



The 2009 Comprehensive HIV Services Plan for the Houston Area

Through December 31, 2011

Effective January 1, 2009

Mission Statement

We, the Houston Comprehensive Planning Committee, have come together to update the Comprehensive HIV Services Plan for the Houston EMA/HSDA guided by the following mission:

We will provide a plan that will be inclusive of the entire continuum of care to improve the quality of life for those infected with and/or affected by HIV/AIDS in the Houston EMA/HSDA by taking a leadership role in the planning and assessment of HIV resources, resulting in the delivery of prevention and care services that are accessible, efficient and culturally affirming until the end of the epidemic is realized.

Vision Statement

From 2009 to 2011, the community will continue to work together to improve and expand a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for communities affected by HIV and AIDS.

Shared Values

The following Shared Values outline the GUIDING PRINCIPLES that planners, service providers, consumers and community leaders agree will guide the development and delivery of HIV Services within the geographic area. The guiding principles are informed by the Health Resources and Services Administration's (HRSA) focus on uninsured, underserved and special needs populations, as defined by the following goals:

- Goal 1: Improve Access to Health Care**
- Goal 2: Improve Health Outcomes**
- Goal 3: Improve the Quality of Health Care**
- Goal 4: Eliminate Health Disparities**
- Goal 5: Improve the Public Health and Health Care Systems**
- Goal 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies**
- Goal 7: Achieve Excellence in Management Practices**

These are the guiding principles set by the Comprehensive Planning Committee:

1. Better serve the underserved in response to the HIV epidemic's growing impact among minority and hard-to-reach populations.
2. Ensure access to existing and emerging HIV/AIDS prevention strategies and treatments to make a difference in the lives of people at risk for or living with HIV disease.
3. Adapt to changes in the health care delivery system and the role of Ryan White Program services in filling gaps.
4. Be able to document outcomes.
5. Be driven by and advocate for consumer needs.
6. Acknowledge the value of service provider expertise.
7. Be culturally affirming to the intended audience.

Under the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the purpose of comprehensive HIV services planning is to help members of our community develop a detailed picture of the current and future local HIV/AIDS epidemic and to guide decisions about HIV-related services and resources in our region.

This plan is offered as a tool for decision-making. It is designed to be utilized by HIV Planning Groups, funders of HIV prevention and care and others.

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LETTER OF CONCURRENCE FROM HARRIS COUNTY JUDGE ED EMMETT



December 15, 2008

To Elected Officials and all Concerned Citizens:

The 2009-2011 Comprehensive HIV Services Plan for the Houston Area is an important tool in establishing a strategy for the prevention of, and the health care and outcomes for people living with HIV/AIDS in the six-county Eligible Metropolitan Area (EMA) and the ten-county HIV Service Delivery Area (HSDA).

I commend the Houston Comprehensive Planning Committee for updating the plan and making it inclusive of the entire continuum of care. Their work will help to improve the quality of life for those infected with and/or affected by HIV/AIDS in the Houston EMA/HSDA. In addition, the committee has focused on the uninsured, underserved, and special needs population in response to the Health Resources and Services Administration's (HRSA) directives.

I encourage elected officials and others to review the document as you implement your area's HIV care plan. Effective prevention, better care, and greater efficiency can be attained if we work together and use the 2009-2011 HIV/AIDS Comprehensive Plan as a guide for our work.

Sincerely,

A handwritten signature in blue ink, appearing to read "Ed Emmett", is written over a horizontal line.

Ed Emmett
County Judge

LETTER OF CONCURRENCE FROM CITY OF HOUSTON MAYOR BILL WHITE



CITY OF HOUSTON
Department of Health and Human Services

Bill White

Mayor

Stephen L. Williams, M.Ed., M.P.A.
Director
Health and Human Services Department
8000 N. Stadium Drive
Houston, Texas 77054-1823

T.713.794.9311
F.713.798.0862
www.houstonhealth.org

December 4, 2008

Dear Houston Area Citizens:

I offer my support of the 2009 Comprehensive HIV Services Plan developed by the Comprehensive Planning Committee. The Houston area is fortunate to have the expertise of all the volunteers that worked on this plan, and their hard work is well reflected in the document.

This plan allows our community to better address the needs of people affected by HIV and provides us a format to assure an effective, collaborative system that incorporates both prevention and care services.

I encourage other elected officials in the Houston area to use the information in the plan to the greatest extent possible in determining resource allocation and in developing HIV/AIDS policies.

Sincerely,

A handwritten signature in dark ink that reads "Bill White".

Bill White
Mayor

Council Members: Toni Lawrence • Jarvis Johnson • Anne Clutterbuck • Wanda Adams • Michael Sullivan • M.J. Khan • Pam Holm • Adrian Garcia
James Rodriguez • Peter Brown • Sue Lovell • Melissa Noriega • Ronald C. Green • Jolanda Jones • Controller: Annise D. Parker

LETTER OF CONCURRENCE FROM RYAN WHITE PART A

Houston Area HIV Services Ryan White Planning Council
2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax
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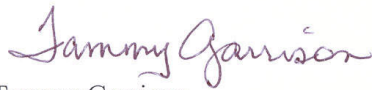
December 1, 2008

Dear Friends and Colleagues,

As Chair of the Houston Ryan White Planning Council, I wish to thank the many individuals who helped to create this three-year Comprehensive HIV Services Plan. Our partners in the formation of this document included representatives from all Ryan White Program planning bodies, administrative organizations and the Houston HIV Prevention Community Planning Group. Individuals who participated in writing, reviewing and approving the plan included people living with HIV/AIDS, health planners, service providers and other stakeholders.

I look forward to working with these same organizations and individuals to implement our plan so that, together, we can continue to improve the quality of services offered to those in need throughout our community.

Sincerely,



Tammy Garrison
Chair
Ryan White Planning Council

LETTER OF CONCURRENCE FROM RYAN WHITE PART C



We will create a healthier community and be recognized as one of America's best community-owned healthcare systems.

P.O. BOX 66769, Houston, TX 77266-6769

www.hchdonline.com

December 2008

Ryan White Planning Council
2223 West Loop South, Suite 240
Houston, Texas 77027

Dear Colleagues:

Once again the Harris County Hospital District is pleased to have been a part of developing the HIV/AIDS Comprehensive Plan for the Houston EMA. As the grantee of Ryan White Part C funds for Harris County, we recognize every day the value of working in concert with other grantees and providers in the area to ensure the best possible focus of our efforts.

We look forward to continued opportunities for working with the Planning Council to plan and provide services those living with HIV and AIDS in Harris County.

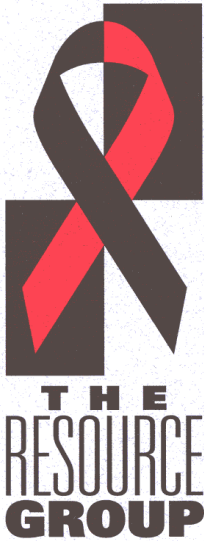
Sincerely,

A handwritten signature in cursive script, appearing to read "Pete Rodriguez".

Pete Rodriguez, RNBSN, ACRN
Director of HIV Services
Harris County Hospital District

We improve our community's health by delivering high quality health care to Harris County residents.

LETTER OF CONCURRENCE FROM RYAN WHITE PART D



HOUSTON
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HIV/AIDS
RESOURCE
GROUP, INC.

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December 1, 2008

Houston Ryan White Planning Council
2223 W. Loop S. #240
Houston, Texas 77027

Dear Colleagues,

As the Ryan White Part D administrative agency (grantee), Houston Regional HIV/AIDS Resource Group, Inc extends our concurrence with the Houston Area 2009 Comprehensive HIV/AIDS Service Plan. We recognize the importance of this plan in directing service delivery to individuals infected with HIV/AIDS. We would also like to congratulate and offer our gratitude for the efforts of all involved in the development of this plan.

Thank you,

Yvette Garvin
Executive Director

CONTRIBUTORS

This updated Comprehensive HIV Services Plan is the result of countless hours of participation and effort by members of our community who are committed to improving the HIV prevention and care delivery system. Individuals who contributed their expertise included people living with HIV/AIDS (PLWHA), people who provide services to PLWHA and others.

The following list of contributors reflects the diversity in geographic, racial, ethnic, sexual orientation and gender that exists within communities infected and affected by HIV and AIDS. The participation and input of each contributor was essential to the process, and all are greatly appreciated.

Hope Aadam	Charles Henley	Beau Mitts
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INTRODUCTION

H-I-V. Alone, these are three simple letters. Put them together and they identify a disease with an impact of extraordinary proportions. What was once a relatively unknown and concentrated disease has evolved into an epidemic reaching all corners of the globe. It knows no national boundary or division of race, ethnicity, age, sex, or socioeconomic status. Since HIV was identified over twenty-five years ago, more than 42 million people – men and women, black and white, rich and poor, old and young – have become infected. Over 30 million people have developed AIDS. In 2007 alone, approximately 2.1 million died from AIDS-related illnesses, and 2.5 million were newly diagnosed with HIV (6,849 new infections each day).

The HIV epidemic has challenged humankind on all levels of thought – from medical and scientific to social and cultural to economic and political. Clinicians have sought new approaches to treat a disease with new and varying clinical manifestations, while scientists have struggled to find a cure. AIDS advocates have forced controversial subjects like sexuality, drug use, discrimination, sexual inequality, and economic marginalization to the forefront of social and political debate in order to draw attention to the plight of those at risk for and living with HIV. In April 2000, in the wake of catastrophic social consequences of HIV overseas, the United States government declared HIV/AIDS a threat to national security and pledged more resources to battle the disease. Under the Ryan White CARE Act, healthcare and social service workers have worked tirelessly to respond to the need for complete, quality HIV care and services. Meanwhile, people and their families living with HIV have fought against sometimes overwhelming social and cultural stigmas simply to live safe, healthy lives. In 2006, the Ryan White CARE Act was amended and became the Ryan White HIV/AIDS Treatment Modernization Act of 2006 with a sunset clause of September 2009.

Countless individuals, organizations, and communities the world over have responded admirably to the challenge of fighting the HIV epidemic. This document represents the continuing efforts of one local community, the greater Houston, Texas area, to prevent the spread of HIV and care for those who are living with HIV and their families.

Comprehensive Planning

The HIV epidemic places a heavy strain on medical and social services. The complexities of the clinical conditions and their impact on the social and economic lives of those who are infected and their families create a confusing maze of services. Adding to the confusion of the care services are those meant to prevent the spread of infection. Organizations and individuals in local communities have needed to come together in order to develop, organize and maintain the most effective, efficient systems of care for people at risk for and living with HIV and their families. One of their most important activities is Comprehensive Planning, or the creation of a complete picture of the HIV epidemic and available resources with a detailed strategy for action. In the

greater Houston area, there are a multitude of people and agencies dedicated to the fight against HIV. While the efforts of all are worthwhile, below is a short description of two major planning groups.

Ryan White Planning Council (RWPC): The RWPC is a 40-member volunteer group of community members who help determine which services are most needed by people living with HIV in ten counties of Southeast Texas: Chambers, Fort Bend, Harris, Liberty, Montgomery, Waller, Colorado, Austin, Walker and Wharton. The RWPC prioritizes the services and decides the best way to allocate funds received under Part A (emergency aid to cities) and Part B (aid to states and territories) of the Ryan White HIV/AIDS Treatment Modernization Act as well as State Services dollars. [For more information about the RWPC, please call 713-572-3724.]

Houston HIV Prevention Community Planning Group (CPG): The CPG is a Comprehensive Planning group that works toward improving the effectiveness of services at local health departments and community-based organizations as they develop and implement HIV prevention programs. Representatives of affected populations, epidemiologists, behavioral scientists, HIV/AIDS prevention providers and health department staff work together to create an HIV prevention plan for Harris County that will be responsive to the local epidemic. [For more information about the CPG, please call 713-794-9092.]

History of the Comprehensive Planning Committee

In 1999, the RWPC led local planning groups and many others in the community in the creation of the first Comprehensive Planning Committee (CPC). The CPC served as an *ad hoc* committee of the RWPC, but was composed of the people who plan for, administer, provide, and use HIV care and prevention services in all ten counties of the HSDA (see Section I for a map of the area). Within the designated geographic area, efforts were made to include as many people as possible and to make the CPC as representative of the local epidemic as possible. The first meeting took place in March 1999, with over 100 people in attendance, to discuss the reasons for a Comprehensive Plan and the structure of the process. The CPC then developed a mission so that the members could clarify the purpose of the CPC and provide a framework for making decisions, a vision that described how the plan was to work, and shared values that were to be the guiding principles that shaped the system of care.

The next step for the CPC was to develop workgroups that would focus on key areas important to the community's service delivery system, or continuum of care. The workgroup areas were: medical services, support services, coordination, client and public advocacy, infrastructure, prevention, and implementation. Members of the workgroups developed and prioritized critical issues based on what are called the "Five A's": affordable, accessible, appropriate, available, and accountable. The idea was to develop a system in which services were *affordable* to all people at risk for or living with HIV and their families, *accessible* to all people, *appropriate* for different cultural and

socioeconomic populations, *available* to meet the needs of all people, and *accountable* to the funding sources and consumers for providing services at high quality.

Once the critical issues were reviewed and revised, the CPC developed an ideal continuum of care. That is, they formed a picture of a system that would meet the health and social service needs of all people at risk for and living with HIV and their families. Since not all aspects of this ideal continuum were in existence, the CPC developed a set of goals that, if reached, would result in a realization of the ideal. Each goal had a series of specific objectives and tasks that the HIV community would follow in order to reach the goals. The final step for the CPC was to develop a way to ensure that the HIV community was making progress in reaching the goals and that these goals continued to make sense to the community.

For many years, representatives from all of the participating planning bodies met quarterly through membership on the Joint Comprehensive Planning Committee (JCPC). The goal of this free-standing committee was to monitor the progress being made by the different planning bodies in meeting the goals outlined in the plan. In 2003, with the consent of the other planning bodies, the function of the JCPC was folded into the HIV Planning Committee, a standing committee of the Ryan White Planning Council. Membership on the standing committee continues to include representation from the other planning bodies in the Greater Houston Area.

Although many of the resources that were missing from the original continuum of care have since been developed, comprehensive planning continues to help the Houston-area HIV community make better decisions about changes that have to be made to the system of care. It allows the planning bodies to see where they are, where they want to be, how they are going to get there, and what to do once they are there. This updated *Comprehensive HIV Services Plan for the Houston Area* is a compilation of this information for ten counties of Southeast Texas. It is intended as a living, working guide for those who plan, administer, and provide HIV services in order to improve the quality of life for people at risk for and living with HIV and their families.

EXECUTIVE SUMMARY

The purpose of a Comprehensive HIV Services Plan is a) to provide a road map for developing a system of care; b) to present a detailed picture of the local HIV/AIDS epidemic, and; c) to guide decisions about HIV-related services and resources in our area. A Comprehensive Plan outlines goals, objectives, and strategies for delivering services by reviewing needs assessment and other data (evaluation, contract monitoring), existing resources to meet those needs, and barriers to care. It also reflects the community's vision and values about how to best deliver HIV/AIDS care, particularly in light of limited resources.

The Comprehensive HIV Services Plan for the Houston Area is presented as a tool for decision-making. It is intended to be utilized by HIV planning groups, funders of HIV prevention and care, and any individuals or groups who desire to improve health outcomes among people at risk for HIV infection and those who are already living with HIV in the greater Houston area.

Where Are We Now?

The Comprehensive HIV Services Plan focuses on two HIV planning areas – the Eligible Metropolitan Area (EMA) and the HIV Service Delivery Area (HSDA). The EMA is the geographic area eligible to receive Ryan White Program Part A funds, and consists of six counties in southeast Texas (Chambers, Fort Bend, Harris, Liberty, Montgomery and Waller). The HSDA is the area eligible to receive Ryan White Program Part B funds and State Services funding, and encompasses ten counties that include the six EMA counties plus Austin, Colorado, Walker and Wharton counties. The EMA and HSDA areas cover 9,415 square miles containing more than 4.3 million people. However, 98% of those 4.3 million people reside in Harris County. Harris County is the most populous county in Texas, the third most populous in the nation, and home to approximately 95% of the HSDA's reported HIV/AIDS cases. The City of Houston in Harris County is the largest city in Texas and the fourth largest in the United States and has over 90% of the EMA's reported AIDS cases.

From the beginning of the epidemic, Texas has seen some of the highest numbers of reported AIDS cases. As of December 2006, the number of reported living HIV and AIDS cases for the Houston HSDA area was 19,355. Harris County is home to nearly 95% of living HIV and AIDS cases in the HSDA. Increasing trends in HIV and AIDS diagnoses are being seen among women, African Americans and youth between the ages of 13 and 24. In 2000, Congress wrote into the Ryan White Care Act a mandate for grantees to respond to "unmet need," which is defined as "HIV positive individuals that are aware of their status and not receiving regular medical care." This mandate continues through the 2006 Ryan White HIV/AIDS Treatment Modernization Act. During 2007, there were an estimated 3,592 (32%) diagnosed PLWA and 3,588 (45%) not receiving HIV primary medical care. The total number of PLWHA who had unmet need in the Houston EMA through the end of 2007 was 7,180 (37%). These estimates

provided by the Texas Department of State Health Services indicate that Houston (37%) had the highest level of unmet need compared to other EMAs in the state (Fort Worth 31%, San Antonio 30%, Dallas 26% and Austin 23%).

According to the 2005 Houston Area HIV/AIDS Needs Assessment, the highest ranked HIV needs either related directly to medical care (such as vision and oral health care) or facilitated access to medical care (such as health insurance and case management). For both the 2005 and 2008 Needs Assessments, the most frequently reported barrier to services was lack of information. Since 2004, the Comprehensive Plan of the Houston HIV Prevention Community Planning Group (CPG) has strongly recommended that local prevention efforts focus on effectively coordinating prevention and primary care services for PLWHA, including widespread and accessible HIV testing resources.

The 2008 Houston Area HIV/AIDS Needs Assessment found that the most frequently reported medical services accessed by survey respondents were primary medical care, HIV/AIDS medications, medical case management and dentist visits. The most frequently reported barriers for core medical services were related to difficulties making or keeping appointments, waiting times for services and informational barriers. Providers reported barriers related to lack of funding, lack of transportation to services, shortage of community partnerships/linkages, community awareness of services, staffing issues and immigration barriers.

Where Are We Going?

An HIV continuum of care is “a coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV infection to meet their health care and psychological service needs throughout all stages of illness.” The Houston area Continuum of Care developed in 1999 is presented as a “rail system” that identifies and tracks the HIV services deemed necessary to those who are living within the Houston area. The five tracks in Houston’s continuum of care are:

1. Public Advocacy to the General Public;
2. Outreach to At Risk Populations;
3. Prevention of HIV infection;
4. Early Treatment of HIV infection, and;
5. AIDS Treatment to PLWHA.

Over the next three years, the community will continue working together to expand a coordinated system of HIV/AIDS prevention and care in order to improve the health outcomes and quality of life for the infected and affected communities. The services must be available to meet the needs of individuals and families, accessible to all populations infected with, affected by, or at-risk for HIV/AIDS, affordable to all populations infected or affected by HIV/AIDS, appropriate for different cultural and socio-economic populations and prevention/care needs, and accountable to the funding sources and clients for providing services at high quality.

The development and delivery of HIV services within the Houston area must:

- Better serve the underserved in response to the HIV epidemic's growing impact among minority and hard-to-reach populations.
- Ensure access to existing and emerging HIV/AIDS prevention strategies and treatments to make a difference in the lives of people at risk for or living with HIV disease.
- Adapt to changes in the health care delivery system and the role of Ryan White Program services in filling gaps.
- Be able to document outcomes.
- Be driven by and advocate for consumer needs.
- Acknowledge the value of service provider expertise.
- Be culturally affirming to the intended audience.

The Houston Continuum of Care shows the ideal linkages between a full range of client-centered, cost-effective services that would unify the prevention and treatment of the HIV epidemic in the greater Houston area to achieve the following client or individual level outcomes:

- Prevent persons from becoming HIV positive
- Prevent persons who are already HIV positive from progressing to AIDS
- Improve or maintain the health status and quality of life of people living with HIV or AIDS
- Provide a dignified death to those who are at the end-stage of AIDS
- Improve linkages to and between services

How Will We Get There?

Included in the reauthorized Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 2000, as well as the Ryan White HIV/AIDS Treatment Modernization Act of 2006, is a mandate that communities create “multi-year Comprehensive Plans that will:

- Address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities;
- Establish and support an HIV care continuum;
- Coordinate resources among other Federal and local programs, and;
- Address the needs of those who know their HIV status and are not in care as well as the needs of those who are currently in the care system.

In order to address these mandates, the Comprehensive HIV Services Plan for the Houston Area has adopted the following strategic goals:

Goal 1: Identify individuals who know their HIV status but are not in care and develop strategies for informing these individuals of services and enabling their use of HIV related services.

Goal 2: Reduce the impact of stigma on access to and retention in care and to break down barriers.

Goal 3: Provide education and advocacy to encourage HIV+ individuals to get education, stay in treatment, access treatments and be aware of best practices.

Goal 4: Improve coordination and collaboration among non medical service providers.

Goal 5: Eliminate disparities in access and services for historically underserved populations.

Goal 6: Coordinate services with HIV prevention programs including outreach and early intervention services.

Goal 7: Coordinate services with substance abuse prevention and treatment programs.

Goal 8: Prevent youth from becoming HIV+.

Goal 9: Continue to develop new programming tactics whereby training, educational material, and clinical measurements continue to support improved HIV epidemiological data outcomes.

Goal 10: Provide goals, objectives, timelines and appropriate allocation of pay/funds services as determined by clients and community.

As part of the review of the Comprehensive Plan, findings from the 2005 and 2008 Houston Area HIV/AIDS Needs Assessments were analyzed based on the HRSA guidelines and expectations in order to better determine the community's progress in complying with these. Findings from this analysis are presented in Chapter Nine.

How Will We Monitor Our Progress?

Implementation of the Comprehensive Plan is an ongoing effort among several planning and administrative bodies. Previous Houston Area HIV/AIDS Needs Assessment results are reviewed in conjunction with the Comprehensive Plan by the Planning Council's "How to Best Meet the Needs" Committee/process. Monitoring the implementation activities of the Comprehensive Plan is handled through the Comprehensive HIV Planning Committee, whose membership includes representatives from Parts A, B, C, D, F(SPNS) as well as Prevention. Outcomes are measured by the Ryan White Grants Administration Office using an established set of process and clinical outcome measures.

Methodology

Community Participation in the 2009 Houston Area HIV/AIDS Comprehensive Plan

The 2009 Houston Area HIV/AIDS Comprehensive Plan was updated using several mechanisms for community input. Various approaches – mailed surveys, community meetings and provider interviews – ensured that the update process incorporated a wide range of input from HIV and non-HIV segments of the Houston community. By making deliberate efforts to include providers outside of the traditional CDC and Ryan White funded networks, the reach of the Houston Area HIV/AIDS Comprehensive Plan extends beyond the “usual players” and brings fresh voices to the planning table.

The 2009 Houston Area HIV/AIDS Comprehensive Plan reflects the voices of over 100 persons infected with and affected by HIV/AIDS, service providers and community leaders across Houston area counties.

Mail Surveys

The purpose of the surveys was to solicit input from service providers, consumers and community leaders regarding changes to the Mission, Vision, Goals and Objectives from the previous Comprehensive Plan. A total of 250 surveys were mailed to agencies listed in the HIV/AIDS Resource Guide (“The Blue Book”). The number of returned surveys was 53 (21%). Surveys represented a range of respondent types such as persons with HIV/AIDS, community leaders and service providers. Service providers comprised the largest category of respondents.

The surveys were four pages long and contained the Mission, Vision, Goals and Objectives from the previous Comprehensive Plan. Respondents were asked to review the lists and suggest any additions or changes if needed.

The vast majority of respondents agreed with the existing Mission, Vision, Goals and Objectives. The few suggested changes were grammatical in nature. This suggests that the key issues from the previous Comprehensive Plan continue to be relevant. Results from the surveys were compiled and incorporated into the community meetings.

Community Meetings

Two community meetings were convened to solicit community input into the Comprehensive Plan update process. The objectives of the community meetings were:

1. To define and develop shared values or guiding principles that shape the HIV system of care in the Houston area. These shared values and goals were compared to current planning documents, and to outcomes of the survey that was conducted in support of this effort.
2. To define long-term goals and objectives regarding systems planning and evaluation, including action steps for each objective.

3. To provide input for an action plan outlining strategies and activities for implementation.
4. To make recommendations from community input for evaluating and monitoring the community's progress in defining these goals.

Findings from the mailed surveys served as the foundation for discussions at each community meeting.

In an effort to encourage community ownership of the update process (rather than being limited to Ryan White or CDC interests), the meetings were facilitated by an independent vendor whose neutrality was based on unfamiliarity with both HIV/AIDS and the Houston community.

Both meetings were held during June 2007 and located along a major bus route in central Houston. The community meetings were open to the public and publicized using fliers, email announcements, bulk fax announcements and word of mouth. One meeting was held during the day and another in the evening in order to accommodate various personal schedules. Meals were provided at both meetings. A total of 40 participants attended the community meetings.

Provider Interviews

A total of 11 structured interviews were conducted with service providers outside the traditional HIV/AIDS service system. The purpose of these provider interviews was to understand their experiences providing HIV services, their perceived HIV/AIDS needs for their areas and to identify collaboration strategies between HIV and non-HIV agencies. Interview selection was based on any combination of the following criteria:

1. Did not receive CDC or Ryan White funds for direct services related to HIV/AIDS
2. Delivered health or social services to hard to reach populations, particularly the newly diagnosed or out-of-care
3. Located in areas without easy access to CDC or Ryan White funded services (i.e., suburbs, rural counties)

Interviews were conducted using a prepared questionnaire and asked the following questions:

- What services does your organization provide?
- What populations does your agency serve?
- Has your agency ever had any HIV positive clients? If Yes, what services did they need?
- In your area, where can someone get an HIV test or learn about HIV?
- How can organizations teach people in your agency or area about HIV?

- When someone finds out they have HIV, how can agencies help them get into medical care?
- In your area, where can someone with HIV get medical care?
- Sometimes people with HIV have a hard time seeing a doctor. Why do you think that is?
- How can other agencies help people in your agency or area feel less afraid about seeing a doctor for HIV, and keep up with their doctor visits for HIV?
- What types of HIV services does your agency or area need?
- What are the best ways HIV and non-HIV agencies can communicate and work together on HIV?

Provider respondents represented four counties (Harris, Austin, Fort Bend, Waller), towns (Webster, Baytown, Humble, CyFair, Richmond) and a range of services including housing and rental assistance, emergency financial assistance, food banks, substance abuse treatment programs, counseling and support groups, domestic violence shelters, translation/interpretation, educational/GED programs, employment training, transportation and convalescent care. Targeted populations included women and children, youth, substance abusers, homeless, recently released, immigrants and refugees.

All providers interviewed stated that they did not collect information on the HIV status of their clients. Most were not sure if they had provided services to any persons living with HIV. None stated that HIV status was a criterion for receiving services. While most providers did not know of any HIV services in their areas, virtually all said they would refer individuals needing HIV services to agencies within the Houston CDC/Ryan White systems. Stigma and fear were reported most often as barriers to preventive and clinical care for HIV. Across the board, all providers felt that information about existing services (including referral contacts) was crucial for effective collaborations between themselves and HIV-specific agencies. Providers also felt that educational programs targeted to their communities, as well as their staff, would improve their capacity for addressing the HIV needs in their areas.

Section I

WHERE ARE WE NOW?

A Description of the Houston Area

CHAPTER 1: GEOGRAPHY & HIV PLANNING REGIONS

There are multiple funding sources for prevention and care services that are distributed through different agencies at the Federal level. These funding sources are then locally distributed to and overseen by different fiscal organizations, or administrative agencies, and planning bodies. Consequently, the planning and service provision areas are also different. This chapter presents a brief geographic description of the different HIV planning areas that would be expected to benefit from and utilize this Comprehensive Plan.

The Eligible Metropolitan Area (EMA) is the geographic area eligible to receive Ryan White Program Part A funds, which are passed through the EMA's top elected official. The boundaries of the metropolitan area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the Centers for Disease Control and Prevention (CDC). There are over 50 metropolitan areas across the nation designated as eligible to receive Ryan White Program Part A funding. Some EMAs include just one city, other EMAs are composed of several cities and/or counties, and some EMAs extend over more than one state. The Houston EMA is a six county area that consists of Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller counties in southeast Texas. The land area of the EMA is 5,921 square miles with a population of 4,177,646 for a population density of 705.6 people per square mile (see Map 1).

The HIV Service Delivery Area (HSDA) is the Texas geographic area eligible to receive Ryan White Program Part B funds through the Texas Department of State Health Services (DSHS). The Houston HSDA is a 10-County area that contains the six EMA counties plus the adjacent Austin, Colorado, Walker, and Wharton counties. The land area of the HSDA is 9,415 square miles with a population of 4,324,572 for a population density of 459.3 people per square mile.

Of the total population of 4,324,572 in the ten-county HSDA, 3,400,578 (98.2%) reside in Harris County. The population density of Harris County is 1,630 people per square mile. Harris County is the most populous county in Texas, the third most populous in the nation, and the home of approximately 95% of the HSDA's reported HIV/AIDS cases. The City of Houston in Harris County is the largest city in Texas and the fourth largest in the United States. Houston has over 90% of the EMA's reported AIDS cases and is the least densely populated major metropolitan area in the nation. Philadelphia (135 sq miles), Chicago (227.1 sq miles), and Boston (49 sq miles) combined would fit within the city limits of Houston (539.6 sq miles) with room to spare.

The Houston Area Ryan White Planning Council plans for Ryan White Program Part A services in the EMA. The City of Houston is directly funded by the CDC for prevention activities in Harris County. The Houston HIV Prevention Community Planning Group (CPG) plans for CDC-funded HIV prevention activities.

Population

Each of these counties experienced growth in population since the last census in 1990. The percent change in population ranged from 3.1% in Wharton County to 61.2% in Montgomery County. The average percent change across all counties was 29.6%. Along with Montgomery County, the other counties bordering Harris County also saw significant growth: Chambers had a 29.6% change, Fort Bend County 57.2%, Liberty County 33.1%, and Waller County 39.7%. Harris County itself showed a 20.7% change in population (similar to that for the State, 22.8%). Table 1, below, illustrates the population number, population density and square mileage of the counties in the HSDA.

Table 1: Population, Square Miles and Population Density by Geographic Area from 2000 Census Data

County	Population	Square Miles	Population Density
Austin	23,590	653	36
Chambers	26,031	599	43
Colorado	20,390	963	21
Fort Bend	354,452	875	405
Harris	3,400,578	1,729	1,966
Liberty	70,154	1,160	60
Montgomery	293,768	1,044	281
Walker	61,758	788	78
Waller	32,663	514	64
Wharton	41,188	1,090	38
EMA	4,177,646	5,921	706
HSDA	4,324,572	9,415	459

The population in all of the counties is predominantly White, ranging from 57.0% in Fort Bend County to 88.3% in Montgomery County. African Americans are the largest minority group in each county, ranging from 3.5% in Montgomery County to 29.2% in Waller. The largest Asian/Pacific Islander (API) population, 11.2%, resides in Fort Bend County. The American Indian/Alaskan Native population consistently is in the 0.3% to 0.5% range across all counties. The “Other” category includes those who designated themselves as multiracial, with the highest percentage (3.0%) in Harris County.

The median age for the entire area is 34.1 years, meaning half of the population is older and half is younger. This is slightly over the median age of 32.3 years for the entire

state. The median ages for the individual counties fell within the 30 to 40 year age range. Fort Bend County has the largest percentage of people under 18 years old (32%) and the smallest over 65 years old (18.6%). Walker County had the smallest percentage of people under 18 (18%) and Colorado County had the largest over 65 (18.6%).

The Hispanic population is considered separately because this profile follows Federal guidelines and treats Hispanic as an *ethnic* categorization, rather than as a race. This means that the Hispanic category is not mutually exclusive of the racial categories; in other words, a person could be both Hispanic and White or Hispanic and American Indian. With that in mind, the average percentage of Hispanics across all counties is 18.9%. Harris County has the largest proportion of Hispanics at 32.9%, with the majority (80.1%) of Mexican origin. Chambers County has the lowest proportion of Hispanics (10.8%). Overall, Harris County and neighboring Fort Bend County are the most racially/ethnically diverse counties in the area.

Most of the residents in the 10-county area live in Houston, the largest city in Texas and the fourth largest city in the United States (behind New York, Los Angeles and Chicago). Within city limits, the estimated population is 1.8 million, with the gender distribution split down the middle – 50.1% female and 49.9% male. The median age is slightly younger than the surrounding areas (30.9 years). The city also is more racially/ethnically diverse, with 49.3% of Houston's population White, 25.3% African American, 5.4% Asian/Pacific Islander, 0.4% American Indian, and 16.5% listing another race (with 3.1% multiracial). Over a third of the city's total population (37.4%) is Hispanic.

Economics

The 2000 U.S. Census also provided us with some economic information. For example, the 1997 estimated median household income for the area ranged from just under \$29,000 to just over \$55,000, with an average of almost \$37,000. This compares favorably to the statewide median of \$34,478. However, the numbers of people living below the poverty level were not insignificant. The percentage of people living below poverty ranges from 8.0% in Fort Bend County to 20.9% in Waller County, with an average for all counties of 15.0%. For children, the range is from 10.6% in Fort Bend to 26.9% in Waller, for an average of 20.0%. The statewide rates were 13.3% overall and 19.9% for children. Table 2 shows the poverty rates for 1997 and compares the total and rates for children in 1997 and 1999.

Table 2: Poverty Estimates by County

County	1997 Median Household Income	1997 Persons Below Poverty (%)	1997 Children Below Poverty (%)	1999 Total (%)	1999 Children (%)
Austin	\$33,945	13.1	17.7	15.9	22.3
Chambers	\$43,345	10.8	16.5	13.9	17.2
Colorado	\$28,966	17.1	23.9	20.1	28.9
Fort Bend	\$55,164	8.0	10.6	10.5	14.3
Harris	\$39,037	15.2	20.9	12.6	20.0
Liberty	\$31,683	17.2	22.9	17.8	22.3
Montgomery	\$46,292	10.3	14.6	11.6	15.4
Walker	\$30,971	19.9	22.5	18.3	20.0
Waller	\$29,832	20.9	26.9	18.9	25.7
Wharton	\$30,531	17.4	23.0	18.5	25.2

Commensurate with the significant percentage of people living at or under the Federal Poverty level is the high percentage of uninsured.

Table 3 presents this information by county and includes additional estimates for 1999 from the Texas Health and Human Services Commission. Increases were noted in all but a few counties: Harris, and Walker Counties, and in Waller County for children only. Although numbers were not available for each county, statewide, the majority of those living in poverty in 1997 were female (55.3%) and Hispanic (53.2%).

Table 3: Estimated People Without Insurance by County, 1999

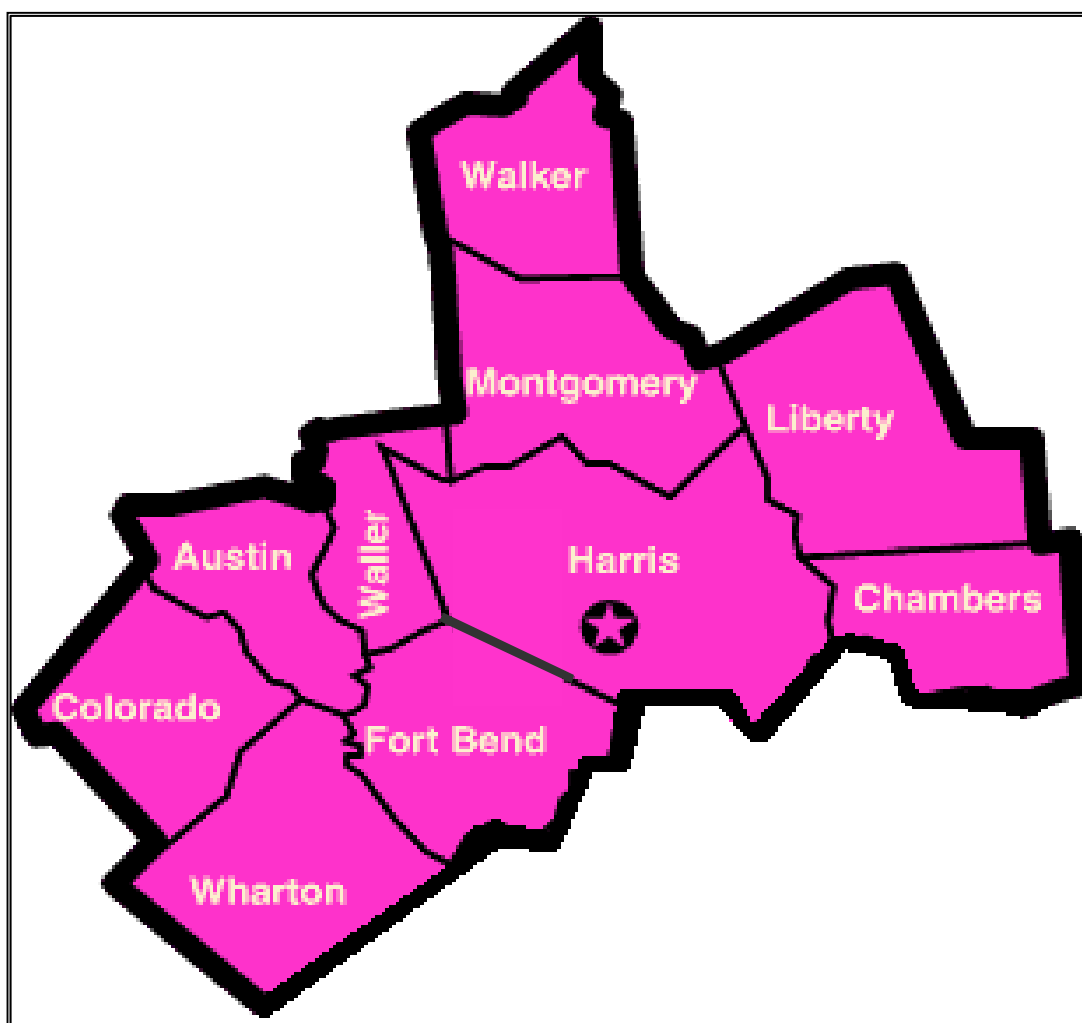
County	All people (%)	Children (0-18 years old) (%)	Adults (19-64 years old) (%)
Austin	19.9	22.7	24.4
Chambers	20.3	20.8	23.7
Colorado	20.8	24.0	26.7
Fort Bend	22.7	22.4	24.6
Harris	25.5	25.5	28.1
Liberty	22.4	22.8	26.2
Montgomery	20.1	21.0	22.6
Walker	25.4	22.9	29.5
Waller	25.4	25.1	30.1
Wharton	23.1	25.0	27.5

Unemployment by county is high, though it has decreased slightly in most of the counties in the HSDA from 1998 to 2001:

Table 4: Unemployment Rate by County

County	1998	December 2001
Austin	3.3%	2.7%
Chambers	4.2%	4.2%
Colorado	3.9%	3.2%
Fort Bend	2.9%	3.2%
Harris	4.2%	4.6%
Liberty	6.5%	6.3%
Montgomery	3.4%	3.7%
Walker	2.2%	2.0%
Waller	4.3%	4.0%
Wharton	5.6%	4.8%
Texas	4.0%	5.1%

MAP 1: HOUSTON EMA/HSDA



CHAPTER 2: EPIDEMIOLOGICAL PROFILE

***2008 Integrated Epidemiological Profile
for HIV/AIDS Prevention & Care Planning
Houston, Texas***

Published: March 2008

EXECUTIVE SUMMARY

SOCIODEMOGRAPHIC DATA

The Houston-Area EMA is comprised of six counties and the HSDA includes these six plus four others. The population center of the region is Harris County, with over 80% of the EMA population and nearly 79% of the HSDA population. Outside Harris County most counties are rural with three EMA counties and two HSDA counties reporting 60% or more rural residents. The populations of both the EMA and HSDA are projected to grow at a faster rate than Texas overall, 18% compared to 16% for the state. The fastest growing counties are those adjacent to Harris, and include Montgomery (29%), Fort Bend (27%) and Waller (26%).

In Harris and Fort Bend Counties, minorities make up the “majority” of residents. White/Anglo are the majority in all other counties.

- ✚ Hispanics/Latinos make up 30% of the EMA’s and HSDA’s populations and 32% of the state’s.
 - Twenty percent of EMA and HSDA residents were born outside the U. S. This compares to 14% in the state of Texas. These foreign born residents most frequently come from North, Central and South America.
 - Mexico is the most frequent place of foreign birth, accounting for about half of those born outside the U. S.
 - Approximately one-third of EMA and HSDA residents are “linguistically isolated,” meaning they speak English less than “very well.” The predominant second language is Spanish.
- ✚ Non-Hispanic Blacks/African-Americans are 17% of the people in the region compared to 11% in Texas.
- ✚ Asians are 5% of the local population and less than 3% of those living in the state. Fort Bend County has the largest percentage of Asian residents.

Both the EMA and the HSDA have higher median incomes than the state overall. Within the EMA, the median income is nearly \$47,000 per year and within the HSDA, the median income is \$42,000. This compares to just under \$40,000 for Texas. Fort Bend (\$64,000 per year) and Montgomery (\$50,000 per year) have the two highest median incomes as well as the highest levels of educational attainment.

The EMA and HSDA have lower poverty rates than Texas overall, but the poverty rate is higher than found throughout the U. S. The region has approximately 14% poverty; the state has 15.4%, and the U. S. has only 12.4%.

As a state, Texas ranked first in the U. S. in 1998 according to percent of population uninsured (24.5%) and second in size of the uninsured population (4,880,000). In the

10-county area, counties ranged between one-fifth and one-quarter of their populations uninsured. In addition, all of the HSDA counties have full or partial designation as medically underserved areas (MUA). Six entire counties are designated as medically underserved.

- ✚ Liberty County, the county with the highest unemployment in the region, has the highest mortality rate of the 10 HSDA Counties, ranking thirteenth in the state of Texas. They have the highest infant mortality rate in the state, and are in the top 15 for cancer, lower respiratory diseases and accidents.
- ✚ Fort Bend has the lowest death rate of the ten HSDA counties, ranking 197 in the state.

SURVEILLANCE DATA

At the end of 2005, a total of 18,109 people were living with HIV/AIDS in the Houston HSDA, more than half (10,031; 58%) of whom had an AIDS diagnosis. There were 800 newly reported HIV cases, and 942 new AIDS cases for the year. Between 1999 and 2004, people living with AIDS increased 40% in both the Houston EMA and HSDA areas.

There are people living with HIV/AIDS in all 10 HSDA counties with almost 95% of cases reported in Harris County. Fort Bend County has 388 residents with HIV or AIDS, and Montgomery County has 287. Aside from Liberty County with its 80 cases, most other counties have less than 50 people living with HIV or AIDS.

Males have an HIV prevalence rate that is two times higher than that of females, and an AIDS prevalence rate that is four times higher. However, there are indications of an increase in new HIV infections among women, who represent 33% of living HIV cases in both the EMA and HSDA, but only 22% of living AIDS cases.

Blacks/African-Americans have the highest rate of new HIV and new AIDS infections – almost five times higher than the infection rate for Hispanics/Latinos and more than seven times higher than that of Whites/Anglos. More than half of new diagnoses for both HIV and AIDS are among Blacks/African-Americans (56%), followed by Hispanics/Latinos (23%) and Whites/Anglos (20%). Black/African-American women constitute the largest percentage of newly diagnosed women of childbearing age. Hispanic men are infected with HIV at a rate of more than 4.2 times that of Hispanic/Latina women, and 4.6 times higher for AIDS. There is also an increase in new HIV and AIDS diagnoses among Hispanic MSMs.

The 25 to 44 age group has the highest rates of new HIV and AIDS infections. The HIV infection rate among youth aged 13 to 24 is over two times higher than their rate for AIDS diagnoses. Black/African-American youth in particular are disproportionately affected by HIV/AIDS.


Male to male contact accounts for 42% of all HIV/AIDS cases in the HSDA, followed

by heterosexual contact (23%), intravenous drug use (12%) and mothers at risk (16%). Unreported risk among those with HIV accounts for approximately 37% of new HIV diagnoses and 22% of AIDS diagnoses.


SERVICE UTILIZATION

Service utilization, other than primary care, is evaluated using the CPCDMS system, which includes Ryan White Part A and B data. Service utilization trends increased between 2004 and 2006. Case management use increased 44%; dental care use increased 7%; substance use services increased 3% and mental health therapy and counseling increased 3%.


Primary Medical Care:

-  White PLWHA is under represented in primary medical care services. Primary care is accessed proportionally by PLWHA of all ages and both genders.



Case Management:

-  White PLWHA is under represented in case management. The utilization is proportional by age and gender. From 2004 to 2006, utilization increased from 3,784 clients to 5,477 clients. Case management services have declined slightly in Whites/Anglos and increased slightly in Hispanics/Latinos. There was also a slight decrease in adults aged 25-44 but an increase in older adults. There appears to be fewer reported cases of risk associated with MSM.

Dental Care:

-  There is a disproportionately higher access of dental care by older adults. Since 2004, there has been a decrease in adults aged 25-44.

Substance Abuse Treatment:

-  Males appear to be slightly under represented in service utilization. Treatment is used more by Hispanics/Latinos and under-utilized by Whites/Anglos. Youth and adults aged 25-44 tended to utilize this service more, while there is under representation in substance abuse clients for older adults aged 45 to 64.
-  Utilization increased from 216 clients in 2004 to 656 clients in 2006; this increase, however, is not in Part A clients but in clients served under SAMHSA-funded programs. During this period, there was a slight decline in service utilization by White PLWHA. Male clients decreased from 77% to 68%, while female clients increased from 23% to 32%. Adults aged 25-44 decreased from 74% to 68%. Finally, data showed a marked increase in the risk category of heterosexual contact (24% to 41%) and a slight decrease in homeless clients.

Mental Health Therapy and Counseling:

-  For 2006, the proportions across all demographic categories appear to be similar

to their representation in service utilization. Whites/Anglos and Hispanics/Latinos had declined in their service usage from 2004 to 2006 while Blacks/African-Americans increased (34% to 45%). Adults aged 25-44 had declined while clients reporting the risk behaviors of heterosexual contact and MSM increased in their usage of the service during that time period.

ADAP:

- Ⓡ Hispanic PLWHA over utilize ADAP services while White PLWHA appear to be under represented among ADAP clients when compared to their distribution within the regional epidemic. Usage by gender and age group appear to be proportional when compared to the regional epidemic.

UNMET NEEDS ESTIMATES

Identifying people who are aware of their HIV positive status and who are not receiving HIV medical care is a Health Resources Services Administration (HRSA) mandate, and a central focus of regional and national planning. One of the first steps in designing effective interventions is identifying the number and characteristics of those who are out-of-care, known as the “unmet need.”

Although it may seem straightforward, the difficulty in estimating unmet need lies in the many data sources that must be brought together. Inconsistent data and inadequate data are problems. In addition, trying to avoid duplication so people are only counted once can be difficult, particularly if their insurance has changed or they have switched providers. With that said, the following represents the current “best” estimates of the unmet need for the Houston EMA:

- Ⓡ Approximately half of people living with HIV and AIDS in the Houston EMA are outside the medical care system. This includes nearly 52% of men and 47% of women.
- Ⓡ Considering the race and ethnicity of those with unmet need, Whites/Anglos have the largest percentage outside the medical care system, nearly 55%. Over 52% of Blacks/African-Americans are outside the care system, and Hispanics/Latinos have the lowest unmet need, 40%.
- Ⓡ Examining unmet need by age using current data sources, the largest unmet need is among pediatrics, age 0 – 12, with over 63% out-of-care. This result will likely change with additional information from Medicaid. Youth include the largest in-care percentage, with 44.4% out-of-care. Both the 25 to 44 year group and 45 to 64 year group have 51% out-of-care.

Acquiring additional data to enhance these estimates is necessary. Data needs include: Medicaid data, Medicare data, additional private insurer data, additional private physician data with patient profiles by race and age.

INTRODUCTION

In order to effectively plan and implement HIV prevention and care services, local organizations require profiles of individuals who are infected with and at risk for acquiring HIV disease. Information about who is infected, their backgrounds and risk factors lay the foundation for local and regional prevention and care planning. This epidemiological profile provides detailed information about the current HIV/AIDS epidemic in the Houston Eligible Metropolitan Area (EMA) and Health Service Delivery Area (HSDA). The Houston EMA includes a six county area with Harris County/Houston at the center. Other counties comprising the EMA include: Chambers, Fort Bend, Liberty, Montgomery and Waller. The HSDA is composed of these six plus Austin, Colorado, Walker and Wharton counties.

The Health Resources Services Administration (HRSA), the organization that oversees federal funding for care of people living with HIV and AIDS (PLWHA) through Ryan White Program Parts A through F, and the Centers for Disease Control and Prevention (CDC), the organization that is responsible for HIV surveillance and prevention activities, have recently drafted guidelines for epidemiological profiles that bring together information from HIV care, surveillance and prevention. These guidelines identify five key questions that should be answered by the epidemiological profile. These include:

1. What are the sociodemographic characteristics of the general population in your service area?
2. What is the scope of the HIV/AIDS epidemic in your service area?
3. What are the indicators for risk of HIV infection and AIDS in the population covered by your service area?
4. What are the patterns of service utilization of HIV-infected persons in your area?
5. What are the number and characteristics of persons who know they are HIV-positive but who are not receiving HIV primary medical care?

This epidemiological profile is organized around these five questions, with each representing a section of the report.

DATA SOURCES

Data were compiled from a variety of sources to provide the most complete picture of the HIV epidemic in the Houston EMA/HSDA. When interpreting the data, keep in mind that each data source has strengths and limitations. A brief description of each data source follows.

SOCIODEMOGRAPHIC DATA

U. S. Bureau of the Census (Census Bureau)

The government, through the Bureau of the Census, collects and provides information about the people and the economy of the United States. The Census

Bureau's website (www.census.gov) includes data on demographic characteristics of the population, such as age, race, Hispanic ethnicity and gender/sex. It also provides information on family structure, educational attainment, income level, housing status and the proportion of people who live at or below the poverty level.

Information is available for very small geographic areas, such as block groups, but for this analysis county-level data is used. Totals for the six county EMA and the ten county HSDA are provided. In most cases, statewide information for Texas is provided for comparison.

When collecting data, the Census Bureau collects information on race and ethnicity separately. Therefore, Hispanic ethnicity is collected for people of both white and black races. Within race, however, it is possible to identify members of each race that are non-Hispanic. In order to provide information that is consistent and comparable to the HIV surveillance data, this report differentiates people who are White/Anglo, non-Hispanic, black non-Hispanic and Hispanic. Some information, such as poverty, is only collected by race (white, black, Asian) with ethnicity (Hispanic or non-Hispanic) included as a separate category. In these cases, direct comparisons from population data cannot be made (e.g. the racial breakdown of the population cannot be compared with the racial breakdown of those living in poverty).

Texas Comptroller's Winter 2001-2002 County Forecast

County and state population projections to 2010 are from this source. Projections are based upon the 2000 U. S. Census.

Texas Department of Labor

While the Census Bureau provided unemployment data from 2000, more current information is available from the Texas Department of Labor. Average unemployment from 2003 is used.

Texas Department of State Health Services (DSHS)

The Texas Department of State Health Services (DSHS) collects county-level data for a range of health status indicators. These include natality and morbidity and mortality for a range of diseases. For this profile, DSHS's publication, "Selected Demographic and Public Health Measures: Rankings for Texas Counties 1998-2000," is used. This report combines data from 1998 through 2000, and provides county rankings from highest to lowest, with identical values given the same rank. Mortality and morbidity measures with 20 or fewer numerator events in the three-year period are not ranked and designated as "NR." Natality measures based on a denominator of 20 or fewer are also not ranked. Mortality data used in this report were age-adjusted using the 2000 standard population. The system for coding of mortality changed between 1998 and 1999. Please refer to the full report for an explanation of these changes.

DSHS data is also used for Medicaid enrollment statistics. These were taken from the DSHS website by county.

HIV/AIDS SURVEILLANCE

AIDS was made a reportable disease in the State of Texas in March of 1983, while HIV infection became voluntarily reportable in 1987. In February 1994, the Control of Communicable Disease Act of Texas was amended to expand the information that must be reported for an HIV infection. The new regulations required name based reporting for all HIV-infected individuals less than 13 years of age. Laboratories that perform CD4 testing have been required to report suspect AIDS cases (those with a CD4 count below 200 or a CD4 percent below 14%) since January 1994. In January 1999, HIV infection became reportable for all persons who have a diagnostic test performed after 1998. On January 1, 2000, a detectable viral load was added to the reportable diagnostic tests.¹

Texas is one of several states that have unique HIV/AIDS reporting. Whereas most states are responsible for all HIV/AIDS reporting, six Texas cities are designated as independent reporting sites. To ensure complete HIV/AIDS reporting at the state level, Houston transfers its data to the State who then provides this data to the Centers for Disease Control and Prevention. With the initiation of name-based reporting of HIV, and to standardize reporting jurisdictions for all communicable diseases, the Houston Department of Health and Human Services (HDHHS) reporting jurisdiction was modified to include only Houston and Harris County. Since 1989 Houston has received direct funding from the CDC to conduct HIV/AIDS surveillance.

HIV and AIDS data are systematically collected and entered into the HIV/AIDS Reporting System (HARS) developed by the CDC. A systematic surveillance system has been established to ensure that data is as complete as possible, and quality assurance procedures are in place.

DATA LIMITATIONS

The data for HIV may not be representative of the epidemic in the population in that some individuals may not know they are positive therefore do not test. In addition, individuals who choose to test anonymously rather than confidentially, will not be reported or contribute to an accurate picture of the epidemic.

HIV data has not been reportable for as many years as has AIDS in Texas, therefore HIV data is not as complete as AIDS data and trend analysis of HIV data cannot be properly performed. In addition, reporting lags may contribute to underestimations in the data. Although every effort is made to identify sources of AIDS and HIV reports, HIV/AIDS recent data is not complete.

When data reports, encompass two jurisdictional areas, data are affected by

¹ The Houston Department of Health and Human Services (HDHHS) conducts HIV/AIDS surveillance as authorized in the Texas Administrative Code, Title 25, Part 1, Chapter 97. Rule §97.132 of Subchapter F. This requires physicians, dentists, hospitals, clinical laboratories and certain school officials to report HIV and AIDS to the local health authority. The Surveillance Program collects data in accordance with Rule §97.133 of Subchapter F which requires that reports of AIDS, HIV infection, CD4+T lymphocyte cell count below 200 cells/microliter, or CD4+ T-lymphocyte percentage of less than 14% shall be made using all of the information (collected by the reporting entities listed in Rule §97.132) found in the most current version of forms CDC 50.42B, CDC 50.42C, or STD-28.

reporting schedules. For example, Houston data includes only the City of Houston and Harris County. Any reports that would require Houston data also, would have to come through the Texas HARS system. Reporting delays or data cleaning at the State level would not allow a complete and timely picture.

HIV/AIDS CORE SURVEILLANCE PROJECTS

The HIV/AIDS Core Surveillance Program consists of the following projects: HIV/AIDS Surveillance, Expanded HIV Risk Assessment Project (EHRAP) and Sampling for Transmission Risk (STR). The Program also has the following Supplemental Projects: Enhanced Perinatal Surveillance (EPS), Adult Spectrum of Disease Project (ASD), HIV Testing Survey (HITS), Supplement to HIV/AIDS Surveillance (SHAS), Survey of HIV Disease and Care (SHDC), Behavioral Surveillance, HIV Incidence Surveillance and the Program Evaluation Project. The special projects are designed to capture information about HIV/AIDS that are beyond the scope of core surveillance. These studies are conducted in select populations and may not be representative of the epidemic in the general population. These studies are also time sensitive and limited in scope.

CENTRALIZED PATIENT CARE DATA MANAGEMENT SYSTEM (CPCDMS)

Houston's Centralized Patient Care Data Management System (CPCDMS) is a computer database application that compiles and tracks health, demographic and service utilization. The system enables Ryan White Part A funded agencies and other users to share client eligibility information and to document services delivered to clients. Records are created, accessed and updated by providers via high-speed Internet connections using each client's unique 11-character code. Client demographic information is collected through a registration process that establishes a client's eligibility for Part A services. Examples of information collected at registration include: race, ethnicity, income, mode of transmission, co-morbidities, insurance status, year of diagnoses and more. Service providers enter service encounter information for each client. This information, broken out by service contract and funding source into units, supports billing and other reporting activities.

QUESTION 1.1:



WHAT ARE THE SOCIODEMOGRAPHIC CHARACTERISTICS OF THE GENERAL POPULATION IN HOUSTON?

This section provides information on the demographic & socioeconomic characteristics of the EMA and HSDA.





SUMMARY

The EMA is comprised of six counties and the HSDA includes these six plus four others. The population center of the region is Harris County, with over 80% of the EMA population and nearly 79% of the HSDA population. Outside Harris County most counties are rural with three EMA counties and two HSDA counties reporting 60% or more rural residents.

The EMA and HSDA are projected to grow at a faster rate than Texas overall, 18% compared to 16% for the state.

-  The fastest growing counties include Montgomery (29%), Fort Bend (27%) and Waller (26%).
-  Age groups with significant projected growth in the EMA and HSDA include 13 to 24, 45 to 64 and 65 and older.

In Harris and Fort Bend Counties, minorities make up the “majority” of residents. White/Anglo are the majority in all other counties.

-  White, non-Hispanics are the largest population group in the EMA and the HSDA, comprising 46% of the EMA’s and HSDA’s populations compared to 52% of the state’s.
-  Hispanics/Latinos make up 30% of the EMA’s and HSDA’s populations and 32% of the state’s.
-  Non-Hispanic Blacks/African-Americans are 17% of the people in the region compared to 11% in Texas.
-  Asians are 5% of the local population and less than 3% of those living in the state.

Twenty percent of EMA and HSDA residents were born outside the U. S. This compares to 14% in the state of Texas. These foreign born residents most frequently come from North, Central and South America. Mexico is the most frequent place of foreign birth, accounting for about half of those born outside the U. S.

Approximately one-third of EMA and HSDA residents are “linguistically isolated,” meaning they speak English less than “very well.” The predominant second language is Spanish.

Within the EMA, the median income is nearly \$47,000 per year which is \$5,000 higher than in the HSDA and \$7,000 higher than is found in the state.

- ✚ Fort Bend County residents have the highest median household income in the HSDA, nearly \$64,000 per year.
- ✚ Montgomery County is second highest with over \$50,000 per year.
- ✚ These two counties also have the highest level of educational attainment.

In 2003, unemployment in the EMA, HSDA and state was in the range of 6.8% to 6.9%.

- ✚ Liberty County had the highest 2003 unemployment rate, 10.4%.

Both the EMA and the HSDA have lower rates of poverty than in Texas overall, with 13.9% and 14%, respectively, living in poverty compared to 15.4% for the state.

As a state, Texas ranked first in the U. S. in 1998 according to percent of population uninsured (24.5%) and second in size of the uninsured population (4,880,000). In the HSDA, county populations ranged between one-fifth and one-quarter uninsured.

All of the HSDA counties have full or partial federal designation as medically underserved areas. Six entire counties are designated as medically underserved.

Harris County has 18 neighborhoods with medically underserved census tracts. In addition, Harris County has four medically underserved populations. The latter are populations which are medically disadvantaged due to economic, racial or ethnic reasons.

Liberty County has the highest mortality rate of the 10 HSDA counties, ranking thirteenth in the state of Texas. They have the highest infant mortality rate in the state, and are in the top 15 for cancer, lower respiratory diseases and accidents.

Fort Bend has the lowest death rate of the ten HSDA counties, ranking 197 in the state.

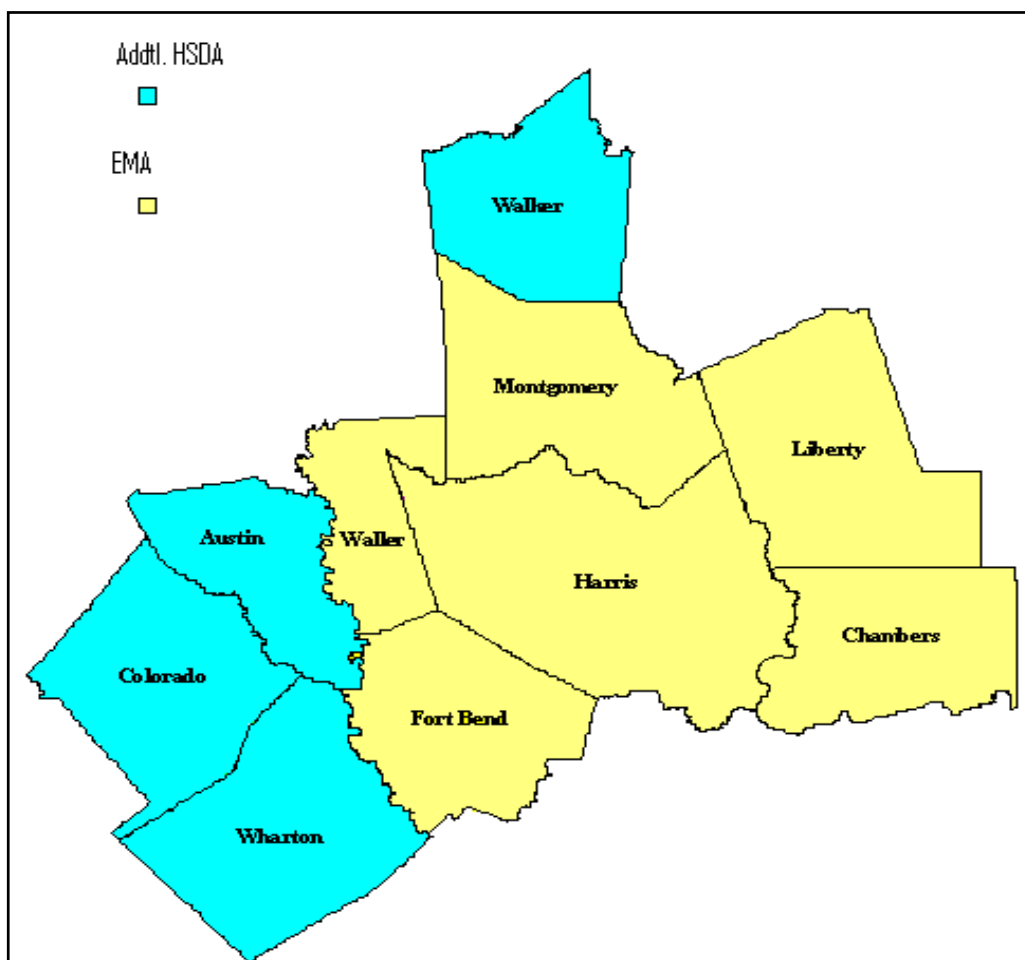
THE GEOGRAPHIC REGION

The Houston area HSDA, referred to in this document, covers 9,415 square miles of southeast Texas and makes up 3.5% of the state's area. It is an area roughly the size of the state of New Hampshire.

Ten counties make up the region, and throughout this document they are grouped by the HIV community planning funding sources. Under the Ryan White Program, the Health Resources Services Administration (HRSA) uses the Eligible Metropolitan Area (EMA) for Ryan White Part A funding, and Health Services Delivery Area (HSDA) for funding under Part B.

- Ⓡ The EMA includes six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery and Waller.
- Ⓡ The HSDA is composed of these six plus Austin, Colorado, Walker and Wharton. Figure 1.1.1 maps the EMA and identifies the four additional counties that make up the HSDA.

Figure 1.1.1
HOUSTON EMA/HSDA AREA MAP






An Eligible Metropolitan Area (EMA) is an area designated by the Health Resources and Services Administration (HRSA) – a division of the United States Department of Health and Human Services – as eligible to receive Ryan White Program Part A funds. An EMA must have a population of at least 500,000 persons and a total of at least 2,000 cumulative AIDS cases (as reported by the Centers for Disease Control for the most recent 5-year period). The geographic boundaries of EMAs are defined by the U. S. Census Bureau; some EMAs include just one city, some are composed of several cities and/or counties and others extend over more than one state. The Houston EMA is a 6-County area that consists of Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller counties in southeast Texas.

The Houston HIV Service Delivery Area (HSDA) is a 10-county area designated by the state to receive Ryan White Part B and DSHS funds. The counties within the HSDA encompass the entire EMA with the addition of Austin, Colorado, Walker and Wharton counties. Part B and DSHS funds are intended to improve the quality, availability and organization of health care and support services for PLWHA (with an emphasis on rural populations) and are administered by the Houston Regional HIV/AIDS Resource Group. In addition to Part B and DSHS funds, the Resource Group administers other local HIV/AIDS funding streams such as Part C (funding to community-based organizations for outpatient early intervention services) and Part D (services for children, youth, women and families).

The Houston HSDA, including the entire EMA, contains more than 4.3 million people across 9,415 square miles (population density = 299.47 people/square mile), with 98% of the population residing in Harris County (population density = 1,630 people/square mile). Harris County is the most populous county in Texas, the third most populous in the nation, and the home of approximately 95% of the HSDA's reported HIV/AIDS cases.

URBAN VS. RURAL AND POPULATION DENSITY

The U. S. Census Bureau identified urban and rural areas within regions. Harris County is home to Houston, the urban center of the region.

-  Over 98% of the Harris County's 3,400,000 residents are considered urban residents.
-  Other counties with large percentages of urban residents include Fort Bend (89.9%), Montgomery (64.0%) and Walker (63.7%).
-  The population of three EMA counties and two HSDA counties have 60% or greater rural residents. These include: Chambers (64.2%), Liberty (64.1%), Waller (63.4%), Austin (62.8%) and Colorado (60.4%). Refer to Table 1.1.1.

Population density considers the number of residents for every square mile of land area.


-  The most rural counties have the lowest population density, and the most urban have the highest. Population density for each county is reflected in Table 1.1.2.

Table 1.1.1
HOUSTON EMA/HSDA COUNTIES AND TOTAL URBAN VS. RURAL AREAS, 2000

County	Total Population	Urban Population	Rural Population
Chambers	26,031	35.8%	64.2%
Fort Bend	354,452	89.9%	10.1%
Harris	3,400,578	98.2%	1.8%
Liberty	70,154	35.9%	64.1%
Montgomery	293,768	64.0%	36.0%
Waller	32,663	36.6%	63.4%
EMA TOTAL	4,177,646	93.2%	6.8%
Austin	23,590	37.2%	62.8%
Colorado	20,390	39.6%	60.4%
Walker	61,758	63.7%	36.3%
Wharton	41,188	50.3%	49.7%
HSDA TOTAL	4,324,572	91.8%	8.2%
TEXAS TOTAL	20,851,820	82.5%	16.6%

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004



Table 1.1.2
HOUSTON EMA/HSDA COUNTIES AND TOTAL POPULATION DENSITY, 2000

County	Population	Land Area in Square Miles	Population Density per Square Mile of Land Area
Chambers	26,031	599.31	43.4
Fort Bend	354,452	874.64	405.3
Harris	3,400,578	1,728.83	1967.0
Liberty	70,154	1,159.68	60.5
Montgomery	293,768	1,044.03	281.4
Waller	32,663	513.63	63.6
EMA TOTAL	4,177,646	5,920.12	470.2
Austin	23,590	652.59	36.1
Colorado	20,390	962.95	21.2
Walker	61,758	787.45	78.4
Wharton	41,188	1,090.13	37.8
HSDA TOTAL	4,324,572	9,413.24	299.47
TEXAS TOTAL	20,851,820	261,797.12	79.6

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

POPULATION DISTRIBUTION AND GROWTH

According to the 2000 U. S. Census report, there are 4,324,572 persons residing in the 10-county HSDA area.

-  This is 20% of the population of Texas in the EMA and 21% in the HSDA.
-  Over 81% of the people living in the EMA live in Harris County and nearly 79% of those in the HSDA live in Harris County.

- ✂ The second largest county is Fort Bend (9%) followed by Montgomery County (7%).
- ✂ The smallest counties by population include Colorado, Austin and Chambers, each with less than 30,000 residents.

Both the EMA and the HSDA populations are projected to grow approximately 18% between 2000 and 2010. This is faster growth than the 16% that is projected for Texas overall.

- ✂ The fastest growing counties include Montgomery (29%), Fort Bend (27%) and Waller (26%).
- ✂ The slowest growing counties are the four outside the EMA, Colorado (3.5%), Wharton (5.8%), Austin (8.4%) and Walker (9.6%). Refer to Table 1.1.3.
- ✂ The 45 to 64 age group is projecting the greatest growth in the EMA, HSDA and state, between 41% and 45%.
- ✂ This is followed by the 65+ group, but the EMA and HSDA are projected to grow at a faster rate than the state, 37% for the EMA, 35% for the HSDA compared to 22% for Texas.
- ✂ Youth, those 13 to 24 years, are projected to increase 15% in the EMA and 14% in the HSDA compared to 12% for the state. Refer to Table 1.1.4. Refer to Appendix A for population projections by age, gender and county.
- ✂ Relatively slow growth, 6.5%, is projected for the 25 to 44 year age group.

Table 1.1.3

HOUSTON EMA/HSDA COUNTIES & TOTAL POPULATION GROWTH BY COUNTY, 2000 - 2010

County	Population 2000		Population 2010		Percent Change 2000-2010
	#	%*	#	%*	
Chambers	26,031	0.6%	31,375	0.6%	20.5%
Fort Bend	354,452	8.2%	449,811	8.8%	26.9%
Harris	3,400,578	78.6%	3,951,682	77.6%	16.2%
Liberty	70,154	1.6%	81,930	1.6%	16.8%
Montgomery	293,768	6.8%	379,363	7.5%	29.1%
Waller	32,663	0.8%	41,137	0.8%	25.9%
EMA Total	4,177,646	96.6%	4,935,298	96.9%	18.1%
Austin	23,590	0.6%	25,582	0.5%	8.4%
Colorado	20,390	0.5%	21,101	0.4%	3.5%
Walker	61,758	1.4%	67,664	1.3%	9.6%
Wharton	41,188	1.0%	43,560	0.9%	5.8%
HSDA Total	4,324,572	100.0%	5,093,205	100.0%	17.8%
Texas Total	20,851,820	100.0%	24,178,507	100.0%	16.0%

Source: Texas comptroller's winter 2001-2002 county forecast (www.window.state.tx.us). Retrieved on March 25, 2004.

*Reflects percent of total HSDA population




Table 1.1.4
HOUSTON EMA/HSDA & TEXAS TOTAL PROJECTED POPULATION CHANGE BY AGE
2000 - 2010

County	Population 2000		Population 2010		Percent Change 2000-2010
	#	%	#	%	
EMA COUNTIES					
Under 2 years	137,130	3.3%	149,476	3.0%	9.0%
2 - 12 years	755,031	18.1%	798,633	16.2%	5.8%
13 - 24 years	744,824	17.8%	857,075	17.4%	15.1%
25 - 44 years	1,379,256	33.0%	1,468,249	29.7%	6.5%
45 - 64 years	850,192	20.4%	1,236,403	25.1%	45.4%
65 and older	311,213	7.4%	425,462	8.6%	36.7%
Total	4,177,646	100.0%	4,935,298	100.0%	18.1%
HSDA COUNTIES					
Under 2 years	140,638	3.3%	153,444	3.0%	9.1%
2 - 12 years	775,471	17.9%	819,610	16.1%	5.7%
13 - 24 years	777,164	18.0%	889,303	17.5%	14.4%
25 - 44 years	1,420,468	32.8%	1,512,477	29.7%	6.5%
45 - 64 years	881,084	20.4%	1,273,478	25.0%	44.5%
65 and older	329,747	7.6%	444,893	8.7%	34.9%
Total	4,324,572	100.0%	5,093,205	100.0%	18.1%
TEXAS					
Under 2 years	652,970	3.1%	730,538	3.0%	11.9%
2 - 12 years	3,608,917	17.3%	3,868,799	16.0%	7.2%
13 - 24 years	3,799,040	18.2%	4,256,960	17.6%	12.1%
25 - 44 years	6,537,409	31.4%	6,915,579	28.6%	5.8%
45 - 64 years	4,186,017	20.1%	5,892,533	24.4%	40.8%
65 and older	2,067,467	9.9%	2,514,098	10.4%	21.6%
Texas Total	20,851,820	100.0%	24,178,507	100.0%	16.0%

Source: Texas comptroller's winter 2001-2002 county forecast (www.window.state.tx.us). Retrieved on March 25, 2004.

RACE/ETHNICITY

While the EMA and the HSDA have similar racial and ethnic make ups, they differ from Texas overall.

-  White, non-Latinos are the largest population group in the HSDA, comprising 46% of overall HSDA population.
-  Hispanics/Latinos are a somewhat smaller percentage in the EMA and HSDA than the state, 30% in the region and 32% in the state.
-  Non-Hispanic Blacks/African-Americans are a larger percentage of the population in the EMA and HSDA than in the state, making up over 17% of the people in the region compared to 11% in Texas.

- ⓧ Larger percentages of Asians also live in the EMA and HSDA than in the state overall. Asians are 5% of the regional population and less than 3% of those living in the state. Refer to Table 1.1.5, and Figure 1.1.2.

In Harris and Fort Bend Counties, minorities make up the “majority” of residents. White/Anglo are the majority in all other counties.

- ⓧ By county, Harris County has the most racially and ethnically diverse population with 33% Hispanic/Latino, 18% Black/African-American and 5% Asian.
- ⓧ The counties with the largest percentages of Black/African-American residents are Waller (29%), Walker (24%), and Fort Bend (20%).
- ⓧ The counties with the largest percentage of Hispanic/Latino residents are Harris (33%), Wharton (31%) and Fort Bend (21%).
- ⓧ Fort Bend County has the largest percentage of Asian residents with over 11%. Refer to Table 1.1.5 and Figure 1.1.3.
- ⓧ In the EMA and HSDA, women make up a larger percentage of the Black/African-American population than men, and men are a larger percentage of the Hispanic/Latino population than women. Refer to Table 1.1.6.
- ⓧ Of the Hispanic/Latino population, the largest percentage is of Mexican heritage. Mexicans comprise 24% of Harris County residents and 22% of Wharton County residents.
- ⓧ Twenty percent of EMA and HSDA residents were born outside the U. S. This compares to 14% in the state of Texas. In both the region and the state, these foreign born residents most frequently come from North, Central and South America. Mexico is the most frequent place of foreign birth, accounting for about half of those born outside the U. S.
- ⓧ Approximately 4% of the EMA and HSDA populations were born in Asia.

Table 1.1.5
HOUSTON EMA/HSDA COUNTIES & TOTAL POPULATION BY RACE & ETHNICITY, 2000

County	Total Pop	White, Non-Hispanic	Black/ African-American, Non-Hispanic	Hispanic/Latino	Asian, Non-Hispanic	Other, Non-Hispanic
	N	%	%	%	%	%
Chambers	26,031	77.6%	9.7%	10.8%	0.7%	1.2%
Fort Bend	354,355	46.2%	19.6%	21.1%	11.2%	1.9%
Harris	3,399,186	42.1%	18.2%	32.9%	5.1%	1.6%
Liberty	70,136	74.6%	12.8%	10.9%	0.3%	1.5%
Montgomery	293,688	81.4%	3.4%	12.6%	1.1%	1.4%
Waller	32,660	49.9%	29.1%	19.4%	0.4%	1.3%
EMA TOTAL	4,176,056	46.1%	17.2%	29.9%	5.2%	1.6%
Austin	23,589	71.9%	10.5%	16.1%	0.3%	1.2%
Colorado	20,387	64.6%	14.5%	19.7%	0.2%	1.0%
Walker	61,733	60.1%	23.8%	14.1%	0.8%	1.3%
Wharton	41,170	53.0%	14.7%	31.3%	0.3%	0.7%
HSDA TOTAL	4,322,935	46.6%	17.3%	29.6%	5.0%	1.6%
TEXAS TOTAL	20,851,820	52.4%	11.3%	32.0%	2.7%	1.6%

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

Percentage calculations are based on the total population of each gender

Table 1.1.6
HOUSTON EMA/HSDA TOTAL POPULATION BY RACE, ETHNICITY & GENDER, 2000

County	Total Pop	White, Non-Hispanic	Black/ African-American, Non-Hispanic	Hispanic/Latino	Asian, Non-Hispanic	Other, Non-Hispanic
	N	%	%	%	%	%
EMA-female	2,098,020	46.5%	18.3%	28.5%	5.2%	1.6%
EMA-male	2,079,626	45.6%	16.2%	31.3%	5.2%	1.7%
HSDA-female	2,165,988	47.0%	18.2%	28.2%	5.0%	1.6%
HSDA-male	2,158,584	46.1%	16.3%	31.0%	5.0%	1.7%

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

Percentage calculations are based on the total population of each gender

Figure 1.1.2
HOUSTON EMA/HSDA AND TEXAS TOTAL POPULATION BY RACE & ETHNICITY, 2000

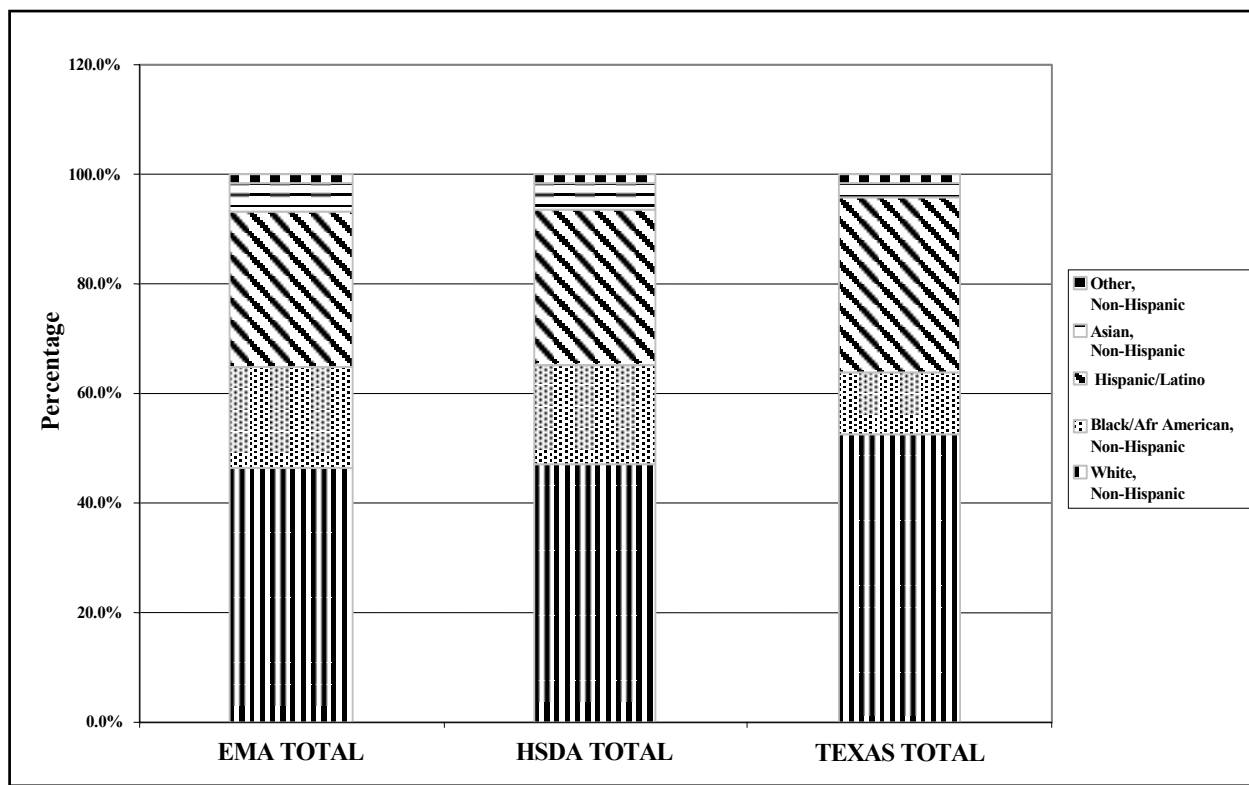


Figure 1.1.3
HOUSTON EMA/HSDA COUNTIES POPULATION BY RACE AND ETHNICITY, 2000

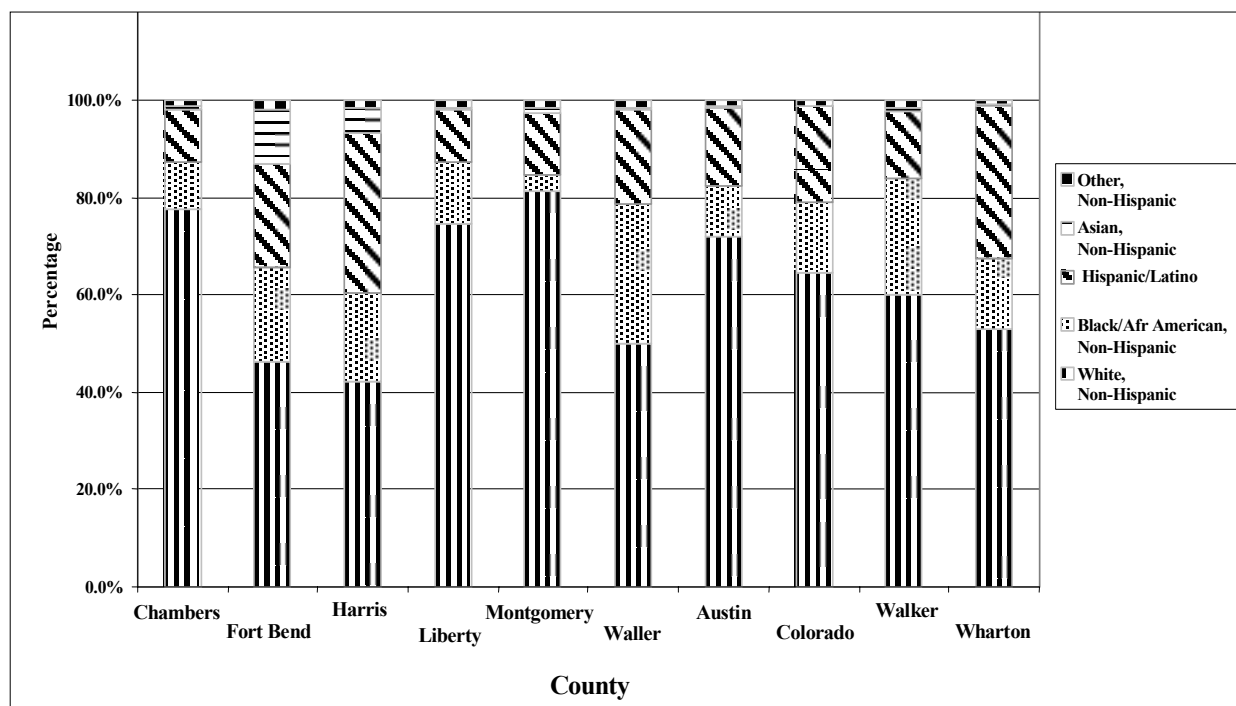


Table 1.1.7
HOUSTON EMA/HSDA COUNTIES & TOTAL HISPANIC/LATINO BY COUNTRY OF ORIGIN, 2000

County	Total Pop	Hispanic or Latino	Mexican	Puerto Rican	Cuban	Central American	South American	Other Hispanic or Latino
Chambers	26,031	10.8%	9.2%	0.1%	0.1%	0.1%	0.0%	1.3%
Fort Bend	354,452	21.1%	14.5%	0.3%	0.3%	1.0%	0.7%	4.3%
Harris	3,400,578	32.9%	24.0%	0.4%	0.2%	2.3%	0.7%	5.3%
Liberty	70,154	10.9%	9.2%	0.1%	0.0%	0.1%	0.0%	1.4%
Montgomery	293,768	12.6%	9.5%	0.2%	0.1%	0.7%	0.3%	1.9%
Waller	32,663	19.4%	16.0%	0.2%	0.1%	0.2%	0.1%	2.8%
EMA TOTAL	4,177,646	29.9%	21.7%	0.3%	0.2%	2.0%	0.6%	4.9%
Austin	23,590	16.1%	13.4%	0.1%	0.2%	0.2%	0.1%	2.2%
Colorado	20,390	19.7%	15.4%	0.1%	0.2%	0.1%	0.1%	4.0%
Walker	61,758	14.1%	11.7%	0.1%	0.0%	0.8%	0.1%	1.4%
Wharton	41,188	31.3%	22.1%	0.1%	0.1%	0.1%	0.0%	8.9%
HSDA TOTAL	4,324,572	29.6%	21.5%	0.3%	0.2%	2.0%	0.6%	4.9%
TEXAS TOTAL	20,851,820	32.0%	24.3%	0.3%	0.1%	0.7%	0.2%	6.2%

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

Percentage calculations are based on the total population of each gender

Figure 1.1.4
HOUSTON EMA/HSDA AND TEXAS HISPANIC/LATINO BY COUNTRY OF ORIGIN, 2000

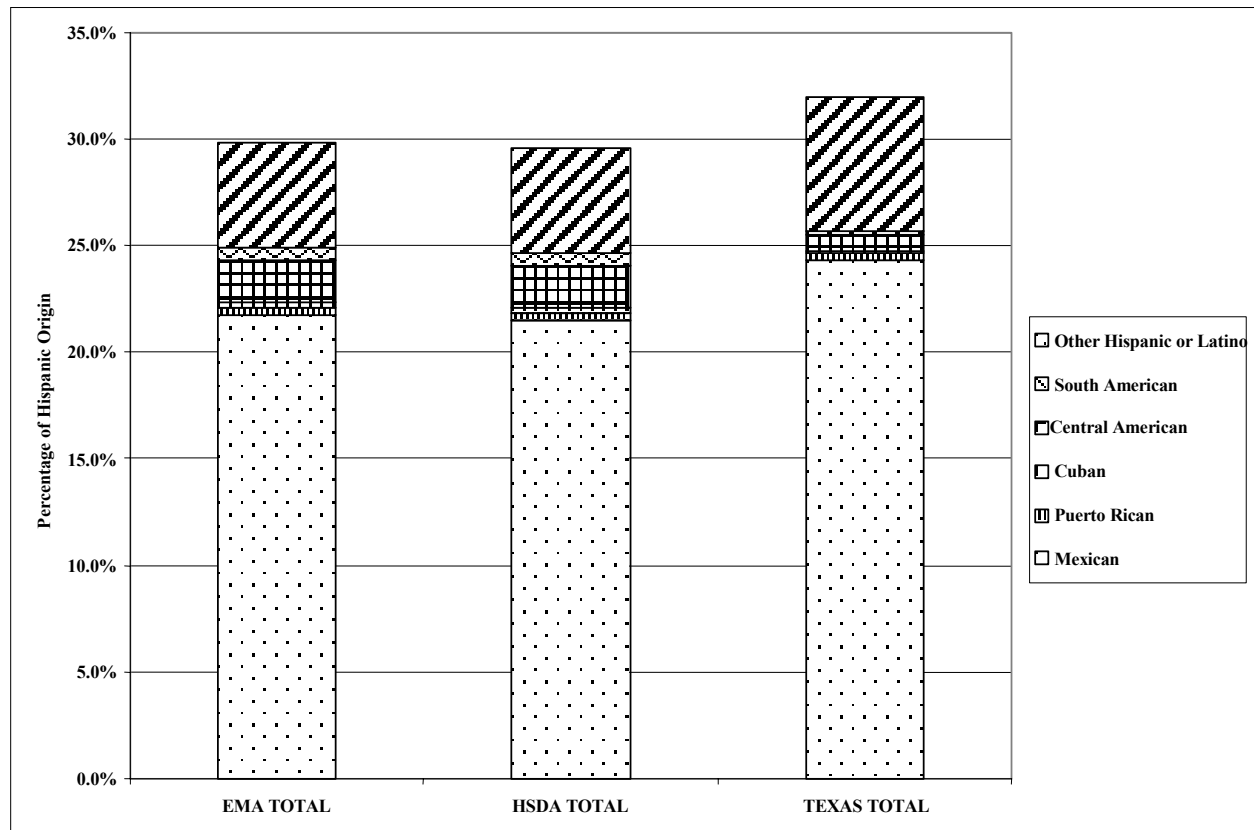


Figure 1.1.5
HOUSTON EMA/HSDA COUNTIES HISPANIC/LATINO BY COUNTRY OF ORIGIN, 2000

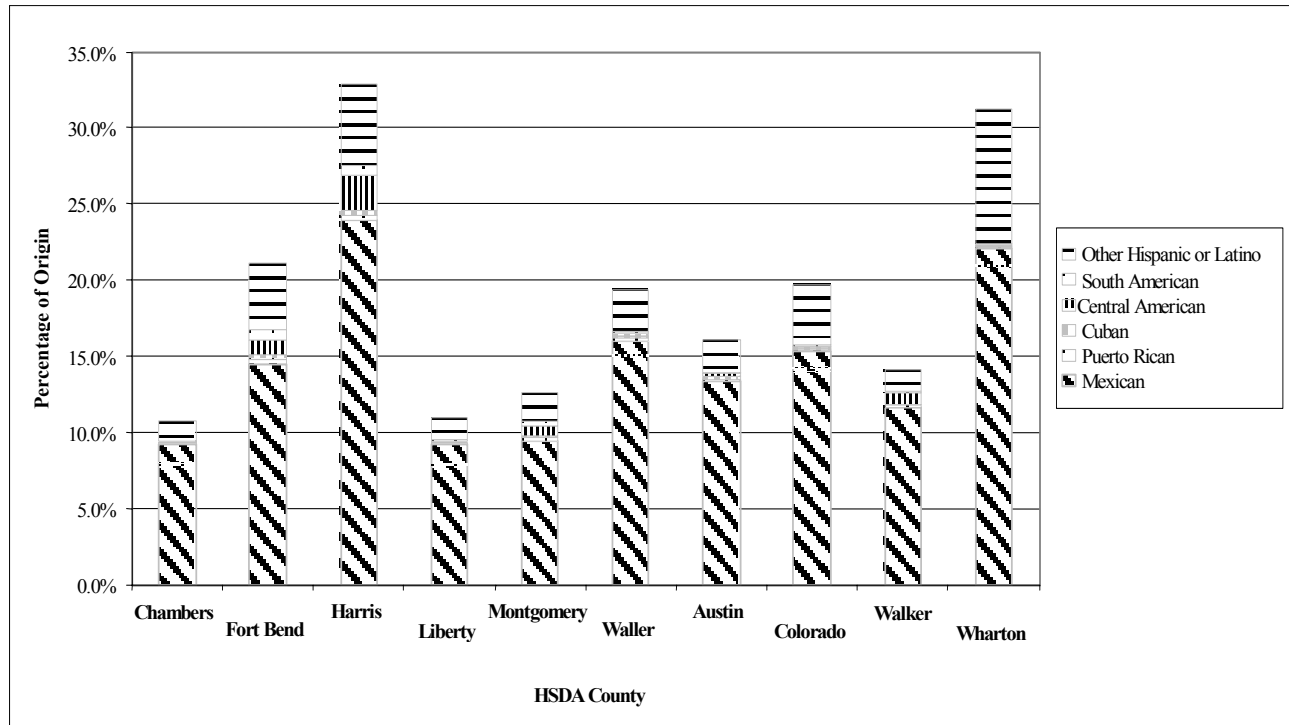
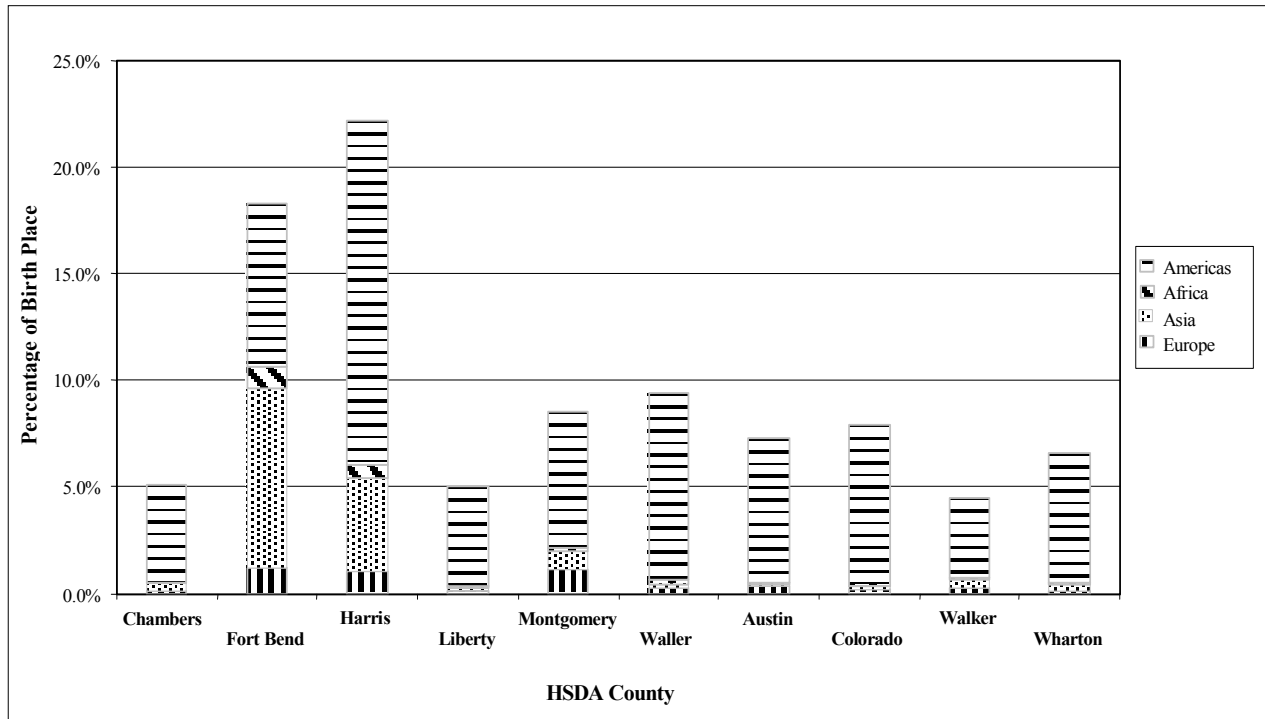


Table 1.1.8
HOUSTON EMA/HSDA COUNTIES & TOTAL FOREIGN BORN BY PLACE OF BIRTH, 2000

County	Total Population	Total Foreign Born	Birth Place for Foreign Born				
			Europe	Asia	Africa	Americas	Mexico
Chambers	26,031	5.1%	0.1%	0.3%	0.0%	4.6%	4.4%
Fort Bend	354,452	18.3%	1.2%	8.4%	1.0%	7.6%	4.5%
Harris	3,400,578	22.2%	1.1%	4.3%	0.7%	16.1%	11.6%
Liberty	70,154	5.1%	0.1%	0.2%	0.1%	4.7%	4.3%
Montgomery	293,768	8.6%	1.1%	0.9%	0.2%	6.4%	4.7%
Waller	32,663	9.4%	0.3%	0.2%	0.2%	8.8%	8.0%
EMA Total	4,177,646	20.5%	1.1%	4.3%	0.6%	14.4%	10.3%
Austin	23,590	7.3%	0.3%	0.1%	0.0%	6.8%	6.1%
Colorado	20,390	7.9%	0.2%	0.2%	0.0%	7.5%	7.1%
Walker	61,758	4.5%	0.2%	0.4%	0.1%	3.7%	2.8%
Wharton	41,188	6.6%	0.1%	0.3%	0.1%	6.1%	5.7%
HSDA Total	4,324,572	20.0%	1.0%	4.2%	0.6%	14.1%	10.2%
TEXAS Total	20,851,820	13.9%	3.5%	10.8%	1.5%		

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.
Percentage calculations are based on the total population of each gender

Figure 1.1.6
HOUSTON EMA/HSDA COUNTIES FOREIGN BORN BY PLACE OF BIRTH, 2000



LINGUISTIC ISOLATION

Approximately one-third of EMA and HSDA residents are “linguistically isolated,” meaning they speak English less than “very well.”

- ⚡ More than one-third of the people living in Harris County and 30% of the people living in Fort Bend speak English less than “very well.”
- ⚡ The largest percentages of linguistically isolated people are Spanish speaking.
- ⚡ More than one-quarter of those who speak Indo-European languages (i.e., Spanish, Italian, Portuguese, Russian, German, Bengali, etc) are linguistically isolated.
- ⚡ Very few of those speaking Asian and Pacific Islander languages report being linguistically isolated. Refer to Table 1.1.9.

Table 1.1.9
HOUSTON EMA/HSDA COUNTIES & TOTAL LINGUISTIC ISOLATION*, 2000

County	Total 5+ Pop	English Only Pop	Speak other than English						
			Total Pop**	Spanish		Indo-European		Speak Asian/Pacific Island	
				Total Pop	LI†	Total Pop	LI†	Total Pop	LI†
Chambers	24,205	88.3%	2,834	2,265	43.9%	460	29.1%	87	8.0%
Fort Bend	327,666	69.3%	100,596	57,612	40.0%	16,603	24.8%	22,409	4.4%
Harris	3,121,999	63.8%	1,129,856	898,885	52.9%	87,470	28.2%	116,285	4.5%
Liberty	65,425	87.7%	8,030	7,042	44.4%	733	13.4%	129	0.0%
Montgomery	271,298	86.2%	37,552	31,077	49.4%	4,258	18.3%	1,854	6.0%
Waller	30,397	81.9%	5,513	4,994	52.9%	364	25.0%	74	13.5%
EMA Total	3,840,990	66.6%	1,284,381	1,001,875	52.0%	109,888	27.2%	140,838	4.5%
Austin	22,056	82.9%	3,770	2,967	46.6%	795	29.1%	87	8.0%
Colorado	19,150	80.1%	3,818	3,130	49.1%	626	26.0%	24	54.2%
Walker	58,854	85.7%	8,390	7,586	44.4%	455	18.2%	285	1.1%
Wharton	38,401	73.3%	10,239	9,145	35.7%	989	19.3%	74	5.4%
HSDA Total	3,979,451	67.1%	1,310,598	1,024,703	51.8%	112,753	27.1%	141,308	4.5%
TEXAS Total	19,241,518	68.8%	6,010,753	5,195,182	45.6%	358,019	25.8%	374,330	4.6%

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

*Linguistic Isolation = speaks English less than “very well.”

**Total Pop reflects all speaking that language.

† LI = Percentage of those speaking the language who are linguistically isolated/speak English less than “very well.”

SOCIOECONOMIC STATUS

Median household income helps explain how much money people in the region earn. Since it is for “household”, it is the combined amount of money earned by everyone living in a household. The “median income” means that half the people living in the region/county earn less than that amount and half earn more. While the higher median income is better for the region, it has to be considered against the cost of living in an area and the number of people in each household. Typically, the cost of living in urban areas is higher than in rural areas.

People living in the EMA and HSDA have higher median household incomes than people throughout the entire state of Texas. Within the EMA, the median income is nearly \$47,000 per year which is \$5,000 higher than in the HSDA and \$7,000 higher than is found in the state.

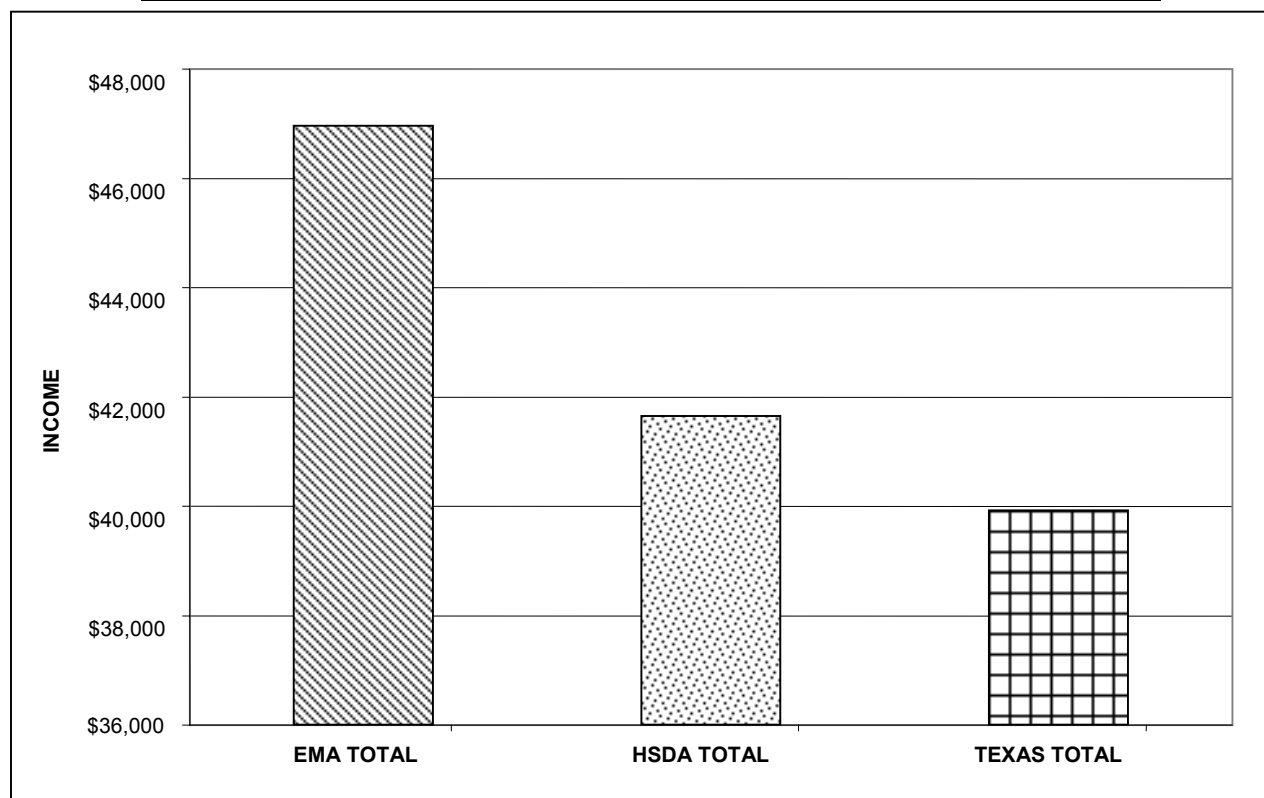
- ✂ Fort Bend County residents have the highest median household income of all the counties in the HSDA with nearly \$64,000 per year.
- ✂ The area with the second highest median income is Montgomery County with over \$50,000 per year.
- ✂ Counties with the lowest median household income are three of the four HSDA counties outside the EMA: Colorado, Wharton and Walker. Refer to Table 1.1.10 and Figure 1.1.7.

Table 1.1.10
HOUSTON EMA/HSDA COUNTIES & TOTAL MEDIAN HOUSEHOLD INCOME, 2000

County	Median Household Income
Chambers	\$47,964
Fort Bend	\$63,831
Harris	\$42,598
Liberty	\$38,361
Montgomery	\$50,864
Waller	\$38,136
EMA Total	\$46,959
Austin	\$38,615
Colorado	\$32,425
Walker	\$31,468
Wharton	\$32,208
HSDA Total	\$41,647
TEXAS Total	\$39,927

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

Figure 1.1.7
HOUSTON EMA/HSDA & TEXAS TOTAL MEDIAN HOUSEHOLD INCOME, 2000



OWNER COST AND GROSS RENT AS A PERCENTAGE OF HOUSEHOLD INCOME

The U. S. Census Bureau tracks the percentage of household income that is spent on housing. For people that own their homes, owner cost includes all expenses required to own a home such as mortgage payments, real estate taxes, homeowners' insurance, utilities, condominium and association fees, etc. For people that rent their home or apartment, this includes rent, utilities and other associated costs. These costs are reported as a percentage of household income. Unfortunately, the same percentages are not used for owner cost and renter cost, so direct comparisons are not possible. (Table 1.1.11 and Table 1.1.12)






-  Considering owner cost, five HSDA counties have approximately two-thirds of residents whose owner cost is less than 20% of household income. These are generally rural counties.
-  The counties with the most residents with owner costs more than 20% of household income are the most urban counties, including Fort Bend (54.1%), Harris (59.1%) and Montgomery (60.3%).
-  Waller County has the highest percentage with owner cost greater than 35% of income (17.1%). This is followed by Fort Bend County (14.3%) and Harris County (14.3%). Refer to Table 1.1.11
-  Chambers, Liberty and Austin Counties have the lowest renter costs, including the largest percentages of their populations with renter costs below 15% of income.
-  Walker County has the highest renter cost, with 42% of the population spending 35% or more of their incomes on rent. This is followed by Waller County with 29% of their residents at that level. Harris, Liberty and Montgomery all have approximately 27% of their residents dedicating 35% or more of their incomes to rent. (Table 1.1.12)

Table 1.1.11
HOUSTON EMA/HSDA COUNTIES OWNER COST AS PERCENTAGE
OF HOUSEHOLD INCOME, 2000

County	Total N ¹	<20% %	20-24% %	25-34% %	>35% %
Chambers	5,320	68.1%	11.7%	9.4%	10.7%
Fort Bend	81,296	54.1%	15.6%	15.6%	14.7%
Harris	592,221	59.1%	13.4%	13.2%	14.3%
Liberty	10,097	66.5%	10.4%	11.3%	11.8%
Montgomery	59,089	60.3%	14.3%	12.8%	12.5%
Waller	4,125	61.0%	11.2%	10.7%	17.1%
EMA Total	752,148	58.8%	13.7%	13.4%	14.1%
Austin	3,956	68.0%	10.0%	10.9%	11.1%
Colorado	3,742	69.6%	6.9%	10.1%	13.4%
Walker	6,165	64.2%	12.5%	11.3%	12.0%
Wharton	7,592	68.2%	9.9%	10.2%	11.7%
HSDA Total	773,603	59.0%	13.6%	13.3%	14.1%
Texas Total	3,809,005	59.6%	13.4%	13.3%	13.7%

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

¹ Includes only households that monthly cost was computed.

Figure 1.1.8
HOUSTON EMA/HSDA & TEXAS OWNER COST AS PERCENTAGE OF HOUSEHOLD INCOME
2000

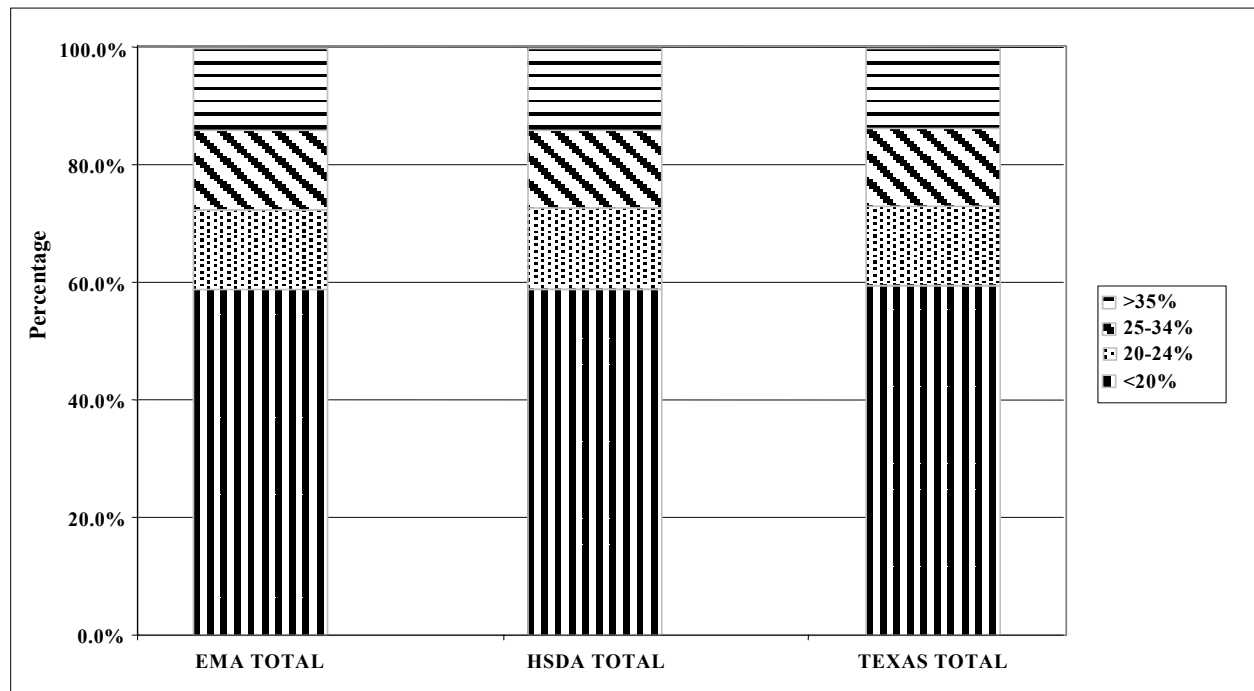


Figure 1.1.9
HOUSTON EMA/HSDA COUNTIES OWNER COST AS PERCENTAGE OF HOUSEHOLD INCOME,
2000

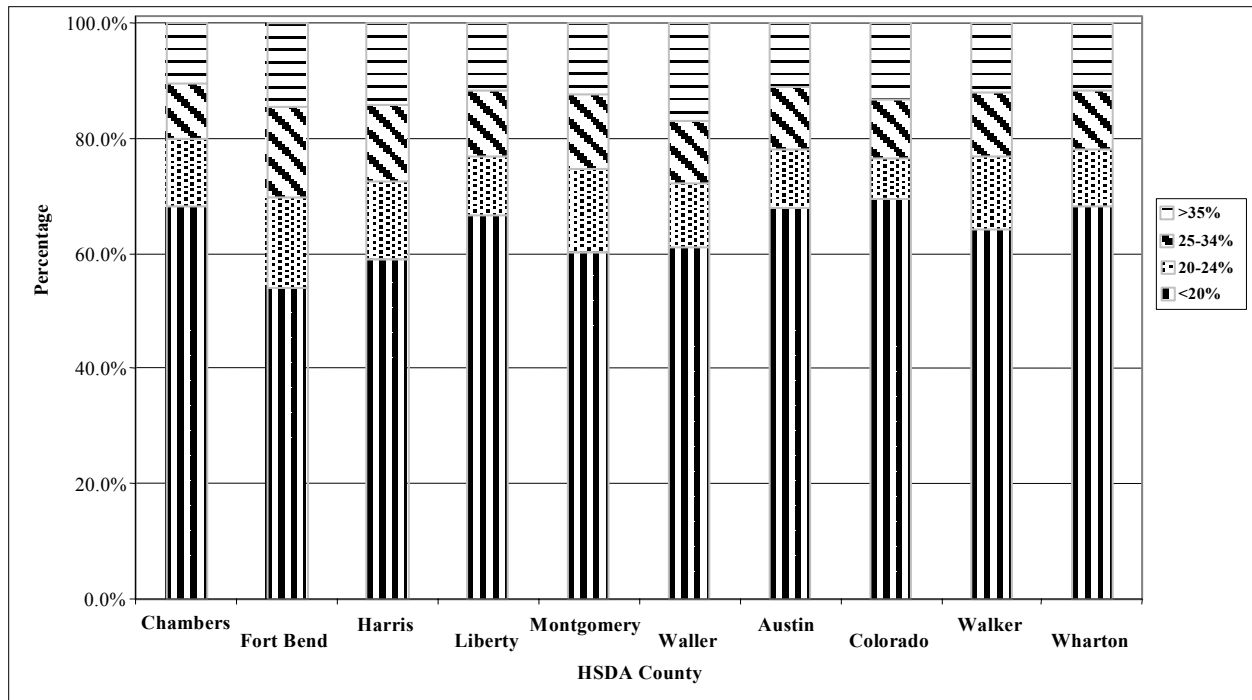


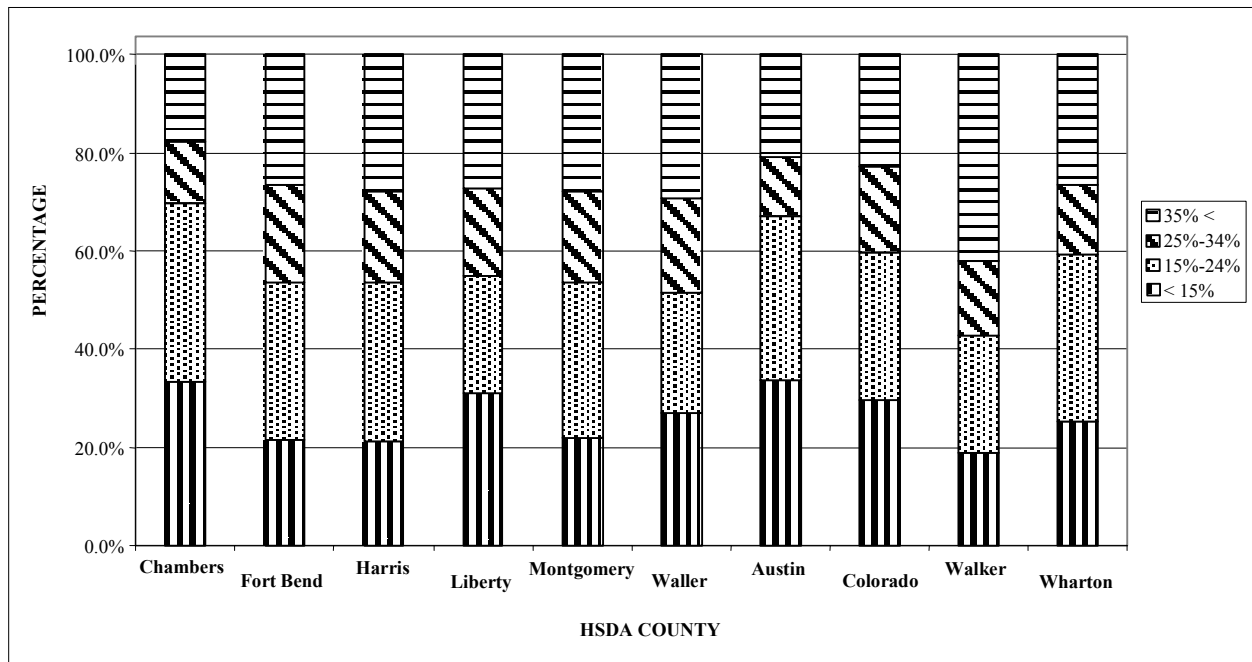
Table 1.1.12
HOUSTON EMA/HSDA COUNTIES GROSS RENT AS A PERCENTAGE OF HOUSEHOLD INCOME,
2000

County	Total households*	<15%	15%-24%	25%-34%	>35%
Chambers	1,238	33.5%	36.3%	12.4%	17.7%
Fort Bend	19,652	21.8%	31.9%	19.8%	26.5%
Harris	507,029	21.3%	32.3%	18.6%	27.8%
Liberty	4,136	31.1%	23.8%	17.8%	27.2%
Montgomery	20,397	22.1%	31.6%	18.6%	27.7%
Waller	2,341	27.0%	24.5%	19.2%	29.3%
EMA Total	554,793	21.5%	32.1%	18.7%	27.7%
Austin	1,581	33.6%	33.5%	12.0%	20.8%
Colorado	1,305	29.6%	30.2%	17.2%	23.0%
Walker	6,423	18.9%	23.9%	15.3%	41.9%
Wharton	3,769	25.4%	33.9%	14.3%	26.4%
HSDA Total	567,871	21.5%	32.1%	18.6%	27.8%

* Total households of which rental statistics are calculated.

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

Figure 1.1.10
HOUSTON EMA/HSDA COUNTIES
GROSS RENT AS PERCENTAGE OF HOUSEHOLD INCOME



EMPLOYMENT STATUS

The most current employment data at the county level is from 2003. In 2003, unemployment in the EMA, HSDA and state was 6.8% to 6.9%. Refer to Table 1.1.13.

- ✚ The county with the highest unemployment was Liberty, with 10.4% unemployment.
- ✚ Those with the lowest were Walker (3.3%), Austin and Colorado (both with 4.8%).
- ✚ It should be noted that although employment is high in Walker and Colorado Counties, median household income is among the lowest in the region.

Table 1.1.13
HOUSTON EMA/HSDA COUNTIES EMPLOYMENT STATUS OF RESIDENTS
OVER 16 YEARS OF AGE, 2003

County	Pop 16+	# In labor force	Unemployed	Unemployed
			#	%
Chambers	21,033	13,010	810	6.2%
Fort Bend	282,690	208,885	12,291	5.9%
Harris	2,654,562	1,891,103	132,911	7.0%
Liberty	56,120	31,972	3,341	10.4%
Montgomery	238,131	160,205	8,577	5.4%
Waller	27,222	15,177	1,033	6.8%
EMA Total	3,279,758	2,320,352	158,963	6.9%
Austin	18,726	14,341	692	4.8%
Colorado	16,186	8,446	409	4.8%
Walker	53,685	23,973	803	3.3%
Wharton	31,688	19,695	1,353	6.9%
HSDA Total	3,400,043	2,386,807	162,220	6.8%
Texas Total	16,454,277	10,910,344	737,516	6.8%

Source: Texas Workforce Commission's Labor Market Information Department (www.tracer2.com). Retrieved on March 25, 2004.

Unemployed % is based on the number of persons in labor force.

EDUCATIONAL ATTAINMENT

Educational attainment reflects each person in an area's highest grade in school. The EMA, HSDA and state are similar with 11% going through eighth grade or less, 13% going to high school, but not graduating, approximately half graduating from high school and possibly attending some college, and roughly one-quarter receiving a bachelor's degree in college or higher. Refer to Table 1.1.14 and Figures 1.1.11 and 1.1.12.

- ✂ Counties with the highest percentage getting their high school diploma or more include: Fort Bend (84.3%), Montgomery (81.6%), Chambers (77.0%), Harris (74.6%), and Waller (73.9%).
- ✂ Counties with the highest percentage of residents who did not go beyond eighth grade include: Colorado, Wharton, Austin and Harris.
- ✂ High numbers of students may explain counties showing both the highest percentage of high school diplomas and those who did not go beyond eighth grade.

Table 1.1.14
HOUSTON EMA/HSDA COUNTIES EDUCATIONAL ATTAINMENT, 2000

County	Total Pop >25	Less than 9th grade	9th-12th grade, no diploma	High School Graduate, Some College, Associate	Bachelor or higher
Chambers	16,348	8.5%	14.5%	64.9%	12.1%
Fort Bend	214,461	7.2%	8.5%	47.4%	36.9%
Harris	2,067,399	12.1%	13.3%	47.7%	26.9%
Liberty	44,206	10.5%	19.9%	61.5%	8.1%
Montgomery	183,743	6.3%	12.1%	56.3%	25.3%
Waller	18,395	11.1%	15.1%	57.1%	16.8%
EMA Total	2,544,552	11.2%	12.9%	48.7%	27.2%
Austin	15,280	12.2%	13.2%	57.2%	17.3%
Colorado	13,383	15.6%	15.3%	54.6%	14.4%
Walker	36,678	10.4%	16.6%	54.7%	18.3%
Wharton	25,567	15.5%	14.7%	55.4%	14.3%
HSDA Total	2,635,460	11.3%	13.0%	48.9%	26.8%
Texas Total	12,790,893	11.5%	12.9%	52.4%	23.2%

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

¹ is based on 25+ total population.

Figure 1.1.11
HOUSTON EMA/HSDA & TEXAS EDUCATIONAL ATTAINMENT, 2000

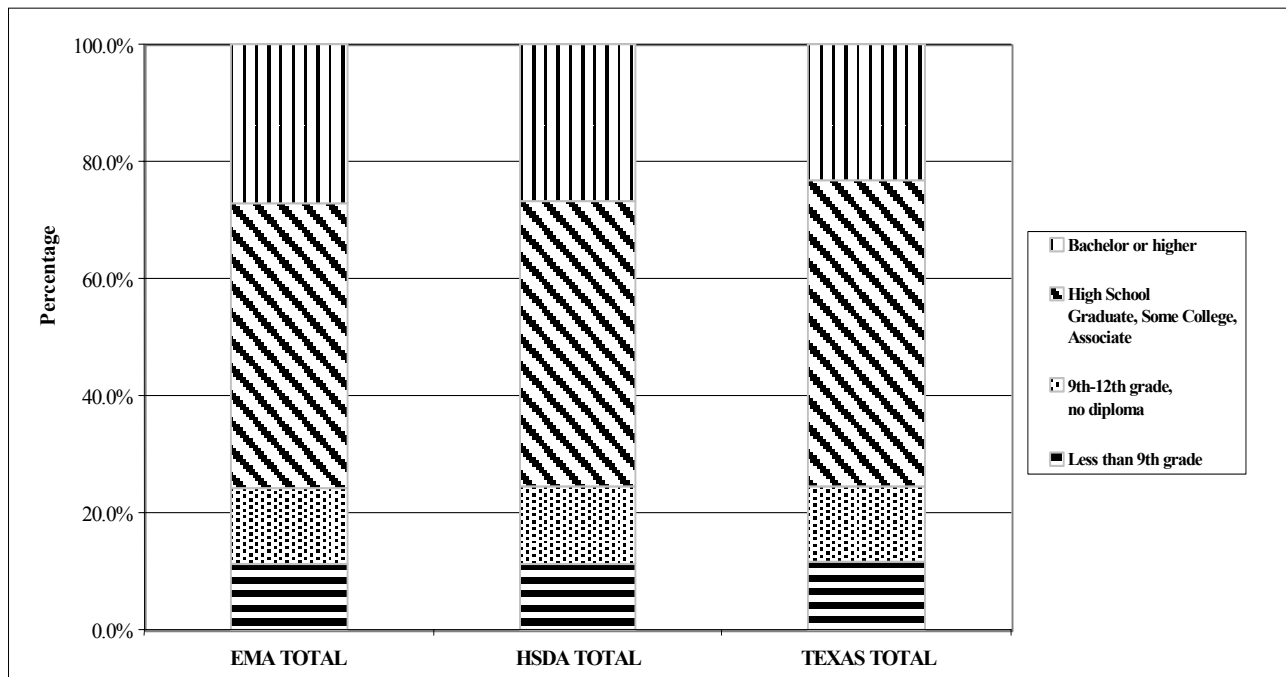
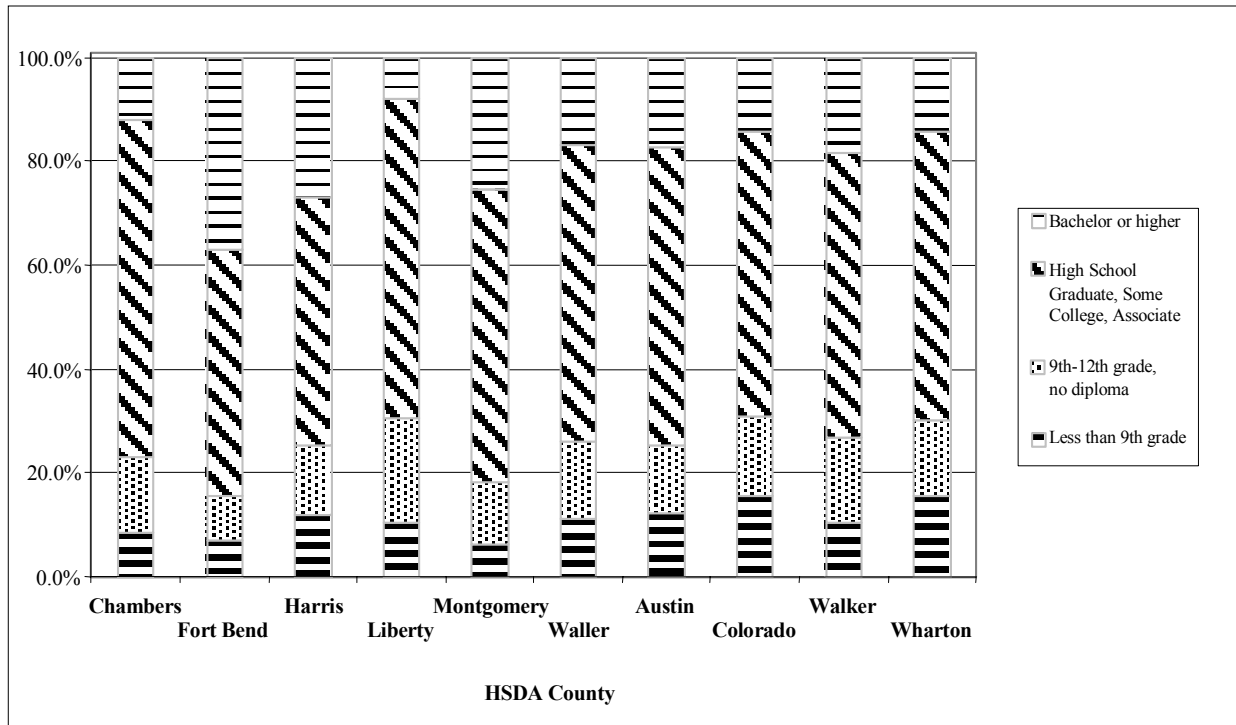


Figure 1.1.12
HOUSTON EMA/HSDA COUNTIES EDUCATIONAL ATTAINMENT, 2000



POVERTY STATUS

Both the EMA and the HSDA have lower rates of poverty than in Texas overall, with 13.9% and 14%, respectively, living in poverty compared to 15.4% for the state. Both the local and statewide percentages are larger than the 12.4% nationally who are living in poverty.

- ✂ Counties with the highest levels of poverty include Walker, Colorado and Wharton which are three of the four counties that are only part of the HSDA, and Waller and Harris in the EMA.
- ✂ Blacks/African-Americans in the EMA and HSDA make up a higher percentage of those living in poverty than is found throughout the state. Whites/Anglos and Hispanics/Latinos in the EMA and HSDA represent smaller percentages of those living in poverty when compared with the state overall. (Table 1.1.15)
- ✂ Children and others under 25 years of age are a large percentage of those living in poverty throughout the EMA, HSDA and state. (Table 1.1.16)
 - Families with single females as head of household comprise a large percentage of families in poverty. (Table 1.1.17)

Table 1.1.15
HOUSTON EMA/HSDA COUNTIES POVERTY LEVEL BY RACE, 2000

County	Total	Population for whom poverty status is determined: below poverty level		White	Black	Other [‡]	Hispanic [‡]
	N	N	%	%*	%*	%*	%*
Chambers	25,719	2,833	11.0%	6.5%	2.5%	2.1%	2.6%
Fort Bend	349,010	24,953	7.1%	2.9%	1.7%	2.6%	3.3%
Harris	3,360,536	503,234	15.0%	6.0%	4.2%	4.8%	7.5%
Liberty	64,878	9,296	14.3%	9.5%	3.0%	1.8%	2.8%
Montgomery	291,519	27,376	9.4%	7.0%	0.9%	1.5%	2.4%
Waller	29,487	4,718	16.0%	6.0%	6.5%	3.5%	5.4%
EMA Total	4,121,149	572,410	13.9%	5.9%	3.7%	4.3%	6.7%
Austin	23,345	2,814	12.1%	6.5%	2.6%	3.0%	4.7%
Colorado	19,543	3,171	16.2%	8.0%	4.9%	3.3%	5.0%
Walker	44,904	8,253	18.4%	10.6%	6.1%	1.6%	2.6%
Wharton	40,519	6,703	16.5%	8.1%	4.4%	4.0%	7.9%
HSDA Total	4,249,460	593,351	14.0%	6.0%	3.8%	4.2%	6.6%
Texas Total	20,287,300	3,117,609	15.4%	8.9%	2.6%	3.9%	8.2%

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

[‡] Hispanic and Other are not mutually exclusive.

* Percentages are based on total population of whom population status is determined.

Table 1.1.16
HOUSTON EMA/HSDA COUNTIES POVERTY BY AGE AND GENDER, 2000

Male							
County	Total Population	Income below poverty level		<25	25-44	45-64	65 ≤
	N	N	%	%*	%*	%*	%*
Chambers	25,719	1,213	4.7%	2.5%	0.8%	1.0%	0.3%
Fort Bend	349,010	11,438	3.3%	1.8%	0.8%	0.5%	0.2%
Harris	3,360,536	233,388	6.9%	3.9%	1.9%	0.8%	0.3%
Liberty	64,878	3,991	6.2%	3.5%	1.3%	1.0%	0.4%
Montgomery	291,519	12,091	4.1%	2.2%	1.1%	0.6%	0.3%
Waller	29,487	2,391	8.1%	4.6%	2.0%	1.2%	0.3%
EMA Total	4,121,149	264,512	6.4%	3.6%	1.8%	0.8%	0.3%
Austin	23,345	1,200	5.1%	2.5%	1.1%	1.0%	0.5%
Colorado	19,543	1,285	6.6%	3.4%	1.3%	1.0%	0.8%
Walker	44,904	3,672	8.2%	5.7%	1.3%	0.8%	0.5%
Wharton	40,519	3,024	7.5%	3.7%	1.6%	1.5%	0.7%
HSDA Total	4,249,460	273,693	6.4%	3.6%	1.8%	0.8%	0.3%
Texas Population	20,287,300	1,406,608	6.9%	4.0%	1.7%	0.9%	0.4%
Female							
County	Total Population	Income below poverty level		<25	25-44	45-64	65 ≤
	N	N	%	%*	%*	%*	%*
Chambers	25,719	1,620	6.3%	2.5%	1.7%	1.3%	0.7%
Fort Bend	349,010	13,515	3.9%	1.8%	1.2%	0.6%	0.4%
Harris	3,360,536	269,846	8.0%	4.0%	2.5%	1.0%	0.6%
Liberty	64,878	5,305	8.2%	3.4%	2.3%	1.2%	1.2%
Montgomery	291,519	15,285	5.2%	2.3%	1.5%	0.9%	0.6%
Waller	29,487	2,327	7.9%	3.7%	2.3%	1.0%	0.9%
EMA Total	4,121,149	307,898	7.5%	3.6%	2.3%	1.0%	0.6%
Austin	23,345	1,614	6.9%	2.7%	1.6%	1.1%	1.5%
Colorado	19,543	1,886	9.7%	4.1%	2.1%	1.4%	2.1%
Walker	44,904	4,581	10.2%	6.3%	2.1%	0.8%	1.1%
Wharton	40,519	3,679	9.1%	3.8%	2.0%	1.6%	1.7%
HSDA Total	4,249,460	319,658	7.5%	3.7%	2.3%	1.0%	0.6%
Texas Population	20,287,300	1,711,001	8.4%	4.2%	2.3%	1.7%	0.8%

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

* All percentages are based on total population of each gender.

Table 1.1.17
HOUSTON EMA/HSDA COUNTIES POVERTY BY FAMILY LEVEL, 2000

County	Families: Total	Families: Income in 1999 below poverty level		Married- couple family	Male householder; no wife present	Female householder; no husband present
	N	N	%	%	%	%
Chambers	7,221	601	8.3%	4.4%	0.5%	3.4%
Fort Bend	93,808	5,139	5.5%	2.8%	0.5%	2.2%
Harris	840,630	101,693	12.1%	5.8%	1.1%	5.2%
Liberty	17,937	1,998	11.1%	5.5%	0.8%	4.8%
Montgomery	80,723	5,766	7.1%	3.8%	0.5%	2.9%
Waller	7,837	901	11.5%	6.2%	1.3%	4.1%
EMA Total	1,048,156	116,098	11.1%	5.4%	1.0%	4.7%
Austin	6,493	570	8.8%	5.5%	0.5%	2.8%
Colorado	5,385	660	12.3%	6.2%	0.9%	5.2%
Walker	11,533	1,225	10.6%	5.1%	0.9%	4.6%
Wharton	10,774	1,430	13.3%	6.7%	1.5%	5.0%
HSDA Total	1,082,341	119,983	11.1%	5.4%	1.0%	4.7%
Texas Population	5,283,474	632,676	12.0%	6.0%	1.0%	5.1%

HEALTH AND INSURANCE STATUS

The most current data on insurance status at the county level are from 1999. As a state, Texas ranked first in the U. S. in 1998 according to percent of population uninsured (24.5%) and second in size of the uninsured population (4,880,000). In the HSDA, county populations ranged between one-fifth and one-quarter uninsured.

- ✚ Overall, Austin County had the lowest percentage of uninsured, 19.9%, and Harris County had the highest, 25.5%.
- ✚ Chambers County had the lowest percentage of uninsured children (20.8%) and Harris County had the highest (25.5%).
- ✚ Montgomery County had the lowest percentage of uninsured adults (22.6%) and Waller County had the highest (30.1%).
- ✚ A demographic breakdown of those living without insurance was not available by county. Statewide, the majority was male (53.6%) and Hispanic (48.3%).






Table 1.1.18
HOUSTON EMA/HSDA COUNTIES ESTIMATED PERCENTAGE OF RESIDENTS
WITHOUT INSURANCE, 1999

County	All People	Ages 0 - 18	Ages 19 – 64
	%	%	%
EMA			
Chambers	20.3	20.8	23.7
Fort Bend	22.7	22.4	24.6
Harris	25.5	25.5	28.1
Liberty	22.4	22.8	26.2
Montgomery	20.1	21.0	22.6
Waller	25.4	25.1	30.1
HSDA			
Austin	19.9	22.7	24.4
Colorado	20.8	24.0	26.7
Walker	25.4	22.9	29.5
Wharton	23.1	25.0	27.5
Texas	24.5		

Source: "Houston-Area 2002 Epidemiological Profile," page 10. Texas Health and Human Services Commission.

NATALITY CHARACTERISTICS

Natality statistics provide information about births in the region. These include general information such as birth rate and fertility rate as well as risk information that reflect risk to either the mother or baby.

-  Harris County has the highest birth rate and fertility rate in both the EMA and the HSDA. The birth rate ranks seventeenth out of all counties in the state, and the fertility rate is thirty-ninth. High birth and fertility rates result in a growing county population.
-  The nine other EMA and HSDA counties have birth rates and fertility rates that are lower than the state of Texas overall.
-  Wharton County demonstrates the highest risk in the percentage of adolescent mothers and lack of prenatal care in the first trimester, but their percentage of low birth weight infants is one of the lowest in the region.
-  Liberty, Austin, Colorado and Wharton counties have higher percentages of adolescent mothers than found in the state.
-  Chambers, Liberty, Austin and Wharton counties have higher percentages of mothers who do not receive prenatal care in the first trimester than found in the state.

- ⚡ Harris, Waller and Colorado counties have higher percentages of low birth weight infants than found in Texas overall. Refer to Table 1.1.19.
- ⚡ Infant mortality is presented in Table 1.1.19 with other mortality statistics. Chambers, Liberty, Montgomery, Colorado and Walker counties have higher infant death rates than found in the state overall.

Table 1.1.19
HOUSTON EMA/HSDA COUNTIES RATES & COUNTY RANKINGS FOR NATALITY
CHARACTERISTICS, 1998 - 2000

County	Crude Birth Rate		Fertility Rate			
	Rate	Rank	Rate	Rank		
EMA						
Chambers	12.1	171	53.2	232		
Fort Bend	14.2	104	58.7	202		
Harris	18.7	17	81.3	39		
Liberty	15.2	71	70.6	88		
Montgomery	15.5	63	67.6	119		
Waller	16.1	50	65.5	147		
HSDA						
Austin	14.8	86	73	72		
Colorado	13	145	67.6	119		
Walker	10.3	225	50	242		
Wharton	14.9	80	71.5	83		
Texas	17.4		76.7			
County	Adolescent Mothers		No Prenatal Care First Trimester		Low Birth Weight	
	%	Rank	%	Rank	%	Rank
EMA						
Chambers	4.9	218	22.3	83	6.9	163
Fort Bend	3.4	239	13.4	222	7.3	133
Harris	5.3	207	18.0	144	7.5	113
Liberty	6.5	170	22.3	83	7.3	133
Montgomery	4.4	232	17.8	147	6.5	191
Waller	7.8	111	19.6	123	7.6	108
HSDA						
Austin	6.2	180	22.6	77	6.7	176
Colorado	7.8	111	20.0	114	7.8	87
Walker	5.6	197	15.4	194	7.3	133
Wharton	9.4	53	35.1	15	6.4	197
Texas	6.0		20.8		7.4	

Rates reflect averages for 1998 – 2000 values and are per 100,000 population.

Source: "Selected Demographic & Public Health Measures: Rankings for Texas Counties 1998–2000".

MORTALITY CHARACTERISTICS

Mortality characteristics present death rates overall and for specific disease processes. These rates include deaths occurring over three years, 1998 through 2000. The 254 counties throughout Texas are ranked, and these rankings are also presented. (Refer to Table 1.1.20)




-  Liberty County has the highest mortality rate of the 10 HSDA Counties, ranking thirteenth in the state of Texas. They have the highest infant mortality rate in the state, and are in the top 15 for cancer, lower respiratory diseases and accidents.
-  Fort Bend has the lowest death rate of the ten HSDA counties, ranking 197 in the state.
-  Comparing the number of county deaths to overall deaths in the state for specific disease processes, reveals the following:
 - Liberty, Montgomery, Waller, Austin and Colorado counties have higher death rates from heart disease than the state.
 - Fort Bend, Harris, Liberty, Montgomery, Colorado and Walker counties have higher death rates from stroke than found in the state overall.
 - All EMA and HSDA counties except Fort Bend County and Austin County have higher death rates from cancer than Texas overall.
 - Chambers, Liberty, Montgomery, Waller and Walker counties have higher death rates from lower respiratory disease than Texas overall.
 - Chambers, Montgomery, Austin, Colorado and Wharton counties have higher death rates from diabetes than the state overall.
 - All EMA and HSDA counties except Fort Bend County and Harris County have higher death rates from accidents than found in the state.

Table 1.1.20
HOUSTON EMA/HSDA COUNTIES RATES & COUNTY RANKINGS FOR
MORTALITY CHARACTERISTICS AGE ADJUSTED DEATH RATES PER 100,000 POPULATION
1998 - 2000

County	All Deaths		Heart		Stroke		Cancer	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
EMA								
Chambers	888.2	149	237.7	186	138.7	145	227.0	48
Fort Bend	834.5	197	259.1	155	148.2	109	194.6	148
Harris	880.3	161	267.9	147	144.4	124	200.7	128
Liberty	1,092.9	13	323.3	42	147.4	113	265.0	11
Montgomery	981.6	77	295.0	94	155.0	89	225.0	56
Waller	910.2	141	301.0	82	138.9	144	211.0	99
HSDA								
Austin	890	147	331.3	31	131.1	167	188.1	174
Colorado	1,015.5	48	318.6	50	163.0	60	214.3	86
Walker	983.6	74	269.5	143	155.3	87	222.1	69
Wharton	852.9	183	239.4	181	119.9	184	208.3	106
Texas	891.2		269.7		141.4		198.8	
County	Lower Respiratory		Diabetes		Accidents		Infant Mortality	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
EMA								
Chambers	52.5	58	37.4	36	49.5	85	7.4	NR
Fort Bend	34.5	135	24.5	99	25.7	150	4.9	34
Harris	35.5	133	27.0	84	33.9	139	5.7	29
Liberty	69.9	14	25.7	88	78.1	14	11.3	1
Montgomery	56.6	46	31.5	59	47.4	90	6.5	21
Waller	46.4	93	26.4	NR	60.9	43	4.1	NR
HSDA								
Austin	28.8	144	35.5	41	57.5	51	4.8	NR
Colorado	29.7	142	42.6	26	82.4	13	11.6	NR
Walker	40.9	111	30.0	69	51.2	77	8.3	NR
Wharton	21.7	149	43.7	21	42.4	110	2.2	NR
Texas	44.8		30.7		38.6		6.1	

Rates reflect averages for 1998 – 2000 values.

Source: "Selected Demographic & Public Health Measures: Rankings for Texas Counties 1998-2000"

NR = 20 or fewer numerator events in the three year period are not ranked

MORBIDITY CHARACTERISTICS

Morbidity characteristics reflect the impact of an illness that does not result in death. The following presents the morbidity for three sexually transmitted diseases (STD): chlamydia, gonorrhea and AIDS. (Refer to Table 1.1.21)

- ⚡ Waller County has among the highest rates of both chlamydia and gonorrhea infection in the state, ranking sixth for the former and seventh for the latter.
- ⚡ Harris County is second in the state for AIDS morbidity, and also ranks highly for both STDs.
- ⚡ In the HSDA, both Walker and Wharton counties are in the top 50 counties in Texas for chlamydia and gonorrhea, with Wharton ranking 34 for the former and 28 for the latter, and Walker ranking 42 and 48, respectively.

Table 1.1.21
HOUSTON EMA/HSDA COUNTIES RATES & RANKINGS FOR MORBIDITY CHARACTERISTICS,
1998 - 2000

County	Reported Cases: Chlamydia		Reported Cases: Gonorrhea		Reported Cases: AIDS	
	Rate	Rank	Rate	Rank	%	Rank
EMA						
Chambers	69.3	196	18.0	NR	5.1	NR
Fort Bend	137.1	167	62.0	97	7.8	24
Harris	347.6	41	193.4	23	30.5	2
Liberty	170.7	141	77.3	87	10.3	16
Montgomery	108.6	181	43.6	120	6.5	32
Waller	611.8	6	325.8	7	6.7	NR
HSDA						
Austin	142	158	80.9	84	5.7	NR
Colorado	175.3	138	84.3	80	0	NR
Walker	340.5	42	131.8	48	2.9	NR
Wharton	363.5	34	183.3	28	4.8	NR
Texas	316.4		162.4		16.2	

Rates reflect averages for 1998 – 2000 values and are per 100,000 population.

Source: "Selected Demographic and Public Health Measures: Rankings for Texas Counties 1998 – 2000"




NR = 20 or fewer numerator events in the three year period are not ranked.

MEDICALLY UNDERSERVED

Medically underserved status is designated to areas or populations having a shortage of personal health care services according to U. S. Department of Health and Human Services' rules. Designations are based on weighted values assigned to the following four health care demands and resource indicators:

- Percentage of elderly population (over 65 years)
- Poverty rate
- Infant mortality rate
- Ratio of primary care physicians per 1,000 population

In order to be considered medically underserved the index score of these indicators will be less than or equal to the national average of 62.

-  Medically Underserved Areas (MUAs) are based on the demographics of the entire population in an area and the overall index scores are less than or equal to 62.
-  Medically Underserved Populations (MUPs) focus on specific populations and represent only a portion of an areas population. These specific populations encounter barriers to primary care access. The barriers may be economic (e.g. low income or Medicaid-eligible populations) or sociologic (e.g. cultural or linguistic). For only these populations the index score is less than or equal to 62. Other populations may have higher scores.
-  Exceptional MUPs (MUP-GOV) have index scores above the designated 62, but unusual local conditions that serve as barriers to access or availability of personal health services. The governor makes the MUP designation.

Nationally MUAs and MUPs were designated over five to ten years ago and are not regularly reviewed. Within the Houston area HSDA, however, most have been designated within the last two to four years, indicating a more current shortage.




-  All of the HSDA counties have full or partial designation as MUA. Six entire counties are designated as medically underserved.
-  Harris County has 18 neighborhoods with MUA designated census tracts. In addition, Harris County has four MUPs, one of which was designated by the governor.
-  Montgomery, Fort Bend and Colorado counties have MUA designated census tracts.

Table 1.1.22
HOUSTON EMA/HSDA COUNTIES MEDICALLY UNDERSERVED AREAS, 2004

County	Designation	Area Description
Chambers	MUA	Whole County
Fort Bend	MUA	Census Tracts 704-706, 707.02-707.03, 707.11, 707.21, 711-714
Harris	MUA	<p>Acres Home, Census Tracts 524, 525.02-525.04, 530.02, 531.01, 531.03, 530.03</p> <p>Aldine, Census Tracts 222.01, 222.02, 223.01, 223.02, 223.03, 224.01, 240.02</p> <p>Baytown, Census Tracts 264, 264.99, 265, 266, 270, 271, 272, 273</p> <p>Casa de Amigo, Census Tracts 503.01, 503.02, 505.01, 505.02, 506.01, 506.02, 507.01, 507.02, 508, 509.02, 509.03, 512, 514.01, 514.02, 515.02</p> <p>Central Harris, Census Tracts 201.01, 201.02, 204.00, 205.03, 502.00, 504.00</p> <p>East-Central Houston, Census Tracts 202.10, 202.20, 203.01, 203.02, 203.03, 208.02, 208.03, 209, 210.01, 214.01</p> <p>Galena Park/Jacinto City, Census Tracts 210.22, 211, 211.99, 212, 232, 232.99</p> <p>ID 03465, Census Tracts 400.25, 400.26, 401.01, 401.02, 402.01, 402.02</p> <p>Independence Heights, Census Tracts 509.01, 510.00, 519.02, 520.01, 520.03, 520.02, 521.01-521.03</p> <p>North Central, Census Tracts 240.01, 240.03, 532.02, 533.01-533.03, 535.20</p> <p>Northeast Central, Census Tracts 311.00, 311.99, 312.00</p> <p>Ripley, Census Tracts 300.22, 300.23, 301.01, 301.02, 302, 308.2, 309.01, 309.02, 309.03, 310, 313.01, 313.02, 314.02, 319.01, 321.01, 321.02</p> <p>Settegast, Census Tracts 207.01, 207.02, 208.01, 215.01, 215.02, 215.03, 216.01, 216.02, 217.01, 217.02, 218.01, 218.02, 218.03, 218.04, 219.00, 225.03, 225.04, 227.00</p> <p>South Central, Census Tracts 318.02, 318.03, 319.02, 325.01, 325.02, 327.01, 327.02, 328.01, 328.02, 328.03, 339.03, 340, 342, 343.01, 343.02</p> <p>South Service Area, Census Tracts 329.02, 329.03</p> <p>Southern Third Ward, Census Tracts 3122-3124, 3127-3130, 3132-3138</p> <p>Trinity Gardens, Census Tracts 205.01, 205.98, 206.01, 206.98, 207.03, 207.04</p> <p>West Pasadena, Census Tracts 350.01, 350.02, 350.03, 350.04, 351, 353.01, 356.01, 356.02, 356.03</p>
	MUP	<p>Alief, Low Income, Census Tracts 424.01, 435.01, 435.02</p> <p>Spring Branch, Low Income, Census Tracts 5201-5207, 5210-5224</p> <p>Third Ward, Low Income, Census Tracts 300.24, 303.00, 304.01, 304.02, 305.01, 305.02</p>
	MUP-GOV	S.W. Houston, Spanish-speaking, Poverty: Census Tracts 416.01, 419.01, 419.04-419.06, 423.05, 423.07, 424.02, 424.03, 425.04
Liberty	MUA	Whole County

(Table Continues)

(Table Continued)

County	Designation	Area Description
Montgomery	MUA	Census Tracts 904, 905, 910.10, 910.20, 911.02, 912.01
Waller	MUA	Whole County
Austin	MUA	Whole County
Colorado	MUA	Census tracts 1501, 1502
Wharton	MUA	Whole County
Walker	MUA	Whole County

Data Source: U. S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, Shortage Designation Branch, 4350 East-West Highway, 9th Floor, Bethesda, MD 20814

Prepared by: Texas Department of State Health Services, Center for Health Statistics, Health Professions Resource Center. Designations as of 6/4/04. www.DSHS.state.tx.us/dpa/01mua-wc.htm

HOMELESSNESS

In March 2003, the Coalition for the Homeless of Houston/Harris County, Inc. published their report, "Homeless Service Demands 2003, An Analysis of Trends, Services, Demographics." This report, while not specific to people living with HIV disease, provides background information on homelessness nationally and in the Houston area. It includes results of a survey of homeless individuals and homeless shelter providers. Key points to consider include:

- ⓧ Recent studies reveal that men continue to be the most represented group among the homeless, but families with children are increasing at a rapid rate. A 2001 U. S. Conference of Mayors Survey projects 40% of homeless are families.
- ⓧ This same study states the homeless population is 50% African-American, 35% white/Anglo, 12% Hispanic, 2% Native American and 1% Asian.
- ⓧ According to the National Coalition for the Homeless, as many as 22% of single adult homeless individuals have some form of "severe and persistent mental illness;" 34% have addiction disorders; approximately half of homeless women and children have experienced recent domestic violence.
- ⓧ One of the main reasons for homelessness is an increasing lack of affordable housing, due to increasing rents.

The survey of 18 emergency shelter providers, conducted in January 2003, found an overall average of over 100% occupancy in Houston and Harris County. Occupancy rates ranged from 14% for a shelter in Humble to 149% for a large shelter in Houston. Shelters by type of clients served are presented in Table 1.1.24.

- ⓧ Providers reported that of their clients, 81.5% were male and 19.5% were female. In addition, 58% were African-American, 23% white/Anglo, 14% Hispanic, 4% Native American and 1% Asian.

Table 1.1.23

AVAILABLE EMERGENCY SHELTER BEDS & OCCUPANCY HOUSTON & HARRIS COUNTY, 2003

Area	Available Beds	Emergency Shelter Clients	Percent Occupancy
Harris County	1,996	2,068	103.6%
Houston	1,680	1,818	108.2%

Source: "Homeless Service Demands 2003, An Analysis of Trends, Services, Demographics"

Table 1.1.24

AVAILABLE EMERGENCY SHELTER BY TYPE, HARRIS COUNTY 2003

Type of Shelter	#	%
Family	5	15.6%
Men	8	25.0%
Women	6	18.8%
Women with Children	9	28.1%
Men with Children	2	6.3%
Youth	1	3.1%
Other	1	3.1%
Total	32	100.0%

Source: "Homeless Service Demands 2003, An Analysis of Trends, Services, Demographics" based on survey of 18 shelters. Shelters may provide services to multiple populations

QUESTION 1.2:

WHAT IS THE SCOPE OF THE HIV/AIDS EPIDEMIC IN THE HOUSTON REGION?

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). Although these men are still disproportionately affected by the epidemic, African-Americans s by far represent the majority of cases and recent trends also identify an increase among Hispanic men.

This section provides detailed information about demographic and risk characteristics of HIV-infected people. It describes cases reported through December 31, 2005. Mortality (deaths) reporting lags, so 2004 is considered the most recent complete year of data and is used in this report.

This report uses Texas Department of State Health Services (DSHS) HIV/AIDS surveillance data through December 31, 2005, with data extracted as of July 18, 2006. Although this is the most current data available for the purposes of this report, the incidence (newly diagnosed cases) and prevalence (people living with HIV/AIDS) may be incomplete due to delays in data reporting and processing. It is felt, however, that the data presented here provides an accurate picture of the epidemic and its current trends.

In addition to reporting delays, HIV data is incomplete since reporting was not begun until 1999. People who were diagnosed with HIV before 1999 who have not had another HIV diagnostic test and who have not converted to AIDS are not included in this data.

Cases of HIV diagnosed in 2005 (incidence) and people living with HIV, not AIDS (prevalence) can generally be thought of as people that became infected more recently than new AIDS diagnoses and people living with AIDS. This analysis will compare people diagnosed with HIV to those diagnosed with AIDS and people living with HIV to those living with AIDS to identify trends in the epidemic in the EMA and HSDA.

In this section, data is presented for both the EMA and the HSDA. Although tables appear similar, and differences between the two regions are relatively small, please be aware that EMA-specific tables follow HSDA tables.

SUMMARY

- ⦿ Both HIV and AIDS diagnoses demonstrated relatively stable trends between 2000 and 2002. Starting in 2003, however, a decline in both HIV and AIDS diagnoses was seen and that trend has continued into 2005.
- ⦿ In 2005, 792 persons in the Houston HSDA were diagnosed with HIV that had not progressed to AIDS, and 852 PLWH received an AIDS diagnosis.
- ⦿ Approximately half of those with new diagnoses of both HIV and AIDS are non-Hispanic black at 53%, 20% are non-Hispanic white, and 26% are Hispanic/Latino.
 - Latino men are infected with HIV at a rate of more than 4 times that of Latina women, and their AIDS infection rate is 3 times higher.
- ⦿ Blacks/African-Americans have the highest rate of new HIV and new AIDS infections. It is four times higher than the rate of infection for Hispanics/Latinos and almost seven times higher than that of Whites/Anglos.
 - Black/African-American women make up the largest percentage of newly diagnosed women of childbearing age. The proportions are significantly higher than those of Whites/Anglos and Hispanics/Latinos.
 - Black/African-American youth are disproportionately affected by HIV and AIDS.
- ⦿ Although prevalence numbers are similar between MSM of color and White MSM, the number of new diagnoses among MSM of color is higher than White/Anglo MSM. Over time, this will result in a larger number of MSM of color with HIV disease than White/Anglo MSM in the Houston area.
- ⦿ Although numbers of newly diagnosed IDU are small, white IDU should be monitored as a potential emerging population.
 - White IDU make up 22% of new HIV diagnoses compared to 16% of AIDS diagnoses.
- ⦿ Unreported risk among those with HIV accounts for approximately 34% of new HIV diagnoses and 22% of AIDS diagnoses.

HIV AND AIDS 2005 INCIDENCE (NEW DIAGNOSES)

Incidence is a term commonly used in epidemiology in referring to newly diagnosed cases. Incidence may be designated over a period of time that the new cases were diagnosed. For this report, incidence reflects cases diagnosed throughout 2005. As mentioned above, it is believed that the data presented in this report is reflective of trends in the epidemic, but totals may be incomplete due to reporting delays.

In 2005, the EMA had 45 fewer diagnosed cases of HIV and the same number of

diagnosed cases of AIDS when compared to the HSDA.

- ⦿ In 2005, 792 persons in the Houston HSDA were diagnosed with HIV that had not progressed to AIDS, and 852 PLWH received an AIDS diagnosis. In the EMA, these numbers were 747 for HIV and 852 for AIDS. The latter include both people who have not been diagnosed with HIV disease before (new diagnoses) and people who had previously been diagnosed as HIV positive and their disease progressed from HIV to AIDS. Since the numbers are similar, the 2005 HIV infection rate is approximately 16 per 100,000 for both the HSDA and EMA.
- ⦿ The race/ethnicity profiles of those newly diagnosed with HIV and AIDS are almost identical in both the EMA and HSDA.
 - Approximately 51% of new HIV diagnoses were among black, non-Hispanics compared to 54% of AIDS diagnoses.
 - Twenty-one percent of HIV diagnoses were among white, non-Hispanics, compared to 18% for AIDS diagnoses.
 - The percentage of HIV and AIDS diagnoses were 25% and 27%, respectively, for Hispanic/Latino.
- ⦿ Blacks/African-Americans had the highest rate of new HIV and new AIDS infections (106/100,000). This is four times greater than that of Hispanics/Latinos (27/100,000) and almost seven times that of Whites/Anglos (15/100,000).
 - Data shows that for both HIV and AIDS cases, new diagnoses among Hispanics/Latinos appear to have been on a steady increase overall in recent years.
 - Diagnoses among African-Americans show decreasing trends for both HIV and AIDS diagnoses.
- ⦿ Generalizing about transmission mode is difficult since unreported risk is very high among newly diagnosed. Unreported risk among those with HIV accounts for approximately 34% of new diagnoses and 22% of those with AIDS diagnoses.
 - Forty-one percent of new HIV infections were attributed to MSM, and 18% were attributed to heterosexual contact. These two transmission modes accounted for the highest proportion of newly diagnosed HIV infections during 2005 compared to intravenous drugs users (4%) and MSM/IDU (3%).
- ⦿ Harris County clearly remains the epicenter of the epidemic with 98% of 2005 newly diagnosed HIV and AIDS cases, up from the proportion of 95% in 2004. It was home to the highest proportion of new HIV and AIDS infections during 2004.
- ⦿ HIV diagnoses demonstrated a relatively stable trend between 2000 and 2002. In 2003, this trend appeared to change as a decline in HIV diagnoses was seen. For AIDS diagnoses, the trends for both the HSDA and EMA appears to have been higher from 2002 through 2004.

- Between 2000 and 2002, HIV diagnoses in both the HSDA and EMA increased slightly, about 1%, but between 2002 and 2005, these diagnoses declined 25%.
- Recent media reports have speculated about Centers for Disease Control & Prevention's (CDC) pending estimates of new HIV infections in the United States. According to a December 2, 2007 press release posted on the CDC website, Dr. Kevin Fenton (Director, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention) emphasizes that the new estimates are not yet final. The estimates have been submitted for further analysis and rigorous scientific review to ensure the accuracy of the complex new methods and of the estimates themselves. The CDC anticipates releasing the new estimates in early 2008.

Table 1.2.1-H
HSDA HIV, AIDS AND TOTAL DIAGNOSES, 2005

HSDA	New HIV			New AIDS			New HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	792	100.0	16.4	852	100.0	17.7	1,644	100.0	34.1
Gender									
Male	570	72.0	23.6	592	69.5	24.5	1,162	70.7	48.1
Female	222	28.0	9.2	260	30.5	10.8	482	29.3	20.0
Race/Ethnicity									
White/Anglo	169	21.3	8.1	151	17.7	7.3	320	19.5	15.4
Black/ African-American	403	50.9	49.4	460	54.0	56.4	863	52.5	105.8
Hispanic/Latino	198	25.0	12.3	230	27.0	14.3	428	26.0	26.7
Other	22	2.8	6.7	11	1.3	3.3	33	2.0	10.0
Age (yrs)									
0-12	4	0.5	*	0	0.0	*	4	0.2	*
13-24	147	18.6	*	49	5.8	*	196	11.9	*
25-44	493	62.2	33.4	544	63.8	36.8	1,037	63.1	70.2
45-64	136	17.2	12.1	238	27.9	21.2	374	22.7	33.4
65+	12	1.5	3.2	21	2.5	5.5	33	2.0	8.7
Transmission Mode									
MSM	326	41.2	*	278	32.6	*	604	36.7	*
IDU	30	3.8	*	94	11.0	*	124	7.5	*
MSM/IDU	21	2.7	*	37	4.3	*	58	3.5	*
Heterosexual	144	18.2	*	256	30.0	*	400	24.3	*
Not Classified	267	33.7	*	186	21.8	*	453	27.6	*
Urban/Rural									
Harris County	768	97.0	20.8	836	98.1	22.6	1,604	97.6	43.4
Rural Counties	24	3.0	2.1	16	1.9	1.4	40	2.4	3.5

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.1-E
EMA HIV, AIDS AND TOTAL DIAGNOSES, 2005

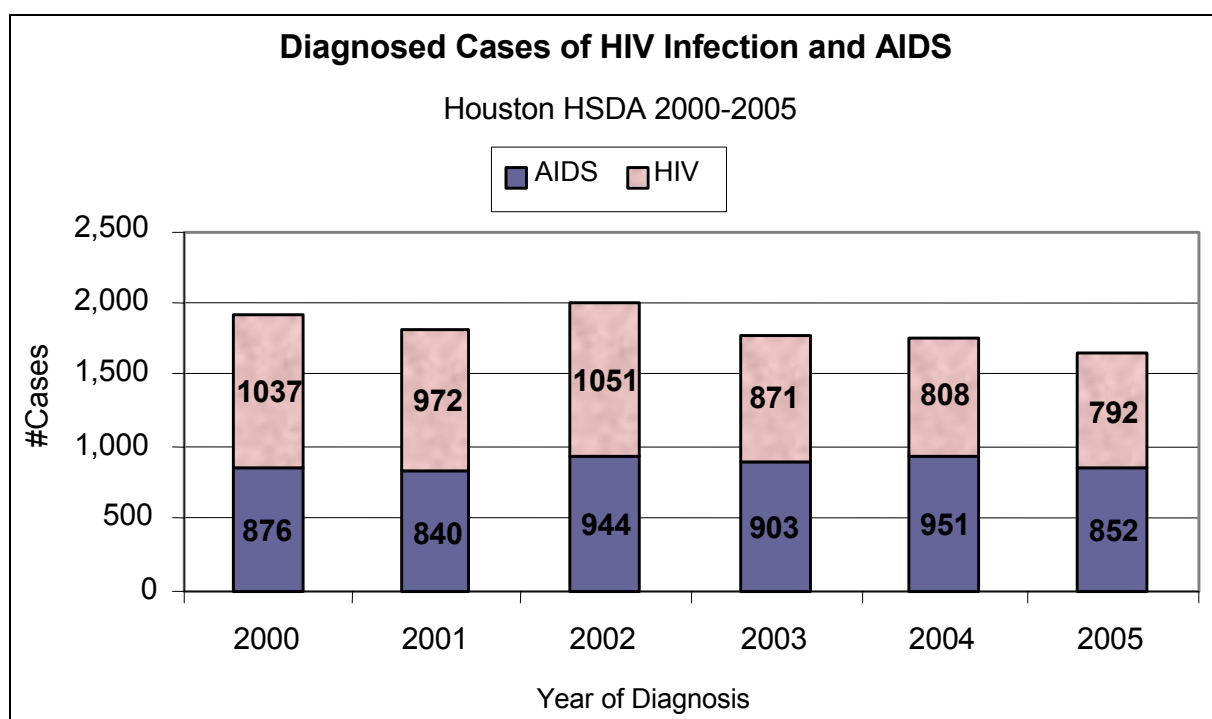
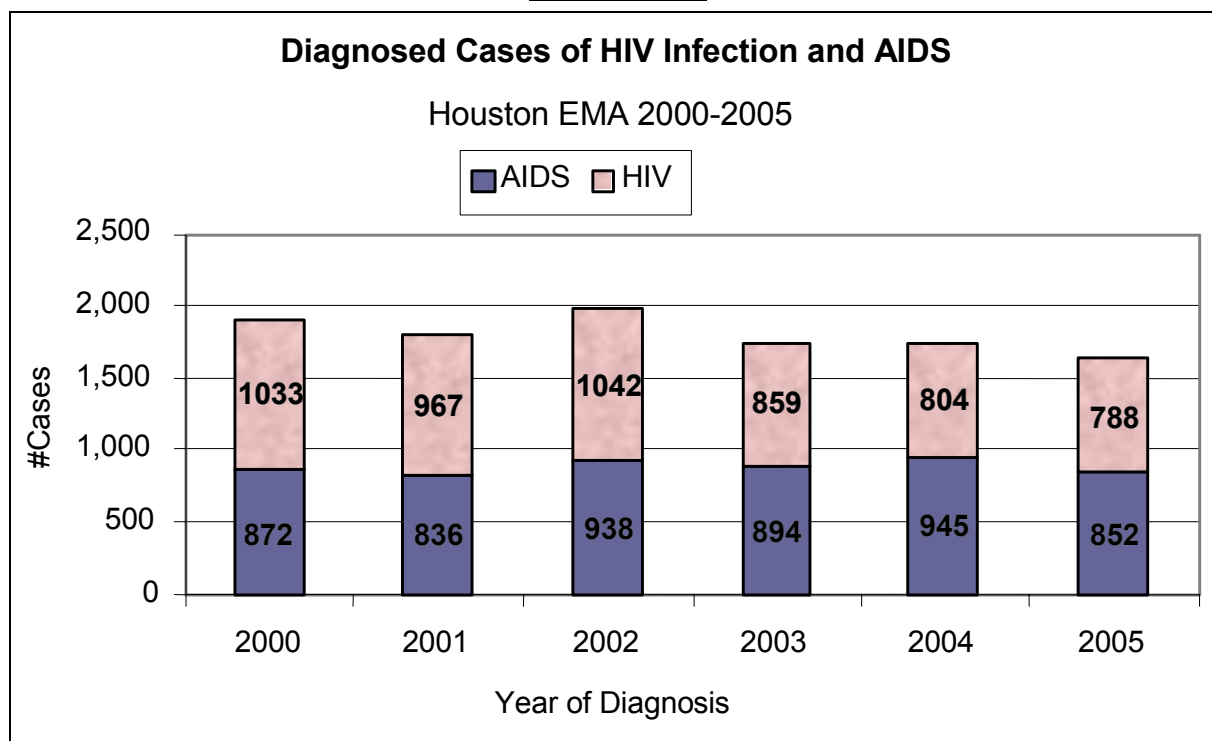
EMA	New HIV			New AIDS			New HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	747	100.0	16.0	852	100.0	18.2	1,599	100.0	34.2
Gender									
Male	537	71.9	23.0	592	69.5	25.4	1,129	70.6	48.4
Female	210	28.1	9.0	260	30.5	11.1	470	29.4	20.1
Race/Ethnicity									
White/Anglo	161	21.6	8.1	151	17.7	7.6	312	19.5	15.7
Black/African-American	376	50.3	47.6	460	54.0	58.2	836	52.3	105.8
Hispanic/Latino	189	25.3	12.0	230	27.0	14.6	419	26.2	26.7
Other	21	2.8	6.4	11	1.3	3.4	32	2.0	9.8
Age (yrs)									
0-12	4	0.5	*	0	0.0	*	4	0.3	*
13-24	138	18.5	*	49	5.8	*	187	11.7	*
25-44	471	63.1	32.8	544	63.8	37.8	1,015	63.5	70.6
45-64	122	16.3	11.2	238	27.9	21.9	360	22.5	33.1
65+	12	1.6	3.3	21	2.5	5.8	33	2.1	9.2
Transmission Mode									
MSM	308	41.2	*	278	32.6	*	586	36.6	*
IDU	28	3.7	*	94	11.0	*	122	7.6	*
MSM/IDU	21	2.8	*	37	4.3	*	58	3.6	*
Heterosexual	130	17.4	*	256	30.0	*	386	24.1	*
Not Classified	256	34.3	*	186	21.8	*	442	27.6	*
Mother at Risk	4	0.5	*	0	0.0	*	4	0.3	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode





Figure 1.2.1
TRENDS IN DIAGNOSED HIV INFECTION AND AIDS
2000 – 2005



*It should be noted that reporting lag may later increase the 2005 totals.

HIV AND AIDS PREVALENCE (PEOPLE LIVING WITH HIV AND AIDS)

While incidence, described on page 61, 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 diagnosed with AIDS. Texas' system of HIV reporting began in 1999. Since that time, records of HIV prevalence have improved every year, but it cannot be assumed that the 2005 numbers for people living with HIV reflect everyone in the region who is HIV positive and knows their status. People who were diagnosed with HIV disease before 1999, who have not progressed to AIDS and who have not had an HIV test after 1999 will not be included. The following statistics should be considered with that in mind.

-  The difference in the number of people living with HIV or AIDS does not vary significantly between the EMA and HSDA. In 2005, a total of 18,109 people were living with either HIV or AIDS in the HSDA. This compares to 17,999 in the EMA. For those living with HIV or AIDS, the EMA includes 99% of people with HIV or AIDS in the HSDA. All trends reported are the same in the EMA and the HSDA.
 - A total of 7,583 people are living with an HIV diagnosis in the HSDA and 7,534 in the EMA.
 - Similarly, 10,526 are living with AIDS in the HSDA, and 10,465 in the EMA.
-  Comparing people living with HIV to people living with AIDS reveals an increase in HIV disease among women in both the EMA and HSDA.
 - In both the EMA and HSDA, women were 32% of people living with HIV in 2005, but were only 22% of people living with AIDS, an indication of increasing new infections among women.
 - The prevalence rate for HIV among males was twice that of females. Males' AIDS prevalence rate, however, was almost four times that of females.
-  Blacks/African-Americans in both the EMA and HSDA are disproportionately affected by HIV and AIDS with the prevalence rates significantly higher among Blacks/African-Americans than other racial or ethnic groups.
 - Comparing HIV and AIDS rates, Blacks/African-Americans have an overall rate that is four times higher than Whites/Anglos, while the HIV (not AIDS) rate is almost five times higher than Whites/Anglos.
 - The overall rate is five times higher among Blacks/African-Americans than Hispanics, and the HIV (not AIDS) rate is six times higher for Blacks/African-Americans than Hispanics/Latinos.
-  Comparing HIV and AIDS percentages for transmission mode identifies changes in the epidemic. It should be noted that the number of people with unreported risk must be considered when evaluating this information.

- In the Houston HSDA, the most frequent mode of HIV transmission is male-to-male sex, with 37% of people living with HIV reporting this as their mode of infection and nearly 45% of those with AIDS identifying it.
- Heterosexual transmission may be increasing, with one-quarter of those living with HIV reporting it compared to 23% of those with AIDS.
- Harris County is home to nearly 95% of people living with both HIV and AIDS. Fort Bend County has 399 residents with HIV or AIDS, and Montgomery has 285. Aside from Liberty County, with 75 cases, most other counties have less than 15 people living with HIV or AIDS.

Trends in the number of people living with HIV and AIDS between 2000 and 2005 are presented in Figure 1.2.2. Since 1999 was the first year that Texas had HIV reporting, the HIV numbers only reflect people who were tested for HIV that year and are incomplete. Over the six years since HIV reporting began, the reported number of people living with HIV has become more complete with each passing year, but cannot be assumed to be all-inclusive. Therefore, the review of trends must be considered with that information in mind.




-  Prevalence data between 2000 and 2005 show an increasing trend in the number of living HIV and AIDS cases in the HSDA
-  Since 2000, reported HIV cases increased 37% in both the EMA and HSDA.
-  Between 2000 and 2005, people living with AIDS increased 38% in both the EMA and the HSDA.

Table 1.2.2-H
HSDA PREVALENCE OF HIV, AIDS AND TOTAL, 2005

HSDA	Living with HIV			Living with AIDS			Living with HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	7,583	100.0	157.2	10,526	100.0	218.2	18,109	100.0	375.4
Gender									
Male	5,163	68.1	213.7	8,189	77.8	339.0	13,352	73.7	552.7
Female	2,420	31.9	100.5	2,337	22.2	97.0	4,757	26.3	197.5
Race/Ethnicity									
White/Anglo	2,118	27.9	102.1	3,502	33.3	168.8	5,620	31.0	270.9
Black/African-American	4,026	53.1	493.5	4,744	45.1	581.5	8,770	48.4	1,075.1
Hispanic/Latino	1,338	17.6	83.4	2,187	20.8	136.3	3,525	19.5	219.7
Other	101	1.3	30.7	93	0.9	28.3	194	1.1	59.0
Age (yrs)									
0-1	5	0.1	*	0	0	*	5	0.0	*
2-12	115	1.5	*	32	0.3	*	147	0.8	*
13-24	612	8.1	*	200	1.9	*	812	4.5	*
25-44	4,712	62.1	318.8	5,459	51.9	369.4	10,171	56.2	688.2
45-64	2,041	26.9	182.1	4,544	43.2	405.4	6,585	36.4	587.5
65+	98	1.3	25.9	291	2.8	76.8	389	2.1	102.7
Transmission Mode									
MSM	2,808	37.0	*	4,737	45.0	*	7,545	41.7	*
IDU	725	9.6	*	1,361	12.9	*	2,086	11.5	*
MSM/IDU	317	4.2	*	734	7.0	*	1,051	5.8	*
Heterosexual	1,865	24.6	*	2,378	22.6	*	4,243	23.4	*
Not Classified	1,681	22.2	*	1,211	11.5	*	2,892	16.0	*
Mother at Risk	157	2.1	*	70	0.7	*	227	1.3	*
Urban/Rural									
Fort Bend	162	2.1	34.9	237	2.3	51.1	399	2.2	86.1
Harris	7,194	94.9	194.8	9,994	94.9	270.6	17,188	94.9	465.4
Liberty	35	0.5	46.6	40	0.4	53.2	75	0.4	99.8
Montgomery	127	1.7	33.6	158	1.5	41.8	285	1.6	75.4
Other Counties	65	0.9	*	97	0.9	*	162	0.9	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.2-E
EMA PREVALENCE OF HIV, AIDS AND TOTAL, 2005

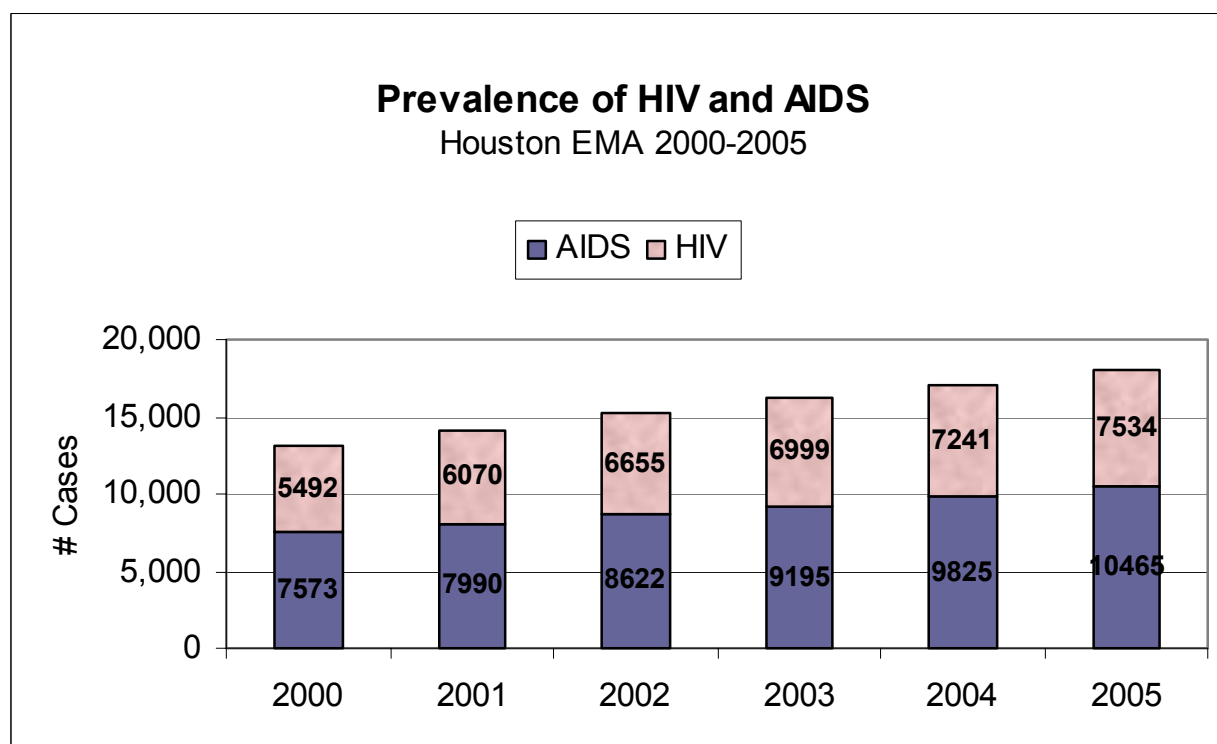
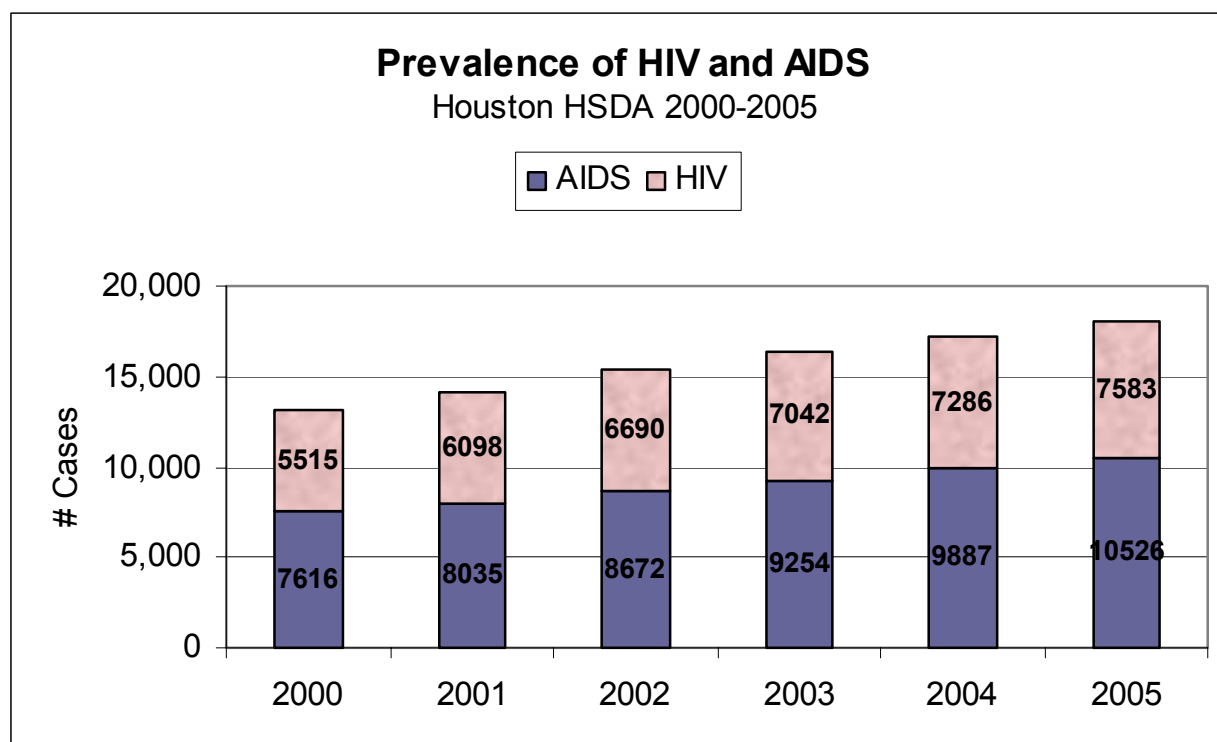
EMA	Living with HIV			Living with AIDS			Living with HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	7,534	100.0	161.2	10,465	100.0	223.9	17,999	100.0	7,534
Gender									
Male	5,140	68.2	220.2	8,146	77.8	348.9	13,286	73.8	5,140
Female	2,394	31.8	102.4	2,319	22.2	99.2	4,713	26.2	2,394
Race/Ethnicity									
White/Anglo	2,108	28.0	106.2	3,468	33.1	174.7	5,576	31.0	2,108
Black/African-American	3,994	53.0	505.5	4,726	45.2	598.2	8,720	48.4	3,994
Hispanic/Latino	1,331	17.7	84.7	2,178	20.8	138.6	3,509	19.5	1,331
Other	101	1.3	30.9	93	0.9	28.4	194	1.1	101
Age (yrs)									
0-1	5	0.1	*	0	0	*	5	0.0	5
2-12	115	1.5	*	32	0.3	*	147	0.8	115
13-24	597	7.9	*	198	1.9	*	795	4.4	597
25-44	4,685	62.2	325.9	5,432	51.9	377.9	10,117	56.2	4,685
45-64	2,034	27.0	187.2	4,516	43.2	415.6	6,550	36.4	2,034
65+	98	1.3	27.3	287	2.7	79.8	385	2.1	98
Transmission Mode									
MSM	2,798	37.1	*	4,722	45.1	*	7,520	41.8	2,798
IDU	725	9.6	*	1,350	12.9	*	2,075	11.5	725
MSM/IDU	317	4.2	*	732	7.0	*	1,049	5.8	317
Heterosexual	1,857	24.6	*	2,368	22.6	*	4,225	23.5	1,857
Not Classified	1,650	21.9	*	1,190	11.4	*	2,840	15.8	1,650
Mother at Risk	157	2.1	*	68	0.6	*	225	1.3	157

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Figure 1.2.2
PERSONS LIVING WITH HIV INFECTION AND PERSONS LIVING WITH AIDS 2000 - 2005



MORTALITY

Since reporting deaths (mortality) of people living with HIV and AIDS is often delayed due to the confirmation and checking that is required, 2004 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.






-  In the HSDA, 20 deaths were among those with HIV, and 228 were among those with AIDS.
-  Overall, the rates of death among persons with HIV or AIDS were higher among Blacks/African-Americans compared to all other racial/ethnic groups. Not all data are available due to data cell size limitations.
 - The overall mortality rate among Blacks/African-Americans (25/100,000) was over six times that of Whites/Anglos (4/100,000).
 - Black/African-American males with HIV or AIDS died at a rate over four times that of White/Anglo males, and almost five times that of Hispanic/Latino males.
 - Black/African-American females had a staggering mortality rate of 23 times that of White/Anglo females and 13 times that of Hispanic/Latina females. (Table 1.2.3) Trends from 2003 clearly show that there has been a tremendous increase in the mortality rates of Black/African-American females (rates were 11 times that of Whites/Anglos and 7 times that of Hispanics/Latinos back in 2003).
-  Overall death rates among people with HIV or AIDS were higher among men than women.
 - Among the HIV-related deaths, 20 (77%) were male, and 6 (23%) were female.
 - For deaths from AIDS, 228 (72%) were male and 90 (28%) were female.
 - The rates of death among males was over two times that of females for HIV and AIDS.
-  In the Houston HSDA, the highest combined HIV and AIDS mortality was among MSM. Deaths from AIDS was highest among MSM cases (37%) followed by cases related to heterosexual contact (29%), IDU (15%) and MSM/IDU (8%). (Table 1.2.4)
-  There was a decrease in the number of HIV deaths between 2000 and 2001; however, from 2002 to 2003, the number of deaths showed an increase. Mortality data for 2004 showed a slight decrease in the number of deaths. Future releases of these data should be monitored for any continuing trends in HIV/AIDS mortality. (Table 1.2.5 and Figure 1.2.3)

Table 1.2.3-H
HSDA DEATHS OF PERSONS WITH HIV/AIDS BY RACE/ETHNICITY AND GENDER, 2004

Race/Ethnicity	Male			Female			Total		
	#	%	Rate	#	%	Rate	#	%	Rate
White/Anglo	72	20.9	7.0	8	2.3	0.8	80	23.3	3.9
Black/African-American	121	35.2	31.9	78	22.7	18.4	199	57.8	24.8
Hispanic/Latino	53	15.4	6.6	10	2.9	1.4	63	18.3	4.1
Other	2	0.6	1.3	0	0.0	0.0	2	0.6	0.6
Total	248	72.1	10.5	96	27.9	4.1	344	100.0	7.3

Source: Texas Department of State Health Services. Percentages calculated as percentage of total cases.

Table 1.2.3-E
EMA DEATHS OF PERSONS WITH HIV/AIDS BY RACE/ETHNICITY AND GENDER 2004

Race/Ethnicity	Male			Female			Total		
	#	%	Rate	#	%	Rate	#	%	Rate
White/Anglo	71	20.8	7.3	8	2.3	0.8	79	23.2	4.0
Black/African-American	119	34.9	32.6	78	22.9	18.9	197	57.8	25.3
Hispanic/Latino	53	15.5	6.7	10	2.9	1.4	63	18.5	4.2
Other	2	0.6	1.3	0	0.0	0.0	2	0.6	0.6
Total	245	71.8	10.7	96	28.2	4.2	341	100.0	7.4

Source: Texas Department of State Health Services. Percentages calculated as percentage of total cases.

Table 1.2.4
HSDA DEATHS AMONG HIV AND AIDS CASES
BY GENDER, RACE/ETHNICITY, AGE AND TRANSMISSION MODE 2004

HSDA	HIV Deaths			AIDS Deaths			HIV/AIDS Deaths		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	26	100.0	0.5	318	100.0	6.7	344	100.0	7.3
Gender									
Male	20	76.9	0.8	228	71.7	9.6	248	72.1	10.5
Female	6	23.1	0.3	90	28.3	3.8	96	27.9	4.1
Race/Ethnicity									
White/Anglo	6	23.1	0.3	74	23.3	3.6	80	23.3	3.9
Black/African-American	17	65.4	2.1	182	57.2	22.7	199	57.8	24.8
Hispanic/Latino	<3	*	*	61	19.2	3.9	*	*	*
Other	<3	*	*	<3	*	*	*	*	*
Age (yrs)									
0-24	<3	*	*	7	2.2	0.4	*	*	*
25-44	11	42.3	0.8	162	50.9	11.1	173	50.3	11.8
45-64	10	38.5	0.9	132	41.5	12.3	142	41.3	13.3
65+	4	15.4	1.1	17	5.3	4.7	21	6.1	5.8
Transmission Mode									
MSM	5	19.2	*	118	37.1	*	123	35.8	*
IDU	6	23.1	*	47	14.8	*	53	15.4	*
MSM/IDU	3	11.5	*	24	7.5	*	27	7.8	*
Heterosexual	<3	*	*	93	29.2	*	*	*	*
Not Classified	9	34.6	*	33	10.4	*	42	12.2	*
Mother at Risk	<3	*	*	<3	*	*	*	*	*
Urban/Rural									
Harris County	24	92.3	0.7	303	95.3	8.3	327	95.1	9.0
Rural Counties	<3	*	*	15	4.7	1.4	*	*	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.5-H
HSDA DEATHS OF PERSONS WITH HIV/AIDS 2000 - 2004

Year	HIV	AIDS	HIV/AIDS
2000	19	423	442
2001	15	421	436
2002	20	307	327
2003	29	321	350
2004	26	318	344

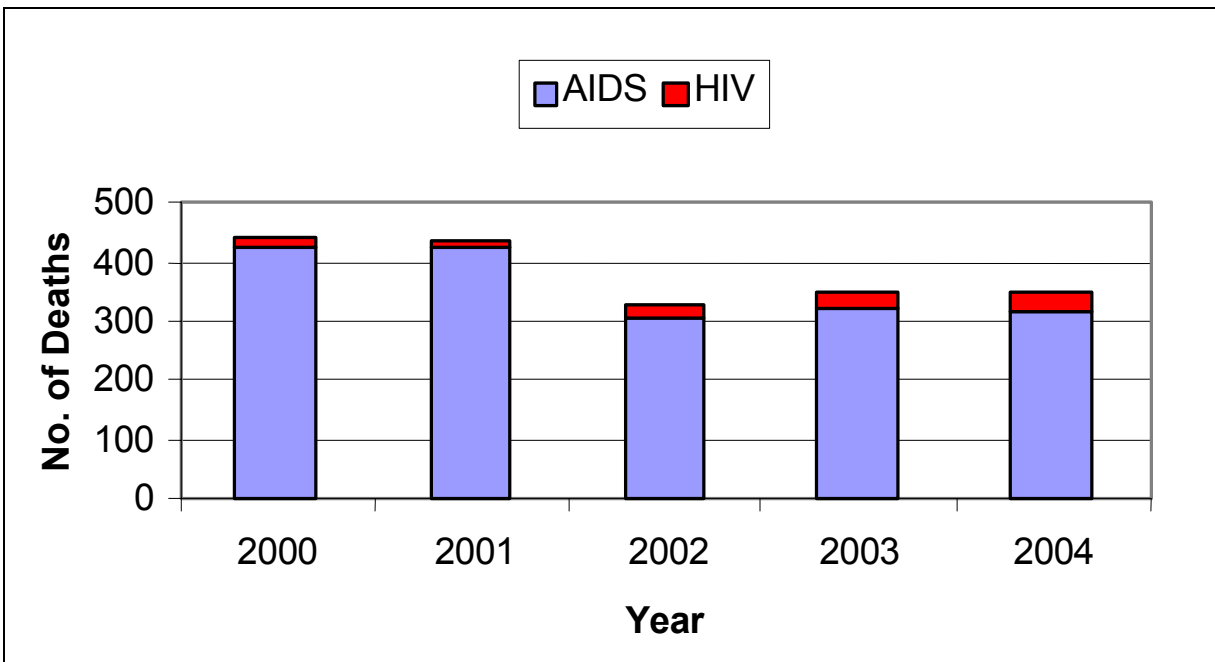
Source: Texas Department of State Health Services

Table 1.2.5-E
EMA DEATHS OF PERSONS WITH HIV/AIDS 2000 - 2004

Year	HIV	AIDS	HIV/AIDS
2000	18	422	440
2001	15	419	434
2002	20	306	326
2003	28	321	349
2004	26	315	341


Source: Texas Department of State Health Services


Figure 1.2.3
HSDA DEATHS OF PERSONS WITH HIV/AIDS 2000 - 2004



HIV WITH TUBERCULOSIS COMORBIDITY

Tuberculosis (TB) may present as a comorbid condition with AIDS. People with HIV are more susceptible to TB, and it can be more difficult to treat in people with AIDS. Two data sources help us understand the number of people who are co-infected with HIV, the City of Houston and the Texas Department of State Health Services (DSHS).

-  The City of Houston maintains records of all TB diagnoses, and categorizes them with and without HIV. Reporting of TB is generally on a timely basis, but information on HIV testing is, at times, delayed.

-  The Texas Department of State Health Services (DSHS) maintains information on TB diagnoses for all people diagnosed with HIV or AIDS. The advantage of DSHS data is that the entire HSDA is included. The disadvantage is that the data does not include date of TB diagnosis. Therefore, DSHS data on TB is best considered only for those newly diagnosed, since those are the only cases that can be confirmed during the current year. In addition, the reporting delay is evident in the DSHS data when compared to the Houston data.

Based upon City of Houston data, the number of people living with AIDS who have TB is relatively stable. DSHS data indicates a decline in cases, but this may be attributed to reporting delays.

Table 1.2.6.TB-1
HOUSTON AND HSDA PERSONS DIAGNOSED WITH AIDS WHO ALSO HAVE TB
2000 - 2004

HSDA New AIDS Diagnoses with TB*				Houston
Year	AIDS	w/TB	%	TB/AIDS*
2000	1037	54	5.6%	49
2001	972	58	6.0%	61
2002	1051	49	4.7%	52
2003	871	32	3.7%	59
2004	808	39	4.8%	53

Source: Texas Department of State Health Services and Houston Department of Health and Human Services

*Not all diagnosed with TB received an HIV test.

The Bureau of TB Control routinely offers HIV testing to its clients. In 2006, HIV test results were available for 91% of those with TB. Of those for whom a test result is not available, the reasons include that the client refused an HIV test, the client died, the result of the HIV test was not known or the client was not offered an HIV test. The following chart describes the HIV status of those with TB in Houston. A case of TB is counted for the year that it was confirmed as a case. In 2006, 54 (19%) of the 278 people over 15 years old with TB tested positive for HIV. Twenty-one (39%) of the 54 were newly diagnosed with HIV. Among the 110 people aged 25-44 with TB, 32 (29%) tested positive for HIV.

Table 1.2.6.TB-2
HOUSTON TB CASES TESTED FOR HIV
2002 - 2006

Cohort Year	# Cases		Total TB Cases Tested for HIV		TB/HIV Coinfection			HIV Negative		No HIV Test Results		No Results: Reason				
	#	%	#	% of all Cases	% of all Cases With HIV Results	#	%	#	%	#	%	# HIV Tested, Results Unknown	# Recommended for HIV Testing	# Refused	# Died	# Not Offered
2002	308		205	67%	52	17%	25%	153	50%	103	33%	39	63	1	0	0
2003	327		262	80%	59	18%	23%	203	62%	65	20%	14	0	50	1	0
2004	334		326	98%	53	16%	16%	273	82%	8	2%	1	6	1	0	0
2005	253		238	94%	29	12%	12%	209	83%	14	6%	0	3	3	0	8
2006	278		253	91%	54	19%	21%	199	72%	25	9%	3	7	4	5	6
Total	1500		1284	86%	247	17%	19%	1037	69%	215	14%	57	79	59	6	14

SPECIAL POPULATIONS




HRSA has identified special populations that are disproportionately impacted by the HIV epidemic. Both nationally and in the Houston region, these populations demonstrate increased risk, incidence and/or prevalence. These include men of color who have sex with men, White/Anglo men who have sex with men, injecting drug users, women of childbearing age, youth, Blacks/African-Americans and Hispanics/Latinos. This section outlines these populations, examining both incidence and prevalence in the HSDA and EMA.

In this section, incidence (new diagnoses) is only reported for the HSDA. This is because differences between EMA and HSDA populations are typically very minimal. Prevalence (those living with HIV/AIDS) is presented for both the EMA and the HSDA.

MEN OF COLOR WHO HAVE SEX WITH MEN **WHITE/ANGLO MEN WHO HAVE SEX WITH MEN**


This population is defined by race and mode of transmission. HRSA has designated men of color who have sex with men (MCSM) to include all men who are not white/Anglo. The mode of transmission is either male sex with men (MSM) or MSM combined with injecting drug use (IDU). Totals may be underrepresented to the extent that MSM are included among those who have not reported their risk.

Over 4,514 MCSM living with HIV/AIDS reside in the HSDA, and the EMA has only 13 fewer. A slightly smaller number of White/Anglo MSM cases live in the HSDA, 4,082. This compares to 4,068 in the EMA. Percentages among the HSDA and EMA are nearly identical.


-  Although prevalence numbers are relatively similar between MCSM and White/Anglo MSM, the number of new diagnoses among MCSM is much higher than White/Anglo MSM. Over time, this will result in a larger number of MCSM with HIV disease than white/Anglo MSM in the Houston area.
 - A total of 237 MCSM were diagnosed with HIV in 2005, and 110 White/Anglo MSM were diagnosed.
 - In addition, 206 MCSM were diagnosed with AIDS in 2005 and 109 White/Anglos MSM received this diagnosis.
-  Comparing MCSM living with HIV and those living with AIDS, the percentages of Blacks/African-Americans is similar for both HIV and AIDS. Fifty-eight percent of MCSM with HIV are Black/African-American, while 57% of those with AIDS are Black/African-American.
-  The 25 to 44 age group is the largest, but HIV diagnoses among those 13 to 24 years old reveal a possible increase in infections in this younger age group.
 - Comparing new HIV infections with new AIDS infections among MCSM by age, the largest group of which both HIV and AIDS diagnoses were 25 to 44 years with 67% of HIV diagnoses and 69% of AIDS diagnoses. This age

group showed a decrease when compared to the proportion of 77% from the previous year.

- Nearly a quarter of new HIV infections were among MCSM age 13 to 24 years, while 11% of new AIDS infections were diagnosed in MCSM in this age group.

 The number and proportion of MSM youth of color (13-24 yrs old) with HIV/AIDS is more than 8 times that of White/Anglo MSM youth of similar age.

- In 2005, there were 21 (2%) White/Anglo MSM youth living with HIV and 5 (<1%) living with AIDS.
- During that same year, there were 163 (10%) MSM youth of color living with HIV and 61(2%) living with AIDS.

 Among MCSM and White/Anglo MSM, almost all new HIV infections (95% and 91%, respectively) and diagnosed AIDS cases (87% and 90%) were attributed to MSM-related behaviors.

- Approximately 96%-97% of MCSM and White/Anglo MSM with HIV or AIDS live in Harris County.
- Ninety-nine percent of MCSM diagnosed with either HIV or AIDS in 2005 live in Harris County, while for White/Anglo MSM, 98% live in Harris County.

Table 1.2.7
HOUSTON-AREA HSDA HIV AND AIDS INCIDENCE AMONG MCSM, 2005

HSDA	New HIV		New AIDS		New HIV/AIDS	
	#	%	#	%	#	%
Total	237	100.0	206	100.0	443	100.0
Race/Ethnicity						
Black/African-American	115	48.5	114	55.3	229	51.7
Hispanic/Latino	115	48.5	89	43.2	204	46.0
Other	7	3.0	3	1.5	10	2.3
Age (yrs)						
13-24	55	23.2	23	11.2	78	17.6
25-44	158	66.7	142	68.9	300	67.7
45-64	24	10.1	36	17.5	60	13.5
65+	0	0.0	5	2.4	5	1.1
Transmission Mode						
MSM	226	95.4	180	87.4	406	91.6
MSM/IDU	11	4.6	26	12.6	37	8.4
Urban/Rural						
Harris County	234	98.7	205	99.5	439	99.1
Rural Counties	3	1.3	<3	*	*	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Table 1.2.8-H
HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG MCSM, 2005

HSDA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	1,719	100.0	2,795	100.0	4,514	100.0
Race/Ethnicity						
Black/African-American	999	58.1	1,590	56.9	2,589	57.4
Hispanic/Latino	681	39.6	1,165	41.7	1,846	40.9
Other	39	2.3	40	1.4	79	1.8
Age (yrs)						
13-24	163	9.5	61	2.2	224	5.0
25-44	1,193	69.4	1,684	60.3	2,877	63.7
45-64	357	20.8	1,016	36.4	1,373	30.4
65+	6	0.3	34	1.2	40	0.9
Transmission Mode						
MSM	1,525	88.7	2,387	85.4	3,912	86.7
MSM/IDU	194	11.3	408	14.6	602	13.3
Ten-Counties						
Austin	<3	*	0	0.0	*	*
Chambers	<3	*	0	0.0	*	*
Colorado	<3	*	<3	*	*	*
Fort Bend	30	1.7	66	2.4	96	2.1
Harris	1,674	97.4	2,701	96.6	4,375	96.9
Liberty	<3	*	3	0.1	*	*
Montgomery	6	0.3	13	0.5	19	0.4
Walker	<3	*	<3	*	*	*
Waller	<3	*	6	0.2	*	*
Wharton	<3	*	5	0.2	*	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Table 1.2.8-E
HOUSTON-AREA EMA HIV AND AIDS PREVALENCE AMONG MCSM, 2005

EMA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	1,712	100.0	2,789	100.0	4,501	100.0
Race/Ethnicity						
Black/African-American	994	58.1	1,586	56.9	2,580	57.3
Hispanic/Latino	679	39.7	1,163	41.7	1,842	40.9
Other	39	2.3	40	1.4	79	1.8
Age (yrs)						
13-24	159	9.3	61	2.2	220	4.9
25-44	1,190	69.5	1,680	60.2	2,870	63.8
45-64	357	20.9	1,014	36.4	1,371	30.5
65+	6	0.4	34	1.2	40	0.9
Transmission Mode						
MSM	1,518	88.7	2,383	85.4	3,901	86.7
MSM/IDU	194	11.3	406	14.6	600	13.3

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Table 1.2.9
HOUSTON-AREA HSDA HIV AND AIDS INCIDENCE AMONG WHITE/ANGLO MSM, 2005

HSDA	New HIV		New AIDS		New HIV/AIDS	
	#	%	#	%	#	%
Total	110	100.0	109	100.0	219	100.0
Age (yrs)						
13-44	85	77.3	62	56.9	147	67.1
45+	25	22.7	47	43.1	72	32.9
Transmission Mode						
MSM	100	90.9	98	89.9	198	90.4
MSM/IDU	10	9.1	11	10.1	21	9.6
Urban/Rural						
Harris County	109	99.1	106	97.2	215	98.2
Rural Counties	<3	*	3	2.8	*	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Table 1.2.10-H
HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG WHITE/ANGLO MSM, 2005

HSDA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	1,406	100.0	2,676	100.0	4,082	100.0
Age (yrs)						
13-24	21	1.5	5	0.2	26	0.6
25-44	856	60.9	1,075	40.2	1,931	47.3
45-64	507	36.1	1,509	56.4	2,016	49.4
65+	22	1.6	87	3.3	109	2.7
Transmission Mode						
MSM	1,283	91.3	2,350	87.8	3,633	89.0
MSM/IDU	123	8.7	326	12.2	449	11.0
Ten-Counties						
Austin	<3	*	4	0.1	*	*
Chambers	<3	*	<3	*	*	*
Colorado	<3	*	<3	*	*	*
Fort Bend	7	0.5	48	1.8	55	1.3
Harris	1,361	96.8	2,543	95.0	3,904	95.6
Liberty	5	0.4	11	0.4	16	0.4
Montgomery	29	2.1	55	2.1	84	2.1
Walker	3	0.2	4	0.1	7	0.2
Waller	<3	*	7	0.3	*	*
Wharton	<3	*	3	0.1	*	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Table 1.2.10-E
HOUSTON-AREA EMA HIV AND AIDS PREVALENCE AMONG WHITE/ANGLO MSM, 2005

EMA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	1,403	100.0	2,665	100.0	4,068	100.0
Age (yrs)						
13-24	21	1.5	5	0.2	26	0.6
25-44	854	60.9	1,072	40.2	1,926	47.3
45-64	506	36.1	1,503	56.4	2,009	49.4
65+	22	1.6	85	3.2	107	2.6
Transmission Mode						
MSM	1,280	91.2	2,339	87.8	3,619	89.0
MSM/IDU	123	8.8	326	12.2	449	11.0

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

INJECTING DRUG USERS

Injecting drug users (IDU) include those whose specified transmission modes are either IDU or MSM/IDU. The HSDA has 3,137 people living with either HIV or AIDS who contracted the disease via injecting drug use, while the EMA has 3,124 cases.

- ✚ Transmission via injecting drug use may be declining.
 - Fifty-five IDU in the HSDA were diagnosed with HIV and 131 were diagnosed with AIDS in 2005.
 - The number living with HIV who were infected via injecting drugs (725) is almost half of those living with AIDS (1,361).
- ✚ For both HIV, approximately two-thirds are among men and one-third are among women. For AIDS diagnoses, however, 73% are among men and 27% among women.
- ✚ Although numbers of newly diagnosed IDU are small, Hispanic/Latino and White/Anglo IDU should be monitored as a potential emerging population. White/Anglo IDU make up 21% of new HIV diagnoses compared to 16% of AIDS diagnoses. Hispanics/Latinos also exhibit decreasing HIV diagnoses relative to AIDS, composing 12% of the HIV diagnoses (compared to 24% from the previous year) and 18% of AIDS. Black/African-American IDU are approximately two-thirds of both new HIV diagnoses (67%) and those diagnosed with AIDS (65%).
- ✚ Among those living with HIV and AIDS, 28% are White/Anglo, 60% are Black/African-American and 12% are Hispanic/Latino.
- ✚ Approximately half of IDU living with HIV or AIDS are in the 25 to 44 age group. Forty-nine percent are older than this and 2% are younger.
- ✚ Approximately two-thirds of those living with HIV or AIDS were infected via injecting drug use alone, and one-third was infected by a combination of injecting drug use and MSM.
- ✚ Harris County is home to almost all newly diagnosed IDU.

Table 1.2.11
HOUSTON-AREA HSDA HIV AND AIDS INCIDENCE AMONG INJECTING DRUG USERS, 2005

HSDA	New HIV		New AIDS		New HIV/AIDS	
	#	%	#	%	#	%
Total	51	100.0	131	100.0	182	100.0
Gender						
Male	38	74.5	81	61.8	119	65.4
Female	13	25.5	50	38.2	63	34.6
Race/Ethnicity						
White/Anglo	11	21.6	21	16.0	32	17.6
Black/African-American	34	66.7	85	64.9	119	65.4
Hispanic/Latino	6	11.8	24	18.3	30	16.5
Other	0	0.0	<3	*	*	*
Age (yrs)						
13-44	38	74.5	69	52.7	107	58.8
45-64	13	25.5	62	47.3	75	41.2
65+	0	0.0	0	0.0	0	0.0
Transmission Mode						
IDU	30	58.8	94	71.8	124	68.1
MSM/IDU	21	41.2	37	28.2	58	31.9
Urban/Rural						
Harris County	50	98.0	131	100.0	181	99.5
Rural Counties	<3	*	0	0.0	*	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Table 1.2.12-H
HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG INJECTING DRUG USERS, 2005

HSDA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	1,016	100.0	1,992	100.0	3,008	100.0
Gender						
Male	664	65.4	1,457	73.1	2,121	70.5
Female	352	34.6	535	26.9	887	29.5
Race/Ethnicity						
White/Anglo	287	28.2	585	29.4	872	29.0
Black/African-American	625	61.5	1,155	58.0	1,780	59.2
Hispanic/Latino	101	9.9	245	12.3	346	11.5
Other	3	0.3	7	0.4	10	0.3
Age (yrs)						
13-24	39	3.8	15	0.8	54	1.8
25-44	593	58.4	982	49.3	1,575	52.4
45-64	381	37.5	960	48.2	1,341	44.6
65+	3	0.3	35	1.8	38	1.3
Transmission Mode						
IDU	716	70.5	1,306	65.6	2,022	67.2
MSM/IDU	300	29.5	686	34.4	986	32.8
Ten-Counties						
Austin	0	0.0	2	0.1	2	0.1
Chambers	0	0.0	0	0.0	0	0.0
Colorado	0	0.0	1	0.1	1	0.0
Fort Bend	17	1.7	31	1.6	48	1.6
Harris	978	96.3	1,909	95.8	2,887	96.0
Liberty	4	0.4	8	0.4	12	0.4
Montgomery	16	1.6	25	1.3	41	1.4
Walker	1	0.1	6	0.3	7	0.2
Waller	0	0.0	6	0.3	6	0.2
Wharton	0	0.0	4	0.2	4	0.1

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Table 1.2.12-E
HOUSTON-AREA EMA HIV AND AIDS PREVALENCE AMONG INJECTING DRUG USERS, 2005



EMA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	1,042	100.0	2,082	100.0	3,124	100.0
Gender						
Male	689	66.1	1,518	72.9	2,207	70.6
Female	353	33.9	564	27.1	917	29.4
Race/Ethnicity						
White/Anglo	286	27.4	591	28.4	877	28.1
Black/African-American	650	62.4	1,219	58.5	1,869	59.8
Hispanic/Latino	101	9.7	262	12.6	363	11.6
Other	5	0.5	10	0.5	15	0.5
Age (yrs)						
13-24	37	3.6	10	0.5	47	1.5
25-44	600	57.6	952	45.7	1,552	49.7
45-64	400	38.4	1,078	51.8	1,478	47.3
65+	5	0.5	42	2.0	47	1.5
Transmission Mode						
IDU	725	69.6	1,350	64.8	2,075	66.4
MSM/IDU	317	30.4	732	35.2	1,049	33.6

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

WOMEN OF CHILD BEARING AGE

HRSA has defined women of childbearing age as those between the ages of 13 and 44. In this population, new HIV and AIDS infections totaled 360 in 2005 in the HSDA. The number of women of childbearing age living with HIV or AIDS in the EMA is 3,124, while the number in the HSDA is 3,319.

-  Black/African-American women comprise the largest percentage of newly diagnosed women of childbearing age and of women living with HIV or AIDS.
 - Seventy-one percent of both new HIV and AIDS diagnoses were among Black/African-American women of childbearing age.
-  Most of these women were infected through heterosexual contact. In addition, according to the CDC and other experts, for those without reported risk, the transmission mode is most often heterosexual sex. These women may not know how they were infected if they were not aware of the HIV status of their partner(s).
 - Approximately 38% of women newly diagnosed with HIV or AIDS do not have

reported risk. Ten percent report injecting drug use and 53% report heterosexual risk. For those newly diagnosed with HIV, 5% report injecting drug use, 45% report heterosexual risk and almost 51% do not have any reported risk. The 51% unreported risk may be due to none of the women's risk categories fitting into those standardized by the Centers for Disease Control & Prevention (CDC).

- Sixteen percent of women living with either HIV or AIDS in the EMA report injecting drug use as their mode of transmission, and 59% report heterosexual contact. Twenty-three percent do not have reported risk. These percentages are similar to those within the HSDA.


 Harris County contains almost all of the new HIV and AIDS infections among women of childbearing age, with 98% of all cases.

Table 1.2.13
HOUSTON-AREA HSDA HIV AND AIDS INCIDENCE AMONG WOMEN 13-44, 2005

HSDA	New HIV		New AIDS		New HIV/AIDS	
	#	%	#	%	#	%
Total	182	100.0	178	100.0	360	100.0
Race/Ethnicity						
White/Anglo	15	8.2	14	7.9	29	8.1
Black/African-American	130	71.4	126	70.8	256	71.1
Hispanic/Latino	32	17.6	34	19.1	66	18.3
Other	5	2.7	4	2.2	9	2.5
Age (yrs)						
13-24	57	31.3	16	9.0	73	20.3
25-44	125	68.7	162	91.0	287	79.7
Transmission Mode						
IDU	9	4.9	26	14.6	35	9.7
Heterosexual	81	44.5	109	61.2	190	52.8
Not Classified	92	50.5	43	24.2	135	37.5
Mother at Risk	0	0.0	0	0.0	0	0.0
Urban/Rural						
Harris County	176	96.7	175	98.3	351	97.5
Rural Counties	6	3.3	3	1.7	9	2.5

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.14-H
HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG WOMEN 13-44, 2005

HSDA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	1,814	100.0	1,505	100.0	3,319	100.0
Race/Ethnicity						
White/Anglo	228	12.6	172	11.4	400	12.1
Black/African-American	1,316	72.5	1,078	71.6	2,394	72.1
Hispanic/Latino	243	13.4	246	16.3	489	14.7
Other	27	1.5	9	0.6	36	1.1
Transmission Mode						
IDU	230	12.7	298	19.8	528	15.9
Heterosexual	1,032	56.9	931	61.9	1,963	59.1
Not Classified	525	28.9	245	16.3	770	23.2
Mother at Risk	20	1.1	25	1.7	45	1.4
Ten-Counties						
Austin	4	0.2	0	0.0	4	0.1
Chambers	0	0.0	<3	*	*	*
Colorado	6	0.3	<3	*	*	*
Fort Bend	46	2.5	30	2.0	76	2.3
Harris	1,704	93.9	1,440	95.7	3,144	94.7
Liberty	8	0.4	7	0.5	15	0.5
Montgomery	27	1.5	16	1.1	43	1.3
Walker	5	0.3	5	0.3	10	0.3
Waller	6	0.3	4	0.3	10	0.3
Wharton	8	0.4	<3	*	*	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.14-E
HOUSTON-AREA EMA HIV AND AIDS PREVALENCE AMONG WOMEN 13-44, 2005

EMA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	1,791	100.0	1,498	100.0	3,289	100.0
Race/Ethnicity						
White/Anglo	226	12.6	170	11.3	396	12.0
Black/African-American	1,298	72.5	1,075	71.8	2,373	72.1
Hispanic/Latino	240	13.4	244	16.3	484	14.7
Other	27	1.5	9	0.6	36	1.1
Transmission Mode						
IDU	230	12.8	296	19.8	526	16.0
Heterosexual	1,026	57.3	929	62.0	1,955	59.4
Not Classified	508	28.4	243	16.2	751	22.8
Mother at Risk	20	1.1	24	1.6	44	1.3





Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

YOUTH

HRSA has defined youth as young people between the ages of 13 and 24 years. The HSDA has only 17 more youth living with HIV/AIDS than the EMA, so information presented applies to youth in both geographic regions.

-  In 2005, a total of 196 youth between the ages of 13 and 24 were newly diagnosed with HIV or AIDS in the Houston HSDA.
-  Young women comprise 48% of those living with either HIV or AIDS in this age group.
-  Black/African-American youth are disproportionately affected by HIV and AIDS, at 63% of new cases, and also the largest group infected with HIV disease comprising 68% of those living with either HIV or AIDS. This compares to 11% for White/Anglo youth and 21% for Hispanic/Latino youth.
-  Among youth 13 to 24 years, sexual contact is the typical transmission mode.
 - Nearly 42% new HIV infections were attributed to male-to-male sex, and 22% were attributed to heterosexual contact.
 - Among newly diagnosed AIDS cases, 51% were attributed to male-to-male sex, while 27% were attributed to heterosexual contact.
 - For those living with HIV disease, 30% report MSM, and 30% report heterosexual risk as their risk category. Another 1% report MSM/IDU and 5% report IDU.


-  Almost 95% of HIV diagnoses and 96% of AIDS diagnoses were among Harris County youth.

Table 1.2.15
HOUSTON-AREA HSDA HIV AND AIDS INCIDENCE AMONG YOUTH 13-24, 2005

HSDA	New HIV		New AIDS		New HIV/AIDS	
	#	%	#	%	#	%
Total	147	100.0	49	100.0	196	100.0
Gender						
Male	90	61.2	33	67.3	123	62.8
Female	57	38.8	16	32.7	73	37.2
Race/Ethnicity						
White/Anglo	10	6.8	6	12.2	16	8.2
Black/African-American	94	63.9	28	57.1	122	62.2
Hispanic/Latino	41	27.9	15	30.6	56	28.6
Other	<3	*	0	0.0	*	*
Transmission Mode						
MSM	61	41.5	25	51.0	86	43.9
Heterosexual	32	21.8	13	26.5	45	23.0
Not Classified	51	34.7	8	16.3	59	30.1
Other	3	2.0	3	6.1	6	3.1
Urban/Rural						
Harris County	139	94.6	47	95.9	186	94.9
Rural Counties	8	5.4	<3	*	*	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.16-H
HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG YOUTH 13-24, 2005

HSDA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	612	100.0	200	100.0	812	100.0
Gender						
Male	311	50.8	114	57.0	425	52.3
Female	301	49.2	86	43.0	387	47.7
Race/Ethnicity						
White/Anglo	67	10.9	21	10.5	88	10.8
Black/African-American	418	68.3	133	66.5	551	67.9
Hispanic/Latino	124	20.3	45	22.5	169	20.8
Other	3	0.5	<3	*	*	*
Transmission Mode						
MSM	177	28.9	63	31.5	240	29.6
IDU	30	4.9	7	3.5	37	4.6
MSM/IDU	7	1.1	3	1.5	10	1.2
Heterosexual	182	29.7	48	24.0	230	28.3
Not Classified	161	26.3	34	17.0	195	24.0
Mother at Risk	45	7.4	38	19.0	83	10.2
Ten-Counties						
Austin	<3	*	0	0.0	*	*
Chambers	0	0.0	0	0.0	0	0.0
Colorado	4	0.7	<3	*	*	*
Fort Bend	16	2.6	3	1.5	19	2.3
Harris	567	92.6	190	95.0	757	93.2
Liberty	3	0.5	0	0.0	3	0.4
Montgomery	10	1.6	<3	*	*	*
Walker	5	0.8	<3	*	*	*
Waller	<3	*	3	1.5	*	*
Wharton County	5	0.8	0	0.0	5	0.6

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.16-E
HOUSTON-AREA EMA HIV AND AIDS PREVALENCE AMONG YOUTH 13-24, 2005

EMA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	597	100.0	198	100.0	795	100.0
Gender						
Male	305	51.1	113	57.1	418	52.6
Female	292	48.9	85	42.9	377	47.4
Race/Ethnicity						
White/Anglo	66	11.1	20	10.1	86	10.8
Black/African-American	406	68.0	133	67.2	539	67.8
Hispanic/Latino	122	20.4	44	22.2	166	20.9
Other	3	0.5	<3	*	*	*
Transmission Mode						
MSM	173	29.0	63	31.8	236	29.7
IDU	30	5.0	7	3.5	37	4.7
MSM/IDU	7	1.2	3	1.5	10	1.3
Heterosexual	177	29.6	48	24.2	225	28.3
Not Classified	155	26.0	34	17.2	189	23.8
Mother at Risk	45	7.5	36	18.2	81	10.2

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

BLACKS/AFRICAN-AMERICANS

Surveillance data are gathered for Blacks without national distinction. While it can be assumed that most of these Blacks are African-Americans, surveillance data do not differentiate between African-Americans, Africans, Caribbean-Africans, etc.

- ✚ In 2005, a total of 863 Blacks/African-Americans were newly diagnosed with HIV or AIDS in the Houston HSDA, at a rate of 106 per 100,000. The number AIDS diagnoses was 460, compared to 403 new diagnoses for HIV. For those living with AIDS, the rate 582 per 100,000 is higher than for those with an HIV diagnosis only, at 494 per 100,000.
- ✚ Black/African-American males comprised the largest group of the newly diagnosed (60%), and the distribution of proportions of new HIV infections compared to AIDS across gender was similar.
- ✚ Women are approximately 43% of those living with HIV, and they are 34% of those living with AIDS, so there appears to be an increasing trend for Black/African-American women with HIV disease.
- ✚ Blacks/African-Americans age 25 to 44 had the highest proportions of both HIV and AIDS diagnoses, but there may be a possible increasing trend among Black/African-American youth.
 - Due to data limitations, numbers for youth age 13 to 24 is not available, but the age group 0 to 24 had a higher proportion of HIV diagnoses than AIDS diagnoses, at 24% for HIV and 6% for AIDS.
 - A similar trend exists in the prevalence data, with 10% of Blacks/African-Americans living with HIV being youth, while only 3% of those living with AIDS are youth.
- ✚ Among Blacks/African-Americans with newly diagnosed HIV or AIDS, 29% were attributed to male-to-male sex, and 22% were attributed to heterosexual contact. Risk was not reported for 42% new HIV diagnoses and 26% of new AIDS diagnoses.
- ✚ Harris County is home to almost 98% of African-Americans diagnosed with HIV or AIDS.

Table 1.2.17
HOUSTON AREA HSDA HIV AND AIDS INCIDENCE AMONG BLACKS/AFRICAN-AMERICANS,
2005

HSDA	New HIV			New AIDS			New HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	403	100.0	49.4	460	100.0	56.4	863	100.0	105.8
Gender									
Male	245	60.8	63.6	276	60.0	71.7	521	60.4	135.3
Female	158	39.2	36.7	184	40.0	42.7	342	39.6	79.4
Age (yrs)									
0-24	95	23.6	28.1	28	6.1	8.3	123	14.3	36.4
25-44	228	56.6	94.4	279	60.7	115.5	507	58.7	209.9
45-64	76	18.9	42.1	137	29.8	75.9	213	24.7	118.0
65+	4	1.0	7.1	16	3.5	28.5	20	2.3	35.6
Transmission Mode									
MSM	107	26.6	*	94	20.4	*	201	23.3	*
IDU	26	6.5	*	65	14.1	*	91	10.5	*
MSM/IDU	8	2.0	*	20	4.3	*	28	3.2	*
Heterosexual	93	23.1	*	161	35.0	*	254	29.4	*
Not Classified	168	41.7	*	119	25.9	*	287	33.3	*
Urban/Rural									
Harris County	389	96.5	59.1	453	98.5	68.8	842	97.6	127.8
Rural Counties	14	3.5	8.9	7	1.5	4.5	21	2.4	13.4

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.18-H
HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG BLACKS/AFRICAN-AMERICANS,
2005

HSDA	Living with HIV			Living with AIDS			Living with HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	4,026	100.0	493.5	4,744	100.0	581.5	8,770	100.0	1,075.1
Gender									
Male	2,281	56.7	592.2	3,115	65.7	808.7	5,396	61.5	1,400.8
Female	1,745	43.3	405.3	1,629	34.3	378.4	3,374	38.5	783.6
Age (yrs)									
0-1	0	0.0	*	0	0.0	*	0	0.0	*
2-12	91	2.3	*	20	0.4	*	111	1.3	*
13-24	418	10.4	*	133	2.8	*	551	6.3	*
25-44	2,403	59.7	994.8	2,598	54.8	1,075.5	5,001	57.0	2,070.4
45-64	1,063	26.4	588.8	1,864	39.3	1,032.5	2,927	33.4	1,621.3
65+	51	1.3	90.8	129	2.7	229.7	180	2.1	320.5
Transmission Mode									
MSM	860	21.4	*	1,283	27.0	*	2,143	24.4	*
IDU	511	12.7	*	922	19.4	*	1,433	16.3	*
MSM/IDU	139	3.5	*	307	6.5	*	446	5.1	*
Heterosexual	1,338	33.2	*	1,523	32.1	*	2,861	32.6	*
Not Classified	1,046	26.0	*	657	13.8	*	1,703	19.4	*
Mother at Risk	114	2.8	*	46	1.0	*	160	1.8	*
Ten-Counties									
Austin	9	0.2	358.3	3	0.1	119.4	12	0.1	477.7
Chambers	<3	*	*	0	0.0	0.0	*	*	*
Colorado	8	0.2	280.7	0	0.0	0.0	8	0.1	280.7
Fort Bend	90	2.2	94.0	118	2.5	123.2	208	2.4	217.2
Harris	3,849	95.6	584.4	4,565	96.2	693.1	8,414	95.9	1,277.5
Liberty	14	0.3	153.2	9	0.2	98.5	23	0.3	251.6
Montgomery	29	0.7	199.1	21	0.4	144.2	50	0.6	343.3
Walker	8	0.2	55.2	7	0.1	48.3	15	0.2	103.4
Waller	11	0.3	120.8	13	0.3	142.8	24	0.3	263.6
Wharton	*	*	*	8	0.2	137.9	*	*	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.18-E
HOUSTON-AREA EMA HIV AND AIDS PREVALENCE AMONG BLACKS/AFRICAN-AMERICANS,
2005

EMA	Living with HIV			Living with AIDS			Living with HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	3,994	100.0	505.5	4,726	100.0	598.2	8,720	100.0	1,103.7
Gender									
Male	2,267	56.8	611.8	3,104	65.7	837.6	5,371	61.6	1,449.4
Female	1,727	43.2	411.7	1,622	34.3	386.6	3,349	38.4	798.3
Age (yrs)									
0-1	0	0.0	*	0	0.0	*	0	0.0	*
2-12	91	2.3	*	20	0.4	*	111	1.3	*
13-24	406	10.2	*	133	2.8	*	539	6.2	*
25-44	2,385	59.7	1,018.4	2,589	54.8	1,105.5	4,974	57.0	2,123.9
45-64	1,061	26.6	604.5	1,855	39.3	1,056.8	2,916	33.4	1,661.3
65+	51	1.3	94.7	129	2.7	239.6	180	2.1	334.4
Transmission Mode									
MSM	855	21.4	*	1,281	27.1	*	2,136	24.5	*
IDU	511	12.8	*	914	19.3	*	1,425	16.3	*
MSM/IDU	139	3.5	*	305	6.5	*	444	5.1	*
Heterosexual	1,332	33.4	*	1,522	32.2	*	2,854	32.7	*
Not Classified	1,025	25.7	*	652	13.8	*	1,677	19.2	*
Mother at Risk	114	2.9	*	46	1.0	*	160	1.8	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

HISPANICS/LATINOS

The HSDA has 3,525 Hispanics/Latinos living with HIV or AIDS. The EMA has 3,509 cases of Hispanics/Latinos. Percentages between the two regions are nearly identical.

- ⦿ In 2005, a total of 428 Hispanics/Latinos were newly diagnosed with HIV or AIDS in the Houston HSDA, at a rate of 27 per 100,000. Infection rates were at 12 per 100,000 for HIV diagnoses and 14 per 100,000 for AIDS diagnoses.
- ⦿ Hispanic men were infected with HIV at a rate of more than four times that of women and their AIDS infection rate is approximately three times that of women.
- ⦿ As with other populations, the 25 to 44 year age group was the largest, but infections among youth are increasing.
 - Nearly three-quarters of new HIV and AIDS diagnoses were among Hispanics/Latinos age 25 to 44 years.
 - Nearly 21% of new HIV cases were among youth, while 7% of new AIDS cases were among youth. Similarly, 9% of Hispanics/Latinos living with HIV were youth while 2% living with AIDS were youth.
- ⦿ Sexual activity, either MSM or heterosexual, was the transmission mode for almost all Hispanics/Latinos diagnosed with HIV and those living with HIV or AIDS.
 - MSM were a higher percentage of those diagnosed with HIV (57%) than those diagnosed with AIDS (36%).
 - Forty-seven percent of Hispanics/Latinos living with HIV and 49% of those living with AIDS report MSM as their transmission mode.
 - Heterosexual contact is the transmission mode for 22% of Hispanics/Latinos living with HIV and 25% of those living with AIDS.
- ⦿ Harris County is home to 96% of Hispanics/Latinos living with HIV or AIDS. In addition, Harris County had almost all the new HIV infections and diagnosed AIDS cases among Hispanics/Latinos during 2005 at 99%.

Table 1.2.19
HOUSTON AREA HSDA HIV AND AIDS INCIDENCE AMONG HISPANICS/LATINOS, 2005

HSDA	New HIV			New AIDS			New HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	198	100.0	12.3	230	100.0	14.3	428	100.0	26.7
Gender									
Male	162	81.8	19.3	180	78.3	21.4	342	79.9	40.7
Female	36	18.2	4.7	50	21.7	6.5	86	20.1	11.3
Age (yrs)									
0-1	<3	*	*	0	0.0	*	*	*	*
2-12	0	0.0	*	0	0.0	*	0	0.0	*
13-24	41	20.7	*	15	6.5	*	56	13.1	*
25-44	137	69.2	24.4	173	75.2	30.8	310	72.4	55.1
45-64	17	8.6	7.3	39	17.0	16.7	56	13.1	23.9
65+	<3	*	*	3	1.3	5.3	*	*	*
Transmission Mode									
MSM	112	56.6	*	83	36.1	*	195	45.6	*
IDU	3	1.5	*	18	7.8	*	21	4.9	*
MSM/IDU	3	1.5	*	6	2.6	*	9	2.1	*
Heterosexual	33	16.7	*	73	31.7	*	106	24.8	*
Not Classified	45	22.7	*	50	21.7	*	95	22.2	*
Urban/Rural									
Harris County	195	98.5	14.1	228	99.1	16.5	423	98.8	30.6
Rural Counties	3	1.5	1.4	<3	*	*	*	*	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.20-H
HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG HISPANICS/LATINOS, 2005

HSDA	Living with HIV			Living with AIDS			Living with HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	1,338	100.0	83.4	2,187	100.0	136.3	3,525	100.0	219.7
Gender									
Male	1,034	77.3	122.9	1,811	82.8	215.3	2,845	80.7	338.3
Female	304	22.7	39.8	376	17.2	49.2	680	19.3	89.1
Age (yrs)									
0-1	3	0.2	*	0	0.0	*	3	0.1	*
2-12	16	1.2	*	12	0.5	*	28	0.8	*
13-24	124	9.3	*	45	2.1	*	169	4.8	*
25-44	958	71.6	170.4	1,369	62.6	243.4	2,327	66.0	413.8
45-64	224	16.7	95.7	718	32.8	306.9	942	26.7	402.6
65+	13	1.0	22.9	43	2.0	75.6	56	1.6	98.5
Transmission Mode									
MSM	628	46.9	*	1,067	48.8	*	1,695	48.1	*
IDU	48	3.6	*	165	7.5	*	213	6.0	*
MSM/IDU	53	4.0	*	98	4.5	*	151	4.3	*
Heterosexual	296	22.1	*	553	25.3	*	849	24.1	*
Not Classified	283	21.2	*	272	12.4	*	555	15.7	*
Mother at Risk	24	1.8	*	19	0.9	*	43	1.2	*
Ten-Counties									
Austin	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0
Chambers	0	0.0	0.0	<3	*	*	*	*	*
Colorado	<3	*	*	3	0.1	64.4	*	*	*
Fort Bend	28	2.1	26.9	49	2.2	47.1	77	2.2	74.0
Harris	1,282	95.8	92.6	2,099	96.0	151.6	3,381	95.9	244.2
Liberty	3	0.2	29.7	<3	*	*	*	*	*
Montgomery	17	1.3	28.1	23	1.1	38.0	40	1.1	66.1
Walker	<3	*	*	3	0.1	31.7	*	*	*
Waller	<3	*	*	4	0.2	52.2	*	*	*
Wharton	5	0.4	34.8	3	0.1	20.9	8	0.2	55.7

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode

Table 1.2.20-E
HOUSTON-AREA EMA HIV AND AIDS PREVALENCE AMONG HISPANICS/LATINOS, 2005

EMA	Living with HIV			Living with AIDS			Living with HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	1,331	100.0	84.7	2,178	100.0	138.6	3,509	100.0	223.4
Gender									
Male	1,032	77.5	125.6	1,806	82.9	219.7	2,838	80.9	345.3
Female	299	22.5	39.9	372	17.1	49.7	671	19.1	89.6
Age (yrs)									
0-1	3	0.2	*	0	0.0	*	3	0.1	*
2-12	16	1.2	*	12	0.6	*	28	0.8	*
13-24	122	9.2	*	44	2.0	*	166	4.7	*
25-44	955	71.8	173.1	1,365	62.7	247.5	2,320	66.1	420.6
45-64	222	16.7	97.2	715	32.8	312.9	937	26.7	410.1
65+	13	1.0	23.5	42	1.9	76.1	55	1.6	99.6
Transmission Mode									
MSM	626	47.0	*	1,065	48.9	*	1,691	48.2	*
IDU	48	3.6	*	164	7.5	*	212	6.0	*
MSM/IDU	53	4.0	*	98	4.5	*	151	4.3	*
Heterosexual	295	22.2	*	550	25.3	*	845	24.1	*
Not Classified	279	21.0	*	270	12.4	*	549	15.6	*
Mother at Risk	24	1.8	*	18	0.8	*	42	1.2	*

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U. S. Census estimates.

*Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

"Not Classified" represents reported cases of HIV or AIDS for which there is no associated transmission mode



QUESTION 1.3:

WHAT ARE THE INDICATORS OF RISK FOR HIV/AIDS INFECTION IN THE HOUSTON AREA?




The previous chapter described the distribution and trends of HIV infection and AIDS diagnoses throughout the Houston HSDA and EMA. The purpose of this chapter is to examine available data on risk behaviors and markers in the Houston EMA from two perspectives: 1) Factors that affect the risk of acquiring HIV infection among HIV-negative persons (STDs, HIV testing), and; 2) Factors that affect the risk of transmitting HIV infection among HIV-positive persons (MSMs, injection drug users, heterosexuals).

SUMMARY



Gonorrhea Trends:

-  Overall, the number of gonorrhea cases in both the Houston HSDA and in Harris County has been declining over recent years. Breakdowns by sex show similar trends in reported gonorrhea cases for the Houston HSDA.
-  From 2002 to 2003, all HSDA counties outside of Harris reported decreases in gonorrhea cases except for Chambers county, which reported a slight increase. The number of cases in Austin and Wharton counties remained approximately the same.

Syphilis Trends:

-  Unlike gonorrhea, the number of reported syphilis cases in the Houston HSDA has been steadily increasing. The number of syphilis cases in 2003 is twice that reported in 1999.
 - The Houston Department of Health and Human Services Bureau of Epidemiology reported a syphilis outbreak among MSM in Houston during 2005.
-  However, Harris County is the only HSDA county experiencing such an increase. All other counties have experienced a decrease or leveling of reported syphilis cases.
-  A breakdown by sex shows that the increase in syphilis cases is most significant among males. Between 1999 and 2003, the number of syphilis cases among males has tripled; among women, the number of cases has decreased by almost half.

HIV Testing:

-  In 2003, a total of 29,827 HIV tests were reported for the Houston HSDA.
-  The vast majority of HIV tests reported to the State's HIV Counseling and

Testing system were confidential, and conducted during field visits or at HIV Testing Sites.

- Ⓡ In terms of HIV exposure categories, “non-targeted” constituted the majority of HIV tests, followed by female-to-male sex, male-to-male sex and injection drug users.

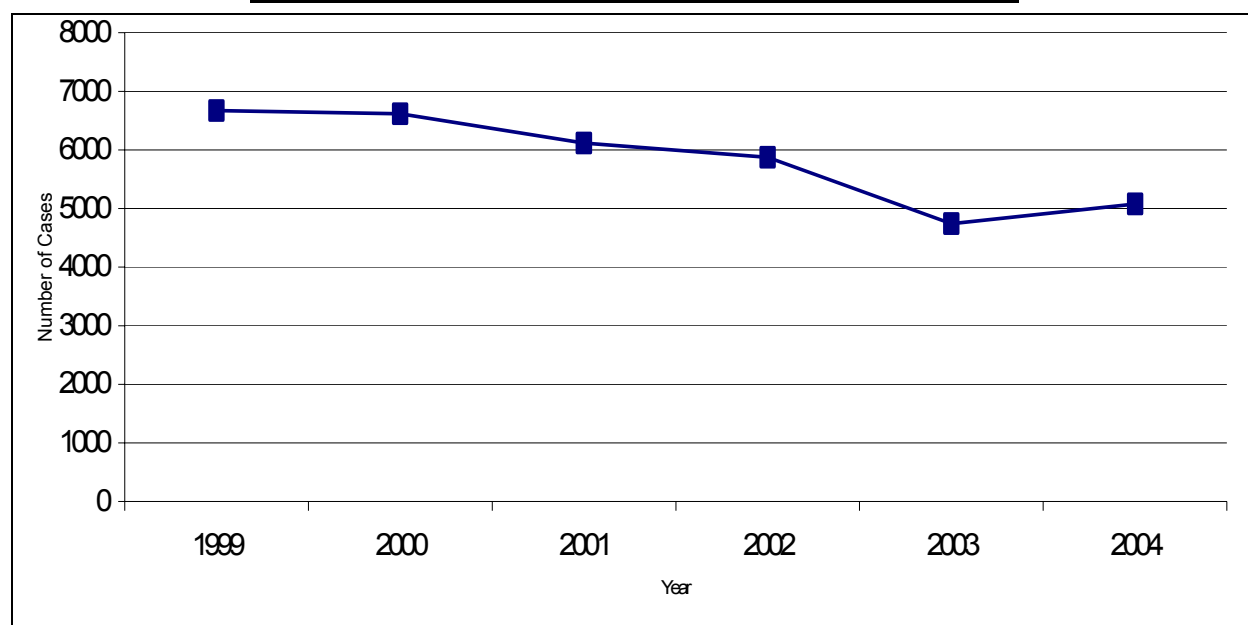
STD TRENDS: GONORRHEA

- Ⓡ Overall, the number of gonorrhea cases in both the Houston HSDA and in Harris County has been declining over the past 5 years.
- Ⓡ From 2002 to 2004, all but two HSDA counties reported decreases in gonorrhea cases. Compared to 2003, Colorado County reported an increase of 3 new cases, and Harris County reported an increase of 413.

Table 1.3.1
GONORRHEA CASES BY YEAR AND COUNTY, 1999-2004

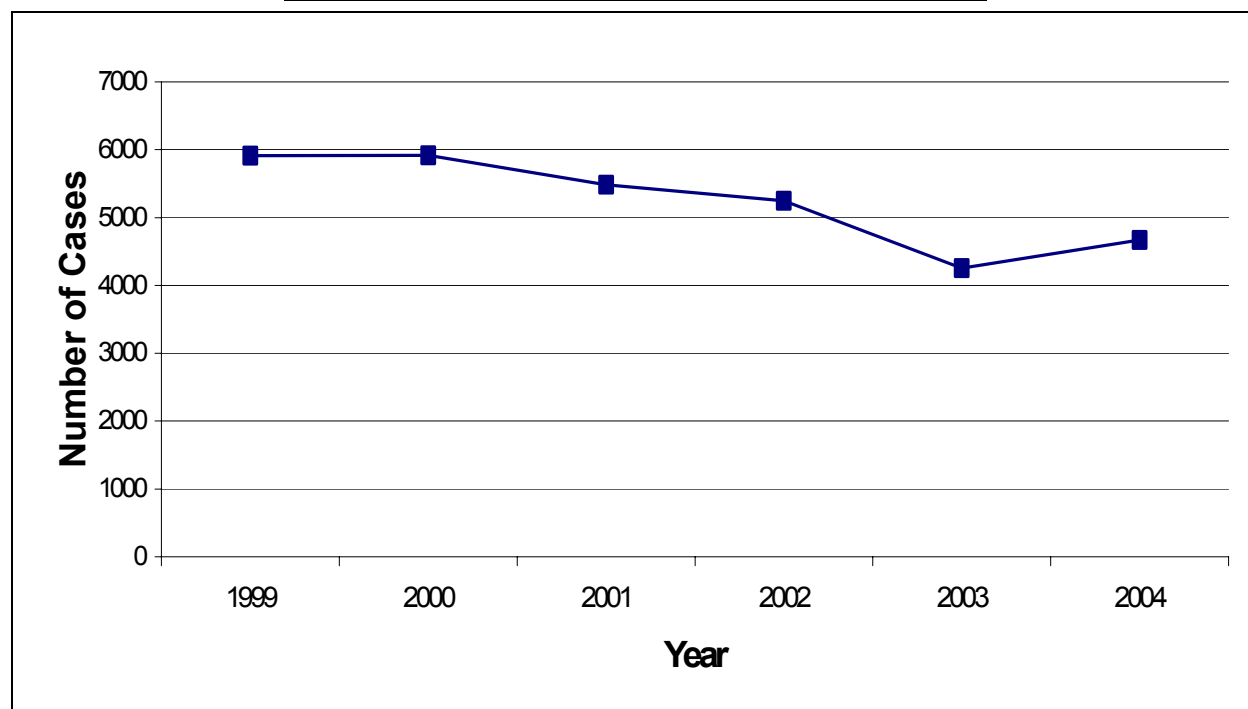
HSDA	1999	2000	2001	2002	2003	2004
Austin	16	14	4	9	9	5
Chambers	6	2	8	11	16	15
Colorado	21	11	21	27	13	16
Fort Bend	219	208	166	178	145	131
Harris	5,914	5,917	5,486	5,246	4,257	4,670
Liberty	63	45	57	80	52	61
Montgomery	143	155	135	137	105	81
Walker	68	100	95	71	41	26
Waller	126	107	85	64	56	52
Wharton	99	55	61	51	51	23
Total	6,675	6,614	6,118	5,874	4,745	5,080

Figure 1.3.1
GONORRHEA CASES IN THE HOUSTON HSDA, 1999-2004



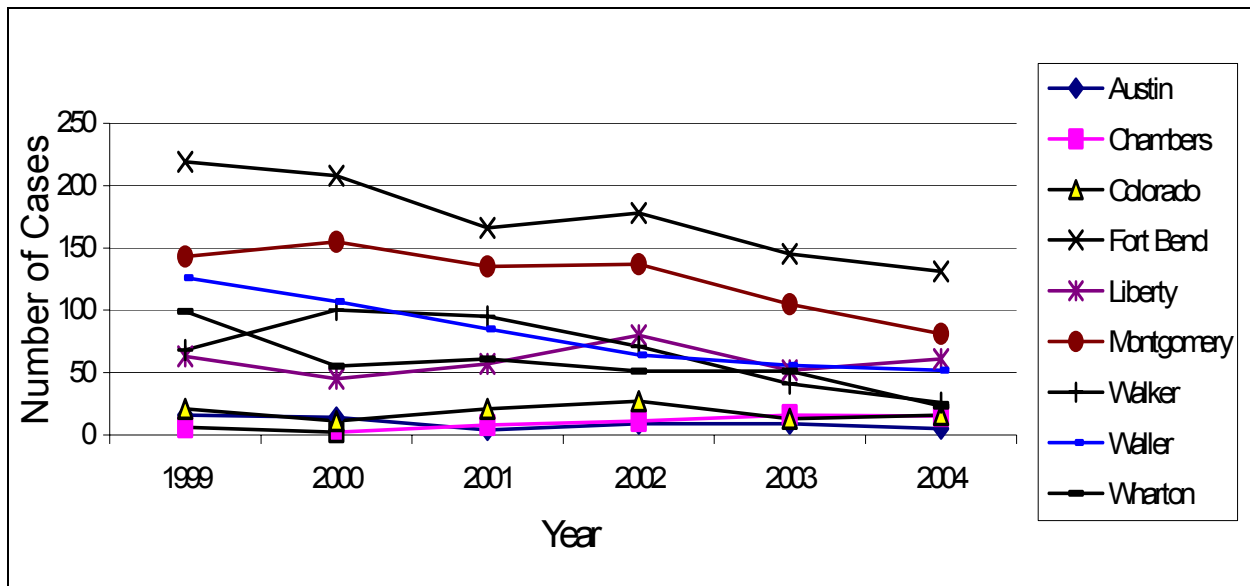
Source: Texas HIV/STD Surveillance Report, HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services (DSHS)

Figure 1.3.2
GONORRHEA CASES IN HARRIS COUNTY, 1999-2004



Source: Texas HIV/STD Surveillance Report, HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services (DSHS)

Figure 1.3.3
GONORRHEA CASES OUTSIDE HARRIS COUNTY, 1999-2004



Source: Texas HIV/STD Surveillance Report, HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services (DSHS)

Table 1.3.2
GONORRHEA CASES BY YEAR, SEX AND COUNTY, 1999-2003

HSDA	1999		2000		2001		2002		2003	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Austin	3	13	5	9			2	7	5	4
Chambers					7	1	8	3	10	6
Colorado	9	12	6	5	11	10	10	17	7	6
Fort Bend	95	122	84	123	64	102	86	92	69	76
Harris	3,184	2,682	2,925	2,988	2,821	2,659	2,706	2,536	2,279	1,978
Liberty	29	34	17	28	26	31	23	57	18	34
Montgomery	48	95	51	103	52	83	56	81	48	57
Walker	29	37	41	58	42	52	28	43	18	23
Waller	62	62	48	57	31	54	32	32	17	36
Wharton	30	69	22	33	17	44	19	32	22	29
Total	3,493	3,128	3,200	3,405	3,071	3,040	2,970	2,900	2,493	2,249

* Grayed out cells have had the demographic breakdowns suppressed due to small cell sizes.

Figure 1.3.4
GONORRHEA CASES IN THE HOUSTON HSDA, BY SEX, 1999-2003

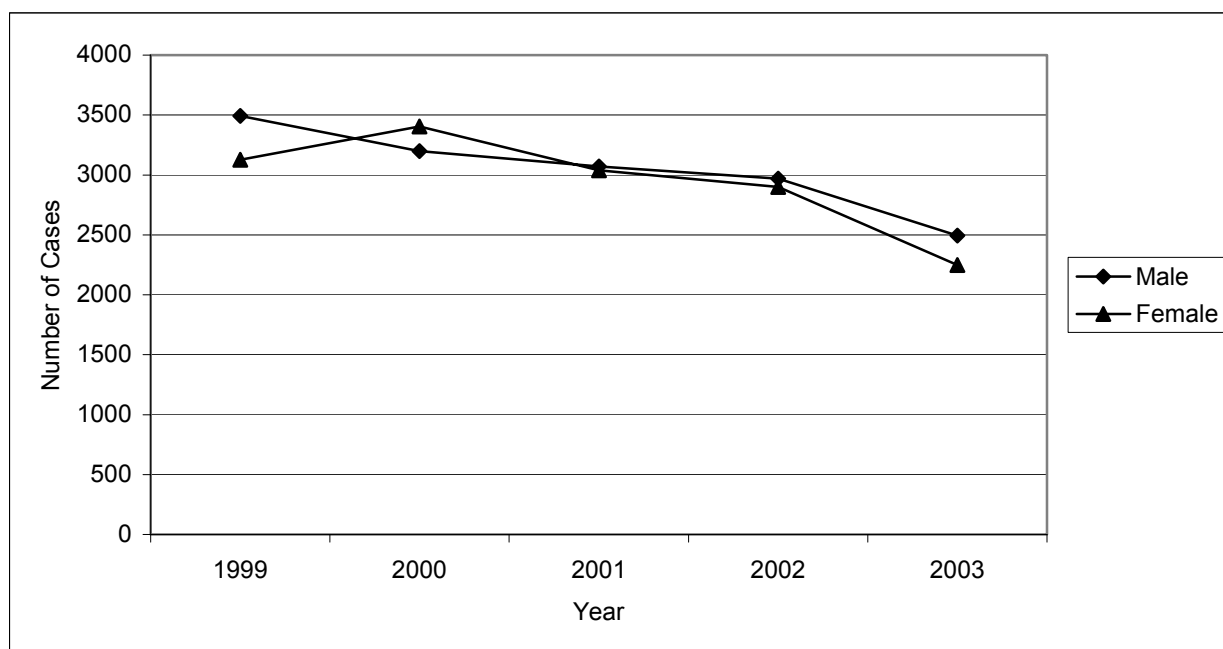


Figure 1.3.5
GONORRHEA CASES IN HARRIS COUNTY, MALE 1999-2003

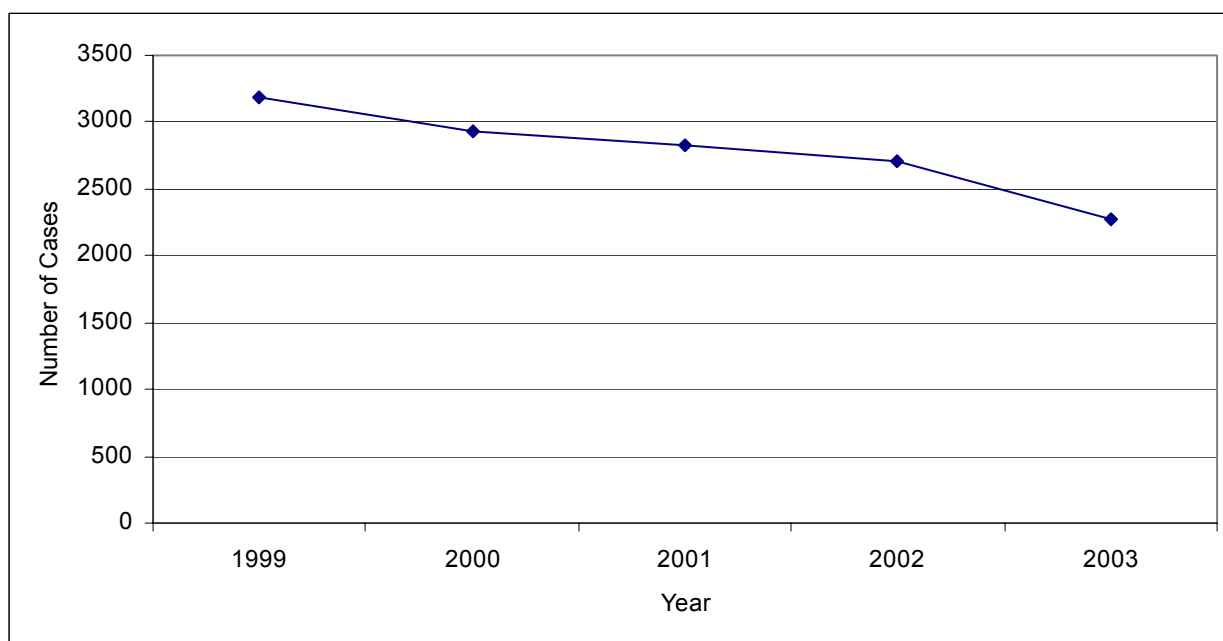


Figure 1.3.6
GONORRHEA CASES IN HARRIS COUNTY, FEMALE 1999-2003

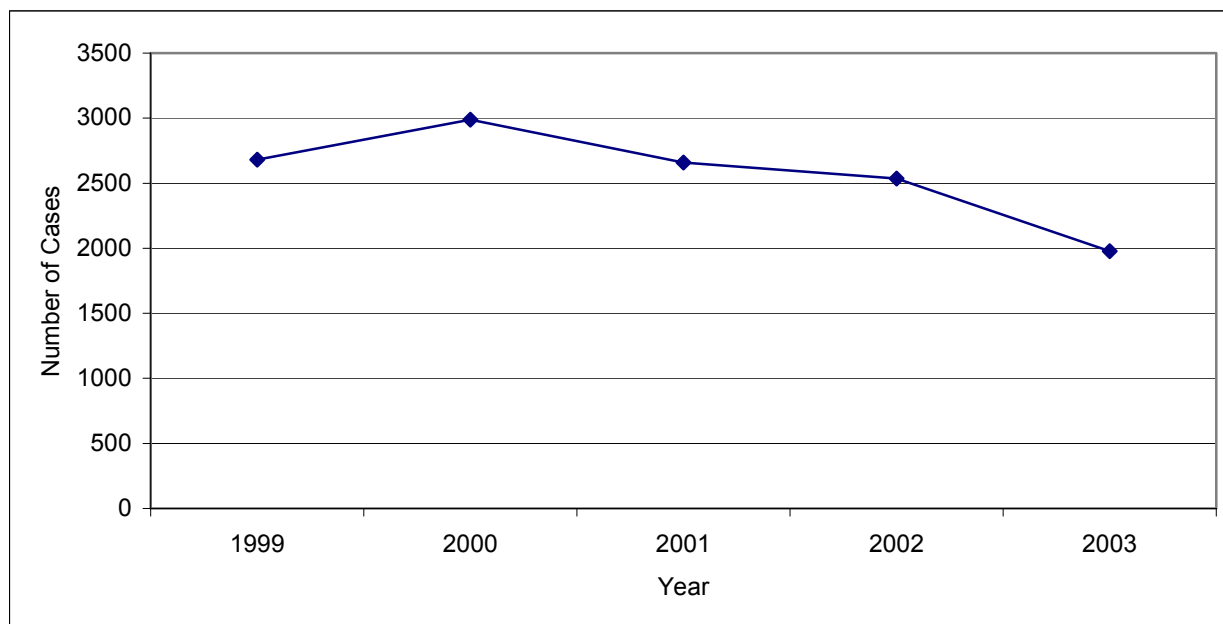


Figure 1.3.7
GONORRHEA CASES OUTSIDE HARRIS COUNTY, MALE 1999-2003

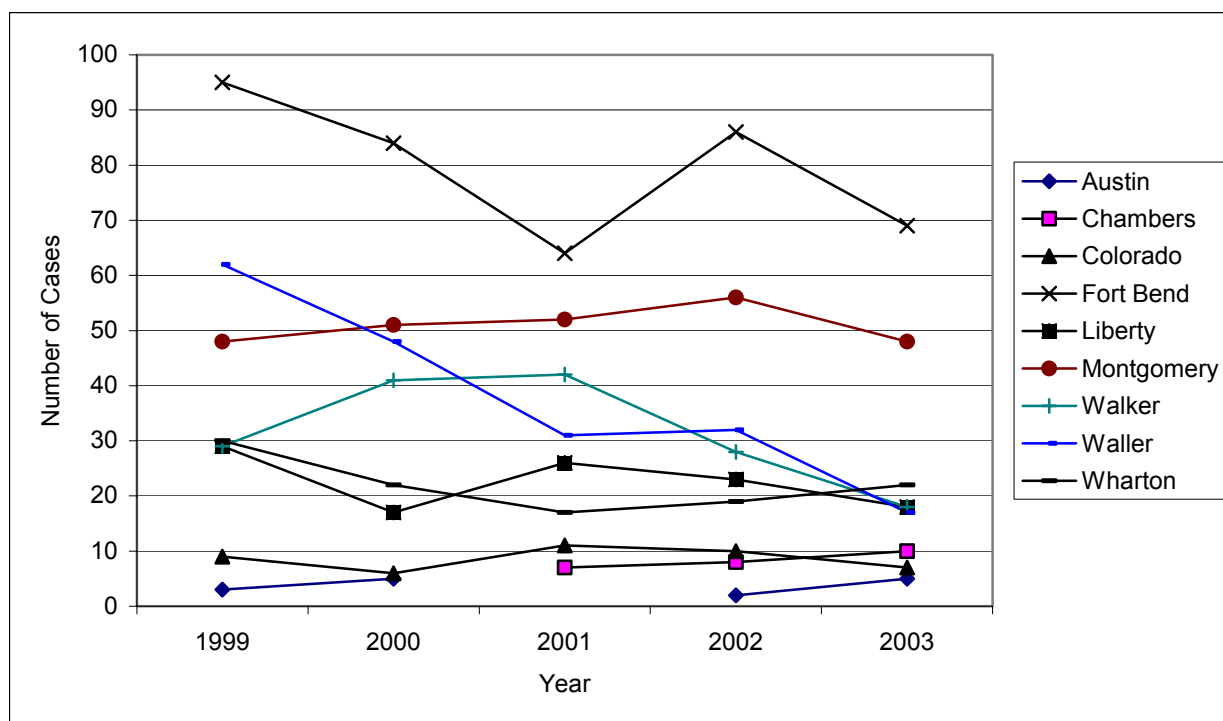
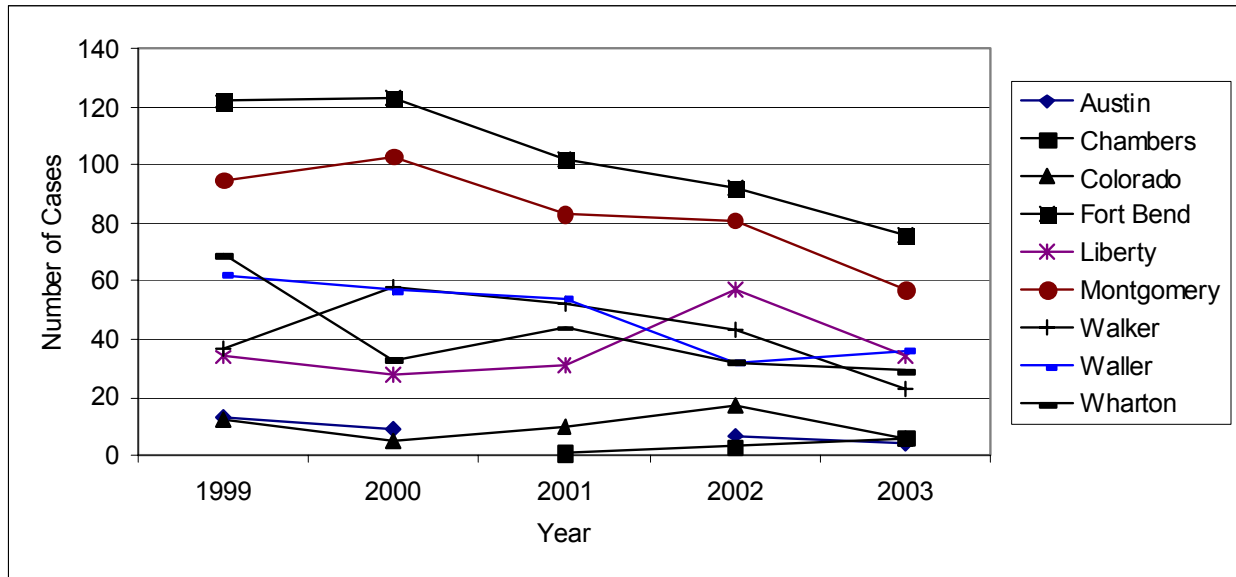


Figure 1.3.8
GONORRHEA CASES OUTSIDE HARRIS COUNTY, FEMALE 1999-2003



STD TRENDS: SYPHILIS



-  Although lower in prevalence than gonorrhea, the number of reported syphilis cases in the Houston HSDA has been increasing. The number of cases in 2004 has almost doubled that of 2002.
-  A breakdown by sex shows that the increase in syphilis cases is significant among males. Between 1999 and 2003, the number of syphilis cases among males has tripled; among women, the number of cases has decreased by almost half. Again, this trend is limited to Harris County – however, for some of the HSDA counties outside of Harris, the sex of cases was sometimes unknown.

Table 1.3.3
SYPHILIS CASES BY YEAR AND COUNTY, 1999-2004

HSDA	1999	2000	2001	2002	2003	2004
Austin	0	1	0	0	0	0
Chambers	0	0	0	0	0	0
Colorado	2	0	1	0	0	0
Fort Bend	21	14	6	7	9	6
Harris	70	70	101	111	193	213
Liberty	0	1	1	2	2	5
Montgomery	2	1	0	2	2	3
Walker	1	0	0	0	0	0
Waller	0	2	0	0	0	0
Wharton	5	2	1	0	0	0
Total	101	91	110	122	206	227

Source: The Texas Department of State Health Services

Figure 1.3.9
SYPHILIS CASES IN THE HOUSTON HSDA, 1999-2003

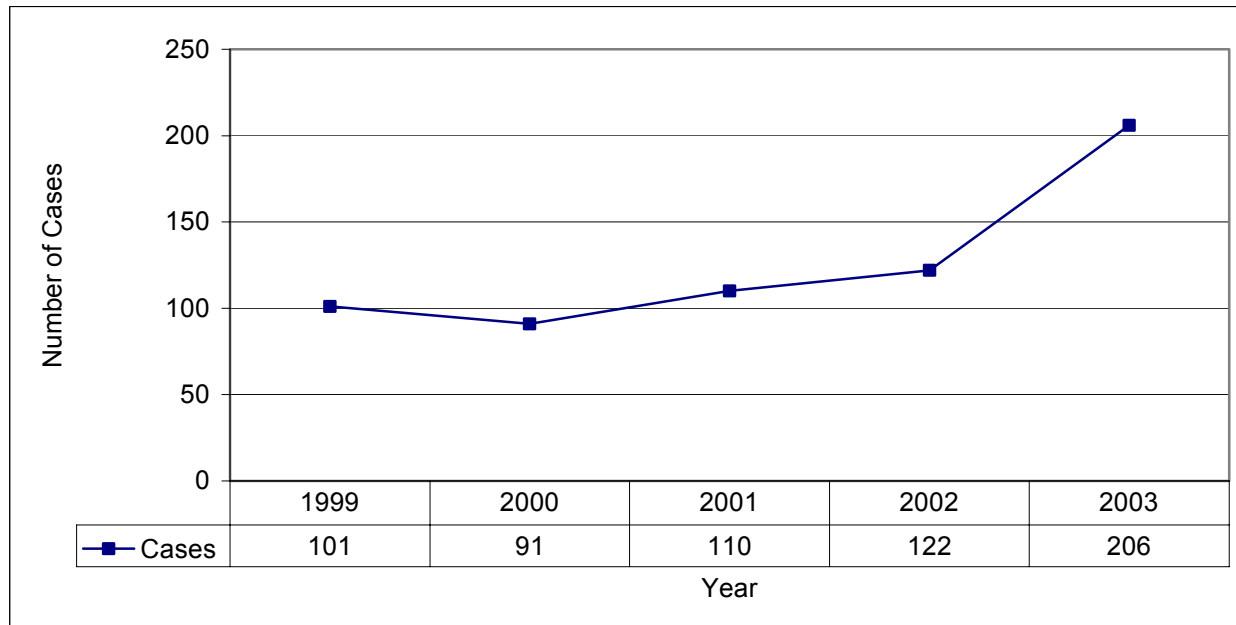


Figure 1.3.10
SYPHILIS CASES IN HARRIS COUNTY, 1999-2004

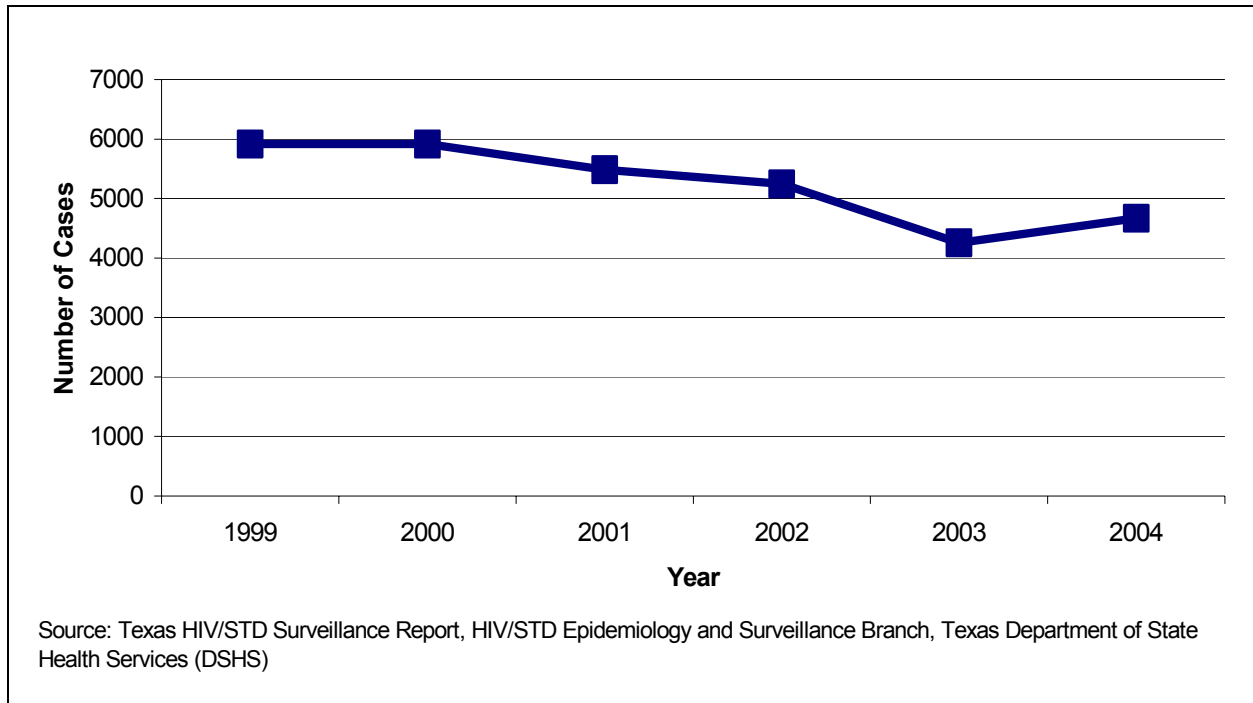


Figure 1.3.11
SYPHILIS CASES OUTSIDE HARRIS COUNTY, 1999-2004

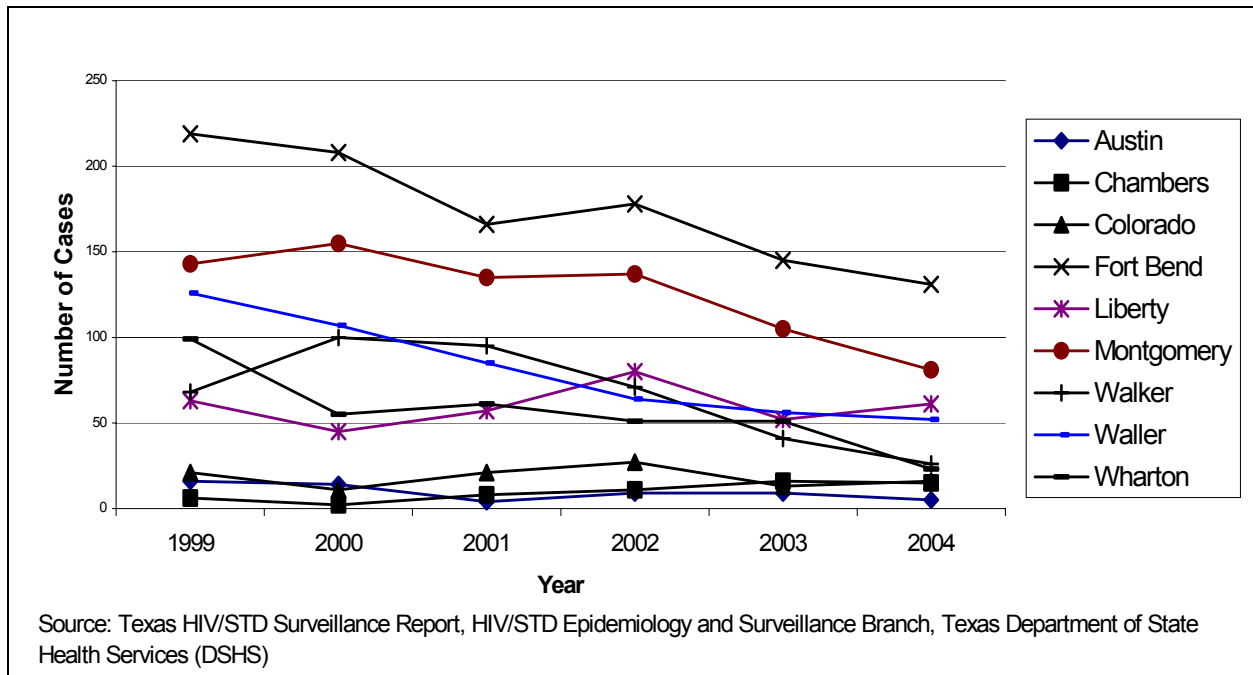


Table 1.3.4
SYPHILIS CASES BY YEAR, SEX AND COUNTY, 1999-2003

HSDA	1999		2000		2001		2002		2003	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Austin	0	0			0	0	0	0	0	0
Chambers	0	0	0	0	0	0	0	0	0	0
Colorado			0	0			0	0	0	0
Fort Bend	13	8	5	9					4	5
Harris	44	26	43	27	73	28	95	16	176	17
Liberty	0	0								
Montgomery					0	0				
Walker			0	0	0	0	0	0	0	0
Waller	0	0			0	0	0	0	0	0
Wharton							0	0	0	0
Total	61	40	52	39	77	33	103	19	183	23

* Grayed out cells have had the demographic breakdowns suppressed due to small cell sizes.

Figure 1.3.12
SYPHILIS CASES IN THE HOUSTON HSDA, BY SEX 1999-2003

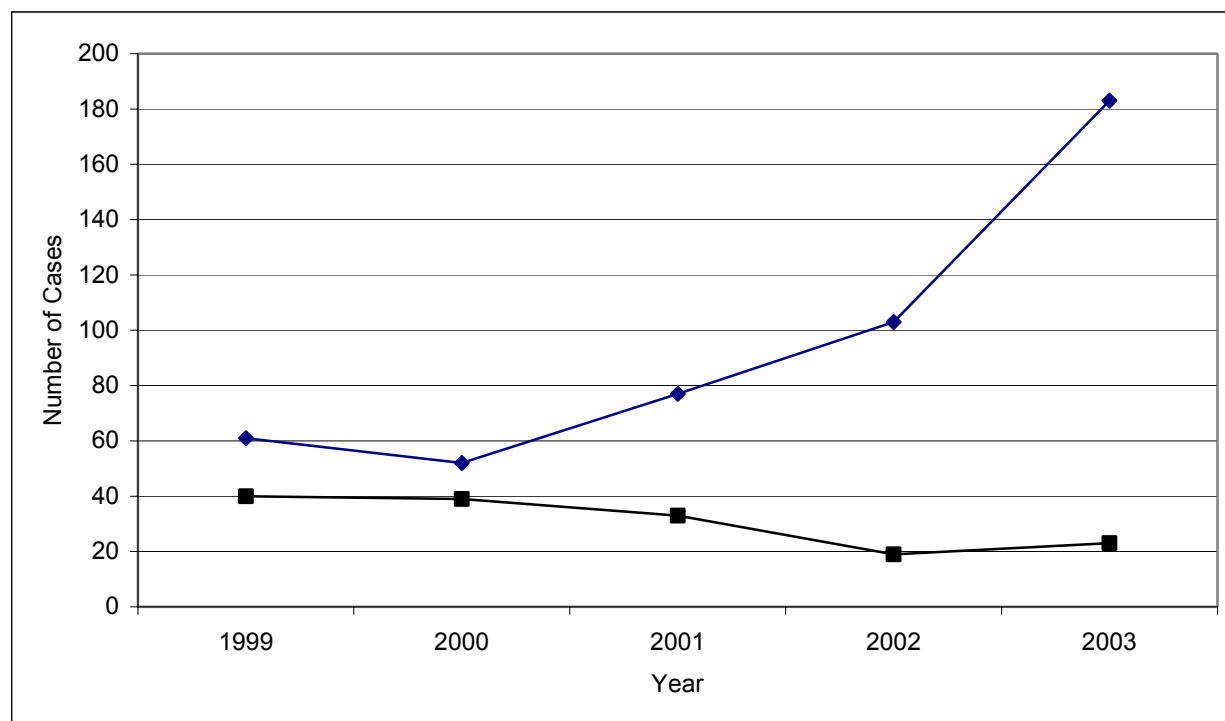


Figure 1.3.13
SYPHILIS CASES IN HARRIS COUNTY, MALE 1999-2003

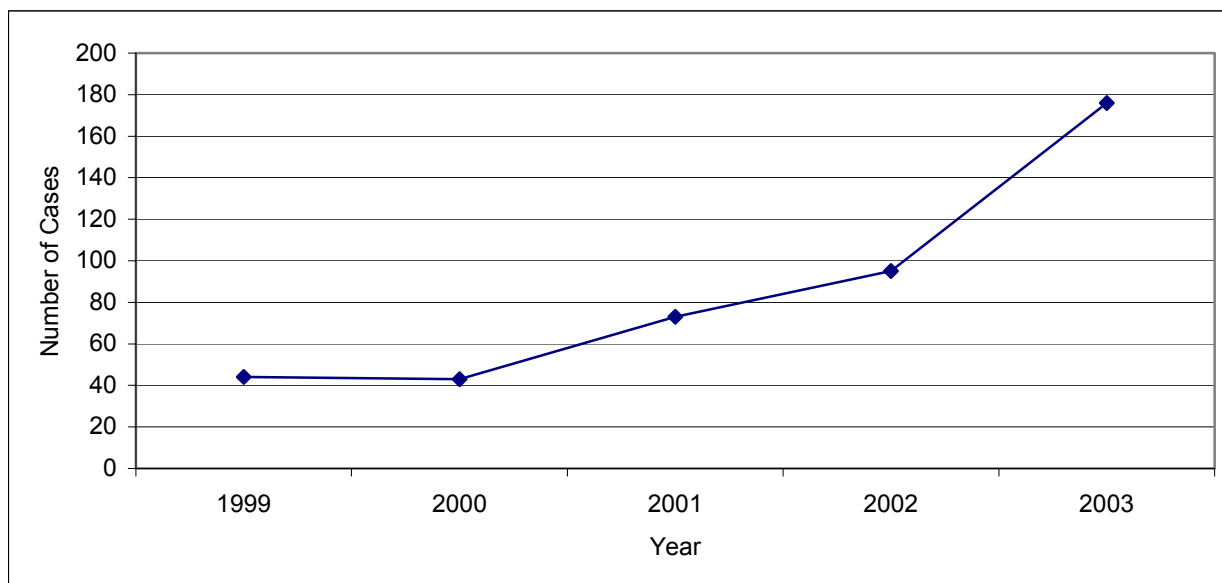
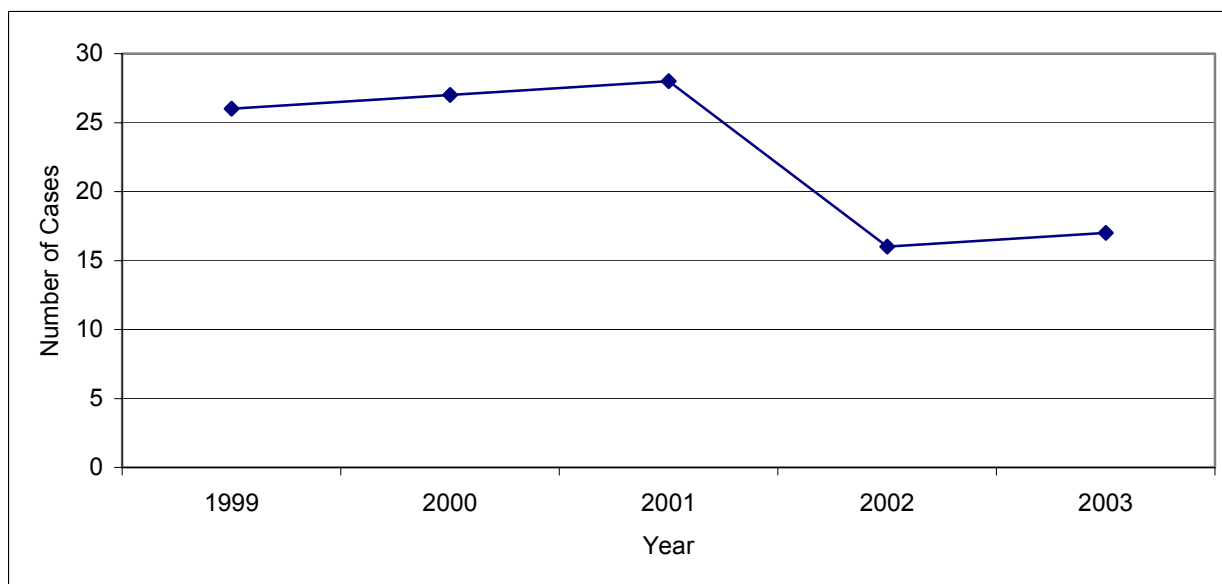


Figure 1.3.14
SYPHILIS CASES IN HARRIS COUNTY, FEMALE 1999-2003



The Houston Department of Health and Human Services Bureau of Epidemiology reported a syphilis outbreak among MSM in Houston during 2006.

Surveillance of syphilis is focused on primary and secondary (P&S) syphilis because these are the stages in which syphilis is infectious, and because it signals recent infection with syphilis. Syphilis is one of several infectious diseases that are reportable in the state of Texas. When a person tests positive for syphilis, a report is submitted to the Texas Department of State Health Services (DSHS). Reports are then forwarded to the local jurisdiction for follow-up, which includes notification, treatment, and interview for partner elicitation and notification. Syphilis case follow-up in Houston and Harris County is carried out by the HDHHS Bureau of HIV/STD and Viral Hepatitis Prevention.

From January 1, 2007 through October 31, 2007, there were 393 confirmed cases of P&S syphilis. Of the 393 cases, 376 (96%) were interviewed. Of those interviewed; 122 (32%) were HIV positive, 154 (41%) were HIV negative, 39 (10%) were of unknown HIV status, and 61 (16%) had not been tested for HIV.

Table 1.3.5
HIV STATUS AMONG ALL INTERVIEWED SYPHILIS CLIENTS, HOUSTON/HARRIS COUNTY,
01/01/07 - 10/31/07

# Cases	# Interviewed	Current HIV Status			
		Positive	Negative	Unknown	No Test
393	376 (96%)	122 (32%)	154 (41%)	39 (10%)	61 (16%)

Source: Houston Department of Health and Human Services, Bureau of Epidemiology

Due to a 2005 outbreak of syphilis among MSM in Houston, the HDHHS Bureau of Epidemiology performed additional analyses on this subpopulation.

From January 1, 2007 through October 31, 2007, there were 180 confirmed cases of P&S syphilis among MSM. Of these cases, 179 (99%) were interviewed. Of those interviewed; 99 (55%) were HIV positive, 53 (30%) were HIV negative, 8 (4%) were of unknown HIV status, and 21 (12%) had not been tested for HIV.

Table 1.3.6
HIV STATUS AMONG INTERVIEWED MSM SYPHILIS CLIENTS HOUSTON/HARRIS COUNTY,
01/01/07 - 10/31/07

# Cases	# Interviewed	Current HIV Status			
		Positive	Negative	Unknown	No Test
180	179 (99%)	99 (55%)	53 (30%)	8 (4%)	21 (12%)

Source: Houston Department of Health and Human Services, Bureau of Epidemiology

HIV TESTING

Data on HIV testing patterns can provide information that is helpful in focusing HIV counseling and testing programs. The data may also be used to help identify potential gaps in HIV surveillance data, which represents only persons who have been tested for HIV. For HIV/AIDS Prevention and Care Planning, HIV counseling and testing data were obtained from the Counseling and Testing System at the Texas Department of State Health Services (DSHS). These data represent the only available data for HIV counseling and testing in the Houston HSDA.

- ⚡ In 2003, a total of 29,827 HIV tests were reported for the Houston HSDA.
- ⚡ For the city of Houston, 11,407 individuals received HIV Counseling, Testing and Referral (CTR) services through programs funded by the Houston Department of Health and Human Services in 2006.
 - The number tested decreased from 2005 to 2006 due to the introduction of Protocol Based Counseling (PBC), which incorporates a counseling session tailored to the reported risk of the client. The session requires about 45 minutes per HIV test performed.
 - This change moved the focus of HIV testing from quantity to quality of services. Fewer clients were tested, but the testing was more appropriately targeted, which is evident in the increase in HIV positivity rate from 1.6% to 2.2%.
- ⚡ The vast majority of HIV tests reported to the state's HIV counseling and testing system were confidential and conducted during field visits or at HIV testing sites.
- ⚡ In terms of HIV exposure categories, "non-targeted" constituted the majority of HIV tests, followed by heterosexual sex, male-to-male sex and injection drug use.

Table 1.3.7
NUMBER OF HIV TESTS REPORTED, BY SEX AND COUNTY, 2003

HSDA	Male	Female	TOTAL
Austin	8	6	14
Chambers	7	10	17
Colorado	11	2	13
Fort Bend	188	210	398
Harris	16,966	11,760	28,726
Liberty	16	12	28
Montgomery	209	167	376
Walker	97	108	205
Waller	21	12	33
Wharton	13	4	17
TOTAL	17,536	12,291	29,827

Table 1.3.8
NUMBER OF HIV TESTS REPORTED, BY TEST TYPE AND COUNTY, 2003

HSDA	HIV test type		TOTAL
	Anonymous	Confidential	
Austin	1	12	13
Chambers	1	13	14
Colorado	1	12	13
Fort Bend	74	308	382
Harris	2,666	25,790	28,456
Liberty	0	28	28
Montgomery	21	349	370
Walker	3	198	201
Waller	3	30	33
Wharton	3	13	16
TOTAL	2,773	26,753	29,526

Table 1.3.9
NUMBER OF HIV TESTS REPORTED, BY HIV EXPOSURE CATEGORY AND COUNTY, 2003

HSDA	MSM/ IDU	MSM	IDU	F/MS	Non- targeted	TOTAL
Austin	0	2	0	9	3	14
Chambers	1	0	4	11	1	17
Colorado	0	2	1	10	0	13
Fort Bend	1	51	23	226	97	398
Harris	286	4,963	1,193	7,145	15,150	28,737
Liberty	0	5	8	13	2	28
Montgomery	5	31	156	151	34	377
Walker	1	15	32	153	4	205
Waller	0	5	3	16	9	33
Wharton	0	2	0	11	4	17
TOTAL	294	5,076	1,420	7,745	15,304	29,839

Table 1.3.10
NUMBER OF HIV TESTS REPORTED, BY HIV TEST SITE TYPE AND COUNTY, 2003

HSDA	HIV/CTS Testing Site	STD Clinic	Drug Treatment Facility	Family Planning Clinic	Primary Health Care Facility	Corrections	Field Visit	Education/Other	TOTAL
Austin	6	1	0	2	0	3	2	0	14
Chambers	1	0	6	2	0	4	4	0	17
Colorado	3	0	2	1	0	6	1	0	13
Fort Bend	141	3	16	177	0	19	42	0	398
Harris	5,761	2,587	288	2,863	2,542	4,197	10,384	115	28,737
Liberty	2	0	5	5	0	11	5	0	28
Montgomery	50	1	32	70	0	158	66	0	377
Walker	5	0	12	139	0	44	5	0	205
Waller	12	1	1	5	0	1	13	0	33
Wharton	7	0	4	3	0	3	0	0	17
TOTAL	5,988	2,593	366	3267	2,542	4446	10,522	115	29,839

Figure 1.3.15
POSITIVE HIV TEST RESULTS FROM HOUSTON DHHS-FUNDED CTR (COUNSELING, TESTING AND REFERRAL) PROGRAMS, BY YEAR OF TEST & RACE/ETHNICITY, AS OF AUGUST 7, 2007

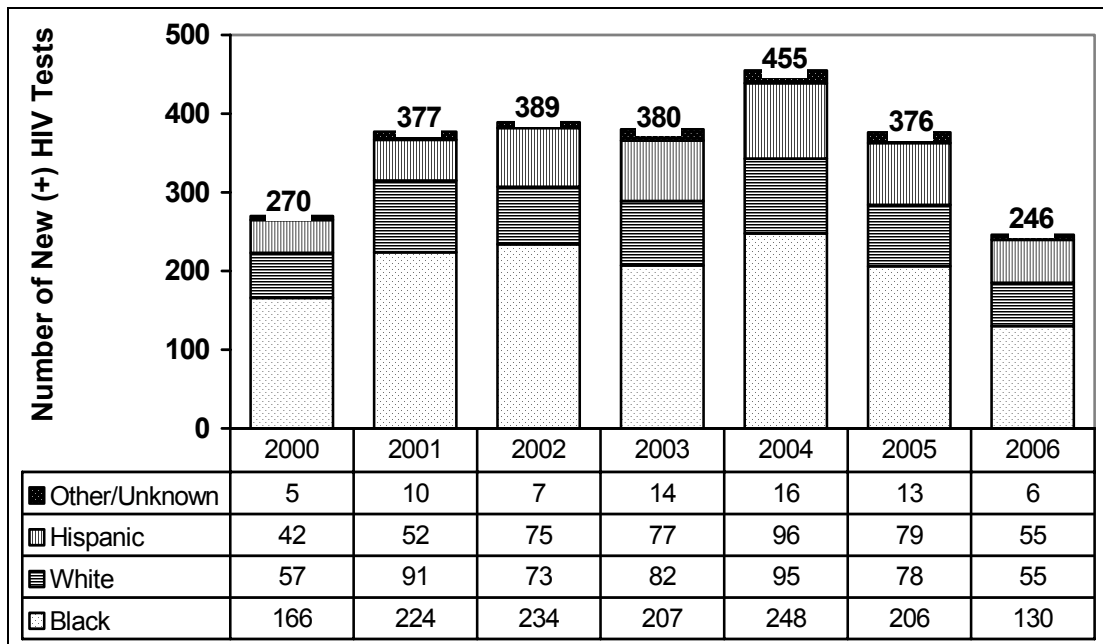
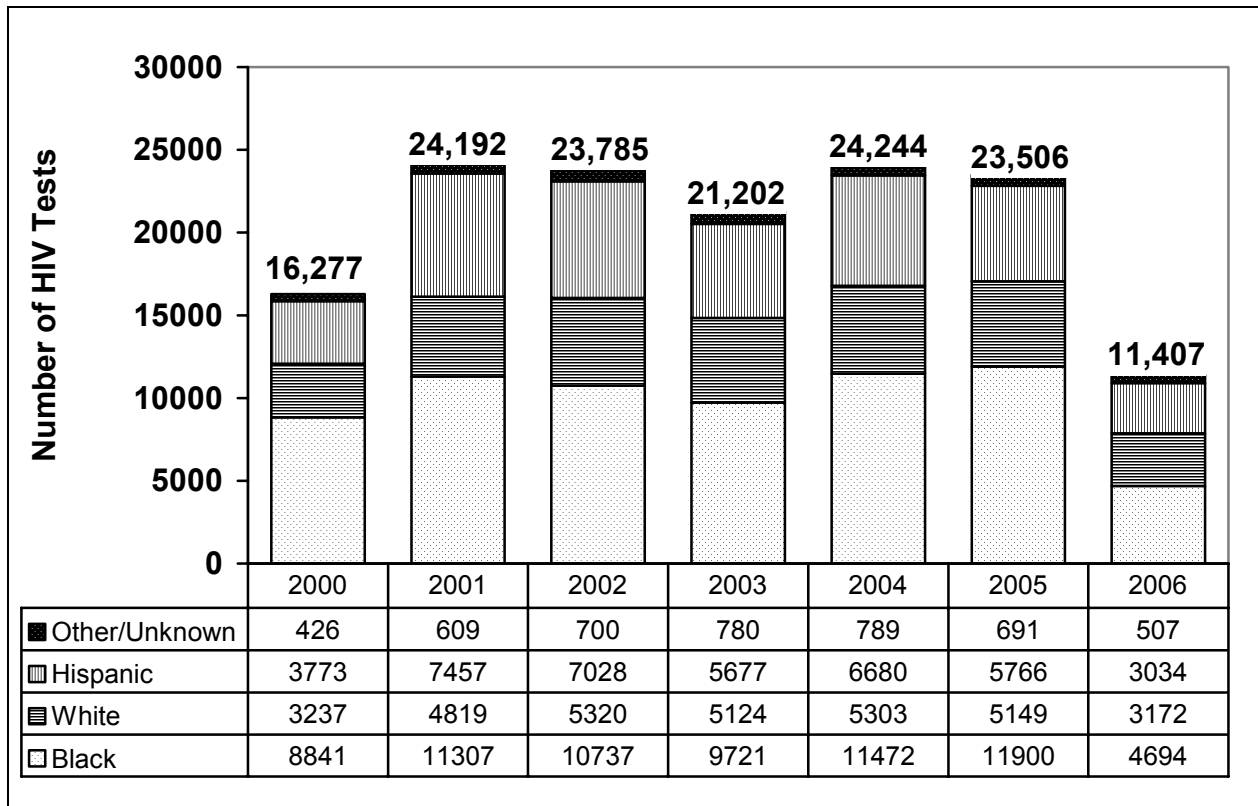


Figure 1.3.16
TOTAL HIV TESTS FROM HOUSTON DHHS-FUNDED CTR PROGRAMS BY YEAR OF TEST AND RACE/ETHNICITY, AS OF AUGUST 7, 2007



For the city of Houston, of the 11,407 tested, 4,694 (41%) were Black/African-American, 3,172 (28%) were White/Anglo, 3,034 (26%) were Hispanic/Latino, and 507 (4%) were of other or unknown race/ethnicity.

Of the 11,407 clients tested, 246 (2%) were newly diagnosed with HIV. Of those who were newly diagnosed; 130 (53%) were Black/African-American, 55 (22%) were White/Anglo, 55 (22%) were Hispanic/Latino, and 6 (2%) were of other or unknown race/ethnicity.

QUESTION 2.1:

WHAT ARE THE PATTERNS OF UTILIZATION OF HIV SERVICES OF PEOPLE LIVING IN THE HOUSTON REGION?

Data was obtained from the Centralized Patient Care Data Management System (CPCDMS) operated by the Ryan White Part A Program for all services except primary care and AIDS Drug Assistance Program (ADAP). CPCDMS was established for data collection in 2000 and identifies unduplicated patients for providers funded by Parts A, B, C and D as well as non-Ryan White funds such as Substance Abuse and Mental Health Services Administration (SAMHSA). It requires initial client registration with annual updates for re-enrollment. The initial registration requests detailed information on, among other things, risk factors and co-morbidities. This information is not necessarily updated during re-enrollment. Data presented on transmission mode and subpopulations is generally based on responses provided at initial registration.

Primary care data used only CPCDMS data in 2001 and 2002. In 2003, however, this data was expanded with patient profiles from Parts C and D, the Harris County Jail and the Veterans Administration. Since then, CPCDMS has incorporated jail data, Part C and most of Part D. For 2006, additional data was obtained from Part D and the VA.

SUMMARY

Utilization patterns on primary medical care, case management, dental care, substance abuse treatment, mental health therapy and counseling and ADAP services are compared to surveillance data on those living with HIV disease (Tables 1.2.2-H and 1.2.2-E). Service utilization trends increased between 2004 and 2006. Case management use increased by 44%; dental care use increased by 7%; substance abuse treatment increased by three times; and mental health therapy and counseling increased by 3%.

Primary medical care:

- ⚡ White/Anglo PLWHA are under-represented in primary medical care services. Primary care is accessed proportionally by PLWHA of all ages and both genders.

Case management:

- ⚡ White/Anglo PLWHA is under represented in case management. The utilization is proportional by age and gender. From 2004 to 2006, utilization increased from 3,784 clients to 5,477 clients. Case management services have declined slightly in Whites/Anglos and increased slightly in Hispanics/Latinos. There was also a slight decrease in adults aged 25-44 but an increase in older adults. There appears to be fewer reported cases of risk associated with MSM.

Dental care:

- Ⓡ There is a disproportionately higher access of dental care by older adults. Since 2004, there has been a decrease in adults aged 25-44.

Substance abuse treatment:

- Ⓡ Males appear to be slightly under represented in service utilization. Treatment is used more by Hispanics/Latinos and under-utilized by Whites/Anglos. Youth and adults aged 25-44 tended to utilize this service more, while there is under-representation in substance abuse clients for older adults aged 45 to 64.
- Ⓡ Utilization increased from 216 clients in 2004 to 656 clients in 2006; this increase, however, is not in Part A clients but in clients served under SAMHSA-funded programs. During this period, there was a slight decline in service utilization by White/Anglo PLWHA. Male clients decreased from 77% to 68%, while female clients increased from 23% to 32%. Adults aged 25-44 decreased from 74% to 68%. Finally, data showed a marked increase in the risk category of heterosexual contact (24% to 41%) and a slight decrease in homeless clients.

Mental health therapy and counseling:

- Ⓡ For 2006, the proportions across all demographic categories appear to be similar to their representation in service utilization. Whites/Anglos and Hispanics/Latinos had declined in their service usage from 2004 to 2006 while Blacks/African-Americans increased (34% to 45%). Adults aged 25-44 had declined while clients reporting the risk behaviors of heterosexual contact and MSM increased in their usage of the service during that time period.

ADAP:

- Ⓡ Hispanic/Latino PLWHA over utilized ADAP services while White/Anglo PLWHA appear to be under-represented among ADAP clients when compared to their distribution within the regional epidemic. Usage by gender and age group appear to be proportional when compared to the regional epidemic.

PRIMARY CARE SERVICES

The following data-related issues should be considered when reviewing the primary care utilization data:

- Ⓡ The Veterans Administration reported 762 patients. Among these, 25 males died during the year. These patients are included in the patient counts.
- Ⓡ Additional Part D data were received from The Resource Group and those records were unduplicated against data from CPCDMS and reported in the table.
- Ⓡ Because previous years' utilization data do not contain the same level of detail, comparisons with previous years are not made.

In 2006, a total of 8,173 people received primary medical care through Ryan White Parts A through D, the Harris County Jail and the VA. The following compares primary care utilization (Table 2.1.1) to surveillance data on those living with HIV disease.

- ⚡ Medical care services are used proportionately by men and women. Approximately 71% of primary medical care patients are men, and 74% of those living with HIV or AIDS are men.
- ⚡ The percentages of Blacks/African-Americans and Hispanics/Latinos who use primary medical care services through these funding sources are similar to their percentages among those living with HIV or AIDS. Whites/Anglos, however, under utilize medical care services.
 - Blacks/African-Americans are 48% of those living with HIV or AIDS and Hispanics/Latinos are 20%, while these two groups are 54% and 23%, respectively, among those accessing primary medical care.
 - Whites/Anglos make up 31% of those living with HIV disease but only comprise 23% of those accessing primary medical care services.
- ⚡ Primary medical care use is proportional by age.
 - Older adults, aged 45 to 64, are 36% of the regional epidemic and of those accessing primary medical care.
 - People in the 25 to 44 age range are 56% of those living with the virus and 54% of those accessing primary medical care
 - Youth, aged 13 to 24 years, are 4% of those with HIV disease and 5% of those receiving primary medical care.

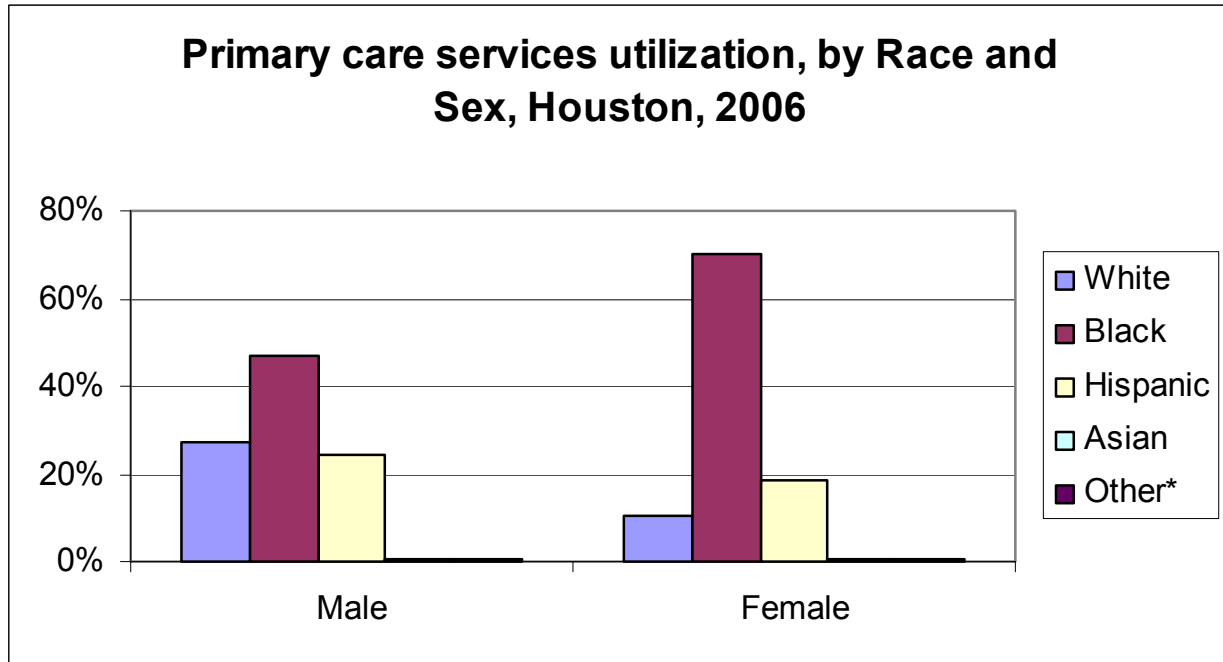
Table 2.1.1
PRIMARY CARE UTILIZATION BY GENDER, RACE AND AGE, 2006

	Male		Female		Total	
	#	%	#	%	#	%
Total	5,818	71%	2,355	29%	8,173	100%
Race						
White/Anglo	1,597	27%	245	10%	1,842	23%
Black/African-American	2,743	47%	1,648	70%	4,391	54%
Hispanic/Latino	1,408	24%	440	19%	1,848	23%
Asian	44	1%	10	0%	54	1%
Other*	26	0%	12	1%	38	0%
Age						
0-12	147	3%	148	6%	295	4%
13-24	231	4%	195	8%	426	5%
25-44	3,140	54%	1,271	54%	4,411	54%
45-64	2,203	38%	711	30%	2,914	36%
65+	97	2%	30	1%	127	2%

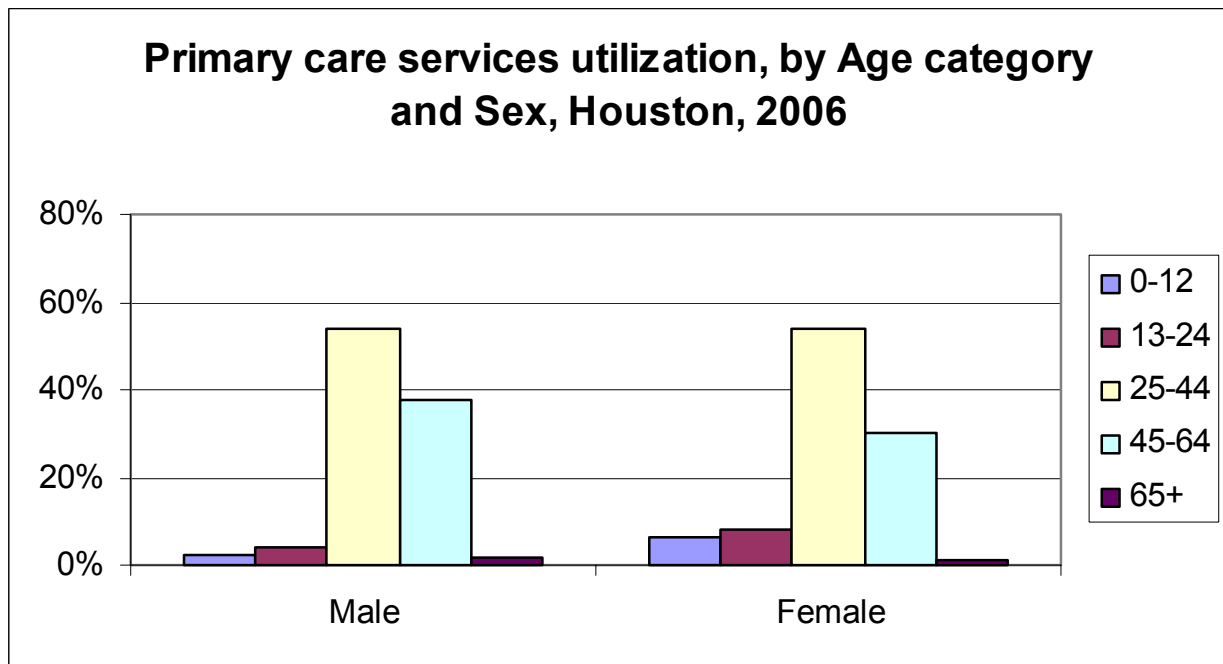
Data is approximate, including primary care data from CPCDMS and additional Part D data from The Resource Group and the VA.

*"Other" includes Native Americans, Pacific Islanders, and multi-race.

Figure 2.1.1
PRIMARY CARE UTILIZATION



***Other" includes Native Americans, Pacific Islanders and multi-race.



CASE MANAGEMENT SERVICES

- ✶ Case management services were used by 5,477 unduplicated clients in 2006 (Table 2.1.2).
 - In comparing case management service utilization to the profile of the epidemic in the region, services are utilized proportionately across all ages and genders.
 - Blacks/African-Americans use case management services to a greater extent than Whites/Anglos. Whites/Anglos are 31% of PLWHA in the region, but only 22% of case management clients, and Blacks/African-Americans are 48% of PLWHA, but 54% of case management clients. Hispanics/Latinos use case management services proportionately since they make up 20% of the epidemic and 22% of case management clients.
- ✶ Case management use had increased from 3,784 clients in 2004 to 5,477 clients in 2006 (Table 2.1.3).
 - On a percentage basis, use of case management services has declined slightly in White PLWHA during this time (from 26% to 22%). Utilization by gender remained relatively stable during this time.
 - By age, case management use decreased slightly among adults age 25 to 44 years, from 59% to 55%, but increased among older PLWHA, from 34% to 38%.
- ✶ Examining PLWHA comorbidities and special situations presented in Table 2.1.4, there appear to be fewer reported cases of risk associated with MSM, from 29% to 24%.

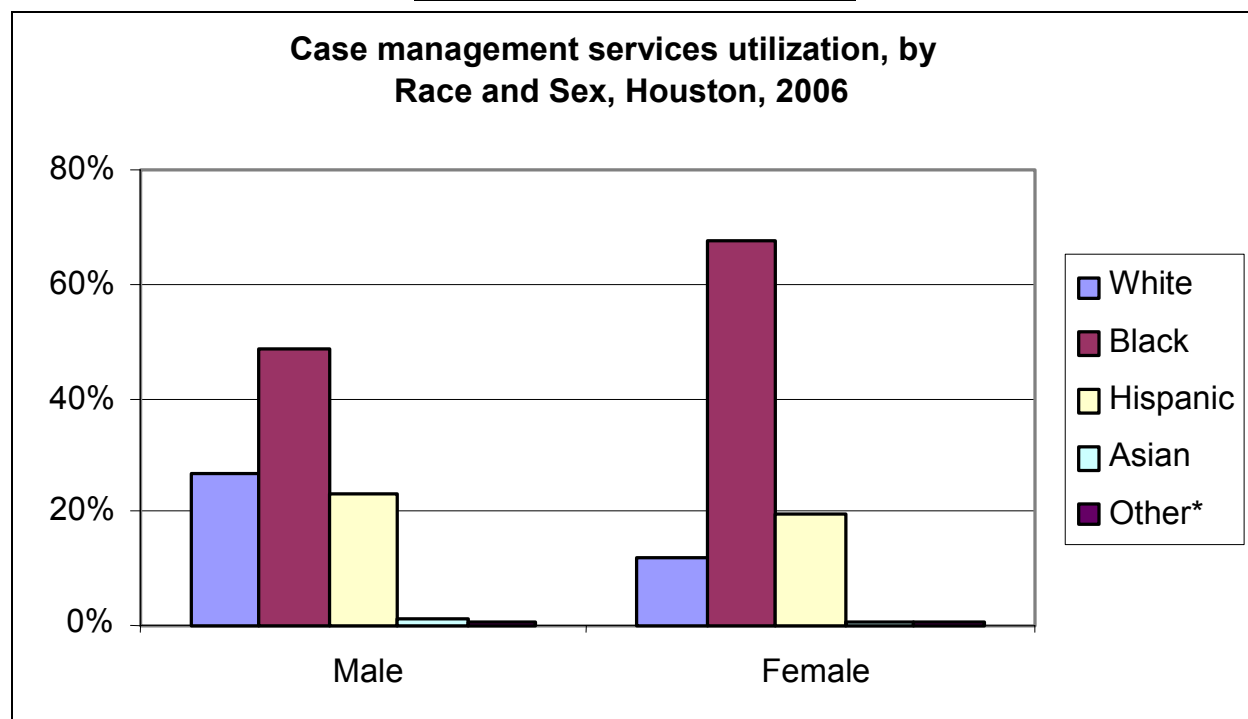
Table 2.1.2
CASE MANAGEMENT UTILIZATION BY GENDER, RACE AND AGE, 2006

	Case Management					
	Male		Female		Total	
	#	%	#	%	#	%
Total	3,893	71%	1,584	29%	5,477	100%
Race						
White/Anglo	1,033	27%	183	12%	1,216	22%
Black/African-American	1,895	49%	1,077	68%	2,972	54%
Hispanic/Latino	911	23%	311	20%	1,222	22%
Asian	33	1%	6	0%	39	1%
Other*	21	1%	7	0%	28	1%
Age						
0-12	11	0%	9	1%	20	0%
13-24	160	4%	100	6%	260	5%
25-44	2,084	54%	926	58%	3,010	55%
45-64	1,565	40%	526	33%	2,091	38%
65+	73	2%	23	1%	96	2%

Data from CPCDMS.

* "Other" includes Native Americans, Pacific Islanders and multi-race.

Figure 2.1.2
CASE MANAGEMENT UTILIZATION



*Other includes Native American, Pacific Islander and multi-race.

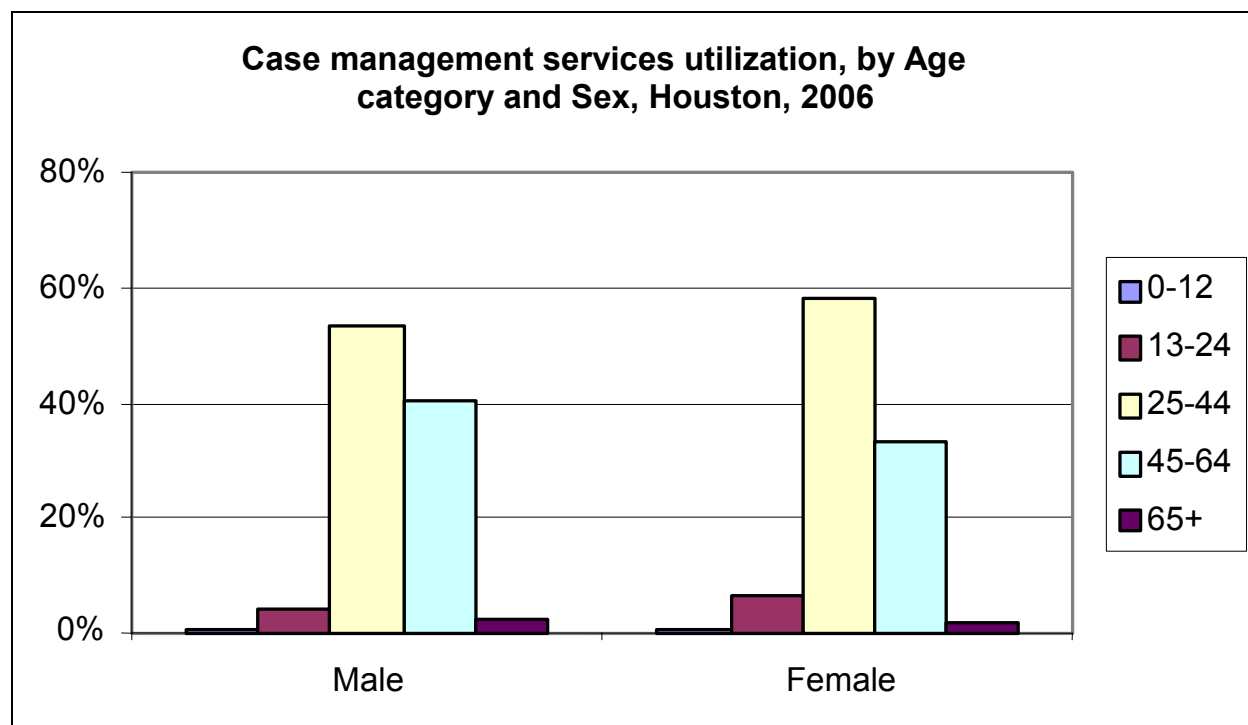


Table 2.1.3
CASE MANAGEMENT UTILIZATION BY GENDER, RACE AND AGE, 2004 - 2006

	Case Management					
	2004		2005		2006	
	(N=3,784)		(N=3,740)		(N=5,477)	
	#	%	#	%	#	%
Race						
White/Anglo	972	26%	987	26%	1,216	22%
Black/African-American	2,045	54%	1,959	52%	2,972	54%
Hispanic/Latino	722	19%	739	20%	1,222	22%
Asian	21	1%	28	1%	39	1%
Other*	24	1%	27	1%	28	1%
Sex						
Male	2,665	70%	2,688	72%	3,893	71%
Female	1,119	30%	1,052	28%	1,584	29%
Age						
0-12	80	2%	53	1%	20	0%
13-24	168	4%	179	5%	260	5%
25-44	2,223	59%	2,146	57%	3,010	55%
45-64	1,268	34%	1,313	35%	2,091	38%
65+	45	1%	49	1%	96	2%

Data from CPCDMS.

* "Other" includes Native Americans, Pacific Islanders and multi-race.

Table 2.1.4
CASE MANAGEMENT UTILIZATION BY TRANSMISSION MODE AND SUBPOPULATIONS,
2004 - 2006

	Case Management					
	2004		2005		2006	
	(N=3,784)		(N=3,740)		(N=5,477)	
	#	%	#	%	#	%
Transmission Mode**						
Perinatal Transmission	103	3%	83	2%	53	1%
Hemophilia Coagulation	4	0%	4	0%	3	0%
Transfusion	69	2%	63	2%	54	1%
Heterosexual Contact	1,301	34%	1,249	33%	1,749	32%
MSM (not IDU)	1,110	29%	1,128	30%	1,297	24%
IV Drug Use (not MSM)	140	4%	132	4%	140	3%
MSM/IDU	17	0%	17	0%	18	0%
Multiple Exposure Categories	142	4%	181	5%	193	4%
Other risk	889	23%	975	26%	1,864	34%
Subpopulation**						
Unduplicated clients	3,784	100%	3,740	100%	5,477	100%
Monolingual (Spanish)	388	10%	371	10%	680	12%
Deaf/hard of hearing	82	2%	76	2%	79	1%
Blind/sight impaired	157	4%	142	4%	182	3%
Homeless	146	4%	212	6%	132	2%
Transgender M to F	19	1%	17	0%	26	0%
Transgender F to M	2	0%	1	0%	1	0%
Within Harris County	3,542	94%	3,390	91%	5,116	93%
Outside Harris County	242	6%	350	9%	361	7%
Active substance abuse	218	6%	243	6%	278	5%
Active psychiatric illness	219	6%	205	5%	242	4%

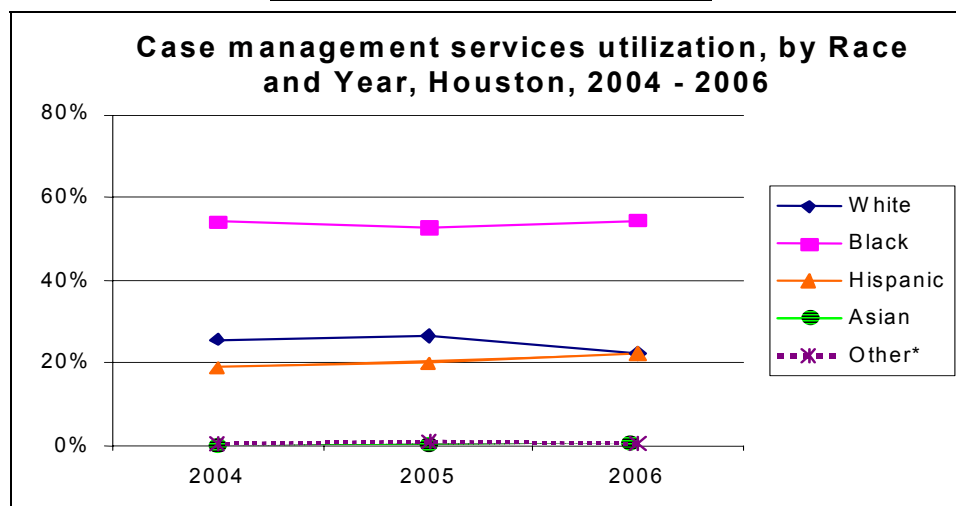
** Not mutually exclusive.

Data from CPCDMS.

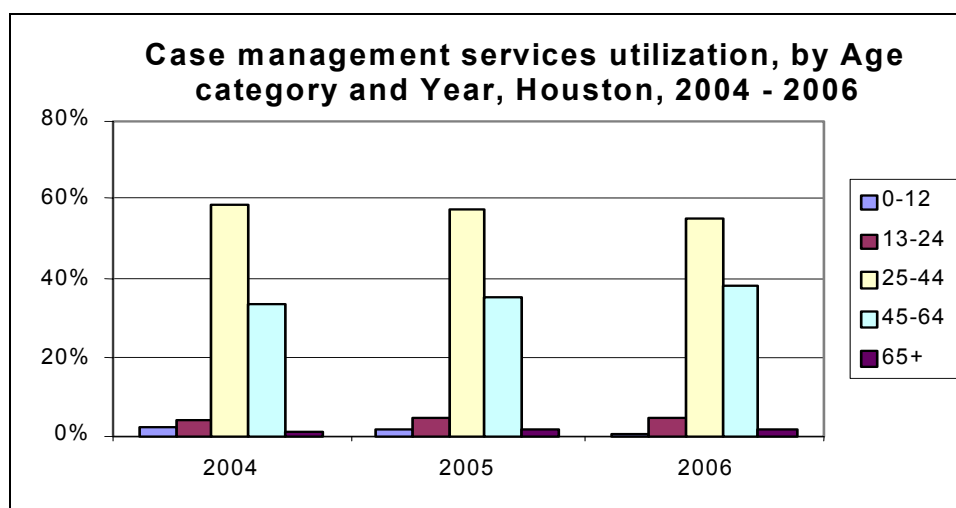
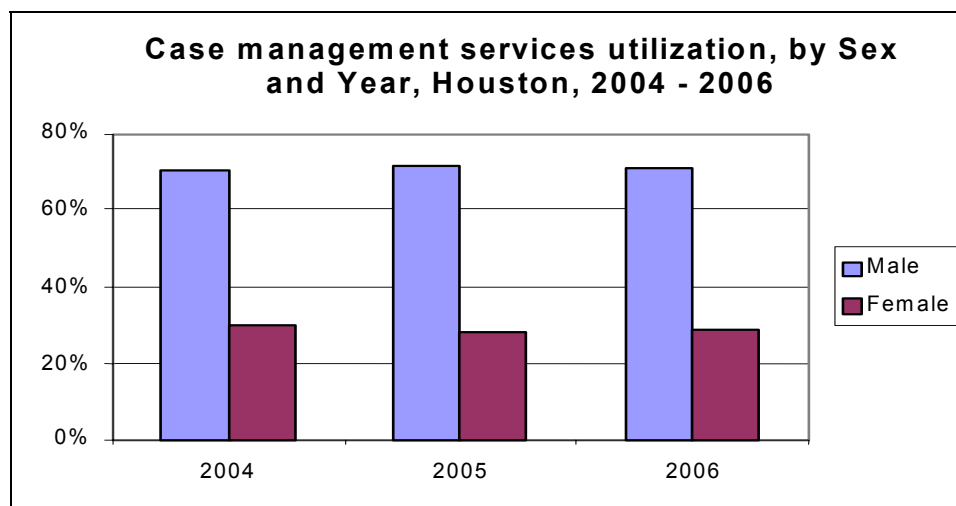
Most information on transmission mode and comorbidities is obtained during initial registration and not updated.

Initial registration could have occurred at any time between 2004 and 2006.

Figure 2.1.3
CASE MANAGEMENT UTILIZATION



**Other* includes Native Americans, Pacific Islanders, and multi-race.



DENTAL SERVICES

- ⦿ Overall, the proportions by race are comparable between service utilization and the regional epidemic.
 - Whites/Anglos are 31% of PLWHA and 30% of those who use dental services.
 - Blacks/African-Americans are 48% of PLWHA and 45% of those who use dental services
 - Hispanics/Latinos are 20% of PLWHA in the region and 24% of those who use dental services.
- ⦿ Dental services are under utilized by adults and used disproportionately by older adults.
 - PLWHA aged 45 to 64 make up 36% of the infected population in the Houston area, but they are 48% of dental care users.
 - PLWHA aged 25 to 44 make up 56% of the epidemic but only 48% of dental care clients.
 - Youth are 4% of PLWHA and are 2% of dental care users, so there may be a slight under-representation in service utilization.
- ⦿ The proportions of men and women using dental services are similar to their respective proportions in the epidemic.
- ⦿ Between 2004 and 2005, use of dental services had increased by 7%.
 - Those aged 25 to 44 were 56% in 2004, declining to 48% in 2006, and those aged 45 to 64 were 41% of dental care patients in 2004, increasing to 48% in 2006.

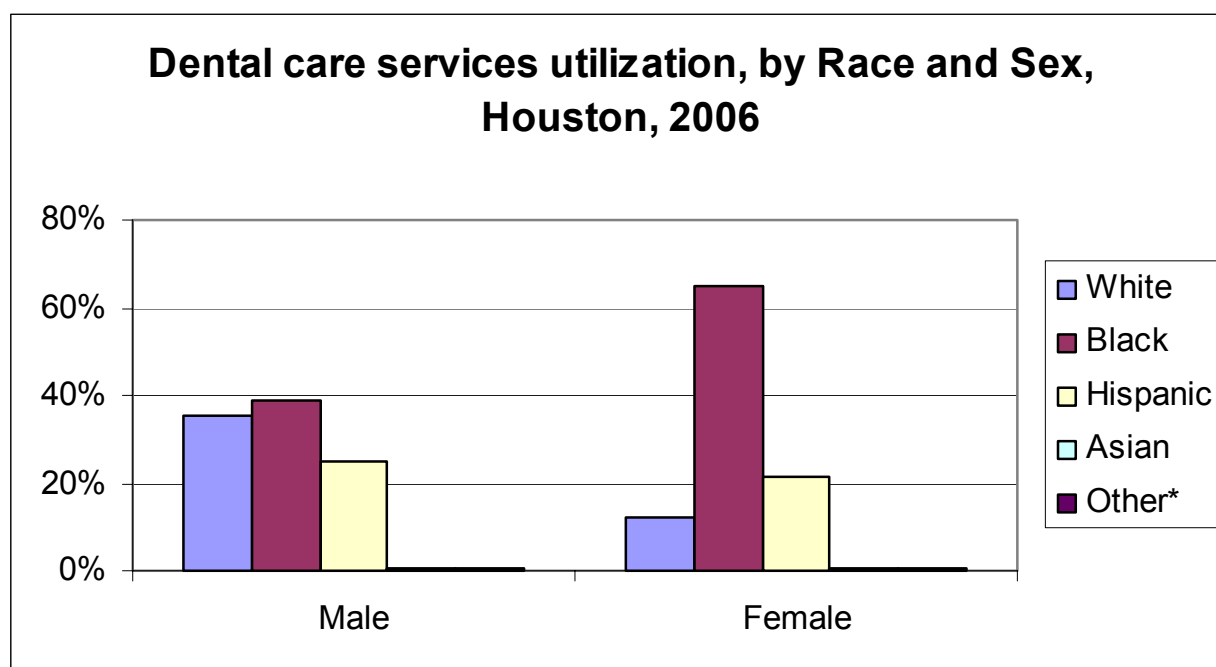
Table 2.1.5
DENTAL SERVICE UTILIZATION BY GENDER, RACE AND AGE, 2006

	DENTAL CARE					
	Male		Female		Total	
	#	%	#	%	#	%
Total	1,676	76%	543	24%	2,219	100%
Race						
White/Anglo	589	35%	66	12%	655	30%
Black/African-American	651	39%	354	65%	1,005	45%
Hispanic/Latino	416	25%	117	22%	533	24%
Asian	12	1%	4	1%	16	1%
Other*	8	0%	2	0%	10	0%
Age						
0-12	0	0%	0	0%	0	0%
13-24	28	2%	17	3%	45	2%
25-44	790	47%	281	52%	1,071	48%
45-64	825	49%	234	43%	1,059	48%
65+	33	2%	11	2%	44	2%

Data from CPCDMS.

* "Other" includes Native Americans, Pacific Islanders and multi-race.

Figure 2.1.4
DENTAL SERVICE UTILIZATION



**"Other" includes Native Americans, Pacific Islanders, and multi-race.

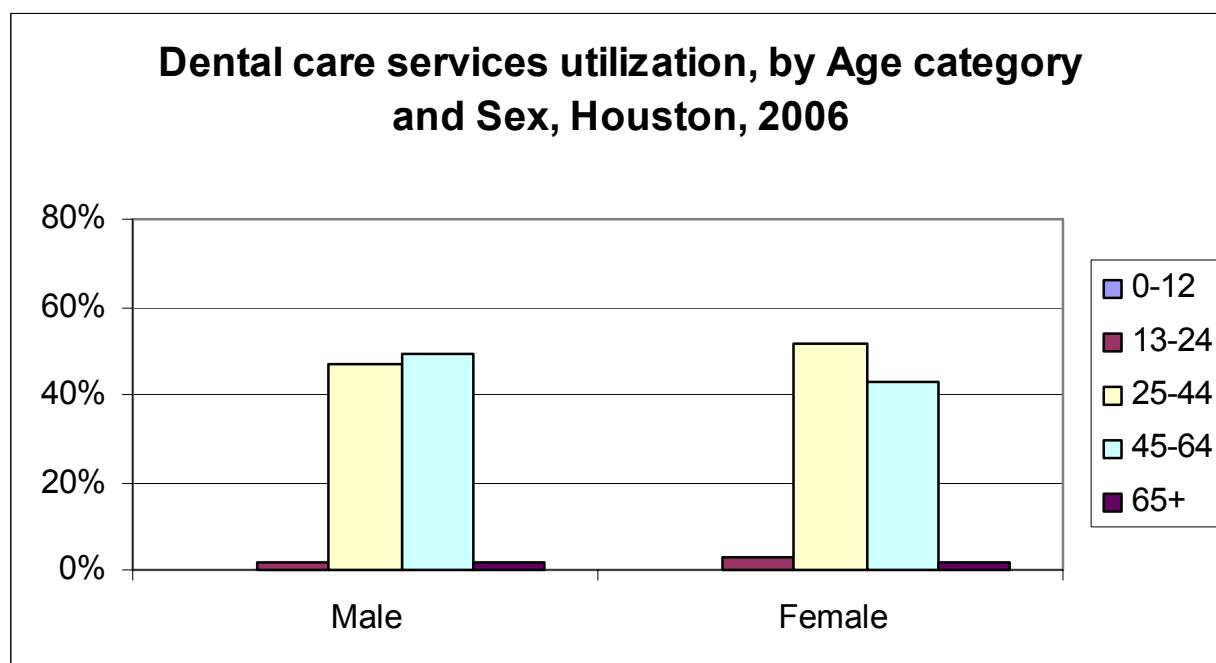


Table 2.1.6
DENTAL SERVICE UTILIZATION BY GENDER, RACE AND AGE, 2004 - 2006

	Dental Care					
	2004		2005		2006	
	(N=2,080)		(N=2,280)		(N=2,219)	
	#	%	#	%	#	%
Race						
White/Anglo	651	31%	652	30%	655	30%
Black/African-American	933	45%	986	45%	1,005	45%
Hispanic/Latino	473	23%	542	25%	533	24%
Asian	13	1%	17	1%	16	1%
Other*	10	0%	11	0%	10	0%
Sex						
Male	1,574	76%	1,682	76%	1,676	76%
Female	506	24%	526	24%	543	24%
Age						
0-12	0	0%	0	0%	0	0%
13-24	44	2%	45	2%	45	2%
25-44	1,165	56%	1,173	53%	1,071	48%
45-64	844	41%	957	43%	1,059	48%
65+	27	1%	33	1%	44	2%

Data from CPCDMS.

* "Other" includes Native Americans, Pacific Islanders and multi-race.

Table 2.1.7
DENTAL SERVICE UTILIZATION
BY TRANSMISSION MODE AND SUBPOPULATIONS
2003 - 2005

	Dental Care					
	2004		2005		2006	
	(N=2,080)		(N=2,280)		(N=2,219)	
	#	%	#	%	#	%
Transmission Mode**						
Perinatal Transmission	4	0%	5	0%	4	0%
Hemophilia Coagulation	3	0%	2	0%	3	0%
Transfusion	31	1%	33	1%	29	1%
Heterosexual Contact	456	22%	483	22%	500	23%
MSM (not IDU)	592	28%	603	27%	636	29%
IV Drug Use (not MSM)	50	2%	49	2%	55	2%
MSM/IDU	13	1%	12	1%	11	0%
Multiple Exposure Categories	63	3%	57	3%	63	3%
Other risk	679	33%	765	35%	752	34%
Subpopulation**						
Unduplicated clients	2,080	100%	2,208	100%	2,219	100%
Monolingual (Spanish)	262	13%	303	14%	296	13%
Deaf/hard of hearing	33	2%	26	1%	23	1%
Blind/sight impaired	57	3%	60	3%	60	3%
Homeless	39	2%	45	2%	19	1%
Transgender M to F	4	0%	2	0%	4	0%
Transgender F to M	2	0%	1	0%	1	0%
Within Harris County	1,992	96%	2,121	96%	2,106	95%
Outside Harris County	88	4%	87	4%	113	5%
Active substance abuse	77	4%	89	4%	94	4%
Active psychiatric illness	81	4%	79	4%	88	4%

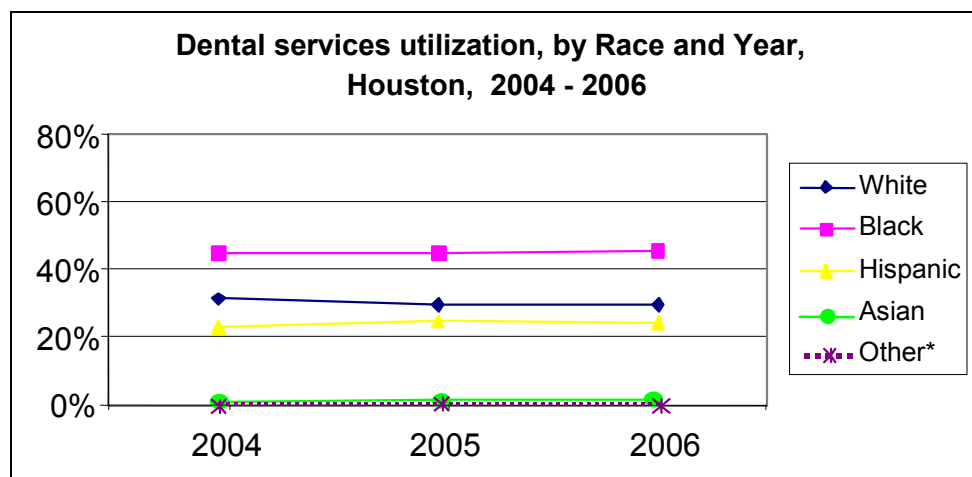
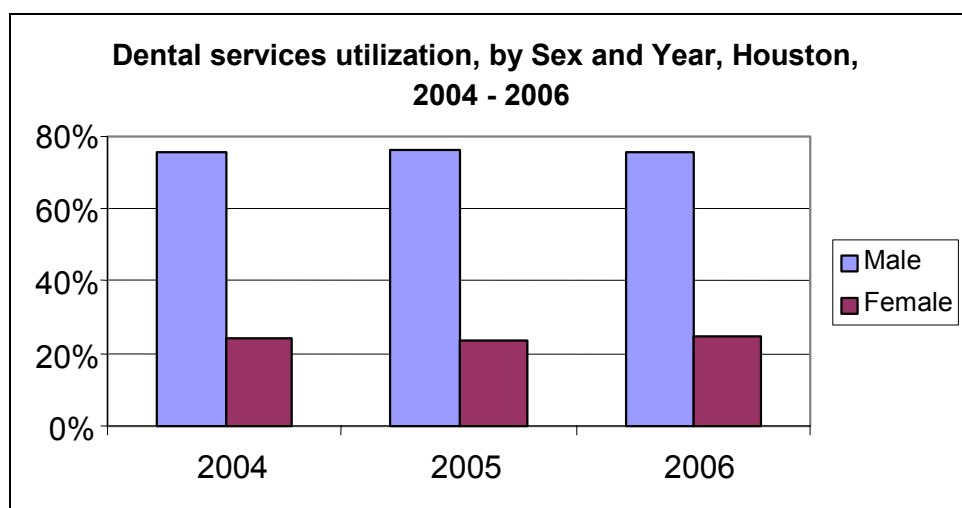
** Not mutually exclusive.

Data from CPCDMS.

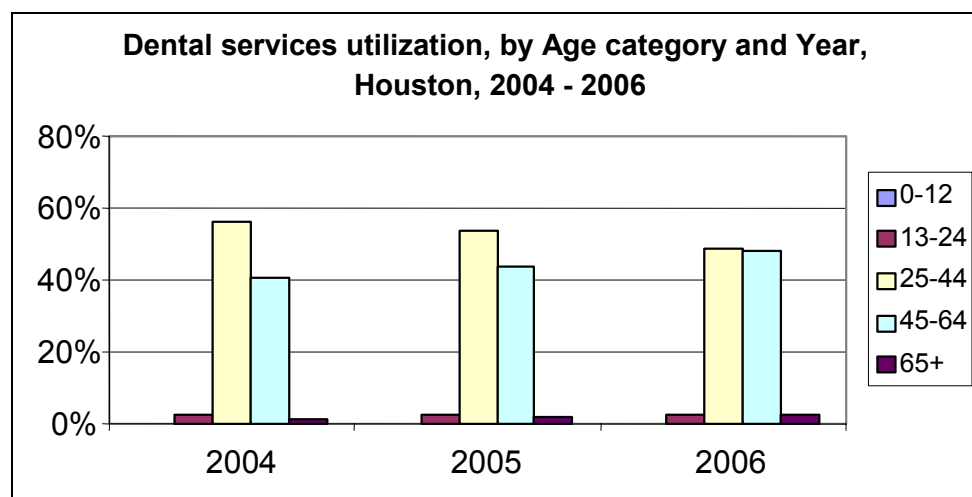
Most information on transmission mode and comorbidities is obtained during initial registration and not updated.

Initial registration could have occurred at any time between 2004 and 2006.

Figure 2.1.5
DENTAL SERVICE UTILIZATION



**"Other" includes Native Americans, Pacific Islanders, and multi-race.



SUBSTANCE ABUSE TREATMENT



-  In 2006, substance abuse treatment services were used by 656 clients.
- When compared to the regional epidemic, men appear to under-utilize services; 74% of PLWHA are men while 68% accessed this service.
 - Whites/Anglos and Hispanics/Latinos show disproportionate usage of the services. Whites/Anglos represent 31% among PLWHA but only comprise 18% among clients utilizing substance abuse treatment; while Hispanics/Latinos are 20% of PLWHA but represent 35% of clients receiving services. Blacks/African-Americans represent 48% and 46%, respectively.
 - Older adults aged 45-64 are under represented in this service, as they comprise 36% in the region but only 23% among those utilizing the service. Treatment is also being used disproportionately by youth and adults aged 25-44; youth represent 4% among PLWHA but are 8% among clients accessing services; adults aged 25 to 44 show 56% among PLWHA but 68% among those using the services.
-  Substance abuse treatment utilization had increased from 216 clients in 2004 to 656 clients in 2006. This large increase in utilization is largely due to the addition of services funded by SAMHSA now being tracked in CPCDMS.
- Male clients decreased from 77% to 68%, while female clients increased from 23% to 32%.
 - There was a slight decline in service utilization by White/Anglo PLWHA from 23% to 18%.
 - Adults aged 25 to 44 declined in their usage from 74% to 68%.
 - Data shows a marked increase in the risk category of heterosexual contact (24% to 41%) and a slight decrease in homeless clients.

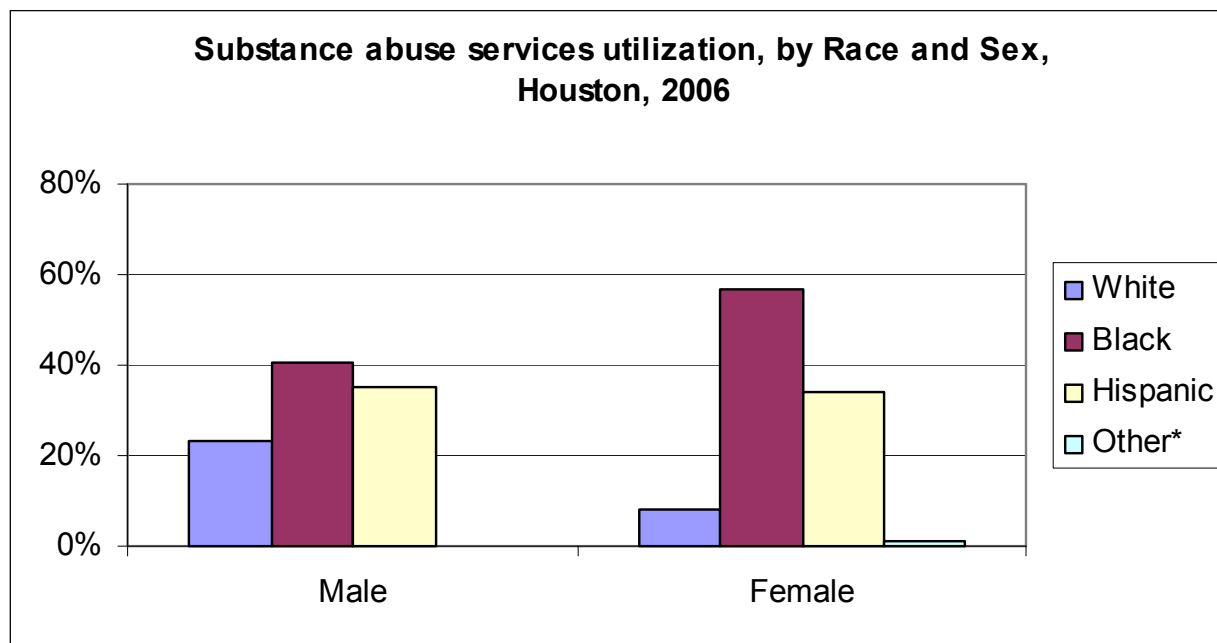
Table 2.1.8
SUBSTANCE ABUSE TREATMENT UTILIZATION BY GENDER, RACE AND AGE, 2006

	SUBSTANCE ABUSE					
	Male		Female		Total	
	#	%	#	%	#	%
Total	446	68%	210	32%	656	100%
Race						
White/Anglo	103	23%	17	8%	120	18%
Black/African-American	182	41%	119	57%	301	46%
Hispanic/Latino	157	35%	71	34%	228	35%
Asian	3	1%	1	0%	4	1%
Other*	1	0%	2	1%	3	0%
Age						
0-12	0	0%	0	0%	0	0%
13-24	31	7%	22	10%	53	8%
25-44	303	68%	145	69%	448	68%
45-64	108	24%	41	20%	149	23%
65+	4	1%	2	1%	6	1%

Data from CPCDMS.

* "Other" includes Native Americans, Pacific Islanders and multi-race.

Figure 2.1.6
SUBSTANCE ABUSE TREATMENT UTILIZATION



***Other* includes Native Americans, Pacific Islanders, and multi-race.

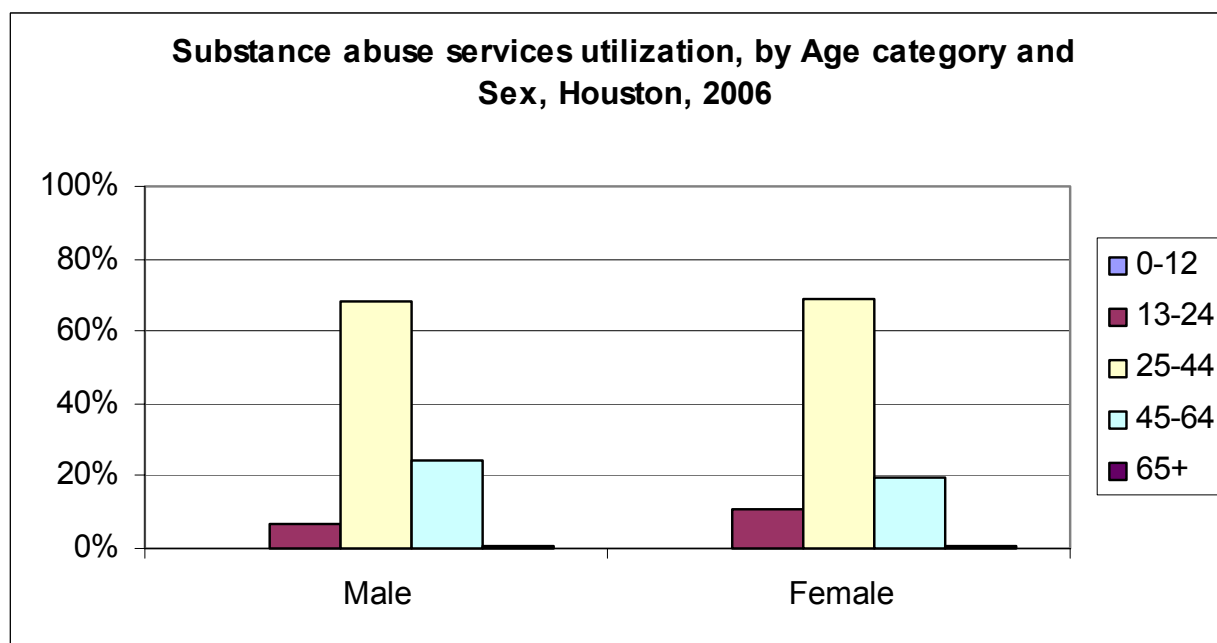


Table 2.1.9
SUBSTANCE ABUSE TREATMENT UTILIZATION BY GENDER, RACE AND AGE, 2004 - 2006

	SUBSTANCE ABUSE					
	2004		2005		2006	
	(N=216)		(N=273)		(N=656)	
	#	%	#	%	#	%
Race						
White/Anglo	50	23%	57	21%	120	18%
Black/African-American	90	42%	142	52%	301	46%
Hispanic/Latino	73	34%	73	27%	228	35%
Asian	1	0%	1	0%	4	1%
Other*	2	1%	0	0%	3	0%
Sex						
Male	166	77%	211	77%	446	68%
Female	50	23%	62	23%	210	32%
Age						
0-12	0	0%	0	0%	0	0%
13-24	14	6%	22	8%	53	8%
25-44	159	74%	186	68%	448	68%
45-64	43	20%	61	22%	149	23%
65+	0	0%	4	1%	6	1%

Data from CPCDMS.

* "Other" includes Native Americans, Pacific Islanders and multi-race.

Table 2.1.10
SUBSTANCE ABUSE TREATMENT UTILIZATION Y TRANSMISSION MODE AND SUBPOPULATIONS
2004 - 2006

	SUBSTANCE ABUSE					
	2004		2005		2006	
	(N=216)		(N=273)		(N=656)	
	#	%	#	%	#	%
Transmission Mode**						
Perinatal Transmission	1	0%	1	0%	5	1%
Hemophilia Coagulation	0	0%	0	0%	0	0%
Transfusion	5	2%	8	3%	10	2%
Heterosexual Contact	51	24%	83	30%	269	41%
MSM (not IDU)	80	37%	93	34%	220	34%
IV Drug Use (not MSM)	7	3%	4	1%	16	2%
MSM/IDU	1	0%	0	0%	0	0%
Multiple Exposure Categories	8	4%	14	5%	26	4%
Other risk	57	26%	78	29%	125	19%
Subpopulation**						
Unduplicated clients	216	100%	273	100%	656	100%
Monolingual (Spanish)	53	25%	32	12%	151	23%
Deaf/hard of hearing	2	1%	2	1%	13	2%
Blind/sight impaired	4	2%	11	4%	49	7%
Homeless	15	7%	22	8%	31	5%
Transgender M to F	3	1%	2	1%	15	2%
Transgender F to M	0	0%	0	0%	0	0%
Within Harris County	211	98%	267	98%	644	98%
Outside Harris County	5	2%	6	2%	12	2%
Active substance abuse	25	12%	19	7%	42	6%
Active psychiatric illness	13	6%	12	4%	33	5%

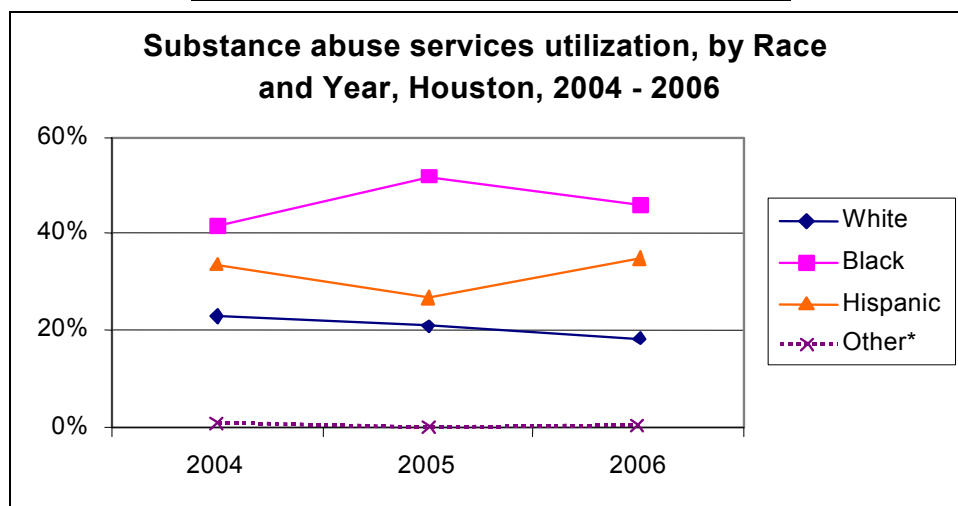
** Not mutually exclusive.

Data from CPCDMS.

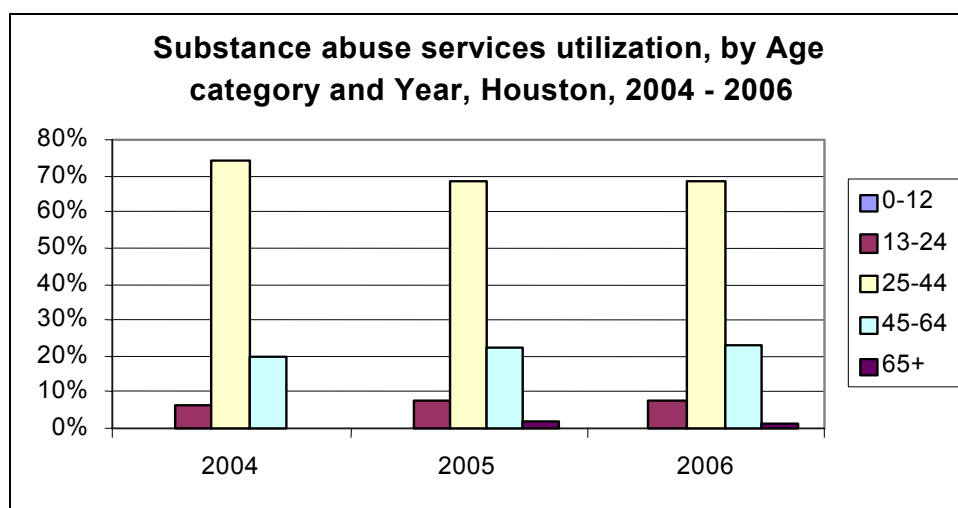
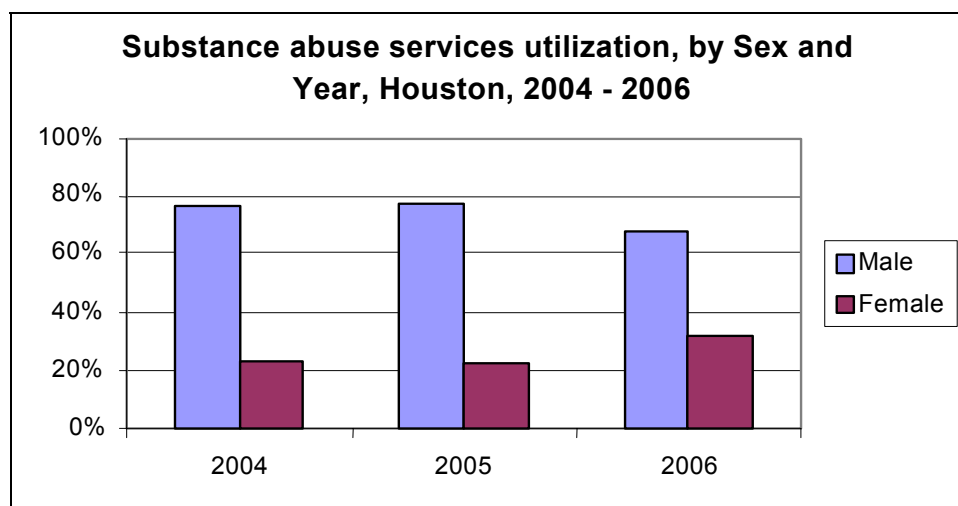
Most information on transmission mode and comorbidities is obtained during initial registration and not updated.

Initial registration could have occurred at any time between 2004 and 2006.

Figure 2.1.7
SUBSTANCE ABUSE TREATMENT UTILIZATION



**"Other" includes Native Americans, Pacific Islanders, and multi-race.



MENTAL HEALTH THERAPY AND COUNSELING



-  For 2006, the proportions across all demographic categories appear to be relatively similar to their representation in service utilization.
- Whites/Anglos comprise 31% of PLWHA in the region and are 35% of those using mental health services.
 - Blacks/African-Americans are 48% of PLWHA and 45% of mental health clients.
 - Hispanics/Latinos are 20% of the regional epidemic and 18% of those accessing mental health services.
 - There may be a slight over-representation of youth in service utilization as they represent 4% among PLWHA but 7% of mental health clients.
-  Use of mental health services had increased 3% between 2004 and 2006.
- Use of services by Whites/Anglos declined from 41% in 2004 to 35% in 2006. Hispanics/Latinos also decreased their service utilization from 24% to 18%. Meanwhile, Blacks/African-Americans increased their service utilization from 34% to 45%.
 - Youth increased their mental health service usage slightly from 4% to 7% while adults aged 25-44 declined in their service access from 64% to 59%.
 - In terms of reported risk behavior, the categories of heterosexual contact increased slightly from 23% to 27%.

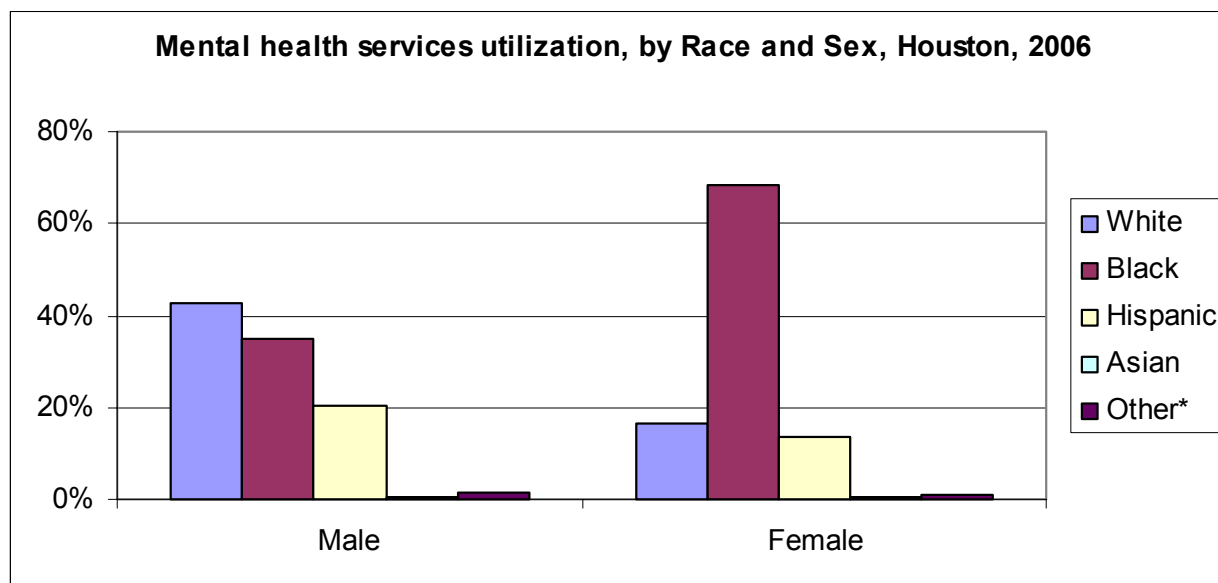
Table 2.1.11
MENTAL HEALTH THERAPY AND COUNSELING UTILIZATION BY GENDER, RACE AND AGE,
2006

	MENTAL HEALTH					
	Male		Female		Total	
	#	%	#	%	#	%
Total	471	72%	187	28%	658	100%
Race						
White/Anglo	202	43%	31	17%	233	35%
Black/African-American	165	35%	128	68%	293	45%
Hispanic/Latino	95	20%	25	13%	120	18%
Asian	3	1%	1	1%	4	1%
Other*	6	1%	2	1%	8	1%
Age						
0-12	1	0%	5	3%	6	1%
13-24	25	5%	19	10%	44	7%
25-44	278	59%	107	57%	385	59%
45-64	167	35%	55	29%	222	34%
65+	0	0%	1	1%	1	0%

Data from CPCDMS.

* "Other" includes Native Americans, Pacific Islanders and multi-race.

Figure 2.1.8
MENTAL HEALTH THERAPY AND COUNSELING UTILIZATION



**"Other" includes Native Americans, Pacific Islanders, and multi-race.

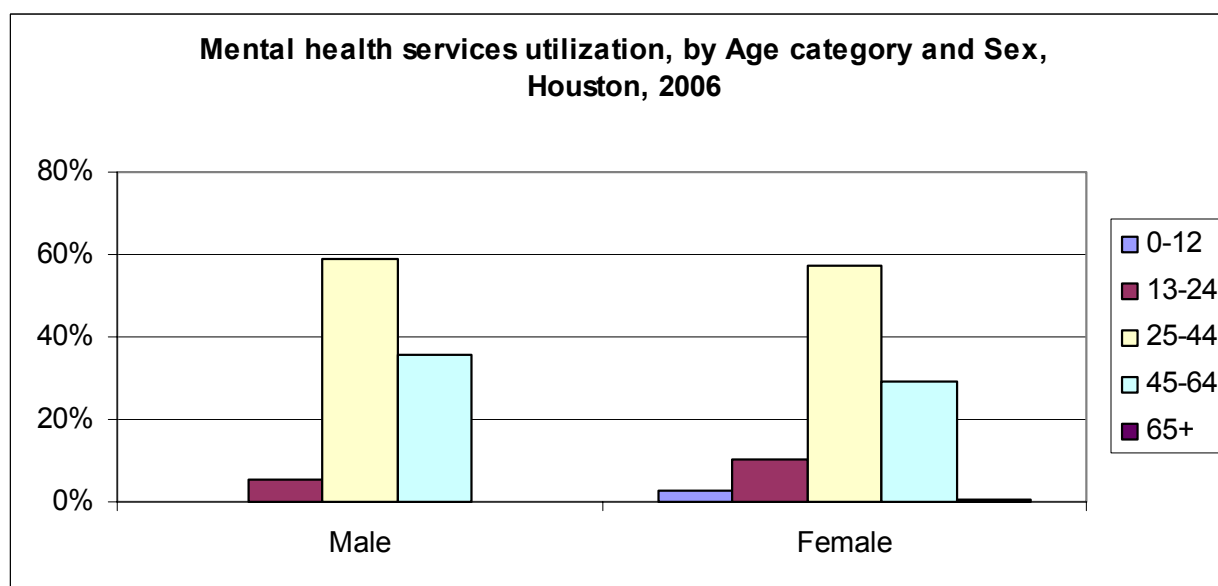


Table 2.1.12
MENTAL HEALTH THERAPY AND COUNSELING UTILIZATION BY GENDER, RACE AND AGE,
2004 - 2006

	MENTAL HEALTH CARE					
	2004		2005		2006	
	(n=641)		(n=635)		(n=658)	
	#	%	#	%	#	%
Race						
White/Anglo	266	41%	249	39%	233	35%
Black/African-American	218	34%	261	41%	293	45%
Hispanic/Latino	152	24%	120	19%	120	18%
Asian	2	0%	2	0%	4	1%
Other*	3	0%	3	0%	8	1%
Sex						
Male	456	71%	424	67%	471	72%
Female	185	29%	211	33%	187	28%
Age						
0-12	1	0%	6	1%	6	1%
13-24	24	4%	19	3%	44	7%
25-44	411	64%	396	62%	385	59%
45-64	202	32%	212	33%	222	34%
65+	3	0%	2	0%	1	0%

Data from CPCDMS.

* "Other" includes Native Americans, Pacific Islanders and multi-race.

Table 2.1.13
MENTAL HEALTH THERAPY AND COUNSELING UTILIZATION BY TRANSMISSION MODE AND
SUBPOPULATIONS, 2004 - 2006

	MENTAL HEALTH CARE					
	2004		2005		2006	
	(n=641)		(n=635)		(n=658)	
	#	%	#	%	#	%
Transmission Mode**						
Perinatal Transmission	2	0%	7	1%	16	2%
Hemophilia Coagulation	1	0%	1	0%	1	0%
Transfusion	11	2%	13	2%	12	2%
Heterosexual Contact	146	23%	161	25%	179	27%
MSM (not IDU)	252	39%	226	36%	277	42%
IV Drug Use (not MSM)	13	2%	19	3%	13	2%
MSM/IDU	6	1%	5	1%	2	0%
Multiple Exposure Categories	25	4%	26	4%	25	4%
Other risk	176	27%	171	27%	137	21%
Subpopulation**						
Unduplicated clients	641	100%	635	100%	658	100%
Monolingual (Spanish)	89	14%	59	9%	41	6%
Deaf/hard of hearing	8	1%	3	0%	7	1%
Blind/sight impaired	26	4%	19	3%	24	4%
Homeless	15	2%	22	3%	15	2%
Transgender M to F	3	0%	3	0%	6	1%
Transgender F to M	2	0%	1	0%	1	0%
Within Harris County	590	92%	613	97%	620	94%
Outside Harris County	51	8%	22	3%	38	6%
Active substance abuse	37	6%	45	7%	57	9%
Active psychiatric illness	45	7%	36	6%	46	7%

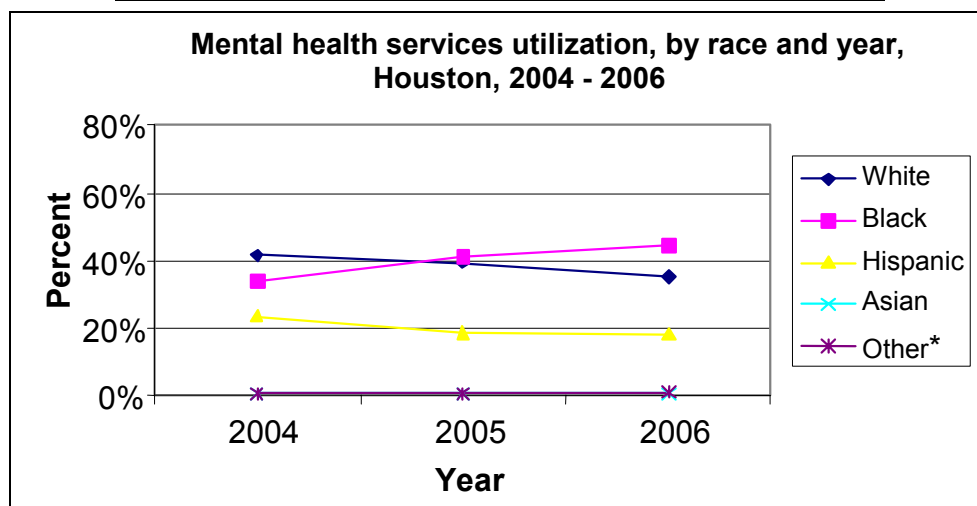
** Not mutually exclusive.

Data from CPCDMS.

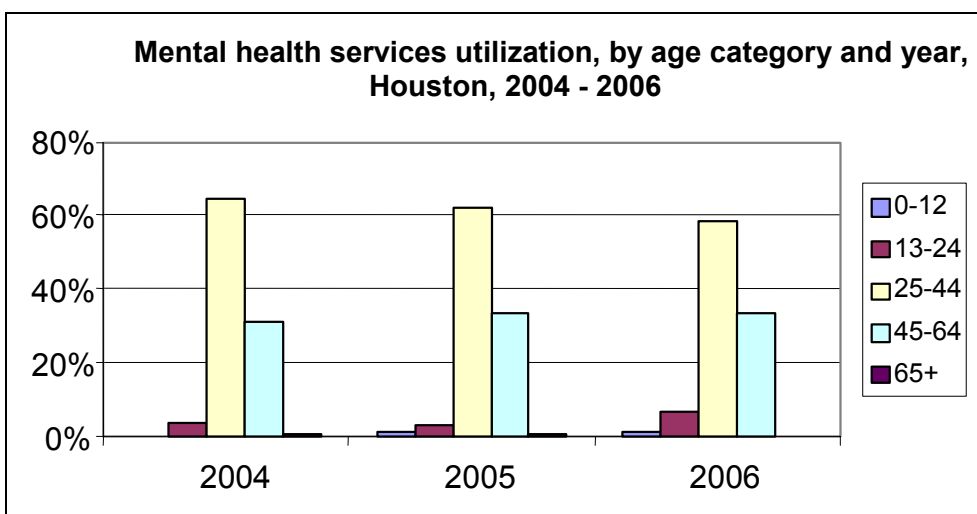
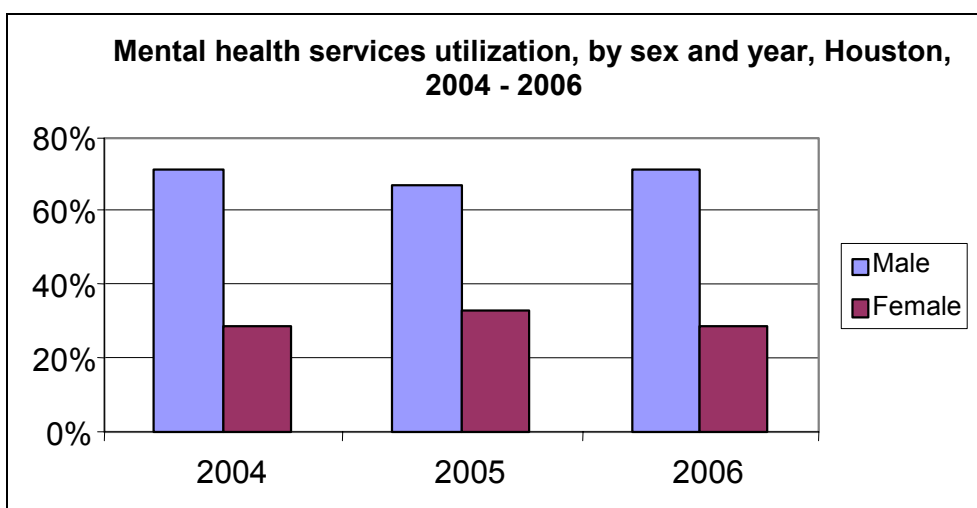
Most information on transmission mode and comorbidities is obtained during initial registration and not updated.

Initial registration could have occurred at any time between 2004 and 2006.

Figure 2.1.9
MENTAL HEALTH THERAPY AND COUNSELING UTILIZATION



**"Other" includes Native Americans, Pacific Islanders, and multi-race.



AIDS DRUG ASSISTANCE PROGRAM



-  The AIDS Drug Assistance Program (ADAP) was used by more Hispanic/Latino PLWHA in 2006 and under utilized by the Whites/Anglos.
- Hispanics/Latinos make up 20% of PLWHA in the region but are 29% of ADAP clients.
 - Whites/Anglos are 31% of PLWHA but only 24% of ADAP clients.
 - Blacks/African-Americans are 48% of PLWHA and are 45% of ADAP clients.
-  When examined by gender and age categories, the proportions of ADAP usage appears to be similar among the different groups when compared to their distribution in the regional epidemic.

Table 2.1.14
ADAP UTILIZATION, HOUSTON HSDA, 2006

	Male		Female		Total*	
	#	%	#	%	#	%
Total	3,581	74%	1,220	25%	4,807	100%
Race						
White/Anglo	1,000	28%	146	12%	1,146	24%
Black/African-American	1,415	40%	745	61%	2,162	45%
Hispanic/Latino	1,079	30%	307	25%	1,389	29%
Asian	38	1%	7	1%	45	1%
Other**	49	1%	15	1%	65	1%
Age						
0-12	7	0%	8	1%	15	0%
13-24	91	3%	63	5%	154	3%
25-44	2,133	60%	766	63%	2,905	60%
45-64	1,293	36%	360	30%	1,653	34%
65+	57	2%	23	2%	80	2%

Source: Texas Department of State Health Services, Texas HIV Medication Program.

*Total includes Transgender individuals, not listed separately above.

** "Other" includes Native Americans, Pacific Islanders and multi-race.

QUESTION 2.2:

WHAT ARE THE NUMBER AND CHARACTERISTICS OF PERSONS WHO KNOW THEY ARE HIV-POSITIVE, BUT WHO HARE NOT RECEIVING PRIMARY MEDICAL CARE?

When Congress reauthorized the Ryan White Program in 2000, they placed an increased emphasis on identifying people who are HIV positive and not receiving medical care. Congress' ultimate goal is to link these people into the HIV medical care system. To this end, the Health Resources Services Administration (HRSA) wants EMAs to quantify people who are not receiving HIV medical care in their areas, and develop strategies to reach them and bring them into the care system. People are out-of-care if they have not received HIV medical care in the last 12 months. HRSA has made this very specific by defining medical care as having had blood tests to monitor their HIV condition, either CD4 count or viral load test, and/or taking HIV medication, known as antiretroviral medication. HRSA has coined the term "unmet need" to refer to these people who are not receiving HIV medical care because their needs are not being met in the medical care system.

In addition to requesting a simple "count" of the unmet need, HRSA would like a profile of the population who is out-of-care. This profile will inform outreach and service activities being designed to link populations with the care system.

In order to quantify the unmet need, data about the number of people receiving HIV medical care must be compared to the prevalence, or number of people living with HIV disease. While this sounds simple in theory, a wide range of data issues make this a complex task. The following presents the data elements developed by the Houston EMA, and the calculations of unmet need using 2003 data.

Following the initial Unmet Need estimates in 2003, the Texas Department of State Health Services (DSHS) began generating unmet need estimates for each planning area. The DSHS estimates are included after the 2003 data. Both estimate reports are included because the 2003 data, while older, show breakdowns by race, age and gender whereas the DSHS reports do not provide such detail but do contain more recent data.

PREVALENCE

The surveillance data presented in this report is an indication of the number of people with HIV disease, and it is felt that the percentages and trends are an accurate reflection of the epidemic in the region. In terms of total prevalence, however, this surveillance data has limitations since HIV reporting did not begin until 1999. Anyone diagnosed with HIV before 1999, who has not progressed to AIDS and who has not had

another HIV test, is not included in the surveillance figures. Therefore, the surveillance data should not be considered complete for estimating the unmet need.

In the summer of 2003, the Centers for Disease Control and Prevention (CDC) provided the Houston EMA with a prevalence estimate that they developed for the region. This estimate, based on December 31, 2002 data, increases the prevalence figures to account for those who are not included in the surveillance statistics.

For this 2004 unmet need calculation, the CDC prevalence estimate, 20,045, is increased only by the number of new HIV cases diagnosed in 2003, or 604 cases. This results in a total prevalence of 20,649 people living with either HIV or AIDS in the Houston EMA.

Since the surveillance data presented in this profile is considered an accurate reflection of the epidemic in the region, demographics of the unmet need population are calculated based upon the percentages within the surveillance data.

SERVICE UTILIZATION

CPCDMS provides excellent unduplicated patient counts and profiles of patients receiving Part A and B services. This data was accurately augmented with data from Parts C and D. The Harris County Jail and the Veterans Administration Hospital provided their patient data. These data were integrated with CPCDMS and are presented in Table 2.1.1. Slight data discrepancies are footnoted on that table.

In order to estimate the number of people receiving HIV medical care from a private provider, the Ryan White Program conducted a survey of major insurers and private physicians who treat large number of people living with HIV disease. Most major insurers responded, either in July 2003 or April 2004. The most recent responses are used. These insurers provided data on total number of patients with HIV covered by their plans and the gender of these patients. Other demographic profile information was not available.

Physician responses were limited, but four practitioners provided information on 1,072 patients. These physicians provided both gender and racial distribution. That distribution is applied to the total number of HIV patients covered by the private insurers. It should be noted that one physician reported 5% of patients were of Asian race. Basing percentages on this figure may overstate the Asian number receiving care and should be further examined.

Since neither physicians nor insurers provided age information, the CPCDMS age profile is applied. This profile includes age-adjusted Veterans Administration (VA) data. The VA data was allocated to age groups that correspond to the age groups used in this profile.

Medicaid data, prepared by the Texas Health and Human Services Commission, showed the number of people treated for HIV or AIDS during calendar year 2003. The Medicaid profile includes both Part A and Part B Medicaid claims and encounter data.

Medicare data are not included.

RESULTS

Without including Medicare data, an estimated 42.13% of people living with HIV and AIDS in the Houston EMA are outside the medical care system. This includes nearly 47.75% of men and 25.94% of women. (Table 2.2.1)

Considering the race and ethnicity of those with unmet need, Whites/Anglos have the largest percentage outside the medical care system, nearly 52%. Almost 40% of Blacks/African-Americans are outside the care system, and Hispanics/Latinos have the lowest unmet need, 34.74%. (Table 2.2.2)

Examining unmet need by age using current data sources, the largest unmet need is among pediatrics, age 0 – 12, with 56.45% out-of-care. Youth include the largest in-care percentage, with 33.50% out-of-care. Both the 25 to 44 year group and 45 to 64 year group have approximately 42% out-of-care. (Table 2.2.3)

Table 2.2.1
HOUSTON EMA 2003 UNMET NEED ESTIMATE GENDER PROFILE

	HIV/AIDS Prevalence	In-Care CPCDMS*	In-Care Private**	In-Care Medicaid***	Total In-Care	Total Unmet Need	Unmet Need Percentage
Total	20,649	7,331	2,850	1,769	11,950	8,699	42.13%
Gender							
Men	15,322	5,361	2,017	627	8,005	7,317	47.75%
Women	5,327	1,970	833	1,142	3,945	1,382	25.94%

* Includes Parts A, B, C, D, Ft Bend Family Health Center, Harris County Jail and Veterans Administration.

VA data includes 19 people who died during 2003.

Jail data inconsistent on race with discrepancy of one client.

Part D data from Texas Children's Hospital may reflect duplicate data of Hispanic ethnicity.

** Totals provided by gender. Insurers include: BC/BS of Texas, CIGNA, United Healthcare, Humana.

*** Includes Part A and Part B Medicaid data.

Table 2.2.2
HOUSTON EMA 2003 UNMET NEED ESTIMATE RACIAL/ETHNIC PROFILE

		Total	White, non Hispanic	Black, non- Hispanic	Hispanic	Other
HIV/AIDS	Prevalence	20,649	6,835	9,912	3,696	206
In-Care	CPCDMS*	7,331	1,896	3,903	1,450	82
In-Care	Private**	2,850				
Private race	Profile Male	2,017	914	472	587	46
Private race	Profile Female	833	286	338	167	42
In-Care***	Medicaid Male	627	105	368	110	44
In Care***	Medicaid Female	1,142	103	907	98	34
Total	In-Care	11,950	3,304	5,988	2,412	164
Total	Unmet Need	8,699	3,531	3,924	1,284	42
Unmet Need	Percentage	42.13%	51.66%	39.59%	34.74%	20.39%

* Includes Parts A, B, C, D, Ft Bend Family Health Center, Harris County Jail and Veterans Administration.

VA data includes 19 people who died during 2003.

Jail data inconsistent on race with discrepancy of one client.

Part D data from Texas Children's Hospital may reflect duplicate data of Hispanic ethnicity.

** Totals provided by gender. Insurers include: BC/BS of Texas, CIGNA, United Healthcare, Humana.

*** Includes Part A and Part B Medicaid data.

Private utilization by race is based upon a survey of private physicians (n=4).

Table 2.2.3
HOUSTON EMA 2003 UNMET NEED ESTIMATE AGE PROFILE

		Total	0 - 12	13 - 24	25 - 44	45 - 64	65+
HIV/AIDS	Prevalence	20,649	248	991	12,369	6,690	372
In-Care	CPCDMS*	7,331	54	416	4,355	2,359	127
In-Care	Private**	2,850					
Private Age	Profile Male		20	61	1,190	706	40
Private Age	Profile Female		17	75	516	225	8
In-Care***	Medicaid Male	627	6	38	370	201	12
In Care***	Medicaid Female	1,142	11	69	674	365	23
Total	In-Care	11,950	108	659	7,105	3,856	210
Total	Unmet Need	8,699	140	332	5,264	2,834	162
Unmet Need	Percentage	42.13%	56.45%	33.50%	42.56%	43.36%	43.55%

* Includes Parts A, B, C, D, Ft Bend Family Health Center, Harris County Jail, Veterans Administration.

VA data includes 19 people who died during 2003.

Jail data inconsistent on race with discrepancy of one client.

Part D data from Texas Children's Hospital may reflect duplicate data of Hispanic ethnicity.

** Totals provided by gender. Insurers include: BC/BS of Texas, CIGNA, United Healthcare, Humana.

*** Includes Part A and Part B Medicaid data.

Utilization by age is based up on percentages from CPCDMS.

Veterans Administration patients redistributed to under 65 year age groups.

This section profiles the PLWHA who appear to have no HIV-related medical care. The cases outlined here were reported in or before 2004, alive at any point in 2004, had a diagnosis residence county in the EMA and were not matched to cases in any of the care provider/care payer sources.²

Table 2.2.4
NUMBER AND PROPORTION OF LIVING HIV/AIDS CASES WITH UNMET NEED:
HOUSTON EMA, 2004

	Number of Cases with Unmet Need	% of Cases with Unmet Need
Overall	7,328	42.6
Gender		
Male	5,522	43.6
Female	1,806	39.7
Race/Ethnicity		
White/Anglo	2,361	43.0
Black/African-American	3,635	43.7
Hispanic, all races	1,248	38.7
Asian Pacific Islander	45	37.8
American Indian/Alaskan Native	9	50.0
Other/Not Specified	30	76.9
Mode of Transmission		
MSM	2,938	40.9
IDU	902	44.6
MSM / IDU	389	39.5
Heterosexual Contact	1,518	37.7
Not Classified	1,466	54.4
Other ³	115	38.3
Age in 2004		
0-1	0	0.0
2-12	66	36.7
13-24	364	45.6
25-34	1,546	43.6
35-44	2,652	41.0
45-54	1,931	42.3
55-64	649	45.5
65+	120	50.6

In 2004, there were 7,328 PLWHA who did not appear to be receiving care, which is about 43% of living HIV/AIDS cases in the Houston EMA. This is slightly lower than the proportion with unmet need seen in 2003, which was 44%. While this may appear to be an unremarkable difference, given the rising prevalence of the Houston EMA, it

² The figures given for prevalence in the epidemiologic profile should not be used in tandem with the figures in this section, as the mechanics of estimating unmet need preclude the adjustments and redistributions used to enhance the accuracy of the epidemiologic estimates.

³ Pediatric, occupational exposures, hemophilia, transfusion, and other blood exposures.

suggests efforts to get people into care are slightly ahead of the natural growth of the epidemic.

When looking at the profile of PLWHA out of care, consider both the size of the group with unmet need and the proportion of the group with unmet need; if one group has a proportion out of care that is much higher than other groups, it raises questions about barriers to care unique to this group.

A greater number and proportion of males are out of care compared to females. The table on the next page shows that a quarter of males out of care are White/Anglo MSM (1,501 out of 5,522 men out of care). The large number of White/Anglo MSM out of care drives the large proportion of Whites/Anglos out of care. However, Black/African-American MSM also show a large proportion out of care.

When looking at the major modes of transmission, IDU have the greatest proportion out of care (45%), with male IDU having greater proportions out of care than female IDU. Among male IDU, Whites/Anglos have the greatest proportion out of care but Blacks/African-Americans have the highest numbers. MSM have the next highest proportion out of care followed by MSM/IDU (41% and 40%, respectively). In both of these populations, Whites/Anglos and Blacks/African-Americans have the greatest numbers and proportions out of care. About 38% of heterosexually transmitted cases have unmet medical needs, with the majority of these cases being Black/African-American: two out of three heterosexually transmitted cases with unmet needs are Black/African-American. In heterosexually transmitted cases, as in the larger population of PLWHA with unmet needs, males have a greater proportion of their population with unmet medical needs.

The large number and percentage out of care in the Not Classified group could indicate two things: that these are newer cases which haven't yet had a full surveillance investigation, or these are older cases that are lost to follow-up with no risk established. We are examining the data to shed more light on which explanation is better supported.

Table 2.2.5
NUMBER AND PROPORTION OF LIVING HIV/AIDS CASES WITH UNMET NEED, BY SEX, 2004





	Males with Unmet Need		Females with Unmet Need		Total
	#	%	#	%	
MSM					
White/Anglo	1,501	42.4	-	-	1,501
Black/African-American	846	41.8	-	-	846
Hispanic, all races	564	36.3	-	-	564
Asian Pacific Islander	16	32.0	-	-	16
Total	2,938	40.9	-	-	2,938
IDU					
White/Anglo	120	51.7	81	40.3	201
Black/African-American	346	46.6	256	40.6	602
Hispanic, all races	73	47.7	21	38.2	94
Total	543	47.9	359	40.4	902
MSM/IDU					
White/Anglo	178	40.2	-	-	178
Black/African-American	167	41.4	-	-	167
Hispanic, all races	43	31.4	-	-	43
Total	389	39.5	-	-	389
Heterosexual Contact					
White/Anglo	71	40.3	115	38.3	186
Black/African-American	394	42.8	679	37.1	1,073
Hispanic, all races	129	36.4	121	29.3	250
Asian Pacific Islander	4	26.7	4	33.3	8
Total	598	40.8	920	35.9	1,518
Not Classified					
White/Anglo	202	48.6	76	53.5	278
Black/African-American	542	60.5	330	47.9	872
Hispanic, all races	226	59.8	56	47.5	282
Asian Pacific Islander	13	46.4	5	62.5	18
Total	990	57.3	476	49.2	1,466

While the 35-44 age group has the largest number of persons out of care, the proportion of its population out of care (41%) is one of the lowest. Only the 2-12 has a smaller proportion of its population out of care.

As mentioned above, more detailed analysis can help to identify subpopulations with large proportions out of care. Among males, White/Anglo MSM have the greatest number out of care and IDU and males without risk classification have higher proportions out of care. Black/African-American females represent the majority of females with unmet medical needs, while females of all races/ethnicities without risk classification stand out with higher proportions out of care.

UNMET NEED RECOMMENDATIONS

In order to enhance the unmet need calculations, the following actions are recommended:

-  Attempt to obtain Medicare data or some indication of the percentage of Medicare patients in the EMA.
-  Increase the physician response to the patient profile survey.
-  Survey physicians for patient age profiles to compare with the CPCDMS profile used here.
-  Consider surveying additional, large private insurers.

APPENDIX: A

POPULATION PROJECTIONS BY AGE, GENDER AND COUNTY

Population Change

County	Population 2000		Population 2010		% Change 2000-2010
	#	%	#	%	
Chambers					
Under 2 years	672	2.6%	770	2.5%	14.6%
2-12 years	4,504	17.3%	4,273	13.6%	-5.1%
13-24 years	4,473	17.2%	5,775	18.4%	29.1%
25-44 years	7,783	29.9%	8,173	26.0%	5.0%
45-64 years	6,249	24.0%	9,068	28.9%	45.1%
65 and older	2,350	9.0%	3,316	10.6%	41.1%
Total	26,031	100.0%	31,375	100.0%	20.5%
Fort Bend					
Under 2 years	10,475	3.0%	10,798	2.4%	3.1%
2-12 years	69,263	19.5%	63,465	14.1%	-8.4%
13-24 years	60,807	17.2%	88,613	19.7%	45.7%
25-44 years	114,336	32.3%	110,664	24.6%	-3.2%
45-64 years	79,402	22.4%	141,207	31.4%	77.8%
65 and older	20,169	5.7%	35,064	7.8%	73.9%
Total	354,452	100.0%	449,811	100.0%	26.9%
Harris					
Under 2 years	114,059	3.4%	124,181	3.1%	8.9%
2-12 years	611,189	18.0%	655,435	16.6%	7.2%
13-24 years	611,150	18.0%	670,299	17.0%	9.7%
25-44 years	1,136,376	33.4%	1,219,700	30.9%	7.3%
45-64 years	674,909	19.8%	946,732	24.0%	40.3%
65 and older	252,895	7.4%	335,335	8.5%	32.6%
Total	3,400,578	100.0%	3,951,682	100.0%	16.2%
Liberty					
Under 2 years	1,986	2.8%	2,263	2.8%	13.9%
2-12 years	11,826	16.9%	12,101	14.8%	2.3%
13-24 years	11,995	17.1%	14,568	17.8%	21.5%
25-44 years	22,134	31.6%	23,300	28.4%	5.3%
45-64 years	15,021	21.4%	20,729	25.3%	38.0%
65 and older	7,192	10.3%	8,969	10.9%	24.7%
Total	70,154	100.0%	81,930	100.0%	16.8%
Montgomery					
Under 2 years	8,975	3.1%	10,292	2.7%	14.7%
2-12 years	53,217	18.1%	57,250	15.1%	7.6%
13-24 years	48,105	16.4%	67,694	17.8%	40.7%
25-44 years	90,013	30.6%	95,900	25.3%	6.5%
45-64 years	67,910	23.1%	108,793	28.7%	60.2%
65 and older	25,548	8.7%	39,434	10.4%	54.4%
Total	293,768	100.0%	379,363	100.0%	29.1%

(Table continues)

COUNTY	POPULATION 2000		POPULATION 2010		PERCENT CHANGE 2000-2010
	#	%	#	%	
Waller					
Under 2 years	963	2.9%	1,172	2.8%	21.7%
2-12 years	5,032	15.4%	6,109	14.9%	21.4%
13-24 years	8,294	25.4%	10,126	24.6%	22.1%
25-44 years	8,614	26.4%	10,512	25.6%	22.0%
45-64 years	6,701	20.5%	9,874	24.0%	47.4%
65 and older	3,059	9.4%	3,344	8.1%	9.3%
Total	32,663	100.0%	41,137	100.0%	25.9%
Austin					
Under 2 years	625	2.6%	674	2.6%	7.8%
2-12 years	3,774	16.0%	3,630	14.2%	-3.8%
13-24 years	3,877	16.4%	4,319	16.9%	11.4%
25-44 years	6,218	26.4%	6,045	23.6%	-2.8%
45-64 years	5,601	23.7%	7,175	28.0%	28.1%
65 and older	3,495	14.8%	3,739	14.6%	7.0%
Total	23,590	100.0%	25,582	100.0%	8.4%
Colorado					
Under 2 years	484	2.4%	606	2.9%	25.2%
2-12 years	3,043	14.9%	2,939	13.9%	-3.4%
13-24 years	3,509	17.2%	3,478	16.5%	-0.9%
25-44 years	4,848	23.8%	4,997	23.7%	3.1%
45-64 years	4,715	23.1%	5,446	25.8%	15.5%
65 and older	3,791	18.6%	3,635	17.2%	-4.1%
Total	20,390	100.0%	21,101	100.0%	3.5%
Walker					
Under 2 years	1,235	2.0%	1,329	2.0%	7.6%
2-12 years	6,619	10.7%	7,408	10.9%	11.9%
13-24 years	17,446	28.2%	16,728	24.7%	-4.1%
25-44 years	19,230	31.1%	22,060	32.6%	14.7%
45-64 years	11,702	18.9%	13,718	20.3%	17.2%
65 and older	5,526	8.9%	6,421	9.5%	16.2%
Total	61,758	100.0%	67,664	100.0%	9.6%
Wharton					
Under 2 years	1,164	2.8%	1,359	3.1%	16.8%
2-12 years	7,004	17.0%	7,000	16.1%	-0.1%
13-24 years	7,508	18.2%	7,703	17.7%	2.6%
25-44 years	10,916	26.5%	11,126	25.5%	1.9%
45-64 years	8,874	21.5%	10,736	24.6%	21.0%
65 and older	5,722	13.9%	5,636	12.9%	-1.5%
Total	41,188	100.0%	43,560	100.0%	5.8%

CHAPTER 3: HISTORY OF RESPONSE TO THE HIV EPIDEMIC IN THE HOUSTON AREA

Community Response

At the beginning of the chronicled history of people infected with HIV disease in the U.S., government response was limited or silent. In 1981, there were three AIDS cases were reported, although it has since been determined that there were actually ten cases. In a time where little information was known about the disease, community response came in the form of grass roots organizations and other community organizations. The two organizations that were the basis of forming other groups were the Montrose Clinic (now known as Legacy Community Health Services) and Montrose Counseling Center. Following these two came groups such as KS AIDS Foundation (later known as AIDS Foundation Houston) and others. Grass roots efforts spawned a number of firsts in the country, such as McAdory House (a residential facility), FIRM (the largest religious response to HIV/AIDS in the country, which provided Care Team support and education), The Assistance Fund (provided money for insurance premiums), the Pet Patrol (helping people with HIV/AIDS keep their pets) and others.

As these grass roots organizations took hold, efforts were made in engaging traditional forms of funding. The response in the early eighties was again tepid or non-existent, partly due to an economic depression caused by the collapse of the oil and gas industry. United Way of the Texas Gulf Coast did provide funding for the care of AIDS patients to Visiting Nurses as early as 1986. But due to the depressed economy, United Way prohibited any new organizations – which most HIV/AIDS organizations were – from applying for funds. Therefore, it was not until 1991 that United Way provided economic support to the Montrose Clinic and Montrose Counseling Center.

On the political scene in 1985, then Mayor of Houston Kathy Whitmire reluctantly agreed to support a referendum prohibiting the City from discriminating against gay and lesbian individuals in their hiring practices. When the referendum was soundly defeated, gay and lesbian leaders began to feel that key political leaders were distancing themselves from the gay community. Since many gay and lesbian leaders were founding board members of key community based HIV/AIDS agencies, this began a long period of distrust and finger pointing among local politicians, gay and lesbian leaders and social service providers. To make matters worse, mainstream and other service providers entering the AIDS arena were not interested in collaborating with agencies founded by members of the gay and lesbian community for fear of losing their credibility with political leaders. Even gay grass roots organizations did not trust other gay grass roots organizations for fear of being dragged into the political quagmire.

Throughout this whole time, the Mayor, responsible for surveillance and prevention, and the County Judge, responsible for medical and social services, appointed at least four different task forces to study the impact of HIV/AIDS. Most of the task forces were fraught with discord and produced few recommendations and little action.

A privately owned hospital corporation called AMI, opened the Institute for Immunology in the mid 1980s which was the first hospital in the country dedicated to treating people with HIV/AIDS. It closed after one year. Important research projects being conducted through the “AIDS Hospital” came to an end because no local hospital would assume responsibility for the projects. As a result, AMI returned several million dollars in AIDS research money to the Federal government.

In the late 1980s, the AIDS Foundation was a primary source of social service support for people living with HIV/AIDS. Brown MacDonald, one of the Executive Directors of the Foundation was quoted as saying that until the late 1980s, “80% of the foundation’s budget came from passing a hat at local gay bars”. In an effort to meet the needs of their clients, the AIDS Foundation hired one case manager to provide case management services to over 600 clients. Despite the help of volunteers, it quickly became clear that they could hardly provide crisis management to that many clients.

In the midst of the closure of the Institute of Immunology in 1986-87, the Robert Wood Johnson Foundation was awarding case management demonstration grants to cities with large populations of HIV/AIDS patients. In Texas, these funds went to Dallas. These demonstration grants proved that case management is an effective means of linking clients with medical and social services given adequate funding and resources. The Health Resources and Services Administration (HRSA) incorporated this service and expanded funding to case management so that AIDS patients throughout the country could receive case management services. (See section on Congressional Response for more information on HRSA.) When Houston became eligible for these funds, distrust among agencies was so high that instead of placing case managers in one organization, Houston designed a “decentralized system” that placed case managers in agencies throughout the geographic area. The first HRSA demonstration grant for case management was awarded to Harris County in 1989.

After closure of the AMI hospital, patients with private insurance were routed to other hospitals owned by AMI. Those without private insurance were referred to the Harris County Hospital District. Overnight, the Hospital District found itself with over 700 AIDS patients on their doorstep. In May 1989, Thomas Street Clinic, a publicly-funded outpatient clinic for people living with HIV/AIDS, was established by the Harris County Hospital District and represented an important step forward in the County’s willingness to provide quality healthcare services to PLWHA. Today, Thomas Street Health Center is cited as one of the best in the country.

In 1988, then County Judge Jon Lindsay announced the formation of the Greater Houston HIV/AIDS Alliance (GHHA) which was a private corporation designed to bring private and public players to the same table to coordinate services for PLWHA. For example, United Way provided staff support and got a seat on the governing board. Funding streams were still meager, but in 1987, the Texas Department of Health through State Services funding (general appropriations), began a limited amount of funding for community-based organizations. In 1989, they began targeting the highest infection areas, such as Houston, Dallas, Austin and San Antonio.

In the meantime, small groups of individuals were raising private funds through special events in an effort to support the cause. The first significant event was in 1986 at “An Evening of Hope,” which raised close to \$100,000 for the Bering Foundation. Chaired by Carolyn Farb, Houston’s “First Lady of Philanthropy”, this was the first special event to receive mainstream media coverage. In September 1987 “Art Against AIDS” was a collaborative effort between the local arts community and United Way. Arts groups, like the ballet, the symphony, local art galleries and others, dedicated the proceeds from a special performance or the sale of artwork to AIDS. This effort was also effective in heightening the awareness of HIV/AIDS. That same year, the Houston Chapter of the Design Industries Foundation for AIDS (DIFFA) was formed. Between 1987 and 1996, the Houston Chapter of DIFFA raised \$2.7 million, making DIFFA/Houston the largest private funder of HIV/AIDS in the Houston area.

On the prevention side, funding to prevent the spread of the infection became available from the Centers for Disease Control (now called the Centers for Disease Control and Prevention) in 1985. The Montrose Clinic was one of the first agencies to receive such funding. Three years later, Over the Hill, an African American grass roots organization serving the newly released from prison population, received funds to provide testing and counseling.

From 1984 to 1988, the City of Houston Department of Health and Human Services received funding for prevention activities as part of the AIDS Prevention and Surveillance Grant, through the Texas Department of Health (TDH) – now the Department of State Health Services (DSHS). Funding from the Department of State Health Services included support primarily for surveillance activities with and for publication of the monthly AIDS Update. A very limited amount of money was spent for education targeted to the general public through information campaigns. Additionally, the City of Houston contributed funding to provide brochures for “AIDS Awareness Week”, the general public, and men who have sex with men.

The Perinatal Prevention Project was funded by CDC to the City of Houston in September 1988. This was a pilot program to identify and offer voluntary counseling and testing to women who were high risk or HIV positive and enrolled in family planning, maternity and sexually transmitted disease clinics.

In 1988, the City of Houston received additional funding from the Department of State Health Services to expand the AIDS education activities to develop a citywide HIV/AIDS speakers bureau in conjunction with the AIDS Foundation Houston and to develop AIDS education modules to address each segment of the Houston population in regards to sex, race and income status. Each module consisted of films/videos, pamphlets, risk factor information and a list of speakers who completed training to conduct AIDS presentations. The City also received \$3,500 to conduct a minority initiative program targeted to beauty shops, barbershops, and morticians.

In 1989, the City of Houston received funding directly from the CDC specifically for HIV prevention activities, one of only six cities in the nation to be directly-funded. Funds supported health education, HIV counseling and testing, public information and minority initiative campaigns. Funds were also allocated through the grant to fund over 15 community-based organizations and agencies. To date, the CDC has continued support through this directly funded cooperative agreement.

On the care side, it wasn't until November 1990 that the first Federal funding became available through the Ryan White CARE Act. These funds dramatically changed the grass roots nature of service delivery in the Houston area.

In early 1990, burgeoning funding, coupled with an increasing number of clients, strained the capabilities of an already fragile system. County Judge Jon Lindsay, who controlled all the money for the GHHA, asked that all funding be moved under the jurisdiction of the County Health Department.

Due to ongoing conflicts between the GHAA Board, the executive director, County and State officials, The Greater Houston HIV/AIDS Alliance was dissolved in 1993 and Federal and State funding streams were redirected. Ryan White Title I (now referred to as Part A) funding remained with Harris County. Funding from the Texas Department of State Health Services and Ryan White Title II (Part B) moved to the newly formed Houston Regional HIV/AIDS Resource Group. Both groups still retain the funding to this day, using similar planning bodies and monitoring systems.

Government Response

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, signed into law in 1990 by President George H. Bush, was created by Congress in response to the enormous impact HIV/AIDS was having on the nation at that time. The monies appropriated by this act were to fund HIV/AIDS care services in those areas most affected by HIV/AIDS. The Ryan White Program has been reauthorized by Congress three times since 1990 – in 1996, 2000, and 2006. It is now called the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and is due to be reauthorized again in 2009. The Health Resources and Services Administration (HRSA) has the lead responsibility for the implementation of the Program.

The Ryan White Program is intended to improve the quality of life for those affected by the epidemic and increase access to care for underserved populations by helping communities and States increase the availability of core, outpatient medical services, and thereby reducing utilization of more costly inpatient care (such as hospitals).

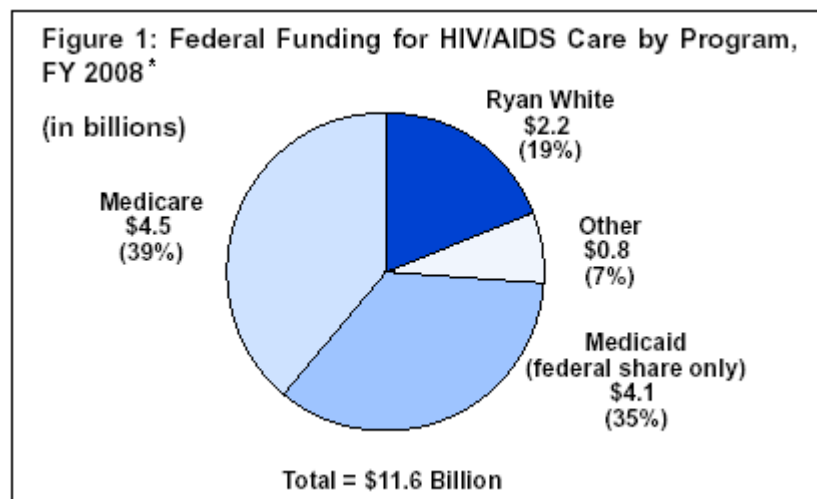
Congressionally defined “core medical services” include: Outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community based health services; mental health services; substance abuse

outpatient care; and medical case management, including treatment adherence services.

As people of color, especially African Americans, became infected with HIV/AIDS, activists at the Federal level began working to ensure that more HIV/AIDS money was specifically targeted to minorities. As a result of the Congressional Black Caucus Initiative (CBC) in 1999, a Ryan White set-aside in the amount of \$177,690 was used to target Houston HIV/AIDS care dollars specifically towards services for African Americans and Hispanics. This amount was in addition to money that the local planning body was already targeting to minority populations. In 2000, the CBC allocation rose to \$937,955 and in 2008 totaled \$1.6 million. On the prevention side, the City of Houston also received CBC money to target minorities in the area of prevention.

As unduplicated HIV case reporting numbers became available in mid-1999, resultant to Texas moving to name-based HIV reporting in addition to AIDS reporting, the realization that HIV was disproportionately affecting the African American community became even clearer. It also became clear that the amount of money set aside in the CBC initiatives (now referred to as the Minority AIDS Initiative) was not enough to effectively address the impact of HIV/AIDS in communities of color. Prevention and care advocates pushed their elected officials to declare a “State of Emergency” in the African American community in the hopes that even more resources and services would be targeted toward communities of color. In November 1999, County Judge Robert Eckels declared an HIV/AIDS State of Emergency in the African American community. Mayor Lee Brown made a similar declaration on World AIDS Days on December 1, 1999.

As shown in the chart below, Ryan White Program funds are to be the “funder of last resort” and are the third largest source of federal funding for HIV/AIDS care in the U.S. after Medicare and Medicaid.



* OMB and DHHS Office of the Budget, April 2008.

Source: “HIV/AIDS Policy Fact Sheet: The Ryan White Program,” Kaiser Family Foundation, June 2008.

The Ryan White Program consists of several “Parts” (formerly referred to as Titles), through which funding is provided across the country (see Figure 2). In recognition of

the varying and changing nature of the HIV/AIDS epidemic, Ryan White grantees have been given discretion to design many aspects of their local programs, including setting client eligibility requirements and service priorities. The recent reauthorization of the Ryan White Program added a requirement that at least 75% of funds be spent on “core medical services” under Parts A through C.

Part A: Funds to “eligible metropolitan areas” (EMAs), those with a cumulative total of more than 2,000 reported AIDS cases over the most recent 5-year period, and “transitional grant areas” (TGAs), those with 1,000 – 1,999 reported AIDS cases over the most recent 5-year period. EMAs are required to establish Planning Councils, local bodies tasked with assessing needs, developing a plan for the delivery of HIV care, and setting priorities for the allocation of funds.

Part B: Funds to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and 5 other territories and associated jurisdictions. States provide services directly, through sub-grantees, and/or through associations of organizations set up to plan for and deliver HIV care.

Part C: Funds granted directly to public and private organizations for early intervention services and capacity development and planning.

Part D: Funds to provide family-centered and community-based services to children, youth, and women living with HIV and their families.

Part F: Includes the following components: AIDS Education and Training Centers (AETCs); Dental Programs; Minority AIDS Initiative (MAI); and Special Projects of National Significance (SPNS).

Figure 2: Ryan White Program by Part, Funding & Grantees ^{3,4, 10, 11}			
Part	FY 2008		Number of Grantees
	\$	%	
Part A	\$627.1	29%	22 EMAs; 34 TGAs
Part B	\$1,195.2	55%	59 States/Territories; 19 ECs
<i>ADAP (non-add)</i>	\$794.4	--	59 States/Territories
Part C	\$198.8	9%	357 EIS, 22 Capacity/Planning
Part D	\$73.7	3%	90 Grantees
Part F AETC	\$34.1	2%	4 National, 11 Regional Centers
Part F Dental	\$12.9	1%	65 Reimbursement; 12 Partnership
Part F SPNS	\$25.0	1%	54 Grantees
TOTAL	\$2,166.8	100%	

³ DHHS HRSA, Justification of Estimates for Appropriations Committee, FY 2009.

⁴ OMB and DHHS Office of the Budget, April 2008.

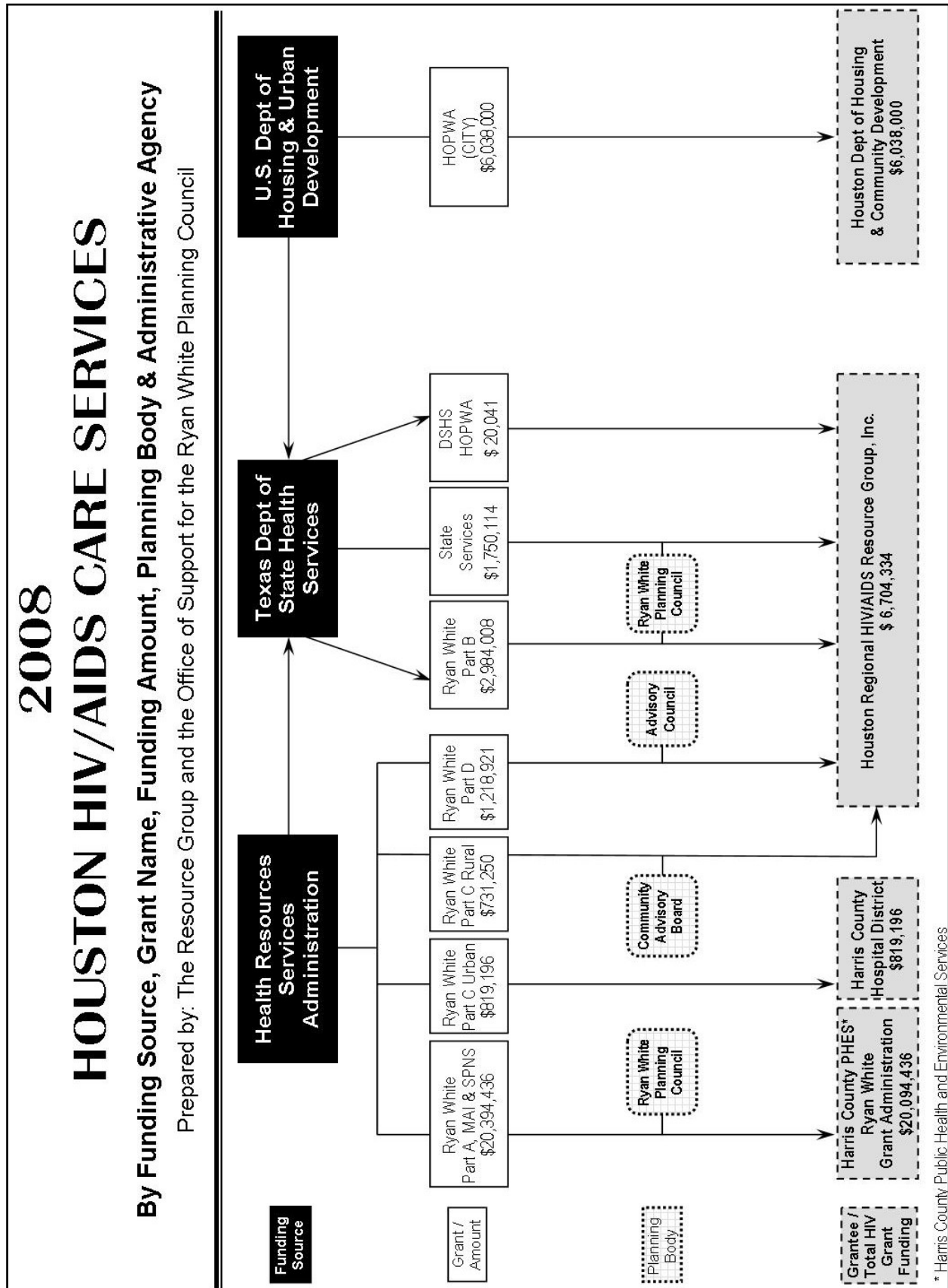
¹⁰ HRSA, HIV/AIDS Bureau, personal communication, May 2008.

¹¹ HRSA: www.hrsa.gov

Source: "HIV/AIDS Policy Fact Sheet: The Ryan White Program," Kaiser Family Foundation, June 2008.

As indicated in Figure 3, Ryan White Program funds are administered locally by the Harris County Health Department, Ryan White Grants Administration (Part A and SPNS), the Houston Regional HIV/AIDS Resource Group (Parts B, C Rural and State Services) and Harris County Hospital District (Part C Urban). Additional government funds used to provide care to people infected with HIV/AIDS include Housing Opportunities for People with AIDS (HOPWA), a U.S. Department of Housing and Urban Development program administered locally by the Houston Department of Housing and Community Development.

Figure 3: Houston Area HIV/AIDS Care Services Funding



Results of Stable Funding on the Community Response

Since becoming directly funded by the CDC, the City of Houston Department of Health and Human Services (HDHHS) has received over \$100 million for prevention services in Houston and Harris County. The Houston Department of Health and Human Services has an annual budget of approximately \$100 million, and 49% of that budget consists of grant funding from a variety of sources, including local, state, and federal funders. The Bureau of HIV/STD and Viral Hepatitis Prevention (Bureau), within the Houston Department of Health and Human Services, was founded in 1989 when it was funded for HIV prevention services received directly from the Centers for Disease Control and Prevention (CDC) for the first time. The Bureau has an operating budget of approximately \$9 million consisting of federal, state, and local funding sources, and is one of only six local jurisdictions directly-funded by the Centers for Disease Control and Prevention (CDC) for HIV Prevention Services.

One purpose of the Bureau is to develop an effective response to the HIV/AIDS epidemic in Houston/Harris County by improving our response to HIV infection and associated risk factors, preventing the spread of HIV, maximizing health and social outcomes and coordinating effective and efficiently targeted comprehensive services for those at risk for, living with or affected by HIV. Approximately 13 direct service community-based organizations (CBOs) are funded to provide HIV/STD Counseling, Testing, and Referral Services (CTR), Health Education/Risk Reduction (HE/RR), Social Marketing, and Comprehensive Risk Counseling Services (CRCS). With a staff of 76 individuals, the Bureau serves as an administrative agent to these CBOs, conducting monitoring and evaluation activities and providing capacity building and technical assistance as needed as well as providing Partner Services directly to those individuals newly diagnosed with HIV or syphilis within Houston or Harris County.

Between 1991 and 2008, the Houston area has received over \$262 million in Ryan White Part A funding alone. Additional funds have been provided through Ryan White Parts B, C and D and the county provides over \$14 annually for medical care through the Harris County Hospital District and the County Jail.

The Hospital District continues to receive the largest portion of Ryan White funds, since medical care is a top priority and since the Hospital District traditionally serves the largest number of clients. As the Ryan White Program became more responsive to the needs of underserved minorities, primary care sites expanded into alternative community locations, resulting in the need for increased ancillary services and medications.

As the care network began to stabilize and players in the AIDS arena began to rebuild trust in the mid 1990's, the epidemic began to change. With the advent of new and powerful treatments, the lives of PLWHA changed as well. People with HIV/AIDS are living longer and functioning better than ever before. The use of highly active anti-retroviral treatments (HAART) prescribed at the appropriate time has slowed or even halted the progression of the disease in many people, enhancing the quality and duration of life in most cases. With these new medications changing the lives of clients,

it also prompted a change in measuring services. The emphasis is now on medical outcomes, and services have changed in respect to how they can measure that important aspect of clients' lives.

In the second decade of the epidemic, significant, stable funding from Federal, State and local government, monitoring requirements that go along with government funding, and an increase in private funds being granted directly to service organizations serving people living with HIV and AIDS, enabled the Houston HIV/AIDS community to create a continuum of care that now provides consistent, quality care to over 8,000 men, women and children living with HIV and AIDS in the ten-county area.

In 1998, Ryan White Grants Administration, a division of the Harris County Health Department, began to work with the Ryan White Planning Council, local service providers and others to design and implement a Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a web-based database that allows Ryan White funded agencies and others to share client eligibility information and document and bill for services delivered to clients. Providers enter registration, encounter and medical update information for each client. Comprehensive, non-identifying client data are collected, including client demographic, co-morbidity, biological marker, mortality and service utilization data. Since 2000, the CPCDMS has been an invaluable tool for community planning and evaluating client health outcomes.

A number of agencies have chosen to merge making more services available at central locations. An HIV/AIDS resource directory, commonly known as "The Blue Book" used to list over 300 agencies who self identified as providing services specifically for HIV positive individuals. The 2008 – 2009 directory lists 157 agencies.

In 2007, the Texas Department of State Health Services asked the Ryan White Part A funded Planning Council to provide recommendations for service priorities and allocations for Part B and State Services dollars. Recommendations included allocating 100% of the dollars needed for a particular service to one funding source, as opposed to two Ryan White funding sources, in an effort to streamline the administration and monitoring process for several service categories.

New Ideas in Prevention and Testing

In 2006, the Center for Disease Control (CDC) issued new guidelines on how individuals should be tested for HIV, specifically, that all individuals between the ages of 13 and 64 should be routinely screened for HIV in healthcare settings. The CDC further specified that the screening should be on a voluntary, opt-out basis. The CDC recognized that while targeted testing remains important in prevention programs, routine screening is important in determining new infections, by making the testing a standard diagnostic tool.

The CDC found the following criteria that support routine screening:

- It is a serious health disorder that can be diagnosed before symptoms develop;

- It is detectable by reliable, inexpensive, and noninvasive screening tests;
- infected patients can have years of life to gain if treatment is initiated early, before symptoms develop;
- The costs of screening are reasonable in relation to the anticipated benefits.

In response to these new guidelines, the CDC awarded the City of Houston Department of Health and Human Services (HDHHS) funds to expand HIV testing services and establish routine, opt-out HIV screening in several local hospital and community health centers. The Houston Department of Health and Human Services contracts with the Harris County Hospital District (HCHD), Memorial Hermann Healthcare System (a private hospital) and Legacy Community Health Services to implement this project. Two Level I trauma centers (Ben Taub and Memorial Hermann) as well as one Level III trauma center (LBJ) are implementing routine, opt-out HIV screening in their emergency departments. Legacy is implementing routine, opt-out HIV screening in their two Federally Qualified Health Centers (FQHC). This project anticipates screening more than 70,000 individuals per year and identifying more than 600 individuals newly diagnosed with HIV.

The Future

According to the Henry J. Kaiser Family Foundation:

“The Ryan White HIV/AIDS Program, first enacted as an emergency measure, has grown to become a main part of the fabric of HIV care and services in the United States, playing a critical role in the lives of low-income people with HIV/AIDS who have no other source of care. However, because it is a discretionary federal grant program, its funding depends on annual appropriations by Congress, and funding levels do not necessarily correspond to the number of people who need services or the actual costs of services... In addition, as payer of last resort, the Ryan White care system is sensitive to the current capacity of and changes in the larger health care system around it. Recent signs of a new economic downturn at the national and state levels, for example, may mean increased demands on Ryan White-funded services at a time when less funding is available for the program.”

CHAPTER 4: ASSESSMENT OF CARE AND PREVENTION NEEDS

Introduction

The purpose of the 2008 Houston Area HIV/AIDS Comprehensive Needs Assessment was to gather information on:

- Levels of access to core and supportive services;
- Experience of barriers;
- HIV testing histories;
- Entry to care;
- In-care and out-of-care status;
- Treatment regimens;
- Perceptions of health status;
- Mental health symptoms;
- Substance use and abuse;
- Housing status;
- Financial information, and;
- Basic demographics of a sample of people living with HIV/AIDS (PLWHA) in the 10-county Houston HSDA.

This information is used by community-based planning bodies in order to:

- Prioritize fundable services from a consumer point-of-view, including needed services not currently offered;
- Determine funding allocations for those services based upon money available within the various partner organizations, and to inform other funding sources which pay for similar services;
- Make programmatic recommendations on how to best meet the needs of clients
- Support efforts to plan a comprehensive system of HIV/AIDS care; and
- Provide supporting documentation for annual Health Resources and Services Administration (HRSA) and Department of State Health Services (DSHS) grant applications.

Methodology

The 2008 Houston Area HIV/AIDS Needs Assessment was comprised of the following elements:

- Client survey, including Risk Behavior Items
- Provider survey
- Focus groups
- Resource Inventory
- Gaps Analysis

Client Survey

A total of 764 client surveys were administered from March through August 2007. Surveys were administered by the Ryan White Planning Council Health Planner, Council Coordinator, Ryan White Part B Health Planner, Houston Department of Health & Human Services Health Planner and two graduate students trained in survey administration. Survey administration locations included clinics, agencies, and outreach vans targeting the homeless population. Spanish surveys were administered with the help of a bilingual survey administrator or hired interpreter.

Provider Survey

A detailed provider survey was developed and administered in order to evaluate services delivered to PLWHA throughout the EMA/HSDA and develop a Resource Inventory. The Planning Council's Office of Support mailed the provider surveys to the 156 agencies listed in the *Blue Book*, the Houston Area HIV Resource Directory, and other health and social service providers. Forty-eight surveys were returned as a result of these efforts.

In accordance with HRSA requirements, information collected from provider surveys were analyzed to produce a resource inventory. At a minimum, the inventory should include information about HIV services in the EMA/HSDA and other supportive and ancillary services that, though not HIV-specific, are likely to be utilized by PLWHA.

Risk Behavior Items

Prevention items included on the Needs Assessment survey were recommended by the Houston Department of Health & Human Services staff, according to the definition of risk for HIV transmission developed by the Centers for Disease Control & Prevention (CDC). These questions focused on behaviors that might lead a person living with HIV to transmit their infection or to be re-infected with HIV, which can complicate treatment options and therefore the well being of that person.

Gaps Analysis

The Gaps Analysis portion of the report addresses types of barriers most often reported by survey respondents, barriers most often reported by providers, services with the highest number of barriers, maps generated from survey data and a brief description of overall themes.

Survey Respondents

There were 764 total PLWHA respondents to the 2008 Need Assessment consumer survey. This total represents 4.21% of the 18,109 reported people living with HIV/AIDS in the Houston HSDA during 2006.

The majority of consumer survey respondents were men (66%). Women represented 31% of all respondents, and transgender male-to-females represented 2%. None of the respondents identified as transgender female-to-male. Among women, 6% said they were pregnant at the time of the survey, and 4% said they did not know their pregnancy

status. The average age of respondents was 43 years. Virtually all respondents were above the age of 25; approximately 48% of all respondents were between the ages of 25-44, and another 48% were above the age of 45. Only 4% were youth between the ages of 18 and 24. (See Appendix A of the Needs Assessment for a Special Study on HIV+ Youth).

More than half of all respondents identified as Black/African American (56%). Twenty-three percent identified as white, 18% as Latino, and 3% as Asian, Native American or multi-racial. The race distribution of respondents resembles the 2006 HIV/AIDS prevalence for the Houston HSDA, where 48% of cases were among African Americans, 31% among whites, 19% among Latinos and 1% among Others.

Just over half (55%) of all respondents identified as straight or heterosexual. About a third (32%) identified as gay/lesbian, 8% as bisexual and 1% as undecided. Four percent said they preferred not to disclose their sexual orientation.

More than three quarters (77%) of respondents had a high school degree/GED or less. Fifteen percent had a college degree, 2% had a graduate/professional degree and 5% had some technical training. Only 2 respondents reported receiving no education.

A total of 119 (16%) of all survey respondents reported being released from jail or prison during the previous year. PLWHA eligible for veteran benefits represented 5% of all respondents.

The tables below show the 2005 HIV/AIDS prevalence for the Houston EMA compared to the 2008 Needs Assessment survey sample.

Table 5: HIV/AIDS Prevalence, Houston EMA, 2005

Males		White		Black		Hispanic		Other		Total	
		N	%	N	%	N	%	N	%	N	%
Age	0-12	5	0%	57	1%	14	0%	<3	<1	77	1%
	13-24	45	1%	270	5%	108	4%	<3	<1	425	3%
	25-44	2,347	47%	2,888	54%	1,899	67%	105	70%	7,239	54%
	45+	2,564	52%	2,181	40%	824	29%	42	28%	5,611	42%
Total		4,961	100%	5,396	100%	2,845	100%	150	100%	13,352	100%

Females		White		Black		Hispanic		Other		Total	
		N	%	N	%	N	%	N	%	N	%
Age	0-12	<3	n/a	54	2%	17	3%	<3	n/a	75	2%
	13-24	43	7%	281	8%	61	9%	<3	n/a	387	8%
	25-44	357	54%	2,113	63%	428	63%	34	77%	2,932	62%
	45+	257	39%	926	27%	174	26%	6	14%	1,363	29%
Total		659	100%	3,374	100%	680	100%	44	100%	4,757	100%

Table 6: Client Survey Respondent Demographics, 2008 Needs Assessment

Males		White		Black		Hispanic		Other		Total	
		N	%	N	%	N	%	N	%	N	%
Age	18-24	2	2%	10	4%	4	4%	0	0%	16	3%
	25-44	54	43%	108	41%	60	61%	7	47%	229	45%
	45+	71	56%	148	56%	35	35%	8	53%	262	52%
Total		127	100%	266	100%	99	100%	15	100%	507	100%

Females		White		Black		Hispanic		Other		Total	
		N	%	N	%	N	%	N	%	N	%
Age	18-24	2	5%	14	9%	2	5%	1	33%	19	8%
	25-44	19	45%	77	50%	21	53%	2	67%	119	50%
	45+	21	50%	62	41%	17	43%	0	0%	100	42%
Total		42	100%	153	100%	40	100%	3	100%	238	100%

The following table shows survey administration sites for all 764 client surveys, by type of venue and in-care status. The types of venues will show where surveys were administered and where out-of-care PLWHA were most often identified.

Table 7: Type of Venue by Out-of-Care Status

Type of Venue	In Care	Out of Care	Total
RW HIV agency or program	341 (50%)	8 (10%)	349 (46%)
Hospital district	154 (22%)	6 (8%)	160 (21%)
Transitional Housing/SRO	87 (13%)	12 (16%)	99 (13%)
Publicity/Press	18 (3%)	24 (31%)	42 (6%)
Word of mouth	8 (1%)	21 (27%)	29 (4%)
Drug Treatment Program	23 (3%)	0	23 (3%)
HIV Prevention agency or program	15 (2%)	0 (0%)	15 (2%)
Street Outreach	10 (2%)	3 (4%)	13 (2%)
Non RW HIV agency or program	13 (2%)	0 (0%)	13 (2%)
Non-HIV	10 (2%)	3 (4%)	13 (2%)
VA	6 (1%)	0	6 (<1%)
Telephone	2 (<1%)	0 (0%)	2 (<1%)
TOTAL	687	77	764

Access to Core Services

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table below shows the list of core services:

Primary Medical Care	Psychiatric Services or Medicine
HIV/AIDS Medications	Psychological Counseling
Dentist Visits	Substance Abuse Treatment
Medical Case Management	Rehabilitation Services
Home Health Care	

For all respondents, the top three “easy to get” core services were primary medical care (72%), HIV/AIDS medications (64%) and medical case management (57%). The top three core services that respondents reported “some difficulty getting” were dentist visits (32%), primary medical care (23%) and HIV/AIDS medications (21%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that respondents said they “did not need” in the past year were home health care (74%), rehabilitation services (71%) and substance abuse treatment (65%).

Access to Supportive Services

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table below shows the list of supportive services:

Child Care Services	Housing-Related Services
Child Welfare Services	Legal Services
Day/Respite Care for Adults	Nutritional Counseling
Developmental Assessment	Permanency Planning
Emergency Financial Assistance	Referrals to Services
Employment Assistance	Referrals to Clinical Research
Food Bank	Support Groups
HIV Education for HIV+ Individuals	Translation/Interpretation
Rental Assistance/Shelter Vouchers	Transportation
	Household Items

For all respondents, the supportive services that were selected most often (thus implying high helpfulness/usefulness) by respondents were food bank, emergency financial assistance, transportation, rental assistance and housing-related services.

The top five “easy to get” supportive services (based on number of responses) were food bank (n=247), transportation (n=145), HIV education for HIV+ individuals (n=117), emergency financial assistance (n=104) and nutritional counseling (n=98). The top five supportive services that respondents reported “some difficulty getting” were emergency financial assistance (n=244), rental assistance/shelter vouchers (n=172), housing-related services (n=170), transportation (n=139) and employment assistance (n=130). The presence of certain support services in both the “easy to get” and “some difficulty getting” lists is a reflection of their high utilization rates. Conversely, the five supportive services that respondents did not need in the past year, but still identified as useful/helpful were emergency financial assistance (n=35), legal services (n=31), housing-related services (n=24), employment assistance (n=21) and food bank (n=19).

Survey respondents that had “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

Barriers to Core Services

The table below shows the list of barriers provided to survey respondents:

Barriers			
A	The services are not in my area	L	People at the agency don't speak my language
B	I don't know where to get the services	M	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	N	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	O	Substance abuse
E	I was told I am not eligible to get the services	P	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	Q	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	R	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	S	Homeless/unstable housing
I	It's hard for me to get there	T	CM left/staff turnover
J	There is no one to watch my kids if I go there	U	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	V	Immigration status

Among all respondents, the three core services with the highest number of barriers were dentist visits (n=431), primary medical care (n=332) and HIV/AIDS medications (n=269). Within dentist visits, the most commonly reported barriers were “It’s hard to make or keep appointments” (n=87), “I would have to wait too long to get the services” (n=74), and “I don’t know where to get the services” (n=58). For primary medical care, the most common barriers for all respondents were “It’s hard to make or keep appointments” (n=53), “It’s hard for me to get there” (n=53), and “I would have to wait too long to get the services” (n=41). For HIV/AIDS medications, the most common barriers for all respondents were “The services cost too much” (n=48), “I would have to wait too long to get the services” (n=44) and “I don’t know where to get the services” (n=27).

The barriers experienced most often by all respondents across all core services were “It’s hard to make or keep appointments” (n=275), “I would have to wait too long to get the services” (n=261) and “I don’t know where to get the services” (n=255).

Barriers to Supportive Services

Similar to the core services table, survey respondents that had “some difficulty” getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

Among all respondents, the five supportive services with the highest number of barriers were emergency financial assistance (n=455), housing-related services (n=312), rental assistance/shelter vouchers (n=290), transportation (n=231), and employment assistance (n=201). Within emergency financial assistance, the most commonly reported barriers were “I would have to wait too long to get the services” (n=80), “I don’t know where to get the services” (n=78) and “I was told I am not eligible for this service” (n=66). For both housing-related services and rental assistance/shelter vouchers, the most common barriers for all respondents were “I don’t know where to get the services” (n=67) and “I would have to wait too long to get the services” (n=55). For transportation, the most common barriers for all respondents were “I don’t know where to get the services” (n=49) and “The services are not in my area” (n=31).

The barriers experienced most often by all respondents across all supportive services were “I don’t know where to get the services” (n=599), “I would have to wait too long to get the service” (n=319) and “The services are not in my area” (n=244).

Most Commonly Reported Barriers

Core Services

For the core services, the three barriers reported most often by all 764 survey respondents were difficulties making or keeping appointments, long wait times for services and informational barriers.

Core Services: Top 3 Reported Barriers, Total Respondents

1	It's hard to make or keep appointments (275 reports)
2	I would have to wait too long to get the services (265 reports)
3	I don't know where to get the services (255 reports)

Supportive Services

For the supportive services, the three barriers reported most often by all 764 survey respondents were informational barriers, long wait times and services not being in respondents’ areas.

Supportive Services: Top 3 Reported Barriers, Total Respondents

1	I don't know where to get the services (599 reports)
2	I would have to wait too long to get the services (319 reports)
3	The services are not in my area (244 reports)

Services Associated with the Highest Number of Reported Barriers

Core Services

The three core services with the highest numbers of reports of barriers for all 764 respondents were:

1. Dentist visits (431 reports)
2. Primary medical care (332 reports)
3. HIV/AIDS medications (269 reports)

It is important to note that these three services also have the highest number of access attempts – therefore, the high volume of access attempts may be correlated with the high number of barrier reports.

Dentist Visits

For dentist visits, the barrier reported most often was related to difficulties making or keeping appointments (87 reports). Barriers reported less often for this service were lack of childcare during services (6 reports), jail/prison history (5 reports), fear/denial/stigma (4 reports), homelessness/unstable housing (1 report) and personal health issues (1 report).

Primary Medical Care

For primary medical care, the barrier reported most often was related to difficulties getting to services (53 reports). Barriers reported less often for this service were being told, or not believing, they were eligible for services (8 and 9 reports, respectively), jail/prison history (8 reports), lack of child care during services (4 reports), fear/denial/stigma (3 reports), language barriers (3 reports) and incarceration (1 report).

HIV/AIDS Medications

For HIV/AIDS medications, the barrier reported most often was related to cost of services (48 reports). Barriers reported less often for this service were difficulties with paperwork (7 reports), lack of child care during services (7 reports), language barriers (5 reports), personal health issues (4 reports), jail/prison history (4 reports), homelessness/unstable housing (1 report), fear/denial/stigma (1 report), and incarceration (1 report).

Supportive Services

The three supportive services with the most reports of barriers were Emergency Financial Assistance (455 reports), housing-related services (312) and rental assistance/shelter vouchers (290 reports)

Emergency Financial Assistance

For Emergency Financial Assistance, the barrier reported most often was related to long wait times for services (80 reports). Barriers reported less often for this service were personal health issues (5 reports), difficulties with paperwork (4 reports), lack of child

care during services (4 reports), fear/denial/stigma (3 reports), homelessness/unstable housing (1 report) and language barriers (1 report).

Housing Related Services

For Housing Related Services, the barrier reported most often was related to informational barriers (67 reports). Barriers reported less often for this service were not enough resources (7 reports), being afraid someone finding out about HIV status (7 reports), homelessness/unstable housing (5 reports), lack of child care during services (4 reports), fear/denial/stigma (1 report), difficulties with paperwork (1 report) and language barriers (1 report).

Rental Assistance/Shelter Vouchers

For Rental Assistance/Shelter Vouchers, the barrier reported most often was related to informational barriers (51 reports). Barriers reported less often for this service were jail/prison history (8 reports), being afraid someone will find out about HIV status (7 reports), homelessness/unstable housing (5 reports), personal health issues (4 reports), difficulties with paperwork (3 reports), immigration status (2 reports), lack of child care at services (2 reports), staff turnover (1 report) and substance abuse (1 report).

Risk Behaviors

Of the total 764 sample, 56 respondents reported they had exchanged sex for drugs or money in the past 6 months. This accounts for approximately 11% of the respondents answering this question (most of those who skipped this question had not had sex in the past 6 months). One hundred forty one (29%) respondents reported that they had engaged in anonymous sex with at least one partner. Of the 764 respondents, 60 reported having sex with more than five partners in the past 6 months. This is approximately 8% of those responding to the question.

Of the entire sample, 235 reported having had sex without a barrier in the past 6 months. This is 45.45% of those who had sex in the past 6 months and 30.76% of the total population.

Forty seven (47) respondents reported that they had injected a substance (legal or illegal) in the past 6 months. Of those 47, 12 reported that they had shared injecting equipment in the past 6 months. This is 25.53% of those reporting the injection of a substance, and 1.57% of the overall sample.

One hundred twenty two (122) respondents reported that they do not have a main sex partner, 219 reported that their main sex partner was HIV-positive, 111 reported that their main sex partner was HIV-negative, 51 were unsure of their main sex partner's serostatus, and 18 preferred not to say. Two hundred forty three (243) respondents did not respond to this question, which is nearly the number reporting zero sex partners in the past 6 months (239).

Barriers Reported by Providers

Providers were asked to indicate any barriers experienced in providing services to people living with HIV or AIDS. Overall, the five most frequently reported barrier among providers was “there is a lack of funding” (n=14). In addition, other commonly reported barriers were “there is a lack of transportation to our services” (n=11), shortage of community partnerships/linkages” (n=11), “the community is unaware of the availability of services” (n=7), “insufficient staff” (n=6), “immigration issues” (n=6).

Among providers that reported experiencing “other” barriers, the following issues were specified manually on the survey: “need for shelter”, “unhealthy environment for PLWHA”, “burden of reporting requirements”, and “lack of transgender services”.

CHAPTER 5: CURRENT SYSTEM OF CARE

Continuum of Care

A continuum of care is a model of how a community is using, or would like to use, its resources. In the case of HIV, as defined by the Health Resources and Services Administration (HRSA), a continuum of care is “a coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV infection to meet their health care and psychological service needs throughout all stages of illness.” These services usually include:

- Primary and secondary prevention of HIV infection
- Treatment and prevention outreach to both the general public and to identified at-risk populations
- Medical and social services, particularly primary medical care, HIV related medications, mental health treatment, substance abuse treatment, oral health and case management services.
- Support services that ensure universal access to medical and social services to all PLWHA who need service

An ideal continuum of care is a “wish list” of a set of services offered to PLWHA, identifying all health and social services that may be needed. This wish list then can be compared to the actual system of care, or the resource inventory, so that the HIV community can determine whether the services that are currently available fit the clients’ current and projected needs.

Developed in 1999, the Houston Area Continuum of Care is conceptualized as a sort of “rail system” that identifies and tracks the HIV services deemed necessary to those who are living within the Houston area. This rail system concept allows people living in the area to get in or out of the system depending on their general knowledge of the HIV virus, including how it is transmitted; their serostatus; their health; and their individual desire to stay within the system. The five tracks on Houston’s continuum of care are:

- A: Public Advocacy to the General Public
- B: Outreach to At Risk Populations
- C: Prevention of HIV infection
- D: Early Treatment of HIV infection
- E: AIDS Treatment to PLWA

Each track is intended to reach a different audience:

Track A includes general HIV health and prevention messages and is intended for the general population. The ultimate “destination”, or goal, of this track is to build public support for HIV prevention and care services.

Track B includes mobile clinics, counseling and testing, community outreach and hotlines and is intended for those populations who have been identified as at risk. The ultimate goal of this track is that people are informed of their serostatus, that is, whether they are HIV positive or negative.

Track C includes audience specific prevention messages as well as support groups and individual prevention counseling and is intended to reach those who choose to test for HIV and then discover that they are HIV negative. The goal of this track is that people maintain their negative status.

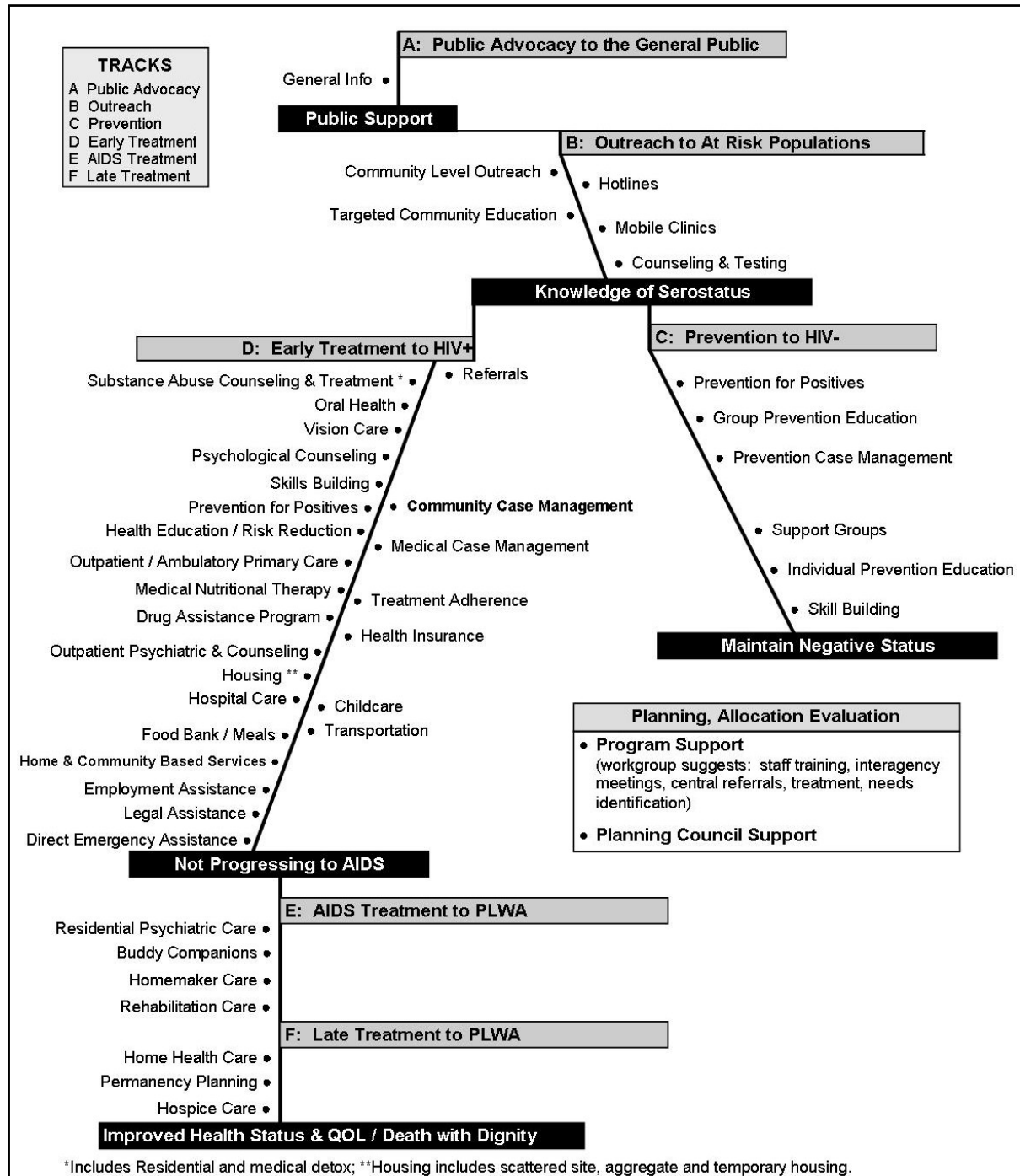
Track D outlines an enormous array of services including everything from substance abuse treatment to case management and is intended to reach those who test positive for HIV. The goal of this track is that people with HIV not progress to AIDS (and should a cure develop over the period this document is valid, the “destination” would include moving back to track C or B or A).

Track E includes home health care, hospice care and rehabilitation and is intended for those individuals who receive an AIDS diagnosis. The goal of this track is for people with AIDS to improve their health status and quality of life (and hopefully they will return to track D), or, if necessary, to create the conditions that will allow for death with dignity.

This track paradigm allows the continuum of care to be imagined as a system that will easily embrace both individuals who are infected and those individuals who are at risk for infection but test negative. Additionally, the multiple tracks allow movement by clients across the system. As medications become more sophisticated and more successful – at both maintaining the health of recently diagnosed individuals and reviving the health of those individuals whose infections have progressed – the system will need to facilitate a client’s ability to get in and out of disparate modes of care with grace, ease, and simplicity.

The image on the following page illustrates the skeletal framework of this “track” system continuum of care.

Figure 4: Houston Area HIV/AIDS Continuum of Care



Note: This is not an eligibility chart - services that are listed as especially needed by people with AIDS does not mean that people with HIV (not AIDS) are not eligible. And conversely, services listed as especially needed by PLWH to help prevent progression to AIDS, does not mean that PLWHAs are not eligible for those services.

The following listing presents information about the HIV service agencies and the services they provide in the Houston area continuum of care. The listing shows the clients each organization services and lists the funding sources (identifying the amounts

of those funds by source) for each of the care organizations. The information was gathered from providers who volunteered their information in previous Needs Assessment processes. For this document, we have linked the agencies to the model of the system of care by describing on which track each agency falls along the continuum of care for HIV prevention and care services (shown in bold next to the service).

Summary of Service Providers

According to the 2008-2009 Blue Book, each track of the continuum of care is being addressed by the service providers. Below is a quick summary:

- Track A: Public Advocacy to the General Public:** 42 agencies currently provide public advocacy to the general public.
- Track B: Outreach to At Risk Populations:** 59 agencies currently provide outreach to at risk populations.
- Track C: Prevention to HIV negative:** 26 agencies currently provide prevention messages and support to individuals who test HIV-.
- Track D: Early Treatment to HIV positive:** 157 agencies currently provide early treatment to individuals who are HIV+.
- Track E: AIDS Treatment to PLWA:** 34 agencies currently provide treatment and care to PLWA.

CHAPTER 6: INVENTORY OF AVAILABLE LOCAL, STATE AND FEDERAL RESOURCES

A resource inventory is simply an accounting of all the resources available in a community. These include service providers, the services they offer, and the money available for these services.

The Ryan White HIV/AIDS Treatment Modernization Act, the largest sole source of HIV/AIDS funding, specifies that funds be expended only for core medical services (listed below) and supportive services that are needed for individuals with HIV/AIDS to achieve medical outcomes.

Core Services

- Outpatient and ambulatory health services
- AIDS drug assistance program
- AIDS pharmaceutical assistance
- Oral health care
- Early intervention services
- Health insurance premium and cost sharing assistance
- Home health care
- Medical nutritional therapy
- Hospice services
- Home and community-based health services
- Mental health services
- Substance abuse outpatient care
- Medical case management, including treatment adherence services

For the most current and up-to-date inventory of HIV prevention and care services, please see HIV resources directory commonly known as the “Blue Book,” published by the Office of Support for the Ryan White Planning Council. The Blue Book can be viewed online at www.rwpc.org or ordered by calling 713-572-3724.

The following table reports on the availability of public funding for HIV-related care services within the Part A EMA and the Part B HSDA from Federal, State and local sources for Fiscal Year 2008. The row headings identify the categories of funding available to the EMA which are to be reported as: (1) an aggregate amount for each service category; and (2) as a proportion of the amount of Ryan White Part A, Part B, Federal, State, and local funding available for a service category.

Ryan White Part A Funds - Reflects FY 2008 formula and supplemental funds allocated to each broad service category. Amount does not reflect any FY 2007 funds that were carried over into FY 2008.

Other Federal Funds - Indicates the total amount of funds available for each broad service category from additional Federal sources such as Ryan White Parts A, B, C, D and Special Projects of National Significance (SPNS); HRSA-funded pediatric/family demonstration projects; HOPWA; locally-allocated Community Development Block Grant funding (CDBG); National Institutes of Health (NIH) AIDS Clinical Trials Group (ACTG) and Community Projects for Clinical Research in AIDS (CPCRA); Substance Abuse and Mental Health Services Administration (SAMHSA) HIV funds; or other identifiable Federal funding.

State Funds - Indicates the aggregate amount of State-appropriated funds allocated to each of the service categories listed in the table.

Table 8: Amount and Percent of Public Funding by Source

Service Category	Part A	% of total	Part B	% of total	State Services	% of total	Total Allocation
Oral Health	1,035,353	71%	420,325	29%	0	0%	1,455,678
Medical Case Management	1,824,717	83%	186,000	8%	199,794	9%	2,210,511
Local Medication Program	2,425,538	74%	862,882	26%	0	0%	3,288,420
Mental Health Services	210,798	58%	0	0%	155,000	42%	365,798
Health Insurance	373,135	30%	618,526	50%	246,929	20%	1,238,590
Substance Abuse Svcs-Outpatient	25,051	100%	0	0%	0	0%	25,051
Medical Nutritional Therapy	147,530	49%	153,795	51%	0	0%	301,325
Early Intervention Services	0	0%	0	0%	166,211	100%	166,211
Home and Community Based Svcs	148,972	38%	242,000	62%	0	0%	390,972
Hospice Services	99,315	23%	0	0%	323,600	77%	422,915
Transportation	466,539	71%	188,000	29%	0	0%	654,539
Food Bank	0	0%	0	0%	550,580	100%	550,580
Non-Medical Case Management	1,079,062	100%	0	0%	0	0%	1,079,062
Legal Assistance	248,304	65%	52,480	14%	80,000	21%	380,784
Linguistic Services	0	0%	0	0%	28,000	100%	28,000
Rehabilitation	99,960	100%	0	0%	0	0%	99,960
Total Service Dollar Allocations	17,398,962	0.79	2,984,008		1,750,114		22,133,084
Quality Management	434,760						
Administration	1,639,077						
Total Non-service Dollar Allocations	2,073,837						
Total FY 2008 Grant Funds	19,472,799		2,984,008		1,750,114		22,133,084

Section II

WHERE DO WE NEED TO GO?

CHAPTER 7: CONTINUUM OF CARE FOR HIGH QUALITY CORE SERVICES

A Shared Vision

From 2009 to 2011, the community will continue to work together to improve and expand a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for infected and affected communities. The realization of this vision is informed by the Houston area Continuum of Care.

Operational Definition of Continuum of Care

The ideal continuum of care represents a comprehensive range of services needed by individuals and families at-risk infected and affected by HIV/AIDS. The Houston Area Continuum of Care model describes an ideal system of care that bridges prevention services with care and treatment, and responds to dynamic community needs in a holistic, coordinated, and timely manner.

The Continuum of Care model is a framework for decision-making, and can be used to inform and guide planning bodies, providers, community leaders and consumers in setting priorities and allocating funds for HIV/AIDS services. The Continuum can also guide the Houston area HIV community toward the following objectives:

1. Reduce redundancy of administrative burden and services in the system while ensuring adequate access to those who live in distant areas.
2. Provide adequate input of services through multiple points of access. Think of this as designing a ticketing facility. For HIV and AIDS services, we need not only direct outlets (testing), but adequate links to emergency rooms, drug treatment, STD clinics, and acute care facilities.
3. Facilitate services while not overburdening the staff and capacity of the system.
4. Ensure continuity of services so that consumers find that they are able to move around the system and will not be stuck at any one station.

Elements of the Continuum of Care

The Houston area Continuum of Care takes into account several factors: 1) the mission and vision statements of the various planning bodies; 2) the goals and objectives of the planning bodies; 3) the services available in the delivery system; 4) the linkages necessary to ensure efficiency and effectiveness; and 5) the coordinating mechanisms that can be utilized to ensure effective linkages are established and maintained.

The Continuum of Care is characterized by a range of elements that inform the development and delivery of services in the Houston area. These elements include:

- Identifying and addressing needs of unserved/underserved populations
- Including prevention and care services
- Providing services in an efficient and effective manner
- Providing services in a seamless manner as a person moves among the different levels of care
- Providing high quality and culturally appropriate services
- Advocating for PLWHA service needs
- Encouraging cooperation in the coordination/delivery of services
- Assuring that the community in need is aware of available prevention and care resources
- Promoting the dissemination of information to all constituencies
- Identifying needs, gaps and barriers
- Planning capacity to meet needs
- Improving the quality of life
- Assuring that the system is free of discrimination based on race, color, creed, gender, religion, sexual orientation, disability, or age
- Assuring that PLWHA, the general public, and providers are included in the process

The Houston area Continuum of Care encourages service linkages as the mechanism for creating a seamless system of services that enables clients to easily navigate within different levels of care. The Continuum model illustrates how services can be linked among the wide range of service providers in Houston.

Table 9: Continuum of Care Tracks

TRACK	START	DESTINATION
A. Public Advocacy to the General Public	No awareness of AIDS	Support for HIV/AIDS services
B. Outreach to at Risk Populations	No awareness of serostatus	Awareness of serostatus
C. Prevention to HIV-	Aware of negative status	Maintenance of negative status
D. Early Treatment to HIV+	Awareness of infection	No progression to AIDS
E. AIDS Treatment to PLWA	AIDS diagnosis	Improved health status and quality of life or death with dignity

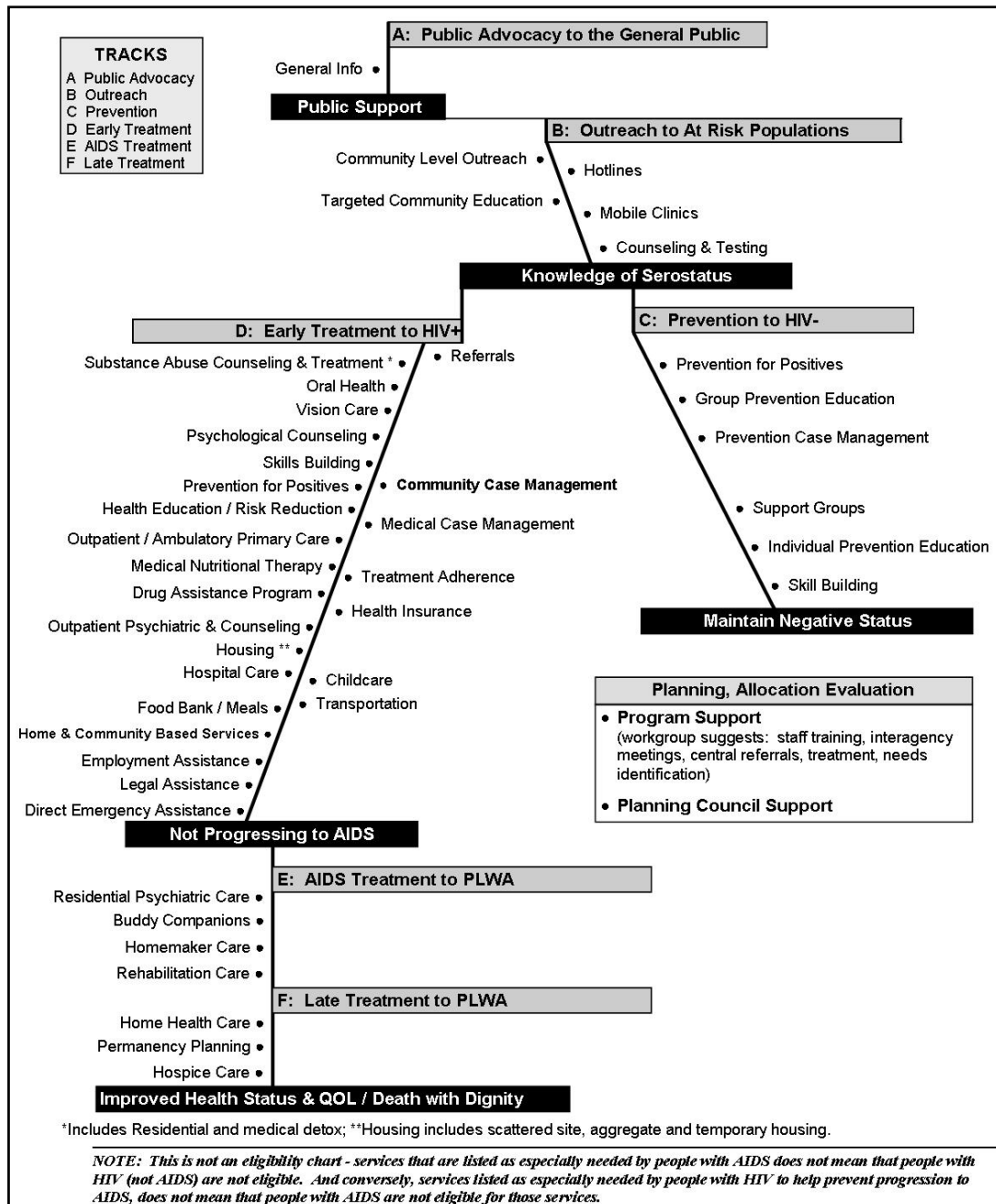
The Houston Area Continuum of Care is shown on the following page (Figure 5).

The Houston area Continuum of Care is characterized by three main features. First, it has several tracks, each of which is defined by its outcomes. Second, consumers can enter the system at any point on the track. Third, each track runs both ways – consumers can travel up or down each track.

Five attributes can be applied to the Continuum. Referred to as the “5 A’s”, the delivery system is designed to be:

- Available to meet the needs of the PLWHA and their caregivers
- Accessible to all populations infected or affected by HIV/AIDS
- Affordable to all populations infected or affected by HIV/AIDS
- Appropriate for different cultural and socio-economic populations and care needs
- Accountable to the funders and clients for providing contracted services at high quality

Figure 5: Houston Area Continuum of Care



Operational Definition of Core Medical Services

Core Medical Services refer to those services deemed by the Ryan White HIV/AIDS Treatment Modernization Act as most necessary to ensure good medical outcomes for people with HIV / AIDS. The Core Medical Services are defined as:

- outpatient and ambulatory health services;
- pharmaceutical assistance;
- substance abuse outpatient services;
- oral health;
- medical nutritional therapy;
- health insurance premium assistance;
- home health care;
- hospice services;
- mental health services;
- early intervention services; and
- medical case management, including treatment adherence services.

Congress wants to ensure that Ryan White Federal funds are used to pay for essential medical care; thus, areas receiving Ryan White funds under Parts A, B, and C must spend at least 75% of funds on core medical services.

The remaining 25% of funds may be spent on support services. Support services are defined as services that improve access to the core medical services, and directly contribute to achieving positive clinical outcomes for persons with HIV/AIDS. Support services are defined as:

- outreach;
- medical transportation;
- language services;
- respite care for persons caring for individuals with HIV/AIDS; and
- referrals for health care and other support services.

A Shared Set of Values

The Houston area HIV/AIDS community shares a set of values that guide the development and delivery of HIV Services within the geographic area. These values, as informed by HRSA guidelines, address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities; establish and support an HIV care continuum; coordinate resources among other Federal and local programs; and address the needs of those who know their HIV status and are not in care as well as the needs of those who are currently in the care system.

Guiding Principles

The guiding principles for the Houston Area HIV/AIDS Comprehensive Plan are informed by the Ryan White reauthorization principles which are intended to strengthen federal HIV treatment programs. The reauthorization principles include a focus on primary care and treatment, efforts to increase flexibility to target resources and ensuring accountability using sound fiscal management and tools to evaluate program effectiveness

As such, the guiding principles used by the Houston HIV/AIDS community are as follows:

1. Better serve the underserved in response to the HIV epidemic's growing and widespread impact among minority and hard-to-reach populations.
2. Ensure access to effective HIV/AIDS prevention and care services to make a difference in the lives of people infected and affected by HIV and AIDS.
3. Adapt to changes in the health care delivery system and the role of the Ryan White Treatment Modernization Act in filling service gaps.
4. Accurately document service outcomes and demonstrate the effectiveness of treatment, care and prevention strategies.
5. Respond to and advocate for consumer needs.
6. Provide services that are sensitive to the cultural and linguistic needs of specific communities.

Section III

HOW WILL WE GET THERE?

CHAPTER 8: GOALS, OBJECTIVES & ACTION STEPS

In the previous section, we described the ideal Continuum of Care for the Houston area. Here, we present community-defined goals and objectives for transforming our ideal vision into reality.

CDC & HRSA Goals and Objectives

At the Federal level on the *prevention* side, the CDC recommends that in order to implement a comprehensive HIV prevention program, State, local, and territorial health departments that receive HIV Prevention Cooperative Agreement funds should assure that efforts in their jurisdictions include a compilation of essential components.

CDC Goals for Prevention

1. HIV prevention community planning;
2. Epidemiologic and behavioral HIV/AIDS surveillance, as well as collection of other health and demographic data relevant to HIV risks, incidence, or prevalence;
3. HIV prevention counseling, testing, referral, and partner counseling and referral services, with strong linkages to medical care, treatment, and other needed services;
4. Health education and risk reduction (HE/RR) activities, including individual-, group-, and community-level interventions;
5. Easy access to diagnosis and treatment of other sexually transmitted diseases;
6. School-based education efforts for youth;
7. Public information programs;
8. Quality assurance and training;
9. Laboratory support;
10. HIV prevention capacity-building activities, including expansion of the public health infrastructure by contracting with non-governmental organizations, especially community-based organizations;
11. Evaluation of major program activities, interventions, and services; and
12. An HIV prevention technical assistance assessment and plan.

On the care side at the Federal level, HRSA has identified the following goals for the effective provision of care to individuals with HIV disease or AIDS and requests that those concerned with HIV/AIDS care focus attention on them.

HRSA Goals for Care

- Goal 1: Improve Access to Health Care
- Goal 2: Improve Health Outcomes
- Goal 3: Improve the Quality of Health Care
- Goal 4: Eliminate Health Disparities
- Goal 5: Improve the Public Health and Health Care Systems
- Goal 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies
- Goal 7: Achieve Excellence in Management Practices

Houston Area HIV/AIDS Goals, Objectives & Action Steps

In order to address these mandates, the Comprehensive HIV Services Plan for the Houston Area has adopted the following strategic goals:

- Goal 1:** Identify individuals who know their HIV status but are not in care and develop strategies for informing these individuals of services and enabling their use of HIV related services.
- Goal 2:** Reduce the impact of stigma on access to and retention in care and break down barriers.
- Goal 3:** Provide education and advocacy to encourage HIV+ individuals to get education, stay in treatment, access treatments and be aware of best practices.
- Goal 4:** Improve coordination and collaboration among non-medical service providers.
- Goal 5:** Eliminate disparities in access to and services for historically underserved populations.
- Goal 6:** Coordinate services with HIV prevention programs including outreach and early intervention services.
- Goal 7:** Coordinate services with substance abuse prevention and treatment programs.
- Goal 8:** Prevent youth from becoming HIV+.
- Goal 9:** Continue to develop new programming tactics whereby training, educational materials and clinical measurements continue to support improved HIV epidemiological data outcomes.
- Goal 10:** Provide goals, objectives, timelines and appropriate allocation of pay/funds to services as determined by clients and community.

GOAL 1: Identify individuals who know their HIV status but are not in care and develop strategies for informing these individuals of services and enabling their use of HIV related services.	
OBJECTIVE	ACTION STEPS
Increase access to services through new information campaigns and changing tactics in educational methods.	<ul style="list-style-type: none"> Develop at least one new educational/information campaign per year. Distribute risk reduction packages that include information on HIV testing, partner counseling and referral services (PCRS), sexually transmitted infections and safer sex materials.
Improve collaboration and communication between current HIV/AIDS Service providers.	<ul style="list-style-type: none"> Identify 3 new methods for enhancing collaboration and communication among service providers. Share staff training materials and resources among service providers collaborating on current and future projects.
“Change the Message”, go “outside the box” to identify strategies to inform those who know their HIV status but are not in care.	<ul style="list-style-type: none"> Through the use of current system data, reduce by 10% annually, the number not in care.
As programs are developed to bring out-of-care PLWHA into the care system, medical care services must be incrementally expanded. Current providers have limited capacity to serve large volumes of additional patients. Through targeted development, new and expanded programs should reduce perceived barriers to care for those who are currently outside the care system.	<ul style="list-style-type: none"> Provide community-based case managers and others connected to the out-of-care community with detailed information for referral of uninsured to funded programs. Continue to monitor quality and client satisfaction at existing primary care provider sites. Consider assessment of barriers to care in out-of-care population and the development of a plan to address barriers. Maintain regularly scheduled HIV testing and counseling at 11 Part C community health centers. Meet with clinic directors, visit clinic sites and provide supervision to bilingual and culturally competent

GOAL 1: Identify individuals who know their HIV status but are not in care and develop strategies for informing these individuals of services and enabling their use of HIV related services.

	<p>Outreach staff.</p> <ul style="list-style-type: none"> • Provide adherence assessment, education and monitoring to patients at Part C facilities, and review each client's readiness to begin or change HAART. • Provide medical care information targeted to HIV positive people who are not yet receiving medical care.
Consider funding model programs that combine targeted outreach and medical care for specific out-of-care populations.	<ul style="list-style-type: none"> • Target service linkage workers to segments of the out-of-care population and at counseling and testing sites. • Maintain regularly scheduled HIV testing and counseling at 11 Part C community health centers. • Provide in-service meetings for clinic staff regarding HIV testing and other HIV treatment basics.
Examine why out-of-care youth are not utilizing Houston's primary medical care targeting youth.	<ul style="list-style-type: none"> • Continue to collect data in order to examine factors that influence entry into care for youth.
Support existing programs and establish new program(s) to facilitate entry into the medical care system upon release from jail/prison. Ensure that such programs address disclosure concerns for soon-to-be released and recently released PLWHA.	<ul style="list-style-type: none"> • Offer services that help HIV positive people get medical care after being released from jail/prison.
Increase targeted HIV medical care information for out-of-care populations. Vary the format and message in order to maintain interest.	<ul style="list-style-type: none"> • Continue to provide annual trainings to medical and social service providers regarding HIV-related medical issues for special populations. • Distribute informational materials in languages other than English.

GOAL 2: Reduce the impact of stigma on access to and retention in care and break down barriers.	
OBJECTIVE	ACTION STEPS
Identify barriers that prevent the community from successfully addressing HIV/AIDS in the community.	<ul style="list-style-type: none"> Target two barriers and develop actions addressing communication, educational, and training presentations and/or materials each year. Reduce the impact of stigma and increase retention in care by 10%.
Find new ways to demonstrate the impact of HIV prevention and testing efforts.	<ul style="list-style-type: none"> Implement action steps related to testing.
Address the special needs of the mentally ill, substance abusing, and homeless populations.	<ul style="list-style-type: none"> Study the special needs of these populations and develop one written document that focuses on this issue annually.

GOAL 3: Provide education and advocacy to encourage HIV+ individuals to get education, stay in treatment, access treatments and be aware of best practices.	
OBJECTIVE	ACTION STEPS
Educate HIV+ individuals to stay in care and access treatment. Include "Prevention for Positives" to decrease transmission.	<ul style="list-style-type: none"> Document an increase in the provision of education and advocacy events by 25%.

GOAL 4: Improve coordination and collaboration among non medical service providers.	
OBJECTIVE	ACTION STEPS
Develop a forum for collaboration and communication between community-based organizations, e.g., a Service Providers Caucus.	<ul style="list-style-type: none"> Hold at least two documented events to improve collaboration and communication between community-based organizations.

GOAL 5: Eliminate disparities in access to and services for historically underserved populations.	
OBJECTIVE	ACTION STEPS
Provide aggressive, but positive education for traditionally at risk groups and the general population.	<ul style="list-style-type: none"> Through the use of current system data, continue to monitor for any disparities in access to and services for underserved populations.
Enhance access to services targeted to underserved communities.	<ul style="list-style-type: none"> Continue to use Minority AIDS Initiative and general Part A funds to enhance allocations in service categories such as primary medical care, case management and mental health that target underserved communities including African Americans, Latinos, recently released, homeless and not-in-care. Monitor allocations for primary care, case management and mental health services targeted to women, African Americans, Latinos and men who have sex with men (MSM). Maintain HIV counseling and Orasure testing at two Part C Community Health Centers, and four additional Part C Homeless Program sites.
To supplement earlier studies, additional research should be considered to better understand the reasons for the rate of out-of-care and never-in-care among African American MSM.	<ul style="list-style-type: none"> Conduct special studies to examine factors that influence entry into care for MSM of color. Consider developing additional prevention strategies targeted to individuals who have sex with both men and women. Continue recommending and implementing effective evidence based interventions targeting individuals at highest risk. Consider special studies targeting individuals who have sex with both men and women to examine prevention needs and effective prevention strategies.

GOAL 5: Eliminate disparities in access to and services for historically underserved populations.	
OBJECTIVE	ACTION STEPS
	<ul style="list-style-type: none"> • Target prevention efforts to individuals who are bisexual (have sex with both men and women). • Continue to provide annual trainings to medical and social service providers regarding HIV-related medical issues for special populations.
Ensure that healthcare providers, especially those who do not regularly treat PLWHA are aware of the complications of anti-retroviral therapies and the particular risk to African American men, who are also at risk for diabetes and cardiovascular disease.	<ul style="list-style-type: none"> • Institute a Part C adherence team which will oversee the assessment, education, medication initiation & follow-up of new starts and changes to regimen.
Continue to require that all HIV medical care providers offer treatment adherence programs. Whenever possible, target treatment adherence services to African Americans.	<ul style="list-style-type: none"> • Consider a special study examining the specific and unique needs of recently released HIV positive individuals. • Continue to provide programs that provide emergency housing and HIV/AIDS medication assistance to the recently or soon-to-be released persons – particularly persons of color.
Develop a comprehensive transitional program that matches the newly released with a medical care provider, source for medications and basic resources.	<ul style="list-style-type: none"> • Continue to offer referrals to Houston area services providing job training, transportation and other transitional services.
Within the comprehensive transitional program, incorporate insurance eligibility and other efforts to economically support the recently released.	<ul style="list-style-type: none"> • Continue to offer referrals to Houston area services that provide clinical and medical care services
Provide health screenings that include the range of co-morbidities to which the incarcerated appear to be more susceptible.	
Support existing programs and establish new programs(s) to facilitate entry into the medical care system upon release from jail/prison. Ensure that such programs address disclosure concerns for soon-to-be and recently released	<ul style="list-style-type: none"> • Continue to provide programs that offer clinical and medical care assistance to recently or soon-to-be released persons.

GOAL 5: Eliminate disparities in access to and services for historically underserved populations.	
OBJECTIVE	ACTION STEPS
PLWHA.	
Increase utilization of case managers who specialize in meeting the needs of PLWHA who are recently released from jail/prison.	<ul style="list-style-type: none"> Employ case managers who specialize in the needs of HIV positive people who are recently released from jail or prison.
Continue to expand linkages between jail/prison and the community care system in order to effectively transition recently released into care.	<ul style="list-style-type: none"> Community-based case managers may make emergency food bank referrals for clients who are being released for incarceration. When accessed, these food banks may provide important linkages to the care system. Continue to provide Blue Books at no cost to incarcerated individuals, as well as information on programs in the community targeted to incarcerated individuals and the recently released.
Through collaborations, begin implementation of a plan to expand transitional housing options.	<ul style="list-style-type: none"> Facilities should target specific populations with housing and other services, such as transitional housing for: substance abuse treatment, recently released, women, etc. Begin with a pilot project with the goal of expanding services or targeting additional populations over time. Consider expanding programs to ease transition out of incarceration for those with substance abuse issues. Such a program has been developed by the Texas Department of Criminal Justice, to provide those released with an opportunity to reside in a halfway house and receive substance abuse treatment
Examine reasons for low use of mental health services by recently released and develop targeted services and service promotion for these consumers.	<ul style="list-style-type: none"> Offer services that encourage HIV positive people who are recently released from jail/prison to use mental health services.

GOAL 5: Eliminate disparities in access to and services for historically underserved populations.	
OBJECTIVE	ACTION STEPS
Expand the availability of support groups to the recently released.	<ul style="list-style-type: none"> Continue to offer referrals to Houston area services that provide individual/group counseling and support groups
Continue to provide information to primary care providers, especially obstetricians/gynecologists and emergency medicine physicians about their role in HIV testing and diagnosis.	<ul style="list-style-type: none"> Part C Counseling and Testing Supervisor will continue to meet with clinic directors and visit clinic sites. Part C Counseling and Testing Supervisor will continue to provide in-service meetings for clinic staff regarding HIV testing and other HIV treatment basics. Examine possible partnerships with private medical providers to increase routine HIV screening in medical settings. Continue to provide annual trainings to medical and social service providers regarding HIV-related medical issues for special populations
Continue to develop a program that appropriately communicates HIV status to women, provides prevention information to the seronegative and transitions the newly diagnosed to early intervention services.	<ul style="list-style-type: none"> Continue to implement and monitor evidence based interventions targeting at risk females. Provide educational and early intervention services for HIV positive women.
Examine barriers to use of medication reimbursement programs by women.	<ul style="list-style-type: none"> Consider a study to explore access and availability issues for women.
Continue to educate HIV positive women about the importance of gynecologic care in order to increase utilization of OB/GYN services.	<ul style="list-style-type: none"> Educate HIV positive women about the importance of OB/GYN care.
Expand OB/GYN treatment options and locations for offering care to HIV+ women.	<ul style="list-style-type: none"> Publicize the availability of the Part C Women's Program to community-based HIV service providers and other Ryan White funded primary care providers.
Include OB/GYN care at primary care sites.	<ul style="list-style-type: none"> Provide educational and early intervention services for HIV positive women.

GOAL 5: Eliminate disparities in access to and services for historically underserved populations.	
OBJECTIVE	ACTION STEPS
Expand the availability of support groups for women.	<ul style="list-style-type: none"> • Provide support groups for HIV positive women.
Continue to provide prevention education for young mothers and children through schools, social service agencies, youth development programs and churches.	<ul style="list-style-type: none"> • Examine possible partnerships and strategies to expand prevention activities targeting at risk youth • Provide prevention education for young mothers.
Develop and implement programs that serve youth 18 years or older.	<ul style="list-style-type: none"> • Conduct special studies to examine factors that influence entry into care for youth.
Expand outreach, testing and early intervention programs to youth.	<ul style="list-style-type: none"> • Consider special studies to examine prevention needs and appropriate prevention messages targeting at risk youth. • Provide prevention education for youth.
Examine reasons for low use of mental health services by youth.	<ul style="list-style-type: none"> • Conduct special studies to examine factors that influence entry into care for youth.
Expand the availability of support groups for youth.	<ul style="list-style-type: none"> • Provide support groups for youth
Examine reasons youth are not utilizing Houston's youth-focused primary medical care.	<ul style="list-style-type: none"> • Drawing upon expertise gleaned from other programs across the country, consider incorporating additional components such as: a youth peer counseling program to support youth in the medical care system, using technology in both care and education, etc. • Conduct special studies to examine factors that influence entry into care for youth.
Evaluate the effectiveness of case managers targeting services for youth and consider the need to expand availability.	<ul style="list-style-type: none"> • Employ case managers that specialize in the needs of youth.
Expand outreach, testing and early intervention programs to monolingual Spanish speakers.	<ul style="list-style-type: none"> • Distribute informational brochures in Spanish, explaining routine opt-out HIV screening and risk reduction information.

GOAL 6: Coordinate services with HIV prevention programs including outreach and early intervention services.		
OBJECTIVE	ACTION STEPS	
Use Comprehensive Needs Assessment data to inform Community Planning Group of outreach and early intervention activities and services.	<ul style="list-style-type: none"> Through the use of current system data and, increase by 25% annually, outreach and early intervention activities and services in the Houston EMA/HSDA. 	
Provide outreach, counseling, and HIV testing to residents of the Houston area.	<ul style="list-style-type: none"> Maintain regularly scheduled bilingual and culturally competent OraSure testing at community health centers. Ensure delivery of test results and any indicated confirmatory tests. Provide bilingual and culturally competent pre- and post-test counseling Coordinate with agencies such as public and community HIV testing sites, emergency rooms, jails, and providers of supportive services to provide primary care to patients who test HIV+ at these locations. Support efforts to adapt existing HIV testing protocols to guide implementation of routine, opt-out HIV screening at health care sites throughout the area. Ensure the follow-up of newly positive individuals through notification and linkage to primary care services. 	
Provide hepatitis B and C screening and treatment.	<ul style="list-style-type: none"> Support efforts to conduct hepatitis C screening routinely for all new patients at clinics. Conduct educational sessions regarding hepatitis B & C available to community members and groups. Provide hepatitis B & C support groups 	

GOAL 7: Coordinate services with substance abuse prevention and treatment programs.

OBJECTIVE	ACTION STEPS
Use Comprehensive Needs Assessment data to inform substance abuse prevention and treatment programs, activities and services.	<ul style="list-style-type: none"> Use current comprehensive needs assessment data to inform substance abuse prevention and treatment programs, activities and services.
Incorporate mental health therapy/counseling and substance abuse treatment into model programs, and evaluate their effectiveness in moving the newly diagnosed into care.	<ul style="list-style-type: none"> Continue to require that all Part C clinical providers provide appropriate referrals to substance abuse, mental health, case management and social services.
Enhance collaboration between housing programs and substance abuse treatment.	<ul style="list-style-type: none"> Collaborate with housing or substance abuse treatment programs to provide services for IV drug users or other substance users.
Develop substance abuse treatment programs for diverse populations, including the uninsured.	<ul style="list-style-type: none"> Consider a special study examining the specific and unique needs of HIV+ substance users and what barriers to care exist within this population.
Identify opportunities to leverage funding through partnerships with substance abuse treatment programs	<ul style="list-style-type: none"> Place clinical and community-based case managers in a substance abuse treatment setting. Continue to require that all Part C clinical providers provide appropriate referrals to substance abuse, mental health, case management and social services.
Explore alternative models of providing mental health and substance abuse counseling at primary care sites.	<ul style="list-style-type: none"> Continue to place psychiatric services at all Part A primary care sites.
Continue to educate substance abuse treatment providers to more effectively treat HIV positive consumers.	<ul style="list-style-type: none"> Collaborate with housing or substance abuse treatment programs to provide services for IV drug users or other substance users.
Continue to educate consumers, case managers and primary care providers about the availability of free substance abuse treatment and the availability of various substance abuse treatment approaches.	<ul style="list-style-type: none"> Place clinical and community-based case managers in a substance abuse treatment setting.

GOAL 8: Prevent youth from becoming HIV+.	
OBJECTIVE	ACTION STEPS
Through schools and other age pertinent institutions/events, provide education and training that is emotional and hard hitting but personal.	<ul style="list-style-type: none"> • Contact 100% of schools within EMA for dissemination of educational material. • Conduct training presentations to 30% of schools within the EMA. • Through formal requests, ask 100% of schools within the EMA to add HIV/AIDS education as part of their sex education classes.

GOAL 9 : Continue to develop new programming tactics whereby training, educational material, and clinical measurements continue to support improved HIV epidemiological data outcomes.	
OBJECTIVE	ACTION STEPS
Identify special groups (e.g., teens) and conduct community meetings to seek out improved methods/messages that can best reach targeted group.	<ul style="list-style-type: none"> • Identify one special group per year and conduct one focus group to better understand ways to improve outreach.

GOAL 10: Provide goals, objectives, timelines and appropriate allocation of pay/funds services as determined by clients and community.	
OBJECTIVE	ACTION STEPS
Complete comprehensive planning process so that data can be utilized by the service allocation and priority setting committees.	<ul style="list-style-type: none"> • Provide goals, objectives, timelines and appropriate allocation of pay/funds to services as determined by clients and community.

Section IV

HOW WILL WE MONITOR OUR PROGRESS?

CHAPTER 9: IMPLEMENTATION, MONITORING & EVALUATION

Improving Client Level Data

The Houston area is fortunate to have an effective client-level tracking system in place that manages and produces client level data for planning purposes.

The Centralized Patient Care Data Management System (CPCDMS) is an encrypted, real-time, de-identified client-level database that links all Houston area Ryan White Part A, B, C and SPNS-funded agencies, as well as other local HIV/AIDS services providers, together via the Internet. Providers access the CPCDMS through their Web browser and enter registration, encounter and medical update information for each client, including demographic, co-morbidity, biological marker, service utilization, outcomes survey and assessment data.

Using Data for Evaluation

Measure	Data Source
Local HIV/AIDS epidemiological data	Surveillance reports
Local care & prevention needs	Needs Assessments
Provider capacity and resources	Resource Inventories
Legislative, regulatory, and/or treatment guidelines	Federal resources
Quality of care	Standards of Care
Project Monitoring	Quality Management

Quality of Care

Since FY 1999, the Evaluation and Quality Management Section of the Ryan White Grant Administration has facilitated annual work groups composed of Ryan White Planning Council members, service providers, consumers and subject experts to review and revise standards of care for each funded service category. These local standards are derived from U.S. Public Health Service guidelines as well as other relevant industry standards and federal, state and local licensing requirements. Measurement thresholds are set at 100%.

Project Monitoring

The Project Monitoring Team of the Ryan White Grant Administration (RWGA) ensures:

- Coordination and implementation of programmatic monitoring processes for Ryan White Part A funded service providers.
- Provision of on-going technical assistance to providers.

- Development and implementation of Site Visit Guidelines, client grievances/complaints procedures and technical assistance tools.
- The integrity of data in the CPCDMS.
- Timely resolution of consumer concerns/complaints involving Ryan White Part A-funded services.

The Resource Group, as the Administrative Agent/Grantee for Ryan White Program Parts B and C (Urban), performs Quality Compliance Reviews on each of its Subgrantees at least annually. Quality Compliance Reviews are designed to verify the Subgrantee's observance of applicable rules and regulations for the funded service(s). Quality Compliance Reviews focus on issues of clinical, consumer involvement, data management, fiscal, programmatic and quality management issues.

Additionally, The Resource Group provides technical assistance to its Subgrantees. The Resource Group provides technical assistance proactively based on issues identified during Quality Compliance Reviews, issues identified through the joint committees of the Ryan White Planning Council, changes in requirements from the Department of State Health Services, etc. Subgrantees may also request technical assistance from The Resource Group.

Quality Management

The Ryan White Grant Administration (RWGA) has established a comprehensive clinical quality management (CQM) program in order to identify needs and gaps in services and to ensure that quality services are delivered to clients. The Houston EMA uses CQM data to evaluate programs, identify which service categories to fund and to administer the Part A grant. The EMA's CQM program includes the development of a CQM plan, establishment of processes that ensure services are provided in accordance with Health and Human Services (HHS) treatment guidelines, standards of care (SOC) and the inclusion of quality-related expectations into Request for Proposals (RFP) and contracts.

CQM plan components include the following:

- Mission, Vision & Goals
- Framework for the Quality Management Program
- Commitment of staff resources
- Ryan White Grant Administration Clinical Quality Management Committee
- Ryan White Planning Council (RWPC) Quality Assurance (QA) Committee

Mission, Vision and Goals - The Quality Management program is a coordinated, comprehensive, and continuous effort to monitor and improve the quality of care provided to PLWHA throughout the EMA. RWGA will develop strategies to ensure that the delivery of services to all Ryan White Program eligible PLWHA is equitable and adheres to the most recent Health and Human Services (HHS) treatment guidelines and clinical practice standards. The overarching goals of the CQM program include the

establishment of a QM infrastructure within RWGA that supports QM programs at subcontractor agencies and the utilization of measurement systems including consumer input that enhance multidisciplinary data driven CQM projects resulting in improved health outcomes.

Framework of the Quality Management Program - Continuous Quality Improvement (CQI) refers to a management process or “approach to the continuous study and improvement of processes or providing health care services to meet the needs of individuals and others (Joint Commission, Glossary CAMH).” The CQI process includes Quality Planning, Quality Control/Measurement, and Quality Improvement. Each of these components is incorporated into the Houston EMA’s approach to CQM and facilitates the primary goal of improving health outcomes and quality of life for PLWHA.

Commitment of staff resources - Two full-time Grantee staff positions oversee the implementation of the CQM program. Both staff have completed the National Quality Center (NQC) Training of Trainers (TOT) CQM curriculum.

Ryan White Grant Administration Clinical Quality Management Committee - In February 2007, RWGA received QM TA from the NQC as part of the continuous effort to strengthen the Houston EMA QM program. The TA included comprehensive assessment of the QM program. Following recommendations from the NQC consultant, the RWGA QM section instituted cross-agency multidisciplinary CQM committee, distinct from the Ryan White Planning Council Quality Assurance (QA) Committee, in February 2008. The CQM committee meets quarterly. The core function of the committee is to assist the RWGA QM section in the development, implementation and evaluation of the Houston EMA QM plan. The CQM Committee also provides technical input into the development of HIV care services SOC, planning for educational activities for subcontractors and consumers and the development of various assessment and chart review tools

Ryan White Planning Council (RWPC) Quality Assurance (QA) Committee - This formalized information loop between the administrative agency and the Planning Council ensures that Council members have the CQM data they need when prioritizing services and allocating resources. This RWPC committee is one means by which RWGA staff members provide CQM and clinical chart review data, outcomes evaluation, SOC and client satisfaction measurement activities to the RWPC. All annual chart review and client satisfaction survey reports, semi-annual outcomes reports and SOC revisions are presented to the QA committee at appropriate intervals during the grant year. Committee members then evaluate and share the information with the entire Planning Council, which in turn uses the data to evaluate funded services and make decisions during its annual, community-wide How to Best Meet the Needs (HTBMTN) process.

Internal Processes for Monitoring the CQM Plan

At the beginning of each grant year, RWGA QM Section team members collaborate with the RWPC’s Office of Support and QA Committee to establish a timeline for collecting, reporting and analyzing CQM data. These timelines are incorporated into the QM Plan.

RWGA reports on the results of all CQM activities to the CQM committee members as needed, and to service subcontractors and Council members semi-annually. Report due dates and deliverables are specified in the Memorandum of Understanding between RWGA and the Planning Council, thereby ensuring the Grantee is accountable for producing the reports in a timely manner. CQM committee and staff, and the Manager of RWGA ensure that the timeline is followed and that accurate, useful data is presented.

Standards of Care and Outcome Measures

Each year, RWGA facilitates workgroups composed of RWPC members, service subcontractors, consumers and subject experts to review and revise the SOC and outcome measures for each funded service category. This process was enhanced in FY 2008. The CQM committee members comprised of physicians and other experts from various disciplines perform the initial review providing technical input prior to the workgroups review sessions. Local standards are derived from HHS guidelines as well as other relevant industry standards and federal, state and local licensing requirements. The EMA's comprehensive evaluation program, initiated in FY 2001, tracks key indicators for client outcomes, with most thresholds set at 75%. Outcomes and indicators to be measured are reviewed and revised each year. RWGA regularly monitors the EMA's data collection system to make sure service subcontractors are entering their outcomes data as required by their Part A contracts. Regular site monitoring visits are conducted by RWGA at all subcontractors to ensure compliance with the standards of care. The Houston EMA's Standards of Care and Outcome Measures may be viewed at <http://www.hcphe.org/rwga/standards>.

Annual Clinical Chart Reviews

Chart review results are used to assist in the development of agency specific CQM plans. Subcontractors also review the results from their chart reviews and identify areas of care in need of improvement. Subcontractors develop CQM plans to address the identified areas.

The Centralized Patient Care Data Management System (CPCDMS)

The CPCDMS is a real-time, de-identified, client-level database that links service subcontractors together through the Internet. Providers enter registration, encounter and medical update information for each client, including demographic, co-morbidity, biological marker, service utilization, outcomes survey and assessment data. Using this information, RWGA is continually developing reports that summarize trends in client demographics, service utilization and outcomes.

Client Satisfaction

In FY 2002 RWGA developed and implemented a methodology for measuring client satisfaction that is consistent across all Part A and MAI-funded service categories. This methodology employs the use of a self-administered survey tool with questions that address the service, the subcontractor and the Ryan White continuum of care as a whole. For FY 2008, in addition to the paper-based surveys, clients also have the ability to complete the client satisfaction survey online. This web-based client satisfaction

process augments the annual paper-based survey method and provides consumers with the opportunity to submit “real time” client satisfaction input year round, either through computer kiosks located at subcontractor sites, or via the Internet through an off-site personal computer, at home, at public libraries and elsewhere.

RWGA QM staffs also conduct focus groups with consumers at each Part A and MAI-funded primary medical care subcontractor. Focus group participants are invited to share their opinions and concerns regarding a number of topics.

Inclusion of Provisions in Subcontracts and RFP Language

Subcontractors must describe their internal quality improvement programs and activities in RFP submissions. Reimbursements may be withheld if subcontractors do not comply with required CQM activities or if outcomes evaluation and other data are not submitted as required.

Agency-Level CQM Program Development

The goal of agency-level CQM program development is to formalize a structured, system-wide approach for planning, implementing and evaluating quality improvement efforts among Part A and MAI-funded subcontractors. The Houston EMA’s CQM program includes training and support for the development of agency-level CQM programs and quality improvement goals. Each subcontractor must submit an annual CQM plan to RWGA. The plan must include applicable EMA-wide performance measures selected for improvement based on chart review results and outcomes evaluation data. Providers are also required to evaluate their service delivery systems and processes to identify areas for improvement and include performance measures for those areas as well in the CQM plan. Quarterly updates are required and must include the results of the subcontractor’s internal data collection activities. RWGA provides technical support and guidance to the subcontractors as they develop and update their CQM plans.

Ongoing Evaluation and Addressing Areas for Improvement

In FY 2006, RWGA expanded its CQM program to include the facilitation of regularly scheduled case management workgroup meetings. The goal of the workgroups, which met monthly, was to ensure subcontractor input in the improvement process, and to standardize CQM efforts where it is feasible. Through the workgroup’s efforts standardized comprehensive assessments and corresponding services plan documents for each of the EMA’s three case management interventions (Medical, Clinical and Non-Medical/Service Linkage) were developed and implemented. Additionally, a case management clinical chart review tool has been developed and is pending implementation. During the FY 2008 QM planning process, the RWGA CQM committee determined areas needing improvement from chart review findings, outcomes data reports and professional guidelines, and incorporated these into performance goals for the grant year. RWGA facilitated CQM committee meetings in FY 2008 to develop standardized medication adherence assessment tools and revise existing case management assessment tools to reflect current guidelines and SOC.

Measuring Clinical Outcomes

Outcomes Evaluation

Outcomes are measured by the Harris County Ryan White Grants Administration Department using an established set of process and clinical outcome measures. Members of planning bodies participate in the review of these outcome measures on a bi-annual basis.

In addition to these system goals and objectives, system and client outcomes can be measured to determine their effectiveness. Several client outcomes can be inferred from the goals and objectives above. These address the needs of all of the consumers within the continuum of care. They include: 1) preventing persons from becoming HIV positive; 2) preventing persons from progressing from HIV to AIDS; 3) improving or maintaining health status of PLWA; 4) sustaining or improving the quality of life of PLWA; 5) providing a dignified death to those who are at the end-stage of AIDS; and 6) providing appropriate linkages between services.

In FY 2001 the Evaluation and Quality Management Section of Ryan White Grant Administration implemented comprehensive outcomes evaluation for all funded service categories. Examples of outcomes measured in the Houston EMA include:

- Health outcomes such as changes in CD4+ counts, viral load tests and stage of illness
- KAP (knowledge, attitudes and practices) outcomes such as changes in service utilization rates and adherence to drug treatment regimens
- Cost-effectiveness outcomes such as fewer days of HIV-related hospitalization
- Quality of life outcomes such as increased ability to perform activities of daily living

Client-level outcomes and indicators are tailored to the goals and objectives of each service category. Data collection methods include the CPCDMS, self-administered pre- and post-tests and standardized provider assessments.

Section V

GLOSSARY OF TERMS

Access to Services: The extent to which clients can receive the service, assuming that it is available to clients. Numerous factors may influence access to services even though the service is deemed available to the client.

ADAP: see AIDS Drug Assistance Program.

Administrative Agency: A lead, or administrative, agency authorized to receive funds and distribute them according to service priorities established in the HIV care plan. An administrative agency may be a State or County health department, a community foundation, a public trust, a community-based organization, an AIDS service organization or an incorporated non-profit agency. In the Houston area, the administrative agency for Part A of the Ryan White Program is Ryan White Grant Administration, Public Health and Environmental Services, Harris County Department of Health; for Part B, the administrative agency is The Houston Regional HIV/AIDS Resource Group.

AETC: see AIDS Education and Training Center.

AI/A: American Indian/Alaska Native.

AIDS Drug Assistance Program (ADAP): ADAP was created as part of the Ryan White CARE Act and is administered under Part B. ADAP provided medications to low-income people living with HIV/AIDS who are uninsured, under-insured and/or lack coverage for medications.

AIDS Education and Training Center (AETC): The AETC was created as part of the Ryan White CARE Act and is administered under Part F. The AETC program is a network of regional centers that conduct targeted, multi-disciplinary education and training programs for health care providers.

API: Asian/Pacific Islander.

ASO: AIDS service organization.

Availability: Primarily concerned with whether the service was offered to the client/community.

Barriers: A number of factors or circumstances that prohibit or inhibit access and/or use of services. The reason for and source of barriers are diverse.

CARE Act: see Ryan White CARE Act; since 2006 it is referred to as the Ryan White Program.

CAEAR: Cities Advocating Emergency AIDS Relief Coalition

CBO: Community-Based Organization.

CDC: see Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention (CDC): The Centers for Disease Control and Prevention is a Federal agency of the Department of Health and Human Services. The CDC mission is to promote health and quality of life by preventing and controlling disease, injury and disability. The CDC is the Federal agency responsible for tracking diseases that endanger public health, such as HIV.

Community Forum or Public Meeting: A small-group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion. Similar to but less formal than a focus group, it usually includes a larger group; participants are often self-selected (i.e., not randomly selected to attend).

Community Planning Coalition/Group (CPG): The CDC started a program in which people from at-risk communities and those who are HIV positive utilize data from scientists and other professionals in order to decide the most effective HIV prevention programs and methods for stopping the spread of HIV infection in their area. In the Houston area, the group is the Houston HIV Prevention Community Planning Group which covers Harris County.

Comprehensive Planning: The process of determining the organization and delivery of HIV services; strategy used by a planning body to improve decision-making about the services and maintain a continuum of care.

Consortium: Part B of the Ryan White Program created and authorized consortia. A consortium is an association of public, private non-profit, and community-based organizations operating within an HSDA and individuals who are community leaders, persons representative of populations affected by HIV, people infected with HIV, and family members/caregivers of people with HIV. The consortium determines how Federal and State grant funds will be used in its geographic area to treat and provide services to people with HIV/AIDS. In the Houston area, the consortium was disbanded in 2003 and the Texas Department of State Health Services asked the Ryan White Planning Council to fulfill this planning function.

Continuum of Care: A set of services and linking mechanisms that responds to an individual or family's changing needs for HIV prevention and care. A continuum of care is the complete system of providers and available resources (Ryan White Program and others) for people at risk for or living with HIV and their families within a particular geographic service area, from primary care to supportive services.

Core services: Outpatient and ambulatory services including AIDS Drug Assistance Program (ADAP), AIDS pharmaceutical assistance, oral health, early intervention, health insurance premium assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services, outpatient substance abuse treatment and medical case management, including treatment adherence services.

CPC/CPG: see Community Planning Coalition/Group.

CTRPN/E: Counseling, Testing, Referral and Partner Notification/Elicitation

DSHS: Texas Department of State Health Services; formerly the Texas Department of Health (TDH).

Eligible Metropolitan Area (EMA): A designation used by the Ryan White Program to identify an area eligible for funds under Part A (aid to metropolitan areas hardest hit by HIV). The Houston EMA consists of the following six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.

EMA: See Eligible Metropolitan Area.

Epidemic: The spread of an infectious disease through a population or geographic area.

Epidemiologic Profile: A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specific geographic area.

Epidemiology: The study of factors associated with diseases and their distribution in the population.

Focus Group: A method of information collection involving a carefully planned discussion among a small group led by a trained moderator.

HAART: Highly Active Anti-Retroviral Treatment

Health Resources and Services Administration (HRSA): The Health Resources and Services Administration directs national health programs that improve the Nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA administers the Ryan White CARE Act.

HIV Service Area (HSA): A designation used by the City of Houston Health Department within the city limits. HSA's approximate neighborhood boundaries.

HIV Service Delivery Area (HSDA): A designation used by the Ryan White Program

to identify an area eligible for funds under Part B (formula funding to states and territories). There are six HSDAs in the East Texas Planning Area: Beaumont-Port Arthur (covering 3 counties), Galveston (covering 3 counties), Houston (covering 10 counties), Lufkin (covering 12 counties), Texarkana (covering 9 counties), and Tyler (covering 14 counties).

Homeless: Not having a stable residence in one's name. The term homeless applies equally to a person who has a temporary hotel room paid by a city program for indigents, a person sleeping in a shelter or in a car, and a person who is staying with a relative because she or he cannot afford to pay rent. It also refers to someone in temporary or transitional housing for substance abuse or other types of treatment.

Housing Opportunities for People with AIDS (HOPWA): HOPWA is a Federal program of the Department of Housing and Urban Development. HOPWA provides housing assistance and supportive services for low-income people with HIV/AIDS and their families. Locally, this program is administered by the City of Houston Housing and Community Development Department.

HOPWA: see Housing Opportunities for People with AIDS.

HRSA: See Health Resources and Services Administration.

HSA: See HIV Service Area.

HSDA: See HIV Service Delivery Area.

IDU: Injection drug use(r).

In care: Self-reported as having had a CD4 test, viral load test or antiretroviral medication during the last 12 months.

KAP: Knowledge, Attitudes and Practices. Typically used to describe survey instruments that measure those particular variables in relation to a particular behavior.

MCSM: Men of color who have sex with men exposure category.

MSM: Men who have sex with men exposure category.

Need for Service: The extent the service was requested. May encompass terms such as was the service wanted, desired, necessary to address health problems/concerns.

Needs Assessment: A process of collecting information about the needs of people at risk of or living with HIV and their families (both those receiving care and those not in care), identifying current resources available to meet those needs and determining what gaps in care exist.

Out-of-Care: Self-reported as not having had a CD4 test, viral load test or antiretroviral medication during the last 12 months.

Part A: Under the Ryan White Program, funding is given to eligible metropolitan areas hardest hit by the HIV epidemic. In the Houston EMA, Part A funding is given to the Harris County Judge, administered by the Harris County Health Department (Ryan White Grant Administration). The planning body for these funds is the Houston Area HIV Services Ryan White Planning Council. Until 2006, these funds were referred to as Title I.

Part B: Under the Ryan White Program, funding is given by formula to States and territories to improve the quality, availability, and organization of health care and support services for people and families living with HIV/AIDS. There is an emphasis on rural populations. In Texas, funding is given to the Department of State Health Services. Until 2006, these funds were referred to as Title II.

Part C: Under the Ryan White Program, funding is given to community-based organizations for outpatient early intervention services. Until 2006, these funds were referred to as Title III.

Part D: Under the Ryan White Program, funding is given to public and non-profit entities to coordinate services to, and improve access to research for, children, youth, women, and families. Until 2006, these funds were referred to as Title IV.

Planning Council: Planning Councils are volunteer planning groups composed of community members who prioritize services and allocate funds under Title I of the Ryan White CARE Act. In the Houston area, the planning council is known as the Houston Area HIV Services Ryan White Planning Council.

PLWHA: People (or person) living with HIV/AIDS; PLWH and PLWA and PWA also are used.

Prevention Services: Interventions, strategies, programs, and structures designed to change behavior that may lead to HIV infection or other disease. Examples of HIV prevention services include street outreach, educational sessions, condom distribution, and mentoring and counseling programs.

Public Health Service Area (PHSA): Service area used for public health planning.

Recently Released: Self-reported as having been released from jail/prison after being incarcerated during the past year.

Ryan White CARE Act: On August 18, 1990, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Reauthorized in 1996 and 2000, the CARE Act is designed to improve the quality and availability of care for individuals and families affected by HIV/AIDS. The CARE Act includes the following

major programs: Part A, Part B, Part C, Part D and Part F. The CARE Act is now the largest sole source of HIV funding in the Nation and is now called the Ryan White Treatment Modernization Act of 2006.

SES: Socio-economic Status. Social and Economic indicators like income and education. SES is consistently correlated with differences in health outcomes.

Sexually Transmitted Infection (STI): A disease that is spread through intimate sexual contact, such as HIV, herpes, syphilis, and gonorrhea.

Special Projects of National Significance (SPNS): Administered by Part F of the Ryan White Program. This program supports the development of innovative models of HIV care and is designed to address special care needs of individuals with HIV/AIDS in minority and hard-to-reach populations.

SPNS: see Special Projects of National Significance.

Supportive Services: Those services that enable PLWHA to access and/or remain in primary medical care. Supportive services must be linked to medical outcomes and include outreach, medical transportation, linguistic services, respite care for people caring for HIV/AIDS patients, referrals for health care and other support services and case management.

Title I: See Part A.

Title II: See Part B.

Title III: See Part C.

Title IV: See Part D.

Unmet need: HRSA/HAB defines unmet need as the need for HIV-related health services by individuals with HIV who know their HIV status and are not receiving regular primary health care. Note: This definition differs from HRSA's definition of only primary medical care, defined as CD4 count, viral load test/HAART for those who know their HIV status.

VA: Department of Veterans Affairs

Section VI

PLANNING RESOURCES

The following reports are available from the Ryan White Planning Council Office of Support:

2005 and 2008 Houston Area HIV/AIDS Needs Assessment
2008 Integrated Epidemiological Profile for HIV/AIDS Prevention & Care Planning
Special Study: Access to Care among HIV+ Latino Immigrants (2006)
Special Study: Barriers to Care Among HIV+ Youth (2006)
Houston EMA/HSDA Environmental Scan (2004)
2008-2009 HIV/AIDS Resource Directory, more commonly known as the “Blue Book”

Most reports are available online at: www.rwpc.org/Publications/publication_listing.htm.
Hardcopies and CD-Rom versions can be mailed by request.

Contact: Ryan White Planning Council Office of Support
2223 West Loop South, Suite 240
Houston, TX 77027
Phone: 713-572-3724
Fax: 713-572-3740
TTD: 713-572-2813
www.rwpc.org

The following reports are available from the Harris County Public Health and Environmental Services Ryan White Grant Administration:

FY 2008 Outcome Measures (by service category)
FY 2008 Standards of Care (by service category)
FY 2007 Chart Review Reports (Dental Care, Home Health Care, Hospice Care, Primary Care and Vision Care)
FY 2007 Client Satisfaction Report

Contact: Harris County Public Health and Environmental Services
Ryan White Grant Administration Section
2223 West Loop South, Room 417
Houston, TX 77027
Phone: 713-439-6033
Fax: 713-439-6338
www.hcphes.org/rwga/

The following reports are available from the Houston Regional HIV/AIDS Resource Group:

Regional Continuum of Care

2008-2010 Statewide Coordinated Statement of Need

2008-2009 HIV/AIDS Resource Directory, more commonly known as the “Blue Book”

Contact: Houston Regional HIV/AIDS Resource Group
500 Lovett Boulevard, Suite 100
Houston, TX 77006
Phone: 713-526-1016
Fax: 713-526-2369
www.hivresourcegroup.org

The following reports are available from the City of Houston Department of Health and Human Services:

HIV/STD Surveillance Information

Epidemiology of Sexually Transmitted Diseases

Contact: Bureau of Epidemiology
HIV/STD Surveillance
8000 N. Stadium Drive, 4th Floor
Houston, TX 77054
Phone: 713-794-9441
Fax: 713-794-9391
www.houstontx.gov/health/Epidemiology

Houston HIV/STD Prevention Needs Assessment Report, 2008

2004-2006 HIV Prevention Comprehensive Plan and 2007 Update

Contact: Bureau of HIV/STD and Viral Hepatitis Prevention
8000 N. Stadium Drive, 5th Floor
Houston, TX 77054
Phone: 713-794-9092
Fax: 713-798-0830
www.houstontx.gov/health/HIV-STD

The Houston Department of Health and Human Services main website is www.houstonhealth.org.

The following reports are available from the Texas Department of State Health Services:

2008-2010 Statewide Coordinated Statement of Need

Texas HIV/STD Surveillance information

Texas Integrated Epidemiologic Profile for HIV/AIDS Prevention & Services Planning

Contact: DSHS HIV/STD Program
1100 West 49th Street
Austin, TX 78756
Phone: 512-533-3000
Fax: 512-371-4672
www.dshs.state.tx.us/hivstd/default.shtm

The following reports are available from the HRSA-HIV/AIDS Bureau:

Outcomes Evaluation Technical Assistance Guide (2001)

Needs Assessment Self Assessment Module (2003)

Comprehensive HIV Services Planning Self-Assessment Module (2003)

Contact: HRSA-HIV/AIDS Bureau Information Center
P.O. Box 2910
Merrifield, VA 22116
Phone: 1-888-Ask-HRSA
TTY: 1-877-4TY-HRSA
Fax: 703-821-2098
E-mail: ask@hrsa.gov
www.ask.hrsa.gov



This document is available for download at www.rwpc.org.

To request a copy on CD-rom, please contact:

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