Houston Area HIV Services Ryan White Planning Council

COMPREHENSIVE PLAN REVIEW

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COMPREHENSIVE PLAN REVIEW

INTRODUCTION

Consistent with the HRSA HIV/AIDS planning process, the community is conducting a review of the Houston EMA/HSDA Comprehensive Plan. This document is intended to inform that process by providing a:

1. Listing of the current HRSA mandates and strategies regarding comprehensive plan reviews
2. Review of the current comprehensive plan that includes charts illustrating location of HRSA-mandated topics in the most recent comprehensive plan, status of the topics and location of revisions
3. Synopsis of the findings of the Needs Assessment relevant to the HRSA mandates
4. Listing of the current comprehensive plan goals
5. Synopsis of the findings of the Needs Assessment relevant to the comprehensive planning goals
6. Title I Planning Council recommendations for the next planning year.

The findings of the Needs Assessment in combination with the record of the activities and recommendations of the Comprehensive HIV Planning Committee form the basis of the following review.

SECTION 1: WHERE WE ARE NOW: WHAT IS OUR CURRENT SYSTEM OF CARE?

Topic	Included in the 2000 Comprehensive Plan	Updated in this Document	Page Number
A. Description of EMA	**Yes**	**Yes**	4
B. Epidemiological Profile	**Yes**	**Yes**	7
Current local epidemic	Yes	Yes	7
Future Trends	No	Yes	17
Response	Yes	Yes	17
C. Assessment of Need	**Yes**	**Yes**	17
HIV care needs	Yes	Yes	17
Gaps in care	Yes	Yes	18
D. Description of Continuum of Care	**Yes**	**Unchanged**	19
E. Resource Inventory	**Yes**	**Yes**	19
F. Provider Profile	**Yes**	**Yes**	20
Provider capacity	Yes	Yes	20
Provider capability	No	Yes	20
G. Barriers to care	**Yes**	**Yes**	20
Client perspective	Yes	Yes	20
Provider perspective	Yes	Yes	21
Policy issues	No	Yes	21
Infrastructure constraints	No	Yes	21

In compliance with HRSA standards and consistent with best practices in public health planning, the Houston EMA/HSDA undertook an assessment of the needs of people living with HIV/AIDS (PLWH/A) in the community. The assessment was conducted from November 2001 through April 2002 as a collaboration among the:

- Ryan White Planning Council
- Houston Local Needs Assessment Task Force (LNATF) of the
- State of Texas Assembly Group East (STAGE)
- Houston Regional HIV/AIDS Resource Group
- Harris County Hospital District
- Harris County Public Health and Environmental Services - HIV Services
- The City of Houston Prevention Community Planning Group (CPG)
- Housing Opportunities for Persons with AIDS (HOPWA).

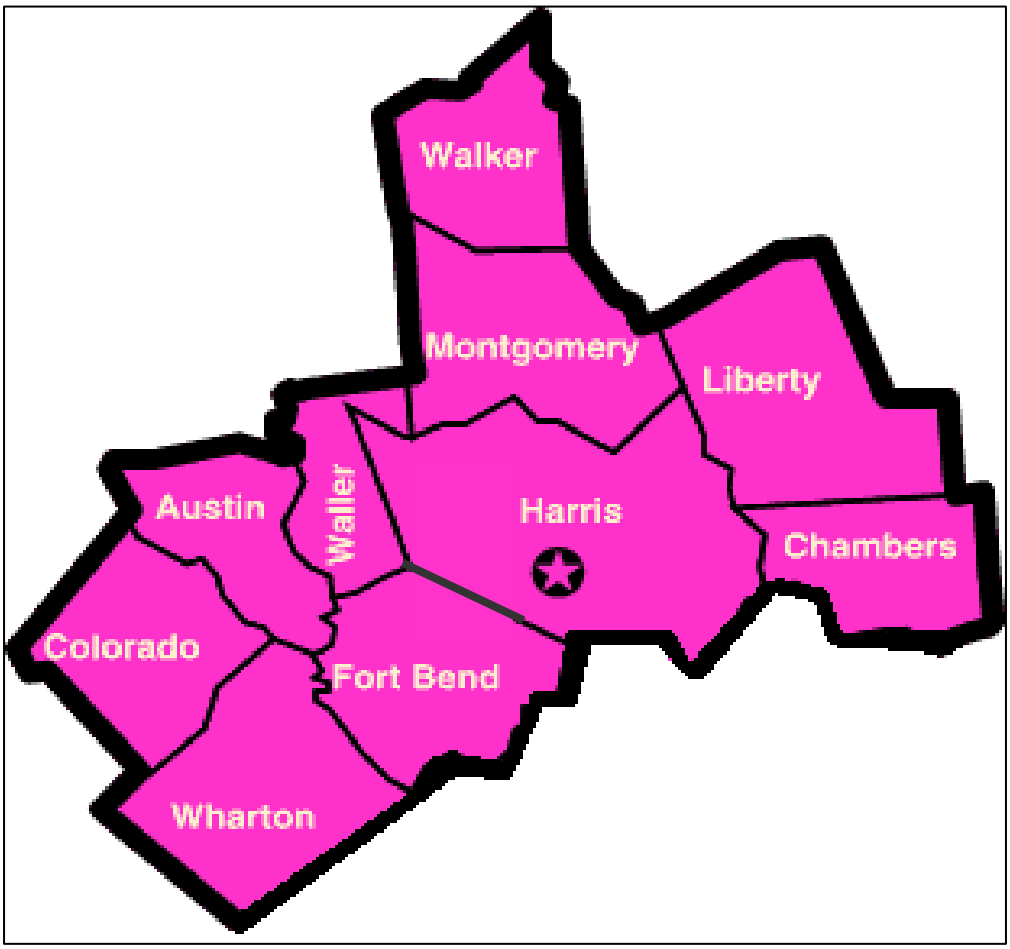
During the course of the needs assessment 640 individuals were surveyed, 15 focus groups, 20 key informant interviews and 20 street-intercept short surveys were conducted. Sections A-G, which follow, discuss the findings of the needs assessment in the context of the comprehensive plan review.

A. DESCRIPTION OF THE HOUSTON EMA/HSDA

Geographic area

As shown in the following map, Figure 1, the Houston HSDA is defined as a ten-county area that encompasses 6 (six) counties contiguous with the City of Houston plus 4 (four) additional counties (Austin, Colorado, Walker, and Wharton). The EMA is composed of six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller. The HSDA is comprised of these six plus Austin, Colorado, Walker, and Wharton Counties. The 2000 census-based population for these counties and the HSDA as a whole is 4,324,572.

Figure 1: Map of the Houston HSDA



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
TOTAL	*12,826,790*	*24,751*	*459*

The population in all of the counties is predominantly Anglo, 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 34.13 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 Anglo, 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 (%)	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 percent 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 decrease 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%*

B. EPIDEMIOLOGICAL PROFILE - CURRENT LOCAL EPIDEMIC

Cumulative Cases

Cumulative case reports show the total number of people ever reported to have an AIDS diagnosis, regardless of whether these people are still living. From the beginning of the epidemic, Texas has seen some of the highest number of reported AIDS cases, with almost 57,000 through September 2001. Tables 5 through 7 show the demographic profile of reported cumulative AIDS cases for Texas. The majority is male (88%), Anglo (53%), between 30 and 39 years old (47%), and attributed to unprotected male-to-male sex (59%).

Table 5. Cumulative Reported AIDS Cases, By Age Group, Texas – Through 9/30/01

Age group	Total
13-19	386
20-29	11,752
30-39	26,265
40-49	12,747
50+	4,856
Total	*56,006*

Table 6. Cumulative Reported AIDS Cases, By Gender And Race/Ethnicity, Texas – Through 9/30/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	1,828	27,345	29,173
African American	3,541	12,344	15,885
Hispanic	1,081	9,586	10,667
Other/Not specified	31	250	281
Total	*6,481*	*49,525*	*56,006*

Table 7. Cumulative Reported AIDS Cases, By Gender And Behavioral Risk, Texas – Through 9/30/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	32,830	32,830
Injection drug use (IDU)	2,318	5,565	7,883
MSM and IDU	0	5,131	5,131
Heterosexual contact	2,774	1,951	4,725
Other/Not specified	1,389	4,048	5,437
Total	*6,481*	*49,525*	*56,006*

Throughout the years, the Houston area typically has accounted for about one-third of AIDS cases in Texas. Through December 2001, the number of cumulative reported cases was 20,086, or 35% of the total for the State of Texas. Following the State pattern, most of these were male (87%), Anglo (51%), between 30 and 39 years old (46%), and attributed to unprotected male-to-male sex (59%). Tables 8 through 10 provide more details.

Table 8. Cumulative Reported AIDS Cases, By Gender And Age Group, Houston Area – Through 12/31/01

Age group	Female	Male	Total
13-19	85	73	158
20-29	784	3,333	4,117
(20-24)	*(281)*	*(717)*	*(998)*
(25-29)	*(503)*	*(2,616)*	*(3,119)*
30-39	1,016	8,199	9,215
40-49	506	4,226	4,732
50-59	163	1,223	1,386
60-69	54	335	389
70+	18	71	89
Total	*2,626*	*17,460*	*20,086*

Table 9. Cumulative Reported AIDS Cases, By Gender And Race/Ethnicity, Houston Area – Through 12/31/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	523	9,669	10,192
African American	1,740	5,095	6,835
Hispanic	358	2,623	2,981
Other/Not specified	5	73	78
Total	*2,626*	*17,460*	*20,086*

Table 10. Cumulative Reported AIDS Cases, By Gender And Behavioral Risk, Houston Area – Through 12/31/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	11,925	11,925
Injection drug use (IDU)	872	1,599	2,471
MSM and IDU	0	1,748	1,748
Heterosexual contact	1,375	1,055	2,430
Other/Not specified	379	1,133	1,512
Total	*2,626*	*17,460*	*20,086*

Living AIDS Cases

While a profile of cumulative cases help show the road AIDS has taken in a community, the focus of the service delivery system is on the people who are living with HIV/AIDS. According to the Texas Department of Health (TDH), through December 31, 2001, there were 24,531 people living with AIDS in Texas. Most of the people with AIDS are male (84%), Anglo (44%) or African American (33%), between the ages of 30 and 39 (48%), and attributed to unprotected male-to-male sex (51%). Tables 11 through 13 show the demographic profile of these cases.

Table 11. Living Reported AIDS Cases, By Gender And Age Group, Texas – Through 12/31/01

Age group	Female	Male	Total
13-19	111	123	234
20-29	1,137	3,891	5,028
(20-24)	(395)	(886)	(1,281)
(25-29)	(742)	(3,005)	(3,747)
30-39	1,608	10,076	11,684
40-49	765	4,969	5,734
50-59	223	1,267	1,490
60-69	54	251	305
70+	16	40	56
Total	*3,914*	*20,617*	*24,531*

Table 12. Living Reported AIDS Cases, By Gender And Race/Ethnicity, Texas – Through 12/31/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	1,001	9,701	10,702
African American	2,188	5,946	8,134
Hispanic	700	4,826	5,526
Other/Not specified	25	144	169
Total	*3,914*	*20,617*	*24,531*

Table 13. Living Reported AIDS Cases, By Gender And Behavioral Risk, Texas – Through 12/31/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	12,559	12,559
Injection drug use (IDU)	1,295	2,624	3,919
MSM and IDU	0	2,134	2,134
Heterosexual contact	1,716	1,157	2,873
Other/Not specified	903	2,143	3,046
Total	*3,914*	*20,617*	*24,531*

In the 10-county Houston area, there were more than 7,600 people reported to be living with AIDS in 2001. Again, the majority of living AIDS cases is male (81%), between 30 and 39 years old (45%), and attributed to unprotected male-to-male sex (50%). In terms of race/ethnicity, however, most living AIDS cases were among African Americans (41% *vs.* 39% for Anglos). Tables 14 through 16 provide more details.

Table 14. Living Reported AIDS Cases, By Gender And Age Group, Houston Area – Through 12/31/01

Age group	Female	Male	Total
13-19	57	39	96
20-29	443	1,139	1,582
(20-24)	(159)	(275)	(434)
(25-29)	(284)	(864)	(1,148)
30-39	584	2,882	3,466
40-49	287	1,568	1,855
50-59	88	434	522
60-69	18	76	94
70+	3	18	21
Total	*1,480*	*6,156*	*7,636*

Table 15. Living Reported AIDS Cases, By Gender And Race/Ethnicity, Houston Area – Through 12/31/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	252	2,763	3,015
African American	991	2,159	3,150
Hispanic	235	1,189	1,424
Other/Not specified	2	45	47
Total	*1,480*	*6,156*	*7,636*

Table 16. Living Reported AIDS Cases, By Gender And Behavioral Risk, Houston Area – Through 12/31/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	3,796	3,796
Injection drug use (IDU)	437	639	1,076
MSM and IDU	0	612	612
Heterosexual contact	835	601	1,436
Other/Not specified	208	508	716
Total	*1,480*	*6,156*	*7,636*

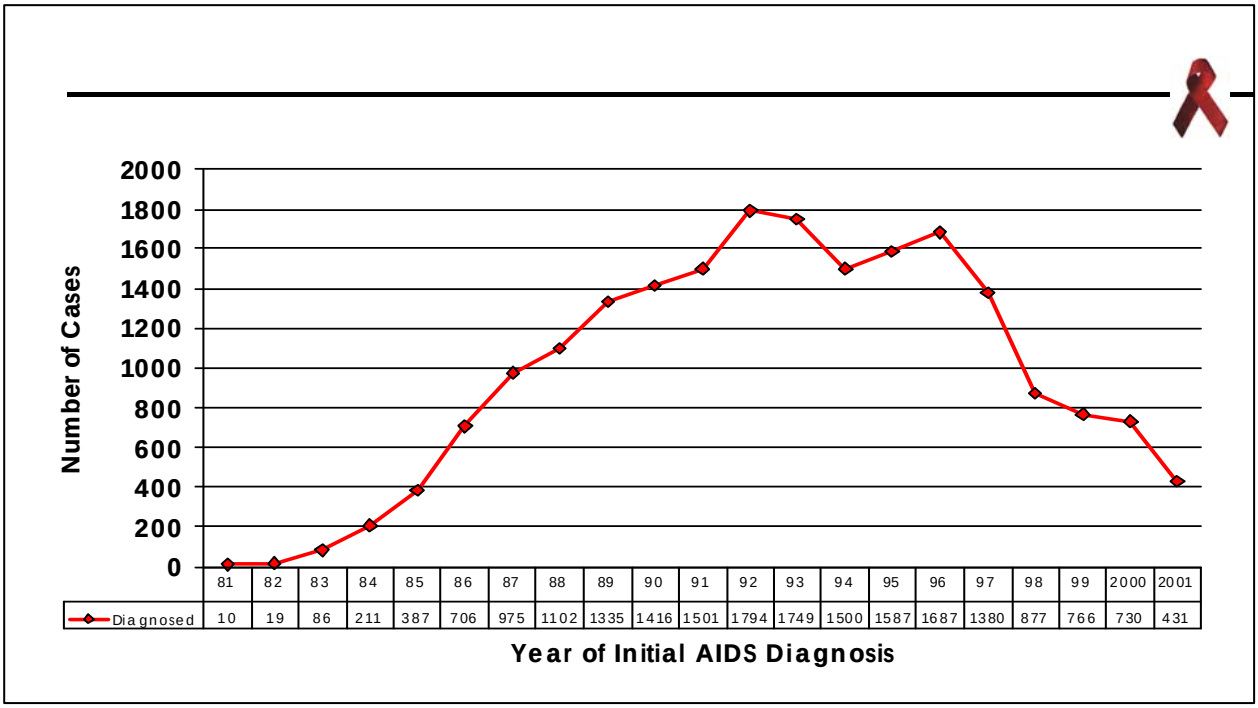
Trends in AIDS diagnoses

The numbers presented above provide an overall picture of AIDS at a particular point in time. By looking at the course of the epidemic over time, the community will get a better understanding of what to expect in the future.

In the Houston area, the number of AIDS cases diagnosed each year has dropped steadily since 1996, falling from 1,687 that year to 431 in 2001. While that is good news overall, communities of color have seen steady increases in their proportion of the total number of cases diagnosed each year. In 1997, African Americans surpassed Anglos for the first time, accounting for 47% of cases; in 2001, that percentage increased to 54%. The Hispanic population has seen less dramatic, but still steady, increases. In 2001, they too surpassed the Anglo community, accounting for 23% of the AIDS cases diagnosed (vs. 22% for Anglos). In terms of behavioral risk, the proportion of AIDS diagnoses attributed to unprotected heterosexual contact has increased, accounting for 27% of the total in 2001. By contrast, the proportion attributed to unprotected male-to-male sex has steadily decreased from a high of 75% at the beginning of the epidemic to a low of 33% in 2001. It also is worthy of note that the proportion of cases with an unknown attributable risk behavior has increased steadily to 27% of cases diagnosed in 2001. These are cases for which not enough information regarding sexual partners is known to fit the stringent CDC definition of heterosexual contact. Based on data gathered by the local health department, however, it is thought that many of these cases among females actually can be attributed to unprotected heterosexual contact. The following three figures show the percentage of AIDS cases diagnosed each year through 2001 and the distribution for age, race/ethnicity, and behavior risk.

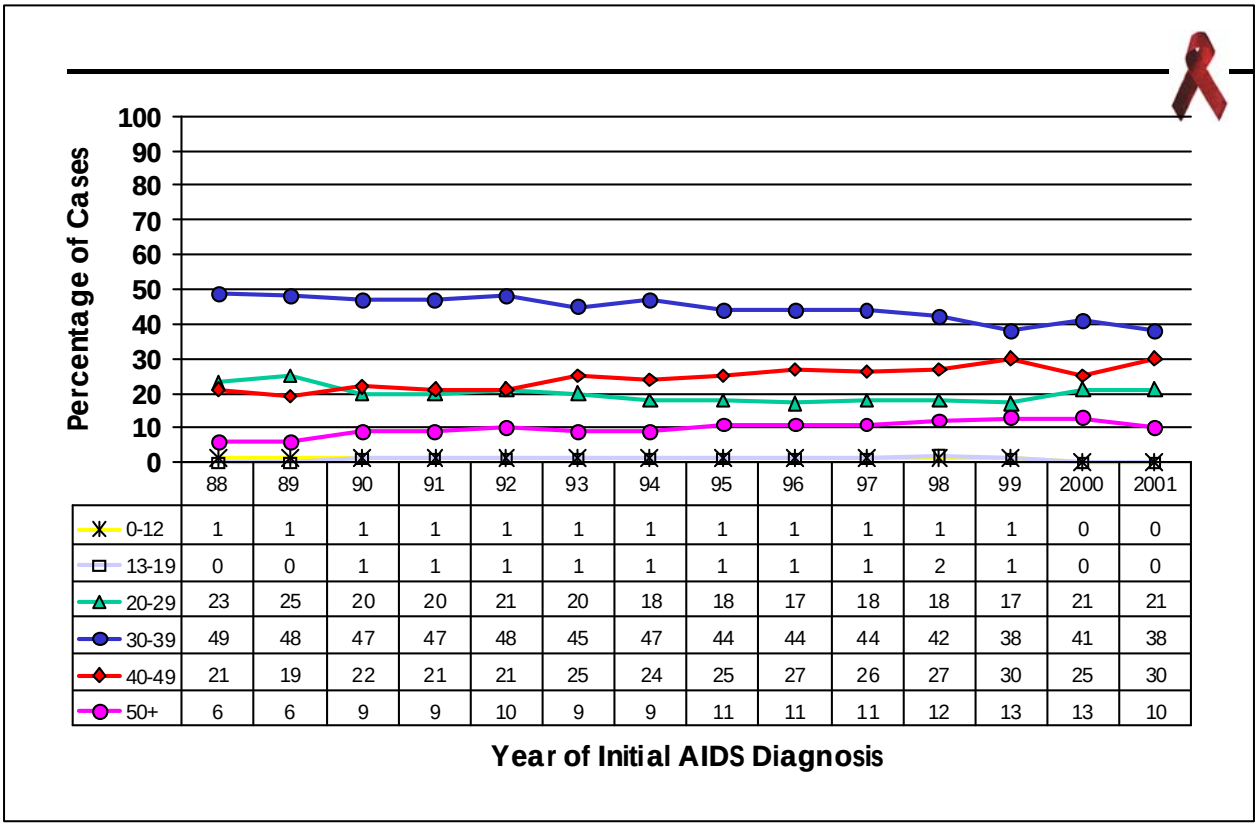
By contrast, cases attributed to unprotected male-to-male sex have steadily decreased from a high of 75% at the beginning of the epidemic to a low of 33% in 2001. It also is worthy of note that the number of cases with an unknown attributable risk behavior has increased steadily to 27% of cases diagnosed in 2001. These are cases for which not enough information regarding sexual partners is known to fit the stringent CDC definition of heterosexual contact. Based on data gathered by the local health department, however, it is thought that many of these cases among females actually can be attributed to unprotected heterosexual contact. The following three figures show the number of AIDS cases diagnosed each year through 2001 and the distribution for age, race/ethnicity, and behavior risk.

Figure 2: AIDS Cases By Year of Diagnosis, Houston area - Through December 31, 2001



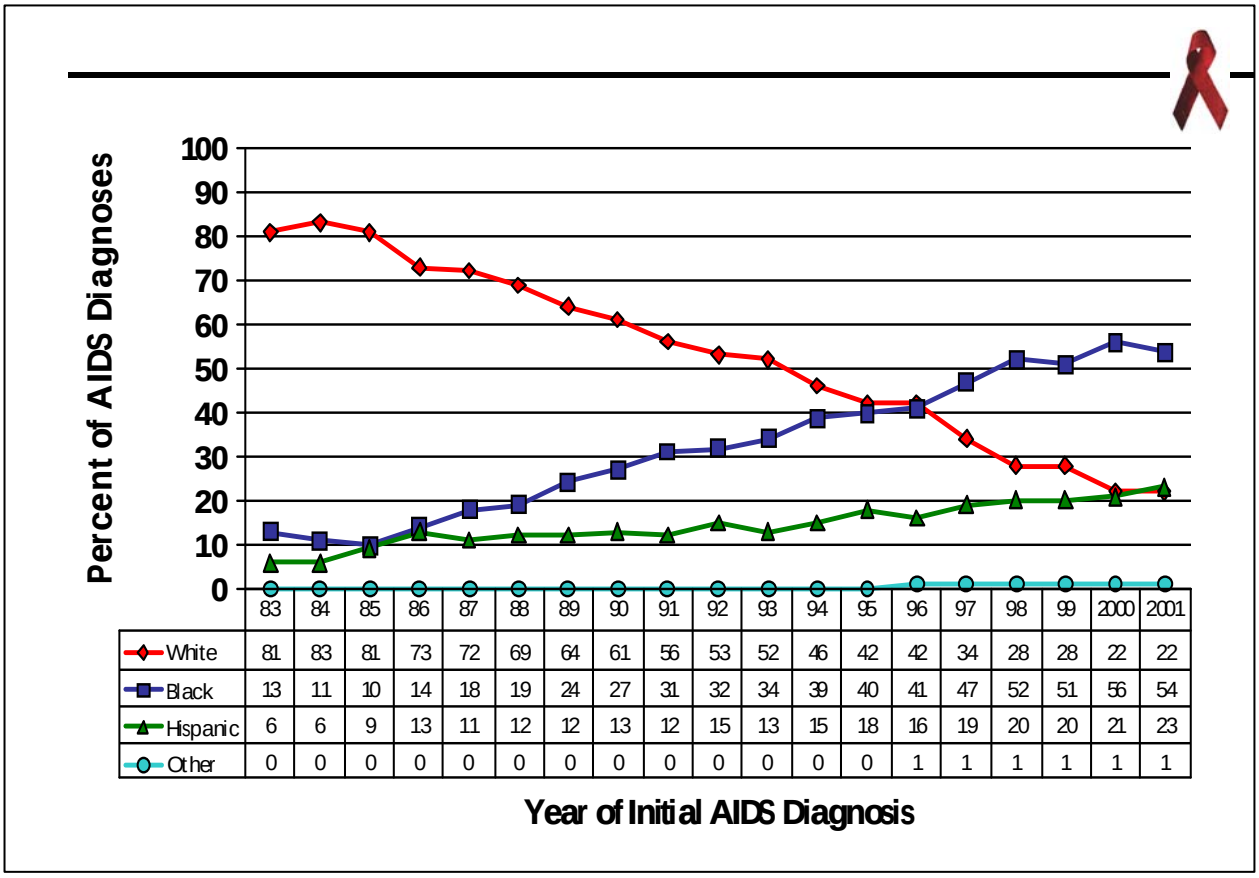
	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000	2001
Diagnosed	10	19	86	211	387	706	975	1102	1335	1416	1501	1794	1749	1500	1587	1687	1380	877	766	730	431

Figure 3: Percent of AIDS Diagnoses By Age Group, Houston area - Through December 31, 2001



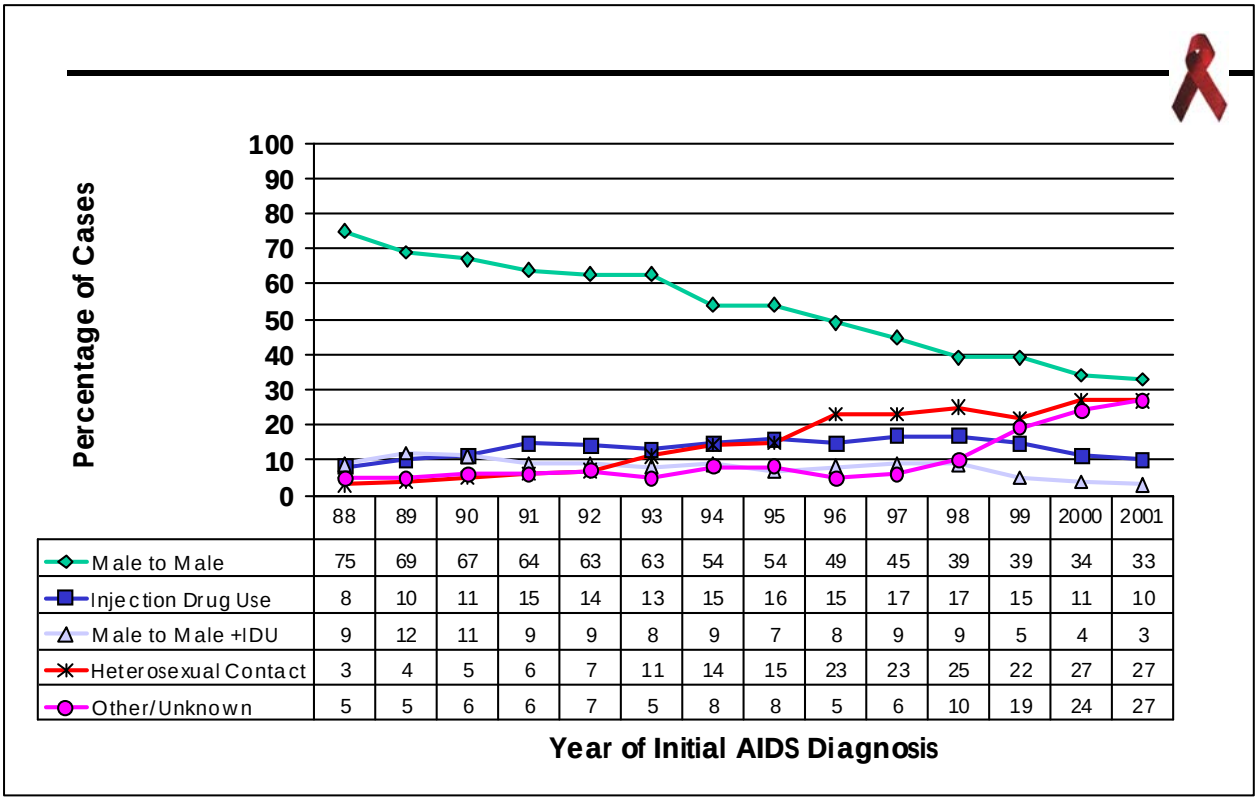
	88	89	90	91	92	93	94	95	96	97	98	99	2000	2001
0-12	1	1	1	1	1	1	1	1	1	1	1	1	0	0
13-19	0	0	1	1	1	1	1	1	1	1	2	1	0	0
20-29	23	25	20	20	21	20	18	18	17	18	18	17	21	21
30-39	49	48	47	47	48	45	47	44	44	44	42	38	41	38
40-49	21	19	22	21	21	25	24	25	27	26	27	30	25	30
50+	6	6	9	9	10	9	9	11	11	11	12	13	13	10

Figure 4: Percent of AIDS Diagnoses By Race/Ethnicity and Year of Diagnosis, Houston area - Through December 31, 2001



	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000	2001
White	81	83	81	73	72	69	64	61	56	53	52	46	42	42	34	28	28	22	22
Black	13	11	10	14	18	19	24	27	31	32	34	39	40	41	47	52	51	56	54
Hispanic	6	6	9	13	11	12	12	13	12	15	13	15	18	16	19	20	20	21	23
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1	1

Figure 5: Percent of AIDS Diagnoses By Behavioral Risk Houston area - Through December 31, 2001



	88	89	90	91	92	93	94	95	96	97	98	99	2000	2001
Male to Male	75	69	67	64	63	63	54	54	49	45	39	39	34	33
Injection Drug Use	8	10	11	15	14	13	15	16	15	17	17	15	11	10
Male to Male +IDU	9	12	11	9	9	8	9	7	8	9	9	5	4	3
Heterosexual Contact	3	4	5	6	7	11	14	15	23	23	25	22	27	27
Other/Unknown	5	5	6	6	7	5	8	8	5	6	10	19	24	27

Reported HIV Cases

As stated earlier, the number of AIDS cases does not tell the whole story. Looking at the number of reported HIV cases gives us a better indication of more recent trends in infection. Remember, these include only the HIV positive tests from confidential testing sites after January 1, 1999 and those with detectable viral load assays after January 2, 2000. They do not necessarily capture those people who tested positive before that date, those who tested positive at anonymous sites, or those who never got tested anywhere, anytime. Because HIV reporting is a relatively new process and the numbers are very similar, we will look at living reported infections and not cumulative infections.

According to TDH, through December 31, 2001, there were over 10,500 reported cases of people living with HIV infection. The demographics of HIV infections look a little different than those of people living with AIDS. Most people living with HIV infection are male (71%). About 39% are between the ages of 30 and 39 and 31% are between the ages of 20 and 29. Just over one third of cases are attributed to unprotected male-to-male sex (36%). Cases attributed to unprotected heterosexual contact and unsafe injection drug use each account for about 16% of the total cases and cases that cannot be attributed to one of the specified behaviors account for 25% of the total. More African Americans (43%) are living with HIV in Texas than any other race/ethnicity. Anglos are next with 36% of the cases, followed by Hispanics with about 20%. Tables 17 through 19 show more details.

Table 17. Living Reported HIV Infections, By Gender And Age Group, Texas – Through 12/31/01

Age group	Female	Male	Total
13-19	341	140	481
20-29	1,142	2,136	3,278
(20-24)	*(581)*	*(802)*	*(1,383)*
(25-29)	*(561)*	*(1,334)*	*(1,895)*
30-39	935	3,184	4,119
40-49	457	1,522	1,979
50-59	136	387	523
60-69	26	78	104
70+	8	15	23
Total	*3,045*	*7,462*	*10,507*

Table 18. Living Reported HIV Infections, By Gender And Race/Ethnicity, Texas – Through 12/31/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	686	3,074	3,760
African American	1,836	2,714	4,550
Hispanic	503	1,583	2,086
Other/Not specified	20	91	111
Total	*3,045*	*7,462*	*10,507*

Table 19. Living Reported HIV Infections, By Gender And Behavioral Risk, Texas – Through 12/31/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	3,778	3,778
Injection drug use (IDU)	695	999	1,694
MSM and IDU	0	691	691
Heterosexual contact	1,233	482	1,715
Other/Not specified	1,117	1,512	2,629
Total	*3,045*	*7,462*	*10,507*

Through December 2001, TDH reports just over 3,400 people living with HIV in the Houston area. The profile of people living with HIV differs from that of people living with AIDS. While males still account for the majority of people living with HIV, the difference between the genders is far less dramatic: 64% for males *vs.* 36% for females. In terms of age, there is an even split between the 20 to 29 and the 30 to 39 groups, each accounting for about 36%. African Americans account for 58% of people living with HIV, more than twice the percentage in the Anglo community (27%). Finally, the number of cases attributed to unprotected sex is almost the same for heterosexual sex as it is for male-to-male sex, at 27% and 33%, respectively. Tables 20 through 22 show more details.

Table 20. Living Reported HIV Infections, By Gender And Age Group, Houston Area – Through 12/31/01

Age group	Female	Male	Total
13-19	124	31	155
20-29	544	702	1,246
(20-24)	(319)	(296)	(615)
(25-29)	(225)	(406)	(631)
30-39	341	910	1,251
40-49	167	409	576
50-59	49	104	153
60-69	6	20	26
70+	2	5	7
Total	*1,233*	*2,181*	*3,414*

Table 21. Living Reported HIV Infections, By Gender And Race/Ethnicity, Houston Area – Through 12/31/01

Race/ethnicity	Female	Male	Total
Anglo Non-Hispanic	164	758	922
African American	929	1,055	1,984
Hispanic	135	355	490
Other/Not specified	5	13	18
Total	*1,233*	*2,181*	*3,414*

Table 22. Living Reported HIV Infections, By Gender And Behavioral Risk, Houston Area – Through 12/31/01

Behavioral risk	Female	Male	Total
Male-to-male sex (MSM)	0	1,139	1,139
Injection drug use (IDU)	224	228	452
MSM and IDU	0	161	161
Heterosexual contact	705	228	933
Other/Not specified	304	425	729
Total	*1,233*	*2,181*	*3,414*

Pediatric HIV/AIDS

One of the bright spots in the fight against HIV is the success in reducing the number of AIDS cases among children aged 0 to 12 years. Table 23 presents the number of children living with HIV/AIDS by race/ethnicity and gender.

Table 23. Reported Living Pediatric AIDS Cases And HIV Infections, Houston Area – Through 12/31/01

Race/ethnicity	Living with AIDS			Living with HIV		
	Female	Male	Total	Female	Male	Total
Anglo	3	3	6	6	14	20
African American	22	19	41	51	51	102
Hispanic	12	10	22	10	9	19
Other/Not specified	0	0	0	4	4	8
Total	*37*	*32*	*69*	*71*	*78*	*149*

Estimates of HIV prevalence

When an individual becomes ill with full-blown AIDS, typically some contact is made with the medical care profession, and a case report to the HIV/AIDS Surveillance Program of the local health department results. AIDS incidence (number of *new* cases) and prevalence (number of cases at a particular point in time) data are therefore reasonably complete and portray an accurate picture of the AIDS epidemic in an area. With the advent of HAART therapy, a dramatic decrease in the number of AIDS cases has resulted. This good news story means that monitoring only AIDS cases, while very accurate, does not describe the full impact of HIV infection in a population.

Even reporting of HIV infection can only give one part of the HIV epidemic picture. HIV infection reporting in the state of Texas captures only those with a diagnostic test for HIV since January 1, 1999 and those with a detectable viral load since January 1, 2000. Since HIV infection itself does not necessarily result in any contact with a medial care provider, the data collected by the local health department most accurately reflects the testing behaviors of the community. In other words the HIV data reflects those who decide to test for some reason, such as they:

- Consider themselves at risk for HIV.
- Participate in an outreach/testing event.
- Have some illness that triggers testing.
- Have some other condition or enter a program where testing is routine, such as pregnancy, military recruitment, Job Corps entrance.

What this means is that the reported HIV data, even combined with the reported AIDS data, cannot fully describe the impact of the epidemic in an area. To fully describe what is occurring in any given community, one must use scientifically driven estimates, which include the following components:

The number of people who:

- Have newly diagnosed AIDS?
- Are living with AIDS?
- Have been reported with HIV infection?

What proportion of the people:

- Who know they are HIV infected have been reported under the new guidelines?
- With HIV infection have not tested and do not know their status?

Many sources of data can be used to derive estimates of HIV prevalence (all those with HIV disease in an area) including:

- Blinded seroprevalence surveys,
- Survey of Child Bearing Women,
- Experience of states with long term HIV infection reporting,
- Surveys of testing behavior,
- Review of medical records of newly reported HIV infected individuals to determine first HIV positive test date (i.e. how long they have been positive),
- Information about individuals with HIV infection that was not reportable under the guidelines.

Using all these types of data, several different models and estimates have been made for the total impact of HIV disease in the Houston area. Estimates range from 14,000 to 25,000, with a general consensus that the most acceptable estimate of total HIV infected individuals in the area is between 18,000 and 22,000.

Impact of HIV/AIDS by Geographic Area

Because we are talking about a 10-county area, it is important to highlight some geographic differences in the HIV epidemic. Foremost, with Houston at its center, Harris County accounts for the overwhelming majority of people living with HIV/AIDS. Of the 11,268 cases reported through December 2001, 95% were living in Harris County. But do not let the relatively small numbers in the other counties lull you into thinking that HIV does not exist outside the urban areas. Table 24 shows the number of reported living cases in the rest of the area. Please note that in order to maintain confidentiality, some counties have been combined.

Table 24. Living Reported HIV Infections And AIDS Cases, By County – Through 12/31/01

County	AIDS cases	HIV infections	Total
Harris	7,296	3,375	10,671
Fort Bend	183	77	260
Montgomery	111	66	177
Chambers, Liberty, Walker	64	23	87
Austin, Colorado, Waller, and Wharton	51	22	73
Total	*7,705*	*3,563*	*11,268*

B. EPIDEMIOLOGICAL PROFILE – FUTURE TRENDS

Because the state of Texas has only required reporting of HIV infection since 1999, the community has just now begun amassing sufficient data to undertake the development of appropriate algorithms for predicting trends in HIV infection in aggregate and within populations most at risk.

B. EPIDEMIOLOGICAL PROFILE – RESPONSE

See Section 2 of this document (pages 22 – 36).

C. ASSESSMENT OF NEED – HIV CARE NEEDS

The 2002 Needs assessment identified and ranked specific HIV care needs. Table 25 provides a summary of these findings that are the result of the client survey. The percent represents the thoughts of the respondents who utilize or could utilize these services, with the ranking of "1" indicating those most needed.

Table 25. HIV Care Need and Need Ranking

SERVICE	PERCENT	RANK
Support Services*	74.9	1
Ambulatory/Outpatient Medical Care**	69.6	2
Dental Care	58.1	3
Emergency Medical Services	52.6	4
Drug Reimbursement Program	50.1	5
Social Case Management	46.8	6
Mental Health Therapy/Counseling	45.4	7
Nutritional Services	42.5	8
Inpatient Services	36.2	9
Rehabilitation***	27.2	10
Patient Education Services	26.7	11
Prevention Education	22.7	12
Substance Abuse Treatment/Counseling	22.2	13
Home Health Care	19.9	14
Research	19.4	15
Long Term Care	19.3	16
Hospice	5.9	17

* Support Services include: Adult Day Care, Buddy/Companion Services, Child Care, Client Advocacy/Legal Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Health Insurance Payments, Housing Assistance, Housing, Outreach Services, Referral, Transportation, and Translation.

**Ambulatory/Outpatient Medical Care includes: Primary Medical Care, Vision Care, Obstetrics & Gynecology, Pediatric Care, Specialty Care and Infectious Diseases.

***Rehabilitation includes: Physical Therapy, Speech Pathology, Low-Vision Training Services and Early Intervention Services.

In summary, survey respondents feel their greatest needs relate directly to medical care and the services such as case management which link them too medical care and other services. The fact that Home Health Care, Long Term Care, and Hospice are ranked lower may be indicative of the changing nature of HIV/AIDS related to better treatment options. However, interpreting this data is subject to limitation of the design of the study. For example, the survey sample was primarily composed of ambulatory, relatively healthy respondents. Clients that were homebound were underreported in the Needs Assessment sample. A second challenge was the misinterpretation by survey respondents of such terms as long-term care, rehabilitation and research.

C. ASSESSMENT OF NEED – GAPS IN CARE

The Needs Assessment client survey also identified existing gaps in services and ranked the results. Table 26 provides a summary of these results that are ranked by those services perceived to have the largest gap. A "gap" is defined as those who responded "yes" to need and "no" to the statement on the survey "Check the box that indicates if you believe that this service is available to you."

Table 26. Service Ranked by Perceived Gap

SERVICE	PERCENT	RANK
Support Services	42.7	1
Ambulatory/Outpatient Medical Care	31.9	2
Emergency Medical Services	24.9	3
Inpatient Services	16.4	4
Rehabilitation	11.6	5
Mental Health Therapy/Counseling	10.2	6
Home Health Care	9.7	7
Long Term Care	9.2	8
Patient Education Services	8.9	9
Prevention Education	8.3	10
Nutritional Services	6.2	11
Drug Reimbursement Program	5.9	12
Research	4.7	13
Dental Care	3.4	14
Social Case Management	3.3	15
Substance Abuse Treatment/Counseling	2.4	16
Hospice	2.1	17

The high percentage ranking of Support Services and Ambulatory/Outpatient Medical Care can be expected due to the high use and need for these services. Also, the survey design for this question was such that this outcome could be anticipated due to the fact that many services were included in these categories.

D. DESCRIPTION OF THE CURRENT CONTINUUM OF CARE

The 1999 Comprehensive Plan identifies five "tracks" for the Houston area continuum of care. These are as follows:

1. Public Advocacy to the General Public
2. Outreach to At-Risk Populations
3. Prevention of HIV Infection
4. Early Treatment of HIV Infection
5. AIDS Treatment to PLWA

Comprehensive Plan Goals A, B, G, and F specifically impact the continuum of care, while Goal C works toward improving services offered within that continuum. An update of progress toward achieving these goals is provided in Section 3 of this document. This concept is also further described in Section 2 of this document.

E. RESOURCE INVENTORY

The Planning Council maintains a listing of all ASOs and non-ASOs providing services to PLWH/A in the Houston area. Published as a resource guide under the name of the “Blue Book”, this guide is updated annually and will soon be available on-line. A copy of this document is included.

F. PROFILE OF PROVIDER - CAPACITY AND CAPABILITY

The needs assessment identified a gap in information on provider capacity and capability. As a result of this, the Planning Council has begun a two-pronged approach to closing this gap. This process includes:

1. Surveying ASO's about key service volumes, staffing, and funding.
2. Identifying benchmarks for similar services, specifically related to volume and staffing levels.

This process will be completed this year, and the results may be used in the future as one aspect of measurement related to service effectiveness.

G. BARRIERS TO CARE – CLIENT PERSPECTIVE

The Needs Assessment evaluated service accessibility based upon client perception. Table 27 lists each service by percentage/rank of those who reported difficulty accessing needed care.

Table 27. Services Ranked by Difficulty of Access

SERVICE	PERCENT	RANK
Support Services*	33.7	1
Ambulatory/Outpatient Medical Care**	18.4	2
Emergency Medical Services	12.3	3
Rehabilitation***	11.3	4
Long Term Care	10.4	5
Inpatient Services	9.4	6
Social Case Management	9.3	7
Patient Education Services	9.2	8
Home Health Care	8.4	9
Mental Health Therapy/Counseling	8.2	10
Research	8	11
Prevention Education	7.9	12
Drug Reimbursement Program	7.6	13
Hospice	7.2	14
Dental Care	6.8	15
Substance Abuse Treatment/Counseling	5.8	16
Nutritional Services	5.7	17

* Support Services include: Adult Day Care, Buddy/Companion Services, Child Care, Client Advocacy/Legal Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Health Insurance Payments, Housing Assistance, Housing, Outreach Services, Referral, Transportation, and Translation.

**Ambulatory/Outpatient Medical Care includes: Primary Medical Care, Vision Care, Obstetrics & Gynecology, Pediatric Care, Specialty Care and Infectious Diseases.

***Rehabilitation includes: Physical Therapy, Speech Pathology, Low-Vision Training Services and Early Intervention Services.

Table 28 identifies questions from the survey that are the top 12 ranked by the percentage responding that it is a barrier to accessing services. A barrier is defined as those who responded "hard to get" in response to the survey question "Check the box that describes how easy it was for you to get the service."

Table 28. **Barriers to Accessing Services**

QUESTION	PERCENT
I did not know that the treatment/service was available	33.8
There was too much paperwork and/or red tape	28.2
I did not know the location of the organization	27.3
I could not find my way through the system	25.7
I could not qualify for services because of rules and regulations	25
I did not know where to go or who to ask for help	24.8
I had to wait too long to get an appointment or to see someone	24.4
The organization providing the service made me feel like a number	24.1
I could not get referrals for the service I needed	22.5
I did not have insurance	21.3
I was too upset to think about treatment	20.3
Funding was not available to offer the service	20.1

Additional frequent written comments focus on having too much income to qualify for the service and having transportation barriers.

G. BARRIERS TO CARE – PROVIDER PERSPECTIVE

See chapter entitled “Provider Profile” in the 2002 Houston HIV/AIDS Needs Assessment.

G. BARRIERS TO CARE – POLICY ISSUES

See chapter entitled “Themes and Recommendations” in the 2002 Houston HIV/AIDS Needs Assessment.

G. BARRIERS TO CARE – INFRASTRUCTURE CONSTRAINTS

See chapter entitled “Themes and Recommendations” in the 2002 Houston HIV/AIDS Needs Assessment.

SECTION 2: WHERE DO WE NEED TO GO: WHAT SYSTEM OF CARE DO WE WANT?

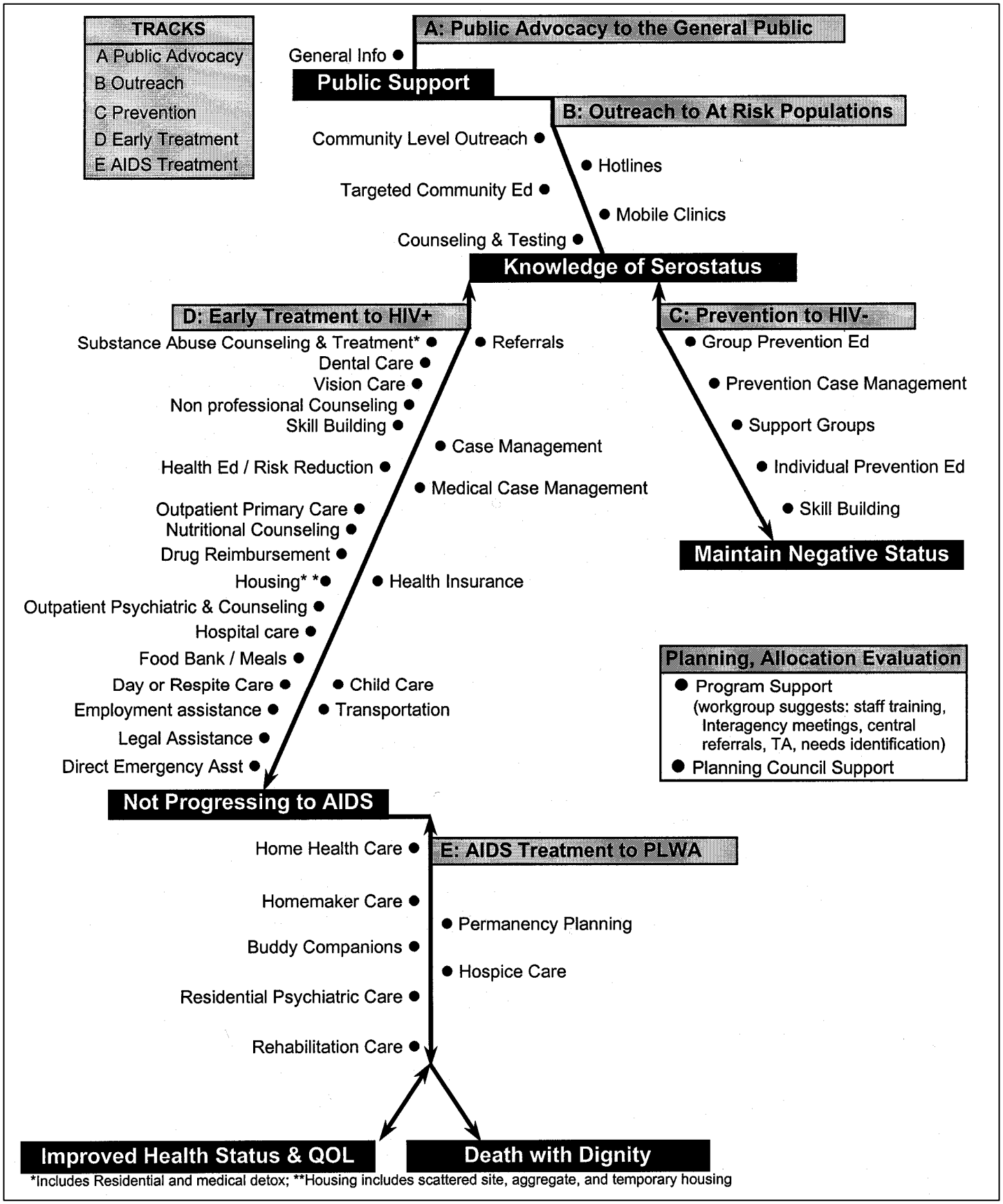
Topic	INCLUDED IN THE 2000 COMPREHENSIVE PLAN	UPDATED IN THIS DOCUMENT
Shared Vision	Yes	Unchanged
Shared Values	Yes	Unchanged

A Continuum of Care model was developed as an integral part of this Comprehensive Plan. Since it's development, it has been used as a guide to inform decisions related to implementation. This model is summarized below.

The Houston area Continuum of Care is conceptualized as a “rail system” that identifies and tracks the HIV services deemed necessary to those who are living within the Houston area. This rail system concept will allow people living in the area to access the system depending on their general knowledge of the virus, including how it is transmitted, their serostatus, their health and their individual desire to stay within the system. The 5 tracks of the continuum of care are:

- Public Advocacy to the General Public
    - Includes general HIV health and prevention messages and is intended for the general population. The goal of this track is to build public support for HIV prevention and care services.
- Outreach to At-risk Populations
    - Includes mobile clinics, counseling and testing, community outreach and hotlines and is intended for those populations who have been identified as at-risk. The goal of this track is that people are informed of their serostatus.
- Prevention of HIV Infection
    - Includes audience-specific prevention messages as well as support groups and individual prevention counseling and is intended to reach those who chose to test for HIV and then discover they are HIV-negative. The goal of this track is continued prevention of HIV infection.
- Early Treatment of HIV Infection
    - Outlines an enormous array of services including such services as substance abuse treatment and case management and is intended to reach those who test positive for HIV. The goal of this track is that people with HIV not to progress to AIDS.
- AIDS Treatment to PLWH/A
    - Includes home health care, hospice care and rehabilitation and is intended for those individuals who receive AIDS diagnosis. The goal of this track is that people with AIDS improve health status and quality of life.

The following chart illustrates the components of each track and the relationship among each.



*Includes Residential and medical detox; **Housing includes scattered site, aggregate, and temporary housing

SECTION 3: HOW WILL WE GET THERE: WHAT STEPS CAN WE TAKE TO DEVELOP THIS IDEAL SYSTEM? WHAT STRATEGIES ARE NEEDED TO ASSURE ACCESS TO THE SYSTEM?

Topic	INCLUDED IN THE 2000 COMPREHENSIVE PLAN	UPDATED IN THIS DOCUMENT
Goals, objectives and activities	Yes	Yes
Short Term annual goals and objectives for care and for treatment	Yes	Yes
Measurable objectives	Yes	Yes

The following are the goals developed for the Comprehensive Plan, along with an update on progress toward achieving these goals. Progress is monitored by the Comprehensive HIV Planning Committee, a standing committee of the Ryan White Planning Council and the Joint Comprehensive Planning Committee, a coalition of local planning bodies. Progress is described under Goal B below.

Comprehensive Plan Goal A

> By February 28, 2005, 100% of the clients who participate in the HIV services system in the Houston area will more easily understand the system and how to navigate through it, will experience a minimum of repetition and complication in the intake and eligibility process, and will be linked to all needed services as efficiently as possible.

Progress

The 1999 Needs Assessment found that clients frequently reported being deterred from receiving services by service delivery systems inefficiencies, characterized as “red tape.” In neither the survey nor in the focus groups of the 2002 Needs Assessment were these issues characterized as significant a barrier as in the previous study. Some exceptions were the “block” scheduling policy of one provider and the policies of some Title I providers requiring clients to re-establish eligibility for services each time a client is referred to a provider for the first time.

The implementation of the Centralized Patient Care Data Management System (CPCDMS) has streamlined the intake and eligibility process and facilitated linkages to needed services. Once a client has been registered in the CPCDMS by a case management, primary care or outreach provider, he or she is eligible for all Title I services (and in many cases services provided by other funding sources). An annual eligibility update ensures that clients will have contact with a case manager or primary care provider at least once a year.

Although remarkable progress has been achieved, several populations still struggle for access to care. Immigrant/refugee groups, many of whom are monolingual, non-

English speaking, face often daunting burdens from language and cultural barriers to care. Those recently released from incarceration are frequently unable to acquire medications beyond their transition dose, because they have not secured housing or transportation.

Comprehensive Plan Goal B

> By February 28, 2005, services for clients will be improved through increased cooperation and coordination of service providers and improved administration functions.

Progress

There has been significant progress toward achieving this goal. In 2000 the Joint Comprehensive Planning Committee (JCPC) was formed to encourage better coordination and communication between Ryan White planning bodies in the region. This group has been charged with the task of implementing the goals stated in the comprehensive plan and monitoring progress. The group meets quarterly. Results of improved coordination can be seen in the results of the 2002 Needs Assessment. Both client and provider surveys and focus groups indicated minimal areas where coordination of service was a problem. Two areas identified were:

1. Sharing of client information between agencies. Clients feel they are asked for the same information too often.
2. Provider networking among those serving immigrant populations.

Many agencies also reported collaborations with other ASOs or non-ASOs. For example, of the 51 agencies responding to the provider survey, 22% reported collaborations with churches and 18% with civic organizations.

Regarding the improvement of administrative functions, the Planning Council has performed service effectiveness studies including the Service Effectiveness Evaluation of Ryan White Title I Primary Care Services In Harris County completed in 2000. Results of these studies are given to service providers for their use in improving administration and service provision. The findings of the studies are also reflected in the themes and recommendations of the Needs Assessment and informed the “How to Best Meet the Need” process as well as the Priority and Allocations Committee and others.

Case management services for PLWH/A are coordinated through the Houston Area HIV Case Management System (HIV/CMS) a decentralized system comprised of fifteen agencies that represent six funding streams and include community-based organizations (CBOs), minority CBOs, private clinics, public clinics and counseling and testing sites. HIV/CMS agencies are required to participate in several activities to ensure coordination of services. These include monthly supervisor meetings, bi-monthly case manager meetings, periodic mandatory trainings and use of the CPCDMS, which was designed to support a case management model of care.

Comprehensive Plan Goal C

By February 28, 2005, the quality of care for PLWH/A in the Houston area will be improved by clear standards of operation.

Progress

Several activities intended to ensure quality of care are carried out for Title I services. Current initiatives include:

1. Standards of care are in place for all Title I funded programs. The standards are reviewed and approved each year by RWPC members, consumers and service providers and monitored on an annual basis. These guidelines establish minimum standards for staff training, client rights, program accessibility, timeliness of services, documentation and supervision.
2. Outcomes evaluation is performed for all Title I funded programs. The outcome measures are reviewed and approved each year by RWPC members, consumers and service providers. Categories of outcomes include health, quality of life, knowledge, attitudes and practices (KAP) and cost-effectiveness measures. Analysis from outcomes data is provided to the Council and providers on a quarterly basis.
3. Ongoing clinical chart review activities are underway for Title I direct medical services to ensure that services are adherent to Public Health Service guidelines or other established industry standards.

Comprehensive Plan Goal D

By February 28, 2005, all HIV care, prevention and research will be fully funded, including new and innovative services.

Progress

The following itemizes progress to date toward achieving this goal:

1. Procedures are in place to keep the Planning Council and agencies updated on legislative/appropriations processes.
2. Coordination of providers and consumers in national and statewide advocacy efforts.
3. An Ad Hoc committee of the Planning Council has been established to address issues related to funding shortages for the ADAP program.
4. The Ryan White Planning Council has a standing committee entitled the Advances in Medical Treatment and Medications Committee. Membership is made up of medical personnel and PLWH/A whose primary role is to provide the Council with medical updates, make medically-related recommendations to the "How To Best Meet the Need" process, and organize presentations to the community at large on issues such as Depression and HIV, Side Effect Management, HIV and Substance Abuse, and more.

Results of the 2002 Needs Assessment are also being utilized to reallocate resources to services which demonstrate increased demand and to create new services not required in the past.

Comprehensive Plan Goal E

By February 28, 2005, reduce transmission of HIV by 25%.

Progress

The State of Texas began collecting data on HIV infection in 1999. Due to this, there is inadequate data to trend on a local level. Also, any trends which may show increases may be suspect due to improvements in reporting and testing. The Planning Council will be addressing this issue in 2002 with the development of trended local data and appropriate measurement algorithms.

Current epidemiological data gathered for the Needs Assessment does provide information demonstrating a change in populations being impacted by HIV/AIDS. This information has influenced the direction of prevention and testing services toward these changing demographics. Five population-focused special studies were performed for the 2002 Needs Assessment which address special needs for prevention and testing.

The City of Houston Department of Health and Human Services will be evaluating this goal in 2002 with the possibility of revision. The City of Houston will also be targeting faith communities (particularly African-American churches), and has completed a needs assessment among African-American populations from which prevention strategies will be developed.

Comprehensive Plan Goal F

By February 28, 2005, increase the number of people who are receiving early and ongoing medical care for HIV/AIDS, in an attempt to close the gap between those testing positive or previously known to be positive, and those in medical care.

Progress

The 2002 Needs Assessment included a special study of Out-of-Care (OOC) individuals living with HIV. This study identified specific populations most identified with OOC individuals; African-American MSM, Youth 13-24, Incarcerated and Recently Released Individuals, and Females (Women of Child Bering Age, 15-45). Among the recommendations of this Needs Assessment is further study of the OOC population and discussion of policies related to OOC and Never-in-Care. As a result, one action that the Planning Council took was to allocate an additional $88,000 for Early Intervention Services specifically targeting youth. The Planning Council and service providers will be further addressing these issues based upon the outcome of the Needs Assessment and follow-up studies.

Several Title I programs and activities specifically target newly diagnosed and OOC PLWH, with the goal of linking them with medical care. These include:

1. Outreach services are targeted to African Americans, rural populations, homeless PLWH and PLWH who are recently released from incarceration. In addition, an outreach team is co-located at City of Houston counseling and testing facilities.
2. Primary medical care and case management providers are required to have a certain number of collaborative agreements with facilities that are considered to be Points of Entry into the continuum of care, such as counseling and testing sites, substance abuse treatment facilities, jails and emergency rooms. These agreements stipulate the number of clients to be referred to the primary care or case management provider each year.
3. FY 2003 will see the introduction of Early Intervention Services, a new Title I service category that will target youth. The goal is to bring newly diagnosed youth into the continuum of care, providing age-appropriate assistance in accessing primary care and navigating the system of care

Comprehensive Plan Goal G

> By February 28, 2005, people with HIV/AIDS who are in the Houston area system of care will have an improved understanding of and access to all available therapeutic and treatment medications, including non-prescription drugs.

Progress

Through the efforts of the Planning Council Quality Assurance and the Advances in Medication and Treatment Committees, information and education is made available to clients on accessing and using medication programs. The Quality Assurance Committee works to improve methods of screening for eligibility and to link clients with ADAP services, and to evaluate the effectiveness of services. Medical Care Coordinators are at primary care sites to insure that providers are knowledgeable about all HIV related programs including ADAP. The Advances in Medication and Treatment Committee organizes bi-monthly presentations for case managers, clients and others on topics such as Depression and HIV, Side Effect Management, HIV and Substance Abuse, and others.

Harris County HIV Services has completed a review of pharmaceutical buying and distribution policies and procedures which has resulted in recommendations for improvements. The Title I drug reimbursement program is now fully 340 B compliant, which has increased cost-effectiveness and provided clients with options for receiving their medications. Also, in recognition of challenges in funding for the ADAP program, the Planning Council has established an Ad Hoc committee to address future problems, and has allocated additional funding for medications while continuing funding for nutritional supplements and insurance support for people with HIV/AIDS.

SECTION 4: HOW WILL WE MONITOR OUR PROGRESS: HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR SHORT TERM AND LONG TERM GOALS?

Topic	INCLUDED IN THE 2000 COMPREHENSIVE PLAN	UPDATED IN THIS DOCUMENT
Implementation plan	Yes	Yes
Monitoring plan	Yes	Yes
Evaluation plan	Yes	Yes

In keeping with the format suggested by HRSA, the following outlines the Planning Council's process for implementing, monitoring, and evaluating progress toward achieving short term and long term goals.

Implementation:

Implementation of the Comprehensive Plan is a coordinated effort through the Planning Council and the Administrative Agent for Title I funds, the Harris County Health Department's HIV Services Section. The Needs Assessment results are reviewed in conjunction with the Comprehensive Plan by the Planning Council's "How to Best Meet the Needs" Committee/process. This Committee makes recommendations to the "Priorities and Allocations" Committee which aligns financial allocations to planning goals and needs. Contracts are then established with service providers through the Harris County HIV Services Department.

Monitoring:

Monitoring implementation of the Comprehensive Plan is handle through the Comprehensive HIV Planning Committee. This committee meets monthly, and uses a Planning Notebook that includes goals, tasks, assigned responsibility, and timelines for implementation. Quarterly Partner meetings are also held with the Joint Comprehensive Planning Committee (JCPC). Contract monitoring is handled through the Harris County HIV Services Department and includes fiscal oversight, site visits to agencies, and compliance monitoring.

Outcome Evaluation:

Outcomes are measured by the Harris County HIV Services Department using an established set of process and clinical outcome measures. The Planning Council will be developing a set of Comprehensive Plan specific outcome measures that will complement the HIV Services indicators.

HAB/DSS GUIDELINES/EXPECTATIONS

Included in the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, reauthorized in October 2000, are mandates related to the expectations and guidelines in the needs assessments and comprehensive plans. The mandates indicate that communities will create "multi-year comprehensive plans that will:

1. Address disparities in HIV care, access and services among affected sub-populations and historically underserved communities;

2. Establish and support an HIV care continuum;
3. Coordinate resources among federal and local programs;
4. 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."

HRSA further specifies strategic planning goals, related to the mandates, which communities should incorporate into their planning, prioritizing and allocations processes:

A. Identify individuals who know their HIV status but are not in care and strategies for informing these individuals of services and enable their use of HIV-related services;
B. Eliminate disparities in access and services for historically underserved populations;
C. Coordinate services with HIV prevention programs including outreach and early intervention services;
D. Coordinate services with substance abuse prevention and treatment programs;
E. Provide goals, objectives, timelines and appropriate allocation of funds (as determined by the needs assessment).

As part of the review of the comprehensive plan, findings from the most recent needs assessment were analyzed based on the HRSA guidelines and expectations in order to better determine the community's progress in complying with these. The following lists the guidelines and lists relevant findings and recommendations from the needs assessment.

RELEVANT NEEDS ASSESSMENT THEMES AND RECOMMENDATIONS

The Houston Area EMA/HSDA 2002 Comprehensive Needs Assessment generated themes that were consistently reported by survey respondents and focus group participants. The following section lists several of the themes that are relevant to the HRSA mandates.

A. Identify individuals who know their HIV status but are not in care and strategies for informing these individuals of services and enable their use of HIV-related services

Findings

Survey respondents indicated that 12% had not accessed primary medical care (out-of-care) within the 6 months previous to their participation in the survey and an additional 7% had never received HIV-related primary medical care (never-in-care). Among the special populations: out-of-care status was reported by 13% of African-American MSMs, 15% of the female respondents, 19% of the incarcerated/recently released and 26% of the youth (ages 13-24).

Never-in-care status was reported by 10% of the African-American MSMs, 5% of the females, 12% of the incarcerated/recently released and 9% of the youth. Of these, approximately 46% cited personal choice as the reason they had not sought care, approximately 33% of the out-of-care cited provider advice (actual or perceived) as the reason for their care status and 21%, cited access barriers.

Selected Recommendations

1. Increase outreach to the out-of-care and never-in-care PLWH/A.
2. Assure that provider service capacity grows in tandem with successful outreach efforts.
3. Focus outreach to youth (ages 13-24) and to PLWH/A who are incarcerated and recently released from incarceration.
4. Consider conducting periodic street interviews, such as those undertaken in the Needs Assessment to elicit additional strategies to recruit the out-of-care and never-in-care.
5. Increase testing in community sites other than clinics.

B. Eliminate disparities in access and services for historically underserved populations

Detailed studies were performed to gather information about the perception of barriers and disparities in care among 4 traditionally underserved populations:

- African-American Men who have sex with men (MSM)
- Women of childbearing age (age 15-45)
- Individuals who are currently incarcerated or recently released from incarceration
- Youth (ages 13-24).

Barriers to access were most consistently reported for Support Services, such as transportation, housing, food bank and emergency financial assistance. Youth, however, report barriers in access to primary medical care. Since Title II has recently funded an outpatient clinic targeting adolescents, the Title I Planning Council will require through the Standards of Care that the new Early Intervention Workers targeting youth work closely with clinic personnel. Of note, all other groups rated primary care second in presenting barriers to access.

Support staff for the Ryan White Planning Council are members of a coalition to improve continuity of care for the soon-to-be and recently released. This Offender Continuum of Care effort includes leadership from medical people inside the city, county, state and federal prisons, CDC, the Texas Department of Corrections, local service providers and others. Last week participants in this project provided HIV/AIDS training to peer educators from 22 units within the state prison system. Three years ago The Office of Support for the Ryan White Planning Council started distributing the HIV/AIDS Resource Guide through chaplains in the prisons. The Office now receives 15-20 letters a week from inmates requesting resource guides.

Findings

African-American MSM

1. Among survey respondents, African-American MSMs were better educated, more likely to carry employer-sponsored or private insurance or COBRA and receive medication payment assistance than any other group and in comparison to the entire survey sample.
2. Despite this profile, African-American MSMs reported a higher level of out-of-care and never-in-care status than the full survey sample. Though more than 35% report that their healthcare providers indicated that they did not need HIV-related care within the 6 months prior to participating in the survey, the need for primary care not related to HIV is implied. For example, in comparison to the full sample, this group reports higher levels of hypertension, higher rates of gonorrhea and syphilis and the second highest level (incarcerated/ recently released are highest) of substance use (42% AA MSM, 36% all respondents).
3. Several focus group participants expressed concern for those men who have sex with both men and women, regardless of whether they self-identify as bi-sexual.
4. Gaps in support services were reported by 41% of AA MSM respondents, 35% reported gaps in ambulatory/outpatient medical care. The highest barriers to access were reported for support services (37%), ambulatory/outpatient medical care (17%) and 13% home health care.

Selected Recommendations

1. 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 the AA MSM.
2. Consider developing additional prevention strategies targeted to individuals who have sex with both men and women.
3. Ensure that healthcare providers, especially those who do not regularly treat PLWH/A, 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.

Findings

Incarcerated/Recently Released Individuals (IR/R)

1. This group represented the highest risk factors of any of the special study groups. Over 50% were disabled, 53% reported substance use, 45% had a history of injection drug use, 19% were out-of-care and 12 % were never in care.
2. The IR/R ranked mental health and substance abuse treatment services higher than did any other group (35% and 32% respectively)
3. Medication access and adherence is reported by the IR/R as a significant challenge, especially at the point of transition out of the judicial system. Respondents indicated that at release, they received at a maximum, a 10-day supply of medications. Many encountered numerous barriers to access and were unable to acquire additional medications.

4. Access to housing, transportation and employment were significant challenges cited by those released from incarceration.
5. The IR/R detailed a higher rate of co-morbidities, including: hypertension, neuropathy, thought/memory disorders, high cholesterol, pneumocystis pneumonia and diseases of the lung, liver and heart.
6. IR/R reported highest gaps in service for support services (53%) and ambulatory/outpatient medical care (39%). Reports of barriers follows this pattern (41% for support services and 20% for ambulatory outpatient medical care).

Selected Recommendations

1. 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.
2. Consider the development of a comprehensive transitional program that matches the newly released with a medical care provider, source for medications and basic resources. This is especially important for those who have not secured housing upon release.
3. Within the comprehensive transition program, incorporate insurance eligibility and other efforts to economically support the recently released. These services need to be anticipated prior to release.
4. Attempt to provide health screening that includes the range of co-morbidities to which the incarcerated appear to be more susceptible.

Findings

Women of Childbearing Age

1. More than 56% of the female survey respondents were diagnosed with HIV in the context of medical care for other conditions—14% were diagnosed at the time of pregnancy testing, 19% during an emergency room encounter.
2. Women were less likely to use AIDS Drug Assistance Programs (ADAP) or other medication reimbursement benefits despite their high use of antiretroviral therapy.
3. In comparison to the entire survey sample, more women were out-of-care (15% vs. 12%) and fewer were never-in-care (5% vs. 7%). Women were less likely to report their care status as a personal choice (36% vs. 46%) and more likely to indicate the reason as provider advice (41% vs. 33%). However, their reports of "current viral load" most closely resembles reports of "highest viral load."
4. Women were more likely than the entire survey sample to indicate that they had been diagnosed with diabetes (13% vs. 8%), heart disease (11% vs. 7%) and pneumocystis pneumonia (16% vs. 14%).
5. Women cited barriers to care most frequently for support services (38%) and ambulatory outpatient medical care (23%)

6. In this survey sample, the rates of injection drug use among women was higher than the total respondent sample and second among the special study groups. Only the incarcerated/recently released, many of whom were also women, had higher reported rates. The rate of other substance use was lower, however, for women.

Selected Recommendations

1. Continue to provide information to primary care providers, especially obstetricians/gynecologists and emergency medicine physicians about their role in HIV testing and diagnosis.
2. Continue to develop programs that more sensitively communicate HIV status to women and provide prevention information to the seronegative and effective and timely transition to early intervention services to those diagnosed with HIV.
3. Assess barriers to use of medication reimbursement programs by women and attempt to remediate these.
4. Explore the conditions that lead to the women that do not seek medical care most frequently because of provider advice.

Findings

Youth

1. Youth consistently reported a need for more prevention education at an earlier age.
2. Youth were the least likely to be insured and of those who are, several lose coverage at age 18.
3. This group is especially likely to be out of the system of medical care due to a lack of awareness of available services, a lack of means for payment for services, and the misperception of their health risk.
4. Surveillance data suggests that the rate of new infection among youth is increasing and that 25% to 30% of those infected may be unaware. A recent study published by the CDC notes that among the study population, 77% of young HIV positive MSMs may not know their HIV status. (McKellar et. al. 2002 CDC)
5. Of those youth who were out-of-care, 7.2% indicated that they were infected perinatally.

Selected Recommendations

1. Continue to provide prevention education at earlier ages through schools, social service agencies, youth development programs and churches. Extend patient education programs targeted to young mothers.
2. Develop and implement better programs for insuring youth who are 18 years or older.
3. Expand outreach, testing and early intervention programs to youth.

C. Coordinate services with HIV prevention program including outreach and early intervention services

HIV-related health planning groups throughout the community have organized judiciously to better coordinate efforts among the range of activities within the scope of the Ryan White Care Act. Both providers and PLWH/A participate in each of the planning bodies, with many individuals holding memberships in several groups simultaneously. The Needs Assessment and the Comprehensive Plan were developed and approved by several partners, representing the various Ryan White Titles, as well as Housing Opportunities for Persons with AIDS (HOPWA).

As stated earlier, the Quality Assurance and Priority and Allocations Committees of the Title I Ryan White Planning Council initiated the assignment of funds to Early Intervention Services.

D. Coordinate services with substance abuse prevention and treatment programs

Most of the substance abuse prevention and treatment programs targeted toward PLWH/A in the EMA/HSDA are funded by the Texas Council on Alcohol and Drug Abuse (TCADA). TCADA funds HIV Early Intervention Services, HIV Street Outreach and all levels of treatment, including detox, partial hospitalization or day treatment, intensive outpatient and transitional (usually referred to as aftercare). Region 6 covers a wide geographic area, designated as 2 sectors, Region 6a: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton counties and Region 6b: Galveston, Brazoria and Matagorda counties.

Presently, the Montrose Counseling Center (MCC) is the only TCADA-funded site for HIV Early Intervention and HIV Street Outreach. Although MCC is the only site specifically targeting PLWH/A, these individuals would be able to seek treatment wherever they might choose. Several treatment sites exist in the Houston metropolitan area, many of which are not funded by TCADA.

The federal agency, Substance Abuse and Mental Health Services Agency (SAMHSA) is also a significant source of funding for substance abuse treatment. Several sites in the EMA/HSDA receive SAMHSA funding. These include: 1) Montrose Counseling Center; 2) Houston Area Community Services; and 3) New Directions Clubs. Staff members from two of these three agencies serve as members of the Ryan White Planning Council.

Several findings from the 2002 HIV Comprehensive Needs Assessment were consistent with those of other Title 1 grantees, as reported by HRSA. For example:

- Houston EMA/HSDA, the preponderance of funded programs are for outpatient substance abuse therapy;
- Respondents to the Needs Assessment, who reported substance abuse problems, also cited lack of adequate housing as a significant barrier to maintaining sobriety;

- Providers noted that mental health treatment often is not linked with substance abuse treatment
- There is insufficient screening by primary care providers of substance abuse issues
- Cultural issues related to HIV and substance abuse represent increasing challenges for both clients and providers.

The significance of the challenge of substance abuse among the respondents to the Needs Assessment was noteworthy. The topic arose as a concern in each of the 15 focus groups, in all of the street interviews and among survey respondents.

E. Provide goals, objectives, timelines and appropriate allocation of funds (as determined by the Needs Assessment)

Goals, objectives and timelines

The Comprehensive HIV Planning Committee of the Ryan White Planning Council created as part of the Comprehensive Plan, measurable goals with time-based objectives. (See Chapter 9 of the 2000 Comprehensive HIV Services Plan.)

Appropriate Allocations

Consistent throughout the Needs Assessment were respondent claims of the importance of ambulatory/outpatient medical care, medications, dental care and support services, especially mental health care. Further, these findings are consistent with national and state trends, findings from previous studies, provider reports, the Title I computer data system (CPCDMS) utilization reports. The Priorities and Allocations Committee is apprised of this information and allocations reflect this information. For example, for FY03 the committee allocated an additional $700,000 to Ambulatory/Outpatient/Medical Care, $134,000 to Dental Care, $285,941 to Drug Reimbursement and $104,00 to Mental Health Services.

Table 29 illustrates the rankings by All Respondents to the Use, Needs, Barriers and Gaps by selected Service Categories and the priority and allocation assigned to each.

Table 29: All Respondents Use, Need, Barriers and Gaps by Selected Service Category with FY03 Priority and Allocation

Service Category	Use	Need	Barrier	Gap	Priority	Increase in FY03 Allocation	TOTAL FY03 Allocation
	N=17	N=17	N=17	N=17	N=26		
Ambulatory Care**	1	2	2	2	1	$701,837	$7,805,872
Case Management	5	6	7	15	4	$32,616	$1,974,177
Nutritional Services	9	8	17	11	11	$6,571	$154,036
Support Services*	2	1	1	1	NA	- $53,232	$4,040,758
Dental Care	4	3	15	14	3	$134,024	$910,609
Substance Abuse Treatment	13	13	16	16	7	$4,623	$61,409
Drug Reimbursement Program	6	5	13	12	2	$285,941	$2,300,119
Mental Health Services	8	7	10	6	8	$104,497	$279,216
Hospice	17	17	14	17	23	$30,050	$197,964
Home Health Care	16	14	9	7	19	$18,477	$245,435
Rehabilitation***	10	10	4	5	15	$13,463	$88,451

* Support Services include: Adult Day Care, Buddy/Companion Services, Child Care, Client Advocacy/Legal Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Health Insurance Payments, Housing Assistance, Housing, Outreach Services, Referral, Transportation, and Translation.

**Ambulatory/Outpatient Medical Care includes: Primary Medical Care, Vision Care, Obstetrics & Gynecology, Pediatric Care, Specialty Care and Infectious Diseases.

***Rehabilitation includes: Physical Therapy, Speech Pathology, Low-Vision Training Services and Early Intervention Services.