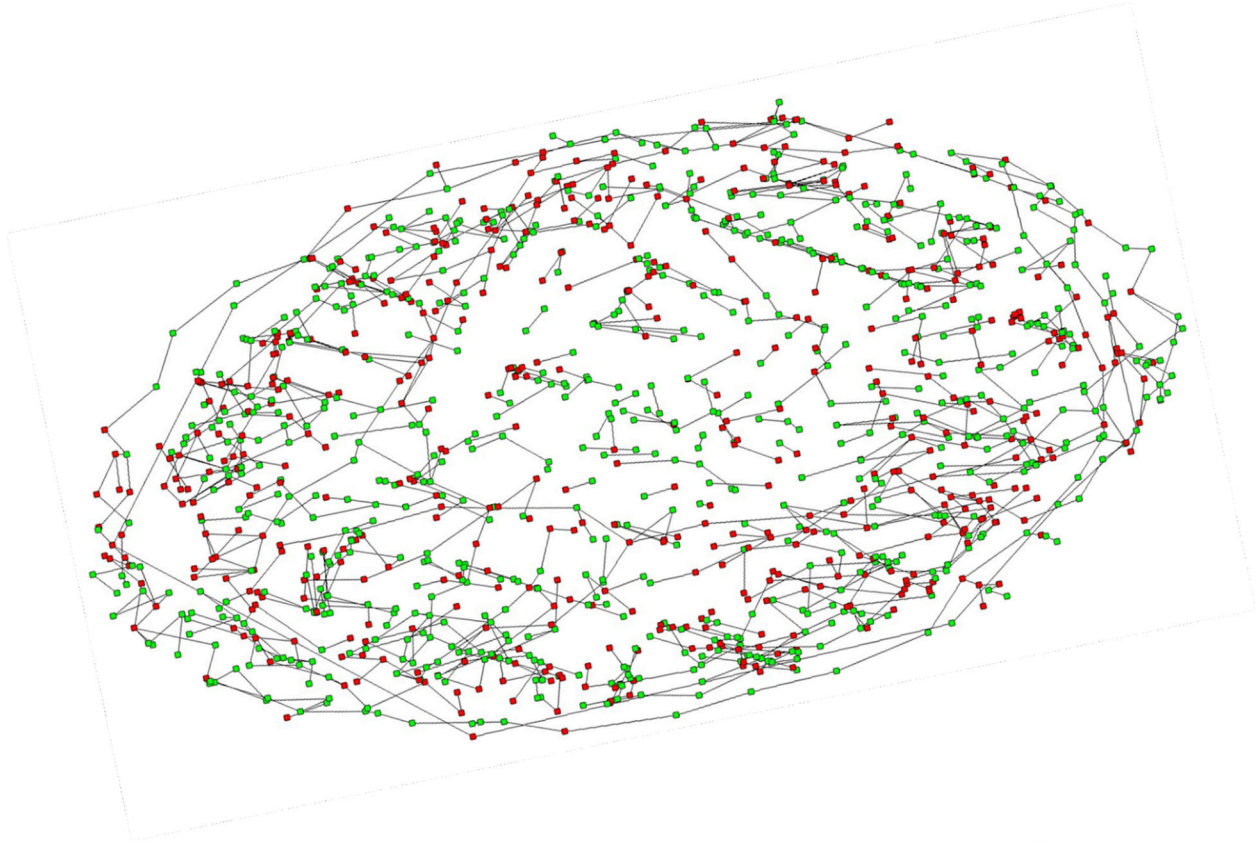


2022 Dallas EMA/HSDA Status Neutral Needs Assessment



Executive Summary

This section to be finalized after feedback from stakeholder partners is gleaned

Table of Contents

Background.....	4
Impact of COVID-19 on Service Delivery.....	6
Impact of MPox.....	8
Political Harassment of Transgender Individuals.....	8
Impact of Stigma and Ethnocentrism.....	9
Lack of Health Insurance.....	10
Goal Setting.....	11
Methods.....	11
Overall SNNA Sampling Strategy.....	13
Survey Instrument Creation.....	15
Survey Instrument Dissemination.....	15
Focus Group Facilitation and Key Stakeholder Interview Guide Process.....	16
Focus Group and Key Stakeholder Recruitment and Competition.....	17
Mixed Methods Analysis Recreation.....	17
Limitations.....	19
Results.....	20
Outreach Efforts Results.....	20
Summary Sample Demographics.....	24
Summary Results.....	25
Focus Groups and Key Stakeholder Interview Results.....	41
Overall Results Across SNNA Components.....	45
Findings.....	46
Resource Inventory.....	46
Profile of Provider Capacity and Capability.....	47
Assessment of Service Gaps and Unmet Needs.....	48
Discussion and Recommendations.....	49
Recommendation 1: Health System Strengthening.....	50
Recommendation 2: Public Health Campaigns on EHE.....	54
Recommendation 3: Cultural Humility Training for ALL.....	54
Recommendation 4: Biomedical Intervention Training for ALL.....	55
Recommendation 5: The HIV Community as a Human Resource.....	56
Additional Discussion.....	57
Bibliography.....	58
Acknowledgements.....	58

Table of Figures

CREATE THIS TABLE ONCE FEEDBACK HAS BEEN RECEIVED ON ANY NEW TABLES/FIGURES

Background

The Dallas County Health Department and Ryan White Planning Council HSDA contracted with Ready Aim Innovate, a program of Hager Health, LLC (RAI) to conduct a Status Neutral Needs Assessment (SNNA). The purpose of the SNNA is to update the current profile of the HIV epidemic in the greater Dallas area. The SNNA provides information on the Dallas Eligible Metropolitan Area and Health Services Delivery Areas (EMA/HSDA) and the Sherman-Denison HSDA comprising eleven counties – Collin, Cooke, Dallas, Denton, Ellis, Fannin, Grayson, Hunt, Kaufman, Navarro, and Rockwall. These counties are diverse in both their geographies, size, and demographics. Dallas County is a major metropolitan city home to nearly 2.6 million residents, while some of the smaller more rural communities such as Navarro and Fannin County have 54,000 and 37,000 residents respectively¹. The availability of data for the counties within the catchment areas varies as highly as their geographies and sizes with the most robust data being available for Dallas County. As it is generally accepted that the HIV epidemiological profile for the Dallas AA is reflective of the overall trends in Texas, some data will be more focused on the Dallas region. English and Spanish are the primary languages spoken in the Dallas AA with Mandarin Chinese and Vietnamese, representing less than 15% of the total population. Less is known about those at high risk for HIV because higher risk behaviors often happen outside of the medical system and are not as well defined or tracked. The syndemics of syphilis and HIV continues to be a driving force in new HIV infections (Wu et al, 2021). Syphilis infections are often used as a proxy for higher risk sexual practices with increased risk of HIV acquisition, especially in men who have sex with men. Data from annual Dallas HIV/STI profiles were compared and identified increased risk (Ibid). In 2018, syphilis rates were highest amongst those ages 15-34 which mimics the HIV epidemic in the Dallas AA (DCHHS, 2019). Similarly, the rates of probable and confirmed congenital syphilis cases in Dallas County increased by 130% from 2017 to 2018 (DCHHS, 2019). Congenital syphilis is a proxy indicator for increased susceptibility for women in the Dallas AA and also speaks to a lack of connection to prevention and treatment services. The presence of other STI infections also increases HIV transmission risk. Recent Dallas HIV/STI profiles report consistent increases in the number of chlamydia and gonorrhea infections leading up to the COVID-19 pandemic. As such, it is imperative that the Dallas AA has aggregated local data from individuals engaging in higher risk behaviors. Using the most recent data sets from the Texas Health Data Sets (2018, 2019), the Kaiser Family Foundation (2019, 2020) and Ryan White Services Data (HRSA 2010-2019) the following is known:

- Nearly 60% of Texans report having never taken an HIV test; this number has remained static since 2013;
- Of those newly diagnosed in Texas, 14% report a risk factor associated with Injection Drug Use (IDU); 61% have a risk factor of men who have sex with men (MSM), and 23% report a heterosexual risk factor;
- Men are 4.5 times more likely to be diagnosed with HIV than their female counterparts in Texas (2019);

¹ US Census

- Of the 94,630 people living with HIV in Texas, only 46% were receiving any type of Ryan White Service (2018); 75% of those receiving Ryan White services in Texas are living below 138% of the Federal Poverty Line;
- There were 89 documented cases of transgender individuals diagnosed with HIV in Texas in 2019, however there total number of transgender persons in Texas is currently not measured so it is not yet possible to determine the significance as a reflection of total population;
- Black and Latinx women and men are overly represented in the rate of new HIV cases in Texas; and
- In 2019, 21% of HIV diagnoses in Texas were made late corresponding in an AIDS diagnosis within the year.
- According to AIDSvu, the percent of the population lacking health insurance in 2019 averages to roughly 20% of the public in the Dallas AA region. This translates to approximately 1.1 million people in the region who lack health insurance according to 2020 census data.

The SNNA has been highlighted as an innovative practice by the CDC, recognizing Texas as one of five EHE jurisdictions to “improve access to social services for all people”². In alignment with this approach, this evaluation includes those with higher vulnerability to HIV infection as well as those currently living with HIV/AIDS. This assessment will also highlight how behavioral and biomedical interventions can be incorporated to prevent the spread of HIV as well as the role of ongoing engagement in care utilizing treatment as prevention (TASP). Priority populations for the local EMA and HSDAs include Hispanic men and women, African American men and women, Caucasian men and women, Men who have sex with men, Transgender persons, and youth (13 – 24 years). Within these populations, Black MSM,

STATUS NEUTRAL AT THE COMMUNITY LEVEL



Example of a community level status neutral approach from an agency perspective, leveraging internal services and external partnerships with agencies providing community prioritized services.

² <https://www.cdc.gov/hiv/policies/data/status-neutral-issue-brief.html>

Hispanic/Latinx men, Hispanic/Latinx women, transgender men and men, and youth living and youth at risk of contracting HIV/AIDS require additional attention due to an enhanced risk to HIV exposure and were those targeted for the surveys, focus groups, and key informant interviews.

With enhanced focused on locally relevant populations, a true status neutral approach includes the following elements at the community level

The number of new HIV infections in the Dallas County EHE jurisdiction has remained consistent at approximately 4,500 new infections per year through 2019. However, there was a substantial drop in HIV diagnoses in Dallas between in 2020 with 2020 having the lowest number of new cases reported since 2008³. Similarly, the number of HIV tests in Texas fell from 2018 to 2019 and continued to drop during the course of the COVID-19 epidemic. Conversely, preliminary CDC data indicates the number of PrEP users has increased steadily since 2017 from 9.5% to approximately 24% in 2022⁴.

Impact of Covid-19 on Services Delivery

Beginning in 2020, COVID-19 cases increased exponentially across the Globe, with thousands of cases occurring in the United States on a daily basis. The impact of the COVID-19 pandemic was felt significantly in the jurisdictions being evaluated by the Status Neutral Needs Assessment, with nearly 700,000 cases in Dallas alone^{5,6}. The entirety of North Texas was identified as a “red zone” area in August 2021 by county issues indicating an extremely high risk of COVID infection; to date the counties have not met the “green” criteria of “New Normal with All Recommended Vaccine Doses⁷

The coronavirus pandemic left an indelible mark on the care provided to individuals living with or at risk for HIV infection in Dallas and the surrounding counties. Dallas followed a national trend in which HIV testing numbers dropped significantly with the start of the pandemic and have yet to achieve pre-pandemic levels. Between 2019 and 2020, the number of HIV tests conducted decreased by 17%⁸. Other interruptions to health services included:

- Individuals self selecting out of testing to comply with public health and social distancing recommendations
- Health Departments redirecting resources from other service delivery areas including sexual health services

³https://www.google.com/url?q=https://aidsvu.org/local-data/united-states/south/texas/&sa=D&source=docs&ust=1677776104944124&usg=AOvVaw2VDFSmEeeMKtSNY_nfrRaf

⁴https://www.google.com/url?q=https://ahead.hiv.gov/locations/texas&sa=D&source=docs&ust=1677776104949104&usg=AOvVaw1p7lxu0W9_tesAnwj11rKz

⁵<https://www.google.com/url?q=https://www.nytimes.com/interactive/2021/us/dallas-texas-covid-cases.html&sa=D&source=docs&ust=1677776104943034&usg=AOvVaw3gh7Lra3fSCee1GJ5da241>

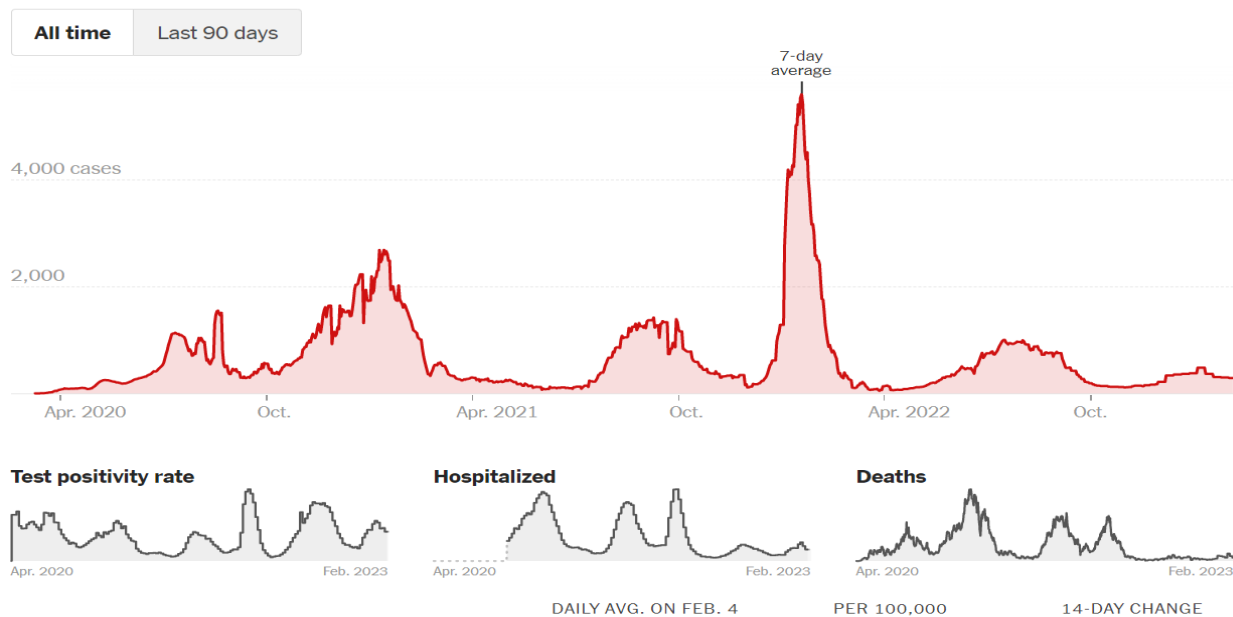
⁶ <https://www.nytimes.com/interactive/2021/us/dallas-texas-covid-cases.html>

⁷ <https://www.dallascounty.org/covid-19/guidance-health.php>

⁸ DiNenno EA, Delaney KP, Pitasi MA, et al. HIV Testing Before and During the COVID-19 Pandemic — United States, 2019–2020. *MMWR Morb Mortal Wkly Rep* 2022;71:820–824. DOI: <http://dx.doi.org/10.15585/mmwr.mm7125a2>

- Community based organizations and AIDS Service Centers closing, providing less in person services,
- Staffing shortages due to infectious disease providers being reassigned to COVID related work, illness amongst front line workers, and an increase in healthcare worker resignations.
- Loss of employer based health insurance⁹

New reported cases



New York Times: Texas Latest Map and Case Count (Accessed 5 February 2023)

These challenges were not unique to our catchment area with national data showing that *the* COVID-19 pandemic was highly disruptive to HIV service systems and resulted in the redistribution of staff to manage the crisis and severely diminished reporting capacity. Infectious disease providers and staff were overwhelmed by the immediate service needs of COVID-19 and managing waves of death. Such emergency efforts in public health departments at the local, county, and state level reduced the capacity for effective data reporting from 2020 to 2022. Similar demands were placed on the service provider organizations where staffing, funding, and material resources were stretched beyond comparison. This comprehensive status-neutral needs assessment is timely in identifying both the emerging trends following the COVID-19 pandemic and how the pandemic has changed the landscape of those living with and at risk for HIV. Research is being conducted in this topic area, and an article published during the height of the pandemic by the Lancet (Jang et al, 2020) reported the following factors:

⁹ Hoover KW, Zhu W, Gant ZC, et al. HIV Services and Outcomes During the COVID-19 Pandemic — United States, 2019–2021. *MMWR Morb Mortal Wkly Rep* 2022;71:1505–1510. DOI: <http://dx.doi.org/10.15585/mmwr.mm7148a1>

- Implementation of quarantine, social distancing, and community containment measures have reduced access to routine HIV testing;
- Timely linkage to HIV care could be hindered during the COVID-19 pandemic;
- People living with HIV who should have initiated antiretroviral therapy (ART) in hospitals might be deterred or delayed because hospitals are busy treating patients with COVID-19; and
- The COVID-19 pandemic might also hinder ART continuation as some pharmacies decrease their operating hours and providers, inundated with COVID-19 related job responsibilities, take longer to respond to message and refill requests.

Other authors confirm that COVID-19 negatively impacted self-management among people aware of their HIV status due to myriad stressors and structural challenges that disrupted their ability to engage in their care (Wion and Miller, 2021).

It is important to note other recent trends impacting the Dallas EMA, HSDA, and Sherman-Denison HSDA including:

- The impact of Mpox on service delivery;
- The current political harassment of transgender individuals on service delivery;
- The impact of stigma and racism/ethnocentrism on service delivery; and
- The lack of health insurance and prescription coverage for both those living with and at higher risk for HIV infection

Impact of Mpox

The rise of Mpox during the COVID epidemic further strained infectious disease resources through synergistic interactions; those with highest potential to Mpox exposure were the same as those with the highest vulnerability of acquiring HIV—men who have sex with other men. However, within this syndemic, we saw a different kind of community mobilization within the LGBTQ community given their experience from the early days of organizing and advocating around HIV without waiting for federal leadership¹⁰. In this way, Mpox was largely controlled within the United States¹¹. Mpox was contained much more rapidly through this grassroots approach, and as will be discussed below, this type of community led interaction is also paramount for Ending the HIV Epidemic in Texas.

Political Harassment of Transgender Individuals

Across the nation, there are currently over 300 bills focused on limiting the rights of those who identify as transgender, gender nonconforming, and nonbinary. Texas currently has 23 of these

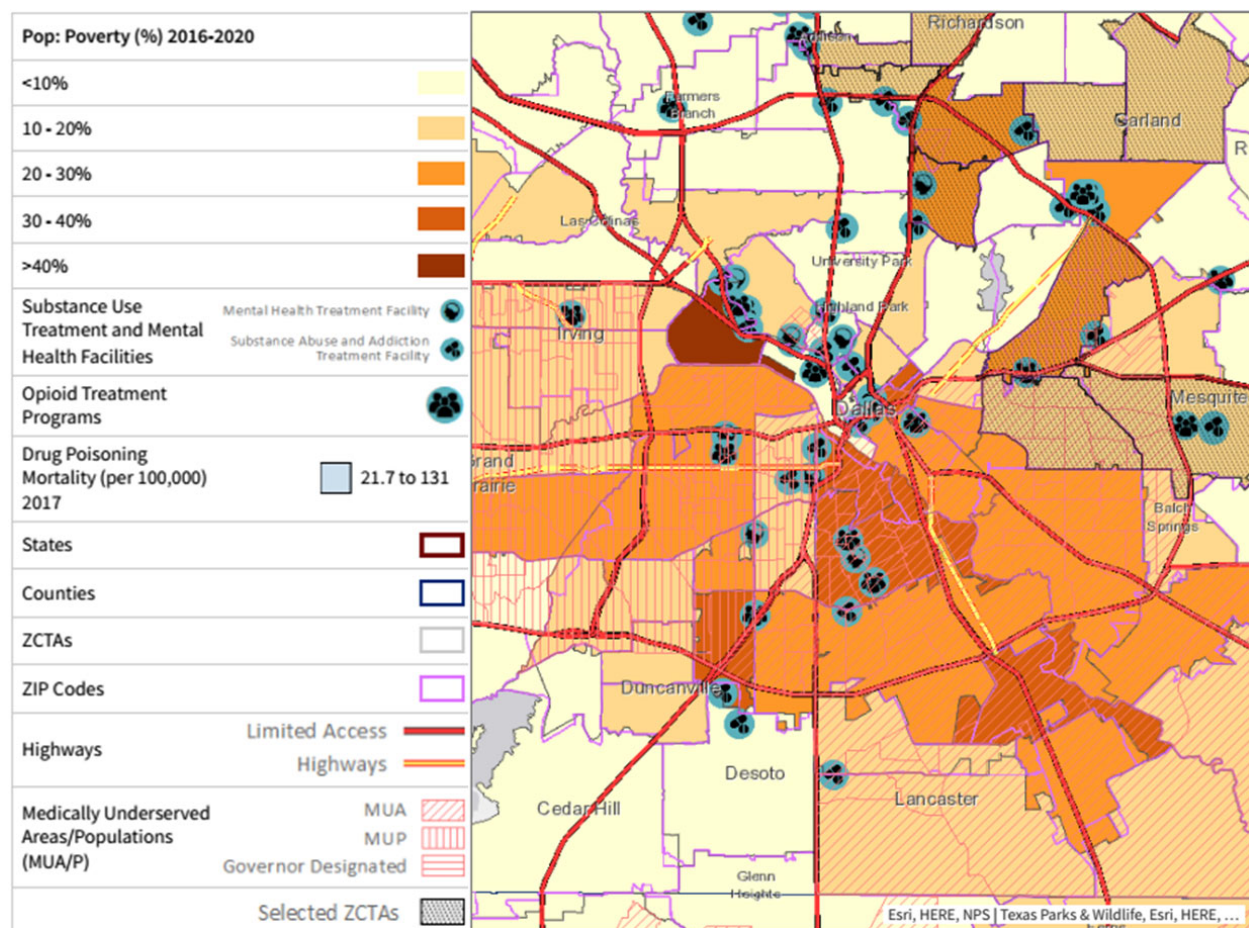
¹⁰<https://www.google.com/url?q=https://www.statnews.com/2022/06/08/lessons-from-aids-playbook-are-guiding-response-to-monkeypox-outbreak/&sa=D&source=docs&ust=1677776104959270&usg=AOvVaw06J3j826D7iFLvlseHd5m5>

¹¹<https://www.google.com/url?q=https://www.ajmc.com/view/contributor-on-world-aids-day-lessons-drawn-from-hiv-mpox-and-covid-19&sa=D&source=docs&ust=1677776104959964&usg=AOvVaw18IXgLBMSNSVODv4JACtZY>

legislative initiatives aimed at limiting civil liberties and the right to freedom of expression¹². This political campaign has also been broadly promoted at the community level through various levels of media and constituency organizing. Noted later in the results session, we see the direct impact of this on the perceived safety by trans* identified individuals to access services and participate in the community.

Impact of Stigma and Ethnocentrism

Demographically, Texas is predominately white comprising 78% of the population, followed by Latinx at 40.2, and Black/African American at 13.2 %. True health equity would show a similar burden reflective of population demographics. As aforementioned, we see enormous disparities in the acquisition of HIV with Black/African Americans shouldering the highest burden.



¹²<https://www.google.com/url?q=https://www.aclu.org/legislative-attacks-on-lgbtq-rights?state%3DTX&sa=D&source=docs&ust=1677776104946720&usg=AOvVaw21twDLayV7QcPyHqLBFAYt>



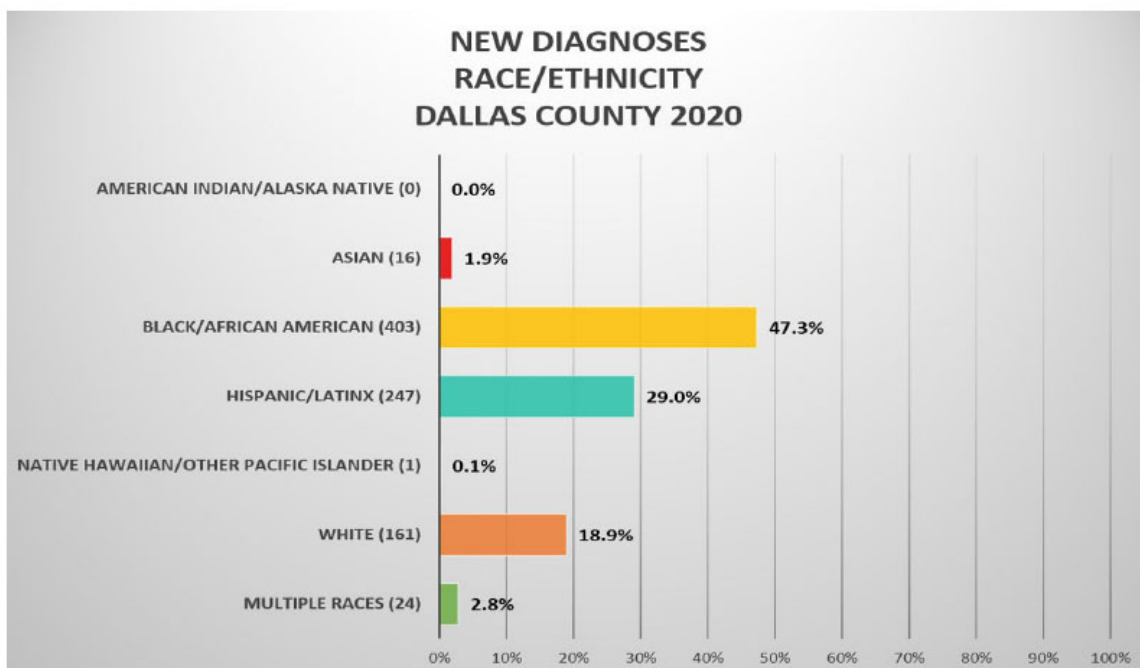


Figure 2. New Diagnoses of HIV in Dallas County by Race/Ethnicity 2020
Source: Texas HSDA

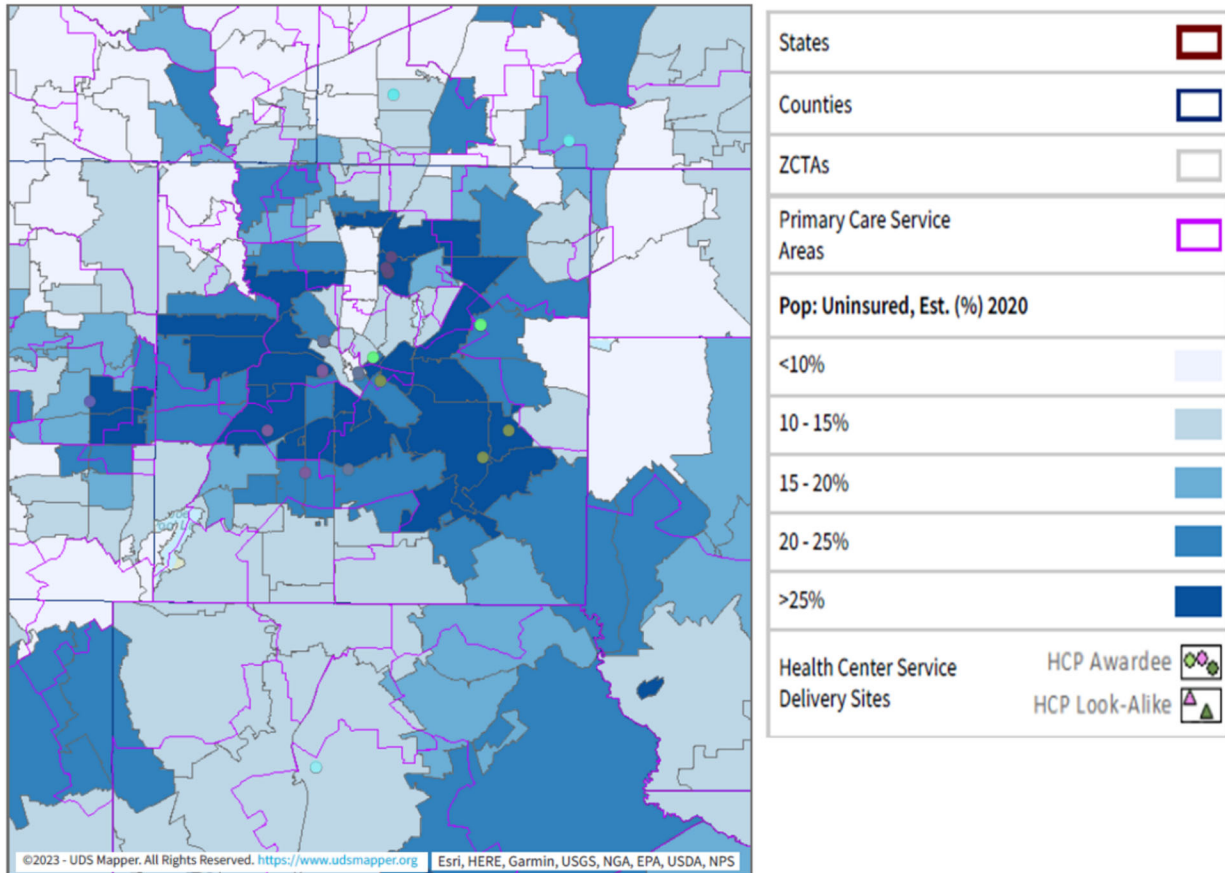
We also see this reflected in poorer health outcomes from the intersectionality of the stigma of living with HIV compounded by the additional stigmas of racism and ethnocentrism. Fear of stigma and discrimination lends itself to decreases in HIV testing amongst priority populations and lack of engagement in preventive services such as PrEP, PEP, and fear of accessing community based services.

Lack of Health Insurance

Texas is one of twelve states that has not participated in Medicaid expansion. If Texas were to expand its Medicaid program, 1,432,900 uninsured nonelderly adults would become eligible for coverage, 34% of the state's uninsured nonelderly adult population¹³. Within the community of those living with HIV, Medicaid expansion could result in up to 28% of PLWH/A obtaining health insurance coverage. The financial eligibility threshold for the AIDS Drug Assistance Program (ADAP) is also extremely low at 200% of the FPL. In contrast, Maryland, a state which has accepted Medicaid Expansion, the ADAP eligibility threshold is 500% of the FPL. Florida, which is also a non-Medicaid Expansion state, has an ADAP limit of 400%. While we do not know the number of adults ages 18-64 that could benefit from prevention services in Texas, it can still be clearly stated that a lack of insurance creates a clear barrier to biomedical and other clinic level interventions.

¹³<https://www.google.com/url?q=https://files.kff.org/attachment/fact-sheet-medicaid-expansion-TX&sa=D&source=docs&ust=1677776104960543&usg=AOvVaw289YkvU0Lz5PeEstWdHIHe>

Uninsured Dallas Metropolitan areas, 2020 UDS Data

**Goal Setting**

The SNNA design is strongly aligned with the goals of the four pillars of the Ending the HIV Epidemic (EHE) and the 2022 -2026 Dallas Regional Area Integrated HIV Prevention and Care Plan CY 2022 - 2026 (Integrated Plan):

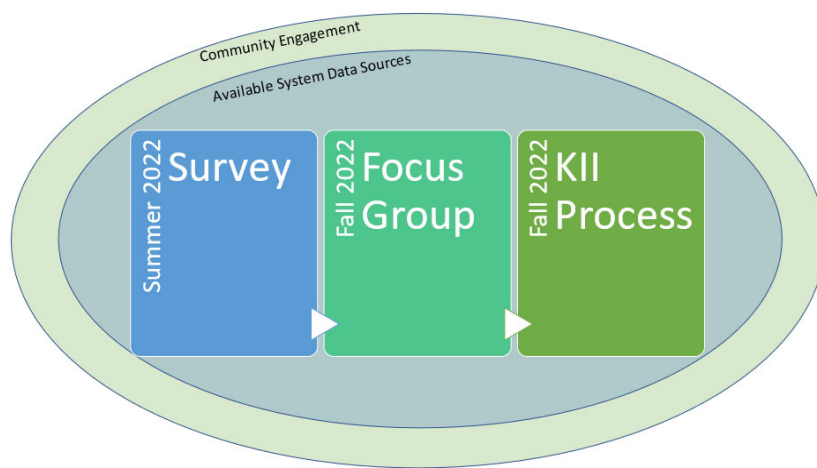
- Diagnose all Dallas Regional Residents as quickly as possible.
- Treat all HIV diagnoses quickly and effectively.
- Prevent new transmissions among Dallas Regional Residents using proven methods and strategies.
- Respond quickly to potential outbreaks by getting prevention and treatment services to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

Methods

The Dallas SNNA was designed to occur in three phases of data collection – a traditional survey disseminated using respondent-driven sampling, a series of focus groups, and a set of key stakeholder interviews. This model is an evidence-based approach standard to RAI’s step-wise

needs assessment process. The three status-neutral, community-focused evaluation activities were bookended by discussion featuring substantial input by a wide range of stakeholder groups, including HIV planning organizations, non-funded service provider organizations, and HIV community social groups. Beginning with available system data, the RAI team engaged HIV service system stakeholders in the Dallas EMA/HSDA to identify key target populations and geographies to conduct the survey. For example, key HIV planning bodies provided a “starter” survey with preferred domains and verbiage that was integrated into the standard RAI HIV community needs assessment, recruit respondents, and develop recommendations were all shaped with the influence of the local community.

To construct the resource inventory, statement of provider capability and capacity, and the assessment of unmet service needs, a mixed methods data analysis was required. Quantitative and qualitative information of various types were collected including social determinants of health information related to local HIV and STI transmission, listings of available services at key service provider organizations, and the degree to which currently available services in the Dallas EMA/HSDA meet the needs of the community. The accompanying diagram provides a visual of the overall process.



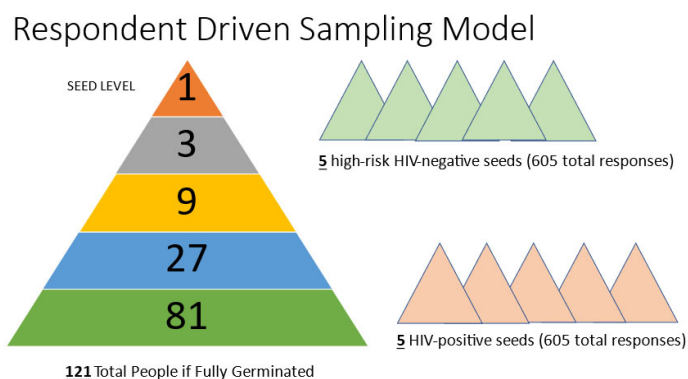
To identify the service needs of the HIV community, the Project Director and Research Director began by meeting with HIV planning bodies and key HIV service system leaders of the Dallas EMA/HSDA. A uniform question set (Appendix X) was used during these meetings to ascertain trends across the target areas and target populations, including service needs and utilization patterns within the HIV-positive and high-risk negative aspects of the HIV community. Community liaisons and the Peer Community Health Worker connected with Consumer Advisory Boards at HIV service organizations in the Dallas AA region and collected information to inform our process of survey respondent, focus group participant, and key stakeholder interview participants.

As previously mentioned, core evidence-based strategies used to develop the SNNA included respondent-driven sampling, mixed methods data analysis, and key informant frameworks. In addition, the SNNA was created using an implementation science approach that allowed for quick strategically planned adjustments to occur while data collection was in progress. Each of these will be described in detail below relevant to the specific methods of each component of the SNNA.

Overall SNNA Sampling Strategy

RAI utilized a snowball sampling strategy across the three components of the SNNA. The strategy was informed by the initial conversations with local key informants. In these meetings with Planning Council members, local RWHAP subrecipient organization leaders, and the CQM Program staff it was determined that certain populations would be exceedingly challenging to access and assess using traditional approaches. These groups were defined as those with a high HIV incidence and prevalence and who are typically absent from HIV planning body meetings and do not appear in other existing qualitative data assessments. RAI outreach staff created a strategy to target specific agencies and venues around the Dallas eligible metropolitan area to identify access to those populations that key informants had noted would be hard to reach using this definition. Such agencies were requested to provide an introduction to participants at their programs who were known to have large social networks or who served as gatekeepers to their specific communities. It was determined early on to use an overall data-to-care approach to sample the population. Methods standard to the HIV field are woefully inadequate in assessing the true extent of community need and unmet need by only focusing on information collected from individuals currently in care and accessing care at a specific site in a specific time frame. RAI and DCHHS believed we could and should do better.

The snowball sampling strategy began with the targeted initiation of the survey instrument in specific settings. If successful, respondent-driven sampling with three referrals up to five levels would allow for 121 respondents for each seed. To that end, a carefully planned strategy to estimate how respondent referrals would flow through the community and across key subpopulations was needed. The accompanying diagram demonstrates how five initial high-risk negative “seeds” and five initial HIV-positive “seeds” would lead to roughly 86% data capture (1210 of 1400 expected responses). According to this plan, the remaining 14% of the desired respondents would be approached on a one-by-one basis to get more from key groups that are missing from the collected dataset with the goal of 700 HIV-positive and 700 high-risk negative cases in the end. In the event that “seeds” did not germinate fully into a set of 121 respondents, the “reseeding” strategy noted above would be followed per our implementation science approach. The reseeding would happen as many times as needed to reach the full number of survey respondents required by the deliverables (n=1400). The strategy of seeding based on the intersection of demography, geography, and implementation science is a strongly data-to-care model.

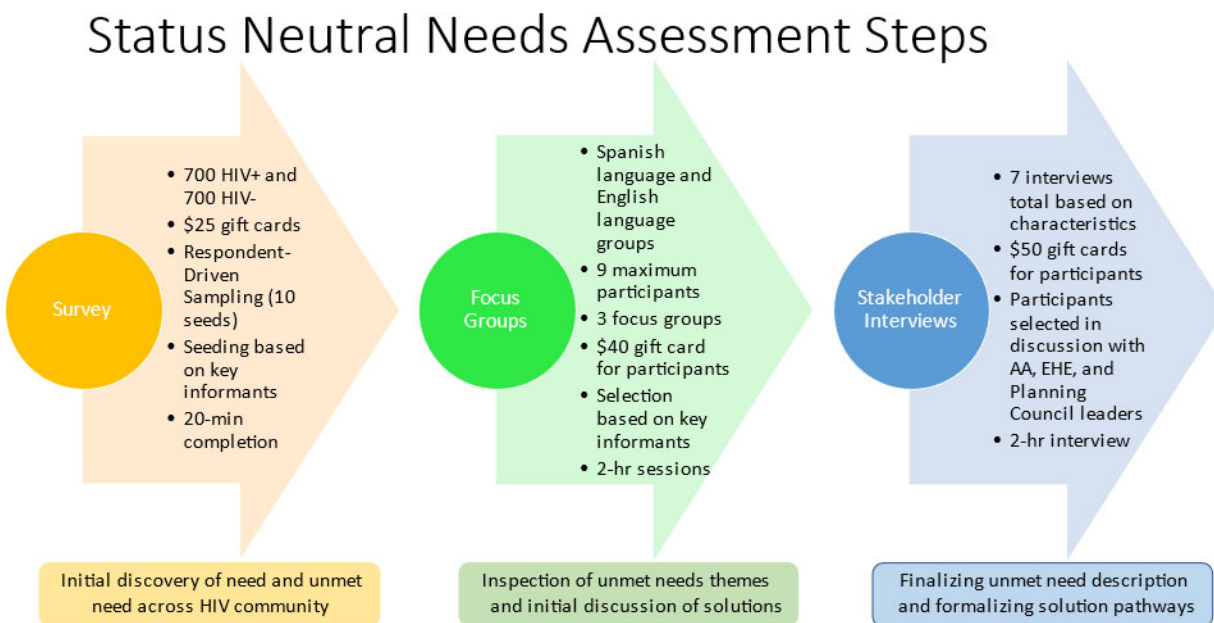


Following the survey, focus groups were designed to process pre-digested survey data to identify themes in the results and to create early sets of potential remedies and

recommendations. The survey data were to be blended with other available to assist the focus groups to have the most complete picture of service needs for the entire HIV community - those with HIV and those at high-risk for HIV. Participants for the focus group were to be identified by the emerging needs exhibited in the survey data and/or to help correct for key populations that are still missing from the data. Specific Where needed, key informants would be used to help build support for participating in the focus groups.

Following the focus group, the data from the surveys and the focus groups would be merged to create a more advanced picture of community needs, patterns of unmet needs, and options for potential action to improve the Dallas area HIV service system. Interviewees were identified using a starter list provided by the Dallas Planning Council and appended to in discussion with other key informants in the Dallas region during initial conversations.

RAI's implementation science approach for the SNNA provided for the opportunity to swap the timing of the focus group and key stakeholder interviews if for some reason the survey data collection process was lagging. Other implementation science options for sampling strategy included: refreshed key informant meetings with additional questions on how and where to access key populations, and a reversion to traditional data collection for such community needs assessments where staff are positioned in care organizations to directly collect the survey data. The following diagram exhibits the initial plan for strategic building of needs assessment data across the three components of the SNNA using RAI's data to care approach.



Survey Instrument Creation

The SNNA survey instrument consisted of 55 questions including 105 total items programmed into the Formsite online data collection tool. The survey started with a welcome message and instructions including asking respondents for their informed consent to complete the survey. The body of the survey covered key domains essential to identifying community need and identifying unmet need among the respondents. DCHHS planned for the SNNA survey component to be incentivized at \$25 per respondent up to 1400 total responses. Surveys were translated into Spanish and back-translated to verify their reliability. Clients were offered either version based on their preferences.

Survey questions were designed to identify the extent to which the service community addresses social determinants of health and meets other core needs. Respondents were asked questions related to their identities, residence, and other demographic factors focused on baseline social determinants of health. This included history with the criminal justice system, preferred language, income and insurance status, highest educational level attained, and housing and food (in)security among other details. Respondents were also asked about HIV status and risk factor information, HIV and STI and testing habits, knowledge about PrEP, PEP, and U=U information, medication adherence history, medical & support services access patterns. In addition, the SNNA survey included a strong vein of questions related to discrimination and implicit bias. Finally, the survey included fields to capture contact information facilitating incentive distribution and to identify the three referral respondents based on the survey dissemination method.

Survey Instrument Dissemination

RAI outreach staff used the framework created by the research staff to seed the survey instrument. A Quick Response (QR) code was created with the survey link. RAI outreach staff were instructed to use the Quick Response (QR) code to help recruit initial respondents. RAI outreach staff met with respondents and provided links to smart phones to use or tablets for respondents to use to complete the survey.

Seeds were selected based on the data to care process described above where the RAI research staff and outreach staff shared information on key characteristics and geographies of interest based on risk patterns evident in the epidemiological profile. RAI outreach staff met with seeds in person to collect the seed survey data and set referrals in motion. Referrals were processed through the same online software (Formsite) used to collect the data. Once submitted, Formsite generated an email to each referred person to invite them to take the survey and access the incentive. The survey software allowed us to track IP address information to verify that unique individuals were completing the survey and track that they were being completed within the continental United States.

RAI outreach staff was also deployed to do survey recruitment with populations that might have limited access to online recruitment. Staff were provided with the QR code and were able to use either a tablet or cell phone to assist in completing surveys with individuals in public settings.

Early in the survey instrument deployment, there were challenges with the respondent driven sampling methodology (described in detail below in Results and Discussion/Recommendations sections). To ensure timely data collection, a system of constant reseeding was established. The survey QR code was added to fliers for dissemination at partnering agencies and for inclusion in pharmacy pickup bags. In the end, several waves of recruitment were conducted using online data applications to supplement venue recruitment strategies.

Focus Group Facilitation and Key Stakeholder Interview Guides and Processes

According to the initial SNNA design, the survey was to occur first, followed by the focus group, and finishing with the stakeholder interviews. It was always planned for the focus group facilitation guide and the key stakeholder interview guide would be developed after a critical mass of survey data was collected to ensure practical and usable questions were asked and appropriate probes included. At a high level, these more targeted SNNA components were intended to generate cross-cutting themes, identify emerging challenges, and get community perspectives into appropriate solutions bases.

When there was a delay in survey data collection based on a lack of followup by referred respondents, the RAI research team decided to change the order of the interviews and focus groups based on the implementation science approach. The key stakeholders would be invited to take the survey for an additional incentive and could then act as additional survey seeds.

Seven two-hour key stakeholder interviews were planned. Interviewees each received a \$50 gift card as an incentive. The key stakeholder interview guide was established to focus on key drivers and barriers to care. Interviewees were promised their responses would be coded and their identities blinded from DCHHS and other stakeholder knowledge. Probes for each question focused on what would have made the experience better or less bad, recommendations they would make to service system leaders, advice they would have for friends, and more questions to ground responses in real human terms (eg, one change they would make to the Dallas area service system to make their lives easier, what advice related to healthcare would you give a friend moving to Dallas, and specific examples of stigma and discrimination they have witnessed). The interview tool covered four main question areas: excellent service, terrible service, what to do if there were unlimited resources, and issues of stigma around HIV, PrEP, and U=U. Key stakeholder interviews were conducted by the SNNA Project Director and Research Director, both people with HIV for more than 15 years.

Three focus groups were planned with up to 15 participants each. Each participant received a \$40 incentive for their participation. Discussions were designed to last 90 to 120 minutes and in order to receive the incentive, participants needed to be present the entire time, have their cameras on, and participate both vocally and via chat room function. The facilitation guide was

almost exactly the same as the key stakeholder interview guide, because of the range of responses gleaned from the interviews. The RAI research team believed it was vitally important to explore in greater detail the themes of excellence, stigma, and discrimination that appeared in the survey data and become even more apparent in the key stakeholder interviews. The focus groups focused extensively on how certain realities made participants feel as human beings. The intent of these questions was to create a connection between stigma, behavior, harms, and opportunities to impact the public in more positive ways. The RAI research specialist who identifies with the HIV high-risk community facilitated the focus groups.

Focus Group and Key Stakeholder Recruitment and Composition

The data to care approach described in the overall sampling methods was used to establish the composition of the interviewee list and the focus group recruitment activity. Ensuring the key informant interviews are equally diverse as the surveys and focus groups was a key priority of the RAI team. This is important, as people considered to be knowledgeable about system dynamics at the appropriate level tend to be demographically and experientially similar, an artifact that the comprehensive status neutral needs assessment also seeks to address. When RAI pivoted to rely on interviewees to assist in survey recruitment, it was essential to ensure the cross-sections would be appropriately reflective for blended analysis across SNNA components, but also lead to reflective survey data collection. To be clear, RAI included black MSM, Hispanic/Latinx men, Hispanic/Latinx women, Transgender men and women, Youth living with HIV/AIDS, Youth at risk of contracting HIV/AIDS, Priority Populations that may be at risk of acquiring HIV as primary characteristics for interviewees. As mentioned previously, interviewees were identified based on a starter list provided by Dallas Planning Council and added to based on discussions with other key informants.

Following the data to care approach, the SNNA focus groups were targeted to focus on vulnerable populations missing from the collected survey data. Two focus groups were planned in English and one was planned in Spanish. As will be described below, the Spanish focus group had no participants so an additional English focus group was provided. One of the English focus groups was exclusively for the gender-expansive community and served as a safe place for that community. Recruitment for each focus group emphasized diversity of geography and involved key populations discussed above. RAI outreach staff relied on key informants as well as outreach and inreach to traditional hard to reach affected communities (e.g., people who use drugs, those who engage in transactional sex, those who are unstably housed, etc.) to ensure that all relevant risk groups are involved in the discussion.

Mixed Methods Data Analysis Procedures

The RAI team is made up of various elements of the HIV community, including people with HIV, people at high risk for HIV, and people who identify with key HIV risk groups in the Dallas region. As a result, the RAI research staff identifies closely with Dallas key populations. More than a symbol, shared identity is important for information bias, particularly classification bias,

during analytic processes. RAI prides itself on its demographic heterogeneity and that there is a great deal of commonality with communities of focus in its work.

The three components of the SNNA were analyzed separately at first and then analyzed all together. This method allowed for each component to be examined in its entirety and its results fed into the next component in a stepwise fashion. Multi-factor analysis rooted in demographic factors allowed for the detection of disparities and inequities. Further exploration of issues focused on service need and availability/ accessibility based on geography, language, and individual cultural fit.

All surveys were coded and analyzed by the Clinical Data Analyst using Jamovi™ version 2.3 software. Thematic analysis, applying the framework approach, was conducted including basic coding of the data and organization of codes into broad domains, whose purpose is to allow for various side-by-side and cross-tabulation (multi-variable) analyses. The epidemiological profile was used to direct survey seeding and analysis, focus group recruitment and facilitation guide creation, and the same for the key informant interview component. These data served as a reference point for discussion and potential recommendations on a population health basis. The data analysis process included organizing information and analyzing it in order to identify key needs, trends, and critical issues. The research team was able to visually represent the themes identified with key supporting quotes from the data (see Results section below). For example, an important aspect of the analysis is the network analysis associated with respondent-driven sampling and is reflective of the demographics of the Dallas region HIV epidemic.

The method used for analyzing data from focus groups and interviews involved the creation of a code book and then subsequently coding all recorded discussion material for key data points based on the code book. The purpose of the code book is to create a list of key areas of focus that can be evenly applied across each focus group and interview transcript. The data used in RAI's qualitative analysis was coded by one research team member and confirmed by a second team member. Statistical analyses included overall frequency data and frequency of responses for "in-care," "out-of-care," for each priority population and geographic segment.

Cross-tabulations with tests of significance for "out-of-care" were conducted within each priority population and geographic segment. These cross tabulations profiled each population, outlining their characteristics (socioeconomic, demographic, etc.), needs, barriers and unmet needs/service gaps. These profiles include comorbidities reported in the survey including domestic violence, substance use, and mental illness among survey respondents. All survey data were analyzed to obtain necessary information and recommendations.

RAI's analysis of these data was used to generate sets of findings and recommendations provided below. Preliminary results were shared with the Dallas Planning Council Needs Assessment Committee to obtain input on final recommendations. The Dallas Planning Council Executive Committee and broader Planning Council were also given the opportunity to provide their comments and ask questions before the SNNA report was considered FINAL.

Limitations

RAI's sampling methodology and other design elements for this needs assessment were calibrated to extend far outside the typical circles of input and feedback that are received from past needs assessment exercises. In many respects, the results received broke all expectations, but certain key populations were less prevalent in the data than expected. For example, a larger share of the respondents were expected to identify as LGBT. In addition, a larger share of the respondents were expected to identify as Hispanic. While RAI created a spanish-language version of the survey, there was almost no uptake and no onward referrals were picked up through respondent-driven sampling. As a result, these factors affect the generalization of results across aspects of the LGBT and Hispanic populations. RAI outreach staff went to extraordinary lengths to reach Hispanic respondents, which are described below in the Results section.

Almost all surveys were done on individual phones and other devices. Dallas County Health and Human services provided an iPad to assist in collection of data by outreach staff with folks who lack their own devices. RAI provided a mobile hotspot device to assist in areas where bandwidth is low. Unfortunately, the hotspot device was spotty based on local network strength and did not add much value in urban and rural areas alike with poor mobile access.

There was a missed opportunity to seed the SNNA survey instrument among gay men, particularly gay Hispanic men, at special events on the nightlife strip on Cedar Springs Rd. For future assessments, it is recommended that outreach staff spend at least one or two evenings on the nightlife strip to enroll LGBT people in community health assessment activities.

Three weeks into RAI's collection of data using the survey instrument, large numbers of responses were made in short periods of time, many of which had foreign IP addresses. The RAU research team took measures to ensure data collected in Formsite was secure and had not been breached. A lengthy process of data verification, cleaning, and revalidation was conducted to ensure that analyzed data were free from junk responses from pirates and others trying to access the incentive. To this end, a large amount of the research team's hired effort was spent on data integrity leaving less than the planned amount of time for the extensive expected cross-tabular analyses.

At several points in the survey deployment, individuals knowledgeable on survey deployment methods cautioned that the planned incentive payment schedule would be insufficient. The planned schedule was one \$25 per completed survey with a maximum of 1 survey to be completed per individual. For respondent driven sampling, there is typically additional incentive provided for each referral that completes the survey. \$45-\$75 would be more appropriate to provide a lump sum for survey completion, but enough additional payment for each completed referral to compel followup with all referrals. If RAI's methods had included the additional incentive payment for referrals, perhaps there would have been a greater degree of follow through on referrals that were made.

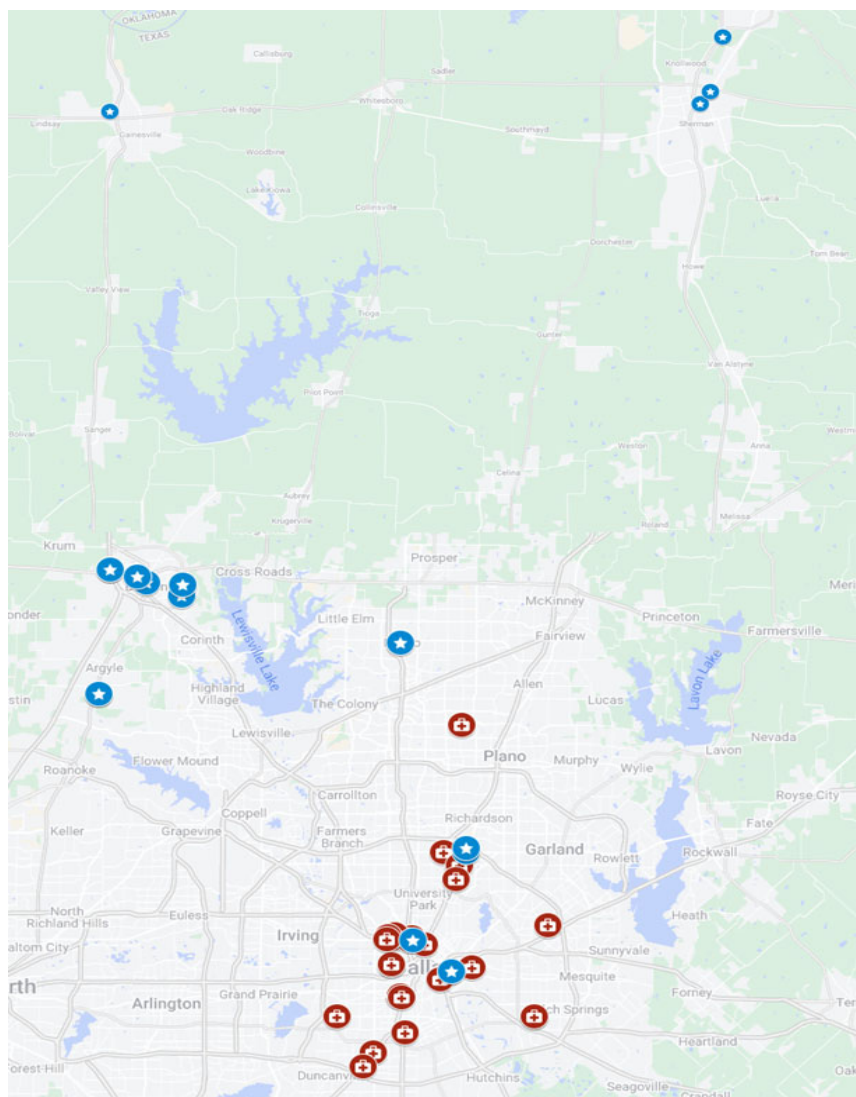
Several individuals approached to provide key stakeholder interviews declined, because they believed the incentive level was too low. In responding to the request for interviews, the would-be respondents stated that gift cards of this value level are also used for smaller commitments that made \$50 feel like too little for a one-on-one interview lasting up to two hours.

Results

The primary results of the SNNA focus on the three components of the needs assessment: the survey, the focus groups, and the key stakeholder interviews. In addition to reporting these results, the RAI team believes it is important to share additional information about outreach efforts and their relative success and failure in reaching new populations, especially hard to reach groups. For ease of review, this section is divided into five sections to allow for a thorough review of data from the assessment components, but bookended with additional details from the outreach team on their efforts.

Outreach Effort Results

In order to successfully complete the survey instrument using the respondent driven sampling method, a careful effort to seed the survey was made to ensure inclusion of results from all relevant groups. As mentioned previously, the epidemiological profile for the Dallas region was used to identify key groups of people whose responses to the survey and other SNNA components would be critical to synthesizing the need and unmet framework. The accompanying map was used to identify potential geographic priorities for survey seeding. On the map, red circles indicate where the RAI outreach staff should consider seeding the survey among people with HIV. The blue circles represent where the RAI outreach staff should consider seeding the survey among people at high risk for HIV. It is important to note that people with HIV were able to refer to high risk negatives to complete the survey and vice-versa. In the social



network graphic below, the interconnectedness of positive and high risk negative is evident.

In an effort to understand why certain populations were difficult to reach, the RAI research team interviewed the outreach team on their activities and the relative successes and challenges they faced in trying to recruit survey participants.

When asked which groups were approached and what the result was, the outreach team provided the following spreadsheet containing the exact names and addresses of all the groups reached out to in order to seed the survey and assist with RAI's outreach efforts. In summary, organizations catering to victims of human trafficking, pregnant women facing domestic violence and homelessness, centers of rehabilitation from substance use, clinics dedicated to Hispanic populations, CBOs for LGBTQ+, Denton County's testing sites, Adult Friend Finder dating site, Grindr, Sniffies, places where ranch hands frequent like the pit stop in Sanger where many migrant workers buy cases of beer after work, livestock and ranch stores with bulletin boards, and social media pages geared to Hispanic audiences. Additionally, outreach was conducted for the street homeless population, AHF/AIN, ASD housing programs (Hillcrest House and Evergreen House), and the Dallas Public Library. These locations were carefully selected by outreach staff to get substantial input from the chronically unhoused, people involved in high risk behaviors, black heterosexual people, and black and brown gay and sexually expansive people.

When asked about the relative success of working with various organizations on SNNA outreach, results were mixed. Organizations that already have experience working with HIV and STDs were the easiest to engage, including Ranch Hands Rescue, Callie Clinic, and Denton County Health Department. Other groups, including RWHAP funded entities in the exurbs were challenging to work with and it is not clear that staff at these organizations understood the purpose of the SNNA, RAI's approaches, and the vital role they could play in addressing historic wrongs. Cold calling and relying on the "Contact Us" form yielded the least results, while having a specific person to contact facilitated outreach and recruitment. Finding the right people to take this survey in a rural population was challenging because there are less people to begin with, people are more spread out, and signs of risk are less overt (and in fact actively hidden by people). Importantly, the Hispanic population is even more difficult to observe signs of risk due to cultural characteristics and issues related to safety rooted in regional politics. In rural north TX, there is a trend of increased drug use in the ranch-hand community so the outreach team targeted places where such people frequent as described above. While Adult Friend Finder seemed promising on the surface in terms of being able to select the desired type of sexual activity (i.e., HIV risk), people engaged there were more interested in chatting and entertainment, masking true patterns of risk.

Table X: RAI Outreach Team Organizational Partners

Organization	Key Informant	County
Texas Healthcare Advisory Council	Healthcare	Collin
North Texas Medical Center	Healthcare	Cooke
North Texas Rural Resilience	Mixed high risk clientele	Cooke
Abounding Prosperity	Mixed high risk clientele and PWH	Dallas
ACCESS Clinic at Moody	Mixed high risk clientele	Dallas
AHF Dallas / AIN	RWHAP clients	Dallas
AIDS Services of Dallas	RWHAP and high risk negative clients	Dallas
Bluitt Flowers Health Center	Youth aged 14-25	Dallas
CAN Community Health Center	Mixed high risk clientele	Dallas
Dallas Hope Charities	Unstably Housed	Dallas
Foremost Family Health	Mixed high risk clientele	Dallas
Healing Hands Ministry	Alternative Therapies	Dallas
LBU Community Clinics	Mixed high risk clientele	Dallas
Mission East Dallas / Metroplex Project	Mixed high risk clientele	Dallas
Mosaic Family Services, Inc.	Mixed high risk clientele	Dallas
Parkland Health	RWHAP clients	Dallas
Prism Health of North Texas	RWHAP clients	Dallas
Refugee Services of Texas	Refugees and Migrants	Dallas
Resource Center Dallas	RWHAP clients	Dallas
The Afiya Center	Pregnancy Center	Dallas
UTSW	Middle class clients	Dallas
Arabian Rescue Therapy	LGBTQ+ Community	Denton
Blue Haven	Counseling for pregnant woman	Denton
Bob's House of Home	Unstably Housed	Denton
C7 Human Trafficking Coalition	Victims of trafficking	Denton
Denton County Public Health	Public Health Department	Denton
Giving Grace	Shelter for families of substance abuse and other causes	Denton
Health Services of North Texas	PLWH	Denton
NA	PLWH	Denton
OUTreach Denton	LGBTQ+ Community	Denton
Ranch Hands Rescue	Victims of trafficking, esp males	Denton
Sober Living LLC	People in recovery	Denton
Treasured Vessels Foundation	Victims of trafficking	Denton
Woman 2 Woman Pregnancy Resource Center	Counseling for pregnant woman	Denton
Association for People Affected by Addiction	People with active addiction and those in recovery	Grayson
Callie Clinic	RWHAP clients	Grayson
Sherman-Denison Veterans Administration	Unstably Housed and Severe Mental Illness	Grayson
Texoma Medical Center	Healthcare	Grayson
Genesis Center	Counseling for pregnant woman	Kaufman
Kaufman County Hispanic Council	LatinX community	Kaufman

Beyond service organizations, social media is another important source of engagement for the key populations of interest to the Dallas SNNA. This includes the buy/sell pages on social media

apps/sites like Facebook and NextDoor. These pages are used for anything and everything and it is very local (some pages, like NextDoor require proof that users live in the area. To avoid phishers, pirates, and other risks for junk responses, the RAI outreach team only posted the Spanish flier with the QR code on such sites. The Hispanohablante outreach staff person only received 2 inquiries out of all the pages posted demonstrating that this method is not as effective as relying on personal connections to have the survey filled out. Moreover, the majority of Hispanic people do not have health insurance and commonly forgo necessary care. This again relates to the conflicting priorities of health care versus documentation status since the legal system has been especially punitive for minor things lately (even the number of white people having run-ins with the law has recently increased anecdotally). An important example to share is that one Spanish respondent lost vision in her eye from a health condition and now that it is an emergency, still will not be seen until May based on her finances and provider availability. She and her family are undocumented so they cannot find work that pays enough to get the necessary medical care. These related issues compound each other for all kinds of undocumented people, but especially for LatinX groups.

Among sites that RAI outreach staff were successful in engaging, the staff at these organizations were open to assisting in doing outreach to other groups and agencies. Examples include Ranch Hands Rescue and Callie Clinic. In addition, AAPA provided referrals to transitional housing programs, although the referrals came late and the outreach staff did not have the opportunity to seed the SNNA survey instrument in these settings. In addition, the team was referred to Dallas CAN Academy for high school aged at-risk youth, but again the outreach staff ran out of time to meet the Academy principal. In the future, it is recommended that whomever does the next series of assessments starts with these settings. Dallas CAN Academy includes a school where pregnant teenagers can continue learning while caring for their unborn baby.

When asked if they were directly connected to client contacts for seeding, outreach staff said they were mostly able to make the link. There was a sense that most sites understood what the outreach staff was asking for and were able to connect to clients for seeding. Where the seeding process often broke down was when the seed respondent didn't know who to pass this survey to in terms of making referrals. Many genuinely did not know people to send this along to, because they did not want their personal contacts to feel uncomfortable or under any microscopes. This points to the fact that in certain urban and rural areas social networks are smaller and more spread apart - people are more isolated related to their HIV community affiliation than RAI had anticipated. For rural areas, it is not uncommon to have to drive a long distance to connect with others, and there is no public transit system outside the urban core and the near suburbs like Denton (Denton proper has a light rail and bus system that travels within Denton city, which also reaches Carrollton where it connects to the Dallas system, but not beyond). A respondent from Callie mentioned that there was a gay-bar in Sherman but closed after the pandemic due to the owners passing away from COVID-19. Since then, there have been no local physical places where people convene to meet other people, it is usually done through dating and social apps and social media at this point. Glitterbomb in Denton, an event

where drag queens perform and the house/ball community convenes, was closed for the season November to February, but would be an excellent place to engage with LGBT folks from the suburbs in future assessment cycles.

When asked if the client contacts the outreach staff were introduced to were diverse and demographically reflective of the regional pandemic or if they favored any specific group, there was a sense of true diversity, with certain key gaps noted. For example, one outreach staff person noted that he would have liked to have gotten some young white males to do the survey. In addition, middle income people were missing from the survey so it is possible we will not have a good sense of how middle class people at high risk and living with HIV have their needs met or not.

When asked if they were strung along or ignored by outreached provider organizations under any circumstances, the outreach team had different experiences. While the outreach worker responsible for central Dallas expressed no problem in linking with sites with limited exception, the outreach worker in the outer counties of the Dallas region expressed extreme challenges in working with organizations. While all groups reached out to where theoretically excited by the work, expressed relief that someone was doing the work at this level, and philosophically aligned with the work, momentum was lost when it came time to meet with clients and seed the actual survey instrument. The primary determining characteristics for challenges of access and engagement focused on A.) inexperience working in the HIV/STI field and B.) focus on populations that are currently “under siege” in Texas, including individuals involved in (or needing) harm reduction services, undocumented persons and families, and gender expansive people. Some of these organizations stated plainly “I don’t know you and I cannot risk ruining my clients lives by having the rug pulled out from under them. I’m sorry, but this is not going to happen here”. For groups in category B, the real constraints revolved around timing (holidays and state audits), getting approvals in time from other leadership (as was the case for Women 2 Women), weather (the team lost two weeks, because the lack of plows and sand trucks snowed everyone in). The one organization that was VEHEMENTLY opposed was the sober living director and this is likely because the background of most of the folks in the program involves illegal drug use (like meth) and client run-ins with the legal system (many were in prison for years and highly justice-involved/experienced).

Survey Sample Demographics

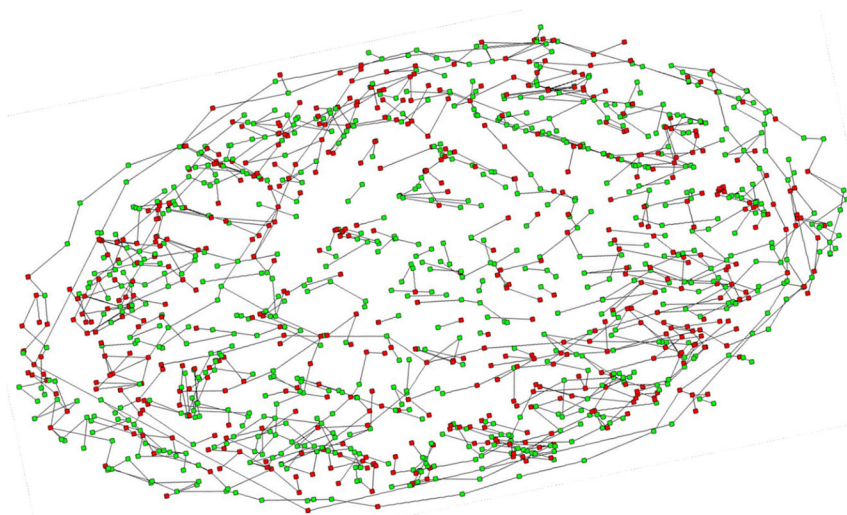
The Dallas SNNA survey instrument was deployed between November 2022 and January 2023 using the methods laid out above to recruit respondents (characteristics summarized below).

Table 1: Demographics	HIV positive			HIV negative		
	n	#	%	n	#	%
Age Ranges						
0 - 12 years old	674	0	0.0%	1363	0	0.0%
13 - 17 years old	674	0	0.0%	1363	2	0.1%
18 - 24 years old	674	109	16.2%	1363	211	15.5%
25 - 34 years old	674	332	49.3%	1363	527	38.7%
35 - 44 years old	674	141	20.9%	1363	429	31.5%
45 - 54 years old	674	41	6.1%	1363	107	7.9%
55 - 64 years old	674	41	6.1%	1363	58	4.3%
65 +	674	10	1.5%	1363	29	2.1%
Race/Ethnicity						
Black/African American	674	358	53.1%	1363	556	40.8%
Hispanic/Latinx	674	54	8.0%	1363	197	14.5%
White	674	251	37.2%	1363	566	41.5%
Asian	674	11	1.6%	1363	36	2.6%
Native Hawaiian or Pacific Islander	674	9	1.3%	1363	20	1.5%
American Indian or Alaska Native	674	3	0.4%	1363	14	1.0%
Other race/ethnicity	674	2	0.3%	1363	5	0.4%
Gender Identity						
Cis male	674	444	65.9%	1363	678	49.7%
Cis Female	674	196	29.1%	1363	658	48.3%
Trans Male/Transman	674	13	1.9%	1363	12	0.9%
Trans Female/Transwoman	674	17	2.5%	1363	12	0.9%
Genderqueer/Gender non-conforming	674	4	0.6%	1363	5	0.4%
Nonbinary	674	1	0.1%	1363	9	0.7%
Prefer not to answer gender identity	674	1	0.1%	1363	3	0.2%
Different gender identity not listed (please e	674	1	0.1%	1363	1	0.1%
Sexual Orientation						
Gay or Same-Gender-Loving Man	674	157	23.3%	1363	74	5.4%
Lesbian or Same-Gender-Loving Woman	674	64	9.5%	1363	59	4.3%
Bisexual	674	78	11.6%	1363	179	13.1%
Queer	674	10	1.5%	1363	68	5.0%
Straight or Heterosexual	674	353	52.4%	1363	967	70.9%
Pansexual	674	10	1.5%	1363	6	0.4%
Sexual Orientation: Prefer not to answer	674	8	1.2%	1363	21	1.5%
Different or other sexual identity not listed (674	2	0.3%	1363	1	0.1%
Other sexual orientation	674	1	0.1%	1363	0	0.0%

Survey Results

The online survey received 5,727 responses. Surveys that were incomplete, or had an IP address from outside the United States, or took less than 5 minutes to complete were excluded from analysis. After removing these responses, we were left with 2,046 responses. The diagram to the right depicts the social network model that emerged from respondent driven sampling. Red dots are people with HIV and green dots are people at high risk for HIV. There is a high

level of interconnection between the positive and high-risk negative segments of the Dallas area HIV community. Generally speaking, there is a high level of interconnectedness among people who were able to provide referrals, but as mentioned previously, many respondents were unable to name referrals and provide their contact information.



Of the 2,046 survey respondents who successfully completed the survey, the majority of participants (70%) were between the ages of 25 and 44 (See Appendix X) with the range of participants from 16 to 70+. Nearly 16% of our respondents were under 24 comprising the second largest demographic. This result is significant and reflective of the success of the community liaison in reaching this vulnerable population as the highest rate of new infections is under the age of 24 with the percentage of those living with HIV in Texas currently measured at 4%¹⁴. Of the total respondents, 5.3% intended as PLWHA; of those respondents under 25, 34% identified as living with HIV.

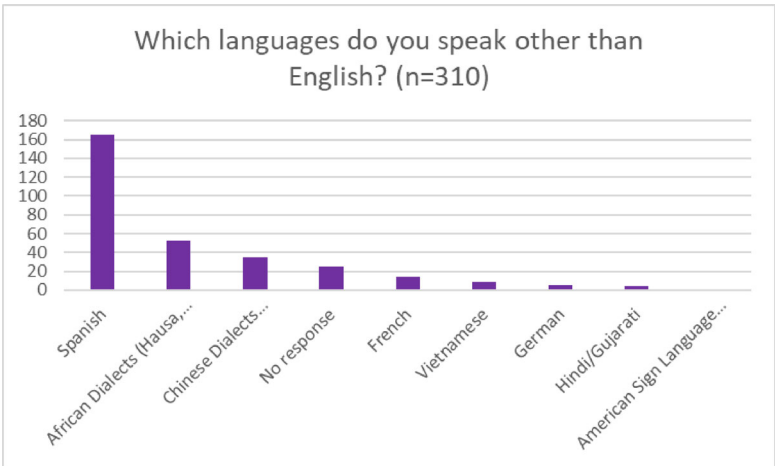
The racial and ethnic breakdown of survey respondents were predominantly male and self identified as Black/African American. We were underrepresented of Latinx respondents; barriers to this will be addressed further in the discussion section. Interestingly, the majority of survey respondents identified as heterosexual. The Williams Institute, which tracks data of LGBTQ+ individuals nationwide, reports that only 4% of Texans report being a member of the queer community and 4% of the total respondents identify as living in Dallas. As such, this sample is in alignment with other published figures since 35% of respondents identified as being of a sexual orientation other than heterosexual.

The majority of the sample identified as either Black/African American (44.9%) or White/Caucasian (40%). Only 12.3% identified as of Hispanic or Latino origin. This appears to be somewhat lower than expected for the region. Roughly 97% identified as cisgender, while 3% identified as other than cisgender. Cisgender men accounted for the majority of respondents (55%) with cisgender women composing (42%) of our respondents. A large proportion identified as heterosexual (67%), but it is important to remember that self-identified sexual orientation does not often correspond to sexual behavior. It is important to note that 32% of respondents report prior periods of incarceration and approximately 20% have engaged in sex in exchange for money or basic personal necessities.

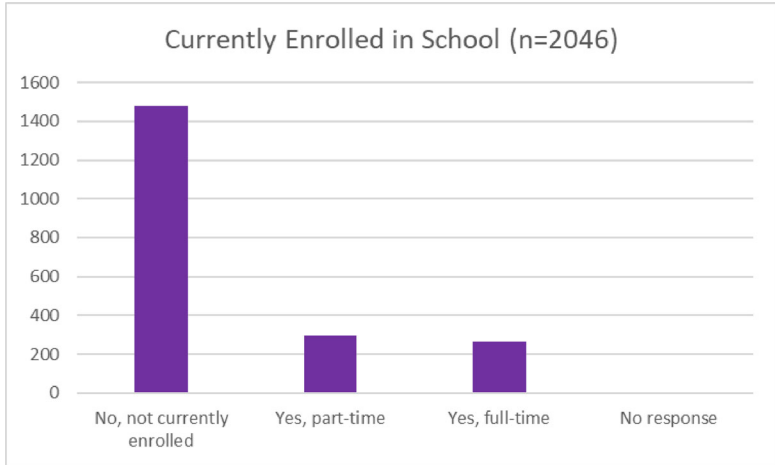
¹⁴ AIDSvu

The following tables, graphs, and images provide additional detail on demographic characteristics of survey respondents.

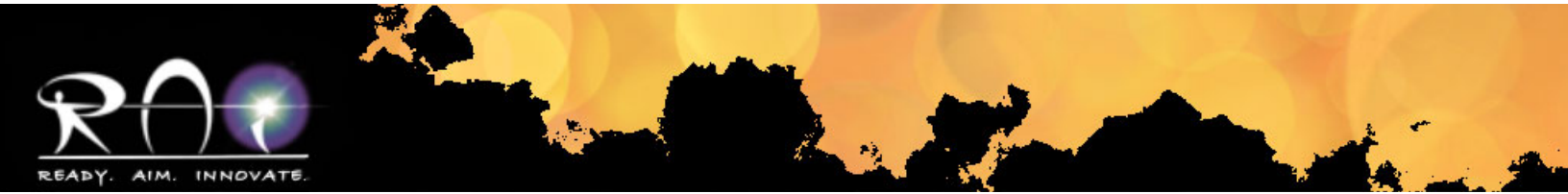
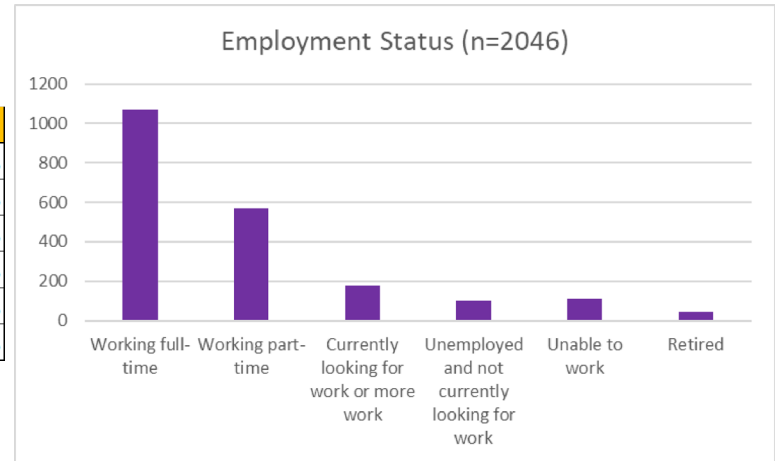
Which languages do you speak other than English?	n=310	%
Spanish	165	53.23%
African Dialects (Hausa, Igbo, Amharic, Yoruba, etc...)	52	16.77%
Chinese Dialects (Mandarin, Cantonese, Formosan, etc...)	35	11.29%
No response	25	8.06%
French	14	4.52%
Vietnamese	9	2.90%
German	5	1.61%
Hindi/Gujarati	4	1.29%
American Sign Language (ASL)	1	0.32%



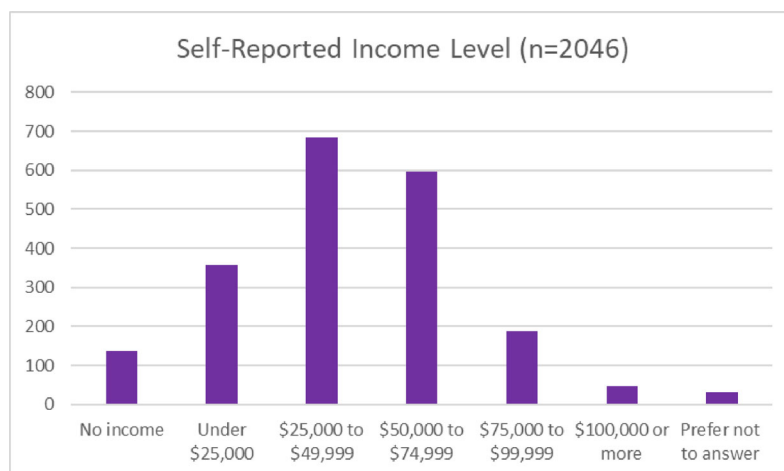
Currently Enrolled in School	n=2046	%
No, not currently enrolled	1479	72.29%
Yes, part-time	298	14.57%
Yes, full-time	264	12.90%
No response	5	0.24%



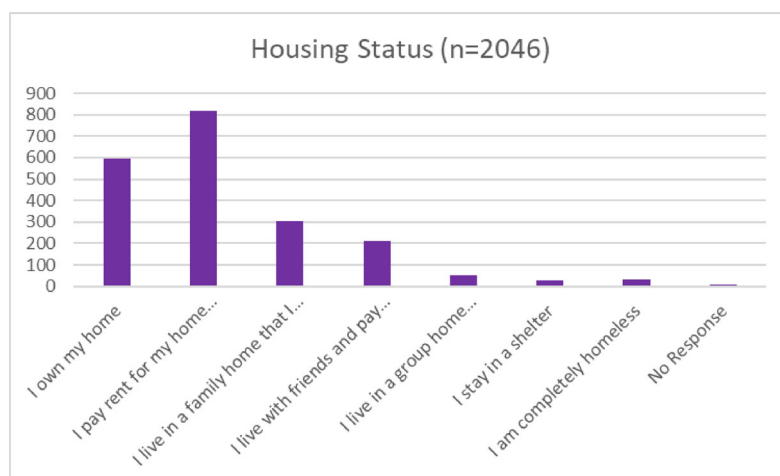
Employment Status	n=2046	%
Working full-time	1068	52.20%
Working part-time	569	27.81%
Currently looking for work or more work	179	8.75%
Unemployed and not currently looking for work	98	4.79%
Unable to work	109	5.33%
Retired	42	2.05%



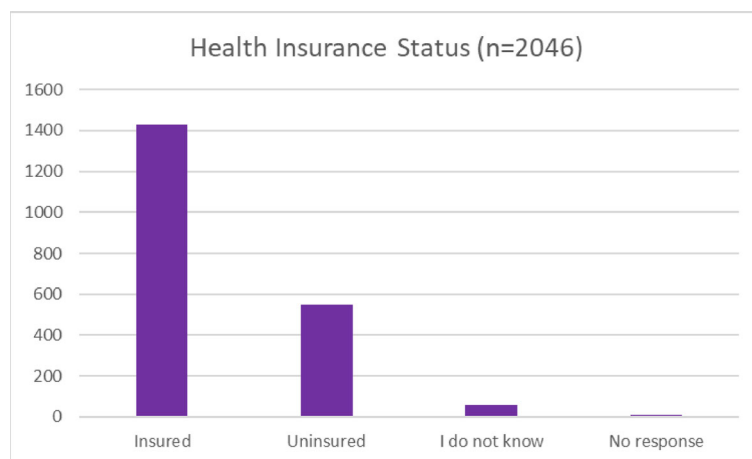
Self-Reported Income Level	n=2046	%
No income	137	6.70%
Under \$25,000	358	17.50%
\$25,000 to \$49,999	685	33.48%
\$50,000 to \$74,999	597	29.18%
\$75,000 to \$99,999	189	9.24%
\$100,000 or more	48	2.35%
Prefer not to answer	32	1.56%



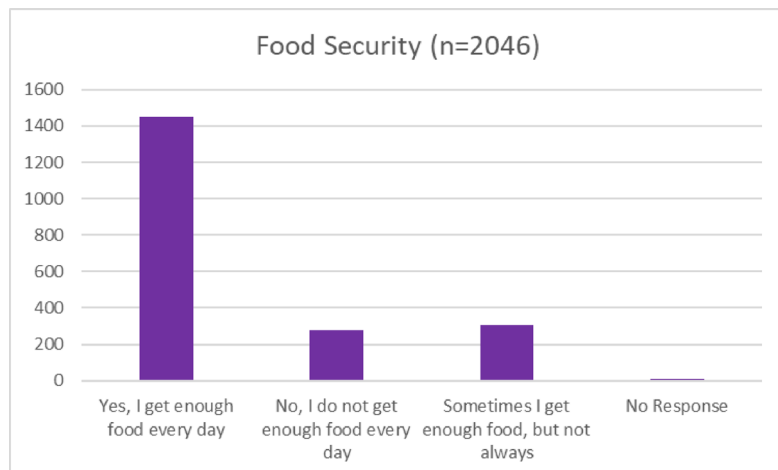
Housing Status	n=2046	%
I own my home	594	29.03%
I pay rent for my home (alone or with others)	817	39.93%
I live in a family home that I do not pay for	306	14.96%
I live with friends and pay little or what I can	211	10.31%
I live in a group home (based on a charity or program)	50	2.44%
I stay in a shelter	28	1.37%
I am completely homeless	33	1.61%
No Response	7	0.34%



Health Insurance Status	n=2046	%
Insured	1429	69.84%
Uninsured	551	26.93%
I do not know	59	2.88%
No response	7	0.34%

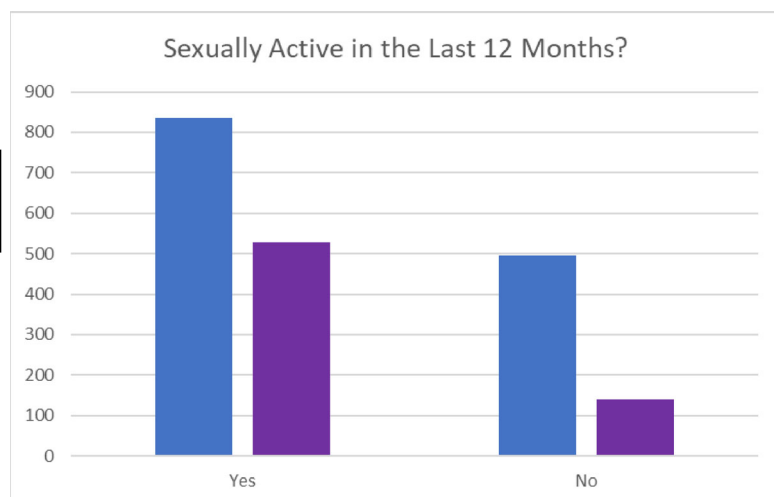


Food Security	n=2046	%
Yes, I get enough food every day	1450	70.87%
No, I do not get enough food every day	278	13.59%
Sometimes I get enough food, but not always	308	15.05%
No Response	10	0.49%

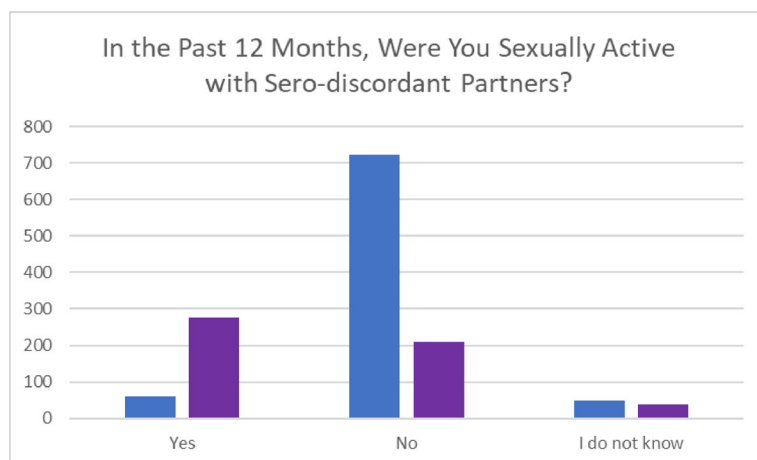


The following series of tables and graphs show patterns of HIV risk in the last 12 months. High risk HIV-negative in black, HIV-positive in red.

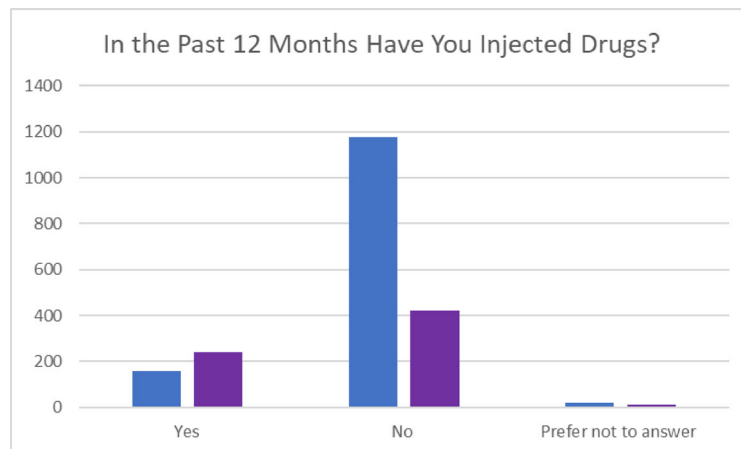
Sexually Active in the Last 12 Months?	n=1364	%	n=674	%
Yes	835	61.20%	529	78.50%
No	494	36.20%	141	20.90%



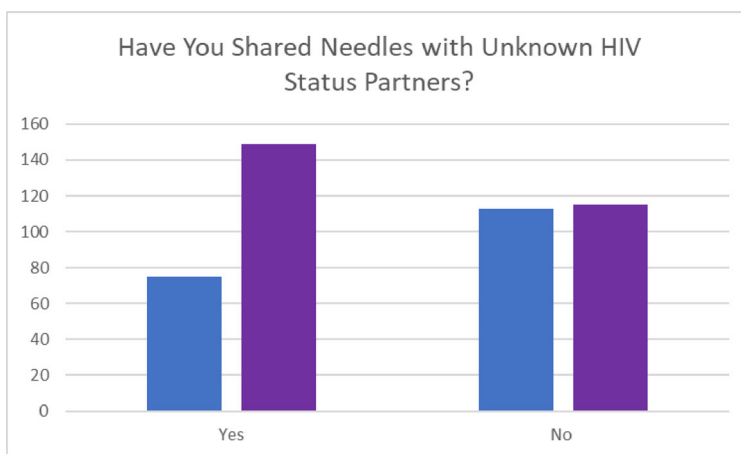
In the Past 12 Months, Were You Sexually Active with Sero-discordant Partners?	n=835	%	n=529	%
Yes	61	7.30%	276	52.20%
No	721	86.30%	210	39.70%
I do not know	48	5.70%	39	7.40%



In the Past 12 Months Have You Injected Drugs?	n=1364	%	n=674	%
Yes	157	11.50%	242	35.90%
No	1179	86.40%	420	62.30%
Prefer not to answer	20	1.50%	11	1.60%

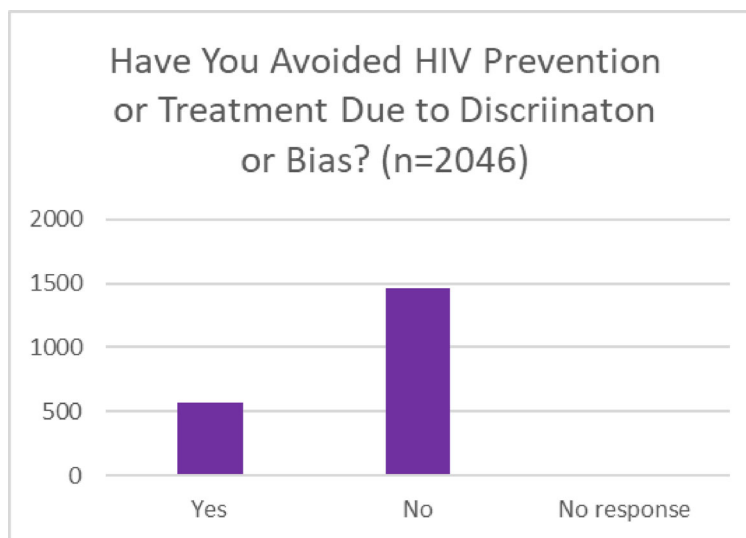


Have You Shared Needles with Unknown HIV Status Partners?	n=157	%	n=242	%
Yes	75	47.80%	149	61.60%
No	113	72.00%	115	47.50%

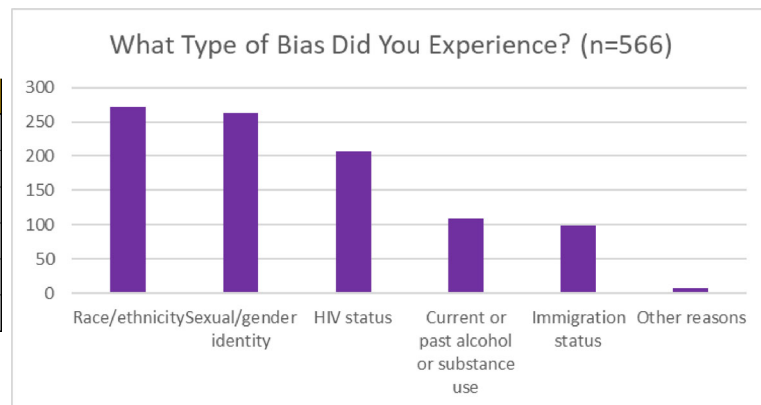


In consideration of these risk patterns, the next tables and graphs show how people avoid healthcare due to discrimination

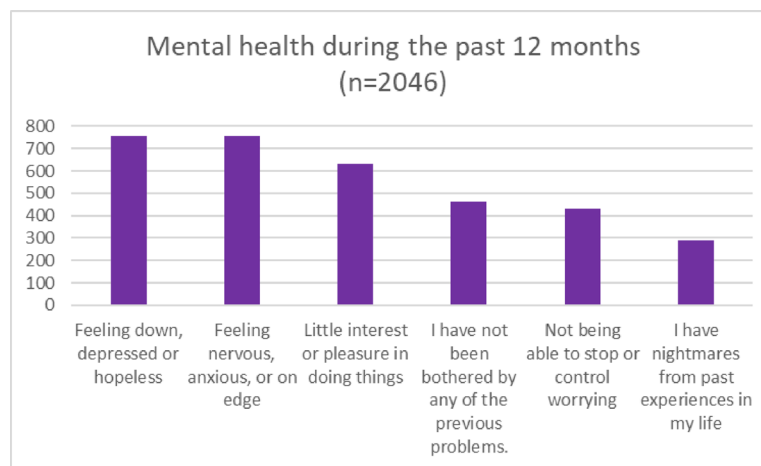
Have you avoided testing or prevention services because of discrimination or bias?	n=2046	%
Yes	566	27.70%
No	1464	71.60%
No response	16	0.80%



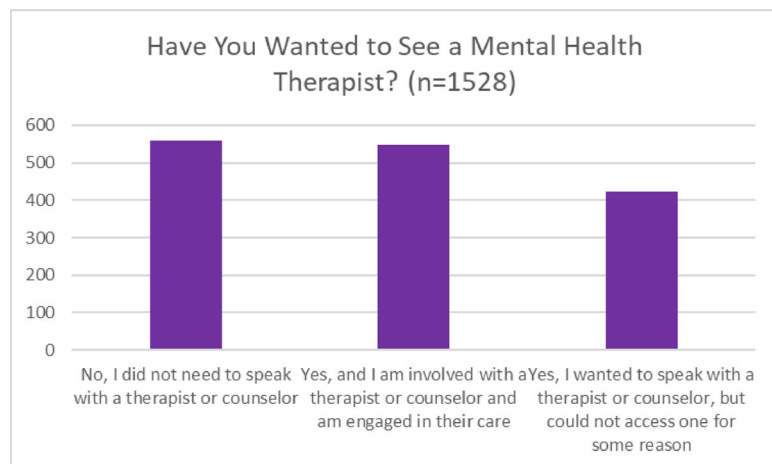
Which type of bias did you experience?	n=566	%
Race/ethnicity	272	48.10%
Sexual/gender identity	263	46.50%
HIV status	207	36.60%
Current or past alcohol or substance use	110	19.40%
Immigration status	99	17.50%
Other reasons	7	1.20%



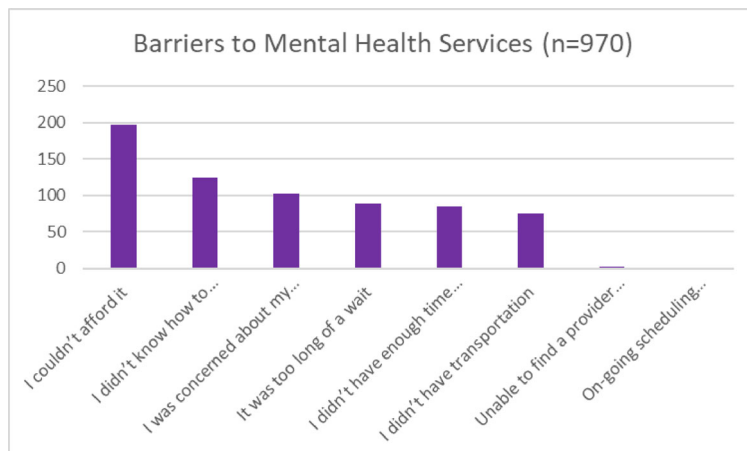
Mental Health Challenges During the Past 12 Months	n=2046	%
Feeling down, depressed or hopeless	758	37.00%
Feeling nervous, anxious, or on edge	754	36.90%
Little interest or pleasure in doing things	632	30.90%
I have not been bothered by any of the previous problems.	462	22.60%
Not being able to stop or control worrying	431	21.10%
I have nightmares from past experiences in my life	290	14.20%



Have You Wanted to See a Mental Health Therapist?	n=1528	%
No, I did not need to speak with a therapist or counselor	558	36.50%
Yes, and I am involved with a therapist or counselor and am engaged in their care	547	35.80%
Yes, I wanted to speak with a therapist or counselor, but could not access one for some reason	423	27.70%

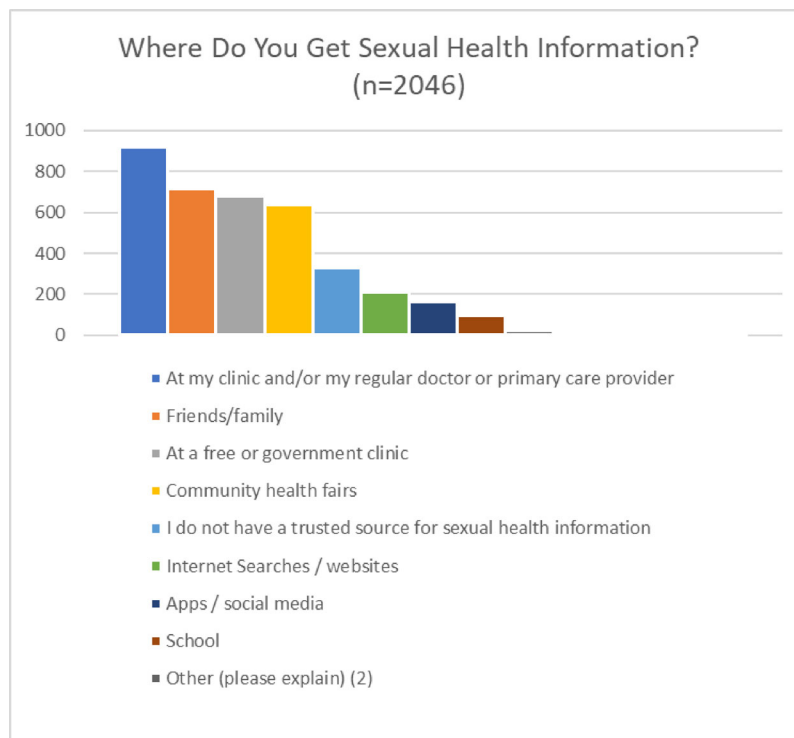


Barriers to Mental Health Services	n=970	%
I couldn't afford it	197	20.30%
I didn't know how to find/access a therapist or counselor	124	12.80%
I was concerned about my privacy and potential discrimination	102	10.50%
It was too long of a wait	88	9.10%
I didn't have enough time off work	85	8.80%
I didn't have transportation	75	7.70%
Unable to find a provider match with similar background	2	0.20%
On-going scheduling conflicts/availability	1	0.10%

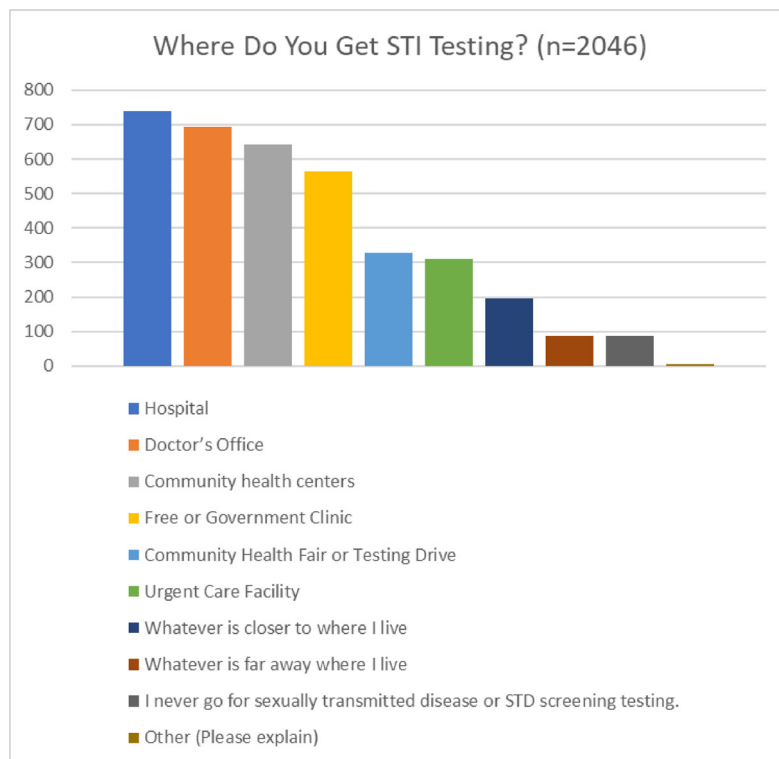


The next series of graphs focuses on where people get their sexual health information.

Sexual health information sources	n=2046	%
At my clinic and/or my regular doctor or primary care provider	920	45.00%
Friends/family	713	34.80%
At a free or government clinic	678	33.10%
Community health fairs	635	31.00%
I do not have a trusted source for sexual health information	328	16.00%
Internet Searches / websites	212	10.40%
Apps / social media	163	8.00%
School	95	4.60%
Other (please explain) (2)	21	1.00%
Another local organization	16	0.80%
Television	4	0.20%
Family & Friends	2	0.10%
More information is unnecessary	2	0.10%

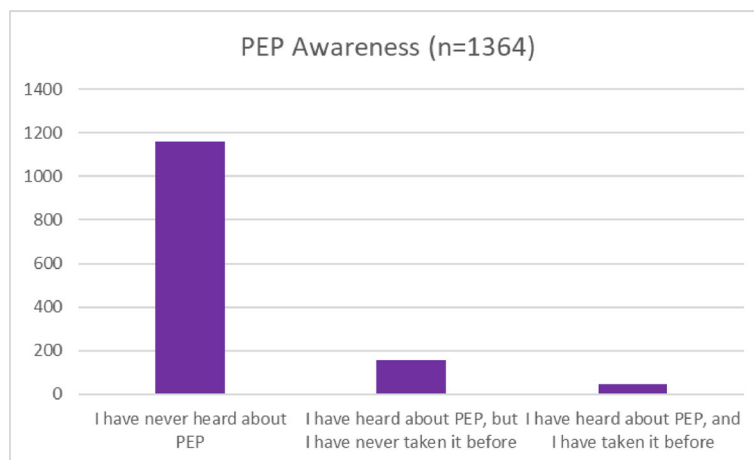


STD testing site	n=2046	%
Hospital	740	36.20%
Doctor's Office	693	33.90%
Community health centers	641	31.30%
Free or Government Clinic	564	27.60%
Community Health Fair or Testing Drive	328	16.00%
Urgent Care Facility	310	15.20%
Whatever is closer to where I live	197	9.60%
Whatever is far away where I live	87	4.30%
I never go for sexually transmitted disease or STD screening testing.	86	4.20%
Other (Please explain)	6	0.30%

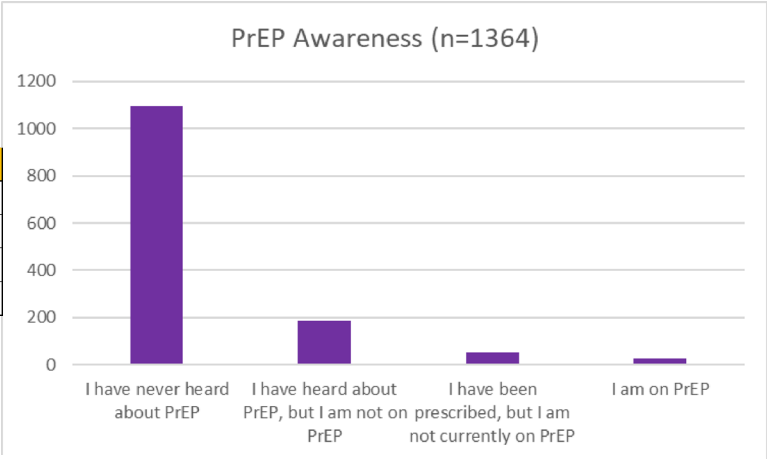


The next tables and graphs show public knowledge of biomedical HIV prevention interventions. Only high-risk negatives were asked about PEP and PrEP knowledge. All were asked about U=U knowledge. Word clouds were created based on open ended questions.

PEP Awareness	n=1364	%
I have never heard about PEP	1162	85.19%
I have heard about PEP, but I have never taken it before	158	11.58%
I have heard about PEP, and I have taken it before	44	3.23%



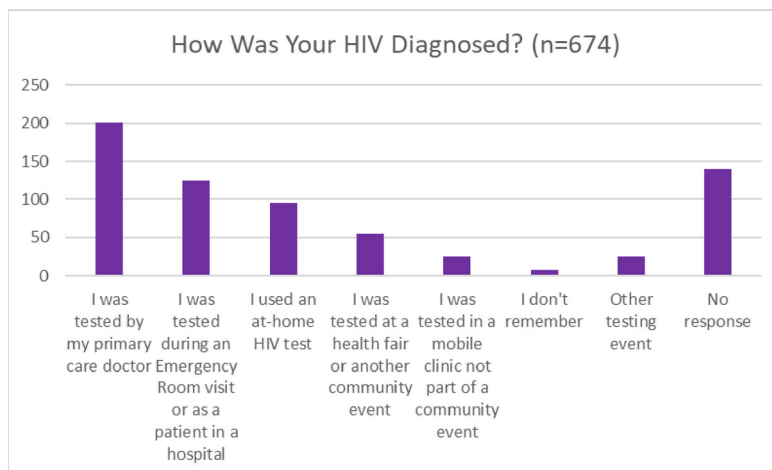
PrEP Awareness	n=1364	%
I have never heard about PrEP	1094	80.21%
I have heard about PrEP, but I am not on PrEP	188	13.78%
I have been prescribed, but I am not currently on PrEP	53	3.89%
I am on PrEP	29	2.13%



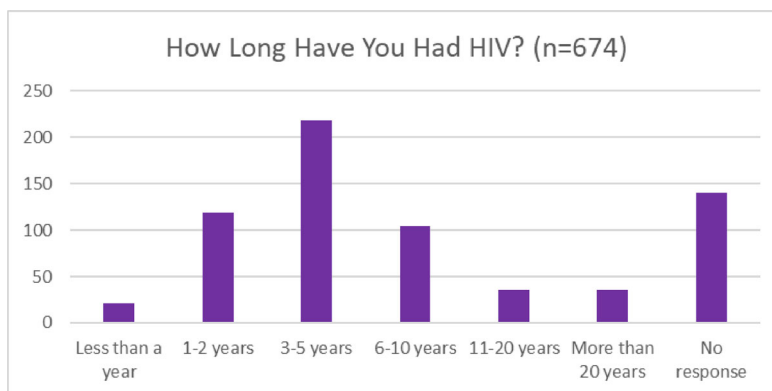
PrEP Wordcloud - In your own words, what is PrEP?

The following tables and graphics discuss matters of HIV diagnosis, linkage to care, and ongoing engagement in care.

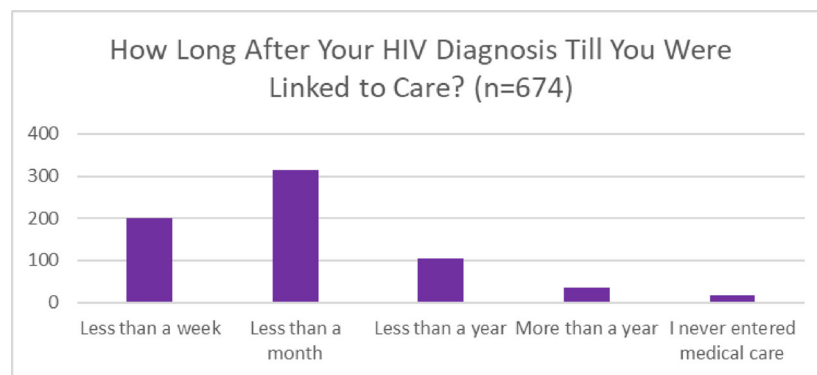
How was HIV diagnosed?	n=674	%
I was tested by my primary care doctor	201	29.82%
I was tested during an Emergency Room visit or as a patient in a hospital	125	18.55%
I used an at-home HIV test	95	14.09%
I was tested at a health fair or another community event	54	8.01%
I was tested in a mobile clinic not part of a community event	26	3.86%
I don't remember	8	1.19%
Other testing event	25	3.71%
No response	140	20.77%



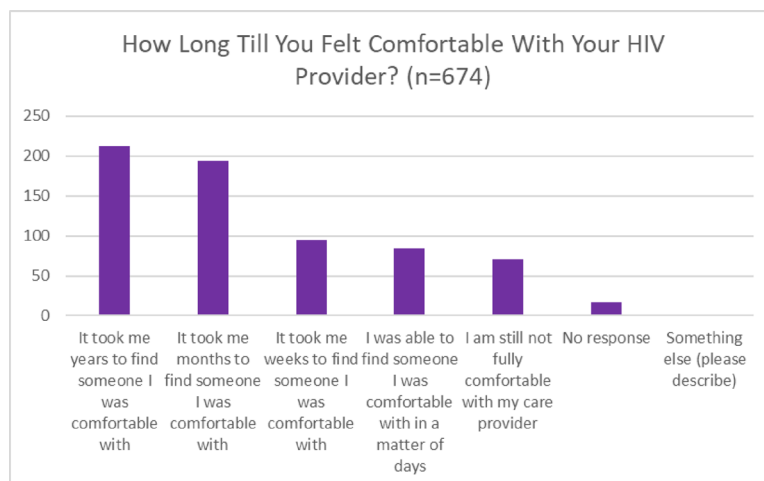
Length of time living with HIV	n=674	%
Less than a year	21	3.12%
1-2 years	119	17.66%
3-5 years	218	32.34%
6-10 years	105	15.58%
11-20 years	36	5.34%
More than 20 years	35	5.19%
No response	140	20.77%



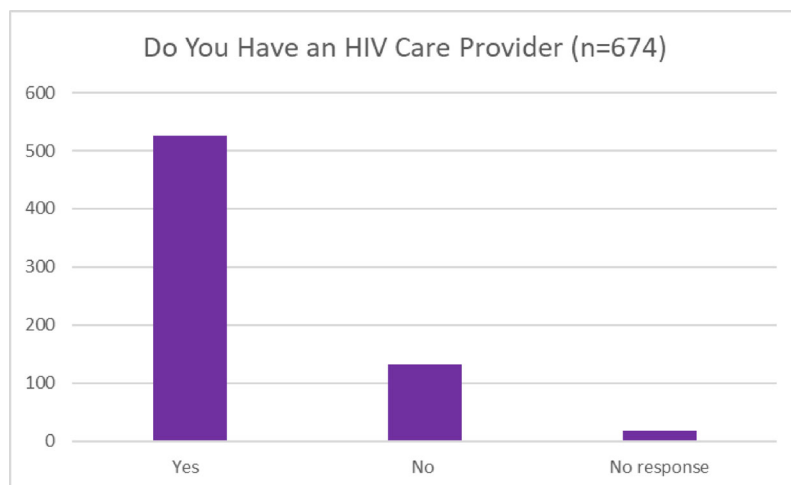
Linkage to care after HIV diagnosis	n=674	%
Less than a week	200	29.67%
Less than a month	315	46.74%
Less than a year	106	15.73%
More than a year	36	5.34%
I never entered medical care	17	2.52%



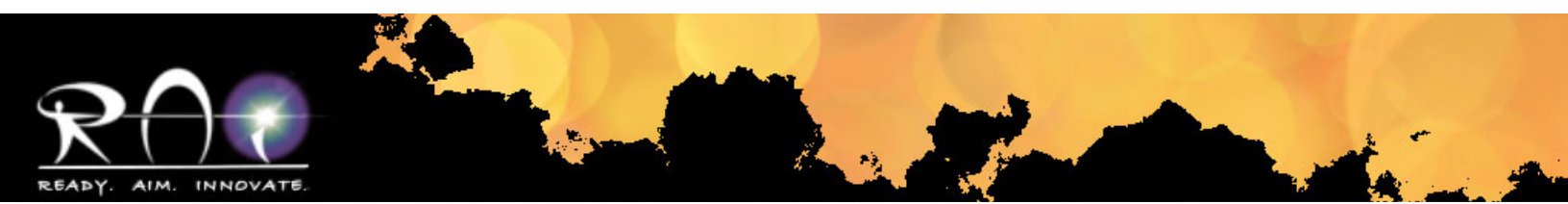
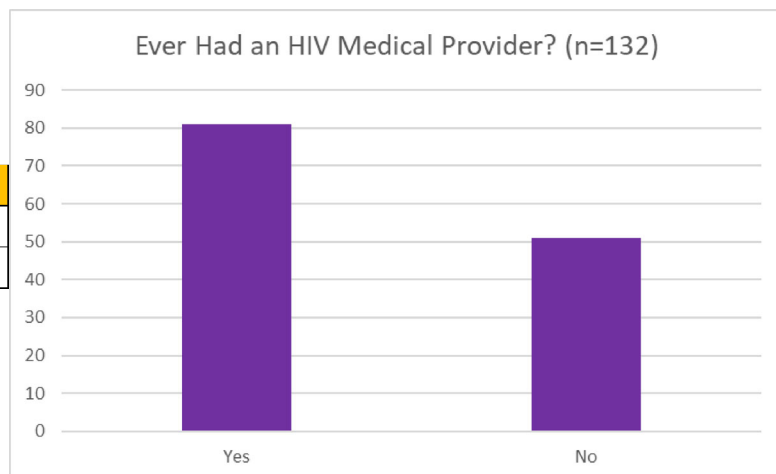
Time until comfortable in care	n=674	%
It took me years to find someone I was comfortable with	212	31.50%
It took me months to find someone I was comfortable with	194	28.80%
It took me weeks to find someone I was comfortable with	95	14.10%
I was able to find someone I was comfortable with in a matter of days	84	12.50%
I am still not fully comfortable with my care provider	70	10.40%
No response	17	2.50%
Something else (please describe)	2	0.30%



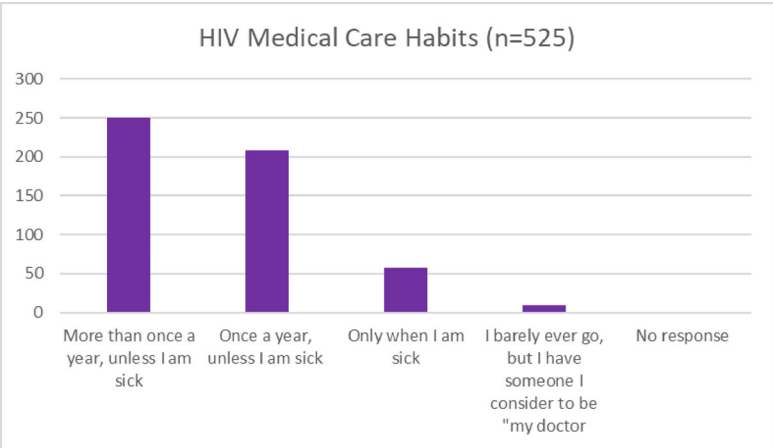
Do You Have an HIV Care Provider	n=674	%
Yes	525	77.89%
No	132	19.58%
No response	17	2.52%



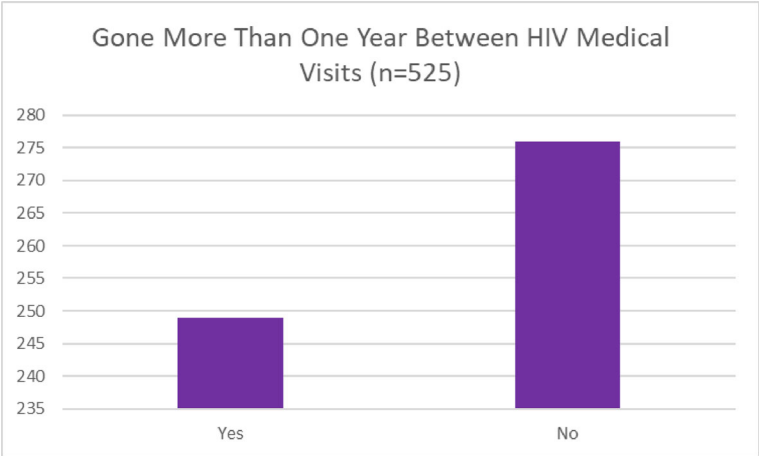
Ever Had an HIV Medical Provider?	n=132	%
Yes	81	61.40%
No	51	38.60%



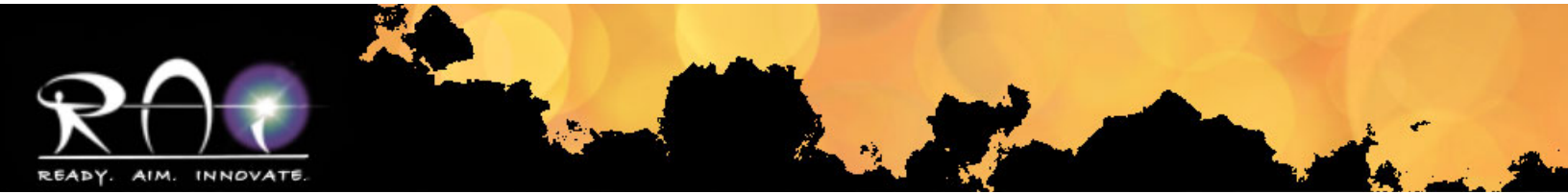
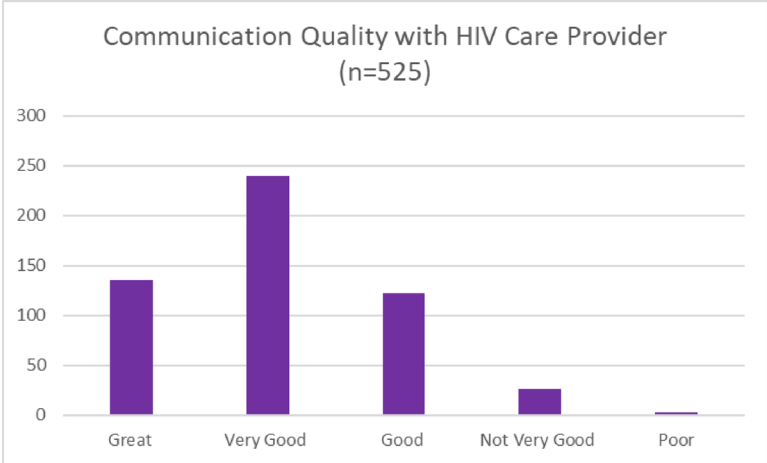
HIV Medical Care Habits	n=525	%
More than once a year, unless I am sick	250	37.10%
Once a year, unless I am sick	208	30.90%
Only when I am sick	57	8.50%
I barely ever go, but I have someone I co	10	1.50%
No response		



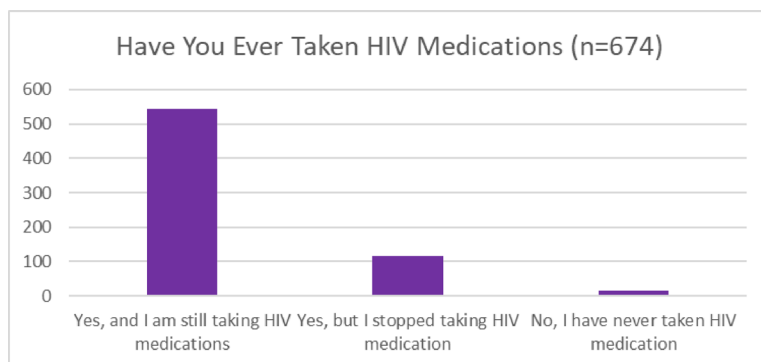
Gone More Than One Year Between HIV Medical Visits	n=525	%
Yes	249	47.40%
No	276	52.60%



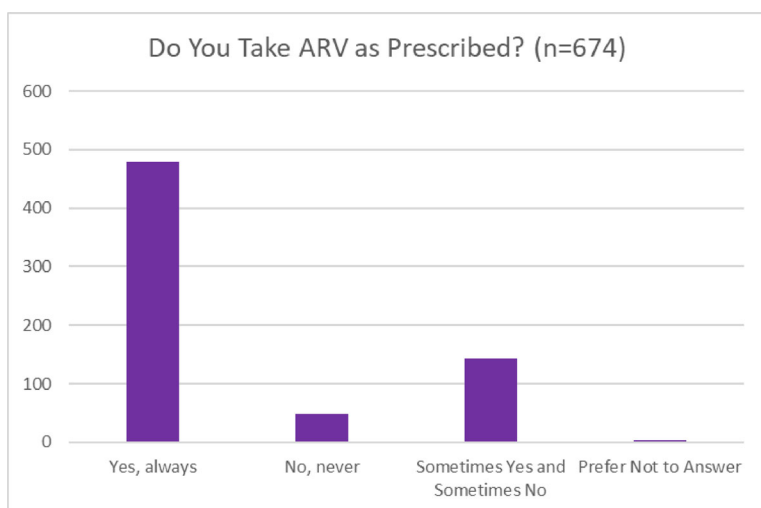
Communication Quality with HIV Care Provider	n=525	%
Great	135	25.70%
Very Good	239	45.50%
Good	122	23.20%
Not Very Good	26	5.00%
Poor	3	0.60%



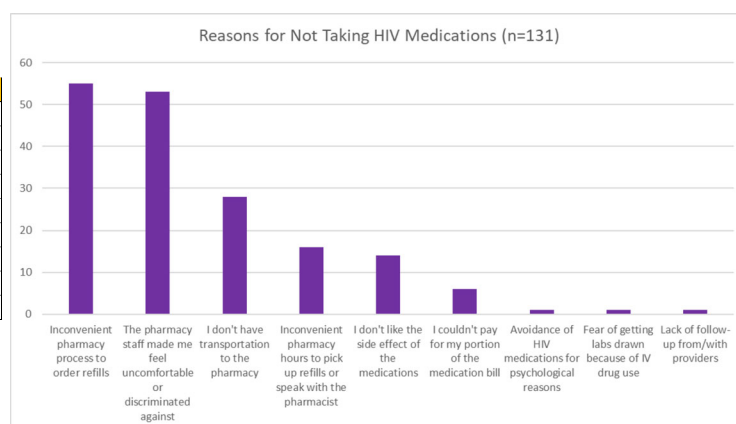
Ever taken HIV medications	n=674	%
Yes, and I am still taking HIV medications	543	80.60%
Yes, but I stopped taking HIV medication	116	17.20%
No, I have never taken HIV medication	15	2.20%



Do you take your medications as prescribed?	n=674	%
Yes, always	479	71.10%
No, never	48	7.10%
Sometimes Yes and Sometimes No	144	21.40%
Prefer Not to Answer	3	0.40%

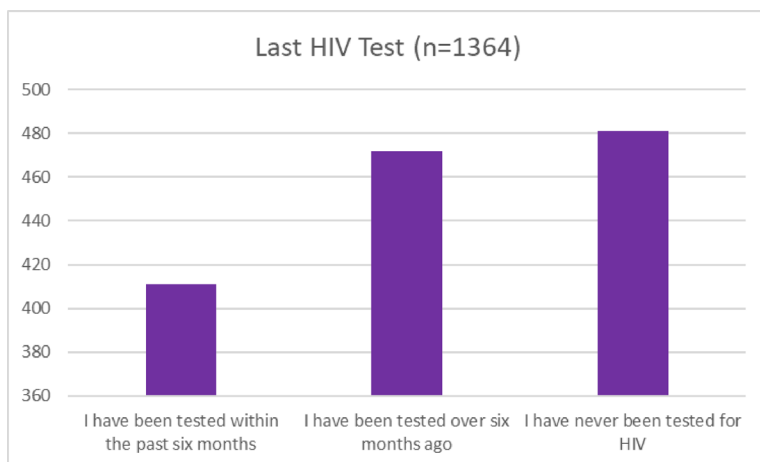


Reasons for not taking HIV medications	n=131	%
Inconvenient pharmacy process to order refills	55	42.00%
The pharmacy staff made me feel uncomfortable or discriminated against	53	40.50%
I don't have transportation to the pharmacy	28	21.40%
Inconvenient pharmacy hours to pick up refills or speak with the pharmacist	16	12.20%
I don't like the side effect of the medications	14	10.70%
I couldn't pay for my portion of the medication bill	6	4.60%
Avoidance of HIV medications for psychological reasons	1	0.80%
Fear of getting labs drawn because of IV drug use	1	0.80%
Lack of follow-up from/with providers	1	0.80%



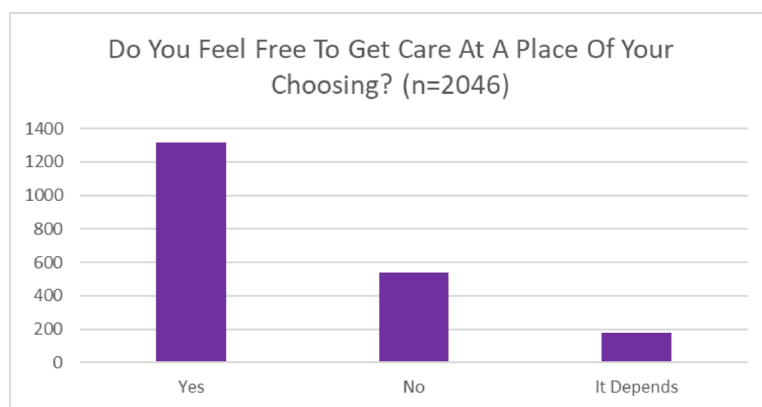
The following tables and graphics show healthcare seeking behavior of high-risk negatives.

Last HIV Test	n=1364	%
I have been tested within the past six months	411	30.10%
I have been tested over six months ago	472	34.60%
I have never been tested for HIV	481	35.30%

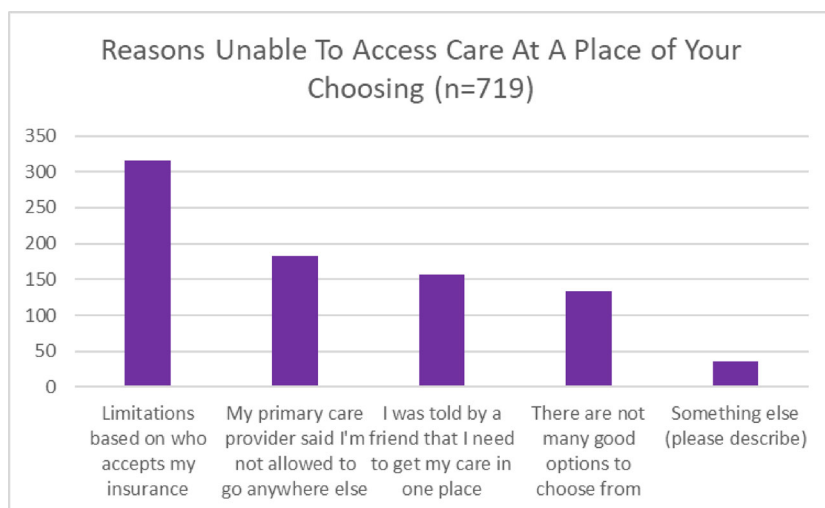


The following tables and graphics exhibit the Dallas area HIV community's sense that they are in charge of their own care destiny.

Feel free to access care anywhere?	n=2046	%
Yes	1312	64.10%
No	538	26.30%
It Depends	181	8.80%
No response	15	0.70%



Reasons unable to access care anywhere:	n=719	%
Limitations based on who accepts my insurance	316	43.90%
My primary care provider said I'm not allowed to go anywhere else	183	25.50%
I was told by a friend that I need to get my care in one place	157	21.80%
There are not many good options to choose from	133	18.50%
Something else (please describe)	36	5.00%



Focus Group and Key Stakeholder Interviewee Results

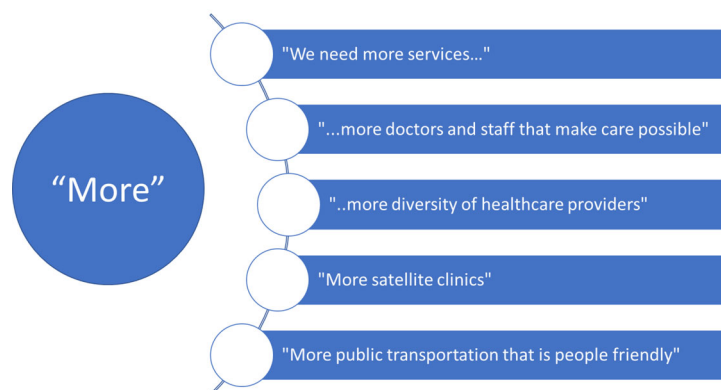
Recruitment for one-on-one interviews and focus groups occurred between January and February 2023, resulting in numerous key stakeholder interviews (n=6) and three focus groups (n=26). The eligibility criteria for both activities were individuals must 1) be aged 18 or older; 2) live and reside in the eleven county service area for the Dallas regional HIV service system (Dallas EMA/HSDA); 3) be able to read and respond in English or Spanish. Participants were recruited via word of mouth and by direct outreach by RAI outreach staff in collaboration with Dallas area community organizational partners including, LGBT community-based organizations, healthcare centers. As mentioned previously focus group participants who were active in the discussion and kept their cameras on received a \$40 gift card incentive. Interviewees each received a \$50 gift card incentive. In total, most discussions took between 90 and 120 minutes.

Focus Group and Interviewee Themes and Uncovered Issues

The RAI research team identified seven primary themes among the issues uncovered in the focus groups and key stakeholder interviews. The themes emerged from the code book analysis completed and verified by independent members of the research team. The code book primarily identified uncovered issues that were then grouped into the following themes: “More is Needed”, Lack of Comfort”, “Customer Service”, “Communication”, “Safety”, “Stigma”, and “Dallas Region Lagging in Progress”.

The greatest theme to emerge from the data related to how people need “more” from the Dallas regional HIV service system. This does not only refer to the number of services provided.

The overwhelming consensus was that the Dallas HIV service system should be “doing more” in a wide variety of ways, including not only more services but also in site location, access and staff. This result speaks broadly to the need for more providers, more provider locations, and more choice when it comes to care. In particular, there is the need for more services outside of downtown Dallas, the need for better transportation and support to access services, and a shift in the workforce so that it has more hearts and hands available to serve the HIV community and so that it more closely resembles the service population demographically.



The next prominent theme to emerge from the key stakeholder interviews and focus groups was how respondents felt a lack of comfort when they seek care and services in the Dallas region. This “lack of comfort” is highly predictive of poorer outcomes across the HIV Care Continuum¹⁵. Specific to this assessment, respondents indicated repeatedly that they did not like or trust the repeated questions by their doctors and other providers. In other words, the necessary and required screenings for social determinants of health were flagged by clients as problematic.

¹⁵ Giordano T. P. (2011). Retention in HIV care: what the clinician needs to know. *Topics in antiviral medicine*, 19(1), 12–16.

While these screeners are necessary in order to provide good care, many in the American medical industry are ill prepared to administer these screenings and sometimes inadvertently trigger their patients. Clients are left with a sense that they as a person do not matter and only the answers to these questions matter. In order to reach and retain clients, the care setting and environment must be comfortable. Several clients noted feeling “stuck” in unproductive care relationships with their providers and wishing they had alternatives. This is a recipe for potential disaster in the form of clients quietly quitting their care and disappearing until they have an HIV-related health emergency they can no longer ignore.



Next, many focus group participants and interviewees relayed how they feel there is a lack of customer service when it comes to engaging with various elements of the Dallas HIV service system, particularly when it comes to certain facilities. Importantly, it was noted that there is a difference in quality of service and treatment when race and insurance status are factored in. For example, focus group participants noted that it appeared only well-off white people were offered Harvoni and other HCV cures. Another related example,



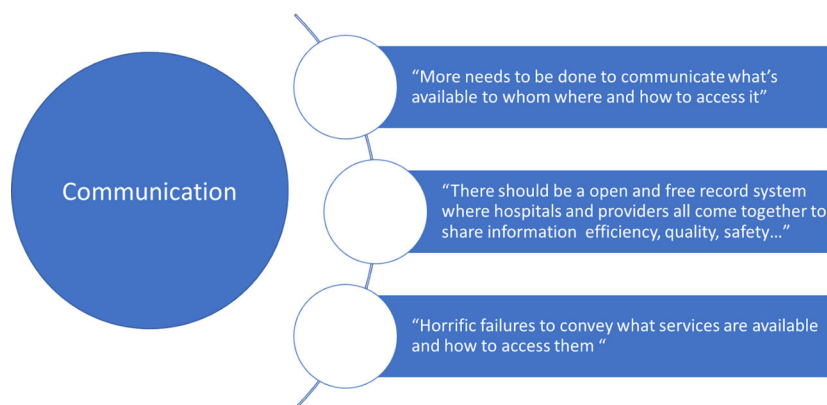
respondents that work within the HIV service system noted that HIV provider organization staff are opposed to injectable PrEP and HIV treatment for reasons related to client class, risk patterns, and what the providers assume the client adherence to the injections would be. Moreover, the providers in the Dallas region are not routinely educating their clients on U=U and when clients ask their providers about it, they are told “U=U is not relevant to you”. This is not a universal characteristic of all HIV providers and HIV service organizations, but is highly pervasive in the Dallas HIV service system. It is important to note this, because the relatively few providers of good-faith and knowledge of state-of-the-art HIV science are quickly burned out or suffer moral injury when they are prevented from doing what they know is right. The public witnesses all this in silence and are left with a sense that they have little control over their destinies. The Institute for Healthcare Improvement quadruple aim¹⁶ notes that customer service starts with happy providers so it is essential to unpack and rapidly address the challenges that

¹⁶ “On the Quadruple Aim: Why Expand Beyond the Triple Aim”. IHI Blog. Available: <https://www.ihl.org/communities/blogs/on-the-quintuple-aim-why-expand-beyond-the-triple-aim>

lead to poor provider morale, burnout, a denial of science, and a failure to uptake important advancements in HIV prevention, care, and treatment.

Overall, it is clear that there are multiple breaks in communication in Dallas regional HIV service system as it affects client care. This is not limited to direct communication between the HIV community and the HIV providers and service providers, but also inter-agency communication. Many participants lamented the fact that they often have to re-submit eligibility and other information that should be readily available.

Additionally, there are thoughts that some information is guarded or withheld from certain patients, this again relates to the U=U, LAART, and HCV cure challenges described above. The perception of withheld information also relates to clients having a very unclear idea of what services are available to whom, where, and when. One client is given a grant to surgically fix their teeth, but another client is told to “let their teeth rot out of their head”. This challenge is related to both a sense that clients do not know what is available overall and this situation worsens the more panicked, anxious, or distraught the client in regarding what is happening with their bodies. The time when they are most vulnerable is sometimes when they are most tone-policed and boxed in regarding their behavior.



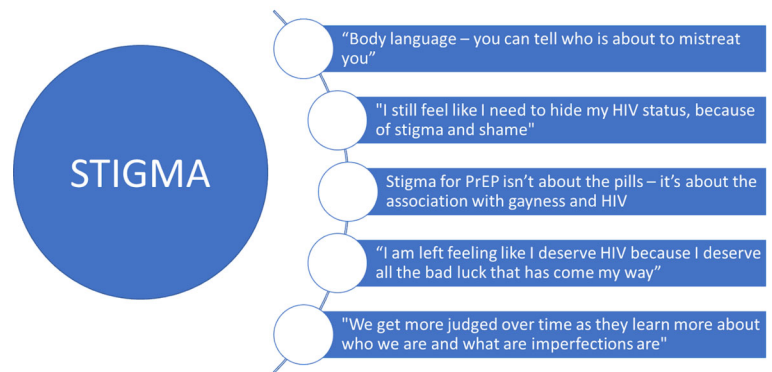
Participants were vocal when the notion of their safety was introduced. When considering the current culture-wars climate, many highlighted their concern for themselves and their friends. This was a popular theme mentioned when we asked participants to state the one thing they wish would change about the Dallas region HIV service system to improve their health and wellbeing. Furthermore, this lack of safety was especially concerning for transgender

population and members of the Hispanic/LatinX immigrant community who currently feel “hunted” in Texas. Gender expansive folks noted being physically attacked on the streets, the murders of their friends they see happening with relative impunity, the psychological violence unleashed on them by the HIV service system, especially certain providers, and the sense of constant threat and siege emerging from Austin and featured on television. When asked how they feel safe, multiple private messages were sent to the focus group facilitators that “I carry a gun in my purse, bra, car and keep one in my bedroom side table and near both my front and back doors”. This sense of needing to be heavily armed speaks to this population believing they

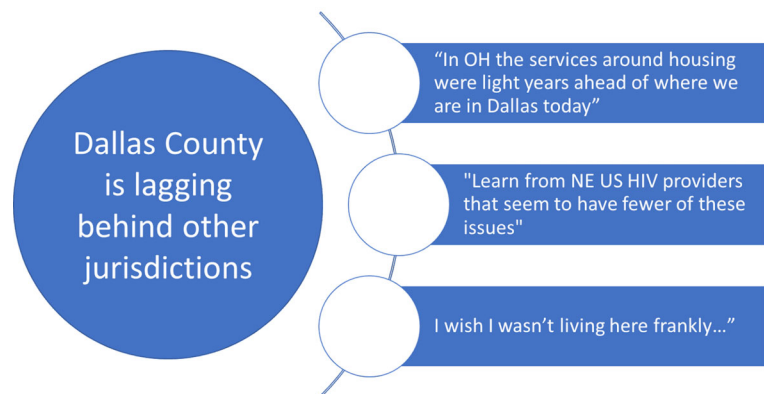


are “under siege”. The LatinX community mostly avoided this assessment, because there is a legitimate fear that they will be put on a bus and sent thousands of miles away from their families. The LatinX community in Dallas believes this is already happening and has resulted in them disappearing into the background until it is absolutely necessary to interact with any type of authority group, including the medical system.

Throughout each focus group and in most interviews, the theme of weaponized HIV Stigma bubbled up. Experiences of both Internalized Stigma and sources of Public and Institutional Stigma were revealed and speak to the lack of visibility, attention, and focus on advancing an end to the HIV epidemic based on state of the art HIV science. When asked if they ever felt “pitied” by their care providers, respondents noted that they only get pity when discussing issues of HIV risk and broader risks; the sense that “the more they get to know me, the more they pity me and my life” emerged strongly among black gay men. For black people of all backgrounds, a sense that the provider only wants me to answer their Yes/No questions and not provide any additional context emerged; clients are rudely cut off when they try to add context. Among gender expansive people, respondents noted that their providers do not pity them as much as fear them. The words used by staff, their body language and tone of voice, the relative patience or impatience that is shown to one group versus another, observed differences in treatment options provided to one group versus another, and a sense that only surface level interactions are preferred all play into the theme of stigma.



The final theme to emerge focused on a comparison of the Dallas region HIV service system and what is done is other locations around the United States. Numerous respondents shared their experiences with programs in other places and how they wish the Dallas region could adopt the methods of other jurisdictions, believing that these changes would be a great addition to the region. Of note, respondents focused on the HIV service systems in place in the northeastern US and parts of the industrial midwest. RAI would like to note that these comments are rooted in respondent perceptions of “greener grass” based on their negative current feelings of the Dallas HIV service system. In fact, there is no perfect service system, but it is natural to seek greener pastures when feeling miserable or generally unhappy with what people experience day to day. The purpose for RAI’s inclusion of this theme in the results is to demonstrate how all the other



themes come together within people to produce a sense of desperation and wanting to leave. Instead of leaning into the relative despair this theme represents, we address positive solutions in our findings and recommendations sections below.

Overall Results Across SNNA Components

Among the Street Homeless population, the majority of interactions were with men ages 45 and up. A lot of them were curious about what PrEP was, because they didn't know. When the word HIV was mentioned, the common response was "OH! I don't have that. I don't have THAT!!" as if in reaction to an accusation. For the younger homeless men (up to age 35), there was a greater awareness of PrEP, PEP, and U=U than was seen with older men. For women who were homeless, they said they had never heard of PEP and they were all excited to hear about an "HIV morning after pill" and the women were surprised that such a therapy existed.

Among individuals reached at AHF/AIN, a majority of the engagements occurred with homeless people with HIV who were participants in the "hot meals program". There was a strange silence in interacting with these people, as if they were afraid to say too much and focused on saying just enough to qualify for the incentive by answering all survey questions. Where possible, they avoided providing open-ended responses. Respondents at AHF/AIN were accustomed to these types of assessments and there was no surprise at the questions or their intent. Clients explained "They do surveys all the time here and this just feels like business as usual for me when I'm here at AHF/AIN".

Among individuals engaged at ASD's Hillcrest House, the majority were living with HIV and experiencing severe mental illness. Individuals in this setting had a very low literacy level, but the majority knew about PrEP, PEP, and U=U.

Among individuals engaged at ASD's Evergreen House, the majority were older adults also with low literacy levels. As opposed to Hillcrest House, Evergreen House residents had zero knowledge of HIV science, PrEP, PEP, or U=U. In this setting, residents are predominantly white females who are generally considered low risk, though their presence in the housing program indicates they likely have a higher risk level than is assumed by the broader system.

Among individuals engaged at the Dallas Public Library, the majority were homeless individuals who had a history of justice involvement. The individuals were present to participate in a long-standing Gilead support group for people with HIV and were accustomed to discussing issues related to HIV and HIV risk. There was an average level of knowledge of HIV science, U=U, PrEP, and PEP.

No matter where homeless people were engaged, all were delighted to receive a physical gift card as opposed to the amazon gift card. This was a meaningful nuance for them. When working with homeless people, they were open to sharing their experiences collectively when completing the survey in a group setting and were interested in providing immediate support to each other when the need arose. This is profound, because it relates to the survey finding that

many people rely on their friends/family for information and support - more so than they rely on the system to educate and support them.

Findings

From the surveys, focus groups, and key informant interviews, the RAI team has identified groupings of key findings by service category and unmet need which will be further elaborated upon in the Discussion and Recommendations section. Findings to populations that were not surveyed were not estimated using probability sampling. RAI also did not apply findings to populations only minimally represented in the needs assessment process. It is recommended that future assessments engage these populations directly to gain their input and feedback. Across the key populations we found similar themes including the impact of stigma, a dearth of or nonexistence of services and service providers, a general community landscape of discrimination and intolerance, and frustration due to lack of representation, moral injury, and an uncoordinated system of care beyond the RWHAP program. This is particularly true of those accessing prevention services noting that there are services available to the HIV community of which they cannot avail themselves such as housing support, medical care, food and nutrition, and transportation services. When asked the “Magic Wand” question, individuals from both the focus group and the key informant interviews emphasized looking beyond what can happen through DCHHS alone and to look more broadly on potential public/private partnerships. These partnerships can not only strengthen the system of care, it can also invigorate the community. The results shared above are only a fraction of what this dataset has to offer. It is recommended that DCHHS and RAI continue to leverage this datasource for additional results and to develop additional findings and recommendations.

Resource Inventory

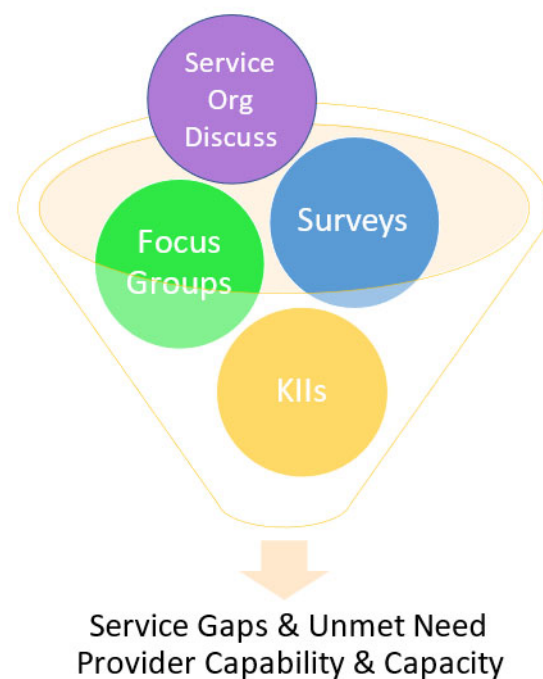
Resource Inventories are essential HIV service system tools used at different levels for multiple reasons. Government officials may use resource inventories to identify opportunities to strengthen the service safety net through funding or service redefinition. The community may use resource inventories to navigate care systems. Provider organizations may use resource inventories to expand their referral networks and other relationships in the field. The Research Director has already worked at multiple levels within the Dallas region HIV service system and has an intimate understanding of the siloed resources available. RAI’s “meatball chart” tool is used to identify funding for different specific services at specific organizations and sites. The tool clearly shows geographic service gaps and other opportunities for a variety of stakeholders to engage in health system strengthening activities. A primary goal of resource inventories is to deconstruct silos and better concretize the safety net, which are simplified using the meatball chart. The Resource Inventory was built-out from the existing Dallas meatball chart based on the resources identified by DCHHS and in consideration of community feedback and the current outreach activities for the SNNA.

The Resource Inventory must be a living breathing document as organizational funding and contacts can change multiple times throughout the year. Community, provider organizations, and public health all have needs that are met by an easy-to-use resource inventory. This is especially relevant in this post- COVID-19 pandemic era where many organizations have been required to shift their focus, change staffing patterns, and modify. programs. This has made some traditional service providers less available to meet the needs of those living with or at risk for HIV infection. It is incumbent that underutilized agencies and nontraditional service providers are identified to support EHE efforts in alignment with local and national best practices. The survey RAI develops will be simple enough to administer annually to maintain an updated meatball chart to be used as a communication and planning tool by DCHHS. The Meatball chart and resource inventory listed in Appendix X further identifies our regional stakeholder groups, funded partners, non-network providers, and business groups and associations.

Profile of Provider Capacity and Capability

The Profile of Provider Capacity and Capability is drawn from the Resource Inventory by pulling out the most relevant services, geographies, and populations to describe how well the system is currently calibrated to address the actual needs in the field. Beyond affirming that resources are present, the profile of provider capacity and capability starts to get at the nature and quality of those resources specific to the community's real needs. Nature and quality of services speaks to the geography, cultural and linguistic competency/justice, patient/client choice, transportation burden, access to payers, and expected wait times. In addition, ease of system navigation, referral and linkage follow-up, eligibility determination and documentation are all structural barriers that limit people's care-seeking behavior and engagement in healthcare.

In reviewing data from the surveys, focus groups, and key stakeholder interviews, various gaps in provider capacity and capability were noted. While there is a strong passion basis within provider organizations, there is also a great deal of stigma, discrimination, and misinformation. Sometimes these adverse events happen at the highest levels of leadership in organizations. It is essential to note that individuals who have been living with HIV the longest have the most favorable opinions and feedback related to provider capacity and capability. For example, folks newer to HIV care will bristle at wait times of more than a month, but for more experienced people, they are pleased the wait times have decreased to that level from more than a year previously. Another example has to do with the attitudes of staff and their perceived degree of helpfulness. Folks newer to HIV care are confused by unclear communication and conflicting messaging coming from within and across organizations. Folks



who are more experienced state that the level of system organization has vastly improved over the last 10 years and improvements have quickened their pace in the last 5 years.

It is important to note that one area has decreased over time, the passion basis of the providers serving the HIV community. Folks, the most experienced folks, remember a time when providers went out of their way to give hugs and dole out free meals and more in the 80s and early 90s. With the introduction of RWHAP, the influence of funding watered down the passion, because additional folks were drawn into the field for reasons beyond passion. More recently, the latest infusion of cash into the HIV movement related to 340b has seen another hit to provide passion. Some respondents stated that recently HIV care is about the same passion level as any other care, which is a significant departure to the way things felt even 10 years ago.

One final area of provider capability and capacity has to do with the lagging knowledge of the state of the art HIV science in the Dallas region. It is apparent that some providers are denying that U=U is a viable advancement and is reasonable to promote with patients. It is also apparent that some providers are discriminating against clients based on their race and perceived financial status when making key treatment decisions. These are important gaps to immediately address using the full range of resources DCHHS has at its disposal.

Assessment of Service Gaps/Unmet Need

Available data suggest that there is a significant level of unmet need in the Dallas AA region. The 2019 Texas treatment cascade for Dallas states that 5,122 people with HIV (21% of total) are out of care (eHARS data). According to AIDSvu, the percent of the population lacking health insurance in 2019 averages to roughly 20% of the public in the Dallas AA region. This translates to approximately 1.1 million people in the region who lack health insurance according to 2020 census data. This is the minimum of the true range of uninsured people. People who lack insurance are reliably not engaged in ongoing primary care, but people with insurance are not necessarily engaged in primary care. According to CDC methodology, it is expected that roughly 3,400 people are living with HIV in the Dallas AA region, but are unaware of their diagnosis. Uninsured individuals, particularly those with HIV, may find PEP and PrEP largely out of reach due to the number of medical appointments and monitoring lab work required for PrEP care. Even if individuals can access the medicine itself for free, they may not be able to afford the cost of visits or expensive lab testing. Working adults without health insurance may also have barriers in requesting time off of work for quarterly monitoring visits. Dallas County also has a very low PrEP to Need Ratio (PRN) indicating significant unmet need. While this is also a national issue of underutilization of PrEP and accessibility both Dallas and Texas fall below the national average¹⁷.

Of additional concern is the dearth of mental health and substance use services. From our survey results, nearly 35% of respondents identified a risk factor of injection drug use, with 61% of those reporting that they shared injection equipment with someone of unknown HIV status. In states with legal syringe exchange programs, the rate of transmission is under 3%. In Texas,

¹⁷ AIDSvu

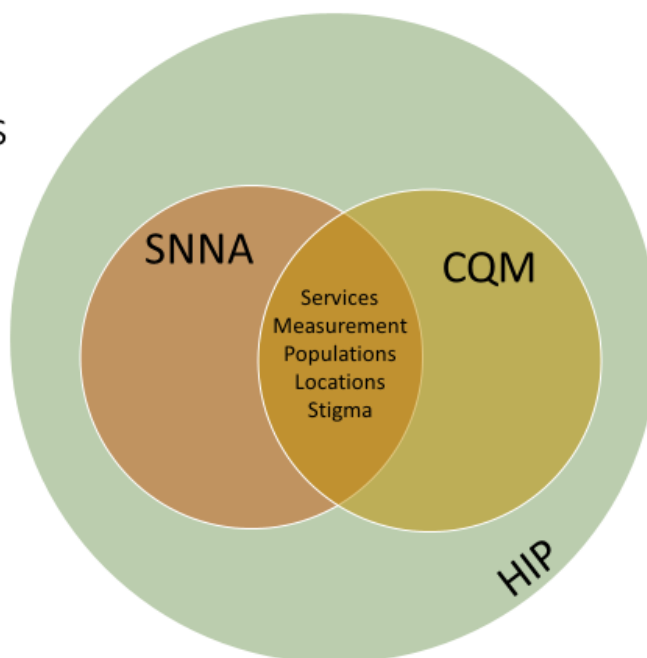
the rate of acquisition of HIV amongst People Who Inject Drugs (PWID) is 16.3% for women and 3.2% of men. However, when we include those with a dual risk factor of male to male sexual contact and injection drug use, the combined rate is over 10%. This is a real area of opportunity to make a significant impact in the reduction of transmission amongst PWID. While there is a federal funding ban on the purchase of syringes, federal funding can and must be used to provide harm reduction services to PWID. Harm reduction programs are evidenced based with improved outcomes over abstinence based service delivery in linking people to ongoing substance use treatment, reduced susceptibility to HIV infection, and achieving sobriety. The majority of people who attempt to stop problematic drug use will have at least one relapse in their recovery process; systems must be in place so that those who use substances are not lost to care. Services must be available and provided in a way that is non-punitive, separate from the carceral system, bias and stigma free, and compassionate using evidenced based medical treatment models. Without substance use services, the Dallas catchment area could easily find themselves in the position that Scott County, India encountered 6 years ago or Kanawha County, West Virginia in 2019.

Silos between mental health and substance use treatment also result in a dearth of services as many individuals require both for co-occurring disorders. Here again, we see the problem of “wrong doors” in which patients with substance use issues may be turned away from programs that solely focus on mental health services. Mental Health America, in 2022, ranked Texas as lowest in the nation for access to mental health services (51 out of 51 including Washington DC). 21% of those living with a mental health diagnosis reported insurance as a barrier to accessing mental health treatment and 73% of youth reporting an inability to get treatment despite a willingness to engage in mental health treatment. As noted above, over 70% of survey participants responded affirmatively to negative mental health systems including excessive worrying, nightmares, anxiety, or feeling down, depressed, and hopeless. 28% identified barriers to engagement with the primary causes being cost and a lack of knowledge of how to engage in the mental health system. People who are struggling and cannot access help are known to have poorer health outcomes and may also be at a higher likelihood of drug and alcohol misuse.

Discussion and Recommendations

In 2022, multiple assessment activities engaged the HIV community across levels. This included this SNNA, the HIV Integrated Plan (HIP), and multiple activities undertaken by the RWHAP clinical quality management (CQM) program. The vast majority of the organizations and other parties included in the Resource Inventory in the Findings section above participated in one or more of these activities. Collectively, these activities have an essential overarching recommendation - in order to support the HIV community in the Dallas region, much more work must be done to engage with the community to elicit ongoing data on needs, unmet needs, and how to establish and maintain vital services for everyone. The following diagram shows how the 2022 assessments overlap in purpose to arrive at this conclusion.

HIV Community Assessments in Dallas in 2022



Many action-oriented steps can be elicited from the findings of the Dallas SNNA. Of primary concern is how the DCHHS, as the unquestioned leader of the regional HIV service system can address the levels of fear and mistrust of the greater system of care. RAI's recommendations for the Dallas system of care are broken down into five primary categories:

1. Broad Health System Strengthening Activities (from planning to evaluation)
2. Public Health Campaigns to Educate the Public on HIV and Ending the Epidemic
3. Cultural Humility Training for ALL (customer service emphasis)
4. Special U=U and Broader Biomedical Intervention Training/Messaging for ALL
5. Development of of the HIV community as a specific human resource to End the HIV Epidemic and Achieve Together

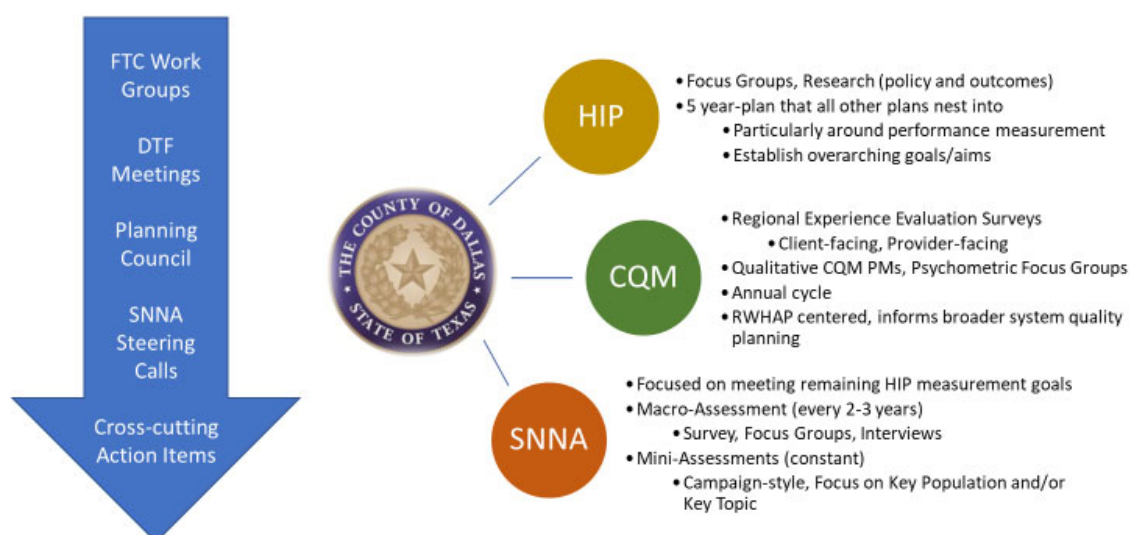
Recommendation 1: Health System Strengthening

RAI's first recommendation is to rethink the interaction of systems with the HIV prevention and treatment landscape. For DCHHS, this means recalibrating the HIV planning and evaluation mechanisms in place to ensure that each component adds specific value to the overall vision and mission. For example, the 2022 assessment activities exhibited above can be blended with the Resource Inventory to create a new model to build information and consensus in HIV planning. In the following diagram, each required aspect of HIV service system planning blends with existing mechanisms for service planning and evaluation. The mechanisms for service planning and evaluation include the Dallas Fast Track Counties (FTC) Work Groups, the Dallas EHE Task Force (DTF) Meetings, and Dallas Planning Council. In our recommendation, we include a new internal planning group for status neutral needs assessment steering designed to direct the constant cycles of mini-assessments and to assist in planning the less frequent macro-assessments. In this model, the natural relationship where HIP is planned every 5 years

based on all available data from the previous five years, constant mini-assessments will allow for a catch-all related to key HIP performance measures that have not been gleaned from any other activity. Authority and decision making flows from the group of broadest scope and stakeholder expertise down to the narrowest. RAI proposes shared action items across all activities to ensure that HIP goals and performance measurement mandates are met.

The recommendation for Health System Strengthening goes beyond HIV service planning and evaluation. Included is a plan to address the very real impact the current service system has on the HIV community in the Dallas region. Respondents noted feeling disconnected, unsure of where to go for assistance, and a lack of consistency in responses from individuals within funded systems. This can be addressed through training and a multimedia approach.

Building Knowledge, Building Consensus



Patients and clients must be able to access the system of care through a “No Wrong Door” approach. By this we mean, at whatever point an individual accesses the system of care, there should be a built-in network to ensure that the patient is linked to the service requested and all efforts are made to engage the individual in the appropriate level of care; prevention or treatment services.

- A series of listing sessions for the results of the Needs Assessment and Integrated Plan should be organized to target key geographies and populations. and increased participation by providers and pharmacists in the Ryan White Planning Council.
- The Planning Council, and particularly the Needs Assessment Committee, should develop a workplan from the recently conducted HIP and SNNA to maintain momentum on engagement by those who have participated thus far and to bring in newly motivated constituents and partners.

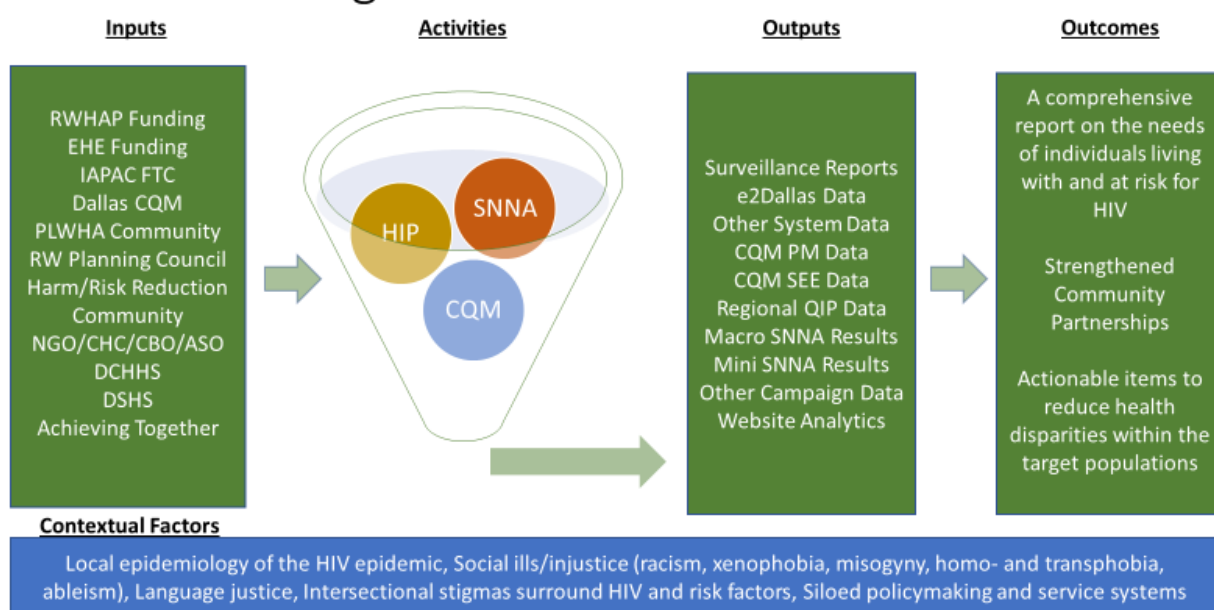
- Another option is to create a synthesis of patient satisfaction or stigma surveys at the system level and across funded organizations. It is important to have an ongoing method to assess these challenges at a system level and to have immediate solutions on hand to address adverse findings. This suite of activities should be enforced within the RFP, contract, and monitoring processes. In particular, system-sponsored training, workshops, and other capacity building can be required and enforced. There are numerous partners including local AETC that can assist in designing trainings and consultants are available to assist system leaders understand how best to manipulate components like RFPs and more for the purpose of accomplishing this goal. In addition, information from the Needs Assessment and the Integrate Plan should be shared with the public to glean open feedback and input more broadly.
- One approach may be networking sessions in which employees from various agencies have the opportunity to develop personal connections or virtual drop-in sessions for ASO leadership to identify where their staff are currently struggling to bridge systems of care.
- Building public-private partnerships may also be strengthened by webinars and educational services to nontraditional avenues such as school nurses, college health centers, and employee assistance programs.
- There is an array of best practices available that can be shared with DCHHS and other HIV system stakeholders using timely and effective methods of skill-building.
- An intervention, specifically for the newly diagnosed, is to create a safety net provider for those who are newly diagnosed for direct intervention. This could be a phone hotline, a funded peer position, or creation of a new staff role to provide a soft landing to those experiencing crisis around their new diagnosis

When thinking of infrastructure changes, it is essential to leverage online approaches that simplify communication and encourage buy-in, especially following the COVID-19 pandemic and M-Pox outbreak. From a Health System Strengthening standpoint this means increasing the number of high quality websites, advertisements, social media accounts, and other tangible presence. This builds public trust in authorities and counteracts the tendency to look to friends and family for information before looking to experts. This will in turn increase public knowledge, allow for everyone to have equal footing in knowing which resources are available and how to access them, and confidence that their information is being used in a secure and controlled manner that furthers their care. While the systems of care may in and of themselves be complicated, communication regarding resources and entry points should be clear and simply stated.

- An important element is to create a central repository for information sharing across care providers. The Dallas region and perhaps the entire DFW area should work toward establishing an electronic health exchange (eHX) or Regional Health Information Organization (RHIO) to champion the care of all people everywhere in the region. This is something that came up repeatedly in RAI's engagement with respondents related to the HIV service system, but it would greatly improve the lives of all people living in the region. Such a system would also improve the ability of regional care providers to provide high quality care to all people.

- Another important element is cross sharing of information and cross promotion of organizations and parties included in the Resource Inventory. Information can be widely shared through improved websites with HIV prevention and treatment information; websites should be routinely updated and able to cross reference each other - be it webpages dedicated to sharing system information and campaigns, CQM program webpages, the IAPAC FTC dashboard, or the Dallas Planning Council website.
- Another essential element is in data collection and data transparency to support Achieving Together and EHE. Data transparency not only builds buy-in but also creates accountability at the systems level. This includes increased reporting in where 340b dollars are being reinvested into the service system and in assuring that service category components are being fully delivered. In addition, there are no federal reporting matrices or national quality standards for prevention programs akin to the Ryan White Services report. It is our recommendation that DCHHS be drivers in acquiring and collecting this type of information in conjunction with funded programs providing prevention services. In addition, working outside of the funded system to create a more unified system of care under DCHHS leadership would make the Dallas region one of the foremost in the nation in terms of EHE planning and evaluation activities. The following diagram shows how multiple assessments and activities blend together in a combined logic model.

Combined Logic Model for Dallas Assessments



Recommendation 2: Public Health Campaigns to Educate the Public on Ending the HIV Epidemic

The SNNA findings related to a lack of visibility, a lack of feeling acknowledged, and the lack of public knowledge of key biomedical interventions is the basis for this recommendation. Respondents noted that public health campaigns and other visual signs at any level that HIV is a priority in the Dallas AA region would be a great benefit. Core to feeling acknowledged is feeling seen, especially in seeing oneself reflected in the images and other content produced through each campaign. In particular, the issue of acknowledgement speaks to the importance of public facing material being highly inclusive and diverse in every meaning of the word.

- Based on the models described in RAI's first recommendation, DCHHS can provide leadership on public messaging campaigns using a data to care approach that features key populations and messages as the need arises. The purpose is to support marginalized communities and counter hostile community messaging they receive. In addition to including diverse people in images and consumable content, it is essential that the groups hired to create these materials have tangible connections to the communities they are attempting to reach.
- Other opportunities to encourage buy-in is to increase the transparency of data sharing and promoting data to care information and best practices. This can be done through websites, print media campaigns, and various social media platforms.
- The campaigns should leverage all available supports from the Resource Inventory and be designed in a way that aims to share costs with segments of civil society. Additional public/private partnerships should be formed to fill gaps in efficacy. In creating campaigns this way, there will be less delay on account of government approval pathways and a greater focus on what needs to happen expediently on the ground.
- Specific training packages and recommended requirements for provider organizations are included in recommendations 3 and 4 below. Public facing campaigns that are not backed up by visible change at the system or provider level will only waste further credibility.

Recommendation 3: Cultural Humility Training or ALL

There is a call to action for DCHHS to ensure that funded agencies provide services without stigma and with increased cultural humility. Stigma and cultural humility are closely related to one another as discrimination based on intersectional identities of gender, race, immigration status, language status, and more combine to exacerbate baseline HIV stigma. This is a system-wide issue from patients feeling uncomfortable with pharmacy staff to feeling "stuck" with providers who are not meeting their needs. Opportunities available to address this issue cover a range of possibilities.

- Information from the listening sessions described in recommendation 1 should be used to develop these trainings in conjunction with synthesized data from
- People living with HIV and those seeking preventive care should be educated and empowered to demand culturally affirming, high quality, respectful medical care and pharmacy (THMP, APA, and others). Health care systems and ASOs should deliver the same without question or expectation of additional funding. The public is an important enforcer and informer on these topics.

- Beyond the funded network of RWHAP organizations, DCHHS might consider including an open door policy where non funded groups can RSVP to attend meetings. Tying training “sprints” with certain areas of the non-RWHAP community could accompany specific public health campaigns related to recommendation 2.
- DCHHS can work with external partners to create combined training initiatives that allow for blended funding and objectives that meet the broader needs of the HIV community and not just focus on the narrower needs of any given funding stream. This includes ensuring that DCHHS favored training is completed through ECHO in-service calls, local professional conferences, and other opportunities.
- There is an extraordinary array of HIV-focused and broader focused resources intended to address cultural humility and HIV stigma. The creation of specific content can be done on a collaborative basis. Existing training resources should be used first and new training only created when absolutely necessary.
- All such trainings for HIV provider organizations and their staff should be made part of contract requirements and part of monitoring and evaluation. Where possible, DCHHS should advocate for its partners to follow suit to increase the mandate for cultural humility across the local medical field (i.e., helping change processes for business licensure, medical licensure, medicaid participation, and other requirements to ensure that folks participate in this type of training).

Recommendation 4: Biomedical Intervention Training for ALL

Next, the SNNA uncovered the need for ongoing required training on biomedical interventions. It is simply unacceptable in 2023 to have providers at RWHAP funded agencies advising their clients that U=U is irrelevant to them. It is unacceptable for people to be denied HCV cures, injectable PrEP, and other recent advancements in HIV science due to provider or organizational level ignorance as to what the state of the science is. Many recent advancements are counter to traditional thinking and beliefs related to HIV making them hard to accept, but it is incumbent on us to NEVER GIVE UP on education and science.

- Similar to the strategies for recommendation 3, DCHHS should consider the full range of potential speakers and subject matter experts on this topic.
- DCHHS should consider making participation in such training compulsory for all staff and for staff at all funded organizations.
- DCHHS should consider remediation (QA) training to refresh service provider staff on current HIV science when it is made aware that providers are not keeping up with the field as it advances. Potentially consider the creation of a central DCHHS-managed grievance process that includes a timeline for expected acknowledgement and response of grievances.
- DCHHS should consider working broadly with partners to deliver these training and mandates so that the needs of narrow funding stream requirements do not distract from the broader picture and need of the local HIV community.
- Consider the creation of a Conference of Summitt providing CEUs to clinical staff (MD, RN/LPNs, Social Workers) to widely share the recommendations and work plan

developed by the Planning Council. This will also be an opportunity for developing a central network to attract new talent to work towards Ending the HIV Epidemic

Recommendation 5: The HIV Community As a Human Resource

RAI's final formal recommendation is to create activated consumers through additional training and support. More than that, it is recommended that DCHHS work with partners to create a human resource pathway for the local HIV community. Only by acknowledging and rewarding community participation in service system planning and evaluation, can an end to the epidemic be achieved.

- One best practice is to provide formal training for consumers to become peer community health workers of which there are many models in funded EHE jurisdictions. This can be done using internal county resources or using external resources. Some places in the US have worked with community colleges to create free or low-cost certification programs that honor the investment made by the community in their own education and advancement.
- Involving consumers also provides opportunities for informal peer leadership. For example, when RAI outreach staff was conducting the survey with participants he noticed that almost no one knew about PrEP, PEP, and U=U. Our staff took the initiative to provide education at the completion of the survey on these topics resulting in nearly 200 training sessions. Our clients, patients, and consumers are the 'subject matter experts' on what is needed and wanted for prevention and treatment services. By increasing peer training we empower our peers to be community leaders and agents of change in their own systems of care.
- There are many training programs available through the HRSA TAG website, as well as mentoring opportunities through the EHE jurisdictions, technical assistance requests from the HRSA project officer, and private-public partnerships. DCHHS can also learn directly from RAI subject matter experts but conducting specific outreach and conducting listening sessions for particularly vulnerable populations include the TGNC/NB communities, those accessing harm reduction services for substance use, and those for whom English is their second language.
- Listening sessions should be co-led by community leaders and a trained focus group facilitator for the highest level of buy-in. Any time where we can hire the community, we should hire the community. Critical to healthcare self-management (for both HIV care and those at risk), individuals need to have a sense of where and how to look for information and supportive care. They need to be confident enough to insist on getting their needs met. They need to have offered services in a linguistic and cultural framework that meets their needs and expectations. They need to be comfortable that services have payers and they will not be stuck with bills and reports to creditors. There are also a great many other fundamental needs.
- Listening sessions should also be conducted for providers and funded staff to encourage buy-in and accountability. With multiple competing priorities and deliverables, it would be helpful for those receiving RWHAP dollars to align themselves with DCHHS priorities

Additional Discussion On Establishing and Maintaining Vital Services for Everyone

The changes recommended above will take time. This section is not formal recommendations, but a discussion of other issues related to establishing and maintaining vital services for everyone.

From the need to create content, build trust, or work in a system that has been indelibly changed by COVID-19 and Mpox, there are many moving pieces. The past three years have taken a toll on all local public health systems with individuals leaving the profession and expressing high levels of burnout. Infectious disease providers and clinical staff were redirected to COVID from their roles in HIV prevention and treatment; nonprofits closed or reduced activities and we saw this through the decrease in HIV testing and diagnosis. There were also novel approaches that grew from these syndemics such as a move to telehealth removed transportation barriers, improved access for rural communities, and innovative practices such as mail in HIV testing kits. At this stage, it's important to reflect back on what has worked and what has not worked. It is highly recommended that DCHHS consider revising its COOP based on these findings and that the COOP process be revisited every 3-5 years in cycle with integrated planning and/or macro-assessments.

At the national level, there are several advocacy initiatives such as Medicaid Expansion, PrEP for All, and increased ADAP funding that are in the interest of the Dallas area HIV service system. Ryan White funding is tied to the number of individuals living with HIV providing additional incentive for identifying undiagnosed individuals and linking them to care - there are currently many thousand such people. DCHHS can also engage with organizations that are working towards these movements so that every individual in need of PrEP or PEP can access it and that 100% of those living with HIV are able to easily access and enroll in health insurance. There is no need to engage in political lobbying to be engaged with supportive organizations such as the Act Now End AIDS Coalition, larger EHE interagency collaborations, and other agencies that provide education to decision making bodies. In treating the HIV community as a human resource, support organizations can be encouraged to let the community speak up and lobby for itself as needed and when or where it is most appropriate.

Finally, administrative mechanisms incident to creating the Dallas area HIV service system are essential to streamline. All major funding partners in the region are in need of this whether its issuance of RFPs, making funding decisions, paying invoices, administrative and operational delays such as these waste service system credibility. Worse yet, real harm can be done when community partners front time and money and then there are delays in reimbursement. The challenges with City of Dallas HOPWA come to mind, but even the delay in funding this SNNA is an important example of this challenge. In order to be a good partner, the HIV service system funders need to be timely and responsive to community needs and efforts.

Bibliography

IHI

AIDSVU

US Census

<https://www.nytimes.com/interactive/2021/us/dallas-texas-covid-cases.html>

*All footnotes will be included in the bibliography.

Acknowledgements

RAI would not have been able to complete this important work without funding and support from the following contributors:

**Dallas County Health and Human Services
Dallas HIV Planning Council
Dallas HIV Task Force
Dallas Fast Track Counties Workgroup
Regional Ryan White Part A/B Funding Agencies
The Dallas Region HIV Community**

RAI team members responsible for this publication include:

**Katrina Balovlenkov, Project Director
Michael Hager, Research Director
Jeremy Fagan, Research Specialist
Chris Adkins, Research Specialist
Natasha Chiofalo, Outreach Specialist
Ricky Tyler, Outreach Coordinator
Clinton Torian, Outreach Coordinator
LaToya Goodman, Incentives Coordinator**

Special thanks to:

**Miranda Grant, DCHHS EHE Coordinator
Sonya Hughes, DCHHS Grants Management Division Assistant Director (RWHAP)
Glenda Blackmon, Ryan White Planning Council Program Manager**