

Dallas County

Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan

CY 2017 - 2021

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

Section I: Statewide Coordinated Statement of Need/Needs Assessment

Introduction

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

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

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

EPIDEMIOLOGIC OVERVIEW

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

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

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

Figure 1: The Dallas EMA

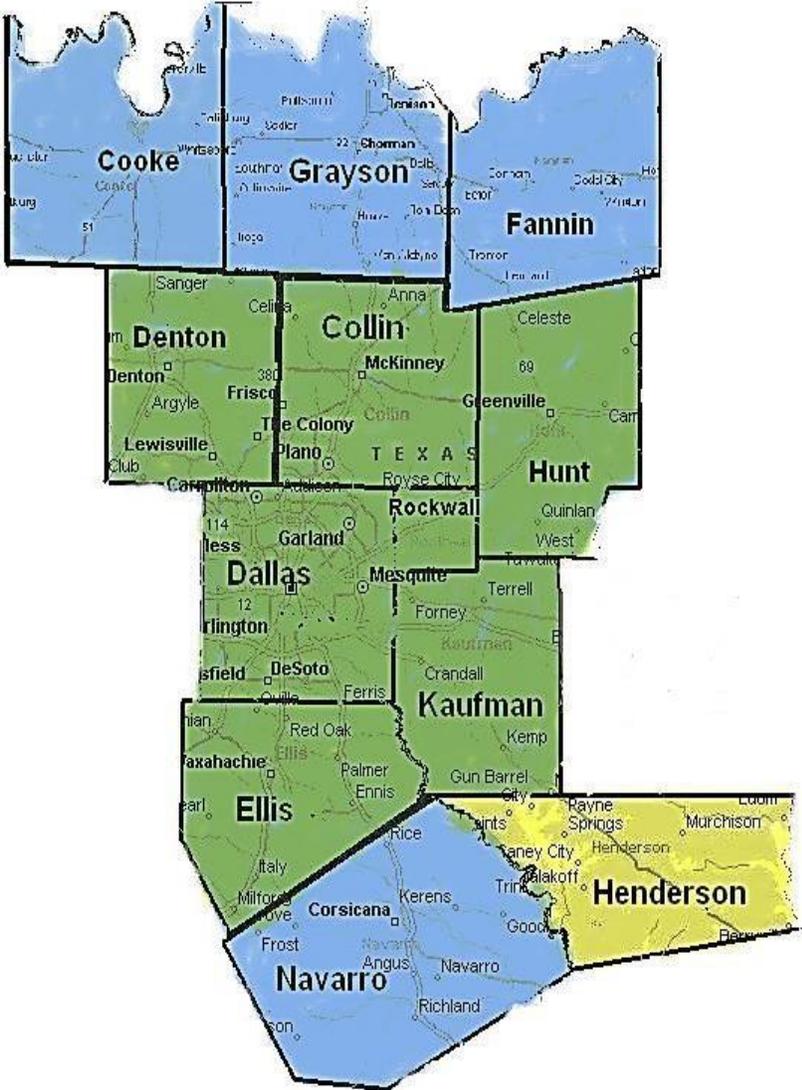


From 2010 to 2014 the Dallas EMA added about 375,000 residents, reaching 4.6 million and increasing the population by 9%. The breakdowns of the population by sex, race/ethnicity, and age group are shown below.

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

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

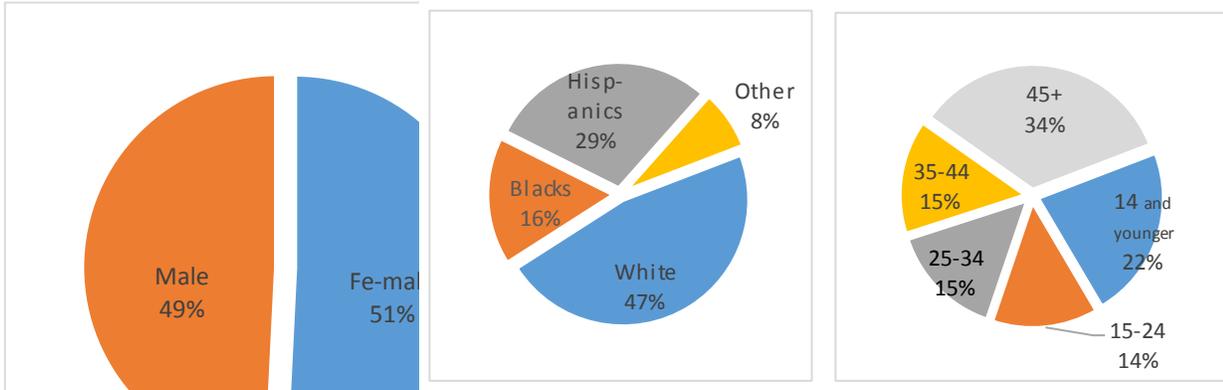
Figure 2: The Dallas Planning Area (Dallas EMA, Dallas HSDA, and Sherman-Dennison HSDA)



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

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

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



Race/Ethnicity

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

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

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

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

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

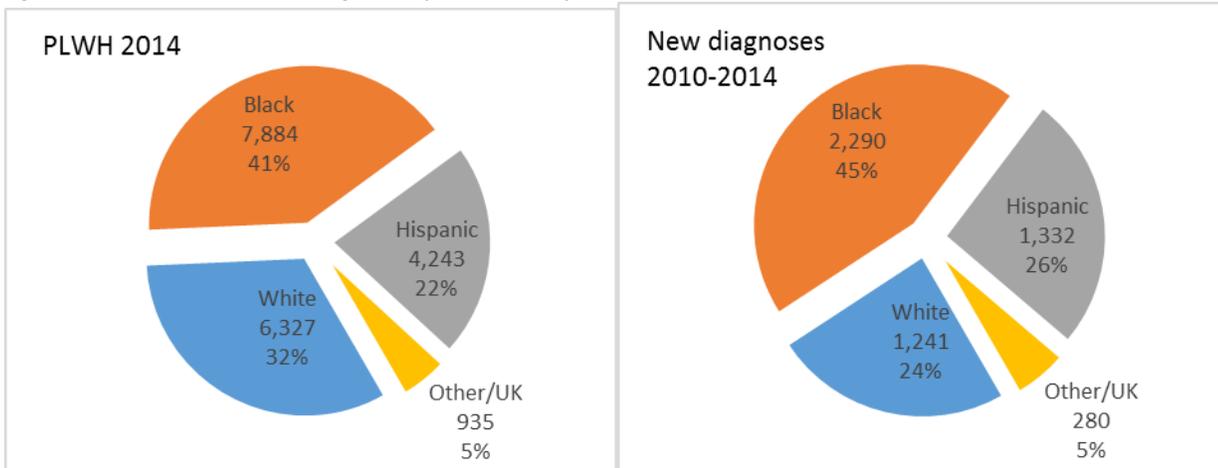


Figure 5: Changes in race/ethnicity of Dallas PLWH and new diagnoses, 2010-2014

PLWH

New Diagnoses

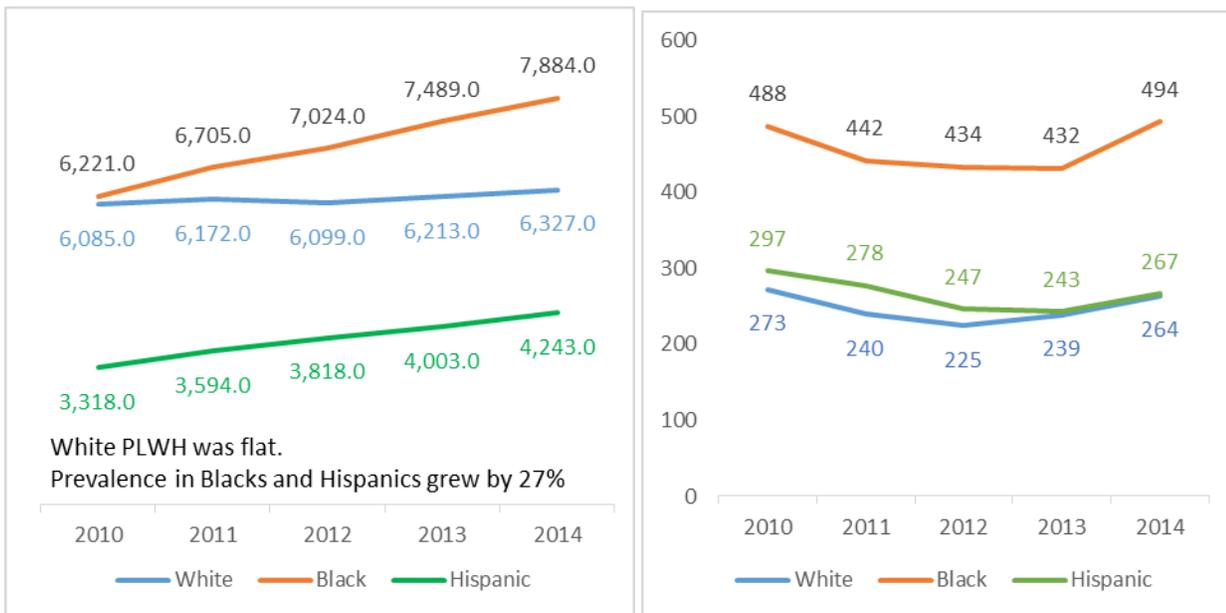
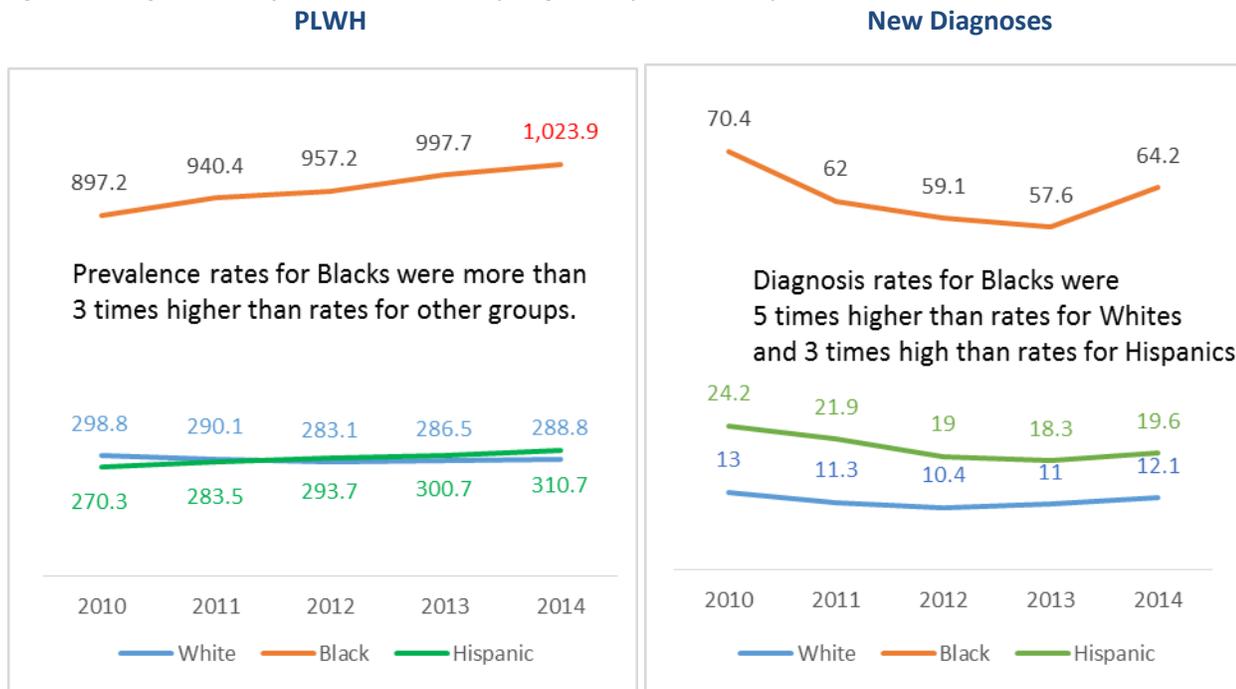


Figure 6: Changes in rates of PLWH and those newly diagnosed by race/ethnicity, Dallas 2010-2014



Age

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

Figure 7: Dallas PLWH and new diagnoses by age

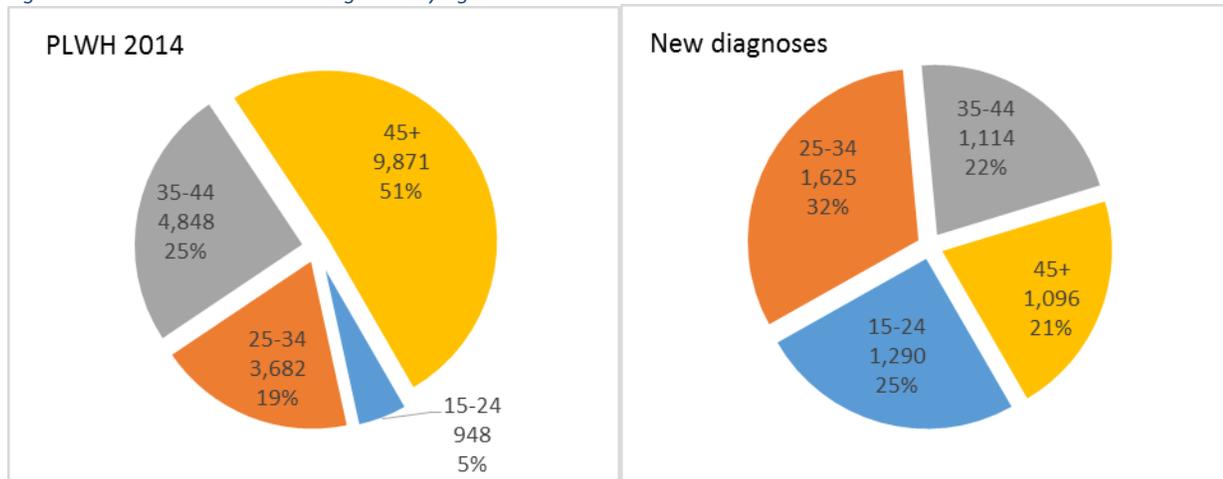
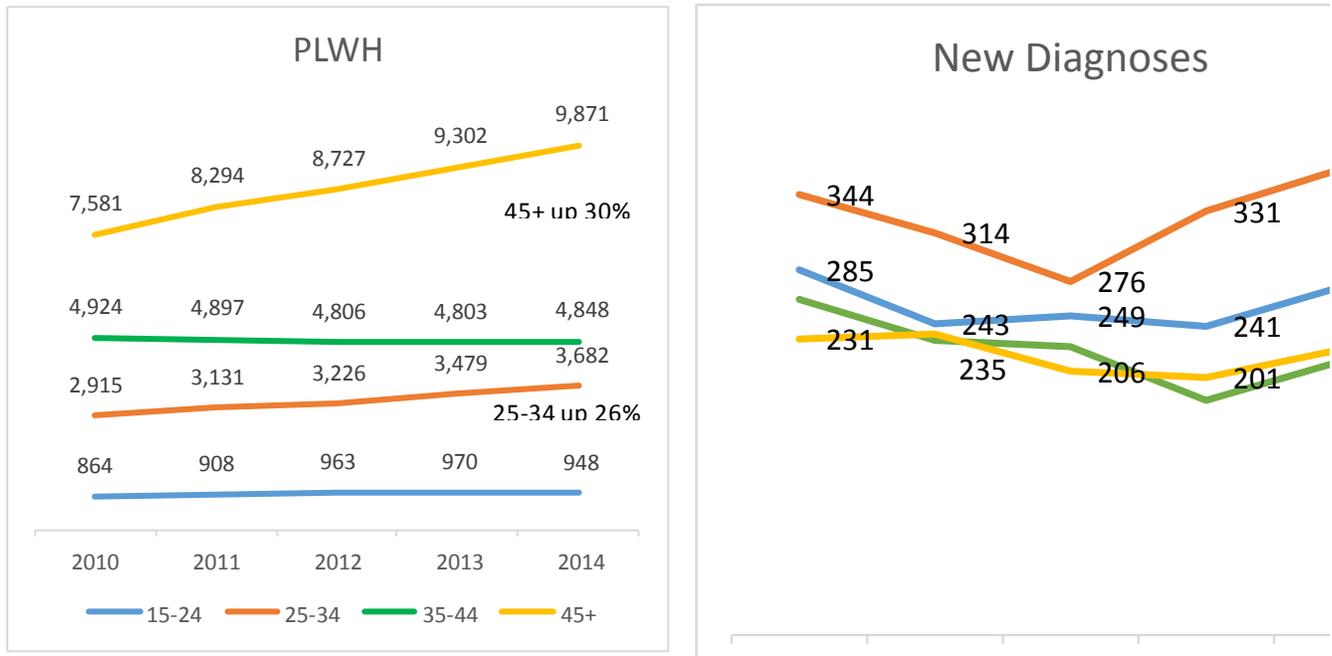


Figure 8: Changes in age of Dallas PLWH and new diagnoses, 2010-2014



Sex

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

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

Figure 9: Dallas PLWH and new diagnoses by sex

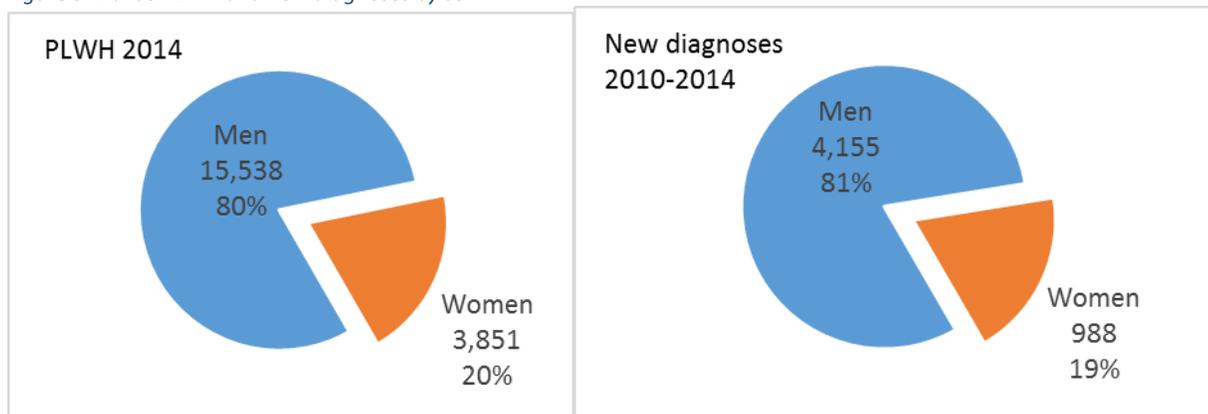


Figure 10: Changes in numbers of men and women in Dallas living with diagnosed HIV infections and with newly diagnosed infections. 2010-2014

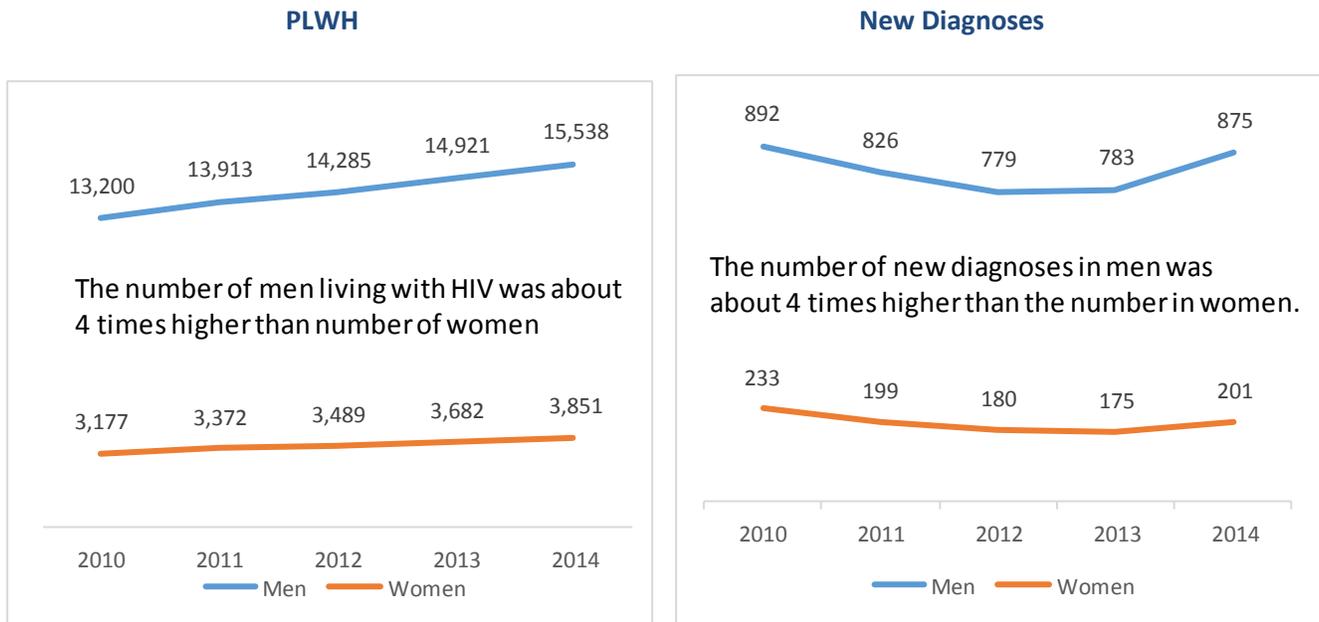
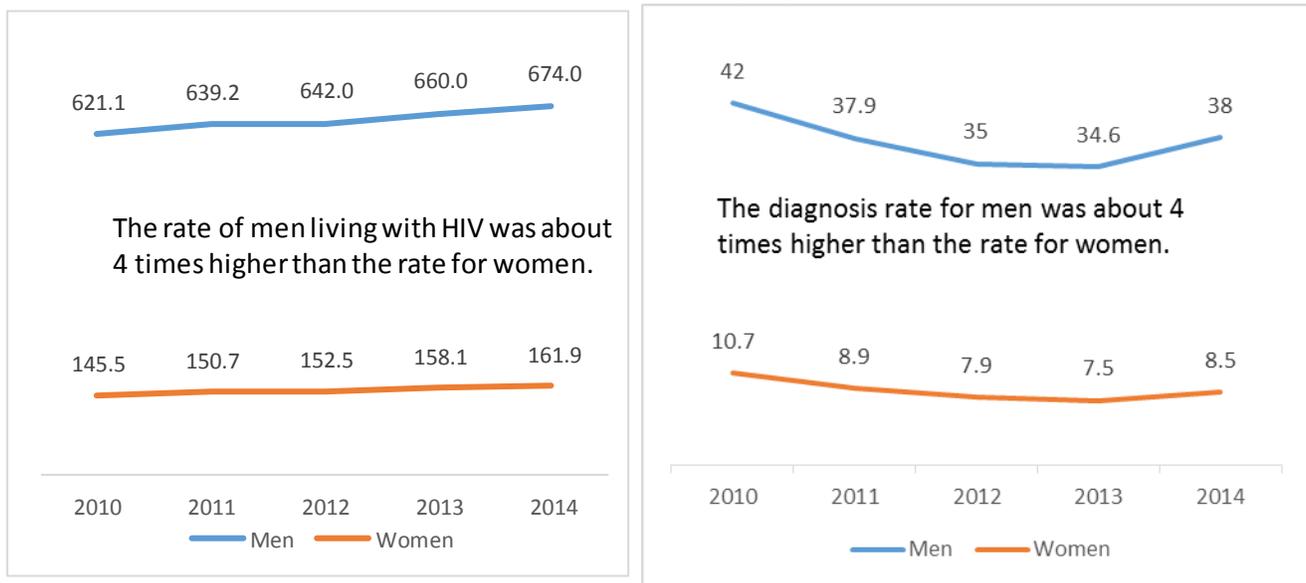


Figure 11: Changes in rates of men and women living with HIV and with newly diagnosed, Dallas 2010-2014



Mode of transmission

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

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

Mode of transmission groups

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

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

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

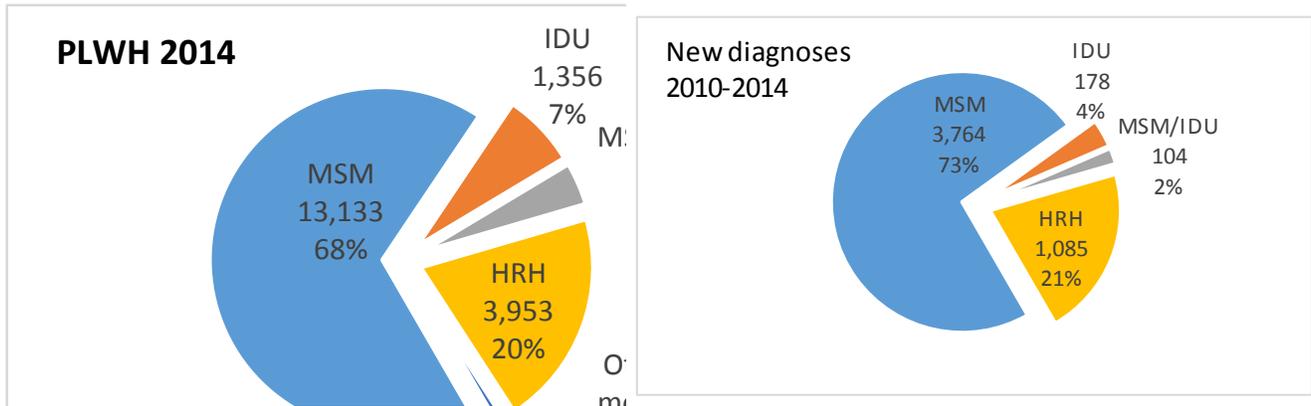
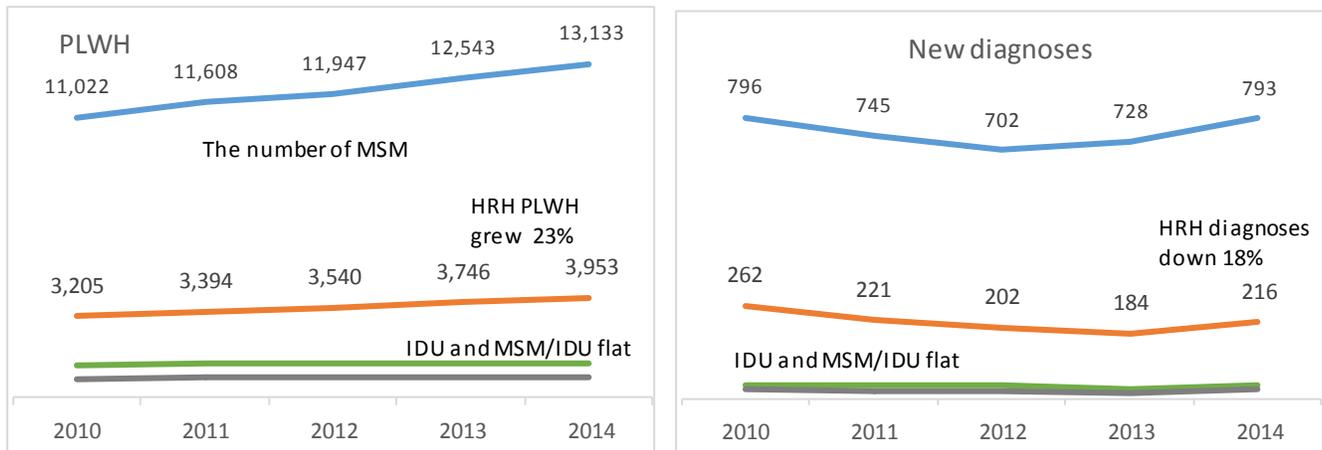


Figure 13: Changes in mode of transmission, Dallas 2010-2014



Gender identity

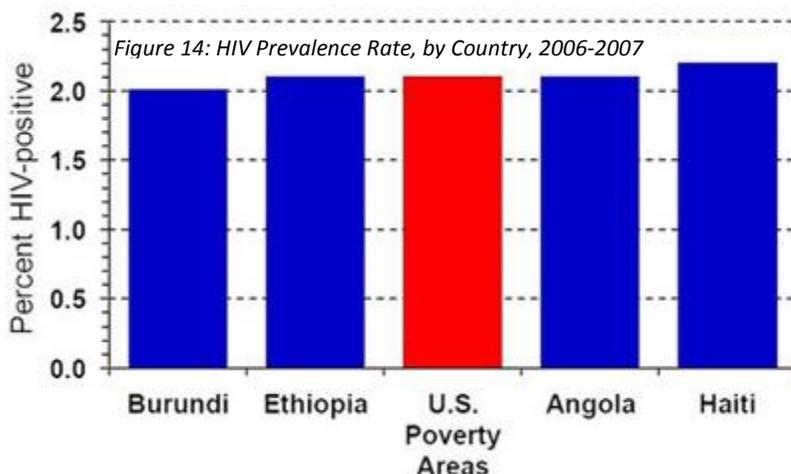
While most of the data in this section was provided by DSHS, gender identity data was not provided. Gender identity information related to HIV in the overall 12 county Dallas Planning Area for this section was obtained from the AIDS Regional Information and Evaluation System (ARIES) pertaining to clients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

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

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

Percentage of federal poverty level & Income

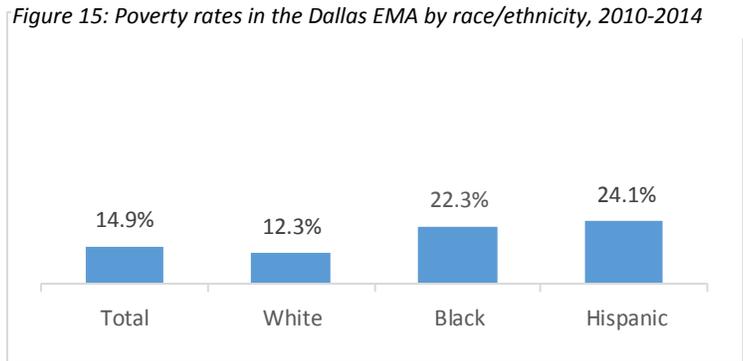
According to The Joint United Nations Programme on HIV/AIDS (UNAIDS), the United States has a concentrated



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

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

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



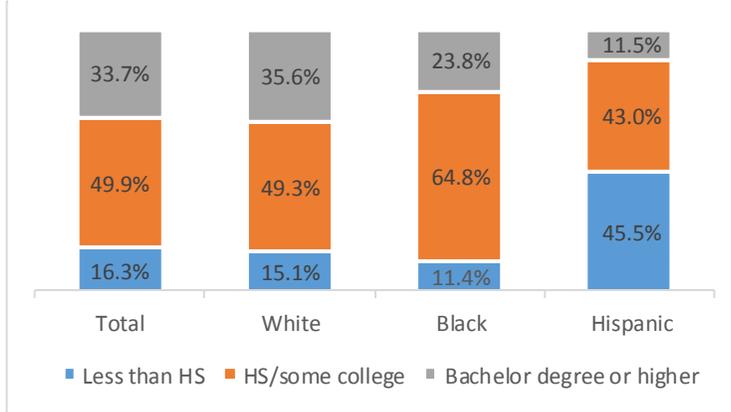
When analyzing the Federal Poverty Level (FPL) of consumers of Ryan White services in the 12 county Dallas Planning Area via the AIDS Regional Information and Evaluation System (ARIES) from 2010 – 2014, the percentage of users that were in the 0% - 100% FPL dropped dramatically in 2014 compared to the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

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

Education

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

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



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

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

Black females with an education of less than 12 years actually experienced an increase in rate of death due to HIV infection from 1993 to 2001³.

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

Cause/Sex	Education in years	Whites			Blacks		
		Rate	Rate	Annual %*	Rate	Rate	Annual %*
		1993	2001	Annual %*	1993	2001	Annual %*
HIV Infection							
Men	All	31.3	6.3	-23.0 [†]	111.3	56.1	-12.1 [†]
	<12 Yrs	28.7	15.4	-12.5 [†]	123.1	120.9	-3.1
	16+ Yrs	31.4	3.5	-28.4 [†]	118.2	28.9	-20.1 [†]
	Rate difference (<12 vs. 16+)	-2.7	12.0		4.9	92.0	
	Rate Ratio, 95% CI (<12 vs. 16+)	0.9 (0.8-1.0)	4.5 (3.9-5.1)		1.0 (0.9-1.2)	4.2 (3.5-5.0)	
Women	All	1.9	0.9	-11.9 [†]	23.1	21.7	-4.6
	<12 Yrs	5.7	5.4	-3.4	41.0	52.9	0.6
	16+ Yrs	0.8	0.1	-22.9 [†]	8.9	5.9	-10.7 [†]
	Rate difference (<12 vs. 16+)	4.9	5.2		32.2	47.1	
	Rate Ratio, 95% CI (<12 vs. 16+)	7.1 (5.2-9.5)	39.2 (22.4-68.6)		4.6 (3.2-6.8)	9.0 (6.3-12.9)	

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

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

Housing and Homelessness

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

Health insurance status

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

Table 1: Texans without health insurance, 2010-2014

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

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

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

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

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

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

Social Determinants

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

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

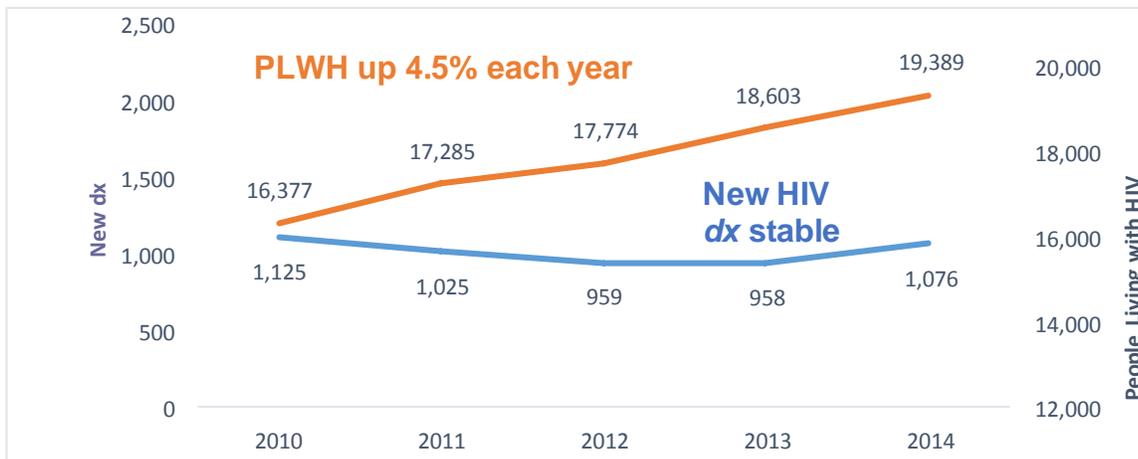
Many of these determinants increase vulnerability to illness and adversely affect health outcomes in Dallas.

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

Number of PLWH

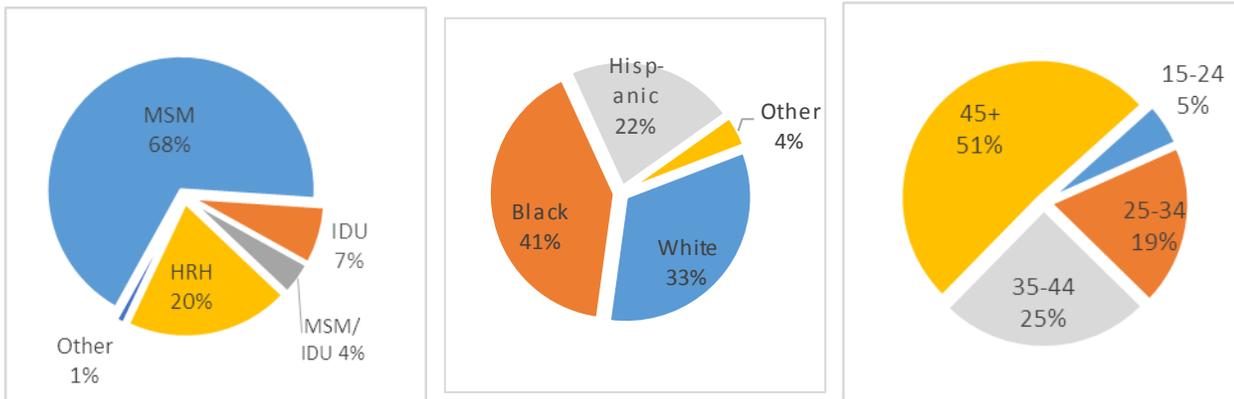
Over the past five years, the number of Dallas EMA residents living with diagnosed HIV infections has increased by about 4.5% a year, from about 16,000 in 2010 to more than 19,000 in 2014 (Figure 18). However, the number of new HIV diagnoses is not rising- the annual number of new diagnoses during this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

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



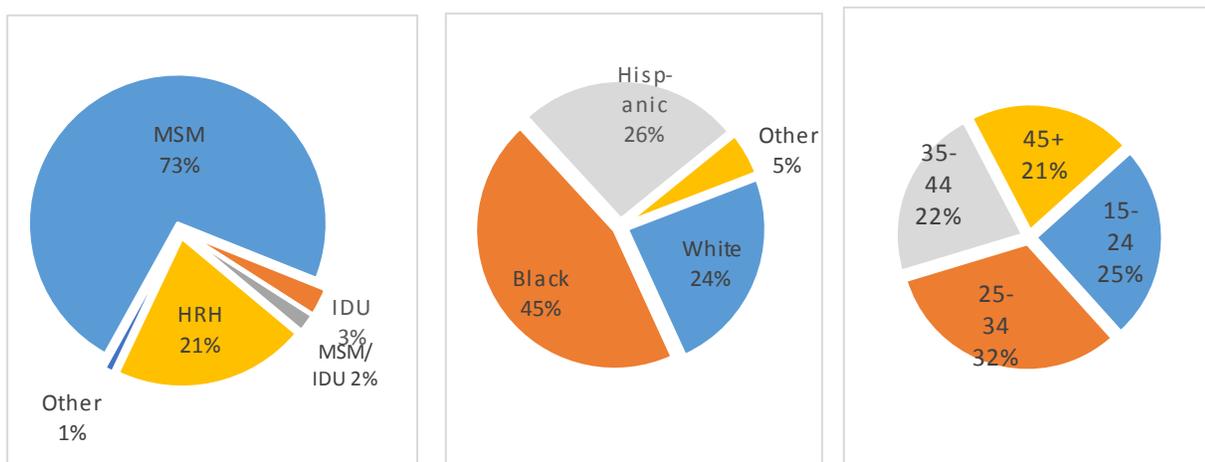
Gay and bisexual men and other men who have sex with men (MSM) made up about 68% of EMA residents living with diagnosed HIV infections in 2014. Heterosexuals made up about 20% of the EMA’s PLWH. Blacks made up the largest racial/ethnic group of PLWH – about two in five PLWH were Black. About half the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

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



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

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



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

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

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

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

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

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

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

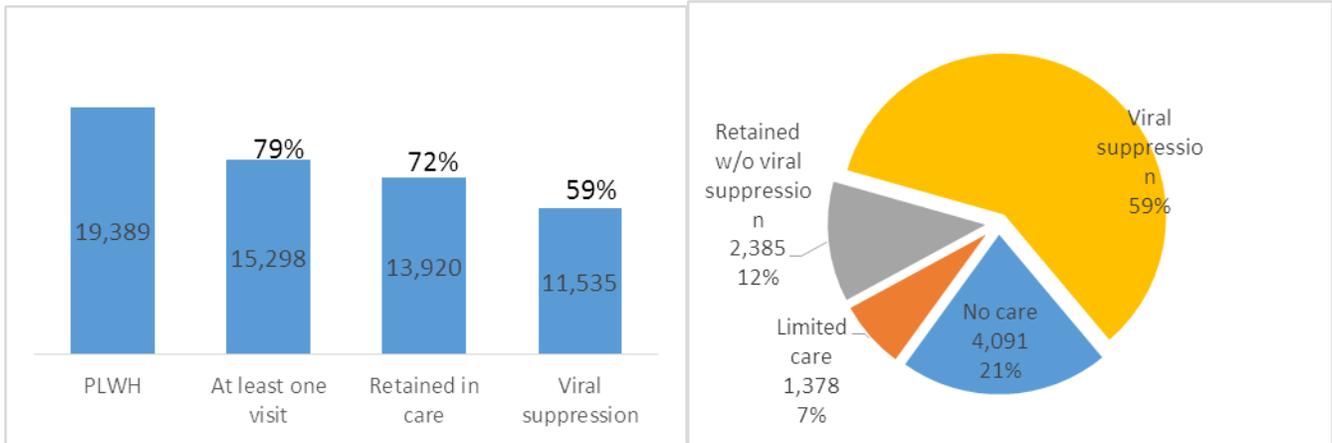


Figure 22 shows MSM as a proportion of HIV prevalence and new diagnoses within race/ethnic groups in the Dallas EMA in 2014. For instance, out of all white PLWH in the Dallas EMA in 2014, 5,282 of them were MSM and 1,045 were categorized as a different mode of transmission, meaning approximately 83%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

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

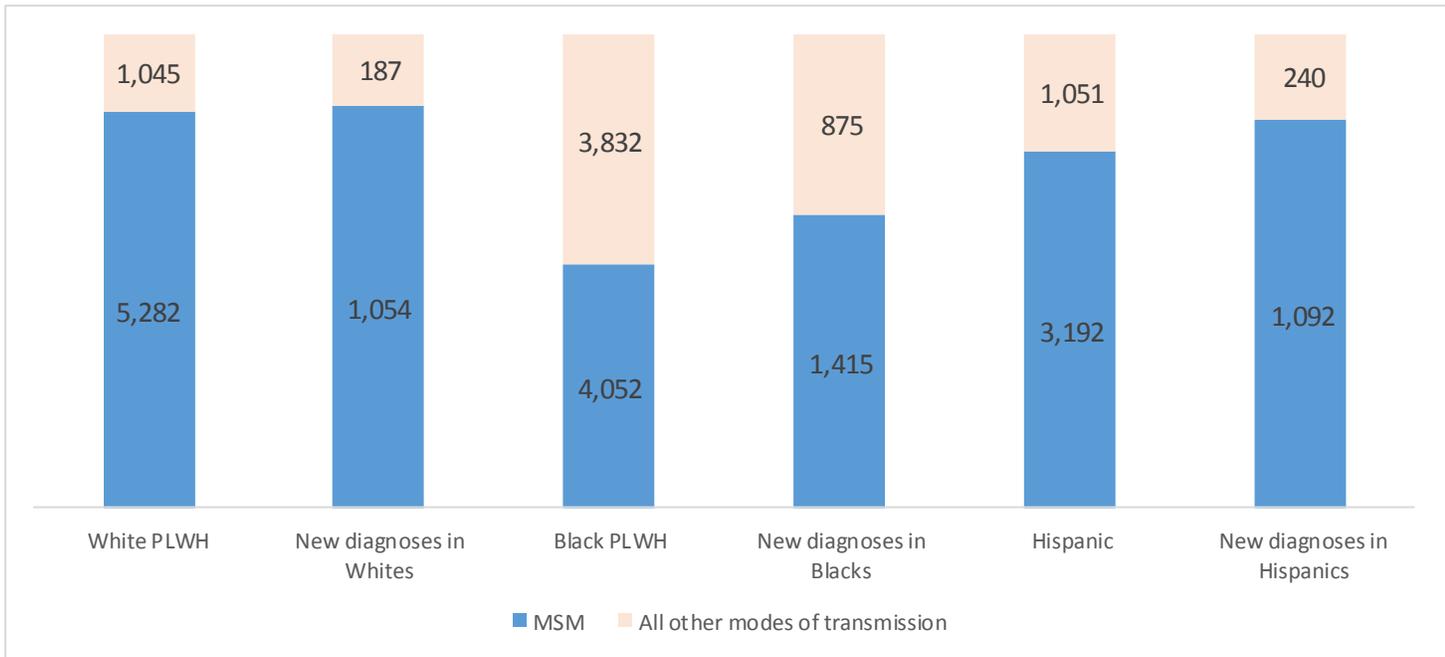
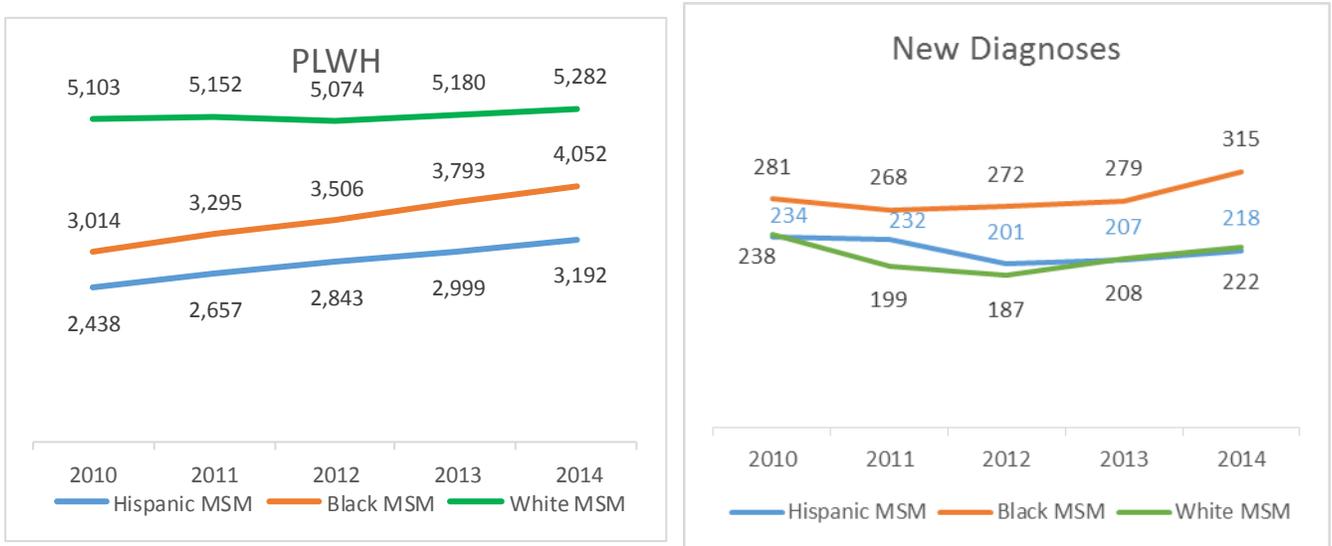


Figure 23: Changes in numbers of PLWH and new diagnoses in MSM, Dallas 2010-2014



Rates

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

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

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

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

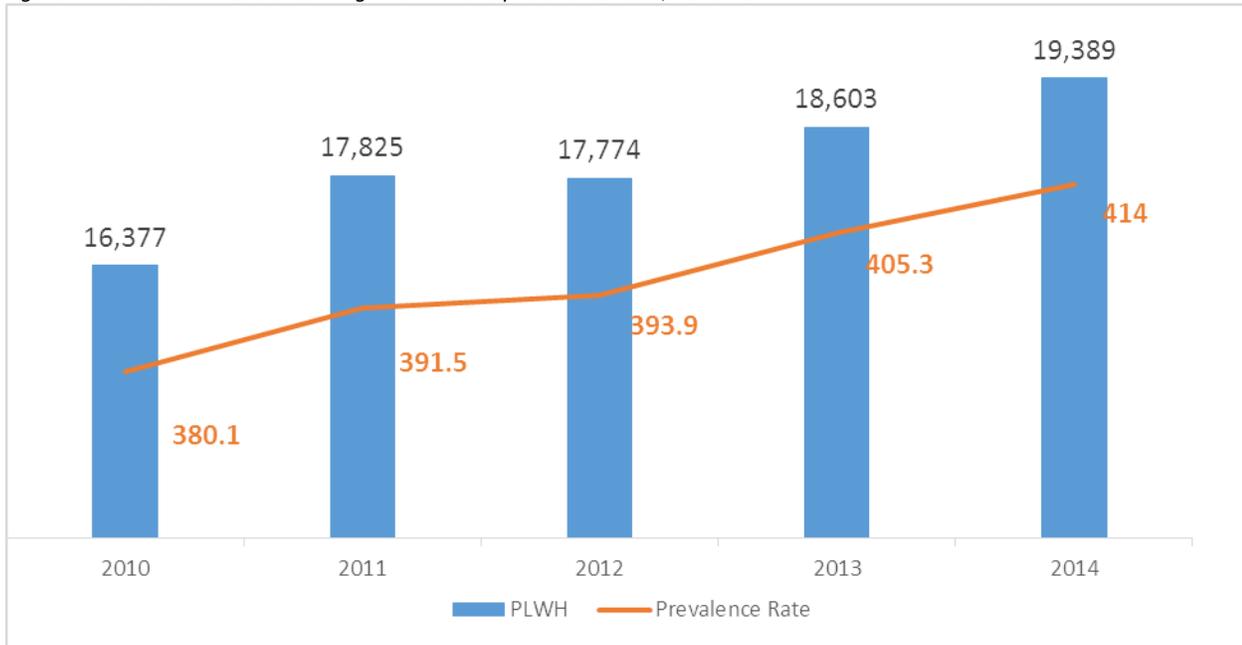
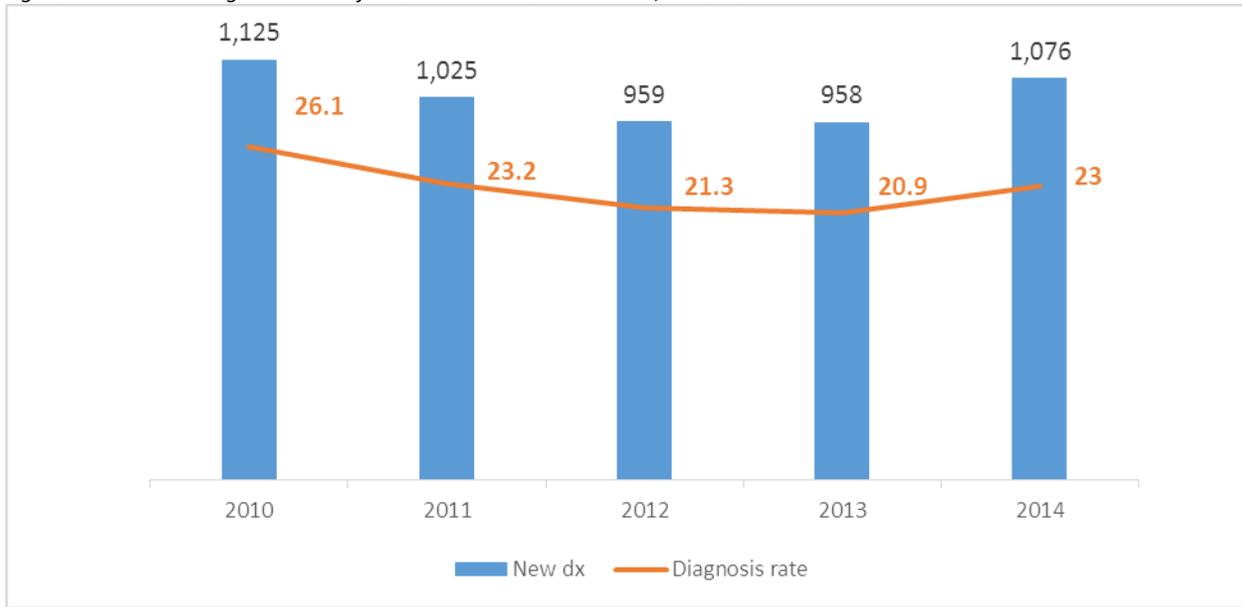


Figure 25: New HIV diagnoses and infection rates in the Dallas EMA, 2010-2014



Snapshot of PLWH and newly diagnosed Dallas EMA residents

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

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

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

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

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

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

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

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

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

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

Rates are per 100,000.

Trends

Estimated HIV incidence from 2009 to 2013

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

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

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

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

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

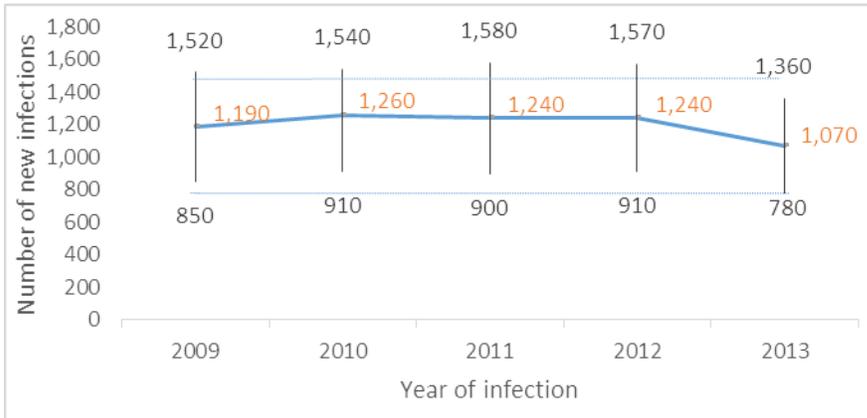


Figure 27: Estimated incidence rate for Dallas EMA adults and adolescents, 2009-2013

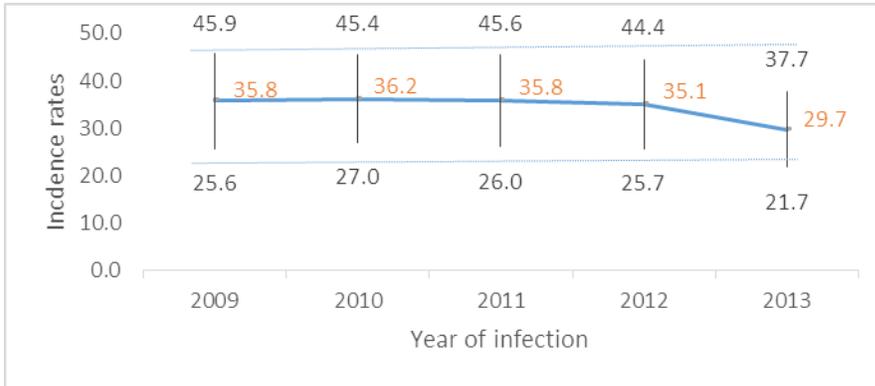


Table 5: Estimates of Texas HIV incidence by sex, race/ethnicity, and mode of transmission, 2009-2013

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

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

Estimates of undiagnosed HIV infections

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

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

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

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

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

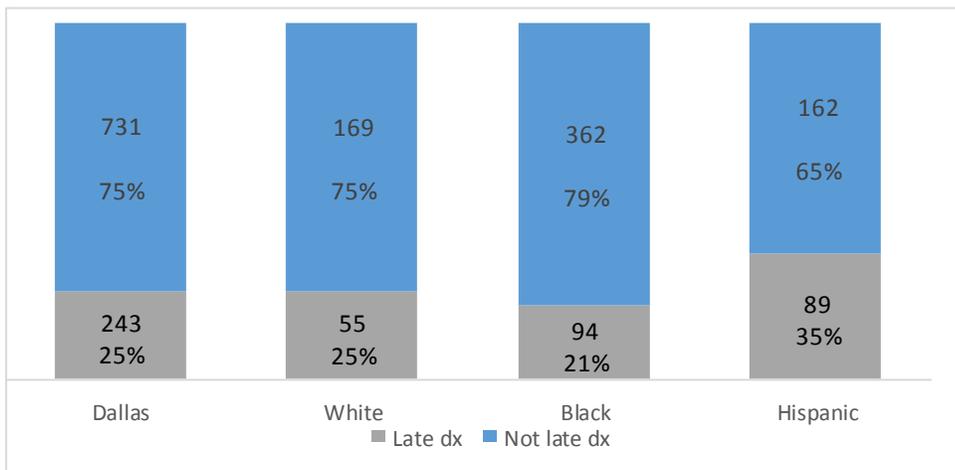
	Estimated proportion of undiagnosed infections		
	Est %	95% CI	
TOTAL	14.1%	11.2%	16.8%
Men	14.7%	12.9%	16.9%
Women	12.8%	8.3%	15.9%
White	9.7%	6.6%	13.0%
Hispanic	19.6%	16.6%	22.8%
Black	12.8%	10.4%	15.5%
MSM	15.9%	13.0%	18.0%
IDU	6.6%	2.5%	10.5%
MSM/IDU	4.2%	0.1%	9.6%
HRH	15.2%	11.6%	18.8%

Late diagnosis

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

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

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



Populations most affected

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

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

Priority Populations

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

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

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

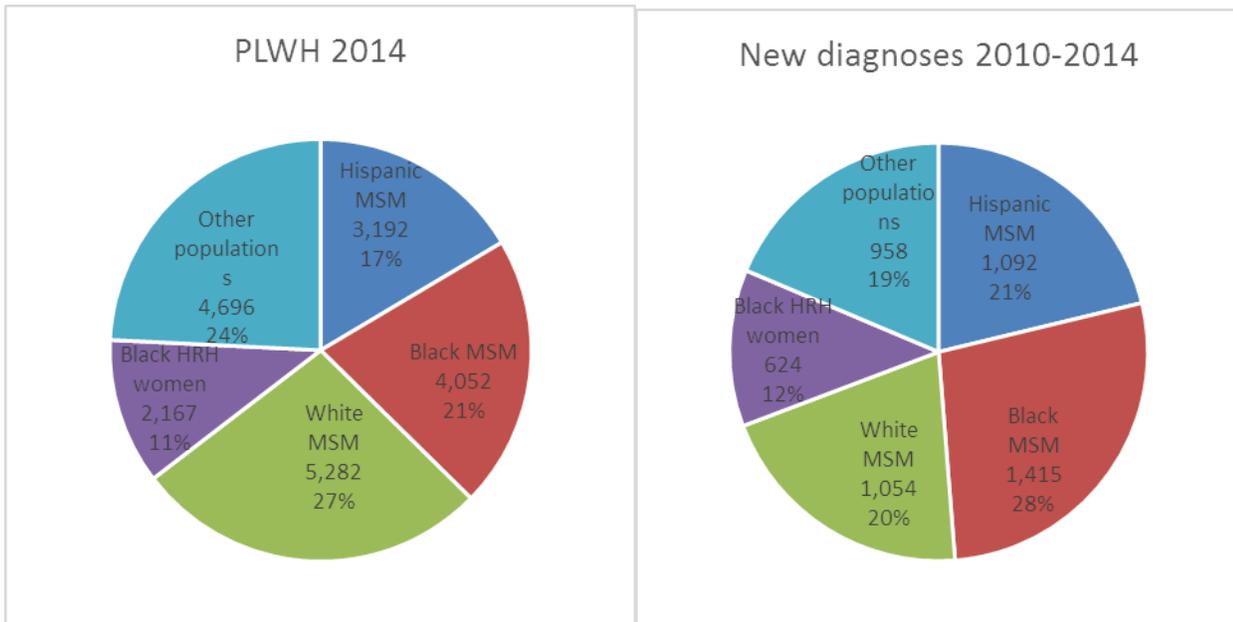
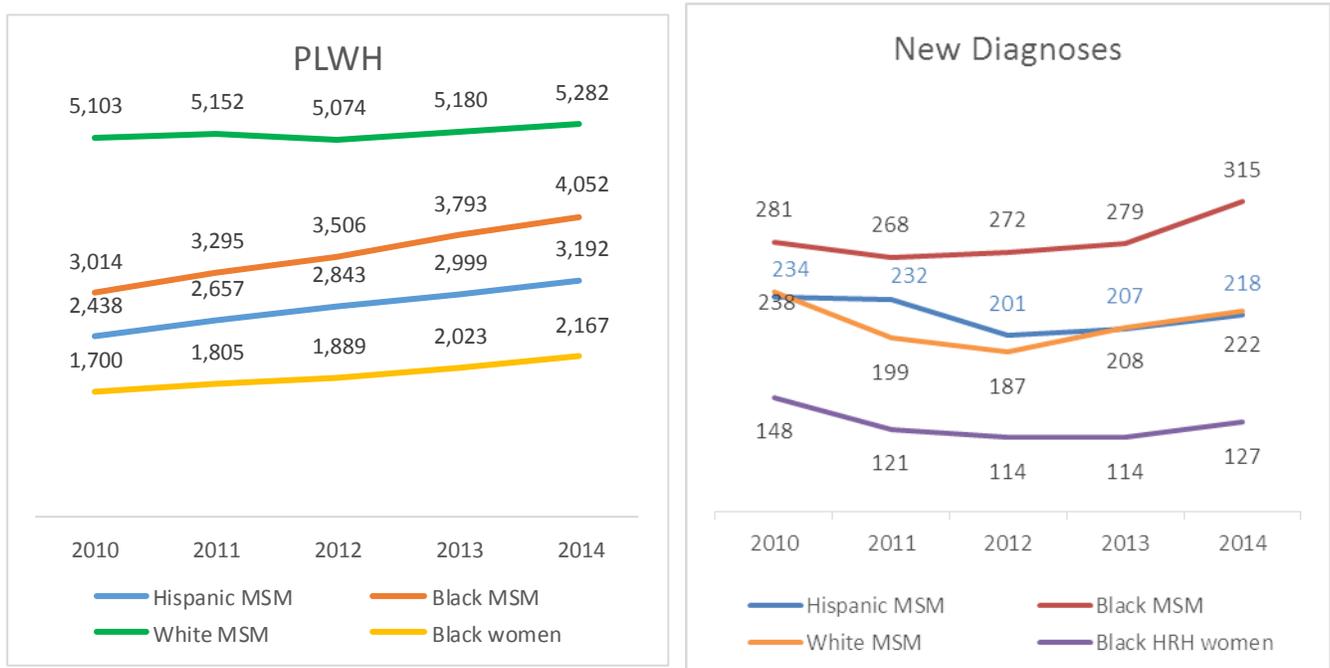


Figure 30: Changes in numbers of PLWH and new diagnoses in priority populations, Dallas 2010-2014



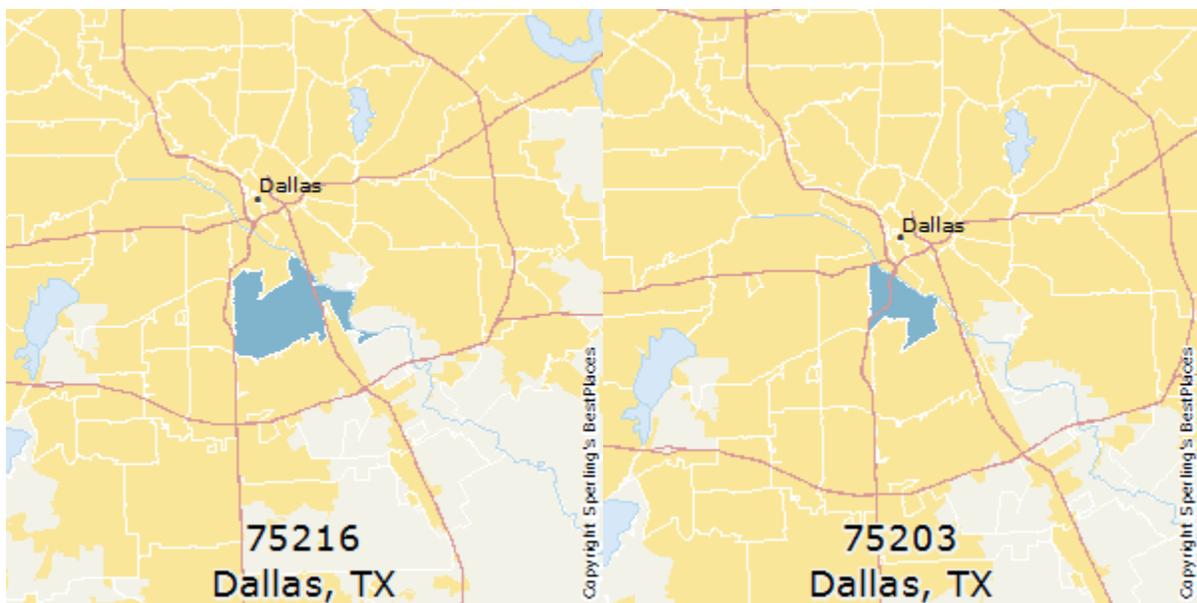
In addition to the four priority populations, this particular plan will target emerging populations of interest, such as transgender and injected (needle-sharing) drug users, in its interventions so that more robust data will be available locally in the future. Particular emphasis will also be placed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

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

Geographic concentrations

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

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



Deaths

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

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

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

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

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

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

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

No deaths in females of other races were reported in 2012

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

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

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

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

Comorbidities: Hepatitis C, Sexually Transmitted Infections and Tuberculosis

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

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

Co-Infection with Hepatitis C Virus

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

Table 9: Texas PLWH with reported HCV infections, 2014

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

Co-Infection with Tuberculosis

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

Co-Infection with Sexually Transmitted Infections

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

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

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

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

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

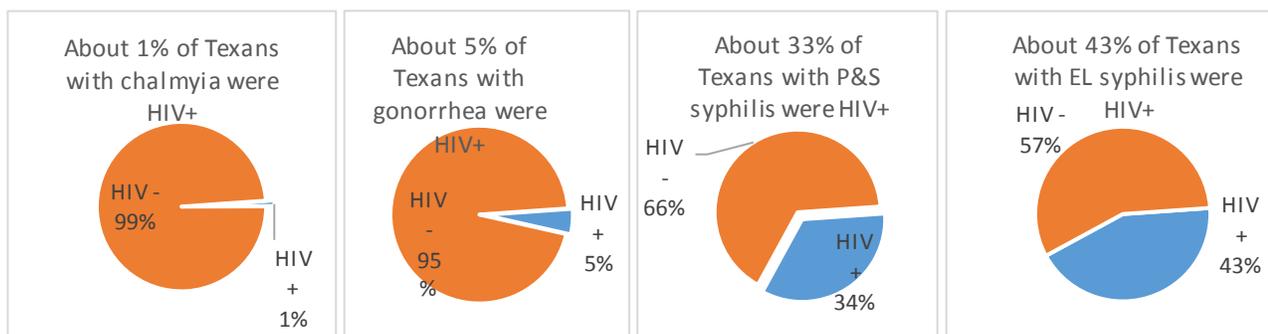
	PLWH	Chlamydia		Gonorrhea		P&S Syphilis		EL Syphilis	
		Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Total PLWH	80,073	1,362	1,700.9	1,596	1,993.2	538	671.9	803	1,002.8
Female	17,350	268	1,544.7	113	651.3	6	34.6	11	63.4
Male	62,723	1,094	1,744.2	1,483	2,364.4	532	848.2	792	1,262.7
15-24	3,983	282	7,081.1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

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

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

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

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



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

Indicators of HIV Risk

HIV risk behaviors in high risk, HIV negative Texans

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

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

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

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

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

Table 14)

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

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

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

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

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

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

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

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

HIV risk behaviors in PLWH currently in care

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

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

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

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

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

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

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

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

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

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

B. HIV CARE CONTINUUM

The HIV Care Continuum for the Dallas EMA

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

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

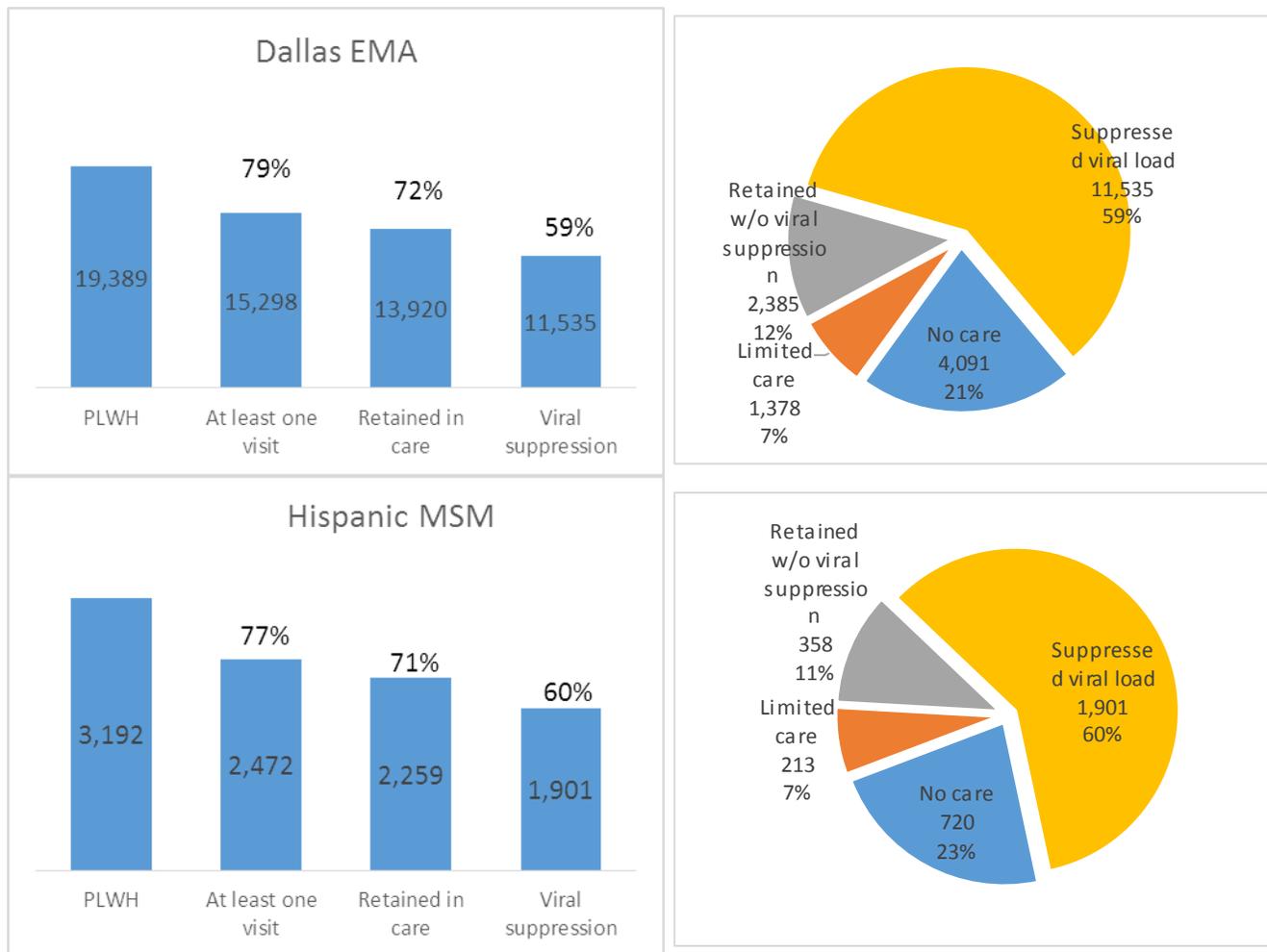
In 2014, almost four out of five of the Dallas PLWH had at least one HIV-related health visit, 72% were retained in care, and 59% were virally suppressed at the end of the year (Figure 32

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

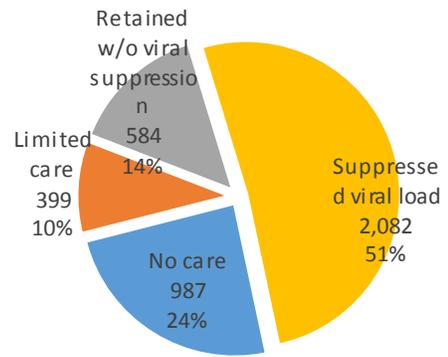
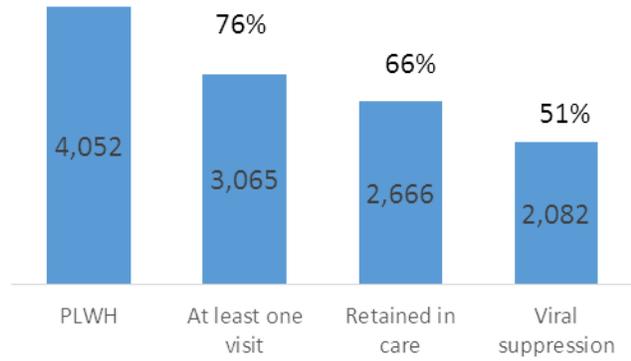
Of the priority populations, Black women and Black MSM had similar rates of retention, proportions of people with no care, and of people who were retained but not virally suppressed. At the state level, however, the suppression outcome for Black MSM can be at least partially explained by a lower estimated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

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

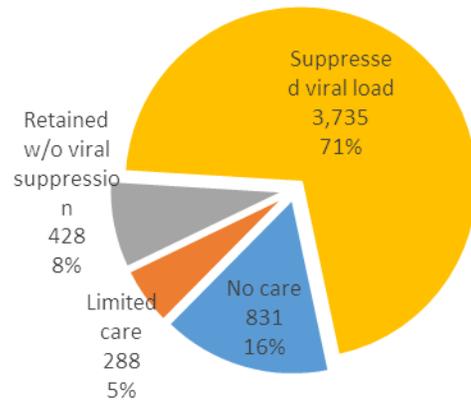
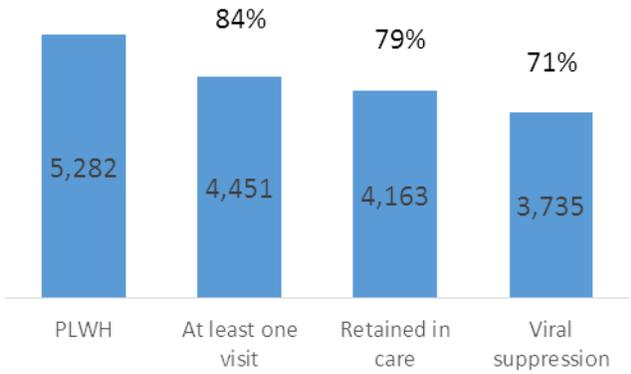
Figure 32: Treatment Cascade and participation in treatment, Dallas EMA 2014



Black MSM



White MSM



Black women

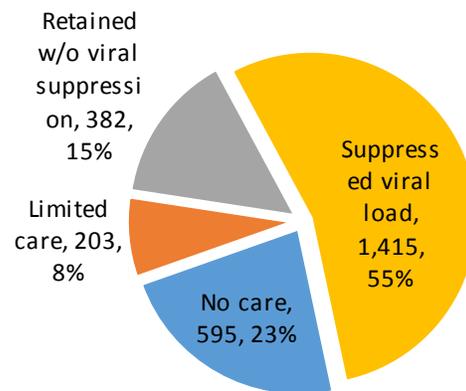
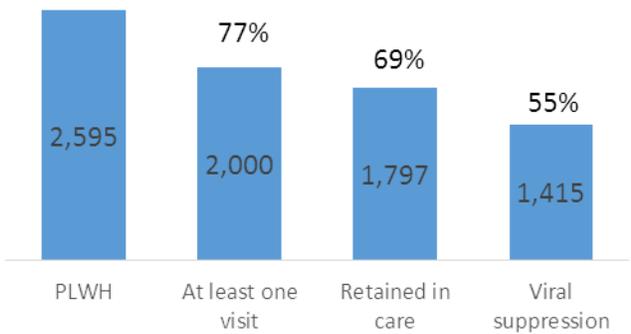


Table 17: Treatment cascades in Dallas by subpopulations, 2014

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

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

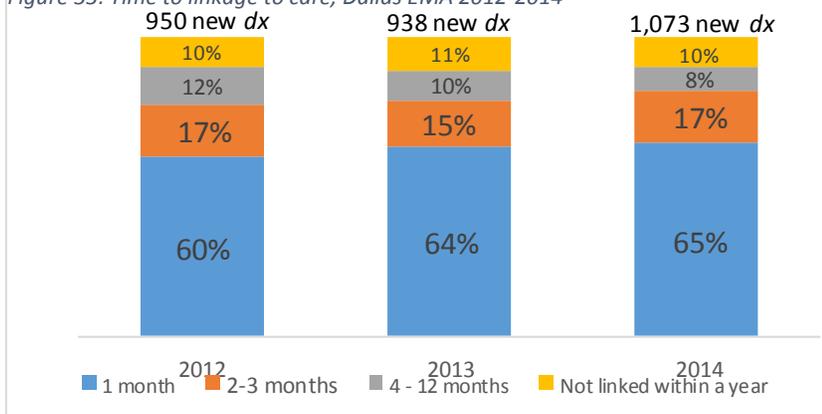
Table 18: Participation in HIV Treatment, Dallas EMA 2014

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

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

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

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



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

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

within 30 days of their diagnosis.

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

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

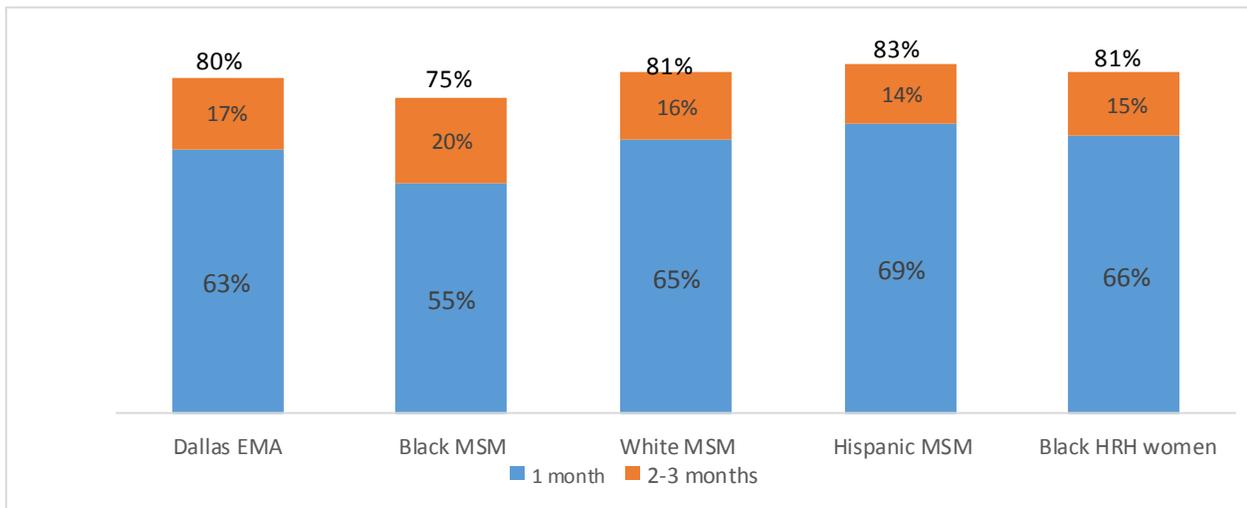
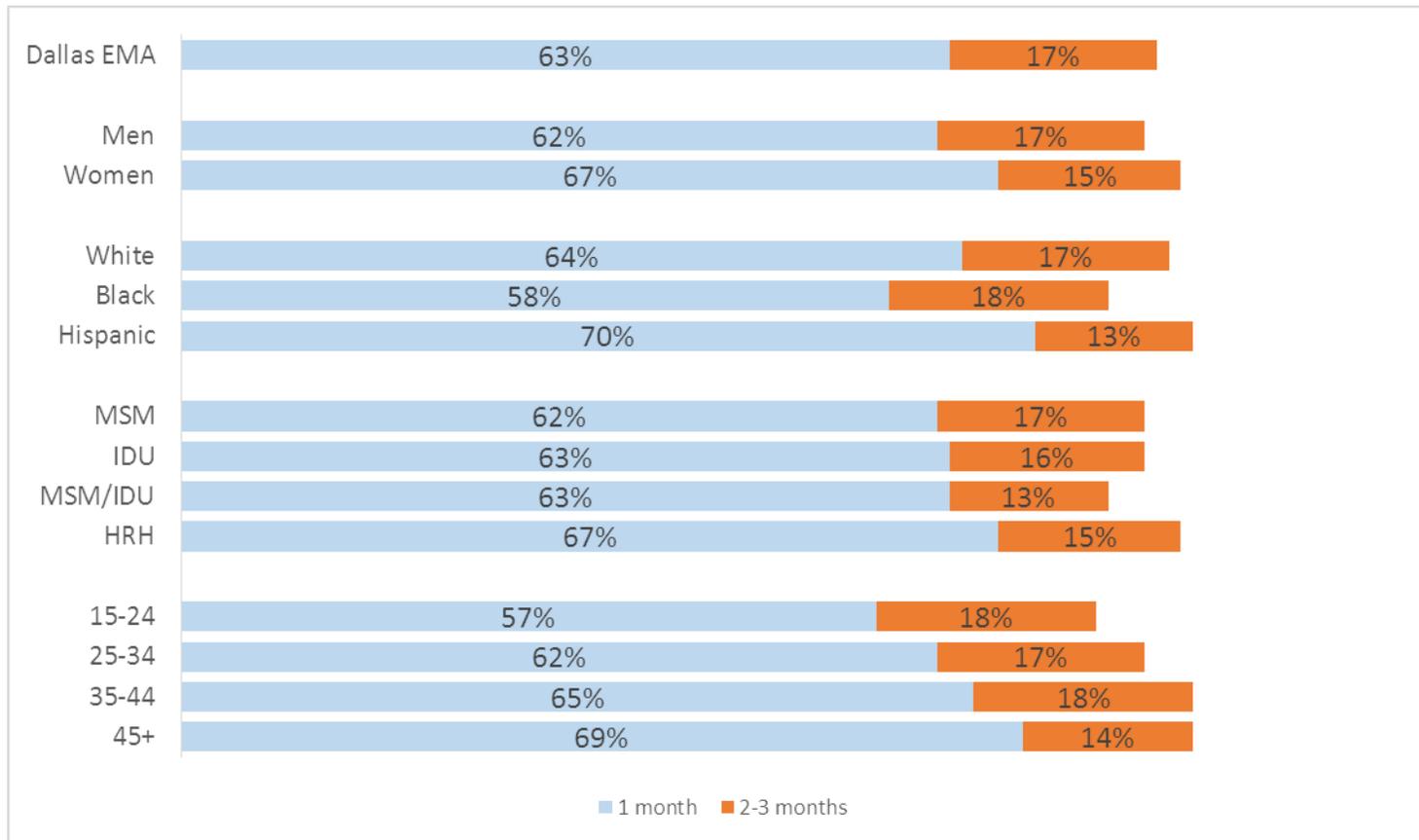


Figure 35: Timely linkage to care by selected characteristics, Dallas EMA 2012-2014



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

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

a. Jurisdictional HIV resources Inventory

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

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

Workforce needs

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

Capacity and Needs

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

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

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

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

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

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

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

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

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

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

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

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

Steps to address gaps:

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

D. ASSESSING NEEDS, GAPS, AND BARRIERS

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

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

Consumer survey

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

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

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

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

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

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

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

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

Out-of-care interviews

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

Data Analysis

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

Respondent Overview

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

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

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

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

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

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

*Number of PLWHA with known Race/Ethnicities.

In terms of transmission modes:

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

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

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

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

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

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

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

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

Provider Focus Group Discussions

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

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

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

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

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

Focus Group Analysis

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

The provider focus group discussion was limited by:

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

GAP Analysis

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

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

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

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

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

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

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

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

GAP ANALYSIS

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

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

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

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

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

HIV OUTPATIENT/AMBULATORY MEDICAL CARE

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

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

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

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

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

EARLY INTERVENTION SERVICES

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

HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE

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

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

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

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

MEDICAL CASE MANAGEMENT

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

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

MEDICAL NUTRITION THERAPY-COUNSELING

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

AIDS DRUG ASSISTANCE PROGRAM AND AIDS PHARMACEUTICAL ASSISTANCE (LOCAL)

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

MENTAL HEALTH SERVICES

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

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

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

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

ORAL HEALTH CARE

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

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

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

SUBSTANCE ABUSE SERVICES

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

CASE MANAGEMENT (NON-MEDICAL)

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

CHILD CARE SERVICES

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

FOOD BANK / HOME-DELIVERED MEALS

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

HOUSING SERVICES

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

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

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

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

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

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

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

EMERGENCY FINANCIAL ASSISTANCE

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

LEGAL SERVICES

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

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

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

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

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

LINGUISTIC SERVICES

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

RESPIRE CARE

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

TRANSPORTATION SERVICES

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

HIV PREVENTION SERVICES

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

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

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

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

SERVICE NEED AND BARRIERS

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

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

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

BARRIERS TO CARE

Services That Are Needed But Are Not Available

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

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

Other comments:

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

Services That Should Be Increased

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

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

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

- Food and meals.

Other suggestions:

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

Services That Should Be Delivered Differently

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

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

Other services that should be delivered differently:

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

E. DATA: ACCESS, SOURCES, AND SYSTEMS

Data Sources Used in the Overview

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

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

Rates and counts

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

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

Sex and gender identity

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

Mode of transmission

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

Information on the general population

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

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

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

STI/HIV and TB/HIV Comorbidity

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

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Collaborations, Partnerships, and Stakeholder Involvement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section III: Monitoring and Improvement

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

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

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

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

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

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

Glossary

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

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

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

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

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

DSHS – Texas Department of State Health Services.

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

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

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

MSM – Men who have sex with men

PLWH – People Living with HIV

UTSW – the University of Texas Southwestern Medical Center

Appendix A: NHBS and MMP

Medical Monitoring Project (MMP)

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

National HIV Behavioral Surveillance (NHBS)

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

Appendix B: Letter of Concurrence

Mrs. Frances Hodge

Dear Mrs. Hodge:

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

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

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

Signature:



Date:

Sept. 26, 2016

Planning Body Chairs



Sept 26, 2016



9-30-16