HIV/AIDS in the Houston EMA and HSDA

The HIV/AIDS epidemic has affected people of all gender, age and racial/ethnic groups in the Houston EMA and HSDA. This effect, however, has not been the same for all groups. In the beginning of the epidemic, HIV disease was most often found among white men who have sex with men (MSM) – today, Blacks/African-Americans by far represent the majority of cases and recent trends also identify an increase among Hispanic/Latino men and women.

This section provides detailed information about the reported demographic and risk characteristics of HIV-infected people through December 31, 2008. Due to reporting lags for mortality (death) statistics, the most recent year for complete mortality data is 2007.

This report uses Texas Department of State Health Services (DSHS) HIV/AIDS Reporting System (HARS) surveillance data through December 31, 2008. Although this is the most current data available for the purposes of this report, newly diagnosed cases and prevalence (people living with HIV/AIDS, or PLWHA) data may be incomplete due to delays in data reporting and processing. In general, however, the data presented here provides an accurate picture of the overall epidemic and its current trends.

This analysis will compare newly diagnosed cases with living cases to identify trends in the epidemic in the Houston EMA and HSDA. Although various tables may appear similar because differences between the two regions are relatively small, please be aware that EMA-specific tables follow HSDA tables. For special populations, new cases are identified for the HSDA only, as the differences are so small that the proportions are virtually identical to new cases among the EMA.

Data Sources

Unless otherwise noted, all surveillance data are from the Texas DSHS HARS. The data represents cases through December 31, 2008, extracted as of September 2009. Please note that the data has not been adjusted for reporting delay nor redistributed for unreported risk exposure. The category of NIR/NRR (No Indicated Risk or No Reported Risk) represents cases of HIV or AIDS whose associated transmission modes remain unclassified. Rates are calculated as cases per 100,000 based upon 2007 and 2008 population estimates from the DSHS Center for Health Statistics.

HIV and AIDS 2008 Incidence (New Diagnoses)

Incidence is a term commonly used in epidemiology to refer to newly diagnosed cases. Incidence may be defined over a period of time that the new cases were diagnosed. *For the purposes of this report, incidence reflects cases diagnosed throughout 2008, and newly diagnosed AIDS cases include both previously diagnosed HIV cases that have progressed to AIDS as well as newly identified AIDS cases that have not been previously identified as HIV positive.*

In 2008, the HSDA had a total of 1,903 newly diagnosed HIV/AIDS cases while the EMA had 1,872 HIV/AIDS cases.

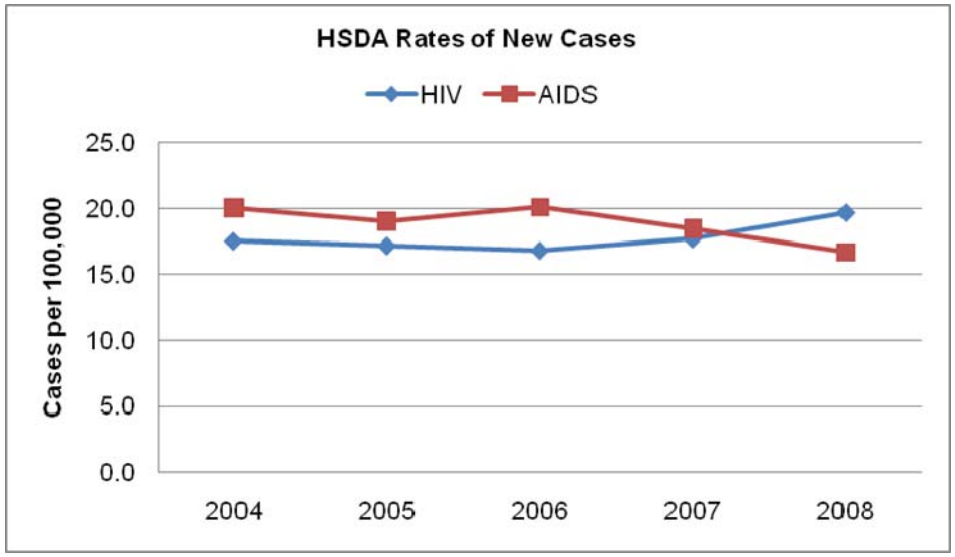
- There were 1,029 newly diagnosed HIV cases that had not progressed to AIDS in the HSDA, and 874 new AIDS diagnoses. In the EMA, these numbers were 1,016 for HIV and 856 for AIDS. Since the numbers are similar, the 2008 HIV infection rate is approximately 20 per 100,000 for both the HSDA and EMA. The demographic proportions of those newly diagnosed with HIV/AIDS are almost identical in the EMA and HSDA.
- Blacks/African-Americans had the highest rate of new HIV infections (65 per 100,000 in the HSDA, up from 59 in 2007). This is almost six times greater than the rate for Hispanics/Latinos (12 per 100,000) and seven times that of Whites (9 per 100,000).
- Generalizing about transmission mode is difficult since unreported risk is very high among the newly diagnosed. Unreported risk among those with new HIV diagnoses accounts for approximately 33%, while 24% of new AIDS diagnoses have unreported risk behavior.
    - Forty-four percent (44%) of new HIV infections were attributed to MSM, and 20% were attributed to heterosexual contact. These two transmission modes accounted for the highest proportion of newly diagnosed HIV infections during 2008 compared to intravenous drugs users (3%) and MSM/IDU (1%).
- Harris County clearly remains the epicenter of the epidemic with 92% and 93% of 2008 newly diagnosed HIV and AIDS cases in the HSDA and EMA, respectively.
- From 2004 to 2006, the rate of HIV diagnoses appeared to remain relatively stable at around 17 per 100,000. Since 2006, it has demonstrated an increase, to approximately 20 per 100,000 (15% increase). For AIDS diagnoses, the rate has remained around 20 per 100,000 from 2004 to 2006. Since 2006, the rate has declined, to around 17 per 100,000 in 2008 (15% decrease).

Table 11: HIV, AIDS and Total Diagnoses, Houston HSDA, 2008

HSDA	New HIV			New AIDS			New HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	1,029	100.0	19.7	874	100.0	16.7	1,903	100.0	36.4
Gender									
Male	771	74.9	29.3	621	71.1	23.6	1,392	73.1	52.9
Female	258	25.1	9.9	253	28.9	9.7	511	26.9	19.6
Race/Ethnicity									
White	187	18.2	9.2	160	18.3	7.9	347	18.2	17.2
Black/African-American	598	58.1	65.2	484	55.4	52.8	1,082	56.9	118.0
Hispanic/Latino	221	21.5	11.5	214	24.5	11.1	435	22.9	22.6
Other	23	2.2	6.2	16	1.8	4.3	39	2.0	10.5
Age (yrs)									
0-12	3	0.3	1.2	0	0.0	0.0	3	.2	1.2
13-24	239	23.2	25.3	61	7.0	6.5	300	15.8	31.8
25-34	324	31.5	38.9	259	29.6	31.1	583	30.6	69.9
35-44	264	25.7	33.4	288	33.0	36.4	552	29.0	69.8
45-54	147	14.3	20.1	183	20.9	25.0	330	17.3	45.1
55+	52	5.1	5.7	83	9.5	9.1	135	7.1	14.8
Transmission Mode									
MSM	450	43.7	*	310	35.5	*	760	39.9	*
IDU	28	2.7	*	86	9.8	*	114	6.0	*
MSM & IDU	8	0.8	*	36	4.1	*	44	2.3	*
Heterosexual	197	19.1	*	231	26.4	*	428	22.5	*
Perinatal Exposure	2	0.2	*	4	0.5	*	6	0.3	*
NIR/NRR	344	33.4	*	207	23.7	*	551	29.0	*
Location									
Harris County	953	92.6	24.0	794	90.8	20.0	1,747	91.8	44.1
Non-Harris County	76	7.4	6.0	80	9.2	6.3	156	8.2	12.3

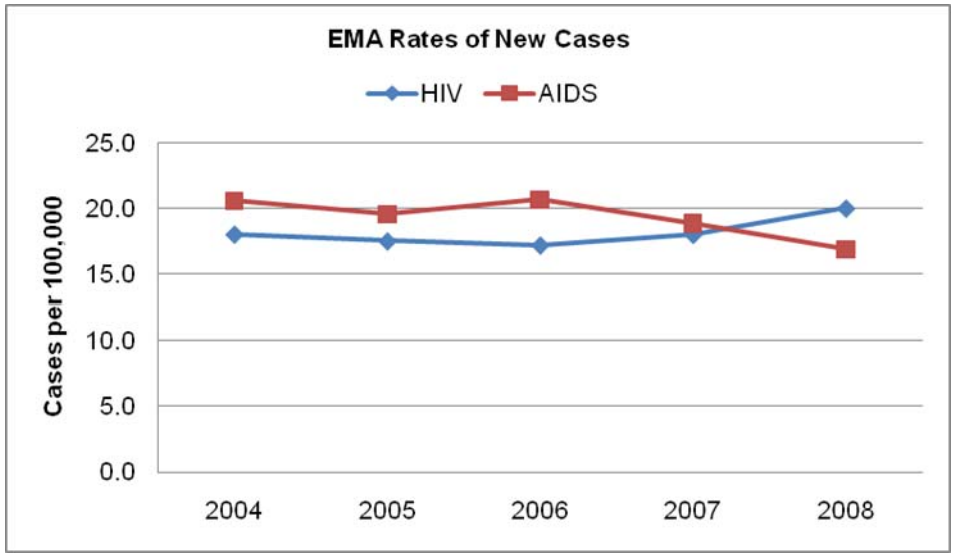
Data source: Texas DSHS HARS Data

Figure 2: Rates of New HIV/AIDS Cases, Houston HSDA, 2004–2008



Data source: Texas DSHS HARS Data

Figure 3: Rates of new HIV/AIDS cases, Houston EMA, 2004–2008



Data source: Texas DSHS HARS Data

HIV and AIDS Prevalence (People Living with HIV and AIDS)

While incidence looks at newly diagnosed cases of HIV and AIDS, prevalence identifies the total number of people living with the disease. The data presented here includes all reported cases of living people diagnosed with HIV and AIDS through the end of 2008.

- The difference in the number of PLWHA does not vary significantly between the EMA and HSDA. In 2008, a total of 20,190 people were living with either HIV or AIDS in the HSDA. This compares to 20,024 in the EMA. The EMA includes 99% of people with HIV or AIDS in the HSDA. All demographic proportions reported are the same in the EMA and the HSDA.
- Comparing PLWH to PLWA reveals an increase in HIV disease among women.
  - Women accounted for approximately 31% of people living with HIV, but only 24% of people living with AIDS. This suggests that there may be an increase in new infections among women.
  - In 2005, the prevalence rate of AIDS among men was about four times that of women's; now in 2008, the rate has declined to

three times that of women.

- Notably, data is showing a possible increase in HIV disease among youth aged 13 to 24: 8% among PLWH are youth while only 2% among PLWA are youth, and the HIV prevalence rate for youth is 74 per 100,000 while the AIDS prevalence rate for youth is only 27 per 100,000.
- Blacks/African-Americans are disproportionately affected by HIV and AIDS with the prevalence rates and proportions both significantly higher than other racial or ethnic groups.
  - Blacks/African-Americans have an overall HIV/AIDS prevalence rate (1078 per 100,000) that is five times higher than that of Hispanics/Latinos.
  - The overall rate is almost four times higher among Black/African-American PLWHA than White PLWHA.
- Blacks/African-Americans account for 53% of PLWH while among PLWA, they account for 46% - this may indicate an increase in HIV infection among the Black/African-American population.
- Cases associated with the No Identified Risk (NIR)/Other risk category could indicate two things: that these were newer cases which have not yet had a full surveillance investigation, or that these were older cases that are lost to follow-up with no risk established. However, CDC believes that heterosexual contact may be the main transmission mode for persons in this category because women may be unaware of how they were infected if they did not know of their partner's HIV status.
  - The most frequently reported mode of HIV transmission is the category of MSM, with 40% of PLWH and 44% of PLWA reporting this as their mode of infection.
- Approximately 25% of PLWHA reported their risk behavior as heterosexual transmission. For unreported risk, HIV cases accounted for 22% while AIDS cases accounted for only 12%.

The five-year trend in the rates of living cases, from 2004 and 2008, shows the following:

- Prevalence data show an overall steady, increasing trend in the rates of living AIDS cases, at 386 per 100,000 in the HSDA and 394 per 100,000 in the EMA. Since 2008, the AIDS prevalence rate has increased about 13%.
- For HIV prevalence rates, data show a slight increase of approximately 5% from 2004 to 2008. The current HIV prevalence rates for the HSDA and EMA are 166 and 162 per 100,000, respectively.

Table 12: Prevalence of HIV and AIDS, Houston HSDA, 2008

HSDA	Living w/ HIV			Living w/ AIDS			Living w/ HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
TOTAL	8,481	100.0	162.1	11,709	100.0	223.8	20,190	100.0	385.8
Gender									
Male	5,897	69.5	224.2	8,921	76.2	339.2	14,818	73.4	563.4
Female	2,584	30.5	99.3	2,788	23.8	107.1	5,372	26.6	206.4
Race/Ethnicity									
White	2,228	26.3	110.2	3,540	30.2	175.1	5,768	28.6	285.2
Black	4,500	53.1	490.7	5,381	46.0	586.8	9,881	48.9	1,077.5
Hispanic	1,627	19.2	84.7	2,657	22.7	138.3	4,284	21.2	223.0
Other	126	1.5	33.9	131	1.1	35.2	257	1.3	69.0
Age (yrs)									
0-1	5	0.1	2.9	1	0.0	0.6	6	0.0	3.4
2-12	87	1.0	10.3	10	0.1	1.2	97	0.5	11.4
13-24	701	8.3	74.3	253	2.2	26.8	954	4.7	101.1
25-34	2,226	26.2	267.0	1,508	12.9	180.9	3,734	18.5	447.8
35-44	2,690	31.7	340.0	3,797	32.4	479.9	6,487	32.1	820.0
45-54	1,974	23.3	269.9	4,105	35.1	561.3	6,079	30.1	831.2
55+	798	9.4	87.5	2,035	17.4	223.2	2,833	14.0	310.8
Transmission Mode									
MSM	3,422	40.3	*	5,169	44.1	*	8,591	42.6	*
IDU	643	7.6	*	1,380	11.8	*	2,023	10.0	*
MSM & IDU	288	3.4	*	739	6.3	*	1,027	5.1	*
Heterosexual	2,076	24.5	*	2,867	24.5	*	4,943	24.5	*
Perinatal Exposure	149	1.8	*	81	0.7	*	230	1.1	*
NIR/NRR	1,890	22.3	*	1,445	12.3	*	3,335	16.5	*
Other	13	0.2	*	28	0.2	*	41	0.2	*
Location									
Harris County	7,962	93.9	200.8	10,996	93.9	277.3	18,958	93.9	478.0
Non-Harris County	519	6.1	41.0	713	6.1	56.3	1,232	6.1	97.2

Data source: Texas DSHS HARS Data

Unmet Need Estimate and Assessment

In 2000, Congress wrote into the Ryan White Care Act a mandate for grantees to respond to "unmet need." Simply, unmet need is defined as "HIV positive individuals that are aware of their status and not receiving regular medical care." According to HRSA, unmet need is determined by identifying the number of people who know their HIV status but are not receiving primary medical care. An individual is considered not in primary medical care when there is no evidence that he or she received any of the following in a defined 12-month period: viral load testing, CD4 cell count or provision of anti-retroviral therapy.

The unmet need estimate equips planning bodies with data to develop strategies for bringing HIV+ people into medical care, and prioritize/allocate services targeted to the populations in need. Some of these strategies include:

- Conducting analyses of HIV prevalence and incidence data;
- Reviewing service utilization data on a regular basis;
- Continuing to identify not-in-care communities through the unmet need framework, needs assessment activities, community focus group and public input forums;
- Placing service providers at community based organizations and agencies with a documented capability to identify out-of-care PLWHA, or at HIV testing sites;
- Supporting services that encourage adherence to medication and treatment.

Unmet need is made up of two parts: estimation of unmet need and assessment of unmet need. Estimation of unmet need is determining the approximate number of people in the EMA who are HIV positive, know their status, and aren't receiving primary medical care. Assessment of unmet need is determining the service needs, gaps, and barriers of the individuals who are not in care. The Houston EMA's updated unmet need estimate for 2009 is provided in the following section, using the HRSA/HAB Unmet Need Framework.

Population Estimates - As of December 31, 2009, the number of PLWA was 12,075 and the number of PLWH (non-AIDS) was 8,870. The total number of PLWHA in the Houston EMA was 20,945.

Estimates of People in Care - The number of PLWA in care was 7,935, or 66% of the total number of PLWA in the EMA. The number of PLWH (non-AIDS) in care was 4,909 (55%) among all PLWH in the EMA. The total number of PLWHA who received HIV primary medical services as of the end of 2009 was 12,844 (61%).

Estimates of Unmet Need - The Houston EMA estimates that 4,140 (34%) of the diagnosed PLWA were not receiving HIV primary medical care as of end of 2009. For PLWH, 3,961 (45%) were found to be out-of-care. Thus, the HIV/AIDS unmet need estimate for the Houston EMA through the end of 2009 was 39% among PLWHA, with approximately 8,101 diagnosed individuals out of care.

Estimation Methods - Unmet need for medical care is defined following the HRSA definition such that a PLWHA is said to have unmet need for medical care if there is no evidence of either a CD4 count, a viral load (VL) test or antiretroviral therapy (ART) during the 12 months of interest. If there is evidence of one of these three things being present, the person is considered to have their medical needs met. The EMA used data supplied by TDSHS as part of a cross-title collaboration to provide an updated unmet need estimate based on data through 2009. The mid-year 2009 eHARS dataset was used for the unmet need analysis. Diagnosed HIV/AIDS cases that had been entered and were living on 12/31/2009 were included for the total population for unmet need in 2009. The following datasets were matched against HIV/AIDS cases in eHARS to determine whether a client had a met medical need:

Texas AIDS Drug Assistance Program (ADAP) - If ART was provided for a client, then that person was considered to have met medical need for the year the medication was provided. Name-based matching was performed to determine persons with a met medical need during 2009.

Electronic Lab Reporting System - The largest providers of laboratory services throughout the state report CD4 and VL measurements to the TDSHS. Name-based matching of these reports was used to determine if individuals received these measurements during 2009.

AIDS Regional Information and Evaluation System (ARIES) - Services provided to RW-eligible clients (all Parts) by funded service providers are reported in ARIES. If a client received a VL lab test, CD4 count, ART, laboratory service or ambulatory/outpatient medical care during 2009, the client was classified as having a met medical need that year. When available, name-based matching was used to detect persons with a met medical need. When client names were not available, matching was based on a unique number generated in the ARIES and eHARS.

Veterans Affairs Program - The EMA also obtained HIV and AIDS patient counts from the local VA Hospital to further refine the estimate of unmet need.

Data Limitations - Please note that the estimates provided may present an overestimation of unmet need due to the following data

limitations:

1) Cases diagnosed in the TDCJ are excluded from this analysis, although some diagnosed within the prison system have since been released and are living in Texas. A systematic source of information on those receiving care within the prison system is not yet available and those who remain incarcerated cannot be distinguished from those who have been released.
2) The updated data for the care provided by private insurance providers and Medicaid is not yet available. Further, Medicare data is not available - it is difficult to obtain client-level Medicare utilization data, since Medicare is a federal benefit that is not administered by state agencies. One potential effect may be found in the 55+ age group showing the highest proportion of unmet medical need. Much of this group is eligible for Medicare benefits, so it is possible that this group is receiving HIV-related care through Medicare.
3) Matches conducted between eHARS and some of the cases in ARIES and between eHARS and private payer data were based on limited data elements and may underestimate the true number of clients with met need.
4) There are persons reported in eHARS who have since moved away (out-migrated cases). A systematic way of identifying and removing these out-migrated cases is not yet in place; these cases remain in the base population and inflate the unmet need estimate.
5) Finally, matching for death data is still pending for 2009.

The Houston EMA is continuing its collaboration with TDSHS and the other four Texas Part A EMAs in a combined effort to update the data annually and to extract data from public and private payers. The partnership works to maintain sound methods of estimating unmet need and implement the adjustments necessary to refine unmet need estimates for PLWHA in Texas.

Table 13: Houston Unmet Need Trends for 2007, 2008 and 2009

Year	PLWH		PLWA	
	#	%	#	%
2007	3,160	40%	3,538	33%
2008	3,472	42%	3,602	32%
2009	3,961	45%	4,140	34%
% Change	25%		17%	

Data Source: Texas DSHS unmet need analysis through 2009, based on matching eHARS with care data from ADAP, ELR and ARIES.

Demographic Analysis of PLWHA with Unmet Need

A demographic analysis of PLWHA with unmet need was performed and the findings are provided in the following table. The percentages represent the proportions of all persons in the corresponding group who had an unmet need in the Houston EMA for 2009. *Please note that the demographic analysis does not include data from the VA Hospital, since the aggregate data obtained could not be further broken down into demographic categories.*

For the Houston EMA, it is estimated that approximately 92% of those with unmet need are in the more urban Harris County, similar to the proportions seen among PLWHA. Males have slightly higher proportions of PLWHA and a greater number with unmet need. Black/African American PLWH have the highest proportion of clients with unmet need at 56%. Interestingly, among PLWA, Whites have a slightly higher proportion (38%) when compared to the other races/ethnicities; this may be related to White PLWA having more access to private providers, whose data is limited at this time. Among the age groups, those 55+ appear to have the greatest proportion of their population out of care for PLWA at 41%; however, Medicare data was not available for this analysis and may explain this greater proportion. When looking at unmet need by exposure category, the risk of IDU had high proportions of their population out of care, yet MSM and the category of heterosexual contact had greater numbers out of care.

In separating HIV cases from AIDS cases, it is evident that unmet need is substantially higher for PLWH when compared to PLWA across all demographic categories; some of these differences may be attributable to the interaction of the case definition for AIDS and the definition of met need. A large proportion of AIDS cases meet the case criteria for AIDS because of CD4 testing, which is also an indicator of met need. Thus, the larger proportion of AIDS cases with met need may be a result of the fact that infected individuals receiving medical care are more likely to have an AIDS diagnosis because they are receiving diagnostic tests. Almost all demographic and exposure categories show significantly greater proportions of unmet need among PLWHs versus PLWHAs; however, these differences between HIV and AIDS are greater among Hispanics/Latinos and Blacks/African-Americans than Whites.

Table 14: Demographic Analysis of PLWHA with Unmet Need

2009	PLWHA		PLWH		PLWA	
	#	%	#	%	#	%
Total	8,885	42	4,548	51	4,337	36
Gender						
Male	6,585	43	3,227	52	3,358	37
Female	2,300	42	1,321	50	979	34
Race/Ethnicity						
White	2,349	40	984	44	1,365	38
Black/African-Am.	4,513	44	2,625	56	1,888	34
Hispanic/Latino	1,899	42	871	49	1,028	37
Other/Unknown	124	44	68	50	56	38
Age						
<2 years	1	14	1	14	*	*
2 – 12 years	31	37	29	36	2	50
13 – 24 years	455	44	397	52	58	22
25 – 34 years	1,663	44	1,236	53	427	29
35 – 44 years	2,606	41	1,387	52	1,219	33
45 – 54 years	2,653	41	1,065	50	1,588	36
55+ years	1,476	46	433	48	1,043	46
Exposure Category						
MSM	4,300	41	2,147	48	2,154	36
IDU	1,218	48	564	60	654	41
MSM/IDU	487	42	184	53	302	38
Heterosexual	2,759	42	1,570	53	1,189	33
Perinatal	93	40	67	44	26	33
Other	28	46	16	57	12	36

Data Source: Texas DSHS 2009 unmet need analysis, based on matching eHARS with care data from ADAP, ELR and ARIES.

Mortality

Since reporting of deaths (mortality reports) of PLWHA is often delayed due to the confirmation and checking that is required, 2007 mortality data is the most recent year that is considered complete and will be presented in this report. It should be noted that deaths may be due to HIV disease as well as other causes. Since mortality data is almost identical in the EMA and HSDA, only the mortality data for the HSDA will be presented for the purposes of this report.

- In the HSDA, 73 deaths were among those with HIV, and 467 were among those with AIDS, giving a total of 540 deaths of PLWHA. For the EMA, the total number of deaths was four fewer, at 536.
- The rate of death among men with HIV (not AIDS) was almost five times as high as the death rate among women with HIV (not AIDS). Overall, the death rate of Male PLWHA was three times as high as Female PLWHA.
- The rates of death among PLWHA were highest among Blacks/African-Americans compared to all other racial/ethnic groups.
- The overall HIV/AIDS mortality rate among Black/African-American PLWHA (34 per 100,000) was nine times that of Hispanics/Latinos and almost five times that of White PLWHA.
- Black/African-American females living with HIV/AIDS had a striking mortality rate (20 per 100,000) of 12 times that of Hispanic/Latino females and 9 times that of White females living with HIV/AIDS.
- HIV/AIDS mortality data showed that adults aged 45 to 54 had the highest rate of death, at 29/100,000 when compared to the other age groups.
- For transmission mode, the highest proportion of HIV/AIDS mortality was among MSM at 33%. Deaths among those with AIDS were highest among MSM cases (34%) followed by cases related to heterosexual contact (29%). For deaths among PLWH, the highest proportion was also among MSM at 26%.
    - The relatively high percentage of NIR/NRR could indicate two things: that these were newer cases which have not yet had a full surveillance investigation, or that these were older cases that are lost to follow-up with no risk established. However, CDC believes that heterosexual contact may be the main transmission mode for persons in this category because women may be unaware of how they were infected if they did not know of their partner's HIV status.
- From 2003 to 2007, the HIV death rate for PLWHA has remained relatively stable, at approximately 11 deaths per 100,000 cases. Future releases of this data should be monitored for any continuing trends in HIV/AIDS mortality.

Table 15: Deaths among HIV and AIDS Cases, Houston HSDA, 2007

HSDA	HIV Deaths			AIDS Deaths			HIV/AIDS Deaths		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	73	100.0	1.4	467	100.0	9.1	540	100.0	10.5
Gender									
Male	59	80.8	2.3	343	73.4	13.3	402	74.4	15.6
Female	14	19.2	0.5	124	26.6	4.9	138	25.6	5.4
Race/Ethnicity									
White	26	35.6	1.3	126	27.0	6.2	152	28.1	7.5
Black/African American	40	54.8	4.4	272	58.2	30.0	312	57.8	34.4
Hispanic/Latino	7	9.6	0.4	65	13.9	3.6	72	13.3	3.9
Other	0	0.0	0.0	4	0.9	1.1	4	0.7	1.1
Age (yrs)									
13-24	3	4.1	0.3	6	1.3	0.6	9	1.7	1.0
25-34	6	8.2	0.7	54	11.6	6.7	60	11.1	7.4
35-44	15	20.5	1.9	150	32.1	19.3	165	30.6	21.2
45-54	27	37.0	3.7	180	38.5	25.0	207	38.3	28.7
55+	22	30.1	2.5	77	16.5	8.8	99	18.3	11.3
Transmission Mode									
MSM	19	26.0	*	158	33.8	*	177	32.8	*
IDU	11	15.1	*	73	15.6	*	84	15.6	*
MSM & IDU	4	5.5	*	37	7.9	*	41	7.6	*
Heterosexual	13	17.8	*	133	28.5	*	146	27.0	*
Perinatal	0	0.0	*	0	0.0	*	0	0.0	*
NIR/NRR	25	34.2	*	66	14.1	*	91	16.9	*
Other	1	1.4	*	0	0.0	*	1	0.2	*
Location									
Harris County	67	91.8	1.7	444	95.1	11.4	511	94.6	13.1
Non-Harris County	6	8.2	0.5	23	4.9	1.9	29	5.4	2.4
Data Source: Texas DSHS HARS Data									

Table 16: Deaths of Persons with HIV/AIDS, Houston HSDA, 2007

HSDA	Male			Female			Total		
Race/Ethnicity	**#**	**%**	**Rate**	**#**	**%**	**Rate**	**#**	**%**	**Rate**
White	129	23.9	12.8	23	4.3	2.2	152	28.1	7.5
Black/African-American	213	39.4	49.5	99	18.3	20.8	312	57.8	34.4
Hispanic/Latino	57	10.6	6.0	15	2.8	1.7	72	13.3	3.9
Other	3	0.6	1.7	1	0.2	0.6	4	0.7	1.1
Total	402	74.4	15.6	138	25.6	5.4	540	100.0	10.5
Data Source: Texas DSHS HARS Data									

Care and Supportive Services in the EMA

Ryan White Part A

HRSA-defined Core Services in the EMA:

Ambulatory/Outpatient Medical Care	Oral Health	Mental Health Services
Case Management (Medical and Clinical)	Substance Abuse	Local Drug Reimbursement Program
Health Insurance Premium/Co-Pay Assistance	Hospice Services	Home Health Care

The Houston EMA has a continuum of care that addresses HIV service needs from diagnosis to end-stage disease. Central to this continuum is primary outpatient medical care. Harris County operates two HIV clinics, one which focuses on early intervention and another which is located in northeast Houston and is the nation's largest freestanding HIV clinic. Community-based options for HIV care include an agency in the Montrose area, which has historically served the gay/MSM community and operates a second site in the heavily African-American Fifth Ward area in northeast Houston; another agency located on Houston's near north side targeting Hispanic and African-American PLWHA; and a third agency, which is located in southwest Houston and focuses on African-American PLWHA. This third agency also targets rural PLWHA through satellite clinics located in far southwest Harris and Montgomery Counties, respectively. A Federally Qualified Health Center in Fort Bend County also targets rural PLWHA. In addition, two local hospitals operate clinics which provide primary medical care services to HIV-positive children. Complementing these primary care providers is a long-standing coordinated case management system including medical case management services embedded in all primary medical care programs, clinical case management co-located at mental health and substance abuse treatment sites and non-medical case management programs located at HIV testing sites.

According to the CPCDMS, during 2006 the Houston EMA served 8,262 unduplicated PLWHA through Part A services, of which 79% of the clients (6,626 individuals) received primary medical care services, up from 73% in FY 2005. Among those receiving primary medical care services, approximately 52% were Blacks/African-Americans, 25% were Hispanics/Latinos and 30% were women. These service utilization data mirror the epidemiological data for the HSDA, indicating that efforts to reach PLWHAs reflect those most affected by the epidemic. To date, 7,204 PLWHA have been served in FY 2007, of which 81% (5,814 individuals) have received primary medical care. The demographics of those receiving primary care are very similar to the proportions from FY 2006, substantiating Houston's con-

tinued success in targeting RW Part A-funded services to historically underserved populations.

The Houston EMA's Continuum of Care (COC), a framework that guides stakeholders in establishing priorities and funding for HIV/AIDS services, has been in place since FY 2000. Representatives from the Ryan White Planning Council, consumers, service providers, and the Houston Department of Health & Human Services prevention community planning group collaborated to create this universal COC. It is conceptualized as a "rail system" that identifies and tracks the HIV-related services deemed necessary for the public and PLWHA in the Houston EMA. This concept theoretically allows people to transition in or out of the system depending on their general knowledge of the HIV virus and its transmission, their serostatus, health and individual desire to stay in the system.

The Houston EMA strives to meet HRSA's goal of increasing access and decreasing disparity in its funded programs. Each year, strategies for ensuring access and minimizing disparity are reviewed and revised during the RWPC's *How to Best Meet the Need* (HTBMTN), priority setting and allocation processes. Five attributes summarize the EMA's goals and objectives for the COC, particularly concerning access to primary care:

- **Availability** - In addition to the local public indigent care hospital system that provides three clinic sites where Harris County residents can receive HIV primary care, the RWPC allocates funding for HIV primary care through three community-based providers that operate a total of six (6) clinics accessible to PLWHA within the entire EMA. In addition, two clinics affiliated with local medical schools provide primary medical care services to pediatric patients.

- **Accessibility** - The RWPC prioritizes and allocates a large sum of money towards transportation services, including vans, bus passes and gas vouchers, to ensure that clients are able to access core medical services.

- **Affordability** - The RWPC has set eligibility requirements for primary medical care at 300% of the FPL and for HIV medications at 500%. These relatively high eligibility criteria were determined to be necessary because of the importance and expense of medical care as well as the small but increasing number of PLWHA who may have returned to work but lack health insurance. Based on FY 2006 data for clients served in the EMA, 89% of PLWHA earn less than $20,000 annually, and approximately 64% earn less than $10,000.

- **Appropriateness** - To accommodate the needs of different populations, three community based primary care providers were awarded primary medical care contracts for FY 2007. These clinics specialize in care to African Americans and Latinos, gay and/or White PLWHA and rural PLWHA. In addition, all Part A-funded primary care facilities are required to have bilingual clinical staff

and medical translators available to accommodate monolingual clients.

- **Accountability** - Clients who receive high quality services are more likely to continue to access those services. Since FY 2000, Part A primary medical care providers and other service providers have been contractually required to provide high quality services according to approved SOC. Clinical Quality Management (CM) initiatives such as clinical chart review ensure that care is provided according to HHS guidelines. In addition, automation of service utilization and billing data in the CPCDMS has further improved programmatic and fiscal accountability.

Ryan White Part B

The Part B Administrative Agency (AA) collaborates with the RWPC to develop the following planning products for Part B and State Services funding received from the Texas Department of State Health Services (DSHS): area service priorities, recommendations for Part B and State Services funding allocations, Standard of Care, Chart Review reporting and Outcome Measures. In addition, both parties collaborate on the production of, and updates to, the Needs Assessment and Comprehensive HIV Services Plan.

The purpose of this collaboration is to improve the quality, availability and organization of primary medical services and essential support services for HIV+ individuals and families in the ten county Houston HIV Service Delivery Area. Similar to the EMA, Core medical services are the central focus of the Houston HSDA.

- As of 2010 Ryan White Part B or State Service grant funded services that are targeted to rural based clients are Legal Assistance Services, Food Pantry, Ambulatory/Outpatient Primary Care and Medical Case Management.
- In FY 2010, the Houston HSDA served 4,700 unduplicated PLWHA through Part B and State Services funding, of 20% (969) Received Ambulatory/Outpatient Primary Care. Among these receiving services under these recourses, approximately 25% were Hispanic, 49% were African American and 26% were Female.
- Representatives from Part B participate in the RWPC's How to Best Meet the Needs Process as outline previously to meet both HRSA's and the DSHS goals of increasing access and decreasing disparities in its funded programs.

Prevention Services

On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the nation's first-ever comprehensive coordinated HIV/AIDS roadmap with and measurable targets to be achieved by 2015. The NHAS is intended to refocus

our existing efforts and deliver better results within current funding levels, as well as demonstrate the need for new investments. It is also a new attempt to set clear priorities and provide leadership for all public and private stake-holders to align their efforts toward a common purpose. There are three primary goals outlined in the strategy:

1. Reducing the number of people who become infected with HIV;
2. Increasing access to care and optimizing health outcomes; and,
3. Reducing HIV-related health disparities.

The Houston Department of Health and Human Services (HDHHS) is directly-funded by the Centers for Disease Control and Prevention (CDC) and the Texas Department of State Health Services (DSHS) to provide HIV and STD prevention and intervention activities for the Houston Area. The HDHHS is also directly-funded by the CDC for a three-year demonstration project entitled Enhanced Comprehensive HIV Prevention Planning (ECHPP) designed to outline local strategies to achieve the goals outlined in the National HIV/AIDS Strategy. The HDHHS is also responsible for the implementation of proven HIV prevention interventions in the Metropolitan Statistical Areas (MSAs) with the highest number of people living with HIV/AIDS. The Houston MSA includes the cities of Houston, Baytown and Sugarland.

Core Houston Area HIV prevention activities include the following:

- **HIV Counseling and Testing**. The HDHHS provides voluntary, client-centered HIV counseling, testing, and referral (CTR) services through its public STD clinics, at the Harris County Jail and juvenile detention facility, through a mobile testing unit, and at the annual mass testing event, *Hip Hop for HIV Awareness*. The HDHHS also supports routine, opt-out HIV testing in local emergency departments and Federally-Qualified Health Centers (FQHCs). Direct service community-based organizations (CBOs) are also funded to provide targeted CTR to high-risk populations. In 2010, the HDHHS provided over 187,000 HIV tests in the Houston Area.
- **Partner Services**. As the local health jurisdiction for Harris County, it is mandated that all laboratory evidence of HIV or AIDS is reported to the HDHHS. The HDHHS then investigates all newly-reported cases of HIV or AIDS. This includes notification to and comprehensive risk counseling with the newly-diagnosed (“prevention with positives”) as well as partner identification, notification, and services, including HIV testing and STD testing and treatment.
- **Health Education and Risk Reduction (HE/RR)**. The HDHHS funds direct service CBOs to conduct evidence-based behavioral

interventions (EBIs) at the individual-, group-, and community-levels that target high-risk HIV-negative individuals and PLWHA and their partners. This also includes implementation of a school-based HIV/STD prevention curriculum for grades 7 – 8.

- **Social Marketing**. The HDHHS conducts community-wide social marketing and media campaigns designed to alter HIV testing and risk reduction behaviors, correct misperceptions and misinformation about HIV in the community, and reduce stigma and discrimination against PLWHA. The HDHHS also conducts mass condom distribution efforts, sponsors HIV awareness events and commemorations such as World AIDS Day, and participates in various community events and health fairs.
- **Condom Distribution.** The HDHHS conducts condom distribution targeting HIV-positive persons and persons at highest risk of acquiring HIV infection by coordinating with community-based organizations, local health departments, tribal organizations, community health centers, federally-qualified health centers, LGBT health centers, STD clinics, hospitals, specialty clinics, bars, clubs, local business partners, etc.
- **Service Linkage**. The HDHHS is funded by Ryan White Part A to employ Service Linkage Workers (SLW) in the public STD clinic setting who link newly-diagnosed and out-of-care PLWHA into Ryan White primary care and/or case management. SLWs at the HDHHS are also cross-trained in disease investigation and can provide partner services for the newly-diagnosed. SLWs also emphasize referrals to services for co-occurring concerns such as mental health, substance abuse, housing, and other health issues.
- **Jurisdictional HIV Prevention Planning.** Recipients of federal HIV prevention funding are required to have in place a prevention planning process that includes the development of a jurisdictional HIV prevention plan and the establishment of an HIV prevention planning group (PPG, formerly HIV Community Planning Group or CPG). The HDHHS coordinates the PPG for the Houston Area. The Houston Area PPG also maintains a series of Task Forces focused on HIV awareness in specific high-risk populations, such as MSM and youth.

The HDHHS will be scaling-up several specific HIV prevention activities in the Houston Area over the course of the three-year demonstration project. These include routine and targeted HIV testing, linkages to care, retention and re-engagement in care, health communications and social marketing, treatment as prevention, and community mobilization. The HDHHS also recently implemented a combination of activities to intensify HIV and STD prevention efforts in the five geographic neighborhoods within the MSA with the highest HIV and STD morbidity. The Strategic AIDS/HIV Focused Emergency Response (SAFER) Initiative will focus HIV/STD prevention activities to the Sunnyside/South Park, Greater Fifth Ward, Acres Homes, Sharpstown/Southwest, and Montrose areas of Houston.