

# **The Comprehensive HIV Services Plan for the Houston Area**

**Through December 31, 2008**



**Draft 10/27/2005**

**Under the Ryan White CARE Act, the purpose of comprehensive HIV services planning is to help members of our community develop a detailed picture of the current and future local HIV/AIDS epidemic and to guide decisions about HIV-related services and resources in our region.**

**This plan is offered as a tool for decision-making. It is designed to be utilized by HIV Planning Groups and any funders of HIV prevention and care**

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# COMPREHENSIVE PLANNING COMMITTEE

## Mission Statement

We, the Houston Comprehensive Planning Committee, have come together to update the Comprehensive HIV Services Plan for the Houston EMA/HSDA guided by the following mission:

We will provide a plan that will be inclusive of the entire continuum of care to improve the quality of life for those infected with and/or affected by HIV/AIDS in the Houston EMA/HSDA by taking a leadership role in the planning and assessment of HIV resources, resulting in the delivery of prevention and care services that are accessible, efficient, and culturally affirming until the end of the epidemic is realized.

## Vision Statement

From 2006 to 2008, the community will continue to work together to improve and expand a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for the infected and affected communities.

## Shared Values

Shared Values outline the GUIDING PRINCIPLES that planners, service providers, consumers, and community leaders agree will guide the development and delivery of HIV Services within the geographic area. The guiding principles are informed by HRSA's focus on uninsured, underserved and special needs populations, as defined by the following goals:

- Goal 1: Improve Access to Health Care
- Goal 2: Improve Health Outcomes
- Goal 3: Improve the Quality of Health Care
- Goal 4: Eliminate Health Disparities
- Goal 5: Improve the Public Health and Health Care Systems
- Goal 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies
- Goal 7: Achieve Excellence in Management Practices

These are the guiding principles set by the Comprehensive Planning Committee:

1. Better serve the underserved in response to the HIV epidemic's growing impact among minority and hard-to-reach populations.
2. Ensure access to existing and emerging HIV/AIDS prevention strategies and treatments to make a difference in the lives of people at risk for or living with HIV disease.
3. Adapt to changes in the health care delivery system and the role of CARE Act services in filling gaps.
4. Be able to document outcomes.
5. Be driven by and advocate for consumer needs.
6. Acknowledge the value of service provider expertise.
7. Be culturally affirming to the intended audience.

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**LETTER OF CONCURRENCE FROM  
COUNTY JUDGE ROBERT ECKELS**

[To be added December 2005]

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**LETTER OF CONCURRENCE FROM  
CITY OF HOUSTON MAYOR BILL WHITE**

[To be added December 2005]

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**LETTER OF CONCURRENCE  
FROM OTHERS**

[To be added December 2005]

## CONTRIBUTORS

This updated Comprehensive HIV Services Plan is the result of countless hours of participation and effort by members of our community who are committed to improving the HIV prevention and care delivery system. Individuals who contributed their expertise included people living with HIV/AIDS (PLWHA) and people who provide services to PLWHA.

Contributors included people familiar with needs assessment methodology, health services planning, and evaluation. The following list of contributors reflects the diversity in geographic, racial, ethnic, sexual orientation and gender that exists within communities infected and affected by HIV and AIDS. The participation and input of each contributor was essential to the process, and all are greatly appreciated.

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## INTRODUCTION

H-I-V. Alone, these are three simple letters. Put them together and they identify a disease with an impact of extraordinary proportions. What was once a relatively unknown and concentrated disease has evolved into an epidemic reaching all corners of the globe. It knows no national boundary or division of race, ethnicity, age, sex, or socioeconomic status. Since HIV was identified more than twenty years ago, more than 42 million people – men and women, black and white, rich and poor, old and young – have become infected. Over 30 million people have developed AIDS. In 2004 alone, approximately 3.1 million died from AIDS-related illnesses, and 4.9 million were newly diagnosed with HIV (13,424 new infections each day).

The HIV epidemic has challenged humankind on all levels of thought – from medical and scientific to social and cultural to economic and political. Clinicians have sought new approaches to treat a disease with new and varying clinical manifestations, while scientists have struggled to find a cure. AIDS advocates have forced controversial subjects like sexuality, drug use, discrimination, sexual inequality, and economic marginalization to the forefront of social and political debate in order to draw attention to the plight of those at risk for and living with HIV. In April 2000, in the wake of catastrophic social consequences of HIV overseas, the United States government declared HIV/AIDS a threat to national security and pledged more resources to battle the disease. Healthcare and social service workers have worked tirelessly to respond to the need for complete, quality HIV care and services. Meanwhile, people and their families living with HIV have fought against sometimes overwhelming social and cultural stigmas simply to live safe, healthy lives.

Countless individuals, organizations, and communities the world over have responded admirably to the challenge of fighting the HIV epidemic. This document represents the continuing efforts of one local community, the greater Houston, Texas area, to prevent the spread of HIV and care for those who are living with HIV and their families.

### **Comprehensive Planning**

The HIV epidemic places a heavy strain on medical and social services. The complexities of the clinical conditions and their impact on the social and economic lives of those who are infected and their families create a confusing maze of services. Adding to the confusion of the care services are those meant to prevent the spread of infection. Organizations and individuals in local communities have needed to come together in order to develop, organize and maintain the most effective, efficient systems of care for people at risk for and living with HIV and their families. One of their most important activities is Comprehensive Planning, or the creation of a complete picture of the HIV epidemic and available resources with a detailed strategy for action. In the greater Houston area, there are a multitude of people and agencies dedicated to the fight against HIV. While the efforts of all are worthwhile, below is a short description of three major planning groups.

*Ryan White Planning Council (RWPC)*: The RWPC is a 40-member volunteer group of community members who help determine which services are most needed by people living with HIV in six counties of Southeast Texas: Chambers, Fort Bend, Harris, Liberty, Montgomery and Waller. The RWPC prioritizes the services and decides the best way to allocate funds received under Title I (emergency aid to cities) of the Federal Ryan White CARE Act. [For more information about the RWPC, please call 713-572-3724.]

*State of Texas Assembly Group East (STAGE)*: STAGE is a regional volunteer planning body responsible to the Texas Department of State Health Services (DSHS) for HIV care and prevention

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planning for Title II/State Services funding in the 51 counties of the East Texas Planning Area. Decisions made by STAGE help guide the DSHS in organizing and maintaining an HIV service delivery system that meets the needs of the East Texas community. The overall mission of STAGE shall be to assess the present and future extent, distribution, and impact of the HIV epidemic in the East Texas Planning Area and support the creation of a comprehensive HIV care and prevention service delivery plan for that area.

Houston HIV Prevention Community Planning Group (CPG): The CPG is a Comprehensive Planning group that works toward improving the effectiveness of services at local health departments and community-based organizations as they develop and implement HIV prevention programs. Representatives of affected populations, epidemiologists, behavioral scientists, HIV/AIDS prevention providers and health department staff work together to create an HIV prevention plan for Harris County that will be responsive to the local epidemic. [For more information about the CPG, please call 713-794-9092.]

### **Comprehensive Planning Committee**

For this 2005 updated Comprehensive Plan, the planning bodies overseeing the project have continued to build upon the foundation set by the members of the original 1999 Comprehensive Planning Committee (CPC). CPC members always represent service providers, consumers and collaborative Care Act partners. Community input into the Comprehensive Plan was, and continues to be, ensured through CPC members' participation in various planning bodies and the results from the most recent Houston Area HIV/AIDS Needs Assessment.

In 1999, the RWPC led local planning groups and many others in the community in the creation of the first Comprehensive Planning Committee (CPC). The CPC served as an *ad hoc* committee of the RWPC, but was composed of the people who plan for, administer, provide, and use HIV care and prevention services in all ten counties of the HSDA (see Section I for a map of the area). Within the designated geographic area, efforts were made to include as many people as possible and to make the CPC as representative of the local epidemic as possible. The first meeting took place in March 1999, with over 100 people in attendance, to discuss the reasons for a Comprehensive Plan and the structure of the process. The CPC then developed a mission so that the members could clarify the purpose of the CPC and provide a framework for making decisions, a vision that described how the plan was to work, and shared values that were to be the guiding principles that shaped the system of care.

The next step for the CPC was to develop workgroups that would focus on key areas important to the community's service delivery system, or continuum of care. The workgroup areas were: medical services, support services, coordination, client and public advocacy, infrastructure, prevention, and implementation. Members of the workgroups developed and prioritized critical issues based on what are called the "Five A's": affordable, accessible, appropriate, available, and accountable. The idea was to develop a system in which services were *affordable* to all people at risk for or living with HIV and their families, *accessible* to all people, *appropriate* for different cultural and socioeconomic populations, *available* to meet the needs of all people, and *accountable* to the funding sources and consumers for providing services at high quality.

Once the critical issues were reviewed and revised, the CPC developed an ideal continuum of care. That is, they formed a picture of a system that would meet the health and social service needs of all people at risk for and living with HIV and their families. Since not all aspects of this ideal continuum were in existence, the CPC developed a set of goals that, if reached, would result in a realization of the ideal. Each goal had a series of specific objectives and tasks that the HIV community would follow in order to reach the goals. The final step for the CPC was to develop a way to ensure that the HIV

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community was making progress in reaching the goals and that these goals continued to make sense to the community.

## **Conclusion**

For many years, representatives from all of the participating planning bodies met quarterly through membership on the Joint Comprehensive Planning Committee (JCPC). The goal of this free-standing committee was to monitor the progress being made by the different planning bodies in meeting the goals outlined in the plan. Two years ago, with the consent of the other planning bodies, the function of the JCPC was folded into the HIV Planning Committee, a standing committee of the Ryan White Planning Council. Membership on the standing committee continues to include representation from the other planning bodies in the Greater Houston Area.

Although many of the resources that were missing from the original continuum of care have since been developed, comprehensive planning continues to help the Houston-area HIV community make better decisions about changes that have to be made to the system of care. It allows the planning bodies to see where they are, where they want to be, how they are going to get there, and what to do once they are there. This updated *Comprehensive HIV Services Plan for the Houston Area* is a compilation of this information for ten counties of Southeast Texas. It is intended as a living, working guide for those who plan, administer, and provide HIV services in order to improve the quality of life for people at risk for and living with HIV and their families.

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## EXECUTIVE SUMMARY

The purpose of a Comprehensive HIV Services Plan is a) to provide a road map for developing a system of care; b) to present a detailed picture of the local HIV/AIDS epidemic, and; c) to guide decisions about HIV-related services and resources in our area. A Comprehensive Plan outlines goals, objectives, and strategies for delivering services by reviewing needs assessment and other data (evaluation, contract monitoring), existing resources to meet those needs, and barriers to care. It also reflects the community's vision and values about how to best deliver HIV/AIDS care, particularly in light of limited resources.

The Comprehensive HIV Services Plan for the Houston Area is presented as a tool for decision-making. It is intended to be utilized by HIV planning groups, funders of HIV prevention and care, and any individuals or groups who desire to improve health outcomes among people at risk for HIV infection and those who are already living with HIV in the greater Houston area.

### Where Are We Now?

The Comprehensive HIV Services Plan focuses on two HIV planning areas – the Eligible Metropolitan Area (EMA) and the HIV Service Delivery Area (HSDA). The EMA is the geographic area eligible to receive Title I CARE Act funds, and consists of six counties in the southeast Texas (Chambers, Fort Bend, Harris, Liberty, Montgomery and Waller). The HSDA is the area eligible to receive Title II CARE Act funds, and encompasses ten counties that include the six EMA counties plus Austin, Colorado, Walker and Wharton counties. The EMA and HSDA areas cover 9,415 square miles containing more than 4.3 million people. However, 98% of those 4.3 million people reside in Harris County. Harris County is the most populous county in Texas, the third most populous in the nation, and home to approximately 95% of the HSDA's reported HIV/AIDS cases. The City of Houston in Harris County is the largest city in Texas and the fourth largest in the United States and has over 90% of the EMA's reported AIDS cases.

From the beginning of the epidemic, Texas has seen some of the highest numbers of reported AIDS cases. As of December 2003, the cumulative number of reported AIDS cases for the Houston area was 22,541, representing a third of all cases statewide. Harris County is home to nearly 95% of living HIV and AIDS cases in the HSDA. Increasing trends in HIV and AIDS diagnoses are being seen among women, African Americans and youth between the ages of 13 and 24. In 2000, Congress wrote into the Ryan White Care Act a mandate for grantees to respond to "unmet need," which is defined as "HIV positive individuals that are aware of their status and not receiving regular medical care." The total estimated number of PLWHA with unmet need in the Houston EMA through the end of 2003 was 5,743, or 37% of all PLWHA.

According to the 2005 Houston Area HIV/AIDS Needs Assessment, the highest ranked HIV needs either related directly to medical care (such as vision and oral health care) or facilitated access to medical care (such as health insurance and case management). The most frequently reported barrier to services was lack of information. Service providers also reported barriers to providing care, such as excessive paperwork, medication coverage difficulties, few transportation options and a lack of mental health and substance abuse treatment options for PLWHA. The 2004-2006 Comprehensive Plan of the Houston HIV Prevention Community Planning Group (CPG) strongly recommends that local prevention efforts focus on effectively coordinating prevention and primary care services for PLWHA, including widespread and accessible HIV testing resources.

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## Where Are We Going?

An HIV continuum of care is “a coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV infection to meet their health care and psychological service needs throughout all stages of illness.” Developed in 1999, the Houston area Continuum of Care is presented as a “rail system” that identifies and tracks the HIV services deemed necessary to those who are living within the Houston area. The five tracks on Houston’s continuum of care are:

- 1) Public Advocacy to the General Public;
- 2) Outreach to At Risk Populations;
- 3) Prevention of HIV infection;
- 4) Early Treatment of HIV infection, and;
- 5) AIDS Treatment to PLWHA.

Over the next five years, the community will continue working together to expand a coordinated system of HIV/AIDS prevention and care in order to improve the health outcomes and quality of life for the infected and affected communities. The services must be *available* to meet the needs of individuals and families, *accessible* to all populations infected with, affected by, or at-risk for HIV/AIDS, *affordable* to all populations infected or affected by HIV/AIDS, *appropriate* for different cultural and socio-economic populations and prevention/care needs, and *accountable* to the funding sources and clients for providing services at high quality.

The development and delivery of HIV services within the Houston area must:

- Better serve the underserved in response to the HIV epidemic's growing impact among minority and hard-to-reach populations.
- Ensure access to existing and emerging HIV/AIDS prevention strategies and treatments to make a difference in the lives of people at risk for or living with HIV disease.
- Adapt to changes in the health care delivery system and the role of CARE Act services in filling gaps.
- Be able to document outcomes.
- Be driven by and advocate for consumer needs.
- Acknowledge the value of service provider expertise.
- Be culturally affirming to the intended audience.

The Houston Continuum of Care shows the ideal linkages between a full range of client-centered, cost-effective services that would unify the prevention and treatment of the HIV epidemic in the greater Houston area to achieve the following client or individual level outcomes:

- Prevent persons from becoming HIV positive
- Prevent persons who are already HIV positive from progressing to AIDS
- Improve or maintain the health status and quality of life of people living with AIDS
- Provide a dignified death to those who are at the end-stage of AIDS
- Improve linkages to and between services

## How Will We Get There?

Included in the reauthorized Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 2000 is a mandate that communities create “multi-year Comprehensive Plans that will:

- Address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities;

- 
- Establish and support an HIV care continuum;
  - Coordinate resources among other Federal and local programs, and;
  - Address the needs of those who know their HIV status and are not in care as well as the needs of those who are currently in the care system.

In order to address these mandates, the Comprehensive HIV Services Plan for the Houston Area has adopted the following strategic goals:

- Goal A: Identify individuals who know their HIV status but are not in care and strategies for informing these individuals of services and enable their use of HIV-related services;
- Goal B: Eliminate disparities in access and services for historically underserved populations;
- Goal C: Coordinate services with HIV prevention programs including outreach and early intervention services;
- Goal D: Coordinate services with substance abuse prevention and treatment programs;
- Goal E: Provide goals, objectives, timelines and appropriate allocation of funds (as determined by the 2005 Houston Area HIV/AIDS Needs Assessment).

As part of the review of the Comprehensive Plan, findings from the most recent 2005 Houston Area HIV/AIDS Needs Assessment were analyzed based on the HRSA guidelines and expectations in order to better determine the community's progress in complying with these. Findings from this analysis are presented in Chapter Nine.

### **How Will We Monitor Our Progress?**

Implementation of the Comprehensive Plan is a coordinated effort among several planning and administrative bodies. The 2005 Houston Area HIV/AIDS Needs Assessment results are reviewed in conjunction with the Comprehensive Plan by the Planning Council's "How to Best Meet the Needs" Committee/process. Monitoring the implementation activities of the Comprehensive Plan is handled through the Comprehensive HIV Planning Committee, whose membership includes representatives from Titles I, II, III and IV as well as CPG. Outcomes are measured by the Harris County HIV Services Department using an established set of process and clinical outcome measures.

Progress in achieving the Goals, Recommendations and Action Steps will be monitored through biannual meetings of representatives of Title I, Title II, Title III, STAGE, and the CPG. The Comprehensive Planning Committee of the Ryan White Planning Council will convene these meetings. Documentation of the progress and status of each action step will be maintained using the tables found in Chapter Ten.

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**Section I**

**WHERE ARE WE NOW?**

*A Description of the Houston Area*

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## CHAPTER 1: GEOGRAPHY & HIV PLANNING REGIONS

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There are multiple funding sources for prevention and care services that are distributed through different agencies at the Federal level. These funding sources are then locally distributed to and overseen by different fiscal organizations, or administrative agencies, and planning bodies. Consequently, the planning and service provision areas are also different. This chapter presents a brief geographic description of the different HIV planning areas that would be expected to benefit from and utilize this Comprehensive Plan.

The Eligible Metropolitan Area (EMA) is the geographic area eligible to receive Title I CARE Act funds, which are passed through the EMA's top elected official. The boundaries of the metropolitan area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the Centers for Disease Control and Prevention (CDC). There are over 50 metropolitan areas across the nation that have been designated as eligible to receive Title I funding. Some EMAs include just one city, other EMAs are composed of several cities and/or counties, and some EMAs extend over more than one state. The Houston EMA is a 6-County area that consists of Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller counties in southeast Texas. The Houston Area Ryan White Planning Council plans for Title I services in the EMA. The land area of the EMA is 5,921 square miles with a population of 4,177,646 for a population density of 705.6 people per square mile (see Map 1).

The HIV Service Delivery Area (HSDA) is the Texas geographic area eligible to receive Title II CARE Act funds through the Texas Department of State Health Services (DSHS). The Houston HSDA is a 10-County area that contains the six EMA counties plus the adjacent Austin, Colorado, Walker, and Wharton counties. The Houston HSDA CARE Consortium plans for Title II and DSHS State Services throughout the HSDA. The land area of the HSDA is 9,415 square miles with a population of 4,324,572 for a population density of 459.3 people per square mile.

Of the total population of 4,324,572 in the ten-county HSDA, 3,400,578 (98.2%) reside in Harris County. The population density of Harris County is 1,630 people per square mile. Harris County is the most populous county in Texas, the third most populous in the nation, and the home of approximately 95% of the HSDA's reported HIV/AIDS cases. The City of Houston in Harris County is the largest city in Texas and the fourth largest in the United States. Houston has over 90% of the EMA's reported AIDS cases and is the least densely populated major metropolitan area in the nation. Philadelphia (135 sq miles), Chicago (227.1 sq miles), and Boston (49 sq miles) combined would fit within the city limits of Houston (539.6 sq miles) with room to spare.

The City of Houston is directly funded by the CDC for prevention activities in Harris County. The Houston HIV Prevention Community Planning Group (CPG) plans for CDC-funded HIV prevention activities.

### **Population**

Each of these counties experienced growth in population since the last census in 1990. The percent change in population ranged from 3.1% in Wharton County to 61.2% in Montgomery County. The average percent change across all counties was 29.6%. Along with Montgomery County, the other counties bordering Harris County also saw significant growth: Chambers had a 29.6% change, Fort Bend County 57.2%, Liberty County 33.1%, and Waller County 39.7%. Harris County itself showed a

20.7% change in population (similar to that for the State, 22.8%). Table 1, below, illustrates the population number, population density and square mileage of the counties in the HSDA.

**Table 1. Population, Square Miles and Population Density by Geographic Area from 2000 Census Data**

County	Population	Square Miles	Population Density
Austin	23,590	653	36
Chambers	26,031	599	43
Colorado	20,390	963	21
Fort Bend	354,452	875	405
Harris	3,400,578	1,729	1,966
Liberty	70,154	1,160	60
Montgomery	293,768	1,044	281
Walker	61,758	788	78
Waller	32,663	514	64
Wharton	41,188	1,090	38
<b>EMA</b>	<b>4,177,646</b>	<b>5,921</b>	<b>706</b>
<b>HSDA</b>	<b>4,324,572</b>	<b>9,415</b>	<b>459</b>

The population in all of the counties is predominantly White, ranging from 57.0% in Fort Bend County to 88.3% in Montgomery County. African Americans are the largest minority group in each county, ranging from 3.5% in Montgomery County to 29.2% in Waller. The largest Asian/Pacific Islander (API) population, 11.2%, resides in Fort Bend County. The American Indian/Alaskan Native population consistently is in the 0.3% to 0.5% range across all counties. The “Other” category includes those who designated themselves as multiracial, with the highest percentage (3.0%) in Harris County.

The median age for the entire area is 34.1 years, meaning half of the population is older and half is younger. This is slightly over the median age of 32.3 years for the entire state. The median ages for the individual counties fell within the 30 to 40 year age range. Fort Bend County has the largest percentage of people under 18 years old (32%) and the smallest over 65 years old (18.6%). Walker County had the smallest percentage of people under 18 (18%) and Colorado County had the largest over 65 (18.6%).

The Hispanic population is considered separately because this profile follows Federal guidelines and treats Hispanic as an *ethnic* categorization, rather than as a race. This means that the Hispanic category is not mutually exclusive of the racial categories; in other words, a person could be both Hispanic and White or Hispanic and American Indian. With that in mind, the average percentage of Hispanics across all counties is 18.9%. Harris County has the largest proportion of Hispanics at 32.9%, with the majority (80.1%) of Mexican origin. Chambers County has the lowest proportion of Hispanics (10.8%). Overall, Harris County and neighboring Fort Bend County are the most racially/ethnically diverse counties in the area.

Most of the residents in the 10-county area live in Houston, the largest city in Texas and the fourth largest city in the United States (behind New York, Los Angeles and Chicago). Within city limits, the estimated population is 1.8 million, with the gender distribution split down the middle – 50.1% female and 49.9% male. The median age is slightly younger than the surrounding areas (30.9 years). The city

also is more racially/ethnically diverse, with 49.3% of Houston’s population White, 25.3% African American, 5.4% Asian/Pacific Islander, 0.4% American Indian, and 16.5% listing another race (with 3.1% multiracial). Over a third of the city’s total population (37.4%) is Hispanic.

**Economics**

The 2000 U.S. Census also provided us with some economic information. For example, the 1997 estimated median household income for the area ranged from just under \$29,000 to just over \$55,000, with an average of almost \$37,000. This compares favorably to the statewide median of \$34,478. However, the numbers of people living below the poverty level were not insignificant. The percentage of people living below poverty ranges from 8.0% in Fort Bend County to 20.9% in Waller County, with an average for all counties of 15.0%. For children, the range is from 10.6% in Fort Bend to 26.9% in Waller, for an average of 20.0%. The statewide rates were 13.3% overall and 19.9% for children. Table 2 shows the poverty rates for 1997 and compares the total and rates for children in 1997 and 1999.

**Table 2. Poverty Estimates by County**

County	1997 Median Household Income	1997 Persons Below Poverty (%)	1997 Children Below Poverty (%)	1999	
				Total (%)	Children (%)
Austin	\$33,945	13.1	17.7	15.9	22.3
Chambers	\$43,345	10.8	16.5	13.9	17.2
Colorado	\$28,966	17.1	23.9	20.1	28.9
Fort Bend	\$55,164	8.0	10.6	10.5	14.3
Harris	\$39,037	15.2	20.9	12.6	20.0
Liberty	\$31,683	17.2	22.9	17.8	22.3
Montgomery	\$46,292	10.3	14.6	11.6	15.4
Walker	\$30,971	19.9	22.5	18.3	20.0
Waller	\$29,832	20.9	26.9	18.9	25.7
Wharton	\$30,531	17.4	23.0	18.5	25.2

Commensurate with the significant percentage of people living at or under the Federal Poverty level is the high percentage of uninsured.

Table 3 presents this information by county and includes additional estimates for 1999 from the Texas Health and Human Services Commission. Increases were noted in all but a few counties: Harris, and Walker Counties, and in Waller County for children only. Although numbers were not available for each county, statewide, the majority of those living in poverty in 1997 were female (55.3%) and Hispanic (53.2%).

**Table 3. Estimated People Without Insurance by County, 1999**

<b>County</b>	<b>All people (%)</b>	<b>Children (0-18 years old) (%)</b>	<b>Adults (19-64 years old) (%)</b>
Austin	19.9	22.7	24.4
Chambers	20.3	20.8	23.7
Colorado	20.8	24.0	26.7
Fort Bend	22.7	22.4	24.6
Harris	25.5	25.5	28.1
Liberty	22.4	22.8	26.2
Montgomery	20.1	21.0	22.6
Walker	25.4	22.9	29.5
Waller	25.4	25.1	30.1
Wharton	23.1	25.0	27.5

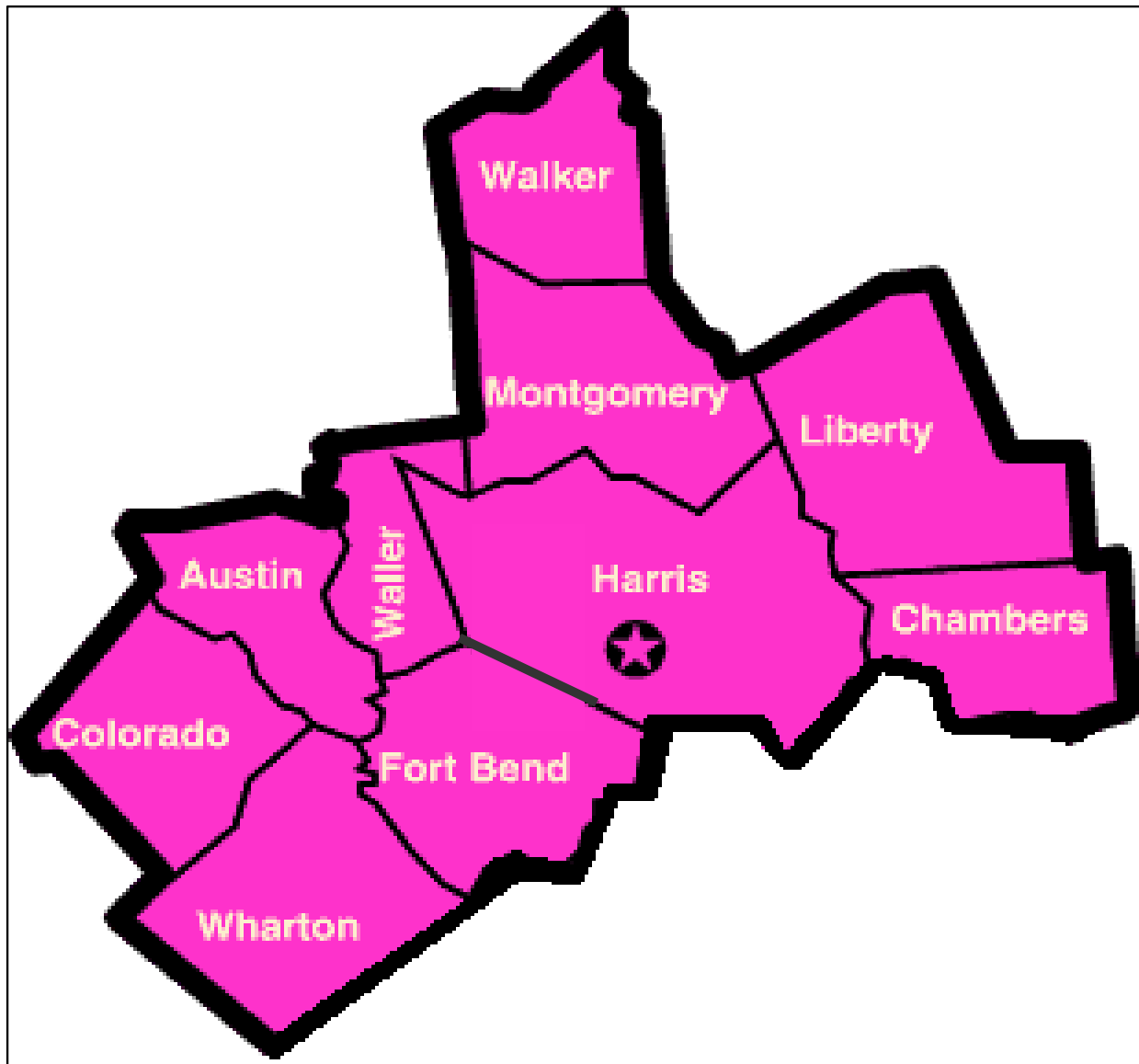
Unemployment by county is high, though it has decrease slightly in most of the counties in the HSDA from 1998 to 2001:

**Table 4. Unemployment rate by County**

<b>County</b>	<b>1998</b>	<b>December 2001</b>
Austin	3.3%	2.7%
Chambers	4.2%	4.2%
Colorado	3.9%	3.2%
Fort Bend	2.9%	3.2%
Harris	4.2%	4.6%
Liberty	6.5%	6.3%
Montgomery	3.4%	3.7%
Walker	2.2%	2.0%
Waller	4.3%	4.0%
Wharton	5.6%	4.8%
<b>Texas</b>	<b>4.0%</b>	<b>5.1%</b>

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**MAP 1: HOUSTON EMA/HSDA**



## CHAPTER 2: EPIDEMIOLOGICAL PROFILE

*Epidemiology is the study of infectious diseases that affect large numbers of people, with a focus on preventing more infections. The most important part of epidemiology for Comprehensive Planning is the distribution of disease, or who is getting it where and when. An epidemiologic profile is a description of the current status of the epidemic with projections for the future.*

### Cumulative Cases

Cumulative case reports show the total number of people ever reported to have an AIDS diagnosis, regardless of whether these people are still living. From the beginning of the epidemic, Texas has seen some of the highest numbers of reported AIDS cases, with almost 63,600 through December 31, 2003. Tables 1 and 2 show the demographic profile of reported cumulative AIDS cases for Texas. The majority is male (87%), White (50%) and attributed to unprotected male-to-male sex (56%).

**Table 5. Cumulative Reported AIDS Cases  
by Gender and Race/Ethnicity, Texas – Through 12/31/03**

Race/Ethnicity	Female	Male	Total
White	2,138	29,439	31,577
African American	4,620	14,299	18,919
Hispanic	1,437	11,299	12,736
Other/Not specified	46	322	368
<b>Total</b>	<b>8,241</b>	<b>55,359</b>	<b>63,600</b>

**Table 6. Cumulative Reported AIDS Cases  
by Gender and Behavioral Risk, Texas – Through 12/31/03**

Behavioral Risk	Female	Male	Total
Male-to-Male Sex (MSM)	0	35,790	35,790
Injection Drug Use (IDU)	2,680	6,213	8,893
MSM and IDU	0	5,634	5,634
Heterosexual Contact	3,505	2,440	5,945
Other/Not specified	2,056	5,282	7,338
<b>Total</b>	<b>8,241</b>	<b>55,359</b>	<b>63,600</b>

Throughout the years, the Houston area typically has accounted for about one-third of AIDS cases in Texas. Through December 2003, the number of cumulative reported cases was 22,541, or 35% of the total for the State of Texas. Most of these were male (85%), White (48%), between 30 and 39 years old (44%), and attributed to unprotected male-to-male sex (57%). Tables 3 through 5 provide more details.

**Table 7. Cumulative Reported AIDS Cases  
by Gender and Age Group, Houston Area – Through 12/31/03**

<b>Age Group</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
< 12	84	87	171
13-19	96	90	186
20-29	941	3,663	4,604
30-39	1,193	8,848	10,041
40-49	657	4,712	5,369
50-59	219	1,392	1,611
60-69	72	382	454
70+	21	84	105
<b>Total</b>	<b>3,283</b>	<b>19,258</b>	<b>22,541</b>

**Table 8. Cumulative Reported AIDS Cases  
by Gender and Race/Ethnicity, Houston Area – Through 12/31/03**

<b>Race/Ethnicity</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
White Non-Hispanic	596	10,247	10,843
African American	2,219	5,882	8,101
Hispanic	458	3,023	3,481
Other/Not specified	10	106	116
<b>Total</b>	<b>3,283</b>	<b>19,258</b>	<b>22,541</b>

**Table 9. Cumulative Reported AIDS Cases  
by Gender and Behavioral Risk, Houston Area – Through 12/31/03**

<b>Behavioral risk</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
Male-to-Male Sex (MSM)	0	12,782	12,782
Injection Drug Use (IDU)	992	1,752	2,744
MSM and IDU	0	1,866	1,866
Heterosexual Contact	1,684	1,286	2,970
Other/Not specified	607	1,572	2,179
<b>Total</b>	<b>3,283</b>	<b>19,258</b>	<b>22,541</b>

### **Living AIDS Cases**

While a profile of cumulative cases help show the road AIDS has taken in a community, the focus of the service delivery system is on the people who are living with HIV/AIDS. According to the Texas Department of State Health Services (DSHS), through December 31, 2003, there were 29,449 people living with AIDS in Texas. Most of the people with AIDS are male (83%), White (41%) or African

American (34%), between the ages of 30 and 39 (31%), and attributed to unprotected male-to-male sex (49%). Tables 6 through 8 show the demographic profile of these cases.

**Table 10. Living Reported AIDS Cases  
by Gender and Age Group, Texas – Through 12/31/03**

Age Group	Female	Male	Total
0-12	46	43	89
13-19	56	34	90
20-29	604	969	1,573
30-39	1,835	7,336	9,171
40-49	1703	10,776	12,479
50-59	645	4,036	4,681
60-69	158	953	1,111
70+	54	201	255
<b>Total</b>	<b>5,101</b>	<b>24,348</b>	<b>29,449</b>

**Table 11. Living Reported AIDS Cases  
by Gender And Race/Ethnicity, Texas – Through 12/31/03**

Race/Ethnicity	Female	Male	Total
White Non-Hispanic	1,195	10,973	12,168
African American	2,926	7,181	10,107
Hispanic	943	5,996	6,939
Other/Not specified	37	198	235
<b>Total</b>	<b>5,101</b>	<b>24,348</b>	<b>29,449</b>

**Table 12. Living Reported AIDS Cases  
by Gender and Behavioral Risk, Texas – Through 12/31/03**

Behavioral Risk	Female	Male	Total
Male-to-Male Sex (MSM)	0	14,546	14,546
Injection Drug Use (IDU)	1,484	2,959	4,443
MSM and IDU	0	2,379	2,379
Heterosexual Contact	2,265	1,528	3,793
Other/Not specified	1,352	2,936	4,288
<b>Total</b>	<b>5,101</b>	<b>24,348</b>	<b>29,449</b>

In the 10-county Houston area, there were more than 9,432 people reported to be living with AIDS in 2003. The majority of living AIDS cases is male (79%), between 25-44 years old (57%), and attributed to unprotected male-to-male sex (47%).

**Table 13. Living Reported AIDS Cases  
by Gender, Houston HSDA – Through 12/31/03**

Gender	2003 Living AIDS	
	#	%
Male	7,477	79.3
Female	1,955	20.7
<b>Total</b>	<b>9,432</b>	<b>100%</b>

**Table 14. Living Reported AIDS Cases  
by Age, Houston HSDA – Through 12/31/03**

Age	2003 Living AIDS	
	#	%
0-1	0	0
2-12	44	0.5
13-24	178	1.9
25-44	5,341	56.6
45-64	3,646	38.7
65+	223	2.4
<b>Total</b>	<b>9,432</b>	<b>100%</b>

**Table 15. Living Reported AIDS Cases  
by Behavioral Risk, Houston HSDA – Through 12/31/03**

Behavioral Risk	2003 Living AIDS	
	#	%
Male-to-male sex (MSM)	4,427	46.9
Injection drug use (IDU)	1,241	13.2
MSM and IDU	672	7.1
Heterosexual contact	1,867	19.8
Other/Not specified	74	0.8
Male-to-male sex (MSM)	1,151	12.2
<b>Total</b>	<b>9,432</b>	<b>100%</b>

In terms of race/ethnicity, most living AIDS cases were among African Americans (43% vs. 37% for Whites). Table 16 provides more details.

**Table 16. Living AIDS cases  
by Ethnicity, Houston HSDA – Through 12/31/03.**

HSDA 2003	2003 Living AIDS	
White, not Hispanic	3,453	36.6
Black, not Hispanic	4,081	43.3
Hispanic	1,820	19.3
Other/Unknown	78	0.8

### **Trends in HIV and AIDS diagnoses**

During 2003, the number of newly diagnose HIV cases was 604 in the HSDA and 598 in the EMA. In addition, 591 people in the HSDA and 584 in the EMA either converted from HIV to AIDS or were initially diagnosed with AIDS that year.

Examining HIV and AIDS diagnoses by gender reveals a trend toward increasing HIV disease among women. This holds true for both the EMA and HSDA. The race/ethnicity profiles of those newly diagnosed with HIV and AIDS are almost identical in both the EMA and HSDA. Half of new HIV diagnoses were among Black, non-Hispanics compared to 51% of AIDS diagnoses.

Although the 25 to 44 age group has the highest rate of new HIV and AIDS infections, the rates are similar for both HIV and AIDS. Youth (age 13 to 24), however, exhibited increasing infections with 2.4 times more HIV diagnoses per 100,000 than AIDS diagnoses.

Generalizing about transmission mode is difficult since unreported risk is very high among newly diagnosed cases. Unreported risk among those with HIV accounts for approximately 42% of new diagnoses and 30% of those with AIDS diagnoses. Harris County is clearly the epicenter of the epidemic with 92% of 2003 newly diagnosed HIV and AIDS cases. It was home to the highest proportion of new HIV and AIDS infections during 2003.

Both HIV and AIDS diagnoses demonstrated a steadily increasing trend between 1999 and 2002. In 2003, this trend changed abruptly and a significant decline in both HIV and AIDS diagnoses was seen. A portion of this change may be attributed to reporting delays and should be further monitored.

### **Reported HIV Cases**

According to DSHS, through December 31, 2003, there were over 18,917 reported cases of people living with HIV infection in Texas. Most people living with HIV infection are male (72%). About 36% are between the ages of 30 and 39 and 20% are between the ages of 20 and 29. Almost 38% are attributed to unprotected male-to-male sex. Cases attributed to unprotected heterosexual contact and unsafe injection drug use account for about 16% and 14% of the total cases respectively, and cases that cannot be attributed to one of the specified behaviors account for 24% of the total. More African Americans (42%) are living with HIV in Texas than any other race/ethnicity. Whites are next with 36% of the cases, followed by Hispanics with 21%. Tables 17 through 19 show more details.

**Table 17. Living Reported HIV Infections  
by Gender and Age Group, Texas – Through 12/31/03**

<b>Age Group</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
0-12	131	149	280
13-19	138	100	238
20-29	1,466	2,277	3,743
30-39	1,768	5,166	6,934
40-49	1,215	4,368	5,583
50-59	399	1,308	1,707
60-69	80	272	352
70+	14	66	80
<b>Total</b>	<b>5,211</b>	<b>13,706</b>	<b>18,917</b>

**Table 18. Living Reported HIV Infections  
by Gender and Race/Ethnicity, Texas – Through 12/31/03**

<b>Race/Ethnicity</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
White Non-Hispanic	1,167	5,672	6,839
African American	3,104	4,842	7,946
Hispanic	880	2,995	3,875
Other/Not specified	60	197	257
<b>Total</b>	<b>5,211</b>	<b>13,706</b>	<b>18,917</b>

**Table 19. Living Reported HIV Infections  
by Gender and Behavioral Risk, Texas – Through 12/31/03**

<b>Behavioral Risk</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
Male-to-male sex (MSM)	0	7,149	7,149
Injection drug use (IDU)	1,019	1,537	2,556
MSM and IDU	0	1,061	1,061
Heterosexual contact	2,203	906	3,109
Other/Not specified	1,989	3,053	5,042
<b>Total</b>	<b>5,211</b>	<b>13,706</b>	<b>18,917</b>

Through December 2003, DSHS reports 6,259 people living with HIV in the Houston HSDA area. Comparing people living with HIV to people living with AIDS reveals an increase in HIV disease among women. In the HSDA, women were 34% of people living with HIV in 2003, but were only 21% of people living with AIDS, an indication of increasing new infections among women. The prevalence rate for HIV among males was nearly twice that for females. Males' AIDS prevalence rate, however, was almost four times that of females.

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African Americans in the HSDA are disproportionately affected by HIV and AIDS with the rate of HIV prevalence significantly higher among African Americans than other racial or ethnic groups. Comparing HIV and AIDS infection rates, African Americans have an overall infection rate that is nearly four times higher than whites, and the HIV (not AIDS) infection rate among African Americans is 5.3 times higher than whites. The overall infection rate is 4.5 times higher among African Americans than Hispanics, and the HIV (not AIDS) infection rate is nearly six times higher for African Americans than Hispanics.

Compared to other age groups, 25 to 44 year olds had the highest proportion (65%) of HIV prevalence. However, HIV prevalence is significantly higher than AIDS prevalence among the younger age groups, indicating possible emerging trends.

In the Houston HSDA, the most frequent mode of HIV transmission is male to male sex, with one third of people living with HIV reporting this as their mode of infection and nearly 47% of those with AIDS identifying it. Heterosexual transmission is increasing, with nearly one-quarter (24.2%) of those living with HIV.

Harris County is home to nearly 95% of people living with both HIV and AIDS. Fort Bend County has over 350 residents with HIV or AIDS, and Montgomery has 264. Most other counties have less than 50 people living with HIV or AIDS.

**Table 20. HSDA Living with HIV 2003**

	#	%
<b>Total</b>	6,258	100
<b>Sex</b>		
Male	4,155	66.4
Female	2,103	33.6
<b>Race/Ethnicity</b>		
White, not Hispanic	1,745	27.9
Black, not Hispanic	3,445	55.0
Hispanic	987	15.8
Other/Unknown	81	1.3
<b>Age (Years)</b>		
0-1	8	0.1
2-12	122	1.9
13-24	573	9.2
25-44	4,060	64.9
45-64	1,430	22.9
65+	65	1
<b>Transmission Mode</b>		
MSM	2,086	33.3
IDU	617	9.9
MSM/IDU	260	4.2
Hetero	1,516	24.2
Mother at Risk	148	2.4
Risk not Reported	1,631	26.1
<b>Ten Counties</b>		
AUSTIN	9	0.1
CHAMBERS	<5	na
COLORADO	<5	na
FORT BEND	132	2.1
HARRIS	5,920	94.6
LIBERTY	29	0.5
MONTGOMERY	123	2
WALKER	12	0.2
WALLER	11	0.2
WHARTON	11	0.2

## Pediatric HIV/AIDS

One of the bright spots in the fight against HIV is the success in reducing the number of AIDS cases among children aged 0 to 12 years. Table 21 presents the number of children living with HIV/AIDS by race/ethnicity and gender.

<b>Race/Ethnicity</b>	<b>Living with AIDS Total</b>	<b>Living with HIV Total</b>
White	6	20
African American	43	118
Hispanic	21	24
Other/Not specified	0	9
<b>Total</b>	<b>70</b>	<b>171</b>

## Impact of HIV/AIDS by Geographic Area

Because we are talking about a 10-county area, it is important to highlight some geographic differences in the HIV epidemic. Foremost, with Houston at its center, Harris County accounts for the overwhelming majority of people living with HIV/AIDS. Of the 15,690 cases reported through December 2003, 95% were living in Harris County. But do not let the relatively small numbers in the other counties lull you into thinking that HIV does not exist outside the urban areas. Table 22 shows the number of reported cases in the rest of the area. Please note that in order to maintain confidentiality, some counties have been combined.

<b>County</b>	<b>AIDS cases</b>	<b>HIV infections</b>	<b>Total</b>
Harris	8,938	5,920	14,858
Fort Bend	219	132	351
Montgomery	141	123	264
Chambers, Liberty, Walker	62	41	110
Austin, Colorado, Waller & Wharton	72	42	107
<b>Total</b>	<b>9,432</b>	<b>6,258</b>	<b>15,690</b>

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## CHAPTER 3: HISTORY OF RESPONSE TO THE HIV EPIDEMIC IN THE HOUSTON AREA

*Background information on the local response to the HIV epidemic is an important piece of effective Comprehensive Planning. An outline of legislative actions, funding activities and past planning efforts will provide a valuable context for current and future planning efforts. A condensed version of the local response in the Houston area is provided below.*

### Community Response

At the beginning of the chronicled history of people infected with HIV disease, government response was limited or silent. In 1981, there were three AIDS cases reported, and it has since been determined that there were actually ten cases. As relatively little information was known at the time, community response came in the form of grass roots organizations and other community organizations formed for other purposes. The two organizations that were the basis of forming other groups were the Montrose Clinic and Montrose Counseling Center. From these two came such groups as KS AIDS Foundation (later known as AIDS Foundation Houston) and others. Grass roots efforts spawned a number of firsts in the country, such as McAdory House (a residential facility), FIRM (the largest religious response to HIV/AIDS in the country, which provides Care Team support and education), The Assistance Fund (provides money for insurance premiums) and others.

As these grass roots organizations took hold, efforts were made in engaging traditional forms of funding. The response in the early eighties was again tepid or non-existent, partly due to an economic depression caused by the collapse of the oil and gas industry. United Way of the Texas Gulf Coast did provide funding for the care of AIDS patients to Visiting Nurses as early as 1986. But, due to the depressed economy, United Way prohibited any new organizations – which most HIV/AIDS organizations were – from applying for funds. Therefore, it was not until 1991 that United Way provided economic support to the Montrose Clinic and Montrose Counseling Center.

On the political scene, the then Mayor of Houston reluctantly agreed in 1985 to support a referendum that would have prohibited the City from discriminating against gay and lesbian individuals in their hiring practices. When the referendum was soundly defeated, gay and lesbian leaders began to feel that key political leaders were distancing themselves from the gay community. Since many of the gay and lesbian leaders were founding board members of agencies like the AIDS Foundation Houston, this began a long period of distrust and finger pointing among local politicians, gay and lesbian leaders and social service providers. To make matters worse, when mainstream and other types of service providers decided to enter the AIDS arena, they were not interested in working collaboratively with agencies founded by members of the gay and lesbian community for fear of losing their credibility with political leaders. Even gay grass roots organizations did not trust other gay grass roots organizations for fear of being dragged into the political quagmire.

Throughout this whole time, the Mayor, who is responsible for surveillance and prevention, and the County Judge, who is responsible for medical and social services such as the Harris County Hospital District, appointed at least four different task forces to study the problem of HIV/AIDS. Most of the task forces were fraught with discord and ended with few recommendations and no action.

In the mid 1980s, AMI, a privately owned hospital corporation, opened the Institute for Immunology, the first hospital in the country dedicated solely to treating people with HIV/AIDS. It lasted one year,

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and was closed. Important research projects being conducted through the “AIDS Hospital” came to an end because no local hospital would assume responsibility for the projects. As a result, AMI returned several million dollars in AIDS research money to the Federal government.

In the late 1980s, the AIDS Foundation was a primary source of social service support for people living with HIV/AIDS. Brown MacDonald, one of the Executive Directors of the foundation was quoted as saying that until the late 1980s, “80% of the foundation’s budget came from passing a hat at local gay bars”. In an effort to meet the needs of their clients, the AIDS Foundation hired one case manager to provide case management services to over 600 clients. Even with the help of volunteer staff, it quickly became clear that they could hardly provide crisis management to that many clients.

In the midst of the closure of the Institute of Immunology in 1986-87, the Robert Wood Johnson Foundation was awarding case management demonstration grants to cities with large populations of HIV/AIDS patients. In Texas, these funds went to Dallas. Because these demonstration grants proved that case management is a highly effective means of linking clients with medical and social services, the Federal government, through the Health Resources and Services Administration (HRSA), incorporated this service and expanded funding so that AIDS patients throughout the country could receive case management services. (See section on Congressional Response for more information on HRSA.) When Houston became eligible for these funds, distrust among agencies was so high that instead of placing case managers in one organization, Houston designed a “decentralized system” that placed case managers in agencies throughout the geographic area. The first HRSA demonstration grant for case management was awarded to Harris County in 1989.

After closure of the AMI hospital, those patients with private insurance were routed into other hospitals owned by AMI. The rest were referred to the Harris County Hospital District. Overnight, the Hospital District found itself with over 700 AIDS patients on their doorstep. In May 1989, the formation of Thomas Street Clinic, a publicly-funded outpatient clinic for people living with HIV/AIDS, was an important step forward in demonstrating the County’s willingness to provide quality healthcare services to PLWHA. Today, Thomas Street Clinic is cited as one of the best in the country.

In 1988, then County Judge Jon Lindsay, announced the formation of the Greater Houston HIV/AIDS Alliance (GHHA), a private corporation designed to bring private and public players to the same table to coordinate services for PLWHA. For example, United Way provided staff support and got a seat on the governing board. Funding streams were still meager, but in 1987, the Texas Department of Health through State Services funding (general appropriations), began a limited amount of funding for community-based organizations. In 1989, they began targeting the highest infection areas, such as Houston, Dallas, Austin and San Antonio.

In the meantime, small groups of individuals were trying to raise private funds, primarily through special events, in an effort to support the cause. The first significant event was “An Evening of Hope,” which raised close to \$100,000 in 1986 for Bering Foundation. Chaired by Carolyn Farb, this was the first special event to receive mainstream media coverage. “Art Against AIDS” was a collaborative effort between the local arts community and United Way. During the month of September 1987, arts groups, like the ballet, the symphony, local art galleries, and others, dedicated the proceeds from a special performance or the sale of artwork to AIDS. This effort was also effective in heightening the awareness of HIV/AIDS. That same year, the Houston Chapter of the Design Industries Foundation for AIDS (DIFFA) was formed. Between 1987 and 1996, the Houston Chapter of DIFFA raised \$2.7 million, making DIFFA/Houston the largest private funder of HIV/AIDS in the Houston area.

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On the prevention side, funding to prevent the spread of the infection became available from The Centers for Disease Control (now called The Center for Disease Control and Prevention) in 1985. The Montrose Clinic was one of the first agencies to receive such funding. Three years later, Over the Hill, an African American grass roots organization serving the newly released from prison population, received funds to provide testing and counseling.

From 1984 to 1988, the City of Houston received funding for prevention activities as part of the AIDS Prevention and Surveillance Grant, through the Texas Department of State Health Services (DSHS). Funding from DSHS included support primarily for surveillance activities with and for publication of the monthly AIDS Update. A very limited amount of dollars was spent for education targeted to the general public through information campaigns. Additionally, the City of Houston contributed funding to provide brochures for “AIDS Awareness Week”, the general public, and men who have sex with men.

The Perinatal Prevention Project was funded by CDC to the City of Houston in September 1988. This was a pilot program to identify and offer voluntary counseling and testing to women who were high risk or HIV positive and enrolled in family planning, maternity and sexually transmitted disease clinics.

In 1988, the city of Houston received additional funding from DSHS to expand the AIDS education activities to develop a citywide HIV/AIDS speakers bureau in conjunction with the AIDS Foundation Houston and to develop AIDS education modules to address each segment of the Houston population in regards to sex, race and income status. Each module consisted of films/videos, pamphlets, risk factor information and a list of speakers who completed training to conduct AIDS presentations. The city also received \$3,500 to conduct a minority initiative program targeted to beauty shops, barbershops, and morticians.

In 1989, the City of Houston, one of only six cities in the nation, received funding directly from the CDC specifically for HIV prevention activities. Funds supported health education, HIV counseling and testing, public information and minority initiative campaigns. Funds were also allocated through the grant to fund over 15 community-based organizations and agencies. To date, the CDC has continued funding through this directly funded cooperative agreement.

On the care side, it wasn't until November 1990 that the first Federal funding became available through the Ryan White CARE Act. These funds dramatically changed the grass roots nature of service delivery in the Houston area.

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, signed into law by then President George H. Bush, was created in response to the enormous impact the HIV/AIDS was having on the nation at that time. The monies appropriated by this act were to fund HIV/AIDS care services in those areas most affected by HIV/AIDS. Eligibility for Title I funding was and is determined by the number of AIDS cases reported in a given area. Due to the huge impact that HIV/AIDS was having on the Houston area in 1990, Houston and the surrounding counties received funding in the first year of allocation – 1991. That funding amounted to \$3.7 million and was a badly needed infusion of stable, comparatively long-term funding.

In early 1990, burgeoning funding, coupled with an increasing number of clients, strained the capabilities of an already fragile system. County Judge Jon Lindsay, who controlled all the money for the GHHA, asked that all funding be moved under the jurisdiction of the County Health Department.

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There was an investigation and a significant amount of money was returned to the Federal government. The Greater Houston HIV/AIDS Alliance was dissolved in 1993, and the resulting controversy over mismanagement and secrecy caused a redirection of Federal and State funding streams. Title I funding remained with Harris County. Funding from DSHS State Services and Title II moved under the newly formed Houston Regional HIV/AIDS Resource Group. Both groups retain that funding to this day. As all players in the AIDS arena began to rebuild trust, the epidemic began to change. With the advent of new and powerful treatments, the lives of PLWHA changed as well. People with HIV/AIDS are living longer and functioning better than ever before. The Hospital District continues to receive the largest portion of funds, since medical care is a top priority and since the Hospital District traditionally serves the largest number of clients. As the CARE Act became more responsive to the needs of underserved minorities, primary care sites expanded into alternative locations, resulting in the need for increased ancillary services and medications. With these new medications changing the lives of clients, it also prompted a change in measuring those services. The emphasis is now on medical outcomes, and services have changed in respect to how they can measure that important aspect of clients' lives.

Since the CARE Act was legislated and Houston began receiving Federal funding, much of the financial burden has been mitigated, as many community-based organizations are now able to deliver services to the HIV affected population in the Houston area. Best of all, in many cases, the newer providers are able to outreach into historically underserved/unserved communities and bring people into services while they are still in the earlier stages of the disease. This early intervention is highly important. The use of highly active anti-retroviral treatments (HAART) prescribed at the appropriate time has slowed or even halted the progression of the disease in many people, enhancing the quality and duration of life in most cases.

As more people of color, especially African Americans, became infected with HIV/AIDS, activists at the Federal level began working to ensure that more HIV/AIDS money was specifically targeted to minorities. As a result of the Congressional Black Caucus Initiative 1999, a Title I CARE Act set-aside in the amount of \$177,690 was used to target HIV/AIDS care dollars specifically towards services for African Americans and Hispanics. This amount was in addition to money that the County was already targeting to minority populations. In 2000, the CBC allocation rose to \$937,955 and in 2005 is now \$1.5 million. On the prevention side, the City of Houston also received CBC money to target minorities in the area of prevention.

However, as unduplicated HIV case reporting numbers became available in mid-1999, resultant to Texas moving to name-based HIV reporting in addition to AIDS reporting, the realization that HIV was disproportionately affecting the African American community became even clearer. It also became clear that the amount of money set aside in the CBC initiatives (now referred to as the Minority AIDS Initiative) were not enough to effectively address the impact of HIV/AIDS in communities of color. Prevention and care advocates pushed their elected officials to declare a "State of Emergency" in the African American community in the hopes that even more resources and services would be targeted toward communities of color. In November 1999, County Judge Robert Eckels declared an HIV/AIDS State of Emergency in the African American community. Mayor Lee Brown made a similar declaration on World AIDS Days on December 1, 1999.

### **Congressional Response**

On August 18, 1990, Congress enacted Public Law (PL) 101-381, known as the Ryan White Comprehensive AIDS Resources Emergency Act, or the CARE Act. On May 20, 1996, this legislation was reauthorized and amended as PL 104-146, or the Ryan White CARE Act Amendments of 1996.

The CARE Act was reauthorized again 2000. President Bush has recommended the CARE Act be reauthorized in 2006 with changes that would allow the Secretary of Health and Human Services greater flexibility in redistributing unallocated balances, make Planning Councils voluntary advisory boards, require that all states submit HIV data by the start of Fiscal Year 2007, and more. It is unclear at this time how Congress will respond to these recommendations.

The CARE Act is intended to help communities and States increase the availability of primary health care and support services in order to reduce utilization of more costly inpatient care (such as hospitals). They are also intended to increase access to care for underserved populations and to improve the quality of life for those affected by the epidemic.

The CARE Act directs assistance to the following areas:

- *Title I* goes to Eligible Metropolitan Areas (EMAs) with the largest numbers of reported cases of AIDS to meet emergency service needs of people living with HIV disease;
- *Title II* goes to all States to improve the quality, availability and organization of health care and support services for individuals living with HIV disease and their families;
- *Title III* goes to public and non-profit entities, such as Community and Migrant Health Center, to support early intervention services for people living with HIV disease. Money is also given for the AIDS Drug Assistance Program (ADAP), which provides medications to low-income individuals with HIV who have limited or no coverage from private insurance or Medicaid.
- *Title IV* goes to clinical research on therapies for children with HIV disease and pregnant women with HIV; it also funds health care to children, youth and their families;
- *Part F* goes to AIDS Education and Training Centers (AETCs), Special Projects of National Significance (SPNS), and the Dental Reimbursement Program.

**Figure 1: Flow of CARE Act Funds**

<b>Title I</b>	<b>Title II</b>	<b>Title III</b>	<b>Title IV</b>	<b>Part F</b>
Federal Grants for Emergency Relief to Eligible Metropolitan Areas ↓	Federal Grants to States and territories ↓	Federal grants for Early Intervention ↓	Federal grants to Pediatric/Family Programs ↓	SPNS, AETCs and the Dental Reimbursement Program ↓
Chief Elected Official Designates HIV Services Planning Council ↓	Governor, Administrative Agent (usually the State Health Dept.) ↓	↓	↓	↓
Governmental Unit (Health Dept.) ↓	Consortia ↓	↓	↓	↓
Community-Based Organizations ↓	Community-Based Organizations ↓	Community-Based Organizations ↓	Community-Based Organizations ↓	Community-Based Organizations ↓
Services to people living with HIV disease	Services to people living with HIV disease	Services to people living with HIV disease	Services to children, youth, women and families living with HIV disease	Services to people living with HIV disease and training for health care professionals

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The Health Resources and Services Administration (HRSA) has the lead responsibility for the implementation of the CARE Act. In 1991 (the first fiscal year of the CARE Act), 16 areas of the nation qualified for funding through Title I.

Today, 51 EMAs receive funding in 21 States, Puerto Rico, and the District of Columbia. In Texas, in addition to the Houston area, there are four other EMAs that receive funding through Title I – Austin, Dallas, Fort Worth/Arlington and San Antonio. The 51 CARE Act EMAs are:

Atlanta GA	Kansas City MO	Ponce PR
Austin TX	Las Vegas NV	Portland OR
Baltimore MD	Los Angeles CA	Riverside-San Bernardino CA
Bergen-Passaic NJ	Miami FL	Sacramento CA
Boston MA	Middlesex-Somerset-Hunterdon NJ	St. Louis MO
Caguas PR	Minneapolis-St. Paul MN	San Antonio TX
Chicago IL	Nassau-Suffolk NY	San Diego CA
Cleveland-Lorain-Elyria OH	Newark NJ	San Francisco CA
Dallas TX	New Haven CT	San Jose CA
Denver CO	New Orleans LA	San Juan PR
Detroit MI	New York NY	Santa Rosa-Petaluma CA
Dutchess Co. NY	Norfolk VA	Seattle, WA
Ft. Lauderdale FL	Oakland CA	Tampa-St. Petersburg FL
Ft. Worth TX	Orange County CA	Vineland-Millville-Bridgeton NJ
Hartford CT	Orlando FL	Washington DC
Houston TX	Philadelphia PA	West Palm Beach FL
Jacksonville FL	Phoenix AZ	
Jersey City NJ		

Including the Houston HSDA, there are currently 26 areas in Texas that receive Title II funding. This HSDA structure has recently been pared down by the Texas Department of Health to seven planning areas: Pan West, Northeast Texas, Northwest Texas, East Texas, Central Texas, South Texas and El Paso. Although coordinated regional planning is taking place within each of these areas, funding continues to be earmarked specifically for the existing HSDA areas.

## CHAPTER 4: ASSESSMENT OF CARE AND PREVENTION NEEDS

A needs assessment is a systematic process of determining the service needs of a defined population. A needs assessment tells us what kinds of services different types of people need and when and where they need them. It should explore the perspectives of people at risk for and living with HIV and their families, service providers, and community representatives. Information is typically collected through surveys, focus groups, interviews, and/or public forums.

The 2005 Houston Area HIV/AIDS Needs Assessment identified and ranked specific HIV care needs. The table below provides a summary of these findings that are the result of the client survey. Services were ranked according to the total number of “yes” responses to the statement, “Do you currently need this service, regardless of whether you are receiving it?” Rankings are based on a total of 45 service categories.

### HIV Care Need and Need Ranking

NEED RANKING	SERVICE	NEED RANKING	SERVICE
1	Ambulatory Care	21	In-Home Support
2	Vision Care	22	Drug Reimbursement
3	Oral Health	23	Outpatient Substance Abuse Services
4	Health Insurance	24	Buddy/Companion Services
5	Case Management	25	Other Supportive Services
5	Food Banks	26	Physical Therapy
6	Bus Pass Assistance	27	Treatment Adherence Services
7	Rental Assistance	28	Outreach
8	Utility Assistance	29	Shelter Vouchers
9	Household Items	30	Home Delivered Meals
10	Support Groups	31	Client Advocacy
11	Nutritional Counseling	32	OB/GYN
12	Nutritional Supplements	33	Early Intervention Services
13	Medical Case Management	33	Home Health Care
14	Referrals	34	Residential Substance Abuse Services
15	Housing Related Services	35	Permanency Planning
16	Psychiatric Treatment & Counseling	36	Low Vision Training
16	Gas/Taxi Vouchers	37	Adult Day Care
17	Van Transportation	38	Child Welfare Services
18	Legal Assistance	39	Hospice Services
19	Psychosocial Support	40	Child Care Services
20	Health Education/Risk Reduction	41	Pediatric Services
21	In-Home Support	42	Speech Pathology

In summary, survey respondents feel their greatest needs relate directly to medical care (such as vision and oral health care) and services such as health insurance and case management, which link them to

medical care and other services. The fact that Home Health Care, Long Term Care, and Hospice are ranked lower may be indicative of the changing nature of HIV/AIDS related to better treatment options. However, interpreting this data is subject to limitation of the design of the study. For example, the survey sample was primarily composed of ambulatory, relatively healthy respondents. Clients that were homebound were underreported in the 2005 Houston Area HIV/AIDS Needs Assessment sample. A second challenge was the misinterpretation by survey respondents of the parameters of some service categories such as referrals and drug reimbursement.

### Assessment Of Need – Gaps In Care

The 2005 Houston Area HIV/AIDS Needs Assessment client survey also identified existing gaps in services and ranked the results. The table below provides a summary of these results that are ranked by those services perceived to have the largest gap. A "gap" is defined as those who responded "yes" to need and "no" to the statement on the survey "Is this service available to you?"

### Service Ranked by Perceived Gap

GAPS RANKING	SERVICE	GAPS RANKING	SERVICE
1	Health Insurance	18	Health Education/Risk Reduction
2	Rental Assistance	18	Other Supportive Services
3	Shelter Vouchers	19	Support Groups
4	Household Items	19	Outpatient Substance Abuse Services
5	Gas/Taxi Vouchers	19	Buddy Companion Services
6	Housing Related Services	19	Outreach
7	Utility Assistance	20	Low Vision Care
7	Nutritional Supplements	20	Adult Day Care
8	Food Bank	21	Child Welfare Services
8	Home Delivered Meals	22	Psychosocial Services
9	Van Transportation	22	Client Advocacy
10	Vision Care	22	Residential Substance Abuse Services
11	Nutritional Counseling	23	Early Intervention Services
11	Home Health Care	24	Treatment Adherence Services
12	Case Management	25	Hospice Care
13	Oral Health	26	Childcare Services
14	In Home Support	27	Psychiatric Treatment & Counseling
15	Legal Services	28	OB/GYN
15	Permanency Planning	29	Physical Therapy
16	Drug Reimbursement	29	Speech Pathology
17	Medical Case Management	30	Referrals
18	Primary Medical Care		
18	Bus Pass Assistance		

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## Profile Of Provider Capacity And Capability

The 2002 Houston Area HIV/AIDS Needs Assessment identified a gap in information on provider capacity and capability. As a result of this, the Planning Council began a two-pronged approach to closing this gap:

1. Surveying ASO's about key service volumes, staffing, and funding.
2. Identifying benchmarks for similar services, specifically related to volume and staffing levels.

This process was completed during the 2005 Houston Area HIV/AIDS Needs Assessment, and the results may be used as one aspect of measurement related to service effectiveness.

The Texas Statewide Coordinated Statement of Need Project (SCSN) developed a comprehensive provider capacity survey, which served as the basis for the Houston-area survey. In order to meet Needs Assessment objectives, questions were added to the SCSN instrument which focused on funding streams by service, staffing levels, staff qualifications, waiting times for appointments, multilingual staff and cultural competency training and available capacity at current resource level. The provider survey was sent to all agencies listed in the Blue Book, the Houston Area HIV Resource Directory published by the Office of Support for the Ryan White Planning Council. In order to enhance the response rate, members of different planning bodies called upon their contacts at key agencies and personally requested support in completing the survey. The results of this effort yielded a total of 83 completed surveys.

Table 23 contains results from the Gaps Analysis of provider capacity. The table lists each service category with the percent of need being met by provider survey respondents and additional system capacity required to provide service to all PLWHA needing but not receiving the service.

The Gaps Analysis generalizes the results of the consumer survey to the entire population of people living with HIV/AIDS in the Houston HSDA. This projects the total need for a service, the extent to which that need is currently being met and estimates the number of PLWHA that need the service who are not having their need met. The gap analysis is accomplished by projecting the need identified by the consumer survey. This can be calculated by:

1. Calculating Total Need by adding all levels of need together (Need Met Easily + Need Met Hard + Need Not Met) or by subtracting those with no need from all consumers responding to the question (Total - No Need).
2. Projecting this need to the population of 15,690 PLWHA in the HSDA identifies total potential need for the service in Region 6. The calculation divides the total need by the total respondents and multiplying by the population of PLWHA (Total Need/Total Respondents x 15,690).
3. The projected need that is being met is compared against the number of consumers receiving the service through provider survey respondent agencies. The total number of HIV positive consumers served by these agencies is presented, and it is used to calculate the percentage of need that is being met by these agencies.
4. The total consumers who need the service but who are not having their need met is calculated by subtracting the total who are having their need met by the total needing the service. This figure is, again, a projection from consumer survey responses.
5. Capacity required to provide service to all needing but not getting service compares those whose need for the service is being met with those whose need is not being met. It should be noted that 31% of respondents were "out-of-care," therefore the number of PLWHA needing but not getting services is large. Bringing these out-of-care consumers into the care system is challenging and will

occur incrementally as targeted strategies are developed. The care system must accommodate this *incremental* growth, but the total additional consumers whose need for services is not being met do not have to be accommodated immediately. Capacity must grow *incrementally* to accommodate need.

**Table 23. Gaps Analysis Results**

<b>SERVICE</b>	<b>Percent of Need Being Met by Provider Survey Respondents</b>	<b>Additional System Capacity Required to Provide Service to ALL Needing but Not Receiving the Service</b>
Ambulatory Care	68%	46%
Vision Care	20%	94%
Oral Health	40%	106%
Health Insurance	--**	--**
Case Management	33%	49%
Food Banks	65%	82%
Transportation (includes Bus Pass Assistance, Van Transportation, Gas/Taxi Vouchers)	29%	71%
Housing Assistance (includes Rental Assistance, Shelter Vouchers)	44%	192%
Emergency Financial Assistance (includes Utility Assistance, In-Home Support, Household Items)	32%	127%
Support Groups	--**	86%
Nutritional Counseling	15%	127%
Nutritional Supplements	30%	190%
Medical Case Management	28%	99%
Referrals	1%	73%
Housing Related Services	23%	300%
Psychological/Psychiatric Treatment & Counseling	68%	92%
Legal Assistance	32%	252%
Psychosocial Support	0%	108%
Health Education/Risk Reduction	N/A*	90%
Drug Reimbursement	--**	--**
Outpatient Substance Abuse Services	4%	141%
Buddy/Companion Services	19%	272%
Other Supportive Services	--**	--**
Rehabilitation Services (includes Physical Therapy, Low Vision Training, Speech Pathology)	17%	140%
Treatment Adherence Services	1%	180%
Outreach	--**	--**
Home Delivered Meals	0%	838%
Client Advocacy	2%	224%

**Table 23. Gaps Analysis Results (continued)**

<b>SERVICE</b>	<b>Percent of Need Being Met by Provider Survey Respondents</b>	<b>Additional System Capacity Required to Provide Service to ALL Needing but Not Receiving the Service</b>
OB/GYN	43%	54%
Early Intervention Services	73%	212%
Home Health Care	6%	313%
Residential Substance Abuse Services	0%	179%
Permanency Planning	--**	--**
Adult Day Care	6.3%	254%
Child Welfare Services	0%	264%
Hospice Services	--**	--**
Child Care Services	38%	269%
Pediatric Services	--**	--**
* Provider survey included both positive and negative clients. --** Gaps Analysis calculations were not conducted for these service categories.		

### **Unmet Need Estimate and Assessment**

In 2000, Congress wrote into the Ryan White Care Act a mandate for grantees to respond to “unmet need.” Simply, unmet need is defined as “HIV positive individuals that are aware of their status and not receiving regular medical care.” According to HRSA, unmet need is determined by identifying the number of people who know their HIV status but are not receiving primary medical care. An individual is considered not in primary medical care when there is no evidence that he or she received any of the following in a defined 12-month period:

- Viral load testing
- CD4 cell count
- Provision of anti-retroviral therapy

Unmet need is made up of two parts: estimation of unmet need and assessment of unmet need. Estimation of unmet need is determining the approximate number of people in the EMA who are HIV positive, know their status, and aren’t receiving primary medical care. Assessment of unmet need is determining the service needs, gaps, and barriers of the individuals who are not in care.

The unmet need estimates for the Houston EMA have been provided in the following table using the framework provided by HRSA’s HIV/AIDS Bureau.

**Figure 2. Unmet Need Framework**

<b>Population Sizes</b>	<b>Value</b>		<b>Data Sources</b>
Number of PLWA during the 12-month period through 12/31/03	9,405		HARS
Number of PLWH (non-AIDS, aware) during the 12-month period through 12/31/03	6,224		HARS
<b>Care Patterns</b>	<b>Value</b>	<b>Percent</b>	<b>Data Sources</b>
Number of PLWA who received the specified HIV primary medical services during the 12-month period through 12/31/2003	6,172	65.6%	HARS , THMP, ELR, URS, VA Hospital, Harris County Jail
Number of PLWH (non-AIDS, aware) who received the specified HIV primary medical services during the 12-month period through 12/31/2003	3,714	59.7%	HARS , THMP, ELR, URS, VA Hospital, Harris County Jail
<b>Calculated Results</b>	<b>Value</b>	<b>Percent</b>	<b>Calculation</b>
Number of PLWA who did not receive primary medical services	3,233	34.4%	Value: A – C. Percent: E/A
Number of PLWH (non-AIDS, aware) who did not receive primary medical services	2,510	40.3%	Value: B – D. Percent: F/B
<b>Total HIV+/aware not receiving specified primary medical services (quantified estimate of unmet need)</b>	<b>5,743</b>	<b>36.7%</b>	<b>Value: E + F. Percent: G/(A + B)</b>

Population Estimates - For a 12-month period through December 31, 2003, the number of PLWA was 9,405 and the number of PLWH (non-AIDS, aware) was 6,224. The total number of people living with HIV or AIDS in the Houston EMA was 15,629.

Estimates of People in Care - Based on the estimates, the number of PLWA in care was 6,172, or 66% of the total number of PLWA in the Houston EMA through December 31, 2003. The number of PLWH (non-AIDS, aware) in care was 3,714 (60%) among all PLWH in the EMA. The total number of PLWHA who received HIV primary medical services as of the end of 2003 was 9,886 (63%).

Estimates of Unmet Need - Using the inputs for care patterns obtained, the Houston EMA estimates that 3,233 (34%) of the diagnosed PLWA are not receiving HIV primary medical care. For PLWH, 2,510 (40%) were found to be out-of-care. After combining the two groups, the total number of PLWHA who have unmet need in the Houston EMA through the end of 2003 was 5,743 (37%) among all PLWHA.

### **Assessment of Unmet Need**

Among HIV/AIDS cases, 95% of PLWHA reside within Harris County, which is the urban center of the EMA. Likewise, 95% of PLWHA with unmet need (6,798 individuals) are also in Harris County. The counties of Fort Bend and Montgomery comprise another 4% of the unmet need population and the remainder (<1%) of the patients who are out of care reside in the counties of Chambers, Liberty and Waller.

**Table 24. Subpopulation Analysis**

	PLWHA Population	Met Need	Unmet Need	% Unmet Need Population	% Category w/ Unmet Need	% PLWHA Population
<b>Total from Framework</b>	<b>15,629</b>	<b>9,886</b>	<b>5,743</b>	<b>100%</b>	<b>36.7%</b>	<b>100%</b>
<b><u>HIV or AIDS</u></b>						
PLWA	9,405	6,172	3,233	56.3%	34.4%	60.2%
PLWH/non-AIDS	6,224	3,714	2,510	43.7%	40.3%	39.8%
<b>Total from Categories</b>	<b>15,629</b>	<b>8,501</b>	<b>7,128</b>	<b>100%</b>	<b>45.6%</b>	<b>100%</b>
<b><u>Gender</u></b>						
Male	11,602	6,180	5,422	76.1%	46.7%	74.2%
Female	4,027	2,321	1,706	23.9%	42.4%	25.8%
<b><u>Race/Ethnicity</u></b>						
White, not Hispanic	5,168	2,613	2,555	35.8%	49.4%	33.1%
Black, not Hispanic	7,493	4,134	3,359	47.1%	44.8%	47.9%
Hispanic	2,805	1,671	1,134	15.9%	40.4%	18.0%
<b><u>Age Group</u></b>						
Children (<13)	173	81	92	1.3%	53.2%	1.1%
Youth (13-19)	129	47	82	1.2%	63.6%	0.8%
Adult Men (20+)	11,465	6,111	5,354	75.1%	46.7%	73.4%
Adult Women (20+)	3,862	2,227	1,635	22.9%	42.3%	24.7%
<b><u>Mode of Exposure</u></b>						
MSM	6,506	3,463	3,043	42.7%	46.8%	41.6%
IDU	1,855	1,054	801	11.2%	43.2%	11.9%
MSM/IDU	931	587	344	4.8%	36.9%	6.0%
Heterosexual	3,370	2,044	1,326	18.6%	39.3%	21.6%
Pediatric	256	127	129	1.8%	50.4%	1.6%
Not Classified	2,686	1,214	1,472	20.7%	54.8%	17.2%

In terms of the demographics of PLWHA who are out of care, an analysis was performed and the findings are provided in the above Table 24. *Please note that the demographic analysis did not include data from the local jail nor the VA Hospital, since the aggregate data provided could not be broken down into demographic categories.* In terms of gender, the majority of PLWHA with unmet medical needs are male at 76% of unmet need cases. African American and White PLWHA account for the largest proportion of unmet need, at 47% and 34%, respectively, when compared to other races/ethnicities. After examining the age breakdowns, the majority of PLWHA with unmet need consists of adult men (age 20 or older) at 75% of HIV/AIDS cases. Children and youth have much smaller numbers than the adults, representing 2.5% of PLWHA who are out-of-care. Within their own age categories, however, 53% of children (< 13 years) have unmet need while 64% of adult men have unmet need. Finally, when analyzing the data by mode of exposure, PLWHA who are MSM (including intravenous drug users) accounted for almost 48% of the unmet need population. Heterosexual contact represents the next highest category of risk reported, at 19% of the unmet need population. The category of “Not Classified” makes up 21% of the unmet need population, although the CDC believes that heterosexual contact is possibly the main transmission mode behind this

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category because women may be unaware of how they were infected if they did not know of their partner's HIV status. If this category is taken into account, then the exposure of heterosexual contact may represent up to 39% of the unmet need population.

Through the unmet need estimate, the Houston EMA/HSDA have identified various issues experienced by PLWHA who have unmet need, including access barriers, housing-related problems, stigma or discrimination associated with HIV infection, drug abuse and lack of knowledge about a person's own health status. There are also challenges unique to the Houston PLWHA, such as lack of transportation and financial constraints due to poverty or lack of health insurance. The number one barrier to accessing services, however, as identified by the 2005 Houston Area HIV/AIDS Needs Assessment, is lack of information. This includes information about services, where they are located, and eligibility requirements.

The unmet need estimate equips planning bodies with data for developing strategies for bringing HIV+ people into medical care, and prioritize/allocate services targeted to the populations in need. Some of these strategies include:

- Conducting analyses of HIV prevalence and incidence data;
- Reviewing service utilization data on a regular basis;
- Continuing to identify not-in-care communities through the unmet need framework, needs assessment activities, community focus group and public input forums;
- Placing service providers at community based organizations and agencies with a documented capability to identify out-of-care PLWHA, or at HIV testing sites;
- Supporting services that encourage adherence to medication and treatment.

### **HIV Prevention Needs**

Since the inception of HIV Prevention Community Planning in 1993, the Houston HIV Prevention Community Planning Group (CPG) and the Houston Department of Health and Human Services (HDHHS) have been working together to develop an effective and comprehensive approach to HIV prevention in Houston.

The 2004-2006 Comprehensive Plan for HIV prevention identifies priority populations and a set of interventions to effectively provide HIV/AIDS Prevention. The plan also addresses prevention by focusing on increased counseling and testing, using evidence-based interventions and prevention with positives. HDHHS will use the plan as the foundation for resource and program allocation decisions in regards to HIV prevention in Houston.

Until recently, targeted primary prevention for people living with HIV and AIDS received minimal serious discussion. For most of the epidemic, the lethality of AIDS overshadowed consideration of sexual behavior among HIV-positive persons. Moreover, there was great concern that attempts to address sexual risk behaviors among HIV-positive persons would only result in further stigmatization of already marginalized groups. With advances in testing and treatment for HIV disease, however, a more traditional epidemiological approach to the control of HIV/AIDS is being widely considered; that is, in addition to focusing on the behaviors of uninfected persons to reduce risk of acquisition, attention is now being given to the behavior of infected individuals to reduce risk of transmission.

With respect to existing scientific literature, several conclusions may be drawn. Studies suggest that some factors influencing sexual risk behaviors among HIV-positive persons are similar to those factors affecting HIV-negative or unknown status persons, such as intentions and self-efficacy for condom use, communication and negotiation skills, and recreational drug use. Other factors appear to be unique

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to HIV-positive persons, such as fear and anxiety related to disclosure of serostatus, feelings of responsibility to protect potential partners, and concerns about protecting oneself from “superinfection” or other sexually transmitted diseases. Still other factors appear to be related to contextual and relational factors that may differentially impact specific subgroups of HIV-positive persons. To be effective, risk reduction interventions must address these multiple and complex influences on the sexual behavior of HIV-positive persons and must do so without incurring further stigmatization of HIV-positive persons. Moreover, these interventions can serve only as a single component of a comprehensive disease control strategy that includes increased HIV testing and improved continuity and quality of care and treatment for HIV-positive persons.

The 2001 HIV Prevention Needs Assessment survey of 217 HIV-positive persons in Houston also offers notable findings about the behaviors and attitudes of this group. First, there is considerable sexual activity among this population, with 52% reporting two or more sex partners during the previous year. Of the 38% describing themselves as in a marriage or committed relationship, 34% reported two or more sex partners in the past year. Although 89% report using a condom at least some of the time, 11% report never using one. As in other studies, a significant proportion (15%-25%) of the study population feared a sexual partner’s reaction to the suggestion of condom use, and was unsure of their ability to correctly use a condom or negotiate condom use. While men appear more likely than women to use a condom, their confidence in their ability to use one consistently is linked to the belief that condom use is “good.” A significant majority of both men and women endorse the idea of disclosure; however, about 20% do not routinely disclose their HIV status to partners, and more than one-third consistently fail to learn the HIV status of their partner. More than one-fourth (28%) endorse the idea that having only one sex partner protects against HIV disease. Those in “committed” relationships may be more at risk for reinfection and transmission, either because of failure to disclose status or perhaps mutual agreement with a partner. While most respondents do not view HIV/AIDS as worse than any other terminal illness, it is not clear how much this opinion reflects their view at the time of infection, whether it may have been influenced by advances in treatment, or whether it influences decisions about risk-taking behavior.

Focus groups with 21 survey respondents in many ways demonstrate the changes that have occurred for those living with HIV since the advent of Highly Active Antiretroviral Therapy (HAART). Concerns about how to face challenges of living rather than the certainty of dying appear uppermost in their minds. With respect to prevention, the data generally complement findings of the survey and offer additional information, as well. All participants emphasize the importance of healthy emotional functioning as a precondition for safe behavior; noting that self care and healthy sexual behavior are unlikely without self-respect and the absence of emotional distress or illness. Just as strongly, participants emphasize the importance of having family support during their illness, and that seeking it can be very difficult. For some, disclosure to families is stopped by fears of rejection because of the illness or homosexuality. African Americans in the groups agree that significant portions of their communities lack basic knowledge about HIV transmission and treatment, and that homophobia contributes to a reluctance to address the issues of both HIV and sexuality. While males in particular convey the sense that disclosure of their HIV status to sexual partners is desirable, they acknowledge that disclosure in fact is far from consistent. In general, suggestions from males about how to encourage safer behavior tend to focus on broad social change, e.g., decreasing homophobia, while women’s tend to emphasize the role of the individual in self-care.

Both the literature review and the 2001 HIV Prevention Needs Assessment with PLWHAs suggest that broad generalizations about the population of PLWHA are not warranted. However, both sources strongly indicate that local prevention efforts aimed at persons living with HIV/AIDS (PLWHA) should emphasize:

- 1) Integration of prevention into primary care,

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- 2) Greater emphasis on skills acquisition,
  - 3) More focused targeting of prevention efforts to specific subpopulations, and;
  - 4) Increased testing of persons who do not know their HIV status.

*These and other recommendations are described more fully below:*

- **Provide comprehensive and ongoing education about treatment and transmission as part of patients' primary medical and mental health care.** Medical and mental health care providers appear to be respected sources of information, and there is evidence that patients may act in ways that they believe will gain the approval of medical care providers. Given the psychosocial distress that is likely to accompany being HIV-positive, emotional support as well as skills building over time are needed to promote accurate understanding of reinfection risk, adoption of safer behaviors, and an increased sense of responsibility for protecting self and others from additional exposure to sexually transmitted infections. Implementation of this recommendation implies a need to expand the training that medical and mental health care providers receive regarding communication about sexual issues and methods of risk reduction. Realistically, these professionals cannot be the sole source of patients' information and support; however, their credibility with patients suggests a crucial role in assessment of problematic behaviors and emotional distress, as well as referral to other appropriate providers. More coordination and collaboration between prevention service providers and care services should be arranged as a first step toward a comprehensive continuum of care that serves both the HIV-infected population and those with whom they are in contact.
- **Insure the availability and accessibility of mental health and other emotional support services.** Discouraging isolation, strengthening coping skills, and providing treatment for the psychological distress and mood disorders that can be indirectly or directly related to unsafe sexual behavior are imperative. More generally, volunteerism and participation in support activities are reported as promoting healthier emotional functioning. A recent evaluation of mental health services for PLWHA in Harris County found that more than 80% of those utilizing the services had benefited in ways that are correlated with lower behavioral risks (Sage Associates, 2000).
- **Design interventions that promote and support (1) disclosure and elicitation of HIV status with sexual partners, (2) consistent condom use, and (3) a sense of responsibility to protect self and others.** While disclosure does not guarantee safer behavior, difficulties with disclosure are of clear concern to local PLWHA. At least one study (Kalichman et al (2001) suggests that using interventions to build behavioral skills and enhance self-efficacy for condom use can significantly reduce sexual risk behaviors. Negotiation skills and communication should be strengthened, especially among females.
- **Target interventions to specific subgroups of PLWHA.** Some factors influencing sexual risk behaviors of PLWHA may vary according to subgroup. Younger MSMs and substance abusers may be particularly in need of interventions to reduce high-risk behavior; providing multiple intervention points is especially important, given the persistent nature of some risk correlates. The African American community may have a range of needs. For some, providing comprehensive information about methods of transmission and treatment may be most appropriate. For others, discussion of homosexuality within the community may be especially useful. The most effective means for delivering the interventions is also likely to be different in different communities. African- American participants in local studies have suggested the church as one appropriate venue to begin discussion about the topics of HIV and homosexuality, and as a less anxiety provoking testing site. It might be helpful to begin this

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process with an examination of how a small number of local black churches have introduced discussion of HIV and homosexuality and/or support for gay members; findings could provide a basis for devising a model to assist other interested churches.

- **Develop more proactive approaches to encourage testing of individuals at high risk.** Current testing efforts appear insufficient to reach the estimated one-third of infected persons who do not know their status. Local participants suggested, among other things, that testing should be free, heavily advertised, available in such easily accessible locations as shopping malls and churches, and encouraged through the use of incentives such as transportation assistance.
- **Incorporate comprehensive HIV prevention and treatment education as a regular component of all substance abuse prevention and treatment programs.** The link, direct or indirect, between substance abuse and HIV risk behavior is clear.
- **Provide a means for regular review of materials used in prevention interventions.** The existence of misconceptions about the transmission and treatment of HIV/AIDS may be related in part to the existence of outdated or inappropriate educational materials. Such materials should be periodically reviewed by knowledgeable and independent community members charged with considering not only accuracy and timeliness, but suitability for target audiences.

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## CHAPTER 5: CURRENT SYSTEM OF CARE

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### Continuum of Care

A continuum of care is a model of how a community is using, or would like to use, its resources. In the case of HIV, as defined by the Health Resources and Services Administration (HRSA), a continuum of care is “a coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV infection to meet their health care and psychological service needs throughout all stages of illness.” These services usually include:

- Primary and secondary prevention of HIV infection
- Treatment and prevention outreach to both the general public and to identified at-risk populations
- Medical and social services, particularly primary medical care, HIV related medications, mental health treatment, substance abuse treatment, oral health and case management services.
- Support services that ensure universal access to medical and social services to all PLWHA who need service

An ideal continuum of care is a “wish list” of a set of services offered to PLWHA, identifying all health and social services that may be needed. This wish list then can be compared to the actual system of care, or the resource inventory, so that the HIV community can determine whether the services that are currently available fit the clients’ current and projected needs.

Developed in 1999, the Houston area Continuum of Care is conceptualized as a sort of “rail system” that identifies and tracks the HIV services deemed necessary to those who are living within the Houston area. This rail system concept allows people living in the area to get in or out of the system depending on their general knowledge of the HIV virus, including how it is transmitted; their serostatus; their health; and their individual desire to stay within the system. The five tracks on Houston’s continuum of care are:

- A: Public Advocacy to the General Public
- B: Outreach to At Risk Populations
- C: Prevention of HIV infection
- D: Early Treatment of HIV infection
- E: AIDS Treatment to PLWA

*Each track is intended to reach a different audience:*

**Track A** includes general HIV health and prevention messages and is intended for the general population. The ultimate “destination”, or goal, of this track is to build public support for HIV prevention and care services.

**Track B** includes mobile clinics, counseling and testing, community outreach and hotlines and is intended for those populations who have been identified as at risk. The ultimate goal of this track is that people are informed of their serostatus, that is, whether they are HIV positive or negative.

**Track C** includes audience specific prevention messages as well as support groups and individual prevention counseling and is intended to reach those who choose to test for HIV and then discover that they are HIV negative. The goal of this track is that people maintain their negative status.

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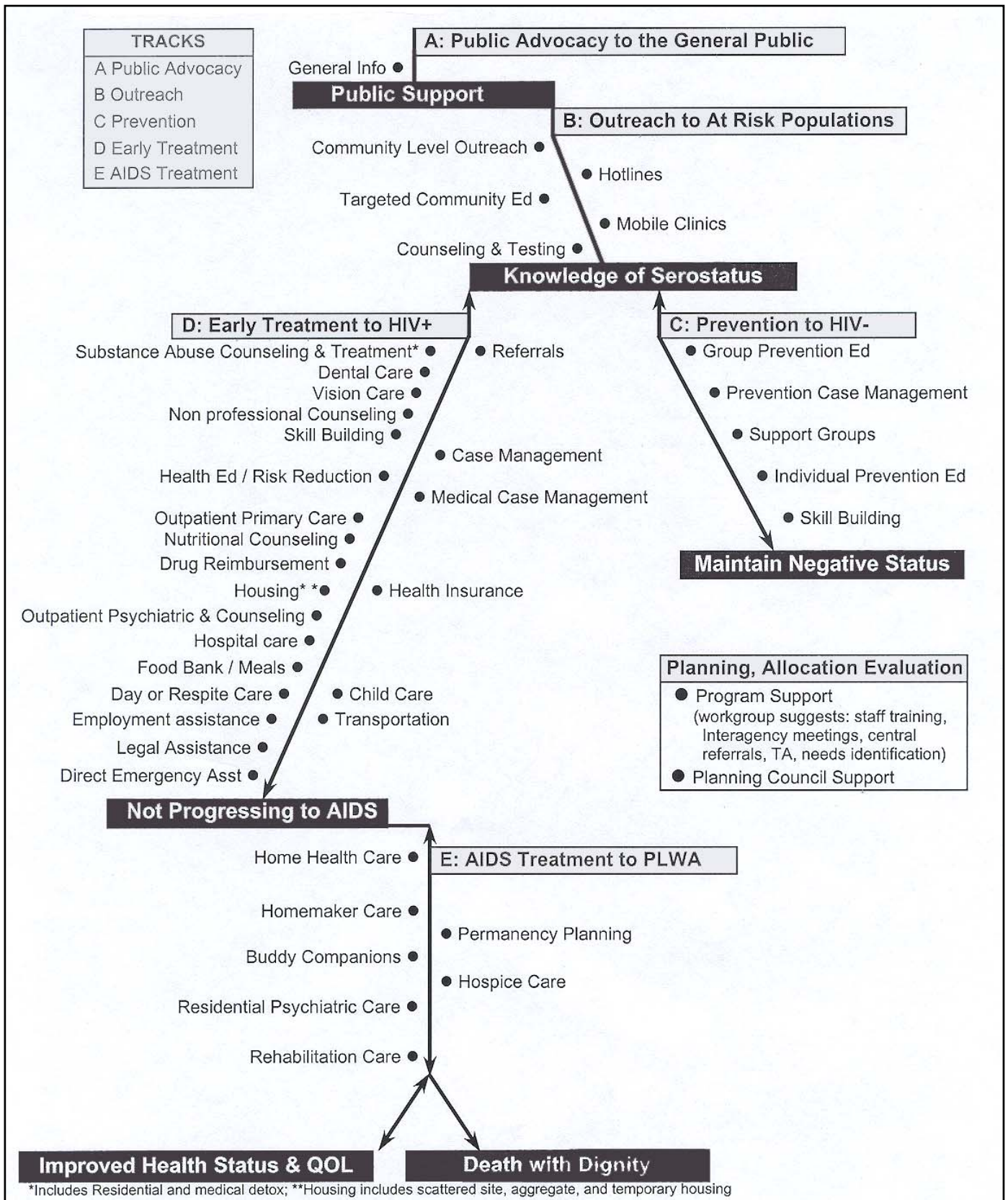
**Track D** outlines an enormous array of services including everything from substance abuse treatment to case management and is intended to reach those who test positive for HIV. The goal of this track is that people with HIV not progress to AIDS (and should a cure develop over the period this document is valid, the “destination” would include moving back to track C or B or A).

**Track E** includes home health care, hospice care and rehabilitation and is intended for those individuals who receive an AIDS diagnosis. The goal of this track is that people with AIDS improve their health status and quality of life (and hopefully they will return to track D), or, if necessary, to create the conditions that will allow for death with dignity.

This track paradigm allows the continuum of care to be imagined as a system that will easily embrace both individuals who are infected and those individuals who are at risk for infection but test negative. Additionally, the multiple tracks allow movement by clients across the system. As medications become more sophisticated and more successful – at both maintaining the health of recently diagnosed individuals and reviving the health of those individuals whose infections have progressed – the system will need to facilitate a client’s ability to get in and out of disparate modes of care with grace, ease, and simplicity.

The image on the following page illustrates the skeletal framework of this “track” system continuum of care.

**Figure 3: Houston Area HIV/AIDS Continuum of Care**



**Note:** This is not an eligibility chart - services that are listed as especially needed by people with AIDS does not mean that people with HIV (not AIDS) are not eligible. And conversely, services listed as especially needed by PLWH to help prevent progression to AIDS, does not mean that PLWHAs are not eligible for those services.

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The following listing presents information about the HIV service agencies and the services they provide in the Houston area continuum of care. The listing shows the clients each organization services and lists the funding sources (identifying the amounts of those funds by source) for each of the care organizations. The information was gathered from providers who volunteered their information in the 1999 Comprehensive Needs Assessment. For this document, we have linked the agencies to the model of the system of care by describing on which track each agency falls along the continuum of care for HIV prevention and care services (shown in bold next to the service).

### **Summary of Service Providers**

*At this time, each track of the continuum of care is being addressed by the service providers. Below is a quick summary:*

- Track A: Public Advocacy to the General Public:** 7 agencies currently provide public advocacy to the general public.
- Track B: Outreach to At Risk Populations:** 11 agencies currently provide outreach to at risk populations.
- Track C: Prevention to HIV negative:** 30 agencies currently provide prevention messages and support to individuals who test HIV-.
- Track D: Early Treatment to HIV positive:** 2 agencies currently provide early treatment to individuals who are HIV+.
- Track E: AIDS Treatment to PLWA:** 17 agencies currently provide treatment and care to PLWA.

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## CHAPTER 6: INVENTORY OF AVAILABLE LOCAL, STATE AND FEDERAL RESOURCES

*A resource inventory is simply an accounting of all the resources available in a community. These include service providers, the services they offer, and the money available for these services.*

The Ryan White CARE Act, the largest sole source of HIV/AIDS funding, cites 31 eligible services categories. These are:

### **Health Care Services:**

- Ambulatory/outpatient medical care
- Dental care
- Drug reimbursement program
- Health insurance (continuation)
- Home and community based care
- Hospice Care
- Inpatient personnel costs
- Mental health services
- Nutritional counseling
- Rehabilitation services
- Substance abuse services
- Transportation
- Treatment adherence services

### **Support Services:**

- Buddy/companion services
- Case management
- Child care services
- Child welfare services
- Client advocacy
- Day or respite care (including child care)
- Direct emergency financial assistance
- Early intervention services
- Food bank/home delivered meals/  
Nutritional supplements
- Health education/risk reduction
- Housing assistance
- Housing related services
- Legal services
- Other/Translation/interpretation services
- Outreach
- Permanency planning
- Psychosocial support services
- Referral

For the most current and up-to-date inventory of HIV prevention and care services, please see the Ryan White Title I publication of HIV resources commonly known as the “Blue Book”. (The Blue Book can be viewed online at [www.rwpc.org](http://www.rwpc.org) or ordered by calling 713-572-3724.)

The following table reports on the availability of public funding for HIV-related care services within the Title I EMA from Federal, State and local sources for Fiscal Year 2005 using the six core service categories, two “complimentary” core services and all other services. The row headings identify the categories of funding available to the EMA which are to be reported as: (1) an aggregate amount for each service category; and (2) as a proportion of the amount of Ryan White Title I, Federal, State, and local funding available for a service category.

**Ryan White Title I Funds** - Reflects FY 2005 formula and supplemental funds allocated to each broad service category. Amount does not reflect any FY 2004 funds that were carried over into FY 2005.

**Other Federal Funds** - Indicates the total amount of funds available for each broad service category from additional Federal sources such as Ryan White Titles II, III, IV, and Special Projects of National Significance (SPNS); HRSA-funded pediatric/family demonstration projects; HOPWA; locally-allocated Community Development Block Grant funding (CDBG); National Institutes of Health (NIH) AIDS Clinical Trials Group (ACTG) and Community Projects for Clinical Research in AIDS (CPCRA); Substance Abuse and Mental Health Services Administration (SAMHSA) HIV funds; or other identifiable Federal funding.

**State Funds** - Indicates the aggregate amount of State-appropriated funds allocated to each of the service categories listed in the table.

**Local Funds** - Indicates the total amount of local city and/or county general revenue spent on services to persons with HIV/AIDS, for each broad service category. To the extent possible, figures reported reflect all funding supporting persons with HIV/AIDS (e.g., local general assistance or “welfare” payments to this population).

**Table 25. Houston EMA (Title I) FY 2005 Funding in the Context of Other Public Funding**

Services	Amount and Percent of Public Funding by Source									
	Ryan White Title I		Other Federal Funds		State Funds		Local Funds		TOTAL FUNDS	
	\$	%	\$	%	\$	%	\$	%	\$	%
Home/Community-Based Support Services	4,120,089	21.5	11,384,431	59.5	3,620,704	18.9	0	0.0	19,125,224	25.3
Ambulatory/Outpatient Medical Care	12,003,898	48.2	1,634,015	606	434,159	1.7	10,781,542	43.3	24,853,614	32.9
State AIDS Drug Assistance Program (ADAP)	0	0.0	0	0.0	23,547,580	100	0	0.0	23,547,580	31.2
Other Outpatient/Community-Based Primary Medical Care Services	1,816,710	54.3	1,274,496	38.1	252,250	7.5	0	0.0	3,343,456	4.4
Inpatient Medical Care Services	0	0.0	0	0.0	0	0.0	3,696,189	100	3,969,189	5.3
Prevention with Positives	0	0.0	473,050	76.3	147,200	23.7	0	0.0	620,250	0.8
<b>TOTAL FUNDS</b>	<b>17,940,697</b>	<b>23.8</b>	<b>14,765,992</b>	<b>19.6</b>	<b>28,001,893</b>	<b>37.1</b>	<b>14,750,731</b>	<b>19.5</b>	<b>75,459,313</b>	<b>100.0</b>

## CHAPTER 7: BARRIERS

### PLWHA Barriers

According to the 2005 Houston Area HIV/AIDS Needs Assessment, information-related barriers were the most frequently identified response to the question “What keeps you from getting [a particular service]?” Examples of information barriers to care included, “I didn’t have the information I needed about these services—that it existed, where to get it, how to qualify, etc.” For the total consumer survey sample, informational barriers to care were the most frequently identified for all services. Only two services, childcare and child welfare, had access barriers identified more frequently than informational.

Informational barriers to care were also the most frequently identified for in-care consumers. The only services with access barriers identified more frequently than informational barriers were vision care, oral health care, OB/GYN services and food bank. Out-of-care consumers most frequently reported informational barriers for all services. The percentage of responses identifying informational barriers ranged from 68% for drug reimbursement and legal services to 49% for vision care and 48% for OB/GYN services.

### Overall Barriers

The following table ranks each service category based on the number of consumer respondents reporting any type of barrier (informational, access/availability, personal/cultural, service delivery) when accessing the service.

#### Services Ranked by Perceived Barrier

Barrier Ranking	Service	Barrier Ranking	Service
1	Housing Assistance – Rental Assistance	19	Home Health Care Services
2	Health Insurance	20	Substance Abuse Services – Counseling
3	Housing-related Services	21	Outreach
4	Emergency Financial Assistance – Utility Assistance	22	Rehabilitation – Physical Therapy
5	Transportation – Gas/Taxi Vouchers	23	Community Case Management
6	Transportation – Van Transportation	24	Substance Abuse Services - Treatment
7	Food Bank	25	Support Groups
8	Emergency Financial Assistance – Household Items	26	Psychological/Psychiatric Treatment & Counseling
9	Housing Assistance – Shelter Vouchers	27	Peer Counseling
10	Transportation – Buss Pass Assistance	28	Rehabilitation – Low Vision Training
11	Nutritional Supplements	29	Early Intervention Services
12	Oral Health	30	Hospice Care
13	Legal Services	31	Health Education/Risk Reduction

Barrier Ranking	Service	Barrier Ranking	Service
14	Vision Care	32	Rehabilitation – Speech Pathology
15	Drug Reimbursement	33	OB/GYN
16	Ambulatory Care	34	Child Care
17	Emergency Financial Assistance – In-Home Support	35	Adult Day Care
18	Medical Case Management	36	Pediatric

### Accessing Care

The 2005 Houston Area HIV/AIDS Needs Assessment also evaluated service accessibility based upon client perception. The following table ranks each service category based on reported difficulty in accessing the service:

### Services Ranked by Difficulty of Access

Barriers Ranking	Service	Barriers Ranking	Service
1	Rental Assistance	20	Outpatient Substance Abuse Services
2	Health Insurance	21	Physical Therapy
3	Housing Related Services	21	Outreach
4	Utility Assistance	22	Case Management
5	Gas/Taxi Vouchers	22	Residential Substance Abuse Services
6	Van Transportation	23	Support Groups
7	Food Bank	24	Psychological Counseling
8	Household Items	24	Psychosocial Support Services
9	Shelter Voucher	25	Low Vision Training
10	Buss Pass Assistance	26	Referrals
11	Nutritional Supplements	27	Permanency Planning
12	Oral Health	28	Early Intervention Services
13	Legal Services	29	Hospice Care
14	Home Delivered Meals	30	Health Education/Risk Reduction
15	Vision Care	31	Child Welfare Services
15	Drug Reimbursement	32	Speech Pathology
16	Primary Medical Care	33	Client Advocacy
16	Other Supportive Services	34	OB/GYN
17	In Home Support	34	Childcare
18	Nutritional Counseling	35	Buddy Companion Services
18	Medical Case Management	36	Day Respite Care
19	Treatment Adherence Services	37	Pediatrics
19	Home Health Care		

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## Provider Barriers

The following barriers were reported through focus groups with service providers.

### *Excessive Paperwork:*

- Case managers increasingly feel burdened with paperwork. Case management supervisors discussed the paperwork burden extensively.

### *Financial Assistance for Consumers:*

- Case management supervisors confirmed the need for financial assistance:
  - *“I think more than that we hear they need money for housing, rent and utilities and financial assistance. They just don’t know where to go... We are constantly hearing that they need rent and utility assistance; they need financial assistance and they don’t know where to go to get it.” (Case Management Supervisors)*

### *Transportation and Housing:*

- Transportation and housing were identified by several members of the non-Ryan White providers as the two most essential needs to link PLWHA with the care system.

### *HIV Medications:*

- Case management supervisors report the cost of HIV medication is a barrier to returning to the workforce.
  - *“It concerns a lot of them. We had a few clients who talked about they finally got themselves on their feet and they are working again and they are off disability. When they are on disability, they find all kinds of very creative ways of stashing away money because they know when they come off disability they won’t have medication.” (Case Management Supervisors)*
- Case management supervisors discussed the need for funding for non-HIV medication, and stated that medications are difficult for their clients to access.
  - *“The thing I hear most about are complaints about medication and access to medication, different types of medication—there are problems with medication. Those persons who need medication they’re not necessarily antiretroviral medication--heart medicine, diabetes, symptoms that come after the HIV. Psychotropics and other disease medications (are needed).”*
- Non-HIV medication coverage varies significantly between insurers, and case management supervisors discussed these differences
  - *“That’s the thing. They have to wait until they’ve got all the approvals in order to get everything covered, if they’ve got those things. If they don’t have any kind of insurance in place when they come in, it’s the luck of the draw”. (Case Management Supervisors)*

### *Mental Health Services:*

- Case management supervisors identified a need for professionally facilitated support groups targeting women.
  - *(Among women PLWHA) “You’ve got some serious disclosure issues. Some serious isolation. Low self-esteem. Disclosure. You’re really gonna have to get them feeling more empowered. You have to address that.” (Case Management Supervisors)*

- 
- Case management supervisors discussed the need for programs integrating mental health therapy and counseling with substance abuse treatment for patient with dual diagnoses.

*Substance Abuse Treatment:*

- Case management supervisors feel that treatment options are limited by HIV status and ability to pay.
- Case management supervisors also identified a need for substance abuse treatment for women with children.
- Another need identified by case management supervisors was for programs for patients with dual mental health and substance abuse diagnoses.
- Ability to pay is a barrier to accessing substance abuse treatment and to the type and duration of treatment available. Providers made the point that substance abuse treatment is accessible if the client has some type of insurance.

*Transportation*

- The case management focus group included one rural case manager who stated that transportation is an ongoing challenge for her clients.
  - *“Especially in the rural counties we don’t have transportation. It’s hard to get to appointments; it’s hard to get to your job... That’s a big problem.” (Case Management Supervisors)*

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**Section II**

**WHERE ARE WE GOING?**

*Our Ideal Continuum of Care*

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## CHAPTER 8: OUR IDEAL CONTINUUM OF CARE

The ideal continuum of care is a term that encompasses the comprehensive range of services needed by individuals and families who are at-risk for and living with HIV infection in order to meet their health care and psychosocial services needs. It is a “wish list” set of services and mechanisms for linking these services that the community would like to offer without the constraint of only working with what resources are currently available. The continuum of care outlines an ideal system that would reduce fragmentation between prevention and care, as well as respond to changing individual and family needs in a holistic, coordinated, and timely manner.

The overall goal of this continuum is to provide a framework for care that will be used to inform and guide the planning bodies, providers, and consumers as they establish priorities and fund HIV/AIDS services. It will provide the structure that will enable any adjustments needed to meet continuing and changing needs.

### **Elements of the Continuum of Care**

This continuum of care takes into account several factors. These are: 1) the mission and vision statements of the various planning bodies, 2) the goals and objectives of the planning bodies, 3) the services available in the delivery system, 4) the linkages necessary to ensure efficiency and effectiveness, and 5) the coordinating mechanisms that can be utilized to ensure effective linkages are established and maintained.

### **System Outcomes**

The mission and vision statements note several common system goals that suggest which services should currently be available and which services should be considered in the Houston area continuum of care. These goals and objectives include:

- Identifying and addressing needs of unserved/underserved populations
- Including prevention and care services
- Providing services in an efficient and effective manner
- Providing services in a seamless manner as a person moves among the different levels of care
- Providing high quality and culturally appropriate services
- Advocating for PLWHA service needs
- Encouraging cooperation in the coordination/delivery of services
- Assuring that the community in need is aware of available prevention and care resources
- Promoting the dissemination of information to all constituencies
- Identifying needs, gaps and barriers
- Planning capacity to meet needs
- Improving the quality of life
- Assuring that the system is free of discrimination based on race, color, creed, gender, religion, sexual orientation, disability, or age
- Assuring that PLWHA, the general public, and providers are included in the process

Five attributes summarize the system goals and objectives. Referred to as the “5 A’s”, the delivery system must be:

- Available to meet the needs of the PLWHA and their caregivers
- Accessible to all populations infected or affected by HIV/AIDS
- Affordable to all populations infected or affected by HIV/AIDS
- Appropriate for different cultural and socio-economic populations and care needs
- Accountable to the funders and clients for providing contracted services at high quality

**Client Outcomes**

In addition to these system goals and objectives, system and client outcomes can be measured to determine its effectiveness. Several client outcomes can be inferred from the goals and objectives above. These address the needs of all of the consumers within the continuum of care. They include: 1) preventing persons from becoming HIV positive; 2) preventing persons from progressing from HIV to AIDS; 3) improving or maintaining health status of PLWA; 4) sustaining or improving the quality of life of PLWA; 5) providing a dignified death to those who are at the end-stage of AIDS; and 6) providing appropriate linkages between services.

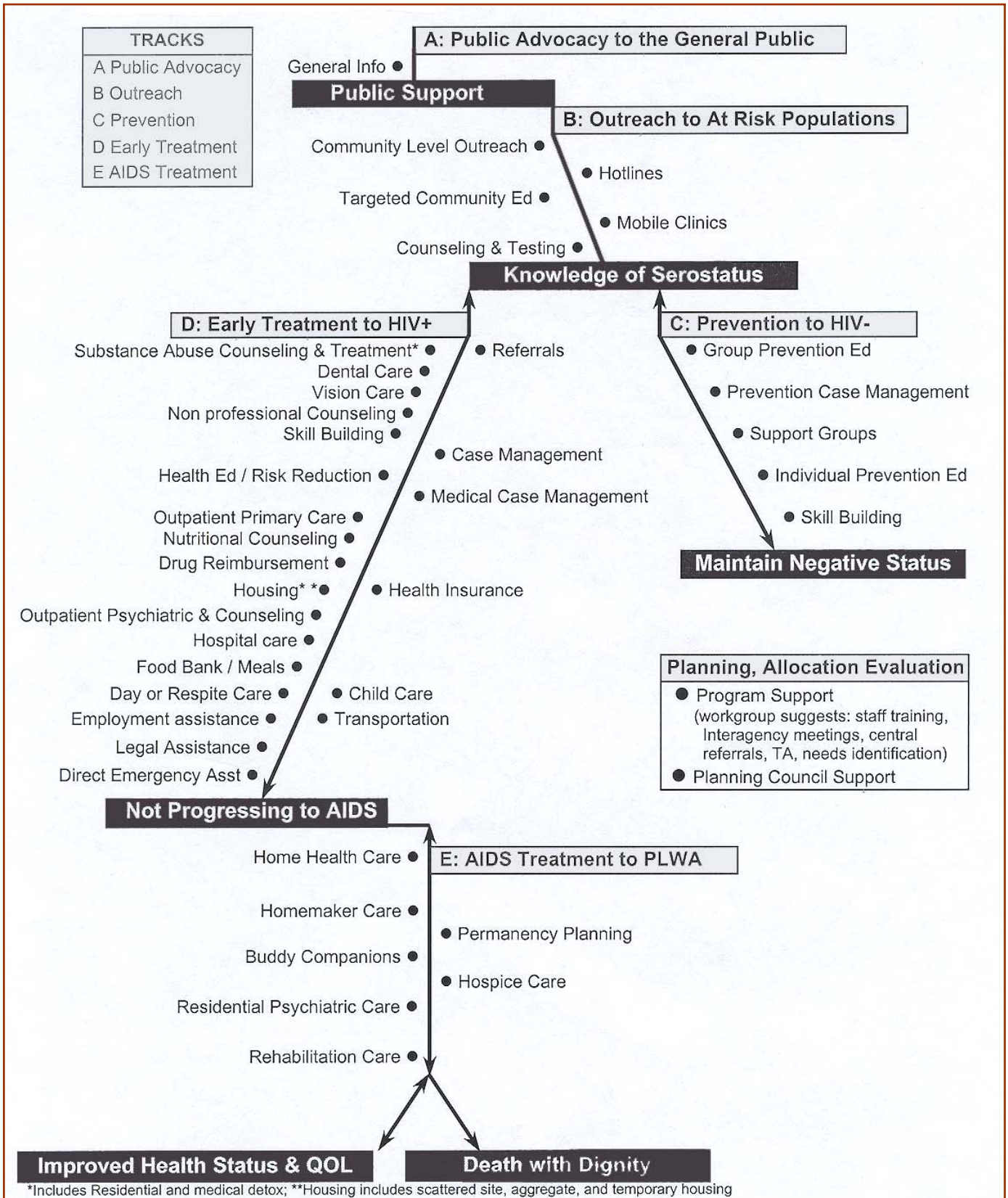
The Houston area continuum of care facilitates the provision of services in a seamless manner so that clients can move easily among the different levels of care. The Houston area has many service providers and in order to provide coordinated services it is important to show how these services can be linked. According to the HRSA guideline, linkages refer to the inter-entity structures.

**Table 26. Continuum of Care Tracks**

<b>TRACK</b>	<b>QUALIFICATION</b>	<b>START</b>	<b>DESTINATION</b>
A. Public Advocacy	General public	No awareness of AIDS	Support for HIV/AIDS services
B. Outreach	High risk behaviors	No awareness of serostatus	Awareness of serostatus
C. Prevention	Knowledge of negative status	Aware of negative status	Maintaining negative status
D. Early Treatment	Early knowledge of HIV positive status	Awareness of infection	No progression to AIDS
E. AIDS Treatment	PLWA	AIDS diagnosis	Improved health status and quality of life or death with dignity

Figure 4, on the following page, shows what that system might look like for Houston. For the HIV positive lines, D and E, the “stations” on the right are those that provide access to the services on the left. Following the figure is a more specific description of the system.

**Figure 4: Houston Area HIV/AIDS Continuum of Care**



**Note:** This is not an eligibility chart - services that are listed as especially needed by people with AIDS does not mean that people with HIV (not AIDS) are not eligible. And conversely, services listed as especially needed by PLWH to help prevent progression to AIDS, does not mean that PLWHAs are not eligible for those services.

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*To summarize the features of this system:*

- It has several tracks, each defined by its outcomes.
- Consumers can enter the system at any point on the track, provided they are qualified.
- Consumers can travel up or down the line.

### **Working With the Continuum**

The model of the continuum of care is meant to be a framework for decision-making as the Houston area HIV community works toward the following objectives:

1. Reduce redundancy of administrative burden and services in the system while ensuring adequate access to those who live in distant areas.
2. Provide adequate input of services through multiple points of access. Think of this as designing a ticketing facility. For HIV and AIDS services, we need not only direct outlets (testing), but adequate links to emergency rooms, drug treatment, STD clinics, and acute care facilities.
3. Facilitate services while not overburdening the staff and capacity of the system.
4. Ensure continuity of services so that consumers find that they are able to move around the system and will not be stuck at any one station.

### **System Goals and Client Outcomes**

In addition to these mission and vision statements, the Comprehensive Planning Committee continues to address three goals to direct their efforts. These goals also help to define the continuum of care in the Houston area. They are:

- Collaborate with and utilize information from all constituencies to plan and deliver high quality and cost effective care.
- Identify and provide services to unserved and underserved populations
- Promote the dissemination of information on HIV prevention, treatment, and resources

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**Section III**

**HOW WE WILL GET THERE?**

*Goals, Objectives and Activities through Year 2008*

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## CHAPTER 9: IMPROVING HIV PREVENTION & CARE IN THE HOUSTON AREA

Comparing “Where We Are” in HIV prevention and care against our ideal continuum, or comprehensive system of prevention and care, helped identify the needs and gaps that must be addressed while continuing to support what is already in place and working effectively.

At the Federal level on the *prevention* side, the CDC recommends that in order to implement a comprehensive HIV prevention program, State, local, and territorial health departments that receive HIV Prevention Cooperative Agreement funds should assure that efforts in their jurisdictions include all of the following essential components:

1. HIV prevention **community planning**;
2. **Epidemiologic and behavioral HIV/AIDS surveillance**, as well as collection of other health and demographic data relevant to HIV risks, incidence, or prevalence;
3. **HIV prevention counseling, testing, referral, and partner counseling and referral services, with strong linkages** to medical care, treatment, and other needed services;
4. **Health education and risk reduction (HE/RR)** activities, including individual-, group-, and community-level interventions;
5. **Easy access to diagnosis and treatment** of other sexually transmitted diseases;
6. **School-based education efforts for youth**;
7. **Public information** programs;
8. **Quality assurance and training**;
9. **Laboratory support**;
10. HIV prevention **capacity-building activities**, including expansion of the public health infrastructure by contracting with non-governmental organizations, especially community-based organizations;
11. **Evaluation** of major program activities, interventions, and services; and
12. An HIV prevention **technical assistance** assessment and plan.

On the care side at the Federal level, HRSA has identified the following goals for the effective provision of care to individuals with HIV disease or AIDS and request that those concerned with HIV/AIDS care focus attention on them:

- Goal 1: Improve Access to Health Care
- Goal 2: Improve Health Outcomes
- Goal 3: Improve the Quality of Health Care
- Goal 4: Eliminate Health Disparities
- Goal 5: Improve the Public Health and Health Care Systems
- Goal 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies
- Goal 7: Achieve Excellence in Management Practices

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## **HRSA Guidelines/Expectations**

Included in the reauthorized Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 2000 is a mandate that communities create “multi-year Comprehensive Plans that will:

- Address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities;
- Establish and support an HIV care continuum;
- Coordinate resources among other Federal and local programs, and;
- Address the needs of those who know their HIV status and are not in care as well as the needs of those who are currently in the care system.

In order to address these mandates, the Comprehensive HIV Services Plan for the Houston Area has adopted the following strategic goals:

- Goal A. Identify individuals who know their HIV status but are not in care and strategies for informing these individuals of services and enable their use of HIV-related services;**
- Goal B. Eliminate disparities in access and services for historically underserved populations;**
- Goal C. Coordinate services with HIV prevention programs including outreach and early intervention services;**
- Goal D. Coordinate services with substance abuse prevention and treatment programs;**
- Goal E. Provide goals, objectives, timelines and appropriate allocation of funds (as determined by the 2005 Houston Area HIV/AIDS Needs Assessment).**

As part of the review of the Comprehensive Plan, findings from the most recent 2005 Houston Area HIV/AIDS Needs Assessment were analyzed based on the HRSA guidelines and expectations in order to better determine the community’s progress in complying with these. The following section lists the guidelines and relevant findings, recommendations and subsequent action steps from the 2005 Houston Area HIV/AIDS Needs Assessment.

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## Relevant 2005 Houston Area HIV/AIDS Needs Assessment Themes & Recommendations

The 2005 Houston Area HIV/AIDS Needs Assessment generated themes that were consistently reported by survey respondents and focus group participants. The following section lists several of the themes that are relevant to the HRSA mandates.

### **Goal A:**

**Identify individuals who know their HIV status but are not in care and strategies for informing these individuals of services and enable their use of HIV-related services**

### **Overall Findings from the 2005 Needs Assessment – Out-of-Care**

“Out-of-care” PLWHA were a critical focus of the 2005 Houston Area HIV/AIDS Needs Assessment. Based on the HRSA definition, out-of-care are those PLWHA who have not had a CD4 test, a viral load test or have not taken antiretroviral medications in the last 12 months. The 654 PLWHA participating in the consumer survey included 31% out-of-care PLWHA. This is consistent with the Centers for Disease Control and Prevention (CDC) estimates that approximately one-third of people diagnosed with HIV disease are outside the care system. The largest proportions of out-of-care survey respondents were among the recently released (72%) and youth aged 13-24 yrs (60%). Among African Americans, IV drug users, Latinos, substance users and women, out-of-care respondents constituted approximately a third of each subpopulation.

*Additional findings are as follows:*

- Men and transgendered PLWHA tended to be out-of-care to a greater extent than women.
- Out-of-care survey respondents were generally younger than in-care.
- Locating out-of-care consumers was more difficult in rural areas. Only 5% of out-of-care respondents lived outside of Harris County.
- Out-of-care PLWHA tend to be in better health, treated for fewer comorbidities and diagnosed with HIV more recently than those in the medical care system; however, they also tend to use emergency rooms for medical care more often than in-care consumers.
- Out-of-care survey respondents included a larger percentage of uninsured (81%) than those in care (41%).
- Out-of-care survey respondents reported higher rates of current IV and street drug use.

Out-of-care consumers were asked their reasons for not accessing medical care. The most frequent response was “I do not believe that I need medical care currently, because I am not sick” (47%). Other reasons included:

- I do not believe medical care would help (27%);
- I do not want to receive medical care (20%);
- I was actively using street drugs or alcohol (16%);
- I was worried someone would force me to take medication (15%);
- They were not open when I could get there (convenient hours) (15%); and
- I was worried that someone would find out about my HIV status if I went there (15%).

**Recommendation A.1:**  
**As programs are developed to bring out-of-care PLWHA into the care system, medical care services must be incrementally expanded. Current providers have limited capacity to serve large volumes of additional patients. Through targeted development, new and expanded programs should reduce perceived barriers to care for those who are currently outside the care system.**

<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
A. Provide community-based case managers and others connected to the out-of-care community with detailed information for referral of uninsured to funded programs.	Title I
B. Continue to monitor quality and client satisfaction at existing primary care provider sites.	Title I, Title II
C. Consider assessment of barriers to care in out-of-care population and the development of a plan to address barriers.	Title I, Title II
D. Maintain regularly scheduled HIV testing and counseling at 11 Title III community health centers.	Title III
E. Meet with clinic directors, visit clinic sites and provide supervision to bilingual and culturally competent Outreach staff.	Title III
F. Provide Adherence assessment, education and monitoring to patients at Title III facilities, and review each client's readiness to begin or change HAART.	Title III
G. Provide medical care information targeted to HIV positive people who are not yet receiving medical care.	Other Planning Bodies or Service Providers

**Recommendation A.2:**  
**Consider funding model programs that combine targeted outreach and medical care for specific out-of-care populations.**

<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Target community-based case management teams to segments of the out-of-care population and standalone community-based case managers at counseling and testing sites.	Title I
b. Maintain regularly scheduled HIV testing and counseling at 11 Title III community health centers.	Title III
c. Provide in-service meeting for clinic staff regarding HIV testing and other HIV treatment basics.	Title III

<b>Recommendation A.3: Examine why out-of-care youth are not utilizing Houston's primary medical care targeting youth.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Conduct special studies to examine factors that influence entry into care for youth.	Title I
<b>Recommendation A.4: Support existing programs and establish new program(s) to facilitate entry into the medical care system upon release from jail/prison. Ensure that such programs address disclosure concerns for soon-to-be released and recently released PLWHA.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Offer services that help HIV positive people get medical care after being released from jail/prison.	Other Planning Bodies or Service Providers
<b>Recommendation A.5: Increase targeted HIV medical care information for out-of-care populations. Vary the format and message in order to maintain interest.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue to provide annual trainings to medical and social service providers regarding HIV-related medical issues for special populations.	Other Planning Bodies or Service Providers

**Goal B:  
Eliminate disparities in access and services for historically underserved populations**

In the 2005 Houston Area HIV/AIDS Needs Assessment, special focus was placed on understanding the perceived barriers and disparities in care among the following traditionally underserved populations:

- African Americans
- Latinos
- Women
- Individuals recently released from incarceration
- Youth (ages 13-24)
- Injecting drug users and other substance users

Although FY 2004 service utilization data show that African Americans, Latinos and women utilize services proportions that match local HIV/AIDS epidemiological data, results from the Needs Assessment suggest that utilization data should be paired with consumer reported data regarding their perceptions of the availability and accessibility of services.

	<b>Males</b>	<b>Females</b>	<b>African American</b>	<b>White</b>	<b>Latino</b>	<b>Other</b>
Net unduplicated clients served during FY 2004	71%	29%	52%	26%	21%	1%
Living HIV/AIDS Cases	76%	24%	46%	37%	17%	1%

### **Overall Findings from the 2005 Needs Assessment – African Americans**

One-third (33.4%) of African Americans surveyed were not receiving HIV medical care. These respondents presented the following profile:

- Younger than in-care African American PLWHA (41% under age 35 compared to 24% of in-care).
- Transmission mode similar to in-care with the following exceptions:
- Smaller percentage reporting injecting drug use as their transmission mode (9% vs. 15% for in-care).
- Larger percentage reporting commercial sex work as their transmission mode (14% vs. 5% for in-care).
- More than 40% are working full-time or part-time. This is double the percentage of in-care African Americans who are working. Nevertheless, incomes are low and are similar to those of the in-care.
- Nearly 75% are uninsured, only 8% report receiving insurance through work.
- Out-of-care tend to be more recently diagnosed, with 47% diagnosed since 2000 compared to 27% of in-care.
- Larger percentages reporting treatment for STI (31%) and TB (12%) in the last 12 months, but other co-morbidities are lower than in-care.
- Higher percentage of current IV drug users (11%) and street drug users (26%).

The most frequently identified reasons for being out-of-care included:

- I do not believe I need medical care currently because I am not sick (46%);
- I do not believe medical care would do me any good (27%);
- I do not want to receive medical care (21%);
- Financial reasons (20%);
- It was too hard to get there (transportation) (19%); and
- I was actively using (street drugs or alcohol) (17%)

When asked, “Do any of the following keep you from getting needed HIV medical care?” the most frequent responses included:

- I don’t have a way to pay for it (32%)

- No way to get there (28%)
- I don't feel welcome (21%)
- Disclosure to partner (19%)

Barriers to care caused by consumers' housing situations were identified. When asked, "Thinking about your housing situation now, do any of the following stop you from taking care of your HIV?", out-of-care African American respondents most frequently identified:

- I'm afraid of others knowing I'm HIV positive (38%)
- I don't have money for rent (27%)
- I don't have enough food (22%)
- I can't get away from drugs in the neighborhood (17%)

*Out-of-care African American's ten most frequently identified unfulfilled service needs include:*

- |                         |                             |
|-------------------------|-----------------------------|
| 1. Primary Medical Care | 6. Food Bank                |
| 2. Vision Care          | 7. Case Management          |
| 3. Health Insurance     | 8. Housing Related Services |
| 4. Rental Assistance    | 9. Oral Health              |
| 5. Household Items      | 10. Utility Assistance      |

<b>Recommendation B.1: Enhance access to services targeted to underserved communities.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue to use Minority AIDS Initiative and general Title I funds to enhance allocations in service categories such as primary medical care case management and mental health that target underserved communities including African Americans, Latinos, recently released, homeless and not-in-care.	Title I
b. Monitor allocations for primary care, case management and mental health services targeted to women, African Americans, Latinos and MSM.	Title I
c. Maintain HIV counseling and Orasure testing at two Title III Community Health Centers, and four additional Title III Homeless Program sites.	Title III
<b>Recommendation B.2: To supplement earlier studies, additional research should be considered to better understand the reasons for the rate of out-of-care and never-in-care among African American MSM.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Conduct special studies to examine factors that influence entry into care for MSM of color.	Title I

<b>Recommendation B.3: Consider developing additional prevention strategies targeted to individuals who have sex with both men and women.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue recommending and implementing effective evidence based interventions targeting individuals at highest risk.	CPG
b. Consider special studies targeting individuals who have sex with both men and women to examine prevention needs and effective prevention strategies.	CPG
c. Target prevention efforts to individuals who are bisexual (have sex with both men and women).	Other Planning Bodies or Service Providers
<b>Recommendation B.4: Ensure that healthcare providers, especially those who do not regularly treat PLWHA are aware of the complications of anti-retroviral therapies and the particular risk to African American men, who are also at risk for diabetes and cardiovascular disease.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue to provide annual trainings to medical and social service providers regarding HIV-related medical issues for special populations.	Other Planning Bodies or Service Providers
<b>Recommendation B.5: Continue to require that all HIV medical care providers offer treatment adherence programs. Whenever possible, target treatment adherence service to African Americans.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Institute a Title III adherence team which will oversee the assessment, education, medication initiation & follow-up of new starts and changes to regimen.	Title III

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## Overall Findings from the 2005 Needs Assessment – Injection Drug Users & Other Substance Users

Injecting drug users (IDU) include consumer survey respondents who currently use or have a history of injecting drugs. They comprise 25% of the survey sample, with one-third being out-of-care.

Most frequently identified reasons for being out-of-care included:

- I do not believe I need medical care currently because I am not sick (54%)
- I was actively using (street drugs or alcohol) (41%)
- I do not want to receive medical care (29%)
- I do not believe medical care would do me any good (27%)
- It was too hard to get there (transportation) (18%)

When asked, “Do any of the following keep you from getting needed HIV medical care?”, out-of-care injecting drug users’ most frequent responses included:

- I don’t have a way to pay for it (43%)
- No way to get there (30%)
- Disclosure to partner (25%)
- I don’t feel welcome (23%)

Barriers to care caused by consumers’ housing situations were identified. When asked, “Thinking about your housing situation now, do any of the following stop you from taking care of your HIV?”, out-of-care IDU respondents most frequently identified:

- I’m afraid of others knowing I’m HIV positive (36%)
- I can’t get away from drugs in the neighborhood (31%)
- I don’t have money for rent (23%)

Out-of-care injecting drug users’ most frequently identified unfulfilled needs include:

- |                             |                       |
|-----------------------------|-----------------------|
| 1. Primary Medical Care     | 7. Vision Care        |
| 2. Health Insurance         | 8. Utility Assistance |
| 3. Oral Health Care         | 9. Shelter Voucher    |
| 4. Rental Assistance        | 10. Food Bank         |
| 5. Housing Related Services | 11. Household Items   |
| 6. Bus Passes               |                       |

Other substance users include consumer survey respondents who currently use or have a history of using street drugs, such as cocaine, poppers, inhalants, etc. These PLWHA comprise one-quarter of the survey sample, and of these 27% are not receiving HIV medical care. In addition, nearly half of out-of-care substance users report current street drug use.

The most frequently identified reasons for being out-of-care include:

- I do not believe I need medical care currently because I am not sick (30%);
- I do not believe medical care would do me any good (30%);
- I do not want to receive medical care (23%);
- Financial reasons (23%);

- They were not open when I could get there (convenient hours) (23%);
- I was worried someone might find out about my HIV status if I went there (23%);
- I was worried someone would force me to take medication (23%).

When asked, “Do any of the following keep you from getting needed HIV medical care?” the most frequent responses included:

- I don’t have a way to pay for it (39%);
- No way to get there (32%); and
- I don’t feel welcome (30%).

Barriers to care caused by consumers’ housing situations were identified. When asked, “Thinking about your housing situation now, do any of the following stop you from taking care of your HIV?” out-of-care substance users’ respondents most frequently identified:

- I’m afraid of others knowing I’m HIV positive (55%);
- I don’t have money for rent (39%);
- I don’t have enough food (30%); and
- I can’t get away from drugs in the neighborhood (20%).

*Out-of-care substance users’ ten most frequently identified unfulfilled service needs include:*

- |                            |                          |
|----------------------------|--------------------------|
| 1. Household Items         | 6. Primary Medical Care  |
| 2. Rental Assistance       | 7. Health Insurance      |
| 3. Nutritional Supplements | 8. Case Management       |
| 4. Utility Assistance      | 9. Buddy/Companion       |
| 5. Food Bank               | 10. Home Delivered Meals |

<b>Recommendation B.6: Incorporate mental health therapy/counseling and substance abuse treatment into model programs, and evaluate their effectiveness in moving the newly diagnosed into care.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue to require that all Title III clinical providers provide appropriate referrals to Substance Abuse, Mental Health, Case Management, and Social Services.	Title III
<b>Recommendation B.7: Enhance collaboration between housing programs and substance abuse treatment.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Collaborate with housing or substance abuse treatment programs to provide services for IV drug users or other substance users.	Other Planning Bodies or Service Providers
<b>Recommendation B.8: Develop substance abuse treatment programs for diverse populations, including the uninsured.</b>	

<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Consider a special study examining the specific and unique needs of HIV+ substance users and what barriers to care exist within this population.	Title I, Title II
<b>Recommendation B.9: Identify opportunities to leverage funding through partnerships with substance abuse treatment programs</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Place clinical and community-based case managers in a substance abuse treatment setting.	Title I
b. Continue to require that all Title III clinical providers provide appropriate referrals to Substance Abuse, Mental Health, Case Management, and Social Services.	Title III
<b>Recommendation B.10: Explore alternative models of providing mental health and substance abuse counseling at primary care sites.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue to place psychiatric services at all Title I primary care sites.	Title I
<b>Recommendation B.11 Continue to educate substance abuse treatment providers to more effectively treat HIV positive consumers.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Collaborate with housing or substance abuse treatment programs to provide services for IV drug users or other substance users.	Other Planning Bodies or Service Providers
<b>Recommendation B.12 Continue to educate consumers, case managers and primary care providers about the availability of free substance abuse treatment and the availability of various substance abuse treatment approaches.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Place clinical and community-based case managers in a substance abuse treatment setting.	Title I

### Overall Findings from the 2005 Needs Assessment - Recently Released Individuals

PLWHA who were recently released from jail or prison are defined as those who report being in jail or prison during the past year. They comprise 17% of the survey sample, and 72% of these respondents were not receiving medical care.

Out-of-care recently released include a smaller percentage of women and a larger percentage of whites than other out-of-care populations. Women account for 25% of out-of-care recently released, and transgendered are 13%. Nearly 30% were white and 11% were Hispanic. One-third were diagnosed with HIV while in jail or prison, but almost 80% had not gotten HIV medical care.

The most frequently identified reasons for being out-of-care included:

- I was actively using (street drugs or alcohol) (35%);
- I do not believe I need medical care currently because I am not sick (33%);
- I do not believe medical care would do me any good (27%); and
- I do not want to receive medical care (23%).

When asked, “Do any of the following keep you from getting needed HIV medical care?” the most frequent responses included:

- I don’t have a way to pay for it (33%);
- No way to get there (31%);
- I don’t feel welcome (23%);
- Disclosure to partner (23%); and
- People don’t understand my culture (23%).

Barriers to care caused by consumers’ housing situations were identified. When asked, “Thinking about your housing situation now, do any of the following stop you from taking care of your HIV? out-of-care recently released respondents most frequently identified:

- I’m afraid of others knowing I’m HIV positive (40%);
- I don’t have money for rent (25%);
- I can’t get away from drugs in the neighborhood (25%).

*Out-of-care recently released ten most frequently identified unfulfilled needs include:*

- |                             |                       |
|-----------------------------|-----------------------|
| 1. Rental Assistance        | 6. Bus Passes         |
| 2. Primary Medical Care     | 7. Utility Assistance |
| 3. Health Insurance         | 8. Household Items    |
| 4. Housing Related Services | 9. Shelter Vouchers   |
| 5. Oral Health              | 10. Food Bank         |

<b>Recommendation B.13</b>	
<b>Develop a comprehensive transitional program that matches the newly released with a medical care provider, source for medications and basic resources.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Consider a special study examining the specific and unique needs of recently released HIV positive individuals.	Title I, Title II
b. Continue to provide programs that provide emergency housing and HIV/AIDS medication assistance to recently or soon-to-be released persons of color.	Other Planning Bodies or Service Providers

<b>Recommendation B.14</b> <b>Within the comprehensive transition program, incorporate insurance eligibility and other efforts to economically support the recently released.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue to offer referrals to Houston area services providing job training, transportation and other transitional services.	Other Planning Bodies or Service Providers
<b>Recommendation B.15</b> <b>Provide health screenings that includes the range of co-morbidities to which the incarcerated appear to be more susceptible.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue to offer referrals to Houston area services that provide clinical and medical care services	Other Planning Bodies or Service Providers
<b>Recommendation B.16</b> <b>Support existing programs and establish new programs(s) to facilitate entry into the medical care system upon release from jail/prison. Ensure that such programs address disclosure concerns for soon-to-be and recently released PLWHA.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue to provide programs that offer clinical and medical care assistance to recently or soon-to-be released persons of color	Other Planning Bodies or Service Providers
<b>Recommendation B.17</b> <b>Increase utilization of case managers who specialize in meeting the needs of PLWHA who are recently released for jail/prison.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Employ case managers who specialize in the needs of HIV positive people who are recently released from jail or prison.	Other Planning Bodies or Service Providers
<b>Recommendation B.18</b> <b>Continue to expand linkages between jail/prison and the community care system in order to effectively transition recently released into care.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. The recently released are able to access Ryan White Title I funded food pantries for a limited time post-release. Community-based case managers may make emergency referrals for clients who are being released for incarceration. When accessed, these food banks may provide important linkages to the care system.	Title I

b. Continue to provide Blue Books at no cost to incarcerated individuals, as well as information on programs in the community targeted to incarcerated individuals and the recently released.	Title I
<b>Recommendation B.19</b> <b>Through collaborations, begin implementation of a plan to expand transitional housing options.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Facilities should target specific populations with housing and other services, such as transitional housing for: substance abuse treatment, recently released, women, etc. Begin with a pilot project with the goal of expanding services or targeting additional populations over time.	Other Planning Bodies or Service Providers
b. Consider expanding programs to ease transition out of incarceration for those with substance abuse issues. Such a program has been developed by the Texas Department of Criminal Justice, to provide those released with an opportunity to reside in a halfway house and receive substance abuse treatment	Other Planning Bodies or Service Providers
<b>Recommendation B.20</b> <b>Examine reasons for low use of mental health services by recently released and develop targeted services and service promotion for these consumers.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Offer services that encourage HIV positive people who are recently released from jail/prison to use mental health services.	Other Planning Bodies or Service Providers
<b>Recommendation B.21</b> <b>Expand the availability to support groups to the recently released.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue to offer referrals to Houston area services that provide individual/group counseling and support groups	Other Planning Bodies or Service Providers

### **Overall Findings from the 2005 Needs Assessment - Women**

Women comprise 37% of the survey sample. This is one of the largest sub-populations in the 2005 Needs Assessment. Twenty-nine percent, or 68 women, are out-of-care.

Out-of-care women are working to a greater extent than other out-of-care populations, and incomes are somewhat higher than other groups. Out-of-care women are more recently diagnosed than other out-of-care populations, with 52% diagnosed since 2000, and a total of 85% diagnosed after 1995. Thirty-five percent of out-of-care women entered the HIV medical care system and dropped out. This compares to 29% of all out-of-care respondents.

Eleven percent of women have been treated for an STI in the past year, and 10% have been treated for hepatitis C. Seven percent of women are current injecting drug users and 27% are current street drug users.

Most frequently identified reasons for being out-of-care included:

- I do not believe I need medical care currently because I am not sick (47%);
- I do not believe medical care would do me any good (28%);
- Financial reasons (25%)
- It was too hard to get there (transportation) (24%).

When asked, “Do any of the following keep you from getting needed HIV medical care?” the most frequent responses included:

- No way to get there (37%);
- I don’t feel welcome (21%); and
- Disclosure to partner (19%).

Out-of-care women also identified transportation as a barrier to HIV medical care through their responses to the question: “In the past 12 months, how many medical appointments have you missed because of transportation problems?” More than 20% of respondents report missing one to five appointments, and 28% report missing five or more appointments.

Barriers to care caused by consumers’ housing situations were identified. When asked, “Thinking about your housing situation now, do any of the following stop you from taking care of your HIV?” out-of-care women respondents most frequently identified:

- I’m afraid of others knowing I’m HIV positive (47%); and
- I don’t have money for rent (21%).

*Out-of-care women’s ten most frequently identified unfulfilled service needs include:*

- |                         |                       |
|-------------------------|-----------------------|
| 1. Primary Medical Care | 6. Utility Assistance |
| 2. Rental Assistance    | 7. Taxi Voucher       |
| 3. Health Insurance     | 8. Household Items    |
| 4. Vision Care          | 9. Van Transportation |
| 5. Bus Passes           | 10. Food Bank         |

<b>Recommendation B.22</b>	
<b>Continue to provide information to primary care providers, especially obstetricians/gynecologists and emergency medicine physicians about their role in HIV testing and diagnosis.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Title III Counseling and Testing Supervisor will continue to meet with clinic directors and visit clinic sites.	Title III
b. Title III Counseling and Testing Supervisor will continue to provide in-service meetings for clinic staff regarding HIV testing and other HIV treatment basics.	Title III

c. Examine possible partnerships with private medical providers to increase routine HIV screening in medical settings.	CPG
d. Continue to provide annual trainings to medical and social service providers regarding HIV-related medical issues for special populations	Other Planning Bodies or Service Providers
<b>Recommendation B.23</b> <b>Continue to develop programs that appropriately communicate HIV status to women, provide prevention information to the seronegative and transitions the newly diagnosed to early intervention services.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Continue to implement and monitor evidence based interventions targeting at risk females.	CPG
b. Provide educational and early intervention services for HIV positive women.	Other Planning Bodies or Service Providers
<b>Recommendation B.24</b> <b>Examine barriers to use of medication reimbursement programs by women.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Consider a study to explore access and availability issues for women.	Title I, Title II
<b>Recommendation B.25</b> <b>Continue to educate HIV positive women about the importance of gynecologic care in order to increase utilization of OB/GYN services.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Educate HIV positive women about the importance of OB/GYN care.	Other Planning Bodies or Service Providers
<b>Recommendation B.26</b> <b>Expand OB/GYN treatment options and locations for offering care for HIV+ women.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Publicize the availability of Title III Women's Program to community-based HIV service providers and other Ryan White funded primary care providers.	Title III
<b>Recommendation B.27</b> <b>Include OB/GYN care for female PLWHA at Title I-funded sites.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>

a. Provide educational and early intervention services for HIV positive women.	Other Planning Bodies or Service Providers
<b>Recommendation B.28</b> <b>Expand the availability of support groups for women.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Provide support groups for HIV positive women.	Other Planning Bodies or Service Providers

### Overall Findings from the 2005 Needs Assessment - Youth

Youth, respondents age 13 to 24 years, are only 10% of the total survey sample, but nearly 60% were out-of-care. This is a relatively small sample of 39 out-of-care youth. These youth were predominantly male (67%), and 10% were transgendered. Whites comprised a larger percentage than other out-of-care populations, 31%. African Americans are 41%, and Hispanic/Latinos are 23%.

Most frequently identified reasons for being out-of-care included:

- I do not believe I need medical care currently because I am not sick (49%);
- I do not believe medical care would do me any good (36%);
- I was actively using (street drugs or alcohol) (23%).

*Out-of-care youth's ten most frequently identified unfulfilled service needs include:*

- |                            |                             |
|----------------------------|-----------------------------|
| 1. Food Bank               | 6. Household Items          |
| 2. Health Insurance        | 7. Rental Assistance        |
| 3. Primary Medical Care    | 8. Nutritional Supplements  |
| 4. Medical Case Management | 9. Housing Related Services |
| 5. Utility Assistance      | 10. Oral Health             |

<b>Recommendation B.29</b> <b>Continue to provide prevention education for young mothers and children through schools, social service agencies, youth development programs and churches.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Examine possible partnerships and strategies to expand prevention activities targeting at risk youth	CPG
b. Provide prevention education for young mothers.	Other Planning Bodies or Service Providers
<b>Recommendation B.30</b> <b>Develop and implement programs to insure youth 18 years or older.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Conduct special studies to examine factors that influence entry into care for youth.	Title I

<b>Recommendation B.31</b> <b>Expand outreach, testing and early intervention programs to youth.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Consider special studies to examine prevention needs and appropriate prevention messages targeting at risk youth.	CPG
b. Provide prevention education for youth.	Other Planning Bodies or Service providers
<b>Recommendation B.32</b> <b>Examine reasons for low use of mental health services by youth.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Conduct special studies to examine factors that influence entry into care for youth.	Title I
<b>Recommendation B.33</b> <b>Expand the availability of support groups for youth.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Provide support groups for youth	Other Planning Bodies or Service Providers
<b>Recommendation B.34</b> <b>Examine reasons youth are not utilizing Houston's youth-focused primary medical care.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Drawing upon expertise gleaned from other programs across the country, consider incorporating additional components such as: A youth peer counseling program to support youth in the medical care system, using technology in both care and education, etc.	Other Planning Bodies or Service Providers
b. Conduct special studies to examine factors that influence entry into care for youth.	Title I
<b>Recommendation B.35</b> <b>Evaluate the effectiveness of case managers targeting services for youth and consider the need to expand availability.</b>	
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>
a. Employ case managers that specialize in the needs of youth.	Other Planning Bodies or Service Providers

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**Goal C: Coordinate services with HIV prevention programs including outreach and early intervention services**

HIV-related health planning groups throughout the community have organized judiciously to better coordinate efforts among the range of activities within the scope of the Ryan White Care Act. Both providers and PLWHA participate in each of the planning bodies, with many individuals holding memberships in several groups simultaneously. The 2005 Houston Area HIV/AIDS Needs Assessment and the Comprehensive Plan were developed and approved by numerous partners representing the various Ryan White Titles as well as Housing Opportunities for Persons with AIDS (HOPWA).

**Goal D: Coordinate services with substance abuse prevention and treatment programs**

Most of the substance abuse prevention and treatment programs targeted toward PLWHA in the EMA/HSDA are funded by the Texas Department of State Health Services Substance Abuse Services, which funds HIV Early Intervention Services, HIV Street Outreach and all levels of treatment, including detox, partial hospitalization or day treatment, intensive outpatient and transitional (usually referred to as aftercare). Region 6 covers a wide geographic area, designated as 2 sectors, Region 6a: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton counties and Region 6b: Galveston, Brazoria and Matagorda counties.

**Goal E: Provide goals, objectives, timelines and appropriate allocation of funds (as determined by the 2005 Houston Area HIV/AIDS Needs Assessment)****Goals, Objectives and Timelines**

The Comprehensive HIV Planning Committee of the Ryan White Planning Council created as part of the Comprehensive Plan, measurable goals with time-based objectives. (See the 2006 - 2008 Action Steps listed in this document).

**Appropriate Allocations**

Consistent throughout the 2005 Houston Area HIV/AIDS Needs Assessment were respondent claims of the importance of ambulatory/outpatient medical care, medications, dental care and support services, especially mental health care. Further, these findings are consistent with national and state trends, findings from previous studies, provider reports, the Title I computer data system (CPCDMS) utilization reports.

The following tables list Service Categories and the priority and allocation assigned to each for Titles I, II, III and IV.

**Table 28. Selected Service Categories  
with Title I Priority and Allocation for FY03 to FY06**

Service Category	Total FY03 Allocation	Total FY04 Allocation	Total FY05 Allocation	Total FY06 Allocation	Change from FY03 to FY06
Ambulatory/Outpatient Medical Care**	\$7,805,872	\$8,236,208	\$8,999,201	\$9,025,335	+ \$1,219,463
Case Management	\$1,974,177	\$2,137,598	\$2,319,440	\$3,161,000	+ \$1,186,823
Dental Care	\$910,609	\$917,026	\$1,014,124	\$1,060,000	+ \$149,391
Substance Abuse Treatment	\$61,409	\$85,745	\$42,850*	\$45,000	-( \$16,409)**
Drug Reimbursement Program	\$2,300,119	\$2,662,518	\$3,038,662	\$2,496,000	+ \$195,881
Mental Health Services	\$279,216	\$211,844*	\$224,000	\$234,000	-( \$45,216)**
Hospice	\$197,964	\$283,639	\$264,643	\$265,000	+ \$67,036
Home Health Care	\$245,435	\$171,263	\$217,853	\$217,000	-( \$28,435)

\*\* Per the 2005 HIV/AIDS Houston Needs Assessment, there were two substantial 3-year SAMHSA grants awarded to the Greater Houston area in 2004.

**Table 29. Selected Service Categories  
with Title II Priority and Allocation for FY03 to FY06**

Service Category	Total FY03 Allocation	Total FY04 Allocation	Total FY05 Allocation	Total FY06 Allocation	Change from FY03 to FY06
Ambulatory/Outpatient Medical Care**	\$207,597	\$328,636	\$268,530	\$342,650	+ \$135,053
Case Management	\$62,400	--	\$59,136	--	--
Dental Care	\$322,310	\$255,000	\$255,000	\$322,215	-( \$95)
Substance Abuse Treatment	--	--	--	--	--
Drug Reimbursement Program	\$392,984	\$371,115	\$371,115	\$371,115	-( \$21,869)**
Mental Health Services	--	--	--	--	--
Hospice	--	--	--	--	--
Home Health Care	\$67,472	\$100,000	\$99,239	\$100,000	+ \$32,528

**Table 30. Selected Service Category with  
State Services Priority and Allocation for FY03 to FY06**

Service Category	Total FY03 Allocation	Total FY04 Allocation	Total FY05 Allocation	Total FY06 Allocation	Change from FY03 to FY06
Ambulatory/Outpatient Medical Care**	--	--	--	--	--
Case Management	\$239,098	\$240,218	\$240,218	\$240,218	+ \$1,120
Dental Care	--	--	--	--	--
Substance Abuse Treatment	--	--	--	--	--
Drug Reimbursement Program	--	--	--	--	--
Mental Health Services	\$80,000	\$80,004	\$80,093	\$80,000	\$0
Hospice	\$144,937	\$114,200	\$114,200	\$131,000	-( \$13,937)
Home Health Care	--	--	--	--	--

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**Section IV**

**HOW WILL WE MONITOR OUR PROGRESS?**

**Implementation, Monitoring & Evaluation**

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## CHAPTER 10: IMPLEMENTATION, MONITORING & EVALUATION

*In keeping with the format suggested by HRSA, the following outlines the process for implementing, monitoring, and evaluating progress toward achieving short term and long term goals.*

### **Implementation:**

Implementation of the Comprehensive Plan is a coordinated effort through the Planning Council and the Administrative Agent, the Harris County Health Department's HIV Services Section. The 2005 Houston Area HIV/AIDS Needs Assessment results are reviewed in conjunction with the Comprehensive Plan by the Planning Council's "How to Best Meet the Needs" Committee/process. This Committee makes recommendations to the "Priorities and Allocations" Committee which aligns financial allocations to planning goals and needs. Contracts are then established with service providers through the Harris County HIV Services Department.

### **Monitoring:**

Monitoring the implementation of the Comprehensive Plan is handled through the Comprehensive HIV Planning Committee whose membership includes representatives from Titles I, II, III and IV as well as CPG. This committee meets quarterly. Contract monitoring for Title I is handled through the Harris County HIV Services Department and includes fiscal oversight, site visits to agencies, and compliance monitoring.

### **Outcome Evaluation:**

Outcomes are measured by the Harris County HIV Services Department using an established set of process and clinical outcome measures. Members of planning bodies participate in the review of these outcome measures on a quarterly basis.

The following are the goals developed for the Comprehensive Plan, along with an update on progress toward achieving these goals. Both the Comprehensive HIV Planning Committee (a standing committee of the Ryan White Planning Council) and the South Texas Assembly Group East (STAGE) (the planning body for Title II) monitor progress towards these goals. Progress is described under each goal listed below.

### **Comprehensive Plan Goal A**

**By February 28, 2008, 100% of the clients who participate in the HIV services system in the Houston area will more easily understand the system and how to navigate through it, will experience a minimum of repetition and complication in the intake and eligibility process, and will be linked to all needed services as efficiently as possible.**

### **Progress**

The 2005 Houston Area HIV/AIDS Comprehensive Needs Assessment identified services that in-care consumers considered hard/somewhat hard to get and those where needs were not being met. The top ten services included:

**Table 31. In-Care Consumer Survey Respondents  
Services that are Hard to Get or Needs that are Unfulfilled**

<b>Service Category</b>	<b>Met Need/Hard %</b>	<b>Need Not Met %</b>	<b>Total %</b>	<b>Leading Barriers to Care</b>
Rental Assistance	12%	36%	48%	Information (50%)
Health Insurance	9%	35%	44%	Information (53%)
Utility Assistance	11%	33%	44%	Information (51%)
Housing Related Services	6%	32%	38%	Information (58%)
Household Items	6%	31%	37%	Information (55%)
Vision Care	7%	28%	35%	Access (41%)
Oral Health Care	7%	27%	34%	Access (46%)
Gas/Taxi Vouchers	6%	27%	33%	Information (53%)
Legal Services	3%	30%	33%	Information (64%)
Food Bank	12%	20%	32%	Access (42%)
<i>Information barriers were defined as: "I didn't have the information I needed about the service."</i>				
<i>Access barriers were defined as: "The services available were too far from home or work"; "Services were not available the hours when I could get there"; "Waiting time was too long," etc.</i>				

The Ryan White Blue Book and the United Way Helpline are two resources for consumers to access services independently. The Blue Book is a well-established resource for consumer referral. It is well organized, easy to use and includes Spanish translation. It is available for free at provider agencies, and case managers distribute it to their clients. Some consumer focus group participants discussed the value of the Blue Book in becoming informed about services. HRSA encourages empowering consumers by enabling them to be responsible for directing their own care. The Blue Book is a significant resource for such consumer empowerment. The United Way Helpline is also a critical resource identified in the Blue Book. Consumers can call the Helpline and receive HIV-specific referrals or referrals to any of the more than 3,000 programs included in the United Way database.

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Based on findings from the 2005 Houston Area HIV/AIDS Needs Assessment, a recommendation was formed to provide a plan to better meet the informational needs of consumers. For the total consumer survey sample, informational barriers to care were the most frequently identified barrier for all services. Only childcare and child welfare were identified more frequently than informational. Informational barriers to care were also the most frequently identified barrier for in-care consumers. Only vision care, oral health care, OB/GYN services and food bank identified access barriers more frequently than informational. Out-of-care consumers most frequently reported informational barriers for all services. The percentage of responses identifying informational barriers ranged from 68% for drug reimbursement and legal services to 49% for vision care and 48% for OB/GYN services. The resulting recommendation involved developing a work group that evaluates informational barriers to care across services and populations, and to consider targeted informational needs of in-care and out-of-care priority populations.

### **Comprehensive Plan Goal B**

**By February 28, 2008, services for clients will be improved through increased cooperation and coordination of service providers and improved administration functions.**

#### **Progress**

Regarding the improvement of administrative functions, the Ryan White Planning Council (RWPC) conducted service effectiveness studies for the planning area. Results of these studies are given to service providers for their use in improving administration and service provision. The findings of the studies are also reflected in the themes and recommendations of the 2005 Houston Area HIV/AIDS Needs Assessment and informed the “How to Best Meet the Need” process as well as each Priority and Allocations Committee for Title I and Title II.

Case management services for PLWHA are coordinated through the Houston Area HIV Case Management System (HIV/CMS), a decentralized system comprised of fifteen agencies that represent six funding streams and include community-based organizations (CBOs), minority CBOs, private clinics, public clinics and counseling and testing sites. HIV/CMS agencies are required to participate in several activities to ensure coordination of services. These include semi-monthly supervisor meetings, semi-monthly case manager meetings, periodic mandatory trainings and use of the CPCDMS, which was designed to support a case management model of care.

Informed by Needs Assessment findings, community members and leaders have recommended a strategy to identify opportunities to collaborate with other funding sources to leverage Ryan White funds. Services may blend HIV care or supportive services, housing, substance abuse, etc., and may target specific populations. As HRSA increasingly focuses CARE Act funding on “core services,” enhanced linkages with community resources for other supportive services will be required. Collaborative relationships and service development with other organizations and funding sources should be strengthened with the goals of filling gaps in care and enhancing service access for PLWHA.

For example, two thirds of provider survey respondents – including 91% of Ryan White funded respondents – reported HIV-specific commitment letters, letters of collaboration, binding agreements or signed memoranda of understanding (MOU) with other agencies. In addition to a larger percentage of Ryan White funded agencies reporting agreements when compared to all survey respondents, Ryan White funded agencies tended to have a larger number of agreements/linkages with both HIV/AIDS and non-HIV/AIDS focused agencies than total respondents.

**Table 32. HIV-specific commitment letters, letters of collaboration, binding agreements or signed Memoranda of Understanding (MOUs) with other agencies**

<i>Does Your Agency Have Above Documents?</i>	Total Respondents n=54		Total Ryan White Respondents n=23	
	#	%	#	%
No	18	33.3%	2	8.7%
Yes	36	66.7%	21	91.3%
<i>Most Frequently Identified Type of Organizations Include:</i>	#	%	#	%
AIDS Service Organization (ASO)	28	51.9%	17	73.9%
Non HIV Social Service Provider	18	33.3%	14	60.9%
Substance Abuse Treatment Facility	15	27.8%	12	52.2%
Mental Health Provider	13	24.1%	11	47.8%
TB Testing/Treatment Provider	11	20.4%	11	47.8%
HIV Testing Site	12	22.2%	11	47.8%
Church	13	24.1%	9	39.1%
STD Clinic	9	16.7%	9	39.1%

*Percentages based upon "n" with multiple answers allowed.*

Additionally, Ryan White funded providers reported tracking referrals to a greater extent than total respondents.

**Table 33. Tracking Referrals**

<i>Do you have a way of tracking referrals?</i>	Total Respondents n=57		Total Ryan White Respondents n=24	
	#	%	#	%
No	22	38.6%	4	16.7%
Yes	35	61.4%	20	83.3%
<i>If so, how?</i>	#	%	#	%
Computer Tracking	16	38.0%	11	40.7%
Paper-based	26	62.0%	16	59.3%

*Percentages based upon "n" with multiple answers allowed.*

### **Comprehensive Plan Goal C**

**By February 28, 2008, the quality of care for PLWHA in the Houston area will be improved by clear standards of operation.**

#### **Progress**

Several activities intended to ensure quality of care are carried out for Title I services. Current initiatives include:

1. Standards of care are in place for all Title I and Title II funded programs. The standards are reviewed and approved each year by appropriate planning body members, consumers and service providers, and are monitored on an annual basis. These guidelines establish minimum standards for staff training, client rights, program accessibility, timeliness of services, documentation and supervision.
2. Outcomes evaluation is performed for all Title I and Title II funded programs. The outcome measures are reviewed and approved each year by RWPC members, consumers and service providers. Categories of outcomes include health, quality of life, knowledge, attitudes and practices (KAP) and cost-effectiveness measures. Analysis from outcomes data is provided to the Council and providers on a quarterly basis.
3. Ongoing clinical chart review activities are underway for Title I and Title II direct medical services to ensure that services are adherent to Public Health Service guidelines or other established industry standards.
4. Initiated in April 2005, the PWA Housing Advisory Group was formed to strengthen networking within the HIV/AIDS housing community, increase transparency in the allocation of housing funds, leverage funds from other sources and recommend partnerships between HOPWA and non-HIV housing programs. Membership on this advisory group includes representatives from all HIV/AIDS planning bodies, private funders, non-profit housing developers, housing experts, HIV/AIDS service providers, consumers and others.

Provider survey respondents identified “opportunities for networking” and “agency training in the areas of cultural competency, patient advocacy and HIV care” as ways to improve services to PLWHA. Among total respondents, “opportunities for networking” was identified more than twice as often when compared with the next ranked service.

**Table 34. Services Needed to Better Serve HIV Positive Clients/Patients**

	Total Respondents n=76		Total Ryan White Respondents n=25	
	#	%	#	%
Opportunities for networking among providers	29	38.2%	12	48%
Training in working with people from other cultures	14	18.4%	8	32%
Training to learn other languages	14	18.4%	8	32%
Training on advocating for clients/patients	12	15.8%	5	20%
Training about providing HIV care	11	14.5%	5	20%
Providing services in a more convenient manner	8	10.5%	5	20%

*Percentages based upon “n” with multiple answers allowed.*

At the time of the Needs Assessment provider survey, 6 out of 69 agencies employed full or part time translators, and more than three-quarters of surveyed agencies employ multilingual staff in professional positions. Among those with multilingual professional staff, almost all had Spanish-speaking staff. Eighteen other languages were spoken by employees across a range of providers. Nearly three-quarters of those responding reported offering cultural competency training for their staff. In most cases this training is mandatory on an annual basis.

**Table 35. Bilingual Staff and Cultural Competence Training**

	Yes		No	
	#	%	#	%
Employ FT/PT Translators (n = 69)	6	8.7%	63	91.3%
Multilingual Professional Staff (n = 67)	52	77.6%	15	22.4%
Spanish	50			
Vietnamese	6			
Chinese	5			
Sign	5			
Offer Cultural Competency Training (n = 65)	48	73.8%	17	26.2%
Mandatory Cultural Competency Training (n =	35	83.3%	7	16.7%
Frequency of training: (= 33)				
Annually	28			
Semi-annually	5			

Source: Profile of Provider Capacity/Capability; Does not include NA and no answer

### **Comprehensive Plan Goal D**

**By February 28, 2008, all HIV care, prevention and research will be fully funded, including new and innovative services.**

#### **Progress**

The following describes recent and ongoing progress toward achieving this goal:

1. Procedures are in place to keep the planning bodies and agencies updated on legislative/appropriations processes.
2. Coordination of providers and consumers in national and statewide advocacy efforts.
3. When necessary, the planning bodies create ad-hoc committees to monitor specific issues. One example is the ADAP Ad-Hoc Committee formed in 2002 to monitor changes being proposed by the State and possible project the impact of these changes on the local planning areas.
4. The Ryan White Planning Council has a standing committee entitled the Advances in Medical Treatment and Medications Committee. Membership is made up of medical personnel and PLWHA whose primary role is to provide the Council with medical updates, make medically-related recommendations to the “How To Best Meet the Need” process, and organize presentations to the community at large on issues such as Depression and HIV, Side Effect Management, HIV and Substance Abuse, and more.
5. Results of the 2005 Houston Area HIV/AIDS Needs Assessment are also being utilized to reallocate resources to services that demonstrate increased demand and to create new services not required in the past.

### **Comprehensive Plan Goal E**

**By February 28, 2008, reduce transmission of HIV by 25%.**

## Progress

The consumer survey asked about sexual risk behaviors. Findings revealed that approximately 53% of both men and women “always” or “usually” use a condom or barrier when having vaginal or anal sex with either a regular partner or a casual partner. Although the transgendered sample is smaller (n=26), 43% report always or usually using a barrier/condom with a regular partner and 51% do so with a casual partner.

## Comprehensive Plan Goal F

**By February 28, 2008, increase the number of people who are receiving early and ongoing medical care for HIV/AIDS, in an attempt to close the gap between those testing positive or previously known to be positive, and those in medical care.**

## Progress

According to data from the 2005 Houston Area HIV/AIDS Needs Assessment, comparing year of HIV diagnosis with the length of time from diagnosis to beginning HIV medical care showed that the percentage beginning care “immediately” after diagnosis decreased over time. Over 50% of respondents diagnosed between 1990 and 1995 report receiving care immediately after diagnosis. This was 43% for those diagnosed between 2000 and 2002, and 40% for PLWHA diagnosed between 2003 and 2004.

	Immediately		Within 6 Months		Within a Year		Longer than One Year		Never		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
<b>1990 - 1995</b>	74	50.3%	25	17.0%	9	6.1%	23	15.6%	16	10.9%	147	100%
<b>1996 - 1999</b>	83	49.7%	20	12.0%	5	3.0%	19	11.4%	40	24.0%	167	100%
<b>2000 - 2002</b>	79	42.5%	23	12.4%	10	5.4%	11	5.9%	63	33.9%	186	100%
<b>2003 - 2004</b>	25	40.3%	8	12.9%	1	1.6%	3	4.8%	25	40.3%	62	100%

However, the consumer survey found that referrals to HIV medical care improved the time between diagnosis and care. For people diagnosed between 2000 and 2002, nearly 54% of those receiving a referral for HIV medical care began care immediately.

Conversely, outcome data from 3/1/04 through 02/28/05 show that 376 newly diagnosed or not-in-care PLWHA utilized outreach services. According to service utilization records, as high as 47.6% of these PLWHA subsequently accessed Title I/III/IV primary care services during this time period. Additionally, 31.9% subsequently accessed Title I/II/Substance Abuse Services (SAS)/DSHS case management services during this time period.

## Comprehensive Plan Goal G

**By February 28, 2008, people with HIV/AIDS who are in the Houston area system of care will have an improved understanding of and access to all available therapeutic and treatment medications, including non-prescription drugs.**

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## **Progress**

Forty four percent of in-care consumer survey respondents reported that their health care provider did speak to them about participating in clinical trials. Responses ranged from 37% of Hispanics to 48% of recently released. Other populations included 45% of women, 43% of African Americans, 39% other substance users and 39% of women.

Drug reimbursement has become so seamless with medical care that consumers who are receiving the service do not identify it as a need that is separate from primary medical care. For example, consumer responses to the need for drug reimbursement do not match their actual experiences in receiving the service. Consumers taking antiretroviral medication and reporting ADAP and/or local drug assistance as their funding source report a limited need for “drug reimbursement” services. It may be assumed that these consumers consider ADAP or local drug reimbursement to be a part of HIV medical care.

In analyzing provider capacity through the provider survey, a local drug reimbursement provider reported the ability to increase local drug reimbursement for an additional 500 consumers. This capacity will be critical as consumers enter the care system.

## **Monitoring Progress**

Progress in achieving the 2006 – 2008 Goals, Recommendations and Action Steps will be monitored through biannual meetings of representatives of Title I, Title II, Title III, STAGE, and the CPG. These meetings will be convened by the Comprehensive Planning Committee of the Ryan White Planning Council. Documentation of the progress and status of each action step will be maintained using the following tables.

**Table 37: Progress Monitoring**

<b>Recommendation A.1: As programs are developed to bring out-of-care PLWHA into the care system, medical care services must be incrementally expanded. Current providers have limited capacity to serve large volumes of additional patients. Through targeted development, new and expanded programs should reduce perceived barriers to care for those who are currently outside the care system.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Provide community-based case managers and others connected to the out-of-care community with detailed information for referral of uninsured to funded programs.	Title I		
b. Continue to monitor quality and client satisfaction at existing primary care provider sites.	Title I, Title II		
c. Consider assessment of barriers to care in out-of-care population and the development of a plan to address barriers.	Title I, Title II		
d. Maintain regularly scheduled HIV testing and counseling at 11 Title III community health centers.	Title III		
e. Meet with clinic directors, visit clinic sites and provide supervision to bilingual and culturally competent Outreach staff.	Title III		
f. Provide Adherence assessment, education and monitoring to patients at Title III facilities, and review each client's readiness to begin or change HAART.	Title III		
g. Provide medical care information targeted to HIV positive people who are not yet receiving medical care.	Other Planning Bodies or Service Providers		

<b>Recommendation A.2: Consider funding model programs that combine targeted outreach and medical care for specific out-of-care populations.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Target community-based case management teams to segments of the out-of-care population and standalone community-based case managers at counseling and testing sites.	Title I		
b. Maintain regularly scheduled HIV testing and counseling at 11 Title III community health centers.	Title III		
c. Provide in-service meeting for clinic staff regarding HIV testing and other HIV treatment basics.	Title III		
<b>Recommendation A.3: Examine why out-of-care youth aren't utilizing Houston's primary medical care targeting youth.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Conduct special studies to examine factors that influence entry into care for youth.	Title I		
<b>Recommendation A.4: Support existing programs and establish new program(s) to facilitate entry into the medical care system upon release from jail/prison. Ensure that such programs address disclosure concerns for soon-to-be released and recently released PLWHA.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Offer services that help HIV positive people get medical care after being released from jail/prison.	Other Planning Bodies or Service Providers		

**Recommendation A.5:  
Increase targeted HIV medical care information for out-of-care populations. Vary the format and message in order to maintain interest.**

2006 - 2008 Action Steps	Party Responsible	Completed	Changes Noted
a. Continue to provide annual trainings to medical and social service providers regarding HIV-related medical issues for special populations.	Other Planning Bodies or Service Providers		

**Recommendation B.1:  
Enhance access to services targeted to underserved communities.**

2006 - 2008 Action Steps	Party Responsible	Completed	Changes Noted
a. Continue to use Minority AIDS Initiative and general Title I funds to enhance allocations in service categories such as primary medical care case management and mental health that target underserved communities including African Americans, Latinos, recently released, homeless and not-in-care.	Title I		
b. Monitor allocations for primary care, case management and mental health services targeted to women, African Americans, Latinos and MSM.	Title I		
c. Maintain HIV counseling and Orasure testing at two Title III Community Health Centers, and four additional Title III Homeless Program sites.	Title III		

<b>Recommendation B.2: To supplement earlier studies, additional research should be considered to better understand the reasons for the rate of out-of-care and never-in-care among African American MSM.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Conduct special studies to examine factors that influence entry into care for MSM of color.	Title I		
<b>Recommendation B.3: Consider developing additional prevention strategies targeted to individuals who have sex with both men and women.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Continue recommending and implementing effective evidence based interventions targeting individuals at highest risk.	CPG		
b. Consider special studies targeting individuals who have sex with both men and women to examine prevention needs and effective prevention strategies.	CPG		
c. Target prevention efforts to individuals who are bisexual (have sex with both men and women).	Other Planning Bodies or Service Providers		
<b>Recommendation B.4: Ensure that healthcare providers, especially those who do not regularly treat PLWHA are aware of the complications of anti-retroviral therapies and the particular risk to African American men, who are also at risk fro diabetes, and cardiovascular disease.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Continue to provide annual trainings to medical and social service providers regarding HIV-related medical issues for special populations.	Other Planning Bodies or Service Providers		

**Recommendation B.5:**

**Continue to require that all HIV medical care providers offer treatment adherence programs. Whenever possible, target treatment adherence service to African Americans.**

2006 - 2008 Action Steps	Party Responsible	Completed	Changes Noted
a. Institute a Title III adherence team which will oversee the assessment, education, medication initiation & follow-up of new starts and changes to regimen.	Title III		

**Recommendation B.6:**

**Incorporate mental health therapy/counseling and substance abuse treatment into model programs, and evaluate their effectiveness in moving the newly diagnosed into care.**

2006 - 2008 Action Steps	Party Responsible	Completed	Changes Noted
a. Continue to require that all Title III clinical providers provide appropriate referrals to Substance Abuse, Mental Health, Case Management, and Social Services.	Title III		

**Recommendation B.7:**

**Enhance collaboration between housing programs and substance abuse treatment.**

2006 - 2008 Action Steps	Party Responsible	Completed	Changes Noted
a. Collaborate with housing or substance abuse treatment programs to provide services for IV drug users or other substance users.	Other Planning Bodies or Service Providers		

<b>Recommendation B.8: Develop substance abuse treatment programs for diverse populations, including the uninsured.</b>			
<b>2006 – 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Consider a special study examining the specific and unique needs of I+ substance users and what barriers to care exist within this population.	Title I, Title II		
<b>Recommendation B.9: Identify opportunities to leverage funding through partnerships with substance abuse treatment programs</b>			
<b>2006 – 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Place clinical and community-based case managers in a substance abuse treatment setting.	Title I		
b. Continue to require that all Title III clinical providers provide appropriate referrals to Substance Abuse, Mental Health, Case Management, and Social Services.	Title III		
<b>Recommendation B.10: Explore alternative models of providing mental health and substance abuse counseling at primary care sites.</b>			
<b>2006 – 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Continue to place psychiatric services at all Title I primary care sites.	Title I		

**Recommendation B.11****Continue to educate substance abuse treatment providers to more effectively treat HIV positive consumers.**

2006 - 2008 Action Steps	Party Responsible	Completed	Changes Noted
a. Collaborate with housing or substance abuse treatment programs to provide services for IV drug users or other substance users.	Other Planning Bodies or Service Providers		

**Recommendation B.12****Continue to educate consumers, case managers and primary care providers about the availability of free substance abuse treatment and the availability of various substance abuse treatment approaches.**

2006 - 2008 Action Steps	Party Responsible	Completed	Changes Noted
a. Place clinical and community-based case managers in a substance abuse treatment setting.	Title I		

**Recommendation B.13****Develop a comprehensive transitional program that matches the newly released with a medical care provider, source for medications and basic resources.**

2006 - 2008 Action Steps	Party Responsible	Completed	Changes Noted
a. Consider a special study examining the specific and unique needs of recently released HIV+ individuals.	Title I, Title II		
b. Continue to provide programs that provide emergency housing and HIV/AIDS medication assistance to recently or soon-to-be released persons of color.	Other Planning Bodies or Service Providers		

<b>Recommendation B.14</b> Within the comprehensive transition program, incorporate insurance eligibility and other efforts to economically support the recently released.			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Continue to offer referrals to Houston area services providing job training, transportation and other transitional services.	Other Planning Bodies or Service Providers		
<b>Recommendation B.15</b> Provide health screenings that includes the range of co-morbidities to which the incarcerated appear to be more susceptible.			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Continue to offer referrals to Houston area services that provide clinical and medical care services	Other Planning Bodies or Service Providers		
<b>Recommendation B.16</b> Support existing programs and establish new programs(s) to facilitate entry into the medical care system upon release from jail/prison. Ensure that such programs address disclosure concerns for soon-to-be and recently released PLWHA.			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Continue to provide programs that offer clinical and medical care assistance to recently or soon-to-be released persons of color	Other Planning Bodies or Service Providers		

**Recommendation B.17****Increase utilization of case managers who specialize in meeting the needs of PLWHA who are recently released for jail/prison.**

<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Employ case managers who specialize in the needs of HIV positive people who are recently released from jail or prison.	Other Planning Bodies or Service Providers		

**Recommendation B.18****Continue to expand linkages between jail/prison and the community care system in order to effectively transition recently released into care.**

<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. The recently released are able to access Ryan White Title I funded food pantries for a limited time post-release. Community-based case managers may make emergency referrals for clients who are being released for incarceration. When accessed, these food banks may provide important linkages to the care system.	Title I		
b. Continue to provide Blue Books at no cost to incarcerated individuals, as well as information on programs in the community targeted to incarcerated individuals and the recently released.	Title I		

<b>Recommendation B.19</b> <b>Through collaborations, begin implementation of a plan to expand transitional housing options.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Facilities should target specific populations with housing and other services, such as transitional housing for: substance abuse treatment, recently released, women, etc. Begin with a pilot project with the goal of expanding services or targeting additional populations over time.	Other Planning Bodies or Service Providers		
b. Consider expanding programs to ease transition out of incarceration for those with substance abuse issues. Such a program has been developed by the Texas Department of Criminal Justice, to provide those released with an opportunity to reside in a halfway house and receive substance abuse treatment	Other Planning Bodies or Service Providers		
<b>Recommendation B.20</b> <b>Examine reasons for low use of mental health services by recently released and develop targeted services and service promotion for these consumers.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Offer services that encourage HIV positive people who are recently released from jail/prison to use mental health services.	Other Planning Bodies or Service Providers		
<b>Recommendation B.21</b> <b>Expand the availability to support groups to the recently released.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Continue to offer referrals to Houston area services that provide individual/group counseling and support groups	Other Planning Bodies or Service Providers		

**Recommendation B.22**

**Continue to provide information to primary care providers, especially obstetricians/gynecologists and emergency medicine physicians about their role in HIV testing and diagnosis.**

<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Title III Counseling and Testing Supervisor will continue to meet with clinic directors and visit clinic sites.	Title III		
b. Title III Counseling and Testing Supervisor will continue to provide in-service meetings for clinic staff regarding HIV testing and other HIV treatment basics.	Title III		
c. Examine possible partnerships with private medical providers to increase routine HIV screening in medical settings.	CPG		
d. Continue to provide annual trainings to medical and social service providers regarding HIV-related medical issues for special populations	Other Planning Bodies or Service Providers		

**Recommendation B.23**

**Continue to develop programs that appropriately communicate HIV status to women, provide prevention information to the seronegative and transitions the newly diagnosed to early intervention services.**

<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Continue to implement and monitor evidence based interventions targeting at risk females.	CPG		
b. Provide educational and early intervention services for HIV positive women.	Other Planning Bodies or Service Providers		

<b>Recommendation B.24 Examine barriers to use of medication reimbursement programs by women.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Consider a study to explore access and availability issues for women.	Title I, Title II		
<b>Recommendation B.25 Continue to educate HIV+ women about the importance of gynecologic care in order to increase utilization of OB/GYN services.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Educate HIV positive women about the importance of OB/GYN care.	Other Planning Bodies or Service Providers		
<b>Recommendation B.26 Expand OB/GYN treatment options and locations for offering care for HIV+ women.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Publicize the availability of Title III Women's Program to community-based HIV service providers and other Ryan White funded primary care providers.	Title III		
<b>Recommendation B.27 Include OB/GYN care for female PLWHA at Title I-funded sites.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Provide educational and early intervention services for HIV positive women.	Other Planning Bodies or Service Providers		

<b>Recommendation B.28</b> <b>Expand the availability of support groups for women.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Provide support groups for HIV positive women.	Other Planning Bodies or Service Providers		
<b>Recommendation B.29</b> <b>Continue to provide prevention education for young mothers and children through schools, social service agencies, youth development programs and churches.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Examine possible partnerships and strategies to expand prevention activities targeting at risk youth	CPG		
b. Provide prevention education for young mothers.	Other Planning Bodies or Service Providers		
<b>Recommendation B.30</b> <b>Develop and implement programs to insure youth 18 years or older.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Conduct special studies to examine factors that influence entry into care for youth.	Title I		

<b>Recommendation B.31 Expand outreach, testing and early intervention programs to youth.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Consider special studies to examine prevention needs and appropriate prevention messages targeting at risk youth.	CPG		
b. Provide prevention education for youth.	Other Planning Bodies or Service Providers		
<b>Recommendation B.32 Examine reasons for low use of mental health services by youth.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Conduct special studies to examine factors that influence entry into care for youth.	Title I		
<b>Recommendation B.33 Expand the availability of support groups for youth.</b>			
<b>2006 - 2008 Action Steps</b>	<b>Party Responsible</b>	<b>Completed</b>	<b>Changes Noted</b>
a. Provide support groups for youth	Other Planning Bodies or Service Providers		

**Recommendation B.34****Examine reasons youth are not utilizing Houston’s youth-focused primary medical care.**

2006 - 2008 Action Steps	Party Responsible	Completed	Changes Noted
a. Drawing upon expertise gleaned from other programs across the country, consider incorporating additional components such as: A youth peer counseling program to support youth in the medical care system, using technology in both care and education, etc.	Other Planning Bodies or Service Providers		
b. Conduct special studies to examine factors that influence entry into care for youth.	Title I		

**Recommendation B.35****Evaluate the effectiveness of case managers targeting services for youth and consider the need to expand availability.**

2006 - 2008 Action Steps	Party Responsible	Completed	Changes Noted
a. Employ case managers that specialize in the needs of youth.	Other Planning Bodies or Service Providers		

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**Section V**  
**GLOSSARY OF TERMS**

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**Access to Services:** The extent to which clients can get or receive the service. Assumes that service was available to clients. Numerous factors may influence access to services even though the service is deemed available to the client.

**ADAP:** see AIDS Drug Assistance Program.

**Administrative Agency:** A lead, or administrative, agency is authorized to receive funds and distribute them according to service priorities established in the HIV care plan. An administrative agency may be a State or County health department, a community foundation, a public trust, a community-based organization, an AIDS service organization, or an incorporated non-profit agency. In the Houston area, the administrative agency for Title I of the Ryan White CARE Act is HIV Services, Public Health and Environmental Services, Harris County Department of Health; for Title II, the administrative agency is The Houston Regional HIV/AIDS Resource Group.

**AETC:** see AIDS Education and Training Center.

**AI/A:** American Indian/Alaska Native.

**AIDS Drug Assistance Program (ADAP):** The ADAP was created as part of the Ryan White CARE Act and is administered under Title II. ADAP provided medications to low-income people living with HIV/AIDS that are uninsured or under-insured and lack coverage for medications.

**AIDS Education and Training Center (AETC):** The AETC was created as part of the Ryan White CARE Act and is administered under Part F. The AETC program is a network of regional centers that conduct targeted, multi-disciplinary education and training programs for health care providers.

**API:** Asian/Pacific Islander.

**ASO:** AIDS service organization

**Availability:** Primarily concerned with whether the service was offered to the client/community.

**Barriers:** A number of factors or circumstances that prohibit or inhibit access and/or use of services. The reason for and source of barriers are diverse.

**CARE Act:** see Ryan White CARE Act.

**CAEAR:** Cities Advocating Emergency AIDS Relief Coalition

**CBO:** Community-Based Organization.

**CDC:** see Centers for Disease Control and Prevention.

**Centers for Disease Control and Prevention (CDC):** The Centers for Disease Control and Prevention is a Federal agency of the Department of Health and Human Services. The CDC mission is to promote health and quality of life by preventing and controlling disease, injury and disability. The CDC is the Federal agency responsible for tracking diseases that endanger public health, such as HIV.

**Community Forum or Public Meeting:** A small-group method of collecting information from community members in which a community meeting is used to provide a directed but highly

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interactive discussion. Similar to but less formal than a focus group, it usually includes a larger group; participants are often self-selected (i.e., not randomly selected to attend).

**Community Planning Coalition/Group:** The CDC started a program in which people from at-risk communities and those who are HIV positive utilize data from scientists and other professionals in order to decide the most effective HIV prevention programs and methods for stopping the spread of HIV infection in their area. In the Houston area, the groups are the Houston HIV Prevention Community Planning Group (covering Harris County) and the East Texas HIV Prevention Community Planning Coalition (covering 51 counties stretching from Matagorda to Texarkana).

**Comprehensive Planning:** The process of determining the organization and delivery of HIV services; strategy used by a planning body to improve decision-making about the services and maintain a continuum of care.

**Consortium:** Title II of the Ryan White CARE Act created and authorized consortia. A consortium is an association of public, private non-profit, and community-based organizations operating within an HSDA and individuals who are community leaders, persons representative of populations affected by HIV, people infected with HIV, and family members/caregivers of people with HIV. The consortium determines how Federal and State grant funds will be used in its geographic area to treat and provide services to people with HIV/AIDS. In the Houston area, the consortium is the Houston HIV Service Delivery Area CARE Consortium.

**Continuum of Care:** A set of services and linking mechanisms that responds to an individual or family's changing needs for HIV prevention and care. A continuum of care is the complete system of providers and available resources (CARE Act and others) for people at risk for or living with HIV and their families within a particular geographic service area, from primary care to supportive services.

**CPC/CPG:** see Community Planning Coalition/Group.

**CTRPN/E:** Counseling, Testing, Referral and Partner Notification/Elicitation

**Eligible Metropolitan Area (EMA):** A designation used by the Ryan White CARE Act to identify an area eligible for funds under Title I (aid to metropolitan areas hardest hit by HIV). The Houston EMA consists of the following six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.

**EMA:** See Eligible Metropolitan Area.

**Epidemic:** The spread of an infectious disease through a population or geographic area.

**Epidemiologic Profile:** A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specific geographic area.

**Epidemiology:** The study of factors associated with health and disease and their distribution in the population.

**Focus Group:** A method of information collection involving a carefully planned discussion among a small group led by a trained moderator.

**HAART:** Highly Active Anti-Retroviral Treatment

**Health Resources and Services Administration (HRSA):** The Health Resources and Services Administration directs national health programs that improve the Nation's health by assuring equitable

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access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA administers the Ryan White CARE Act.

**HIV Service Area (HSA):** A designation used by the City of Houston Health Department within the city limits. HSA's approximate neighborhood boundaries.

**HIV Service Delivery Area (HSDA):** Also known as Health Service Delivery Area. A designation used by the Ryan White CARE Act to identify an area eligible for funds under Title II (formula funding to States and territories). The Houston area HSDA consists of the following ten counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton.

**Housing Opportunities for People with AIDS (HOPWA):** HOPWA is a Federal program of the Department of Housing and Urban Development. HOPWA provides housing assistance and supportive services for low-income people with HIV/AIDS and their families.

**HOPWA:** see Housing Opportunities for People with AIDS.

**HRSA:** See Health Resources and Services Administration.

**HSA:** See HIV Service Area.

**HSDA:** See HIV Service Delivery Area.

**IDU:** Injection drug use(r).

**KAP:** Knowledge, Attitudes and Practices. Typically used to describe survey instruments that measure those particular variables in relation to a particular behavior.

**Need for Service:** The extent the service was requested. May encompass terms such as was the service wanted, desired, necessary to address health problems/concerns.

**Needs Assessment:** A process of collecting information about the needs of people at risk of or living with HIV and their families (both those receiving care and those not in care), identifying current resources (CARE Act and others) available to meet those needs, and determining what gaps in care exist.

**Part F:** Part F of the Ryan White CARE Act administers several programs: 1) Special Projects of National Significance (SPNS), which supports the development of innovative models of HIV care and is designed to address special care needs of individuals with HIV/AIDS in minority and hard-to-reach populations; 2) AETC, program is a network of regional centers that conduct targeted, multi-disciplinary education and training programs for health care providers; and 3) HIV/AIDS Dental Reimbursement Program, which assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to patients with HIV.

**Planning Council:** Planning Councils are volunteer planning groups composed of community members who prioritize services and allocate funds under Title I of the Ryan White CARE Act. In the Houston area, the planning council is known as the Houston Area HIV Services Ryan White Planning Council.

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**PLWHA:** People (or person) living with HIV/AIDS; PLWH and PLWA and PWA also are used.

**Prevention Services:** Interventions, strategies, programs, and structures designed to change behavior that may lead to HIV infection or other disease. Examples of HIV prevention services include street outreach, educational sessions, condom distribution, and mentoring and counseling programs.

**Public Health Service Area (PHSA):** Service area used for public health planning.

**MSM:** Men who have sex with men.

**Ryan White CARE Act:** On August 18, 1990, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Reauthorized in 1996, the CARE Act is designed to improve the quality and availability of care for individuals and families affected by HIV/AIDS. The CARE Act includes the following major programs: Title I, Title II, Title III, Title IV, and Part F. The CARE Act is now the largest sole source of HIV funding in the nation.

**SES:** Socio-economic Status. Social and Economic indicators like income and education. SES is consistently correlated with differences in health outcomes.

**Sexually Transmitted Infection (STI):** A disease that is spread through intimate sexual contact, such as HIV, herpes, syphilis, and gonorrhea.

**Special Projects of National Significance (SPNS):** SPNS is administered by Part F of the Ryan White CARE Act. This program supports the development of innovative models of HIV care and is designed to address special care needs of individuals with HIV/AIDS in minority and hard-to-reach populations.

**SPNS:** see Special Projects of National Significance.

**DSHS:** Texas Department of State Health Services. Was formerly the Texas Department of Health (TDH).

**Title I:** Under the Ryan White CARE Act, funding is given to eligible metropolitan areas hardest hit by the HIV/AIDS epidemic. In the Houston area, Title I funding is given to the Harris County judge, administered by the Harris County Health Department, and guided by the Houston Area HIV Services Ryan White Planning Council.

**Title II:** Under the Ryan White CARE Act, funding is given by formula to States and territories to improve the quality, availability, and organization of health care and support services for people living with HIV/AIDS. There is an emphasis on rural populations. In the Houston area, Title II funding is given to the Texas Department of Health, administered by Houston Regional HIV/AIDS Resource Group, and guided by the Houston HSDA CARE Consortium.

**Title III:** Under the Ryan White CARE Act, funding is given to community-based organizations for outpatient early intervention services. In the Houston area, the Title III grant recipient is the Harris County Hospital District.

**Title IV:** Under the Ryan White CARE Act, funding is given to public and non-profit entities to coordinate services to, and improve access to research for, children, youth, women and families. In the Houston area, the Title IV grant recipient is the Houston Regional HIV/AIDS Resource Group.

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**Section VI**  
**PLANNING RESOURCES**



