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

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Dallas County Ryan White Planning Committee
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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/HDSA 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

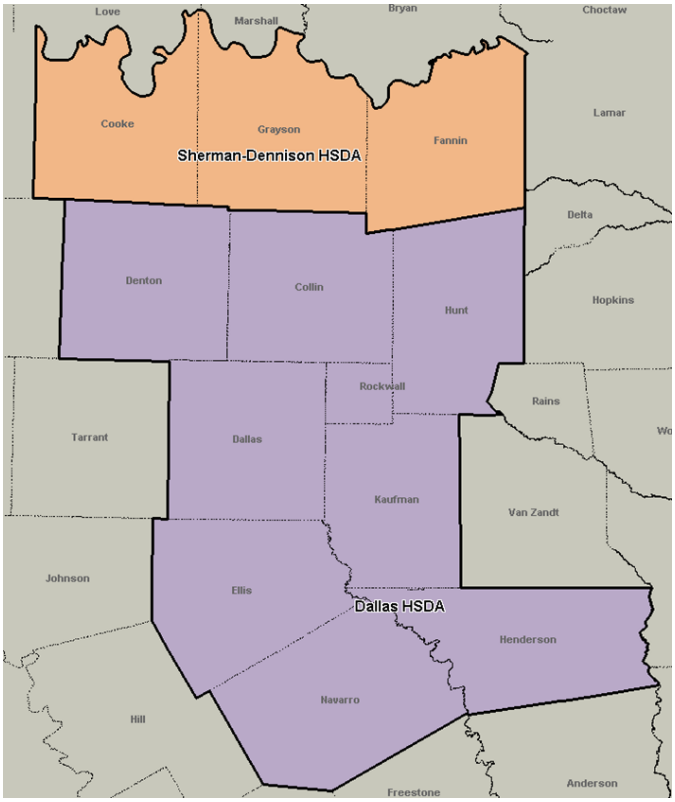


Figure 1. The Dallas EMA

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.

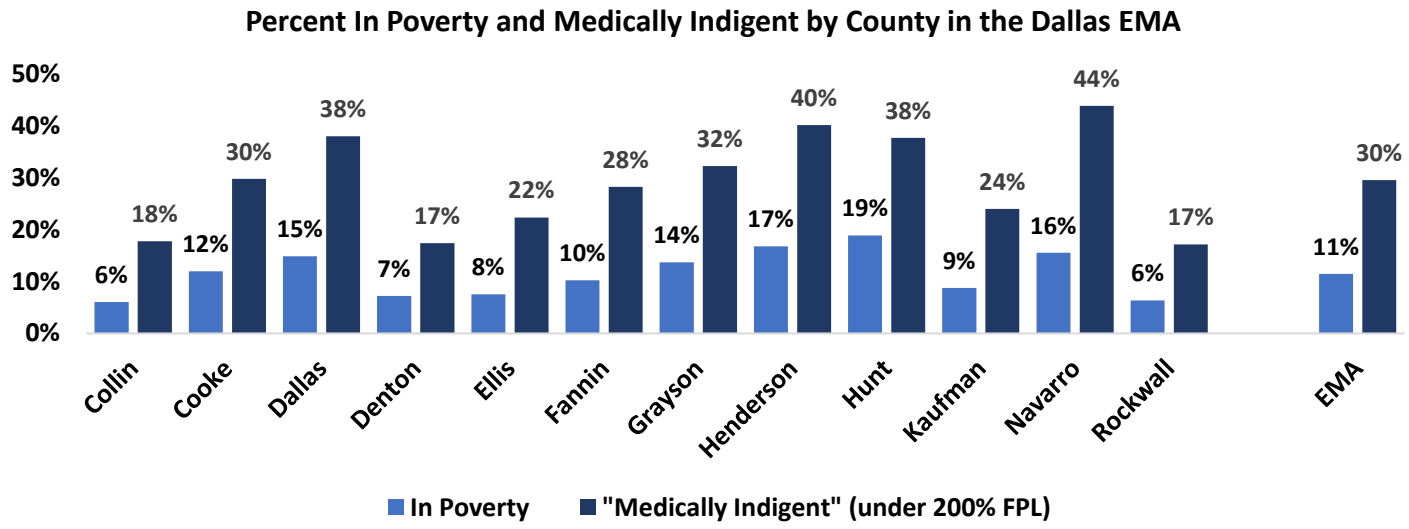
Table 3 presents summarized key statistics for the Dallas EMA that impact disparities or access to services. Because of their small population sizes, Census data did not provide breakdown statistics for Cooke, Fannin, and Navarro counties.

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.



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.

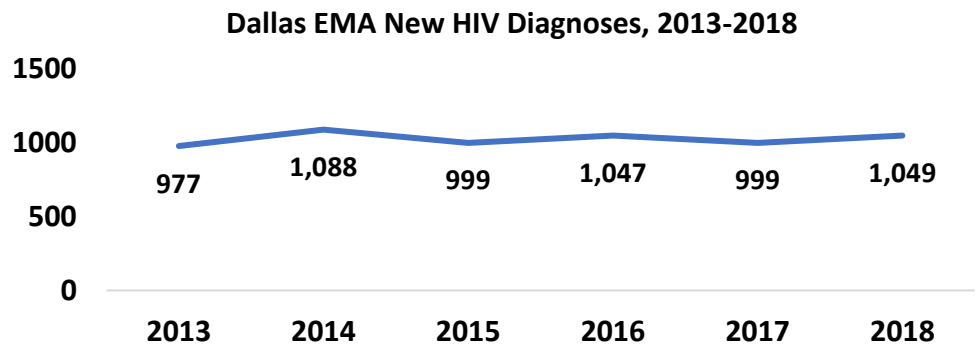
Table 4. Transportation Services Available in the Dallas EMA	
Transit System	**Counties/Cities Served**
Collin County Transit	Subsidized taxi voucher serving Celina, Lowry Crossing, McKinney, Melissa, Princeton, and Prosper. Limited to ages 65 and older; individuals with disabilities who meet one of 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

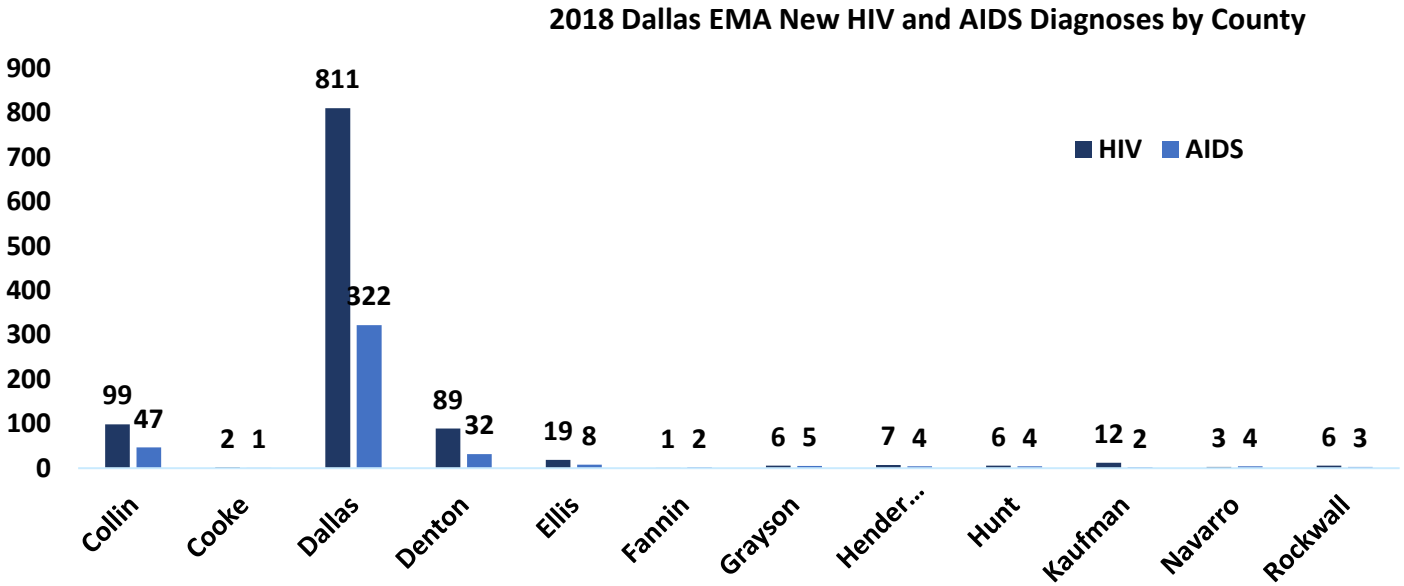
In 2018, the most recent year for which we have statistics, there were 1,049 new cases of HIV diagnosed in the Dallas EMA. As shown in Figure 3, the rate between 2013 and 2018 ranged from the lowest of 977 in 2013 to the high of 1088 in 2014, remaining somewhat steady over the years.



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.

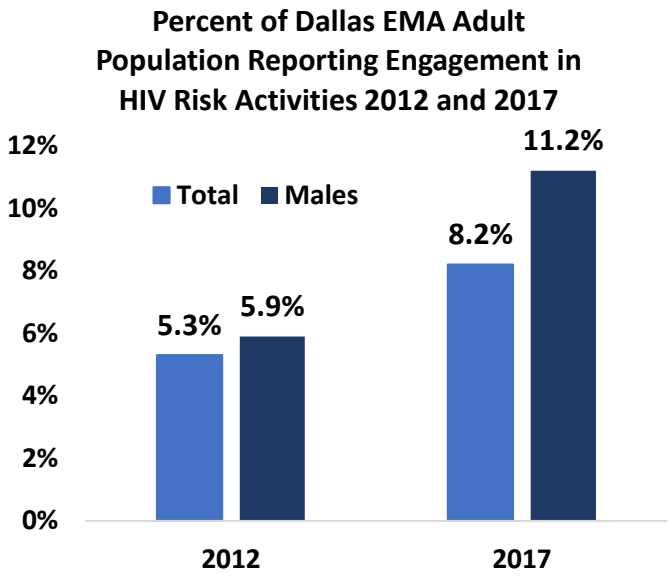


Figure 5. Percent of Dallas EMA Adult Population Engaged in HIV Risk Activities, 2012 and 2017

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

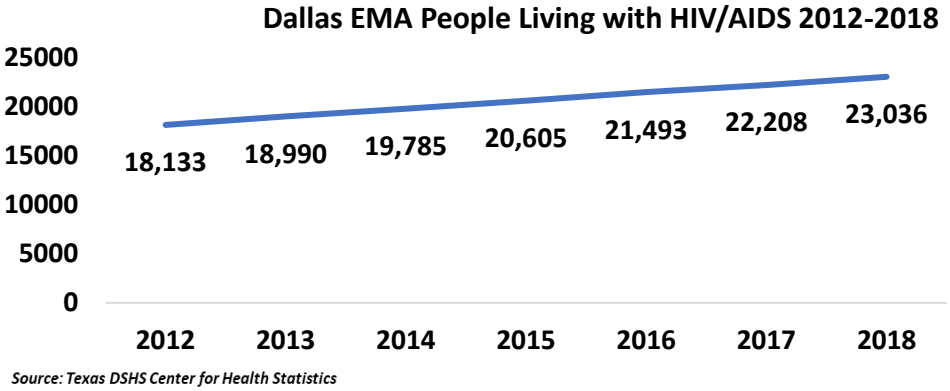


Figure 6. Dallas EMA People Living with HIV/AIDS, 2012-2018

The numbers and rates of PLWHA in the Dallas EMA vary across the counties, with Dallas County having a much her 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.

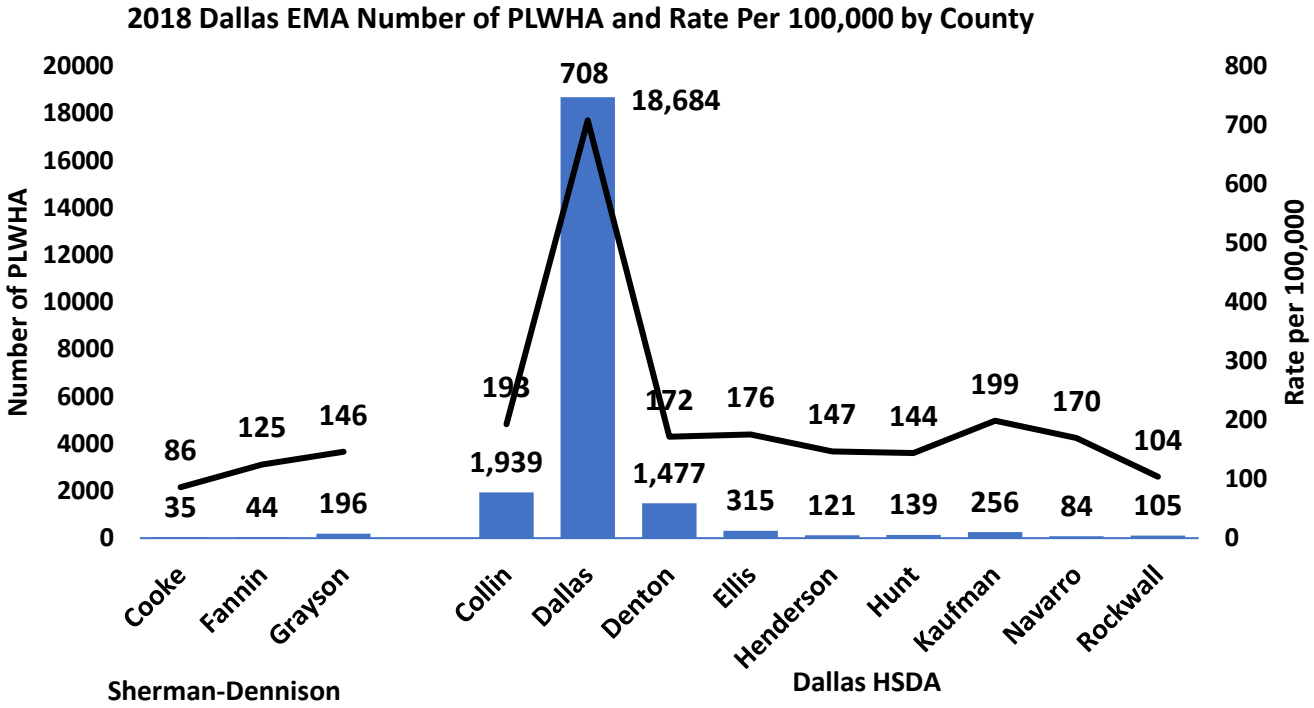


Figure 7. 2018 Dallas EMA Number of PLWHA and Rate per 100,000 by County

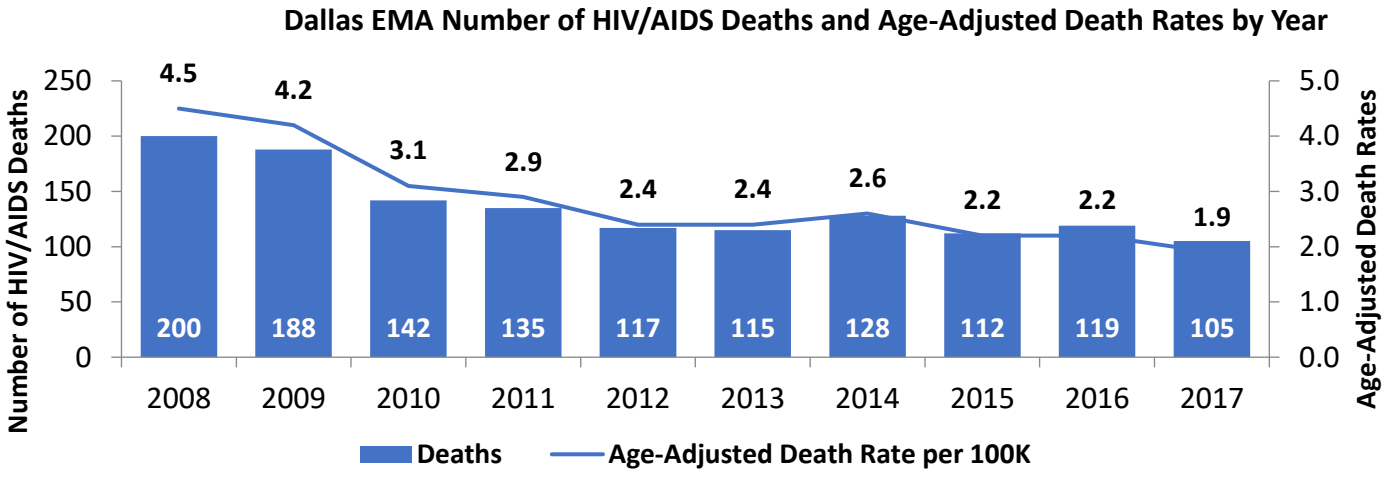
Table 5. Number of PLWHA and % of the Population with HIV/AIDS by ZIP Code		
ZIP Code	**Number of PLWHA**	**% of the Population with HIV/AIDS**
75247	20	2.8%
75219	493	2.1%
75203	262	1.6%
75202	33	1.6%
75246	36	1.6%
75215	205	1.3%
75235	239	1.3%
75216	415	0.8%
75231	282	0.7%
75243	428	0.6%
75228	293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

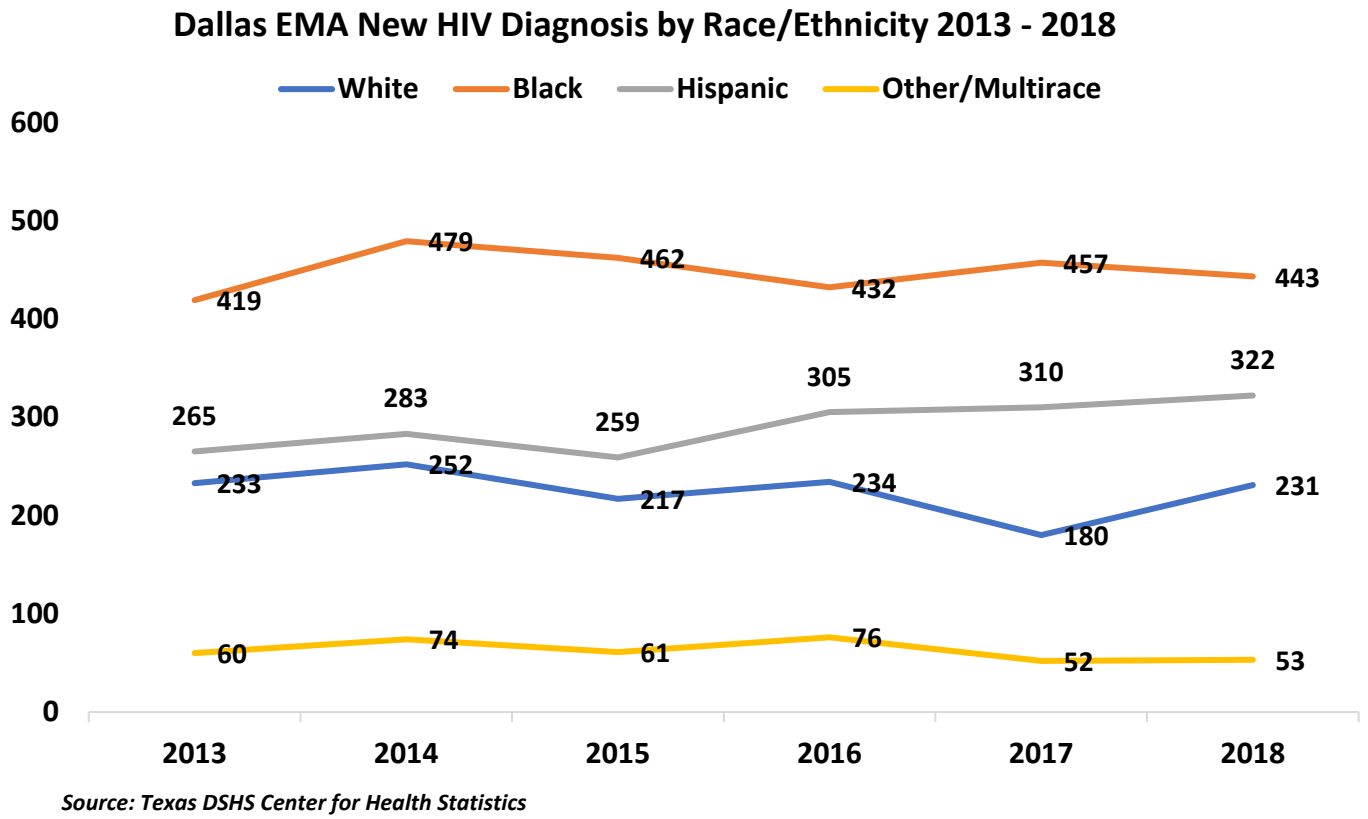
One of the more hopeful developments for transgender individuals locally is the increasing availability of outpatient physician services to meet their gender transition needs. As more Dallas area transwomen and transmen get regular medical care at gender affirming clinics, more will be tested for HIV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



Source: Texas DSHS Center for Health Statistics

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

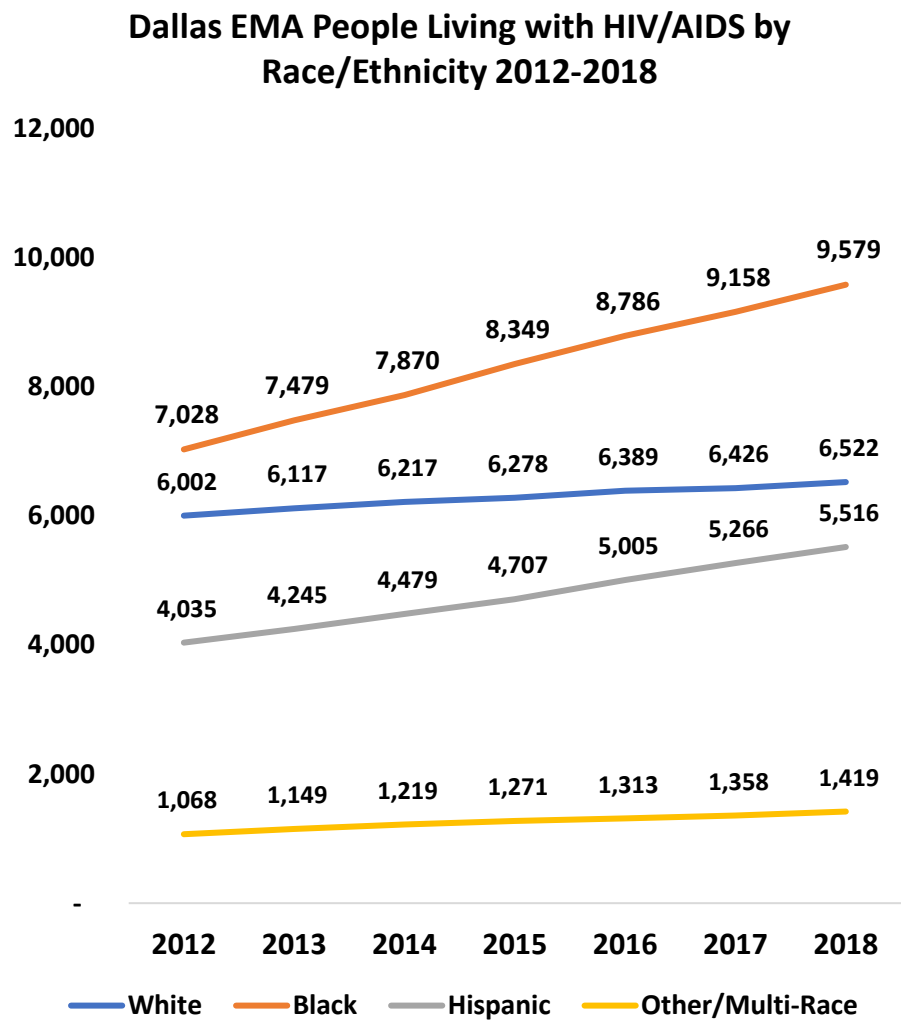


Figure 10. Dallas EMA PLWHA by Race/Ethnicity 2012-2018

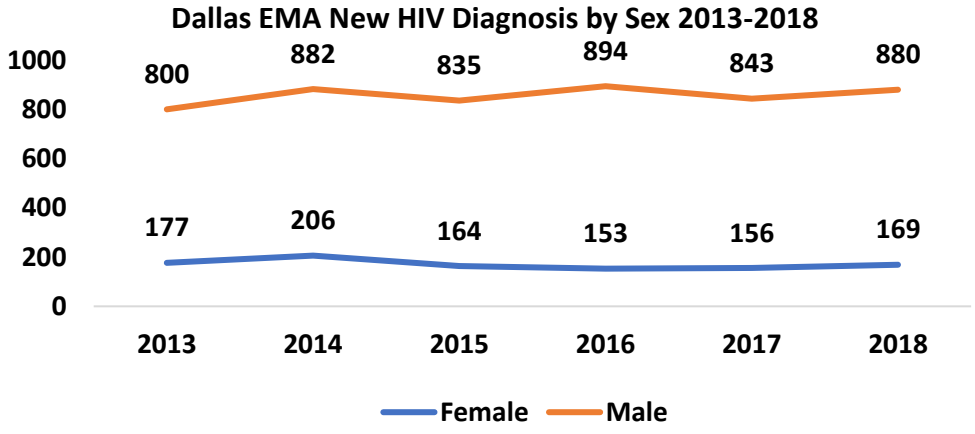
Among PLWHA, the highest prevalence is among Black individuals, followed by White individuals, Hispanic individuals, and Other/Multi-Race. The numbers for all four groups have risen steadily between 2012 and 2018, with a slightly greater incline among Black and Hispanic individuals.

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.

Sex

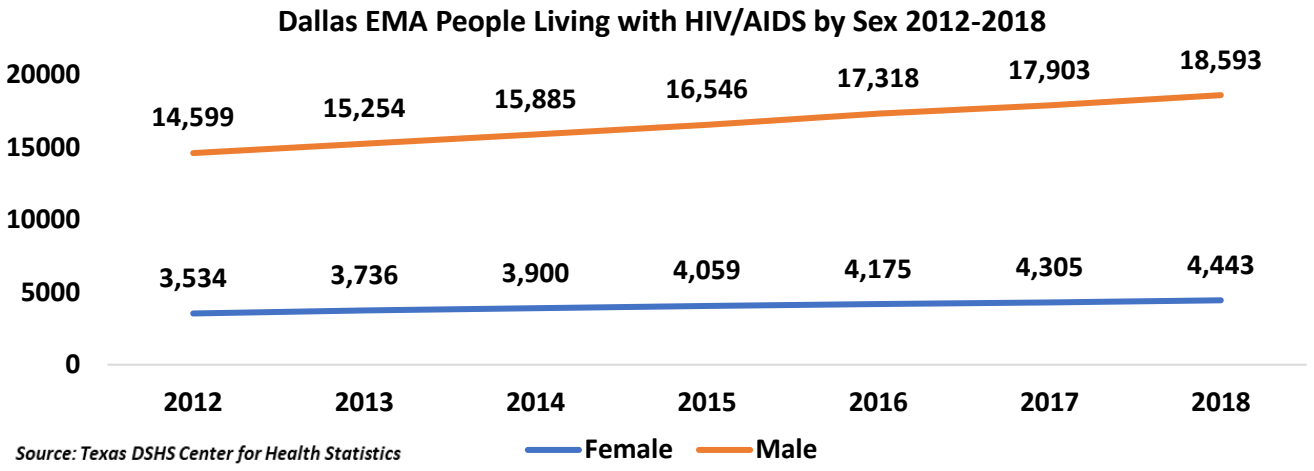
Across the six-year period, the numbers of new cases for men and women has remained somewhat steady, with rates for men over four times higher than those for women.

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



Source: Texas DSHS Center for Health Statistics

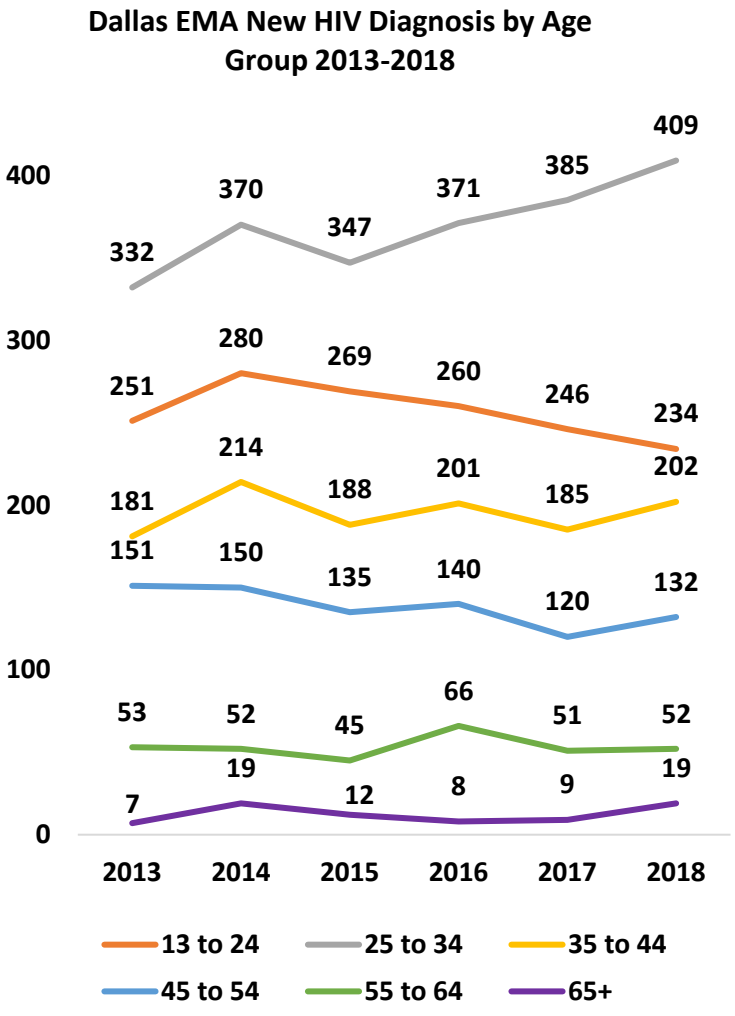
Figure 11. Dallas EMA New HIV Diagnosis by Sex 2013-2018



Source: Texas DSHS Center for Health Statistics

Figure 12. Dallas EMA PLWHA by Sex 2012-2018

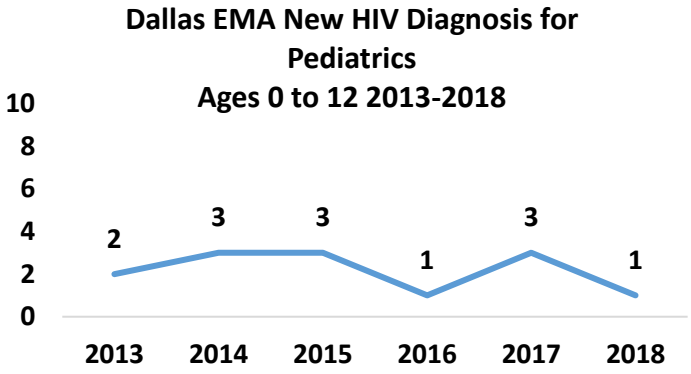
Age



Source: Texas DSHS Center for Health Statistics

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

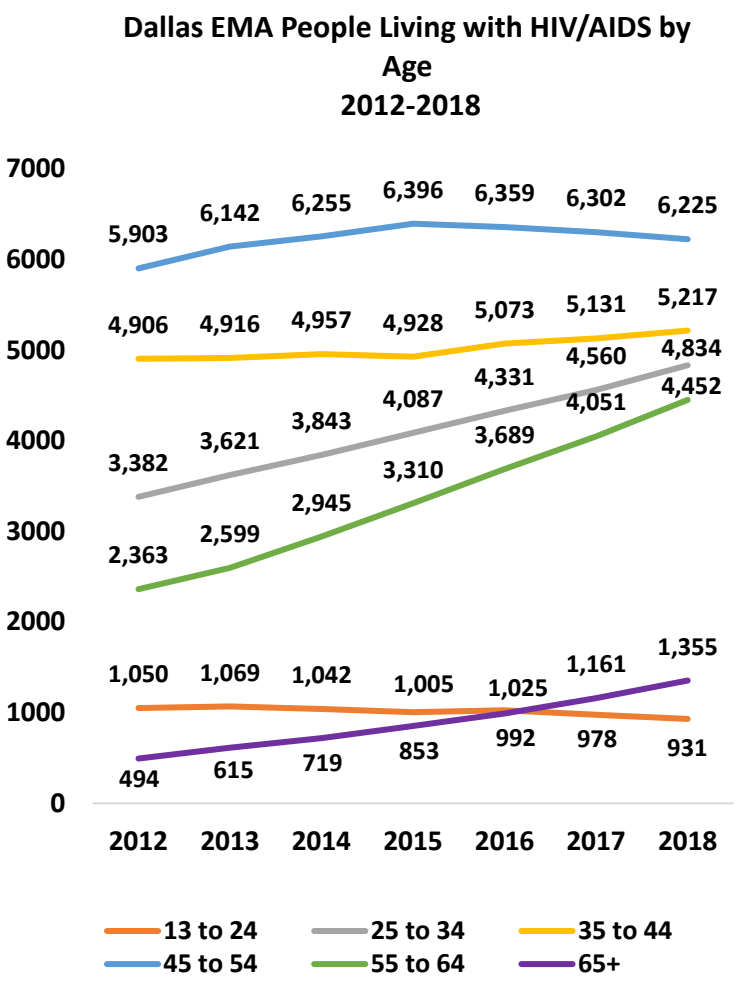
The number of new HIV diagnoses is growing fastest among the 25 to 34 years age group. There has been some increase in the 35 to 44 age group. There has been a steady decline in new cases in the 13 to 24 age group. The 45 to 54 age group showed a slight decline, while the number of new HIV diagnoses 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.



Source: Texas DSHS Center for Health Statistics

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.

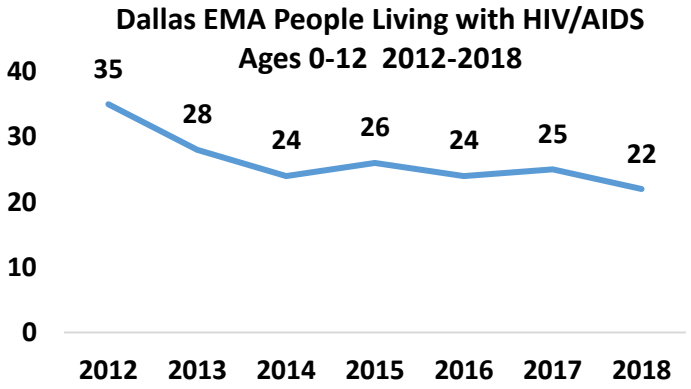


Source: Texas DSHS Center for Health Statistics

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.



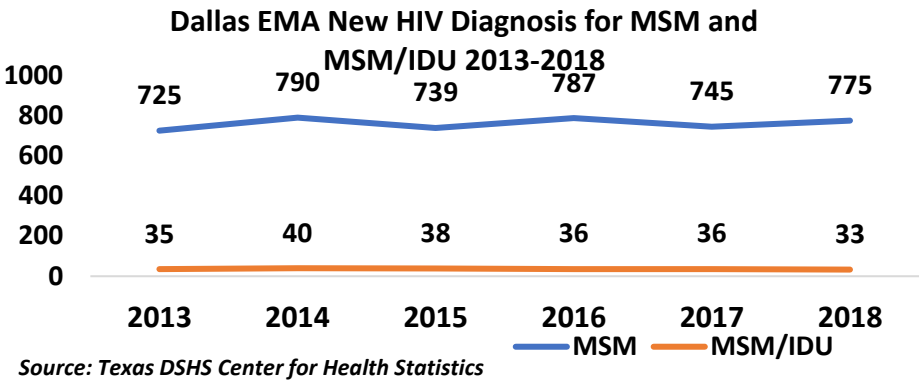
Source: Texas DSHS Center for Health Statistics

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 mean 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).

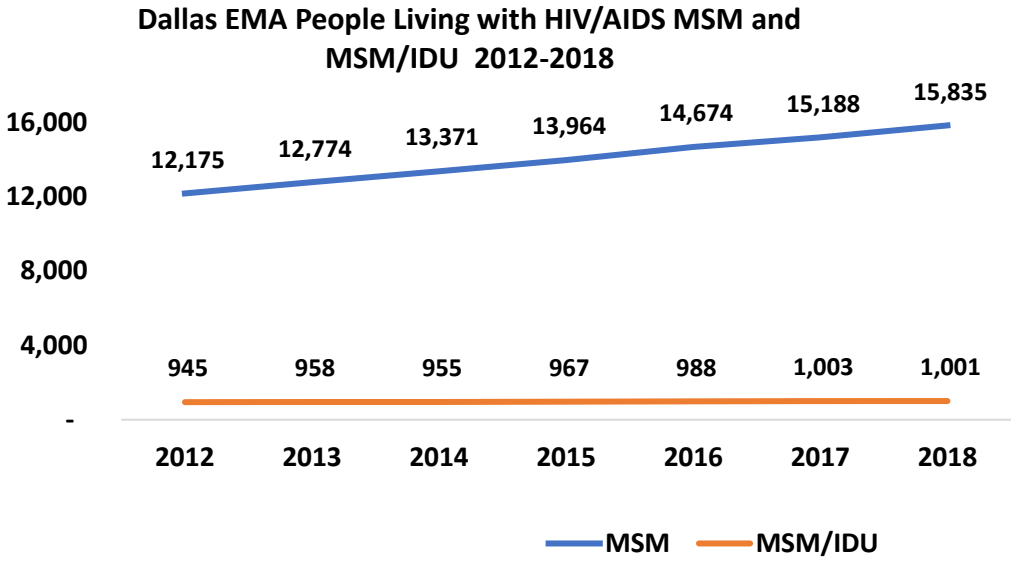
MSM and MSM/IDU

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



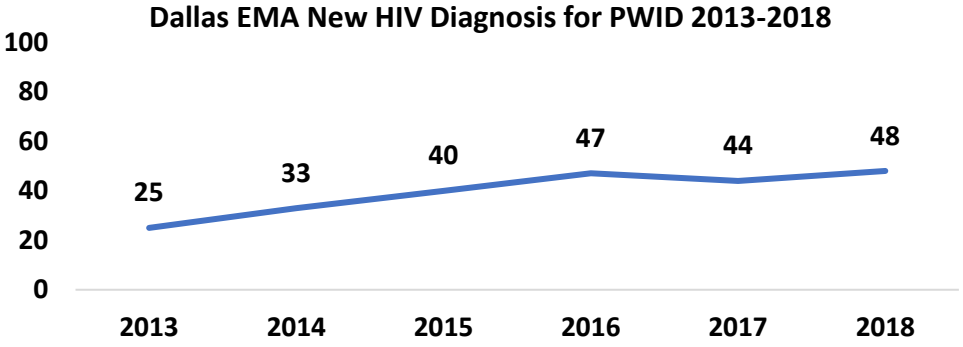
Source: Texas DSHS Center for Health Statistics

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.

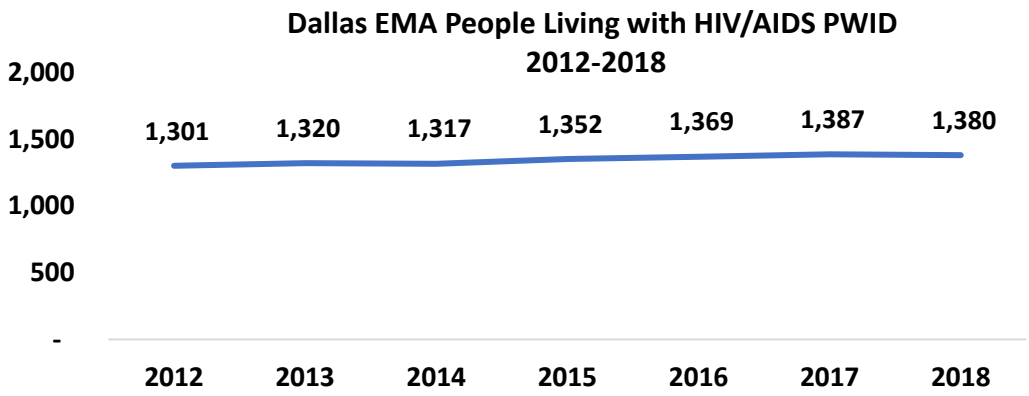
People Who Inject Drugs (PWID)



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.

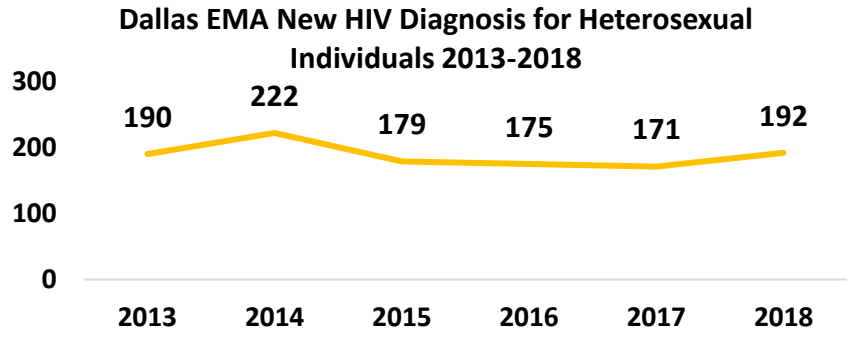
Source: Texas DSHS Center for Health Statistics

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.

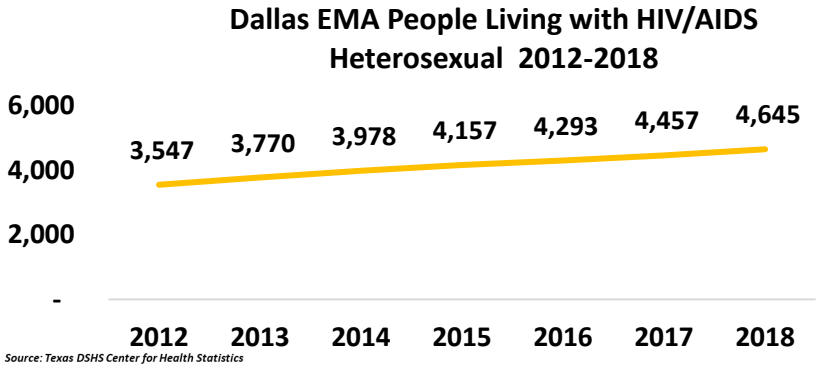
Heterosexual Transmission

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



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.

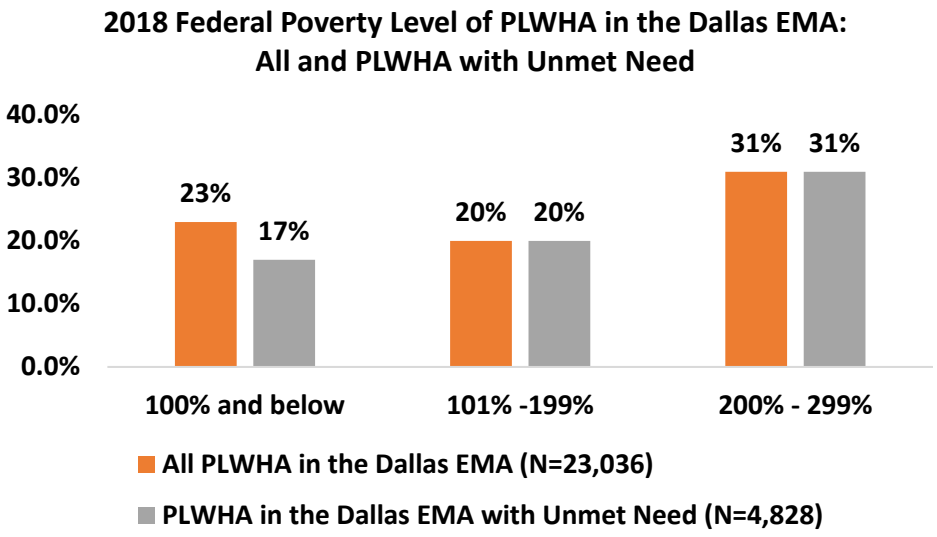
Source: Texas DSHS Center for Health Statistics

Figure 22. Dallas EMA PLWHA Heterosexual 2012-2018

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

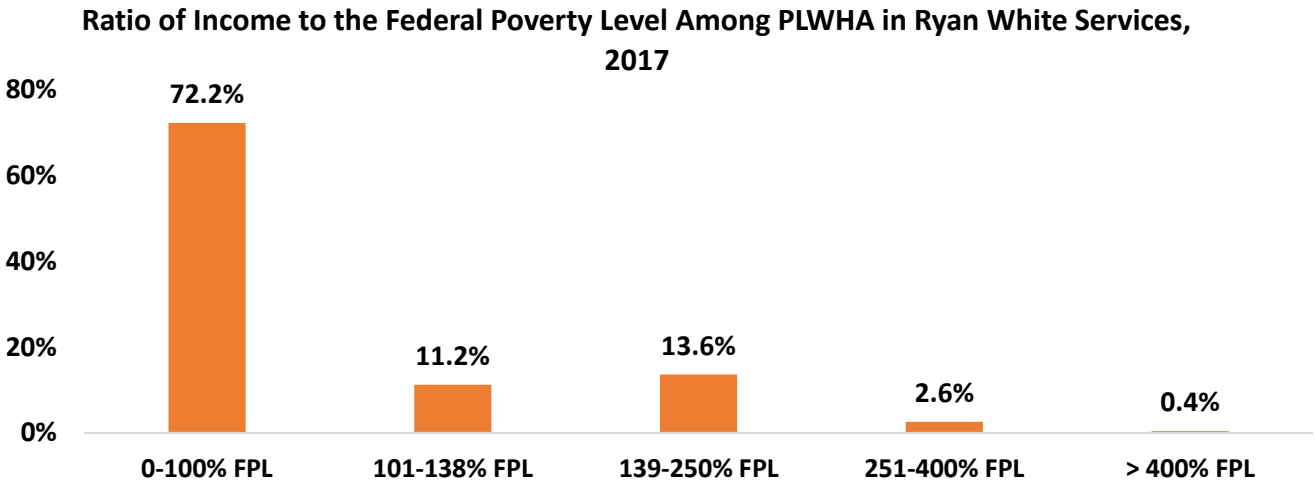


Source: Texas DSHS Center for Health Statistics

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).

Diagnosed
Received a diagnosis of HIV.

Linked to Care
Visited an HIV health care provider within 30 days after learning they were HIV positive.

Retained in Care
Received medical care for HIV infection.

Viral Suppression
Their HIV "viral load" – the amount of HIV in the blood – was at a very low level.

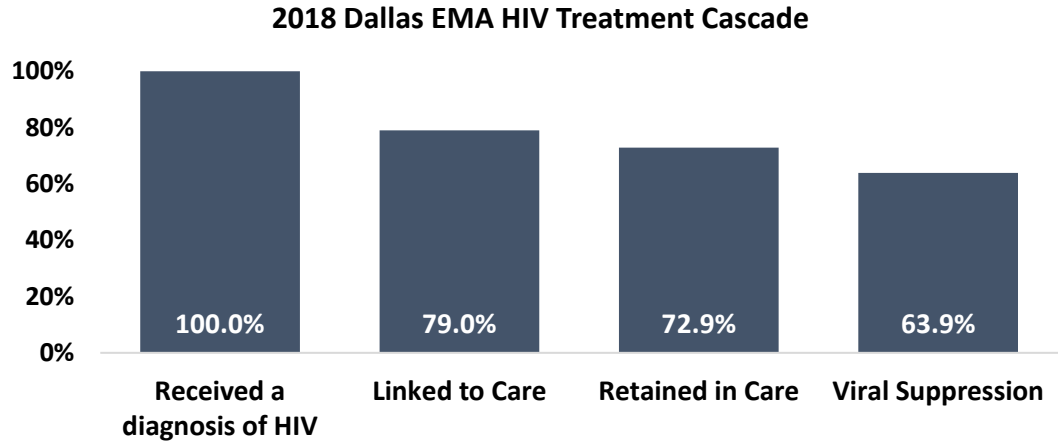


Figure 25 shows that in 2018, 87.7% of PLWHA who were retained in care were virally suppressed.

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.

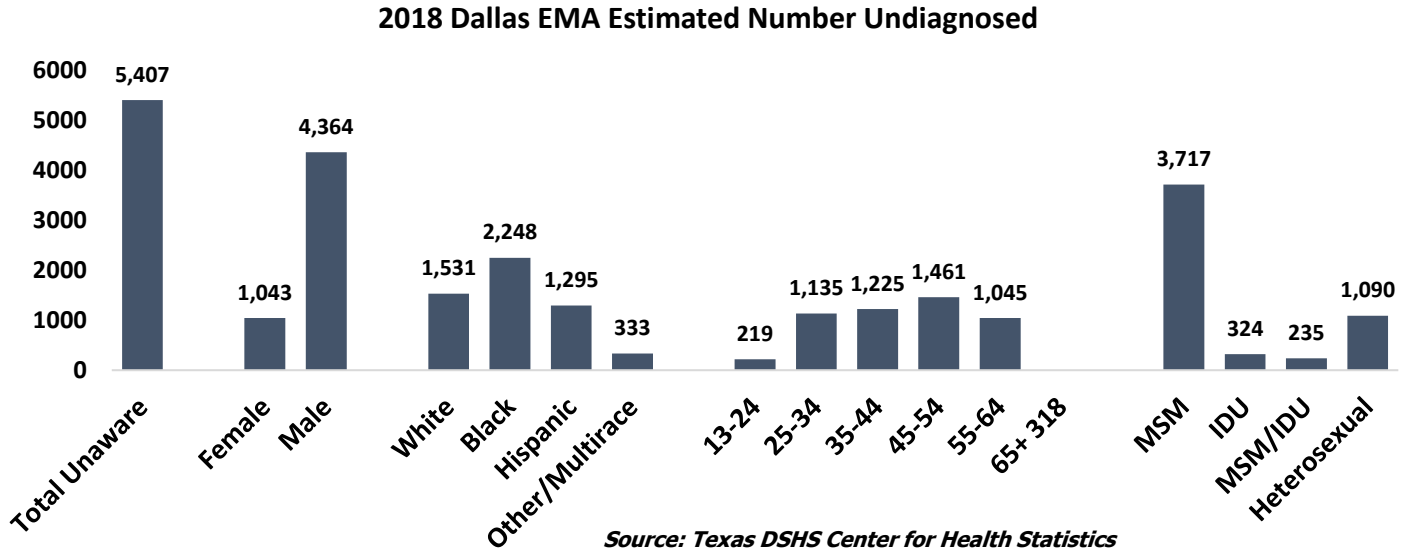


Figure 26. 2018 Dallas EMA Estimated Number Undiagnosed

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.

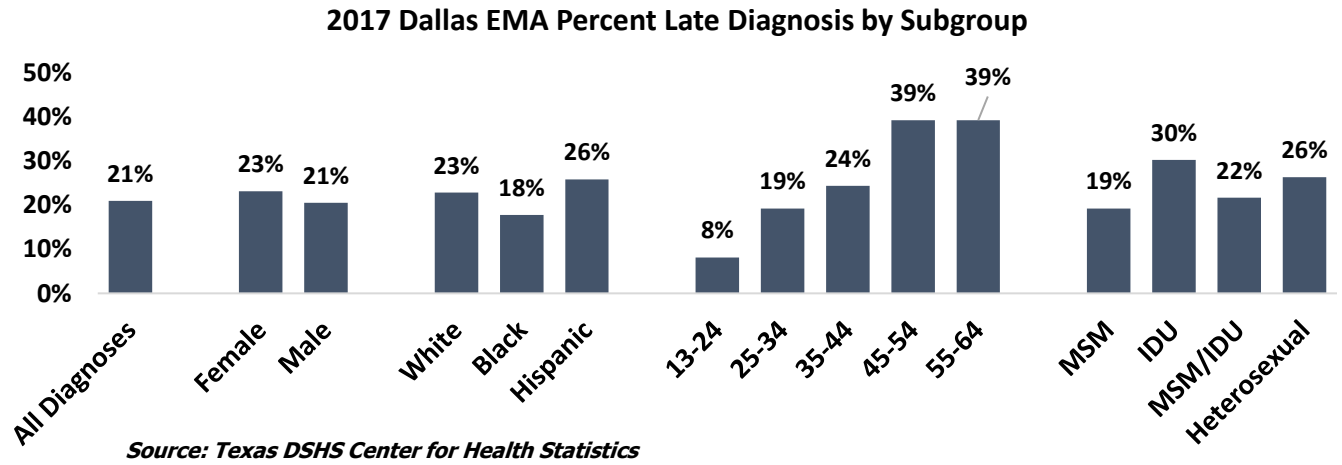
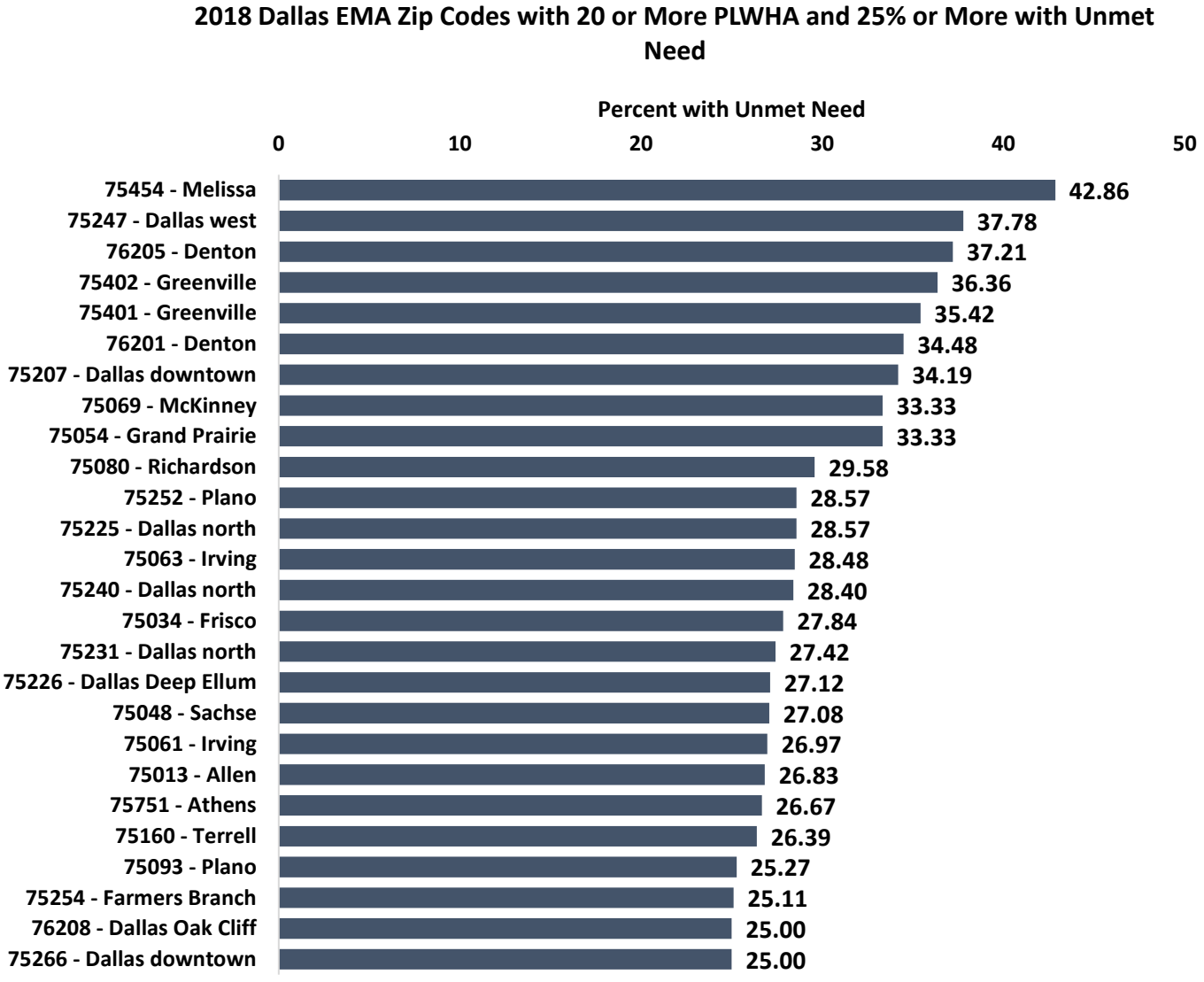


Figure 27. 2017 Dallas EMA Late Diagnosis by Subgroup

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.

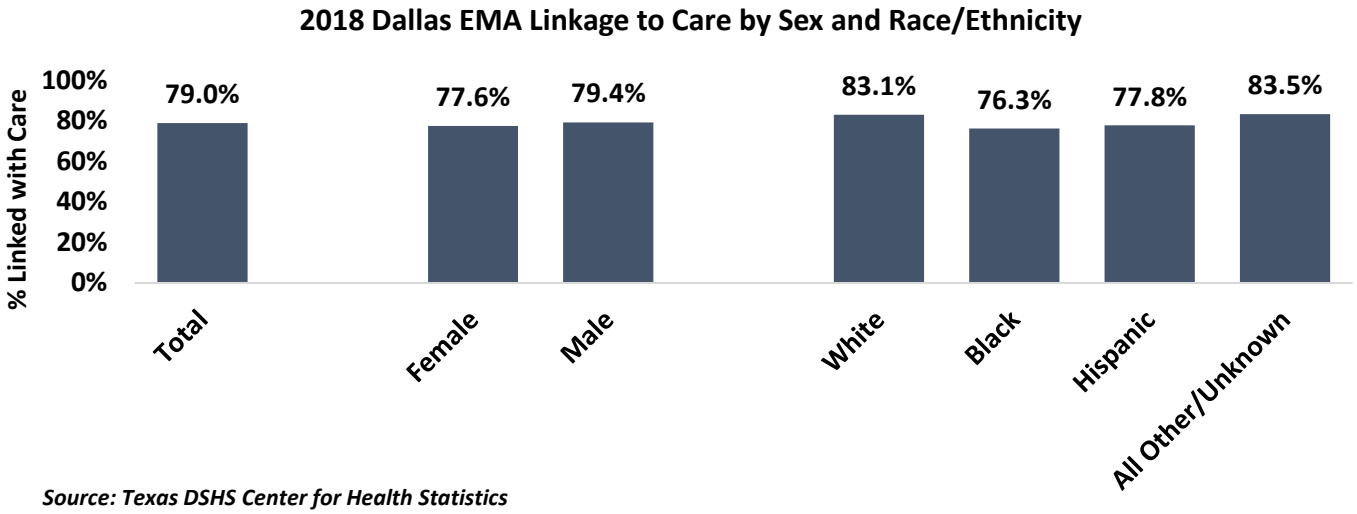


Source: Texas DSHS Center for Health Statistics

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.

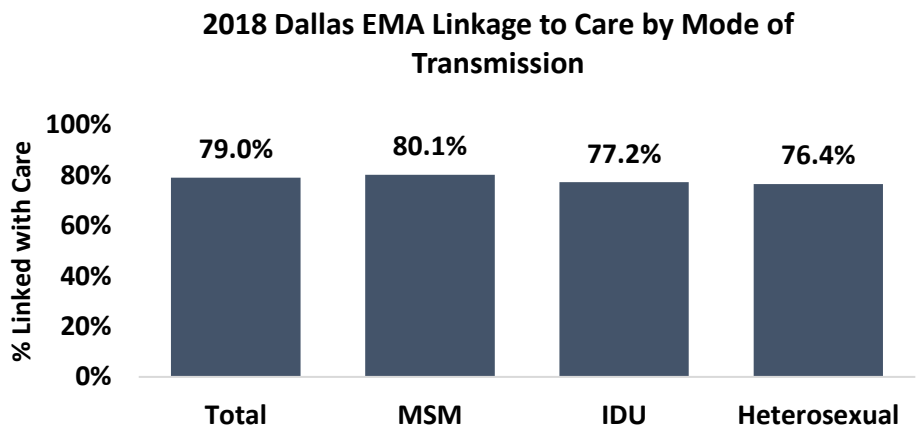
KEY FINDING: Innovative and culturally relevant strategies are needed to overcome logistical barriers, such as transportation, distance, and hours/days of service as well as psychological barriers such as stigma, feelings of invulnerability, and denial.



Source: Texas DSHS Center for Health Statistics

Figure 29. 2018 Dallas EMA Linkage to Care by Sex and Race/Ethnicity

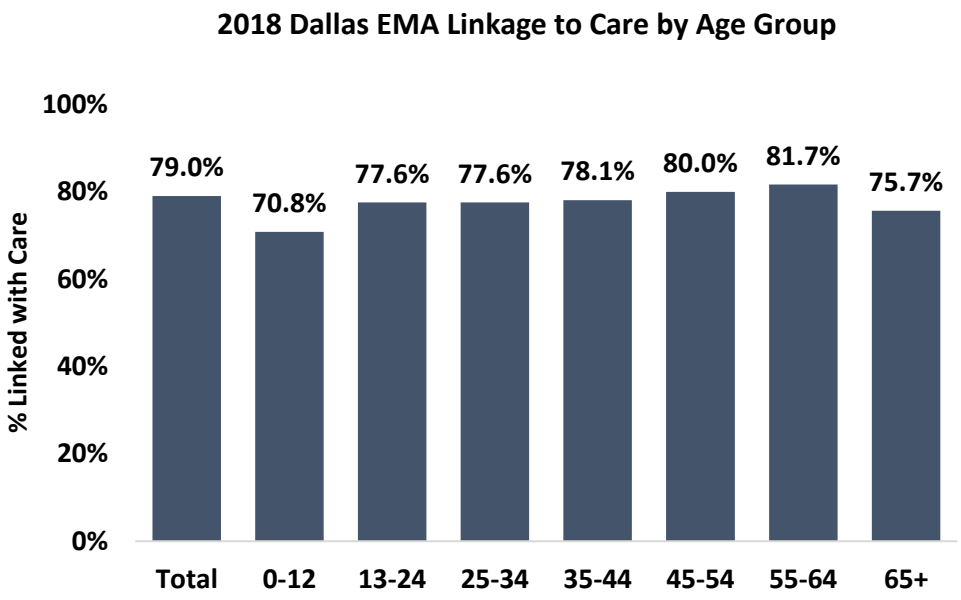
Linkage to care varies by sex and race/ethnicity. A somewhat smaller percentage of females were linked to care compared with males. When broken down by race and ethnicity the percentages linked to care are lower for Black and Hispanic PLWHA compared to White and Other/Unknown.



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.



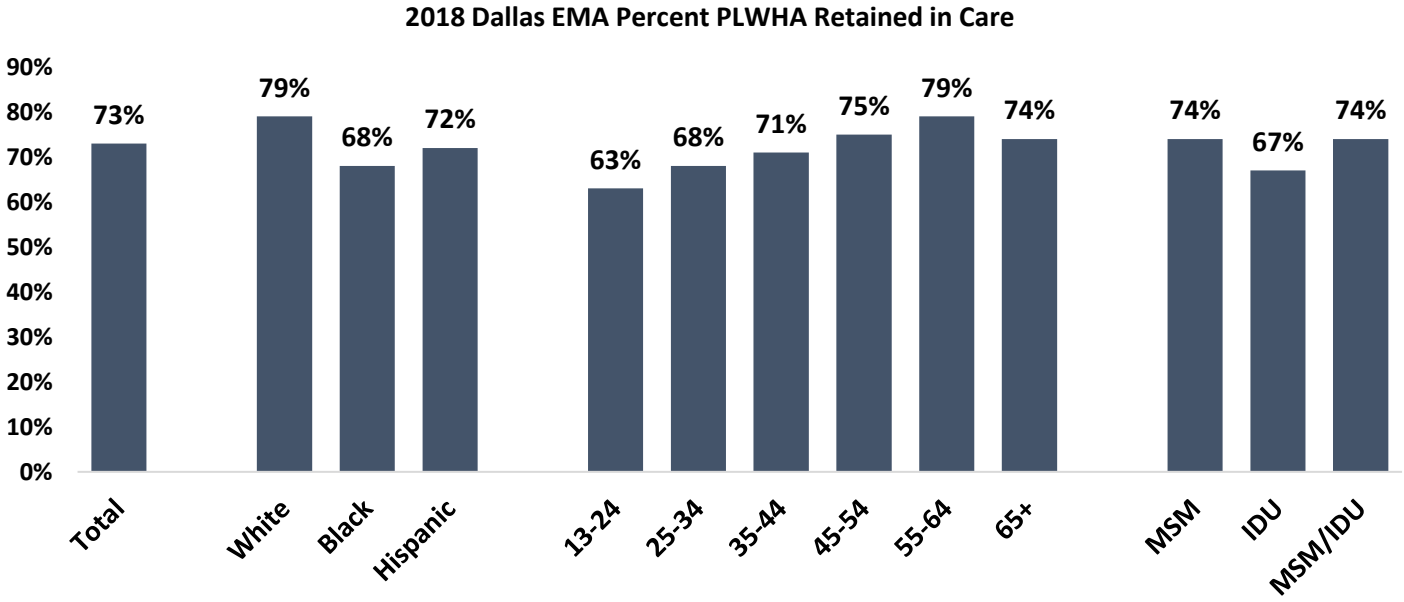
The percent of PLWHA ages 45 to 64 who are linked to care is above the total percent. The percent ages 0 to 12 is the lowest. Ages 65 and older is also lower than the other age groups. The percent linked to care for ages 13-34 is slightly lower than the total percent.

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



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.

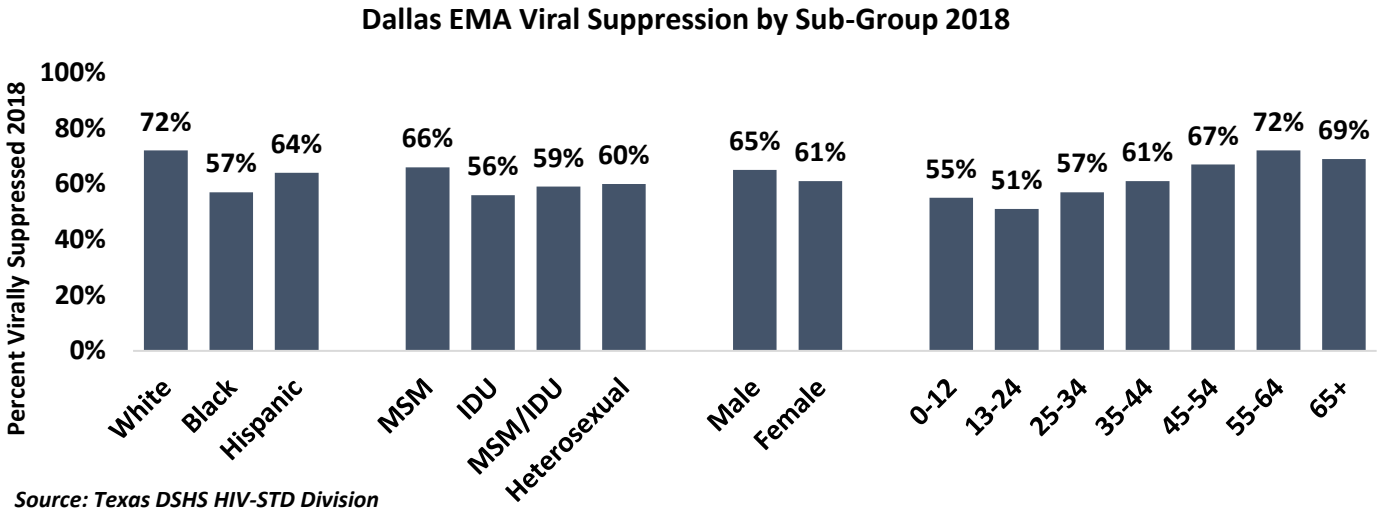


Figure 33. Dallas EMA Viral Suppression by Sub-Group 2018

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.

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.

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.

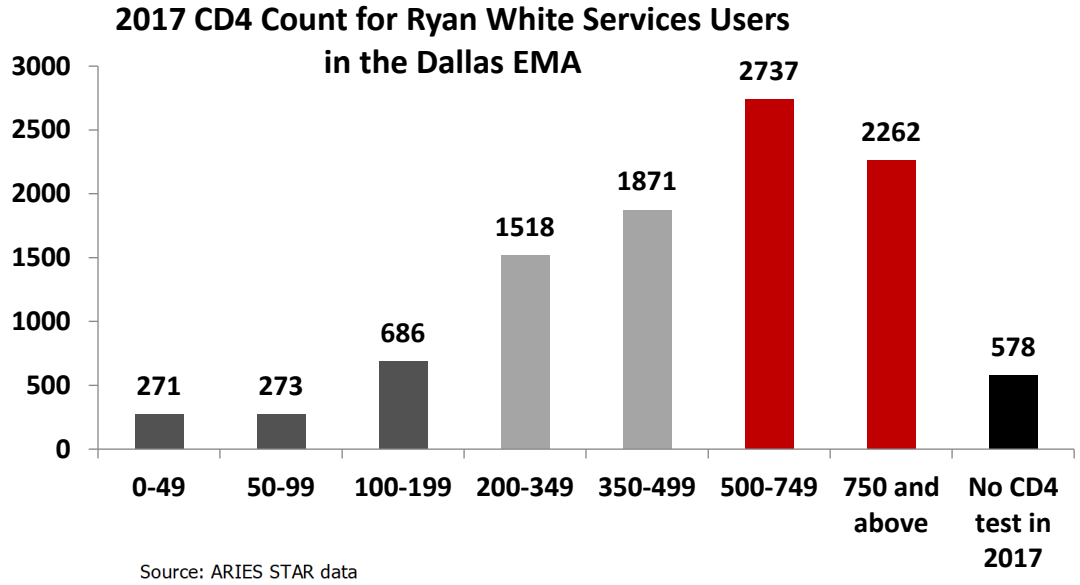


Figure 34. 2017 CD4 Count for Ryan White Services Users in the Dallas EMA

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.

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.

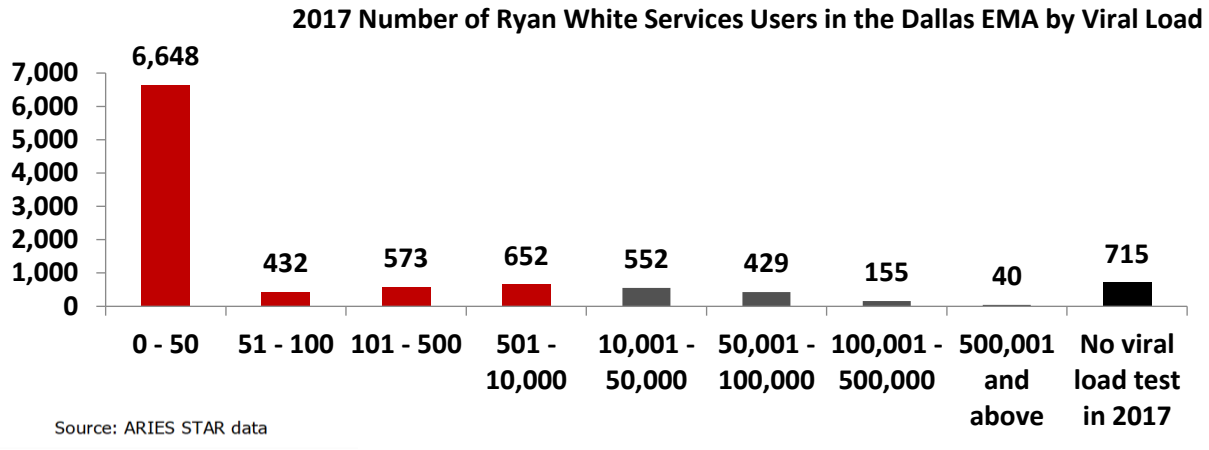


Figure 35. 2017 Number of Ryan White Services Users in the Dallas EMA by Viral Load

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.

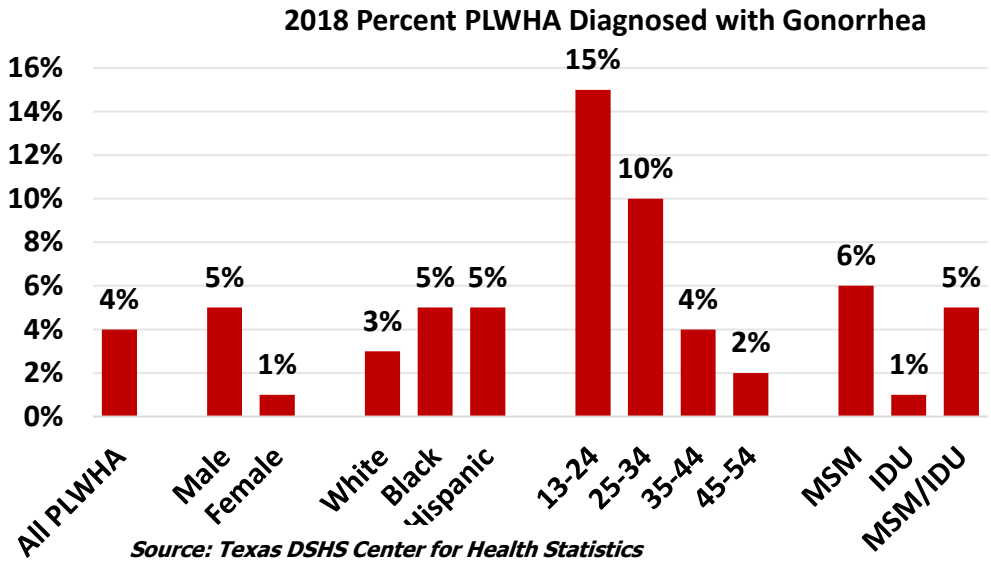
Tuberculosis

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.

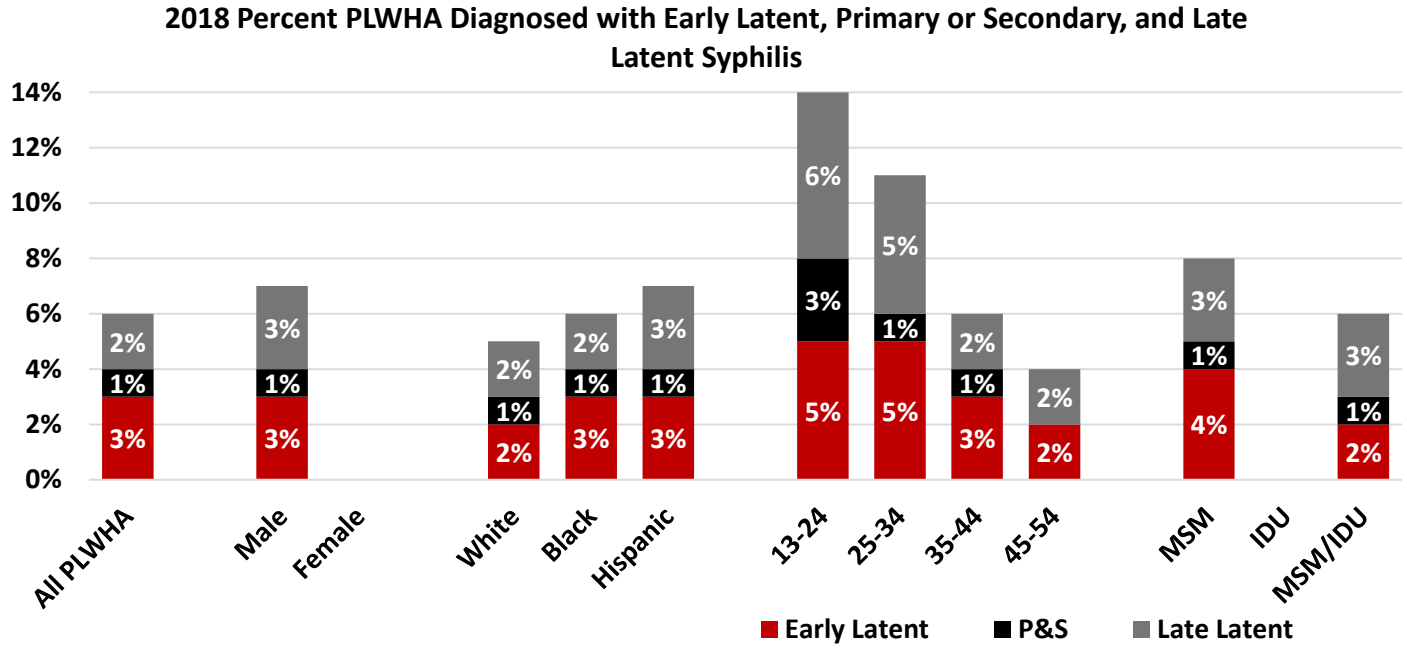
Gonorrhea



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.

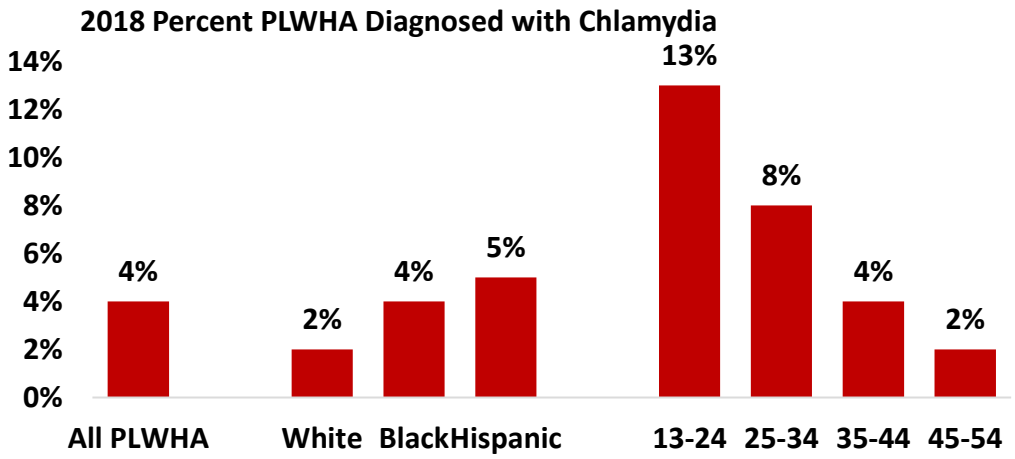
Figure 36. 2018 Percent PLWHA Diagnosed with Gonorrhea

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



Source: Texas DSHS Center for Health Statistics

Figure 37. 2018 Percent PLWHA Diagnosed with Chlamydia

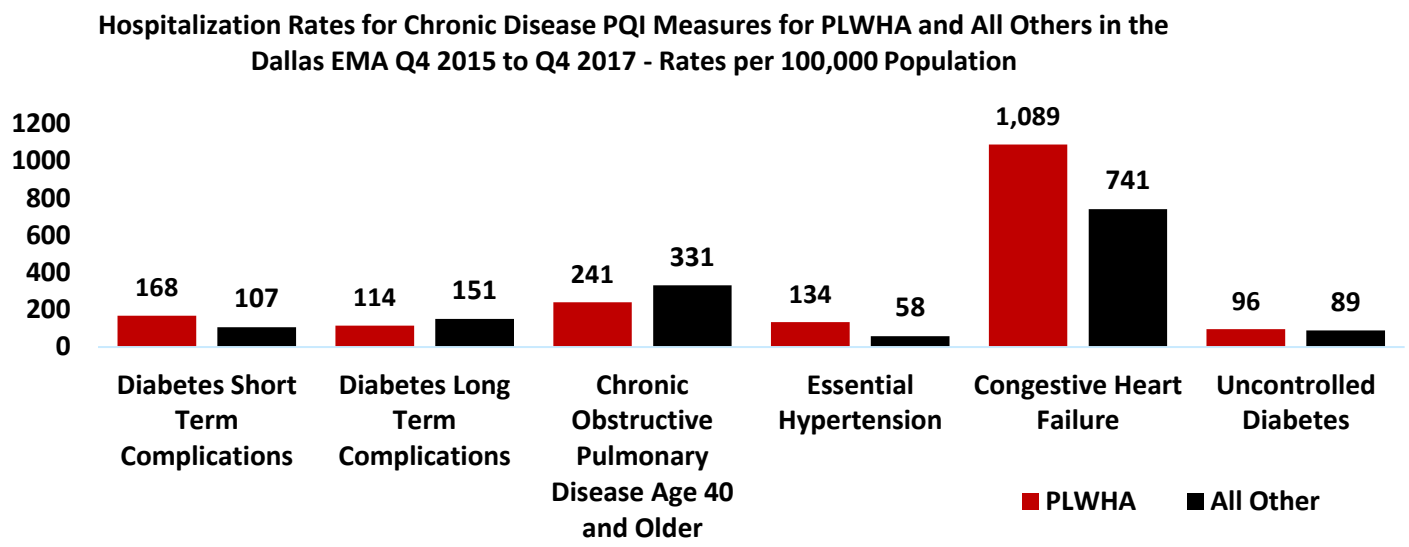
In 2018, 4% of all PLWHA in the Dallas EMA were diagnosed with Chlamydia. Rates varied by age and race/ethnicity with slightly more Hispanic individuals receiving this diagnosis, and much higher percentages of individuals ages 13-34.

KEY FINDINGS: Sexually transmitted infection prevention initiatives are needed to prevent STIs among PLWHA as well are 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 be 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.



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.

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.

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.

Available services

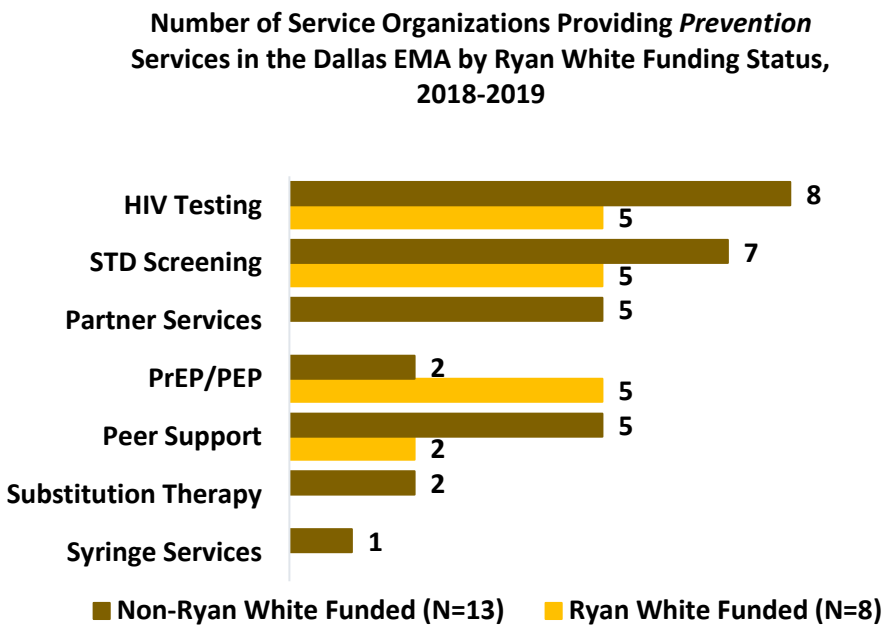


Figure 39. Number of Service Organizations Providing Prevention Services in the Dallas EMA by Ryan White Funding Status 2018-19

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, and support services in 2018-19.

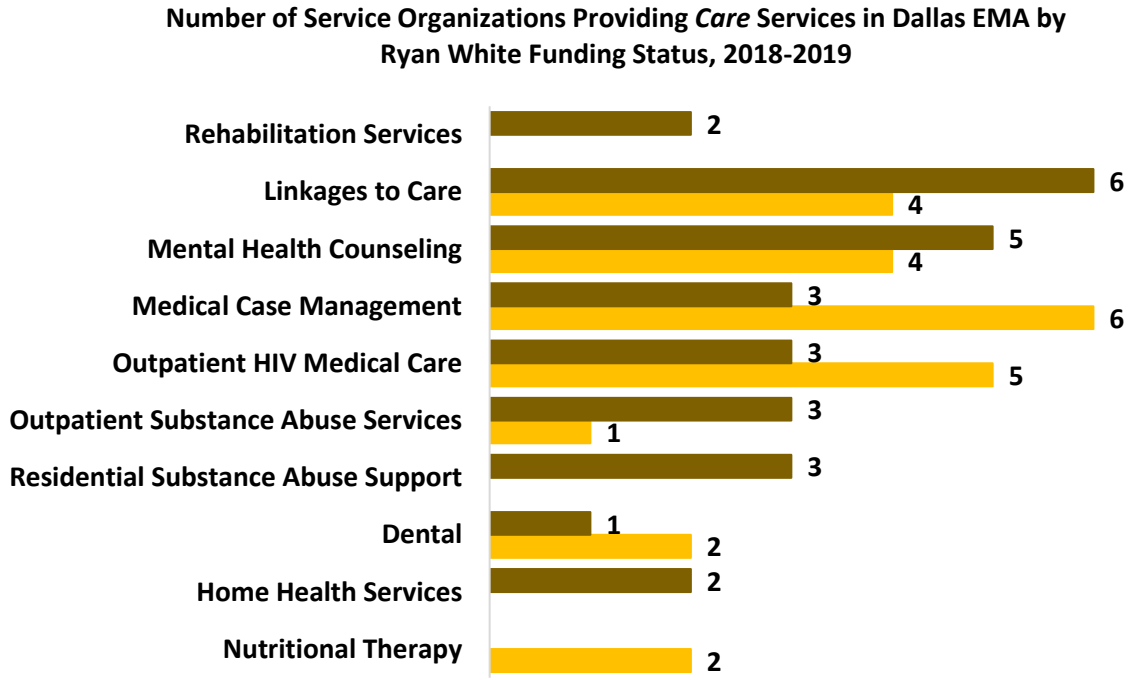


Figure 40. Number of Service Organizations Providing Care Services in Dallas EMA by Ryan White Funding Status 2018-19

[1] There is only one Ryan White funded organization in the Dallas EMA providing language translation services.

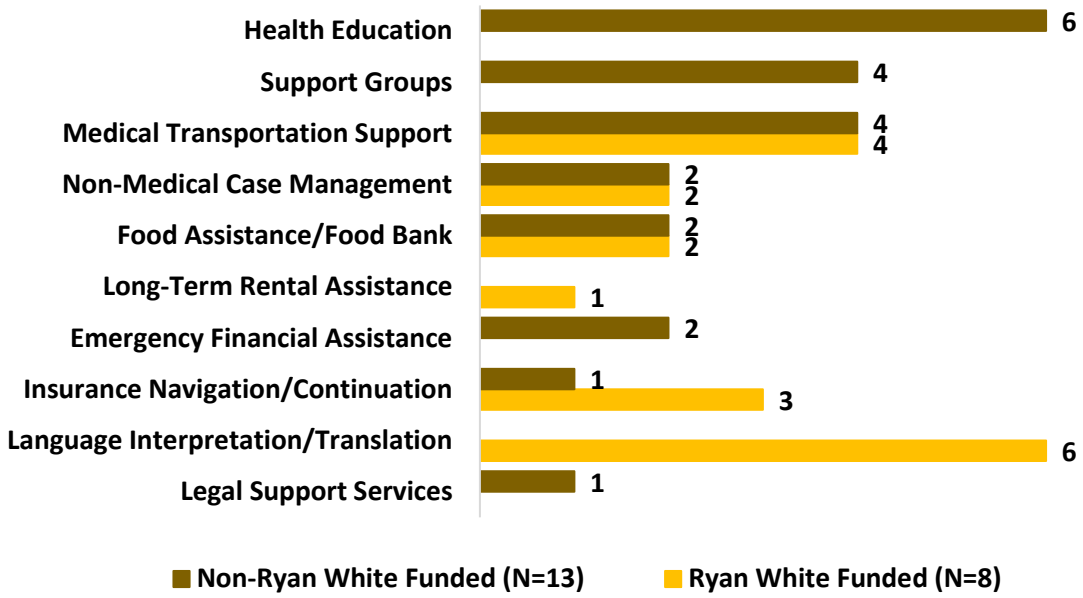


Figure 41. Number Providing Support Services in Dallas EMA by RW Funding Status 2018-19

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% received 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 desserts 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 is 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 form 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**

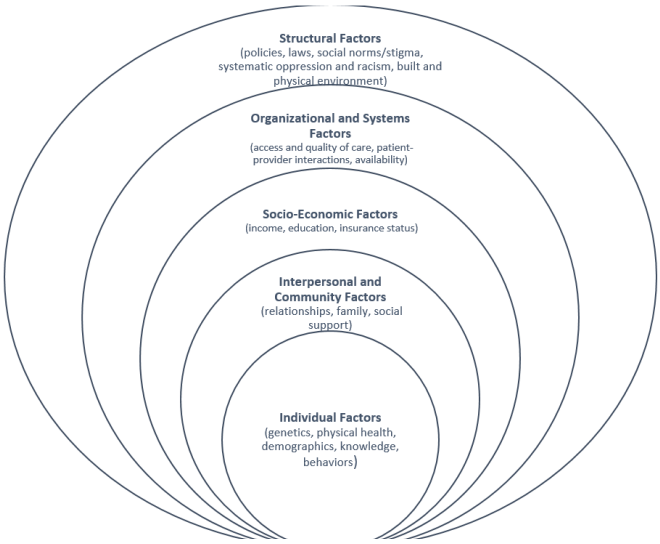


Figure 42. Socio-Economic Framework of Social Determinants of Health

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

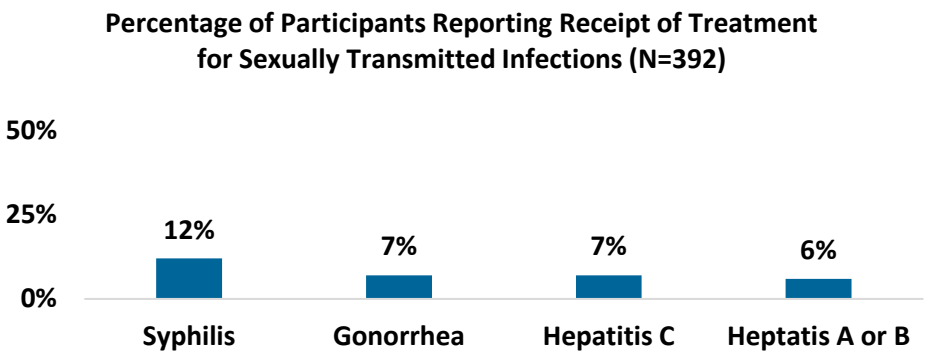


Figure 44. Percent reporting receipt of testing or treatment for syphilis, gonorrhea, hepatitis C, and hepatitis A or B

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), 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).

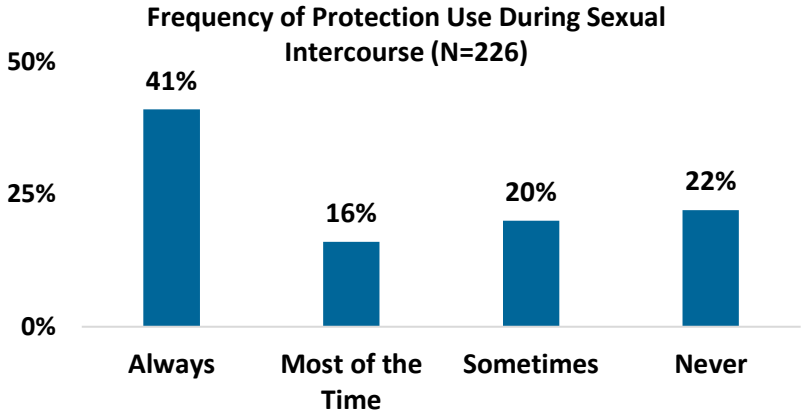


Figure 45. Frequency of Protection Use During Sexual Intercourse

Behavioral Health and Substance Use

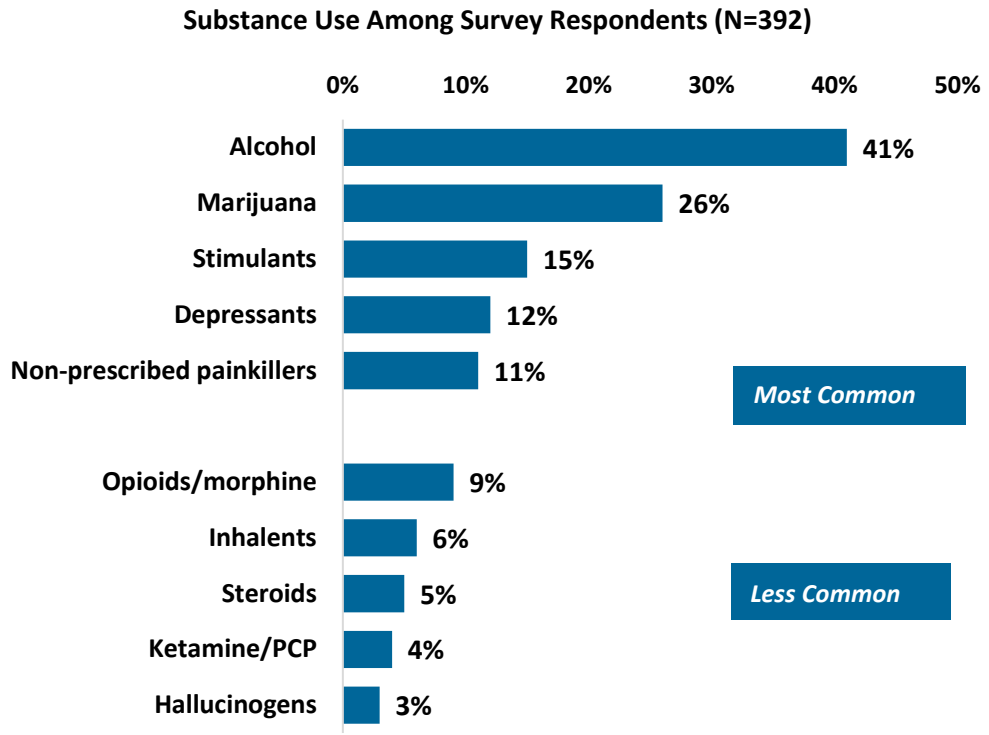


Figure 46 shows the self-reported substance use among the survey respondents. Alcohol and marijuana were the most frequently reported substances used and hallucinogens and ketamine/PCP were the least frequently reported.

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).

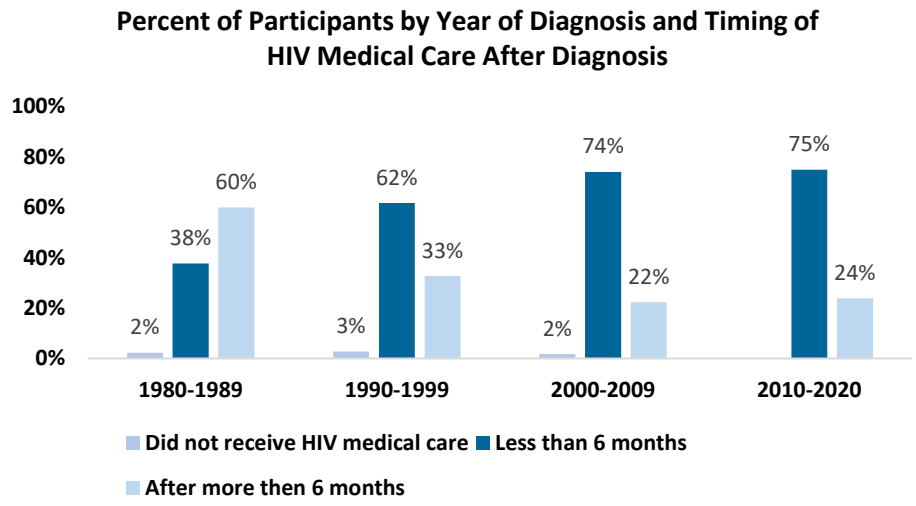


Figure 47. Percent of Participants by Year of Diagnosis and Timing of HIV Medical Care after Diagnosis

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:

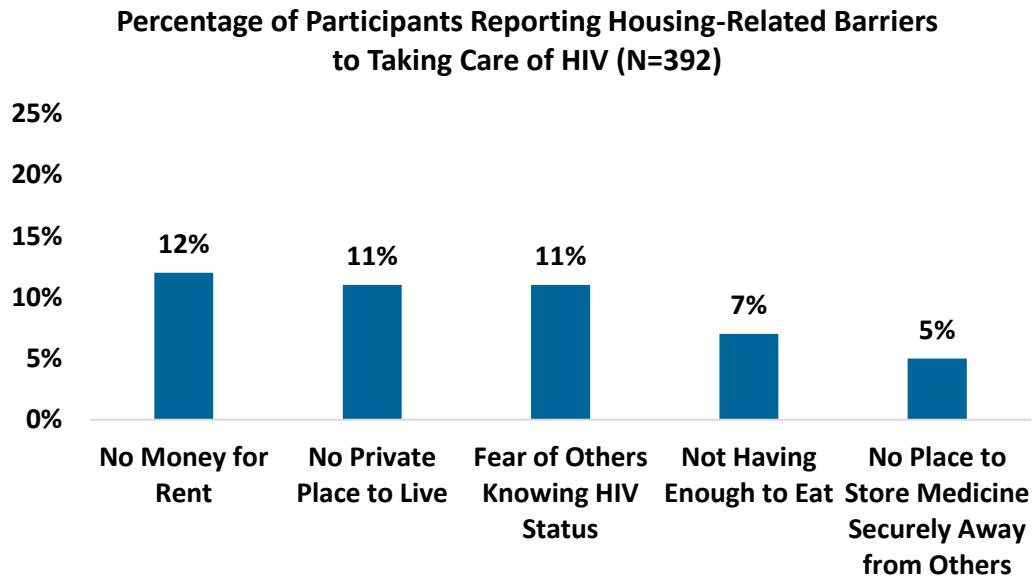
- difficulty getting to the clinic (transportation) (21%, n=14) and
- not having enough money (15%, n=10).

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.

Top 10 Most Common Services Used	Top 10 Most Difficult Services to Use
•Outpatient HIV Medical Care (**57%**)	•Long-Term Housing for People Living with HIV (**14%**)
•Food Bank (**54%**)	•Emergency Financial Assistance for Rent (**14%**)
•Assistance Paying for Medications and Prescriptions (**51%**)	•Assistance Paying for Medications and Prescriptions (**13%**)
•Medical Case Management (**51%**)	•Assistance with Health Insurance Premiums (**10%**)
•Referral to a Specialist (**45%**)	•Referral to a Specialist (**10%**)
•Assistance with Health Insurance Premiums (**41%**)	•Transportation to Medical Care (**10%**)
•Non-Medical Case Management (41%)	•Non-Medical Case Management (**9%**)
•Dental Care (**40%**)	•Food Bank (**9%**)
•Mental Health Counseling (**31%**)	•Referral for Help getting Healthcare or Services (**8%**)
•Referral for Help getting Healthcare or Services (**30%**)	•Outpatient HIV Medical Care (**7%**)

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.

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.

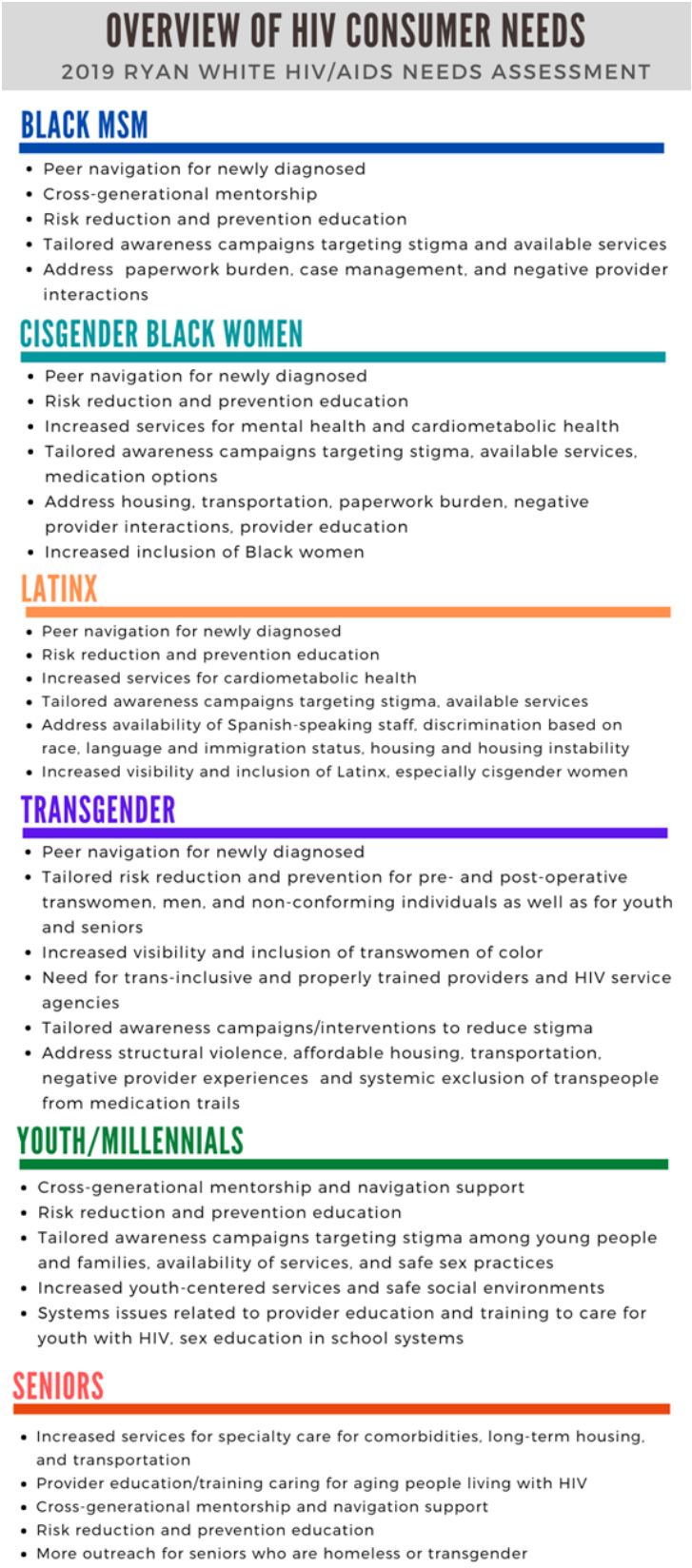


Figure 50. Recommendations based on identified needs for priority populations

Table 9. Comparison of Socio-Demographics, Healthcare Utilization, Sexual Health Practices, and Chronic Health Conditions among Priority Populations						
	Overall	**Black MSM[2]**	**Heterosexual Black Women[1]**	**Youth/ Millennials**	**Seniors**	**Hispanic/ Latinx**
	N= 392	***N=45***	***N=43***	***N=83***	***N=107***	***N=50***
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.

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 LGBQ 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.

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 Grinder 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	• 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	• 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	• 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	• 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 (
Heterosexual Women	63
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 8th 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 analyze 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
____Cooke
____Dallas
____Denton
____Ellis
____Fannin
____Grayson
____Henderson
____Hunt
____Kaufman
____Navarro
____Rockwall

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 **no**t 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

<u>Testing and Medication</u>

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.

	In 2018, what was the average number of days clients had to wait for their 1st appointment?	**In 2018**, 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/respite care for children		
Adult respite 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	☐ Evening Hours ☐ Weekend Hours
Translation Services	☐ Yes ☐ No
Eligibility Criteria for Services?	☐ No ☐ Yes:_____
Costs for Services	☐ Free services available ☐ Co-Pay ☐ Sliding Scale/Fee based on income ☐ Other:_____
Services Available to Youth Under 18 Years Old	☐ Yes ☐ No
Funding Source	☐ Ryan White HIV/AIDS Program, Part A or Part B ☐ State Funding (TDSHS ☐ Federal Funding (Medicaid, Medicare, SAMSHA) ☐ Information Not Available
Prevention Services	☐ HIV Testing ☐ STD Screening ☐ Partner Services ☐ PrEP/PEP Services ☐ Peer Support ☐ Syringe Service Programs ☐ Substitution Therapy (e.g., Methadone) ☐ Individual Counseling ☐ Group Intervention
Care Services for People Living with HIV/AIDS	☐ Linkage to Care ☐ HIV Medical Care ☐ Prevention Services ☐ Insurance Navigation ☐ Home Health Services ☐ Hospice Care ☐ Mental Health Services ☐ Substance Abuse Outpatient Care ☐ Medical Case Management ☐ 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 markedly 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	00	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

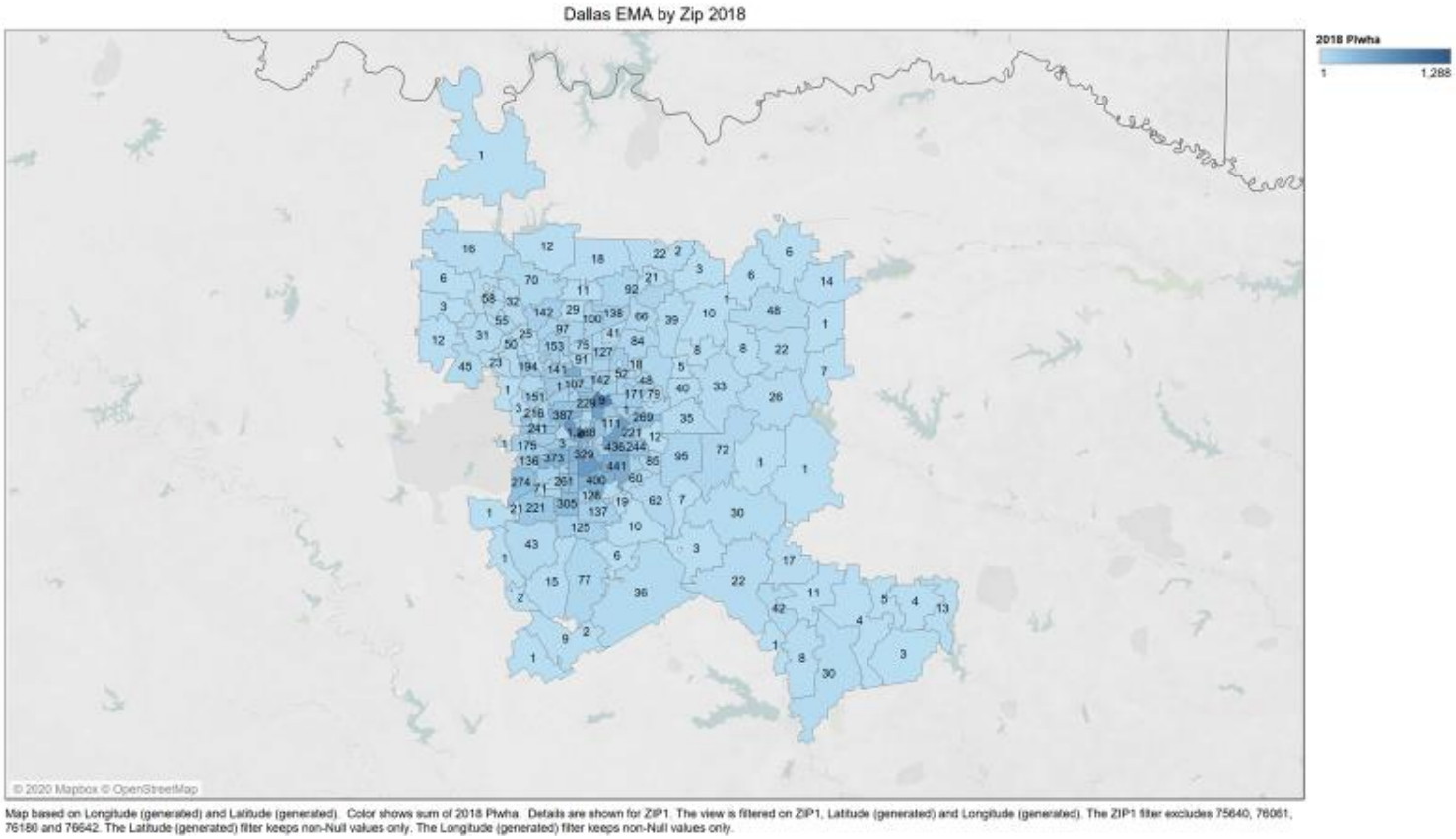
Yellow: below 90% goals

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.bridgenorththexas.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