DRAFT

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee Meeting

2:00 p.m., Thursday, November 10, 2016
Meeting Location: 2223 W. Loop South, Room 532
Houston, Texas 77027

AGENDA

I. Call to Order
   - A. Welcome
   - B. Moment of Reflection
   - C. Adoption of the Agenda
   - D. Approval of the Minutes

Nancy Miertschin and John Lazo, 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/AIDS 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/AIDS 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 with HIV/AIDS", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.)

III. Update on Speakers Bureau — John Lazo, Co-Chair

IV. 2016 Houston HIV Care Services Needs Assessment — Amber Harbolt, Health Planner, Office of Support
   - A. Review 2016 Houston HIV Care Services Needs Assessment Report

V. New Business
   - A. 2012-2016 Comprehensive Plan Year 4 Evaluation
   - B. 2017-2021 Comprehensive Plan Celebration & Kick-Off
   - C. Review Committee Goals
   - D. Quarterly Committee Report

VI. Announcements — Nancy Miertschin and John Lazo, Co-Chairs

VII. Adjourn

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee
11:00 a.m., Thursday, September 15, 2016
2223 West Loop South, Room 416; Houston, Texas 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Nancy Miertschin, Co-Chair	Ted Artiaga, excused	Sha'Terra Johnson-Fairley, TRG
John Lazo, Co-Chair	Denny Delgado	Tori Williams, Office of Support
Curtis Bellard	Herman Finley	Amber Harbolt, Office of Support
David Benson	Robert Noble, excused	Diane Beck, Office of Support
Evelio Salinas Escamilla	Gloria Sierra, excused	
Allen Murray	Denis Kelly, excused	
Johnny Deal	Shital Patel, excused	
Tam Kiehnhoff	Larry Woods	
Esther Ogunjimi	Kevin Aloysius	
	Osaro Mgbere	

Call to Order: Nancy Miertschin, co-chair, called the meeting to order at 11:10 a.m. and asked for a moment of reflection.

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Bellard, Kiehnhoff) to approve the July 29, 2016 minutes.* **Motion carried.** Abstentions: Benson, Deal, Ogunjimi.

Public Comment: None.

FY 2017 EIIHA Target Populations: Harbolt reviewed the attached documents: *Early Identification of Individuals with HIV/AIDS (EIIHA) Planning Process and Requirements, Fiscal Year 2017 Early Identification of Individuals with HIV/AIDS (EIIHA) Target Populations Criteria Worksheet, Fiscal Year 2017 Early Identification of Individuals with HIV/AIDS (EIIHA) Target Populations Selection Matrix* and *EIIHA Workgroup Motions: FY 2017 EIIHA Target Populations 09/12/2016.* Benson asked if Hispanics/Latinos also included Latinas as that is how the population was listed previously. Harbolt assured him that it did and that she writes about both for that population. Escamilla said that recent numbers show that new diagnoses for young Latinos has surpassed the African American population. The committee concluded that since the EIIHA populations are selected for one year, they will look at the age designation for this population again next year to see if it should be changed. ***Motion #3:*** *it was moved and seconded (Escamilla, Benson) to approve following target populations for the FY 2017 EIIHA Plan: 1. African Americans, 2. Hispanics/Latinos age 35 and over, and 3. Men who have Sex with Men (MSM). The Office of Support is to include information on HIV and aging in the EIIHA section of the HRSA application.* **Motion carried unanimously.**

Motion #4: *it was moved and seconded (Benson, Bellard) for Office of Support to include a statement in the EIIHA section of the HRSA application recognizing that currently available*

epidemiologic data do not portray the need for testing, referral, and linkage in at-risk populations such as among those who are transgender, intersex, homeless, or those released from incarceration. **Motion carried unanimously.**

2016 Needs Assessment Service-Specific Fact Sheets: See attached. Harbolt said that the needs assessment would be ready for the committee in October or November.

Announcements: Lazo said that he knows a magician/escape artist living with HIV who will have a show in December and has offered a special discount for Planning Council members. He distributed cards about the event with the discount code. Please see him for additional cards.

Adjournment: The meeting was adjourned at 12:13 p.m.

Submitted by: Approved by:

_____ _____

Amber Harbolt, Office of Support Date Chair of Committee Date

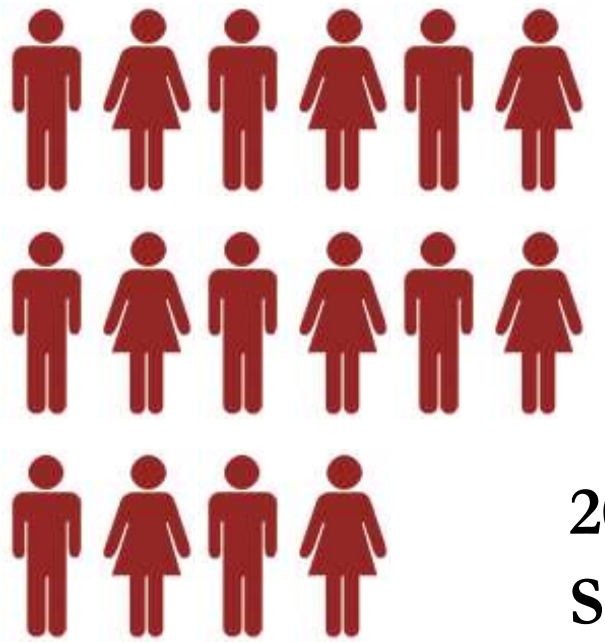
DRAFT

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

2016 Voting Record for Meeting Date September 15, 2016

MEMBERS	Motion #1: **Agenda**				Motion #2: **Minutes**				Motion #3: **FY2017 EIIHA Populations**				Motion #4: **Statement re At-Risk Populations**			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Nancy Miertschin, Co-Chair				C				C				C				C
John Lazo, Co-Chair		X				X				X				X		
Ted Artiaga	X															
Curtis Bellard		X				X				X				X		
David Benson		X						X		X				X		
Denny Delgado	X					X				X				X		
Evelio Salinas Escamilla		X				X				X				X		
Herman Finley	X															
Allen Murray	X				X					X				X		
Robert Noble	X															
Shital Patel	X															
Gloria Sierra	X															
Larry Woods	X															
Kevin Aloysius	X															
Denis Kelly	X															
Tam Kiehnhoff		X			X					X				X		
Osaro Mgbere	X															
Esther Ogunjimi		X						X		X				X		

DRAFT



2016 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
Housing Opportunities for Persons with AIDS
People Living with HIV in the Houston Area and Ryan White HIV/AIDS Program Consumers

Approved: PENDING

Disclaimer:
The 2016 Houston Area HIV Care Services Needs Assessment summarizes primary data collected from January to June 2016 from 507 self-selected, self-identified people living with HIV (PLWH) using either a self-administered written 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 (2014). Though quality control measures were applied, limitations to the raw data and data analysis exist, and other data sources should be used to provide context for and to better understand the results. Data collected through this process represent the most current *primary* data source on PLWH in the Houston Area. Census, surveillance, and other data presented here reflect the most current data available at the time of publication.

Funding acknowledgment:
The 2016 Houston Area HIV Care Services Needs Assessment was made possible with funding from the Ryan White HIV/AIDS Treatment Extension Act of 2009. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Health Resources and Services Administration HIV/AIDS Bureau.

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

Suggested citation:
2016 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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TABLE OF CONTENTS

To be included in final report

ACKNOWLEDMENTS

Collaborating Partners:
The 2016 Houston Area HIV Care Services Needs Assessment is a collaboration of the following partners:

- To be included in final report

Leadership:
The following individuals provided oversight and guidance to the 2016 Houston Area HIV Care Services Needs Assessment process, including survey design, data administration, and the review and approval of this document:

- To be included in final report

Contributors:
The 2016 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:

To be included in final report

Staff, Interns, and Consultants:
To be included in final report

EXECUTIVE SUMMARY

The 2016 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. In 2016, 507 PLWH participated in the Needs Assessment survey, and the results were statistically weighted to better represent the demographic composition of all PLWH in the Houston Area today. The last Needs Assessment was conducted in 2014.

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. Case management
3. Local medication assistance
4. Oral health care, and
5. Health insurance assistance

Compared to the 2016 Needs Assessment, local medication assistance and health insurance assistance rose while oral healthcare and housing fell.

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 2016, at least 75% of the PLWH who said they needed each HIV service *also* said the service was easily accessible to them. There were some services, however, that were less accessible than others: food pantry vouchers, oral health care, and legal services were the three *least* accessible services according to 2016 Houston Area HIV Care Services Needs Assessment. Day treatment and substance abuse services were the most accessible services in 2016.

Barriers to HIV Services in the Houston Area

To improve understanding of barriers to HIV services, the 2016 Houston Area HIV Care Services Needs Assessment also gathers information about the types of difficulties consumers experience when services are not easily accessible. For the first time, the 2016 Houston Area HIV Care Services Needs Assessment uses qualitative accounts of difficulties encountered for each service to provide in-depth information and context about the types barriers PLWH encounter. The most common types of barriers encountered are:

1. Education and awareness issues
2. Wait-related issues
3. Interactions with staff
4. Eligibility issues, and
5. Administrative issues

In addition to the above results, the 2016 Needs Assessment includes detailed information about a variety of issues that impact 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; and
- Needs and barriers for each HIV core medical, support, and housing service currently funded in the Houston Area, presented as a series of Fact Sheets.

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 2016 Houston Area HIV Care Services Needs Assessment is 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 __ individuals assisted in the planning and implementation of the needs assessment, of which __% were PLWH.

For more information about the 2016 Houston Area HIV Care Services Needs Assessment, contact the Office of Support at (713) 572-3724 or visit www.rwpchouston.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 also 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, primary data collected directly from PLWH in the form of a *survey* are the principal source of information for the HIV/ needs assessment process. Surveys are administered every three years to a representative sample of PLWH residing in the Houston Area.

How are HIV needs assessment data used?

Needs assessment data are integral to the information base for HIV services planning, and they are used in almost every decision-making process of the Ryan White Planning Council (**RWPC**), including setting priorities for the allocation of funds, designing services that fit the needs of local PLWH, developing the comprehensive plan, and crafting the annual implementation plan. The community also uses needs assessment data are also used 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:

2016 Houston Area HIV Needs Assessment Group (NAG), Analysis Workgroup, Principles for the 2016 Needs Assessment Analysis. Approved 05-23-16.

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 2016 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 to 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 subject matter 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, __ individuals and staff participated in the planning process, of which at least __% were persons living with HIV (PLWH).

Survey Sampling Plan

Staff calculated the 2016 Houston Area HIV Care Services Needs Assessment sample size based on current total HIV prevalence for the Houston Eligible Metropolitan Area (**EMA**) (2014), with 95% confidence interval, and at both a 3% and 4% margin of error. Respondent composition goals were proportional to demographic and geographic representation in total prevalence. Funded-agency representation was proportional to total client share for the same time period (2014). 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 were necessary.

Survey Tool

Data for the 2016 Houston Area HIV Care Services Needs Assessment were collected using a 45-item paper survey of open-ended, multiple choice, and scaled questions addressing nine topic areas (in order):

- HIV services and wait-related concerns
- HIV diagnosis
- 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 knowledge and behaviors

The Survey Workgroup determined topics and questions, restructuring and streamlining the 75-item 2014 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 2016 Houston Area HIV Care Services Needs Assessment were administered in pre-scheduled group sessions at Ryan White HIV/AIDS Program providers, HIV Prevention providers, housing facilities, support groups, and specific community locations and organizations serving special populations. Staff contacts at each location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through flyers, word of mouth, staff promotion, and cooperation with the Texas Department of State Health Services (**DSHS**).

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. Participants recruited through cooperation with DSHS were interviewed by telephone. Participation was voluntary, anonymous, and monetarily incentivized; and respondents were advised of these conditions verbally and in writing. Most surveys were completed in 15 to 20 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.

A total of 507 consumer surveys were collected from January to June 2016 during 50 survey sessions at 24 survey sites and via telephone.

Data Management

Data entry for the 2016 Houston Area HIV Care Services Needs Assessment was performed by trained staff and interns 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 (n=7). 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 (2014), producing a total weighted sample size of 507 (11% in Spanish). Missing or invalid survey entries are excluded from analysis per variable; therefore, denominators vary across results. Also, proportions may not sum to 100% for every variable due to missing or "check-all" responses. All data management and analysis was performed in IBM© SPSS© Statistics (v. 19). and QSR International© NVivo 10.

Limitations

The 2016 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/AIDS prevalence for the Houston EMA (2014). Results presented from Chapters 2 through the end of this report are proportional for these three demographic categories only. Similarly, the majority of respondents were Ryan White HIV/AIDS Program clients at the time of data collection, but may have received services outside the program that are similar to those currently funded. Therefore, it not possible to determine if results reflect non-Ryan White systems.
- *Sample size and confidence level.* Though the minimum sampling plan goal for the Needs Assessment was 587 surveys, the Comprehensive HIV Planning Committee voted to end data collection at 514 (507 valid) surveys completed in light of the limited amount of time to incorporate Needs Assessment findings into the 2017-2021 Comprehensive Plan. Staff calculated the new margin of error for this sample size as 4.31%, compared to 4% for the original minimum sample size, and verified with a statistician that this would have no bearing on generalizability of findings, particularly as the sample would be weighted by race/ethnicity, sex at birth, and age range.
- *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 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 real-time quality assurance reviews were performed of each survey by trained staff, 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 multiple staff and interns 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:

2016 Houston Area HIV Needs Assessment Group (NAG), Epidemiology Workgroup, 2016 Survey Sampling Principles and Plan, Approved 12-28-15.

Texas Department of State Health Services (DSHS) eHARS data through 12-31-2014, extracted as of summer 2015.

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

BACKGROUND

The Houston Area

Houston is the fourth largest city in the U.S., the largest city in the State of Texas, and as well as one of the most racially 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 just over to 4.5 million residents, over half of which live in the city of Houston.

Beyond Houston and Harris County, local HIV 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 26,041 diagnosed people living with HIV in the Houston EMA (**Table 1**). The majority are male (75%), over the age of 35 (75%), and MSM (56%), while almost half are African American (49%).

TABLE 1-Diagnosed People Living with HIV/AIDS in the Houston EMA, 2015[a]

	#	%
Total	26,041	100.0%
Sex		
Male	19,479	74.8%
Female	6,562	25.2%
Race/Ethnicity		
White	5,341	20.5%
Black/African American	12,721	48.8%
Hispanic/Latino	7,001	26.9%
Other/Multiple Races	978	3.8%
Age at Diagnosis		
0 - 12	68	0.3%
13 - 24	1,357	5.2%
25 - 34	5,115	19.6%
35 - 44	6,327	24.3%
45 - 54	7,463	28.7%
55+	5,711	21.9%
Transmission Risk[b]		
Male-to-male sexual activity (MSM)	14,500	55.7%
Injection drug use (IDU)	2,354	9.0%
MSM/IDU	1,063	4.1%
Heterosexual contact	7,779	29.9%
Perinatal transmission	328	1.3%
Adult other risk	17	0.1%

[a]Source: Texas eHARS. Living HIV and AIDS cases as of12/31/15. Data run August 2016.
[b]Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification.

CDC ranks the Houston Area (specifically, the Houston-Baytown-Sugarland, TX statistical area) 11th highest in the nation for new HIV diagnoses and 13th in cases of HIV Stage 3 (formerly known as AIDS). In July 2015, the White House's National HIV/AIDS Strategy Updated to 2020 prioritized southern states in response to the number and disparities of new HIV diagnoses and HIV mortality in the American South. Of the 26,041 diagnosed PLWH in the Houston Area, 76% are in medical care for HIV, but only 57% 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 to support for 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 administers these funds. The Ryan White Planning Council also designs Part B and State Services for the Houston HSDA.
- HOPWA provides grants to community organizations to meet the housing needs of low-income persons living with HIV/AIDS. HOPWA services include assistance with rent, mortgage, and utility payments, permanency planning, 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, 2014; vol. 26. Published November 2015. Accessed 06/20/2016. Available at: www.cdc.gov/hiv/topics/surveillance/resources/reports/.

U.S. Census Bureau, State and County QuickFacts. Houston (city), Texas. Accessed: 06/20/2016. Available at: http://quickfacts.census.gov/qfd/states/48/4835000.html.

White House Office of National AIDS Policy, National HIV/AIDS Strategy for the United States Updated to 2020. July 2015.

Chapter 1: Demographics

PARTICIPANT COMPOSITION

The following summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2016 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, 93% of needs assessment participants resided in Harris County at the time of data collection. The majority of participants were male (67%), African American/Black (63%), and heterosexual (54%). Greater than half were age 50 or over, with a median age of 50-54.

The average unweighted household income of participants was $9,380 annually, with the majority living below 100% of federal poverty (**FPL**). Most participants paid for healthcare using Medicaid/Medicare and assistance through Harris Health System (Gold Card).

TABLE 1-Select Participant Characteristics, Houston Area HIV Needs Assessment, 2016

	No.	%		No.	%		No.	%
County of residence			Age range (median: 50-54)			Sex at birth		
Harris	464	93.4%	13 to 17	1	0.2%	Male	341	67.3%
Fort Bend	21	4.2%	18 to 24	17	3.4%	Female	166	37.7%
Liberty	1	0.2%	25 to 49	219	43.2%	Intersex	0	-
Montgomery	6	1.2%	50 to 54	123	24.3%	Transgender	20	3.9%
Other	5	1.0%	55 to 64	133	26.2%	Currently pregnant	1	0.2%
			≥65	14	2.8%			
			Seniors (≥50)	270	53.3%			
Primary race/ethnicity			Sexual orientation			Health insurance		
White	60	11.8%	Heterosexual	274	54.0%	Private insurance	53	8.6%
African American/Black	318	62.7%	Gay/Lesbian	171	33.7%	Medicaid/Medicare	307	49.8%
Hispanic/Latino	121	23.9%	Bisexual	39	7.7%	Harris Health System	146	23.7%
Asian American	5	1.0%	Other	23	4.5%	Ryan White	105	17.0%
Other/Multiracial	3	0.6%	MSM	216	42.6%	None	6	1.0%
Immigration status			Yearly income (average: $9,380)					
Born in the U.S.	427	84.6%	Federal Poverty Level (FPL)					
Citizen > 5 years	33	6.5%	Below 100%	278	78.8%			
Citizen < 5 years	4	0.8%	100%	45	12.7%			
Undocumented	10	2.0%	150%	13	3.7%			
Prefer not to answer	22	4.4%	200%	10	2.8%			
Other	9	1.8%	250%	2	0.6%			
			≥300%	5	1.4%			

(**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 2016 needs assessment process to *oversample* PLWH who were also members of groups designated as "special populations" due to socio-economic circumstances or other sources of disparity in the HIV service delivery system.

The results of these efforts are summarized in Table 2.

TABLE 2-Representation of Special Populations, Houston Area HIV Needs Assessment, 2016

	No.	%
Unstable Housing	142	28.0%
Injection drug users (IDU)*	8	1.6%
Men who have sex with men (MSM)	216	42.6%
Not retained in care (last 6 months)	4	0.8%
Recently released from incarceration	41	8.1%
Rural (non-Harris County resident)	33	6.4%
Transgender	20	3.9%

*See Limitations section for further explanation of identification of IDU

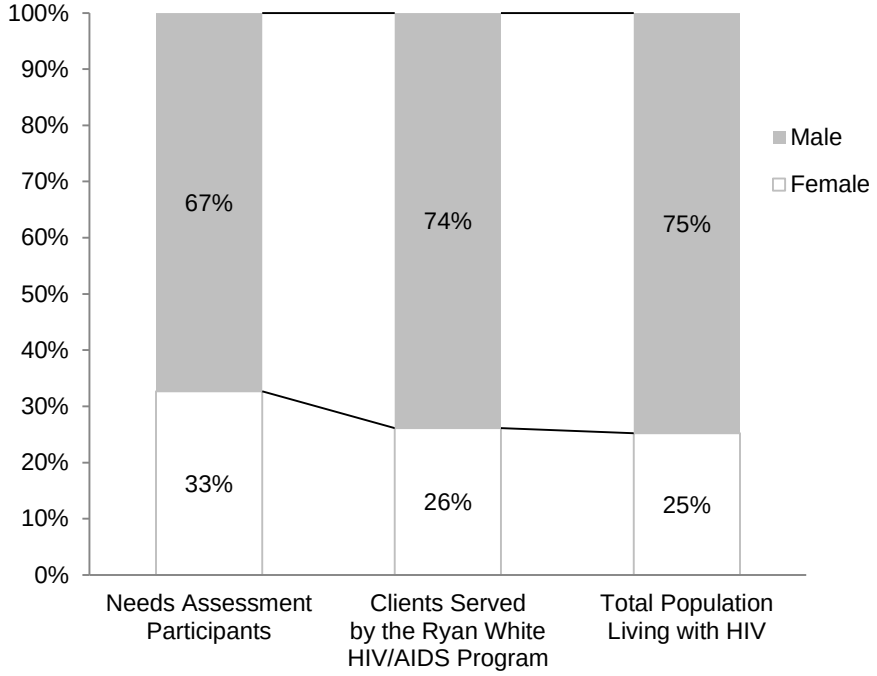
COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

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.

As such, awareness of the level 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 2016 Houston HIV Care Services Needs Assessment, males comprised 67% of participants, but 74% of all Ryan White clients and 75% of 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.

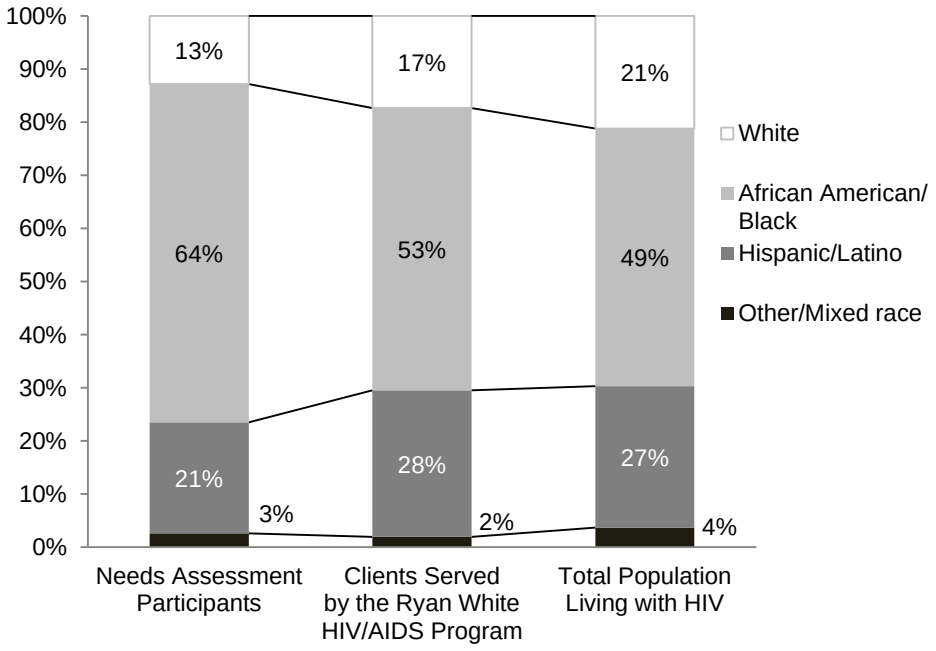
GRAPH 1-Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Infected Population[b] in the Houston EMA, by Sex, 2015



[a]Source: CPCDMS as of 12/31/15, 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). Presented 4/26/16.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/15.

(**Graph 2**) Analysis of race/ethnicity composition also shows disproportionate representation between participants, all Ryan White clients, and all PLWH in the Houston EMA. African American/Black participants were overrepresented at 64% of participants when compared to the proportions of African American/Black Ryan White clients and PLWH. Conversely, White PLWH and Hispanic/Latino PLWH were generally underrepresented in the needs assessment.

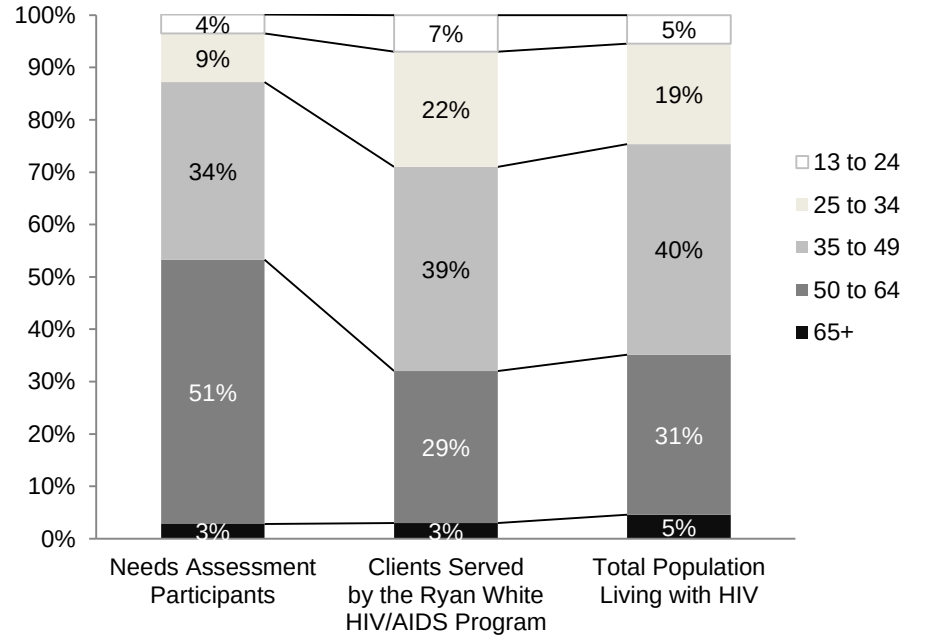
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Infected Population[b] in the Houston EMA, by Race/Ethnicity, 2015



[a]Source: CPCDMS as of 12/31/15, 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). Presented 4/26/16.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/15

(**Graph 3**) Lastly, an analysis of age range shows that more needs assessment participants were older than Ryan White clients and PLWH in the Houston EMA, with 54% of needs assessment participants were 50 years and older, while only than half of all Ryan White clients (32%) and less than half of all PLWH (36%) are in this age group. This suggests that, youth, and young adult PLWH (those age 13 to 34) are generally underrepresented in the needs assessment, while older adults (those age 45 and above) are overrepresented.

GRAPH 3- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Infected Population[b] in the Houston EMA, by Age[c], 2014



[a]Source: FY15 Service Utilization Report as of 2/29/16. 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). Dated 6/08/16
[b]Source: Texas eHARS. Living HIV cases as of 12/31/14.
[c]Excludes ages0-12

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 (2014) *prior to* the analysis of results related to service needs and barriers. This was done because the demographic composition of 2016 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 12-31-2014, extracted as of August 2015.

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

Chapter 2:
Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

As payer of last resort, the Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to people living with HIV (**PLWH**) who may not have sufficient resources for managing HIV disease. 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. 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.

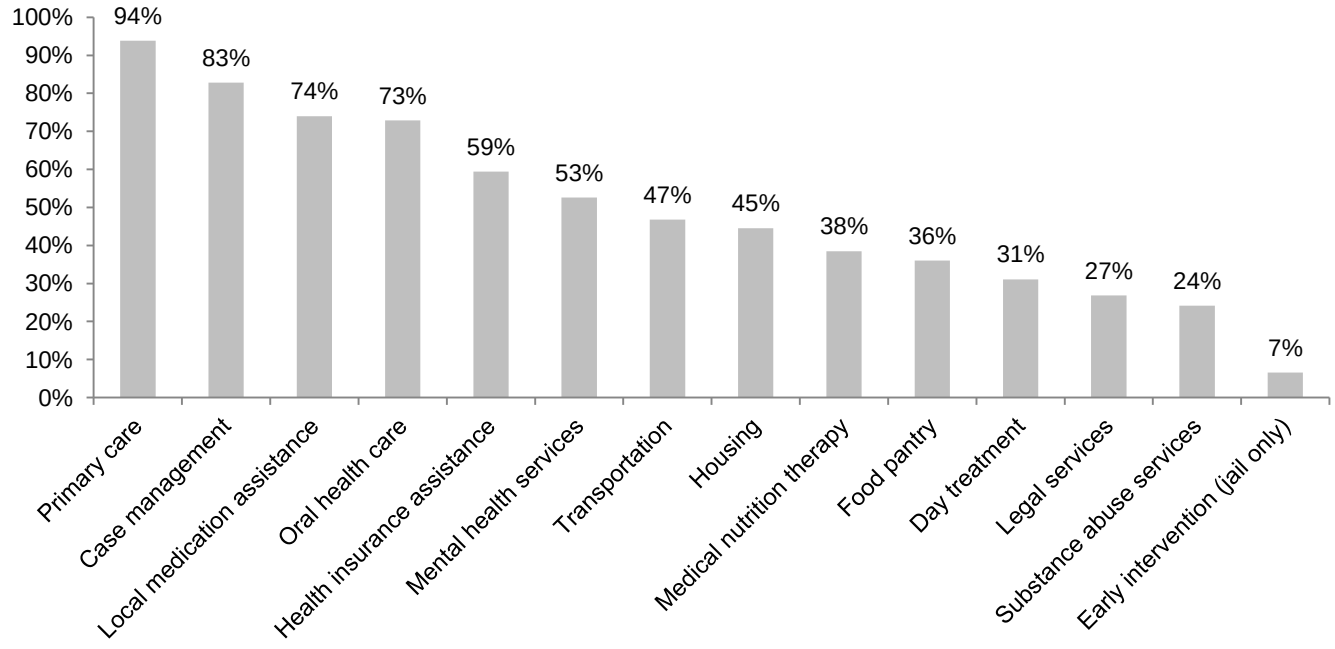
Overall Ranking of Funded Services, by Need

In 2016, 15 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Though no longer funded through the Ryan White HIV/AIDS Program, Food Pantry was also assessed. Participants of the 2016 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. At 94%, primary care was the most needed funded service in the Houston Area, followed by case management at 83%, local medication assistance at 74%, and oral health care at 73%. Primary care had the highest need ranking of any core medical service, while transportation received the highest need ranking of any support service. Compared to the last Houston Area HIV needs assessment conducted in 2014, need ranking increased for many core medical services, and decreased for most support services. The percent of needs assessment participants reporting need for a particular service decreased the most for food pantry, housing, and medical nutrition therapy, while the percent of those indicating a need for health insurance assistance increased 12 percentage points from 2014, the most of any service measured.

GRAPH 1-Ranking of HIV Services in the Houston Area, By Need, 2016

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



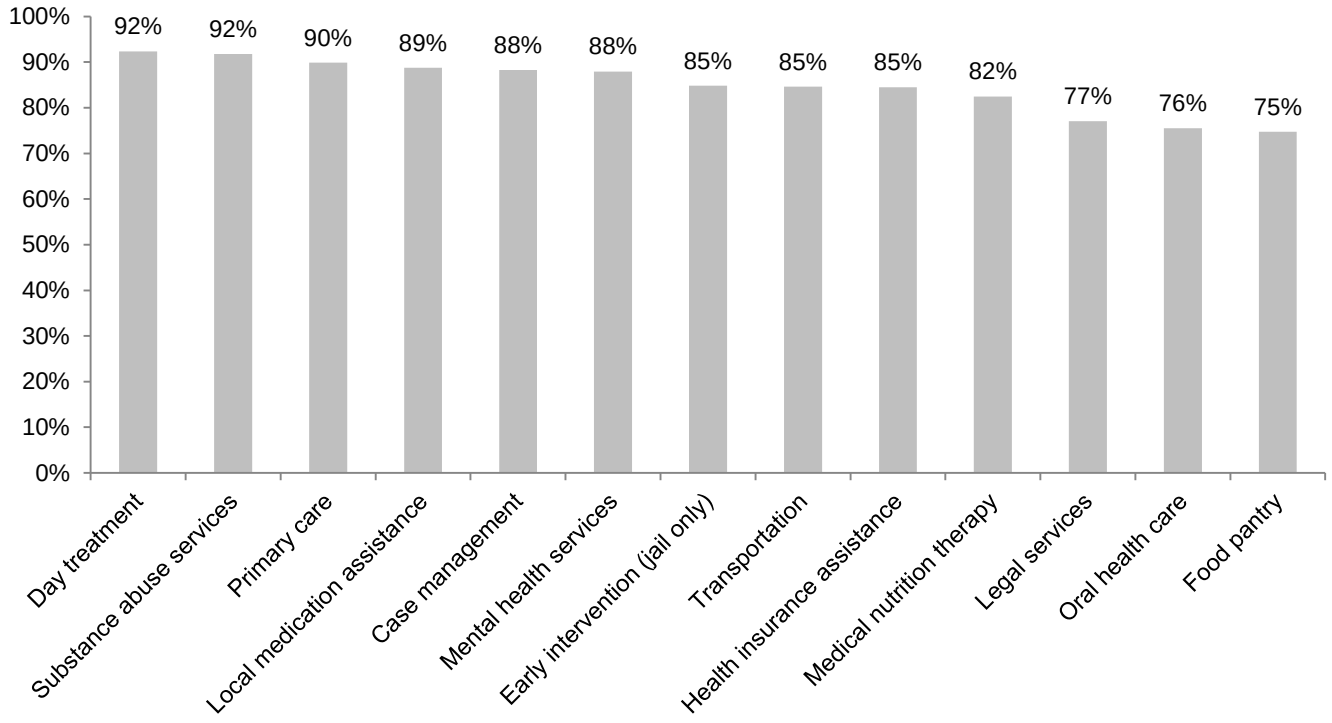
Overall Ranking of Funded Services, by Accessibility

Participants of the 2016 Houston HIV Care Services Needs Assessment 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 two most accessible services were day treatment and substance abuse services at 92% ease of access, followed by primary care at 90% and local medication assistance at 89%. Day treatment had the highest accessibility ranking of any core medical service, while transportation received the highest accessibility ranking of any support service. Compared 2014 needs assessment, reported accessibility increased for each service category, with an average increase of 9 percentage points. The greatest increase in percent of participants reporting ease of access was observed in early intervention services, while transportation experienced the lowest increase in accessibility. The percent of needs assessment participants reporting need for a particular service decreased the most for food pantry, housing, and medical nutrition therapy, while the percent of those indicating a need for health insurance assistance increased 12 percentage points from 2014, the most of any service measured.

GRAPH 2-Ranking of HIV Services in the Houston Area, By Accessibility, 2016

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.



Overall Ranking of Barriers Types Experienced by Consumers

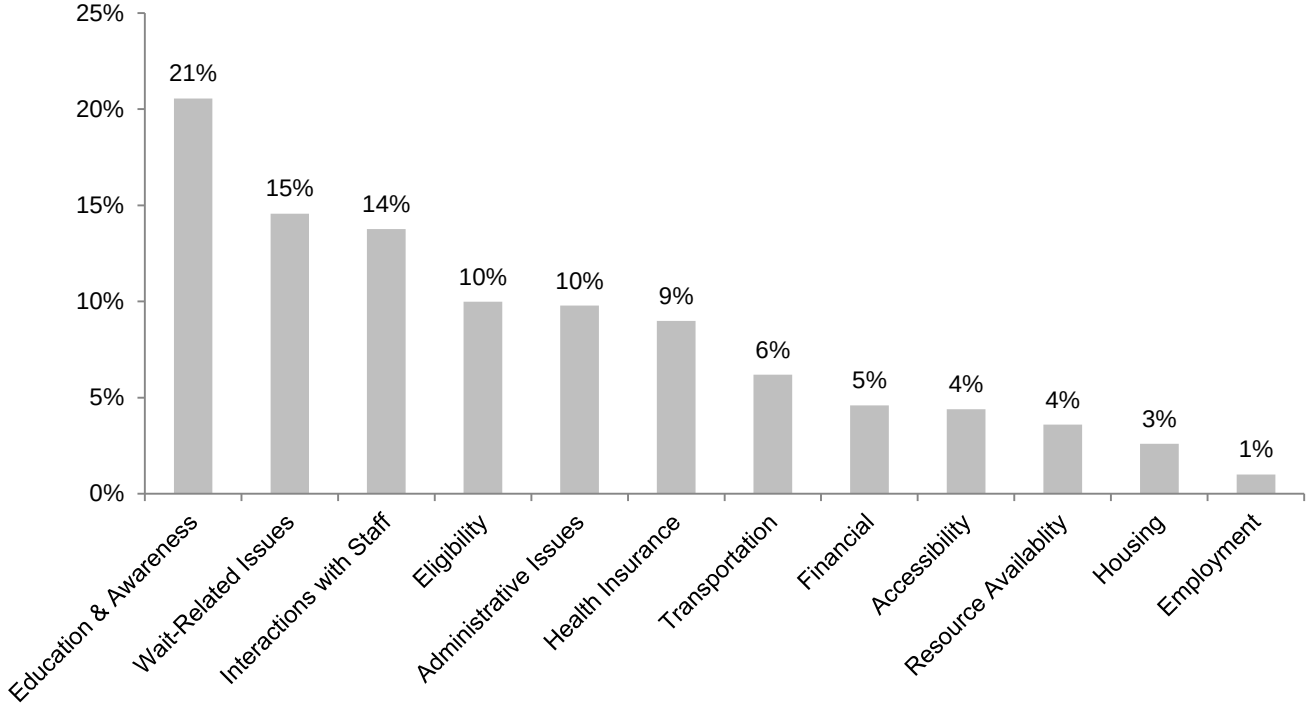
For the first time in the Houston Area HIV Needs Assessment process, participants who reported *difficulty* accessing needed services were asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Recursive abstraction was used to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

(**Graph 3**) Overall, the barrier types reported most often related to service education and awareness issues (21% of all reported barriers); wait-related issues (15%); interactions with staff (14%); eligibility issues (10%); and administrative issues (10%). Employment concerns were reported least often (1%). Due to the change in methodology for barrier assessment between the 2011 and the 2016 HIV needs assessments, a comparison of the change in number of reports of barriers will not be available until the next HIV needs assessment.

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, 2016

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



Descriptions of Barriers Encountered

All funded services were reported to have barriers, with an average of 33 reports of barriers per service. Participants reported the least barriers for Hospice (two barriers) and the most barriers for Oral Health Care (86 barriers). In total, 525 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 82% barriers reported. Being put on a waitlist accounted for a majority (66%) of wait-related issues barriers. Poor communication and/or follow up from staff members when contacting participants comprised a majority (51%) of barriers related to staff interactions. Almost all (86%) of eligibility barriers related to participants being told they did not meet eligibly requirements to receive the service or difficulty obtaining the required documentation to establish eligibility. Among administrative issues, long or complex processes required to obtain services sufficient to create a burden to access comprised most (59%) the barriers reported.

Most (84%) of health insurance-related barriers occurred because the participant was uninsured or underinsured and experiencing coverage gaps for needed services or medications. The largest proportion (81%) of transportation-related barriers occurred when participants had no access to transportation. It is notable that multiple participants reported losing bus cards and the difficulty of replacing the cards presented a barrier to accessing other services. Inability to afford the service accounted for all barriers relating to participant financial resources. The service being offered at a distance that was inaccessible to participants or being recently released from incarceration accounted for most (77%) of accessibility-related barriers, though it is worth note that low or no literacy accounted for 14% of accessibility-related barriers. Receiving resources that were insufficient to meet participant needs accounted for most resource availability barriers. Homelessness accounted for virtually all housing-related barriers. Instances in which the participant's employer did not provide sufficient sick/wellness leave for attend appointments comprised most (60%) employment-related barriers.

TABLE 1-Barrier Proportions within Each Barrier Type, 2016					
Education & Awareness	%	Wait-Related Issues	%	Interactions with Staff	%
Availability (Didn't know the service was available)	50%	**Waitlist** (Put on a waitlist)	66%	**Communication** (Poor correspondence/ Follow up from staff)	51%
Definition (Didn't know what service entails)	7%	**Unavailable** (Waitlist full/not available resulting in client not being placed on waitlist)	15%	**Poor Treatment** (Staff insensitive to clients)	17%
Location (Didn't know where to go [location or location w/in agency])	32%	**Wait at Appointment** (Appointment visits take long)	7%	**Resistance** (Staff refusal/ resistance to assist clients)	13%
Contact (Didn't know who to contact for service)	11%	**Approval** (Long durations between application and approval)	12%	**Staff Knowledge** (Staff has no/ limited knowledge of service)	7%
				Referral (Received service referral to provider that did not meet client needs)	17%
Eligibility	%	Administrative Issues	%	Health Insurance	%
Ineligible (Did not meet eligibility requirements)	48%	**Staff Changes** (Change in staff w/o notice)	12%	**Uninsured** (Client has no insurance)	53%
Eligibility Process (Redundant process for renewing eligibility)	16%	**Understaffing** (Shortage of staff)	2%	**Coverage Gaps** (Certain services/medications not covered)	31%
Documentation (Problems obtaining documentation needed for eligibility)	38%	**Service Change** (Change in service w/o notice)	10%	**Locating Provider** (Difficulty locating provider that takes insurance)	13%
		Complex Process (Burden of long complex process for accessing services)	59%	**ACA** (Problems with ACA enrollment process)	17%
		Dismissal (Client dismissal from agency)	4%		
		Hours (Problem with agency hours of operation)	16%		
Transportation		Financial	%	Accessibility	%
No Transportation (No or limited transportation options)	81%	**Financial Resources** (Could not afford service)	100%	**Literacy** (Cannot read/difficulty reading)	14%
Providers (Problems with special transportation providers such as Metrolift or Medicaid transportation)	19%			**Spanish Services** (Services not made available in Spanish)	9%
				Released from Incarceration (Restricted from services due to probation, parole, or felon status)	32%
				Distance (Service not offered within accessible distance)	45%
Resource Availability	%	Housing	%	Employment	%
Insufficient (Resources offered insufficient for meeting need)	56%	**Homeless** (Client is without stable housing)	100%	**Unemployed** (Client is unemployed)	40%
Quality (Resource quality was poor)	44%	**IPV** (Interpersonal domestic issues make housing situation unsafe)	0%	**Leave** (Employer does not provide sick/wellness leave for appointments)	60%

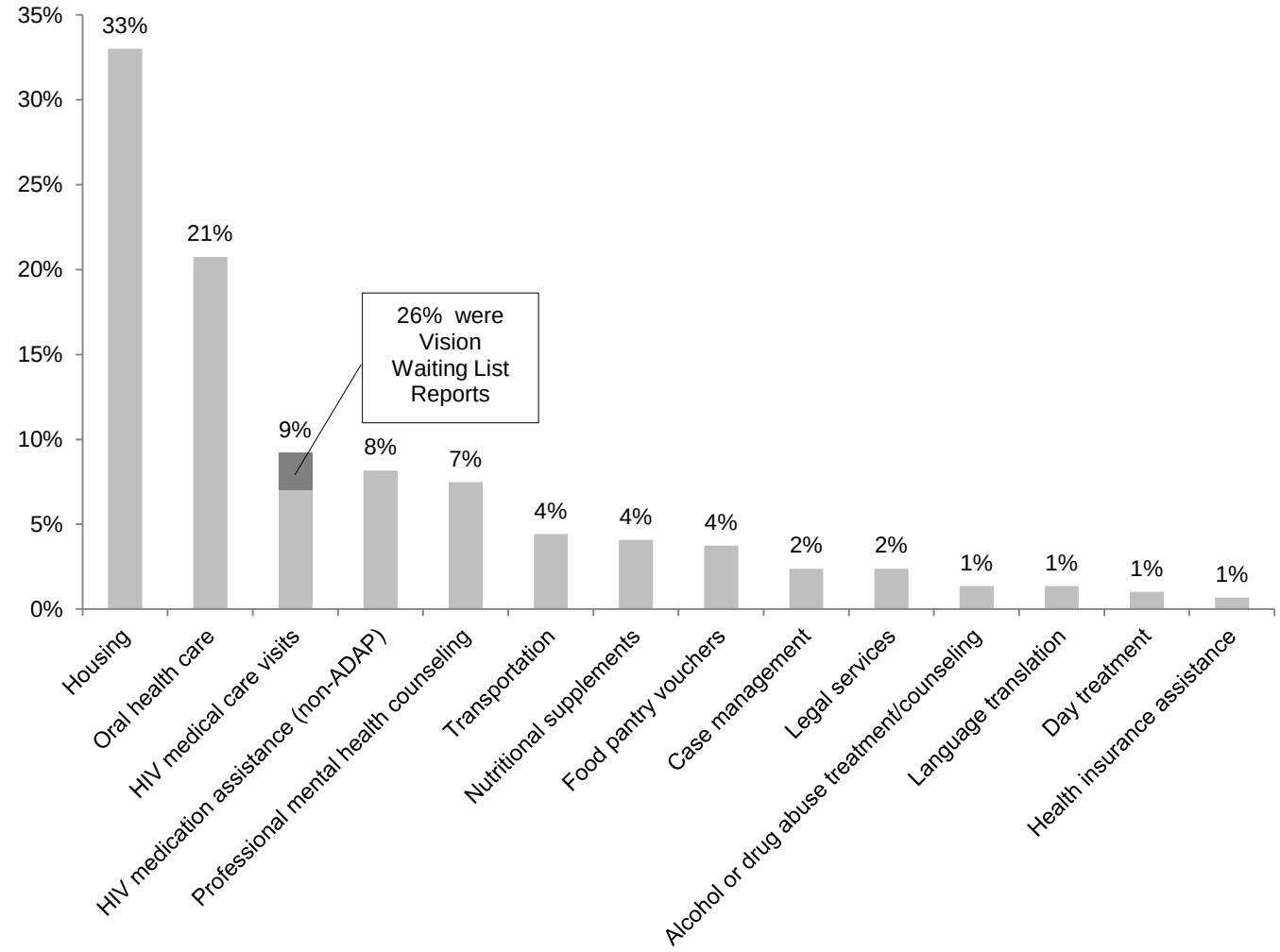
Waiting List Barriers and Experiences

In February 2014, the Ryan White Planning Council formed the ad-hoc Waiting List Workgroup to evaluate the extent to which waiting and waitlists impact the receipt of HIV care and treatment services in the Houston Area, and propose ways to address wait-related issues through changes to the HIV care and treatment system. With input from the Waiting List Workgroup, the 2016 Houston HIV Care Services Needs Assessment included questions specifically designed to elicit information from participants about which services they had been placed on a waiting list for in the past 12 months, the time period between first request for a service and eventual receipt of the service, awareness of other providers of waitlisted services, and services for which clients reported being placed on a waitlist more than once. Thirty-nine percent (39%) of participants indicated that they had been placed on a waiting list for at least one service in the past 12 months.

(**Graph 4**) A third of participant reports of being on a waiting list were for housing services. This was followed by oral health care (21%), HIV medical care (9%), local medication assistance (8%), and professional mental health counseling (7%). Of all participants reporting being on a wait list for HIV medical care visits, 26% indicated being placed on a waiting list specifically for vision services. There were no reports of participants being placed on a wait list for hospice or pre-discharge planning.

GRAPH 4-Percentage of Waiting List Reports by Service, 2016

Definition: Percent of times needs assessment participants reported being on a waiting list for each service.

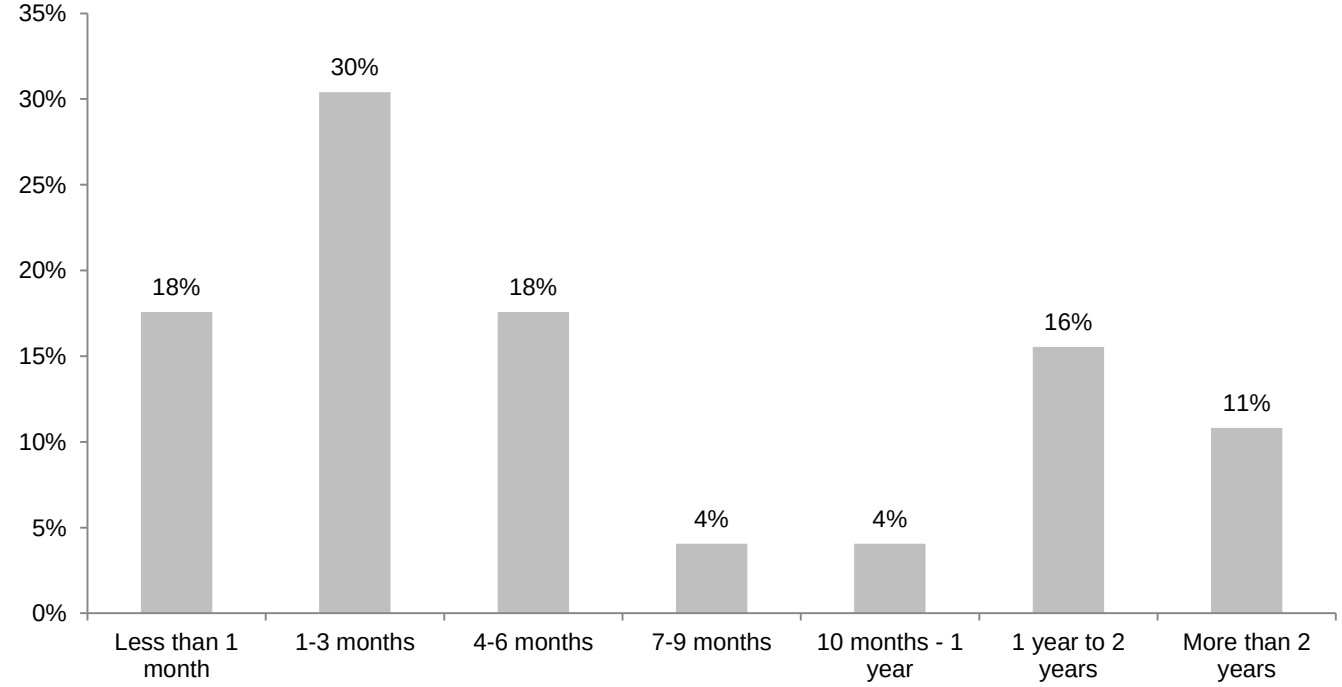


(**Graph 5**) Participant reports of time elapsed from the initial request for a service until receipt of the service vary from 1 day to over 2 years. The greatest number of reports of time elapsed occurred for wait times between one and three months (30%), followed by less than one month (18%) and four to six months 18%).

Most wait times reported for housing services occurred for one to three months (26%), one to two years (26%), or 10 months to one year (18%). It is worth noting that 8% of participants reporting a wait time for housing services had over two years elapse between first request and receipt of service, with several expressing that they were on a housing wait list at the time of survey. Most reports of wait times for oral health care were less than one month (26%) or four to six months (26%). However, 14% of participants indicating a wait time for oral health care services reported wait times of over one year. Finally, most participants (64%) indicating wait times for HIV medical care including vision services reported waiting one to three months.

GRAPH 5-Percentage of Wait Times Reports, 2016

Definition: Percent of times needs assessment participants reported time elapsed from the initial request for a service until receipt of the service each time period.



Awareness of other providers for services operating waiting lists can offer timely service to consumers with acute needs and reduce wait times for those remaining on wait lists. A majority (83%) of participants who reported being on a wait list for at least one in the past 12 months stated that they were not aware of another provider of the service for which they were waiting, or did not remember if they were aware of another provider. Of the remaining 35% of participants who were aware of another provider, over half (59%) reported not seeking service from the alternative provider.

Nearly one-third of participants who reported being placed on a wait list in the past 12 months also reported having been placed on a wait list for the service more than once. This was observed primarily for among participants reporting being placed on a wait list for housing services (34%) and oral health care (29%).

Other Identified Needs

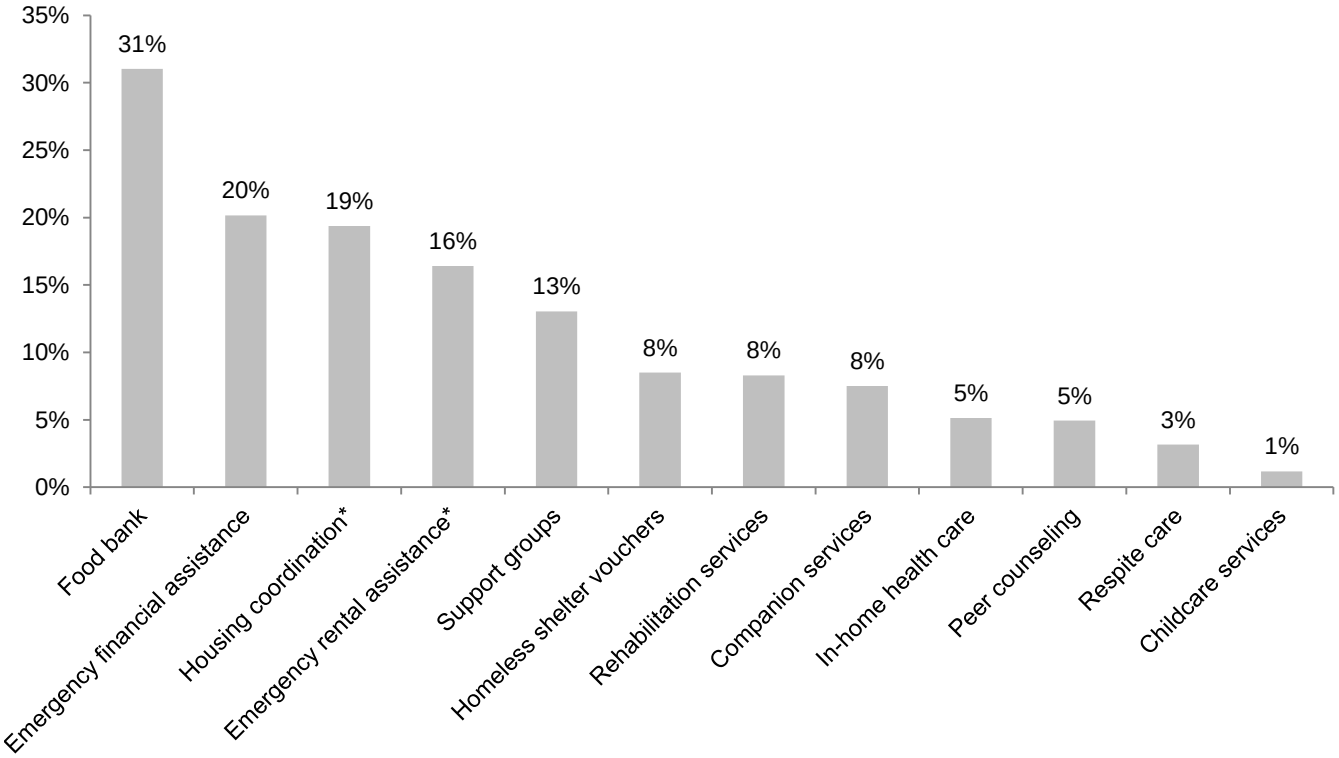
In addition to the HIV services listed above, there are other services allowable for funding by the Ryan White HIV/AIDS Program in local communities if there is a demonstrated need. Several of these other services have been funded by the Ryan White Program in the Houston Area in the past. The 2016 Houston HIV Care Services Needs Assessment measured the need for these services to order to gauge any new or emerging service needs in the community. In addition, some of these services are currently funded through other HIV-specific non-Ryan White sources, namely housing-related services provided by the Housing Opportunities with People with AIDS (HOPWA) program, as indicated.

(**Graph 6**) Twelve other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for Houston Area PLWH. Participants were also encouraged to write-in other types of needed services. Of the 12 services options provided, 31% of participant selected food bank was needed services, a decrease of 14 percentage points from the 2014 needs assessment. Emergency financial assistance was selected second (20%), followed by housing-related services cited third (20%) and fourth (16%), and support groups cited fifth (13%).

Services that were written-in most often as a need (and that are not currently funded by Ryan White) were (*in order*): employment assistance and job training, vision hardware/glasses, and services for spouses/partners.

GRAPH 6-Other Needs for HIV Services in the Houston Area, 2016

Definition: Percent of needs assessment participants, who selected each service in response to the survey question,"What other kinds of services do you need to help you get your HIV medical care?"



*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.

Chapter 3: Needs Across the HIV Care Continuum

HIV CARE CONTINUUM

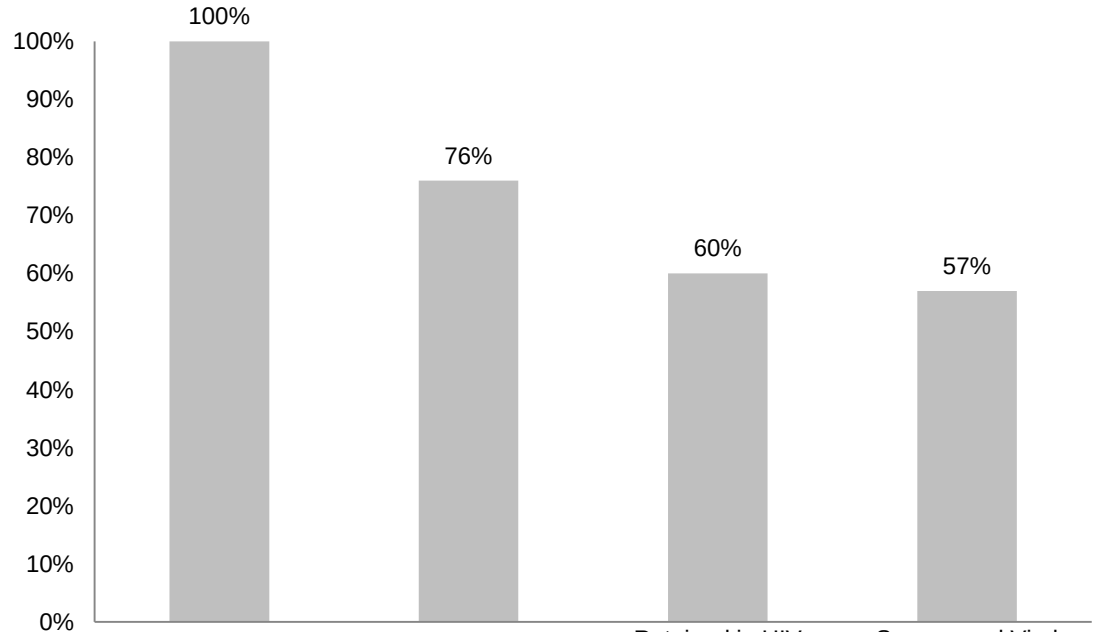
In July 2012, the Centers for Disease Control and Prevention (CDC) released an analysis of the number and percentage of people in the U.S. at each stage of the HIV care continuum originally developed by Gardner et al (2011). The continuum represents the sequential stages of HIV care – from being diagnosed 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 2016 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. Finally, as the defining component of achieving viral suppression, motivations among participants not currently taking antiretroviral medication are assessed at the end of this chapter

GRAPH 1-Houston Area HIV Care Continuum, 2015



***No. persons who are HIV diagnosed in 2015 in the Houston EMA.**
****No. persons who are HIV diagnosed with met need in 2015 in the Houston EMA.**
*****No. HIV diagnosed persons with retained in care (PLWH with at least 2 visits, labs, or ARVs in 12 months, at least 3 months apart) in 2015 in the Houston EMA.**
+No. HIV diagnosed persons whose last VL of 2015 <=200 (among persons with >=1 VL test) in 2015 in the Houston EMA.
Data Source: TDSHS, HIV Care Continuum for the Houston EMA, 2015. Data from among adults and adolescents (>= 13 years of age as of end of the year 2015) residing in Texas diagnosed with HIV infection through 2015 and living with HIV infection on 12/31/2015. Data extracted as of August 2016

TESTING AND DIAGNOSIS

The 2016 Houston HIV Care Services Needs Assessment asked participants to share some 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 people living with HIV (PLWH) who are aware of their status. This corresponds with both the National HIV/AIDS Strategy (NHAS) Updated to 2020 indicator to increase the percentage of people living with HIV who know their serostatus to at least 90% by 2020 and the Houston Area 2017-2021 Comprehensive Plan goal to maintain and, if possible, increase the percentage of individuals with a positive HIV test result identified through targeted HIV testing who are informed of their positive status, beginning at 94.4%.

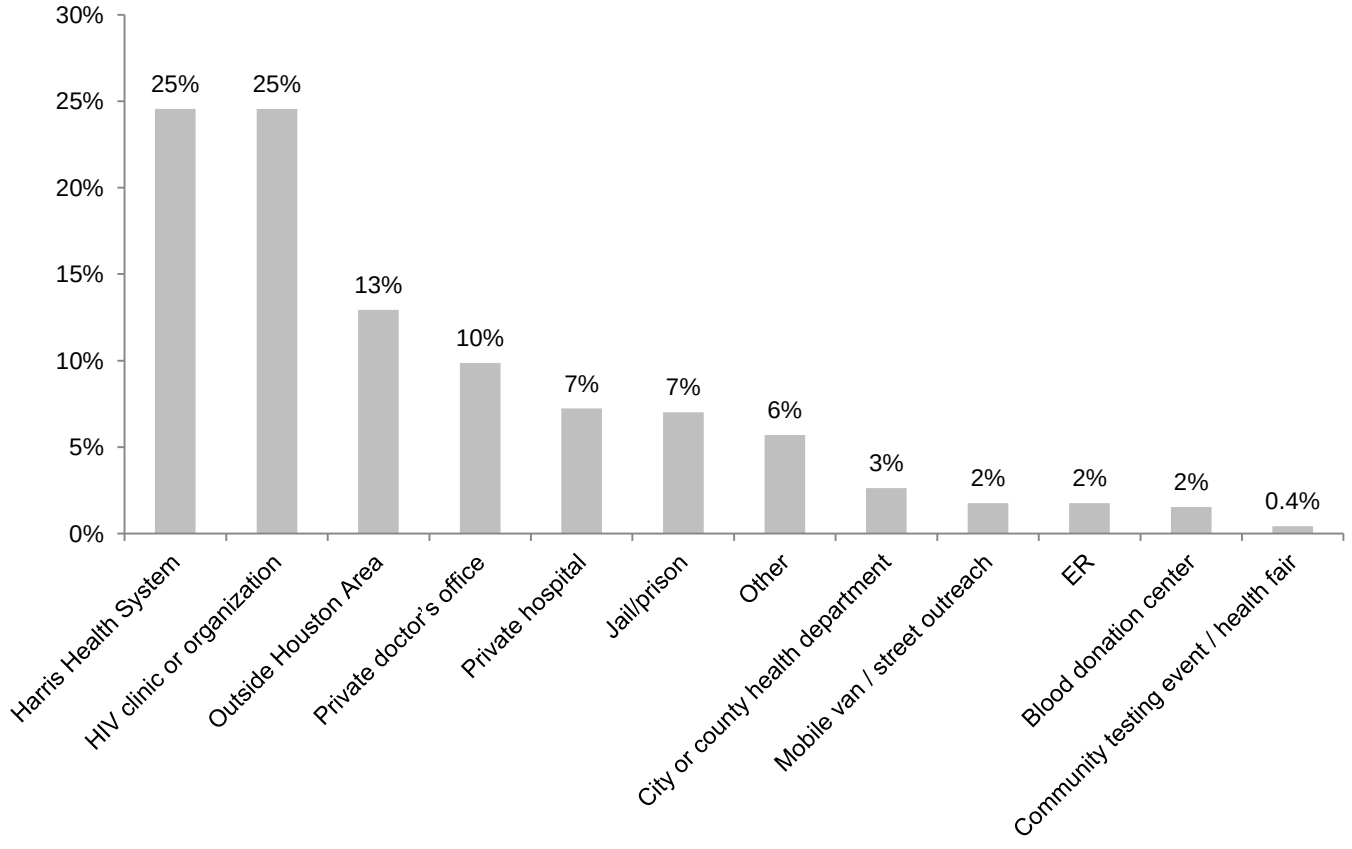
HIV Testing Location

(**Graph 2**) The most common location for being diagnosed with HIV among needs assessment participants was tie between a Harris Health System facility or an HIV clinic or organization at 25%, followed by receipt of diagnosis outside the Houston area (13%), a private doctor's office or clinic (10%), and a private hospital or ER (7%). At less than 1%, community testing events and health fairs were cited least often.

While out of care, unstably housed, MSM, and transgender PLWH as were diagnosed most often at a Harris Health System facility, population-level analysis shows some difference in diagnosis location for other groups. Youth (age 18 to 24) were diagnosed most often at a blood donation center while newly diagnosed PLWH were diagnosed most often at an HIV clinic or organization. Rural participants (not residing in Houston/Harris County) were diagnosed most often outside the Houston area. PLWH released from incarceration in the past 12 months were diagnosed most often while incarcerated.

GRAPH 2-Locations of HIV Diagnosis for PWLH in the Houston Area, 2016

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

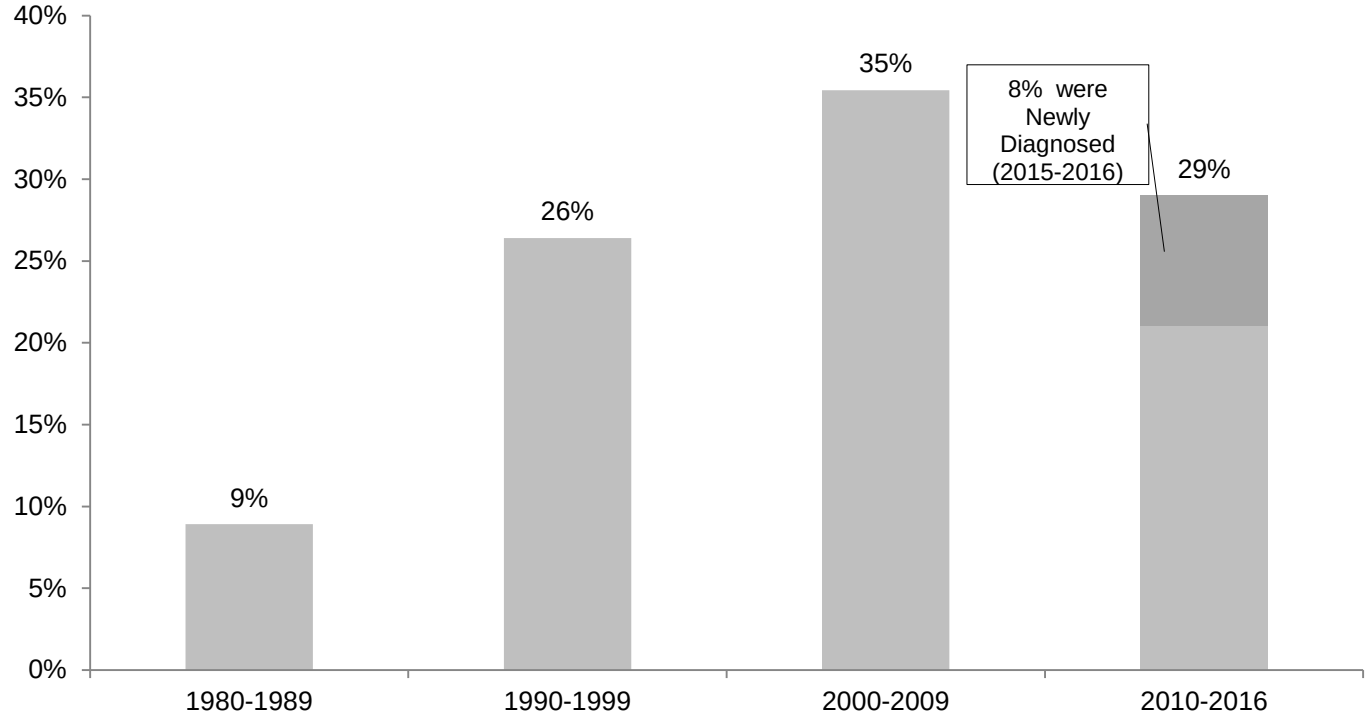


Year HIV Diagnosed

(**Graph 3**) The average length of time since HIV diagnosis among needs assessment participants was 13 years. This means that most participants were diagnosed prior to major expansions in HIV testing in the Houston Area, including annual mass testing events and routine/opt-out testing. More participants were diagnosed between 2000 and 2009 than any other time period. However, the mean number of participants diagnosed each year between 2010 and 2016 was 21, more than any other diagnosis time period.

GRAPH 3-Year of HIV Diagnosis for PWLH in the Houston Area, 2016

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



LINKAGE TO CARE

The 2016 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. The NHAS Updated to 2020 indicator and Houston Area 2017-2021 Comprehensive Plan goal to increase linkage to HIV care within one month of diagnosis to at least 85%

Notes: As the average length of time since HIV diagnosis among needs assessment participants was 13 years, most participants were diagnosed prior to the introduction of proactive service linkage efforts such as Service Linkage Workers. Service linkage activities and barriers to timely linkage are discussed for all participants and newly diagnosed participants in **Graph 4** and **Graph 5**.

Linkage Services at Diagnosis

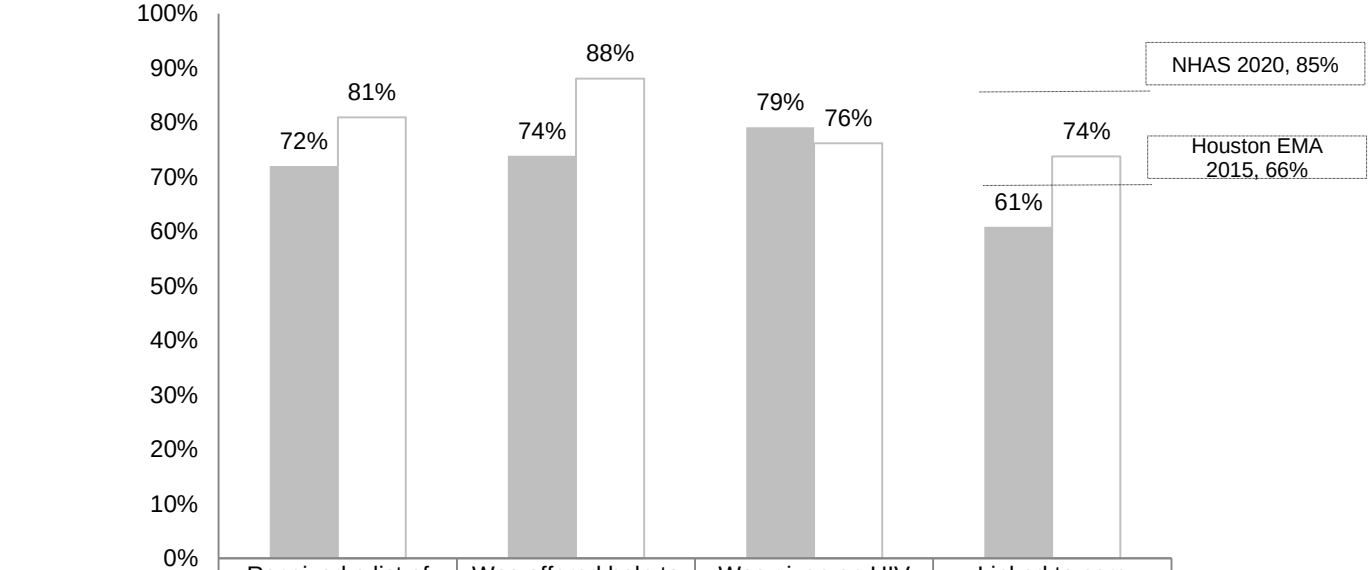
(**Graph 4**) 61% of all needs assessment participants reported linkage to care within 1 month of diagnosis. 72% reported receiving a list of HIV clinics at the time of diagnosis (also referred to as *passive* linkage), while slightly higher proportions (74% and 79%) reported *active* linkage, either assistance obtaining HIV care or an appointment for their first medical visit.

Among participants who were *newly diagnosed,* 74% reported linkage to care within 1 month. This group also reported receiving a list of clinic and being offered help to obtain care more often than did all participants. 81% received a list of HIV clinics at the time they were diagnosed, 88% were offered assistance in obtaining HIV care, and 76% were provided an appointment for their first medical visit.

Among the newly diagnosed, reported linkage to care exceeds epidemiological data show for the Houston EMA. According to those data (generated by the Texas Department of State Health Services), 66% of persons in the Houston EMA were linked to care within 1 months of diagnosis (2015).

GRAPH 4-Service Linkage Activities Received at the Time of HIV Diagnosis in the Houston Area, 2016

Definition: Percent of needs assessment participants who received each of type of linkage service at the time of diagnosis, and the percent reporting being linked to HIV medical care within 1 months of diagnosis.

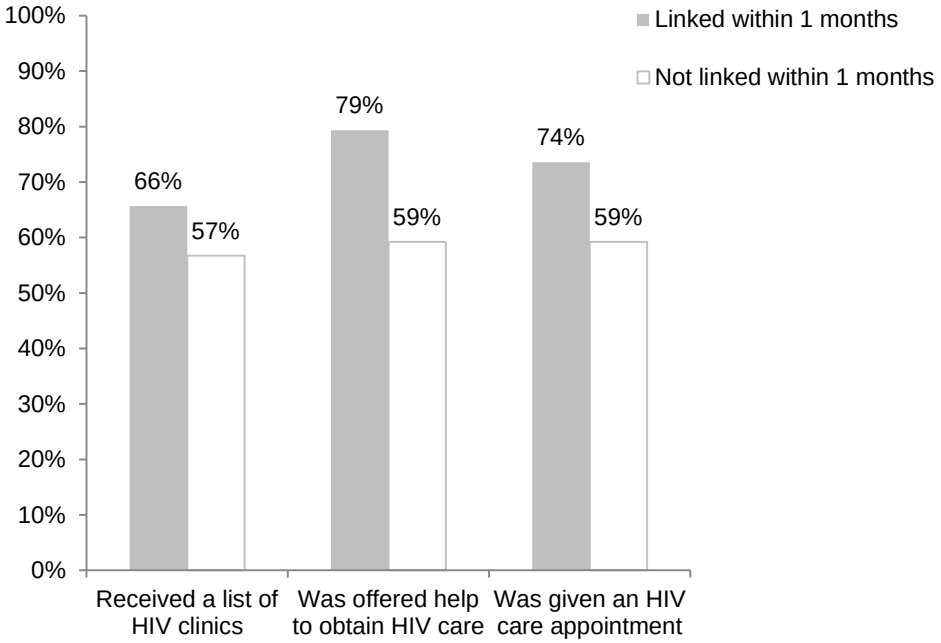


	Received a list of HIV clinics	Was offered help to obtain HIV care	Was given an HIV care appointment	Linked to care within 1 months
All participants	72%	74%	79%	61%
Newly diagnosed	81%	88%	76%	74%

(**Graph 5**) Receipt of an appointment for the first medical visit appears to be positively associated with early linkage: 74% of those who linked to care within 1 months received an appointment at the time of diagnosis, while only 59% of those who did *not* link to care within 1 months received an appointment at the time of diagnosis.

GRAPH 5-Service Linkage Activities Received at the Time of HIV Diagnosis in the Houston Area, by Linkage Timeframe, 2016

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



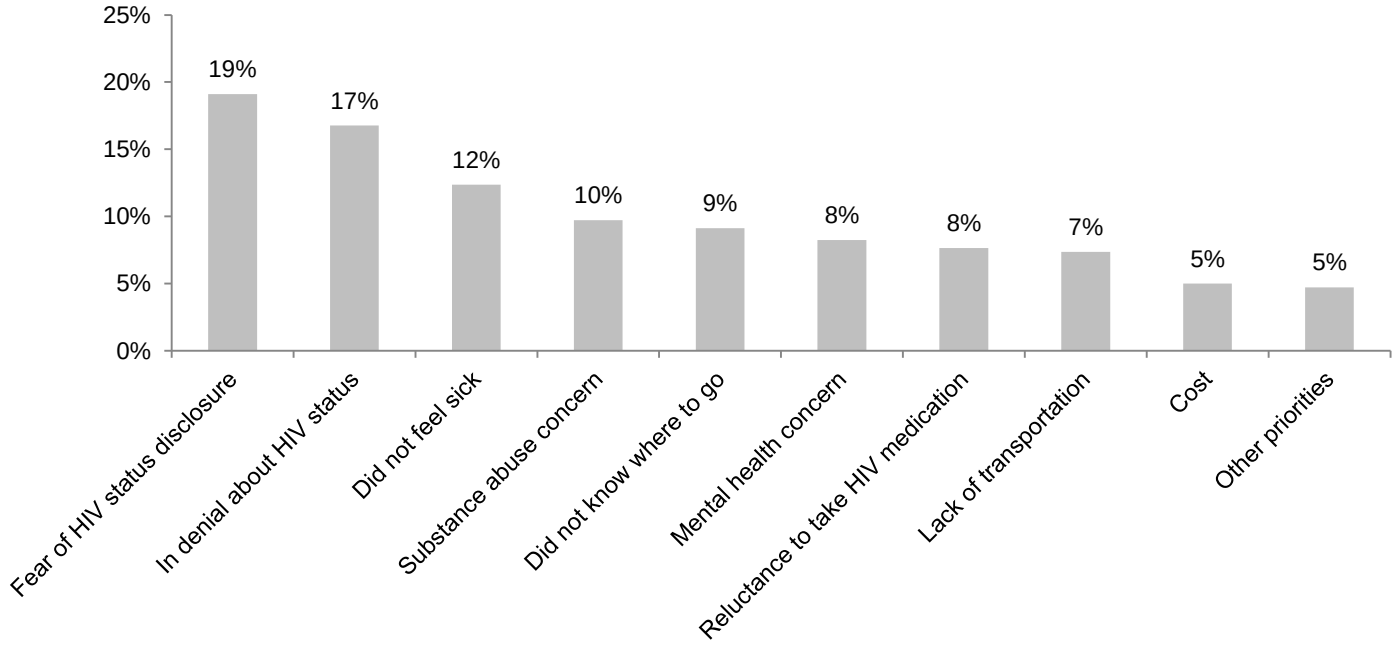
Barriers to Early Linkage

(**Graph 6**) Participants who delayed entry into HIV care for more than 1 month after diagnosis were asked the reasons for delayed entry. Ten 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 10 options provided, fear of HIV status disclosure was selected most often at 19% of all reasons reported. This was closely followed by denial (17%) and not feeling sick (12%). The most common write-in reasons for delayed entry were delay issues with the provider such as appointment rescheduling and having been diagnosed before HIV medication was available.

GRAPH 6-Reasons for Delayed Linkage to HIV Care in the Houston Area, 2016

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.



RETENTION IN CARE

The 2016 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. The NHAS Updated to 2020 retention indicator and Houston Area 2017-2021 Comprehensive Plan retention objective is to increase retention in HIV medical care to at least 90%.

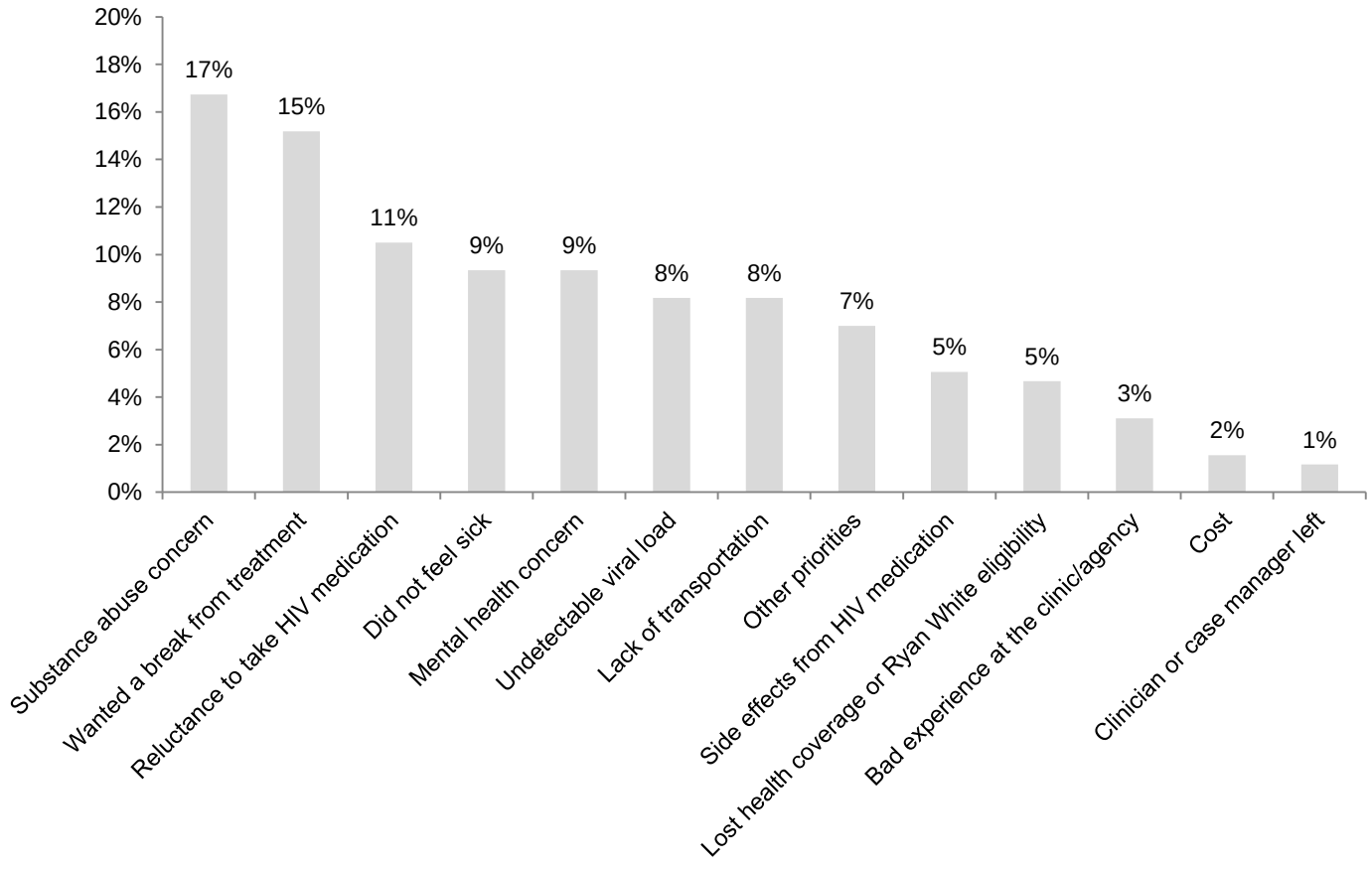
Notes: Most needs assessment participants (99%) reported being retained HIV care in the past 12 months. This is likely an artifact of the sampling process and does not represent the Houston Area as a whole. According to local epidemiological data (generated by the Texas Department of State Health Services), 76% 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 (2015)

Barriers to Retention in Care

(**Graph 7**) 71% of needs assessment participants reported no 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. Thirteen commonly reported reasons were included as options in the consumer survey. Participants could also write-in their reasons. Of the 13 options provided, substance abuse concerns selected most often at 17% of all reasons reported. This was followed by wanting to take a break from treatment (15%), reluctance to take HIV medication (11%), not feeling sick (9%), and mental health concerns (9%). The most common write-in reason for falling out of care was relocation.

GRAPH 7-Reasons for Falling Out of HIV Care in the Houston Area, 2016

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 .



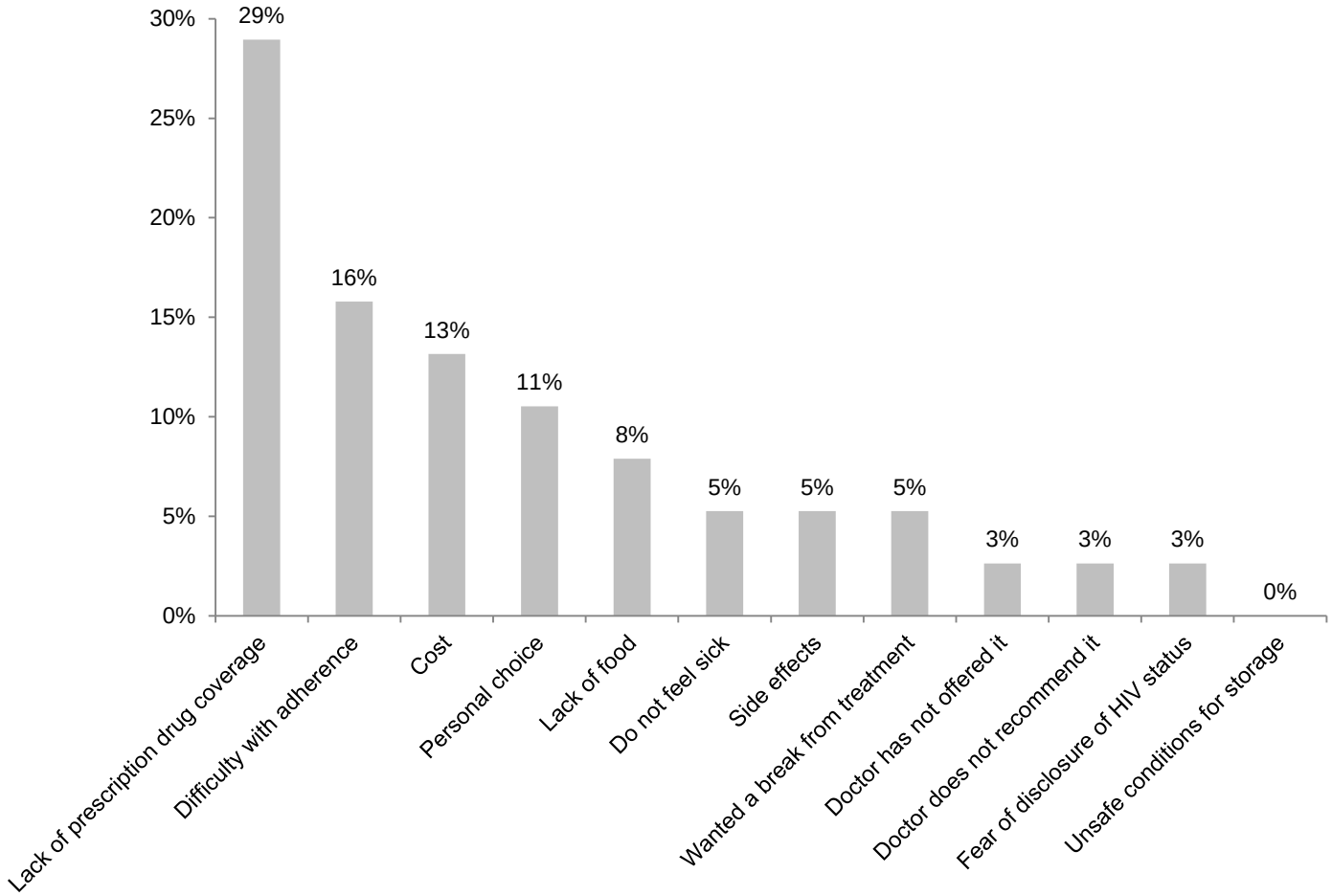
HIV MEDICATION

Barriers to HIV Medication

(**Graph 7**) Though 91% of participants reported currently taking HIV medications at the time of survey, information on barriers to medication adherence helps communities design services to ensure HIV medication is available and accessible and support viral suppression. Participants who were not taking HIV medications at the time of survey asked to share the reason they were not taking medication. Twelve commonly reported reasons were provided, and participants could also write in their response. Of the 12 options provided, the reason selected most often at 29% of all reasons reported lack of prescription drug coverage. This was followed by difficulty taking HIV medication as directed (16%), cost (13%), personal choice (11%), and lack of correct food to take with HIV medication (8%). The most common write-in reasons for not taking HIV medication were not getting a refill, having an undetectable viral load, forgetting to take medication, and waiting on the pharmacy to deliver the medication via mail.

GRAPH 7-Barriers to HIV Medication in the Houston Area, 2016

Definition: Percent of times each item was reported by needs assessment participants as the reason they were not currently taking HIV medication.



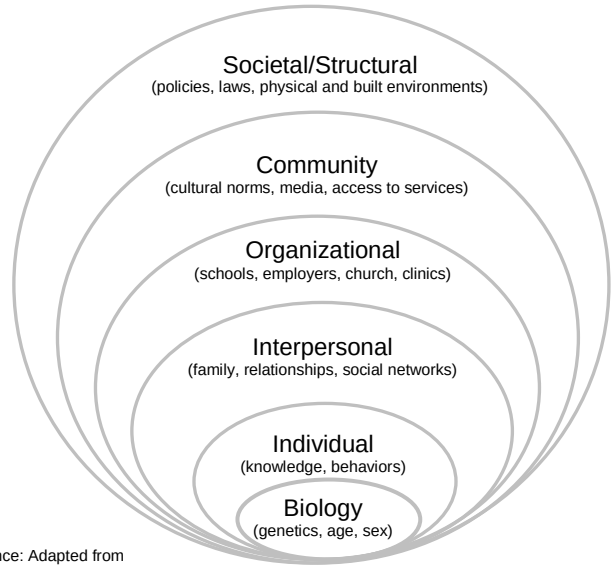
Chapter 4:
Determinants of HIV Care

DETERMINANTS OF HIV CARE

Based on a model called the socio-ecological framework of health (**Figure 1**), *determinants of health* are the layers of individual, community, and societal level factors that can influence health, risk, resources, and access to care. Biological factors typically include bodily or physical factors such as genetics, age, sex at birth, and ability/disability. Individual determinants include personal knowledge and behaviors that influence health such as safer sex practices, substance use, needle sharing, unprotected sex, and smoking. Interpersonal interactions such as family, relationships, and social networks influence health risks or protections like intimate partner violence and social support. Organizational components like schools, employers, churches, and clinics can either facilitate or hinder access to health resources, services, and information. Community-level determinants like cultural norms, media, and accesses to services surrounding an area or a group can influence stigma, awareness, and healthcare seeking behaviors. Societal/structural determinants refer to both social structures that influence health such as laws, public policy, structural violence like income, gender, or racial discrimination or inequality, as well as the physical environment such as pollution, food deserts, and overcrowded conditions.

The 2016 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, and can 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 due to the presence of other personal, community, or societal level conditions.

FIGURE 1-The Socio-Ecological Framework of Health



Reference: Adapted from *Healthy People 2020, Determinants of Health*

CO-OCCURING HEALTH CONDITIONS

The 2016 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, auto-immune disorders, and infectious diseases. Participants were also encouraged write in other conditions not listed. Overall, two-thirds of needs assessment participants (68%) reported a current diagnosis of *at least one* co-occurring physical health condition. This proportion was also positively associated with participant age, with 84% of participants age 50 and over reporting at least one co-occurring physical health condition, compared to 54% of participants age 18 to 24.

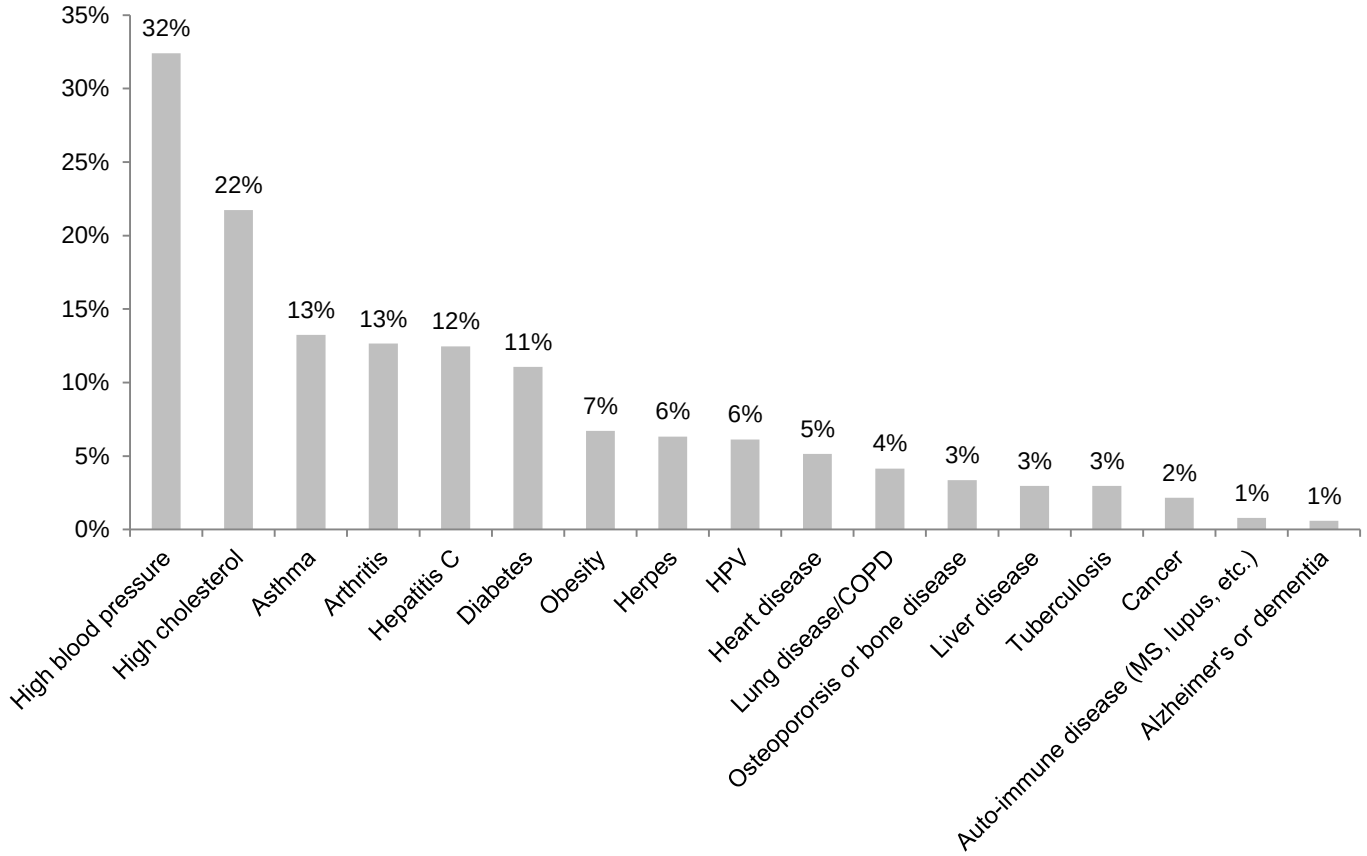
Notes: Mental health conditions were addressed separately from physical health conditions in the survey, and those results are presented in the *Behavioral Health* section of this Chapter. Additionally, non-HIV sexually transmitted diseases (**STD**s) testing diagnosis, and treatment are discussed in the *HIV Prevention Behaviors and Risks* section of this Chapter.

Chronic and Co-Occurring Conditions

(**Graph 1**) The most frequently reported chronic and/or co-occurring health condition was was hypertension (32% of participants), followed by high cholesterol (22%), asthma (13%), arthritis (13%), hepatitis C (12%), and diabetes (11%). Among the 3% of participants who reported being diagnosed with tuberculosis, 20% experiencing active tuberculosis. The most common write-in chronic conditions included (*in order*): chronic back pain, thyroid disease, neuropathy, blood clotting disorders, hepatitis B, sleep disorders, and seizures/epilepsy.

GRAPH 1-Chronic and Co-Occurring Disease among PLWH in the Houston Area, 2016

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



Emergency Care

The Houston Area experiences a unique challenge in meeting the health and medical needs for a large PLWH population that is unable to access non-Ryan White health care coverage due to the state of Texas decision to not expand Medicaid. As such, emergency care comprises a substantial component of non-Ryan White funded care provided to PLWH in the Houston Area, and can provide insight into the prevention and management of both chronic conditions and opportunistic infections.

The 2016 Houston HIV Care Services Needs Assessment asked participants had sought care from an emergency room/emergency department in the past 12 months because they felt sick. Among all participants, 31% sought emergency care in the past 12 months due to feeling sick. When participants reporting incomes below 100% FPL were analyzed, 34% reported seeking emergency care for feeling sick in the past 12 months.

BEHAVIORAL HEALTH

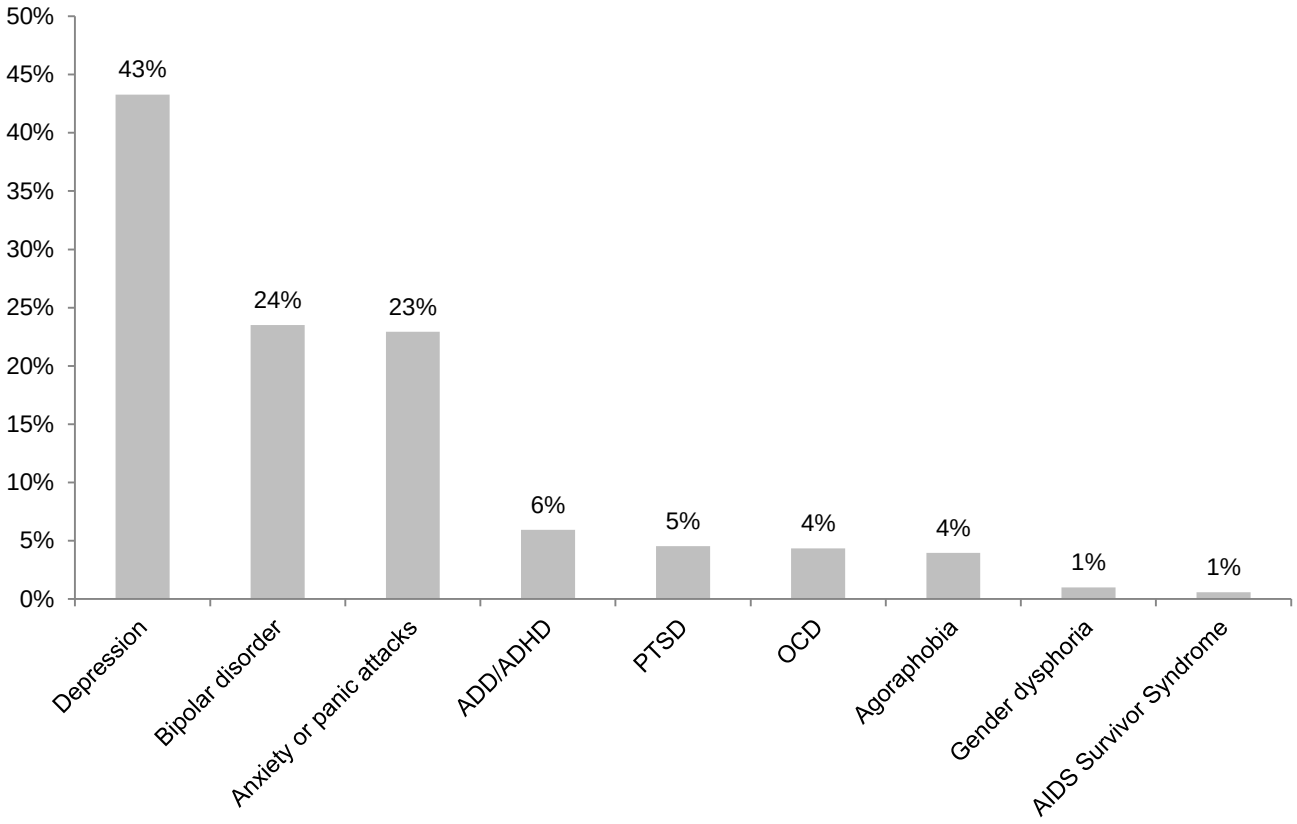
Behavioral health refers to the range of conditions related to or impacting mental or emotional well-being. It includes both diagnosed mental illness, indications of psychological distress, and substance use and misuse (Substance Abuse and Mental Health Services Administration, 2011). The 2016 Houston HIV Care Services Needs 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 (57%) reported having a current *diagnosis* of at least one mental health condition from among a provided list of common conditions, a three percentage point increase from the 2014 needs assessment. The most frequently reported diagnosis was for depression at 42% of participants, followed by bipolar disorder and anxiety or panic attacks. All write-in mental health diagnoses were psychosis or schizophrenia.

GRAPH 2-Mental Health Diagnoses among PLWH in the Houston Area, 2016

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



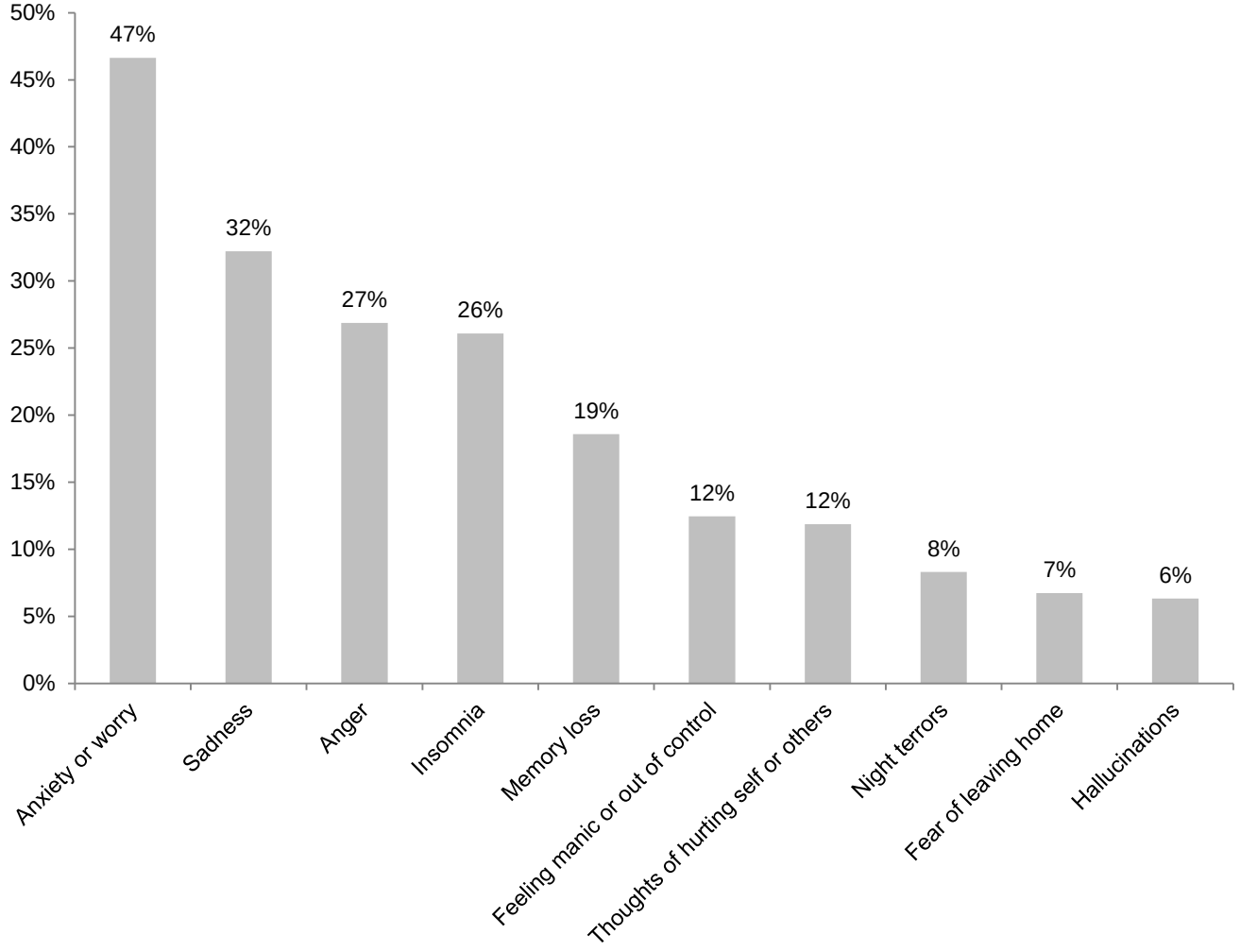
Mental/Emotional Distress

(**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, 65% of participants reported at least one such symptom, an increase of 4 percentage points from the 2014 needs assessment. Of those listed, the most frequently reported was anxiety or worry (47% of participants), followed by sadness (32%), anger (27%), insomnia (26%), and memory loss (19%). The most common write-in mental/emotional distress symptoms were loneliness/isolation, trouble focusing, and mood swings

GRAPH 3-Mental/Emotional Distress Symptoms among PLWH in the Houston Area, 2016

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.



Social Support

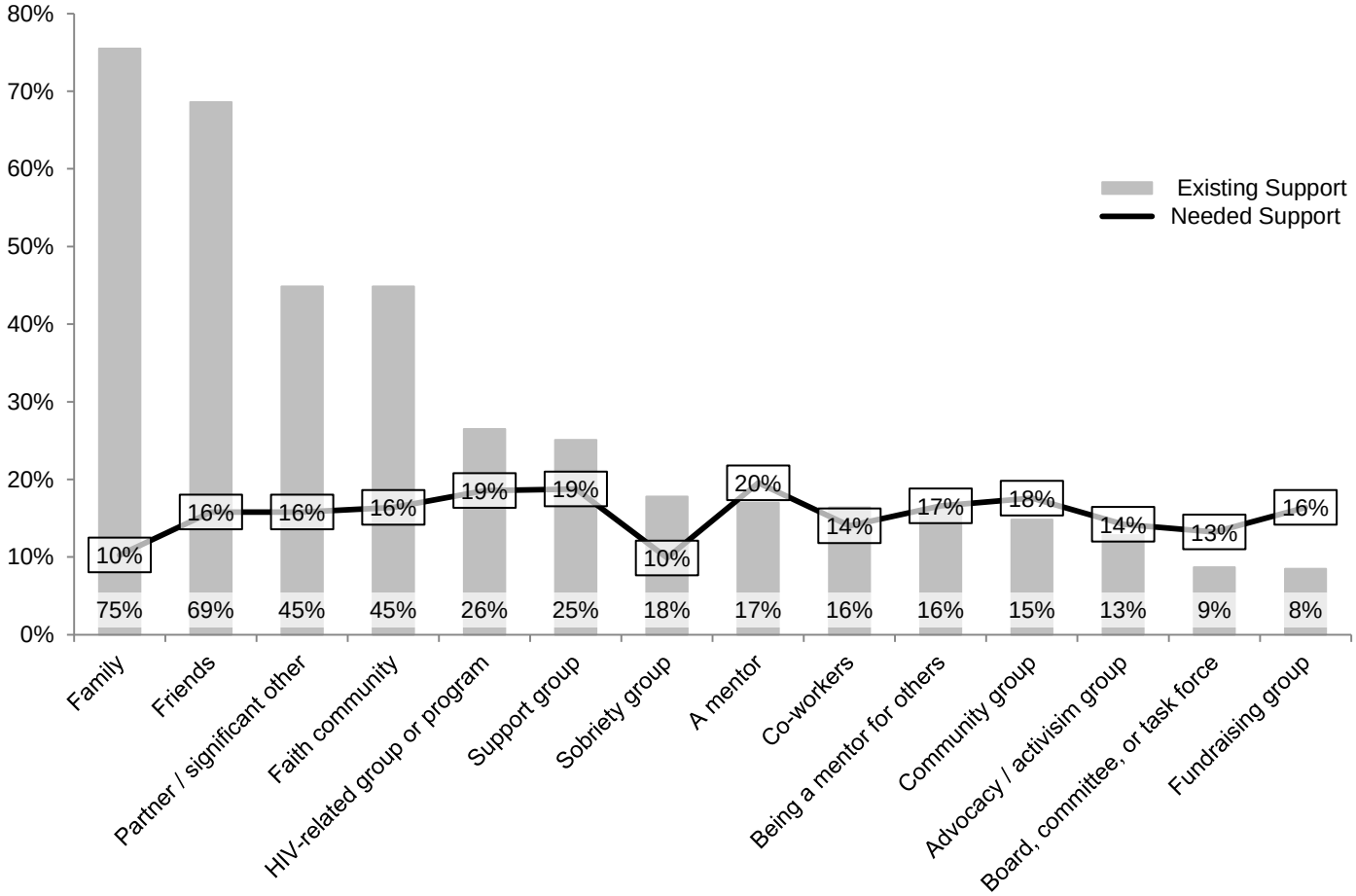
Participants were asked about sources of social support for managing HIV, including emotional support, assistance, advice, and/or companionship. The majority of participants (71%) reported feeling that they had sufficient social support in their lives.

Variance in sufficient levels of social support was observed upon population-level analysis. Ninety-two percent (92%) of participant age 18-24 felt they had sufficient social support, whereas 69% of participants age 50 and over felt they had sufficient social support. Proportions of sufficient social support were also lower among participants who were unstably housed (51%), recently released from incarceration (57%), or transgender (59%).

(**Graph 4**) Participants were also asked to review a list of 14 types of social support, and indicate whether each type was a source of support they currently had, did not currently have, but needed, and neither had nor needed. The most frequently reported *existing* sources of social support were family (85% of participants), friends (69%), a partner or significant other (45%), a faith community (45%), and an HIV-related group or program. Participants were also encouraged to write in other existing sources of social support, the most common of which were a substance abuse counselor and doing volunteer work. The most frequently reported *needed* sources of social support were a mentor (20%), an HIV-related program (19%) or support group (19%), a community group, and opportunities to mentor others (17%). The greatest disparity between existing and needed sources of social support were observed for fundraising groups (8 percentage points), a board, committee, or task force (5 percentage points), having a mentor (3 percentage points), and community groups (3 percentage points).

GRAPH 4-Existing and Needed Sources of Social Support among PLWH in the Houston Area, 2016

Definition: Percent of needs assessment participants, who reported having or not having, but needing, various sources of social support



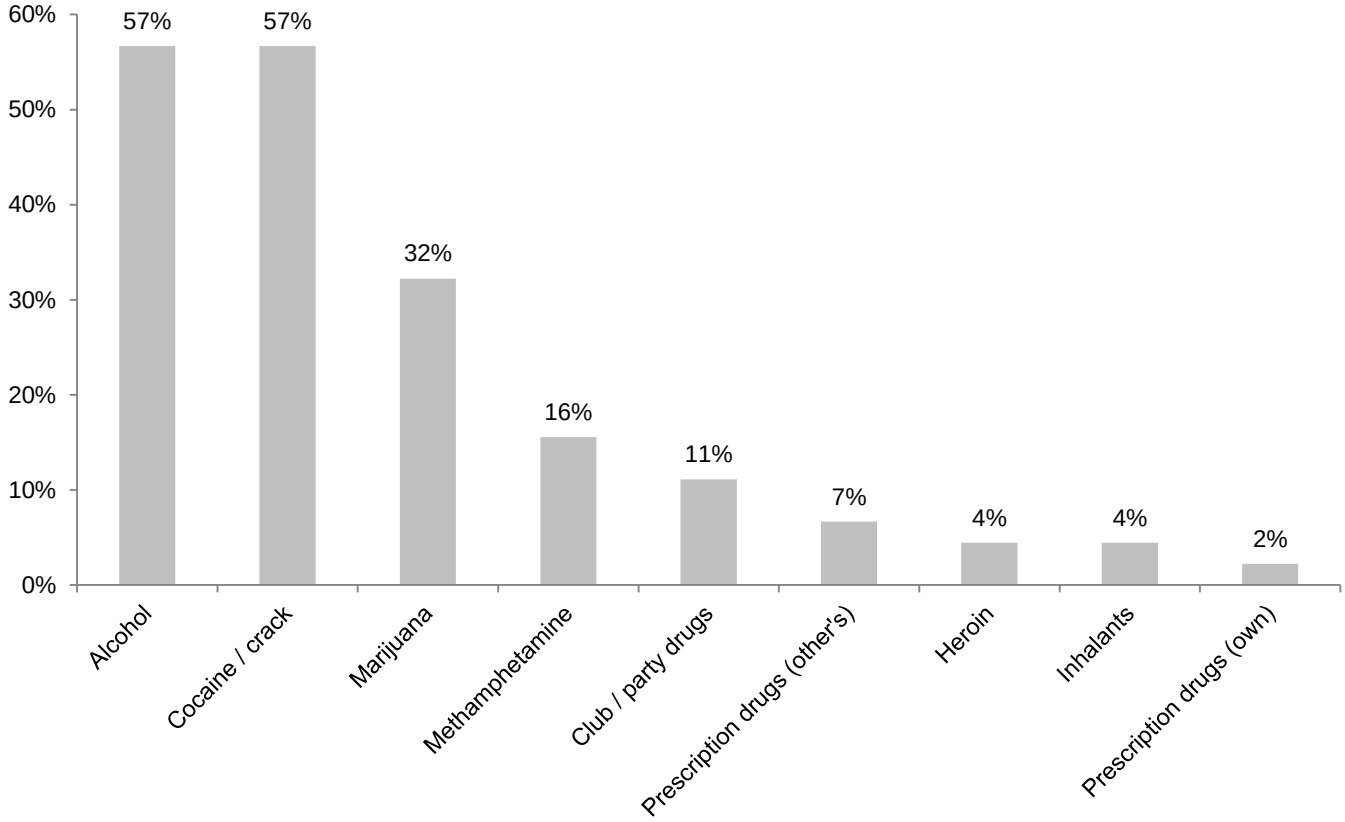
Substance Use

(**Graph 5**) Participants were asked to indicate whether alcohol or drug use had ever interfered with the participant getting HIV medical. 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. While 50% of the participants indicated a history of alcohol or drug use, only 18% identified this substance use as a barrier to HIV care.

Among participants who indicated alcohol or drug use had ever interfered with getting HIV medical care, equal proportions (57%) of indicated that alcohol and cocaine/crack was used, followed by marijuana (32%), methamphetamine (16%), and club/party drugs (11%). No participants indicated hallucinogens or legal drug use as a barrier to care, and there were no substances written in.

GRAPH 5-Substance Use as a Barrier to Care among PLWH in the Houston Area, 2016

Definition: Percent of each substance used when participants reported history of substance use barriers



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 income, 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. (Source: Centers for Disease Control and Prevention. *Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States*. October 2010). The 2016 Houston HIV Care Services Needs Assessment asked participants about these social and economic circumstances.

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 $10,522, or $877 per month. This average annual is more than 5 times lower than the average median household income of the general population in the Houston HSDA, and more than 6 times lower than the average household income of the general population in the Houston EMA in 2014. Among participants reporting income, 71% reported incomes below 100% of the 2016 Federal Poverty Level (**FPL**). Comparatively, the average percentage below 100% FPL was 16% for the general population in Houston HSDA and 15% in the Houston EMA in 2014.

TABLE 1-Average Annual Household Income and Federal Poverty Level among PLWH in the Houston Area, 2016

	Mean Annual Household Income	Percentage Below 100% of Federal Poverty Level
PLWH (2016)	$10,522	71%
HSDA Average (2014)[a]	$56,073	16%
EMA Average (2014)[a]	$63,328	15%

[a]Source: U.S. Census. 2010-2014 American Community Survey 5-Year Estimates. DP03: SELECTED ECONOMIC CHARACTERISTICS. Retrieved on 11/3/16.

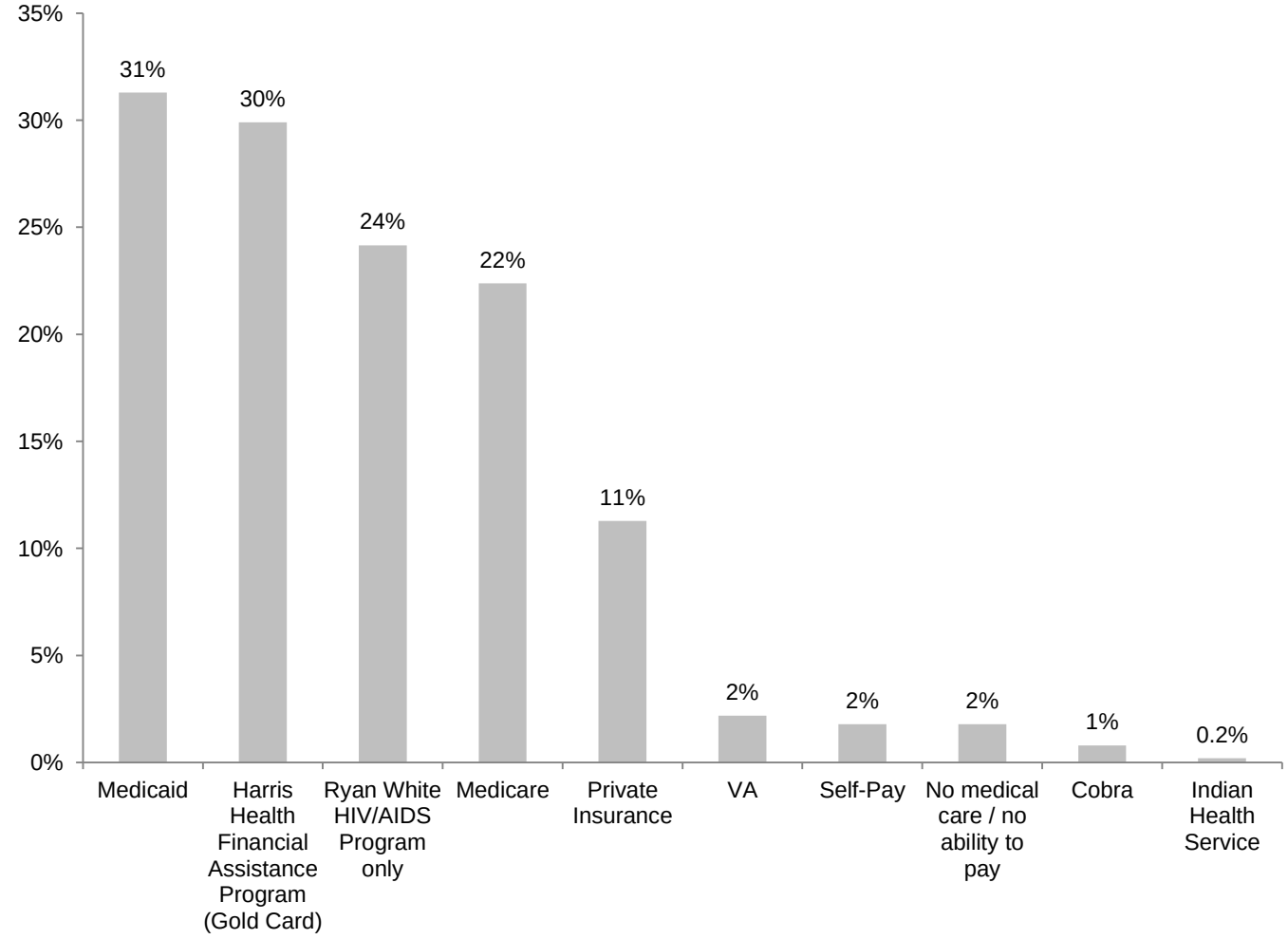
Medical Care Coverage

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 6**) 24% of participants stated they receive medical care *only* for HIV through the Ryan White Program, 2% stated that they pay for all medical care for themselves or their family out-of-pocket with no assistance, and 2% stated they did not receive medical care due to inability to pay. This means that the remaining participants (or 72%) 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, 32% of participants said they have Medicaid, 30% were in the Harris Health Financial Assistance Program (formerly Gold Card), and 22% had Medicare. Additionally, 11% had private health insurance. This is an increase of 175% from the 4% of participants who reported having private insurance in the 2014 needs assessment. This is most likely due to a combination of the opening of the Federal Health Insurance Marketplace as well as proactive efforts in the Houston Area to educate and assist PLWH with enrollment in Qualified Health Plans (QHP).

GRAPH 6-Sources of Medical Care Coverage among PLWH in the Houston Area, 2016

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 HIV/AIDS Program and if they did not receive medical care due to inability to pay.

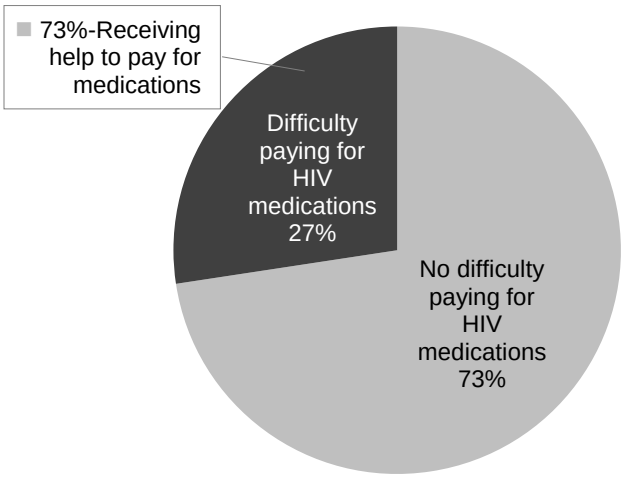


(Graph 7, Graph 8, and **Graph 9)** Participants were asked if they had experienced difficulty paying for prescription medications for HIV, other co-occurring physical conditions, or mental health conditions. Results are as follows (*in order*):

- 27% of participants on HIV medications reported difficulty paying for their prescriptions and, of those reporting difficulty, 73% were receiving financial assistance.

GRAPH 7-Difficulty Paying for HIV Medications among PLWH in the Houston Area, 2016

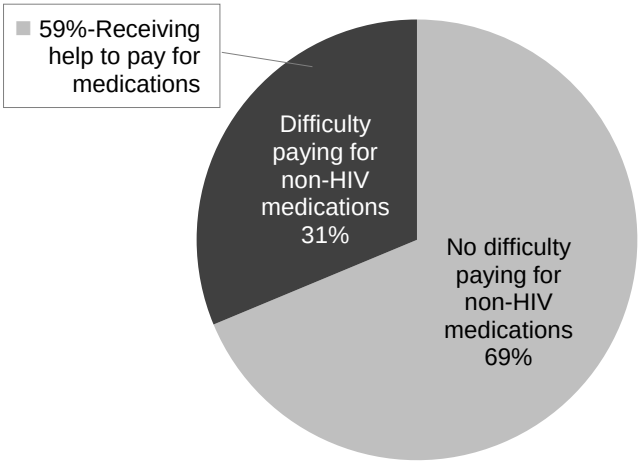
Definition: Percent of needs assessment participants who indicated difficulty paying for HIV medications and, of those, the percent receiving help.



- 31% 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, 59% were receiving financial assistance.

GRAPH 8-Difficulty Paying for Non-HIV Medications among PLWH in the Houston Area, 2016

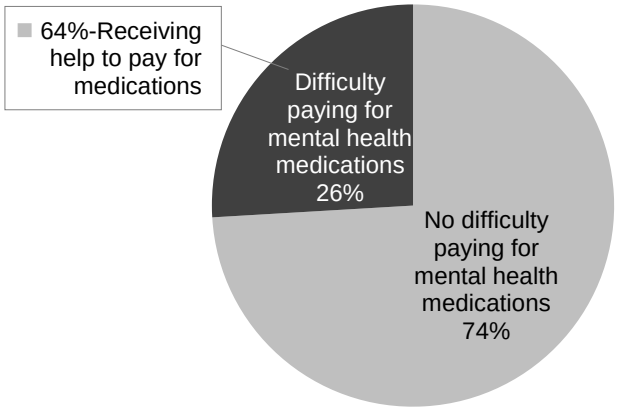
Definition: Percent of needs assessment participants who indicated difficulty paying for medications for non-HIV health conditions and, of those, the percent receiving help.



- 26% 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 9-Difficulty Paying for Mental Health Medications among PLWH in the Houston Area, 2016

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

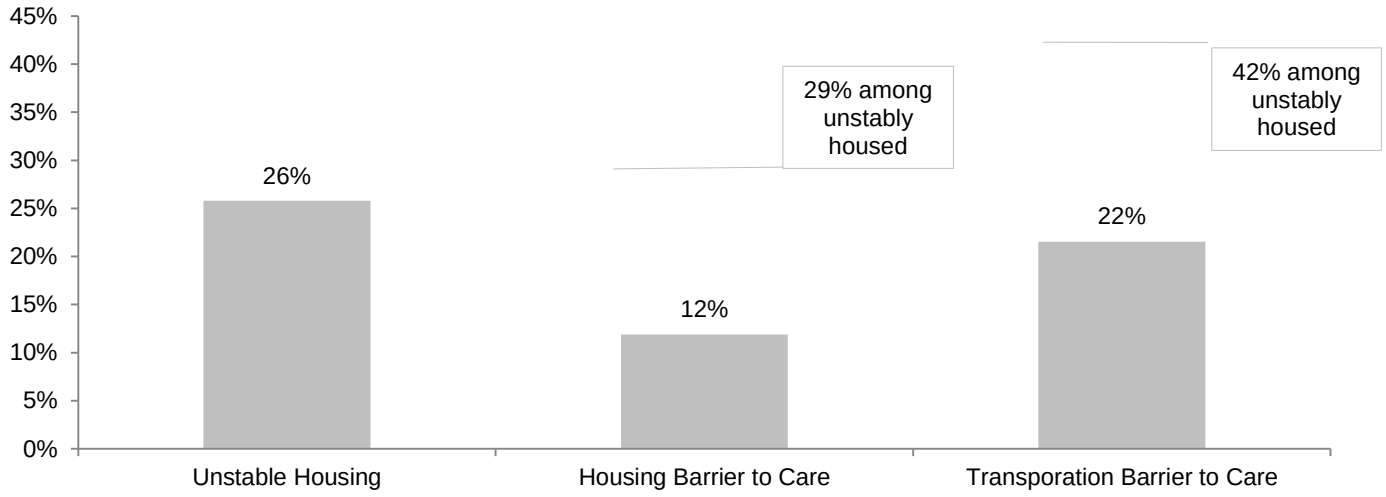


Housing and Transportation

(Graph 10) When asked whether their housing was stable, 74% of participants reported currently experiencing unstable housing situations. Participants were also asked whether their housing and transportation situations have interfered with getting HIV medical care. Twelve percent (12%) of all participants reported that their housing situation was a barrier to care, while 22% reported their transportation situation was a barrier to care. These proportions increased to 29% and 42% respectively when analyzed for unstably housed participants.

GRAPH 10-Housing and Transportation Barriers among PLWH in the Houston Area, 2016

Definition: Percent of needs assessment participants who selected reported unstable housing, a housing situation that interfered with HIV medical care, or a transportation situation that interfered with HIV medical care

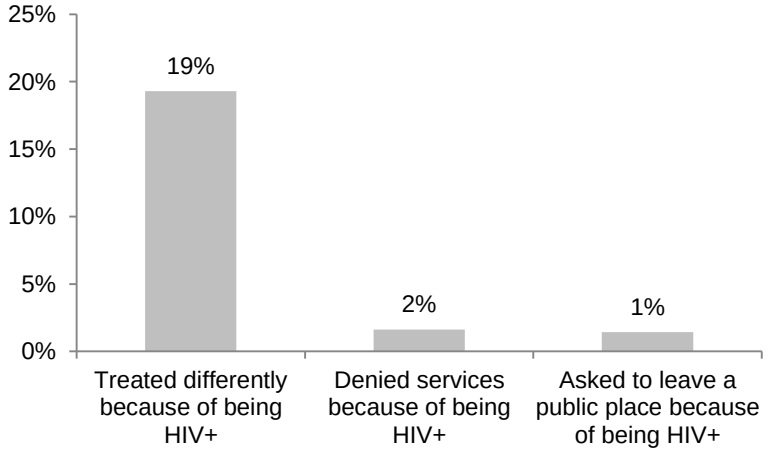


EXPERIENCE WITH DISCRIMINATION AND VIOLENCE

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. (Source: Health Resources and Services Administration, HIV/AIDS Bureau, *HRSA CARE Action*, Intimate Partner Violence, September 2009). The physical and emotional effects of experiencing discrimination and violence can impact the health of PLWH as well as their ability to access HIV care and other needed resources. The 2016 Houston HIV Care Services Needs Assessment explored participant experiences with discrimination, physical violence, and psychological violence.

GRAPH 11-HIV-Related Discrimination in the Houston Area, 2016

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

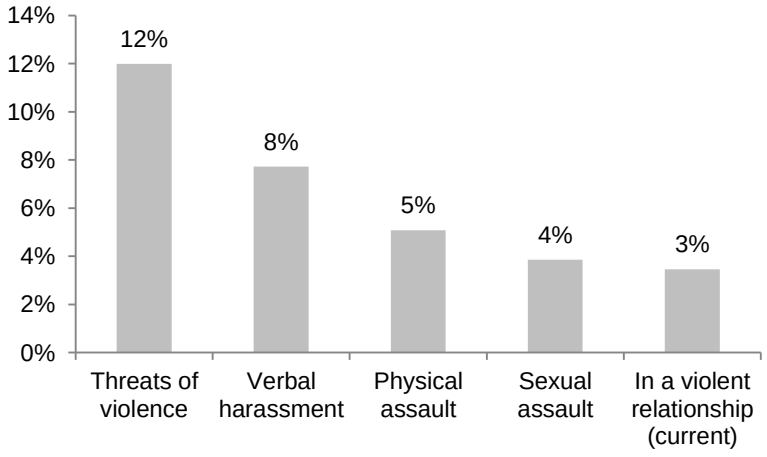


HIV-Related Discrimination

(**Graph 11**) Twenty percent (20%) of participants reported experiencing some form of discrimination in the past 12 months, most often in the form of being treated differently because of their positive status (19%), though this very rarely resulted in being denied services (2%) or being asked to leave a public place (1).

GRAPH 12-Violence Experienced by PLWH in the Houston Area, 2016

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



Experience with Violence

(**Graph 12**) Another 13% reported being threatened in the past 12 months, most often as threats of violence (12%) or verbal harassment (8%). Four percent (5%) had been physically assaulted, and 4% had been sexually assaulted. Among participants whose answers indicated they were transgender or gender non-conforming, the proportions who reported experiencing physical assault or sexual assault rose to 9% and 16%, respectively. Three percent (3%) of participants reported being in an intimate relationship with someone who made them feel afraid, threatened, isolated, who forced them to have sex, or who physically hurt them at the time of survey.

HIV PREVENTION BEHAVIORS AND RISKS

Please see 11-10-16 Comprehensive HIV Planning Committee Meeting Handout

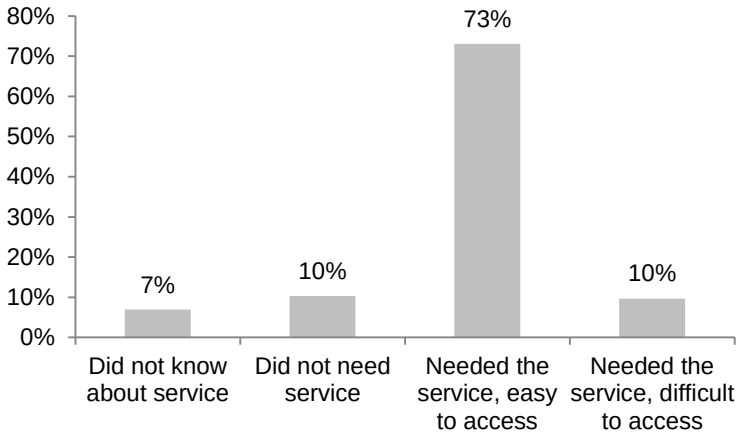
Service-Specific Fact Sheets

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 2016 Houston HIV Care Services Needs Assessment, 83% of participants indicated a need for *case management* in the past 12 months. 73% reported the service was easy to access, and 10% reported difficulty. 7% stated they did not know the service was available.

GRAPH 1-Case Management, 2016



(**Table 1**) When barriers to *case management* were reported, the most common barrier type was interactions with staff (54%). 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.

TABLE 1-Top 5 Reported Barrier Types for Case Management, 2016

	No.	%
1. Interactions with Staff (S)	19	54%
2. Education and Awareness (EA)	6	17%
3. Administrative (AD)	5	14%
4. Resource Availability (R)	2	6%
5. Eligibility (EL)	1	3%

(**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 other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.

In addition, more MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Case Management, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	7%	8%	1%	9%	7%	13%	13%	7%	7%
Did not need service	11%	8%	10%	11%	11%	0%	13%	7%	16%
Needed, easy to access	73%	76%	72%	73%	72%	87%	75%	76%	68%
Needed, difficult to access	10%	9%	17%	7%	11%	0%	0%	11%	9%

TABLE 3-Case Management, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[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%

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

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 2016 Houston HIV Care Services Needs Assessment, 31% of participants indicated a need for *day treatment* in the past 12 months. 29% reported the service was easy to access, and 2% reported difficulty. 18% stated that they did not know the service was available.

(**Table 1**) When barriers to *day treatment* were reported, the most common barrier types were administrative (complex processes), eligibility (ineligible), health insurance-related (being uninsured), interactions with staff (poor communication or follow up), transportation (lack of transportation).

GRAPH 1-Day Treatment, 2016

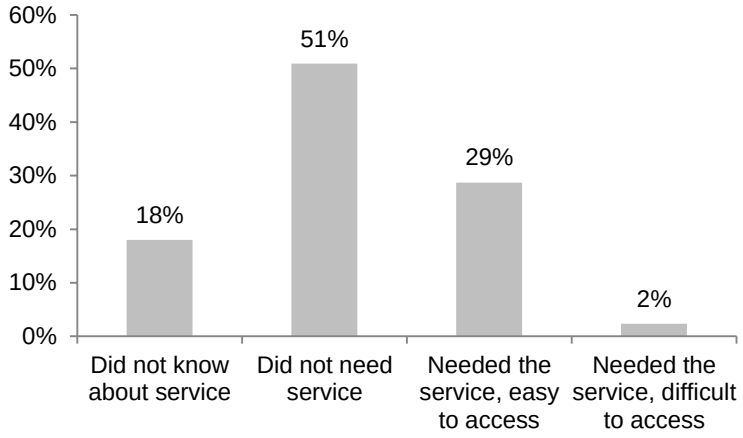


TABLE 1-Top 5 Reported Barrier Types for Day Treatment, 2016

	No.	%
1. Administrative (AD)	1	17%
2. Eligibility (EL)	1	17%
3. Health Insurance Coverage (I)	1	17%
4. Interactions with Staff (S)	1	17%
5. Transportation (T)	1	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 males than females found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.
- In addition, more unstably housed PLWH found the service difficult to access when compared to all participants.

TABLE 2- Day Treatment, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	18%	18%	28%	17%	15%	0%	30%	20%	12%
Did not need service	49%	56%	56%	49%	50%	53%	52%	45%	61%
Needed, easy to access	30%	23%	13%	33%	31%	47%	17%	32%	24%
Needed, difficult to access	2%	3%	3%	1%	5%	0%	0%	2%	3%

TABLE 3- Day Treatment, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	27%	19%	50%	24%	32%	18%
Did not need service	38%	49%	50%	38%	50%	27%
Needed, easy to access	32%	30%	0%	38%	18%	55%
Needed, difficult to access	3%	2%	0%	0%	0%	0%

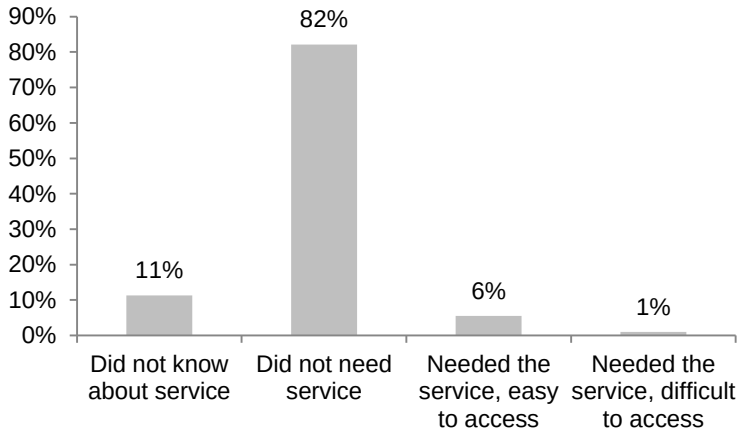
[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

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 2014 Houston Area HIV needs assessment, 7% of participants indicated a need for *early intervention services* in the past 12 months. 6% reported the service was easy to access, and 1% reported difficulty. 11% stated that they did not know the service was available.

GRAPH 1-Early Intervention (Jail Only), 2016



(**Table 1**) When barriers to *early intervention services* were reported, the most common barrier type was accessibility (40%). Accessibility barriers reported include release from incarceration.

TABLE 1-Top 4 Reported Barrier Types for Early Intervention (Jail Only), 2016

		No.	%
1.	Accessibility (AC)	2	40%
2.	Interactions with Staff (S)	1	20%
3.	Resource Availability (R)	1	20%
4.	Transportation (T)	1	20%
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(**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 males than females found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.
- In addition, more recently release and unstably housed PLWH found the service difficult to access when compared to all participants.

TABLE 2-Early Intervention (Jail Only), by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	8%	13%	13%	7%	14%	4%	15%	7%
Did not need service	81%	86%	86%	80%	88%	43%	96%	77%	88%
Needed, easy to access	6%	5%	1%	6%	5%	43%	0%	6%	5%
Needed, difficult to access	1%	2%	0%	2%	0%	0%	0%	1%	1%

TABLE 3-Early Intervention (Jail Only), by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	11%	12%	0%	26%	0%	9%
Did not need service	78%	82%	100%	26%	97%	86%
Needed, easy to access	9%	6%	0%	42%	3%	5%
Needed, difficult to access	2%	1%	0%	5%	0%	0%

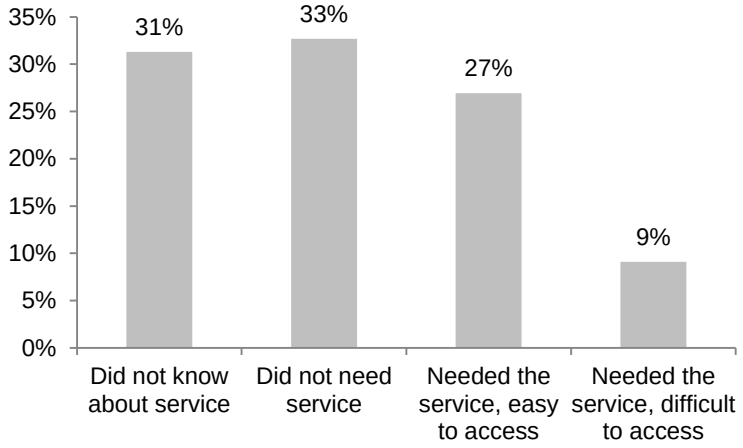
[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

FOOD PANTRY

Food pantry is the provision of food and/or household items to persons living with HIV (PLWH). This service can be provided in the form of actual goods (such as through a food bank) or as vouchers for food. In the Houston Area, other non-Ryan White programs provide food bank services to PLWH.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 36% of participants indicated a need for *food pantry* in the past 12 months. 27% reported the service was easy to access, and 9% reported difficulty. 31% stated that they did not know the service was available.

GRAPH 1-Food Pantry, 2016



(**Table 1**) When barriers to *food pantry* were reported, the most common barrier type was education and awareness (45%). Education and awareness barriers reported include lack of knowledge about service availability, location, staff contact.

TABLE 1-Top 5 Reported Barrier Types for Food Pantry, 2016

		No.	%
1.	Education and Awareness (EA)	19	45%
2.	Eligibility (EL)	5	12%
3.	Interactions with Staff (S)	5	12%
4.	Resource Availability (R)	3	7%
5.	Transportation (T)	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 *food pantry*, 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 25 to 49 found the service accessible than other age groups.
- In addition, more out of care, unstably housed, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Food Pantry, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	32%	30%	33%	31%	31%	21%	48%	32%	28%
Did not need service	34%	27%	40%	28%	36%	36%	52%	31%	33%
Needed, easy to access	26%	31%	16%	33%	23%	43%	0%	30%	27%
Needed, difficult to access	8%	12%	10%	8%	10%	0%	0%	8%	12%

TABLE 3-Food Pantry, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	42%	31%	50%	28%	35%	29%
Did not need service	17%	36%	0%	28%	41%	19%
Needed, easy to access	31%	23%	0%	38%	15%	52%
Needed, difficult to access	11%	10%	50%	5%	9%	0%

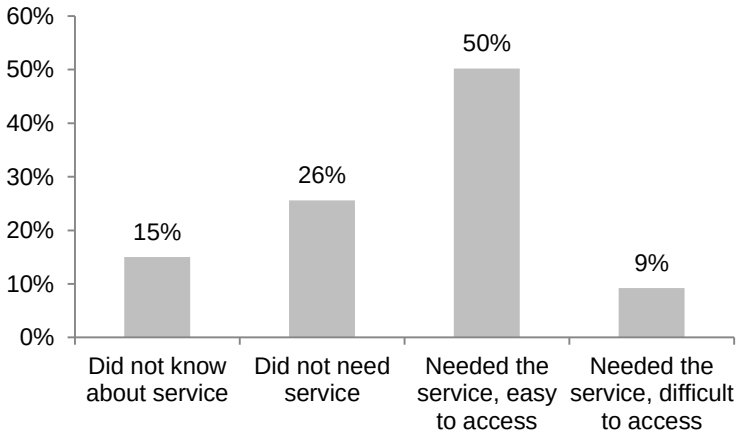
[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

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, 59% of participants indicated a need for *health insurance assistance* in the past 12 months. 50% reported the service was easy to access, and 9% reported difficulty. 15% stated that they did not know the service was available.

GRAPH 1-Health Insurance Assistance, 2016



(**Table 1**) When barriers to *health insurance assistance* were reported, the most common barrier type was related to health insurance coverage (31%). Health insurance-related barriers reported include being uninsured, having coverage gaps, and difficulty with ACA enrollment.

TABLE 1-Top 5 Reported Barrier Types for Health Insurance Assistance, 2016

	No.	%
1. Health Insurance Coverage (I)	15	31%
2. Education and Awareness (EA)	10	21%
3. Administrative (AD)	6	13%
4. Eligibility (EL)	6	13%
5. Financial (F)	5	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:

- More males than females 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 rural PLWH found the service difficult to access when compared to all participants.

TABLE 2-Health Insurance Assistance, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	14%	19%	8%	17%	16%	20%	35%	18%	8%
Did not need service	25%	27%	26%	27%	25%	0%	30%	23%	28%
Needed, easy to access	52%	42%	54%	46%	53%	67%	30%	50%	54%
Needed, difficult to access	8%	12%	11%	10%	6%	13%	4%	9%	9%

TABLE 3-Health Insurance Assistance, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	21%	12%	0%	16%	15%	5%
Did not need service	27%	25%	0%	24%	24%	27%
Needed, easy to access	42%	56%	100%	42%	47%	64%
Needed, difficult to access	9%	7%	0%	18%	15%	5%

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

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 2016 Houston HIV Care Services Needs Assessment, 7% of participants indicated a need for *hospice* in the past 12 months. 7% reported the service was easy to access, and 0.1% reported difficulty. 16% stated that they did not know the service was available.

(**Table 1**) When barriers to *hospice* were reported, the only barrier type identified was education and awareness (lack of knowledge about the availability the service)

TABLE 1- Reported Barrier Type for Hospice, 2016

		No.	%
1.	Education and Awareness (EA)	2	100%
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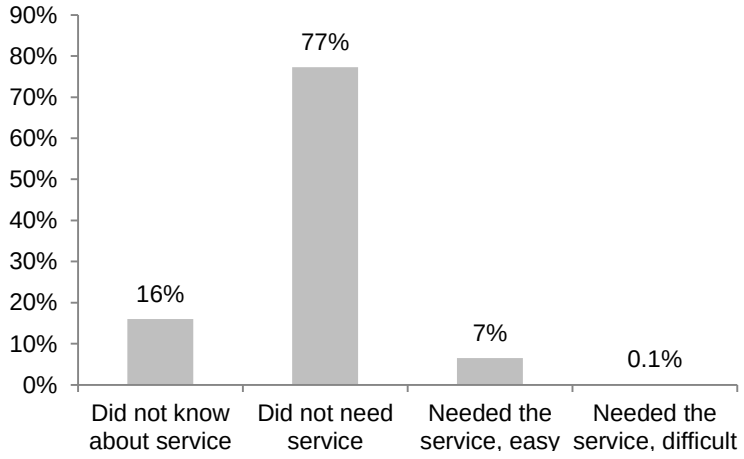
GRAPH 1-Hospice, 2016



(**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 males than females found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 50+ found the service accessible than other age groups.
- No PLWH in special populations found the service difficult to access compared to all participants.

TABLE 2-Hospice, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	16%	17%	10%	16%	20%	0%	21%	18%	12%
Did not need service	77%	77%	84%	75%	74%	13%	75%	77%	78%
Needed, easy to access	7%	6%	6%	8%	5%	87%	4%	5%	11%
Needed, difficult to access	0%	0%	0%	0%	0%	0%	0%	0%	0%

TABLE 3- Hospice, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	20%	13%	50%	21%	15%	14%
Did not need service	74%	80%	50%	74%	79%	77%
Needed, easy to access	6%	7%	0%	5%	6%	9%
Needed, difficult to access	0%	0%	0%	0%	0%	0%

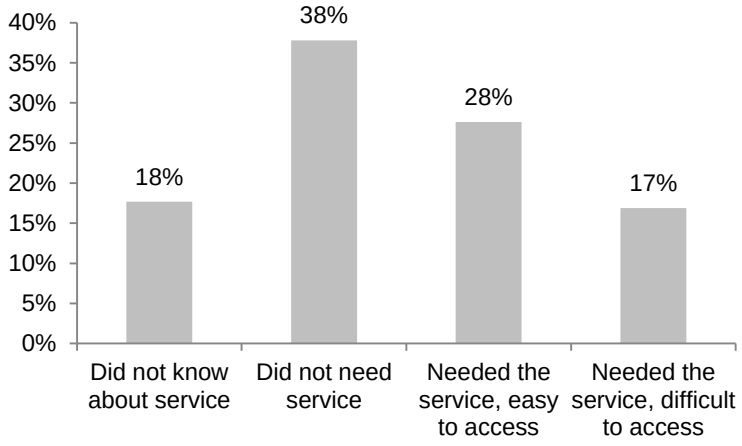
[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

HOUSING

Housing for persons living with HIV (PLWH) is provided by the Housing Opportunities for People with AIDS (HOPWA) program through the Houston Housing and Community Development Department. Services include short-term rent, mortgage, and utility assistance as well as community-based supportive housing facilities for PLWH and their families.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 45% of participants indicated a need for *housing* in the past 12 months. 28% reported the service was easy to access, and 17% reported difficulty. 18% stated that they did not know the service was available.

GRAPH 1-Housing, 2016



(**Table 1**) When barriers to *housing* were reported, the most common barrier types were education and awareness (25%) and wait-related issues (25%). Education and awareness barriers reported include lack of knowledge about service availability, location, staff contact, and definition. Wait-related barriers reported include placement on a waiting list, being told a wait list was full/unavailable, and long durations between application and approval.

TABLE 1-Top 5 Reported Barrier Types for Housing, 2016

		No.	%
1.	Education and Awareness (EA)	22	25%
2.	Wait (W)	22	25%
3.	Eligibility (EL)	12	14%
4.	Housing (H)	8	9%
5.	Interactions with Staff (S)	7	8%

(**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 *housing*, this analysis shows the following:

- More females than males found the service accessible.
- More African American/black 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 unstably housed and transgender PLWH found the service difficult to access when compared to all participants.

TABLE 2-Housing, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	20%	11%	19%	23%	6%	35%	20%	13%
Did not need service	41%	28%	47%	29%	42%	81%	26%	36%	41%
Needed, easy to access	27%	30%	20%	35%	22%	13%	35%	28%	26%
Needed, difficult to access	15%	22%	22%	17%	14%	0%	4%	16%	20%

TABLE 3-Housing, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	29%	18%	50%	18%	24%	14%
Did not need service	19%	45%	50%	26%	56%	33%
Needed, easy to access	20%	23%	0%	42%	12%	33%
Needed, difficult to access	33%	14%	0%	13%	9%	19%

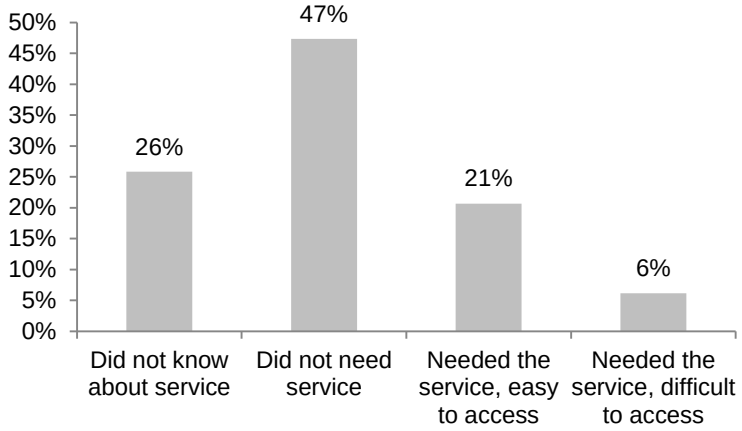
[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

LEGAL SERVICES

Legal services provides licensed attorneys to persons living with HIV (PLWH) to assist with permanency planning and various legal interventions that maintain health and other benefits. This includes estate planning, wills, guardianships, and powers-of-attorney as well as discrimination, entitlement, and insurance disputes.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 27% of participants indicated a need for *legal services* in the past 12 months. 21% reported the service was easy to access, and 6% reported difficulty. 26% stated that they did not know the service was available.

GRAPH 1-Legal Services, 2016



(**Table 1**) When barriers to *legal services* were reported, the most common barrier type was education and awareness (54%). Education and awareness barriers reported include lack of knowledge about service availability, staff contact, definition, and location.

TABLE 1-Top 5 Reported Barrier Types for Legal Service, 2016

	No.	%
1. Education and Awareness (EA)	13	54%
2. Interactions with Staff (S)	7	29%
3. Administrative (AD)	1	4%
4. Eligibility (EL)	1	4%
5. Financial (F)	1	4%

(**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 *legal services*, this analysis shows the following:

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

TABLE 2-Legal Services, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	27%	23%	30%	25%	31%	36%	43%	30%	17%
Did not need service	47%	47%	40%	50%	34%	21%	43%	46%	49%
Needed, easy to access	20%	23%	20%	20%	20%	43%	13%	19%	25%
Needed, difficult to access	6%	8%	10%	4%	15%	0%	0%	5%	9%

TABLE 3-Legal Services, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	31%	26%	50%	27%	17%	23%
Did not need service	43%	47%	50%	43%	48%	65%
Needed, easy to access	22%	22%	0%	19%	31%	6%
Needed, difficult to access	5%	6%	0%	11%	3%	6%

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

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 2016 Houston HIV Care Services Needs Assessment, 74% of participants indicated a need for *local HIV medication assistance* in the past 12 months. 66% reported the service was easy to access, and 8% reported difficulty. 10% 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 related to health insurance coverage (24%). Health insurance-related barriers reported include having coverage gaps and being uninsured.

GRAPH 1-Local HIV Medication Assistance, 2016

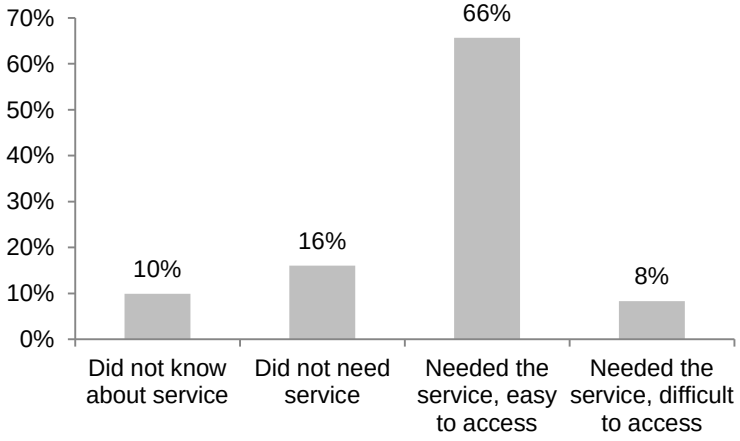


TABLE 1-Top 5 Reported Barrier Types for Local HIV Medication Assistance, 2016

	No.	%
1. Health Insurance Coverage (I)	8	24%
2. Administrative (AD)	4	12%
3. Education and Awareness (EA)	3	9%
4. Eligibility (EL)	3	9%
5. Financial (F)	3	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 *local HIV medication assistance*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial 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, rural and recently released PLWH found the service difficult to access when compared to all participants.

TABLE 2-Local HIV Medication Assistance, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	10%	9%	7%	12%	9%	0%	5%	11%	8%
Did not need service	18%	11%	16%	17%	11%	53%	14%	14%	20%
Needed, easy to access	65%	68%	71%	62%	73%	33%	76%	66%	64%
Needed, difficult to access	7%	11%	7%	9%	7%	13%	5%	8%	8%

TABLE 3-Local HIV Medication Assistance, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	12%	8%	100%	13%	0%	14%
Did not need service	19%	18%	0%	3%	12%	14%
Needed, easy to access	61%	67%	0%	74%	73%	71%
Needed, difficult to access	8%	8%	0%	11%	15%	0%

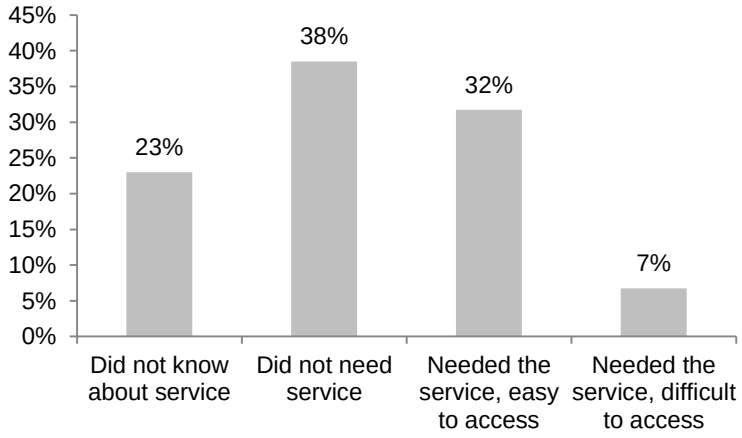
[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

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 2016 Houston HIV Care Services Needs Assessment, 38% of participants indicated a need for *medical nutrition therapy* in the past 12 months. 32% reported the service was easy to access, and 7% reported difficulty. 23% stated that they did not know the service was available.

GRAPH 1-Medical Nutrition Therapy, 2016



(**Table 1**) When barriers to *medical nutrition therapy* were reported, the most common barrier types was education and awareness (34%) Education and awareness barriers reported include lack of knowledge about service availability and location.

TABLE 1-Top 5 Reported Barrier Types for Medical Nutrition Therapy, 2016

	No.	%
1. Education and Awareness (EA)	10	34%
2. Administrative (AD)	4	14%
3. Eligibility (EL)	4	14%
4. Interactions with Staff (S)	3	10%
5. Wait (W)	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 *medical nutrition therapy*, this analysis shows the following:

- More male than females found the service accessible.
- More African American/black PLWH than other race/ethnicities found the service accessible.
- More PLWH age 25 to 49 found the service accessible than other age groups.
- In addition, more rural and unstably housed PLWH found the service difficult to access when compared to all participants.

TABLE 2-Medical Nutrition Therapy, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	24%	19%	21%	24%	23%	14%	54%	23%	18%
Did not need service	37%	42%	40%	35%	40%	71%	29%	36%	45%
Needed, easy to access	32%	31%	30%	34%	31%	14%	13%	35%	29%
Needed, difficult to access	6%	8%	9%	7%	5%	0%	4%	6%	8%

TABLE 3-Medical Nutrition Therapy, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	35%	22%	0%	18%	40%	14%
Did not need service	28%	37%	100%	34%	34%	36%
Needed, easy to access	30%	35%	0%	42%	14%	45%
Needed, difficult to access	8%	7%	0%	5%	11%	5%

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

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.

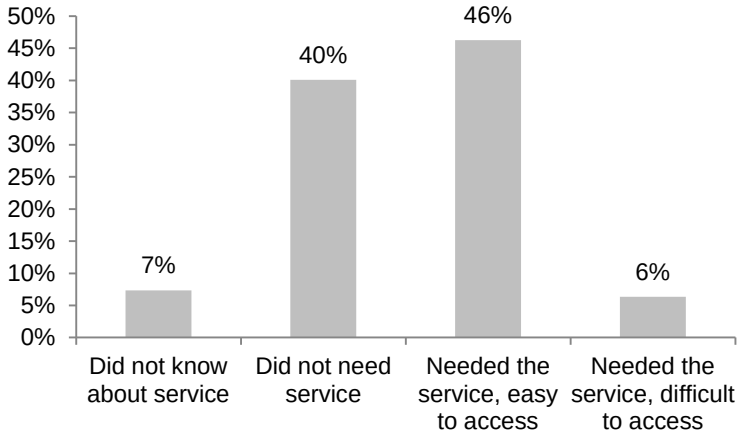
(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 53% of participants indicated a need for *mental health services* in the past 12 months. 46% reported the service was easy to access, and 6% reported difficulty. 7% stated that they did not know the service was available.

(**Table 1**) When barriers to *mental health services* were reported, the most common barrier types were administrative (25%) and wait-related barriers (25%). Administrative barriers reported include hours of operation, complex processes, and staff changes without notification to the client. Wait-related barriers reported include placement on a waitlist.

TABLE 1-Top 5 Reported Barrier Types for Mental Health Services, 2016

	No.	%
1. Administrative (AD)	6	25%
2. Wait (W)	6	25%
3. Health Insurance Coverage (I)	2	8%
4. Interactions with Staff (S)	2	8%
5. Resource Availability (R)	2	8%

GRAPH 1-Mental Health Services, 2016



(**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 females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to24 found the service accessible than other age groups.
- In addition, more rural and unstably housed PLWH found the service difficult to access when compared to all participants.

TABLE 2-Mental Health Services, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	8%	6%	4%	8%	9%	0%	13%	8%	6%
Did not need service	40%	39%	29%	41%	47%	40%	33%	39%	43%
Needed, easy to access	46%	48%	57%	45%	39%	60%	54%	47%	44%
Needed, difficult to access	6%	8%	10%	6%	5%	0%	0%	6%	7%

TABLE 3-Mental Health Services, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	11%	5%	0%	3%	0%	14%
Did not need service	25%	37%	50%	22%	50%	18%
Needed, easy to access	53%	51%	50%	69%	35%	68%
Needed, difficult to access	10%	6%	0%	6%	15%	0%

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

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).

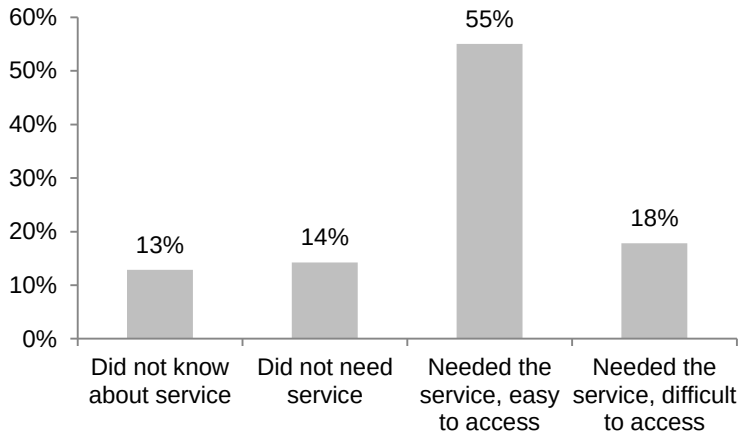
(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 73% of participants indicated a need for *oral health care* in the past 12 months. 55% reported the service was easy to access, and 18% reported difficulty. 13% stated that they did not know the service was available.

(**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, being told a wait list was full/unavailable, and long durations between application and approval.

TABLE 1-Top 5 Reported Barrier Types for Oral Health Care, 2016

	No.	%
1. Wait (W)	29	35%
2. Interactions with Staff (S)	11	13%
3. Health Insurance Coverage (I)	10	12%
4. Eligibility (EL)	8	10%
5. Administrative (AD)	7	8%

GRAPH 1-Oral Health Care, 2016



(**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 females than males found the service accessible.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 50+ found the service accessible than other age groups.
- In addition, more rural, unstably housed, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Oral Health Care, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	13%	12%	3%	16%	15%	13%	35%	15%	6%
Did not need service	16%	8%	8%	17%	15%	7%	13%	16%	11%
Needed, easy to access	54%	60%	68%	51%	52%	60%	35%	50%	66%
Needed, difficult to access	17%	20%	21%	17%	18%	20%	17%	19%	16%

TABLE 3-Oral Health Care, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	17%	11%	0%	21%	9%	14%
Did not need service	12%	14%	0%	29%	6%	10%
Needed, easy to access	47%	55%	100%	34%	50%	71%
Needed, difficult to access	25%	19%	0%	16%	35%	5%

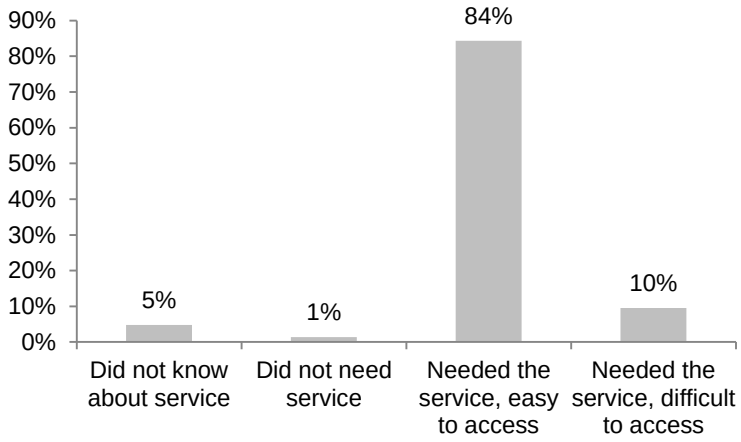
[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

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 2016 Houston HIV Care Services Needs Assessment, 94% of participants indicated a need for *primary HIV medical care* in the past 12 months. 84% reported the service was easy to access, and 10% reported difficulty. 5% stated that they did not know the service was available.

GRAPH 1-Primary HIV Medical Care, 2016



(**Table 1**) When barriers to *primary HIV medical care* were reported, the most common barrier type was administrative (19%). Administrative barriers reported include complex processes, staff, hours of operation, understaffing, and service changes without client notification.

TABLE 1-Top 5 Reported Barrier Types for Primary HIV Medical Care, 2016

	No.	%
1. Administrative (AD)	8	19%
2. Interactions with Staff (S)	6	14%
3. Transportation (T)	6	14%
4. Wait (W)	6	14%
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 *primary HIV medical care*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH and whites 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, rural, transgender, recently released, and unstably housed PLWH found the service difficult to access when compared to all participants.

TABLE 2-Primary HIV Medical Care, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	5%	3%	5%	4%	6%	0%	0%	6%	4%
Did not need service	1%	2%	0%	2%	2%	0%	0%	2%	2%
Needed, easy to access	84%	86%	83%	85%	85%	87%	83%	83%	86%
Needed, difficult to access	10%	9%	12%	9%	8%	13%	17%	10%	9%

TABLE 3-Primary HIV Medical Care, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	7%	4%	0%	11%	0%	14%
Did not need service	0%	1%	0%	0%	0%	0%
Needed, easy to access	81%	85%	67%	79%	79%	73%
Needed, difficult to access	12%	10%	33%	11%	21%	14%

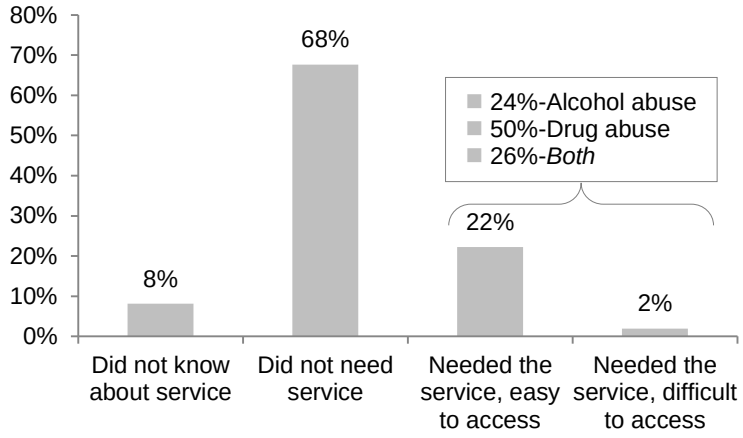
[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

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 abuse concern in an outpatient setting and in accordance with state licensing guidelines. This includes services for alcohol abuse and/or abuse of legal or illegal drugs.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 24% of participants indicated a need for *substance abuse services* in the past 12 months. 22% reported the service was easy to access, and 2% reported difficulty. 8% stated they did not know the service was available. When analyzed by type of substance concern, 24% of participants cited alcohol, 56% cited drugs, and 26% cited both.

GRAPH 1-Substance Abuse Services, 2016



(**Table 1**) When barriers to *substance abuse services* were reported, the most common barrier types were education and awareness (lack of knowledge about location), eligibility (ineligibly), and health-insurance related (being uninsured).

TABLE 1-Top 3 Reported Barrier Types for Substance Abuse Services, 2016

	No.	%
1. Education and Awareness (EA)	1	33%
2. Eligibility (EL)	1	33%
3. Health Insurance Coverage (I)	1	33%
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(**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 white PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 50+ found the service accessible than other age groups.
- In addition, more recently released, unstably housed, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Substance Abuse Services, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	8%	8%	2%	10%	11%	0%	30%	9%	4%
Did not need service	69%	64%	73%	65%	70%	60%	48%	68%	70%
Needed, easy to access	21%	26%	24%	23%	17%	40%	17%	22%	24%
Needed, difficult to access	2%	2%	1%	2%	2%	0%	4%	2%	1%

TABLE 3-Substance Abuse Services, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	14%	9%	50%	8%	9%	18%
Did not need service	61%	68%	50%	42%	88%	50%
Needed, easy to access	23%	21%	0%	39%	3%	32%
Needed, difficult to access	2%	2%	0%	11%	0%	0%

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

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 2016 Houston HIV Care Services Needs Assessment, 47% of participants indicated a need for *transportation services* in the past 12 months. 40% reported the service was easy to access, and 7% reported difficulty. 10% stated they did not know the service was available. When analyzed by type transportation assistance sought, 84% of participants needed bus passes, 10% needed van services, and 6% needed both forms of assistance.

(**Table 1**) When barriers to *transportation services* were reported, the most common barrier type was transportation (28%). Transportation barriers reported include both lack of transportation and difficulty with special transportation providers.

GRAPH 1-Transportation Services, 2016

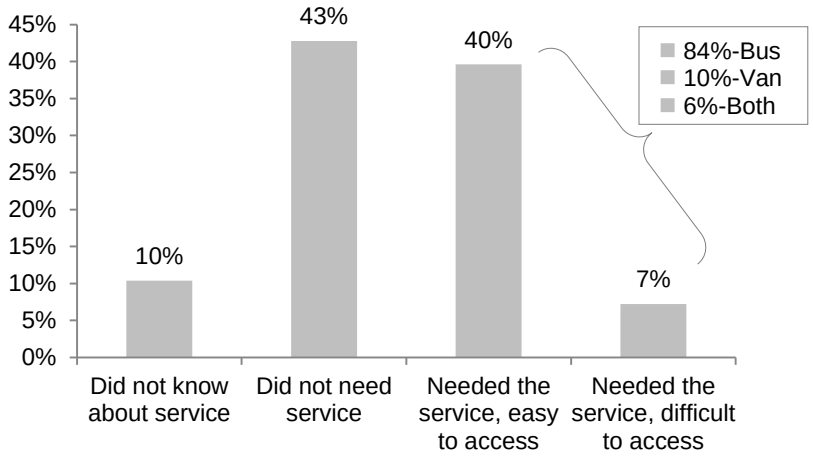

TABLE 1-Top 5 Reported Barrier Types for Transportation Services, 2016

		No.	%
1.	Transportation (T)	9	28%
2.	Education and Awareness (EA)	6	19%
3.	Eligibility (EL)	4	13%
4.	Accessibility (AC)	3	9%
5.	Resource Availability (R)	3	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 *transportation services,* this analysis shows the following:

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

TABLE 2-Transportation Services, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	11%	8%	7%	9%	15%	13%	22%	10%	9%
Did not need service	47%	31%	55%	36%	41%	87%	43%	44%	40%
Needed, easy to access	35%	55%	27%	48%	38%	0%	30%	38%	44%
Needed, difficult to access	8%	6%	10%	8%	5%	0%	4%	8%	7%

TABLE 3-Transportation Services, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	17%	13%	50%	8%	6%	14%
Did not need service	27%	49%	50%	22%	72%	18%
Needed, easy to access	46%	31%	0%	59%	16%	50%
Needed, difficult to access	10%	8%	0%	11%	6%	18%

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

d

2016 Houston Area HIV Care Services Needs Assessment
Approved: PENDING

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2016 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 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**