

Dallas County

Dallas Regional Area Integrated HIV **Prevention and Care Plan**

CY 2022-2026

Dallas County Health and Human Services in
collaboration with Community Solutions Inc.
December 8th, 2022

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Section I. Executive Summary

Approach

The Development of the CDC/HRSA Integrated HIV Prevention and Care Plan, CY 2022-2026 for the Dallas Regional areas was a collaborative process of the Ryan White Parts A and B Administrative Agency, Ryan White Planning Council, funded service providers, HIV Task Force, Fast Track Counties committee, consumers, and community stakeholders. A steering committee was convened comprised of members of each of these groups to guide the integrated planning process, and meetings were held monthly from August-December 2022. Goal-specific workgroups were convened in October 2022 to craft the goals, objectives, and strategies for the integrated plan, as well as provide feedback on how progress toward meeting them should be tracked, reviewed, and communicated to stakeholders. Finally, listening sessions with consumers were held to hear directly from them about what should be done to improve access to care and resources in the Dallas regional area.

Following the implementation of the Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan, CY 2017-2021 (Appendix A), several important changes have been enacted, despite the COVID-19 pandemic taking place during much of the last 2 years of the Plan's implementation. Many of the Ryan White-funded organizations now offer more flexible hours which makes it easier for consumers to access them. Several clinics have been relocated that have increased the capacity of clients served as well as the types of services offered. Providers have been able to make several changes in how they provide services, including updating their forms to be more inclusive, providing increased education on transgender issues, increasing cultural humility and awareness, and implementing of a Rapid Start Clinic. Finally, there has been an increase in funding resources available due to funds from the American Rescue Act. As a result, there are now more housing opportunities available for people living with HIV (PLWH).

Even still, consumers that participated in the Ryan White Planning Council of the Dallas Area 2019 Comprehensive HIV/AIDS Needs Assessment (Appendix B) and 2022 listening sessions identified several areas where improvement is still needed. While the American Rescue Act has made more housing opportunities for PLWH available, there is still a need for additional safe and affordable housing opportunities, particularly for middle to low-income individuals and families, including families with a history of incarceration and aging/elderly PLWH. Some providers have started offering the injectable, long-acting PrEP option, but it has not been made widely available, particularly to identified priority populations as noted later in this plan. PLWH continue to face barriers such as access, transportation, and financial challenges when trying to access treatment and care services and supports. Mental health and substance use needs have increased, especially during the COVID-19 pandemic, and there are gaps in services available services and support to help PLWH manage stress and anxiety. Finally,

transportation continues to be a challenge for PLWH to access services and resources, particularly those in rural areas.

The goals to be addressed throughout this Plan include:

- Diagnose all Dallas Regional Residents as quickly as possible.
- Treat all HIV diagnoses quickly and effectively.
- Prevent new transmissions among Dallas Regional Residents using proven methods and strategies.
- Respond quickly to potential outbreaks by getting prevention and treatment services to Dallas Regional Residents who need them.

Within the goals, the objectives and strategies are meant to help address the needs highlighted from previous plans and consumer feedback.

Documents Submitted to Meet Requirements

The following documents were reviewed and/or referenced throughout this Plan to meet the requirements as outlined:

- Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan, CY 2017-2021.
- 2018 Achieving Together: A Community Plan to End the HIV Epidemic in Texas.
- Ryan White Council of the Dallas Area 2019 Comprehensive HIV/AIDS Needs Assessment.
- Ryan White Planning Council of the Dallas Area Interim Needs Assessment- August 2021.
- 2021-2022 Community Services Handbook: A Guide for North Texans Living with HIV.

Section II. Community Engagement and Planning Process

Jurisdiction Planning Process

Dallas County Health and Human Services (DCHHS) used multiple strategies to develop this collaborative, data-driven, results-oriented planning process creating the Dallas Regional HIV Prevention and Care Plan (Integrated Plan). The planning process provided community stakeholders with an opportunity to take stock of current priorities, goals, and plans, engage diverse perspectives from across the community – especially people living with HIV or AIDS (PLWHA) and others with meaningful and relevant lived experience – to develop strategies that will drive community-wide efforts to support the health and well-being of PLWH and reach the goal of a 90% reduction in new transmissions.

DCHHS engaged a community planning and development firm called Community Solutions, Inc. (Community Solutions) to facilitate the planning process. Based in Indianapolis, Indiana, Community Solutions has provided organizational strategic planning and community-wide planning support to dozens of groups who have a strong desire to make a meaningful impact in the community.

Entities Involved in the Planning Process

The planning process was guided by a Steering Committee (Appendix C) composed of key leaders in prevention and care settings throughout the service area and across agencies that convened monthly from August through December 2022 (Appendix D). Steering Committee members advised on the scope and framework of the Integrated Plan, helped to identify key partners and data sources, and co-designed the approach to gathering community input. Well over one hundred people who are members of the previously existing Ryan White Planning Council, HIV Task Force, Fast Track Counties committee, as well as representatives from Ryan White funded agencies, were invited to participate on the Steering Committee. Ultimately, forty-eight (48) people joined the Steering Committee, including five who identified as PLWH (Appendix C). Throughout the process, Steering Committee members were encouraged to reach out to additional community stakeholders, especially PLWH, to participate in Steering Committee and workgroup meetings to ensure the voice of consumers provided guidance throughout the process.

Collaborating with the Steering Committee, Community Solutions developed a framework for the Integrated Plan that is organized around the four pillars of the National Ending the HIV Epidemic (EHE) Plan - Diagnose, Treat, Prevent and Respond. Workgroups of experts and community members were organized around each of the four pillars, and they were able to provide additional detail to the goals and objectives, as well as outline specific strategies and timelines for accomplishing them. During the month of October, there were four (4) goal-specific workgroups convened where stakeholders, including PLWH, provided targeted guidance and feedback on the Plan's goals, objectives, and strategies. Each workgroup meeting saw about 13 people in attendance, including at least one PLWH. Feedback on the plan's goals, objectives and strategies are captured in Section VI.

Role of the RWHAP Part A Planning Council/Planning Body

The Ryan White Planning Council (RWPC) is a community group appointed by the County Judge to plan the organization and delivery of HIV services funded by Part A, Part B, Minority AIDS Initiative (MAI) and State Services of the Ryan White HIV/AIDS Treatment Act. Council members are volunteers who have been carefully selected to reflect the diversity of the community; they represent the general public, people living with HIV, funded service providers, and other health and social service organizations. The mission of the Ryan White Planning Council of the Dallas Planning Area is to optimize the health and well-being of people living with HIV/AIDS through coordination, evaluation, and continuous planning to

improve the North Texas regional system of medical, supportive, and preventative services. Currently there are 26 members of the RWPC, and 7 seats are vacant. The racial breakdown of the members is as follows: 14 Black, 8 white, 3 Latinx, 1 AAPI.

The RWPC has six (6) standing sub-committees, two (2) of which were integrally involved in the development of the integrated plan. The Planning & Priorities Committee oversees the projects of the RWPC (including implementation of the integrated plan) and is responsible for advising the Administrative Agency on how best to meet the need for prioritized services. The Consumer Council Committee is comprised of PLWH, and advocates on critical issues for the Dallas Regional HIV community, such as the service prioritization and setting process.

The Community Solutions team attended monthly full RWPC and Planning & Priorities meetings, from July through December. Although there were members of both groups who also served on the integrated planning steering committee, attending these meetings was an opportunity to connect with consumers and groups that were serving consumers in the Dallas Regional area and hear directly from them on what was going on in the communities.

Role of the Dallas HIV Task Force

The Dallas HIV Task Force is a local collaboration committed to a compassionate, inclusive, and comprehensive approach seeking to enhance the prevention, care, and treatment of HIV/AIDS in the Dallas Health Services Delivery Area and the communities served in the Ryan White Eligible Metropolitan Area. The HIV Task Force meets monthly and is comprised of consumers, community stakeholders, representatives from ASOs, members of the Ryan White Planning Council and Administrative Agency. Fifteen members of the Task Force participated on the integrated planning steering committee. In addition, a listening session was held in September with 11 consumers who are part of the HIV Task Force.

Role of the Fast Track Counties Committee

The Fast-Track Cities initiative is a global partnership between cities and municipalities around the world and four core partners – the International Association of Providers of AIDS Care (IAPAC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme (UN-Habitat), and the City of Paris. Mayors and other city/municipal officials designate their cities as Fast-Track Cities by signing the Paris Declaration on Fast-Track Cities, which outlines a set of commitments to achieve the initiative's objectives. Initially heavily focused on the 90-90-90 targets, the Paris Declaration was recently updated to establish attainment of the three 90 targets as the starting point on a trajectory towards getting to zero new HIV infections and zero AIDS-related deaths.

In 2019, Dallas became a Fast Track County and as such meets quarterly with stakeholders, medical providers, and consumers with the goal of coordinating activities and reporting outcomes on 90-90-90 goals. These meetings are hosted by the Medical Director of Dallas County Health and Human Services. Members of the Fast Track Counties committee were

invited to participate on the integrated plan steering committee, and the committee received regular updates on the work of the steering committee during the throughout the planning process.

Collaboration with RWHAP Parts – SCSN Requirement

RWPC members were invited to serve on the steering committee and workgroups that were convened to oversee the integrated planning process. Members participated in three (3) steering committee meetings from August-November 2022 to develop the structure of the Integrated Plan and identify additional partners who should be involved in the process. There were approximately 26 participants per meeting, and minutes for each of the steering committee meetings are included in Appendix D.

Engagement of People with HIV – SCSN Requirement

In addition to the steering committee and goal-specific workgroup meetings, three (3) listening sessions were held in September. The listening sessions were conducted during the already scheduled Planning & Priorities and Consumer Council Committee meetings, as well as the HIV Task Force meeting. PLWH and other consumers were asked to respond to the following questions:

- What are some words you would use to describe what your experience has been in terms of getting the care you want and/or need?
- What the gaps in services or supports that you need? What is missing?
- Have there been any resources/services that have worked particularly well for you?
- If you had a magic wand, what would you do to make it possible for everyone to get the care they want?

The Integrated Plan also engaged PLWH in identification of service gaps and needs through the 2019 Ryan White Council of the Dallas Area Needs Assessment (Appendix B). This needs assessment utilized Consumer Focus Groups and Consumer Surveys to identify areas where PLWH saw the biggest need for improvement. As a follow-up, an Interim Needs Assessment was conducted in 2021 that collected feedback from PLWH on the gaps identified in the 2019 needs assessment and the changes implemented (Appendix E). The 2022 Dallas Area Needs Assessment is currently underway. Any findings or recommendations generated through that assessment will be incorporated into the annual review and updated process of the Integrated Plan.

Section III. Contributing Data Sets and Assessments

Data Sharing and Use

The data discussed and highlighted in this section were provided by Dallas County Health and Human Services and Texas State Health Department, through a series of data files, reports, and plans. Dallas regional population data was gathered from the Census. Dallas County Health and Human Services has data-sharing agreements that can be provided on request.

Epidemiologic Snapshot

This snapshot reviews trends in data and characteristics for populations with newly acquired HIV, populations currently living with HIV, populations that do not know their status, and persons at risk for exposure to HIV.

Populations with Newly Acquired HIV

Within Dallas County in 2020, cisgender men accounted for 78.1% (N=665) of newly acquired HIV, transgender women accounted for 2.2% (N=19), and transgender men account for 0.1% (N=1) of all new diagnoses (Figure 1). In previous years (2015 – 2019) transgender populations that acquired HIV remained consistent in counts. Data regarding accurate numbers for transgender men and women is limited due to inconsistent practices for capturing gender-related demographic information.

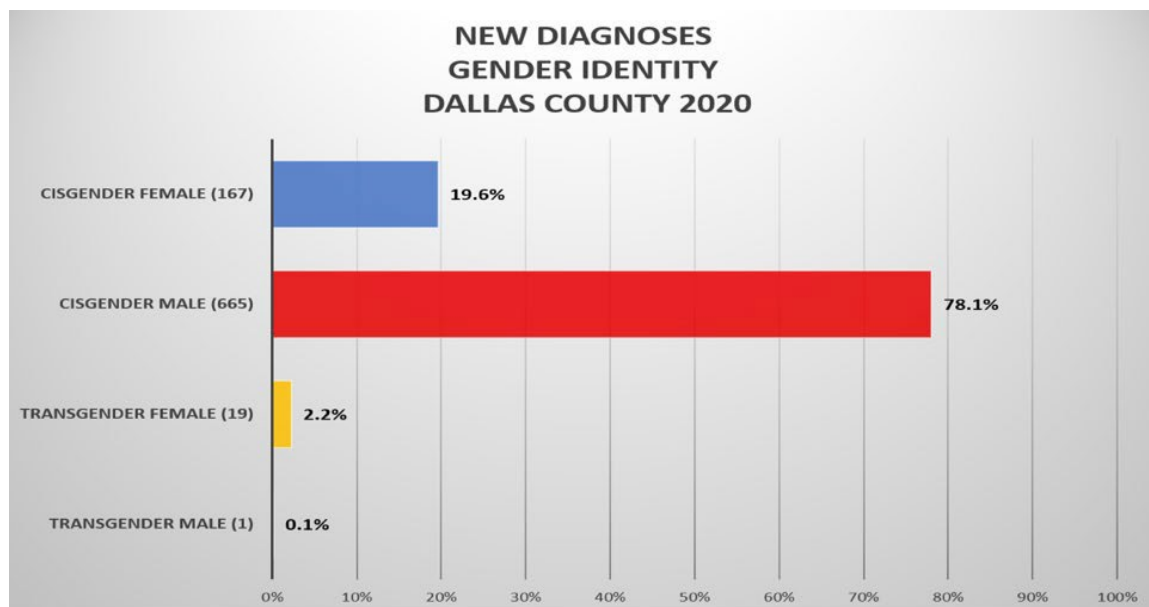


Figure 1. New Diagnoses of HIV by Gender Identity in Dallas County 2020

Source: Texas HSDA

Within the Sherman-Denison region, gay and bisexual men, and other men who have sex with men (MSM) have consistently represented the majority percentage of newly acquired HIV transmissions in the past 5 years (2015 – 2020). For transgender populations living within the Sherman-Denison region, there is limited data regarding newly acquired HIV transmissions. Transgender women living in Sherman-Denison accounted for 1% (N=1) of newly acquired

HIV transmissions in 2020. There is no available data for previous years regarding transgender men.

Consistent with national trends, Black and Latinx populations were disproportionately affected by HIV in 2020. Black residents of Dallas County represented 47.3% (N=403) of all newly acquired HIV cases in 2020. Hispanic residents represented 29% (N= 247) of all newly acquired cases, white and Asian residents represented 18.9% (N=161) and 1.9% (N=16) of all newly acquired HIV transmissions in Dallas County, respectively (Figure 2).

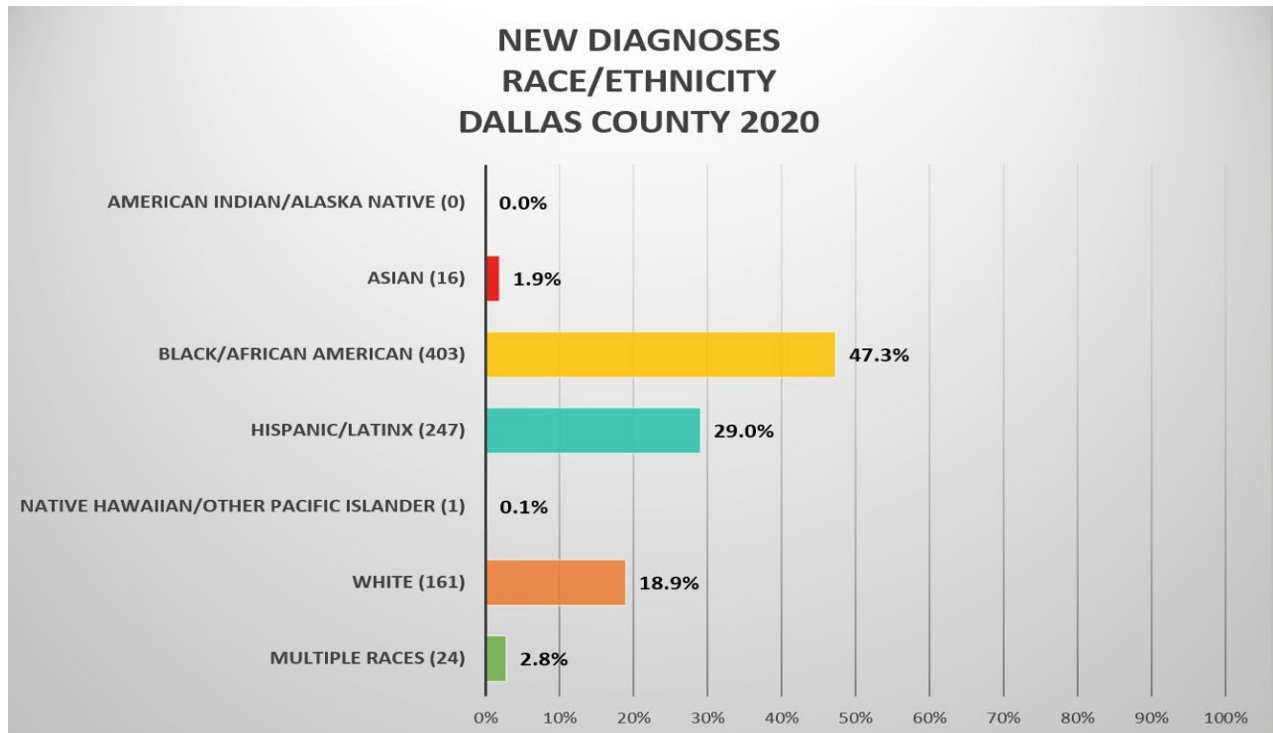


Figure 2. New Diagnoses of HIV in Dallas County by Race/Ethnicity 2020
Source: Texas HSDA

Within the Sherman-Denison region, there were 3 newly acquired cases of HIV for both Latinx and white residents and 2 newly acquired HIV cases for Black residents. In previous years (2015 – 2020) white residents of the Sherman-Denison region represented the majority of newly acquired cases, but this rate declined between 2016 thru 2018 (Figure 3).

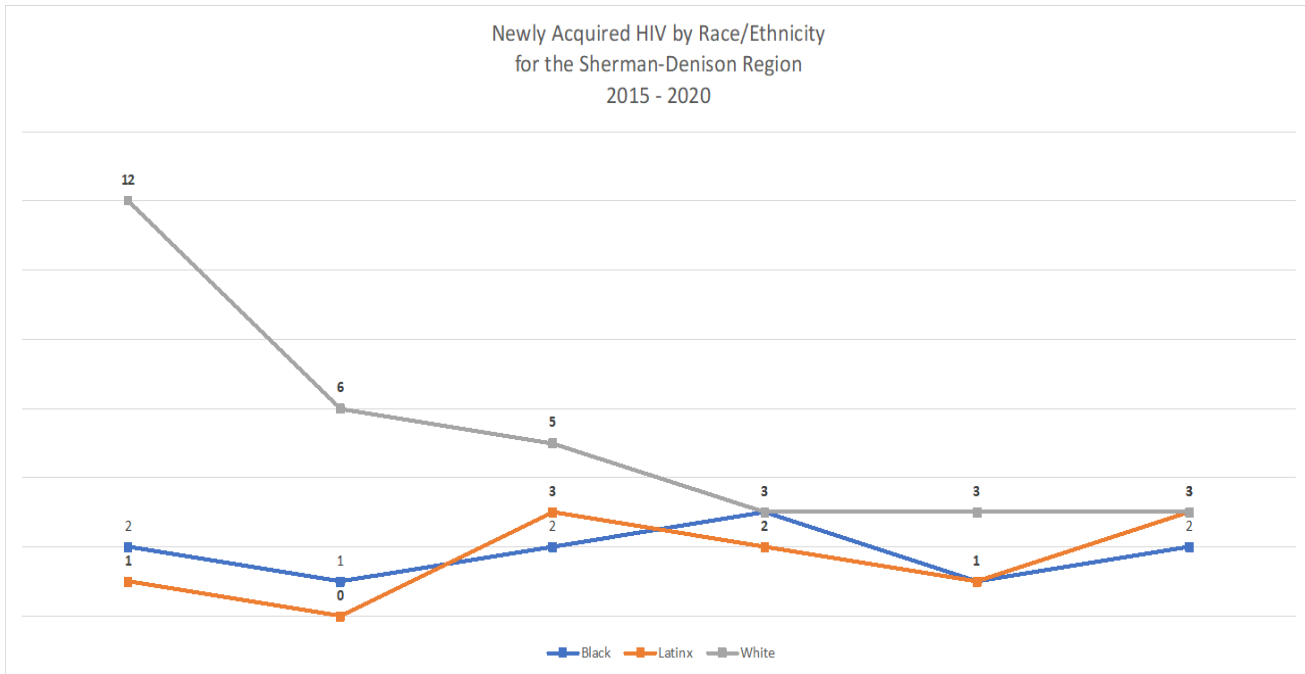


Figure 3. Newly Acquired HIV Trend by Race/Ethnicity for Sherman-Denison Region 2015 - 2020
Source: Texas HSDA

Consistent with national trends, Dallas County residents between ages 25–34 represented the majority of newly acquired HIV cases for 2020, followed by residents aged 15–34. The age group with the highest number of cases over the past 5 years (2015 – 2020), has consistently been age group 25-34 (Figure 4).

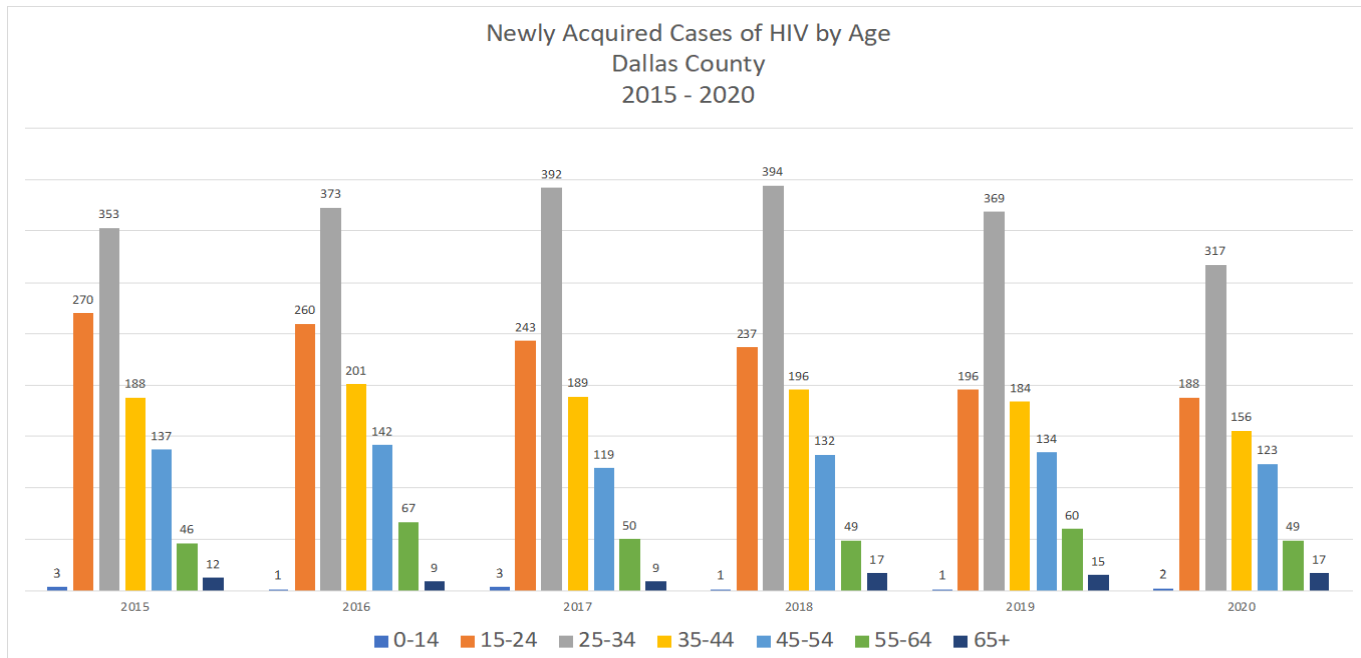


Figure 4. Newly Acquired Cases of HIV by Age Dallas County 2015 – 2020
Source: Texas HSDA

The Sherman-Denison region in recent years (2019-2020) has seen an increase in newly acquired HIV cases among residents of ages 25-34 years old, though other age groups could be underrepresented due to the COVID-19 pandemic (Figure 5).

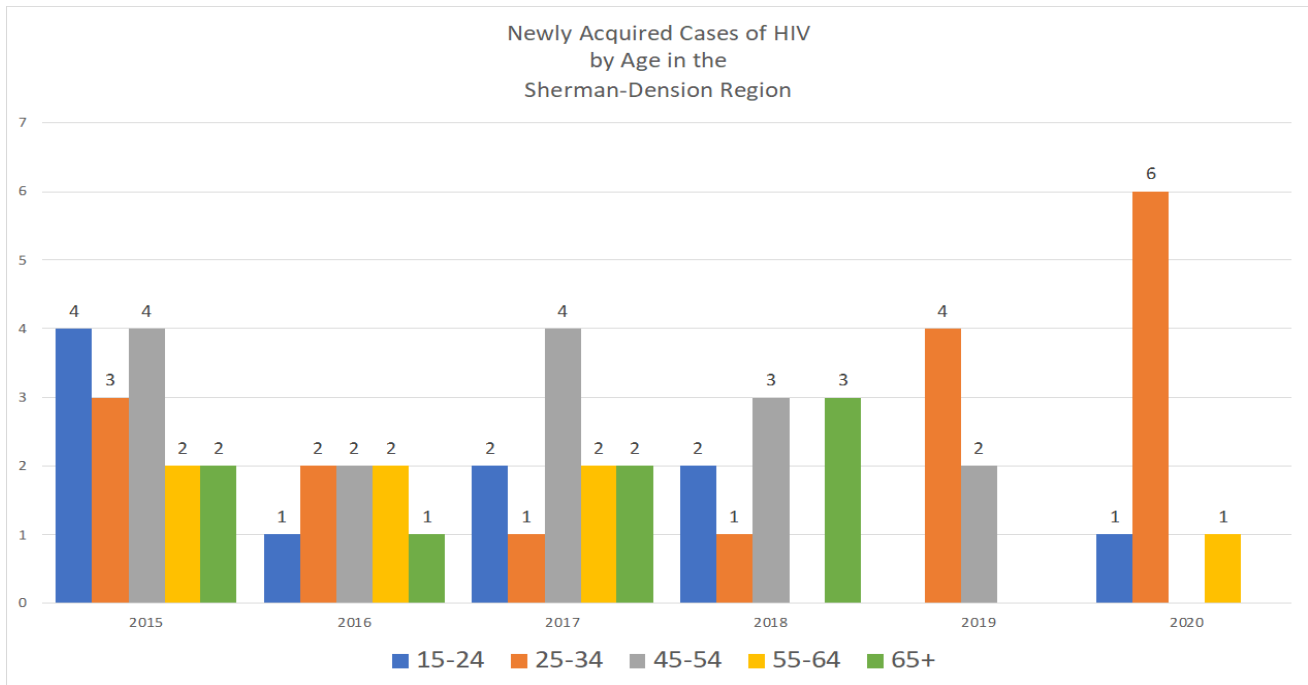


Figure 5. Newly Acquired Cases of HIV by Age Sherman-Denison 2015 – 2020
Source: Texas HSDA

Consistent with trends over the past five years (2015 – 2020) gay and bisexual men and other MSM have consistently represented the majority of all new HIV diagnoses within Dallas County. For modes of transmission outside of MSM, women who have sex with men (WSM) have had consistently higher counts of newly acquired cases in previous years (2015 – 2020), when compared to people who inject drugs (PWID), men who have sex with men who also have sex with people who inject drugs (PWID/MSM), and men who have sex with women (MSW) (Figure 6). Within the Sherman-Denison region, trend data for 2015 – 2020 for these groups is limited.

Populations at Risk of Exposure to HIV

Within the Dallas region, cisgender men were 4 times more likely to acquire HIV in 2020 when compared to cisgender women. In previous years (2015 – 2020) cisgender men have consistently been 4 times more likely to acquire HIV within the Dallas region. In previous years (2015 – 2015) transgender women have been at greater risk for acquiring HIV in the Dallas region (data regarding transgender men has been either non-existent or limited).

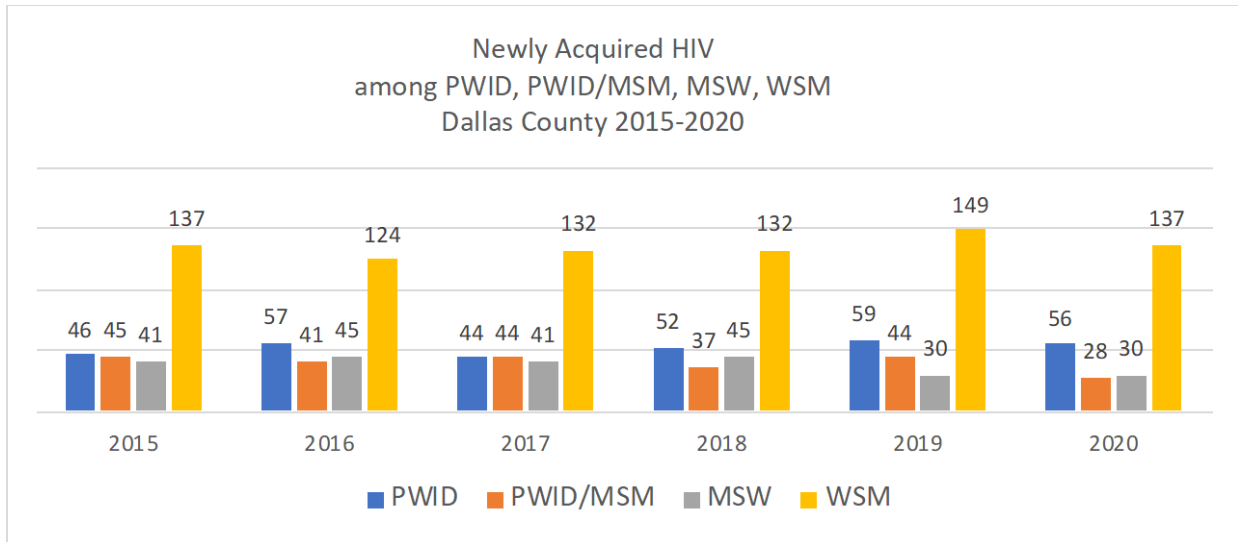


Figure 6. Newly acquired HIV cases among PWID, PWID/MSM, MSW, and WSM within Dallas County 2015 – 2020

Consistent with national trends, Black and Latinx MSM, continue to be the populations with the greatest risk of acquiring HIV in 2020 within the Dallas region. Residents in the Dallas region, who identified as Black were 1.6 times more likely to acquire HIV in 2020.

Populations Living with HIV within the Dallas Region

At the end of 2021, the total number of Dallas region residents living with HIV was 25,492 (Figure 7). The Dallas region represented 24.7% of the total number of residents within the Texas cascade system living with HIV.

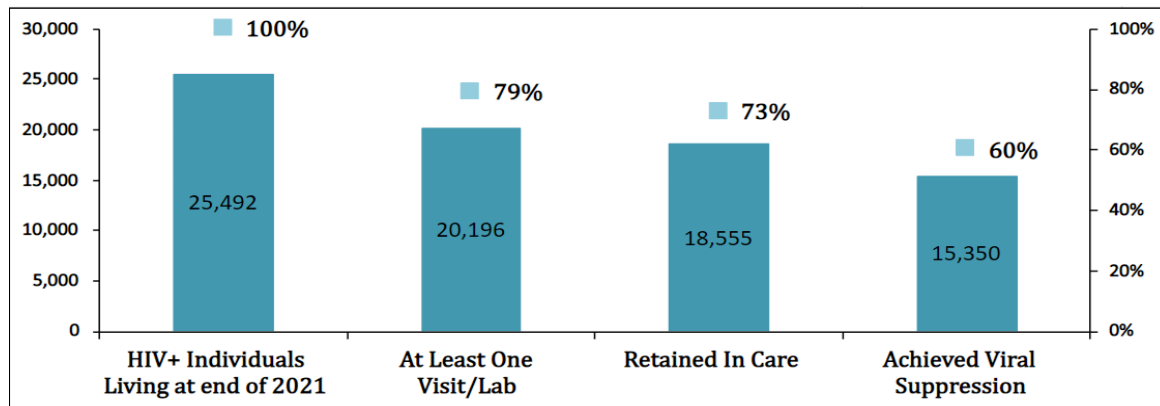


Figure 7. Texas HIV Treatment Cascade for Dallas Region 2021

Source: Enhanced HIV Reporting System as of July 1, 2022, Medicaid, ELR, Ryan White Services Data (ARIES), ADAP, and Private Payers

Priority populations identified by the HIV National Strategic Plan for the Dallas region, include Black and Latinx men who have sex with men, Black women who have sex with men, white men who have sex with men, and transgender people.

Black residents represent 22% of the total population (N=2,613,539) within the Dallas region, yet Black residents account for 42% (N=10,509) of the total prevalence of people PLWH within the Dallas region in 2020. Similarly, Latinx residents represent 40% of the total population, and account for 25% (N=6,109) of the total prevalence of PLWH within the Dallas region in 2020. Trends in previous years (2015 – 2020) have shown an increase in PLWH among priority populations. Between 2015 – 2020, the number of Latinx MSM living with HIV increased by 29%, Black MSM experienced an increase of 31%, White MSM experienced an increase of 3%, Black WSM experienced an increase of 16%, and transgender residents experienced an increase of 59% within the Dallas region (Figure 8).

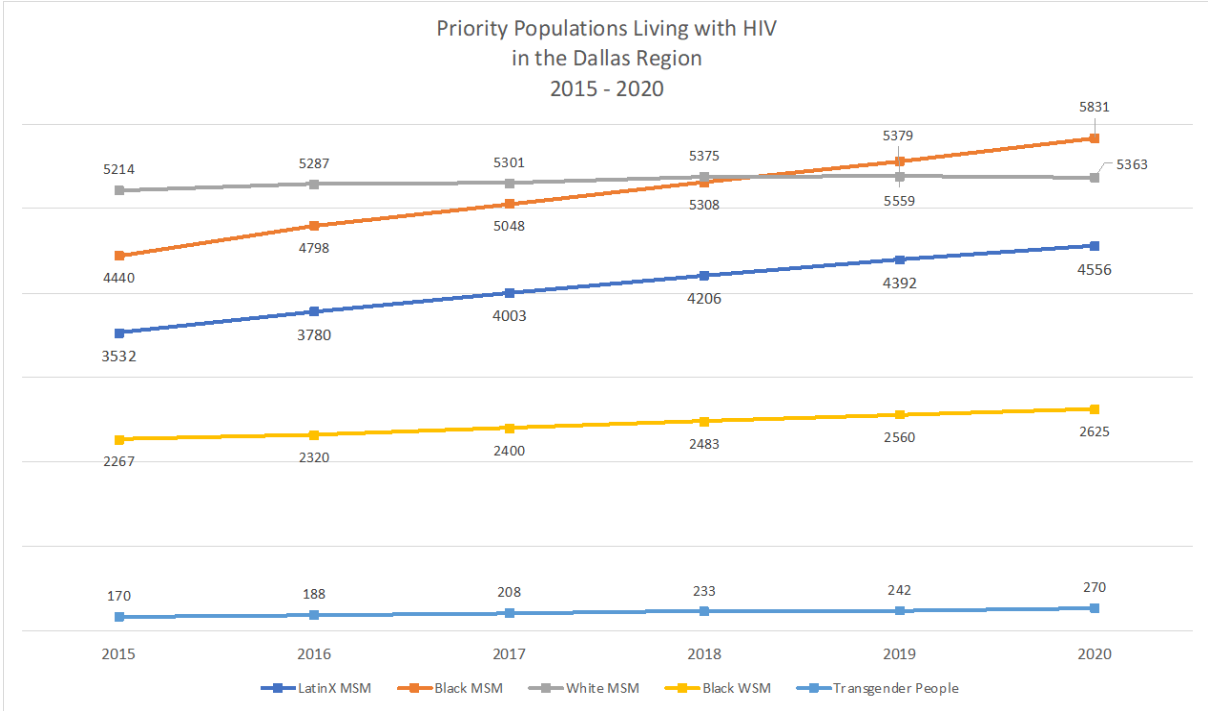


Figure 8. Priority Populations Living with HIV in the Dallas Region 2015 – 2020

In 2020, 6% (N=1,488) of PLWH in Dallas County identified as people who inject drugs. 4.6% (N=1,126) of PLWH identified as MSM and PWID. Over the past 5 years (2015-2020) the number of PLWH who identify as people who inject drugs has increased 8.2%. Trends for PLWH who identified as MSM and PWID have also increased by 9.2% over the 5-year period.

Populations Living with Undiagnosed HIV

Due to the COVID-19 pandemic, estimates regarding the number of people in the Dallas region living with HIV is likely to have been depressed because of decreased HIV testing. General trends over previous versus exact figures should be considered.

In 2020, most people suspected to be living with undiagnosed HIV are men who have sex with men (MSM), followed by women who have sex with men (WSM), and men who have sex with women (MSW). The largest estimated population by race living with undiagnosed HIV is Black MSM (Figure 9).

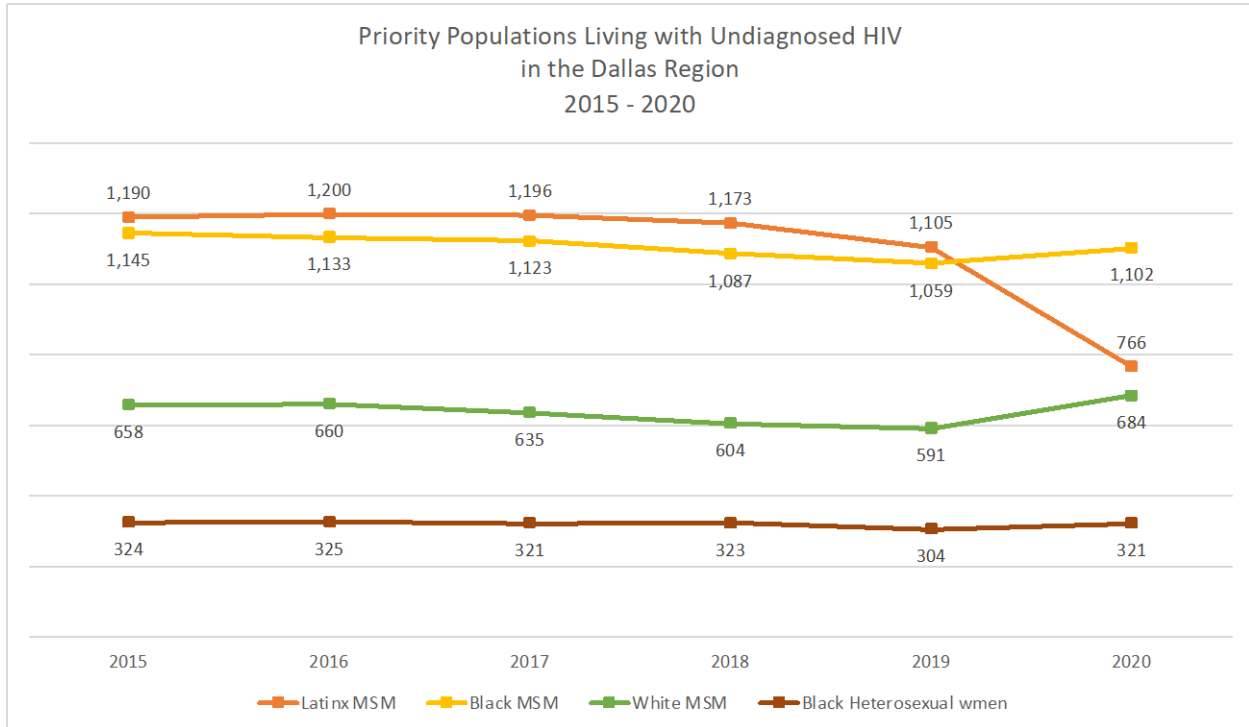


Figure 9. Priority populations living with Undiagnosed HIV in Dallas Region 2015 – 2020
 Source: Routine disease surveillance for the number of people with diagnosed HIV, with the total prevalence, proportion diagnosed, and number of people with undiagnosed HIV estimates were produced using a CDC algorithm customized for use with Texas jurisdictions.

Estimates regarding the number of people who are transgender or gender-diverse living with undiagnosed HIV in the Dallas region is limited or not available.

HIV Prevention, Care and Treatment Resource Inventory

Through various Ryan White, state, federal, and local funding, the Dallas region can offer a variety of medical and/or supportive services for PLWH (Appendix E). Currently, there are a total of 21 organizations offering services for PLWH in the Dallas EMA through RW funding. ¹

Ryan White Funded Organizations and Services Provided	AIDS pharmaceutical assistance	Case management	Emergency financial assistance	Food bank/home delivered meal	Health insurance assistance	Housing	Legal services	Linguistics	Medical case management	Medical transportation	Mental health services	Non-medical case management	Oral Health	Outpatient medical care	Outreach lost to care	Referral for healthcare	Respite care (Adult)	Substance abuse
AHF Healthcare Center (Dallas)																		
AIDS Services of Dallas (ASD)																		
Bryan's House																		
Callie Clinic																		
Community Dental Care																		
Health Services of North Texas																		
Legacy Cares																		
Legal Hospice of Texas																		
Parkland Hospital																		
Prism Health North Texas																		
Resource Center Health Campus																		

Strengths and Gaps

The 2019 Ryan White Council of the Dallas Area Needs Assessment and Ryan White Planning Council of the Dallas Area Interim Needs Assessment- August 2021 findings, along with feedback from the 2022 Listening Sessions were used to identify the changes and updates made since the implementation of the Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan- CY 2017-2021. Many Ryan White-funded organizations offer flexible hours, allowing for easier access to services. Extensive language services are available at most Ryan White-funded organizations, as well as diverse options for payment. In the Dallas region, there are also a range of services and resources available to youth under the age of 18. The most prevalent needs not being met were affordable housing, mental health care, and

¹ 2019 RW Needs Assessment

prevention messaging. Rural areas have specific unmet needs that include funding needed for outreach, peer support and navigation, support groups, and PrEP/nPEP. These are long-existing challenges that do not appear to have any infrastructure or funding available to support them. As such, this is an opportunity to engage groups serving PLWH or other at-risk populations and enlist their help in developing solutions to serve these populations.

Housing

There is a need for increased safe, affordable housing opportunities, specifically for middle to low-income individuals and families, including individuals with a history of incarceration and homes for aging/elderly PLWH. For those who earn above federal housing support income guidelines, there is a need for more assistance in obtaining and maintaining housing. Although these individuals exceed income guidelines, those guidelines do not account for medical and other expenses, causing a further financial strain on this group of individuals.

There has been an increase in funding for housing resources available, specifically because of the American Rescue Act funds. Additionally, Dallas County has purchased a hotel in partnership with Catholic Charities and the City of Dallas for COVID-19 that will be used to offer 180 units of permanent supportive housing (PSH) to PLWH. St. Jude offers PSH, and the county will be expanding access to Emergency Housing Vouchers (EHVs). Individuals can be placed on the housing priority list by calling the MDHA Homeless Crisis Line.

Medical Care

Since the implementation of the Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan- CY 2017-2021, the Dallas region has worked to increase access to medical care and treatment throughout the city. The Dallas region now has clinics with more flexible hours, including Saturday and evening hours available at one clinic, as well as a new Rapid Start Clinic. The relocation of the Amelia Court Clinic, now known as the Adult Comprehensive Care and Engagement Support Services (ACCESS) Clinic, has been relocated to increase capacity of clients served and services offered, including HIV care and treatment, referral services, geriatric care and healthy aging, and behavioral health.² In addition, the Community Health Center for Health Empowerment PrEP Clinic has begun providing HIV care to decrease the share of clients who were not getting connected to treatment. The Dallas region has also implemented mobile testing units located outside of nightclubs in two districts to increase testing access, which are being utilized by many.

Further, changes reported by providers include updates to forms to be more inclusive, increased education on transgender issues, increased cultural humility and awareness, full wraparound services (including pharmacy and medical clinic), increased Spanish-speaking services and additional bilingual therapist(s), and implementation of a Rapid Start Clinic.

² <https://www.parklandhealth.org/locations/adult-comprehensive-care-and-engagement-support-se-148>

Listening Session participants shared that the use of injectable, long-acting PrEP offered by some service providers has been useful to help protect patients' HIV/AIDS status, ultimately reducing patient stress and anxiety. These injectable medications, however, have not yet been rolled out on a large-scale.

In terms of prevention, treatment, and care services and supports, barriers need to be addressed to ensure PLWH are not facing additional challenges and burdens in receiving necessary care. Medical staff and patient communication improvements, specifically to include a focus on the quality of life, should be implemented to reduce stigma surrounding HIV/AIDS. The ability to pay for medical and oral care remains a challenge for PLWH in the Dallas region. Inadequate services and supports available in immigration detention centers, as well as challenges in accessing care post-release from criminal justice systems, is an additional gap in services. Reduced paperwork requirements, increased PrEP/nPEP, and improvements in access and affordability for necessary medications and healthcare services and supports should be implemented to decrease patient burden and stress. For PLWH who are age 16 or younger, testing is not easily available, thus identifying a need for universal testing to be implemented in healthcare and sports physicals for individuals aged 13 to 64.

Prevention

The HIV Taskforce is working to increase distribution of free condoms through partnerships with community-based organizations, social service organizations, and other non-profit organizations. Prism Health North Texas has implemented a new program called Nice Package. This program was implemented to provide contactless delivery options for condoms to decrease transmission rates.

There has been an increase in the Dallas region of providers offering PrEP and nPEP.

Mental Health and Substance Use

There has been an increase in the need for mental health and substance use disorder (SUD) services and supports, specifically strategies for coping with anxiety and depression caused by isolation and fear during the pandemic. There are also current gaps in the available services and supports for managing stress. Increases in available mental health and SUD services and support are especially needed for PLWH who are underinsured, uninsured, and/or living in poverty, as well as those living in rural areas.

Peer Support

Participants in the Listening Session conversations noted that the ability to connect with other individuals living with HIV/AIDS has been beneficial. Peer support, including support groups, provides a platform to expand trust, have a conversation around areas they are struggling in, and gain new insights and perspectives. Holding non-traditional support groups has allowed for greater comfortability in attending and voicing concerns. Although progress

has been made to increase the availability of services and supports, gaps were still identified that need to be addressed.

Transportation

Transportation presents additional challenges in accessing all necessary services and resources. Utilization of ride-share services, such as Uber and Lyft, and gas cards in lieu of bus tickets would be beneficial in assisting PLWH who have disabilities in accessing services. PLWH who have disabilities also have an additional barrier to accessing healthy groceries. Assistance with grocery shopping and carrying groceries into the homes would be helpful.

Needs Assessment

Dallas County Health and Human Services employs multiple methods of assessing HIV prevention and care service needs and barriers to services for residents of the Dallas Region. Importantly, PLWH are actively recruited and engaged in community planning and oversight activities to ensure that the voice and perspective of people with lived experience influences the system. While a Comprehensive Needs Assessment is currently underway in the jurisdiction – and therefore results are not yet available to inform this Plan – data on service needs and barriers drawn from three other recent planning and/or assessment processes were consulted in the development of this Plan:

- Ryan White Planning Council of the Dallas Area Interim Needs Assessment- August 2021
- Ryan White Council of the Dallas Area 2019 Comprehensive HIV/AIDS Needs Assessment
- Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan, CY 2017-2021.

In 2019, the Dallas region facilitated the Ryan White Planning Council of the Dallas Area 2019 Comprehensive HIV/AIDS Needs Assessment (Appendix B). The plan was meant to assist in developing funding allocation priorities and a comprehensive plan aimed at meeting the needs of people living with HIV/AIDS. The objectives of the Comprehensive Needs Assessment were to:

- Identify trends in the HIV epidemic within the Dallas region, focusing on recent changes and emerging affected populations.
- Identify consumer service needs, needs that are not currently being fulfilled, service utilization patterns, and barriers to care.
- Obtain detailed information and analyze the treatment initiation gap for PLWH after being diagnosed.
- Obtain detailed information on PLWH with unmet need for medical care; including demographics, barriers, and strategies to connect to care.
- Identify and evaluate the system of HIV care, evaluating current capacity gaps, and barriers (including but not limited to eligibility barriers) in the continuum and treatment cascade. This will include HIV/AIDS services providers and providers of service that PLWH use.

- Evaluate the systems for and rate of linking PLWH into medical care.
- Identify and evaluate the impact of health care reform on Ryan White enrollment and types of services most needed after PLWH enroll in expanded Medicaid programs or health insurance exchanges/marketplaces.
- Evaluate and interpret the use of alcohol and other non-prescribed drugs and the impact on adherence and make recommendations to identify the best approach to address the subject.

Epidemiologic data were collected and compiled by Brad Walsh at Parkland Health and Hospital System. The Texas State Department of Health Services provided quantitative data for incidence, prevalence, trends, co-morbidities, and services. He also obtained ARIES data from the local provider data system to supplement the state data. These data were provided to the contractor, Susan Wolfe, and Associates, who conducted additional analyses, compilation, and used the data to prepare graphs for this report. Additional data were obtained online from the United States Census American Community Survey and the Center for Disease and Control Prevention risk surveys.

a. **Priorities**

The following are the key priorities that arose from the needs assessment process:

Identify trends in the HIV epidemic within the Dallas region, focusing on recent changes and emerging affected populations.

The incidence of new cases has remained fairly steady since 2013. The highest numbers of new HIV and AIDS diagnoses are in Dallas County, followed by Collin and Denton Counties. The prevalence of HIV/AIDS in the Dallas region continues to rise. Both the number of PLWH and the rate per 100,000 population is highest in Dallas County. Collin and Denton Counties have higher numbers of PLWH compared with other counties in the Dallas region. The rate of prevalence per 100,000 persons is higher in Collin and Kaufman Counties. The remaining counties have lower prevalence and rates.

HIV/AIDS mortality rates for Black PLWH in the Dallas region are over five times the rate for non-Hispanic white PLWH, suggesting a need to identify the reasons for the higher death rate and address them.

There is a lack of data for transgender individuals. Reliable estimates for the number are difficult to find, and HIV rates are unknown. Recent HRSA HIV/AIDS program client-level data suggest there are 157 identified transgender individuals receiving Ryan White services in the Dallas region. There is no such data available for counties in the Sherman-Denison HSDA.

Results of the breakdown of new cases by race and ethnicity suggest that efforts to prevent racial and ethnic disparities in new cases and reduce new cases overall would have the greatest impact by targeting African American and Hispanic/Latinx communities. Also, new diagnoses are fastest growing among the 25 to 34 years age group.

New diagnoses of HIV among MSM continue to rise in recent years (2015-2020) indicating a need to increase prevention efforts and messaging that specifically targets MSM.

Poverty rates are high among PLWH in the Dallas EMA. While the poverty rate for individuals residing in the Dallas region is 11%, an estimated 23% of PLWH in the Dallas region have incomes at or below the poverty level. Data were not available for the Sherman-Dennison HSDA.

Emerging health issues and comorbidities that complicate HIV care include sexually transmitted infections, obesity, diabetes, heart disease, and hypertension. Providers also reported increased mental health problems and substance abuse. Because of improvements in treatment, more PLWH are living longer which is increasing the need for specialized geriatric care for this population.

Identify consumer service needs, needs that are not currently being fulfilled, service utilization patterns, and barriers to care.

Providers in the Dallas region identified challenges to HIV/AIDS prevention. Younger people who did not see the epidemic in the beginning view HIV/AIDS as another chronic but treatable disease. There is still stigma associated with HIV and it creates barriers to treatment. HIV prevention should be included with general health prevention messaging such as prevention regarding illicit drug use, improving diet, and increased exercise. Even with PrEP, people need to understand the need to use condoms to prevent other sexually transmitted infections. Messaging needs to be tailored toward audiences that experience the highest rates of transmission.

Barriers to HIV care cited by survey participants were the amount of time it takes to get care, the paperwork burden, the time it takes to get an appointment, lack of weekend and evening hours, the clinic treats HIV and not their other medical conditions, and the staff does not understand their culture. It is important to keep in mind that survey participants were predominantly from the Dallas region. Evidence from data and providers suggests that for individuals living in suburban and rural areas, the paucity of services locally and resources and time necessary to reach services located in Dallas may also serve as a barrier.

Obtain detailed information and analyze the treatment initiative gap for PLWH after being diagnosed.

Barriers to successful linkage to care were identified using consumer surveys and focus groups. Patients perceived stigma when they go to HIV clinics. There are institutional barriers such as considerable time elapsing and the paperwork burden between diagnoses and seeing a provider. PLWHA sometimes have higher order needs, such as housing instability or unresolved trauma that need to be resolved before they will seek treatment. Transportation may not be available, especially in rural areas. Psychosocial barriers include denial or having to come out to their families as they share their diagnosis.

Obtain detailed information on PLWH with unmet need for medical care; including demographics, barriers, and strategies to connect to care.

In 2021 the State of Texas estimated that as many as 3,997 individuals in the Dallas region may be undiagnosed. Estimated numbers were higher among males, Black people, people ages 25-34, and MSM.

Among PLWH, in 2021, in the Dallas region, 79% were linked to care; 73% were retained in care, and 60% were virally suppressed. A total of 87.7% of PLWH who were retained in care were virally suppressed.³

There are barriers to retaining PLWH in care. There is a high administrative burden with paperwork required every six months. Information is not centralized so PLWH who are seeking care must complete such updates with all of their providers. Youth lose their Medicaid coverage when they turn 19 and may drop out of care at that time. Resources are primarily centralized around downtown Dallas and not easily accessible to individuals living in Dallas County outside of the city or in other rural counties. Sometimes other needs arise and take priority, such as loss of housing, substance abuse issues, or life disruptions where people fall out of their routines. Not all PLWH are comfortable with all providers, and they may leave treatment after a couple of appointments.

Programs that are successful at linking people to and keeping people in care are generally collaborative, comprehensive, and offer a single system of care where all partners are fully informed. They offer high quality care with sincere and knowledgeable providers. They are often innovative and will try a variety of strategies and are designed specifically to meet the needs of the population they serve.

³ Enhanced HIV AIDS Reporting System, “Texas HIV Treatment Cascade for Dallas EMA,” 2022.

In summary, efforts to improve retention in care are needed, specifically targeting Black PLWH, younger PLWH (ages 13-44), and PWID. Efforts should focus on linking Black PLWH to care and retaining them in care to increase their viral suppression percent. Additional efforts should be focused on Hispanic/Latinx PLWH whose numbers are increasing and whose percentage of virally suppressed is less than that of White PLWH, as well as PWID and ages 44 or younger individuals among the PLWH population. Innovative and culturally relevant strategies are needed to overcome logistical barriers such as transportation, geographic distance, and hours/days of service as well as psychological barriers such as stigma, feelings of invulnerability, and denial.

Identify and evaluate the system of HIV care, evaluating current capacity gaps, and barriers (including but not limited to eligibility barriers) in the continuum and treatment cascade. This will include HIV/AIDS services providers and providers of services that PLWH use.

The Dallas region has excellent health care, although it is not necessarily available for or accessible by all PLWH in the Dallas region. There is an insufficient supply of mental health care available to meet the needs of the population. There is also a need for mental health providers who are knowledgeable about LGBTQ individuals, HIV, and navigating life with HIV, as well as more culturally appropriate and community competent providers. Dental and vision services also need increased capacity in more locations.

There are 21 identified organizations providing a spectrum of HIV related services to PLWH in the Dallas region who may not have sufficient resources for disease management. Potential areas of improvement identified include relatively longer wait times for dental care (average 0 to 50 days) and mental health counseling (average 0 to 10 days). These wait times were substantially longer than other services such as outpatient HIV medical care (0-7 days) or outpatient OB/GYN services (0-2 days).

The most prevalent needs not being met were needs for affordable housing, mental health care, and prevention messaging. Rural areas had specific unmet needs that included funding needed for outreach, peer support and navigation, support groups, and PrEP/PEP. Needs varied across priority populations.

Prevention services are not universally available throughout the Dallas region. They need to target specific geographies and populations and be more culturally responsive to them. Planning and assessment efforts for prevention need to be more inclusive and examine within group variation. PrEP and PEP are not accessible to everyone. There is a need for more widely available education about safe sex.

Prevention initiatives need to target stigma among the larger population and within sub-populations, including rural, African American, and Latinx communities.

Evaluate the system for and rate of linking PLWH into medical care.

In 2021, 12% of PLWH in the Dallas region were not linked to care. The percent of PLWH with unmet needs and 20 or more PLWH was highest in the 75454 (Melissa; 43%); 75247 (Dallas west; 38%); 76205 (Denton; 37%); 75402 (Greenville, 36%); and 75401 (Greenville, 35%) zip codes. Many areas with unmet needs did not have Ryan White-funded services in proximity or were in rural areas or suburbs that do not have specialized HIV care.

Linkage to care varied by sex and race/ethnicity for previous years (2020), showing that 75.6% of cisgendered women were linked to care compared to 75.8% of cisgender men linked to care. Of transgender women, 84% were linked to care and 100% of transgender men were linked to care. Data is limited regarding transgender populations due to being unable to ascertain what percentage of clients were asked about their gender identity vs being assumed by the provider. Percentages linked to care are lower for Black and Hispanic PLWH (74.1%) compared to White PLWH (77.8%).

In summary, targeted efforts to link PLWH with care in the Dallas region are needed for women, Black and Hispanic persons, PWID, heterosexual individuals, transgender individuals, and age groups 0-12, 13-24, and 65 and older. Peer support and peer navigation were suggested as potentially effective strategies.

Identify and evaluate the impact of health care reform on Ryan White enrollment and types of services most needed after PLWH enroll in expanded Medicaid programs or health insurance exchanges/marketplaces.

Respondents to the provider survey reported that the impact of the Affordable Care Act on their organizations and clients was mixed that there was mostly little to no impact. This was primarily attributable to Texas not accepting the expanded Medicaid provision. Other problems cited were restrictive eligibility requirements and insurance premiums that are not affordable, adding to the barriers to clients accessing care.

Evaluate and interpret the use of alcohol and other non-prescribed drugs and the impact on adherence and make recommendations to identify the best approach to address the subject.

Providers reported they are seeing an increase in substance abuse among PLWH. Consumer respondents reported the most frequently used substances were alcohol, marijuana, stimulants, depressants, and non-prescribed painkillers. Among

consumers who dropped out of care, 26% reported using drugs as a reason. They also reported there are few services available for low-income PLWH who need substance abuse treatment. Substance abuse and other behavioral health services should be integrated into primary care. Resources are needed to expand inpatient substance abuse treatment as well. Explore the feasibility of programs that provide both housing and substance abuse aftercare support.

Recommendations for Services

Target prevention initiatives toward youth (ages 13-35), Black, and Hispanic/Latinx communities, and MSM. Make testing more widely available, and work to have it incorporated into more routine health care. Provide testing at health fairs and large community events. Inform youth that they can be tested without parental consent. Provide youth with more consistent sexual health information and education.

Expand to more geographic locations and target populations identified as needing prevention and intervention services. Include individuals from underserved populations when developing strategies at the table as decision-makers (e.g., transgender individuals; more people of color; youth).

Address racial disparities at multiple levels. At the individual level, target unmet needs. At the community level, address stigma toward LGBTQ individuals and HIV/AIDS. At the systems level, systemic racism must be acknowledged and addressed.

Identify ways that the paperwork burden on both consumers and providers can be reduced. Consider a universal intake system and longer periods between required re-certification.

Join with other groups to advocate for Medicaid expansion and affordable housing options. As Dallas neighborhoods continue to gentrify, an increasing number of low-income individuals and families are being pushed out and unable to find affordable housing, including PLWH. Such work can also help improve access and stability for people living in rural communities.

Provide comprehensive services with one-stop shops to the extent possible. Include services to meet psychosocial needs and peer navigators who can provide guidance and support.

Take a deep dive into examining the system of care. Incorporate more evaluation into services to determine both their efficiency and effectiveness and use findings for continuous improvement. Include voices of Black gay men, Black and Hispanic

heterosexual women, members of the transgender communities, and others who have been traditionally excluded at the table for planning and decisions (2019 Needs Assessment- Appendix B pp. 12-16).

b. Actions Taken

The 2019 needs assessment report was delivered in March 2020, just before Dallas County begin to experience the impact of COVID-19. This left little opportunity for providers and the RWPC to give it adequate attention as they have been busy since that time managing the impact of the pandemic on their organizations and consumers. Nonetheless, the interviews and focus groups asked questions to determine whether providers and consumers had seen or heard of the results from the 2019 needs assessment. They also asked about changes made by providers and consumers' observations of changes.

Did providers and consumers hear or see the results?

Consumers who participated in the focus groups reported they were not aware of the results. Among providers, more than half had seen the report or at least browsed parts that were relevant to them.

What changes did providers make?

Providers described some changes they had made after they read the results of the needs assessments. Others had made changes that were unrelated to the results, but consistent with the recommendations, nonetheless. Some changes that were planned had to be put on a back burner due to COVID-19.

Rural providers outside of the Dallas region did not find the needs assessment to be helpful because it focuses primarily on the needs of populations they do not serve.

Reported changes based on the needs assessment are listed below.

- Including clients more often in decisions about how services are provided.
- Using the data to support grant writing and shifting grants to specifically support *medical* case management.
- Integrating primary care with the management of HIV in a clinic to improve access and reduce stigma of visiting an HIV service only clinic.
- Working across the Dallas region to reduce the eligibility burden with each agency having its own eligibility burden and clients having to do the same things multiple times, creating undue burden. This is still a work in progress.
- Increasing access and the number of new patients seen.

- Doing research about transgender issues; engaging in work on cultural humility and awareness; and changing forms to be more inclusive and include preferred name, as they are required to enroll people based on their legal names.
- Providing full wraparound services with pharmacy and a full medical clinic. This includes Spanish-speaking services, including transcription services for others.
- Implementing a Rapid Start Clinic. They were already considering it, but the needs assessment influenced them to move forward.
- Being intentional about hiring more bilingual staff.

What changes did consumers observe?

Consumers reported they have seen some changes since the 2019 needs assessment was completed, although they are not sure that they were related, or expressed that they were unrelated.

- One clinic is open on some Saturdays and has evening hours.
- Another clinic opened and there is more access in different parts of the city, including the southern sector and Fair Park area.
- The Amelia Court clinic moved to the new professional building at Parkland. Staff have more resources and room to provide care.
- The Community Health Center for Health Empowerment PrEP clinic started HIV care because they were seeing so many come in for testing who were not getting into care.
- Mobile testing units were out by nightclub locations in the Design District and Cedar Springs areas. They noticed a lot of people out and about participating in the mobile units (2019 Needs Assessment- Appendix B pp. 8-10).

Interim Needs Assessment- August 2021

In 2020, Susan Wolfe and Associates, LLC (SWA), in collaboration with Dr. Kyrah Brown from the University of Texas at Arlington presented the report with the results of the 2019 Dallas EMA Ryan White Needs Assessment. When the report was presented, the Ryan White Planning Council (RWPC) prepared a plan to respond to the findings and began implementing the plan. Shortly after the Needs Assessment findings were shared, however, the COVID-19 epidemic disrupted the operations of systems providing health and supportive care for PLWH and providers were forced to develop alternative ways to conduct outreach and deliver care.

In 2021, as COVID-19 rates declined and vaccination rates increased, there were expectations that providers and PLWH would be able to return to providing and receiving services with the same methods used pre-COVID-19. However, COVID-19 era

adaptations led to innovations and new ways of doing things that may be retained. The Interim Needs Assessment offered an opportunity to capture not only the impact of COVID-19 on providers and consumers, but also the lessons learned.

The purpose of the Interim Needs Assessment was to:

- Identify how COVID-19 impacted the care delivery system and outreach, especially for underserved populations and populations with special needs.
- Determine the extent to which COVID-19 impacted individuals from identified underserved populations and their ability to access prevention and care services (Interim Needs Assessment- Appendix E).

c. Approach

The Key Informant Surveys were conducted by the contractor, Dr. Susan Wolfe. Dallas County Health and Human Services provided Dr. Wolfe with a list of organizations, contact names, and contact information for individuals who play a key role in the development and provision of services to PLWH in the Dallas region. E-mail invitations were sent to individuals from 27 different organizations requesting their participation. Recipients were asked to click on a link to Sign-Up Genius to select a date and time slot to schedule their interview. Follow-up invitations were sent to non-respondents after the sign-up deadline passed. Twenty-three individuals responded and signed up to be interviewed. One individual was unable to participate at her designated time due to an unforeseen event; one had to cancel because of a conflict and did not reschedule; and another did not show at the scheduled time. The final number of interviews was 20 key informants.

The interview was conducted using a semi-structured interview protocol via Zoom conferencing technology on the computer or telephone. All Key Informants agreed to having their interviews recorded. Interviews lasted from 45 minutes to 1.5 hours and averaged one hour. Three interviewees were unable to complete the entire interview because of scheduling conflicts or other time limitations. All interviews were completed between October 17, 2019, and November 25, 2019.

Organizations represented housing services, health care services, mental health services, children's health services, consumers, policy and advocacy services, transgender services, and other service providers serving PLWH in the Dallas region. Nineteen respondents served Dallas County and one respondent served the Sherman-Dennison HDSA.

Twelve focus groups were conducted. Three of the focus groups were conducted in June and July of 2018 by the Care Coordination Ad Hoc Committee. Two focus groups were conducted in April and June 2019 by Brad Walsh from Parkland Health and

Hospital System. The remaining seven focus groups were conducted by the contractor, Susan Wolfe and Associates. All focus groups used a standard, semi-structured protocol. Eleven of the 12 focus groups were recorded. Participants were asked if they consented to recording and one participant in one group asked that the focus group not be recorded. Participants were asked to sign an informed consent form and each participant received a gift card as compensation for their time and input. All focus groups were arranged by Dallas County Health and Human Services in collaboration with service providers. The purpose of the focus groups was to gain added input from priority populations (2019 Needs Assessment- Appendix B pp. 2-6).

Section IV: Situational Analysis

Dallas region stakeholders have been building local momentum to address the HIV epidemic. There are many groups engaged in activities aimed at ending the HIV epidemic in the Dallas Region, including the Ryan White Planning Council, HIV Task Force and Fast Track Cities Committee. While each group has identified priorities and developed plans, they have not yet been able to land on an approach that would allow them to collaborate and leverage each other's resources and strengths effectively. The Integrated Plan provided an opportunity to engage key stakeholders from across the community to work together to develop shared priorities and collaborative strategies for HIV prevention and care in the Dallas Region. A cross-sector group of stakeholders was convened comprised of members of these active community groups to guide the planning process. This steering committee ensured that the community input described in Section II and the Data and Assessments discussed in Section III were used to identify current strengths, challenges, and identified needs for HIV prevention and care in the Dallas Region.

Diagnose

It is important to note that the COVID-19 pandemic has created challenges for not only the affected populations but for reviewing crucial data regarding new cases of HIV. Due to the COVID-19 pandemic, the counts of newly diagnosed persons with HIV are likely to be artificially low; thus, interpretation of the year-to-year trend in diagnoses should be approached with caution until more yearly data is available.

Testing for individuals under the age of 16 has been identified as an area of improvement as testing is not easily available for this age group. In 2019, men who have sex with women, men who inject drugs, women who inject drugs, and men who have sex with men and people who inject drugs were all more likely to be designated as AIDS-presenting at diagnosis. Data suggests that among women who have sex with men, numbers may be artificially low in 2020 due to, among other factors, the limited number and types of settings offering high-quality HIV testing as well as a lack of pervasive peer norms in support of HIV testing.

An identified strength is that all Parkland facilities have implemented opt-out testing. Further coordination with government institutions and other public/private partnerships are needed to increase access to testing. Collaboration with hospital emergency departments, schools, and correctional facilities has also been identified as an area of improvement.

Structural inequalities in Dallas area systems of care show that cultural proficiency training for providers and staff could lead to the removal of a barrier to care for these high-risk populations. Black and Latinx residents of the Dallas region are disproportionately affected by the HIV epidemic. These communities accounted for 76.3% (N=650) of all new HIV diagnoses in 2020 compared to their white counterparts who accounted for 18.9% (N=161). There are structural and systemic issues that lead to barriers to access to care for Black and Latinx residents. In the Ryan White Planning Council of the Dallas Area Interim Needs Assessment- August 2021 (Interim Needs Assessment), Black communities reported barriers to care including poor experiences with providers, a lack of providers of color, and distance from providers. Latinx communities continue to face language barriers due to the availability of Spanish-speaking case managers and providers.

Identified needs for the Dallas area include priority prevention methods for the following communities: gay, bisexual, and other men who have sex with men and residents between the ages of 24 – 34. Men who have sex with men accounted for 70% (N=596) of all new HIV diagnoses followed by women who have sex with men at 16.2% (N=138), and then people who inject drugs at 6.5% (N=55) of all new diagnoses for HIV in 2020.

Treatment

At the end of 2021, of the 25,492 Dallas area residents living with HIV, 20,196 residents were in care within the Texas HIV treatment cascade system. Of the residents that were in care, 18,555 were designated retained in care; 15,350 achieved viral suppression. Identified strengths in the program are that 74% of all new diagnoses were linked to care within 1 month (Figure 10).

Stage	Number of Clients	Percentage of Clients
Total New Diagnoses	964	
Linked in 1 month	717	74%
Linked in 2-3 months	85	9%
Linked in 4-12 months	47	5%
Linked in 12+ months	3	0%
Not Linked	112	12%

Figure 10

One area of strength includes enhanced integrated care models. AHF Healthcare Center, Prism Health North Texas, and ASD all offer integrated care models which enable

psychosocial, mental health, and substance abuse treatment, as well as risk reduction counseling that is co-located with HIV primary care providers. Increased public and private partnerships to address the gaps in coverage has been identified as an area of improvement.

Other strengths identified in the 2021 Interim Needs Assessment include reports of flexible hours in Ryan White funded organizations, as well as extensive language services, and diverse options for payment. Some providers within Dallas area reported offering more specialized services for target populations, such as services specifically for transgender consumers, including a transgender clinic. Participants also reported a range in youth services for populations under the age of 18.

Barriers to HIV treatment cited by survey participants were the amount of time it takes to get care, the paperwork burden, the time it takes to get an appointment, lack of weekend and evening hours, the clinic treats HIV and not their other medical conditions, and the staff does not understand their culture. Evidence from data and providers suggests that for individuals living in suburban and rural areas, the paucity of services locally and resources and time necessary to reach services located in Dallas may also serve as a barrier.

While there is a lack of data pertaining to PLWH who identify as transgender, participants in the Interim Needs Assessment identified a lack of services pertaining to transgender individuals as a challenge. Transgender women report barriers related to fear given the number of transgender women who have been murdered. Transgender men report receiving limited attention regarding their specific needs. Both transgender men and women reported experiencing discrimination by providers.

Increased supports for populations in immigration detention centers, and post-release support from criminal justice systems is another identified need. Improvements are also needed in affordability of services and medications.

Prevent

In 2021, 15,350 Dallas area residents achieved viral suppression within the Texas HIV treatment cascade system. The use of long-acting PrEP has been useful in protecting patient status. Within the Dallas metro area there are 10 PrEP providers for uninsured populations and 17 locations that assist patients in accessing PrEP through verifying insurance and other options of assistance. The Sherman-Denison region has limited services with only one service provider for PrEP for the region.⁴ Increasing data monitoring of PrEP usage has been identified as an area of improvement, and planning is ongoing to address this need. Another area of improvement is employing harm reduction techniques such as syringe service programs.

⁴ "PrEP Locator: A National Database for US PrEP Providers," US PrEP Provider Directory, accessed November 28, 2022, <https://preplocator.org/>.

Other challenges identified by providers in the Interim Needs Assessment include stigma, lack of prevention messaging, and condom usage. Providers stated that younger populations tend to not understand the severity of living with HIV, and view HIV as another chronic but treatable disease. Providers expressed challenges due to stigma as a barrier to prevention methods in the Ryan White needs assessment. Stigma is highest among Black and Latinx communities. This caused providers to struggle with getting people tested and into care, especially if there is a risk of being identified as HIV positive from being seen at a care facility.

The Interim Needs Assessment identified areas of service gaps within the Ryan White network. These gaps in services included many social determinants of health which include housing instability, transportation services, and services in rural areas. Specific service gaps for rural communities include a lack of funding for outreach, peer support, and PrEP/PEP (Appendix E).

Respond

In order to detect and respond to outbreaks, the ability to distinguish between new and pre-existing diagnoses is critical. Data sharing across organizations and sectors is important in increasing the capacity to detect and respond to outbreaks. However, the challenges of data security and maintaining of confidentiality are presented with any expansion of data access. Organizations are often cautious in respect to this; therefore, consensus among relevant organizations regarding data sharing is needed.

In the event of an outbreak, connecting people quickly to the prevention and treatment services they need is critical. The challenges of fragmentation of services between various organizations and the need for clients to provide data multiple times, as expressed in listening sessions, present challenges in responding to outbreaks efficiently. Greater collaboration among service providers and coordination across counties is needed.

The DCHHS has a broad plan that utilizes the health department which could serve as a starting point in data sharing to increase the capacity to detect and respond to outbreaks. CQM data may also prove to be an opportunity that will also provide important insights. Increased funding for data surveillance and the expansion of public/private partnerships will be needed. Uniform data reporting requirements are also needed.

Priority Populations

Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, each of the goals, objectives and key activities/strategies has a focus on the priority populations that have been identified. There are specific activities noted to engage with priority populations, or organizations that work with them, to ensure they get access to the services and resources needed.

Section V: 2022-2026 Goals and Objectives

Goals and Objectives Description

The goals and objectives in this section were developed through a number of activities during the Integrated Planning process:

- A crosswalk of existing plans was completed to identify similarities among the goals, objectives, and strategies of each plan.
- Listening sessions were conducted with PLWH and other consumers to hear directly from them about what should be done to improve access to care and resources.
- The Integrated Planning Steering Committee convened monthly and helped develop the goals and objectives noted in this section.
- Goal-specific workgroups were convened to revise the goals and objectives as necessary, as well as to identify specific strategies the jurisdiction should engage in to meet the goals as outlined.

Goal 1: Diagnose all Dallas Regional Residents as quickly as possible

Objective 1- 90% of Dallas Regional Residents will know their HIV status.

Key Activities/Strategies:

1. Develop and implement strategies for testing residents in rural communities.
 - Establish baseline testing data.
 - Engage mobile medical partners.
 - Increase the efficacy of at-home testing.
2. Develop a “community calendar” for Dallas Regional Residents to access that will provide updated testing information.
 - Compile a list of partners who should be engaged to provide information to populate the community calendar.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: Specialty groups in rural counties; primary care providers; large employers; Black Greek organizations (Divine 9); community centers; transportation providers.

Data Indicator(s): Total number of tests performed; community calendar developed.

Data Source(s): DCHHS, EHE Coordinator, HIV Task Force, RWPC, ASOs, CBOs, Stakeholders.

Objective 2- Promote and increase community-based HIV testing opportunities in healthcare and non-healthcare settings.

Key Activities/Strategies:

1. Convene/attend conferences and meetings to share information and resources for healthcare providers and other healthcare professionals around HIV testing strategies and support.
2. Expand or increase opt-out, routine screening in healthcare and other institutional settings, particularly in highly impacted communities.
 - Develop educational materials for providers to have readily available and visible in their offices.
3. Encourage and support CBOs use of targeted social media posts encouraging routine testing.
4. Develop community-based strategies for targeted testing for priority populations.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: Dallas County Medical Society; ER staff; OB/GYN providers; primary care providers; large medical systems, particularly those who serve members of priority populations; insurance groups; corrections personnel.

Data Indicator(s): Total number of tests performed; number of community testing events listed on community calendar; number of social media posts from CBOs encouraging routine testing.

Data Source(s): DCHHS, EHE Coordinator, HIV Task Force, RWPC, ASOs, CBOs, Stakeholders.

Goal 2: Treat all HIV diagnoses quickly and effectively

Objective 1- Increase the percentage of Dallas Regional residents who are linked to care within 14 days of diagnosis

Key Activities/Strategies:

1. Develop and implement a survey to understand the most pressing social determinants of health that PLWH need support with.
2. Standardize the definition of “linkage to care.”
3. Provide culturally responsive training to case managers.
4. Establish a ‘warm handoff’ system where providers connect people receiving a positive diagnosis directly to a case manager/navigator.

Target Population(s): All Dallas Regional Residents who are PLWH, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: AIDS Education Technical Assistance Consortium (AETC); academic institutions; technical training programs; organizations that work with the unhoused population; organizations that serve priority populations.

Data Indicator(s): Social determinants of health survey developed and implemented; standardized definition of “linkage to care” created; number of case managers who complete culturally responsive training; linkage to care data.

Data Source(s): DCHHS, AETC, TBD

Objective 2- Increase the percentage of Dallas Regional residents who are living with HIV that are retained in care.

Key Activities/Strategies:

1. Maintain a network of case managers so they can keep caseloads low and address other social determinants of health for their clients.
2. Recruit and hire people with lived experience (HIV positive, experience utilizing the system) to serve as case managers and navigators.
3. Provide training and professional development for PLWH to earn a living wage and develop the tools necessary for the role for which they are hired.

Target Population(s): All Dallas Regional Residents who are PLWH, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women

- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: AETC; academic institutions; technical training programs; organizations that work with the unhoused population; organizations that serve priority populations

Data Indicator(s): TBD

Data Source(s): TBD

Objective 3- Increase the percentage of Dallas Regional Residents who are living with HIV that are reconnected to care within 90 days of contact.

Key Activities/Strategies:

1. Establish a ‘warm handoff’ system where providers reconnect people getting reestablished in care directly to a case manager/navigator.
2. Recruit and hire people with lived experience (HIV positive, experience utilizing the system) to serve as case managers and navigators.
3. Provide training and professional development for PLWH to earn a living wage and develop the tools necessary for the role for which they are hired.

Target Population(s): All Dallas Regional Residents who are PLWH, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: AETC; academic institutions; technical training programs; organizations that work with the unhoused population; organizations that serve priority populations

Data Indicator(s): TBD

Data Source(s): TBD

Objective 4- Enhance the HIV care continuum that coordinates resources and services.

Key Activities/Strategies:

1. Create opportunities for case managers to build relationships with case managers outside of their service delivery areas.

2. Remove siloes that exist between organizations.
3. Develop local “medical neighborhoods” where clients can access multiple services in a single location. The services should be available in the evenings and on weekends.

Target Population(s): All Dallas Regional Residents who are PLWH, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: AETC; academic institutions; technical training programs; primary care providers; large medical systems, particularly those who serve members of priority populations; Insurance groups.

Data Indicator(s): TBD

Data Source(s): TBD

Goal 3: Prevent new transmissions among Dallas Regional Residents using proven methods and strategies

Objective 1- Increase the use of PrEP and nPEP by 50%, especially for priority populations.

Key Activities/Strategies:

1. Collaborate with providers to provide strategies to help them identify and prescribe PrEP to priority populations they serve.
2. Create awareness and opportunities and availability of nPEP to community members.
3. Community organizations should identify and hire credible messengers to engage community members in prevention activities.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: DCHHS, HIV Task Force, EHE Coordinator, pharmaceutical companies.

Data Indicator(s): Number of providers offering PrEP and nPEP prescriptions; number of credible messengers hired by community organizations.

Data Source(s): TBD

Objective 2- Employ harm reduction strategies that are proven to prevent the transmission of HIV.

Key Activities/Strategies:

1. Engage and educate State Representatives who are from and/or represent priority populations.
2. Advocate for policies that ease restrictions on proven harm reduction strategies.
3. Engage and train non-traditional partners to reach community members who engage in high-risk behaviors.
4. Gather a report on the landscape of sexual health education in schools.
5. Promote comprehensive sexual health education through schools.

Target Population(s): All Dallas Regional Residents, especially PLWH who are members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: Local social media influencers; State Representatives; organizations that provide food support; houselessness outreach workers; sex workers; organizations that serve the LGBTQ community; high schools and universities.

Data Indicator(s): Report on the landscape of sexual health education in schools; laws enacted that ease restrictions on harm reduction strategies.

Data Source(s): TBD

Objective 3- Develop and conduct workforce development/training for healthcare professionals on HIV testing guidelines, risk factors, prevention tools and culturally responsive efforts.

Key Activities/Strategies:

1. Educate providers on talking to their patients about sexual health and risk.
2. Educate providers on cultural competency/humility and anti-stigma.
3. Integrate HIV and sexual health education into curricula at medical schools, nursing schools, and other schools that train healthcare professionals.

Target Population(s): High school and university students; students in medical schools, nursing schools and other healthcare fields.

Key Partners: Primary care providers; food providers; houselessness outreach workers; sex workers; organizations that serve the LGBTQ community.

Data Indicator(s): TBD

Data Source(s): TBD

Goal 4: Respond quickly to potential outbreaks by getting prevention and treatment services to Dallas Regional Residents who need them

Objective 1- Ensure accurate and reliable data is available to the appropriate entities for prompt surveillance efforts.

Key Activities/Strategies:

1. Develop a “standard of care” around data collection.
2. Ensure that data use agreements (between the county, testing agencies, community organizations, hospitals, etc.) are current and MOUs are in place.
3. Develop strategies to collect data about the transgender population.
4. Increase funding to support trends identified by surveillance data.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: DCHHS, EHE Coordinator, HIV Task Force, RWPC, ASOs, CBOs, Stakeholders.

Data Indicator(s): TBD

Data Source(s): TBD

Objective 2- Engage in local and regional outbreak response planning to be implemented when outbreaks are detected.

Key Activities/Strategies:

1. Determine whether there is a local/regional outbreak response plan.
 - If so, review and update the plan, as necessary.
 - If not, identify an entity that will be responsible for developing and implementing a response plan.
2. Identify an objective entity that can host an annual data sharing event.
3. Review zip code data to understand prevalence among priority populations.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: CDC, State/Local Health Departments, Community Organizations

Data Indicator(s): Identification or development of an outbreak response plan; identification of an objective entity to hold an annual data sharing event; TBD.

Data Source(s): TBD

Objective 3- Increase access to support services that address social determinants of health for Dallas Regional residents.

Key Activities/Strategies:

1. Develop and implement a survey to understand the most pressing social determinants of health that PLWH need support with.
2. Conduct a crosswalk of existing plans to identify strategies to support the needs of PLWH.
3. Increase the public/private partnership to address gaps in the Ryan White part A network.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: DCHHS, EHE Coordinator, HIV Task Force, RWPC, ASOs, CBOs, Stakeholders.

Data Indicator(s): Social determinants of health survey; TBD

Data Source(s): TBD

Updates to Other Strategic Plans Used to Meet Requirements

There were no updates to other strategic plans to meet the requirements of this section.

Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up

2022-2026 Integrated Planning Implementation Approach

As previously discussed, there are multiple groups in the Dallas region engaged in activities aimed at ending the HIV epidemic. Specific strategies around implementing, monitoring, and evaluating the integrated plan will be developed in more detail in the coming year, when several of the groups will be going through a restructuring process. Part of the restructuring will involve clarifying the roles they will have in monitoring the progress of the goals, objectives, and strategies of the integrated plan.

Implementation

DCHHS will create a report template that all Ryan White- funded agencies and entities that were part of the integrated planning process will complete on a quarterly basis. The report template will contain consistent reporting detail including metrics such as HIV testing data, viral suppression, number of community-based testing events, etc. Currently, Ryan White-funded agencies submit invoices that also capture some potentially relevant data, so they will be reviewed to determine what should be reported across all agencies. The jurisdiction will determine which entity will be responsible for compiling and sharing the data collected. The data collected from the template is the first step for the jurisdiction to begin gathering relevant data that will assist with understanding whether the goals and objectives have been met.

DCHHS is considering establishing a system-wide Case Manager whose primary responsibility will be to lead a Regional Case Management Operating Committee. As this role is being

developed, there is consideration that this role will also assist in exploring and establishing regular data collection from the funded agencies.

Monitoring

There are several groups that will play a role in overseeing the implementation and monitoring of the 2022-2026 Integrated Plan, including the HIV Task Force, Fast Track Counties committee and Ryan White Planning Council. It should be noted that in 2023, both the HIV Task Force and Fast Track Counties committees will convene to revamp how they do their work. Discussions will involve clarifying the mission of each group, the role of leadership, how each group will be staffed, and the role of the committees for each. Currently, the HIV Task Force meets monthly, and the Fast Track Counties committee meets quarterly, and this is likely to continue. They will also consider the respective roles they play with implementation and monitoring of the Integrated Plan, including the identification of a liaison responsible for receiving and sharing information with the Ryan White Planning Council.

The Planning and Priorities committee of the Ryan White Planning Council is tasked with overseeing projects and will receive updates about the status of goals and objectives. For each monthly meeting, there will be a standing agenda item dedicated to updating the committee on the progress of the goals and objectives of the plan. Any critical updates and/or recommendations will be made to the Ryan White Planning Council.

Evaluation

The jurisdiction, through the Continuous Quality Management (CQM) Committee of the RWPC, will continue to refine the metrics used to evaluate the Integrated Plan. While the data template is the first step to having regular and consistent data available to track progress, the development of a data dashboard that metrics will be reported directly into is a longer-term goal for the jurisdiction. This will allow real-time and trend data to be available to allow the jurisdiction to make informed decisions about how funding should be allocated to best meet the needs of Dallas Regional residents. Until then, funded agencies will complete and submit the data templates on a quarterly basis, and then present the findings to the RWPC.

Improvement

The Planning and Priorities Committee will review the Plan on an annual basis to assess its implementation. They will also review the data that has been collected over the previous year to determine whether there has been progress made toward meeting the goals, objectives, and strategies as outlined. If there are changes recommended to any areas of the plan, they will be submitted to the full RWPC for discussion and adoption.

Reporting and Dissemination

The Ryan White Planning Council will ensure that each of its committees receives quarterly updates on the progress of implementing the Plan, as well as any changes made based on

evaluation and improvement efforts. In addition, the liaisons to the HIV Task Force and Fast Track Counties committee will ensure those entities receive *at least* quarterly updates that are provided to the RWPC.

Section VII: Letters of Concurrence

RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)

Dear CDC DHAP and HRSA HAB:

The Ryan White Planning Council Dallas *concur*s for the inclusion of specified updates to be incorporate with the following submission by the Dallas County Department of Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The Ryan White Planning Council Dallas has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV.

The Ryan White Planning Council Dallas *concur*s that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The Ryan White Planning Council Dallas and Standing Committee Members participated in the Steering Committee, in addition to listening sessions that were aimed at getting input on needs, priorities, gaps, and opportunities. In addition, three listening sessions were conducted in September 2022 to hear directly from consumers about what should be done to improve access to care and resources. Individuals were convened in September 2022 to discuss current strengths and gaps in services for Dallas County residents living with HIV/AIDS.

The Ryan White Part A Planning Council received multiple updates about the status of the Integrated Planning process, in which several Planning Council members participated. In addition, members of the Planning and Priorities and Consumer Council Committee (sub-committees of the RWPC) who are also PLWHA assisted in recruiting and convening other consumers to participate in listening sessions and share feedback on what should be done to improve access to care and services, particularly for identified priority populations.

The Ryan White Planning Council Dallas and Standing Committees have an established monthly schedule to conduct meeting whereby the EHE/Grants Department will have standing agenda items dedicated for presentation from program representatives.

The signature(s) below confirms the *concurrence* of the Ryan White Planning Council Dallas with the Integrated HIV Prevention and Care Plan.

Signature:  Date: 12/14/2022
Helen Zimba Ryan White Planning Council Co Chair(s)

Dallas HIV Task Force (EHE Planning Body)

Program Officer Name

Dear Program Officer,

The HIV Task Force **concurs** with the following submission by the Dallas County Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The planning body has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body **concurs** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The HIV Task Force serves as the EHE Planning Body and received multiple updates about the status of the Integrated Planning process, in which several HIV Task Force members participated. In addition, members of the Task Force who are also PLWHA assisted in recruiting and convening other consumers to participate in listening sessions and share feedback on what should be done to improve access to care and services, particularly for identified priority populations.

The signatures below confirm the **concurrence** of the planning bodies with the Integrated HIV Prevention and Care Plan.

Signatures: Miranda Grant

Miranda Grant (HIV Task Force Co-Chair)

Date: December 8, 2022

Appendix A: Dallas County Dallas Eligible Metropolitan Area Integrated
HIV Prevention and Care Plan CY 2017 - 2021

Dallas County

Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan

CY 2017 - 2021

Dallas County Health and Human Services
Grants Division
9/29/2016

Section I: Statewide Coordinated Statement of Need/Needs Assessment

Introduction

The development of this CDC/HRSA Integrated HIV Prevention and Care Plan for the Dallas Planning Area was a collaborative process among the Ryan White Parts A and B Administrative Agency, Ryan White Planning Council support staff, Ryan White funded service providers, CDC directly funded prevention service providers, Ryan White consumers and Planning Council members, the local Housing Opportunities for Persons with AIDS (HOPWA) grantee, AIDS Education and Training Center (AETC), and the University of Texas-Southwestern. This group will comprise the ad hoc Integrated Prevention and Care Plan Committee during the implementation phase of this plan.

The group coordinated with the Texas Department of State Health Services to develop sections of the Statewide Coordinated Statement of Need, including the Epidemiologic Overview and the HIV Care Continuum for this area. All of the data for these sections are for the eight-county Dallas Eligible Metropolitan Area (EMA) unless otherwise stated. The eight counties that consist of the Dallas EMA are Dallas, Denton, Collin, Ellis, Henderson, Hunt, Kaufman, and Rockwall counties. Some of the epidemiological data for this section is not available locally. State data is utilized in conjunction with Ryan White utilization data to expand and provide greater information for these sections.

The epidemiologic overview presents information on known cases of HIV infection in the Dallas EMA diagnosed through December 31, 2014 and reported as of June 30, 2015, as this was the most recent data available during the planning phase of this integrated prevention and care plan. While the Dallas Planning Area as a whole also includes counties in the Dallas Health Services Delivery Area (HSDA) and the Sherman-Dennison HSDA, the vast majority of the epidemic lives within the counties included in the Dallas EMA. The other four counties that make up the entirety of the Dallas Planning Area along with the Dallas EMA include Cooke, Fannin, Grayson, and Navarro counties.

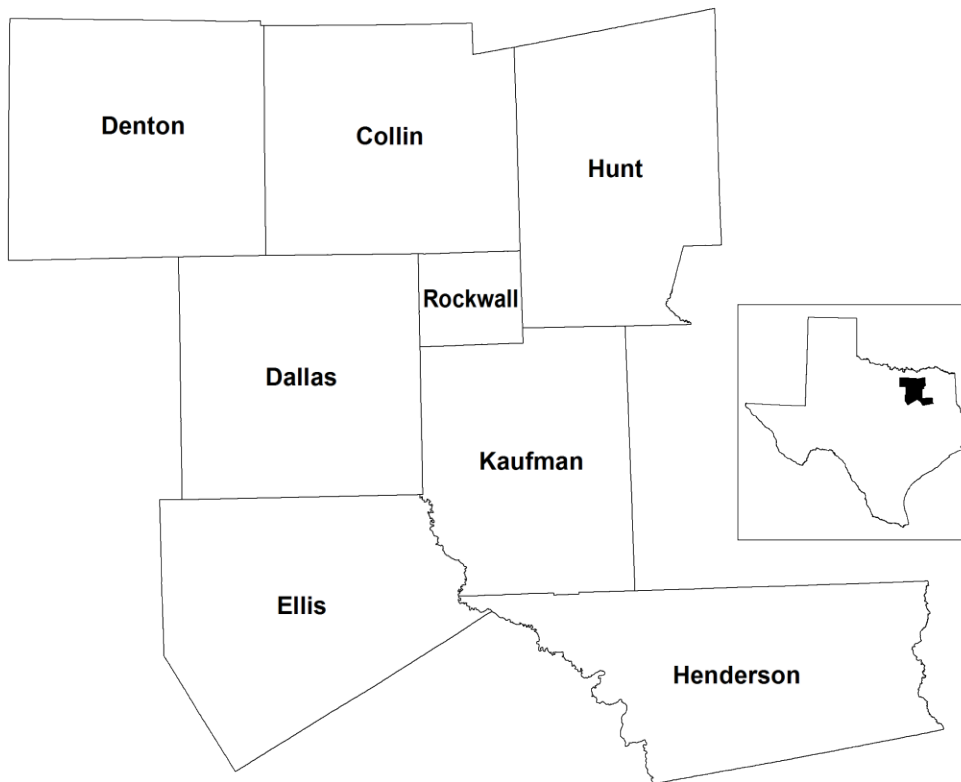
EPIDEMIOLOGIC OVERVIEW

a. Describe (map and/or narrative) the geographical region of the jurisdiction (i.e., Eligible Metropolitan Area) with regard to communities affected by HIV infection.

The information in this section is drawn from the National Center for Health Statistics and results from the Census Bureau's *American Community Survey* (information collected across 2010-2014) and *Supplement to the Current Population Survey* (2014).

The Dallas EMA covers eight counties in north east Texas, as shown in Figure 1. The city of Dallas sits in Dallas County, the largest in terms of general population and people living with a diagnosed HIV infection.

Figure 1: The Dallas EMA

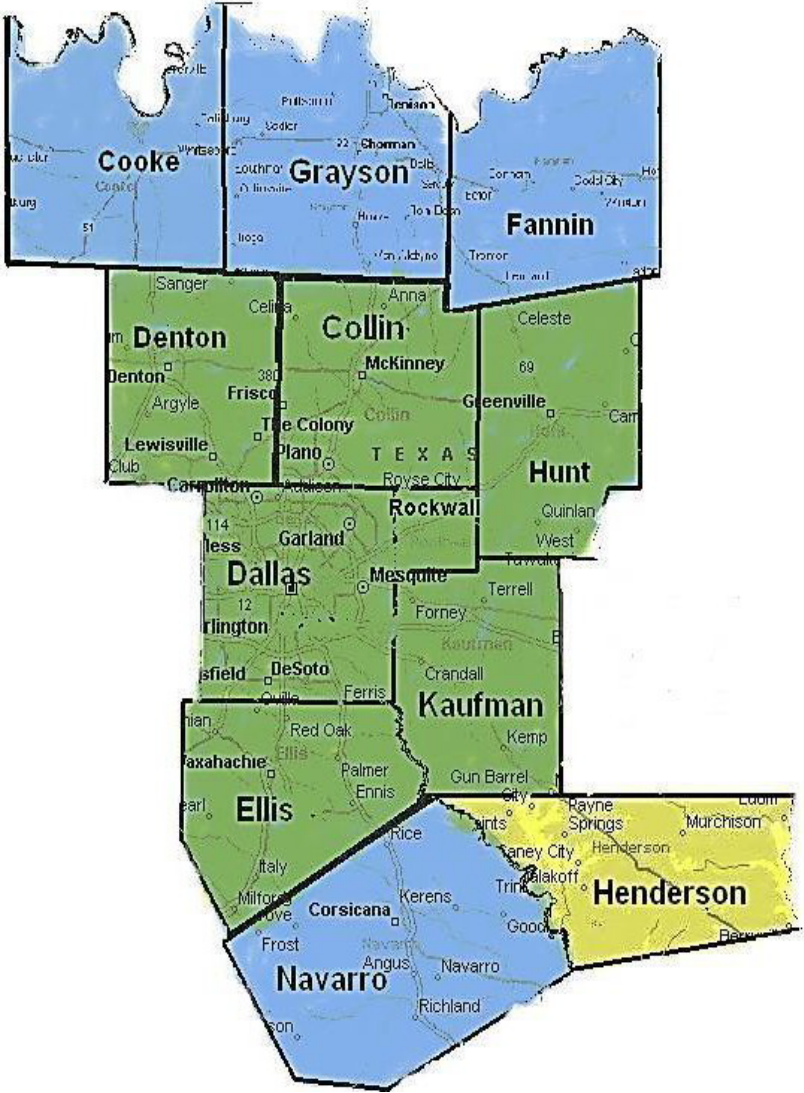


From 2010 to 2014 the Dallas EMA added about 375,000 residents, reaching 4.6 million and increasing the population by 9%. The breakdowns of the population by sex, race/ethnicity, and age group are shown below.

Overall, the Dallas Planning Area (DPA) for services, as shown in Figure 2, also includes the Dallas Health Services Delivery Area (HSDA) and the Sherman-Dennison HSDA. The Dallas HSDA has seven counties in common with the Dallas EMA, but also includes Navarro County. The Sherman-Dennison HSDA consists of Cook, Fannin, and

Grayson Counties. The data in this report provided by DSHS reflects numbers from the Dallas EMA only, which has the highest concentration of PLWH in the area.

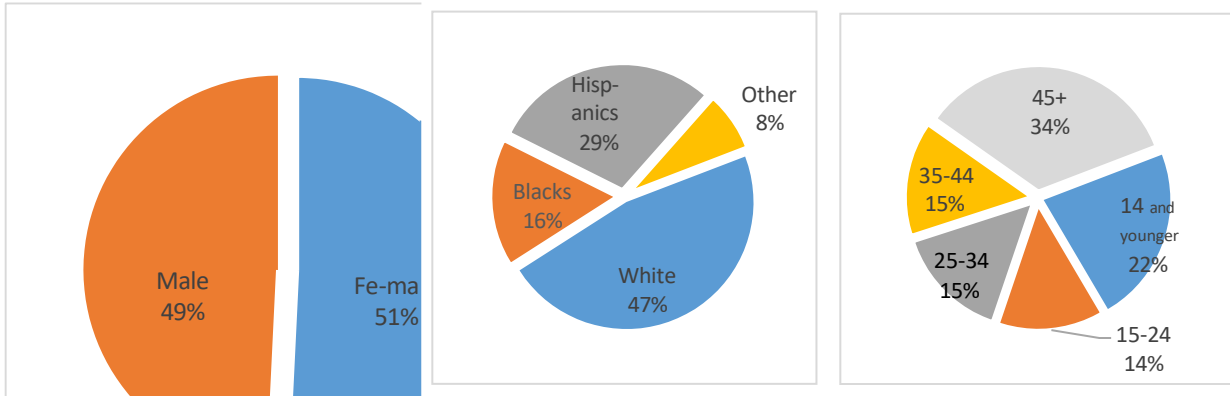
Figure 2: The Dallas Planning Area (Dallas EMA, Dallas HSDA, and Sherman-Dennison HSDA)



b. Describe (table, graph, and/or narrative) the socio-demographic characteristics of persons newly diagnosed, PLWH, and persons at higher risk for HIV infection in the service area, including the following, as available in the geographical region of the jurisdiction:

i. Demographic data (e.g., race, age, sex, transmission category, current gender identity)

Figure 3: Dallas EMA population in 2014 by sex, race/ethnicity and age



Race/Ethnicity

Blacks make up about 16% of the population of the EMA, but more than 40% of the PLWH in the area. Between 2010 and 2014, the number of Black PLWH in the EMA rose by about a quarter, and the 2014 prevalence rate indicates that more than 1% of Black residents of the EMA were living with diagnosed HIV infections (1,023.9 PLWH per 100,000 = 1.02 per 100 residents of the EMA). Prevalence rates for Blacks were consistently three times higher than the rates for Whites or Hispanics, and rose about 14% between 2010 and 2014.

Blacks also made up 45% of those newly diagnosed over the past five years, with the number of new diagnoses in Blacks being about 70% to 80% higher than diagnoses among Whites and Hispanics. The diagnosis rate for Blacks was consistently five times higher than the rate in Whites and three times higher than the diagnosis rates for Hispanics for 2010-2014.

The number of White PLWH and the prevalence rate were flat, as were the number of new diagnoses and the diagnosis rate for this group. By 2014 there were 12 Black PLWH for every 10 White PLWH.

The rate of growth for Hispanic PLWH was similar to the rate for Blacks, but there were 19 Black PLWH for every 10 Hispanic PLWH. The number and rate of new diagnoses in Hispanics shows a slow downward trend.

Figure 4: Dallas PLWH and new diagnoses by race/ethnicity

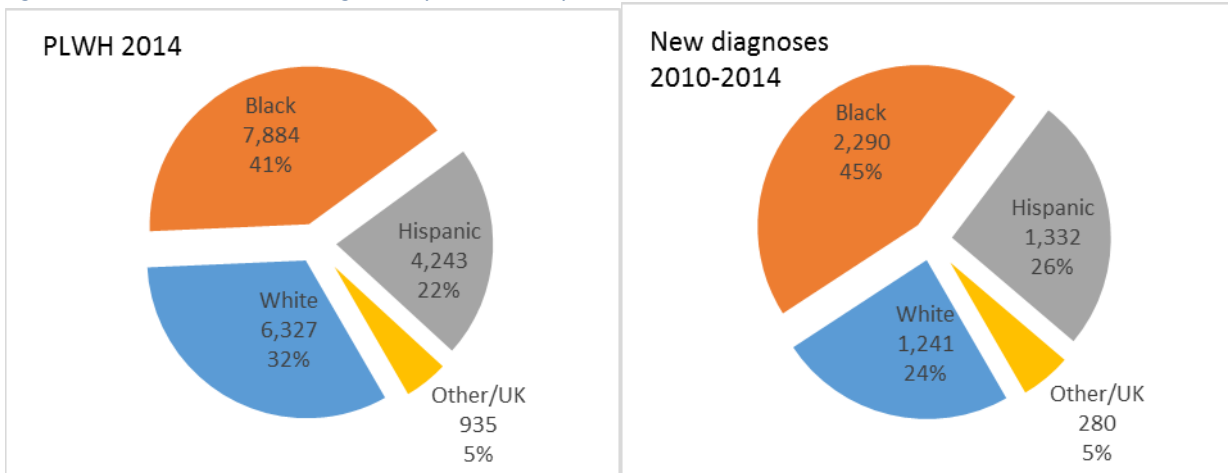


Figure 5: Changes in race/ethnicity of Dallas PLWH and new diagnoses, 2010-2014

PLWH

New Diagnoses

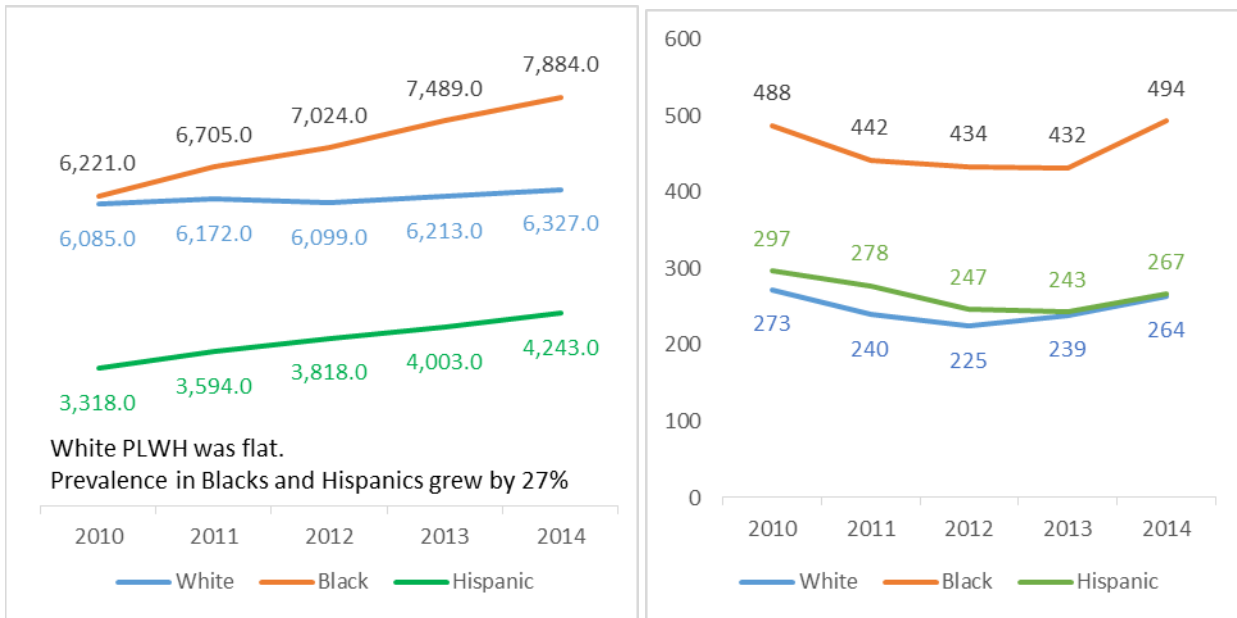
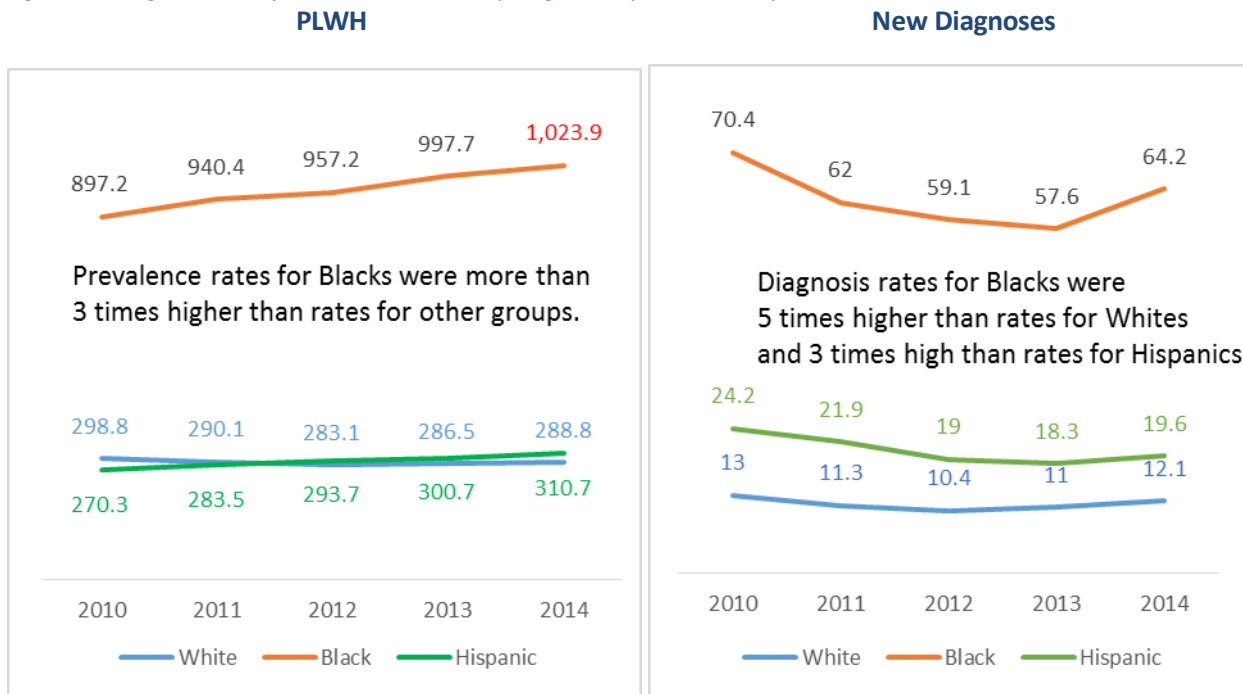


Figure 6: Changes in rates of PLWH and those newly diagnosed by race/ethnicity, Dallas 2010-2014



Age

About half the PLWH in the EMA are 45 or older, another quarter are 35-44 years old and a quarter are 34 and younger. Both the number of PLWH 25-34 and 45 or older increased, but other age groups were flat. It is difficult to discern trends in the age of EMA residents who were diagnosed between 2010-2014 due to individuals moving from one category to another in a given year.

Figure 7: Dallas PLWH and new diagnoses by age

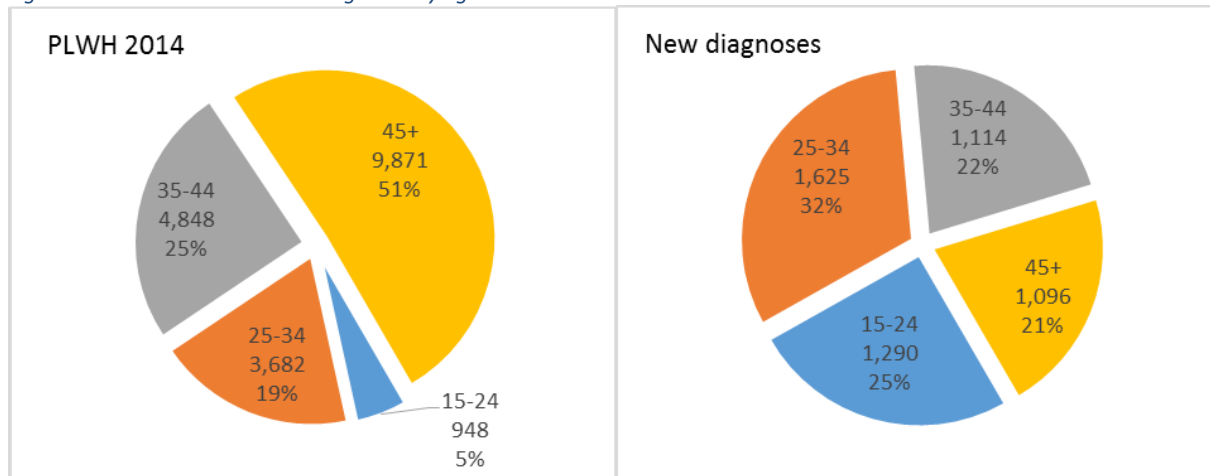
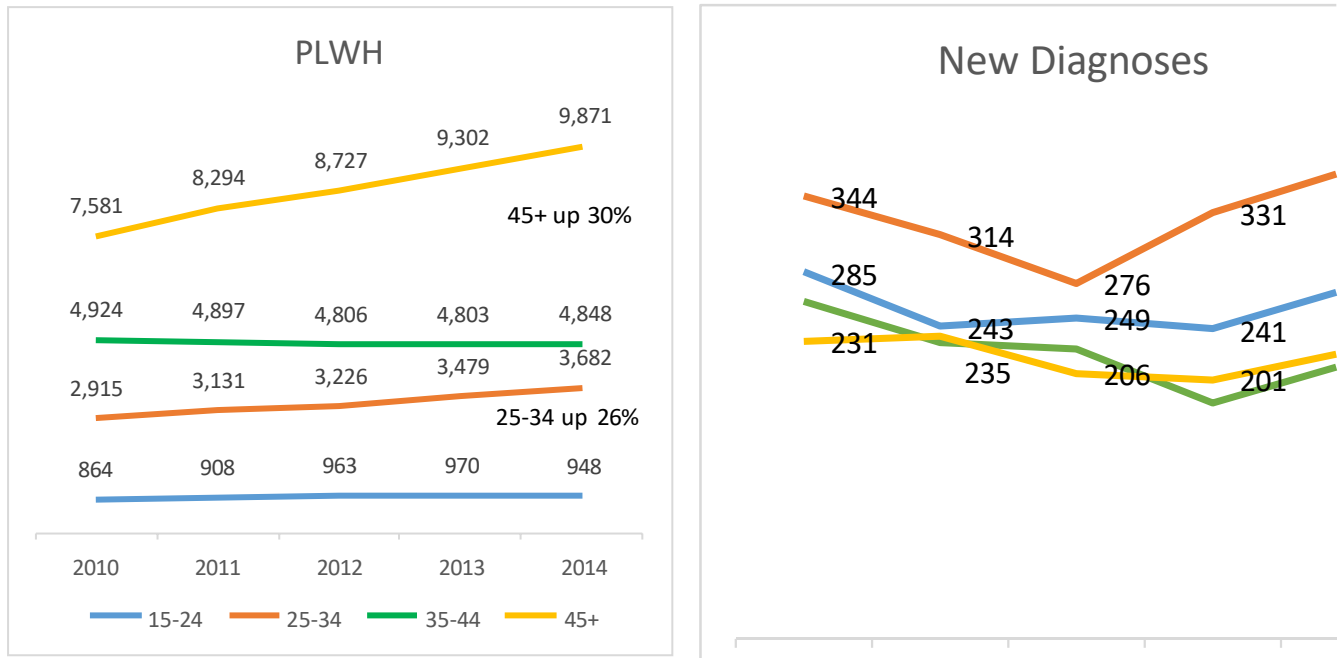


Figure 8: Changes in age of Dallas PLWH and new diagnoses, 2010-2014



Sex

About four out of five PLWH in the Dallas EMA in 2014 were men. The number of men and women grew at the same pace, so the prevalence rate of HIV for men was consistently four times higher than the rate for women.

Men also made up about four of five new diagnoses in the EMA. The decreasing numbers of infections seen in women is a continuation of a trend from 2005-2009; from 2010 – 2014 the number of new diagnoses in women fell by 14%. For men, numbers of new diagnoses fell from 2005 to 2009, but were flat from 2010-2014.

Figure 9: Dallas PLWH and new diagnoses by sex

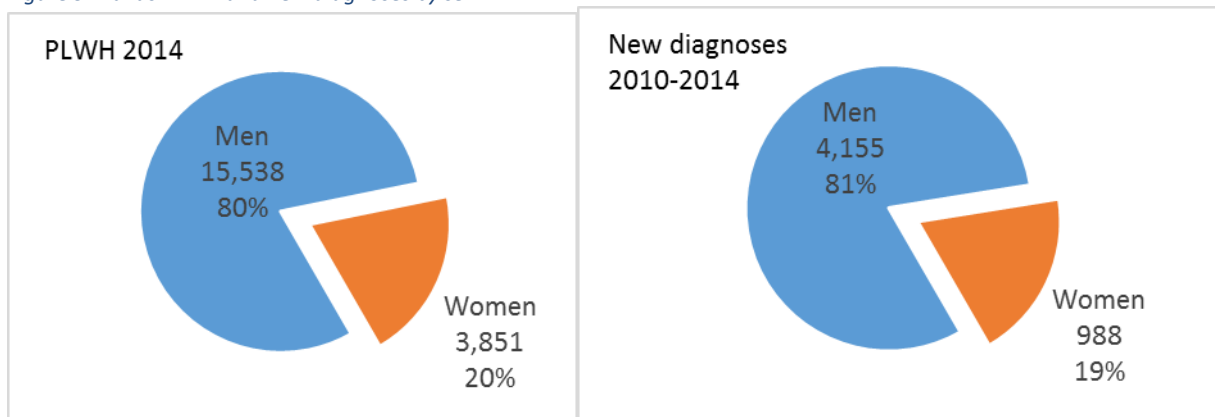


Figure 10: Changes in numbers of men and women in Dallas living with diagnosed HIV infections and with newly diagnosed infections. 2010-2014

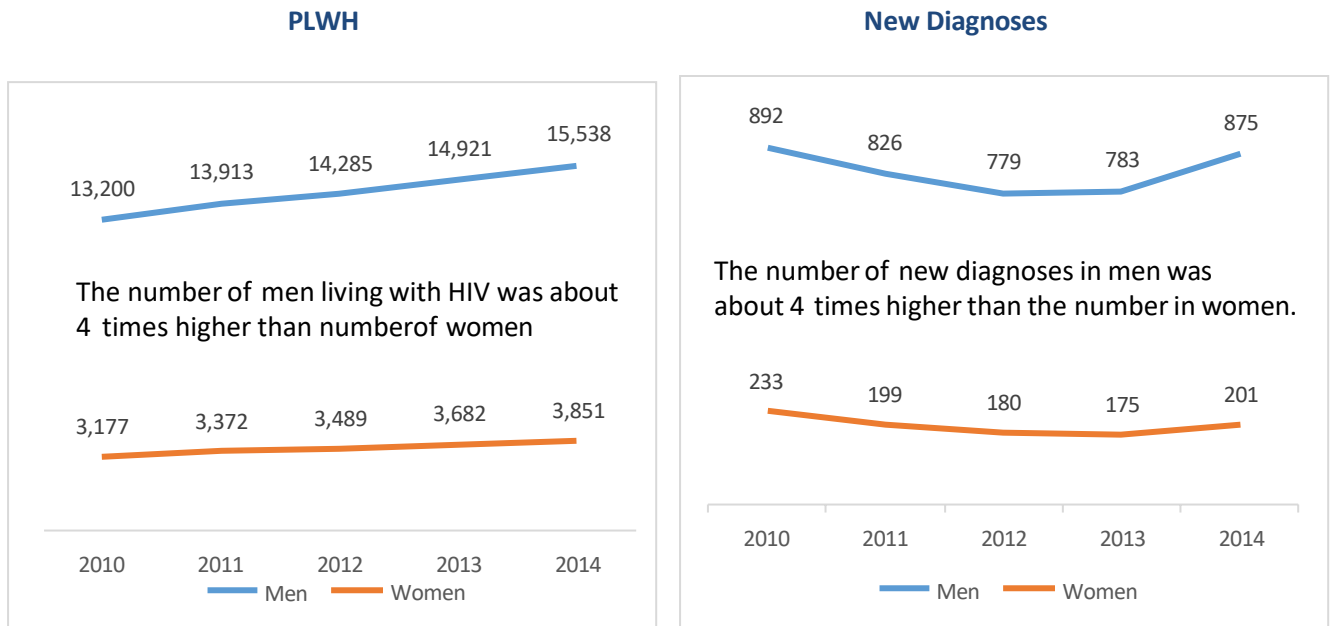
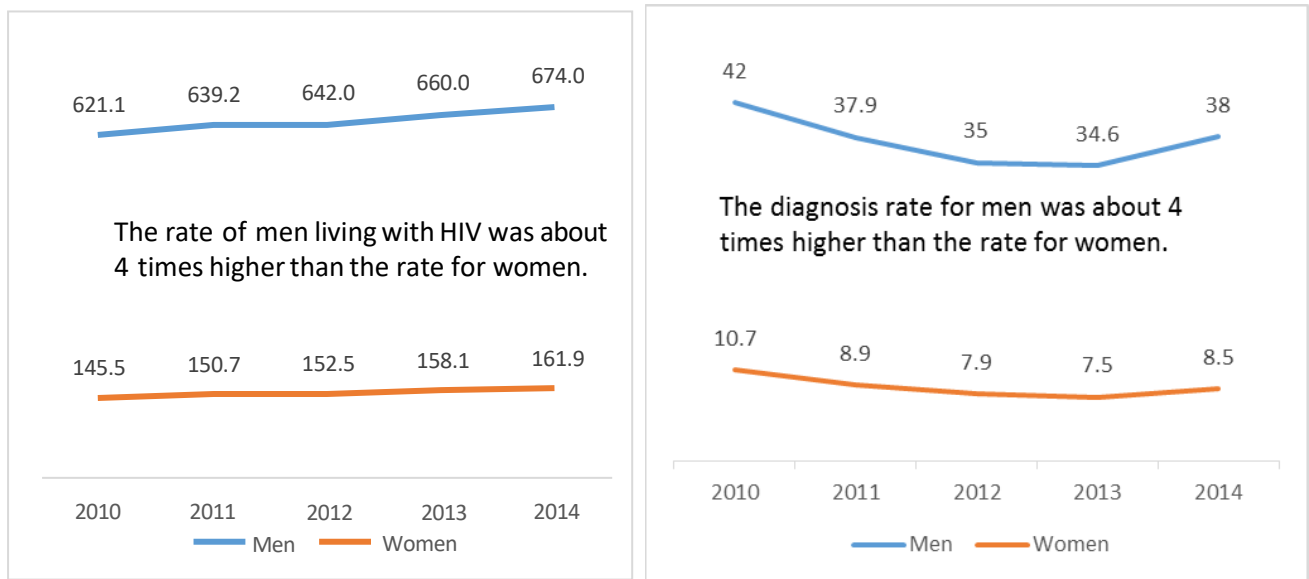


Figure 11: Changes in rates of men and women living with HIV and with newly diagnosed, Dallas 2010-2014



Mode of transmission

Public health surveillance uses the term *mode of transmission* to categorize information about people with HIV based on the most likely way they became infected. The most common modes of transmission groups are gay and bisexual men and other men who have sex with men (MSM), high risk heterosexuals (HRH), injection drug users (IDU), and MSM who also inject drugs (MSM/IDU). While locally, the planning body in Dallas believes it would be more appropriate for mode of transmission categories to better represent how each individual transmitted the disease with categories such as condomless anal sex, condomless vaginal sex, and/or sharing needles with someone who has HIV, the data received for this plan from the Texas Department of State Health Services (DSHS) used the more traditional mode of transmission categories. HIV can also be transmitted from mother to child or through blood transfusions or other medical exposures; these latter two categories account for very few PLWH.

In 2014, more than three in five PLWH and more than three in four of those newly diagnosed in Dallas were in MSM. There were three times as many PLWH and new diagnoses in MSM than in heterosexuals, the next largest group. Dallas residents with heterosexually acquired infections were about one in five PLWH or people with new diagnoses, and the number of new diagnoses in this group decreased by about 18% from 2010-2014.

Mode of transmission groups

Mode of transmission refers to the most likely way a person with HIV became infected. Major modes of transmission in Texas are

- MSM:** gay men, bisexual men, and other men who have sex with men
- HRH:** high-risk heterosexuals
- IDU:** heterosexual injection drug users
- MSM/IDU:** MSM who also inject drugs

Figure 12: Dallas PLWH and new diagnoses by mode of transmission

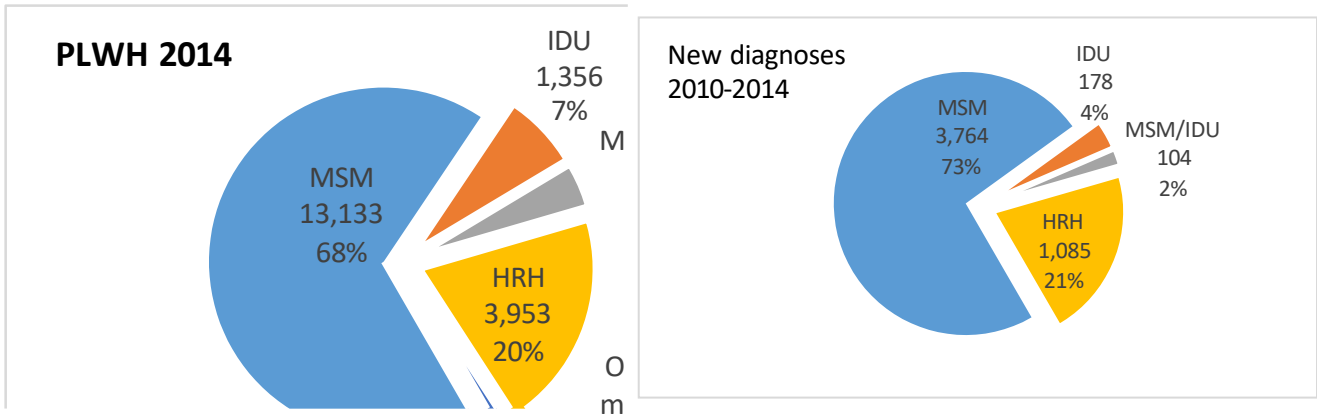
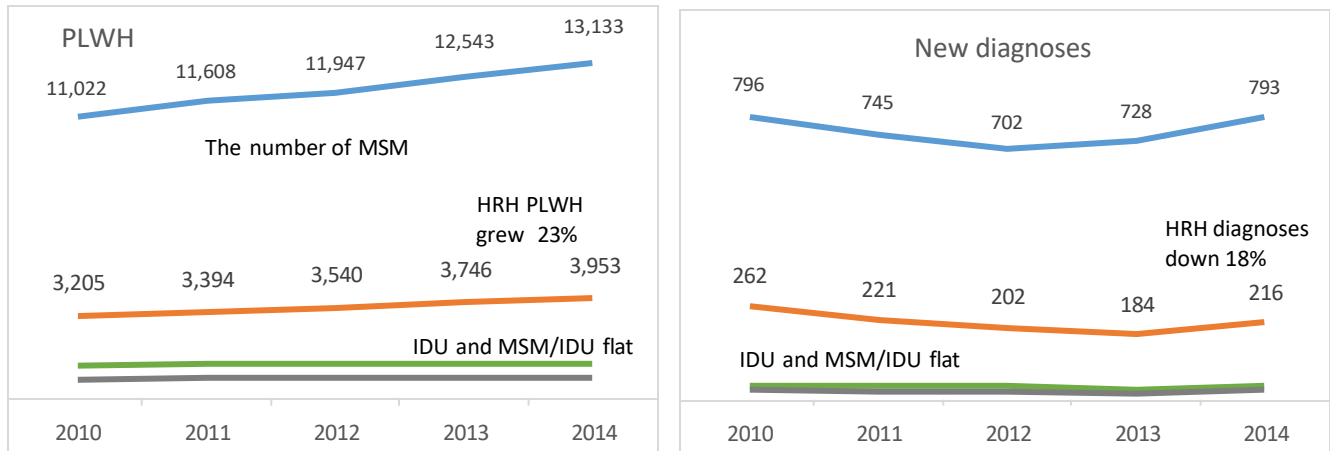


Figure 13: Changes in mode of transmission, Dallas 2010-2014



Gender identity

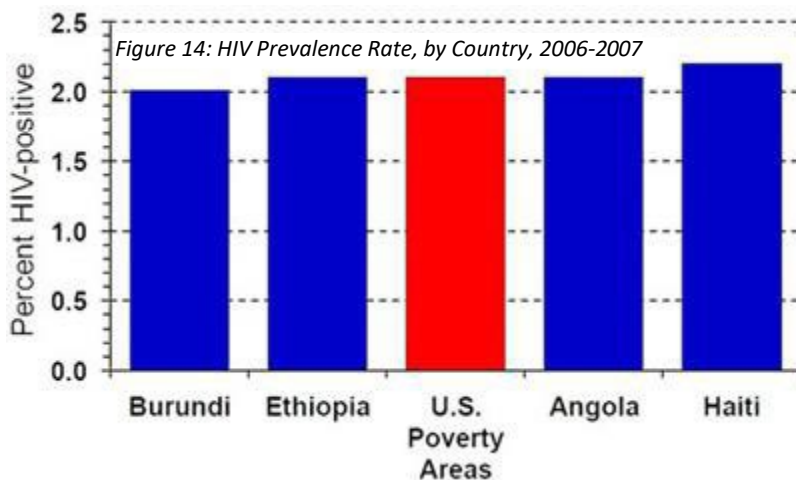
While most of the data in this section was provided by DSHS, gender identity data was not provided. Gender identity information related to HIV in the overall 12 county Dallas Planning Area for this section was obtained from the AIDS Regional Information and Evaluation System (ARIES) pertaining to clients receiving Ryan White funded services.

In 2014, 77% of Ryan White clients identified as male, whereas 22% identified as female and less than 1% identified as transgender. These numbers have been fairly consistent over the last five years (2010-2014). The percentage of Ryan White clients that identify as male has varied from 76% - 77%; the percentage of Ryan White clients that identify as female has varied from 22% - 24%; and the number of Ryan White clients that identify as transgender has varied from 0.49% - 0.65%.

ii. Socioeconomic data (e.g., percentage of federal poverty level, income, education, health insurance status, etc.)

Percentage of federal poverty level & Income

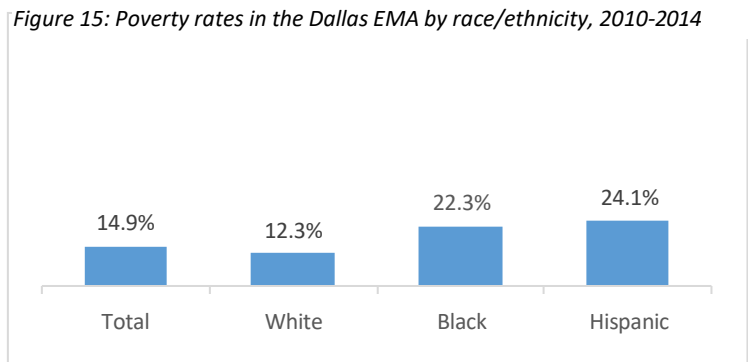
According to The Joint United Nations Programme on HIV/AIDS (UNAIDS), the United States has a concentrated



HIV epidemic, primarily among MSM and IDUs and has greatly affected the economically disadvantaged in many urban areas. The Centers for Disease Control and Prevention (CDC) defines a concentrated HIV epidemic as when the HIV prevalence rate is <1% in the general population, but >5% in at least one high-risk subpopulation, such as MSM. The CDC recently conducted

a study in 25 urban areas, including Dallas, which found the HIV prevalence rate to be so high in urban poverty areas, that the rate is more than 20 times greater than the rate among all heterosexuals in the U.S. HIV prevalence rates in urban poverty areas in the U.S. is similar to rates found in low-income countries such as Burundi, Ethiopia, Angola, and Haiti. HIV prevalence rates in Dallas and other U.S. urban areas are inversely related to annual household income as shown in Figure 14².

Poverty influences health directly and indirectly. Income directly affects the ability to pay for health care or health insurance. Low income is both a cause and effect for factors such as low educational attainment and housing and job instability that are associated with poor health.¹ In 2014, nearly 15% of EMA residents were living in poverty. Racial/ethnic minorities bore a higher burden of poverty – one in four Hispanic and one in five Black Dallas residents lived in poverty compared to less than one in seven Whites as shown in Figure 15.



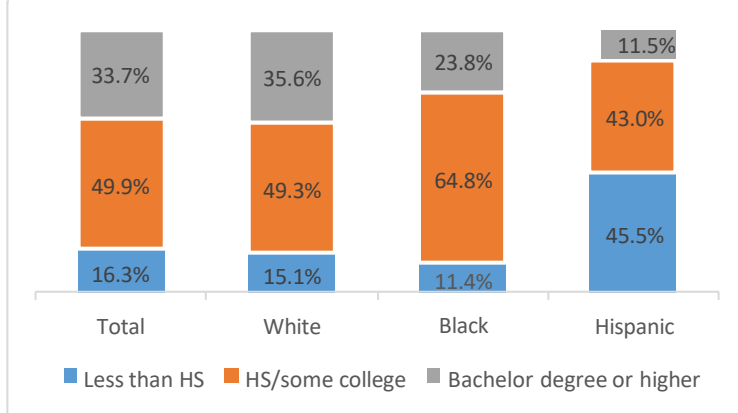
When analyzing the Federal Poverty Level (FPL) of consumers of Ryan White services in the 12 county Dallas Planning Area via the AIDS Regional Information and Evaluation System (ARIES) from 2010 – 2014, the percentage of users that were in the 0% - 100% FPL dropped dramatically in 2014 compared to the previous four calendar years. 60% of Ryan White consumers fell within this range in 2014, whereas in the previous four calendar years the percentage of Ryan White consumers that fell within this FPL was 68% in 2010 and 2011, 69% in 2012, and 70% in 2013.

²Data sources: NHBS-HET-1 2006-7 and UNAIDS HIV Estimates 2007. From: Denning P and DiNenno E. Communities in Crisis: Is There a Generalized HIV Epidemic in Impoverished Urban Areas of the United States? The Centers for Disease Control and Prevention. <http://www.cdc.gov/hiv/group/poverty.html>

Education

People with low levels of educational attainment (less than 12 years of formal schooling) have higher mortality rates from all causes than people with higher levels of educational attainment.² About 16% of Dallas EMA

Figure 16: Levels of educational attainment, Dallas EMA 2010-2014



residents aged 25 and older do not hold a high school diploma (or have earned a GED or equivalent). For Hispanic residents, the proportion is almost three times higher – more than two in five have not completed high school.

Trends in death rates due to HIV infection in the U.S. show that death rates for both whites and blacks individuals decreased substantially from 1993 to 2001 (Figure 17). However, both white and black men with an educational attainment of less than 12 years experienced a much lower decrease in death rates compared to those with an educational level above 16 years. Black females with an education of less than 12 years actually experienced an increase in rate of death due to HIV infection from 1993 to 2001³.

Figure 17: Trends in age-standardized death rates (per 100,000) for HIV infection with decreasing trend in the general population among 25-64 year old U.S. adults by race, sex, and education, 1993-2001

Cause/Sex	Education in years	Whites			Blacks		
		Rate	Rate	Annual %*	Rate	Rate	Annual %*
HIV Infection							
Men	All	31.3	6.3	-23.0 [†]	111.3	56.1	-12.1 [†]
	<12 Yrs	28.7	15.4	-12.5 [†]	123.1	120.9	-3.1
	16+ Yrs	31.4	3.5	-28.4 [†]	118.2	28.9	-20.1 [†]
	Rate difference (<12 vs. 16+)	-2.7	12.0		4.9	92.0	
	Rate Ratio, 95% CI (<12 vs. 16+)	0.9 (0.8-1.0)	4.5 (3.9-5.1)		1.0 (0.9-1.2)	4.2 (3.5-5.0)	
Women	All	1.9	0.9	-11.9 [†]	23.1	21.7	-4.6
	<12 Yrs	5.7	5.4	-3.4	41.0	52.9	0.6
	16+ Yrs	0.8	0.1	-22.9 [†]	8.9	5.9	-10.7 [†]
	Rate difference (<12 vs. 16+)	4.9	5.2		32.2	47.1	
	Rate Ratio, 95% CI (<12 vs. 16+)	7.1 (5.2-9.5)	39.2 (22.4-68.6)		4.6 (3.2-6.8)	9.0 (6.3-12.9)	

²Hummer, RA & Hernandez, EM (2013). The Effect of Educational Attainment on Adult Mortality in the United States. *Population Bulletin* 68, no. 1.

³Jemal A, Ward E, Anderson R, et al. Widening of Socioeconomic Inequalities in U.S. Death Rates, 1993-2001. *PLoS One*. 2008; 3(5): 1-8.

Housing and Homelessness

A 2016 Point-In-Time (PIT) homeless count, conducted by the Metro Dallas Homeless Alliance found an increase of 21% in the homeless population in Dallas and Collin Counties over the 2015 PIT Count. Nearly one half of those defined as being unsheltered were homeless for greater than one year⁴. In addition to poor overall physical health being more pronounced among those without a home, rates of mental illness, substance abuse, tuberculosis, hypertension, diabetes, and asthma are all higher. The rate of those living with HIV infection in the U.S. homeless population is estimated to be as high as 3.5% compared to 0.006% in the overall U.S. population⁵. This rate is consistent with historical PIT Counts from 2011 to 2015 in Dallas and Collin Counties, which show the rate of those living with HIV in the homeless population at between 3% and 6% of the homeless population.

Health insurance status

Texas is one of the states that has yet to expand its Medicaid program under the Affordable Care Act (ACA), and is home to the largest number of uninsured individuals of any state in the country (Table 1). Studies have shown that uninsured persons are less likely to have a regular source of health care and to receive needed medical care, and are more likely to die from health-related problems. Chronically-ill uninsured adults delay or forgo checkups and therapies, including medications. Low rates of insurance coverage in a community can also hurt the health of people with insurance. Data show that privately insured, working-age adults in areas with lower insurance rates are less likely to report having a place to go for care when sick, getting routine preventive care, and seeing a specialist when needed.⁶ Uninsured PLWH are especially vulnerable to poor health outcomes, including an increased risk of death.⁷

Table 1: Texans without health insurance, 2010-2014

	Total	White	Black	Hispanic
Texas	21.9%	21.0%	19.6%	33.7%
Austin TGA	17.6%	16.7%	15.6%	29.6%
Dallas EMA	21.5%	19.8%	20.4%	39.0%
Fort Worth TGA	20.3%	18.7%	20.9%	36.4%
Houston EMA	23.5%	22.2%	20.0%	38.4%
San Antonio TGA	18.7%	17.9%	15.3%	23.9%
East Texas area	20.1%	19.4%	20.0%	36.5%
US-Mexico border	31.7%	31.6%	15.2%	34.3%

⁴ <http://www.mdhadallas.org/state-of-the-homeless-address-2016/>

⁵ Zlotnick C and Zenger S. Survey findings on characteristics and health status of clients treated by the federally funded (US) Health Care for the Homeless Programs. *Health and Social Care in the Community*. 2008; 17(1): 18-26.

Between 2010 and 2014, a little more than one in five Dallas residents did not have health insurance. The proportion of Blacks and Whites with health coverage was similar, but the proportion of Hispanics with health insurance was much lower – only about 61 percent had coverage.

Supplemental data from the Census Bureau shows that the proportion of non-elderly Texans with insurance increased from 2013 to 2014, although these increases were primarily in Texans with higher incomes. The number of uninsured Texans dropped by 17 percent, but the number of uninsured persons living in poverty dropped by only ten percent.

The Medical Monitoring Project is a special surveillance study that focuses on a representative sample of PLWH receiving HIV-related care in the U.S. In 2011, 25% of the respondents reported that they had no health insurance coverage; however, due to the sampling methods, only PLWH in medical care were assessed. Those living with HIV not in medical care may be more likely to have even higher rates of being uninsured.

Social Determinants

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, live, work, and age. Examples of social determinants include:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Residential segregation
- Language/Literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- Culture

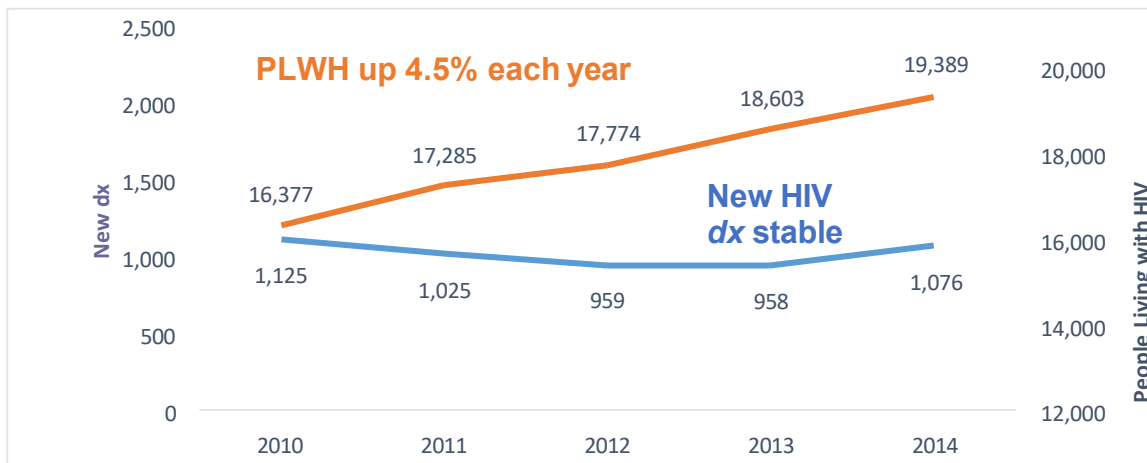
Many of these determinants increase vulnerability to illness and adversely affect health outcomes in Dallas.

- c. Describe (table, graph, and/or narrative) the burden of HIV in the service area using HIV surveillance data and the characteristics of the population living with HIV (i.e., number of PLWH, rates, trends, populations most affected, geographic concentrations, deaths, etc.).

Number of PLWH

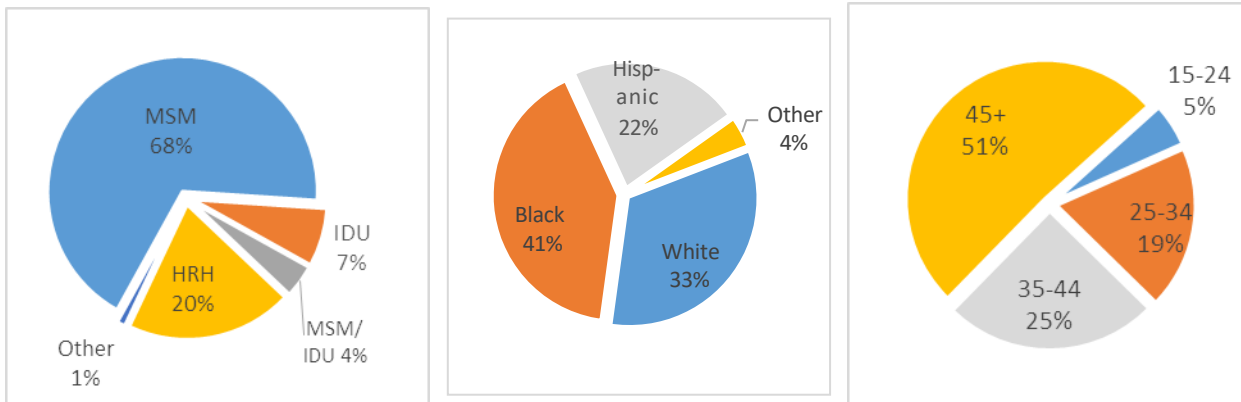
Over the past five years, the number of Dallas EMA residents living with diagnosed HIV infections has increased by about 4.5% a year, from about 16,000 in 2010 to more than 19,000 in 2014 (Figure 18). However, the number of new HIV diagnoses is not rising- the annual number of new diagnoses during this time period was stable as is shown by DSHS data which indicated that there were between 780 and 1,360 new infections in 2013. The number of people living with HIV (PLWH) has increased because highly effective treatment has lengthened their lives – people with HIV who get early treatment (and stay on treatment) have lifespans nearly comparable with people without HIV.

Figure 18: Dallas EMA residents living with diagnosed HIV infections and residents with new HIV diagnoses, 2010-2014



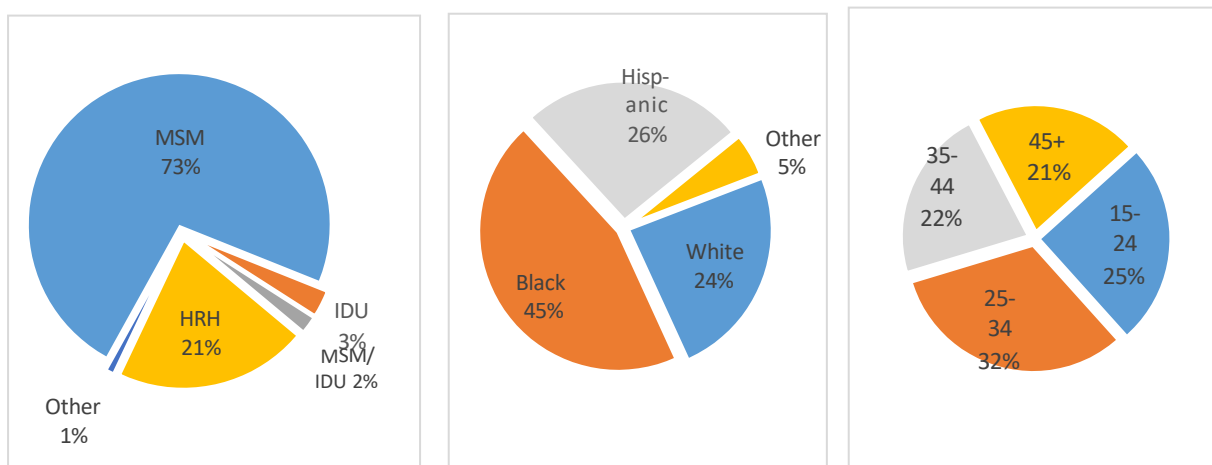
Gay and bisexual men and other men who have sex with men (MSM) made up about 68% of EMA residents living with diagnosed HIV infections in 2014. Heterosexuals made up about 20% of the EMA’s PLWH. Blacks made up the largest racial/ethnic group of PLWH – about two in five PLWH were Black. About half the PLWH were 45 or older.

Figure 19: 2014 PLWH in Dallas EMA by mode of transmission, race/ethnicity, and age



MSM have an even larger presence among those newly diagnosed, with MSM making up almost three out of four of those diagnosed between 2010-2014 (Figure 20). Heterosexuals made up about 20% of new diagnoses, which is similar to their representation in PLWH, but the count of High-Risk Heterosexuals (HRH) diagnoses fell by about 18% between 2010 and 2014. IDU diagnoses made up only about 3%, and were stable across the previous five years. Blacks made up almost half of the residents with new diagnoses, with White and Hispanic residents each accounting for about one quarter. Finally, the profile of Texans with new diagnoses is much younger than the profile of PLWH overall – more than three in five new diagnoses are in those younger than age 35, primarily young MSM.

Figure 20: Dallas EMA residents newly diagnosed with HIV from 2010-2014 by mode of transmission, race/ethnicity, age at diagnosis



Blacks make up about 16% of the population of the EMA, but more than 40% of the PLWH in the area. The 2014 prevalence rate indicates that more than 1% of Black residents of the EMA were living with diagnosed HIV infections. Prevalence rates for Blacks were consistently three times higher than rates for Whites or Hispanics, and rose about 14% between 2010 and 2014.

Reducing new HIV infections rests in: delivering targeted and effective prevention programs to local residents at very high risk; reducing the number of local residents living with undiagnosed HIV infections; and increasing access to effective and continuous treatment. The primary hallmark of good care is suppressed HIV viral load – a sustained reduction in the amount of virus in an infected person’s blood. Suppressed viral load not only benefits the person living with HIV, but also decreases the chance that HIV will be passed on to others.

In 2014, an estimated four in five EMA residents with diagnosed infections had at least one HIV-treatment visit, with one in five receiving no care. Almost three in five PLWH had viral suppression at the end of 2014. The remaining one in five EMA residents received some HIV-related care, but did not have suppressed viral load, as depicted in Figure 21 below.

PLWH stands for people living with HIV, which is also called *prevalence*. Annual prevalence is the number of people with diagnosed infections who were alive and residing in Texas as of the end of the year. It does not include people with undiagnosed infections.

New HIV diagnoses is shortened to new *dx*. An annual count of new diagnoses shows the number of people with first-time diagnoses of HIV infections in people who were residing in Texas at the time their diagnosis was made.

Rates allow direct comparison of HIV in groups of different sizes and show the intensity of HIV infection. Prevalence rates show the number of PLWH per 100,000, and diagnosis rates show the number of new HIV

Figure 21: Participation in HIV treatment and viral load suppression in the Dallas EMA, 2014

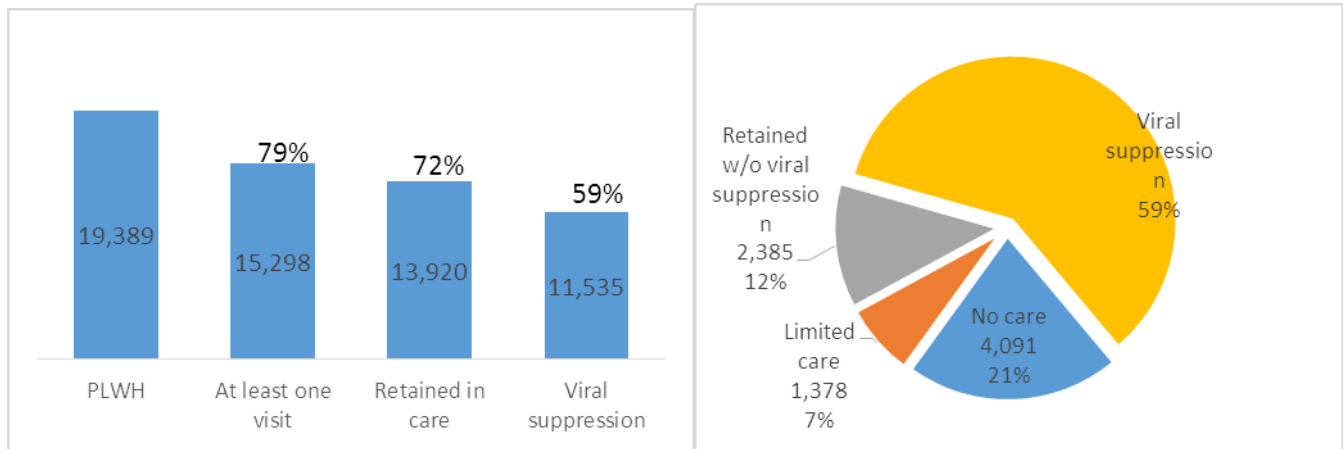


Figure 22 shows MSM as a proportion of HIV prevalence and new diagnoses within race/ethnic groups in the Dallas EMA in 2014. For instance, out of all white PLWH in the Dallas EMA in 2014, 5,282 of them were MSM and 1,045 were categorized as a different mode of transmission, meaning approximately 83% of white PLWH in the Dallas EMA in 2014 were MSM. Conversely, 4,052 black PLWH were MSM in the Dallas EMA in 2014 and 3,832 were categorized as a different mode of transmission, which means that 51% of black PLWH in the Dallas EMA in 2014 were MSM. Figure 23 shows the five year trends in PLWH and new diagnoses in the Dallas EMA from 2010-2014 for Hispanic MSM, Black MSM, and White MSM. New diagnoses has decreased slightly among Hispanic and White MSM groups, but has increased among Black MSM.

Figure 22: MSM as a proportion of all PLWH and new diagnoses in race/ethnic groups in the Dallas EMA, 2014

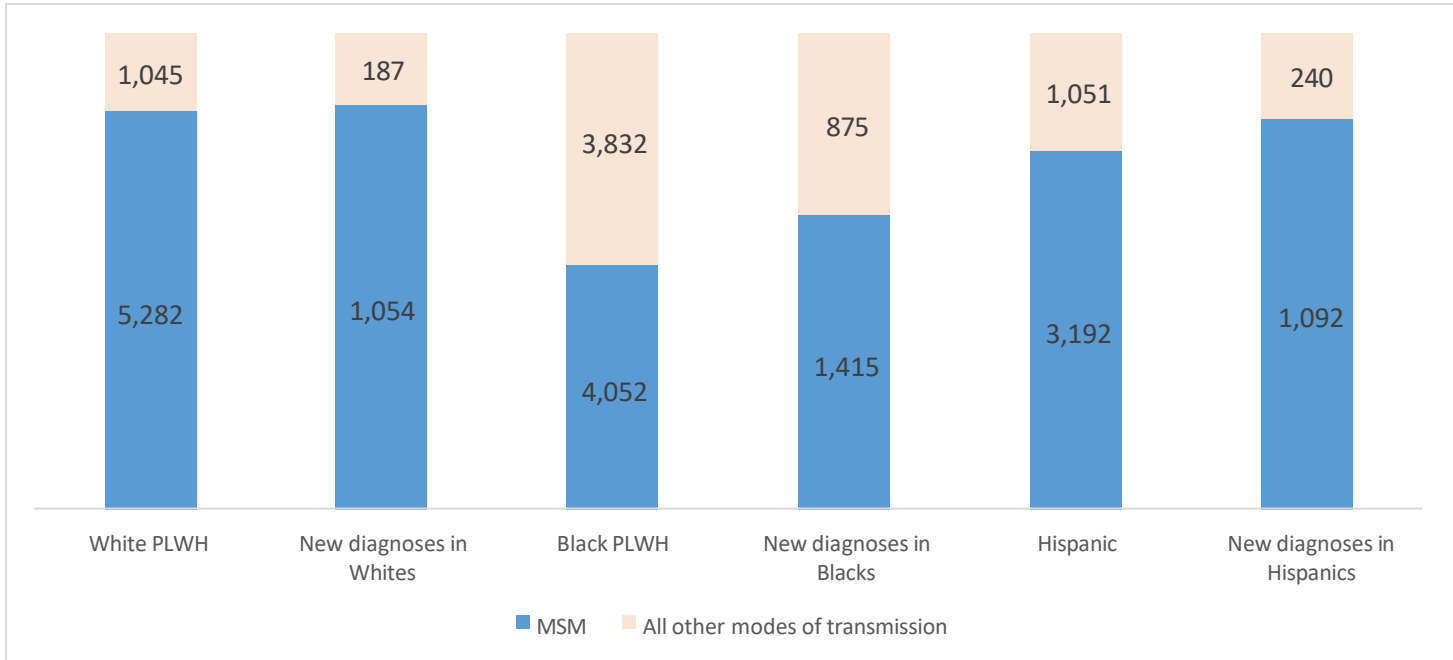
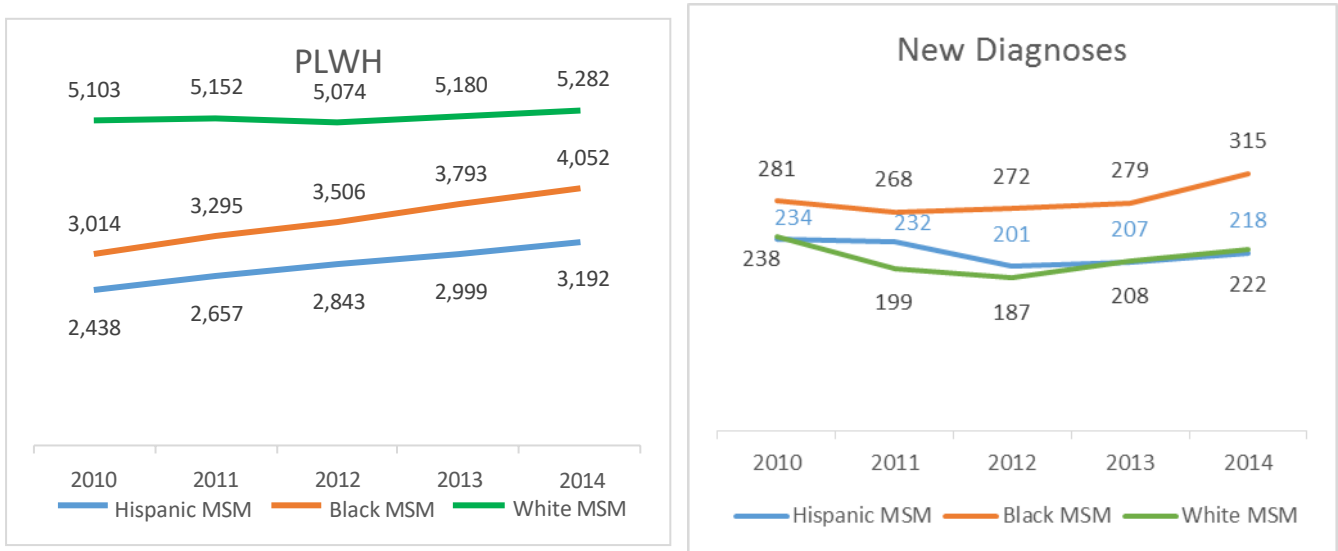


Figure 23: Changes in numbers of PLWH and new diagnoses in MSM, Dallas 2010-2014



Rates

This section provides information on the number of people living with diagnosed HIV infections as of the end of 2014 and on new HIV diagnoses from 2010 – 2014 (Figure 24). Cumulative counts of all new infections in that five-year period were used in addition to information tracking the annual number of new diagnoses. Using five

years of diagnoses provides a more reliable comparison point-to-prevalence than does a single year of new diagnoses.

The number of persons living with a diagnosed HIV infection in the Dallas EMA grew by 18% between 2010 and 2014. Over the same time period, new diagnoses fell from 2010 through 2013, and then slightly rebounded in 2014. Given the steady growth in population, the diagnosis rate in 2014 was 12% lower than in 2010 (Figure 25).

Figure 24: Dallas EMA residents living with HIV and prevalence rates, 2010-2014

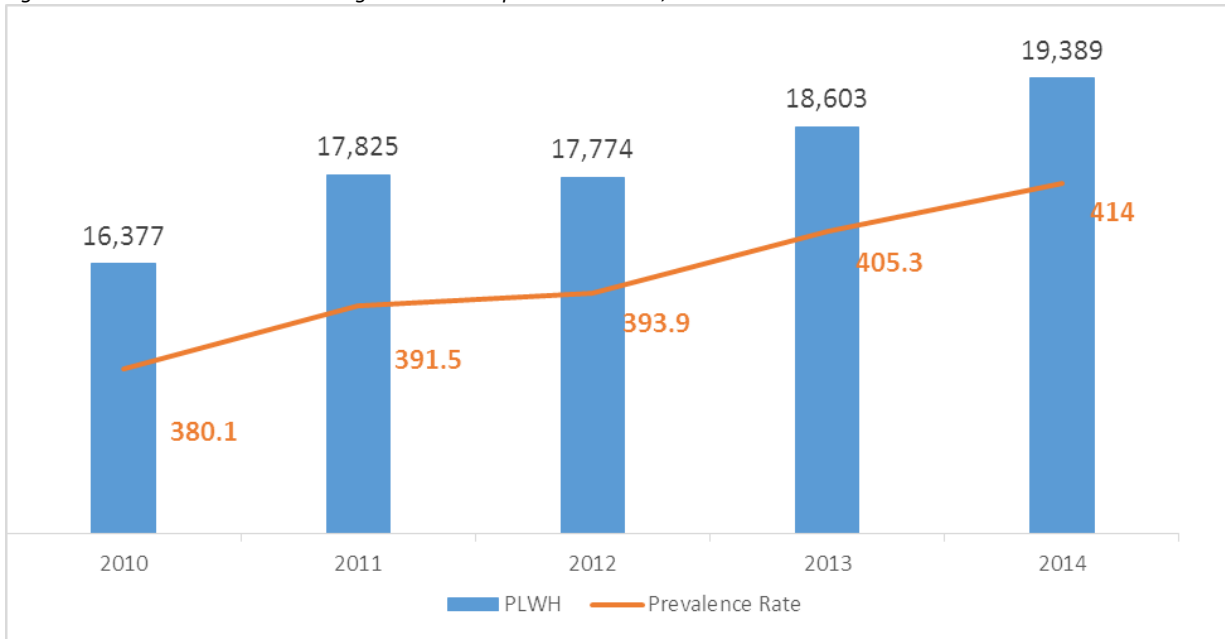
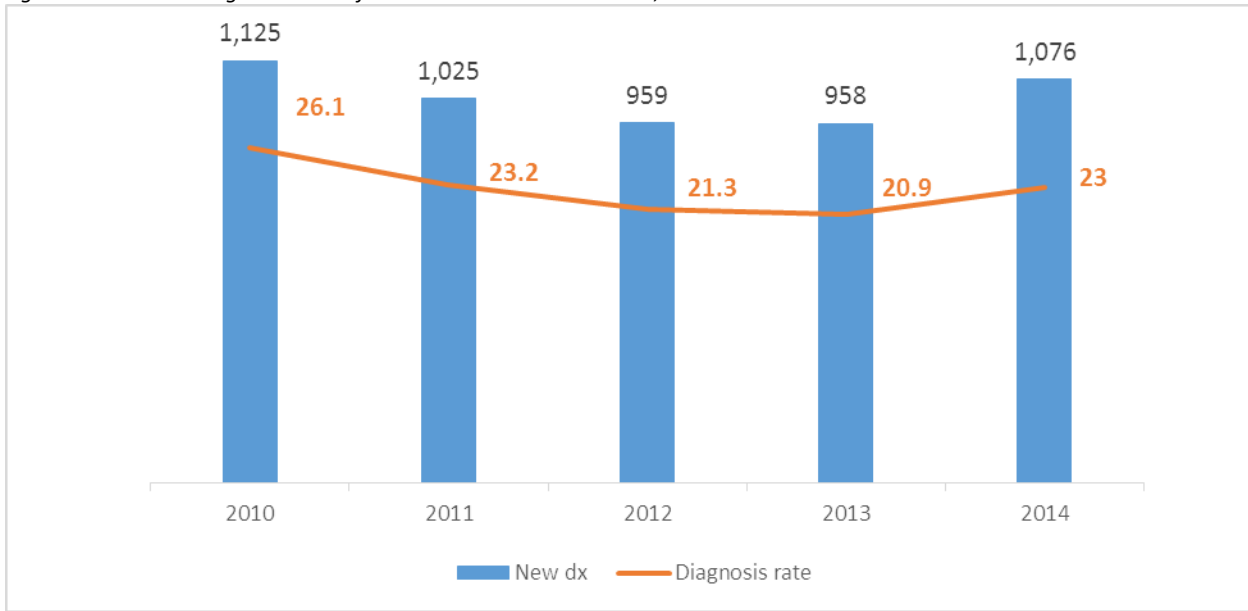


Figure 25: New HIV diagnoses and infection rates in the Dallas EMA, 2010-2014



Snapshot of PLWH and newly diagnosed Dallas EMA residents

As in years past, in 2014 about four out of five Dallas EMA residents living with HIV were men. Gay, bisexual, and other men who have sex with men (MSM) made up about 68% of the PLWH, with heterosexual men and women making up an additional 20%. Black Dallas EMA residents made up almost two in five PLWH, and more than half were 45 years old or older. Tables 2 - 4 at the end of this section provide more detail.

Table 2: PLWH in the Dallas EMA, 2010-2014

Dallas EMA																
	2010			2011			2012			2013			2014			Change
	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate	
Total	16,377		380.1	17,285		391.5	17,774		393.9	18,603		405.3	19,389		414.0	18%
Female	3,177	19%	145.5	3,372	20%	150.7	3,489	20%	152.5	3,682	20%	158.1	3,851	20%	161.9	21%
Male	13,200	81%	621.1	13,913	80%	639.2	14,285	80%	642.2	14,921	80%	660.1	15,538	80%	674.0	18%
White	6,085	37%	289.8	6,172	36%	290.1	6,099	34%	283.1	6,213	33%	286.5	6,327	33%	288.8	4%
Black	6,221	38%	897.2	6,705	39%	940.4	7,024	40%	957.2	7,489	40%	997.7	7,884	41%	1023.9	27%
Hispanic	3,318	20%	270.3	3,594	21%	283.5	3,818	22%	293.7	4,003	22%	300.7	4,243	22%	310.7	28%
Other	171	1%	59.4	185	1%	60.3	193	1%	59.7	202	1%	59.5	229	1%	64.1	34%
Unknown	582	4%		629	4%		640	4%		696	4%		706	4%		21%
MSM	11,022	67%		11,608	67%		11,947	67%		12,543	67%		13,133	68%		19%
IDU	1,270	8%		1,342	8%		1,334	8%		1,355	7%		1,356	7%		7%
MSM/IDU	734	5%		789	5%		796	5%		799	4%		791	4%		8%
HRH	3,205	20%		3,394	20%		3,540	20%		3,746	20%		3,953	20%		23%
Ped*	122	<1%		127	<1%		132	<1%		137	<1%		133	<1%		9%
Adult Other	25	<1%		25	<1%		25	<1%		23	<1%		23	<1%		-8%
0-14	57	<1%	5.7	55	<1%	5.4	52	<1%	5.1	49	<1%	4.7	40	<1%	3.8	
15-24	864	5%	145.0	908	5%	149.7	963	5%	155.6	970	5%	154.3	948	5%	148.1	10%
25-34	2,951	18%	451.2	3,131	18%	471.9	3,226	18%	478.2	3,479	19%	510.8	3,682	19%	530.4	25%
35-44	4,924	30%	751.6	4,897	28%	735.4	4,806	27%	709.7	4,803	26%	703.3	4,848	25%	702.1	-2%
45+	7,581	46%	542.1	8,294	48%	567.8	8,727	49%	576.6	9,302	50%	596.2	9,871	51%	612.6	30%

*Pediatric cases are those who acquired their HIV infection through mother to child transmission

The profile of Dallas residents newly diagnosed with HIV differs from that of PLWH. MSM have an even larger presence among those newly diagnosed, with MSM making up almost three out of four of those diagnosed between 2010-2014. Heterosexuals made up about 20% of new diagnoses, which is similar to their representation among PLWH, but the count of HRH diagnoses fell about 18% between 2010 and 2014. IDU diagnoses made up only about 3%, and were stable across the previous five years. Blacks made up almost half of the residents with new diagnoses, with White and Hispanic residents each accounting for about one quarter of the total. Finally, the profile of Dallas residents with new diagnoses is much more youthful than the profile of PLWH – more than three in five younger than 35, driven by increased diagnoses in young MSM.

Table 3: New HIV diagnoses in the Dallas EMA< 2010-2014

	2010			2011			2012			2013			2014			5 year totals		Change
	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate	#	%	
Total	1,125	100	26.1	1,025	100	23.2	959	100	21.3	958	100	20.9	1,076	100	23	5,143		-4%
Female	233	21%	10.7	199	19%	8.9	180	19%	7.9	175	18%	7.5	201	19%	8.5	988	19%	-14%
Male	892	79%	42	826	81%	37.9	779	81%	35	783	82%	34.6	875	81%	38	4,155	81%	-2%
White	273	24%	13	240	23%	11.3	225	23%	10.4	239	25%	11	264	25%	12.1	1,241	24%	-3%
Black	488	43%	70.4	442	43%	62	434	45%	59.1	432	45%	57.6	494	46%	64.2	2,290	45%	1%
Hispanic	297	26%	24.2	278	27%	21.9	247	26%	19	243	25%	18.3	267	25%	19.6	1,332	26%	-10%
Other	23	2%	8	17	2%	5.5	12	1%	3.7	13	1%	3.8	27	3%	7.6	92	2%	17%
Unknown	44	4%	.	48	5%	.	41	4%	.	31	3%	.	24	2%	.	188	4%	-45%
MSM	796	71%		745	73%		702	73%		728	76%		793	74%		3,764	73%	0%
IDU	39	3%		38	4%		35	4%		27	3%		39	4%		178	3%	0%
MSM/IDU	26	2%		18	2%		18	2%		17	2%		25	2%		104	2%	-4%
HRH	262	23%		221	22%		202	21%		184	19%		216	20%		1,085	21%	-18%
Ped*	1	0%		3	0%		2	0%		2	0%		3	0%		11	0%	200%
0-14	3	0%	0.3	3	0%	0.3	3	0%	0.3	2	0%	0.2	3	0%	0.3	14	0%	0%
15-24	285	25%	47.8	243	24%	40.1	249	26%	40.2	241	25%	38.3	272	25%	42.5	1,290	25%	-5%
25-34	344	31%	52.6	314	31%	47.3	276	29%	40.9	331	35%	48.6	364	34%	52.4	1,629	32%	6%
35-44	262	23%	40	230	22%	34.5	225	23%	33.2	183	19%	26.8	214	20%	31	1,114	22%	-18%
45+	231	21%	16.5	235	23%	16.1	206	21%	13.6	201	21%	12.9	223	21%	13.8	1,096	21%	-3%

*Pediatric cases are those who acquired their HIV infection through mother to child transmission

Table 4: Prevalence rates for Texas MSM by area of residence and race/ethnicity, 2012

	All MSM	White MSM	Black MSM	Hispanic MSM
Texas	6,966.0	4,834.4	19,590.6	6,542.2
Austin TGA	4,692.4	4,000.3	10,022.1	5,063.5
Dallas EMA	7,575.0	5,765.3	17,997.7	6,462.5
Fort Worth TGA	3,865.2	2,596.7	11,638.9	3,579.0
Houston EMA	7,867.4	5,513.2	19,782.4	6,476.6
San Antonio TGA	6,976.4	4,220.7	12,790.3	8,195.5

Rates are per 100,000.

Trends

Estimated HIV incidence from 2009 to 2013

Incidence is the total number of new HIV infections in a given period. The estimates use the results from a laboratory test and information from newly-diagnosed persons about HIV testing and treatment history to characterize an infection as *recent* or *long-term*. *Recent* means that the HIV infection probably occurred in the last 12 months, and *long term* means that HIV infection happened more than a year ago. Information on the diagnoses categorized as recent infections is combined to estimate HIV incidence (new HIV infections).⁸

The estimates are reported as *point estimates* and *95% confidence intervals* for each year. The point estimate is the best estimate of the true number of new HIV infections in a given year. The *95%* confidence interval is the range of values with a 95% probability of containing the true number of incident HIV infections. Changes in point estimates are statistically significant only if a point estimate lies outside the confidence intervals for the other estimates. For example, suppose the estimate of new infections for 2004 shows a point estimate of 4,000 new infections and a confidence interval of 3,000 to 5,000 new infections. If the point estimate for 2005 is 4,500 new infections, then this is not a true increase in new infections because 4,500 falls within the 2004 confidence interval of 3,000 to 5,000.

Between 2009 and 2013, the annual number of new infections in adults and adolescents in the EMA was stable; in 2013, there were between 780 and 1,360 new infections (Figure 26). An incidence rate is the number of new HIV infections per 100,000 adults and adolescents. The estimated incidence rate during this time period was stable, as indicated in both Figure 27 and Table 5.

⁸ More information about the methods is found at <http://www.plosone.org/article/info:doi/10.1371/journal.pone.0017502>.

Figure 26: Estimated new HIV infections in adults and adolescents in the Dallas EMA, 2009-2013

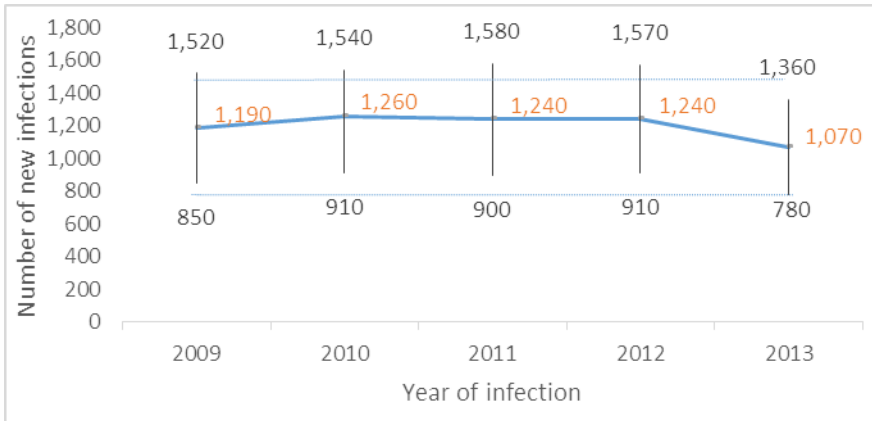


Figure 27: Estimated incidence rate for Dallas EMA adults and adolescents, 2009-2013

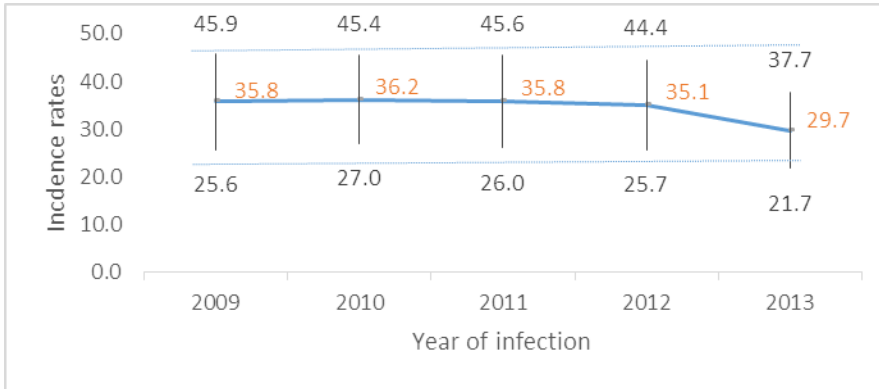


Table 5: Estimates of Texas HIV incidence by sex, race/ethnicity, and mode of transmission, 2009-2013

Men												
	MSM			IDU			MSM/IDU			HRH		
	Est #	95% CI		Est #	95% CI		Est #	95% CI		Est #	95% CI	
White	4,921	4,117	5,725	171	58	284	318	164	471	125	27	223
Black	5,379	4,530	6,229	298	141	454	128	25	231	748	497	999
Hispanic	6,532	5,575	7,489	177	54	301	210	88	331	330	170	490

Women						
	IDU			HRH		
	Est #	95% CI		Est #	95% CI	
White	274	126	421	455	263	647
Black	355	181	529	2,553	2,035	3,070
Hispanic	181	62	300	972	691	1,253

Estimates of undiagnosed HIV infections

DSHS has estimated the proportions of Texans with undiagnosed infections for 2009-2013; these estimates are not available for local areas. DSHS based these estimates on complex algorithms

developed by the CDC. As with estimates of incidence, the best way to look at the number and proportion of undiagnosed infections is by looking at the 95% CI for each group (Table 6). In 2013, an estimated 11% to 17% of Texas PLWH had undiagnosed infections.

The greatest number of estimated undiagnosed infections are in MSM- they make up two out of three Texans with undiagnosed infections; DSHS estimates that about 13% to 18% of Texas MSM living with HIV have not yet been diagnosed. Two groups are close to or have surpassed the 90% diagnosis rate goal: IDU and MSM/IDU.

Hispanics are the race/ethnic group that has the highest proportion of undiagnosed infections: about 17% to 23% of Hispanic PLWH have not yet been diagnosed. Hispanics made up two out of every five undiagnosed PLWH in 2013. Keep in mind that most new infections in Hispanics are in MSM.

Table 6: Estimates of proportion of Texans living with undiagnosed HIV infections, 2013

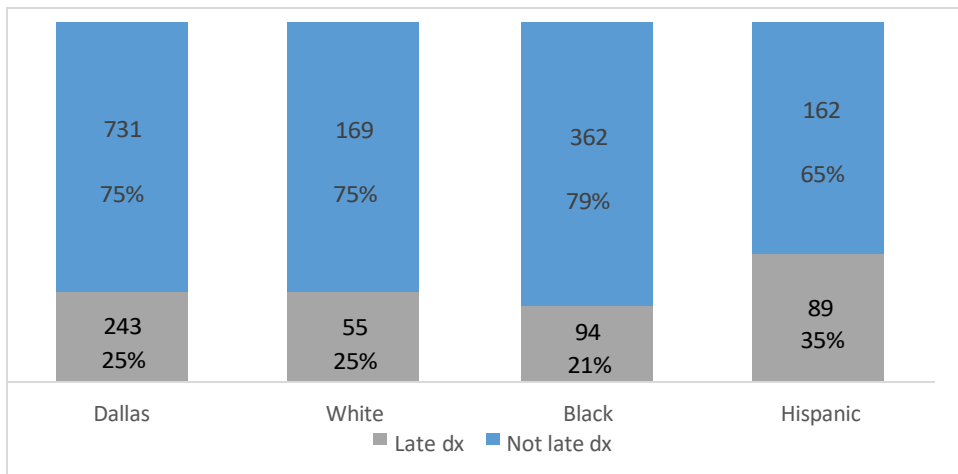
	Estimated proportion of undiagnosed infections		
	Est %	95% CI	
TOTAL	14.1%	11.2%	16.8%
Men	14.7%	12.9%	16.9%
Women	12.8%	8.3%	15.9%
White	9.7%	6.6%	13.0%
Hispanic	19.6%	16.6%	22.8%
Black	12.8%	10.4%	15.5%
MSM	15.9%	13.0%	18.0%
IDU	6.6%	2.5%	10.5%
MSM/IDU	4.2%	0.1%	9.6%
HRH	15.2%	11.6%	18.8%

Late diagnosis

To classify the effects of an HIV infection on immune functioning, people with HIV infections are grouped by stages; a Stage 3 classification indicates severe immune suppression, more commonly known as AIDS. Persons with a Stage 3 classification within three months of their diagnosis have a late diagnosis.

In 2014, about one in four of the diagnoses in the Dallas EMA were late. Late diagnosis was most common among Hispanics, where more than one in three had a late diagnosis. Rates of late diagnosis are about 1.4 times higher in Hispanics than in Whites and 1.7 times higher than in Blacks (Figure 28).

Figure 28: Late diagnoses of HIV infection in the Dallas EMA by race/ethnicity, 2014



Populations most affected

A closer look at how race and ethnicity and mode of transmission interact

Although MSM are the largest single group of PLWH and newly diagnosed persons in the EMA, the mode of transmission profiles differs by race/ethnicity. More than four out of five White PLWH are MSM as are three of every four Hispanic PLWH in the EMA. MSM are the largest group of Black PLWH – they make up about half of Black PLWH-and almost two out of three newly diagnosed Blacks. Further, while White MSM are still the largest group of PLWH in the EMA, the gap between the number of White MSM and Black and Hispanic MSM PLWH is closing. Prevalence in White MSM was flat across the past five years, but the number of Black and Hispanic MSM rose by a third.

Priority Populations

Achieving the goals of the *National HIV/AIDS Strategy* and the *Texas HIV Plan* requires a common focus on the groups at highest risk of acquiring or transmitting HIV – the priority populations for the Texas Plan. These populations are also included in the outcomes of Goals 2 and 3 of the NHAS, as well as this plan, which include increasing access to care and eliminating health disparities. In the Dallas EMA, four groups made up three out of four PLWH, and four out of five of the new diagnoses over the last five years: Black MSM, Hispanic MSM, White MSM, and Black heterosexual women (*Figure 29*). All public health strategies for reducing new infections or improving outcomes must include actions for these groups.

Figure 30 shows the number of new diagnoses in Black MSM rising slightly (roughly 12%) while new diagnoses in Black women, Hispanic MSM, and White MSM dropping slightly (about 7% for Hispanic and White MSM, about 14% for Black HRH women). New diagnoses in all other groups fell about 13%.

Figure 29: Priority populations in Dallas PLWH and residents with new HIV diagnoses

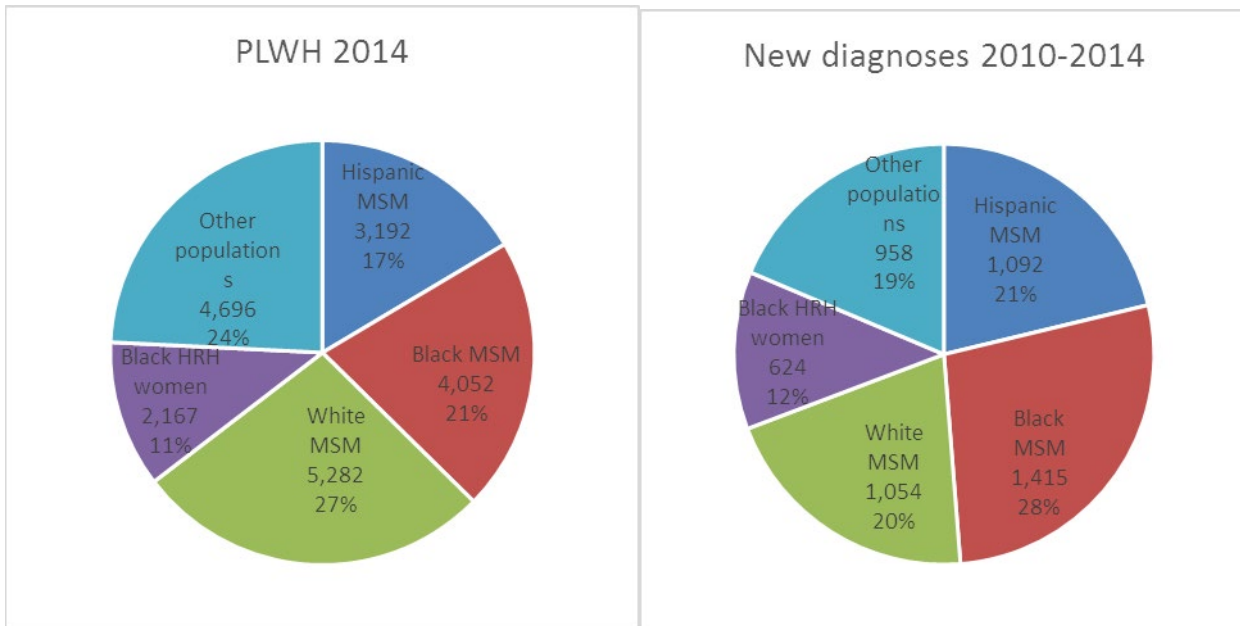
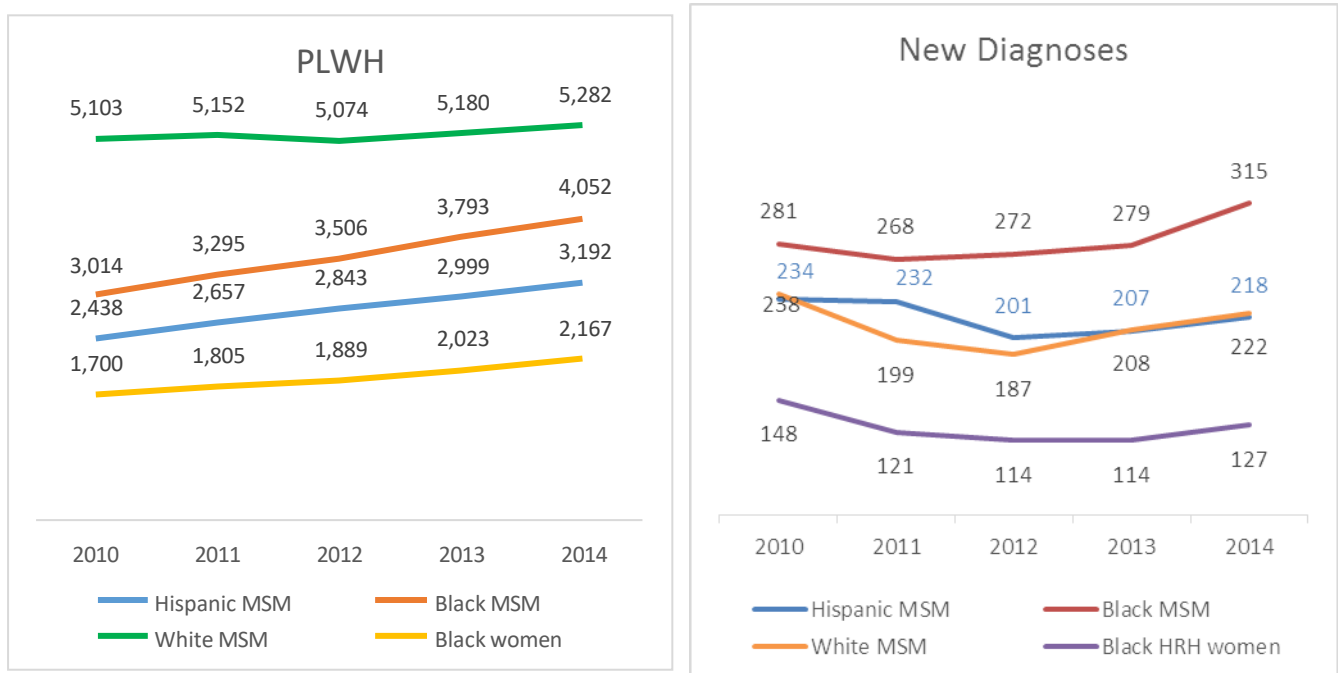


Figure 30: Changes in numbers of PLWH and new diagnoses in priority populations, Dallas 2010-2014



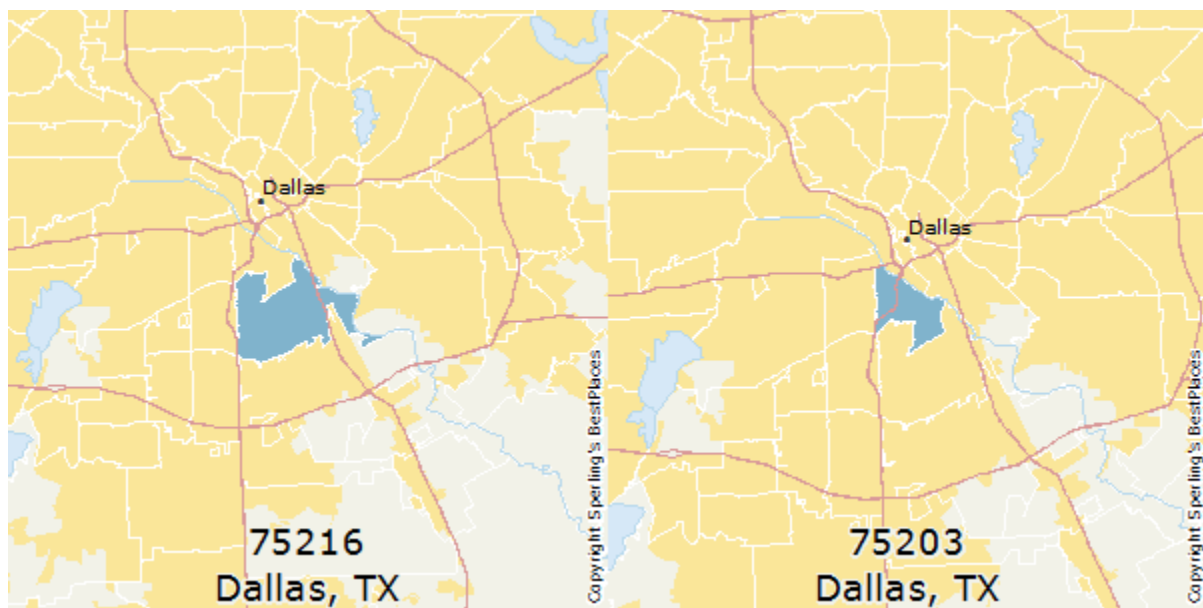
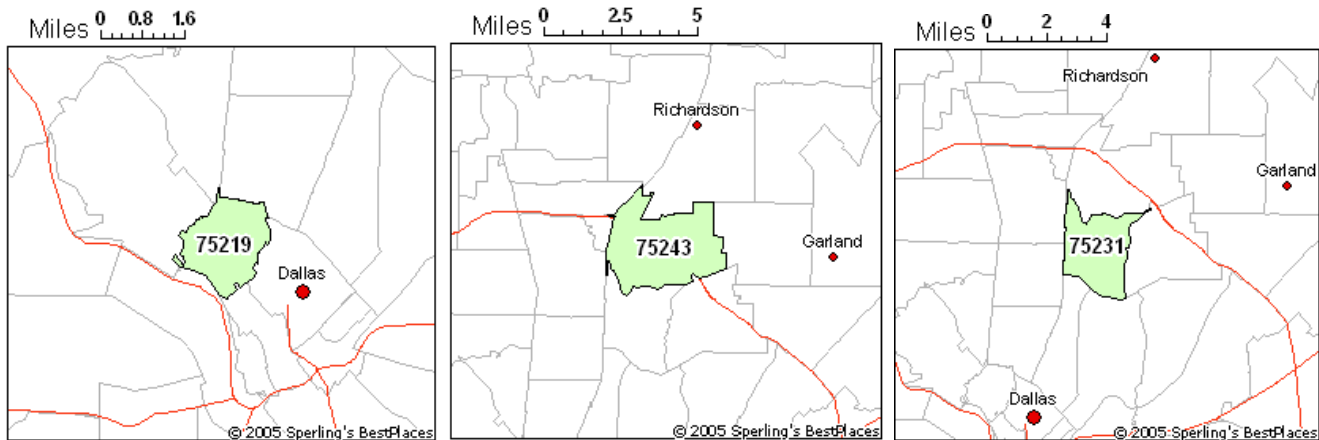
In addition to the four priority populations, this particular plan will target emerging populations of interest, such as transgender and injected (needle-sharing) drug users, in its interventions so that more robust data will be available locally in the future. Particular emphasis will also be placed on education, poverty, health insurance

status, and homelessness, as important social determinants of health, and will help to guide the developed public health strategies.

Geographic concentrations

Geographic concentration was measured by the concentration of Ryan White clients in the AIDS Regional Information and Evaluation System (ARIES) in the 12 county Dallas Planning Area. From January 1, 2015 to December 31, 2015, out of 10,025 Ryan White consumers, services were used by at least 300 individual consumers in the following five zip codes: 75219 (529 consumers), 75243 (387 consumers), 75216 (376 consumers), 75203 (312 consumers), and 75231 (300 consumers).

In the maps below, you see that 75219 is just northwest of downtown Dallas. 75243 and 75231 are adjacent and are on the northeast side of Dallas, near the cities of Richardson and Garland. 75216 and 75203 are adjacent as well and are on the south side of Dallas.



Deaths

The number of deaths in any one area of Texas is too limited for detailed analysis. Since HIV mortality rates are too low to allow for adequate analysis for a specific locality, mortality data presented below are for Texas as a whole.

Nearly half of the deaths due to HIV in 2013 occurred in Blacks and almost 30% occurred in Hispanics. Table 7 shows age-adjusted rate of death due to HIV in Texas PLWH. The rate of deaths due to HIV in Blacks is 5.8 times higher than the rate for Whites and 3.8 times the rate for Hispanics. The rate for Hispanics is 1.5 higher than the rate for Whites.

Table 8 shows the age-adjusted rate of death due to any cause in PLWH. PLWH deaths are more often due to factors other than their HIV, including diseases associated with older age, which become more common as PLWH live longer. In contrast to deaths attributed to HIV infections, the overall deaths in PLWH do not show the same race/ethnic differences. The highest rates of death in PLWH are in people who acquired their infections through injection drug use (including MSM/IDU).

Table 7: Age-adjusted rate of death due to HIV per 100,000 population, Texas 2012

Race/Ethnicity	Male Rate	Female Rate	Total Rate
Total	4.5	1.3	2.9
White	2.7	0.4	0.8
Black	13.2	5.5	4.6
Hispanic	4.0	1.0	1.2
Other Races	1.0	***	0.2

Age adjustments used the 2000 U.S. Standard Population (11 age groups, Distribution #1)

Deaths due to HIV are those where HIV is listed as the underlying cause on a death certificate (ICD Codes B20-B24)

No deaths in females of other races were reported in 2012

Table 8: Age-adjusted rate of death due to all causes in Texans living with a diagnosed HIV infection, Texas 2012

Race/Ethnicity & Risk Group	Male Rate	Female Rate	Total Rate
Total	19.3	25.5	20.5
White	26.5	27.2	25.4
Black	20.7	24.1	19.9
Hispanic	17.0	25.4	19.3
Other Races	9.6	**	7.8
MSM	16.2	N/A	16.2
IDU	25.3	25.3	25.0
MSM/IDU	30.9	N/A	30.9
Heterosexual	22.9	24.6	22.4
Pediatric	4.5	2.3	3.5

Age adjustments used the 2000 U.S. Standard Population (11 age groups, Distribution #1)

No deaths in females of other race or females with other risk were reported in 2012

Comorbidities: Hepatitis C, Sexually Transmitted Infections and Tuberculosis

When a person living with HIV has other health conditions or disease diagnoses, such as tuberculosis or mental health and/or substance use disorders, it is called a co-infection or a co-morbidity. Infection with HIV can increase the vulnerability of PLWH to co-infection with sexually transmitted infections (STI), tuberculosis (TB), and hepatitis C virus (HCV), among others. Co-infection can complicate treatment, reduce its effectiveness, and hamper treatment adherence. New STIs or HCV infections may be indicators of condomless sex, which can increase the chance of transmitting HIV, HCV, and other STIs.

To better understand co-infection in Texas PLWH, DSHS matched the routine disease surveillance databases for HIV, STI (chlamydia, gonorrhea, and syphilis), TB, and HCV infection which enabled reporting of the proportion of PLWH with reported comorbidities. These figures do not, however, represent the proportion of **all** PLWH with STIs, HCV infections, or latent TB. Unfortunately, HIV treatment guidelines that recommend screening for HCV, STI, and TB are not uniformly followed, and asymptomatic STIs and HCV infections may go undetected. Clinicians may not test for STI in the rectum or throat, which also allows infections to go undetected. Finally, the way public health disease reporting is carried out can also affect the statistics on co-infection. For example, in Texas only acute HCV infections are reported, not chronic infections. Without knowing how many infections are ongoing, it is not possible to get accurate data about the number of PLWH living with HCV infections.

Co-Infection with Hepatitis C Virus

Because of the limited information on HCV infections, this report includes data on only the number and proportion of co-infected persons in various geographic areas. The figures represent PLWH in 2014 who had a reported acute HCV infection in 2014 or earlier.

Table 9: Texas PLWH with reported HCV infections, 2014

	PLWH with reported HCV infections	Proportion of PLWH with reported HCV infections
Texas	7,396	9%
Austin	622	10%
Dallas	1,598	27%
Fort Worth	502	8%
Houston	1,754	29%
San Antonio	578	10%
East Texas	567	9%
US-Mexico border	398	7%

Co-Infection with Tuberculosis

Persons living with HIV who also have latent tuberculosis (TB) infection are more likely to develop TB disease because their immune systems are compromised. In Texas the rate of TB in PLWH is 16 times the rate in the general population. In 2014, almost 2% of Texas PLWH had received a TB diagnosis subsequent to their HIV diagnosis, and a little more than 2% of PLWH in the Dallas EMA had received such a diagnosis, Hispanics and Asians with HIV were more likely to have TB disease due to the endemic levels of TB in their countries of origin (data not shown).

Co-Infection with Sexually Transmitted Infections

In Texas, PLWH were considered to have an STI co-infection if their STI diagnosis occurred at least 30 days before their HIV diagnosis, was concurrent with their HIV diagnosis, or was made at any date after their HIV diagnosis. PLWH may have more than one diagnosis of any STI over the course of one year. To calculate the rate of diagnoses among PLWH, the total number of STI diagnoses in PLWH was used as the numerator and the total number of PLWH was used as the denominator.

Table 10 shows the number and rate of selected STI diagnoses in Texas PLWH in 2014. P&S syphilis refers to primary and secondary syphilis, and EL syphilis refers to early latent syphilis. The rates are per 100,000 PLWH. More than 1% of Texas PLWH had a reported STI infection in 2014. Gonorrhea and chlamydia were the most common STIs. However, syphilis infections are much more prevalent in PLWH compared to HIV-negative persons. In Texas, PLWH are 176.8 times more likely to be diagnosed with P&S Syphilis than HIV-negative persons. The disparity in chlamydia and gonorrhea case rates between PLWH and HIV-negative persons is not as large: PLWH are 3.6 times more likely to be diagnosed with chlamydia and 16.3 times more likely to be diagnosed with gonorrhea compared to HIV-negative persons. The demographic profile of PLWH diagnosed with STIs is similar to that of persons diagnosed with STIs in the general population. Young PLWH ages 15-34, Black and Hispanic PLWH, and MSM are more likely to have a diagnosed STI.

Table 11 shows the high burden of STI among MSM living with a diagnosed HIV infection. Rates are especially high for Black MSM; these men are less likely to have consistent HIV treatment and may not have the benefit of recommended routine screening for STI.

Figure 31 shows that in 2014, PLWH made up 1% - 5% of persons with chlamydia or gonorrhea infections, but they made up more than a third of P&S and EL syphilis cases. Ongoing syphilis transmission is increasingly limited to MSM in Texas.

Table 10: STI cases and incidence among Texans living with a diagnosed HIV infection, 2014

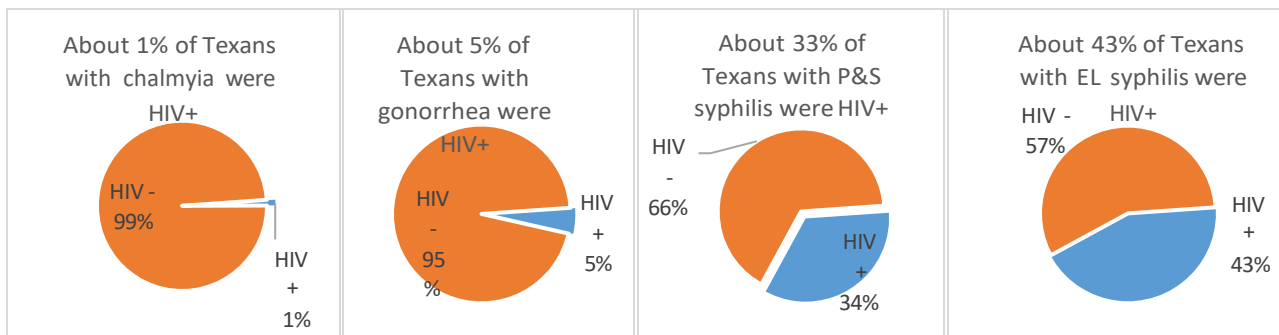
	PLWH	Chlamydia		Gonorrhea		P&S Syphilis		EL Syphilis	
		Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Total PLWH	80,073	1,362	1,700.9	1,596	1,993.2	538	671.9	803	1,002.8
Female	17,350	268	1,544.7	113	651.3	6	34.6	11	63.4
Male	62,723	1,094	1,744.2	1,483	2,364.4	532	848.2	792	1,262.7
15-24	3,983	282	7,081.1	323	8,109.5	100	2,510.7	122	3,063.0
25-34	14,914	568	3,807.7	683	4,578.7	215	1,441.3	292	1,957.5
35-44	19,763	302	1,528.1	330	1,669.8	110	556.6	201	1,017.1
45+	41,120	210	510.7	260	632.3	113	274.8	188	457.2
White	22,184	227	1,023.3	359	1,618.3	136	613.1	205	924.1
Black	29,895	590	1,973.6	688	2,301.4	193	645.6	258	863.0
Hispanic	24,607	474	1,926.3	459	1,865.3	181	735.6	305	1,239.5
Austin	5,304	140	2,639.5	198	3,733.0	66	1,244.3	89	1,678.0
Dallas	15,403	394	2,557.9	484	3,142.2	137	889.4	256	1,662.0
Houston	21,978	441	2,006.6	506	2,302.3	148	673.4	170	773.5
Fort Worth	4,635	70	1,510.2	86	1,855.4	56	1,208.2	75	1,618.1
San Antonio	4,248	113	2,660.1	133	3,130.9	58	1,365.3	98	2,307.0

Table 11: STI cases and incidence among Texas MSM living with a diagnosed HIV infection, 2014

	PLWH	Chlamydia		Gonorrhea		P&S Syphilis		EL Syphilis	
		Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
MSM	40,381	886	2,194.1	1,266	3,135.1	462	1,144.1	683	1,691.4
Black MSM	10,455	336	3,213.8	507	4,849.4	162	1,549.5	210	2,008.6
Hispanic MSM	13,751	331	2,407.1	394	2,865.2	156	1,134.5	268	1,948.9
White MSM	14,582	178	1,220.7	297	2,036.8	120	822.9	176	1,207.0

* The number of MSM PLWH differs from other reports because cases were not adjusted to assign mode of exposure to persons with no reported risk.

Figure 31: Proportions of Texans with diagnosed STI who are living with a HIV infection, 2014



- scribe (table, graph, and/or narrative) the indicators of risk for HIV infection in the population covered by your service area using the following, as available in the jurisdiction:

Indicators of HIV Risk

HIV risk behaviors in high risk, HIV negative Texans

Data in this section come from the Dallas data collection site of the National HIV Behavioral Survey (NHBS). This information may not reflect the state as a whole. For more information, please Appendix A.

In Texas, young Black MSM have the highest rates of new HIV diagnoses. However, NHBS data indicate that White and Hispanic MSM in Dallas are more likely to engage in high-risk behaviors. Though White and Hispanic MSM seem to be engaging in riskier behavior, they may have less exposure to HIV in their sexual networks consisting of other White and Hispanic MSM, among whom HIV prevalence is lower. Results are shown in Table 12.

Injecting substances increase risk of HIV transmission through needles and equipment and certain injectable drugs lower inhibition and increase the likelihood of engaging in high-risk sexual behavior. Among people who inject drugs in Dallas, a large proportion of respondents reported sharing needles or other injection equipment,

exchanging money or drugs for sex, and having condomless sexual intercourse. All of these activities are also risk factors for Hepatitis C and B infections, which can increase the chance of complications from HIV. Results are shown in Table 13.

A high proportion of high-risk heterosexuals reported having condomless sex with a partner of the opposite sex. Older respondents were more likely to report exchanging sex for money or drugs. (*This study collected data at sites in the city limits of Dallas but did not specify the residence of the respondents)

Table 14)

Table 12: HIV risk behaviors in HIV-negative MSM over the last 12 months, Dallas* 2014

	N	Ave. number of male sex partners	Condomless anal sex						Used injection or non-injection drugs		Self-reported syphilis infection	
			With a male partner		With a male partner of unknown HIV status		With an HIV-positive male partner		N	%	N	%
		N	N	%	N	%	N	%	N	%	N	%
Total	368	7	227	62%	79	21%	19	5%	211	57%	129	35%
White	141	8	89	63%	25	18%	13	9%	83	59%	52	37%
Black	111	5	60	54%	25	23%	3	3%	59	53%	30	27%
Hispanic	86	6	54	63%	21	24%	3	3%	47	55%	33	38%
15-24	65	8	41	63%	13	20%	4	6%	41	63%	25	38%
25-34	116	8	82	71%	34	29%	10	9%	65	56%	50	43%
35-44	89	5	53	60%	18	20%	2	2%	50	56%	33	37%
45+	98	5	51	52%	14	14%	3	3%	55	56%	21	21%

*This study collected data at sites in the city limits of Dallas, but did not specify the residence of the respondents

Table 13: HIV risk behaviors in HIV-negative IDU over the past 12 months, Dallas* 2012

	N	Ave. number of sex partners	Shared needles		Shared drug paraphernalia		Exchanged money or drugs for sex		Had condomless sex	
			N	%	N	%	N	%	N	%
Total	506	6	202	40%	343	68%	198	39%	238	47%
White	52	22	28	54%	35	67%	16	31%	13	25%
Black	426	4	161	38%	288	68%	165	39%	212	50%
Hispanic	13	12	5	38%	11	85%	11	85%	7	54%
15-24	4	6	3	75%	3	75%	1	25%	2	50%
25-34	48	10	24	63%	29	76%	22	58%	14	37%
35-44	54	24	26	48%	39	72%	28	52%	24	44%
45+	410	3	149	36%	272	66%	147	36%	198	48%

*This study collected data at sites in the city limits of Dallas, but did not specify the residence of the respondents

Table 14: HIV risk behavior in HIV-negative high-risk heterosexuals over the last 12 months, Dallas 2013

	N	Ave. number of opposite-sex partners	Had condomless sex with a partner of the opposite sex	Exchanged money or drugs for sex		Had condomless sex with an HIV+ partner		
		N	N	%	N	%	N	%
Total	545	3	233	43%	110	20%	211	57%
White	22	5	12	55%	3	14%	83	59%
Black	467	4	195	42%	103	22%	59	53%
Hispanic	49	2	22	45%	3	6%	47	55%
15-24	65	8	41	63%	13	20%	0	0%
25-34	116	8	82	71%	34	29%	1	0%
35-44	89	5	53	60%	18	20%	0	0%
45+	98	5	51	52%	14	14%	0	0%

HIV risk behaviors in PLWH currently in care

Data in this section come from the Texas and Houston Medical Monitoring Project (MMP) sites. Data are representative of PLWH receiving care in Texas. For more information, please see Appendix A.

The average number of sex partners is higher among White MSM than among other race/ethnicity groups. A large proportion of sexually active MSM living with HIV report having condomless anal sex with a male partner over the past 12 months. However, the data shows that most of these reported acts were with another person living with HIV. This may be an indication of serosorting, a practice of selecting sexual partners of the same HIV status. Serosorting for condomless anal sex still leaves both PLWH and HIV- negative MSM open to STI infections. Self-reported syphilis infection among sexually active MSM is low; however, latent infections can be asymptomatic and may go unnoticed in the absence of regular screening. About a third of MSM respondents also reported drug use, including inject drug use, in the past 12 months. This is concerning, as drug use can lower inhibitions and contribute to high-risk sexual behavior. The proportion of MSM reporting high-risk behavior did not decrease with age. See the summarized results in Table 15.

Sexually active heterosexual persons living with HIV also reported high levels of risk behavior in the past 12 months (Table 16). While they reported fewer sexual partners on average, a higher proportion of heterosexual persons living with HIV reported sex with an HIV-negative or status unknown partner compared to MSM living with HIV. Unlike MSM living with HIV, the proportion of heterosexual persons living with HIV who engage in

high-risk behavior decreased with age. Drug use among heterosexuals living with HIV in the 18- 29 age group is much higher compared to other age groups in both heterosexuals and MSM living with HIV.

Table 15: Indicators of HIV risk in the last 12 months among MSM in care for their HIV infections, Texas 2013-2014

	Ave number of male sex partners		Condomless anal sex with male partner		Condomless anal sex with male partner whose HIV status was discordant or unknown		Self-reported syphilis infection		Used injection or non-injection drugs	
	N	N	N	%	N	%	N	%	N	%
Total	130	5	59	45%	17	14%	21	13%	38	30%
White	45	8	25	54%	7	17%	6	10%	13	30%
Black	42	2	20	45%	5	11%	7	13%	13	27%
Hispanic	40	3	13	34%	5	13%	7	14%	10	29%
18-29	26	7	12	51%	6	24%	3	12%	7	29%
30-39	36	3	20	52%	4	13%	8	16%	14	36%
40-49	39	4	11	29%	3	9%	5	8%	6	17%
50+	29	3	16	52%	4	11%	5	15%	11	38%

* Cell suppressed for numbers less than 3 ** Percentages are weighted

Table 16: Indicators of HIV risk in the last 12 months among sexually active heterosexuals in HIV care, Texas 2013-2014

	Ave number of opposite -sex partners		Condomless vaginal or anal sex with partner of the opposite sex		Condomless vaginal or anal sex with partner of discordant or unknown HIV status		Used injection or non-injection drugs	
	n		n	%	n	%	n	%
Total	122	2	43	36%	28	23%	28	24%
White	18	1	8	47%	4	23%	4	26%
Black	65	1	24	38%	19	30%	16	23%
Hispanic	37	3	11	29%	5	14%	6	20%
18-29	10	2	4	41%	4	41%	6	64%
30-39	26	1	12	44%	8	31%	6	25%
40-49	43	1	16	35%	11	24%	13	30%
50+	43	2	11	30%	5	13%	3	9%

* Cell suppressed for numbers less than 3 ** Percentages are weighted Cell sizes less than 10 may produce unstable estimates

B. HIV CARE CONTINUUM

The HIV Care Continuum for the Dallas EMA

The 2014 HIV Treatment Continuum for local areas has four indicators as depicted by the four bars. The first is the number of people living with diagnosed HIV infections as of the end of 2014. The second bar shows the number of PLWH who had at least one episode of HIV-related treatment. The third bar shows PLWH retained in care, meaning that there were at least two episodes of treatment at least 90 days apart or who had suppressed viral load regardless of the number or spacing of visits. The fourth bar shows the proportion of PLWH had suppressed viral load at the end of the year. This information is created by merging information from disease surveillance with several sources of information on treatment and care. They include program data from treatment providers in the Ryan White HIV/AIDS Program, information from Texas Medicaid and from some private health plans.

The corresponding pie charts with each cascade show each individual in an exclusive grouping as opposed to cumulative groupings, as is the case with the bar graphs (Figure 32). For example, for the Dallas EMA, both the bar and pie graphs show the status of the 19,389 PLWH along the treatment cascade. However, the bar graph is cumulative. Out of the 19,389 PLWH in 2014, there were 15,298 that had at least one episode of HIV-related treatment, and of that group, 13,920 were retained in care, and 11,535 of the individuals retained in care were virally suppressed. However, the pie graph to its right shows that out of the 19,389 PLWH in 2014: there were 4,091 that were not in care; there were 1,378 that had limited care; there were 2,385 that were retained in care, but without viral suppression; and, there were 11,535 that were virally suppressed (as also depicted in the bar graph). The pie graph counts each individual once, in one exclusive group and is used to describe the intensity of engagement with the care system: PLWH with no HIV-related care, with limited care (only one visit for PLWH with non-suppressed viral load), PLWH who are retained in treatment but who are not virally suppressed, and those who have suppressed viral load.

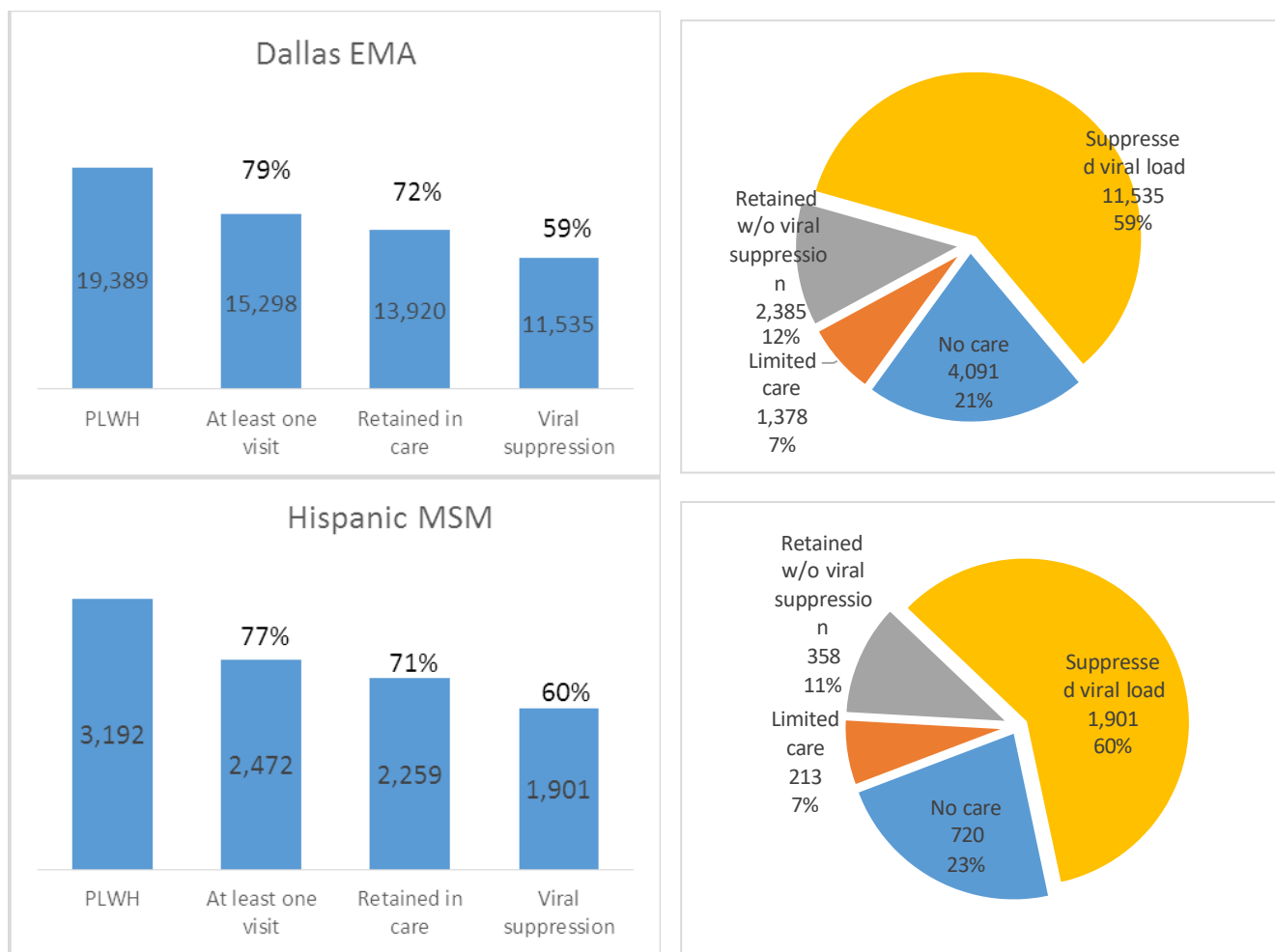
In 2014, almost four out of five of the Dallas PLWH had at least one HIV-related health visit, 72% were retained in care, and 59% were virally suppressed at the end of the year (Figure 32

Table). The best outcomes were for Whites and those 45 and older, two groups with a great deal of overlap (Table 17).

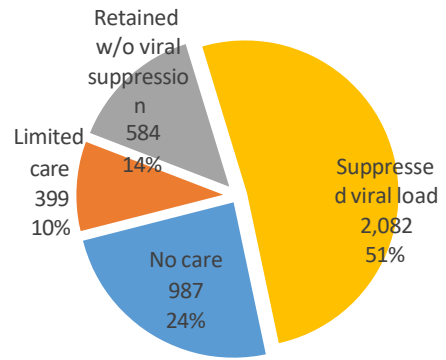
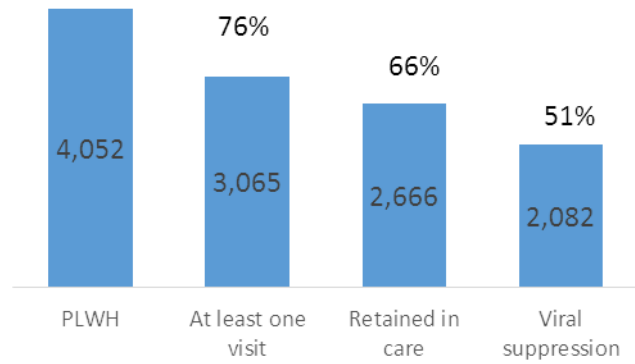
Of the priority populations, Black women and Black MSM had similar rates of retention, proportions of people with no care, and of people who were retained but not virally suppressed. At the state level, however, the suppression outcome for Black MSM can be at least partially explained by a lower estimated level of ART use.

Younger PLWH had much lower levels of participation in treatment and of viral suppression, as did IDU. Both of these were smaller populations at the opposite ends of the age spectrum. Almost all of the younger PLWH were MSM of color, particularly Black men (Table 18).

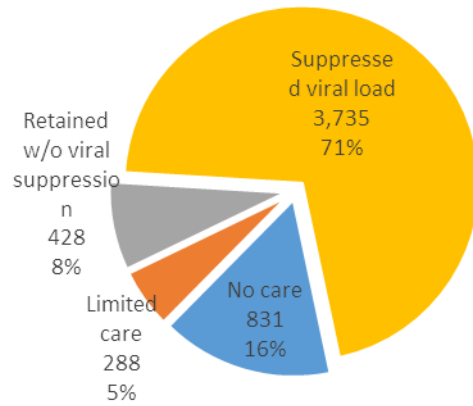
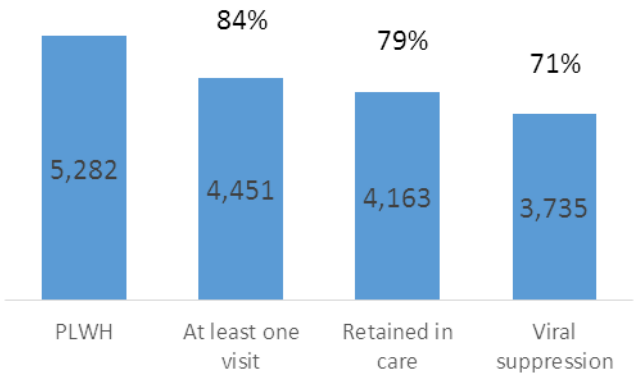
Figure 32: Treatment Cascade and participation in treatment, Dallas EMA 2014



Black MSM



White MSM



Black women

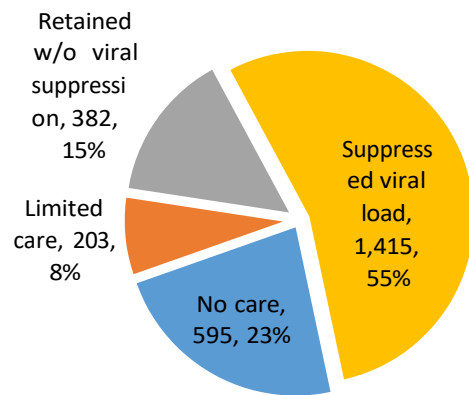
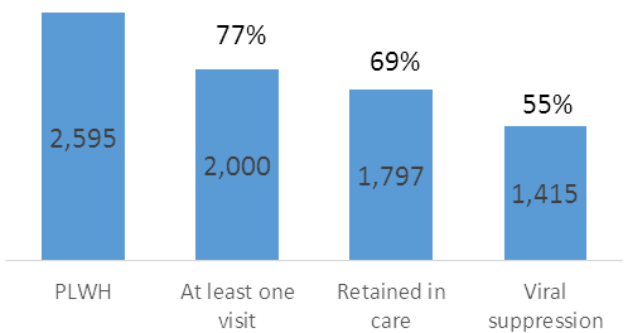


Table 17: Treatment cascades in Dallas by subpopulations, 2014

	PLWH	At least one visit		Retained in care		Suppressed viral load	
All PLWH	19,389	15,298	79%	13,920	72%	11,535	59%
Males	15,538	12,302	79%	11,210	72%	9,375	60%
Women	3,851	2,996	78%	2,710	70%	2,160	56%
Whites	6,327	5,285	84%	4,930	78%	4,363	69%
Blacks	7,884	5,961	76%	5,267	67%	4,095	52%
Hispanics	4,243	3,253	77%	2,986	70%	2,484	59%
15-24	948	738	78%	528	56%	354	37%
25-34	3,682	2,809	76%	2,386	65%	1,835	50%
35-44	4,848	3,763	78%	3,422	71%	2,778	57%
45-54	6,204	5,043	81%	4,765	77%	4,070	66%
55+	3,667	2,905	79%	2,780	76%	2,472	67%
MSM	13,133	10,508	80%	9,575	73%	8,117	62%
IDU or MSM-IDU	2,146	1,654	77%	1,508	70%	1,134	53%
Heterosexual	3,953	3,018	76%	2,726	69%	2,206	56%
White MSM	5,282	4,451	84%	4,163	79%	3,735	71%
Black MSM	4,052	3,065	76%	2,666	66%	2,082	51%
Hispanic MSM	3,192	2,472	77%	2,259	71%	1,901	60%
Black Women⁹	2,595	2,000	77%	1,797	69%	1,415	55%

⁹ This group includes all Black women and not only Black heterosexual women.

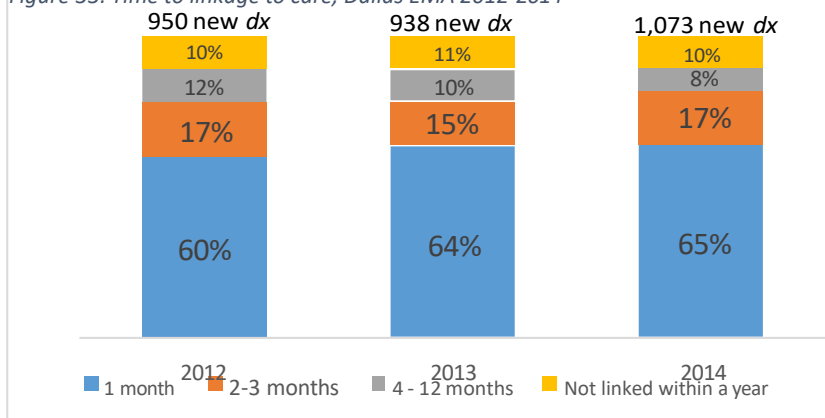
Table 18: Participation in HIV Treatment, Dallas EMA 2014

	PLWH	No Care		Limited Care		Retained but not suppressed		Viral suppression	
All PLWH	19,389	4,091	21%	1,378	7%	2,385	12%	11,535	59%
Men	15,538	3,236	21%	1,092	7%	1,835	12%	9,375	60%
Women	3,851	855	22%	286	7%	550	14%	2,160	56%
Whites	6,327	1,042	16%	355	6%	567	9%	4,363	69%
Blacks	7,884	1,923	24%	694	9%	1,172	15%	4,095	52%
Hispanics	4,243	990	23%	267	6%	502	12%	2,484	59%
15-24	948	210	22%	210	22%	174	18%	354	37%
25-34	3,682	873	24%	423	11%	551	15%	1,835	50%
35-44	4,848	1,085	22%	341	7%	644	13%	2,778	57%
45-54	6,204	1,161	19%	278	4%	695	11%	4,070	66%
55+	3,667	762	21%	125	3%	308	8%	2,472	67%
MSM	13,133	2,625	20%	933	7%	1,458	11%	8,117	62%
IDU or MSM-IDU	2,146	492	23%	146	7%	374	17%	1,134	53%
Heterosexual	3,953	935	24%	292	7%	520	13%	2,206	56%
White MSM	5,282	831	16%	288	5%	428	8%	3,735	71%
Black MSM	4,052	987	24%	399	10%	584	14%	2,082	51%
Hispanic MSM	3,192	720	23%	213	7%	358	11%	1,901	60%
Black Women	2,595	595	23%	203	8%	382	15%	1,415	55%

Linkage to HIV treatment for persons newly diagnosed in 2012 -2014

Linkage to medical care after an HIV diagnosis is an important first step in getting the treatment needed to live a long, healthy, and productive life, and it is important that care not be delayed. When timely linkage is referenced in this section, it refers to getting HIV care within three months of diagnosis. CD4 and viral load tests, outpatient visits, and filled prescriptions for antiretroviral medications were used as markers of care. The counts

Figure 33: Time to linkage to care, Dallas EMA 2012-2014



of new diagnoses in this section exclude people who died before the end of the year of their diagnosis, so these figures will not match those given earlier in this report.

Figure 33 shows that 82% of Dallas EMA residents who were diagnosed in 2014 were linked to care within three months of their diagnosis, up from 77% in 2012. In Dallas, as in the rest of the state, most people were linked

within 30 days of their diagnosis.

When evaluating timely linkage in subgroups, information for 2012-2014 was combined; looking at combined data makes the comparisons more reliable. Figure 34 shows that Black MSM linkage rates are lower than the other priority groups – about 75% compared to around 81%. Linkage rates for younger EMA residents are also low; most of the new diagnoses in those under 35 years of age are in Black MSM and, to a lesser extent, Hispanic MSM.

Figure 34: Timely linkage to care in HIV Plan priority populations, Dallas EMA 2012-2014

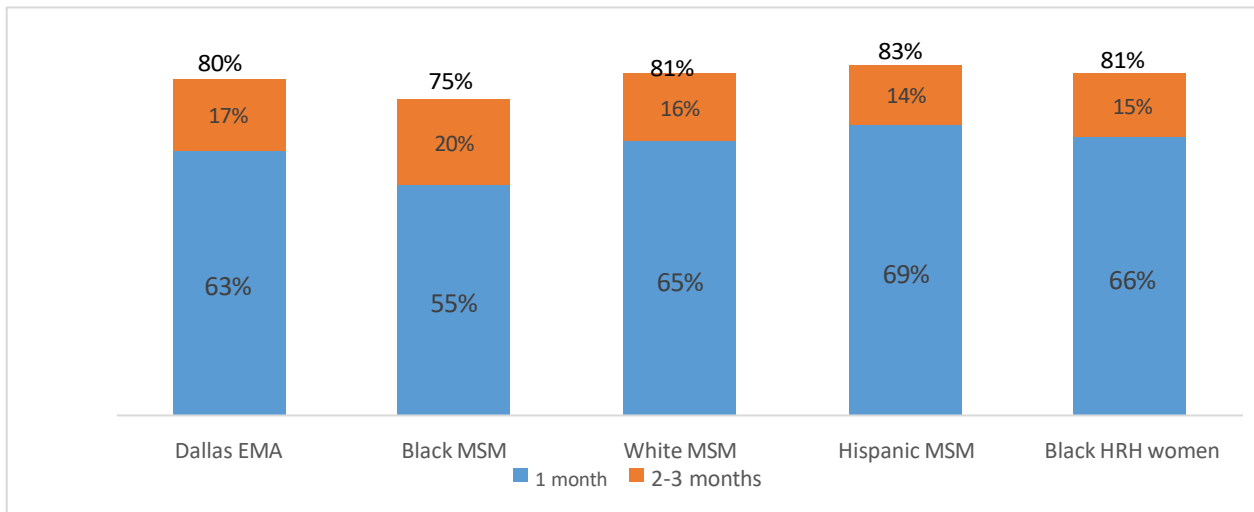
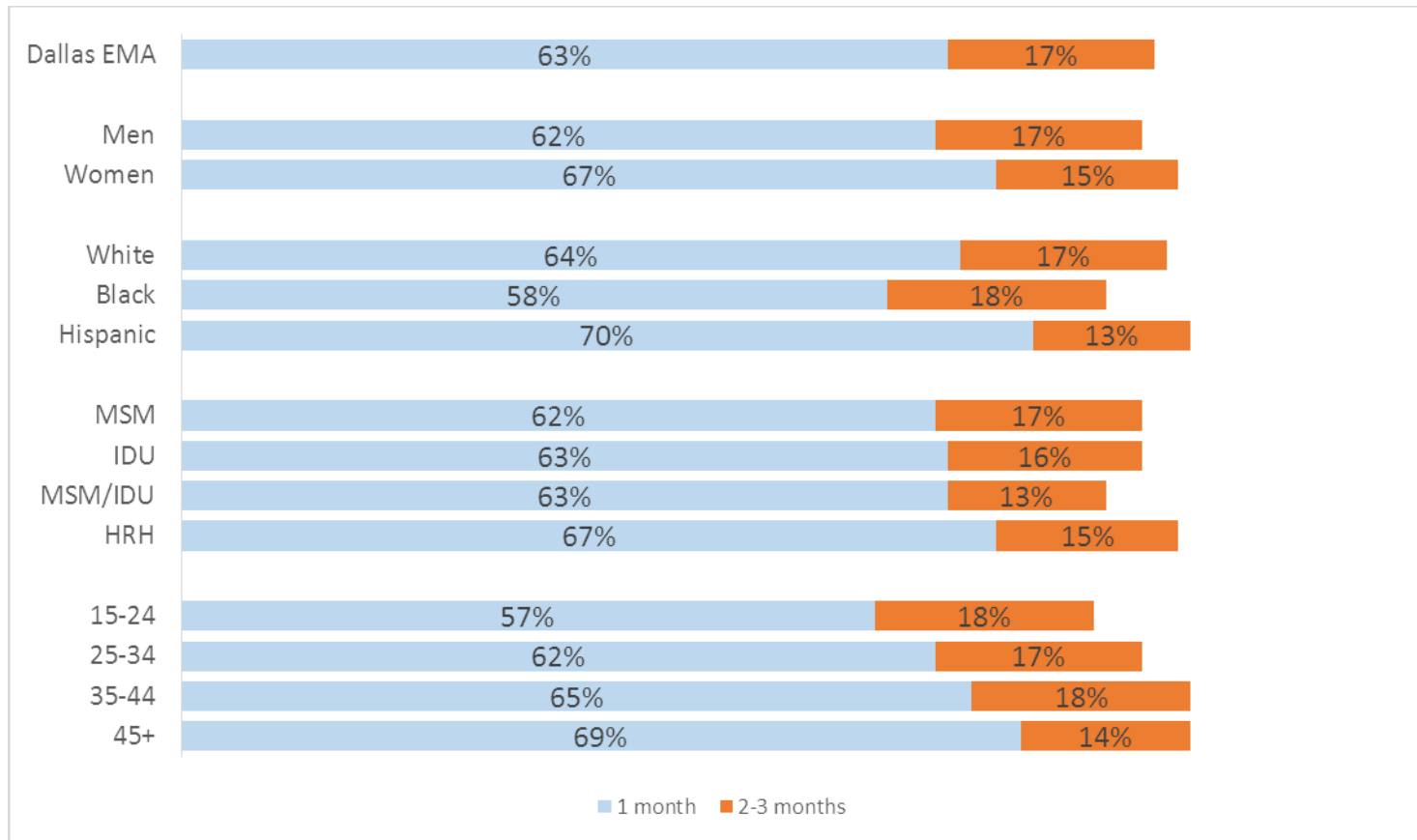


Figure 35: Timely linkage to care by selected characteristics, Dallas EMA 2012-2014



The HIV Care Continuum is utilized in planning, prioritizing, targeting, and monitoring available resources in response to the needs of PLWH in the jurisdiction. 13,133 of the 19,389 PLWH in 2014 were MSM. This was the basis for breaking this down and identifying White MSM, Black MSM, and Hispanic MSM as three out of our four priority populations. The Dallas EMA also utilizes Minority AIDS Initiatives funds that specifically fund services for people of minority race and ethnicities.

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

a. Jurisdictional HIV resources Inventory

An inventory of jurisdictional HIV resources, including prevention and care, is included in the table on the next page.

		Financial and Human Resources Inventory		Funding Source							
		2015 Budget		Anticipated 2016 Budget							
	Amt / %	Amt / %									
RW Part A	\$16,094,168 / 46.07%	\$16,094,168 / 47.75%	X								
RW Part B	\$3,820,464 / 10.94%	\$3,787,260 / 11.24%	X	X							
RW Part C	\$1,124,774 / 3.22%	\$1,124,774 / 3.34%	X								
RW Part D	\$2,064,336 / 5.91%	\$2,064,336 / 6.13%	X	X							
RW Part F **	\$2,871,145 / 8.22%	\$2,871,145 / 8.52%		X	X						
CDC	\$3,479,649 / 9.96%	\$3,479,649 / 10.32%									
SAMHSA	\$1,898,964 / 5.44%	\$698,964 / 2.07%		X							
HOPWA	\$1,962,719 / 5.62%	\$1,962,719 / 5.82%			X						
TX DSHS	\$1,620,199 / 4.64%	1,620,199 / 4.81%	X								
TOTAL:	\$34,936,418	\$33,703,214									
** RW Part F funding focus is on the AIDS Educational Training Center Program, which trains diverse groups of clinicians and works w/ other multidisciplinary HIV care team members.											
						HIV TESTING, PREVENTION & LINKAGE					
						HIV PREVENTION – ROUTINE TESTING					
						CORE MEDICAL RELATED SERVICES					
						Outpatient/Ambulatory Health Services					
						AIDS Drug Assistance Program Treatments					
						AIDS Pharmaceutical Assistance					
						Oral Health Care					
						Early Intervention Services (EIS)					
						Health Ins. Premium & Cost Sharing Assistance					
						Home Health Care					
						Home & Community Based Health Services					
						Hospice Services					
						Mental Health Services					
						Medical Nutrition Therapy					
						Medical Case Management including Treatment Adherence Services					
						Substance Abuse Outpatient Care					
						Substance Abuse Services -Residential					
						SUPPORTIVE SERVICES					
						Non-medical Case Management Services					
						Child Care Services					
						Emergency Financial Assistance					
						Food Bank/Home Delivered Meals					
						Health Education/Risk Reduction					
						Housing					
						Legal Services - See Other Professional Services					
						Linguistic Services					
						Medical Transportation					
Other Professional Services											
Outreach Services											
Psychosocial Support Services											
Referral for Health Care & Support Services											
Rehabilitation Services											
Respite Care											

b. Provide a narrative description of the HIV Workforce Capacity in the jurisdiction and how it impacts the HIV prevention and care service delivery system.

Workforce needs

In order to serve the needs of PLWHA as well as those at risk for HIV, the Dallas jurisdiction needs a diverse workforce comprising of individuals with different educational backgrounds, expertise and experience. This includes physicians and mid-level practitioners who have expertise in HIV medical care as well as those who are able to treat co-occurring conditions and have an excellent understanding of both the medical and psychosocial needs of PLWHA. The workforce must also comprise of allied health professionals who have the willingness and competence to work in the HIV arena, including navigators, counselors, outreach workers, intervention specialists and others who are willing and able to work with people at multiple levels. In addition to prevention and treatment modalities, it is imperative that providers at all levels are knowledgeable about trauma informed care, strengths-based and solution-focused counseling, motivational interviewing, harm reduction techniques and providing culturally and linguistically appropriate services (CLAS).

Capacity and Needs

The Dallas jurisdiction is home to two medical schools as well as schools which provide baccalaureate and graduate degree programs in nursing, allied health, social work, public health and other relevant disciplines. The area also has several Federally Qualified Health Centers and major health systems and is home to the South Central AIDS Education and Training Center (AETC).

In spite of the resources available, the Dallas area faces severe workforce challenges related to capacity and competence with regard to HIV care, treatment and prevention.

- HIV education and training have not been areas of focus in most professional education programs.
- Care for PLWHA and HIV prevention services have traditionally been concentrated among a few selected providers which has translated to the need for increased training and education among non-HIV providers regarding the nuances of providing care to PLWHA and effective strategies for preventing HIV acquisition among those who are at risk.
- Inadequate competence among non-HIV providers regarding the treating PLWHA with co-occurring conditions including mental health and substance use disorders in order to optimize outcomes.
- An aging workforce and a declining supply of clinicians with HIV experience are causing medical provider shortages which will have a critical impact on the effective delivery of HIV health care.
- An aging population of PLWHA and the complexity of HIV treatments leading to higher consumption of health care services resulting in increased caseloads/visits in the context of inadequate capacity.
- Increased HIV prevalence leading to increased demand for HIV related services.
- Diminished provider reimbursement as a result of static or falling public funding may impact the jurisdiction's ability to increase and improve HIV workforce capacity.

- An increase in racially and ethnically diverse, as well as younger populations living with and at risk for HIV, increases the demand for a culturally competent workforce reflective of the population served. Unfortunately, the health care professions do not in general mirror the population being served.
- Stigma, prejudice, and concerns related to the complexity of HIV care medical and other service providers in the Dallas area are persistent barriers to providing effective care.

c. Provide a narrative description of how different funding sources interact to ensure continuity of HIV prevention, care, and treatment services in the jurisdiction.

Dallas area organizations that serve the HIV *positive* community have historically worked together to ensure that HIV positive people have access to necessary services on the continuum of care. However, the interactions between prevention focused services and those that provide care for the broader community have been more sporadic and may be defined by specific projects rather than systematic processes. Several strong partnerships exist between individual community based organizations (CBOs), between the local health department – Dallas County Health and Human Services and CBOs, and between other relevant organizations based on need. Collaborations may be informal or formalized through memoranda of understanding or service agreements. In addition, the Texas Department of State Health Services, the Ryan White Planning Council and other planning bodies facilitate interaction between various entities.

d. Provide a narrative description identifying any needed resources and/or services in the jurisdiction which are not being provided, and steps taken to secure them.

The Dallas area has some significant deficits in terms of key resources both for prevention and treatment:

(i) Almost no resources are available for uninsured or under insured individuals at high risk for HIV to access Pre-exposure prophylaxis (PrEP) or Non- Occupational Post Exposure Prophylaxis (nPEP). Whereas counseling and education resources are available through various sources there are almost no health care providers who will provide PrEP to people without insurance.

(ii) Mental health treatment capacity is extremely limited especially for those without health insurance and/or documentation. When people needing services are finally able to access them, they may have dropped out of care or may no longer be motivated to access care.

(iii) Substance abuse treatment capacity is inadequate both in terms of inpatient and outpatient treatment services. The situation is exacerbated for those without health insurance and documents and leads to significant challenges.

(iv) Specialty care is limited for people who are uninsured or under-insured. In addition, for those who have obtained health insurance through the marketplace, access is curtailed because of extremely narrow provider networks. Access to care is negatively impacted in Texas as a whole because it did not expand Medicaid.

Steps to address gaps:

Stakeholders have taken multiple steps both independently and in collaboration to address the gaps in resources by seeking additional funding, educating policy makers, the community and others, as well as through strategic partnerships.

D. ASSESSING NEEDS, GAPS, AND BARRIERS

a. Describe the process used to identify HIV prevention and care service needs of people at higher risk for HIV and PLWH (diagnosed and undiagnosed).

The Dallas Planning Area conducts a comprehensive needs assessment¹⁰ in order to identify care and service needs of people at higher risk for HIV and people living with HIV (PLWH). The latest needs assessment in this area was the 2013 Comprehensive HIV Needs Assessment. Data included in this needs assessment were population counts from the 2000 and 2010 Census, estimates for the 2012 population by county, as well as socioeconomic indicators such as income, poverty, and race/ethnicity. The needs assessment also included data from the Texas Department of State Health Services (DSHS) for the epidemiological profile, which reflected information on the epidemic in the entire Dallas Planning Area. Information collected during routine surveillance included HIV and AIDS morbidity and mortality data, focusing on data trends between 2008 and 2012, sexually transmitted diseases, and tuberculosis, and unmet need estimates which identify the number of people who are HIV-positive and out-of-care/returned to care.¹¹

Consumer survey

In addition to the data gathered and information obtained for the 2013 Comprehensive Needs Assessment, a survey of 637 people living with HIV was conducted during December 2013. This included 448 (70%) consumers receiving HIV medical care and 189 (30%) who were out-of-care/returned to care. The goal in designing the consumer survey was to obtain the desired information using the shortest, most consumer-friendly approach.

The survey was designed to obtain information about in-care, out-of-care/returned to care and each special population. It included questions in the following areas:

- Initial screening of PLWHA to determine whether they were in-care or out-of-care/returned to care and met the survey sampling criteria.
- Questions identifying reasons for being out-of-care, problems associated with HIV medical care and/or for dropping out of care.

¹⁰ Ryan White Planning Council for the Dallas Area, Comprehensive HIV Needs Assessment, 2013, published at www.dallascounty.org/departments/rwpc/hiv_needsassessment.php

¹¹ 2013 Out-of-care Criteria. PLWHA qualified to participate in the out-of-care interviews if they met one of the following criteria: (1) Not currently receiving HIV medical care, with at least 12 months since the last medical appointment. This is the HRSA definition of "out-of-care" which is "no HIV medical care, no viral load or CD4 counts and no antiretroviral medications in the last 12 months." These people may or may not be receiving other Ryan White or HIV services. (2) Diagnosed between 2010 and 2013 that failed to link to care within six months of diagnosis. They may currently be in care. (3) Diagnosed between 2010 and 2013, linked to care after diagnosis but dropped out-of-care for at least six months. They may now be back in care. (4) Dropped out-of-care for at least 12 months but are now back in care. They should have been back in care for no more than two years. (5) Began care in either 2012 or 2013 after no linkage to care after diagnosis. These people may be in care now, and may have been diagnosed at any time in the past.

- Information about diagnosis and linkage to care.
- Barriers to HIV medical care.
- Questions about current housing situations and housing service options.
- Use of and need for 26 different services most of which can be funded by Ryan White and are included in the RWPC's Continuum of Care.
- Substance abuse treatment service needs.
- Questions about the impact of the Affordable Care Act.
- Ranking of the most important/critical service needs.

A pure random sample was not feasible in this situation since it requires that every PLWHA in the Dallas region has an equal probability of selection for the survey. Therefore, a stratified convenience sample was used.

- The sampling plan that conformed to the profile of the epidemic was developed, but the final sample was more reflective of Ryan White AIDS Regional Information and Evaluation System (ARIES) consumers. This was due to:
 - Expedited survey completion timetable
 - Remote survey completion
 - Oversampling of special populations of Black/African-American men and women and Hispanic/Latino men and women.
- Out-of-care/returned to care, homebound/disabled, and other consumers were able to access the survey on-line.

Out-of-care interviews

Ryan White funded and non-funded agencies were approached to access out-of-care consumers who were willing to participate in the interview process, though referrals only came from Ryan White funded agencies. In the end, reaching out of care PLWH proved to be difficult and only 30 interviews were completed. These responses are included in the qualitative portion of this report.

Data Analysis

Using on-line survey format, immediate tabulation of all consumer responses was possible. During the course of the field work, respondent profiles were used to analyze the composition of the sample. The profiles included the number surveyed from each priority population, sample demographics, transmission mode, and county of residence. Once the surveys were completed, the data were reviewed and cleaned prior to analysis with the eCOMPAS survey system.

Respondent Overview

Survey respondents conformed to the ARIES profile of Ryan White funded service users more than to the overall epidemic with regard to gender and race.¹² The age profile of respondents showed they were older than those reflected in the regional epidemic or those using services. These issues were reviewed with the Needs Assessment Work Group and they determined that the sample should be accepted in that it was representative of the Ryan White funded population.

¹² For the respondent overview, epidemiology data are obtained from Texas DSHS HIV Surveillance, 2012 and ARIES data are obtained from DCHHS, December 1 2012 through November 30, 2013.

- Gender of the survey sample was very close to that found in the population using services (Table 19). The survey sample included 76% male respondents and 23% female. This compared to 78% males and 23% females infected in the region.
 - The epidemic included 20% female and 80% male. No transgender individuals were reflected in the data on the epidemic. Although those receiving services were 0.5% transgender and those in the survey represented 1.8%.
 - Provider key informants suggested ARIES data may under-represent transgender as some may be included using their birth gender.

Table 19			
Comparison of Consumer Survey Sample with Regional Epidemic			
Gender			
Gender	Epidemiology n=17,840	ARIES n=9,225	Consumer Survey n=615
Female	19.7%	21.9%	22.6%
Male	80.3%	77.6%	76.3%
Transgender	NA	0.5%	1.8%

- Considering race, Whites/Caucasians were under-represented in the survey sample when compared to the epidemic, but closely resembled the in-care population (Table 20). Whites/Caucasians comprised 36% of the regional epidemic but were 28% of the survey sample. Whites/Caucasians were 29% of the population receiving services. Black/African-Americans made up 41% of the epidemic but were 48% of the sample, and 46% of those receiving services. Hispanics comprised 22% of the epidemic and of those surveyed, but were 21% of those receiving services.

Table 20			
Comparison of Consumer Survey Sample with Regional Epidemic			
Race/Ethnicity			
Race/Ethnicity	Epidemiology n=17,292*	ARIES n=9,225	Consumer Survey n=615
White/Caucasian	36.5%	29.0%	27.8%
Black/African-American	40.7%	46.4%	48.3%
Hispanic/Latino	21.6%	21.5%	18.9%

*Number of PLWHA with known Race/Ethnicities.

In terms of transmission modes:

- Survey respondents' most frequently identified transmission mode were male-to-male sex (MSM) with 47% identifying this mode (Table 21). It compared to 67% of the epidemic reporting MSM transmission mode, and 56% of those in care.
- Heterosexual transmission was identified by 37% of survey respondents compared to 20% of the epidemic, and 28% in care.

- Shared needles/injecting drug use (IDU) was identified by 10% of those surveyed. This compared to 8% IDU in the regional epidemic and 4% of those in care.

Transmission Mode	Epidemiology n=17,841	ARIES n=9,225	Consumer Survey n=615
MSM	67.2%	55.8%	46.7%
IDU	7.6%	4.4%	9.6%
Heterosexual	19.9%	28.4%	37.2%

Considering age of respondents, the sample was older than the regional epidemic (Table 22).

- The sample and the epidemic include approximately 2% of PLWHA in the 13 to 24 age range.
- The 25 to 44 age group comprises 45% of the epidemic and 36% of the survey sample.
- The 45+ age group is 49% of the epidemic and 62% of the sample.

Age Group	Epidemiology n=17,840	ARIES n=9,225	Consumer Survey n=615
<2	0.0%	0.0%	0.0%
2-12	0.2%	0.4%	0.2%
13-24	5.4%	5.2%	3.4%
25-44	45.0%	46.5%	34.5%
45+	49.4%	47.9%	62.0%

As is the case with the administration of large scale surveys, some data limitations were identified. Many of these were minimized by having the survey read to consumers with low literacy and by automated skip logic so that question sequencing was done seamlessly for consumers. Nevertheless, potential survey limitations were:

- The in-care survey was primarily administered through Ryan White funded agencies. Thus, a larger percentage of PLWHA who qualify for Ryan White services may be represented.
- Misunderstanding or misinterpreting words or terms. This was minimized by previous survey validation and review of survey wording by a health literacy expert.
- Forced selection of responses without the options of “not applicable,” “don’t know” or “refused.”
- The possibility of selecting contradictory responses which was minimized using the on-line survey skip logic.

Provider Focus Group Discussions

Three focus groups directly with service providers offered additional insight into consumer needs for the broad cross section of clients they served.

- Two of the groups were comprised of Ryan White funded medical and non-medical case managers, who interacted with clients daily.
- The third focus group was conducted with Ryan White funded and non-funded outreach, counseling and testing, and linkage to care providers. Non-Ryan White funded participants of this group received a \$70 honorarium.

The Needs Assessment Work Group identified the number of case managers from each Ryan White funded agency to invite.

The prevention/linkage to care group was conducted in February 2014. Deferring this group allowed identification of areas for further research after results had begun to be compiled. This group was selected based on the limited out-of-care/return to care consumer participation.

Provider focus groups were planned to gain in depth, detailed information to enhance the understanding of client needs, including special populations, service gaps, barriers to care, impact of health care reform, reasons for consumers not receiving care, changes in the epidemic since 2010, and suggestions to improve care within the current funding environment.

Focus Group Analysis

For both consumer and provider focus groups, verbatim transcriptions were made from voice recorders. All responses were grouped by theme and commonality of response. Results are included in this report by theme, service category, and relevant priority population.

The provider focus group discussion was limited by:

- All participants of the case manager focus groups worked for Ryan White funded agencies.
- Not all agencies were represented.

GAP Analysis

The gap analysis utilizes the results of the consumer survey along with the provider focus groups, out-of-care consumer interviews, key informant interviews, provider survey and the provider inventory to inform the analysis. In doing so, the following issues were considered:

- How highly the service was ranked by survey respondents.
- The unfulfilled need ranking of respondents.
- The current availability and capacity as reported by the provider survey and inventory.
- The degree of difficulty consumers reported when attempting to access the service.
- The percent of respondents experiencing barriers, and qualitative information obtained through interviews and focus groups.

b. Describe the HIV prevention and care service needs of persons at risk for HIV and PLWH.

Table 23 shows the rankings for the total service needs of PLWH from the 2013 HIV Comprehensive Needs Assessment. This table breaks the data down by the total sample, in-care respondents, and out-of-care respondents. As shown below, dental care was ranked the highest need of the total sample, as well as among both in-care and out-of-care respondents. 64% of respondents reported a need for dental care. Dental care was also the third highest ranked unfulfilled need for all three groups. HIV outpatient medical care was the second highest overall ranked need with 56% of respondents reporting a need for the service, but this service was not ranked nearly as high insofar as being an unfulfilled need. Food bank was ranked the third highest need with 43% of respondents reporting a need. Emergency long-term rental assistance was ranked the highest unfulfilled need out of all of the services.

SERVICE	TOTAL SAMPLE			IN-CARE		OUT-OF-CARE	
	Total Need Rank	% of Need reported in the sample	Unfulfilled Need Rank	Total Need Rank	Unfulfilled Need Rank	Total Need Rank	Unfulfilled Need Rank
Dental Care	1	63.5%	3	1	3	1	3
HIV Outpatient Medical Care	2	55.7%	11	2	12	2	12
Food Bank	3	43.2%	6	3	6	3	4
Help Paying for Prescription Medications	4	41.8%	8	4	7	4	9
Primary Medical Care for general medical care not related to HIV	5	29.6%	7	5	9	6	5
Medical Care from a Specialist referred by your HIV doctor	6	27.5%	16	6	15	7	16
Emergency Long-Term Rental Assistance (Voucher)	7	27.4%	1	8	1	5	1
Help paying for co-pays and deductibles for HIV medical care visits and medications	8	26.4%	10	7	10	9	14
Mental Health Counseling	9	24.2%	21	10	21	8	17
Medical Case Management	10	23.3%	4	11	4	11	6
Transportation to Medical Care—Bus Pass/Van Service	11	23.0%	18	9	18	13	19
Emergency Financial Assistance for Rent/Mortgage or Utilities	12	22.5%	2	12	2	10	2
Nutritional Counseling	13	19.6%	13	14	13	11	11
Employment Services	14	17.4%	14	15	17	15	8

Table 23
Total Sample, In-Care and Out-of-Care
Service Need Ranking

SERVICE	TOTAL SAMPLE			IN-CARE		OUT-OF-CARE	
	Total Need Rank	% of Need reported in the sample	Unfulfilled Need Rank	Total Need Rank	Unfulfilled Need Rank	Total Need Rank	Unfulfilled Need Rank
Transportation to Other Services	15	17.1%	20	13	20	16	20
Job training Services	16	16.7%	15	16	14	14	12
Education Services	17	14.9%	12	16	11	17	18
Payment to continue health insurance	18	14.5%	19	18	16	19	21
Legal Services	19	13.2%	17	19	19	21	15
Non-Medical Case Management	20	13.2%	9	20	8	17	10
Facility Based Housing (Assisted Living Facility)	21	10.4%	5	21	5	20	7
Respite Care for Adults	22	6.4%	24	22	24	23	24
Outpatient Substance Abuse Treatment	23	6.4%	25	23	26	22	23
Early Intervention to help you get into HIV medical care (Out-of-Care Only) ¹³	24	5.5%	22			24	22
Translation or Interpretation	25	5.5%	26	26	25	25	27
Child Care while at a medical or other appointment	26	5.0%	23	24	23	26	25
Respite Care for HIV positive Children	27	4.6%	27	27	27	26	26

c. cribe the service gaps (i.e., prevention, care and treatment, and necessary support services e.g. housing assistance and support) identified by and for persons at higher risk for HIV and PLWH.

GAP ANALYSIS

The gap analysis utilized the results of the consumer survey along with the provider focus groups, out-of-care consumer interviews, key informant interviews, provider survey and the provider inventory to inform the analysis. In doing so, the following issues were considered:

- How highly the service was ranked as needed by survey respondents.
- The unfulfilled need ranking of respondents.
- The current availability and capacity as reported by the provider survey and inventory.
- The degree of difficulty consumers reported when attempting to access the service.

¹³ This question was only asked of out-of-care clients.

- The percent of respondents experiencing barriers, and qualitative information obtained through interviews and focus groups.

Gap analysis per service category according to the 2013 HIV Comprehensive Needs Assessment:

HIV OUTPATIENT/AMBULATORY MEDICAL CARE

Medical services ranked as extremely important with consumers. HIV medical care was ranked second in need and eleventh in unmet need. Primary medical care not related to HIV ranked fifth in need and seventh in unmet need. Specialty care ranked sixth in need and sixteenth in unmet need. The amount of time it takes at the clinic and transportation concerns were the top hardships in getting HIV outpatient medical care. Thirty percent of consumers had an unmet need for HIV medical care.

Thirty-six percent of consumers reported an unmet need for primary care services. The most frequently mentioned barrier to primary care was “to get all my care from my HIV doctor.” Focus groups confirmed that regular GYN screenings for mammograms and pap tests were among the hardest referrals to get.

Twenty-eight percent of respondents indicated an unmet need for specialty care. With PLWHA living longer, the likelihood of developing a chronic condition will only continue to increase. Forty-eight percent of survey respondents reported a chronic disease condition.

Focus group discussions focused primarily on the difficulty of obtaining primary and specialty care services for patients and the extremely long waits for appointments. Another issue discussed was the amount of time, and the paperwork burden for those seeking HIV outpatient medical care.

Information from the provider capacity survey suggested that limited resources would make it difficult to expand capacity.

EARLY INTERVENTION SERVICES

Early intervention services were ranked among the lowest service needs by those out-of-care (twenty-fourth). It was also ranked twenty-second in terms of unmet need. Information obtained from focus groups suggest that post-test counseling was not always provided or provided effectively. Barriers to the service included a lack of knowledge and the paperwork burden. Services must have been delivered in a culturally competent manner to ensure the individual received referral and linkage to essential services. The system in 2013 had capacity for 75 additional patients. Unless services are improved, demand is likely to remain low.

HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE

Help in paying for continued insurance ranked eighteenth in need and nineteenth in unfulfilled need. Twenty-five percent of consumers indicated an unmet need for this service.

Based on survey responses from providers, the availability of resources was unlikely to meet the need.

Helping paying for co-pays and deductibles for HIV medical care visits and medications ranked eighth in need and tenth in unmet need. Thirty-one percent of consumers reported an unmet need for this service. Out-of-care consumers indicated that the cost of medications was both a barrier and a reason for PWLHA dropping out-of-care. According to the survey, the largest barriers to getting assistance with co-pays and deductibles were

the lack of consumer knowledge about the service and amount of paperwork involved. Although the need for this service ranked in the top third, available resources were unlikely to meet the need.

MEDICAL CASE MANAGEMENT

Medical case management ranked tenth in need but fourth in unmet need. Forty-three percent of consumers indicated their needs for this service were unmet. The primary barrier to the receipt of medical case management services were that the case manager was not available/hard to reach, identified by 30%, with an additional 18% indicating the case manager does not follow-up and too much paperwork. Since 2007, the unfulfilled need for case management services has increased. According to provider focus group participants, case loads were unmanageable and the paperwork burden was so great that most felt that establishing eligibility and performing updates had become the bulk of their work.

Two-thirds of the agencies providing case management had wait times of less than a week to four weeks for an appointment. The system reported an additional capacity for 25 clients which was far below that required to meet the unfulfilled need identified in the survey.

MEDICAL NUTRITION THERAPY-COUNSELING

Consumers gave medical nutritional counseling a mid-level service need ranking (thirteenth). Eighty-six percent of consumers reported that their need for this service was easily met. Thirty percent indicated an unmet need, including 35% of those out-of-care consumers with an unmet need. Limited additional capacity was available to those needing the service.

AIDS DRUG ASSISTANCE PROGRAM AND AIDS PHARMACEUTICAL ASSISTANCE (LOCAL)

Help paying for medications was the fourth ranked service, and the eighth ranked unfulfilled need. Seventy-five percent of consumers found the service easy to access and 36% had an unfulfilled need. Respondents identified lack of knowledge of the services as the largest barrier to receiving pharmaceutical assistance. This was followed by high co-pays and deductibles and "I didn't qualify." Medication assistance was one of the most needed services and like many of the top rated need services there was little expansion capacity within the funded agencies to fulfill needs.

MENTAL HEALTH SERVICES

Mental health counseling ranked ninth overall in need and twenty-first in unfulfilled need. Twenty-four percent of consumers identified an unfulfilled need. Individuals who used mental health services tended to be in-care. Among survey respondents, 72% of those using services were in-care.

Nearly a third of survey respondents had been diagnosed with depression within the last 12 months. Black/African-American women (36%) followed by MSM (32%) had the highest percentage of depression. The primary barrier to receiving care as reported by survey respondents was "I didn't know where to go." This was identified by 46% of consumers reporting barriers. The second most frequently identified barrier was "I didn't want to use the service" (18%).

According to the provider inventory, an additional 55 consumers could have been treated by existing providers.

The extent of unfulfilled need combined with existing capacity was consistent with the lack of awareness of available resources and the stigma attached to receiving care for a mental health issue.

ORAL HEALTH CARE

Dental services continued to be the number one need identified by survey respondents. It was ranked third in terms of unfulfilled need. Seventy-four percent of those who did not use the service needed it. The top ranked barrier to receiving care was the long wait to get an appointment, identified by 43% of those indicating a barrier, followed by limited funding (19%).

Information from the provider inventory was illuminating. There were only three Ryan White funded agencies – one had a six week wait, and one had a 30-day wait with the services being referred out with a lengthy referral process. One agency reported the ability to serve an additional 400 people. These findings were corroborated by results from the focus groups which emphasized the long waits for appointments, the high demand for services, and the fact that at least one agency was seeing patients quickly.

Based on focus group responses, it was apparent that reduced funding and the paperwork and the multi-stage referral process had become significant barriers to the receipt of services.

SUBSTANCE ABUSE SERVICES

Half of surveyed consumers reported having used some type of alcohol or street drugs in the past six months. Of that population, one-half had considered seeking substance abuse treatment and reported free treatment or immediate admission to care as the support they believed would help them get treatment. The sizable portion of the population belied the low ranked total need for services and unfulfilled need. In addition, case managers indicated that wait times to enter programs combined with the lack of ongoing support and the paucity of residential treatment programs was also problematic with regard to keeping consumers drug-free. The changing pattern of drug use from IV drugs and crack to meth, and the lack of providers providing services to patients addicted to meth further exacerbated the problem. In addition, the five Ryan White funded providers reported additional capacity for just 20 new clients.

CASE MANAGEMENT (NON-MEDICAL)

The service ranked relatively low in total need (twentieth) but was ninth highest ranked in unfulfilled need. Eighty percent of consumers felt this service was easily obtained. Thirty-five percent of consumers identified an unfulfilled need, which was highest among out-of-care Black/African-American Women and Hispanic/Latino Men and Women. Waiting periods for the service were variable among the Ryan White funded providers and there was existing additional capacity for 50 new clients. Focus groups bore out some continuing confusion about the role and responsibilities of non-medical vs. medical case managers. Among barriers, case manager availability was consumers' primary concern, and the size of existing caseloads was of concern to case managers. Outreach to those populations with the highest unfulfilled needs would ensure that existing additional capacity is utilized effectively.

CHILD CARE SERVICES

Child care services ranked low in terms of total need and unfulfilled need, and has been since 2007. Utilization was low but among those who needed the service the principal barrier to obtaining the service was a lack of knowledge about the service. There was a low availability of additional existing capacity among Ryan White funded providers. Ensuring that the population in need of the service is able to obtain it may require additional education about its availability and purpose.

FOOD BANK / HOME-DELIVERED MEALS

Food Bank services total need and unfulfilled need were highly ranked among both in-care and out-of-care consumers, and has been so since 2007. Eighty-six percent of consumers using the service found it easily obtained and 37% reported an unfulfilled need. The most common barrier to obtaining the service was location/transportation. Four Ryan White funded agencies providing Food Bank services reported a combined existing additional capacity to serve 10 additional clients. Four Ryan White funded agencies providing Congregate Meals reported a combined existing additional capacity to serve 21 additional clients and two agencies providing Home Delivered meals reported additional capacity to serve just one additional client. High utilization, high need ranking and generally high unfulfilled need combined with limited additional capacity and the importance of proper nutrition for PLWHA make this service a critical yet underfunded component of services provided for the PLWHA.

HOUSING SERVICES

The local 2013 Comprehensive HIV Needs Assessment demonstrated that consumers living with HIV considered housing to be a critical need in the Dallas area. Long-term rental assistance ranked the 7th highest overall need and the highest unfulfilled need, and emergency financial assistance for rent/mortgage and utilities as the 12th overall and 2nd highest unmet need, while facility-based assisted living ranked as the 21st highest need and 5th highest unmet need. Up to 27% of consumers who needed housing assistance (and asked for it) did not receive help.

At the time, about 3.9% of HIV+ consumers were homeless on the streets or in a shelter, and identified several housing barriers to HIV care, including having no bed to sleep in, no private place to live, no place to store medications, no money for rent, no telephone where they could be reached, and not enough food to eat. About 23.3% who were living with someone else expressed concerns about disclosure of HIV status, having no private place to live, and no place to store medications. In contrast, those renting or owning their own housing (about 61.9%) had few housing barriers to care, but were afraid of disclosure of HIV status and not having enough to eat.

Likewise, over 50% of consumers indicated that they were severely cost burdened by their housing, paying over 50% of their monthly income toward their rent/mortgage and utilities, and most indicating that they did not have enough money to pay for housing or were put on a waiting list for housing. As explained earlier, in 2014, nearly 15% of EMA residents were living in poverty. With HIV prevalence being 20 times higher in lower socio-economic areas, a significant portion of persons living with HIV are also living in poverty. The Medical Monitoring Project¹⁴ revealed the difficult economic circumstances of most persons living with HIV, with 41% of HIV participants in 2013 relying primarily on SSI or SSDI as their primary source of income, 66.3% living on less than \$20,000 in annual income, and almost 47% living below the federal poverty level (or at an extremely low income level).¹⁵ Yet, according to the National Low Income Housing Coalition (NLIHC) Out of Reach Study, a

¹⁴ Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection, Medical Monitoring Project, United States, 2013 Cycle (June 2013–May 2014), published at www.cdc.gov/hiv/pdf/statistics/systems/mmp/cdc-hiv-hssr-mmp-2013.pdf.

¹⁵ “Extremely low income” (30% of the Area Median Income) for a one-person household in the Dallas area in 2016 equates to \$15,050 in annual income (published at www.huduser.gov/portal/datasets/il/il16/index.html). The 2016 poverty guideline for a one-person household is \$11,880 in annual income (published at www.aspe.hhs.gov/poverty-guidelines).

renter in the Dallas area must earn an annual income of \$31,840 to afford a one-bedroom apartment at the HUD fair market rent (\$796) for the area.¹⁶ The housing gap is significant.

Compounding the housing needs experienced by persons living with HIV in the Dallas EMA, research studies nevertheless demonstrate that housing plays a critical role both in HIV prevention (by reducing the risk of HIV transmission) and in HIV care (by improving health outcomes) and that housing may be a “stronger predictor” of improved HIV health outcomes than other factors such as gender, race, age, substance use, mental health issues, or social services.¹⁷ Nevertheless, the Dallas area (like many areas of the country) is experiencing a critical shortage of available affordable housing units, according to the NLIHC Affordable Housing Gap Analysis, which shows that the Dallas-Fort Worth area has a shortage of over 174,000 housing units that would be affordable to extremely low income persons, with only 19 units available per 100 households.¹⁸ Persons living with HIV on extremely low incomes cannot find available affordable housing and must compete for what housing units and assistance is available.

EMERGENCY FINANCIAL ASSISTANCE

Emergency Financial Assistance (EFA) for Rent/Mortgage/Utilities was the second highest ranked unfulfilled need for both in-care and out-of-care consumers. Fifty percent of consumers had needed help with housing within the last six months of the survey, but just 34% had received it; of which 80% percent said they needed the service, 70% said they did not know about the service, and 27% said they requested, but did not receive the service. Facility-Based Housing was the fifth highest ranked unfulfilled need for consumers. Just 9% of consumers received this service within the last six months of the survey, but 39% stated a need for it; of which 63% percent said they did not know about the service, and 32% said they requested but did not receive the service. Long Term Rental Assistance Voucher was the first ranked unfulfilled need for consumers. Just 13% of consumers received this service within the last six months of the survey, but 83% stated a need for it; of which 62% percent said they did not know about the service, and 27% said they requested but did not receive the service. Nearly 40% of consumers resided in a location other than an apartment/house or mobile home that they rented or owned in their own name and 52%% of consumers spent almost half or half of their income on rent/mortgage and utilities. The greatest percentages of barriers to care were predictably found among consumers living in homeless shelters or on the street/in a car. Barriers to obtaining housing assistance were highly variable by residence type. Given the highly ranked need, the available additional capacity seemed nearly non-existent.

LEGAL SERVICES

Legal services ranked nineteenth in overall need and seventeenth in unfulfilled needs. Approximately 27% of those who didn't access these services in the last year had an unfulfilled need. Approximately 24% of those surveyed reported no barriers to care, over 50% “did not know about the service,” and 38% indicated that the

¹⁶ National Low Income Housing Coalition, Out of Reach Report, 2016, published at www.nlihc.org/orr. Affordable is defined as paying no more than 30% of annual income on housing expenses.

¹⁷ Refer to studies cited in HIV Care Continuum: The Connection between Housing and Improved Outcomes Along the HIV Care Continuum, U.S. Department of Housing and Urban Development, November 2014, published at www.hudexchange.info/resource/4143/connection-between-housing-and-improved-outcomes (see footnotes 4 through 9). See also National AIDS Housing Coalition, Fact Sheet: Housing Is HIV Prevention & Care, 2013, published at www.nationalaidshousing.org/PDF/FactSheet.pdf

¹⁸ National Low Income Housing Coalition, The Affordable Housing Gap Analysis, March 2016, published at www.nlihc.org/research/gap-report. Note that the national average is 31 units available per 100 households.

services provided were limited as they “need lawyers for other things.” There are only two Ryan White funded legal services agencies. One has a short wait and capacity for 5-10 additional consumers. The other agency has a 30-day wait time. There were 11 agencies in total providing legal services for PLWH in the DPA. The needs for services outweighed the ability of the agencies funded by Ryan White dollars, suggesting the need to reach out to other agencies providing legal services in the DPA.

LINGUISTIC SERVICES

The stated need for Linguistic/Translation services was very low; it ranked twenty-fifth out of 27 in need, and only 6% of consumers identified an unfulfilled need, and just 3% of out-of-care consumers had an unfulfilled need. Seventy percent of consumers using the service found it easily obtained. Of the unfulfilled need, in-care Hispanic/Latino Men and Women had the highest percentage (16.4%). Of those reporting barriers, 65% stated it was because they did not know the service was available. Focus groups revealed that monolingual speakers were at greater risk for not accessing care and that while for some the language barrier was an issue, the greater concern may be that many were also new to the country and may not have been able to navigate the system well – regardless of language barriers. There were two Ryan White funded providers and existing additional capacity for 20 new clients. This was a low ranked need, low utilization service but may be crucial to the population it is targeted towards.

RESPIRE CARE

Respite Care for Adults was ranked very low in overall need and just 9% of consumers had an unfulfilled need. Eighty-four percent of consumers found their service need easily met. Eighty percent of consumers felt this service was easily obtained. Respite Care for Children was the lowest ranked service in overall need and 92% of those who used the service found it easily obtained. There was existing additional capacity for 10 adult clients and 10 children. Given the low priority of stated need, the relatively low utilization of the service and existing additional capacity there appeared to be few, if any, gaps in service need and availability.

TRANSPORTATION SERVICES

Twenty-nine percent of consumers who had dropped out of care for six months or more in the last five years identified transportation issues as a contributing factor. Transportation to medical care ranked eleventh in overall need and eighteenth in unfulfilled need. Fifty-eight percent of consumers found the service easily obtained and 27% had an unfulfilled need. The unfulfilled need was highest among out-of-care Black/African-American Men and Hispanic/Latino Men and Women. The primary barrier identified by consumers was the need to take multiple buses to their clinic. Transportation to other services was ranked lower than transportation to medical care and 74% of consumers found their need for the service easily met. Fifty-six percent of consumers did not know about service availability. Among Ryan White Transportation to Medical Care funded providers, there existed additional capacity for 40 clients for bus passes and 60 new clients for van service. Focus groups revealed a sense that the use of transportation services for just medical appointments created some limitations for clients. Out-of-care consumer interviews revealed a general sense that transportation (funded or not) creates many difficulties when consumers have to make choices about remaining in care.

HIV PREVENTION SERVICES

Although prevention services were not ranked by consumers, consumer behaviors as evidenced by survey response, suggested that additional work needed to be done in this area to educate consumers about risk. This was also borne out in the focus group discussion.

Less than 50% of consumers used protection when engaging in sexual activity. Given reports from the out-of-care interviews and by provider focus groups this number may be under-estimated given beliefs that HIV cannot be transmitted through oral sex and that being in a long term relationship does not require that people use protection.

There are four agencies funded to provide prevention services in the DPA and most of the providers expressed the belief that prevention efforts have to be re-emphasized, targeted and reinvented.

d. crite barriers to HIV prevention and care services, including, but not limited to:

SERVICE NEED AND BARRIERS

The consumer survey services section asked the following questions about the 26 core and support services outlined:

- **Do You Use This Service Now or Over the Past Year?**
 - If a service is being used, it is assumed the service is needed.
 - If the service is being used, the next question asks about ease of use.
 - If the service is not being used, the next question asks about need for the service.
- **How Easy Was It For You To Get the Service?**
 - The number and percentage of people who use the service and found it easy to get is presented as **Need Met Easily**
 - The number and percentage of people who use the service and found it hard or somewhat hard to get is presented as **Need Met Hard**.
 - Anyone with a service that was hard or somewhat hard to get was asked the reason under the barriers section.
- **Unfulfilled need for a service.**
 - If someone is not using the service but states a need for it, he/she is considered to have an unfulfilled need for the service.
 - The number and percentage of people who have an unfulfilled need is presented as **Need Not Met**.
 - Anyone with an unfulfilled need was asked the reason under the barriers section.
- **Barriers to Care.**
 - If a service fulfilled the criteria for either Need Met Hard or Somewhat Hard or Need Not Met, the respondent was asked either, **“What is the *main* reason you were not able to get this service?”** or **“What is the *main* reason this service was hard to get?”**
 - Specific barriers were identified for each service.
 - A list of “problems” with HIV medical care asked early in the survey replaced the barrier questions for Ambulatory/Outpatient Medical Care.

The service need and barriers are provided for the total sample, in-care and out-of-care consumer respondents.¹⁹ For most services, the priority populations' service need and barriers are also presented. The total number of respondents for any question is displayed with "n."

BARRIERS TO CARE

Services That Are Needed But Are Not Available

Providers were asked to identify services that are not available to people living with HIV/AIDS. While the majority of providers felt that the full continuum is available, some service gaps were mentioned:

- Vision and hearing
- Transportation
- Food
- Routine testing at medical sites
- Low-cost housing options
- Specialist physicians, including psychiatry
- Inpatient hospital coverage
- Affordable child care and employment opportunities

Other comments:

- While providers offer a full array of services, none are available without full and complete documentation.
- Undocumented PLWHA that remain "hidden" or do not present to service providers will be left out of care.

Services That Should Be Increased

Providers commented on the need for treatment retention and services related to keep PLWHA in care. Specific services mentioned multiple times include:

- Treatment adherence counseling;
- Medical case management;
- Transportation and public bus passes;

¹⁹ Throughout this section in-care consumers are those that responded *positively* to any of the following questions: Have you had any of the following within the last 12 months? (1) CD4 tests, (2) Anti-retroviral medication; (3) Viral load tests. Consumers meeting one of the following five criteria were considered out-of-care. (1) Consumers not currently receiving HIV medical care, with at least 12 months since the last medical appointment. These consumers meet the HRSA definition of "out-of-care" which is "no HIV medical care, no viral load or CD4 counts and no antiretroviral medications in the last 12 months." These people may or may not be receiving other Ryan White or HIV services. (2) Consumers diagnosed between 2010 and 2013 that failed to link to care within six months of diagnosis. These consumers may currently be in care. (3) Consumers diagnosed between 2010 and 2013, linked to care after diagnosis but dropped out-of-care for at least six months. These consumers may now be back in care. (4) Consumers who dropped out-of-care for at least 12 months but are now back in care. They should have been back in care for no more than two years. (5) Consumers who began care in either 2012 or 2013 after no linkage to care after diagnosis. These people may be in care now, and may have been diagnosed at any time in the past.

- Food and meals.

Other suggestions:

- Expand approved dental codes to mirror Medicaid; change funding to a fee-for-service model;
- Provide in-home assistance with activities of daily living;
- More available housing for PLWHA.

Services That Should Be Delivered Differently

The majority of comments focused on the system of medical and non-medical case management.

- Some providers favored funding only medical case management in primary care settings, arguing that only medically experienced professionals have the experience to navigate healthcare systems.
- Case management intake and centralized eligibility documentation would increase access.

Other services that should be delivered differently:

- Translation services in languages other than Spanish;
- Dental services in Denton;
- Housing.

E. DATA: ACCESS, SOURCES, AND SYSTEMS

Data Sources Used in the Overview

This overview presents information on known cases of Human Immunodeficiency Virus (HIV) in the Dallas Eligible Metropolitan Area (Dallas EMA) diagnosed through December 31, 2014 and reported as of June 30, 2015. Information on people living with HIV (PLWH), or prevalence, represents the cumulative total of people diagnosed with HIV who are not known to have died and have a current residence in the Dallas EMA. Information on new HIV diagnoses in 2014 includes people residing in the Dallas EMA with a new diagnosed case of HIV infection. Cases are considered new diagnoses regardless of the stage of disease at the time of diagnosis. Statistics on new diagnoses of HIV are based on the earliest available diagnosis date.

The primary source of information for this report comes from disease surveillance. Texas laws and regulations require health care professionals and laboratories report test results or results of diagnostic evaluation that indicate infection with HIV. These results are maintained in the Texas Electronic HIV/AIDS Reporting System (eHARS). eHARS does not include those unaware of their HIV infection or those who tested positive for HIV infection solely through anonymous testing.

Rates and counts

When making decisions about resource allocation and setting priorities, it is important to include both the total number and rate of cases. If the population of different groups is of significantly different sizes, rates of new diagnoses and number of PLWH offer better comparison between such groups. HIV rates are usually expressed in terms of 100,000 members of the defined population. *Prevalence rates* show

the number of PLWH per 100,000 members of the population, and *diagnosis rates* show the number of new diagnoses per 100,000 members of the population. For example, the current prevalence rate of PLWH in Texas is 302.1 per 100,000, meaning that there are about 302 PLWH for every 100,000 Texans. The current newly reported HIV case rate is 16.3 per 100,000, meaning that there are about 16 new diagnoses for every 100,000 Texans. Comparing case rates shows the relative difference of the burden of disease across groups with different population sizes, allowing for the identification of which demographic or geographic areas are being disproportionately impacted.

Sex and gender identity

The information in disease surveillance on sex reflects biological sex. This report does not include information on transgender persons. DSHS began collecting information on gender identity in 2014; additional information on gender identity and HIV risk will not be available for at least another two years.

Mode of transmission

The mode of exposure assigned to each HIV case represents the most likely way that the individual became infected with HIV based on the risk behaviors found during disease reporting or investigation. Nearly 15% of new HIV cases are reported without an identified risk factor. DSHS uses a multiple imputation method to assign a risk factor for these which replaces missing risk factors with a range of possible values. Estimates of population sizes for risk behavior groups, with the exception of Men who have Sex with Men (MSM), are unknown; therefore, case rates were not calculated for Injection Drug Use (IDU), persons engaging in condomless heterosexual sex, and MSM/IDU. The 2014 Census Data used for calculating MSM population estimates was not available at the time of this report; therefore, the latest year available data on HIV rates in MSM is 2013.

Information on the general population

The profile contains information on the overall population of Dallas; the sources for those data are numerous, and cited within the text.

Information on linkage to treatment, retention in care, ART prescription, and HIV viral suppression

The profile also contains information on several aspects of treatment and care for PLWH, such as linkage to care, prescription of antiviral medication (ART) and maintenance in treatment. This information is created by merging information from disease surveillance with several sources of information on treatment and care. They include program data from publicly funded treatment providers in the Ryan White HIV/AIDS (Parts A-D, including the Texas AIDS Drug Assistance Program), information from Texas Medicaid and from some private health plans. Information from special surveillance studies, especially the Medical Monitoring Project, a project involving chart reviews and interviews with a representative sample of patients in care with Texas HIV medical providers were also used for estimates of ART prescription.

STI/HIV and TB/HIV Comorbidity

A cross-registry match was performed between eHARS and the Texas Sexually Transmitted Disease (STI), Hepatitis C, and tuberculosis (TB) registries to identify PLWH co-infected with TB or any of three reportable STIs (chlamydia, gonorrhea, and syphilis) during 2014. PLWH were considered to be co-infected if their co-infection was diagnosed ≥ 30 days prior to their HIV diagnosis or at any date in 2014 after their HIV diagnosis.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

1. **NHAS Goal:** Reduce new HIV infections
 - a. **Objective 1:** By the end of 2021, increase the percentage of people living with HIV who know their serostatus by at least 10 percent.
 - i. **Strategy:** Increase testing programs that effectively reach high-risk populations

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, DCHHS, UTSW, and other prevention-funded entities	Reinvigorate the HIV Testing Coalition	High risk HIV negative individuals	Active HIV Testing Coalition
By the end of 2021:	CBO's, DCHHS, Ryan White Part C and Part D Service Providers, UTSW, and other prevention-funded entities	Conduct targeted HIV testing in areas/ locations where and times when people at high risk for HIV can be accessed	Hispanic MSM, black MSM, white MSM, black heterosexual women, and transgender individuals.	Number of tests performed; percent positive
By the end of 2021:	CBO's, DCHHS, Ryan White Part C and Part D Service Providers, UTSW, and other prevention-funded entities	Partner with other community organizations to facilitate collaborative testing activities serving populations at risk for HIV	Hispanic MSM, black MSM, white MSM, black heterosexual women, transgender individuals, and veterans	Number of tests performed; percent positive
By the end of 2021:	CBO's, Ryan White Part C and Part D Service Providers, UTSW, and other prevention-funded entities	Access and test social contacts of HIV positive individuals and those at high risk for infection	Social networks of HIV infected individuals and those at high risk for infection	Number of tests performed; percent positive
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based	Offer testing when utilizing evidence-based interventions and	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of activities delivered; number of individuals

	organizations and educational institutions	effective strategies		enrolled; and number of individuals graduated
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ii. **Strategy:** Promote routine testing programs

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Prevention-funded entities	Educate individuals about routine testing and promote routine testing	Individuals who have not had an HIV test within the previous 12 months	Number of individuals engaged in information sessions
By the end of 2021	AETC, Test Texas Coalition, CBOs, educational institutions	Educate providers about routine testing and promote routine testing	Primary care providers, emergency rooms, urgent care centers, correctional institutions, and community health centers	Number of information sessions engaging primary care providers, emergency rooms, urgent care centers, correctional institutions, and community health centers
By the end of 2021:	DSHS, area hospitals	Implement routine HIV testing in at least one new area hospital emergency room	Individuals who have not had an HIV test within the previous 12 months	Number of tests performed; percent positive
By the end of 2021:	DSHS, FQHCs and other community health clinics	Implement routine HIV testing in at least one new area community health clinic or service	Individuals who have not had an HIV test within the previous 12 months	Number of tests performed; percent positive
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based	Utilize effective strategies, including social media to promote	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of individuals reached through social media and

	organizations and educational institutions	routine testing		effective strategies (self reported)
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iii. **Strategy:** Utilize partner notification services to test sexual and social partners of newly diagnosed individuals

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	DCHHS	Locate, interview, and test sexual contacts of newly diagnosed individuals	Sexual partners of newly HIV infected individuals	Number of tests performed; percent positive
By the end of 2021:	DCHHS	Locate, interview, and test social contacts of newly diagnosed individuals	Social networks of newly HIV infected individuals	Number of tests performed; percent positive

b. **Objective 2:** By the end of 2021, increase the percentage of young gay and bisexual men who are engaged in activities that reduce the risk of HIV by at least 10 percent.

i. **Strategy:** Expand access to effective prevention services, including PrEP and PEP.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, local hospitals, and community health centers, and other prevention-funded entities	Create and sustain at least one community PrEP clinic which allows access regardless of insurance or financial resources	Uninsured MSM that are at high risk for HIV infection	Number of uninsured, high-risk individuals receiving PrEP
By the end of 2021:	CBOs, local hospitals, and community health centers, and other prevention-funded entities	Offer PrEP services for high-risk populations	Recently released from prison, Hispanic MSM, black MSM, white MSM, black heterosexual women, and transgender	Number of high-risk individuals accessing PrEP

			individuals.	
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Continue and improve strategic condom distribution activities	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of condoms distributed; number of distribution sites
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize evidence-based interventions and effective strategies	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of activities delivered; number of individuals enrolled; and number of individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize trained community health workers and other peer-based programs in communities most impacted by HIV/AIDS	High risk populations for HIV infections, including MSM, women, trans individuals, youth, and other data-driven priority populations	Number of community health workers, number of referrals into PrEP and PEP services

- ii. **Strategy:** Expand prevention services for people living with HIV by ensuring effective psychosocial support

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	HUD, HOPWA, DCHHS, City of Dallas Housing Programs, CBOs	Reduce barriers to accessing housing services	Homeless and at risk of homelessness individuals living with HIV	Number of homeless and at risk individuals in permanent housing
By the end of 2021:	CBOs	Enhance integrated care models that enable psychosocial,	Newly diagnosed individuals, individuals with co-occurring medical conditions	Number of people accessing co-located services and support

		mental health, and substance abuse treatment and risk reduction counseling to be co-located with HIV primary medical care ²⁰		
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize evidence-based interventions and effective strategies to expand support for people living with HIV	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of activities delivered; number of individuals enrolled; and number of individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize trained community health workers and other peer-based programs in communities most impacted by HIV/AIDS	People who engage in high risk behaviors for HIV infections, including MSM, women, trans individuals, youth, and other data-driven priority populations	Number of community health workers and other peer-based programs staff trained; number of peer-based programs

- iii. **Strategy:** Tackle misperceptions, stigma, and discrimination to break down barriers to HIV prevention, testing, and care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Ryan White Planning Council	Identify key areas and barriers which affect the care continuum	Individuals living with HIV	Barriers identified
By the end of	Ryan White Planning	Conduct at least a	Lost-to-care	Needs

²⁰ Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014.

2021:	Council/Administrative Agency	biannual comprehensive needs assessment that helps identify gaps in the care continuum	individuals; clients utilizing Ryan White-funded services	assessment completed
By the end of 2021:	CBOs	Utilize evidence-based social marketing and education campaigns, and leverage digital tools and new media technologies	Populations and communities at greatest risk for HIV	Number of programs utilizing social media; number of hits, followers, interactions by community and clients on social media
By the end of 2021:	Ryan White Planning Council, community organizations such as the Positive Justice Project	Decrease stigma and discrimination resulting from criminal practices that target people living with HIV through education.	Local law enforcement and district attorneys, general population	Number of dissemination activities; number of persons attending symposiums, meetings, etc.
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize evidence-based interventions and effective strategies	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of activities delivered; number of individuals enrolled; and number of individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Increase outreach, including utilizing community health workers, to at least four communities or populations	Traditionally non-targeted populations	Number of outreach activities; Number of individuals reached

		traditionally not targeted		
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c. **Objective 3:** By the end of 2021, increase the percentage of all individuals who are engaged in activities that reduce the risk of HIV by at least 10 percent.

i. **Strategy:** Expand access to effective prevention services, including PrEP and PEP.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2019:	CBOs, local hospitals, and community health centers	Create and sustain at least one community PrEP clinic which allows access regardless of insurance or financial resources	Black women, transgender women, and people who engage in condomless heterosexual sex	Number of community PrEP clinics
By the end of 2021:	CBOs, local hospitals, and community health centers	Offer PrEP services	Recently released from prison, black women, transgender women, and people who engage in condomless heterosexual sex, MSM, serodiscordant couples	Number of individuals receiving PrEP in the priority population
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Continue and improve strategic condom distribution activities	Individuals who engage in HIV-risk behaviors	Number of condoms distributed; number of distribution sites
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational	Utilize evidence-based interventions and effective strategies	Individuals who engage in HIV-risk behaviors	Number of activities delivered; number of individuals enrolled; and number of

	institutions			individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize trained community health workers and other peer-based programs in communities most impacted by HIV/AIDS	People who engage in high risk behaviors for HIV infections, including MSM, women, trans individuals, youth, and other data-driven priority populations	Number of community health workers and other peer-based programs staff trained; number of peer-based programs

- ii. **Strategy:** Expand prevention services for people living with HIV by ensuring effective psychosocial support

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	HUD, HOPWA, DCHHS, City of Dallas Housing Programs, CBOs	Reduce barriers to provide access to housing services	Homeless and at risk for homeless individuals living with HIV	Number of people living with HIV in permanent supportive housing
By the end of 2021:	CBOs	Enhance integrated care models that enable psychosocial, mental health, and substance abuse treatment and risk reduction counseling to be co-located with HIV primary medical care ²¹	Newly diagnosed individuals, individuals with co-occurring medical and mental health conditions	Number of people accessing co-located services and support
By the end of	CBOs, local	Utilize evidence-	Individuals who	Number of

²¹ Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014.

2021:	hospitals, community clinics, faith-based organizations and educational institutions	based interventions and effective strategies	engage in HIV-risk behaviors	activities delivered; number of individuals enrolled; and number of individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize trained community health workers and other peer-based programs in communities most impacted by HIV/AIDS	People who engage in high risk behaviors for HIV infections, including MSM, women, trans individuals, youth, and other data-driven priority populations	Number of community health workers and other peer-based programs staff trained; number of peer-based programs

iii. **Strategy:** Tackle misperceptions, stigma, and discrimination to break down barriers to HIV prevention, testing, and care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Ryan White Planning Council	Identify key areas and barriers which affect the care continuum	Individuals living with HIV who are at or below 200% of the FPL	Barriers identified
By the end of 2021:	Ryan White Planning Council/Administrative Agency	Conduct at least a biannual comprehensive needs assessment that helps identify gaps in the care continuum	Lost-to-care individuals; clients utilizing Ryan White-funded services	Needs assessment completed
By the end of 2021:	CBOs	Utilize evidence-based social marketing and education campaigns, and leverage digital tools and new	Populations and communities at greatest risk for HIV	Number of programs utilizing social media; number of hits, followers, interactions by

		media technologies		community and clients on social media
By the end of 2021:	DCHHS	Work with local law enforcement and district attorneys to ensure better implementation of DSHS recalcitrant policy as opposed to criminal prosecution	Recently released from prison, including black women, transgender women, and people who engage in condomless heterosexual sex, MSM, serodiscordant couples	The number of meetings between local law enforcement and the work group.
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize evidence-based interventions and effective strategies	Individuals who engage in HIV-risk behaviors	Number of activities delivered; number of individuals enrolled; and number of individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Increase outreach to at least four communities traditionally not targeted, but which have high risk behaviors that can increase acquisition and transmission of HIV and AIDS.	Traditionally non-targeted, high-risk populations	Number of outreach activities; Number of individuals reached

2. NHAS Goal: Increase access to care and improving health outcomes for PLWH

a. **Objective 1:** By the end of 2021, increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their diagnosis by at least 10 percent.

i. **Strategy:** Intensify at the community level the ability for patients to access HIV medical care within one month of diagnosis

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Ryan White Administrative Agency	Capture and report annually on the number and percentage of Ryan White-funded clients that are linked to HIV medical care within one month of entering services	Newly diagnosed individuals without health insurance or eligible for Ryan White-funded services	Time to Early Intervention or first Intake Visit; Time to First Completed Medical Appointment
By the end of 2021:	CBOs	Conduct intensive linkage to care activities for clients that are likely to not be engaged in medical care	Newly diagnosed, high-risk individuals, homeless individuals, those recently released from prison	Number of clients utilizing services per year; number linked to medical care

ii. **Strategy:** Intensify linkage to care efforts across health systems and community partners

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, UTSW, RWPC, AETC, State partners (TX HIV Syndicate)	Inform community partners about results of the latest needs assessments related to barriers to care and facilitators to linkage to promote collaboration	Front line and other key staff within and outside of the Ryan White system of medical care	Number of individuals engaged in information sessions Number of occurrences where Needs Assessment Results were shared
By the end of	AETC	Educate medical	Medical providers	Individuals who

2021:		providers about current HIV treatment modalities and protocols utilizing multiple educational platforms	at Community Health Centers, ACOs, etc.	have not had an HIV test within the previous 12 months
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iii. **Strategy:** Ensure HIV testing organizations maintain a robust capacity to ensure linkage to care

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, DCHHS STI Testing, EIC, UTSW	Implement effective service agreements with HIV medical providers	HIV medical providers	Number of agreements developed that promote timely linkage
By the end of 2021:	CBOs, DCHHS STI Testing, EIC, UTSW	Ensure that testing organizations have aligned testing and linkage efforts	Newly diagnosed PLWH from testing sites	Number of individuals who test positive linked to care
By the end of 2021:	RWPC, CBOs, DCHHS STI Testing, EIC, UTSW	Identify and disseminate specific solutions to address barriers that prevent PLWH from linking to and being retained in care	Medical, social service support organizations (influencers and frontline staff)	Number of effective strategies developed and implemented; number of newly diagnosed individuals completing first HIV medical visit; number of PLWH retained in care

b. **Objective 2:** By the end of 2021, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 65 percent.

i. **Strategy:** Address barriers to accessing behavioral health and substance abuse treatment services which inhibit the ability to stay adherent to HIV medications.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, County Mental Health Authorities	Support capacity to screen, treat, and/or link to substance abuse and mental health services	PLWH	Number of PLWH screened for SA/MH disorders; number of people screening positive for SA/MH disorders
By the end of 2021:	Ryan White-funded HIV primary care providers & CBOs, Ryan White Grant Administrative Agency	Support comprehensive, coordinated, integrated patient-centered mental health and/or substance abuse care and treatment	PLWH at high risk for co-occurring mental health and substance abuse conditions	Number of clients that utilize both outpatient medical care and mental health or substance abuse services

- ii. **Strategy:** Address gaps in support services which impact a client’s ability to effectively access medical care

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs	Improve access to transportation	PLWH with transportation needs	Number of Ryan White clients receiving assistance
By the end of 2021:	CBOs	Improve access to childcare services	PLWH with children	Number of Ryan White clients with children accessing childcare services
By the end of 2021:	CBOs and HOPWA grantee	Improve access to Housing Services	PLWH with housing needs	Number of clients receiving housing assistance

- iii. **Strategy:** Ensure adequate workforce capacity to enable the latest evidence-based HIV treatment.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	AETC	Coordinate and complete at least 1 to 2 preceptorships per month allowing opportunities to clinically shadow clinicians in multiple settings for the care of HIV+ patients	All Types of Providers: 1. Physicians 2. Nurses, 3. Nurse Practitioners 4. Physician Assistants 5. Allied Health Professionals 6. Oral Health Professionals 7. Dentists 8. Social Workers 9. Case Managers 10. Community Health Workers 11. Pharmacists	Records for All Participants Including: 1. AETC Event Records 2. Participant Evaluations
By the end of 2021:	AETC	Provide ongoing longitudinal training to at least three primary care providers AND/OR primary care clinics about the long-term care of HIV+ patients.	Primary Care Providers/Clinics	Records for All Participants Including: 1. AETC Event Records 2. Participant Log showing Ongoing Training 3. Participant Evaluations

3. NHAS Goal: Reducing HIV-related disparities and health inequities

- a. **Objective 1:** By 2021, create, distribute, and monitor progress of a local HIV Care Continuum that is targeted to reduce HIV infections and improve health outcomes among priority populations.

- i. **Strategy:** Develop a baseline of HIV-related disparities in the community for monitoring to ensure progress.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 6/30/2017:	Ryan White Planning Council/ Administrative Agency	Collect and analyze state and local data on local disparities in access to care, retention in care, and clinical outcomes	Black/African American and Hispanic/Latino MSM	Data presented to stakeholders at July 2017 Planning and Priorities Meeting
By 9/30/2017	Ryan White Planning Council, Administrative Agency, Ryan White Providers, Community Prevention Providers	Develop strategies and protocols from analyzed data to address HIV-related health disparities on the local level Implement at participating CBOs	Populations identified in step 1.	Strategies and protocols developed with stakeholder input, and disseminated to providers
By 12/31/2017 And quarterly thereafter	EMA/HSDA Quality Management Coordinator	Develop a monitoring system to review progress toward the reduction of health disparities	Funded providers	Quarterly monitoring will show improvement within three quarters, or the implemented strategies and protocols will be reviewed for efficacy.
06/30/2018 And semi-annually thereafter	EMA/HSDA Quality Management Coordinator	Monitored results for the prior 12 months (as available) will be disseminated to the Planning & Priorities Committee semiannually.	RWPC and the Planning & Priorities Committee	Reporting scheduled on committee agendas.

- ii. **Strategy:** Support engagement in care for groups with low-levels of viral suppression.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
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By 6/30/2017	Ryan White Planning Council Administrative Agency Ryan White Providers	Expanding on collected data, conduct surveys of convenience (patient population) at provider sites of persons in the target populations to get their feedback on the types of activities that would support retention in care and reduce non-adherence.	Individuals from target populations who are not virally suppressed	Completed surveys and data presented to Priorities & Planning Committee July 2017 meeting
By 12/31/2017	Ryan White Planning Council Administrative Agency Ryan White Providers Community Prevention Providers	With TA from HRSA, DSHS, and local experts, develop interventions that improve engagement of target populations in ongoing HIV care to improve health outcomes and reduce HIV related health disparities	N/A	Interventions developed and disseminated to provider sites for implementation
By 6/30/2018 And semiannually thereafter	EMA/HSDA Quality Management Coordinator	Perform Continuous Quality Improvement on enacted interventions to identify the top interventions for each target population. Monitor the retention of targeted populations to measure efficacy of those interventions. Report results to the Priorities & Planning Committee semiannually.	N/A	Reporting scheduled on committee agendas.

- iii. **Strategy:** Improve viral suppression among persons experiencing/formerly experiencing HIV-related disparities by 15%.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 06/30/2017	Ryan White Planning Council Administrative Agency	Establish baseline viral suppression averages for each demographic identified as experiencing HIV-related disparities	Black/ African American and Hispanic/ Latino MSM Black Women Transgender Women	Baselines measured & reported to Priorities & Planning Committee by July 2017 meeting
By 09/30/2017 And quarterly thereafter	EMA/HSDA Quality Management Coordinator	Monitor progress toward the improvement of viral suppression rates among persons experiencing/ formerly experiencing HIV-related health disparities	N/A	Viral suppression rates among persons experiencing HIV-related health disparities
06/30/2018 And semi-annually thereafter	EMA/HSDA Quality Management Coordinator	Monitoring results for the prior 12 months (as available) will be disseminated to the Priorities & Planning Committee semiannually.	N/A	Reporting scheduled on committee agendas.

- iv. **Strategy:** Ensure available funding for undocumented immigrants or individuals not otherwise eligible for health insurance or Medicare/Medicaid.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Ryan White Planning Council/Administrative Agency	Apply for available funding for	Undocumented immigrants or individuals not otherwise eligible for health insurance or Medicare/Medicaid	Submitted grant proposals
By the end of 2021:	CBOs, RWPC Planning & Priorities and	Ensure inclusion and adequate	Undocumented immigrants or	Inclusion of represented

	Allocations Committees, Administrative Agency	representation of priority populations during the prioritization and allocation process	individuals not otherwise eligible for health insurance or Medicare/Medicaid	priority populations in needs assessments
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b. **Objective 2:** By the end of 2021, reduce disparities in rate of new diagnosis by at least 10 percent in identified priority populations.

i. **Strategy:** Adopt structural approaches to reduce HIV infections and improve health outcomes

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, RWPC	Conduct regular culturally appropriate awareness campaigns on HIV risk, importance of getting tested, and engaging in care	Hispanic MSM, black MSM, white MSM, black heterosexual women, and transgender individuals.	Number of campaigns conducted; number of Latino/a individuals getting tested for HIV; number of HIV positive Latino/a individuals engaging in medical care
By the end of 2021:	CBOs,	Culturally appropriate outreach and education conducted within the Latino/a community by Promotors	Hispanic MSM, black MSM, white MSM, black heterosexual women, and transgender individuals.	Number of outreach activities conducted; number of Latino/a individuals interacting with Promotors; number of individuals engaged in activities

- ii. **Strategy:** Create new and alternative settings for effective HIV prevention and treatment activities

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, community organizers, community leaders	Intensify community engagement through culturally appropriate outreach teams that reflect priority populations	Younger communities of color and lower SES, Black and Hispanic MSM	Number of educational outreach events, Number of partnerships with community organizations, Number of social media interactions
By the end of 2021:	CBOs, community organizers, community leaders	Engage priority population youth via social media	Hispanic MSM youth, black MSM youth, white MSM youth, young black heterosexual women, and transgender youth.	Social media likes, follows, and shares
By the end of 2021:	CBOs, specifically organizations serving priority population communities	Utilize prevention strategies from Goal 1 with local service organizations to increase HIV testing in nontraditional settings among priority populations.	Hispanic MSM, black MSM, white MSM, black heterosexual women, and transgender individuals.	Number of testing events in priority population communities

- iii. **Strategy:** Establish system-wide workforce development requirements for adopting the Culturally and Linguistically Appropriate Service (CLAS) standards developed by the Office of Minority Health into practices and protocols that address systemic issues contributing to health disparities.

Timeframe	Responsible	Activity	Target Population	Data Indicators
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	Parties			
By the end of 2021	DCHHS, DSHS, Office of Mental Health (OMH), CBOs	Convene a work group of funders and stakeholders to work with OMH staff to develop minimum staff training requirements for RW Sub-Recipients regarding the 15 OMH CLAS Standards.	Ryan White sub-recipients	Work group convened
By the end of 2021	DCHHS, DSHS, Office of Mental Health (OMH)	Policies and procedures, contract verbiage, and other requirements codified.	Ryan White sub-recipients	Policies, procedures, and other verbiage established and prepared for implementation in contracts established.

B. Collaborations, Partnerships, and Stakeholder Involvement

a. Describe the specific contributions of stakeholders and key partners to the plan.

When the workgroup was formed to steer the planning process of the CDC/HRSA Integrated HIV Prevention and Care Plan for 2017-2021, the goal was to form a planning group that had representatives from HIV prevention programs, the local Housing Opportunities for Persons with AIDS (HOPWA) grantee, AIDS Education and Training Center representatives, Federally Qualified Health Centers, Ryan White funded care providers, consumers of Ryan White services, Ryan White Planning Council members, support staff, and Dallas County Health and Human Services (Ryan White Parts A and B Administrative Agency) representatives. All of these different stakeholders and key partners had equal opportunities to come to the planning sessions and respond to the ongoing plan electronically. For the Epidemiologic Overview and HIV Care Continuum portions of Section I in this plan, the work group sent a formal letter of request to the Texas Department of State Health Services (DSHS) for their

assistance. The state responded positively and sent in a completed section with 2014 state surveillance data. The group then worked together (mostly consisting of Community Based Organizations, the local research university and medical school, Ryan White consumers and Ryan White Planning Council members) on rearranging the Epidemiologic Profile so that it would fit in with the CDC/HRSA Integrated HIV Prevention and Care Plan Guidance that was released in June 2015. Volunteers from two separate CBOs took the lead on creating the Financial and Human Resources Inventory from relevant previously submitted applications and verifying the data from the Grants Division of Dallas County Health and Human Services.

The group also had a local CBO take the lead on creating the foundation for the actual Integrated HIV Prevention and Care Plan in Section II. The group then divided into three groups that corresponded to the first three National HIV/AIDS Strategy Goals: reduce new HIV infections; increase access to care and improving health outcomes for PLWH; and reducing HIV-related disparities and health inequities. Each of these groups still consisted of local CBOs, Ryan White consumers, DCHHS health educators, RWPC members, and representatives for the University of Texas – Southwestern. Once the objectives, strategies, and activities under all three goals were finalized, and the first section was complete, the Ryan White Planning Council support staff collaborated with the Planning Council’s leadership to work on the sections regarding the collaborative process and concurrence from the planning bodies.

b. Describe stakeholders and partners not involved in the planning process, but who are needed to more effectively improve outcomes along the HIV Care Continuum.

This process could have used a larger contingent of PLWH that was more reflective of the epidemic in Dallas. While consumers were part of the planning process, more consumers could have been utilized to enrich this perspective, specifically from Hispanics and Trans people, as well as youth from all walks of earth.

c. Provide a letter of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan from the co-chairs of the planning body and the health department representatives (Appendix B)

C. PEOPLE LIVING WITH HIV (PLWH) AND COMMUNITY ENGAGEMENT

a. Describe how the people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic in the jurisdiction.

The people involved in developing the Integrated HIV Prevention and Care Plan was more reflective of the prevention and care services provided in the jurisdiction than the epidemic itself. Black MSM, White MSM, and Black Heterosexual women were represented in the CDC/HRSA Integrated HIV Prevention and Care Planning Work Group insofar as HIV-positive members were concerned, though all were underrepresented.

b. Describe how the inclusion of PLWH contributed to the plan development.

Throughout this planning process, the CDC/HRSA Integrated HIV Prevention and Care Planning Work Group had 13 official meetings. 11 of 13 meetings included someone living with HIV at the table and all 13 meetings invited PLWH. The two meetings that were without someone living with HIV were due to scheduling conflicts.

During the planning process, PLWH contributed heavily in determining the identified priority populations, specifically identifying heterosexual black women as a priority population, as well as contributions throughout the plan insofar as activities and what would be feasible and effective when working with HIV-positive populations.

c. Describe the methods used to engage communities, people living with HIV, those at substantial risk of acquiring HIV infection and other impacted population groups to ensure that HIV prevention and care activities are responsive to their needs in the service area.

The Ryan White Planning Council of the Dallas EMA provided the work group with engaged people living with HIV. The only method used to engage the people involved in the planning process was a call to action at the Planning Council level. The Ryan White Planning Council has a Consumer Council Committee that engages and educates the community on topics most pertinent to People Living with HIV in the Dallas community. This committee has been and will continue to be updated on the plan and allow for feedback opportunities so that the voice of PLWH is not lost during the development and implementation of this plan.

d. Describe how impacted communities are engaged in the planning process to provide critical insight into developing solutions to health problems to assure the availability of necessary resources.

Community outreach and educational forums are opportunities to engage impacted communities and seek input and critical insight to take back to the planning work group to aid in developing solutions to health problems and assure the availability of necessary resources. Additionally, much of the data pulled for this report was taken from the 2013 Comprehensive HIV Needs Assessment, which engaged many people that are part of impacted communities. When discussing needs of PLWH, and barriers for PLWH to get into and remain in care, this was pulled directly from impacted communities.

Section III: Monitoring and Improvement

a. Describe Process for regularly updating planning bodies and stakeholders on progress of plan implementation, soliciting feedback, and using feedback for improvements.

The Dallas EMA will utilize the current planning body that developed the CDC/HRSA Integrated HIV Prevention and Care Plan to have regular meetings to assess and evaluate progress made on the submitted plan. Like this plan, the ad hoc committee that will implement and evaluate the plan will be dynamic as well, as there will be efforts to improve representation of the at-risk populations. Representatives from this group will invite both CDC HIV Prevention and Ryan White Care providers to Ryan White Planning Council meetings to give quarterly feedback to the Ryan White Planning Council of the Dallas EMA and the public regarding this progress. Ryan White funded agencies, including CBOs and stakeholders, regularly attend these meetings, so all interested parties will be given the opportunity to be present at these meetings and solicit feedback for improvements to the work group that created the Integrated HIV Prevention and Care Plan. All Ryan White Planning Council meetings must comply with the Texas Open Meetings Act, which means that the public is notified of each meeting's agenda with no less than 72 hours of notice, which will help with the soliciting of feedback.

b. Describe plan to monitor and evaluate implementation of goals from Section II.

The CBOs, DCHHS, UTSW, Ryan White Part C and D Providers and other prevention funded entities will address each SMART objective throughout the duration of this plan. The ad hoc Integrated Plan committee will track the progress of each SMART objective and present them at the Ryan White Planning Council meetings when the quarterly reports are given as described above. There will also be a regular collection of data from agencies to provide a basis for evaluation and learning. Data and information from new HIV infections, routine testing, partner notifications, expanded preventative services, stigma and barrier breakdowns, community engagement, linkage to care, gaps in services, and HIV treatment disparities, that reflect the demographic from the partner agencies will guide the Dallas EMA to monitor and evaluate their goals, objectives and strategies in the Integrated HIV Prevention and Care Plan by the timeframe indicated in the plan. Each SMART objective has data indicators that will be measured by individual agencies, collected by the ad hoc Integrated Plan committee, and reported to the community at the Ryan White Planning Council meetings. After data is collected and analyzed, the ad hoc Integrated Plan committee will make adjustments to the plan as needed.

c. Describe strategy to utilize surveillance and program data to assess and improve health outcomes along HIV Care Continuum – strategic long range planning.

Epidemiologic data and information that is gathered by both local agencies carrying out activities outlined in this plan, as well as by the Texas Department of State Health Services, are needed to assess the projected need beyond the Integrated HIV Prevention and Care Plan by 2021 to support long-range improvement in health outcomes along the HIV Care Continuum. The data will be utilized to monitor which activities are effective, and where activities are effective amongst which populations. While the plan will be in place for 2017-2021, it will also be treated as a living document that will be adjusted throughout the implementation process. All adjustments during the implementation process will be data-driven adjustments. Surveillance and program data will assess populations in need and service gaps, as well as incidence and diagnosis among the current priority populations throughout the duration of this plan.

Glossary

AETC – AIDS Education and Training Center – Program supports the National HIV/AIDS Strategy by building clinician capacity and expertise along the HIV Care Continuum.

ARIES – AIDS Regional Information and Evaluation System – System used to collect and analyze the utilization of Ryan White services

CBO – Community Based Organization – public or private nonprofit that is representative of a community or a significant segment of a community and is engaged in meeting community needs, in this case, as related to HIV

Dallas EMA – Dallas Eligible Metropolitan Area - covers eight counties in north east Texas, including Collin, Dallas, Denton, Ellis, Henderson, Hunt, Kaufman, and Rockwall counties.

DCHHS – Dallas County Health and Human Services. This agency serves as the administrative agency for Ryan White Part A, MAI, Part B, and Texas Department of State Health Services funds.

DSHS – Texas Department of State Health Services.

FQHCs – Federally Qualified Health Centers – include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid.

HOPWA – Housing Opportunities for Persons With AIDS – the only Federal program dedicated to the housing needs of people living with HIV/AIDS.

IDU – Intravenous Drug User – a person who introduces a drug into their bloodstream via a hollow hypodermic needle and syringe, which is pierced through the skin into the body.

MSM – Men who have sex with men

PLWH – People Living with HIV

UTSW – the University of Texas Southwestern Medical Center

Appendix A: NHBS and MMP

Medical Monitoring Project (MMP)

MMP collects behavioral and clinical information from a nationally representative sample of adults receiving medical care for HIV infection in outpatient facilities in the United States and Puerto Rico. The Texas and Houston MMP sites are two of 23 project areas that were funded to conduct data collection activities for the 2013 MMP data collection cycle. Patients who received medical care during January–April 2013 at an MMP participating facility were interviewed once during June 2013–April 2014 regarding HIV care experiences, health behaviors, risk behaviors, and unmet need during the 12 months preceding the interview. In addition, patients' medical records were abstracted for documentation of medical care including prescription of ART and HIV viral load and clinical outcomes for the 24 months preceding the interview. All percentages were weighted for the probability of selection and adjusted for nonresponse bias.

National HIV Behavioral Surveillance (NHBS)

NHBS is an ongoing behavioral surveillance system that collects cross-sectional data among populations at high risk for acquiring HIV, including men who have sex with men (MSM), injection drug users (IDU), and heterosexuals at high risk for HIV infection (HET). NHBS activities are implemented in one-year cycles so that data are collected from each risk group every three years; these study cycles are referred to as NHBS- MSM, NHBS-IDU, and NHBS-HET. Individuals who consent to participate undergo an anonymous interview, receive an HIV test and are given a monetary incentive for their participation.

Appendix B: Letter of Concurrence

Mrs. Frances Hodge

Dear Mrs. Hodge:

The Ryan White Planning Council of the Dallas Area concurs with the following submission by Dallas County Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The planning body leadership has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The signature(s) below confirms the concurrence of the planning body leadership with the Integrated HIV Prevention and Care Plan.

Signature:



Date:

Sept. 26, 2016

Planning Body Chairs



Appendix B: Ryan White Planning Council of the Dallas Area 2019
Comprehensive HIV/AIDS Needs Assessment February 2020



Ryan White Planning Council of the Dallas Area 2019 Comprehensive HIV/AIDS Needs Assessment February 2020

Susan M. Wolfe, Ph.D.
Susan Wolfe and Associates, LLC

Kyrah K. Brown, Ph.D.
The University of Texas at Arlington

In collaboration with Dallas County Health and Human Services, the Ryan White Planning Council of the Dallas Area, and Brad Walsh, MPH CPH, Parkland Health & Hospital System.

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Collaborating Partners

People Living with HIV in the greater Dallas area and Ryan White HIV/AIDS Program Consumers
Dallas County Health and Human Services
Dallas County Ryan White Planning Committee
Dallas County, Ryan White Grant Administration
Parkland Health Systems
Resource Center

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Callie Clinic

Kelly Fretwell
Glenn Moreland
Norma Piel-Brown

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Oscar Salinas
Christopher Webb

Dallas County Health and Human Services

Grace Balaoing
Glenda Blackmon Johnson, Manager
Justin M. Henry, MPH, Health Planner
Annie Sawyer-Williams, Coordinator

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Joyce Tapley

Gilead Sciences

Kelly Richter

Health Services North Texas

Louise Weston-Ferrill

HIV/AIDS Housing Services

Lori Davidson

Legacy Counseling Center

Melissa Grove

Los Barrios Unidos Community Clinic

Sharon Davis
Claudia Romie

Mission East Dallas

Charles Wiltraut

Parkland Health and Hospital System

Crystal Curtis, Bluit Flowers
Jane Fitzpatrick
Jonathan Gute
Gwendolyn Martin
Kendra Tevis
Brad Walsh

Prism Health of North Texas

Evan Avanzino
Victoria Langston
Karin Petties
Justin Vander

Recovery Resource Council

Kelvin Divinity

Resource Center Dallas

Gary Benecke
JP Cano
Jalenzski
Robert Lynn
Daniel Sanchez

Ryan White Planning Council

Lionel Hillard
Helen E. Turner

Southern Black Policy and Advocacy Network

Venton Hill-Jones

University of Texas at Arlington

Jerrise Anthony, Intern
Tamaya Bailey BSW, Intern
Claudy Jean Pierre BSPH, Intern
Simisola Adamo
Karla Aguilar
Merline Fougere
Alicia Hernandez
Goody Howard, MSW
J'Vonnah Maryman, PhD
Berford Moncriste
Jackeline Perez
Mercy Obasanya
Crystal Orisakwe
Jocelyn Payan
Boluwatife Sanusi
Kalu-Anya Udochu
Lauren Wernet
Kelly Zarate

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Acronyms

ACA	Affordable Care Act
AIDS	Acquired Immunodeficiency Syndrome
ARIES	AIDS Regional Information and Evaluation System
CDC	Centers for Disease Control and Prevention
CHIP	Children’s Health Insurance Program
DPA	Dallas Planning Area
DSHS	Texas Department of State Health Services
EFA	Emergency Financial Assistance
eHARS	Enhanced HIV/AIDS Reporting System
EIIHA	Early Intervention of Individuals with HIV/AIDS
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
FPL	Federal Poverty Level
HCC	HIV/AIDS Care Continuum
HHS	Health and Human Services
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
HSDA	Health Service Delivery Area
LPAP	Local Pharmaceutical Assistance Program
MSM	Men who have Sex with Men
PEP	Post-Exposure Prophylaxis
PLWHA	People Living with HIV or AIDS
PrEP	Pre-Exposure Prophylaxis
RWPC	Ryan White Planning Council of the Dallas Area



Chapter 1: Introduction, Methods, and Conclusions

Introduction

The Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program provides HIV care and treatment services to low-income people living with HIV who are underinsured or underserved. It provides a comprehensive system of HIV primary medical care, essential support services, and medications for people living with HIV. The goal is to improve health outcomes and reduce HIV transmission among hard-to-reach populations. Title XXVI – HIV Health Care Services Program, in the Public Health Service Act as amended through Public Law 116-69 (enacted November 21, 2019) requires that grantees establish an HIV Health Services Planning Council whose duties include:

1. Determining the size and demographics of the population of individuals with HIV/AIDS,
2. Determining the needs of the population,
3. Establishing priorities for allocating funds that were allocated to the eligible area, and
4. Developing a comprehensive plan for the organization and delivery of health and support services.

The purpose of this report is to describe the size, demographics, and needs of the population of individuals with HIV/AIDS to facilitate establishment of funding allocation priorities and development of a comprehensive plan for the Dallas Eligible Metropolitan Area (EMA) and HIV Services Delivery Area (HSDA) and the Sherman-Denison HSDA. This service area is comprised of Collin, Cooke, Dallas, Denton, Ellis, Fannin, Grayson, Henderson, Hunt, Kaufman, Navarro, and Rockwall Counties. The objectives of the Comprehensive Needs Assessment are shown in [Table 1](#).

Table 1. Objectives of the 2019 Comprehensive Ryan White Needs Assessment
Identify trends in the HIV epidemic within the Dallas EMA/HSDA and Sherman Denison HSDA, focusing on recent changes and emerging affected populations.
Identify consumer service needs, needs that are not currently being fulfilled, service utilization patterns, and barriers to care.
Obtain detailed information and analyze the treatment initiation gap for People Living with HIV/AIDS (PLWHA) after being diagnosed.
Obtain detailed information on PLWHA with unmet need for medical care; including demographics, barriers, and strategies to connect to care.
Identify and evaluate the system of HIV care, evaluating current capacity gaps, and barriers (including but not limited to eligibility barriers) in the continuum and treatment cascade. This will include HIV/AIDS services providers and providers of service that PLWHA use.
Evaluate the system for and rate of linking PLWHA into medical care.
Identify and evaluate the impact of health care reform on Ryan White enrollment and types of services most needed after PLWHA enroll in expanded Medicaid programs or health insurance exchanges/marketplaces.
Evaluate and interpret the use of alcohol and other non-prescribed drugs and the impact on adherence and make recommendations to identify the best approach to address the subject.

This report presents the findings from analysis of the data that were collected to meet the needs assessment objectives, and their implications for meeting needs of PLWHA. It should be noted that this report includes appendices which provide detailed breakdowns of epidemiological data for each county in the Dallas EMA/HSDA and Sherman-Dennison HSDA.

Methods

Quantitative and qualitative data were collected from multiple sources using a variety of methods. They are summarized in [Table 2](#).

Table 2. Quantitative and Qualitative Data Sources and Methods

Quantitative epidemiologic and demographic data collected from the Texas Department of State Health Services, the U.S. Census, and other official data sources
A Consumer Survey of 392 PLWHA
Key Informant Interviews with 20 HIV Service Providers
Twelve (12) Consumer Focus Groups, that included youth (ages 18-24), African American women, Latinx men and women, PLWHA Over Age 55; men who have sex with men (MSM), individuals residing in rural areas, and transgender men and women
A Ryan White HIV Services Provider Capacity Survey completed by 8 of 9 service- providers
Website reviews and/or telephone surveys with 13 other service providers using a structured data collection template

Details about each data collection method and the respondents are presented in [Appendix A](#) of this report. Copies of the data collection tools are presented in [Appendix B](#) of this report.

Conclusions

This needs assessment mostly met its objectives. Findings and conclusions are presented in this section by objective, along with overall recommendations for services and the next needs assessment process.

Identify trends in the HIV epidemic within the Dallas EMA/HSDA and Sherman Denison HSDA, focusing on recent changes and emerging affected populations.

The incidence of new cases have remained fairly steady since 2013. The highest numbers of new HIV and AIDS diagnoses are in Dallas County, followed by Collin and Denton Counties. The prevalence of HIV/AIDS in the Dallas EMA continues to rise. Both the number of PLWHA and the rate per 100,000 population is highest in Dallas County. Collin and Denton Counties have higher numbers of PLWHA compared with other counties in the Dallas EMA. The rate per 100,000 is higher in Collin and Kaufman Counties. The remaining counties have lower prevalence and rates.

Results show that HIV/AIDS rates are declining in the Dallas EMA, but not for everyone. HIV/AIDS mortality rates for Black PLWHA in the Dallas HSDA are over five times the rate for non-Hispanic white PLWHA, suggesting a need to identify the reasons for the higher death rate and address them.

There is a lack of data for transgender individuals. Reliable estimates for the number are difficult to find, and HIV rates are unknown. Recent HRSA HIV/AIDS program client-level data suggest there are 157 identified transgender individuals receiving Ryan White services in the Dallas EMA. There is no such data available for counties in the Sherman-Denison HSDA. Results of the breakdown of new cases by race and ethnicity suggest that efforts to prevent racial and ethnic disparities in new cases and reduce new cases overall would have the greatest impact by targeting the African American and Hispanic/Latinx communities. Also, new diagnoses are growing fastest among the 25 to 34 years age group.

Rates among MSM continue to rise indicating a need to increase prevention efforts and messaging that specifically targets MSM.

Poverty rates are high among PLWHA in the Dallas EMA. While the poverty rate for individuals residing in the Dallas EMA is 11%, an estimated 23% of PLWHA in the Dallas EMA have incomes at or below the poverty level. Data were not available for the Sherman-Dennison HSDA.

Emerging health issues and comorbidities that complicate HIV care include sexually transmitted infections, obesity, diabetes, heart disease, and hypertension. Providers also reported increased mental health problems and substance abuse. Because of improvements in treatment, more PLWHA are living longer which is increasing the need for specialized geriatric care for this population. This needs assessment met this objective.

Identify consumer service needs, needs that are not currently being fulfilled, service utilization patterns, and barriers to care.

Providers in the Dallas and Sherman-Dennison HSDA's identified challenges to HIV/AIDS prevention. Younger people who did not see the epidemic in the beginning view HIV/AIDS as another chronic but treatable disease. There is still stigma associated with HIV and it creates barriers to treatment. HIV prevention should be included with general health prevention messaging such as drugs, diet, and exercise. Even with PrEP, people need to understand the need to use condoms to prevent other sexually transmitted infections. Messaging needs to be tailored toward audiences that experience the highest rates of transmission.

Barriers to HIV care cited by survey participants were the amount of time it takes to get care, the paperwork burden, the time it takes to get an appointment, lack of weekend and evening hours, the clinic treats HIV and not their other medical conditions, and the staff does not understand their culture. It is important to keep in mind that survey participants were predominantly from the Dallas. Evidence from data and providers suggests that for individuals living in suburban and rural areas, the paucity of services locally and resources and time necessary to reach services located in Dallas may also serve as a barrier. This needs assessment met this objective.

Obtain detailed information and analyze the treatment initiative gap for PLWHA after being diagnosed.

Barriers to successful linkage to care were identified using consumer surveys and focus groups. Patients perceived stigma when they go to HIV clinics. There are institutional barriers such as considerable time elapse and the paperwork burden between diagnoses and seeing a provider. PLWHA sometimes have higher order needs, such as housing instability or unresolved trauma that need to be resolved before they will seek treatment. Transportation may not be available, especially in rural areas. Psychosocial barriers include denial or having to come out to their families as they share their diagnosis. This needs assessment met this objective.

Obtain detailed information on PLWHA with unmet need for medical care; including demographics, barriers, and strategies to connect to care.

The State of Texas estimated that as many as 5,407 individuals in the Dallas EMA may be undiagnosed. Estimated numbers were higher among males, Blacks, ages 45-54, and MSM. Additionally, 21% of diagnoses in 2017 were late diagnoses with less than one year between the HIV and AIDS diagnosis.

Among PLWHA in the Dallas EMA, 79% were linked to care; 72.9% were retained in care, and 63.9% were virally suppressed. A total 87.7% of PLWHA who were retained in care were virally suppressed.

There are barriers to retaining PLWHA in care. There is a high administrative burden with paperwork required every six months. Information is not centralized so PLWHA who are seeking care must complete such updates with all of their providers. Youth lose their Medicaid coverage when they turn 19 and may drop out of care at that time. Resources are primarily centralized around downtown Dallas and not easily accessible to individuals living in Dallas County outside of the city or in other rural counties. Sometimes other needs arise and take priority, such as loss of housing, substance abuse issues, or life disruptions where people fall out of their routines. Not all PLWHA are comfortable with all providers and they may leave treatment after a couple of appointments.

Programs that are successful at linking people to and keeping people in care are generally collaborative, comprehensive, and offer a single system of care where all partners are fully informed. They offer high quality care with sincere and knowledgeable providers. They are often innovative and will try a variety of strategies and are designed specifically to meet the needs of the population they serve.

In summary, efforts to improve retention in care are needed, specifically targeting Black PLWHA, younger PLWHA (ages 13-44), and PWID. Efforts should focus on linking Black PLWHA to care and retaining them in care to increase their viral suppression percent. Additional efforts should be focused on Hispanic/Latinx PLWHA whose numbers are increasing and whose percentage of virally suppressed is less than that of White PLWHA, as well as PWID and ages 44 or younger individuals among the PLWHA population. Innovative and culturally relevant strategies are needed to overcome logistical barriers such as transportation, geographic distance, and hours/days of service as well as psychological barriers such as stigma, feelings of invulnerability, and denial. This needs assessment met this objective.

Identify and evaluate the system of HIV care, evaluating current capacity gaps, and barriers (including but not limited to eligibility barriers) in the continuum and treatment cascade. This will include HIV/AIDS services providers and providers of services that PLWHA use.

The Dallas EMA has excellent health care, although it is not necessarily available for or accessible by all PLWHA in the Dallas EMA. There is an insufficient supply of mental health care available to meet the needs of the population. There is also a need for mental health providers who are knowledgeable about LGBTQ individuals, HIV, and navigating life with HIV, as well as more culturally appropriate and community competent providers. Dental and vision services also need increased capacity in more locations.

There are 21 identified organizations providing a spectrum of HIV related services to PLWHA in the Dallas EMA who may not have sufficient resources for disease management. In terms of accessibility, most Ryan White funded organizations provide flexible hours, extensive language services (although only one language interpretation service), permit diverse payment options, and provide distinctive services to youth under the

age of 18. Potential areas of improvement identified include relatively longer wait times for dental care (average 0 to 50 days) and mental health counseling (average 0 to 10 days). These wait times were substantially longer than other services such as outpatient HIV medical care (0-7 days) or outpatient OB/GYN services (0-2 days).

The most prevalent needs not being met were needs for affordable housing, mental health care, and prevention messaging. Rural areas had specific unmet needs that included funding needed for outreach, peer support and navigation, support groups, and PrEP/PEP. Needs varied across priority populations.

Prevention services are not universally available throughout the Dallas EMA. They need to target specific geographies and populations and be more culturally responsive to them. Planning and assessment efforts for prevention need to be more inclusive and examine within group variation. PrEP and PEP are not accessible to everyone. There is a need for more widely available education about safe sex. Prevention initiatives need to target stigma among the larger population and within sub-populations, including rural, African American, and Latinx communities. This needs assessment met this objective.

Evaluate the system for and rate of linking PLWHA into medical care.

In 2018, 21% of PLWHA in the Dallas EMA were not linked to care. The percent of PLWHA with unmet need and 20 or more PLWHA was highest in the 75454 (Melissa; 43%); 75247 (Dallas west; 38%); 76205 (Denton; 37%); 75402 (Greenville, 36%); and 75401 (Greenville, 35%) zip codes. Many areas with unmet need did not have Ryan White funded services in proximity, were in rural areas or suburbs that do not have specialized HIV care.

Linkage to care varied by sex and race/ethnicity. A somewhat smaller percentage of females were linked to care compared with males; and percentages linked to care are lower for Black and Hispanic PLWHA compared to White and Other/Unknown.

In summary, targeted efforts to link PLWHA with care in the Dallas EMA are needed for women, Black and Hispanic persons, PWID, heterosexual individuals, and age groups 0-12, 13-24, and 65 and older. Peer support and peer navigation were suggested as potentially effective strategies. This needs assessment met this objective.

Identify and evaluate the impact of health care reform on Ryan White enrollment and types of services most needed after PLWHA enroll in expanded Medicaid programs or health insurance exchanges/marketplaces.

Respondents to the provider survey reported that the impact of the Affordable Care Act on their organizations and clients was mixed that there was mostly little to no impact. This was primarily attributable to Texas not accepting the expanded Medicaid provision. Other problems cited were client ineligibility, clients' inability to afford premiums, and its overall ineffectiveness with increasing access to care. This needs assessment met this objective.

Evaluate and interpret the use of alcohol and other non-prescribed drugs and the impact on adherence and make recommendations to identify the best approach to address the subject.

Providers reported they are seeing an increase in substance abuse among PLWHA. Consumer respondents reported the most frequently used substances were alcohol, marijuana, stimulants, depressants, and non-prescribed pain killers. Among consumers who dropped out of care, 26% reported using drugs as a reason. They also reported there are few services available for low income PLWHA who need substance abuse treatment. Substance abuse and other behavioral health services should be integrated into primary care. Resources are needed to expand inpatient substance abuse treatment as well. Explore the feasibility of programs such as Oxford House that provide both housing and substance abuse aftercare support. This needs assessment met this objective.

Recommendations for Services

Target prevention initiatives toward youth (ages 13-35), Black, and Hispanic/Latinx communities and MSM. Make testing more widely available, and work to have it incorporated into more routine health care. Provide testing at health fairs and large community events. Inform youth that they can be tested without parental consent. Provide youth with more consistent sexual health information and education.

Expand to more geographic locations and target populations identified as needing prevention and intervention services. Include individuals from underserved populations when developing strategies at the table as decision makers (e.g., transgender individuals; more people of color; youth).

Address racial disparities at multiple levels. At the individual level target unmet needs. At the community level, address stigma toward LGBTQ individuals and HIV/AIDS. At the systems level, systemic racism must be acknowledged and addressed.

Identify ways that the paperwork burden on both consumers and providers can be reduced. Consider a universal intake system and longer periods between required re-certification.

Join with other groups to advocate for Medicaid expansion and affordable housing options. As Dallas neighborhoods continue to gentrify, an increasing number of low-income individuals and families are being pushed out and unable to find affordable housing, including PLWHA. Such work can also help improve access and stability for people living in rural communities.

Provide comprehensive services with one-stop shops to the extent possible. Include services to meet psychosocial needs and peer navigators who can provide guidance and support.

Take a deep dive into examining the system of care. Incorporate more evaluation into services to determine both their efficiency and effectiveness and use findings for continuous improvement. Include voices of Black gay men, Black and Hispanic heterosexual women, members of the transgender communities, and others who have been traditionally excluded at the table for planning and decisions. More specific practice recommendations are discussed in each chapter of this report.

Needs Assessment Limitations

A more detailed report of methodologies and relevant limitations are presented in [Appendix A](#). Although the epidemiologic profile includes data from Dallas EMA/HSDA and Sherman-Dennison HSDA, most of the consumer survey participants resided in Dallas county. Therefore, survey data should be interpreted with caution.

Recommendations for Future Needs Assessments

First, future needs assessments should allow for at least 18 months for training, scheduling, data retrieval, data collection, and analysis before it is due for submission. Due to time restrictions, the methodologies for the present needs assessment were implemented concurrently and not sequentially. This is important because the epidemiological data could have informed sampling strategies for consumer surveys and focus groups. Second, future needs assessments should use more participatory methods, which also take more time to do. Outreach, engagement, and training for consumers and providers to participate in the design, data collection, analysis, and reporting is crucial for giving consumers a sense of ownership and increasing the chances that a more truly representative sample of voices will be included. This approach will also provide for a more comprehensive view of service needs in areas that were not reached by this or prior needs assessments. Finally, prior to the next needs assessment, it is recommended that the consumer survey length is shortened to include only the most important questions; and that questions are revised to read at a 7th or 8th grade reading level.



Chapter 2: HIV/AIDS in the Dallas EMA

The Region

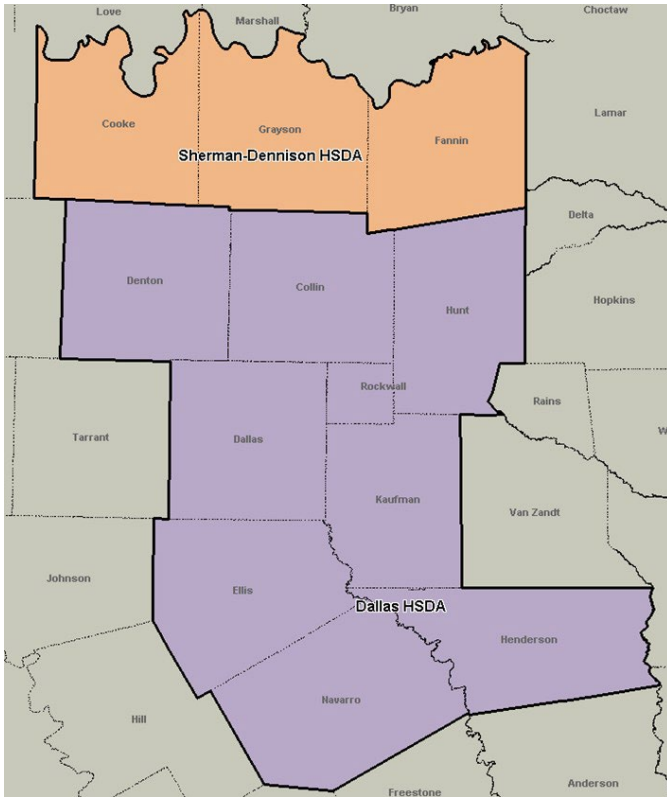


Figure 1. The Dallas EMA

For this report the Dallas Eligible Metropolitan Area (EMA) consists of Collin, Dallas, Denton, Ellis, Henderson, Hunt, Kaufman, Navarro, and Rockwall Counties of the Dallas Health Services Delivery Area (HSDA), and Cooke, Fannin, and Grayson Counties of the Sherman-Dennison HSDA. According to the US Census Bureau’s American Community Survey, in 2017 the total population of the EMA was 5,246,370: 5,040,889 in the Dallas HSDA and 205,481 in the Sherman-Dennison HSDA. A map of the Dallas EMA that shows the counties that are included, the Sherman-Dennison HSDA, and the Dallas HSDA is presented in Figure 1.

Table 3 presents summarized key statistics for the Dallas EMA that impact disparities or access to services. Because of their small population sizes, Census data did not provide breakdown statistics for Cooke, Fannin, and Navarro counties.

Table 3. Key Statistics for the Dallas EMA That Impact Disparities or Access to Services

Racial and Ethnic Distribution	The population of Dallas County is less than 50% White Non-Hispanic, unlike the other counties in the EMA where the percent of White Non-Hispanic residents range from 52.4% (Collin) to 81.2% (Fannin). Dallas County has the largest populations of Black Non-Hispanic and Hispanic residents, in absolute numbers and as percentages of the total population.
Age Distribution	Dallas County, where the majority of People Living With HIV/AIDS (PLWHA) reside, is the only county where more than half of residents are age 34 or younger.
Income Disparities	The percent of people living in poverty ranged from 5.0% to 21.1%. The lowest poverty rates were in Rockwall, Collin, Denton, and Ellis Counties and the highest were in Henderson, Dallas, Kaufman, and Hunt Counties. The mean household incomes in Collin, Denton, and Rockwall counties were all over \$100,000 per year.
Lack of Health Insurance	The percent of individuals with no health insurance ranged from 11.1% in Denton County to 21.7% in Dallas County with the percent in all counties higher than the U.S. average of 8.9%.
Education Disparities	Education level across counties varied from 5.7% of individuals in Rockwall County with less than a high school education to 20.3% in Dallas County.
Transportation Access	Between 1.3% (Rockwall County) and 7.0% (Hunt and Kaufman Counties) of households did not have access to a vehicle.

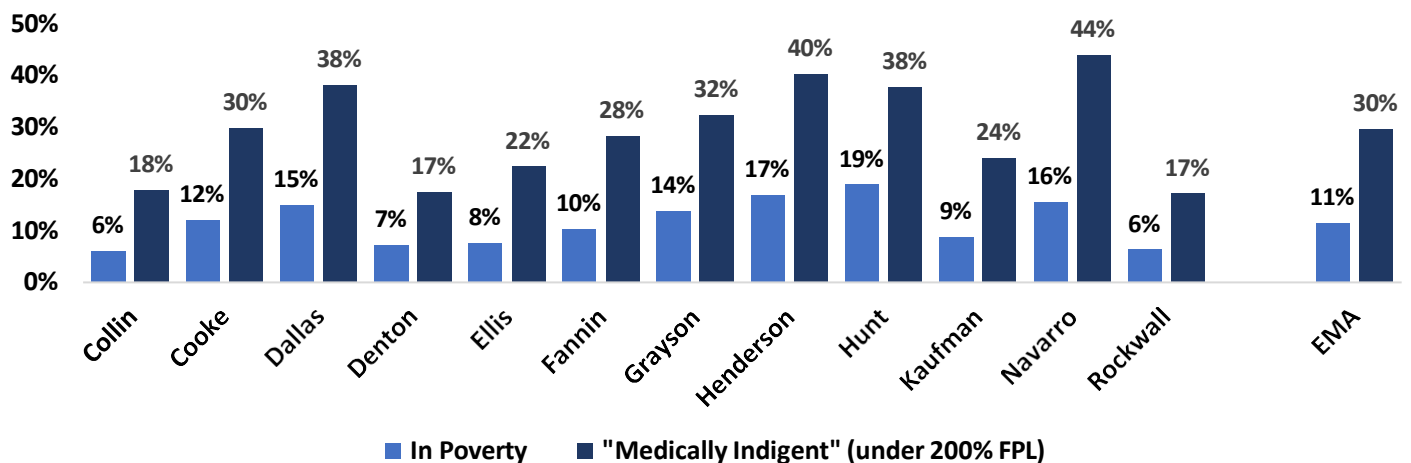
Table 3. Key Statistics for the Dallas EMA That Impact Disparities or Access to Services

Language Barriers	The percent of people who speak English less than very well ranged from 2.8% (Collin County) to 19.7% (Dallas County).
Internet Access	The percent of households with Broadband Internet ranged from 70.8% in Grayson County to 96.1% in Rockwall County.

Source: American Community Survey 2018 One-Year Estimates <https://www.census.gov/programs-surveys/acs/data.html>

Poverty is an important indicator for access to medical care. Those who are under 200% of the Federal Poverty Level (FPL) are considered "Medically Indigent." Most do not qualify for assistance, have no source of health coverage available and no way to pay for necessary medical care.

Percent In Poverty and Medically Indigent by County in the Dallas EMA



Source: U.S. Census Data 2018.

Figure 2. Percent in Poverty and Medically Indigent by County in the Dallas EMA

Figure 2 shows that overall, 30% of residents in the Dallas EMA are medically indigent, with 11% living below the FPL. This rate varies across counties with the highest rates of medically indigent in Navarro (44%), Henderson (40%), Hunt (38%) and Dallas (38%) counties. The lowest percentage of medically indigent are in Rockwall (17%), Denton (17%), and Collin (18%) counties.

Transportation for medical care can be a barrier to care for some populations. Some areas in the Dallas EMA have public transportation, and public transportation is limited to specific areas or populations or not at all available in other areas. For example, the cities of Cedar Hill and Duncanville, both located in the southwestern section of Dallas county, have no public transportation available. Transportation services that are available are summarized in Table 4.

Table 4. Transportation Services Available in the Dallas EMA

Transit System	Counties/Cities Served
Collin County Transit	Subsidized taxi voucher serving Celina, Lowry Crossing, McKinney, Melissa, Princeton, and Prosper. Limited to ages 65 and older; individuals with disabilities who meet one of seven criteria; or low income.

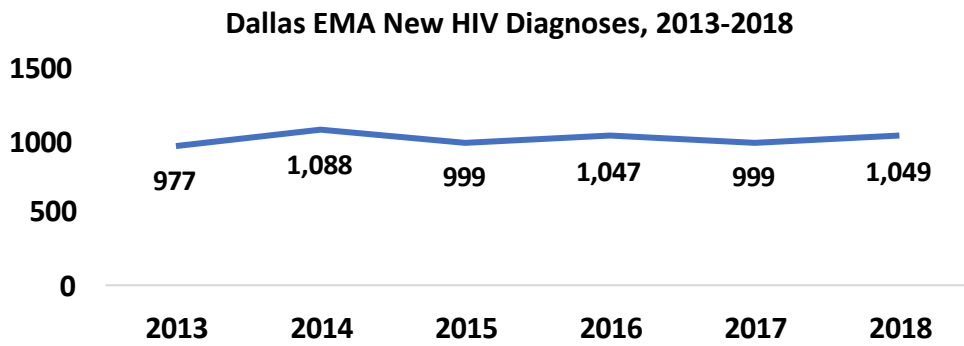
Table 4. Transportation Services Available in the Dallas EMA

Transit System	Counties/Cities Served
Community Transit Service	Rural transportation services in Navarro and Ellis Counties; reservation based.
The Connection	For residents of Hunt county, reservation-based public transit services are available to all residents. Subsidized and/or discount services for seniors, individuals with disabilities, and low-income residents in Hunt County.
Dallas Area Rapid Transit (DART)	Dallas County (cities north of Interstate 20) Collin County (Plano) One route to Glenn Heights
DART – Collin County Rides	Wylie, Allen and Fairview age 65 or older OR have a certified disability.
Grand Connection	Dallas County, Grand Prairie for age 60 and older and individuals with a physical or mental disability
STAR Transit	Kaufman County Rockwall County Some medical transportation for: Dallas County cities of Mesquite, Balch Springs, Sunnyvale, Seagoville, Hutchins, DeSoto, Rowlett Ellis County cities of Waxahachie and Ennis Navarro County the city of Corsicana
Texoma Area Paratransit System (TAPS)	By-appointment medical transportation for: Grayson County Cooke County Fannin County
Denton County Transit Authority (DCTA)	Denton County (Denton, Lewisville, Highland Village)
GoBus (East Texas Council of Governments)	By-appointment public transportation for Henderson County, low- or no-cost for seniors, free for veterans and military; others are charged \$2 per trip; connects eastward toward Tyler/Longview area, no connections toward Dallas

Detailed population and demographic information by county is presented in [Appendix C](#) of this report.

New HIV Diagnosis

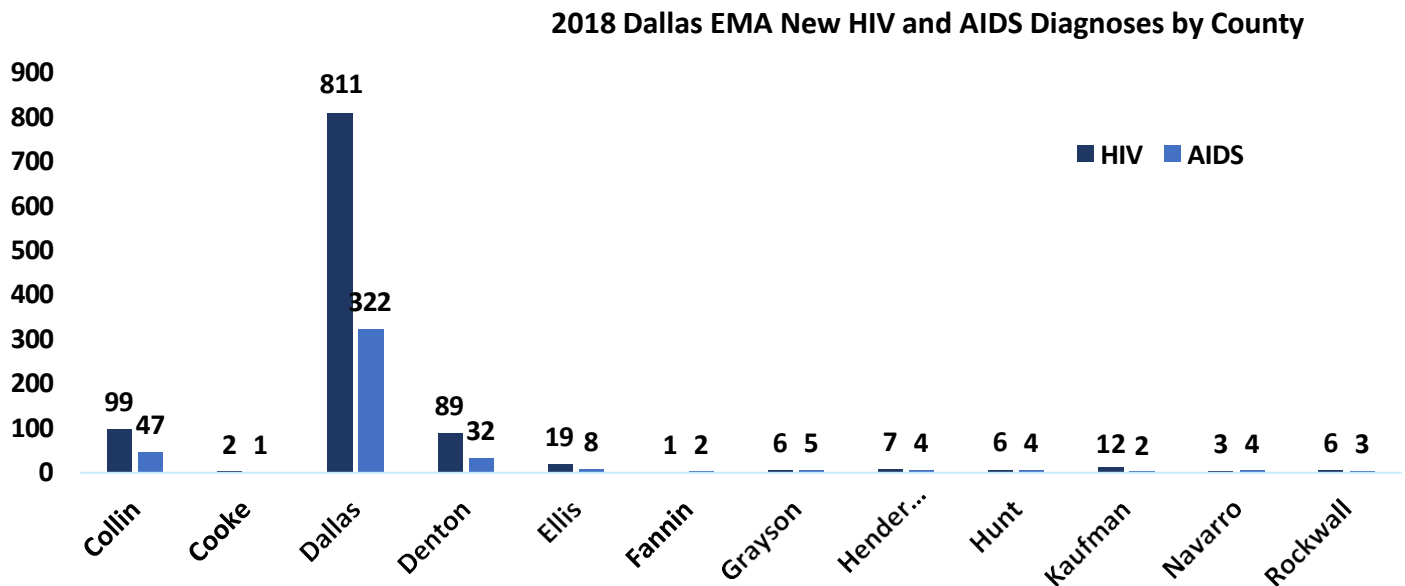
In 2018, the most recent year for which we have statistics, there were 1,049 new cases of HIV diagnosed in the Dallas EMA. As shown in [Figure 3](#), the rate between 2013 and 2018 ranged from the lowest of 977 in 2013 to the high of 1088 in 2014, remaining somewhat steady over the years.



Source: Texas DSHS Center for Health Statistics
 Figure 3. Dallas EMA New HIV Diagnoses, 2013-2018

The new HIV diagnoses in 2018 was not evenly distributed across counties in the Dallas EMA. Dallas County had the highest number of cases (see Figure 4), followed by Collin and Denton counties. Dallas, Collin, and Denton Counties are among the 25 counties in Texas with the highest number of new HIV and AIDS diagnoses. Dallas is

number two for new HIV diagnoses in the state with 30.7 cases per 100,000 population, and number three for new AIDS diagnoses with 12.2 per 100,000. Both Collin and Ellis Counties were also among the top 25 counties in Texas for the rate per 100,000 for AIDS diagnoses. Fourteen of the 50 cities in Texas were located in the Dallas EMA: Dallas (#2), Irving (#9), Garland (#16), Grand Prairie (#18), Plano (#20), Mesquite (#22), Denton (#27), Carrollton (#30), Lewisville (#35), Richardson (#40), Cedar Hill (#44), Frisco (#45), DeSoto (#49), and McKinney (#50).



Source: Texas DSHS Center for Health Statistics
 Figure 4. 2018 Dallas EMA New HIV and AIDS Diagnoses by County

More detailed trend data for HIV and AIDS diagnoses, including breakdowns by county and sub-groups are presented in [Appendix D, Table D.1](#).

State of Texas Achieving Together Plan

The State of Texas has adopted *Achieving Together*, a plan to reduce new HIV infections by 50% annually by 2030. Progress toward this goal can be achieved if 90% of PLWHA know their HIV status, 90% of those who know their status are on antiretroviral therapy (ART), and 90% of those on ART achieve viral suppression. Because PLWHA who are virally suppressed are not infectious, achieving these goals will reduce the number of opportunities for HIV transmission in the state, and reduce the number of new HIV infections annually. Detailed data by subgroup for progress toward meeting these goals are presented in [Appendix D, Table D.2](#).

Engagement in High Risk Activities

The CDC's Behavioral Risk Factor Surveillance System (BRFSS) Survey collects state data about U.S. residents regarding health-related risk behaviors. One of the questions asked is "Do any of these situations apply to you: injected any drug other than those prescribed for you, been treated for a sexually transmitted disease or STD, have given or received money or drugs in exchange for sex, had anal sex, or had four or more sex partners?" Results from Dallas EMA counties (Figure 5) show that the responses to this question suggest that the rate of high-risk behavior was higher in 2017 compared with 2012, or (because of the wording of the question) that more individuals in the Dallas EMA had been treated for an STD. A higher percentage of males reported high risk behavior compared with the total population.

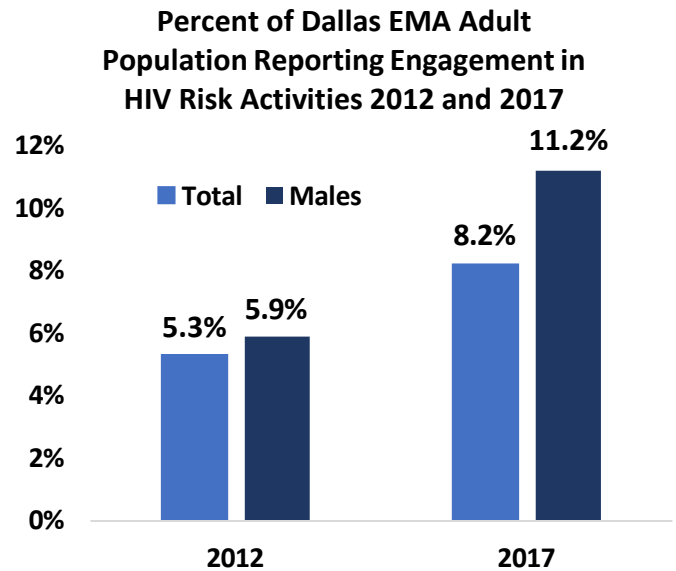
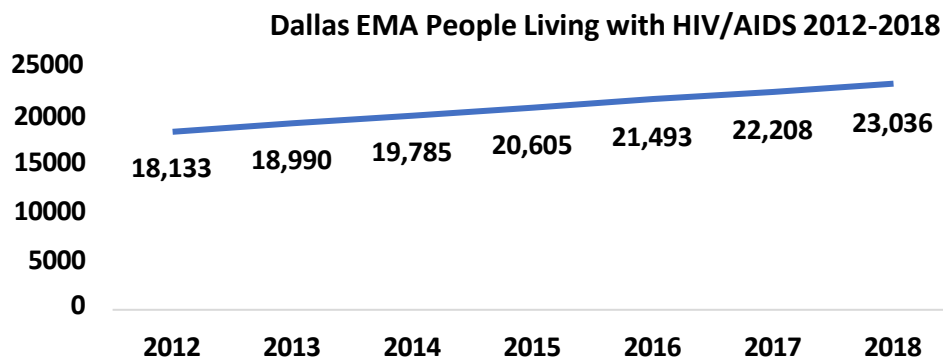


Figure 5. Percent of Dallas EMA Adult Population Engaged in HIV Risk Activities, 2012 and 2017

KEY FINDING: The 2017 report of progress toward the Achieving Together goals indicates that priority populations for prevention and intervention, populations within the North Texas HIV epidemic who are farthest from the Achieving Together goals are women, transgender people, Blacks (men, MSM, and women), under age 24, and injection drug users.

People Living with HIV/AIDS

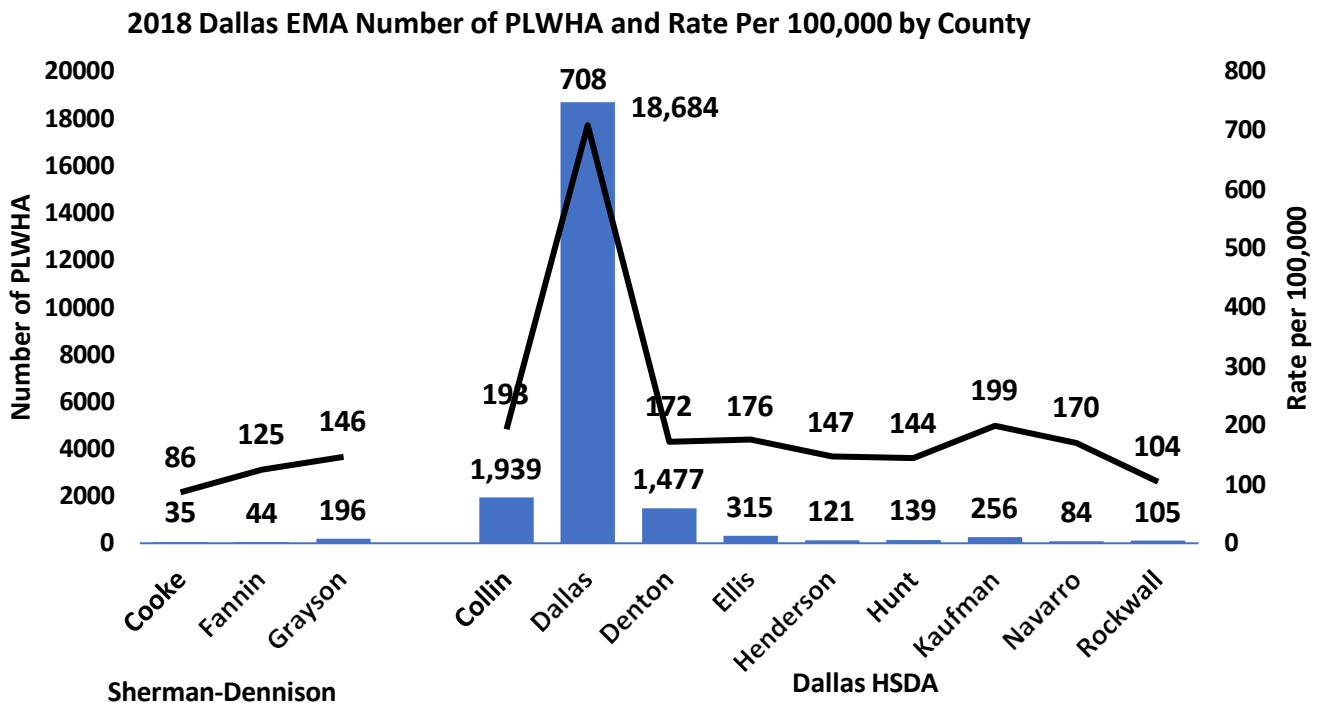


Source: Texas DSHS Center for Health Statistics

Figure 6. Dallas EMA People Living with HIV/AIDS, 2012-2018

The numbers and rates of PLWHA in the Dallas EMA vary across the counties, with Dallas County having a much higher number and rate than the other counties. Dallas, Collin, and Denton counties were among the 25 counties in Texas with the highest number of cases. In 2018, Dallas, Kaufman, and Collin Counties were among the top 25 counties in Texas with the highest case rates per 100,000.

The number of people living with HIV/AIDS continues to rise steadily with 4,903 more cases in 2018 compared with 2012 (Figure 6). The rise is due to the number of new diagnoses and HIV positive individuals moving to the Dallas EMA and is offset by deaths and individuals moving away from the Dallas EMA.



Source: Texas DSHS Center for Health Statistics

Figure 7. 2018 Dallas EMA Number of PLWHA and Rate per 100,000 by County

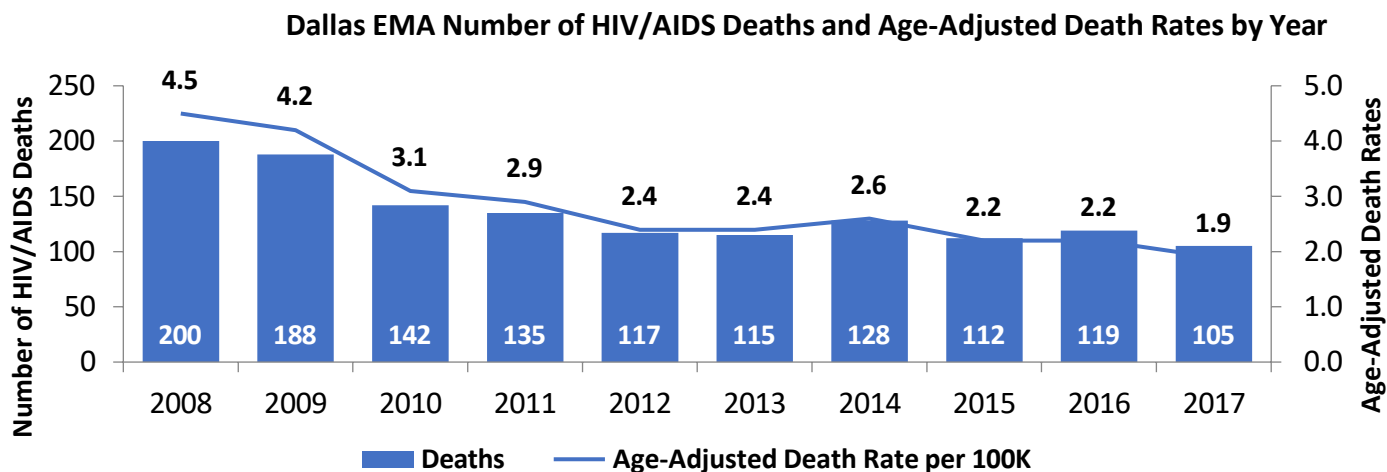
Table 5. Number of PLWHA and % of the Population with HIV/AIDS by ZIP Code		
ZIP Code	Number of PLWHA	% of the Population with HIV/AIDS
75247	20	2.8%
75219	493	2.1%
75203	262	1.6%
75202	33	1.6%
75246	36	1.6%
75215	205	1.3%
75235	239	1.3%
75216	415	0.8%
75231	282	0.7%
75243	428	0.6%
75228	293	0.4%
75217	258	0.3%

Table 5 shows the Dallas EMA ZIP codes with the most PLWHA and/or the highest HIV prevalence rates in the Dallas EMA. They are listed in order of the highest prevalence rates.

The smallest number of PLWHA among these ZIP codes, 75247, has the highest percent of the population with HIV/AIDS. This is likely due to the size of the population residing in this area, which is northwest of downtown Dallas. The highest number is in ZIP code 75219 which is located just north of downtown Dallas. All the ZIP codes with the highest number and percentage of the population are located in the City of Dallas.

Deaths

The number of persons dying from HIV/AIDS annually in the Dallas EMA has fallen since 2008 (Figure 8). The age-adjusted death rate during that time-period fell by more than half, from 4.54 deaths per 100,000 in 2008 to 1.91 per 100,000 in 2017. The median age at death for those who died from HIV/AIDS in the Dallas EMA increased by over nine years, from 43.4 years in 2008 to 52.9 years in 2017. These statistics suggest that the Ryan White service providers and the broader healthcare community in the EMA have reduced mortality and improved longevity for PLWHA.



Source: Texas DSHS Center for Health Statistics

Figure 8. Dallas EMA Number of HIV/AIDS Deaths and Age-Adjusted Death Rates by Year, 2008-2017

Although county-level HIV/AIDS case fatality rates are not available for most of the counties in the EMA, annualized five-year case fatality rates for the three largest counties for 2012-2016 were: Collin (3.68 deaths per 1,000 PLWHA), Dallas (5.28 deaths per 1,000 PLWHA), and Denton (5.51 deaths per 1,000 PLWHA). For the other nine counties (Cooke, Ellis, Fannin, Grayson, Henderson, Hunt, Kaufman, Navarro, Rockwall) combined, the 2012-16 annualized case fatality rate was 11.41 deaths per 1,000 PLWHA. Taken together these statistics show improvements in case-fatality rates from 2012 to 2017.

HIV/AIDS mortality rates for the Dallas HSDA are higher for Black PLWHA (6.2 deaths per 100,000 population) compared with non-Hispanic white PLWHA (1.1 deaths per 100,000).

***KEY FINDING:** The results that highlight the locations of PLWHA suggest that the concentration of Ryan White services in Dallas, Collin, and Denton Counties, where the large majority (95%) of PLWHA in the EMA live, could serve as a disadvantage for PLWHA living farther from Dallas County, in areas of Dallas County that do not have services and lack transportation.*

The results also show that HIV/AIDS mortality rates for Black PLWHA in the Dallas HSDA are over 5 times the rate for non-Hispanic white PLWHA. This suggests there is a need to identify reasons for the higher death rate and address them.



Chapter 3: Disparities and Sub-Populations

Transgender Individuals

Reliable estimates for the number of transgender individuals in the Dallas EMA population are difficult to find. Applying national estimates of between one and five transgender individuals per 1,000 adults, we can estimate that 4,000-20,000 Dallas EMA adults are transgender, in addition to a possible few hundred teens.

Given estimated HIV-positive rates of around 14% for transwomen in the United States, (Becasen, Denard, Mullins, Higa, & Sipe, 2019), there may be between 560 and 2,800 HIV-positive transgender individuals in the Dallas EMA. A federal grant-funded project (National HIV Behavioral Surveillance) to carry out data collection among transgender PLWHA is under way in Dallas and may provide clearer data in the future.

The most recent HRSA HIV/AIDS Program Client-Level Data Report counted 157 identified transgender individuals receiving Ryan White services in the Dallas EMA. Transgender PLWHA who are in care for HIV achieve viral suppression 80% of the time.

Many primary care clinicians do not have, or do not use, data fields in their electronic medical records to document transgender status. There are social and psychological barriers to transgender individuals admitting their status to healthcare providers and others when it is not clinically relevant to do so, which could lead to underreporting in HIV statistics, as well as lower HIV testing rates.

For all these reasons there is cause for concern about whether HIV positive transgender adults in the area have been diagnosed and are in treatment. Until better data are available about HIV prevalence among transgender adults in the Dallas EMA, it is difficult to know how many HIV positive transgender individuals there are, whether they are aware of and using Ryan White services, and whether those services meet their needs.

One of the more hopeful developments for transgender individuals locally is the increasing availability of outpatient physician services to meet their gender transition needs. As more Dallas area transwomen and transmen get regular medical care at gender affirming clinics, more will be tested for HIV and counseled about precautions, and the chances of stopping the HIV epidemic in this group will increase.

Race/Ethnicity

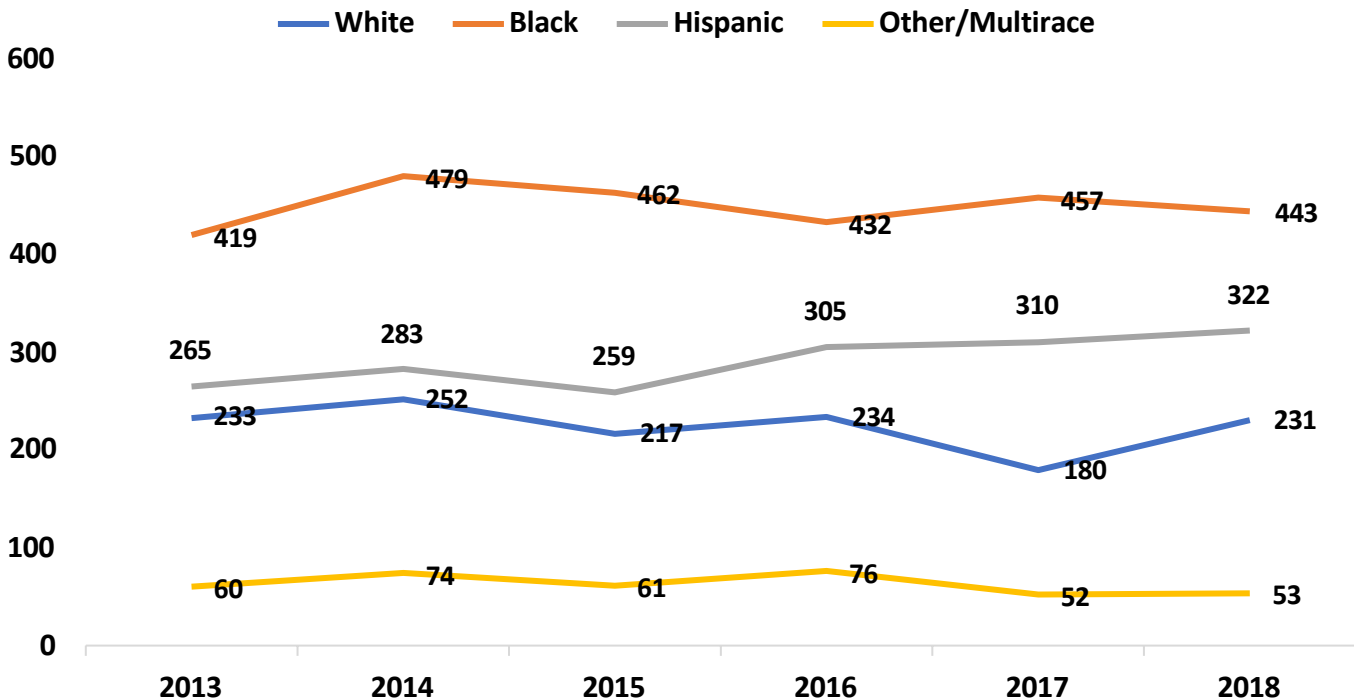
The number of new HIV cases diagnosed for Black individuals is disproportionately highest across all years. For example, in 2017 the number of new HIV cases in the Dallas EMA among Black individuals was 46% of the total number of new cases even though only 13.8% of the Dallas EMA population was Black.

The number of cases for Hispanic individuals was also disproportionately high. While 24.4% of the population in the Dallas EMA was Hispanic in 2017, 31% of new HIV cases diagnosed were Hispanic individuals. Data indicate the number of new HIV diagnoses for Hispanic individuals has been trending upward since 2015.

Notably, non-Hispanic Black individuals are significantly more likely to have been tested for HIV in their lifetime, compared to non-Hispanic White individuals and Hispanic individuals. In 2017, 65.5% of the Black adult population in the Dallas EMA reported they had been tested for HIV on the CDC’s BRFSS survey, compared with 41.9% of White individuals and 30.7% Hispanic individuals who participated in the survey.

KEY FINDING: Results of the breakdown of new cases by race and ethnicity suggest that efforts to prevent racial and ethnic disparities in new cases and reduce new cases overall would have the greatest impact by targeting the African American and Hispanic communities.

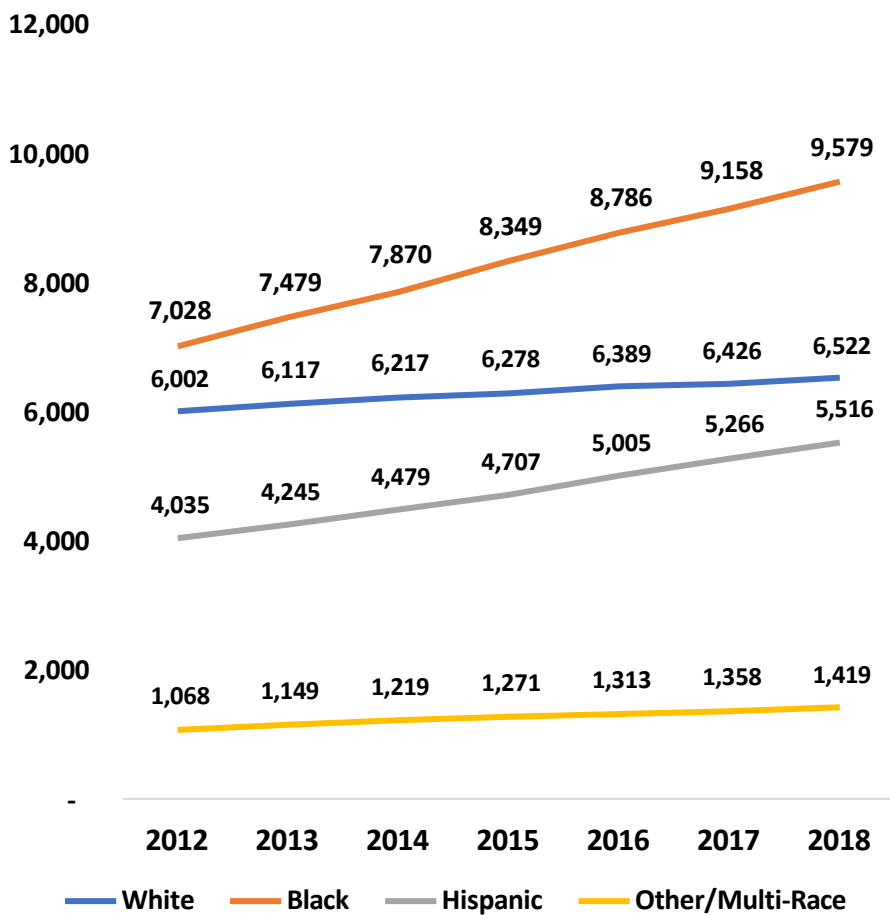
Dallas EMA New HIV Diagnosis by Race/Ethnicity 2013 - 2018



Source: Texas DSHS Center for Health Statistics

Figure 9. Dallas EMA New HIV Diagnosis by Race/Ethnicity 2013-2018

Dallas EMA People Living with HIV/AIDS by Race/Ethnicity 2012-2018



Among PLWHA, the highest prevalence is among Black individuals, followed by White individuals, Hispanic individuals, and Other/Multi-Race. The numbers for all four groups have risen steadily between 2012 and 2018, with a slightly greater incline among Black and Hispanic individuals.

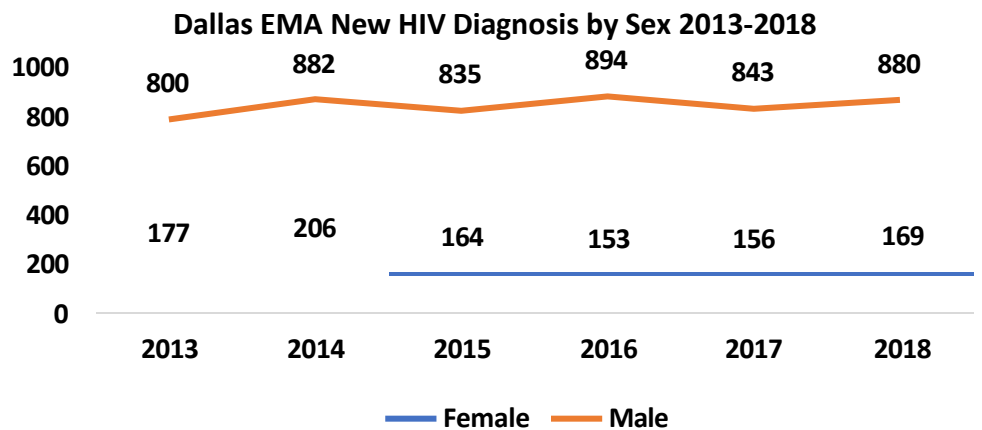
In 2018, there were a higher number of White PLWHA compared with Hispanic individuals. The gap in numbers between the two groups has been narrowing since 2012. With the higher rates of new HIV cases among Hispanic individuals compared with White individuals, it is possible that over time the number of Hispanic PLWHA will exceed that of White PLWHA.

Figure 10. Dallas EMA PLWHA by Race/Ethnicity 2012-2018

Sex

Across the six-year period, the numbers of new cases for men and women has remained somewhat steady, with rates for men over four times higher than those for women.

The differences are also reflected in the prevalence of PLWHA, where 80.7% are male.



Source: Texas DSHS Center for Health Statistics

Figure 11. Dallas EMA New HIV Diagnosis by Sex 2013-2018

Dallas EMA People Living with HIV/AIDS by Sex 2012-2018

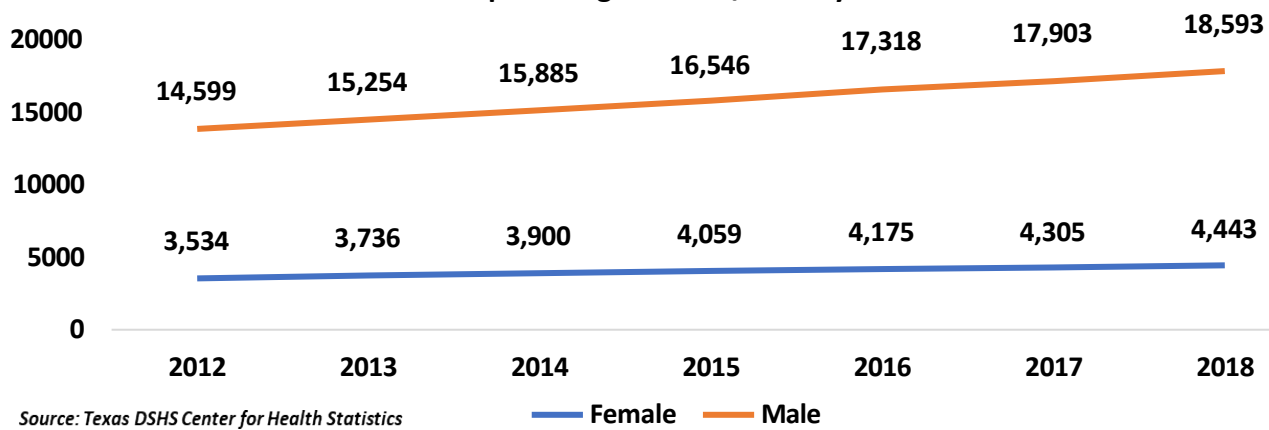


Figure 12. Dallas EMA PLWHA by Sex 2012-2018

Age

Dallas EMA New HIV Diagnosis by Age Group 2013-2018

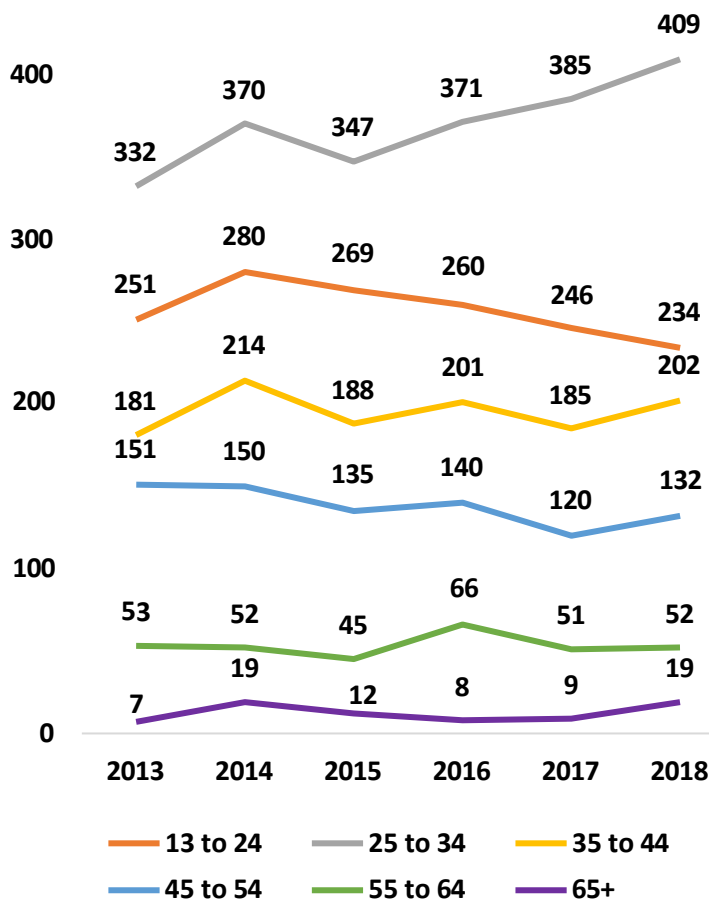


Figure 14. Dallas EMA New HIV Diagnosis by Age Group 2013-2018

The number of new HIV diagnoses is growing fastest among the 25 to 34 years age group. There has been some increase in the 35 to 44 age group. There has been a steady decline in new cases in the 13 to 24 age group. The 45 to 54 age group showed a slight decline, while the number of new HIV diagnoses for the 55 to 64 years age group has remained somewhat steady other than an increase in 2016. The 65+ age group fluctuated from seven to 19 cases per year across this six-year period.

Dallas EMA New HIV Diagnosis for Pediatrics Ages 0 to 12 2013-2018

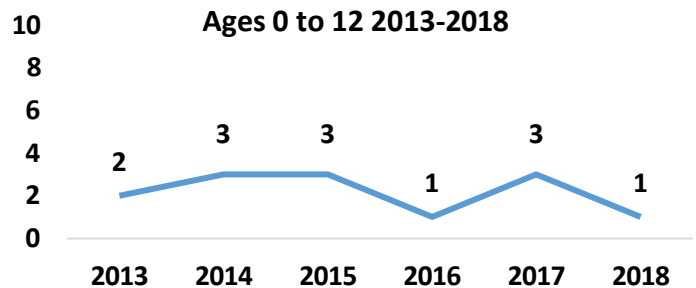
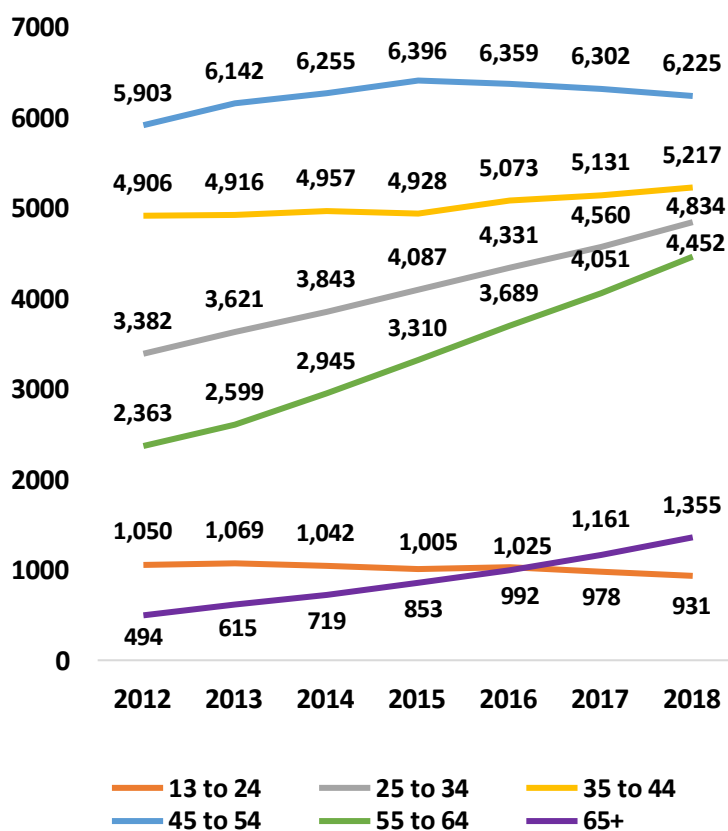


Figure 13. Dallas EMA New HIV Diagnosis for Pediatrics Ages 0 to 12 2013-2018

Pediatric cases remained low, ranging from one to three per year.

Dallas EMA People Living with HIV/AIDS by Age 2012-2018

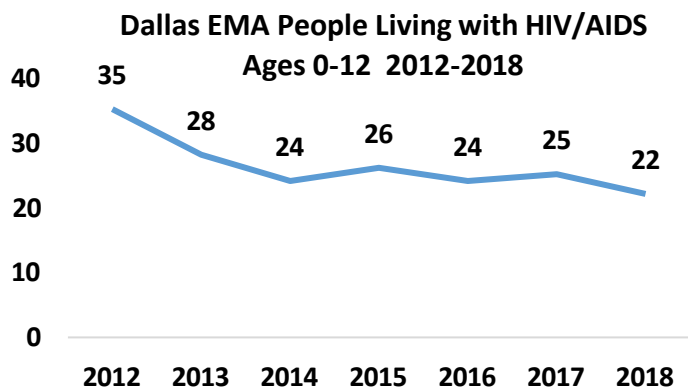


Source: Texas DSHS Center for Health Statistics

Figure 15. Dallas EMA PLWHA by Age 2012-2018

The age distribution of PLWHA is changing and does not mirror the distribution of the new HIV diagnoses by age group. The largest number of PLWHA is in the 45-54 age group, and the second largest is 35-44 age group. There is substantial growth among both the 25-34 age group and 55-64 age group. Among the 25-34 age group the rise in PLWHA is likely attributable to the rising numbers of new cases, whereas the rise in the 55-64 and 65+ age groups are primarily due to an aging PLWHA population.

As we see a decline in new cases among the 13-24 age group, we also see a decline in PLWHA in the same age group. Pediatric cases of PLWHA have continued to decline as the incidence of new HIV/AIDS cases among children ages 0-12 remains low.



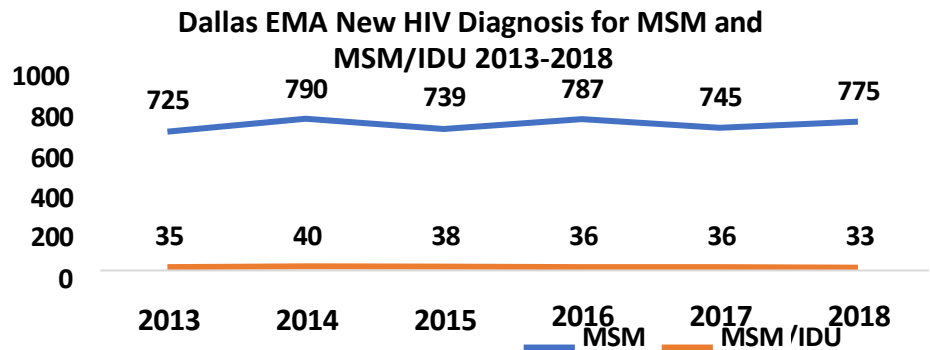
Source: Texas DSHS Center for Health Statistics

Mode of Transmission

There are multiple ways that HIV can be spread from person to person. For surveillance purposes, transmission categories are used and persons with more than one reported risk factor area classified in the transmission category listed first in the hierarchy, so they are only counted one time (CDC, 2016). The only exception is men who report sexual contact with other men *and* injection drug use has been combined into a separate category. The categories used are male-to-male sexual contact (MSM), heterosexual contact, injection drug use (IDU and PWID) and male-to-male sexual contact and injection drug use (MSM/IDU).

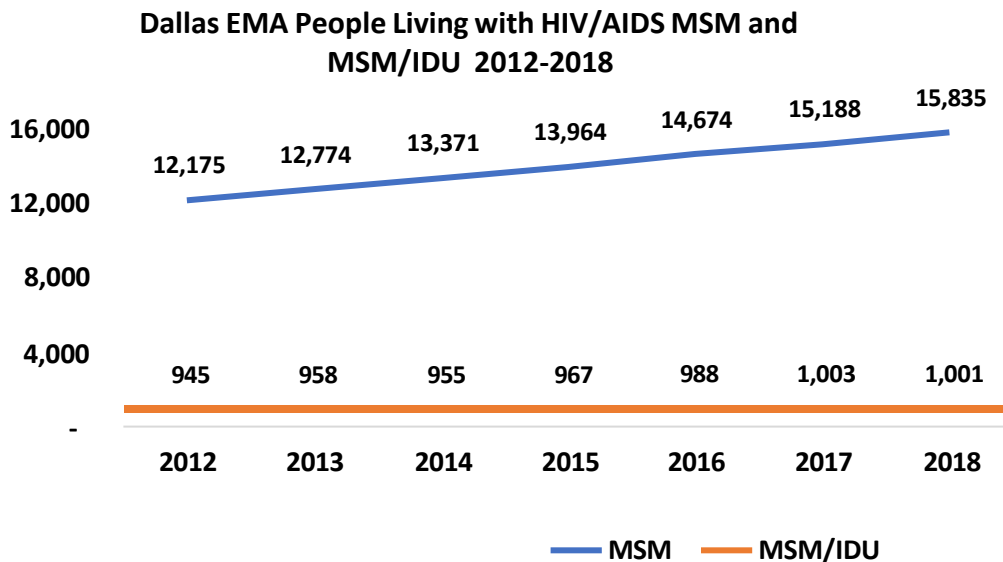
MSM and MSM/IDU

Men having sex with men (MSM) remains the most prevalent mode of transmission in the Dallas EMA, with a low number of them potentially attributed to intravenous drug use (IDU).



Source: Texas DSHS Center for Health Statistics

Figure 17. Dallas EMA New HIV Diagnosis for MSM and MSM/IDU 2013-2018



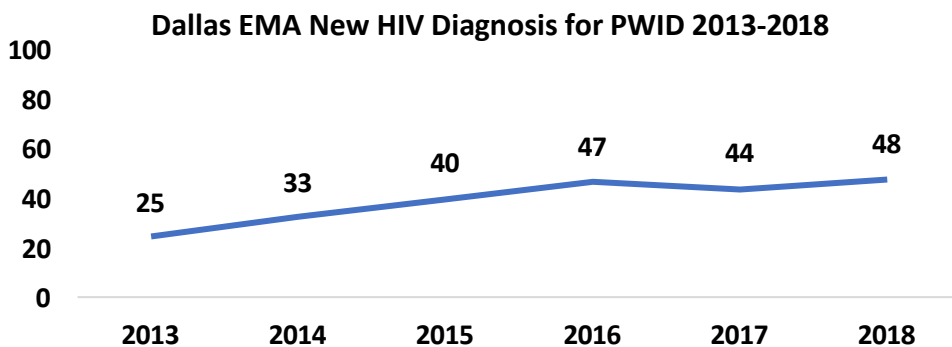
Source: Texas DSHS Center for Health Statistics

Figure 18. Dallas EMA PLWHA MSM and MSM/IDU 2012-2018

The prevalence of PLWHA whose mode of transmission was MSM continues to rise at a steady rate consistent with the steady rate of new HIV diagnoses among this group.

KEY FINDING:
The continuing rise in cases where MSM is the mode of transmission indicates a need to increase prevention efforts and messaging targeting MSM.

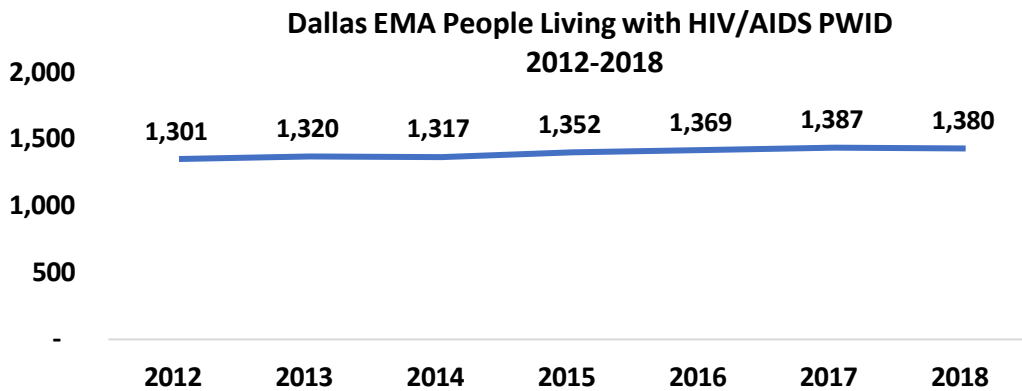
People Who Inject Drugs (PWID)



Source: Texas DSHS Center for Health Statistics

Figure 19. Dallas EMA New HIV Diagnosis for PWID 2013-2018

The number of new HIV diagnoses for people who inject drugs in the Dallas EMA rose from a low of 25 in 2013, to a high of 48 in 2018.



The prevalence of PLWHA whose mode of transmission was intravenous drug use has remained somewhat steady, rising by 79 individuals when comparing 2012 and 2018.

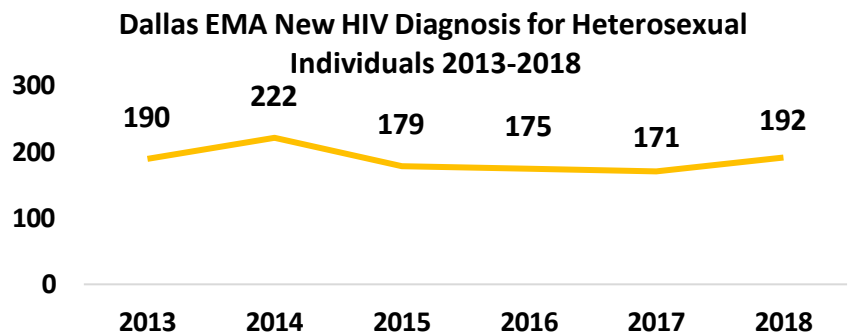
Source: Texas DSHS Center for Health Statistics

Figure 20. Dallas EMA PLWHA PWID 2012-2018

KEY FINDING: While prevention efforts should be continued and draw upon the most effective prevention methods for PWID, they should not be considered a targeted priority for new prevention initiatives at this time. The number of new cases for this mode of transmission should be monitored in the event this changes.

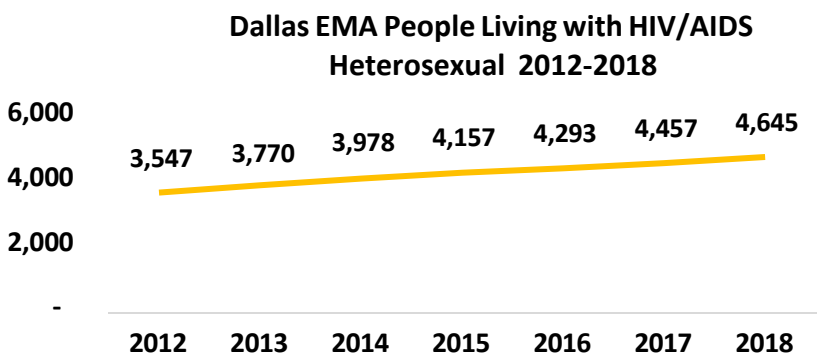
Heterosexual Transmission

Heterosexual transmission is the second most common route of HIV infection in the Dallas EMA. Heterosexual transmission has remained somewhat steady from 2013 to 2018.



Source: Texas DSHS Center for Health Statistics

Figure 21. Dallas EMA New HIV Diagnosis for Heterosexual Individuals 2013-2018



Source: Texas DSHS Center for Health Statistics

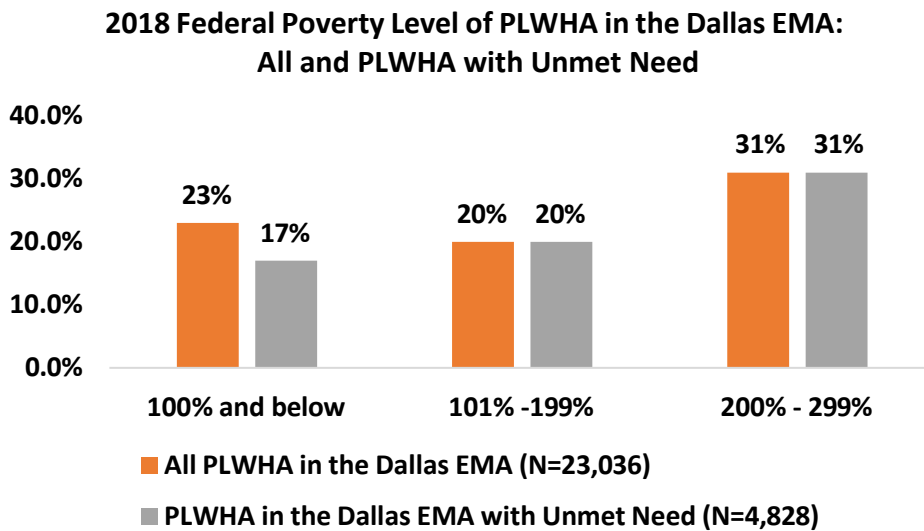
Figure 22. Dallas EMA PLWHA Heterosexual 2012-2018

While the number of new diagnoses for transmission to heterosexuals has been steady, the actual number of PLWHA with high-risk heterosexual transmission as the mode of transmission continues to rise. This is the second largest group among PLWHA.

Socioeconomics

Socioeconomic factors and social determinants of health that impact HIV/AIDS prevention, the prevalence of PLWHA, and access to care include poverty, education, housing/homelessness, health insurance, language, disabilities, and access to transportation.

Poverty

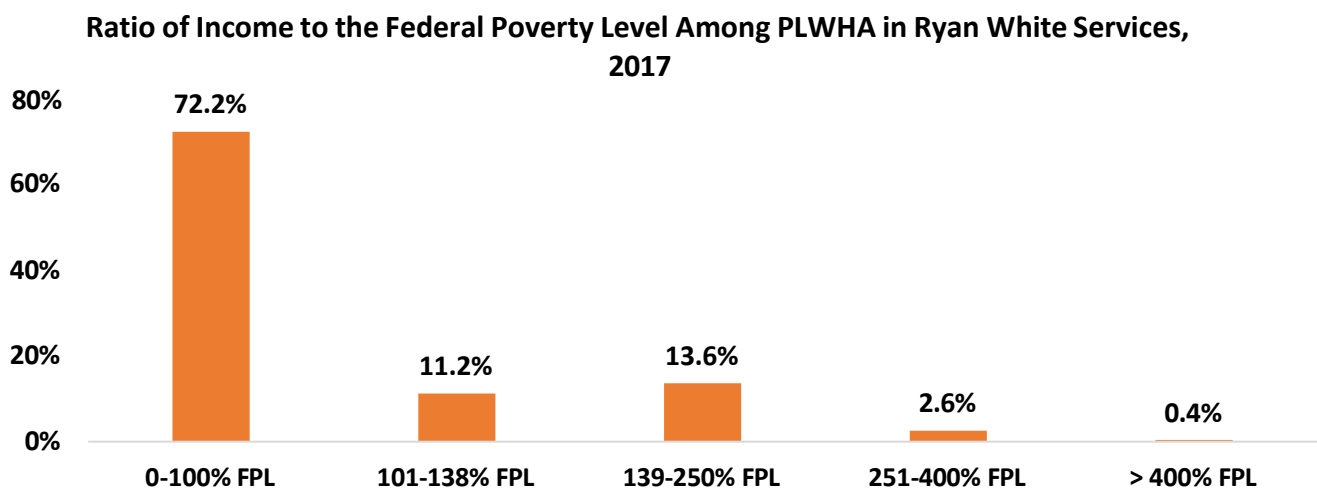


Source: Texas DSHS Center for Health Statistics

Poverty is more common among PLWHA compared with the general population. Whereas 11% of individuals residing in the Dallas EMA live at or below the FPL, an estimated 23% of PLWHA are at or below the FPL. An estimated 5,667 (24.6%) of the 23,036 PLWHA in the Dallas EMA in 2018 did not have health insurance. Among the 4,828 identified as having unmet medical needs, an estimated 821 (17%) did not have medical insurance.

Figure 23. 2018 Federal Poverty Level PLWHA in the Dallas EMA

Whereas 11% of individuals residing in the Dallas EMA live at or below the FPL; among Ryan White Service users, the percentage is 72.2%, or over six times the rate.



Source: Ryan White HIV/AIDS Program Annual Client-Level Data Report

Figure 24. Ratio of Income to the FPL Among PLWHA in Ryan White Services 2017

Housing and Homelessness

Housing challenges and homelessness are common among PLWHA, consistent with the high prevalence of poverty. Among 2017 Ryan White services users in the Dallas EMA, 300 (2.94%) had a housing status classified as unstable, which includes homeless in a shelter or homeless on the streets, and another 4,278 (41.94%) had a housing situation classified as temporary, which includes living with relatives or friends, in transitional housing, in jail or in a healthcare facility.

Texas State Department of Health Services data estimated 898 (3.9%) of 23,036 PLWHA were homeless in the Dallas EMA in 2018. Among the 4,828 determined to have unmet medical needs, 164 (3.4%) were homeless.

Incarcerated

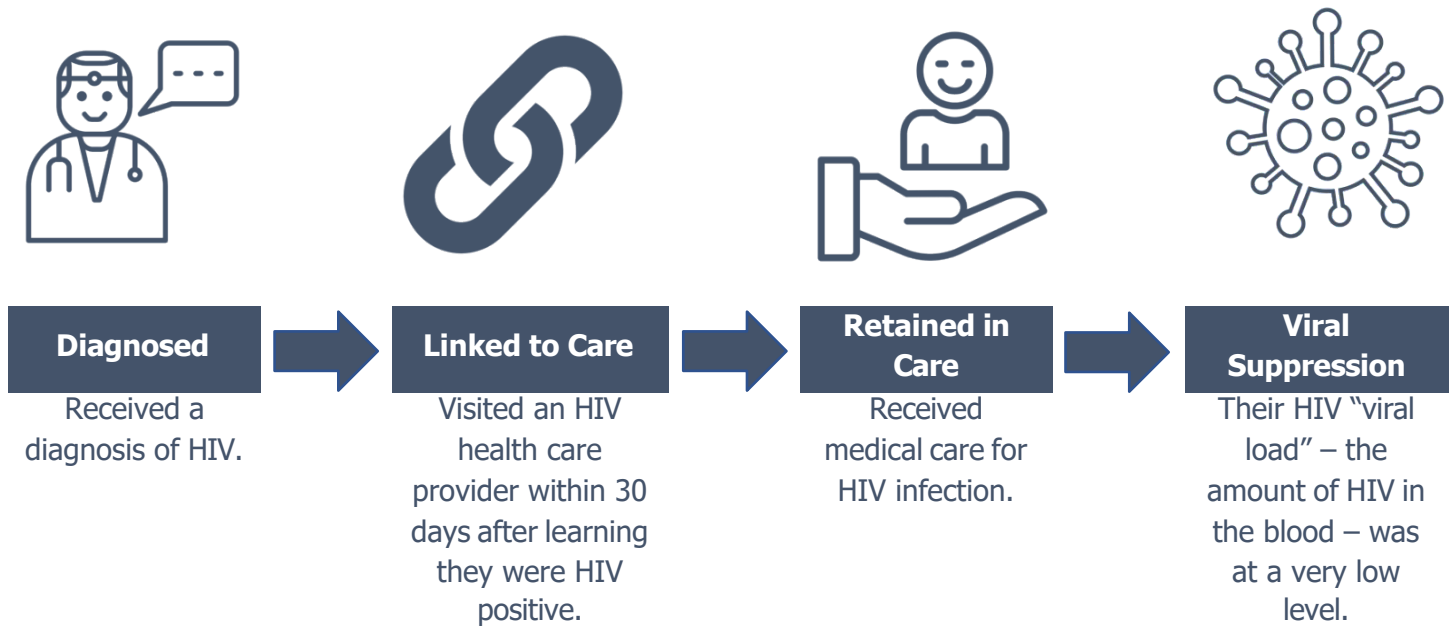
In 2018, there were an average 389 offenders who are PLWHA whose residence is Dallas County, and likely additional incarcerated PLWHA whose county of residence is within the Dallas EMA. An estimated 123 of those from Dallas County were released, which suggests more than 123 individuals who will need to establish or re-establish their HIV medical care and other services. The number per year of HIV positive inmates released per year between 2004 and 2017 ranged from 124 to 254.



Chapter 4: The HIV Care Continuum

The HIV Care Continuum

An important goal of the Ryan White program is getting PLWHA into medical care, retaining them in care, and helping them reach a state of viral suppression, where the virus is at undetectable levels in their bloodstream. Reducing the viral load is important for PLWHA to stay healthy, have improved quality of life, and live longer. The continuum is displayed below (CDC, 2019).



2018 Dallas EMA HIV Treatment Cascade

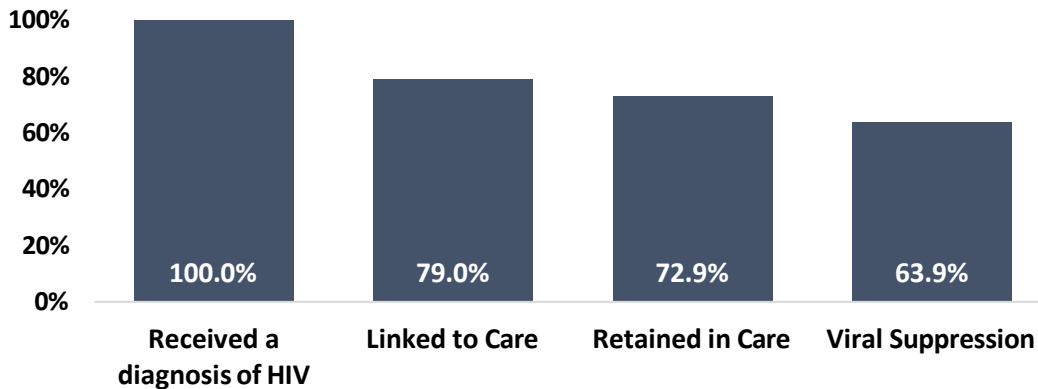


Figure 25 shows that in 2018, 87.7% of PLWHA who were retained in care were virally suppressed.

Source: Texas DSHS HIV-STD Division

Figure 25. Dallas EMA Treatment Cascade among PLWHA 2018

Diagnosis

The first step in the continuum of care is diagnosis. In 2018 the Texas Department of State Health Services estimated 5,407 individuals were likely positive and unaware. They estimated that for 2018, when the estimated unaware individuals are added to those who have been diagnosed, the prevalence of HIV/AIDS in the Dallas EMA may be as high as 28,443 individuals. Estimated numbers of unaware individuals by subgroups are shown in Figure 26.

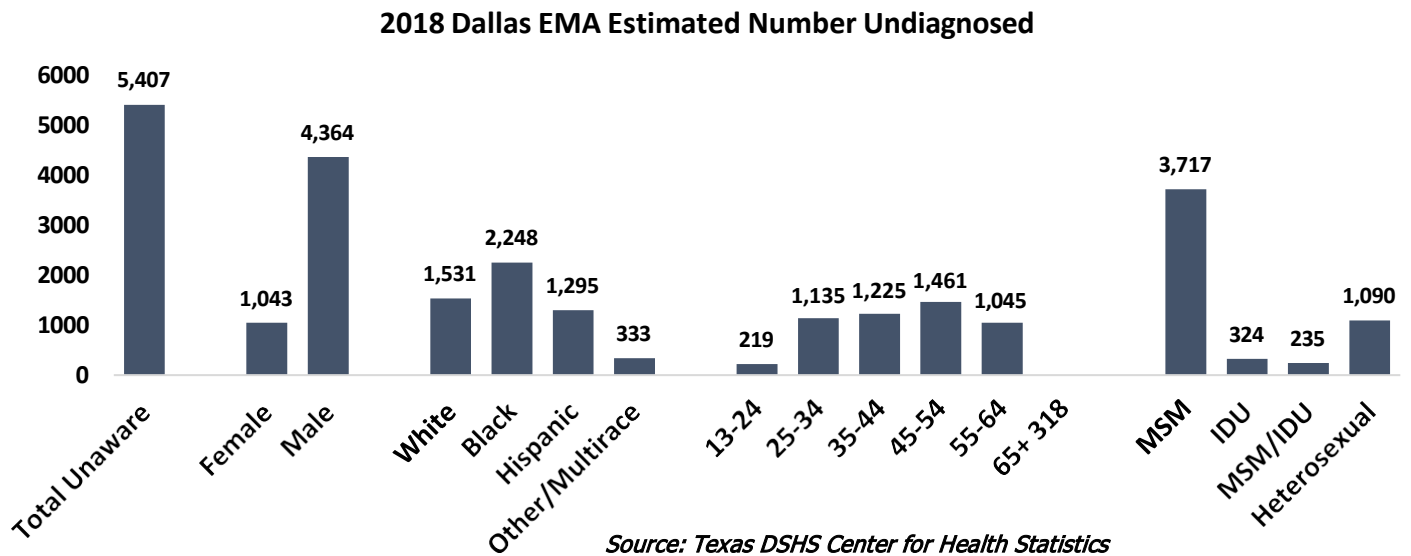


Figure 26. 2018 Dallas EMA Estimated Number Undiagnosed

Many PLWHA also have a late diagnosis where there is less than one year between the HIV and AIDS diagnosis. In 2017 the Texas Department of State Health Services reported that 209 of the 999 new diagnoses (21%) were late diagnoses. Figure 27 shows the percent of late diagnoses by subgroups. Late diagnoses were substantially higher among Hispanic PLWHA, ages 45-64, people who inject drugs, and heterosexual PLWHA.

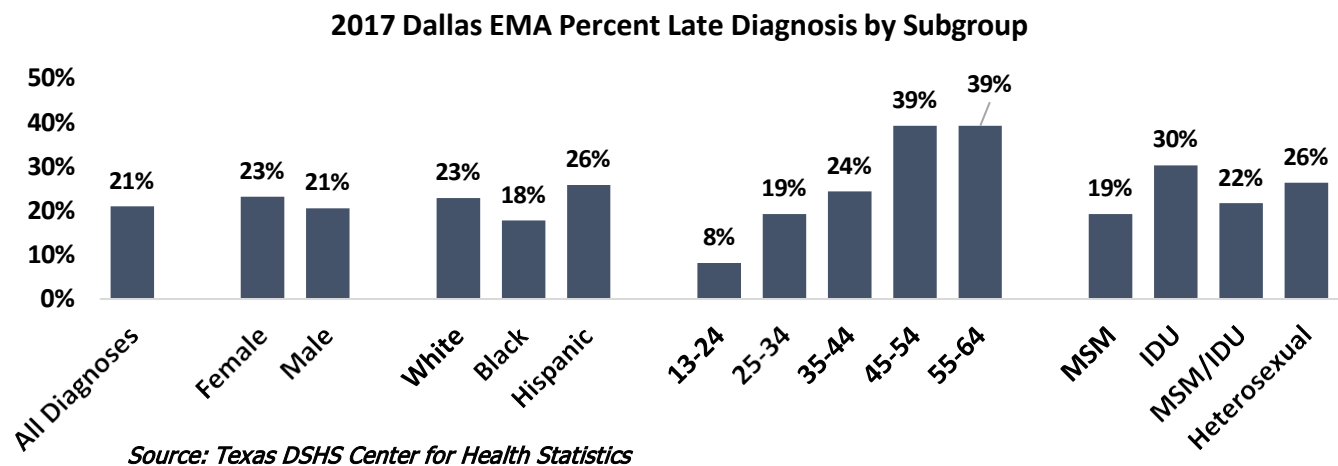


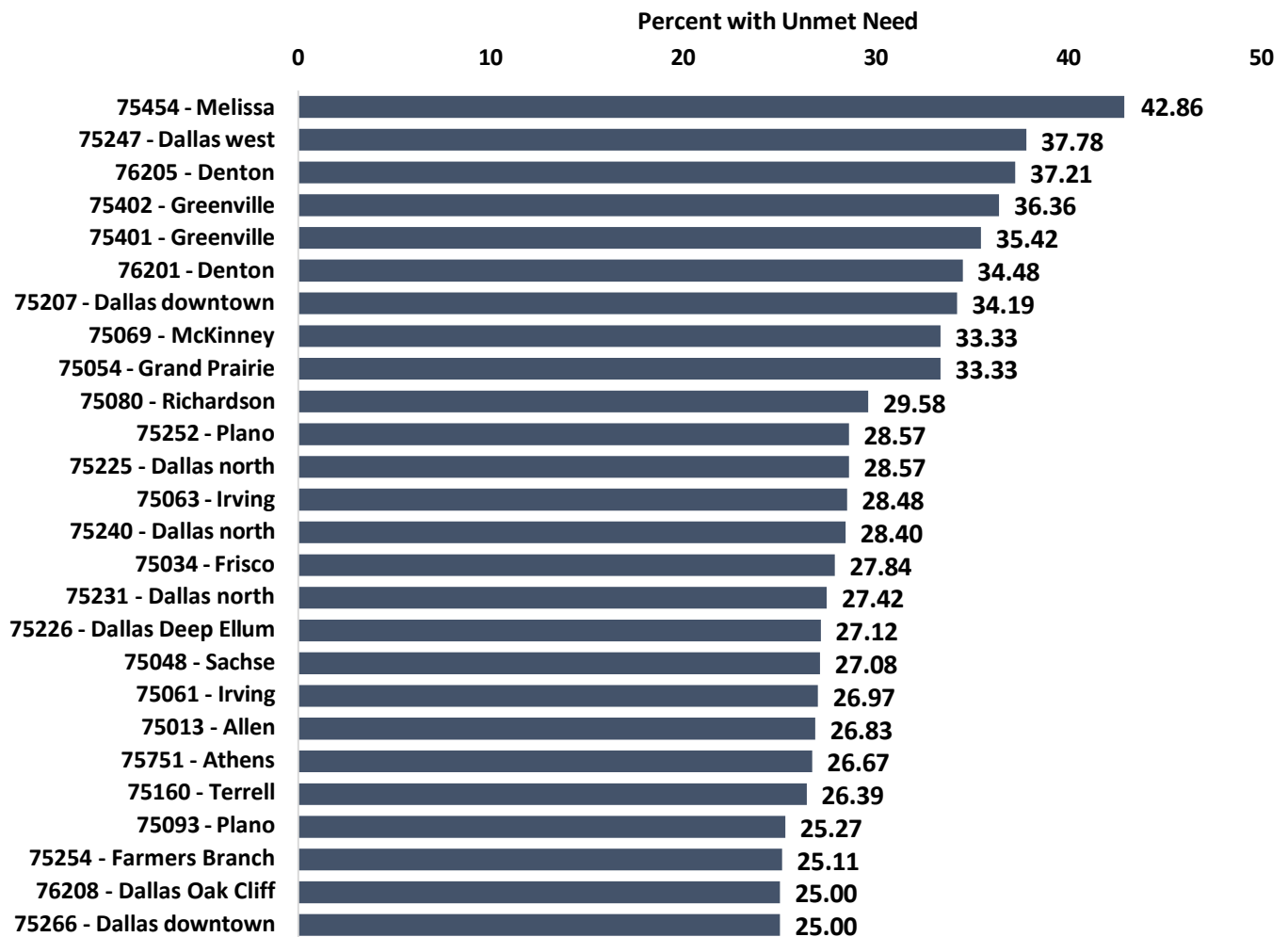
Figure 27. 2017 Dallas EMA Late Diagnosis by Subgroup

Linkage to Care 2018

To achieve viral suppression, PLWHA who know their status first need to seek medical care, and then need to be retained in care. The Texas State Department of Health Services defines unmet need as “the number and proportion of persons living with HIV in Texas who know their status and are not in HIV-related medical care.”

Innovative approaches are needed to overcome logistical and psychological barriers to reduce unmet need. In 2018 20.96% - one out of every five - of 23,036 PLWHA in the Dallas EMA were classified as “unmet need” by the State of Texas Department of Health Services. Figure 28 below shows the number and percent of PLWHA with unmet need in 2018 by zip code and city for all zip codes that had 20 or more cases and 25% or more unmet need. Zip codes that had fewer than 20 cases and unmet need of 25% or more included areas of the City of Dallas, Eustace, Commerce, Justin, and Farmersville.

2018 Dallas EMA Zip Codes with 20 or More PLWHA and 25% or More with Unmet Need



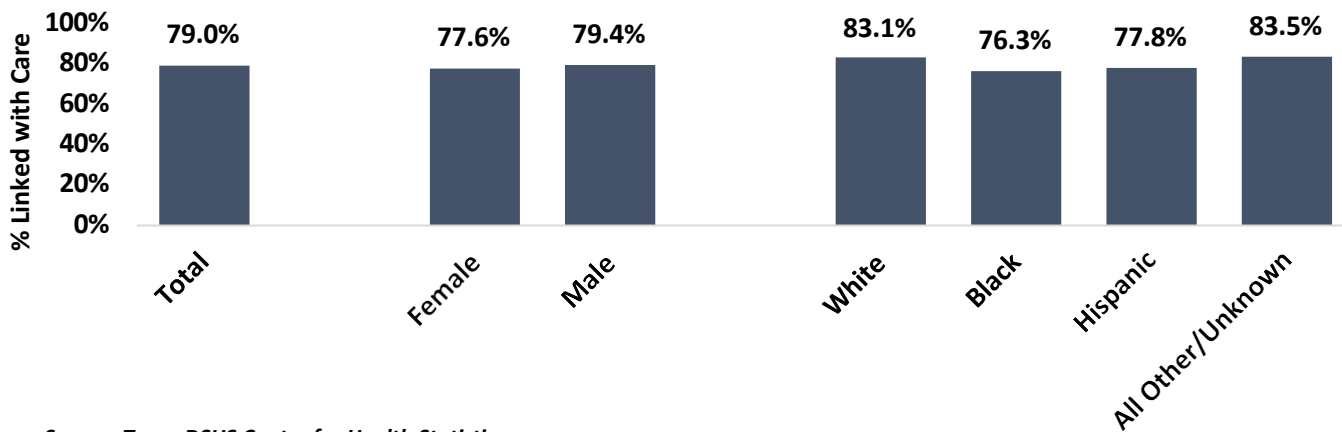
Source: Texas DSHS Center for Health Statistics

Figure 28. 2018 Dallas EMA Zip Codes with 20 or More PLWHA and 25% or More with Unmet Need

While some of these zip codes have available Ryan White funded services in proximity, many are in rural areas, or suburbs that do not have specialized HIV care.

KEY FINDING: Innovative and culturally relevant strategies are needed to overcome logistical barriers, such as transportation, distance, and hours/days of service as well as psychological barriers such as stigma, feelings of invulnerability, and denial.

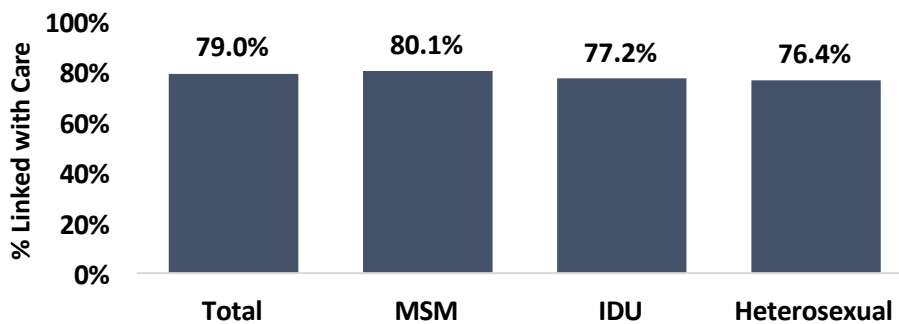
2018 Dallas EMA Linkage to Care by Sex and Race/Ethnicity



Source: Texas DSHS Center for Health Statistics
 Figure 29. 2018 Dallas EMA Linkage to Care by Sex and Race/Ethnicity

Linkage to care varies by sex and race/ethnicity. A somewhat smaller percentage of females were linked to care compared with males. When broken down by race and ethnicity the percentages linked to care are lower for Black and Hispanic PLWHA compared to White and Other/Unknown.

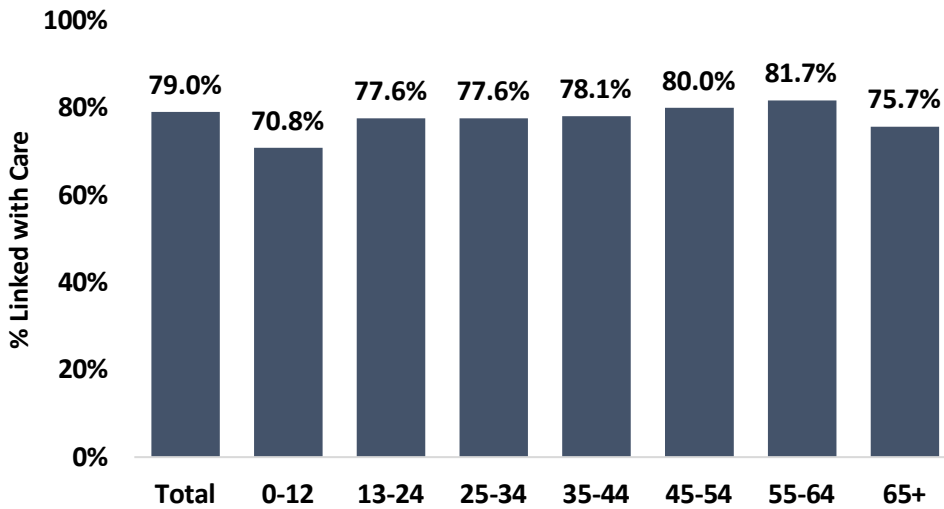
2018 Dallas EMA Linkage to Care by Mode of Transmission



Source: Texas DSHS Center for Health Statistics
 Figure 30. 2018 Dallas EMA Linkage to Care by Mode of Transmission

PLWHA whose mode of transmission was MSM have rates similar to the total population. Individuals whose mode of transmission was intravenous drug use had a somewhat lower percentage linked with care; heterosexual transmission had the lowest percentage.

2018 Dallas EMA Linkage to Care by Age Group



The percent of PLWHA ages 45 to 64 who are linked to care is above the total percent. The percent ages 0 to 12 is the lowest. Ages 65 and older is also lower than the other age groups. The percent linked to care for ages 13-34 is slightly lower than the total percent.

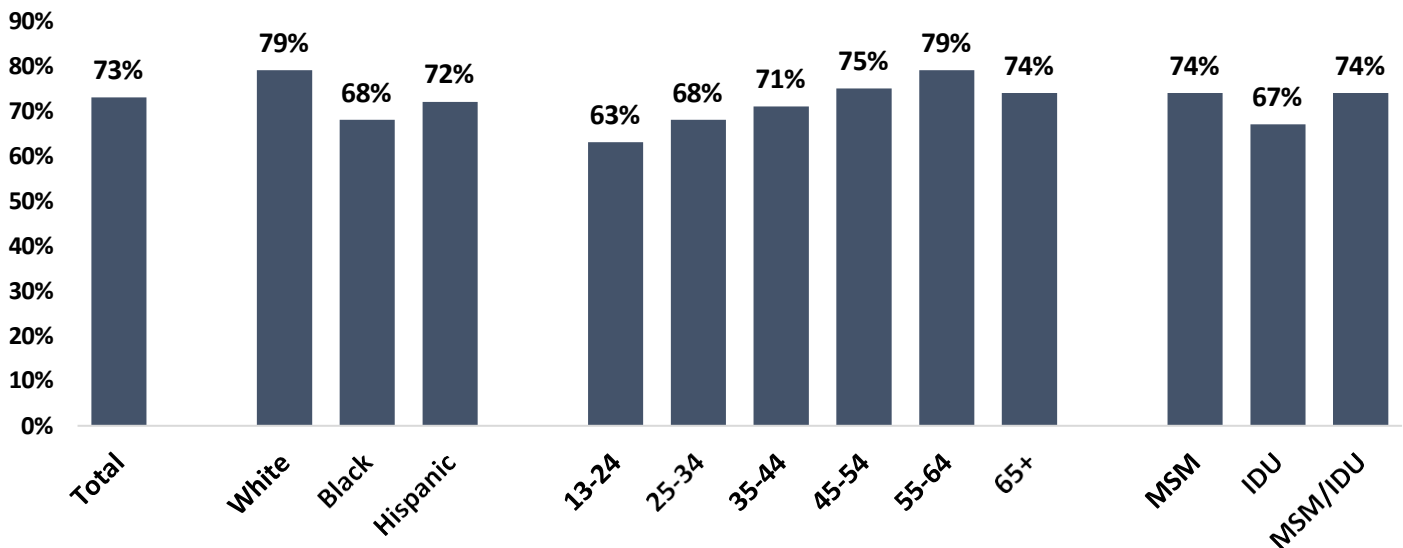
Source: Texas DSHS Center for Health Statistics

Figure 31. 2018 Dallas EMA Linkage to Care by Age Group

KEY FINDING: Targeted efforts to link PLWHA with care in the Dallas EMA are needed for women, Black and Hispanic persons, PWID, heterosexual individuals, and age groups 0-34 and 65 and older.

Retention in Care

2018 Dallas EMA Percent PLWHA Retained in Care



Source: Texas DSHS Center for Health Statistics

Figure 32. 2018 Dallas EMA Percent PLWHA Retained in Care

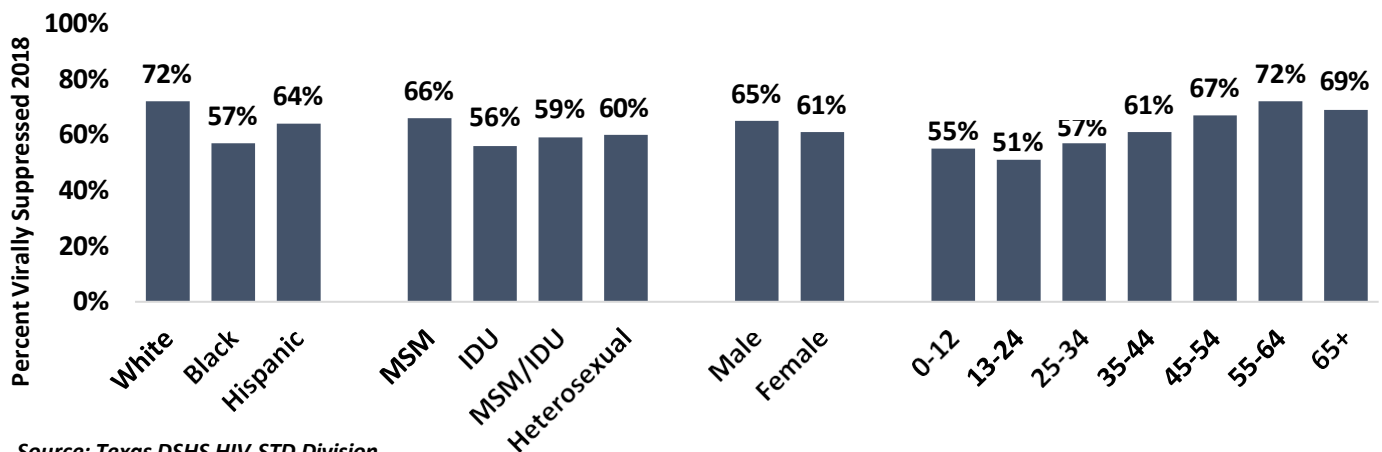
Figure 32 shows that in 2018 73% of PLWHA in the Dallas EMA were retained in care. This percentage varied across groups with a substantially higher percent of White PLWHA and a substantially lower percent of Black PLWHA retained in care. The percentages also varied by age and younger (ages 13-44) PLWHA showed lower percent retained in care compared with older PLWHA (45-64). The percentage of those whose mode of transmission was IDU was also substantially lower compared with the population overall.

KEY FINDING: Efforts to improve retention in care are needed, specifically targeting Black PLWHA, younger PLWHA (ages 13-44), and individuals whose mode of transmission was IDU.

Viral Suppression

In the Dallas EMA in 2018, 64% of PLWHA were virally suppressed. This is higher than the State of Texas average of 61%. Figure 33 shows that viral suppression was not equitable across groups. First, there were racial/ethnic disparities. Whites were substantially higher than Hispanics (who were equivalent to the Dallas EMA percentage), and both Whites and Hispanics were substantially higher than Blacks.

Dallas EMA Viral Suppression by Sub-Group 2018



Source: Texas DSHS HIV-STD Division

Figure 33. Dallas EMA Viral Suppression by Sub-Group 2018

Viral suppression percentages for the PWID population are also low, suggesting there is a need to target substance abuse prevention to PLWHA and intervention services for PWID within the HIV/AIDS population. A lower percentage of females are virally suppressed compared with males, suggesting a need for outreach to female PLWHA. Differences across age groups show that rates are lower among PLWHA who are age 44 or younger, especially those in the 0-12 and 13-24 age groups.

KEY FINDING: Efforts should focus on linking Black PLWHA to care and retaining them in care to increase their viral suppression percent. Additional efforts should be focused on Hispanic PLWHA whose numbers are increasing and whose percentage of virally suppressed is less than that of White PLWHA, as well as PWID and ages 44 or younger individuals among the PLWHA population.

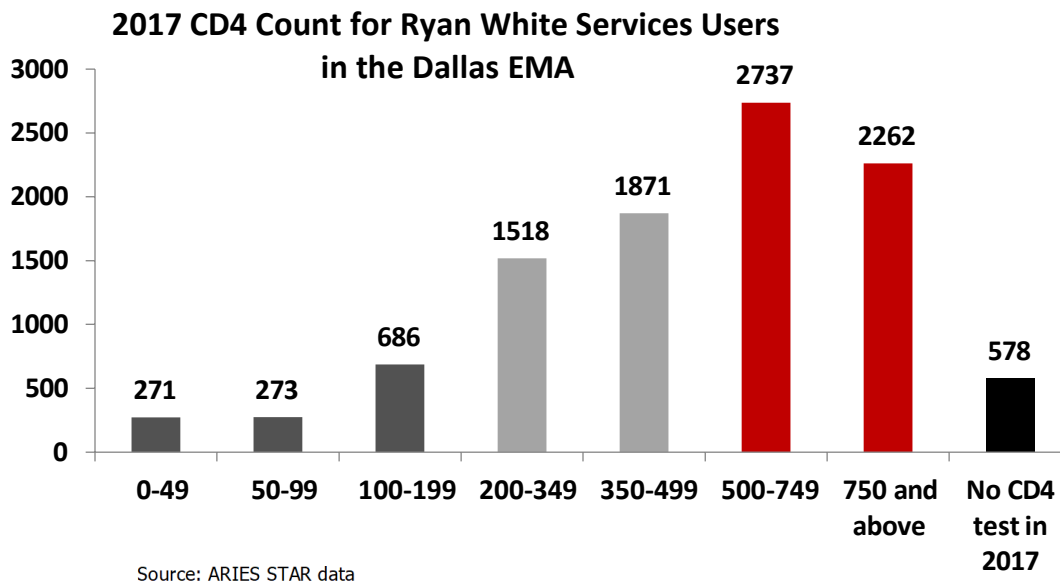


Chapter 5: Health Status of PLWHA and Co-Occurring Conditions

Since the scale-up of antiretroviral therapy, HIV has become a chronic disease and PLWHA are now surviving and aging and requiring lifelong care and treatment. PLWHA across all age groups have increased risk of chronic complications and comorbidities that include sexually transmitted infections, noncommunicable diseases, and other disorders. These may be pre-existing, HIV-related, or due to aging (World Health Organization, n.d.).

Health Status of PLWHA

One measure of the health of PLWHA is the CD4 lymphocyte count which measures the number of CD4 cells in the blood (MedlinePlus.gov, n.d.). CD4 cells are white blood cells that fight infection, and HIV attacks and destroys CD4 cells. If too many are lost, the body will have trouble fighting off infections. The CD4 test can also be used to check how well HIV medicines are working. A normal count is 500-1,200 cells per cubic millimeter; 250-500 cells is an abnormal count and means an individual may be infected with HIV; and 200 or fewer cells per cubic millimeter indicates AIDS and a high risk of life-threatening opportunistic infections. Data from the 2017 ARIES STAR system for 9,618 Ryan White services users indicate that 1,230 (13%) had results below 200; 3,389 (35%) had abnormal results; and 4,999 (52%) had results in the normal range.



According to data from the ARIES STAR system, 3,347 (32.82%) PLWH who use Ryan White services in the Dallas EMA have CDC-defined AIDS or disabling AIDS (Figure 34). Five hundred fifteen (5.05%) are taking PCP prophylaxis.

Figure 34. 2017 CD4 Count for Ryan White Services Users in the Dallas EMA

Viral load testing is used to measure how much of the HIV virus is in the body by determining the number of HIV copies in a milliliter of blood (WebMD, n.d.). It is used to determine how well treatment is working and guide treatment choices, as well as how fast the disease will progress. Keeping the viral load low is important to reduce complications and to prolong life. A high viral load is considered 100,000 copies or more; a lower HIV viral load is below 10,000 copies. The goal of HIV treatment is less than 20 copies.

Figure 35 shows that among the 9,481 Ryan White Services users who were tested in 2017, 8,305 (88%) had viral loads at 10,000 copies or below and 195 (2%) had viral load counts of 100,001 or greater.

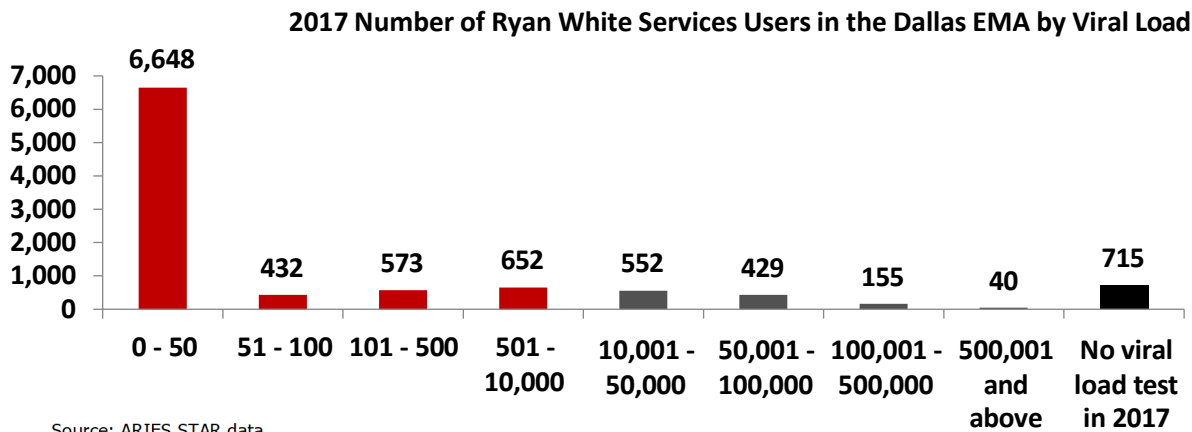


Figure 35. 2017 Number of Ryan White Services Users in the Dallas EMA by Viral Load

Hepatitis

The Centers for Disease Control and Prevention estimates that about 25% of people with HIV are co-infected with hepatitis C, and about 10% are co-infected with hepatitis B. From this we can estimate that about 5,600 PLWH in the Dallas EMA are co-infected with hepatitis C, and perhaps 2,240 are co-infected with hepatitis B. The most common route for hepatitis C infection is through intravenous drug use, although sexual transmission does occur. Receipt of blood products before 1992 could also have led to hepatitis C infection.

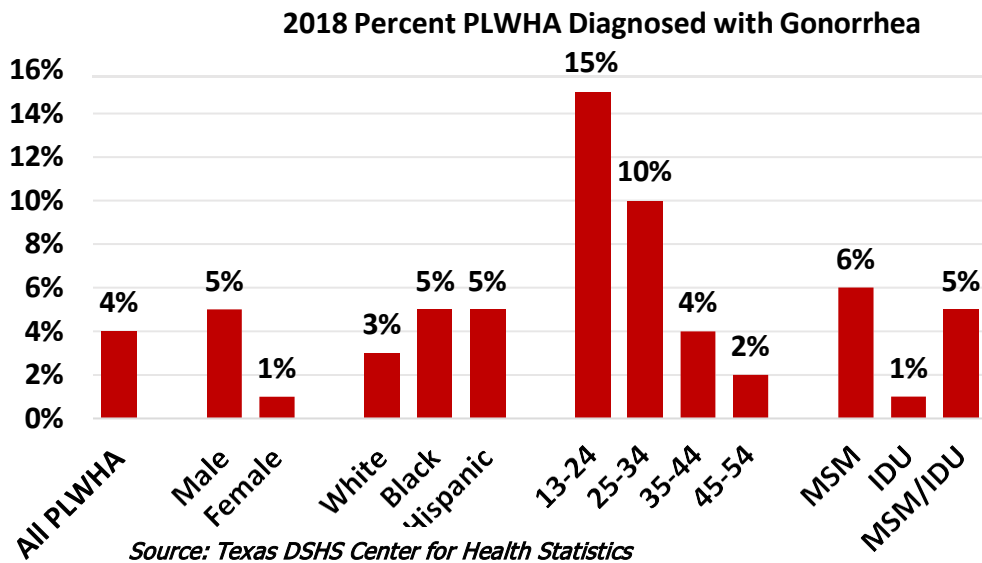
Tuberculosis

Data on PLWHA who used Ryan White services in the Dallas EMA in 2017 indicate that 107 (1.05%) out of 1,738 PLWHA tested for tuberculosis by IGRA blood test had a positive result.

Sexually Transmitted Infections

Sexually transmitted infections (STI) among PLWHA indicate they are continuing to engage in high risk sexual behaviors. Initiatives aimed at reducing STIs among this population will also help to reduce HIV transmission. STIs can increase the risk of spreading HIV in that PLWHA are more likely to shed HIV when they have urethritis or a genital ulcer (CDC, 2019). Both syphilis and gonorrhea are closely linked with HIV.

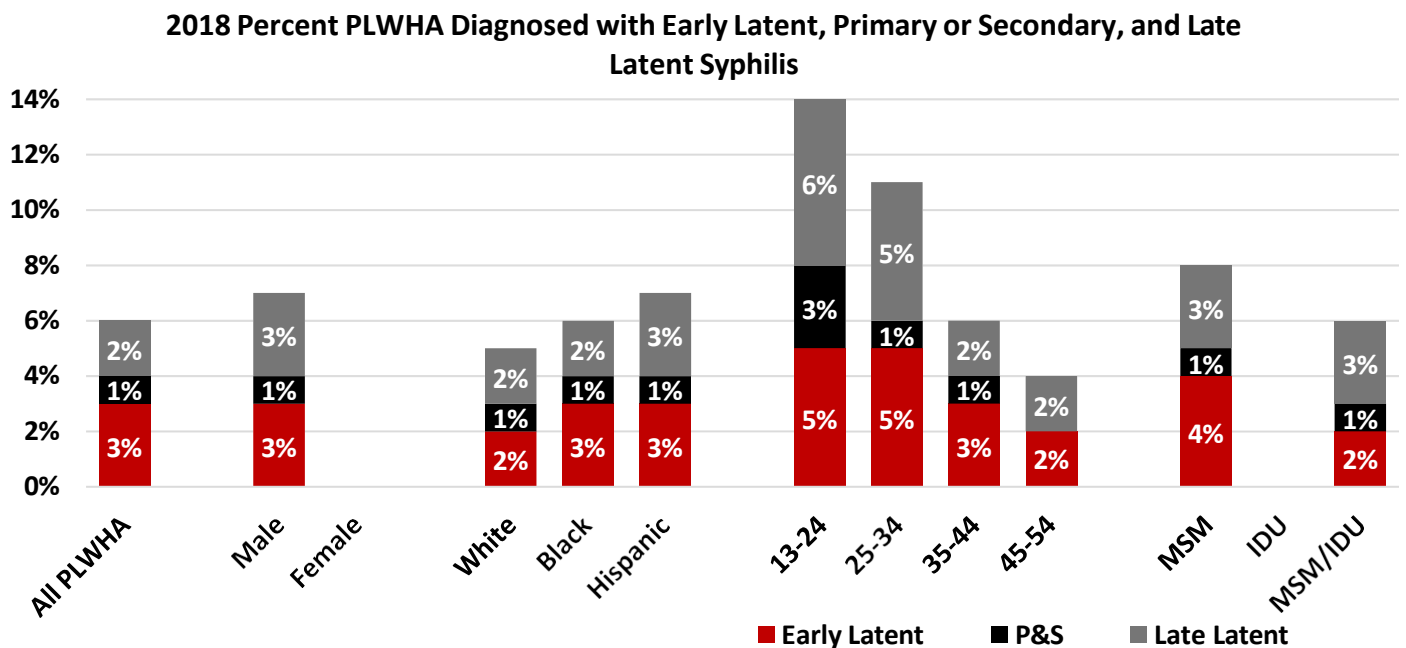
Gonorrhea



In 2018 4% of PLWHA in the Dallas EMA were diagnosed with Gonorrhea. Percentages were higher among males compared with females; slightly higher among Black and Hispanic PLWHA, and higher among ages 13-34. For mode of transmission, rates were somewhat higher among MSM compared with other groups.

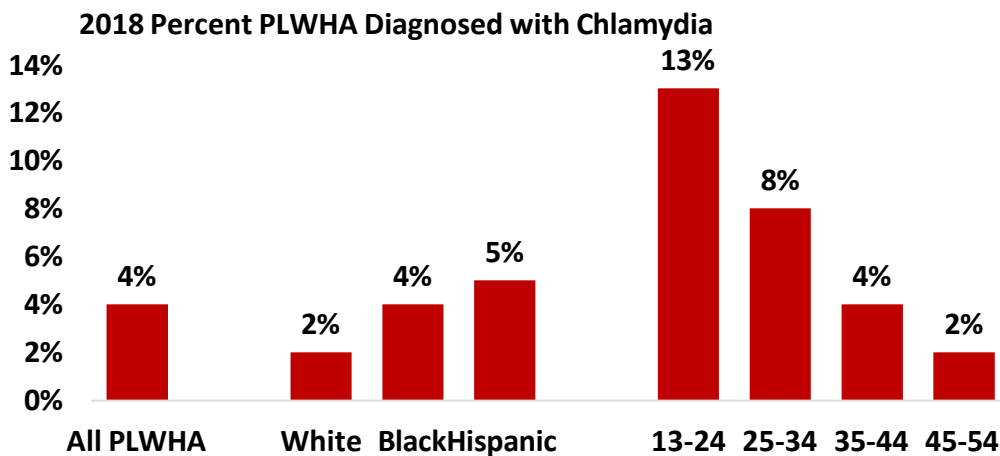
Figure 36. 2018 Percent PLWHA Diagnosed with Gonorrhea

Syphilis



In 2018, 6% of PLWHA in the Dallas EMA were diagnosed with Syphilis. They were primarily male with a slightly higher percentage among Hispanic individuals and MSM, and much higher percentages among PLWHA ages 13-34.

Chlamydia



In 2018, 4% of all PLWHA in the Dallas EMA were diagnosed with Chlamydia. Rates varied by age and race/ethnicity with slightly more Hispanic individuals receiving this diagnosis, and much higher percentages of individuals ages 13-34.

Source: Texas DSHS Center for Health Statistics

Figure 37. 2018 Percent PLWHA Diagnosed with Chlamydia

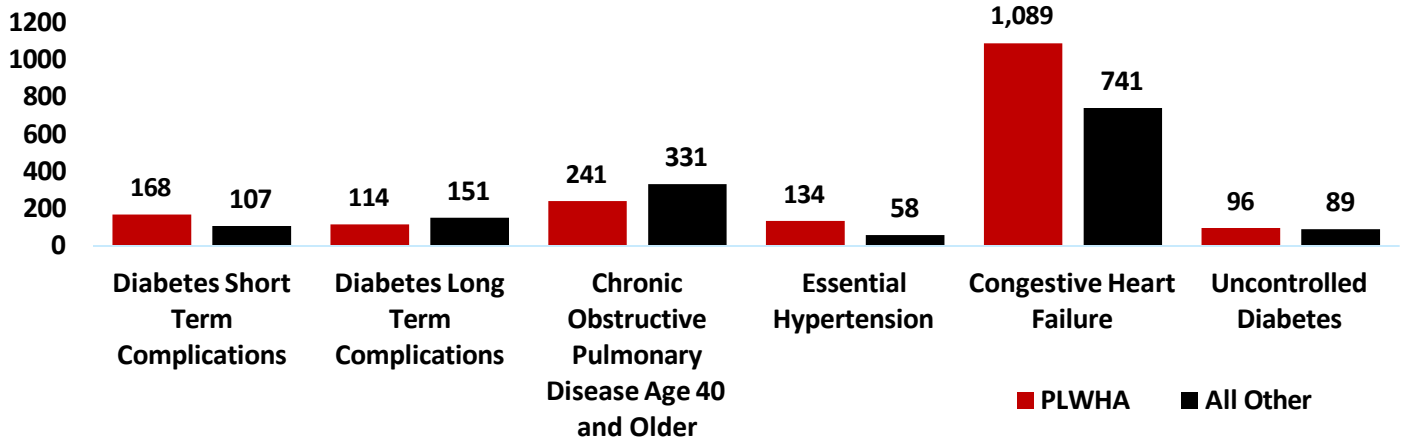
KEY FINDINGS: Sexually transmitted infection prevention initiatives are needed to prevent STIs among PLWHA as well as preventing the spread of HIV. While messaging should be conveyed to all PLWHA, additional efforts should target males, MSM, and PLWHA ages 13-34.

Chronic Diseases

The US Agency for Healthcare Research and Quality (AHRQ) has created metrics for analyzing healthcare quality in communities (AHRQ, n.d.). The Prevention Quality Indicators (PQIs) are designed to use hospitalizations to help evaluate the state of outpatient primary care in communities. PQI diagnoses include many complications of common chronic diseases, such as diabetes complications, congestive heart failure, hypertension out of control and chronic pulmonary diseases. Many hospitalizations in these categories could have been controlled or avoided with better disease management, better access to primary care or to medications, or better patient compliance.

A major purpose of Ryan White funding is to support primary care for PLWHA and analysis of PQI hospitalization rates for PLWH can help evaluate the chronic disease management of PLWHA relative to the broader population. Figure 38 shows that PLWHA had higher hospitalization rates per 100,000 population for short term diabetes complications, essential hypertension, and congestive heart failure. PLWHA had lower hospitalization rates for long-term diabetes complications and chronic obstructive pulmonary disease among age 40 and older.

Hospitalization Rates for Chronic Disease PQI Measures for PLWHA and All Others in the Dallas EMA Q4 2015 to Q4 2017 - Rates per 100,000 Population



Source: Dallas Fort Worth Hospital Council Education and Research Foundation

Figure 38. Hospitalization Rates for Chronic Disease PQI Measures for PLWHA and All Other in the Dallas EMA



Chapter 6: Service Needs and Barriers

Available Services and Provider-Reported Needs

Overview

There are 21 identified organizations in the Dallas EMA providing a spectrum of HIV-related services to PLWHA who may not have sufficient resources for disease management. One of the primary objectives of this HIV/AIDS Needs Assessment was to gather and evaluate information about available services in the Dallas EMA. To accomplish this objective, the evaluation team administered the Ryan White HIV Services Provider Capacity Survey ([Appendix B.4](#)) to nine Ryan White funded organizations during November 2019 through February 2020. Eight of the nine organizations completed the survey. The evaluation team also used the Resource Directory Data Collection Template ([Appendix B.5](#)) to identify organizations that were not funded by Ryan White in the Dallas EMA and document their HIV-related services. A Resource Inventory can be found in [Appendix F.1](#).

In terms of accessibility, most Ryan White funded organizations provide flexible hours, extensive language services, permit diverse payment options, and provide distinctive services to youth under the age of 18. Potential areas of improvement identified include relatively longer wait times for dental care (average 0 to 50 days) and mental health counseling (average 0 to 10 days). These wait times were substantially longer than other services such as outpatient HIV medical care (0-7 days) or outpatient OB/GYN services (0-2 days).

Staff at Ryan White funded organizations provided feedback about the impact of the Affordable Care Act, changes in the consumer population, and perceived service needs and improvements. The most common feedback was that the Affordable Care Act was minimally effective in increasing insurance coverage among consumers. Staff also reported some shifting patient population demographics such as younger consumers, aging consumers and consumers experiencing homelessness. Moreover, staff discussed several systems-level changes that could improve service delivery such as developing a universal intake system and removing the semi-annual recertification requirement. Staff also discussed the need for greater focus on specialty care services for HIV-related conditions (e.g., hyperlipidemia) and improving the integration of behavioral health services in on-site HIV primary care programs.

Data collected from the provider survey was supplemented by responses to the 20 key informant surveys. Questions asked about prevention, linkage to care, retention in care, emerging health issues, changes since 2016, unmet needs, policy and practice issues affecting prevention and intervention, special population needs, the role social media might play, and suggestions to improve the system (see [B.2: Key Informant Interview Protocol](#)).

KEY FINDINGS: Ryan White funded organizations play a key role in delivering clinical and non-clinical support services such as insurance navigation and case management, whereas organizations not funded by Ryan White create a balance in the continuum by providing a wide range of support services such as support groups and health education services.

Available services

Number of Service Organizations Providing *Prevention* Services in the Dallas EMA by Ryan White Funding Status, 2018-2019

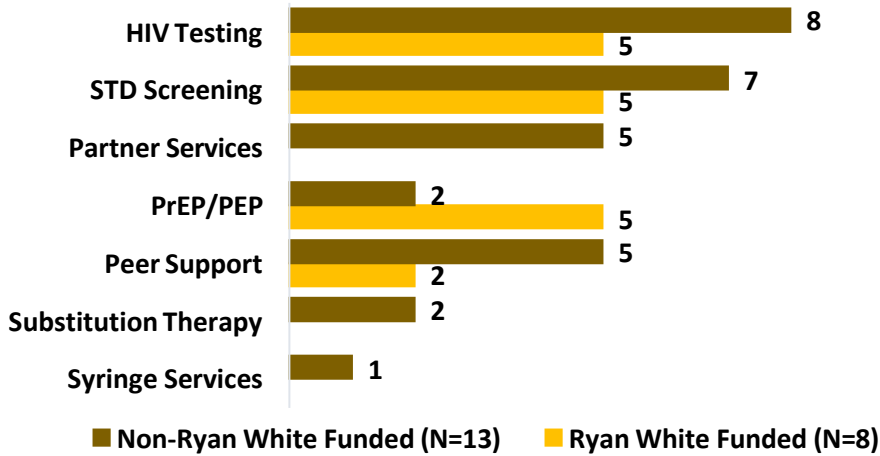


Figure 39. Number of Service Organizations Providing Prevention Services in the Dallas EMA by Ryan White Funding Status 2018-19

and support services in 2018-19.

The most common services provided by all 21 organizations included HIV testing, STD screening, linkages to care, medical case management, mental health services, non-medical case management, and medical transportation support. Ryan White funded organizations were more likely to provide PrEP/PEP services, medical case management, outpatient HIV medical care, insurance navigation/continuation, and language/translation services.

Figure 39, Figure 40, and

Error! Reference source not found.¹ show the numbers of service organizations in the Dallas EMA that provided prevention, care,

Number of Service Organizations Providing *Care* Services in Dallas EMA by Ryan White Funding Status, 2018-2019

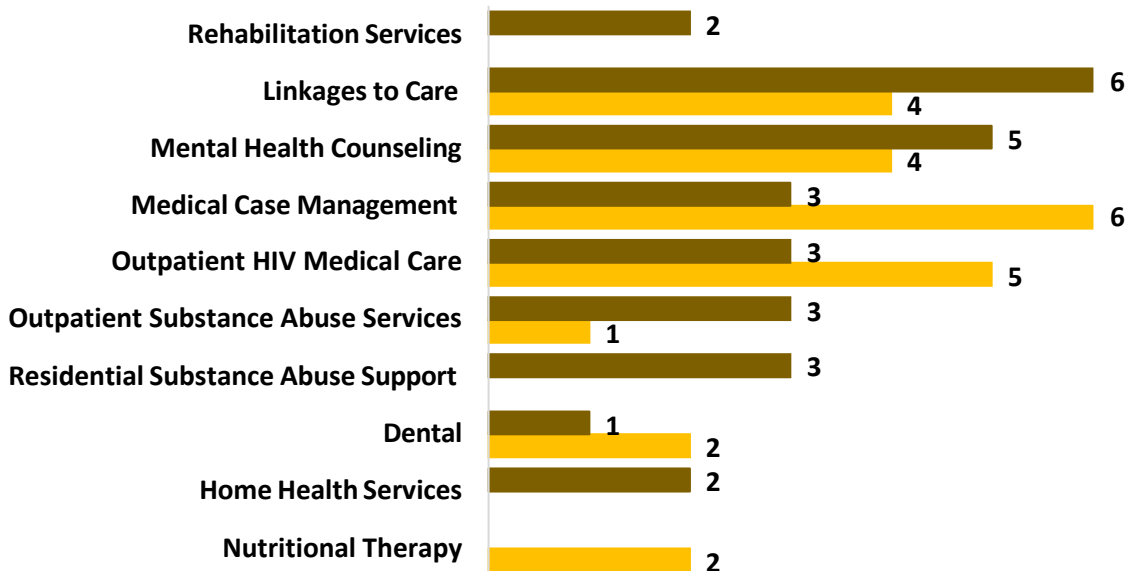


Figure 40. Number of Service Organizations Providing Care Services in Dallas EMA by Ryan White Funding Status 2018-19

¹ There is only one Ryan White funded organization in the Dallas EMA providing language translation services.

Number of Service Organizations Providing *Support Services* in Dallas EMA by Ryan White Funding Status, 2018-2019

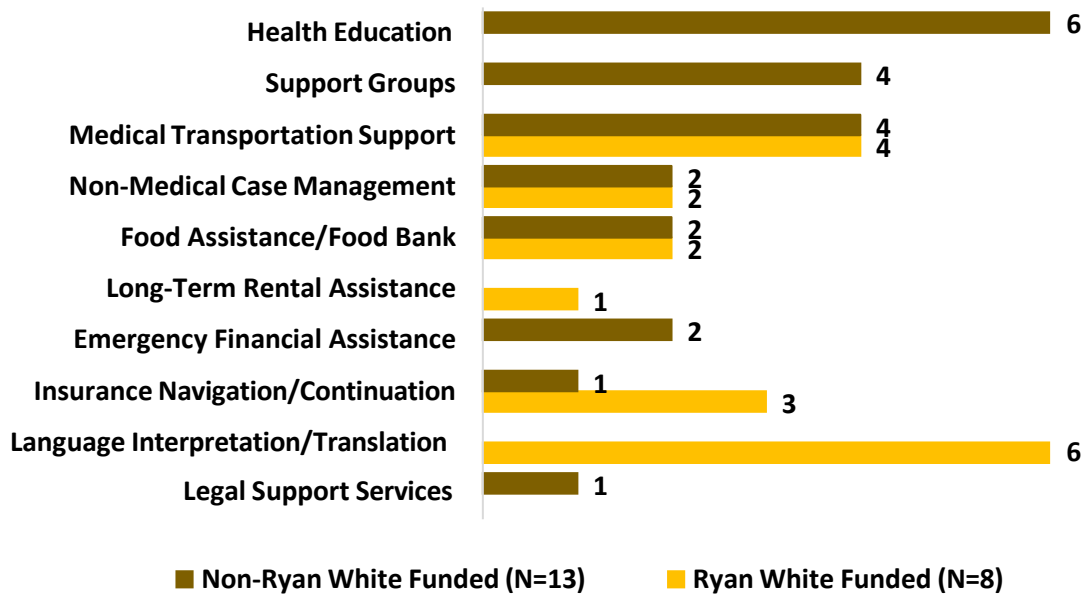


Figure 41. Number Providing Support Services in Dallas EMA by RW Funding Status 2018-19

In addition to the actual services provided, availability of services is increased when barriers, including hours, language, and age barriers, are removed.

Table 6. Dallas EMA Service Organization Characteristics by Ryan White Funding Status 2018-2019

Service Characteristics	Number of Provider Organizations with Ryan White Funding (N=8)	Number of Provider Organizations without Ryan White Funding (N=13)
Evening Hours	4	13
Weekend Hours	6	4
Language Translation Services	6	11
Interpretation Services	1	0
Services for Youth under 18 years old	6	8

Overview of Service Organizations Funded by Ryan White

Most Ryan White funded service organizations in the Dallas EMA/HSDA reported that more than 75% of their clients were people living with HIV, provided language/translation services, provided diverse payment options, and provided services for youth under the age of 18 years old.

Table 7. Characteristics of Ryan White Funded Service Organizations in the Dallas EMA 2018-2019	
Characteristics	Number of Organization (N=8)
County	
Dallas	6
Denton	1
Grayson	1
Percentage of Clients are PLWH	
0% to 5%	2
26% to 50%	1
76% to 100%	5
Weekend Hours	
Yes	1
Evening Hours	
Yes	
Language/Translation Services	
Yes	6
Available Payment Options	
Private insurance	6
Tricare/Military Insurance	3
Medicare/Medicaid	6
Free Services Available	5
Co-Pay	5
Sliding Scale/Fee-Based on Income	7
Services Available for Youth 18 and Younger	
Yes	6
HIV Prevention Services for HIV+ Individuals Available	
Yes	6

Most Ryan White funded organizations provided HIV testing, STD screening, PrEP/PEP, linkages to care, outpatient HIV medical care, mental health counseling, and non-medical case management. For most services, the average wait time ranged between 0 to 3 days, with the exception of outpatient medical care (on average 0-7 days), mental health counseling (on average 0-10 days), and dental care (on average 0 to 50 days). [Table](#)

8 provides information by service type including the number of Ryan White funded organizations that offer the service, the range of wait days, and the aggregated number of unduplicated clients that were served in 2018.

Table 8. Service Delivery Characteristics of Ryan White Funded Service Organizations by Service Type 2018

	Number of Ryan White Funded Organizations Offering Service	Range of Wait Time (Days)	Aggregated Number of Unduplicated Clients Served
Prevention Services			
HIV Testing	5	0	101,913
STD Screening	5	0	95,249
Partner Services	0	-	-
PrEP/PEP	5	0	2120
Peer Support	2	0	501
Syringe Services	0	-	-
Substitution Therapy	0	-	-
Care Services			
Linkages to Care	4	0-3	1,300
Outpatient HIV Medical Care	5	0-7	12,371
Outpatient OB/GYN Services	2	0-2	607
Hepatitis C Treatment	0	-	-
Outpatient Substance Abuse Care	1	0	15
Residential Substance Abuse Care	0	-	-
Home Health Services	0	-	-
Hospice Care	0	-	-
Mental Health Counseling	4	0-10	875
Medical Case Management	6	0-7	3,200
Dental	2	0-50	590
Medical Nutritional Therapy	2	0-3	149
Rehabilitation Services	0	-	1,450
Support Services			
Non-Medical Case Management	7	0-3	4,519
Emergency Financial Assistance for Utilities	0	-	-
Emergency Financial Assistance for Rent/Mortgage	0	-	-
Assistance with Co-Pays and Deductibles	3	0-3	126
Health Insurance Continuation Assistance	3	0-3	293
Long-Term Rental Assistance	1	30	30
Facility-Based Housing	1	0	210
Medical Transportation	3	0-5	2,299
Medical Transportation Van	4	0	413
Non-Medical Transportation	2	0	286
Language Translation Services	6	0	104

Table 8. Service Delivery Characteristics of Ryan White Funded Service Organizations by Service Type 2018

	Number of Ryan White Funded Organizations Offering Service	Range of Wait Time (Days)	Aggregated Number of Unduplicated Clients Served
Language Interpretation	1	-	-
Legal Services	0	-	-
Child Care Services	0	-	-
Day/Respite Care for Children	0	-	-
Adult Respite Care	1	0	156
Education Services	0	-	-
Job Training Services	0	-	-
Employment Services	1	0	210
Food Bank	2	0-2	1,388
Home Delivered Meals	3	0-2	1,497
Support Groups for PLWHA	0	-	-
Support Groups for Family/Partners	0	-	-

Provider Perspectives

Data in this section of the report are synthesized from the Ryan White-Funded Services Provider Capacity Survey and the Key Informant Interviews. In the provider capacity survey, each responding provider organization was presented open-ended questions related to the impact of the Affordable Care Act on clients and services, changes in consumer population, and perceived service needs and improvements. The Key Informant Interview asked questions about prevention efforts, attitudes about prevention, and prevention challenges; linkages to care and barriers to care linkage; HIV health, mental health, dental health, and vision care; emerging health issues and changes since 2016; policy and practice issues; special population needs; the role of social media; and suggestions to improve the system of care.

Prevention Services

The 2017 CDC National HIV Behaviorally Surveillance Report includes self-reported exposure to prevention efforts from 406 HIV negative MSM and 97 HIV positive MSM. Among both the HIV negative and positive MSM from the Dallas-Fort Worth Metropolitan Area who responded, 72.2% reported they had received free condoms. Individual or group level intervention was reported by 24.4% of HIV negative MSM respondents and 36.1% of HIV positive MSM respondents. Among HIV negative MSM respondents, 83.7% reported PrEP awareness and 18.2% PrEP use.

Prevention is not universally available throughout the Dallas EMA. Providers were asked to describe availability and accessibility of HIV prevention efforts in the Dallas EMA, and appropriateness for specific at-risk populations. Responses suggested that while there is a great deal being done regarding prevention, there needs to be more done and more resources available, especially for specific populations. Prevention efforts

and resources are available and accessible in specific geographic areas, especially in the center of the City of Dallas, and unavailable in rural areas.

Prevention efforts need to target specific geographies and populations and be more culturally responsive to them. Challenges were cited to reaching specific populations, including people living in rural areas, heterosexual individuals, transgender persons, and ethnic and racial minority groups. Some groups and neighborhoods are not easily accessible. Undocumented individuals and those who are seeking residency are hesitant to be tested because of a fear that a positive test may result in their deportation. Some racial and ethnic groups are in denial of the problem or their sexual behaviors and fail to address the risk. Prevention initiatives need to address the stigma associated with being LGBTQ in some communities, and of being HIV positive.

Planning and assessment efforts need to be more inclusive and examine within group variation. One respondent noted that Dallas needs to go deeper with planning and assessment. This included looking at within group diversity and assessing the social determinants of health within each group. The respondent also recommended listening. Too often, when planning and assessing the projects are approached with a lens that suggests that the planners and assessors already have the answers rather than seeking answers from the focal groups. There was also mention of a need for more diversity and new faces around the planning table.

PrEP and PEP are not accessible to all. One respondent reported that most PrEP usage is by white, insured MSMs who have access to it. There is none available in rural areas. PrEP is also expensive and not easily accessible to many who need it, especially the uninsured and underinsured.

There is a need for more widely available education about safe sex. One respondent reported that for the past 14 years the messages about safe sex have been dialed down. Individuals in rural areas were described as having discomfort with talking about sexual behaviors.

Prevention initiatives should target stigma. Stigma is another barrier that prevents both testing and interferes with treatment initiation and continuation. There is stigma associated with being LGBTQ within some populations, particularly among rural populations, African American, and Latinx communities. Some religious leaders continue to preach anti-LGBTQ messages to their congregations which further discourages their members from seeking testing or treatment out of fear they will be seen or recognized if they do.

Attitudes Toward Prevention

Providers perceive public attitudes toward prevention as mixed – some supportive, others poor. While some providers perceive public attitudes as supportive, others seen them as improving and changing, but still needing to progress, and others see knowledge and attitudes as being poor outside of the HIV community. Many people are unaware of the benefits of prevention and screening to reduce HIV transmission. Many people are still uncomfortable with talking about sex and some cultures still do not accept such conversations. There is a need to engage in more comprehensive messaging and share advances in HIV prevention and treatment more widely with the general public. There is also a need to go beyond general messaging and print materials to having more people share their stories. People respond more to personal narratives by people who look like them. Prevention initiatives need to reach into schools and rural areas.

Some providers suggested it would be helpful to normalize condom use. There is a perception of resistance to condom use among providers, especially among males, some cultures, and younger people.

Some providers view the recent PrEP commercials on television as a step toward opening conversations and normalizing prevention efforts. Health care providers need more knowledge about HIV and PrEP. Those

who work directly with HIV care are knowledgeable, but the private sector has been hesitant about expanding knowledge. Community based physicians should be knowledgeable about PrEP and offering it to patients.

Some providers report their clients have positive attitudes about prevention, others reported mixed attitudes where some are open, and others are not. Some providers noted that they have clients who are not thinking about prevention because they have larger concerns, such as income, employment, housing, and other issues. Mental health issues can be barriers to messaging. In some cases, before messaging to clients or certain populations, it is important to recognize their experience and get past their trauma.

Prevention Challenges

Providers described many challenges to educating and changing high risk behaviors. They included:

- Younger people did not see the epidemic in the beginning and how many people initially died. They view HIV/AIDS as another chronic, treatable disease and do not take it as seriously and understand that it is still an issue.
- There is still stigma associated with HIV and it gets in the way. Even health care workers who work with HIV patients are stigmatized among others in their profession. HIV prevention should be included in general health prevention messaging such as drugs, diet, and exercise.
- HIV prevention involves behavior change and it is not easy to convince people to change their lifestyle.
- There is a need to move away from messaging via flyers and create a stronger social media presence. Social influencers need to be involved and need to mirror the populations they are trying to reach.
- People need to understand that even with PrEP they still need to use condoms to prevent other sexually transmitted infections.
- Messaging to all populations needs to be right for the audience. Find out where people really are. Overcome mistrust and community apathy. Much messaging is targeted to the poor and people who use programs. HIV affects everyone and messaging needs to be targeting everyone, including those who do not live in poverty. Also need messaging to reach MSM in heterosexual marriages who do not want to admit to what they are doing.
- Education is important. People often Google for information and what they are learning does not match the messaging that is provided by health educators and providers. The health educators and providers must keep up with current information.
- The focus is too much on data and not in looking at what each community needs. We need to address and acknowledge the disparities, but not define communities by them.
- General health care needs to get on board. Some individuals reported they have been stigmatized by health care workers. HIV testing should be routine in emergency rooms and urgent care centers.

Barriers to Successful Linkage to Care and Strategies to Overcome Them

Interview respondents were asked to describe barriers that prevent successful linkage to care for consumers who have not linked to care, and what can be done to alleviate them. Barriers described and suggested strategies included:

- Patients perceived **stigma** when they go to HIV clinics. Medical providers who give the diagnosis need to treat patients who are positive with respect and dignity, which was described as especially problematic in rural areas. Patients need to know that there are places they can go where they will be treated with dignity and privacy. Providers need to be more comfortable talking about sex as well. Teenagers are often linked into adult care sites and may feel uncomfortable. Medicaid expansion is needed so that people can go different hospitals and clinics that they choose.
- There are **institutional barriers**. Getting into care for lower income individuals requires burdensome paperwork and bureaucracy to get certified as eligible. Considerable time may elapse between the diagnosis and seeing a provider. The Fast Track concept needs to be played out effectively in Dallas whereby individuals get tested, diagnosed, and begin treatment on the same day.
- The **cost of care and medications** may appear prohibitive to lower income individuals. Individuals need more information and accurate information about what is available and what they may qualify for. There is excessive misinformation among PLWHA in rural areas especially.
- Many individuals have other issues they are dealing with and **higher order needs** to meet at the time they are diagnosed, such as housing instability.
- **Transportation** may not be available, especially in rural areas. Providers need to get creative and consider mobile units, pop-up clinics, and providing HIV care in nontraditional places where people are. They may need to go to the communities that are affected and change the system rather than fix the current systems that are not working for all PLWHA.
- There may be **psychosocial barriers**. Some may be in denial as they receive their diagnosis and it might not sink in. For others, this may be the time they will need to come out to their families as they share their diagnosis. Peer support and peer linkages are important, so they are not navigating this alone.

Barriers to Successful Retention in Care and Strategies to Overcome Them

Interview respondents were asked to describe barriers for consumers who drop out of care after a short or long time, and what can be done to alleviate them. Barriers and strategies described included:

- There is a high **administrative burden** on PLWHA and providers. Information is not centralized, and updates are required every six months at every provide, including presenting paperwork. This is especially challenging for people who have mental health challenges and homeless individuals whose paperwork is sometimes lost. A centralized intake and information system would reduce the burden on patients as they would need to present their information to only one provider, and annual updates rather than every six months would lessen the frequency. This would also ease the burden on providers as the responsibility for updating information would be spread across providers.
- **Youth** present special challenges. When they reach age 19, they have to transition to the adult system, and they lose their Medicaid coverage. If they feel fine, they will stop taking their medications and drop out of medical care.
- Resources are centralized around downtown Dallas. Dallas County and the Dallas EMA is a very large geographic area whereby going to appointments requires finding private **transportation** for many and substantial **time investments** to travel to the sites where resources are located. It also requires time and many PLWHA cannot get that much time off work for a doctor's visit. Services

that are available in more geographic areas with more convenient hours may be helpful to retain many individuals in care.

- **Financial issues** and loss of insurance may push some PLWHA out of care. They may be unaware of Ryan White services and supports, especially if they live in areas where services are sparse, and the surrounding population is fairly affluent.
- **Other needs or problems** may overwhelm or take priority. Loss of housing and homelessness, substance abuse issues, or life disruptions whereby people simply fall out of their routine can disrupt care. Individuals simply may feel unable to cope with having HIV. A comprehensive approach that takes care of all needs – medical, psychosocial, and financial is needed to retain many PLWHA in care. Peer support may also be helpful.
- **Discomfort with the provider** whereby the PLWHA does not feel comfortable may cause them to leave treatment after a couple of appointments. They may feel disconnected from their provider or that their provider doesn't care. When they leave care, they may receive three phone calls and a letter. Response teams that engage in outreach and provide a more personal touch may be helpful. Check-in texts and reminders, more frequent touchpoints and encouragement may also increase provider-patient engagement.
- Some patients are uncomfortable being seen entering "HIV" clinics (**stigma**) and fear being seen by someone they know who is unaware of their status. Consider offering specialized HIV treatment in regular health centers where people are being treated for a range of health issues.
- If patients **feel good physically** then care may not be a priority. If they have been in treatment for a long time, they may feel like they want to take a break. Some PLWHA get their medications and do not understand the need to follow up with regular lab work. Education about the importance of staying in treatment and on medications, including reasons why and how it impacts their health, may encourage them to continue treatment even when they feel well.
- **Other** potential reasons that were offered included people who move to this area and do not know where to access services, or undocumented individuals who are fearful of going to new places or unfamiliar areas of town.
- **More information** about why people are dropping out would be helpful and then tailor interventions to overcome barriers. There is a need to examine the system to see how it might be changed to keep more people in treatment.

Features of Successful Programs at Linking People to Care and Keeping Them in Care

Interview respondents named several programs that are successful at linking people to care and keeping them in care. Features of those programs that made the difference included:

- They offer HIV specific care and link mental health and substance abuse care with the medical care. There is a **single system of care** and all partners in the system are fully informed. They offer high quality care with sincere and knowledgeable providers.
- They offer **support** via social workers and case managers providing medical case management with frequent touch points. Some also offer peer advocates and navigators. They help walk patients through the process of getting into care.
- They **collaborate** with other providers to offer **comprehensive** medical care coupled with services for other needs. Other needs include access to housing programs, since affordable housing allows people to focus on their health needs and transportation. They serve as one-stop shops.

- They are **innovative** and try a variety of strategies. Strategies that were cited that have been successful in the past include walk-in clinics, street outreach, routine testing in emergency rooms, flexible hours and times, and fast-tracking people into care.
- They are designed specifically to meet the **needs of the population they are serving**.

Present State of Care Services

Key informants were asked to describe the present state of HIV health care (primary and secondary), mental health care, dental care, and vision care.

HIV Health Care

Respondents generally agreed that the Dallas EMA has **excellent health care**, although it is **not necessarily available or accessible by all PLWHA** in the Dallas EMA. For example, much of the health care and services are located around the Oak Lawn and Oak Cliff areas in the City of Dallas but are missing in other parts of the city. There is less or no specialized HIV care available outside of Dallas County, including in Collin County which has a high prevalence of PLWHA. There is good care available even in some rural areas, but it is also not necessarily accessible to everyone. There are not enough providers with knowledge of how to treat PLWHA. Specialty care remains challenging, especially for the transgender community.

Mental Health Care

All agreed that there is **not enough mental health care available**, and in some places, there is none. While Parkland, Prism Health, and the federally qualified health centers provide mental health and psychiatric services, there are not enough to meet the need. The mental health system in Dallas was described by one respondent as “not a real functioning mental health care system.” Low income persons and individuals who are homeless have a high need for mental health care, especially since many of them experience higher levels of trauma. Many individuals will not have the capacity to discuss their health care and medications until they are able to navigate their trauma. **There is also a need for mental health providers who are knowledgeable about LGBTQ individuals, HIV, and navigating life with HIV, as well as more culturally appropriate and community competent providers.** There are an insufficient number of inpatient mental health and substance abuse facilities, especially for low income persons and individuals who are homeless. More mental health services are needed along with innovative strategies such as telemedicine to expand access to more populations.

Dental Care

Dental services are available in Dallas, and to some extent in rural areas, but capacity is an issue. There is a need for more providers in more locations. There are not enough providers for low income, uninsured, and underinsured PLWHA. Services also need to be more comprehensive and able to treat a wider variety of dental issues. Some low-income individuals have high dental care needs as they have never had dental care in their lives. When PLWHA visit dental services that are outside of their HIV care network, they are asked to disclose their HIV status, and many do not want to do so. **More dental providers specifically for PLWHA are needed in more locations.**

Vision Care

Vision care is available through some providers in Dallas County and contracts in some rural areas. The federally qualified health centers offer vision care (Los Barrios works with UT Southwestern). Ryan White services do not cover vision needs, although some providers expressed that it should be part of a comprehensive package of medical treatment. Some PLWHA reported that when they accessed vision services at Parkland (outside of the HIV services), they encountered stigma when they were asked about their payment source. **More vision care options are needed, especially for low income individuals and in rural areas.**

Emerging Health Issues and Comorbidities that Complicate HIV Care

Interview respondents were asked to describe emerging health issues and comorbidities that are complicating HIV care. Many of these health issues are prevalent across society and were described as having been “prevalent in South Dallas for decades”. They include obesity, diabetes, heart disease, and hypertension. Respondents reported they are seeing increases in mental health problems, including depression, and substance abuse. Sexually transmitted infections continue to be high. Some reported that they are seeing more hepatitis B and C, as well as liver and renal diseases. With improvements in care that are prolonging life for PLWHA they are also seeing more aging related issues and the need for specialized geriatric care is growing. Food desserts in urban and rural areas are leading to nutrition deficiencies. Issues mentioned by one individual each included perinatal transmission – it is low, but babies are still coming in from other towns and countries that lack specialized care; dental health issues; toxoplasmosis; and PLWHA who go to multiple doctors and have drug interactions.

Impact of the Affordable Care Act on the Agency and Consumers

Respondents reported that the impact of the Affordable Care Act on their organizations and clients was **mixed and there was mostly little to no impact**. Respondents were asked to describe the impact, if any, the Affordable Care Act (ACA) had on their agency and clients between 2017 and 2019. Some responses suggested that ACA had a minimal impact on their organizations and clients. For example, some respondents described issues related to client ineligibility, clients’ inability to afford premiums, and its overall ineffectiveness in increasing access to care.

- *“Those who could afford a Marketplace Plan were directed by our Certified Application Counselors to apply. Due to the restrictions on who the plans listed as providers, many of those patients had to find providers on their insurance network.”*
- *“The Affordable Care Act had little impact on our agency since we are not a medical provider. The majority of our clients receive Medicaid and/or Medicare, with few having private health insurance coverage. We did update our documents, as well as our policies and procedures to ensure that all clients are advised of the ACA and educated about its offerings, open enrollment periods, or when they experience a qualifying life event.”*
- *“Almost none - it is under-utilized, and since TX did not expand Medicaid, it provides little effect.”*

On the other hand, the ACA reportedly had the opposite effect on some of the organizations. The following quote is an example provided by one respondent:

- *"It allowed many clients to qualify for their own health insurance policy providing them access to medical care, medications and other associated services. The Premium Tax Credit and Ryan White Insurance Assistance Program were very important in assisting low income clients to afford their medical coverage... It helped get more clients on insurance".*

Provision of Affordable Care Act education and support to consumers

The organizations support and educate their consumers by **referring them to community partners for navigation if the consumers are interested and eligible**. Two organizations reported that they screen their clients and assess them for eligibility for the Affordable Care Act. Also, benefits counselors are available at some organizations to assist patients with the Affordable Care Act.

- *"Our staff routinely assess patients for eligibility for ACA plans and where possible, works with them to find an appropriate plan that covers the medications they are taking... We have an open enrollment period where we educate and/or guide clients on what is available through the ACA".*

Most important system-wide changes that could improve service delivery

Three organizations surveyed and four key informants reported the development of a **universal intake system** with patients' information that can be made visible to all organizations on the survey. Implementing a universal intake system will allow eligible patients to receive services without the troublesome burden of having to complete repeated paperwork. It will also reduce the workload across providers as they share the administrative burden. Two of the organizations suggested to make the enrollment and re-certification process easier by designating that re-certification is conducted annually and an interim certification only being conducted when necessary. One interview respondent suggested a system that shows a green light for patients whose documentation is current and a red light if they need documents when they check into any provider for services. The following quotes were extracted from respondent comments.

- *"Development of a universal intake system with information sharing that will allow eligible patients to receive services without duplication of intake process from agency to agency."*
- *"An improved computer system, beyond and possible replacing ARIES, easily accessible and user-friendly shared by all sub-recipients that would allow us to more easily serve clients across multiple organizations/services within Dallas EMA/HSD."*
- *"Removing the semi-annual recertification requirement. We need to lobby HRSA to remove this barrier to care. Hand-in-hand with that issue is a review of locally required paperwork for access to services to remove as much redundancy as possible for patients."*

Key informant respondents cited additional issues that could improve the system. Among them were:

- More flexible EMA boundaries are needed. Parkland can only serve Dallas County residents so that PLWHA living in other counties cannot access specialists at Parkland. Providers in the Sherman-Denison HSDA regularly have people coming in from Collin County and Oklahoma, but they are not able to assist them because they are outside of their HSDA, even though they are funded with federal monies.
- The requirement to have a case manager drives some people away. Consider dropping the requirement for those who require only a brochure (or provide them with a comprehensive resource guide) with all the information they need to coordinate their care. Requirements to have case managers arrange services slows down some people who are able to coordinate their own care. Provide multiple channels that alert individuals as to where the resources are – apps, emails, 211, social media. Use more peer navigators from the target population. They are often more knowledgeable about how to navigate the system than many providers.
- Let people know that other than LGBTQ people have HIV. Women need to see more people like themselves. Heterosexual males are reluctant to get tested because someone might think they engaged in gay sex. Provide services at sites that are not known as specific “HIV” sites.
- Testing needs to be more widespread. Provide incentives for people who get tested. Have testing available at every festival, health fair, or other large community events.
- Inform more youth that they can receive testing and treatment for sexually transmitted infections and HIV without parental consent. Provide funding for youth who do not have coverage so that they will not need to disclose to parents. Provide them with more consistent sexual health information and education. Challenge the policies that water down the education or focus on abstinence only.
- More education and outreach is needed in outlying areas to include rural and suburban settings. Education should include perinatal transmission prevention. Address access issues and other barriers that are specific to these settings.
- Provide partner treatment whereby partners are engaged into PrEP or other treatment. The availability of PrEP needs to be increased in general.
- Engage in efforts to meet practical needs. Advocate for affordable housing policies for low income and PLWHA. Creativity is needed to address homelessness and the shortage of affordable housing in the Dallas EMA. Address food deserts in urban and rural areas. In many communities, dollar stores are becoming the only source of groceries and PLWHA lack access to nutritious food, compromising their health.
- Medicaid expansion is needed. Treatment needs to be more affordable.
- Fund medical and dental students and nurses by expanding and continuing to provide student loan payoffs for those who will work in FQHCs and other high-need settings. Attract more people of color to work in the care system so that patients are seen by people who look like them.
- Reduce the burden of engaging in care. Allow appointment scheduling before paperwork is completed. Allow PLWHA to be seen more quickly and not wait for appointments. Co-locate services in the same place. Learn more about the patient experience and issues and how they experience the system based on social determinants of health. Make clinics more accessible with extended hours. Use more technology solutions such as virtual case management and automated text reminders for medications.
- There is a need to make changes to the overall system of care. It needs to incorporate the social determinants of health model. Entities that include the county, federal government, state, and the RWPC need to all get on the same page. Formalized ties between Fast Track, the HIV Task Force, and the RWPC are needed to make sure there is no duplication of effort. For example, one respondent

described difficulties with a recent RFP process that included a difficult application. After people struggled and finally turned their applications in, they were informed that it had been recalled. There is a need to improve coordination and create a plan that will holistically address the epidemic. Voices of Black gay men, members of the transgender communities, and others who have traditionally been excluded need to be at the table.

- Engage in more evaluation of services to avoid continuing to spend money on things that are not working, and to identify areas for improvement among services and service coordination.

Population changes since 2016

The organizations surveyed reported seeing an increase in HIV positive patients among the younger and older populations since 2016. The geriatric population of patients with HIV are living longer and require more services, such as housing and dental. The younger generation that is being diagnosed with HIV are finding themselves in a financial crisis and eventually becoming homeless. The following quote was extracted from one respondent's comment.

- *"HSNT has identified an increase in patients age 25-44. Therefore, we have increased our focus on digital outreach to connect younger PLWH to care. HSNT has a significant number of patients age 45-64 and we have increased focus on comorbidities with this age group... Increasing youth population becoming HIV positive and an aging HIV population in general."*
- *"HIV Services has not seen a significant shift in demographics or areas served in the past three years, but homelessness has been growing among our patient population during this period."*

Changes since 2016 cited by interview respondents ranged from positive to neutral to negative. Only one respondent reported they have not seen a lot of changes. More frequently mentioned changes were they are seeing more transgendered clients; more Spanish speaking Latinx PLWHA; more PLWHA with problems finding affordable housing; more who are willing to talk about mental health; more asking for PrEP; and patients are living longer and fewer HIV positive are not getting AIDS.

Positive changes noted by one respondent each were they are seeing HIV positive mothers with nondetectable viral loads are breastfeeding and require monitoring; females that were born HIV positive are now having babies that are HIV negative; more people are getting tested; quality of live continues to improve as more are educated; there are more peer navigators; and people are talking more and more openly about HIV/AIDS. There have been some paradigm shifts with rapid linkages to care, rapid antiviral medications, and people are suppressed sooner. There is also new messaging such as U=U (undetectable equals untransmittable).

Neutral observations of changes include they are seeing more women; more "discordant" couples whereby one is positive and the other negative; more aging PLWHA; and more in the system who are newly diagnosed.

Negative changes reported included increases in substance abuse, domestic violence, and sexually transmitted infections. They are seeing more younger people in rural areas and more uninsured individuals. There has been talk about behavioral health, but no extra resources made available to mitigate the concerns. In the last five years Dallas County has had some issues and some parts of the system work and others do

not. Newly diagnosed individuals tend to be under 35 years of age and not enough is being done to target them, transgender persons, and people of color.

Services PLWHA Need That are Not Available

Interview respondents reported a variety of significant client care and prevention needs that are not being met. Most prevalent among them were the needs for affordable housing, mental health care (including HIV specific psychiatric care and inpatient substance abuse care), and prevention messaging. Many landlords are unwilling to accept HOPWA vouchers. There is a need to build more low-income housing and silver living homes that would accommodate lower income PLWHA.

Testing is not easily available for all individuals, especially youth ages 16 and younger. One respondent recommended universal testing as part of health care and sports physicals for all individuals ages 13 to 64. PrEP access overall needs to be expanded and it needs to be more affordable. There is a high need for access to primary health care regardless of ability to pay. Paperwork required to get medication needs to be reduced. More funding is needed to address co-morbidities, dental care, and vision care. More peer support is needed for PLWHA.

Rural areas had specific unmet needs that included a need for funding for outreach, peer support and navigation, support groups, and PrEP/PEP. They also need more funding for prevention initiatives. Community education may be helpful to overcome stigma that is especially high within rural communities.

Education is needed for PLWHA and physicians. PLWHA need to understand the importance of preventive health care since many would rather save their money for when they become sick. Physicians in some areas are unaware that they may be treating people who are at risk of contracting HIV, or maybe HIV positive.

Overall, there is a lack of representation of some high-risk population and people of color in the workforce and in the decision-making processes.

Medication access and availability of affordable and adequate housing were services survey respondents reported that the people need. Transportation along with co-pay and insurance assistance were also services listed that clients need. The following quote was extracted from one respondent comment.

- *"HSNT serves the rural population in Denton, Collin, Hunt, Kaufman and Rockwall counties. These counties lack transportation infrastructure and therefore rely on HSNT's transportation services. Additionally, there are fewer social service organizations that can address needs such as help with filing a tax return, senior centers for services such as exercise, transportation to grocery stores or help with filling out Medicare applications."*
- *"Transportation is inequitable. An individual eligible for RW care with a care at the same federal poverty level as another eligible individual gets no gas support but the one without a car can access transportation. This creates a disparate system of support. Housing is always top of this list. I would also argue accessibility is locality. For instance, to get bus vouchers individuals have to go to the Stemmons Corridor to get them. Some individuals living South of the Trinity won't cross into this area. Also there are no community based services in East Dallas County (Garland/Mesquite) or Southwest Dallas County (Cedar Hill, Lancaster, DeSoto and Duncanville). In terms of specific populations Asians*

comprise hundreds of thousands of individuals in our area but are virtually non-existent in care. Accessibility can be discomfort with perceived lack of affirming care for a given population. For instance Black women feel very marginalized right now. While they are extremely supportive of the focus on the needs of transgender women, they feel overshadowed by this as well. They also feel disenfranchised from access to PrEP and in general not included in planning or service delivery consideration."

- *"The homeless need medication lockers. Miami has instituted this out-of-the-box system and has seen a 100% viral suppression among persons in the program. (<https://abcnews.go.com/US/wireStory/medication-lockers-miamis-homeless-living-hiv-66548230>). More than services, the community needs to improve its infrastructure surrounding the response to HIV. We need to institute a Rapid Response Network for the County/EMA/HSDA that pinpoints areas where new molecular HIV clusters are popping up so the DCHD can notify the community affected. This could be replicated from the process for notifying people of West Nile and tailored to reduce stigma - it would need to be sensitive to the populations, and it would need to go out to key community partners (non-Ryan White) to ensure the messages reach the community - churches, civic groups, community clinics and community centers, etc."*

Services That Should be Increased to Improve the Health and/or Access for PLWHA

Organizations reported services such as job training, job recruitment, mental health, nutrition resources and substance misuse treatment are services that should be increased to improve health outcomes for patients living with HIV/AIDS. More HIV outpatient centers and locations are also services that were reported to help increase the health outcomes for HIV/AIDS patients. That was especially true for those patients who live in the rural Dallas EMA areas. The following quotes were extracted from two respondent comments.

"Services are available to help PLWHA get to medical appointments and to maintain adherence to medications. However, the need is also great to help those in rural settings get to social support services which are mainly located in Dallas. In many cases, our patients in rural areas are very isolated from others who they identify with."

"Specialty Care Services for HIV-related conditions (hyperlipidemia; cancer, etc.) need to be funded as a line-item for all clinical organizations. Currently, one provider has a "set-aside" for specialty care that allows them to pay for outpatient care for HIV-related conditions, but if you're a patient at another site, you have to leave your medical home to go to this other clinic to get care for co-related conditions."

Available Services That Should be Delivered with a Different Approach or at Different Locations

Responses obtained from the provider capacity surveys suggest mental health services, substance abuse services, and Part A funding are services that should be delivered with a different approach. There needs to be support services accessible via the computer/internet to help serve clients living in rural areas. The following quote was extracted from one respondent comment.

"Behavioral Health Services must be integrated on-site in HIV primary care programs. There needs to be more of a "treat 'em while you got 'em" approach to HIV primary care in order to ensure patients get the care and support they need without having to be referred to other sites for services possibly on different days."

"There needs to be funding for all clinical sites to attain or develop the infrastructure to achieve on-site service integration to best serve the communities. Additionally, the Planning Council should consider updating its geographic directives for how and where services must be delivered to best impact the hardest-hit zip codes in the EMA. Many are still relevant, but many more have come to the forefront since the last review - and new data has a better ability to pinpoint areas smaller than places like 'Stemmons Corridor'."

The Role of Social Media

All interview respondents agreed there is a role for social media in prevention and services awareness, changing local attitudes toward prevention, and changing attitudes toward PLWHA. One respondent expressed concern that it may be overused and they were not sure about effectiveness, and another expressed concern that people may not be honest or may put out incorrect information.

Prevention and Services Awareness

Social media can be useful for creating awareness, sharing facts about HIV and available services that people do not know, telling people where they can get free testing and where to go for HIV care, to advertise upcoming events, and targeting ads to specific neighborhoods. It has the potential to reach a lot of people very quickly. Unlike static web sites, social media works well for health providers to share information and updates quickly. They can share do's and don'ts for safe sex practices and other messages. It is especially effective with the younger generation. Recommendations included using hashtags with other things people may be looking at; using "social influencers" to spread the messaging; putting recent commercials for PrEP on social media; and targeting each social media message to its intended audience. Respondents noted that Facebook is primarily for older people and other sites are more effective for younger audiences (Tik Tok, Instagram).

Changing Local Attitudes Toward Prevention

Social media can be useful to overcome lack of knowledge about HIV among the general population by providing awareness and education messaging. Messages might also emphasize the importance of early testing and how to stay HIV negative. Respondents recommended localized campaigns that emphasize the work being done by local people, using people that look like the target audience, and talking about it as a public health message and not a moral issue.

Some respondents noted some reservations that included that the commercials for PrEP area already doing well, so they were not sure how much added impact social media may have and that it could be helpful only if it is done correctly. While we need good social media, one respondent noted that we also need a more comprehensive system to change attitudes that includes educators and parents.

Changing Attitudes Toward PLWHA

Respondents shared multiple ideas for such social media campaigns. They recommended sharing little clips and blurb stories about people who are living healthy with HIV and women who have uninfected babies. Show stories of couples where one is positive and the other negative, and how they are able to manage. Use local people with name recognition who are popular and trustworthy to share messages. Use social media to debunk many myths and stereotypes of PLWHA. Messaging needs to show that people living with HIV are no different than those who are negative. They need to normalize conversations so that people discuss it just as they talk about diabetes or bunions. Social media campaigns should also address the racial disparities and include conversations about racial justice.

Specific Needs of Sub-Populations

Hispanic Men and Women

Services need to reduce language and cultural barriers with providers who speak Spanish, readily accessible interpreters, and linguistic and cultural translation of materials into Spanish. Promotions (including billboards) should be in Spanish as well. More Hispanic workers are needed in the field. Physicians who serve Hispanic individuals need to be educated for more culturally sensitive engagement.

There is a stigma about immigration nationally at this time. Many Hispanic men and women do not trust the medical or care systems. Many fear deportation and avoid using any services at all. As a result, in some communities Hispanic PLWHA are hard to reach. Another consequence is that many females are remaining in abusive relationships.

HIV stigma is huge within the community. There is a need to more awareness and education. Many Hispanic PLWHA have chronic conditions and are not receiving treatment. They need advocates from within and outside of the community.

African American Men and Women

There is still a high degree of stigma around HIV and LGBTQ within the African American community. There is a need for more awareness and education throughout the community. Two providers recommended they start by working with churches and increasing church leaders' knowledge.

African American men and women have limited trust in health care systems. They are very aware of how they are spoken to and approached by providers. They experience health care differently than other populations and more frequently face discrimination. Black women with HIV/AIDS especially do not feel like the medical care provider community is responding to their unique needs. Providers need to engage in more culturally sensitive ways. There is a need for more clinical staff that are reflective of the community, and to partner with organizations like HBCU's and the faith community to identify and recruit them. Because of this lack of trust, African American populations are difficult to reach in rural areas and more resources are needed for health care workers to engage them. Many LGBTQ community members of color identify first with their ethnicity rather than their sexuality and systems need to be mindful of how they can honor both identities.

Historic and systemic racism had had a disproportionate economic impact on the African American communities in the Dallas EMA, which has led to multiple unmet needs in this community. There is a high need for mental health services; more affordable housing is needed; regular medical care is needed to prevent chronic conditions; education quality needs to be improved to match that of more affluent communities; and access to good paying jobs is needed.

African American PLWHA need a voice and acknowledgement of leadership in the field. Too often the community is viewed and subsequently treated based on “data” and community members have little input in their own care. Prevention and intervention initiatives should assume a strength-based approach that acknowledges resilience and strength within the community.

Men Who Have Sex with Men (MSM)

Many challenges among MSM are attributable to stigma and cultural insensitivity. There are still pockets of locations in the Dallas EMA where gay men are stigmatized and need places to go where they will be treated in a dignified manner. This is especially problematic in rural areas where there are large populations of MSM, but communities are small, and everyone knows everyone. Questions are asked in ways that are insensitive. For example, rather than asking if men are heterosexual or homosexual, ask if they have sex with men, women, or both. Providers need better skills for discussing preventive measures MSM can take when they are having sex. There is a need for providers to better understand the culture.

Younger MSM present special challenges. They minimize the importance of prevention. Many are not using protection and do not know who their partners are. Younger, underage MSM are sometimes unaware that having adult partners is against the law and medical personnel are required to disclose to police and CPS when they encounter them.

They need wider knowledge of the availability of PrEP and PEP, as well as more prevention messages. Providers reported they are treating some PLWHA multiple times for sexually transmitted infections.

White and MSM of color have different issues and needs. There is a need to acknowledge that MSM are not all white and that they exist in spaces other than Oak Lawn. Resources are needed in other communities. Young Black MSM are sometimes targeted for excessive stigma and violence. White MSM with HIV/AIDS are feeling the effects of aging.

Transgender Persons

Some providers interviewed reported that the health care and social service systems have not done a good job of meeting the needs of the transgender population. There is a paucity of medical staff who are knowledgeable about transgender health care needs. For example, there are no providers in the Dallas EMA to do gynecology checks for post-operative transgender women, and few providers understand how to manage their hormones. The transgender clinic is separate from the HIV clinic so their care for each is not well coordinated and transgender individuals with HIV/AIDS need to access two separate health care systems. Practical and economic factors require many to prioritize one care need over another, and many transgender individuals choose their hormones over their HIV medications. Providers are needed who can have conversations to know if all their medical needs are being addressed as well as specialized programs and agencies that focus on them.

Transgender individuals are stigmatized within the general population and even within the LGBTQ and HIV population. To ensure equity and cultural sensitivity staff need training on appropriate pronouns and to reduce

microaggressions transgender individuals regularly encounter. For example, there are issues with being asked about the sex they were assigned at birth and the name on their insurance, most databases lack options to identify them. Documentation in general needs to be more sensitive to the transgender community. Forms often do not offer a box that represents them. Organizations need to create more places where they can be comfortable and normalized, including restrooms. The stigmatization within the general population has led to safety concerns as they are often targeted for violence and even homicide.

Transgender persons face multiple life challenges. Finding and maintaining employment is often challenging. It would be helpful if there were more centralized places where they could share experiences. There is a need for more mentors for younger transgender individuals.

Too often when prevention and intervention services are planned those involved only go to transgender persons for information. They need to be less invisible and included in the problem definitions and solutions that are developed.

Youth

Youth need to overcome their feelings of invincibility and reduce risk behaviors. More education is needed to help them with decision making and about HIV and the risks. More information needs to be provided in schools.

A special concern is youth-parent relationships. Many youth who contract HIV do not want their parents to find out. Many LGBTQ youth are kicked out of their homes when their parents learn of their sexuality and HIV status at a time when they most need acceptance, tolerance, and love from their families and friends. Among Black and Hispanic MSM youth, one interview respondent reported that seven out of every 10 are not welcome in their homes. Safe spaces are needed where they can come together socially and receive mentoring. More spaces are needed that work for Black and Hispanic LGBTQ youth.

Doctors need to do more thorough screenings of youth, including for HIV and sexually transmitted infections. While many parents were described as resistant to this, the youth accept the idea. They are more open-minded than older PLWHA and want more information.

Youth should be engaged and included in the design and development of prevention and intervention initiatives. Such efforts should meet them where they are. Youth need different literature and messaging than that developed for adults.

Chapter 7: Consumer Perspectives



Overview

This chapter presents findings from consumer surveys and focus groups. Whereas the epidemiological profiles provides information about the trends and distribution of HIV, consumer perspectives provide additional context that can help guide planning.

Consistent with the HIV epidemiological profile of the Dallas EMA/HSDA (see [Chapter 2](#)), the majority of the sample included individuals who identified as male, reported being unemployed and low-income, and reported being in-care. An overall summary of survey participant demographics is shown in [Appendix A.4: Consumer Survey](#). The majority of the 392 survey participants resided in Dallas County (94%), were diagnosed before 2010 (79%). About half of the survey participants were ages 50 or older (52%), self-identified as non-Hispanic Black (44%), and self-identified as homosexual (42%). Regarding socio-economic characteristics, 77% of participants reported having some form of health insurance coverage, 72% reported being unemployed, 66% reported a monthly income of \$999 or less, and 27% reported that more than half of their monthly income was spent on housing expenses (housing instability).

Twelve focus groups were completed with over 90 individuals. Focus groups with consumers, especially consumers identified as a priority population, provided rich insight into their experiences navigating HIV care.

Key Findings

- Structural/systemic barriers to HIV care such as affordable housing and adequate transportation were reported among all consumer groups.
- To care for an increasingly diverse consumer population, more socio-culturally and linguistically appropriate care is needed.
- There is a stated need for elevating the voices of and outreach to heterosexual Black and Latina women, Black and Latinx transgender people, African American and Latin community, Youth, and Rural consumers.

Determinants of HIV Care

Determinants of HIV care refer to social, cultural, economic, and organizational factors that can influence a population’s healthcare access, utilization, and quality. The socio-ecological framework ([Figure 42](#)) illustrates how there are individual determinants of HIV care, socioeconomic determinants of HIV care, and systems-related determinants of HIV care.

Individual/Interpersonal determinants include personal knowledge and behaviors that influence health such as attitudes and perceptions, physical health, mental health, sexual health behaviors, substance use, social support, and relationships. **Socio-economic**

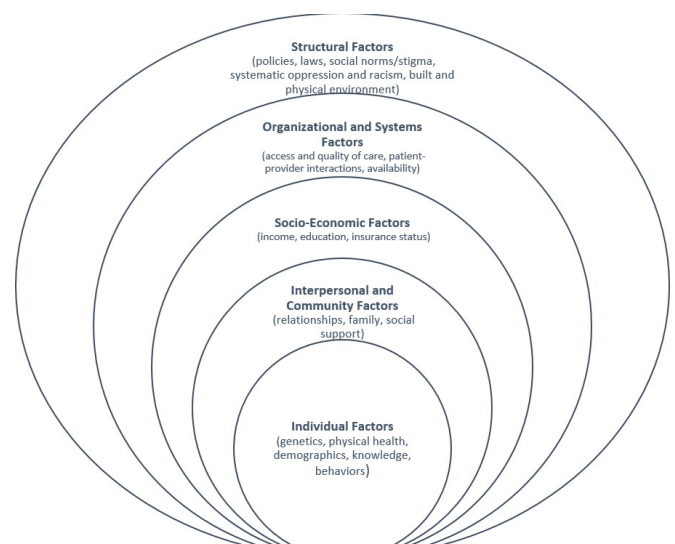


Figure 42. Socio-Economic Framework of Social Determinants of Health

determinants include educational attainment, insurance coverage, income, employment, housing, and transportation. **Systems-related determinants** include organizational or systems-wide characteristics such as accessibility of services, quality of services, distribution of services, and quality of staff-client interactions. **Structural determinants** refer to both social structures that influence health (e.g., laws, public policy, systemic oppression and inequality based on race, gender/gender identity, sexual orientation, class) and the physical environment such as pollution and food deserts.

People living with HIV/AIDS (PLWHA) experience an array of barriers to accessing, utilizing, and remaining in care. An effective approach to understanding and addressing the barriers experienced by PLWHA involves examination beyond the individual. Throughout the needs assessment process, consumers were asked to report on a number of perceived barriers to care. The socio-ecological framework was used to understand those barriers to HIV care that extend beyond the individual. Drawing on the findings presented in this chapter, [Figure 43](#) provides a synthesized illustration of the multi-level barriers to care reported by consumers.

In this section, determinants and barriers to HIV care are organized by individual/interpersonal factors, socio-economic factors, and structural/systems factors.

Individual/Interpersonal Determinants

Viral Load Testing Practices

The largest percent of survey participants (81%, N=317) reported they received the CD4 test in the last 12 months. Among the 29 survey participants reporting no receipt of the CD4 test in the last 12 months, half reported not feeling sick (52%, n=15) as a barrier and one-quarter reported too much paperwork (24%, n=7) as a barrier. See [Table 9](#) for a comparison of viral load testing by priority population.

Chronic and Co-Occurring Health Conditions

Participants reported receipt of testing or treatment for sexually transmitted infections and health conditions.

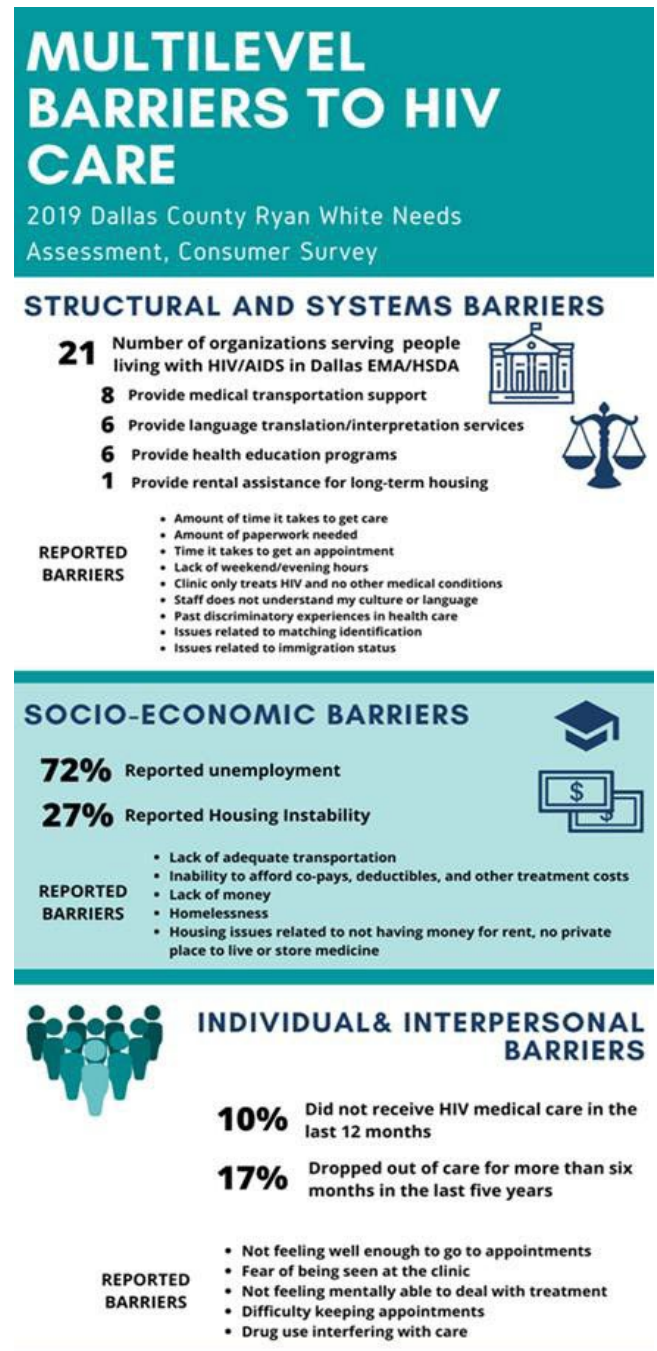


Figure 43. Multilevel Barriers to HIV Care

Percentage of Participants Reporting Receipt of Treatment for Sexually Transmitted Infections (N=392)

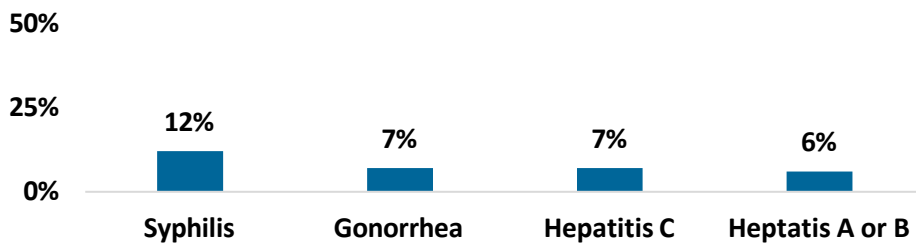


Figure 44. Percent reporting receipt of testing or treatment for syphilis, gonorrhea, hepatitis C, and hepatitis A or B

depression (34%, n=135), diabetes (11%, n=42), and heart disease (6%, n=25). Overall, 37% of participants reported having two or more chronic co-occurring health conditions. See Table 9 for a comparison of the percentage of participants reporting receiving treatment for cardiometabolic health conditions by priority population.

Sexual Health Practices

Fifty-eight percent of all participants reported having sexual intercourse in the last 12 months. Of the 226 participants indicating they had sexual intercourse in the last 12 months, 41% reported always using protection (see Figure 45). Twenty-six percent of participants reported that they did not disclose their HIV status to their partner or potential partner. Among those that did not disclose their status (N=102), the most common reasons for not disclosing their status included:

- being afraid of their partner’s reaction (27%, n=28),
- undetectable viral load (22%, n=22), and
- not wanting to tell others about HIV status (18%, n=18).

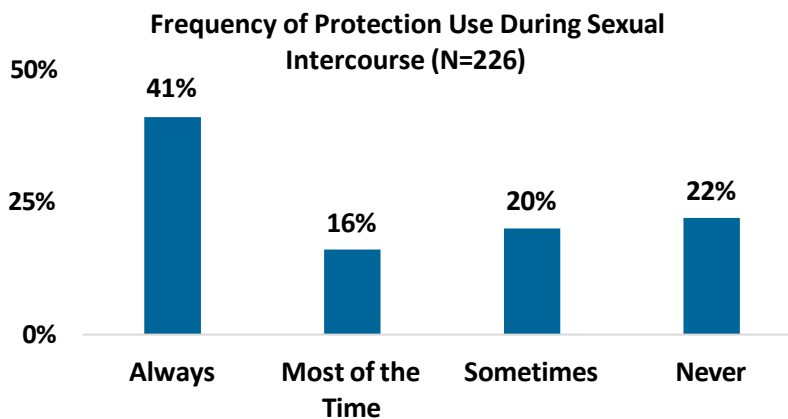


Figure 45. Frequency of Protection Use During Sexual Intercourse

Figure 44 presents the percentage of participants reporting receipt of testing or treatment for syphilis, gonorrhea, hepatitis C, and hepatitis A or B. For a summarized comparison of treatment for sexually transmitted infections and other communicable infections by priority population see Table 9. A greater proportion of participants reported receiving testing or treatment for high blood pressure (34%, n=133),

Behavioral Health and Substance Use

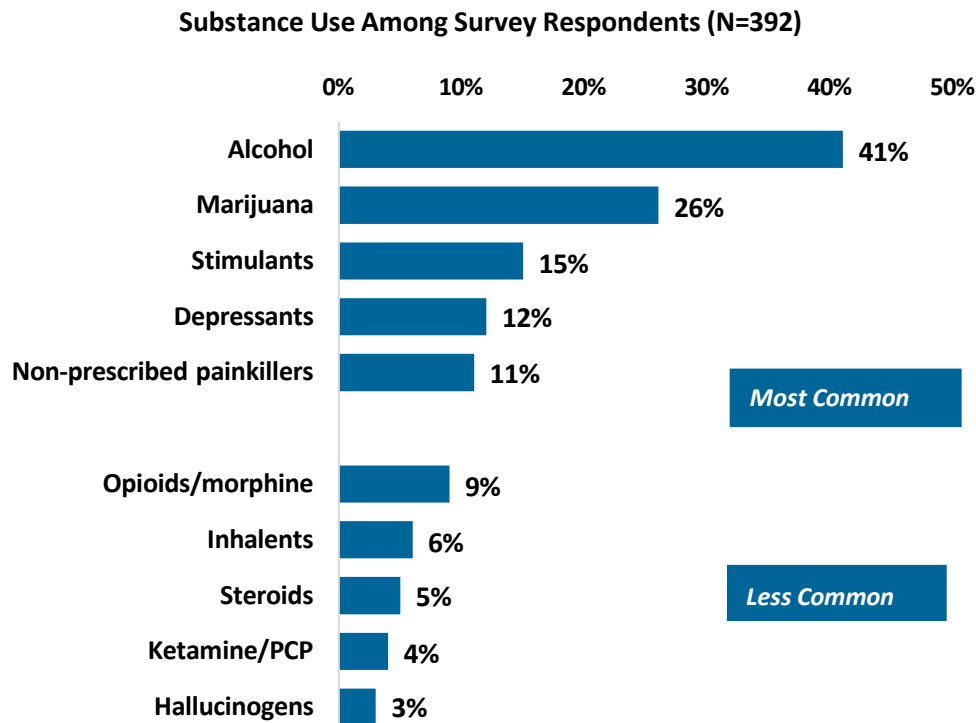


Figure 46 shows the self-reported substance use among the survey respondents. Alcohol and marijuana were the most frequently reported substances used and hallucinogens and ketamine/PCP were the least frequently reported.

Figure 46. Reported Substance Use Among Survey Respondents

Individual/Interpersonal Barriers to Care

Barriers to Care

Eighty percent (80%) of participants reported they received HIV medical care in the last 12 months and 10% reported no receipt of HIV medical care in the last 12 months. Among all participants (N=392), the most common individual/interpersonal factors that made it difficult to get care included:

- not feeling well enough to go to appointments (6%, n=24),
- fear of being seen at the clinic (5%, n=20), and
- not feeling mentally able to deal with treatment (4%, n=16).

Dropping Out of Care

Of the 392 participants, 17% reported they dropped out of care for more than six months at a time during the last five years. Among those who dropped out of care (n=66), the most common reasons for dropping out of care included:

- using drugs (26%, n=17),
- difficulty keeping appointments (23%, n=15),
- being tired of taking medicine (21%, n=14), and
- not feeling sick (18%, n=12).

Timing of HIV Medical Care After Diagnosis

Of the 392 participants, 63% reported starting HIV medical care within six months of diagnosis and 30% reported starting HIV medical care after six months of diagnosis. Among those who started care after 6 months (n=118), the most common reasons for no receipt of HIV medical care within six months after diagnosis included:

- not feeling sick (32%, n=38),
- not wanting to think about being HIV positive (31%, n=36),
- and not wanting to take medicine (21%, n=25).

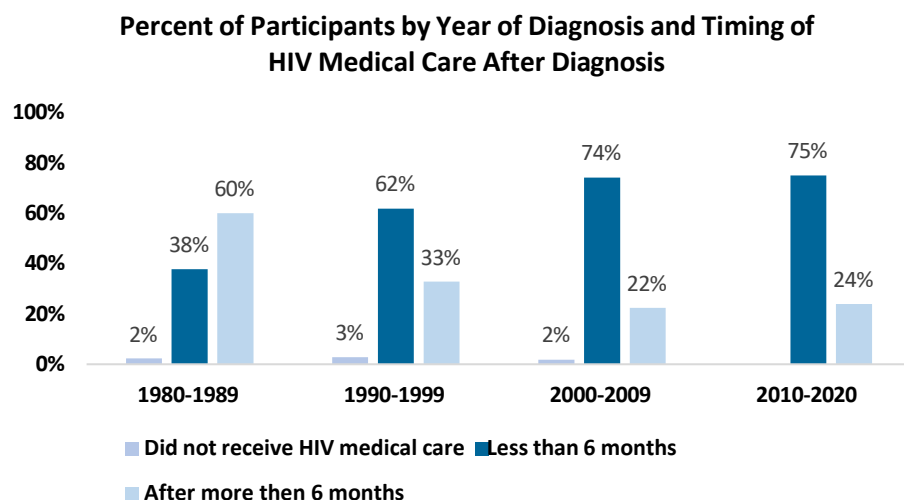


Figure 47. Percent of Participants by Year of Diagnosis and Timing of HIV Medical Care after Diagnosis

In addition, participants' start of HIV medical care depended on when they were diagnosed. As shown in Figure 47, participants diagnosed in the last 20 years reported starting HIV medical care within six months after diagnosis. It is important to note that the Ryan White HIV/AIDS program legislation passed in 1990. As shown in Figure 47, there is a noticeable decline in the percentage of participants who reported that they started care after six months highlighting the overall effectiveness of the Ryan White HIV/AIDS program.

Socio-Economic Determinants of HIV Care

Barriers to Care

Of the 392 participants, 80% reported they received HIV medical care in the last 12 months and 10% reported no receipt of HIV medical care in the last 12 months. The most common socio-economic factors that made it difficult to get care included:

- not having transportation (10%, n=41),
- inability to afford co-pays, deductibles and other costs of treatment (9%, n=39), and
- being homeless (5%, n=21).

Dropping Out of Care

Of the 392 participants, 17% (n=66) reported they dropped out of care for more than six months at a time during the last five years. Among those who dropped out of care, the most common socio-economic factors related to dropping out of care included:

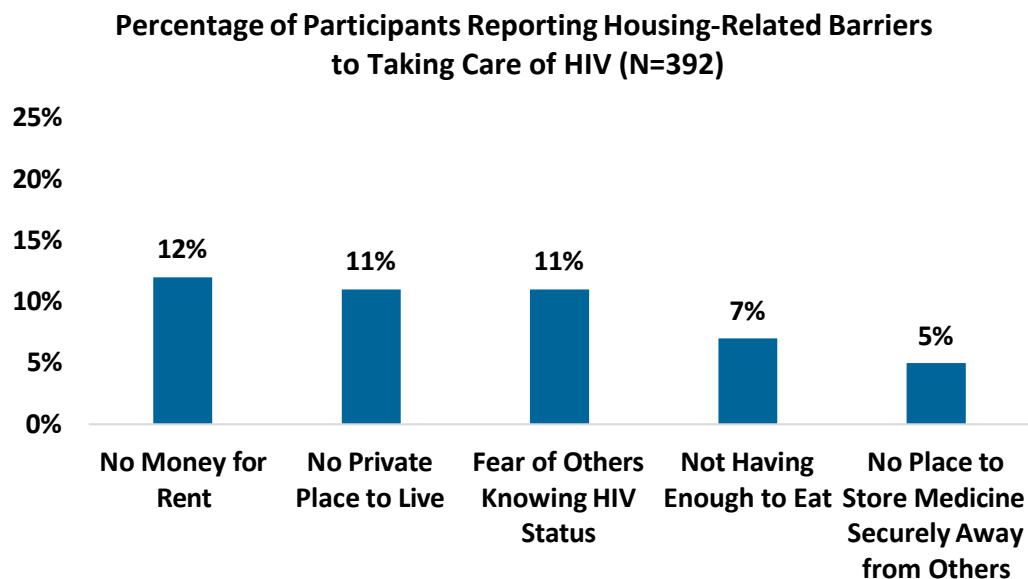
- difficulty getting to the clinic (transportation) (21%, n=14) and
- not having enough money (15%, n=10).

Timing of HIV Medical Care After Diagnosis

Of the 392 participants, 63% reported starting HIV medical care within six months of diagnosis and 30% reported started HIV medical care six months after diagnosis. Among those who started care after six months (n=118), the most common reasons for not receiving HIV medical care within six months after diagnosis included:

- transportation issues (10%, n=12) and
- lack of money (7%, n=9).

Housing-Related Barriers



All participants were asked to report if they had any housing-related barriers. The most common housing-related barriers to taking care of HIV are presented below in [Figure 48](#).

Figure 48. Survey Participant Reported Housing Related Barriers

Systems and Structural Determinants of HIV Care

Barriers to Care

Of the 392 participants, 80% of participants reported they received HIV medical care in the last 12 months whereas 10% reported no receipt of HIV medical care in the last 12 months. Among all participants (N=392), the most common system or structural factors that made it difficult to get care included:

- the amount of time it takes to get care (16%, n=61),
- the amount of paperwork needed (14%, n=56),
- the time it takes to get an appointment (12%, n=47),
- lack of weekend hours (10%, n=40),
- no evening hours (8%, n=31),
- the clinic only treats HIV and no other medical conditions (4%, n=14) and
- staff does not understand my culture (3%, n=13).

Dropping Out of Care

Of the 392 participants, 17% reported they dropped out of care for more than six months at a time during the last five years. Few participants reported systems or structural reasons such as feeling discriminated against at the clinic (8%, n=5) and staff not understanding their language (2%, n=1).

Timing of HIV Medical Care After Diagnosis

Of the 392 participants, 63% reported starting HIV medical care within six months of diagnosis and 30% reported starting HIV medical care after six months of diagnosis. Among those who started care after 6 months (n=118), the most common reasons for no receipt of HIV medical care within six months after diagnosis included:

- not having the necessary ID/ID not matching identity (8%, n=9),
- past experiences with denial, harassment, threats, or violence in health care (7%, n=8),
- the clinic asks too many personal questions (7%, n=8),
- long waiting time to get an appointment (6%, n=7), and
- I do not have legal status in the US (4%, n=5).

Service Utilization and Access

Participants reported which services they used in the last 12 months. [Figure 49](#) presents the top ten services used most by participants and the top ten services that were difficult to access. The majority of participants reported that the services used were easy to get. For each of the services, the majority of participants reported that the service was used and easy to access or they did not need the service.

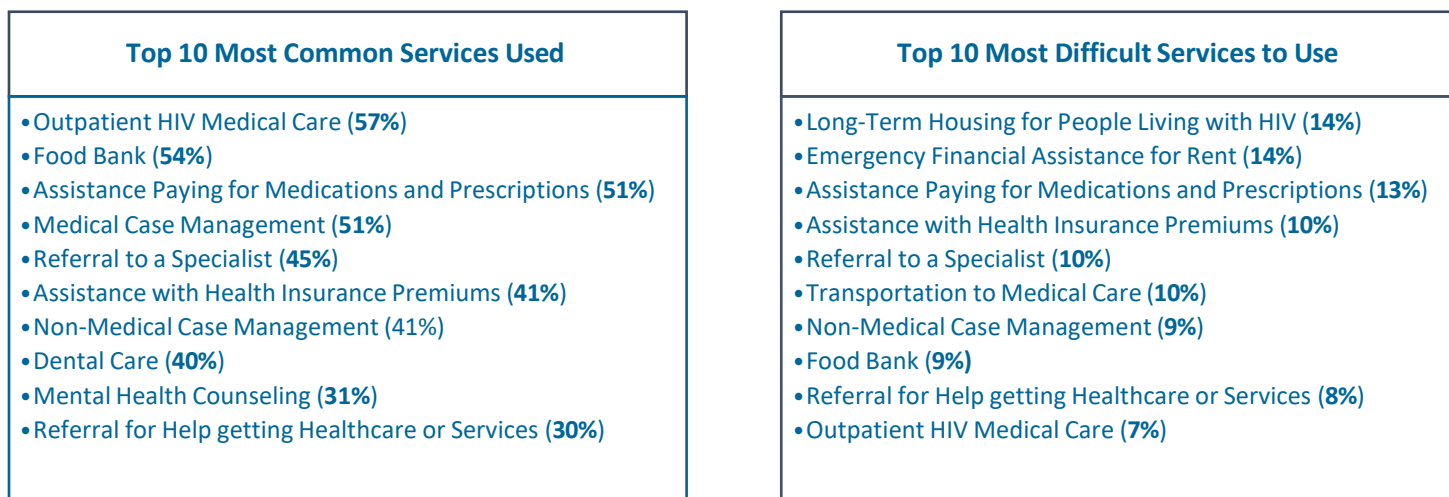


Figure 49. Top Ten Services Most Used and Top Ten Services Most Difficult to Access

Perspectives Among Priority Populations

This section provides an overview of findings for each priority population. Please refer to Appendix [A.4: Detailed Methodology for Consumer Survey](#) for the detailed consumer survey methods and [Table 9](#) for a table comparing key demographic and behavioral characteristic for each priority population.

The most common themes identified across all groups included the impact of stigma on HIV medical care and social support, structural barriers related to affordable housing and transportation, systems barriers related to recertification processes, provider capacity and availability, the need for peer navigation and mentorship, and the need for inclusive care and increased engagement of heterosexual Black and Latinx women, Black and Latinx transpeople, and Youth. [Figure 50](#) presents key recommendations based on the needs identified by survey and focus group data from each priority population.

[Figure 50](#) presents the demographics and individual-level determinants of HIV care for the entire survey sample and by priority populations. Unfortunately, the sample size for participants who identified as Transgender was not large enough to make between-group comparisons.

OVERVIEW OF HIV CONSUMER NEEDS

2019 RYAN WHITE HIV/AIDS NEEDS ASSESSMENT

BLACK MSM

- Peer navigation for newly diagnosed
- Cross-generational mentorship
- Risk reduction and prevention education
- Tailored awareness campaigns targeting stigma and available services
- Address paperwork burden, case management, and negative provider interactions

CISGENDER BLACK WOMEN

- Peer navigation for newly diagnosed
- Risk reduction and prevention education
- Increased services for mental health and cardiometabolic health
- Tailored awareness campaigns targeting stigma, available services, medication options
- Address housing, transportation, paperwork burden, negative provider interactions, provider education
- Increased inclusion of Black women

LATINX

- Peer navigation for newly diagnosed
- Risk reduction and prevention education
- Increased services for cardiometabolic health
- Tailored awareness campaigns targeting stigma, available services
- Address availability of Spanish-speaking staff, discrimination based on race, language and immigration status, housing and housing instability
- Increased visibility and inclusion of Latinx, especially cisgender women

TRANSGENDER

- Peer navigation for newly diagnosed
- Tailored risk reduction and prevention for pre- and post-operative transwomen, men, and non-conforming individuals as well as for youth and seniors
- Increased visibility and inclusion of transwomen of color
- Need for trans-inclusive and properly trained providers and HIV service agencies
- Tailored awareness campaigns/interventions to reduce stigma
- Address structural violence, affordable housing, transportation, negative provider experiences and systemic exclusion of transpeople from medication trails

YOUTH/MILLENNIALS

- Cross-generational mentorship and navigation support
- Risk reduction and prevention education
- Tailored awareness campaigns targeting stigma among young people and families, availability of services, and safe sex practices
- Increased youth-centered services and safe social environments
- Systems issues related to provider education and training to care for youth with HIV, sex education in school systems

SENIORS

- Increased services for specialty care for comorbidities, long-term housing, and transportation
- Provider education/training caring for aging people living with HIV
- Cross-generational mentorship and navigation support
- Risk reduction and prevention education
- More outreach for seniors who are homeless or transgender

Figure 50. Recommendations based on identified needs for priority populations

Table 9. Comparison of Socio-Demographics, Healthcare Utilization, Sexual Health Practices, and Chronic Health Conditions among Priority Populations

	Overall	Black MSM²	Heterosexual Black Women¹	Youth/ Millennials	Seniors	Hispanic/ Latinx
	<i>N= 392</i>	<i>N=45</i>	<i>N=43</i>	<i>N=83</i>	<i>N=107</i>	<i>N=50</i>
Socio-Demographic Characteristics						
Average Age (standard deviation)	49 (12.07)	45 (10.83)	48 (11.00)	32 (4.16)	58 (6.023)	52 (12.56)
Age range	19 - 79	29 - 62	29 - 75	19 - 39	50 - 79	28 - 75
Diagnosed in last 10 years	21%	29%	26%	65%	4%	24%
Housing Instability	27%	29%	30%	18%	36%	39%
Uninsured	16%	24%	9%	24%	12%	20%
Unemployed	72%	73%	65%	50%	80%	60%
Disability Status	32%	22%	35%	6%	35%	24%
Need Help Finding Job	14%	29%	14%	21%	12%	20%
Healthcare Use						
Started HIV medical care in less than 3 months	47%	53%	58%	46%	41%	40%
Received HIV medical care in the last 12 months	80%	91%	79%	72%	83%	82%
In the last 5 years, dropped out of care for more than six months	17%	22%	21%	18%	16%	8%
HIV positive peer would have made it easier to get medical care	66%	76%	77%	63%	69%	70%
Taken HIV medication in the last 12 months	81%	87%	83%	74%	89%	82%
Received CD4 test in the last 12 months	81%	89%	84%	76%	89%	84%
Sexual Health Practices						
Had sex in the last 12 months	58%	73%	67%	74%	48%	66%
Used protection always during sex	41%	30%	41%	24%	45%	54%
Disclosed HIV status to partner/potential partner	74%	82%	79%	65%	78%	74%
Co-Occurring Chronic Health Conditions						
Received treatment for depression	34%	27%	54%	33%	35%	42%
Received treatment for one or more sexually transmitted infections	17%	29%	5%	37%	13%	28%
Received treatment for one or more communicable infections	14%	16%	5%	7%	16%	26%
Received treatment for one or more cardiometabolic conditions	39%	27%	70%	18%	47%	34%
Received treatment for two or more co-occurring chronic health conditions	37%	29%	54%	33%	44%	50%

² Percentages can become unstable/unreliable when the sample size is less than 50. Interpret with caution.

Black MSM

The survey sample included 45 participants self-identified as Black Men who have sex with men (MSM). Compared to the overall sample, Black MSM participants had slightly higher reports of being diagnosed in the last 10 years, housing instability, being uninsured, and needing help finding a job. Black MSM participants were more likely to report starting HIV medical care in less than three months after diagnosis and more likely to report receiving HIV medical care in the last 12 months. Slightly more Black MSM participants reported dropping out of care for more than six months at a time in the last five years and were more likely to indicate that having a HIV positive peer would have helped them stay in care when first diagnosed. In addition, more Black MSM participants reported taking their HIV medication and receiving a CD4 test in the last 12 months compared to the overall sample. Whereas 73% of Black MSM participants reported sexual activity in the last 12 months, 30% reported using protection always or most of the time and 82% reported disclosing their status to their partner/potential partner. A greater percentage of Black MSM participants reported being treated for one or more sexually transmitted infections.

Table 10. Key Themes from Focus Groups with Black MSM (N=11)

Theme	Description of Participant Responses
Service Availability, Accessibility and Needs	Services are widely available and accessible. The underlying problem is largely related to people’s limited awareness about the available services.
Stigma	Stigma associated with HIV/AIDS as well as with homosexuality in the African American community is still a major barrier. Stigma and people’s fear of others knowing their status creates a major barrier to seeking and utilizing HIV medical care services.
Systems of Care Issues	The amount of required paperwork is overwhelming. Navigating the care system from initial diagnosis to care connection is challenging. Better coordination would help to prevent others from ‘falling through the cracks’ as they navigate the system. There is a lack of communication between organizations and services; and a need for systems that talk to one another to reduce the burden on consumers.
Staffing Issues	Dissatisfied with the existing gaps in case management. Case managers are difficult to get in touch with and many lack empathy and professionalism. There is a need for more case managers or social workers who also have flexible schedules or availability.
Cross-Generational Mentorship	A major need for more mentorship programs focused on matching older consumers with younger consumers to help them navigate the healthcare system and life in general. Also, a need for organizations and advocates to engage in more outreach in middle and high schools in order to increase knowledge and awareness about HIV prevention and address misconceptions.
Youth Knowledge and Awareness	Major concern about common misconceptions that younger people may have about HIV. These misconceptions include lack of understanding that HIV is a chronic disease and comes with other comorbidities and that there is a major financial and emotional cost to living with HIV (e.g., cost of prescriptions, not being able to pursue certain careers). Additional concern that PrEP messaging contributes to youth’s already existing tendency to feel invincible. There is a belief that many youth’s lack of understanding about PrEP could actually contribute to more risk behaviors.
Outreach	There is a desire for more commercials and social media advertisements that represent all races and genders. More specifically, more messaging tailored to the African American community.

Heterosexual Black Women (HBW)

The survey sample included 43 participants self-identified as cisgender, heterosexual Black women (HBW). Compared to the overall sample, HBW participants had slightly higher reports of being diagnosed in the last 10 years, housing instability, and disability status. HBW were less likely to report being uninsured or unemployed. HBW participants were more likely to report starting HIV medical care in less than three months after diagnosis and slightly more likely to report dropping out of care for more than six months at a time in the last five years. A greater percentage of HBW participants reported that having a HIV positive peer would have helped them stay in care when first diagnosed. In addition, a greater percentage of HBW reported taking their HIV medication and receiving a CD4 test in the last 12 months. Sixty-seven percent of HBW participants reported having sex in the last 12 months, 41% reported using protection always or most of the time, and 79% reported disclosing their HIV status to their partner/potential partner. A greater percentage of HBW participants reported receiving treatment for depression, receiving treatment for one or more cardiometabolic conditions, and receiving treatment for two or more co-occurring chronic health conditions.

Table 11. Themes from Focus groups with Heterosexual Black Women (N=~19)

Theme	Description of Participant Responses
Service Availability, Accessibility and Needs	General satisfaction with the available services. There is a need for long-term housing options, transportation, and ensuring that locations aren't so spread out, which according to participants, can make a difference if one is using public transportation.
Stigma	HIV stigma and denial of diagnosis continue to be major barriers in Black communities (including Black immigrant communities). Being members of churches or close-knit communities, there is some fear associated with being seen at treatment clinics which would result in others 'knowing their business'.
Provider Education	There is concern about limited HIV education among providers and health workers. Participants felt that most providers needed more education about PrEP and PEP. Moreover, it has been important to know their own bodies and to advocate for their health in the health care setting. Many participants felt unheard when expressing concerns about their HIV medications, its side effects, and having to switch medications. There was a common feeling that providers need to listen and learn from patients, especially since they are not the ones with the disease or having to take the medication.
Systems of Care Issues	There was dissatisfaction with lack of communication between agencies and the overwhelming amount of paperwork. The recertification process was perceived as overwhelming and ineffective; and negatively impacted their employment due to visiting various locations. Whereas some were satisfied with care quality and coordination; some felt like they were being "herded like cattle" and treated with little empathy. For example, there was discontent with the idea of having so many caseworkers for different services and the feeling that people are 'making a living off of our disease'.
Peer Navigation	There is a need for more peer mentorship and peer navigation programs for Black women. Suggested that any agency providing HIV testing should also provide peer mentorship/navigation programs to help women know who to talk to and where to get the necessary information. This was especially important considering many participants felt that their primary physician was uncomfortable discussing the topic of HIV with them.

Table 11. Themes from Focus groups with Heterosexual Black Women (N=~19)

Representation and Inclusion	There is frustration with current messaging and services and; and overall feelings of exclusion. While some women have attempted to serve on consumer advisory boards, they have faced barriers to participation such as consumer advisory boards “meeting their quota” and other technicalities.
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Hispanic/Latinx

The survey sample included 50 participants that self-identified as Hispanic and lesbian, gay, bisexual, transgender, or queer. The average age of Hispanic/Latinx participants was 52 years old. Compared to the overall survey sample, Hispanic/Latinx participants were more likely to report housing instability, being uninsured, and needing help finding a job.

Compared to the overall survey sample, Hispanic/Latinx participants were slightly more likely to report receiving HIV medical care in the last 12 months and less likely to report dropping out of care for more than six months at a time in the last five years. Seventy percent of Hispanic/Latinx participants reported that having a HIV positive peer would have made it easier to get HIV medical care and other services when first diagnosed. Hispanic/Latinx participants were slightly more likely to report taking their medications and receiving a CD4 test in the last 12 months. Whereas, 66% of Hispanic/Latinx participants reported sexual activity in the last 12 months, 54% reported protection was used always or most of the time and 74% reported telling their partner/potential partner about their status. Fifty-five percent of Hispanic/Latinx participants reported having two or more chronic cardiovascular-related health conditions (compared to 37% for the overall sample). [Table 12](#) presents key themes emerging from focus groups.

Table 12. Key Themes from Focus Groups with Hispanic/Latinx

Theme	Description of Participant Responses
Service Availability, Accessibility, and Needs	There is a perceived abundance of services available and that one has to know how to look for them and be ‘resourceful’. However, there was consensus that many faced challenges accessing services and that there were still major service needs. For example, there were concerns related to differences in prescription wait times between hospitals/clinics. Participants also described a major need for dental care, vision care, reliable transportation and long-term housing options. Participants also discussed the need for more culturally-sensitive education about HIV/AIDS, how it spreads, and prevention to increased knowledge and reduce stigma in Latin/Latinx communities. Several felt that men needed to be targeted for HIV educational programs more than women.
Stigma	Stigma is a major barrier in the Latin/Latinx community and shame prevents people from getting tested or seeking care. The topic of HIV/AIDS is taboo and participants felt that major media outlets (e.g., Telemundo) don’t discuss it. One participant explained that oftentimes people will tell others that they have cancer rather than disclose their HIV status. In the community, there is a lot of misinformation about how HIV is transmitted; and community members will avoid physical contact with people who are living with HIV.
Peer Mentorship and Navigation	There is a need for individuals within the Latin/Latinx community to come together to support one another. There was an expressed need for peer navigation for those who are newly diagnosed and needing help and social support.

Table 12. Key Themes from Focus Groups with Hispanic/Latinx

Systems of Care Issues	Within systems of care, providers should take time to listen to patients and show empathy rather than treating them as 'business as usual'. There is also a need for more Spanish-speaking providers, case managers, and social workers. Finally, system issues such as long waiting times for prescriptions and provider shortages were common sources of frustration.
Housing Instability	Housing and housing instability is a major issue. According to participants, financial instability often led to housing instability which then affects one's ability to navigate care. Also, participants described long waiting lists for housing options and the perception that the system seems to reward those with substance abuse or related issues with housing. Housing instability is also a major issue among undocumented PLWHA who are afraid of others finding out their immigration status.
Language, Immigration Status, and Discrimination	While some participants felt that they were treated fairly, many others reported feeling discriminated against. For example, one participant stated, "We are discriminated against on three levels: HIV positive, do not speak English, and for being Latino." Participants felt that sometimes because of their immigration status (or perceived immigration status) doctors pass them over and patients cannot self-advocate because of language barriers. Participants also reported housing discrimination. Recent practices such as requiring social security numbers for food banks and other services presented a major structural barrier. Finally, participants explained that "it is difficult for those within the Latin community, the African American community, and the Latin Black community; and that if there isn't a focus on us there won't be any improvement."
Representation and Inclusion	Participants felt that there is no major effort by medical professionals, media, etc to address HIV in the Latin/Latinx community. Participants reported feeling invisible in the larger conversations about HIV/AIDS and prevention efforts. For instance, one participant explained that since Anglo-Americans have the lowest rates of HIV transmissions, more focus should be placed on "Latinos and African Americans". In addition, participants expressed concerns about stigma among heterosexual women living with HIV. Several participants described how stigma negatively impacts heterosexual women. For instance, according to participants, many women in the Latin community will contract HIV from their husbands who have sex with other men. These women expressed concerns about the risk of transmitting HIV to their children. Therefore, heterosexual women felt the need for more education programs targeted towards men and more support services for heterosexual women.

Transgender Men and Women

The number of survey participants identifying as transgender was too small to disaggregate for comparison. However, one focus group was conducted with individuals who self-identified as transgender women and men (N=3).

Table 13. Key Themes from Focus Groups with Transgender Individuals (N=3)

Theme	Description of Participant Responses
Service Availability, Accessibility and Needs	Participants reported having adequate access to services, but explained that awareness of available services was still an issue for many people. Participants explained that there was a need for trans-inclusive mental health services medical providers and HIV service organizations. For instance, participants described in detail negative, discriminatory experiences navigating mental health and medical care services. Participants also described a major need for housing. Participants raised concerns about availability of trans-inclusive providers in urban and rural areas.
Trans-appropriate care and tailored education	First, participants discussed the need for providers that could provide appropriate, compassionate care for transpeople. Participants discussed important nuances in the care of transpeople. For example, when treating a transperson who is HIV positive, providers must understand if they are pre or post-operative and what this means for their care. Participants also discussed how risk reduction education needs to be tailored specifically for the transcommunity. For example, one participant expressed uncertainty about gay trans men’s understanding of how HIV is transmitted. Participants explained that as transpeople transition and sexuality becomes more fluid there is a need for tailored education around how HIV can be transmitted. Second, access to female hormones as well as considerations regarding the interaction of HIV medication and female hormones arose as an important consideration. Third, participants discussed trans seniors who may have transitioned later in life or was not part of the LGBTQ scene before transition. For this group, there is a need for tailored education on AIDS and aspects of the community that they missed out on. Fourth, there is a need for prevention efforts focused on transyouth who may experience homelessness or engage in survival sex work. Finally, participants discussed the need for services and prevention education for intersex persons.
Stigma and Violence	Participants explained that stigma associated with HIV/AIDS and transpeople is prominent in Black and Latinx communities, in the wider community, and even in healthcare and social services settings. Stigma, combined with a culture of violence towards transpeople, especially transpeople of color, makes navigating daily life challenging—which has implications for one’s ability to navigate care.
Discrimination and Racism	Some participants explained that education about transpeople is needed for people who identify as lesbian, gay and bisexual. Participants described experiences with transphobia and racial discrimination within the LBG community. As one participant described, “we’ve got to stick together or we’ve lost.”
Outreach	Participants frequently described the transcommunity as disconnected. For example, many transpeople, especially transpeople of color, may not congregate in common spaces, associate with other transpeople, or be a part of the LGBTQ scene. Also, because of stigma and structural violence, participants explained that outreach is challenging. Approaching other transpeople can be extremely dangerous for oneself and other people who may not have disclosed their transition. Participants did report that social media, flyers, and television ads on mainstream networks featuring transpeople has noticeably increased.
Systems of Care Issues: Mistrust and Mistreatment	According to participants, many transpeople avoid seeking care for fear of mistreatment or a desire to avoid dealing with the frustration of providers’ lack of knowledge and training in caring for transpeople. Related, some participants reported mistrust in the HIV care system. For example, there were concerns about the excessive recertification process, perceived poor management of paperwork, and concerns related to identity theft or vulnerability of sensitive information.

Table 13. Key Themes from Focus Groups with Transgender Individuals (N=3)

Representation and Inclusion	Participants recognized that Black trans and Latinx trans women were largely missing from HIV conversations and prevention efforts. Since some Black and Latinx trans women may resort to survival sex work, participants explained there is a need for some targeted outreach. Participants discussed the importance of including more transgender men and cisgendered heterosexual women in clinical trials for medications to understand absorption rates. There is limited understanding of medication effectiveness which can impact viral suppression and protection.
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Youth and Millennials (19 – 39 years old)

The survey sample included 83 participants identifying as lesbian, gay, bisexual, queer, or transgender and aged 19 to 39 years old (youth and millennials were combined due to small sample size for youth). Compared to the overall sample, youth/millennial participants were more likely to be diagnosed in the last 10 years, uninsured, and needing help finding a job. Youth/millennial participants were less likely to report receiving medical care in the last 12 months, taking HIV medication, and receiving a CD4 test in the last 12 months. Slightly fewer youth/millennial participants reported that having a HIV positive peer would have made it easier to get medical care and other services. Whereas 74% of youth/millennial participants reported having sex in the last 12 months, 24% reported protection always or most of the time, and 65% reported disclosing their HIV status to their partner/potential partner. A greater percentage of youth/millennial participants reported receiving treatment for one or more sexually transmitted infections compared to the overall sample.

Table 14. Key Themes from Focus Groups with HIV+ Youth (18-24 years old; N=6)

Theme	Description of Participant Responses
Service Availability, Accessibility, and Needs	Participants recognized a number of available prevention programs and treatment clinics, but admitted that it took some effort to find out where services were available. In rural areas there are limited prevention programs, testing or treatment services available. Money and awareness are two key barriers; and having somewhere to go or call at late at night would be beneficial (rather than trying to go to the emergency room). There needs to be a 24-hour hotline to help youth get connected to care and youth-centric, safe spaces to go; but the reality is that not many are available, especially for youth in rural areas.
Stigma	In rural areas, there are barriers related to social norms and stigma. For example, being kicked out of an establishment for engaging in public displays of affection with their same-sex partner. There is a lot of fear about HIV in the community and that no one really wants to talk about it. Shame associated with one's status also prevents youth from getting treatment. For instance, one participant explained that he was afraid that his family would kick him out so he hid his status and did not get treated.
Systems of Care Issues	According to participants, "it seems like you get tested, find out you have HIV, and then everything gets fuzzy." Participants expressed frustration and some confusion when having to navigate the health system to get the appropriate care or support. Some participants explained that all their age group knows, in terms of prevention, are condoms, PrEP, and nPEP; and expressed a need for more education.

Table 14. Key Themes from Focus Groups with HIV+ Youth (18-24 years old; N=6)

Relationships	Navigating intimate relationships and social media as a young person presents challenges. For example, on apps such as Grindr or Tinder, some people may disclose their status, but it is hard to really know. Youth resort to looking up strangers on Google to make sure they 'check out'. There are also challenges with family relationships. Many of the participants' families were not accepting of their identities; and were not open to discussing HIV. As one participant described, "we can't even mention the word 'gay', so how are we going to talk about HIV."
Sexual Health Education and Outreach in Schools	School districts have rules about youth who identify as lesbian, gay, bisexual, transgender, or queer and parents refusing to sign waivers for sexual educators to talk about anal sex. It is difficult to talk to adults about sex, especially anal sex, because they get uncomfortable. There is a need for schools to allow for discussions on STI prevention, HIV/AIDS, and sexual/reproductive health. The best strategies to reach youth are flyers, billboards, social media (Twitter, Snapchat, Instagram, Facebook).
Provider-Youth Interactions	There are barriers associated with their primary care providers not knowing how to care for someone with HIV and that there is a need for more education. As a result, participants feel as though they don't get clear answers to their questions from providers.

Seniors (50+ years old)

The survey sample included one-hundred and seven participants aged 50 years old or older who self-identified as lesbian, gay, bisexual, queer, or transsexual. Compared to the overall sample, seniors were more likely to report housing instability, being unemployed, and having disability status. Senior participants were more likely to report receive of HIV medical care in the last 12 months. While most senior MSM were diagnosed 20 to 30 years ago, 69% reported that help from a HIV positive peer would have made it easier to get HIV medical care and other services when first diagnosed. In addition, seniors were more likely to report taking their HIV medication and receiving a CD4 test in the last 12 months. Less than half of seniors reported having sex in the last 12 months, 45% reported protection was used always or most of the time, and 78% reported disclosing their HIV status to their partner/potential partner. Slightly more senior participants reported having two or more chronic cardiovascular-related health conditions than the overall sample.

Table 15. Key Themes from Focus Groups with Seniors (N=6)

Theme	Description
Service Availability, Accessibility and Needs	There are enough services were available, and generally good quality. The biggest issue is people's awareness of these services. There is a major need for long-term housing options for people living with HIV and mental health/counseling services. Existing housing options have long waiting lists (2-3 years) and the housing subsidies are still high if one's monthly income is limited considering the cost of living and medications. This group provided suggestions related to providing public shows and restrooms for people to clean up; or investing in 18-wheeler trucks with trailers that include mobile showers and restrooms. In terms of accessibility, participants described how there used to be a lot of people living in one area where services were within short distances, but many have had to relocate due to the rising cost of housing in the area. Participants expressed that ridesharing services (e.g., Uber) would be beneficial especially for those with disabilities who have to wait for hours for pick-ups. Also, many individuals do not utilize available services because of a commonly-held notion that they are taking services away from others who need it the most.

Stigma	Stigma is a common barrier that results in people (straight and gay) avoiding use of services for fear of others knowing their status. Extremist attitudes and beliefs from prominent religious organizations in Texas contributes to stigma and makes young people feel disempowered.
Systems of Care Issues	There is dissatisfaction with existing mental health services due to so much time spent on administrative paperwork during visits. There is minimal time for counseling.
Cross-Generational Mentorship	There is a need for more mentorship programs that match younger consumers with older consumers. The HIV positive mentors would help those who are newly diagnosed navigate the health care system and provide a source of support.
Targeted Outreach	There is a need for more outreach to homeless populations and the transgender community. These two groups are often isolated and don't receive a lot of messaging about services and education. There is a major concern for youth and the need for targeted education in and outside of school settings. Youth needed to know how to prevent HIV and STI transmission, how to navigate relationship issues, and needed to see how HIV impacts everyone to reduce stigma. This group suggested having gatherings—not focused on HIV—to help build community and educate people.
Specialized Care	There are unique challenges related to aging people living with HIV. General primary care providers do not understand the comorbidities in senior HIV patients. These comorbidities include diabetes, osteoporosis, bone pain, neuropathy, and other health conditions related to older medications. Providers sometimes don't understand how HIV medications interact with medications for other chronic health conditions, which can be frustrating.

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Appendix A: Detailed Methods

A.1: Detailed Methodology for Epidemiologic and Secondary Data Collection

Epidemiologic data were collected and compiled by Brad Walsh at Parkland Health and Hospital System. The Texas State Department of Health Services provided quantitative data for incidence, prevalence, trends, co-morbidities, trends, and services. He also obtained ARIES data from the local provider data system to supplement the state data. These data were provided to the contractor, Susan Wolfe and Associates, who conducted additional analyses, compilation, and used the data to prepare graphs for this report. Additional data were obtained online from the United States Census American Community Survey and the Center for Disease and Control Prevention risk surveys.

A.2: Detailed Methodology for Key Informant Surveys

The Key Informant Surveys were conducted by the contractor, Dr. Susan Wolfe. Dallas County Health and Human Services provided Dr. Wolfe with a list of organizations, contact names, and contact information for individuals who play a key role in the development and provision of services to PLWHA in the Dallas EMA. E-mail invitations were sent to individuals from 27 different organizations requesting their participation. Recipients were asked to click on a link to *Sign-Up Genius* to select a date and time slot to schedule their interview. Follow-up invitations were sent to non-respondents after the sign-up deadline passed. Twenty-three individuals responded and signed up to be interviewed. One individual was unable to participate at her designated time due to an unforeseen event; one had to cancel because of a conflict and did not reschedule; and another did not show at the scheduled time. The final number of interviews was 20 key informants.

The interview was conducted using a semi-structured interview protocol (see appendix [B.2: Key Informant Interview Protocol](#)) via Zoom conferencing technology on the computer or telephone. All Key Informants agreed to having their interviews recorded. Interviews lasted from 45 minutes to 1.5 hours, and averaged one hour. Three interviewees were unable to complete the entire interview because of scheduling conflicts or other time limitations. All interviews were completed between October 17, 2019 and November 25, 2019.

Organizations represented housing services, health care services, mental health services, children's health services, consumers, policy and advocacy services, transgender services, and other service providers serving PLWHA in the Dallas EMA. Nineteen respondents served Dallas County and one respondent served the Sherman-Dennison HDSA.

A.3: Detailed Methodology for Consumer Focus Groups

Twelve focus groups were conducted. Three of the focus groups were conducted in June and July of 2018 by the Care Coordination Ad Hoc Committee. Two focus groups were conducted in April and June 2019 by Brad Walsh from Parkland Health and Hospital System. The remaining seven focus groups were conducted by the contractor, Susan Wolfe and Associates. All focus groups used a standard, semi-structured protocol (see Appendix [B.3: Consumer Focus Group Protocol](#)). Eleven of the 12 focus groups were recorded. Participants were asked if they consented to recording and one participant in one group asked that the focus group not be recorded. Participants were asked to sign an informed consent form and each participant received a gift card

as compensation for their time and input. All focus groups were arranged by Dallas County Health and Human Services in collaboration with service providers.

The purpose of the focus groups was to gain added input from priority populations. Populations, sites, dates, and numbers of participants are listed below.

Table 16. Focus Group Populations, Sites, Dates, and Participants			
Priority Population	Site	Date	Number of Participants
Black Women		06/18/2018	12
Black MSM		07/16/2018	6
Hispanic Individuals	AIDS Services of Dallas	07/31/2018	9
Mixed demographic	Access Information Network	04/29/2019	11
Rural Community	Callie Clinic	06/14/2019	7
Aging Population	The Resource Center Dallas	10/04/2019	6
Latin MSM	The Resource Center Dallas	10/10/2019	12
Black Women	The Afiya Center	10/10/2019	7
Black MSM	The Spot	10/29/2019	5
Latinx Individuals	AIDS Services of Dallas	11/26/2019	12
Youth	Fuze/United Black Ellument	12/09/2019	6
Transgender	Prism Health North Texas	12/11/2019	3

A.4: Detailed Methodology for Consumer Survey

Planning

The planning of the consumer survey for the 2019 Dallas HIV/AIDS Comprehensive Needs Assessment was a collaborative process between Dallas County Health and Human Services, the Dallas County Ryan White Planning Council Committees, agencies and providers, and the evaluation team. The Ryan White Planning Council Health Planner led the scheduling of data collection activities at partnering sites; and collaborated with the evaluation team to determine the data collection logistics and processes at each site. The evaluation team was responsible for training undergraduate and graduate student interns and volunteers on the data collection protocol, the data entry protocol, survey administration and verbal survey interviewing, data management and data analysis. All student interns and volunteers completed Human Subjects Protections Training and completed coursework in working with vulnerable populations.

As shown in Table 18, prior to data collection, the evaluation team spent time editing the existing consumer survey questions to improve comprehension, modifying the survey to reduce length, adding skip-logic on paper-based and online versions of the survey to reduce survey fatigue, and working with a professional translation service to translate the survey and flyers from English to Spanish.

Sampling Plan

We calculated the sample size based on the current total HIV prevalence for the Dallas Eligible Metropolitan Area (2018), with a 95% confidence interval at a 5% margin of error. Eligibility criteria included individuals who were age 18 years or older, live in one of the Dallas EMA/HSDA counties, diagnosed with HIV and/or AIDS, and have not already completed the survey. Efforts were taken to over-sample in rural locations, youth (via social media), and out-of-care. However, the two-month timeframe for data collection presented a key challenge.

Survey Tool

Consumer-reported data for the 2019 Dallas HIV/AIDS Comprehensive Needs Assessment were collected using a 90-item survey (paper and online) of open-ended, multiple-choice, and scaled questions addressing x areas (in order):

- Socio-Demographics
- Health History
- Medical Care (Testing & Medication, Care Utilization)
- Health Behaviors (Alcohol Use, Substance Use)
- Intimate Relationships (Sexual Activity, Condom Use, Disclosure)
- Use of Prevention/Intervention Services
- Barriers to Services

The topics and questions covered in the survey were retained from previous years' survey. A cover sheet explained the purpose of the survey, risks and benefits, planned data uses, and consent.

Data Collection

We administered consumer surveys at pre-scheduled sessions at Ryan White HIV/AIDS Program providers, housing facilities, and specific community locations and organizations. Staff contacts at each location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through flyers, word-of-mouth, social media, and staff promotion. Surveys were self-administered in English and Spanish, with staff and interns available for verbal interviewing for individuals who needed assistance. There were also bilingual staff and/or interns who provided verbal interviewing when needed. Participation was voluntary, anonymous, and monetarily incentivized (\$15); and respondents were advised of these conditions verbally and in writing. Most surveys were completed in 20 to 30 minutes. Surveys were received on-site by trained staff, interns, and evaluation team for completion and translation of written comments. Completed surveys were logged into a centralized survey database. Online survey participants were provided with an auto-generated unique code at the end of the completed survey. Participants were instructed to contact the Ryan White Planning Council Health Planner to provide the code and arrange a time to retrieve their gift card.

In total, 421 consumer surveys were collected from December 2019 to January 2020 during 10 sessions at six survey sites (including one rural location and one housing facility). The final sample size was 392 after eliminating ineligible cases.

Data Management and Analysis

Trained student interns completed data entry using a data entry protocol. Skip-logic questions were entered based on first-order responses and only affirmative responses were entered for "check-all-that-apply"

questions. Additional variables were generated or recoded during data cleaning to prepare for analysis. Data weighting was not applied. Missing or invalid survey entries per variable were excluded from analysis; therefore, denominators across results vary. All proportions were not calculated with a denominator of 392 for every variable due to missing or “check-all-that-apply” responses. All data management and analysis was performed in IBM SPSS Statistics Version 25.

The final sample size was 392. Table 19 provides a summary demographics for participant included in the final sample.

Limitations

There are several limitations that should be considered when interpreting and using the findings from the consumer survey.

Convenience Sampling and Representativeness

We used a convenience sampling strategy, rather than random sampling, for this portion of the Needs Assessment. As a result, the majority of the sample represent PLHWA in urban settings (Dallas County) and in care receiving Ryan White Program services. This sample is less representative of youth (18 to 24-year-olds), transgender women and men, heterosexual women, individuals experiencing homelessness, and individuals living in rural settings. Therefore, findings should be interpreted with caution.

Sample Size

The minimum sampling plan goal for the consumer survey was 366. Although the current sample exceeded this goal, a longer data collection period would have allowed for a greater sample size.

Bias

Survey participants were self-selected and self-identified, and the answers provided on survey questions were self-reported. Data from these anonymous self-report surveys could not be corroborated with health records. Consequently, results should not be used as empirical evidence of reported outcomes. There is also a potential for social desirability bias, which refers to the tendency of participants to answer questions in a manner that will be viewed favorably by others. To minimize this potential bias, effort was taken to explain to participants that their feedback was anonymous and that their responses would not affect their receipt of services in any way. Finally, because of the lengthy survey, it is possible that many participants experienced respondent fatigue, or when participants become tired of the survey task. Respondent fatigue can affect the quality of the data and lead to nonresponse bias.

Table 17. Geographic representation of survey respondents		
County	Percent PLWHA	Percent Survey Respondents
Cooke	.01%	0%
Fannin	.02%	0%
Grayson	.8%	0.7%
Collin	8.4%	2.3%
Dallas	81.1%	94.1%
Denton	6.0%	0.7%
Ellis	1.4%	0.5%
Henderson	0.5%	0.2%
Hunt	0.6%	0%
Kaufman	1.1%	0.2%
Navarro	0.3%	0%
Rockwall	0.4%	0%

Efforts were made to obtain as geographically and otherwise representative population as possible. The majority of PLWHA reside in Dallas County (81.1%). Efforts were made to obtain survey data from the other counties, but they were not as successful as intended. For example, the survey team spent a half day in Grayson County and only received two responses. The survey team and DCHHS also contacted providers and asked them to distribute surveys. A comparison of the proportion of PLWHA in the Dallas EMA and the 392 survey respondents is shown in Table 17.

Survey Tool

Due to variability in comprehension of surveys by respondents, we cannot assure full data accuracy. Although quality reviews of each completed survey were performed real-time, there were missing data as well as evidence of misinterpretation of survey questions and/or response options. It is possible that literacy and language barriers contributes to this limitation.

Data Management

There is a potential for bias related to multiple student interns entering survey data. Although a data entry protocol was used, it is possible that data entry errors occurred.

Despite these limitations, the data from the consumer survey can be useful in describing the perspectives and experiences of PLWHA in the Dallas area and draw conclusions on how to best meet the HIV service needs of this population.

Timeline

Table 18. Survey Project Timeline	
Month	Activities
August 2019 – September 2019	<ul style="list-style-type: none"> • Prepared key informant interview protocol, scheduled key informant interviews, and began interview data collection • Prepared focus group protocol, scheduled focus group sessions, and began focus group data collection
October 2019 – November 2019	<ul style="list-style-type: none"> • Completed modifications to consumer survey, received approval on survey and recruitment materials • Planned data collection sessions and sites • Began consumer survey data collection • Began provider survey and resource inventory data collection

Table 18. Survey Project Timeline	
Month	Activities
December 2019 – January 2020	<ul style="list-style-type: none"> Completed key informant interview data collection Completed focus group data collection Completed consumer survey data collection Completed provider survey and resource inventory data collection
January/February	<ul style="list-style-type: none"> Completed data analysis for key informant interviews, focus groups, and consumer survey

Table 19. Survey Participants' Demographic Characteristics (N=392)	
Demographics	N (%)
County	
Dallas	369 (94%)
All Other Counties: Collin, Denton, Ellis, Grayson, Henderson, Kaufman	19 (5%)
Missing	4 (1%)
Priority Population	
Men who have sex with men (MSM)	158 (40%)
Black MSM	45 (11%)
Heterosexual Black Women	43 (11%)
Heterosexual Women	63 (16%)
Seniors (50 years and older)	158 (40%)
Youth/Millennials (18-39 years)	83 (21%)
Out-of-Care (last 12 months)	39 (10%)
Age	
18 – 30 years old	25 (6%)
31- 49 years old	125 (32%)
50 or older	205 (52%)
Missing	37 (9%)
Race/Ethnicity	
Hispanic	69 (18%)
Non-Hispanic Black	174 (44%)
Non-Hispanic White	103 (26%)
Non-Hispanic Other	25 (6%)
Prefer Not to Answer	21 (5%)
Gender Identity	
Female	82 (21%)
Male	288 (73%)
Transgender	9 (2%)
Other/Selected Multiple	4 (1%)
Prefer not to answer	2 (1%)
Missing	7 (2%)
Sexual Attraction/Identity	
Homosexual	166 (42%)
Heterosexual	127 (32%)

Table 19. Survey Participants' Demographic Characteristics (N=392)

Demographics	N (%)
Bisexual	2 (1%)
Queer	46 (12%)
Other/Selected Multiple	18 (5%)
Prefer not to answer	25 (6%)
Missing	8 (2%)
Insurance Status/Type	
Private Insurance	22 (6%)
Parkland Health First	77 (20%)
Medicare	111 (28%)
Medicaid	62 (16%)
COBRA	4 (1%)
Other	25 (6%)
No Insurance	61 (16%)
Missing	30 (8%)
Veteran	
Yes	31 (8%)
No	349 (89%)
Prefer not to answer	4 (1%)
Missing	0 (0%)
Living Situation	
Living with someone else temporarily	31 (8%)
Living with someone else permanently	60 (15%)
Homeless living in shelter or on the street	32 (8%)
Living in residential hospice or supportive living facility	36 (9%)
Living in boarding house or half-way house	17 (4%)
Living in an apartment, house, or mobile home in own name without a subsidy	61 (16%)
Living in an apartment, house, or mobile home in own name with a subsidy	102 (26%)
Other	41 (10%)
Missing	12 (3%)
Educational Background	
Less than 8 th Grade	16(4%)
Some High School	44 (11%)
High School Diploma/GED	120 (31%)
Technical/Trade School	11 (3%)
Some College	115 (29%)
Completed College	46 (12%)
Graduate Degree	15 (4%)
Other	6 (2%)
Missing	19 (5%)
Employment	
Working Full-Time	43 (11%)
Working Part-Time	57 (15%)
Not Working	283 (72%)

Table 19. Survey Participants' Demographic Characteristics (N=392)

Demographics	N (%)
Missing	9 (2%)
Percentage of Monthly Income Spent on Housing Expenses	
Less than half	78 (20%)
Almost half	86 (22%)
More than half	107 (27%)
Don't Know	31 (8%)
I do not pay housing expenses right now	79 (20%)
Missing	11 (3%)
Incarcerated in the Last Two Years	
Yes	66 (17%)
No	315 (80%)
Missing	11 (3%)
Year of HIV Diagnosis	
1979 or earlier	4 (1%)
1980 to 1989	45 (12%)
1990 to 1999	107 (27%)
2000 to 2009	112 (29%)
2010 to 2020	84 (2%)
Missing	40 (10%)

A.5: Detailed Methodology for Provider Capacity Survey and Resource Inventory

Inventory of HIV Service Providers without Ryan White HIV/AIDS Program Funding

In September 2019, the evaluation team trained a group of five graduate public health students to generate a resource inventory of agencies serving people living with HIV and/or AIDS without Ryan White HIV/AIDS Program funding. The student team generated a list of agencies in the target counties within the Dallas EMA. Using the resource inventory template, students performed internet searches and made phone calls to organizations to verify key information. The student team used a snowball sampling technique to identify additional organizations. By November 2019, the student team identified 14 organizations (one organization was funded by Ryan White HIV/AIDS program and 13 organizations were not funded by Ryan White HIV/AIDS program).

Challenges

There were four key challenges during data collection. First, there were two organizations with websites that contained incomplete information which presented challenges with data retrieval and could have important implications for consumers seeking information. Second, the team experienced difficulty identifying and contacting personnel at five organizations. Third, two organizations had websites that were out of date. Finally, two organizations on the original list were no longer in business.

Limitations

A substantial amount of the data obtained about organizations' programs and services were based on publicly available information. There is a possibility that some data is outdated or incorrect. To prevent inaccuracy, the student team called the organizations but attempts to contact key personnel was not always successful.

Ryan White HIV Service Provider Capacity Survey

In November 2019, the Ryan White Planning Council Health Planner provided the evaluation team with a list of nine organizations funded by the Ryan White HIV/AIDS Program along with contact information. The Ryan White HIV Service Provider Capacity Survey was administered to nine organizations during November 2019 through February 2020. Eight of the nine organizations (88%) completed the survey. Once data collection was complete, services information from the non-Ryan White funded organizations was combined with services information obtained from the provider capacity survey. The provider capacity survey was administered through Qualtrics and data were analyzed using IBM SPSS version 25. Open-ended responses were analyzed using thematic analysis.

Challenges

The evaluation team experienced some challenges with obtaining responses from providers. It is possible that the nature of some of the questions (e.g., number of unduplicated clients served by service type) posed a challenge for respondents which delayed survey completion.

Limitations

It is possible that some providers interpreted certain questions differently than others. For the next phase of the survey, the evaluation team will address survey question specificity and clarity. Also, the evaluation team used the provider capacity survey from previous years. This version of the survey does not capture detailed information about service capacity. Therefore, steps will be taken to ensure that the survey is designed to address this topic.

Complete Resource Inventory

We identified 21 organizations serving people living with HIV and/or AIDS in the Dallas EMA, which are included in the final resource inventory.

Appendix B: Data Collection Instruments

B.1: Consumer Survey

CONSENT

I have read the information about this needs assessment and how the information will be used and protected. I also understand that this survey is completely voluntary and my receipt of services is not dependent on my completion of this survey. All of my questions about this survey have been answered.

Yes, I choose to participate in this survey.

No, I decline to participate in this survey.

How would you like to complete this survey?

I would like to complete the survey on my own.

I would like you to read the questions to me and mark my answer.

SECTION 1: SURVEY ELIGIBILITY

Please begin by answering the following questions to find out if you are eligible to complete this survey.

A. Are you a person diagnosed with HIV/AIDS?

Yes – Please continue to the next question.

No – We are sorry, you are not eligible to complete the survey.

Do not know – We are sorry, you are not eligible to complete the survey. Please get tested because everyone should know their HIV status!

Prefer not to answer – We understand; however, we are sorry that unless we know your status is positive, you are not eligible to complete this survey.

B. Has anyone interviewed you or have you taken an online survey about your HIV service needs in return for a gift card in the last two (2) months?

Yes – We are sorry, you are not eligible to complete the survey

No – Please continue to the next question.

Do not know – We are sorry, you are not eligible to complete the survey.

C. Do you live in Collin, Cooke, Dallas, Denton, Ellis, Fannin, Grayson, Henderson, Hunt, Kaufman, Navarro, or Rockwall county?

Yes – Please continue to the next question.

No – We are sorry, you are not eligible to complete the survey.

SECTION 2: DEMOGRAPHIC INFORMATION

General

1. What county do you live in?

Collin

Henderson

Cooke

Hunt

Dallas

Kaufman

Denton

Navarro

Ellis

Rockwall

Fannin

Grayson

2. What year were you born? _____

3. Are you Hispanic/Latino?

Yes

No

Prefer not to answer

4. How would you describe your racial background? (Please check all that apply)

Black/African-American

White/Caucasian

Asian

Native American / Alaskan Native

Hawaiian or other Pacific Islander

Other (describe): _____

5. What kind of health insurance do you have that covers your HIV medical care (NOTE: Ryan White is NOT insurance)? **(Check only one. If you have more than one, check the one that pays first.)**

Private Insurance

COBRA (continuation of insurance that you had with your last employer)

Medicare

Medicaid

Parkland HealthFirst

Other (describe): _____

I do not have any health insurance

Educational and Military Background

6. Have you ever served in the United States military?

- Yes
 No
 Prefer not to answer

7. How far did you go in school?

- Eighth grade or less
 Some high school
 High school graduate/GED
 Technical or trade school
 Some college
 Completed college
 Graduate degree(s)
 Other (describe): _____

Household and Employment

8. Where do you live now? **(Check only one response)**

- At my parent's or relative's home—permanent
 At my parent's or relative's home—temporary
 At another person's apartment/home—permanent
 At another person's apartment/home—temporary
 In a rooming or boarding house
 In a "supportive living" facility (Assisted Living Facility or nursing home)
 In a half-way house, transitional housing or treatment facility (drug or psychiatric)
 Homeless (on the street or in car)
 In an apartment/house/mobile home that I own or rent in my name (with subsidy)
 In an apartment/house/mobile home that I own or rent in my name (without subsidy)
 Homeless shelter
 Domestic Violence shelter
 Residential hospice facility or skilled nursing home
 Other (describe): _____

9. Do any of the following housing-related reasons stop you from taking care of your HIV?

- No private place to live
- Afraid of others knowing I am HIV positive
- No money for rent
- No bed to sleep in
- No place to store my medicines securely, away from others
- No telephone where someone can reach me
- No heating and/or cooling (air conditioning)
- Not enough food to eat
- Cannot get away from drugs/alcohol
- Other (describe): _____
- None of the above

10. What is the ZIP code where you live? If you are homeless or living in a shelter, please write "99999".

11. What percentage or portion of your *monthly income* do you spend on housing expenses including rent/mortgage and utilities?

- I do not pay any rent/mortgage or utilities right now
- Less than half
- Almost half
- More than half
- Do Not Know

12. How many children under the age of 18 live in your household?

- None
- One
- Two
- Three
- Four or more

13. What is your current job situation?

Work full-time

Work part-time

Not working

14. If you are not working, which best describes you?

I am a student

I am looking for a job/need help finding a job

I am retired

My health keeps me from working – I am on disability

My health keeps me from working – I am **not** on disability

I work as a volunteer

I am homeless

I do not want or need to work

Other (describe): _____

I am working

15. Which of the following best describes your current monthly income?

Less than \$500

\$500 - \$999

\$1,000 - \$1,999

More than \$2,000

Prefer not to answer

Gender and Sexual Identity

16. Which best describes your current gender identity (the sex you see yourself as now)? **(Check all that apply)**

Male

Female

Transgender male (female-to-male)

Transgender female (male-to-female)

Gender variant/Nonconforming

Other (describe): _____

Prefer not to answer

17. How would you describe your sexual attraction/identity? **(Choose one or more)**

Heterosexual or Straight

Homosexual (Gay or Lesbian)

Queer

Bisexual

Other (describe): _____

Prefer not to answer

18. What sex were you assigned at birth (in other words, what is the sex listed on your original birth certificate)?

Male

Female

Intersex

History in Correctional Facilities

19. Have you been in jail or prison for more than one month during the past two years?

Yes

No

20. If yes, did you receive HIV medical care while in jail or prison?

Yes

No

I was not in jail or prison

21. After you were released, did any of the following stop you from getting HIV care?

Did not know where to go for medical care

Did not know where to go for an intake or to get case management

Afraid to tell others I am HIV positive

Could not find a place to live/did not know where to go for housing assistance

Could not stop using drugs and/or alcohol

Fear of discrimination, harassment, denial of service, or violence

I was not in jail or prison

SECTION 3: HEALTH HISTORY

22. How do you think you got HIV? **(Mark all that apply)**

Having sex with a man

Having sex with a woman

Sharing needles

Blood products/Transfusion

Perinatal transmission (born with it or infected at birth)

Having sex with a transman, transwoman, transperson, or gender nonconforming person

Other (describe): _____

Do not know

Prefer not to answer

23. What year were you first diagnosed with HIV (estimate if you do not know)? _____

24. How soon after your diagnosis did you start HIV medical care?

In less than 3 months

Within 3 to 6 months

After more than 6 months

I have not received HIV medical care

25. When you were diagnosed, would help from an HIV positive peer have made it easier to get HIV medical care and other needed services?

Yes No Do not know

26. If you did not get HIV medical care in less than 6 months after your diagnosis, why did you not get HIV medical care after diagnosis? **(Check all that apply)**

I did not feel sick

I did not want to think about being HIV positive

I did not want to take medicines

Too much paperwork

I was afraid to be seen at the clinic

The appointments cause problems with my job

The clinic asks too many personal questions

- I use or was using drugs or alcohol
- Hard to get there (transportation)
- Long waiting time to get an appointment
- I do not have needed identification (ID)/my ID does not match who I am
- Services are not in my language
- I do not have legal status in the U.S.
- I do not have money to pay
- I am homeless
- Discomfort with physical exams
- Past experience with denial, harassment, threats or violence in healthcare settings
- Past experience with providers who did not understand my identity
- Other (describe): _____
- I got HIV medical care within 6 months of my diagnosis

SECTION 4: MEDICAL CARE

27. Have you *ever* been in HIV medical care? Yes No
28. Have you received HIV medical care in the last 12 months?
 Yes No Do not know
29. If you have ever been in HIV medical care, when was the last time you received HIV medical care?
 _____(year)

30. Please check all of the reasons listed below that made it difficult for you to get HIV medical care in the last year? **(Check all that apply)**

- Amount of time it takes at the clinic
- Paperwork needed
- The time it takes to get an appointment
- I have to miss work to go to medical appointments
- I am afraid of being seen at the clinic.
- No evening hours (after 5PM)
- No weekend hours
- The clinic only treats HIV and no other medical conditions
- I cannot afford the co-pays, deductibles and other costs of treatment and medicines
- I do not have transportation so it is hard to get there
- I do not feel mentally able to deal with the treatment
- Sometimes I do not feel well enough to go to my appointment
- It is too hard to follow the medical advice
- The staff does not speak my language
- The staff does not understand my culture
- I am in a domestic violence/sexual assault situation
- I am homeless (on the street or in car)
- I live in a homeless shelter
- It was not hard to get medical care
- Other (describe): _____

31. In the last five years (since 2014), did you ever drop out of care for more than six months at a time?

- Yes (skip to Q#32) No (skip to Q#33) Do not know (skip to Q#33)

32. If yes, why did you drop out of care? **(Check all that apply)**

- I did not feel sick
- I did not need or want medical care
- I was tired of taking medicines
- I was tired of going to the clinic
- I needed a break
- It was hard to keep appointments
- The appointments took too long
- I was using drugs
- I was using alcohol
- I did not have money
- I moved and did not know where to go
- It was hard to get to the clinic (transportation)
- Staff does not understand my culture
- Staff does not understand my language
- I feel discriminated against at the clinic
- Other (describe): _____
- I did not drop out of care
- Prefer not to answer

33. Would support from an HIV positive peer have helped you to stay in care?
 Yes No Do not know I did not drop out of care

Testing and Medication

34. A CD4 test is a blood test that measures how well your body can fight an infection. It is important to tell the doctor if you may have HIV infection, and if so, if it is well controlled. Have you had a CD4 test or a viral load test within the last 12 months?

Yes (skip to #35) No (skip to #36) Do not know (skip to #36)

35. Has your CD4 count ever been less than 200?

Yes No Do not know

36. Have you taken HIV medicines (antiretroviral) in the last 12 months?

Yes (skip to Q#36) No (skip to Q#38) Do not know

37. Is your viral load undetectable?
 Yes No Do not know

38. If you have **not** had a CD4 or viral load test, taken HIV medicines (antiretroviral), or received HIV medical care in the last 12 months, why are you not getting HIV medical care? (**Check all that apply**)

I do not feel sick

I do not need or want medical care

I do not want to think about being HIV positive

I am afraid to get medical care

It is too much trouble

I do not want to take medicines

Too much paperwork is needed

I am afraid to be seen at the clinic

The appointments cause problems with my job

The clinic asks too many personal questions

I do not like the physical exam

I use drugs or alcohol

It is hard to get there (transportation)

Long waiting time to get an appointment

I do not have needed identification (ID)/my ID does not match who I am

Services are not in my language

I do not have legal status in the U.S.

I do not have money to pay

I feel discriminated against at the clinic

Other (please describe): _____

I have received HIV medical care in the last 12 months

39. In the past 12 months, have you received medical treatment for any of the following? **(Check all that apply)**

- Syphilis
- Gonorrhea
- Chlamydia
- Hepatitis A or B
- Hepatitis C
- TB (tuberculosis)
- Diabetes
- High Blood Pressure
- Heart Disease
- Depression
- Other (describe): _____
- None of the above

SECTION 5: HEALTH BEHAVIORS

Alcohol Use

For the next two questions, we will define a “drink” as one 12-ounce can of beer, a five-ounce glass of wine, or a three-ounce shot of liquor, or a drink with about that much liquor in it.

40. When you drink, how many beverages containing alcohol do you have per day?

- 1-2 drinks
- 3-4 drinks
- 5-6 drinks
- 6 or more drinks
- Prefer not to answer
- I do not drink

41. In the past 4 months, how often have you had six or more beverages containing alcohol on at least one occasion?

- _____ Less than monthly
- _____ Monthly
- _____ Weekly
- _____ Daily or almost daily
- _____ Never
- _____ Prefer not to answer
- _____ I do not drink

Substance Use

42. In the **past 6 months**, please circle the answer the best describes how often you have used each of the substances listed below.

Beverages containing alcohol	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer
Marijuana	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer
Depressants (barbiturates, benzodiazepines, Valium, Xanax)	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer
Ketamine / PCP	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer
Hallucinogens (LSD, mushrooms)	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer
Opioids / Morphine (Codeine, Fentanyl, Heroin, Opium, oxycodone, hydrocodone)	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer
Stimulants (amphetamine, Cocaine, crack, MDMA-ecstasy, Methamphetamine, meth, crystal ice, speed)	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer

Steroids	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer
Prescription painkillers not prescribed by your doctor	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer
Inhalants (paint, etc.)	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer
Other (describe)	Never	Once a month	2-4 times a month	Once a week	4 or more times a week	Prefer not to answer

43. Have you injected non-prescribed substances in the past two months?

Yes No

44. If a needle exchange program were available to provide clean needles/works/syringes, would you use it?

Yes No I do not know

I do not inject substances

45. Have you thought about getting substance abuse treatment in the last year?

Yes No I don't need treatment

46. If you have thought about treatment, what will help you get into treatment?

Admission to a program as soon as I am ready

Knowing where to go

Free treatment

Transportation to treatment

Housing after completing treatment

Having someone to care for my family/children while I receive treatment

Other (describe): _____

I have not thought about treatment or I do not need treatment

None of the above

SECTION 6: INTIMATE RELATIONSHIPS

In the following questions:

- ✓ Sex refers to vaginal, anal, or oral sex (someone putting their penis into your body or putting your penis into someone else's body)
- ✓ Protection refers to using a female condom, a male condom, or a dental dam

47. In the past 12 months, have you had sex?

Yes No

48. When you have sex, how often do you use protection?

Never

Some of the time

Most of the time

Always

I do not have sex / had not had sex in the past 12 months

49. Do you tell your partner or potential partners about your HIV status?

Yes No Sometimes

50. If no or sometimes, why not?

I am afraid of how they will react

I do not want to tell others I am HIV positive

I do not think they care

They do not want to talk about it

I use protection

My partner uses PrEP

My viral load is undetectable

I always tell them

Other: _____ (please specify)

SECTION 7: USE OF PREVENTION/INTERVENTION SERVICES

51. Listed below are services you may have needed and may have used. For each service listed, please circle the answer that best describes if you needed and used it and how easy or hard it was to use.

HIV outpatient medical care	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Outpatient OB/Gyn care	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Medical care from a specialist referred by HIV doctor (heart, skin, diabetes, other)	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Help paying for medications and prescriptions	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Help paying for medications and prescriptions / other pharmaceutical assistance	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Early Intervention to get into HIV medical care	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Ryan White funding to help with health insurance premium, co-pay, or deductible	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Home health care	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Home and community-based health services – home aids and assistants	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get

Hospice services	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Mental health counseling	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Medical nutritional counseling	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Medical case management	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Non-medical case management – help accessing support services	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Outpatient substance abuse treatment	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Substance abuse services - residential	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Childcare	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Child assessment and early intervention	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Emergency financial assistance	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Food bank	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get

Health education and risk reduction – how to prevent HIV	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Long-term housing for people living with HIV (PLWH)	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Emergency assistance for rent or mortgage	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Legal services to help obtain services, benefits, outline advance directives, or establish guardianship	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Translation or interpretation services	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Transportation to medical care	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Outreach to help you get HIV tested	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Outreach to help you get into HIV medical care	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Legal help with writing your will	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Psychosocial support services – group counseling to help cope with HIV	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get

Referral help to get health care or supportive services	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Rehabilitation services	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Respite care for HIV positive children	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Respite care for adults	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get
Treatment adherence counseling	This does not apply to me	I did not need this	Needed but did not use	Used and was easy to get	Used but was somewhat hard to get	Used but was hard to get

SECTION 8: BARRIERS TO SERVICES

The next set of questions is to help us learn the reasons why you may not have received services that you needed. For each of the services that you needed and did not get, please check the ONE answer that best describes the MAIN reason why you did not get it.

52. What is the *main* reason you did not get **HIV Outpatient Medical Care**? (Please check ONLY ONE).

- Difficult to get appointment
 Not sure how to get this service
 High co-pay or deductible
 Other (please describe): _____
 Did not need HIV Outpatient Medical Care
 I am getting HIV Outpatient Medical Care

53. What is the *main* reason you did not get **outpatient OB/Gyn care**? (Please check ONLY ONE).

- Difficult to get appointment
 High co-pay or deductible
 Want to see a female doctor
 I am not a woman or transman
 Other (please describe): _____
 Did not need outpatient OB/Gyn care
 I got outpatient OB/Gyn care

54. What is the ***main*** reason you did not get **medical care from a specialist** referred by your HIV doctor? (Please check ONLY ONE).

- Difficult to get appointment
- Service not available
- High co-pay or deductible
- Other (please describe): _____
- Did not need medical care from a specialist referred by my HIV doctor
- I am getting medical care from a specialist referred by my HIV doctor

55. What is the ***main*** reason you did not get **help paying for medications and prescriptions**? (Please check ONLY ONE).

- Don't know about this service
- High co-pay or deductible
- I don't qualify
- Other (please describe): _____
- Did not need help paying for medications and prescriptions
- I am getting help paying for medications and prescriptions

56. What is the ***main*** reason you did not get **help paying for medications and prescriptions/other pharmaceutical assistance**? (Please check ONLY ONE).

- Didn't know about the service
- High co-pay or deductible
- Don't qualify
- Other (please describe): _____
- Did not need help paying for medications and prescriptions/other pharmaceutical assistance
- I am getting help paying for medications and prescriptions/other pharmaceutical assistance

57. What is the ***main*** reason you did not get **dental visits**? (Please check ONLY ONE).

- Waiting list for an appointment
- Limited funding available
- Documentation requirements
- Afraid of the dentist
- I don't qualify
- Other (please describe): _____
- Did not need dental visits
- I am getting dental visits

58. What is the ***main*** reason you did not get **early intervention to help you get into HIV medical care?** (Please check ONLY ONE).

- Don't know about this service
- Not sure I understand it
- I have not been out of care – I have gotten medical care for my HIV in the past 12 months
- Other (please describe): _____
- Did not need early intervention to help me get into HIV medical care
- I got early intervention to help me get into HIV medical care

59. What is the ***main*** reason you did not get **Ryan White funding to help with your health insurance premium, co-pay, or deductible?** (Please check ONLY ONE).

- Don't know about this service
- Don't want any insurance
- Don't know what to do about insurance
- Other (please describe): _____
- Did not need Ryan White funding to help with health insurance premiums, co-pays, or deductibles.
- I got Ryan White funding to help with health insurance premiums, co-pays, or deductibles.

60. What is the ***main*** reason you did not get **home health care?** (Please check ONLY ONE).

- Don't know about this service
- Found an easier way to get it
- Don't qualify
- Other (please describe): _____
- Did not need home health care
- I got home health care

61. What is the ***main*** reason you did not get **home and community-based health services – home aides and assistants?** (Please check ONLY ONE).

- Don't know about this service
- Found an easier way to get it
- Don't qualify
- Other (please describe): _____
- Did not need Home and Community-Based Health Services – home aides and assistants
- I got Home and Community-Based Health Services – home aides and assistants

62. What is the ***main*** reason you did not get **hospice services**? (Please check ONLY ONE).

Don't know about this service

Found an easier way to get it

Don't qualify

Other (please describe): _____

Did not need Hospice Services

I got Hospice Services

63. What is the ***main*** reason you did not get **mental health counseling**? (Please check ONLY ONE).

Don't want to use this service

Afraid of what people would think if they found out

Do not believe in it or that it would help

Don't know where to go

Other (please describe): _____

Did not need mental health counseling

I got mental health counseling

64. What is the ***main*** reason you did not get **medical nutritional counseling**? (Please check ONLY ONE).

Don't know about this service

Available somewhere else

It is not available

Other (please describe): _____

Did not need medical nutritional counseling

I got medical nutritional counseling

65. What is the ***main*** reason you did not get **medical case management** – help with coordination of your medical care offered at medical and dental locations? (Please check ONLY ONE).

Case manager not available/hard to reach

Too much paperwork

Case manager does not follow up

Other (please describe): _____

Did not need medical case management

I got medical case management

66. What is the ***main*** reason you did not get **non-medical case management** – help accessing support services? (Please check ONLY ONE).

- Case manager not available/hard to reach
- Too much paperwork
- Case manager does not follow up
- Other (please describe): _____
- Did not need non-medical case management
- I got non-medical case management

67. What is the ***main*** reason you did not get **outpatient substance abuse treatment**? (Please check ONLY ONE).

- Not available
- The hours it is open
- Transportation issues
- Housing problems
- Other (please describe): _____
- Did not need outpatient substance abuse treatment
- I got outpatient substance abuse treatment

68. What is the ***main*** reason you did not get **substance abuse services - residential**? (Please check ONLY ONE).

- Don't know about this service
- Don't qualify
- Too much paperwork
- Other (please describe): _____
- I did not need Substance Abuse Services – Residential
- I got Substance Abuse Services - Residential

69. What is the ***main*** reason you did not get **childcare while at a medical or other appointment**? (Please check ONLY ONE).

- Don't know about this service
- Don't qualify for this service
- Do not have children in the home
- Other (please describe): _____
- Did not need childcare
- I got childcare

70. What is the ***main*** reason you did not get **child assessment and early intervention**? (Please check ONLY ONE).

- Don't know about this service
- Don't qualify for this service
- Do not have children in the home
- Other (please describe): _____
- Did not need child assessment and early intervention
- I got child assessment and early intervention

71. What is the ***main*** reason you did not get **Emergency Financial Assistance**? (Please check ONLY ONE).

- Limited funding
- Too much paperwork
- Don't qualify
- Not able to get appointment in time
- Utility company not accepting voucher
- Other (please describe): _____
- Did not need Emergency Financial Assistance
- I got Emergency Financial Assistance

72. What is the ***main*** reason you did not use the **Food Bank**? (Please check ONLY ONE).

- Location/transportation
- Hours it is open
- Inconsistent quality food
- Inconsistent amount of food
- They did not have the food that I eat
- Other (please describe): _____
- Did not need the Food Bank
- I used the Food Bank

73. What is the ***main*** reason you did not get **Health Education and Risk Reduction** – information on how to prevent HIV? (Please check ONLY ONE).

- Don't know about this service
- Found an easier way to get it
- Don't qualify
- Other (please describe): _____
- Did not need Health Education and Risk Reduction
- I got Health Education and Risk Reduction education

74. What is the ***main*** reason you did not get **Long-Term Housing for PLWH**? (Please check ONLY ONE).

- Limited funding
- Too much paperwork
- Don't qualify
- Waiting list
- Landlord refused to accept voucher
- Other (please describe): _____
- Did not need Long-Term Housing for PLWH
- I got Long-Term Housing for PLWH

75. What is the ***main*** reason you did not get **Emergency Assistance for Rent or Mortgage**? (Please check ONLY ONE).

- Limited funding
- Too much paperwork
- Don't qualify
- Landlord refused to accept voucher
- Other (please describe): _____
- Did not need Emergency Assistance for Rent or Mortgage
- I got Emergency Assistance for Rent or Mortgage

76. What is the ***main*** reason you did not get **Legal Services** to help you work through a problem obtaining services/benefits, outline advance directives or establish guardianships? (Please check ONLY ONE).

- Don't know about this service
- Limited services – need a lawyer for other things
- Other (please describe): _____
- Did not need Legal Services for this reason
- I got Legal Services for this reason

77. What is the ***main*** reason you did not get **Translation or Interpretation Services**? (Please check ONLY ONE).

- Don't know about this service
- Service not available when I need it
- Use a friend or family member for language help
- Other (please describe): _____
- I did not need Translation or Interpretation Services
- I used Translation or Interpretation Services

78. What is the ***main*** reason you did not get **Transportation to Medical Care**? (Please check ONLY ONE).

Don't live near public transportation

Must take more than one bus to the clinic

Hard to take a bus if ill

Other (please describe): _____

I did not need Transportation to Medical Care

I got Transportation to Medical Care

79. What is the ***main*** reason you did not get **outreach to help you get HIV tested**? (Please check ONLY ONE).

Don't know about this service

Don't trust the outreach worker

I have not been out of medical care for my HIV in the past 12 months

Other (please describe): _____

I did not need outreach to help me get HIV tested

I got outreach to help me get HIV tested

80. What is the ***main*** reason you did not get **outreach to help you get into HIV medical care**? (Please check ONLY ONE).

Don't know about this service

Don't trust the outreach worker

I have not been out of medical care for my HIV in the past 12 months

Other (please describe): _____

I did not need outreach to help me get into HIV medical care

I got outreach to help me get into HIV medical care

81. What is the ***main*** reason you did not get **legal help with writing your will**? (Please check ONLY ONE).

Don't know about this service

Need a lawyer for other things

Other (please describe): _____

Did not need legal help with writing my will

I got legal help with writing my will

82. What is the ***main*** reason you did not get **psychosocial support services – group counseling to help cope with HIV?** (Please check ONLY ONE).

- Don't know about this service
- Inconvenient for my schedule
- Didn't think it would help
- Other (please describe): _____
- Did not need psychosocial support services
- I got psychosocial support services

83. What is the ***main*** reason you did not get **referral help for getting health care or supportive services?** (Please check ONLY ONE).

- Don't know about this service
- Don't qualify
- Other (please describe): _____
- Did not need referral help for getting health care or supportive services
- I got referral help for getting health care or supportive services

84. What is the ***main*** reason you did not get **rehabilitation services?** (Please check ONLY ONE).

- Don't know about this service
- Don't qualify
- Too much paperwork
- Other (please describe): _____
- Did not need rehabilitation services
- I got rehabilitation services

85. What is the ***main*** reason you did not get **respite care for HIV+ children?** (Please check ONLY ONE).

- Don't know about this service
- Don't qualify
- I do not have HIV+ children in my care
- Other (please describe): _____
- I did not need respite care for HIV+ children
- I got respite care for HIV+ children

86. What is the ***main*** reason you did not get **respite care for adults** (activities during the day for impaired adults)? (Please check ONLY ONE).

- Don't know about this service
- Don't qualify
- Other (please describe): _____
- I did not need respite care for adults
- I got respite care for adults

87. What is the ***main*** reason you did not get **treatment adherence counseling**? (Please check ONLY ONE).

- Don't know about this service
- Found an easier way to get it
- Don't qualify
- Other (please describe): _____
- Did not need treatment adherence counseling
- I got treatment adherence counseling

88. Please list or describe any **service** you need that is not available and that we did not already list in this survey.

89. Where are you taking this survey:

- Parkland-Amelia Court
- Parkland-Southeast Dallas Health Center (SDHC)
- Parkland-Bluitt-Flowers Health Center
- Parkland-Women's Specialty Clinic
- Resource Center of Dallas
- Prism Health North Texas—South Dallas Clinic
- Prism Health North Texas—Oak Cliff Clinic
- Prism Health North Texas—Jefferson Site
- AIDS Healthcare Foundation (AHF)
- Health Services of North Texas (HSNT)
- Your Health Clinic/Callie Clinic
- Another place _____

90. Where would you like to pick up your gift card?
- Parkland-Amelia Court
 - Parkland-Southeast Dallas Health Center (SDHC)
 - Parkland-Bluitt-Flowers Health Center
 - Parkland–Women’s Specialty Clinic
 - Resource Center of Dallas
 - Prism Health North Texas—South Dallas Clinic
 - Prism Health North Texas—Oak Cliff Clinic
 - Prism Health North Texas—Jefferson Site
 - AIDS Healthcare Foundation (AHF)
 - Health Services of North Texas (HSNT)
 - Dallas County Health and Human Services (Suite 200)

THANK YOU FOR YOUR HELP WITH THIS SURVEY

B.2: Key Informant Interview Protocol

1. How would you describe HIV **prevention** efforts in the Dallas Region?
 - a. How available and accessible are services?
 - b. How appropriate are services to specific at-risk populations?
2. How would you describe public attitudes toward **prevention** steps such as counseling, consistent condom use, and use of PrEP?
 - a. How would you describe client attitudes toward such steps?
3. What challenges do you see to educating and changing behaviors of those at high risk for HIV infections regarding preventing infection, getting tested, and about the use of PrEP?
4. What barriers prevent successful linkage to care for consumers who have never linked to care?
 - a. What barriers are there for consumers who dropped out of care after a few initial appointments?
 - b. What barriers are there for consumers who have dropped out of care after being in care for a long period of time?
 - c. What do you think can be done to get any of these groups successfully linked to care?
5. Which programs and/or services are you aware of that have been successful in linking people to care?
 - a. What programs or services have been successful in keeping people in the care system?
6. How would you assess the present state of HIV health care in your area, including primary and specialty care?
 - a. What about mental health care?
 - b. Dental health?
 - c. Vision care?
7. What are some emerging health issues, including comorbidities, in your area and to what extent and how are they complicating HIV care?
8. Thinking about your clients, what changes have you seen since 2016? (for example, emerging populations, population characteristics, size, location, comorbidities, quality of life, productivity)
9. What do you see as the most significant client care and prevention needs that are not being met?
 - a. What do you think needs to be done to address the needs (funding, collaboration, peer support, outreach)?
10. What policy or practice issues are you aware of that may contribute to challenges for prevention or intervention, accessibility of services, or that otherwise interfere with the needs of those infected or affected by HIV/AIDS?
11. I am going to name a few special populations, and I would like you to tell me what you consider to be the most unique need of each population named, and what needs to be done to better meet their needs.
 - a. Hispanic men and women
 - b. African American men and women
 - c. Men who have sex with men
 - d. Transgender persons
 - e. Youth (ages 13-24)
12. What role do you think social media might be able to play in local prevention efforts in this region or for outreach to people living with HIV/AIDS?
 - a. What role do you think social media might be able to play in changing local attitudes toward prevention?
 - b. What about changing public attitudes toward individuals infected with or affected by HIV/AIDS?
 - c. To create awareness of services that will help to meet some unmet needs?

13. Do you have any suggestions for improving the system or process the client goes through to achieve rapid linkage to care, engagement in care, retention in care and medical adherence, and viral load suppression?

Thank you for taking time to complete this interview. If you have any additional comments, please feel free to share them now, or email them to me.

B.3: Consumer Focus Group Protocol

Focus Group Guide

Hello. My name is _____ and I am working to gather information for the Ryan White Needs Assessment. As part of the information gathering, we are doing a series of focus groups like this one to gather information from people living with or affected by HIV/AIDS. It is important for you to know that whatever you say in this room is confidential. We will not be reporting on who participated in the focus groups, nor will we be sharing any information that will identify you. Your responses will be analyzed with the responses from all groups and used to identify and report on service needs. Before we start, it would be helpful to get to know each other a little. Can you each please tell me your first name, or at least the first name that you want to be known by here?

Now, I would like to ask if I have permission to record this session. These recordings will be heard only by our needs assessment team members and they will be protected on secure drives. NOW START RECORDER.

1. Please tell me your view of HIV **prevention** services in the Dallas EMA/HSDA based on availability, accessibility, appropriateness, or other factors.
2. What are the gaps in HIV **prevention** services in the region?
3. What existing prevention and early intervention services need to be improved or expanded?
 - a. What types of improvements would be helpful?
4. What issues or barriers do individuals who are newly identified experience in getting linked to care?
5. How would you assess the present state of HIV treatment and support services?
 - a. Probe for transportation, housing, mental health, other support.
6. Are there any special populations that you feel have special needs that are not being met?
7. What are the best ways to share information with people who are living with HIV or AIDS?

B.4: Ryan White HIV Services Provider Capacity Survey

Provider Capacity Survey

Every three years, the Ryan White Planning Council of the Dallas Area (RWPC) works with other organizations to learn about the needs and experiences of people living with HIV/AIDS in Dallas and nearby cities. As a part of the 2019 Comprehensive Needs Assessment, this provider capacity survey will help with understanding the current capacity of HIV/AIDS service providers. Your responses to the questions will be used to create an inventory of resources by organization and to inform the discussion of strengths and needs related to HIV/AIDS services.

This survey may take you 25 to 40 minutes to complete. You have the option to save and continue later if needed.

This survey is being administered by Susan Wolfe and Associates, LLC in partnership with the Ryan White Planning Council of the Dallas Area. If you have any questions, please contact Dr. Susan Wolfe at susan@susanwolfeandassociates.com.

We appreciate your help in completing this survey by Friday, November 22, 2019 by 5:00PM.

General Agency Information

Please provide general information about your agency.

Q1 Agency Name
(Please do not use acronyms)

Q2 Please provide the name of the person completing this survey.

Q3 Please provide the agency's mailing address: STREET ADDRESS, CITY, STATE, ZIP CODE

Q4 Please provide the agency's 10-digit telephone number
(example: 817-222-2222)

Q5 Please provide the email address for the person completing this survey.

Q45 Please provide the website URL for your agency.

Q44 In which county is your agency located (drop down menu with list of Dallas EMA counties)

Q38 AGENCY CHARACTERISTICS

The following questions will help inform the development of a resource inventory that will be included in the final report to the Dallas County Planning Council.

Q8 Please provide the times that your agency opens and closes on the following days.

	Hour Open (e.g., 7:00 a.m.)	Hour Close (e.g., 8:00 p.m.)
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

Q9 What percentage of your clients are people living with HIV/AIDS?

- 0 to 5% (1)
- 6 to 10% (2)
- 11 to 25% (3)
- 26 to 50% (4)
- 51 to 75% (5)
- 76 to 100% (6)

Q39 Does your agency offer language translation services?

- Yes (1)
- No (2)
- Not Sure (3)

Q63 (If yes) For which languages do you provide translation services?

- Arabic (9)
- Cantonese (8)
- Chinese Mandarin (7)
- French (3)
- Korean (6)
- Native American languages (Dine/Navajo, Ute, Paiute, Shoshone, etc.) (13)
- Portuguese (4)
- Punjabi (10)
- Samoan or Tongan (12)
- Spanish (1)
- Swahili (14)
- Tagalog (11)
- Vietnamese (2)
- Other (15) _____

Q40 What payment options are available at your agency?

- Private Insurance (5)
- Tricare/Military insurance (6)
- Medicare/Medicaid (7)
- Free services available (1)
- Co-pay (2)
- Sliding scale/fee-based on income (3)
- Other (4) _____

Q41 Does your agency provide services to youth living with HIV/AIDS who are under 18 years old?

- Yes (1)
- No (2)
- Not Sure (3)

Q42 What type(s) of funding does your agency receive?

- Ryan White HIV/AIDS Program (1)
 - State Funding (2)
 - Federal Funding (Medicaid, Medicare, SAMSHA) (3)
 - Private Funding/Donations (4)
 - Other (5) _____
-

Q49 Does your agency provide HIV prevention services?

Yes (1)

No (2)

Q50 Does your agency provide HIV prevention services for HIV+ individuals?

Yes (1)

No (2)

Q52 If no, what percentage of your HIV+ clients do you refer to other agencies for prevention services?

0 to 5% (1)

6 to 10% (2)

11 to 25% (3)

26 to 50% (4)

51 to 75% (5)

76 to 100% (6)

Q47 Please indicate if you serve any of the following populations

- Hispanic/Latino men (4)
- Hispanic/Latina women (10)
- African American men (11)
- African American women (12)
- Transgender persons (13)
- Youth (13-24 years) (14)
- Men who have sex with men (MSM) (15)
- Aging (55+) (5)
- Other underserved groups (16) _____

Q23 **SERVICE DELIVERY**

This section includes questions about the type of services delivered by your agency, the average wait time for receipt/connection to these services, and the number of clients that are served by these services with your current capacity.

Q19 **Prevention Services**

The next set of questions request information about the unique/unduplicated number of individuals served by each program/service in 2018.

If you are unsure about numbers either use your best estimate. If you do not know, please type in "000" into the space.

If there are services listed that you do not provide, please leave blank.

	In 2018, what was the average number of days clients had to wait for the first appointment?	In 2018, approximately how many unduplicated clients were served?
HIV Testing		
STD Screening		
Partner Services		
PrEP/PEP		
Peer support		
Syringe service programs		
Substitution therapy (e.g., methadone)		

Q55 Please provide a brief description of the prevention services that your agency delivers.

The next set of questions request information about the unique/unduplicated number of individuals served by each program/service in 2018.

If you are unsure about numbers either use your best estimate. If you do not know, please type in "000" into the space. If there are services listed that you do not provide, please leave blank.

Q53 Care Services for People Living with HIV/AIDS

	In 2018, what was the average number of days clients had to wait for their first appointment?	In 2018, approximately how many unduplicated clients were served?
Linkages to care		
Outpatient HIV medical care		
Outpatient OB/GYN care for HIV+ women		
Outpatient Hepatitis C treatment		
Outpatient substance abuse care		
Residential substance abuse care		
Other outpatient specialty care		
Home health services		
Hospice care		
Mental health counseling services		
Medical case management		
Dental services		
Medical nutritional therapy		
Rehabilitation services (e.g., physical therapy, occupational therapy, speech, etc.)		

Q57 Please provide a brief description of the care services that your agency delivers.

Q54 Support Services for People Living with HIV/AIDS

The next set of questions request information about the unique/unduplicated number of individuals served by each program/service in 2018.

If you are unsure about numbers use your best estimate. If you do not know, please type "000" into the space. If there are services that you do not provide, please leave blank.

	<u>In 2018</u> , what was the average number of days clients had to wait for their 1 st appointment?	<u>In 2018</u> , approximately how many unduplicated clients were served?
Non-medical case management		
Emergency financial assistance for utilities		
Assistance with co-pays and deductibles		
Health insurance continuation assistance		
Long-term rental assistance voucher		
Facility-based housing (assisted living)		
Medical transportation – bus pass		
Medical transportation – van service		
Non-medical transportation		
Language/translation services		

Legal services (e.g., help with accessing legal services)		
Childcare services		
Day/respice care for children		
Adult respice care		
Education services		
Job training services		
Employment services		
Food banks		
Home delivered meals		
Support groups for PLWHA		
Support groups for family or partners of PLWHA		

Q58 Please provide a brief description of the support services that your agency delivers.

Q7 Open-Ended Questions

This section includes critical questions related to the impact of the Affordable Care Act, service barriers, and service needs.

Q10 What impact did the Affordable Care Act have on your agency and clients between 2017 and 2019?

Q11 What is your organization doing/planning to do to educate and support clients relative to ACA?

Q12 Briefly describe the single most important system-wide change (other than funding) that would improve services for all people living with or affected by HIV/AIDS?

Q64 Since 2016, has your agency observed changes in the populations served? If yes, please briefly describe those changes (e.g., changes in need, changes in geographic location).

Q13 What services do people living with HIV/AIDS need that are not available or are accessible to specific populations?

Q14 What services should be increased to improve the health and/or access for people living with HIV/AIDS?

Q15 Are the services that are available but that should be delivered with a different approach or in different locations?

Q59 THANK YOU

Thank you for taking the time to complete this Needs Assessment survey. Your answers are valuable and will help to ensure a comprehensive report regarding the needs for people living with HIV/AIDS. This survey is being administered by Susan Wolfe and Associates, LLC in partnership with the Ryan White Planning Council of the Dallas Area .If you have any questions, please contact Dr. Susan Wolfe at susan@susanwolfeandassociates.com.

Q60 Additional Comments: If you have any additional comments on topics or issues that were not addressed in this survey, please share them here.

B.5: Resource Directory Data Collection Template

RESOURCE INVENTORY

COUNTY NAME

Organization Name	
Street	
Address/City/State/Zip Code	
County	
Phone Number	
Website	
Hours	<input type="checkbox"/> Evening Hours <input type="checkbox"/> Weekend Hours
Translation Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eligibility Criteria for Services?	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Costs for Services	<input type="checkbox"/> Free services available <input type="checkbox"/> Co-Pay <input type="checkbox"/> Sliding Scale/Fee based on income <input type="checkbox"/> Other: _____
Services Available to Youth Under 18 Years Old	<input type="checkbox"/> Yes <input type="checkbox"/> No
Funding Source	<input type="checkbox"/> Ryan White HIV/AIDS Program, Part A or Part B <input type="checkbox"/> State Funding (TDSHS) <input type="checkbox"/> Federal Funding (Medicaid, Medicare, SAMSHA) <input type="checkbox"/> Information Not Available
Prevention Services	<input type="checkbox"/> HIV Testing <input type="checkbox"/> STD Screening <input type="checkbox"/> Partner Services <input type="checkbox"/> PrEP/PEP Services <input type="checkbox"/> Peer Support <input type="checkbox"/> Syringe Service Programs <input type="checkbox"/> Substitution Therapy (e.g., Methadone) <input type="checkbox"/> Individual Counseling <input type="checkbox"/> Group Intervention
Care Services for People Living with HIV/AIDS	<input type="checkbox"/> Linkage to Care <input type="checkbox"/> HIV Medical Care <input type="checkbox"/> Prevention Services <input type="checkbox"/> Insurance Navigation <input type="checkbox"/> Home Health Services <input type="checkbox"/> Hospice Care <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Substance Abuse Outpatient Care <input type="checkbox"/> Medical Case Management <input type="checkbox"/> Dental Services

**Support Services for People
Living with HIV/AIDS**

- Non-Medical Care Management
- Emergency Financial Assistance
- Food Assistance
- Health Education
- Housing
- Legal
- Medical Transportation Services
- Support Groups
- Rehabilitation Services
- Residential Substance Abuse Services
- Treatment Adherence Counseling

Appendix C: Dallas EMA Detailed Demographics

C.1. Dallas EMA County Demographics 2017

County	Population #	Sex		Race / Ethnicity					Age Group				
		Male #	Female #	White* %	Black* %	Hispanic %	Asian/ Other* %	More than One Race / Unknown %	Age 14 and under %	Age 15-24 %	Age 25-34 %	Age 35-44 %	Age 45 and Older %
Cooke	39,895	19,211	20,684	77.2%	3.1%	15.2%	2.4%	2.1%	19.1%	12.8%	12.6%	12.4%	42.7%
Fannin	34,446	17,779	16,667	81.2%	7.1%	9.7%	2.4%	0.0%	17.5%	12.5%	12.5%	12.0%	45.5%
Grayson	131,140	64,739	66,401	74.3%	5.9%	10.7%	3.3%	5.7%	19.8%	12.6%	11.7%	11.6%	44.2%
Sherman-Dennison HSDA	205,481	101,729	103,752	76.0%	5.6%	11.4%	3.0%	4.0%	19.3%	12.6%	12.0%	11.8%	44.1%
Collin	1,005,146	494,709	510,437	52.4%	7.2%	12.2%	10.8%	17.4%	21.5%	12.9%	12.5%	15.9%	37.1%
Dallas	2,618,148	1,291,395	1,326,753	30.9%	20.4%	35.0%	5.6%	8.0%	22.2%	13.8%	16.3%	13.8%	33.9%
Denton	836,210	411,328	424,882	52.5%	7.1%	14.8%	6.8%	18.9%	20.7%	13.7%	14.8%	15.3%	35.4%
Ellis	173,620	85,650	87,970	57.4%	8.0%	20.6%	1.5%	12.5%	22.1%	13.6%	13.1%	12.9%	38.3%
Henderson	81,064	39,814	41,250	79.6%	6.4%	10.8%	1.7%	1.6%	17.4%	11.0%	11.7%	11.7%	48.2%
Hunt	93,872	45,671	48,201	69.9%	8.0%	12.9%	2.8%	6.5%	20.0%	14.4%	12.1%	11.9%	41.6%
Kaufman	122,883	59,791	63,092	59.9%	9.1%	14.6%	1.9%	14.5%	23.2%	12.9%	13.2%	14.0%	36.7%
Navarro	48,701	23,902	24,799	59.7%	13.9%	23.6%	2.2%	0.7%	22.3%	14.0%	10.2%	12.4%	40.9%
Rockwall	96,788	47,644	49,144	61.1%	4.9%	13.1%	3.2%	17.7%	21.6%	13.2%	11.3%	14.4%	39.5%
Dallas HSDA	5,040,889	2,484,031	2,558,858	42.6%	14.1%	24.9%	6.4%	11.9%	21.7%	13.5%	14.8%	14.4%	35.5%
Dallas EMA	5,246,370	2,583,760	2,662,610	43.9%	13.8%	24.4%	6.2%	11.6%	21.6%	13.5%	14.7%	14.3%	35.9%

*Non-Hispanic

Source: U.S. Census Bureau American FactFinder

C.2. Dallas EMA Other Statistics 2018

Table 20. Dallas EMA Other Statistics 2018													
County	Population*	% No health insurance	% Public health insurance	% Not employed	Median Household Income	% No Car	% With Internet	% Disability	% Speak English less than well	% SNAP	% Below poverty level	% Less than high school	Median rent
Sherman-Dennison HSDA	205,481												
Cooke**	39,895												
Fannin**	34,446												
Grayson	131,140	19.7%	35.0%	3.2%	\$68,561	3.8%	70.8%	15.2%	2.7%	9.4%	11.6%	10.2%	\$894
Dallas HSDA	5,040,889												
Collin	969,603	11.3%	16.5%	2.5%	\$96,051	2.5%	94.0%	7.1%	10.0%	2.8%	6.7%	6.1%	\$1,391
Dallas	2,618,148	15.2%	28.4%	2.9%	\$59,839	6.7%	82.7%	9.2%	19.7%	9.9%	14.1%	20.3%	\$1,125
Denton	836,210	11.1%	17.3%	2.9%	\$88,117	2.8%	93.8%	8.0%	7.8%	4.5%	7.6%	6.4%	\$1,228
Ellis	173,620	15.9%	26.4%	2.2%	\$77,794	2.7%	95.3%	13.0%	7.7%	7.2%	9.3%	11.1%	\$1,052
Henderson	81,064	20.0%	44.6%	2.8%	\$42,020	5.8%	80.2%	18.7%	2.8%	12.4%	21.1%	17.2%	\$750
Hunt	93,872	18.5%	33.9%	3.1%	\$55,248	7.0%	82.6%	15.3%	4.8%	11.7%	12.7%	13.4%	\$931
Kaufman	122,883	15.3%	29.8%	4.7%	\$66,668	7.0%	81.1%	13.2%	6.2%	10.6%	13.4%	14.3%	\$996
Navarro**	48,701												
Rockwall	96,788	12.5%	18.8%	3.7%	\$100,595	1.3%	96.1%	7.2%	3.9%	3.4%	5.0%	5.7%	\$1,649
Dallas EMA	5,246,370												
Texas	28,787,290	17.7%	29.0%	3.1%	\$60,629	5.3%	84.5%	11.4%	13.8%	11.9%	14.9%	16.0%	\$1,046
U.S.	325,719,178	8.9%	35.6%	3.1%	\$61,937	8.5%	85.1%	12.6%	8.3%	11.3%	13.1%	11.7%	\$1,058

*Source: U.S. Census Bureau American FactFinder 2017
 **Data were not available for these counties because of their small populations.
 Source: U.S. Census Bureau American Community Survey 2018 1-Year Estimates

Cells colored in yellow represent percentages or amounts that are marked worse than the state average; cells colored in green represent percentages or amounts that markedly better than the state average.

Appendix D: Surveillance Data and Characteristics of Population Living with HIV

D1. Incidence: People with a new HIV Diagnosis

Table 21. Incidence: People with New HIV Diagnosis												
Group	2013		2014		2015		2016		2017		2018	
	#	%	#	%	#	%	#	%	#	%	#	%
Total	977	100.0	1,088	100.0	999	100.0	1,047	100.0	999	100.0	1,049	100.0
Female	177	18.1	206	18.9	164	16.4	153	14.6	156	15.6	169	16.1
Male	800	81.9	882	81.1	835	83.6	894	85.4	843	84.4	880	83.9
White, non-Hispanic	233	23.8	252	23.2	217	21.7	234	22.3	180	18.0	231	22.0
Black, non-Hispanic	419	42.9	479	44.0	462	46.2	432	41.3	457	45.7	443	42.2
Hispanic	265	27.1	283	26.0	259	25.9	305	29.1	310	31.0	322	30.7
Other	13	1.3	18	1.7	15	1.5	22	2.1	17	1.7	15	1.4
Multi-Race	47	4.8	56	5.1	46	4.6	54	5.2	35	3.5	38	3.6
0-12	2	0.2	3	0.3	3	0.3	1	0.1	3	0.3	1	0.1
13-24	251	25.7	280	25.7	269	26.9	260	24.8	246	24.6	234	22.3
25-34	332	34.0	370	34.0	347	34.7	371	35.4	385	38.5	409	39.0
35-44	181	18.5	214	19.7	188	18.8	201	19.2	185	18.5	202	19.3
45-54	151	15.5	150	13.8	135	13.5	140	13.4	120	12.0	132	12.6
55-64	53	5.4	52	4.8	45	4.5	66	6.3	51	5.1	52	5.0
65+	7	0.7	19	1.7	12	1.2	8	0.8	9	0.9	19	1.8
MSM	725	74.2	790	72.6	739	73.9	787	75.2	745	74.6	775	73.8
IDU	25	2.6	33	3.1	40	4.0	47	4.5	44	4.4	48	4.5
MSM/IDU	35	3.6	40	3.7	38	3.8	36	3.5	36	3.6	33	3.2
Heterosexual	190	19.4	222	20.4	179	17.9	175	16.7	171	17.1	192	18.4
Pediatric	2	0.2	3	0.3	3	0.3	2	0.2	3	0.3	1	0.1
Adult Other	0	0.0	0		0	0	0	0	0	0	0	0

D.2: Status of Groups Toward Texas Achieving Together Plan

Table 8. Continuum of Care, Parity Table, Dallas HSDA, 2017, and Relationship to the “Achieving Together” State Plan (Source: Texas DSHS HIV-STD Division)

	PLWH		Evidence of Care (At least one visit)		Retained in Care		Suppressed		% Suppressed of those retained
	#	%	#	%	#	%	#	%	
All PLWH	22,044	100%	17,332	79%	16,030	73%	14,019	64%	87%
Women	4,292	19%	3,329	78%	3,079	72%	2,586	60%	84%
Men	17,610	80%	13,869	79%	12,841	73%	11,345	64%	88%
Transgender People	142	1%	124	87%	110	77%	88	62%	80%
White	6,530	30%	5,422	83%	5,127	79%	4,713	72%	92%
Black	9,262	42%	7,029	76%	6,329	68%	5,263	57%	83%
Latinx	5,083	23%	3,896	77%	3,656	72%	3,261	64%	89%
<=24	965	4%	759	79%	620	64%	489	51%	79%
25-44	9,562	43%	7,354	77%	6,625	69%	5,619	59%	85%
45-64	10,361	47%	8,343	81%	7,946	77%	7,127	69%	90%
65+	1,156	5%	866	75%	839	73%	784	68%	93%
MSM	15,074	68%	12,006	80%	11,143	74%	9,951	66%	89%
Injection Drug Use	2,325	11%	1,777	76%	1,628	70%	1,314	57%	81%
Heterosexual Contact	4,473	20%	3,407	76%	3,142	70%	2,665	60%	85%
White MSM	5,443	25%	4,549	84%	4,321	79%	4,039	74%	93%
Black MSM	4,952	22%	3,769	76%	3,372	68%	2,816	57%	84%
Latino MSM	3,812	17%	2,964	78%	2,777	73%	2,510	66%	90%
Black Women	2,416	11%	1,853	77%	1,688	70%	1,420	59%	84%
Transgender People	142	1%	124	87%	110	77%	88	62%	80%

Red: priority population, farthest from 90% goals

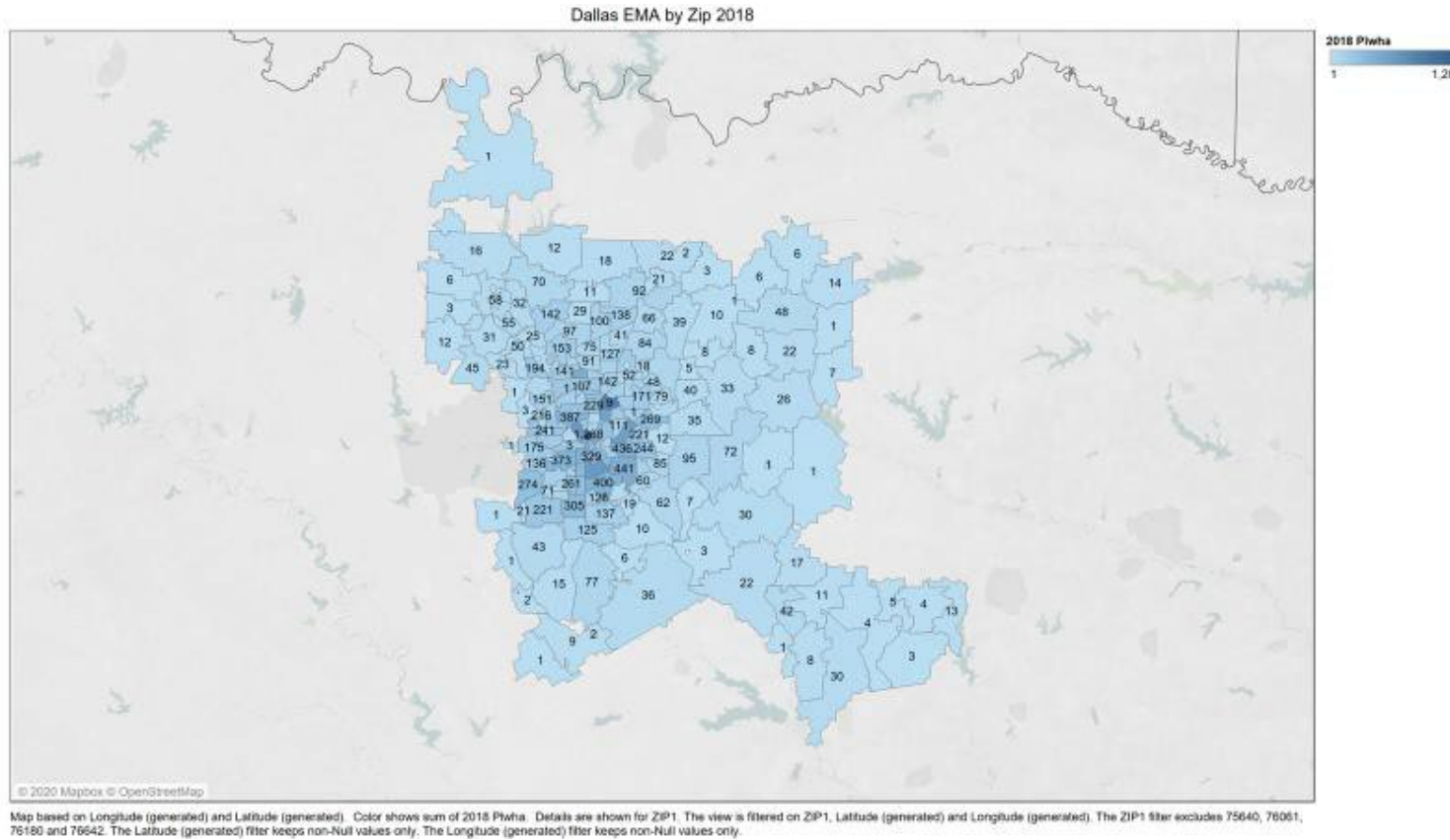
Yellow: below 90% goals

Green: at or above the 90% goals for the Achieving Together plan

D3. Prevalence: People Living with HIV/AIDS

Table 22. Prevalence: People Living with HIV/AIDS												
Group	2013		2014		2015		2016		2017		2018	
	#	%	#	%	#	%	#	%	#	%	#	%
Total	18,990	100.0	19,785	100.0	20,605	100.0	21,493	100.0	22,208	100.0	23,036	100.0
HIV	8,931	47.0	9,517	48.1	10,051	48.8	10,651	49.6	11,180	50.3	11,864	51.5
AIDS	10,059	53.0	10,268	51.9	10,554	51.2	10,842	50.4	11,028	49.7	11,172	48.5
Female	3,736	19.7	3,900	19.7	4,059	19.7	4,175	19.4	4,305	19.4	4,443	19.3
Male	15,254	80.3	15,885	80.3	16,546	80.3	17,318	80.6	17,903	80.6	18,593	80.7
White, non-Hispanic	6,117	32.2	6,217	31.4	6,278	30.5	6,389	29.7	6,426	28.9	6,522	28.3
Black, non-Hispanic	7,479	39.4	7,870	39.8	8,349	40.5	8,786	40.9	9,158	41.2	9,579	41.6
Hispanic	4,245	22.4	4,479	22.6	4,707	22.8	5,005	23.3	5,266	23.7	5,516	23.9
Other	188	1.0	209	1.1	228	1.1	253	1.2	272	1.2	305	1.3
Multi-Race	961	5.1	1,010	5.1	1,043	5.1	1,060	4.9	1,086	4.9	1,114	4.8
0-12	28	0.1	24	0.1	26	0.1	24	0.1	25	0.1	22	0.1
13-24	1,069	5.6	1,042	5.3	1,005	4.9	1,025	4.8	978	4.4	931	4.0
25-34	3,621	19.1	3,843	19.4	4,087	19.8	4,331	20.2	4,560	20.5	4,834	21
35-44	4,916	25.9	4,957	25.1	4,928	23.9	5,073	23.6	5,131	23.1	5,217	22.6
45-54	6,142	32.3	6,255	31.6	6,396	31.0	6,359	29.6	6,302	28.4	6,225	27.0
55-64	2,599	13.7	2,945	14.9	3,310	16.1	3,689	17.2	4,051	18.2	4,452	19.3
65+	615	3.2	719	3.6	853	4.1	992	4.6	1,161	5.2	1,355	5.9
MSM	12,774	67.3	13,371	67.6	13,964	67.8	14,674	68.3	15,188	68.4	15,835	68.7
IDU	1,320	6.9	1,317	6.7	1,352	6.6	1,369	6.4	1,387	6.2	1,380	6.0
MSM/IDU	958	5.0	955	4.8	967	4.7	988	4.6	1,003	4.5	1,001	4.3
Heterosexual	3,770	19.9	3,978	20.1	4,157	20.2	4,293	20.0	4,457	20.1	4,645	20.2
Pediatric	146	0.8	141	0.7	145	0.7	148	0.7	154	0.7	156	0.7
Adult Other	22	0.1	22	0.1	21	0.1	21	0.1	19	0.1	19	0.1

D4. Geographic Concentrations



The map on this page shows the numbers by ZIP Code. The 20 ZIP Codes and their cities with the highest numbers of PLWHA are listed below. All are located in Dallas County, and 19 of the 20 are in the City of Dallas.

Figure 51. Numbers of PLWHA by ZIP

#	ZIP Code, City	# PLWHA	#	ZIP Code, City	# PLWHA	#	ZIP Code, City	# PLWHA	#	ZIP Code, City	# PLWHA
1	75219 Dallas	1,288	6	75231 Dallas	558	11	75207 Dallas	427	16	75224 Dallas	338
2	75243 Dallas	857	7	75204 Dallas	460	12	75208 Dallas	419	17	75215 Dallas	336
3	75235 Dallas	636	8	75287 Dallas	448	13	75241 Dallas	400	18	75203 Dallas	329
4	75216 Dallas	618	9	75217 Dallas	441	14	75220 Dallas	387	19	75115 DeSoto	305
5	75228 Dallas	579	10	75227 Dallas	436	15	75211 Dallas	373	20	75206 Dallas	282

D5. Co-Morbidities – Sexually Transmitted Infections Dallas EMA 2018

Table 23. Co-Morbidities - Sexually Transmitted Infections Dallas EMA 2018												
Group	Total 2018 HIV/AIDS		Chlamydia		Gonorrhea		Early Latent Syphilis		P&S Syphilis		Late Latent Syphilis	
	#	%	#	%	#	%	#	%	#	%	#	%
Total	23,036	100.0	838	3.6	982	4.3	602	2.6	155	0.7	527	2.3
Female	4,443	19.3	67	1.5	33	0.7	7	0.2	3	0.1	12	0.3
Male	18,593	80.7	771	4.1	949	5.1	595	3.2	152	0.8	515	2.8
White, non-Hispanic	6,522	28.3	155	2.4	208	3.2	142	2.2	33	0.5	114	1.7
Black, non-Hispanic	9,579	41.6	355	3.7	454	4.7	245	2.6	65	0.7	222	2.3
Hispanic	5,516	23.9	271	4.9	265	4.6	174	3.2	44	0.8	155	2.8
Other	305	1.3	13	4.3	14	4.6	4	1.3	2	0.7	7	2.3
Multi-Race	1,114	4.8	44	3.9	50	4.5	37	3.3	11	1.0	29	2.6
0-12	22	0.1	0	0.0	0	0.	0	0.0	0	0.0	0	0.0
13-24	931	4.0	118	12.7	139	14.9	45	4.8	27	2.9	56	6.0
25-34	4,834	21	381	7.9	491	10.2	226	4.7	67	1.4	221	4.6
35-44	5,217	22.6	197	3.8	208	4.0	169	3.2	27	0.5	120	2.3
45-54	6,225	27.0	99	1.6	101	1.6	101	1.6	22	0.4	101	1.6
55-64	4,452	19.3	38	0.9	37	0.8	54	1.2	8	0.2	21	0.5
65+	1,355	5.9	5	0.4	6	0.4	7	0.5	4	0.3	8	0.6
MSM	15,835	68.7	711	4.5	882	5.6	565	3.6	143	0.9	476	3.0
IDU	1,380	6.0	22	1.6	13	0.9	4	0.3	1	0.1	6	0.4
MSM/IDU	1,001	4.3	33	3.3	47	4.7	23	2.3	6	0.6	28	2.8
Heterosexual	4,645	20.2	67	1.4	36	0.8	9	0.2	3	0.1	14	0.3
Pediatric	156	0.7	5	3.2	5	3.2	1	0.6	1	0.6	3	1.9
Adult Other	19	0.1	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

Appendix E: Demographic Characteristics People Living with HIV

E.1: Demographic Data PLWHA 2018 in the Dallas EMA

Table 24. Demographic Data PLWHA 2018 in the Dallas EMA				
All PLWHA			23,036	
Race/Ethnicity	Mode of Transmission	Age Group	Female	Male
All	All	All	4447	18598
White Non-Hispanic	MSM	13-24		83
		25-34		599
		35-44		857
		45-54		1646
		55-64		1669
		65+		554
	IDU or MSM/IDU	13-24	1	8
		25-34	16	65
		35-44	25	105
		45-54	51	170
		55-64	40	155
		65+	12	32
	Sex with Male / Sex with Female	13-24	8	
		25-34	44	7
		35-44	6	16
		45-54	92	31
		55-64	65	29
		65+	35	13
	Perinatal Transmission / Adult Other	0-1	1	
		2-12	4	1
		13-24	30	1
		25-34	9	3
		35-44	2	3
		45-54	1	2
55-64		1	3	
65+			2	

Race/Ethnicity	Mode of Transmission	Age Group	Female	Male	
Black Non-Hispanic	MSM	13-24		386	
		25-34		1869	
		35-44		1201	
		45-54		1055	
		55-64		627	
		65+		128	
	IDU or MSM/IDU	13-24		5	14
		25-34		44	72
		35-44		69	124
		45-54		127	196
		55-64		112	232
		65+		46	74
	Sex with Male / Sex with Female	13-24		63	6
		25-34		459	67
		35-44		728	132
		45-54		705	205
		55-64		393	144
		65+		142	59
	Perinatal Transmission / Adult Other	0-1		1	2
		2-12		4	9
		13-24		30	24
		25-34		9	14
		35-44		2	
		45-54		1	
55-64			1	2	

Race/Ethnicity	Mode of Transmission	Age Group	Female	Male	
Hispanic	MSM	13-24		189	
		25-34		1027	
		35-44		1180	
		45-54		1147	
		55-64		533	
		65+		122	
	IDU or MSM/IDU	13-24		1	10
		25-34		15	56
		35-44		25	79
		45-54		37	113
		55-64		19	73
		65+		6	15
	Sex with Male / Sex with Female	13-24		22	0
		25-34		91	24
		35-44		206	57
		45-54		194	65
		55-64		93	45
		65+		26	14
	Perinatal Transmission / Adult Other	0-1			
		2-12		1	1
		13-24		10	7
		25-34		4	6
		35-44			2
		45-54			
		55-64		1	1
		65+			

Race/Ethnicity	Mode of Transmission	Age Group	Female	Male	
All Other / Unknown	MSM	13-24		46	
		25-34		273	
		35-44		212	
		45-54		256	
		55-64		140	
		65+		36	
	IDU or MSM/IDU	13-24		1	2
		25-34		2	7
		35-44		13	19
		45-54		16	32
		55-64		11	23
		65+		7	9
	Sex with Male / Sex with Female	13-24		7	1
		25-34		46	6
		35-44		77	19
		45-54		59	23
		55-64		27	13
		65+		16	8
	Perinatal Transmission / Adult Other	0-1			
		2-12		1	2
		13-24		1	3
		25-34		1	2
		35-44			1
		45-54			
		55-64		1	2
		65+			1

Appendix F: Provider Capacity and Resource Inventory

#	Agencies/Organizations with Ryan White funding	County
1	AIDS Interfaith Network 2600 N. Stemmons Freeway, Suite 151, Dallas, TX 75207 214-943-4444 www.AINDallas.org	Dallas County
2	AIDS Services of Dallas 400 S. Zang Blvd., #210, Dallas, TX 75203 214-941-4411 www.aidsdallas.org	Dallas County
3	Bryan's House 3610 Pipestone Rd, Dallas, TX 75212 214-559-3946 www.bryanshouse.org	Dallas County
4	Callie Clinic 1521 Baker Rd, Sherman, TX 75090 903-891-1972 www.callieclinic.org	Grayson County
5	Dallas County Hospital District-Parkland 1936 Amelia Court, Dallas TX 75235 214-590-5647 https://www.parklandhospital.com/hiv-aids-services	Dallas County
6	Prism Health of North Texas 351 W. Jefferson Blvd, Suite 300, Dallas, TX 75208 214-521-5191 www.phntx.org/	Dallas County
7	Resource Center of Dallas 5750 Cedar Springs Rd, Dallas, TX 75235 214-540-4454 www.myresourcecenter.org	Dallas County
8	AIDS Healthcare Foundation 7777 forest Lane B-122, Dallas TX 75230 972-383-1060 www.aidshealth.org www.hivcare.org www.freehivtest.net	Dallas County
9	Health Services of North Texas 4401 N Interstate 35 Unit 312, Denton, TX 76207 940-381-1501 www.healthntx.org	Denton County

Organizations/Agencies without Ryan White Funding serving PLWHA

#	Organizations/Agencies	County
1	Abounding Prosperity, Inc. 2311 Martin Luther King Jr Blvd. Suite C, Dallas, TX 75215 214-421-4800 www.aboundingprosperity.org	Dallas County
2	AIDS Walk South Dallas 701 Commerce St., Suite 718, Dallas, TX 75202 469-610-3755 www.aidswalksouthdallas.com	Dallas County
3	Avita Pharmacy 219 Sunset Ave., Suite 118-A, Dallas, TX 75208 214-943-5187 www.avitapharmacy.org	Dallas County
4	The Afiya Center 501 Wynnewood Village, Suite 213, Dallas, TX 75237 214-579-8895 www.theafiyacenter.org	Dallas County
5	Homeward Bound, Inc. 5300 University Hills Blvd. Dallas, TX 75241 214-941-3500 www.homewardboundinc.org	Dallas County
6	The Bridge Homeless Recovery Center 1818 Corsicana St. Dallas, TX 75201 214-670-1100 www.bridgenorththetexas.org	Dallas County
7	The Council on Alcohol and Drug Abuse 1349 Empire Central Dr. #800 Dallas, TX 75247 214-522-8600 www.dallascouncil.org	Dallas County
8	UT Southwestern School of Health Professions 5323 Harry Hines Blvd. Dallas, TX 75390 469-291-2873 https://www.utsouthwestern.edu/education/school-of-health-professions/about/outreach/cpiu/	Dallas County
9	Pride Pharmacy 4015 Lemmon Ave., Dallas, TX 75219 214-954-7389 www.vitals.com/pharmacy/pride	Dallas County
10	The Salvation Army DFW 8787 N Stemmons Fwy Dallas TX 75247 214-637-8100 www.salvationarmydfw.org	Dallas County
11	Greenville Community Health Center 4311 Wesley St., Greeville, TX 75401 903-455-5959 www.greenvillehealthcenter.org	Hunt County

#	Organizations/Agencies	County
12	Los Barrios Unidos Community Center 809 Singleton Blvd. Dallas TX 75212 214-540-0300 www.losbarriosunidos.org	Dallas County
13	The Health Center of Helping Hands 401 W Rush St. Suite 100, Rockwall, TX 75087 972-772-8194 www.rockwallhelpinghands.com	Rockwall County

Appendix C: Integrated Plan Steering Committee Roster

First Name	Last Name	Organization/Affiliation
Chris	Adkins	N/A
Katrina	Balovle	Needs Assessment Research Team
Darion	Banister	NASTAD
Robert	Baxter	Abounding Prosperity
Tracee	Belzle	UT Southwestern Medical Center, Dallas, TX
James	Berglund	Community Liaison- Gilead
Kofi	Bissah	ADAP Liaison, Dallas County
Glenda	Blackmon-Johnson	Dallas County HHS- RWPC Program Manager
Logane	Brazile	Dallas County HHS- RWPC Coordinator
Tres	Brown	Empowerment Program Manager, Resource Center
Chloe	Carter	PCCI, Dallas
Kevin	Chadwin-Davis	Arttitude; RWPC; Kind Clinic Dallas
Isabel	Clark	DSHS Austin
Lori	Davidson	City of Dallas (HOPWA)
John	Dornheim	RWPC- Chair
Ted	Douglas	Prism Health North Texas
Amanda	Evans	MD-UTSW PedsID & Children's ARMS/HIV Clinic
Miranda	Grant	Dallas County HHS, EHE Coordinator
Michael	Hager	Needs Assessment Research Team
Dwight	Harry	ASD
Brooke	Henderson	Legacy Counseling Center dba Legacy Cares
Danielle	Hill	Dallas County HHS/EHE Program
Lionel	Hillard	Consumer, Advocate
Nicole	Holmes	Manager, Health Equity- NASTAD
Phil	Huang	Dallas County HHS
Sonya	Hughes	Dallas County HHS, Ryan White Grants Management Division
AJ	Johnson	Dallas County HHS- EHE
Teri	Johnson	Health Services of North Texas
Jaiden	Lake	Dallas County EHE
Allison	Liddell	THR
Scott	Lyles	Center for Health Empowerment

Elyse	Malanowski	PT Specialist SCAETC- Prism North Texas
Brittany	Miller	Southern Black Policy & Advocacy Network (SBPAN)
Jacqueline	Naeem	PCCI
Karin	Petties	Prism Health North Texas
Norma	Piel-Brown	Callie Clinic
Ratonia	Runnels	Legacy Cares
Oscar	Salinas	CQM Dallas County
Jasmine	Sanders	Dallas County HHS- RWPC Planner
Joyce	Tapley	CEO, Foremost Family Health Centers
Walter	Taylor	North Texas Behavioral Health Authority
Helen	Turner	Community Advocate & 38-year AIDS survivor/RWPC
Corinne	Vick	Gilead Sciences, HIV Treatment Specialist
Chris	Walker	ViiV Healthcare
Shamyra	Williams	Contracts Manager- AHF
Andrew	Wilson	Prism Health North Texas
Joni	Wysocki	AIN/AHF
Cindy	Zoellner	HIV & HCV Clinical Pharmacy Specialist, Parkland Hospital & UTSW ID Division

Appendix D: Dallas County IP Steering Committee Notes

Dallas County Integrated Plan Steering Committee Meeting Notes

August 16, 2022, at 3:00 pm CST

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Attendees

Name	Organization/Affiliation
Chris Adkins	N/A
Darion Banister	NASTAD
Robert Baxter	Abounding Prosperity
Tracee Belzle	UT Southwestern Medical Center, Dallas, TX
Kofi Bissah	ADAP Liaison Dallas County
Tres Brown	Empowerment Program Manager w/ Resource Center
Chloe Carter	PCCI out of Dallas
Isabel Clark	DSHS Austin
Lori Davidson	City of Dallas (HOPWA)
Kevin Chadwin Davis	Board of Directors at Artitude, Member of the Ryan White Planning Council, and Intern at Kind Clinic Dallas
John Dornheim	Ryan White Chair
Ted Douglas	Program Manager - Prism Health North Texas
Amanda Evans	MD - UTSW PedsID & Children's ARMS/HIV Clinic
Dwight Harry	ASD

Brooke Henderson	Legacy Counseling Center dba Legacy Cares
Danielle Hill	Dallas County Health & Human Services/EHE program
Lionel Hillard	Consumer, Advocate
Nicole Holmes	Manager, Health Equity – NASTAD
Phil Huang	DCHHS
Sonya Hughes	Dallas County Health and Human Services, Ryan White Grants Management Division
AJ Johnson	Dallas County HHS – EHE
Teri Johnson	Health Services of North Texas
Jaiden Lake	Dallas County EHE
Allison Liddell	THR
Elyse Malanowski	PT Specialist SCAETC-Prism North Texas
Brittany Miller	Southern Black Policy & Advocacy Network (SBPAN)
Jacqueline Naeem	PCCI
Karin Petties	Prism Health North Texas
Norma Piel-Brown	Callie Clinic
Ratonia Runnels	Legacy Cares
Oscar R Salinas	CQM Dallas County
Joyce Tapley	CEO, Foremost Family Health Centers
Walter Taylor	North Texas Behavioral Health Authority
Helen E Turner	Community Advocate & 38 yr. AIDS Survivor/RWPC
Corinne Vick	Gilead Sciences, HIV Treatment Specialist
Shamyra Williams	Contracts Manager (AHF)
Andrew Wilson	Prism Health North Texas
Joni Wysocki	AIN/AHF
Cindy Zoellner	HIV & HCV Clinical Pharmacy Specialist, Parkland Hospital and UTSW ID Division

The meeting was facilitated by Ashley Barnett and Lauren Hansen with Community Solutions, Inc.

Welcome and Introductions

Miranda Grant with Dallas County EHE welcomed attendees to the Dallas County Integrated Plan Steering Committee Meeting. Attendees were asked to type their name and organization/affiliation into the chat box. She then turned the meeting over to Ashley Barnett with Community Solutions, Inc., who facilitated the meeting.

Overview of the Process

Ashley welcomed the group to the Steering Committee meeting and thanked them for their participation in the development of the 2022-2026 Integrated Plan. She reviewed the roles and responsibilities of the Steering Committee as well as the timeline for completing the Plan. It was also noted that while this Steering Committee will sunset following submission of the Plan, participants are encouraged to remain engaged in the implementation and monitoring of the goals, objectives and strategies that will be developed over the next few months. Additional details can be found in Appendix A.

Review of Integrated Plan Guidance from HRSA

Ashley provided an overview of the guidance received from HRSA about the structure of the Integrated Plan. She also outlined the already-existing reports that Community Solutions has access to that are being reviewed for inclusion in the report, where appropriate. The group then engaged in a discussion about other data and resources to be considered as the Plan is developed:

- Federally Qualified Health Centers (FQHC), they have been provided some funding the last couple of years for use of PrEP.
- South Central Aids Education Training Centers (AETC) is also here, they may have some assessment docs. (Karen will email Ashley)
- The external Clinical Quality Management (CQM) Program is currently doing Focus Groups accessing the needs of PLHIV/A. Contact: Oscar Salinas.
- The Afiya Center.
- The Healing Together Group.
- Common Threads.
- Gilead, ViiV Healthcare, they have a community liaison.
- Cathedral of Hope – they have a housing program.
- Legacy Cares (Legacy Counseling Center).
- Dallas Family Access Network (DFAN) provides HIV care for women, children, youth, and infants. They are just now looking at FY2022 data and could be of help.
- Abounding Prosperity.

Action Items & Next Steps

Steering Committee members were asked to continue thinking about additional resources that could be helpful in informing the Integrated Plan; additional resources can be sent directly to Ashley Barnett at ashley@communitysolutionsinc.net.

Inclusion of community voice in this process is paramount, so Community Solutions will be holding up to 5 listening sessions with consumers/PLHIV/A to ensure their experiences help guide the development of the Integrated Plan. We will coordinate with existing groups to hold the sessions.

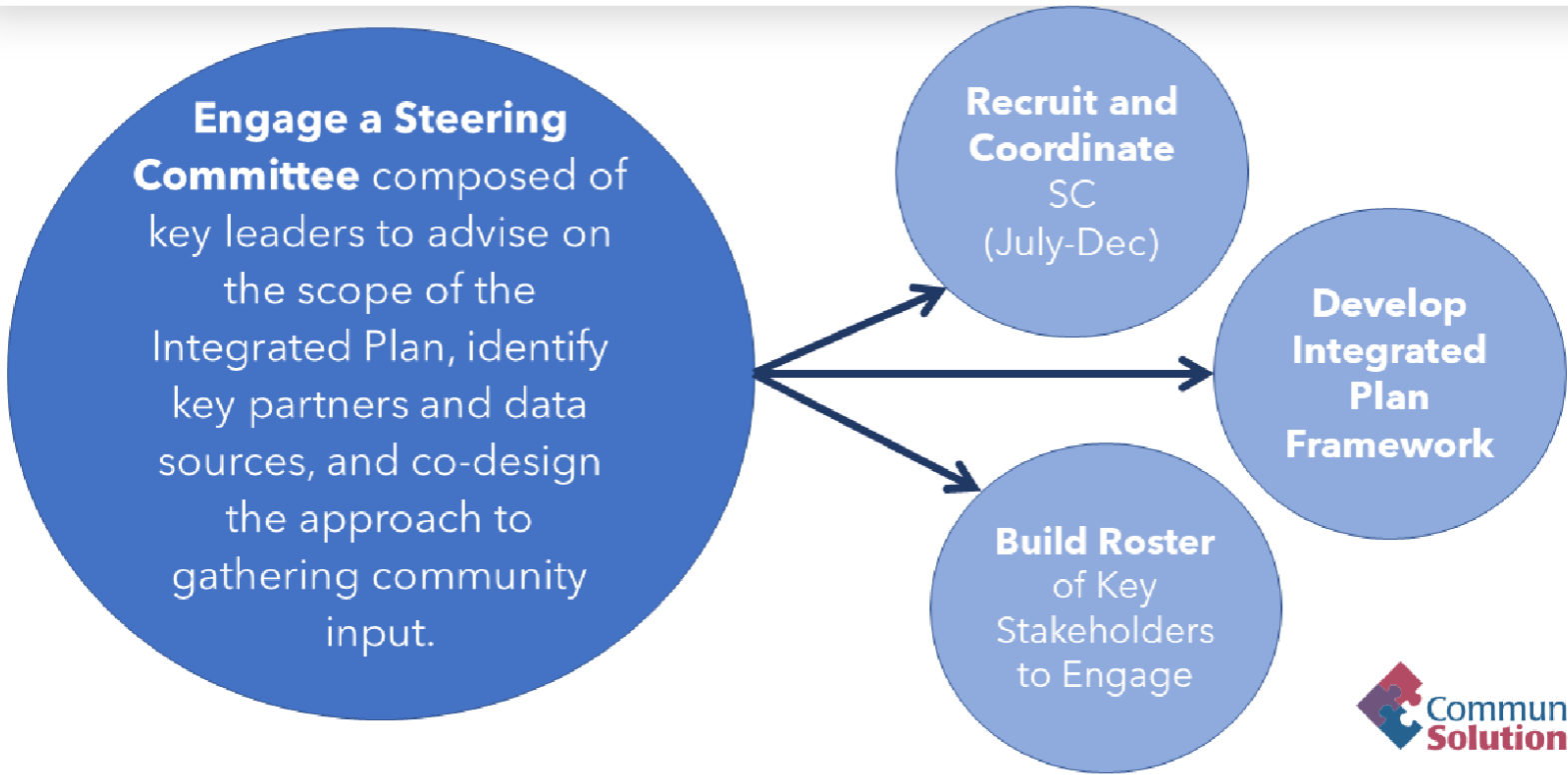
The next Steering Committee meeting will be held Thursday, September 22, 2022, at 9:00 AM CST. Participants will receive a meeting request within the next week. During this meeting, the Steering Committee will review an initial framework of the Integrated Plan and provide input on entities that can assist in development of the goals, objectives and strategies.

2022 Integrated HIV Plan Steering Committee Meeting

August 16, 2022



Form and Engage a Steering Committee



Planning Timeline

- Conduct crosswalk analysis - August 2022
- Conduct listening sessions with up to 5 key stakeholder groups- Sept. 2022
- Engage Steering Committee and workgroups- monthly through December 2022
- Submit draft of Integrated Plan to Steering Committee for feedback- November 3, 2022
- Submit final draft of Integrated Plan- December 8, 2022



Integrated Plan Outline

- Section I- Executive Summary
 - Section II- Community Engagement and Planning Process
 - Section III- Contributing Data Sets and Assessments
 - Section IV- Situational Analysis
 - Section V- 2022-2026 Goals and Objectives
 - Section VI- 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up
-

Data and Reports

- 2017-2021 Integrated Plan
- Achieving Together Plan
- EHE Workplan
- Fast Track Cities Plan
- 2021-2022 Community Services Handbook
- 2019 Ryan White Planning Council of the Dallas Area Needs Assessment
- 2021 Mini Needs Assessment

WHERE ELSE SHOULD WE LOOKING?

Action Items & Next Steps

- Steering Committee- Consider additional data and reports to be used for the Integrated Plan
 - Community Solutions- hold up to 5 listening sessions with consumers/PLWHA
 - Schedule the next Steering Committee Meeting
-

Contact Information

Ashley Barnett, Community Solutions, Inc.

Ashley@communitysolutionsinc.net

Lisa Osterman, Community Solutions, Inc.

Losterman@communitysolutionsinc.net

Dallas County Integrated Plan Steering Committee Meeting

September 22, 2022- 9:00 am CST

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Attendees

Name	Organization/Affiliation
Chris Adkins	N/A
Darion Banister	NASTAD
Robert Baxter	Abounding Prosperity
James Berglund	Community Liaison- Gilead
Glenda Blackmon-Johnson	Dallas County HHS-RWPC Program Manager
Logane Brazile	Dallas County HIV Task Force
Lori Davidson	City of Dallas (HOPWA)
John Dornheim	RWPC Chair
Ted Douglas	Program Manager- Prism Health North Texas
Miranda Grant	Dallas County HIV Task Force
Michael Hager	Dallas CQM
Brooke Henderson	Legacy Counseling Center dba Legacy Cares
Lionel Hillard	Consumer, Advocate
Nicole Holmes	Manager, Health Equity- NASTAD
Phil Huang	DCHHS
Sonya Hughes	Dallas County HHS, Ryan White Grants Management Division
AJ Johnson	Dallas County HHS- EHE

Venton Jones	HIV TF Chair and CEO of Southern Black Policy and Advocacy Network
Allison Liddell	THR
Scott Lyles	Center for Health Empowerment
Karin Petties	Prism Health North Texas
Ratonia Runnels	Legacy Cares
Jasmine Sanders	Dallas County HHS- RWPC Planner
Helen E. Turner	Community Advocate & 38 yr. AIDS Survivor/RWPC
Andrew Wilson	Prism Health North Texas
Marlon Wilson	EHE Social Worker
Katy Womble	Chief of Staff to Dr. Huang, Dallas County HHS
Joni Wysocki	AIN/ANF

Welcome and Introductions

Ashley Barnett welcomed attendees and reviewed the meeting agenda.

Integrated Plan Crosswalk

Ashley Barnett shared the background and details on the strategy that we took to go through the crosswalk.

Joni Wysocki and Chris Adkins suggested that Community Solutions use the Dallas Community Health Needs Assessment and financial modeling data for the crosswalk. Michael Hager said that they will be sharing survey results, focus group info, and other information that they have with Community Solutions for the crosswalk.

Integrated Plan Draft Framework Review

For this portion of the meeting, attendees reviewed the draft goals and objectives for the Integrated Plan and were asked to provide feedback on them. Ashley also asked the group to consider what groups/entities could be engaged to help further refine and build out the information presented.

It was suggested that financial modeling data be incorporated across all the goals to ensure planning is realistic.

Goal: Diagnose all Dallas EMA residents as quickly as possible

Attendees suggested that there should be collaboration at the county level since that is where the dollars come from. Michael Hager mentioned that we need to think specifically

about getting ahead of the forces that try to maintain the status quo. He would not be surprised if we found things related to disparities surrounding testing of different populations.

There should be consideration to adding strategies around mobile testing for the regions in more rural counties that do not have enough staff to commit to the getting clients tested.

- There was a suggestion to add “reach people who live in rural counties” as a strategy.
- Add a strategy to get testing to the rural areas.

Andrew Wilson mentioned this goal may be too broad; it sounds like we are going to test all residents. The thought was making sure that everyone knows their status.

“As quickly as possible” suggests that you are looking to reduce time it takes to get people tested, and not just opt out testing.

Helen Turner mentioned she likes the broadness of the goal.

- Should it read “Diagnose all Dallas EMA residents *with HIV* as quickly as possible?”

Allison Liddell mentioned rural medicine – the goal for system wide testing is to reach rural areas.

- People who are contracted to do testing should be engaged to participate in work groups.

Goal: Treat all HIV diagnoses quickly and effectively

Chris Adkins said this goal needs a rapid start objective, i.e., same day to 72 hours linkage to medication after new diagnoses.

Social Determinants of Health (SDOH) should be mentioned here because it frames treatment as a person- and community-first activity.

Andrew Wilson said we need baselines on new diagnoses so specific percentage increases can be determined.

Scott Lyles noted that in the EHE plan, they set the goal to have people linked to care within 24 hours.

- Larger jurisdictions are doing this – in Austin they did a study and found out how quickly they can link people to care. One of things they saw as a result of the survey was that they were able to reduce the average amount of time it took to link people to care.

Joni Wysocki mentioned that FindHelp.org could be a good resource. Miranda noted that EHE is already contracting with this group.

Venton Jones said there is a need to acknowledge some of the policy changes and capture them in the strategy.

Goal: Prevent new transmissions among Dallas EMA residents by using proven methods and strategies.

Venton Jones said to improve the communities' capacity to engage in HIV planning could be a strategy. We need to increase the community's capacity.

Multiple people said we need racial health equity strategies here.

Goal: Respond quickly to potential outbreaks by getting prevention and treatment services to Dallas EMA residents who need them.

One of the key items in the policy agenda is to make sure that plan goals and activities are appropriately resourced and funded to meet the objectives.

For the Treatment and Prevention goals, there should be an objective around public/private partnerships that bring in other elements of civil society appropriately to address the HIV epidemic.

- Public-private partnerships come into play here.
 - Faith based communities.
 - Public health acts as a “white savior” – need to leverage better partnerships inside of government and county/local government interaction.
 - Miranda said we need to make sure the social determinants are encompassed in these strategies.
 - Chris mentioned that ATC is currently training pharmacists on long acting injectables.
 - Making sure that plan activities are funded – policy agenda

Scott Lyles provided the following recommendations:

- Define linkage to care for Dallas EMA.
- Identify the current base (community-wide average) for linkage to care in Dallas EMA.
- Adopt community-wide goal for linkage to care consistent with Fast Track Cities and EHE goals [24-hour linkage to care].
- Identify barriers to for specific populations.
- Adopt timeline to achieve community-wide linkage goal.
- Consider making linkage goal status neutral (linkage to HIV treatment for positive diagnosis and linkage to PrEP/PEP for negative dx at risk of HIV).

Areas of Expertise for Workgroups

The Dallas AIDS walk discussion group in South Dallas is important to include.

Venton Jones noted that since the workgroups would likely have many of the same people, one strategy could be combining the groups into one (or two meetings) and build out the discussion around specific topics.

Chris Adkins reiterated that all discussions should include how to get public financing to things like expanding Medicaid and other strategies that would result in bringing down the cost of care.

Lionel Hillard suggested that partners who work with people who are incarcerated individuals be included.

Michael Hager said that CQM has been interested in doing more with community. They put together a calendar for the broader perspective, with anything that could be of interest to the HIV community goes on this calendar – Michael with share. We could connect with the people in these other meetings to glean more insight into specific areas/elements of the community's perspective.

Venton Jones said the Consumer Council Committee could share the information and connect PLWH and other groups collaborating with them.

Karin Petties asked about a dedicated effort/work group focusing on the healthcare landscape in Texas and needed changes for sustainability and continuity. She noted that Venton Jones' comment on integrating policy would fit here as well as a focus on funding needs to sustain all these efforts. Everything is predicated on limited resources, so Michael Hager's concept of private/public partnerships fits here too - how well are we working with FQHCs and other groups? This could be an area to build on, in consideration of leveraging our medical schools to integrate more direct consideration for expanding educational capacity.

Action Items & Next Steps

Steering Committee members were asked to continue thinking about additional resources that could be helpful in informing the Integrated Plan; additional resources can be sent directly to Ashley Barnett at ashley@communitysolutionsinc.net.

The next Steering Committee meetings will be held Thursday, October 20, 2022, at 10:00 AM CST and Monday, November 14, 2022, at 10:00 AM CST.

2022 Integrated HIV Plan Steering Committee Meeting

September 22, 2022



Integrated Plan Crosswalk

What is it?

A way to identify common priorities, goals, and strategies

What's included?

Several components were reviewed to identify where similarities and differences exist.



Integrated Plan Crosswalk

Which documents were reviewed?

2017-2021 Integrated Plan

Achieving Together Plan

EHE Workplan

Fast Track Cities Plan

2021-2022 Community Services Handbook

2019 Ryan White Planning Council of the Dallas Area NA

2021 Mini NA



Integrated Plan DRAFT Goals & Objectives

Goal: **Diagnose** all Dallas EMA residents as quickly as possible

Objectives:

- Increase the percentage of Dallas EMA residents who know their HIV status
- Promote and increase community-based HIV testing opportunities in healthcare and non-healthcare settings
- Develop strategies for targeting testing for priority populations



Integrated Plan DRAFT Goals & Objectives

Goal: **Treat** all HIV diagnoses quickly and effectively

Objectives:

- Increase the percentage of Dallas EMA residents who are linked to care within 30 days of diagnosis
- Increase the percentage of Dallas EMA residents who are retained to care
- Increase the percentage of Dallas EMA residents who are virally suppressed
- Develop and implement an HIV care continuum that coordinates resources and services



Integrated Plan DRAFT Goals & Objectives

Goal: **Prevent** new transmissions among Dallas EMA residents by using proven methods and strategies

Objectives:

- Increase the use of PrEP and PEP, especially for priority populations
- Employ harm reduction strategies, such as syringe services programs (SSPs), that are proven to prevent the transmission of HIV
- Develop and conduct workforce development/training for healthcare professionals on HIV testing guidelines, risk factors, prevention tools and culturally responsive efforts



Integrated Plan DRAFT Goals & Objectives

Goal: **Respond** quickly to potential outbreaks by getting prevention and treatment services to Dallas EMA residents who need them

Objectives:

- Expand data capacity to ensure data quality and access/sharing for prompt surveillance efforts
- Engage in local and regional outbreak response planning to be implemented when outbreaks are detected



Areas of Expertise for Workgroups

- Engaging community-based partners in strategic, guideline-based, culturally responsive **outreach and testing**. (Diagnose, Prevent)
- Effective, collaborative deployment of **disease intervention specialists/partner services**. (Diagnose, Prevent)
- Increasing awareness, access to, and uptake of **PrEP and PEP**. (Prevent)
- Increasing access to **harm reduction** resources, especially SSPs. (Prevent)
- Building **systems of care** with accessible healthcare, coordinated services and supports as one-stop multi-service organizations and/or through collaboration/co-location, referrals, and communication/data sharing (Treat)
- Supporting health and well-being of people living with HIV through formal and informal **peer support** resources and activities (Treat)

Areas of Expertise for Workgroups

- **Streamlining and coordinating data** collection, reporting, and sharing for program management and surveillance purposes (Diagnose, Prevent, Treat, Respond)
- Collaborative local and regional outbreak **response planning** (Respond)
- Developing **communication strategies** to strengthen the system, reduce barriers/obstacles to testing, prevention tools, and quality care, and reduce/eliminate stigma. (Diagnose, Prevent, Treat, Respond)
- Developing a **policy agenda** to strengthen the system, reduce barriers/obstacles to testing, prevention tools, and quality care, and reduce/eliminate stigma. (Diagnose, Prevent, Treat, Respond)

Areas of Expertise for Workgroups

- **Workforce development strategies** to increase the availability of evidence-based, culturally responsive, high-quality resources, supports, and services.
 - Training **healthcare professionals** on testing guidelines, risk factors, and prevention tools for priority populations and the general public. (Diagnose, Prevent)
 - Engaging **primary care providers** in culturally responsive, evidence-based prevention strategies, testing, linkage to care and treatment. (Diagnose, Prevent, Treat)
 - Educating **students** in healthcare and human services fields. (Diagnose, Prevent, Treat)
 - Professional development/training and education of **case managers, social workers, and staff at social service organizations and ASOs**. (Diagnose, Prevent, Treat)
 - Enlisting **long-term care providers** in helping clients who are living with HIV to link, retain, and reengage them in care. (Treat)

Currently Existing Committees/Workgroups

- Ryan White Planning Council
 - Executive/Nominations
 - Planning & Priorities
 - Allocations
 - Evaluation
 - Consumer Council
 - Needs Assessment
- HIV Task Force
- Fast Track County Workgroup
- Others?

Action Items & Next Steps

- Summarize key themes and recommendations from Listening Sessions
- Convene workgroups to build out goals, objectives and strategies for the Integrated Plan



Upcoming Steering Committee Meetings

Thursday, October 20 at 10:00am

Monday, November 14 at 10:00am



Contact Information

Ashley Barnett, Community Solutions, Inc.

Ashley@communitysolutionsinc.net

Lisa Osterman, Community Solutions, Inc.

Losterman@communitysolutionsinc.net



THANK YOU!

Your participation, guidance and feedback is invaluable!



Dallas County Integrated Plan Steering Committee Meeting

November 14, 2022- 10:00am CST

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Attendees

Name	Organization/Affiliation
Chris Adkins	N/A
James Berglund	Community Liaison- Gilead
Glenda Blackmon-Johnson	Dallas County HHS-RWPC Program Manager
Logane Brazile	Dallas County HIV Task Force
Bendu Coleman	UT Southwestern
Miranda Grant	Dallas County HIV Task Force
Danielle Hill	Dallas County HHS- EHE Program
Sonya Hughes	Dallas County HHS- Ryan White Grants Management Division
Jasmine Sanders	Dallas County HHS- RWPC Planner
Dr. Walter Taylor	North Texas Behavioral Health Authority
Helen E. Turner	Community Advocate & 38 yr. AIDS Survivor/RWPC
Andrew Wilson	Prism Health North Texas
Joni Wysocki	AIN/ANF

Welcome and Introductions

Ashley Barnett welcomed attendees and reviewed the meeting agenda.

Integrated Plan Walkthrough & Review

Ashley opened the floor for feedback on the plan. Everyone in attendance either had already given their feedback to Ashley or communicated that they will be giving their feedback

before close of business on November 15th. Ashley walked through the IP and opened the floor for discussion.

Who would sign the letters of concurrence on behalf of the HIV Task Force and Steering Committee? Miranda mentioned she would send out a SurveyMonkey survey to collect the votes and collectively sign it as a committee.

Chris brought up how the current plan didn't address the priority population enough. He expressed that there was not enough in the IP on the current political landscape, how they're demonizing trans people being, and how that will affect the structural vulnerability of the plan. Also, minority women's health needs to be addressed more as a priority population. The plan needs to make trans individuals more of a focus, with measures for these objectives as well. There was concurrence from the group on this.

Chris provided this link on trans waves in Dallas:

<https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7120a1-H.pdf>

The group addressed the specific risks and barriers of people of Mexican and Latino descent. There is an anti-Latino/anti-immigrant – specifically Mexican- bias in Dallas County. There is a unique type of bias towards Mexican people that could be addressed here. There is some concurrence on this.

Andrew asked if the goal “90% of Dallas residents get tested” was realistic. Chris mentioned that it's worth keeping that large testing goal to further progress along. Then what is the strategy to get to that?

It was noted that information on the chart on page 12 is old. SC members said they do have the 2021/2022 resource inventory. The data on the chart came from 2019. Ashley mentioned that the Needs Assessment information will be looped in on the monitoring section as well.

Somewhere in the report, it is mentioned extended night and weekend hours. One noted that that is not the case. Helen mentioned that Parkland gave it a try with night and weekends, but then the pandemic changed what they could offer.

One suggested mentioning the Fast-Track Cities work being done. Partnerships with CVS and WALGREENS: specifically, Walgreens there is potential for even more partnership. This could go under the response section.

One asked if the goals are going to be turned into SMART goals. The answer is yes, the objective needs to be SMART goal style.

On the objective “connect resident to care within 90 days” – one mentioned that the link to care should be equally quick as diagnoses, 72 hours.

We should switch all mention of “target” populations to “priority” populations.

Action Items & Next Steps

Ashley said that the Executive Summary section will be reworked quite a bit and they will be adding more to the community engagement and planning sections after today's feedback.

Steering Committee members were asked to submit any feedback and additional resources to Ashley Barnett at ashley@communitysolutionsinc.net by November 15.

This is the last Steering Committee meeting. Ashley and the Community Solutions team will be working to complete and send the final draft of the Integrated Plan by December 8th.

Appendix E: Ryan White Planning Council of the Dallas Area Interim
Needs Assessment August 2021



Ryan White Planning Council of the Dallas Area Interim Needs Assessment August 2021

Susan M. Wolfe, PhD

Susan Wolfe and Associates, LLC

In collaboration with Dallas County Health and Human Services and the Ryan White Planning Council of the Dallas Area.

Acknowledgements

I would like to thank everyone who assisted with this project.

Collaborating Partners

Dallas County Ryan White Grant Administration
Dallas County Ryan White Needs Assessment Committee
Dallas County Ryan White Planning Council
People Living with HIV in the greater Dallas area and Ryan White HIV/AIDS Program Consumers

The 2021 Dallas Area Interim HIV/AIDS Needs Assessment was made possible by the following individuals who assisted with the scheduling of focus groups, provided information and feedback, and contributed in many other ways.

Ryan White Planning Council and Needs Assessment Committee

Hosea Crowell
Kevin Chadwin Davis, Community Liaison, ASP Cares
John Dornheim
Amanda S. Evans, MD
Linda Freeman
Miranda K. Grant
Lionel Hillard
Dawn D. Johnson, MD
Mary Mallory, R.N., PPCNP-BC, ARMS Clinic
Sattie Nyachwaya
Cesar Termulo, Associate Medical Director, Parkland COPC
Helen Turner
Auntjuan Wiley, CEO, AIDS Walk South Dallas, Inc.
Donna Wilson
Roberto Zamarripa, Bilingual Case Manager, AIDS Services of Dallas

Community Members and Service Providers

Akosua Addo, Prism North Texas
Gary Benecke, Resource Center
Jonathon Bingham, Fiscal/Program Coordinator, Community Dental Care
Jonathan Cowans, Practice Manager, AHF (I need the full name of this organization)
Crystal Curtis, HIV Grants Program Director, Parkland Health and Hospital System
Melissa Grove, Executive Director, Legacy Counseling
Yolanda Jones, Vice President, Chief Operating Officer, AIDS Services of Dallas
Traswell Livingston, AIDS Services of Dallas
Kellie Norcott, Program Manager, Parkland Health and Hospital System
Nisa Ortez, Client Service Coordinator, Legal Hospice of Texas
Gwen Palmore, Callie Clinic
Norma Piel-Brown, Compliance Officer, Callie Clinic

Doreen Rue, Health NTX
Joni Wysocki, Chief Operating Officer, AIN Dallas

Dallas County Health and Human Services

Sonya M. Hughes, MPH, CPH, Assistant Director, Ryan White Grants Compliance
Glenda Blackmon Johnson, MS, MPH, RWPC Program Manager
Logane Brazile, BSPH, Program Coordinator, RWPC

We would also like to acknowledge and extend a heartfelt thank-you to all the anonymous individuals who participated in interviews and focus groups. We could not have done this without you.

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Background and Purpose

In 2020 Susan Wolfe and Associates, LLC (SWA) in collaboration with Dr. Kyras Brown from the University of Texas at Arlington presented the report with the results of the 2019 Dallas EMA Ryan White Needs Assessment. Since the report was presented, the Ryan White Planning Council (RWPC) prepared a plan to respond to the findings and began implementing the plan. Shortly after the needs assessment findings were shared, the COVID-19 epidemic disrupted the operations of systems providing health and supportive care for people living with HIV/AIDS (PLWHA) and providers were forced to develop alternative ways to conduct outreach and deliver care.

In 2021 as COVID-19 rates decline and vaccination rates increase, there are expectations that providers and PLWHA will be able to return to providing and receiving services with the same methods used pre-COVID-19. However, COVID-19 era adaptations led to innovations and new ways of doing things that may be retained. This interim needs assessment offers an opportunity to capture not only the impact of COVID-19 on providers and consumers, but also the lessons learned.

The purpose of this mini-needs assessment is to:

1. Identify how COVID-19 impacted the care delivery system and outreach, especially for underserved populations and populations with special needs.
2. Determine the extent to which COVID-19 impacted individuals from identified underserved populations and their ability to access prevention and care services.

Methods

SWA gathered the information needed through key informant interviews with providers and focus groups with previously identified underserved populations. Each of these methods are described in more detail below.

Provider Interviews

Key informant interviews using a semi-structured interview protocol were conducted with 14 prevention and care providers in the Dallas EMA Service area representing 11 different organizations.

Dallas County Health and Human Services provided a list of 20 Ryan White service providers representing 12 different organizations to SWA. An email was sent to each provider on the list with an invitation to participate and a link to SignUpGenius, an online scheduling system. Many dates and time slots were presented to provide options for different days of the week and times of day. Invited participants were also provided an opportunity to email the SWA team if none of the days and time slots worked for them.

Two of the individuals on the list provided contact information for alternative respondents, both of whom participated in the interview. Four of the prospective interviewees actively declined participation as they felt the other representative from their organization that we had contacted would be better suited to provide the answers to the questions. Two passively declined and never responded to any of the emails that were sent. Interviews were conducted by Dr. Susan Wolfe, CEO and Community Consultant from SWA or one of her associates, Jenn Ballentine.

The interview questions were developed by SWA in collaboration with members of the RWPC. The interview protocol that was used is presented in Appendix A.

Focus Groups with Identified Underserved Populations

Five focus groups were conducted with populations that were identified as underserved and having unique needs:

- Black Men (9 participants)
- Black women (5 participants)
- Hispanic/Latino men¹ (7 participants)
- Two focus groups with transgender men and women (5 participants total).

A Spanish language interpreter was provided for the focus groups with Hispanic/Latino men. Each focus group took approximately one hour to complete, and participants were each given a \$15 gift card as compensation for their time.

All focus groups were conducted by Dr. Susan Wolfe. Four of the five groups were conducted via Zoom and all sessions were recorded with verbal consent from the participants. One group was conducted in person with appropriate social distancing and all participants wearing masks in compliance with public health recommendations. The session was audio-recorded with verbal consent from the participants.

The initial plan included one focus group each with Hispanic/Latina women, youth living with HIV/AIDS, and youth who are not living with HIV/AIDS. Efforts were made to organize these groups, but attempts were unsuccessful.

The focus group protocol and questions were developed by SWA in collaboration with members of the RWPC. The focus group protocol that was used is presented in Appendix B.

¹ This focus group included one transgender woman.

Findings

Changes Made Resulting from the 2019 Needs Assessment

The 2019 needs assessment report was delivered in March 2020, just before Dallas County begin to experience the impact of COVID-19. This left little opportunity for providers and the RWPC to give it adequate attention as they have been busy since that time managing the impact of the pandemic on their organizations and consumers. Nonetheless, the interviews and focus groups asked questions to determine whether providers and consumers had seen or heard of the results from the 2019 needs assessment. They also asked about changes made by providers and consumers' observation of changes.

Did providers and consumers hear or see the results?

Consumers who participated in the focus groups reported they were not aware of the results. Among providers, more than half had seen the report, or at least browsed parts that were relevant to them.

What changes did providers make?

Providers described some changes they had made after they read the results of the needs assessments. Others had made changes that were unrelated to the results, but consistent with the recommendations, nonetheless. One provider remarked that they engage in continuous improvement whereby when they see something that needs to be improved, they just do it. Some changes that were planned had to be put on a back burner due to COVID-19.

Rural providers outside of the Dallas EMA did not find the needs assessment to be helpful because it focuses primarily on the needs of populations they do not serve.

Reported changes based on the needs assessment are listed below.



Including clients more often in decisions about how services are provided. Involving them in decisions about grant applications.



Using the data to support grant writing. Shifting grants to specifically support *medical* case management.



Integrating primary care with management of HIV in a clinic to improve access and reduce stigma of visiting an HIV services only clinic.



Working across the EMA to reduce the eligibility burden with each agency having its own eligibility and clients having to do the same things multiple times creating undue burden. This is still a work in progress.



Increasing access and the number of new patients seen.



Doing research about transgender issues. Engaging in work on cultural humility and awareness. Changing forms to be more inclusive and include preferred name, as they are required to enroll people based on their legal names.



Providing full wraparound services with pharmacy and a full medical clinic. This includes Spanish-speaking services, including transcription services for others.



Implementing a Rapid Start Clinic. They were already considering it, but the needs assessment influenced them to move forward.



Adding an additional bilingual therapist.

What changes did consumers observe?

Consumers reported they have seen some changes since the 2019 needs assessment was completed, although they are not sure that they were related, or expressed that they were unrelated.



One clinic is open on some Saturdays and has evening hours.



Another clinic opened and there is more access in different parts of the city, including the southern sector and Fair Park area.



The Amelia Court clinic moved to the new professional building at Parkland. Staff have more resources and room to provide care.



The Community Health Center for Health Empowerment PREP clinic started HIV care because they were seeing so many come in for testing who were not getting into care.



Mobile testing units were out by nightclub locations in the Design District and Cedar Springs areas. They noticed a lot of people out and about participating in the mobile units.

How COVID-19 Affected Service Delivery

Changes made because of COVID-19

Some providers reported they did not miss a beat in transitioning to services during COVID-19. They mainly provided resources rather than clinical services and were able to continue providing meals, transportation, and other resources without shutting down for even one day. They did need to make modifications to how services were provided. One provider described a process where their consumers held their ID up to the glass door and bus passes were distributed through the mail slot in the door. They plan to soon replace this with a prescription window.

Clinics reported they limited their service capacity during the pandemic. The need for social distancing required that patients not sit in waiting rooms. Wellness screenings for staff and visitors were implemented, including contactless temperature taking. Patients were not allowed to come in unless they had appointments. Clinic staff reported that some patients who did not have access to technology wanted to come in for services. Others reported they still had people coming in for HIV testing. Saturday clinics were discontinued. In some instances, patients came in to give blood for testing, but follow-up visits were done via telemedicine. Clinics also used at home testing for sexually transmitted infections so they could continue to provide the service.

Many providers shared that they were forced to either close their doors at first, or throughout the pandemic. Administrative services especially transitioned to working from home. Resource centers were closed. Some services that were suspended temporarily were able to make needed adaptations and soon reopened and continued to provide services. A service provider reported that their consumers were still coming to the door, so they installed an intercom so they could talk to them safely.

Meal programs were forced to adapt as well. They transitioned from serving in-person, community meals to providing meals-to-go whereby consumers could come by and pick up their meals. Demand for meal services reportedly increased during the pandemic. Housing programs delivered meals to residents and whatever staff were on site pitched in and helped out.

Physical workplace adaptations were necessary to ensure social distancing and other precautions. Windows needed to be sealed and signs put up. One provider had patients go into the exam room where the doctor met with them virtually. Other adaptations included a time clock that measures temperature, new furniture that could be cleaned and spaced out better, desk shields and glass barriers, new air filters, and touch free light switches. Water fountains and snacks were removed. Van drivers were provided with Tyvek suits to cover them

completely, plexiglass dividers between driver and rider, and face shields and masks for themselves and masks to provide to their riders.

Dental services were forced to shut down completely until they could obtain proper PPE and other needed safety measures. Even after they opened, services were slowed. Dental providers saw some patients via telehealth. Although they were unable to receive reimbursement for those services, they continued to provide them.

Organizations that provide housing had many considerations. They were challenged with making changes to protect all residents. This required looking at all their policies and procedures, ensuring that residents adhered to public safety protocols such as mask requirements and visitation restrictions. There were challenges with residents visiting neighbors in their rooms in some instances. At the same time these providers continued to provide meals and other services. They did not have the option to close even temporarily or to allow staff to work from home. COVID-19 testing was performed regularly for residents and staff. If a resident tested positive, one provider reported they moved them to a hotel and delivered food to them to keep other residents safe.

Legal services transitioned to providing services over the phone. Legal papers such as wills still had to be signed in person with witnesses, so attorneys met with their clients and witnesses in outdoor settings like porches as a safer practice.

Telemedicine and Technology Solutions

The health care providers who participated in the interviews reported they were engaging in telemedicine. For some providers, little effort was required to make the change as they were already providing some services via telemedicine. These organizations had already started the transition before COVID-19 and it was one of their goals to make this change. Even though they were ready, they still reporting having some challenges along the way. This was especially true for their patients who did not have easy access to Internet or telephones.

Other health care providers who were not set up for telemedicine had to shut down as they took the necessary steps to plan and implement the services. Providers reported it did not take very long, two weeks in some instances, to prepare and change their service protocols. There were also expenses involved in making the change. In some instances, staff required training to implement telemedicine. It is difficult to provide services without headsets, and for some they were still on back order at the time they were interviewed in the summer of 2021.

Case management and behavioral health services also used telehealth services to deliver care and meet with their clients. For many, COVID-19 was very isolating, and they needed to meet face-to-face to the extent it was possible. Telehealth provided that opportunity. Ultimately, case management and behavioral health providers found that the ability to deliver services via technology was somewhat dependent on where their clients were and their individual needs. Legal services also found they were able to use technology to continue to provide services throughout the pandemic.

Telemedicine services allowed providers to bring services to patients in rural areas and in shelters. One challenge was that there are rural areas, and even areas in Dallas County where there are problems with cell phone reception and broadband access. Even providing wireless hot spots did not help if there was no broadband access. Another challenge was ensuring that the services they were using were compliance with the Health Insurance Portability and Accountability Act (HIPAA) federal law that was passed to protect sensitive patient health information.

An additional benefit for providers was that telemedicine did not require having staff on premises, which allows for infinite capacity as providers do not need to maintain or pay for office space for them. However, it should be noted that in some instances, providers needed to provide their staff with resources such as laptops and headsets so they could work remotely. There were also challenges when staff needed to scan and upload documents as all did not have access to the needed equipment.

Dental services set up phone banks with dentists on call 24 hours a day, seven days a week for their patients and for patients throughout the State of Texas. They were not allowed to bill for the services but provided them anyways. Medical providers reported lost revenues as they were not reimbursed at the same rates as they are for in-person visits. One reported losing 40% of their revenue due to providing services via telemedicine.

Providers cited benefits for consumers as being less stigmatizing as they will not be seen seeking care at HIV clinics. It is also more convenient, they do not need transportation, and can seek counseling more discretely if needed. The downside is the lack of technology capabilities and having to spend time educating patients. Some data plans do not support video calls. During the pandemic it allowed mental health services to continue as therapists were able to work from home to make virtual visits.

Consumers expressed mixed opinions about receiving care via telemedicine. Some consumers viewed it as a positive change to be able to visit with their doctors on the telephone or through their computer. Even those who expressed positive opinions still expressed that sometimes they liked or felt a need for an in-person visit with their doctor, but they liked the telemedicine option. Mostly, those who preferred telemedicine did so because of the convenience and time savings it offered them.

Others expressed they felt that virtual visits were forced upon them. Others missed seeing their doctors face to face. Some found telemedicine to be distracting as there was activity going around them as they tried to engage with their doctors. Others complained of longer wait times for when they had to wait for a callback. They felt the visits were shorter and they got less time with their doctors. They also felt the visits were less thorough and the level of care was not the same. They also found it hard to communicate without physical or eye contact.

Some were concerned that they had fewer blood draws. Others preferred in person in case there was a need for testing at the time of their visit. They could go straight to the labs or x-ray

when they visited in person. Telemedicine visits were difficult for newly diagnosed individuals as they were unable to get the support needed. Telemedicine was viewed by some as one more form of isolation that affected people mentally.

Perhaps the greatest challenge with telemedicine was for those who did not have access to the technology needed to access care online. Sometimes the visits were dropped if Internet connections were not good. There was more potential for miscommunication. Consumers who were not tech savvy had to learn to use features such as Zoom and MyChart to get access to their records and health information and it was challenging for some.

Some consumers who were less positive about telemedicine still saw some benefits. They enjoyed being able to talk to someone and having prescriptions filled more quickly. They also enjoyed not having to drive in traffic. They felt it should be retained as an option.

While telemedicine was the most prevalent technology solution applied, other technologies were also used. There was more use of electronic medical records noted both before and during the pandemic. Patients appreciated this because it gave them easier access to their medical records and allowed them to check for drug interactions. They felt their records were kept better. Medical providers are able to access their records across facilities. It reduced testing as doctors could see test results from prior tests.

One provider used an app whereby consumers could use it to click and send pictures of documentation they needed to submit. Then the provider could simply call or text to let the consumer know that the information was received. DocuSign was another frequently used technology solution to obtain signatures. Digitizing records made it much easier for audits as they no longer required the use of multiple large binders to share records.

Communications included email, telephones, and online conference platforms such as Zoom, Microsoft Teams and WebEx. Providers were able to provide support groups and continue Community Advisory Board meetings virtually each week. One provider stressed the importance of having cameras on during meetings and replicating the experience of being in-person where you can read body language.

Intake and Recertification

Intake and recertification were consistently described as problematic during the 2019 Needs Assessment. The amount of paperwork and requirements were described as barriers to care. The paperwork demands were described as burdensome by both providers and consumers. Intake information is not centralized, and recertifications are required on the consumers' birthdays and then every six months, including having consumers present paperwork and documentation. Individuals who are not housed or who have mental health challenges sometimes lose their paperwork. This not only burdens consumers but adds to the administrative burden on providers.

The pandemic required greater flexibility regarding intake and recertification processes. Providers were able to utilize emergency applications from the state and Dallas County for Ryan White and the state administered Part B AIDS Drug Assistance Program (ADAP). Providers relied on document pickup and drop-off or email procedures where they received documents curbside or at the front desk. Assessments were done over the telephone rather than in-person. Some providers used technological solutions for signatures such as DocuSign, others were able to allow verbal signatures. One medical provider is working to develop the recertification process through MyChart where patients due for recertification will be able to answer questions and upload information.

The timelines were extended, and the six-month eligibility requirement was extended. Consumers who were eligible in March of 2020 were eligible through December. There was more flexibility on paperwork due dates as well. Despite the easing of restrictions, providers struggled to get paperwork from some consumers who were noncompliant, which hurts them when they are audited.

As the intake and recertification process returns to pre-pandemic requirements, providers are feeling the burden. Some providers became more proactive with recertification processes. They called consumers who were due to renew to ensure they did so before their eligibility expired, and they lost access to services. Prior to COVID-19 the responsibility was on the consumer to keep track.

Consumers commented on how much simpler the easing of these procedures were for them. They liked being able to report their information over the phone and email pictures of documentation or copies of emails with information such as their electricity bills. They suggested that these procedures be retained as an option. Other consumers reported delays in recertification and people being taken off the rolls, causing multiple problems.

Policies and Processes Changes

Providers changed policies and practices to shift to allowing staff to work from home all the time, or at least part of the time. Some offices reported having rotating schedules for staff to reduce the number that were in their offices at the same time. This was especially important for a time when N95 protective masks were in short supply. Providers also reported taking turns coming into the office to scan documents.

Some providers reported a need to examine many of their policies and procedures and to write new ones. These included how to do verbal consent, notations, telehealth clinical documentation, signs that had to be posted, contingency plans, COVID-19 materials, messages to clients, state guidelines, COVID-19 testing, sexually transmitted infection testing, vaccine access, operational changes for safety, the use of PPE, human resources policies regarding illnesses, and an educational plan for vaccines. Providers in some instances described doing complete rewrites of former policies and writing all new policies to support necessary practice changes.

As new information came in, procedures and policies had to be changed. One provider described that “things were changing by the minute.” At the same time, providers were working to comply with requirements from funders. One provider created a COVID-19 guidance plan that was broken down by department. They also surveyed residents to find out how they felt about the regular testing and other changes and held virtual town halls so residents could question leadership and share information.

Providers adapted existing services to provide deliveries, bundle services so they were more coordinated. They created tracking mechanisms whereby they could determine changes in eligibility and track when recertification was due for clients.

How changes affected Service Providers

Changes impacted service providers’ staff positively and negatively. Administration, case managers and other staff were either put on rotation or shifted to remote work responsibilities. While many staff were positive about these changes, others experienced challenges. Staff who had children in the home were balancing the needs of home and family at the same time they were caring for consumers and meeting their work obligations. Some staff were forced to work remotely because of exposure to COVID-19 or family member exposure, others were forced to deplete their paid leave. There were also instances where staff lost family members during COVID-19.

Positive Effects

One positive effect that was described was that COVID-19 and the changes required made them look more closely at how they did everything, and question whether some things were necessary, such as required documents. As they revert to business as usual, they are continuing to re-examine the efficiency and effectiveness of process, and the necessity of some requirements. Providers expressed this as an opportunity for improvement.

Some providers viewed the need to innovate to manage during the pandemic as a positive impact. Some of the changes included drive through service delivery options whereby consumers did not have to leave their car to receive food. Tables were set up outdoors for people who did not have cars so they could walk up and pick up what they needed.

Some providers were able to add new staff that were needed on-site for services providing housing during the pandemic. One added a physician specialist to provide psychiatric services for residents with mental health needs when there are crises. The doctor meets patients in their rooms, so they do not need to go anywhere to receive services.

Organizations received funding to invest in newer technologies and processes that will be beneficial if something like this occurs again in the future. One provider was forced to digitize paper files and viewed that as an opportunity as they will move forward fully digital.

Providers saw fewer no-shows for telemedicine and telephone appointments compared with in-person clinical services.

One provider reported that Dallas County was helpful when they called on them. They provided guidelines and helped them to understand them.

Staff were forced to work remotely in many instances and found that they were able to work effectively from home when necessary. The result was even as services were reopening, many decided to maintain flexible and remote work schedules. This has had added benefits such as addition of new workstations and more parking availability. There is increased capacity to add more staff. There were still some challenges as staff at some provider organizations needed to set up systems to take turns so they could safely come into the office to scan and upload paper files and documentation.

The demands of adapting to the pandemic provided a learning experience for providers. Some were surprised that they were able to pivot as quickly as they did to accommodate needed changes. Providers were pleased with the extent to which their staff stepped up to meet the moment and do what needed to be done.

Negative Effects

Providers described negative effects of the changes they made during COVID-19 as well. In some instances, before COVID-19, providers served as sources of social support for consumers. While they were unable to provide in-person services, they were also unable to provide the level of support some consumers needed. They could not provide refuge to those who needed a safe space to visit when they were feeling lonely or experiencing mental health challenges.

Providers also lost some staff who were afraid to come to work during the pandemic and decided to leave employment and stay home. They have since been challenged with seeking new staff to fill positions, including clinical staff for medical and psychological services. Some providers lost a substantial number of staff who were burned out and rethinking work/life balance. Volunteer pools shrunk considerably during COVID, leaving providers with even fewer human resources. Staff training reduced as staff were working remotely and sitting at computer screens all day.

Clinics were not able to close all gaps in terms of patient care and quality of care as they cannot do everything over the Internet. Because of this, some patients discontinued care and they are working to get them back. Although, they are concerned that the resurgence from the Delta variant may once again force them to roll back services. Likewise, flexibility needed to manage during the pandemic meant daily huddles and regular meetings were discontinued.

While one service provider reported leaning on Dallas County, another expressed they felt Dallas County was not very proactive. They did not receive technical assistance or information about best practices. The county was late to respond to some of their requests and they

perceived the agency as inefficient. They felt the county should have met with every agency and assessed their needs. They felt the county failed them.

Safety precautions especially affected providers' ability to conduct outreach services, including presentations and testing throughout the community. Others who had contact with the public during this time were challenged by patients or others who did not want to wear masks.

Some providers lost funding from some sources during this time as well, although they continued to pay staff. Providers who receive funding on a fee for service basis lost substantial revenue as they were forced to cut back on the number of individuals served.

There were also expenses involved in preparing to meet safety requirements for re-opening. In the absence of mask mandates, providers needed to install safety shields, purchase masks, sanitizers, and face shields for staff and clients, and make other structural adaptations in order to ensure staff and consumer safety. They had to expand janitorial services to provide daily sanitation of the entire facilities.

Providers also noted that the work toward implementing changes from the 2019 needs assessment had to take a back seat to COVID-19. It still is as the pandemic was resurging with the Delta variant at the time of this report.

Dental services experienced negative effects from the COVID-19 pandemic. They were forced to close for a substantial amount of time by the State of Texas Dental Board and CDC guidance. They experienced a backup of new patients and slow down in completing treatment plans. They are still working to catch up on referrals as they receive at least a dozen new referrals per day. They may be unable to accommodate them for months. Even after reopening, CDC, ADA, and clinical leadership allowed them to only do certain types of treatment. They underspent their grant funds in 2020 and this year are still advocating to get the funding back as they are increasing services once again. Some providers have not been able to accept any new patients at all. They have unused space but are unable to hire staff to use it. This was true before COVID-19 to some extent and is a greater problem with increased demand for services.

Some providers reported that some of their clients died during COVID-19, and some lost staff members. Some lost as many as 30 clients that they were aware of and suspected there were more. They were unsure if PLWHA were disproportionately impacted by the pandemic and were curious to know whether that had been examined. It created additional stress on staff who had relationships with those who were lost.

How changes affected consumers

Consumers described many changes that worked well for them during COVID-19. One was the requirement to remain at least six feet apart. This required limited access and resulted in less crowded waiting rooms and shorter wait times. Clinics stopped walk-ins as well, relying on an Urgent Care line whereby a nurse assessed the urgency of their need and scheduled a same-

day appointment only if it was necessary. Additionally, once things started opening again some consumers found that getting most care and surgeries done was easier.

Some of the consumers generally liked the virtual visits and hoped they will continue. They determined that they like being able to decide for themselves if their needs require an in-person visit. A consumer shared that some doctors required a negative COVID-19 test before they would allow for an in-person visit. They saw this safety measure as positive given that if medical staff became sick from COVID-19 they would be shorter of staff. Patients who tested positive for COVID-19 were told to go to the emergency room where they were equipped to handle it.

Consumers commented on how helpful and supportive many services and individuals were throughout the pandemic. One consumer who volunteered some time with an agency reported that the agency has asked them to become more involved. Another described how a service provider reached out to them every month to see if they were mentally okay and taking their medications. Not only were services helpful, but in some cases, consumers commented on how helpful other individuals were during this time. A consumer commented on how they reached out to another individual who told them about Abounding Prosperity and how helpful that was.² Another commented on how the pandemic provided an opportunity to meet many phenomenal sisters and brothers.

Consumers described some ways that services during COVID-19 could have been improved. Updating websites with current information would have been helpful. Consumers often start their search for information by using search engines such as Google or Bing, and they provide links to websites. They also go to social media such as Facebook to seek information about hours, services available, and how to access clinics. When information was not current, consumers remarked that they were unsure whether to go for their medical care or not, having to call in or rely on word of mouth from other consumers.

When consumers did call in, they were often confronted with a series of recordings asking them to push buttons, and then were put on hold. This was true for all service providers and compounded the stress of seeking information. They recommended some Ryan White money be used to hire staff to answer phones in person. If this is not a possibility, if consumers are placed on hold, they shared that it would be useful to know the hold time, or to be able to leave their name and number for a callback.

Consumers also cited problems with services during COVID-19. Some felt they were put off as they were scheduled for appointments and then cancelled. They commented about customer service not being as good as they would have liked. One consumer who was hospitalized complained that a nurse treated them rudely and then left the door open when the individual was cleaning themselves, violating their privacy.

² Consumers cited Naomi Green and Helen Turner as two individuals who were especially helpful to others throughout the pandemic.

Some consumers described a need for more health care services availability during COVID-19. They described situations where they felt sick yet had to wait to get an appointment. Access to medical services was limited, and some found it upsetting that they were sent home if they showed up at a clinic with a cough or fever since that is where they should be getting medical treatment for it. One visited their HIV doctor in person for an hour and a half, only to inadvertently find out later that the doctor had COVID-19. Notably, this doctor was not a Ryan White provider.

Some consumers who used telemedicine services expressed that they spent much of the time talking with nursing assistants and did not feel they had adequate time with their doctors who know them and their medical needs better. They felt like they have the relationship with their doctors, but the nurses and medical assistants only know them on paper.

While consumers who resided in an apartment complex specifically for PLWHA were homebound due to COVID-19 precautions, a large storm occurred, and they were left without electricity and water for days. They felt there is a need to prioritize community housing such as theirs for restoration of basic services given their medical vulnerabilities.

Service Delivery Models that will be Retained

The most frequently cited new service delivery model that providers reported they would adopt and retain is telehealth for both clinical and case management services. One provider will be giving patients tablets so they will be able to participate in telehealth. They reported being able to see more patients and higher show rates. They will also explore the potential of additional virtual services, such as social support groups and behavioral health. Virtual services save patients transportation time and addresses transportation barriers.

Providers reported they will continue to hold some meetings virtually. One provider that transitioned to digitizing all documentation and calendars plans to continue the practice and further develop digital content management and other systems. Phone appointments and telephone case management will also be continued as needed. Residential services will continue to provide workstations for residents who lack access to computers and tablets.

More flexible work options such as remote work and flexible hours will be retained by some providers.

Drive through services may be continued in some instances, especially for those who remain uncomfortable entering buildings and having closer interactions. Providers also received funding to purchase gift cards and hand them out to consumers to help with needs during this time. They plan to continue the practice for as long as they are able.

Not all providers reported they will be maintaining COVID-19 practices. Some expressed eagerness to return to providing services as they did before the pandemic.

Lessons Learned about Service Delivery from Managing COVID-19

Providers shared a number of lessons they learned from managing their responses to the COVID-19 pandemic. A provider shared that they learned that the things that were on their wish list with reasons why they could not do them could, in fact, be done. They merely required the right person in the organization to say “yes,” and the mind shift COVID-19 forced them to have. They questioned why consumers were required to come in person twice a year to recertify their eligibility. They now do not understand why this is considered necessary. The same was true for Ryan White billing procedures as they appreciated the ability to email a spreadsheet. Providers are hopeful that change will be retained.

Being open to change was also cited as a lesson learned. Being more flexible and understanding the importance of communication with everyone was also stressed. With prior change efforts there was constant evaluation of options and resources and adoption and implementation of the changes never moved forward. COVID-19 forced the changes. Communication modes among staff have increased to incorporate technology, more cell phone communication.

Providers learned that when they put their mind to accomplishing something they can find a way to make it happen. COVID-19 improved service delivery models, created more options, allowed providers to serve more people. Providers learned that they are adaptable.

The importance of in-person socialization and human interactions was recognized. Providers recognized how important services such as community meals and provision of spaces where consumers can rest, play, get hugs as needed, and gather is for their well-being.

Trust between administration and staff and between providers and consumers is important. Administrators found that staff will be productive if they work remotely. During the period when staff worked remotely they completed their work and delivered services. Additionally, traffic and smog and other environmental effects of commuting were reduced. On the other hand, the extensive screen time from using Zoom and other online technologies can be draining. Patients will also do what is needed and are deserving of trust as well.

Unit and cost-based services do not always work well. Providers are paid if clients or patients show up, but are not paid if they don't, even though they have allocated the time. No-shows result in lost revenues creating budgeting challenges.

Engaging in more technology-based services will require hybrid models to accommodate those without access to Internet and required devices, and those who are not technologically savvy. Many clients have embraced changes to doing what is needed by technological means as they are able, and others have not.

How COVID-19 Affected Access to Medications

Impact on timelines and access

The transition to telemedicine created some delays for consumers to get prescriptions filled and medication changes, but nothing substantial. Bureaucratic processes sometimes compromised patients' access to life-saving medications. One consumer reported needing an inhaler, but because their prescription had expired, they had to wait and make an appointment at a time when they were experiencing substantial breathing problems.

Some consumers found it burdensome when they went to get medications and were asked for identification before they could receive them. Others felt that it is becoming more and more difficult to get their medications, and it sometimes took too long. They were denied their medications if there was an error. Since the clinic moved from Amelia Court to the professional building at Parkland, patients found they have to walk further and endure more complications to get their medications filled. Consumers commented on the long wait times to get prescriptions filled at Parkland. Sometimes when consumers went to get medications (from Parkland and other sources), the medications were not available, and they had to make a second trip.

Providers also reported challenges with the "patchwork" system through which some PLWHA get their medications. In these cases, they may get HIV medications through the ADAP program, but other medications from Parkland and other sources. Getting all of the medications they needed was challenging, especially in regard to them getting a 90-day supply.

Others expressed that some people were not getting medications at all during the pandemic, including needed medications for mental health care. One of the consequences was that consumers reported knowing individuals who were sharing their prescription medications with others or obtaining medications through the black market. In one instance, a consumer was able to receive needed medications only after a provider intervened on their behalf.

Access is also limited in instances where certification or insurance preauthorization is delayed. Ryan White took longer to confirm eligibility through Austin sometimes which complicated the process. Providers reported backlogs at ADAP. There have been changes regarding access for some medications. Some medications were dropped from the Texas Department of State Health Services formulary, including medications for breathing and high blood pressure. Consumers were told it was so that they could concentrate on them receiving their HIV medications, without considering that not having those medications available will exacerbate their HIV care needs.

There were some positive experiences with obtaining needed medications. Consumers reported in some instances that they were able to have medications delivered at no added charge. However, one consumer reported that their family was picking up their medications for them during the pandemic and they were never told about delivery services. Too often information

was shared via word of mouth among consumers as providers did not pass the knowledge on routinely. Deliveries were also difficult to access for individuals who live where the entrance is gated. Medications sent through the mail were sometimes delayed or never received. Consumers commented on how much easier it was when they were able to get a 90-day supply of their medications.

Some consumers commented that COVID-19 had no impact on their ability to get their medications. Some providers also did not perceive any impact from their perspectives. In some instances, patients had clearly not shared their challenges with them. In other instances, they did not provide services relevant to access to medications. One provider reported having worked closely with their patients who were on the ADAP program to ensure there were no medication delays through the emergency application process and time extensions.

Impact on adherence to protocols

Inability to access medications when they were needed sometimes interfered with adherence to protocols. Consumers reported they missed some doses, which could potentially have negative impact on their health.

Transgender men and women reported having challenges with accessing hormone therapy. As a result, they went without them for some time and suffered ill effects. They commented on how the bouncing back and forth can potentially endanger their health. They also commented that obtaining needed hormones is easier in Dallas County compared with some other urban areas throughout the state. Transgender individuals residing in rural areas are especially challenged with getting the medications they need.

Impact on Underserved Populations

Providers reported some challenges that persist across all underserved populations, especially among individual with lower incomes. Some were COVID-19 related, others persisted since before COVID-19. Perhaps most challenging for providers was their inability to conduct outreach to underserved populations during the COVID-19 pandemic. They networked among themselves and were able to refer existing consumers, but they were not able to reach individuals who were not yet diagnosed or newly diagnosed. Some outreach during COVID-19 was conducted virtually, but underserved populations often lack technology needed to interact in this manner.

Access to services for all underserved populations proved to be a challenge before and during COVID-19 for many reasons. Multiple factors can affect access, including geography, employment requirements, family obligations, availability, and finances.

Transportation was a major challenge for PLWHA before the pandemic as identified as a barrier to care during the 2019 Needs Assessment, and then the need was exacerbated during COVID-19. Those who do not have private vehicles must rely on public transportation such as the bus

or the DART Rail. These options are often crowded, and other riders may not take proper safety precautions such as distancing or wearing masks. Being in an enclosed space close to unmasked individuals posed a major health risk for everyone, but especially those who are immunocompromised. For many PLWHA, this meant they were unable to travel freely to reach services to meet their needs.

Those with transportation challenges were also limited in accessing childcare services. Although they may have been available, they were unable to safely travel to drop their children off. Transportation safety concerns also created challenges for maintaining employment as for many, public transportation is their only way to get to their workplace. Many underserved PLWHA are already challenged with maintaining employment if they are not healthy because of the need to more frequently take time off to seek care.

Underserved populations often lack access to technology or the Internet. Many rely on public spaces, such as the library, when they need to use a computer or go online. With libraries closed their access was cut off. While some were able to transition to use smart phones, there were still many others who did not have phones that would accommodate telehealth visits or other virtual services. For example, one provider reported that government-issued phones are flip phones and do not accommodate video calls. Even individuals with smart phones were not always able to use their email to send documents or do other tasks that require a tablet or computer.

Many Ryan White recipients work hourly wage jobs and as service workers. Their hours were cut during COVID-19 which had a negative impact on their finances. Individuals with lesser incomes generally do not have access to credit cards, which are necessary for having food delivered, which meant they were forced to leave their homes and enter public spaces to get food and other basic needs met. Grocery delivery and Amazon, which so many individuals who have adequate resources relied on during the pandemic, were not options for them.

PLWHA were high risk during COVID-19 which forced some to leave their jobs. Others were concerned about sharing their diagnosis with their employers so they could more easily take care of their health needs during this vulnerable time. There was a reported increase in employment discrimination during this time as employers tried to force them back to work while they were high risk.

Affordable housing was identified as a need in the 2019 Needs Assessment and continues to be a challenge for all underserved populations. They were challenged with maintaining housing and meeting other basic needs before COVID-19, and even more as their income fell after COVID-19. While there was a moratorium on evictions, rent assistance and other help available during the pandemic, as the pandemic assistance is coming to an end many are behind in their rent payments and at risk of being evicted.

COVID-19 restricted in-person connections and isolated individuals. Many of the elderly who have been aging through the system were especially affected as they were "locked in" and unable to engage in social interactions that were important for their well-being. They were most

vulnerable given both their age and being immunocompromised. Loneliness is associated with poorer health and well-being. Providers expressed concern about consumers being re-traumatized with the stigma of the COVID-19 virus and memories of the stigma of HIV.

Black Men who Have Sex with Men (MSM)

Black MSM reported some of the same issues that were identified during the 2019 Needs Assessment. These included access to services and negative provider interactions. Their issues were less COVID-19 related than they were ongoing from before the pandemic.

One prevalent theme was a sense that they were not being provided access to the same types of services. They commented about differential referrals whereby they see others sent to the higher quality “Neiman Marcus” services and they are referred to the “K-Mart” services by the same referral systems.

There is also the perception that as people of color they do not get the same access to health care services, even if they have insurance. The services are often not offered to them. One focus group participant described an incident where he showed up in the Emergency Room of a local hospital without identification and was treated as indigent. Once they found his insurance, they started doing more to care for his needs.

They described the racial disparities with HIV services as “alive and well.” The level of service they receive depends on who they talk to, who is at the front desk, who answers the phone, or just who is there when they walk through the door. Too often the staff at the HIV services organizations, case manager, and people in management positions are not people of color and/or do not have HIV, so they have no idea what their lives are like.

Providers expressed challenges in Black and Latino communities where stigma is highest. It continued to create problems with getting people to be tested and getting HIV positive individuals into care. This is especially true if they are receiving services at places where there is a risk of being identified as HIV positive from being seen there.

Providers reported they had more challenges reaching young Black men. They did not connect or remain engaged virtually. Their program is built around personal interactions and social support. Another provider noted that their services are not located in an area close to where many of the Black PLWHA reside, which requires them to use public transportation to reach them. They did not see many Black PLWHA during the pandemic because of this. Alternatively, another provider who has a site focusing on young Black MSM maintained a peer navigator, case manager, and client advocate and reported that they were able to keep their participants engaged.

Black Women

Black women reported that they have not seen many changes since 2019. Some things were described as having gotten a little better, but the structural inequities continue, and were exacerbated by COVID-19 when everything stopped. There are still issues with the systems of care as described in the prior needs assessment. They felt that not enough was being done. Staff and clinicians still require more education and training (as was identified in 2019). They were described as “not knowing the difference between cultural humility and cultural competency.” There is a need for better communication and true transparency among providers.

The need for representation with more Black women at the table when policies are developed was reiterated by this group. They requested that not only should Black people be at the table, but they should be “effectively” at the table where they are being heard. Too often policies are developed and then presented to consumers to authenticate, and then the policy makers claim they sought input. They are not seeking input throughout the development process where they should be bringing people into the talks during formation. Staff, community members, and everyone should be provided training so they can more effectively engage in these processes.

Black women also described problems with being able to trust some of the doctors they have seen. This was particularly true with some of the clinics as compared to having their own private doctor. They described instances where they have found important health information was withheld from them, including their diagnosis. They also described being given medications for mental illness and sleep problems by physicians who did not even discuss the medications, their purpose, or why they were prescribing them. Policy for the services they receive allows for virtual visits after one in-person visit per year. The women who participated in this focus group expressed that this policy did not always provide them with opportunities for in-person visits when they felt they were necessary. They described the clinics as being like musical chairs – if the music stops some are left out. Black women described a need for improved peer support and social systems that they could rely upon to share information with one another.

Transgender Men and Women

Challenges identified in the 2019 Needs Assessment persisted and were amplified in some ways by COVID-19. Transgender individuals in both focus groups shared that they still encounter disrespect from service providers. Members of one group expressed feelings of disenfranchisement among the LGBTQ community and feelings that even they are unable to relate to their needs and challenges.

Maintaining employment is challenging for many transgender individuals due to discrimination. Some transgender consumers described having their hours cut back and enduring disparaging comments from supervisors. Discriminatory behavior and disrespect were described as especially problematic for those who transition while they are at a workplace as co-workers failed to understand or accept their change.

Transgender men described getting little attention in comparison to transgender women. They felt a need for more attention to their issues as well as more visibility. There is little representation of transgender men, and they have little opportunity to meet or socialize with other transgender men, thus, they and their specific needs are relatively invisible. They expressed interest in someone providing groups where they could safely gather. They have observed instances where transgender men get their hormones from others because they do not feel comfortable or safe seeking them from other sources.

Transgender women expressed continued fear of speaking out given the number of transgender women who have been murdered. They are being killed simply for being themselves which has pushed many transgender women into hiding. Dating can put them in precarious situations and one consumer expressed the importance of letting men know she is transgender up front so there are no questions later, and no chance of a misunderstanding that can later put her in danger.

Transgender consumers noted that for any transgender woman or man, unless they can pass without any questions, that they are transgender is the first thing many people see. They described being “looked at by genitals rather than who they are.”

Another challenge they confront is with their names. Many who have not yet had their names legally changed face discomfort when attending events where their government name, rather than their chosen name, is placed on name tags or used to identify them. They are often put in the position of explaining their names and chosen pronouns. Some people continue to call them by their government name or the wrong pronouns, which they view as clearly and purposefully disrespectful.

Some providers have services specifically for transgender consumers, including a transgender clinic. Others reported they are working to improve in this area and offer more specialized services, including affinity groups. Legal services reported an increase in transgender individuals coming forth for name changes and they are offering that service.

The individuals participating in the focus group for transgender men and women were asked for input regarding how the Ryan White Planning Council could encourage and obtain more engagement with representatives of the transgender community. Suggestions were:

- Get into the community and meet with small groups. Ask members to tell a friend, and then another friend, and use word of mouth. Provide food and hold sessions in the evening. Or consider sponsoring lunch or brunch.
- Promote a sense of safety among participants.
- Host mini-conferences with topics of interest.
- When people engage, make sure they are honestly engaged and participating. And when people engage and participate, continue to make them feel welcome and valued.
- Go to where transgender men and women gather rather than asking them to come to where you are. Meet them where they are.

- Host meetings via Zoom whereby transgender individuals can talk, vent, ask questions. Really listen to their frustrations. Ensure their voices are genuinely and completely heard.

Hispanic and Latino/a Men and Women

Concerns described in the focus group with Hispanic/Latino men were generalizable to the entire Hispanic and Latino/a population or the larger population of underserved PLWHA. They described transportation and other problems consistent with those other groups are facing as well. Many of the challenges that were present before COVID-19 continued and were exacerbated by the pandemic.

For Hispanic and Latino/a PLWHA, language barriers continue as there are still too few Spanish speaking case managers and other providers. Focus group participants reported one Spanish speaking case manager available to them and insufficient Latino/a representation among services. They also stated that the providers have acknowledged the problem and are working on it.

Service providers admitted to difficulties keeping the Latino/a community engaged because so many were essential workers and continued to work. It was difficult to engage them virtually while they were at work. Many did not have access to the technology needed to engage virtually, which affected services to them.

Language barriers were challenges for service providers. They often used language lines to translate for telemedicine appointments. Some have Spanish speaking staff, others described difficulties finding bilingual service providers given the rate they can afford to pay. Spanish speaking professionals are often in demand so they are able to choose higher paying jobs.

One provider whose center holds groups for Latina women was challenged as they were unable to continue meeting. They were also unable to continue outreach to the Latino/a communities.

Youth

While we were unable to gather information directly from youth via the focus groups, providers provided some insights into challenges experienced by youth. One provider reported that they have youth who visit multiple times per week for peer support and interaction. When they closed the doors during COVID-19 that option was no longer available to them.

Another youth services provider experienced a decline in retention. To date, they have not been able to bring the youth back, as they perceived they were taking advantage of restrictions against leaving their homes. This was reinforced by another provider who reported they did not see many newly diagnosed consumers and youth. They are challenged with where to go to give them needed information.

Other Underserved Populations that were Identified

Providers mentioned other populations that were underserved in addition to those identified in the prior needs assessment and for this interim project. Further information is provided about them below.

Rural Populations

Rural populations were described as having challenges as well, especially access to services and medications. One provider requested tablets for their consumers living in rural areas so they would be able to engage in telehealth on a regular basis. Transgender individuals residing in rural areas face additional challenges as they often do not have access to needed hormones.

Uninsured

Sometimes uninsured individuals are challenged when seeking health care services outside of the Ryan White system, such as emergency medical services. There is the perception that when they are in an emergency room or similar situation the medical providers slow down what they are doing and offer less care depending on the ability to pay.

Incarcerated Individuals

There was little opportunity for outreach to incarcerated individuals during the pandemic. Providers were unable to reach them with education and resources.

Unhoused PLWHA

Several providers mentioned challenges serving the unhoused population during COVID. Outreach services were curtailed during this time, and many individuals who are unhoused lack technology or even basic telephones. One provider developed a relationship with the police to help to find them. They dropped off food and other needed supplies, including hygiene packs, to shelters where they knew their unhoused participants were staying.

Unhoused individuals were challenged during COVID-19 as shelters were forced to cut their capacity to meet public health recommendations. More unhoused individuals were referred for permanent housing during this time.

Current Unmet Needs

Consumers and service providers described many continuing and new unmet needs. Many PLWHA still have problems getting their most basic needs met. Clothing is a need for many women. They described a need for a clothing store where they would be able to obtain what they need. Access to healthy food is problematic for those who are living in food deserts. They expressed a desire to be able to eat better to help control cholesterol and diabetes. Resources

for exercise are also inaccessible for many PLWHA, which has made it difficult for them to maintain a healthy weight. As long as COVID-19 continues to threaten health, money for effective masks and other personal protective equipment is needed.

Many PLWHA are challenged with finding jobs or getting better jobs. Some lack job search knowledge and skills and others need more education. Getting a job sometimes requires having enough money to prepare a professional resume, dress for interviews, and pay for other self-presentation related needs to be more competitive in the employment market such as a good haircuts, makeup, and dental care. Many were denied unemployment and needed help with appeals. Others needed assistance with accessing other funds that were available through the stimulus packages. During COVID-19 many consumers left their jobs that required them to interact with the public. It was too high risk for them, especially prior to the availability of vaccines. Some also felt uncomfortable disclosing their status to employers to be able to take extra precautions needed.

While Ryan White provides funding for dental services, there is still not enough dental care available. The services that are available are often overloaded. Providers described a need for payment and arrangements with private dentists to treat patients. Limitations on the ability to provide dental services throughout the pandemic and added precautions has resulted in delays and appointments being pushed back.

Housing continues to be a challenge, especially with the current housing market whereby prices and rents are continuing to rise. Housing for individuals and families with moderate or low incomes has long been in short supply. Now it is becoming in even shorter supply and making it increasingly difficult for many to find or maintain housing. Housing assistance has been available during the pandemic, however individuals whose incomes exceed guidelines but have expenses from medical care and other needs are unable to access it.

COVID-19 was of such urgency that other medical problems took a back seat throughout the pandemic. Primary care physicians did not always provide enough quality time to get questions answered. They felt a need for better communication between themselves and medical staff, with added focus on their quality of life.

The isolation and fear of contracting or transmitting COVID-19 left some consumers with mental health problems, such as anxiety and depression. Consumers described the period as very stressful as they had to make so many adaptations. Providers also noticed increased stress and mental health concerns among those they served. The isolation was especially harmful for those who already had mental health challenges. One provider noted having to do three mental health warrants for consumers who were in a psychotic state.

Transportation continues to be a problem, especially for those who do not reside or work in areas where public transportation is available. They are forced to rely on private modes such as Uber, Lyft, or cab fare which can be expensive. Even simple errands such as trips to the grocery store or pharmacy became expensive. As many whose incomes are near or below poverty levels or those who have experienced credit problems from mounting medical bills or other financial

challenges lack access to credit cards, delivery was not an option. Those who reside in areas where public transportation is available found it risked their health given crowded conditions and the number of riders who did not wear masks. Consumers requested they be allowed gas money in lieu of bus tickets.

Transportation challenges also persist for PLWHA who have disabilities, such as those who are unable to walk. Providers were reported to recommend transportation services that are not accessible even after they are told about the disabilities. In addition to providing transportation, there is a need for assistance with tasks such as shopping, such as someone to help carry everything back to their homes.

Learning about what services and assistance is available is still challenging for many PLWHA. Information is seldom volunteered and obtaining complete and accurate information is often challenging. Many currently rely on knowledge being passed from others, which is an entirely random process. Consumers recommended a centralized resource guide that continues to provide current information. Consumers voiced a need for resources available in a single location where they would be able to get all their needs met. This would reduce the need to provide transportation to multiple sites and would make it easier for those who need information about services.

Experience with Vaccinations

Successes with Vaccinating PLWHA

Providers made many efforts to ensure patients were vaccinated. PLWHA were considered priority. The providers reported having much success with the populations they served. They provided on-site vaccination clinics, transportation to vaccination clinics, and providers also connected them with appointments, accurate information, and ample encouragement. Some attended special training to learn how to encourage people and get past hesitancy. Most reported all or nearly all their staff were vaccinated. Many reported higher than average vaccination rates among those they serve. Nearly all the consumers who participated in the focus groups were vaccinated.

Challenges with Vaccinating PLWHA

Providers reported that challenges with vaccinating PLWHA were no different than those being reported for the general population. These include mistrust, misinformation, hesitancy as they wait to see how others react, and questions about safety and efficacy. There are especially challenges with individuals with mental health problems. Providers reported they are promoting vaccinations, and even giving gift cards to staff to ensure they are fully vaccinated.

Some consumers expressed vaccine hesitancy. One consumer was hesitant to get vaccinated until they decided to get it so they could access services. Others expressed a need for more accurate information to be spread. They described many people they knew who were afraid of

the vaccine or feared the side effects. They heard stories of people who fainted or died from it. Consumers in one group admitted they knew more people who died from COVID-19 and reported they lost many friends, acquaintances, and family members to it.

Impact of the Vaccination on Consumers

Many consumers reported that receiving the vaccination gave them some peace of mind. It increased their comfort level with going to more crowded places, although they still wear masks and socially distance from others. It has allowed them to reduce their isolation. Consumers reported they are still avoiding unvaccinated friends and family members, even with the vaccine.

Some are still hesitant to go places and wear masks near all people, reporting they are still as afraid of COVID-19 as they were when it first came out. They feel that having HIV makes them much more vulnerable, even with the vaccine.

Some consumers reported they experienced side effects, such as a sore arm or tiredness from the vaccine but were still fine. Consumers who reported they had COVID-19 described much more discomfort from the disease such as pain and chills compared with getting the vaccine.

COVID-19 Impact on Other Vaccinations

Some providers expressed that COVID-19 had taken over and they heard little about any other vaccines. Others reported that their clients received all the needed vaccines. Medical providers reported they administered a high number of flu vaccines and had no challenges convincing people to get it.

Suggestions

Providers and consumers reported that access to services remains a challenge for all underserved populations. Consolidation of more services is needed (clinics, pharmacy, food, dental, housing assistance) so that underserved populations can go to only one provider instead of several. Also, if someone has multiple appointments at multiple organizations, that can interfere with their ability to obtain and maintain employment. More flexible services with after hours and weekend availability are needed.

In addition to time and geography, access to some services is limited culturally. Some consumers expressed they have received poor service and others feel the services are not culturally accessible having experienced microaggressions from staff. Cultural humility training and creating a culture that is accepting and comfortable for all individuals is important, especially when serving vulnerable populations such as PLWHA.

Consider exploring transportation alternatives to public transportation that is crowded and unregulated for safety precautions in the event there is another pandemic or similar threat posed to PLWHA.

More case managers who have HIV and are persons of color are needed. More efforts need to be made to recruit more case managers to resemble the population they are serving. If there are too few qualified individuals available, consider investing in supporting individuals to obtain their Community Health Worker certification. This minimal investment would go far to increase the pool of available workers.

Future Needs Assessments

When asking questions about housing needs, be sure to ask if they are already in a program funded by HOPWA or Ryan White. This is important because it substantiates the continued need for housing support. If a disproportionate number of individuals who are housed through these services respond to the needs assessment survey and report they have no needs for housing, the result may be interpreted as less need for these programs, although there is clearly still a high need.

Consider expanding the focal populations for future needs assessments to include representation from rural populations. In the 2019 Needs Assessment and for this one, large portions of the EMA were not represented. Also, it is important to more fully incorporate the Sherman-Dennison EMA which also represents a large, mostly rural population.

Finally, begin conducting outreach to underrepresented populations as soon as possible to prepare for the 2022 needs assessment. Work to engage the consultant who will conduct the assessment soon to provide sufficient time for outreach and relationship building ahead of time. This will ensure a more participatory process by more individuals and more underrepresented populations for more accurate and representative results. The Request for Applications should go out no later than October 2021 to complete the needs assessment by the end of January 2023.

Appendix A: Key Informant Interview Protocol

RWNA-Mini Key Informant Interview Protocol

Introduction

Thank you for agreeing to talk with us today about your experience with providing Ryan White services. My name is Dr. Susan Wolfe and I have been asked by The Ryan White Planning to speak with you about your experience.

This interview is part of a mini-needs assessment. The Ryan White Planning Council's Needs Assessment Committee will use this information to inform future work and for quality improvement.

Before we get started, I want to let you know that:

- ✓ We appreciate your time and honest opinions about these topics.
- ✓ You do not have to answer any questions that make you feel uncomfortable, and you can stop or even leave the call any time you want.
- ✓ The information you provide today will be confidential. The information will be shared with The committee, but you will not be personally identified.
- ✓ I would like to record the conversation today just so I can go back and make sure I have captured your thoughts accurately. I will erase it as soon as I write a summary of the main points from today's talk.

Do I have your permission to record this conversation?

Do you have any questions before we begin?

Let's start by talking about the 2019 Needs Assessment.

1. Did you have an opportunity to read or hear about the results of the needs assessment?
 - a. (If yes) Did you make any changes in your organization or to your services based on the findings?

Now I would like to learn more about how COVID has affected your organization and services you provide.

2. How did COVID affect your service delivery?
 - a. What changes did you need to make because of COVID?

- b. How did COVID impact your organization and services. Please share both good and bad effects.
 - c. How did COVID impact your service delivery processes, or how your services are delivered? Specifically:
 - i. Did you engage in telehealth or telemedicine?
 - ii. Was there any impact on timelines for medications?
 - iii. Did you change intake processes?
 - iv. Was the recertification process changed?
 - v. What other processes changed?
 - vi. What policies were changed?
 - d. Did you adopt new service delivery models?
 - i. (if yes) Please describe them.
 - ii. (if yes) What features of the new service delivery models do you plan to retain when you are able to return to business as usual (if any)?
 - e. What did you learn about service delivery from your experience managing COVID that can be useful for you or for others to know as you move forward?
3. How did COVID affect your ability to respond to needs and conduct outreach to each of the groups that I will name?
- a. Black men who have sex with men (MSM)
 - b. Transgender individuals
 - c. Hispanic/Latinx women
 - d. Hispanic/Latinx men
 - e. Black women
 - f. Youth
4. Based on your observations and experience, what challenges have you seen among the underserved populations I described? (*probe for each of the groups if they are relevant*)
- a. Please share challenges that have persisted since before COVID?
 - b. Now please share challenges that were specifically related to COVID?
5. Based on your observations and experience, what successes have you seen or heard of in regard to vaccinating PLWHA?
6. Based on your observations and experience, what challenges have you seen or heard of in regard to vaccinating PLWHA?
- a. Has there been COVID related impact on other vaccinations, i.e., pneumonia and flu).

Thank you for taking time to talk with me today and sharing this information. Is there anything else you would like to talk about or share before we end the interview?

Appendix B: Focus Group Protocol

RWNA-Mini Focus Groups Protocol

Introduction

Hello. My name is Susan Wolfe and I am working to gather information for an interim Ryan White Needs Assessment. As part of the information gathering, we are doing a series of focus groups like this one to gather information from people living with or affected by HIV/AIDS. It is important for you to know that whatever you say in this space is confidential. We will not be reporting on who participated in the focus groups, nor will we be sharing any information that will identify you. Your responses will be analyzed with the responses from all groups and used to identify and report on service needs. Before we start, it would be helpful to get to know each other a little. Can you each please tell me the name that you want to be known by here?

Now, I would like to ask if I have permission to record this session. These recordings will be heard only by me and they will be protected on my secure drive.

Do I have your permission to record this conversation?

Do you have any questions before we begin?

- 1. What changes did you see in prevention and care that can be attributed to the needs assessment findings (if any)?**
- 2. How did COVID affect your access to prevention services and care, or access of people who know?**
 - a. How did it affect access to medications?**
 - b. How did it affect adherence to medication protocols?**
- 3. How did you or people you know experience changes providers made to adapt to COVID?**
 - a. What worked well?**
 - b. What could be done differently?**
- 4. Have you received a vaccination, or do you plan to receive one?**
 - a. (If yes) How has this affected your life?**
 - b. (If no) Why not?**

5. What needs do you still have that are not being met? (*probe specific to each group, based on needs and challenges identified from the last needs assessment*)

Questions to ask both youth groups

6. What are their concerns as young people?
 - a. The Ryan White Planning Council would like more involvement of youth (ages 13-24). What do you think might be a good way to get youth interested in participating?

Questions to ask high-risk youth not living with HIV

7. What ideas do you have to reach out and encourage more youth to be tested for HIV?
 - a. What do you think keeps them from being tested?
8. How much do you know about PEP and PREP?
 - a. Where do you usually get your information about sexual health?
 - i. Do you feel like you know all you need to know, or would you like resources for more information?

Questions to ask Transgender group

9. The Ryan White Planning Council would like more involvement from the Transgender community. What do you think would be a good way to engage with Transgender individuals and bring them to the table?
 - a. What are the barriers to engagement?

Thank you for taking time to talk with me today and share this information. Is there anything else you would like to talk about or share before we end the focus group?