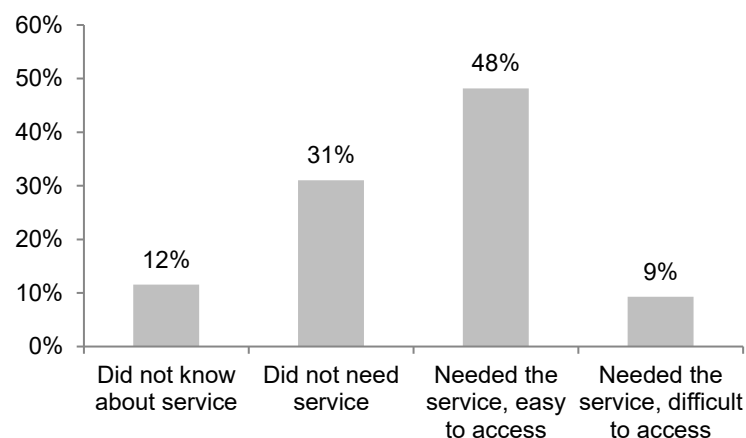


TABLE 1-Top 5 Reported Barrier Types for Health Insurance Assistance, 2020

	No.	%
1. Eligibility (EL)	9	23%
2. Financial (F)	9	23%
3. Health Insurance Coverage (I)	7	18%
4. Administrative (AD)	5	13%
5. Education and Awareness (EA)	4	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *health insurance assistance*, this analysis shows the following:

- No difference in service accessibility by sex at birth.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more transgender, homeless, MSM, and rural PLWH found the service difficult to access when compared to all participants.

TABLE 2-Health Insurance Assistance, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	9%	15%	13%	8%	12%	0%	12%	11%
Did not need service	30%	34%	43%	29%	32%	12%	14%	30%	34%
Needed, easy to access	48%	48%	40%	48%	50%	58%	81%	47%	49%
Needed, difficult to access	9%	9%	3%	9%	10%	15%	5%	12%	6%

TABLE 3-Health Insurance Assistance, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	21%	11%	16%	25%	17%	13%
Did not need service	32%	30%	42%	25%	23%	25%
Needed, easy to access	34%	47%	42%	43%	49%	33%
Needed, difficult to access	13%	12%	0%	8%	11%	29%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

HOSPICE

Hospice is end-of-life care for persons living with HIV (PLWH) who are in a terminal stage of illness (defined as a life expectancy of 6 months or less). This includes room, board, nursing care, mental health counseling, physician services, and palliative care.

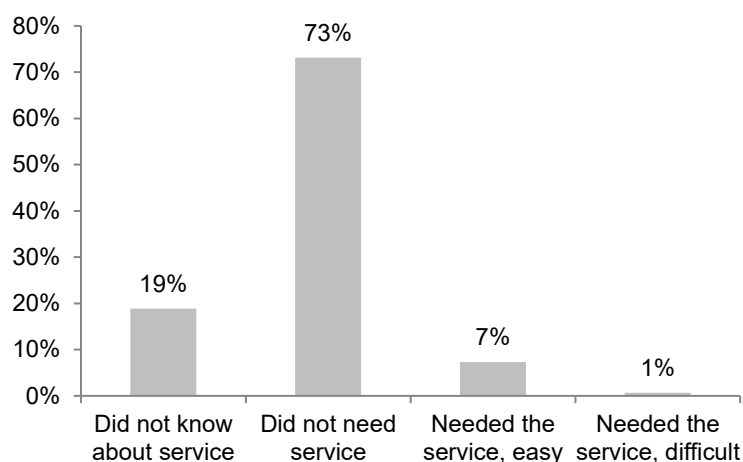
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 8% of participants indicated a need for *hospice* in the past 12 months. 7% reported the service was easy to access, and 1% reported difficulty. 17% stated that they did not know the service was available.

(**Table 1**) Only two barriers were reported for hospice. This number is too small to detect any pattern in service barriers for hospice.

TABLE 1- Reported Barrier Types for Hospice, 2020

	No.	%
1. Health Insurance Coverage (I)	1	50%
2. Transportation (T)	1	50%

GRAPH 1-Hospice, 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *hospice*, this analysis shows the following:

- More females than males found the service accessible.
- More White, Hispanic/Latino, and other/multiracial PLWH found the service accessible than Black/African American PLWH.
- More PLWH age 50+ found the service accessible than other PLWH age 25 to 49.
- In addition, more MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Hospice, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	20%	15%	10%	18%	23%	23%	10%	23%	13%
Did not need service	72%	78%	87%	76%	65%	65%	95%	67%	80%
Needed, easy to access	8%	5%	3%	5%	11%	12%	0%	9%	6%
Needed, difficult to access	0%	1%	0%	1%	0%	0%	0%	1%	0%

TABLE 3- Hospice, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	19%	8%	26%	27%	11%	36%
Did not need service	68%	54%	61%	63%	83%	64%
Needed, easy to access	13%	33%	13%	11%	6%	0%
Needed, difficult to access	0%	1%	0%	0%	0%	0%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

LOCAL HIV MEDICATION ASSISTANCE

Local HIV medication assistance, technically referred to as the *Local Pharmacy Assistance Program (LPAP)*, provides HIV-related pharmaceuticals to persons living with HIV (PLWH) who are not eligible for medications through other payer sources, including the state AIDS Drug Assistance Program (ADAP).

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 79% of participants indicated a need for *local HIV medication assistance* in the past 12 months. 74% reported the service was easy to access, and 5% reported difficulty. 6% stated that they did not know the service was available.

(**Table 1**) When barriers to *local HIV medication assistance* were reported, the most common barrier type was eligibility (25%). Eligibility barriers reported include redundant or complex processes for meeting/renewing eligibility, problems obtaining documentation needed for eligibility and not meeting eligibility requirements.

GRAPH 1-Local HIV Medication Assistance, 2020

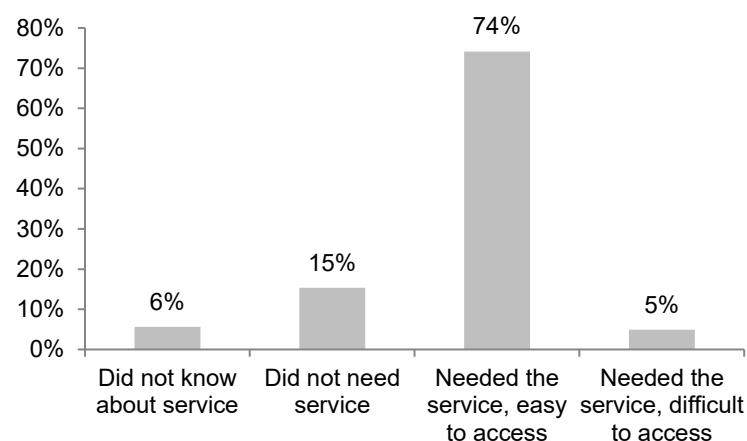


TABLE 1-Top 5 Reported Barrier Types for Local HIV Medication Assistance, 2020

	No.	%
1. Eligibility (EL)	7	25%
2. Administrative (AD)	4	14%
3. Education and Awareness (EA)	4	14%
4. Health Insurance Coverage (I)	4	14%
5. Interactions with Staff (S)	3	11%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *local HIV medication assistance*, this analysis shows the following:

- More males than females found the service accessible.
- More White PLWH than other race/ethnicities found the service accessible.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, homeless, MSM, rural, and transgender PLWH found the service difficult to access when compared to all participants.

TABLE 2-Local HIV Medication Assistance, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	7%	2%	1%	5%	7%	8%	0%	6%	6%
Did not need service	16%	12%	29%	17%	10%	4%	14%	15%	16%
Needed, easy to access	73%	79%	69%	72%	76%	88%	81%	73%	75%
Needed, difficult to access	4%	7%	1%	5%	6%	4%	5%	6%	3%

TABLE 3-Local HIV Medication Assistance, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	11%	6%	10%	6%	6%	8%
Did not need service	15%	17%	20%	8%	17%	46%
Needed, easy to access	68%	71%	70%	83%	71%	42%
Needed, difficult to access	6%	6%	0%	3%	6%	4%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

MEDICAL NUTRITION THERAPY

Medical nutrition therapy provides nutrition supplements and nutritional counseling to persons living with HIV (PLWH) outside of a primary care visit by a licensed registered dietician based on physician recommendation and a nutrition plan. The purpose of such services can be to address HIV-associated nutritional deficiencies or dietary needs as well as to mitigate medication side effects.

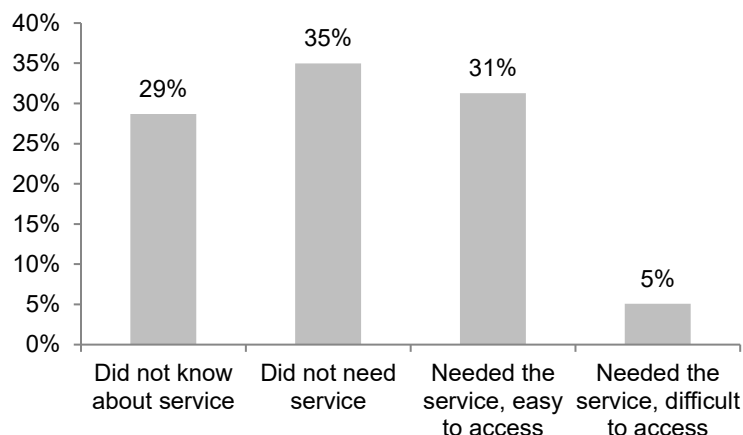
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 36% of participants indicated a need for *medical nutrition therapy* in the past 12 months. 31% reported the service was easy to access, and 5% reported difficulty. 29% stated that they did not know the service was available.

(**Table 1**) When barriers to *medical nutrition therapy* were reported, the most common barrier type was education and awareness (35%) Education and awareness barriers reported include lack of knowledge about service availability, what the service entails, and who to contact to access the service.

TABLE 1-Top 3 Reported Barrier Types for Medical Nutrition Therapy, 2020

	No.	%
1. Education and Awareness (EA)	8	35%
2. Eligibility (EL)	6	26%
3. Interactions with Staff (S)	4	17%

GRAPH 1-Medical Nutrition Therapy, 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *medical nutrition therapy*, this analysis shows the following:

- More female than males found the service accessible.
- More Hispanic/Latino PLWH than other race/ethnicities found the service accessible.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Medical Nutrition Therapy, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	29%	28%	24%	28%	31%	27%	19%	35%	20%
Did not need service	35%	33%	36%	35%	36%	27%	71%	30%	39%
Needed, easy to access	31%	33%	36%	31%	31%	38%	10%	29%	37%
Needed, difficult to access	5%	6%	4%	6%	2%	12%	0%	6%	4%

TABLE 3-Medical Nutrition Therapy, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	29%	31%	35%	41%	43%	17%
Did not need service	37%	36%	45%	28%	40%	54%
Needed, easy to access	24%	29%	16%	30%	17%	29%
Needed, difficult to access	10%	4%	3%	2%	0%	0%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

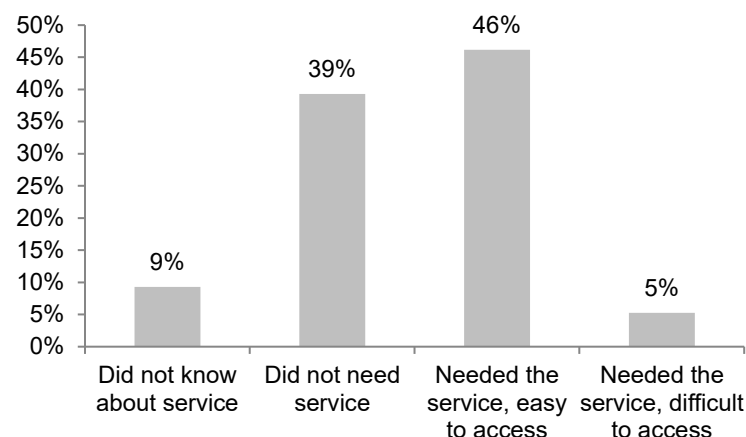
MENTAL HEALTH SERVICES

Mental health services, also referred to as *professional mental health counseling*, provides psychological counseling services for persons living with HIV (PLWH) who have a diagnosed mental illness. This includes group or individual counseling by a licensed mental health professional in accordance with state licensing guidelines.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 51% of participants indicated a need for *mental health services* in the past 12 months. 46% reported the service was easy to access, and 5% reported difficulty. 9% stated that they did not know the service was available.

(**Table 1**) When barriers to *mental health services* were reported, the most common barrier types were administrative, and education and awareness (each 22%). Administrative barriers reported include staff changes, hours of operation, client dismissal from the agency, and understaffing. Education and awareness barriers reported include lack of knowledge about service availability, where to go to access the service, and who to contact to access the service.

GRAPH 1-Mental Health Services, 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *mental health services*, this analysis shows the following:

- More males than females found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more recently released, rural, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 1-Top 5 Reported Barrier Types for Mental Health Services, 2020

	No.	%
1. Administrative (AD)	7	22%
2. Education and Awareness (EA)	7	22%
3. Health Insurance Coverage (I)	4	13%
4. Interactions with Staff (S)	3	9%
5. Transportation (T)	3	9%

TABLE 2-Mental Health Services, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	11%	5%	6%	10%	11%	12%	5%	12%	6%
Did not need service	39%	39%	35%	40%	42%	19%	43%	36%	44%
Needed, easy to access	46%	47%	47%	45%	45%	54%	52%	46%	45%
Needed, difficult to access	4%	8%	12%	5%	2%	12%	0%	5%	5%

TABLE 3-Mental Health Services, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	16%	9%	7%	11%	11%	8%
Did not need service	38%	38%	63%	25%	57%	54%
Needed, easy to access	39%	48%	30%	49%	17%	33%
Needed, difficult to access	7%	5%	0%	14%	11%	4%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

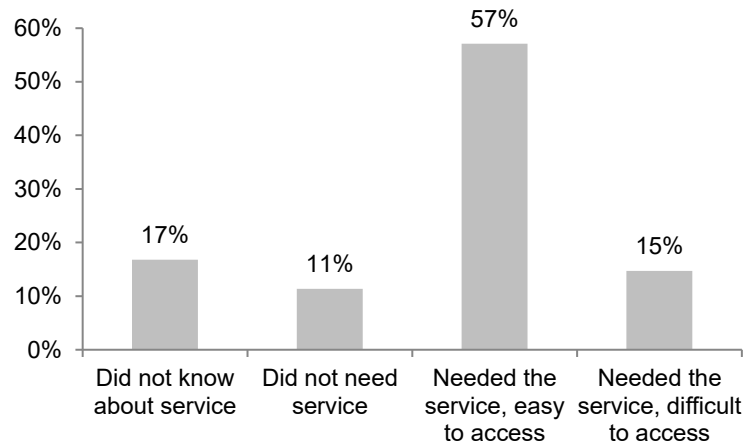
ORAL HEALTH CARE

Oral health care, or dental services, refers to the diagnostic, preventative, and therapeutic services provided to persons living with HIV (PLWH) by a dental health care professional (such as a dentist or hygienist). This includes examinations, periodontal services (such as cleanings and fillings), extractions and other oral surgeries, restorative dental procedures, and prosthodontics (or dentures).

(Graph 1) In the 2020 Houston HIV Care Services Needs Assessment, 72% of participants indicated a need for *oral health care* in the past 12 months. 57% reported the service was easy to access, and 15% reported difficulty. 17% stated that they did not know the service was available.

(Table 1) When barriers to *oral health care* were reported, the most common barrier type was wait-related issues (35%). Wait-related barriers reported include placement on a waitlist, long waits at appointments, and being told to call back as a wait list was full/unavailable. Of note, at least seven participants reported unprompted that their provider stated Ryan White does not cover prosthodontics, and that the participants would need to pay several hundred dollars out of pocket for treatment. Administrative agent and agency staff were notified immediately to resolve this issue.

GRAPH 1-Oral Health Care, 2020



(Table 2 and Table 3) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *oral health care*, this analysis shows the following:

- More males than females found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 18 to 24 found the service accessible than other age groups.
- In addition, more out of care, recently released, and MSM found the service difficult to access when compared to all participants.

TABLE 1-Top 5 Reported Barrier Types for Oral Health Care, 2020

	No.	%
1. Wait (W)	20	22%
2. Interactions with Staff (S)	16	18%
3. Health Insurance Coverage (I)	12	13%
4. Education and Awareness (EA)	11	12%
5. Administrative (AD)	9	10%

TABLE 2-Oral Health Care, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	18%	12%	6%	19%	19%	15%	24%	22%	8%
Did not need service	11%	12%	22%	12%	8%	4%	14%	9%	14%
Needed, easy to access	57%	59%	49%	55%	63%	54%	52%	52%	65%
Needed, difficult to access	14%	17%	22%	14%	10%	27%	10%	17%	12%

TABLE 3-Oral Health Care, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	34%	15%	34%	20%	9%	8%
Did not need service	6%	10%	9%	11%	20%	13%
Needed, easy to access	45%	59%	34%	50%	69%	67%
Needed, difficult to access	15%	16%	22%	19%	3%	13%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

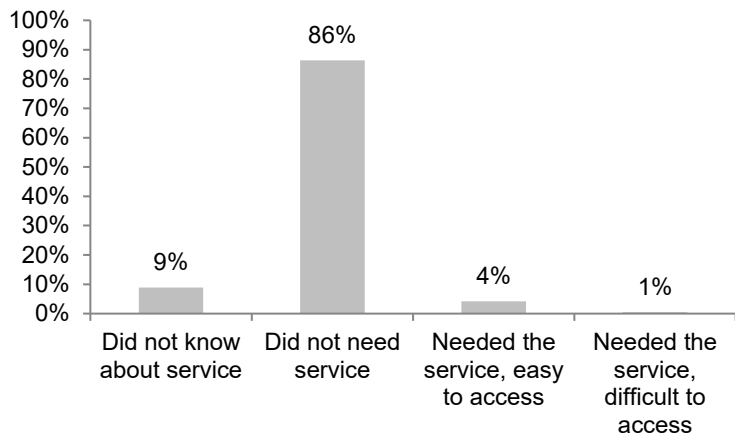
^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

OUTREACH SERVICES

Outreach services are provided for people living with HIV (PLWH) who have missed primary medical care appointments without rescheduling, and who may have other risk factors for falling out of care. The goal of *outreach services* is to support retention in care. Services are field-based, and include assistance with medical appointment setting and accessing supportive services, advocating on behalf of clients to decrease service gaps and remove barriers to services, and helping clients develop and utilize independent living skills and strategies.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 5% of participants indicated a need for *outreach services* in the past 12 months. 4% reported the service was easy to access, and 1% reported difficulty. 9% stated that they did not know the service was available.

GRAPH 1-Outreach Services, 2020



(**Table 1**) When barriers to *outreach services* were reported, the most common barrier type was interactions with staff (71%). Interactions with staff barriers reported include poor correspondence or follow up.

TABLE 1-Top Reported Barrier Type for Outreach Services, 2020

	No.	%
1. Interactions with Staff (S)	5	71%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *outreach services*, this analysis shows the following:

- More males than females found the service accessible.
- More Black/African American and Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more homeless, MSM, recently released, and transgender PLWH found the service difficult to access when compared to all participants.

TABLE 2-Outreach Services, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	22%	17%	22%	19%	22%	23%	57%	25%	11%
Did not need service	42%	40%	57%	45%	33%	38%	24%	34%	53%
Needed, easy to access	34%	40%	17%	34%	42%	38%	19%	37%	34%
Needed, difficult to access	3%	2%	4%	2%	2%	0%	5%	3%	1%

TABLE 3-Outreach Services, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	23%	23%	20%	28%	26%	21%
Did not need service	28%	42%	37%	30%	37%	42%
Needed, easy to access	37%	32%	43%	39%	37%	35%
Needed, difficult to access	12%	3%	0%	3%	0%	2%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

PRIMARY HIV MEDICAL CARE

Primary HIV medical care, technically referred to as *outpatient/ambulatory medical care*, refers to the diagnostic and therapeutic services provided to persons living with HIV (PLWH) by a physician or physician extender in an outpatient setting. This includes physical examinations, diagnosis and treatment of common physical and mental health conditions, preventative care, education, laboratory services, and specialty services as indicated.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 89% of participants indicated a need for *primary HIV medical care* in the past 12 months. 80% reported the service was easy to access, and 90% reported difficulty. 7% stated that they did not know the service was available.

(**Table 1**) When barriers to *primary HIV medical care* were reported, the most common barrier type was transportation (26%). Transportation barriers reported include having no or limited transportation options, and having problems with special transportation providers such as Metrolift or Medicaid transportation

GRAPH 1-Primary HIV Medical Care, 2020

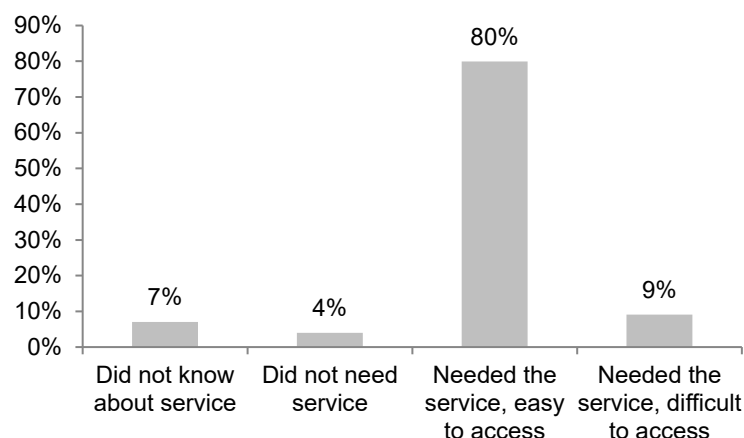


TABLE 1-Top 5 Reported Barrier Types for Primary HIV Medical Care, 2020

	No.	%
1. Transportation (T)	11	26%
2. Education and Awareness (EA)	8	19%
3. Interactions with Staff (S)	8	19%
4. Eligibility	4	9%
5. Wait (W)	4	9%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *primary HIV medical care*, this analysis shows the following:

- More females than males found the service accessible.
- More White PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more rural, out of care, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Primary HIV Medical Care, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	8%	4%	1%	5%	12%	0%	0%	9%	5%
Did not need service	4%	4%	9%	3%	3%	0%	0%	2%	8%
Needed, easy to access	92%	85%	86%	83%	74%	92%	76%	79%	83%
Needed, difficult to access	9%	8%	4%	8%	12%	8%	24%	11%	5%

TABLE 3-Primary HIV Medical Care, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	10%	9%	19%	9%	3%	13%
Did not need service	2%	5%	10%	2%	0%	13%
Needed, easy to access	82%	77%	55%	83%	71%	75%
Needed, difficult to access	6%	10%	16%	6%	26%	0%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

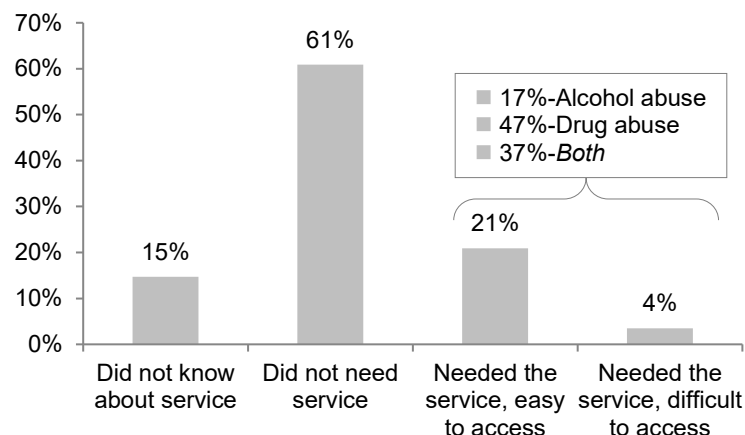
^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

SUBSTANCE ABUSE SERVICES

Substance abuse services, also referred to as *outpatient alcohol or drug abuse treatment*, provides counseling and/or other treatment modalities to persons living with HIV (PLWH) who have a substance use disorder concern in an outpatient setting and in accordance with state licensing guidelines. This includes services for alcohol use and/or use of legal or illegal drugs.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 24% of participants indicated a need for *substance abuse services* in the past 12 months. 21% reported the service was easy to access, and 4% reported difficulty. 15% stated they did not know the service was available. When analyzed by type of substance concern, 17% of participants cited alcohol, 47% cited drugs, and 37% cited both.

GRAPH 1-Substance Abuse Services, 2020



(**Table 1**) When barriers to *substance use services* were reported, the most common barrier type was education and awareness (46%). Education and awareness barriers reported include lack of knowledge about service availability

TABLE 1-Top 2 Reported Barrier Types for Substance Abuse Services, 2020

	No.	%
1. Education and Awareness (EA)	4	46%
2. Transportation (T)	2	18%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *substance abuse services*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more recently released and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Substance Abuse Services, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	7%	12%	12%	18%	19%	43%	15%	12%
Did not need service	59%	68%	69%	63%	58%	58%	43%	59%	65%
Needed, easy to access	20%	23%	16%	21%	21%	23%	10%	22%	21%
Needed, difficult to access	4%	3%	3%	5%	2%	0%	5%	4%	2%

TABLE 3-Substance Abuse Services, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	13%	18%	16%	15%	23%	8%
Did not need service	55%	60%	61%	44%	71%	71%
Needed, easy to access	20%	18%	23%	24%	6%	17%
Needed, difficult to access	12%	3%	0%	18%	0%	4%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

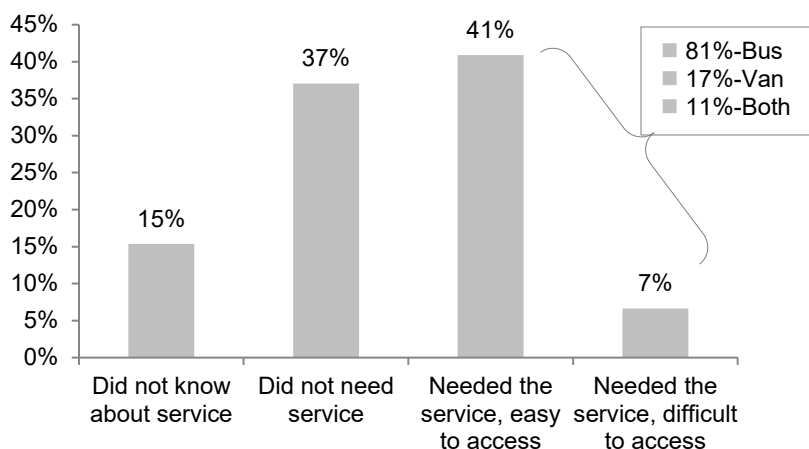
^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

TRANSPORTATION

Transportation services provides transportation to persons living with HIV (PLWH) to locations where HIV-related care is received, including pharmacies, mental health services, and substance abuse services. The service can be provided in the form of public transportation vouchers (bus passes), gas vouchers (for rural clients), taxi vouchers (for emergency purposes), and van-based services as medically indicated.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 48% of participants indicated a need for *transportation services* in the past 12 months. 41% reported the service was easy to access, and 7% reported difficulty. 15% stated they did not know the service was available. When analyzed by type transportation assistance sought, 81% of participants needed bus passes, 17% needed van services, and 11% needed both forms of assistance.

GRAPH 1-Transportation Services, 2020



(**Table 1**) When barriers to *transportation services* were reported, the most common barrier type was education and awareness (24%). Education and awareness barriers reported include lack of knowledge about service availability and where to go to access the service.

TABLE 1-Top 5 Reported Barrier Types for Transportation Services, 2020

	No.	%
1. Education and Awareness (EA)	7	24%
2. Resource Availability (R)	5	17%
3. Transportation (T)	5	17%
4. Eligibility (EL)	3	10%
5. Financial (F)	3	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *transportation services*, this analysis shows the following:

- More males than females found the service accessible..
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more homeless, out of care, and recently released PLWH found the service difficult to access when compared to all participants.

TABLE 2-Transportation Services, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	10%	5%	14%	8%	12%	43%	20%	7%
Did not need service	38%	35%	51%	32%	81%	31%	14%	38%	37%
Needed, easy to access	39%	47%	36%	49%	9%	38%	43%	35%	50%
Needed, difficult to access	6%	8%	8%	5%	1%	19%	5%	7%	7%

TABLE 3-Transportation Services, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	7%	19%	30%	12%	14%	8%
Did not need service	28%	38%	17%	21%	71%	32%
Needed, easy to access	51%	37%	40%	59%	14%	16%
Needed, difficult to access	15%	6%	13%	8%	0%	4%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender

VISION CARE

Vision care, technically a subcategory of primary HIV medical care, provides optometric/ophthalmologic treatment, vision screening, and glasses to people living with HIV (PLWH). This does not include fitting of contact lenses.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 68% of participants indicated a need for *vision care* in the past 12 months. 59% reported the service was easy to access, and 9% reported difficulty. 16% stated they did not know the service was available.

(**Table 1**) When barriers to *vision care* were reported, the most common barrier type was wait-related issues. Wait-related barriers reported include scheduling appointments 2-3 months out, placement on a waitlist, being told to call back as a wait list was full/unavailable, and long waits at appointments.

GRAPH 1-Vision Care, 2020

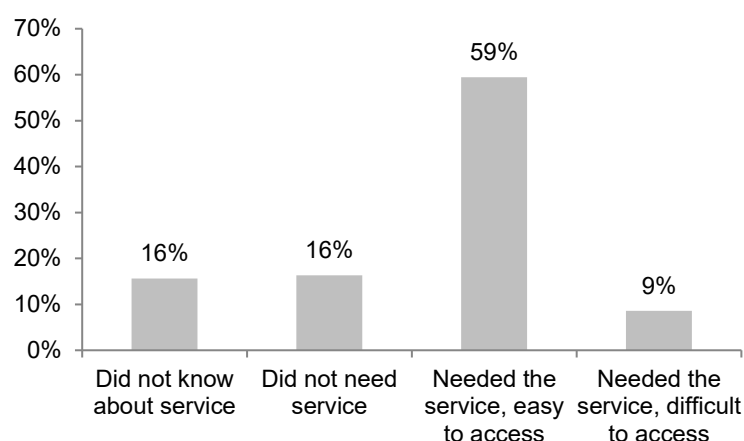


TABLE 1-Top 5 Reported Barrier Types for Vision Care, 2020

	No.	%
1. Wait (W)	15	34%
2. Health Insurance Coverage (I)	8	18%
3. Education and Awareness (EA)	6	14%
4. Financial (F)	4	9%
5. Interactions with Staff (S)	3	7%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *vision care*, this analysis shows the following:

- More males than females found the service accessible.
- More Black/African American PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more homeless and out of care PLWH found the service difficult to access when compared to all participants.

TABLE 2-Vision Care, by Demographic Categories, 2020

Experience with the Service	Sex (at birth)		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	10%	12%	15%	15%	15%	14%	21%	8%
Did not need service	16%	18%	19%	21%	11%	4%	62%	15%	15%
Needed, easy to access	60%	58%	60%	56%	65%	69%	14%	56%	69%
Needed, difficult to access	7%	14%	9%	8%	9%	15%	14%	9%	8%

TABLE 3-Vision Care, by Selected Special Populations, 2020

Experience with the Service	Homeless ^a	MSM ^b	Out of Care ^c	Recently Released ^d	Rural ^e	Transgender ^f
Did not know about service	20%	17%	10%	28%	6%	20%
Did not need service	16%	13%	10%	16%	20%	24%
Needed, easy to access	51%	63%	70%	47%	66%	56%
Needed, difficult to access	13%	7%	10%	9%	6%	0%

^aPersons reporting current homelessness ^bMen who have sex with men ^cPersons with no evidence of HIV care for 12 mo.

^dPersons released from incarceration in the past 12 mo. ^eNon-Houston/Harris County residents ^fPersons with discordant sex assigned at birth and current gender



**2020 Houston Area HIV Care Services Needs Assessment
Approved: PENDING**

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2020 QUARTERLY REPORT COMPREHENSIVE HIV PLANNING COMMITTEE

Status of Committee Goals and Responsibilities (*means mandated by HRSA):

1. Assess, evaluate, and make ongoing recommendations for the Comprehensive HIV Prevention and Care Services Plan and corresponding areas of the End HIV Plan, in collaboration toward the development of one local ending the HIV epidemic plan.

2. *Determine the size and demographics of the estimated population of individuals who are unaware of their HIV status.

3. *Work with the community and other committees to develop a strategy for identifying those with HIV who do not know their status, make them aware of their status, and link and refer them into care.

4. *Explore and develop on-going needs assessment and comprehensive planning activities including the identification and prioritization of special studies.

5. *Review and disseminate the most current Joint Epidemiological Profile.

Committee Chairperson

Date