



2014 Houston Area HIV/AIDS Needs Assessment

A collaboration of:

Houston Area HIV Services Ryan White Planning Council

Houston HIV Prevention Community Planning Group

Harris County Public Health Services, Ryan White Grant Administration

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

Houston Regional HIV/AIDS Resource Group, Inc.

Harris Health System

Housing Opportunities for Persons with AIDS

Coalition for the Homeless of Houston/Harris County

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

March 2014

Disclaimer:

The 2014 Houston Area HIV/AIDS Needs Assessment summarizes primary data collected from June to November 2013 from 678 self-selected, self-identified HIV infected individuals using either a self-administered written survey or verbal interview. The majority of respondents resided in Houston/Harris County at the time of data collection. Data were statistically weighted for sex at birth, primary race/ethnicity, and age range based on a three-level stratification of HIV/AIDS prevalence in the Houston EMA (2012). Though quality control measures were applied, limitations to the raw data and data analysis exist, and other data sources should be used to provide context for and to better understand the results. Data collected through this process represent the most current *primary* data source on people living with HIV/AIDS in the Houston Area. Census, surveillance, and other data presented here reflect the most current data available at the time of publication.

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

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EXECUTIVE SUMMARY

The 2014 Houston Area HIV/AIDS Needs Assessment presents data on the HIV service needs, barriers, and other factors influencing access to HIV care for people living with HIV/AIDS (PLWHA) in the Houston Area as determined through a consumer survey. The overall goal of a needs assessment is to ensure the consumer point-of-view is infused into the data-driven decision-making activities of local HIV planning. Data are used to help set priorities for the allocation of HIV services funds, in the development of the comprehensive HIV plan, and in the design of annual service implementation plans. In 2014, 684 consumers participated in the Needs Assessment survey, and the results were statistically weighted to better represent the demographic composition of all PLWHA in the Houston Area today. The last Needs Assessment was conducted in 2011.

HIV Service Needs in the Houston Area

According to the 2014 Needs Assessment, all funded HIV services in the Houston Area are needed by consumers. The top five most needed services are:

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

Compared to the 2011 Needs Assessment, local medication assistance and medical nutrition therapy fell in terms of need among core medical services, while transportation eclipsed food pantry vouchers as the most needed non-medical support service.

Accessibility of HIV Services in the Houston Area

In addition to revealing the most needed HIV services in the Houston Area, the 2014 Needs Assessment provides information about access to those services, which helps planners better understand where barriers to services may exist.

In 2014, at least half of the consumers who said they needed each HIV service *also* said the service was easily accessible to them. There were some services, however, that were less accessible than others: housing, early intervention services in the Harris County Jail, medical nutrition therapy, and food pantry vouchers for rural clients were the five *least* accessible services according to 2014 Needs Assessment. Day treatment and primary care were the most accessible services in 2014.

Barriers to HIV Services in the Houston Area

To further understand barriers to HIV services, the 2014 Needs Assessment also gathers information about the types of difficulties consumers experience when services are not easily accessible. Overall, few barriers to services were reported in 2014. When they were reported, however, the most common are:

1. Not knowing where to go for the service
2. Not knowing how to get the service
3. Wait time
4. Lack of transportation, and
5. Believing they were not eligible for the service

In addition to the above results, the 2014 Needs Assessment includes detailed information about a variety of issues that impact access to care, including:

- Service needs and barriers at each stage of the HIV care continuum, from HIV testing and initial diagnosis to treatment and viral load suppression.
- The social, economic, health (both physical and mental), and behavioral characteristics of PLWHA that may help or hinder access to HIV care.
- Service needs and barriers specific to persons who are out of care for HIV; and
- Needs and barriers for each HIV core medical, support, and housing service currently funded in the Houston Area, presented as a series of Fact Sheets.

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

The 2014 Houston Area HIV/AIDS Needs Assessment is a collaboration between the Ryan White Planning Council, HIV Prevention Community Planning Group, Ryan White Grant Administration, Houston Department of Health and Human Services Bureau of HIV/STD and Viral Hepatitis Prevention, The Resource Group, Harris Health System, Housing Opportunities for Persons with AIDS (HOPWA), and the Coalition for the Homeless of Houston/Harris County. A total of 94 individuals assisted in the planning and implementation of the needs assessment, of which 18% were PLWHA.

For more information about the 2014 Needs Assessment, contact the Office of Support at (713) 572-3724 or visit www.rwpchouston.org.

INTRODUCTION

What is an HIV/AIDS needs assessment?

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

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

In the Houston Area, primary data collected directly from PLWHA in the form of a *consumer survey* are the principal source of information for the HIV/AIDS needs assessment process. Consumer surveys are administered every three years to a representative sample of PLWHA residing in the Houston Area.

How are HIV/AIDS needs assessment data used?

Needs assessment data are integral to the information base for HIV services planning, and they are used in almost every decision-making process of the Ryan White Planning Council, including setting priorities for the allocation of funds, developing the comprehensive plan, and crafting the annual implementation plan. Needs assessment data are also used for a variety of *non-Council* purposes, such as in funding applications, evaluation and monitoring, and the improvement of services by individual providers.

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

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

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

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

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

Sources:

- 2014 Houston Area HIV/AIDS Needs Assessment Group (NAG), Analysis Workgroup, Principles for the 2014 Needs Assessment Analysis. Approved 11-14-13.
- U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Ryan White HIV/AIDS Program Part A Manual Revised 2013. Section XI, Ch 3: Needs Assessment.

METHODOLOGY

Needs Assessment Planning

Planning the 2014 Houston Area HIV/AIDS needs assessment was a collaborative process between HIV prevention and care stakeholders, the Houston Area Planning Bodies for HIV prevention and care, all Ryan White HIV/AIDS Program Parts, and individual providers and consumers of HIV services. To guide the overall process and to provide specific subject matter expertise, a series of ad hoc groups was formed under the auspices of the Ryan White Planning Council:

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

In total, 94 individuals and staff participated in the planning process, of which at least 18% were persons living with HIV/AIDS (PLWHA).

Consumer Sampling Plan

The 2014 Houston Area HIV/AIDS needs assessment sample size was auto-generated by the *MaCorr Research* web-based calculator based on current total HIV/AIDS prevalence for the Houston Eligible Metropolitan Area (EMA) (2011), a 95% confidence interval, and a 4% confidence level. Respondent composition goals were proportional to demographic and geographic representation in total prevalence. Funded-agency representation was proportional to total client share for the same time period (2011). Efforts were also taken to over-sample out-of-care consumers and members of special populations. Hand tallies of select respondent characteristics were conducted during survey administration to assess real-time progress toward attainment of sampling goals.

Consumer Survey

Data for the 2014 Houston Area HIV/AIDS needs assessment were collected using a 75-item paper-and-

pencil survey of open-ended, multiple choice, and scaled questions addressing nine topics (in order):

- HIV services
- HIV diagnosis
- HIV care history
- Non-HIV health issues (incl. mental health)
- Substance use
- Housing and transportation
- Financial resources
- Demographics
- HIV prevention activities

Topics and questions were determined by the Survey Workgroup by revising the 2011 needs assessment survey. Experts were also engaged to review specific questions. Consistency with the federally-mandated HIV prevention needs assessment for the Houston Area was assured through the development of a crosswalk of survey domains and questions. A cover sheet explained the purpose of the survey, risks and benefits, planned data uses, and consent. A one-page tear-sheet of emergency resources was also attached, and liability language was integrated within the survey.

Texas Children's Hospital provided IRB review of the survey for use with minors at their facility.

Data Collection

Consumer surveys for the 2014 Houston Area HIV/AIDS needs assessment were administered in pre-scheduled group sessions at Ryan White HIV/AIDS Program providers, HIV Prevention providers, housing facilities, support groups, and specific community locations and organizations serving special populations. Staff contacts at each location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through print and online advertisements, flyers, word of mouth, and staff promotion.

Inclusion criteria were an HIV or AIDS diagnosis and residency in counties in the greater Houston Area. Participants were self-selected and self-identified according to these criteria. Surveys were self-administered in English, Spanish, and large-print formats, with staff and bilingual interpreters available for verbal interviewing. Out-of-care consumers were interviewed by telephone. Participation was voluntary, anonymous, and monetarily incentivized; and respondents were advised of these conditions verbally and in writing. Most surveys were completed in 20 to 45 minutes. Surveys were reviewed on-site by trained staff, interns, and interpreters for completion and

translation of written comments; completed surveys were also logged in a centralized tracking database.

A total of 684 consumer surveys were collected from June to November 2013 during 52 survey sessions at 33 survey sites and via telephone.

Data Management

Data entry for the 2014 Houston Area HIV/AIDS needs assessment was performed by trained staff and interns at the Ryan White Planning Council Office of Support using simple numerical coding. Skip-logic questions were entered based on first-order responses; and affirmative responses only were entered for “check-all” questions. Additional variables were recoded during data entry and data cleaning. Surveys that could not be accurately entered by staff were eliminated (n=6). Data were periodically reviewed for quality assurance, and a line-list level data cleaning protocol was applied prior to analysis. In addition, a data weighting syntax was created and applied to the sample for: sex at birth, primary race/ethnicity, and age group based on a three-level stratification of current HIV/AIDS prevalence for the Houston EMA (2012). This resulted in the exclusion of seven additional surveys, producing a total weighted sample size of 671 (12% in Spanish). Missing or invalid survey entries are excluded from analysis per variable; therefore, denominators will vary across results. Also, proportions may not sum to 100% for every variable due to missing or “check-all” responses. All data management and analysis was performed in IBM© SPSS© Statistics (v. 19).

Limitations

Data produced by the 2014 Houston Area HIV/AIDS needs assessment are unique because they reflect the first-hand perspectives of PLWHA in the Houston Area. However, there are limitations to the generalizability, reliability, and accuracy of the results that should be considered during their interpretation and use. These limitations are summarized below:

- *Convenience sampling.* Multiple administrative methods were used to survey a representative sample of PLWHA in the Houston Area proportional to geographic, demographic, transmission risk, and other characteristics. Despite such efforts, respondents were not randomly selected, and the resulting sample is not proportional to current HIV/AIDS prevalence. To mitigate this bias, data were statistically weighted for sex at birth, primary race/ethnicity, and age group using current HIV/AIDS prevalence for the Houston EMA

(2012). Results presented in Chapters 2 - 5 (excluding demographics of the out-of-care) are proportional for these three demographic categories only. Similarly, the majority of respondents were Ryan White HIV/AIDS Program clients at the time of data collection. Therefore, it not possible to determine if results reflect non-Ryan White systems.

- *Reporting bias.* Survey participants were self-selected and self-identified, and the answers they provided to survey questions were self-reported. Because the survey tool was anonymous, data could not be corroborated with medical or other records. Consequently, results should not be used as empirical evidence of reported outcomes. Other data sources should be used if confirmation of results is needed.
- *Instrumentation.* Full data accuracy cannot be assured due to variability in comprehension and completeness of surveys by individual respondents. Though real-time quality assurance reviews were performed of each survey by trained staff, there were missing data as well as indications of misinterpretation of survey questions. It is possible that literacy and language barriers contributed to this limitation as well. In addition, some surveys for consumers under age 18 were completed on their behalf by their primary caregiver.
- *Data management.* The use of multiple staff and interns to enter survey data could have produced transcription and transposition errors in the dataset. A line-list level data cleaning protocol was applied to help mitigate errors.

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

Sources:

- 2014 Houston Area HIV/AIDS Needs Assessment Group (NAG), Epidemiology Workgroup, 2013 Survey Sampling Principles and Plan, Approved 4-2-13.
- Sample Size Calculator © 2003-2013 MaCorr Research. Located at: www.macorr.com/sample-size-calculator.htm. Redirected from: U.S. Department of Health and Human Services, Health Resources and Services Administration, <http://bphc.hrsa.gov/policiesregulations/performance measures/patientsurvey/calculating.html>.
- Texas Department of State Health Services (TDSHS) eHARS data through 12-31-2012, extracted as of July 2013.
- University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPSS Statistics 20, Post-stratification weights, 2009.

BACKGROUND

The Houston Area

Houston is the fourth largest city in the United States as well as its most racially diverse major metropolitan area. Houston is also the least densely populated major metropolitan area, spanning 600 square miles. Houston is the population center of Harris County, the most populous county in the State of Texas and the third most populous in the country. Currently, Harris County has close to 4.1 million residents, over half of which live in the city of Houston.

Though they serve as its population center, the greater Houston Area extends *beyond* Houston and Harris County in regards to HIV/AIDS. There are currently four geographic service areas in the greater Houston Area that must be considered in HIV planning:

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

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

HIV/AIDS in the Houston Area

As has occurred nationwide over the course of the HIV/AIDS epidemic, the number of new cases of HIV/AIDS in the Houston Area has become relatively stable; HIV-related mortality has steadily declined, and the number of people living with HIV/AIDS has steadily increased. According to current disease surveillance data, there are 22,830 people living with HIV or AIDS in the Houston EMA (**Table 1**). The majority are male (74%), under the age of 35 (52%), and MSM (53%), while almost half are African American (49%).

TABLE 1—People Living with HIV/AIDS in the Houston EMA, 2012^a

	No.	%
Total	22,830	100.0%
Sex		
Male	16,922	74.1%
Female	5,908	25.9%
Race/Ethnicity		
White	5,203	22.8%
African American/Black	11,135	48.8%
Hispanic/Latino	5,744	25.2%
Other/Mixed race	748	3.3%
Age at Diagnosis		
0 - 12	250	1.1%
13 - 24	3,549	15.5%
25 - 34	7,990	35.0%
35 - 44	6,790	29.7%
45 - 54	3,250	14.2%
55+	1,001	4.4%
Transmission Risk^b		
Male-to-male sexual activity (MSM)	12,088	52.9%
Injection drug use (IDU)	2,363	10.4%
MSM/IDU	1,059	4.6%
Heterosexual contact	7,010	30.7%
Perinatal transmission	291	1.3%
Adult other risk	21	0.1%

^aSource: Texas eHARS. Living HIV and AIDS cases as of 12/31/12. Data run July 2013.

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

According to CDC, the Houston Area (specifically, the Houston-Baytown-Sugarland, TX statistical area) ranks 12th highest in the nation for HIV. In July 2010, the National HIV/AIDS Strategy released by the White House designated the Houston-Baytown-Sugarland, TX area as the eighth most HIV-impacted local jurisdiction in the country.

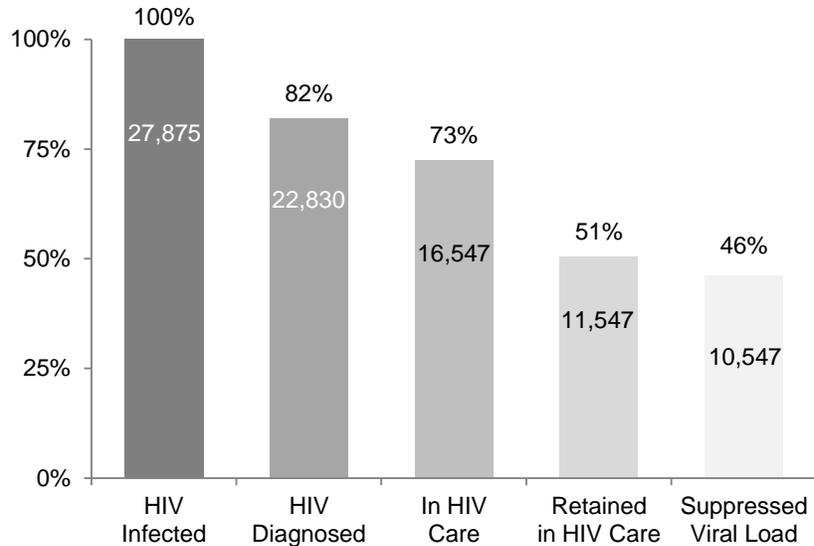
Of the 22,830 persons living with HIV/AIDS in the Houston Area, 73% are in medical care for HIV, but only 46% have managed their HIV disease to such a level that they have a suppressed viral load (**Graph 1**).

HIV Services in the Houston Area

HIV services in the Houston Area are provided by governmental agencies and non-profit organizations that offer direct HIV services and/or function as Administrative Agents that contract to direct service providers. The aim is to create a seamless system of care for people at risk for or living with HIV/AIDS that includes a full array of educational, clinical, mental, social, and support services. In addition, two local HIV Planning Bodies provide a mechanism for those infected and affected by HIV to help design services. Each of the primary touchstones in the Houston Area HIV service delivery system is described below:

- Comprehensive HIV prevention activities in the Houston Area are provided by the Houston Department of Health and Human Services (HDHHS), a directly-funded CDC grantee, and the TDSHS. Prevention activities include health education and risk reduction, HIV testing, disease investigation and partner services, and linkage to care. The Houston Area HIV Prevention Community Planning Group helps design HIV prevention activities.
- The Ryan White HIV/AIDS Program Part A and MAI provide core medical and support services for HIV-infected residents of the Houston EMA. These funds are administered by the Ryan White Grant Administration of Harris County Public Health Services. The Houston Area Ryan White Planning Council designs Part A and MAI funded services for the Houston EMA.
- The Ryan White HIV/AIDS Program Part B and State Services provide core medical and support services for HIV-infected residents of the Houston HSDA. These funds are administered by the Houston Regional HIV/AIDS Resource Group. The Ryan White Planning Council also designs Part B and State Services for the Houston HSDA.
- HOPWA provides grants to community organizations to meet the housing needs of

GRAPH 1-Number and Proportion of People with HIV in Selected Stages of the Continuum of HIV Care in the Houston EMA, 2012



Source: Program Planning and Evaluation Group, HIV/STD Branch at the Texas Department of State Health Services, August 2013.

low-income persons living with HIV/AIDS. HOPWA services include assistance with rent, mortgage, and utility payments, permanency planning, and supportive housing. These funds are administered by the City of Houston Housing and Community Development for the Houston EMSA.

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

Sources:

Centers for Disease Control and Prevention, HIV Surveillance Report, 2011; vol. 23. Published February 2013. Accessed 12/11/13. Available at: www.cdc.gov/hiv/topics/surveillance/resources/reports/.

Emerson, M.O, et al, *Houston Region Grows More Racially/Ethnically Diverse, With Small Declines in Segregation: A Joint Report Analyzing Census Data from 1990, 2000, and 2010*, The Kinder Institute for Urban Research and The Hobby Center for the Study of Texas, March 2012.

U.S. Census Bureau, State and County QuickFacts. Houston (city), Texas. Last Revised: 27-June-2013. Available at: <http://quickfacts.census.gov/qfd/states/48/4835000.html>.

U.S. Census Bureau, U.S. Census Briefs, Population Distribution and Change: 2000 to 2010, C2010BR-01, Issued March 2011.

White House Office of National AIDS Policy, National HIV/AIDS Strategy for the United States. July 2010.



Chapter 1: Demographics

PARTICIPANT COMPOSITION

A summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2014 Houston Area HIV/AIDS needs assessment provides both a “snapshot” of who is living with HIV/AIDS in the Houston Area today as well as context for other needs assessment results.

(Table 1) Overall, 95% of needs assessment participants were residing in Houston/Harris County at the time of data collection. The majority of participants were male (62%), African American/Black (65%), and heterosexual (56%). Over half was between the ages of 25 and 49 with an average age of 46.

The average household income of participants was \$8,088 per year, with the majority living at 100% of federal poverty (FPL). Other socio-economic characteristics of participants include: 35% disabled, 39% unemployed, 57% using public transportation as their primary transportation means, and 60% using public health insurance in the form of Medicaid and/or Medicare. A majority reported living in their own house/apartment (67%) with a small proportion in group housing facilities (8%).

TABLE 1-Select Participant Characteristics, Houston Area HIV/AIDS Needs Assessment, 2014

	No.	%		No.	%		No.	%
County of residence			Age (range: 14 to 69; average: 46)			Sex assigned at birth		
Houston/Harris	646	95.3%	13 to 24	36	5.4%	Male	420	62.1%
Fort Bend	20	2.9%	25 to 49	350	52.1%	Female	254	37.6%
Liberty	2	0.3%	50 to 64	274	40.8%	Intersex	2	0.3%
Montgomery	4	0.6%	65+	12	1.8%	Transgender	24	3.5%
Other	5	0.7%	Adolescents (13 to 17)	8	1.2%	Currently pregnant	4	1.1%
Primary race/ethnicity			Sexual orientation			Education level		
White	102	15.0%	Heterosexual	374	55.7%	Less than high school	143	21.2%
African American/Black	440	64.9%	Gay/Lesbian	209	31.1%	High school diploma	235	34.8%
Hispanic/Latino	122	18.0%	Bisexual	67	10.0%	GED	108	16.0%
Asian American	2	0.3%	Other	22	3.3%	Technical degree	62	9.2%
Other/Mixed race	12	1.8%	MSM	250	37.4%	Post-secondary degree	113	16.7%
Employment status			Immigration status			Yearly income (average: \$8,088)		
Employed (FT/PT)	128	18.9%	Born in the U.S.	504	75.8%	Federal Poverty Level (FPL)		
Temporary worker	52	7.7%	Citizen > 5 years	100	15.0%	100%	486	89.2%
Unemployed	265	39.1%	Citizen < 5 years	3	0.5%	150%	40	7.3%
Disabled	237	35.0%	Undocumented	6	0.9%	200%	10	1.8%
Retired	32	4.7%	Prefer not to answer	27	4.1%	250%	5	0.9%
Student	24	3.5%	Other	25	3.8%	300% or higher	4	0.7%
Health insurance			Housing status			Transportation		
Private insurance	32	4.7%	Own house/apartment	450	66.7%	Own vehicle	185	29.1%
Medicaid/Medicare	409	60.1%	Stay with others	125	18.5%	Public transportation	360	56.6%
Harris Health System	145	21.3%	Group facility	57	8.4%	Walk/bike	26	4.1%
Ryan White only	148	22.3%	Hotel/motel	4	0.6%	Borrow/carpool	42	6.6%
None	9	1.4%	Homeless	39	5.8%	None	9	1.4%

(Table 2) Certain subgroups of HIV infected persons have been historically underrepresented in HIV data collection, thereby limiting the ability of local communities to address their needs in the data-driven decision-making processes of HIV planning. To help mitigate underrepresentation in Houston Area data collection, efforts were made during the 2014 needs assessment process to *oversample* persons living with HIV/AIDS who were also members of groups designated as “special populations” due to socio-economic circumstances or other sources of disenfranchisement from the HIV service delivery system.

The results of these efforts are summarized in Table 2.

	No.	%
Adolescents (age 13 to 17)	8	1.2%
Homeless	39	5.8%
Injection drug users (IDU)	10	1.5%
Men who have sex with men (MSM)	250	37.4%
Out of care (last 12 months)	46	6.8%
Recently released from incarceration	89	13.2%
Rural (non-Harris County resident)	30	4.4%
Transgender	24	3.5%

COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

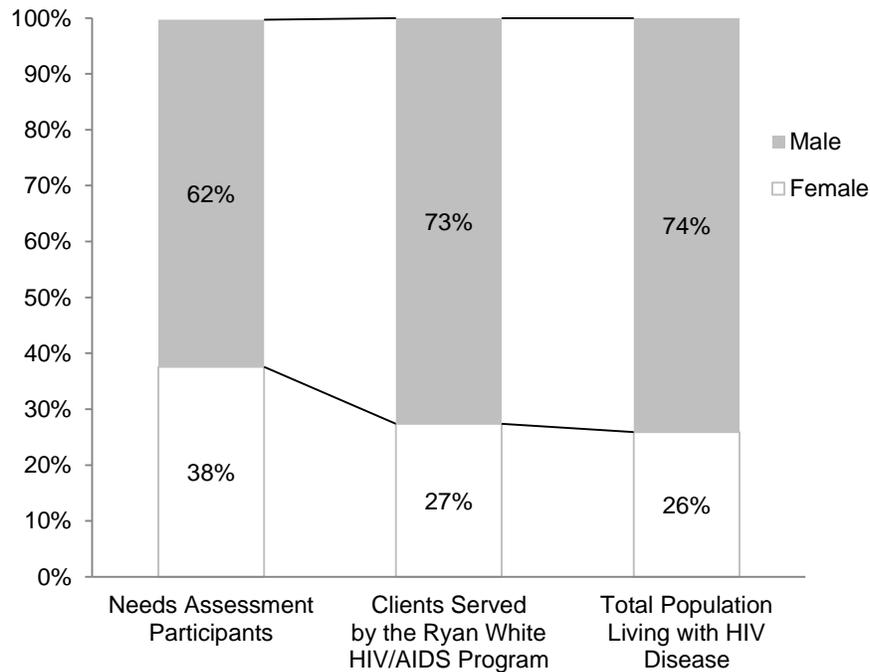
HIV/AIDS needs assessments are intended to generate information about the needs and service barriers of persons living with HIV/AIDS (PLWHA) in a specific geographic area, so that Planning Bodies and other stakeholders can design HIV services that best meet their needs. Because it would not be feasible to survey every PLWHA in a major metropolitan area, multiple administrative and statistical methods are used to generate a sample of PLWHA that are reliably representative of *all* PLWHA in the area. The same is true in regards to assessing the needs of clients of the Ryan White HIV/AIDS Program.

Therefore, it is useful, when reviewing needs assessment results, to understand the level of representation of participants compared to all

PLWHA in the area and to all clients served by the Ryan White Program as well as to document actions taken to mitigate any disproportional results.

(**Graph 1**) In the 2014 Houston Area HIV/AIDS Needs Assessment, males were 62% of participants, but 73% of all Ryan White clients and 74% of all PLWHA in the Houston Eligible Metropolitan Area (EMA). In general, this means that male PLWHA were underrepresented in the needs assessment and, conversely, female PLWHA were overrepresented.

GRAPH 1-Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients^a and Total HIV Infected Population^b in the Houston EMA, by Sex, 2012

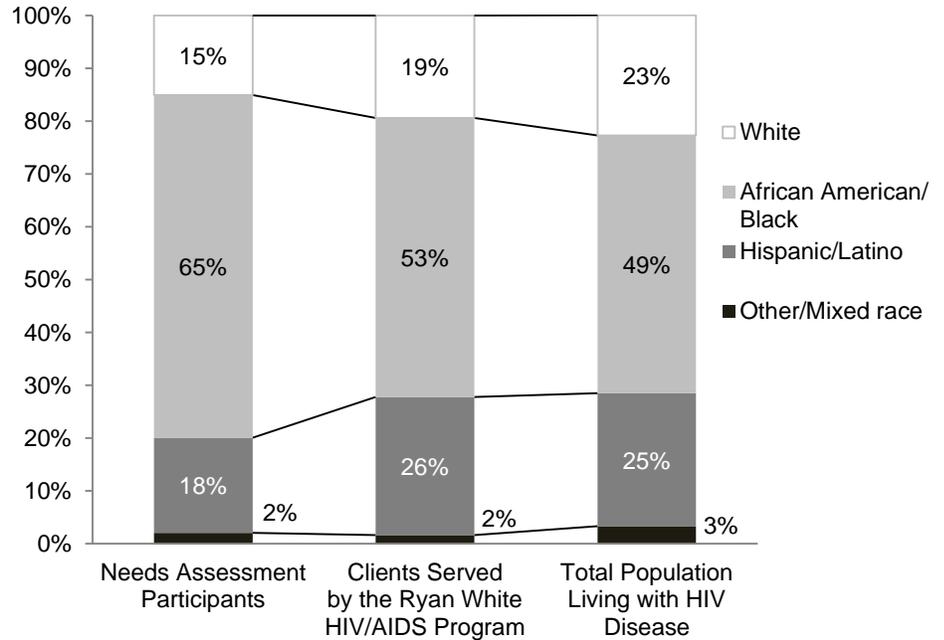


^aSource: CPCDMS as of 12/31/12. Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Presented 4/17/13.

^bSource: Texas eHARS. Living HIV cases as of 12/31/12.

(Graph 2) An analysis of race/ethnicity also shows disproportions between the composition of participants, all Ryan White clients, and all PLWHA in the Houston EMA. In general, at 65% of needs assessment participants, African American/Black PLWHA were overrepresented when compared to their proportion of all Ryan White clients and all PLWHA and. Conversely, this means that White PLWHA and Hispanic/Latino PLWHA were generally underrepresented in the needs assessment.

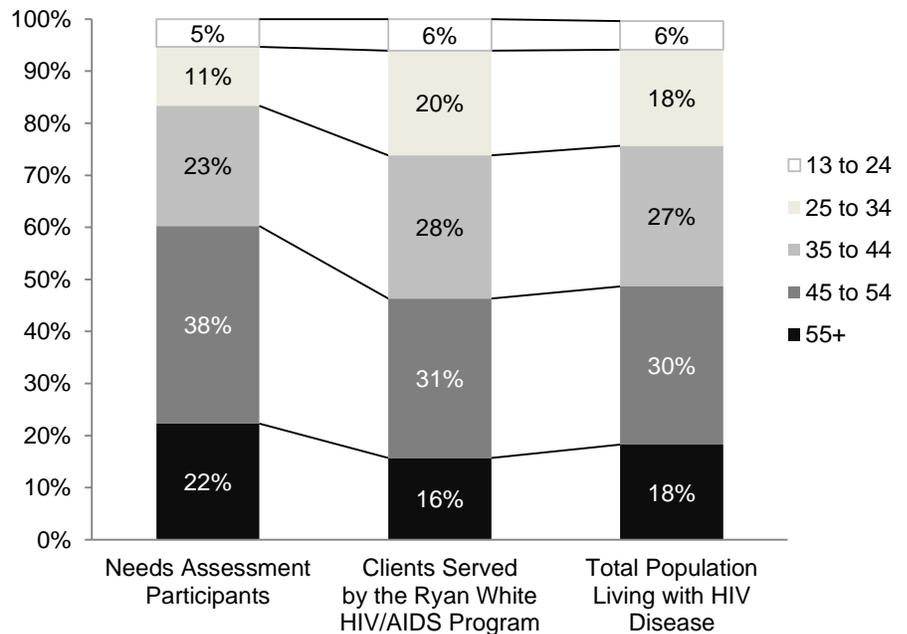
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients^a and Total HIV Infected Population^b in the Houston EMA, by Race/Ethnicity, 2012



^aSource: CPCDMS as of 12/31/12. Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Presented 4/17/13.
^bSource: Texas eHARS. Living HIV cases as of 12/31/12.

(Graph 3) Lastly, an analysis of age shows that needs assessment participants were, in general, older than Ryan White clients and PLWHA in the Houston EMA as a whole. For example, 60% of needs assessment participants were 45 years and older, while less than half of all Ryan White clients (47%) and less than half of all PLWHA (48%) are in this age group. This suggests that, youth, young adult, and middle adult PLWHA (those age 13 to 44) are generally underrepresented in the needs assessment, while older adults (those age 45 and above) are overrepresented.

GRAPH 3- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients^a and Total HIV Infected Population^b in the Houston EMA, by Age, 2012



^aSource: CPCDMS as of 12/31/12. Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Presented 4/17/13.
^bSource: Texas eHARS. Living HIV cases as of 12/31/12.

Weighting the Sample

Because the demographic composition of 2014 Houston Area HIV/AIDS needs assessment participants was *not* comparable to the composition of all PLWHA in the Houston EMA, needs assessment data were statistically weighted by sex at birth, primary race/ethnicity, and age group using current HIV/AIDS prevalence for the Houston EMA (2012) *prior to* the analysis of results related to service needs and barriers. This means that the results presented in the remaining Chapters of this document (excluding demographics of the out-of-care in Chapter 5) are proportional for these three demographic categories only. Appropriate statistical methods were applied throughout the process in order to produce an accurately weighted sample, including a three-level stratification of prevalence data and subsequent data weighting syntax. This resulted in the exclusion of seven consumer surveys from the dataset, producing a total weighted sample size of 671. Missing or invalid survey entries are additionally excluded in the statistical analysis; therefore, denominators will further vary across results. All data management and analysis, including weighting, was performed in IBM© SPSS© Statistics (v. 19).

Sources:

Texas Department of State Health Services (TDSHS) eHARS data through 12-31-2012, extracted as of July 2013.

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



Chapter 2: Overall Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

The Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to persons living with HIV/AIDS (PLWHA) who may not have sufficient resources for managing HIV disease. At the local level, determinations of which HIV services to provide are made by the Houston Area HIV Services Ryan White Planning Council. In addition, housing services for PLWHA are provided through the federal Housing Opportunities for People with AIDS (HOPWA) program. The primary purpose of an HIV/AIDS needs assessment is to gather information about the need for and barriers to services funded by the Ryan White HIV/AIDS Program locally as well as other federal programs like HOPWA.

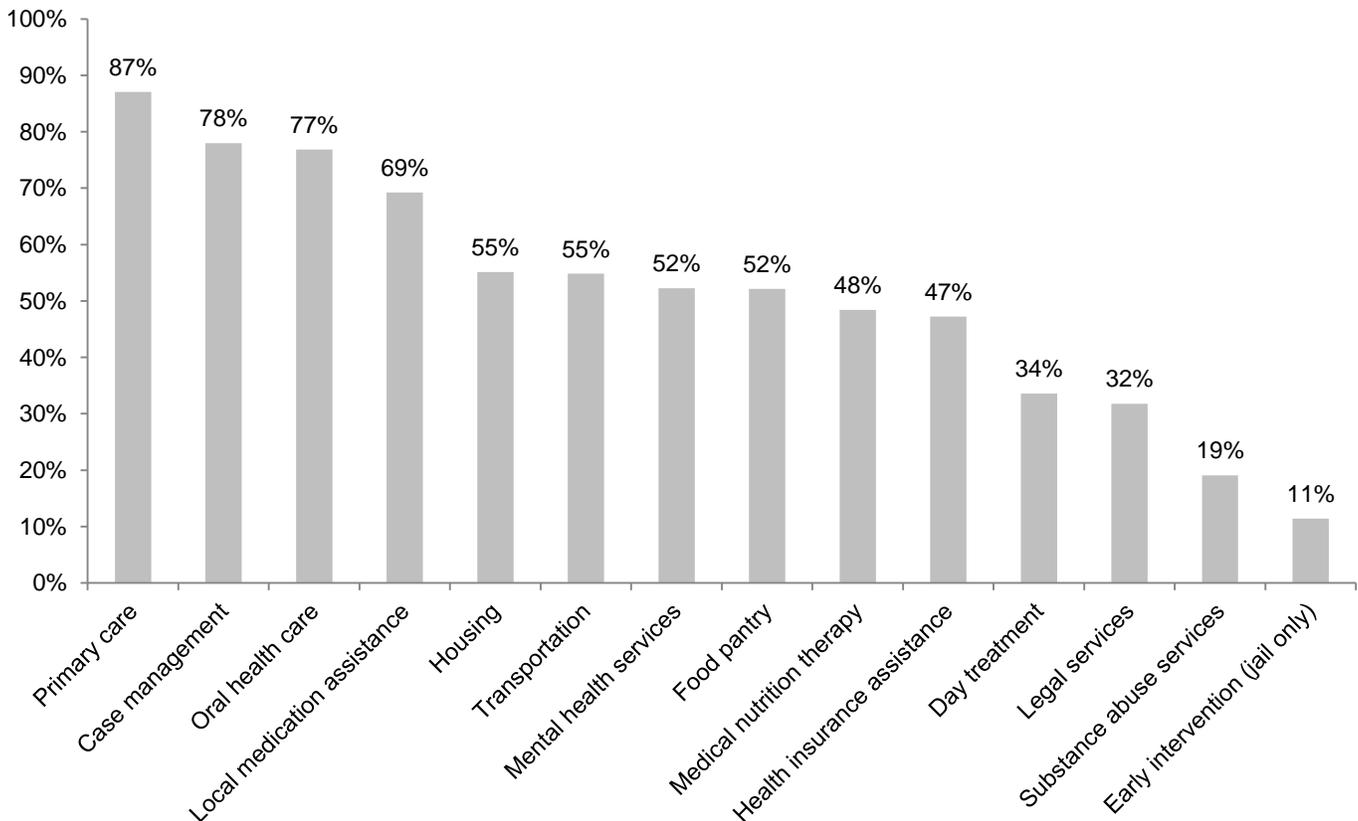
Overall Ranking of Funded Services, by Need

In 2013, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2014 Houston Area HIV/AIDS needs assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 1**) All funded services received a ranking of need by needs assessment participants. At 87%, primary care was the most needed funded service in the Houston Area, followed by case management at 78% and oral health care at 77%. When compared to the last Houston Area HIV/AIDS needs assessment conducted in 2011, local medication assistance and medical nutrition therapy both fell in the ranking among core medical services, while transportation eclipsed food pantry as the most needed non-medical support service.

GRAPH 1-Ranking of HIV Services in the Houston Area, By Need, 2014

Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



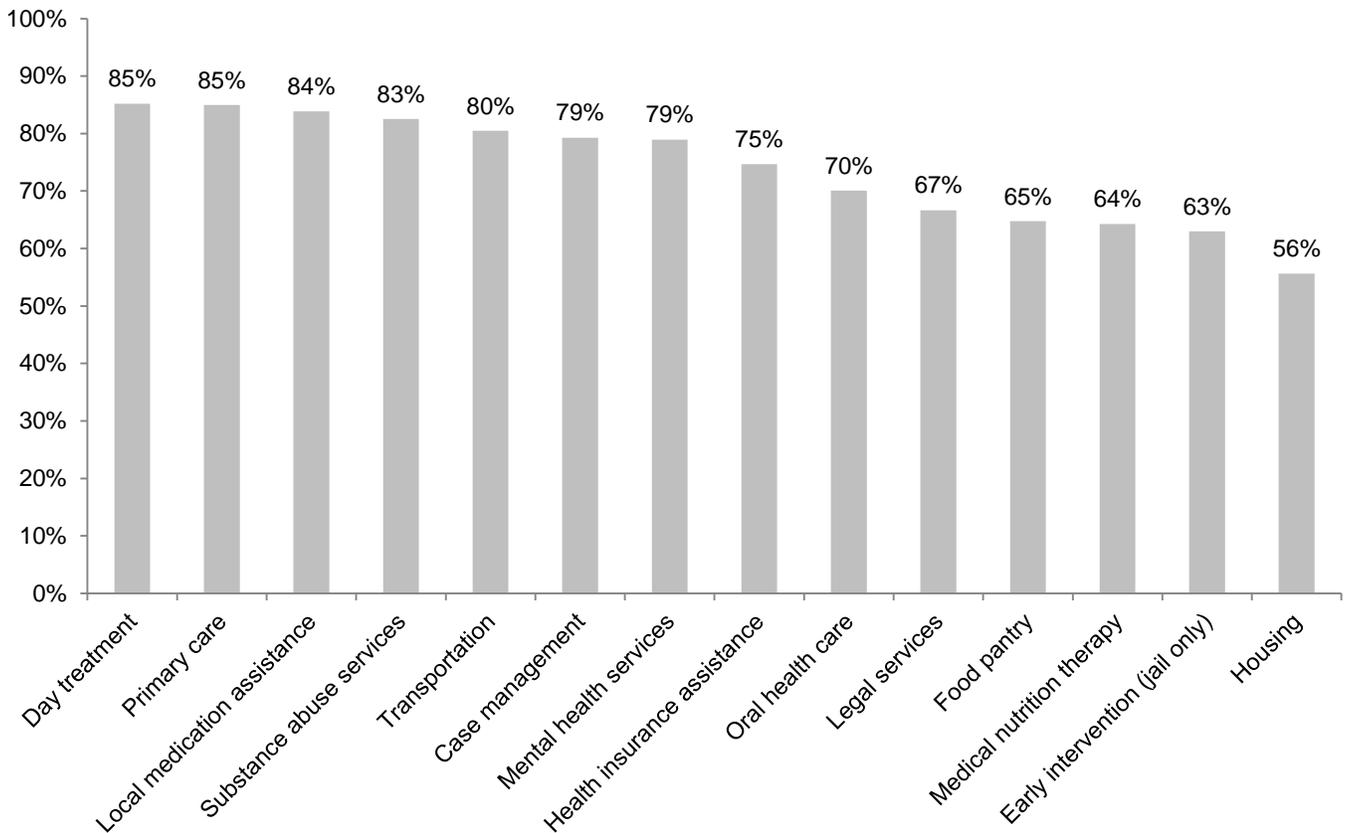
Overall Ranking of Funded Services, by Accessibility

Participants of the 2014 Houston Area HIV/AIDS needs assessment were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. Furthermore, if difficulty was experienced, participants were asked to identify the specific issue or barrier that caused the difficulty. Results for both topics are presented below.

(Graph 2) For each funded service, at least half of the needs assessment participants who stated they needed the service in the past 12 months also stated the service was accessible to them. At 85% easy to access, both day treatment and primary care were the most accessible funded services in the Houston Area. At 56% easy to access, housing was the least accessible funded service in the Houston Area for those who reported a need for it. On average, all Houston Area services were accessible to 75% of the participants who stated they had a need for them.

GRAPH 2-Ranking of HIV Services in the Houston Area, By Accessibility, 2014

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



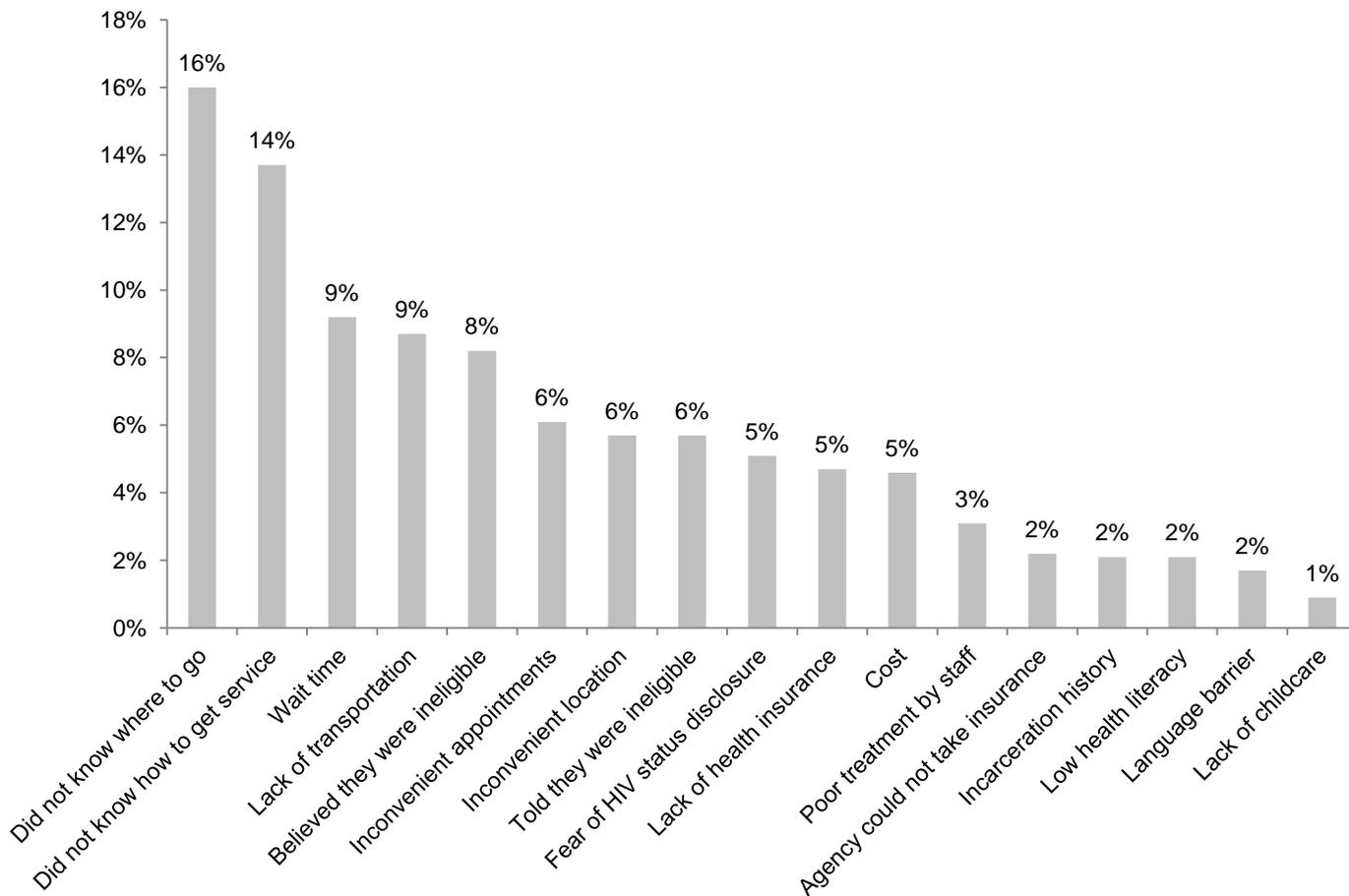
Overall Ranking of Barriers Experienced by Consumers

A list of 17 commonly experienced barriers to services was presented to needs assessment participants from which to select the specific condition or issue that made the service they needed *difficult* to access. Results show that all funded services were reported to have barriers. The average was 166 reports of barriers per service, with a low of 34 and a high of 366. In total, 2,483 reports of barriers were indicated in the sample across all services. This represents a 30% *decrease* in the number of reported barriers when compared to the last Houston Area HIV/AIDS needs assessment conducted in 2011.

(**Graph 3**) Overall, the barrier experienced most often by PLWHA (when barriers were reported) was lack of knowledge of where to go for the service (16% of all reported barriers), followed by lack of knowledge of *how* to access the service (14%), and wait time for the service (9%). Lack of childcare was reported least often (1%).

GRAPH 3-Ranking of Barriers to HIV Services in the Houston Area, 2014

Definition: Percent of times each barrier was reported by needs assessment participants, regardless of service, when barriers were present.



Other Identified Needs

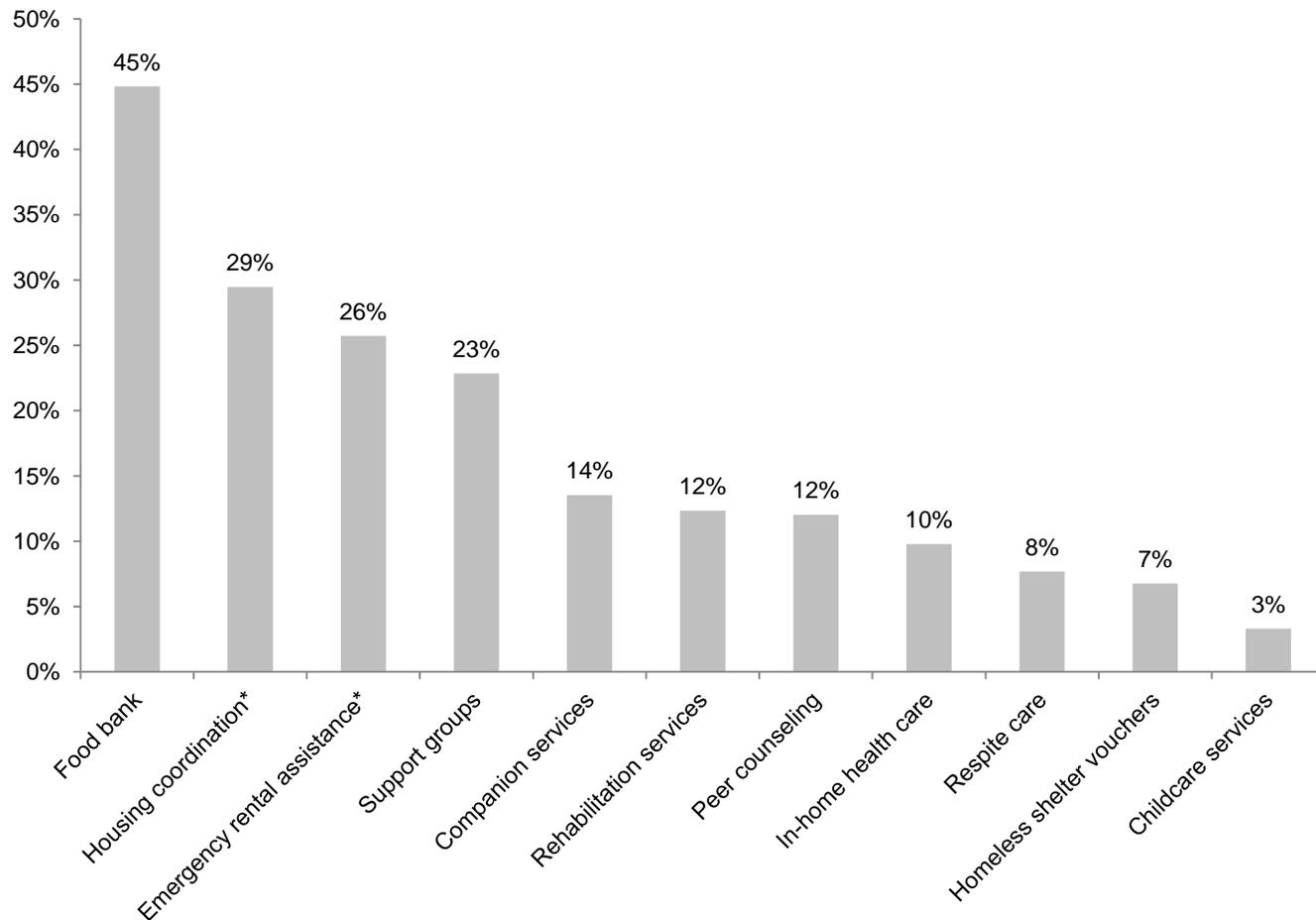
In addition to the HIV services listed above, there are other services allowable for funding by the Ryan White HIV/AIDS Program in local communities if there is a demonstrated need. Several of these other services have been funded by the Ryan White Program in the Houston Area in the past. The 2014 Houston Area HIV/AIDS needs assessment queried the need for these other services that are not currently funded by Ryan White in order to gauge any new or emerging service needs in the community. In addition, some of these services are currently funded through other HIV-specific non-Ryan White sources, namely housing-related services provided by the Housing Opportunities with People with AIDS (HOPWA) program, as indicated.

(Graph 4) Eleven other/non-Ryan White funded HIV-related services were assessed in the consumer survey. Participants could also write-in other types of services that they needed. Of the 11 preset options provided, food bank was selected most often as a need at 45% of respondents. Housing-related services were cited second and third. It should be noted that

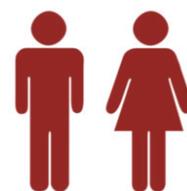
Services that were written-in most often as a need (and that are not currently funded by Ryan White) were (*in order*): employment assistance and job training, vision hardware/glasses, food stamps, and social groups.

GRAPH 4-Other Needs for HIV Services in the Houston Area, 2014

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



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



Chapter 3: Needs Across the Engagement in Care Continuum

HIV TREATMENT CASCADE

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

Application of the treatment cascade model locally allows communities to measure the extent to which national goals related to HIV awareness, linkage to care, and viral load suppression are being achieved. Areas of fall-off in the continuum can be identified, and targeted efforts can be launched to fill gaps.

Engagement in Care in the Houston Area

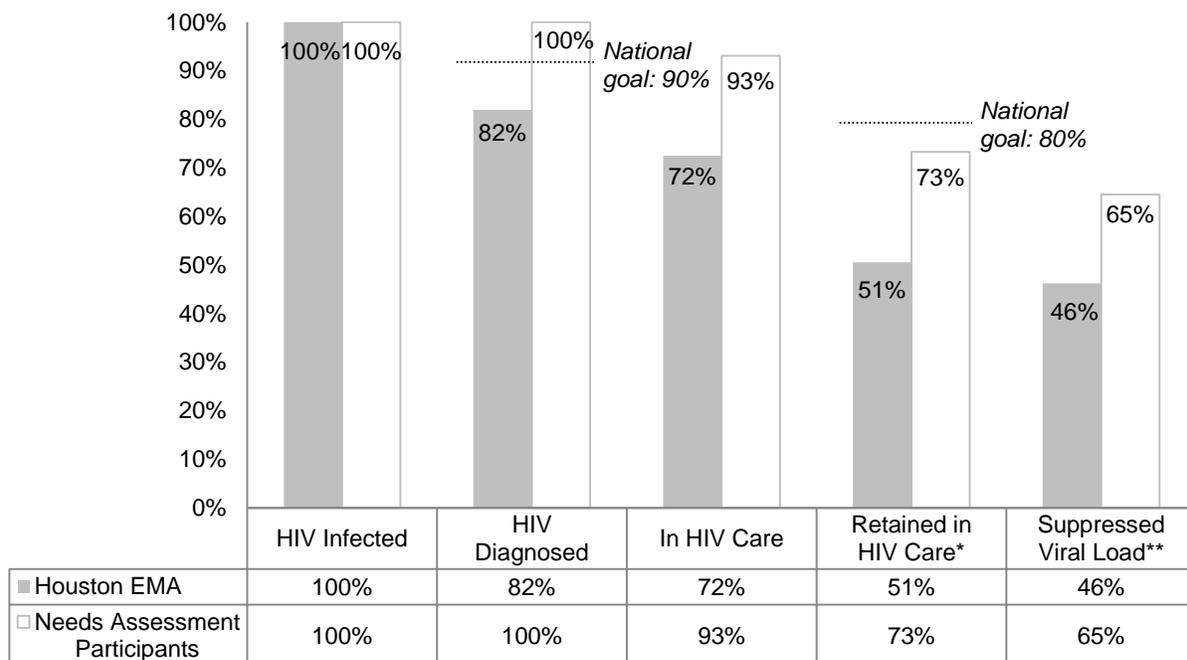
An HIV treatment cascade for the Houston Area has been developed using local epidemiological data (See *Background on the Houston Area*, page 10). Its results can be compared to what persons living with HIV/AIDS (PLWHA) themselves report regarding

their level of engagement in care, as revealed in 2014 Houston Area HIV/AIDS needs assessment data.

(**Graph 1**) Though there are differences between the two data sources (See Graph 1 notes), this comparison shows that, across the continuum, a larger proportion of needs assessment participants are engaged in care than are Houston Area PLWHA as a whole. This is consistent with the fact that the majority of needs assessment participants were surveyed at HIV care sites. However, when fall-off is examined between each stage of the cascade, the proportions in both data sets are comparable: for both, close to 10% of PLWHA fall-off the continuum between diagnosis and being in care, and about 20% fall off between being in care and being *retained* in care. Needs assessment participants show larger fall-off between retention and viral load suppression, though this could be due to differences in data collection (See Graph 1 notes).

Additional details about the experience of needs assessment participants at selected stages of the cascade are described in the rest of this Chapter.

GRAPH 1-Comparison of the Proportion of People in Selected Stages of the HIV Care Continuum in the Houston EMA^a as Reported in the 2014 Houston Area HIV/AIDS Needs Assessment and National Goals^b



^aSource: Planning and Evaluation Group, HIV/STD Branch at the Texas Department of State Health Services, August 2013.

*Retained in HIV care for the Houston EMA is the proportion of PLWHA with ≥2 medical visits or labs, 3 to 6 months apart, within 12 months; for NA participants, it equals the proportion of PLWHA reporting no break in HIV care for more than 12 months since initial diagnosis.

**Suppressed viral load for the Houston EMA is the proportion of PLWHA with a last viral load test value of ≤ 200 copies/mL; for NA participants, it equals the proportion of PLWHA reporting an undetectable viral load.

^bSource: National HIV/AIDS Strategy, July 2010.

TESTING AND DIAGNOSIS

The 2014 Houston Area HIV/AIDS needs assessment asked participants about their HIV diagnosis, including where and why they tested for HIV. These results can help planners identify effective locations and motivations for HIV testing in the Houston Area toward the goal of increasing the proportion of HIV-infected people who are aware of their status. The National HIV/AIDS Strategy (NHAS) goal for HIV awareness is 90%.

Notes: Among needs assessment participants, the average length of HIV diagnosis was 12 years, with the majority diagnosed for between 4 and 20 years; 4% were diagnosed for less than 1 year. This means that most participants were diagnosed with HIV prior to major expansions in HIV testing in the Houston Area, including annual mass testing events and routine HIV testing in public hospitals and emergency rooms. This history is evident in the results presented here.

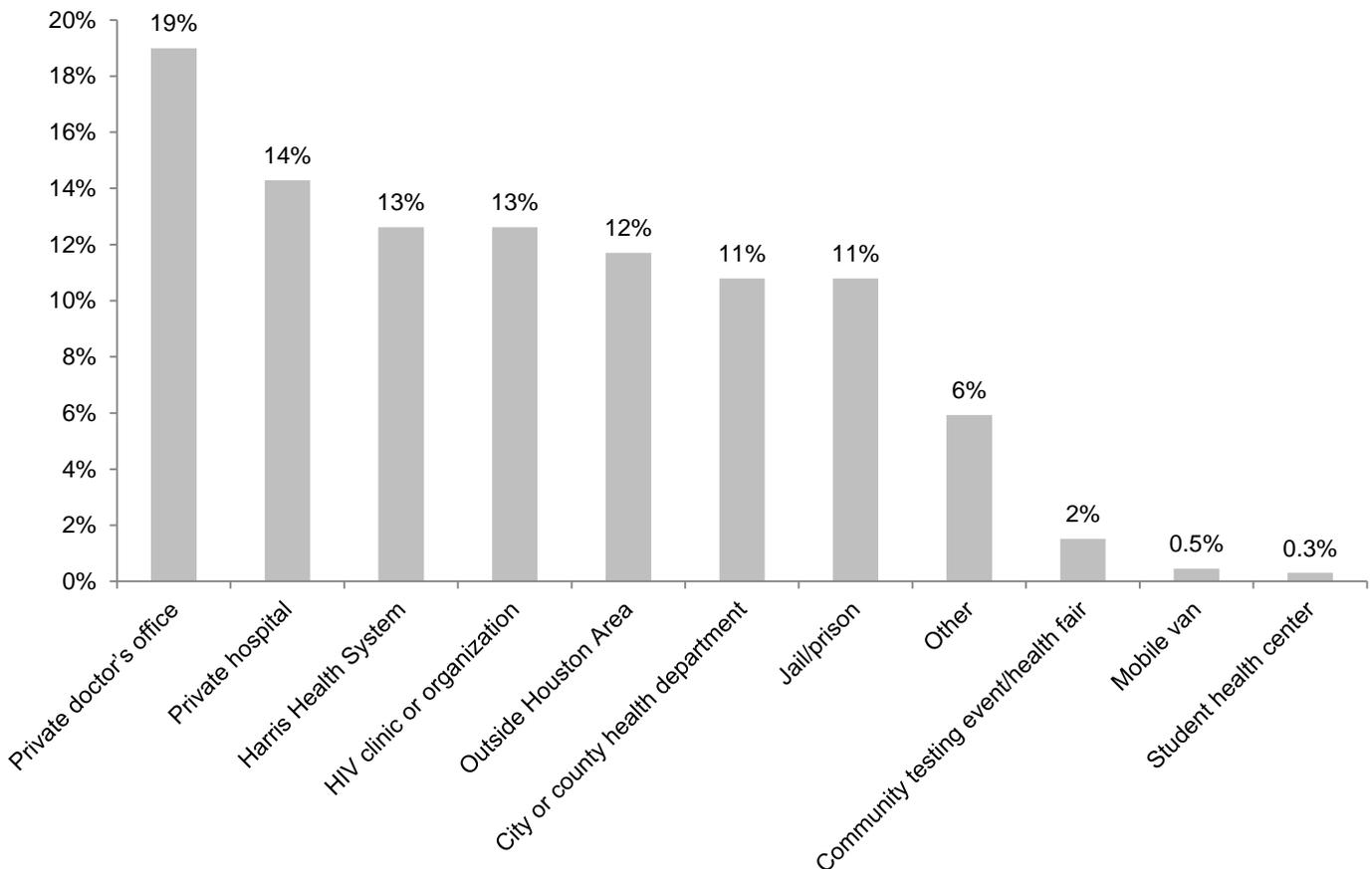
HIV Testing Location

(**Graph 1**) The most common location for being diagnosed with HIV among needs assessment participants was a private doctor's office at 19%, followed by a private hospital or ER (which does not include hospitals in Harris Health System) and a tie between a location within Harris Health System and an HIV clinic or organization (which could be either a Ryan White HIV/AIDS Program provider or an HIV Prevention provider). At less than 1%, a mobile van and a student health center were cited least often.

Population-level analysis shows some differences from these overall results. Young PLWHA (age 13 to 24) and the out-of-care were diagnosed most often at a private hospital or ER. Transgender and MSM PLWHA were diagnosed most often at an HIV clinic or organization. PLWHA released from incarceration in the past 12 months were diagnosed most often while incarcerated.

GRAPH 1-Locations for HIV Diagnosis in the Houston Area, 2014

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



Reasons for HIV Testing

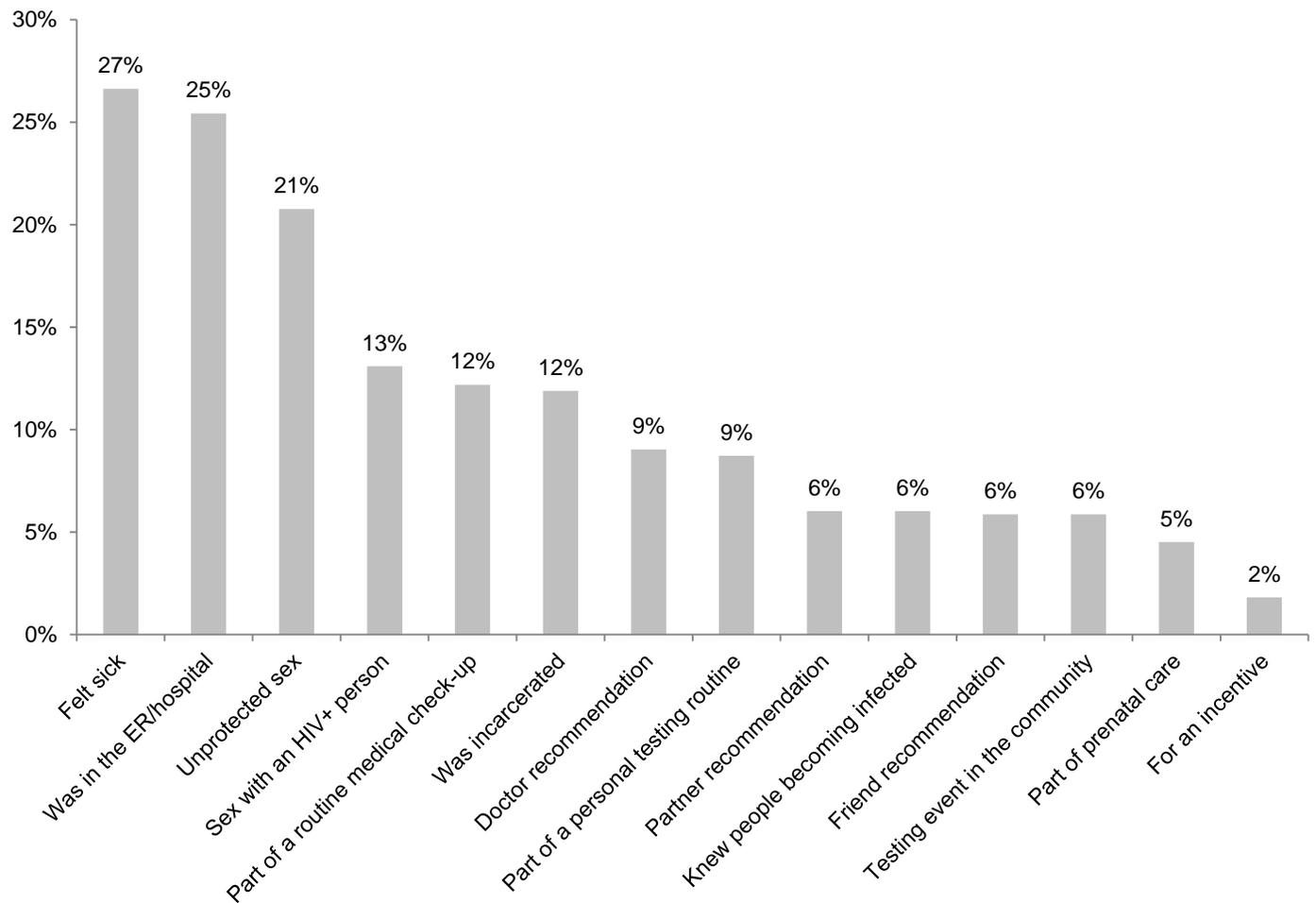
(Graph 2) Fourteen commonly reported reasons for receiving an HIV test were included as options in the consumer survey. Participants could also write-in their reasons for testing. Of the 14 preset options provided, feeling sick was selected most often as the motivation for testing at 26% of participants. Being tested while in the emergency room or hospital was cited second, and having unprotected sex was third. In order to receive an incentive (such as a gift card) was cited least.

These results can be categorized into three general types of reasons for testing (*in order*): a personal motivation such as engaging in a high-risk behavior, a policy or program that resulted in HIV testing, and the recommendation of others, including doctors and social networks.

Most common write-in reasons for testing were (*in order*): needle-sharing, blood donation, sexual assault, perinatal infection, testing for a different STD, and contact to a disease investigation (DIS).

GRAPH 2-Reasons for HIV Testing in the Houston Area, 2014

Definition: Percent of needs assessment participants who reported each of the following reasons for testing for HIV at the time they were diagnosed.



LINKAGE TO CARE

The 2014 Houston Area HIV/AIDS needs assessment asked participants about their initial entry into HIV care following diagnosis. These results can help planners identify strategies for ensuring newly-diagnosed persons are linked to HIV care in a timely manner. They can also help identify some of the reasons people delay entry into care, which could then be addressed by changes to HIV services. The National HIV/AIDS Strategy (NHAS) goal for linkage to care is 85% of persons linked within 3 months of their diagnosis.

Notes: Among needs assessment participants, the average length of HIV diagnosis was 12 years, with the majority diagnosed for between 4 and 20 years; 4% were diagnosed for less than 1 year. This means that most participants were diagnosed with HIV prior to the establishment of expanded linkage efforts (such as Service Linkage Workers) in the Houston Area funded by the Ryan White HIV/AIDS Program and other local sources. This history is evident in the results presented here.

Linkage Services at Diagnosis

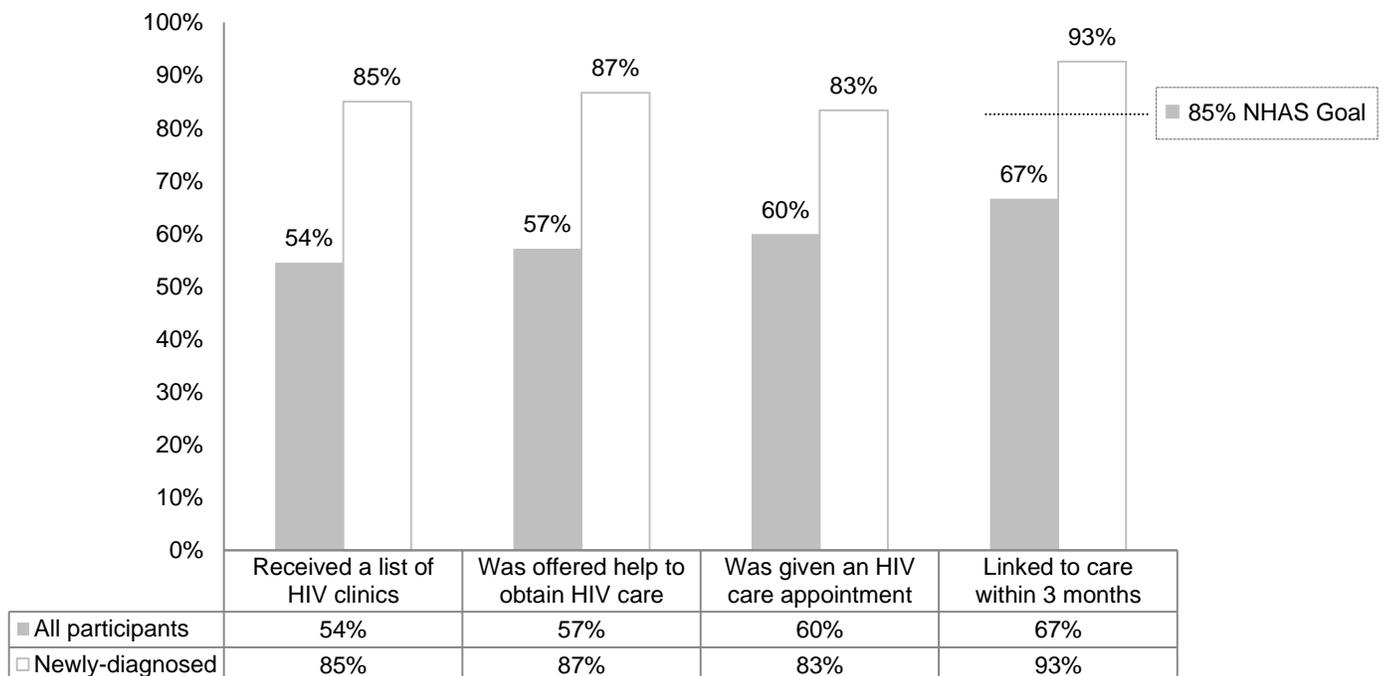
(**Graph 1**) 67% of all needs assessment participants reported linkage to care within 3 months of diagnosis. 54% reported receiving a list of HIV clinics at the time of diagnosis (also referred to as *passive* linkage), while slightly higher proportions (57% and 60%) reported *active* linkage, either assistance obtaining HIV care or an appointment for their first medical visit.

For needs assessment participants who were *newly-diagnosed* (or diagnosed for less than 1 year at the time of data collection), 93% reported linkage to care within 3 months. This group also reported receiving both passive and active linkage more often than did all participants. 85% received a list of HIV clinics at the time they were diagnosed, 87% were offered assistance in obtaining HIV care, and 83% were provided an appointment for their first medical visit.

Among the newly-diagnosed, reported linkage to care exceeds the national goal. It also exceeds what local epidemiological data show for the Houston Area. According to those data (generated by the Texas Department of State Health Services), 78% of persons in the Houston Area are linked to care within 3 months of diagnosis (2012).

GRAPH 1-Service Linkage Activities Received at the Time of HIV Diagnosis in the Houston Area, 2014

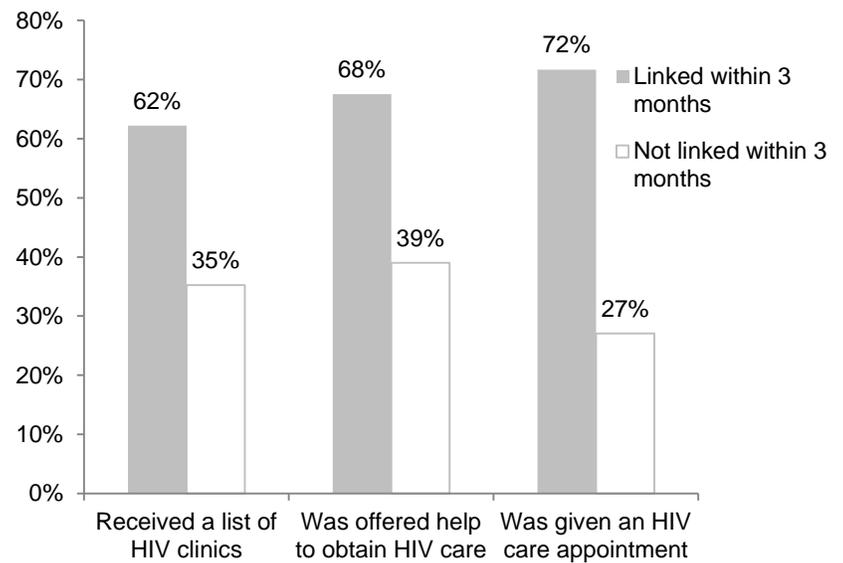
Definition: Percent of needs assessment participants who received each of type of linkage service at the time of diagnosis, and the percent reporting being linked to HIV medical care within 3 months of diagnosis.



(Graph 2) Receipt of an appointment for the first medical visit appears to be positively associated with early linkage: 72% of those who linked to care within 3 months received an appointment at the time of diagnosis, while only 27% of those who did *not* link to care within 3 months received an appointment at the time of diagnosis.

GRAPH 2-Service Linkage Activities Received at the Time of HIV Diagnosis in the Houston Area, by Linkage Timeframe, 2014

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



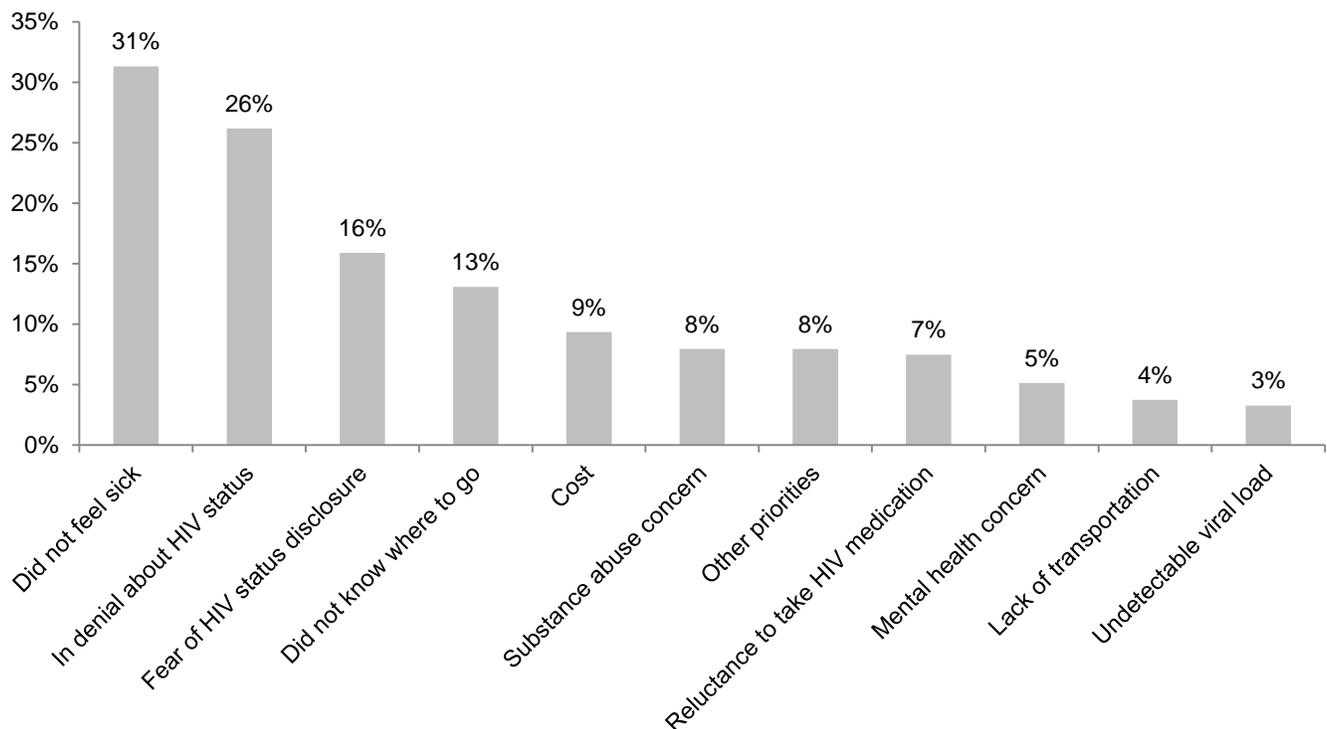
Barriers to Early Linkage

(Graph 3) Participants who delayed entry into HIV care for more than 3 months after diagnosis were asked to identify the reasons for delayed entry. Eleven commonly reported reasons were included as options in the consumer survey. Participants could also write-in their reasons. Of the 11 preset options provided,

not feeling sick was selected most often at 31% of all reasons reported. Denial was cited second, and fear of others discovering their HIV status was third. The most common write-in reason for delayed entry was incarceration.

GRAPH 3-Reasons for Delayed Linkage to HIV Care in the Houston Area, 2014

Definition: Percent of times each item was reported by needs assessment participants as the reason they were not linked to HIV care within 3 months of diagnosis.



RETENTION IN CARE

The 2014 Houston Area HIV/AIDS needs assessment asked participants about the continuity of their HIV care since diagnosis. It gathered information about the factors that help people maintain care for HIV over time and those that have served as barriers to continuous care. These results can help planners identify effective assets and strategies for increasing retention in care in the Houston Area. The National HIV/AIDS Strategy (NHAS) goal for continuous HIV care is 80%.

Notes: The majority of needs assessment participants (93%) reported being in HIV care in the past 12 months. This is most likely an artifact of the data collection process and not a representation of the Houston Area as a whole. According to local epidemiological data (generated by the Texas Department of State Health Services), 73% of all HIV-infected persons in the Houston Area were in HIV care in the past 12 months (2012). In addition, 73% of needs assessment participants reported no interruption in their HIV care for 12 months or more since diagnosis, whereas local epidemiological data

show that 48% of persons in the Houston Area have had no break in care (2012). The results presented here reflect a population purporting high and consistent levels of engagement in care over time.

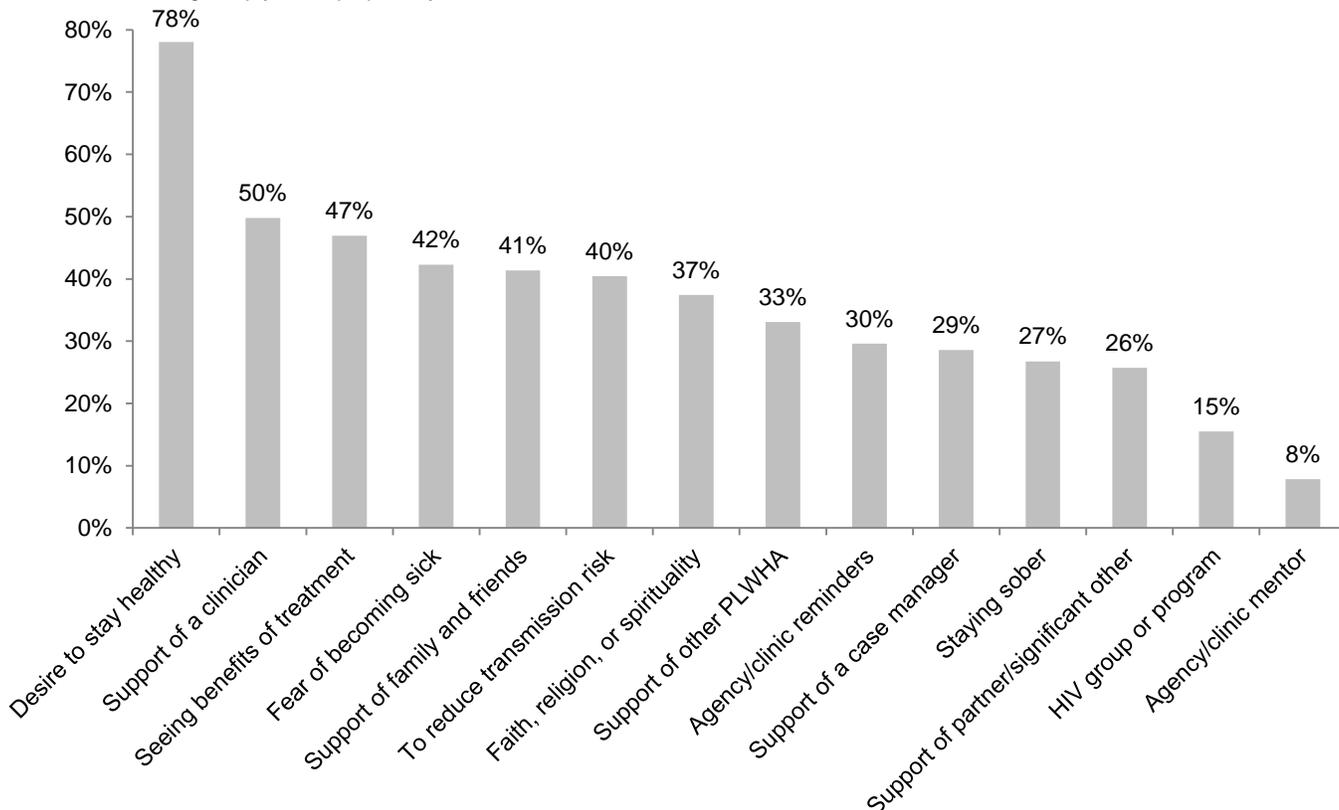
Assets for Retention in Care

(**Graph 1**) Fourteen commonly reported factors that help people maintain HIV care over time were included as options in the consumer survey. Participants could also write-in other factors. Of the 14 preset options provided, the desire to stay healthy was selected most often at 78% of participants. The support of a doctor or nurse was cited second, and seeing the benefits of treatment was third. The most common write-in reason was the support of a specific AIDS-service organization or clinic.

These results can be categorized into four general types of assets for retention in care (*in order*): a personal motivation, the support of social networks, the support of staff, and a policy or program that provides support.

GRAPH 1-Assets for Retention in HIV Care in the Houston Area, 2014

Definition: Percent of needs assessment participants who selected each option in response to the survey question, "What kinds of things help you keep up with your HIV medical care?"

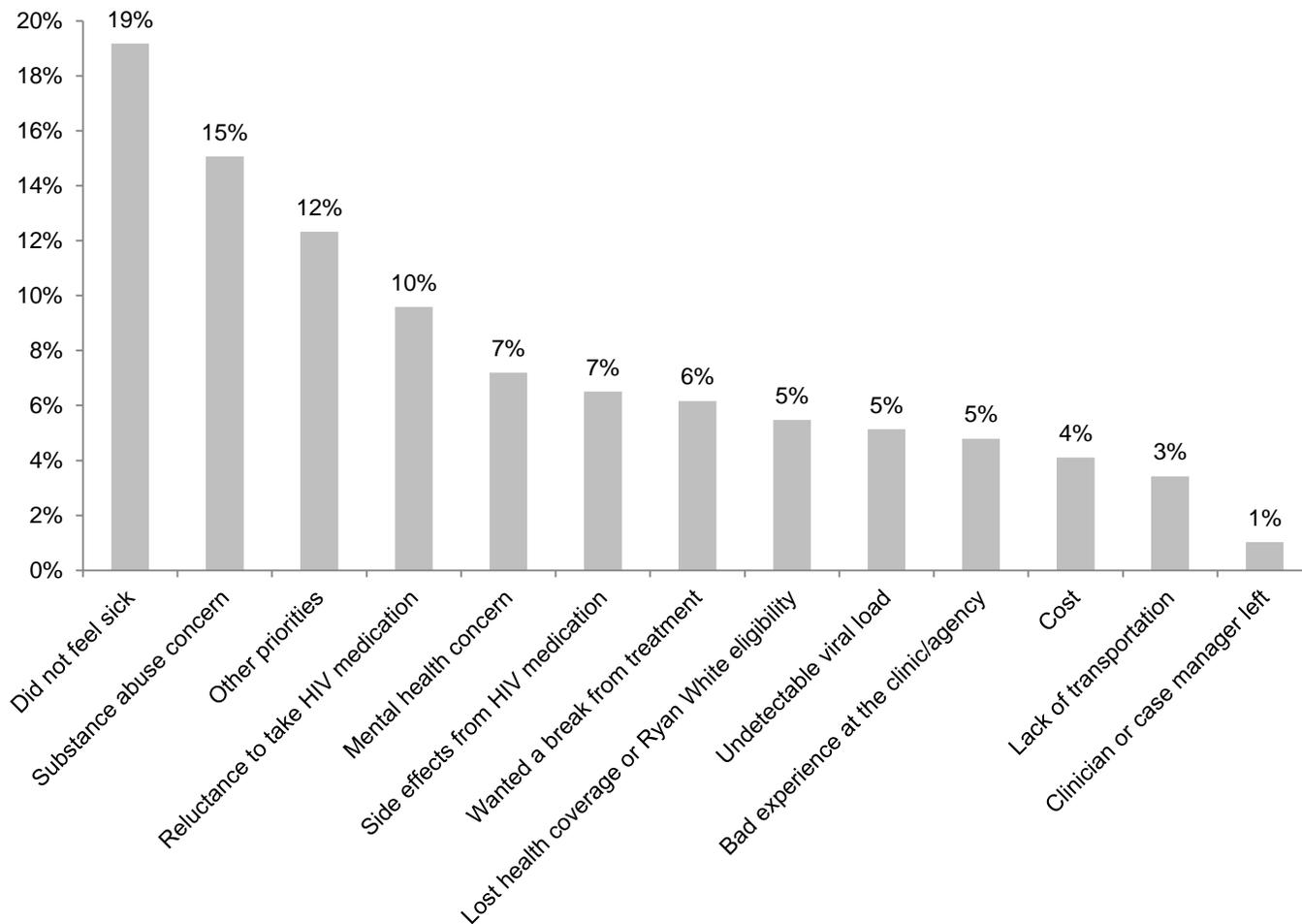


Barriers to Retention in Care

(Graph 2) Participants who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey. Participants could also write-in their reasons. Of the 13 preset options provided, not feeling sick was selected most often at 19% of all reasons reported. A problem with substance use was cited second, and having other priorities at the time was third. The most common write-in reasons for falling out of care were (*in order*): incarceration, relocation, and denial about being HIV positive.

GRAPH 2-Reasons for Falling Out of HIV Care in the Houston Area, 2014

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



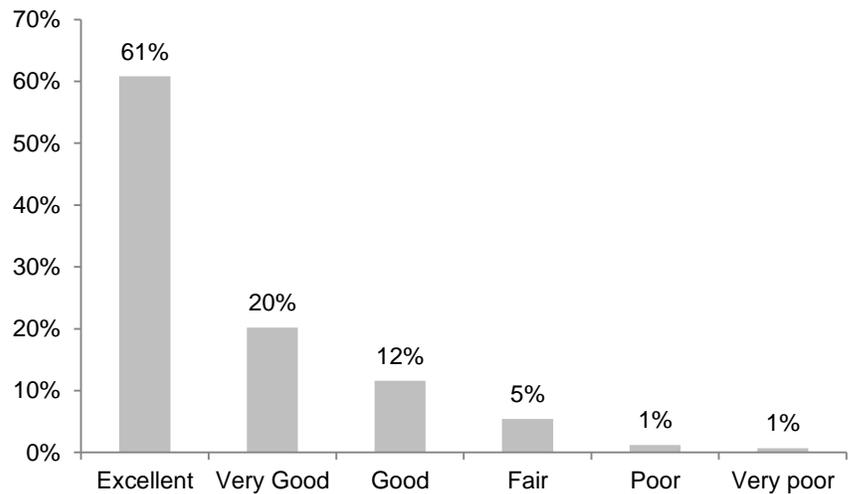
HIV MEDICATION

The 2014 Houston Area HIV/AIDS needs assessment asked participants about their experience with HIV medication, or antiretroviral therapy (ART), including adherence, barriers, and HIV-related health outcomes. These results can help planners identify needs for medication readiness and adherence efforts. They can also help identify some of the barriers people face to HIV medication, which could then be addressed by changes to HIV services.

Notes: Among needs assessment participants, the average length of HIV diagnosis was 12 years, with the majority diagnosed for between 4 and 20 years; 4% were diagnosed for less than 1 year. This means that most participants have been managing HIV disease since clinical guidelines have recommended ART for all HIV-infected individuals, regardless of CD4 (or t-cell) count, including the newly-diagnosed. This history is evident in the results presented here, as 85% of participants report ART.

GRAPH 1-Self Assessed Medication Adherence in the Houston Area, 2014

Definition: Percent of needs assessment participants rating themselves from excellent to very poor in response to the survey question, “Thinking about the past 4 weeks, on average how would you rate your ability to take all of your HIV pills as prescribed?”



Medication Adherence

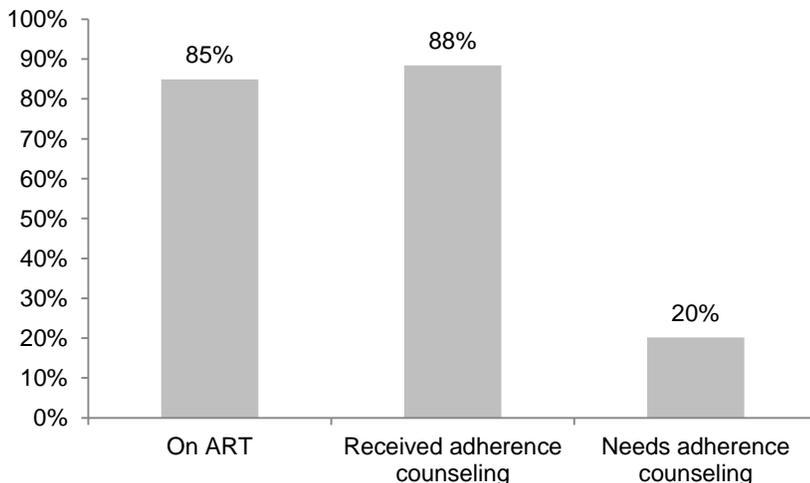
(**Graph 1**) Participants were asked to self-assess their adherence to their HIV medication schedule using the same measure used in professional treatment adherence assessments in the Houston Area.

According to this measure, the majority of participants (61%) are “excellent” in their adherence, with 1% “very poor.” The average number of pills taken per day for HIV was reported at 3; with the majority (70%) taking pills once per day.

(**Graph 2**) Participants were asked if an HIV professional had ever spoken with them about staying on schedule with their HIV medication and if additional adherence counseling was needed. Of the 84% reporting ART, 88% stated they had received adherence counseling from an HIV professional; and 20% stated a need for additional counseling. There were no notable associations between these results and self-assessed medication adherence above.

GRAPH 2-Medication Adherence Counseling in the Houston Area, 2014

Definition: Percent of needs assessment participants on ART, and, of those, percent that received adherence counseling and that need additional counseling.

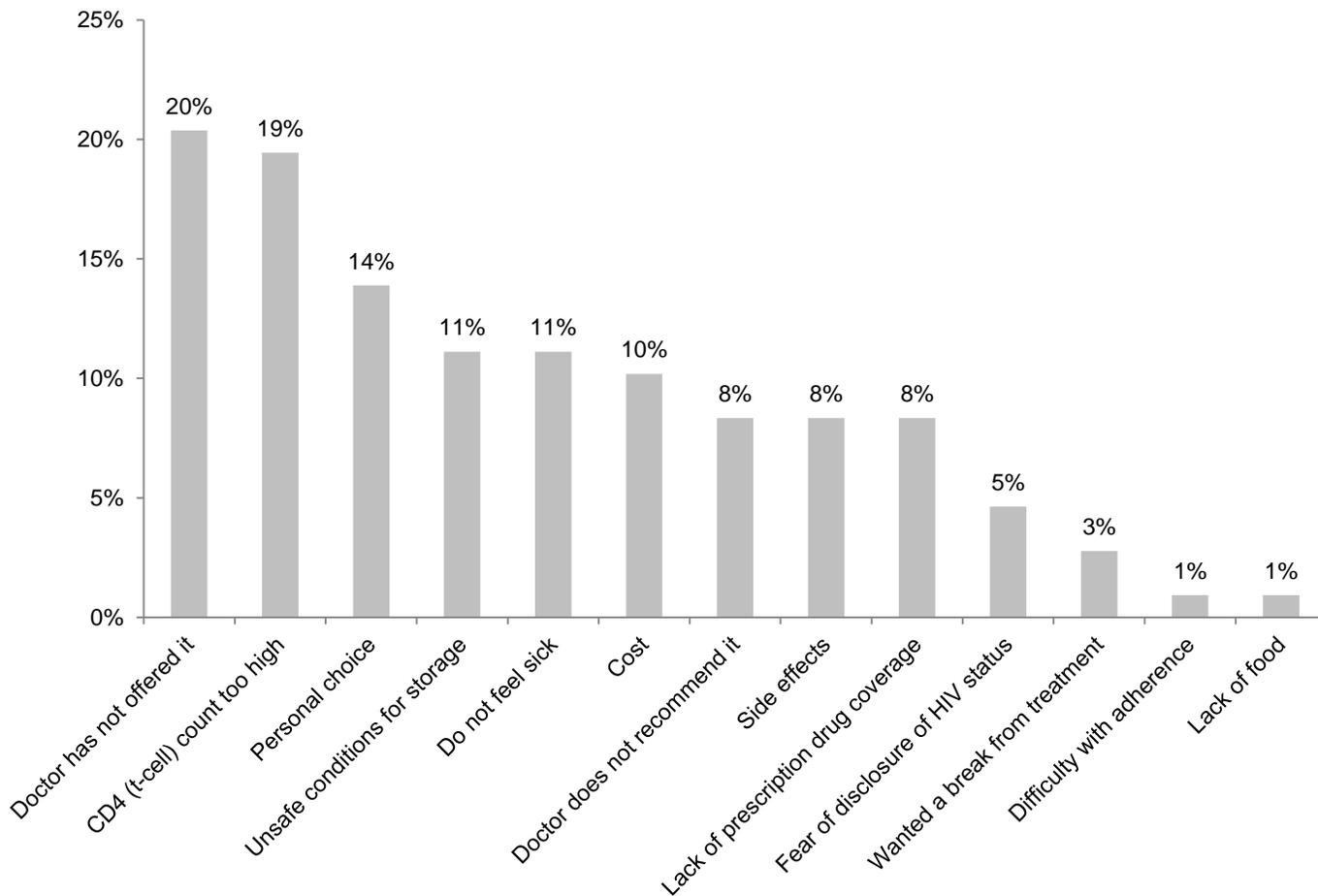


Barriers to HIV Medication

(Graph 3) Participants not on ART were asked why they were not currently taking HIV medication. Thirteen commonly reported reasons were included as options in the consumer survey. Participants could also write-in their reasons. Of the 13 preset options provided, the reason selected most often at 20% of all reasons reported was that a doctor had not offered it. A CD4 (t-cell) count that was too high was cited second, and the personal choice to not take medication was third. The most common write-in reason for not taking HIV medication was not having an HIV doctor or being out of care.

GRAPH 3- Barriers to HIV Medication in the Houston Area, 2014

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



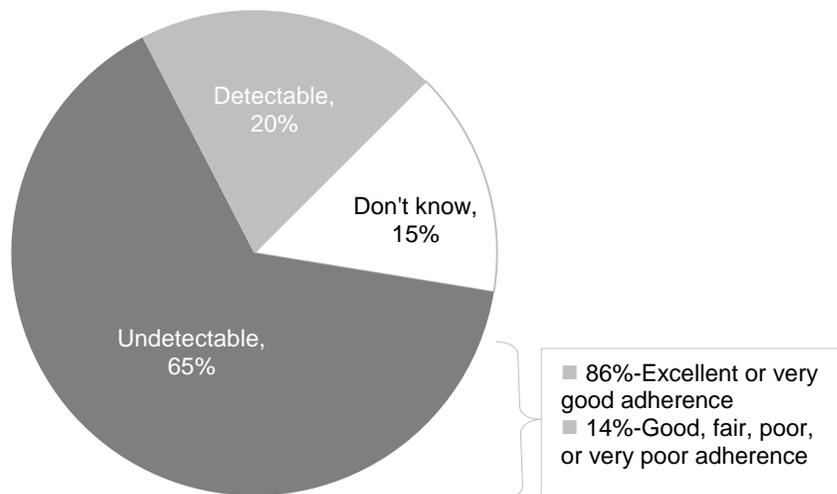
Medication Related Outcomes

Participants were asked about two monitoring tests used to measure the efficacy of HIV treatment: viral load and CD4 (or t-cell) count:

- Viral load is the amount of HIV virus in the blood stream. An HIV viral load that is so low it is undetectable by current technology is a goal of HIV treatment. At a minimum, a *suppressed* viral load (a viral load at ≤ 200 copies/mL) helps HIV-infected individuals stay healthy and reduces the risk of transmitting the virus to others.
- A CD4 (or t-cell) count measures the amount of CD4 cells in the blood stream. CD4 cells are a type of white blood cell that helps fight infection. The CD4 count is a commonly used indicator of the strength of an HIV-infected individual's immune system. A goal of HIV treatment is to sustain high CD4 counts (350 to 500), which will help individuals stay healthy and reduce the complications of HIV.

GRAPH 4-Self-Reported HIV Viral Load in the Houston Area, 2014

Definition: HIV viral load test results reported by needs assessment participants at the time of the assessment.

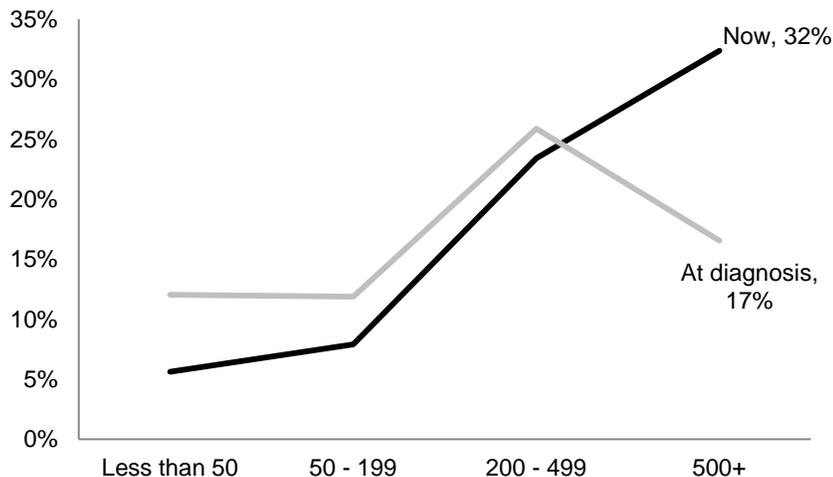


(Graph 4) The majority of needs assessment participants (65%) reported an undetectable viral load. 20% stated their virus was detectable, and 15% could not recall or did not know their viral load. In addition,

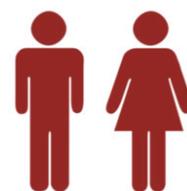
there appears to be a positive relationship between medication adherence and viral load outcomes. Of participants with an undetectable viral load, 86% reported “very good to excellent” adherence, and 14% reported “good” adherence at best.

GRAPH 5-Self-Reported CD4 (t-cell) Counts in the Houston Area, 2014

Definition: Percent of needs assessment participants reporting each CD4 (or t-cell) counts level at the time of the assessment and at first diagnosis.



(Graph 5) The desired trend in CD4 counts was reported by needs assessment participants. As HIV treatment has been received, participants report higher amounts of CD4 cells: 32% of participants reported a current CD4 count of 500 or higher; at diagnosis, 17% reported a high CD4 count. The converse relationship is also true for low CD4 counts (less than 50) now vs. at diagnosis. Approximately one-third of participants could not recall or did not know their CD4 count either now or when they were first diagnosed.

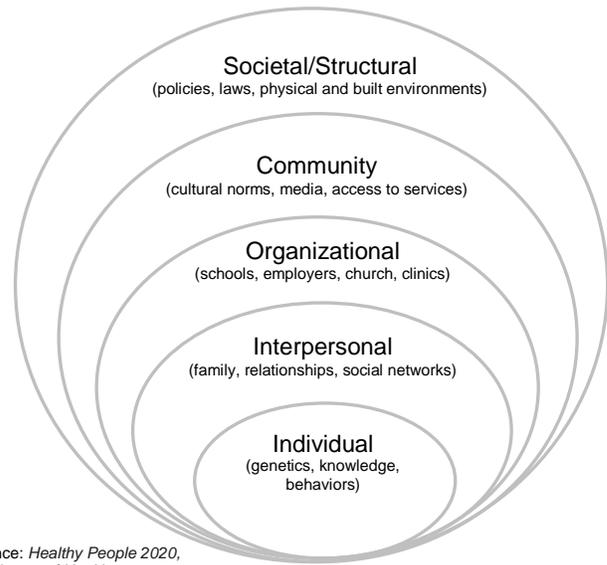


Chapter 4: Determinants of HIV Care

DETERMINANTS OF HIV CARE

Based on a model called the socio-ecological framework of health (**Figure 1**), *determinants of health* are the range of individual, community, and societal level factors that can influence health status and access to care both positively and negatively. They include personal behaviors and knowledge, socio-economic circumstances, and the physical conditions of everyday life. The needs of persons living with HIV/AIDS (PLWHA) will be influenced by all of these factors. Therefore, the 2014 Houston Area HIV/AIDS needs assessment asked participants about some of the individual, community, and societal level health determinants that can affect HIV care. The details of these conditions and experiences are described in the rest of this Chapter. Results can be used to both better understand the HIV care needs and patterns of PLWHA in the Houston Area as well as to identify new or emerging areas of need related to HIV care due to the presence of other personal, community, or societal level conditions.

FIGURE 1-The Socio-Ecological Framework of Health



Reference: *Healthy People 2020, Determinants of Health*

CO-OCCURRING HEALTH CONDITIONS

The 2014 Houston Area HIV/AIDS needs assessment asked participants if they had a current diagnosis of a physical health condition *in addition to* HIV/AIDS. Options provided in the consumer survey included common chronic diseases, autoimmune disorders, infectious diseases, and non-HIV sexually transmitted diseases (STDs). Participants could also write-in other conditions not listed. Overall, two-thirds of needs assessment participants (66%) reported a current diagnosis of *at least one* co-occurring physical health condition. This proportion was also positively associated with participant age, with 82% of participants age 50 to 64 reporting at least one co-occurring physical health condition compared to 30% of participants age 13 to 24.

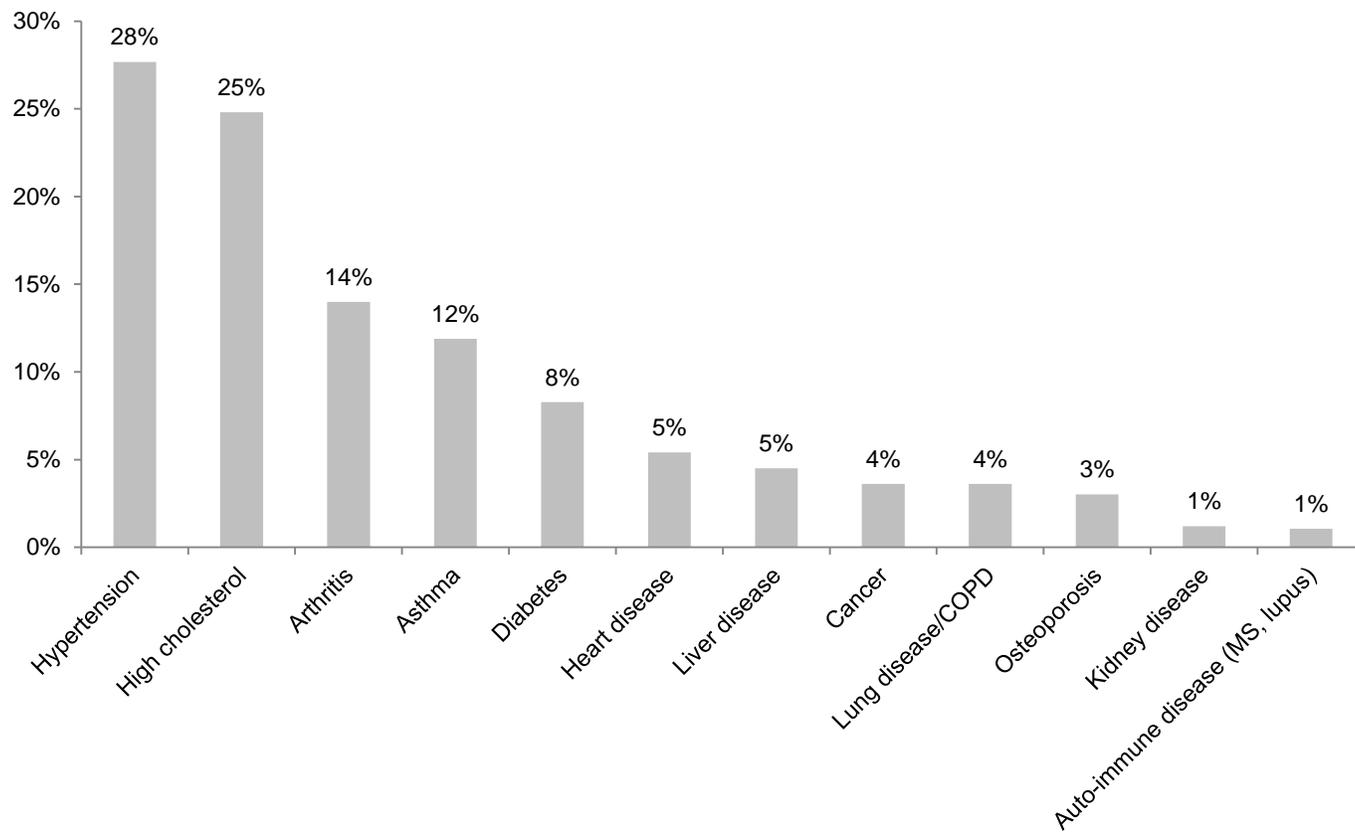
Notes: Mental health conditions were addressed separately from physical health conditions in the consumer survey, and those results are presented in the *Behavioral Health* section of this Chapter.

Chronic Disease

(**Graph 1**) Of non-infectious health conditions (or chronic diseases), the most frequently reported was hypertension (28% of participants), followed by high cholesterol (25%) and arthritis (14%). These three proportions are comparable to or lower than what is self-reported for the general Houston Area population. (Source: SMART BRFSS: Houston-Sugar Land-Baytown, TX Metropolitan Statistical Area, 2009-2011). Common write-in diagnoses included (*in order*): anemia, gastrointestinal disorders, epilepsy, and stroke.

GRAPH 1-Chronic Disease among PLWHA in the Houston Area, 2014

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

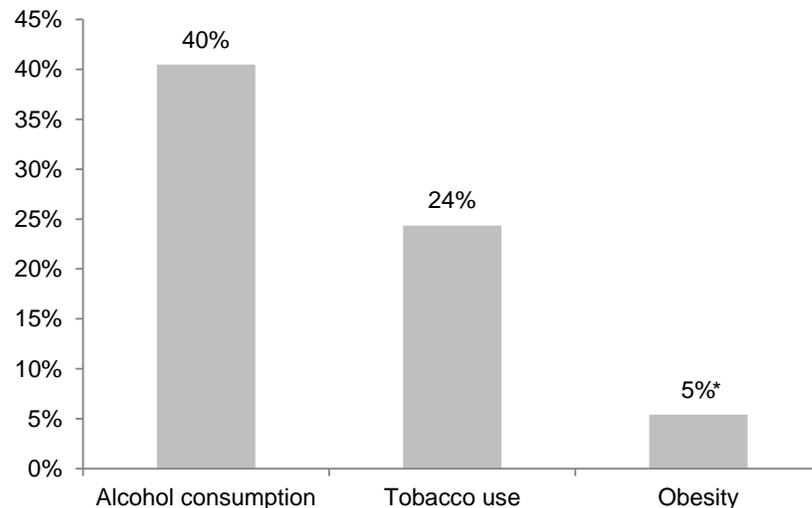


Health Risk Behaviors

(Graph 2) According to the Centers for Disease Control and Prevention, four behaviors contribute to the majority of chronic disease in the U.S.: physical inactivity, poor nutrition, tobacco use, and excess alcohol use. Needs assessment participants were asked about similar behaviors: use of alcohol in the past 12 months (which was reported by 40% of participants), use of tobacco in the past 12 months (reported by 24% of participants), and current obesity (reported by 5% of participants*). In addition, both alcohol and tobacco use appear to be negatively associated with participant age, with larger proportions of young participants (age 13 to 24) reporting use than of those age 25 and older.

GRAPH 2-Health Risk Behaviors among PLWHA in the Houston Area, 2014

Definition: Percent of needs assessment participants reporting each of the following individual risk behaviors related to chronic disease.



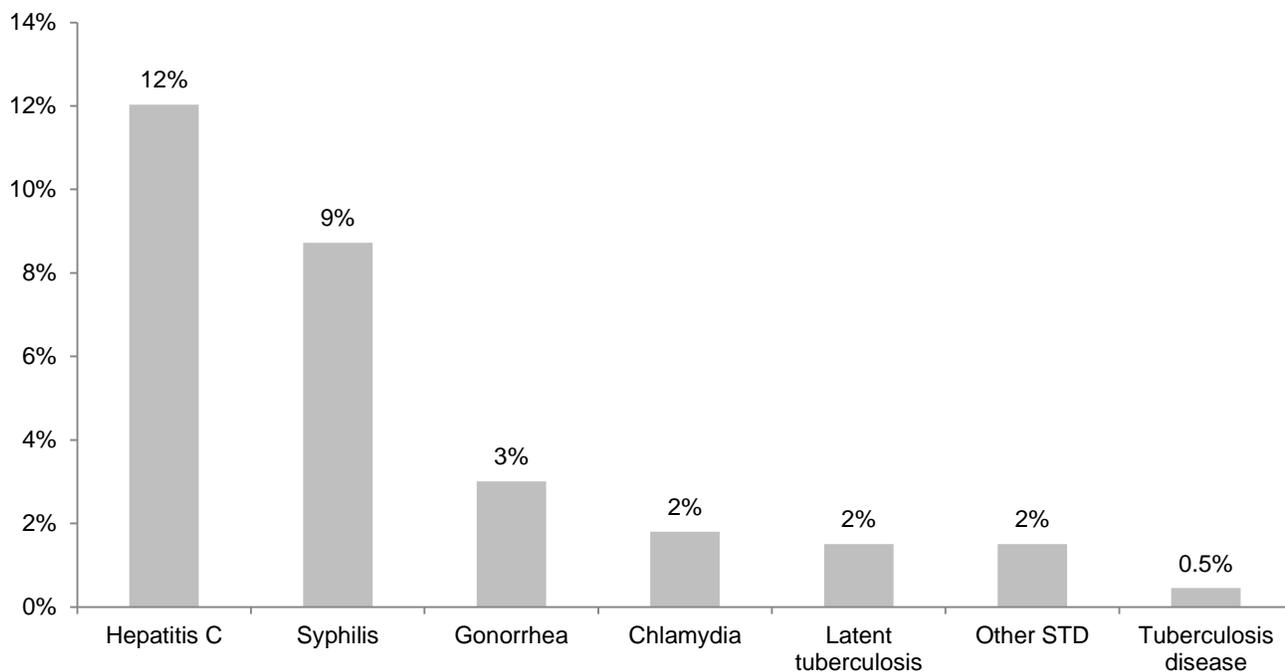
*Since the proportion reporting obesity among the general Houston Area population is 6 times greater, this is most likely a reporting bias. Results for alcohol and tobacco use are more reliable. (Source: SMART BRFSS; Houston-Sugar Land-Baytown, TX Metropolitan Statistical Area, 2009-2011).

Co-Infection

(Graph 3) Of infectious health conditions (including other STDs), the most frequently reported was Hepatitis C (12% of participants). 9% of participants reported a syphilis co-infection in the last 6 months. Less than 1% of participants reported current tuberculosis disease, which is a diagnostic criterion for AIDS. Of those reporting a concurrent bacterial STD (Chlamydia, gonorrhea, or syphilis), 82% reported receiving treatment. In addition, co-infection with a bacterial STD appears to be negatively associated with participant age, with 21% of participants age 13 to 24 reporting co-infection compared to 4% of participants age 45 and older.

GRAPH 3-Co-Infection among PLWHA in the Houston Area, 2014

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



BEHAVIORAL HEALTH

Behavioral health refers to the range of conditions related to or impacting mental or emotional well-being. It includes both diagnosed mental illness and indications of psychological distress as well as substance use and misuse. (Source: Substance Abuse and Mental Health Services Administration, 2011). The 2014 Houston Area HIV/AIDS needs assessment asked participants about each of type of behavioral health concern including current mental health diagnoses, mental/emotional distress symptoms, and substance use and abuse. Each type is discussed in detail in this Chapter.

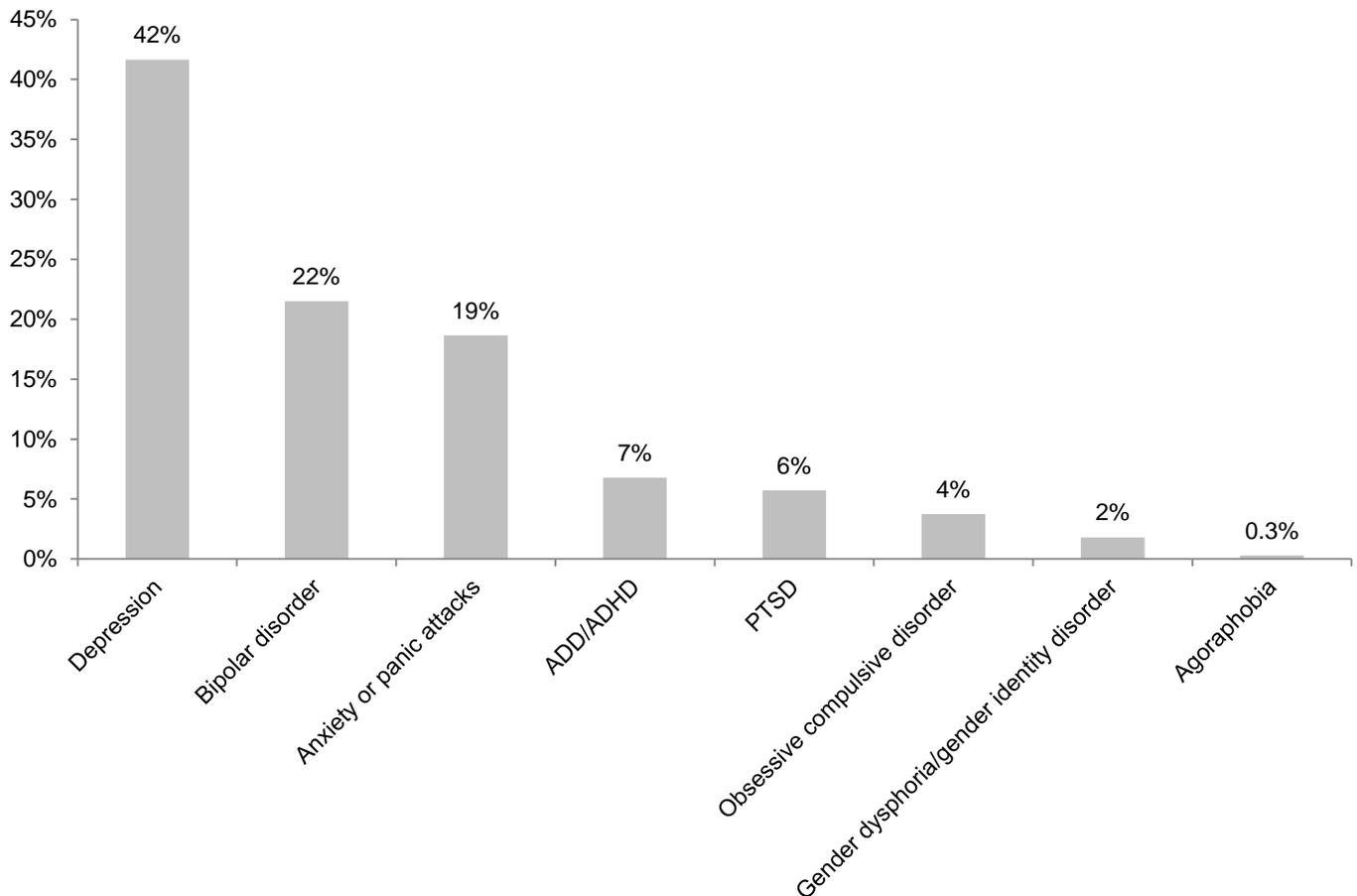
Notes: Physical health conditions were addressed separately from mental health conditions in the consumer survey, and those results are presented in the *Co-Occurring Health Conditions* section of this Chapter.

Mental Health Diagnoses

(**Graph 1**) Over half of needs assessment participants (54%) reported having a current *diagnosis* of at least one mental health condition from among a preset list of common illnesses. The most frequently reported diagnosis was for depression at 42% of participants.

GRAPH 1-Mental Health Diagnoses among PLWHA in the Houston Area, 2014

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

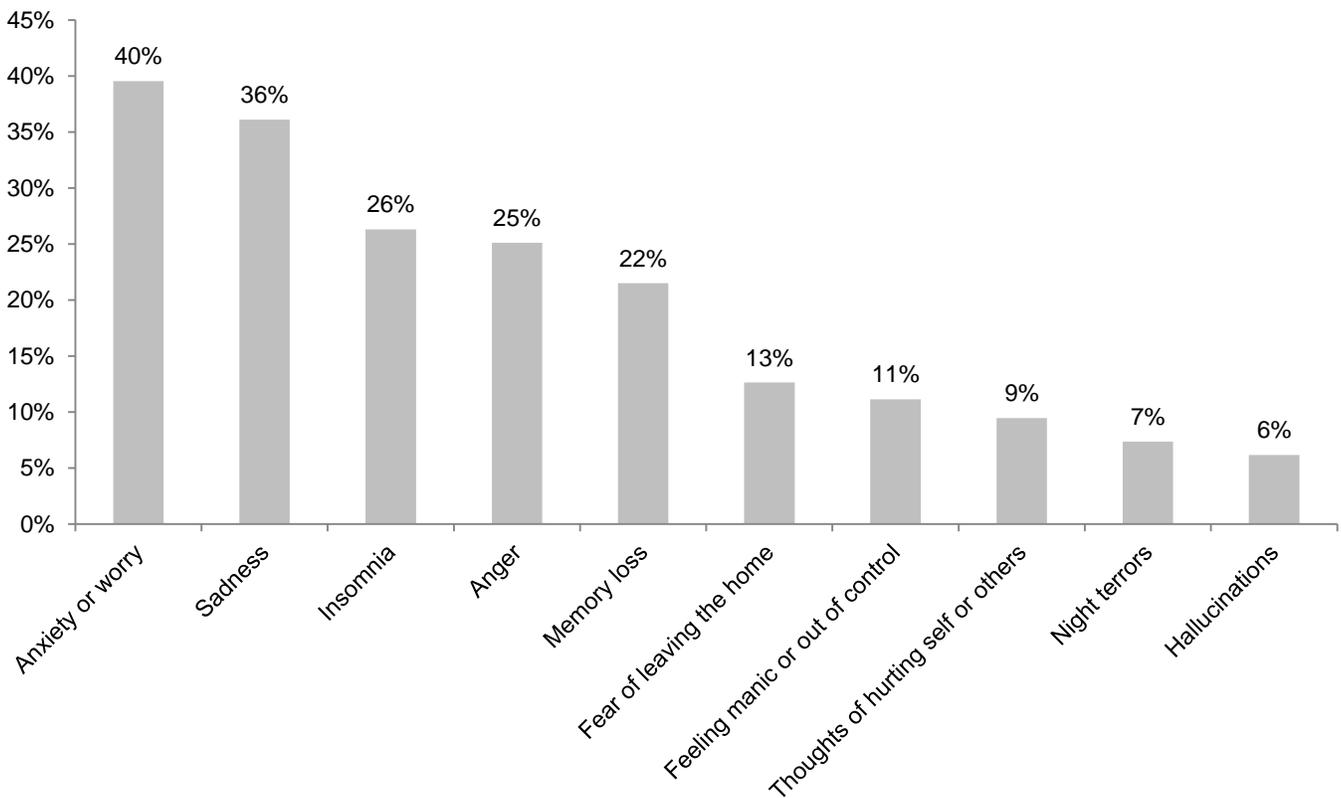


Mental/Emotional Distress

(Graph 2) In addition to mental health diagnoses, participants were also asked if they had experienced any symptoms of mental/emotional distress in the past 12 months *to such an extent* that they desired professional help. Overall, 61% of participants reported at least one such symptom. Of those listed, the most frequently reported was anxiety or worry (40% of participants), followed by sadness (36%) and insomnia (26%).

GRAPH 2-Mental/Emotional Distress Symptoms among PLWHA in the Houston Area, 2014

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



Mental/Emotional Support

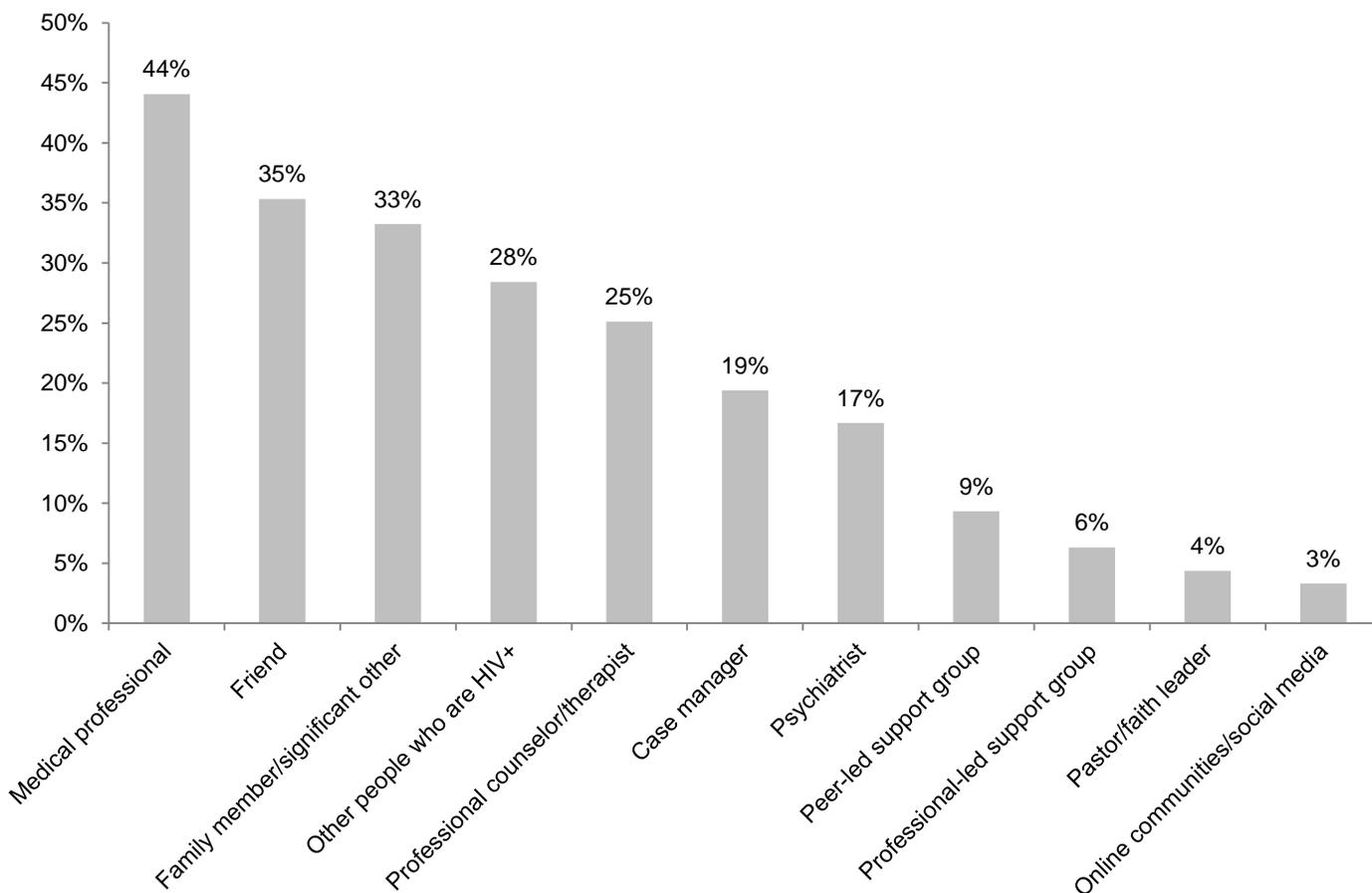
(Graph 3) Participants were also asked about their mental/emotional support systems for managing HIV. The majority of participants (89%) reported having at least one person or group they can talk to about their concerns. These included mental health professionals, peers, social networks, support groups, and virtual communities. The most frequently reported type of support was from a medical professional such as a doctor or nurse at 44% of participants. Friends, family members/significant others, and HIV infected peers were also cited by about one-third of participants.

The proportion reporting *no* source of mental/emotional support in 2014 (11%) was lower than in the last Houston Area HIV/AIDS needs assessment conducted in 2011, when 19% of participants said they had *no* person or group they can talk to about their concerns.

Population-level analysis shows some differences from these overall results. The proportion of PLWHA who are out of care who report no source of support is 3 times greater than all participants; and the proportions of young PLWHA (age 13 to 24) and the homeless who report no support are 2 times greater.

GRAPH 3-Mental/Emotional Support Sources among PLWHA in the Houston Area, 2014

Definition: Percent of needs assessment participants who selected each option in response to the survey question, "Who do you talk to most often about your HIV diagnosis?"

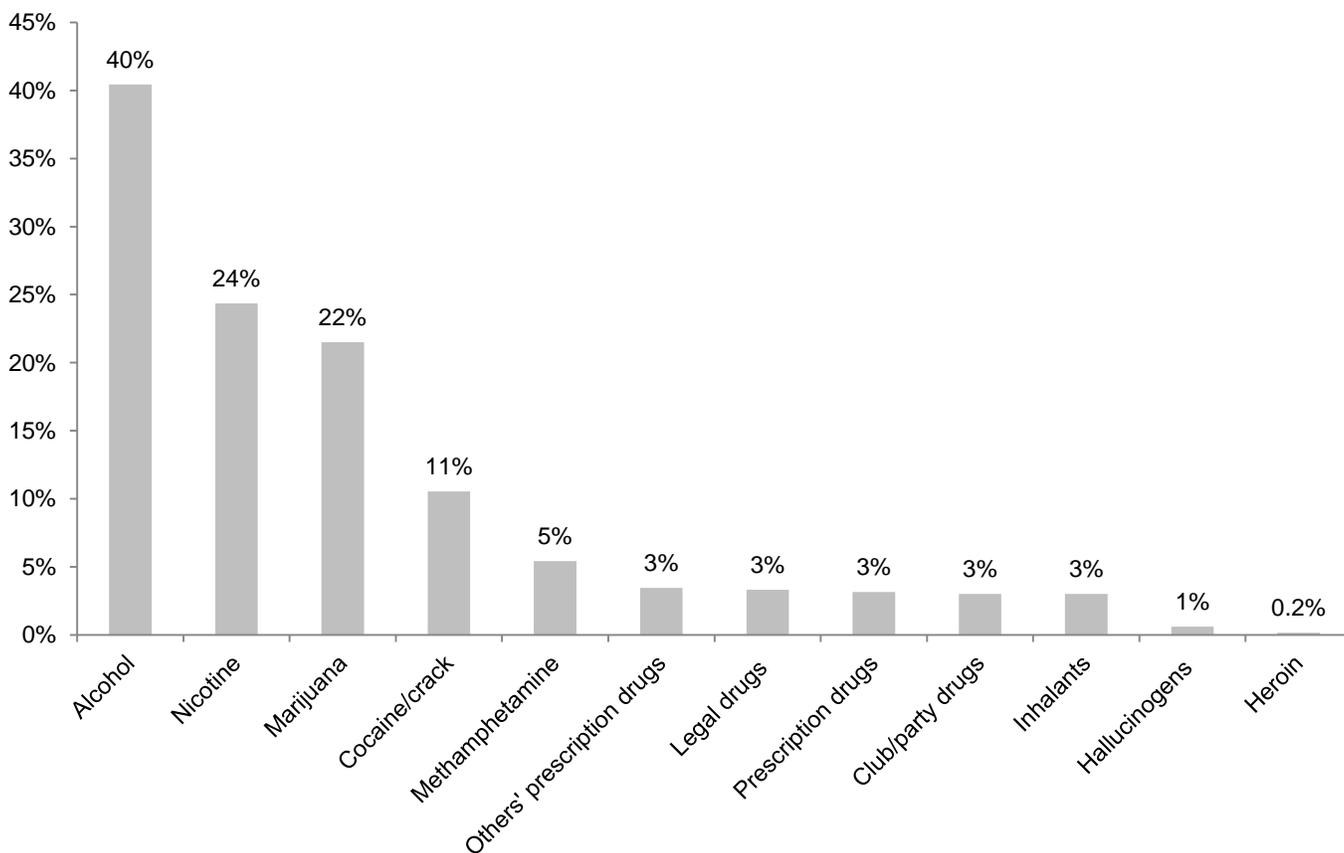


Substance Use and Abuse

(Graph 4) Participants were asked to identify any substances they had used in any amount in the past 12 months, selecting from a preset list of both legal and illegal drugs, including alcohol and nicotine. This is of concern since substance use can impact adherence to HIV care affect as well as overall health outcomes. In total in the past 12 months, 40% of participants reported using alcohol, 24% reported using nicotine, and 33% reported using an illicit drug of some kind, including those obtained legally but used differently than intended. The most frequently reported illicit substance used was marijuana (22% of participants).

GRAPH 4-Use of Alcohol and Other Drugs among PLWHA in the Houston Area, 2014

Definition: Percent of needs assessment participants who reported using each substance in any amount in the past 12 months.



In addition to the use of substances, the consumer survey also measured substance *abuse* using the Two-Item Conjoint Screen (TICS), a validated screening tool for the detection of current substance use disorders. The TICS includes two screening questions; a positive response to both questions indicates a 75% likelihood of substance abuse. (Source: Brown, RL et al, A two-item conjoint screen for alcohol and other drug problems. *Journal of the American Board of Family Medicine*, 2001, 14: 95-106).

According to this tool at the highest sensitivity:

- 10% of participants have a likelihood of alcohol abuse.
- 10% of participants have a likelihood of drug abuse.
- In addition, 10% of participants agreed that their alcohol or drug use had made it difficult for them to obtain HIV care at some time.
- 41% stated they use alcohol or drugs, but it has not interfered with their HIV care.

SOCIO-ECONOMIC DETERMINANTS OF HEALTH

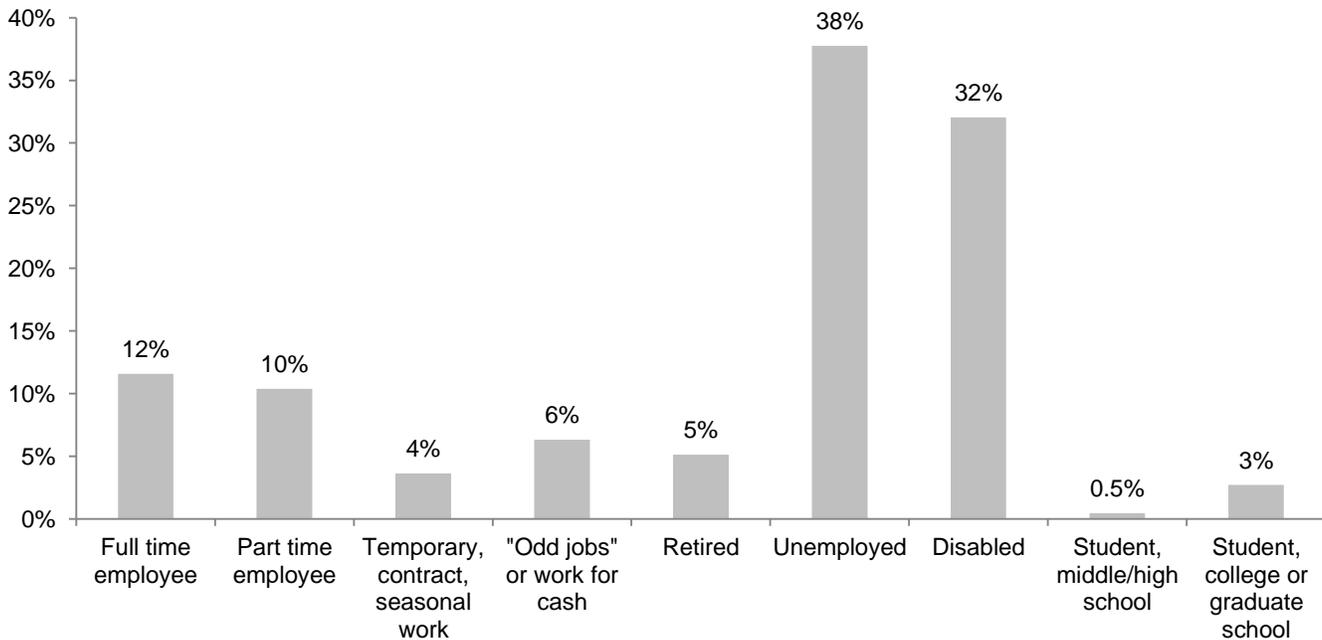
The social and economic circumstances of individuals can directly influence their health status and access to care. Factors such as employment, income, education, housing, transportation, and medical coverage all serve as either gateways or barriers to health. These factors are often the underlying causes for health disparities in certain populations. (Source: Centers for Disease Control and Prevention. *Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States*. October 2010). The 2014 Houston Area HIV/AIDS needs assessment asked participants about these social and economic circumstances.

Employment

(**Graph 1**) Participants were asked to indicate their current employment status. 38% stated they were currently unemployed, and 32% stated they were not working due to a disability. Both proportions are over 4 times higher than what is reported by the general Houston Area population. (Source: U.S. Census. 2009-2011 American Community Survey 3-Year Estimates. DP03: Selected Economic Characteristics. Retrieved on 1/31/13).

GRAPH 1-Employment Status among PLWHA in the Houston Area, 2014

Definition: Percent of needs assessment participants who indicated each type of current employment status.



Household Income

(Table 1) Participants were asked to estimate their current monthly household income and to identify any sources of supplemental income. The average annual household income reported across respondents was \$8,555, or \$753 per month, which is over 7 times lower than the average median household income of the general Houston Area population. In addition, the

proportion of participants reporting each type of supplemental income was higher than the general Houston Area population. 25% reported receiving Social Security, 25% reported disability benefits, 3% reported cash assistance (in the form of TANF/AFDC), and 31% reported food stamps.

TABLE 1-Average Household Income and Supplemental Income among PLWHA in the Houston Area, 2014

	Mean Annual Household Income	Percent Receiving Each Type of Supplemental Income			
		Social Security	Disability	Cash Public Assistance	Food Stamps
PLWHA (2014)	\$8,555	26%	25%	3%	31%
EMA Average (2011) ^a	\$60,926	23%	4%	2%	10%

^aSource: U.S. Census. 2009-2011 American Community Survey 3-Year Estimates. DP03: SELECTED ECONOMIC CHARACTERISTICS. Retrieved on 1/31/13.

Educational Attainment

(Table 2) Needs assessment participants were asked about their educational attainment, which was defined as the highest level of education they had *finished*. A comparable proportion of participants to the general Houston Area population reported having less than a

high school education (19%); however, a lower proportion of participants reported completing a higher education degree (11% compared to 29% of the general Houston Area population).

TABLE 2-Educational Attainment among PLWHA in the Houston Area, 2014

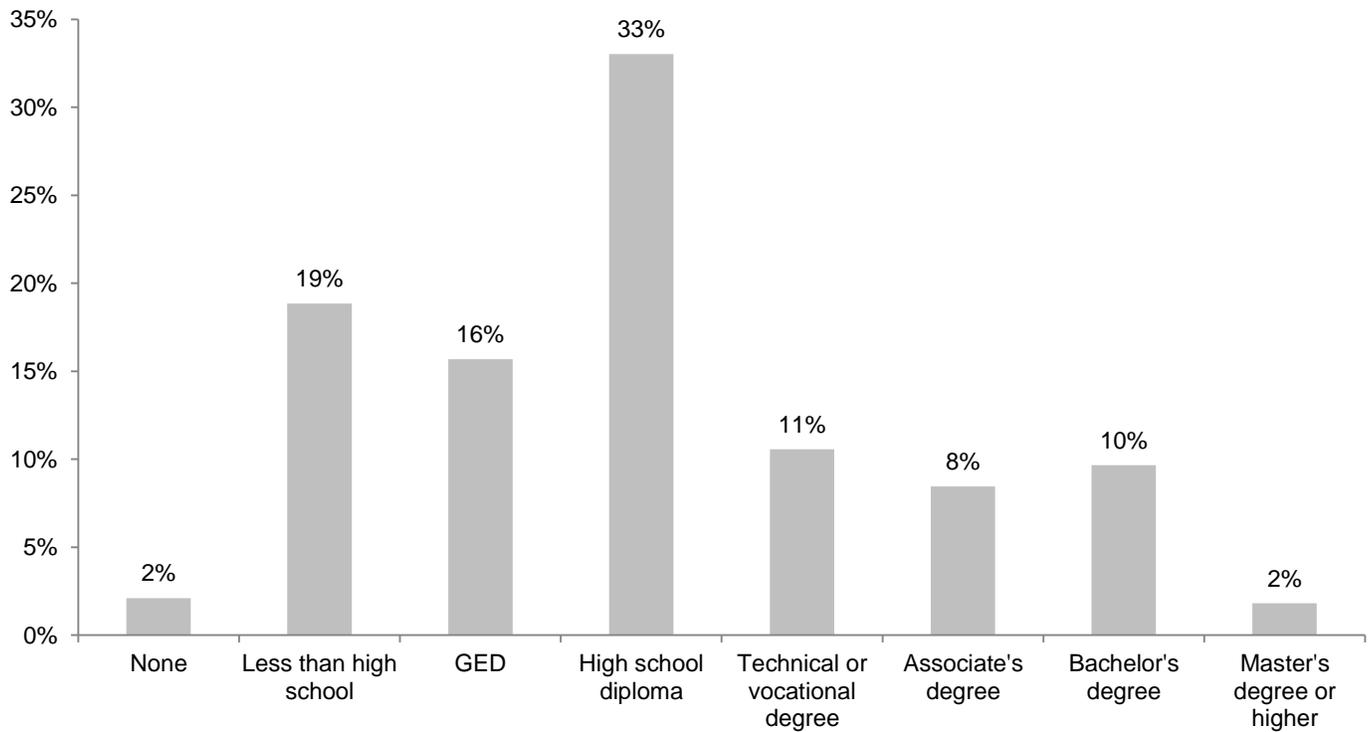
	Less than high school	High school diploma or GED	Bachelor's degree or higher
PLWHA (2014)	19%	49%	11%
EMA Average (2011) ^a	19%	23%	29%

^aSource: U.S. Census. 2009-2011 American Community Survey 3-Year Estimates. S2301: EMPLOYMENT STATUS. Retrieved on 1/31/13. Population is age 25 to 64.

(Graph 2) At 33%, the largest proportion of participants had a high school diploma. Equal proportions reported no education and a Master's degree or higher (2%).

GRAPH 2-Educational Attainment among PLWHA in the Houston Area, 2014

Definition: Percent of needs assessment participants who completed each level of education.

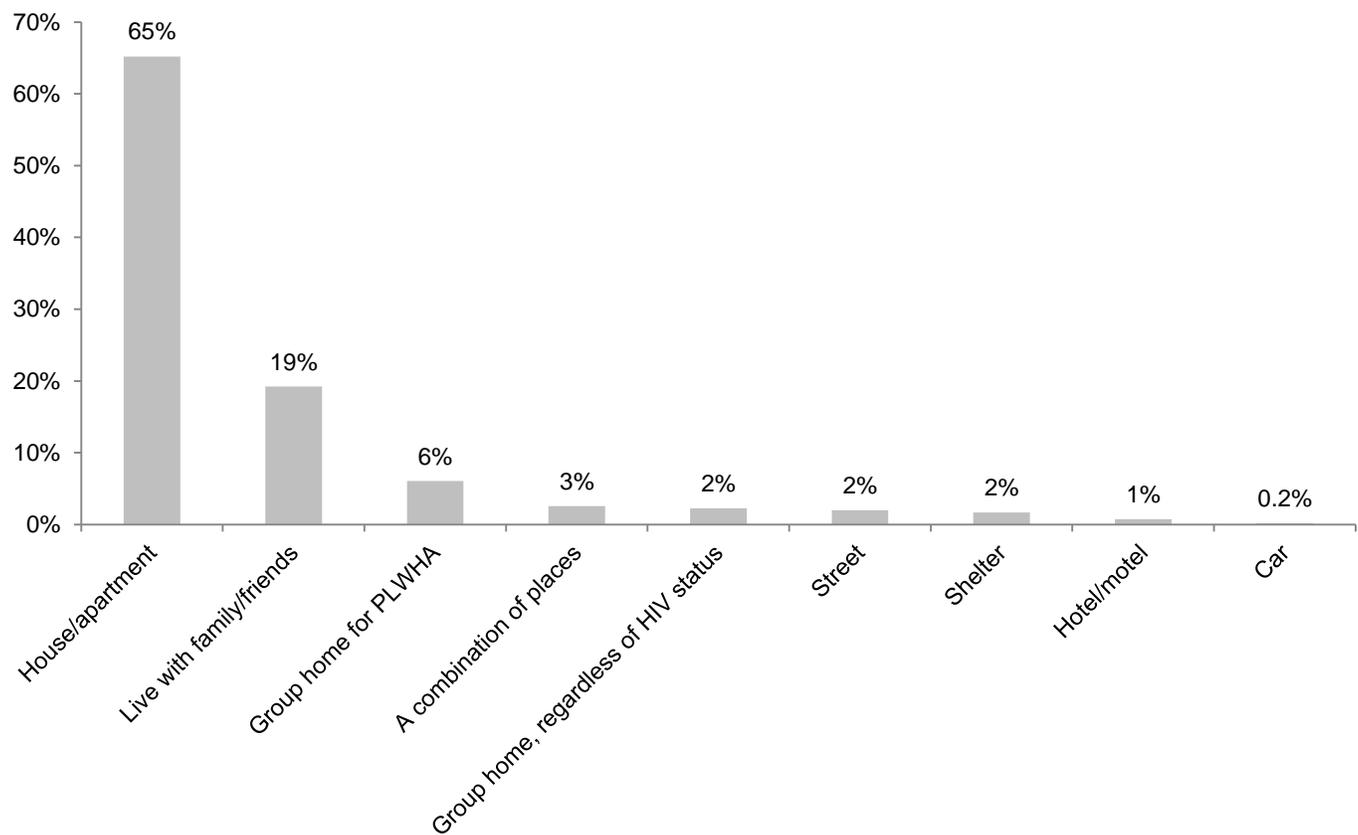


Housing and Transportation

(Graph 3) The majority of participants (65%) resided in their own house or apartment; 14% stated their housing was subsidized. In addition, 27% of participants felt their current housing situation was unstable, and 7% met the local definition of homelessness at the time of the survey, which includes residing most often in a shelter, car, street, or an inconsistent combination of various locations.

GRAPH 3-Housing Status among PLWHA in the Houston Area, 2014

Definition: Percent of needs assessment participants who selected each type of housing in response to the survey question, "Where do you sleep most often?"



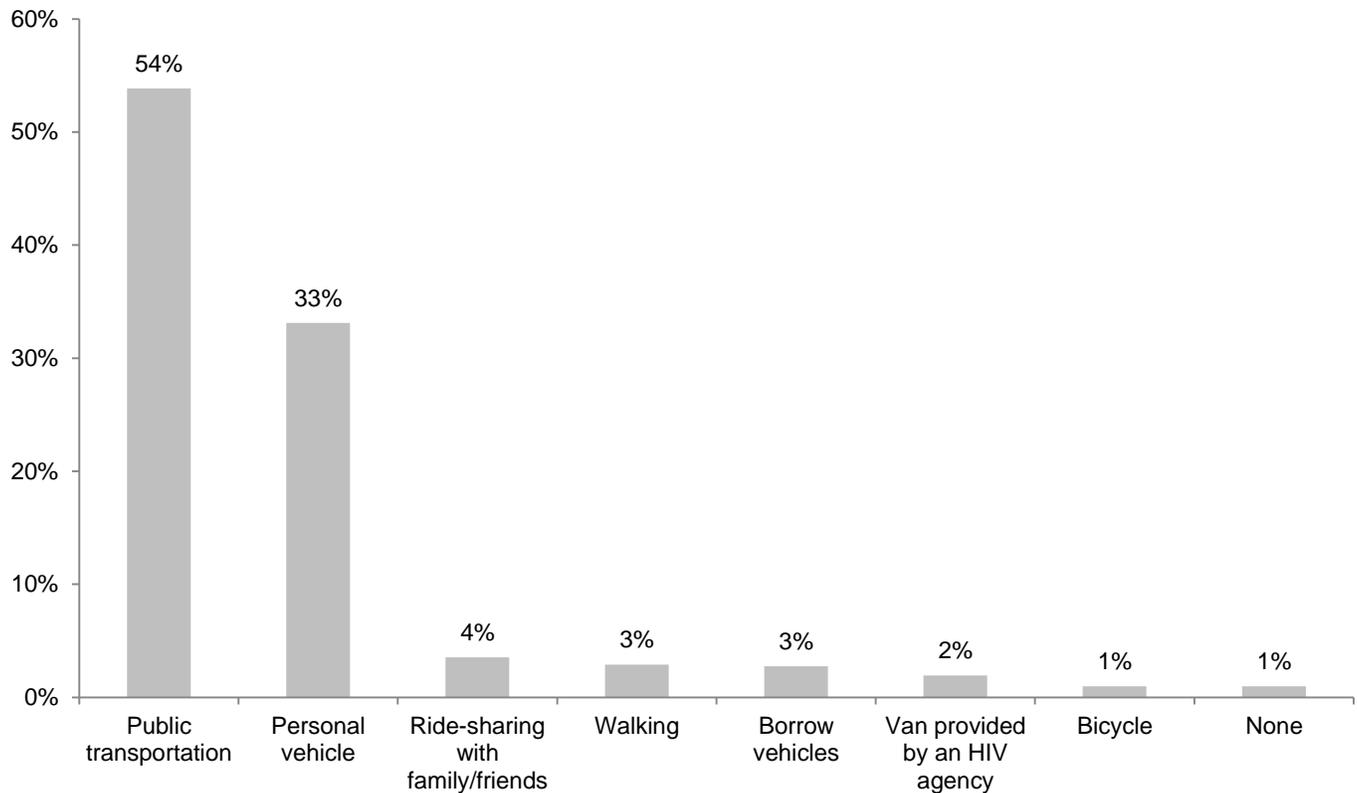
Participants were also asked if their housing situation had ever made it difficult for them to obtain HIV care. In total, 20% of participants stated that housing had been a barrier to care at some time since their diagnosis. Of those reporting housing as a difficulty, the reasons given were:

- 48% had to divert money from HIV care to housing-related expenses;
- 31% stated they could not keep their HIV status private where they were living;
- 20% stated they had no place to safely store their HIV medications;
- 18% had relocated, and it was no longer convenient to access their HIV care provider; and
- 14% stated they did not have time to access HIV care due to the time needed to search for housing.

(Graph 4) The majority of participants (54%) reported using the Houston Area public transportation system, or METRO, as their primary mode of transportation. This includes METRO buses, trains, and vans. 33% of participants reported having their own vehicle, and 1% reported having no transportation.

GRAPH 4-Transportation among PLWHA in the Houston Area, 2014

Definition: Percent of needs assessment participants who selected each option as their primary mode of transportation.



Medical Care Coverage

Participants were asked details about their medical care coverage for themselves and their families, including if their only medical care is for HIV through the Ryan White HIV/AIDS Program, if they did not receive medical care due to the inability to pay, and any difficulties they have encountered paying for prescription medications for HIV or other health conditions.

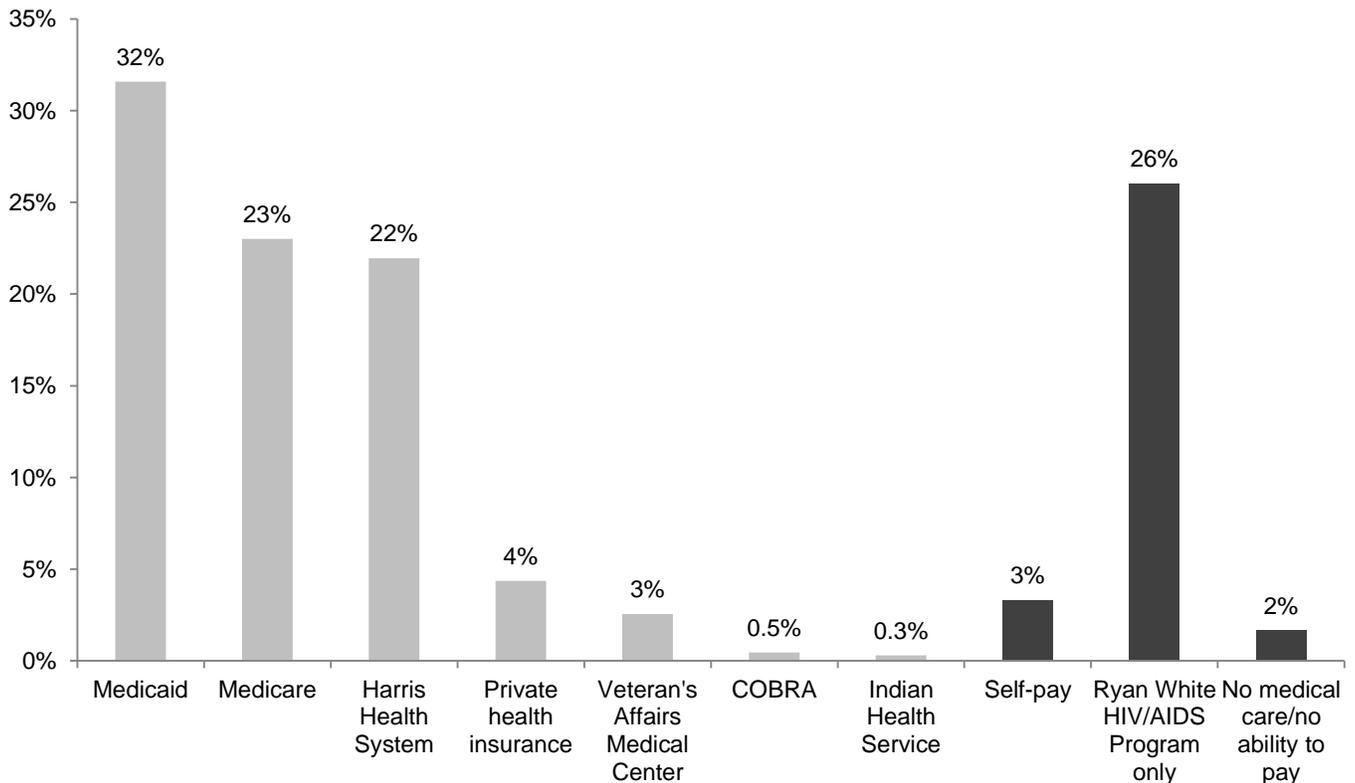
(Graph 5) 26% of participants stated they receive medical care *only* for HIV through the Ryan White Program, 3% stated that they pay for all medical care for themselves or their family out-of-pocket with no

assistance, and 2% stated they did not receive medical care due to inability to pay. This means that the remaining participants (or 69%) reported *some form* of medical coverage, including public health insurance such as Medicaid or Medicare, private health insurance, or health care via programs for specific populations such as veterans or American Indians/Alaska Natives.

Of these specific sources for coverage, 32% of participants said they have Medicaid, 23% Medicare, 22% were in the Harris Health System (formerly Gold Card), and 4% have private health insurance.

GRAPH 5-Sources of Medical Care Coverage among PLWHA in the Houston Area, 2014

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



(Graph 6, Graph 7, and Graph 8) Participants were asked if they had experienced difficulty paying for prescription medications for HIV or other co-occurring physical or mental health conditions if prescribed. Results are as follows (*in order*):

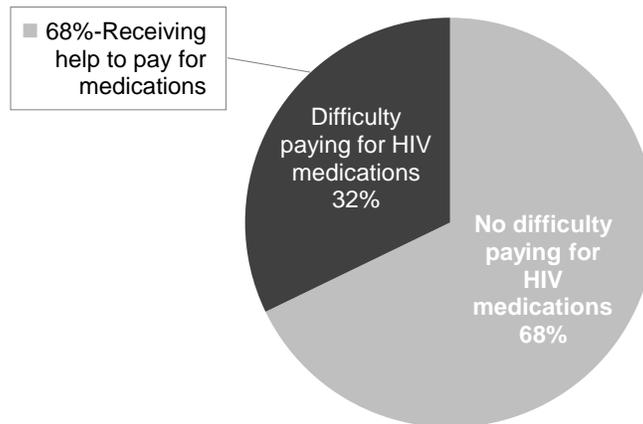
- 32% of participants on HIV medications reported difficulty paying for their prescriptions at least “some of the time.” 16% reported difficulty paying “all of the time.” Of those reporting difficulty, 68% were receiving financial assistance.

- 38% of participants on medication for a mental health condition reported difficulty paying for their prescriptions at least “some of the time.” 20% reported difficulty paying “all of the time.” Of those reporting difficulty, 53% were receiving financial assistance.

- 41% of participants on medication for a co-occurring physical health conditions (other than HIV) reported difficulty paying for their prescriptions at least “some of the time.” 20% reported difficulty paying “all of the time.” Of those reporting difficulty, 55% were receiving financial assistance.

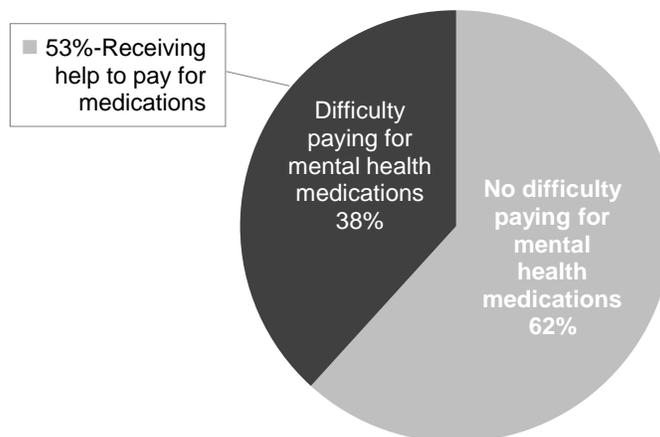
GRAPH 6-Difficulty Paying for HIV Medications among PLWHA in the Houston Area, 2014

Definition: Percent of needs assessment participants who indicated difficulty paying for HIV medications at least “some of the time” and, of those, the percent receiving help.



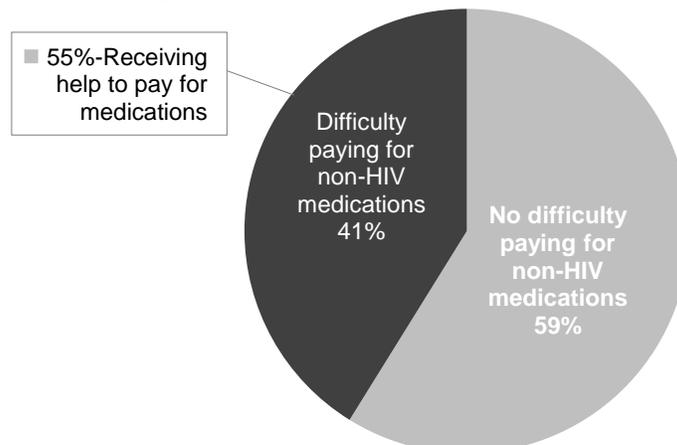
GRAPH 7-Difficulty Paying for Mental Health Medications among PLWHA in the Houston Area, 2014

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



GRAPH 8-Difficulty Paying for Non-HIV Medications among PLWHA in the Houston Area, 2014

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



EXPERIENCE WITH DISCRIMINATION AND VIOLENCE

Despite the widespread presence of HIV in the U.S., persons living with HIV/AIDS (PLWHA) can encounter differential treatment, or discrimination, due to their HIV status. Research also suggests a link between HIV and violence, including intimate partner violence. (Source: Health Resources and Services Administration, HIV/AIDS Bureau, *HRSA CARE Action*, Intimate Partner Violence, September 2009). Negative experiences like discrimination and violence can impact the physical and emotional health of PLWHA as well as their ability to access HIV care. Therefore, the 2014 Houston Area HIV/AIDS needs assessment asked participants if they had experienced differential treatment due to being HIV infected as well as any physical or sexual violence.

HIV-Related Discrimination

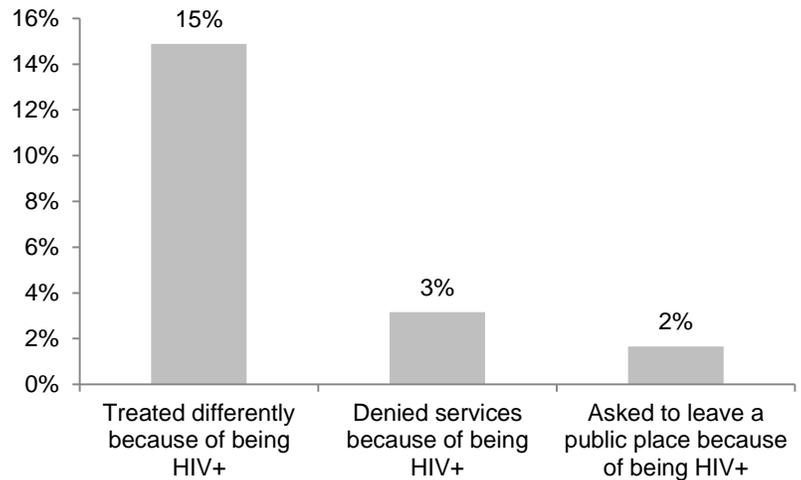
(Graph 1) 15% of needs assessment participants said they had been treated differently sometime in the past 12 months because of their HIV status. 3% said they were denied services and 2% said they were asked to leave a public place.

Experience with Violence

(Graph 2) From 3% to 8% of needs assessment participants experienced some form of violence in the past 12 months. 3% reported sexual assault; 5% reported physical assault; and 8% were threatened with violence. 5% stated they were currently in an intimate relationship with someone who made them feel afraid, threatened, or isolated or who physically or sexually assaults them.

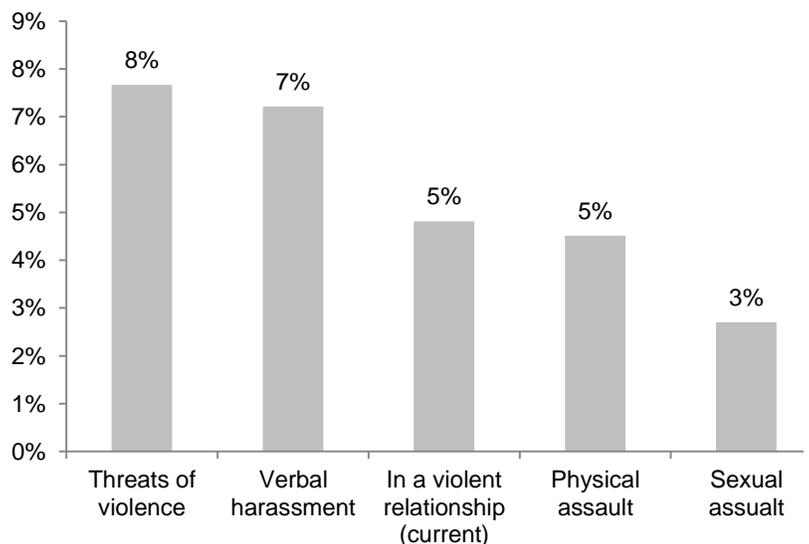
GRAPH 1-HIV-Related Discrimination in the Houston Area, 2014

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



GRAPH 2-Violence Experienced by PLWHA in the Houston Area, 2014

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



HIV PREVENTION BEHAVIORS AND RISKS

Behaviors that prevent HIV are medically important for persons who are HIV infected. Prevention behaviors lower the risk of HIV transmission to others as well as acquisition of other sexually transmitted diseases (STDs) or blood borne infections. (Source: Health Resources and Services Administration, HIV/AIDS Bureau, Guide for HIV/AIDS Clinical Care, *Preventing HIV Transmission/Prevention with Positives*, January 2011). Therefore, the 2014 Houston Area HIV/AIDS needs assessment asked participants about their needs related to HIV prevention information and the practice of safer sex behaviors.

Access to HIV Prevention Information

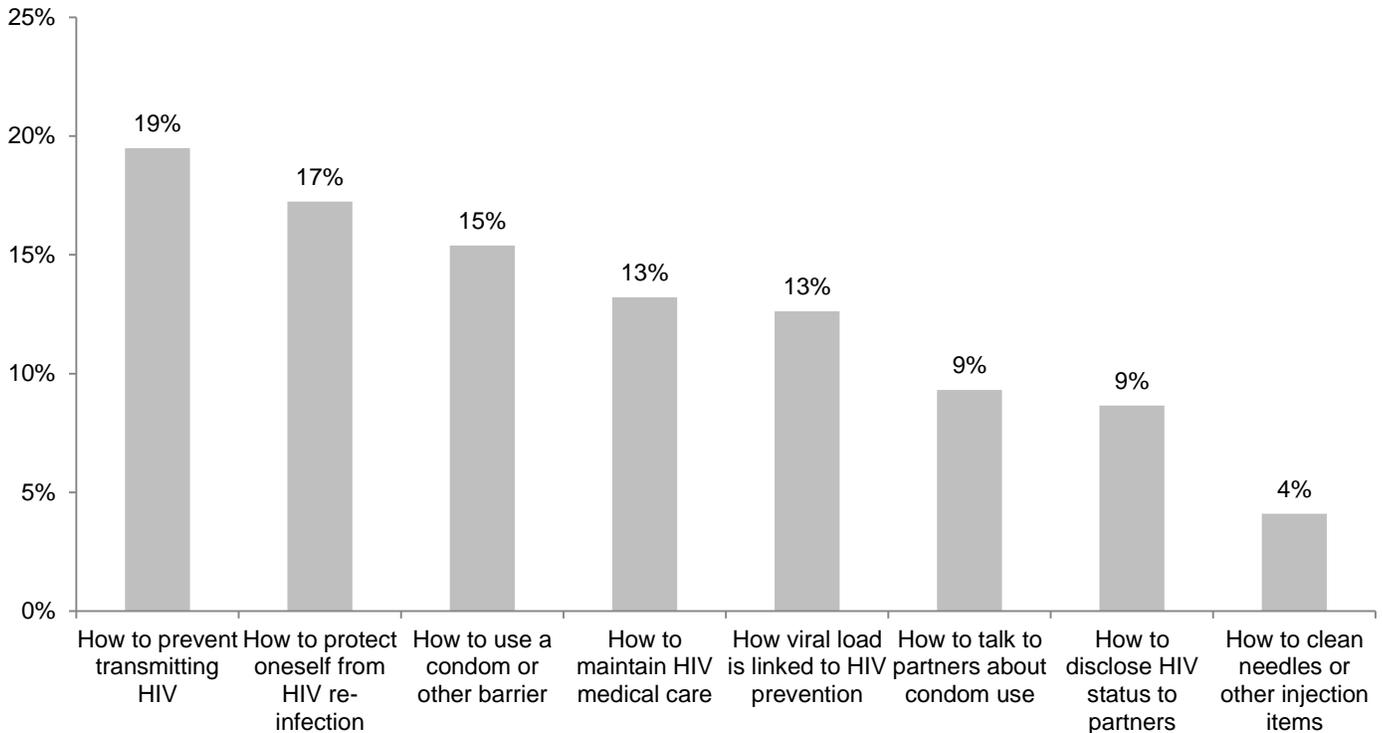
Needs assessment participants were asked if they had received any information about HIV prevention in the past 12 months. Overall, 70% of participants said they *had* received information in the past year (30%

had not). Those who had received information were then asked to identify the specific HIV prevention topics they learned about and from where they learned them. Lists of 8 key HIV prevention topics and 15 common locations or sources for HIV prevention information were provided. Participants could also write-in other topics or locations.

(Graph 1) The HIV prevention topic received most often by participants (when information had been received in the past 12 months) was how to prevent HIV transmission to others (19% of all reported topics), followed by how to protect oneself from infection with a different strain of HIV (17%) and how to use a condom or other barrier (15%). How to clean injection equipment was reported least (4%). The most common write-in topic was information about new HIV medications.

GRAPH 1-HIV Prevention Topics Received by PLWHA in the Houston Area, 2014

Definition: Percent of times each HIV prevention topic was reported as received by needs assessment participants in the past 12 months.



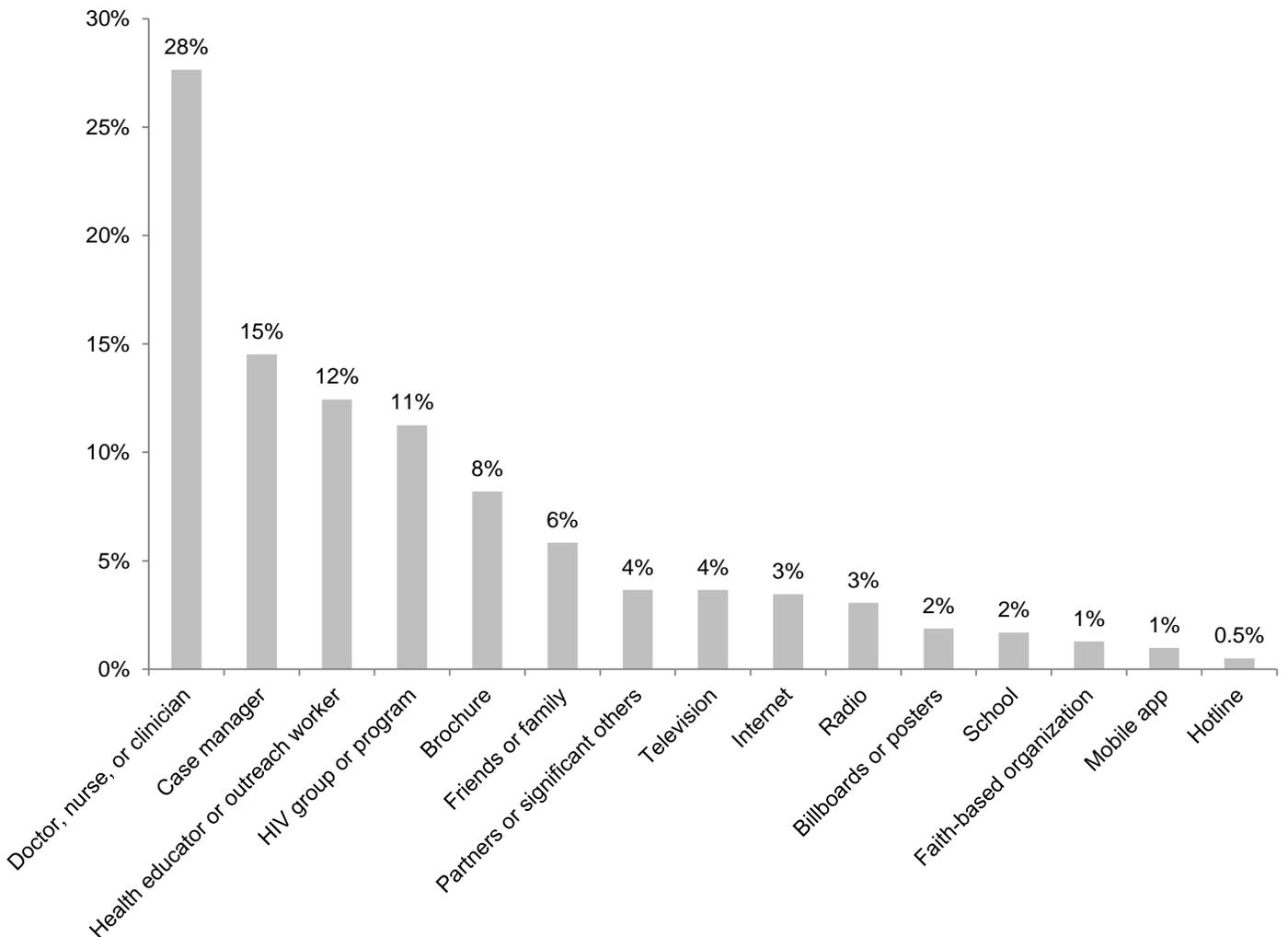
(**Graph 2**) The location or source cited most often by participants for receiving HIV prevention information (when information had been received in the past 12 months) was a medical professional (28% of all reported locations or sources), followed by a case manager (15%) and by a health educator or outreach worker (12%). At less than 1%, a hotline was reported least. The most common write-in locations or sources for HIV prevention information were (*in order*): an AIDS-service organization or clinic, books and

magazines, and the Houston Area HIV/AIDS Resource Guide or “Blue Book.”

These results can be categorized into four general types of locations or sources for HIV prevention information for persons who are HIV positive (*in order*): a professional working in the HIV field, the individual’s social networks, and the media, including both traditional (such as radio and television) and online media.

GRAPH 2-Locations or Sources for HIV Prevention to PLWHA in the Houston Area, 2014

Definition: Percent of times each location or source was reported by needs assessment participants as the location or source for HIV prevention education received in the past 12 months.



Sexual Activity and Condom Use

Participants were asked details regarding current sexual activity and use of safer sex practices, in particular, condom use, condom negotiation, and disclosure of HIV status to potential sex partners. Specific HIV transmission risks, such as needle-sharing and sex bartering, were also queried in the consumer survey.

Overall, 67% of participants stated they had engaged in some form of sexual activity (vaginal, anal, or oral) in the past 12 months. Of those,

- 82% had a main sex partner; 18% did not.
- 44% said their main sex partner was also HIV positive, 28% said their main sex partner was HIV negative, and 10% said they did not know the HIV status of their main sex partner.

(Table 1) 41% of participants said they *always* use condoms during sexual activity. However, population-level analysis shows some differences within overall results. Persons over age 25 reported

universal condom use 2 times less often than young PLWHA (age 13 to 24), while white PLWHA reported universal condom use 3 times less often as persons of other race/ethnicities.

In addition, those who did not know the HIV status of their main sex partner and those without a main sex partner reported universal condoms use less often. While there did not appear to be a connection between self-reported condom use and viral load, the number of participants reporting universal condom use *does* drop for those with poorer self-assessed HIV treatment adherence.

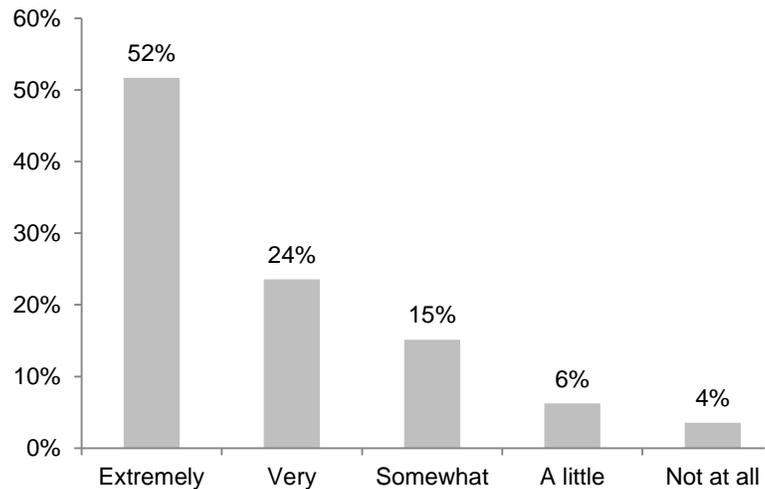
(Graph 3) All sexually active participants, regardless of reported condom use, were asked to rate their comfort discussing condoms with sex partners. The majority (52%) said they felt “extremely” comfortable, while 4% said they were “not at all” comfortable.

TABLE 1-Universal Condom Use among PLWHA in the Houston Area, by Demographic Categories, 2014

	% Reporting Always Using Condoms
All Participants	41%
Sex/Gender	
Male	40%
Female	44%
Transgender	63%
Race/Ethnicity	
White	19%
African American/Black	47%
Hispanic/Latino	52%
Other/Mixed race	27%
Age at Survey	
13 to 24	64%
25 to 49	40%
50 to 64	38%
65+	43%

GRAPH 3-Comfort Discussing Condoms among PLWHA in the Houston Area, 2014

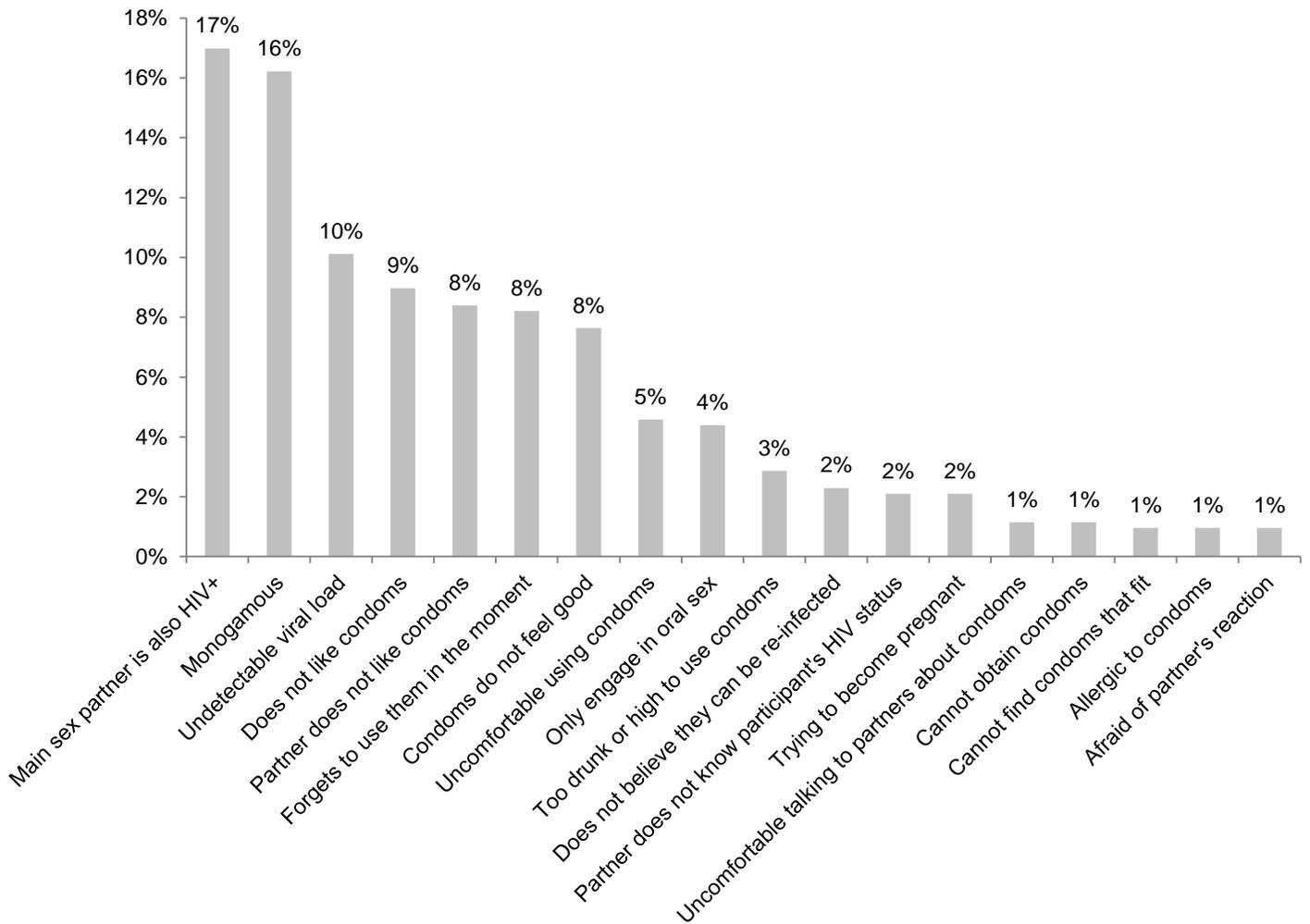
Definition: Percent of needs assessment participants rating themselves from extremely to not at all in response to the survey question, “How comfortable are you talking to sex partners about using a condom?”



(Graph 4) When participants did *not* always use condoms, they were asked to select from a pre-determined list of 18 common reasons for not using condoms. Participants could also write-in their reasons. The most frequently reported reason for not always using condoms during sexual activity was having a main sex partner who is also HIV positive (at 17% of reasons reported), followed by having only one sex partner, or being monogamous (16%), and having an undetectable viral load (10%).

GRAPH 4- Barriers to Condom Use among PLWHA in the Houston Area, 2014

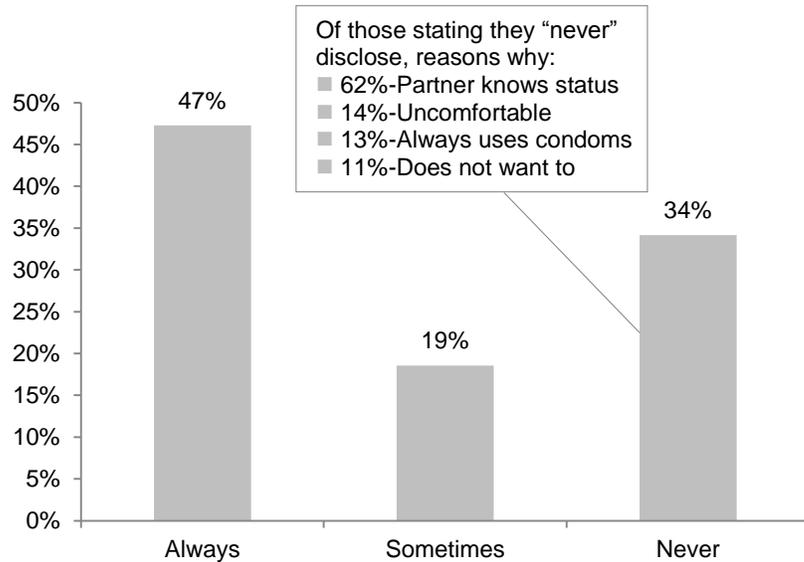
Definition: Percent of times each reason for not always using condoms during sexual activity was reported among all reasons given by sexually active needs assessment participants who were sexually active and did not always use condoms.



(Graph 5) Needs assessment participants were asked how frequently they disclosed their HIV status to current or potential sex partners. Overall, 47% stated they “always” disclose their HIV status with every partner, while 34% stated they never disclose their HIV status. Of those stating “never,” the most common reason given was that their main sex partner already knows their HIV status, followed by discomfort with disclosure.

GRAPH 5-Disclosure of HIV Status among PLWHA in the Houston Area, 2014

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



Lastly, needs assessment participants were asked if they had engaged in four specific behaviors in the past 12 months known to carry high risk for HIV transmission: sex under the influence of substances, sex bartering (or exchanging sex for resources), needle-sharing, and sex with a known needle-sharer. Results are as follows,

- 21% of needs assessment participants reported having sex while “drunk or high.”

- 6% reported exchanging sex for money, housing, drugs, or other needs.
- 2% reported using someone else’s needles to inject themselves.
- 3% reported having sex with someone who they know uses other people’s needles to inject themselves.



Chapter 5: Profile of the Out-of-Care

PROFILE OF THE OUT-OF-CARE

Details about people living with HIV/AIDS (PLWHA) who are *not* in HIV care are of particular importance to local HIV planning. This information helps planners design HIV services in such a way as to better prevent delays or interruptions in care. Continuous HIV care is a national goal for both HIV prevention and care stakeholders, as it can lead to improved health outcomes for individuals as well as reduced transmission of HIV. (Source: Centers for Disease Control and Prevention, The Prevention Benefits of HIV Treatment, <http://www.cdc.gov/hiv/prevention/research/tap/index.html>, April 2013). Proactive efforts were made to include out-of-care PLWHA in the 2014 Houston Area HIV/AIDS needs assessment (See: *Methodology*, page 7), and results presented throughout this document include out-of-care consumers. This Chapter highlights results *only* for out-of-care consumers and as they compare to the entire needs assessment sample.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(Table 1) In total, 46 participants in the 2014 Houston Area HIV/AIDS needs assessment met all criteria for being defined as out of care. This is 7% of the entire needs assessment sample.

100% of out-of-care participants were residing in Houston/Harris County at the time of data collection. Like all needs assessment participants, the majority of out-of-care participants were male (67%), African American/Black (76%), and between the ages of 25 and 49 (65%). However, unlike all needs assessment participants, the majority of the out-of-care was *not* heterosexual; instead, 50% of out-of-care participants identified as MSM.

Several socio-economic characteristics of out-of-care participants were also different from all participants. For example, more out-of-care participants reported full/part-time employment (39% v. 19%); fewer reported having public health insurance in the form of Medicaid and/or Medicare (41% v. 60%); more reported using public transportation as their primary transportation means (71% v. 57%); and more were homeless at the time of data collection (13% v. 6%).

Notes: “Out-of-care” is defined in this analysis as PLWHA who indicated in their consumer survey that they had not received any of the following in the past 12 months: an HIV primary care visit, a prescription for HIV medication, or an HIV monitoring test (viral load or CD-4). This definition is consistent with national and state out-of-care criteria. (Source: Texas Department of State Health Services, Texas Unmet/Met Need Project, August 2013).

In addition, 20% of the out-of-care had been released from incarceration in the past 12 months compared to 13% of all participants.

Characteristics of the out-of-care (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Adults between the ages of 25 and 49
- MSM
- With higher occurrences of employment, private sector health insurance, use of public transportation, homelessness, and recent incarceration.

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Chapter were statistically weighted using current HIV/AIDS prevalence for the Houston EMA (2012) in order to produce proportional results (See: *Methodology*, page 7).

TABLE 1-Characteristics of Out-of-Care PLWHA, Houston Area HIV/AIDS Needs Assessment, 2014

No.		%	No.		%	No.		%
County of residence			Age			Sex assigned at birth		
Harris	46	100.0%	13 to 24	1	2.2%	Male	31	67.4%
Fort Bend	0	0.0%	25 to 49	30	65.2%	Female	15	32.6%
Liberty	0	0.0%	50 to 64	14	30.4%	Intersex	0	0.0%
Montgomery	0	0.0%	65+	1	2.2%	Transgender	2	4.3%
Other	0	0.0%	Adolescents (13 to 17)	0	0.0%	Currently pregnant	0	0.0%
Primary race/ethnicity			Primary sexual orientation			Education level		
White	5	10.9%	Heterosexual	20	43.5%	Less than high school	12	26.1%
African American/Black	35	76.1%	Gay/Lesbian	13	28.3%	High school diploma	22	47.8%
Hispanic/Latino	5	10.9%	Bisexual	12	26.1%	GED	7	15.2%
Asian American	0	0.0%	Other	1	2.2%	Technical degree	1	2.2%
Other/Mixed race	1	2.2%	MSM	23	50.0%	Post-secondary degree	3	6.5%
Employment status			Immigration status			Federal Poverty Level (FPL)		
Employed (FT/PT)	18	39.1%	Born in the U.S.	38	82.6%	100%	40	95.2%
Temporary worker	0	0.0%	Citizen > 5 years	6	13.0%	150%	2	4.8%
Unemployed	15	32.6%	Citizen < 5 years	0	0.0%	200%	0	0.0%
Disabled	11	23.9%	Undocumented	0	0.0%	250%	0	0.0%
Retired	1	2.2%	Prefer not to answer	1	2.2%	300% or higher	0	0.0%
Student	0	0.0%	Other	1	2.2%	Recently Incarcerated	9	19.6%
Health insurance			Housing status			Transportation		
Private insurance	6	13.0%	Own house/apartment	23	51.1%	Own vehicle	6	13.6%
Medicaid/Medicare	19	41.3%	Stay with others	11	24.4%	Public transportation	31	70.5%
Harris Health System	13	28.3%	Group facility	5	11.1%	Walk/bike	4	9.1%
Ryan White only	3	6.5%	Hotel/motel	0	0.0%	Borrow/carpool	3	6.8%
None	4	8.7%	Homeless	6	13.3%	None	0	0.0%

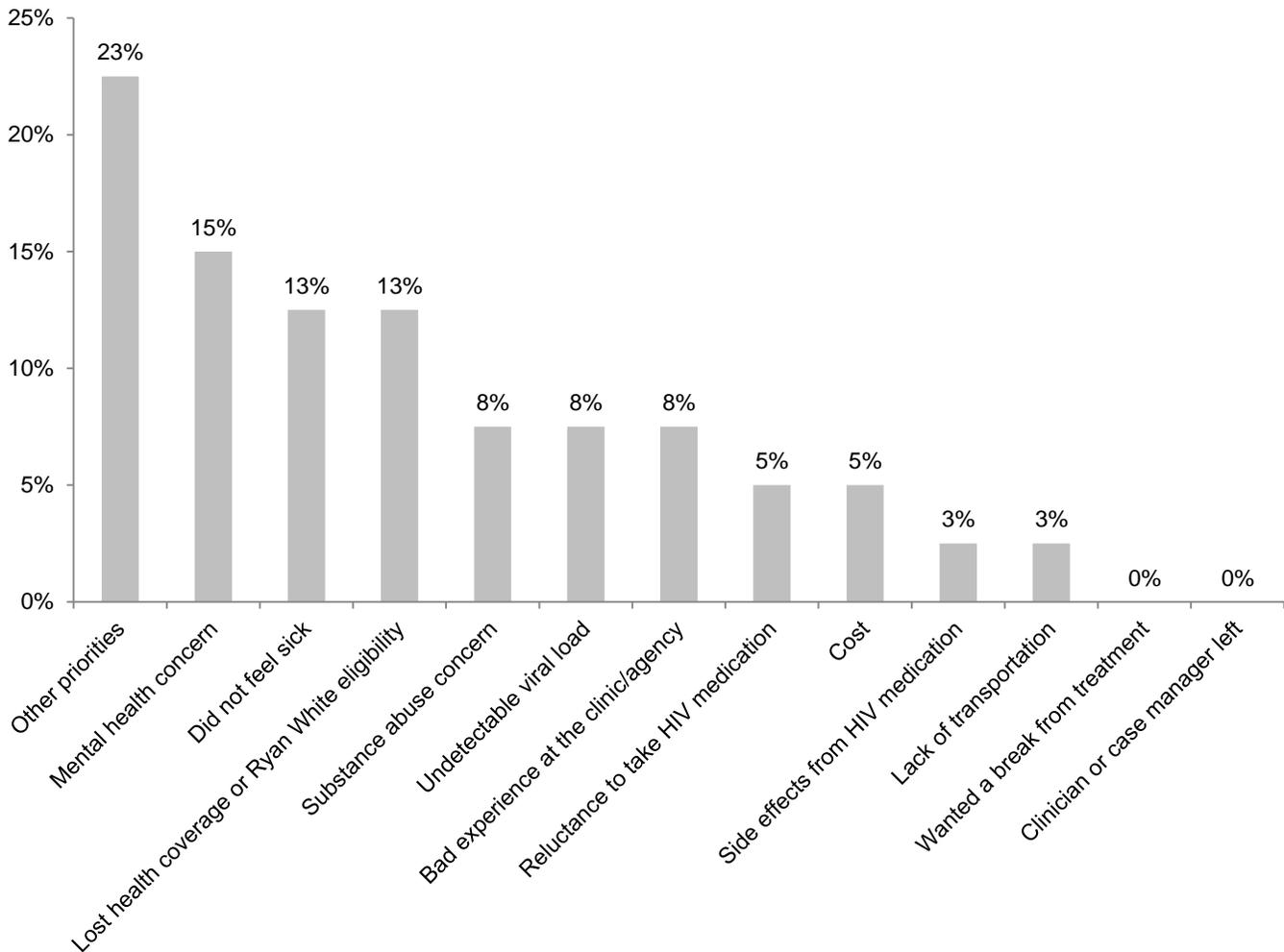
REASONS FOR DISENGAGEMENT IN HIV CARE

All participants in the 2014 Houston Area HIV/AIDS needs assessment who reported a break in HIV care for 12 months or more were asked to identify the reasons they interrupted care, selecting from a preset list of 13 commonly reported reasons. Not feeling sick was selected most often by *all* participants, followed by having a problem with substance use and having other priorities at the time in addition to HIV.

(Graph 1) Among out-of-care participants, having priorities other than HIV was cited most often as the reason for interrupting HIV care (at 23% of reported reasons), followed by having a mental health concern and not feeling sick. A problem with substance use was cited fifth out of all 13 reasons. The most common write-in reasons for falling out of care were the same as for all participants: denial of HIV status, incarceration, and relocation.

GRAPH 1-Reasons for Falling Out of HIV Care among Out-of-Care PLWHA in the Houston Area, 2014

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



RANKING OF NEED FOR HIV SERVICES

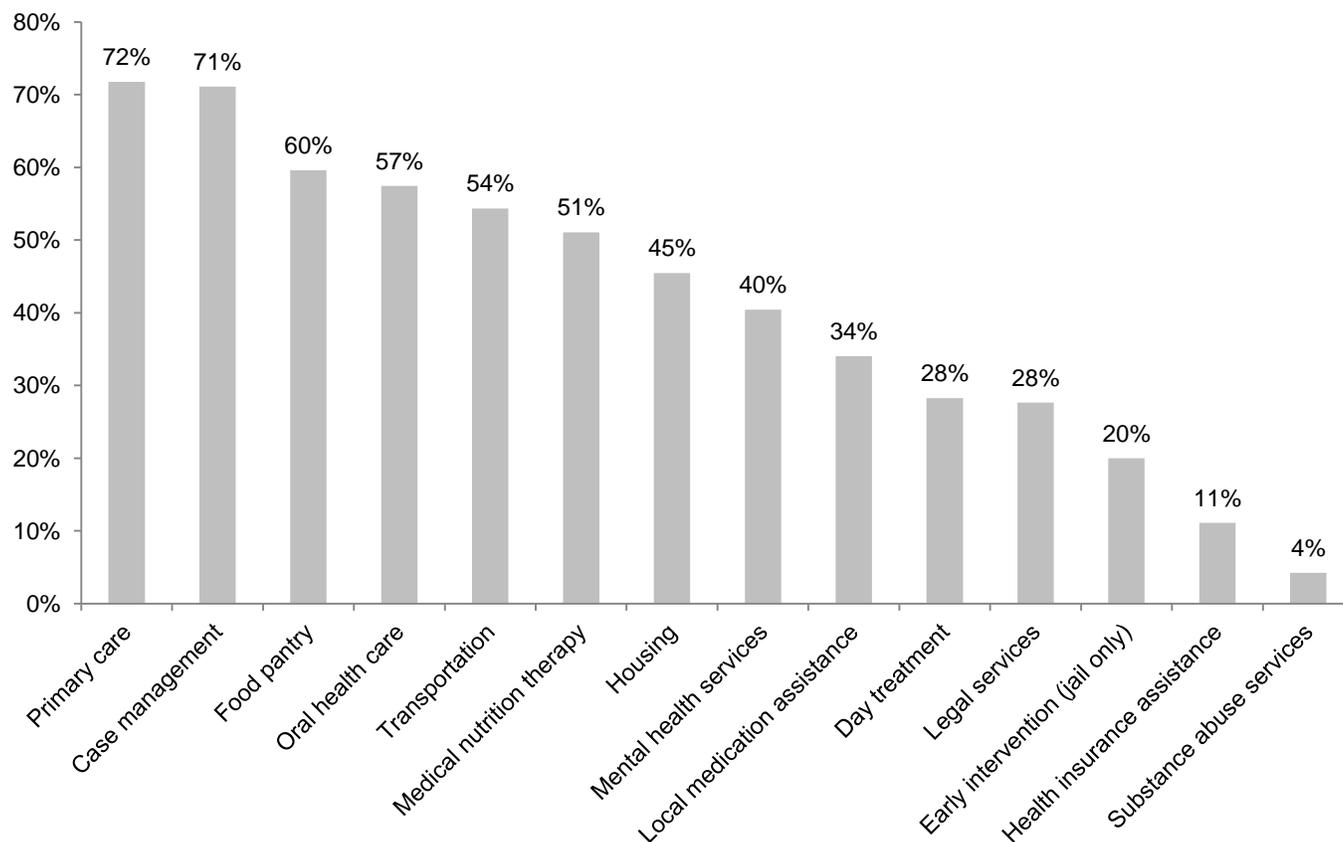
Funded Services

In 2013, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. All participants of the 2014 Houston Area HIV/AIDS needs assessment were asked to indicate which of these funded services they needed in the past 12 months. Among all participants, primary care was the most needed funded service in the Houston Area, followed by case management and oral health care.

(Graph 1) Among out-of-care participants, primary care was also the most needed funded service at 72% of out-of-care respondents, followed by case management and food pantry. Among all participants, however, food pantry was cited eighth out of all the funded services.

GRAPH 1-Ranking of HIV Services among Out-of-Care PLWHA in the Houston Area, By Need, 2014

Definition: Percent of out-of-care needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

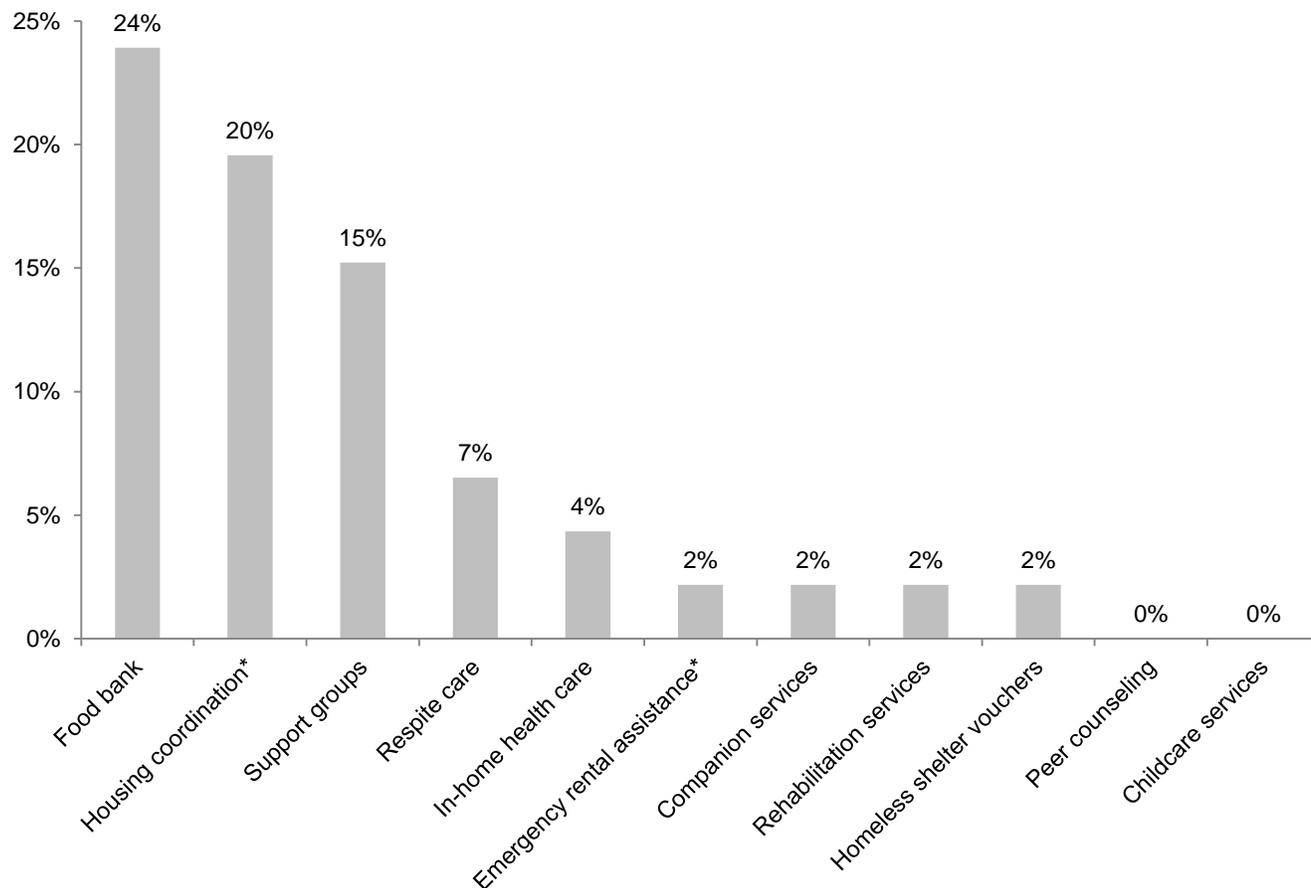
In addition to assessing need for currently funded HIV services, the 2014 Houston Area HIV/AIDS needs assessment also queried the need for other services that are allowable, but not currently funded, by the Ryan White HIV/AIDS Program in order to gauge any new or emerging service needs in the community. Among all needs assessment participants, food bank and housing-related services were selected most often from among the preset list of 11 allowable other/non-Ryan White funded HIV-related services.

(**Graph 2**) Among out-of-care participants, food bank was also the most needed other service at 24% of respondents, followed by housing coordination and support groups. Among all participants, support groups were cited fourth out of all 11 other services.

Participants could also write-in other services needed (that are not currently funded by Ryan White). For out-of-care participants, frequent write-in services were (*in order*): vision care and hardware/glasses, additional housing assistance, employment assistance and job training, and help obtaining public benefits.

GRAPH 2-Other Needs for HIV Services among Out-of-Care PLWHA in the Houston Area, 2014

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



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

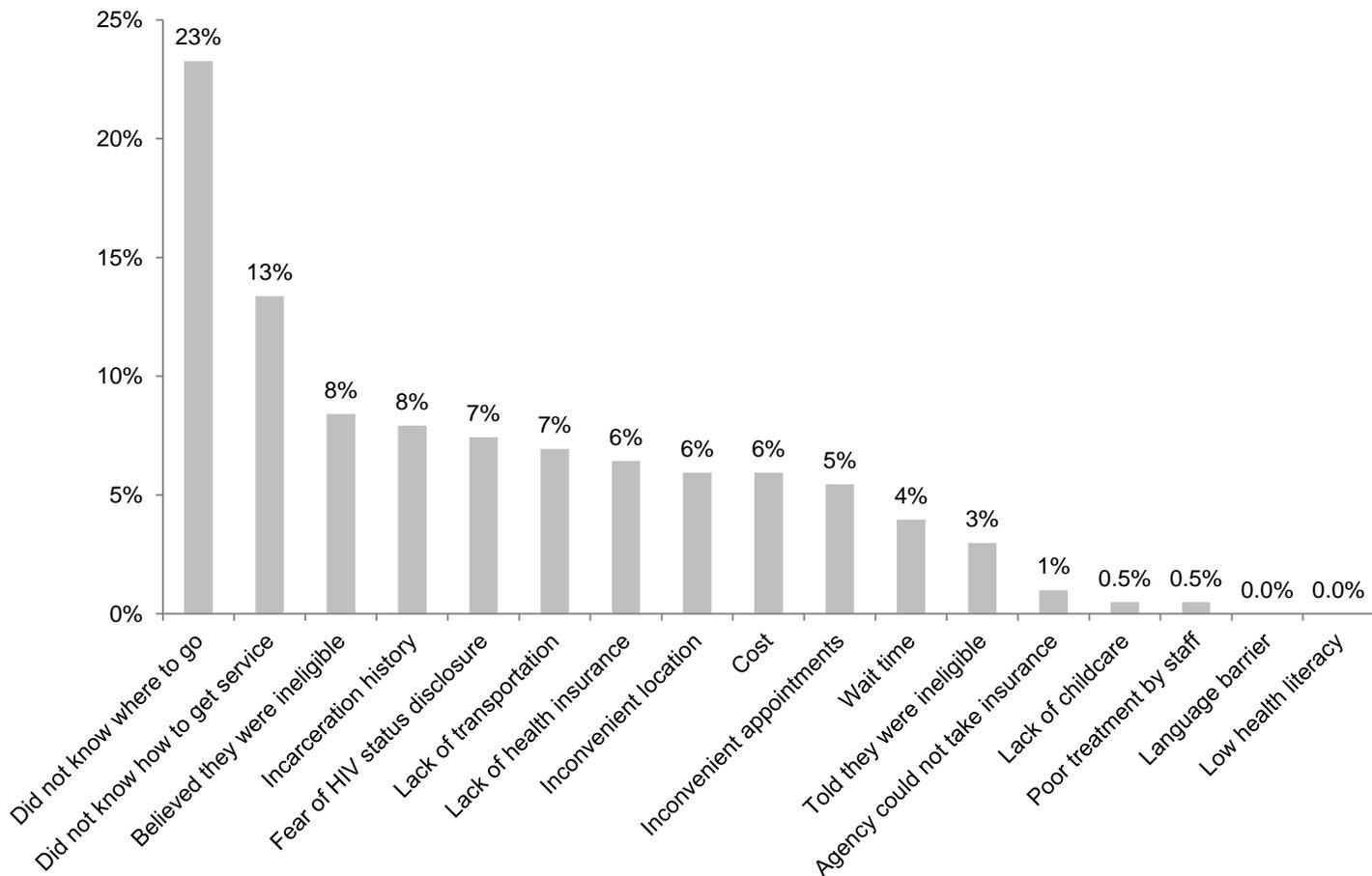
OVERALL BARRIERS TO HIV CARE

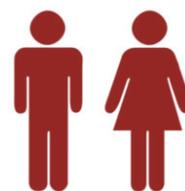
A list of 17 commonly experienced barriers to HIV services was presented to all participants of the 2014 Houston Area HIV/AIDS needs assessment from which to select the specific condition or issue that made the service they needed *difficult* to access. For all participants, the barrier experienced most often (when barriers were reported) was lack of knowledge of where to go for the service, followed by lack of knowledge of *how* to access the service and wait time for the service.

(**Graph 1**) Among out-of-care participants, the barrier experienced most often (when barriers were reported) was also lack of knowledge of where to go for the service (at 23% of barriers reported), followed by lack of knowledge of *how* to access the service and believing they were ineligible for the service. There were no reports of language barriers or low health literacy for out-of-care participants.

GRAPH 1-Ranking of Barriers to HIV Services among Out-of-Care PLWHA in the Houston Area, 2014

Definition: Percent of times each barrier was reported by out-of-care needs assessment participants, regardless of service, when barriers were present.





Service-Specific Fact Sheets

CASE MANAGEMENT

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 78% of participants indicated a need for *case management* in the past 12 months. 62% reported the service was easy to access, and 16% reported difficulty. 9% stated they did not know the service was available.

(**Table 1**) When barriers to *case management* were reported, the most common was lack of knowledge, both of where to go for the service and of how to receive the service (both 16% of all reported barriers to this service).

GRAPH 1-Case Management, 2014

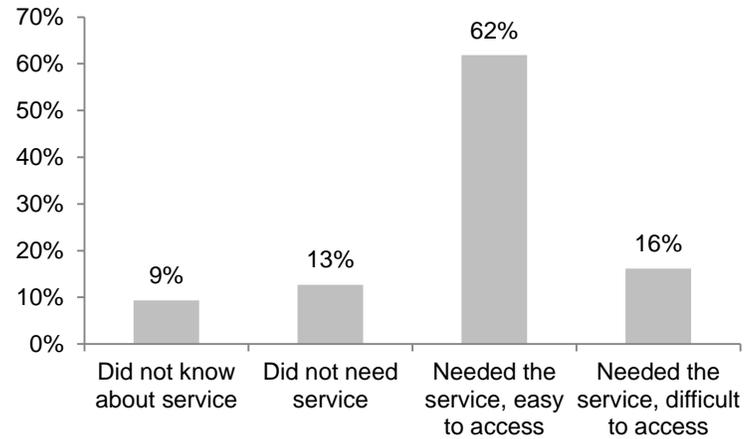


TABLE 1-Top 10 Reported Barriers to Case Management, 2014

	No.	%
1. Did not know where to go	28	16%
2. Did not know how to get service	28	16%
3. Wait time	17	9%
4. Lack of transportation	15	8%
5. Believed they were ineligible	13	7%
6. Lack of health insurance	10	6%
7. Poor treatment by staff	10	6%
8. Inconvenient appointments	9	5%
9. Cost	8	4%
10. Fear of HIV status disclosure	8	4%

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

- More males than females found the service accessible.
- More White PLWHA found the service accessible than other race/ethnicities.
- More PLWHA age 13 to 24 found the service accessible than other age groups.
- In addition, more homeless, out of care, recently released, and transgender PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Case Management, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	9%	11%	6%	8%	15%	10%	6%	9%	10%
Did not need service	14%	10%	11%	12%	16%	0%	18%	11%	13%
Needed, easy to access	63%	60%	68%	61%	57%	65%	70%	61%	61%
Needed, difficult to access	15%	18%	15%	18%	12%	25%	6%	18%	16%

TABLE 3-Case Management, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	0%	14%	7%	7%	12%	0%	15%
Did not need service	33%	5%	12%	22%	10%	7%	7%
Needed, easy to access	67%	49%	67%	13%	57%	93%	56%
Needed, difficult to access	0%	33%	14%	58%	22%	0%	22%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

DAY TREATMENT

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 34% of participants indicated a need for *day treatment* in the past 12 months. 29% reported the service was easy to access, and 5% reported difficulty. 19% stated that they did not know the service was available.

(**Table 1**) When barriers to *day treatment* were reported, the most common was lack of knowledge of where to go for the service (18% of all reported barriers to this service).

GRAPH 1-Day Treatment, 2014

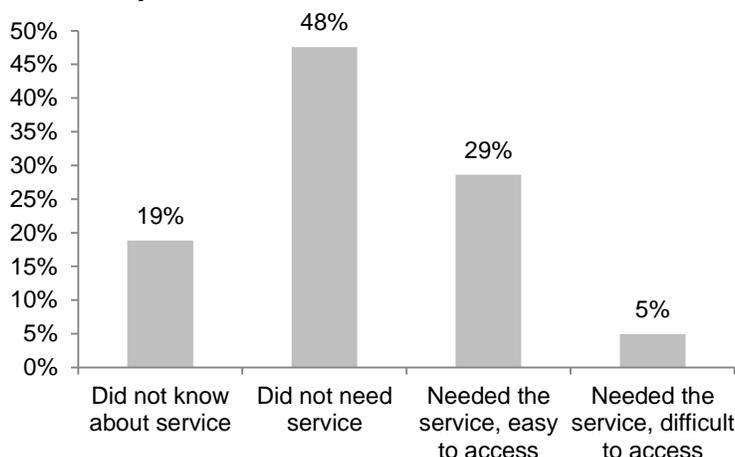


TABLE 1-Top 10 Reported Barriers to Day Treatment, 2014

	No.	%
1. Did not know where to go	13	18%
2. Lack of transportation	10	14%
3. Did not know how to get service	9	12%
4. Believed they were ineligible	6	8%
5. Poor treatment by staff	5	7%
6. Fear of HIV status disclosure	5	7%
7. Cost	4	5%
8. Language barrier	4	5%
9. Inconvenient location	3	4%
10. Agency could not take insurance	3	4%

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

- More males than females found the service accessible.
- More Hispanic/Latino PLWHA found the service accessible than other race/ethnicities.
- More PLWHA age 13 to 24 found the service accessible than other age groups.
- In addition, more homeless, out of care, and recently released PLWHA found the service difficult to access when compared to all participants.

TABLE 2- Day Treatment, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	19%	19%	18%	16%	25%	25%	9%	21%	18%
Did not need service	47%	49%	61%	48%	34%	40%	58%	47%	47%
Needed, easy to access	30%	26%	19%	31%	33%	30%	33%	28%	29%
Needed, difficult to access	5%	5%	3%	5%	7%	5%	0%	5%	6%

TABLE 3- Day Treatment, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	17%	20%	23%	7%	20%	10%	22%
Did not need service	67%	32%	45%	65%	46%	59%	44%
Needed, easy to access	17%	39%	27%	9%	24%	31%	30%
Needed, difficult to access	0%	9%	4%	20%	11%	0%	4%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

EARLY INTERVENTION (JAIL ONLY)

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 11% of participants indicated a need for *early intervention services* in the past 12 months. 7% reported the service was easy to access, and 4% reported difficulty. 9% stated that they did not know the service was available.

(**Table 1**) When barriers to *early intervention services* were reported, the most common was not being offered the service while incarcerated in Harris County Jail (29% of all reported barriers to this service).

GRAPH 1-Early Intervention (Jail Only), 2014

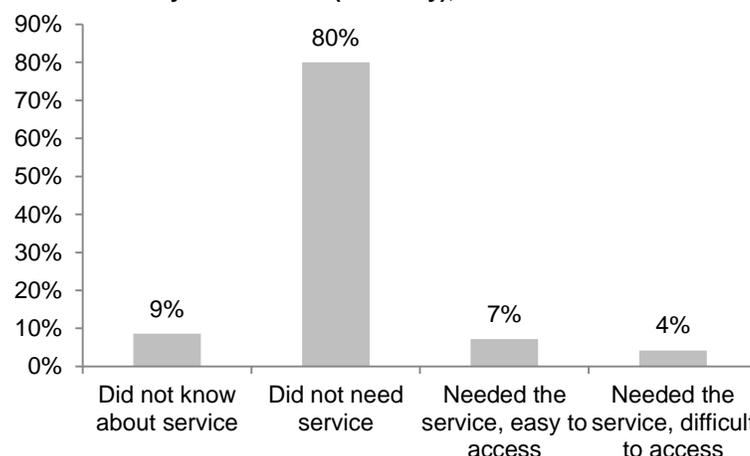


TABLE 1-Top 10 Reported Barriers to Early Intervention (Jail Only), 2014

	No.	%
1. Was not offered the service	15	29%
2. Poor treatment by staff	11	21%
3. Did not know how to get service	7	13%
4. Not in jail long enough	7	13%
5. Inconvenient while in jail	4	8%
6. Fear of HIV status disclosure	3	6%
7. Wait time	2	4%
8. Told they were ineligible	2	4%
9. Low health literacy	1	2%
10. Believed they were ineligible	0	0%

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

- More males than females found the service accessible.
- More white PLWHA found the service accessible than other race/ethnicities.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more homeless, MSM, out of care, recently released, and rural PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Early Intervention (Jail Only), by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	8%	10%	3%	10%	10%	10%	3%	10%	8%
Did not need service	79%	84%	81%	78%	82%	85%	94%	81%	78%
Needed, easy to access	8%	4%	9%	8%	6%	0%	3%	4%	11%
Needed, difficult to access	5%	2%	7%	4%	1%	5%	0%	5%	4%

TABLE 3-Early Intervention (Jail Only), by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	0%	16%	8%	4%	13%	7%	15%
Did not need service	100%	58%	81%	76%	39%	86%	58%
Needed, easy to access	0%	14%	6%	4%	25%	0%	23%
Needed, difficult to access	0%	12%	5%	16%	23%	7%	4%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

FOOD PANTRY

Food pantry is the provision of food and/or household items to persons living with HIV/AIDS (PLWHA). They can be provided in the form of actual goods (such as through a food bank) or as vouchers for food. In the Houston Area, the Ryan White HIV/AIDS Program funds food vouchers for rural clients only; other local programs provide food bank services to PLWHA in the urban areas.

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 52% of participants indicated a need for *food pantry* in the past 12 months. 34% reported the service was easy to access, and 18% reported difficulty. 27% stated that they did not know the service was available.

(**Table 1**) When barriers to *food pantry* were reported, the most common was lack of knowledge of where to go for the service (26% of all reported barriers to this service).

GRAPH 1-Food Pantry, 2014

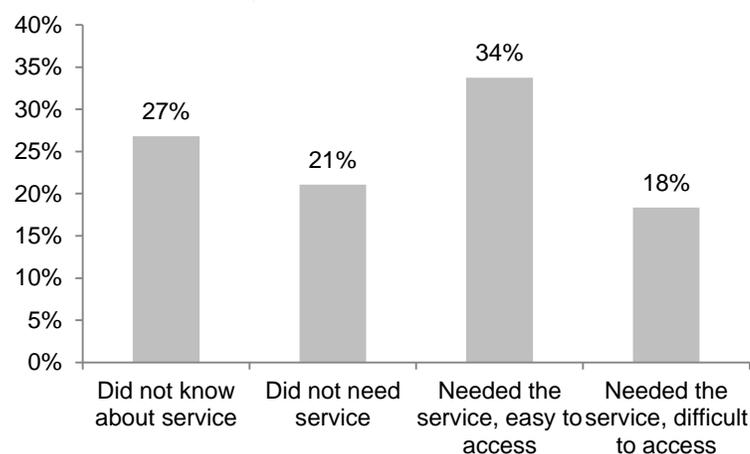


TABLE 1-Top 10 Reported Barriers to Food Pantry, 2014

	No.	%
1. Did not know where to go	53	26%
2. Did not know how to get service	47	23%
3. Believed they were ineligible	23	11%
4. Lack of transportation	15	7%
5. Told they were ineligible	13	6%
6. Inconvenient location	12	6%
7. Inconvenient appointments	7	3%
8. Fear of HIV status disclosure	6	3%
9. Incarceration history	6	3%
10. Language barrier	5	2%

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

- More females than males found the service accessible.
- More African American/Black PLWHA found the service accessible than other race/ethnicities.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more homeless, out of care, recently released, and transgender PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Food Pantry, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	28%	24%	32%	18%	38%	25%	24%	28%	26%
Did not need service	22%	20%	27%	18%	20%	35%	38%	21%	20%
Needed, easy to access	33%	35%	22%	43%	26%	40%	35%	31%	36%
Needed, difficult to access	17%	21%	20%	20%	16%	0%	3%	19%	19%

TABLE 3-Food Pantry, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	0%	35%	29%	9%	26%	24%	26%
Did not need service	67%	12%	25%	32%	14%	28%	4%
Needed, easy to access	33%	26%	29%	21%	32%	48%	48%
Needed, difficult to access	0%	28%	17%	38%	28%	0%	22%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

HEALTH INSURANCE ASSISTANCE

Health insurance assistance, also referred to as *health insurance premium and cost-sharing assistance*, provides financial assistance to persons living with HIV/AIDS (PLWHA) who have third-party health insurance coverage (such as private insurance, COBRA, or Medicare) so they can obtain or maintain health care benefits. This includes funding for premiums, deductibles, and co-pays for both medical visits and medication.

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 47% of participants indicated a need for *health insurance assistance* in the past 12 months. 35% reported the service was easy to access, and 12% reported difficulty. 16% stated that they did not know the service was available.

(**Table 1**) When barriers to *health insurance assistance* were reported, the most common was lack of knowledge of where to go for the service (16% of all reported barriers to this service).

GRAPH 1-Health Insurance Assistance, 2014

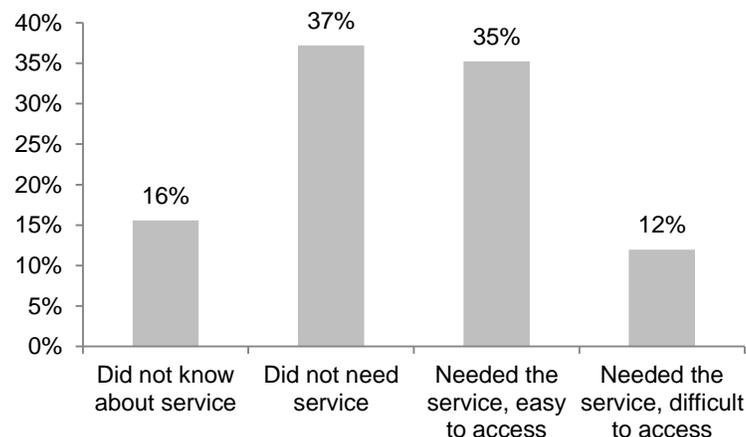


TABLE 1-Top 10 Reported Barriers to Health Insurance Assistance, 2014

	No.	%
1. Did not know where to go	28	16%
2. Did not know how to get service	21	12%
3. Believed they were ineligible	20	12%
4. Lack of health insurance	16	9%
5. Told they were ineligible	15	9%
6. Lack of transportation	13	8%
7. Fear of HIV status disclosure	11	6%
8. Wait time	11	6%
9. Cost	8	5%
10. Inconvenient location	6	4%

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

- More females than males found the service accessible.
- More PLWHA of other/mixed race and African American found the service accessible than other race/ethnicities.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more adolescents, MSM, recently released, and transgender PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Health Insurance Assistance, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	15%	17%	16%	17%	15%	5%	21%	18%	13%
Did not need service	37%	38%	42%	36%	35%	35%	47%	40%	33%
Needed, easy to access	34%	38%	30%	38%	33%	50%	24%	30%	41%
Needed, difficult to access	13%	7%	12%	10%	17%	10%	9%	12%	12%

TABLE 3-Health Insurance Assistance, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	17%	26%	14%	13%	17%	7%	18%
Did not need service	33%	26%	40%	76%	39%	39%	32%
Needed, easy to access	33%	40%	32%	2%	28%	50%	36%
Needed, difficult to access	17%	9%	15%	9%	17%	4%	14%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

HOSPICE

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 7% of participants indicated a need for *hospice* in the past 12 months. 6% reported the service was easy to access, and 1% reported difficulty. 13% stated that they did not know the service was available.

(**Table 1**) When barriers to *hospice* were reported, the most common was inconvenient location of the service (12% of all reported barriers to this service).

GRAPH 1-Hospice, 2014

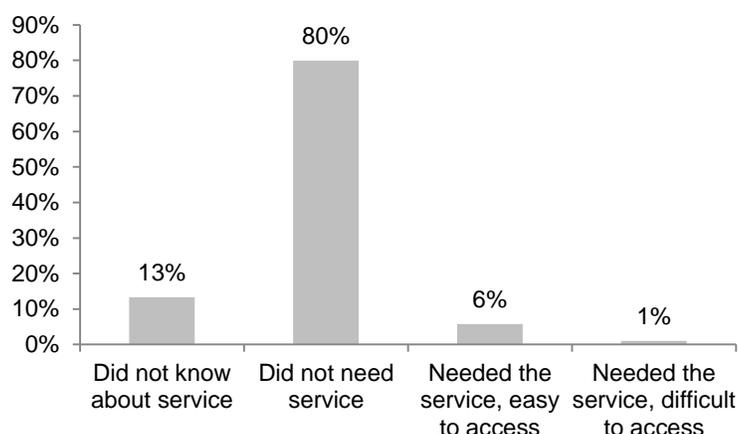


TABLE 1-Top 10 Reported Barriers to Hospice, 2014

	No.	%
1. Inconvenient location	4	12%
2. Did not know how to get service	3	9%
3. Inconvenient appointments	3	9%
4. Cost	3	9%
5. Wait time	3	9%
6. Fear of HIV status disclosure	3	9%
7. Did not know where to go	2	6%
8. Lack of health insurance	2	6%
9. Agency could not take insurance	2	6%
10. Believed they were ineligible	2	6%

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

- More males than females found the service accessible.
- More Hispanic/Latino PLWHA found the service accessible than other race/ethnicities.
- More PLWHA age 13 to 24 found the service accessible than other age groups.
- In addition, more recently released PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Hospice, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	13%	14%	5%	10%	27%	15%	18%	13%	13%
Did not need service	79%	82%	95%	82%	60%	85%	73%	80%	80%
Needed, easy to access	6%	4%	0%	6%	11%	0%	9%	5%	6%
Needed, difficult to access	1%	1%	0%	1%	2%	0%	0%	1%	1%

TABLE 3- Hospice, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	17%	23%	14%	4%	13%	0%	21%
Did not need service	67%	66%	79%	96%	74%	93%	54%
Needed, easy to access	17%	11%	6%	0%	11%	7%	25%
Needed, difficult to access	0%	0%	0%	0%	2%	0%	0%

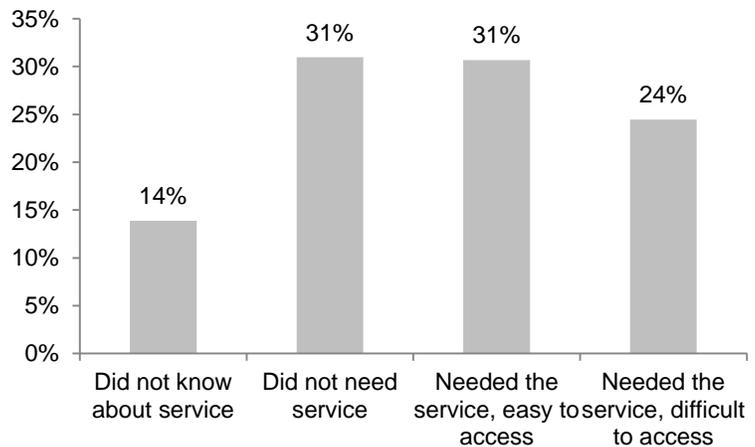
^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

HOUSING

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 55% of participants indicated a need for *housing* in the past 12 months. 31% reported the service was easy to access, and 24% reported difficulty. 14% stated that they did not know the service was available.

GRAPH 1-Housing, 2014



(**Table 1**) When barriers to *housing* were reported, the most common was lack of knowledge of where to go for the service (20% of all reported barriers to this service).

TABLE 1-Top 10 Reported Barriers to Housing, 2014

	No.	%
1. Did not know where to go	75	20%
2. Did not know how to get service	66	18%
3. Wait time	48	13%
4. Believed they were ineligible	36	10%
5. Told they were ineligible	30	8%
6. Lack of transportation	24	7%
7. Inconvenient location	15	4%
8. Inconvenient appointments	14	4%
9. Fear of HIV status disclosure	13	4%
10. Cost	11	3%

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

- More females than males found the service accessible.
- More African American/Black PLWHA found the service accessible than other race/ethnicities.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more homeless, MSM, out of care, and recently released PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Housing, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	14%	13%	9%	13%	19%	21%	9%	15%	14%
Did not need service	32%	29%	38%	28%	28%	53%	42%	32%	29%
Needed, easy to access	28%	38%	21%	37%	30%	16%	30%	29%	33%
Needed, difficult to access	26%	21%	32%	22%	24%	11%	18%	25%	25%

TABLE 3-Housing, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	0%	19%	13%	14%	11%	17%	15%
Did not need service	83%	9%	35%	41%	18%	59%	26%
Needed, easy to access	0%	26%	26%	5%	29%	24%	41%
Needed, difficult to access	17%	47%	26%	41%	41%	0%	19%

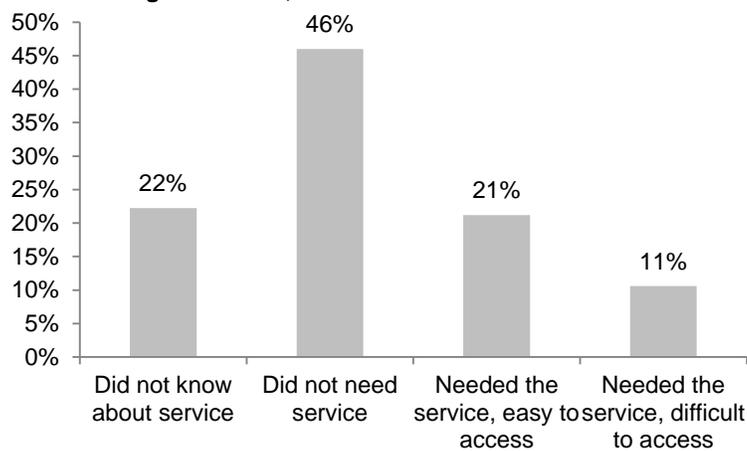
^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

LEGAL SERVICES

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 32% of participants indicated a need for *legal services* in the past 12 months. 21% reported the service was easy to access, and 11% reported difficulty. 22% stated that they did not know the service was available.

GRAPH 1-Legal Services, 2014



(**Table 1**) When barriers to *legal services* were reported, the most common were lack of knowledge, both of how to receive the service and where to go for the service (both 17% of all reported barriers to this service).

TABLE 1-Top 10 Reported Barriers to Legal Services, 2014

	No.	%
1. Did not know how to get service	27	17%
2. Did not know where to go	26	17%
3. Inconvenient location	15	10%
4. Told they were ineligible	14	9%
5. Believed they were ineligible	13	8%
6. Cost	12	8%
7. Inconvenient appointments	11	7%
8. Wait time	9	6%
9. Fear of HIV status disclosure	8	5%
10. Lack of transportation	7	4%

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

- More females than males found the service accessible.
- More African American/Black PLWHA found the service accessible than other race/ethnicities.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more homeless, MSM, out of care, and recently released PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Legal Services, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	24%	17%	25%	17%	31%	10%	21%	23%	22%
Did not need service	45%	50%	48%	49%	34%	75%	55%	47%	44%
Needed, easy to access	20%	23%	17%	24%	20%	10%	18%	16%	27%
Needed, difficult to access	11%	10%	10%	10%	15%	5%	6%	14%	8%

TABLE 3-Legal Services, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	20%	26%	24%	15%	30%	17%	30%
Did not need service	80%	37%	43%	57%	39%	48%	41%
Needed, easy to access	0%	14%	20%	6%	17%	31%	30%
Needed, difficult to access	0%	23%	12%	21%	13%	3%	0%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

LOCAL HIV MEDICATION ASSISTANCE

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 69% of participants indicated a need for *local HIV medication assistance* in the past 12 months. 58% reported the service was easy to access, and 11% reported difficulty. 10% stated that they did not know the service was available.

(**Table 1**) When barriers to *local HIV medication assistance* were reported, the most common were lack of transportation and lack of knowledge of where to go for the service (both 13% of all reported barriers to this service).

GRAPH 1-Local HIV Medication Assistance, 2014

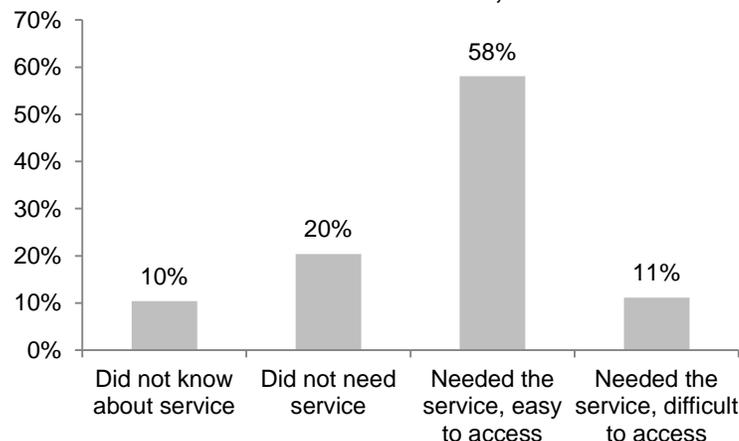


TABLE 1-Top 10 Reported Barriers to Local HIV Medication Assistance, 2014

	No.	%
1. Lack of transportation	20	13%
2. Did not know where to go	19	13%
3. Lack of health insurance	15	10%
4. Inconvenient appointments	14	9%
5. Did not know how to get service	13	9%
6. Believed they were ineligible	12	8%
7. Fear of HIV status disclosure	10	7%
8. Cost	10	7%
9. Wait time	8	5%
10. Inconvenient location	20	13%

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

- More males than females found the service accessible.
- More Hispanic/Latino PLWHA than other race/ethnicities found the service accessible.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more adolescents, MSM, out of care, recently released, and transgender PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Local HIV Medication Assistance, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	9%	14%	11%	11%	10%	5%	18%	11%	9%
Did not need service	20%	22%	23%	23%	11%	29%	24%	19%	21%
Needed, easy to access	59%	55%	56%	56%	63%	62%	48%	58%	59%
Needed, difficult to access	12%	9%	11%	10%	16%	5%	9%	11%	11%

TABLE 3-Local HIV Medication Assistance, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	60%	21%	7%	9%	13%	7%	7%
Did not need service	0%	16%	20%	57%	24%	14%	21%
Needed, easy to access	20%	58%	61%	6%	45%	72%	54%
Needed, difficult to access	20%	5%	13%	28%	18%	7%	18%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

MEDICAL NUTRITION THERAPY

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 48% of participants indicated a need for *medical nutrition therapy* in the past 12 months. 31% reported the service was easy to access, and 17% reported difficulty. 21% stated that they did not know the service was available.

(**Table 1**) When barriers to *medical nutrition therapy* were reported, the most common was lack of knowledge of where to go for the service (20% of all reported barriers to this service).

GRAPH 1-Medical Nutrition Therapy, 2014

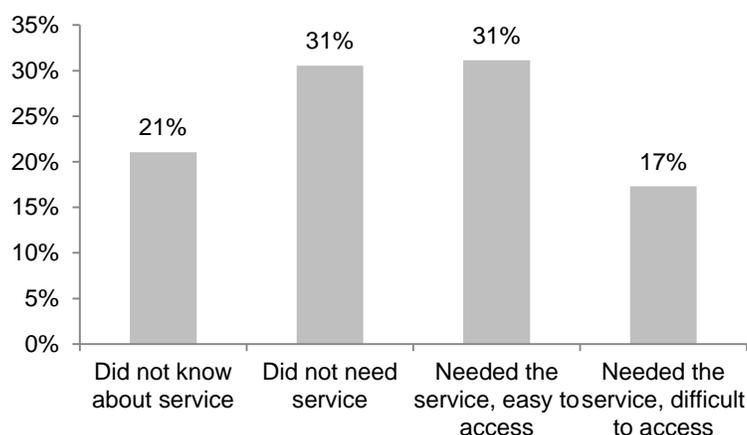


TABLE 1-Top 10 Reported Barriers to Medical Nutrition Therapy, 2014

	No.	%
1. Did not know where to go	45	20%
2. Did not know how to get service	39	17%
3. Believed they were ineligible	24	11%
4. Lack of transportation	17	7%
5. Wait time	15	7%
6. Cost	14	6%
7. Lack of health insurance	13	6%
8. Told they were ineligible	13	6%
9. Inconvenient location	12	5%
10. Fear of HIV status disclosure	8	4%

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

- More females than males found the service accessible.
- More PLWHA of other/mixed race and Hispanic/Latino PLWHA found the service accessible.
- More PLWHA age 25 to 44 found the service accessible than other age groups.
- In addition, more homeless, MSM, out of care, and recently released PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Medical Nutrition Therapy, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	20%	22%	23%	19%	25%	15%	6%	24%	20%
Did not need service	29%	34%	28%	36%	23%	25%	73%	26%	30%
Needed, easy to access	31%	32%	26%	30%	35%	50%	15%	35%	30%
Needed, difficult to access	19%	12%	24%	15%	17%	10%	6%	15%	20%

TABLE 3-Medical Nutrition Therapy, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	0%	19%	20%	13%	29%	17%	30%
Did not need service	100%	30%	25%	36%	26%	59%	26%
Needed, easy to access	0%	30%	33%	6%	24%	21%	37%
Needed, difficult to access	0%	21%	21%	45%	21%	3%	7%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

MENTAL HEALTH SERVICES

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 52% of participants indicated a need for *mental health services* in the past 12 months. 41% reported the service was easy to access, and 11% reported difficulty. 8% stated that they did not know the service was available.

(**Table 1**) When barriers to *mental health services* were reported, the most common was lack of knowledge of how to get the service (13% of all reported barriers to this service).

GRAPH 1-Mental Health Services, 2014

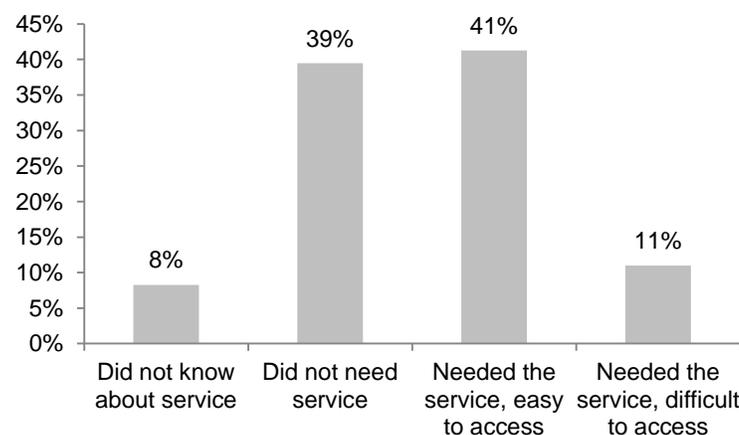


TABLE 1-Top 10 Reported Barriers to Mental Health Services, 2014

	No.	%
1. Did not know how to get service	19	13%
2. Inconvenient appointments	17	12%
3. Lack of health insurance	15	10%
4. Lack of transportation	14	10%
5. Did not know where to go	13	9%
6. Wait time	12	8%
7. Inconvenient location	11	8%
8. Poor treatment by staff	9	6%
9. Cost	7	5%
10. Fear of HIV status disclosure	7	5%

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

- More females than males found the service accessible.
- More white PLWHA found the service accessible than other race/ethnicities.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more homeless, out of care, and recently released PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Mental Health Services, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	8%	8%	8%	8%	10%	5%	6%	8%	8%
Did not need service	42%	33%	30%	41%	43%	55%	64%	41%	36%
Needed, easy to access	40%	46%	47%	41%	38%	25%	21%	40%	45%
Needed, difficult to access	10%	13%	15%	10%	9%	15%	9%	11%	11%

TABLE 3-Mental Health Services, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	0%	7%	8%	2%	7%	3%	11%
Did not need service	100%	30%	37%	57%	38%	48%	32%
Needed, easy to access	0%	44%	44%	11%	41%	41%	50%
Needed, difficult to access	0%	19%	11%	30%	14%	7%	7%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

ORAL HEALTH CARE

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

(Graph 1) In the 2014 Houston Area HIV/AIDS needs assessment, 77% of participants indicated a need for *oral health care* in the past 12 months. 54% reported the service was easy to access, and 23% reported difficulty. 12% stated that they did not know the service was available.

(Table 1) When barriers to *oral health care* were reported, the most common was wait time (16% of all reported barriers to this service).

GRAPH 1-Oral Health Care, 2014

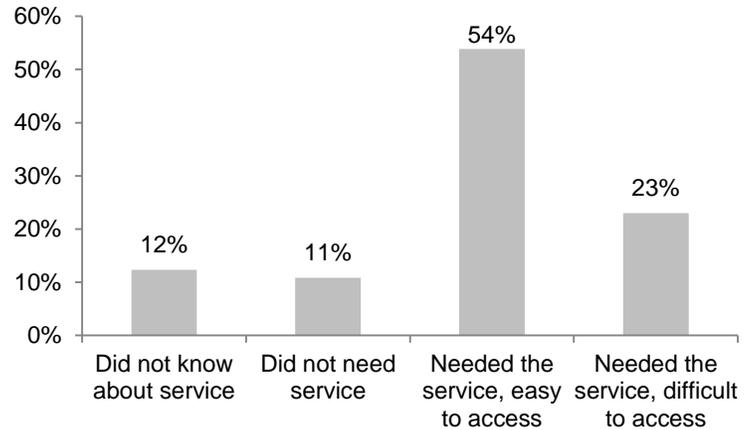


TABLE 1-Top 10 Reported Barriers to Oral Health Care, 2014

	No.	%
1. Wait time	50	16%
2. Inconvenient appointments	44	14%
3. Did not know where to go	31	10%
4. Lack of transportation	25	8%
5. Inconvenient location	24	8%
6. Did not know how to get service	22	7%
7. Lack of health insurance	20	6%
8. Believed they were ineligible	19	6%
9. Told they were ineligible	17	5%
10. Cost	13	4%

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

- More females than males found the service accessible.
- More PLWHA of other/mixed race and African American found the service accessible than other race/ethnicities.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more homeless, MSM, out of care, and recently released PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Oral Health Care, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	13%	10%	16%	10%	14%	10%	18%	12%	12%
Did not need service	11%	11%	5%	13%	13%	5%	21%	11%	9%
Needed, easy to access	54%	55%	54%	57%	45%	71%	50%	52%	56%
Needed, difficult to access	23%	24%	25%	20%	28%	14%	12%	25%	22%

TABLE 3-Oral Health Care, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	0%	21%	12%	15%	16%	10%	11%
Did not need service	20%	9%	9%	28%	10%	7%	4%
Needed, easy to access	80%	44%	54%	15%	45%	60%	64%
Needed, difficult to access	0%	26%	26%	43%	29%	23%	21%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

PRIMARY HIV MEDICAL CARE

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 87% of participants indicated a need for *primary HIV medical care* in the past 12 months. 74% reported the service was easy to access, and 13% reported difficulty. 7% stated that they did not know the service was available.

(**Table 1**) When barriers to *primary HIV medical care* were reported, the most common was wait time (14% of all reported barriers to this service).

GRAPH 1-Primary HIV Medical Care, 2014

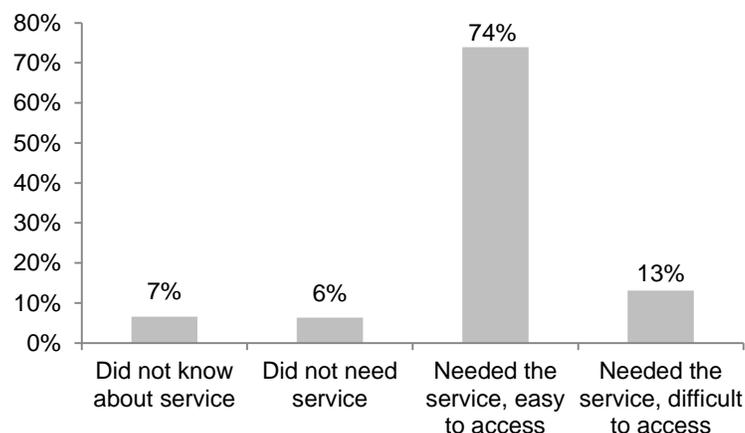


TABLE 1-Top 10 Reported Barriers to Primary HIV Medical Care, 2014

	No.	%
1. Wait time	28	14%
2. Did not know where to go	25	12%
3. Lack of transportation	21	10%
4. Inconvenient appointments	19	9%
5. Fear of HIV status disclosure	19	9%
6. Did not know how to get service	12	6%
7. Inconvenient location	12	6%
8. Lack of health insurance	10	5%
9. Cost	10	5%
10. Agency could not take insurance	9	4%

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

- More males than females found the service accessible.
- More PLWHA of other/mixed race and whites found the service accessible than other race/ethnicities.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more homeless, out of care, recently released, and transgender PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Primary HIV Medical Care, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	7%	7%	5%	6%	10%	0%	9%	8%	6%
Did not need service	6%	7%	7%	6%	6%	0%	12%	5%	7%
Needed, easy to access	75%	71%	78%	73%	70%	85%	76%	71%	77%
Needed, difficult to access	12%	16%	10%	14%	14%	15%	3%	17%	11%

TABLE 3-Primary HIV Medical Care, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	33%	2%	6%	7%	9%	0%	11%
Did not need service	17%	2%	6%	22%	5%	0%	7%
Needed, easy to access	50%	70%	78%	11%	63%	96%	63%
Needed, difficult to access	0%	26%	11%	61%	23%	4%	19%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

SUBSTANCE ABUSE SERVICES

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 19% of participants indicated a need for *substance abuse services* in the past 12 months. 16% reported the service was easy to access, and 3% reported difficulty. 9% stated they did not know the service was available. When analyzed by type of substance concern, 24% of participants cited alcohol, 35% cited drugs, and 41% cited both.

(**Table 1**) When barriers to *substance abuse services* were reported, the most common were lack of knowledge of where to go for the service and fear that others would learn their status (both 12% of all reported barriers to this service).

GRAPH 1-Substance Abuse Services, 2014

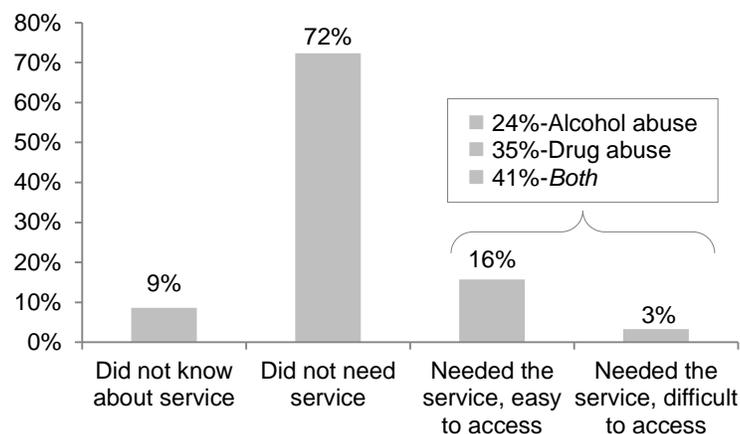


TABLE 1-Top 10 Reported Barriers to Substance Abuse Services, 2014

	No.	%
1. Did not know where to go	8	12%
2. Fear of HIV status disclosure	8	12%
3. Believed they were ineligible	7	11%
4. Did not know how to get service	6	9%
5. Lack of transportation	6	9%
6. Inconvenient location	5	8%
7. Cost	4	6%
8. Wait time	4	6%
9. Low health literacy	4	6%
10. Lack of health insurance	3	5%

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

- More females than males found the service accessible.
- More African American/Black PLWHA found the service accessible than other race/ethnicities.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more MSM and recently released PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Substance Abuse Services, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	9%	8%	6%	9%	9%	16%	9%	10%	7%
Did not need service	72%	72%	77%	70%	72%	74%	85%	77%	67%
Needed, easy to access	15%	19%	16%	18%	13%	11%	6%	10%	22%
Needed, difficult to access	4%	1%	1%	3%	6%	0%	0%	4%	3%

TABLE 3-Substance Abuse Services, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	0%	12%	9%	4%	13%	10%	12%
Did not need service	100%	69%	74%	91%	61%	72%	85%
Needed, easy to access	0%	17%	14%	4%	19%	17%	4%
Needed, difficult to access	0%	2%	4%	0%	6%	0%	0%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender

TRANSPORTATION

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

(**Graph 1**) In the 2014 Houston Area HIV/AIDS needs assessment, 55% of participants indicated a need for *transportation services* in the past 12 months. 44% reported the service was easy to access, and 11% reported difficulty. 11% stated they did not know the service was available. When analyzed by type of conveyance, 89% of participants were provided bus passes, and 11% van services.

(**Table 1**) When barriers to *transportation services* were reported, the most common was lack of transportation (18% of all reported barriers to this service).

GRAPH 1-Transportation Services, 2014

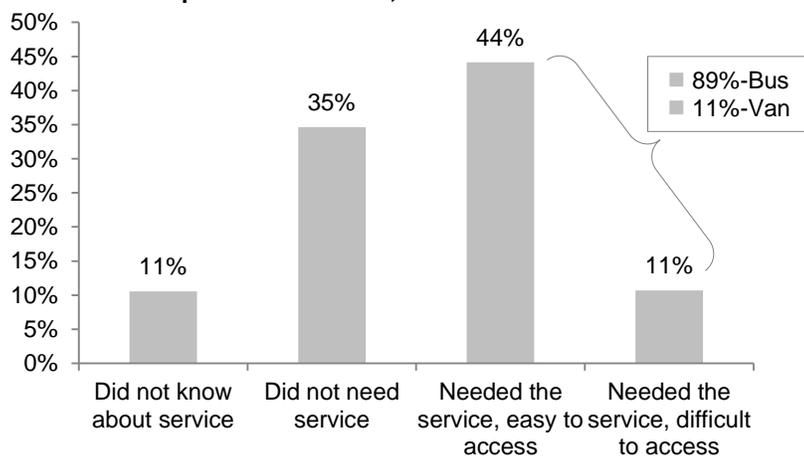


TABLE 1-Top 10 Reported Barriers to Transportation Services, 2014

	No.	%
1. Lack of transportation	24	18%
2. Did not know where to go	23	17%
3. Did not know how to get service	21	15%
4. Wait time	11	8%
5. Believed they were ineligible	11	8%
6. Inconvenient appointments	8	6%
7. Told they were ineligible	6	4%
8. Inconvenient location	5	4%
9. Lack of health insurance	5	4%
10. Cost	5	4%

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

- Males and females found the service equally accessible.
- More African American/Black PLWHA found the service accessible than other race/ethnicities.
- More PLWHA age 45+ found the service accessible than other age groups.
- In addition, more homeless, out of care, and recently released PLWHA found the service difficult to access when compared to all participants.

TABLE 2-Transportation Services, by Demographic Categories, 2014

Experience with the Service	Sex		Race/ethnicity				Age		
	Male	Female	White	Black	Hispanic	Other	13-24	25-44	45+
Did not know about service	10%	11%	10%	9%	12%	30%	0%	12%	10%
Did not need service	36%	31%	43%	29%	39%	30%	45%	37%	31%
Needed, easy to access	44%	44%	37%	49%	42%	40%	45%	40%	48%
Needed, difficult to access	9%	14%	9%	14%	7%	0%	9%	11%	10%

TABLE 3-Transportation Services, by Selected Special Populations, 2014

Experience with the Service	Adolescents ^a	Homeless ^b	MSM ^c	Out of care ^d	Recently Released ^e	Rural ^f	Transgender ^g
Did not know about service	0%	14%	11%	15%	15%	3%	14%
Did not need service	67%	19%	36%	30%	23%	62%	21%
Needed, easy to access	33%	47%	43%	20%	47%	31%	54%
Needed, difficult to access	0%	21%	10%	35%	15%	3%	11%

^aPersons aged 13 to 17 ^bPersons living in a shelter, street, vehicle, or no defined location ^cMen who have sex with men ^dPersons with no evidence of HIV care for 12 mo. ^ePersons released from incarceration in the past 12 mo. ^fNon-Houston/Harris County residents ^gPersons with discordant sex assigned at birth and current gender



2014 Houston Area HIV/AIDS Needs Assessment
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