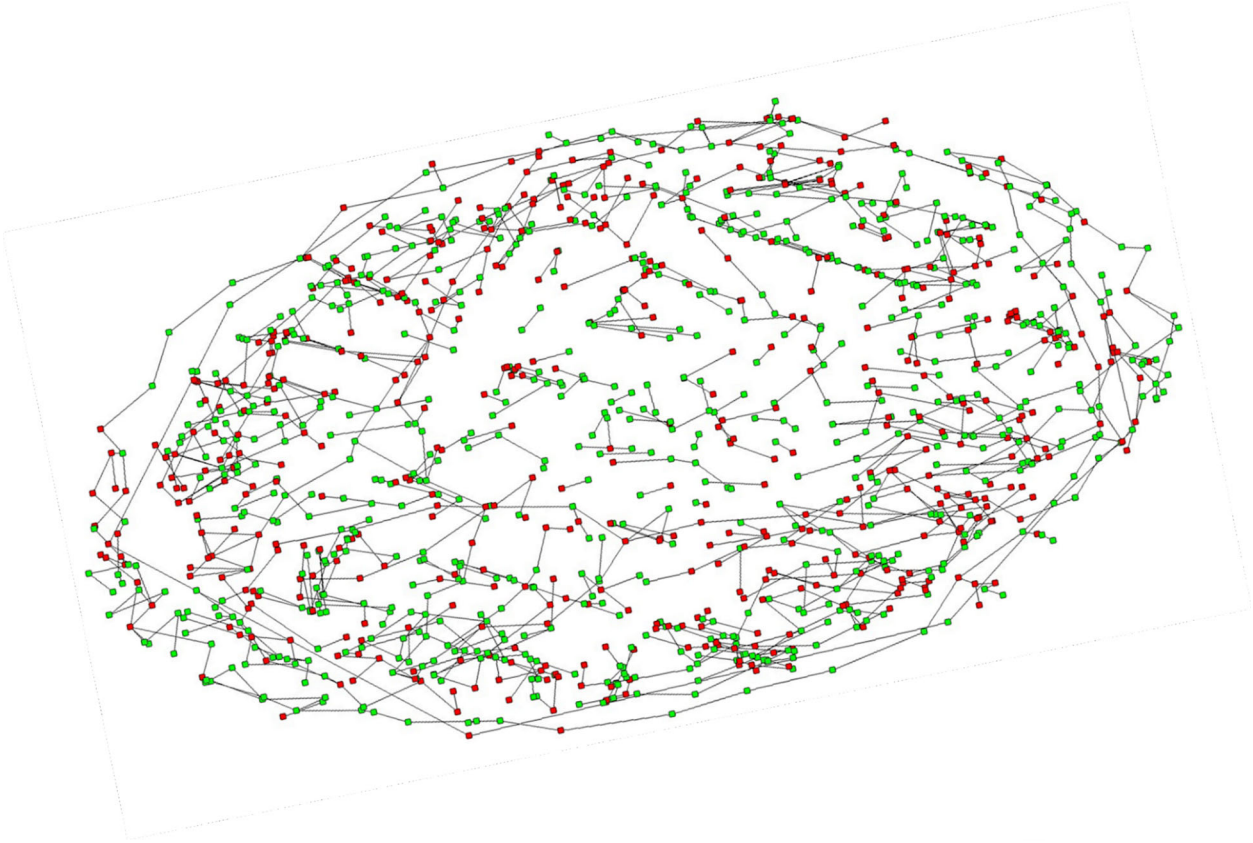
2022 Dallas EMA/HSDA Status Neutral Needs Assessment



Executive Summary

The Status Neutral Needs Assessment for the Dallas Eligible Metropolitan Area, Dallas Health Service Delivery Areas, and Sherman-Denison Health Service Delivery Areas (Dallas EMA/HSDA) was conducted between August 2022–February 2023. The assessment used a mixed methods approach including a respondent driven sampling survey with 2,046 respondents, seven key informant interviews, and three focus groups with 26 participants. Survey data was analyzed using Jamovi 2.3.9 and the focus groups and key informant interviews were coded for qualitative analysis. Priority populations for the Dallas EMA/HSDA include Hispanic men and women, Black/African American men and women, Caucasian men and women, men who have sex with men (MSM), persons of transgender or gender nonconforming experience (TGNC), and youth (13 – 24 years). Within these populations, Black MSM, Hispanic/Latinx MSM, Hispanic/Latinx women, transgender men and men, and youth living with and at risk of contracting HIV/AIDS require additional attention due to an enhanced risk to HIV exposure and were those targeted for the surveys, focus groups, and key informant interviews.

There was very low representation from Latino (n= 251) and TGNC (n=75) communities in the survey; to that end closed focus groups for TGNC participants were conducted and those for whom Spanish was their primary language. The focus group for TGNC individuals was well attended and there was TGNC representation in the key informant interviews. However, we were unable to engage any monolingual Spanish speakers for the focus groups or key informant interviews. Our findings indicate that the current sociopolitical climate is deterring individuals from these communities to remain insular fearing potential safety and legal ramifications from those with whom they are not already closely connected.

Some key results and findings include:

- Of 1,400 expected responses (700 PWH and 700 people at high-risk for HIV), 2046 total people were reached, including 674 PWH (91% of the 700 person goal).
- 62.9% of Black MSM respondents (n=194) reported that they were diagnosed between 3 to 5 years ago indicating that diagnoses occurred prior to the COVID epidemic. Changes in access to testing may have affected the ability to identify, diagnose and prevent infections in a timely manner since the advent of COVID because of lack of access to testing resources. This is also reflected in decreased HIV testing numbers for the Dallas region in 2020 and 2021.
- 36% of survey respondents living with HIV reported a history of injection drug use within the past 12 months (n=242); of those 61% reported sharing injection equipment.
- Among youth with HIV (n=109), most (62.4%) reported having a serodiscordant sexual partnership in the past year while a similar majority, 63.3%, reported that they had never heard of Undetectable= Untransmittable.

- ➢ Of respondents who reported that they were not living with HIV (n=1370), over 85% were unaware of PrEP despite having at least 1 behavior placing them at higher risk of HIV acquisition.
- ➢ In assessing provider capacity and capability, we noted significant strengths in the number of service providers for those within the RWHAP; there is a need to identify additional services for those at risk of HIV acquisition and those who are newly diagnosed.
- ➢ Across the existing provider network, however, there was consistent feedback that providers are not routinely educating their patients on U=U, PrEP, and PEP.
- ➢ When looking at particular areas of attention in unmet needs and gaps, the most significant issues were the high rate of uninsured individuals, and the lack of mental health and substance use service providers given the number of respondents who noted mental health symptoms and safety concerns.

Based on these findings and others detailed in this report, the following recommendations are being made.

- ➢ Strengthening the system of care by holding community listening sessions to share the results of the SNNA and using the SNNA as a jumping off point for population specific small scale needs assessments.
- ➢ Increase HIV testing and outreach to Black MSM, Latino MSM, and TGNC populations to identify, diagnose and treat new infections that may have been missed during COVID19 restrictions.
- ➢ Creating a safety net system for direct intervention for newly diagnosed individuals. This would be a centralized linkage source to facilitate entry to care for those experiencing uncertainty around their new diagnosis.
- ➢ Developing public health campaigns to educate the public on Ending the HIV Epidemic including U=U, PrEP, and PEP messaging; Messaging should be positive with diverse representation in all print and multimedia advertisements.
- ➢ Requiring cultural humility training and biomedical intervention training for all staff of funded programs-including frontline staff, support staff, and clinical staff as respondents noted feeling stigmatized and discriminated against at various levels of organizational leadership.
- ➢ Creating activated consumers through additional training and support and pursuing partnerships to create pathways for peer community health worker certification.
- ➢ Involving consumers at every level of the decision-making process to create leadership opportunities and leverage community expertise to create novel interventions for the Dallas AA.

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Background

The Dallas County Health Department's Ending the HIV Epidemic Division and the Ryan White Planning Council HSDA contracted with Ready Aim Innovate, a program of Hager Health, LLC (RAI) to conduct a Status Neutral Needs Assessment (SNNA). The purpose of the SNNA is to update the current profile of the HIV epidemic in the greater Dallas area. The SNNA provides information on the Dallas Eligible Metropolitan Area and Health Services Delivery Areas (EMA/HSDA) and the Sherman-Denison HSDA comprising eleven counties – Collin, Cooke, Dallas, Denton, Ellis, Fannin, Grayson, Hunt, Kaufman, Navarro, and Rockwall. These counties are diverse in their geographies, size, and demographics. Dallas County is a major metropolitan city home to nearly 2.6 million residents, while some of the smaller more rural communities such as Navarro and Fannin County have 54,000 and 37,000 residents respectively[1]. The availability of data for the counties within the catchment area varies with the most robust data being available for Dallas County. As it is generally accepted that the HIV epidemiological profile for the Dallas Administrative Agency (AA) is reflective of overall trends in Texas, some data will be more focused on the Dallas region and other data will more broadly speak to HIV in TX overall.

Less is known about those at increased vulnerability for HIV infection within these 11 counties, as higher risk behaviors are not as well accounted for given the lack of reporting requirements for those outside of the HIV system of care. The syndemic of syphilis and HIV continues to be a driving force in new HIV infections[2]. Syphilis infections are often used as a proxy for higher risk sexual practices with increased risk of HIV acquisition, especially in men who have sex with men. Data from annual Dallas HIV/STI profiles were compared and identified increased risk[3]. In 2018, syphilis rates were highest amongst those ages 15-34 which mimics the HIV epidemic in the Dallas AA[4]. Similarly, the rates of probable and confirmed congenital syphilis cases in Dallas County increased by 130% from 2017 to 2018[5]. Congenital syphilis is a proxy indicator for increased susceptibility for women in the Dallas AA and also speaks to a lack of access to prevention and treatment services. The presence of other STI infections also increases HIV transmission risk. Recent Dallas HIV/STI profiles report consistent increases in the number of chlamydia and gonorrhea infections leading up to the COVID-19 pandemic. As such, it is imperative that the Dallas AA has aggregated local data from individuals engaging in higher risk behaviors. Using the most recent data sets from the Texas Health Data Sets (2018, 2019), the Kaiser Family Foundation (2019, 2020) and Ryan White Services Data (HRSA 2010-2019) the following is known:

- Nearly 60% of Texans report having never taken an HIV test; this number has remained static since 2013;

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[1] (n.d.). *Quick Facts Texas*. United States Census Bureau. https://www.census.gov/quickfacts/TX

[2] Wu MX, Moore A, Seel M, et al. Congenital syphilis on the rise: the importance of testing and recognition. Med J Aust 2021; 215: 345–347.

[3] Ibid.

[4] Dallas County Health and Human Services. HIV and STI Statistics, 2019.

[5] Ibid.

- Of those newly diagnosed in Texas, 14% report a risk factor associated with Injection Drug Use (IDU); 61% have a risk factor of men who have sex with men (MSM), and 23% report a heterosexual risk factor;
- Men are 4.5 times more likely to be diagnosed with HIV than their female counterparts in Texas (2019);
- Of the 94,630 people living with HIV in Texas, only 46% were receiving any type of Ryan White Service (2018); 75% of those receiving Ryan White services in Texas are living below 138% of the Federal Poverty Line;
- There were 89 documented cases of transgender individuals diagnosed with HIV in Texas in 2019, however the total number of transgender persons in Texas is not currently measured so it is not yet possible to determine the significance as a reflection of total population
- Black and Latinx women and men are overly represented in the rate of new HIV cases in Texas
- In 2019, 21% of those diagnosed in Texas were late diagnoses, defined as receiving an AIDS diagnosis within one year of the initial HIV diagnosis
- According to AIDSVu, the percent of the population lacking health insurance in 2019 averages to roughly 20% of the public in the Dallas AA region. This translates to approximately 1.1 million people in the region without health insurance according to 2020 census data.

The Status Neutral Needs Assessment (SNNA) has been highlighted as an innovative practice by the CDC, recognizing Dallas, Texas as one of five EHE jurisdictions to “improve access to social services for all people”[6]. In alignment with this approach, this evaluation includes those with higher vulnerability to HIV infection as well as those currently living with HIV/AIDS. This assessment also highlights how behavioral and biomedical interventions can be incorporated to prevent the spread of HIV as well as the role of ongoing engagement in care utilizing treatment as prevention (TASP).

Priority populations for the EMA/HSDA include Hispanic men and women, Black/African American men and women, Caucasian men and women, men who have sex with men (MSM), persons of transgender or gender nonconforming experience (TGNC), and youth (13 – 24 years). Within these populations, Black MSM, Hispanic/Latinx men, Hispanic/Latinx women, transgender men and men, and youth living and youth at risk of contracting HIV/AIDS require additional attention due to an enhanced risk to HIV exposure and were those targeted for the surveys, focus groups, and key informant interviews. With enhanced focused on locally relevant populations, a true status neutral approach includes the following elements in Figure 1 at the community level:

[6] Issue Brief: Status Neutral HIV Care and Service Delivery | Policy and Law | HIV/AIDS | CDC

Figure 1: Status Neutral Framework at Community Level (DCHHS, 2022)

The number of new HIV infections in the Dallas County EHE jurisdiction has remained consistent at approximately 750 new infections per year through 2019. There was a substantial drop in new HIV diagnoses in Dallas from 2019 with 2020 having the lowest number of new cases reported since 2008[7]. Correspondingly, the number of HIV tests in Texas fell from 2018 to 2019 and continued to drop during the course of the COVID-19 epidemic. While testing efforts having stagnated, preliminary CDC (2021b) data indicates the number of PrEP users across Texas has increased steadily since 2017 from 9.5% to approximately 24% in 2022[8].

Impact of Covid-19 on Services Delivery

Beginning in 2020,COVID-19 cases increased exponentially across the Globe, with thousands of cases occurring in the United States on a daily basis. The impact of the COVID-19 pandemic was felt significantly in the jurisdictions being evaluated by the Status Neutral Needs Assessment, with nearly 700,000 cases to date in Dallas alone[9],[10] as shown in Figure 2. The entirety of North Texas was identified as a “red zone” area in August 2021 by county issues indicating an extremely high risk of COVID infection; to date the counties have not met the “green” criteria of “New Normal with All Recommended Vaccine Doses[11].

[7]AIDSVu (2023). *Local Data: Texas*. https://aidsvu.org/local-data/united-states/south/texas/
[8]DHHS (2023). America's HIV Epidemic Analysis Dashboard. Indicator Data for Texas. https://ahead.hiv.gov/locations/texas
[9]New York Times (2023, February 5). *Tracking Coronavirus in Dallas County, Texas: Latest Map and Case Count*. https://www.nytimes.com/interactive/2021/us/dallas-texas-covid-cases.html
[10] Ibid
[11] Dallas County (n.d.). *Coronavirus Health and Safety Guidance*. https://www.dallascounty.org/covid-19/guidance-health.php

The coronavirus pandemic left an indelible mark on the care provided to individuals living with or at risk for HIV infection in Dallas and the surrounding counties. Dallas followed a national trend in which HIV testing numbers dropped significantly with the start of the pandemic and have yet to achieve pre-pandemic levels. Between 2019 and 2020, the number of HIV tests conducted decreased by 17%[12]. Other interruptions to health services included:

- Individuals choosing not to engage in testing to comply with public health and social distancing recommendations;
- Health Departments redirecting resources from other service delivery areas including sexual health services;
- Community-based organizations and AIDS Service Centers closing or providing less in person services;
- Staffing shortages due to infectious disease providers being reassigned to COVID related work, illness amongst front line workers, and an increase in healthcare worker resignations; and
- Loss of employer-based health insurance[13].

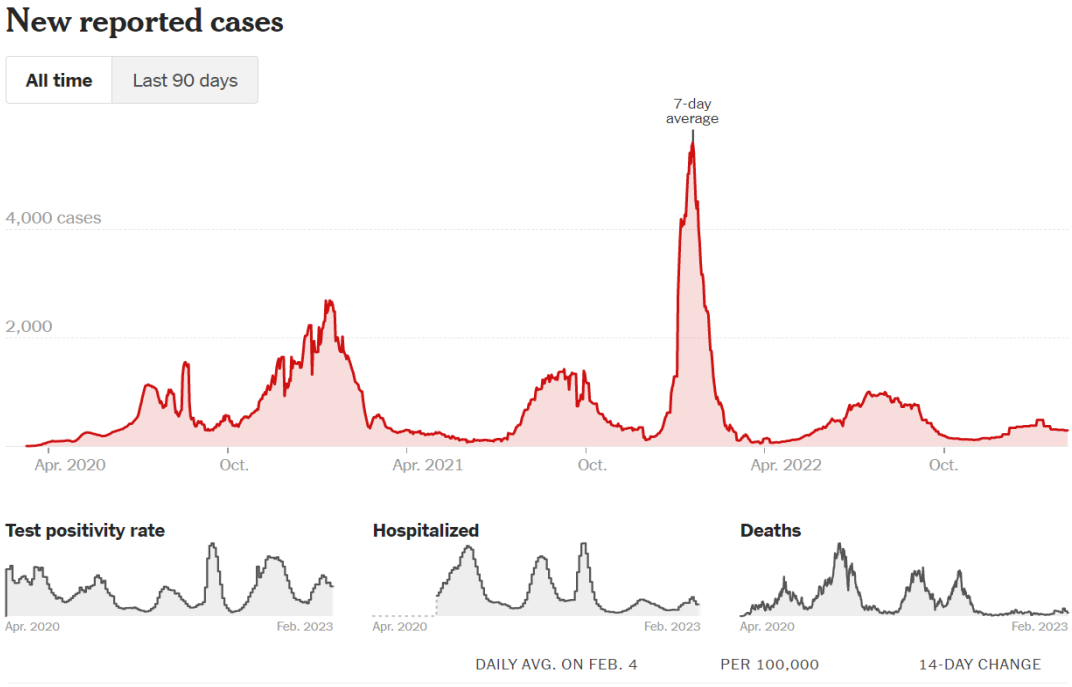


Figure 2: New York Times: Texas Latest Map and Case Count (Accessed 5 February 2023)

These challenges were common across the country with national data showing the COVID-19 pandemic was highly disruptive to HIV service systems and resulted in the redistribution of staff to manage the crisis and severely diminished reporting capacity. Infectious disease providers

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

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

and staff were overwhelmed by the immediate service needs of COVID-19. Emergency response efforts in public health departments at the local, county, and state level reduced the capacity for effective data reporting from 2020 to 2022. Similar demands were placed on service provider organizations where staffing, funding, and materials normally stretched thin were additionally strained. This comprehensive status-neutral needs assessment is timely in identifying both the emerging trends following the COVID-19 pandemic and how the pandemic has changed the landscape of those living with and at risk for HIV. An article published during the height of the pandemic by the Lancet HIV (Jiang et al, 2020) reported that:

- Implementation of quarantine, social distancing, and community containment measures have reduced access to routine HIV testing;
- Timely linkage to HIV care could be hindered during the COVID-19 pandemic;
- People living with HIV who should have initiated antiretroviral therapy (ART) in hospitals might be deterred or delayed because hospitals are busy treating patients with COVID-19;
- The COVID-19 pandemic might also hinder ART continuation as some pharmacies decreased their operating hours and providers, inundated with COVID-19 related job responsibilities, take longer to respond to message and refill requests; and
- COVID-19 negatively impacted self-management among people aware of their HIV status due to myriad stressors and structural challenges that disrupted their ability to engage in their care (Wion and Miller, 2021).

It is important to note other recent trends impacting the Dallas EMA/HSDA including:

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

Impact of Mpox

The rise of Mpox during the COVID epidemic further strained infectious disease resources through synergistic interactions; those with highest potential to Mpox exposure were the same as those with the highest vulnerability of acquiring HIV-men who have sex with other men. However, within this syndemic, we saw a different kind of community mobilization within the LGBTQ community given their experience from the early days of organizing and advocating around HIV without waiting for federal leadership[14]. In this way, Mpox was largely controlled within the United States[15]. Mpox was contained much more rapidly through grassroots approaches, and as will be discussed below, this type of community led interaction is paramount for Ending the HIV Epidemic in Texas.

[14]Mast, J. (2022, June 8). How the hard lessons of the AIDS crisis are shaping the response to the monkeypox outbreak. *Stat News*. https://www.statnews.com/2022/06/08/lessons-from-aids-playbook-are-guiding-response-to-monkeypox-outbreak/

[15]Halkitis, P. N. (2022). Contributor: On World AIDS Day—Lessons Drawn From HIV, Monkeypox, and COVID-19. *AJMC*. https://www.ajmc.com/view/contributor-on-world-aids-day-lessons-drawn-from-hiv-mpox-and-covid-19

Political Harassment of Transgender Individuals

Across the nation, there are currently over 300 bills focused on limiting the rights of those who identify as transgender, gender nonconforming, and nonbinary. Texas currently has 23 of these legislative initiatives aimed at limiting civil liberties and the right to freedom of expression[16]. This political campaign has also been broadly promoted at the community level through various levels of media and constituency organizing. Noted later in the results session, we see the direct impact of this on the perceived safety by trans* identified individuals in access services and participating in the community.

Impact of Stigma and Ethnocentrism

Demographically, Texas is predominately white compromising 78% of the population, followed Black/African American at 13.2%. Of respondents, 40.2% of residents identify as Latinx as their ethnicity. True health equity would show a similar burden reflective of population demographics. However, we see enormous disparities in the acquisition of HIV with Black/African Americans shouldering the highest burden. We also see this reflected in poorer health outcomes from the intersectionality of the stigma of living with HIV compounded by the additional stigmas of racism and ethnocentrism. Figure 3 shows the heatmap of poverty for Dallas County and where there are areas of greater poverty in the county. Fear of stigma and discrimination lends itself to decreases in HIV testing amongst priority populations and lack of engagement in preventive services such as PrEP, PEP, and fear of accessing community-based services. Figure 4 shows the racial breakdown of HIV diagnoses in the Dallas region.

[16]American Civil Liberties Union. (2023, March 10). Mapping Attacks on LGBTQ Rights in U.S. State Legislatures. Retrieved March 11, 2023, from https://www.aclu.org/legislative-attacks-on-lgbtq-rights

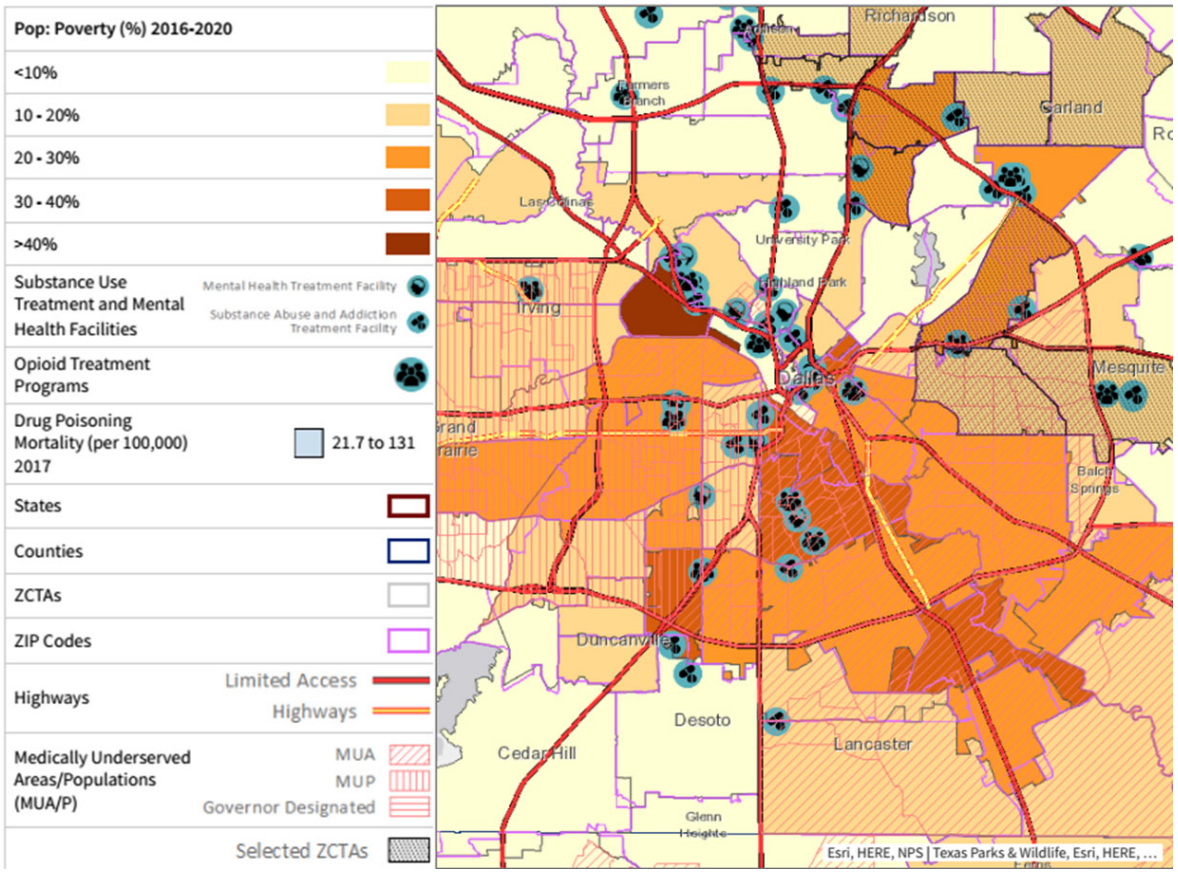


Figure 3: Population (%) living in poverty, Dallas Metropolitan areas, 2020 UDS Data.

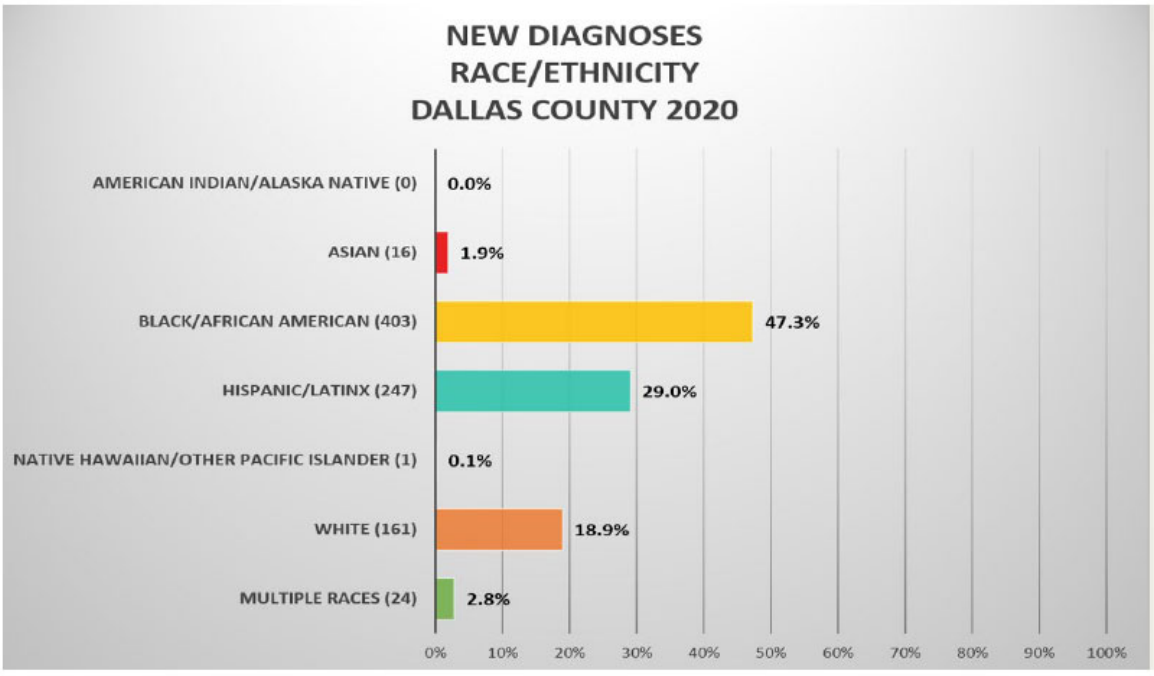


Figure 4: New diagnoses of HIV in Dallas County by Race/Ethnicity 2020 (TX HSDA, 2020)

Lack of Health Insurance

Texas is one of twelve states that has not participated in Medicaid expansion. If Texas were to expand its Medicaid program, 1,432,900 uninsured nonelderly adults would become eligible for coverage, 34%of the state's uninsured nonelderly adult population[17]. Within the community of those living with HIV, Medicaid expansion could result in up to 28% of currently uninsured PLWH/A obtaining health insurance coverage. The financial eligibility threshold for the AIDS Drug Assistance Program (ADAP) is also extremely low at 200% of the FPL. In contrast, Maryland, a state which has accepted Medicaid Expansion, has an ADAP eligibility threshold of 500% of the FPL. Florida, which is also a non-Medicaid Expansion state, has an ADAP limit of 400%. While we do not know the number of adults ages 18-64 that could benefit from prevention services in Texas, it can still be clearly stated that a lack of insurance creates a clear barrier to biomedical and other clinic level interventions. Figure 5 shows the percentage of uninsured persons in the Dallas region using a heatmap.

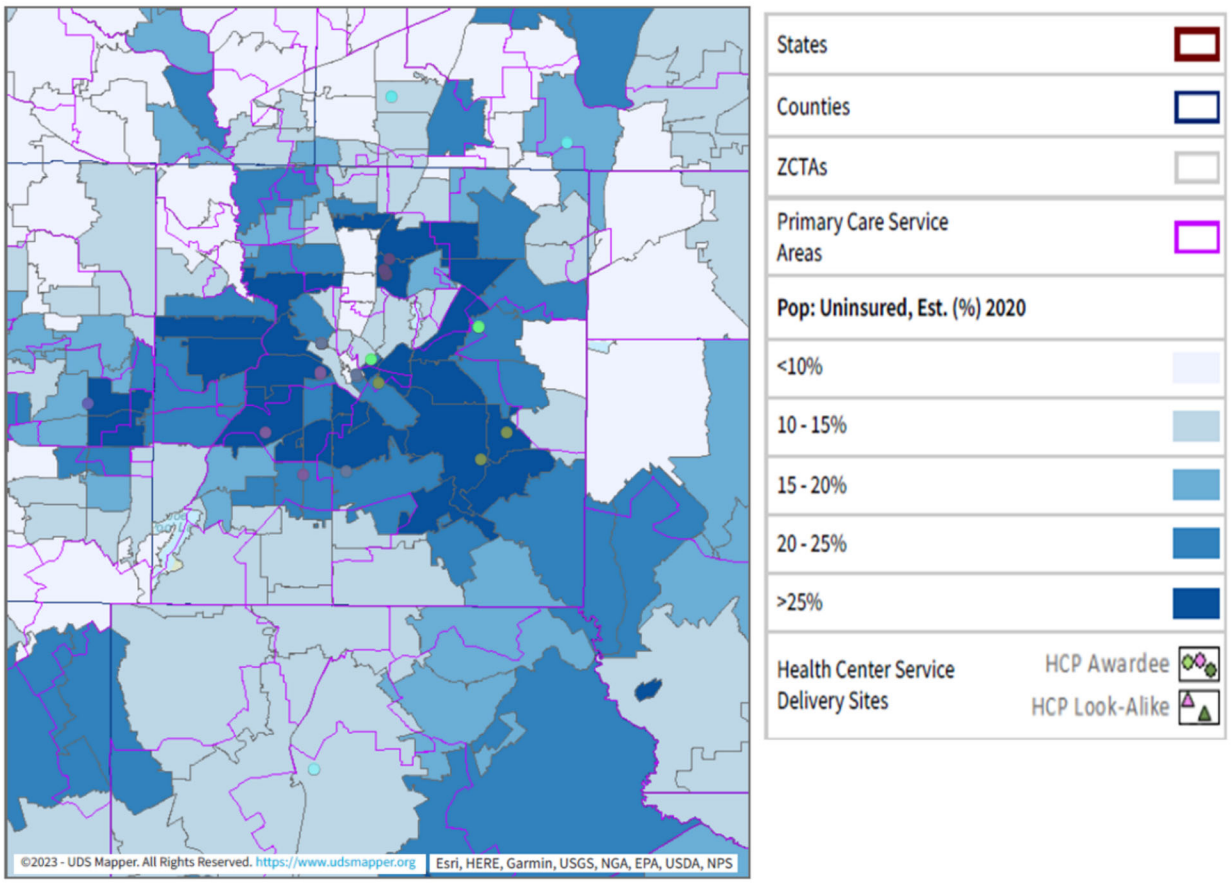


Figure 5: Uninsured People in the Dallas Metropolitan Area (UDS, 2020)

[17]KFF (2020.). *Fact Sheet*. Medicaid Expansion Texas. https://files.kff.org/attachment/fact-sheet-medicaid-expansion-TX

Goal Setting

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

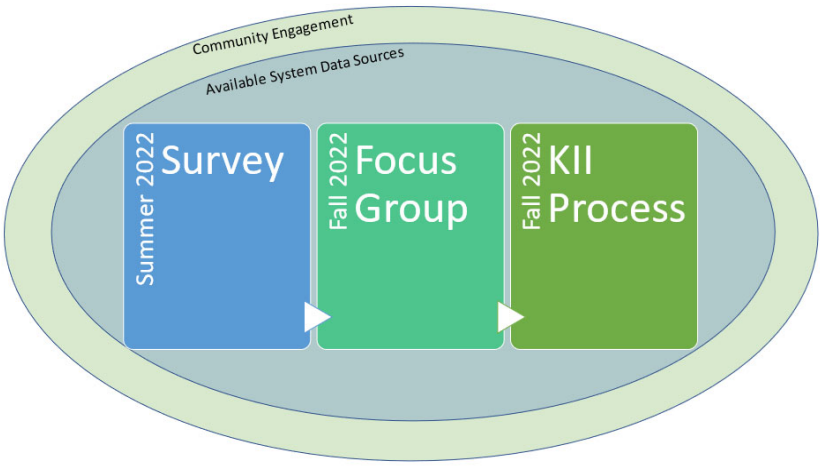
- Diagnose all Dallas Regional Residents as quickly as possible.
- Treat all HIV diagnoses quickly and effectively.
- Prevent new transmissions among Dallas Regional Residents using proven methods and strategies.
- Respond quickly to potential outbreaks by getting prevention and treatment services to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

Methods

The Dallas SNNA was designed for three phases of data collection – a traditional survey disseminated using respondent-driven sampling, a series of focus groups, and a set of key stakeholder interviews. This model is an evidence-based approach standard to RAI's step-wise needs assessment process. The three status-neutral, community-focused evaluation activities were bookended by discussion featuring substantial input by a wide range of stakeholders, including HIV planning organizations, non-funded service provider organizations, and HIV community social groups. Beginning with available system data, the RAI team engaged HIV service system stakeholders in the Dallas EMA/HSDA to identify key target populations and geographies to conduct the survey. Throughout this process, a RAI representative attended every RW Needs Assessment Committee meeting to keep the community as the center of this process. For example, key HIV planning bodies provided a "starter" survey with preferred domains and verbiage that was integrated into the SNNA survey; gave recommendations on participating in specific HIV community events; recruited survey respondents, and developed recommendations with feedback from the local community.

Figure 6: Dallas Needs Assessment Inputs

To construct the resource inventory, the statement of provider capability and capacity, and the assessment of unmet service needs, a mixed methods data analysis was chosen. Quantitative and qualitative information were collected including social determinants of health factors, listings of available services at key service provider organizations, and the degree to which currently available services in the Dallas EMA/HSDA meet the needs of the community. Figure 6 provides a visual of the overall process.



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

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

Overall SNNA Sampling Strategy

RAI utilized a snowball sampling strategy across the three components of the SNNA. The strategy was informed by the initial conversations with local key informants. In meeting with Planning Council members, local RWHAP subrecipient organization leaders, and CQM Program staff it was determined that certain subpopulations, such as those with a high community incidence and prevalence of HIV might be more challenging to access and assess; these individuals are also typically absent from HIV planning body meetings and poorly represented in existing qualitative data assessments. RAI outreach staff created a strategy to target specific agencies and venues around the Dallas EMA/HSDAs to identify access points to those populations that key informants noted may be hard to engage. To encourage trust, agencies were requested to provide an introduction to participants at their programs who were known to have large social networks or who served as gatekeepers to their specific communities. It was also determined early on to use an overall data-to-care approach to sample the population. Methods standard to the HIV field may not fully identify the true extent of community unmet need as they traditionally focus on data collection from individuals currently in care and accessing services at a specific site in a specific time frame. RAI and DCHHS believed we could and should do better.

The snowball sampling strategy began with the targeted initiation of the survey instrument in specific settings such as libraries, meal programs and supportive service agencies. Initial survey participants were identified as “seeds” . If successful, respondent-driven sampling per individual with three referrals up to five levels would allow for 121 respondents for each seed. To that end, a carefully planned strategy to estimate how respondent referrals would flow through the community and across key subpopulations was needed. The accompanying diagram demonstrates how five initial high-risk negative “seeds” and five initial HIV-positive “seeds”

would lead to roughly 86% data capture (1210 of 1400 expected responses). According to this plan, the remaining 14% of the desired respondents would be approached on a one-by-one basis to get more from key groups that are missing from the collected dataset with the goal of 700 HIV-positive and 700 high-risk negative cases in the end. In the event that "seeds" did not germinate fully into a set of 121 respondents, the "reseeding" strategy noted above would be followed per our implementation science approach. The reseeding would happen as many times as needed to reach the full number of survey respondents required by the deliverables (n=1400). The strategy of seeding based on the intersection of demography, geography, and implementation science is a strongly data-to-care model.

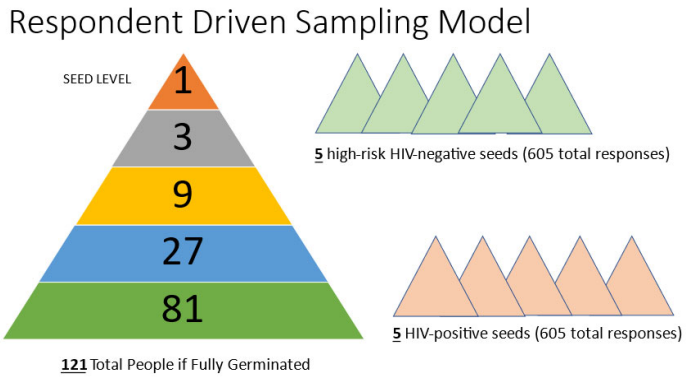


Figure 7: Respondent Driven Sampling Model for Dallas Needs Assessment

Following the survey, focus groups were designed to process pre-digested survey data to identify themes in the results and to create early sets of potential remedies and recommendations. The survey data were to be blended with other available to assist the focus groups to have the most complete picture of service needs for the entire HIV community - those with HIV and those at high-risk for HIV infection. Participants for the focus group were to be identified by the emerging needs exhibited in the survey data and/or to help correct for key populations that were still missing from the data.

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

RAI's implementation science approach for the SNNA allowed for timing modifications for the focus group and key stakeholder interviews if the survey data collection process was lagging. Other implementation science options for sampling strategy included: refreshed key informant meetings with additional questions on how and where to access key populations, and a reversion to traditional data collection for such community needs assessments where staff are positioned in care organizations to directly collect the survey data. Figure 8 exhibits the initial plan for strategic building of needs assessment data across the three components of the SNNA using RAI's data to care approach.

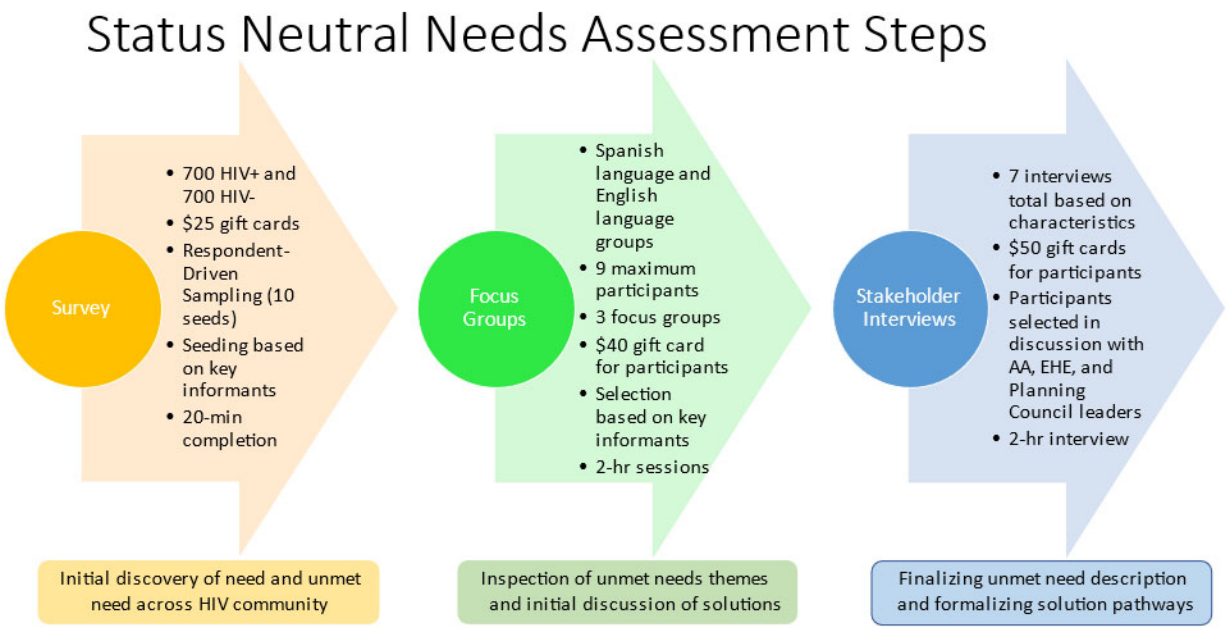


Figure 8: Status Neutral Needs Assessment Steps

Survey Instrument Creation

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

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

Survey Instrument Dissemination

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

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

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

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

Focus Group Facilitation and Key Stakeholder Interview Guides and Processes

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

Seven two-hour key stakeholder interviews were planned. Interviewees each received a $50 gift card as an incentive. The key stakeholder interview guide focused on key drivers and barriers to care. Respondents were made aware that their responses would be coded and their identities blinded from DCHHS and other stakeholders. Probes for each question focused on what would have made care experience better or less problematic, recommendations they would make to service system leaders, advice they would have for friends, and additional questions to ground

responses in real human terms. Under this umbrella were questions such as one change they would make to the Dallas area service system to make their lives easier, what advice related to healthcare would you give a friend moving to Dallas, and specific examples of stigma and discrimination they have witnessed. The interview tool covered four main question areas: excellence vs subpar service, what to do if there were unlimited resources, and issues of stigma around HIV, PrEP, and U=U. Key stakeholder interviews were conducted by the SNNA Project Director and Research Director, both of whom are known to the community as living publicly with HIV

Three focus groups were planned with up to 15 participants each. Each participant received a $40 incentive for their participation. Discussions were designed to last 90 to 120 minutes and in order to receive the incentive, participants needed to be present the entire time, have their cameras on, and participate both vocally and via chat room function. The facilitation guide was similar to the key stakeholder interview guide based on the feedback and range of responses gleaned from the interviews. The RAI research team believed it was vitally important to explore in greater detail the themes of excellence, access, and stigma and discrimination that appeared in the survey data and become even more apparent in the key stakeholder interviews. The groups focused extensively on how certain realities made participants feel as human beings. The intent of these questions was to create a connection between stigma, behavior, harms, and opportunities to impact the public in more positive ways. The RAI research specialist who identifies with the HIV high-risk community facilitated the focus groups.

Focus Group and Key Stakeholder Recruitment and Composition

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

Following the data to care approach, the SNNA focus groups were targeted to focus on vulnerable populations missing from the collected survey data. Two focus groups were planned in English and one was planned in Spanish. As will be described below, the Spanish focus group had no participants so an additional English focus group was provided. One of the English focus groups was exclusively for the gender-expansive community to provide a safe

nonjudgmental platform for that community. Recruitment for each focus group emphasized diversity of geography and involved key populations discussed above. RAI outreach staff relied on key informants as well as outreach and inreach to traditional hard to reach affected communities (e.g., people who use drugs, those who engage in transactional sex, those who are unstably housed, etc.) to ensure that all relevant risk groups are involved in the discussion.

Mixed Methods Data Analysis Procedures

The RAI team is made up of various elements of the HIV community, including people with HIV, people at high risk for HIV, and people who identify with key HIV risk groups in the Dallas region. As a result, the RAI research staff identifies closely with Dallas key populations. More than a symbol, shared identity is important for information bias, particularly classification bias, during analytic processes. RAI prides itself on its demographic heterogeneity and that there is a great deal of commonality with communities of focus in its work.

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

All surveys were coded and analyzed by the Clinical Data Analyst. Thematic analysis, applying the framework approach, was conducted including basic coding of the data and organization of codes into broad domains to allow for various side-by-side and cross-tabulation (multi-variable) analyses. The epidemiological profile was used to direct survey seeding and analysis, focus group recruitment and facilitation guide creation, and the same for the key informant interview component. These data served as a reference point for discussion and potential recommendations on a population health basis. The data analysis process included organizing information and analyzing it to identify key needs, trends, and critical issues. The research team was able to visually represent the themes identified with key supporting quotes from the data (see Results section below).

The method used for analyzing data from focus groups and interviews involved the creation of a code book and then subsequently coding all recorded discussion material for key data points. The purpose of the code book is to create a list of key areas of focus that can be evenly applied across each focus group and interview transcript. The data used in RAI's qualitative analysis was coded by one research team member and confirmed by a second team member. Statistical analyses included overall frequency data and frequency of responses for "in-care," "out-of-care," for each priority population and geographic segment. Cross-tabulations with tests of significance for "out-of-care" were conducted within each priority population and geographic segment. These cross tabulations profiled each population, outlining their characteristics (socioeconomic, demographic, etc.), needs, barriers and unmet needs/service gaps. These profiles include comorbidities reported in the survey including domestic violence, substance use, and mental illness symptoms among survey respondents. All survey data were analyzed to obtain necessary information and recommendations.

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

Limitations

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

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

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

Three weeks into RAI's collection of data using the survey instrument, large numbers of responses were made in short periods of time, many of which had foreign IP addresses. The RAI research team took measures to ensure data collected in Formsite was secure and had not been breached. A lengthy process of data verification, cleaning, and revalidation was conducted to ensure that analyzed data were free from junk responses from pirates and others trying to access the incentive.

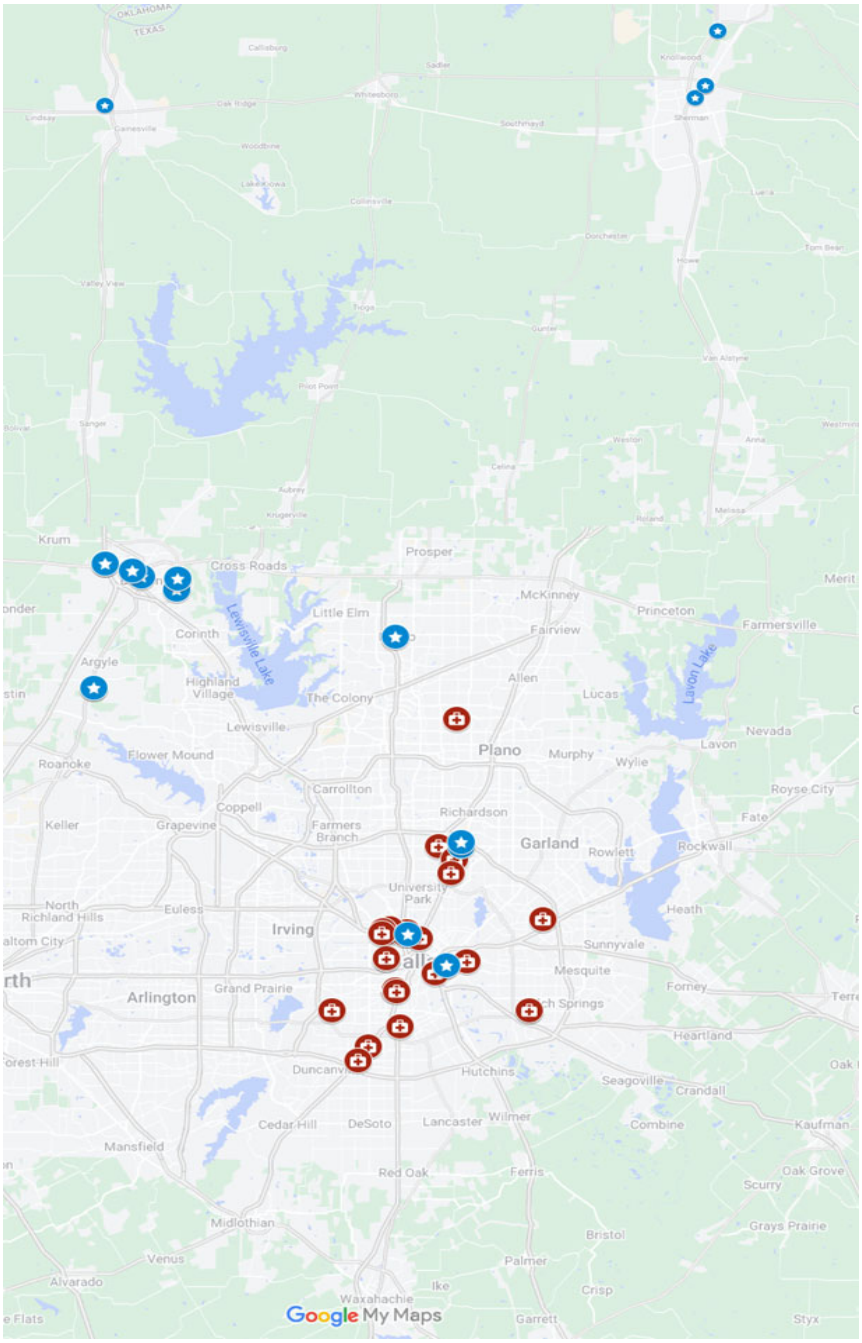
At several points in the survey deployment, individuals knowledgeable on survey deployment methods cautioned that the planned incentive payment schedule would be insufficient. The planned schedule was one $25 per completed survey with a maximum of 1 survey to be completed per individual. For respondent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

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

Results

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

Figure 9: RAI Suggested Seeding Map for Surveys

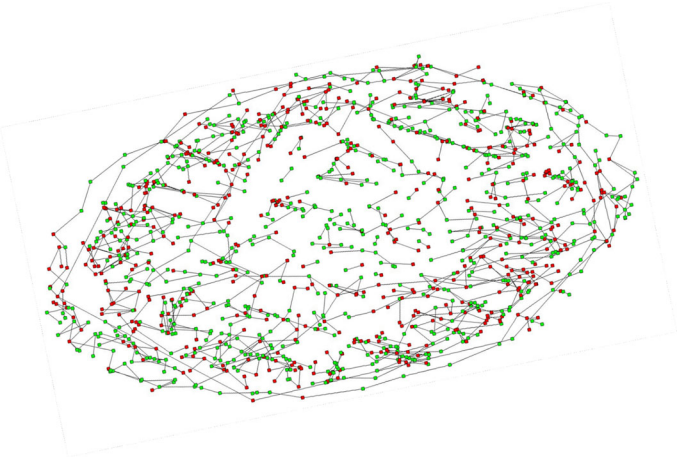


Outreach Effort Results

In order to successfully complete the survey instrument using the respondent driven sampling method, a careful effort to seed the survey was made to ensure inclusion of results from all relevant groups. As mentioned previously, the epidemiological profile for the Dallas region was used to identify key groups of people whose responses to the survey and other SNNA components would be critical to synthesizing the need and unmet framework. Figure 9 (to the right) was used to identify potential geographic priorities for survey seeding. On the

map, red circles indicate where the RAI outreach staff considered seeding the survey among people with HIV. The blue circles represent where the RAI outreach staff considered seeding the survey among people at high risk for HIV. It is important to note that people with HIV were able to refer to high risk negatives to complete the survey and vice-versa. In the social network graphic in figure 10 below, the interconnectedness of PLWH/A and higher risk negatives is evident.

Figure 10: Needs Assessment Social Network



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

When asked which groups were approached and what the result was, the outreach team provided in Attachment C containing the exact names and addresses of all the groups reached out to in order to seed the survey and assist with RAI's outreach efforts.

For our suburban and rural communities, we targeted organizations catering to victims of human trafficking, pregnant women facing domestic violence and homelessness, centers of rehabilitation from substance use, clinics dedicated to Hispanic populations, CBOs for LGBTQ+, Denton County's testing sites, Adult Friend Finder dating site, Grindr, Sniffies, social media pages geared to Hispanic audiences, and places where ranch hands frequent (like the pit stop in Sanger where many migrant workers buy cases of beer after work, and livestock and ranch stores with bulletin boards). Additionally, outreach was conducted for the street homeless population, housing programs, and the Dallas Public Library. These locations were carefully selected by outreach staff to get substantial input from the chronically unhoused, those with histories of incarcerations, and people with a higher susceptibility to HIV infection including black heterosexual women, and black and brown gay and sexually expansive people.

When community liaisons were asked about the relative success of working with various organizations on SNNA outreach, results were mixed. Within our rural communities, organizations that already have experience working with HIV and STDs were the easiest to engage as well as the Denton County Health Department. Other groups, including HRSA funded entities in the suburbs and rural areas were challenging to work with and it is not clear that staff at these organizations understood the purpose of the SNNA and the ability to be at the forefront of information and data sharing. Cold calling and relying on the "Contact Us" form yielded the least results, while having a specific contact person facilitated outreach and recruitment. Finding the right people to take this survey in a rural population was challenging because of low population density, and few areas where communities congregate. Risk factors

such as male to male sexual conduct is less apparent in communities that do not have a 'gayborhood' and injection drug use is being actively hidden due to the real fears of legal consequences. Importantly, the Hispanic population is even more difficult to observe signs of risk due to cultural characteristics and issues related to safety rooted in regional politics[18]. Due to the national rise in substance use since the beginning of COVID, community liaisons prioritized areas where PWID congregated. A full list of organizational partners reached by the RAI outreach team can be found in Attachment C

Beyond service organizations, social media is another important source of engagement for the key populations of interest to the Dallas SNNA. This includes the buy/sell pages on social media apps/sites like Facebook and NextDoor. These pages are used for anything and everything and are very local (some pages, like NextDoor require proof that users live in the area). While dating apps such Adult Friend Finder seemed promising on the surface in terms of being able to select the desired type of sexual activity (i.e., anonymous sex), people engaged there were more interested in chatting and entertainment rather than setting up encounters to meet. Grindr, a mobile phone dating application, yielded mixed results. Our community liaison noted that several potential contacts thought that the SNNA outreach was a scam to steal personal identifying information. The Spanish speaking outreach staff person only received two inquiries out of all the pages posted demonstrating that this method is not as effective as relying on personal connections to have the survey completed. This relates to the conflicting priorities of health care versus documentation status since xenophobic political rhetoric and the legal system has created a fearful environment. One example to share is that a Spanish respondent shared that she lost vision in her eye from a health condition and even though it is now an emergency, still will not be seen until May because of the cost and provider availability. The client and her family are undocumented so they cannot find work that pays enough to get the necessary medical care. These related issues compound each other for all kinds of undocumented people, but especially for Latinx groups currently in the political spotlight.

Among sites in rural and suburban areas that RAI outreach staff were successful in engaging, the staff offered to assist in doing outreach to other groups and agencies.. In addition, a peer led substance use service organization provided referrals to transitional housing programs but coordination during the survey period was not possible, The team was also referred to Dallas area high school for at-risk youth and pregnant adolescents that may be a potential future site for listening sessions and mini-needs assessments.

When asked if they were directly connected to client contacts for seeding, outreach staff said they were mostly able to make the link. There was a sense that most sites understood what the outreach staff members were asking for and were able to connect to clients for seeding. Where the seeding process often broke down was when the seed respondent didn't know who to pass this survey to in terms of making referrals. Many genuinely did not know people to send this along to, because they did not want their personal contacts to feel uncomfortable or under any

[18] Furman, R., Negi, N. J., Iwamoto, D. K., Rowan, D., Shukraft, A., & Gragg, J. (2009). Social work practice with Latinos: Key issues for social workers. Social Work, 54(2), 167-174.

microscopes. This failure to disseminate points to the fact that in certain urban and rural areas social networks are smaller and more spread apart - people are more isolated related to their HIV community affiliation than RAI had anticipated. For rural areas, it is not uncommon to have to drive a long distance to connect with others, and there is no public transit system outside the urban core and the near suburbs like Denton (Denton proper has a light rail and bus system that travels within Denton city, which also reaches Carrollton where it connects to the Dallas system, but not beyond). A respondent from a rural clinic mentioned that there was a gay bar in Sherman that closed after the pandemic due to the owners passing away from COVID-19. Since then, there have been no local physical places where people from the queer community in rural areas can congregate to meet other people; social interaction is usually done through dating and social apps and social media at this point. Glitterbomb in Denton, an event where drag queens perform and the house/ball community convenes, was closed for the season, but would be an excellent place to engage with LGBT folks from the suburbs in future assessment cycles.

When asked if the client contacts the outreach staff were introduced to were diverse and demographically reflective of the regional pandemic or if they favored any specific group, there was a sense of true diversity, with certain key gaps noted. For example, one outreach staff person noted that he would have liked to have gotten some young white males to do the survey. Our final tally of respondents, fortunately, did not lack for white male participation.

When asked if they were strung along or ignored by outreached provider organizations under any circumstances, the outreach team had different experiences. While the outreach worker responsible for central Dallas expressed no problem in linking with sites with limited exception, the outreach workers in the outer counties of the Dallas region expressed extreme challenges in working with organizations. While all groups reached out to where theoretically excited by the work and philosophically aligned with the work, momentum was lost when it came time to meet with clients and seed the actual survey instrument. The primary determining characteristics for challenges of access and engagement focused on A.) inexperience working in the HIV/STI field and B.) focus on populations that are currently “under siege” in Texas, including individuals involved in (or needing) harm reduction services, undocumented persons and families, and gender expansive people. Some of these organizations stated plainly “I don’t know you and I cannot risk ruining my clients lives by having the rug pulled out from under them. I’m sorry, but this is not going to happen here”. For groups in category B, the real constraints revolved around timing (holidays and state audits), getting approvals in time from other leadership (as was the case for Women 2 Women), and inclement weather events. The local grassroots harm reduction program in Northeast Texas and a rural sober living program in Denton county were both opposed to permitting access to their participants, most likely because they feared possible legal or safety consequences.

Survey Sample Demographics

The Dallas SNNA survey instrument was deployed between November 2022 and January 2023 using the methods laid out above to recruit respondents (summarized in Table 1).

Survey Results

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

Of the 2,046 survey respondents who successfully completed the survey, the majority of participants (70%) were between the ages of 25 and 44 with the range of participants from 16 to 70+. Nearly 16% of our respondents were under 24 comprising the second largest demographic. This result is significant and reflective of the success of the community liaison in reaching this vulnerable population as the highest rate of new infections is under the age of 24 with the percentage of those living with HIV in Texas currently measured at 4%[19]. Of the total respondents, 5.3% intended as PLWHA; of those respondents under 25, 34% identified as living with HIV.

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

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

[19] AIDSVu

[20] Chandra, A., Copen, C. E., & Mosher, W. D. (2013). Sexual behavior, sexual attraction, and sexual identity in the United States: Data from the 2006–2010 National Survey of Family Growth. International handbook on the demography of sexuality, 45-66.

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

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

Table 2 and Figure 11

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

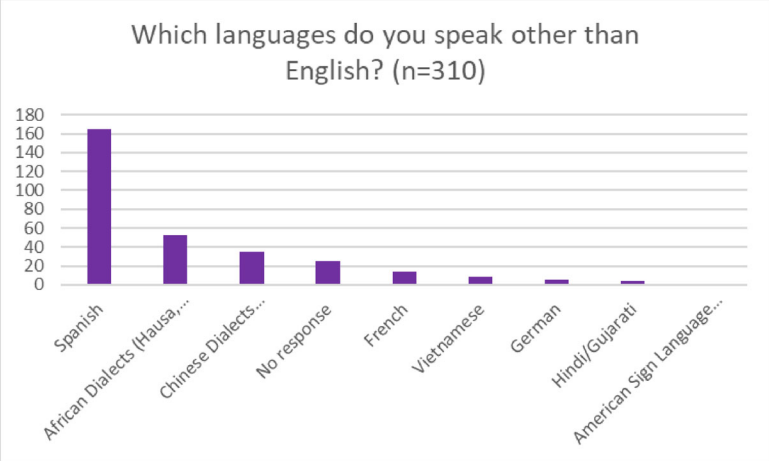


Table 3 and Figure 12

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

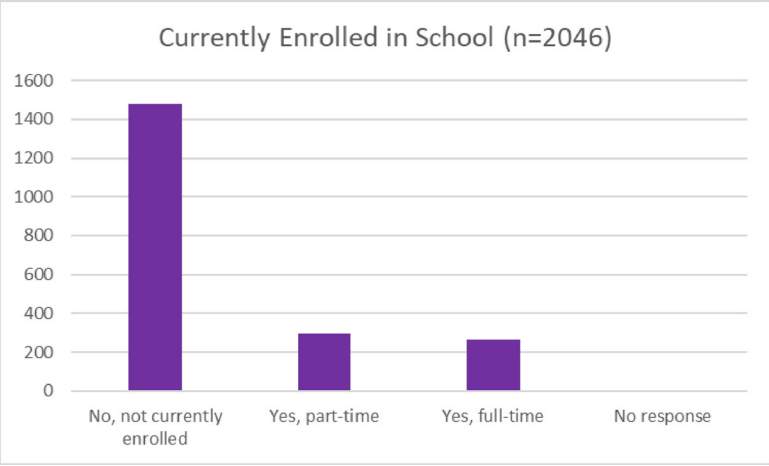


Table 4 and Figure 13

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

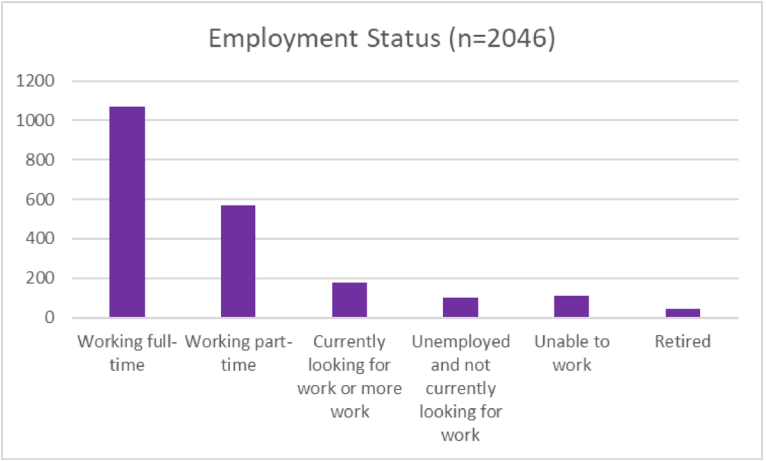


Table 5 and Figure 14

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

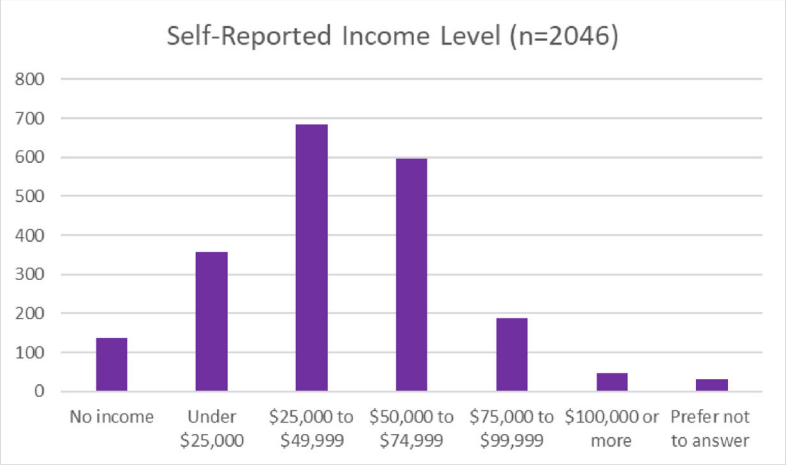


Table 6 and Figure 15

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

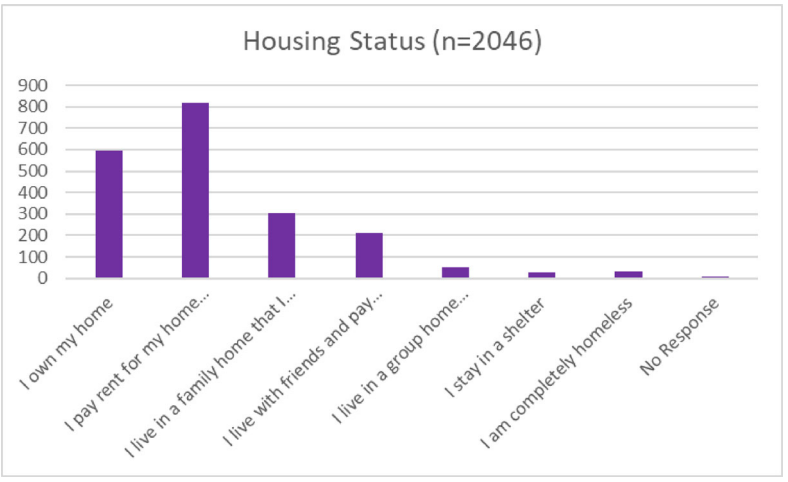


Table 7 and Figure 16

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

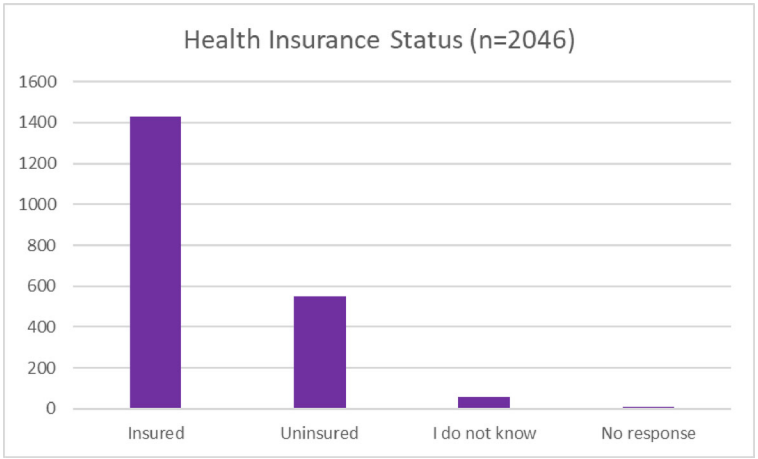
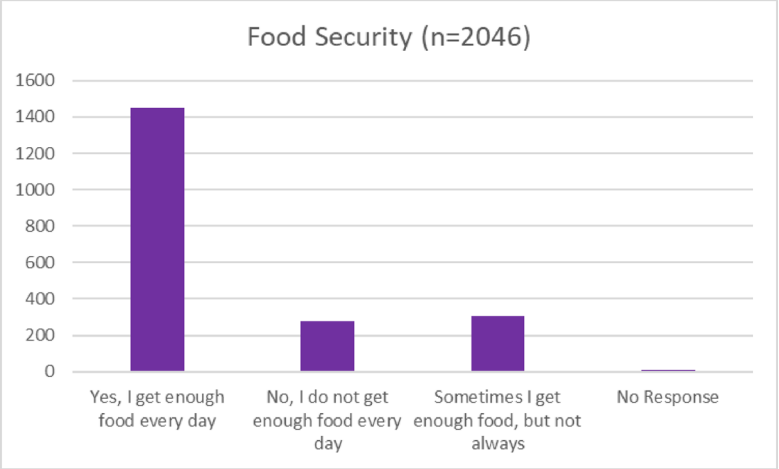


Table 8 and Figure 17

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



The following series of tables and graphs show patterns of HIV risk in the last 12 months. Findings for those who are at risk of acquiring HIV are in Black; Findings for people living with HIV are in red.

Table 9 and Figure 18

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

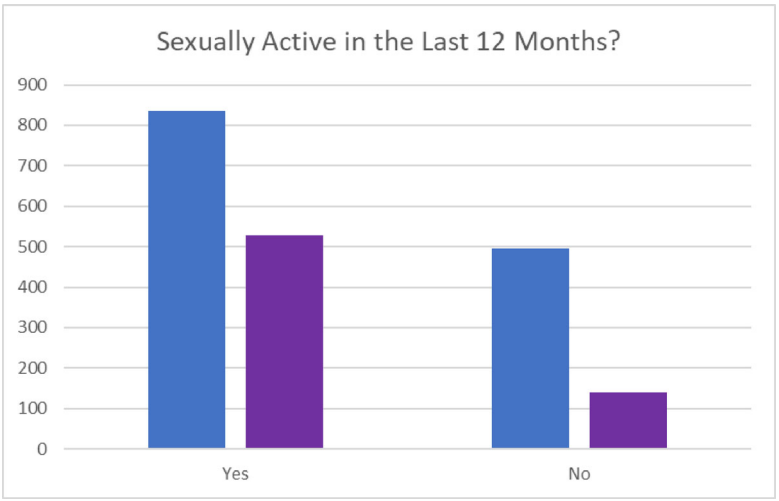


Table10 and Figure 19

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

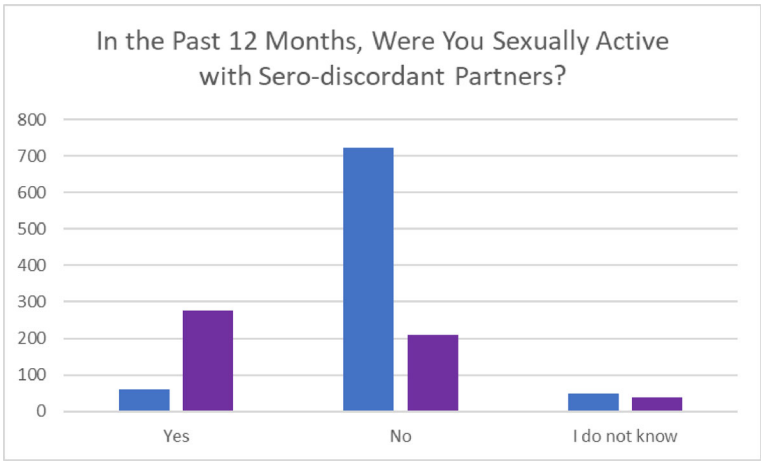


Table 11 and Figure 20

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

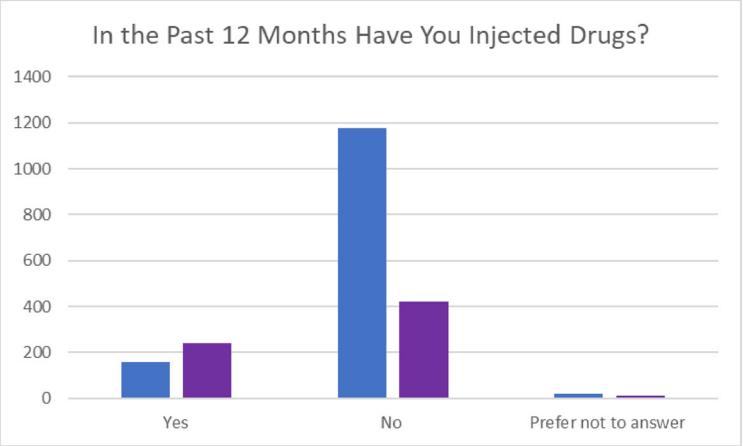
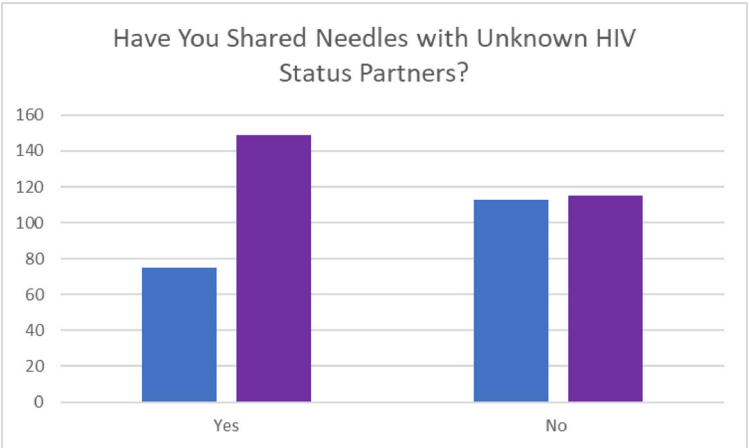


Table 12 and Figure 21

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



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

Table 13 and Figure 22

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

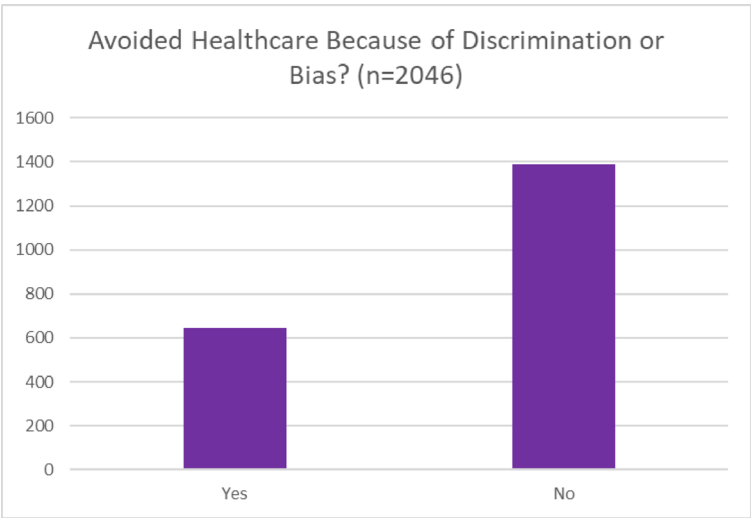


Table 14 and Figure 23

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

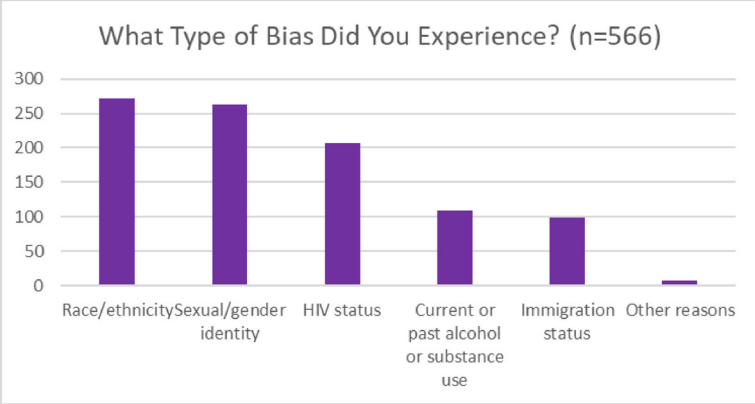


Table 15 and Figure 24

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

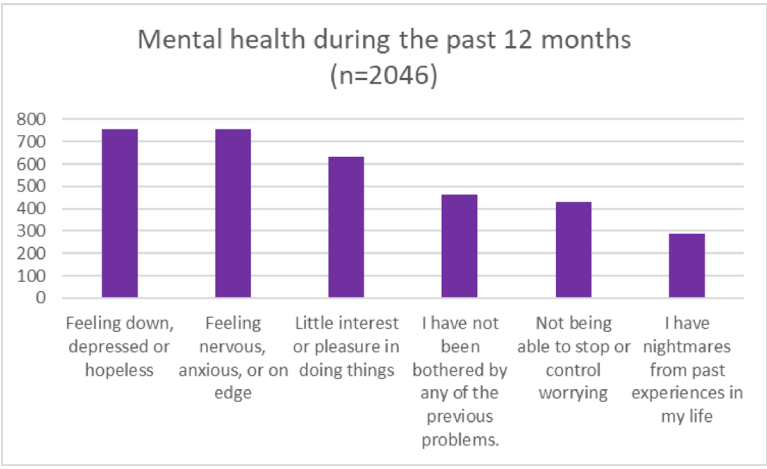


Table 16 and Figure 25

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

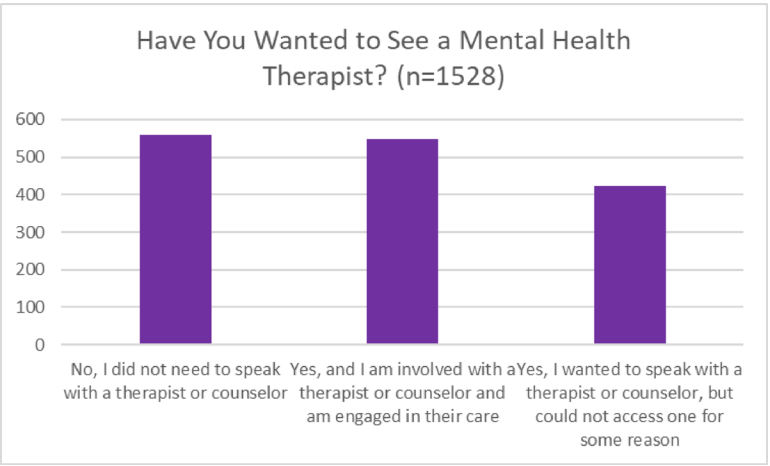
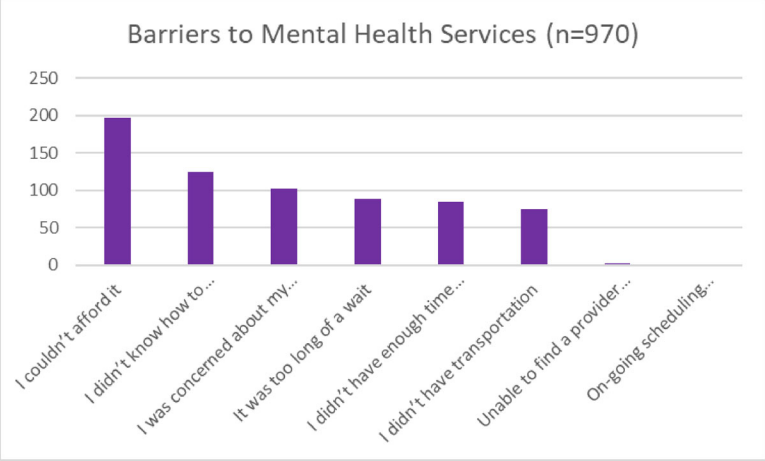


Table 17 and Figure 26

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



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

Table 18 and Figure 27

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

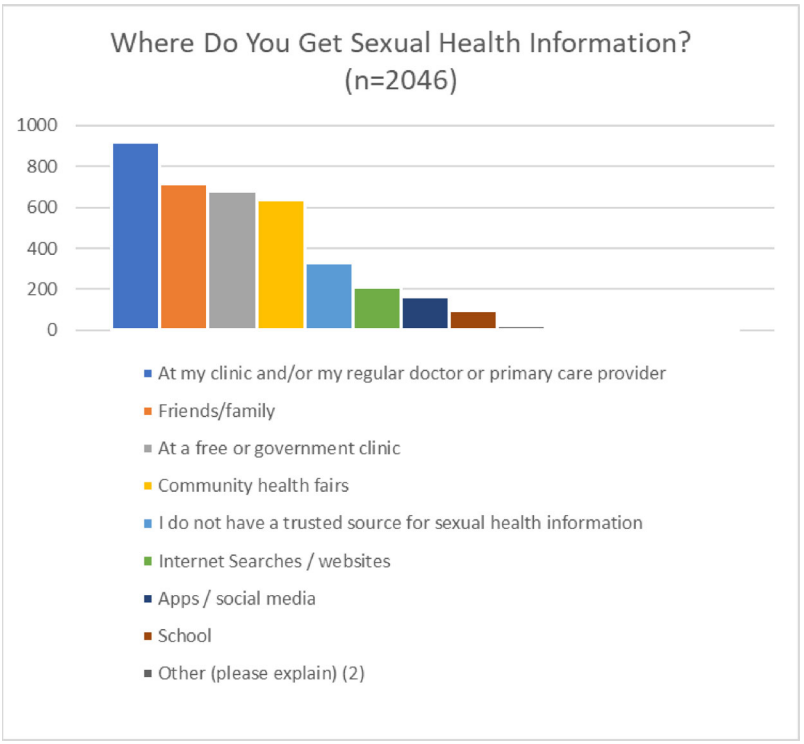
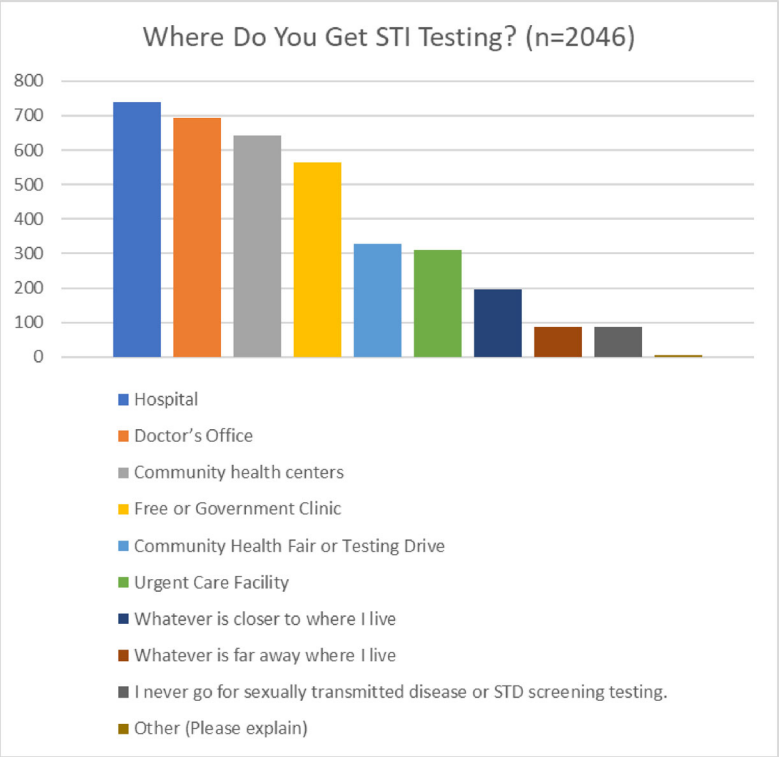


Table 19 and Figure 28

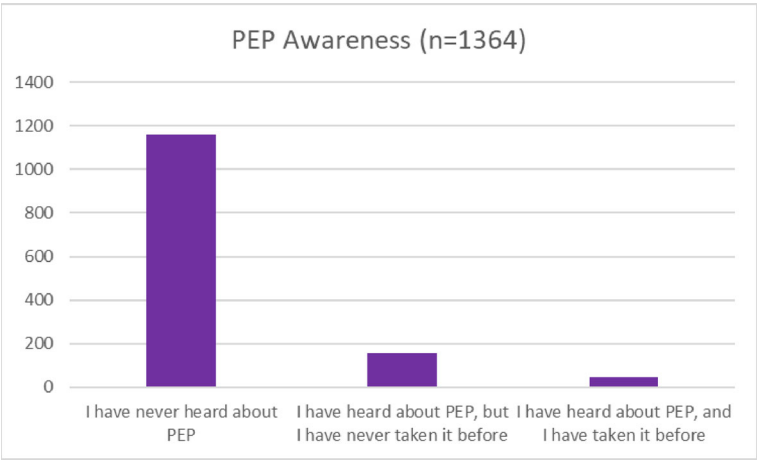
STD testing site	n=2046	%
Hospital	740	36.20%
Doctor's Office	693	33.90%
Community health centers	641	31.30%
Free or Government Clinic	564	27.60%
Community Health Fair or Testing Drive	328	16.00%
Urgent Care Facility	310	15.20%
Whatever is closer to where I live	197	9.60%
Whatever is far away where I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



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

Table 20 and Figure 29

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



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

Table 21 and Figure 30

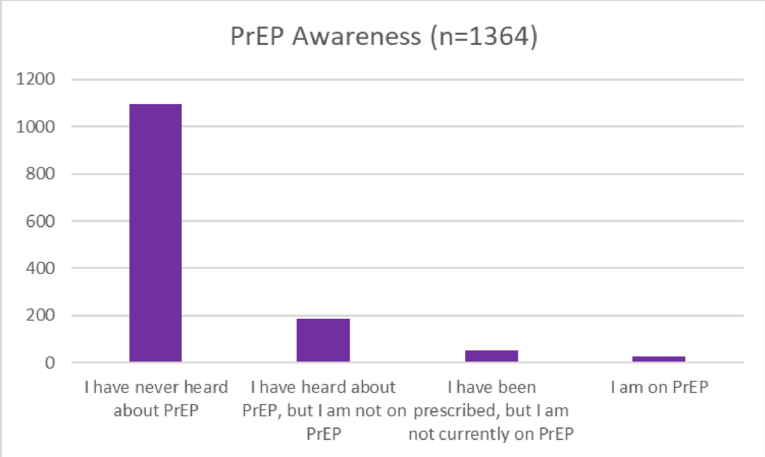


Figure 31: PrEP Word Cloud - In your own words, what is PrEP?

Table 22 and Figure 32

U=U awareness	n=2046	%
I have never heard of U=U	1561	76.30%
I have heard of U=U, but am not sure what it means	184	9.00%
I know about U=U and what it means	289	14.10%
No response	12	0.60%

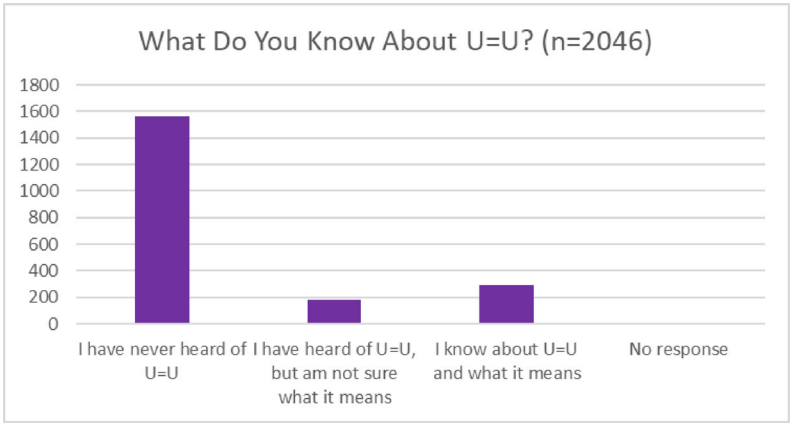


Figure 33: U=U Word Cloud - In your own words, what is U=U?

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

Table 23 and Figure 34

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

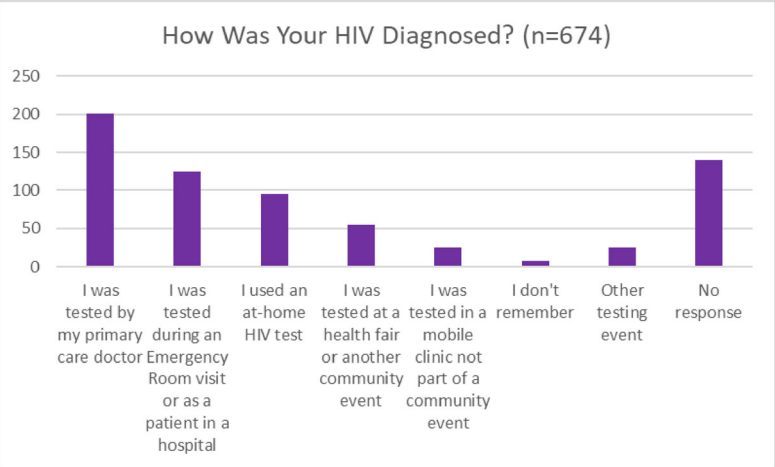


Table 24 and Figure 35

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

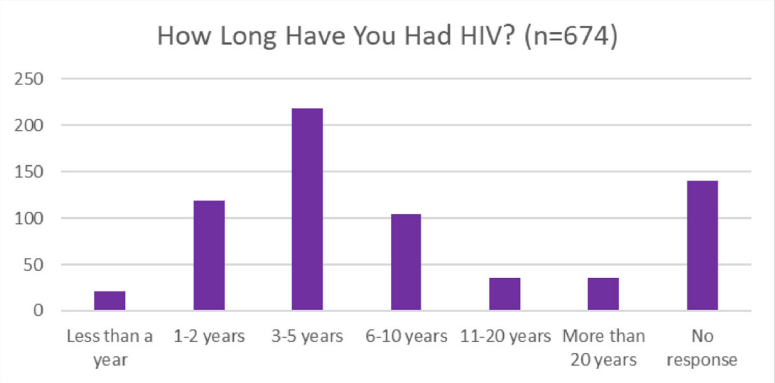


Table 25 and Figure 36

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

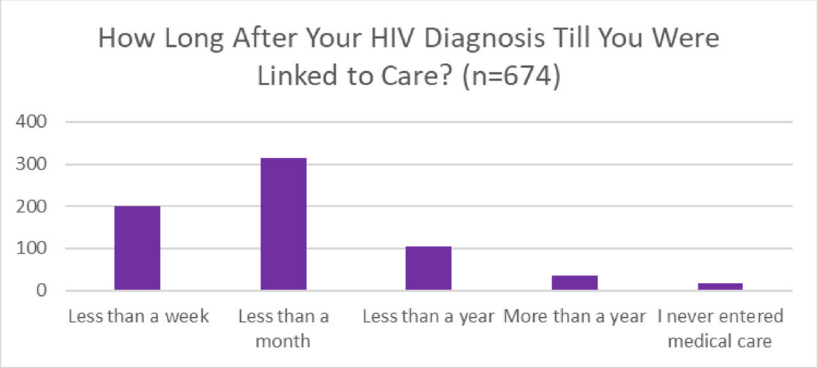


Table 26 and Figure 37

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

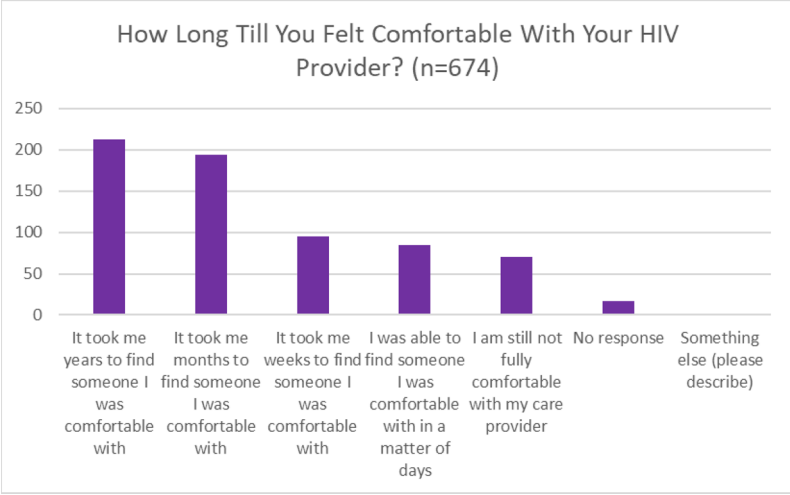


Table 27 and Figure 38

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

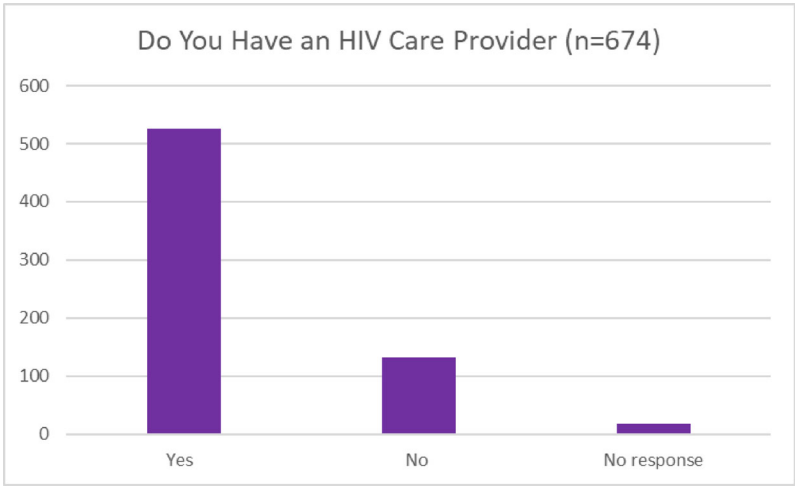


Table 28 and Figure 39

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

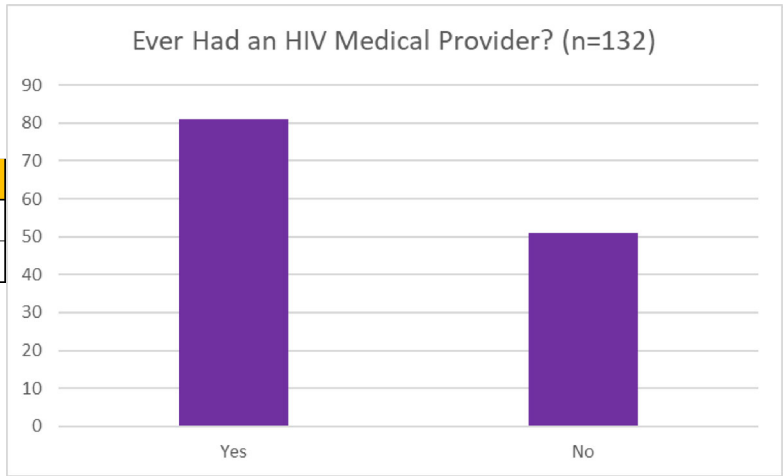


Table 29 and Figure 40

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

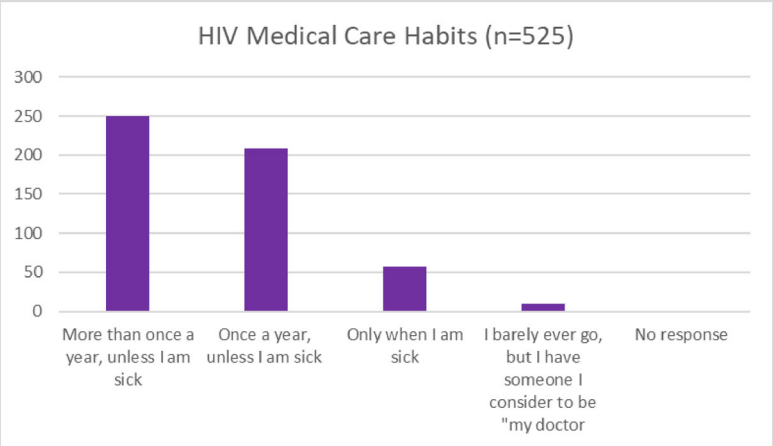


Table 30 and Figure 41

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

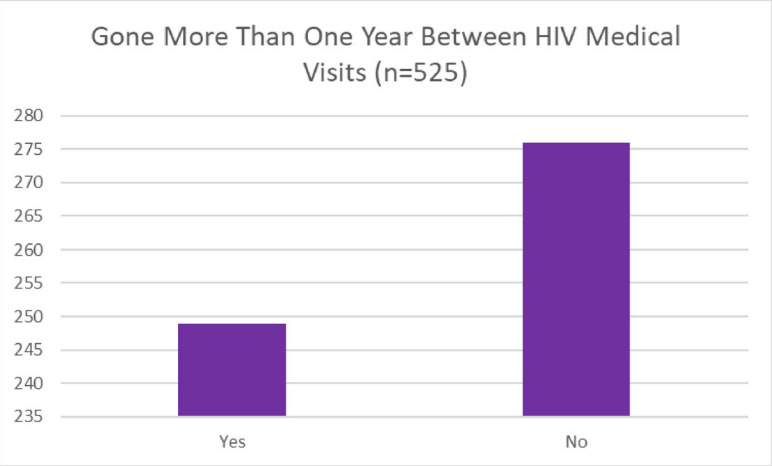


Table 31 and Figure 42

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

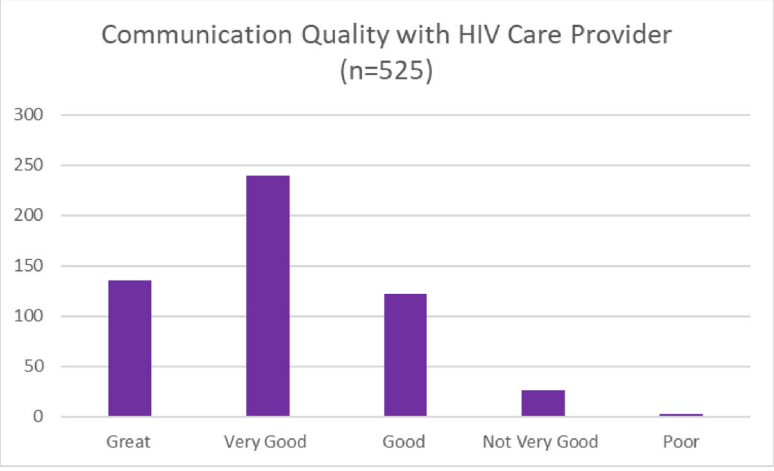


Table 32 and Flower 43

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

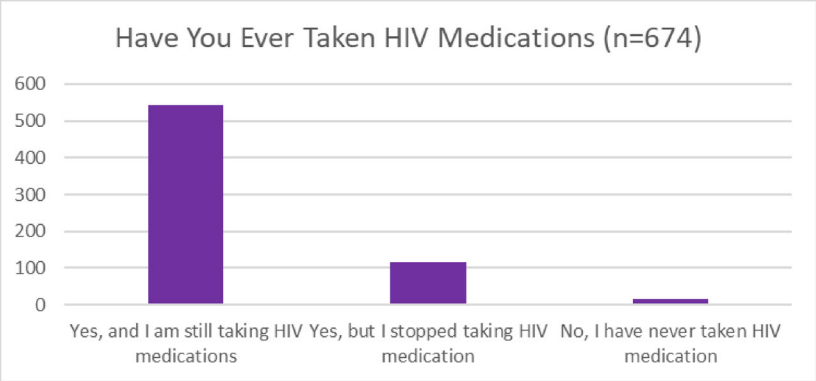


Table 33 and Figure 44

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

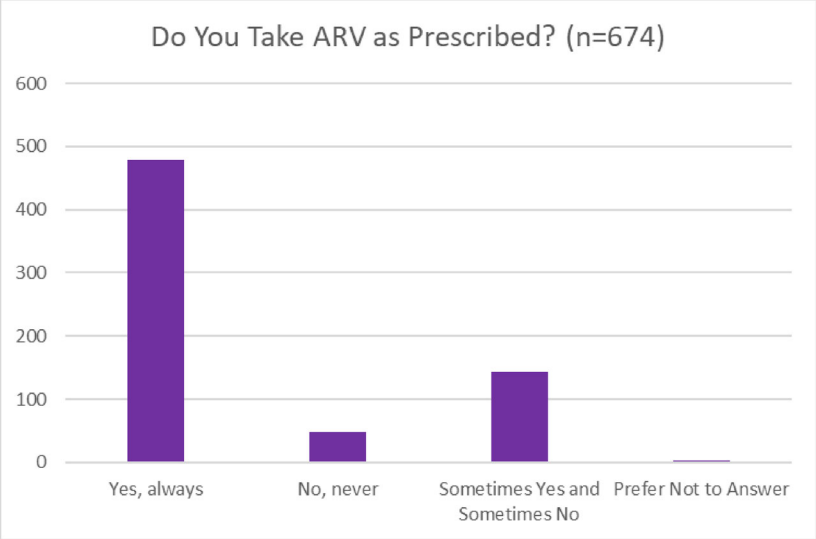
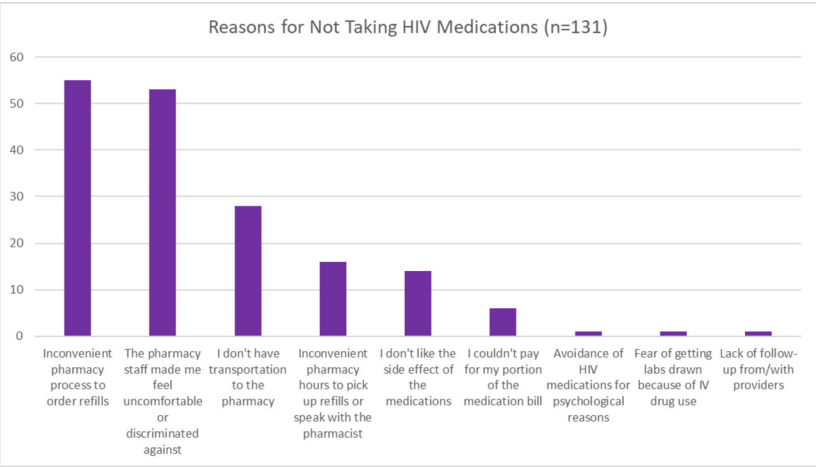


Table 34 and Figure 45

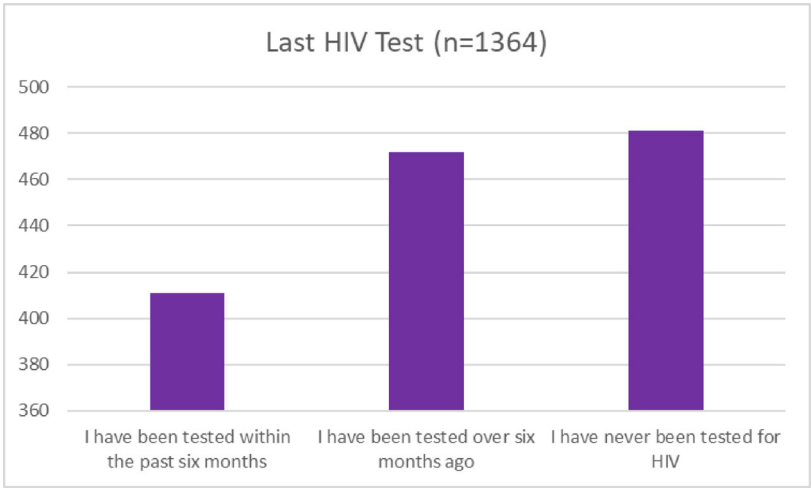
Reasons for not taking HIV medications	n=131	%
Inconvenient pharmacy process to order refills	55	42.00%
The pharmacy staff made me feel uncomfortable or discriminated against	53	40.50%
I don't have transportation to the pharmacy	28	21.40%
Inconvenient pharmacy hours to pick up refills or speak with the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



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

Table 35 and Figure 46

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



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

Table 36 and Figure 47

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

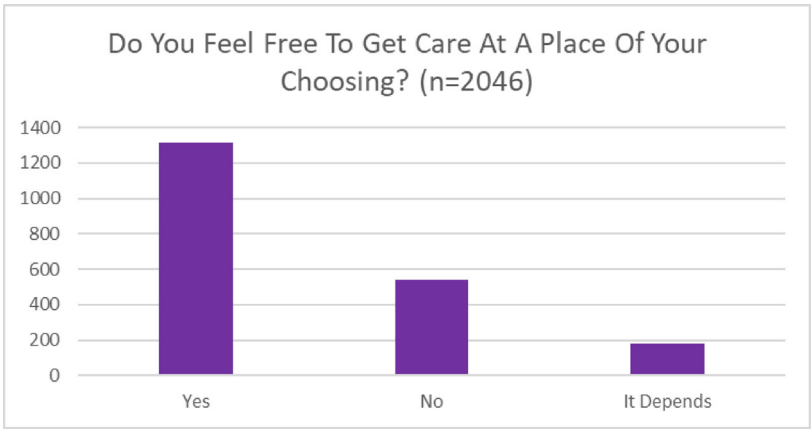
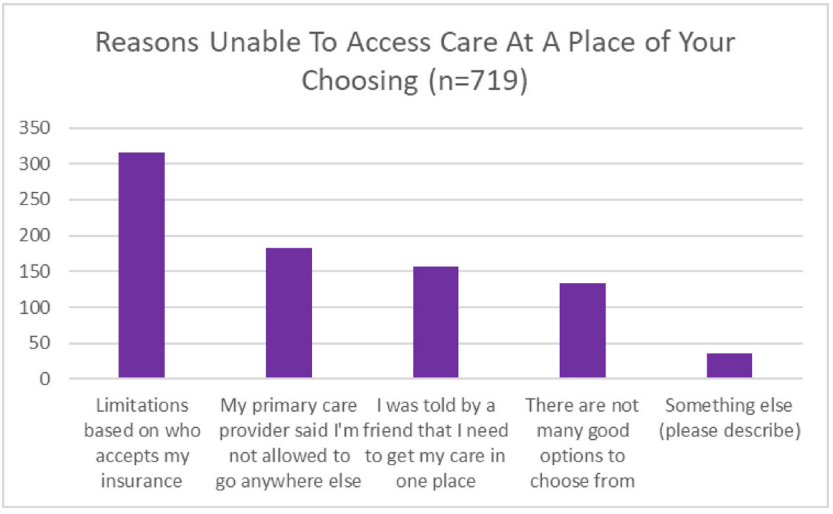


Table 37 and Figure 48

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



Significant Survey Findings for Key Populations

Black Men Who Have Sex With Men

Among respondents, 194, or 9.4% of respondents, identified as a black man who has sex with men (BMSM). The majority of these men were between the ages of 25-34 (59.8%). The majority report having full time employment (63.9%) and having some type of medical insurance (53.1%), and report earning $25-$49,999 per year.

Only 5.2% report having never been tested for HIV. The most commonly reported methods of testing were by being tested by a primary care provider (20.6%), use of at-home HIV test kits (13.9%), or at a health fair or community event (13.9%).

Of the 194 respondents, 72 respondents reported that they do not have HIV, with only 3% reported currently being on PrEP. Few reported that they have been prescribed PrEP in the past (8%). Only 12.5% have heard of PrEP but were not currently taking it and of all BMSM, only 27% reported knowing what PrEP is.

The majority of our BMSM respondents (62.9%) report being diagnosed with HIV. Of those diagnosed, 14% were diagnosed within the last two years. The majority of the BMSM (19.6%) report having been diagnosed within the last three to five years while 12.9% report they were diagnosed more than 10 years ago. As testament to the hard work being done at community level, All the BMSM in our survey report having been linked to medical care and 58.8% report that they have a primary provider that covers their HIV care.

Among respondents 48.5% reported that they currently take all their medications as prescribed. While 14.4% reported that they have previously been prescribed medications but are not currently taking them. None report that they have ‘never’ been prescribed medications, which leaves approximately 37.1% with unaccounted for adherence behaviors.

Hispanic/Latinx Men Who Have Sex With Men

Among respondents, 53 reported being of Hispanic or Latino origin and being men who had sex with other men (LMSM). The majority of these men were between the ages of 25-34 years old, 56.6% were working full time or part-time (26.4%), 62.3% reporting that they had health insurance, earning either $25,000-49,999 per year (37.7%) or $50,000 and 74,999 per year (30.2%). Of these Latino men, only 37.7% reported speaking Spanish as well as English. Despite the higher range of reported incomes, food scarcity was an issue among these men with 51% reporting experiencing some periods of not having enough to eat during the last year.

Among these respondents, 96.2% report that they have been tested at least once in their life. The majority report that they have been tested by their primary care provider (22.6%), through an emergency room visit (7.5%) or other method and venue (5.7%). Very few were reported to be tested at community events or health fairs, at a mobile clinic outreach event, or, or being

unable to recall how or where they were last tested for HIV (1.9% each). None reported using a home-test kit. A discrepancy appears to exist in reported testing behavior and testing access.

Among the 24 respondents who were HIV negative, only 17% reported having a primary care provider. Similarly, only 16% reported currently being on PrEP. 4% reported having been prescribed PrEP, but were not currently on it, while another 16% had heard of PrEP but were not currently taking it. The majority of all Latino MSM (28.3%) had not heard of PrEP.

Among LMSM respondents, 54.7% were diagnosed with HIV, a full quarter of them reported they were diagnosed at birth. Among all living with HIV, 76% reported that they had a primary care provider who managed their HIV infection. Only 3.8% report having **never** been linked to medical care. None reported being diagnosed within the last year. Many of the LMSM (41.3%) reported being diagnosed within one to five years. Many of these men (82%) report they have been prescribed HIV medications and are currently taking them, while 10.3% report having been prescribed although not currently taking medications, and 6.8% reported having never taken HIV medications. Falling out of care is an issue with this group, 38% reported that while they were in care, there had been a period when they went more than a year between visits to their doctor. Among LMSM, 58.5% reported they have never heard of U=U, while 20.8% reported they had heard of it and knew what it meant.

<u>Hispanic/Latinx Women</u>

Among all Latina respondents (n=120), the majority were either between the ages of 25-34 years old (58.3%) or 35-44 years old (25%). Roughly one in five of these women were multilingual English and Spanish speakers. Heterosexuals composed 65% of the Latina respondents, while others reported being bisexual (25%), Queer (4.2%), or Lesbian (5%) and and 2.5% prefer not to answer about their sexual orientations.

Most of the women were working full time (79%) and/or part time (33%), possibly indicating that they were working more than one job. Many of these women were earning $25,000 to $49,999 (47.5%) or $50,000 or more per year (40%), yet only a third of them reported having health insurance available through an employer, while 24% were receiving Medicaid or medical assistance. Risk behaviors amongst this group were low, with only 2.5% having reported a history of intravenous drug use, 5% engaging in sex exchange, and only 7.5% reporting a history of prior incarceration.

Among all Latina respondents, 55% reported that they have been tested for HIV, yet only five respondents reported where or how they had received a test. Only two women reported being on PrEP. The vast majority (87.5%) reported that they had never heard of PrEP and 90% reported they had never heard about PEP and only 4.2% reported they had been diagnosed with HIV.

Transgender and Gender Non-Conforming People

Transgender and gender non-conforming (TGNC) individuals were scarcely represented in the survey (n=75). The majority of TGNC individuals were black (47.9%) or white (32.4%). TGNC individuals were relatively young, being 18-24 years old (43.7%) or 25-34 years old (33.8%). TGNC individuals had low incomes (45.1%) with most earning less than $25,000 per year. Roughly a third (32.4%) of the sample reported working full-time, part-time (26.8%), or looking for work (22.5%), disabled (11.3%), unemployed yet not looking for work (7%). Most TGNC people reported having health insurance (60.6%). Only 11.3% reported having insurance through an employer, while 14% had insurance purchased through a health insurance exchange, and 28.2% reported having Medicaid or medical assistance. About half of the sample reported that they had engaged in sex exchange and 39.4% reported experiencing food insecurity in the past year.

HIV testing behaviors amongst TGNC individuals varied greatly. Almost 10% reported they had never been tested for HIV, while 25.4% had been tested within the last six months and 15.5% had been tested over six months ago. This leaves 49.2% unaccounted for in terms of testing timeframes. Of those TGNC people who were HIV negative, only 5% had been prescribed PrEP. Similarly, another 5% had been prescribed PrEP but had not yet taken it. Nearly 20% had heard of PrEP but were not taking it. Overall, 35.2% of all TGNC individuals had not heard of PrEP.
HIV infection was fairly high among our TGNC respondents with 49.3% reporting that they were living with HIV. Only 6% had never been linked to medical care. Many of those linked to care (74%) were reported they were currently on medication, while 26% had been prescribed medications, but were not currently taking them. A little more than a third of TGNC people living with HIV reported that they had gone more than a year between doctor visits in the past. Among TGNC who were HIV positive, 17% reported recent intravenous drug use had shared needles with a person of unknown HIV status and 57% reported having a sero-discordant sexual partner. Only one in five reported that they had heard of and knew about U=U.

Youth Living with HIV/AIDS

Youth living with HIV (YLWH) made up a significant proportion of 18–24-year-olds (n=109). The majority of YLWH were black (64.2%) or white (27.5%). Most YLWH reported being heterosexual (56%), while 17.4% reported being gay, 14% identified lesbian, 6.4% as bisexual. The majority were cis gender male (52.3%), cis gender female (35.8%), and 12% as TGNC.
The vast majority of YLWH earned less than $50,000 per year (75.2%). PLWH reported working either full time (28.4%) or part time (45%), looking for work (12%), or unable to work (6.4%). A large portion of YLWH reported being enrolled in school either full time (46.8%) or part time (45.9%). The majority reported that they had health insurance (76.1%).

None of these youth reported their prior habits with HIV testing. Only 58 respondents provided information on their diagnosis time frame. Of those who reported, the majority (28.4%) had been diagnosed 3-5 years ago. While 27.6% reported they had been diagnosed within the last two years. This would suggest that COVID19 changes to HIV testing availability may have had a negative impact on youth testing behaviors and diagnoses.

The YLWH where overwhelming connected to medical care, only 4.6% reported that they have never been linked to medical care. 80% reported that they had a primary care provider that was managing their HIV care. Of those in medical care, 72.5% reported they were currently prescribed medication and taking it as prescribed and 25.7% reported that they had been prescribed medication, but were not currently taking it. Most (62.4%) reported having a sero-discordant sexual partner in the past year. Most YLWH (63.3%) reported that they had never heard of U=U.

People Who Inject Drugs (PWID)

Our survey reached a significant number of individuals who injected drugs (n=399). A small percentage (5.5%) of our respondents identified as TGNC. Most (55.6%) identified as cisgender male or cisgender female (39.8%). In terms of sexual orientation, heterosexuals made up the majority of respondents (57.9%), followed by gay or same gender loving (12.8%), and bisexual (13.8%). Those who were between the ages of 25-34 years old were the largest age group (50.9%), followed by those between 18-24 years of age (30.8%). In terms of race and ethnicity, 54.6% reported they were black, followed by whites (35.1%) and Latinos (6.5%). BMSM accounted for 11.8% and LMSM made up 4.3% of respondents. In terms of economic factors, the vast majority reported earning less than $50,000 per year, with 72% reporting that they have health insurance. Most reported that they regularly had enough to eat (56.4%), but a very large majority also reported that they engage in sex exchange (63.7%).

Among those with a recent history of intravenous drug use, avoiding or delaying seeking preventative care was positively and significantly correlated with race/ethnicity ($r=0.63$, $p<.001$), immigration status ($r=0.37$, $p<.001$), HIV status ($r=0.54$, $p<.001$), substance abuse history ($r=0.39$, $p<.001$), sexual and gender identity ($r=0.62$, $p<.001$). Avoiding or delaying accessing primary medical care was also positively and significantly correlated with race/ethnicity ($r=0.62$, $p<.001$), immigration status ($r=0.35$, $p<.001$), HIV status ($r=0.48$, $p<.001$), substance abuse history ($r=0.37$, $p<.001$), sexual and gender identity ($r=0.58$, $p<.001$). The impact of fear of discrimination was stronger for preventative services than for primary medical care. This difference may be due to feeling okay while considering seeking prevention services may facilitate forbearance, whereas they may feel more impetus to seek care when feeling ill or injured.

Focus Group and Key Stakeholder Interviewee Results

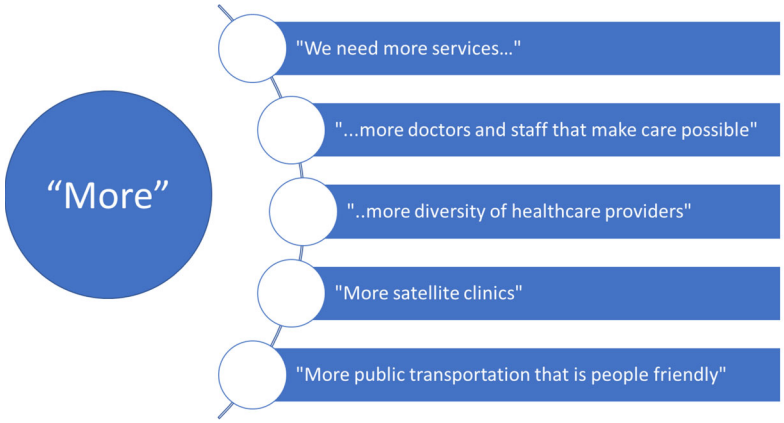
Recruitment for one-on-one interviews and focus groups occurred between January and February 2023, resulting in seven key stakeholder interviews and three focus groups (n=26). The eligibility criteria for both activities were individuals must 1) be aged 18 or older; 2) live and reside in the eleven county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

card incentive. Key Informant Interviewees (KII) each received a $50 gift card incentive. In total, most discussions took between 90 and 120 minutes.

Focus Group and Interviewee Themes and Uncovered Issues

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

Figure 49: Focus Group Theme “More”



The greatest theme to emerge from the data related to how people need ”more” from the Dallas regional HIV service system (Figure 49). The overwhelming consensus was that the Dallas HIV service system should be “doing more” in a wide variety of ways, including not only more services but also new site locations, increased access to care and additional staffing. This result speaks broadly of the need for more providers, more provider locations, and more choice when it comes to care. In particular, there is a need for more services outside of downtown Dallas and better transportation and support to access. There were also comments that it would be preferable for the community so that it more closely resembles the service population demographically.

Figure 50: Focus Group Theme “Lack of Comfort”

The next prominent theme to emerge from the key stakeholder interviews and focus groups was how respondents felt a lack of comfort when they sought care and services in the Dallas region (Figure 50). This “lack of comfort” is highly predictive of poorer outcomes across the HIV Care Continuum[21]. Specific to this assessment, respondents indicated repeatedly that they did not like or trust the repeated screenings by their doctors and other providers. In other words, the necessary and required evaluations for social determinants of health

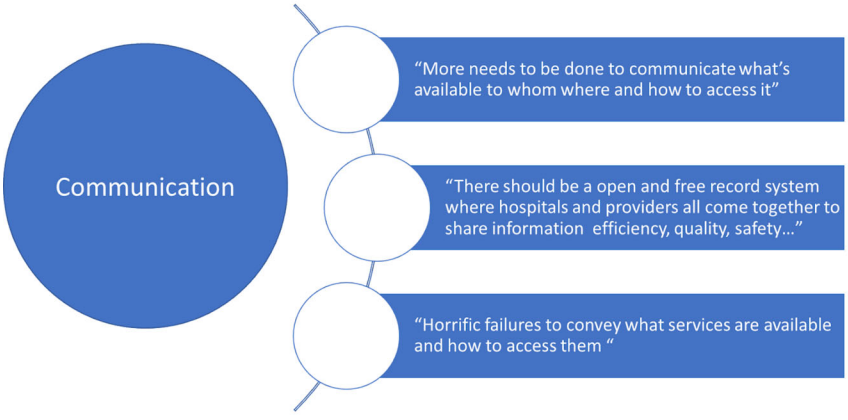
[21] Giordano T. P. (2011). Retention in HIV care: what the clinician needs to know. *Topics in antiviral medicine*, *19*(1), 12–16.

were flagged by clients as problematic. While these screeners are necessary in order to provide good care, most respondents felt their providers were ill equipped to ask these questions and appropriately respond. Some interviewees also noted they felt as if they were meeting check boxes as opposed to receiving individual attention. In order to reach and retain clients, the care setting and environment must be comfortable. Several clients noted feeling "stuck" in unproductive care relationships with their providers and wishing they had alternatives. This is a potential opening for people to fall out of care.

Figure 51: Focus Group Theme "Customer Service"

Many focus group participants and interviewees relayed feeling that there is a lack of well-trained front facing customer service staff within Dallas HIV service system (Figure 51). Importantly, it was also stated by more than one participant that there is a difference in the quality of service and treatment when race and insurance status are factored in. For example, some focus group participants noted that it appeared only well-off white people were offered the newest HCV treatments. Additional feedback, related to respondents working within the HIV service system, was the perception that HIV provider organization staff are opposed to injectable PrEP and HIV treatment for reasons related to client class, risk patterns, and adherence assumptions. Moreover, survey and focus group respondents noted that providers are not routinely educating them and their collaterals on U=U and noted when some clients ask their providers about it, they were told "U=U is not relevant to you". This is not a universal characteristic of all HIV providers or HIV service organizations, but it is concerning that we find this at all within the AA's system of care.

Figure 52: Focus Group Theme "Communication"



Overall, it was identified that there are multiple breakdowns in communication within the Dallas regional HIV service system that affects patient care (Figure 52). This is not limited to direct communication between those living with HIV and their medical and supportive services providers, but also inter-agency communication. Many participants lamented the fact that they often have to re-submit eligibility and other information that should be readily available can be challenging to access. Additionally, there

are thoughts that some information is guarded or withheld from certain patients, this again relates to the U=U, HAART, and HCV cure challenges described above. The perception of withheld information also relates to clients having a very unclear idea of what services are available to whom, where, and when. One client was given a grant to surgically fix their teeth, but another client was told to "let their teeth rot out of their head". Without the right mechanism in place to address challenges early on, we are unable to prevent crisis situations and or needs for urgent and emergent care.

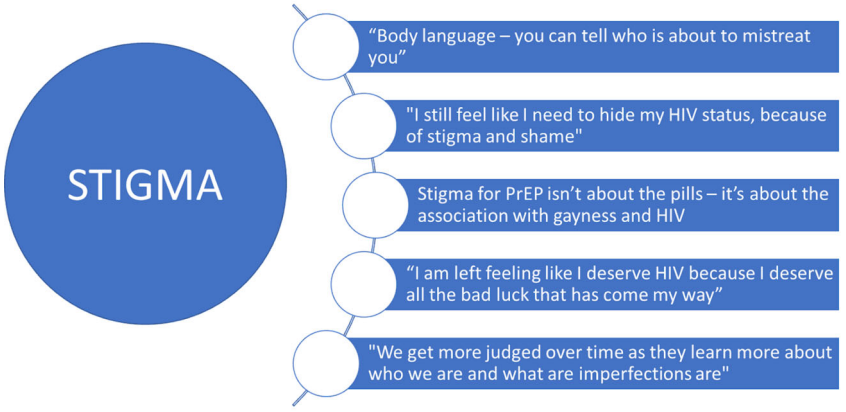
Figure 53: Focus Group Theme "Safety"

Participants were vocal when the concept of personal safety and acceptance was introduced (Figure 53). When considering the current culture-wars climate, many highlighted their concern for themselves and their friends. This was a popular theme identified when we asked participants to state the one thing they wish would change about the Dallas region HIV service system to improve their health and wellbeing. Furthermore, this feeling of lack of safety was especially concerning for transgender population and members of the Hispanic/Latinx immigrant community who currently feel "hunted" in Texas. Gender expansive folks noted being physically attacked on the streets, the murders of their friends they see happening with relative impunity, the psychological violence unleashed on them by the HIV service system, and the sense of constant threat and siege emerging from Austin and featured on television. Texas currently has 23 proposed bills that impact the rights and freedoms of the LGBTQIA+ community[22]. When asked what they do to feel safe, multiple private messages were sent to the focus group facilitators that "I carry a gun in my purse, bra, car and keep one in my bedroom side table and near both my front and back doors". This sense of needing to be heavily armed speaks to this population believing they are "under siege". The Latinx community mostly avoided this assessment. Without the information from interviews, we can only assume that there was hesitancy to engage with any type of authority group including the medical system because there is a legitimate fear that they will be put on a bus and sent thousands of miles away from their families[23].

Throughout each focus group and in most KII, the theme of weaponized HIV stigma was prominent (Figure 54). Experiences of both internalized stigma and institutional stigma were discussed and spoke to the lack of visibility, attention, and focus on advancing an end to the HIV epidemic based on state-of-the-art HIV

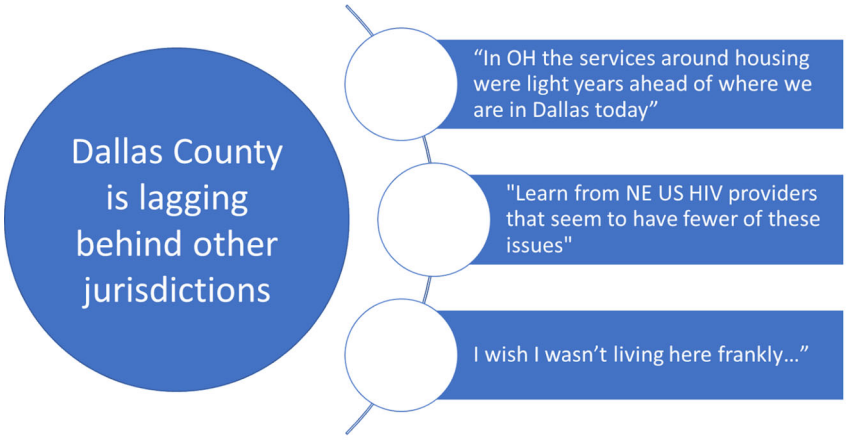
[22] American Civil Liberties Union. (2023, March 10). Mapping Attacks on LGBTQ Rights in U.S. State Legislatures. Retrieved March 11, 2023, from https://www.aclu.org/legislative-attacks-on-lgbtq-rights
[23] Neukam, S. (2022, September 16). GOP governors bus migrants to Kamala Harris' home and Martha's Vineyard. The Texas Tribune. https://www.texastribune.org/2022/09/15/greg-abbott-texas-kamala-harris-migrant-bus/

Figure 54: Focus Group Theme "Stigma"



science. During the focus groups, the theme of 'pity' from professional health care staff emerged. Respondents noted being pitied when discussing issues of HIV risk and broader risks; the sense that "the more they get to know me, the more they pity me and my life" emerged strongly among black gay men. For black people of all backgrounds, there was a sense that the provider "only wanted me to answer their Yes/No questions" and not provide any additional context; some participants noted being rudely cut off when they try to add context. Among gender expansive people, respondents noted that their providers do not pity them as much as fear them. Participants noted the words used by staff, their body language and tone of voice, the relative patience or impatience that is shown to one group versus another, observed differences in treatment options provided to one group versus another, and a sense that only surface level interactions all lead into the theme of stigma.

Figure 55: Focus Group Theme "Dallas County Lagging"



The final theme to emerge focused on a comparison of the Dallas region HIV service system and what is done is other locations around the United States (Figure 55). Numerous respondents shared their experiences with programs in other places and how they wish the Dallas region could adopt the methods of other jurisdictions, believing that these changes would be a great addition to the care provided. Respondents were most aware and focused on the HIV service systems in place in the northeastern US and parts of the industrial Midwest.. The purpose for RAI's inclusion of this theme in the results is to demonstrate how all the other themes come together within people to produce a sense of wanting to create lasting change alongside concerns that relocating may be the best way to have their health care needs met.

Overall Results Across SNNA Components

Among the Street Homeless population, the majority of interactions were with men ages 45 and older. Feedback from our community liaisons notes many were curious about what PrEP was as they were unfamiliar with the concept. However, when HIV was mentioned, responses included

that “OH! I don't have that. I don't have THAT!!" as if in reaction to an accusation. For unstably housed men under 35, there was a greater awareness of PrEP, PEP, and U=U than was seen with older men. For unstably housed women, they said they had never heard of PEP and they were all excited to hear about an “HIV morning after pill” and surprised that such therapy existed.

Among individuals reached at community-based centers, a majority of the engagements occurred with unstably housed people living with HIV who were participants in the "hot meals program". Per the community liaison, it was a challenge interacting with this cohort, as they seemed reticent, saying only the minimum required to qualify for the incentive. Where possible, they avoided providing open-ended responses. Respondents at these ASOs were accustomed to these types of assessments and there was no surprise at the questions or their intent. Clients explained "They do surveys all the time here and this just feels like business as usual for me when I’m here at [agency]”.

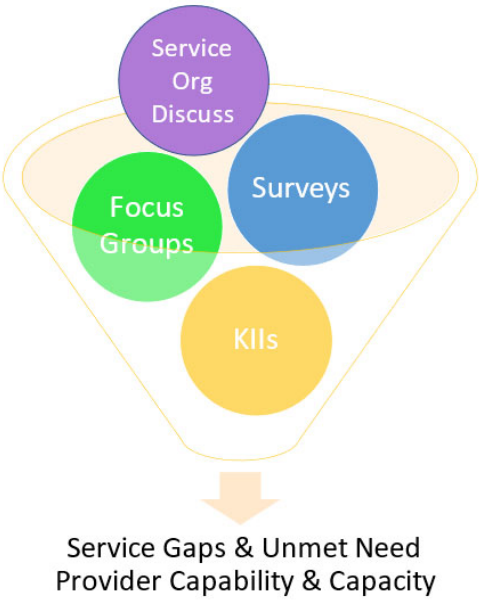
Among individuals engaged at a residential housing program that serves individuals living with HIV and dually diagnosed with severe mental illness per the housing criteria, individuals in this demonstrated a very low literacy level, but the majority knew about PrEP, PEP, and U=U. Correspondingly, among individuals engaged at another housing program, the majority were older adults also with low literacy levels. Within this older cohort, residents had zero knowledge of HIV science, PrEP, PEP, or U=U. In this setting, residents are predominantly white females who are generally considered low risk, though their presence in the housing program indicates they likely have a higher risk level than is assumed by the broader system.

There were also two main cohorts reached through the Dallas County Public Library system. The majority were unstably housed individuals who had a history of justice involvement. They had very limited knowledge on PrEP, PEP, or U=U. The smaller group was composed of individuals participating in a long-standing Gilead support group for people with HIV and were accustomed to discussing issues related to HIV and HIV risk. There was an average level of knowledge of HIV science, U=U, PrEP, and PEP in this group.

No matter where those who are unstably housed were engaged, all were pleased to receive a physical gift card as opposed to the gift card for online shopping. This was a meaningful nuance as those who are unstably housed may not be able to use an online gift card which requires a shipping address. When our outreach team was working with various unstably housed populations, they were observed as being open to sharing their experiences collectively, completing the survey in a group setting, and providing immediate support to each other when the need arose.

Findings

Figure 56: Synthesis of Results into Findings



From the surveys, focus groups, and key informant interviews, the RAI team has identified groupings of key findings by service category and unmet need which will be further elaborated upon in the Discussion and Recommendations section (Figure 56). Findings to populations that were not surveyed were not estimated using probability sampling. RAI did not apply findings to populations only minimally represented in the needs assessment process. It is recommended that future assessments engage these populations directly to gain their input and feedback. Across the key populations we found similar themes including the impact of stigma, a dearth of services and service providers, frequent discrimination and intolerance, a frustration due to lack of representation, and an uncoordinated system of care outside of the RWHAP system of care. This is particularly true of those accessing prevention services noting that there are services available to the HIV community of which they cannot avail themselves such as housing support, medical care, food and nutrition, and transportation services. When asked the "Magic Wand" question, individuals from both the focus group and the key informant interviews emphasized looking beyond what can happen through DCHHS alone and to look more broadly on potential public/private partnerships such as the role of pharmacies in providing prevention services. These partnerships can not only strengthen the system of care, it can also invigorate the community. It is recommended that DCHHS and RAI continue to leverage this data source for additional results and to develop additional findings and recommendations.

Resource Inventory

Resource Inventories are essential HIV service system tools used at different levels for multiple reasons. Government officials may use resource inventories to identify opportunities to strengthen the service safety net through funding or service redefinition. The community may use resource inventories to navigate care systems. Provider organizations may use resource inventories to expand their referral networks and other relationships in the field. In Attachment A, a "meatball chart" tool is used to identify funding for different services at specific organizations and sites. The tool identifies geographic service gaps and provides opportunities for a variety of stakeholders to engage in health system strengthening activities. A primary goal of resource inventories is to deconstruct silos and better operationalize the safety net.

The Resource Inventory must be a living breathing document as organizational funding and contacts can change multiple times throughout the year. Community, provider organizations, and public health all have needs that are met by an easy-to-use resource inventory. This is especially relevant in this post- COVID-19 pandemic era where many organizations have been required to shift their focus, change staffing patterns, and modify programs. This has made

some traditional service providers less available to meet the needs of those living with or at risk for HIV infection. It is incumbent that underutilized agencies and nontraditional service providers are identified to support EHE efforts in alignment with local and national best practices. The survey RAI develops will be simple enough to administer annually thereby maintaining an updated meatball chart to be used as a communication and planning tool by DCHHS. The Meatball chart further identifies our regional stakeholder groups, funded partners, non-network providers, and business groups and associations.

Profile of Provider Capacity and Capability

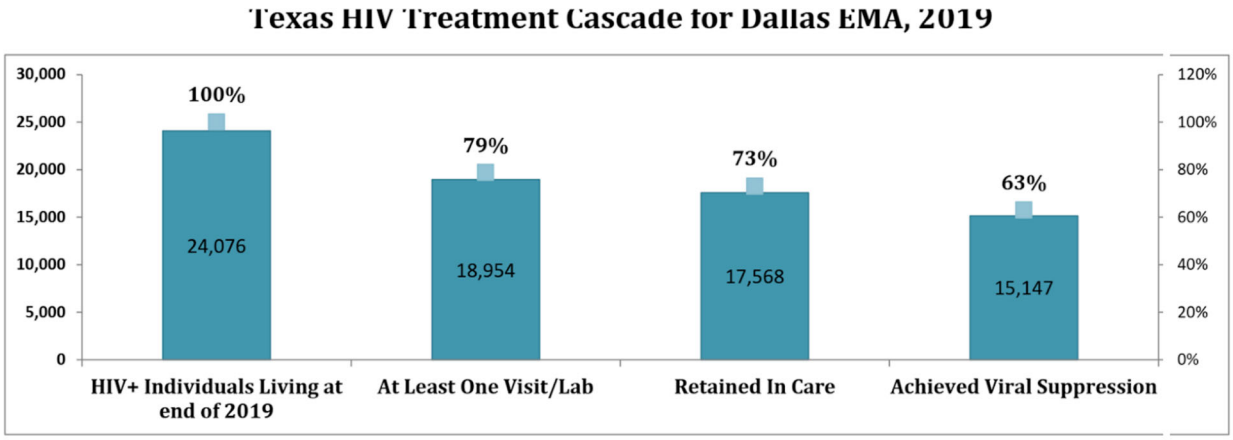
The Profile of Provider Capacity and Capability is drawn from the Resource Inventory. By culling together the most relevant services to the geographies and populations within the catchment area, we can ascertain how well the system is currently calibrated to meet the actual needs in the field. Beyond affirming that resources are present, the profile of provider capacity and capability lends itself to specificity in measuring the appropriateness of those resources specific to the community's real needs. Nature and quality of services speaks to the geography, cultural and linguistic competency/justice, patient/client choice, transportation burden, access to payers, and expected wait times. In addition, ease of system navigation, referral and linkage follow-up, eligibility determination and documentation are all structural barriers that limit people's engagement in healthcare.

In reviewing data from the surveys, focus groups, and key stakeholder interviews, various gaps in provider capacity and capability were noted. While respondents noted a strong passion basis within the majority of provider organizations, it was also noted that there is also a great deal of stigma, discrimination, and misinformation. In the focus groups and KIIs, adverse events happened across levels of leadership in organizations. It is essential to note that individuals who have been living with HIV the longest have the most favorable opinions and feedback related to provider capacity and capability. For example, those newer to HIV care will express dissatisfaction with wait times of more than a month, but for more experienced people, they are pleased the wait times have decreased to that level from more than a year previously. Another example has to do with the attitudes of staff and their perceived degree of helpfulness. Respondents newer to HIV care expressed confusion from unclear communication and conflicting messaging coming from within and across organizations. Those who are more experienced state that the level of system organization has vastly improved over the last 10 years and improvements have accelerated in the last 5 years.

Of note, one area identified as decreasing over time for those longer in care was the passion of the providers serving the HIV community and the difference in personalized services. Long term survivors remember a time when providers went out of their way to give hugs and dole out free meals and other community initiatives in the 1980s and early 90s. Long term survivors in the focus groups perceived that the introduction of the Ryan White Care Act influenced clinical care by watering down this personal connection as service providers entered the field for reasons other than a shared connection or passion.

One final area of provider capability and capacity noted was the time lag of sharing knowledge about the most cutting-edge medicine and practices such as U=U. It was apparent that some providers are denying that U=U is credible science and it is not being promoted universally with those reached across the three research modalities. There was also significant feedback in respondents identifying discriminatory experiences based on race and perceived financial status when making key treatment decisions. These are important gaps to immediately address using the full range of resources within the jurisdiction's disposal.

Figure 57: Texas HIV Treatment Cascade 2019



Assessment of Service Gaps/Unmet Need

Available data suggest that there is a significant level of unmet need in the Dallas AA region. The 2019 Texas treatment cascade for Dallas states that 5,122 people with HIV (21% of total) are out of care (eHARS data) as defined by not having a lab visit in the service year[24] (Figure 57). One factor that may compound this is the large percentage of Texans who do not have health insurance. According to AIDSVu, the percent of the population lacking health insurance in 2019 averages to roughly 20% of the public in the Dallas AA region. This translates to approximately 1.1 million people in the region who lack health insurance according to 2020 census data and UDS data. This is the minimum of the true range of uninsured people[25]. While people with insurance may or may not be reliably engaged in ongoing primary care, people without insurance face a higher burden of not being engaged in primary care due to cost factors[26]. Without expanded Medicaid, many people living with and at risk for HIV infection also risk not having access to affordable health insurance. According to CDC(2021a) methodology, it is expected that roughly 3,400 people are living with HIV in the Dallas AA region, but are

[24] Dallas County Health and Human Services [DCHSS]. (n.d.). Texas HIV Treatment Cascade for Dallas EMA, 2019. HIV Early Intervention Services -. Retrieved March 11, 2023, from https://www.dallascounty.org/Assets/uploads/docs/rwpc/2019_Dallas_EMA_Cascade.pdf

[25] (n.d.). *Quick Facts Texas*. United States Census Bureau. https://www.census.gov/quickfacts/TX

[26] Rakshit, S. et al (2023, January 30). *How does cost affect access to healthcare?* Peterson - FKK Health System Tracker.

unaware of their diagnosis[27]. Without insurance or knowledge of free HIV testing services, individuals may forgo routine or risk-based testing. Uninsured individuals, particularly those at higher vulnerability for HIV, may find PEP and PrEP largely out of reach due to the number of medical appointments and monitoring lab work required for PrEP care. Even if individuals can access the medicine itself for free, they may not be able to afford the cost of visits or expensive lab testing. Working adults without health insurance may also have barriers in requesting time off of work for quarterly monitoring visits. Overall, Dallas County has a very low PrEP to Need Ratio (PNR) indicating significant unmet need. While the underutilization of PrEP and limited PrEP accessibility is a challenge nationwide, both Dallas and Texas fall below the national average[28].

Of additional concern is the dearth of mental health and substance use services. From our survey results, nearly 35% of respondents identified a risk factor of injection drug use, with 61% of those reporting that they shared injection equipment with someone of unknown HIV status. In states with legal syringe exchange programs, the rate of transmission is under 3%. In Texas, the rate of acquisition of HIV amongst People Who Inject Drugs (PWID) is 16.3% for women and 3.2% of men. However, when we include those with a dual risk factor of male to male sexual contact and injection drug use, the cumulative rate is over 10%. This is a real area of opportunity to make a substantial impact in the reduction of transmission amongst PWID. While there is a federal funding ban on the purchase of syringes, federal funding can and must be used to provide harm reduction services to PWID. Harm reduction programs are evidenced based with documented improved outcomes over abstinence-based service delivery in linking people to ongoing substance use treatment, to reduced susceptibility to HIV infection, and to achieving sobriety[29].[3031] Nationwide, 40-60% of those who attempt to stop problematic drug use will have at least one relapse in their recovery process; systems must be in place so that those who use substances are not lost to care[32]. Services must be available and provided in a way that is non-punitive, separate from the carceral system, bias and stigma free, and compassionate using evidenced based medical treatment models. Without substance use services, the Dallas catchment area could easily find themselves in the position of large-scale

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[27] Centers for Disease Control and Prevention. (2021). Estimated HIV incidence and prevalence in the United States, 2015–2019. HIV Surveillance Supplemental Report 2021;26(No. 1). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed February 12, 2023

[28] AIDSVu (2023). *Local Data: Dallas County, TX*. https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/#Percent%20of%20adults%20(age%201

[29] ACP. (2017) Health and public policy to facilitate effective prevention and treatment of substance use disorders involving illicit and prescription drugs: An American College of Physicians Position Paper. *Ann Intern Med.* 166 (10), 733-736 DOI: 10.7326/M16-2953

[30] Stancliff S, Phillips BW, Maghsoudi N, Joseph H (2015) Harm reduction: front line public health. *Journal of Addictive Diseases* 34:2-3:206-219

[31] Vearrier, L. (2019). The value of harm reduction for injection drug use: A clinical and public health ethics analysis. Disease-a-Month, 65(5), 119-141.

[32] NIDA. 2023, March 9. Treatment and Recovery. Retrieved from https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery on 2023, March 13

HIV outbreaks such as Scott County, Indiana encountered in 2015 or Kanawha County, West Virginia in 2019[33],[34].

Silos between mental health and substance use treatment also result in a dearth of services as many individuals require both for co-occurring disorders. Here again, we see the problem of "wrong doors" in which patients with substance use issues may be turned away from programs that solely focus on mental health services or vice versa[35]. Mental Health America, in 2022, ranked Texas as lowest in the nation for access to mental health services (51 out of 51 including Washington DC)[36]. Within our findings, 21% of those living with a mental health diagnosis reported insurance as a barrier to accessing mental health treatment and 73% of youth reporting an inability to get treatment despite a willingness to engage in mental health treatment. As noted above, over 70% of survey participants responded affirmatively to experiencing negative mental health symptoms including excessive worrying, nightmares, anxiety ,or feeling down, depressed, and hopeless. 28% identified barriers to engagement with the primary causes being cost and a lack of knowledge of how to engage in the mental health system. People who are struggling and cannot access help are known to have poorer health outcomes and may also be at a higher likelihood of drug and alcohol misuse.

Discussion and Recommendations

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

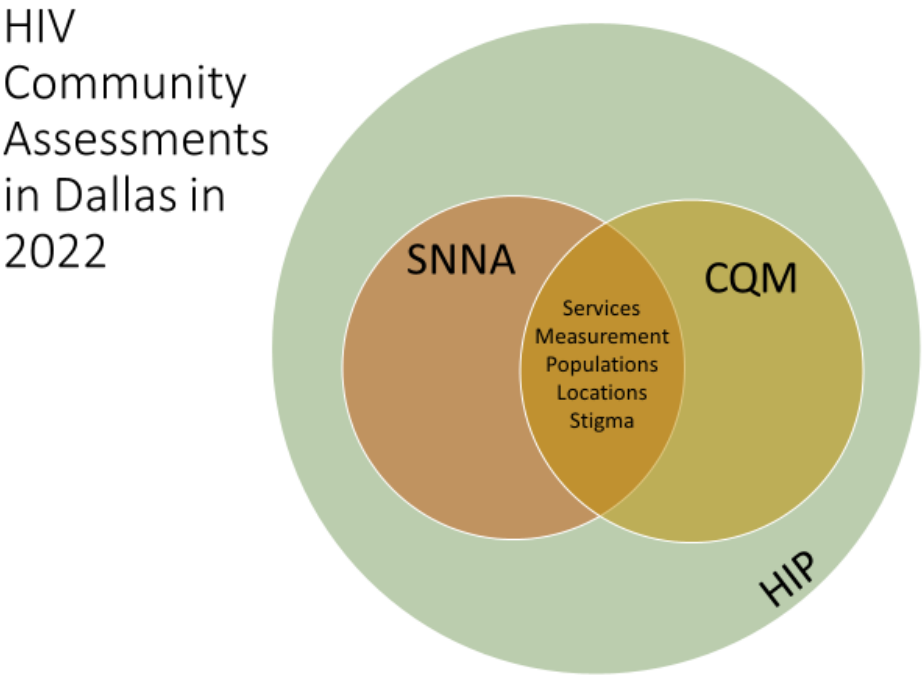
[33]Center for Disease Control (2021, August 3). *Final CDC Recommendations on Kanawha County HIV Outbreak Presented*. West Virginia Department of Health & Human Resources. https://dhhr.wv.gov/News/2021/Pages/Final-CDC-Recommendations-on-Kanawha-County-HIV-Outbreak-Presented-.aspx

[34] Gonsalves GS, Crawford FW. Dynamics of the HIV outbreak and response in Scott County, IN, USA, 2011-15: a modeling study. Lancet HIV. 2018 Oct;5(10):e569-e577. doi: 10.1016/S2352-3018(18)30176-0. Epub 2018 Sep 13. PMID: 30220531; PMCID: PMC6192548.

[35] SAMHSA (2022, September 27). *Co-Occurring Disorders: Diagnoses and Integrated Treatments*. https://www.samhsa.gov/co-occurring-disorders

[36] Mental Health America (2023). Ranking the States 2022 https://mhanational.org/issues/2022/ranking-states

Figure 58: HIV Community Assessments Framework



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

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

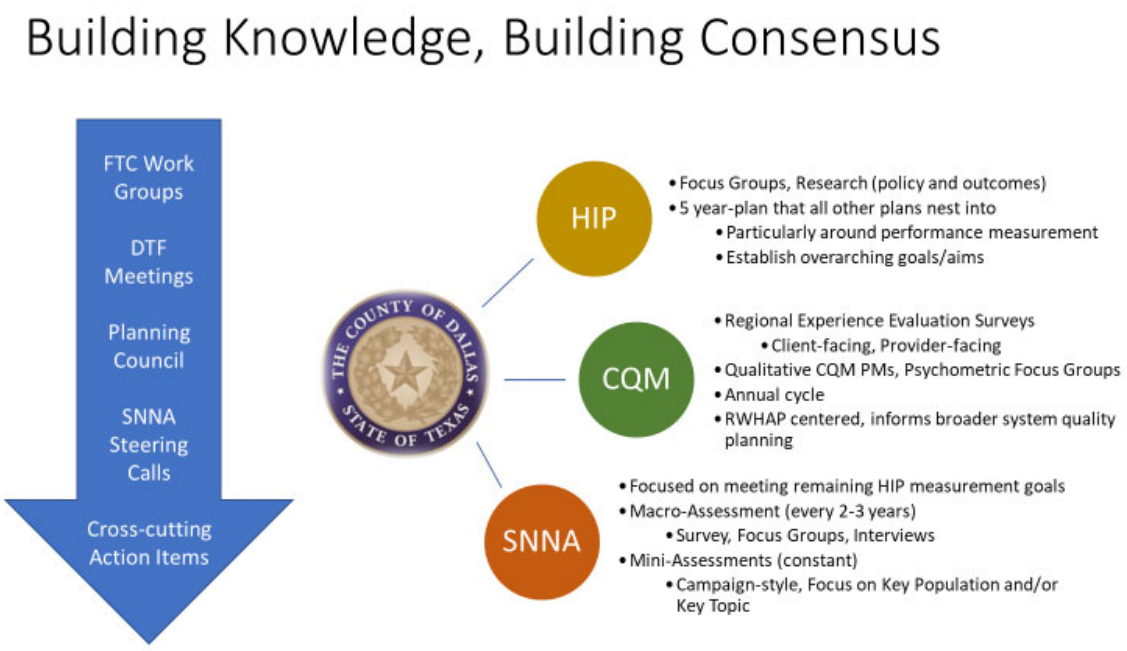
Recommendation 1: Health System Strengthening

RAI's first recommendation is to rethink the interaction of systems with the HIV prevention and treatment landscape. For DCHHS, this means recalibrating the HIV planning and evaluation mechanisms to ensure that each component adds specific value to the overall vision and mission. For example, the 2022 assessment activities in Figure 58 can be blended with the Resource Inventory to create a new model to build information and consensus in HIV planning. In the following diagram, each required aspect of HIV service system planning blends with existing mechanisms for service planning and evaluation. The mechanisms for service planning and evaluation include the Dallas Fast Track Counties (FTC) Work Groups, the Dallas EHE Task Force (DTF) Meetings, and the Dallas Planning Council. Our first recommendation is that DCHHS develop a new internal planning group for status neutral needs assessment steering

design to direct constant cycles of mini-assessments for key populations and to assist in planning the less frequent macro-assessments. In this model, the HIP retains its central importance and is updated every 5 years based on all available data, mini-assessments will allow for a more rapid cycle of potential research and change related to key HIP performance measures that have not been gleaned from other activities. Authority and decision-making flows from the group of broadest scope and stakeholder expertise down to the narrowest. RAI proposes shared action items across all funded initiatives to ensure that HIP goals and performance measurement mandates are met (Figure 59).

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

Figure 59: Framework to Reorganize Information Flow and Advisory Bodies



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

- A series of listening sessions for the results of the Needs Assessment and Integrated Plan should be organized to target key geographies and populations. This should

include opportunities for increased participation by providers and pharmacists in the Ryan White Planning Council.

- The Planning Council, and particularly the Needs Assessment Committee, should develop a workplan from the recently conducted HIP and SNNA to maintain momentum by those who have participated thus far to bring in newly motivated constituents and partners.
- The AA may also consider the need to create a synthesis of patient satisfaction or stigma surveys at the system level and across funded organizations. Within this, it is important to have both an ongoing method to assess these challenges at a system level and to immediate solutions to deploy to address adverse findings. This suite of activities should be enforced within the contractual obligations of all funded requests for proposals (RFPs). In particular, system-sponsored training, workshops, and other capacity building can be required and enforced.
- An additional systems approach is to hold networking sessions in which employees from various agencies have the opportunity to develop personal connections through in person or virtual drop-in sessions and for ASO leadership to identify where there are existing struggles to bridge systems of care.
- Building public-private partnerships can also be strengthened by webinars and educational services to nontraditional partners such as school nurses, college health centers, and employee assistance programs.
- There is an array of best practices available that can be shared with DCHHS and other HIV system stakeholders using timely and effective methods of skill-building.
- Our recommended intervention to address the needs of the newly diagnosed, is to create a safety net system for direct intervention. A centralized linkage source that could be a phone hotline, a website messenger function, a funded peer position, or creation of a new staff role to provide a soft landing to those experiencing uncertainty around their new diagnosis.

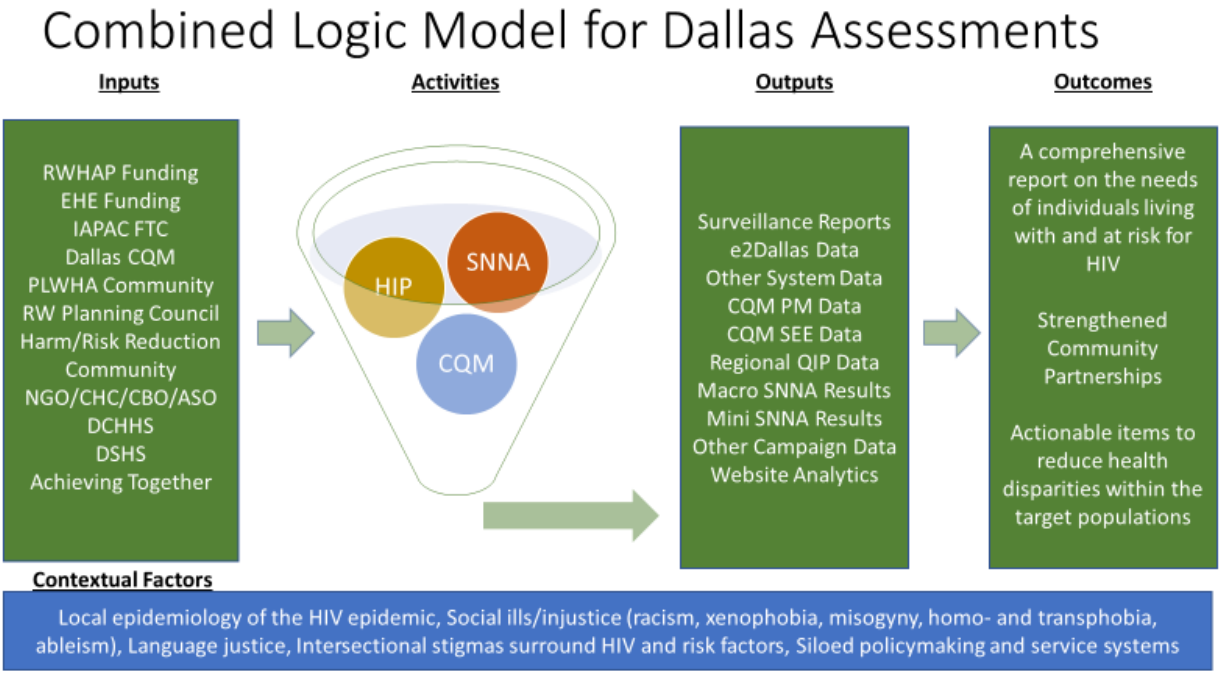
When thinking of infrastructure changes, it is essential to leverage online approaches that simplify communication and encourage buy-in, especially following the COVID-19 pandemic and M-Pox outbreak. From a Health System Strengthening standpoint this means increasing the number of high-quality websites,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

- An important element is to create a central repository for information sharing across care providers. The Dallas EMA and HSDAs should work toward establishing an electronic health exchange (eHX) or Regional Health Information Organization (RHIO) to champion the care of all people everywhere in the region. The ability to have shared information and the need to not repeat personal histories came up repeatedly in RAI's engagement

with respondents related to the HIV service system. It would greatly improve the lives of all people living in the region regardless of HIV status. Such a system would also improve the ability of regional care providers to provide high quality care to all people.

- Another important element is cross promotion of organizations and parties included in the Resource Inventory. Information can be widely shared through routine website maintenance. Ideally, websites should be updated and able to cross reference each other as the newest information becomes available. These may be web pages dedicated to sharing system information and campaigns, CQM program webpages, the FTC dashboard, or the Dallas Planning Council website.
- Within these recommendations is in data collection and data transparency to support Ending the HIV Epidemic. Data transparency builds buy-in and creates accountability at the systems level. This includes increased reporting as to how 340b dollars are being reinvested into the service system and in assuring that service category components are being fully delivered. Within this recommendation, RAI acknowledges that there are no federal reporting matrices or national quality standards for prevention programs akin to the Ryan White Services report. It is our recommendation that DCHHS be drivers in acquiring and collecting this type of information in conjunction with funded programs providing prevention services. Working outside of the funded system to create a more unified system of care under DCHHS leadership would make the Dallas region one of the foremost in the nation in terms of EHE planning and evaluation activities. Figure 60 shows how multiple assessments and activities blend together in a combined logic model.

Figure 60: Combined Logic Model Across Assessments



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

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

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

Recommendation 3: Cultural Humility Training for ALL

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

- Information from the listening sessions described in recommendations above should be used to develop these trainings in conjunction with synthesized data from the SNNA and CQM efforts
- People living with HIV and those seeking preventive care should be educated and empowered to demand culturally affirming, high quality, respectful medical care and pharmacy services. Health care systems and ASOs should deliver the same messaging

without question or expectation of additional funding. The public is an important enforcer and informer on these topics.

- Beyond the funded network of RWHAP organizations, DCHHS might consider including an open door policy where non funded groups can RSVP to attend meetings and trainings. Combining segments of the non-RWHAP community with the current systems of care can also accompany specific public health campaigns related to these recommendations.
- DCHHS can work with external partners to create combined training initiatives that allow for blended funding and objectives that meet the broader needs of the HIV prevention and treatment community and not just focus on the narrower needs of any given funding stream.
- There is an extraordinary array of HIV-focused and broader focused resources intended to address cultural humility and HIV stigma. The creation of specific content can be done on a collaborative basis. Existing training resources should be used first and new training only created when absolutely necessary.
- All such trainings for HIV prevention and treatment provider organizations and their staff should made part of contract requirements and part of monitoring and evaluation. Where possible, DCHHS should advocate for its partners to follow suit to increase the mandate for cultural humility across the local medical field (i.e., helping change processes for business licensure, medical licensure, Medicaid participation, and other requirements to ensure that folks participate in this type of training).

Recommendation 4: Biomedical Intervention Training for ALL

The SNNA uncovered the need for ongoing required training on biomedical interventions. It is simply unacceptable in 2023 to have providers at RWHAP funded agencies relaying to their clients that U=U is irrelevant to them. It is unacceptable for people to be denied HCV cures, injectable PrEP, and other recent advancements in HIV science due to provider or organizational level bias. While we acknowledge many recent advancements are counter to traditional HIV prevention messaging and may require extensive follow up to educate patients, it is incumbent on us to always persevere in promoting the newest science and evolving practices.

- Similar to the strategies for recommendation 3, DCHHS should consider the full range of potential speakers and subject matter experts on this topic.
- DCHHS should consider making participation in such training compulsory for all staff and for staff at all funded organizations.
- DCHHS should consider remediation training to refresh service provider staff on current HIV science if made aware that specific provider agencies are not sharing advances in the field and using outdated information and practices. This may include the development of a central DCHHS-managed grievance process that includes a timeline for expected acknowledgement and response of grievances.
- DCHHS should consider working broadly with partners to deliver these training and mandates so that the needs of narrow funding stream requirements do not distract from the broader picture and need of the local HIV community.

- Consider the creation of a Conference or Summit providing CEUs to clinical staff (MD, RN/LPNs, Social Workers) to widely share the recommendations and work plan developed by the Planning Council. This will also be an opportunity for developing a central network to attract new talent to work towards Ending the HIV Epidemic

Recommendation 5: The HIV Community As a Human Resource

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

- One best practice is to provide formal training for consumers to become peer community health workers of which there are many models in funded EHE jurisdictions. One example is the New York State Certified Peer Training program which provides free training opportunities for those living with or at risk of HIV to specialize as community health workers in harm reduction, HCV navigation, or HIV navigation. The curriculum includes didactic learning as well as an internship component. Peer training can be done using internal county resources or through external resources. Some jurisdictions in the US have worked with community colleges to create free or low-cost certification programs that honor the investment made by the community in their own education and advancement.
- Involving consumers also provides opportunities for informal peer leadership. For example, when RAI outreach staff was conducting the survey with participants, one community liaison outreach worker noticed that almost no one knew about PrEP, PEP, and U=U. Our staff took the initiative to provide education at the completion of the survey on these topics resulting in nearly 200 training sessions. Our clients, patients, and consumers are the 'subject matter experts' on what is needed and wanted for prevention and treatment services. By increasing peer training we empower our peers to be community leaders and agents of change in their own systems of care.
- There are many training programs available through the HRSA website, as well as mentoring opportunities through the EHE jurisdictions, technical assistance requests from the HRSA project officer, and private-public partnerships. DCHHS can also learn directly from RAI subject matter experts but conducting specific outreach and conducting listening sessions for particularly vulnerable populations include the TGNC/NB communities, those accessing harm reduction services for substance use, and those for whom English is their second language.
- Listening sessions should be co-led by community leaders and a trained focus group facilitator for the highest level of buy-in. Any time where we can hire the community, we should hire the community. Critical to healthcare self-management (for both HIV care and those at higher vulnerability to HIV infection), individuals need to have a sense of where and how to look for information and supportive care. They need to be confident enough to insist on getting their needs met. They need to be offered services in a linguistic and cultural framework that meets their needs and expectations. They need to

be comfortable that when accessing funded services, they will not be stuck with large bills or be reported to creditors.

- Listening sessions should also be conducted for providers and funded staff to encourage buy-in and accountability. With multiple competing priorities and deliverables, it would be helpful for those receiving RWHAP dollars to align themselves with DCHHS priorities.

Additional Discussion On Establishing and Maintaining Vital Services for Everyone

The changes recommended above will take time. These recommendations may be taken as a whole or in part as best serves to the AA. Within all of these recommendations we once again return to the need to acknowledge the ever changing political, social, and healthcare landscape within which these changes will take place.

From the need to create content, build trust, or work in a system that has been indelibly changed by COVID-19 and Mpox, there are many moving pieces. The past three years have taken a toll on all local public health systems with individuals leaving the profession and expressing high levels of burnout. Infectious disease providers and clinical staff were redirected to COVID-19 response activities from their roles in HIV prevention and treatment. Nonprofits closed or reduced activities and this could be seen through the decrease in HIV testing and diagnosis. There were also novel approaches that grew from these syndemics such as a move to telehealth which removed transportation barriers and improved access for rural communities. There were innovative practices such as mail in HIV testing kits. At this stage, it's important to reflect back on success and challenges from these novel and trying times. It is highly recommended that DCHHS consider revising its Continuity of Operations Plan (COOP) based on these findings and that the COOP process be revisited every 3-5 years in cycle with integrated planning and/or macro-assessments.

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

Finally, administrative mechanisms must be streamlined. All major funding partners in the region are in need of this process improvement, whether its issuance of funding proposals, funding decisions, paying invoices, and administrative and operational delays which decrease system credibility. Worse yet, service delivery can be impacted when there are delays in

reimbursement. In order to be a good partner, the HIV service system funders need to be timely and responsive to community needs and efforts.

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Attachment A: Dallas HIV Services adn Funding Meatball Chart

AA Funded Agencies		CORE MEDICAL SERVICES										SUPPORT SERVICES											PREVENTION SERVICES							
Name	Type	APA/LPAP	EIS	HIPCS/HIA	MedTrans	MCM	MNT	MH	OAHS	Oral	SU	EFA	FB/HDM	HS	HERR	Ling	nMCM	OPS	Outreach	Referral	Respite	Support	ON-Test	MOB-Test	Coll-Test	OptOut	PrEP	STD Test	Condoms	U=U
ASD	CBO/ASO				★◊	★◊							★◊	★◊			★◊			★◊										
LCC	CBO/ASO							★			★		★◊	★◊			★◊			★◊										
LHT	CBO/ASO																	★◊		★◊										
SBPAN	CBO/ASO																													
DCHHS	County HD																						⅄					⅄		
AHF*	FQHC/CHC	★◊			★◊	★◊			★◊				★◊			★	★◊			★◊	★		⅄	⅄			⅄	⅄		
APWC	FQHC/CHC																						⅄				⅄	⅄		
CC	FQHC/CHC	◊	◊	◊	◊ʘ	◊ʘ	◊		◊ʘ				◊		◊		◊ʘ		◊ʘ	◊			⅄	⅄			⅄	⅄		
CHEDC	FQHC/CHC																						⅄				⅄	⅄		
HSNT	FQHC/CHC	★◊		★◊	★◊	★◊		★	★◊											★◊			⅄				⅄	⅄		
PHNT^	FQHC/CHC	★◊		★◊		★◊		★	★◊	★◊					★		★◊			★◊			⅄				⅄	⅄		
RCD	FQHC/CHC			★◊					★◊	★◊			★◊				★◊			★◊			⅄				⅄	⅄		
PHSD	Hospital	★◊	ǂ		◊	★◊ǂʘ		★	★◊ǂʘ		★						★◊ǂʘ		★ǂ	★◊		ǂʘ	⅄			⅄	⅄	⅄		

NOT AA Funded		CORE MEDICAL SERVICES										SUPPORT SERVICES											PREVENTION SERVICES							
Name	Type	APA/LPAP	EIS	HIPCS/HIA	MedTrans	MCM	MNT	MH	OAHS	Oral	SU	EFA	FB/HDM	HS	HERR	Ling	nMCM	OPS	Outreach	Referral	Respite	Support	ON-Test	MOB-Test	Coll-Test	OptOut	PrEP	STD Test	Condoms	U=U
NTIDC	CBO/ASO																						⅄							
RCHH	CBO/ASO																						⅄							
THA	CBO/ASO																						⅄							
CCHCS	County HD																						⅄							
DCHD	County HD																						⅄							
GCHD	County HD																						⅄							
NCHD	County HD																						⅄							
CV	FQHC/CHC																						⅄							
FFHC	FQHC/CHC																						⅄							
LBUCC	FQHC/CHC																						⅄							
MDMGCMD	FQHC/CHC																						⅄							
MEDMC	FQHC/CHC																						⅄							
PPGTND	FQHC/CHC																						⅄							
SWFM	FQHC/CHC																						⅄							
TPUC	FQHC/CHC																						⅄							
UCT	FQHC/CHC																						⅄							
UITCT	FQHC/CHC																						⅄							
UPG	FQHC/CHC																						⅄							
VCARE	FQHC/CHC																						⅄							
W2WHC	FQHC/CHC																						⅄							
BMC	Hospital																						⅄							
MPMC	Hospital																						⅄							
NMC	Hospital																						⅄							
UTSW	Hospital																						⅄							
CVS MC	Pharmacy																						⅄							
SCRIPX	Pharmacy																						⅄							
TINRX	Pharmacy																						⅄							

* AHF and AIN administratively merged in 2020, but are maintaining separate brand identities

^ PHNT acquired Community Dental in May 2022 and have successfully merged programs

BH stopped being a subrecipient organization in summer 2022

★ **RWHAP Part A Funded Service or other DCHHS funding support**

◊ **RWHAP Part B Funded Service or other DSHS funding support**

ǂ **RWHAP Part C Funded Service**

ʘ **RWHAP Part D Funded Service**

⅄ **Prevention Funded Service**

Attachment B: Uniform Questions for Non-RWHAP Service Providers

- What are some ways that your organization would like to collaborate with organizations that received RWHAP funding?
- What are some priority issues you would like to see addressed for the living with or at risk for HIV acquisition?
- Who is missing from the table? Where do we lack representation?
- What is your number one priority for EHE work?
- How do you see your role in EHE for the Dallas region?
- What is something that I didn't ask you today that I should have? What else would you like to share?

Attachment C: List of Outreach Agencies

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

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Interview Guide

We are going to spend some time talking about experiences that you face in and around Dallas County. We'll start by talking about experiences you have faced in regards to seeking healthcare and social services and branch off from there.

FACILITATOR NOTE: State that this is a sex positive/ no judgment zone. Adhering to "Vegas rules" and will only be used to guide future plans for folks . You want candid and honest answers.

- Can anyone here tell me about a good/amazing experience about getting care(list examples…finding a provider, getting to the appointment, getting meds, etc) in Dallas County? (get #/total)
    - Tell me about it. What made it so good, be as specific/detailed as you want.
    - Now, what could have made that experience even better…aka what would take that 10/10 to a 15/10?
- Can anyone tell me about a poor/bad experience they have received in Dallas County? (Get #/total)
    - Tell Me about it? What made it so bad be as specific/detailed as you want.
    - Now, what could have made that experience better…aka what would take that 1/10 to a 5/10?

FACILITATOR NOTE: State "I want everyone to take the next 2 minutes to imagine that you were given a magic wand that could get around politics, and produced endless money and energy." Then proceed with the questions below.

- What changes would you make to our system?
- What policies/requirements (paperwork, limits on benefits, etc) would you change?
- What services would you want to see and where would you want to see them in place?

FACILITATOR NOTE: Attempt to get the "stories" of how care was sought after and accessed. Push them to "tell their narrative" Details and themes are good to try and get here.

- Have you heard of PrEP?
    - How would you explain it to a friend?
        - Has anyone heard about ways to get PrEP? If so,tell me.
        - Does anyone know someone who wanted to get PrEP and couldn't? Tell me about that process?
        - Does anyone know someone who was able to easily get PrEP? Tell me about that process
- When I say "PrEP Stigma" what comes to your mind? Put it in your own words
    - Have you or anyone you know faced PrEP Stigma? Tell me about it.
        - Probe for details, agency, timeframe, etc
        - How did you feel when this occurred/heard about it? What did you do at that moment/how did you respond?
        - If you could go back, what would you do/say/act differently?
- Has anyone heard of U=U, Undetectable=Untransmittable?
    - If so, explain it in your own words as if you were talking to a friend.
    - Have you heard of anyone having trouble getting

Dallas County PLWH Needs Assessment
Interview Guide

- When I say "HIV Stigma" what comes to your mind? Put it in your own words
  - Have you or anyone you know faced HIV Stigma? Tell me about it.
    - Probe for details, agency, timeframe, etc
    - How did you feel when this occurred/heard about it? What did you do at that moment/how did you respond?
    - you could go back, what would you do/say/act differently?

FACILITATOR NOTE: We know that getting the care you need can be easy at times, and can sometimes be very difficult. We want to know about both sides of the spectrum.

- Let's start with the difficult instances…tell us about some instances that made it difficult to access the services you needed…to take care of yourself.
  - How did this make you feel?
  - Now let's hear about when things were easy
    - How did this make you feel?
    - Do you feel that people who are HIV+ get different treatment from those who are HIV- ?
    - Why…How so?

FACILITATOR NOTE: We want ideas about an intervention. We are attempting to explore barriers to and facilitators of: peer health navigation/advocate support receipt (e.g., confidentiality concerns), medicine/clinical services (e.g. transport, pharmacy, clinic location), full treatment access (e.g. insurance, scheduling) and other things

- As a person living in Dallas County & NE Texas, can you describe **<u>one thing</u>** that you wished all health providers/community organizations would do that would make your life better.

- If a program existed that was dedicated to helping "people like you" get healthcare (the medicine you need…think "all of the above"…what would it look like"
  - What would make you want to sign up?
  - What would turn you off from such a program?
- Do you think people in the community use such a program?
  - What would they be excited to see?
  - What would their concerns be?
  - How would we advertise such a program?

After today's discussion, if you had a friend who was moving to Dallas County and needed to be linked to healthcare…what advice would you give them?

- Where should they go?
- Who should they talk to?
- Who should they avoid?
- Who can help them the most?

[TURN OFF THE TAPE]

<u>POST-INTERVIEW DE-BRIEF</u>

1. Do you have any questions about the interview or the study that I can answer?

2. How was the interview experience for you?
3. Was there anything that made you uncomfortable or feel offended in any way?
    a. [If so, apologize, ask for specific feedback. Tell the respondent that you will bring back this feedback to the research team.]

Thank you for your participation in this interview. We appreciate the time you took to talk with us. If you have more questions or comments about the study, feel free to contact [contact info} whose phone number is included in the copy of the consent form I provided you with.

Before you leave, I'd like to get some background information on you. Some of these questions will seem obvious, but we want to ask rather than assume. *[Interviewer: please write answers directly on sheet through the end of this page.]*

1. How do you identify in terms of race or ethnicity?
2. How do you identify in terms of sexual or gender identity?
3. How do you identify in terms of sexual orientation?
4. What is the highest level of education that you have had?
5. What is your job/occupation/profession?
6. If any, what is your religion or religious origin/background? [Interviewer: get specific information about denomination, lineage, etc.]
7. What is your age (or approximate age)?
8. What country were you born in?
9. (If not U.S.) What year did you move to the U.S.?
10. What neighborhood do you currently live in? (if not answered already; get as specific as possible)?
11. Who do you live with? (i.e. friends, boyfriend/partner, family…)

If you know of someone that you think we should interview, would you be willing to text them a link to the survey. (have QR code or short link so they can send it while they are there…..you want to see them send it :)

INTERVIEWER COMMENTS: