2008 Houston Area HIV/AIDS Needs Assessment

A COLLABORATIVE PROJECT OF THE:

Ryan White Planning Council

Houston Regional HIV/AIDS Resource Group

Harris County Hospital District

Harris County Public Health and Environmental Services Ryan White Grant Administration

Houston Department of Health and Human Services (HDHHS)

City of Houston HIV Prevention Community Planning Group (HHPCPG)

Housing Opportunities for Persons with AIDS (HOPWA)

Coalition for the Homeless of Houston/Harris County

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- Houston Regional HIV/AIDS Resource Group
- Harris County Hospital District
- Harris County Public Health & Environmental Services - Ryan White Grant Administration
- Houston Department of Health and Human Services (HDHHS)
- City of Houston HIV Prevention Community Planning Group (CPG)
- Housing Opportunities for Persons with AIDS (HOPWA)
- Coalition for the Homeless of Houston/Harris County

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Table of Contents

EXECUTIVE SUMMARY **1**
INTRODUCTION 1
METHODOLOGY 1
CLIENT SURVEY 2
PROVIDER SURVEY 2
RISK BEHAVIOR ITEMS 2
GAPS ANALYSIS 2
SURVEY RESPONDENTS 3
ACCESS TO CORE SERVICES 5
ACCESS TO SUPPORTIVE SERVICES 5
BARRIERS TO CORE SERVICE 7
BARRIERS TO SUPPORTIVE SERVICES 7
MOST COMMONLY REPORTED BARRIERS 8
SERVICES WITH THE HIGHEST NUMBER OF REPORTED BARRIERS 9
RISK BEHAVIORS 10
BARRIERS REPORTED BY PROVIDERS 11

INTRODUCTION & BACKGROUND **13**
PURPOSE OF THE NEEDS ASSESSMENT 13
ABOUT THE HOUSTON EMA AND HSDA 15
DEMOGRAPHICS OF THE HOUSTON HSDA 18
⇒ RACE/ETHNICITY 20
⇒ LINGUISTIC ISOLATION 22
⇒ SOCIOECONOMIC STATUS 23
⇒ EMPLOYMENT STATUS 24
⇒ EDUCATIONAL ATTAINMENT 25
⇒ POVERTY STATUS 26
⇒ HEALTH AND INSURANCE STATUS 27
HIV/AIDS IN THE HOUSTON EMA AND HSDA 28

⇒ HIV and AIDS Incidence (2005) 29
⇒ HIV and AIDS Prevalence 31
⇒ Mortality 35
Special Populations 37
⇒ Men who have sex with men (MSM) 37
⇒ Injection Drug Users (IDU) 41
⇒ Women of Childbearing age 43
⇒ Youth, age 18 - 24 45
⇒ Blacks/African-Americans 47
⇒ Hispanics/Latinos 49
HIV/Tuberculosis Coinfection 51
HIV/Syphilis Coinfection 52
HIV/Hepatitis C Coinfection 53
HIV Counseling and Testing Data 54
Unmet Need Estimate and Assessment 57
Care & Supportive Serivces in the EMA: Ryan White Part A 60
Care & Supportive Serivces in the HSDA: Ryan White Part B 62
Prevention Services in the HSDA 63
The Needs Assessment Planning Process 67
Structure of the Needs Assessment 68
⇒ Client Survey 68
⇒ Provider Survey 70
⇒ Resource Inventory 71
⇒ Prevention Items 71
⇒ Gaps Analysis 72

Findings By Population 73
All Respondents 73
In Care Respondents 103
Out-of-Care Respondents 129
Women 153

YOUTH 179
AFRICAN-AMERICANS 205
LATINOS/HISPANICS 233
WHITE MEN WHO HAVE SEX WITH MEN 261
MEN OF COLOR WHO HAVE SEX WITH MEN 287
SUBSTANCE ABUSERS 315
PLWHA WITH MENTAL HEALTH SYMPTOMS 341
RECENTLY RELEASED 369
HOMELESS RESPONDENTS 397

FINDINGS BY SERVICE - CORE SERVICES 425
PRIMARY MEDICAL CARE 425
HIV/AIDS MEDICATIONS 431
DENTIST VISITS 436
MEDICAL CASE MANAGEMENT 441
HOME HEALTH CARE 447
PSYCHIATRIC SERVICES 452
PSYCHOLOGICAL COUNSELING SERVICES 457
REHABILITATION 462
SUBSTANCE ABUSE TREATMENT SERVICES 467

FINDINGS BY SERVICE - SUPPORTIVE SERVICES 473
CHILD CARE SERVICES 473
CHILD WELFARE SERVICES 478
DAY/RESPITE CARE FOR ADULTS 483
DEVELOPMENTAL ASSESSMENT 488
EMERGENCY FINANCIAL ASSISTANCE 493
EMPLOYMENT ASSISTANCE 498
FOOD PANTRY 503
HOUSEHOLD ITEMS 508
HIV EDUCATION FOR HIV+ INDIVIDUALS 513
HOUSING-RELATED SERVICES 518

Legal Services 523
Nutritional Counseling 528
Permanency Planning 533
Referrals to Clinical Research 538
Referrals to Services 543
Rental Assistance/Shelter Vouchers 547
Support Groups 552
Transportation 557
Translation/Interpretation 563

Resource Inventory 569

Gaps Analysis 579
Most Commonly Reported Barriers:
Core Services 579
Supportive Services 581
Services Associated with the Highest Number of Reported Barriers:
Core Services 583
⇒ Dentist Visits 584
⇒ Primary Medical Care 585
⇒ HIV/AIDS Medications 586
Supportive Services 587
⇒ Emergency Financial Assistance 587
⇒ Housing-Related Services 588
⇒ Rental Assistance/Shelter Vouchers 589
Gaps Analysis: Service Barriers 590
Gaps Analysis: Referrals 591
Gaps Analysis: Prevention 592
HIV Transmission and Reinfection Risk Behavior
In Care versus Out-of-Care 599
Youth versus All Respondents 600
White MSM versus MSM of Color 600

GEOMAPPING **601**
HIV/AIDS IN HARRIS COUNTY, BY ZIP CODE 602
LOCATION OF OUT-OF-CARE RESPONDENTS IN THE HSDA 603
HIV/AIDS PREVALENCE IN THE HSDA 604
HIV/AIDS PREVALENCE IN HARRIS COUNTY 605
LOCATION OF SURVEY RESPONDENTS IN RELATION TO RYAN WHITE PRIMARY CARE CLINICS 606

CONCLUSIONS **607**

APPENDIX A: SPECIAL STUDIES **609**
ACCESS TO CARE AMONG HIV+ LATINO IMMIGRANTS 611
BARRIERS TO CARE AMONG HIV+ YOUTH 631

APPENDIX B: NEEDS ASSESSMENT TOOLS **651**
CLIENT SURVEY 653
CUE CARDS 665
PROVIDER SURVEY 667

APPENDIX C: OFFICIAL HRSA SERVICE DEFINITIONS **681**

GLOSSARY **687**

Executive Summary

Introduction

The purpose of the 2008 Houston Area HIV/AIDS Comprehensive Needs Assessment is to gather information on:

- Levels of access to core and supportive services;
- Experience of barriers;
- HIV testing histories;
- Entry to care;
- In-care and out-of-care status;
- Treatment regimens;
- Perceptions of health status;
- Mental health symptoms;
- Substance use and abuse;
- Housing status;
- Financial information; and
- Basic demographics of a sample of people living with HIV/AIDS (PLWHA) in the 10-county Houston HSDA.

This information is used by community-based planning bodies in order to:

- Prioritize fundable services from a consumer point-of-view, including needed services not currently offered;
- Determine funding allocations for those services based upon money available within the various partner organizations, and to inform other funding sources which pay for similar services;
- Make programmatic recommendations on how to best meet the needs of clients;
- Support efforts to plan a comprehensive system of HIV/AIDS care; and
- Provide supporting documentation for annual Health Resources and Services Administration (HRSA) and Department of State Health Services (DSHS) grant applications.

Methodology

The 2008 Houston Area HIV/AIDS Needs Assessment is comprised of the following elements:

- Client survey, including Risk Behavior Items
- Provider survey
- Focus groups
- Resource Inventory
- Gaps Analysis

Client Survey

A total of 764 client surveys were administered from March through August 2007. Surveys were administered by the Ryan White Planning Council Health Planner, Council Coordinator, Ryan White Part B Health Planner, Houston Department of Health & Human Services Health Planner and two graduate students trained in survey administration. Survey administration locations included clinics, agencies and outreach vans targeting the homeless population. Spanish surveys were administered with the help of a bilingual survey administrator or hired interpreter.

Provider Survey

A detailed provider survey was developed and administered in order to evaluate services delivered to PLWHA throughout the EMA/HSDA, and to develop a Resource Inventory. The Planning Council's Office of Support mailed the provider surveys to agencies listed in the *Blue Book*, the Houston Area HIV Resource Directory, and other health and social service providers. Forty-eight surveys were returned as a result of these efforts.

In accordance with HRSA requirements, information collected from provider surveys was analyzed to produce a resource inventory. At a minimum, the inventory should include information about HIV services in the EMA/HSDA and other supportive and ancillary services that, though not HIV-specific, are likely to be utilized by PLWHA.

Risk Behavior Items

Prevention items included on the Needs Assessment survey were recommended by the Houston Department of Health & Human Services staff, according to the definition of risk for HIV transmission developed by the Centers for Disease Control & Prevention (CDC). These questions focused on behaviors that might lead a person living with HIV to transmit their infection or to be re-infected with HIV, which can complicate treatment options and therefore the well-being of that person.

Gaps Analysis

The Gaps Analysis portion of the report addresses types of barriers most often reported by survey respondents, barriers most often reported by providers, services with the highest number of barriers, maps generated from survey data and a brief description of overall themes.

SURVEY RESPONDENTS

There were 764 total PLWHA respondents to the 2008 Needs Assessment consumer survey. This total represents 4.21% of the 18,109 reported people living with HIV/AIDS in the Houston HSDA during 2006.

The majority of consumer survey respondents were men (66%). Women represented 31% of all respondents, and transgender male-to-females represented 2%. None of the respondents identified as transgender female-to-male. Among women, 6% said they were pregnant at the time of the survey, and 4% said they did not know their pregnancy status. The average age of respondents was 43 years. Virtually all respondents were above the age of 25; approximately 48% of all respondents were between the ages of 25-44, and another 48% were above the age of 45. Only 4% were youth between the ages of 18 and 24. (See Appendix A for a Special Study on HIV+ Youth).

More than half of all respondents identified as Black/African American (56%). Twenty-three percent identified as White/Anglo, 18% as Hispanic/Latino, and 3% as Asian, Native American or multi-racial. The race distribution of respondents resembles the 2006 HIV/AIDS prevalence for the Houston HSDA, where 48% of cases were among Blacks/ African Americans, 31% among Whites/Anglos, 19% among Hispanics/Latinos and 1% among Others.

Just over half (55%) of all respondents identified as straight or heterosexual. About a third (32%) identified as gay/lesbian, 8% as bisexual and 1% as undecided. Four percent said they preferred not to disclose their sexual orientation.

More than three-quarters (77%) of respondents had a high school degree/GED or less. Fifteen percent had a college degree, 2% had a graduate/professional degree and 5% had some technical training. Only 2 respondents reported receiving no education.

A total of 119 (16%) of all survey respondents reported being released from jail or prison during the previous year. PLWHA eligible for veteran benefits represented 5% of all respondents.

The tables on page 4 show the 2005 HIV/AIDS prevalence for the Houston EMA compared to the 2008 Needs Assessment survey sample.

HIV/AIDS Prevalence, Houston EMA, 2005

Males		White		Black		Hispanic		Other		Total	
		N	%	N	%	N	%	N	%	N	%
Age	0 - 12	5	0%	57	1%	14	0%	<3	<1	77	1%
	13 - 24	45	1%	270	5%	108	4%	<3	<1	425	3%
	25 - 44	2,347	47%	2,888	54%	1,899	67%	105	70%	7,239	54%
	45+	2,564	52%	2,181	40%	824	29%	42	28%	5,611	42%
	Total	**4,961**	**100%**	**5,396**	**100%**	**2,845**	**100%**	**150**	**100%**	**13,352**	**100%**

Females		White		Black		Hispanic		Other		Total	
		N	%	N	%	N	%	N	%	N	%
Age	0 - 12	<3	n/a	54	2%	17	3%	<3	n/a	75	2%
	13 - 24	43	7%	281	8%	61	9%	<3	n/a	387	8%
	25 - 44	357	54%	2,113	63%	428	63%	34	77%	2,932	62%
	45+	257	39%	926	27%	174	26%	6	14%	1,363	29%
	Total	**659**	100%	**3,374**	100%	**680**	100%	**44**	100%	**4,757**	100%

Client survey respondent demographics, 2008 Needs Assessment

Males		White		Black		Hispanic		Other		Total	
		N	%	N	%	N	%	N	%	N	%
Age	13 - 24	2	2%	10	4%	4	4%	0	0%	16	3%
	25 - 44	54	43%	108	41%	60	61%	7	47%	229	45%
	45+	71	56%	148	56%	35	35%	8	53%	262	52%
	Total	**127**	**100%**	**266**	**100%**	**99**	**100%**	**15**	**100%**	**507**	**100%**

Females		White		Black		Hispanic		Other		Total	
		N	%	N	%	N	%	N	%	N	%
Age	13 - 24	2	5%	14	9%	2	5%	1	33%	19	8%
	25 - 44	19	45%	77	50%	21	53%	2	67%	119	50%
	45+	21	50%	62	41%	17	43%	0	0%	100	42%
	Total	**42**	100%	**153**	100%	**40**	100%	**3**	100%	**238**	100%

The following table shows survey administration sites for all 764 client surveys, by type of venue and out-of-care status. The types of venues will show where surveys were administered and where out-of-care PLWHA were most often identified.

TYPE OF VENUE BY OUT-OF-CARE STATUS

Survey Venue	In Care	Out of Care	Total
RW HIV agency or program	341 (50%)	8 (10%)	349 (46%)
Hospital district	154 (22%)	6 (8%)	160 (21%)
Transitional Housing/SRO	87 (13%)	12 (16%)	99 (13%)
Publicity/Press	18 (3%)	24 (31%)	42 (6%)
Word of mouth	8 (1%)	21 (27%)	29 (4%)
Drug Treatment Program	23 (3%)	0	23 (3%)
HIV Prevention agency or program	15 (2%)	0 (0%)	15 (2%)
Street Outreach	10 (2%)	3 (4%)	13 (2%)
Non RW HIV agency or program	13 (2%)	0 (0%)	13 (2%)
Non-HIV	10 (2%)	3 (4%)	13 (2%)
VA	6 (1%)	0	6 (<1%)
Telephone	2 (<1%)	0 (0%)	2 (<1%)
TOTAL	**687**	**77**	**764**

Access to Core Services

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table below shows the list of core services:

- Primary Medical Care
- HIV/AIDS Medications
- Dentist Visits
- Medical Case Management
- Home Health Care
- Psychiatric Services or Medicine
- Psychological Counseling
- Substance Abuse Treatment
- Rehabilitation Services

For all respondents, the top three “easy to get” core services were Primary Medical Care (72%), HIV/AIDS Medications (64%) and Medical Case Management (57%). The top three core services that respondents reported “some difficulty getting” were Dentist visits (32%), Primary Medical Care (23%) and HIV/AIDS Medications (21%). The presence of Primary Medical Care and HIV/AIDS Medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that respondents said they “did not need” in the past year were Home Health Care (74%), Rehabilitation Services (71%) and Substance Abuse Treatment (65%).

Access to Supportive Services

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-

defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table below shows the list of supportive services:

Supportive Services	
Child Care Services	Legal Services
Child Welfare Services	Nutritional Counseling
Day/Respite Care for Adults	Permanency Planning
Developmental Assessment	Referrals to Services
Emergency Financial Assistance	Referrals to Clinical Research
Employment Assistance	Support Groups
Food Bank	Rental Assistance/Shelter Vouchers
HIV Education for HIV+ Individuals	Translation/Interpretation
Household Items	Transportation
Housing-Related Services	

For all respondents, the supportive services that were selected most often (thus implying high helpfulness/usefulness) by respondents were Food Bank, Emergency Financial Assistance, Transportation, Rental Assistance and Housing-Related Services.

The top five "easy to get" supportive services (based on number of responses) were Food Bank (n=247), Transportation (n=145), HIV Education for HIV+ Individuals (n=117), Emergency Financial Assistance (n=104) and Nutritional Counseling (n=98). The top five supportive services that respondents reported "some difficulty getting" were Emergency Financial Assistance (n=244), Rental Assistance/Shelter Vouchers (n=172), Housing-Related Services (n=170), Transportation (n=139) and Employment Assistance (n=130). The presence of certain support services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates. Conversely, the five supportive services that respondents did not need in the past year, but still identified as useful/helpful were Emergency Financial Assistance (n=35), Legal Services (n=31), Housing-Related Services (n=24), Employment Assistance (n=21) and Food Bank (n=19).

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

Barriers to Core Services

The table below shows the list of barriers provided to survey respondents:

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get
C	I would have to wait too long to get the	**N**	Difficulties with paperwork (due to volume,
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get
G	The people who run the services are not	**R**	Fear, denial or stigma (internal and/or
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go	**U**	Not enough, resources/funds run out too
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Among all respondents, the three core services with the highest number of barriers were Dentist Visits (n=431), Primary Medical Care (n=332) and HIV/AIDS Medications (n=269). Within Dentist Visits , the most commonly reported barriers were “It’s hard to make or keep appointments” (n=87), “I would have to wait too long to get the services” (n=74), and “I don’t know where to get the services” (n=58). For Primary Medical Care, the most common barriers for all respondents were “It’s hard to make or keep appointments” (n=53), “It’s hard for me to get there” (n=53), and “I would have to wait too long to get the services” (n=41). For HIV/AIDS Medications, the most common barriers for all respondents were “The services cost too much” (n=48), “I would have to wait too long to get the services” (n=44) and “I don’t know where to get the services” (n=27).

The barriers experienced most often by all respondents across all core services were “It’s hard to make or keep appointments” (n=275), “I would have to wait too long to get the services” (n=261) and “I don’t know where to get the services” (n=255).

Barriers to Supportive Services

Similar to the core services table, survey respondents that had “some difficulty” getting a supportive service were asked to describe the barriers they experienced.

Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

Among all respondents, the five supportive services with the highest number of barriers were Emergency Financial Assistance (n=455), Housing-Related Services (n=312), Rental Assistance/Shelter Vouchers (n=290), Transportation (n=231), and Employment Assistance (n=201). Within Emergency Financial Assistance , the most commonly reported barriers were "I would have to wait too long to get the services" (n=80), "I don't know where to get the services" (n=78) and "I was told I am not eligible for this service" (n=66). For both Housing-Related Services and Rental Assistance/Shelter Vouchers, the most common barriers for all respondents were "I don't know where to get the services" (n=67) and "I would have to wait too long to get the services" (n=55). For Transportation, the most common barriers for all respondents were "I don't know where to get the services" (n=49) and "The services are not in my area" (n=31).

The barriers experienced most often by all respondents across all supportive services were "I don't know where to get the services" (n=599), "I would have to wait too long to get the service" (n=319) and "The services are not in my area" (n=244).

MOST COMMONLY REPORTED BARRIERS

Core Services

For the core services, the three barriers reported most often by all 764 survey respondents were difficulties making or keeping appointments, long wait times for services and informational barriers.

CORE SERVICES: TOP 3 REPORTED BARRIERS, TOTAL RESPONDENTS

1	**It's hard to make or keep appointments** (275 reports)
2	**I would have to wait too long to get the services** (265 reports)
3	**I don't know where to get the services** (255 reports)

Supportive Services

For the supportive services, the three barriers reported most often by all 764 survey respondents were informational barriers, long wait times and services not being in respondents' areas.

SUPPORTIVE SERVICES: TOP 3 REPORTED BARRIERS, TOTAL RESPONDENTS

1	**I don't know where to get the services** (599 reports)
2	**I would have to wait too long to get the services** (319 reports)
3	**The services are not in my area** (244 reports)

SERVICES ASSOCIATED WITH
THE HIGHEST NUMBER OF REPORTED BARRIERS

Core Services

The three core services with the highest numbers of reports of barriers for all 764 respondents were:

CORE SERVICES: TOP 3 REPORTS OF BARRIERS, TOTAL RESPONDENTS

1	**Dentist Visits** (431 reports)
2	**Primary Medical Care** (332 reports)
3	**HIV/AIDS Medications** (269 reports)

It is important to note that these three services also have the highest number of access attempts – therefore, the high volume of access attempts may be correlated with the high number of barrier reports.

Dentist Visits

For Dentist Visits, the barrier reported most often was related to difficulties making or keeping appointments (87 reports). Barriers reported less often for this service were lack of child care during services (6 reports), jail/prison history (5 reports), fear/denial/stigma (4 reports), homelessness/unstable housing (1 report) and personal health issues (1 report).

Primary Medical Care

For Primary Medical Care, the barrier reported most often was related to difficulties getting to services (53 reports). Barriers reported less often for this service were being told, or not believing, they were eligible for services (8 and 9 reports, respectively), jail/prison history (8 reports), lack of child care during services (4 reports), fear/denial/stigma (3 reports), language barriers (3 reports) and incarceration (1 report).

HIV/AIDS Medications

For HIV/AIDS Medications, the barrier reported most often was related to cost of services (48 reports). Barriers reported less often for this service were difficulties with paperwork (7 reports), lack of child care during services (7 reports), language barriers (5 reports), personal health issues (4 reports), jail/prison history (4 reports), homelessness/ unstable housing (1 report), fear/denial/stigma (1 report) and incarceration (1 report).

Supportive Services

The three supportive services with the most reports of barriers were Emergency Financial Assistance (455 reports), Housing-Related Services (312) and Rental Assistance/ Shelter Vouchers (290 reports)

Emergency Financial Assistance

For Emergency Financial Assistance, the barrier reported most often was related to long wait times for services (80 reports). Barriers reported less often for this service were personal health issues (5 reports), difficulties with paperwork (4 reports), lack of child care during services (4 reports), fear/denial/stigma (3 reports), homelessness/unstable housing (1 report) and language barriers (1 report).

Housing Related Services

For Housing Related Services, the barrier reported most often was related to informational barriers (67 reports). Barriers reported less often for this service were not enough resources (7 reports), being afraid someone finding out about HIV status (7 reports), homelessness/unstable housing (5 reports), lack of child care during services (4 reports), fear/denial/stigma (1 report), difficulties with paperwork (1 report) and language barriers (1 report).

Rental Assistance/Shelter Vouchers

For Rental Assistance/Shelter Vouchers, the barrier reported most often was related to informational barriers (51 reports). Barriers reported less often for this service were jail/ prison history (8 reports), being afraid someone will find out about HIV status (7 reports), homelessness/unstable housing (5 reports), personal health issues (4 reports), difficulties with paperwork (3 reports), immigration status (2 reports), lack of child care at services (2 reports), staff turnover (1 report) and substance abuse (1 report).

Risk Behaviors

Of the total 764 sample, 56 respondents reported they had exchanged sex for drugs or money in the past 6 months. This accounts for approximately 11% of the respondents answering this question (most of those who skipped this question had not had sex in the past 6 months). One hundred forty-one (29%) respondents reported that they had engaged in anonymous sex with at least one partner. Of the 764 respondents, 60 reported having sex with more than five partners in the past 6 months. This is approximately 8% of those responding to the question.

Of the entire sample, 235 reported having had sex without a barrier in the past 6 months. This is 45% of those who had sex in the past 6 months and 30% of the total population.

Forty-seven (47) respondents reported that they had injected a substance (legal or illegal) in the past 6 months. Of those 47, 12 reported that they had shared injecting equipment in the past 6 months. This is 25% of those reporting the injection of a substance, and 1% of the overall sample.

One hundred twenty-two (122) respondents reported that they do not have a main sex partner, 219 reported that their main sex partner was HIV-positive, 111 reported that

their main sex partner was HIV-negative, 51 were unsure of their main sex partner's serostatus, and 18 preferred not to say. Two hundred forty-three (243) respondents did not respond to this question, which is nearly the number reporting zero sex partners in the past 6 months (239).

Barriers Reported by Providers

Providers were asked to indicate any barriers experienced in providing services to people living with HIV or AIDS. Overall, the five most frequently reported barrier among providers was "there is a lack of funding" (n=14). In addition, other commonly reported barriers were "there is a lack of transportation to our services" (n=11), shortage of community partnerships/linkages" (n=11), "the community is unaware of the availability of services" (n=7), "insufficient staff" (n=6) and "immigration issues" (n=6).

Among providers that reported experiencing "other" barriers, the following issues were specified manually on the survey: "need for shelter", "unhealthy environment for PLWHA", "burden of reporting requirements" and "lack of transgender services".

Introduction & Background

Purpose of the Needs Assessment

A needs assessment is an essential tool for planning. It is a systematic process of determining the service needs of a defined population, and 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 living with HIV and their service providers. Information is typically collected through surveys, focus groups, interviews and/or public forums.

In addition, the 2000 CARE Act Reauthorization placed additional emphasis on identifying people with HIV/AIDS who know their status and are not receiving primary medical care and engaging these individuals in care. In the 2008 Houston Area HIV/AIDS Needs Assessment report, these individuals are described as being "out-of-care". Determining needs of out-of-care PLWHA and developing and/or funding services to meet their needs is critical to fulfilling these legislative mandates.

According to HRSA, 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

The unmet need estimate equips planning bodies with data to develop 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 groups 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.

Legislative mandates dictate that such an assessment include:

- Consultation with People Living With HIV/AIDS (PLWHA);
- Consultation with HIV/AIDS service providers and others;
- Identification of populations with severe needs and comorbidities as indicated

from epidemiological data; and

- Evaluation of the effectiveness of available resources and services in meeting needs.

The purpose of the 2008 Houston Area HIV/AIDS Comprehensive Needs Assessment is to gather information on:

- Levels of access to core and supportive services;
- Experience of barriers;
- HIV testing histories;
- Entry to care;
- In-care and out-of-care status;
- Treatment regimens;
- Perceptions of health status;
- Mental health symptoms;
- Substance use and abuse;
- Housing status;
- Financial information; and
- Basic demographics of a sample of people living with HIV/AIDS (PLWHA) in the 10-county Houston HSDA.

This information is used by community-based planning bodies in order to:

- Prioritize fundable services from a consumer point-of-view, including needed services not currently offered;
- Determine funding allocations for those services based upon money available within the various partner organizations, and to inform other funding sources which pay for similar services;
- Make programmatic recommendations on how to best meet the needs of clients;
- Support efforts to plan a comprehensive system of HIV/AIDS care; and
- Provide the supporting documentation for annual Health Resources and Services Administration (HRSA) and Department of State Health Services (DSHS) grant applications.

About The Houston Eligible Metropolitan Area (EMA) and Health Services Delivery Area (HSDA)

The 2008 Houston Area HIV/AIDS Needs Assessment encompasses a 10-county planning area which includes both the Houston Eligible Metropolitan Area (EMA) and Health Services Delivery Area (HSDA).

An Eligible Metropolitan Area (EMA) is an area designated by the Health Resources and Services Administration (HRSA), a division of the United States Department of Health and Human Services, as eligible to receive Ryan White CARE Act Part A funds. An EMA must have a population of at least 500,000 persons and a total of at least 2,000 cumulative AIDS cases (as reported by the Centers for Disease Control for the most recent 5-year period). The geographic boundaries of EMAs are defined by the US Census Bureau; some EMAs include just one city, some are composed of several cities and/or counties and others 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 purpose of Part A funds is to provide emergency relief to metropolitan areas disproportionately affected by HV/AIDS. In Houston, Part A funds are awarded to the Harris County Judge's Office and administered by the Ryan White Grant Administration office of Harris County Public Health and Environmental Services. Each year, the EMA subcontracts approximately $17 million in Part A funds to local agencies providing medical and supportive services to PLWHA.

The Houston HIV Service Delivery Area (HSDA) is a 10-county area designated by the state to receive Ryan White Part B and DSHS State Services funds. The counties within the HSDA encompass the entire EMA with the addition of Austin, Colorado, Walker and Wharton counties. Part B and DSHS State Services funds are intended to improve the quality, availability and organization of health care and support services for PLWHA (with an emphasis on rural populations), and are administered by the Houston Regional HIV/AIDS Resource Group. In addition to Part B and State Services funds, the Resource Group administers other local HIV/AIDS funding streams such as Part C (funding to community-based organizations for outpatient early intervention services) and Part D (services for children, youth, women and families).

The Houston HSDA, including the entire EMA, contains more than 4.3 million people across 9,415 square miles (population density = 459.3 people/square mile), with 98% of the population residing in Harris County (population density = 1,630 people/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 HSDAs 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 EMAs 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.

FIGURE 1.1.1: HOUSTON EMA/HSDA AREA MAP

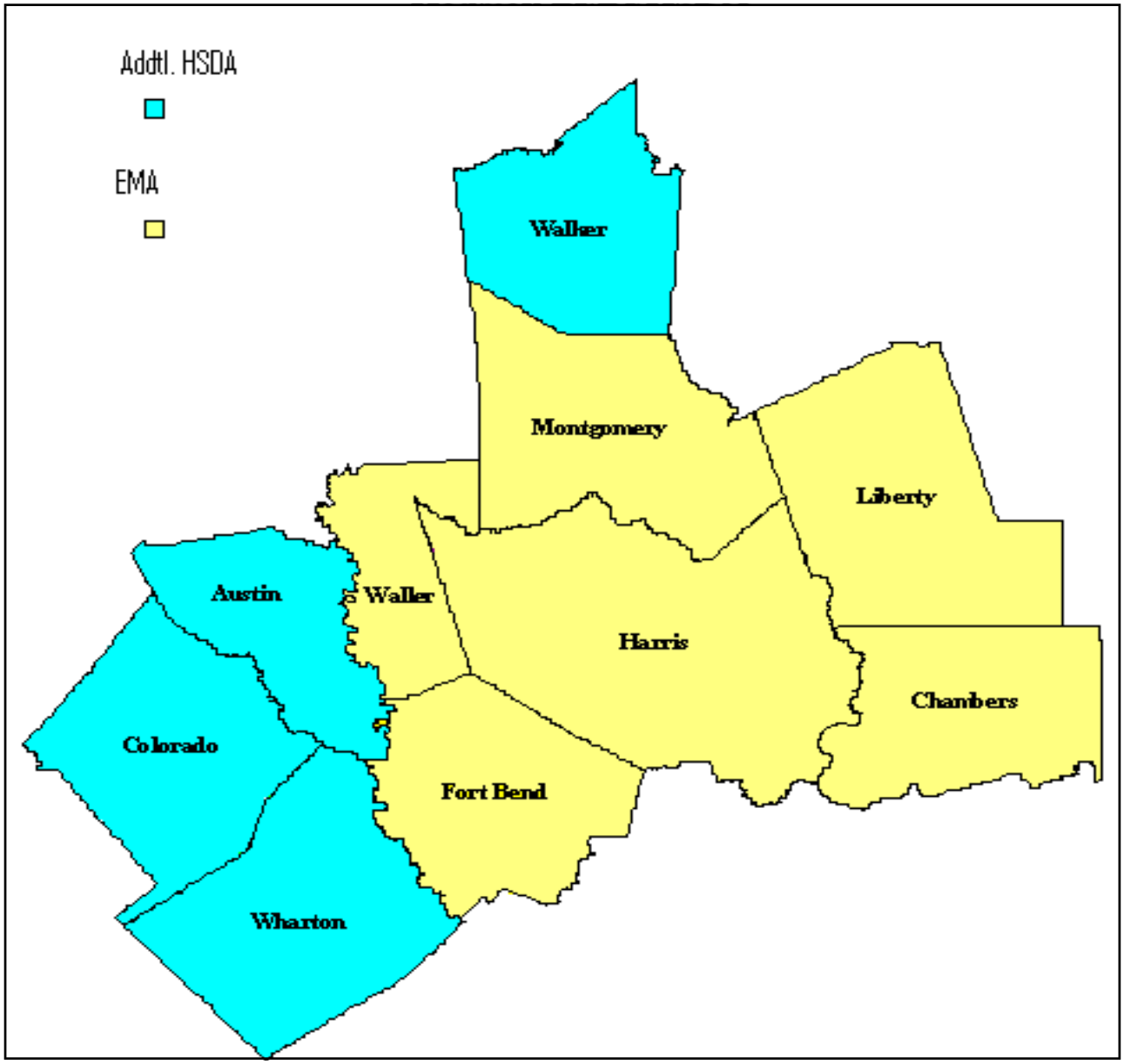


TABLE 1.1.1: HOUSTON EMA/HSDA COUNTIES AND TOTAL URBAN VS. RURAL AREAS, 2000

County	Total Population	Urban Population	Rural Population
Chambers	26,031	36%	64%
Fort Bend	354,452	90%	10%
Harris	3,400,578	98%	2%
Liberty	70,154	36%	64%
Montgomery	293,768	64%	36%
Waller	32,663	37%	63%
EMA TOTAL	**4,177,646**	**93%**	**7%**
Austin	23,590	37%	63%
Colorado	20,390	40%	60%
Walker	61,758	64%	36%
Wharton	41,188	50%	50%
HSDA TOTAL	**4,324,572**	**92%**	**8%**
TEXAS TOTAL	**20,851,820**	**83%**	**17%**

Source: U.S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004

TABLE 1.1.2: HOUSTON EMA/HSDA COUNTIES AND TOTAL POPULATION DENSITY, 2000

County	Population	Land Area in square miles	Population Density per square mile of land area
Chambers	26,031	599.31	43.4
Fort Bend	354,452	874.64	405.3
Harris	3,400,578	1,728.83	1967.0
Liberty	70,154	1,159.68	60.5
Montgomery	293,768	1,044.03	281.4
Waller County	32,663	513.63	63.6
EMA TOTAL	**4,177,646**	**5,920.12**	**470.2**
Austin	23,590	652.59	36.1
Colorado	20,390	962.95	21.2
Walker	61,758	787.45	78.4
Wharton	41,188	1,090.13	37.8
HSDA TOTAL	**4,324,572**	**9,413.24**	**299.47**
TEXAS TOTAL	**20,851,820**	**261,797.12**	**79.6**

Source: U.S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

DEMOGRAPHICS OF THE HOUSTON HSDA

According to the 2000 U.S. Census report, there are 4,324,572 persons residing in the 10-county HSDA area.

- This is 20% of the population of Texas in the EMA and 21% in the HSDA.
- Over 81% of the people living in the EMA live in Harris County and nearly 79% of those in the HSDA live in Harris County.
- The second largest county is Fort Bend (9%) followed by Montgomery County (7%).
- The smallest counties by population include Colorado, Austin, and Chambers, each with less than 30,000 residents.

Both the EMA and the HSDA populations are projected to grow approximately 18% between 2000 and 2010. This is faster growth than the 16% that is projected for Texas overall.

- The fastest growing counties include Montgomery (29%), Fort Bend (27%) and Waller (26%).
- The slowest growing counties are the four outside the EMA, Colorado (4%), Wharton (6%), Austin (8%) and Walker (10%).

TABLE 1.1.3: CURRENT AND PROJECTED POPULATION NUMBERS, HOUSTON HSDA, 2000 AND 2010

County	Population 2000		Population 2010		Percent Change 2000-2010
	#	%*	#	%*	
Chambers	26,031	0.6%	31,375	0.6%	21%
Fort Bend	354,452	8%	449,811	9%	27%
Harris	3,400,578	79%	3,951,682	78%	16%
Liberty	70,154	2%	81,930	2%	17%
Montgomery	293,768	7%	379,363	8%	29%
Waller	32,663	0.8%	41,137	0.8%	26%
EMA Total	**4,177,646**	**97%**	**4,935,298**	**97%**	**18%**
Austin	23,590	0.6%.	25,582	0.5%	8%
Colorado	20,390	0.5%	21,101	0.4%	4%
Walker	61,758	1%	67,664	1%	10%
Wharton	41,188	1%	43,560	0.9%	6%
HSDA Total	**4,324,572**	**100%**	**5,093,205**	**100%**	**18%**
Texas Total Population	**20,851,820**	**100%**	**24,178,507**	**100%**	**16%**

* Reflects percent of total HSDA population

Source: Texas comptroller's winter 2001-2002 county forecast (www.window.state.tx.us). Retrieved on March 25, 2004.

- The 45 to 64 age group is projecting the greatest growth in the EMA, HSDA and state, between 41% and 45%.
- This is followed by the 65+ group, but the EMA and HSDA are projected to grow at a faster rate than the state, 37% for the EMA, 35% for the HSDA compared to 22% for Texas.
- Youth, those 13 to 24 years, are projected to increase 15% in the EMA and 14% in the HSDA compared to 12% for the state. Refer to Table 1.1.4. Refer to Appendix A for population projections by age, gender and county.
- Relatively slow growth, 6.5%, is projected for the 25 to 44 year age group.

TABLE 1.1.4: HOUSTON EMA/HSDA AND TEXAS PROJECTED POPULATION CHANGE BY AGE , 2000 – 2010

County	Population 2000		Population 2010		Percent Change 2000-2010
	#	%	#	%	
EMA COUNTIES					
Under 2 years	137,130	3%	149,476	3%	9%
2-12 years	755,031	18%	798,633	16%	6%
13-24 years	744,824	18%	857,075	17%	15.
25-44 years	1,379,256	33%	1,468,249	30%	7%
45-64 years	850,192	20%	1,236,403	25%	45%
65 and older	311,213	7%	425,462	9%	37%
Total	**4,177,646**	**100%**	**4,935,298**	**100%**	**18%**
HSDA COUNTIES					
Under 2 years	140,638	3%	153,444	3%	9%
2-12 years	775,471	17%	819,610	16%	6%
13-24 years	777,164	18%	889,303	17%	14%
25-44 years	1,420,468	32%	1,512,477	29%	7%
45-64 years	881,084	20%	1,273,478	25%	45%
65 and older	329,747	7%	444,893	8%	35%
Total	**4,324,572**	**100%**	**5,093,205**	**100%**	**18%**
TEXAS					
Under 2 years	652,970	3%	730,538	3%	12%
2-12 years	3,608,917	17%	3,868,799	16%	7%
13-24 years	3,799,040	18%	4,256,960	17%	12%
25-44 years	6,537,409	31%	6,915,579	28%	6%
45-64 years	4,186,017	20%	5,892,533	24%	41%
65 and older	2,067,467	9%	2,514,098	10%	22%
TEXAS TOTAL POPULATION	**20,851,820**	**100%**	**24,178,507**	**100%**	**16%**

Source: Texas comptroller's winter 2001-2002 county forecast (www.window.state.tx.us). Retrieved on March 25, 2004.

Race/Ethnicity

While the EMA and the HSDA have similar racial and ethnic make ups, they differ from Texas overall.

- White, non-Latinos are the largest population group in the HSDA, comprising 46% of overall HSDA population.
- Latinos/Latinas are a somewhat smaller percentage in the EMA and HSDA than the state, 30% in the region and 32% in the state.
- Non-Latino Black/African-Americans are a larger percentage of the population in the EMA and HSDA than in the state, making up over 17% of the people in the region compared to 11% in Texas.
- Larger percentages of Asians also live in the EMA and HSDA than in the state overall. Asians are 5% of the regional population and less than 3% of those living in the state. Refer to Table 1.1.5, and Table 1.1.6.

In Harris and Fort Bend counties, minorities make up the "majority" of residents. White/Anglo are the majority in all other counties.

- By county, Harris County has the most racially and ethnically diverse population with 33% Hispanic/Latino, 18% Black/African-American and 5% Asian.
- The counties with the largest percentages of Black/African-American residents are Waller (29%), Walker (24%), and Fort Bend (20%).
- The counties with the largest percentage of Hispanic/Latino residents are Harris (33%), Wharton (31%) and Fort Bend (21%).
- Fort Bend County has the largest percentage of Asian residents with over 11%.
- In the EMA and HSDA, women make up a larger percentage of the Black/African-American population than men, and men are a larger percentage of the Hispanic/ Latino population than women.
- Of the Hispanic/Latino population, the largest percentage is of Mexican heritage. Mexicans comprise 24% of Harris County residents and 22% of Wharton County residents.
- Twenty percent of EMA and HSDA residents were born outside the U.S. This compares to 14% in the state of Texas. In both the region and the state, these foreign born residents most frequently come from North, Central and South America. Mexico is the most frequent place of foreign birth, accounting for about half of those born outside the U.S.
- Approximately 4% of the EMA and HSDA populations were born in Asia.

TABLE 1.1.5: HOUSTON EMA/HSDA COUNTIES AND TOTAL POPULATION BY RACE AND ETHNICITY, 2000

County	Total Pop	White, Non-Hispanic	Black/African-American, Non-Hispanic	Hispanic/ Latino	Asian, Non-Hispanic	Other, Non-Hispanic
	N	%	%	%	%	%
Chambers	26,031	77.6%	9.7%	10.8%	0.7%	1.2%
Fort Bend	354,355	46.2%	19.6%	21.1%	11.2%	1.9%
Harris	3,399,186	42.1%	18.2%	32.9%	5.1%	1.6%
Liberty	70,136	74.6%	12.8%	10.9%	0.3%	1.5%
Montgomery	293,688	81.4%	3.4%	12.6%	1.1%	1.4%
Waller	32,660	49.9%	29.1%	19.4%	0.4%	1.3%
EMA TOTAL	**4,176,056**	**46.1%**	**17.2%**	**29.9%**	**5.2%**	**1.6%**
Austin	23,589	71.9%	10.5%	16.1%	0.3%	1.2%
Colorado	20,387	64.6%	14.5%	19.7%	0.2%	1.0%
Walker	61,733	60.1%	23.8%	14.1%	0.8%	1.3%
Wharton	41,170	53.0%	14.7%	31.3%	0.3%	0.7%
HSDA TOTAL	**4,322,935**	**46.6%**	**17.3%**	**29.6%**	**5.0%**	**1.6%**
TEXAS TOTAL	**20,851,820**	**52.4%**	**11.3%**	**32.0%**	**2.7%**	**1.6%**

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.
Percentage calculations are based on the total population of each gender

TABLE 1.1.6: HOUSTON EMA/HSDA TOTAL POPULATION BY RACE, ETHNICITY AND GENDER, 2000

	Total Pop	White, Non-Hispanic	Black/African-American, Non-Hispanic	Hispanic/ Latino	Asian, Non-Hispanic	Other, Non-Hispanic
	N	%	%	%	%	%
EMA-female	2,098,020	46.5%	18.3%	28.5%	5.2%	1.6%
EMA-male	2,079,626	45.6%	16.2%	31.3%	5.2%	1.7%
HSDA-female	2,165,988	47.0%	18.2%	28.2%	5.0%	1.6%
HSDA-male	2,158,584	46.1%	16.3%	31.0%	5.0%	1.7%

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.
Percentage calculations are based on the total population of each gender

Linguistic Isolation

Approximately one-third of EMA and HSDA residents are "linguistically isolated," meaning they speak English less than "very well."

- More than one-third of the people living in Harris County and 30% of the people living in Fort Bend speak English less than "very well."
- The largest percentages of linguistically isolated people are Spanish speaking.
- More than one quarter of those who speak Indo-European languages (i.e., Spanish, Italian, Portuguese, Russian, German, Bengali, etc) are linguistically isolated.
- Very few of those speaking Asian and Pacific Islander languages report being linguistically isolated. Refer to Table 1.1.7.

TABLE 1.1.7: HOUSTON EMA/HSDA COUNTIES AND TOTAL LINGUISTIC ISOLATION 2000

County	Total 5+ Pop	English Only Pop	Speak other than English						
			Total Pop	Spanish		Indo-European		Speak Asian & Pacific Island	
				Total Pop	LI	Total Pop	LI	Total Pop	LI
Chambers	24,205	88.3%	2,834	2,265	43.9%	460	29.1%	87	8.0%
Fort Bend	327,666	69.3%	100,596	57,612	40.0%	16,603	24.8%	22,409	4.4%
Harris	3,121,999	63.8%	1,129,856	898,885	52.9%	87,470	28.2%	116,285	4.5%
Liberty	65,425	87.7%	8,030	7,042	44.4%	733	13.4%	129	0.0%
Montgomery	271,298	86.2%	37,552	31,077	49.4%	4,258	18.3%	1,854	6.0%
Waller	30,397	81.9%	5,513	4,994	52.9%	364	25.0%	74	13.5%
EMA TOTAL	**3,840,990**	**66.6%**	**1,284,381**	**1,001,875**	**52.0%**	**109,888**	**27.2%**	**140,838**	**4.5%**
Austin	22,056	82.9%	3,770	2,967	46.6%	795	29.1%	87	8.0%
Colorado	19,150	80.1%	3,818	3,130	49.1%	626	26.0%	24	54.2%
Walker	58,854	85.7%	8,390	7,586	44.4%	455	18.2%	285	1.1%
Wharton	38,401	73.3%	10,239	9,145	35.7%	989	19.3%	74	5.4%
HSDA TOTAL	**3,979,451**	**67.1%**	**1,310,598**	**1,024,703**	**51.8%**	**112,753**	**27.1%**	**141,308**	**4.5%**
TEXAS TOTAL	**19,241,518**	**68.8%**	**6,010,753**	**5,195,182**	**45.6%**	**358,019**	**25.8%**	**374,330**	**4.6%**

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.
Linguistic Isolation = speaks English less than "very well."
Total Pop reflects all speaking that language.
LI = Percentage of those speaking the language who are linguistically isolated/speak English less than "very well."

Socioeconomic Status

Median household income helps explain how much money people in the region earn. Since it is for "household," it is the combined amount of money earned by everyone living in a household. The "median income" means that half the people living in the region/ county earn less than that amount and half earn more. While the higher median income is better for the region, it has to be considered against the cost of living in the area and the number of people in each household. Typically, the cost of living in urban areas is higher than in rural areas.

People living in the EMA and HSDA have higher median household incomes than people throughout the entire state of Texas. Within the EMA, the median income is nearly $47,000 per year which is $5,000 higher then in the HSDA and $7,000 higher than is found in the state.

- Fort Bend County residents have the highest median household income of all the counties in the HSDA with nearly $64,000 per year.
- The area with the second highest median income is Montgomery County with over $50,000 per year.
- Counties with the lowest median household income are three of the four HSDA counties outside the EMA—Colorado, Wharton and Walker. Refer to Table 1.1.8.

TABLE 1.1.8: HOUSTON EMA/HSDA COUNTIES AND TOTAL MEDIAN HOUSEHOLD INCOME, 2000

County	Median Household Income
Chambers	$47,964
Fort Bend	$63,831
Harris	$42,598
Liberty	$38,361
Montgomery	$50,864
Waller	$38,136
EMA TOTAL	**$46,959**
Austin	$38,615
Colorado	$32,425
Walker	$31,468
Wharton	$32,208
HSDA TOTAL	**$41,647**
TEXAS TOTAL	**$39,927**

Source: U. S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

Employment Status

The most current employment data at the county level is from 2003. In 2003, unemployment in the EMA, HSDA and state was 6.8% to 6.9%. Refer to Table 1.1.13.

- The county with the highest unemployment was Liberty, with 10.4% unemployment.
- Those with the lowest were Walker (3.3%), Austin and Colorado (both with 4.8%).
- It should be noted that although employment is high in Walker and Colorado Counties, median household income is among the lowest in the region.

TABLE 1.1.9: HOUSTON EMA/HSDA COUNTIES
EMPLOYMENT STATUS OF RESIDENTS OVER 16 YEARS OF AGE, 2003

County	Population age 16+	# in Labor Force	Unemployed	
Chambers	21,033	13,010	810	6.2%
Fort Bend	282,690	208,885	12,291	5.9%
Harris	2,654,562	1,891,103	132,911	7.0%
Liberty	56,120	31,972	3,341	10.4%
Montgomery	238,131	160,205	8,577	5.4%
Waller	27,222	15,177	1,033	6.8%
EMA TOTAL	**3,279,758**	**2,320,352**	**158,963**	**6.9%**
Austin	18,726	14,341	692	4.8%
Colorado	16,186	8,446	409	4.8%
Walker	53,685	23,973	803	3.3%
Wharton	31,688	19,695	1,353	6.9%
HSDA TOTAL	**3,400,043**	**2,386,807**	**162,220**	**6.8%**
TEXAS TOTAL	**16,454,277**	**10,910,344**	**737,516**	**6.8%**

Source: Texas Workforce Commission's Labor Market Information Department (www.tracer2.com). Retrieved on March 25, 2004.

Unemployed % is based on the number of in labor force.

Educational Attainment

Educational attainment reflects each person in an area's highest grade in school. The EMA, HSDA and state are similar with 11% going through eighth grade or less, 13% going to high school, but not graduating, approximately half graduating from high school and possibly attending some college, and roughly one quarter receiving a bachelor's degree in college or higher. Refer to Table 1.1.9 and Table 1.1.10.

- Counties with the highest percentage getting their high school diploma or more include: Fort Bend (84.3%), Montgomery (81.6%), Chambers (77.0%), Harris (74.6%), and Waller (73.9%).
- Counties with the highest percentage of residents who did not go beyond eighth grade include: Colorado, Wharton, Austin and Harris.

TABLE 1.1.10: HOUSTON EMA/HSDA COUNTIES EDUCATIONAL ATTAINMENT, 2000

County	Total Pop >25	Less than 9th grade	9th-12th grade, no diploma	High School Graduate, Some College, Associate	Bachelor or higher
Chambers	16,348	8.5%	14.5%	64.9%	12.1%
Fort Bend	214,461	7.2%	8.5%	47.4%	36.9%
Harris	2,067,399	12.1%	13.3%	47.7%	26.9%
Liberty	44,206	10.5%	19.9%	61.5%	8.1%
Montgomery	183,743	6.3%	12.1%	56.3%	25.3%
Waller	18,395	11.1%	15.1%	57.1%	16.8%
EMA TOTAL	**2,544,552**	**11.2%**	**12.9%**	**48.7%**	**27.2%**
Austin	15,280	12.2%	13.2%	57.2%	17.3%
Colorado	13,383	15.6%	15.3%	54.6%	14.4%
Walker	36,678	10.4%	16.6%	54.7%	18.3%
Wharton	25,567	15.5%	14.7%	55.4%	14.3%
HSDA TOTAL	**2,635,460**	**11.3%**	**13.0%**	**48.9%**	**26.8%**
TEXAS TOTAL	**12,790,893**	**11.5%**	**12.9%**	**52.4%**	**23.2%**

Source: U.S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.
Note[1] is based on 25+ total population.

Poverty Status

Both the EMA and the HSDA have lower rates of poverty than in Texas overall, with 13.9% and 14%, respectively, living in poverty compared to 15.4% for the state. Both the local and statewide percentages are larger than the 12.4% nationally who are living in poverty.

- Counties with the highest levels of poverty include Walker, Colorado and Wharton which are three of the four counties that are only part of the HSDA, and Waller and Harris in the EMA.
- Blacks/African-Americans in the EMA and HSDA make up a higher percentage of those living in poverty than is found throughout the state. Whites and Latinos in the EMA and HSDA represent smaller percentages of those living in poverty when compared with the state overall. (Table 1.1.11)
- Children and others under 25 years of age are a large percentage of those living in poverty throughout the EMA, HSDA and state.
- Families with single females as head of household comprise a large percentage of families in poverty.

TABLE 1.1.11: HOUSTON EMA/HSDA COUNTIES POVERTY LEVEL BY RACE, 2000

County	Total	Population below poverty level		White	Black/ African American	Other*	Latino*
	N	N	%	%**	%**	%**	%**
Chambers	25,719	2,833	11.0%	6.5%	2.5%	2.1%	2.6%
Fort Bend	349,010	24,953	7.1%	2.9%	1.7%	2.6%	3.3%
Harris	3,360,536	503,234	15.0%	6.0%	4.2%	4.8%	7.5%
Liberty	64,878	9,296	14.3%	9.5%	3.0%	1.8%	2.8%
Montgomery	291,519	27,376	9.4%	7.0%	0.9%	1.5%	2.4%
Waller	29,487	4,718	16.0%	6.0%	6.5%	3.5%	5.4%
EMA TOTAL	**4,121,149**	**572,410**	**13.9%**	**5.9%**	**3.7%**	**4.3%**	**6.7%**
Austin	23,345	2,814	12.1%	6.5%	2.6%	3.0%	4.7%
Colorado	19,543	3,171	16.2%	8.0%	4.9%	3.3%	5.0%
Walker	44,904	8,253	18.4%	10.6%	6.1%	1.6%	2.6%
Wharton	40,519	6,703	16.5%	8.1%	4.4%	4.0%	7.9%
HSDA TOTAL	**4,249,460**	593,351	**14.0%**	**6.0%**	**3.8%**	**4.2%**	**6.6%**
TEXAS TOTAL	**20,287,300**	**3,117,609**	**15.4%**	**8.9%**	**2.6%**	**3.9%**	**8.2%**

* Latino and Other races are not mutually exclusive.
** All the percentages are based on total population of whom population status is determined.
Source: U.S. Census Bureau, 2000 (www.census.gov). Retrieved on March 25, 2004.

Health and Insurance Status

The most current data on insurance status at the county level are from 1999. As a state, Texas ranked first in the U.S. in 1998 according to percent of population uninsured (24.5%) and second in size of the uninsured population (4,880,000). In the HSDA, county populations ranged between one fifth and one-quarter uninsured.

- Overall, Austin County had the lowest percentage of uninsured, 19.9%, and Harris County had the highest, 25.5%.
- Chambers County had the lowest percentage of uninsured children (20.8%) and Harris County had the highest (25.5%).
- Montgomery County had the lowest percentage of uninsured adults (22.6%) and Waller County had the highest (30.1%).
- A demographic breakdown of those living without insurance was not available by county. Statewide, the majority was male (53.6%) and Latino (48.3%).

TABLE 1.1.12: HOUSTON EMA/HSDA COUNTIES
ESTIMATED PERCENTAGE OF RESIDENTS WITHOUT INSURANCE, 1999

County	All People	0 - 18 Years Old	19 – 64 Years Old
	%	%	%
EMA			
Chambers	20.3	20.8	23.7
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
Waller	25.4	25.1	30.1
HSDA			
Austin	19.9	22.7	24.4
Colorado	20.8	24.0	26.7
Walker	25.4	22.9	29.5
Wharton	23.1	25.0	27.5
Texas	24.5		

Source: "Houston-Area 2002 Epidemiological Profile," page 10. Texas Health and Human Services Commission

HIV/AIDS IN THE HOUSTON EMA AND HSDA

The HIV/AIDS epidemic has affected people of all gender, age and racial/ethnic groups in the Houston EMA and HSDA. This effect, however, has not been the same for all groups. In the beginning of the epidemic, HIV disease was most often found among White men who have sex with men (MSM) – today, African-Americans by far represent the majority of cases and recent trends also identify an increase among Hispanic/Latino men.

This section provides detailed information about demographic and risk characteristics of HIV-infected people. It describes cases reported through December 31, 2005. Mortality (deaths) reporting lags, so 2004 is considered the most recent complete year of data and is used in this report.

This report uses Texas Department of State Health Services (DSHS) HIV/AIDS surveillance data through December 31, 2005, with data extracted as of July 18, 2006. Although this is the most current data available for the purposes of this report, the incidence (newly diagnosed cases) and prevalence (people living with HIV/AIDS) may be incomplete due to delays in data reporting and processing. It is felt, however, that the data presented here provides an accurate picture of the epidemic and its current trends.

In addition to reporting delays, HIV data is incomplete since reporting was not begun until 1999. People who were diagnosed with HIV before 1999 who have not had another HIV diagnostic test or who have not converted to AIDS are not included in this data.

Cases of HIV diagnosed in 2005 (incidence) and people living with HIV, not AIDS (prevalence) can generally be thought of as people that became infected more recently than new AIDS diagnoses and people living with AIDS. This analysis will compare people diagnosed with HIV to those diagnosed with AIDS and people living with HIV to those living with AIDS to identify trends in the epidemic in the EMA and HSDA.

Summary

- In 2005, 792 persons in the Houston HSDA were diagnosed with HIV that had not progressed to AIDS, and 852 PLWH received an AIDS diagnosis.
- Unreported/unidentified risk among those with HIV accounts for approximately 34% of new HIV diagnoses and 22% of AIDS diagnoses.
- Approximately half of those with new diagnoses of both HIV and AIDS are non-Latino Black/African-American at 53%, 20% are non-Latino White, and 26% are Latino.
  - Latino men are infected with HIV at a rate of more than 4 times that of Latina women, and their AIDS infection rate is 3 times higher.
- Blacks/African-Americans have the highest rate of new HIV and new AIDS infections. It is four times higher than the rate of infection for Hispanics/Latinos and almost seven times higher than that of Whites.

  - Black/African-American women make up the largest percentage of newly diagnosed women of childbearing age. The proportions are significantly higher than those of Whites and Latinos.
  - Black/African-American youth are disproportionately affected by HIV and AIDS.
- Although prevalence numbers are similar between MSM of color and White MSM, the number of new diagnoses among MSM of color is higher than white/Anglo MSM. Over time, this will result in a larger number of MSM of color with HIV disease than white/Anglo MSM in the Houston area.
- Although numbers of newly diagnosed IDU are small, White IDU should be monitored as a potential emerging population.
- White IDU make up 22% of new HIV diagnoses compared to 16% of AIDS diagnoses.

HIV and AIDS 2005 Incidence (New Diagnoses)

Incidence is a term commonly used in epidemiology in referring to newly diagnosed cases. Incidence may be designated over a period of time that the new cases were diagnosed. For this report, incidence reflects cases diagnosed throughout 2005. As mentioned above, it is believed that the data presented in this report is reflective of trends in the epidemic, but totals may be incomplete due to reporting delays.

In 2005, the EMA had 45 fewer diagnosed cases of HIV and the same number of diagnosed cases of AIDS as compared to the HSDA.

- In 2005, 792 persons in the Houston HSDA were diagnosed with HIV that had not progressed to AIDS, and 852 PLWH received an AIDS diagnosis. In the EMA, these numbers were 747 for HIV and 852 for AIDS. The latter include both people who have not been diagnosed with HIV disease before (new diagnoses) and people who had previously been diagnosed as HIV positive and their disease progressed from HIV to AIDS. Since the numbers are similar, the 2005 HIV infection rate is approximately 16 per 100,000 for both the HSDA and EMA.
- The race/ethnicity profiles of those newly diagnosed with HIV and AIDS are almost identical in both the EMA and HSDA.
  - Approximately 51% of new HIV diagnoses were among Black/African-American, non-Latinos compared to 54% of AIDS diagnoses.
  - Twenty one percent of HIV diagnoses were among White, non-Latinos, compared to 18% for AIDS diagnoses.
  - The percentage of HIV and AIDS diagnoses were 25% and 27%, respectively, for Latino.

- Blacks/African-Americans had the highest rate of new HIV and new AIDS infections (106/100,000). This is four times greater than that of Latinos (27/100,000) and almost seven times that of Whites (15/100,000).
  - Data shows that for both HIV and AIDS cases, new diagnoses among Latinos appear to have been on a steady increase overall in recent years.
- Generalizing about transmission mode is difficult since unreported risk is very high among newly diagnosed. Unreported risk among those with HIV accounts for approximately 34% of new diagnoses and 22% of those with AIDS diagnoses.
- Forty one percent of new HIV infections were attributed to MSM, and 18% were attributed to heterosexual contact. These two transmission modes accounted for the highest proportion of newly diagnosed HIV infections during 2005 compared to intravenous drugs users (4%) and MSM/IDU (3%).
- Harris County remains clearly the epicenter of the epidemic with 98% of 2005 newly diagnosed HIV and AIDS cases, up from the proportion of 95% in 2004. It was home to the highest proportion of new HIV and AIDS infections during 2004.
- HIV diagnoses demonstrated a relatively stable trend between 2000 and 2002. In 2003, this trend appeared to change as a decline in HIV diagnoses was seen. For AIDS diagnoses, the trends for both the HSDA and EMA appears to have been higher from 2002 through 2004.

Between 2000 and 2002, HIV diagnoses in the both the HSDA and EMA increased slightly, about 1%, but between 2002 and 2005, these diagnoses declined 25%.

- Recent media reports have speculated about the Centers for Disease Control & Prevention (CDC) pending estimates of new HIV infections in the United States. According to a December 2, 2007 press release posted on the CDC website, Dr. Kevin Fenton (Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention) emphasizes that the new estimates are not yet final. The estimates have been submitted for further analysis and rigorous scientific review to ensure the accuracy of the complex new methods and of the estimates themselves. The CDC anticipates releasing the new estimates in early 2008.

TABLE 1.2.1: HSDA HIV, AIDS AND TOTAL DIAGNOSES, 2005

HSDA	New HIV			New AIDS			New HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	**792**	**100.0**	**16.4**	**852**	**100.0**	**17.7**	**1,644**	**100.0**	**34.1**
Gender									
Male	570	72.0	23.6	592	69.5	24.5	1,162	70.7	48.1
Female	222	28.0	9.2	260	30.5	10.8	482	29.3	20.0
Race/Ethnicity									
White/Anglo	169	21.3	8.1	151	17.7	7.3	320	19.5	15.4
Black/African-American	403	50.9	49.4	460	54.0	56.4	863	52.5	105.8
Hispanic/Latino	198	25.0	12.3	230	27.0	14.3	428	26.0	26.7
Other	22	2.8	6.7	11	1.3	3.3	33	2.0	10.0
Age (yrs)									
0 - 12	4	0.5	*	0	0.0	*	4	0.2	*
13 - 24	147	18.6	*	49	5.8	*	196	11.9	*
25 - 44	493	62.2	33.4	544	63.8	36.8	1,037	63.1	70.2
45 - 64	136	17.2	12.1	238	27.9	21.2	374	22.7	33.4
65+	12	1.5	3.2	21	2.5	5.5	33	2.0	8.7
Transmission Mode									
MSM	326	41.2	*	278	32.6	*	604	36.7	*
IDU	30	3.8	*	94	11.0	*	124	7.5	*
MSM/IDU	21	2.7	*	37	4.3	*	58	3.5	*
Heterosexual	144	18.2	*	256	30.0	*	400	24.3	*
Not Classified	267	33.7	*	186	21.8	*	453	27.6	*
Urban/Rural									
Harris County	768	97.0	20.8	836	98.1	22.6	1,604	97.6	43.4
Rural Counties	24	3.0	2.1	16	1.9	1.4	40	2.4	3.5

* Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

HIV and AIDS Prevalence (People Living with HIV and AIDS)

While incidence, described above, looks at newly diagnosed cases of HIV and AIDS, prevalence identifies the total number of people living with the disease. The data presented here includes all reported cases of living people diagnosed with HIV and diagnosed with AIDS. Texas' system of HIV reporting began in 1999. Since that time, records of HIV prevalence have improved every year, but it cannot be assumed that the 2005 numbers for people living with HIV reflect everyone in the region who is HIV positive

and knows their status. People who were diagnosed with HIV disease before 1999, who have not progressed to AIDS or who have not had an HIV test after 1999 will not be included. The following statistics should be considered with that in mind.

- The difference in the number of people living with HIV or AIDS does not vary significantly between the EMA and HSDA. In 2005, a total of 18,109 people were living with either HIV or AIDS in the HSDA. This compares to 17,999 in the EMA. For those living with HIV or AIDS, the EMA includes 99% of people with HIV or AIDS in the HSDA. All trends reported are the same in the EMA and the HSDA.
  - A total of 7,583 people are living with an HIV diagnosis in the HSDA and 7,534 in the EMA.
  - Similarly, 10,526 are living with AIDS in the HSDA, and 10,465 in the EMA.
- Comparing people living with HIV to people living with AIDS reveals an increase in HIV disease among women in both the EMA and HSDA.
  - In both the EMA and HSDA, women were 32% of people living with HIV in 2005, but were only 22% of people living with AIDS, an indication of increasing new infections among women.
  - The prevalence rate for HIV among males was twice that of females. Males' AIDS prevalence rate, however, was almost four times that of females.
- Blacks/African-Americans in both the EMA and HSDA are disproportionately affected by HIV and AIDS with the prevalence rates significantly higher among Blacks/African-Americans than other racial or ethnic groups.
  - Comparing HIV and AIDS rates, Blacks/African-Americans have an overall rate that is four times higher than Whites, while the HIV (not AIDS) rate is almost five times higher than Whites.
  - The overall rate is five times higher among Blacks/African-Americans than Latinos, and the HIV (not AIDS) rate is six times higher for Blacks/African-Americans than Latinos.
- Comparing HIV and AIDS percentages for transmission mode identifies changes in the epidemic. It should be noted that the number of people with unreported risk must be considered when evaluating this information.
  - In the Houston HSDA, the most frequent mode of HIV transmission is male-to-male sex, with 37% of people living with HIV reporting this as their mode of infection and 45% of those with AIDS identifying it.
  - Heterosexual transmission may be increasing, with one-quarter of those living with HIV reporting it compared to 23% of those with AIDS.

- Harris County is home to nearly 95% of people living with both HIV and AIDS.

- Fort Bend County has 399 residents with HIV or AIDS, and Montgomery has 285. Aside from Liberty County, with 75 cases, most other counties have less than 15 people living with HIV or AIDS.
  - Prevalence data between 2000 and 2005 show an increasing trend in the number of living HIV and AIDS cases in the HSDA Figure 1.2.2.
  - Since 2000, reported HIV cases increased 37% in both the EMA and HSDA.
  - Between 2000 and 2005, people living with AIDS increased 38% in both the EMA and the HSDA.

FIGURE 1.2.1: PERSONS LIVING WITH HIV INFECTION AND PERSONS LIVING WITH AIDS 2000 - 2005

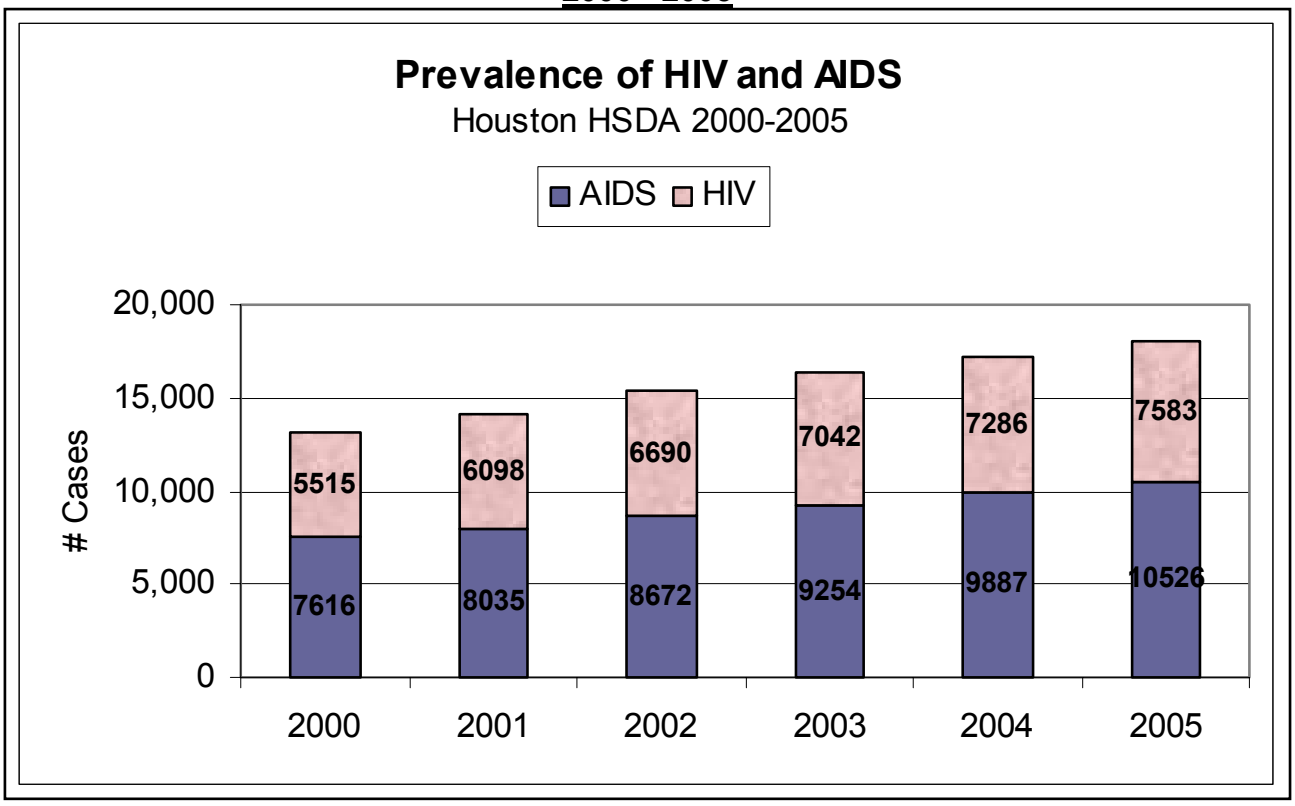


TABLE 1.2.2: HSDA PREVALENCE OF HIV, AIDS AND TOTAL, 2005

HSDA	Living with HIV			Living with AIDS			Living with HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	**7,583**	**100.0**	**157.2**	**10,526**	**100.0**	**218.2**	**18,109**	**100.0**	**375.4**
Gender									
Male	5,163	68.1	213.7	8,189	77.8	339.0	13,352	73.7	552.7
Female	2,420	31.9	100.5	2,337	22.2	97.0	4,757	26.3	197.5
Race/Ethnicity									
White/Anglo	2,118	27.9	102.1	3,502	33.3	168.8	5,620	31.0	270.9
Black/African-American	4,026	53.1	493.5	4,744	45.1	581.5	8,770	48.4	1,075.1
Hispanic/Latino	1,338	17.6	83.4	2,187	20.8	136.3	3,525	19.5	219.7
Other	101	1.3	30.7	93	0.9	28.3	194	1.1	59.0
Age (yrs)									
0 - 1	5	0.1	*	0	0	*	5	0.0	*
2 - 12	115	1.5	*	32	0.3	*	147	0.8	*
13 - 24	612	8.1	*	200	1.9	*	812	4.5	*
25 - 44	4,712	62.1	318.8	5,459	51.9	369.4	10,171	56.2	688.2
45 - 64	2,041	26.9	182.1	4,544	43.2	405.4	6,585	36.4	587.5
65+	98	1.3	25.9	291	2.8	76.8	389	2.1	102.7
Transmission Mode									
MSM	2,808	37.0	*	4,737	45.0	*	7,545	41.7	*
IDU	725	9.6	*	1,361	12.9	*	2,086	11.5	*
MSM/IDU	317	4.2	*	734	7.0	*	1,051	5.8	*
Heterosexual	1,865	24.6	*	2,378	22.6	*	4,243	23.4	*
Not Classified	1,681	22.2	*	1,211	11.5	*	2,892	16.0	*
Mother at Risk	157	2.1	*	70	0.7	*	227	1.3	*
Urban/Rural Counties									
Fort Bend	162	2.1	34.9	237	2.3	51.1	399	2.2	86.1
Harris	7,194	94.9	194.8	9,994	94.9	270.6	17,188	94.9	465.4
Liberty	35	0.5	46.6	40	0.4	53.2	75	0.4	99.8
Montgomery	127	1.7	33.6	158	1.5	41.8	285	1.6	75.4
Other Counties	65	0.9	*	97	0.9	*	162	0.9	*

* Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

Mortality

Since reporting of deaths (mortality) of people living with HIV and AIDS is often delayed due to the confirmation and checking that is required, 2004 mortality data is the most recent year that is considered complete and will be presented in this report. It should be noted that deaths may be due to HIV disease as well as other causes.

- In 2004, there were a total of 344 deaths among people with HIV/AIDS in the HSDA.
  - In the HSDA, 26 deaths were among those with HIV, and 318 were among those with AIDS.
  - Overall, the rates of death among persons with HIV or AIDS were higher among Blacks/African-Americans compared to all other racial/ethnic groups. Not all data is available due to data cell size limitations.
- The overall mortality rate among Blacks/African-Americans (25/100,000) was over six times that of Whites (4/100,000).
  - Black/African-American males with HIV or AIDS died at a rate over four times that of White males, and almost five times that of Latino males.
  - Black/African-American females had a staggering mortality rate of 23 times that of White females and 13 times that of Latina females. (Table 1.2.3) Trends from 2003 clearly show that there has been a tremendous increase in the mortality rates of Black/African-American females (rates were 11 times that of Whites and 7 times that of Latinos back in 2003).
- Overall death rates among people with HIV or AIDS were higher among men than women.
  - Among the HIV-related deaths, 20 (77%) were male, and 6 (23%) were female.
  - For deaths from AIDS, 228 (72%) were male and 90 (28%) were female.
  - The rates of death among males was over two times that of females for HIV and AIDS.
- In the Houston HSDA, the highest combined HIV and AIDS mortality was among MSM. Deaths from AIDS was highest among MSM cases (37%) followed by cases related to heterosexual contact (29%), IDU (15%) and MSM/IDU (8%). (Table 1.2.3)
- There was a decrease in the number of HIV deaths between 2000 and 2001; however, from 2002 to 2003, the number of deaths showed an increase. Mortality data for 2004 showed a slight decrease in the number of deaths. Future releases of these data should be monitored for any continuing trends in HIV/AIDS mortality.

TABLE 1.2.3: HSDA DEATHS AMONG HIV AND AIDS CASES BY GENDER, RACE/ETHNICITY, AGE AND TRANSMISSION MODE, 2004

HSDA	HIV Deaths			AIDS Deaths			HIV/AIDS Deaths		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	**26**	**100.0**	**0.5**	**318**	**100.0**	**6.7**	**344**	**100.0**	**7.3**
Gender									
Male	20	76.9	0.8	228	71.7	9.6	248	72.1	10.5
Female	6	23.1	0.3	90	28.3	3.8	96	27.9	4.1
Race/Ethnicity									
White/Anglo	6	23.1	0.3	74	23.3	3.6	80	23.3	3.9
Black/African-American	17	65.4	2.1	182	57.2	22.7	199	57.8	24.8
Hispanic/Latino	<3	*	*	61	19.2	3.9	*	*	*
Other	<3	*	*	<3	*	*	*	*	*
Age (yrs)									
0 - 24	<3	*	*	7	2.2	0.4	*	*	*
25 - 44	11	42.3	0.8	162	50.9	11.1	173	50.3	11.8
45 - 64	10	38.5	0.9	132	41.5	12.3	142	41.3	13.3
65+	4	15.4	1.1	17	5.3	4.7	21	6.1	5.8
Transmission Mode									
MSM	5	19.2	*	118	37.1	*	123	35.8	*
IDU	6	23.1	*	47	14.8	*	53	15.4	*
MSM/IDU	3	11.5	*	24	7.5	*	27	7.8	*
Heterosexual	<3	*	*	93	29.2	*	*	*	*
Not Classified	9	34.6	*	33	10.4	*	42	12.2	*
Mother at Risk	<3	*	*	<3	*	*	*	*	*
Urban/Rural									
Harris County	24	92.3	0.7	303	95.3	8.3	327	95.1	9.0
Rural Counties	<3	*	*	15	4.7	1.4	*	*	*

* Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

TABLE 1.2.4: HSDA DEATHS OF PERSONS WITH HIV/AIDS, 2000 - 2004

Year	HIV	AIDS	HIV/AIDS
2000	19	423	442
2001	15	421	436
2002	20	307	327
2003	29	321	350
2004	26	318	344

Source: Texas Department of State Health Services

SPECIAL POPULATIONS

HRSA has identified special populations that are disproportionately impacted by the HIV epidemic. Both nationally and in the Houston region, these populations demonstrate increased risk, incidence and/or prevalence. These include men of color who have sex with men, White/Anglo men who have sex with men, injecting drug users, women of childbearing age, youth, Blacks/African-Americans and Latinos/Latinas. This section outlines these populations, examining both incidence and prevalence in the HSDA and EMA.

In this section, incidence (new diagnoses) is only reported for the HSDA. This is because differences between EMA and HSDA populations are typically very minimal. Prevalence (those living with HIV/AIDS) is presented for both the EMA and the HSDA.

Men Who Have Sex with Men (MSM)

This population is defined by race and mode of transmission. HRSA has designated men of color who have sex with men (MSM of color) to include all men who are not White/ Anglo. The mode of transmission is either male sex with men (MSM) or MSM combined with injecting drug use (IDU). Totals may be underrepresented to the extent that MSM are included among those who have not reported their risk.

Over 4,514 MSM of color living with HIV/AIDS reside in the HSDA, and the EMA has only 13 fewer. A slightly smaller number of White/Anglo MSM cases live in the HSDA, 4,082. This compares to 4,068 in the EMA. Percentages among the HSDA and EMA are nearly identical.

- Although prevalence numbers are relatively similar between MSM of color and White MSM, the number of new diagnoses among MSM of color is much higher than White/Anglo MSM. Over time, this will result in a larger number of MSM of color with HIV disease than White/Anglo MSM in the Houston area.
  - A total of 237 MSM of color were diagnosed with HIV in 2005, and 110 White/ Anglo MSM were diagnosed.
  - In addition, 206 MSM of color were diagnosed with AIDS in 2005 and 109 White/ Anglos MSM received this diagnosis.

Comparing MSM of color living with HIV and those living with AIDS, the percentages of Blacks/African-Americans is similar for both HIV and AIDS. Fifty eight percent of MSM of color with HIV are Black/African-American, while 57% of those with AIDS are Black/African-American.

The 25 to 44 age group is the largest, but HIV diagnoses among those 13 to 24 years old reveal a possible increase in infections in this younger age group.

- Comparing new HIV infections with new AIDS infections among MSM of color by age, the largest group of which both HIV and AIDS diagnoses were 25 to 44 years with 67% of HIV diagnoses and 69% of AIDS diagnoses. This age group showed a decrease when compared to the proportion of 77% from the previous year.
- Nearly a quarter of new HIV infections were among MSM of color age 13 to 24 years, while 11% of new AIDS infections were diagnosed in MSM of color in this age group.

The number and proportion of MSM youth of color (13-24 yrs old) with HIV/AIDS is more than 8 times that of White MSM youth of similar age.

- In 2005, there were 21 (2%) White MSM youth living with HIV and 5 (<1%) living with AIDS.
- During that same year, there were 163 (10%) MSM youth of color living with HIV and 61(2%) living with AIDS.

Among MSM of color and White/Anglo MSM, almost all new HIV infections (95% and 91%, respectively) and diagnosed AIDS cases (87% and 90%) were attributed to MSM-related behaviors.

- Approximately 96%-97% of MSM of color and white/Anglo MSM with HIV or AIDS live in Harris County.
- Ninety-nine percent of MSM of color diagnosed with either HIV or AIDS in 2005 live in Harris County, while for White/Anglo MSM, 98% live in Harris County.

TABLE 1.2.5: HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG MSM OF COLOR, 2005

HSDA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	**1,719**	**100.0**	**2,795**	**100.0**	**4,514**	**100.0**
Race/Ethnicity						
Black/African-American	999	58.1	1,590	56.9	2,589	57.4
Hispanic/Latino	681	39.6	1,165	41.7	1,846	40.9
Other	39	2.3	40	1.4	79	1.8
Age (yrs)						
13 - 24	163	9.5	61	2.2	224	5.0
25 - 44	1,193	69.4	1,684	60.3	2,877	63.7
45 - 64	357	20.8	1,016	36.4	1,373	30.4
65+	6	0.3	34	1.2	40	0.9
Transmission Mode						
MSM	1,525	88.7	2,387	85.4	3,912	86.7
MSM/IDU	194	11.3	408	14.6	602	13.3
County						
Austin	<3	*	0	0.0	*	*
Chambers	<3	*	0	0.0	*	*
Colorado	<3	*	<3	*	*	*
Fort Bend	30	1.7	66	2.4	96	2.1
Harris	1,674	97.4	2,701	96.6	4,375	96.9
Liberty	<3	*	3	0.1	*	*
Montgomery	6	0.3	13	0.5	19	0.4
Walker	<3	*	<3	*	*	*
Waller	<3	*	6	0.2	*	*
Wharton	<3	*	5	0.2	*	*

* Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

TABLE 1.2.6: HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG WHITE MSM, 2005

HSDA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	**1,406**	**100.0**	**2,676**	**100.0**	**4,082**	**100.0**
Age (yrs)						
13 - 24	21	1.5	5	0.2	26	0.6
25 - 44	856	60.9	1,075	40.2	1,931	47.3
45 - 64	507	36.1	1,509	56.4	2,016	49.4
65+	22	1.6	87	3.3	109	2.7
Transmission Mode						
MSM	1,283	91.3	2,350	87.8	3,633	89.0
MSM/IDU	123	8.7	326	12.2	449	11.0
County						
Austin	<3	*	4	0.1	*	*
Chambers	<3	*	<3	*	*	*
Colorado	<3	*	<3	*	*	*
Fort Bend	7	0.5	48	1.8	55	1.3
Harris	1,361	96.8	2,543	95.0	3,904	95.6
Liberty	5	0.4	11	0.4	16	0.4
Montgomery	29	2.1	55	2.1	84	2.1
Walker	3	0.2	4	0.1	7	0.2
Waller	<3	*	7	0.3	*	*
Wharton	<3	*	3	0.1	*	*

* Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

Injecting Drug Users

Injecting drug users (IDU) include those whose specified transmission modes are either IDU or MSM/IDU. The HSDA has 3,008 people living with either HIV or AIDS who contracted the disease via injecting drug use, while the EMA has 2,994 cases. Transmission via injecting drug use may be declining.

Fifty-five IDU in the HSDA were diagnosed with HIV and 131 were diagnosed with AIDS in 2005.

The number living with HIV who were infected via injecting drugs (1,016) is almost half of those living with AIDS (1,992).

- For both HIV, approximately two-thirds are among men and one-third are among women. For AIDS diagnoses, however, 73% are among men and 27% among women.
- Although numbers of newly diagnosed IDU are small, Latino and White IDU should be monitored as a potential emerging population. White IDU make up 21% of new HIV diagnoses compared to 16% of AIDS diagnoses. Latinos also exhibit decreasing HIV diagnoses relative to AIDS, composing 12% of the HIV diagnoses (compared to 24% from the previous year) and 18% of AIDS. Black/African-American IDU are approximately two-thirds of both new HIV diagnoses (67%) and those diagnosed with AIDS (65%).
- Among those living with HIV and AIDS, 28% are White, 60% are Black/African-American and 12% are Latino.
- Approximately half of IDU living with HIV or AIDS are in the 25 to 44 age group. Forty six percent are older than this and 2% are younger.
- Approximately two-thirds of those living with HIV or AIDS were infected via injecting drug use alone, and one-third was infected by a combination of injecting drug use and MSM.
- Harris County is home to almost all newly diagnosed IDU.

TABLE 1.2.7: HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG INJECTING DRUG USERS, 2005

HSDA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	**1,016**	**100.0**	**1,992**	**100.0**	**3,008**	**100.0**
Gender						
Male	664	65.4	1,457	73.1	2,121	70.5
Female	352	34.6	535	26.9	887	29.5
Race/Ethnicity						
White/Anglo	287	28.2	585	29.4	872	29.0
Black/African-American	625	61.5	1,155	58.0	1,780	59.2
Hispanic/Latino	101	9.9	245	12.3	346	11.5
Other	3	0.3	7	0.4	10	0.3
Age (yrs)						
13 - 24	39	3.8	15	0.8	54	1.8
25 - 44	593	58.4	982	49.3	1,575	52.4
45 - 64	381	37.5	960	48.2	1,341	44.6
65+	3	0.3	35	1.8	38	1.3
Transmission Mode						
IDU	716	70.5	1,306	65.6	2,022	67.2
MSM/IDU	300	29.5	686	34.4	986	32.8
County						
Austin	0	0.0	2	0.1	2	0.1
Chambers	0	0.0	0	0.0	0	0.0
Colorado	0	0.0	1	0.1	1	0.0
Fort Bend	17	1.7	31	1.6	48	1.6
Harris	978	96.3	1,909	95.8	2,887	96.0
Liberty	4	0.4	8	0.4	12	0.4
Montgomery	16	1.6	25	1.3	41	1.4
Walker	1	0.1	6	0.3	7	0.2
Waller	0	0.0	6	0.3	6	0.2
Wharton	0	0.0	4	0.2	4	0.1

* Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

Women of Child Bearing Age

HRSA has defined women of childbearing age as those between the ages of 13 and 44. In this population, new HIV and AIDS infections totaled 360 in 2005 in the HSDA. The number of women of childbearing age living with HIV or AIDS in the EMA is 3,124, while the number in the HSDA is 3,319.

- Black/African-American women comprise the largest percentage of newly diagnosed women of childbearing age and of women living with HIV or AIDS.

Seventy one percent of both new HIV and AIDS diagnoses were among Black/ African-American women of childbearing age.

- Most of these women were infected through heterosexual contact. In addition, according to the Centers for Disease Control & Prevention (CDC) and other experts, for those without reported risk (i.e., their risks do not fit in one of the defined risk categories), the transmission mode is most often heterosexual sex. These women may not know how they were infected if they were not aware of the HIV status of their partner(s).

Approximately 38% of women newly diagnosed with HIV or AIDS do not have reported risk. Ten percent report injecting drug use and 53% report heterosexual risk. For those newly diagnosed with HIV, 5% report injecting drug use, 45% report heterosexual risk and almost 51% do not have any reported risk. The 51% unreported risk may be due to none of the women's' risk categories fitting into those standardized by the Centers for Disease Control & Prevention (CDC).

Sixteen percent of women living with either HIV or AIDS in the EMA report injecting drug use as their mode of transmission, and 59% report heterosexual contact. Twenty three percent do not have reported risk. These percentages are similar to those within the HSDA.

- Harris County contains almost all of the new HIV and AIDS infections among women of childbearing age, with 98% of all cases.

TABLE 1.2.8: HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG WOMEN 13-44, 2005

HSDA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	**1,814**	**100.0**	**1,505**	**100.0**	**3,319**	**100.0**
Race/Ethnicity						
White/Anglo	228	12.6	172	11.4	400	12.1
Black/African-American	1,316	72.5	1,078	71.6	2,394	72.1
Hispanic/Latino	243	13.4	246	16.3	489	14.7
Other	27	1.5	9	0.6	36	1.1
Transmission Mode						
IDU	230	12.7	298	19.8	528	15.9
Heterosexual	1,032	56.9	931	61.9	1,963	59.1
Not Classified	525	28.9	245	16.3	770	23.2
Mother at Risk	20	1.1	25	1.7	45	1.4
County						
Austin	4	0.2	0	0.0	4	0.1
Chambers	0	0.0	<3	*	*	*
Colorado	6	0.3	<3	*	*	*
Fort Bend	46	2.5	30	2.0	76	2.3
Harris	1,704	93.9	1,440	95.7	3,144	94.7
Liberty	8	0.4	7	0.5	15	0.5
Montgomery	27	1.5	16	1.1	43	1.3
Walker	5	0.3	5	0.3	10	0.3
Waller	6	0.3	4	0.3	10	0.3
Wharton	8	0.4	<3	*	*	*

* Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

Youth

HRSA has defined youth as young people between the ages of 13 and 24 years. The HSDA has only 17 more youth living with HIV/AIDS than the EMA, so information presented applies to youth in both geographic regions.

- In 2005, a total of 196 youth between the ages of 13 and 24 were newly diagnosed with HIV or AIDS in the Houston HSDA.
- Young women comprise 48% of those living with either HIV or AIDS in this age group.
- Black/African-American youth are disproportionately affected by HIV and AIDS, at 63% of new cases and also the largest group infected with HIV disease, comprising 68% of those living with either HIV or AIDS. This compares to 11% for White/Anglo youth and 21% for Hispanic/Latino youth.
- Among youth 13 to 24 years, sexual contact is the most commonly reported transmission mode.
  - Nearly 42% new HIV infections were attributed to male-to-male sex, and 22% were attributed to heterosexual contact.
  - Among newly diagnosed AIDS cases, 51% were attributed to male-to-male sex, while 27% were attributed to heterosexual contact.
  - For those living with HIV disease, 30% report MSM, and 28% report heterosexual risk as their risk category. Another 1% report MSM/IDU and 5% report IDU.
- Almost 95% of HIV diagnoses and 96% of AIDS diagnoses were among Harris County youth.

TABLE 1.2.9: HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG YOUTH 13-24, 2005

HSDA	Living with HIV		Living with AIDS		Living with HIV/AIDS	
	#	%	#	%	#	%
Total	**612**	**100.0**	**200**	**100.0**	**812**	**100.0**
Gender						
Male	311	50.8	114	57.0	425	52.3
Female	301	49.2	86	43.0	387	47.7
Race/Ethnicity						
White/Anglo	67	10.9	21	10.5	88	10.8
Black/African-American	418	68.3	133	66.5	551	67.9
Hispanic/Latino	124	20.3	45	22.5	169	20.8
Other	3	0.5	<3	*	*	*
Transmission Mode						
MSM	177	28.9	63	31.5	240	29.6
IDU	30	4.9	7	3.5	37	4.6
MSM/IDU	7	1.1	3	1.5	10	1.2
Heterosexual	182	29.7	48	24.0	230	28.3
Not Classified	161	26.3	34	17.0	195	24.0
Mother at Risk	45	7.4	38	19.0	83	10.2
County						
Austin	<3	*	0	0.0	*	*
Chambers	0	0.0	0	0.0	0	0.0
Colorado	4	0.7	<3	*	*	*
Fort Bend	16	2.6	3	1.5	19	2.3
Harris	567	92.6	190	95.0	757	93.2
Liberty	3	0.5	0	0.0	3	0.4
Montgomery	10	1.6	<3	*	*	*
Walker	5	0.8	<3	*	*	*
Waller	<3	*	3	1.5	*	*
Wharton	5	0.8	0	0.0	5	0.6

* Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

Blacks/African-Americans

Surveillance data are gathered for Blacks/African-Americans without national distinction. While it can be assumed that most of these Blacks/African-Americans are African-Americans, surveillance data do not differentiate between African-Americans, Africans, Caribbean-Africans, etc.

- In 2005, a total of 861 Blacks/African-Americans were newly diagnosed with HIV or AIDS in the Houston HSDA, at a rate of 106 per 100,000. The number of AIDS diagnoses was 460, compared to 403 new diagnoses for HIV. For those living with AIDS, the rate 582 per 100,000 is higher than for those with an HIV diagnosis only, at 494 per 100,000.
- Black/African-American males comprised the largest group of the newly diagnosed (60%), and the distribution of proportions of new HIV infections compared to AIDS across gender was similar.
- Women are approximately 43% of those living with HIV, and they are 34% of those living with AIDS, so there appears to be an increasing trend for Black/African-American women with HIV disease.
- Blacks/African-Americans aged 25 to 44 had the highest proportions of both HIV and AIDS diagnoses.

A similar trend exists in the prevalence data, with 10% of Blacks/African-Americans living with HIV being youth, while only 3% of those living with AIDS are youth.

- Among Blacks/African-Americans with newly diagnosed HIV or AIDS, 22% were attributed to male-to-male sex, and 29% were attributed to heterosexual contact. Risk was not reported for 42% new HIV diagnoses and 26% of new AIDS diagnoses.
- Harris County is home to almost 98% of Blacks/African-Americans diagnosed with HIV or AIDS.

TABLE 1.2.10: HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG BLACK/AFRICAN-AMERICANS, 2005

HSDA	Living with HIV			Living with AIDS			Living with HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	**4,026**	**100.0**	**493.5**	**4,744**	**100.0**	**581.5**	**8,770**	**100.0**	**1,075.1**
Gender									
Male	2,281	56.7	592.2	3,115	65.7	808.7	5,396	61.5	1,400.8
Female	1,745	43.3	405.3	1,629	34.3	378.4	3,374	38.5	783.6
Age (yrs)									
0 - 1	0	0.0	*	0	0.0	*	0	0.0	*
2 - 12	91	2.3	*	20	0.4	*	111	1.3	*
13 - 24	418	10.4	*	133	2.8	*	551	6.3	*
25 - 44	2,403	59.7	994.8	2,598	54.8	1,075.5	5,001	57.0	2,070.4
45 - 64	1,063	26.4	588.8	1,864	39.3	1,032.5	2,927	33.4	1,621.3
65+	51	1.3	90.8	129	2.7	229.7	180	2.1	320.5
Transmission Mode									
MSM	860	21.4	*	1,283	27.0	*	2,143	24.4	*
IDU	511	12.7	*	922	19.4	*	1,433	16.3	*
MSM/IDU	139	3.5	*	307	6.5	*	446	5.1	*
Heterosexual	1,338	33.2	*	1,523	32.1	*	2,861	32.6	*
Not Classified	1,046	26.0	*	657	13.8	*	1,703	19.4	*
Mother at Risk	114	2.8	*	46	1.0	*	160	1.8	*
County									
Austin	9	0.2	358.3	3	0.1	119.4	12	0.1	477.7
Chambers	<3	*	*	0	0.0	0.0	*	*	*
Colorado	8	0.2	280.7	0	0.0	0.0	8	0.1	280.7
Fort Bend	90	2.2	94.0	118	2.5	123.2	208	2.4	217.2
Harris	3,849	95.6	584.4	4,565	96.2	693.1	8,414	95.9	1,277.5
Liberty	14	0.3	153.2	9	0.2	98.5	23	0.3	251.6
Montgomery	29	0.7	199.1	21	0.4	144.2	50	0.6	343.3
Walker	8	0.2	55.2	7	0.1	48.3	15	0.2	103.4
Waller	11	0.3	120.8	13	0.3	142.8	24	0.3	263.6
Wharton	*	*	*	8	0.2	137.9	*	*	*

* Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

Hispanics/Latinos

The HSDA has 3,525 Hispanics/Latinos living with HIV or AIDS. The EMA has 3,509 cases of Hispanics/Latinos. Percentages between the two regions are nearly identical.

- In 2005, a total of 428 Hispanics/Latinos were newly diagnosed with HIV or AIDS in the Houston HSDA, at a rate of 27 per 100,000. Infection rates were at 12 per 100,000 for HIV diagnoses and 14 per 100,000 for AIDS diagnoses.
- Hispanic/Latino men were infected with HIV at a rate of more than four times that of Hispanic/Latina women and their AIDS infection rate is approximately three times that of women.
- As with other populations, the 25 to 44 year age group was the largest, but infections among youth are increasing.

Nearly three-quarters of new HIV and AIDS diagnoses were among Hispanics/ Latinos age 25 to 44 years.

Nearly 21% of new HIV cases were among Hispanic/Latino youth, while 7% of new AIDS cases were among youth. Similarly, 9% of Hispanics/Latinos living with HIV were youth while 2% living with AIDS were youth.

- Sexual activity, either MSM or heterosexual, was the transmission mode for almost all Hispanics/Latinos diagnosed with HIV and those living with HIV or AIDS.
  - MSM were a higher percentage of those diagnosed with HIV (57%) than those diagnosed with AIDS (36%).
  - Forty seven percent of Hispanics/Latinos living with HIV and 49% of those living with AIDS report MSM as their transmission mode.
  - Heterosexual contact is the transmission mode for 22% of Hispanics/Latinos living with HIV and 25% of those living with AIDS.
- Harris County is home to 96% of Hispanics/Latinos living with HIV or AIDS. In addition, Harris County had almost all new HIV infections and diagnosed AIDS cases among Hispanics/Latinos during 2005 at 99%.

TABLE 1.2.11: HOUSTON-AREA HSDA HIV AND AIDS PREVALENCE AMONG HISPANICS/LATINOS, 2005

HSDA	Living with HIV			Living with AIDS			Living with HIV/AIDS		
	#	%	Rate	#	%	Rate	#	%	Rate
Total	**1,338**	**100.0**	**83.4**	**2,187**	**100.0**	**136.3**	**3,525**	**100.0**	**219.7**
Gender									
Male	1,034	77.3	122.9	1,811	82.8	215.3	2,845	80.7	338.3
Female	304	22.7	39.8	376	17.2	49.2	680	19.3	89.1
Age (yrs)									
0 - 12	19	1.4	*	12	0.5	*	31	0.9	*
13 - 24	124	9.3	*	45	2.1	*	169	4.8	*
25 - 44	958	71.6	170.4	1,369	62.6	243.4	2,327	66.0	413.8
45 - 64	224	16.7	95.7	718	32.8	306.9	942	26.7	402.6
65+	13	1.0	22.9	43	2.0	75.6	56	1.6	98.5
Transmission Mode									
MSM	628	46.9	*	1,067	48.8	*	1,695	48.1	*
IDU	48	3.6	*	165	7.5	*	213	6.0	*
MSM/IDU	53	4.0	*	98	4.5	*	151	4.3	*
Heterosexual	296	22.1	*	553	25.3	*	849	24.1	*
Not Classified	283	21.2	*	272	12.4	*	555	15.7	*
Mother at Risk	24	1.8	*	19	0.9	*	43	1.2	*
County									
Austin	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0
Chambers	0	0.0	0.0	<3	*	*	*	*	*
Colorado	<3	*	*	3	0.1	64.4	*	*	*
Fort Bend	28	2.1	26.9	49	2.2	47.1	77	2.2	74.0
Harris	1,282	95.8	92.6	2,099	96.0	151.6	3,381	95.9	244.2
Liberty	3	0.2	29.7	<3	*	*	*	*	*
Montgomery	17	1.3	28.1	23	1.1	38.0	40	1.1	66.1
Walker	<3	*	*	3	0.1	31.7	*	*	*
Waller	<3	*	*	4	0.2	52.2	*	*	*
Wharton	5	0.4	34.8	3	0.1	20.9	8	0.2	55.7

* Census estimates do not provide certain category breakdowns, thus some rates could not be calculated. Values for specified categories less than 3 cannot be displayed, so applicable data are either denoted as such or recategorized in a manner to mask true values.

Source: Texas Department of State Health Services. Rates are calculated per 100,000 based upon 2005 U.S. Census estimates.

HIV/TUBERCULOSIS COINFECTION

Tuberculosis (TB) may present as a comorbid condition with HIV or AIDS. People with HIV are more susceptible to TB, and it can be more difficult to treat in people with AIDS. Two data sources help us understand the number of people with tuberculosis who are co-infected with HIV, the Houston Department of Health & Human Services and the Texas Department of State Health Services (DSHS).

- The Houston Department of Health & Human Services maintains a record of all TB diagnoses and categorizes them with and without HIV. Reporting of TB is generally on a timely basis but information on HIV testing is, at times, delayed.
- The Texas Department of State Health Services (DSHS) maintains information on TB diagnoses for all people diagnosed with HIV or AIDS. The advantage of DSHS data is that the entire HSDA is included. The disadvantage is that the data does not include date of TB diagnosis. Therefore, DSHS data on TB is best considered only for those newly diagnosed, since those are the only cases that can be confirmed during the current year. In addition, the reporting delay is evident in the DSHS data when compared to the Houston data.

Based upon Houston Department of Health & Human Services data, the number of people living with AIDS who have TB is relatively stable. DSHS data indicates a decline in cases, but this may be attributed to reporting delays.

TABLE 1.2.12: HOUSTON AND HSDA PERSONS DIAGNOSED WITH AIDS WHO ALSO HAVE TB, 2000 - 2004

HSDA New AIDS Diagnoses with TB*				Houston
Year	AIDS	w/TB	%	TB/AIDS*
2000	1,037	54	5.6%	49
2001	972	58	6.0%	61
2002	1,051	49	4.7%	52
2003	871	32	3.7%	59
2004	808	39	4.8%	53

*Not all diagnosed with TB received an HIV test

Source: Texas Department of State Health Services and Houston Department of Health and Human Services

The Bureau of TB Control routinely offers HIV testing to its clients. In 2006, HIV test results are were available for 91% of those with TB. Of those for whom a test result is not available, the reasons include that the client refused an HIV test, the client died, the result of the HIV test was not known or the client was not offered an HIV test. The following chart describes the HIV status of those with TB in Houston. A case of TB is counted for the year that it was confirmed as a case. In 2006, 54 (19%) of the 278 people over 15 years old with TB tested positive for HIV. Twenty-one (39%) of the 54 were newly diagnosed with HIV. Among the 110 people aged 25-44 with TB, 32 (29%) tested positive for HIV.

TABLE 1.2.13: HOUSTON HIV STATUS OF TB CASES, AGE 15 AND OLDER 2002-2006

Total TB Cases Tested for HIV			TB/HIV Coinfection				HIV Negative	
Cohort Year	# Cases	#	%	#	% of all cases	% of all cases with HIV	#	%
2002	308	205	67%	52	17%	25%	153	50%
2003	327	262	80%	59	18%	23%	203	62%
2004	334	326	98%	53	16%	16%	273	82%
2005	253	238	94%	29	12%	12%	209	83%
2006	278	253	91%	54	19%	21%	199	72%
Total	1,500	1,284	86%	247	17%	19%	1,037	69%

No HIV Test Results		No Results: Reason				
#	%	# Recommended for HIV Testing	# HIV Tested, Results Unknown	# Refused	# Died	# Not Offered
103	33%	63	39	1	0	0
65	20%	0	14	50	1	0
8	2%	6	1	1	0	0
14	6%	3	0	3	0	8
25	9%	7	3	4	5	6
215	14%	79	57	59	6	14

HIV/SYPHILIS COINFECTION

Surveillance of syphilis is focused on primary and secondary (P&S) syphilis because these are the stages in which syphilis is infectious, and because it signals recent infection with syphilis. Syphilis is one of several infectious diseases that are reportable in the state of Texas. When a person tests positive for syphilis, a report is submitted to Texas Department of State Health Services (DSHS). Reports are then forwarded to the local jurisdiction for follow-up, which includes notification, treatment, and interview for partner elicitation and notification. Syphilis case follow-up in Houston and Harris County is carried out by the HDHHS Bureau of HIV/STD and Viral Hepatitis Prevention.

From January 1, 2007 through October 31, 2007, there were 393 confirmed cases of P&S syphilis. Of the 393 cases, 376 (96%) were interviewed. Of those interviewed; 122 (32%) were HIV positive, 154 (41%) were HIV negative, 39 (10%) were of unknown HIV status, and 61 (16%) had not been tested for HIV.

TABLE 1.2.14: HIV STATUS AMONG ALL INTERVIEWED CLIENTS 01/01/07 - 10/31/07, HOUSTON/HARRIS COUNTY, TX

# Cases	# Interviewed	Current HIV Status			
		Positive	Negative	Unknown	No Test
393	376 (96%)	122 (32%)	154 (41%)	39 (10%)	61 (16%)

Source: Houston Department of Health and Human Services, Bureau of Epidemiology

Due to a 2005 outbreak of syphilis among MSM in Houston, the HDHHS Bureau of Epidemiology performs performed additional analysis analyses on this subpopulation.

From January 1, 2007 through October 31, 2007, there were 180 confirmed cases of P&S syphilis among MSM. Of these cases, 179 (99%) were interviewed. Of those interviewed; 99 (55%) were HIV positive, 53 (30%) were HIV negative, 8 (4%) were of unknown HIV status, and 21 (12%) had not been tested for HIV.

TABLE 1.2.15: MSM HIV STATUS AMONG INTERVIEWED CLIENTS 01/01/07 - 10/31/07, HOUSTON/HARRIS COUNTY, TX

# Cases	# Interviewed	Current HIV Status			
		Positive	Negative	Unknown	No Test
180	179 (99%)	99 (55%)	53 (30%)	8 (4%)	21 (12%)

Source: Houston Department of Health and Human Services, Bureau of Epidemiology

HIV/HEPATITIS C VIRUS (HCV) COINFECTION

There is limited information about HCV/HIV coinfection both locally and at the national level. Below is an excerpt and on the following page is a table summarizing HIV/ HCV coinfection from a report published by the U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau in April 2006 "Care and Treatment for Hepatitis C and HIV Coinfection: Expanding Access Through the Ryan White Care Act".

The prevalence of HCV coinfection is higher than most people realize. In the United States, HCV prevalence among all PLWHA is estimated to be 15 to 30 percent, and it is more than three times higher - from 50 to 90 percent - among people who acquired HIV through IDU [Intravenous Drug Use]. Two to four people who are coinfected with HCV and HIV are more likely than those with HCV alone to develop end-stage liver disease because HIV accelerates progression of HCV. Hepatitis C can be treated, even in PLWHA. End-stage liver disease is preventable in many patients: The first steps are educating patients about HCV, providing appropriate screening and diagnosis, and assessing the need for HCV treatment, all in a supportive context.

TABLE 1.2.16: HCV PREVALENCE AMONG PEOPLE WHO ARE HIV-POSITIVE

Cohort	Sample Size	Total HCV Prevalence (%)	Prevalence in Subpopulations
Adult AIDS Clinical Trials Group (AACTG)	213	16.1	72.7% among "high-risk" group (Participants with hemophilia or history of injection drug use)
AIDS Linked to the Intravenous Experience (ALIVE) Cohort Baltimore, MD	934	97.6	*
Community Programs for Clinical Research on AIDS (CPCRA)	2705	16.6	61.9% among participants with a history of injection drug use
San Francisco Community Health Network	2859	39.4	*
HIV Atlanta Cohort Study (HIVACS)	970	31.6	*
New York City, Cohort of HIV Positive Current & Former Injection Drug Users	557	75	*

*Data not provided

Note on Self-Reported HCV Status

The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with active hepatitis C.[1]

HIV COUNSELING AND TESTING DATA

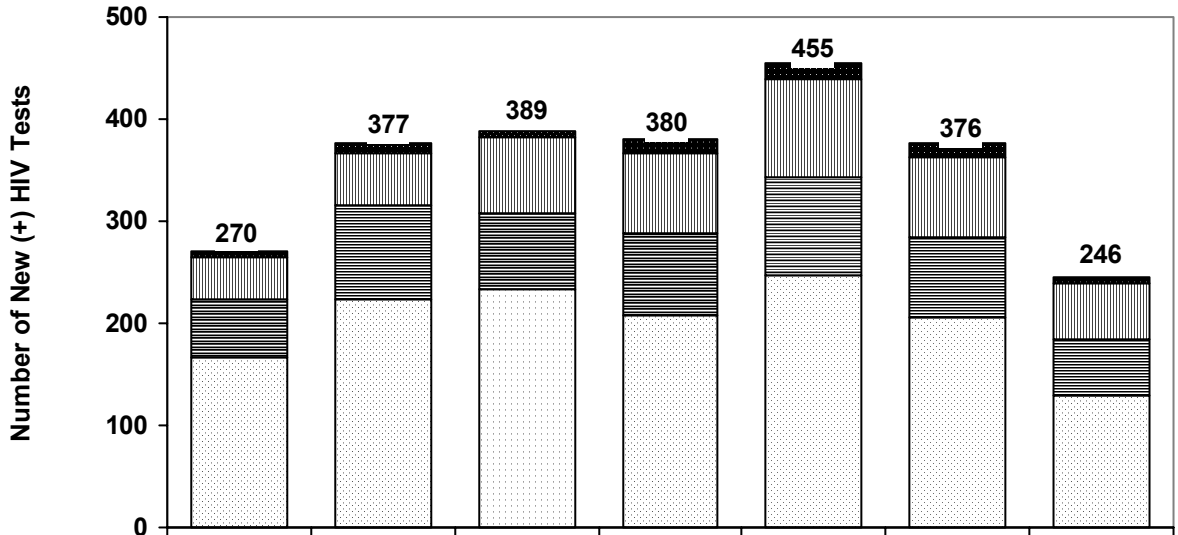
In 2006, 11,407 clients received HIV Counseling, Testing, and Referral (CTR) services through programs funded by HDHHS. The number tested decreased from 2005 to 2006 due to the introduction of Protocol Based Counseling (PBC), which incorporates a counseling session tailored to the reported risk of the client. The session requires about 45 minutes per HIV test performed. This change moved the focus of HIV testing from quantity to quality of services. Fewer clients were tested, but the testing was more appropriately targeted, which is evident in the increase in HIV positivity rate from 1.6% to 2.2%.

Of the 11,407 tested, 4,694 (41%) were Black/African-American, 3,172 (28%) were White/Anglo, 3,034 (26%) were Hispanic/Latino and 507 (4%) were of other or unknown race/ethnicity. Of the 11,407 clients tested, 246 (2%) were newly diagnosed with HIV. Of those who were newly diagnosed; 130 (53%) were Black/African-American, 55 (22%) were

[1] "The Importance of Laboratory Test Results in Hepatitis C Infection," David Bernstein, MD, FACP, FACG, www.hcvadvocate.org.

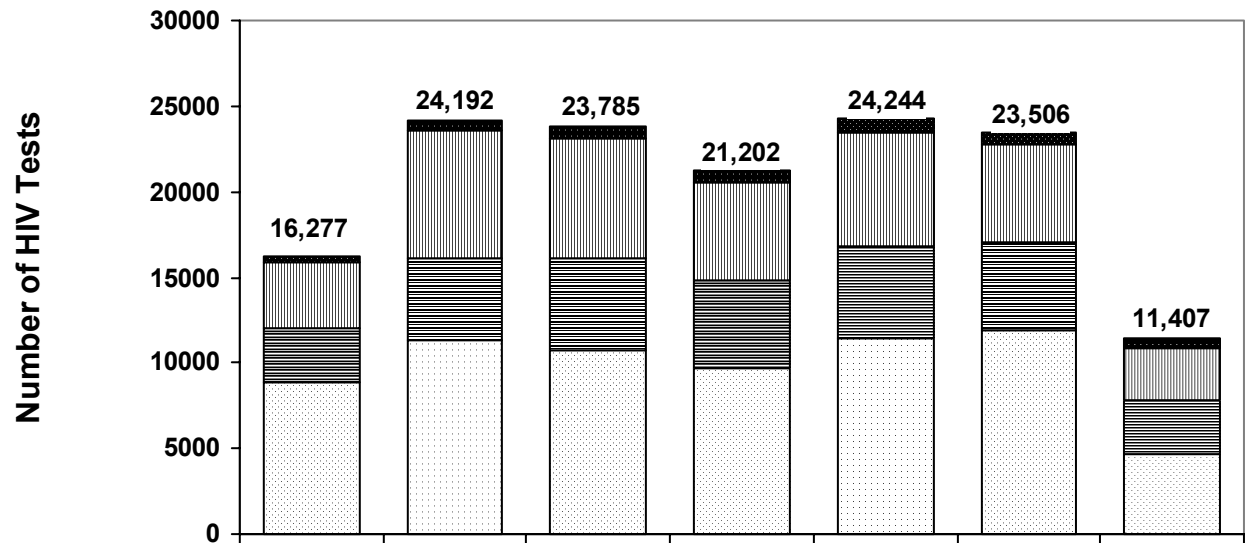
White/Anglo, 55 (22%) were Hispanic/Latino and 6 (2%) were of other or unknown race/ethnicity.

FIGURE 1.2.2: TOTAL NEW (+) HIV TESTS FROM HOUSTON DEPARTMENT OF HEALTH & HUMAN SERVICES-FUNDED CTR (COUNSELING, TESTING AND REFERRAL) PROGRAMS BY YEAR OF TEST AND RACE/ETHNICITY, AS OF AUGUST 7, 2007



	2000	2001	2002	2003	2004	2005	2006
Other/Unknown	5	10	7	14	16	13	6
Hispanic	42	52	75	77	96	79	55
White	57	91	73	82	95	78	55
Black	166	224	234	207	248	206	130

FIGURE 1.2.3: TOTAL HIV TESTS FROM HOUSTON DEPARTMENT OF HEALTH & HUMAN SERVICES-FUNDED CTR (COUNSELING, TESTING AND REFERRAL) PROGRAMS BY YEAR OF TEST AND RACE/ETHNICITY, AUGUST 7, 2007



	2000	2001	2002	2003	2004	2005	2006
Other/Unknown	426	609	700	780	789	691	507
Hispanic	3773	7457	7028	5677	6680	5766	3034
White	3237	4819	5320	5124	5303	5149	3172
Black	8841	11307	10737	9721	11472	11900	4694

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

The unmet need estimate equips planning bodies with data to develop 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.

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.

TABLE 1.3.1: UNMET NEED ESTIMATE

Population Sizes	Value	Data Source(s)
Number of persons living with AIDS (PLWA), for the period of January - December 2006.	11,589	HARS, cases entered and living on or before 12/31/2006; cases in Texas Department of Criminal Justice (TDCJ) removed.
Number of persons living with HIV (PLWH) (non-AIDS/aware), for the period of January - December 2006.	7,786	HARS, cases entered and living on or before 12/31/2006; cases in TDCJ removed.
Total number of HIV+/aware for the period of January - December 2006.	19,375	
Care Patterns	**Value**	**Data Source(s)**
Number of PLWA who received the specified HIV primary medical care during the 12-month period (calendar year 2006).	7,691	Evidence of met need found in HARS, through matches with AIDS Drug Assistance Program (ADAP), Ryan White program data (all Parts), Medicaid, private insurers or data from electronic laboratory reporting of viral load and CD4 results; VA hospital
Number of PLWH (non-AIDS/aware) who received the specified HIV primary medical care during the 12-month period (calendar year 2006).	4,275	Same as above
Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period (calendar year 2006).	11,966	
Number of PLWA who did not receive the specified HIV primary medical care.	3,898	Value A - Value D. Percent: Value G/ Value A
Number of PLWH (non-AIDS/aware) who did not receive the specified HIV primary medical care.	3,511	Value B - Value E. Percent: Value H/ Value B
Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need).	7,409	Value C - Value F. Percent: Value I/ Value C

For the Houston EMA, African-American PLWH have the highest proportion of clients with unmet need at 58%. Interestingly, among PLWA, Whites have a slightly higher proportion when compared to the other races/ethnicities. Among the age groups, those above the age of 55 appear to have the greatest proportion of their population out of care for PLWA; however, Medicare data was not available for this analysis and may explain this greater proportion. When looking at unmet need by exposure category, IDU have high proportions of their population out of care, yet MSM have the greatest numbers out of care.

The large number and percentage of out-of-care in the 'No Identified Risk (NIR)/ Other' category could indicate two things: that these are newer cases which have not yet had a full surveillance investigation, or that these are older cases that are lost to follow-up with no risk established. However, Centers for Disease Control & Prevention (CDC)

believes that heterosexual contact may be the main transmission mode for persons in this category because women may be unaware of how they were infected if they did not know of their partner's HIV status and risk behaviors. If this category is taken into account, then the exposure of heterosexual contact may represent a much higher proportion of the unmet need population.

In separating out HIV cases versus AIDS cases of unmet need, it is evident that the proportion of PLWH who are not receiving medical care is greater than the proportion among PLWA. However, some of this difference may be attributable to the interaction of the case definition for AIDS and the definition of met need. The larger proportion of AIDS cases with met need might be explained in two ways; one, the fact that an AIDS diagnosis is only confirmed through medical care such as CD4 and viral load tests, or; two, individuals may begin experiencing symptoms associated with an AIDS diagnosis, thus triggering a decision to seek medical care. Nevertheless, while Whites have similar proportions of unmet need regardless of disease status, this is not true for Hispanics/ Latinos and African-Americans. For both of these racial/ethnic groups, the unmet need among African-American and Hispanic/Latino HIV cases is much higher than it is for AIDS cases.

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 Centers for Disease Control & Prevention (CDC) believes that heterosexual contact is possibly the main transmission mode behind this 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, substance 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, as identified by the current, as well as prior, Houston Area HIV/AIDS Needs Assessments, continues to be lack of information. This includes information about services, where they are located, and eligibility requirements.

CARE/SUPPORTIVE SERVICES IN THE EMA: RYAN WHITE PART A

HRSA-defined Core Services in the EMA:

Ambulatory/Outpatient Medical Care	Oral Health
Case Management (Medical & Clinical)	Local Drug Reimbursement Program
Mental Health Services	Health Insurance
Substance Abuse	Home Health Care
Hospice Services	Rehabilitation Services/Physical Therapy

The Houston EMA has a continuum of care that addresses HIV service needs from diagnosis to end-stage disease. Central to this continuum is outpatient primary medical care. Harris County operates two HIV clinics, one which focuses on early intervention; and another which is located in northeast Houston and is the nation's largest freestanding HIV clinic. Community-based options for HIV care include an agency in the Montrose area, which has historically served the gay/MSM community and operates a second site in the heavily Black/African-American Fifth Ward area in northeast Houston; another agency located on Houston's near north side, targeting Hispanic/Latino and Black/African-American PLWHA; and a third agency, which is located in southwest Houston and focuses on Black/African-American PLWHA. This third agency also targets rural PLWHA through satellite clinics located in far southwest Harris and Montgomery Counties, respectively. A Federally Qualified Health Center in Ft. Bend County also targets rural PLWHA. In addition, two local hospitals operate clinics which provide primary medical care services to HIV-positive children. Complementing these primary care providers is a long-standing coordinated case management system including medical case management services embedded in all primary medical care programs, clinical case management co-located at mental health and substance abuse treatment sites and non-medical case management programs located at HIV testing sites.

According to the CPCDMS, during 2006 the Houston EMA served 8,262 unduplicated PLWHA through Part A services, of which 79% of the clients (6,626 individuals) received primary medical care services, up from 73% in FY 2005. Among those receiving primary medical care services, approximately 52% were Blacks/African-Americans, 25% were Hispanics/Latinos and 30% were women. These service utilization data mirror the epidemiological data for the HSDA, indicating that efforts to reach PLWHA reflect those most affected by the epidemic. To date, 7,204 PLWHA have been served in FY 2007, of which 81% (5,814 individuals) have received primary medical care. The demographics of those receiving primary care are very similar to the proportions from FY 2006, substantiating Houston's continued success in targeting RW Part A-funded services to historically underserved populations.

The Houston EMA's Continuum of Care (COC), a framework that guides stakeholders in establishing priorities and funding for HIV/AIDS services, has been in place since FY 2000. Representatives from the Ryan White Planning Council, consumers, service providers, and the Houston Department of Health & Human Services prevention

community planning group collaborated to create this universal COC. It is conceptualized as a "rail system" that identifies and tracks the HIV-related services deemed necessary for the public and PLWHA in the Houston EMA. This concept theoretically allows people to transition in or out of the system depending on their general knowledge of the HIV virus and its transmission, their serostatus, health and individual desire to stay in the system.

The Houston EMA strives to meet HRSA's goal of increasing access and decreasing disparity in its funded programs. Each year, strategies for ensuring access and minimizing disparity are reviewed and revised during the RWPC's *How to Best Meet the Need* (HTBMN), priority setting and allocation processes. Five attributes summarize the EMA's goals and objectives for the COC, particularly concerning access to primary care:

Availability - In addition to the local public indigent care hospital system that provides three clinic sites where Harris County residents can receive HIV primary care, the RWPC allocates funding for HIV primary care through three community-based providers that operate a total of six (6) clinics accessible to PLWHA within the entire EMA. In addition, two clinics affiliated with local medical schools provide primary medical care services to pediatric patients.

Accessibility - The RWPC prioritizes and allocates a large sum of money towards transportation services, including vans, bus passes and gas vouchers, to ensure that clients are able to access core medical services.

Affordability - The RWPC has set eligibility requirements for primary medical care at 300% of the FPL and for HIV medications at 500%. These relatively high eligibility criteria were determined to be necessary because of the importance and expense of medical care as well as the small but increasing number of PLWHA who may have returned to work but lack health insurance. Based on FY 2006 data for clients served in the EMA, 89% of PLWHA earn less than $20,000 annually, and approximately 64% earn less than $10,000.

Appropriateness - To accommodate the needs of different populations, three community based primary care providers were awarded primary medical care contracts for FY 2007. These clinics specialize in care to African Americans and Latinos, gay and/or White PLWHA and rural PLWHA. In addition, all Part A-funded primary care facilities are required to have bilingual clinical staff and medical translators available to accommodate monolingual clients.

Accountability - Clients who receive high quality services are more likely to continue to access those services. Since FY 2000, Part A primary medical care providers and other service providers have been contractually required to provide high quality services according to approved SOC. Clinical Quality Management (CM) initiatives such as clinical chart review ensure that care is provided according to HHS guidelines. In addition, automation of service utilization and billing data in the CPCDMS has further improved programmatic and fiscal accountability.

CARE/SUPPORTIVE SERVICES IN THE HOUSTON HSDA: RYAN WHITE PART B

The Part B Administrative Agency (AA) collaborates with the RWPC to develop the following planning products for Part B and State Services funding received from the Texas Department of State Health Services: area service priorities, recommendations for Part B and State Services funding allocations, and Standards of Care. In addition, both parties collaborate on the production of, and updates to, the Needs Assessment and Comprehensive HIV Services Plan.

The purpose of this collaboration is to improve the quality, availability and organization of health care and support services for individuals and families with HIV infection in the ten (10) county Houston HSDA. Similar to the EMA, primary care is a central focus of the Houston HSDA.

In an effort to support client access to primary care and other providers within the entire HSDA, the Part B AA has awarded a total of ten community-based service providers, including two providers that focus on primary care, transportation, and food pantry services for rural-based clients.

In FY 2006, the Houston HSDA served 6,137 unduplicated PLWHA through Part B and State Services funding, of which 4% (266) received rural primary medical care. Among those receiving services under these resources, approximately 58% were African Americans, 25% were Hispanics and 22% were women. In

Representatives from Part B participate in the RWPC's *How to Best Meet the Need* (HTBMN) process as outlined above to meet both HRSA's and the Department of State Health Services' goals of increasing access and decreasing disparities in its funded programs.

In support of the goals and objectives outlined for the COC, the following attributes summarize the Part B AA's activities to ensure access to primary care for clients within the HSDA:

Availability – The Part B AA and RWPC collaborate to recommend Part B and State Services funding allocations for core medical and support services. This process has ensured that gaps in services are appropriately addressed through available funds in the EMA/HSDA. For FY2008, Part B allocated funds for adult day/respite care and food bank, both of which will not be funded by Part A for the EMA.

Accessibility – Through the collaborative EMA/HSDA planning process, the Part B AA and RWPC prioritizes and allocates Part B and State Services funding towards rural transportation services, as well as bus passes and gas vouchers, to ensure that clients residing in and outside of Harris county are able to access core medical services.

Affordability - The Part B AA participates in workgroups coordinated by the RWPC. These workgroups establish eligibility requirements for primary medical

care in response to number of PLWHA in need of resources to access medical care.

Appropriateness - To accommodate the needs of different populations, including rural clients, two (2) community-based primary care providers were awarded primary medical care contracts under Part B and State Services in FY2007. These care sites specialize in care to rural PLWHA. In addition, Part B specifically funds interpreter services for a community-based provider within Harris county to accommodate monolingual and deaf clients.

Accountability - Primary medical care providers and other service providers funded under Part B and State Services are contractually required to provide quality services according to approved SOC. The Part B Clinical Coordinator and Quality Management Coordinator implements initiative such as clinical chart reviews and quality improvement plans, if needed, to ensure that care is provided according to HHS guidelines. In addition, automation of service utilization and billing data in the ARIES has further improved programmatic and fiscal accountability.

PREVENTION SERVICES IN THE HSDA

One purpose of the Bureau of HIV/STD and Viral Hepatitis Prevention is to develop an effective response to the HIV/AIDS epidemic in Houston/Harris County by: (1)improving our response to HIV infection and associated risk factors, (2) preventing the spread of HIV, (3) maximizing health and social outcomes, and (4) coordinating effective and efficiently targeted comprehensive services for those at risk for, living with, or affected by HIV.

The HDHHS maintains partnerships to create prevention service delivery networks, to implement multiple morbidity programming, to implement structural interventions and to implement site-specific (e.g. county jails) or community-specific (e.g. faith community) interventions.

HIV prevention partnerships most often are in the form of contracted services with community-based organizations (CBOs), local hospitals and clinics, and programs within the HDHHS. These contracts are primarily supported with funds from the Centers for Disease Control and Prevention (CDC), the Texas Department of State Health Services (DSHS), Ryan White, and the Houston Department of Health & Human Services.

The Bureau of HIV/STD and Viral Hepatitis Prevention provides for HIV/STD Prevention Services in the following categories:

Category 1: Health Education/Risk Reduction (HE/RR)

- Activities include outreach, individual-level interventions (ILI), group-level interventions (GLI), community-level interventions (CLI) and health communication/ public information (HC/PI) targeted to high-risk HIV-negative persons and HIV-positive persons.

- This category is intended to increase knowledge, awareness and skills for the purpose of: decreasing prevalence of HIV risk behaviors, maintaining and reinforcing risk reduction behaviors, creating community norms and values that support HIV risk reduction efforts, and learning one's HIV status and disclosure of HIV serostatus when appropriate..

- This category secondarily serves as a vehicle to refer HIV at-risk persons of unknown HIV serostatus to available HIV counseling, testing and referral services.

- All programs serving persons living with HIV must integrate a partner elicitation strategy into their respective program designs.

- These interventions also facilitate linkages to services in both clinic and community-based settings (e.g., substance abuse treatment settings, HIV counseling, testing and referral services) and are intended to support behaviors and practices that prevent transmission of HIV.

Category 2: HIV/STD Counseling, Testing and Referral (CTR) including Syphilis Elimination

- Activities include risk assessment, rapid and conventional HIV-antibody testing, disclosure counseling, post-disclosure counseling, partner counseling, referral services and social networks targeted to persons of unknown HIV status.

- Targeted HIV Screening and Protocol-Based Counseling are the funded CTR interventions. This category emphasizes confidential HIV testing services and supports traditional settings (clinic-based) for HIV testing as well as non-traditional settings such as community-based venues, outreach settings, and mass testing days. All HIV CTR programs also receive Syphilis Elimination funding and are required to concurrently test for Syphilis when testing for HIV.

- The technology for HIV counseling, testing and referral services (CTR) has improved so that community-based providers (where available) now have a choice to offer individuals two different HIV testing technologies: conventional CTR and Rapid Testing. Conventional CTR requires that a screening test for HIV antibodies be performed (e.g. EIA, ELISA). If HIV antibodies are detected with the screening test, a highly specific, confirmatory test (e.g. Western Blot, IFA) must be performed. Both Conventional CTR and Rapid Testing can be provided either confidentially or anonymously; however, Rapid Testing allows the individual being tested to receive his or her HIV test results within a half hour of being tested. Rapid HIV testing is only a screening test for HIV antibodies, and positive results are considered "presumptive" until confirmatory results can be obtained through a conventional HIV testing technology.

- HIV counseling, testing and referral services (CTR) is a voluntary, client-centered interaction process through which an individual seeks to learn his or her HIV status. During this process, the individual receives basic HIV/AIDS information, an explanation of testing procedures and test results, a review of strategies to prevent

HIV infection or transmission, information and offering of partner counseling and referral services, and the delivery of client-centered, linked referrals. Referrals are made as appropriate to the needs of the individual whether that person is newly diagnosed HIV positive or HIV negative.

Category 3: Comprehensive Risk Counseling Services (CRCS)

- CRCS is targeted to HIV-negative persons at high risk for HIV infection and HIV-positive persons at high risk for HIV transmission. The goal of this category is promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. CRCS is intended for persons having, or likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or re-infection. CRCS is essentially a hybrid of HIV risk-reduction counseling and traditional case management. Clients must complete a minimum of four (4) sessions.

- The core elements of CRCS require the assessment of HIV risk behaviors and other psychosocial and health service needs. CRCS provides intensive, individualized support and prevention counseling to assist persons in remaining HIV-negative, or to reduce the risk of HIV transmission by those persons who are HIV-positive. CRCS should not duplicate services funded by psychosocial case management services.

Category 4: Social Marketing

- Social Marketing is_designed to alter HIV testing and risk reduction behaviors, correct misperceptions and misinformation, and create a supportive environment for communication about what it means to be HIV-positive or HIV-negative. This intervention addresses the community norms and other barriers preventing individuals from testing or accessing needed services, including: 1) fear of the impact of an HIV diagnosis, 2) lack of knowledge about testing sites and procedures, and 3) lack of knowledge about the health care system.

Category 5: School-Based Programs

- School based programs include the development and provision of an innovative HIV/AIDS training program that increases broad school-based support for HIV/AIDS education among school administration, teachers, medical staff, school boards, parent-teacher organizations and parents for comprehensive HIV education and prevention activities for students.

Category 6: HIV Prevention Program Evaluation, Technical Assistance and Capacity Building

- This category includes Behavioral Scientists to assist local HIV prevention providers in the development of evidenced-based, behavior theory-based and behavioral risk group-specific interventions, to ensure collection of relevant program evaluation markers and to assist with program assessment and refinement efforts.

CDC Requirements

HIV Prevention Community Planning is a required component of comprehensive HIV prevention programs. HDHHS is required to establish a Community Planning Group (CPG), as Houston is directly funded for HIV Prevention services. All 50 state health departments, as well as that of Washington, DC, and the health departments of Chicago, Houston, Los Angeles, New York City, Philadelphia and San Francisco are required to establish a CPG as a direct grantee of the CDC for cooperative agreement HIV prevention funds.

One of the three goals of HIV Prevention Community Planning is to: Identify priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction. This is achieved by developing a comprehensive plan for HIV prevention. This comprehensive plan includes an Epidemiologic Profile, a Community Services Assessment (CSA), prioritized target populations, appropriate science-based prevention activities/interventions and a letter of concurrence/concurrence with reservations/non-concurrence via written response from the CPG.

The CPG is required to develop at least one Comprehensive Plan every five years. It must address HIV prevention funds for the entire jurisdiction and inform decisions about how all (local, state, federal, private) HIV prevention funds are allocated. This plan must be updated annually and the final plan for the 2004-2008 project period is to guide the five-year funding cycle that begins January 2009.

Prioritized Risk Groups

In 2004, based on a comprehensive review of local HIV epidemiology, the CPG developed and recommended for adoption the use of a behavioral risk group (BRG) model to allocate HIV prevention resources. This recommendation was a departure from the previous target population model that did not significantly factor in the behavioral HIV risk of targeted groups.

Over the past year (2005-2006), the CPG reviewed numerous secondary data sources to assess met and unmet HIV prevention needs and evaluate the appropriateness of the current BRG model. Recently, the CPG re-affirmed the existing BRG model for the purposes of priority setting, resource allocation and prevention program planning with some minor adjustments. The CPG recommended that transgenders, incarcerated individuals and individuals recently released from incarceration be considered populations of special need. Additionally, the CPG recognized the continued importance of placing the highest priority for prevention resources on people of color, youth and persons living with HIV within each BRG and special population and forwarded recommendations accordingly.

The six prioritized Behavioral Risk Groups (BRG) include:

- Males who have sex with males (MSM);
- Females who have sex with males (FSM);

- Males who have sex with females (MSF);
- Male injection drug users (M/IDU);
- Female injection drug users (F/IDU), and;
- Males who have sex with males and use injection drugs (MSM/IDU).

Additional priority populations include:

- Persons living with HIV/AIDS, and;
- Youth (persons ages 13 to 24).

Additional populations of special need include:

- Transgenders;
- Incarcerated individuals, and;
- Individuals recently released from incarceration.

BRG categories are mutually exclusive and persons at risk for HIV are counted in only one BRG category. HIV-positive individuals are a high priority in every behavioral risk group, in addition to high-risk HIV-negative individuals and those who do not know their serostatus. In order to bring about a reduction in new infections, it is of primary importance that programs reach HIV-positive individuals. Interventions for HIV-positive individuals (both those who know their serostatus and those who are unaware that they are positive) should be designed to address their risk behavior as well as meet their specific needs.

Also, the CPG recommends that interventions be targeted to prioritized behavioral risk groups and subpopulations in accordance with the CDC definition of persons at very high risk for HIV. In summary, persons at very high risk for HIV are defined as someone who, within the past 6 months, has had 1) unprotected sex with a person who is living with HIV; 2) unprotected sex in exchange for money or drugs; 3) multiple (greater than 5) or anonymous unprotected sex or needle-sharing partners; or 4) a sexually transmitted disease diagnosis.

THE NEEDS ASSESSMENT PLANNING PROCESS

The planning process for the 2008 Houston Area HIV/AIDS Needs Assessment was intended to be a collaborative process between Ryan White Parts A and B, as well as Prevention Services at the Houston Department of Health and Human Services. A description of the process, including the workgroup bodies involved throughout, is as follows:

The overall process for the 2008 Houston Area HIV/AIDS Needs Assessment was guided by the Needs Assessment Group (NAG). The Needs Assessment Group consisted

of representatives from partner organizations, consumers, service providers and other community members. In addition to overall guidance, a major role of the NAG was to review all work products generated by the following workgroups:

Epidemiology Workgroup: Reviewed epidemiological data and unmet need estimates for determining subpopulation sample sizes for the Needs Assessment. These sample sizes helped to develop a strategy for data collection. The workgroup also reviewed final products before they were forwarded to external planning bodies for approval.

Data Collection Workgroup: Focused on the development and administration of the client survey and subsequent focus groups; identified locations for survey administration; developed effective strategies for participant recruitment, and; focused on reaching out-of-care survey respondents. The workgroup also reviewed final products before they were forwarded to external planning bodies for approval.

Resource Inventory Workgroup: Assisted in the development of the provider survey and subsequent focus groups; identified methods for survey administration, and; developed effective strategies for maximizing survey responses. The workgroup also reviewed the resource inventory report and other final products before they were forwarded to external planning bodies for approval.

Gap Analysis Workgroup: Assessed service gaps based on participant and provider survey responses, and; identified barriers to care using data on service utilization and provider capacity. The workgroup also reviewed the gaps analysis report and other final products before they were forwarded to external planning bodies for approval.

STRUCTURE OF THE 2008 HOUSTON AREA HIV/AIDS NEEDS ASSESSMENT

The 2008 Houston Area HIV/AIDS Needs Assessment is comprised of the following elements:

- Client survey
  - Including Risk Behavior Items
- Provider survey
- Focus groups
- Resource Inventory
- Gaps Analysis

CLIENT SURVEY

Methodology

The Client Survey is a 10-page survey consisting of approximately 69 items measuring access to services, HIV testing & diagnosis history, entry into care, general health status, HIV treatment regimens, comorbidities, substance use and abuse, mental health, housing status, financial information and basic demographic characteristics. An additional 16 items measuring risk behaviors were included at the end of the survey.

At the beginning of the client survey, two tables were presented – one for core services, the other for supportive services. For the nine HRSA-defined core services,

respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

Survey Administration

A total of 764 surveys were administered from March through August 2007. Surveys were administered by the Ryan White Planning Council Health Planner, Council Coordinator, Ryan White Part B Health Planner, Houston Department of Health & Human Services Health Planner and two graduate students trained in survey administration. Survey administration locations included clinics, agencies and outreach vans targeting the homeless population. Spanish surveys were administered with the help of a bilingual survey administrator or a hired interpreter.

Survey data were entered into the Statistical Package for the Social Sciences (SPSS) statistical software application by the Health Planner and Assistant Coordinator. Data cleaning and analyses were conducted using SPSS.

A total of 9 focus groups were also conducted – 3 with providers (hospice and case management staff) and 6 with PLWHA (Spanish speaking HIV+ Latinos, English speaking HIV+ Latinos, HIV+ men, HIV+ women). Focus groups were recorded with a digital voice recorder, and summarized for overall themes.

Survey Limitations

The following limitations should be considered when interpreting the results from the client survey:

- Sampling Method: Survey data were based on a convenience sample, and therefore may not accurately reflect the general population of PLWHA in the Houston HSDA. A convenience sample is a group of people under study who have been assembled based on the ease of interviewing them or on accessibility to their records, etc. While this type of sampling can help produce good information about a topic, its major disadvantage is that there is no way of knowing if the group is representative of the population as a whole.

- Although methods were used to encourage a random sample (fliers posted throughout the community, newspaper ads, etc), the respondents were generally referred to the survey through a convenience sampling method.
- Literacy: There may have been differences in understanding survey items based on the literacy levels of respondents. Although survey administrators routinely offered to discretely assist respondents with literacy problems, some respondents may not have asked for assistance due to embarrassment.

PROVIDER SURVEY

A detailed provider survey was developed in order to evaluate services delivered to PLWHA throughout the EMA/HSDA, and develop a Resource Inventory.

Survey Design and Sample

The Provider Survey was developed and approved by the Resource Inventory Workgroup. A prevention component of the survey was developed in collaboration with the Houston Department of Health & Human Services HIV/STD Prevention Bureau.

In order to achieve objectives outlined by the Health Resources and Services Administration (HRSA) and the workgroup, questions on the provider survey addressed the following areas: types of services provided, funding streams, staffing levels, barriers to providing care to PLWHA, number of clients served, multilingual staff and ability to refer clients to services.

The Planning Council's Office of Support mailed the provider survey to agencies listed in the *Blue Book*, the Houston area HIV resource directory, and other referred health and social service providers. Included in the mailed packet was a letter of explanation signed by the co-chairs of the Needs Assessment Group and a stamped envelope addressed to the Planning Council Office of Support. Service providers were also allowed to fax in completed surveys. Soon after the mailing, workgroup members made follow-up phone calls to select providers with whom they had an existing relationship. Forty-eight surveys were returned as a result of these efforts. All returned surveys were entered into SPSS 12.0.

Survey Limitations

Limitations associated with the Provider Survey include, but are not limited to, the following:

- Based upon comments indicated on returned surveys, the perception of a focus exclusively on services for PLWHA appeared to discourage full completion of the survey by non-HIV specific providers.
- Clear explanations of each service category was not included on the survey, thus some respondents may have indicated providing a service that does not adhere to HRSA service definitions.

Responses relating to agency barriers (i.e., waiting time for appointment, funded services, etc.) were not specific to service categories, but rather in regards to servicing PLWHA. Therefore, no conclusions can be determined regarding barriers to providing the specific services, but rather just broadly to PLWHA.

RESOURCE INVENTORY

In accordance with HRSA requirements, information collected from provider surveys were analyzed to produce a resource inventory. At a minimum, the inventory should include information about HIV services in the EMA/HSDA and other supportive and ancillary services that, though not HIV-specific, are likely to be utilized by PLWHA.

Methodology

Information collected from the provider surveys were paired with the *Blue Book*, the Houston area HIV resource directory, to supplement information on the 48 returned provider surveys. In an effort to adhere to HRSA's resource inventory model, a table was developed to present the information in a user-friendly format. Information on funding sources were extracted from the provider surveys and added to the table to provide a more accurate understanding of area resources.

Limitations

It is important to understand certain limitations in this inventory when utilizing this information. Though the table includes information on non-HIV specific services that are needed among PLWHA, this inventory does not reflect any agency processes that may discourage clients from accessing the services. In addition, it does not provide an indication of each agency's capacity to effectively serve PLWHA. Thus, it can only be concluded that the services reflected in the inventory are available to clients in the EMA/HSDA, but other unknown accessibility factors need to be considered when utilizing this information.

PREVENTION ITEMS

Methodology

Prevention items included on the Needs Assessment survey were recommended by the HDHHS staff, according to the definition of risk for HIV transmission developed by the CDC. These questions focused on behaviors that might lead a person living with HIV to transmit their infection or to be re-infected with HIV, which can complicate treatment options, therefore jeopardizing the well-being of that person.

These items were then reviewed by the Needs Assessment Group (NAG) to assure that the questions were tailored for and appropriate to people living with HIV and AIDS.

Limitations

A limitation of risk assessment questionnaires in general is that risk behaviors are self-reported. Stigma around many behavioral risks (drug use, sexual activity, etc) for HIV transmission and re-infection may lead an interviewee to avoid self-reporting of these behaviors. Although anonymity was assured to all interviewees, the face-to-face interview format may have further discouraged interviewees from answering questions about risk behaviors honestly.

GAPS ANALYSIS

The Gaps Analysis portion of the report addresses types of barriers reported most often by survey respondents, barriers reported most often by providers, services with the highest number of barriers, maps generated from survey data and a brief description of overall themes.

Findings by Population

ALL RESPONDENTS

Overview

There were 764 total respondents to the 2008 Need Assessment consumer survey. This total represents 4.21% of the 18,109 living HIV/AIDS cases in the Houston HSDA during 2006.

Demographics

TABLE 1.1: GENDER, PREGNANCY STATUS AND AGE, TOTAL SAMPLE VS. 2005 HSDA PREVALENCE

	Total 764 Respondents		HSDA HIV/AIDS	
	N	%	N	%
Gender				
Male	507	66%	13,352	74%
Female	238	31%	4,757	26%
Transgender – Male to Female	19	2%	--*	--
Pregnant				
Yes	15	6%		
Don't Know	9	4%		
Age Range = 18 to 73; Avg = 43				
18-24	37	4%	812**	4%
25-44	363	48%	10,171	56%
45+	364	48%	6,974	39%

* Transgender prevalence data are not available.
** Surveillance data reports this age category as 13-24.
*** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of consumer survey respondents were men (66%). Women represented 31% of all respondents, and transgender Male to Female represented 2%. None of the respondents identified as transgender Female to Male.

Among women, 6% said they were pregnant at the time of the survey, and 4% said they did not know their pregnancy status.

The average age of respondents was 43 years, ranging from 18 to 73. Virtually all respondents were above the age of 25; approximately 48% of all respondents were between the ages of 25-44, and another 48% were above the age of 45. Only 4% were youth between the ages of 18 and 24.

TABLE 1.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, TOTAL SAMPLE

Race/Ethnicity	N	%
White/Anglo	174	23%
Black/African-American	429	56%
Hispanic/Latino	141	18%
Asian	5	1%
Native American	6	1%
Multiracial	9	1%

Sexual Orientation	N	%
Straight/Heterosexual	417	55%
Gay/Lesbian	241	32%
Bisexual	62	8%
Undecided	11	1%
Prefer not to say	31	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half of all respondents identified as Black/African-American (56%). Twenty-three percent identified as White, 18% as Hispanic/Latino, and 3% as Asian, Native American or multi-racial. The race distribution of respondents resembles the 2006 HIV/AIDS prevalence for the Houston HSDA, where 48% of cases were among Blacks/African-Americans, 31% among whites, 19% among Latinos and 1% among Others.

Just over half (55%) of all respondents identified as straight or heterosexual. About a third (32%) identified as gay/lesbian, 8% as bisexual and 1% as undecided. Four percent said they preferred not to disclose their sexual orientation.

TABLE 1.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, TOTAL SAMPLE

Education	N	%
Less than high school	145	19%
High school degree/GED	444	58%
College degree	111	15%
Graduate/Professional degree	19	2%
Some technical training	42	5%
None	2	0%
During the past year, have you been released from jail or prison?		
Yes	119	16%
Are you eligible for veteran benefits?		
Yes	39	5%
No	677	89%
Don't Know	48	6%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than three-quarters (77%) of respondents had a high school degree/GED or less. Fifteen percent had a college degree, 2% had a graduate/professional degree and 5% had some technical training. Only 2 respondents reported receiving no education.

A total of 119 (16%) of all survey respondents reported being released from jail or prison during the previous year.

PLWHA eligible for veteran benefits represented 5% of all respondents.

Immigration Status & Primary Language

TABLE 1.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, TOTAL SAMPLE

	N	%
Born outside US	94	12%
Length of residency Range = 2 to 47 yrs; Avg = 18 yrs		
Immigration status	**N**	**%**
Citizen	694	91%
Permanent Resident	15	2%
Visa	9	1%
Undocumented	46	6%

** Percentages may not add up to 100% due to rounding or missing survey responses.

As a whole, most consumer survey respondents were born in the US. Foreign born respondents represented 12% all respondents. Among the foreign born, lengths of residency in the US ranged from 2 to 47 years with an average residency of 18 years.

Among all 764 respondents, the vast majority (91%) were US citizens. Two percent were permanent residents, 1% visa holder and 6% were undocumented.

TABLE 1.5: PREFERRED LANGUAGE, TOTAL SAMPLE

Preferred language at home with family/friends	**N**	**%**
English	669	88%
Spanish	63	8%
English/Spanish	23	3%
Other	3	0%
Preferred language when seeing a doctor	**N**	**%**
English	690	90%
Spanish	65	9%
English/Spanish	7	1%
Other	2	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by consumer survey respondents. Approximately 88% said they were most comfortable speaking English at home with family/friends, and 90% said they were most comfortable speaking English with their doctor. Between 8% and 9% were most comfortable speaking Spanish and 1% to 3% preferred a combination of English and Spanish.

Job Status & Income

TABLE 1.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, TOTAL SAMPLE

Job status	N	%
Full time	75	10%
Part time	67	9%
Temporary/contract/odd jobs	45	6%
Not working due to disability	295	39%
Unemployed	258	34%
Retired	22	3%
Average monthly income during past 6 months	Range = $0 to $7,000; Avg = $662.72	
Approximate yearly income	Range = $0 to $84,000; Avg = $7,952.69	
Approximate yearly income	**N**	**%**
Up to 300% Federal Poverty Level (2007 – 2008)	745	98%
Up to 200% Federal Poverty Level (2007 – 2008)	729	95%
Up to 100% Federal Poverty Level (2007 – 2008)	610	80%
Total income dependents	Range = 1 to 9	Avg = 1.5
Income dependents under 18	Range = 0 to 6	Avg =.6

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately three-quarters (76%) of all respondents were unemployed at the time of the survey; 34% were unemployed, 39% were not working due to disability, and 3% were retired. Ten percent were working full-time, 9% part-time and 6% had temporary/contract/ odd jobs.

Per-month incomes ranged from $0 to $7,000, with an average of $662.72 per month. Yearly incomes were calculated as ranging from $0 to $84,000, for an average of $7,952.69 per year. The number of dependents per income ranged from 1 to 9 (average 1.5), with an average of .6 being under the age of 18. Based on estimated yearly incomes and household sizes, at least 80% of all respondents fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 1.7: SOURCES OF INCOME ASSISTANCE TOTAL SAMPLE

Sources of income assistance	N	%
None	186	24%
Hourly wages/Salary	65	9%
SSI	194	25%
SSDI	169	22%
Social Security	82	11%
TANF/AFDC	15	2%
Food Stamps	161	21%
Rental Subsidy/Section 8	45	6%
Workers Comp	0	0%
Unemployment	10	1%
Private Disability	11	1%
VA Benefits	9	1%
Child support	3	0%
Family/friends	12	2%
Pension/Retirement/Savings	5	1%
Other	3	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among all survey respondents were Supplemental Security Income (SSI) (25%), Social Security Disability Insurance (SSDI) (22%) and food stamps (21%). No survey respondents received worker's compensation.

Almost a quarter (24%) of all respondents reported no source of income.

Paying for Medical Care

TABLE 1.8: SOURCES OF PAYMENT FOR MEDICAL CARE, TOTAL SAMPLE

Paying for medical care	N	%
I don't receive medical care because I can't pay for it	42	5%
Private insurance/COBRA	23	3%
VA	25	3%
Medicaid	254	33%
Medicare	173	23%
Self-Pay	33	4%
Gold Card/County	246	32%
Ryan White/ADAP	87	11%
Other (MHMRA)	9	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Medicaid (33%), the Gold Card (32%) and Medicare (23%) were the most common methods of paying for medical care. Eleven percent of all respondents reported Ryan White/ADAP and 3% reported the Veteran's Administration Hospital. Five percent of respondents said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 1.9: LENGTH OF HIV DIAGNOSIS, TOTAL SAMPLE

Length of diagnosis Avg = 10.3 years	N	%
Less than 1 year	27	4%
1-4 years	213	28%
5-10 years	176	23%
11-15 years	167	22%
16-20 years	116	15%
21 and over	61	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Respondents reported being diagnosed as HIV positive an average of 10.3 years, ranging from 5 months to 22.5 years.

TABLE 1.10: LOCATION OF HIV DIAGNOSIS, TOTAL SAMPLE

Location of diagnosis	N	%
Private doctor	122	16%
ER	75	10%
In hospital stay	119	16%
HIV-specific testing site	69	9%
Public or community clinic	194	25%
Jail/Prison	94	12%
Community testing location	51	7%
Alcohol or drug treatment facility	24	3%
Blood/Plasma donation	2	0%
Work/insurance related	6	1%
Other	7	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A quarter (25%) of respondents received their diagnoses at a public or community clinic. Other common diagnosis locations for overall respondents were private doctor's offices (16%), during inpatient hospitalization (16%), emergency room visits (10%) and jail or prison (12%). Less frequently identified locations included HIV-specific testing sites (9%), community testing locations (bars, health fairs, events) (7%), alcohol/drug treatment facilities (3%), military recruitment offices (1%) and blood/plasma donation centers (<1%).

TABLE 1.11: REASONS FOR HIV TESTING, TOTAL SAMPLE

Reasons for testing	N	%
Recommended by provider	104	14%
Had sex with someone HIV+	132	17%
ER/Hospital stay	131	17%
Felt sick	208	27%
Engaged in risky behavior	172	23%
Was in prison/jail	69	9%
During pregnancy care	29	4%
Routine check up/testing	55	7%
Blood/plasma donation	14	2%
Work/insurance related	10	1%
Partner notification	2	0%
Knew someone with HIV	6	1%
Rape survivor	2	0%
Incentive offered	2	0%
In drug treatment program	5	1%
Recommended by friends	2	0%
Other	10	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were because respondents "felt sick" (27%) and because they "engaged in risky behavior" (23%). Other common reasons included "had sex with someone HIV+" (17%), during hospitalization or emergency room treatment (17%), or because the test was recommended by a physician or other service provider (14%). Less frequent reasons were incarceration (9%), routine check-up (7%), during prenatal care (4%), work or insurance requirements (1%), knowing someone with HIV (1%), partner notification (<1%), victim of rape (<1%) or because there was a financial incentive offered with the test (<1%).

TABLE 1.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, TOTAL SAMPLE

Assistance at diagnosis	N	%
Information about HIV/AIDS	405	53%
Medical services	376	49%
Counseling	265	35%
Help with food or shelter	98	13%
Alcohol or drug treatment services	68	9%
Supportive Services	7	1%
Other	4	1%
None	196	26%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis were information about HIV/AIDS (53%), assistance with medical services (49%) and counseling (35%). Less frequently reported were help with food or shelter (13%), alcohol or drug treatment services (9%), and information on non-medical supportive services (1%). A total of 196 (26%) of all respondents reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 1.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, TOTAL SAMPLE

Time to first doctor visit	N	%
Less than 1 month	373	49%
1-6 months	180	24%
6-12 months	77	10%
More than 12 months	117	15%
Never	16	2%

Time to CD4/Viral Load	N	%
Less than 1 month	298	39%
1-6 months	223	29%
6-12 months	74	10%
More than 12 months	142	19%
Never	24	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Almost half (49%) of all respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 24% of respondents, 1 to 6 months passed before seeing a doctor. Ten percent waited between 6 to 12 months, and 15% waited more than a year to see a doctor for HIV. A total of 16 (2%) of all respondents said they still had not

seen a doctor for HIV. Likewise, 39% reported receiving their first CD4/viral load test within one month of being diagnosed, 29% within 1-6 months, 10% between 6-12 months and 19% waited more than a year. A total of 24 (3%) said they had never received a CD4 or viral load test.

TABLE 1.14: REASONS FOR DELAYED ENTRY INTO CARE, TOTAL SAMPLE

Reasons for waiting more than 6 months	N	%
Afraid	103	13%
Didn't feel sick	82	11%
Jail/prison	34	4%
Doing drugs	52	7%
Denial	95	12%
Didn't want to take meds	49	6%
No money	38	5%
Depressed/emotional problems	81	11%
No stable place to live	44	6%
Other	19	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were fear (13%), denial (12%), depression/emotional problems (11%) and didn't feel sick (11%). Other reasons were drug use (7%), no desire to take medications (6%), lack of stable place to live (6%), no money (5%), incarceration (4%), or other reasons (2%) such as family obligations or lack of information.

Maintenance in Care

TABLE 1.15: TIME SINCE LAST VISIT TO DOCTOR & VIRAL LOAD & CD4 & HIV MEDICATION PRESCRIPTION, TOTAL SAMPLE

Last visit to doctor for HIV	N	%
Less than 6 months	635	83%
6-12 months	50	7%
More than 12 months	60	8%
Never/Don't Know	16	2%
Last viral load	**N**	**%**
Less than 6 months	617	81%
6-12 months	52	7%
More than 12 months	61	8%
Never/Don't Know	33	4%

Last CD4	N	%
Less than 6 months	624	82%
6-12 months	51	7%
More than 12 months	57	7%
Never/Don't Know	31	4%
Last HIV meds prescription	**N**	**%**
Less than 6 months	499	65%
6-12 months	55	7%
More than 12 months	89	12%
Never/Don't Know	117	15%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of respondents said their most recent doctor's visit (83%), viral load (81%), CD4 test (82%) and HIV medication prescription (65%) were within the past 6 months.

TABLE 1.16: FREQUENCY OF DOCTOR'S VISITS, TOTAL SAMPLE

No doctor visits more than 6 months?	N	%
Yes	322	42%
No	434	57%
No doctor visits more than 12 months?	**N**	**%**
Yes	188	25%
No	537	70%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among respondents who have seen a doctor for HIV, 42% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 25% reported not seeing a doctor for 12 months or more.

TABLE 1.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, TOTAL SAMPLE

Reasons for no doctor visits	N	%
Case manager left	12	2%
Doctor left	18	2%
Agency closed down	5	1%
Doing drugs	104	14%
Program closed down	6	1%
Did not want to take meds	92	12%
Bad experience with provider	33	4%
Lost stable housing	75	10%
Lost my job	39	5%
Lost health insurance	26	3%
Tired of regimen	65	9%
Felt fine	84	11%
Worried about side effects	55	7%
Denial	64	8%
Jail/prison	13	2%
No transportation	11	1%
Depression/emotional barriers	5	1%
Had to care for children/family member	4	1%
Other	22	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for falling out of care were drug use (14%), no desire to take medications (12%), didn't feel sick (11%) and loss of stable housing (10%).

TABLE 1.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, TOTAL SAMPLE

First place of care	N	%	Most often location of care	N	%
Private Clinic/Doctor's Office	158	21%	Private Clinic/Doctor's Office	174	23%
Public clinic/community health center	418	55%	Public clinic/community health center	492	64%
Prison/jail	75	10%	Prison/jail	20	3%
VA Hospital	20	3%	VA Hospital	24	3%
ER/Hospital	75	10%	ER/Hospital	28	4%
I have not received care for	15	2%	I have not received care for	21	3%
Other	0	0%	Other	1	<1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was a public clinic or community health center (55%). Other locations were private clinic/doctor's office (21%), prison/jail (10%), an emergency room/hospital (10%), or the Veteran's Administration Hospital (3%).

Locations of ongoing care were mostly a public clinic or community health center (64%) or private clinic/doctor's office (23%). A total of 24 (3%) of all respondents received care most often from the Veteran's Administration Hospital. Prison/jail was the most common location of care for 3% of all respondents, and emergency rooms/hospitals were most common for 4% of respondents.

TABLE 1.19: KNOWLEDGE OF CASE MANAGER, TOTAL SAMPLE

Case Manager	N	%
Yes	546	71%
No	120	16%
Don't Know	95	12%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (71%) of respondents reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services. Sixteen percent said they did not have such a person assisting them, and 12% said they didn't know.

Health Status

TABLE 1.20: SELF-REPORTED HEALTH STATUS, TOTAL SAMPLE

How would you describe your health overall	N	%
Excellent	125	16%
Good	331	43%
Fair	244	32%
Poor	61	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 16% said "Excellent," 43% said "Good," 32% said "Fair" and 8% said "Poor."

TABLE 1.21: SELF-REPORTED PHYSICAL HEALTH STATUS & ER OR HOSPITAL VISITS, TOTAL SAMPLE

During the past month, has your physical health interfered with normal activities?	N	%
No	312	41%
Yes – Some of the time	380	50%
Yes – all of the time	64	8%
ER visit in past 6 months	241	32%
Hospital stay in past 6 months	169	22%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Half (50%) of all respondents reported that during the past month, their physical health had interfered with normal activities some of the time. Eight percent said their physical health interfered all of the time.

For the 6 months prior to the survey, 32% of all respondents reported an emergency room visit and 22% reported being admitted to a hospital for one or more nights.

TABLE 1.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, TOTAL SAMPLE

Symptoms during past month Range = 1 to 12; Avg = 5	N	%
Trouble with thinking, concentrating or memory	365	48%
Depressed or sad, trouble thinking	494	65%
Aches, fatigue, lightheadedness, weak all over	340	45%
Fevers, chills, sweats	214	28%
Poor appetite, weight loss	228	30%
Trouble with eyes or ears	269	35%
Trouble with nose or sinuses, headaches	269	35%
Trouble with mouth or swallowing	123	16%
Nausea, vomiting, diarrhea, abdominal pain	247	32%
Coughing, wheezing, or chest pain, trouble breathing	207	27%
Rash, itch, herpes, or other skin trouble	188	25%
Numbness, tingling or pain in an arm or leg	283	37%
Other	0	0%
None	82	11%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The number of symptoms reported by all respondents during the past month ranged from 1 to 12, with an average of 5. The top three reported symptoms were feeling depressed or sad/trouble sleeping (65%), trouble with thinking, concentrating or memory (48%) and aches/fatigue/lightheadedness/weak all over (45%).

TABLE 1.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, TOTAL SAMPLE

First CD4/T-cell	N	%	Current CD4/T-cell	N	%
Less than 50	106	14%	Less than 50	48	6%
50-99	32	4%	50-99	23	3%
100-199	64	8%	100-199	75	10%
200-349	121	16%	200-349	125	16%
350-499	109	14%	350-499	132	17%
500+	141	18%	500+	159	21%
Don't Know/Can't Remember	187	24%	Don't Know/Can't Remember	199	26%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of 141 (18%) of all respondents reported their first CD4/T-cell counts as 500+; 30% were 200 to 499, 12% were 50 to 199, and 14% were less than 50. Current CD4/T-cell counts were 500+ for 21% of all respondents; 200 to 499 for 33%, 50 to 199 for 13%, and less than 50 for 6% of respondents. Almost a quarter (24%) didn't know or couldn't remember their first CD4/T-cell count, and 26% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 1.24: HIV MEDICATIONS, TOTAL SAMPLE

Currently taking HIV meds	N	%
Yes	548	72%
No	213	28%
How many pills do you take in one day?	Avg = 5	

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of all survey respondents (72%) said they were currently taking HIV medications. The number of pills taken in one day ranged from 1 to 28, with an average of 5 pills per day.

TABLE 1.25: SELF-REPORTED MEDICATION ADHERENCE, TOTAL SAMPLE

Medication adherence	N	%
I have not missed any doses in the past month	283	37%
Missed a few, but took nearly all	216	28%
Took more than half	20	3%
About half	19	2%
Some, but not half	25	3%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	496	65%
No	203	27%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among respondents currently taking HIV medications, 37% reported perfect adherence and 28% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 65% said "Yes" and 27% said "No."

TABLE 1.26: REASONS FOR NOT TAKING HIV MEDICATIONS, TOTAL SAMPLE

Reasons for not taking HIV medications	N	%
Side effects	27	4%
Not effective	9	1%
Too difficult to take as prescribed	10	1%
No doctor has offered them	18	2%
I choose not to take them	49	6%
Doctor did not think it was a good idea for me	37	5%
T-cell too high	74	10%
Cannot pay	16	2%
Confidentiality concerns	16	2%
Didn't feel sick	5	1%
Have not seen doctor	14	2%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "T-cell count too high" (10%) followed by "I choose not to take them" (6%), "doctor did not think it was a good idea for me" (5%) and "too many unpleasant side effects" (4%).

TABLE 1.27: MEDICATIONS FOR NON-HIV CONDITIONS, TOTAL SAMPLE

How many pills do you take in one day for non-HIV conditions? (Avg = 4)	N	%
Diabetes	69	9%
High blood pressure	218	29%
High cholesterol	107	14%
Depression/emotional problems	309	40%
Eye drops/glaucoma	5	1%
Acid reflux	30	4%
Anemia	4	1%
Sleep	18	2%
Allergies/Sinus	11	1%
Pain	26	3%
Antibiotics	8	1%
Arthritis	9	1%
Asthma	9	1%
Neuropathy	15	2%
Nausea	0	0%
Hormones	5	1%
Other	18	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, respondents took an average of 4 non-HIV pills per day. The most common conditions associated with the non-HIV pills were depression/emotional problems (40%), high blood pressure (29%), high cholesterol (14%) and diabetes (9%).

TABLE 1.28: TOTAL PILL BURDEN AND ABILITY TO PAY, TOTAL SAMPLE

Total Pills (HIV + non-HIV) Avg = 4		
How often do you have trouble paying for these or other non-HIV meds?	**N**	**%**
Never	439	57%
Less than half the time	99	13%
More than half the time	61	8%
Always	112	15%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was 4.

More than half (57%) of all respondents reported never having problems paying for HIV or non-HIV medications, and 13% had problems less than half the time. Eight percent had problems more than half the time, and 15% said they always had problems paying for their medications.

Comorbidities

TABLE 1.29: HEPATITIS C AND TB STATUS, TOTAL SAMPLE

Hep C Test?	N	%
Yes	603	79%
No	113	15%
Don't Know	47	6%
Positive for Hep C?	**N**	**%**
Yes	191	25%
No	491	64%
Don't know	79	10%

TB skin test?	N	%
Yes	695	91%
No	61	8%
Result	**N**	**%**
Positive	113	15%
Negative	536	70%
Don't Know	25	3%
History of active TB?	**N**	**%**
Yes	104	14%
No	643	84%
Don't Know	14	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (79%) of all respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 25% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C. test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

Almost all (91%) respondents had received a skin test for TB, and 15% reported a positive result. A total of 104 (14%) reported a history of active TB.

Mental Health

TABLE 1.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, TOTAL SAMPLE

	N	%
At least one mental health condition	452	59%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	334	44%
Hallucinations	79	10%
Serious thoughts of suicide	88	12%
Attempted suicide	25	3%
Wanted to hurt or harm yourself	76	10%
Wanted to hurt or harm someone else	74	10%
Trouble controlling anger leading to physical violence	126	16%
Problems requiring meds	213	28%
None	294	38%
At least one serious indicator (suicide/homicidal or requiring meds)	217	28%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (59%) of all respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced symptoms were serious anxiety/tension (44%), problems requiring medications (28%) trouble controlling anger leading to physical violence (16%) and serious thoughts of suicide (12%).

TABLE 1.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, TOTAL SAMPLE

Since being diagnosed, ever talked with therapist?	**N**	**%**
Yes	522	68%
No	240	31%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	497	65%
No	265	35%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	432	57%
No	326	43%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 68% of respondents said they had talked with a therapist or psychologist for help with depression or emotional problems and 65% had talked to a doctor or psychiatrist for medications. More than half (57%) said they had participated in a support group since being diagnosed with HIV.

Substance Use & Abuse

TABLE 1.32: SUBSTANCE USE, TOTAL SAMPLE

Total Number of substances Range = 1 to 12; Avg = 2	N	%
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	35	5%
Street Methadone (non-treatment)	10	1%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	29	4%
Barbituates (seconal, tuinal, downers)	11	1%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	38	5%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	6	1%
Amphetamines (speed, uppers, crystal meth, ice, glass)	30	4%
Marijuana, Hashish (grass, weed)	174	23%
Heroin	11	1%
Cocaine (powder), Crack	206	27%
Ecstasy, X, MDA, GHB	25	3%
Ketamine (K, Special K)	7	1%
None	421	55%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, 45% of respondents reported using at least one substance during the past year. The numbers of substances ranged from 1 to 12, with an average of 2. The most commonly used substances for all respondents were cocaine (27%) and marijuana (23%).

TABLE 1.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, TOTAL SAMPLE

In the last year, ever drunk more than meant to?	N	%
Yes	233	30%
No	529	69%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	236	31%
No	516	68%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	199	26%
No	562	74%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	239	31%
No	515	67%
Indicator of Alcohol Abuse	292	38%
Indicator of Substance Abuse	248	32%
Abuse of both drugs and alcohol	167	22%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 38% of all respondents indicated possible alcohol abuse, and 32% indicated possible substance abuse. A total of 167 (22%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 1.34: SOCIAL SUPPORT, TOTAL SAMPLE

Of all the people you feel close to, how many have you told about being HIV+?	N	%
All	255	33%
Some	418	55%
None	88	12%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	604	79%
No	156	20%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 33% had disclosed their HIV status to all and 55% had disclosed their status to some. A total of 88 (12%) had not told their HIV status to any of the people to whom they feel close. Overall, 79% of respondents said there were people they could depend on for help if really needed; however, only 45% of those who had told their HIV status to no one said they had people to depend on.

Housing

TABLE 1.35: HOUSING STATUS, TOTAL SAMPLE

Where do you most often sleep?	N	%
Apartment/House	585	77%
Group home/halfway house	86	11%
Shelter	46	6%
Street	43	6%
Other	4	1%
Do you feel your housing situation is stable?	**N**	**%**
Yes	487	64%
No	277	36%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of respondents (77%) reported sleeping most often in an apartment/

house. Others reported group home/halfway house (11%), shelter (6%), street (6%) and other (1%) locations such as with family/friends. More than half (64%) of all respondents felt their housing situation was stable, and 36% felt their housing situation was unstable.

TABLE 1.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, TOTAL SAMPLE

In the past year, has your housing situation made it difficult to get HIV care?	N	%
Yes	204	27%
No	558	73%
Reasons	**N**	**%**
I could not keep my status private	49	6%
No place to store meds	53	7%
Money for food	107	14%
Money for rent	112	15%
Money for utilities	84	11%
Money for household supplies	92	12%
No stable address	8	1%
Used money on drugs	1	0%
Rules	3	0%
Lack of transportation	3	0%
No child care	3	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of 204 (27%) respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The most common reasons for these difficulties were the need to spend money on rent (15%), food (14%), household supplies (12%) or utilities (11%) rather than HIV-related care. Other reasons were not having a place to store medications (7%) and being unable to keep their HIV status private (6%).

ACCESS TO CORE SERVICES

TABLE 1.37: ACCESS TO CORE SERVICES, TOTAL SAMPLE

Core Services	In the past 12 months...					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	173	23%	550	72%	41	5%
HIV/AIDS Medications	164	21%	487	64%	113	15%
Dentist Visits	246	32%	380	50%	138	18%
Medical Case Management	134	18%	438	57%	192	25%
Home Health Care	75	10%	122	16%	567	74%
Psychiatric Services or Medicine	102	13%	338	44%	324	42%
Psychological Counseling	87	11%	350	46%	327	43%
Substance Abuse Treatment	57	7%	213	28%	494	65%
Rehabilitation Services	58	8%	167	22%	539	71%

** Percentages may not add up to 100% due to rounding or missing survey responses.

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For all respondents, the top three “easy to get” core services were primary medical care (72%), HIV/AIDS medications (64%) and medical case management (57%). The top three core services that respondents reported “some difficulty getting” were dentist visits (32%), primary medical care (23%) and HIV/AIDS medications (21%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that respondents said they “did not need” in the past year were home health care (74%), rehabilitation services (71%) and substance abuse treatment (65%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 1.38: ACCESS TO SUPPORTIVE SERVICES, TOTAL SAMPLE

Supportive Services	In the past 12 months...					
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service	%*
Child Care Services	35	64%	9	16%	11	20%
Child Welfare Services	6	46%	3	23%	4	31%
Day/Respite Care for Adults	9	30%	10	33%	11	37%
Developmental	5	63%	1	13%	2	25%
Emergency Financial Assistance	244	64%	104	27%	35	9%
Employment Assistance	130	74%	25	14%	21	12%
Food Bank	122	31%	247	64%	19	5%
HIV Education for HIV+ Individuals	36	22%	117	71%	11	7%
Rental Assistance/Shelter Vouchers	172	63%	82	30%	18	7%
Housing-Related Services	170	64%	71	27%	24	9%
Legal Services	75	44%	64	38%	31	18%
Nutritional Counseling	48	31%	98	64%	7	5%
Permanency Planning	19	53%	9	25%	8	22%
Referrals to Services	53	38%	78	56%	9	6%
Referrals to Clinical Research	37	49%	31	41%	8	11%
Support Groups	75	40%	94	50%	18	10%
Translation/Interpretation	7	13%	44	83%	2	4%
Transportation	139	47%	145	49%	13	4%
Household Items	95	67%	40	28%	7	5%

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For all respondents, the supportive services that were selected most often (thus implying high helpfulness/usefulness) by respondents were food bank, emergency financial assistance, transportation, rental assistance and housing-related services.

The top five “easy to get” supportive services (based on number of responses) were food bank (n=247), transportation (n=145), HIV education for HIV+ individuals (n=117),

emergency financial assistance (n=104) and nutritional counseling (n=98). The top five supportive services that respondents reported "some difficulty getting" were emergency financial assistance (n=244), rental assistance/shelter vouchers (n=172), housing-related services (n=170), transportation (n=139) and employment assistance (n=130).

The presence of certain support services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates. Conversely, the five supportive services that respondents did not need in the past year, but still identified as useful/helpful were emergency financial assistance (n=35), legal services (n=31), housing-related services (n=24), employment assistance (n=21) and food bank (n=19). ["n=*value*" indicates the number of responses for each service category.]

Barriers Reported per Core Service Category

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The table on the following page shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. For example, the first cell in the row for primary medical care shows that barrier A ("The services are not in my area") was listed as a barrier 25 times for primary medical care. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

TABLE 1.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, TOTAL SAMPLE

Core Services	Barriers																					
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	Total
Primary Medical Care	25	31	**41**	24	8	9	31	**53**	**53**	8	20	3	8	10	0	1	4	3	0	0	0	**332**
HIV/AIDS Medications	16	**27**	**44**	**48**	17	13	22	19	23	7	10	5	4	7	0	1	4	1	1	0	0	**269**
Dentist Visits	33	**58**	**74**	26	15	17	27	**87**	43	6	10	0	5	24	0	0	1	4	1	0	0	**431**
Medical Case Management	19	**34**	**29**	10	10	8	**29**	**33**	16	2	9	1	7	1	0	2	0	2	0	7	0	**219**
Home Health Care	7	**21**	8	7	**13**	**12**	8	8	7	1	4	1	3	0	0	0	1	1	7	0	0	**109**
Psychiatric Services or Medicine	15	**23**	**30**	20	13	7	20	**31**	21	4	7	1	1	0	0	0	3	0	0	0	0	**196**
Psychological Counseling	12	25	17	18	7	11	11	25	19	3	6	0	1	0	1	0	4	1	0	0	0	**161**
Substance Abuse Treatment	9	**15**	**11**	8	6	6	9	7	**12**	4	6	1	6	0	0	0	0	2	1	0	0	**103**
Rehabilitation Services	9	**21**	7	7	9	7	5	**12**	**12**	1	6	1	0	0	0	0	0	1	0	0	1	**99**
Total	**145**	**255**	**261**	**168**	**98**	**90**	**162**	**275**	**206**	**36**	**78**	**13**	**35**	**42**	**1**	**4**	**17**	**15**	**10**	**7**	**1**	**1,919**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Among all respondents, the three core services with the highest number of barriers were dentist visits (n=431), primary medical care (n=332) and HIV/AIDS medications (n=269). Within dentist visits, the most commonly reported barriers were "It's hard to make or keep appointments" (n=87), "I would have to wait too long to get the services" (n=74), and "I don't know where to get the services" (n=58). For primary medical care, the most common barriers for all respondents were "It's hard to make or keep appointments" (n=53), "It's hard for me to get there" (n=53), and "I would have to wait too long to get the services" (n=41). For HIV/AIDS medications, the most common barriers for all respondents were "The services cost too much" (n=48), "I would have to wait too long to get the services" (n=44) and "I don't know where to get the services" (n=27).

The barriers experienced most often by all respondents across all core services were "It's hard to make or keep appointments" (n=275), "I would have to wait too long to get the services" (n=261) and "I don't know where to get the services" (n=255).

Barriers Reported per Supportive Service Category

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The table on the following page shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among all respondents, the five supportive services with the highest number of barriers were emergency financial assistance (n=455), housing-related services (n=312), rental assistance/shelter vouchers (n=290), transportation (n=231) and employment assistance (n=201). Within emergency financial assistance, the most commonly reported barriers were "I would have to wait too long to get the services" (n=80), "I don't know where to get the services" (n=78) and "I was told I am not eligible for this service" (n=66). For both housing-related services and rental assistance/shelter vouchers, the most common barriers for all respondents were "I don't know where to get the services" (n=67) and "I would have to wait too long to get the services" (n=55). For transportation, the most common barriers for all respondents were "I don't know where to get the services" (n=49) and "The services are not in my area" (n=31).

The barriers experienced most often by all respondents across all supportive services were "I don't know where to get the services" (n=599), "I would have to wait too long to get the service" (n=319) and "The services are not in my area" (n=244). ["n=*value*" indicates the number of responses for each service category.]

TABLE 1.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, TOTAL SAMPLE

Supportive Services	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Child Care Services	**9**	**16**	6	**7**	3	4	1	2	6	4	1	1	0	0	0	0	0	0	0	0	1	0	**61**
Child Welfare Services	1	**4**	1	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**9**
Day/Respite Care for Adults	2	**3**	1	0	1	0	2	1	1	2	2	0	0	0	0	0	1	0	0	0	0	0	**16**
Developmental Assessment	1	**3**	**3**	0	0	1	0	1	1	1	1	0	0	0	0	0	1	0	0	0	0	0	**13**
Emergency Financial Assistance	42	**78**	**80**	12	**66**	36	27	36	23	4	12	1	13	4	0	0	5	3	1	0	12	0	**455**
Employment Assistance	21	**62**	13	2	12	**18**	8	9	12	2	13	2	**23**	0	0	0	2	0	1	0	1	0	**201**
Food Bank	**26**	**37**	24	4	15	18	6	5	**32**	0	4	0	1	2	2	0	1	0	3	0	14	1	**195**
HIV Education for HIV+ Individuals	5	**18**	3	5	1	2	1	**7**	5	0	4	3	1	0	2	0	1	1	0	0	1	0	**60**
Rental Assistance/Shelter Vouchers	20	**51**	**47**	14	**28**	24	20	27	12	2	7	0	8	3	1	0	4	0	5	1	14	2	**290**
Housing-Related Services	30	**67**	**55**	15	**31**	22	13	16	16	4	7	1	21	1	0	0	0	1	5	0	7	0	**312**
Legal Services	8	**31**	**14**	8	8	4	8	**12**	5	0	3	5	4	2	0	1	1	0	0	1	1	0	**116**
Nutritional Counseling	5	21	7	3	3	4	4	10	6	0	2	2	0	1	0	0	0	0	0	0	0	0	**68**
Permanency Planning	2	**14**	**3**	**4**	1	2	1	1	2	0	2	0	0	0	0	0	0	1	0	0	0	0	**33**
Referrals to Services	8	**22**	**12**	4	2	5	**12**	7	7	1	2	1	0	2	0	0	0	0	2	1	0	0	**88**
Referrals to Clinical Research	**6**	**23**	5	1	**6**	**6**	0	3	5	0	1	0	0	0	0	0	0	0	0	0	0	0	**56**
Support Groups	**11**	**44**	5	2	2	7	2	7	**14**	2	4	1	1	0	0	0	1	1	1	0	4	0	**109**
Translation/Interpretation	0	**2**	1	0	0	0	0	1	0	0	0	**4**	0	0	0	0	0	0	0	0	0	0	**8**
Transportation	**31**	**49**	**24**	13	19	11	10	18	**24**	3	5	1	2	8	1	0	3	1	3	0	4	1	**231**
Household Items	**16**	**54**	**15**	9	10	11	6	5	8	1	4	0	1	0	0	0	1	1	0	0	0	0	**142**
Total	**244**	**599**	**319**	**104**	**208**	**175**	**121**	**168**	**180**	**27**	**74**	**22**	**75**	**23**	**6**	**1**	**21**	**9**	**21**	**3**	**59**	**4**	**2,463**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions

A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 1.41: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Total Respondents	
				N	%
Sex for Drugs/Money	56	461	9	526	7%
Anonymous Sex Partner(s)	141	352	N/A	493	18%
Greater than 5 Sex Partners	60	694	N/A	754	8%

The variables in the table above are used to assess very high risk for HIV infection (transmitting or reinfection). If a person fits one of these criteria, they are considered to be at very high risk. These variables are having exchanged sex for drugs or money in the past 6 months, having engaged in anonymous sex in the past six months and reporting more than 5 sex partners or needle sharing partners in the past 6 months[2]. The number of needle sharing partners in the past 6 months was not a variable that was collected in this survey.

For the overall sample, 56 (7%) respondents reported that they had exchanged sex for drugs or money in the past 6 months. One hundred forty-one (18%) respondents reported that they had engaged in anonymous sex with at least one partner. Of the 754 respondents, 60 (8%) reported having sex with more than five partners in the past 6 months.

TABLE 1.42: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION)

High Risk Variables	Yes	No	Prefer Not to Say[1]/Don't Know	Total Respondents	
				N	%
Unprotected Sex	235	282	N/A	517	31%
Shared Injecting Equipment	12	35	N/A	47	2%
Serodiscordant Sex Partner(s)	111	314	69	521	15%

Those at high risk for HIV infection include those who engaged in unprotected sex (vaginal or anal sex without a barrier), shared injecting equipment, or whose partner was not of the same HIV status (serodiscordant). Of the entire sample, 235 (31%) reported having had sex without a barrier in the past 6 months.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.
[2] From CDC "DEBI Interventions and CBO Program Announcement Definitions," April, 2004.

TABLE 1.43: SHARED INJECTION EQUIPMENT

Substance Injected	Respondents Who Shared Injection Equipment
Cocaine	5
Prescription Testosterone	1
Steroids	1
Multiple Substances ("steroids/v-6/meth")	1
Not Specified	4
Total	**12**

Forty-seven (6%) respondents reported that they had injected a substance (legal or illegal) in the past 6 months. Of those 47, 12 (2%) reported that they had shared injecting equipment in the past 6 months. Substances injected by those who shared injection equipment include cocaine (5), prescription testosterone (1), steroids (1), and multiple substances (1). Not everyone who shared injection equipment indicated what substance they were injecting. For the purposes of identifying risk of HIV transmission or reinfection, the most important thing to know is whether injection equipment is being shared. The substance being injected is important to know in order to target prevention activities to the activities in which people are practicing this risk behavior. Those sharing injection equipment are not exclusively injecting illegal drugs.

TABLE 1.44: HIV STATUS OF MAIN SEX PARTNER

What is the HIV status of your main sex partner?	Total Respondents	
	N	%
I do not have a main sex partner	122	16%
HIV positive	219	29 %
HIV negative	111	15%
I am not sure	51	7%
Prefer not to say	18	2%
No response	243	32%
In the last 6 months, how many people did you have sex with?	**N**	**%**
Zero	239	31%

HIV status of a person's main sex partner is important for two reasons. First, if the main sex partner is HIV-negative, there is a risk of transmitting HIV to the negative partner. Second, if the main sex partner is HIV-positive, there is a risk to both partners of re-infection. If a person is reinfected with HIV, the treatment regimen that they are on may cease to be effective. Regardless of the serostatus of a respondent's main sex partner, use of a barrier is an important strategy to protect the health of both partners.

The item used to measure serodiscordance is, “What is the HIV status of your main sex partner?.” One hundred twenty-two (16%) respondents reported that they do not have a main sex partner, 219 (29%) reported that their main sex partner was HIV-positive, 111 (15%) reported that their main sex partner was HIV-negative, 51 (7%) were unsure of their main sex partner’s serostatus and 18 (2%) preferred not to say.

Two hundred forty-three (32%) respondents did not respond to this question, which is nearly the number reporting zero sex partners in the past 6 months (239, 31%).

Findings by Population

In-Care Respondents

Overview

There were 687 total in-care respondents to the 2008 Need Assessment consumer survey. This total represents 90% of the total 764 respondents.

In-care respondents were defined as any respondents that had received a viral load test, CD4 count or prescription for HIV/AIDS medications within the 12 months prior to taking the survey.

Demographics

Table 2.1: Gender, pregnancy status and age, In care

Gender		**N**	**%**
Male		468	68%
Female		207	30%
Transgender – Male to Female		18	3%
Pregnant		**N**	**%**
Yes		12	6%
Don't Know		6	3%
Age	Range 18 to 73; Avg = 44	**N**	**%**
18-24		30	4%
25-44		323	47%
45+		334	49%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of in-care respondents were male (68%); women represented 30% of in-care respondents, and transgender Male to Female represented 3%. None of the respondents identified as transgender Female to Male.

Among women, 6% said they were pregnant at the time of the survey, and 3% said they did not know their pregnancy status.

The average age of respondents was 44 years, ranging from 18 to 73. Almost all (96%) in-care respondents were above the age of 25; 47% were between the ages of 25-44, and another 49% were above the age of 45. Thirty (4%) were youth between the ages of 18 and 24.

TABLE 2.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, IN CARE

Race/Ethnicity	N	%
White/Anglo	153	22%
Black/African-American	377	55%
Hispanic/Latino	138	20%
Asian	5	1%
Native American	5	1%
Multiracial	9	1%

Sexual Orientation	N	%
Straight/Heterosexual	364	53%
Gay/Lesbian	228	33%
Bisexual	57	8%
Undecided	8	1%
Prefer not to say	28	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (55%) of in-care respondents identified as Black/African-American; 22% identified as white/Anglo, 20% as Hispanic/Latino, and 3% as Asian, Native American or multi-racial.

More than half (53%) of in-care respondents identified as straight or heterosexual; 33% identified as gay/lesbian, 8% as bisexual and 1% undecided. Twenty-eight (4%) said they preferred not to disclose their sexual orientation.

TABLE 2.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, IN CARE

Education	N	%
Less than high school	126	18%
High school degree/GED	398	58%
College degree	104	15%
Graduate/Professional degree	18	3%
Some technical training	38	6%
None	2	0%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	102	15%
Are you eligible for veteran benefits?	**N**	**%**
Yes	35	5%
No	606	88%
Don't Know	46	7%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (76%) in-care respondents had a high school degree/GED or less; 15% had a college degree, 3% had a graduate/professional degree and 6% had some technical training. Two reported receiving no education.

A total of 102 (15%) of all survey respondents reported being released from jail or prison during the previous year.

PLWHA eligible for veteran benefits represented 5% of in-care respondents.

Immigration Status & Primary Language

TABLE 2.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, IN CARE

	N	%
Born outside US	91	13%
Length of residency Range = 2 to 47 yrs; Avg = 18 yrs		
Immigration status	**N**	**%**
Citizen	618	90%
Permanent Resident	14	2%
Visa	9	1%
Undocumented	46	7%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The foreign born represented 13% of in-care respondents. Lengths of residency in the US ranged from 2 to 47 years, with an average residency of 18 years.

Among in-care respondents, 90% were US citizens, 2% were permanent residents, 1% visa holders and 7% undocumented.

TABLE 2.5: PREFERRED LANGUAGE, IN CARE

Preferred language at home with family/friends	**N**	**%**
English	592	86%
Spanish	69	10%
English/Spanish	23	3%
Other	3	0%
Preferred language when seeing a doctor	**N**	**%**
English	613	89%
Spanish	65	9%
English/Spanish	7	1%
Other	2	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by in care consumer survey respondents - 86% said they were most comfortable speaking English at home with family/friends and 89% said they were most comfortable speaking English with their doctor. When seeing a doctor, 9% were most comfortable speaking Spanish and 1% preferred a combination of English and Spanish.

Job Status & Income

TABLE 2.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, IN CARE

Job status	N	%
Full time	71	10%
Part time	61	9%
Temporary/contract/odd jobs	40	6%
Not working due to disability	279	41%
Unemployed	212	31%
Retired	22	3%
Average monthly income during past 6 months	Avg = $677.37	
Approximate yearly income	Avg = $8,128.47	
Up to 300% Federal Poverty Level (2007 – 2008)	671	98%
Up to 200% Federal Poverty Level (2007 – 2008)	656	95%
Up to 100% Federal Poverty Level (2007 – 2008)	543	79%
Total income dependents	Range = 1 to 9; Avg = 1	
Income dependents under 18	Avg = .3	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (75%) in-care respondents were unemployed at the time of the survey; 31% were unemployed, 41% were not working due to disability and 3% were retired. Seventy-one (10%) were working full-time, 9% part-time and 6% had temporary/contract/odd jobs.

The highest reported monthly income was $7,000, with an average of $677.37 per month. The average yearly income was $8,128.47. The number of dependents per income ranged from 1 to 9, with an average of less than one (.3) being under the age of 18. Based on estimated yearly incomes and household sizes, 79% of in-care respondents fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 2.7: SOURCES OF INCOME ASSISTANCE, IN CARE

Sources of income assistance	N	%
None	157	23%
Hourly wages/Salary	54	8%
SSI	178	26%
SSDI	161	23%
Social Security	74	11%
TANF/AFDC	12	2%
Food Stamps	144	21%
Rental Subsidy/Section 8	44	6%
Workers Comp	0	0%
Unemployment	8	1%
Private Disability	11	2%
VA Benefits	9	1%
Child support	2	0%
Family/friends	12	2%
Pension/Retirement/Savings	5	1%
Other	3	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among in-care survey respondents were Supplemental Security Income (SSI) (26%), Social Security Disability Insurance (SSDI) (23%) and food stamps (21%). No survey respondents received worker's compensation.

One hundred fifty-seven (23%) in-care respondents reported no source of income.

Paying for Medical Care

TABLE 2.8: SOURCES OF PAYMENT FOR MEDICAL CARE, IN CARE

Paying for medical care	N	%
I don't receive medical care because I can't pay for it	16	2%
Private insurance/COBRA	20	3%
VA	24	3%
Medicaid	225	33%
Medicare	168	24%
Self-Pay	33	5%
Gold Card/County	229	33%
Ryan White/ADAP	87	13%
Other (MHMRA)	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Gold Card (33%), Medicaid (33%) and Medicare (24%) were the most common methods of paying for medical care; 13% of in-care respondents reported Ryan White/ ADAP and 3% reported the Veteran's Administration Hospital. Sixteen (2%) of in-care respondents said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 2.9: LENGTH OF HIV DIAGNOSIS, IN CARE

Length of diagnosis Range = 5 mos to 22.5 yrs; Avg = 11	N	%
Less than 1 year	22	3%
1-4 years	181	26%
5-10 years	158	23%
11-15 years	162	24%
16-20 years	103	15%
21 and over	58	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

In-care respondents reported being HIV positive an average of 11 years, ranging from 5 months to 22.5 years.

TABLE 2.10: LOCATION OF HIV DIAGNOSIS, IN CARE

Location of diagnosis	N	%
Private doctor	114	17%
ER	67	10%
In hospital stay	112	16%
HIV-specific testing site	63	9%
Public or community clinic	173	25%
Jail/Prison	82	12%
Community testing location	39	6%
Alcohol or drug treatment facility	22	3%
Blood/Plasma donation	2	0%
Work/insurance related	5	1%
Other	7	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A quarter (25%) of in-care respondents received their diagnoses at a public or community clinic. Other common diagnosis locations were private doctor's office (17%), during a hospital stay (16%) or jail/prison (12%).

TABLE 2.11: REASONS FOR HIV TESTING, IN CARE

Reasons for testing	N	%
Recommended by provider	98	14%
Had sex with someone HIV+	113	16%
ER/Hospital stay	118	17%
Felt sick	192	28%
Engaged in risky behavior	154	22%
Was in prison/jail	59	9%
During pregnancy care	23	3%
Routine check up/testing	52	8%
Blood/plasma donation	12	2%
Work/insurance related	10	1%
Partner notification	1	0%
Knew someone with HIV	4	1%
Rape survivor	2	0%
Incentive offered	1	0%
In drug treatment program	3	0%
Recommended by friends	1	0%
Other	5	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were feeling sick (28%) and engaged in risky behavior (22%).

TABLE 2.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, IN CARE

Assistance at diagnosis	N	%
Information about HIV/AIDS	371	54%
Medical services	355	52%
Counseling	249	36%
Help with food or shelter	95	14%
Alcohol or drug treatment services	63	9%
Supportive Services	5	1%
Other	5	1%
None	166	24%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to in-care respondents were information about HIV/AIDS (54%), medical services (52%) and counseling (36%). A total of 166 (24%) of in-care respondents reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 2.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, IN CARE

Time to first doctor visit	N	%
Less than 1 month	346	50%
1-6 months	165	24%
6-12 months	69	10%
More than 12 months	101	15%
Never	5	1%

Time to CD4/Viral Load	N	%
Less than 1 month	277	40%
1-6 months	209	30%
6-12 months	65	9%
More than 12 months	128	19%
Never	5	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Half (50%) of in-care respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 24% of in-care respondents, 1 to 6 months passed before seeing a doctor, 10% waited between 6 to 12 months and 15% waited more than a year to see a doctor for HIV. A total of 5 (1%) of in-care respondents said they still had not seen a doctor for HIV. Likewise, 40% reported receiving their first CD4/viral load test within one month of being diagnosed, 30% within 1-6 months, 9% between 6-12 months and 19% waited more than a year. A total of 5 (1%) said they had never received a CD4 or viral load test.

TABLE 2.14: REASONS FOR DELAYED ENTRY INTO CARE, IN CARE

Reasons for waiting more than 6 months	N	%
Afraid	81	12%
Didn't feel sick	68	10%
Jail/prison	31	5%
Doing drugs	42	6%
Denial	74	11%
Didn't want to take meds	41	6%
No money	30	4%
Depressed/emotional problems	68	10%
No stable place to live	34	5%
Other	5	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were fear (12%), denial (11%), didn't feel sick (10%) and depressed/emotional problems (10%).

Maintenance in Care

TABLE 2.15: TIME SINCE LAST VISIT TO DOCTOR & VIRAL LOAD & CD4 & HIV MEDICATION PRESCRIPTION, IN CARE

Last visit to doctor for HIV	N	%
Less than 6 months	628	91%
6-12 months	47	7%
More than 12 months	4	1%
Never/Don't Know	5	1%
Last viral load	**N**	**%**
Less than 6 months	617	90%
6-12 months	52	8%
More than 12 months	7	1%
Never/Don't Know	10	1%

Last CD4	N	%
Less than 6 months	624	91%
6-12 months	51	7%
More than 12 months	7	1%
Never/Don't Know	4	1%
Last HIV meds prescription	**N**	**%**
Less than 6 months	499	73%
6-12 months	55	8%
More than 12 months	50	7%
Never/Don't Know	79	11%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of in-care respondents said their most recent doctor's visit (91%), viral load (90%), CD4 test (91%) and HIV medication prescription (73%) were within the past 6 months.

TABLE 2.16: FREQUENCY OF DOCTOR'S VISITS, IN CARE

No doctor visits more than 6 months?	N	%
Yes	264	38%
No	421	61%
No doctor visits more than 12 months?	**N**	**%**
Yes	134	20%
No	523	76%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among in-care respondents who have seen a doctor for HIV, 38% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 20% reported not seeing a doctor for 12 months or more.

TABLE 2.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, IN CARE

Reasons for no doctor visits	N	%
Case manager left	11	2%
Doctor left	13	2%
Agency closed down	5	1%
Doing drugs	90	13%
Program closed down	5	1%
Did not want to take meds	78	11%
Bad experience with provider	26	4%
Lost stable housing	57	8%
Lost my job	29	4%
Lost health insurance	20	3%
Tired of regimen	57	8%
Felt fine	63	9%
Worried about side effects	46	7%
Denial	50	7%
Jail/prison	12	2%
No transportation	7	1%
Depression/emotional barriers	3	0%
Had to care for children/family member	3	0%
Other	3	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for falling out of care were doing drugs (13%) and didn't want to take medications (11%).

TABLE 2.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, IN CARE

First place of care	N	%
Private Clinic/Doctor's Office	145	21%
Public clinic/community health ctr	384	56%
Prison/jail	64	9%
VA Hospital	18	3%
ER/Hospital	71	10%
I have not received care for HIV	2	0%
Other	0	0%

Most often location of care	N	%
Private Clinic/Doctor's Office	160	23%
Public clinic/community health ctr	462	67%
Prison/jail	18	3%
VA Hospital	22	3%
ER/Hospital	19	3%
I have not received care for HIV	2	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was a public clinic/ community health center (56%). This was also the most common location for ongoing care (67%). A total of 22 (3%) of in-care respondents received care most often from the Veteran's Administration Hospital.

TABLE 2.19: KNOWLEDGE OF CASE MANAGER, IN CARE

Case Manager	N	%
Yes	520	76%
No	93	14%
Don't Know	71	10%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (76%) in-care respondents reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services, 14% said they did not have such a person assisting them and 10% said they didn't know.

Health Status

TABLE 2.20: SELF-REPORTED HEALTH STATUS, IN CARE

How would you describe your health overall	N	%
Excellent	119	17%
Good	301	44%
Fair	211	31%
Poor	53	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 17% said "Excellent," 44% said "Good," 31% said "Fair" and 8% said "Poor."

TABLE 2.21: SELF-REPORTED PHYSICAL HEALTH STATUS & ER OR HOSPITAL VISITS, IN CARE

During the past month, has your physical health interfered with normal activities?	N	%
No	282	41%
Yes – Some of the time	343	50%
Yes – all of the time	56	8%
ER visit in past 6 months	207	30%
Hospital stay in past 6 months	146	21%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Half (50%) of in-care respondents reported that during the past month, their physical health had interfered with normal activities some of the time and 8% said their physical health interfered all of the time.

For the 6 months prior to the survey, 30% of in-care respondents reported an emergency room visit and 21% were admitted to a hospital for one or more nights.

TABLE 2.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, IN CARE

Symptoms during past month Range = 1 to 12; Avg = 5	N	%
Trouble with thinking, concentrating or memory	331	48%
Depressed or sad, trouble thinking	434	63%
Aches, fatigue, lightheadedness, weak all over	305	44%
Fevers, chills, sweats	187	27%
Poor appetite, weight loss	199	29%
Trouble with eyes or ears	237	34%
Trouble with nose or sinuses, headaches	233	34%
Trouble with mouth or swallowing	113	16%
Nausea, vomiting, diarrhea, abdominal pain	220	32%
Coughing, wheezing, or chest pain, trouble breathing	179	26%
Rash, itch, herpes, or other skin trouble	171	25%
Numbness, tingling or pain in an arm or leg	255	37%
Other	3	0%
None	77	11%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The number of symptoms reported by all respondents during the past month ranged from 1 to 12, with an average of 5. The top three reported symptoms were depressed or sad, trouble thinking (63%), trouble with thinking, concentrating or memory (48%) and aches, fatigue, lightheadedness, weak all over (44%).

TABLE 2.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, IN CARE

First CD4/T-cell	N	%
Less than 50	101	15%
50-99	31	5%
100-199	61	9%
200-349	114	17%
350-499	99	14%
500+	128	19%
Don't Know/Can't Remember	151	22%

Current CD4/T-cell	N	%
Less than 50	48	7%
50-99	23	3%
100-199	72	10%
200-349	119	17%
350-499	130	19%
500+	155	23%
Don't Know/Can't Remember	138	20%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of 128 (19%) in-care respondents reported their first CD4/T-cell counts as 500+; 31% were 200 to 499, 14% were 50 to 199, and 15% were less than 50. Current CD4/T-cell counts were 500+ for 23% of in-care respondents; 200 to 499 for 36%, 50 to 199 for 13%, and less than 50 for 7% of in-care respondents. Less than a fourth (22%) didn't know or couldn't remember their first CD4/T-cell count, and 20% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 2.24: HIV MEDICATIONS, IN CARE

Currently taking HIV meds	N	%
Yes	539	78%
No	145	21%
How many pills do you take in one day?	Range = 1 to 28; Avg = 5	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (78%) said they were currently taking HIV medications. The number of pills taken in one day ranged from 1 to 28, with an average of 5 pills per day.

TABLE 2.25: SELF-REPORTED MEDICATION ADHERENCE, IN CARE

Medication adherence	N	%
I have not missed any doses in the past month	280	52%
Missed a few, but took nearly all	210	39%
Took more than half	19	4%
About half	17	3%
Some, but not half	25	5%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	473	69%
No	158	23%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among in-care respondents currently taking HIV medications, 41% reported perfect adherence and 31% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 69% said "Yes" and 23% said "No."

TABLE 2.26: REASONS FOR NOT TAKING HIV MEDICATIONS, IN CARE

Reasons for not taking HIV medications	N	%
Side effects	18	3%
Not effective	6	1%
Too difficult to take as prescribed	7	1%
No doctor has offered them	11	2%
I choose not to take them	29	4%
Doctor did not think it was a good idea for me	33	5%
T-cell too high	64	9%
Cannot pay	6	1%
Confidentiality concerns	6	1%
Didn't feel sick	4	1%
Have not seen doctor	3	0%
Other	3	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "T-cell too high" (9%) followed by "Doctor did not think it was a good idea for me" (5%), and "I choose not to take them" (4%).

TABLE 2.27: MEDICATIONS FOR NON-HIV CONDITIONS, IN CARE

How many pills do you take in one day for non-HIV conditions? Avg = 4	N	%
Diabetes	65	9%
High blood pressure	199	29%
High cholesterol	103	15%
Depression/emotional problems	295	43%
Eye drops/glaucoma	5	1%
Acid reflux	28	4%
Anemia	4	1%
Sleep	16	2%
Allergies/Sinus	11	2%
Pain	24	3%
Antibiotics	8	1%
Arthritis	9	1%
Asthma	8	1%
Neuropathy	14	2%
Nausea	0	0%
Hormones	5	1%
Other	10	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, in-care respondents took an average of 4 non-HIV pills per day. The most common conditions associated with the non-HIV pills were depression/emotional problems (43%), High blood pressure (29%) and high cholesterol (15%).

TABLE 2.28: TOTAL PILL BURDEN AND ABILITY TO PAY, IN CARE

Total Pills (HIV + non-HIV)	Avg = 7	
How often do you have trouble paying for these or other non-HIV meds?	N	%
Never	408	59%
Less than half the time	94	14%
More than half the time	54	8%
Always	95	14%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was 7. More than half (59%) of in-care respondents reported never having problems paying for HIV or non-HIV medications, 14% had problems less than half the time, 8% had problems more than half the time, and 14% said they always had problems paying for their medications.

Comorbidities

TABLE 2.29: HEPATITIS C AND TB STATUS, IN CARE

Hep C Test?	N	%
Yes	554	81%
No	98	14%
Don't Know	34	5%
Positive for Hep C?	**N**	**%**
Yes	172	25%
No	450	66%
Don't know	62	9%

TB skin test?	N	%
Yes	628	91%
No	54	8%
Result	**N**	**%**
Positive	102	15%
Negative	480	70%
Don't Know	21	3%
History of active TB?	**N**	**%**
Yes	99	14%
No	575	84%
Don't Know	10	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (81%) in-care respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 25% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

Almost all (91%) in-care respondents had received a skin test for TB, and 15% reported a positive result. A total of 99 (14%) reported a history of active TB.

Mental Health

TABLE 2.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, IN CARE

	N	%
At least one mental health condition	402	59%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	296	43%
Hallucinations	67	10%
Serious thoughts of suicide	75	11%
Attempted suicide	20	3%
Wanted to hurt or harm yourself	65	9%
Wanted to hurt or harm someone else	65	9%
Trouble controlling anger leading to physical violence	105	15%
Problems requiring meds	195	28%
None	285	41%
At least one serious indicator (suicide/homicidal or requiring meds)	195	28%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (59%) of in-care respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced symptoms were serious anxiety/tension (43%), and problems requiring meds (28%).

TABLE 2.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, IN CARE

Since being diagnosed, ever talked with therapist?	N	%
Yes	489	71%
No	196	29%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	472	69%
No	213	31%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	404	59%
No	277	40%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 71% of in-care respondents had talked with a therapist or psychologist for help with depression or emotional problems, 69% had talked to a doctor or psychiatrist for medications, and 59% had participated in a support group.

Substance Use & Abuse

TABLE 2.32: SUBSTANCE USE, IN CARE

Total Number of substances Range = 1 to12; Avg = 2	N	%
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	35	5%
Street Methadone (non-treatment)	7	1%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	25	4%
Barbituates (seconal, tuinal, downers)	8	1%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	33	5%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	5	1%
Amphetamines (speed, uppers, crystal meth, ice, glass)	27	4%
Marijuana, Hashish (grass, weed)	154	22%
Heroin	9	1%
Cocaine (powder), Crack	179	26%
Ecstasy, X, MDA, GHB	23	3%
Ketamine (K, Special K)	6	1%
None	383	56%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, 44% of in-care respondents reported using at least one substance during the past year. The numbers of substances ranged from 1 to 12, with an average of 2. The most commonly used substances for in-care respondents were cocaine (26%) and marijuana (22%).

TABLE 2.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, IN CARE

In the last year, ever drunk more than meant to?	N	%
Yes	209	30%
No	476	69%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	208	30%
No	467	68%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	175	25%
No	509	74%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	214	31%
No	463	67%
Indicator of Alcohol Abuse	259	38%
Indicator of Substance Abuse	222	32%
Abuse of both drugs and alcohol	148	22%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 38% of in-care respondents indicated possible alcohol abuse, and 32% indicated possible substance abuse. A total of 148 (22%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 2.34: SOCIAL SUPPORT, IN CARE

Of all the people you feel close to, how many have you told about being HIV+	N	%
All	238	35%
Some	372	54%
None	74	11%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	560	82%
No	123	18%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 35% had disclosed their HIV status to all and

54% had disclosed their status to some. A total of 74 (11%) had not told their HIV status to any of the people to whom they feel close. Overall, 82% of in-care respondents said there were people they could depend on for help if really needed; however, 18% did not.

Housing

TABLE 2.35: HOUSING STATUS, IN CARE

Where do you most often sleep?	N	%
Apartment/House	539	78%
Group home/halfway house	78	11%
Shelter	34	5%
Street	32	5%
Other	4	1%
Do you feel your housing situation is stable?	**N**	**%**
Yes	457	67%
No	230	33%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (78%) reported sleeping most often in an apartment/house. Others reported group home/halfway house (11%), shelter (5%), street (5%) and other (1%) locations. More than half (67%) of in-care respondents felt their housing situation was stable, and 33% felt their housing situation was unstable.

TABLE 2.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, IN CARE

In the past year, has your housing situation made it difficult to get HIV care?	N	%
Yes	162	24%
No	523	76%
Reasons	**N**	**%**
I could not keep my status private	41	6%
No place to store meds	40	6%
Money for food	83	12%
Money for rent	91	13%
Money for utilities	70	10%
Money for household supplies	74	11%
No stable address	6	1%
Used money on drugs	0	0%
Rules	3	0%
Lack of transportation	1	0%
No child care	1	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of 162 (24%) in-care respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The most common reasons for these difficulties were needing to use money for rent (13%), food (12%) and household supplies (11%).

ACCESS TO CORE SERVICES

TABLE 2.37: ACCESS TO CORE SERVICES, IN CARE

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	130	19%	537	78%	20	3%
HIV/AIDS Medications	136	20%	474	69%	77	11%
Dentist Visits	211	31%	370	54%	106	15%
Medical Case Management	101	15%	430	63%	156	23%
Home Health Care	59	9%	120	17%	508	74%
Psychiatric Services or Medicine	79	11%	332	48%	276	40%
Psychological Counseling	65	9%	337	49%	285	41%
Substance Abuse Treatment	45	7%	204	30%	438	64%
Rehabilitation Services	45	7%	165	24%	477	69%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For all in-care respondents, the top three “easy to get” core services were primary medical care (78%), HIV/AIDS medications (69%) and medical case management (63%). The top three core services that respondents reported “some difficulty getting” were dentist visits (31%), HIV/AIDS medications (20%) and primary medical care (19%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that in-care respondents said they “did not need” in the past year were home health care (74%), rehabilitation services (69%) and substance abuse treatment (64%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 2.38: ACCESS TO SUPPORTIVE SERVICES, IN CARE

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service	%*
Child Care Services	24	3%	9	1%	10	1%
Child Welfare Services	5	1%	3	0%	4	1%
Day/Respite Care for Adults	6	1%	10	1%	9	1%
Developmental	4	1%	0	0%	1	0%
Emergency Financial Assistance	212	31%	100	15%	31	5%
Employment Assistance	113	16%	23	3%	20	3%
Food Bank	105	15%	230	33%	16	2%
HIV Education for HIV+ Individuals	27	4%	116	17%	9	1%
Rental Assistance/Shelter Vouchers	148	22%	79	11%	17	2%
Housing-Related Services	144	21%	65	9%	22	3%
Legal Services	63	9%	63	9%	28	4%
Nutritional Counseling	43	6%	98	14%	4	1%
Permanency Planning	18	3%	8	1%	6	1%
Referrals to Services	40	6%	75	11%	6	1%
Referrals to Clinical Research	30	4%	30	4%	5	1%
Support Groups	64	9%	92	13%	17	2%
Translation/Interpretation	7	1%	44	6%	2	0%
Transportation	120	17%	142	21%	13	2%
Household Items	86	13%	39	6%	6	1%

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For in-care respondents, the supportive services that were selected most often (thus implying high helpfulness/usefulness) were food bank, emergency financial assistance, transportation, rental assistance/shelter vouchers and housing related services. The top five "easy to get" supportive services (based on number of responses) were food bank, transportation, HIV education for HIV positive individuals, emergency financial assistance and nutritional counseling. The top supportive services respondents reported "some difficulty getting" were emergency financial assistance, rental assistance/shelter vouchers, housing related services, transportation and employment assistance. The presence of support services in both the "easy to get" and "some difficulty getting" lists is a reflection of high utilization rates. The supportive services that respondents did not need in the past year, but still identified as useful/helpful were emergency financial assistance, legal services, housing related services, employment assistance, support groups and rental assistance/shelter vouchers.

Barriers Reported per Core Service Category

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among in-care respondents, the three core services with the highest number of barriers were dentist visits, primary medical care and HIV/AIDS medications. Within dentist visits, the most commonly reported barriers were "It's hard to make or keep appointments," and "I would have to wait too long to get the services." For primary medical care, the most common barriers "It's hard to make or keep appointments," "It's hard for me to get there," and "I would have to wait too long to get the services."

The barriers experienced most often across all core services were "It's hard to make or keep appointments" and "I would have to wait too long to get the services."

TABLE 2.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, IN CARE

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Primary Medical Care	19	20	**35**	15	6	4	24	**41**	**37**	5	12	3	6	7	0	1	4	2	0	0	0	0	**241**
HIV/AIDS Medications	14	15	**39**	**39**	15	8	**19**	11	17	4	4	4	3	6	0	1	2	1	0	0	0	0	**202**
Dentist Visits	26	**44**	**63**	16	11	8	25	**75**	33	4	4	0	3	18	0	0	1	3	1	0	0	0	**335**
Medical Case Management	15	22	**25**	6	7	2	**23**	**30**	11	1	3	1	6	1	0	1	0	2	0	6	0	0	**162**
Home Health Care	5	**17**	7	6	**9**	7	7	6	5	1	1	1	1	0	0	0	1	1	5	0	0	0	**80**
Psychiatric Services or Medicine	13	**18**	**25**	14	11	5	15	**25**	16	4	5	1	0	0	0	0	2	0	0	0	0	0	**154**
Psychological Counseling	10	**16**	14	13	5	8	6	**21**	**15**	3	4	0	1	0	1	0	3	1	0	0	0	0	**121**
Substance Abuse Treatment	5	**12**	**9**	5	2	4	8	6	**10**	3	3	1	6	0	0	0	0	2	0	0	0	0	**76**
Rehabilitation Services	5	**15**	7	3	6	4	4	**11**	**9**	1	2	1	0	0	0	0	0	1	0	0	1	0	**70**
Total	**112**	**179**	**224**	**117**	**72**	**50**	**131**	**226**	**153**	**26**	**38**	**12**	**26**	**32**	**1**	**3**	**13**	**13**	**6**	**6**	**1**	**0**	**1,441**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Barriers Reported per Supportive Service Category

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among all in-care respondents, the five supportive services with the highest number of barriers were emergency financial assistance, housing related services, rental assistance/shelter vouchers, transportation and employment assistance. Within emergency financial assistance, the most common barriers were "I would have to wait too long to get the services," "I don't know where to get the services," and "I was told I am not eligible for this service."

The barriers experienced most often by in-care respondents across all supportive services were "I don't know where to get the services," "I would have to wait too long to get the services," and "The services are not in my area."

TABLE 2.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, IN CARE

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Child Care Services	**7**	**11**	6	**7**	3	4	1	2	6	4	1	1	0	0	0	0	0	0	0	0	0	0	**53**
Child Welfare Services	1	**4**	1	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**9**
Day/Respite Care for Adults	1	**2**	0	0	0	0	**2**	1	1	1	1	0	0	0	0	0	1	0	0	0	0	0	**10**
Developmental Assessment	1	**2**	**2**	0	0	1	0	1	1	1	1	0	0	0	0	0	1	0	0	0	0	0	**11**
Emergency Financial Assistance	37	**69**	**72**	9	**53**	31	21	29	17	3	6	1	12	4	0	0	5	2	1	0	12	0	**384**
Employment Assistance	**18**	**56**	11	2	10	14	6	8	10	2	9	2	**19**	0	0	0	2	0	1	0	1	0	**171**
Food Bank	**24**	**35**	16	1	12	14	4	2	**28**	0	2	0	1	2	2	0	1	0	3	0	14	1	**162**
HIV Education for HIV+ Individuals	**5**	**14**	2	3	1	2	1	**4**	2	0	2	3	0	0	1	0	1	0	0	0	1	0	**42**
Rental Assistance/Shelter Vouchers	16	**47**	**42**	12	**25**	16	15	19	8	2	4	0	8	3	1	0	2	0	5	1	12	1	**239**
Housing-Related Services	24	**60**	**49**	12	**27**	17	10	13	12	2	4	1	17	1	0	0	0	1	4	0	5	0	**259**
Legal Services	6	**28**	**13**	5	5	4	6	**10**	4	0	2	4	3	2	0	1	1	0	0	1	1	0	**96**
Nutritional Counseling	4	**18**	**7**	1	1	3	4	**10**	5	0	0	2	0	1	0	0	0	0	0	0	0	0	**56**
Permanency Planning	1	**14**	**3**	**3**	1	1	1	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	**27**
Referrals to Services	5	**16**	**8**	3	2	2	**8**	6	4	0	0	1	0	1	0	0	0	0	1	1	0	0	**58**
Referrals to Clinical Research	4	**20**	3	1	4	4	0	3	**5**	0	0	0	0	0	0	0	0	0	0	0	0	0	**44**
Support Groups	**11**	**37**	4	2	1	5	2	5	**11**	1	4	1	1	0	0	0	1	1	1	0	3	0	**91**
Translation/Interpretation	0	2	1	0	0	0	0	1	0	0	0	4	0	0	0	0	0	0	0	0	0	0	**8**
Transportation	**27**	**41**	**23**	10	15	9	9	17	20	2	3	1	2	6	1	0	3	0	2	0	3	1	**195**
Household Items	**13**	**52**	**12**	8	8	9	5	3	8	1	2	0	1	0	0	0	1	0	0	0	0	0	**123**
Total	**205**	**528**	**275**	**80**	**168**	**136**	**95**	**135**	**144**	**20**	**41**	**21**	**64**	**20**	**5**	**1**	**19**	**5**	**18**	**3**	**52**	**3**	**2,038**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions

A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 2.41: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA IN-CARE (N=687)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of In Care Reporting Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	56	461	9	6%	56	7%
Anonymous Sex Partner(s)	141	352	N/A	17%	141	18%
Greater than 5 Sex Partners	60	694	N/A	8%	60	8%

Of those meeting the HRSA In-Care definition, 44 (6%) reported that they had engaged in sex for drugs or money in the past 6 months, while 56 (7%) of all respondents reported this risk factor. One hundred seventeen (17%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 141 (18%) of all respondents. Fifty two (8%) of those who are in care reported that they had more than 5 sex partners in the past 6 months, which is the same proportion (8%) of all respondents reporting that they had more than 5 sex partners. For each element of the definition of very high risk of HIV transmission, a lower or identical proportion of the in-care group identified themselves as meeting the definition.

TABLE 2.42: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA IN-CARE (N=687)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of In Care Reporting Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	235	282	N/A	30%	235	31%
Shared Injecting Equipment	12	35	N/A	1%	12	2%
Serodiscordant Sex Partner(s)	111	314	69	15%	111	15%

Of those meeting the HRSA In-Care definition, 203 (30%) reported that they had unprotected sex at least some of the time, while 235 (31%) of the entire sample reported this risk factor. Nine (1%) of those In-Care reported that they had shared injecting equipment at least some of the time, while 12 (2%) of the total sample had shared injecting equipment. One hundred four (15%) of those In-Care reported that they had an HIV-negative sex partner, which is the same proportion (15%) of all respondents reporting that they had an HIV negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

OUT-OF-CARE RESPONDENTS

Overview

There were 77 total out-of-care respondents to the 2008 Need Assessment consumer survey. This total represents 10% of the total 764 survey respondents.

Out-of-care respondents were defined as any respondents that had not received a viral load test, CD4 count or prescription for HIV/AIDS medications within the 12 months prior to taking the survey.

Demographics

TABLE 3.1: GENDER, PREGNANCY STATUS AND AGE, OUT-OF-CARE

Gender	**N**	**%**
Male	45	58%
Female	31	40%
Transgender – Male to Female	1	1%
Pregnant	**N**	**%**
Yes	3	4%
Don't Know	3	4%
Age Range = 18 to 61; Avg = 40	**N**	**%**
18-24	7	9%
25-44	40	52%
45+	30	39%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half of out-of-care respondents were male (58%); women represented 40% of out-of-care respondents, and transgender Male to Female represented 1%. None of the respondents identified as transgender Female to Male.

Among women, 4% said they were pregnant at the time of the survey, and 4% said they did not know their pregnancy status.

The average age of respondents was 40 years, ranging from 18 to 61. Almost all (91%) out-of-care respondents were above the age of 25; 52% were between the ages of 25-44, and another 39% were above the age of 45. Seven (9%) were youth between the ages of 18 and 24.

TABLE 3.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, OUT-OF-CARE

Race/Ethnicity	N	%
White/Anglo	21	27%
Black/African-American	52	68%
Hispanic/Latino	3	4%
Asian	0	0%
Native American	1	1%
Multiracial	0	0%

Sexual Orientation	N	%
Straight/Heterosexual	53	69%
Gay/Lesbian	13	17%
Bisexual	5	6%
Undecided	3	4%
Prefer not to say	3	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (68%) of out-of-care respondents identified as Black/African-American; 27% identified as white/Anglo, 4% as Hispanic/Latino, and 1% as Native American.

Most (69%) out-of-care respondents identified as straight or heterosexual; 17% identified as gay/lesbian, 6% as bisexual and 4% undecided. Three (4%) said they preferred not to disclose their sexual orientation.

TABLE 3.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, OUT-OF-CARE

Education	N	%
Less than high school	19	25%
High school degree/GED	46	60%
College degree	7	9%
Graduate/Professional degree	1	1%
Some technical training	4	5%
None	19	25%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	17	22%
Are you eligible for veteran benefits?	**N**	**%**
Yes	4	5%
No	71	92%
Don't Know	2	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (85%) out-of-care respondents had a high school degree/GED or less; 9% had a college degree, 1% had a graduate/professional degree and 5% had some technical training. Nineteen (25%) reported receiving no education.

A total of 17 (22%) of out-of-care survey respondents reported being released from jail or prison during the previous year.

PLWHA eligible for veteran benefits represented 5% of out-of-care respondents.

Immigration Status & Primary Language

TABLE 3.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, OUT-OF-CARE

	N	%
Born outside US	3	4%
Length of residency	Range = 17 to 26 yrs; Avg = 27 yrs	
Immigration status	**N**	**%**
Citizen	76	99%
Permanent Resident	1	1%
Visa	0	0%
Undocumented	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The foreign born represented 4% of out-of-care respondents. Lengths of residency in the US ranged from 17 to 26 years, with an average residency of 27 years.

Among out-of-care respondents, 99% were US citizens and 1% were permanent residents.

TABLE 3.5: PREFERRED LANGUAGE, OUT-OF-CARE

Preferred language at home with family/friends	**N**	**%**
English	77	100%
Spanish	0	0%
English/Spanish	0	0%
Other	0	0%
Preferred language when seeing a doctor	**N**	**%**
English	77	100%
Spanish	0	0%
English/Spanish	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

English was the primary language reported for out-of-care respondents.

Job Status & Income

TABLE 3.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, OUT-OF-CARE

Job status	N	%
Full time	4	5%
Part time	6	8%
Temporary/contract/odd jobs	5	6%
Not working due to disability	16	21%
Unemployed	46	60%
Retired	0	0%
Average monthly income during past 6 months	Avg = $532.03	
Approximate yearly income Avg = $6,384.31	**N**	**%**
Up to 300% Federal Poverty Level (2007 – 2008)	74	96%
Up to 200% Federal Poverty Level (2007 – 2008)	73	95%
Up to 100% Federal Poverty Level (2007 – 2008)	67	87%
Total income dependents	Range = 1 - 8	Avg = 1.65
Income dependents under 18	Avg = .5	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (81%) out-of-care respondents were unemployed at the time of the survey; 60% were unemployed and 21% were not working due to disability. Four (5%) were working full-time, 8% part-time and 6% had temporary/contract/odd jobs.

The highest reported monthly income was $4,500, with an average of $532.03 per month. The average yearly income was $6,384.31. The number of dependents per income ranged from 1 to 8, with an average of less than one (.5) being under the age of 18. Based on estimated yearly incomes and household sizes, 87% of out-of-care respondents fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 3.7: SOURCES OF INCOME ASSISTANCE, OUT-OF-CARE

Sources of income assistance	N	%
None	29	38%
Hourly wages/Salary	11	14%
SSI	16	21%
SSDI	8	10%
Social Security	8	10%
TANF/AFDC	3	4%
Food Stamps	17	22%
Rental Subsidy/Section 8	1	1%
Workers Comp	0	0%
Unemployment	2	3%
Private Disability	0	0%
VA Benefits	0	0%
Child support	1	1%
Family/friends	0	0%
Pension/Retirement/Savings	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among out of care survey respondents were food stamps (22%), Supplemental Security Income (SSI) (21%) and hourly wages/salary (14%). No survey respondents received worker's compensation.

Twenty nine (38%) out-of-care respondents reported no source of income.

Paying for Medical Care

TABLE 3.8: SOURCES OF PAYMENT FOR MEDICAL CARE, OUT-OF-CARE

Paying for medical care	N	%
I don't receive medical care because I can't pay for it	26	34%
Private insurance/COBRA	3	4%
VA	1	1%
Medicaid	29	38%
Medicare	5	6%
Self-Pay	0	0%
Gold Card/County	16	21%
Ryan White/ADAP	0	0%
Other (MHMRA)	3	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Medicaid (38%) and Gold Card (21%) were the most common methods of paying for medical care; no out-of-care respondents reported using Ryan White/ADAP and one reported the Veteran's Administration Hospital. Twenty six (34%) of out-of-care respondents said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 3.9: LENGTH OF HIV DIAGNOSIS, OUT-OF-CARE

Length of diagnosis Avg = 11 yrs	**N**	**%**
Less than 1 year	5	6%
1-4 years	32	42%
5-10 years	18	23%
11-15 years	5	6%
16-20 years	13	17%
21 and over	3	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Out-of-care respondents reported being HIV positive an average of 11 years, ranging from 6 months to 22.5 years.

TABLE 3.10: LOCATION OF HIV DIAGNOSIS, OUT-OF-CARE

Location of diagnosis	**N**	**%**
Private doctor	8	10%
ER	8	10%
In hospital stay	7	9%
HIV-specific testing site	6	8%
Public or community clinic	21	27%
Jail/Prison	12	16%
Community testing location	12	16%
Alcohol or drug treatment facility	2	3%
Blood/Plasma donation	1	1%
Work/insurance related	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than a quarter (27%) of out-of-care respondents received their diagnoses at a public or community clinic. Other common diagnosis locations were jail/prison (16%) or community testing location (16%).

TABLE 3.11: REASONS FOR HIV TESTING, OUT-OF-CARE

Reasons for testing	N	%
Recommended by provider	6	8%
Had sex with someone HIV+	19	25%
ER/Hospital stay	13	17%
Felt sick	16	21%
Engaged in risky behavior	18	23%
Was in prison/jail	10	13%
During pregnancy care	6	8%
Routine check up/testing	3	4%
Blood/plasma donation	2	3%
Work/insurance related	0	0%
Partner notification	1	1%
Knew someone with HIV	2	3%
Rape survivor	0	0%
Incentive offered	1	1%
In drug treatment program	2	3%
Recommended by friends	1	1%
Other	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were had sex with someone with HIV (25%), engaged in risky behavior (23%) and felt sick (21%).

TABLE 3.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, OUT-OF-CARE

Assistance at diagnosis	N	%
Information about HIV/AIDS	34	44%
Medical services	21	27%
Counseling	16	21%
Help with food or shelter	3	4%
Alcohol or drug treatment services	5	6%
Supportive Services	2	3%
Other	1	1%
None	30	39%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to out-of-care respondents were information about HIV/AIDS (44%), medical services (27%) and counseling (21%). A total of 30 (39%) of out-of-care respondents reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 3.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, OUT-OF-CARE

Time to first doctor visit	N	%
Less than 1 month	27	35%
1-6 months	15	19%
6-12 months	8	10%
More than 12 months	16	21%
Never	11	14%

Time to CD4/Viral Load	N	%
Less than 1 month	21	27%
1-6 months	14	18%
6-12 months	9	12%
More than 12 months	14	18%
Never	19	25%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A little over a third (35%) of out-of-care respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 19% of out-of-care respondents, 1 to 6 months passed before seeing a doctor, 10% waited between 6 to 12 months, and 21% waited more than a year to see a doctor for HIV. A total of 11 (14%) of out-of-care respondents said they still had not seen a doctor for HIV. Likewise, 27% reported receiving their first CD4/viral load test within one month of being diagnosed, 18% within 1-6 months, 12% between 6-12 months and 18% waited more than a year. A total of 19 (25%) said they had never received a CD4 or viral load test.

TABLE 3.14: REASONS FOR DELAYED ENTRY INTO CARE, OUT-OF-CARE

Reasons for waiting more than 6 months	N	%
Afraid	22	29%
Didn't feel sick	14	18%
Jail/prison	3	4%
Doing drugs	10	13%
Denial	21	27%
Didn't want to take meds	8	10%
No money	8	10%
Depressed/emotional problems	13	17%
No stable place to live	10	13%
Other	3	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were fear (29%), denial (27%), didn't feel sick (18%) and depressed/emotional problems (17%).

Maintenance in Care

TABLE 3.15: FREQUENCY OF DOCTOR'S VISITS, OUT-OF-CARE

No doctor visits more than 6 months?	N	%
Yes	58	75%
No	19	25%
No doctor visits more than 12 months?	**N**	**%**
Yes	54	70%
No	23	30%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among out-of-care respondents who have seen a doctor for HIV, 75% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 70% reported not seeing a doctor for 12 months or more.

TABLE 3.16: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, OUT-OF-CARE

Reasons for no doctor visits	N	%
Case manager left	1	1%
Doctor left	5	6%
Agency closed down	0	0%
Doing drugs	14	18%
Program closed down	1	1%
Did not want to take meds	14	18%
Bad experience with provider	7	9%
Lost stable housing	18	23%
Lost my job	10	13%
Lost health insurance	6	8%
Tired of regimen	8	10%
Felt fine	21	27%
Worried about side effects	9	12%
Denial	14	18%
Jail/prison	1	1%
No transportation	4	5%
Depression/emotional barriers	2	3%
Had to care for children/family member	1	1%
Other	6	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for falling out-of-care were felt fine (27%) and lost stable housing (23%).

TABLE 3.17: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, OUT-OF-CARE

First place of care	N	%
Private Clinic/Doctor's Office	13	17%
Public clinic/community health ctr	34	44%
Prison/jail	11	14%
VA Hospital	2	3%
ER/Hospital	4	5%
I have not received care for HIV	13	17%
Other	0	0%

Most often location of care	N	%
Private Clinic/Doctor's Office	14	18%
Public clinic/community health ctr	30	39%
Prison/jail	2	3%
VA Hospital	2	3%
ER/Hospital	8	10%
I have not received care for HIV	16	21%
Other	3	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was a public clinic/ community health center (44%). This was also the most common location for ongoing care (39%). A total of 2 (3%) out-of-care respondents received care most often from the Veteran's Administration Hospital.

TABLE 3.18: KNOWLEDGE OF CASE MANAGER, OUT-OF-CARE

Case Manager	N	%
Yes	26	34%
No	27	35%
Don't Know	24	31%

Approximately a third (34%) of out-of-care respondents reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services, 35% said they did not have such a person assisting them, and 31% said they didn't know.

Health Status

TABLE 3.19: SOURCES OF PAYMENT FOR MEDICAL CARE, OUT-OF-CARE

How would you describe your health overall	N	%
Excellent	6	8%
Good	30	39%
Fair	33	43%
Poor	8	10%

When asked to describe their overall health, 8% said "Excellent," 39% said "Good," 43% said "Fair" and 10% said "Poor."

TABLE 3.20: SELF-REPORTED PHYSICAL HEALTH STATUS & ER OR HOSPITAL VISITS, OUT-OF-CARE

During the past month, has your physical health interfered with normal activities?	N	%
No	30	39%
Yes – Some of the time	37	48%
Yes – all of the time	8	10%
ER visit in past 6 months	34	44%
Hospital stay in past 6 months	23	30%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Almost half (48%) of out-of-care respondents reported that during the past month, their physical health had interfered with normal activities some of the time and 10% said their physical health interfered all of the time.

For the 6 months prior to the survey, 44% of out-of-care respondents reported an emergency room visit and 30% were admitted to a hospital for one or more nights.

TABLE 3.21: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, OUT-OF-CARE

Symptoms during past month Avg = 5	N	%
Trouble with thinking, concentrating or memory	34	44%
Depressed or sad, trouble thinking	60	78%
Aches, fatigue, lightheadedness, weak all over	35	45%
Fevers, chills, sweats	27	35%
Poor appetite, weight loss	29	38%
Trouble with eyes or ears	32	42%
Trouble with nose or sinuses, headaches	36	47%
Trouble with mouth or swallowing	10	13%
Nausea, vomiting, diarrhea, abdominal pain	27	35%
Coughing, wheezing, or chest pain, trouble breathing	28	36%
Rash, itch, herpes, or other skin trouble	17	22%
Numbness, tingling or pain in an arm or leg	28	36%
Other	3	4%
None	5	6%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average number of symptoms reported by out-of-care respondents for the previous month was 5. The top three reported symptoms were depressed or sad, trouble thinking (78%), trouble with nose or sinuses, headaches (47%) and aches, fatigue, lightheadedness, weak all over (45%).

TABLE 3.22: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, OUT-OF-CARE

First CD4/T-cell	N	%
Less than 50	5	6%
50-99	1	1%
100-199	3	4%
200-349	7	9%
350-499	10	13%
500+	13	17%
Don't Know/Can't Remember	36	47%

Current CD4/T-cell	N	%
Less than 50	0	0%
50-99	0	0%
100-199	3	4%
200-349	6	8%
350-499	2	3%
500+	4	5%
Don't Know/Can't Remember	61	79%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of 13 (17%) out-of-care respondents reported their first CD4/T-cell counts as 500+; 22% were 200 to 499, 5% were 50 to 199, and 6% were less than 50. Current CD4/T-cell counts were 500+ for 5% of out-of-care respondents; 200 to 499 for 12%, and 50 to 199 for 4%. Almost half (47%) didn't know or couldn't remember their first CD4/T-cell count, and 79% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 3.23: REASONS FOR NOT TAKING HIV MEDICATIONS, OUT-OF-CARE

Reasons for not taking HIV medications	N	%
Side effects	9	12%
Not effective	3	4%
Too difficult to take as prescribed	3	4%
No doctor has offered them	7	9%
I choose not to take them	20	26%
Doctor did not think it was a good idea for me	4	5%
T-cell too high	10	13%
Cannot pay	10	13%
Confidentiality concerns	10	13%
Didn't feel sick	1	1%
Have not seen doctor	11	14%
Other	6	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "I choose not to take them" (26%).

TABLE 3.24: MEDICATIONS FOR NON-HIV CONDITIONS, OUT-OF-CARE

How many pills do you take in one day for non-HIV conditions? Avg = 2	N	%
Diabetes	4	5%
High blood pressure	19	25%
High cholesterol	4	5%
Depression/emotional problems	14	18%
Eye drops/glaucoma	0	0%
Acid reflux	0	0%
Anemia	0	0%
Sleep	2	3%
Allergies/Sinus	0	0%
Pain	2	3%
Antibiotics	0	0%
Arthritis	0	0%
Asthma	1	1%
Neuropathy	1	1%
Nausea	0	0%
Hormones	0	0%
Other	4	5%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, out-of-care respondents took an average of 2 non-HIV pills per day. The most common conditions associated with the non-HIV pills were high blood pressure (25%) and depression/emotional problems (18%).

TABLE 3.25: ABILITY TO PAY FOR NON-HIV MEDICATIONS, OUT-OF-CARE

How often do you have trouble paying for these or other non-HIV meds?	N	%
Never	31	40%
Less than half the time	5	6%
More than half the time	7	9%
Always	17	22%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Less than half (40%) of out-of-care respondents reported never having problems paying for HIV or non-HIV medications, 6% had problems less than half the time, 9% had problems more than half the time, and 22% said they always had problems paying for their medications.

Comorbidities

TABLE 3.26: HEPATITIS C AND TB STATUS, OUT-OF-CARE

Hep C Test?	N	%
Yes	49	64%
No	15	19%
Don't Know	13	17%
Positive for Hep C?	**N**	**%**
Yes	19	25%
No	41	53%
Don't know	17	22%

TB skin test?	N	%
Yes	67	87%
No	10	13%
Result	**N**	**%**
Positive	11	14%
Negative	56	73%
Don't Know	4	5%
History of active TB?	**N**	**%**
Yes	5	6%
No	68	88%
Don't Know	4	5%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (64%) of out-of-care respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 25% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C. test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

The majority (87%) of out-of-care respondents had received a skin test for TB, and 14% reported a positive result. A total of 5 (6%) reported a history of active TB.

Mental Health

TABLE 3.27: SELF-REPORTED MENTAL HEALTH SYMPTOMS, OUT-OF-CARE

	N	%
At least one mental health condition	50	65%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	12	16%
Hallucinations	12	16%
Serious thoughts of suicide	13	17%
Attempted suicide	5	6%
Wanted to hurt or harm yourself	11	14%
Wanted to hurt or harm someone else	9	12%
Trouble controlling anger leading to physical violence	21	27%
Problems requiring meds	18	23%
None	24	31%
At least one serious indicator (suicide/homicidal or requiring meds)	22	29%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (65%) of out-of-care respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced symptoms were trouble controlling anger leading to physical violence (27%), and problems requiring meds (23%).

TABLE 3.28: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, OUT-OF-CARE

Since being diagnosed, ever talked with therapist?	**N**	**%**
Yes	33	43%
No	44	57%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	25	32%
No	52	68%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	28	36%
No	49	64%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 43% of out-of-care respondents had talked with a therapist or psychologist for help with depression or emotional problems, 32% had talked to a doctor or psychiatrist for medications, and 36% had participated in a support group.

Substance Use & Abuse

TABLE 3.29: SUBSTANCE USE, OUT-OF-CARE

Total Number of substances Range = 1 to 12; Avg = 2	N	%
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	0	0%
Street Methadone (non-treatment)	3	4%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	4	5%
Barbituates (seconal, tuinal, downers)	3	4%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	5	6%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	1	1%
Amphetamines (speed, uppers, crystal meth, ice, glass)	3	4%
Marijuana, Hashish (grass, weed)	20	26%
Heroin	2	3%
Cocaine (powder), Crack	27	35%
Ecstasy, X, MDA, GHB	2	3%
Ketamine (K, Special K)	1	1%
None	38	49%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, 51% of out-of-care respondents reported using at least one substance during the past year. The numbers of substances ranged from 1 to 12, with an average of 2. The most commonly used substances for out-of-care respondents were cocaine (35%) and marijuana (26%).

TABLE 3.30: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, OUT-OF-CARE

In the last year, ever drunk more than meant to?	N	%
Yes	24	31%
No	53	69%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	28	36%
No	49	64%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	24	31%
No	53	69%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	25	32%
No	52	68%
Indicator of Alcohol Abuse	33	43%
Indicator of Substance Abuse	26	34%
Abuse of both drugs and alcohol	19	25%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 43% of out-of-care respondents indicated possible alcohol abuse, and 34% indicated possible substance abuse. A total of 19 (25%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 3.31: SOCIAL SUPPORT, OUT-OF-CARE

Of all the people you feel close to, how many have you told about being HIV+?	N	%
All	17	22%
Some	46	60%
None	14	18%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	44	57%
No	33	43%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 22% had disclosed their HIV status to all and 60% had disclosed their status to some. A total of 14 (18%) had not told their HIV status to any of the people to whom they feel close. Overall, 57% of out-of-care respondents said there were people they could depend on for help if really needed; however, 43% did not.

Housing

TABLE 3.32: HOUSING STATUS, OUT-OF-CARE

Where do you most often sleep?	N	%
Apartment/House	45	58%
Group home/halfway house	8	10%
Shelter	12	16%
Street	11	14%
Other	1	1%
Do you feel your housing situation is stable?	**N**	**%**
Yes	30	39%
No	47	61%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (58%) reported sleeping most often in an apartment/house. Others reported group home/halfway house (10%), shelter (16%), street (14%) and other (1%) locations. More than half (61%) of out-of-care respondents felt their housing situation was unstable.

TABLE 3.33: HOUSING SITUATION AND UTILIZATION OF HIV CARE, OUT-OF-CARE

In the past year, has your housing situation made it difficult to get HIV care	N	%
Yes	36	47%
No	41	53%
Reasons	**N**	**%**
I could not keep my status private	8	10%
No place to store meds	14	18%
Money for food	24	31%
Money for rent	22	29%
Money for utilities	14	18%
Money for household supplies	18	23%
No stable address	0	0%
Used money on drugs	0	0%
Rules	0	0%
Lack of transportation	8	10%
No child care	8	10%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of 36 (47%) out-of-care respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The most common reasons for these difficulties were needing to use money for rent (29%), food (31%) and household supplies (23%).

ACCESS TO CORE SERVICES

TABLE 3.34: ACCESS TO CORE SERVICES, OUT-OF-CARE

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	43	56%	13	17%	21	27%
HIV/AIDS Medications	28	36%	13	17%	36	47%
Dentist Visits	35	45%	10	13%	32	42%
Medical Case Management	33	43%	8	10%	36	47%
Home Health Care	16	21%	2	3%	59	77%
Psychiatric Services or Medicine	23	30%	6	8%	48	62%
Psychological Counseling	22	29%	13	17%	42	55%
Substance Abuse Treatment	12	16%	9	12%	56	73%
Rehabilitation Services	13	17%	2	3%	62	81%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not

need the service within the past year. The table above shows the reported access levels for each core service.

For out-of-care respondents, the top three "easy to get" core services were primary medical care (17%), HIV/AIDS medications (17%) and psychological counseling (17%). The top three core services that respondents reported "some difficulty getting" were primary medical care (56%), dentist visits (45%) and medical case management (43%). The presence of primary medical care on both the "easy to get" and "some difficulty getting" lists is due to the fact that they are the two most accessed services. Conversely, the three core services that out-of-care respondents said they "did not need" in the past year were rehabilitation services (81%), home health care (77%) and substance abuse treatment (73%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 3.35: ACCESS TO SUPPORTIVE SERVICES, OUT-OF-CARE

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Child Care Services	11	92%	0	0%	1	8%
Child Welfare Services	1	100%	0	0%	0	0%
Day/Respite Care for Adults	3	60%	0	0%	2	40%
Developmental	1	33%	1	33%	1	33%
Emergency Financial Assistance	32	80%	4	10%	4	10%
Employment Assistance	17	85%	2	10%	1	5%
Food Bank	17	46%	17	46%	3	8%
HIV Education for HIV+ Individuals	9	75%	1	8%	2	17%
Rental Assistance/Shelter Vouchers	24	86%	3	11%	1	4%
Housing-Related Services	26	76%	6	18%	2	6%
Legal Services	12	75%	1	6%	3	19%
Nutritional Counseling	5	63%	0	0%	3	38%
Permanency Planning	1	25%	1	25%	2	50%
Referrals to Services	13	68%	3	16%	3	16%
Referrals to Clinical Research	7	64%	1	9%	3	27%
Support Groups	11	79%	2	14%	1	7%
Translation/Interpretation	0	0%	0	0%	0	0%
Transportation	19	86%	3	14%	0	0%
Household Items	9	82%	1	9%	1	9%

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels

of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For out-of-care respondents, the supportive services that were selected most often (thus implying high helpfulness/usefulness) were emergency financial assistance, food bank, housing related services, rental assistance and transportation. The top "easy to get" supportive service (based on number of responses) was food bank. The top supportive services respondents reported "some difficulty getting" were emergency financial assistance, housing related services, rental assistance/shelter vouchers and transportation. The presence of support services in both the "easy to get" and "some difficulty getting" lists is a reflection of high utilization rates. Some supportive services that respondents did not need in the past year, but still identified as useful/helpful were emergency financial assistance, food bank, legal services, nutritional counseling, referrals to services and referrals to clinical research.

Barriers Reported per Core Service Category

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among out-of-care respondents, the three core services with the highest number of barriers were dentist visits, primary medical care and HIV/AIDS medications. For both dentist visits and primary medical care, the most commonly reported barriers were "It's hard to make or keep appointments," and "I would have to wait too long to get the services."

The barriers experienced most often across all core services were "I don't know where to get the services," "It's hard for me to get there," and "The services cost too much."

TABLE 3.36: BARRIERS REPORTED PER CORE SERVICE CATEGORY, OUT-OF-CARE

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Primary Medical Care	6	**11**	6	9	2	5	7	12	**16**	3	8	0	2	0	3	0	0	0	1	0	0	0	**91**
HIV/AIDS Medications	2	**12**	5	**9**	2	5	3	8	6	3	6	1	1	0	1	0	0	2	0	1	0	0	**67**
Dentist Visits	7	**14**	**11**	10	4	9	2	12	10	2	6	0	2	0	6	0	0	0	1	0	0	0	**96**
Medical Case Management	4	**12**	4	4	3	**6**	**6**	3	5	1	**6**	0	1	0	0	0	1	0	0	0	1	0	**57**
Home Health Care	2	**4**	1	1	**4**	**5**	1	2	2	0	3	0	2	0	0	0	0	0	0	2	0	0	**29**
Psychiatric Services or Medicine	2	5	5	**6**	2	2	5	**6**	5	0	2	0	1	0	0	0	0	1	0	0	0	0	**42**
Psychological Counseling	2	**9**	3	**5**	2	3	**5**	4	4	0	2	0	0	0	0	0	0	1	0	0	0	0	**40**
Substance Abuse Treatment	**4**	3	2	3	**4**	2	1	1	2	1	3	0	0	0	0	0	0	0	0	1	0	0	**27**
Rehabilitation Services	**4**	**6**	0	**4**	3	3	1	1	3	0	**4**	0	0	0	0	0	0	0	0	0	0	0	**29**
Total	**33**	**76**	**37**	**51**	**26**	**40**	**31**	**49**	**53**	**10**	**40**	**1**	**9**	**0**	**10**	**0**	**1**	**4**	**2**	**4**	**1**	**0**	**478**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Barriers Reported per Supportive Service Category

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among out-of-care respondents, the five supportive services with the highest number of barriers were emergency financial assistance, housing related services, rental assistance/shelter vouchers, transportation and food bank. Within emergency financial assistance, the most common barrier was "I was told I am not eligible for this service."

The barriers experienced most often by out-of-care respondents across all supportive services were "I don't know where to get the services," "I would have to wait too long to get the services," "I was told I am not eligible for this service," and "The services are not in my area."

TABLE 3.37: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, OUT-OF-CARE

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Child Care Services	2	**5**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**8**
Child Welfare Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Day/Respite Care for Adults	1	1	1	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	**6**
Developmental Assessment	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Emergency Financial Assistance	5	**9**	**8**	3	**13**	5	6	7	6	1	6	0	1	0	0	0	0	1	0	0	0	0	**71**
Employment Assistance	3	**6**	2	0	2	4	2	1	2	0	4	0	4	0	0	0	0	0	0	0	0	0	**30**
Food Bank	2	2	**8**	3	3	4	2	3	4	0	2	0	0	0	0	0	0	0	0	0	0	0	**33**
HIV Education for HIV+ Individuals	0	4	1	2	0	0	0	3	3	0	2	0	1	0	1	0	0	1	0	0	0	0	**18**
Rental Assistance/Shelter Vouchers	4	4	5	2	3	**8**	5	**8**	4	0	3	0	0	0	0	0	2	0	0	0	2	1	**51**
Housing-Related Services	**6**	**7**	**6**	3	4	5	3	3	4	2	3	0	4	0	0	0	0	0	1	0	2	0	**53**
Legal Services	2	**3**	1	**3**	**3**	0	2	2	1	0	1	1	1	0	0	0	0	0	0	0	0	0	**20**
Nutritional Counseling	1	**3**	0	2	2	1	0	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0	**12**
Permanency Planning	1	0	0	1	0	1	0	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0	**6**
Referrals to Services	3	**6**	**4**	1	0	3	**4**	1	3	1	2	0	0	1	0	0	0	0	1	0	0	0	**30**
Referrals to Clinical Research	2	**3**	2	0	2	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	**12**
Support Groups	0	**7**	1	0	1	2	0	2	**3**	1	0	0	0	0	0	0	0	0	0	0	1	0	**18**
Translation/Interpretation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Transportation	**4**	**8**	1	3	**4**	2	1	1	**4**	1	2	0	0	2	0	0	0	1	1	0	1	0	**36**
Household Items	**3**	2	**3**	1	2	2	1	2	0	0	2	0	0	0	0	0	0	1	0	0	0	0	**19**
Total	**39**	**71**	**44**	**24**	**40**	**39**	**26**	**33**	**36**	**7**	**33**	**1**	**11**	**3**	**1**	**0**	**2**	**4**	**3**	**0**	**7**	**1**	**425**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions					
A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 3.38: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA OUT-OF-CARE (N=77)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of Out-of-care Reporting Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	12	50	0	16%	56	7%
Anonymous Sex Partner(s)	24	35	N/A	31%	141	18%
Greater than 5 Sex Partners	8	69	N/A	10%	60	8%

Of those meeting the HRSA Out-of-care definition, 12 (16%) reported that they had engaged in sex for drugs or money in the past 6 months, while 56 (7%) of all respondents reported this risk factor. Twenty four (31%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 141 (18%) of all respondents. Eight (10%) of those who are out-of-care reported that they had more than 5 sex partners in the past 6 months, while 60 (8%) of all respondents reported that they had more than 5 sex partners. For each element of the definition of very high risk of HIV transmission, a higher proportion of the out-of-care group identified themselves as meeting the definition.

TABLE 3.39: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA OUT-OF-CARE (N=77)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of Out-of-care Reporting Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	32	30	N/A	42%	235	31%
Shared Injecting Equipment	3	6	N/A	4%	12	2%
Serodiscordant Sex Partner(s)	7	43	12	9%	111	15%

Of those who are out-of-care, 32 (42%) reported that they had unprotected sex at least some of the time, while 235 (31%) of the entire sample reported this risk factor. Three (4%) of those out-of-care reported that they had shared injecting equipment at least some of the time, compared with 12 (2%) of the total sample reporting this risk factor. Seven (9%) of those out-of-care reported that they had an HIV-negative sex partner, while 111 (15%) of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

WOMEN

Overview

A total of 238 women completed the 2008 Need Assessment consumer survey. This total represents 31% of the total 764 survey respondents.

Demographics

TABLE 4.1: PREGNANCY STATUS AND AGE, WOMEN

Pregnant		N	%
Yes		15	6%
Don't Know		9	4%
Age	Range = 18 to 70; Avg = 42	**N**	**%**
18-24		19	8%
25-44		119	50%
45+		100	42%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among these women, 15 (6%) said they were pregnant at the time of the survey, and 9 (4%) said they did not know their pregnancy status. The average age of respondents was 42 years, with ages ranging from 18 to 70. The majority of these women were above the age of 25; approximately 50% were between the ages of 25-44, and another 42% were above the age of 45. Nineteen (8%) were youth between the ages of 18 and 24.

TABLE 4.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, WOMEN

Race/Ethnicity	N	%
White/Anglo	42	18%
Black/African-American	153	64%
Hispanic/Latino	40	17%
Asian	0	0%
Native American	1	0%
Multiracial	2	1%

Sexual Orientation	N	%
Straight/Heterosexual	214	90%
Gay/Lesbian	6	3%
Bisexual	10	4%
Undecided	1	0%
Prefer not to say	5	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (64%) identified as Black/African-American. Approximately 18% identified as White/Anglo, 17% as Hispanic/Latino, and 1% as Multiracial. One respondent identified as Native American, while none identified as Asian.

The majority of these women (64%) identified as straight or heterosexual. About six (3%) identified as gay/lesbian, 4% as bisexual. One respondent identified as undecided, and five (2%) said they preferred not to disclose their sexual orientation.

TABLE 4.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, WOMEN

Education	N	%
Less than high school	64	27%
High school degree/GED	127	53%
College degree	28	12%
Graduate/Professional degree	5	2%
Some technical training	14	6%
None	0	0%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	30	13%
Are you eligible for veteran benefits?	**N**	**%**
Yes	5	2%
No	221	93%
Don't Know	12	5%

The majority (80%) of female respondents had a high school degree/GED or less. Approximately 12% had a college degree, 2% had a graduate/professional degree and 6% had some technical training. None reported receiving no education.

A total of 30 (13%) of female survey respondents reported being released from jail or prison during the previous year.

Five female respondents (2%) were eligible for veteran benefits.

Immigration Status & Primary Language

TABLE 4.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, WOMEN

	N	%
Born outside U.S.	25	11%
Length of residency Range = 3 to 37 yrs; Avg = 13 yrs		
Immigration status	**N**	**%**
Citizen	217	91%
Permanent Resident	2	1%
Visa	4	2%
Undocumented	15	6%

** Percentages may not add up to 100% due to rounding or missing survey responses.

As a whole, foreign-born women represented 11% of all female respondents. Among the foreign born, lengths of residency in the U.S. ranged from 3 to 37 years with an average residency of 13 years.

Among all women, the majority (91%) were U.S. citizens. Two female respondents (1%) were permanent residents, 2% visa holder and 6% were undocumented.

TABLE 4.5: PREFERRED LANGUAGE, WOMEN

Preferred language at home with family/friends	N	%
English	207	87%
Spanish	23	10%
English/Spanish	7	3%
Other	1	0%
Preferred language when seeing a doctor	**N**	**%**
English	214	90%
Spanish	22	9%
English/Spanish	1	0%
Other	1	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by female survey respondents. Approximately 87% said they were most comfortable speaking English at home with family/friends, and 90% said they were most comfortable speaking English with their doctor. Twenty-two respondents (9%) were most comfortable speaking Spanish only and one (0%) preferred a combination of English and Spanish with their doctor.

Job Status & Income

TABLE 4.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, WOMEN

Job status	N	%
Not working due to disability	97	41%
Unemployed	87	37%
Part time	25	11%
Full time	17	7%
Temporary/contract/odd jobs	10	4%
Retired	2	1%
Average monthly income during past 6 months	Range = $0 - $6,200	Avg = $560.82
Approximate yearly income	**N**	**%**
Up to 300% FPL (2007 – 2008)	236	99%
200% FPL (2007 – 2008)	233	98%
100% FPL (2007 – 2008)	213	90%
Total income dependents	Range = 1 - 8	Avg = 2
Income dependents under 18	Range = 0 - 6	Avg = .6

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately 22% of all these respondents were employed at the time of the survey; 37% were unemployed, 41% were not working due to disability, and 1% were

retired. Seventeen respondents (7%) were working full-time, 11% part-time and 4% had temporary/contract/odd jobs. Per-month incomes ranged from $0 to $6,200, with an average of $561 per month.

The number of dependents per income ranged from 1 to 8 (average 2), with an average of less than one dependent being under the age of 18.

Based on estimated yearly incomes and household sizes, 90% of all respondents from this subgroup fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 4.7: SOURCES OF INCOME ASSISTANCE, WOMEN

Sources of income assistance	N	%
Food Stamps	74	31%
SSI	72	30%
None	50	21%
SSDI	42	18%
Hourly wages/Salary	19	8%
Social Security	19	8%
Rental Subsidy/Section 8	15	6%
TANF/AFDC	12	5%
Family/friends	6	3%
Child support	3	1%
Pension/Retirement/Savings	2	1%
Unemployment	2	1%
Private Disability	3	1%
VA Benefits	0	0%
Workers Comp	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among these survey respondents were food stamps (31%), Supplemental Security Income (SSI) (30%) and Social Security Disability Insurance (SSDI) (18%). No survey respondents received worker's compensation. Fifty respondents (21%) from this subgroup reported no source of income.

Paying for Medical Care

TABLE 4.8: SOURCES OF PAYMENT FOR MEDICAL CARE, WOMEN

Paying for medical care	N	%
Medicaid	99	42%
Medicare	37	16%
Gold Card/County	27	11%
Other	26	11%
I don't receive medical care because I can't pay for it	19	8%
Private insurance/COBRA	4	2%
Self-Pay	10	4%
VA	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

According to the Centralized Patient Care Data Management System (CPCDMS), 6,961 clients paid for primary medical care using Ryan White funding resources. Among women that completed the survey, Medicaid (42%), the Medicare (16%), and the Gold Card/County (11%) were the most common methods of paying for medical care. The Harris County Gold Card program assists eligible low-income residents with medical expenses and prescriptions.

Eleven percent of all women surveyed reported other resources and none reported the Veteran's Administration Hospital. Eight percent of these respondents said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 4.9: LENGTH OF HIV DIAGNOSIS, WOMEN

Length of diagnosis	N	%
Less than 1 year	8	3%
1-4 years	82	35%
5-10 years	60	25%
11-15 years	46	19%
16-20 years	27	11%
21 and over	13	6%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of respondents (35%) reported being diagnosed as HIV positive between 1 and 4 years.

TABLE 4.10: LOCATION OF HIV DIAGNOSIS, WOMEN

Location of diagnosis	N	%
Public or community clinic	61	26%
In hospital stay	42	18%
Private doctor	37	16%
Jail/Prison	26	11%
ER	23	10%
HIV-specific testing site	20	8%
Community testing location	18	8%
Alcohol or drug treatment facility	8	3%
Work/insurance related	2	1%
Blood/Plasma donation	1	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Over one-quarter (26%) of women surveyed received their diagnoses at a public or community clinic. Other common diagnosis locations for overall respondents were in a hospital stay (18%), a private doctor (16%). Less frequently identified locations included jail/prison (11%), emergency rooms (10%), community testing locations (8%) and HIV-specific testing sites (8%).

TABLE 4.11: REASONS FOR HIV TESTING, WOMEN

Reasons for testing	N	%
Felt sick	46	19%
Had sex with someone HIV+	37	16%
ER/Hospital stay	36	15%
Engaged in risky behavior	38	16%
Recommended by provider	31	13%
During pregnancy care	26	11%
Was in prison/jail	23	10%
Routine check up/testing	22	9%
Work/insurance related	4	2%
Other	3	1%
Knew someone with HIV	2	1%
In drug treatment program	2	1%
Recommended by friends	2	1%
Blood/plasma donation	1	0%
Partner notification	1	0%
Incentive offered	1	0%
Rape survivor	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were due to feeling sick (19%), having sex with someone HIV positive (16%), and engaging in risky behavior (16%). Other common reasons included during an ER/hospital stay (15%), due to being recommended by a provider (13%), or because of pregnancy care (11%).

TABLE 4.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, WOMEN

Assistance at diagnosis	N	%
Information about HIV/AIDS	137	58%
Medical services	113	47%
Counseling	89	37%
None	58	24%
Help with food or shelter	30	13%
Alcohol or drug treatment services	19	8%
Supportive Services	3	1%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to these respondents were information about HIV/AIDS (58%), medical services (47%) and counseling (37%). A total of fifty-eight (24%) respondents reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 4.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, WOMEN

Time to first doctor visit	N	%
Less than 1 month	114	48%
1-6 months	68	29%
6-12 months	28	12%
More than 12 months	26	11%
Never	2	1%

Time to CD4/Viral Load	N	%
Less than 1 month	83	35%
1-6 months	89	37%
6-12 months	25	11%
More than 12 months	31	13%
Never	10	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (48%) of all women surveyed reported seeing a doctor for HIV within one month of receiving their diagnosis. For 29% of these respondents, 1 to 6 months passed before seeing a doctor. Approximately 12% waited between 6 to 12 months, and 11% waited more than a year to see a doctor for HIV. A total of two respondents (1%) said they still had not seen a doctor for HIV. Likewise, 35% reported receiving their first CD4/ viral load test within one month of being diagnosed, 37% within 1-6 months, 11% between 6-12 months and 13% waited more than a year. A total of ten respondents (4%) said they had never received a CD4 or viral load test.

TABLE 4.14: REASONS FOR DELAYED ENTRY INTO CARE, WOMEN

Reasons for waiting more than 6 months	N	%
Afraid	33	14%
Denial	31	13%
Depressed/emotional problems	25	11%
Didn't feel sick	17	7%
No stable place to live	17	7%
Doing drugs	14	6%
Jail/prison	12	5%
Didn't want to take meds	13	5%
No money	9	4%
Other	5	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were fear (14%), denial (13%), depression/emotional problems (11%). Other reasons were shelter instability (7%), not feeling sick (7%), and being in jail/prison (5%).

Maintenance in Care

TABLE 4.15: TIME SINCE LAST VISIT TO DOCTOR AND VIRAL LOAD AND CD4 AND HIV MEDICATION PRESCRIPTION, WOMEN

Last visit to doctor for HIV	N	%
Less than 6 months	185	78%
6-12 months	20	8%
More than 12 months	24	10%
Never/Don't Know	8	3%
Last viral load	**N**	**%**
Less than 6 months	179	75%
6-12 months	18	8%
More than 12 months	29	12%
Never/Don't Know	11	5%

Last CD4	N	%
Less than 6 months	184	77%
6-12 months	19	8%
More than 12 months	22	9%
Never/Don't Know	12	5%
Last HIV meds prescription	**N**	**%**
Less than 6 months	148	62%
6-12 months	20	8%
More than 12 months	30	13%
Never/Don't Know	38	16%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of women surveyed said their most recent doctor's visit (78%), viral load (75%), CD4 test (77%) and HIV medication prescription (62%) were within the past 6 months.

TABLE 4.16: FREQUENCY OF DOCTOR'S VISITS, WOMEN

No doctor visits more than 6 months?	N	%
Yes	102	43%
No	132	55%
No doctor visits more than 12 months?	**N**	**%**
Yes	60	25%
No	164	69%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Table 4.16 above outlines the number and percentage of respondents who did not visit a doctor for over 6 months or more since being diagnosed. Among respondents who have seen a doctor for HIV, 43% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 25% reported not seeing a doctor for 12 months or more.

TABLE 4.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, WOMEN

Reasons for no doctor visits	N	%
Doing drugs	33	14%
Felt fine	31	13%
Did not want to take meds	29	12%
Denial	27	11%
Lost stable housing	23	10%
Tired of regimen	16	7%
Worried about side effects	17	7%
Lost my job	12	5%
Bad experience with provider	9	4%
No transportation	7	3%
Lost health insurance	6	3%
Doctor left	5	2%
Jail/prison	3	1%
Had to care for children/family member	4	2%
Case manager left	4	2%
Program closed down	2	1%
Depression/emotional barriers	2	1%
Agency closed down	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Table 4.17 above provides an outline of supplementary responses to the previous table and outlines the specific reasons reported for not visiting a doctor for more than 6

months among this subgroup. The most frequently reported reasons for falling out of care were due to doing drugs (14%), feeling fine (13%), not wanting to take meds (12%) and denial (11%).

TABLE 4.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, WOMEN

First place of care	N	%		Most often location of care	N	%
Public clinic/community health ctr	132	55%		Public clinic/community health ctr	149	63%
Private Clinic/Doctor's Office	53	22%		Private Clinic/Doctor's Office	59	25%
ER/Hospital	24	10%		ER/Hospital	13	5%
Prison/jail	20	8%		Prison/jail	7	3%
I have not received care for HIV	8	3%		I have not received care for HIV	9	4%
VA Hospital	0	0%		VA Hospital	0	0%
Other	0	0%		Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was a public clinics/ community health centers (55%). Other locations were private clinics/doctor offices (22%), emergency rooms/hospitals (10%), or prisons/jails (8%). Locations of ongoing care were public clinics/community health centers or public clinics/doctor offices (25%). No respondents received care most often from the Veteran's Administration Hospital.

TABLE 4.19: KNOWLEDGE OF CASE MANAGER, WOMEN

Case Manager	N	%
Yes	172	72%
No	40	17%
Don't Know	25	11%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of women surveyed (72%) reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services and to assist in accessing medical-related services. Forty respondents (17%) said they did not have such a person assisting them, and 11% said they didn't know.

Health Status

TABLE 4.20: SOURCES OF PAYMENT FOR MEDICAL CARE, WOMEN

How would you describe your health overall	N	%
Excellent	33	14%
Good	107	45%
Fair	83	35%
Poor	13	5%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 14% said "Excellent," 45% said "Good," 35% said "Fair" and 5% said "Poor."

TABLE 4.21: SELF-REPORTED PHYSICAL HEALTH STATUS AND ER OR HOSPITAL VISITS, WOMEN

During the past month, has your physical health interfered with normal activities?	N	%
No	91	38%
Yes – Some of the time	121	51%
Yes – all of the time	24	10%
ER visit in past 6 months	93	39%
Hospital stay in past 6 months	58	24%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (51%) of all women surveyed reported that during the past month, their physical health had interfered with normal activities some of the time. Approximately 10% said their physical health interfered all of the time.

For the 6 months prior to the survey, 39% of all respondents in this group reported an emergency room visit and 24% reported being admitted to a hospital for one or more nights.

TABLE 4.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, WOMEN

Symptoms during past month	N	%
Trouble with thinking, concentrating or memory	132	55%
Depressed or sad, trouble thinking	174	73%
Aches, fatigue, lightheadedness, weak all over	113	47%
Trouble with eyes or ears	99	42%
Trouble with nose or sinuses, headaches	93	39%
Nausea, vomiting, diarrhea, abdominal pain	85	36%
Numbness, tingling or pain in an arm or leg	86	36%
Coughing, wheezing, or chest pain, trouble breathing	81	34%
Fevers, chills, sweats	71	30%
Poor appetite, weight loss	71	30%
Rash, itch, herpes, or other skin trouble	56	24%
Trouble with mouth or swallowing	40	17%
None	18	8%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The number of symptoms reported by all respondents during the past month ranged from 1 to 12. The top three reported symptoms were depression/sadness or trouble

thinking (73%), trouble with memory or concentration (55%) and aches, fatigue, or lightheadedness (47%).

TABLE 4.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, WOMEN

First CD4/T-cell	N	%
Less than 50	28	12%
50-99	8	3%
100-199	26	11%
200-349	23	10%
350-499	38	16%
500+	45	19%
Don't Know/Can't Remember	68	29%

Current CD4/T-cell	N	%
Less than 50	15	6%
50-99	6	3%
100-199	24	10%
200-349	35	15%
350-499	38	16%
500+	46	19%
Don't Know/Can't Remember	71	30%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of forty-five (19%) of these respondents reported their first CD4/T-cell counts as 500+; 26% were 200 to 499, 14% were 50 to 199, and 12% were less than 50. Current CD4/T-cell counts were 500+ for 19% of all women surveyed; 200 to 499 for 31%, 50 to 199 for 13%, and less than 50 for 6% of all respondents from this subgroup. Sixty-eight respondents (29%) didn't know or couldn't remember their first CD4/T-cell count, and 30% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 4.24: HIV MEDICATIONS, WOMEN

Currently taking HIV meds	N	%
Yes	167	70%
No	70	29%
How many pills do you take in one day?	Range = 1 to 28	Avg = 5

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of respondents (70%) said they were currently taking HIV medications. The number of pills taken in one day ranged from 1 to 28, with an average of five pills per day.

TABLE 4.25: SELF-REPORTED MEDICATION ADHERENCE, WOMEN

Medication adherence	N	%
I have not missed any doses in the past month	76	32%
Missed a few, but took nearly all	72	30%
Took more than half	5	2%
About half	9	4%
Some, but not half	8	3%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	151	63%
No	59	25%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among all women surveyed currently taking HIV medications, 32% reported perfect adherence and 30% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 63% said "Yes" and 25% said "No."

TABLE 4.26: REASONS FOR NOT TAKING HIV MEDICATIONS, WOMEN

Reasons for not taking HIV medications	N	%
T-cell too high	19	8%
I choose not to take them	16	7%
Doctor did not think it was a good idea for me	14	6%
Side effects	10	4%
No doctor has offered them	9	4%
Cannot pay	7	3%
Confidentiality concerns	7	3%
Have not seen doctor	6	3%
Too difficult to take as prescribed	5	2%
Not effective	4	2%
Didn't feel sick	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "T-cell too high" (8%) followed by "I choose not to take them" (7%), "doctor did not think it was a good idea for me" (6%).

TABLE 4.27: MEDICATIONS FOR NON-HIV CONDITIONS, WOMEN

How many pills do you take in one day for non-HIV conditions?	N	%
Depression/emotional problems	101	42%
High blood pressure	63	26%
High cholesterol	27	11%
Diabetes	23	10%
Pain	12	5%
Acid reflux	13	5%
Sleep	7	3%
Neuropathy	5	2%
Anemia	4	2%
Arthritis	3	1%
Asthma	3	1%
Allergies/Sinus	2	1%
Antibiotics	1	0%
Eye drops/glaucoma	1	0%
Nausea	0	0%
Hormones	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

In Table 4.27 above, the "N" represents the number of respondents indicating taking pills for the associated non-HIV conditions. The most common conditions associated with the non-HIV pills were depression/emotional problems (42%), high blood pressure (26%), high cholesterol (11%) and diabetes (10%).

TABLE 4.28: TOTAL PILL BURDEN AND ABILITY TO PAY, WOMEN

Total Pills (HIV + non-HIV)	Avg = 7	
How often do you have trouble paying for these or other non-HIV meds?	**N**	**%**
Never	132	55%
Less than half the time	33	14%
More than half the time	17	7%
Always	33	14%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was seven. Over half (55%) of all respondents from this subgroup reported never having problems paying for HIV or non-HIV medications, and 14% had problems less than half the time. Seven percent had problems more than half the time, and 14% said they always had problems paying for their medications.

Comorbidities

TABLE 4.29: HEPATITIS C AND TB STATUS, WOMEN

Hep C Test?	N	%
Yes	179	75%
No	44	18%
Don't Know	15	6%
Positive for Hep C?	**N**	**%**
Yes	55	23%
No	147	62%
Don't know	35	15%

TB skin test?	N	%
Yes	222	93%
No	12	5%
Result	**N**	**%**
Positive	21	9%
Negative	179	75%
Don't Know	8	3%
History of active TB?	**N**	**%**
Yes	22	9%
No	212	89%
Don't Know	4	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (75%) of all women surveyed respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 23% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C. test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

Likewise, the majority of respondents (93%) respondents had received a skin test for TB, and 9% reported a positive result. A total of twenty-two (9%) reported a history of active TB.

Mental Health

TABLE 4.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, WOMEN

	N	%
At least one mental health condition	154	65%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	108	45%
Hallucinations	18	8%
Serious thoughts of suicide	28	12%
Attempted suicide	11	5%
Wanted to hurt or harm yourself	26	11%
Wanted to hurt or harm someone else	29	12%
Trouble controlling anger leading to physical violence	51	21%
Problems requiring meds	66	28%
None	78	33%
At least one serious indicator (suicide/homicidal or requiring meds)	72	30%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Over half (65%) of all respondents from this subgroup reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced symptoms were serious anxiety/tension (45%), problems with medications (28%), and trouble controlling anger (21%).

TABLE 4.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, WOMEN

Since being diagnosed, ever talked with therapist?	**N**	**%**
Yes	169	71%
No	69	29%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	163	68%
No	75	32%
Since being diagnosed, ever attended a support subgroup?	**N**	**%**
Yes	136	57%
No	101	42%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 71% of women surveyed said they had talked with a therapist or psychologist for help with depression or emotional problems and 68% had talked to a doctor or psychiatrist for medications. Over half (57%) said they had participated in a support subgroup since being diagnosed with HIV.

Substance Use & Abuse

TABLE 4.32: SUBSTANCE USE, WOMEN

Total Number of substances Range = 1 to 6; Avg = 2	**N**	**%**
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	2	1%
Street Methadone (non-treatment)	1	0%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	56	24%
Barbituates (seconal, tuinal, downers)	5	2%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	1	0%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	3	1%
Amphetamines (speed, uppers, crystal meth, ice, glass)	7	3%
Marijuana, Hashish (grass, weed)	2	1%
Heroin	1	0%
Cocaine (powder), Crack	41	17%
Ecstasy, X, MDA, GHB	1	0%
Ketamine (K, Special K)	8	3%
None	147	62%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The numbers of substances used among women ranged from 1 to 6, with an average of two. The most commonly used substances for all respondents were cocaine (24%) and marijuana (17%).

TABLE 4.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, WOMEN

In the last year, ever drunk more than meant to?	**N**	**%**
Yes	58	24%
No	178	75%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	62	26%
No	169	71%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	62	26%
No	173	73%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	72	30%
No	161	68%
Indicator of Alcohol Abuse	73	31%
Indicator of Substance Abuse	74	31%
Abuse of both drugs and alcohol	46	19%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.). The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 31% of all women surveyed indicated possible alcohol abuse, and 31% indicated possible substance abuse. Approximately 19% indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 4.34: SOCIAL SUPPORT, WOMEN

Of all the people you feel close to, how many have you told about being HIV+?	N	%
All	79	33%
Some	129	54%
None	29	12%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	192	81%
No	45	19%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 33% had disclosed their HIV status to all and 54% had disclosed their status to some. Approximately 12% had not told their HIV status to any of the people to whom they feel close. Overall, 81% of respondents in this group said there were people they could depend on for help if really needed.

Housing

TABLE 4.35: HOUSING STATUS, WOMEN

Where do you most often sleep?	N	%
Apartment/House	192	81%
Street	16	7%
Subgroup home/halfway house	15	6%
Shelter	14	6%
Other	1	0%
Do you feel your housing situation is stable?	**N**	**%**
Yes	151	63%
No	87	37%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of women surveyed (81%) reported sleeping most often in an apartment/house. Others reported subgroup home/halfway house (6%), shelter (6%),

street (7%) and other (0%) locations. More than half (63%) of all respondents felt their housing situation was stable, and 37% felt their housing situation was unstable.

TABLE 4.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, WOMEN

In the past year, has your housing situation made it difficult to get HIV care?	N	%
Yes	74	31%
No	164	69%
Reasons	**N**	**%**
Money for food	41	17%
Money for rent	39	16%
Money for household supplies	35	15%
Money for utilities	31	13%
I could not keep my status private	22	9%
No child care	22	9%
No place to store meds	16	7%
Lack of transportation	6	3%
No stable address	2	1%
Rules	1	0%
Used money on drugs	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of seventy-four respondents (31%) said that in the past year, their housing situation made it difficult for them to get HIV care. The most common reasons for these difficulties were using money for food (17%), rent (16%), or household supplies (15%).

ACCESS TO CORE SERVICES

TABLE 4.37: ACCESS TO CORE SERVICES, WOMEN

Service Category	In the past 12 months…					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	57	24%	167	70%	14	6%
HIV/AIDS Medications	49	21%	149	63%	40	17%
Dentist Visits	89	37%	108	45%	41	17%
Medical Case Management	46	19%	134	56%	58	24%
Home Health Care	25	11%	27	11%	186	78%
Psychiatric Services or Medicine	39	16%	103	43%	96	40%
Psychological Counseling	33	14%	101	42%	104	44%
Substance Abuse Treatment	13	5%	64	27%	161	68%
Rehabilitation Services	15	6%	50	21%	173	73%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For all women surveyed, the top three “easy to get” core services were primary medical care (70%), HIV/AIDS medications (63%) and medical case management (56%). The top three core services that respondents reported “some difficulty getting” were dentist visits (37%), primary medical care (24%) and HIV/AIDS medications (21%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that women said they “did not need” in the past year were home health care (78%), rehabilitation services (73%) and substance abuse treatment (68%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 4.38: ACCESS TO SUPPORTIVE SERVICES, WOMEN

Service Category	In the past 12 months…				
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service
Child Care Services	24	73%	7	21%	2
Child Welfare Services	4	50%	2	25%	2
Day/Respite Care for Adults	2	20%	5	50%	3
Developmental	3	75%	0	0%	1
Emergency Financial Assistance	69	61%	37	32%	8
Employment Assistance	32	67%	10	21%	6
Food Bank	39	35%	67	61%	4
HIV Education for HIV+ Individuals	9	17%	40	77%	3
Rental Assistance/Shelter Vouchers	63	67%	28	30%	3
Housing-Related Services	64	73%	19	22%	5
Legal Services	19	42%	14	31%	12
Nutritional Counseling	12	36%	19	58%	2
Permanency Planning	6	50%	2	17%	4
Referrals to Services	16	36%	26	59%	2
Referrals to Clinical Research	13	57%	8	35%	2
Support Groups	29	36%	43	53%	9
Translation/Interpretation	3	100%	0	0%	0
Transportation	45	45%	53	52%	3
Household Items	37	67%	17	31%	1

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For all women surveyed, the supportive services that were selected most often (thus implying high helpfulness/usefulness) were emergency financial assistance, rental assistance/shelter vouchers, housing-related services, transportation and food bank.

The top five “easy to get” supportive services (based on number of responses) were

food bank (n=67), transportation (n=53), support subgroups (n=43), HIV education for HIV positive individuals (n=40), and emergency financial assistance (n=37). The top five supportive services that respondents reported "some difficulty getting" were emergency financial assistance (n=69), housing-related services (n=64), rental assistance/shelter vouchers (n=63), transportation (n=45), and household items (n=37). The presence of certain support services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates. Conversely, the five supportive services that respondents did not need in the past year, but still identified as useful/helpful were legal services (n=12), support subgroups (n=9), emergency financial assistance (n=8), employment assistance (n=6), and housing-related services (n=5). ["n=*value*" indicates the number of responses for each service category.]

Barriers Reported per Core Service Category

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among women surveyed, the three core services with the highest number of barriers were dentist visits (n=177), primary medical care (n=135), and HIV/AIDS medications (n=99). Within dentist visits, the most commonly reported barriers were: "It's hard to make or keep appointments" (n=29), "I would have to wait too long to get the services" (n=27), "it's hard for me to get there" (n=21), and "I don't know where to get the service" (n=21). For primary medical care, the most common barriers for respondents from this subgroup were: "it's hard for me to get there" (n=24), "it's hard to make or keep appointments" (n=22), and I don't know where to get the service" (n=14). For HIV/AIDS medications, the most common barriers reported among women were: "the services cost too much" (n=17), "I would have to wait too long to get the services" (n=12), and "I don't know where to get the services" (n=11), and "it's hard for me to get there" (n=11).

The barriers experienced most often by all women surveyed respondents across all core services were: "it's hard to make or keep appointments" (n=107), "I don't know where to get the services" (n=100), and "it's hard for me to get there" (n=97).

TABLE 4.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, WOMEN

Service Category	Barriers																			
	A	B	C	D	E	F	G	H	I	J	K	L	M	O	P	Q	R	S	T	U	Total
Primary Medical Care	6	**14**	8	12	3	8	8	**22**	**24**	7	13	0	3	3	0	1	1	2	0	0	**135**
HIV/AIDS Medications	5	**11**	**12**	**17**	7	5	4	9	**11**	4	7	2	1	2	0	1	0	0	1	0	**99**
Dentist Visits	12	**21**	**27**	15	7	10	9	**29**	**21**	6	6	0	0	12	0	0	1	1	0	0	**177**
Medical Case Management	7	**11**	9	4	3	8	**11**	**16**	10	2	3	0	1	0	0	2	0	1	0	2	**90**
Home Health Care	0	**7**	3	2	4	**5**	4	2	2	0	3	0	0	0	0	0	0	1	2	0	**35**
Psychiatric Services or Medicine	6	**14**	**11**	9	5	5	6	**13**	**11**	4	4	0	0	0	0	0	2	0	0	0	**90**
Psychological Counseling	4	**11**	6	**10**	1	2	5	8	**10**	3	2	0	0	0	1	0	2	1	0	0	**66**
Substance Abuse Treatment	1	**5**	1	**4**	0	3	1	2	**5**	3	2	1	0	0	0	0	0	0	0	0	**28**
Rehabilitation Services	1	**6**	2	3	0	3	1	**6**	3	1	2	1	0	0	0	0	0	0	0	0	**29**
Total	**42**	**100**	**79**	**76**	**30**	**49**	**49**	**107**	**97**	**30**	**42**	**4**	**5**	**17**	**1**	**4**	**6**	**6**	**3**	**2**	**749**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Barriers Reported per Supportive Service Category

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among all women surveyed, the five supportive services with the highest number of barriers were emergency financial assistance (n=153), housing-related services (n=139), rental assistance/shelter vouchers (n=130), transportation (n=89), and food bank (n=72). Within emergency financial assistance, the most commonly reported barriers were "I would have to wait too long to get the services" (n=26), "the services are not in my area" (n=21),"I don't know where to get the services" (n=20). For housing-related services, the most common barriers for these respondents were "I don't know where to get the services" (n=25), I would have to wait too long to get the services" (n=22), and "I was told I am not eligible to get the services" (n=14). For rental assistance/shelter vouchers, the most common barriers for women were "I don't know where to get the services" (n=16), "I would have to wait too long to get the services" (n=16), and "I don't think I'm eligible to get the services" (n=13).

The barriers experienced most often by all women surveyed across all supportive services were "I don't know where to get the services" (n=199), "I would have to wait too long to get the services" (n=112), and "it's hard for me to get there" (n=101).

TABLE 4.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, WOMEN

Service Category	Barriers																				
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	P	Q	R	S	U	V	Total
Child Care Services	6	14	6	**9**	**7**	2	2	1	7	5	1	1	0	0	0	0	0	0	1	0	**62**
Child Welfare Services	0	1	1	0	1	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	**5**
Day/Respite Care for Adults	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	**3**
Developmental Assessment	0	2	2	0	0	1	0	1	1	1	1	0	0	0	0	0	0	0	0	0	**9**
Emergency Financial Assistance	**21**	**20**	**26**	4	**20**	11	9	14	11	3	6	0	2	1	0	1	0	0	4	0	**153**
Employment Assistance	5	**15**	3	0	4	2	1	2	5	2	5	1	4	0	0	0	0	0	0	0	**49**
Food Bank	**12**	**13**	6	1	3	4	1	3	**18**	0	2	0	0	2	0	1	0	0	5	1	**72**
HIV Education for HIV+ Individuals	1	5	0	1	0	0	1	0	1	0	1	0	0	0	0	0	0	0	1	0	**11**
Rental Assistance/Shelter Vouchers	11	**16**	**16**	9	11	**13**	9	9	7	2	5	0	4	2	0	3	0	3	8	2	**130**
Housing-Related Services	12	**25**	**22**	7	**14**	10	6	10	10	3	6	0	7	0	0	0	0	3	4	0	**139**
Legal Services	2	**11**	2	3	2	1	1	2	3	0	1	0	2	1	1	0	0	0	0	0	**32**
Nutritional Counseling	2	6	2	1	1	2	0	3	4	0	2	0	0	1	0	0	0	0	0	0	**24**
Permanency Planning	0	4	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**6**
Referrals to Services	1	**8**	3	0	0	1	2	3	4	1	1	0	0	2	0	0	0	1	0	0	**27**
Referrals to Clinical Research	2	**6**	3	0	3	3	0	1	4	0	0	0	0	0	0	0	0	0	0	0	**22**
Support Groups	**6**	**17**	3	0	2	4	0	1	**6**	1	1	0	0	0	0	0	1	1	0	0	**43**
Translation/Interpretation	0	0	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	**3**
Transportation	**10**	**16**	8	5	8	4	3	6	**12**	3	2	0	1	5	0	2	1	2	1	0	**89**
Household Items	**8**	**20**	6	4	6	3	2	4	6	1	3	0	0	0	0	1	1	0	0	0	**65**
Total	**99**	**199**	**112**	**44**	**82**	**61**	**38**	**62**	**101**	**22**	**37**	**3**	**20**	**15**	**1**	**8**	**3**	**10**	**24**	**3**	**944**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions

A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 4.41: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA WOMEN (N=238)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of Women Reporting Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	24	139	3	10%	56	7%
Anonymous Sex Partner(s)	27	134	N/A	11%	141	18%
Greater than 5 Sex Partners	5	231	N/A	2%	60	8%

Of women surveyed, 24 (10%) reported that they had engaged in sex for drugs or money in the past 6 months, while 56 (7%) of all respondents reported this risk factor. Twenty seven (11%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 141 (18%) of all respondents. Five (2%) of the women surveyed reported that they had more than 5 sex partners in the past 6 months, while 60 (8%) of all respondents reported that they had more than 5 sex partners.

TABLE 4.42: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA WOMEN (N=238)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of Women Reporting Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	72	96	N/A	30%	235	31%
Shared Injecting Equipment	2	8	N/A	1%	12	2%
Serodiscordant Sex Partner(s)	56	94	18	24%	111	15%

Of women surveyed, 72 (30%) reported that they had unprotected sex at least some of the time, while 235 (31%) of the entire sample reported this risk factor. Two (1%) women sampled reported that they had shared injecting equipment at least some of the time, compared with 12 (2%) of the total sample reporting this risk factor. Fifty-six (24%) of women reported that they had an HIV-negative sex partner, while 111 (15%) of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

YOUTH

Overview

A total of 37 total youth, respondents aged 13 to 24 years, completed the 2008 Need Assessment consumer survey. This total represents 5% of the total 764 survey respondents.

[See Appendix A for a Special Study on HIV+ Youth, conducted by the Ryan White Planning Council and Part A Health Planner].

Demographics

TABLE 5.1: GENDER, PREGNANCY STATUS, YOUTH

Gender	N	%
Male	16	43%
Female	19	51%
Transgender – Male to Female	2	5%
Pregnant	**N**	**%**
Yes	5	26%
Don't Know	2	11%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of respondents were female (51%). Males represented 43% of all respondents in this subgroup, and transgender Male to Female youth represented 5%. None of the respondents identified as transgender Female to Male. Among females, 26% said they were pregnant at the time of the survey, and 11% said they did not know their pregnancy status.

TABLE 5.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, YOUTH

Race/Ethnicity	N	%
White/Anglo	4	11%
Black/African-American	26	70%
Hispanic/Latino	6	16%
Asian	0	0%
Native American	1	3%
Multiracial	0	0%

Sexual Orientation	N	%
Straight/Heterosexual	26	70%
Gay/Lesbian	8	22%
Bisexual	3	8%
Undecided	0	0%
Prefer not to say	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of these youth identified as Black/African-American (70%).

Approximately 16% identified as Hispanic/Latino, 11% identified as white/Anglo, and 3% as Native American. None identified as Asian or multiracial.

The majority (70%) of all youth respondents identified as straight or heterosexual. About 22% identified as gay/lesbian, and 8% as bisexual. None identified as undecided or said they preferred not to disclose their sexual orientation.

TABLE 5.3: EDUCATION LEVEL AND INCARCERATION HISTORY AND VETERAN BENEFITS ELIGIBILITY, YOUTH

Education	**N**	**%**
Less than high school	7	19%
High school degree/GED	25	68%
College degree	3	8%
Graduate/Professional degree	0	0%
Some technical training	2	5%
None	0	0%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	6	16%
Are you eligible for veteran benefits?	**N**	**%**
Yes	0	92%
No	34	8%
Don't Know	3	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Over half (87%) of respondents in this subgroup had a high school degree/GED or less. Eight percent had a college degree, and 5% had some technical training. None reported having a graduate/professional degree or receiving no education.

A total of six respondents (16%) from this subgroup reported being released from jail or prison during the previous year.

No youth reported being eligible for veteran benefits represented.

Immigration Status & Primary Language

TABLE 5.4: FOREIGN BORN AND LENGTH OF RESIDENCY AND IMMIGRATION STATUS, YOUTH

	N	%
Born outside U.S.	6	16%
Length of residency	Range = 6 to 17 yrs; Avg = 9 yrs	
Immigration status	**N**	**%**
Citizen	32	87%
Permanent Resident	1	3%
Visa	0	0%
Undocumented	4	11%

** Percentages may not add up to 100% due to rounding or missing survey responses.

As a whole, foreign-born youth represented 16% of all respondents from this subgroup. Among the foreign born, lengths of residency in the U.S. ranged from 6 to 17 years with an average residency of 9 years.

Among all youth respondents, 87% were U.S. citizens. Three percent were permanent residents and 11% were undocumented. None indicated being visa holders.

TABLE 5.5: PREFERRED LANGUAGE, YOUTH

Preferred language at home with family/friends	**N**	**%**
English	30	81%
Spanish	3	8%
English/Spanish	3	8%
Other	1	3%
Preferred language when seeing a doctor	**N**	**%**
English	33	89%
Spanish	3	8%
English/Spanish	0	0%
Other	1	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by youth respondents. Approximately 81% said they were most comfortable speaking English at home with family/ friends, and 89% said they were most comfortable speaking English with their doctor. Eight percent were most comfortable speaking Spanish only and none preferred a combination of English and Spanish with their doctor.

Job Status & Income

TABLE 5.6: JOB STATUS AND AVERAGE INCOME AND INCOME DEPENDENTS, YOUTH

Job status	N	%
Full time	6	16%
Part time	5	14%
Temporary/contract/odd jobs	1	3%
Not working due to disability	10	27%
Unemployed	15	41%
Average monthly income during past 6 months	Range = $0 to $6,200; Avg = $662.72	
Approximate yearly income	**N**	**%**
Up to 300% FPL (2007 – 2008)	36	97%
Up to 200% FPL (2007 - 2008)	36	97%
Up to 100% FPL (2007 - 2008)	35	95%
Total income dependents	Avg = 2	
Income dependents under 18	Avg = .81	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately 44% of all youth respondents were employed at the time of the survey. Forty-one percent were unemployed, 27% were not working due to disability. Among employed youth respondents, 16% were working full-time, 14% part-time and 3% had temporary/contract/odd jobs.

Per-month incomes ranged from $0 to $6,200, with an average of $663 per month. The average number of dependents per income was 2, with an average of less than 1 being under the age of 18. Based on estimated yearly incomes and household sizes, 97% of all youth respondents fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 5.7: SOURCES OF INCOME ASSISTANCE, YOUTH

Sources of income assistance	N	%
None	14	38%
Hourly wages/Salary	7	19%
SSI	7	19%
SSDI	1	3%
Social Security	2	5%
TANF/AFDC	5	14%
Food Stamps	13	35%
Rental Subsidy/Section 8	0	0%
Workers Comp	0	0%
Unemployment	2	5%
Private Disability	0	0%
VA Benefits	0	0%
Child support	0	0%
Family/friends	2	5%
Pension/Retirement/Savings	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among youth survey respondents were food stamps (35%), hourly wages/salary (19%) and Supplemental Security Income (SSI) (19%). No survey respondents received worker's compensation.

A total of 14 youth respondents (38%) within this subgroup reported no source of income.

Paying for Medical Care

TABLE 5.8: SOURCES OF PAYMENT FOR MEDICAL CARE, YOUTH

Paying for medical care	N	%
I don't receive medical care because I can't pay for it	2	5%
Private insurance/COBRA	0	0%
VA	0	0%
Medicaid	12	32%
Medicare	0	0%
Self-Pay	2	5%
Gold Card/County	15	41%
Other	3	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

According to the Centralized Patient Care Data Management System (CPCDMS), 6,961 clients paid for primary medical care using Ryan White funding resources. Among youth respondents, the Gold Card/County (41%), Medicaid (32%) and other resources were reported to be common methods of paying for medical care. The Harris County Gold Card program assists eligible low-income residents with medical expenses and prescriptions. Approximately 5% of youth respondents said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 5.9: LENGTH OF HIV DIAGNOSIS, YOUTH

Length of diagnosis Range = 9 mos to 12 yrs; Avg = 4 yrs	N	%
Less than 1 year	2	5%
1-4 years	26	70%
5-10 years	6	16%
11-15 years	1	3%
16-20 years	0	0%
21 and over	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Youth respondents reported being diagnosed as HIV positive an average of 4 years, ranging from 9 months to 12 years.

TABLE 5.10: LOCATION OF HIV DIAGNOSIS, YOUTH

Location of diagnosis	N	%
Private doctor	6	16%
ER	6	16%
In hospital stay	6	16%
HIV-specific testing site	2	5%
Public or community clinic	11	30%
Jail/Prison	2	5%
Community testing location	3	8%
Alcohol or drug treatment facility	0	0%
Blood/Plasma donation	0	0%
Work/insurance related	0	0%
Other	1	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (30%) of youth respondents received their diagnoses at a public or community clinic. Other common diagnosis locations for youth respondents were a private doctor (16%), emergency room (16%), and in a hospital stay (16%). Less frequently identified locations included community testing location (8%), HIV-specific testing site (5%), or jail/prison (5%).

TABLE 5.11: REASONS FOR HIV TESTING, YOUTH

Reasons for testing	N	%
Recommended by provider	9	24%
Had sex with someone HIV+	5	14%
ER/Hospital stay	6	16%
Felt sick	15	41%
Engaged in risky behavior	8	22%
Was in prison/jail	1	3%
During pregnancy care	0	0%
Routine check up/testing	4	11%
Blood/plasma donation	0	0%
Work/insurance related	0	0%
Partner notification	0	0%
Knew someone with HIV	1	3%
Rape survivor	0	0%
Incentive offered	0	0%
In drug treatment program	0	0%
Recommended by friends	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were feeling sick (41%) and being recommended by a provider (24%). Other common reasons included engaging in risky behavior (22%), during an emergency room/hospital stay (16%), or because of routine check ups/testing (11%). Less frequent reasons were knowing someone with HIV (3%) and being in jail/prison (3%).

TABLE 5.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, YOUTH

Assistance at diagnosis	N	%
Information about HIV/AIDS	26	70%
Medical services	22	59%
Counseling	14	38%
Help with food or shelter	5	14%
Alcohol or drug treatment services	0	0%
Supportive Services	0	0%
Other	0	0%
None	6	16%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to youth respondents were information about HIV/AIDS (70%), medical services (59%), counseling (38%), and help with food or shelter (14%). A total of six youth respondents (16%) reported

receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 5.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, YOUTH

Time to first doctor visit	N	%
Less than 1 month	19	51%
1-6 months	12	32%
6-12 months	4	11%
More than 12 months	2	5%
Never	0	0%

Time to CD4/Viral Load	N	%
Less than 1 month	18	49%
1-6 months	13	35%
6-12 months	3	8%
More than 12 months	2	5%
Never	1	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately half (51%) of all youth respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 32% of youth respondents, 1 to 6 months passed before seeing a doctor. A smaller percentage (11%) waited between 6 to 12 months, and 5% waited more than a year to see a doctor for HIV. None said they still had not seen a doctor for HIV. Likewise, 49% reported receiving their first CD4/viral load test within one month of being diagnosed, 35% within 1-6 months, 8% between 6-12 months and 5% waited more than a year. One respondent (3%) said they had never received a CD4 or viral load test.

TABLE 5.14: REASONS FOR DELAYED ENTRY INTO CARE, YOUTH

Reasons for waiting more than 6 months	N	%
Afraid	5	14%
Didn't feel sick	2	5%
Jail/prison	1	3%
Doing drugs	0	0%
Denial	6	16%
Didn't want to take meds	2	5%
No money	1	3%
Depressed/emotional problems	3	8%
No stable place to live	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were denial (16%), fear (14%), and depression/emotional problems (8%). Other reasons were due to not feeling sick (5%), not wanting to take medications (5%), being in jail/prison (3%), and/or not having any money (3%).

Maintenance in Care

TABLE 5.15: TIME SINCE LAST VISIT TO DOCTOR AND VIRAL LOAD AND CD4 AND HIV MEDICATION PRESCRIPTION, YOUTH

Last visit to doctor for HIV	N	%
Less than 6 months	28	76%
6 - 12 months	2	5%
More than 12 months	6	16%
Never/Don't Know	1	3%
Last viral load	**N**	**%**
Less than 6 months	25	68%
6 - 12 months	4	11%
More than 12 months	5	14%
Never/Don't Know	3	8%

Last CD4	N	%
Less than 6 months	25	68%
6 - 12 months	4	11%
More than 12 months	4	11%
Never/Don't Know	4	11%
Last HIV meds prescription	**N**	**%**
Less than 6 months	19	51%
6 - 12 months	2	5%
More than 12 months	5	14%
Never/Don't Know	11	30%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of youth respondents said their most recent doctor's visit (76%), viral load (68%), CD4 test (68%) and HIV medication prescription (51%) were within the past 6 months.

TABLE 5.16: FREQUENCY OF DOCTOR'S VISITS, YOUTH

No doctor visits more than 6 months?	N	%
Yes	14	38%
No	22	59%
No doctor visits more than 12 months?	**N**	**%**
Yes	10	27%
No	27	73%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Table 5.16 above outlines the number and percent of respondents who did not visit a doctor for over 6 months or more since being diagnosed. Among youth respondents who have seen a doctor for HIV, 38% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 27% reported not seeing a doctor for 12 months or more.

TABLE 5.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, YOUTH

Reasons for no doctor visits	N	%
Case manager left	2	5%
Doctor left	1	3%
Agency closed down	1	3%
Doing drugs	0	0%
Program closed down	0	0%
Did not want to take meds	6	16%
Bad experience with provider	2	5%
Lost stable housing	3	8%
Lost my job	1	3%
Lost health insurance	2	5%
Tired of regimen	1	3%
Felt fine	5	14%
Worried about side effects	1	3%
Denial	5	14%
Jail/prison	0	0%
No transportation	1	3%
Depression/emotional barriers	0	0%
Had to care for children/family member	0	0%
Other	1	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Table 5.17 above provides an outline of supplementary responses to the previous table and outlines the specific reasons reported for not visiting a doctor for more than 6 months among this subgroup. The most frequently reported reasons for falling out of care were not wanting to take medications (16%), feeling fine (14%), denial (14%) and loss of stable housing (8%).

TABLE 5.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, YOUTH

First place of care	N	%
Private Clinic/Doctor's Office	11	30%
Public clinic/community health ctr	20	54%
Prison/jail	2	5%
VA Hospital	0	0%
ER/Hospital	4	11%
I have not received care for HIV	0	0%
Other	0	0%

Most often location of care	N	%
Private Clinic/Doctor's Office	10	27%
Public clinic/community health ctr	24	65%
Prison/jail	0	0%
VA Hospital	0	0%
ER/Hospital	2	5%
I have not received care for HIV	1	3%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was public clinics/

community health centers (54%). Other locations were private clinics/doctor offices (30%), emergency rooms/hospitals (11%) and prisons/jails (5%). Locations of ongoing care were public clinics/community health centers (65%), private clinics/doctor offices (27%), or emergency rooms/hospitals (5%). One respondent (3%) in this subgroup indicated having not received care for HIV.

TABLE 5.19: KNOWLEDGE OF CASE MANAGER, YOUTH

Case Manager	N	%
Yes	27	73%
No	6	16%
Don't Know	3	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (73%) of youth respondents reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services to assist in accessing medical-related services. Approximately 16% said they did not have such a person assisting them, and 8% said they didn't know.

Health Status

TABLE 5.20: SELF-REPORTED HEALTH STATUS, YOUTH

How would you describe your health overall	N	%
Excellent	7	19%
Good	17	46%
Fair	13	35%
Poor	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 19% said "Excellent," 46% said "Good," 35% said "Fair" and none said "Poor."

TABLE 5.21: SELF-REPORTED PHYSICAL HEALTH STATUS & ER OR HOSPITAL VISITS, YOUTH

During the past month, has your physical health interfered with normal activities?	N	%
No	18	49%
Yes – Some of the time	17	46%
Yes – all of the time	1	3%
ER visit in past 6 months	12	32%
Hospital stay in past 6 months	9	24%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Forty-six percent (46%) of all youth respondents reported that during the past month, their physical health had interfered with normal activities some of the time. A smaller percentage (3%) said their physical health interfered all of the time. For the 6 months prior to the survey, 32% of all youth respondents reported an emergency room visit and 24% reported being admitted to a hospital for one or more nights.

TABLE 5.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, YOUTH

Symptoms during past month Range = 1 to 11; Avg = 5	**N**	**%**
Trouble with thinking, concentrating or memory	17	46%
Depressed or sad, trouble thinking	24	65%
Aches, fatigue, lightheadedness, weak all over	19	51%
Fevers, chills, sweats	9	24%
Poor appetite, weight loss	14	38%
Trouble with eyes or ears	9	24%
Trouble with nose or sinuses, headaches	15	41%
Trouble with mouth or swallowing	3	8%
Nausea, vomiting, diarrhea, abdominal pain	17	46%
Coughing, wheezing, or chest pain, trouble breathing	10	27%
Rash, itch, herpes, or other skin trouble	5	14%
Numbness, tingling or pain in an arm or leg	6	16%
Other	0	0%
None	6	16%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The number of symptoms reported by all respondents during the past month ranged from 1 to 11, with an average of five. The top three reported symptoms were depression or sadness (65%), aches, fatigue and lightheadedness (51%), and trouble with concentration or memory (46%).

TABLE 5.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, YOUTH

First CD4/T-cell	**N**	**%**
Less than 50	2	5%
50-99	1	3%
100-199	1	3%
200-349	3	8%
350-499	11	30%
500+	5	14%
Don't Know/Can't Remember	14	38%

Current CD4/T-cell	**N**	**%**
Less than 50	1	3%
50-99	0	0%
100-199	4	11%
200-349	5	14%
350-499	4	11%
500+	3	8%
Don't Know/Can't Remember	19	52%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of five (14%) youth respondents reported their first CD4/T-cell counts as 500+; 38% were 200 to 499, 6% were 50 to 199, and 5% were less than 50. Current CD4/T-cell counts were 500+ for 8% of all youth

respondents; 200 to 499 for 25%, 50 to 199 for 11%, and less than 50 for 3% of youth respondents. Thirty-eight percent didn't know or couldn't remember their first CD4/T-cell count, and more than half (52%) didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 5.24: HIV MEDICATIONS, YOUTH

Currently taking HIV meds	N	%
Yes	20	54%
No	17	46%
How many pills do you take in one day?	Range = 1 to 12; Avg = 4	

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (54%) of respondents from this subgroup said they were currently taking HIV medications. The number of pills taken in one day ranged from 1 to 12, with an average of four (4) pills per day.

TABLE 5.25: SELF-REPORTED MEDICATION ADHERENCE, YOUTH

Medication adherence	N	%
I have not missed any doses in the past month	12	32%
Missed a few, but took nearly all	6	16%
Took more than half	0	0%
About half	0	0%
Some, but not half	2	5%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	21	57%
No	9	24%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among youth respondents currently taking HIV medications, 32% reported perfect adherence and 16% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 57% said "Yes" and 24% said "No."

TABLE 5.26: REASONS FOR NOT TAKING HIV MEDICATIONS, YOUTH

Reasons for not taking HIV medications	N	%
Side effects	1	3%
Not effective	2	5%
Too difficult to take as prescribed	2	5%
No doctor has offered them	2	5%
I choose not to take them	3	8%
Doctor did not think it was a good idea for me	4	11%
T-cell too high	8	22%
Cannot pay	2	5%
Confidentiality concerns	2	5%
Didn't feel sick	0	0%
Have not seen doctor	4	11%
Other	1	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "T-cell too high" (22%) followed by "doctor did not think it was a good idea for me" (11%), "have not seen doctor" (11%) and I choose not to take them" (8%).

TABLE 5.27: MEDICATIONS FOR NON-HIV CONDITIONS, YOUTH

How many pills do you take in one day for non-HIV conditions? Range = 0 to 6; Avg = .72	N	%
Diabetes	1	3%
High blood pressure	3	8%
High cholesterol	0	0%
Depression/emotional problems	6	16%
Eye drops/glaucoma	0	0%
Acid reflux	0	0%
Anemia	0	0%
Sleep	0	0%
Allergies/Sinus	0	0%
Pain	0	0%
Antibiotics	0	0%
Arthritis	0	0%
Asthma	2	5%
Neuropathy	0	0%
Nausea	0	0%
Hormones	1	3%
Other	1	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

In Table 5.27, the "N" represents the number of respondents indicating taking pills for the associated non-HIV conditions. On average, youth respondents took less than one non-HIV pills per day. The most common conditions associated with the non-HIV pills were depression/emotional problems (16%), high blood pressure (8%), and asthma (5%).

TABLE 5.28: TOTAL PILL BURDEN AND ABILITY TO PAY, YOUTH

Total Pills (HIV + non-HIV)	Avg = 3	
How often do you have trouble paying for these or other non-HIV meds?	**N**	**%**
Never	20	54%
Less than half the time	3	8%
More than half the time	2	5%
Always	3	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was three (3).

The majority (54%) of all youth respondents reported never having problems paying for HIV or non-HIV medications, and 8% had problems less than half the time. A smaller percentage (5%) had problems more than half the time, and 8% said they always had problems paying for their medications.

Comorbidities

TABLE 5.29: HEPATITIS C AND TB STATUS, YOUTH

Hep C Test?	N	%
Yes	28	76%
No	7	19%
Don't Know	2	5%
Positive for Hep C?	**N**	**%**
Yes	2	5%
No	31	84%
Don't know	4	11%

TB skin test?	N	%
Yes	31	84%
No	6	16%
Result	**N**	**%**
Positive	2	5%
Negative	29	78%
Don't Know	1	3%
History of active TB?	**N**	**%**
Yes	0	0%
No	37	100%
Don't Know	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (76%) of all youth respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 5% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the

blood, a person is diagnosed with hepatitis C.

Likewise, the majority (84%) of respondents had received a skin test for TB, and 5% reported a positive result. No respondents indicated a history of active TB.

Mental Health

TABLE 5.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, YOUTH

	N	%
At least one mental health condition	21	57%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	12	32%
Hallucinations	2	5%
Serious thoughts of suicide	7	19%
Attempted suicide	2	5%
Wanted to hurt or harm yourself	7	19%
Wanted to hurt or harm someone else	9	24%
Trouble controlling anger leading to physical violence	10	27%
Problems requiring meds	7	19%
None	16	43%
At least one serious indicator (suicide/homicidal or requiring meds)	14	38%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (57%) of all youth respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced symptoms were serious anxiety/tension (32%), trouble controlling anger that lead to physical violence (27%), and wanting to hurt or harm someone else.

TABLE 5.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, YOUTH

Since being diagnosed, ever talked with therapist?	**N**	**%**
Yes	27	73%
No	10	27%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	21	57%
No	16	43%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	23	62%
No	14	38%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 73% of youth respondents said they had talked with a therapist or psychologist for help with depression or emotional problems and 57% had talked to a doctor or psychiatrist for medications. More than half (62%) said they had participated in a support group since being diagnosed with HIV.

Substance Use & Abuse

TABLE 5.32: SUBSTANCE USE, YOUTH

Total Number of Substances Range = 1 to 4; Avg = 2	N	%
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	0	0%
Street Methadone (non-treatment)	0	0%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	1	3%
Barbituates (seconal, tuinal, downers)	0	0%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	1	3%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	0	0%
Amphetamines (speed, uppers, crystal meth, ice, glass)	0	0%
Marijuana, Hashish (grass, weed)	14	38%
Heroin	0	0%
Cocaine (powder), Crack	7	19%
Ecstasy, X, MDA, GHB	5	14%
Ketamine (K, Special K)	0	0%
None	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the numbers of substances used by youth ranged from 1 to 4, with an average of two. The most commonly used substances for all respondents were marijuana (38%) and cocaine (19%).

TABLE 5.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, YOUTH

In the last year, ever drunk more than meant to?	N	%
Yes	8	22%
No	28	76%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	6	16%
No	30	81%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	7	19%
No	29	78%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	8	22%
No	28	76%
Indicator of Alcohol Abuse	10	27%
Indicator of Substance Abuse	9	24%
Abuse of both drugs and alcohol	5	14%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 27% of all youth respondents indicated possible alcohol abuse, and 24% indicated possible substance abuse. A total of five youth (14%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 5.34: SOCIAL SUPPORT, YOUTH

Of all the people you feel close to, how many have you told about being HIV+?	N	%
All	5	14%
Some	27	73%
None	5	14%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	29	78%
No	8	22%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 14% had disclosed their HIV status to all and the majority (73%) had disclosed their status to only some. A total of five youth (14%) had not told their HIV status to any of the people to whom they feel close. Overall, the majority (78%) of youth respondents said there were people they could depend on for help if really needed.

Housing

TABLE 5.35: HOUSING STATUS, YOUTH

Where do you most often sleep?	N	%
Apartment/House	24	65%
Group home/halfway house	2	5%
Shelter	6	16%
Street	4	11%
Other	1	3%
Do you feel your housing situation is stable?	**N**	**%**
Yes	21	57%
No	16	43%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (65%) of youth reported sleeping most often in an apartment/house. Others reported group home/halfway house (5%), shelter (16%), street (11%) and other (3%) locations. More than half (57%) of all respondents felt their housing situation was

stable, and 43% felt their housing situation was unstable.

TABLE 5.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, YOUTH

In the past year, has your housing situation made it difficult to get HIV care	N	%
Yes	9	24%
No	28	76%
Reasons	**N**	**%**
I could not keep my status private	5	14%
No place to store meds	0	0%
Money for food	7	19%
Money for rent	4	11%
Money for utilities	3	8%
Money for household supplies	3	8%
No stable address	0	0%
Used money on drugs	0	0%
Rules	0	0%
Lack of transportation	0	0%
No child care	2	5%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of nine respondents (24%) respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The most common reasons for these difficulties were due to using money for food (19%), not being able to keep one's status private (14%), and using money for rent (11%).

ACCESS TO CORE SERVICES

TABLE 5.37: ACCESS TO CORE SERVICES, YOUTH

Service Category	In the past 12 months…					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	10	27%	26	70%	1	3%
HIV/AIDS Medications	7	19%	20	54%	10	27%
Dentist Visits	20	54%	11	30%	6	16%
Medical Case Management	7	19%	19	51%	11	30%
Home Health Care	2	5%	5	14%	30	81%
Psychiatric Services or Medicine	7	19%	7	19%	23	62%
Psychological Counseling	7	19%	12	32%	18	49%
Substance Abuse Treatment	2	5%	4	11%	31	84%
Rehabilitation Services	1	3%	4	11%	32	86%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For all youth respondents, the top three “easy to get” core services were primary medical care (70%), HIV/AIDS medications (54%) and medical case management (51%). The top two core services that respondents reported “some difficulty getting” were dentist visits (54%), primary medical care (27%. The following services were equally reported as the third in having “some difficulty getting” or accessing: HIV/AIDS medications, medical case management, psychiatric services, psychological counseling (19%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that youth respondents said they “did not need” in the past year were rehabilitation services (86%), substance abuse treatment (84%), and home health care (81%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 5.38: ACCESS TO SUPPORTIVE SERVICES, YOUTH

Service Category	In the past 12 months…				
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service
Child Care Services	7	19%	1	3%	0
Child Welfare Services	1	3%	0	0%	0
Day/Respite Care for Adults	1	3%	0	0%	0
Developmental	1	3%	0	0%	1
Emergency Financial Assistance	15	41%	2	5%	0
Employment Assistance	13	35%	2	5%	0
Food Bank	10	27%	10	27%	0
HIV Education for HIV+ Individuals	3	8%	10	27%	0
Rental Assistance/Shelter Vouchers	11	30%	4	11%	1
Housing-Related Services	9	24%	3	8%	1
Legal Services	2	5%	2	5%	1
Nutritional Counseling	1	3%	2	5%	0
Permanency Planning	0	0%	0	0%	1
Referrals to Services	0	0%	6	16%	0
Referrals to Clinical Research	1	3%	2	5%	0
Support Groups	2	5%	8	22%	2
Translation/Interpretation	0	0%	1	3%	0
Transportation	8	22%	7	19%	0
Household Items	6	16%	2	5%	0

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For all youth respondents, the supportive services that were selected most often (thus implying high helpfulness/usefulness) were food bank, emergency financial assistance, rental assistance/shelter vouchers, employment assistance and transportation.

The top five “easy to get” supportive services (based on number of responses) were

food bank (n=10), HIV education for HIV positive individuals (n=10), support groups (n=8), transportation (n=7), and referrals to services (n=6). The top five supportive services that respondents reported "some difficulty getting" were emergency financial assistance (n=15), employment assistance (n=13), rental assistance/shelter vouchers (n=11), food bank (n=10), and housing-related services (n=9). The presence of certain support services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates. Conversely, the supportive services that respondents did not need in the past year, but still identified as useful/helpful were support groups (n=2), development assessments (n=1), rental assistance/shelter vouchers (n=1), housing-related services (n=1), legal services (n=1), and permanency planning (n=1). ["n=*value*" indicates the number of responses for each service category.]

Barriers Reported per Core Service Category

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among youth respondents, the three core services with the highest number of barriers were dentist visits (n=51), primary medical care (n=34), psychiatric services or medicine (n=26). Within dentist visits (the service with the most barriers), the most commonly reported barriers were ""I don't know where to get the services" (n=10), "it's hard to make or keep appointments" (n=6), and "the services are not in my area" (n=6). For primary medical care (the service with the second most common barriers), the most common barrier for youth respondents was "the services cost too much" (n=5). In addition, for primary medical care, "it's hard to make or keep appointments", "it's hard for me to get there", and "I'm afraid someone will find out about my HIV" were equally reported barriers among youth (n=4). For psychiatric services or medicine (the service with the third most common barriers), the most common barrier for youth respondents was "it's hard to make or keep appointments" (n=4). In addition, for psychiatric services, "I would have to wait too long to get the services", "I was told I am not eligible to get the services", and "the people who run the services are not friendly" were equally reported barriers among youth (n=3).

The barriers experienced most often by all youth respondents across all core services were "I don't know where to get the services" (n=22), "It's hard to make or keep appointments" (n=19), and "It's hard for me to get there" (n=18). ["n=*value*" indicates the number of responses for each service category.]

TABLE 5.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, YOUTH

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Primary Medical Care	3	2	1	**5**	1	1	3	**4**	**4**	3	4	1	1	1	0	0	0	0	0	0	0	0	**34**
HIV/AIDS Medications	1	1	2	2	**3**	0	0	2	0	3	1	0	2	0	0	0	1	0	0	0	0	0	**18**
Dentist Visits	**6**	**10**	5	3	5	1	3	**6**	4	2	2	0	0	3	0	0	0	1	0	0	0	0	**51**
Medical Case Management	1	**4**	3	0	2	0	**4**	3	2	1	1	0	0	0	0	0	0	0	0	0	0	0	**21**
Home Health Care	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Psychiatric Services or Medicine	1	2	3	2	3	1	3	**4**	3	2	2	0	0	0	0	0	0	0	0	0	0	0	**26**
Psychological Counseling	1	2	1	1	1	1	2	0	**4**	1	0	0	1	0	0	0	0	0	0	0	0	0	**15**
Substance Abuse Treatment	0	0	1	0	0	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	0	**4**
Rehabilitation Services	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	**2**
Total	**14**	**22**	**16**	**13**	**16**	**4**	**15**	**19**	**18**	**13**	**10**	**1**	**5**	**4**	**0**	**0**	**1**	**2**	**0**	**0**	**0**	**0**	**173**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Barriers Reported per Supportive Service Category

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among all youth respondents, the five supportive services with the highest number of barriers were emergency financial assistance (n=38), rental assistance/shelter vouchers (n=32), child care services (n=29), housing-related services (n=26), and transportation (n=19). Within emergency financial assistance (the service with the most barriers), the two most commonly reported barriers were "I don't know where to get the services" (n=7) and "I would have to wait too long to get the services" (n=5). For rental assistance/shelter vouchers (the service with the second most common barriers), the two most commonly barriers for youth respondents were "I don't know where to get the services" (n=5) and "I would have to wait too long to get the services" (n=4). For child care services (the service with the third most common barriers), the most commonly reported barriers for youth respondents were "it's hard for me to get there" (n=6) and "the services cost too much" (n=5).

The barriers experienced most often by all youth respondents across all supportive services were "I don't know where to get the services" (n=50), "It's hard for me to get there" (n=21), and "It's hard to make or keep appointments" (n=17). ["n=*value*" indicates the number of responses for each service category.]

TABLE 5.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, YOUTH

Service Category	Barriers																				
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	P	Q	R	S	U	V	Total
Child Care Services	3	3	2	**5**	3	0	1	2	**6**	3	0	0	0	0	0	0	0	0	1	0	**29**
Child Welfare Services	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	**2**
Day/Respite Care for Adults	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	**1**
Developmental Assessment	0	1	1	0	0	1	0	1	1	1	1	0	0	0	0	0	0	0	0	0	**7**
Emergency Financial Assistance	3	**7**	**5**	1	4	1	3	4	3	3	1	0	0	1	0	0	0	0	2	0	**38**
Employment Assistance	2	**8**	0	0	0	2	1	0	2	1	0	0	0	0	0	0	0	0	0	0	**16**
Food Bank	0	**6**	1	1	0	1	1	2	2	0	0	0	0	0	0	0	0	0	2	0	**16**
HIV Education for HIV+ Individuals	1	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	**4**
Rental Assistance/Shelter Vouchers	2	**5**	**4**	1	2	2	3	3	2	2	1	0	0	1	0	0	0	1	2	1	**32**
Housing-Related Services	2	**7**	2	1	**3**	2	2	2	2	2	0	0	1	0	0	0	0	0	0	0	**26**
Legal Services	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	**2**
Nutritional Counseling	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Permanency Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Referrals to Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Referrals to Clinical Research	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Support Groups	0	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
Translation/Interpretation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Transportation	1	**5**	1	2	2	1	2	2	2	1	0	0	0	0	0	0	0	0	0	0	**19**
Household Items	0	**3**	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**6**
Total	**14**	**50**	**16**	**12**	**14**	**13**	**15**	**17**	**21**	**15**	**3**	**0**	**1**	**2**	**0**	**1**	**0**	**1**	**7**	**1**	**203**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions

A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 5.41: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA YOUTH (18-24) (N=37)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of Youth Reporting Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	4	27	0	11%	56	7%
Anonymous Sex Partner(s)	7	22	N/A	19%	141	18%
Greater than 5 Sex Partners	3	33	N/A	8%	60	8%

Of youth surveyed, 4 (11%) reported that they had engaged in sex for drugs or money in the past 6 months, while 56 (7%) of all respondents reported this risk factor. Seven (19%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 141 (18%) of all respondents. Three (8%) of youth surveyed reported that they had more than 5 sex partners in the past 6 months and 60 (8%) of all respondents reported that they had more than 5 sex partners.

TABLE 5.42: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA YOUTH (18-24) (N=37)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of Youth Reporting Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	14	16	N/A	38%	235	31%
Shared Injecting Equipment	1	1	N/A	3%	12	2%
Serodiscordant Sex Partner(s)	14	14	3	38%	111	15%

Of youth surveyed, 14 (38%) reported that they had unprotected sex at least some of the time, while 235 (31%) of the entire sample reported this risk factor. One (3%) youth sampled reported that they had shared injecting equipment at least some of the time, compared with 12 (2%) of the total sample reporting this risk factor. Fourteen (38%) youth reported that they had an HIV-negative sex partner, while 111 (15%) of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

AFRICAN-AMERICANS

Overview

There were 429 total Black/African-American respondents to the 2008 Need Assessment consumer survey. This total represents 56% of the total 764 survey respondents.

Demographics

TABLE 6.1: GENDER, PREGNANCY STATUS AND AGE, BLACKS/AFRICAN-AMERICANS

Gender	**N**	**%**
Male	266	62%
Female	153	36%
Transgender – Male to Female	10	2%
Pregnant	**N**	**%**
Yes	5	1%
Don't Know	8	2%
Age Avg = 43	**N**	**%**
18 - 24	26	6%
25 - 44	192	45%
45+	211	49%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of Black/African-American respondents were male (62%), while females comprised 36% of all respondents from this subgroup. Eight respondents (2%) identified as transgender Male to Female.

Among females, 1% said they were pregnant at the time of the survey, and 2% said they did not know their pregnancy status.

The average age of respondents was 43 years, ranging from 18 to 70. Approximately 45% were between the ages of 25-44, and another 49% were above the age of 45. Six percent (6%) were youth between the ages of 18 and 24.

TABLE 6.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, BLACKS/AFRICAN-AMERICANS

Sexual Orientation	N	%
Straight/Heterosexual	292	68%
Gay/Lesbian	91	21%
Bisexual	30	7%
Undecided	6	1%
Prefer not to say	10	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Sixty-eight percent (68%) of all Black/African-American respondents identified as straight or heterosexual. About 21% identified as gay/lesbian, 7% as bisexual and 1% as undecided. Ten respondents (2%) said they preferred not to disclose their sexual orientation.

TABLE 6.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, BLACKS/AFRICAN-AMERICANS

Education	N	%
Less than high school	84	20%
High school degree/GED	271	63%
College degree	47	11%
Graduate/Professional degree	6	1%
Some technical training	20	5%
None	0	0%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	80	19%
Are you eligible for veteran benefits?	**N**	**%**
Yes	26	6%
No	377	88%
Don't Know	26	6%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Eighty-three percent (83%) of respondents had a high school degree/GED or less. Eleven percent had a college degree, 1% had a graduate/professional degree and 5% had some technical training. None reported receiving no education.

A total of 80 (19%) survey respondents reported being released from jail or prison during the previous year.

Approximately 6% of Black/African-American respondents reported being eligible for veteran benefits.

Immigration Status & Primary Language

TABLE 6.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, BLACKS/AFRICAN-AMERICANS

	N	%
Born outside U.S.	9	2%
Length of residency Range = 3 to 45 yrs; Avg = 20 yrs		
Immigration status	**N**	**%**
Citizen	426	99%
Permanent Resident	0	0%
Visa	2	0%
Undocumented	1	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

As a whole, foreign-born Black/African-American respondents represented 2% of all respondents from this subgroup. Among the foreign born, lengths of residency in the U.S. ranged from 3 to 45 years with an average residency of 20 years.

Among all Black/African-American respondents, 99% were U.S. citizens. None were permanent residents, less than 1% were visa holders or undocumented.

TABLE 6.5: PREFERRED LANGUAGE, BLACKS/AFRICAN-AMERICANS

Preferred language at home with family/friends	**N**	**%**
English	423	99%
Spanish	1	0%
English/Spanish	3	1%
Other	2	0%
Preferred language when seeing a doctor	**N**	**%**
English	427	100%
Spanish	0	0%
English/Spanish	0	0%
Other	2	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by Black/African-American survey respondents. Approximately 99% said they were most comfortable speaking English at home with family/friends, and nearly all respondents said they were most comfortable speaking English with their doctor.

Job Status & Income

TABLE 6.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, BLACKS/AFRICAN-AMERICANS

Job status	N	%
Full time	26	6%
Part time	36	8%
Temporary/contract/odd jobs	19	4%
Not working due to disability	169	40%
Unemployed	169	40%
Retired	9	2%
Average monthly income during past 6 months	Range = $0 to $7,000; Avg = $575.31	
Approximate yearly income	**N**	**%**
Up to 300% FPL (2007 – 2008)	423	99%
Up to 200% FPL (2007 - 2008)	419	97%
Up to 100% FPL (2007 - 2008)	368	85%
Total income dependents	Range = 1 to 9 ; Avg = 2	
Income dependents under 18	0 to 6	Avg = .6

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately 18% of all Black/African-American respondents were employed at the time of the survey; 40% were unemployed, 40% were not working due to disability, and 2% were retired. Six percent were working full-time, 8% part-time and 4% had temporary/ contract/odd jobs.

Per-month incomes ranged from $0 to $7,000, with an average of $575 per month. Yearly incomes were calculated as ranging from $0 to $84,000, for an average of $6,904 per year.

The number of dependents per income ranged from 1 to 9 (average 2), with an average of less than one dependent being under the age of 18.

Based on estimated yearly incomes and household sizes, 99% of all Black/African-American respondents fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 6.7: SOURCES OF INCOME ASSISTANCE, BLACKS/AFRICAN-AMERICANS

Sources of income assistance	N	%
SSI	124	29%
None	106	25%
SSDI	92	21%
Food Stamps	89	21%
Social Security	39	9%
Hourly wages/Salary	34	8%
Rental Subsidy/Section 8	18	4%
TANF/AFDC	11	3%
VA Benefits	7	2%
Unemployment	6	1%
Private Disability	3	1%
Family/friends	3	1%
Pension/Retirement/Savings	3	1%
Other	3	1%
Child support	2	0%
Workers Comp	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among Black/African-American survey respondents were Supplemental Security Income (SSI) (29%), Social Security Disability Insurance (SSDI) (21%) and food stamps (21%). No survey respondents received worker's compensation.

Approximately twenty-five percent (25%) of all respondents from this subgroup reported no source of income.

Paying for Medical Care

TABLE 6.8: SOURCES OF PAYMENT FOR MEDICAL CARE, BLACKS/AFRICAN-AMERICANS

Paying for medical care	N	%
Medicaid	156	36%
Gold Card/County	146	34%
Medicare	89	21%
Other	35	8%
I don't receive medical care because I can't pay for it	31	7%
Self-Pay	16	4%
VA	14	3%
Private insurance/COBRA	7	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

According to the Centralized Patient Care Data Management System (CPCDMS), 6,961 clients paid for primary medical care using Ryan White funding resources. Among African-American respondents, Medicaid (36%), the Gold Card/County (34%) and Medicare (21%) were the most common methods of paying for medical care. Approximately 8% of all Black/African-American respondents reported other methods and 3% reported the Veteran's Administration Hospital. Seven percent of respondents from this subgroup said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it. The Harris County Gold Card program assists eligible low-income residents with medical expenses and prescriptions.

HIV Testing & Diagnosis History

TABLE 6.9: LENGTH OF HIV DIAGNOSIS, BLACKS/AFRICAN-AMERICANS

Length of diagnosis	N	%
Less than 1 year	14	3%
1-4 years	113	26%
5-10 years	102	24%
11-15 years	99	23%
16-20 years	63	15%
21 and over	35	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

TABLE 6.10: LOCATION OF HIV DIAGNOSIS, BLACKS/AFRICAN-AMERICANS

Location of diagnosis	N	%
Public or community clinic	107	25%
Jail/Prison	76	18%
In hospital stay	63	15%
Private doctor	55	13%
ER	46	11%
HIV-specific testing site	28	7%
Community testing location	32	7%
Alcohol or drug treatment facility	15	3%
Work/insurance related	3	1%
Blood/Plasma donation	2	0%
Other	2	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (25%) of Black/African-American respondents received their diagnoses at a public or community clinic. Other common diagnosis locations for overall respondents included jail/prison (18%), in a hospital stay (15%), private doctor (13%), and emergency rooms (11%). Less frequently identified locations included HIV-specific testing sites (7%), community testing locations (7%), alcohol or drug treatment facilities (3%), and through

work/insurance related testing processes.

TABLE 6.11: REASONS FOR HIV TESTING, BLACKS/AFRICAN-AMERICANS

Reasons for testing	N	%
Felt sick	107	25%
Recommended by provider	101	24%
Had sex with someone HIV+	83	19%
Engaged in risky behavior	87	20%
ER/Hospital stay	64	15%
Was in prison/jail	52	12%
During pregnancy care	18	4%
Routine check up/testing	34	8%
Blood/plasma donation	8	2%
Other	7	2%
Work/insurance related	3	1%
Knew someone with HIV	4	1%
Partner notification	2	0%
In drug treatment program	3	1%
Rape survivor	0	0%
Incentive offered	1	0%
Recommended by friends	2	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The two most frequently reported reasons for seeking HIV testing were feeling sick (25%) and being recommended by a provider (24%). Other common reasons included having engaged in risky behavior (20%), had sex with some HIV+ (19%), or because of an emergency room/hospital stay (15%). Less frequent reasons were due to jail/prison testing processes (12%), routine check ups/testing (8%), and during pregnancy care (4%), blood/plasma donation (2%).

TABLE 6.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, BLACKS/AFRICAN-AMERICANS

Assistance at diagnosis	N	%
Information about HIV/AIDS	223	52%
Medical services	216	50%
Counseling	146	34%
None	101	24%
Help with food or shelter	64	15%
Alcohol or drug treatment services	55	13%
Supportive Services	5	1%
Other	4	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to Black/ African-American respondents were information about HIV/AIDS (52%), medical services (50%) and counseling (34%). Less frequently reported were receiving help with food or shelter (15%), alcohol or drug treatment services (13), and supportive services (1%). A total of 101 Black/African-American respondents (24%) reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 6.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, BLACKS/AFRICAN-AMERICANS

Time to first doctor visit	N	%
Less than 1 month	213	50%
1-6 months	96	22%
6-12 months	49	11%
More than 12 months	59	14%
Never	12	3%

Time to CD4/Viral Load	N	%
Less than 1 month	162	38%
1-6 months	126	29%
6-12 months	48	11%
More than 12 months	78	18%
Never	14	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Half (50%) of all Black/African-American respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 29% of respondents from this subgroup, 1 to 6 months passed before seeing a doctor. Approximately 11% waited between 6 to 12 months, and 14% waited more than a year to see a doctor for HIV. A total of 12 (3%) of all Black/African-American respondents said they still had not seen a doctor for HIV. Likewise, 38% reported receiving their first CD4/viral load test within one month of being diagnosed, 29% within 1-6 months, 11% between 6-12 months and 18% waited more than a year. A total of 14 (3%) said they had never received a CD4 or viral load test.

TABLE 6.14: REASONS FOR DELAYED ENTRY INTO CARE, BLACKS/AFRICAN-AMERICANS

Reasons for waiting more than 6 months	N	%
Afraid	61	14%
Didn't feel sick	43	10%
Jail/prison	26	6%
Doing drugs	34	8%
Denial	65	15%
Didn't want to take meds	29	7%
No money	19	4%
Depressed/emotional problems	45	10%
No stable place to live	24	6%
Other	12	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were

denial (15%), fear (14%), not feeling sick (10%) and being depressed or experiencing emotional problems (10%). Other reasons were doing drugs (8%), not wanting to take meds (7%), not having a stable place to live (6%), and being in jail/prison (6%).

Maintenance in Care

TABLE 6.15: TIME SINCE LAST VISIT TO DOCTOR & VIRAL LOAD & CD4 & HIV MEDICATION PRESCRIPTION, BLACKS/AFRICAN-AMERICANS

Last visit to doctor for HIV	N	%
Less than 6 months	344	80%
6-12 months	32	7%
More than 12 months	39	9%
Never/Don't Know	12	3%
Last viral load	**N**	**%**
Less than 6 months	334	78%
6-12 months	32	7%
More than 12 months	41	10%
Never/Don't Know	21	5%

Last CD4	N	%
Less than 6 months	339	79%
6-12 months	32	7%
More than 12 months	38	9%
Never/Don't Know	19	4%
Last HIV meds prescription	**N**	**%**
Less than 6 months	270	63%
6-12 months	28	7%
More than 12 months	50	12%
Never/Don't Know	77	18%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of Black/African-American respondents said their most recent doctor's visit (80%), viral load (78%), CD4 test (79%) and HIV medication prescription (63%) were within the past 6 months.

TABLE 6.16: FREQUENCY OF DOCTOR'S VISITS, BLACKS/AFRICAN-AMERICANS

No doctor visits more than 6 months?	N	%
Yes	196	46%
No	227	53%
No doctor visits more than 12 months?	**N**	**%**
Yes	113	26%
No	287	67%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Table 6.16 above outlines the number and percentage of respondents who did not visit a doctor for over 6 months or more since being diagnosed. Among Black/African-American respondents who have seen a doctor for HIV, 46% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 26% reported not seeing a doctor for 12 months or more.

TABLE 6.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, BLACKS/AFRICAN-AMERICANS

Reasons for no doctor visits	N	%
Case manager left	4	1%
Doctor left	11	3%
Agency closed down	3	1%
Doing drugs	75	17%
Program closed down	1	0%
Did not want to take meds	55	13%
Bad experience with provider	14	3%
Lost stable housing	44	10%
Lost my job	18	4%
Lost health insurance	14	3%
Tired of regimen	33	8%
Felt fine	42	10%
Worried about side effects	31	7%
Denial	39	9%
Jail/prison	8	2%
No transportation	5	1%
Depression/emotional barriers	2	0%
Had to care for children/family member	0	0%
Other	15	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Table 6.17 above provides an outline of supplementary responses to the previous table. The table outlines the specific reasons reported for not visiting a doctor for more than 6 months among this subgroup. The most frequently reported reasons for falling out of care were due to doing drugs (17%), not wanting to take meds (13%), feeling fine (10%) and loss of stable housing (10%).

TABLE 6.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, BLACKS/AFRICAN-AMERICANS

First place of care	N	%
Private Clinic/Doctor's Office	78	18%
Public clinic/community health ctr	214	50%
Prison/jail	68	16%
VA Hospital	11	3%
ER/Hospital	45	10%
I have not received care for HIV	11	3%
Other	0	0%

Most often location of care	N	%
Private Clinic/Doctor's Office	91	21%
Public clinic/community health ctr	272	63%
Prison/jail	16	4%
VA Hospital	15	3%
ER/Hospital	16	4%
I have not received care for HIV	16	4%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Table 6.18 provides an outline of supplementary responses to the previous table and outlines the specific reasons reported for not visiting a doctor for more than 6 months among this subgroup. The most commonly reported location of initial care for HIV was a public clinic/community health center (50%). Other locations reported included private clinics/doctor offices (18%), prisons/jails (16%), emergency room/hospital (10%), or a VA hospital (3%). The two most frequently reported locations of ongoing care were public clinics/community health centers (63%) or private clinics/doctor offices (21%). A total of 15 (3%) of all Black/African-American respondents received care most often from the Veteran's Administration Hospital.

TABLE 6.19: KNOWLEDGE OF CASE MANAGER, BLACKS/AFRICAN-AMERICANS

Case Manager	N	%
Yes	306	72%
No	66	15%
Don't Know	55	13%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (72%) of Black/African-American respondents reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services to assist in accessing medical-related services. Approximately 15% said they did not have such a person assisting them, and 13% said they didn't know.

Health Status

TABLE 6.20: SOURCES OF PAYMENT FOR MEDICAL CARE, BLACKS/AFRICAN-AMERICANS

How would you describe your health overall	N	%
Excellent	78	18%
Good	178	41%
Fair	144	34%
Poor	26	7%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 18% said "Excellent," 41% said "Good," 34% said "Fair" and 7% said "Poor."

TABLE 6.21: SELF-REPORTED PHYSICAL HEALTH STATUS & ER OR HOSPITAL VISITS, BLACKS/AFRICAN-AMERICANS

During the past month, has your physical health interfered with normal activities?	N	%
No	194	45%
Yes – Some of the time	191	45%
Yes – all of the time	40	10%
ER visit in past 6 months	139	32%
Hospital stay in past 6 months	106	25%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half of all Black/African-American respondents (55%) indicated that, during the past month, their physical health had interfered with normal activities some of the time or all of the time.

For the 6 months prior to the survey, 32% of all respondents from this subgroup reported an emergency room visit and 25% reported being admitted to a hospital for one or more nights.

TABLE 6.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, BLACKS/AFRICAN-AMERICANS

Symptoms during past month Avg = 5	N	%
Trouble with thinking, concentrating or memory	198	46%
Depressed or sad, trouble thinking	273	64%
Aches, fatigue, lightheadedness, weak all over	173	40%
Fevers, chills, sweats	115	27%
Poor appetite, weight loss	129	30%
Trouble with eyes or ears	164	38%
Trouble with nose or sinuses, headaches	151	35%
Trouble with mouth or swallowing	66	15%
Nausea, vomiting, diarrhea, abdominal pain	130	30%
Coughing, wheezing, or chest pain, trouble breathing	122	28%
Rash, itch, herpes, or other skin trouble	110	26%
Numbness, tingling or pain in an arm or leg	148	34%
Other	6	1%
None	42	10%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The number of symptoms reported by all respondents during the past month ranged from 1 to 12, with an average of five. The top three reported symptoms were depressed or sad (64%), trouble concentrating or with memory (46%) and lightheadedness or fatigue (40%).

TABLE 6.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, BLACKS/AFRICAN-AMERICANS

First CD4/T-cell	N	%
Less than 50	56	13%
50-99	16	5%
100-199	36	8%
200-349	51	12%
350-499	57	13%
500+	90	21%
Don't Know/Can't Remember	120	28%

Current CD4/T-cell	N	%
Less than 50	27	6%
50-99	13	3%
100-199	37	9%
200-349	59	14%
350-499	63	15%
500+	93	22%
Don't Know/Can't Remember	134	31%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of 90 (21%) Black/African-American respondents reported their first CD4/T-cell counts as 500+; 25% were 200 to 499, 13% were 50 to 199, and 13% were less than 50. Current CD4/T-cell counts were 500+ for 22% of all respondents; 200 to 499 for 29%, 50 to 199 for 12%, and less than 50 for 6% of Black/African-American respondents. Approximately 28% didn't know or couldn't remember their first CD4/T-cell count, and 31% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 6.24: HIV MEDICATIONS, BLACKS/AFRICAN-AMERICANS

Currently taking HIV meds	N	%
Yes	299	70%
No	129	30%
How many pills do you take in one day?	Range = 1 to 20; Avg = 5	

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of respondents (70%) said they were currently taking HIV medications. The number of pills taken in one day ranged from 1 to 20, with an average of five pills per day.

TABLE 6.25: SELF-REPORTED MEDICATION ADHERENCE, BLACKS/AFRICAN-AMERICANS

Medication adherence	N	%
I have not missed any doses in the past month	150	35%
Missed a few, but took nearly all	113	26%
Took more than half	13	3%
About half	13	3%
Some, but not half	19	4%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?		
Yes	285	66%
No	104	24%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among Black/African-American respondents currently taking HIV medications, 35% reported perfect adherence and 26% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 66% said "Yes" and 24% said "No."

TABLE 6.26: REASONS FOR NOT TAKING HIV MEDICATIONS, BLACKS/AFRICAN-AMERICANS

Reasons for not taking HIV medications	N	%
Side effects	12	3%
Not effective	5	1%
Too difficult to take as prescribed	7	2%
No doctor has offered them	13	3%
I choose not to take them	27	6%
Doctor did not think it was a good idea for me	24	6%
T-cell too high	42	10%
Cannot pay	8	2%
Confidentiality concerns	10	2%
Didn't feel sick	1	0%
Have not seen doctor	12	3%
Other	10	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "T-cell count too high" (10%) followed by "I chose not to take them" (6%), "doctor did not think it was a good idea for me" (6%). Less frequently reported reasons for not taking HIV medications included the following: "no doctor has offered them" (3%), side effects (3%), "have not seen doctor" (3%), "too difficult to take as prescribed" (2%), "cannot pay" (2%), "confidentiality concerns" (2%), and "not effective" (1%).

TABLE 6.27: MEDICATIONS FOR NON-HIV CONDITIONS, BLACKS/AFRICAN-AMERICANS

How many pills do you take in one day for non-HIV conditions?	N	%
Diabetes	40	9%
High blood pressure	147	34%
High cholesterol	44	10%
Depression/emotional problems	149	35%
Eye drops/glaucoma	4	1%
Acid reflux	16	4%
Anemia	3	1%
Sleep	7	2%
Allergies/Sinus	6	1%
Pain	14	3%
Antibiotics	4	1%
Arthritis	4	1%
Asthma	8	2%
Neuropathy	8	2%
Nausea	0	0%
Hormones	3	1%
Other	9	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, Black/African-American respondents took an average of 3 non-HIV pills per day. The most common conditions associated with the non-HIV pills were depression/ emotional problems (35%), high blood pressure (34%), high cholesterol (10%) and diabetes (9%).

TABLE 6.28: TOTAL PILL BURDEN AND ABILITY TO PAY, BLACKS/AFRICAN-AMERICANS

How often do you have trouble paying for these or other non-HIV meds?	N	%
Never	239	56%
Less than half the time	55	13%
More than half the time	29	7%
Always	67	16%
Total Pills (HIV + non-HIV) Range = 0 to 45; Avg = 3		

** Percentages may not add up to 100% due to rounding or missing survey responses.

In Table 6.28 above, the "N" represents the number of respondents indicating taking pills for the associated non-HIV conditions. The average combined HIV and non-HIV pill burden per day was three.

The majority (56%) of all Black/African-American respondents reported never having problems paying for HIV or non-HIV medications, and 13% had problems less than half the time. Approximately 7% had problems more than half the time, and 16% said they always

had problems paying for their medications.

Comorbidities

TABLE 6.29: HEPATITIS C AND TB STATUS, BLACKS/AFRICAN-AMERICANS

Hep C Test?	N	%
Yes	338	79%
No	73	17%
Don't Know	18	4%
Positive for Hep C?	**N**	**%**
Yes	111	26%
No	274	64%
Don't know	43	10%

TB skin test?	N	%
Yes	390	91%
No	35	8%
Result	**N**	**%**
Positive	85	20%
Negative	269	63%
Don't Know	16	4%
History of active TB?	**N**	**%**
Yes	73	17%
No	347	81%
Don't Know	7	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (79%) of all Black/African-American respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 26% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

Approximately 91% of respondents had received a skin test for TB, and 20% reported a positive result. A total of 73 (17%) reported a history of active TB.

Mental Health

TABLE 6.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, BLACKS/AFRICAN-AMERICANS

	N	%
At least one mental health condition	249	58%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	177	41%
Hallucinations	51	12%
Serious thoughts of suicide	44	10%
Attempted suicide	17	4%
Wanted to hurt or harm yourself	44	10%
Wanted to hurt or harm someone else	42	10%
Trouble controlling anger leading to physical violence	80	19%
Problems requiring meds	110	26%
None	167	39%
At least one serious indicator (suicide/homicidal or requiring meds)	119	28%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Over half (58%) of all Black/African-American respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced mental health symptoms were serious anxiety/tension (41%), problems requiring medications (26%), and trouble controlling anger that leads to physical violence (19%).

TABLE 6.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, BLACKS/AFRICAN-AMERICANS

Since being diagnosed, ever talked with therapist?	**N**	**%**
Yes	281	66%
No	146	34%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	269	63%
No	158	37%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	261	61%
No	164	38%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 66% of Black/African-American respondents said they had talked with a therapist or psychologist for help with depression or emotional problems and 63% had talked to a doctor or psychiatrist for medications. More than half (61%) said they had participated in a support group since being diagnosed with HIV.

Substance Use & Abuse

TABLE 6.32: SUBSTANCE USE, BLACKS/AFRICAN-AMERICANS

Total Number of substances Avg = 2	N	%
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	8	2%
Street Methadone (non-treatment)	2	0%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	7	2%
Barbituates (seconal, tuinal, downers)	2	0%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	10	2%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	2	0%
Amphetamines (speed, uppers, crystal meth, ice, glass)	2	0%
Marijuana, Hashish (grass, weed)	100	23%
Heroin	4	1%
Cocaine (powder), Crack	131	31%
Ecstasy, X, MDA, GHB	12	3%
Ketamine (K, Special K)	1	0%
None	230	54%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average number of substances used was 2. The most commonly used substances for all respondents were cocaine (31%) and marijuana (23%).

TABLE 6.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, BLACKS/AFRICAN-AMERICANS

In the last year, ever drunk more than meant to?	N	%
Yes	129	30%
No	298	69%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	137	32%
No	284	66%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	130	30%
No	296	69%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	154	36%
No	270	63%
Indicator of Alcohol Abuse	167	39%
Indicator of Substance Abuse	159	37%
Abuse of both drugs and alcohol	113	26%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 39% of all Black/African-American respondents indicated possible alcohol abuse, and 37% indicated possible substance abuse. A total of 113 (26%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 6.34: SOCIAL SUPPORT, BLACKS/AFRICAN-AMERICANS

Of all the people you feel close to, how many have you told about being HIV+?	**N**	**%**
All	135	31%
Some	236	55%
None	56	13%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	348	81%
No	79	18%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 31% had disclosed their HIV status to all and 55% had disclosed their status to some. A total of 56 (13%) had not told their HIV status to any of the people to whom they feel close. Overall, 81% of Black/African-American respondents said there were people they could depend on for help if really needed.

Housing

TABLE 6.35: HOUSING STATUS, BLACKS/AFRICAN-AMERICANS

Where do you most often sleep?	**N**	**%**
Apartment/House	303	70%
Group home/halfway house	59	14%
Shelter	36	8%
Street	28	7%
Other	3	1%
Do you feel your housing situation is stable?	**N**	**%**
Yes	271	63%
No	158	37%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (70%) of respondents reported sleeping most often in an apartment/ house. Others reported group home/halfway house (14%), shelter (8%), street (7%) and other (1%) locations. Approximately 63% of all respondents felt their housing situation was stable, and 37% felt their housing situation was unstable.

TABLE 6.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, BLACKS/AFRICAN-AMERICANS

In the past year, has your housing situation made it difficult to get HIV care?	N	%
Yes	129	30%
No	298	69%
Reasons	**N**	**%**
I could not keep my status private	37	9%
No place to store meds	33	8%
Money for food	63	15%
Money for rent	66	15%
Money for utilities	48	11%
Money for household supplies	52	12%
No stable address	0	0%
Used money on drugs	0	0%
Rules	0	0%
Lack of transportation	3	1%
No child care	37	9%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of 129 (30%) respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The three most common reasons for these difficulties were due to using money for food (15%), rent (15%), and/or household supplies (12%). Other reasons were using money for utility payments (11%), not having child care (9%), not being able to keep one's status private (9%), and not having a place to store medications (8%).

ACCESS TO CORE SERVICES

TABLE 6.37: ACCESS TO CORE SERVICES, BLACKS/AFRICAN-AMERICANS

Service Category	In the past 12 months…					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	95	22%	312	73%	22	5%
HIV/AIDS Medications	83	19%	278	65%	68	16%
Dentist Visits	135	31%	214	50%	80	19%
Medical Case Management	78	18%	246	57%	105	24%
Home Health Care	53	12%	74	17%	302	70%
Psychiatric Services or Medicine	61	14%	174	41%	194	45%
Psychological Counseling	46	11%	187	44%	196	46%
Substance Abuse Treatment	38	9%	147	34%	244	57%
Rehabilitation Services	40	9%	103	24%	286	67%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For all Black/African-American respondents, the top three “easy to get” core services were primary medical care (73%), HIV/AIDS Medications (65%) and medical case management (57%). The top three core services that respondents reported “some difficulty getting” were dentist visits (31%), primary medical care (22%), HIV/AIDS medications (19%) and medical case management (18%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that Black/African-American respondents said they “did not need” in the past year were home health care (70%), rehabilitation services (67%) and substance abuse treatment (57%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 6.38: ACCESS TO SUPPORTIVE SERVICES, BLACKS/AFRICAN-AMERICANS

Service Category	In the past 12 months….				
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service
Child Care Services	23	66%	5	14%	7
Child Welfare Services	5	56%	2	22%	2
Day/Respite Care for Adults	5	33%	5	33%	5
Developmental	4	80%	0	0%	1
Emergency Financial Assistance	120	60%	65	32%	16
Employment Assistance	72	73%	17	17%	10
Food Bank	66	43%	77	50%	10
HIV Education for HIV+ Individuals	21	22%	70	73%	5
Rental Assistance/Shelter Vouchers	92	61%	51	34%	9
Housing-Related Services	104	59%	58	33%	14
Legal Services	42	44%	39	41%	15
Nutritional Counseling	25	36%	41	59%	3
Permanency Planning	6	40%	4	27%	5
Referrals to Services	26	35%	46	62%	2
Referrals to Clinical Research	26	55%	18	38%	3
Support Groups	38	31%	76	62%	8
Translation/Interpretation	2	40%	3	60%	0
Transportation	74	44%	88	52%	7
Household Items	61	64%	30	31%	5

*** Percentages based on total number of respondents within each service category.*

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For all Black/African-American respondents, the supportive services that were selected most often (thus implying high helpfulness/usefulness) were Emergency Financial Assistance, Housing-Related Services, Transportation, Food Bank and Rental Assistance/ Shelter Vouchers.

The top five “easy to get” supportive services (based on number of responses) were Transportation (n=88), Food Bank (n=77), Support Groups (n=76), HIV Education for HIV

positive Individuals (n=70), and Emergency Financial Assistance (n=65). The top five supportive services that respondents reported "some difficulty getting" were Emergency Financial Assistance (n=120), Housing-Related Services (n=104), Rental Assistance/ Shelter Vouchers (n=92), Employment Assistance (n=72), and Food Bank (n=66). The presence of certain support services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates.

Conversely, the five supportive services that respondents did not need in the past year, but still identified as useful/helpful were Emergency Financial Assistance (n=16), Legal Services (n=15), Housing-Related Services (n=13), Employment Assistance (n=10), and Food Bank (n=10).

BARRIERS REPORTED PER CORE SERVICE CATEGORY

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among Black/African-American respondents, the three core services with the highest number of barriers were dentist visits (n=242), primary medical care (n=188), HIV/ AIDS medications (n=145). Within dentist visits, the three most commonly reported barriers were "it's hard to make or keep appointments" (n=49), "I don't know where to get the services" (n=36), "I would have to wait too long to get the services" (n=34). For primary medical care, the most common barriers for Black/African-American respondents were "it's hard for me to make or keep appointments" (n=32), "it's hard for me to get there" (n=31), and "I don't know where to get the services" (n=20). For HIV/AIDS medications, the most common barriers for Black/African-American respondents were "the services cost too much" (n=25), "I would have to wait too long to get the services" (n=22), and "I don't know where to get the services" (n=19).

The barriers experienced most often by all Black/African-American respondents across all core services were "it's hard to make or keep appointments" (n=170), "I don't know where to get the services" (n=163), and "I would have to wait too long to get the services" (n=138). ["n=*value*" indicates the number of responses for each service category.]

TABLE 6.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, BLACKS/AFRICAN AMERICANS

Core Services	Barriers																					
	A	B	C	D	E	F	G	H	I	J	K	L	M	O	P	Q	R	S	T	U	V	Total
Primary Medical Care	14	**20**	18	17	2	7	11	**32**	**31**	5	15	1	7	4	0	0	1	3	0	0	0	**188**
HIV/AIDS Medications	12	**19**	**22**	**25**	10	7	8	9	13	3	8	0	4	2	0	0	2	1	0	0	0	**145**
Dentist Visits	19	**36**	**34**	19	8	13	11	**49**	18	5	8	0	4	14	0	0	0	3	1	0	0	**242**
Medical Case Management	15	**22**	**19**	5	5	6	16	**24**	11	2	7	0	6	0	0	2	0	0	0	2	0	**142**
Home Health Care	5	**17**	3	6	**7**	**8**	5	5	4	0	3	0	3	0	0	0	1	1	4	0	0	**72**
Psychiatric Services or Medicine	9	**11**	**19**	10	9	7	9	**22**	13	3	5	0	1	0	0	0	1	0	0	0	0	**119**
Psychological Counseling	7	**13**	**10**	5	4	8	7	**15**	9	2	4	0	1	0	1	0	3	0	0	0	0	**89**
Substance Abuse Treatment	6	**10**	**7**	5	4	4	6	5	5	2	4	1	5	0	0	0	0	1	1	0	0	**66**
Rehabilitation Services	**7**	**15**	6	6	6	4	3	**9**	6	0	4	1	0	0	0	0	0	1	0	0	1	**69**
Total	**94**	**163**	**138**	**98**	**55**	**64**	**76**	**170**	**110**	**22**	**58**	**3**	**31**	**20**	**1**	**2**	**8**	**10**	**6**	**2**	**1**	**1,132**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among all Black/African-American respondents, the five supportive services with the highest number of barriers were emergency financial assistance (n=225), housing-related services (n=178), rental assistance/shelter vouchers (n=157), transportation (n=120), employment assistance (n=117). Within emergency financial assistance, the most commonly reported barriers were "I don't know where to get the services" (n=42), "I was told I am not eligible to get the services" (n=34), and "I would have to wait too long to get the services" (n=31). For housing-related services, the most common barriers for Black/ African-American respondents were "I don't know where to get the services" (n=39), "I would have to wait too long to get the services" (n=30), and "the services are not in my area" (n=16). For rental assistance/shelter vouchers, the most common barriers for Black/ African-American respondents were "I don't know where to get the services" (n=25), I would have to wait too long to get the services" (n=18), and "I don't think I'm eligible to get the services" (n=16).

The barriers experienced most often by all Black/African-American respondents across all supportive services were "I don't know where to get the services" (n=326), "I would have to wait too long to get the services" (n=147), and "the services are not in my area" (n=140). ["n=*value*" indicates the number of responses for each service category.]

TABLE 6.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, BLACKS/AFRICAN AMERICANS

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Child Care Services	**8**	**11**	7	5	**8**	5	2	2	5	4	1	0	0	0	0	0	0	0	0	0	1	0	**59**
Child Welfare Services	1	**4**	0	1	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	**9**
Day/Respite Care for Adults	2	2	1	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	**8**
Developmental Assessment	1	2	2	0	0	1	0	1	1	1	1	0	0	0	0	0	1	0	0	0	0	0	**11**
Emergency Financial Assistance	22	**42**	**31**	7	**34**	17	12	18	14	4	7	0	7	0	1	0	0	1	2	1	5	0	**225**
Employment Assistance	**13**	**31**	7	1	8	12	7	4	8	1	8	1	**14**	0	0	0	0	2	0	0	0	0	**117**
Food Bank	**17**	**21**	9	1	8	7	5	3	**15**	0	1	0	1	0	1	1	0	1	0	1	7	0	**99**
HIV Education for HIV+ Individuals	3	**11**	0	2	0	1	0	**6**	2	0	2	0	1	0	0	1	0	1	1	0	0	0	**31**
Rental Assistance/Shelter Vouchers	12	**25**	**18**	11	13	**16**	9	14	8	1	4	0	8	1	1	0	2	0	3	1	9	1	**157**
Housing-Related Services	**16**	**39**	**30**	13	14	15	6	10	9	3	3	0	13	0	0	0	1	0	4	0	2	0	**178**
Legal Services	**6**	**18**	**6**	5	5	3	4	**8**	4	0	2	1	3	0	0	0	1	0	1	1	0	0	**68**
Nutritional Counseling	2	**10**	1	1	1	3	2	**6**	**5**	0	2	1	0	1	0	0	0	0	0	0	0	0	**35**
Permanency Planning	1	**4**	1	1	1	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**12**
Referrals to Services	4	**13**	**6**	1	0	3	2	2	4	1	1	0	0	2	0	0	0	0	2	0	0	0	**41**
Referrals to Clinical Research	4	**16**	3	1	**5**	**5**	0	2	3	0	1	0	0	0	0	0	0	0	0	0	0	0	**40**
Support Groups	6	**23**	4	1	2	5	0	**7**	**9**	1	0	0	0	0	0	1	1	0	0	1	0	0	**61**
Translation/Interpretation	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Transportation	12	**24**	**13**	9	10	6	2	11	**15**	3	2	0	1	7	0	0	1	1	2	0	1	0	**120**
Household Items	**10**	**29**	7	**8**	7	**8**	3	2	4	1	0	0	0	0	0	0	1	1	0	0	0	0	**81**
Total	**140**	**326**	**147**	**68**	**117**	**109**	**55**	**97**	**107**	**22**	**36**	**3**	**48**	**11**	**4**	**3**	**8**	**7**	**15**	**5**	**25**	**1**	**429**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions					
A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 6.41: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA BLACKS/AFRICAN-AMERICANS (N=429)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of African-Americans Reporting Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	42	256	6	6%	56	7%
Anonymous Sex Partner(s)	79	208	N/A	17%	141	18%
Greater than 5 Sex Partners	26	399	N/A	8%	60	8%

Of Blacks/African-Americans surveyed, 42 (10%) reported that they had engaged in sex for drugs or money in the past 6 months, while 56 (7%) of all respondents reported this risk factor. Seventy-nine (18%) reported that they had one or more anonymous sex partners in the past 6 months, as did 141 (18%) of all respondents. Twenty-six (6%) Blacks/African-Americans surveyed reported that they had more than 5 sex partners in the past 6 months, while 60 (8%) of all respondents reported that they had more than 5 sex partners.

TABLE 6.42: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), BLACKS/AFRICAN-AMERICANS (N=429)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of African-Americans Reporting Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	140	164	N/A	30%	235	31%
Shared Injecting Equipment	4	11	N/A	1%	12	2%
Serodiscordant Sex Partner(s)	62	199	44	15%	111	15%

Of Blacks/African-Americans surveyed, 140 (33%) reported that they had unprotected sex at least some of the time, while 235 (31%) of the entire sample reported this risk factor. Four (1%) Blacks/African-Americans sampled reported that they had shared injecting equipment at least some of the time, compared with 12 (2%) of the total sample reporting this risk factor. Sixty-two (14%) Blacks/African-Americans reported that they had an HIV-negative sex partner, while 111 (15%) of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

LATINOS/HISPANICS

Overview

There were 141 total Latino/Hispanic respondents to the 2008 Need Assessment consumer survey. This total represents 18% of the total 764 survey respondents.

[*See Appendix A for a Special Study on HIV+ Latinos, conducted by the Ryan White Planning Council and Part A Health Planner*].

Demographics

TABLE 7.1: GENDER, PREGNANCY STATUS AND AGE, LATINOS/HISPANICS

Gender	**N**	**%**
Male	99	70%
Female	40	28%
Transgender – Male to Female	2	1%
Pregnant	**N**	**%**
Yes	5	13%
Don't Know	0	0%
Age Avg = 41	**N**	**%**
18-24	6	4%
25-44	83	59%
45+	52	37%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of Latino/Hispanic respondents were male (70%), while females represented 28% of all respondents. Two respondents (1%) identified as transgender Male to Female.

Among females, 13% said they were pregnant at the time of the survey, and none said they did not know their pregnancy status.

The average age of respondents was 41 years, ranging from 18 to 71. Approximately 59% were between the ages of 25-44, and another 37% were above the age of 45. Four percent (4%) were youth between the ages of 18 and 24.

TABLE 7.2: SEXUAL ORIENTATION, LATINOS/HISPANICS

Sexual Orientation	N	%
Straight/Heterosexual	61	43%
Gay/Lesbian	50	35%
Bisexual	11	8%
Undecided	1	1%
Prefer not to say	16	11%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Forty-three percent (43%) of all Latino/Hispanic respondents identified as straight or heterosexual. About fifty (i.e., 35%) identified as gay/lesbian, 8% as bisexual and 1% as undecided. Eleven percent said they preferred not to disclose their sexual orientation.

TABLE 7.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, LATINOS/HISPANICS

Education	N	%
Less than high school	36	26%
High school degree/GED	73	52%
College degree	16	11%
Graduate/Professional degree	2	1%
Some technical training	12	9%
None	2	1%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	11	8%
Are you eligible for veteran benefits?	**N**	**%**
Yes	2	1%
No	119	84%
Don't Know	20	14%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Seventy-eight percent (78%) of Latino/Hispanic respondents had a high school degree/GED or less. Approximately 11% had a college degree, 1% had a graduate/ professional degree and 9% had some technical training. Two respondents (1%) indicated not receiving any form of education.

A total of 11 (8%) of all survey respondents reported being released from jail or prison during the previous year.

Approximately 1% of Latino/Hispanic PLWHA reported being eligible for veteran benefits.

Immigration Status & Primary Language

TABLE 7.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, LATINOS/HISPANICS

	N	%
Born outside U.S.	78	55%
Length of residency	Range = 2 to 40 yrs; Avg = 16 yrs	
Immigration status	**N**	**%**
Citizen	77	55%
Permanent Resident	12	9%
Visa	7	5%
Undocumented	45	32%

** Percentages may not add up to 100% due to rounding or missing survey responses.

As a whole, foreign-born Latino/Hispanic respondents represented 55% of all respondents from this subgroup. Among the foreign born, lengths of residency in the U.S. ranged from 2 to 40 years with an average residency of 16 years.

Among all Latino/Hispanic respondents, more than half (55%) were U.S. citizens. Twelve respondents (9%) were permanent residents, 5% visa holders and 32% were undocumented.

TABLE 7.5: PREFERRED LANGUAGE, LATINOS/HISPANICS

Preferred language at home with family/friends	**N**	**%**
English	54	38%
Spanish	68	48%
English/Spanish	19	13%
Other	0	0%
Preferred language when seeing a doctor	**N**	**%**
English	69	49%
Spanish	65	46%
English/Spanish	7	5%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, Spanish was the primary language reported most often by Latino/Hispanic survey respondents. Approximately 38% said they were most comfortable speaking English at home with family/friends, and 49% said they were most comfortable speaking English with their doctor. Thirteen percent (13%) preferred a combination of English and Spanish at home with family/friends, while 5% preferred this same language combination when seeing a doctor.

Job Status & Income

TABLE 7.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, LATINOS/HISPANICS

Job status	N	%
Not working due to disability	37	26%
Unemployed	37	26%
Full time	29	21%
Part time	22	16%
Temporary/contract/odd jobs	11	8%
Retired	4	3%
Average monthly income during past 6 months	Range = $0 - $4,500; Avg = $714.33	
Approximate yearly income	Range = $0 - $54,000; Avg = $8,571.91	
Up to 300% FPL (2007 – 2008)	137	97%
Up to 200% FPL (2007 - 2008)	131	93%
Up to 100% FPL (2007 - 2008)	107	76%
Total income dependents	1 to 7	Avg = 2
Income dependents under 18	0 to 5	Avg = .6

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately 44% of all Latino/Hispanic respondents were employed at the time of the survey; 26% were unemployed, 26% were not working due to disability, and 3% were retired. In regards to employed respondents, 21% were working full-time, 16% part-time and 8% had temporary/ contract/odd jobs.

Per-month incomes ranged from $0 to $4,500, with an average of $714 per month. Yearly incomes were calculated as ranging from $0 to $54,000, for an average of $8,572 per year. The number of dependents per income ranged from 1 to 7 (average of 2), with an average of less than 1 being under the age of 18. Based on estimated yearly incomes and household sizes, 97% of all Latino/Hispanic respondents fell within 300% of the 2007 – 2008 Federal Poverty Level (FPL) guidelines.

Sources of Income Assistance

TABLE 7.7: SOURCES OF INCOME ASSISTANCE, LATINOS/HISPANICS

Sources of income assistance	N	%
None	38	27%
Food Stamps	36	26%
SSI	20	14%
Rental Subsidy/Section 8	19	13%
SSDI	17	12%
Hourly wages/Salary	16	11%
Social Security	13	9%
TANF/AFDC	4	3%
Unemployment	4	3%
Family/friends	4	3%
Private Disability	1	1%
Child support	1	1%
Pension/Retirement/Savings	1	1%
Workers Comp	0	0%
VA Benefits	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among Latino/Hispanic survey respondents were food stamps (26%), Supplemental Security Income (SSI) (14%) and Rental Subsidy/ Section 8 (13%). No survey respondents received worker's compensation.

Twenty-seven percent (27%) of all Latino/Hispanic respondents reported no source of income.

Paying for Medical Care

TABLE 7.8: SOURCES OF PAYMENT FOR MEDICAL CARE, LATINOS/HISPANICS

Paying for medical care	N	%
Gold Card/County	55	39%
Medicaid	31	22%
Other	25	18%
Medicare	24	17%
Self-Pay	8	6%
Private insurance/COBRA	7	5%
I don't receive medical care because I can't pay for it	3	2%
VA	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

According to the Centralized Patient Care Data Management System (CPCDMS), 6,961 clients paid for primary medical care using Ryan White funding resources. Among Latino/Hispanic respondents, Gold card/county (39%), Medicaid (22%) and Medicare (17%) were the most common methods of paying for medical care. The Harris County Gold Card program assists eligible low-income residents with medical expenses and prescriptions. Eighteen percent (18%) of all Latino/Hispanic respondents reported using other methods and none reported the Veteran's Administration Hospital. Two percent of respondents from this subgroup said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 7.9: LENGTH OF HIV DIAGNOSIS, LATINOS/HISPANICS

Length of diagnosis Avg = 8 yrs	N	%
Less than 1 year	7	5.0
1-4 years	53	37.6
5-10 years	40	28.4
11-15 years	20	14.2
16-20 years	13	9.2
21-25 years	7	5.0

** Percentages may not add up to 100% due to rounding or missing survey responses.

Latino/Hispanic respondents reported being diagnosed as HIV positive an average of eight (8) years, ranging from 8 months to 23 years.

TABLE 7.10: LOCATION OF HIV DIAGNOSIS, LATINOS/HISPANICS

Location of diagnosis	N	%
Private doctor	23	16%
ER	15	11%
In hospital stay	27	19%
HIV-specific testing site	20	14%
Public or community clinic	40	28%
Jail/Prison	2	1%
Community testing location	5	4%
Alcohol or drug treatment facility	5	4%
Blood/Plasma donation	1	1%
Work/insurance related	3	2%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of Latino/Hispanic respondents (28%) received their diagnoses at a public or community clinic. Other common diagnosis locations for overall respondents were

in a hospital stay (19%) and at a private doctor's office (16%). Less frequently identified locations included HIV testing sites (14%), emergency rooms (11%), community testing locations (4%), alcohol or drug treatment facilities (4%), jail/prison (1%), and blood/plasma donation sites (1%).

TABLE 7.11: REASONS FOR HIV TESTING, LATINOS/HISPANICS

Reasons for testing	N	%
Recommended by provider	17	12%
Had sex with someone HIV+	24	17%
ER/Hospital stay	31	22%
Felt sick	48	34%
Engaged in risky behavior	29	21%
Was in prison/jail	5	4%
During pregnancy care	6	4%
Routine check up/testing	7	5%
Blood/plasma donation	2	1%
Work/insurance related	6	4%
Partner notification	0	0%
Knew someone with HIV	0	0%
Rape survivor	0	0%
Incentive offered	0	0%
In drug treatment program	0	0%
Recommended by friends	0	0%
Other	3	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The two most frequently reported reasons for seeking HIV testing were due to feeling sick (34%) and an ER/hospital stay (22%). Other common reasons included having engaged in risky behavior (21%), having sex with an HIV positive person (17%), or because of being recommended for testing by a provider (12%). Less frequent reasons were due to a routine check up/testing (5%), being in prison/jail (4%), receiving pregnancy care (4%), and blood/plasma donation (1%).

TABLE 7.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, LATINOS/HISPANICS

Assistance at diagnosis	N	%
Information about HIV/AIDS	65	46%
Medical services	80	57%
Counseling	58	41%
Help with food or shelter	14	10%
Alcohol or drug treatment services	5	4%
Supportive Services	0	0%
Other	0	0%
None	28	20%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to Latino/ Hispanic respondents were medical services (57%), information about HIV/AIDS (46%) and counseling (41%). Less frequently reported were help with food or shelter (10%) and alcohol or drug treatment services (4%). A total of 28 (20%) of all Latino/Hispanic respondents reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 7.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, LATINOS/HISPANICS

Time to first doctor visit	N	%
Less than 1 month	76	54%
1-6 months	36	26%
6-12 months	9	6%
More than 12 months	19	13%
Never	0	0%

Time to CD4/Viral Load	N	%
Less than 1 month	62	44%
1-6 months	44	31%
6-12 months	10	7%
More than 12 months	21	15%
Never	3	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Fifty-four percent (54%) of all Latino/Hispanic respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 26% of respondents from this subgroup, 1 to 6 months passed before seeing a doctor. Six percent waited between 6 to 12 months, and 13% waited more than a year to see a doctor for HIV. No respondents indicated having not seen a doctor for HIV. Likewise, 44% reported receiving their first CD4/viral load test within one month of being diagnosed, 31% within 1-6 months, 7% between 6-12 months and 15% waited more than a year. A total of 3 (2%) said they had never received a CD4 or viral load test.

TABLE 7.14: REASONS FOR DELAYED ENTRY INTO CARE, LATINOS/HISPANICS

Reasons for waiting more than 6 months	N	%
Afraid	15	11%
Didn't feel sick	10	7%
Jail/prison	3	2%
Doing drugs	3	2%
Denial	11	8%
Didn't want to take meds	5	4%
No money	7	5%
Depressed/emotional problems	17	12%
No stable place to live	7	5%
Other	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were due to depression/emotional problems (12%), being afraid (11%), being in denial (8%) and not feeling sick (7%). Other reasons were not having money (5%), not having a stable place to live (5%), not wanting to take medications (4%), and being in jail/prison (2%).

Maintenance in Care

TABLE 7.15: TIME SINCE LAST VISIT TO DOCTOR & VIRAL LOAD & CD4 & HIV MEDICATION PRESCRIPTION, LATINOS/HISPANICS

Last visit to doctor for HIV	N	%
Less than 6 months	129	91%
6-12 months	6	4%
More than 12 months	4	3%
Never/Don't Know	1	1%
Last viral load	**N**	**%**
Less than 6 months	127	90%
6-12 months	6	4%
More than 12 months	4	3%
Never/Don't Know	4	3%

Last CD4	N	%
Less than 6 months	129	91%
6-12 months	7	5%
More than 12 months	2	1%
Never/Don't Know	3	2%
Last HIV meds prescription	**N**	**%**
Less than 6 months	108	77%
6-12 months	11	8%
More than 12 months	10	7%
Never/Don't Know	12	9%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of Latino/Hispanic respondents said their most recent doctor's visit (91%), viral load (90%), CD4 test (91%) and HIV medication prescription (77%) were within the past 6 months.

TABLE 7.16: FREQUENCY OF DOCTOR'S VISITS, LATINOS/HISPANICS

No doctor visits more than 6 months?	N	%
Yes	39	28%
No	102	72%
No doctor visits more than 12 months?	**N**	**%**
Yes	20	14%
No	117	83%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The table above outlines the number and percentage of respondents who did not visit a doctor for over 6 months or more since being diagnosed. Among Latino/Hispanic respondents who have seen a doctor for HIV, 28% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 14% reported not seeing a doctor for 12 months or more.

TABLE 7.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, LATINOS/HISPANICS

Reasons for no doctor visits	N	%
Case manager left	5	4%
Doctor left	3	2%
Agency closed down	1	1%
Doing drugs	5	4%
Program closed down	2	1%
Did not want to take meds	12	9%
Bad experience with provider	1	1%
Lost stable housing	9	6%
Lost my job	6	4%
Lost health insurance	2	1%
Tired of regimen	8	6%
Felt fine	17	12%
Worried about side effects	11	8%
Denial	11	8%
Jail/prison	0	0%
No transportation	3	2%
Depression/emotional barriers	1	1%
Had to care for children/family member	2	1%
Other	4	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The table above provides an outline of supplementary responses to the previous

table and the specific reasons reported for not visiting a doctor for more than 6 months among this subgroup. The most frequently reported reasons for falling out of care were feeling fine (12%), not wanting to take medications (9%), denial (8%), and worrying about side effects (8%).

TABLE 7.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, LATINOS/HISPANICS

First place of care	N	%
Private Clinic/Doctor's Office	23	16%
Public clinic/community health center	103	73%
Prison/jail	0	0%
VA Hospital	0	0%
ER/Hospital	13	9%
I have not received care for HIV	1	1%
Other	0	0%

Most often location of care	N	%
Private Clinic/Doctor's Office	27	19%
Public clinic/community health center	109	77%
Prison/jail	1	1%
VA Hospital	0	0%
ER/Hospital	2	1%
I have not received care for HIV	1	1%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was public clinics/ community health centers (73%). Other locations were private clinics/doctor offices (16%) and ERs/hospitals (9%). Locations of ongoing care were public clinics/community health centers (77%) or private clinics/doctor offices (19%). No Latino/Hispanic respondents reported receiving care most often from the Veteran's Administration Hospital.

TABLE 7.19: KNOWLEDGE OF CASE MANAGER, LATINOS/HISPANICS

Case Manager	N	%
Yes	101	72%
No	28	20%
Don't Know	12	9%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Seventy-two percent (72%) of Latino/Hispanic respondents reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services to assist in accessing medical-related services. Twenty percent (20%) of respondents said they did not have such a person assisting them, and 9% said they didn't know.

Health Status

TABLE 7.20: SELF-REPORTED HEALTH STATUS, LATINOS/HISPANICS

How would you describe your health overall	N	%
Excellent	25	18%
Good	67	48%
Fair	30	21%
Poor	19	13%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 18% said "Excellent," 48% said "Good," 21% said "Fair" and 13% said "Poor."

TABLE 7.21: SELF-REPORTED PHYSICAL HEALTH STATUS & ER OR HOSPITAL VISITS, LATINOS/HISPANICS

During the past month, has your physical health interfered with normal activities?	N	%
No	53	38%
Yes – Some of the time	74	52%
Yes – all of the time	10	7%
ER visit in past 6 months	31	22%
Hospital stay in past 6 months	18	13%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Fifty-two percent (52%) of all Latino/Hispanic respondents reported that during the past month, their physical health had interfered with normal activities some of the time. Seven percent said their physical health interfered all of the time.

For the 6 months prior to the survey, 22% of all Latino/Hispanic respondents reported an emergency room visit and 13% reported being admitted to a hospital for one or more nights.

TABLE 7.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, LATINOS/HISPANICS

Symptoms during past month	N	%
Trouble with thinking, concentrating or memory	63	45%
Depressed or sad, trouble thinking	89	63%
Aches, fatigue, lightheadedness, weak all over	61	43%
Fevers, chills, sweats	27	19%
Poor appetite, weight loss	38	27%
Trouble with eyes or ears	40	28%
Trouble with nose or sinuses, headaches	35	25%
Trouble with mouth or swallowing	19	13%
Nausea, vomiting, diarrhea, abdominal pain	40	28%
Coughing, wheezing, or chest pain, trouble breathing	22	16%
Rash, itch, herpes, or other skin trouble	33	23%
Numbness, tingling or pain in an arm or leg	51	36%
Other	0	0%
None	23	16%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The number of symptoms reported by all respondents during the past month ranged from 1 to 12, with an average of 4. The top three reported symptoms were depression or sadness (63%), trouble thinking, concentrating or remembering (45%) and aching and weakness (43%).

TABLE 7.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, LATINOS/HISPANICS

First CD4/T-cell	N	%
Less than 50	19	13%
50-99	6	4%
100-199	13	9%
200-349	23	16%
350-499	26	18%
500+	17	12%
Don't Know/Can't Remember	36	26%

Current CD4/T-cell	N	%
Less than 50	11	8%
50-99	4	3%
100-199	13	9%
200-349	26	18%
350-499	33	23%
500+	25	18%
Don't Know/Can't Remember	29	21%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of twelve percent (12%) of all Latino/ Hispanic respondents reported their first CD4/T-cell counts as 500+; 35% were 200 to 499, 13% were 50 to 199, and 13% were less than 50. Current CD4/T-cell counts were 500+ for 18% of all Latino/Hispanic respondents; 200 to 499 for 42%, 50 to 199 for 12%, and less than 50 for 8% of respondents. Twenty-six percent (26%) didn't know or couldn't remember their first CD4/T-cell count, and 21% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 7.24: HIV MEDICATIONS, LATINOS/HISPANICS

Currently taking HIV meds	N	%
Yes	113	80%
No	28	20%
How many pills do you take in one day? Range = 1 to 28; Avg = 5		

** Percentages may not add up to 100% due to rounding or missing survey responses.

Eighty percent (80%) of respondents said they were currently taking HIV medications. The number of pills taken in one day ranged from 1 to 28, with an average of five pills per day.

TABLE 7.25: SELF-REPORTED MEDICATION ADHERENCE, LATINOS/HISPANICS

Medication adherence	N	%
I have not missed any doses in the past month	63	45%
Missed a few, but took nearly all	46	33%
Took more than half	2	1%
About half	3	2%
Some, but not half	0	0%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	92	65%
No	42	30%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among Latino/Hispanic respondents currently taking HIV medications, 45% reported perfect adherence and 33% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 65% said "Yes" and 30% said "No."

TABLE 7.26: REASONS FOR NOT TAKING HIV MEDICATIONS, LATINOS/HISPANICS

Reasons for not taking HIV medications	N	%
Side effects	1	1%
Not effective	2	1%
Too difficult to take as prescribed	0	0%
No doctor has offered them	2	1%
I choose not to take them	6	4%
Doctor did not think it was a good idea for me	6	4%
T-cell too high	11	8%
Cannot pay	2	1%
Confidentiality concerns	3	2%
Didn't feel sick	2	1%
Have not seen doctor	0	0%
Other	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "T-cell too high" (8%) followed by "I chose not to take them" (4%), "doctor did not think it was a good idea for me" (4%) and "confidentiality concerns" (2%).

TABLE 7.27: MEDICATIONS FOR NON-HIV CONDITIONS, LATINOS/HISPANICS

	N	%
How many pills do you take in one day for non-HIV conditions?	Avg = 4	
Diabetes	14	10%
High blood pressure	26	18%
High cholesterol	32	23%
Depression/emotional problems	53	38%
Eye drops/glaucoma	1	1%
Acid reflux	5	4%
Anemia	1	1%
Sleep	4	3%
Allergies/Sinus	1	1%
Pain	4	3%
Antibiotics	1	1%
Arthritis	2	1%
Asthma	0	0%
Neuropathy	1	1%
Nausea	0	0%
Hormones	0	0%
Other	4	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

In Table 7.27 above, the "N" represents the number of respondents indicating taking pills for the associated non-HIV conditions.

Overall, Latino/Hispanic respondents took an average of four (4) non-HIV pills per day. The most common conditions associated with the non-HIV pills were depression/ emotional problems (38%), high cholesterol (23%), high blood pressure (18%) and diabetes (10%).

TABLE 7.28: TOTAL PILL BURDEN AND ABILITY TO PAY, LATINOS/HISPANICS

Total Pills (HIV + non-HIV)	Avg = 4	
How often do you have trouble paying for these or other non-HIV meds?	**N**	**%**
Never	86	61%
Less than half the time	17	12%
More than half the time	16	11%
Always	14	10%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was four.

The majority (61%) of all Latino/Hispanic respondents reported never having problems paying for HIV or non-HIV medications, and 12% had problems less than half the time. Sixteen (11%) had problems more than half the time, and 10% said they always had problems paying for their medications.

Comorbidities

TABLE 7.29: HEPATITIS C AND TB STATUS, LATINOS/HISPANICS

Hep C Test?	N	%
Yes	109	77%
No	18	13%
Don't Know	13	9%
Positive for Hep C?	**N**	**%**
Yes	25	18%
No	99	70%
Don't know	16	11%

TB skin test?	N	%
Yes	123	87%
No	**14**	10%
Result	**N**	**%**
Positive	14	10%
Negative	100	71%
Don't Know	9	6%
History of active TB?	**N**	**%**
Yes	17	12%
No	116	82%
Don't Know	7	5%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (77%) of all Latino/Hispanic respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 18% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

The majority (87%) of respondents had received a skin test for TB, and 10% reported a positive result. A total of 17 (12%) reported a history of active TB.

Mental Health

TABLE 7.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, LATINOS/HISPANICS

	N	%
At least one mental health condition	**67**	48%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	55	39%
Hallucinations	10	7%
Serious thoughts of suicide	14	10%
Attempted suicide	3	2%
Wanted to hurt or harm yourself	10	7%
Wanted to hurt or harm someone else	10	7%
Trouble controlling anger leading to physical violence	12	9%
Problems requiring meds	29	21%
None	71	50%
At least one serious indicator (suicide/homicidal or requiring meds)	31	22%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Forty-eight percent (48%) of all Latino/Hispanic respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced symptoms were serious anxiety/tension (39%), emotional problems requiring medications (21%), serious thoughts of suicide (10%) and trouble controlling anger that leads to physical violence (9%).

TABLE 7.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, LATINOS/HISPANICS

Since being diagnosed, ever talked with therapist?	**N**	**%**
Yes	95	67%
No	46	33%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	92	65%
No	49	35%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	77	55%
No	63	45%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 67% of Latino/Hispanic respondents said they had talked with a therapist or psychologist for help with depression or emotional problems and 65% had talked to a doctor or psychiatrist for medications. Seventy-seven respondents (55%) said they had participated in a support group since being diagnosed with HIV.

Substance Use & Abuse

TABLE 7.32: SUBSTANCE USE, LATINOS/HISPANICS

Total Number of substances Range = 1 to 12; Avg = 2	**N**	**%**
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	7	5%
Street Methadone (non-treatment)	3	2%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	6	4%
Barbituates (seconal, tuinal, downers)	3	2%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	4	3%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	3	2%
Amphetamines (speed, uppers, crystal meth, ice, glass)	5	4%
Marijuana, Hashish (grass, weed)	18	13%
Heroin	3	2%
Cocaine (powder), Crack	24	17%
Ecstasy, X, MDA, GHB	5	4%
Ketamine (K, Special K)	3	2%
None	98	70%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the numbers of substances ranged from 1 to 12, with an average of 2. The most commonly used substances for all respondents were cocaine (17%) and marijuana (13%).

TABLE 7.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, LATINOS/HISPANICS

In the last year, ever drunk more than meant to?	**N**	**%**
Yes	34	24%
No	107	76%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	44	31%
No	93	66%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	21	15%
No	120	85%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	29	21%
No	109	77%
Indicator of Alcohol Abuse	48	34%
Indicator of Substance Abuse	31	22%
Abuse of both drugs and alcohol	23	16%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 34% of all Latino/Hispanic respondents indicated possible alcohol abuse, and 22% indicated possible substance abuse. A total of 23 (16%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 7.34: SOCIAL SUPPORT, LATINOS/HISPANICS

Of all the people you feel close to, how many have you told about being HIV+?	N	%
All	36	26%
Some	85	60%
None	20	14%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	100	71%
No	39	28%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 26% had disclosed their HIV status to all and 60% had disclosed their status to some. A total of 20 (14%) had not told their HIV status to any of the people to whom they feel close. Overall, 71% of Latino/Hispanic respondents said there were people they could depend on for help if really needed; 28% of those who had told their HIV status to no one said they had people to depend on.

Housing

TABLE 7.35: HOUSING STATUS, LATINOS/HISPANICS

Where do you most often sleep?	N	%
Apartment/House	122	87%
Group home/halfway house	14	10%
Shelter	1	1%
Street	3	2%
Other	1	1%
Do you feel your housing situation is stable?	**N**	**%**
Yes	91	65%
No	50	35%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Eighty-seven percent (87%) reported sleeping most often in an apartment/house.

Others reported group home/halfway house (10%), shelter (1%), street (2%) and other (1%) locations. The majority of all respondents (65%) of all respondents felt their housing situation was stable, and 35% felt their housing situation was unstable.

TABLE 7.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, LATINOS/HISPANICS

In the past year, has your housing situation made it difficult to get HIV care?	N	%
Yes	30	21%
No	111	79%
Reasons	**N**	**%**
I could not keep my status private	6	4%
No place to store meds	6	4%
Money for food	13	9%
Money for rent	18	13%
Money for utilities	14	10%
Money for household supplies	18	13%
No stable address	1	1%
Used money on drugs	1	1%
Rules	0	0%
Lack of transportation	3	2%
No child care	6	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of 30 (21%) respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The three most common reasons for these difficulties were using money for rent (13%), household supplies (13%), and utilities (10%). Other reasons were due to the following: using money for food (9%), not being able to keep one's status private (4%), not having child care (4%), not having a place to store meds (4%), lacking transportation (2%), not having a stable address (1%), and using money to buy drugs (1%).

ACCESS TO CORE SERVICES

TABLE 7.37: ACCESS TO CORE SERVICES, LATINOS/HISPANICS

Service Category	In the past 12 months…					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	24	17%	113	80%	4	3%
HIV/AIDS Medications	33	23%	99	70%	9	6%
Dentist Visits	38	27%	89	63%	14	10%
Medical Case Management	17	12%	82	58%	42	30%
Home Health Care	7	5%	27	19%	107	76%
Psychiatric Services or Medicine	10	7%	68	48%	63	45%
Psychological Counseling	9	6%	72	51%	60	43%
Substance Abuse Treatment	4	3%	29	21%	108	77%
Rehabilitation Services	4	3%	42	30%	95	67%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For all Latino/Hispanic respondents, the top three “easy to get” core services were Primary Medical Care (80%), HIV/AIDS Medications (70%) and Dentist Visits (63%). The top three core services that respondents reported “some difficulty getting” were Dentist Visits (27%), HIV/AIDS Medications (23%) and Medical Case Management (12%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the top three core services that Latino/Hispanic respondents said they “did not need” in the past year were Substance Abuse Treatment (77%), Home Health Care (76%) and Rehabilitation Services (67%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 7.38: ACCESS TO SUPPORTIVE SERVICES, LATINOS/HISPANICS

Service Category	In the past 12 months…				
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service
Child Care Services	9	60%	4	27%	2
Child Welfare Services	1	33%	0	0%	2
Day/Respite Care for Adults	2	29%	3	43%	2
Developmental	0	0%	0	0%	0
Emergency Financial Assistance	52	67%	20	26%	6
Employment Assistance	26	79%	2	6%	5
Food Bank	19	32%	40	67%	1
HIV Education for HIV+ Individuals	6	17%	27	75%	3
Rental Assistance/Shelter Vouchers	37	66%	15	27%	4
Housing-Related Services	23	68%	8	24%	3
Legal Services	20	61%	8	24%	5
Nutritional Counseling	12	29%	29	71%	0
Permanency Planning	4	67%	2	33%	0
Referrals to Services	6	35%	11	65%	0
Referrals to Clinical Research	2	25%	6	75%	0
Support Groups	13	33%	24	60%	3
Translation/Interpretation	5	29%	10	59%	2
Transportation	21	49%	22	51%	0
Household Items	15	83%	3	17%	0

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For all Latino/Hispanic respondents, the supportive services that were selected most often (thus implying high helpfulness/usefulness) were Emergency Financial Assistance, Food Bank, Rental Assistance/Shelter Vouchers, Transportation and Nutritional Counseling, respectively.

The top five “easy to get” supportive services (based on number of responses) were

Food Bank (n=40), Nutritional Counseling (n=29), HIV Education for HIV+ Individuals (n=27), Support Groups (n=24), and Transportation (n=22). The top five supportive services that respondents reported "some difficulty getting" were Emergency Financial Assistance (n=52), Rental Assistance/Shelter Vouchers (n=37), Employment Assistance (n=26), Housing-Related Services (n=23), and Transportation (n=21). The presence of certain support services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates. Conversely, the supportive services that respondents did not need in the past year, but still identified as useful/helpful were Emergency Financial Assistance (n=6), Employment Assistance (n=6), Legal Services (n=5), and Rental Assistance/Shelter Vouchers (n=4). In addition, HIV Education for HIV+ Individuals (n=3), Housing-Related Services (n=3), and Support Groups (n=3) were equally reported as the fifth most useful/helpful supportive services. ["n=*value*" indicates the number of responses for each service category.]

BARRIERS REPORTED PER CORE SERVICE CATEGORY

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among Latino/Hispanic respondents, the three core services with the highest number of barriers were Dentist Visits (n=68), HIV/AIDS Medications (n=47), and Primary Medical Care (n=43). Within Dentist Visits, the most commonly reported barriers were "It's hard to make or keep appointments" (n=15), "I would have to wait too long to get the services" (n=12), "I don't know where to get the services" (n=8). For HIV/AIDS Medications, the most common barriers for Latino/Hispanic respondents were "The services cost too much" (n=10), "I would have to wait too long to get the services" (n=6), and "The people who run the services are not friendly" (n=6). For Primary Medical Care, the most common barriers for Latino/Hispanic respondents were "I would have to wait too long to get the services" (n=6), "The people who run the services are not friendly" (n=6), and "It's hard for me to get there" (n=6).

The barriers experienced most often by all Latino/Hispanic respondents across all core services were "I would have to wait too long to get the services" (n=39), "I don't know where to get the services" (n=33), and "the people who run the services are not friendly" (n=26). ["n=*value*" indicates the number of responses for each service category.]

TABLE 7.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, LATINOS/HISPANICS

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Primary Medical Care	5	**7**	**6**	1	2	1	**6**	4	**6**	0	2	2	0	0	1	0	0	0	0	0	0	0	**43**
HIV/AIDS Medications	2	4	**6**	**10**	4	3	**6**	1	3	1	1	4	0	0	1	0	0	1	0	0	0	0	**47**
Dentist Visits	7	**8**	**12**	4	3	2	5	**15**	6	0	1	0	0	0	5	0	0	0	0	0	0	0	**68**
Medical Case Management	1	3	**5**	1	1	0	**5**	1	1	0	1	1	1	0	0	0	0	0	1	0	3	0	**25**
Home Health Care	0	0	2	0	1	2	1	0	1	1	1	1	0	0	0	0	0	0	0	1	0	0	**11**
Psychiatric Services or Medicine	3	**4**	**4**	3	1	0	2	1	3	0	2	1	0	0	0	0	0	1	0	0	0	0	**25**
Psychological Counseling	2	**4**	**3**	**4**	0	2	1	1	2	0	1	0	0	0	0	0	0	0	0	0	0	0	**20**
Substance Abuse Treatment	1	0	1	1	1	0	0	0	2	1	1	0	0	0	0	0	0	0	0	0	0	0	**8**
Rehabilitation Services	1	**3**	0	1	0	1	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	**10**
Total	**22**	**33**	**39**	**25**	**13**	**11**	**26**	**24**	**25**	**4**	**11**	**9**	**1**	**0**	**7**	**0**	**0**	**2**	**1**	**1**	**3**	**0**	**257**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	L	People at the agency don't speak my language
B	I don't know where to get the services	M	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	N	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	O	Substance abuse
E	I was told I am not eligible to get the services	P	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	Q	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	R	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	S	Homeless/unstable housing
I	It's hard for me to get there	T	CM left/staff turnover
J	There is no one to watch my kids if I go there	U	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	V	Immigration status

BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among all Latino/Hispanic respondents, the five supportive services with the highest number of barriers were Emergency Financial Assistance (n=92), Rental Assistance/ Shelter Vouchers (n=53), Housing-Related Services (n=44), Transportation (n=33), and Legal Services (n=32). Within Emergency Financial Assistance, the most commonly reported barriers were "I would have to wait too long to get the service" (n=25), "I don't know where to get the service" (n=14), and "I was told I am not eligible for this service" (n=12). For Rental Assistance/Shelter Vouchers, the most common barriers for Latino/Hispanic respondents were "I don't know where to get the services" (n=13), "I would have to wait too long to get the services" (n=11), and "the people who run the services are not friendly" (n=6). For Housing-Related Services, the most common barriers for Latino/ Hispanic respondents were "I don't know where to get the services" (n=11), "I would have to wait too long to get the services" (n=8), and "I was told I am not eligible to get services" (n=7).

The barriers experienced most often by all Latino/Hispanic respondents across all supportive services were "I don't know where to get the services" (n=112), "I would have to wait too long to get the services" (n=69), and "the services are not in my area" (n=40). ["n=value" indicates the number of responses for each service category.]

TABLE 7.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, LATINOS/HISPANICS

Service Category	Barriers																				
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Q	R	S	T	U	V	Total
Child Care Services	1	**4**	1	**4**	0	0	0	0	2	0	1	1	0	0	0	0	0	0	0	0	**14**
Child Welfare Services	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Day/Respite Care for Adults	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Developmental Assessment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Emergency Financial Assistance	8	**14**	**25**	3	**12**	6	6	8	2	0	1	1	1	1	1	1	0	0	2	0	**92**
Employment Assistance	4	**16**	3	1	1	4	0	0	0	1	1	1	4	0	0	0	0	0	0	0	**36**
Food Bank	4	**6**	4	1	2	1	0	0	4	0	1	0	0	0	0	0	0	0	2	1	**26**
HIV Education for HIV+ Individuals	0	3	1	2	0	0	0	0	1	0	1	2	0	0	0	0	0	0	0	0	**10**
Rental Assistance/Shelter Vouchers	3	**13**	**11**	2	3	1	**6**	5	1	0	0	0	0	1	2	0	1	0	3	1	**53**
Housing-Related Services	5	**11**	**8**	1	**7**	3	3	2	2	0	0	1	1	0	0	0	0	0	0	0	**44**
Legal Services	1	**10**	**5**	3	2	1	2	1	1	0	0	3	0	2	0	0	0	0	1	0	**32**
Nutritional Counseling	1	**4**	3	1	1	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	**13**
Permanency Planning	0	**3**	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	**5**
Referrals to Services	1	1	1	0	0	2	3	1	1	0	1	1	0	0	0	0	0	0	0	0	**12**
Referrals to Clinical Research	1	2	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	**5**
Support Groups	2	**7**	0	0	0	0	1	0	3	1	1	1	0	0	0	0	0	0	2	0	**18**
Translation/Interpretation	0	1	0	0	0	0	0	1	0	0	0	4	0	0	0	0	0	0	0	0	**6**
Transportation	**6**	**7**	1	3	1	1	3	2	**4**	0	1	1	1	0	2	0	0	0	0	0	**33**
Household Items	3	**10**	**4**	1	2	1	1	1	2	0	1	0	1	0	0	0	0	0	0	0	**27**
Total	**40**	**112**	**69**	**22**	**31**	**20**	**28**	**23**	**24**	**2**	**9**	**17**	**8**	**4**	**5**	**2**	**1**	**0**	**10**	**2**	**429**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions					
A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 7.41: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA LATINOS/HISPANICS (N=141)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of Latinos/Hispanics Reporting Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	3	86	3	2%	56	7%
Anonymous Sex Partner(s)	23	58	N/A	16%	141	18%
Greater than 5 Sex Partners	12	126	N/A	9%	60	8%

Of Latinos/Hispanics surveyed, 3 (2%) reported that they had engaged in sex for drugs or money in the past 6 months, while 56 (7%) of all respondents reported this risk factor.

Twenty-three (16%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 141 (18%) of all respondents. Twelve (9%) Latinos/ Hispanics surveyed reported that they had more than 5 sex partners in the past 6 months, while 60 (8%) of all respondents reported that they had more than 5 sex partners.

TABLE 7.42: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA LATINOS/HISPANICS (N=141)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of Latinos/Hispanics Reporting Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	35	49	N/A	25%	235	31%
Shared Injecting Equipment	2	2	N/A	1%	12	2%
Serodiscordant Sex Partner(s)	20	51	16	14%	111	15%

Of Latinos/Hispanics surveyed, 35 (25%) reported that they had unprotected sex at least some of the time, while 235 (31%) of the entire sample reported this risk factor.

Two (1%) Latinos/Hispanics sampled reported that they had shared injecting equipment at least some of the time, compared with 12 (2%) of the total sample reporting this risk factor. Twenty (14%) of Latinos/Hispanics reported that they had an HIV-negative sex partner, while 111 (15%) of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

WHITE MSM

Overview

There were 103 total white MSM respondents to the 2008 Need Assessment consumer survey. This total represents 13% of the total 764 survey respondents.

White MSM were defined as any white men who identified themselves as gay or bisexual, or reported having sex with men (regardless of their self-identified sexual orientation).

Demographics

TABLE 8.1: AGE, WHITE MSM

Age Avg = 46	N	%
18-24	1	1%
25-44	44	43%
45+	58	56%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average age of white MSM respondents was 46, ranging from 22 to 73 years old. Virtually all (99%) white MSM respondents were above the age of 25; 43% were between the ages of 25-44, and another 56% were above the age of 45. Only 1 was between the ages of 18 and 24.

TABLE 8.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, WHITE MSM

Sexual Orientation	N	%
Straight/Heterosexual	2	2%
Gay/Lesbian	88	85%
Bisexual	12	12%
Undecided	1	1%
Prefer not to say	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most white MSM respondents identified as gay (85%) and 12% identified as bisexual. Two (2%) identified as straight/heterosexual, but also reported having sex with other men. One was undecided but reported having sex with other men.

TABLE 8.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, WHITE MSM

Education	N	%
Less than high school	3	3%
High school degree/GED	51	50%
College degree	36	35%
Graduate/Professional degree	7	7%
Some technical training	6	6%
None	0	0%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	9	9%
Are you eligible for veteran benefits?	**N**	**%**
Yes	8	8%
No	93	90%
Don't Know	2	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately half (53%) of White MSM respondents had a high school degree/GED or less; 35% had a college degree, 7% had a graduate/professional degree and 6% had some technical training.

A total of 9 (9%) of all White MSM survey respondents reported being released from jail or prison during the previous year. PLWHA eligible for veteran benefits represented 8% of all White MSM respondents.

Immigration Status & Primary Language

TABLE 8.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, WHITE MSM

	N	%
Born outside US	3	3%
Length of residency	Range = 36 to 47; Avg = 42	
Immigration status	**N**	**%**
Citizen	103	100%
Permanent Resident	0	0%
Visa	0	0%
Undocumented	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Foreign born White MSM represented 3% of all White MSM respondents. Lengths of residency in the US ranged from 36 to 47 years with an average residency of 42 years. All white MSM respondents were US citizens.

TABLE 8.5: PREFERRED LANGUAGE, WHITE MSM

Preferred language at home with family/friends	N	%
English	100	97%
Spanish	0	0%
English/Spanish	0	0%
Other	0	0%
Preferred language when seeing a doctor	**N**	**%**
English	100	97%
Spanish	0	0%
English/Spanish	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by White MSM consumer survey respondents. Almost all (97%) said they were most comfortable speaking English at home with family/friends, and 97% said they were most comfortable speaking English with their doctor.

Job Status & Income

TABLE 8.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, WHITE MSM

Job status	N	%
Full time	12	12%
Part time	2	2%
Temporary/contract/odd jobs	8	8%
Not working due to disability	51	50%
Unemployed	23	22%
Retired	7	7%
Average monthly income during past 6 months	Range = $0 to $6,000; Avg = $938.17	
Approximate yearly income	Range = $0 to 72,000; Avg = $11,257.98	
Up to 300% FPL (2007 – 2008)	96	93%
Up to 200% FPL (2007 - 2008)	92	89%
Up to 100% FPL (2007 - 2008)	61	59%
Total income dependents	Range = 1-2	Avg = 1
Income dependents under 18	0	Avg = 0

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (79%) White MSM respondents were unemployed at the time of the survey; 22% were unemployed, 50% were not working due to disability, and 7% were retired.

Twelve (12%) were working full-time, 2% part-time and 8% had temporary/contract/odd jobs.

The maximum monthly income was $6,000 with an average of $938.17. The maximum yearly income was calculated as $72,000, for an average of $11,257.98. The number of dependents per income ranged from 1 to 2, with none being under the age of 18. Based on estimated yearly incomes and household sizes, 59% of all White MSM respondents fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 8.7: SOURCES OF INCOME ASSISTANCE, WHITE MSM

Sources of income assistance	N	%
None	20	19%
Hourly wages/Salary	6	6%
SSI	23	22%
SSDI	38	37%
Social Security	18	17%
TANF/AFDC	0	0%
Food Stamps	15	15%
Rental Subsidy/Section 8	6	6%
Workers Comp	0	0%
Unemployment	0	0%
Private Disability	6	6%
VA Benefits	2	2%
Child support	0	0%
Family/friends	2	2%
Pension/Retirement/Savings	1	1%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among White MSM survey respondents were Social Security Disability Insurance (SSDI) (37%), Supplemental Security Income (SSI) (22%) and Social Security (17%). No survey respondents received worker's compensation.

Twenty (19%) of all White MSM respondents reported no source of income.

Paying for Medical Care

TABLE 8.8: SOURCES OF PAYMENT FOR MEDICAL CARE, WHITE MSM

Paying for medical care	N	%
I don't receive medical care because I can't pay for it	2	2%
Private insurance/COBRA	6	6%
VA	8	8%
Medicaid	26	25%
Medicare	40	39%
Self-Pay	3	3%
Gold Card/County	23	22%
Ryan White/ADAP	19	18%
Other (MHMRA)	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Medicare (39%), Medicaid (25%) and Gold Card (a financial program that provides assistance with medications and health care) (22%) were the most common methods of paying for medical care. Another 18% of White MSM respondents reported Ryan White/ ADAP and 8% reported the Veteran's Administration Hospital. Two (2%) White MSM respondents said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 8.9: LENGTH OF HIV DIAGNOSIS, WHITE MSM

Length of diagnosis Avg = 14 yrs	N	%
Less than 1 year	1	1%
1-4 years	13	13%
5-10 years	17	17%
11-15 years	28	27%
16-20 years	27	26%
21 and over	17	17%

** Percentages may not add up to 100% due to rounding or missing survey responses.

White MSM respondents reported being diagnosed as HIV positive an average of 14 years, ranging from 5 months to 22.5 years.

TABLE 8.10: LOCATION OF HIV DIAGNOSIS, WHITE MSM

Location of diagnosis	N	%
Private doctor	31	30%
ER	9	9%
In hospital stay	13	13%
HIV-specific testing site	11	11%
Public or community clinic	24	23%
Jail/Prison	6	6%
Community testing location	5	5%
Alcohol or drug treatment facility	1	1%
Blood/Plasma donation	2	2%
Work/insurance related	1	1%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately one third (30%) of White MSM respondents received their diagnoses at a public or community clinic, followed by 23% at a public or community clinic.

TABLE 8.11: REASONS FOR HIV TESTING, WHITE MSM

Reasons for testing	N	%
Recommended by provider	20	19%
Had sex with someone HIV+	14	14%
ER/Hospital stay	21	20%
Felt sick	31	30%
Engaged in risky behavior	33	32%
Was in prison/jail	3	3%
During pregnancy care	0	0%
Routine check up/testing	10	10%
Blood/plasma donation	1	1%
Work/insurance related	1	1%
Partner notification	0	0%
Knew someone with HIV	1	1%
Rape survivor	1	1%
Incentive offered	0	0%
In drug treatment program	0	0%
Recommended by friends	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were engaged in risky behavior (32%) and felt sick (30%). Other common reasons included during an ER or hospital stay (20%) or recommended by provider (19%).

TABLE 8.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, WHITE MSM

Assistance at diagnosis	N	%
Information about HIV/AIDS	48	47%
Medical services	38	37%
Counseling	26	25%
Help with food or shelter	6	6%
Alcohol or drug treatment services	3	3%
Supportive Services	0	0%
Other	0	0%
None	44	43%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to White MSM respondents were information about HIV/AIDS (47%), medical services (37%) and counseling (25%). A total of 44 (43%) of white MSM respondents reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 8.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, WHITE MSM

Time to first doctor visit	N	%
Less than 1 month	42	41%
1-6 months	24	23%
6-12 months	12	12%
More than 12 months	23	22%
Never	2	2%

Time to CD4/Viral Load	N	%
Less than 1 month	35	34%
1-6 months	28	27%
6-12 months	11	11%
More than 12 months	28	27%
Never	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Less than half (41%) of White MSM respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 23% of White MSM respondents, 1 to 6 months passed before seeing a doctor. Twelve (12%) waited between 6 to 12 months, and 22% waited more than a year to see a doctor for HIV. A total of 2 (2%) of all White MSM respondents said they still had not seen a doctor for HIV. Likewise, 34% reported receiving their first CD4/viral load test within one month of being diagnosed, 27% within 1-6 months, 11% between 6-12 months and 27% waited more than a year.

TABLE 8.14: REASONS FOR DELAYED ENTRY INTO CARE, WHITE MSM

Reasons for waiting more than 6 months	N	%
Afraid	14	14%
Didn't feel sick	18	17%
Jail/prison	2	2%
Doing drugs	8	8%
Denial	9	9%
Didn't want to take meds	12	12%
No money	8	8%
Depressed/emotional problems	12	12%
No stable place to live	8	8%
Other	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were didn't feel sick (17%), fear (14%), didn't want to take medications (12%) and depressed/ emotional problems (12%).

Maintenance in Care

TABLE 8.15: TIME SINCE LAST VISIT TO DOCTOR & VIRAL LOAD & CD4 & HIV MEDICATION PRESCRIPTION, WHITE MSM

Last visit to doctor for HIV	N	%
Less than 6 months	94	91%
6-12 months	5	5%
More than 12 months	4	4%
Never/Don't Know	0	0%
Last viral load	**N**	**%**
Less than 6 months	88	85%
6-12 months	9	9%
More than 12 months	5	5%
Never/Don't Know	1	1%

Last CD4	N	%
Less than 6 months	88	85%
6-12 months	7	7%
More than 12 months	7	7%
Never/Don't Know	1	1%
Last HIV meds prescription	**N**	**%**
Less than 6 months	67	65%
6-12 months	10	10%
More than 12 months	20	19%
Never/Don't Know	6	6%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of White MSM respondents said their most recent doctor's visit (91%), viral load (85%), CD4 test (85%) and HIV medication prescription (65%) were within the past 6 months.

TABLE 8.16: FREQUENCY OF DOCTOR'S VISITS, WHITE MSM

No doctor visits more than 6 months?	N	%
Yes	47	46%
No	56	54%
No doctor visits more than 12 months?	**N**	**%**
Yes	27	26%
No	73	71%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among White MSM respondents who have seen a doctor for HIV, 46% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 26% reported not seeing a doctor for 12 months or more.

TABLE 8.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, WHITE MSM

Reasons for no doctor visits	N	%
Case manager left	1	1%
Doctor left	3	3%
Agency closed down	1	1%
Doing drugs	10	10%
Program closed down	1	1%
Did not want to take meds	17	17%
Bad experience with provider	9	9%
Lost stable housing	10	10%
Lost my job	9	9%
Lost health insurance	6	6%
Tired of regimen	19	18%
Felt fine	15	15%
Worried about side effects	9	9%
Denial	7	7%
Jail/prison	2	2%
No transportation	0	0%
Depression/emotional barriers	1	1%
Had to care for children/family member	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for falling out of care for more than 6 months were tired of regimen (18%), did not want to take medications (17%) and felt fine (15%).

TABLE 8.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, WHITE MSM

First place of care	N	%	Most often location of care	N	%
Private Clinic/Doctor's Office	38	37%	Private Clinic/Doctor's Office	36	35%
Public clinic/community health center	48	47%	Public clinic/community health center	53	51%
Prison/jail	2	2%	Prison/jail	2	2%
VA Hospital	6	6%	VA Hospital	6	6%
ER/Hospital	9	9%	ER/Hospital	5	5%
I have not received care for HIV	0	0%	I have not received care for HIV	0	0%
Other	0	0%	Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was a public clinic or community health center (47%), followed by a private clinic/doctor's office (37%). Locations of ongoing care were most often a public clinic or community health center (51%) or a private clinic/doctor's office (35%). A total of 6 (6%) of all White MSM respondents received care most often from the Veteran's Administration Hospital.

TABLE 8.19: KNOWLEDGE OF CASE MANAGER, WHITE MSM

Case Manager	N	%
Yes	74	72%
No	14	14%
Don't Know	15	15%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (72%) of White MSM respondents reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services; 14% said they did not have such a person assisting them, and 15% didn't know.

Health Status

TABLE 8.20: SELF-REPORTED HEALTH STATUS, WHITE MSM

How would you describe your health overall	N	%
Excellent	9	9%
Good	53	51%
Fair	37	36%
Poor	4	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 9% said "Excellent," 51% said "Good," 36% said "Fair" and 4% said "Poor."

TABLE 8.21: SELF-REPORTED PHYSICAL HEALTH STATUS & ER OR HOSPITAL VISITS, WHITE MSM

During the past month, has your physical health interfered with normal activities?	N	%
No	33	32%
Yes – Some of the time	63	61%
Yes – all of the time	7	7%
ER visit in past 6 months	31	30%
Hospital stay in past 6 months	24	23%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (61%) of White MSM respondents reported that during the past month, their physical health had interfered with normal activities some of the time, and 7% said their physical health interfered all of the time.

For the 6 months prior to the survey, 30% of White MSM respondents reported an emergency room visit and 23% were admitted to a hospital for one or more nights.

TABLE 8.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, WHITE MSM

Symptoms during past month Avg = 5	N	%
Trouble with thinking, concentrating or memory	55	53%
Depressed or sad, trouble thinking	67	65%
Aches, fatigue, lightheadedness, weak all over	59	57%
Fevers, chills, sweats	35	34%
Poor appetite, weight loss	30	29%
Trouble with eyes or ears	32	31%
Trouble with nose or sinuses, headaches	40	39%
Trouble with mouth or swallowing	22	21%
Nausea, vomiting, diarrhea, abdominal pain	35	34%
Coughing, wheezing, or chest pain, trouble breathing	29	28%
Rash, itch, herpes, or other skin trouble	23	22%
Numbness, tingling or pain in an arm or leg	42	41%
Other	0	0%
None	11	11%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The maximum number of symptoms reported by White MSM respondents was 12, with an average of 5. The top three reported symptoms depressed or sad, trouble thinking (65%), aches, fatigue, lightheadedness, weak all over (57%) and trouble with thinking, concentrating or memory (53%).

TABLE 8.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, WHITE MSM

First CD4/T-cell	N	%	Current CD4/T-cell	N	%
Less than 50	19	18%	Less than 50	8	8%
50-99	6	6%	50-99	4	4%
100-199	3	3%	100-199	13	13%
200-349	31	30%	200-349	27	26%
350-499	14	14%	350-499	18	17%
500+	19	18%	500+	21	20%
Don't Know/Can't Remember	11	11%	Don't Know/Can't Remember	12	12%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of 19 (18%) of all White MSM respondents reported their first CD4/T-cell counts as 500+; 44% were 200 to 499, 9% were 50 to 199, and 18% were less than 50. Current CD4/T-cell counts were 500+ for 20% of all White MSM respondents; 200 to 499 for 43%, 50 to 199 for 17%, and less than 50 for 8% of White MSM respondents. Eleven (11%) didn't know or couldn't remember their first CD4/T-cell count, and 12% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 8.24: HIV MEDICATIONS, WHITE MSM

Currently taking HIV meds	N	%
Yes	74	72%
No	27	26%
How many pills do you take in one day?	Avg = 5	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (72%) said they were currently taking HIV medications. The maximum number of pills per day was 25, with an average of 5 pills per day.

TABLE 8.25: SELF-REPORTED MEDICATION ADHERENCE, WHITE MSM

Medication adherence (among respondents taking HIV medications)	N	%
I have not missed any doses in the past month	39	53%
Missed a few, but took nearly all	30	41%
Took more than half	3	4%
About half	2	3%
Some, but not half	2	3%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	66	64%
No	30	29%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among White MSM respondents currently taking HIV medications, 38% reported perfect adherence and 29% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 64% said "Yes" and 29% said "No."

TABLE 8.26: REASONS FOR NOT TAKING HIV MEDICATIONS, WHITE MSM

Reasons for not taking HIV medications	N	%
Side effects	13	13%
Not effective	2	2%
Too difficult to take as prescribed	3	3%
No doctor has offered them	0	0%
I choose not to take them	8	8%
Doctor did not think it was a good idea for me	3	3%
T-cell too high	13	13%
Cannot pay	2	2%
Confidentiality concerns	0	0%
Didn't feel sick	1	1%
Have not seen doctor	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for not taking HIV medications were "T-cells too high" (13%) and "too many side effects" (13%).

TABLE 8.27: MEDICATIONS FOR NON-HIV CONDITIONS, WHITE MSM

How many pills do you take in one day for non-HIV conditions? Range = 0 to 26; Avg = 5	N	%
Diabetes	10	10%
High blood pressure	27	26%
High cholesterol	23	22%
Depression/emotional problems	56	54%
Eye drops/glaucoma	0	0%
Acid reflux	6	6%
Anemia	0	0%
Sleep	3	3%
Allergies/Sinus	2	2%
Pain	3	3%
Antibiotics	2	2%
Arthritis	1	1%
Asthma	0	0%
Neuropathy	2	2%
Nausea	0	0%
Hormones	0	0%
Other	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

For non-HIV related conditions, the maximum number of pills per day reported by White MSM respondents was 26, with an average of 5 non-HIV pills per day. The most common conditions linked with the non-HIV pills were depression/emotional problems (54%), high blood pressure (26%) and high cholesterol (22%).

TABLE 8.28: TOTAL PILL BURDEN AND ABILITY TO PAY, WHITE MSM

Total Pills (HIV + non-HIV)		Avg = 9
How often do you have trouble paying for these or other non-HIV meds?	**N**	**%**
Never	58	56%
Less than half the time	15	15%
More than half the time	11	11%
Always	18	17%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was nine.

More than half (56%) of White MSM respondents reported never having problems

paying for HIV or non-HIV medications, and 15% had problems less than half the time. Eleven (11%) had problems more than half the time, and 17% said they always had problems paying for their medications.

Comorbidities

TABLE 8.29: HEPATITIS C AND TB STATUS, WHITE MSM

Hep C Test?	N	%
Yes	82	80%
No	11	11%
Don't Know	10	10%
Positive for Hep C?	**N**	**%**
Yes	21	20%
No	73	71%
Don't know	9	9%

TB skin test?	N	%
Yes	96	93%
No	7	7%
Result	**N**	**%**
Positive	6	6%
Negative	90	87%
Don't Know	0	0%
History of active TB?	**N**	**%**
Yes	6	6%
No	97	94%
Don't Know	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (80%) of all White MSM respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 20% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

Likewise, the majority (93%) of respondents had received a skin test for TB, and 6% reported a positive result. A total of 6 (6%) reported a history of active TB.

Mental Health

TABLE 8.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, WHITE MSM

	N	%
At least one mental health condition	74	72%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	55	53%
Hallucinations	10	10%
Serious thoughts of suicide	17	17%
Attempted suicide	1	1%
Wanted to hurt or harm yourself	7	7%
Wanted to hurt or harm someone else	12	12%
Trouble controlling anger leading to physical violence	16	16%
Problems requiring meds	44	43%
None	29	28%
At least one serious indicator (suicide/homicidal or requiring meds)	41	40%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A majority (72%) of White MSM respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced symptoms were serious anxiety/tension (53%) and problems requiring medications (43%).

TABLE 8.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, WHITE MSM

Since being diagnosed, ever talked with therapist?	**N**	**%**
Yes	82	80%
No	21	20%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	81	79%
No	22	21%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	53	51%
No	49	48%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 80% of White MSM respondents said they had

talked with a therapist or psychologist for help with depression or emotional problems, 79% had talked to a doctor or psychiatrist for medications and 51% said they had participated in a support group since being diagnosed with HIV.

Substance Use & Abuse

TABLE 8.32: SUBSTANCE USE, WHITE MSM

Total Number of substances Range = 1 to 7; Avg = 2	**N**	**%**
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	17	17%
Street Methadone (non-treatment)	4	4%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	9	9%
Barbituates (seconal, tuinal, downers)	5	5%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	15	15%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	1	1%
Amphetamines (speed, uppers, crystal meth, ice, glass)	17	17%
Marijuana, Hashish (grass, weed)	28	27%
Heroin	0	0%
Cocaine (powder), Crack	25	24%
Ecstasy, X, MDA, GHB	3	3%
Ketamine (K, Special K)	2	2%
None	51	50%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, 50% of White MSM respondents reported using at least one substance during the past year. The average number of substances was 2, with a maximum of 7 reported. The most commonly used substances among White MSM respondents were marijuana (27%) and cocaine (24%).

TABLE 8.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, WHITE MSM

In the last year, ever drunk more than meant to?	N	%
Yes	48	47%
No	55	53%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	32	31%
No	71	69%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	23	22%
No	80	78%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	29	28%
No	73	71%
Indicator of Alcohol Abuse	49	48%
Indicator of Substance Abuse	30	29%
Abuse of both drugs and alcohol	17	17%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 48% of white MSM respondents indicated possible alcohol abuse, and 29% indicated possible substance abuse. A total of 17 (17%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 8.34: SOCIAL SUPPORT, WHITE MSM

Of all the people you feel close to, how many have you told about being HIV+?	N	%
All	44	43%
Some	54	52%
None	4	4%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	82	80%
No	21	20%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 43% had disclosed their HIV status to all and

52% had disclosed their status to some. A total of 4 (4%) had not told their HIV status to any of the people to whom they feel close. Overall, 80% of White MSM respondents said there were people they could depend on for help if really needed; however, 20% said they had no one to depend on.

Housing

TABLE 8.35: HOUSING STATUS, WHITE MSM

Where do you most often sleep?	N	%
Apartment/House	91	88%
Group home/halfway house	6	6%
Shelter	3	3%
Street	3	3%
Other	0	0%
Do you feel your housing situation is stable?	**N**	**%**
Yes	73	71%
No	30	29%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of White MSM respondents (88%) reported sleeping most often in an apartment/house. Others reported group home/halfway house (6%), shelter (3%) or street (3%). Most (71%) felt their housing situation was stable, and 29% felt their housing situation was unstable.

TABLE 8.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, WHITE MSM

In the past year, has your housing situation made it difficult to get HIV care	N	%
Yes	19	18%
No	84	82%
Reasons	**N**	**%**
I could not keep my status private	1	1%
No place to store meds	5	5%
Money for food	15	15%
Money for rent	14	14%
Money for utilities	12	12%
Money for household supplies	11	11%
No stable address	0	0%
Used money on drugs	0	0%
Rules	0	0%
Lack of transportation	0	0%
No child care	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of 19 (18%) respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The most common reasons for these difficulties were needing to use money for food (15%), rent (14%), or utilities (12%).

ACCESS TO CORE SERVICES

TABLE 8.37: ACCESS TO CORE SERVICES, WHITE MSM

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	30	29%	68	66%	5	5%
HIV/AIDS Medications	28	27%	60	58%	15	15%
Dentist Visits	36	35%	47	46%	20	19%
Medical Case Management	21	20%	59	57%	23	22%
Home Health Care	6	6%	8	8%	89	86%
Psychiatric Services or Medicine	17	17%	52	50%	34	33%
Psychological Counseling	19	18%	53	51%	13	13%
Substance Abuse Treatment	10	10%	13	13%	80	78%
Rehabilitation Services	12	12%	8	8%	83	81%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For White MSM respondents, the top three “easy to get” core services were primary medical care (66%), HIV/AIDS medications (58%) and medical case management (57%). The top three core services that respondents reported “some difficulty getting” were dentist visits (35%), primary medical care (29%) and HIV/AIDS medications (27%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that White MSM respondents said they “did not need” in the past year were home health care (86%), rehabilitation services (81%) and substance abuse treatment (78%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 8.38: ACCESS TO SUPPORTIVE SERVICES, WHITE MSM

Service Category	In the past 12 months…				
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service
Child Care Services	0	0%	0	0%	0
Child Welfare Services	0	0%	0	0%	0
Day/Respite Care for Adults	0	0%	1	1%	3
Developmental	0	0%	1	1%	0
Emergency Financial Assistance	36	35%	9	9%	8
Employment Assistance	16	16%	3	3%	3
Food Bank	20	19%	33	32%	5
HIV Education for HIV+ Individuals	5	5%	9	9%	1
Rental Assistance/Shelter Vouchers	24	23%	7	7%	4
Housing-Related Services	14	14%	3	3%	4
Legal Services	9	9%	9	9%	6
Nutritional Counseling	6	6%	16	16%	2
Permanency Planning	4	4%	3	3%	1
Referrals to Services	16	16%	15	15%	3
Referrals to Clinical Research	6	6%	4	4%	2
Support Groups	16	16%	16	16%	3
Translation/Interpretation	5	5%	0	0%	1
Transportation	27	26%	16	16%	3
Household Items	2	2%	2	2%	0

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

The five supportive services that were selected most often (thus implying high helpfulness/usefulness) were food bank, emergency financial assistance, transportation, rental assistance and support groups. The top five “easy to get” supportive services (based on number of responses) were food bank, nutritional counseling, support groups, transportation and referrals to services. The top supportive services that respondents

reported "some difficulty getting" were emergency financial assistance, transportation, rental assistance/shelter vouchers and food bank. The presence of certain support services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates. Conversely, the top supportive services that respondents did not need in the past year, but still identified as useful/helpful were emergency financial assistance, legal services and food bank.

Barriers Reported per Core Service Category

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among White MSM respondents, the three core services with the highest number of barriers were dentist visits, primary medical care and HIV/AIDS medications. For both dentist visits and primary medical care, the most commonly reported barriers were "It's hard to make or keep appointments" and "I would have to wait too long to get the services." Those were also the barriers reported most often across all other core services.

TABLE 8.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, WHITE MSM

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Primary Medical Care	2	2	**11**	4	3	0	**8**	**11**	8	1	1	0	0	2	0	0	1	0	0	0	0	0	**54**
HIV/AIDS Medications	2	2	**9**	**7**	2	1	**6**	5	3	2	0	1	0	2	0	0	1	0	0	0	0	0	**43**
Dentist Visits	5	5	**17**	1	2	0	**8**	**14**	7	0	0	0	1	1	0	0	0	0	0	0	0	0	**61**
Medical Case Management	1	**4**	3	3	2	0	3	**6**	2	0	1	0	0	0	0	0	0	0	0	0	0	0	**25**
Home Health Care	2	2	1	1	**4**	0	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	**16**
Psychiatric Services or Medicine	1	4	4	**6**	3	0	**5**	**5**	3	0	0	0	0	0	0	0	0	0	0	0	0	0	**31**
Psychological Counseling	1	3	**4**	**6**	3	1	2	**7**	**4**	0	0	0	0	0	0	0	0	0	0	0	0	0	**31**
Substance Abuse Treatment	1	2	**3**	1	1	2	**3**	2	**3**	1	1	0	1	0	0	0	0	1	0	0	0	0	**22**
Rehabilitation Services	1	2	1	0	**3**	1	2	2	**5**	0	1	0	0	0	0	0	0	0	0	0	0	0	**18**
Total	**16**	**26**	**53**	**29**	**23**	**5**	**39**	**54**	**37**	**4**	**4**	**1**	**2**	**5**	**0**	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**301**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Barriers Reported per Supportive Service Category

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among White MSM respondents, the five supportive services with the highest number of barriers were emergency financial assistance, transportation, rental assistance/ shelter vouchers, food bank and housing related services. Within emergency financial assistance, the most commonly reported barriers were "I would have to wait too long to get the services," "I don't know where to get the services," and "I was told I am not eligible for this service."

The barriers experienced most often by all White MSM respondents across all supportive services were "I don't know where to get the services" and "I would have to wait too long to get the services."

TABLE 8.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, WHITE MSM

Service Category	Barriers																				
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Q	R	S	T	U	V	Total
Child Care Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Child Welfare Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Day/Respite Care for Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Developmental Assessment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Emergency Financial Assistance	4	**11**	**13**	0	**10**	7	5	3	4	0	1	0	1	2	1	0	0	0	2	0	**64**
Employment Assistance	2	**10**	0	0	1	0	0	2	2	0	2	0	**3**	0	0	0	0	0	1	0	**23**
Food Bank	4	**5**	3	1	3	**5**	1	0	**9**	0	1	0	0	0	0	0	0	0	2	0	**34**
HIV Education for HIV+ Individuals	**2**	**3**	1	1	1	1	0	1	1	0	1	1	0	0	0	0	0	0	0	0	**13**
Rental Assistance/Shelter Vouchers	1	**9**	**7**	0	4	3	**5**	3	2	0	0	0	0	1	0	0	1	0	2	0	**38**
Housing-Related Services	**4**	**7**	**7**	1	**4**	1	3	0	3	0	0	0	2	1	0	0	0	0	0	0	**33**
Legal Services	1	**2**	**2**	0	1	0	1	**3**	0	0	1	1	0	0	0	0	0	0	0	0	**12**
Nutritional Counseling	0	**4**	1	0	1	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**9**
Permanency Planning	0	3	1	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**7**
Referrals to Services	3	**6**	**5**	3	2	0	**5**	3	2	0	0	0	0	0	0	0	0	1	0	0	**30**
Referrals to Clinical Research	1	**3**	1	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**7**
Support Groups	3	**10**	0	1	0	1	1	0	2	0	1	0	1	0	0	0	0	0	0	0	**20**
Translation/Interpretation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Transportation	**7**	**11**	**8**	1	5	3	5	4	1	0	1	0	0	0	0	0	0	0	2	1	**49**
Household Items	0	**6**	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**7**
Total	**32**	**90**	**49**	**10**	**33**	**22**	**27**	**23**	**26**	**0**	**8**	**2**	**7**	**4**	**1**	**0**	**1**	**1**	**9**	**1**	**346**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions					
A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 8.41: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA MSM (WHITE) (N=102)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of White MSM Reporting Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	6	63	0	6%	56	7%
Anonymous Sex Partner(s)	29	39	N/A	28%	141	18%
Greater than 5 Sex Partners	17	84	N/A	17%	60	8%

Of White men who have sex with men (MSM) surveyed, 6 (6%) reported that they had engaged in sex for drugs or money in the past 6 months, while 53 (7%) of all respondents reported this risk factor.

Twenty-nine (28%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 137 (18%) of all respondents. Seventeen (17%) of White MSM surveyed reported that they had more than 5 sex partners in the past 6 months, while 61 (8%) of all respondents reported that they had more than 5 sex partners.

TABLE 8.42: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA MSM (WHITE) (N=102)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of White MSM Reporting Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	31	38	N/A	30%	235	31%
Shared Injecting Equipment	4	11	N/A	4%	12	2%
Serodiscordant Sex Partner(s)	10	56	3	10%	111	15%

Of White MSM surveyed, 31 (30%) reported that they had unprotected sex at least some of the time, while 236 (31%) of the entire sample reported this risk factor.

Fifteen (15%) people reported that they had injected a substance, while 4 (26%) reported that they had shared injecting equipment at least some of the time. This accounts for 4% of White MSM surveyed, and 2% or the total sample. Ten (10%) White MSM reported that they had an HIV-negative sex partner, while 114 (15%) of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

MSM of Color

(Black/African-American, Latino, Asian, Native American, Multiracial)

Overview

There were 208 total MSM of color respondents to the 2008 Need Assessment consumer survey. This total represents 27% of the total 764 survey respondents.

MSM of color were defined as any non-white (Black/African-American, Latino/ Hispanic, Asian, Native American or Multi-racial) men who identified themselves as gay or bisexual, or reported having sex with men (regardless of their self-identified sexual orientation).

Demographics

Table 9.1: Age, MSM of color

Age Avg = 42	N	%
18-24	7	3%
25-44	114	55%
45+	87	42%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average age of MSM of color respondents was 42, ranging from 18 to 73 years old. Almost all (97%) MSM of color respondents were above the age of 25; 55% were between the ages of 25-44, and another 42% were above the age of 45. Only 3% were youth between the ages of 18 and 24.

Table 9.2: Race/ethnicity and sexual orientation, MSM of color

Race/Ethnicity	N	%
Black/African-American	122	59%
Latino/Hispanic	74	36%
Asian	5	2%
Native American	3	1%
Multiracial	4	2%

Sexual Orientation	N	%
Straight/Heterosexual	17	8%
Gay	136	65%
Bisexual	38	18%
Undecided	6	3%
Prefer not to say	11	5%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of MSM of color identified as Black/African-American (59%), 36% as Latino/Hispanic, and 5% as Asian, Native American or multi-racial.

Most MSM of color respondents identified as gay (65%) and 18% identified as

bisexual. Seventeen (8%) identified as straight/heterosexual, but also reported having sex with other men. Another seventeen (8%) men said they either were undecided or preferred not to disclose their sexual orientation, but reported having sex with other men.

TABLE 9.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, MSM OF COLOR

Education	N	%
Less than high school	30	14%
High school degree/GED	125	60%
College degree	30	14%
Graduate/Professional degree	6	3%
Some technical training	17	8%
None	0	0%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	30	14%
Are you eligible for veteran benefits?	**N**	**%**
Yes	12	6%
No	177	85%
Don't Know	19	9%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (74%) of MSM of color respondents had a high school degree/GED or less; 14% had a college degree, 3% had a graduate/professional degree and 8% had some technical training.

A total of 30 (14%) of all MSM of color survey respondents reported being released from jail or prison during the previous year.

PLWHA eligible for veteran benefits represented 6% of all MSM of color respondents.

Immigration Status & Primary Language

TABLE 9.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, MSM OF COLOR

	N	%
Born outside US	45	22%
Length of residency	Avg = 18 yrs	
Immigration status	**N**	**%**
Citizen	175	84%
Permanent Resident	6	3%
Visa	4	2%
Undocumented	23	11%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Foreign born MSM of color represented 22% of all MSM of color respondents. Lengths of residency in the US ranged from 2 to 40 years with an average residency of 18 years.

Among all MSM of color respondents, 84% were US citizens, 3% were permanent residents, 2% visa holder and 11% were undocumented.

TABLE 9.5: PREFERRED LANGUAGE, MSM OF COLOR

Preferred language at home with family/friends	N	%
English	161	77%
Spanish	31	15%
English/Spanish	15	7%
Other	1	0%
Preferred language when seeing a doctor	**N**	**%**
English	174	84%
Spanish	28	13%
English/Spanish	6	3%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by MSM of color consumer survey respondents. Most (77%) said they were most comfortable speaking English at home with family/friends, and 84% said they were most comfortable speaking English with their doctor. When seeing a doctor, 13% were most comfortable speaking Spanish and 3% preferred a combination of English and Spanish.

Job Status & Income

TABLE 9.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, MSM OF COLOR

Job status	N	%
Full time	32	15%
Part time	25	12%
Temporary/contract/odd jobs	12	6%
Not working due to disability	68	33%
Unemployed	65	31%
Retired	4	2%
Average monthly income during past 6 months	Avg = $731.40	
Approximate yearly income	Avg = $8,776.85	
Up to 300% FPL (2007 – 2008)	201	97%
Up to 200% FPL (2007 - 2008)	196	94%
Up to 100% FPL (2007 - 2008)	153	74%
Total income dependents	Avg = 1	
Income dependents under 18	Avg = .4	

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (66%) of all MSM of color respondents were unemployed at the time of the survey; 31% were unemployed, 33% were not working due to disability, and 2% were retired. Thirty-two (15%) were working full-time, 12% part-time and 6% had temporary/ contract/odd jobs.

The maximum monthly income was $7,000 with an average of $731.40. The maximum yearly income was calculated as $84,000, for an average of $8,776.85. The number of dependents per income ranged from 1 to 9, with an average of less than 1 (.4) being under the age of 18. Based on estimated yearly incomes and household sizes, 74% of all MSM of color respondents fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 9.7: SOURCES OF INCOME ASSISTANCE, MSM OF COLOR

Sources of income assistance	N	%
None	62	30%
Hourly wages/Salary	24	12%
SSI	41	20%
SSDI	44	21%
Social Security	19	9%
TANF/AFDC	1	0%
Food Stamps	37	18%
Rental Subsidy/Section 8	16	8%
Workers Comp	0	0%
Unemployment	4	2%
Private Disability	1	0%
VA Benefits	1	0%
Child support	0	0%
Family/friends	3	1%
Pension/Retirement/Savings	1	0%
Other	2	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among MSM of color survey respondents were Social Security Disability Insurance (SSDI) (21%), Supplemental Security Income (SSI) (20%) and hourly wages/salary (12%). No survey respondents received worker's compensation.

A third (30%) of all MSM of color respondents reported no source of income.

Paying for Medical Care

TABLE 9.8: SOURCES OF PAYMENT FOR MEDICAL CARE, MSM OF COLOR

Paying for medical care	N	%
I don't receive medical care because I can't pay for it	9	4%
Private insurance/COBRA	10	5%
VA	5	2%
Medicaid	52	25%
Medicare	49	24%
Self-Pay	10	5%
Gold Card/County	73	35%
Ryan White/ADAP	25	12%
Other (MHMRA)	3	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Gold Card (a financial program that provides assistance with health care and medications) (35%), Medicaid (25%) and Medicare (24%) were the most common methods of paying for medical care. Another 12% of MSM of color respondents reported Ryan White/ADAP and 2% reported the Veteran's Administration Hospital. Nine (4%) of MSM of color respondents said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 9.9: LENGTH OF HIV DIAGNOSIS, MSM OF COLOR

Length of diagnosis Avg = 11	N	%
Less than 1 year	4	2%
1-4 years	52	25%
5-10 years	49	24%
11-15 years	50	24%
16-20 years	35	17%
21 and over	18	9%

** Percentages may not add up to 100% due to rounding or missing survey responses.

MSM of color respondents reported being diagnosed as HIV positive an average of 11 years, ranging from 8 months to 22.5 years.

TABLE 9.10: LOCATION OF HIV DIAGNOSIS, MSM OF COLOR

Location of diagnosis	N	%
Private doctor	32	15%
ER	20	10%
In hospital stay	27	13%
HIV-specific testing site	24	12%
Public or community clinic	59	28%
Jail/Prison	23	11%
Community testing location	13	6%
Alcohol or drug treatment facility	5	2%
Blood/Plasma donation	1	0%
Work/insurance related	3	1%
Other	1	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than a quarter (28%) of MSM of color respondents received their diagnoses at a public or community clinic. Other common diagnosis locations for overall respondents were at a private doctor's office (15%) or during hospitalization (13%).

TABLE 9.11: REASONS FOR HIV TESTING, MSM OF COLOR

Reasons for testing	N	%
Recommended by provider	25	12%
Had sex with someone HIV+	41	20%
ER/Hospital stay	37	18%
Felt sick	60	29%
Engaged in risky behavior	51	25%
Was in prison/jail	20	10%
During pregnancy care	1	0%
Routine check up/testing	14	7%
Blood/plasma donation	5	2%
Work/insurance related	4	2%
Partner notification	0	0%
Knew someone with HIV	2	1%
Rape survivor	0	0%
Incentive offered	0	0%
In drug treatment program	1	0%
Recommended by friends	0	0%
Other	3	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were feeling sick (29%) and engaged in risky behavior (25%). Other common reasons included had sex with someone with HIV (20%) or during an ER or hospital stay (18%).

TABLE 9.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, MSM OF COLOR

Assistance at diagnosis	N	%
Information about HIV/AIDS	101	49%
Medical services	106	51%
Counseling	75	36%
Help with food or shelter	26	13%
Alcohol or drug treatment services	11	5%
Supportive Services	1	0%
Other	0	0%
None	49	24%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to MSM of color respondents were related to medical services (51%), followed by information about HIV/AIDS (49%) and counseling (36%). A total of 49 (24%) of all MSM of color respondents reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 9.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, MSM OF COLOR

Time to first doctor visit	N	%
Less than 1 month	105	50%
1-6 months	43	21%
6-12 months	17	8%
More than 12 months	37	18%
Never	5	2%

Time to CD4/Viral Load	N	%
Less than 1 month	80	38%
1-6 months	61	29%
6-12 months	22	11%
More than 12 months	43	21%
Never	2	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Half (50%) of all MSM of color respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 21% of MSM of color respondents, 1 to 6 months passed before seeing a doctor. Seventeen (8%) waited between 6 to 12 months, and 18% waited more than a year to see a doctor for HIV. A total of 5 (2%) of all MSM of color respondents said they still had not seen a doctor for HIV. Likewise, 38% reported receiving their first CD4/viral load test within one month of being diagnosed, 29% within 1-6 months, 11% between 6-12 months and 21% waited more than a year. Two (1%) said they

had never received a CD4 or viral load test.

TABLE 9.14: REASONS FOR DELAYED ENTRY INTO CARE, MSM OF COLOR

Reasons for waiting more than 6 months	N	%
Afraid	35	17%
Didn't feel sick	27	13%
Jail/prison	9	4%
Doing drugs	14	7%
Denial	27	13%
Didn't want to take meds	14	7%
No money	14	7%
Depressed/emotional problems	30	14%
No stable place to live	11	5%
Other	4	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were feeling afraid (17%), depressed/emotional problems (14%), denial (13%) and didn't feel sick (13%).

Maintenance in Care

TABLE 9.15: TIME SINCE LAST VISIT TO DOCTOR & VIRAL LOAD & CD4 & HIV MEDICATION PRESCRIPTION, MSM OF COLOR

Last visit to doctor for HIV	N	%
Less than 6 months	180	87%
6-12 months	11	5%
More than 12 months	15	7%
Never/Don't Know	1	0%
Last viral load	**N**	**%**
Less than 6 months	183	88%
6-12 months	10	5%
More than 12 months	13	6%
Never/Don't Know	2	1%

Last CD4	N	%
Less than 6 months	183	88%
6-12 months	10	5%
More than 12 months	13	6%
Never/Don't Know	2	1%
Last HIV meds prescription	**N**	**%**
Less than 6 months	143	69%
6-12 months	11	5%
More than 12 months	18	9%
Never/Don't Know	35	17%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of MSM of color respondents said their most recent doctor's visit (87%), viral load (88%), CD4 test (88%) and HIV medication prescription (69%) were within the past 6 months.

TABLE 9.16: FREQUENCY OF DOCTOR'S VISITS, MSM OF COLOR

No doctor visits more than 6 months?	N	%
Yes	83	40%
No	125	60%
No doctor visits more than 12 months?	**N**	**%**
Yes	50	24%
No	152	73%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among MSM of color respondents who have seen a doctor for HIV, 40% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 24% reported not seeing a doctor for 12 months or more.

TABLE 9.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, MSM OF COLOR

Reasons for no doctor visits	N	%
Case manager left	2	1%
Doctor left	5	2%
Agency closed down	1	0%
Doing drugs	27	13%
Program closed down	0	0%
Did not want to take meds	24	12%
Bad experience with provider	6	3%
Lost stable housing	19	9%
Lost my job	8	4%
Lost health insurance	9	4%
Tired of regimen	12	6%
Felt fine	17	8%
Worried about side effects	20	10%
Denial	17	8%
Jail/prison	3	1%
No transportation	1	0%
Depression/emotional barriers	0	0%
Had to care for children/family member	0	0%
Other	3	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for falling out of care for more than 6 months were doing drugs (13%), did not want to take meds (12%), and concerns about side effects (10%).

TABLE 9.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, MSM OF COLOR

First place of care	N	%
Private Clinic/Doctor's Office	38	18%
Public clinic/community health center	127	61%
Prison/jail	19	9%
VA Hospital	5	2%
ER/Hospital	19	9%
I have not received care for HIV	0	0%
Other	0	0%

Most often location of care	N	%
Private Clinic/Doctor's Office	45	22%
Public clinic/community health center	146	70%
Prison/jail	3	1%
VA Hospital	7	3%
ER/Hospital	2	1%
I have not received care for HIV	5	2%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was a public clinic or community health center (61%), followed by a private clinic/doctor's office (18%). Locations of ongoing care were most often a public clinic or community health center (70%) or a private clinic/doctor's office (18%). A total of 7 (3%) of all MSM of color respondents received care most often from the Veteran's Administration Hospital.

TABLE 9.19: KNOWLEDGE OF CASE MANAGER, MSM OF COLOR

Case Manager	N	%
Yes	153	74%
No	29	14%
Don't Know	24	12%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (74%) of MSM of color respondents reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services; 14% said they did not have such a person assisting them, and 12% didn't know.

Health Status

TABLE 9.20: SELF-REPORTED HEALTH STATUS, MSM OF COLOR

How would you describe your health overall	N	%
Excellent	36	17%
Good	98	47%
Fair	60	29%
Poor	14	7%
During the past month, has your physical health interfered with normal activities?	**N**	**%**
No	92	44%
Yes – Some of the time	102	49%
Yes – all of the time	10	5%
ER visit in past 6 months	47	23%
Hospital stay in past 6 months	26	13%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 17% said “Excellent,” 47% said “Good,” 29% said “Fair” and 7% said “Poor.”

Approximately half (49%) of MSM of color respondents reported that during the past month, their physical health had interfered with normal activities some of the time, and 5% said their physical health interfered all of the time.

For the 6 months prior to the survey, 23% of MSM of color respondents reported an emergency room visit and 13% were admitted to a hospital for one or more nights.

TABLE 9.21: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, MSM OF COLOR

Symptoms during past month Avg = 4	N	%
Trouble with thinking, concentrating or memory	82	39%
Depressed or sad, trouble thinking	123	59%
Aches, fatigue, lightheadedness, weak all over	83	40%
Fevers, chills, sweats	43	21%
Poor appetite, weight loss	61	29%
Trouble with eyes or ears	55	26%
Trouble with nose or sinuses, headaches	53	25%
Trouble with mouth or swallowing	23	11%
Nausea, vomiting, diarrhea, abdominal pain	52	25%
Coughing, wheezing, or chest pain, trouble breathing	42	20%
Rash, itch, herpes, or other skin trouble	55	26%
Numbness, tingling or pain in an arm or leg	76	37%
Other	2	1%
None	29	14%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The maximum number of symptoms reported by MSM of color respondents was 12, with an average of 4. The top three reported symptoms were depressed or sad, trouble thinking (59%), aches, fatigue, lightheadedness, weak all over (40%) and trouble with thinking, concentrating or memory (39%).

TABLE 9.22: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, MSM OF COLOR

First CD4/T-cell	N	%
Less than 50	25	12%
50-99	11	5%
100-199	18	9%
200-349	31	15%
350-499	38	18%
500+	39	19%
Don't Know/Can't Remember	46	22%

Current CD4/T-cell	N	%
Less than 50	13	6%
50-99	7	3%
100-199	18	9%
200-349	36	17%
350-499	47	23%
500+	44	21%
Don't Know/Can't Remember	43	21%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of 39 (19%) of all MSM of color respondents reported their first CD4/T-cell counts as 500+; 33% were 200 to 499, 14% were 50 to 199, and 12% were less than 50. Current CD4/T-cell counts were 500+ for 21% of all MSM of color respondents; 200 to 499 for 40%, 50 to 199 for 12%, and less than 50 for 6% of MSM of color respondents. Forty six (22%) didn't know or couldn't remember

their first CD4/T-cell count, and 21% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 9.23: HIV MEDICATIONS, MSM OF COLOR

Currently taking HIV meds	N	%
Yes	159	76%
No	49	24%
How many pills do you take in one day?	Avg = 5	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (76%) said they were currently taking HIV medications. The maximum number of pills per day was 25, with an average of 5 pills per day.

TABLE 9.24: SELF-REPORTED MEDICATION ADHERENCE, MSM OF COLOR

Medication adherence	N	%
I have not missed any doses in the past month	84	40%
Missed a few, but took nearly all	62	30%
Took more than half	6	3%
About half	1	0%
Some, but not half	9	4%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	144	69%
No	49	24%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among MSM of color respondents currently taking HIV medications, 40% reported perfect adherence and 30% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 69% said "Yes" and 24% said "No."

TABLE 9.25: REASONS FOR NOT TAKING HIV MEDICATIONS, MSM OF COLOR

Reasons for not taking HIV medications	N	%
Side effects	2	1%
Not effective	1	0%
Too difficult to take as prescribed	2	1%
No doctor has offered them	5	2%
I choose not to take them	8	4%
Doctor did not think it was a good idea for me	12	6%
T-cell too high	21	10%
Cannot pay	2	1%
Confidentiality concerns	3	1%
Didn't feel sick	1	0%
Have not seen doctor	2	1%
Other	4	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "T-cells too high" (10%) followed by "doctor did not think it was a good idea for me" (6%), and "I choose not to take them" (4%).

TABLE 9.26: MEDICATIONS FOR NON-HIV CONDITIONS, MSM OF COLOR

How many pills do you take in one day for non-HIV conditions? Range = 0 to 45; Avg = 4	N	%
Diabetes	15	7%
High blood pressure	56	27%
High cholesterol	29	14%
Depression/emotional problems	80	38%
Eye drops/glaucoma	1	0%
Acid reflux	5	2%
Anemia	0	0%
Sleep	6	3%
Allergies/Sinus	4	2%
Pain	6	3%
Antibiotics	3	1%
Arthritis	3	1%
Asthma	0	0%
Neuropathy	5	2%
Nausea	0	0%
Hormones	0	0%
Other	6	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

For non-HIV related conditions, the maximum number of pills per day reported by MSM of color respondents was 45, with an average of 4 non-HIV pills per day. The most common conditions associated with the non-HIV pills were depression/emotional problems (38%), high blood pressure (27%) and high cholesterol (14%).

TABLE 9.27: TOTAL PILL BURDEN AND ABILITY TO PAY, MSM OF COLOR

Total Pills (HIV + non-HIV)	Avg = 8	
How often do you have trouble paying for these or other non-HIV meds?	**N**	**%**
Never	111	53%
Less than half the time	30	14%
More than half the time	18	9%
Always	32	15%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was 8.

More than half (53%) of all MSM of color respondents reported never having problems paying for HIV or non-HIV medications, and 14% had problems less than half the time. Eighteen (9%) had problems more than half the time, and 15% said they always had problems paying for their medications.

Comorbidities

TABLE 9.28: HEPATITIS C AND TB STATUS, MSM OF COLOR

Hep C Test?	**N**	**%**
Yes	166	80%
No	30	14%
Don't Know	12	6%
Positive for Hep C?	**N**	**%**
Yes	43	21%
No	144	69%
Don't know	19	9%

TB skin test?	**N**	**%**
Yes	185	89%
No	23	11%
Result	**N**	**%**
Positive	45	22%
Negative	124	60%
Don't Know	8	4%
History of active TB?	**N**	**%**
Yes	38	18%
No	165	79%
Don't Know	4	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (80%) of all MSM of color respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 21% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test

is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

Likewise, the majority (89%) respondents had received a skin test for TB, and 22% reported a positive result. A total of 38 (18%) reported a history of active TB.

Mental Health

TABLE 9.29: SELF-REPORTED MENTAL HEALTH SYMPTOMS, MSM OF COLOR

	N	%
At least one mental health condition	104	50%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	80	38%
Hallucinations	23	11%
Serious thoughts of suicide	13	6%
Attempted suicide	7	3%
Wanted to hurt or harm yourself	15	7%
Wanted to hurt or harm someone else	19	9%
Trouble controlling anger leading to physical violence	17	8%
Problems requiring meds	49	24%
None	104	50%
At least one serious indicator (suicide/homicidal or requiring meds)	51	25%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Half (50%) of all MSM of color respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced symptoms were serious anxiety/tension (38%) and problems requiring medications (24%).

TABLE 9.30: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, MSM OF COLOR

Since being diagnosed, ever talked with therapist?	**N**	**%**
Yes	140	67%
No	67	32%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	137	66%
No	70	34%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	126	61%
No	79	38%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 67% of MSM of color respondents said they had talked with a therapist or psychologist for help with depression or emotional problems and 66% had talked to a doctor or psychiatrist for medications and 61% said they had participated in a support group since being diagnosed with HIV.

Substance Use & Abuse

TABLE 9.31: SUBSTANCE USE, MSM OF COLOR

Total Number of substances Avg = 2	**N**	**%**
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	10	5%
Street Methadone (non-treatment)	1	0%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	5	2%
Barbituates (seconal, tuinal, downers)	2	1%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	5	2%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	2	1%
Amphetamines (speed, uppers, crystal meth, ice, glass)	6	3%
Marijuana, Hashish (grass, weed)	42	20%
Heroin	2	1%
Cocaine (powder), Crack	53	25%
Ecstasy, X, MDA, GHB	9	4%
Ketamine (K, Special K)	2	1%
None	122	59%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, 41% of MSM of color respondents reported using at least one substance during the past year. The average number of substances was 2, with a maximum of 8 reported. The most commonly used substances among MSM of color respondents were cocaine (25%) and marijuana (20%).

TABLE 9.32: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, MSM OF COLOR

In the last year, ever drunk more than meant to?	N	%
Yes	64	31%
No	144	69%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	74	36%
No	131	63%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	46	22%
No	162	78%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	66	32%
No	140	67%
Indicator of Alcohol Abuse	88	42%
Indicator of Substance Abuse	67	32%
Abuse of both drugs and alcohol	46	22%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.). The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 42% of all MSM of color respondents indicated possible alcohol abuse, and 32% indicated possible substance abuse. A total of 46 (22%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 9.33: SOCIAL SUPPORT, MSM OF COLOR

Of all the people you feel close to, how many have you told about being HIV+?	N	%
All	67	32%
Some	119	57%
None	22	11%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	166	80%
No	40	19%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 32% had disclosed their HIV status to all and 57% had disclosed their status to some. A total of 22 (11%) had not told their HIV status to

any of the people to whom they feel close. Overall, 80% of MSM of color respondents said there were people they could depend on for help if really needed; however, 19% said they had no one to depend on.

Housing

TABLE 9.34: HOUSING STATUS, MSM OF COLOR

Where do you most often sleep?	N	%
Apartment/House	165	79%
Group home/halfway house	29	14%
Shelter	10	5%
Street	4	2%
Other	2	1%
Do you feel your housing situation is stable?	**N**	**%**
Yes	140	67%
No	68	33%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of MSM of color respondents (79%) reported sleeping most often in an apartment/house. Others reported group home/halfway house (14%), shelter (5%), street (2%) and other (1%) locations. Most (67%) felt their housing situation was stable, and 33% felt their housing situation was unstable.

TABLE 9.35: HOUSING SITUATION AND UTILIZATION OF HIV CARE, MSM OF COLOR

In the past year, has your housing situation made it difficult to get HIV care?	N	%
Yes	45	22%
No	162	78%
Reasons	**N**	**%**
I could not keep my status private	9	4%
No place to store meds	7	3%
Money for food	21	10%
Money for rent	25	12%
Money for utilities	19	9%
Money for household supplies	21	10%
No stable address	0	0%
Used money on drugs	0	0%
Rules	2	1%
Lack of transportation	0	0%
No child care	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of 45 (22%) respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The most common reasons for these difficulties were needing to use money for rent (12%), household supplies (10%), or food (10%).

ACCESS TO CORE SERVICES

TABLE 9.36: ACCESS TO CORE SERVICES, MSM OF COLOR

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	38	18%	164	79%	6	3%
HIV/AIDS Medications	38	18%	140	67%	30	14%
Dentist Visits	55	26%	124	60%	29	14%
Medical Case Management	28	13%	118	57%	62	30%
Home Health Care	12	6%	39	19%	157	75%
Psychiatric Services or Medicine	19	9%	96	46%	93	45%
Psychological Counseling	16	8%	100	48%	92	44%
Substance Abuse Treatment	12	6%	63	30%	133	64%
Rehabilitation Services	13	6%	55	26%	140	67%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For all MSM of color respondents, the top three “easy to get” core services were primary medical care (79%), HIV/AIDS medications (67%) and dentist visits (60%). The top three core services that respondents reported “some difficulty getting” were dentist visits (26%), primary medical care (18%) and HIV/AIDS medications (18%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that MSM of color respondents said they “did not need” in the past year were home health care (75%), rehabilitation services (67%) and substance abuse treatment (64%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 9.37: ACCESS TO SUPPORTIVE SERVICES, MSM OF COLOR

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service, but feel it is useful/helpful	%*
Child Care Services	3	1%	0	0%	5	2%
Child Welfare Services	0	0%	1	0%	1	0%
Day/Respite Care for Adults	0	0%	2	1%	3	1%
Developmental	1	0%	0	0%	1	0%
Emergency Financial Assistance	69	33%	30	14%	9	4%
Employment Assistance	42	20%	5	2%	8	4%
Food Bank	32	15%	75	36%	6	3%
HIV Education for HIV+ Individuals	11	5%	39	19%	3	1%
Rental Assistance/Shelter Vouchers	44	21%	31	15%	5	2%
Housing-Related Services	40	19%	24	12%	8	4%
Legal Services	23	11%	22	11%	4	2%
Nutritional Counseling	18	9%	38	18%	2	1%
Permanency Planning	6	3%	3	1%	1	0%
Referrals to Services	10	5%	20	10%	2	1%
Referrals to Clinical Research	6	3%	10	5%	1	0%
Support Groups	21	10%	34	16%	6	3%
Translation/Interpretation	0	0%	7	3%	2	1%
Transportation	27	13%	37	18%	2	1%
Household Items	33	16%	8	4%	0	0%

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For MSM of color respondents, the five supportive services that were selected most often (thus implying high helpfulness/usefulness) were food bank, emergency financial assistance, housing related services, transportation and support groups.

The top five "easy to get" supportive services (based on number of responses) were food bank (n=75), HIV education for HIV+ individuals (n=39), nutritional counseling (n=38), transportation (n=37), and support groups (n=34). The top five supportive services that respondents reported "some difficulty getting" were emergency financial assistance (n=69), rental assistance/shelter vouchers (n=44), employment assistance (n=42), housing-related services (n=40), and household items (n=33). The presence of certain support services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates. Conversely, the supportive services that respondents did not need in the past year, but still identified as useful/helpful were emergency financial assistance (n=9), employment assistance (n=8), housing related services (n=8), food bank (n=6), and support groups (n=6). ["n=value" indicates the number of responses for each service category.]

Barriers Reported per Core Service Category

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among MSM of color respondents, the three core services with the highest number of barriers were dentist visits (n=88), primary medical care (n=63) and HIV/AIDS medications (n=46). Within dentist visits, the most commonly reported barriers were "It's hard to make or keep appointments" (n=22), "I don't know where to get the services" (n=15) and "I would have to wait too long to get the services" (n=14). For primary medical care, the most common barriers for MSM of color respondents were "I would have to wait too long to get the services" (n=12), "It's hard to make or keep appointments" (n=10), and "The people who run the services are not friendly" (n=9).

The barriers experienced most often by MSM of color respondents across all core services were "I would have to wait too long to get the services" (n=60), "I don't know where to get the services" (n=50), and "It's hard to make or keep appointments" (n=49). ["n=value" indicates the number of responses for each service category.]

TABLE 9.38: BARRIERS REPORTED PER CORE SERVICE CATEGORY, MSM OF COLOR

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Primary Medical Care	7	7	**12**	4	2	1	**9**	**10**	6	0	1	1	2	1	0	0	0	0	0	0	0	0	**63**
HIV/AIDS Medications	2	**6**	**9**	**14**	3	1	**6**	0	1	0	0	1	0	1	0	0	1	1	0	0	0	0	**46**
Dentist Visits	7	**15**	**14**	3	4	3	5	**22**	4	0	0	0	3	7	0	0	0	1	0	0	0	0	**88**
Medical Case Management	**6**	5	**10**	0	3	0	**7**	4	0	0	1	0	2	1	0	0	0	0	0	0	0	0	**39**
Home Health Care	1	**3**	2	1	**3**	2	1	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0	**16**
Psychiatric Services or Medicine	2	2	**6**	2	**3**	1	2	**6**	2	0	0	1	0	0	0	0	0	0	0	0	0	0	**27**
Psychological Counseling	1	**4**	**4**	1	2	3	1	**4**	1	0	1	0	0	0	0	0	1	0	0	0	0	0	**23**
Substance Abuse Treatment	2	**3**	2	1	**4**	0	2	1	1	0	0	0	2	0	0	0	0	0	0	0	0	0	**18**
Rehabilitation Services	1	**5**	1	2	**3**	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**15**
Total	**29**	**50**	**60**	**28**	**27**	**11**	**34**	**49**	**16**	**0**	**3**	**3**	**10**	**10**	**0**	**0**	**3**	**2**	**0**	**0**	**0**	**0**	**335**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among all MSM of color respondents, the five supportive services with the highest number of barriers were emergency financial assistance, employment assistance, rental assistance/shelter vouchers, housing related services and household items. Within emergency financial assistance, the most commonly reported barriers were "I would have to wait too long to get the services," "I don't know where to get the services," and "I was told I am not eligible for this service."

The barriers experienced most often by all MSM of color respondents across all supportive services were "I don't know where to get the services" and "I would have to wait too long to get the services."

TABLE 9.39: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, MSM OF COLOR

Service Category	Barriers																				
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Q	R	S	T	U	V	Total
Child Care Services	**9**	1	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**13**
Child Welfare Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Day/Respite Care for Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Developmental Assessment	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Emergency Financial Assistance	6	**17**	**28**	4	**18**	6	6	9	2	0	1	1	4	1	1	2	0	0	4	0	**110**
Employment Assistance	6	**20**	**5**	1	3	**7**	**5**	4	1	0	4	0	7	0	1	0	0	0	0	0	**64**
Food Bank	**6**	**12**	**7**	0	3	3	2	0	2	0	0	0	1	0	0	0	0	0	4	0	**40**
HIV Education for HIV+ Individuals	2	**6**	1	2	0	0	0	**4**	1	0	1	2	0	0	0	0	0	0	0	0	**19**
Rental Assistance/Shelter Vouchers	4	**12**	**16**	1	**7**	3	2	6	2	0	1	0	2	0	0	0	1	1	3	0	**61**
Housing-Related Services	5	**13**	**16**	3	**7**	3	0	2	0	0	1	0	5	0	0	1	0	0	2	0	**58**
Legal Services	3	**8**	**9**	4	2	0	4	4	1	0	0	1	0	0	1	0	0	0	1	0	**38**
Nutritional Counseling	**4**	**6**	**4**	1	1	0	1	**4**	1	0	0	1	0	0	0	0	0	0	0	0	**23**
Permanency Planning	1	**5**	0	1	1	1	1	0	1	0	0	0	0	0	0	1	0	0	0	0	**12**
Referrals to Services	2	**4**	**3**	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	**11**
Referrals to Clinical Research	0	**5**	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**8**
Support Groups	3	**13**	1	0	0	1	1	3	3	0	2	1	0	0	1	0	0	0	2	0	**31**
Translation/Interpretation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Transportation	**5**	**10**	3	1	1	3	2	**4**	3	0	1	1	1	0	0	0	0	0	0	0	**35**
Household Items	**7**	**17**	5	2	3	**6**	3	0	0	0	0	0	0	0	0	0	0	0	0	0	**43**
Total	**63**	**150**	**101**	**20**	**46**	**37**	**29**	**40**	**17**	**0**	**11**	**7**	**20**	**1**	**4**	**4**	**1**	**1**	**16**	**0**	**568**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions					
A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 9.40: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA MSM OF COLOR (N=208)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of MCSM Reporting this Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	17	130	2	8%	56	7%
Anonymous Sex Partner(s)	52	83	N/A	25%	141	18%
Greater than 5 Sex Partners	28	174	N/A	13%	60	8%

Of MSM of color surveyed, 17 (8%) reported that they had engaged in sex for drugs or money in the past 6 months, while 56 (7%) of all respondents reported this risk factor. Fifty-two (25%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 141 (18%) of all respondents. Twenty-eight (13%) of MSM of color surveyed reported that they had more than 5 sex partners in the past 6 months, while 60 (8%) of all respondents reported that they had more than 5 sex partners.

TABLE 9.41: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HRSA MSM OF COLOR (N=208)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of MCSM Reporting this Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	73	63	N/A	37%	235	31%
Shared Injecting Equipment	2	4	N/A	1%	12	2%
Serodiscordant Sex Partner(s)	18	98	22	9%	111	15%

Of MSM of color surveyed, 73 (37%) reported that they had unprotected sex at least some of the time, while 235 (31%) of the entire sample reported this risk factor. Two (1%) MSM of Color sampled reported that they had shared injecting equipment at least some of the time, compared with 12 (2%) of the total sample reporting this risk factor. Twenty-two (9%) of MSM of color reported that they had an HIV-negative sex partner, while 111 (15%) of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

Substance Abusers

Overview

There were 248 total substance abuse respondents to the 2008 Need Assessment consumer survey. This total represents 32% of the total 764 survey respondents.

Substance Abusers were defined as any survey respondents that demonstrated abuse of drugs, as indicated by the Two-item Conjoint Screen.

Demographics

Table 10.1: Gender, pregnancy status and age, Substance Abusers

Gender	**N**	**%**
Male	164	66%
Female	74	30%
Transgender – Male to Female	10	4%
Pregnant	**N**	**%**
Yes	5	7%
Don't Know	3	4%
Age Avg = 43	**N**	**%**
18-24	9	4%
25-44	132	53%
45+	107	43%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half of substance abusers were male (66%); females represented 30% and transgender Male to Female represented 4%. None of the respondents identified as transgender Female to Male.

Among females, 7% said they were pregnant at the time of the survey, and 4% said they did not know their pregnancy status.

The average age of substance abuse respondents was 43, ranging from 18 to 61. Almost all (96%) were above the age of 25; 53% were between the ages of 25-44, 43% were above the age of 45 and 4% were youth between the ages of 18 and 24.

TABLE 10.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, SUBSTANCE ABUSERS

Race/Ethnicity	N	%
White/Anglo	56	23%
Black/African-American	159	64%
Latino/Hispanic	31	13%
Asian	1	0%
Native American	0	0%
Multiracial	1	0%

Sexual Orientation	N	%
Straight/Heterosexual	135	54%
Gay/Lesbian	76	31%
Bisexual	24	10%
Undecided	2	1%
Prefer not to say	11	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half of substance abuse respondents identified as Black/African-American (64%); 23% identified as White/Anglo, 13% as Latino/Hispanic, and less than 1% as Asian, Native American or multi-racial.

More than half (54%) of substance abuse respondents identified as straight or heterosexual; 31% identified as gay/lesbian, 10% as bisexual and 1% as undecided. Eleven (4%) said they preferred not to disclose their sexual orientation.

TABLE 10.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, SUBSTANCE ABUSERS

Education	N	%
Less than high school	53	21%
High school degree/GED	152	61%
College degree	28	11%
Graduate/Professional degree	5	2%
Some technical training	10	4%
None	0	0%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	65	26%
Are you eligible for veteran benefits?	**N**	**%**
Yes	13	5%
No	226	91%
Don't Know	9	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (82%) of substance abuse respondents had a high school degree/GED or less; 11% had a college degree; 2% had a graduate/professional degree, and; 4% had some technical training.

A total of 65 (26%) reported being released from jail or prison during the previous year.

PLWHA eligible for veteran benefits represented 5% of substance abuse respondents.

Immigration Status & Primary Language

TABLE 10.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, SUBSTANCE ABUSERS

	N	%
Born outside US	11	4%
Length of residency	Avg = 19 yrs	
Immigration status	**N**	**%**
Citizen	241	97%
Permanent Resident	1	0%
Visa	0	0%
Undocumented	6	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

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The foreign born represented 4% of substance abuse respondents. Lengths of residency in the US ranged from 6 to 37 years with an average residency of 19 years.

Among substance abuse respondents, 97% were US citizens, less than 1% were permanent residents and 2% were undocumented.

TABLE 10.5: PREFERRED LANGUAGE, SUBSTANCE ABUSERS

Preferred language at home with family/friends	**N**	**%**
English	235	95%
Spanish	8	3%
English/Spanish	4	2%
Other	1	0%
Preferred language when seeing a doctor	**N**	**%**
English	241	97%
Spanish	5	2%
English/Spanish	1	0%
Other	1	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by substance abuse respondents – 95% said they were most comfortable speaking English at home with family/friends, and 97% said they were most comfortable speaking English with their doctor. When seeing a doctor, 2% were most comfortable speaking Spanish.

Job Status & Income

TABLE 10.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, SUBSTANCE ABUSERS

Job status	N	%
Full time	10	6%
Part time	14	6%
Temporary/contract/odd jobs	15	39%
Not working due to disability	96	44%
Unemployed	108	2%
Retired	4	0%
Average monthly income during past 6 months	Avg = $494.95	
Approximate yearly income	Avg = $5,939.37	
Up to 300% FPL (2007 – 2008)	244	98%
Up to 200% FPL (2007 - 2008)	242	98%
Up to 100% FPL (2007 - 2008)	216	87%
Total income dependents	Avg = 1	
Income dependents under 18	Avg = .24	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Almost half (46%) of substance abuse respondents were unemployed at the time of the survey; of these, 2% were unemployed and 44% were not working due to disability. Ten (6%) were working full-time, 6% part-time and 39% had temporary/contract/odd jobs.

The maximum reported monthly income was $4,500, with an average of $494.95 per month. The average yearly income was $5,939.37. The number of dependents per income ranged from 1 to 6, with an average of less than 1 (.24) being under the age of 18. Based on estimated yearly incomes and household sizes, 87% of all substance abuse respondents fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 10.7: SOURCES OF INCOME ASSISTANCE, SUBSTANCE ABUSERS

Sources of income assistance	N	%
None	69	28%
Hourly wages/Salary	15	6%
SSI	61	25%
SSDI	56	23%
Social Security	20	8%
TANF/AFDC	2	1%
Food Stamps	55	22%
Rental Subsidy/Section 8	8	3%
Workers Comp	0	0%
Unemployment	2	1%
Private Disability	5	2%
VA Benefits	5	2%
Child support	1	0%
Family/friends	4	2%
Pension/Retirement/Savings	1	0%
Other	2	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among substance abuse survey respondents were Supplemental Security Income (SSI) (25%), Social Security Disability Insurance (SSDI) (23%) and food stamps (22%). No survey respondents received worker's compensation. Sixty nine (28%) substance abuse respondents reported no source of income.

Paying for Medical Care

TABLE 10.8: SOURCES OF PAYMENT FOR MEDICAL CARE, SUBSTANCE ABUSERS

Paying for medical care	N	%
I don't receive medical care because I can't pay for it	12	5%
Private insurance/COBRA	3	1%
VA	7	3%
Medicaid	87	35%
Medicare	54	22%
Self-Pay	6	2%
Gold Card/County	87	35%
Ryan White/ADAP	22	9%
Other (MHMRA)	2	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Medicaid (35%), the Gold Card (a program that provides assistance to low-income residents with medical expenses and prescriptions) (35%) and Medicare (22%) were the most common methods of paying for medical care. Twenty two (9%) substance abuse respondents reported Ryan White/ADAP and 3% reported the Veteran's Administration Hospital. Twelve (5%) substance abuse respondents said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 10.9: LENGTH OF HIV DIAGNOSIS, SUBSTANCE ABUSERS

Length of diagnosis Avg = 10 yrs	N	%
Less than 1 year	9	4%
1-4 years	74	30%
5-10 years	46	19%
11-15 years	61	25%
16-20 years	41	17%
21 and over	17	7%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Substance abuse respondents reported being HIV positive an average of 10 years, ranging from 6 months to 22.5 years.

TABLE 10.10: LOCATION OF HIV DIAGNOSIS, SUBSTANCE ABUSERS

Location of diagnosis	N	%
Private doctor	34	14%
ER	24	10%
In hospital stay	32	13%
HIV-specific testing site	18	7%
Public or community clinic	64	26%
Jail/Prison	40	16%
Community testing location	16	6%
Alcohol or drug treatment facility	13	5%
Blood/Plasma donation	1	0%
Work/insurance related	4	2%
Other	2	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately a fourth (26%) of substance abuse respondents received their diagnoses at a public or community clinic. Other common diagnosis locations for overall respondents were jail/prison (16%) or private doctor (14%).

TABLE 10.11: REASONS FOR HIV TESTING, SUBSTANCE ABUSERS

Reasons for testing	N	%
Recommended by provider	34	14%
Had sex with someone HIV+	41	17%
ER/Hospital stay	31	13%
Felt sick	68	27%
Engaged in risky behavior	67	27%
Was in prison/jail	34	14%
During pregnancy care	9	4%
Routine check up/testing	15	6%
Blood/plasma donation	8	3%
Work/insurance related	2	1%
Partner notification	2	1%
Knew someone with HIV	2	1%
Rape survivor	1	0%
Incentive offered	1	0%
In drug treatment program	0	0%
Recommended by friends	0	0%
Other	3	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were felt sick (27%) and engaged in risky behavior (27%). Other common reasons included had sex with someone with HIV (17%), recommended by doctor or nurse (14%), or because they were in prison/jail (14%).

TABLE 10.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, SUBSTANCE ABUSERS

Assistance at diagnosis	N	%
Information about HIV/AIDS	127	51%
Medical services	117	47%
Counseling	95	38%
Help with food or shelter	35	14%
Alcohol or drug treatment services	36	15%
Supportive Services	3	1%
Other	0	0%
None	68	27%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to substance abuse respondents were information on HIV/AIDS (51%), medical services (47%) and

counseling (38%). A total of 68 (27%) of all substance abuse respondents reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 10.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, SUBSTANCE ABUSERS

Time to first doctor visit	N	%
Less than 1 month	109	44%
1-6 months	65	26%
6-12 months	34	14%
More than 12 months	34	14%
Never	6	2%

Time to CD4/Viral Load	N	%
Less than 1 month	83	33%
1-6 months	81	33%
6-12 months	29	12%
More than 12 months	48	19%
Never	6	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Less than half (44%) of substance abuse respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 26% of substance abuse respondents, 1 to 6 months passed before seeing a doctor, 14% waited between 6 to 12 months, and 14% waited more than a year to see a doctor for HIV. A total of 6 (2%) of substance abuse respondents said they still had not seen a doctor for HIV. Likewise, 33% reported receiving their first CD4/viral load test within one month of being diagnosed, 33% within 1-6 months, 12% between 6-12 months and 19% waited more than a year. A total of 6 (2%) said they had never received a CD4 or viral load test.

TABLE 10.14: REASONS FOR DELAYED ENTRY INTO CARE, SUBSTANCE ABUSERS

Reasons for waiting more than 6 months	N	%
Afraid	44	18%
Didn't feel sick	20	8%
Jail/prison	14	6%
Doing drugs	29	12%
Denial	35	14%
Didn't want to take meds	17	7%
No money	15	6%
Depressed/emotional problems	36	15%
No stable place to live	22	9%
Other	3	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were fear (18%), depressed/emotional problems (15%), denial (14%) and doing drugs (12%).

Maintenance in Care

TABLE 10.15: TIME SINCE LAST VISIT TO DOCTOR & VIRAL LOAD & CD4 & HIV MEDICATION PRESCRIPTION, SUBSTANCE ABUSERS

Last visit to doctor for HIV	N	%
Less than 6 months	203	82%
6-12 months	20	8%
More than 12 months	20	8%
Never/Don't Know	4	2%
Last viral load	**N**	**%**
Less than 6 months	195	79%
6-12 months	20	8%
More than 12 months	20	8%
Never/Don't Know	12	5%

Last CD4	N	%
Less than 6 months	200	81%
6-12 months	19	8%
More than 12 months	18	7%
Never/Don't Know	10	4%
Last HIV meds prescription	**N**	**%**
Less than 6 months	148	60%
6-12 months	24	10%
More than 12 months	26	10%
Never/Don't Know	49	20%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of substance abuse respondents said their most recent doctor's visit (82%), viral load (79%), CD4 test (81%) and HIV medication prescription (60%) were within the past 6 months.

TABLE 10.16: FREQUENCY OF DOCTOR'S VISITS, SUBSTANCE ABUSERS

No doctor visits more than 6 months?	N	%
Yes	138	56%
No	108	44%
No doctor visits more than 12 months?	**N**	**%**
Yes	74	30%
No	153	62%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among substance abuse respondents who have seen a doctor for HIV, 56% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 30% reported not seeing a doctor for 12 months or more.

TABLE 10.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, SUBSTANCE ABUSERS

Reasons for no doctor visits	N	%
Case manager left	4	2%
Doctor left	8	3%
Agency closed down	1	0%
Doing drugs	77	31%
Program closed down	1	0%
Did not want to take meds	29	12%
Bad experience with provider	15	6%
Lost stable housing	39	16%
Lost my job	15	6%
Lost health insurance	7	3%
Tired of regimen	24	10%
Felt fine	30	12%
Worried about side effects	17	7%
Denial	26	10%
Jail/prison	3	1%
No transportation	4	2%
Depression/emotional barriers	2	1%
Had to care for children/family member	2	1%
Other	5	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for falling out of care were doing drugs (31%), lost stable housing (16%), felt fine (12%) and did not want to take medications (12%).

TABLE 10.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, SUBSTANCE ABUSERS

First place of care	N	%
Private Clinic/Doctor's Office	49	20%
Public clinic/community health center	143	58%
Prison/jail	22	9%
VA Hospital	6	2%
ER/Hospital	24	10%
I have not received care for HIV	4	2%
Other	0	0%

Most often location of care	N	%
Private Clinic/Doctor's Office	50	20%
Public clinic/community health center	167	67%
Prison/jail	10	4%
VA Hospital	6	2%
ER/Hospital	10	4%
I have not received care for HIV	4	2%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common location of initial care for HIV was a public clinic/ community health center (58%). This was also the most often location of ongoing care (67%). A total of 6 (2%) substance abuse respondents received care most often from the Veteran's Administration Hospital.

TABLE 10.19: KNOWLEDGE OF CASE MANAGER, SUBSTANCE ABUSERS

Case Manager	N	%
Yes	187	75%
No	35	14%
Don't Know	26	10%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (75%) substance abuse respondents reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services; 14% said they did not have such a person assisting them; and 10% didn't know.

Health Status

TABLE 10.20: SELF-REPORTED HEALTH STATUS, SUBSTANCE ABUSERS

How would you describe your health overall	N	%
Excellent	35	14%
Good	113	46%
Fair	78	31%
Poor	21	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 14% said "Excellent," 46% said "Good," 31% said "Fair" and 8% said "Poor."

TABLE 10.21: SELF-REPORTED PHYSICAL HEALTH STATUS & ER OR HOSPITAL VISITS, SUBSTANCE ABUSERS

During the past month, has your physical health interfered with normal activities?	N	%
No	89	36%
Yes – Some of the time	129	52%
Yes – all of the time	28	11%
ER visit in past 6 months	91	37%
Hospital stay in past 6 months	68	27%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately half (52%) of substance abuse respondents reported that during the past month, their physical health had interfered with normal activities some of the time, and 11% said their physical health interfered all of the time.

For the 6 months prior to the survey, 37% substance abuse respondents reported an emergency room visit and 27% were admitted to a hospital for one or more nights.

TABLE 10.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, SUBSTANCE ABUSERS

Symptoms during past month Avg = 5	**N**	**%**
Trouble with thinking, concentrating or memory	138	56%
Depressed or sad, trouble thinking	172	69%
Aches, fatigue, lightheadedness, weak all over	113	46%
Fevers, chills, sweats	82	33%
Poor appetite, weight loss	84	34%
Trouble with eyes or ears	106	43%
Trouble with nose or sinuses, headaches	99	40%
Trouble with mouth or swallowing	54	22%
Nausea, vomiting, diarrhea, abdominal pain	85	34%
Coughing, wheezing, or chest pain, trouble breathing	79	32%
Rash, itch, herpes, or other skin trouble	75	30%
Numbness, tingling or pain in an arm or leg	87	35%
Other	0	0%
None	16	6%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The number of symptoms reported by all respondents during the past month ranged from 1 to 12, with an average of 5. The top three reported symptoms were depressed or sad, trouble thinking (69%), trouble with thinking, concentrating or memory (56%) and aches, fatigue, lightheadedness, weak all over (46%).

TABLE 10.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, SUBSTANCE ABUSERS

First CD4/T-cell	N	%	Current CD4/T-cell	N	%
Less than 50	25	10%	Less than 50	18	7%
50-99	14	6%	50-99	7	3%
100-199	20	8%	100-199	34	14%
200-349	39	16%	200-349	46	19%
350-499	34	14%	350-499	34	14%
500+	55	22%	500+	46	19%
Don't Know/Can't Remember	60	24%	Don't Know/Can't Remember	62	25%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of 55 (22%) of all substance abuse respondents reported their first CD4/T-cell counts as 500+; 30% were 200 to 499, 14% were 50 to 199, and 10% were less than 50. Current CD4/T-cell counts were 500+ for 19% of all substance abuse respondents; 200 to 499 for 33%, 50 to 199 for 17%, and less than 50 for 7% of substance abuse respondents. Almost a fourth (24%) didn't know or couldn't remember their first CD4/T-cell count, and 25% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 10.24: HIV MEDICATIONS, SUBSTANCE ABUSERS

Currently taking HIV meds	N	%
Yes	162	65%
No	85	34%
How many pills do you take in one day?	Avg = 5	

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (65%) were currently taking HIV medications. The number of pills taken in one day ranged from 1 to 17, with an average of 5 pills per day.

TABLE 10.25: SELF-REPORTED MEDICATION ADHERENCE, SUBSTANCE ABUSERS

Medication adherence	N	%
I have not missed any doses in the past month	68	27%
Missed a few, but took nearly all	73	29%
Took more than half	9	4%
About half	9	4%
Some, but not half	9	4%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	158	64%
No	65	26%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among substance abuse respondents currently taking HIV medications, 27% reported perfect adherence and 29% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 64% said "Yes" and 26% said "No."

TABLE 10.26: REASONS FOR NOT TAKING HIV MEDICATIONS, SUBSTANCE ABUSERS

Reasons for not taking HIV medications	N	%
Side effects	11	4%
Not effective	3	1%
Too difficult to take as prescribed	3	1%
No doctor has offered them	5	2%
I choose not to take them	22	9%
Doctor did not think it was a good idea for me	17	7%
T-cell too high	33	13%
Cannot pay	6	2%
Confidentiality concerns	7	3%
Didn't feel sick	3	1%
Have not seen doctor	3	1%
Other	2	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "T-cells too high" (13%) followed by "I choose not to take them" (9%) and "doctor did not think it was a good idea for me" (7%).

TABLE 10.27: MEDICATIONS FOR NON-HIV CONDITIONS, SUBSTANCE ABUSERS

How many pills do you take in one day for non-HIV conditions? Avg = 4	**N**	**%**
Diabetes	12	5%
High blood pressure	68	27%
High cholesterol	18	7%
Depression/emotional problems	117	47%
Eye drops/glaucoma	1	0%
Acid reflux	4	2%
Anemia	0	0%
Sleep	7	3%
Allergies/Sinus	3	1%
Pain	8	3%
Antibiotics	3	1%
Arthritis	2	1%
Asthma	5	2%
Neuropathy	4	2%
Nausea	0	0%
Hormones	4	2%
Other	5	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, substance abuse respondents took an average of 4 non-HIV pills per day. The most common conditions associated with the non-HIV pills were depression/emotional problems (47%) and high blood pressure (27%).

TABLE 10.28: TOTAL PILL BURDEN AND ABILITY TO PAY, SUBSTANCE ABUSERS

Total Pills (HIV + non-HIV)	Avg = 7	
How often do you have trouble paying for these or other non-HIV meds?	**N**	**%**
Never	141	57%
Less than half the time	28	11%
More than half the time	18	7%
Always	45	18%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was 7.

More than half (57%) of all substance abuse respondents reported never having problems paying for HIV or non-HIV medications, 11% had problems less than half the time, 7% had problems more than half the time, and 18% said they always had problems paying for their medications.

Comorbidities

TABLE 10.29: HEPATITIS C AND TB STATUS, SUBSTANCE ABUSERS

Hep C Test?	N	%
Yes	199	80%
No	39	16%
Don't Know	10	4%
Positive for Hep C?	**N**	**%**
Yes	85	34%
No	132	53%
Don't know	31	13%

TB skin test?	N	%
Yes	227	92%
No	20	8%
Result	**N**	**%**
Positive	41	17%
Negative	170	69%
Don't Know	7	3%
History of active TB?	**N**	**%**
Yes	48	19%
No	195	79%
Don't Know	5	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (80%) substance abuse respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 34% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

Almost all (92%) respondents had received a skin test for TB, and 17% reported a positive result. A total of 49 (19%) reported a history of active TB.

Mental Health

TABLE 10.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, SUBSTANCE ABUSERS

	N	%
At least one mental health condition	167	67%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	116	47%
Hallucinations	32	13%
Serious thoughts of suicide	39	16%
Attempted suicide	15	6%
Wanted to hurt or harm yourself	39	16%
Wanted to hurt or harm someone else	30	12%
Trouble controlling anger leading to physical violence	55	22%
Problems requiring meds	87	35%
None	81	33%
At least one serious indicator (suicide/homicidal or requiring meds)	167	67%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (67%) of substance abuse respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced symptoms were serious anxiety/tension (47%), problems requiring medications (35%) and trouble controlling anger leading to physical violence (22%).

TABLE 10.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, SUBSTANCE ABUSERS

Since being diagnosed, ever talked with therapist?	N	%
Yes	182	73%
No	66	27%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	177	71%
No	71	29%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	141	57%
No	104	42%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 73% of substance abuse respondents said they had talked with a therapist or psychologist for help with depression or emotional problems, 71% had talked to a doctor or psychiatrist for medications and 57% said they had participated in a support group.

Substance Use & Abuse

TABLE 10.32: SUBSTANCE USE, SUBSTANCE ABUSERS

Total Number of substances Avg = 2	N	%
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	13	5%
Street Methadone (non-treatment)	6	2%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	18	7%
Barbituates (seconal, tuinal, downers)	8	3%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	23	9%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	5	2%
Amphetamines (speed, uppers, crystal meth, ice, glass)	27	11%
Marijuana, Hashish (grass, weed)	113	46%
Heroin	9	4%
Cocaine (powder), Crack	179	72%
Ecstasy, X, MDA, GHB	18	7%
Ketamine (K, Special K)	4	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The numbers of substances used in the past year ranged from 1 to 11, with an average of 2. The most commonly used substances were cocaine (72%) and marijuana (46%).

TABLE 10.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, SUBSTANCE ABUSERS

In the last year, ever drunk more than meant to?	N	%
Yes	140	56%
No	108	44%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	148	60%
No	97	39%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	199	80%
No	49	20%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	239	96%
No	9	4%
Indicator of Alcohol Abuse	167	67%
Indicator of Substance Abuse	248	100%
Abuse of both drugs and alcohol	167	67%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 67% of all substance abuse respondents indicated possible alcohol abuse. A total of 167 (67%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 10.34: SOCIAL SUPPORT, SUBSTANCE ABUSERS

Of all the people you feel close to, how many have you told about being HIV+	N	%
All	90	36%
Some	128	52%
None	28	11%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	202	81%
No	44	18%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 36% had disclosed their HIV status to all and 52% had disclosed their status to some. A total of 28 (11%) had not told their HIV status to any of the people to whom they feel close. Overall, 81% of substance abuse respondents said there were people they could depend on for help if really needed; however, 18% had no one to depend on.

Housing

TABLE 10.35: HOUSING STATUS, SUBSTANCE ABUSERS

Where do you most often sleep?	N	%
Apartment/House	149	60%
Group home/halfway house	57	23%
Shelter	20	8%
Street	21	8%
Other	1	0%
Do you feel your housing situation is stable?	**N**	**%**
Yes	132	53%
No	116	47%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (60%) reported sleeping most often in an apartment/house. Others reported group home/halfway house (23%), shelter (8%), street (8%) and other (less than 1%) locations. Approximately half (53%) of all respondents felt their housing situation was stable, and 47% felt their housing situation was unstable.

TABLE 10.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, SUBSTANCE ABUSERS

In the past year, has your housing situation made it difficult to get HIV care?	N	%
Yes	92	37%
No	155	63%
Reasons	**N**	**%**
I could not keep my status private	24	10%
No place to store meds	26	10%
Money for food	46	19%
Money for rent	47	19%
Money for utilities	34	14%
Money for household supplies	33	13%
No stable address	5	2%
Used money on drugs	1	0%
Rules	1	0%
Lack of transportation	1	0%
No child care	1	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of 92 (37%) respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The most common reasons for these difficulties were needing to use money for rent (19%), food (19%), utilities (14%) and household supplies (13%).

ACCESS TO CORE SERVICES

TABLE 10.37: ACCESS TO CORE SERVICES, SUBSTANCE ABUSERS

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	57	23%	178	72%	13	5%
HIV/AIDS Medications	58	23%	149	60%	41	17%
Dentist Visits	83	33%	113	46%	52	21%
Medical Case Management	53	21%	149	60%	46	19%
Home Health Care	29	12%	37	15%	182	73%
Psychiatric Services or Medicine	40	16%	123	50%	85	34%
Psychological Counseling	35	14%	125	50%	88	35%
Substance Abuse Treatment	38	15%	123	50%	87	35%
Rehabilitation Services	27	11%	53	21%	168	68%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For all substance abuse respondents, the top three "easy to get" core services were primary medical care (72%), HIV/AIDS medications (60%) and medical case management (60%). The top three core services that respondents reported "some difficulty getting" were dentist visits (33%), primary medical care (23%) and HIV/AIDS medications (23%). The presence of primary medical care and HIV/AIDS medications on both the "easy to get" and "some difficulty getting" lists is due to the fact that they are the two most accessed services. Conversely, the core services that substance abuse respondents said they "did not need" in the past year were home health care (73%), rehabilitation services (68%), substance abuse treatment (35%) and psychological counseling (35%).

Access to Supportive Services

Table 10.38: Access to supportive services, Substance Abusers

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service	%*
Child Care Services	11	4%	5	2%	1	0%
Child Welfare Services	1	0%	1	0%	0	0%
Day/Respite Care for Adults	3	1%	4	2%	2	1%
Developmental	1	0%	0	0%	0	0%
Emergency Financial Assistance	76	31%	35	14%	9	4%
Employment Assistance	45	18%	9	4%	6	2%
Food Bank	45	18%	82	33%	10	4%
HIV Education for HIV+ Individuals	14	6%	37	15%	2	1%
Rental Assistance/Shelter Vouchers	59	24%	27	11%	2	1%
Housing-Related Services	71	29%	30	12%	11	4%
Legal Services	20	8%	19	8%	7	3%
Nutritional Counseling	22	9%	31	13%	2	1%
Permanency Planning	5	2%	1	0%	2	1%
Referrals to Services	20	8%	29	12%	6	2%
Referrals to Clinical Research	15	6%	10	4%	0	0%
Support Groups	32	13%	46	19%	9	4%
Translation/Interpretation	1	0%	1	0%	0	0%
Transportation	48	19%	49	20%	2	1%
Household Items	32	13%	14	6%	3	1%

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For substance abuse respondents, the supportive services selected most often (thus implying high helpfulness/usefulness) were food bank, emergency financial assistance, housing related services, transportation and support groups. The top "easy to get" supportive services (based on number of responses) were food bank, transportation, support groups, HIV education for HIV+ individuals and emergency financial assistance. The top supportive services respondents reported "some difficulty getting" were emergency financial assistance, housing-related services, rental assistance/shelter vouchers, transportation, employment assistance and food bank. The presence of certain support services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates. Conversely, the top supportive services respondents did not need in the past year, but still identified as useful/helpful were housing related services, food bank, emergency financial assistance, legal services and support groups.

Barriers Reported per Core Service Category

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among substance abuse respondents, the three core services with the highest number of barriers were dentist visits, primary medical care and HIV/AIDS medications. Within dentist visits, the most common barriers were "It's hard to make or keep appointments," and "I would have to wait too long to get the services." For primary medical care, the most common barriers were "It's hard for me to get there," "It's hard to make or keep appointments," and "I would have to wait too long to get the services."

The barriers experienced most often by substance abuse respondents across all core services were "I would have to wait too long to get the services," "I don't know where to get the services," and "It's hard to make or keep appointments."

TABLE 10.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, SUBSTANCE ABUSERS

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Primary Medical Care	7	13	**16**	7	3	5	9	**17**	**21**	1	11	1	3	4	0	0	1	3	0	0	0	0	**122**
HIV/AIDS Medications	8	**12**	**18**	**13**	7	4	7	5	11	1	3	1	0	0	0	0	3	1	1	0	0	0	**95**
Dentist Visits	11	**19**	**24**	9	1	4	4	**33**	15	2	5	0	2	7	0	0	0	1	0	0	0	0	**137**
Medical Case Management	8	**12**	8	7	1	2	9	**18**	**11**	0	4	0	3	0	0	2	0	0	0	2	0	0	**87**
Home Health Care	5	**8**	3	3	**9**	**7**	4	1	4	0	1	0	1	0	0	0	0	1	4	0	0	0	**51**
Psychiatric Services or Medicine	7	**11**	**15**	6	5	1	10	**12**	7	1	3	0	0	0	0	0	2	0	0	0	0	0	**80**
Psychological Counseling	7	**11**	**11**	7	3	3	6	**9**	8	1	5	0	0	0	0	0	2	1	0	0	0	0	**74**
Substance Abuse Treatment	**9**	**9**	**10**	6	4	4	7	5	8	2	5	1	3	0	0	0	0	1	1	0	0	0	**75**
Rehabilitation Services	**7**	**10**	3	3	5	3	3	4	**8**	0	4	1	0	0	0	0	0	0	0	0	1	0	**52**
Total	**69**	**105**	**108**	**61**	**38**	**33**	**59**	**104**	**93**	**8**	**41**	**4**	**12**	**11**	**0**	**2**	**8**	**8**	**6**	**2**	**1**	**0**	**773**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Barriers Reported per Supportive Service Category

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among all substance abuse respondents, the five supportive services with the highest number of barriers were emergency financial assistance, housing related services, rental assistance, food bank and transportation. Within emergency financial assistance, the most common barriers were "I don't know where to get the services," and "I would have to wait too long to get the services."

The barriers experienced most often by all substance abuse respondents across all supportive services were "I don't know where to get the services," "I would have to wait too long to get the services," and "The services are not in my area."

TABLE 10.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, SUBSTANCE ABUSERS

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Child Care Services	3	**6**	**4**	3	2	3	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**23**
Child Welfare Services	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Day/Respite Care for Adults	1	**2**	0	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	**6**
Developmental Assessment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Emergency Financial Assistance	**19**	**29**	**22**	5	**19**	11	8	12	7	2	7	0	7	1	0	0	1	0	1	0	5	0	**156**
Employment Assistance	**9**	**20**	7	0	2	4	4	6	3	0	2	1	**12**	0	0	0	2	0	1	0	0	0	**73**
Food Bank	**13**	**17**	7	3	8	11	4	5	16	0	3	0	0	0	0	0	1	0	1	0	4	0	**93**
HIV Education for HIV+ Individuals	**4**	**7**	1	2	1	1	0	2	3	0	**3**	1	0	0	0	0	1	0	0	0	0	0	**26**
Rental Assistance/Shelter Vouchers	7	**24**	9	6	**10**	7	5	**10**	5	1	4	0	2	1	1	0	1	0	3	1	8	1	**106**
Housing-Related Services	14	**32**	**19**	5	**14**	11	3	8	6	1	4	0	11	0	0	0	0	1	3	0	3	0	**135**
Legal Services	**4**	**10**	**4**	2	3	**4**	3	2	2	0	1	1	1	0	0	0	0	0	1	0	0	0	**38**
Nutritional Counseling	1	**8**	3	1	2	0	1	**4**	**4**	0	0	1	0	1	0	0	0	0	0	0	0	0	**26**
Permanency Planning	1	**3**	1	1	1	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**12**
Referrals to Services	2	**8**	3	2	0	3	3	3	**5**	0	1	0	0	1	0	0	0	0	2	0	0	0	**33**
Referrals to Clinical Research	1	**11**	2	0	**3**	**3**	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	**22**
Support Groups	4	**18**	3	1	1	**5**	1	4	**8**	2	2	1	1	0	0	0	1	0	1	0	2	0	**55**
Translation/Interpretation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Transportation	**10**	**18**	**10**	6	6	5	4	5	**10**	0	2	1	0	3	0	0	1	1	2	0	0	0	**84**
Household Items	6	**16**	**8**	2	2	**9**	2	3	1	0	4	0	3	0	0	0	1	1	0	0	0	0	**58**
Total	**100**	**230**	**103**	**39**	**75**	**79**	**39**	**66**	**72**	**8**	**35**	**6**	**37**	**7**	**1**	**0**	**10**	**3**	**15**	**1**	**22**	**1**	**949**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions					
A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 10.41: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), SUBSTANCE ABUSE (N=248)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of Substance Abusers Reporting Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	45	142	3	18%	56	7%
Anonymous Sex Partner(s)	63	114	N/A	25%	141	18%
Greater than 5 Sex Partners	33	212	N/A	13%	60	8%

Of those who reported an indicator of substance abuse, 45 (18%) reported that they had engaged in sex for drugs or money in the past 6 months, while 56 (7%) of all respondents reported this risk factor. Sixty-three (25%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 141 (18%) of all respondents. Thirty-three (13%) of those reporting substance abuse surveyed reported that they had more than 5 sex partners in the past 6 months, while 60 (8%) of all respondents reported that they had more than 5 sex partners.

TABLE 10.42: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), SUBSTANCE ABUSE (N=248)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of Substance Abusers Reporting Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	103	87	N/A	42%	235	31%
Shared Injecting Equipment	10	19	N/A	4%	12	2%
Serodiscordant Sex Partner(s)	28	139	23	11%	111	15%

Of those reporting substance abuse surveyed, 103 (42%) reported that they had unprotected sex at least some of the time, while 235 (31%) of the entire sample reported this risk factor. Ten (4%) of those reporting substance abuse surveyed reported that they had shared injecting equipment at least some of the time, compared with 12 (2%) of the total sample reporting this risk factor. Twenty-eight (11%) of those reporting substance abuse reported that they had an HIV-negative sex partner, while 111 (15%) of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

PLWHA with Mental Health Symptoms

Overview

There were 452 total survey respondents with a mental health symptom in the 2008 Need Assessment consumer survey. This total represents 59% of the total 764 survey respondents.

Survey respondents with mental health symptoms were defined as any respondent reporting they experienced at least one of the following symptoms in the past 6 months: serious anxiety/tension; hallucinations; serious thoughts of suicide; attempted suicide; wanted to hurt or harm themself; wanted to hurt or harm someone else; trouble controlling anger leading to physical violence, or problems requiring medications.

Demographics

Table 11.1: Gender, pregnancy status and age, PLWHA with mental health symptoms

Gender	**N**	**%**
Male	286	63%
Female	154	34%
Transgender – Male to Female	12	3%
Pregnant	**N**	**%**
Yes	8	5%
Don't Know	7	5%
Age Avg = 43 yrs	**N**	**%**
18-24	21	5%
25-44	219	48%
45+	212	47%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half of respondents with a mental health symptom were male (63%); women represented 34% of all respondents, and transgender Male to Female represented 3%. No survey respondents identified as transgender Female to Male.

Among women, 5% said they were pregnant at the time of the survey, and 5% said they did not know their pregnancy status.

The average age of respondents with a mental health symptom was 43, ranging

from 18 to 73 years. Almost all (95%) survey respondents with a mental health symptom were above the age of 25; 48% were between the ages of 25-44, and another 47% were above the age of 45 and 5% were youth between the ages of 18 and 24.

TABLE 11.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, PLWHA WITH MENTAL HEALTH SYMPTOMS

Race/Ethnicity	N	%
White/Anglo	125	28%
Black/African-American	249	55%
Hispanic/Latino	67	15%
Asian	3	1%
Native American	3	1%
Multiracial	5	1%

Sexual Orientation	N	%
Straight/Heterosexual	245	54%
Gay/Lesbian	143	32%
Bisexual	39	9%
Undecided	6	1%
Prefer not to say	19	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (55%) of respondents with a mental health symptom identified as Black/African-American; 28% identified as White/Anglo, 15% as Hispanic/Latino, and 3% as Asian, Native American or multi-racial.

Of survey respondents with a mental health symptom, more than half (54%) identified as straight/heterosexual, 32% as gay/lesbian, 9% as bisexual and 1% as undecided. Nineteen (4%) said they preferred not to disclose their sexual orientation.

TABLE 11.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, PLWHA WITH MENTAL HEALTH SYMPTOMS

Education	N	%
Less than high school	96	21%
High school degree/GED	247	55%
College degree	69	15%
Graduate/Professional degree	7	2%
Some technical training	22	5%
None	1	0%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	79	17%
Are you eligible for veteran benefits?	**N**	**%**
Yes	24	5%
No	406	90%
Don't Know	22	5%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (76%) of survey respondents with a mental health symptom had a high school degree/GED or less, 15% had a college degree, 2% had a graduate/professional degree and 5% had some technical training. One reported receiving no education.

A total of 79 (17%) of survey respondents reported being released from jail or prison during the previous year.

PLWHA respondents with a mental health symptom who were eligible for veteran benefits represented 5% of survey respondents with at least one mental health symptom.

Immigration Status & Primary Language

TABLE 11.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, PLWHA WITH MENTAL HEALTH SYMPTOMS

	N	%
Born outside US	44	10%
Length of residency	Avg = 20 yrs	
Immigration status	**N**	**%**
Citizen	420	93%
Permanent Resident	9	2%
Visa	4	1%
Undocumented	19	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Foreign born respondents represented 10% of survey respondents with at least one mental health symptom. Years of residency in the US ranged from 2 to 47, with an average of 20 years.

Among all survey respondents with at least one mental health symptom, 93% were US citizens, 2% permanent residents, 1% visa holder and 4% undocumented.

TABLE 11.5: PREFERRED LANGUAGE, PLWHA WITH MENTAL HEALTH SYMPTOMS

Preferred language at home with family/friends	N	%
English	411	91%
Spanish	27	6%
English/Spanish	11	2%
Other	3	1%
Preferred language when seeing a doctor	**N**	**%**
English	420	93%
Spanish	24	5%
English/Spanish	6	1%
Other	2	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by survey respondents with a mental health symptom. Approximately 91% said they were most comfortable speaking English at home with family/friends, and 93% said they were most comfortable speaking English with their doctor. When seeing a doctor, 5% were most comfortable speaking Spanish and 1% preferred a combination of English and Spanish.

Job Status & Income

TABLE 11.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, PLWHA WITH MENTAL HEALTH SYMPTOMS

Job status	N	%
Full time	35	8%
Part time	27	6%
Temporary/contract/odd jobs	28	6%
Not working due to disability	183	40%
Unemployed	166	37%
Retired	11	2%
Average monthly income during past 6 months	Avg = $753.40	
Approximate yearly income	Avg = $7,952.69	
Up to 300% FPL (2007 – 2008)	442	98%
Up to 200% FPL (2007 - 2008)	431	95%
Up to 100% FPL (2007 - 2008)	359	79%
Total income dependents	Avg = 1	
Income dependents under 18	Avg = .26	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (79%) survey respondents with a mental health symptom were unemployed at the time of the survey; 37% were unemployed, 40% were not working due to disability, and 2% were retired. Thirty-five (8%) were working full-time, 6% part-time and 6% had temporary/contract/odd jobs.

The maximum monthly income was reported as $7,000 with an average of $753.40. The average yearly income was $7,952.69. The maximum number of dependents per income was 7, with an average of .26 being under the age of 18. Based on estimated yearly incomes and household sizes, 79% of survey respondents with a mental health symptom fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 11.7: SOURCES OF INCOME ASSISTANCE, PLWHA WITH MENTAL HEALTH SYMPTOMS

Sources of income assistance	N	%
None	119	26%
Hourly wages/Salary	33	7%
SSI	124	27%
SSDI	96	21%
Social Security	55	12%
TANF/AFDC	7	2%
Food Stamps	89	20%
Rental Subsidy/Section 8	25	6%
Workers Comp	0	0%
Unemployment	7	2%
Private Disability	10	2%
VA Benefits	7	2%
Child support	3	1%
Family/friends	6	1%
Pension/Retirement/Savings	4	1%
Other	1	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among respondents with a mental health symptom were Supplemental Security Income (SSI) (27%), Social Security Disability Insurance (SSDI) (21%) and food stamps (20%). No survey respondents received worker's compensation. Approximately a fourth (26%) of survey respondents with a mental health symptom reported no source of income.

Paying for Medical Care

TABLE 11.8: SOURCES OF PAYMENT FOR MEDICAL CARE, PLWHA WITH MENTAL HEALTH SYMPTOMS

Paying for medical care	N	%
I don't receive medical care because I can't pay for it	29	6%
Private insurance/COBRA	12	3%
VA	17	4%
Medicaid	148	33%
Medicare	96	21%
Self-Pay	15	3%
Gold Card/County	155	34%
Ryan White/ADAP	50	11%
Other (MHMRA)	5	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Gold Card (34%), Medicaid (33%) and Medicare (21%) were the most common methods of paying for medical care. Fifty (11%) survey respondents with a mental health symptom reported Ryan White/ADAP and 4% reported the Veteran's Administration Hospital. Twenty nine (6%) of survey respondents with a mental health symptom said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 11.9: LENGTH OF HIV DIAGNOSIS, PLWHA WITH MENTAL HEALTH SYMPTOMS

Length of diagnosis Avg = 11 yrs	N	%
Less than 1 year	15	3%
1-4 years	116	26%
5-10 years	106	23%
11-15 years	106	23%
16-20 years	72	16%
21 and over	35	8%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Survey respondents with a mental health symptom reported being diagnosed as HIV positive an average of 11 years, ranging from 8 months to 23 years.

TABLE 11.10: LOCATION OF HIV DIAGNOSIS, PLWHA WITH MENTAL HEALTH SYMPTOMS

Location of diagnosis	N	%
Private doctor	69	15%
ER	51	11%
In hospital stay	69	15%
HIV-specific testing site	38	8%
Public or community clinic	111	25%
Jail/Prison	59	13%
Community testing location	32	7%
Alcohol or drug treatment facility	15	3%
Blood/Plasma donation	3	1%
Work/insurance related	4	1%
Other	1	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A fourth (25%) of survey respondents with a mental health symptom received their diagnoses at a public or community clinic. Other common diagnosis locations were during hospital stays (15%), private doctor (15%) or in jail/prison (13%).

TABLE 11.11: REASONS FOR HIV TESTING, PLWHA WITH MENTAL HEALTH SYMPTOMS

Reasons for testing	N	%
Recommended by provider	58	13%
Had sex with someone HIV+	76	17%
ER/Hospital stay	82	18%
Felt sick	126	28%
Engaged in risky behavior	104	23%
Was in prison/jail	44	10%
During pregnancy care	18	4%
Routine check up/testing	30	7%
Blood/plasma donation	11	2%
Work/insurance related	5	1%
Partner notification	2	0%
Knew someone with HIV	5	1%
Rape survivor	2	0%
Incentive offered	2	0%
In drug treatment program	3	1%
Recommended by friends	2	0%
Other	3	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were feeling sick (28%) and engaged in risky behavior (23%). Other common reasons included during an ER visit or hospital stay (18%) or having head sex with someone HIV+ (17%).

TABLE 11.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, PLWHA WITH MENTAL HEALTH SYMPTOMS

Assistance at diagnosis	N	%
Information about HIV/AIDS	228	50%
Medical services	220	49%
Counseling	155	34%
Help with food or shelter	52	12%
Alcohol or drug treatment services	44	10%
Supportive Services	4	1%
Other	2	0%
None	130	29%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to survey respondents with a mental health symptom were information about HIV/AIDS (50%), medical services (49%) and counseling (34%). A total of 130 (29%) of survey respondents with a mental health symptom reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 11.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, PLWHA WITH MENTAL HEALTH SYMPTOMS

Time to first doctor visit	N	%
Less than 1 month	202	45%
1-6 months	115	25%
6-12 months	52	12%
More than 12 months	70	15%
Never	12	3%

Time to CD4/Viral Load	N	%
Less than 1 month	156	35%
1-6 months	143	32%
6-12 months	45	10%
More than 12 months	91	20%
Never	16	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Almost half (45%) of survey respondents with a mental health symptom reported seeing a doctor for HIV within one month of receiving their diagnosis. For 25% of survey respondents with at least one mental health symptom, 1 to 6 months passed before seeing a doctor, 12% waited between 6 to 12 months, and 15% waited more than a year to see a doctor for HIV. A total of 12 (3%) of survey respondents with a mental health symptom said they still had not seen a doctor for HIV. Likewise, 35% reported receiving their first CD4/ viral load test within one month of being diagnosed, 32% within 1-6 months, 10% between

6-12 months and 20% waited more than a year. A total of 16 (4%) said they had never received a CD4 or viral load test.

TABLE 11.14: REASONS FOR DELAYED ENTRY INTO CARE, PLWHA WITH MENTAL HEALTH SYMPTOMS

Reasons for waiting more than 6 months	N	%
Afraid	69	15%
Didn't feel sick	51	11%
Jail/prison	23	5%
Doing drugs	33	7%
Denial	62	14%
Didn't want to take meds	35	8%
No money	26	6%
Depressed/emotional problems	62	14%
No stable place to live	31	7%
Other	1	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were fear (15%), denial (14%), depressed/emotional problems (14%) and didn't feel sick (11%).

Maintenance in Care

TABLE 11.15: TIME SINCE LAST VISIT TO DOCTOR & VIRAL LOAD & CD4 & HIV MEDICATION PRESCRIPTION, PLWHA WITH MENTAL HEALTH SYMPTOMS

Last visit to doctor for HIV	N	%
Less than 6 months	371	82%
6-12 months	28	6%
More than 12 months	39	9%
Never/Don't Know	11	2%
Last viral load	**N**	**%**
Less than 6 months	361	80%
6-12 months	30	7%
More than 12 months	37	8%
Never/Don't Know	23	5%

Last CD4	N	%
Less than 6 months	365	81%
6-12 months	29	6%
More than 12 months	35	8%
Never/Don't Know	22	5%
Last HIV meds prescription	**N**	**%**
Less than 6 months	287	63%
6-12 months	34	8%
More than 12 months	54	12%
Never/Don't Know	76	17%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of survey respondents with a mental health symptom said their most recent doctor's visit (82%), viral load (80%), CD4 test (81%) and HIV medication prescription (63%) were within the past 6 months.

TABLE 11.16: FREQUENCY OF DOCTOR'S VISITS, PLWHA WITH MENTAL HEALTH SYMPTOMS

No doctor visits more than 6 months?	N	%
Yes	205	45%
No	240	53%
No doctor visits more than 12 months?	**N**	**%**
Yes	120	27%
No	303	67%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among survey respondents with a mental health symptom who have seen a doctor for HIV, 45% reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 27% reported not seeing a doctor for 12 months or more.

TABLE 11.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, PLWHA WITH MENTAL HEALTH SYMPTOMS

Reasons for no doctor visits	N	%
Case manager left	7	2%
Doctor left	9	2%
Agency closed down	3	1%
Doing drugs	67	15%
Program closed down	4	1%
Did not want to take meds	66	15%
Bad experience with provider	26	6%
Lost stable housing	50	11%
Lost my job	30	7%
Lost health insurance	20	4%
Tired of regimen	43	10%
Felt fine	56	12%
Worried about side effects	38	8%
Denial	52	12%
Jail/prison	8	2%
No transportation	7	2%
Depression/emotional barriers	5	1%
Had to care for children/family member	3	1%
Other	3	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for falling out of care were doing drugs (15%), didn't want to take medications (15%), felt fine (12%) and denial (12%).

TABLE 11.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, PLWHA WITH MENTAL HEALTH SYMPTOMS

First place of care	N	%
Private Clinic/Doctor's Office	93	21%
Public clinic/community health center	243	54%
Prison/jail	47	10%
VA Hospital	12	3%
ER/Hospital	43	10%
I have not received care for HIV	11	2%
Other	0	0%

Most often location of care	N	%
Private Clinic/Doctor's Office	96	21%
Public clinic/community health center	293	65%
Prison/jail	12	3%
VA Hospital	15	3%
ER/Hospital	22	5%
I have not received care for HIV	12	3%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was a public clinic or community health center (54%) followed by a private clinic or doctor's office (21%). Likewise, locations of ongoing care were a public clinic or community health center (65%) followed by a private clinic or doctor's office (21%). A total of 15 (3%) of survey respondents with a mental health symptom received care most often from the Veteran's Administration Hospital.

TABLE 11.19: KNOWLEDGE OF CASE MANAGER, PLWHA WITH MENTAL HEALTH SYMPTOMS

Case Manager	N	%
Yes	311	69%
No	75	17%
Don't Know	66	15%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (69%) of survey respondents with a mental health symptom reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services; 17% said they did not have such a person assisting them, and 15% didn't know.

Health Status

TABLE 11.20: SELF-REPORTED HEALTH STATUS, PLWHA WITH MENTAL HEALTH SYMPTOMS

How would you describe your health overall	N	%
Excellent	51	11%
Good	175	39%
Fair	172	38%
Poor	51	11%
During the past month, has your physical health interfered with normal activities?	**N**	**%**
No	126	28%
Yes – Some of the time	266	59%
Yes – all of the time	58	13%

** Percentages may not add up to 100% due to rounding or missing survey responses.

TABLE 11.21: ER OR HOSPITAL VISITS, PLWHA WITH MENTAL HEALTH SYMPTOMS

	N	%
ER visit in past 6 months	165	37%
Hospital stay in past 6 months	116	26%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 11% said “Excellent,” 39% said “Good,” 38% said “Fair” and 11% said “Poor.” More than half (59%) of survey respondents with a mental health symptom reported that during the past month, their physical health had interfered with normal activities some of the time. Fifty eight (13%) said their physical health interfered all of the time.

For the 6 months prior to the survey, 37% of survey respondents with a mental health symptom reported an emergency room visit and 26% reported being admitted to a hospital for one or more nights.

TABLE 11.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, PLWHA WITH MENTAL HEALTH SYMPTOMS

Symptoms during past month Avg = 5	N	%
Trouble with thinking, concentrating or memory	284	63%
Depressed or sad, trouble thinking	368	81%
Aches, fatigue, lightheadedness, weak all over	249	55%
Fevers, chills, sweats	160	35%
Poor appetite, weight loss	173	38%
Trouble with eyes or ears	196	43%
Trouble with nose or sinuses, headaches	182	40%
Trouble with mouth or swallowing	96	21%
Nausea, vomiting, diarrhea, abdominal pain	181	40%
Coughing, wheezing, or chest pain, trouble breathing	142	31%
Rash, itch, herpes, or other skin trouble	124	27%
Numbness, tingling or pain in an arm or leg	198	44%
Other	2	0%
None	14	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The maximum number of symptoms during the past month was 12, with an average of 5 symptoms. The top three reported symptoms were depressed or sad, trouble thinking (81%), trouble with thinking, concentrating or memory (63%) and aches, fatigue, lightheadedness, weak all over (55%).

TABLE 11.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, PLWHA WITH MENTAL HEALTH SYMPTOMS

First CD4/T-cell	N	%
Less than 50	49	11%
50-99	14	3%
100-199	39	9%
200-349	76	17%
350-499	73	16%
500+	89	20%
Don't Know/Can't Remember	108	24%

Current CD4/T-cell	N	%
Less than 50	26	6%
50-99	15	3%
100-199	49	11%
200-349	85	19%
350-499	66	15%
500+	94	21%
Don't Know/Can't Remember	114	25%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of 89 (20%) of survey respondents with a mental health symptom reported their first CD4/T-cell counts as 500+; 33% were 200 to 499, 12% were 50 to 199, and 11% were less than 50. Current CD4/T-cell counts were 500+ for 25%; 200 to 499 for 34%, 50 to 199 for 14%, and less than 50 for 6%. Almost a fourth (24%) didn't know or couldn't remember their first CD4/T-cell count, and 25% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 11.24: HIV MEDICATIONS, PLWHA WITH MENTAL HEALTH SYMPTOMS

Currently taking HIV meds	N	%
Yes	315	70%
No	135	30%
How many pills do you take in one day?	Avg = 5	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (70%) respondents with a mental health symptom said they were taking HIV medications. The number of pills taken in one day ranged from 1 to 28, with an average of 5 pills per day.

TABLE 11.25: SELF-REPORTED MEDICATION ADHERENCE, PLWHA WITH MENTAL HEALTH SYMPTOMS

Medication adherence	N	%
I have not missed any doses in the past month	147	33%
Missed a few, but took nearly all	135	30%
Took more than half	14	3%
About half	11	2%
Some, but not half	16	4%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	285	63%
No	119	26%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among survey respondents with a mental health symptom currently taking HIV medications, 33% reported perfect adherence and 30% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 63% said "Yes" and 26% said "No."

TABLE 11.26: REASONS FOR NOT TAKING HIV MEDICATIONS, PLWHA WITH MENTAL HEALTH SYMPTOMS

Reasons for not taking HIV medications	N	%
Side effects	20	4%
Not effective	4	1%
Too difficult to take as prescribed	8	2%
No doctor has offered them	12	3%
I choose not to take them	27	6%
Doctor did not think it was a good idea for me	26	6%
T-cell too high	44	10%
Cannot pay	12	3%
Confidentiality concerns	11	2%
Didn't feel sick	3	1%
Have not seen doctor	10	2%
Other	3	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "T-cells too high" (10%) followed by "doctor did not think it was a good idea for me" (6%), and "I choose not to take them" (6%).

TABLE 11.27: MEDICATIONS FOR NON-HIV CONDITIONS, PLWHA WITH MENTAL HEALTH SYMPTOMS

How many pills do you take in one day for non-HIV conditions?	N	%
	Avg = 4	
Diabetes	39	9%
High blood pressure	135	30%
High cholesterol	66	15%
Depression/emotional problems	258	57%
Eye drops/glaucoma	1	0%
Acid reflux	20	4%
Anemia	2	0%
Sleep	15	3%
Allergies/Sinus	8	2%
Pain	18	4%
Antibiotics	3	1%
Arthritis	4	1%
Asthma	8	2%
Neuropathy	13	3%
Nausea	0	0%
Hormones	3	1%
Other	3	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, survey respondents with a mental health symptom took an average of 4 non-HIV pills per day (maximum of 45). The most common conditions associated with the non-HIV pills were depression/emotional problems (57%), high blood pressure (30%), and high cholesterol (15%).

TABLE 11.28: TOTAL PILL BURDEN AND ABILITY TO PAY, PLWHA WITH MENTAL HEALTH SYMPTOMS

Total Pills (HIV + non-HIV)	Avg = 8	
How often do you have trouble paying for these or other non-HIV meds?	**N**	**%**
Never	243	54%
Less than half the time	58	13%
More than half the time	42	9%
Always	74	16%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was 8.

More than half (54%) of survey respondents with a mental health symptom reported never having problems paying for HIV or non-HIV medications, and 13% had problems less than half the time. Forty-two (9%) had problems more than half the time, and 16% said they always had problems paying for their medications.

Comorbidities

TABLE 11.29: HEPATITIS C AND TB STATUS, PLWHA WITH MENTAL HEALTH SYMPTOMS

Hep C Test?	N	%
Yes	362	80%
No	66	15%
Don't Know	23	5%
Positive for Hep C?	**N**	**%**
Yes	137	30%
No	270	60%
Don't know	45	10%

TB skin test?	N	%
Yes	406	90%
No	40	9%
Result	**N**	**%**
Positive	73	16%
Negative	313	69%
Don't Know	16	4%
History of active TB?	**N**	**%**
Yes	68	15%
No	374	83%
Don't Know	9	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (80%) of survey respondents with a mental health symptom reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 30% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

Likewise, most (90%) respondents had received a skin test for TB, and 16% reported a positive result. A total of 68 (15%) reported a history of active TB.

Mental Health

TABLE 11.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, PLWHA WITH MENTAL HEALTH SYMPTOMS

Symptoms in past month	N	%
Serious anxiety/tension	334	74%
Hallucinations	79	17%
Serious thoughts of suicide	88	19%
Attempted suicide	25	6%
Wanted to hurt or harm yourself	76	17%
Wanted to hurt or harm someone else	74	16%
Trouble controlling anger leading to physical violence	126	28%
Problems requiring meds	213	47%
At least one serious indicator (suicide/homicidal or requiring meds)	217	48%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly experienced symptoms were serious anxiety/tension (74%), problems requiring medications (47%) and trouble controlling anger leading to physical violence (28%).

TABLE 11.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, PLWHA WITH MENTAL HEALTH SYMPTOMS

Since being diagnosed, ever talked with therapist?	N	%
Yes	353	78%
No	99	22%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	352	78%
No	100	22%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	250	55%
No	198	44%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 78% of survey respondents with a mental health symptom said they had talked with a therapist or psychologist for help with depression or emotional problems, 78% had talked to a doctor or psychiatrist for medications and 55% said they had participated in a support group.

Substance Use & Abuse

TABLE 11.32: SUBSTANCE USE, PLWHA WITH MENTAL HEALTH SYMPTOMS

Total Number of substances Avg = 2	**N**	**%**
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	27	6%
Street Methadone (non-treatment)	6	1%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	26	6%
Barbituates (seconal, tuinal, downers)	8	2%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	35	8%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	3	1%
Amphetamines (speed, uppers, crystal meth, ice, glass)	23	5%
Marijuana, Hashish (grass, weed)	127	28%
Heroin	8	2%
Cocaine (powder), Crack	142	31%
Ecstasy, X, MDA, GHB	17	4%
Ketamine (K, Special K)	6	1%
None	208	46%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, 54% of survey respondents with a mental health symptom reported using at least one substance during the past year. The numbers of substances ranged from 1 to 12, with an average of 2. The most commonly used substances were cocaine (31%) and marijuana (28%).

TABLE 11.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, PLWHA WITH MENTAL HEALTH SYMPTOMS

In the last year, ever drunk more than meant to?	N	%
Yes	155	34%
No	296	65%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	154	34%
No	290	64%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	139	31%
No	311	69%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	160	35%
No	288	64%
Indicator of Alcohol Abuse	189	42%
Indicator of Substance Abuse	167	37%
Abuse of both drugs and alcohol	119	26%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 42% of survey respondents with a mental health symptom indicated possible alcohol abuse, and 37% indicated possible substance abuse. A total of 119 (26%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 11.34: SOCIAL SUPPORT, PLWHA WITH MENTAL HEALTH SYMPTOMS

Of all the people you feel close to, how many have you told about being HIV+?	N	%
All	151	33%
Some	245	54%
None	53	12%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	348	77%
No	103	23%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 33% had disclosed their HIV status to all and 54% had disclosed their status to some. A total of 53 (12%) had not told their HIV status to any of the people to whom they feel close. Overall, 77% of survey respondents with a mental health symptom said there were people they could depend on for help if really needed; however, 103 (23%) said they did not have anyone to depend on.

Housing

TABLE 11.35: HOUSING STATUS, PLWHA WITH MENTAL HEALTH SYMPTOMS

Where do you most often sleep?	N	%
Apartment/House	334	74%
Group home/halfway house	50	11%
Shelter	29	6%
Street	38	8%
Other	1	0%
Do you feel your housing situation is stable?	**N**	**%**
Yes	267	59%
No	185	41%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Most (74%) reported sleeping most often in an apartment/house. Others reported group home/halfway house (11%), shelter (6%), street (8%) and other (<1%) locations. More than half (59%) felt their housing situation was stable, and 41% felt their housing situation was unstable.

TABLE 11.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, PLWHA WITH MENTAL HEALTH SYMPTOMS

In the past year, has your housing situation made it difficult to get HIV care	N	%
Yes	139	31%
No	311	69%
Reasons	**N**	**%**
I could not keep my status private	37	8%
No place to store meds	36	8%
Money for food	73	16%
Money for rent	72	16%
Money for utilities	55	12%
Money for household supplies	64	14%
No stable address	6	1%
Used money on drugs	1	0%
Rules	2	0%
Lack of transportation	0	0%
No child care	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of 139 (31%) respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The most common reasons for these difficulties were the needing to use money for food (16%), rent (16%), household supplies (14%) or utilities (12%).

ACCESS TO CORE SERVICES

TABLE 11.37: ACCESS TO CORE SERVICES, PLWHA WITH MENTAL HEALTH SYMPTOMS

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	122	27%	307	68%	23	5%
HIV/AIDS Medications	115	25%	267	59%	70	15%
Dentist Visits	160	35%	209	46%	83	18%
Medical Case Management	97	21%	268	59%	87	19%
Home Health Care	60	13%	70	15%	322	71%
Psychiatric Services or Medicine	81	18%	250	55%	121	27%
Psychological Counseling	71	16%	246	54%	135	30%
Substance Abuse Treatment	40	9%	130	29%	282	62%
Rehabilitation Services	50	11%	99	22%	303	67%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For all survey respondents with at least one mental health symptom, the top three "easy to get" core services were primary medical care (68%), HIV/AIDS medications (59%) and medical case management (59%). The top three core services that respondents reported "some difficulty getting" were dentist visits (35%), primary medical care (27%) and HIV/AIDS medications (25%). The presence of primary medical care and HIV/AIDS medications on both the "easy to get" and "some difficulty getting" lists is due to the fact that they are the two most accessed services. Conversely, the three core services that survey respondents with a mental health symptom said they "did not need" in the past year were home health care (71%), rehabilitation services (67%) and substance abuse treatment (62%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 11.38: ACCESS TO SUPPORTIVE SERVICES, PLWHA WITH MENTAL HEALTH SYMPTOMS

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service, but feel it is useful/helpful	%*
Child Care Services	26	6%	5	1%	3	1%
Child Welfare Services	4	1%	2	0%	1	0%
Day/Respite Care for Adults	6	1%	4	1%	6	1%
Developmental	3	1%	0	0%	1	0%
Emergency Financial Assistance	163	36%	52	12%	17	4%
Employment Assistance	80	18%	14	3%	10	2%
Food Bank	82	18%	138	31%	10	2%
HIV Education for HIV+ Individuals	28	6%	57	13%	5	1%
Rental Assistance/Shelter Vouchers	111	25%	38	8%	12	3%
Housing-Related Services	113	25%	32	7%	20	4%
Legal Services	52	12%	37	8%	18	4%
Nutritional Counseling	36	8%	43	10%	5	1%
Permanency Planning	13	3%	10	2%	6	1%
Referrals to Services	37	8%	36	8%	6	1%
Referrals to Clinical Research	28	6%	14	3%	4	1%
Support Groups	55	12%	50	11%	11	2%
Translation/Interpretation	2	0%	2	0%	0	0%
Transportation	96	21%	71	16%	7	2%
Household Items	55	12%	14	3%	1	0%

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For survey respondents with a mental health symptom, the supportive services that were selected most often (thus implying high helpfulness/usefulness) were emergency financial assistance, food bank, transportation, housing related services and rental assistance/shelter vouchers. The top five “easy to get” supportive services (based on number of responses) were food bank (n=138), transportation (n=71), HIV education for

HIV+ individuals (n=57), emergency financial assistance (n=52), and support groups (n=50). The top five supportive services that respondents reported "some difficulty getting" were emergency financial assistance (n=163), housing related services (n=113), rental assistance/shelter vouchers (n=111), transportation (n=96), and food bank (n=82). The presence of certain services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates. Conversely, services not needed in the past year, but still identified as useful/helpful were housing related services (n=20), legal services (n=18), emergency financial assistance (n=17), rental assistance/shelter vouchers (n=12), and support groups (n=11). ["n=*value*" indicates the number of responses for each service category.]

Barriers Reported per Core Service Category

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among survey respondents with at least one mental health symptom, the three core services with the highest number of barriers were dentist visits (n=297), primary medical care (n=249) and HIV/AIDS medications (n=196). Within dentist visits, the most common barriers were "I would have to wait too long to get the services" (n=55) and "It's hard to make or keep appointments" (n=55). For primary medical care, the most common barriers were "It's hard to make or keep appointments" (n=43) and "It's hard for me to get there" (n=43).

The barriers experienced most often by all survey respondents with a mental health symptom across all core services were "It's hard to make or keep appointments" (n=212), "I don't know where to get the services" (n=205), and "I would have to wait too long to get the services" (n=181).

TABLE 11.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, PLWHA WITH MENTAL HEALTH SYMPTOMS

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Primary Medical Care	17	20	**28**	18	6	6	22	**43**	**43**	7	19	1	8	6	0	0	3	2	0	0	0	0	**249**
HIV/AIDS Medications	11	**20**	**29**	**37**	13	8	15	17	19	6	7	2	3	5	0	0	3	1	0	0	0	0	**196**
Dentist Visits	21	**38**	**55**	20	10	13	17	**55**	32	5	8	0	2	15	0	0	1	4	1	0	0	0	**297**
Medical Case Management	14	**30**	17	8	7	7	**21**	**27**	15	2	9	0	6	0	0	1	0	2	0	4	0	0	**170**
Home Health Care	5	**18**	5	4	**13**	**10**	6	5	6	1	4	1	3	0	0	0	1	1	6	0	0	0	**89**
Psychiatric Services or Medicine	10	**20**	**22**	15	12	7	18	**26**	18	4	6	1	1	0	0	0	3	0	0	0	0	0	**163**
Psychological Counseling	9	**24**	11	14	7	10	10	**21**	15	3	6	0	1	0	1	0	3	1	0	0	0	0	**136**
Substance Abuse Treatment	7	**14**	**8**	7	5	5	5	6	**9**	2	6	1	6	0	0	0	0	1	0	0	0	0	**82**
Rehabilitation Services	7	**21**	6	6	8	6	4	**12**	**10**	1	6	1	0	0	0	0	0	1	0	0	1	0	**90**
Total	**101**	**205**	**181**	**129**	**81**	**72**	**118**	**212**	**167**	**31**	**71**	**7**	**30**	**26**	**1**	**1**	**14**	**13**	**7**	**4**	**1**	**0**	**1,472**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Barriers Reported per Supportive Service Category

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among survey respondents with at least one mental health symptom, the five supportive services with the highest number of barriers were emergency financial assistance (n=308), housing related services (n=203), rental assistance/shelter vouchers (n=193), transportation (n=162), and food bank (n=138). Within emergency financial assistance, the most commonly reported barriers were "I would have to wait too long to get the services," "I don't know where to get the services," and "I was told I am not eligible for this service." For housing related services, the most common barriers were "I don't know where to get the services," and "I would have to wait too long to get the services."

The barriers experienced most often by all survey respondents with a mental health symptom across all supportive services were "I don't know where to get the services," and "I would have to wait too long to get the services."

TABLE 11.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, PLWHA WITH MENTAL HEALTH SYMPTOMS

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Child Care Services	**9**	**12**	6	6	5	4	1	2	**8**	5	2	0	0	0	0	0	0	0	0	0	1	0	**61**
Child Welfare Services	1	2	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**6**
Day/Respite Care for Adults	**2**	**2**	1	0	1	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	**9**
Developmental Assessment	0	1	2	0	0	1	0	1	1	1	1	0	0	0	0	1	1	0	0	0	0	0	**10**
Emergency Financial Assistance	25	**51**	**59**	9	**47**	23	19	28	14	4	7	1	7	2	0	0	1	3	1	0	7	0	**308**
Employment Assistance	**12**	**35**	9	1	8	8	5	7	10	1	10	1	**15**	0	0	2	2	0	1	0	1	0	**128**
Food Bank	16	**28**	12	4	13	12	4	4	**26**	0	3	0	1	0	0	0	1	0	3	0	11	0	**138**
HIV Education for HIV+ Individuals	**5**	**14**	3	3	1	1	0	**7**	**5**	0	4	3	1	0	1	0	1	1	0	0	0	0	**50**
Rental Assistance/Shelter Vouchers	11	**31**	**33**	10	**20**	16	15	**20**	8	2	2	0	5	2	1	1	2	0	4	1	8	1	**193**
Housing-Related Services	14	**41**	**38**	10	**21**	15	6	13	12	3	3	0	15	1	0	0	0	1	4	0	6	0	**203**
Legal Services	**8**	**22**	**10**	6	6	2	4	**8**	4	0	3	4	1	1	0	0	1	0	1	1	0	0	**82**
Nutritional Counseling	3	**16**	**6**	3	3	3	2	**9**	**6**	0	2	0	0	1	0	0	0	0	0	0	0	0	**54**
Permanency Planning	1	8	3	3	1	2	2	2	1	0	0	0	0	0	0	0	0	1	0	0	0	0	**24**
Referrals to Services	5	**15**	**6**	4	2	5	**8**	5	**6**	0	2	0	0	1	0	0	0	0	2	0	0	0	**61**
Referrals to Clinical Research	4	**18**	3	0	**5**	**5**	0	1	3	0	1	0	0	0	0	0	0	0	0	0	0	0	**40**
Support Groups	**7**	**32**	4	1	2	**7**	2	5	**11**	2	3	0	1	0	0	0	0	1	1	0	1	0	**80**
Translation/Interpretation	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	**2**
Transportation	15	**34**	**17**	11	14	6	9	**17**	**19**	2	3	0	1	5	0	0	2	1	2	0	3	1	**162**
Household Items	**8**	**31**	6	5	**8**	5	3	3	7	0	0	0	0	0	0	1	1	1	0	0	0	0	**79**
Total	**146**	**393**	**220**	**77**	**157**	**115**	**81**	**132**	**141**	**22**	**47**	**10**	**47**	**13**	**2**	**5**	**12**	**9**	**19**	**2**	**38**	**2**	**1,690**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions					
A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

Risk Behaviors

TABLE 11.41: VERY HIGH RISK OF HIV TRANSMISSION VARIABLES, PLWHA WITH MENTAL HEALTH SYMPTOMS (N=452)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of All with Mental Health Needs Reporting Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	44	270	6	10%	56	7%
Anonymous Sex Partner(s)	104	198	N/A	23%	141	18%
Greater than 5 Sex Partners	46	402	N/A	10%	60	8%

Of those who reported an indicator of mental health needs, 44 (10%) reported that they had engaged in sex for drugs or money in the past 6 months, while 56 (7%) of all respondents reported this risk factor. One hundred four (23%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 141 (18%) of all respondents. Forty-six (10%) of those reporting an indicator of mental health needs surveyed reported that they had more than 5 sex partners in the past 6 months, while 60 (8%) of all respondents reported that they had more than 5 sex partners.

TABLE 11.42: HIGH RISK OF HIV TRANSMISSION VARIABLES, PLWHA WITH MENTAL HEALTH SYMPTOMS (N=452)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of All with Mental Health Needs Reporting Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	155	159	N/A	34%	235	31%
Shared Injecting Equipment	9	30	N/A	2%	12	2%
Serodiscordant Sex Partner(s)	66	204	46	15%	111	15%

Of those reporting an indicator of mental health needs surveyed, 155 (34%) reported that they had unprotected sex at least some of the time, while 235 (31%) of the entire sample reported this risk factor. Nine (2%) of those reporting an indicator of mental health needs surveyed reported that they had shared injecting equipment at least some of the time, compared with 12 (2%) of the total sample reporting this risk factor. Sixty-six (15%) of those reporting an indicator of mental health needs reported that they had an HIV-negative sex partner, while 111 (15%) of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

RECENTLY RELEASED

Overview

There were 119 total recently released respondents to the 2008 Need Assessment consumer survey. This total represents 16% of the total 764 survey respondents.

Demographics

TABLE 12.1: GENDER, PREGNANCY STATUS AND AGE, RECENTLY RELEASED

Gender	N	%
Male	82	69%
Female	30	25%
Transgender – Male to Female	7	6%
Pregnant	**N**	**%**
Yes	2	2%
Don't Know	0	0%
Age	**N**	**%**
18-24	6	5%
25-44	71	60%
45+	42	35%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of recently released were male (69%). Seven of the respondents (6%) among this subgroup identified as transgender Male to Female. Among females, 2% said they were pregnant at the time of the survey, and none said they did not know their pregnancy status. More than half of recently released respondents were above the age of 25; approximately 60% were between the ages of 25-44, and another 35% were above the age of 45. A smaller percentage (5%) were youth between the ages of 18 and 24.

TABLE 12.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, RECENTLY RELEASED

Race/Ethnicity	N	%
White/Anglo	24	20%
Black/African-American	80	67%
Latino/Hispanic	11	9%
Asian	0	0%
Native American	0	0%
Multiracial	4	3%

Sexual Orientation	N	%
Straight/Heterosexual	64	54%
Gay/Lesbian	34	29%
Bisexual	12	10%
Undecided	2	2%
Prefer not to say	7	6%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of recently released identified as Black/African-American (67%). Twenty percent identified as White/Anglo, 9% as Latino/Hispanic, and 3% as multiracial. No respondents from this subgroup identified as Asian or Native American.

The majority (54%) of all recently released respondents identified as straight or heterosexual. About 34% identified as gay/lesbian, 10% as bisexual and 2% as undecided. Seven respondents (6%) said they preferred not to disclose their sexual orientation.

TABLE 12.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, RECENTLY RELEASED

Education	**N**	**%**
Less than high school	33	28%
High school degree/GED	75	63%
College degree	10	8%
Graduate/Professional degree	0	0%
Some technical training	1	1%
None	0	0%
Are you eligible for veteran benefits?	**N**	**%**
Yes	7	6%
No	108	91%
Don't Know	4	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (91%) of recently released respondents had a high school degree/GED or less. Eight percent had a college degree, 1% had some technical training, and none had a graduate/professional degree. None of the recently released respondents reported that they had received no education.

Approximately 6% of recently released respondents indicated being eligible for veteran benefits.

Immigration Status & Primary Language

TABLE 12.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, RECENTLY RELEASED

	N	**%**
Born outside U.S.	8	7%
Length of residency	Avg = 22 yrs	
Immigration status	**N**	**%**
Citizen	112	94%
Permanent Resident	3	3%
Visa	0	0%
Undocumented	4	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

As a whole, foreign-born recently released represented 7% of all recently released respondents. Among the foreign born, lengths of residency in the U.S. ranged from 6 to 45 years with an average residency of 22 years.

Among all recently released respondents, 94% were U.S. citizens. Approximately 3% were permanent residents, 3% were undocumented, and none were visa holders.

TABLE 12.5: PREFERRED LANGUAGE, RECENTLY RELEASED

Preferred language at home with family/friends	N	%
English	110	92%
Spanish	4	3%
English/Spanish	3	3%
Other	2	2%
Preferred language when seeing a doctor	**N**	**%**
English	110	92%
Spanish	4	3%
English/Spanish	3	3%
Other	2	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by recently released respondents. Approximately 92% said they were most comfortable speaking English both at home with family/friends and with their doctor. Approximately 3% were most comfortable speaking Spanish and 3% preferred a combination of English and Spanish with their doctor. In addition, 2% of recently released respondents preferred to speak some other language when seeing a doctor.

Job Status & Income

TABLE 12.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, RECENTLY RELEASED

Job status	N	%
Unemployed	60	50%
Not working due to disability	45	38%
Part time	5	4%
Temporary/contract/odd jobs	5	4%
Full time	4	3%
Retired	0	0%
Average monthly income during past 6 months	Range = $0 to $1,400; Avg = $332.52	
Approximate yearly income	**N**	**%**
Up to 300% FPL (2007 – 2008)	119	100%
Up to 200% FPL (2007 - 2008)	119	100%
Up to 100% FPL (2007 - 2008)	111	93%
Total income dependents	Range = 1 to 5; Avg = 1	
Income dependents under 18	0 to 4	Avg = .2

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately 11% of all recently released respondents were employed at the time of the survey. Half were unemployed, 38% were not working due to disability, and none were retired. Among those employed, 3% were working full-time, 4% part-time and 4% had temporary/contract/odd jobs.

Per-month incomes ranged from $0 to $1,400, with an average of $333 per month. The number of dependents per income ranged from 1 to 5 (average 1), with an average of less than 1 being under the age of 18. Based on estimated yearly incomes and household sizes, nearly all recently released respondents fell within 100% of the 2007-2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 12.7: SOURCES OF INCOME ASSISTANCE, RECENTLY RELEASED

Sources of income assistance	N	%
None	50	42%
SSI	33	28%
SSDI	19	16%
Food Stamps	9	8%
Rental Subsidy/Section 8	7	6%
Hourly wages/Salary	4	3%
Social Security	4	3%
TANF/AFDC	2	2%
Private Disability	2	2%
VA Benefits	1	1%
Family/friends	1	1%
Pension/Retirement/Savings	1	1%
Workers Comp	0	0%
Unemployment	0	0%
Private Disability	2	2%
Child support	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among recently released survey respondents were Supplemental Security Income (SSI) (28%), Social Security Disability Insurance (SSDI) (16%) and food stamps (8%). No survey respondents received worker's compensation.

Forty-two percent of all recently released respondents reported no source of income.

Paying for Medical Care

TABLE 12.8: SOURCES OF PAYMENT FOR MEDICAL CARE, RECENTLY RELEASED

Paying for medical care	N	%
Gold Card/County	46	39%
Medicaid	39	33%
Medicare	18	15%
Other	16	14%
I don't receive medical care because I can't pay for it	12	10%
VA	4	3%
Self-Pay	4	3%
Private insurance/COBRA	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

According to the Centralized Patient Care Data Management System (CPCDMS), 6,961 clients paid for primary medical care using Ryan White funding resources. Among recently released respondents, the Gold card/county (39%), Medicaid (33%) and Medicare (15%) were the most common methods of paying for medical care.

Approximately 14% of all recently released respondents reported other resources. Ten percent of recently released respondents said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it. The Harris County Gold Card program assists eligible low-income residents with medical expenses and prescriptions.

HIV Testing & Diagnosis History

TABLE 12.9: LENGTH OF HIV DIAGNOSIS, RECENTLY RELEASED

Length of diagnosis	N	%
Less than 1 year	0	0%
1-4 years	38	33%
5-10 years	28	24%
11-15 years	31	26%
16-20 years	12	10%
21 and over	8	7%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of recently released respondents reported being diagnosed as HIV positive between 1 and 4 years.

TABLE 12.10: LOCATION OF HIV DIAGNOSIS, RECENTLY RELEASED

Location of diagnosis	N	%
Jail/Prison	39	33%
Public or community clinic	22	18%
In hospital stay	11	9%
HIV-specific testing site	11	9%
Private doctor	9	8%
Community testing location	10	8%
Alcohol or drug treatment facility	9	8%
ER	6	5%
Blood/Plasma donation	1	1%
Other	1	1%
Work/insurance related	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (33%) of recently released respondents received their diagnoses at a jail or prison. Other common diagnosis locations for overall respondents were public or

community clinics (18%), in a hospital stay (9%) or at an HIV-specific testing site (9%).

TABLE 12.11: REASONS FOR HIV TESTING, RECENTLY RELEASED

Reasons for testing	N	%
Engaged in risky behavior	36	30%
Felt sick	28	24%
Was in prison/jail	24	20%
Had sex with someone HIV+	19	16%
Recommended by provider	18	15%
ER/Hospital stay	11	9%
Routine check up/testing	9	8%
During pregnancy care	3	3%
Other	3	3%
Blood/plasma donation	2	2%
Incentive offered	1	1%
Work/insurance related	0	0%
Partner notification	0	0%
Knew someone with HIV	0	0%
Rape survivor	0	0%
In drug treatment program	0	0%
Recommended by friends	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were due to engaging in risky behavior (30%) and feeling sick (24%). Other common reasons included being in jail/prison (20%), having sex with someone who is HIV positive (16%), or because it was recommended by a provider (15%).

TABLE 12.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, RECENTLY RELEASED

Assistance at diagnosis	N	%
Information about HIV/AIDS	66	55%
Medical services	58	49%
Counseling	47	39%
None	32	27%
Help with food or shelter	18	15%
Alcohol or drug treatment services	16	13%
Other	1	1%
Supportive Services	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis to recently released respondents were information about HIV/AIDS (55%), medical services (49%) and counseling (39%). Less frequently reported were help with food or shelter (15%) and alcohol or drug treatment services (13%). A total of thirty-two respondents (27%) from this subgroup reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 12.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, RECENTLY RELEASED

Time to first doctor visit	N	%
Less than 1 month	45	38%
1-6 months	33	28%
6-12 months	14	12%
More than 12 months	20	17%
Never	7	6%

Time to CD4/Viral Load	N	%
Less than 1 month	36	30%
1-6 months	38	32%
6-12 months	12	10%
More than 12 months	25	21%
Never	8	7%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (38%) of all recently released respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 28% of recently released respondents, 1 to 6 months passed before seeing a doctor. Fourteen respondents (12%) waited between 6 to 12 months, and 17% waited more than a year to see a doctor for HIV. A total of seven (6%) of all recently released respondents said they still had not seen a doctor for HIV. Likewise, 30% reported receiving their first CD4/viral load test within one month of being diagnosed, 32% within 1-6 months, 10% between 6-12 months and 21% waited more than a year. A total of eight respondents (7%) said they had never received a CD4 or viral load test.

TABLE 12.14: REASONS FOR DELAYED ENTRY INTO CARE, RECENTLY RELEASED

Reasons for waiting more than 6 months	N	%
Afraid	23	19%
Depressed/emotional problems	22	18%
Denial	19	16%
Doing drugs	17	14%
Jail/prison	13	11%
No stable place to live	11	9%
Didn't feel sick	11	9%
Didn't want to take meds	8	7%
No money	6	5%
Other	2	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were due to fear (19%), depression/emotional problems (18%), denial (16%) and drug use (14%).

Maintenance in Care

TABLE 12.15: TIME SINCE LAST VISIT TO DOCTOR & VIRAL LOAD & CD4 & HIV MEDICATION PRESCRIPTION, RECENTLY RELEASED

Last visit to doctor for HIV	N	%
Less than 6 months	92	77%
6-12 months	10	8%
More than 12 months	11	9%
Never/Don't Know	5	4%
Last viral load	**N**	**%**
Less than 6 months	86	72%
6-12 months	13	11%
More than 12 months	9	8%
Never/Don't Know	10	8%

Last CD4	N	%
Less than 6 months	86	72%
6-12 months	13	11%
More than 12 months	9	8%
Never/Don't Know	10	8%
Last HIV meds prescription	**N**	**%**
Less than 6 months	70	59%
6-12 months	12	10%
More than 12 months	10	8%
Never/Don't Know	25	21%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of recently released respondents said their most recent doctor's visit (77%), viral load (72%), CD4 test (72%) and HIV medication prescription (59%) were within the past 6 months.

TABLE 12.16: FREQUENCY OF DOCTOR'S VISITS, RECENTLY RELEASED

No doctor visits more than 6 months?	N	%
Yes	65	56%
No	52	44%
No doctor visits more than 12 months?	**N**	**%**
Yes	38	32%
No	70	59%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Table 12.16 above outlines the number and percentage of respondents who did not visit a doctor for over 6 months or more since being diagnosed. Among recently released respondents who have seen a doctor for HIV, over half (56%) reported a period of not seeing a doctor for at least 6 months. Of the respondents who did not see a doctor for at least 6 months, 32% reported not seeing a doctor for 12 months or more.

TABLE 12.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, RECENTLY RELEASED

Reasons for no doctor visits	N	%
Doing drugs	32	27%
Lost stable housing	20	17%
Did not want to take meds	15	13%
Denial	13	11%
Worried about side effects	12	10%
Felt fine	10	8%
Bad experience with provider	7	6%
Lost my job	7	6%
Other	7	6%
Jail/prison	5	4%
Doctor left	3	3%
Lost health insurance	3	3%
Tired of regimen	4	3%
Depression/emotional barriers	3	3%
No transportation	2	2%
Case manager left	1	1%
Agency closed down	0	0%
Program closed down	0	0%
Had to care for children/family member	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Table 12.17 above provides an outline of supplementary responses to the previous table and outlines the specific reasons reported for not visiting a doctor for more than 6 months among this subgroup. The most frequently reported reasons for falling out of care were drug use (27%), shelter instability (17%), not wanting to take medications (13%) and denial (11%).

TABLE 12.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, RECENTLY RELEASED

First place of care	N	%	Most often location of care	N	%
Public clinic/community health center	52	44%	Public clinic/community health center	70	59%
Prison/jail	28	24%	Prison/jail	22	18%
Private Clinic/Doctor's Office	21	18%	Private Clinic/Doctor's Office	11	9%
ER/Hospital	10	8%	ER/Hospital	3	3%
I have not received care for HIV	5	4%	I have not received care for HIV	6	5%
VA Hospital	3	3%	VA Hospital	6	5%
Other	0	0%	Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was a public clinic/ community health center (44%). Other locations were prison/jail (24%), a private clinic/ doctor's office (18%), an emergency room/hospital (8%), or a VA hospital (3%). Frequent locations for receiving ongoing care were public clinics/community health centers (59%) or private clinics/doctor's offices (18%). A total of three (3%) of all recently released respondents received care most often from the Veteran's Administration Hospital.

TABLE 12.19: KNOWLEDGE OF CASE MANAGER, RECENTLY RELEASED

Case Manager	N	%
Yes	80	67%
No	19	16%
Don't Know	20	17%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (67%) of recently released respondents reported having a case manager, social worker or counselor (such as a specific person at a clinic, hospital or community organization) whose job it is to help them get services to assist in accessing medical-related services. Sixteen percent said they did not have such a person assisting them, and 17% said they didn't know.

Health Status

TABLE 12.20: SELF-REPORTED HEALTH STATUS, RECENTLY RELEASED

How would you describe your health overall	N	%
Excellent	23	19%
Good	39	33%
Fair	45	38%
Poor	11	9%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 19% said "Excellent," 33% said "Good," 38% said "Fair" and 9% said "Poor."

TABLE 12.21: SELF-REPORTED PHYSICAL HEALTH STATUS & ER OR HOSPITAL VISITS, RECENTLY RELEASED

During the past month, has your physical health interfered with normal activities?	N	%
No	45	38%
Yes – Some of the time	48	40%
Yes – all of the time	23	19%
ER visit in past 6 months	49	41%
Hospital stay in past 6 months	33	28%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Approximately 40% of all recently released respondents reported that during the past month, their physical health had interfered with normal activities some of the time. Twenty-three respondents (19%) said their physical health interfered all of the time.

For the 6 months prior to the survey, 41% of all recently released respondents reported an emergency room visit and 28% reported being admitted to a hospital for one or more nights.

TABLE 12.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, RECENTLY RELEASED

Symptoms during past month	N	%
Depressed or sad, trouble thinking	90	76%
Trouble with thinking, concentrating or memory	67	56%
Aches, fatigue, lightheadedness, weak all over	56	47%
Poor appetite, weight loss	49	41%
Nausea, vomiting, diarrhea, abdominal pain	50	42%
Trouble with eyes or ears	51	43%
Trouble with nose or sinuses, headaches	54	45%
Coughing, wheezing, or chest pain, trouble breathing	45	38%
Numbness, tingling or pain in an arm or leg	45	38%
Rash, itch, herpes, or other skin trouble	38	32%
Fevers, chills, sweats	40	34%
Trouble with mouth or swallowing	29	24%
None	5	4%
Other	3	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three reported symptoms were depression or sadness (76%), trouble concentrating or remembering (56%) and aches, fatigue, and lightheadedness (47%).

TABLE 12.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, RECENTLY RELEASED

First CD4/T-cell	N	%
Less than 50	7	6%
50-99	7	6%
100-199	8	7%
200-349	18	15%
350-499	13	11%
500+	29	24%
Don't Know/Can't Remember	36	30%

Current CD4/T-cell	N	%
Less than 50	10	8%
50-99	2	2%
100-199	16	13%
200-349	14	12%
350-499	15	13%
500+	22	18%
Don't Know/Can't Remember	39	33%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, approximately 24% of all recently released respondents reported their first CD4/T-cell counts as 500+; 26% were 200 to 499, 13% were 50 to 199, and 6% were less than 50. Current CD4/T-cell counts were 500+ for 18% of all recently released respondents; 200 to 499 for 25%, 50 to 199 for 15%, and less than 50 for 8% of recently released respondents. Approximately 30% didn't know or couldn't remember their first CD4/T-cell count, and 33% didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 12.24: HIV MEDICATIONS, RECENTLY RELEASED

Currently taking HIV meds	N	%
Yes	84	71%
No	34	29%
How many pills do you take in one day?	Range = 1 to 18; Avg = 5	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Seventy-one percent said they were currently taking HIV medications. The number of pills taken in one day ranged from 1 to 18, with an average of five pills per day.

TABLE 12.25: SELF-REPORTED MEDICATION ADHERENCE, RECENTLY RELEASED

Medication adherence	N	%
I have not missed any doses in the past month	36	30%
Missed a few, but took nearly all	33	28%
Took more than half	0	0%
About half	5	4%
Some, but not half	8	7%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	80	67%
No	28	24%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among recently released respondents currently taking HIV medications, 30% reported perfect adherence and 28% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 67% said "Yes" and 24% said "No."

TABLE 12.26: REASONS FOR NOT TAKING HIV MEDICATIONS, RECENTLY RELEASED

Reasons for not taking HIV medications	N	%
T-cell too high	9	8%
I choose not to take them	8	7%
Cannot pay	7	6%
Side effects	6	5%
Doctor did not think it was a good idea for me	6	5%
Confidentiality concerns	6	5%
No doctor has offered them	4	3%
Didn't feel sick	3	3%
Too difficult to take as prescribed	2	2%
Have not seen doctor	2	2%
Other	2	2%
Not effective	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "T-cell too high" (8%) followed by "I choose not to take them" (7%), "[my] doctor did not think it was a good idea for me" (5%) and "confidentiality concerns" (5%).

TABLE 12.27: MEDICATIONS FOR NON-HIV CONDITIONS, RECENTLY RELEASED

How many pills do you take in one day for non-HIV conditions?	N	%
Depression/emotional problems	52	44%
High blood pressure	22	18%
Asthma	5	4%
Diabetes	4	3%
Acid reflux	4	3%
High cholesterol	4	3%
Neuropathy	3	3%
Hormones	3	3%
Other	3	3%
Sleep	2	2%
Pain	2	2%
Allergies/Sinus	1	1%
Arthritis	1	1%
Eye drops/glaucoma	0	0%
Anemia	0	0%
Antibiotics	0	0%
Nausea	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

In Table 12.27 above, the "N" represents the number of respondents indicating taking pills for associated non-HIV conditions. The most common conditions associated with the non-HIV pills were depression/emotional problems (44%) and high blood pressure.

TABLE 12.28: TOTAL PILL BURDEN AND ABILITY TO PAY, RECENTLY RELEASED

Total Pills (HIV + non-HIV)		Avg = 6
How often do you have trouble paying for these or other non-HIV meds?	**N**	**%**
Never	67	56%
Less than half the time	10	8%
More than half the time	5	4%
Always	27	23%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was six.

Approximately (56%) of all recently released respondents reported never having problems paying for HIV or non-HIV medications, and 8% had problems less than half the time. Approximately 4% had problems more than half the time, and 23% said they always had problems paying for their medications.

Comorbidities

TABLE 12.29: HEPATITIS C AND TB STATUS, RECENTLY RELEASED

Hep C Test?	N	%
Yes	91	76%
No	22	18%
Don't Know	6	5%
Positive for Hep C?	**N**	**%**
Yes	33	28%
No	74	62%
Don't know	12	10%

TB skin test?	N	%
Yes	107	90%
No	74	62%
Result	**N**	**%**
Positive	27	23%
Negative	75	63%
Don't Know	2	2%
History of active TB?	**N**	**%**
Yes	23	19%
No	95	80%
Don't Know	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (76%) of all recently released respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 28% said they were positive for Hepatitis C. The screening test that is readily available for HCV is an antibody test similar to that used for HIV testing. A reactive antibody test is a preliminary positive. To be diagnosed with Hepatitis C, a confirmatory test must be completed. The confirmatory test is one that tests for the presence of hepatitis C virus (HCV-RNA). If there is HCV-RNA found in the blood, a person is diagnosed with hepatitis C.

Likewise, the majority of respondents in this subgroup (90%) had received a skin test for TB and 28% reported a positive result. A total of 23 respondents (19%) reported a history of active TB.

Mental Health

TABLE 12.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, RECENTLY RELEASED

	N	%
At least one mental health condition	79	66%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	55	46%
Problems requiring meds	42	35%
None	40	34%
Trouble controlling anger leading to physical violence	34	29%
Wanted to hurt or harm yourself	26	22%
Hallucinations	22	18%
Serious thoughts of suicide	22	18%
Attempted suicide	9	8%
Wanted to hurt or harm someone else	20	17%
At least one serious indicator (suicide/homicidal or requiring meds)	36	30%

** Percentages may not add up to 100% due to rounding or missing survey responses.

More than half (66%) of all recently released respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The two most equally reported symptoms experienced were serious anxiety or tension (46%), problems requiring medication (35%), trouble controlling anger (29%) and wanting to hurt or harm oneself (22%).

TABLE 12.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, RECENTLY RELEASED

Since being diagnosed, ever talked with therapist?	N	%
Yes	85	71%
No	34	29%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	85	71%
No	34	29%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	64	54%
No	55	64%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 71% of recently released respondents said they had talked with a therapist or psychologist for help with depression or emotional problems and 71% had talked to a doctor or psychiatrist for medications. Approximately 54% said they had participated in a support group since being diagnosed with HIV.

Substance Use & Abuse

TABLE 12.32: SUBSTANCE USE, RECENTLY RELEASED

Total Number of substances	N	%
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	62	52%
Street Methadone (non-treatment)	44	37%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	44	37%
Barbituates (seconal, tuinal, downers)	10	8%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	10	8%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	5	4%
Amphetamines (speed, uppers, crystal meth, ice, glass)	5	4%
Marijuana, Hashish (grass, weed)	4	3%
Heroin	4	3%
Cocaine (powder), Crack	4	3%
Ecstasy, X, MDA, GHB	3	3%
Ketamine (K, Special K)	2	2%
None	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly used substances for all respondents were cocaine (52%) and marijuana (37%).

TABLE 12.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, RECENTLY RELEASED

In the last year, ever drunk more than meant to?	N	%
Yes	52	44%
No	67	56%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	52	44%
No	67	56%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	53	45%
No	66	55%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	63	53%
No	56	47%
Indicator of Alcohol Abuse	62	52%
Indicator of Substance Abuse	65	55%
Abuse of both drugs and alcohol	44	37%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice. 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 52% of all recently released respondents indicated possible alcohol abuse, and 55% indicated possible substance abuse. A total of forty-four respondents (37%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 12.34: SOCIAL SUPPORT, RECENTLY RELEASED

Of all the people you feel close to, how many have you told about being HIV+?	N	%
All	42	35%
Some	61	51%
None	15	13%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	95	80%
No	24	20%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 35% had disclosed their HIV status to all and 51% had disclosed their status to some. Approximately 13% had not told their HIV status to any of the people to whom they feel close. Overall, 80% of recently released respondents said there were people they could depend on for help if really needed.

Housing

TABLE 12.35: HOUSING STATUS, RECENTLY RELEASED

Where do you most often sleep?	N	%
Apartment/House	59	50%
Group home/halfway house	29	24%
Shelter	10	8%
Street	20	17%
Other	1	1%
Do you feel your housing situation is stable?	**N**	**%**
Yes	68	57%
No	51	43%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Half of recently released respondents (50%) reported sleeping most often in an apartment/house. Others reported group home/halfway house (24%), shelter (8%), street (17%) and other (1%) locations. Over half (57%) of all respondents felt their housing situation was stable, and 43% felt their housing situation was unstable.

TABLE 12.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, RECENTLY RELEASED

In the past year, has your housing situation made it difficult to get HIV care?	N	%
Yes	47	39%
No	70	59%
Reasons	**N**	**%**
Money for rent	23	19%
Money for food	22	18%
No place to store meds	19	16%
Money for household supplies	16	13%
No child care	16	13%
I could not keep my status private	16	13%
Money for utilities	9	8%
No stable address	7	6%
Rules	7	6%
Lack of transportation	0	0%
Used money on drugs	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Thirty-nine percent of respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The two most common reasons for these difficulties were due to using money for rent (19%) or food (18%).

ACCESS TO CORE SERVICES

TABLE 12.37: ACCESS TO CORE SERVICES, RECENTLY RELEASED

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	32	27%	79	66%	8	7%
HIV/AIDS Medications	29	24%	73	61%	17	14%
Dentist Visits	41	34%	51	43%	27	23%
Medical Case Management	29	24%	66	55%	24	20%
Home Health Care	16	13%	19	16%	84	71%
Psychiatric Services or Medicine	22	18%	58	49%	39	33%
Psychological Counseling	16	13%	59	50%	44	37%
Substance Abuse Treatment	21	18%	52	44%	46	39%
Rehabilitation Services	12	10%	27	23%	80	67%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For all recently released respondents, the top three “easy to get” core services were primary medical care (66%), HIV/AIDS medications (61%) and medical case management (55%). The core services that respondents reported “some difficulty getting” were dentist visits (34%), primary medical care (27%), as well as HIV/AIDS medications (24%) and medical case management (24%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that recently released respondents said they “did not need” in the past year were home health care (71%), rehabilitation services (67%) and psychological counseling (37%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 12.38: ACCESS TO SUPPORTIVE SERVICES, RECENTLY RELEASED

Service Category	In the past 12 months….				
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service
Child Care Services	3	75%	1	25%	0
Child Welfare Services	2	100%	0	0%	0
Day/Respite Care for Adults	2	40%	2	40%	1
Developmental	0	0%	0	0%	0
Emergency Financial Assistance	33	62%	16	30%	4
Employment Assistance	19	59%	8	25%	5
Food Bank	16	24%	45	67%	6
HIV Education for HIV+ Individuals	9	36%	16	64%	0
Rental Assistance/Shelter Vouchers	23	68%	9	26%	2
Housing-Related Services	36	69%	9	17%	7
Legal Services	10	43%	8	35%	5
Nutritional Counseling	11	46%	12	50%	1
Permanency Planning	2	33%	2	33%	2
Referrals to Services	9	43%	11	52%	1
Referrals to Clinical Research	6	46%	6	46%	1
Support Groups	9	28%	21	66%	2
Translation/Interpretation	0	0%	1	100%	0
Transportation	24	41%	32	55%	2
Household Items	7	44%	6	38%	3

* Percentages based on total number of respondents within each service category.

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For all recently released respondents, the supportive services that were selected most often (thus implying high helpfulness/usefulness) were food bank, emergency financial assistance, transportation, housing-related services and rental assistance/shelter vouchers.

The top five "easy to get" supportive services (based on number of responses) were food bank (n=45), transportation (n=32), support groups (n=21), emergency financial assistance (n=16), and HIV education for HIV positive individuals (n=16). The top five supportive services that respondents reported "some difficulty getting" were housing-related services (n=36), emergency financial assistance (n=33), transportation (n=24), rental assistance/shelter vouchers (n=23), and employment assistance (n=19). The presence of certain support services in both the "easy to get" and "some difficulty getting" lists is a reflection of their high utilization rates. Conversely, the two most commonly reported supportive services that respondents did not need in the past year, but still identified as useful/helpful were housing-related services (n=7) and employment assistance (n=5). ["n=*value*" indicates the number of responses for each service category.]

BARRIERS REPORTED PER CORE SERVICE CATEGORY

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among recently released respondents, the three core services with the highest number of barriers were dentist visits (n=78), primary medical care (n=68), medical case management (n=63). Within dentist visits (the service with the most barriers), the most commonly reported barriers were having to wait too long to get the services (n=14), having a hard time making or keeping appointments (n=13), and the high cost of services (n=11). For primary medical care (the service with the second most common barriers), the most common barriers for recently released respondents were having a hard time getting to the service location (n=45), having a hard time making or keeping appointments (n=9), and fearing that someone will find out about one's status (n=8). For medical case management (the service with the third most common barriers), the most common barriers for recently released respondents were not knowing where to get the services (n=9), having to wait too long to get the service (n=8), and having a hard time making or keeping appointments (n=7).

The barriers experienced most often by all recently released respondents across all core services were having to wait too long to get the service (n=60), not knowing where to get the services (n=56), and the high cost of the services (n=51).

TABLE 12.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, RECENTLY RELEASED

Service Category	Barriers																						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Total
Primary Medical Care	2	4	7	7	1	4	3	**9**	**11**	0	**8**	0	6	0	3	0	1	1	1	0	0	0	**68**
HIV/AIDS Medications	3	**6**	**8**	**9**	2	4	3	1	4	1	2	1	2	0	0	0	1	1	0	0	0	0	**48**
Dentist Visits	5	10	**14**	**11**	2	4	3	**13**	6	0	3	0	4	0	2	0	0	0	1	0	0	0	**78**
Medical Case Management	3	**9**	**8**	6	1	3	6	**7**	4	0	5	0	5	0	0	0	2	0	1	0	3	0	**63**
Home Health Care	1	**6**	2	2	**4**	**5**	0	2	2	0	2	0	3	0	0	0	0	0	0	3	0	0	**32**
Psychiatric Services or Medicine	3	4	**9**	4	2	2	2	**8**	**7**	0	4	0	1	0	0	0	0	1	0	0	0	0	**47**
Psychological Counseling	3	**7**	5	5	3	3	2	**6**	3	0	3	0	1	0	0	0	0	2	0	0	0	0	**43**
Substance Abuse Treatment	4	**6**	5	4	2	2	2	3	5	2	5	0	**6**	0	0	0	0	0	0	0	0	0	**46**
Rehabilitation Services	2	**4**	2	3	2	2	1	3	3	0	**5**	1	0	0	0	0	0	0	0	0	0	0	**28**
Total	**26**	**56**	**60**	**51**	**19**	**29**	**22**	**52**	**45**	**3**	**37**	**2**	**28**	**0**	**5**	**0**	**4**	**5**	**3**	**3**	**3**	**0**	**453**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among all recently released respondents, the five supportive services with the highest number of barriers were emergency financial assistance (n=58), housing-related services (n=49), transportation (n=36), employment assistance (n=35), and rental assistance/shelter vouchers (n=34). Within emergency financial assistance (the service with the most barriers), the most commonly reported barriers were being told that one is not eligible to get the services (n=13), not knowing where to get the services (n=9), having to wait too long to get the services (n=7). For housing-related services (the service with the second most common barriers), the most common barriers for recently released respondents were not knowing where to get the services (n=12), having to wait too long to get the services (n=8), and the high cost of the services (n=6). For transportation (the service with the third most common barriers), the most common barriers for recently released respondents were having a hard time getting to the service location (n=6), not knowing where to get the services (n=5), as well as having to wait too long to get the services (n=4) and the high cost of the services (n=4).

The barriers experienced most often by all recently released respondents across all supportive services were not knowing where to get the services (n=72), having to wait too long to get the services (n=39), and being told that one is not eligible to get the services (n=38).

TABLE 12.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, RECENTLY RELEASED

Service Category	Barriers																				
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	S	T	U	Total
Child Care Services	1	1	1	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	**6**
Child Welfare Services	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	**3**
Day/Respite Care for Adults	1	1	1	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	**5**
Developmental Assessment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Emergency Financial Assistance	3	**9**	**7**	1	**13**	5	4	2	4	0	3	0	5	0	0	0	1	0	0	1	**58**
Employment Assistance	5	**9**	2	0	2	5	1	2	2	0	1	0	**6**	0	0	0	0	0	0	0	**35**
Food Bank	2	**6**	1	1	3	3	1	0	**4**	0	2	0	1	0	1	0	0	2	0	1	**28**
HIV Education for HIV+ Individuals	1	**5**	0	1	1	0	0	2	2	0	3	1	0	0	0	0	0	0	0	0	**16**
Rental Assistance/Shelter Vouchers	0	**7**	2	1	3	4	4	4	2	0	1	0	2	1	0	0	0	1	0	2	**34**
Housing-Related Services	4	**12**	**8**	6	5	4	1	3	2	0	1	0	1	1	0	0	0	1	0	0	**49**
Legal Services	1	1	**3**	1	**3**	0	2	1	1	0	2	2	1	0	0	1	0	0	0	0	**19**
Nutritional Counseling	1	**3**	1	0	0	1	2	2	**3**	0	1	0	0	0	0	0	0	0	0	0	**14**
Permanency Planning	0	**1**	**1**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Referrals to Services	**3**	**1**	**3**	0	0	2	2	2	**4**	0	1	0	0	0	0	0	0	0	0	0	**18**
Referrals to Clinical Research	**2**	**4**	**2**	0	1	1	0	0	1	0	1	0	0	0	0	0	0	0	0	0	**12**
Support Subgroups	**2**	**4**	0	1	1	0	0	0	1	0	1	0	1	0	0	0	0	0	0	1	**12**
Translation/Interpretation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Transportation	3	**5**	4	4	3	2	0	2	**6**	0	2	0	1	2	0	0	0	2	0	0	**36**
Household Items	1	**2**	**3**	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**9**
Total	**30**	**72**	**39**	**17**	**38**	**27**	**18**	**21**	**33**	**1**	**20**	**3**	**18**	**5**	**1**	**1**	**1**	**6**	**0**	**5**	**356**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions

A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 12.41: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), RECENTLY RELEASED (N=119)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of Recently Released Reporting this Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	21	62	3	18%	56	7%
Anonymous Sex Partner(s)	27	49	N/A	23%	141	18%
Greater than 5 Sex Partners	16	101	N/A	13%	60	8%

Of those surveyed who were released from jail or prison (recently released), 21 (18%) reported that they had engaged in sex for drugs or money in the past 6 months, while 56 (7%) of all respondents reported this risk factor. Twenty-seven (23%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 141 (18%) of all respondents. Sixteen (13%) of the recently released surveyed reported that they had more than 5 sex partners in the past 6 months, while 60 (8%) of all respondents reported that they had more than 5 sex partners.

TABLE 12.42: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), RECENTLY RELEASED (N=119)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of Recently Released Reporting this Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	39	45	N/A	33%	235	31%
Shared Injecting Equipment	4	5	N/A	3%	12	2%
Serodiscordant Sex Partner(s)	17	51	16	14%	111	15%

Of those recently released from jail or prison surveyed, 39 (33%) reported that they had unprotected sex at least some of the time, while 235 (31%) of the entire sample reported this risk factor. Four (3%) of those recently released from jail or prison surveyed reported that they had shared injecting equipment at least some of the time, compared with 12 (2%) of the total sample reporting this risk factor. Seventeen (14%) of those recently released from jail or prison reported that they had an HIV-negative sex partner, while 111 (15%) of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

HOMELESS RESPONDENTS

Overview

There were 89 total respondents to the 2008 Need Assessment consumer survey who were homeless. This total represents 12% of the total 764 survey respondents.

Demographics

TABLE 13.1: GENDER, PREGNANCY STATUS AND AGE, HOMELESS

Gender	**N**	**%**
Male	59	66%
Female	30	34%
Transgender	0	0%
Pregnant	**N**	**%**
Yes	2	7%
Don't Know	2	7%
Age Avg = 42	**N**	**%**
18-24	10	11%
25-44	39	44%
45+	40	45%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of homeless survey respondents were men (66%). Women represented 34% of all respondents. None of the homeless respondents identified as transgender Male to Female or Female to Male.

Among women, 7% said they were pregnant at the time of the survey, and 7% said they did not know their pregnancy status.

The average age of homeless respondents was 42 years, ranging from 19 to 64. Virtually all homeless respondents were above the age of 25; approximately 44% of all respondents were between the ages of 25-44, and another 45% were above the age of 45. Only 11% were youth between the ages of 18 and 24.

TABLE 13.2: RACE/ETHNICITY AND SEXUAL ORIENTATION, HOMELESS

Race/Ethnicity	N	%
White/Anglo	18	20%
Black/African-American	64	72%
Latino/Hispanic	4	4%
Asian	0	0%
Native American	2	2%
Multiracial	1	1%

Sexual Orientation	N	%
Straight/Heterosexual	63	71%
Gay/Lesbian	15	17%
Bisexual	6	7%
Undecided	2	2%
Prefer not to say	3	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Almost three-quarters of homeless respondents identified as Black/African-American (72%). Twenty percent identified as White/Anglo, 4% as Latino/Hispanic, and 3% as Native American or multi-racial.

Over two thirds (71%) of all homeless respondents identified as straight or heterosexual. Seventeen percent identified as gay/lesbian, 7% as bisexual and 2% as undecided. Three percent said they preferred not to disclose their sexual orientation.

TABLE 13.3: EDUCATION LEVEL & INCARCERATION HISTORY & VETERAN BENEFITS ELIGIBILITY, HOMELESS

Education	N	%
Less than high school	23	26%
High school degree/GED	58	65%
College degree	4	4%
Graduate/Professional degree	0	0%
Some technical training	4	4%
None	0	0%
During the past year, have you been released from jail or prison?	**N**	**%**
Yes	30	34%
Are you eligible for veteran benefits?	**N**	**%**
Yes	5	6%
No	80	90%
Don't Know	4	4%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Almost two-thirds (65%) of homeless respondents had a high school degree/GED or less. Four percent had a college degree, none of the respondents had a graduate/ professional degree, and 4% had some technical training. None of the respondents reported having no education.

A total of 30 (34%) of all homeless survey respondents reported being released from

jail or prison during the previous year.

PLWHA eligible for veteran benefits represented 6% of all homeless respondents.

Immigration Status & Primary Language

TABLE 13.4: FOREIGN BORN & LENGTH OF RESIDENCY & IMMIGRATION STATUS, HOMELESS

	N	%
Born outside US	4	4%
Length of residency	Avg = 24 yrs	
Immigration status	**N**	**%**
Citizen	87	98%
Permanent Resident	1	1%
Visa	0	0%
Undocumented	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

As a whole, most homeless survey respondents were born in the US. Foreign born homeless respondents represented 4% all respondents. Among the foreign born, lengths of residency in the US ranged from 8 to 45 years with an average residency of 24 years.

Among all 89 homeless respondents, the vast majority (98%) were US citizens. One percent were permanent residents, and 1% were undocumented. There were no homeless respondents who possess a Visa.

TABLE 13.5: PREFERRED LANGUAGE, HOMELESS

Preferred language at home with family/friends	**N**	**%**
English	86	97%
Spanish	2	2%
English/Spanish	1	1%
Other	0	0%
Preferred language when seeing a doctor	**N**	**%**
English	88	99%
Spanish	0	0%
English/Spanish	0	0%
Other	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

By far, English was the primary language reported most often by homeless survey respondents. Approximately 97% said they were most comfortable speaking English at home with family/friends, and 99% said they were most comfortable speaking English with

their doctor. Only 2% said they were most comfortable speaking Spanish and 1% preferred a combination of English and Spanish.

Job Status & Income

TABLE 13.6: JOB STATUS & AVERAGE INCOME & INCOME DEPENDENTS, HOMELESS

Job status	N	%
Full time	0	0%
Part time	2	2%
Temporary/contract/odd jobs	8	9%
Not working due to disability	22	25%
Unemployed	55	62%
Retired	1	1%
Average monthly income during past 6 months	Avg = $274.67	
Approximate yearly income	Avg = $3,296.09	
Up to 300% FPL (2007 – 2008)	88	99%
Up to 200% FPL (2007 - 2008)	88	99%
Up to 100% FPL (2007 - 2008)	87	98%
Total income dependents	Range = 1 to 7; Avg = 1.5	
Income dependents under 18	0 to 6	Avg =.34

** Percentages may not add up to 100% due to rounding or missing survey responses.

Over three-quarters (88%) of all homeless respondents were unemployed at the time of the survey; 62% were unemployed, 25% were not working due to disability, and 1% were retired. None of the homeless respondents were working full-time, 2% were working part-time and 6% had temporary/contract/odd jobs.

Per-month incomes ranged from $0 to $3,300, with an average of $274.67 per month. Yearly incomes were calculated as ranging from $0 to $39, 600 for an average of $3296.09 per year. The number of dependents per income ranged from 1 to 7 (average 1.5), with an average of .3 being under the age of 18. Based on estimated yearly incomes and household sizes, nearly all homeless respondents fell within 100% of the 2007 – 2008 Federal Poverty Level guidelines.

Sources of Income Assistance

TABLE 13.7: SOURCES OF INCOME ASSISTANCE, HOMELESS

Sources of income assistance	N	%
None	43	48%
Hourly wages/Salary	5	6%
SSI	17	19%
SSDI	3	3%
Social Security	8	9%
TANF/AFDC	3	3%
Food Stamps	21	24%
Rental Subsidy/Section 8	0	0%
Workers Comp	0	0%
Unemployment	2	2%
Private Disability	2	2%
VA Benefits	2	2%
Child support	0	0%
Family/friends	1	1%
Pension/Retirement/Savings	0	0%
Other	0	0%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The top three sources of income among all homeless respondents were food stamps (24%), SSI (19%) and Social Security (9%). No survey respondents received worker's compensation.

Almost half (48%) of all homeless respondents reported no source of income.

Paying for Medical Care

TABLE 13.8: SOURCES OF PAYMENT FOR MEDICAL CARE, HOMELESS

Paying for medical care	N	%
I don't receive medical care because I can't pay for it	14	16%
Private insurance/COBRA	0	0%
VA	4	4%
Medicaid	27	30%
Medicare	7	8%
Self-Pay	1	1%
Gold Card/County	36	40%
Ryan White/ADAP	1	1%
Other (MHMRA)	2	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Gold Card (40%), Medicaid (30%), and Medicare (8%) were the most common methods of paying for medical care. One percent of all homeless respondents reported Ryan White/ADAP and 4% reported the VA. Sixteen percent of respondents said they didn't receive any medical care (HIV or non-HIV) because they could not pay for it.

HIV Testing & Diagnosis History

TABLE 13.9: LENGTH OF HIV DIAGNOSIS, HOMELESS

Length of diagnosis Avg = 10 yrs	N	%
Less than 1 year	5	6%
1-4 years	32	36%
5-10 years	20	22%
11-15 years	15	17%
16-20 years	11	12%
21-15 years	6	7%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Homeless respondents reported being diagnosed as HIV positive an average of 10 years, ranging from 6 months to 22.5 years.

TABLE 13.10: LOCATION OF HIV DIAGNOSIS, HOMELESS

Location of diagnosis	N	%
Private doctor	14	16%
ER	9	10%
In hospital stay	9	10%
HIV-specific testing site	5	6%
Public or community clinic	20	22%
Jail/Prison	17	19%
Community testing location	10	11%
Alcohol or drug treatment facility	3	3%
Blood/Plasma donation	1	1%
Work/insurance related	0	0%
Other	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Almost a quarter (22%) of homeless respondents received their diagnoses at a public or community clinic. Other common diagnosis locations for overall respondents were private doctor's offices (16%), during inpatient hospitalization (10%), emergency room visits (10%) and jail or prison (19%). Less frequently identified locations included HIV-specific testing sites (6%), community testing locations (bars, health fairs, events) (11%), alcohol/ drug treatment facilities (3%), and blood/plasma donation centers (1%).

TABLE 13.11: REASONS FOR HIV TESTING, HOMELESS

Reasons for testing	N	%
Recommended by provider	7	8%
Had sex with someone HIV+	17	19%
ER/Hospital stay	11	12%
Felt sick	27	30%
Engaged in risky behavior	15	17%
Was in prison/jail	13	15%
During pregnancy care	3	3%
Routine check up/testing	6	7%
Blood/plasma donation	4	4%
Work/insurance related	0	0%
Partner notification	0	0%
Knew someone with HIV	3	3%
Rape victim	0	0%
Incentive offered	1	1%
In drug treatment program	0	0%
Recommended by friends	0	0%
Other	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for seeking HIV testing were because respondents "felt sick" (30%) and because they "had sex with someone who is HIV positive" (19%). Other common reasons included "engaged in risky behavior (17%), incarceration (15%), or as a result of an emergency room visit or hospital stay (12%). Less frequent reasons were routine check-up (7%), during prenatal care (3%), knowing someone with HIV (3%), or because there was a financial incentive offered with the test (1%).

TABLE 13.12: TYPES OF ASSISTANCE RECEIVED AT DIAGNOSIS, HOMELESS

Assistance at diagnosis	N	%
Information about HIV/AIDS	58	65%
Medical services	47	53%
Counseling	36	40%
Help with food or shelter	19	21%
Alcohol or drug treatment services	10	11%
Supportive Services	1	1%
Other	0	0%
None	20	22%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common types of assistance provided at time of diagnosis were information about HIV/AIDS (65%), assistance with medical services (53%) and counseling (40%). Less frequently reported were help with food or shelter (21%), alcohol or drug treatment services (11%), and information on non-medical supportive services (1%). A total of 20 (22%) of these homeless respondents reported receiving no assistance or information at the time of their HIV diagnosis.

Entry to Care

TABLE 13.13: TIME TO FIRST DOCTOR'S VISIT & CD4/VIRAL LOAD, HOMELESS

Time to first doctor visit	N	%
Less than 1 month	41	46%
1-6 months	23	26%
6-12 months	7	8%
More than 12 months	13	15%
Never	5	6%

Time to CD4/Viral Load	N	%
Less than 1 month	34	38%
1-6 months	21	24%
6-12 months	7	8%
More than 12 months	15	17%
Never	11	12%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Almost half (46%) of all homeless respondents reported seeing a doctor for HIV within one month of receiving their diagnosis. For 26% of respondents, 1 to 6 months passed before seeing a doctor. Eight percent waited between 6 to 12 months, and 15% waited more than a year to see a doctor for HIV. A total of 5 (6%) of homeless respondents said they still had not seen a doctor for HIV. Likewise, 38% reported receiving their first CD4/viral load test within one month of being diagnosed, 24% within 1-6 months, 8% between 6-12 months and 17% waited more than a year. A total of 11 (12%) said they had never received a CD4 or viral load test.

TABLE 13.14: REASONS FOR DELAYED ENTRY INTO CARE, HOMELESS

Reasons for waiting more than 6 months	N	%
Afraid	14	16%
Didn't feel sick	6	7%
Jail/prison	1	1%
Doing drugs	7	8%
Denial	15	17%
Didn't want to take meds	3	3%
No money	5	6%
Depressed/emotional problems	13	15%
No stable place to live	10	11%
Other	2	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reasons for waiting more than 6 months to see a doctor were

denial (17%), fear (16%), depression/emotional problems (15%) and no stable place to live (11%). Other reasons were drug use (8%), no desire to take medications (3%), no money (6%), incarceration (1%), or other reasons (2%) such as family obligations or lack of information.

Maintenance in Care

TABLE 13.15: TIME SINCE LAST VISIT TO DOCTOR & VIRAL LOAD & CD4 & HIV MEDICATION PRESCRIPTION, HOMELESS

Last visit to doctor for HIV	N	%
Less than 6 months	58	65%
6-12 months	8	9%
More than 12 months	15	17%
Never/Don't Know	8	9%
Last viral load	**N**	**%**
Less than 6 months	56	63%
6-12 months	9	10%
More than 12 months	12	13%
Never/Don't Know	12	13%

Last CD4	N	%
Less than 6 months	55	62%
6-12 months	8	9%
More than 12 months	14	16%
Never/Don't Know	12	13%
Last HIV meds prescription	**N**	**%**
Less than 6 months	41	46%
6-12 months	7	8%
More than 12 months	12	13%
Never/Don't Know	28	31%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, the majority of homeless respondents said their most recent doctor's visit (65%), viral load (63%), CD4 test (62%) and HIV medication prescription (46%) were within the past 6 months.

TABLE 13.16: FREQUENCY OF DOCTOR'S VISITS, HOMELESS

No doctor visits more than 6 months?	N	%
Yes	50	56%
No	34	38%
No doctor visits more than 12 months?	**N**	**%**
Yes	35	39%
No	42	47%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among homeless respondents who have seen a doctor for HIV, 56% reported a period of not seeing a doctor for at least 6 months. Of the homeless respondents who did not see a doctor for at least 6 months, 39% reported not seeing a doctor for 12 months or more.

TABLE 13.17: REASONS FOR NO DOCTOR VISITS DURING A 6-12 MONTH MINIMUM TIME PERIOD, HOMELESS

Reasons for no doctor visits	N	%
Case manager left	0	0%
Doctor left	1	1%
Agency closed down	0	0%
Doing drugs	18	20%
Program closed down	0	0%
Did not want to take meds	10	11%
Bad experience with provider	9	10%
Lost stable housing	19	21%
Lost my job	6	7%
Lost health insurance	4	4%
Tired of regimen	5	6%
Felt fine	11	12%
Worried about side effects	7	8%
Denial	14	16%
Jail/prison	0	0%
No transportation	7	8%
Depression/emotional barriers	3	3%
Had to care for children/family member	1	1%
Other	6	7%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most frequently reported reasons for falling out of care were lost stable housing (21%), drug use (20%), denial (16%) and didn't feel sick (12%).

TABLE 13.18: INITIAL AND MOST FREQUENT SOURCES OF MEDICAL CARE, HOMELESS

First place of care	N	%
Private Clinic/Doctor's Office	13	15%
Public clinic/community health ctr	36	40%
Prison/jail	14	16%
VA Hospital	2	2%
ER/Hospital	16	18%
I have not received care for HIV	7	8%
Other	0	0%

Most often location of care	N	%
Private Clinic/Doctor's Office	14	16%
Public clinic/community health ctr	50	56%
Prison/jail	6	7%
VA Hospital	3	3%
ER/Hospital	9	10%
I have not received care for HIV	6	7%
Other	1	1%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most commonly reported location of initial care for HIV was a public clinic or community health center (40%). Other locations were private clinic/doctor's office (15%),

prison/jail (16%), or an emergency room/hospital (18%). Locations of ongoing care were mostly a public clinic or community health center (56%) or private clinic/doctor's office (16%). A total of 3 (3%) of all homeless respondents received care most often from the VA hospital. Prison/jail was the most common location of care for 7% of all homeless respondents, and emergency rooms/hospitals were most common for 10% of homeless respondents.

TABLE 13.19: KNOWLEDGE OF CASE MANAGER, HOMELESS

Case Manager	N	%
Yes	60	67%
No	18	20%
Don't Know	11	12%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (67%) of homeless respondents reported having a specific person at a clinic, hospital or community organization (i.e., case manager, social worker or counselor). Twenty percent said they did not have such a person assisting them, and 12% said they didn't know.

Health Status

TABLE 13.20: SELF-REPORTED HEALTH STATUS, HOMELESS

How would you describe your health overall	N	%
Excellent	8	9%
Good	26	29%
Fair	44	49%
Poor	11	12%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When asked to describe their overall health, 9% said "Excellent," 29% said "Good," 49% said "Fair" and 12% said "Poor."

TABLE 13.21: SELF-REPORTED PHYSICAL HEALTH STATUS & ER OR HOSPITAL VISITS, HOMELESS

During the past month, has your physical health interfered with normal activities?	N	%
No	26	29%
Yes – Some of the time	49	55%
Yes – all of the time	13	15%
ER visit in past 6 months	44	49%
Hospital stay in past 6 months	33	37%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Over half (55%) of all homeless respondents reported that during the past month, their physical health had interfered with normal activities some of the time. Fifteen percent said their physical health interfered all of the time.

For the 6 months prior to the survey, 49% of all homeless respondents reported an emergency room visit and 37% reported being admitted to a hospital for one or more nights.

TABLE 13.22: SELF-REPORTED SYMPTOMS DURING THE PREVIOUS 30 DAYS, HOMELESS

Symptoms during past month Avg = 6	**N**	**%**
Trouble with thinking, concentrating or memory	53	60%
Depressed or sad, trouble thinking	70	79%
Aches, fatigue, lightheadedness, weak all over	47	53%
Fevers, chills, sweats	39	44%
Poor appetite, weight loss	43	48%
Trouble with eyes or ears	46	52%
Trouble with nose or sinuses, headaches	45	51%
Trouble with mouth or swallowing	28	31%
Nausea, vomiting, diarrhea, abdominal pain	39	44%
Coughing, wheezing, or chest pain, trouble breathing	39	44%
Rash, itch, herpes, or other skin trouble	30	34%
Numbness, tingling or pain in an arm or leg	34	38%
Other	0	0%
None	3	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The number of symptoms reported by all homeless respondents during the past month ranged from 1 to 12, with an average of 6. The top three reported symptoms were feeling depressed or sad/trouble sleeping (79%), trouble with thinking, concentrating or memory (60%) and aches/fatigue/lightheadedness/weak all over (53%).

TABLE 13.23: SELF-REPORTED INITIAL AND CURRENT CD4/T-CELL COUNTS, HOMELESS

First CD4/T-cell	N	%
Less than 50	5	6%
50-99	4	4%
100-199	5	6%
200-349	8	9%
350-499	11	12%
500+	21	24%
Don't Know/Can't Remember	34	38%

Current CD4/T-cell	N	%
Less than 50	4	4%
50-99	3	3%
100-199	11	12%
200-349	10	11%
350-499	3	3%
500+	15	17%
Don't Know/Can't Remember	41	46%

** Percentages may not add up to 100% due to rounding or missing survey responses.

When aggregating the given ranges, a total of 21 (24%) of all homeless respondents reported their first CD4/T-cell counts as 500+; 21% were 200 to 499, 10% were 50 to 199, and 6% were less than 50. Current CD4/T-cell counts were 500+ for 17% of all respondents; 200 to 499 for 14%, 50 to 199 for 15%, and less than 50 for 4% of respondents. More than two-thirds (38%) didn't know or couldn't remember their first CD4/T-cell count, and almost half (46%) didn't know or couldn't remember their current CD4/T-cell count.

Medications

TABLE 13.24: HIV MEDICATIONS, HOMELESS

Currently taking HIV meds	N	%
Yes	42	47%
No	47	53%
How many pills do you take in one day?	Avg = 6	

** Percentages may not add up to 100% due to rounding or missing survey responses.

Almost half of homeless survey respondents (47%) said they were currently taking HIV medications. The number of pills taken in one day ranged from 1 to 15, with an average of 6 pills per day.

TABLE 13.25: SELF-REPORTED MEDICATION ADHERENCE, HOMELESS

Medication adherence	N	%
I have not missed any doses in the past month	16	18%
Missed a few, but took nearly all	13	15%
Took more than half	2	2%
About half	3	3%
Some, but not half	6	7%
Other	0	0%
Has a nurse, doctor or CM ever talked to you about ways to stay on schedule with meds?	**N**	**%**
Yes	43	48%
No	26	29%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Among homeless respondents currently taking HIV medications, 18% reported perfect adherence and 15% reported near-perfect adherence ("missed a few, but took nearly all"). When asked if a nurse, doctor or case manager had ever talked to them about ways to stay on schedule with meds, 48% said "Yes" and 29% said "No."

TABLE 13.26: REASONS FOR NOT TAKING HIV MEDICATIONS, HOMELESS

Reasons for not taking HIV medications	N	%
Side effects	7	8%
Not effective	3	3%
Too difficult to take as prescribed	3	3%
No doctor has offered them	6	7%
I choose not to take them	12	13%
Doctor did not think it was a good idea for me	6	7%
T-cell too high	11	12%
Cannot pay	6	7%
Confidentiality concerns	4	4%
Didn't feel sick	1	1%
Have not seen doctor	5	6%
Other	5	6%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The most common reason for not taking HIV medications was "I choose not take them" (13%) followed by "T-cell count too high" (12%), too many unpleasant side effects" (8%), and "doctor did not think it was a good idea for me" (7%).

TABLE 13.27: MEDICATIONS FOR NON-HIV CONDITIONS, HOMELESS

How many pills do you take in one day for non-HIV conditions? Avg = 4	N	%
Diabetes	5	6%
High blood pressure	20	22%
High cholesterol	6	7%
Depression/emotional problems	32	36%
Eye drops/glaucoma	0	0%
Acid reflux	2	2%
Anemia	0	0%
Sleep	1	1%
Allergies/Sinus	0	0%
Pain	1	1%
Antibiotics	1	1%
Arthritis	0	0%
Asthma	2	2%
Neuropathy	1	1%
Nausea	0	0%
Hormones	0	0%
Other	12	13%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, homeless respondents took an average of 4 non-HIV pills per day. The most common conditions associated with the non-HIV pills were depression/emotional problems (36%), high blood pressure (22%), high cholesterol (7%) and diabetes (6%).

TABLE 13.28: TOTAL PILL BURDEN AND ABILITY TO PAY, HOMELESS

Total Pills (HIV + non-HIV)	Avg = 6	
How often do you have trouble paying for these or other non-HIV meds?	**N**	**%**
Never	41	46%
Less than half the time	5	6%
More than half the time	7	8%
Always	18	20%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The average combined HIV and non-HIV pill burden per day was 6.

Almost half (46%) of all homeless respondents reported never having problems paying for HIV or non-HIV medications, and 6% had problems less than half the time. Eight percent had problems more than half the time, and 20% said they always had problems paying for their medications.

Comorbidities

TABLE 13.29: HEPATITIS C AND TB STATUS, HOMELESS

Hep C Test?	N	%
Yes	67	75%
No	16	18%
Don't Know	6	7%
Positive for Hep C?	**N**	**%**
Yes	22	25%
No	51	57%
Don't know	15	17%

TB skin test?	N	%
Yes	77	87%
No	10	11%
Result	**N**	**%**
Positive	25	28%
Negative	51	57%
Don't Know	3	3%
History of active TB?	**N**	**%**
Yes	19	21%
No	67	75%
Don't Know	2	2%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority (75%) of all homeless respondents reported that since they were diagnosed with HIV, they had been tested for Hepatitis C, and 25% said they were positive for Hepatitis C.

Almost all (87%) homeless respondents had received a skin test for TB, and 28% reported a positive result. A total of 19 (21%) reported a history of active TB.

Mental Health

TABLE 13.30: SELF-REPORTED MENTAL HEALTH SYMPTOMS, HOMELESS

	N	%
At least one mental health condition	67	75%
Symptoms in past month	**N**	**%**
Serious anxiety/tension	55	62%
Hallucinations	16	18%
Serious thoughts of suicide	23	26%
Attempted suicide	9	10%
Wanted to hurt or harm yourself	25	28%
Wanted to hurt or harm someone else	16	18%
Trouble controlling anger leading to physical violence	31	35%
Problems requiring meds	27	30%
None	22	25%
At least one serious indicator (suicide/homicidal or requiring meds)	28	31%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Three-quarters (75%) of all homeless respondents reported experiencing at least one of a list of mental health symptoms during the previous month. The most commonly experienced symptoms were serious anxiety/tension (62%), trouble controlling anger leading to physical violence (35%), problems requiring medications (30%), wanting to hurt or harm yourself (28%), and serious thoughts of suicide (26%).

TABLE 13.31: SELF-REPORTED UTILIZATION OF MENTAL HEALTH SERVICES, HOMELESS

Since being diagnosed, ever talked with therapist?	**N**	**%**
Yes	58	65%
No	31	35%
Since being diagnosed, ever talked with psychiatrist about meds?	**N**	**%**
Yes	56	63%
No	33	37%
Since being diagnosed, ever attended a support group?	**N**	**%**
Yes	36	40%
No	53	60%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Since being diagnosed with HIV, 65% of homeless respondents said they had talked with a therapist or psychologist for help with depression or emotional problems and 63% had talked to a doctor or psychiatrist for medications. Forty percent said they had participated in a support group since being diagnosed with HIV.

Substance Use & Abuse

TABLE 13.32: SUBSTANCE USE, HOMELESS

Total Number of substances Range = 1 to 8; Avg = 2	**N**	**%**
Inhalants (poppers, glue, gasoline, nitrous, ethyl)	2	2%
Street Methadone (non-treatment)	1	1%
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	3	3%
Barbituates (seconal, tuinal, downers)	3	3%
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	6	7%
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	1	1%
Amphetamines (speed, uppers, crystal meth, ice, glass)	6	7%
Marijuana, Hashish (grass, weed)	33	37%
Heroin	0	0%
Cocaine (powder), Crack	36	40%
Ecstasy, X, MDA, GHB	5	6%
Ketamine (K, Special K)	1	1%
None	35	39%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Overall, 61% of homeless respondents reported using at least one substance during the past year. The numbers of substances ranged from 1 to 8, with an average of 2. The most commonly used substances for all respondents were cocaine (40%) and marijuana (37%).

TABLE 13.33: TWO-ITEM CONJOINT SCREEN (TICS) FOR ALCOHOL OR OTHER SUBSTANCE ABUSE, HOMELESS

In the last year, ever drunk more than meant to?	N	%
Yes	42	47%
No	46	52%
In the last year, ever wanted/needed to cut down on drinking?	**N**	**%**
Yes	39	44%
No	48	54%
In the last year, ever used drugs more than meant to?	**N**	**%**
Yes	33	37%
No	55	62%
In the last year, ever wanted/needed to cut down on drug use?	**N**	**%**
Yes	41	46%
No	47	53%
Indicator of Alcohol Abuse	48	54%
Indicator of Substance Abuse	41	46%
Abuse of both drugs and alcohol	31	35%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The Two-item Conjoint Screen (TICS) tool was used to screen for alcohol or other substance abuse (*Brown RL et al. Journal of the American Board of Family Practice 2001;14:95-106.)*. The two items were "In the last year, have you ever used [alcohol or substance] more than you meant to?" and "In the last year, have you felt you wanted or needed to cut down on your [alcohol or substance] use?" A positive response to either item detects abuse with 80% sensitivity. Results of the screening tool show that 54% of all respondents indicated possible alcohol abuse, and 46% indicated possible substance abuse. A total of 31 (35%) indicated possible abuse of both alcohol and drugs.

Social Support

TABLE 13.34: SOCIAL SUPPORT, HOMELESS

Of all the people you feel close to, how many have you told about being HIV+?	N	%
All	22	25%
Some	43	48%
None	23	26%
Are there people you can depend on to help you if you really need it?	**N**	**%**
Yes	49	55%
No	40	45%

** Percentages may not add up to 100% due to rounding or missing survey responses.

Of all the people they feel close to, 25% had disclosed their HIV status to all and 48% had disclosed their status to some. A total of 23 (26%) had not told their HIV status to any of the people to whom they feel close. Overall, 55% of homeless respondents said there were people they could depend on for help if really needed; however, only 45% of those who had told their HIV status to no one said they had people to depend on.

Housing

TABLE 13.35: HOUSING STATUS, HOMELESS

Where do you most often sleep?	N	%
Apartment/House	0	0%
Group home/halfway house	0	0%
Shelter	46	52%
Street	43	48%
Other	0	0%
Do you feel your housing situation is stable?	**N**	**%**
Yes	16	18%
No	73	82%

** Percentages may not add up to 100% due to rounding or missing survey responses.

The majority of homeless respondents (52%) reported sleeping most often in a shelter. The remaining respondents reported sleeping most often on the street (48%). More than half (82%) of all respondents felt their housing situation was unstable, and only 18% felt their housing situation was stable.

TABLE 13.36: HOUSING SITUATION AND UTILIZATION OF HIV CARE, HOMELESS

In the past year, has your housing situation made it difficult to get HIV care	N	%
Yes	52	58%
No	36	40%
Reasons	**N**	**%**
I could not keep my status private	22	25%
No place to store meds	16	18%
Money for food	30	34%
Money for rent	27	30%
Money for utilities	13	15%
Money for household supplies	19	21%
No stable address	0	0%
Used money on drugs	1	1%
Rules	2	2%
Lack of transportation	2	2%
No child care	3	3%

** Percentages may not add up to 100% due to rounding or missing survey responses.

A total of 52 (58%) homeless respondents said that in the past year, their housing situation made it difficult for them to get HIV care. The most common reasons for these difficulties were the need to spend money for food (34%), rent (30%), household supplies (21%) or utilities (15%) rather than HIV-related care. Other reasons were not having a place to store medications (18%) and being unable to keep their HIV status private (25%).

ACCESS TO CORE SERVICES

TABLE 13.37: ACCESS TO CORE SERVICES, HOMELESS

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%	It was very easy to get this service	%	I did not need this service	%
Primary Medical Care	41	46%	41	46%	7	8%
HIV/AIDS Medications	31	35%	33	37%	25	28%
Dentist Visits	42	47%	22	25%	25	28%
Medical Case Management	24	27%	43	48%	22	25%
Home Health Care	21	24%	9	10%	59	66%
Psychiatric Services or Medicine	27	30%	30	34%	32	36%
Psychological Counseling	20	22%	34	38%	35	39%
Substance Abuse Treatment	17	19%	32	36%	40	45%
Rehabilitation Services	16	18%	14	16%	59	66%

For each HRSA-defined core service, respondents were asked to indicate if they had some difficulty getting the service, if it was very easy to get the service, or if they did not need the service within the past year. The table above shows the reported access levels for each core service.

For homeless respondents, the top three “easy to get” core services were medical case management (48%), primary medical care (46%) and HIV/AIDS medications (37%). The top three core services that respondents reported “some difficulty getting” were dentist visits (47%), primary medical care (46%) and HIV/AIDS medications (36%). The presence of primary medical care and HIV/AIDS medications on both the “easy to get” and “some difficulty getting” lists is due to the fact that they are the two most accessed services. Conversely, the three core services that respondents said they “did not need” in the past year were home health care (66%), rehabilitation services (66%) and substance abuse treatment (45%).

ACCESS TO SUPPORTIVE SERVICES

TABLE 13.38: ACCESS TO SUPPORTIVE SERVICES, HOMELESS

Service Category	In the past 12 months….					
	I had some difficulty getting this service	%*	It was very easy to get this service	%*	I did not need this service	%*
Child Care Services	11	12%	0	0%	1	1%
Child Welfare Services	1	1%	0	0%	0	0%
Day/Respite Care for Adults	0	0%	1	1%	3	3%
Developmental	1	1%	0	0%	1	1%
Emergency Financial Assistance	37	42%	6	7%	6	7%
Employment Assistance	21	24%	2	2%	3	3%
Food Bank	20	22%	14	16%	5	6%
HIV Education for HIV+ Individuals	9	10%	7	8%	4	4%
Rental Assistance/Shelter Vouchers	25	28%	5	6%	1	1%
Housing-Related Services	41	46%	3	3%	6	7%
Legal Services	9	10%	2	2%	4	4%
Nutritional Counseling	9	10%	6	7%	2	2%
Permanency Planning	0	0%	0	0%	1	1%
Referrals to Services	13	15%	6	7%	2	2%
Referrals to Clinical Research	2	2%	4	4%	1	1%
Support Groups	6	7%	11	12%	4	4%
Translation/Interpretation	0	0%	0	0%	0	0%
Transportation	21	24%	12	13%	2	2%
Household Items	9	10%	3	3%	0	0%

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general. The table above shows the reported access levels for each supportive service.

For homeless respondents, the supportive services that were selected most often (thus implying high helpfulness/usefulness) by respondents were housing related services (n=50) and emergency financial assistance (n=49). The top "easy to get" supportive services (based on number of responses) were food bank (n=14), transportation (n=12) and support groups (n=11). The top supportive services that respondents reported "some

difficulty getting" were emergency financial assistance (n=37) and rental assistance/shelter vouchers (n=25). ["n=*value*" indicates the number of responses for each service category.]

Barriers Reported per Core Service Category

Survey respondents that had "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each core service. The numbers in each cell represent how many times a particular barrier was identified for each core service. For example, the first cell in the row for primary medical care shows that barrier A ("The services are not in my area") was listed as a barrier 6 times for primary medical care. The total column on the far right represents the total number of barriers (A-V) for each core service. The total row on the bottom of the table shows the number of times each barrier was identified across all core services.

Among homeless respondents, the three core services with the highest number of barriers were primary medical care (n=103), dental care (n=102) and psychiatric services (n=70). Within primary medical care, the most commonly reported barriers were "It's hard to make or keep appointments" (n=14), "It's hard for me to get there" (n=12) and "I don't know where to get the services" (n=12). For dental services, the most common barriers for all respondents were "I don't know where to get the services" (n=15), "It's hard to make or keep appointments" (n=14) and "I would have to wait too long to get the services" (n=13).

The barriers experienced most often by homeless respondents across all core services were "I don't know where to get the services" (n=80), "I would have to wait too long to get the services" (n=61) and "It's hard to make or keep appointments" (n=58).

TABLE 13.39: BARRIERS REPORTED PER CORE SERVICE CATEGORY, HOMELESS

Core Services	Barriers																		
	A	B	C	D	E	F	G	H	I	J	K	L	M	O	R	S	T	U	Total
Primary Medical Care	6	12	11	10	3	3	8	14	12	5	11	1	3	2	1	1	0	0	**103**
HIV/AIDS Medications	5	9	8	10	5	5	5	6	2	4	4	0	2	1	0	0	0	0	**66**
Dentist Visits	8	15	13	12	8	7	6	14	3	3	7	0	0	4	0	1	1	0	**102**
Medical Case Management	5	11	6	3	2	4	7	7	6	1	4	0	1	1	0	1	0	1	**60**
Home Health Care	2	7	2	3	5	4	2	2	3	0	2	0	0	0	0	1	5	0	**38**
Psychiatric Services or Medicine	5	6	13	7	4	2	9	8	6	2	6	0	0	0	2	0	0	0	**70**
Psychological Counseling	4	8	4	5	3	4	5	3	5	1	4	0	1	0	1	0	0	0	**48**
Substance Abuse Treatment	1	5	3	2	1	2	4	1	4	2	4	0	4	0	0	0	0	0	**33**
Rehabilitation Services	3	7	1	3	0	3	3	3	4	0	5	0	0	0	0	1	0	0	**33**
Total	**39**	**80**	**61**	**55**	**31**	**34**	**49**	**58**	**45**	**18**	**47**	**1**	**11**	**8**	**4**	**5**	**6**	**1**	**553**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Barriers Reported per Supportive Service Category

Similar to the core services table, survey respondents that had "some difficulty" getting a supportive service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. There was no limit to the number of barriers allowed, so respondents were encouraged to list all of the barriers they experienced when getting the service.

The following table shows the number of barriers that were reported for each supportive service. The numbers in each cell represent how many times a particular barrier was identified for each supportive service. The total column on the far right represents the total number of barriers (A-V) for each supportive service. The total row on the bottom of the table shows the number of times each barrier was identified across all supportive services.

Among homeless respondents, the five supportive services with the highest number of barriers were housing related services (n=98), emergency financial assistance (n=97) and rental assistance/shelter vouchers (n=61). Within housing related services, the most commonly reported barriers were "I don't know where to get the services" (n=18), "I would have to wait too long to get the services" (n=13) and "the services are not in my area" (n=11). For emergency financial assistance, the most commonly reported barriers were "I don't know where to get the services" (n=21), "I was told I am not eligible to get the services" (n=12), "the services are not in my area" (n=11) and "I would have to wait too long to get the services" (n=11). For rental assistance/shelter vouchers, the most common barriers were "I don't know where to get the services" (n=11), "I would have to wait too long to get the services" (n=7) and "the services are not in my area" (n=6).

The barriers experienced most often by homeless respondents across all supportive services were "I don't know where to get the services" (n=107), "I would have to wait too long to get the services" (n=55) and "the services are not in my area" (n=50).

TABLE 13.40: BARRIERS REPORTED PER SUPPORTIVE SERVICE CATEGORY, HOMELESS

Supportive Services	Barriers																			
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Q	R	S	U	V	Total
Child Care Services	4	5	4	5	5	0	2	2	5	3	0	0	0	0	0	0	0	1	0	**36**
Child Welfare Services	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	**2**
Day/Respite Care for Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Developmental Assessment	0	0	1	0	0	1	0	1	1	1	1	0	0	0	0	0	0	0	0	**6**
Emergency Financial Assistance	11	21	11	4	12	6	9	4	7	3	7	0	1	0	0	0	1	0	0	**97**
Employment Assistance	3	9	2	0	1	6	1	2	3	0	0	0	3	0	2	0	0	0	0	**32**
Food Bank	2	6	2	2	3	1	1	1	7	0	1	0	0	0	1	0	2	3	0	**32**
HIV Education for HIV+ Individuals	0	5	1	2	1	0	0	2	2	0	3	1	0	0	0	0	0	0	0	**17**
Rental Assistance/Shelter Vouchers	6	11	7	3	3	9	4	4	4	2	5	0	1	0	0	0	0	1	1	**61**
Housing-Related Services	11	18	13	8	5	9	6	6	7	2	3	0	4	0	0	1	3	2	0	**98**
Legal Services	2	3	1	0	1	1	2	1	1	0	2	1	0	0	0	0	1	0	0	**16**
Nutritional Counseling	1	5	0	0	0	1	1	1	0	0	1	0	0	1	0	0	0	0	0	**11**
Permanency Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Referrals to Services	2	4	4	2	0	1	4	1	1	1	2	0	0	0	0	0	1	0	0	**23**
Referrals to Clinical Research	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
Support Groups	0	3	0	1	0	2	0	1	0	0	1	0	1	0	0	0	0	0	0	**9**
Translation/Interpretation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Transportation	5	8	5	6	3	2	2	3	6	2	2	0	0	1	1	0	1	1	0	**48**
Household Items	3	6	3	1	0	1	2	1	0	0	2	0	0	0	0	0	0	0	0	**19**
Total	**50**	**107**	**55**	**34**	**34**	**40**	**34**	**30**	**44**	**15**	**30**	**2**	**10**	**2**	**4**	**1**	**9**	**8**	**1**	**510**

**Some barriers may not be shown if no respondents reported them as barriers for this service

Barrier Descriptions

A	The services are not in my area	**I**	It's hard for me to get there	**P**	Was incarcerated/in jail
B	I don't know where to get the services	**J**	There is no one to watch my kids if I go there	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
C	I would have to wait too long to get the services	**K**	I'm afraid someone will find out about my HIV	**R**	Fear, denial or stigma (internal and/or external)
D	The services cost too much	**L**	People at the agency don't speak my language	**S**	Homeless/unstable housing
E	I was told I am not eligible to get the services	**M**	My jail/prison history makes it hard to get services	**T**	CM left/staff turnover
F	I don't think I'm eligible to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)	**U**	Not enough, resources/funds run out too quickly
G	The people who run the services are not friendly	**O**	Substance abuse	**V**	Immigration status
H	It's hard to make or keep appointments				

RISK BEHAVIORS

TABLE 13.41: VERY HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HOMELESS RESPONDENTS (N=89)

Very High Risk Variables	Yes	No	Prefer Not to Say[1]	Percent of Homeless Reporting Risk Factor	All Respondents (764)	
					N	%
Sex for Drugs/Money	13	52	3	15%	56	7%
Anonymous Sex Partner(s)	25	40	N/A[1]	28%	141	18%
Greater than 5 Sex Partners	13	76	N/A[1]	15%	60	8%

Of those who were homeless, 15% reported that they had engaged in sex for drugs or money in the past 6 months, while 7% of all respondents reported this risk factor. Twenty eight percent (28%) reported that they had one or more anonymous sex partners in the past 6 months, compared with 18% of all respondents. Fifteen percent (15%) of those who are out of care reported that they had more than 5 sex partners in the past 6 months, while 8% of all respondents reported that they had more than 5 sex partners. For each element of the definition of very high risk of HIV transmission, a higher proportion of the homeless group identified themselves as meeting the definition.

TABLE 13.42: HIGH RISK FOR HIV INFECTION (TRANSMITTING OR REINFECTION), HOMELESS RESPONDENTS (N=89)

High Risk Variables	Yes	No	Prefer Not to Say[1]/ Don't Know	Percent of Homeless Reporting Risk Factor	All Respondents (764)	
					N	%
Unprotected Sex	35	31	N/A	39%	235	31%
Shared Injecting Equipment	4	5	N/A	4%	12	2%
Serodiscordant Sex Partner(s)	11	25	11	12%	111	15%

Of those who are homeless, 35 (39%) reported that they had unprotected sex at least some of the time, contrasting with 31% of the entire sample reporting this risk factor. Nine (9) people reported that they had injected a substance, while 4 (4%) reported that they had shared injecting equipment at least some of the time. This accounts for 2% of the total sample. Eleven (11, 12%) of those out of care reported that they had an HIV-negative sex partner, while 15% of the total sample reported that they had an HIV-negative sex partner.

[1] N/A refers to questions for which "Don't know" or "Prefer not to say" were not options.

PRIMARY MEDICAL CARE

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of **Primary Medical Care** is defined as:

Client examination by a qualified Medical Doctor, Nurse Practitioner, and/or Physician's Assistant and includes all ancillary services below:

- Eligibility Screening (as necessary)
- Patient Medication/Treatment Education
- Adherence Education, Counseling and Support
- Medication Access/Linkage
- OB/GYN specialty procedures (as clinically indicated)
- Nutritional Counseling (as clinically indicated)
- Routine Laboratory (as clinically indicated)
- Routine Radiology (as clinically indicated)

Primary Care Office/Clinic Visit is defined as client examination by a qualified Medical Doctor, Nurse Practitioner, and/or Physician's Assistant and includes all ancillary services below:

- Eligibility Screening (as necessary)
- Patient Medication/Treatment Education
- Adherence Education, Counseling and Support
- Medication Access/Linkage
- OB/GYN specialty procedures (as clinically indicated)
- Nutritional Counseling (as clinically indicated)
- Routine Laboratory (as clinically indicated)
- Routine Radiology (as clinically indicated)

Medical Case Management Visit is defined as assessment, education and consultation by an LMSW within a system of information, referral, case management, and/or social

services and includes:

- Social Services/Case Coordination
- Assessment of Readiness for HAART therapy (as indicated)

Psychiatry Visit is defined as provision of outpatient psychiatric care by a Board certified Psychiatrist

Primary Care Office/Clinic Vision Care is defined as a comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS) and ARIES. The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the CPCDMS, a total of 6,961 unduplicated PLWHA received primary medical care services through grants billed to Ryan White Part A, Part B, Part C, Texas Department of State Health Services (DSHS) and Other funding sources. This total represents 38% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

At the beginning of the client survey, respondents were given a list of core services arranged in table format (see Appendix B for copy of client survey). The purpose of the core service table was to collect information on access and barriers to the listed services.

For each HRSA-defined core service, respondents indicated whether they had "some difficulty" getting the service, if it was "very easy" to get the service, or if they "did not need" the service within the past year.

The following table shows the level of access to primary care reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 14.1: REPORTED ACCESS TO PRIMARY MEDICAL CARE IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	723	95%	550	76%	173	24%	41	5%
Subpopulations*								
In Care	667	97%	537	81%	130	19%	20	3%
Out-of-Care	56	73%	13	23%	43	77%	21	27%
Women	224	94%	167	75%	57	25%	14	6%
Youth	36	97%	26	72%	10	28%	1	3%
African-Americans	407	95%	312	77%	95	23%	22	5%
Latinos	137	97%	113	82%	24	18%	4	3%
White MSM	98	95%	68	69%	30	31%	5	5%
MSM of Color	202	97%	164	81%	38	19%	6	3%
Recently Released	111	93%	79	71%	32	29%	8	7%
Substance Abuse	235	95%	178	76%	57	24%	13	5%
Mental Health	429	95%	307	72%	122	28%	23	5%
Homeless	82	92%	41	46%	41	46%	7	8%

* Subpopulations are not mutually exclusive.
** Percentages may not add up to 100% due to rounding.

The vast majority (95%) of all 764 survey respondents reported attempting to access primary medical care during the previous 12 months; a total of 41 (5%) said they did not need this service. The percentage of respondents in each subpopulation that accessed this service remained above 93% – the only exception was among the out-of-care, of which only 73% attempted to access primary medical care during the past year.

Overall, the majority of all survey respondents had an easy time accessing primary medical care – 76% said it was "very easy" to get the service. Among the subpopulations, access to primary medical care appeared easiest for Latinos (82%), those in-care (81%) and MSM of color (81%).

By far, the out-of-care subpopulation had the highest proportion (77%) of those who had some difficulty accessing primary medical care during the past year. Other subpopulations with relatively higher proportions of difficulty were white MSM (31%), the recently released (29%), youth (28%) and respondents with a mental health symptom (28%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for primary medical care. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation. The cells that are shaded and in bold represent barriers with the highest number of reports for each subpopulation.

TABLE 14.2: NUMBER OF REPORTED BARRIERS FOR PRIMARY MEDICAL CARE

	A	B	C	D	E	F	G	H	I	J	K	L	M	O	Q	R	S	Total** Barriers
All Respondents	25	31	41	24	8	9	31	**53**	**53**	8	20	3	8	10	1	4	3	**332**
Subpopulations*																		
In Care	19	20	**35**	15	6	4	24	**41**	**37**	5	12	3	6	7	1	4	2	**241**
Out-of-Care	6	**11**	6	9	2	5	7	**12**	**16**	3	8	0	2	3	0	0	1	**91**
Women	6	**14**	8	12	3	8	8	**22**	**24**	7	13	0	3	3	1	1	2	**135**
Youth	3	2	1	**5**	1	1	3	**4**	**4**	3	**4**	1	1	1	0	0	0	**34**
African-Americans	14	**20**	18	17	2	7	11	**32**	**31**	5	15	1	7	4	0	1	3	**188**
Latinos	5	**7**	**6**	1	2	1	**6**	4	**6**	0	2	2	0	1	0	0	0	**43**
White MSM	2	2	**11**	4	3	0	**8**	**11**	**8**	1	1	0	0	2	0	1	0	**54**
MSM of Color	7	7	**12**	4	2	1	**9**	**10**	6	0	1	1	2	1	0	0	0	**63**
Recently Released	2	4	7	7	1	4	3	**9**	**11**	0	8	0	6	3	1	1	1	**68**
Substance Abuse	7	13	**16**	7	3	5	9	**17**	**21**	1	11	1	3	4	0	1	3	**122**
Mental Health	17	20	**28**	18	6	6	22	**43**	**43**	7	19	1	8	6	0	3	2	**249**
Homeless	6	**12**	11	10	3	3	8	**14**	**12**	5	11	1	3	0	1	1	0	**101**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 332 reports of barriers among respondents who had difficulty accessing primary medical care during the past year. The barriers reported most often for primary medical care were related to scheduling appointments, getting to locations of services and waiting times. The table below shows the top reported barriers reported by subpopulations when accessing primary medical care. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to the table titled, “Number of reported barriers for Primary Medical Care.”

TABLE 14.3: TOP REPORTED BARRIERS FOR PRIMARY MEDICAL CARE BY SUBPOPULATION

	Barriers (ranked by number of reports)
All Respondents	H - It's hard to make or keep appointments (n=53) I - It's hard for me to get there (n=53) C - I would have to wait too long to get the services (n=41)
Subpopulations*	
In Care	H - It's hard to make or keep appointments (n=41) I - It's hard for me to get there (n=37) C - I would have to wait too long to get the services (n=35)
Out-of-Care	I - It's hard for me to get there (n=16) H - It's hard to make or keep appointments (n=12) B - I don't know where to get the services (n=11)
Women	I - It's hard for me to get there (n=24) H - It's hard to make or keep appointments (n=22) B - I don't know where to get the services (n=14)
Youth	D - The services cost too much (n=5) H - It's hard to make or keep appointments (n=4) I - It's hard for me to get there (n=4) K - I'm afraid someone will find out about my HIV (n=4)
African-Americans	H - It's hard to make or keep appointments (n=32) I - It's hard for me to get there (n=31) B - I don't know where to get the services (n=20)
Latinos	B - I don't know where to get the services (n=7) C - I would have to wait too long to get the services (n=6) G - The people who run the services are not friendly (n=6) I - It's hard for me to get there (n=6)
White MSM	C - I would have to wait too long to get the services (n=11) H - It's hard to make or keep appointments (n=11) G - The people who run the services are not friendly (n=8) I - It's hard for me to get there (n=8)
MSM of Color	C - I would have to wait too long to get the services (n=12) H - It's hard to make or keep appointments (n=10) G - The people who run the services are not friendly (n=9)
Recently Released	I - It's hard for me to get there (n=11) H - It's hard to make or keep appointments (n=9) K - I'm afraid someone will find out about my HIV (n=8)
Substance Abuse	I - It's hard for me to get there (n=21) H - It's hard to make or keep appointments (n=17) C - I would have to wait too long to get the services (n=16)
Mental Health	H - It's hard to make or keep appointments (n=43) I - It's hard for me to get there (n=43)
Homeless	H - It's hard to make or keep appointments (n=14) I - It's hard for me to get there (n=12) B - I don't know where to get the services (n=12)

* Subpopulations are not mutually exclusive.

Within all subpopulations (except for Latinos), problems with making or keeping appointments ranked high compared to other barriers. Difficulties getting to service locations were also ranked highly within subpopulations, except within MSM of color.

Information-related barriers were ranked highly within Latinos and the out-of-care, and confidentiality concerns ranked high within youth and the recently released. Youth were the only subpopulation for whom cost of services was high on the list of reported barriers.

HIV/AIDS MEDICATIONS

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of **HIV/AIDS Medications** is defined as:

Local Drug Reimbursement Program is defined as Local (Houston EMA only) drug reimbursement program to provide pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP or other sources. Medications available are those in the State ADAP (Levels I and II) formularies. Clients are limited to a maximum of $1,500 per month per month through this program. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of HIV Services. The cost of Fuzeon™ does not count against a client's monthly maximum.

Non-HIV Medication Needs Program services are defined as reimbursement for provision of non-HIV related medication not already covered under the local drug formulary, not including drugs available free of charge (such as birth control and TB medications). Clients are limited to a maximum of $3,000.00 per contract year in non-HIV medications.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS) and/or ARIES. The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed

collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 2,488 unduplicated PLWHA received HIV/AIDS Medication services through grants billed to Ryan White Part A and Part B. This total represents 14% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

At the beginning of the client survey, respondents were given a list of core services arranged in table format (see Appendix B for copy of client survey). The purpose of the core service table was to collect information on access and barriers to the listed services. For each HRSA-defined core service, respondents indicated whether they had "some difficulty" getting the service, if it was "very easy" to get the service, or if they "did not need" the service within the past year.

The following table shows the level of access to HIV/AIDS medications reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service <u>does not necessarily mean the respondent received the service</u>. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 14.4: REPORTED ACCESS TO HIV/AIDS MEDICATIONS IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	651	85%	487	75%	164	25%	113	15%
Subpopulations*								
In Care	610	89%	474	78%	136	22%	113	15%
Out-of-Care	41	53%	13	32%	28	68%	77	11%
Women	198	83%	149	75%	49	25%	36	47%
Youth	27	73%	20	74%	7	26%	40	17%
African-Americans	361	84%	278	77%	83	23%	10	27%
Latinos	132	94%	99	75%	33	25%	68	16%
White MSM	88	85%	60	68%	28	32%	9	6%
MSM of Color	178	86%	140	79%	38	21%	15	15%
Recently Released	92	77%	51	55%	41	45%	30	14%
Substance Abuse	207	83%	149	72%	58	28%	27	23%
Mental Health	382	85%	267	70%	115	30%	41	17%
Homeless	64	72%	31	35%	33	37%	25	28%

* Subpopulations are not mutually exclusive.
** Percentages may not add up to 100% due to rounding.

The majority (85%) of all 764 survey respondents reported attempting to access HIV/AIDS medications during the previous 12 months; a total of 113 (15%) said they did not need this service. Most subpopulations also reported accessing this service in high proportions (83% to 94%). However, the subpopulations with the lowest proportions accessing HIV/AIDS medications were the recently released (77%), youth (73%) and the out-of-care (53%), in which only approximately half reported accessing HIV/AIDS medications.

Overall, ease of access to HIV/AIDS medications varied across subpopulations. Getting HIV/AIDS medications was “very easy” for 70% to 79% of most subpopulations. MSM of color (79%), those in-care (78%) and African-Americans (77%) reported HIV/AIDS medications as “very easy” in the highest proportions.

By far, the out-of-care subpopulation had the highest proportion (68%) of those who had some difficulty accessing HIV/AIDS medications during the past year. Other subpopulations with relatively higher proportions of difficulty were the recently released (45%), white MSM (32%) and respondents with a mental health symptom (30%).

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a

service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced *in the process of* getting a service.

The following table shows the number of barriers reported for HIV/AIDS medications. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation. The cells that are shaded and in bold represent barriers with the highest number of reports for each subpopulation.

TABLE 14.5: NUMBER OF REPORTED BARRIERS FOR HIV/AIDS MEDICATIONS

	A	B	C	D	E	F	G	H	I	J	K	L	M	O	Q	R	S	T	Total** Barriers
All Respondents	16	27	**44**	**48**	17	13	22	19	23	7	10	5	4	7	1	4	1	1	**269**
Subpopulations*																			
In Care	14	15	**39**	**39**	15	8	19	11	17	4	4	4	3	6	1	2	1	0	**202**
Out-of-Care	2	**12**	5	**9**	2	5	3	**8**	6	3	6	1	1	1	0	2	0	1	**67**
Women	5	11	**12**	**17**	7	5	4	9	**11**	4	7	2	1	2	1	0	0	1	**99**
Youth	1	1	2	2	**3**	0	0	2	0	**3**	1	0	2	0	0	1	0	0	**18**
African-Americans	12	**19**	**22**	**25**	10	7	8	9	13	3	8	0	4	2	0	2	1	0	**145**
Latinos	2	4	**6**	**10**	4	3	**6**	1	3	1	1	4	0	1	0	1	0	0	**47**
White MSM	2	2	**9**	**7**	2	1	**6**	5	3	2	0	1	0	2	0	1	0	0	**43**
MSM of Color	2	6	**9**	**14**	3	1	6	0	1	0	0	1	0	1	0	1	1	0	**46**
Recently Released	3	**6**	**8**	**9**	2	4	3	1	4	1	2	1	2	0	1	1	0	0	**48**
Substance Abuse	8	**12**	**18**	**13**	7	4	7	5	11	1	3	1	0	0	0	3	1	1	**95**
Mental Health	11	20	**29**	**37**	13	8	15	17	19	6	7	2	3	5	0	3	1	0	**196**
Homeless	5	**9**	**8**	**10**	5	5	5	6	2	4	4	0	2	0	0	0	0	0	**66**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 269 reports of barriers among respondents who had difficulty accessing HIV/AIDS medications during the past year. The barriers reported most often for

HIV/AIDS medications were related to waiting times for appointments and cost of services. The table below shows the top reported barriers reported by subpopulations when accessing HIV/AIDS medications. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to the table titled, "Number of reported barriers for HIV/AIDS Medications."

TABLE 14.6: TOP REPORTED BARRIERS FOR HIV/AIDS MEDICATIONS BY SUBPOPULATION

	Barriers (ranked by number of reports)
All Respondents	D – The services cost too much (n=48) C – I would have to wait too long to get the services (n=44)
Subpopulations*	
In Care	C – I would have to wait too long to get the services (n=39) D – The services cost too much (n=39)
Out-of-Care	B – I don't know where to get the services (n=12) D – The services cost too much (n=9) H – It's hard to make or keep appointments (n=8)
Women	D – The services cost too much (n=17) C – I would have to wait too long to get the services (n=12) B – I don't know where to get the services (n=11) I – It's hard for me to get there (n=11)
Youth	E – I was told I am not eligible to get the services (n=3) J – There is no one to watch my kids if I go there (n=3)
African-Americans	D – The services cost too much (n=25) C – I would have to wait too long to get the services (n=22) B – I don't know where to get the services (n=19)
Latinos	D – The services cost too much (n=10) C – I would have to wait too long to get the services (n=6) G – The people who run the services are not friendly (n=6)
White MSM	C – I would have to wait too long to get the services (n=9) D – The services cost too much (n=7) G – The people who run the services are not friendly (n=6)
MSM of Color	D – The services cost too much (n=14) C – I would have to wait too long to get the services (n=9)
Recently Released	D – The services cost too much (n=9) C – I would have to wait too long to get the services (n=8) B – I don't know where to get the services (n=6)
Substance Abuse	C – I would have to wait too long to get the services (n=18) D – The services cost too much (n=13) B – I don't know where to get the services (n=12)
Mental Health	D – The services cost too much (n=37) C – I would have to wait too long to get the services (n=29)
Homeless	D – The services cost too much (n=10) B – I don't know where to get the services (n=9) C – I would have to wait too long to get the services (n=8`)

* Subpopulations are not mutually exclusive.

Within all subpopulations (except for youth), problems with cost of services were

reported frequently as a barrier. Waiting times were also ranked highly within subpopulations, except within the out-of-care and youth. Information-related barriers were ranked highly within the out-of-care, women, African-Americans, the recently released and substance abusers.

DENTIST VISITS

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of ***dentist visits*** is defined as:

Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS) and/or ARIES. The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 2,219 unduplicated PLWHA received dentist visits through grants billed to Ryan White Part A and Part B. This total represents 12% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

At the beginning of the client survey, respondents were given a list of core services arranged in table format (see Appendix B for copy of client survey). The purpose of the core service table was to collect information on access and barriers to the listed services. For each HRSA-defined core service, respondents indicated whether they had "some difficulty" getting the service, if it was "very easy" to get the service, or if they "did not need" the service within the past year.

The following table shows the level of access to dentist visits reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service <u>does not necessarily mean the respondent received the service</u>. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 15.1: REPORTED ACCESS TO DENTIST VISITS IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	626	82%	380	61%	246	39%	138	18%
Subpopulations*								
In Care	581	85%	370	64%	211	36%	106	15%
Out-of-Care	45	58%	10	22%	35	78%	32	42%
Women	197	83%	108	55%	89	45%	41	17%
Youth	31	84%	11	35%	20	65%	6	16%
African-Americans	349	81%	214	61%	135	39%	80	19%
Latinos	127	90%	89	70%	38	30%	14	10%
White MSM	83	81%	47	57%	36	43%	20	19%
MSM of Color	179	86%	124	69%	55	31%	29	14%
Recently Released	92	77%	51	55%	41	45%	27	23%
Substance Abuse	196	79%	113	58%	83	42%	52	21%
Mental Health	369	82%	209	57%	160	43%	83	18%
Homeless	64	72%	42	47%	22	25%	25	28%

* Subpopulations are not mutually exclusive.
** Percentages may not add up to 100% due to rounding.

The majority (82%) of all 764 survey respondents reported attempting to access dentist visits during the previous 12 months; a total of 138 (18%) said they did not need this service. Most subpopulations also reported accessing this service in relatively high proportions – Latinos access this service in the highest proportion (90%) compared to other groups. However, the subpopulations with the lowest proportions accessing dentist visits were substance abusers (79%), the recently released (77%) and the out-of-care (58%).

Overall, the majority of all survey respondents had an easy time accessing dentist visits – 61% said it was "very easy" to get the service. Among the subpopulations, access to dentist visits appeared easiest for Latinos (70%), MSM of color (69%) and those in-care (64%).

By far, the out-of-care subpopulation had the highest proportion (78%) of those who had some difficulty accessing dentist visits during the past year. Other subpopulations with relatively higher proportions of difficulty were youth (65%), women (45%) and the recently released (43%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate

whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for dentist visits. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation. The cells that are shaded and in bold represent barriers with the highest number of reports for each subpopulation.

TABLE 15.2: NUMBER OF REPORTED BARRIERS FOR DENTIST VISITS

	A	B	C	D	E	F	G	H	I	J	K	M	O	Q	R	S	Total** Barriers
All Respondents	33	58	**74**	26	15	17	27	**87**	43	6	10	5	24	1	4	1	**431**
Subpopulations*																	
In Care	26	44	**63**	16	11	8	25	**75**	33	4	4	3	18	1	3	1	**335**
Out-of-Care	7	**14**	11	10	4	9	2	**12**	10	2	6	2	6	0	1	0	**96**
Women	12	21	**27**	15	7	10	9	**29**	21	6	6	0	12	1	1	0	**177**
Youth	**6**	**10**	5	3	5	1	3	**6**	4	2	2	0	3	0	1	0	**51**
African-Americans	19	**36**	**34**	19	8	13	11	**49**	18	5	8	4	14	0	3	1	**242**
Latinos	7	8	**12**	4	3	2	5	**15**	6	0	1	0	5	0	0	0	**68**
White MSM	5	5	**17**	1	2	0	8	**14**	7	0	0	1	1	0	0	0	**61**
MSM of Color	7	**15**	**14**	3	4	3	5	**22**	4	0	0	3	7	0	1	0	**88**
Recently Released	5	10	**14**	11	2	4	3	**13**	6	0	3	4	2	0	1	0	**78**
Substance Abuse	11	19	**24**	9	1	4	4	**33**	15	2	5	2	7	0	1	0	**137**
Mental Health	21	38	**55**	20	10	13	17	**55**	32	5	8	2	15	1	4	1	**297**
Homeless	8	**15**	**13**	**12**	8	7	6	**14**	3	3	7	0	0	0	1	1	**102**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 431 reports of barriers among respondents who had difficulty accessing dentist visits during the past year. The barriers reported most often for dentist visits were related to scheduling appointments, getting to locations of services and waiting

times. The table below shows 2-3 highlighted barriers reported by subpopulations when accessing dentist visits. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to the table titled, "Number of reported barriers for Dentist Visits."

TABLE 15.3: HIGHLIGHTED BARRIERS FOR DENTIST VISITS BY SUBPOPULATION

	Barriers (ranked by number of reports)
All Respondents	H – It's hard to make or keep appointments (n=87) C – I would have to wait too long to get the services (n=74)
Subpopulations*	
In Care	H – It's hard to make or keep appointments (n=75) C – I would have to wait too long to get the services (n=63)
Out-of-Care	B – I don't know where to get the services (n=14) H – It's hard to make or keep appointments (n=12)
Women	H – It's hard to make or keep appointments (n=29) C – I would have to wait too long to get the services (n=27)
Youth	B – I don't know where to get the services (n=10) A – The services are not in my area (n=6) H – It's hard to make or keep appointments (n=6)
African-Americans	H – It's hard to make or keep appointments (n=49) B – I don't know where to get the services (n=36) C – I would have to wait too long to get the services (n=34)
Latinos	H – It's hard to make or keep appointments (n=15) C – I would have to wait too long to get the services (n=12)
White MSM	C – I would have to wait too long to get the services (n=17) H – It's hard to make or keep appointments (n=14)
MSM of Color	H – It's hard to make or keep appointments (n=22) B – I don't know where to get the services (n=15) C – I would have to wait too long to get the services (n=14)
Recently Released	C – I would have to wait too long to get the services (n=14) H – It's hard to make or keep appointments (n=13)
Substance Abuse	H – It's hard to make or keep appointments (n=33) C – I would have to wait too long to get the services (n=24)
Mental Health	C – I would have to wait too long to get the services (n=55) H – It's hard to make or keep appointments (n=55)
Homeless	B – I don't know where to get the services (n=15) H – It's hard to make or keep appointments (n=14) C – I would have to wait too long to get the services (n=13) D – The services cost too much (n=12)

* Subpopulations are not mutually exclusive.

Within all subpopulations, problems making or keeping appointments ranked high compared to other barriers. Waiting times were also ranked highly within subpopulations, except within the out-of-care and youth. Information-related barriers were ranked highly within African-Americans, women, MSM of color, out-of-care and youth.

MEDICAL CASE MANAGEMENT

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of **Medical Case Management** is defined as:

Medical Case Management Visit is defined as assessment, education and consultation by an LMSW within a system of information, referral, case management, and/or social services and includes:

- Screening and Assessment to determine level of need for Medical Case Management services
- Social Services/Case Coordination
- Assessment of Readiness for HAART therapy (as indicated)

Services include screening all primary medical care patients to determine each patient's level of need for **Medical Case Management** services, performing a comprehensive assessment and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care compliance. The *Medical Case Manager* serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. The Medical Case Manager will perform, or contribute to, Readiness Assessments in accordance with HIV Services Quality Management guidelines in order to assess a patient's readiness for HAART.

In the client survey, Medical Case Management was described as, "Case Management services that help you <u>only</u> with medical care, substance abuse or mental health services." However, despite emphasizing "medical care, substance abuse or mental health services," respondents may still have been unclear about the distinction between Medical Case Management versus Social Case Management.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS) and/or ARIES. The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the

EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 4,113 unduplicated PLWHA received Medical Case Management through grants billed to Ryan White Part A, the Texas Department of State Health Services and Other funding sources. This total represents 23% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

At the beginning of the client survey, respondents were given a list of core services arranged in table format (see Appendix B for copy of client survey). The purpose of the core service table was to collect information on access and barriers to the listed services. For each HRSA-defined core service, respondents indicated whether they had “some difficulty” getting the service, if it was “very easy” to get the service, or if they “did not need” the service within the past year.

The following table shows the level of access to Medical Case Management reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely

on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 16.1: REPORTED ACCESS TO MEDICAL CASE MANAGEMENT IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	572	75%	438	77%	134	23%	192	25%
Subpopulations*								
In Care	531	77%	430	81%	101	19%	156	23%
Out-of-Care	41	53%	8	20%	33	80%	36	47%
Women	180	76%	134	74%	46	26%	58	24%
Youth	26	70%	19	73%	7	27%	11	30%
African-Americans	324	76%	246	76%	78	24%	105	24%
Latinos	99	70%	82	83%	17	17%	42	30%
White MSM	80	78%	59	74%	21	26%	23	22%
MSM of Color	146	70%	118	81%	28	19%	62	30%
Recently Released	95	80%	66	69%	29	31%	24	20%
Substance Abuse	202	81%	149	74%	53	26%	46	19%
Mental Health	365	81%	268	73%	97	27%	87	19%
Homeless	67	75%	24	27%	43	48%	22	25%

* Subpopulations are not mutually exclusive.
** Percentages may not add up to 100% due to rounding.

Three fourths (75%) of all 764 survey respondents reported attempting to access Medical Case Management during the previous 12 months; a total of 192 (25%) said they did not need this service. Most subpopulations also reported accessing this service in relatively high proportions – substance abusers (81%), respondents with mental health symptoms (81%) and the recently released (80%) reported accessing this service in the highest proportions compared to other groups. However, the subpopulation that reported the lowest proportion accessing Medical Case Management was the out-of-care (53%).

Overall, the majority of all survey respondents had an easy time accessing Medical Case Management – 77% said it was "very easy" to get the service. Based on survey responses, access to Medical Case Management appeared easiest for Latinos (83%), MSM of color (81%) and those in-care (81%).

By far, the out-of-care subpopulation had the highest proportion (80%) of those who

reported some difficulty accessing Medical Case Management during the past year. Another subpopulation with relatively higher proportions of difficulty was the recently released (31%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced *in the process of* getting a service.

The following table shows the number of barriers reported for Medical Case Management. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation. The cells that are shaded and in bold represent barriers with the highest number of reports for each subpopulation.

TABLE 16.2: NUMBER OF REPORTED BARRIERS FOR MEDICAL CASE MANAGEMENT

	A	B	C	D	E	F	G	H	I	J	K	L	M	O	Q	S	U	Total** Barriers
All Respondents	19	**34**	29	10	10	8	29	**33**	16	2	9	1	7	1	2	2	7	**219**
Subpopulations*																		
In Care	15	22	**25**	6	7	2	23	**30**	11	1	3	1	6	1	1	2	6	**162**
Out-of-Care	4	**12**	4	4	3	6	6	3	5	1	6	0	1	0	1	0	1	**57**
Women	7	**11**	9	4	3	8	**11**	**16**	10	2	3	0	1	0	2	1	2	**90**
Youth	1	**4**	3	0	2	0	**4**	3	2	1	1	0	0	0	0	0	0	**21**
African-Americans	15	**22**	19	5	5	6	16	**24**	11	2	7	0	6	0	2	0	2	**142**
Latinos	1	3	**5**	1	1	0	**5**	1	1	0	1	1	1	0	0	1	3	**25**
White MSM	1	**4**	3	3	2	0	3	**6**	2	0	1	0	0	0	0	0	0	**25**
MSM of Color	6	5	**10**	0	3	0	**7**	4	0	0	1	0	2	1	0	0	0	**39**
Recently Released	3	**9**	**8**	6	1	3	6	7	4	0	5	0	5	0	2	1	3	**63**
Substance Abuse	8	**12**	8	7	1	2	9	**18**	11	0	4	0	3	0	2	0	2	**87**
Mental Health	14	**30**	17	8	7	7	21	**27**	15	2	9	0	6	0	1	2	4	**170**
Homeless	5	**11**	6	3	2	4	**7**	**7**	6	1	4	0	1	0	0	0	0	**60**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	L	People at the agency don't speak my language
B	I don't know where to get the services	M	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	N	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	O	Substance abuse
E	I was told I am not eligible to get the services	P	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	Q	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	R	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	S	Homeless/unstable housing
I	It's hard for me to get there	T	CM left/staff turnover
J	There is no one to watch my kids if I go there	U	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	V	Immigration status

Overall, there were 219 reports of barriers among respondents who had difficulty accessing Medical Case Management during the past year. The barriers reported most often for Medical Case Management were related to lack of information and difficulties making or keeping appointments.

The following table shows several highlighted barriers reported by subpopulations when accessing Medical Case Management. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 16.2 “Number of reported barriers for Medical Case Management.”

TABLE 16.3: HIGHLIGHTED BARRIERS FOR MEDICAL CASE MANAGEMENT BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=34) H – It's hard to make or keep appointments (n=33)
Subpopulations*	
In Care	H – It's hard to make or keep appointments (n=30) C – I would have to wait too long to get the services (n=25)
Out-of-Care	B – I don't know where to get the services (n=12)
Women	H – It's hard to make or keep appointments (n=16) B – I don't know where to get the services (n=11) G – The people who run the services are not friendly (n=11)
Youth	G – The people who run the services are not friendly (n=4) B – I don't know where to get the services (n=4)
African-Americans	H – It 's hard to make or keep appointments (n=24) B – I don't know where to get the services (n=22)
Latinos	C – I would have to wait too long to get the services (n=5) G – The people who run the services are not friendly (n=5)
White MSM	H – It's hard to make or keep appointments (n=6) B – I don't know where to get the services (n=4)
MSM of Color	C – I would have to wait too long to get the services (n=10) G – The people who run the services are not friendly (n=7)
Recently Released	B – I don't know where to get the services (n=9) C – I would have to wait too long to get the services (n=8)
Substance Abuse	H – It's hard to make or keep appointments (n=18) B – I don't know where to get the services (n=12)
Mental Health	B – I don't know where to get the services (n=30) H – It's hard to make or keep appointments (n=27)
Homeless	B – I don’t know where to get the services (n=11) G – The people who run the services are not friendly (n=7) H – It's hard to make or keep appointments (n=7)

* Subpopulations are not mutually exclusive.

Problems with lack of information and making and keeping appointments ranked highly for the majority of subpopulations. Waiting times and unfriendly staff were also ranked highly within subpopulations.

HOME HEALTH CARE

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of ***Home Health Care*** is defined as:

Physician ordered skilled nursing care provided by a Licensed Vocational or Registered Nurse for HIV-infected individuals in their place of residency. Physician-ordered intravenous medication therapies must be administered by a registered nurse in the patient's home or residential facility. Home health aide is defined as a home visit by a Home Health Aide for the purpose of performing specific tasks to allow the patient to remain in his/her place of residency.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS) and/or ARIES. The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 63 unduplicated PLWHA received Home Health Care through grants billed to Ryan White Part A and Part B. This total represents less than 1% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

At the beginning of the client survey, respondents were given a list of core services arranged in table format (see Appendix B for copy of client survey). The purpose of the core service table was to collect information on access and barriers to the listed services. For each HRSA-defined core service, respondents indicated whether they had "some difficulty" getting the service, if it was "very easy" to get the service, or if they "did not need" the service within the past year.

The following table shows the level of access to Home Health Care reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service <u>does not necessarily mean the respondent received the service</u>. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 17.1: REPORTED ACCESS TO HOME HEALTH CARE IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	197	26%	122	62%	75	38%	567	74%
Subpopulations*								
In Care	179	26%	120	67%	59	33%	508	74%
Out-of-Care	18	23%	2	11%	16	89%	59	77%
Women	52	22%	27	52%	25	48%	186	78%
Youth	7	19%	5	71%	2	29%	30	81%
African-Americans	127	30%	74	58%	53	42%	302	70%
Latinos	34	24%	27	79%	7	21%	107	76%
White MSM	14	14%	8	57%	6	43%	89	86%
MSM of Color	51	25%	39	76%	12	24%	157	75%
Recently Released	35	29%	19	54%	16	46%	84	71%
Substance Abuse	66	27%	37	56%	29	44%	182	73%
Mental Health	130	29%	70	54%	60	46%	322	71%
Homeless	30	34%	21	24%	9	10%	59	66%

* Subpopulations are not mutually exclusive.
** Percentages may not add up to 100% due to rounding.

Approximately a fourth (26%) of all 764 survey respondents reported attempting to access Home Health Care during the previous 12 months; the majority (74%) said they did not need this service. Most subpopulations also reported relatively low proportions accessing this service. Youth (19%) and white MSM (14%) were the two subpopulations with the lowest proportion of reported access attempts to Home Health Care.

Although overall use was low, most (62%) respondents that tried to access Home Health Care said it was "very easy" to get. Based on survey responses, access to Home Health Care appeared easiest for Latinos (79%), MSM of color (76%) and those in-care (67%).

By far, the out-of-care subpopulation had the highest proportion (89%) of those who reported some difficulty accessing Home Health Care during the past year.

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Home Health Care. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation. The cells that are shaded and in bold represent barriers with the highest number of reports for each subpopulation.

TABLE 17.2: NUMBER OF REPORTED BARRIERS FOR HOME HEALTH CARE

	A	B	C	D	E	F	G	H	I	J	K	L	M	R	S	T	Total** Barriers
All Respondents	7	**21**	8	7	**13**	12	8	8	7	1	4	1	3	1	1	7	**109**
Subpopulations*																	
In Care	5	**17**	7	6	**9**	7	7	6	5	1	1	1	1	1	1	5	**80**
Out-of-Care	2	4	1	1	4	**5**	1	2	2	0	3	0	2	0	0	2	**29**
Women	0	**7**	3	2	4	5	4	2	2	0	3	0	0	0	1	2	**35**
Youth	0	**1**	0	0	**1**	0	0	0	0	0	0	0	0	0	0	0	**2**
African-Americans	5	**17**	3	6	7	8	5	5	4	0	3	0	3	1	1	4	**72**
Latinos	0	0	**2**	0	1	**2**	1	0	1	1	1	1	0	0	0	1	**11**
White MSM	2	2	1	1	**4**	0	2	2	2	0	0	0	0	0	0	0	**16**
MSM of Color	1	**3**	2	1	**3**	2	1	1	0	0	0	0	1	1	0	0	**16**
Recently Released	1	**6**	2	2	4	5	0	2	2	0	2	0	3	0	0	3	**32**
Substance Abuse	5	**8**	3	3	**9**	7	4	1	4	0	1	0	1	0	1	4	**51**
Mental Health	5	**18**	5	4	**13**	10	6	5	6	1	4	1	3	1	1	6	**89**
Homeless	2	**7**	2	3	**5**	4	2	2	3	0	2	0	0	1	**5**	0	**38**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 109 reports of barriers among respondents who had difficulty accessing Home Health Care during the past year. The barriers reported most often for Home Health Care were related to lack of information and respondents believing – or being

told – they were not eligible for services.

The table below shows several highlighted barriers reported by subpopulations when accessing Home Health Care. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 17.2 "Number of reported barriers for Home Health Care."

TABLE 17.3: HIGHLIGHTED BARRIERS FOR HOME HEALTH CARE BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=21)
Subpopulations*	
In Care	B – I don't know where to get the services (n=17)
Out-of-Care	F – I don't think I'm eligible to get the services (n=5)
Women	B – I don't know where to get the services (n=7)
Youth	Only 2 barriers were reported among youth for this service. Please refer to previous table.
African-Americans	B – I don't know where to get the services (n=17)
Latinos	C – I would have to wait too long to get the services (n=2) F – I don't think I'm eligible to get the services (n=2) Only 11 barriers total were reported. Please refer to previous table.
White MSM	E – I was told I am not eligible to get the services (n=4)
MSM of Color	B – I don't know where to get the services (n=3) E – I was told I am not eligible to get the services (n=3)
Recently Released	B – I don't know where to get the services (n=6)
Substance Abuse	E – I was told I am not eligible to get the services (n=9) B – I don't know where to get the services (n=8)
Mental Health	B – I don't know where to get the services (n=18) E – I was told I am not eligible to get the services (n=13)
Homeless	B – I don't know where to get the services (n=7) E – I was told I am not eligible to get the services (n=5) S - Homeless/unstable housing (n=5)

* Subpopulations are not mutually exclusive.

Problems with lack of information and being told they were ineligible ranked high as barriers for the majority of subpopulations.

PSYCHIATRIC SERVICES

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of ***Psychiatric Services*** is defined as provision of outpatient psychiatric care by a Board certified Psychiatrist. Outpatient psychiatric services must include:

Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.

Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.

Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.

Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders.

Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.

In the client survey, Psychiatric Services were described as, “Psychiatric services or medicine for mental health problems.”

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS) and/or ARIES. The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application,

the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA. It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 1,185 unduplicated PLWHA received Psychiatric Services through grants billed to Ryan White Part A, the Texas Department of State Health Services and Other funding sources. This total represents 7% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

At the beginning of the client survey, respondents were given a list of core services arranged in table format (see Appendix B for copy of client survey). The purpose of the core service table was to collect information on access and barriers to the listed services. For each HRSA-defined core service, respondents indicated whether they had "some difficulty" getting the service, if it was "very easy" to get the service, or if they "did not need" the service within the past year.

The following table shows the level of access to Psychiatric Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service <u>does not necessarily mean the respondent received the service</u>. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 18.1: REPORTED ACCESS TO PSYCHIATRIC SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	440	58%	338	77%	102	23%	324	42%
Subpopulations*								
In Care	411	60%	332	81%	79	19%	276	40%
Out-of-Care	29	38%	6	21%	23	79%	48	62%
Women	142	60%	103	73%	39	27%	96	40%
Youth	14	38%	7	50%	7	50%	23	62%
African-Americans	235	55%	174	74%	61	26%	194	45%
Latinos	78	55%	68	87%	10	13%	63	45%
White MSM	69	67%	52	75%	17	25%	34	33%
MSM of Color	115	55%	96	83%	19	17%	93	45%
Recently Released	80	67%	58	73%	22	28%	39	33%
Substance Abuse	163	66%	123	75%	40	25%	85	34%
Mental Health	331	73%	250	76%	81	24%	121	27%
Homeless	57	64%	27	30%	30	34%	32	36%

* Subpopulations are not mutually exclusive.
** Percentages may not add up to 100% due to rounding.

A little more than half (58%) of all 764 survey respondents reported attempting to access Psychiatric Services during the previous 12 months; a total of 324 (42%) said they did not need this service. Most subpopulations also reported accessing this service in similar proportions – white MSM (67%), the recently released (67%) and substance abusers (66%) reported accessing this service in the highest proportions compared to other groups. However, the subpopulations with the lowest proportion accessing Psychiatric Services were the out-of-care (38%) and youth (38%).

Overall, the majority of all survey respondents had a very easy time accessing Psychiatric Services – 77% said it was "very easy" to get the service. Based on survey responses, access to Psychiatric Services appeared easiest for Latinos (87%), MSM of color (83%) and those in-care (81%).

By far, the out-of-care subpopulation had the highest proportion (79%) of those who reported some difficulty accessing Psychiatric Services during the past year. Another subpopulation with relatively higher proportions of difficulty was youth (50%), although the small size of the subpopulation should be taken into account.

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a

service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced *in the process of* getting a service.

The following table shows the number of barriers reported for Psychiatric Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation. The cells that are shaded and in bold represent barriers with the highest number of reports for each subpopulation.

TABLE 18.2: NUMBER OF REPORTED BARRIERS FOR PSYCHIATRIC SERVICES

	A	B	C	D	E	F	G	H	I	J	K	L	M	R	Total** Barriers
All Respondents	15	23	**30**	20	13	7	20	**31**	21	4	7	1	1	3	**196**
Subpopulations*															
In Care	13	18	**25**	14	11	5	15	**25**	16	4	5	1	0	2	**154**
Out-of-Care	2	5	5	**6**	2	2	5	**6**	5	0	2	0	1	1	**42**
Women	6	**14**	11	9	5	5	6	**13**	11	4	4	0	0	2	**90**
Youth	1	2	3	2	3	1	3	**4**	3	2	2	0	0	0	**26**
African-Americans	9	11	**19**	10	9	7	9	**22**	13	3	5	0	1	1	**119**
Latinos	3	**4**	**4**	3	1	0	2	1	3	0	2	1	0	1	**25**
White MSM	1	4	4	**6**	3	0	**5**	**5**	3	0	0	0	0	0	**31**
MSM of Color	2	2	**6**	2	3	1	2	**6**	2	0	0	1	0	0	**27**
Recently Released	3	4	**9**	4	2	2	2	**8**	7	0	4	0	1	1	**47**
Substance Abuse	7	11	**15**	6	5	1	10	**12**	7	1	3	0	0	2	**80**
Mental Health	10	20	**22**	15	12	7	18	**26**	18	4	6	1	1	3	**163**
Homeless	5	6	**13**	7	4	2	**9**	**8**	6	2	6	0	0	0	**70**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service.

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 196 reports of barriers among respondents who had difficulty accessing Psychiatric Services during the past year. The barriers reported most often for

Psychiatric Services were related to waiting times and difficulties making or keeping appointments.

The table below shows several highlighted barriers reported by subpopulations when accessing Psychiatric Services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 18.2 "Number of reported barriers for Psychiatric Services."

TABLE 18.3: HIGHLIGHTED BARRIERS FOR PSYCHIATRIC SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	H – It's hard to make or keep appointments (n=31) C – I would have to wait too long to get the services (n=30)
Subpopulations*	
In Care	C – I would have to wait too long to get the services (n=25) H – It's hard to make or keep appointments (n=25)
Out-of-Care	D – The services cost too much (n=6) H – It's hard to make or keep appointments (n=6)
Women	B – I don't know where to get the services (n=14) H – It's hard to make or keep appointments (n=13)
Youth	H – It's hard to make or keep appointments (n=4)
African-Americans	H – It's hard to make or keep appointments (n=22) C – I would have to wait too long to get the services (n=19)
Latinos	B – I don't know where to get the services (n=4) C – I would have to wait too long to get the services (n=4)
White MSM	D – The services cost too much (n=6) G – The people who run the services are not friendly (n=5) H – It's hard to make or keep appointments (n=5)
MSM of Color	C – I would have to wait too long to get the services (n=6) H – It's hard to make or keep appointments (n=6)
Recently Released	C – I would have to wait too long to get the services (n=9) H – It's hard to make or keep appointments (n=8)
Substance Abuse	C = I would have to wait too long to get the services (n=15) H – It's hard to make or keep appointments (n=12)
Mental Health	H – It's hard to make or keep appointments (n=26) C – I would have to wait too long to get the services (n=22)
Homeless	C – I would have to wait too long to get the services (n=13) G – The people who run the services are not friendly (n=9) H – It's hard to make or keep appointments (n=8)

* Subpopulations are not mutually exclusive.

Problems with waiting times and making and keeping appointments ranked highly for the majority of subpopulations. Lack of information ranked highly for women and Latinos, and cost of services ranked highly for the out-of-care and white MSM.

PSYCHOLOGICAL COUNSELING SERVICES

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of ***Psychological Counseling Services*** is defined as:

Individual Therapy/counseling is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV-positive or HIV/AIDS affected individual.

Support Groups are defined as professionally led (licensed therapist or counselor) groups that comprise HIV-infected individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV-infected person.

Bereavement Counseling is individual counseling, which assists clients in resolving grief and mourning associated with the death of a parent/partner/family member. Counseling must be initiated and completed within 12 months of the death of the parent/partner/ family member (no more than 24 individual counseling sessions) to a Part A eligible affected child, partner or other family member.

In the client survey, Psychological Counseling Services was described as simply "Psychological Counseling Services."

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS) and/or ARIES. The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed

collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 625 unduplicated PLWHA received Psychological Counseling Services through grants billed to Ryan White Part A, Substance Abuse & Mental Health Services Administration (SAMHSA), the Texas Department of State Health Services and Other funding sources. This total represents 3% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

At the beginning of the client survey, respondents were given a list of core services arranged in table format (see Appendix B for copy of client survey). The purpose of the core service table was to collect information on access and barriers to the listed services. For each HRSA-defined core service, respondents indicated whether they had "some difficulty" getting the service, if it was "very easy" to get the service, or if they "did not need" the service within the past year.

The following table shows the level of access to Psychological Counseling Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service <u>does not necessarily mean the respondent received the service</u>. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 19.1: REPORTED ACCESS TO PSYCHOLOGICAL COUNSELING IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	437	57%	350	80%	87	20%	327	43%
Subpopulations*								
In Care	402	59%	337	84%	65	16%	285	41%
Out-of-Care	35	45%	13	37%	22	63%	42	55%
Women	134	56%	101	75%	33	25%	104	44%
Youth	19	51%	12	63%	7	37%	18	49%
African-Americans	233	54%	187	80%	46	20%	196	46%
Latinos	81	57%	72	89%	9	11%	60	43%
White MSM	72	70%	53	74%	19	26%	31	30%
MSM of Color	116	56%	100	86%	16	14%	92	44%
Recently Released	75	63%	59	79%	16	21%	44	37%
Substance Abuse	160	65%	125	78%	35	22%	88	35%
Mental Health	317	70%	246	78%	71	22%	135	30%
Homeless	54	61%	20	22%	34	38%	35	39%

* Subpopulations are not mutually exclusive.
** Percentages may not add up to 100% due to rounding.

A little more than half (57%) of all 764 survey respondents reported attempting to access Psychological Counseling Services during the previous 12 months; a total of 327 (43%) said they did not need this service. Most subpopulations also reported accessing this service in similar proportions – white MSM (70%) and respondents with a mental health condition (70%) reported accessing this service in the highest proportions compared to other groups. However, the subpopulations with the lowest proportion accessing Psychological Counseling Services were the out-of-care (45%) and youth (51%).

Overall, the majority of all survey respondents had a very easy time accessing Psychological Counseling Services – 80% said it was "very easy" to get the service. Based on survey responses, access to Psychological Counseling Services appeared easiest for Latinos (89%), MSM of color (86%) and those in-care (84%).

By far, the out-of-care subpopulation had the highest proportion (63%) of those who reported some difficulty accessing Psychological Counseling Services during the past year. Another subpopulation with relatively higher proportions of difficulty was youth (37%), although the small size of the subpopulation should be taken into account.

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so

respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Psychological Counseling Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation. The cells that are shaded and in bold represent barriers with the highest number of reports for each subpopulation.

TABLE 19.2: NUMBER OF REPORTED BARRIERS FOR PSYCHOLOGICAL COUNSELING SERVICES

	A	B	C	D	E	F	G	H	I	J	K	M	P	R	S	Total** Barriers
All Respondents	12	**25**	17	18	7	11	11	**25**	19	3	6	1	1	4	1	**161**
Subpopulations*																
In Care	10	**16**	14	13	5	8	6	**21**	15	3	4	1	1	3	1	**121**
Out-of-Care	2	**9**	3	5	2	3	5	4	4	0	2	0	0	1	0	**40**
Women	4	**11**	6	**10**	1	2	5	8	**10**	3	2	0	1	2	1	**66**
Youth	1	2	1	1	1	1	2	0	**4**	1	0	1	0	0	0	**15**
African-Americans	7	**13**	10	5	4	8	7	**15**	9	2	4	1	1	3	0	**89**
Latinos	2	**4**	3	**4**	0	2	1	1	2	0	1	0	0	0	0	**20**
White MSM	1	3	4	**6**	3	1	2	**7**	4	0	0	0	0	0	0	**31**
MSM of Color	1	**4**	**4**	1	2	3	1	**4**	1	0	1	0	0	1	0	**23**
Recently Released	3	**7**	5	5	3	3	2	**6**	3	0	3	1	0	2	0	**43**
Substance Abuse	7	**11**	**11**	7	3	3	6	9	8	1	5	0	0	2	1	**74**
Mental Health	9	**24**	11	14	7	10	10	**21**	15	3	6	1	1	3	1	**136**
Homeless	4	**8**	4	**5**	3	4	**5**	3	**5**	1	4	1	0	0	0	**48**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	H	It's hard to make or keep appointments
B	I don't know where to get the services	I	It's hard for me to get there
C	I would have to wait too long to get the services	J	There is no one to watch my kids if I go there
D	The services cost too much	M	My jail/prison history makes it hard to get services
E	I was told I am not eligible to get the services	P	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	R	Fear, denial or stigma (internal and/or external)
G	The people who run the services are not friendly	S	Homeless/unstable housing

Overall, there were 161 reports of barriers among respondents who had difficulty accessing Psychological Counseling Services during the past year. The barriers reported most often for Psychological Counseling Services were related to lack of information and

difficulties making or keeping appointments. The table below shows several highlighted barriers reported by subpopulations when accessing Psychological Counseling Services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 19.2 "Number of reported barriers for Psychological Counseling Services."

TABLE 19.3: HIGHLIGHTED BARRIERS FOR PSYCHOLOGICAL COUNSELING SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=25) H – It's hard to make or keep appointments (n=25)
Subpopulations*	
In Care	H – It's hard to make or keep appointments (n=21) B - I don't know where to get the services (n=16)
Out-of-Care	B - I don't know where to get the services (n=9)
Women	B - I don't know where to get the services (n=11) D - The services cost too much (n=10) I - It's hard for me to get there (n=10)
Youth	I - It's hard for me to get there (n=4)
African-Americans	H - It's hard to make or keep appointments (n=15) B - I don't know where to get the services (n=13)
Latinos	B - I don't know where to get the services (n=4) D - The services cost too much (n=4)
White MSM	H - It's hard to make or keep appointments (n=7) D - The services cost too much (n=6)
MSM of Color	B - I don't know where to get the services (n=4) C - I would have to wait too long to get the services (n=4) H - It's hard to make or keep appointments (n=4)
Recently Released	B - I don't know where to get the services (n=7) H - It's hard to make or keep appointments (n=6)
Substance Abuse	B - I don't know where to get the services (n=11) C - I would have to wait too long to get the services (n=11)
Mental Health	B - I don't know where to get the services (n=24) H - It's hard to make or keep appointments (n=21)
Homeless	B - I don't know where to get the services (n=8) D - The services cost too much (n=5) G - The people who run the services are not friendly (n=5) I - It's hard for me to get there (n=5)

* Subpopulations are not mutually exclusive.

Problems with lack of information and difficulties making or keeping appointments ranked highly for the majority of subpopulations. Cost of services ranked highly for women, white MSM and Latinos, waiting times ranked highly for MSM of color and substance abusers and difficulty getting to services ranked highly for women and youth.

REHABILITATION SERVICES

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of ***Rehabilitation Services*** is defined as Physician-ordered physical therapy and/or skilled rehabilitation visit (session) provided to one HIV-positive patient in a community-based organization and/or health care facility and/or at the patient's home, including palliative care.

In the client survey, Rehabilitation Services was described as "Rehabilitation services (physical or speech therapy, low vision training) ordered by your doctor."

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS) and/or ARIES. The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 165 unduplicated PLWHA received Rehabilitation Services through grants billed to Ryan White Part A and Other funding sources. This total represents 1% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

At the beginning of the client survey, respondents were given a list of core services arranged in table format (see Appendix B for copy of client survey). The purpose of the core service table was to collect information on access and barriers to the listed services. For each HRSA-defined core service, respondents indicated whether they had "some difficulty" getting the service, if it was "very easy" to get the service, or if they "did not need" the service within the past year.

The following table shows the level of access to Rehabilitation Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service <u>does not necessarily mean the respondent received the service</u>. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 20.1: REPORTED ACCESS TO REHABILITATION SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	225	29%	167	74%	58	26%	539	71%
Subpopulations*								
In Care	210	31%	165	79%	45	21%	477	69%
Out-of-Care	15	19%	2	13%	13	87%	62	81%
Women	65	27%	50	77%	15	23%	173	73%
Youth	5	14%	4	80%	1	20%	32	86%
African-Americans	143	33%	103	72%	40	28%	286	67%
Latinos	46	33%	42	91%	4	9%	95	67%
White MSM	20	19%	8	40%	12	60%	83	81%
MSM of Color	68	33%	55	81%	13	19%	140	67%
Recently Released	39	33%	27	69%	12	31%	80	67%
Substance Abuse	80	32%	53	66%	27	34%	168	68%
Mental Health	149	33%	99	66%	50	34%	303	67%
Homeless	30	34%	16	18%	14	16%	59	66%

* Subpopulations are not mutually exclusive.
** Percentages may not add up to 100% due to rounding.

Less than a third (29%) of all 764 survey respondents reported attempting to access Rehabilitation Services during the previous 12 months; the majority (71%) said they did not need this service. Most subpopulations also had low reports of accessing this service; however, the subpopulations with the lowest proportion accessing Rehabilitation Services were youth (14%), white MSM (19%) and the out-of-care (19%).

Among respondents that tried accessing Rehabilitation Services, the majority (74%) said it was "very easy" to get the service. Based on survey responses, access to Rehabilitation Services appeared easiest for Latinos (91%), and MSM of color (81%).

By far, the out-of-care subpopulation had the highest proportion (87%) of those who reported some difficulty accessing Rehabilitation Services during the past year. Another subpopulation with relatively higher proportions of difficulty was white MSM (60%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents

described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Rehabilitation Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 20.2: NUMBER OF REPORTED BARRIERS FOR REHABILITATION SERVICES

	A	B	C	D	E	F	G	H	I	J	K	L	S	V	Total** Barriers
All Respondents	9	**21**	7	7	9	7	5	**12**	**12**	1	6	1	1	1	99
Subpopulations*															
In Care	5	**15**	7	3	6	4	4	**11**	9	1	2	1	1	1	70
Out-of-Care	4	**6**	0	4	3	3	1	1	3	0	4	0	0	0	29
Women	1	**6**	2	3	0	3	1	**6**	3	1	2	1	0	0	29
Youth	**1**	0	0	0	0	0	0	0	0	0	0	0	**1**	0	2
African-Americans	7	**15**	6	6	6	4	3	**9**	6	0	4	1	1	1	69
Latinos	1	**3**	0	1	0	1	0	1	1	1	1	0	0	0	10
White MSM	1	2	1	0	**3**	1	2	2	**5**	0	1	0	0	0	18
MSM of Color	1	**5**	1	2	**3**	0	1	1	1	0	0	0	0	0	15
Recently Released	2	**4**	2	3	2	2	1	3	3	0	**5**	1	0	0	28
Substance Abuse	7	**10**	3	3	5	3	3	4	**8**	0	4	1	0	1	52
Mental Health	7	**21**	6	6	8	6	4	**12**	10	1	6	1	1	1	90
Homeless	3	**7**	1	3	0	3	3	3	4	0	**5**	0	0	0	**33**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**H**	It's hard to make or keep appointments
B	I don't know where to get the services	**I**	It's hard for me to get there
C	I would have to wait too long to get the services	**J**	There is no one to watch my kids if I go there
D	The services cost too much	**K**	I'm afraid someone will find out about my HIV
E	I was told I am not eligible to get the services	**L**	People at the agency don't speak my language
F	I don't think I'm eligible to get the services	**S**	Homeless/unstable housing
G	The people who run the services are not friendly	**V**	Immigration status

Overall, there were 99 reports of barriers among respondents who had difficulty accessing Rehabilitation Services during the past year. The barrier reported most often for Rehabilitation Services was related to lack of information.

The table below shows several highlighted barriers reported by subpopulations when accessing Rehabilitation Services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 20.2, "Number of reported barriers for Rehabilitation Services."

TABLE 20.3: HIGHLIGHTED BARRIERS FOR REHABILITATION SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B - I don't know where to get the services (n=21)
Subpopulations*	
In Care	B - I don't know where to get the services (n=15)
Out-of-Care	B - I don't know where to get the services (n=6)
Women	B - I don't know where to get the services (n=6) H - It's hard to make or keep appointments (n=6)
Youth	Only 2 barriers were reported among youth for this service. Please see previous table.
African-Americans	B - I don't know where to get the services (n=15)
Latinos	B - I don't know where to get the services (n=3)
White MSM	I - It's hard for me to get there (n=5)
MSM of Color	B - I don't know where to get the services (n=5)
Recently Released	K – I'm afraid someone will find out about my HIV (n=5)
Substance Abuse	B - I don't know where to get the services (n=10)
Mental Health	B - I don't know where to get the services (n=21)
Homeless	C – I would have to wait too long to get the services (n=7) K - I'm afraid someone will find out about my HIV (n=6)

Problems with lack of information ranked high for all subpopulations except white MSM and the recently released. Waiting times and unfriendly staff were also ranked highly within subpopulations. Difficulties making or keeping appointments ranked highly for women.

SUBSTANCE ABUSE TREATMENT SERVICES

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of ***Substance Abuse Treatment Services*** is defined as treatment and/ or counseling HIV/AIDS infected individuals with substance abuse disorders.

In the client survey, Substance Abuse Treatment Services was described as "Alcohol or substance abuse treatment services (outpatient and inpatient)."

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS) and/or ARIES. The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 656 unduplicated PLWHA received Substance Abuse Treatment Services through

grants billed to Ryan White Part A and Substance Abuse & Mental Health Services Administration (SAMHSA). This total represents 4% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

At the beginning of the client survey, respondents were given a list of core services arranged in table format (see Appendix B for copy of client survey). The purpose of the core service table was to collect information on access and barriers to the listed services. For each HRSA-defined core service, respondents indicated whether they had "some difficulty" getting the service, if it was "very easy" to get the service, or if they "did not need" the service within the past year.

The following table shows the level of access to Substance Abuse Treatment Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service <u>does not necessarily mean the respondent received the service</u>. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 21.1: REPORTED ACCESS TO SUBSTANCE ABUSE TREATMENT SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	270	35%	213	79%	57	21%	494	65%
Subpopulations*								
In Care	249	36%	204	82%	45	18%	438	64%
Out-of-Care	21	27%	9	43%	12	57%	56	73%
Women	77	32%	64	83%	13	17%	161	68%
Youth	6	16%	4	67%	2	33%	31	84%
African-Americans	185	43%	147	79%	38	21%	244	57%
Latinos	33	23%	29	88%	4	12%	108	77%
White MSM	23	22%	13	57%	10	43%	80	78%
MSM of Color	75	36%	63	84%	12	16%	133	64%
Recently Released	73	61%	52	71%	21	29%	46	39%
Substance Abuse	161	65%	123	76%	38	24%	87	35%
Mental Health	170	38%	130	76%	40	24%	282	62%
Homeless	49	55%	17	19%	32	36%	40	45%

* Subpopulations are not mutually exclusive.
** Percentages may not add up to 100% due to rounding.

Approximately one third (35%) of all 764 survey respondents reported attempting to access Substance Abuse Treatment Services during the previous 12 months; a total of 494 (65%) said they did not need this service. Most subpopulations also reported accessing this service in similar proportions – substance abusers (65%) and the recently released (61%) reported accessing this service in the highest proportions compared to other groups. However, the subpopulations with the lowest proportion accessing Substance Abuse Treatment Services were youth (16%) and white MSM (22%).

Among respondents that tried accessing Substance Abuse Treatment Services, the majority (79%) said it was "very easy" to get the service. Based on survey responses, access to Substance Abuse Treatment Services appeared easiest for Latinos (88%), women (83%) and MSM of color (84%).

By far, the out-of-care subpopulation had the highest proportion (57%) of those who reported some difficulty accessing Substance Abuse Treatment Services during the past year. Another subpopulation with relatively higher proportions of difficulty was white MSM (43%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so

respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Substance Abuse Treatment Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 21.2: NUMBER OF REPORTED BARRIERS FOR SUBSTANCE ABUSE TREATMENT SERVICES

	A	B	C	D	E	F	G	H	I	J	K	L	M	S	T	Total** Barriers
All Respondents	9	**15**	11	8	6	6	9	7	**12**	4	6	1	6	2	1	**103**
Subpopulations*																
In Care	5	**12**	9	5	2	4	8	6	**10**	3	3	1	6	2	0	**76**
Out-of-Care	**4**	3	2	3	**4**	2	1	1	2	1	3	0	0	0	1	**27**
Women	1	**5**	1	4	0	3	1	2	**5**	3	2	1	0	0	0	**28**
Youth	0	0	1	0	0	0	0	0	1	1	0	0	1	0	0	**4**
African-Americans	6	**10**	**7**	5	4	4	6	5	5	2	4	1	5	1	1	**66**
Latinos	1	0	1	1	1	0	0	0	**2**	1	1	0	0	0	0	**8**
White MSM	1	2	**3**	1	1	2	**3**	2	**3**	1	1	0	1	1	0	**22**
MSM of Color	2	**3**	2	1	**4**	0	2	1	1	0	0	0	2	0	0	**18**
Recently Released	4	**6**	5	4	2	2	2	3	5	2	5	0	**6**	0	0	**46**
Substance Abuse	**9**	**9**	**10**	6	4	4	7	5	8	2	5	1	3	1	1	**75**
Mental Health	7	**14**	8	7	5	5	5	6	**9**	2	6	1	6	1	0	**82**
Homeless	1	**5**	3	2	1	2	4	1	4	2	4	0	4	0	0	33

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 103 reports of barriers among respondents who had difficulty accessing Substance Abuse Treatment Services during the past year. The barriers reported most often for Substance Abuse Treatment Services were related to lack of information and difficulties getting to services. The table below shows several highlighted barriers reported by subpopulations when accessing Substance Abuse Treatment Services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 21.2 "Number of reported barriers for Substance Abuse Treatment Services."

TABLE 21.3: HIGHLIGHTED BARRIERS FOR SUBSTANCE ABUSE TREATMENT SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B - I don't know where to get the services (n=15) I - It's hard for me to get there (n=12)
Subpopulations*	
In Care	B - I don't know where to get the services (n=12) I - It's hard for me to get there (n=10)
Out-of-Care	A - The services are not in my area (n=4) E - I was told I am not eligible to get the services (n=4)
Women	B - I don't know where to get the services (n=5) I - It's hard for me to get there (n=5)
Youth	There were 4 barriers reported among youth for this service. Please refer to previous table.
African-Americans	B - I don't know where to get the services (n=10) C - I would have to wait too long to get the services (n=7)
Latinos	I - It's hard for me to get there (n=2) Only 8 barriers were reported. Please refer to previous table.
White MSM	C - I would have to wait too long to get the services (n=3) G - The people who run the services are not friendly (n=3) I - It's hard for me to get there (n=3)
MSM of Color	E - I was told I am not eligible to get the services (n=4) B - I don't know where to get the services (n=3)
Recently Released	B - I don't know where to get the services (n=6) M - My jail/prison history makes it hard to get services (n=6)
Substance Abuse	C - I would have to wait too long to get the services (n=10) A - The services are not in my area (n=9) B - I don't know where to get the services (n=9)
Mental Health	B - I don't know where to get the services (n=14) I - It's hard for me to get there (n=9)
Homeless	B - I don't know where to get the services (n=5)

* Subpopulations are not mutually exclusive.

Problems with lack of information and difficulties getting to services ranked highly for

the majority of subpopulations. Waiting times and unfriendly staff were also ranked highly within subpopulations. Services not in area ranked highly for the Out-of-Care and substance abusers; waiting times ranked highly for African-Americans, white MSM and substance abusers; being told they were not eligible ranked highly for the Out-of-Care and MSM of color; unfriendly staff ranked highly with white MSM, and; the recently released encountered frequent barriers related to their jail/prison histories.

Child Care Services

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local or HRSA definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Child Care*** under Ryan White Part B is defined as the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or trainings. Child care services while a client is at work is not included in this definition.

In the client survey, Child Day Care was described as “Child Care”.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San

Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 27 unduplicated PLWHA received Child Care services through grants billed to the Texas Department of State Health Services. This total represents less than one percent (<1%) of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Child Care Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 21.1: REPORTED ACCESS TO CHILD CARE SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (n = 764)	44	6%	9	20%	35	80%	720	94%
Subpopulations*								
In Care	33	5%	9	27%	24	73%	654	95%
Out-of-Care	11	14%	0	0%	11	100%	66	86%
Women	31	13%	7	23%	24	77%	207	87%
Youth	8	22%	1	13%	7	88%	29	78%
African-Americans	28	7%	5	18%	23	82%	401	93%
Latinos	13	9%	4	31%	9	69%	128	91%
White MSM	0	0%	0	0%	0	0%	103	100%
MSM of Color	3	1%	0	0%	3	100%	205	99%
Recently Released	4	3%	1	25%	3	75%	115	97%
Substance Abuse	16	6%	5	31%	11	69%	232	94%
Mental Health	31	7%	5	16%	26	84%	421	93%
Homeless	11	12%	11	12%	0	0%	1	1%

* Subpopulations are not mutually exclusive.

Approximately 6% of all 764 survey respondents reported attempting to access child care during the previous 12 months; a total of 720 (94%) said they did not need this service. Youth (8 or 22%), the Out-of-Care (11 or 14%), and women (31 or 13%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing child care was the MSM of color (3 or 1%).

Among respondents that tried accessing child care, 9 or 20% said it was “very easy” to get the service. Based on survey responses, access to child care appeared easiest for Latinos (4 or 31%) and substance abusers (4 or 31%).

By far, the Out-of-Care and MSM of color had the high proportion that reported some difficulty accessing child care during the past year. Another subpopulation with relatively high proportions of difficulty was youth (n = 7 or 88%).

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Child Care Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 21.2: NUMBER OF REPORTED BARRIERS FOR CHILD CARE SERVICES

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	U	V	Total** Barriers
All Respondents	**9**	**16**	6	**7**	3	4	1	2	6	4	1	1	0	0	0	0	1	0	**61**
Subpopulations*																			
In Care	7	**11**	6	7	3	4	1	2	6	4	1	1	0	0	0	0	0	0	**53**
Out-of-Care	2	**5**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**8**
Women	6	**14**	6	9	7	2	2	1	7	5	1	1	0	0	0	0	1	0	**62**
Youth	3	3	2	5	3	0	1	2	**6**	3	0	0	0	0	0	0	1	0	**29**
African-Americans	8	**11**	7	5	8	5	2	2	5	4	1	0	0	0	0	0	1	0	**59**
Latinos	1	**4**	1	**4**	0	0	0	0	2	0	1	1	0	0	0	0	0	0	**14**
White MSM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
MSM of Color	**9**	1	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**13**
Recently Released	1	1	1	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	**6**
Substance Abuse	3	**6**	4	3	2	3	0	0	1	1	0	0	0	0	0	0	0	0	**23**
Mental Health	9	**12**	6	6	5	4	1	2	8	5	2	0	0	0	0	0	1	0	**61**
Homeless	4	**5**	4	**5**	**5**	0	2	2	**5**	3	0	0	0	0	0	0	1	0	**36**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 61 reports of barriers among respondents who had difficulty accessing Child Care Services during the past year. The barriers reported most often for Child Care Services were related to not knowing where to get the service and the lack of

availability of the service.

The table below shows several highlighted barriers reported by subpopulations when accessing child care services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 21.2, "Number of reported barriers for child care services."

TABLE 21.3: HIGHLIGHTED BARRIERS FOR CHILD CARE SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B - I don't know where to get the services (n=16) A - The services are not in my area (n=9)
Subpopulations*	
In Care	B - I don't know where to get the services (n=11)
Out-of-Care	B - I don't know where to get the services (n=5)
Women	B - I don't know where to get the services (n=14)
Youth	I – It's hard for me to get there (n=6)
African-Americans	B - I don't know where to get the services (n=11)
Latinos	B - I don't know where to get the services (n=4) D – The services cost too much (n=4)
White MSM	No barriers were reported among white MSM for this service.
MSM of Color	A – The services are not in my area (n=9)
Recently Released	There were 6 barriers reported among the recently released for this service. Please refer to previous table.
Substance Abuse	B - I don't know where to get the services (n=6)
Mental Health	B - I don't know where to get the services (n=12)
Homeless	B - I don't know where to get the services (n=5) D - The services cost too much (n=5) E - I was told I am not eligible to get the services (n=5) I - It's hard for me to get there (n=5)

*Subpopulations are not mutually exclusive.

Among all respondents, not knowing where to get the services and the lack of availability of services ranked highly. Among the majority of subpopulations, not knowing where to get the services ranked high.

CHILD WELFARE SERVICES

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local or HRSA definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Child Welfare Services*** under Ryan White Part B services is defined as the provision of family preservation/unification, foster care, parenting education, and other child welfare services. Services may be designed to prevent break-up of a family and to reunite family members. Also includes foster care assistance to place children under the age of 21 years, whose parents are unable to care for them, in temporary or permanent homes and to sponsor programs for foster families. This category includes other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights.

In the client survey, Child Welfare Services was described as "Child Welfare".

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to

maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

The Centralized Patient Care Data Management System (CPCDMS) does not track Child Welfare Services; therefore, no utilization data can be reported for this service.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Child Welfare Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 22.1: REPORTED ACCESS TO CHILD WELFARE SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (n = 764)	9	1%	3	33%	6	67%	755	99%
Subpopulations*								
In Care	8	1%	3	37%	5	63%	679	99%
Out-of-Care	1	1%	0	0%	1	100%	76	99%
Women	6	3%	2	33%	4	67%	232	97%
Youth	1	3%	0	0%	1	100%	36	97%
African-Americans	7	2%	2	29%	5	71%	422	98%
Latinos	1	1%	0	0%	1	100%	140	99%
White MSM	0	0%	0	0%	0	0%	103	100%
MSM of Color	1	0%	1	100%	0	0%	207	100%
Recently Released	2	2%	0	0%	2	100%	117	98%
Substance Abuse	2	1%	1	50%	1	50%	246	99%
Mental Health	6	1%	2	33%	4	67%	446	99%
Homeless	1	1%	1	1%	0	0%	0	0%

* Subpopulations are not mutually exclusive.

Approximately 1% of all 764 survey respondents reported attempting to access child welfare during the previous 12 months; a total of 755 (99%) said they did not need this service. Women (3%) and youth (3%) reported accessing this service in the highest proportions compared to other groups. The subpopulations with the lowest proportions accessing child welfare were the white MSM and MSM of color.

Among respondents that tried accessing child welfare, 33% said it was “very easy” to get the service. Based on survey responses, access to child welfare appeared easiest for MSM of color (1 or 100%) and the in care (3 or 37%).

The Out-of-Care, youth, Latinos, and recently released had the highest proportions that reported some difficulty accessing child welfare during the past year. Another subpopulation with relatively high proportions of difficulty was African-Americans (5 or 71%).

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate

whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Child Welfare Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 22.2: NUMBER OF REPORTED BARRIERS FOR CHILD WELFARE SERVICES

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total** Barriers
All Respondents	1	**4**	1	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	**9**
Subpopulations*																				
In Care	1	**4**	1	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	**9**
Out-of-Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Women	0	**1**	**1**	0	**1**	0	0	0	**1**	0	0	0	0	**1**	0	0	0	0	0	**5**
Youth	0	**1**	0	0	0	0	0	0	0	**1**	0	0	0	0	0	0	0	0	0	**2**
African-Americans	1	**4**	0	1	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	**9**
Latinos	0	0	**1**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
White MSM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
MSM of Color	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Recently Released	0	**1**	0	0	**1**	0	0	0	0	0	0	0	0	**1**	0	0	0	0	0	**3**
Substance Abuse	**1**	**1**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Mental Health	1	**2**	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	**6**
Homeless	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	**2**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 9 reports of barriers among respondents who had difficulty accessing Child Welfare Services during the past year. The barriers reported most often for Child Welfare Services was related to not knowing where to get the services.

The table below shows several highlighted barriers reported by subpopulations when accessing child welfare services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 22.2 "Number of reported barriers for child welfare services."

TABLE 22.3: HIGHLIGHTED BARRIERS FOR CHILD WELFARE SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=4)
Subpopulations*	
In Care	B – I don't know where to get the services (n=4)
Out-of-Care	There were no reported barriers among the Out-of-Care for this service.
Women	There were 5 equally reported barriers among women for this service. Please refer to previous table.
Youth	There were 2 equally reported barriers among youth for this service. Please refer to previous table.
African-Americans	B – I don't know where to get the services (n=4)
Latinos	Only one barrier was reported among Latinos for this service. Please refer to previous table.
White MSM	There were no reported barriers among white MSM for this service.
MSM of Color	There were no reported barriers among MSM of color for this service.
Recently Released	Only 3 barriers were reported among the recently released for this service. Please refer to previous table.
Substance Abuse	Only 2 barriers were reported among the substance abusers for this service. Please refer to previous table.
Mental Health	B – I don't know where to get the services. (n=2)
Homeless	Only 2 barriers were reported among the homeless for this service. Please

*Subpopulations are not mutually exclusive.

Not knowing where to get the services ranked high for the majority of subpopulations. There were no reported barriers for this service among the Out-of-Care, white MSM, and MSM of color.

DAY/RESPITE CARE FOR ADULTS

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Day/Respite Care for Adults*** (a.k.a., Adult Day Care) under Ryan White Part B is defined as the provision of medical care and social services in a licensed adult day program for HIV/AIDS infected individuals who are at least 18 years of age. It includes, but is not limited to the provision of personal care, nursing services, hot meals, nutritional counseling, and social activities Services will be provided at least Monday through Friday for a minimum of 10 hours/day. Inpatient hospitals services, nursing home and other long-term care facilities are not included.

In the client survey, Adult Day Care was described as “Day/Respite Care for Adults”. According to the DSHS glossary of HIV services released in August 2007, this service category is now identified as Home and Community Based Health Services.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed

collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 63 unduplicated PLWHA received day/respite care for adults through grants billed to Ryan White Part A and Part B. This total represents less than one percent (<1%) of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Day/Respite Care for Adults reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 23.1: REPORTED ACCESS TO DAY/RESPITE CARE FOR ADULTS IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (n = 764)	19	2%	10	53%	9	47%	745	98%
Subpopulations*								
In Care	16	2%	10	62%	6	38%	671	98%
Out-of-Care	3	4%	0	0%	3	100%	74	96%
Women	7	3%	5	71%	2	29%	231	97%
Youth	1	3%	0	0%	1	100%	36	97%
African-Americans	10	2%	5	50%	5	50%	419	98%
Latinos	5	4%	3	60%	2	40%	136	96%
White MSM	1	1%	1	100%	0	0%	102	99%
MSM of Color	2	1%	2	100%	0	0%	206	99%
Recently Released	4	3%	2	50%	2	50%	115	97%
Substance Abuse	7	3%	4	57%	3	43%	241	97%
Mental Health	10	2%	4	40%	6	60%	442	98%
Homeless	1	1%	0	0%	1	1%	3	3%

* Subpopulations are not mutually exclusive.

Approximately 2% (n=19) of all 764 survey respondents reported attempting to access Day/Respite Care for Adults during the previous 12 months; the majority (745 or 98%) said they did not need this service. Out-of-Care and Latinos reported accessing this service in the highest proportions compared to other groups. The subpopulations with the lowest proportion accessing Day/Respite Care for Adults were white MSM (1 or 1%) and MSM of color (2 or 1%).

Among respondents that tried accessing Day/Respite Care for Adults, over half (10 or 53%) said it was “very easy” to get the service. Based on survey responses, access to Day/Respite Care for Adults appeared easiest for white MSM (1 or 100%), MSM of color (2 or 100%), and women (5 or 71%).

By far, Out-of-Care and youth had the high proportions that reported some difficulty accessing Day/Respite Care for Adults during the past year. Another subpopulation with relatively high proportions of difficulty was PLWHA with mental health symptoms (5 or 60%).

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a

service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Day/Respite Care for Adults. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 23.2: NUMBER OF REPORTED BARRIERS FOR DAY/RESPITE CARE FOR ADULTS

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total** Barriers
All Respondents	2	**3**	1	0	1	0	2	1	1	2	2	0	0	0	0	0	1	0	0	**16**
Subpopulations*																				
In Care	1	**2**	0	0	0	0	**2**	1	1	1	1	0	0	0	0	0	1	0	0	**10**
Out-of-Care	**1**	**1**	**1**	0	**1**	0	0	0	0	**1**	**1**	0	0	0	0	0	0	0	0	**6**
Women	0	0	0	0	0	0	**1**	**1**	**1**	0	0	0	0	0	0	0	0	0	0	**3**
Youth	0	0	0	0	0	0	0	0	0	**1**	0	0	0	0	0	0	0	0	0	**1**
African-Americans	**2**	**2**	1	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	**8**
Latinos	0	0	0	0	0	0	**1**	**1**	0	0	0	0	0	0	0	0	0	0	0	**2**
White MSM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
MSM of Color	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Recently Released	**1**	**1**	**1**	0	**1**	0	0	0	0	0	**1**	0	0	0	0	0	0	0	0	**5**
Substance Abuse	1	**2**	0	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	**6**
Mental Health	**2**	**2**	1	0	1	0	1	0	0	1	1	0	0	0	0	0	0	0	0	**9**
Homeless	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 16 reports of barriers among respondents who had difficulty accessing Day/Respite Care for Adults during the past year. The barrier reported most often for Day/Respite Care for Adults was related to not knowing where to get the services.

The table below shows several highlighted barriers reported by subpopulations when accessing day/respite care for adults. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 23.2 "Number of reported barriers for day/respite care for adults."

TABLE 23.3: HIGHLIGHTED BARRIERS FOR DAY/RESPITE CARE FOR ADULTS BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=3)
Subpopulations*	
In Care	B – I don't know where to get the services (n=2)
Out-of-Care	The Out-of-Care reported 6 barriers equally for this service. Please refer
Women	Women reported 3 barriers equally for this service. Please refer to previous table.
Youth	Only one barrier was reported among youth for this service. Please refer
African-Americans	A – The services are not in my area (n=2) B – I don't know where to get the services (n=2)
Latinos	G – The people who run the services are not friendly (n=1) H – It's hard to make or keep appointments (n=1)
White MSM	No barriers were reported among white MSM.
MSM of Color	No barriers were reported among MSM of color.
Recently Released	Recently released reported 5 barriers equally for this service. Please
Substance Abuse	B – I don't know where to get the services (n=2)
Mental Health	A – The services are not in my area (n=2) B – I don't know where to get the services (n=2)
Homeless	No barriers were reported among the homeless for this service.

*Subpopulations are not mutually exclusive.

Not knowing where to get the services ranked high for the majority of subpopulations. Lack of friendliness among provider staff also ranked highly among the in care (n=2) and Latinos (n=1). Among African-Americans and PLWHA with mental health symptoms, the lack of availability of the service ranked highly.

DEVELOPMENTAL ASSESSMENT

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Developmental Assessment*** (a.k.a., "Pediatric Developmental Assessment and Early Intervention Services") under Ryan White Part B is defined as the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services include assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors.

In the client survey, Pediatric Developmental Assessment and Early Intervention Services was described as "Developmental Assessment (assistance for affected infants and children in relation to the educational system)".

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application,

the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

The Centralized Patient Care Data Management System (CPCDMS) does not track Developmental Assessment Services; therefore, no utilization data can be reported for this service

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Developmental Assessment Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 24.1: REPORTED ACCESS TO DEVELOPMENTAL ASSESSMENT SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (n = 764)	6	1%	1	17%	5	83%	758	99%
Subpopulations*								
In Care	4	1%	0	0%	4	100%	683	99%
Out-of-Care	2	3%	1	50%	1	50%	75	97%
Women	3	1%	0	0%	3	100%	235	99%
Youth	1	3%	0	0%	1	100%	36	97%
African-Americans	4	1%	0	0%	4	100%	425	99%
Latinos	0	0%	0	0%	0	0%	141	100%
White MSM	1	1%	1	100%	0	0%	102	99%
MSM of Color	1	0%	0	0%	1	100%	207	100%
Recently Released	0	0%	0	0%	0	0%	119	100%
Substance Abuse	1	0%	0	0%	1	100%	247	100%
Mental Health	3	1%	0	0%	3	100%	449	99%
Homeless	1	1%	1	1%	0	0%	1	1%

. * Subpopulations are not mutually exclusive.

Approximately 1% of all 764 survey respondents reported attempting to access developmental assessment during the previous 12 months; a total of 758 (99%) said they did not need this service. The Out-of-Care (2 or 3%) and youth (1 or 3%) reported accessing this service in the highest proportions compared to other groups.

Among respondents that tried accessing developmental assessment, 1 or 17% said it was “very easy” to get the service. With the exception of Latinos, white MSM, and the recently released, the majority of subpopulations reported some difficulty accessing developmental assessment during the past year. Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Developmental Assessment Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents

the total number of barriers reported for each subpopulation.

TABLE 24.2: NUMBER OF REPORTED BARRIERS FOR DEVELOPMENTAL ASSESSMENT SERVICES

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total** Barriers
All Respondents	1	**3**	**3**	0	0	1	0	1	1	1	1	0	0	0	0	0	1	0	0	**13**
Subpopulations*																				
In Care	1	**2**	**2**	0	0	1	0	1	1	1	1	0	0	0	0	0	1	0	0	**11**
Out-of-Care	0	**1**	**1**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Women	0	**2**	**2**	0	0	1	0	1	1	1	1	0	0	0	0	0	0	0	0	**9**
Youth	0	**1**	**1**	0	0	**1**	0	**1**	**1**	**1**	**1**	0	0	0	0	0	0	0	0	**7**
African-Americans	1	**2**	**2**	0	0	1	0	1	1	1	1	0	0	0	0	0	1	0	0	**11**
Latinos	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
White MSM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
MSM of Color	0	**1**	**1**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Recently Released	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**	0	0	**1**
Mental Health	0	1	**2**	0	0	1	0	1	1	1	1	0	0	0	0	1	1	0	0	**10**
Homeless	0	0	1	0	0	1	0	1	1	1	1	0	0	0	0	0	0	0	0	**6**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 13 reports of barriers among respondents who had difficulty accessing Developmental Assessment Services during the past year. The barriers reported most often for Developmental Assessment Services were related to not knowing where to get the services and having to waiting too long to get the services.

The table below shows several highlighted barriers reported by subpopulations when accessing developmental assessment services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 24.2 "Number of reported barriers for developmental assessment services."

TABLE 24.3: HIGHLIGHTED BARRIERS FOR DEVELOPMENTAL ASSESSMENT SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B - I don't know where to get the services (n=3) C – I would have to wait too long to get the services (n=3)
Subpopulations*	
In Care	B - I don't know where to get the services (n=2) C – I would have to wait too long to get the services (n=2)
Out-of-Care	B - I don't know where to get the services (n=1) C – I would have to wait too long to get the services (n=1)
Women	B - I don't know where to get the services (n=2) C – I would have to wait too long to get the services (n=2)
Youth	There were 7 equally reported barriers among youth for this service. Please refer to previous table.
African-Americans	B - I don't know where to get the services (n=2) C – I would have to wait too long to get the services (n=2)
Latinos	No barriers were reported among Latinos for this service.
White MSM	No barriers were reported among white MSM for this service.
MSM of Color	B - I don't know where to get the services (n=1) C – I would have to wait too long to get the services (n=1)
Recently Released	No barriers were reported among the recently released for this service.
Substance Abuse	Only one barrier was reported among substance abusers for this service. Please refer to previous table.
Mental Health	C - I would have to wait too long to get the services (n=2)
Homeless	There were 6 equally reported barriers among the homeless for this

*Subpopulations are not mutually exclusive.

Among all respondents and the majority of subpopulations, not knowing where to get the services and having to wait too long to get the services ranked highly. There were no reported barriers among Latinos, white MSM, and the recently released.

EMERGENCY FINANCIAL ASSISTANCE

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Emergency Financial Assistance*** under Ryan White Part B is defined as the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

In the client survey, the actual Part B terminology was used to describe Emergency Financial Assistance.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a

comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 80 unduplicated PLWHA received Emergency Financial Assistance Services through grants billed to HOPWA and Ryan White Part B. This total represents less than one percent (<1%) of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Emergency Financial Assistance reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 25.1: REPORTED ACCESS TO EMERGENCY FINANCIAL ASSISTANCE IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	348	46%	104	30%	244	70%	416	54%
Subpopulations*								
In Care	312	45%	100	32%	212	68%	375	55%
Out-of-Care	36	47%	4	11%	32	89%	41	53%
Women	106	45%	37	35%	69	65%	132	55%
Youth	17	46%	2	12%	15	88%	20	54%
African-Americans	185	43%	65	35%	120	65%	244	57%
Latinos	72	51%	20	28%	52	72%	69	49%
White MSM	45	44%	9	20%	36	80%	58	56%
MSM of Color	99	48%	30	30%	69	70%	109	52%
Recently Released	49	41%	16	33%	33	67%	70	59%
Substance Abuse	111	45%	35	32%	76	68%	137	55%
Mental Health	215	48%	52	24%	163	76%	237	52%
Homeless	43	48%	37	42%	6	7%	6	7%

* Subpopulations are not mutually exclusive.

Nearly half (348 or 46%) of all survey respondents reported attempting to access emergency financial assistance during the previous 12 months; a total 416 (54%) said they did not need this service. Latinos (72 or 51%), MSM of color (99 or 48%), and PLWHA with mental health symptoms (215 or 48%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing emergency financial assistance was the recently released (49 or 41%).

Among respondents that tried accessing emergency financial assistance, 104 (30%) said it was "very easy" to get the service. Based on survey responses, access to emergency financial assistance appeared easiest for women (37 or 35%) and African-Americans (65 or 35%).

By far, the Out-of-Care had the highest proportion that reported some difficulty accessing emergency financial assistance during the past year. Another subpopulation with relatively high proportions of difficulty was youth (15 or 88%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so

respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Emergency Financial Assistance. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 25.2: NUMBER OF REPORTED BARRIERS FOR EMERGENCY FINANCIAL ASSISTANCE

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	Q	R	S	T	U	Total** Barriers
All Respondents	42	**78**	**80**	12	66	36	27	36	23	4	12	1	13	4	1	5	3	1	1	12	**455**
Subpopulations*																					
In Care	37	**69**	**72**	9	53	31	21	29	17	3	6	1	12	4	0	5	2	1	0	12	**384**
Out-of-Care	5	**9**	8	3	**13**	5	6	7	6	1	6	0	1	0	0	0	1	0	0	0	**71**
Women	**21**	20	**26**	4	20	11	9	14	11	3	6	0	2	1	0	1	0	0	0	4	**153**
Youth	3	**7**	**5**	1	4	1	3	4	3	3	1	0	0	1	0	0	0	0	0	2	**38**
African-Americans	22	**42**	31	7	**34**	17	12	18	14	4	7	0	7	0	1	0	1	2	1	5	**225**
Latinos	8	**14**	**25**	3	12	6	6	8	2	0	1	1	1	1	0	1	1	0	0	2	**92**
White MSM	4	1	**13**	0	**10**	7	5	3	4	0	1	0	1	2	0	1	0	0	0	2	**64**
MSM of Color	6	17	**28**	4	**18**	6	6	9	2	0	1	1	4	1	0	1	2	0	0	4	**110**
Recently Released	3	**9**	7	1	**13**	5	4	2	4	0	3	0	5	0	0	1	0	0	0	1	**58**
Substance Abuse	19	**29**	**22**	5	19	11	8	12	7	2	7	0	7	1	0	1	0	1	0	0	**73**
Mental Health	25	**51**	**59**	9	47	23	19	28	14	4	7	1	7	2	0	1	3	2	0	7	**308**
Homeless	11	**21**	11	4	**12**	6	9	4	7	3	7	0	1	0	0	0	0	1	0	0	**97**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 455 reports of barriers among respondents who had difficulty accessing Emergency Financial Assistance during the past year. The barriers reported most often for Emergency Financial Assistance were related to having to wait too long to get the service and not knowing where to get the service.

The table below shows several highlighted barriers reported by subpopulations when accessing emergency financial assistance. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 25.2 "Number of reported barriers for emergency financial assistance."

TABLE 25.3: HIGHLIGHTED BARRIERS FOR EMERGENCY FINANCIAL ASSISTANCE BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	C – I would have to wait too long to get the services (n=80)
Subpopulations*	
In Care	C – I would have to wait too long to get the services (n=72)
Out-of-Care	E – I was told I am not eligible to get the services (n=13)
Women	C - I would have to wait too long to get the services (n=26)
Youth	B - I don't know where to get the services (n=7)
African-Americans	B - I don't know where to get the services (n=42)
Latinos	C - I would have to wait too long to get the services (n=25)
White MSM	C - I would have to wait too long to get the services (n=13)
MSM of Color	C - I would have to wait too long to get the services (n=28)
Recently Released	E - I was told I am not eligible to get the services (n=13)
Substance Abuse	B - I don't know where to get the services (n=29)
Mental Health	C - I would have to wait too long to get the services (n=59)
Homeless	B – I don't know where to get the services (n=21)

*Subpopulations are not mutually exclusive.

Among all respondents, having to wait to long to get the services and not knowing where to get the services ranked highly. These same barriers also ranked high for the

majority of subpopulations. Being told that one is ineligible to get the services, specifically, ranked high for the Out-of-Care, African-Americans, white MSM, MSM of color, and the recently released.

EMPLOYMENT ASSISTANCE

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Employment Assistance*** under Ryan White Part B is defined as the facilitation of entry or re-entry into the workplace in a way that is appropriate to one's health status, work experience, disability benefit status, needs and desires. It includes the provision of GED training and other educational programs, resume writing training, work history evaluations, skills assessments, and job search training.

In the client survey, the actual Part B terminology was used to describe Employment Assistance.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application,

the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the AIDS Regional Information and Evaluation System (ARIES) data system, a total of 128 unduplicated PLWHA received employment assistance services through grants billed to the Texas Department of State Health Services. This total represents less than one percent (<1%) of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Employment Assistance reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 26.1: REPORTED ACCESS TO EMPLOYMENT ASSISTANCE IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	155	20%	25	16%	130	84%	609	80%
Subpopulations*								
In Care	136	20%	23	17%	113	83%	551	80%
Out-of-Care	36	47%	4	11%	32	89%	41	53%
Women	42	18%	10	24%	32	76%	196	82%
Youth	15	41%	2	13%	13	87%	22	59%
African-Americans	89	21%	17	19%	72	81%	340	79%
Latinos	28	20%	2	7%	26	93%	113	80%
White MSM	19	18%	3	16%	16	84%	84	82%
MSM of Color	47	23%	5	11%	42	89%	161	77%
Recently Released	27	23%	8	30%	19	70%	92	77%
Substance Abuse	54	22%	9	17%	45	83%	194	78%
Mental Health	94	21%	14	15%	80	85%	358	79%
Homeless	23	26%	21	24%	2	2%	3	3%

* Subpopulations are not mutually exclusive.

Less than one quarter (155 or 20%) of all survey respondents reported attempting to access Employment Assistance during the previous 12 months; a total of 609 (80%) said they did not need this service. The Out-of-Care (36 or 47%) and youth (15 or 41%) reported accessing this service in the highest proportions compared to other groups. The subpopulations with the lowest proportion accessing Employment Assistance were the women (42 or 18%) and white MSM (19 or 18%).

Among respondents that tried accessing Employment Assistance, 25 or 16% said it was “very easy” to get the service. Based on survey responses, access to Employment Assistance appeared easiest for the recently released (8 or 30%), women (10 or 24%), and African-Americans (17 or 19%).

By far, Latinos (26 respondents or 93%) had the high proportion that reported some difficulty accessing Employment Assistance during the past year. Other subpopulations with relatively high proportions of difficulty were the Out-of-Care and MSM of color.

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Employment Assistance. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 26.2: NUMBER OF REPORTED BARRIERS FOR EMPLOYMENT ASSISTANCE

	A	B	C	D	E	F	G	H	I	J	K	L	M	P	Q	R	S	T	U	V	Total** Barriers
All Respondents	21	**62**	13	2	12	18	8	9	12	2	13	2	**23**	0	2	2	1	0	1	0	**201**
Subpopulations*																					
In Care	18	**56**	11	2	10	14	6	8	10	2	9	2	**19**	0	2	2	1	0	1	0	**171**
Out-of-Care	3	**6**	2	0	2	4	2	1	2	0	4	0	4	0	0	0	0	0	0	0	**30**
Women	5	**15**	3	0	4	2	1	2	5	2	5	1	4	0	0	0	0	0	0	0	**49**
Youth	2	**8**	0	0	0	2	1	0	2	1	0	0	0	0	0	0	0	0	0	0	**16**
African-Americans	13	**31**	7	1	8	12	7	4	8	1	8	1	**14**	0	0	2	0	0	0	0	**117**
Latinos	4	**16**	3	1	1	4	0	0	0	1	1	1	4	0	0	0	0	0	0	0	**36**
White MSM	2	**10**	0	0	1	0	0	2	2	0	2	0	**3**	0	0	0	0	0	1	0	**23**
MSM of Color	6	**20**	5	1	3	7	5	4	1	0	4	0	**7**	0	1	0	0	0	0	0	**64**
Recently Released	5	**9**	2	0	2	5	1	2	2	0	1	0	**6**	0	0	0	0	0	0	0	**35**
Substance Abuse	9	**20**	7	0	2	4	4	6	3	0	2	1	**12**	0	2	0	1	0	0	0	**73**
Mental Health	12	**35**	9	1	8	8	5	7	10	1	10	1	**15**	2	2	0	1	0	1	0	**128**
Homeless	3	**9**	2	0	1	**6**	1	2	3	0	0	0	3	0	2	0	0	0	0	0	**32**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	L	People at the agency don't speak my language
B	I don't know where to get the services	M	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	N	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	O	Substance abuse
E	I was told I am not eligible to get the services	P	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	Q	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	R	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	S	Homeless/unstable housing
I	It's hard for me to get there	T	CM left/staff turnover
J	There is no one to watch my kids if I go there	U	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	V	Immigration status

Overall, there were 201 reports of barriers among respondents who had difficulty accessing Employment Assistance during the past year. The barriers reported most often for Employment Assistance were related to not knowing where to get the services and difficulty getting the service due to jail/prison history.

The table below shows several highlighted barriers reported by subpopulations when accessing employment assistance. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 26.2 "Number of reported barriers for employment assistance."

TABLE 26.3: HIGHLIGHTED BARRIERS FOR EMPLOYMENT ASSISTANCE BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=62) M – My jail/prison history makes it hard to get services (n=23)
Subpopulations*	
In Care	B - I don't know where to get the services (n=56) M - My jail/prison history makes it hard to get services (n=19)
Out-of-Care	B - I don't know where to get the services (n=6)
Women	B - I don't know where to get the services (n=15)
Youth	B - I don't know where to get the services (n=8)
African-Americans	B - I don't know where to get the services (n=31) M - My jail/prison history makes it hard to get services (n=14)
Latinos	B - I don't know where to get the services (n=16)
White MSM	B - I don't know where to get the services (n=10) M - My jail/prison history makes it hard to get services (n=3)
MSM of Color	B - I don't know where to get the services (n=20) M - My jail/prison history makes it hard to get services (n=7)
Recently Released	B - I don't know where to get the services (n=9) M - My jail/prison history makes it hard to get services (n=6)
Substance Abuse	B - I don't know where to get the services (n=20) M - My jail/prison history makes it hard to get services (n=12)
Mental Health	B - I don't know where to get the services (n=35) M - My jail/prison history makes it hard to get services (n=15)
Homeless	B – I don't know where to get the services (n=9)

*Subpopulations are not mutually exclusive.

Not knowing where to get the services ranked high for all subpopulations. Among all respondents, both not knowing where to get the services and jail/prison history making it hard to get services ranked highly.

FOOD PANTRY

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of ***Food Pantry*** under the Ryan White Part A Program is defined as a facility that provides food and related grocery items to include personal hygiene, paper products, cleaning supplies and diapers to an HIV-infected individual on an emergency basis while a long term solution to the client's need is developed. This service does not provide food for affected persons and/or individuals who are caregivers for HIV/AIDS infected persons. Under Ryan White Part B, Food Pantry is defined as the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

In the client survey, Food Pantry was described as "Food Bank."

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 2,841 unduplicated PLWHA received Food Pantry through grants billed to Ryan White Part A, Part B, Texas Department of State Health Services and Other funding sources. This total represents 16% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Food Pantry reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service <u>does not necessarily mean the respondent received the service</u>. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 27.1: REPORTED ACCESS TO FOOD PANTRY IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	369	48%	247	67%	122	33%	395	52%
Subpopulations*								
In Care	335	49%	230	69%	105	31%	352	51%
Out-of-Care	34	44%	17	50%	17	50%	43	56%
Women	106	45%	67	63%	39	37%	132	55%
Youth	20	54%	10	50%	10	50%	17	46%
African-Americans	143	33%	77	54%	66	46%	286	67%
Latinos	59	42%	40	68%	19	32%	82	58%
White MSM	53	51%	33	62%	20	38%	50	49%
MSM of Color	107	51%	75	70%	32	30%	101	49%
Recently Released	61	51%	45	74%	16	26%	58	49%
Substance Abuse	127	51%	82	65%	45	35%	121	49%
Mental Health	220	49%	138	63%	82	37%	232	51%
Homeless	34	38%	20	22%	14	16%	5	6%

* Subpopulations are not mutually exclusive.

Almost half (48%) of all 764 survey respondents reported attempting to access Food Pantry during the previous 12 months; a total of 395 (65%) said they did not need this service. Most subpopulations also reported accessing this service in similar proportions – youth (54%), white MSM (51%), MSM of color (51%), the recently released (51%) and substance abusers (51%) reported accessing this service in the highest proportions compared to other groups. However, the subpopulations with the lowest proportion accessing Food Pantry were African-Americans (33%) and Latinos (42%).

Among respondents that tried accessing Food Pantry, the majority (67%) said it was "very easy" to get the service. Based on survey responses, access to Food Pantry appeared easiest for the recently released (74%) and MSM of color (62%).

By far, the out-of-care (50%) and youth (50%) had the highest proportions that reported some difficulty accessing Food Pantry during the past year. Another subpopulation with relatively higher proportions of difficulty was African-Americans (46%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents

described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Food Pantry. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 27.2: NUMBER OF REPORTED BARRIERS FOR FOOD PANTRY

	A	B	C	D	E	F	G	H	I	J	K	M	O	P	Q	R	S	T	U	V	Total** Barriers
All Respondents	26	**37**	24	4	15	18	6	5	**32**	4	1	2	2	0	1	0	3	0	14	1	**195**
Subpopulations*																					
In Care	24	**35**	16	1	12	14	4	2	**28**	2	1	2	2	0	1	0	3	0	14	1	**162**
Out-of-Care	2	2	**8**	3	3	**4**	2	3	**4**	2	0	0	0	0	0	0	0	0	0	0	**33**
Women	12	**13**	6	1	3	4	1	3	**18**	2	0	2	0	0	1	0	0	0	5	1	**72**
Youth	0	**6**	1	1	0	1	1	2	2	0	0	0	0	0	0	0	0	0	2	0	**16**
African-Americans	**17**	**21**	9	1	8	7	5	3	15	1	1	0	1	1	0	1	0	1	7	0	**99**
Latinos	**4**	**6**	**4**	1	2	1	0	0	**4**	1	0	0	0	0	0	0	0	0	2	1	**26**
White MSM	4	**5**	3	1	3	**5**	1	0	**9**	1	0	0	0	0	0	0	0	0	2	0	**34**
MSM of Color	6	**12**	**7**	0	3	3	2	0	2	0	1	0	0	0	0	0	0	0	4	0	**40**
Recently Released	2	**6**	1	1	3	3	1	0	**4**	2	1	0	1	0	0	0	2	0	1	0	**28**
Substance Abuse	13	**17**	7	3	8	11	4	5	**16**	3	0	0	0	0	1	0	1	0	4	0	**93**
Mental Health	16	**28**	12	4	13	12	4	4	**26**	3	1	0	0	0	1	0	3	0	11	0	**138**
Homeless	2	**6**	2	2	3	1	1	1	**7**	0	1	0	0	0	1	0	2	0	3	0	**32**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 195 reports of barriers among respondents who had difficulty accessing Food Pantry during the past year. The barriers reported most often for Food Pantry were related to lack of information and difficulty getting to the service location. The

table below shows several highlighted barriers reported by subpopulations when accessing Food Pantry. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 27.2 "Number of reported barriers for Food Pantry."

TABLE 27.3: HIGHLIGHTED BARRIERS FOR FOOD PANTRY BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B - I don't know where to get the services (n=37) I - It's hard for me to get there (n=32)
Subpopulations*	
In Care	B - I don't know where to get the services (n=35) I - It's hard for me to get there (n=28)
Out-of-Care	C - I would have to wait too long to get the services (n=8) F - I don't think I'm eligible to get the services (n=4) I - It's hard for me to get there (n=4)
Women	I - It's hard for me to get there (n=18) B - I don't know where to get the services (n=13)
Youth	B - I don't know where to get the services (n=6)
African-Americans	B - I don't know where to get the services (n=21) A - The services are not in my area (n=17)
Latinos	B - I don't know where to get the services (n=6) A - The services are not in my area (n=4) C - I would have to wait too long to get the services (n=4) I - It's hard for me to get there (n=4)
White MSM	I - It's hard for me to get there (n=9) B - I don't know where to get the services (n=5) F - I don't think I'm eligible to get the services (n=5)
MSM of Color	B - I don't know where to get the services (n=12) C - I would have to wait too long to get the services (n=7)
Recently Released	B - I don't know where to get the services (n=6) I - It's hard for me to get there (n=4)
Substance Abuse	B - I don't know where to get the services (n=17) I - It's hard for me to get there (n=16)
Mental Health	B - I don't know where to get the services (n=28) I - It's hard for me to get there (n=26)
Homeless	I – It's hard for me to get there (n=7) B - I don't know where to get the services (n=6)

*Subpopulations are not mutually exclusive.

Problems with lack of information and difficulties getting to services ranked highly for the majority of subpopulations. Services not in area ranked highly for African-Americans and Latinos; waiting times ranked highly for the Out-of-Care, Latinos and MSM of color,

and; not believing they were eligible for services ranked highly for the Out-of-Care and white MSM.

HOUSEHOLD ITEMS

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Household Items*** (a.k.a., a subcategory of the "Other Services" category) under Ryan White Part B is defined as the pickup, delivery, and storage of donated items that include, but are not limited to, furniture, small appliances, kitchen utensils, bathroom accessories and linens.

In the client survey, this subcategory of Other Services was described as "Household Items".

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed

collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 80 unduplicated PLWHA received Household Items through grants billed to Ryan White Part B. This total represents less than one percent (<1%) of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Household Items reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 28.1: REPORTED ACCESS TO HOUSEHOLD ITEMS IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	135	18%	40	30%	95	70%	629	82%
Subpopulations*								
In Care	125	18%	39	31%	86	69%	562	82%
Out-of-Care	10	13%	1	10%	9	90%	67	87%
Women	54	23%	17	31%	37	69%	184	77%
Youth	8	22%	2	25%	6	75%	29	78%
African-Americans	91	21%	30	33%	61	67%	338	79%
Latinos	18	13%	3	17%	15	83%	123	87%
White MSM	4	4%	2	50%	2	50%	99	96%
MSM of Color	41	20%	8	20%	33	80%	167	80%
Recently Released	13	11%	6	46%	7	54%	106	89%
Substance Abuse	46	19%	14	30%	32	70%	202	81%
Mental Health	69	15%	14	20%	55	80%	383	85%
Homeless	12	13%	9	10%	3	3%	0	0%

* Subpopulations are not mutually exclusive.

Approximately 18% (n=135) of all survey respondents reported attempting to access Household Items during the previous 12 months; a total of 629 (82%) said they did not need this service. Women (54 or 23%), youth (8 or 22%), and African-Americans (91 or 21%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing Household Items was white MSM (4 or 4%).

Among respondents that tried accessing Household Items, 30% said it was "very easy" to get the service. Based on survey responses, access to Household Items appeared easiest for white MSM (2 or 50%), recently released (6 or 46%), African-Americans (30 or 33%).

By far, the Out-of-Care had the highest proportion that reported some difficulty accessing Household Items during the past year. Another subpopulation with relatively high proportions of difficulty was Latinos (15 or 83%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Household Items. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 28.2: NUMBER OF REPORTED BARRIERS FOR HOUSEHOLD ITEMS

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	Total** Barriers
All Respondents	**16**	**54**	15	9	10	11	6	5	8	1	4	0	1	0	0	0	1	1	0	**142**
Subpopulations*																				
In Care	**13**	**52**	12	8	8	9	5	3	8	1	2	0	1	0	0	0	1	0	0	**123**
Out-of-Care	**3**	2	**3**	1	2	2	1	2	0	0	2	0	0	0	0	0	0	1	0	**19**
Women	**8**	**20**	6	4	6	3	2	4	6	1	3	0	0	0	0	0	1	1	0	**65**
Youth	0	**3**	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**6**
African-Americans	**10**	**29**	7	8	7	8	3	2	4	1	0	0	0	0	0	0	1	1	0	**81**
Latinos	3	**10**	4	1	2	1	1	1	2	0	1	0	1	0	0	0	0	0	0	**27**
White MSM	0	**6**	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**7**
MSM of Color	7	**17**	5	2	3	6	3	0	0	0	0	0	0	0	0	0	0	0	0	**43**
Recently Released	1	**2**	**3**	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**9**
Substance Abuse	6	**16**	8	2	2	**9**	2	3	1	0	4	0	3	0	0	0	1	1	0	**58**
Mental Health	8	**31**	6	5	8	5	3	3	7	0	0	0	0	0	0	1	1	1	0	**79**
Homeless	**3**	**6**	**3**	1	0	1	2	1	0	0	2	0	0	0	0	0	0	0	0	**19**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	L	People at the agency don't speak my language
B	I don't know where to get the services	M	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	N	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	O	Substance abuse
E	I was told I am not eligible to get the services	P	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	Q	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	R	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	S	Homeless/unstable housing
I	It's hard for me to get there	T	CM left/staff turnover
J	There is no one to watch my kids if I go there	U	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	V	Immigration status

Overall, there were 142 reports of barriers among respondents who had difficulty accessing Household Items during the past year. The barriers reported most often for Household Items were related to not knowing where to get the service and the lack of availability of the service.

The table below shows several highlighted barriers reported by subpopulations when accessing household items. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 28.2 "Number of reported barriers for household items."

TABLE 28.3: HIGHLIGHTED BARRIERS FOR HOUSEHOLD ITEMS BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=54)
Subpopulations*	
In Care	B - I don't know where to get the services (n=52) A - The services are not in my area (n=13)
Out-of-Care	A - The services are not in my area (n=3) C – I would have to wait too long to get the services (n=3)
Women	B - I don't know where to get the services (n=20) A - The services are not in my area (n=8)
Youth	B - I don't know where to get the services (n=3)
African-Americans	B - I don't know where to get the services (n=29) A - The services are not in my area (n=10)
Latinos	B - I don't know where to get the services (n=10)
White MSM	B - I don't know where to get the services (n=6)
MSM of Color	B - I don't know where to get the services (n=17)
Recently Released	C – I would have to wait too long to get the services (n=3) B - I don't know where to get the services (n=2)
Substance Abuse	B - I don't know where to get the services (n=16) F – I don't think I'm eligible to get the services (n=9)
Mental Health	B - I don't know where to get the services (n=31)
Homeless	B – I don't know where to get the services (n=6) A – The services are not in my area (n=3)

*Subpopulations are not mutually exclusive.

Among all respondents, not knowing where to get the services and the lack of service availability in the area ranked highly. Among the recently released, having to wait too long to get the services ranked high, while not thinking one is eligible to get the services ranked high for substance abusers.

HIV EDUCATION FOR HIV+ INDIVIDUALS

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***HIV Education for HIV+ Individuals*** (aka, "Health Education/Risk Reduction") under Ryan White Part B is defined as the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

In the client survey, HIV Education for HIV+ Individuals was described as "HIV Education for HIV+ Individuals."

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data

Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 639 unduplicated PLWHA received HIV Education for HIV+ Individuals through grants billed to the Texas Department of State Health Services. This total represents 4% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to HIV Education for HIV+ Individuals reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African-American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service <u>does not necessarily mean the respondent received the service</u>. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 29.1: REPORTED ACCESS TO HIV EDUCATION FOR HIV+ INDIVIDUALS IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	153	20%	117	76%	36	24%	611	80%
Subpopulations*								
In Care	143	21%	116	81%	27	19%	544	79%
Out-of-Care	10	13%	1	10%	9	90%	67	87%
Women	49	21%	40	82%	9	18%	189	79%
Youth	13	35%	10	77%	3	23%	24	65%
African-Americans	91	21%	70	77%	21	23%	338	79%
Latinos	33	23%	27	82%	6	18%	108	77%
White MSM	14	14%	9	64%	5	36%	89	86%
MSM of Color	50	24%	39	78%	11	22%	158	76%
Recently Released	25	21%	16	64%	9	36%	94	79%
Substance Abuse	51	21%	37	73%	14	27%	197	79%
Mental Health	85	19%	57	67%	28	33%	367	81%
Homeless	16	18%	9	10%	7	8%	4	4%

* Subpopulations are not mutually exclusive.

Less than a fourth (20%) of all 764 survey respondents reported attempting to access HIV Education for HIV+ Individuals during the previous 12 months; the vast majority (80%) said they did not need this service. Youth (35%), MSM of color (24%) and Latinos (23%) reported accessing this service in the highest proportions compared to other groups. However, the subpopulations with the lowest proportion accessing HIV Education for HIV+ Individuals were the Out-of-Care (13%) and white MSM (14%).

Among respondents that tried accessing HIV Education for HIV+ Individuals, the majority (76%) said it was "very easy" to get the service. Based on survey responses, access to HIV Education for HIV+ Individuals appeared easiest for women (82%), Latinos (82%) and those in care (81%).

By far, the out-of-care (90%) had the highest proportion reporting some difficulty accessing HIV Education for HIV+ Individuals during the past year.

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate

whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for HIV Education for HIV+ Individuals. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 29.2: NUMBER OF REPORTED BARRIERS FOR HIV EDUCATION FOR HIV+ INDIVIDUALS

	A	B	C	D	E	F	G	H	I	K	L	M	O	P	Q	R	U	Total** Barriers
All Respondents	5	**18**	3	5	1	2	1	7	5	4	3	1	2	0	1	1	1	**60**
Subpopulations*																		
In Care	**5**	**14**	2	3	1	2	1	4	2	2	3	0	1	0	1	0	1	**42**
Out-of-Care	0	**4**	1	2	0	0	0	3	3	2	0	1	1	0	0	1	0	**18**
Women	1	**5**	0	1	0	0	1	0	1	1	0	0	0	0	0	0	1	**11**
Youth	**1**	0	0	0	0	0	**1**	**1**	**1**	0	0	0	0	0	0	0	0	**4**
African-Americans	3	**11**	0	2	0	1	0	6	2	2	0	1	0	1	0	1	0	**31**
Latinos	0	**3**	1	2	0	0	0	0	1	1	2	0	0	0	0	0	0	**10**
White MSM	2	**3**	1	1	1	1	0	1	1	1	1	0	0	0	0	0	0	**13**
MSM of Color	2	**6**	1	2	0	0	0	4	1	1	2	0	0	0	0	0	0	**19**
Recently Released	1	**5**	0	1	1	0	0	2	2	3	1	0	0	0	0	0	0	**16**
Substance Abuse	**4**	**7**	1	2	1	1	0	2	3	3	1	0	0	0	1	0	0	**26**
Mental Health	5	**14**	3	3	1	1	0	7	5	4	3	1	1	0	1	1	0	**50**
Homeless	0	**5**	1	2	1	0	0	2	2	3	1	0	0	0	0	0	0	**17**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 60 reports of barriers among respondents who had difficulty accessing HIV Education for HIV+ Individuals during the past year. The barrier reported most often for all subpopulations (except for youth) was related to lack of information.

The table below shows several highlighted barriers reported by subpopulations when accessing HIV Education for HIV+ Individuals. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 29.2 "Number of reported barriers for HIV Education for HIV+ Individuals."

TABLE 29.3: HIGHLIGHTED BARRIERS FOR HIV EDUCATION FOR HIV+ INDIVIDUALS BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B - I don't know where to get the services (n=18)
Subpopulations*	
In Care	B - I don't know where to get the services (n=14)
Out-of-Care	B - I don't know where to get the services (n=4)
Women	B - I don't know where to get the services (n=5)
Youth	There were 4 equally reported barriers among women for this service. Please refer to previous table.
African-Americans	B - I don't know where to get the services (n=11)
Latinos	B - I don't know where to get the services (n=3)
White MSM	B - I don't know where to get the services (n=3)
MSM of Color	B - I don't know where to get the services (n=6)
Recently Released	B - I don't know where to get the services (n=5)
Substance Abuse	B - I don't know where to get the services (n=7)
Mental Health	B - I don't know where to get the services (n=14)
Homeless	B - I don't know where to get the services (n=5)

* Subpopulations are not mutually exclusive.

Problems with lack of information and difficulties ranked highest for all subpopulations, except for youth.

HOUSING-RELATED SERVICES

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Housing-Related Services*** (a.k.a., Housing Services) under Ryan White Part B is defined as the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing related referral services included assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

In the client survey, Housing Services were described as “Housing-Related Services”.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed

collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 40 unduplicated PLWHA received Housing-Related Services through grants billed to Ryan White Part A and other funding sources. This total represents less than one percent (<1%) of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Housing-Related Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 30.1: REPORTED ACCESS TO HOUSING-RELATED SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	241	32%	71	29%	170	71%	523	68%
Subpopulations*								
In Care	209	30%	65	31%	144	69%	478	70%
Out-of-Care	32	42%	6	19%	26	81%	45	58%
Women	83	35%	19	23%	64	77%	155	65%
Youth	12	32%	3	25%	9	75%	25	68%
African-Americans	162	38%	58	36%	104	64%	267	62%
Latinos	31	22%	8	26%	23	74%	110	78%
White MSM	17	17%	3	18%	14	82%	86	83%
MSM of Color	64	31%	24	38%	40	63%	144	69%
Recently Released	45	38%	9	20%	36	80%	74	62%
Substance Abuse	101	41%	30	30%	71	70%	147	59%
Mental Health	145	32%	32	22%	113	78%	307	68%
Homeless	44	49%	41	46%	3	3%	6	7%

* Subpopulations are not mutually exclusive.

Nearly one-third (241 or 32%) of all survey respondents reported attempting to access Housing-Related Services during the previous 12 months; a total of 523 (68%) said they did not need this service. The Out-of-Care (32 or 42%) and substance abusers (101 or 41%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing Housing-Related Services was the white MSM (17 or 17%).

Among respondents that tried accessing Housing-Related Services, 71 or 29% said it was “very easy” to get the service. Based on survey responses, access to Housing-Related Services appeared easiest for MSM of color (24 or 38%), African-Americans (58 or 36%), and substance abusers (30 or 30%).

By far, the Out-of-Care (26 or 81%) had the highest proportion that reported some difficulty accessing Housing-Related Services during the past year. Another subpopulation with relatively high proportions of difficulty was the recently released (36 or 80%).

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents

described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Housing-Related Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation

TABLE 30.2: NUMBER OF REPORTED BARRIERS FOR HOUSING-RELATED SERVICES

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Q	R	S	U	Total** Barriers
All Respondents	30	**67**	**55**	15	31	22	13	16	16	4	7	1	21	1	1	1	5	7	**312**
Subpopulations*																			
In Care	24	**60**	**49**	12	27	17	10	13	12	2	4	1	17	1	0	1	4	5	**259**
Out-of-Care	6	**7**	**6**	3	4	5	3	3	4	2	3	0	4	0	0	0	1	2	**53**
Women	12	**25**	**22**	7	14	10	6	10	10	3	6	0	7	0	0	0	3	4	**139**
Youth	2	**7**	2	1	**3**	2	2	2	2	2	0	0	1	0	0	0	0	0	**26**
African-Americans	16	**39**	**30**	13	14	15	6	10	9	3	3	0	13	0	1	0	4	2	**178**
Latinos	5	**11**	**8**	1	7	3	3	2	2	0	0	1	1	0	0	0	0	0	**44**
White MSM	4	**7**	**7**	1	4	1	3	0	3	0	0	0	2	1	0	0	0	0	**33**
MSM of Color	5	**13**	**16**	3	7	3	0	2	0	0	1	0	5	0	0	1	0	2	**58**
Recently Released	4	**12**	**8**	6	5	4	1	3	2	0	1	0	1	1	0	0	1	0	**49**
Substance Abuse	14	**32**	**19**	5	14	11	3	8	6	1	4	0	11	0	0	1	3	3	**135**
Mental Health	14	**41**	**38**	10	21	15	6	13	12	3	3	0	15	1	0	1	4	6	**203**
Homeless	**11**	**18**	13	8	5	9	6	6	7	2	3	0	4	0	0	1	3	2	**98**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 312 reports of barriers among respondents who had difficulty accessing Housing-Related Services during the past year. The barriers reported most often for Housing-Related Services were related to not knowing where to get the services and having to wait too long to get the services.

The following table shows several highlighted barriers reported by subpopulations when accessing housing-related services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 30.2, "Number of reported barriers for housing-related services."

TABLE 30.3: HIGHLIGHTED BARRIERS FOR HOUSING-RELATED SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=67) C – I would have to wait too long to get the services (n=55)
Subpopulations*	
In Care	B – I don't know where to get the services (n=60) C – I would have to wait too long to get the services (n=49)
Out-of-Care	B – I don't know where to get the services (n=7) C – I would have to wait too long to get the services (n=6)
Women	B – I don't know where to get the services (n=25) C – I would have to wait too long to get the services (n=22)
Youth	B – I don't know where to get the services (n=7) E – I was told I am not eligible to get the services (n=3)
African-Americans	B – I don't know where to get the services (n=39) C – I would have to wait too long to get the services (n=30)
Latinos	B – I don't know where to get the services (n=11) C – I would have to wait too long to get the services (n=8)
White MSM	B – I don't know where to get the services (n=7) C – I would have to wait too long to get the services (n=7)
MSM of Color	C – I would have to wait too long to get the services (n=16) B – I don't know where to get the services (n=13)
Recently Released	B – I don't know where to get the services (n=12) C – I would have to wait too long to get the services (n=8)
Substance Abuse	B – I don't know where to get the services (n=32) C – I would have to wait too long to get the services (n=19)
Mental Health	B – I don't know where to get the services (n=41) C – I would have to wait too long to get the services (n=38)
Homeless	B – I don't know where to get the services (n=18) A - The services are not in my area (n=11)

*Subpopulations are not mutually exclusive.

Not knowing where to get the services and having to wait too long to get the services ranked high for the majority of subpopulations. Among youth, being told one is ineligible for the service also ranked highly.

LEGAL SERVICES

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Legal Services*** under Ryan White Part B includes the provision of services to individuals with respect to powers of attorney, do not resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver, which is provided under permanency planning services instead.

In the client survey, the actual Part B terminology was used to describe Legal Services.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed

collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 767 unduplicated PLWHA received Legal Services through grants billed to Ryan White Part A, Part B, the Texas Department of State Health Services, and other funding sources. This total represents approximately 4% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Legal Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 31.1: REPORTED ACCESS TO LEGAL SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	139	18%	64	46%	75	54%	625	82%
Subpopulations*								
In Care	126	18%	63	50%	63	50%	561	82%
Out-of-Care	13	17%	1	8%	12	92%	64	83%
Women	33	14%	14	42%	19	58%	205	86%
Youth	4	11%	2	50%	2	50%	33	89%
African-Americans	81	19%	39	48%	42	52%	348	81%
Latinos	28	20%	8	29%	20	71%	113	80%
White MSM	18	17%	9	50%	9	50%	85	83%
MSM of Color	54	26%	22	41%	23	43%	154	74%
Recently Released	18	15%	8	44%	10	56%	101	85%
Substance Abuse	39	16%	19	49%	20	51%	209	84%
Mental Health	89	20%	37	42%	52	58%	363	80%
Homeless	11	12%	9	10%	2	2%	4	4%

* Subpopulations are not mutually exclusive.

Approximately 18% of all survey respondents reported attempting to access Legal Services during the previous 12 months; a total of 625 (82%) said they did not need this service. MSM of color (54 or 26%), Latinos (28 or 20%), and PLWHA with mental health symptoms (89 or 20%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing Legal Services was the youth (4 or 11%).

Among respondents that tried accessing Legal Services, nearly half (64 or 46%) said it was “very easy” to get the service. Based on survey responses, access to Legal Services appeared easiest for the in care, youth, and white MSM.

By far, the Out-of-Care had the highest proportion that reported some difficulty accessing Legal Services during the past year. Another subpopulation with relatively high proportions of difficulty was Latinos (20 or 71%).

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced *in the process of* getting a service.

The following table shows the number of barriers reported for Legal Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 31.2: NUMBER OF REPORTED BARRIERS FOR LEGAL SERVICES

	A	B	C	D	E	F	G	H	I	K	L	M	N	P	Q	S	T	U	Total** Barriers
All Respondents	8	**31**	**14**	8	8	4	8	12	5	3	5	4	2	1	1	1	1	1	**116**
Subpopulations*																			
In Care	6	**28**	**13**	5	5	4	6	10	4	2	4	3	2	1	1	0	1	1	**96**
Out-of-Care	2	3	1	3	3	0	2	2	1	1	1	1	0	0	0	0	0	0	**20**
Women	2	**11**	2	3	2	1	1	2	3	1	0	2	1	1	0	0	0	0	**32**
Youth	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**2**
African-Americans	6	**18**	6	5	5	3	4	**8**	4	2	1	3	0	0	1	1	1	0	**68**
Latinos	1	**10**	**5**	3	2	1	2	1	1	0	3	0	2	0	0	0	0	1	**32**
White MSM	1	2	2	0	1	0	1	**3**	0	1	1	0	0	0	0	0	0	0	**12**
MSM of Color	3	**8**	**9**	4	2	0	4	4	1	0	1	0	0	0	1	0	0	1	**38**
Recently Released	1	1	**3**	1	**3**	0	2	1	1	2	2	1	0	1	0	0	0	0	**19**
Substance Abuse	4	**10**	4	2	3	4	3	2	2	1	1	1	0	0	0	1	0	0	**38**
Mental Health	8	**22**	**10**	6	6	2	4	8	4	3	4	1	1	0	1	1	1	0	**82**
Homeless	2	**3**	1	0	1	1	2	1	1	2	1	0	0	0	0	1	0	0	**16**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 116 reports of barriers among respondents who had difficulty accessing Legal Services during the past year. The barriers reported most often for Legal Services were related to not knowing where to get the services and having to wait too long

to get the services.

The table below shows several highlighted barriers reported by subpopulations when accessing legal services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 31.2, "Number of reported barriers for legal services."

TABLE 31.3: HIGHLIGHTED BARRIERS FOR LEGAL SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=31) C – I would have to wait too long to get the services (n=14)
Subpopulations*	
In Care	B – I don't know where to get the services (n=28) C – I would have to wait too long to get the services (n=13)
Out-of-Care	Three barriers were ranked equally among the out-of-care for this service. See previous table.
Women	B – I don't know where to get the services (n=11)
Youth	Only two barriers were ranked among youth for this service. See previous table.
African-Americans	B – I don't know where to get the services (n=18) H – It's hard to make or keep appointments (n=8)
Latinos	B – I don't know where to get the services (n=10) C – I would have to wait too long to get the services (n=5)
White MSM	H – It's hard to make or keep appointments (n=3)
MSM of Color	C – I would have to wait too long to get the services (n=9) B – I don't know where to get the services (n=8)
Recently Released	C – I would have to wait too long to get the services (n=3) E – I was told I am not eligible to get the services (n=3)
Substance Abuse	B – I don't know where to get the services (n=10)
Mental Health	B – I don't know where to get the services (n=22) C – I would have to wait too long to get the services (n=10)
Homeless	B - I don't know where to get the services (n=3)

*Subpopulations are not mutually exclusive.

Among all respondents, not knowing where to get the services or having to wait too long to get the services ranked highly. Having to wait to long to get the services also ranked highly among the in care, Latinos, MSM of color, recently released, and PLWHA with mental health symptoms. Among African-Americans and white MSM, difficulty in making or keeping appointments also ranked high.

NUTRITIONAL COUNSELING

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Nutritional Counseling*** (a.k.a., "Medical Nutritional Therapy") under Ryan White Part B is a service provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. It includes the provision of an individual education/counseling session focused on education/counseling concerning therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients.

In the client survey, Medical Nutritional Therapy was described as "Nutritional Counseling".

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a

comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 563 unduplicated PLWHA received Nutritional Counseling services through grants billed to the Texas Department of State Health Services. This total represents approximately 3% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Nutritional Counseling reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 32.1: REPORTED ACCESS TO NUTRITIONAL COUNSELING IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	146	19%	98	67%	48	33%	618	81%
Subpopulations*								
In Care	141	21%	98	70%	43	30%	546	79%
Out-of-Care	5	6%	0	0%	5	100%	72	94%
Women	31	13%	19	61%	12	39%	207	87%
Youth	3	8%	2	67%	1	33%	34	92%
African-Americans	66	15%	41	62%	25	38%	363	85%
Latinos	41	29%	29	71%	12	29%	100	71%
White MSM	22	21%	16	73%	6	27%	81	79%
MSM of Color	56	27%	38	68%	18	32%	152	73%
Recently Released	23	19%	12	52%	11	48%	96	81%
Substance Abuse	53	21%	31	58%	22	42%	195	79%
Mental Health	79	17%	43	54%	36	46%	373	83%
Homeless	15	17%	9	10%	6	7%	2	2%

* Subpopulations are not mutually exclusive.

Approximately 19% of all survey respondents reported attempting to access Nutritional Counseling during the previous 12 months; a total of 618 (81%) said they did not need this service. Latinos (41 or 29%) and MSM of color (56 or 27%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing Nutritional Counseling was the Out-of-Care (5 or 6%).

Among respondents that tried accessing Nutritional Counseling, the majority (98 or 67%) said it was “very easy” to get the service. Based on survey responses, access to Nutritional Counseling appeared easiest for White MSM (16 or 73%), Latinos (29 or 71%), and the in care (98 or 70%).

By far, the Out-of-Care had the high proportion that reported some difficulty accessing Nutritional Counseling during the past year.

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Nutritional Counseling. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 32.2: NUMBER OF REPORTED BARRIERS FOR NUTRITIONAL COUNSELING

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	P	Q	R	S	Total** Barriers
All Respondents	5	**21**	7	3	3	4	4	**10**	6	0	2	2	0	1	0	0	0	0	**68**
Subpopulations*																			
In Care	4	**18**	7	1	1	3	4	**10**	5	0	0	2	0	1	0	0	0	0	**56**
Out-of-Care	1	**3**	0	2	2	1	0	0	1	0	2	0	0	0	0	0	0	0	**12**
Women	2	**6**	2	1	1	2	0	3	**4**	0	2	0	0	1	0	0	0	0	**24**
Youth	0	**1**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
African-Americans	2	**10**	1	1	1	3	2	**6**	5	0	2	1	0	1	0	0	0	0	**35**
Latinos	1	**4**	**3**	1	1	0	1	1	0	0	0	1	0	0	0	0	0	0	**13**
White MSM	0	**4**	1	0	1	1	0	**2**	0	0	0	0	0	0	0	0	0	0	**9**
MSM of Color	4	**6**	4	1	1	0	1	4	1	0	0	1	0	0	0	0	0	0	**23**
Recently Released	1	**3**	1	0	0	1	2	2	**3**	0	1	0	0	0	0	0	0	0	**14**
Substance Abuse	1	**8**	3	1	2	0	1	4	4	0	0	1	0	1	0	0	0	0	**26**
Mental Health	3	**16**	6	3	3	3	2	9	6	0	2	0	0	1	0	0	0	0	**54**
Homeless	1	**5**	0	0	0	1	1	1	0	0	1	0	0	1	0	0	0	0	**11**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service.

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 68 reports of barriers among respondents who had difficulty accessing Nutritional Counseling during the past year. The barriers reported most often for Nutritional Counseling were related to not thinking one is eligible for the services and not

knowing where to get the services. The table below shows several highlighted barriers reported by subpopulations when accessing Nutritional Counseling. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 32.2, "Number of reported barriers for Nutritional Counseling."

TABLE 32.3: HIGHLIGHTED BARRIERS FOR NUTRITIONAL COUNSELING BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=21) H – It's hard to make or keep appointments (n=10)
Subpopulations*	
In Care	B – I don't know where to get the services (n=18) H – It's hard to make or keep appointments (n=10)
Out-of-Care	B – I don't know where to get the services (n=3)
Women	B – I don't know where to get the services (n=6) I – It's hard for me to get there (n=4)
Youth	Only one barrier was ranked among youth for this service. See previous table.
African-Americans	B – I don't know where to get the services (n=10) H – It's hard to make or keep appointments (n=6)
Latinos	B – I don't know where to get the services (n=4) C – I would have to wait too long to get the services (n=3)
White MSM	B – I don't know where to get the services (n=4) H – It's hard to make or keep appointments (n=2)
MSM of Color	B – I don't know where to get the services (n=6)
Recently Released	B – I don't know where to get the services (n=3) I – It's hard for me to get there (n=3)
Substance Abuse	B – I don't know where to get the services (n=8)
Mental Health	B – I don't know where to get the services (n=16)
Homeless	B – I don't know where to get the services (n=5)

*Subpopulations are not mutually exclusive.

Not knowing where to get the services ranked high for the majority of subpopulations. Among all respondents, both not knowing where to get the service and having a hard time making or keeping appointments for the service ranked highly. Among the in care, African-Americans, and white MSM, difficulty in making or keeping appointments also ranked high. Having to wait too long to the services also ranked highly among Latinos.

PERMANENCY PLANNING

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Permanency Planning*** under Ryan White Part B is defined as the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

In the client survey, the actual Part B terminology was used to describe Permanency Planning.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a

comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

Permanency planning is provided within the legal services category. The data cannot be separated; therefore, no utilization data is available for this specific service category.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Permanency Planning reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 33.1: REPORTED ACCESS TO PERMANENCY PLANNING IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	28	4%	9	32%	19	68%	736	96%
Subpopulations*								
In Care	26	4%	8	31%	18	69%	661	96%
Out-of-Care	2	3%	1	50%	1	50%	75	97%
Women	8	3%	2	25%	6	75%	230	97%
Youth	0	0%	0	0%	0	0%	37	100%
African-Americans	10	2%	4	40%	6	60%	419	98%
Latinos	6	4%	2	33%	4	67%	135	96%
White MSM	7	7%	3	43%	4	57%	96	93%
MSM of Color	9	4%	3	33%	6	67%	199	96%
Recently Released	4	3%	2	50%	2	50%	115	97%
Substance Abuse	6	2%	1	17%	5	83%	242	98%
Mental Health	23	5%	10	43%	13	57%	429	95%
Homeless	0	0%	0	0%	0	0%	1	1%

* Subpopulations are not mutually exclusive.

Approximately 4% of all survey respondents reported attempting to access permanency planning during the previous 12 months; the majority (736 or 96%) said they did not need this service. White MSM (7 or 7%) and PLWHA with mental health symptoms (13 or 57%) reported accessing this service in the highest proportions compared to other groups. The subpopulations with the lowest proportion accessing permanency planning were African-Americans (10 or 2%) and substance abusers (6 or 2%).

Among respondents that tried accessing permanency planning, nearly one third (9 or 32%) said it was “very easy” to get the service. Based on survey responses, access to permanency planning appeared easiest for the Out-of-Care (1 or 50%) and recently released (2 or 50%).

By far, substance abusers (5 or 83%) had the highest proportion that reported some difficulty accessing permanency planning during the past year. Another subpopulation with relatively high proportions of difficulty was women (6 or 75%).Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced *in the process of* getting a service.

The following table shows the number of barriers reported for Permanency Planning. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 33.2: NUMBER OF REPORTED BARRIERS FOR PERMANENCY PLANNING

	A	B	C	D	E	F	G	H	I	J	K	L	R	Total** Barriers
All Respondents	2	**14**	3	**4**	1	2	1	1	**11**	0	2	0	1	**33**
Subpopulations*														
In Care	1	**14**	3	3	1	1	1	1	**10**	0	0	0	1	**35**
Out-of-Care	1	0	0	1	0	1	0	0	1	0	**2**	0	0	**6**
Women	0	**4**	**2**	0	0	0	0	0	0	0	0	0	0	**6**
Youth	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
African-Americans	1	**4**	1	1	1	**2**	1	1	0	0	0	0	0	**12**
Latinos	0	**3**	0	0	0	0	1	0	0	0	0	0	1	**5**
White MSM	0	**3**	1	**2**	0	0	0	1	0	0	0	0	0	**7**
MSM of Color	1	**5**	0	1	1	1	1	0	1	0	0	0	1	**12**
Recently Released	0	1	1	0	0	0	0	0	0	0	0	0	0	**2**
Substance Abuse	1	**3**	1	1	1	2	1	2	0	0	0	0	0	**12**
Mental Health	1	**8**	3	3	1	2	2	2	1	0	0	0	1	**24**
Homeless	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service\

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 33 reports of barriers among respondents who had difficulty accessing Permanency Planning during the past year. The barriers reported most often for Permanency Planning were related to not knowing where to get the services and not being able to afford the services.

The table below shows several highlighted barriers reported by subpopulations when accessing permanency planning. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 33.2, "Number of reported barriers for permanency planning."

TABLE 33.3: HIGHLIGHTED BARRIERS FOR PERMANENCY PLANNING BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=14) I – It's hard for me to get there (n=11)
Subpopulations*	
In Care	B - I don't know where to get the services (n=14) I – It's hard for me to get there (n=10)
Out-of-Care	K – I'm afraid someone will find out about my HIV (n=2)
Women	B - I don't know where to get the services (n=4)
Youth	No barriers were reported among youth for this service.
African-Americans	B - I don't know where to get the services (n=4)
Latinos	B - I don't know where to get the services (n=3)
White MSM	B - I don't know where to get the services (n=3)
MSM of Color	B - I don't know where to get the services (n=5)
Recently Released	Only 2 barriers were reported among the recently released for this service. See previous table.
Substance Abuse	B - I don't know where to get the services (n=3)
Mental Health	B - I don't know where to get the services (n=8)
Homeless	No barriers were reported among the homeless for this service.

*Subpopulations are not mutually exclusive.

Among all populations, not knowing where to get the services and the expense of services ranked highly. Among the Out-of-Care, specifically, fear of someone finding out about one's HIV ranked highest among all reported barriers. There were no barriers reported among youth for this service.

REFERRALS TO CLINICAL RESEARCH

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Referrals to Clinical Research*** is defined as the provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research refers to studies in which new treatments—drugs, diagnostics, procedures, vaccines, and other therapies—are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an institutional review board that initially approves and periodically reviews the research.

In the client survey, the actual Part B terminology was used to describe Referrals to Clinical Research.

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San

Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA. It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

The Centralized Patient Care Data Management System (CPCDMS) does not track Referrals to Clinical Research; therefore, no utilization data can be reported for this service.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Referrals to Clinical Research reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 34.1: REPORTED ACCESS TO REFERRALS TO CLINICAL RESEARCH IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	68	9%	31	46%	37	54%	696	91%
Subpopulations*								
In Care	60	9%	30	50%	30	50%	627	91%
Out-of-Care	8	10%	1	12%	7	88%	69	90%
Women	21	9%	8	38%	13	62%	217	91%
Youth	3	8%	2	67%	1	33%	34	92%
African-Americans	44	10%	18	41%	26	59%	385	90%
Latinos	8	6%	6	75%	2	25%	133	94%
White MSM	10	10%	4	40%	6	60%	93	90%
MSM of Color	16	8%	10	63%	6	37%	192	92%
Recently Released	12	10%	6	50%	6	50%	107	90%
Substance Abuse	25	10%	10	40%	15	60%	223	90%
Mental Health	42	9%	14	33%	28	67%	410	91%
Homeless	6	7%	2	2%	4	4%	1	1%

* Subpopulations are not mutually exclusive.

Less than 10% of all 764 survey respondents reported attempting to access Referrals to Clinical Research during the previous 12 months; the majority (696 or 91%) said they did not need this service. The Out-of-Care (10%), African-Americans (8 or 10%), White MSM (10 or 10%), recently released (12 or 10%), and substance abusers (25 or 10%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing Referrals to Clinical Research was Latinos (8 or 6%).

Among respondents that tried accessing Referrals to Clinical Research, nearly half (31 or 46%) said it was “very easy” to get the service. Based on survey responses, access to Referrals to Clinical Research appeared easiest for Latinos (6 or 75%), youth (2 or 67%), and MSM of color (10 or 63%).

By far, Out-of-Care (7 or 88%) had the high proportion that reported some difficulty accessing Referrals to Clinical Research during the past year. Another subpopulation with relatively high proportions of difficulty was PLWHA with mental health symptoms (28 or 67%).

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common

barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Referrals to Clinical Research. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 34.2: NUMBER OF REPORTED BARRIERS FOR REFERRALS TO CLINICAL RESEARCH

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Total** Barriers
All Respondents	6	**23**	5	1	6	6	0	3	5	0	1	0	0	0	0	0	**56**
Subpopulations*																	
In Care	4	**20**	3	1	4	4	0	3	**5**	0	0	0	0	0	0	0	**44**
Out-of-Care	2	**3**	2	0	2	2	0	0	0	0	1	0	0	0	0	0	**12**
Women	2	**6**	3	0	3	3	0	1	**4**	0	0	0	0	0	0	0	**22**
Youth	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
African-Americans	4	**16**	3	1	5	5	0	2	3	0	1	0	0	0	0	0	**40**
Latinos	1	**2**	1	0	0	0	0	0	1	0	0	0	0	0	0	0	**5**
White MSM	1	**3**	1	0	1	0	0	1	0	0	0	0	0	0	0	0	**7**
MSM of Color	0	**5**	1	0	0	2	0	0	0	0	0	0	0	0	0	0	**8**
Recently Released	2	**4**	2	0	1	1	0	0	1	0	1	0	0	0	0	0	**12**
Substance Abuse	1	**11**	2	0	3	3	0	0	1	0	1	0	0	0	0	0	**22**
Mental Health	4	**18**	3	0	5	5	0	1	3	0	1	0	0	0	0	0	**40**
Homeless	0	**2**	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 56 reports of barriers among respondents who had difficulty accessing Referrals to Clinical Research during the past year. The barrier reported most often for Referrals to Clinical Research was related to not knowing where to get the services.

The table below shows several highlighted barriers reported by subpopulations when accessing referrals to clinical research. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 34.2, "Number of reported barriers for referrals to clinical research."

TABLE 34.3: HIGHLIGHTED BARRIERS FOR REFERRALS TO CLINICAL RESEARCH BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=23)
Subpopulations*	
In Care	B - I don't know where to get the services (n=20) I – It's hard for me to get there (n=5)
Out-of-Care	B - I don't know where to get the services (n=3)
Women	B - I don't know where to get the services (n=6) I – It's hard for me to get there (n=4)
Youth	Only 1 barrier was reported among youth for this service. See previous table.
African-Americans	B - I don't know where to get the services (n=16)
Latinos	B - I don't know where to get the services (n=2)
White MSM	B - I don't know where to get the services (n=3)
MSM of Color	B - I don't know where to get the services (n=5)
Recently Released	B - I don't know where to get the services (n=4)
Substance Abuse	B - I don't know where to get the services (n=11)
Mental Health	B - I don't know where to get the services (n=18)
Homeless	B - I don't know where to get the services (n=2)

*Subpopulations are not mutually exclusive.

Not knowing where to get the services ranked high for the majority of subpopulations. Among the in care and women, having a hard time getting to the service also ranked highly.

Referrals to Services

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

Under Part B, ***referral for health care/supportive services*** is defined as the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

In the client survey, Referrals to Services was described as "Referrals to Services."

CPCDMS/ARIES Service Utilization Data

The Centralized Patient Care Data Management System (CPCDMS) does not track referrals to services; therefore, no utilization data can be reported for this service.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Referrals to Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 35.1: REPORTED ACCESS TO REFERRALS FOR SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	131	17%	78	60%	53	40%	633	83%
Subpopulations*								
In Care	115	17%	75	65%	40	35%	572	83%
Out-of-Care	16	21%	3	19%	13	81%	61	79%
Women	42	18%	26	62%	16	38%	196	82%
Youth	6	16%	6	100%	0	0%	31	84%
African-Americans	72	17%	46	64%	26	36%	357	83%
Latinos	17	12%	11	65%	6	35%	124	88%
White MSM	31	30%	15	48%	16	52%	72	70%
MSM of Color	30	14%	20	67%	10	33%	178	86%
Recently Released	20	17%	11	55%	9	45%	99	83%
Substance Abuse	49	20%	29	59%	20	41%	199	80%
Mental Health	73	16%	36	49%	37	51%	379	84%
Homeless	19	21%	13	15%	6	7%	2	2%

* Subpopulations are not mutually exclusive.

Less than a fifth (17%) of all 764 survey respondents reported attempting to access Referrals to Services during the previous 12 months; the vast majority (83%) said they did not need this service. White MSM (30%), the Out-of-Care (21%) and substance abusers (20%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing Referrals to Services was Latinos (12%).

Among respondents that tried accessing Referrals to Services, more than half (60%) said it was "very easy" to get the service. Based on survey responses, access to Referrals to Services appeared easiest for MSM of color (67%), Latinos (65%) and the in-care (65%). All youth that accessed referrals said it was very easy to get the service (100%).

By far, the out-of-care (81%) had the highest proportion that reported some difficulty accessing Referrals to Services during the past year. Another subpopulation with relatively higher proportions of difficulty was white MSM (52%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to

describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Referrals to Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 35.2: NUMBER OF REPORTED BARRIERS FOR REFERRALS TO SERVICES

	A	B	C	D	E	F	G	H	I	J	K	L	N	S	T	Total** Barriers
All Respondents	8	**22**	**12**	4	2	5	**12**	7	7	1	2	1	2	2	1	**88**
Subpopulations*																
In Care	5	**16**	8	3	2	2	8	6	4	0	0	1	1	1	1	**58**
Out-of-Care	3	**6**	4	1	0	3	4	1	3	1	2	0	1	1	0	**30**
Women	1	**8**	3	0	0	1	2	3	4	1	1	0	2	1	0	**27**
Youth	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
African-Americans	4	**13**	6	1	0	3	2	2	4	1	1	0	2	2	0	**41**
Latinos	1	1	1	0	0	2	**3**	1	1	0	1	1	0	0	0	**12**
White MSM	3	**6**	5	3	2	0	5	3	2	0	0	0	0	0	1	**30**
MSM of Color	2	**4**	3	0	0	0	2	0	0	0	0	0	0	0	0	**11**
Recently Released	3	1	3	0	0	2	2	2	**4**	0	1	0	0	0	0	**18**
Substance Abuse	2	**8**	3	2	0	3	3	3	5	0	1	0	1	2	0	**33**
Mental Health	5	**15**	6	4	2	5	8	5	6	0	2	0	1	2	0	**61**
Homeless	2	**4**	**4**	2	0	1	**4**	1	1	1	2	0	0	1	0	**23**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 88 reports of barriers among respondents who had difficulty accessing Referrals to Services during the past year. Except for Latinos and the recently released, the barrier reported most often across all subpopulations was related to lack of information.

The table below shows several highlighted barriers reported by subpopulations when accessing Referrals to Services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 35.2, "Number of reported barriers for Referrals to Services."

TABLE 35.3: HIGHLIGHTED BARRIERS FOR REFERRALS TO SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B - I don't know where to get the services (n=22) C – I would have to wait too long to get the services (n=12) G - The people who run the services are not friendly (n=12)
Subpopulations*	
In Care	B - I don't know where to get the services (n=16)
Out-of-Care	B - I don't know where to get the services (n=6)
Women	B - I don't know where to get the services (n=8)
Youth	No barriers were reported among youth for this service.
African-Americans	B - I don't know where to get the services (n=13)
Latinos	G - The people who run the services are not friendly (n=3)
White MSM	B - I don't know where to get the services (n=6)
MSM of Color	B - I don't know where to get the services (n=4)
Recently Released	I - It's hard for me to get there (n=4)
Substance Abuse	B - I don't know where to get the services (n=8)
Mental Health	B - I don't know where to get the services (n=15)
Homeless	B – I don't know where to get the services (n=4) C – I would have to wait too long to get the services (n=4) G - The people who run the services are not friendly (n=4)

* Subpopulations are not mutually exclusive.

Problems with lack of information ranked highest across subpopulations, except for the recently released and Latinos. For the recently released, difficulties getting to the service location ranked highest. For Latinos, unfriendly staff ranked the highest.

RENTAL ASSISTANCE/SHELTER VOUCHERS

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of Rental Assistance/Shelter Vouchers (a.k.a., a subcategory of "Housing Services") under Ryan White Part B is the provision of short-term assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care.

In the client survey, Housing Services was described as "Rental Assistance/Shelter Vouchers".

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, co-morbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA

receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 62 unduplicated PLWHA received rental assistance/shelter vouchers through grants billed to Ryan White Part A and HOPWA. This total represents less than one percent (<1%) of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to rental assistance/shelter vouchers reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African American female reporting a mental health symptom is included in the Women, African Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 36.1: REPORTED ACCESS TO RENTAL ASSISTANCE/SHELTER VOUCHERS IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	254	33%	82	32%	172	68%	510	67%
Subpopulations*								
In Care	227	33%	79	35%	148	65%	460	67%
Out-of-Care	27	35%	3	11%	24	89%	50	65%
Women	91	38%	28	31%	63	69%	147	62%
Youth	15	41%	4	27%	11	73%	22	59%
African-Americans	143	33%	51	36%	92	64%	286	67%
Latinos	52	37%	15	29%	37	71%	89	63%
White MSM	31	30%	7	23%	24	77%	72	70%
MSM of Color	75	36%	31	41%	44	59%	133	64%
Recently Released	32	27%	9	28%	23	72%	87	73%
Substance Abuse	86	35%	27	31%	59	69%	162	65%
Mental Health	149	33%	38	26%	111	74%	303	67%
Homeless	30	34%	25	28%	5	6%	1	1%

* Subpopulations are not mutually exclusive.

Approximately one-third (33%) of all 764 survey respondents reported attempting to access Rental Assistance/Shelter Vouchers during the previous 12 months; a total of 510 (67%) said they did not need this service. Youth (15 or 41%), women (391 or 8%), and Latinos (52 or 37%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing Rental Assistance/ Shelter Vouchers was the recently released (32 or 27%).

Among respondents that tried accessing Rental Assistance/Shelter Vouchers, less than half (82 or 32%) said it was “very easy” to get the service. Based on survey responses, access to Rental Assistance/Shelter Vouchers appeared easiest for MSM of color (31 or 41%), African Americans (51 or 36%), and in care (79 or 35%).

By far, white MSM had the high proportion that reported some difficulty accessing Rental Assistance/Shelter Vouchers during the past year. Another subpopulation with relatively high proportions of difficulty was PLWHA with mental health symptoms (111 or 74%).

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate

whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced *in the process of* getting a service.

The following table shows the number of barriers reported for Rental/Assistance Shelter Vouchers. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 36.2: NUMBER OF REPORTED BARRIERS FOR RENTAL ASSISTANCE/ SHELTER VOUCHERS

	A	B	C	D	E	F	G	H	I	J	K	M	N	P	Q	S	T	U	V	Total** Barriers
All Respondents	20	**51**	**47**	14	28	24	20	27	12	2	7	8	3	1	4	5	1	14	2	**290**
Subpopulations*																				
In Care	16	**47**	**42**	12	25	16	15	19	8	2	4	8	3	0	2	5	1	12	1	**239**
Out-of-Care	4	4	5	2	3	**8**	5	**8**	4	0	3	0	0	0	2	0	0	2	1	**51**
Women	11	**16**	**16**	9	11	13	9	9	7	2	5	4	2	0	3	3	0	8	2	**130**
Youth	2	**5**	**4**	1	2	2	3	3	2	2	1	0	1	0	0	1	0	2	1	**32**
African-Americans	12	**25**	**18**	11	13	16	9	14	8	1	4	8	1	0	2	3	1	9	1	**157**
Latinos	3	**13**	**11**	2	3	1	6	5	1	0	0	0	1	0	2	1	0	3	1	**53**
White MSM	1	**9**	**7**	0	4	3	5	3	2	0	0	0	1	0	0	1	0	2	0	**38**
MSM of Color	4	**12**	**16**	1	7	3	2	6	2	0	1	2	0	0	0	1	1	3	0	**61**
Recently Released	0	**7**	2	1	3	4	4	4	2	0	1	2	1	0	0	1	0	2	0	**34**
Substance Abuse	7	**24**	9	6	**10**	7	5	**10**	5	1	4	2	1	0	1	3	1	8	1	**106**
Mental Health	11	**31**	33	10	**20**	16	15	**20**	8	2	2	5	2	1	2	4	1	8	1	**193**
Homeless	6	**11**	7	3	3	**9**	4	4	4	2	5	1	0	0	0	0	0	1	1	**61**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 290 reports of barriers among respondents who had difficulty accessing Rental/Assistance Shelter Vouchers during the past year. The barriers reported

most often for Rental/Assistance Shelter Vouchers were related to not knowing where to get the services and having to wait too long to get the services.

The table below shows several highlighted barriers reported by subpopulations when accessing rental assistance/shelter vouchers. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 36.2: "Number of reported barriers for rental assistance/shelter vouchers."

TABLE 36.3: HIGHLIGHTED BARRIERS FOR RENTAL ASSISTANCE/SHELTER VOUCHERS BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B – I don't know where to get the services (n=51) C – I would have to wait too long to get the services (n=47)
Subpopulations*	
In Care	B – I don't know where to get the services (n=47) C – I would have to wait too long to get the services (n=42)
Out-of-Care	F- I don't think I'm eligible to get the services (n=8) H – It's hard to make or keep appointments (n=8)
Women	B – I don't know where to get the services (n=16) C – I would have to wait too long to get the services (n=16)
Youth	B – I don't know where to get the services (n=5)
African-Americans	B – I don't know where to get the services (n=25) C – I would have to wait too long to get the services (n=18)
Latinos	B – I don't know where to get the services (n=13)
White MSM	B – I don't know where to get the services (n=9)
MSM of Color	C – I would have to wait too long to get the services (n=16)
Recently Released	B – I don't know where to get the services (n=7)
Substance Abuse	B – I don't know where to get the services (n=24)
Mental Health	E- I was told I'm not eligible to get the services (n=20) H – It's hard to make or keep appointments (n=20)
Homeless	B – I don't know where to get the services (n=11) F- I don't think I'm eligible to get the services (n=9)

Not knowing where to get the services ranked high for the majority of subpopulations. Not thinking one is eligible to get the services and having a hard time making or keeping appointments for rental assistance/shelter vouchers were also ranked highly among the out of care. Having to wait too long to get the services was a frequently reported barrier among women (n=16), MCM of color (n=16), and PLWHA with mental health symptoms (n=33).

SUPPORT GROUPS

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

The local definition of ***Support Groups*** under the Ryan White Part A Program is defined as professionally led (licensed therapist or counselor) groups that comprise HIV-infected individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV-infected person.

In the client survey, Support Groups was described as "Support Groups."

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a

total of 111 unduplicated PLWHA received Support Groups through grants billed to Ryan White Part A, SAMHSA and Texas Department of State Health Services. This total represents 1% of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Support Groups reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 37.1: REPORTED ACCESS TO SUPPORT GROUPS IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	169	22%	94	56%	75	44%	595	78%
Subpopulations*								
In Care	156	23%	92	59%	64	41%	531	77%
Out-of-Care	13	17%	2	15%	11	85%	64	83%
Women	72	30%	43	60%	29	40%	166	70%
Youth	10	27%	8	80%	2	20%	27	73%
African-Americans	114	27%	76	67%	38	33%	315	73%
Latinos	37	26%	24	65%	13	35%	104	74%
White MSM	32	31%	16	50%	16	50%	71	69%
MSM of Color	55	26%	34	62%	21	38%	153	74%
Recently Released	30	25%	21	70%	9	30%	89	75%
Substance Abuse	78	31%	46	59%	32	41%	170	69%
Mental Health	105	23%	50	48%	55	52%	347	77%
Homeless	17	19%	6	7%	11	12%	4	4%

*Subpopulations are not mutually exclusive.

Less than a fourth (22%) of all 764 survey respondents reported attempting to access Support Groups during the previous 12 months; a total of 595 (78%) said they did not need this service. Substance abusers (31%), white MSM (31%) and women (30%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing Support Groups was the out-of-care (17%).

Among respondents that tried accessing Support Groups, more than half (56%) said it was "very easy" to get the service. Based on survey responses, access to Support Groups appeared easiest for youth (80%), the recently released (70%) and African-Americans (67%).

By far, the out-of-care (85%) had the highest proportion that reported some difficulty accessing Support Groups during the past year. Another subpopulation with relatively higher proportions of difficulty was respondents with a mental health symptom (52%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Support Groups. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 37.2: NUMBER OF REPORTED BARRIERS FOR SUPPORT GROUPS

	A	B	C	D	E	F	G	H	I	J	K	L	M	Q	R	S	U	Total** Barriers
All Respondents	11	**44**	5	2	2	7	2	7	**14**	2	4	1	1	1	1	1	4	**109**
Subpopulations*																		
In Care	**11**	**37**	4	2	1	5	2	5	**11**	1	4	1	1	1	1	1	3	**91**
Out-of-Care	0	**7**	1	0	1	2	0	2	**3**	1	0	0	0	0	0	0	1	**18**
Women	**6**	**17**	3	0	2	4	0	1	**6**	1	1	0	0	0	1	1	0	**43**
Youth	0	1	0	0	0	**2**	0	0	0	0	0	0	0	0	0	0	0	**3**
African-Americans	6	**23**	4	1	2	5	0	7	**9**	1	0	0	0	1	0	0	0	**61**
Latinos	2	**7**	0	0	0	0	1	0	**3**	1	1	1	0	0	0	0	2	**18**
White MSM	3	10	0	1	0	1	1	0	2	0	1	0	1	0	0	0	0	**20**
MSM of Color	3	**13**	1	0	0	1	1	3	3	0	2	1	0	1	0	0	2	**31**
Recently Released	**2**	**4**	0	1	1	0	0	0	1	0	1	0	1	0	0	0	1	**12**
Substance Abuse	4	**18**	3	1	1	5	1	4	**8**	2	2	1	1	1	0	1	2	**55**
Mental Health	7	**32**	4	1	2	7	2	5	**11**	2	3	0	1	0	1	1	1	**80**
Homeless	0	**3**	0	1	0	2	0	1	0	0	1	0	1	0	0	0	0	**9**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 109 reports of barriers among respondents who had difficulty accessing Support Groups during the past year. The barrier reported most often across all subpopulations (except for youth) was related to lack of information.

The table below shows several highlighted barriers reported by subpopulations when accessing Support Groups. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 37.2, "Number of reported barriers for Support Groups."

TABLE 37.3: HIGHLIGHTED BARRIERS FOR SUPPORT GROUPS BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B - I don't know where to get the services (n=44)
Subpopulations*	
In Care	B - I don't know where to get the services (n=37)
Out-of-Care	B - I don't know where to get the services (n=7)
Women	B - I don't know where to get the services (n=17)
Youth	* only 3 barriers reported. Please refer to previous table.
African-Americans	B - I don't know where to get the services (n=23)
Latinos	B - I don't know where to get the services (n=7)
White MSM	B - I don't know where to get the services (n=10)
MSM of Color	B - I don't know where to get the services (n=13)
Recently Released	B - I don't know where to get the services (n=4)
Substance Abuse	B - I don't know where to get the services (n=18)
Mental Health	B - I don't know where to get the services (n=32)
Homeless	B - I don't know where to get the services (n=3)

Problems with lack of information ranked highest for all subpopulations, except for youth.

TRANSPORTATION

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

Parts A and B provide General Transportation services to access medical and/or health-related services for eligible individuals. Transportation will include round trips to single destinations and round trips to multiple destinations. Taxi vouchers will be provided to eligible clients only for identified emergency situations. Caregiver must be allowed to accompany the HIV-infected rider. ***Eligibility for either Urban or Rural Transportation Services is determined by the client's County of residence as documented in the CPCDMS***.

The local definition of ***Transportation (Urban Based)*** under the Ryan White Part A Program is defined as follows:

> Contractor will develop and implement a general transportation program that provides essential transportation services to HRSA-defined Core Services through the use of individual employee or contract drivers with vehicles/vans to Ryan White Part A eligible individuals residing in Harris County. Clients residing outside of Harris County are ineligible for this transportation program. Currently, HRSA defines Core Services as Primary Medical Care, Medications (travel to the local HIV/AIDS medication program provider for purposes of intake and eligibility determination), Oral Health, Mental Health Services, Substance Abuse Treatment and Case Management Services). Exceptions to this requirement require prior written approval from HIV Services.
>
> Essential transportation is defined as transportation to public and private outpatient medical care and physician services, substance abuse and mental health services, pharmacies and other services where eligible clients receive Ryan White defined Core Services and/or medical and health-related care services, including clinical trials, essential to their well-being.
>
> The Contractor shall ensure that the transportation program provides taxi vouchers to eligible clients only in the following cases:
>
> - To access emergency shelter vouchers or to attend social security disability hearings;
> - Van service is unavailable due to breakdown or inclement weather;
> - Client's medical need requires immediate transport;
> - Scheduling Conflicts.

For clients living in the METRO service area, written certification from the client's principal medical provider (e.g. medical case manager) is required to access van-based transportation, to be renewed every 180 days. Medical Certifications should be maintained on-site by the provider in a single file (listed alphabetically by 11-digit code) and will be monitored at least annually during a Site Visit. It is the Contractor's responsibility to determine whether a client resides within the METRO service area. Clients who live outside the METRO service area but within Harris County (e.g. Baytown) are not required to provide a written medical certification to access van-based transportation. All clients living in the Metro service area may receive a maximum of 4 non-certified round trips per year (including taxi vouchers). Non-certified trips will be reviewed during the annual Site Visit. Provider must maintain an up-to-date spreadsheet documenting such trips.

The Contractor must implement the general transportation program in accordance with the Transportation Standards of Care that include entering all transportation services into the Centralized Patient Care Data Management System (CPCDMS) and providing eligible children with transportation services to medical appointments. Only actual mileage transporting eligible clients to and from their destinations will be reimbursed under this contract. The Contractor will make every reasonable effort to ensure that routes are designed in the most efficient manner possible to minimize actual client time in vehicles.

Rural-based Transportation services under Part B are defined similarly except for the general area to be served:

Contractor will develop and implement a general transportation program that provides essential transportation services to HRSA-defined Core Services through the use of individual employee or contract drivers with vehicles/vans to Ryan White Part A eligible individuals residing in the Houston EMA outside of Harris County. Clients residing inside of Harris County are ineligible for this transportation program. Exceptions to this requirement require prior written approval from HIV Services.

In the client survey, Transportation was described as "Transportation (van transportation, bus passes, gas vouchers, taxi vouchers)."

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Ryan White-funded providers, as well as non-Ryan White providers, and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in

February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), in 2006 a total of 2,618 PLWHA received Transportation through grants billed to Ryan White Part A, Part B and Other funding sources. However, it is important to note that the 2,618 includes duplicates due to the way in which this service (and its subcategories) are tracked in CPCDMS. Broken into sub-categories, there were 441 Van-based Transportation services, 1,995 Bus Passes and 182 Gas Cards provided during 2006.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Transportation reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of very small size. The smaller the subpopulation, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much as 5 points. It is important not to rely solely on such percentages when planning for services – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service <u>does not necessarily mean the respondent received the service</u>. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask

as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of "very easy" or reports of "some difficulty" as proxies of service utilization.

TABLE 38.1: REPORTED ACCESS TO TRANSPORTATION SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	284	37%	145	51%	139	49%	480	63%
Subpopulations*								
In Care	262	38%	142	54%	120	46%	425	62%
Out-of-Care	22	29%	3	14%	19	86%	55	71%
Women	98	41%	53	54%	45	46%	140	59%
Youth	15	41%	7	47%	8	53%	22	59%
African-Americans	162	38%	88	54%	74	46%	267	62%
Latinos	43	30%	22	51%	21	49%	98	70%
White MSM	43	42%	16	37%	27	63%	60	58%
MSM of Color	64	31%	37	58%	27	42%	144	69%
Recently Released	56	47%	32	57%	24	43%	63	53%
Substance Abuse	97	39%	49	51%	48	49%	151	61%
Mental Health	167	37%	71	43%	96	57%	285	63%
Homeless	33	37%	21	24%	12	13%	2	2%

* Subpopulations are not mutually exclusive.

A little more than a third (37%) of all 764 survey respondents reported attempting to access Transportation during the previous 12 months; a total of 480 (63%) said they did not need this service. The recently released (47%), white MSM (42%), women (41%) and youth (41%) reported accessing this service in the highest proportions compared to other groups. The subpopulation with the lowest proportion accessing Transportation was the out-of-care (29%).

Among respondents that tried accessing Transportation, approximately half (51%) said it was "very easy" to get the service. Based on survey responses, access to Transportation appeared easiest for MSM of color (58%), the recently released (57%), the in-care (54%), women (54%) and African-Americans (54%).

By far, the out-of-care (86%) had the highest proportion that reported some difficulty accessing Transportation during the past year. Another subpopulation with relatively higher proportions of difficulty was white MSM (63%).

Barriers

Survey respondents that reported "some difficulty" getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so

respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents described the barriers they experienced *in the process of* getting a service.

The following table shows the number of barriers reported for Transportation. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 38.2: NUMBER OF REPORTED BARRIERS FOR TRANSPORTATION

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	Q	R	S	U	V	Total** Barriers
All Respondents	**31**	**49**	24	13	19	11	10	18	24	3	5	1	2	8	1	3	1	3	4	1	**231**
Subpopulations*																					
In Care	**27**	**41**	23	10	15	9	9	17	20	2	3	1	2	6	1	3	0	2	3	1	**195**
Out-of-Care	**4**	**8**	1	3	**4**	2	1	1	**4**	1	2	0	0	2	0	0	1	1	1	0	**36**
Women	10	**16**	8	5	8	4	3	6	**12**	3	2	0	1	5	0	2	1	2	1	0	**89**
Youth	1	**5**	1	2	2	1	2	2	2	1	0	0	0	0	0	0	0	0	0	0	**19**
African-Americans	12	**24**	13	9	10	6	2	11	**15**	3	2	0	1	7	0	1	1	2	1	0	**120**
Latinos	**6**	**7**	1	3	1	1	3	2	4	0	1	1	1	0	0	2	0	0	0	0	**33**
White MSM	7	**11**	**8**	1	5	3	5	4	1	0	1	0	0	0	0	0	0	0	2	1	**49**
MSM of Color	**5**	**10**	3	1	1	3	2	4	3	0	1	1	1	0	0	0	0	0	0	0	**35**
Recently Released	3	**5**	4	4	3	2	0	2	**6**	0	2	0	1	2	0	0	0	2	0	0	**36**
Substance Abuse	**10**	**18**	**10**	6	6	5	4	5	**10**	0	2	1	0	3	0	1	1	2	0	0	**84**
Mental Health	15	**34**	17	11	14	6	9	17	**19**	2	3	0	1	5	0	2	1	2	3	1	**162**
Homeless	5	**8**	5	**6**	3	2	2	3	**6**	2	2	0	0	1	0	1	0	1	1	0	**48**

* Subpopulations are not mutually exclusive.
** Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 231 reports of barriers among respondents who had difficulty accessing Transportation during the past year. The barrier reported most often across all subpopulations (except for the recently released) was related to lack of information.

The table below shows several highlighted barriers reported by subpopulations when accessing Transportation. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 38.2, "Number of reported barriers for Transportation."

TABLE 38.3: HIGHLIGHTED BARRIERS FOR TRANSPORTATION BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	B - I don't know where to get the services (n=49)
Subpopulations*	
In Care	B - I don't know where to get the services (n=41)
Out-of-Care	B - I don't know where to get the services (n=8)
Women	B - I don't know where to get the services (n=16)
Youth	B - I don't know where to get the services (n=5)
African-Americans	B - I don't know where to get the services (n=24)
Latinos	B - I don't know where to get the services (n=7)
White MSM	B - I don't know where to get the services (n=11)
MSM of Color	B - I don't know where to get the services (n=10)
Recently Released	I - It's hard for me to get there (n=6)
Substance Abuse	B - I don't know where to get the services (n=18)
Mental Health	B - I don't know where to get the services (n=34)
Homeless	B – I don't know where to get the services (n=8) D – The services cost too much (n=6) I – It's hard for me to get there (n=6)

Problems with lack of information ranked highest for all subpopulations, except for the recently released. For the recently released, difficulties getting to the service location ranked highest – although, this barrier could very well be linked to problems with transportation.

TRANSLATION/INTERPRETATION

Service category data were collected in the context of their local definitions, rather than their official HRSA definitions. Although the differences between the local and HRSA definitions are minimal, the Data Collection Workgroup felt the local definition approach would promote a realistic assessment of the Houston HSDA Ryan White care system.

Local definitions for each service category will be included in each summary. A list of the official HRSA service category definitions is provided in Appendix C.

Local Definition

For service categories that have not been historically funded in the EMA/HSDA no local definitions have been developed. Consequently, the accepted local definition for the service categories were their official Ryan White Part B definitions, which were developed by the Texas Department of State Health Services (DSHS) in response to guidance provided by HRSA.

The local definition of ***Translation/Interpretation Services*** (a.k.a., "Interpreter Services") under Ryan White Part B is defined as the provision of sign language for deaf and /or hard of hearing and native language interpretation for monolingual HIV positive clients.

In the client survey, Interpreter Services was described as "Translation/ Interpretation".

CPCDMS/ARIES Service Utilization Data

Service utilization information for most services is based on data from the Centralized Patient Care Data Management System (CPCDMS). The CPCDMS is a real-time, de-identified client-level computer database application that allows Part A-funded providers and other users in the EMA to share client eligibility information and document service delivery while maintaining client confidentiality. Service providers enter registration, service encounter and medical update information for each client into the CPCDMS. Client information collected includes demographic, comorbidity, biological marker, mortality and service utilization data. Since its inception in June of 2000, over 10,000 clients have been registered in the CPCDMS.

The AIDS Regional Information and Evaluation System (ARIES), implemented in February 2005, is also a real-time, de-identified client-level computer database application, the ARIES centralizes client data, service details, and agency and staff information to maximize the quality of care and services to clients in need. The system was developed collaboratively for Part B by the State of Texas, County of San Diego, County of San Bernardino, and State of California. Information from the Centralized Patient Care Data Management System can be imported into the ARIES system and filtered to produce a comprehensive picture of service utilization information on both Part B and Part A-funded

providers, as well as other users in the EMA/HSDA.

It is important to note that while CPCDMS does represent the majority of PLWHA receiving Ryan White-funded services in the HSDA, it is incorrect to assume that all 764 survey respondents are enrolled in CPCDMS.

According to the Centralized Patient Care Data Management System (CPCDMS), a total of 32 unduplicated PLWHA received translation/interpretation services through grants billed to the Texas Department of State Health Services. This total represents less than (<1%) of the reported 18,109 PLWHA residing in the Houston EMA/HSDA.

Access (Easy versus Hard)

Similar to the core services, survey respondents were asked to indicate their levels of access to supportive services. Respondents were given a list of 19 HRSA/DSHS-defined supportive services, and asked to select up to 5 services they felt were the most useful for their HIV care. These 5 services could be ones they have, or have not, already used. Respondents could also select services that they themselves did not need, but felt were still important for PLWHA in general.

The following table shows the level of access to Translation/Interpretation Services reported by all respondents. It should be noted that the percentages are based on the sum of respondents within each subpopulation that accessed the service (reported difficulty or ease). It is also important to remember that the subpopulations are not mutually exclusive – in other words, the numbers across the subpopulations do not represent unduplicated respondents. For example, an African American female reporting a mental health symptom is included in the Women, African-Americans and Mental Health subpopulations.

Care should also be taken when making comparisons between subpopulations of a very small size. The smaller the subpopulations, the more sensitive percentages become to changes in the numbers. For example, for very small subpopulations, shifting just one response can change percentages by as much – considering both the proportions and raw numbers will help ensure a more comprehensive understanding of the results.

Lastly, it should be emphasized that reports of access to a service does not necessarily mean the respondent received the service. In the client survey, respondents were asked to report whether they had difficulty getting a service, but the survey did not ask as a follow-up whether the respondent ultimately received the service despite the difficulties. So, care should be taken not to equate reports of “very easy” or reports of “some difficulty” as proxies of service utilization.

TABLE 39.1: REPORTED ACCESS TO TRANSLATION/INTERPRETATION SERVICES IN THE PAST 12 MONTHS

	Total who attempted to access	%	Very Easy	%	Some Difficulty	%	No Need	%
All Respondents (N=764)	51	7%	44	86%	7	14%	713	93%
Subpopulations*								
In Care	51	7%	44	86%	7	14%	636	93%
Out-of-Care	0	0%	0	0%	0	0%	77	100%
Women	3	1%	0	0%	3	100%	235	99%
Youth	1	3%	1	100%	0	0%	36	97%
African-Americans	5	1%	3	60%	2	40%	424	99%
Latinos	15	11%	10	67%	5	33%	126	89%
White MSM	5	5%	0	0%	5	100%	98	95%
MSM of Color	7	3%	7	100%	0	0%	201	97%
Recently Released	1	1%	1	100%	0	0%	118	99%
Substance Abuse	2	1%	1	50%	1	50%	246	99%
Mental Health	4	1%	2	50%	2	50%	448	99%
Homeless	0	0%	0	0%	0	0%	0	0%

* Subpopulations are not mutually exclusive.

Seven percent of all 764 survey respondents reported attempting to access Translation/Interpretation Services during the previous 12 months; the majority (713 or 93%) said they did not need this service. Latinos reported accessing this service in the highest proportions compared to other groups.

Among respondents that tried accessing Translation/Interpretation Services, the majority (44 or 86%) said it was “very easy” to get the service. Based on survey responses, access to Translation/Interpretation Services appeared easiest for youth, MSM of color, and recently released.

By far, the women and white MSM had the highest proportions that reported some difficulty accessing Translation/Interpretation Services during the past year.

Barriers

Survey respondents that reported “some difficulty” getting a service were asked to describe the barriers they experienced. Respondents could choose from a list of common barriers, or write their own. The number of possible reported barriers was unlimited, so respondents were encouraged to list every barrier they encountered when getting a service. It should also be noted that the number of reported barriers does not indicate whether the respondent did, or did not, ultimately receive the service – survey respondents

described the barriers they experienced in the process of getting a service.

The following table shows the number of barriers reported for Translation/ Interpretation Services. The numbers in each cell represent how many times respondents faced a certain type of barrier. The total reported barriers column on the far right represents the total number of barriers reported for each subpopulation.

TABLE 39.2: NUMBER OF REPORTED BARRIERS FOR TRANSLATION/INTERPRETATION SERVICES

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	S	Total** Barriers
All Respondents	0	**2**	1	0	0	0	0	1	0	0	0	**4**	0	0	0	0	**8**
Subpopulations*																	
In Care	0	**2**	1	0	0	0	0	1	0	0	0	4	0	0	0	0	**8**
Out-of-Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Women	0	0	**1**	0	0	0	0	**1**	0	0	0	**1**	0	0	0	0	**3**
Youth	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
African-Americans	0	**1**	**1**	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Latinos	0	1	0	0	0	0	0	1	0	0	0	**4**	0	0	0	0	**6**
White MSM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
MSM of Color	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Recently Released	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Mental Health	0	0	**1**	0	0	0	0	0	0	0	0	**1**	0	0	0	0	**2**
Homeless	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**

*Subpopulations are not mutually exclusive.
**Some barriers may not be shown if no respondents reported them as barriers for this service

Barriers			
A	The services are not in my area	**L**	People at the agency don't speak my language
B	I don't know where to get the services	**M**	My jail/prison history makes it hard to get services
C	I would have to wait too long to get the services	**N**	Difficulties with paperwork (due to volume, confusing process, etc)
D	The services cost too much	**O**	Substance abuse
E	I was told I am not eligible to get the services	**P**	Was incarcerated/in jail
F	I don't think I'm eligible to get the services	**Q**	Personal health issues (too sick to get services, medication resistant, etc)
G	The people who run the services are not friendly	**R**	Fear, denial or stigma (internal and/or external)
H	It's hard to make or keep appointments	**S**	Homeless/unstable housing
I	It's hard for me to get there	**T**	CM left/staff turnover
J	There is no one to watch my kids if I go there	**U**	Not enough, resources/funds run out too quickly
K	I'm afraid someone will find out about my HIV	**V**	Immigration status

Overall, there were 8 reports of barriers among respondents who had difficulty accessing Translation/Interpretation Services during the past year. The barrier reported

most often for Translation/Interpretation Services were related to people at the agency not speaking the language of clients.

The table below shows several highlighted barriers reported by subpopulations when accessing Translation/Interpretation Services. The intent of this table is to highlight the barriers identified most often by respondents – for the full list of barriers, refer to Table 39.2, "Number of reported barriers for Translation/Interpretation Services."

TABLE 39.3: HIGHLIGHTED BARRIERS FOR TRANSLATION/INTERPRETATION SERVICES BY SUBPOPULATION (N=NUMBER OF REPORTS)

	Barriers (ranked by number of reports)
All Respondents	L – People at the agency don't speak my language (n=4) B – I don't know where to get the services (n=2)
Subpopulations*	
In Care	L - People at the agency don't speak my language (n=4) B – I don't know where to get the services (n=2)
Out-of-Care	No Out-of-Care clients reported any barriers for this service.
Women	Only 3 reported barriers. Please refer to previous table.
Youth	No youth reported any barriers for this service.
African-Americans	Only 2 reported barriers. Please refer to previous table.
Latinos	L - People at the agency don't speak my language (n=4)
White MSM	No white MSM reported any barriers for this service.
MSM of Color	No MSM of color reported any barriers for this service.
Recently Released	No recently released clients reported any barriers for this service.
Substance Abuse	No substance abusers reported any barriers for this service
Mental Health	Only 2 reported barriers. Please refer to previous table.
Homeless	No homeless clients reported any barriers for this service.

*Subpopulations are not mutually exclusive.

Among all respondents, the most commonly reported barrier to translation/ interpretation services were people at the agency not being able to speak the client's language (n=4) and not knowing where to get the services (n=2). With the exception of Latinos, the majority of subpopulations reported few, if any, barriers for this service. Among Latinos, problems with agency staff not being able to speak a client's language ranked highest.

Resource Inventory

Overview

The following resource inventory table describes current HIV services provided in the HSDA area by agencies that returned Provider Surveys. The intent of this table is to provide a peek into the HSDA continuum of care through the organizations providing services to PLWH in the service area, regardless of whether those providers receive Ryan White CARE Act funds.

For a complete and detailed listing of agencies throughout the HSDA, please refer to the Houston Resource Guide (also known as the "Blue Book"), available through the Ryan White Planning Council Support Office at (713) 572-3724 or the Houston Regional HIV/ AIDS Resource Group at (713) 526-1016.

AGENCY	SERVICES PROVIDED	CITY	ZIP	AREA	FUNDING SOURCES
AIDS Foundation Houston	Case Management Child-Support Financial Assistance Food Home Assistance & Home Health Care Housing Assistance Housing-Long-Term Information Miscellaneous Services Prevention/Health Education/Risk Reduction Social Support & Activities Volunteer Opportunities	Houston	77027	River Oaks	Ryan White Part A Ryan White Part B Ryan White Part D HOPWA DSHS Foundations Corporate Contributions Individual Contributions United Way City/County Grants Other
AIDS Research Consortium dba Center for AIDS	Education Programs Information Miscellaneous Services Treatment Information & Clinical Trials	Houston	77006	Montrose	
Association for the Advancement of Mexican Americans (AAMA)	Substance Abuse Treatment-Outpatient Substance Abuse Treatment-Residential Clinics-Other Education Programs HIV Testing	Houston	77023	Lawndale	Ryan White Part A Client fees Foundations Corporate Contributions Individual Contributions NIH Other
Association for the Advancement of Mexican Americans, The (AAMA)	Case Management Clothing & Household Items HIV Testing Housing Assistance Prevention/Health Education/Risk Reduction	Houston	77011	Second Ward	None reported

AGENCY	SERVICES PROVIDED	CITY	ZIP	AREA	FUNDING SOURCES
Baylor College of Medicine - Teen Health Clinics	Youth – Medical Care	Houston	77030	Acres Homes Gulfton Kashmere Gardens MacGregor Medical Center Trinity/Houston Gardens	CDC DSHS Foundations
Bayside Community Hospital	Hospitals	Anahuac	77514	Anahuac	None Reported
Bee Busy	HIV Testing Sexually Transmitted Disease Screening Risk Assessment	Houston	77002	Downtown	None Reported
Bering Omega Community Services	Adult Day Programs & Respite Care Dental Services Financial Assistance Hospice Care	Houston	77006	Montrose	Ryan White Part A Ryan White Part B HOPWA DSHS Medicaid Foundations Corporate Contributions Individual Contributions Privately Funded Research Other
Brentwood Community Foundation	Financial Assistance Food Housing Assistance	Houston	77045	Central Southwest	HOPWA Foundations Individual Contributions Other

AGENCY	SERVICES PROVIDED	CITY	ZIP	AREA	FUNDING SOURCES
Career and Recovery Resources, Inc.	Substance Abuse Treatment-Outpatient Deaf & Hard of Hearing Services Employment & Training HIV Testing	Houston	77002	Midtown	HOPWA City/County Grants
Community Endowment Foundation (CEF)	Housing-Long-Term	Houston	77006	Montrose	Client fees Foundations Corporate Contributions Individual Contributions
Corder Place Apartments	Housing-Long-Term	Houston	77021	OST/South Union	HOPWA HUD
Covenant House Texas	Housing-Emergency Shelters Prevention Youth-Housing Youth-Medical Care Youth-Support	Houston	77006	Montrose	Ryan White Part D
Fair Haven Food Pantry	Food Pantry	Houston	77055	Spring Branch	None Reported
Family Services of Greater Houston	Case Management Education Programs Mental Health-Counseling	Houston	77006	Baytown Clear Lake/NASA Memorial Park/ Washington Ave. Montrose Stafford Waller Woodlands	Ryan White Part A Ryan White Part B Ryan White Part D United Way
FamilyTime Foundation	24-Hour Hotline Housing-Emergency Shelters Mental Health-Counseling Women-Housing Women-Support	Humble	77338	Humble	None Reported

AGENCY	SERVICES PROVIDED	CITY	ZIP	AREA	FUNDING SOURCES
Ft. Bend County Women's Center	Housing-Emergency Shelters Mental Health-Counseling Volunteer Opportunities Women-Housing Women-Support	Rosenberg	77471	Rosenberg	Foundations Corporate Contributions Individual Contributions United Way City/County Grants HUD Other
Ft. Bend Family Health Center, Inc.	Case Management Child-Medical Care Child-Support Clinics-HIV Clinics-Other Women-Medical Care Women-Support	Richmond	77469	Richmond	Ryan White Part B DSHS Medicaid Medicare
Fundación Latino Americana Contra el SIDA, Inc. (FLAS, Inc)	Education Programs Prevention	Houston	77036	Sharpstown	Foundations Privately Funded Research Other

	SERVICES PROVIDED	CITY	ZIP	AREA	FUNDING SOURCES
Harris County Hospital District – Thomas Street Clinic	Case Management Clinics-HIV Clinics-Other Dental Services Education Programs HIV Testing Mental Health-Support Groups Nutrition and Wellness Pharmacies Public Assistance Social Support & Activities Treatment Information & Clinical Trials Women-Medical Care Youth-Medical Care Youth-Support	Houston	77054	Acres Homes Aldine Baytown East End Near Northside Oak Forest/Garden Oaks Pasadena Pecan Park Sharpstown	Ryan White Part A Ryan White Part C Ryan White Part D Ryan White Part F DSHS Medicaid Medicare
Harris County Public Health& Environmental Services	Nutrition and Wellness Public Assistance	Houston	77027	Galleria/Post Oak	DSHS Mental Health
Harris County Sheriffs Office	Miscellaneous Services	Houston	77002	Downtown	None Reported
Houston Area Community Services (HACS)	Case Management Clinics-HIV HIV Testing Mental Health-Counseling Prevention Youth-Housing Youth-Support	Houston	77098	Greenway Plaza Heights Montrose	Ryan White Part A Ryan White Part B CDC DSHS City/County Grants HUD
Houston Center for Independent Living	Consumer Assistance Miscellaneous Services	Houston	77036	Sharpstown	Other

AGENCY	SERVICES PROVIDED	CITY	ZIP	AREA	FUNDING SOURCES
Houston Dept of Health and Human Services	Case Management Clinics-Other Information Prevention/Health Education/Risk Reduction Public Assistance	Houston	77054	Astrodome/South Loop Denver Harbor Heights Medical Center	Ryan White Part A Ryan White Part F
Houston Volunteer Lawyers Program	Legal-Advocacy	Houston	77002	Downtown	Ryan White Part A
Lazarus House: A Center for Wellness	Child-Support Nutrition and Wellness	Houston	77004	Midtown	Client fees Foundations Corporate Contributions Individual Contributions Other
Legacy Community Health Services	Clinics-HIV Clinics-Other Education Programs Eye Care HIV Testing Nutrition and Wellness Treatment Information & Clinical Trials Volunteer Opportunities Women-Medical	Houston	77006	Montrose	Ryan White Part A Ryan White Part B CDC City/County Grants
Liberty County Indigent Healthcare	Public Assistance	Liberty	77575	Liberty	None Reported
Lone Star Legal Aid	Legal Services	Houston	77002	Downtown	None Reported
Memorial Hermann Prevention & Recovery Center	Substance Abuse Treatment-12 Step & Support Groups Substance Abuse Treatment-Outpatient Substance Abuse Treatment-Residential	Houston	77054	Medical Center	None Reported

AGENCY	SERVICES PROVIDED	CITY	ZIP	AREA	FUNDING SOURCES
Michael E. DeBakey VA Medical Center	Case Management Substance Abuse Treatment-Outpatient Clinics-HIV Eye Care Financial Assistance Housing Assistance Veterans' Services	Houston	77030	Medical Center	Ryan White Part A
Montrose Counseling Center, Inc.	24-Hour Hotline Case Management Case Management Substance Abuse Treatment-Outpatient Mental Health-Counseling Prevention/Health Education/Risk Reduction Volunteer Opportunities Youth-Support	Houston	77006	Montrose	Ryan White Part A DSHS – Substance Abuse Medicaid Medicare Private Insurance Client fees Foundations
Planned Parenthood of Houston & Southeast Texas, Inc.	Clinics-Other HIV Testing Prevention Women-Medical Care Youth-Medical Care	Houston	77004	Various	CDC DSHS Other
Salvation Army, Houston Area Command	Clothing & Household Items Financial Assistance Food	Houston	77002	Downtown	None Reported

AGENCY	SERVICES PROVIDED	CITY	ZIP	AREA	FUNDING SOURCES
Santa Maria Hostel	Case Management Substance Abuse Treatment-Outpatient Substance Abuse Treatment-Residential Women-Housing Women-Support	Houston	77055	Near Northside Spring Branch	DSHS City/County Grants
Southeast Texas Legal Clinic	Information Legal Services Legal-Advocacy	Houston	77006	Montrose	Ryan White Part A Ryan White Part B DSHS Other
St. Hope Foundation	Case Management Substance Abuse Treatment-12 Step & Support Groups Clinics-HIV Clinics-HIV Education Programs Housing Assistance Mental Health-Counseling Prevention Transportation	Houston	77036	Bellaire Conroe Sharpstown Stafford	Ryan White Part A Ryan White Part B CDC DSHS Medicaid Private Insurance
St. John Vianney Social Services	Clothing & Household Items Financial Assistance Food	Houston	77079	West Memorial	None Reported
Star of Hope	Housing-Emergency Shelters Women-Housing	Houston	77054	Downtown MacGregor Second Ward	None Reported
UT Houston Health Science Center	Case Management Child-Medical Care Clinics-HIV	Houston	77030	Medical Center	Ryan White Part A Medicaid Private Insurance

AGENCY	SERVICES PROVIDED	CITY	ZIP	AREA	FUNDING SOURCES
Visiting Nurse Association of Houston, Inc.	Home Assistance & Home Health Care Hospices	Houston	77007	Heights	Ryan White Part A Ryan White Part B Medicaid Medicare Private Insurance
NAACP	Legal Services Legal-Advocacy	Houston	77004	Third Ward	Ryan White Part A
Northshore Counseling Center	Mental Health Counseling	Houston	77015	Northshore	Medicaid Private Insurance

Most Commonly Reported Barriers

Core Services

For the core services, the three barriers reported most often by all 764 survey respondents were difficulties making or keeping appointments, long wait times for services and informational barriers.

Table 41.1: Core Services: Top 3 Reported Barriers, Total Respondents

1	**It's hard to make or keep appointments** (275 reports)
2	**I would have to wait too long to get the services** (265 reports)
3	**I don't know where to get the services** (255 reports)

The following table shows the full list of barriers included in the client survey, and the core services reporting the highest number of reports for each barrier. The first table lists the “main” or standard barriers that were presented to in the client survey.

TABLE 41.2: CORE SERVICES WITH THE HIGHEST NUMBER OF REPORTS PER BARRIER, MAIN BARRIERS

Main Barriers	Core Service with Highest Reports	# of respondents reporting the barrier	Core Service with Second Highest Reports	# of respondents reporting the barrier	Total Reports
It's hard to make or keep appointments	Dentist Visits	87	Primary Medical Care	53	275
I would have to wait too long to get the services	Dentist Visits	74	HIV/AIDS Medications	44	261
I don't know where to get the services	Dentist Visits	58	Medical Case Management	34	255
It's hard for me to get there	Primary Medical Care	53	Dentist Visits	43	206
The services cost too much	HIV/AIDS Medications	48	Dentist Visits	26	168
The people who run the services are not friendly	Primary Medical Care	31	Medical Case Management	29	162
The services are not in my area	Dentist Visits	33	Primary Medical Care	25	145
I was told I am not eligible to get the services	HIV/AIDS Medications	17	Dentist Visits	15	98
I don't think I'm eligible to get the services	Dentist Visits	17	HIV/AIDS Medications	13	90
I'm afraid someone will find out about my HIV	Primary Medical Care	20	Dentist Visits HIV/AIDS Medications	10 10	78
There is no one to watch my kids if I go there	Primary Medical Care	8	HIV/AIDS Medications	7	36
My jail/prison history makes it hard to get services	Primary Medical Care	8	Medical Case Management	7	35
People at the agency don't speak my language	HIV/AIDS Medications	5	Primary Medical Care	3	13

The following table lists “additional barriers” that were subsequently identified during data analysis as open-ended responses by survey respondents. In other words, the “additional barriers” represent barriers that respondents experienced when trying to access services, but were not included on the standard list.

TABLE 41.3: CORE SERVICES WITH THE HIGHEST NUMBER OF REPORTS PER BARRIER, ADDITIONAL BARRIERS

Main Barriers	Core Service with Highest Reports	# of respondents reporting the barrier	Core Service with Second Highest Reports	# of respondents reporting the barrier	Total Reports
Difficulties with paperwork	Dentist Visits	24	Primary Medical Care	10	42
Personal health issues	Primary Medical Care HIV/AIDS Medications Psychological Counseling	4 4 4	Psychiatric Services or Medications	3	17
Fear, denial or stigma (internal and/ or external)	Dentist Visits	4	Primary Medical Care	3	15
Homeless/unstable housing	Home Health Care	7	--	--	10
CM left/staff turnover	Medical Case Management	7	--	--	7
Was incarcerated/in jail	Medical Case Management	2	Primary Medical Care HIV/AIDS Medications	1 1	4
Using drugs	Psychological Counseling	1	--	--	1
Not enough, resources/funds run out too quickly	Rehabilitation Services	1	--	--	1
Immigration status	--	--	--	--	0
Not enough, resources/funds run out too quickly	Rehabilitation Services	1	--	--	1
Immigration status	--	--	--	--	0

Supportive Services

For the supportive services, the three barriers reported most often by all 764 survey respondents were informational barriers, long wait times and services not being in respondents' areas.

TABLE 41.3: SUPPORTIVE SERVICES: TOP 3 REPORTED BARRIERS, TOTAL RESPONDENTS

1	**I don't know where to get the services** (599 reports)
2	**I would have to wait too long to get the services** (319 reports)
3	**The services are not in my area** (244 reports)

The following table shows the full list of barriers included in the client survey, and the supportive services reporting the highest number of reports for each barrier. The first table lists the "main" or standard barriers that were presented in the client survey.

TABLE 41.4: SUPPORTIVE SERVICES WITH THE HIGHEST NUMBER OF REPORTS PER BARRIER

Main Barriers	Supportive Service with Highest Reports	# of respondents reporting the barrier	Supportive Service with Second Highest Reports	# of respondents reporting the barrier	Total Reports
I don't know where to get the services	EFA*	78	Housing Related Services	67	599
I would have to wait too long to get the services	EFA*	80	Housing Related Services	55	319
The services are not in my area	EFA*	42	Transportation	31	244
I was told I am not eligible to get the services	EFA*	66	Housing Related Services	31	208
It's hard for me to get there	Food Bank	32	Transportation	24	180
I don't think I'm eligible to get the services	EFA*	36	Rental/Shelter**	24	175
It's hard to make or keep appointments	EFA*	36	Rental/Shelter**	27	168
The people who run the services are not friendly	EFA*	27	Rental/Shelter**	20	121
The services cost too much	Housing Related Services	15	Rental/Shelter**	14	104
My jail/prison history makes it hard to get services	Employment Assistance	23	Housing Related Services	21	75
I'm afraid someone will find out about my HIV	Employment Assistance	13	EFA*	12	74
There is no one to watch my kids if I go there	Child Care	4	EFA* Housing Related Services	4 4	27
People at the agency don't speak my language	Legal Assistance	5	Translation/ Interpretation	4	22

*EFA = Emergency Financial Assistance
**Rental/Shelter = Rental Assistance & Shelter Vouchers

The following table lists "additional barriers" that were subsequently identified during data analysis as open-ended responses by survey respondents. In other words, the "additional barriers" represent barriers that respondents experienced when trying to access services, but were not included on the standard list.

TABLE 41.5: SUPPORTIVE SERVICES WITH THE HIGHEST NUMBER OF REPORTS PER BARRIER

Main Barriers	Supportive Service with Highest Reports	# of respondents reporting the barrier	Supportive Service with Second Highest Reports	# of respondents reporting the barrier	Total Reports
Not enough, resources/ funds run out too quickly	Food Bank Rental/Shelter**	14 14	EFA*	12	59
Difficulties with paperwork	Transportation	8	EFA*	4	23
Personal health issues	EFA*	5	Rental/Shelter**	4	21
Homeless/unstable housing	Rental/Shelter**	5	Housing-Related Services	5	21
Fear, denial or stigma (internal and/or external)	EFA*	3	---	---	9
Substance abuse	Food Bank	2	HIV Education for HIV+	2	6
Immigration status	Rental/Shelter**	2	Food Bank Transportation	1 1	4
CM left/staff turnover	Rental/Shelter**	1	Legal Services Referrals to Services	1 1	3
Was incarcerated/in jail	Legal Services	1	---	---	1

*EFA = Emergency Financial Assistance
**Rental/Shelter = Rental Assistance & Shelter Vouchers

SERVICES ASSOCIATED WITH THE HIGHEST NUMBER OF REPORTED BARRIERS

Core Services

The three core services with the highest numbers of reports of barriers for all 764 respondents were:

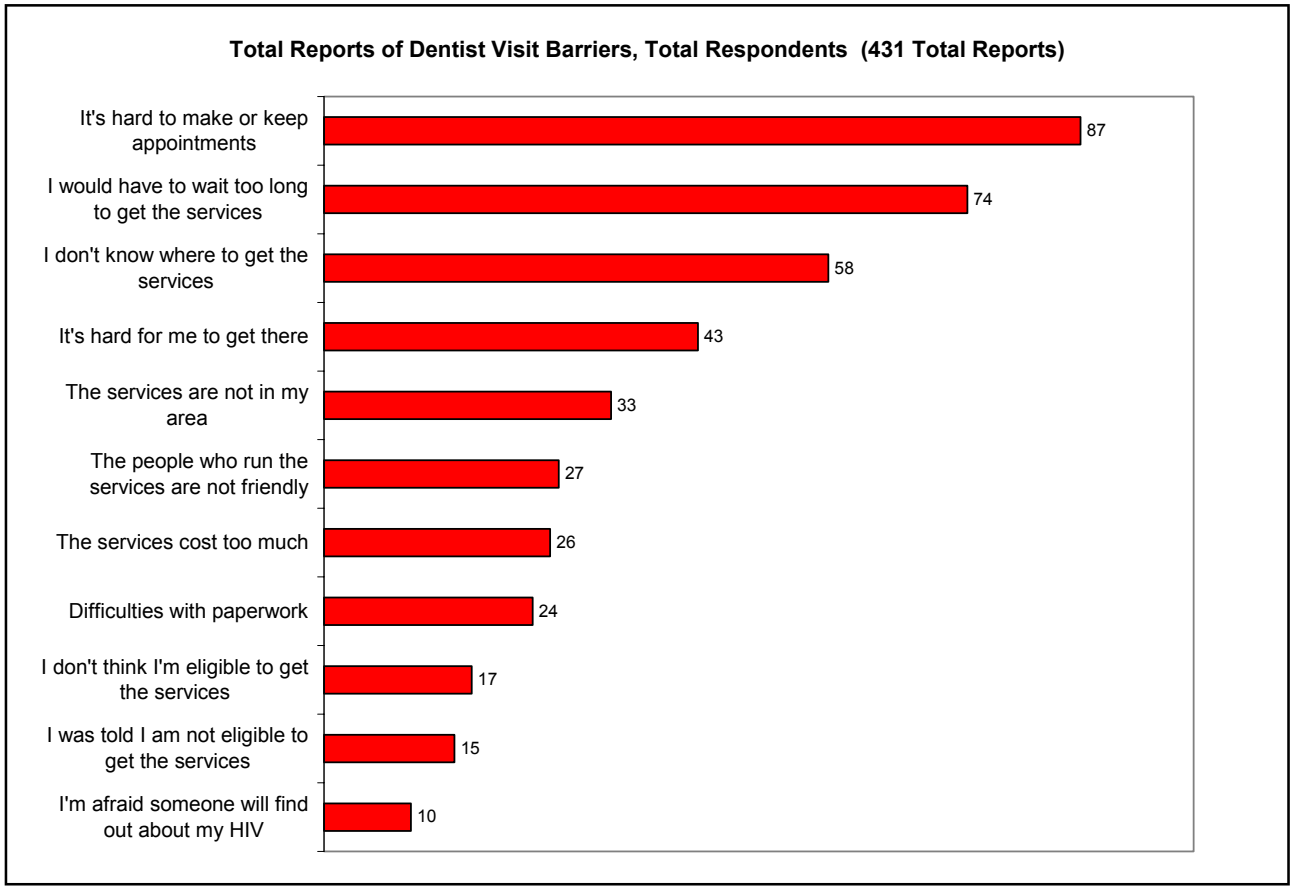
- Dentist visits (431 reports)
- Primary medical care (332 reports)
- HIV/AIDS medications (269 reports)

It is important to note that these three services also have the highest number of access attempts – therefore, the high volume of access attempts may be correlated with the high number of barrier reports.

Dentist Visits

The following graph shows the top barriers reported most often for dentist visits ranked by number of reports. For dentist visits, the barrier reported most often was related to difficulties making or keeping appointments (87 reports).

FIGURE 41.1: BARRIER REPORTS - DENTIST VISITS, ALL RESPONDENTS

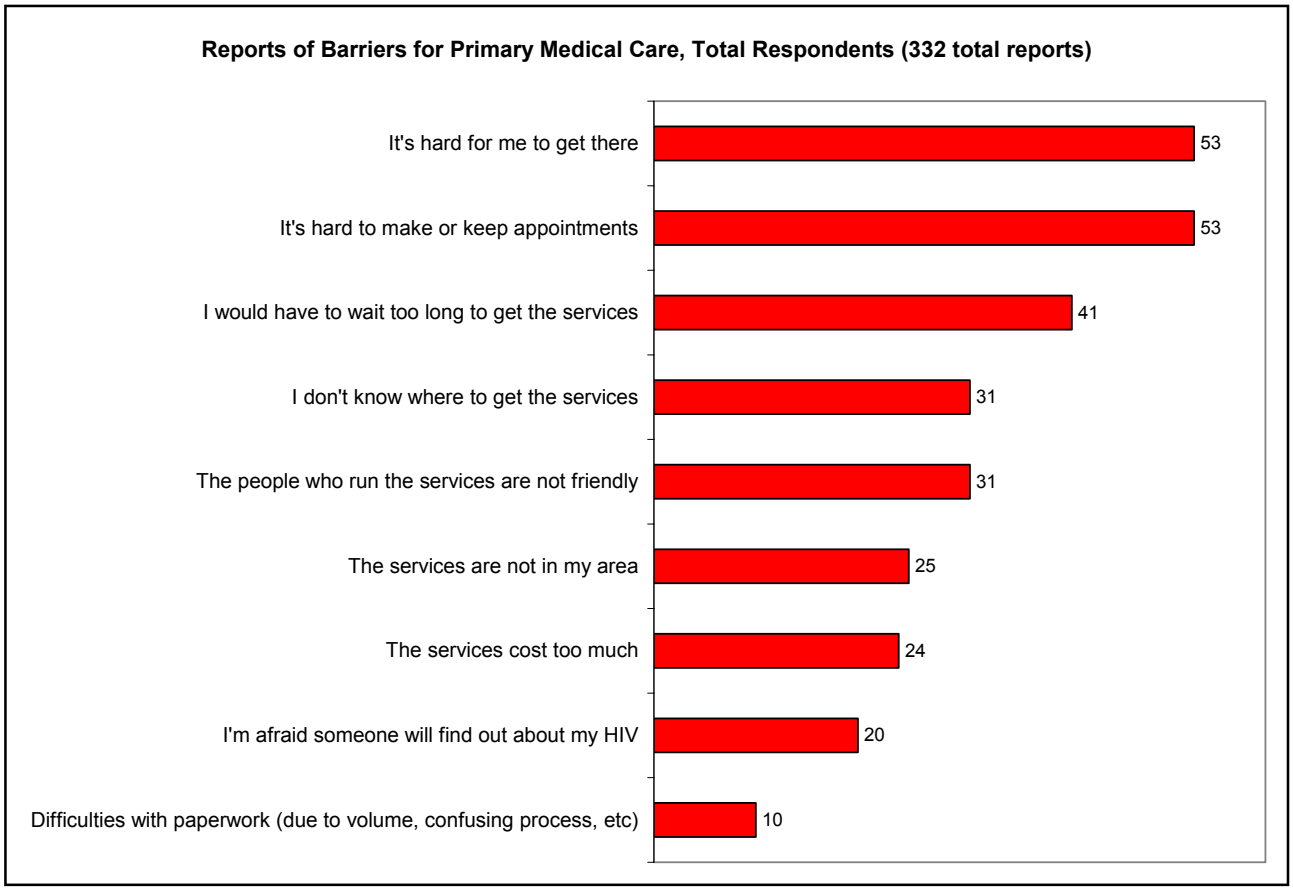


Barriers reported less often for this service were lack of child care during services (6 reports), jail/prison history (5 reports), fear/denial/stigma (4 reports), homelessness/ unstable housing (1 report) and personal health issues (1 report).

Primary Medical Care

The graph below shows the top barriers reported for primary medical care ranked by number of reports. For primary medical care, the barrier reported most often was related to difficulties getting to services (53 reports).

FIGURE 41.2: BARRIER REPORTS - PRIMARY MEDICAL CARE, ALL RESPONDENTS

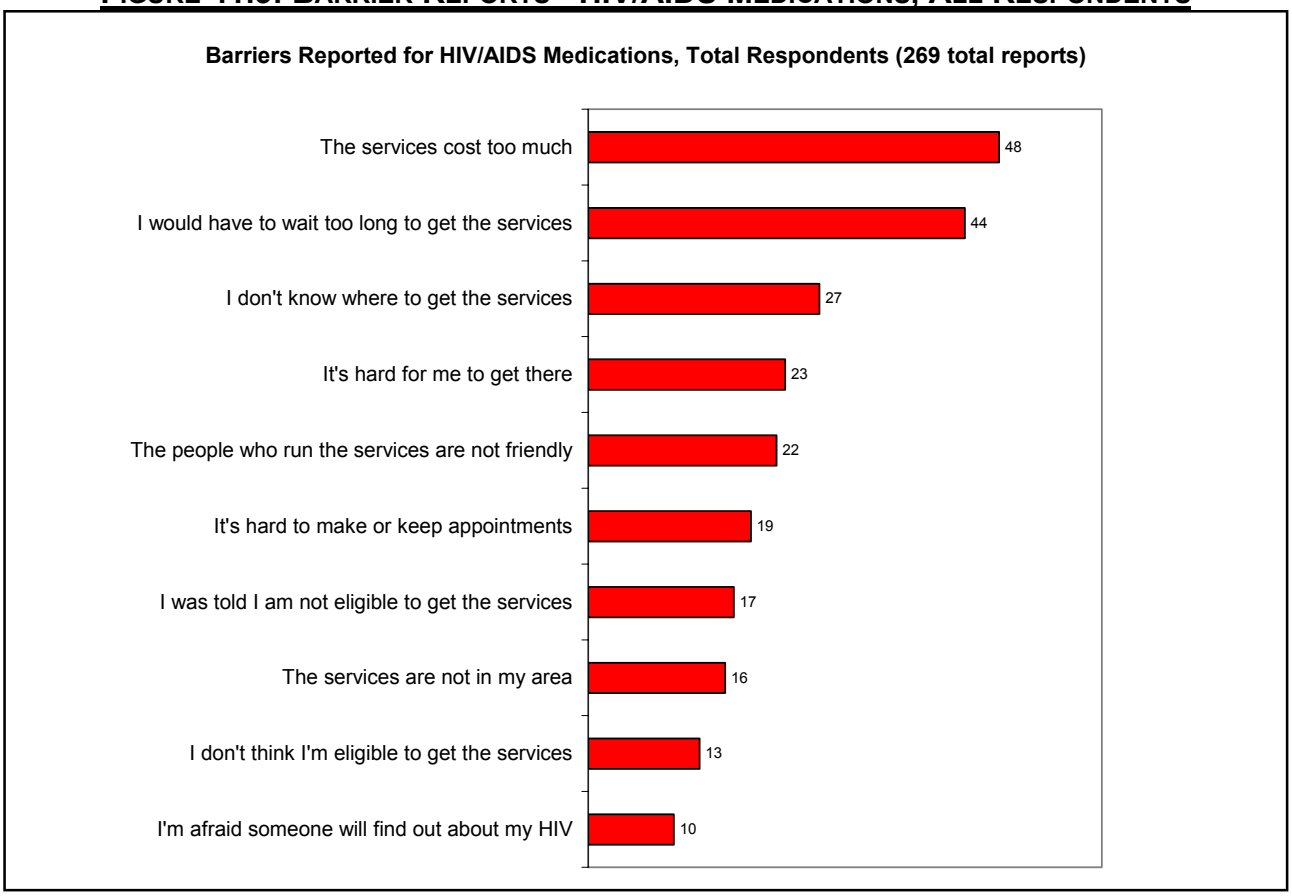


Barriers reported less often for this service were being told, or not believing, they were eligible for services (8 and 9 reports, respectively), jail/prison history (8 reports), lack of child care during services (4 reports), fear/denial/stigma (3 reports), language barriers (3 reports) and incarceration (1 report).

HIV/AIDS Medications

The graph below shows the top barriers reported for HIV/AIDS medications ranked by number of reports. For HIV/AIDS medications, the barrier reported most often was related to cost of services (48 reports).

FIGURE 41.3: BARRIER REPORTS - HIV/AIDS MEDICATIONS, ALL RESPONDENTS



Barriers reported less often for this service were difficulties with paperwork (7 reports), lack of child care during services (7 reports), language barriers (5 reports), personal health issues (4 reports), jail/prison history (4 reports), homelessness/unstable housing (1 report), fear/denial/stigma (1 report), and incarceration (1 report).

Supportive Services

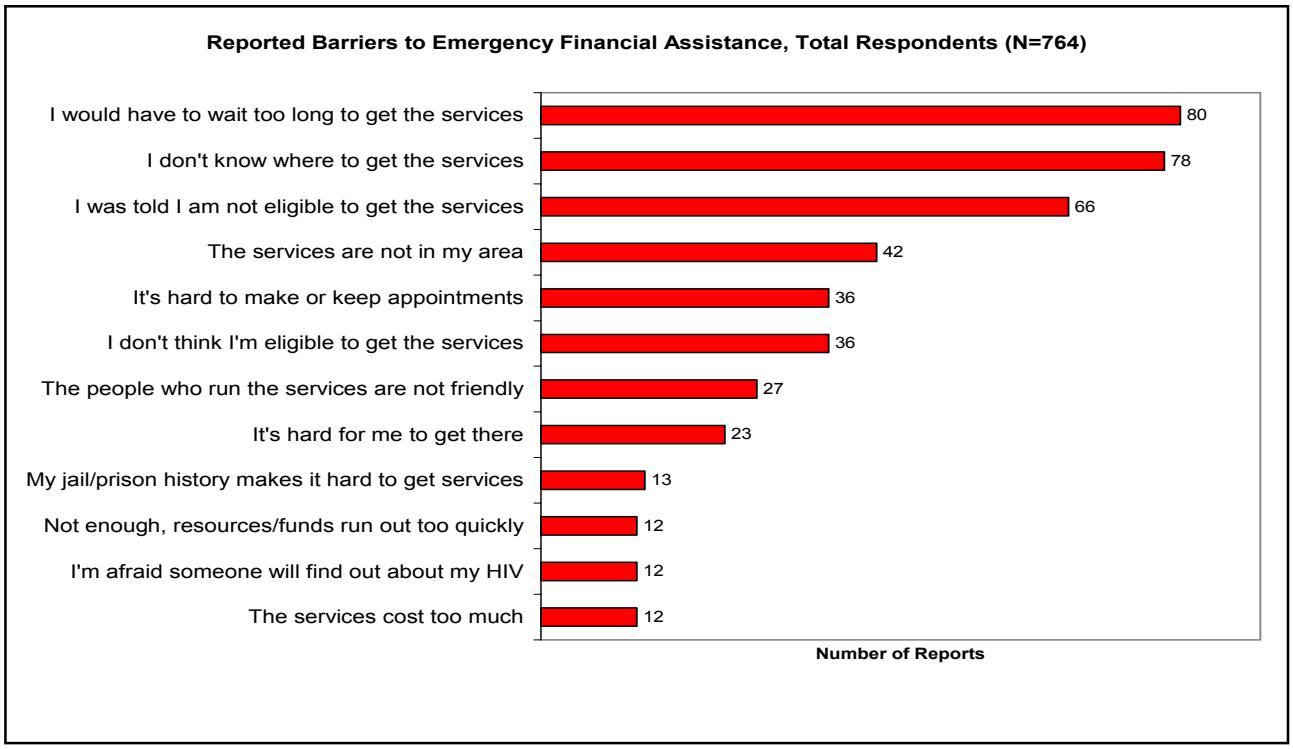
The three supportive services with the highest numbers of reports of barriers for all 764 respondents were:

- Emergency Financial Assistance (455 reports)
- Housing-related services (312)
- Rental assistance/shelter vouchers (290 reports)

Emergency Financial Assistance

The graph below shows the top barriers reported for Emergency Financial Assistance ranked by number of reports. For Emergency Financial Assistance, the barrier reported most often was related to long wait times for services (80 reports).

FIGURE 41.4: BARRIER REPORTS - EMERGENCY FINANCIAL ASSISTANCE, ALL RESPONDENTS

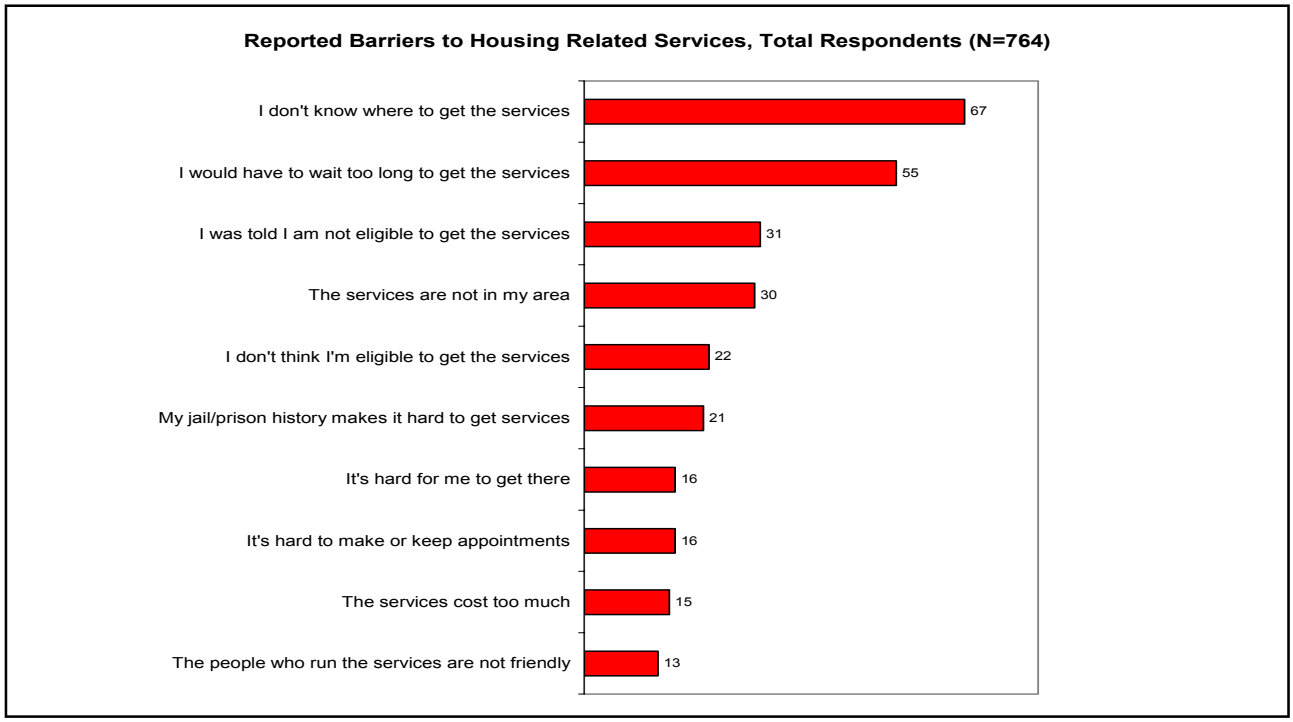


Barriers reported less often for this service were personal health issues (5 reports), difficulties with paperwork (4 reports), lack of child care during services (4 reports), fear/ denial/stigma (3 reports), homelessness/unstable housing (1 report) and language barriers (1 report).

Housing Related Services

The graph below shows the top barriers reported for Housing Related Services ranked by number of reports. For Housing Related Services, the barrier reported most often was related to informational barriers (67 reports).

FIGURE 41.5: BARRIER REPORTS - HOUSING-RELATED SERVICES, ALL RESPONDENTS

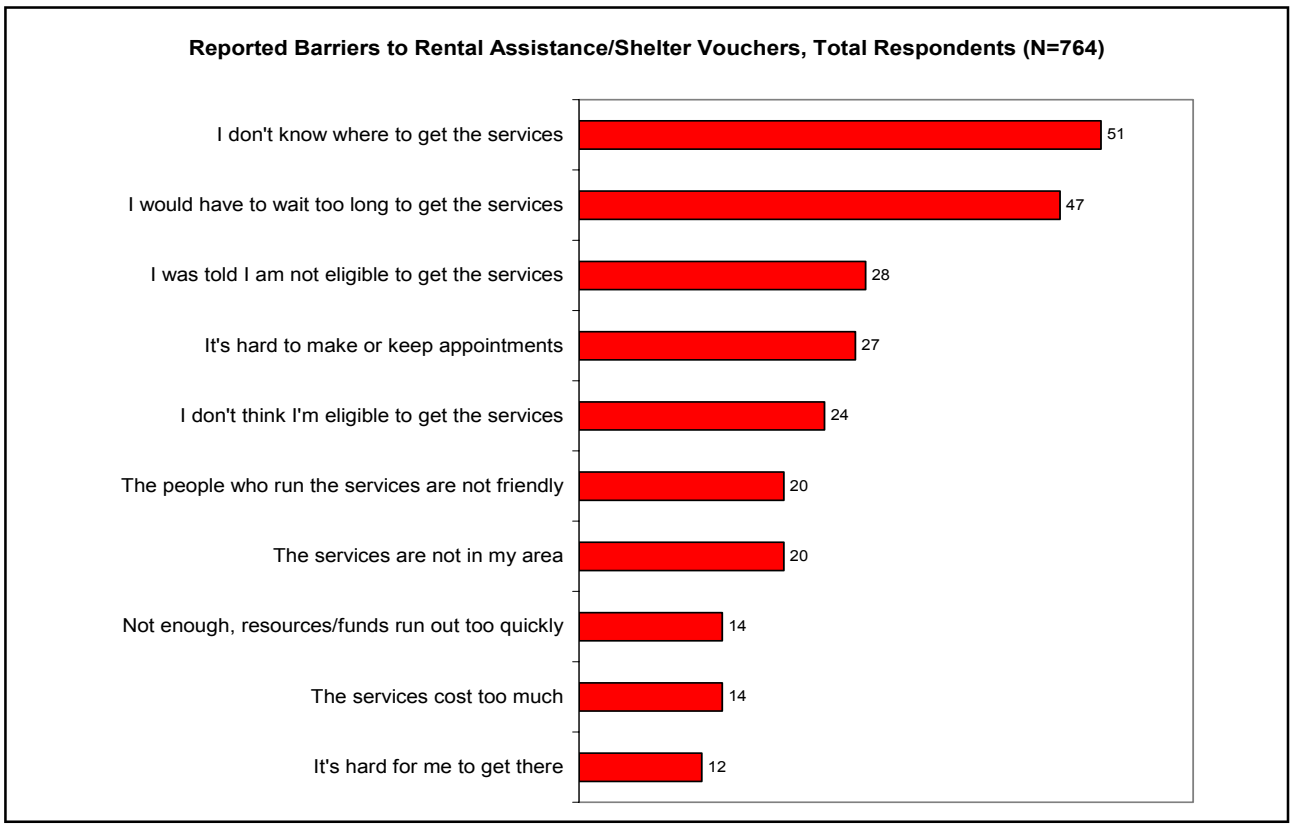


Barriers reported less often for this service were not enough resources (7 reports), being afraid someone finding out about HIV status (7 reports), homelessness/unstable housing (5 reports), lack of child care during services (4 reports), fear/denial/stigma (1 report), difficulties with paperwork (1 report) and language barriers (1 report).

Rental Assistance/Shelter Vouchers

The graph below shows the top barriers reported for Rental Assistance/Shelter Vouchers ranked by number of reports. For Rental Assistance/Shelter Vouchers, the barrier reported most often was related to informational barriers (51 reports).

FIGURE 41.6: BARRIER REPORTS - RENTAL ASSISTANCE/SHELTER VOUCHERS ALL RESPONDENTS



Barriers reported less often for this service were jail/prison history (8 reports), being afraid someone will find out about HIV status (7 reports), homelessness/unstable housing (5 reports), personal health issues (4 reports), difficulties with paperwork (3 reports), immigration status (2 reports), lack of child care at services (2 reports), staff turnover (1 report) and substance abuse (1 report).

GAPS ANALYSIS: SERVICE BARRIERS

TABLE 41.6: TYPES OF BARRIERS REPORTED BY PROVIDERS

Limitations	N	%
There is a lack of funding for our agency	14	29%
There is a lack of transportation to our services.	11	23%
Shortage of community partnerships/linkages (affecting referrals, etc.).	11	23%
The community is unaware of the availability of services.	7	15%
Insufficient Staff	6	13%
Immigration Issues	6	13%
There is a lack of other services the client needs at our program site.	4	8%
We have a lack of childcare.	4	8%
Other	4	8%
Our staff are not comfortable working with HIV+ clients.	3	6%
The waiting lists are too long at our agency.	1	2%
We cannot provide services in appropriate languages.	1	2%
We have problems with issues like licensure, facility permits, etc.	0	0%
We just started providing services for HIV+ individuals.	0	0%
The community doesn't want our services.	0	0%
Clients are unable to afford our service(s).	0	0%

Providers were asked to indicate any barriers experienced in providing services to people living with HIV or AIDS. The table above outlines the types of barriers reported by providers. Overall, the five most frequently reported barrier among providers was "there is a lack of funding" (n=14). In addition, other commonly reported barriers were "there is a lack of transportation to our services" (n=11), shortage of community partnerships/ linkages" (n=11), "the community is unaware of the availability of services" (n=7), "insufficient staff" (n=6), "immigration issues" (n=6).

Among providers that reported experiencing "other" barriers, the following issues were specified manually on the survey: "need for shelter", "unhealthy environment for PLWHA", "burden of reporting requirements", and "lack of transgender services".

GAPS ANALYSIS: REFERRALS

Core Services

The provider survey included a table that allowed the 48 respondents to indicate whether or not they knew where to refer clients for certain services. The table below outlines the reported number of service providers that do not know where to refer clients for core services.

TABLE 41.7: REPORTED NUMBER OF SERVICE PROVIDERS THAT DO NOT KNOW WHERE TO REFER CLIENTS FOR CORE SERVICES

Service	N	%
Rehabilitation services	10	21%
Home Health Care	7	15%
HIV Medications	5	10%
Dental/Oral Health	4	8%
Medical Case Management	3	6%
Alcohol/substance abuse treatment services	3	6%
Primary Medical Care	1	2%
Mental Health	1	2%

Among all core services, rehabilitation services ranked highest as the service to which respondents did not know where to refer clients. Mental health and primary medical care services, however, ranked the lowest as the lowest core services to which respondents did not know where to refer clients.

For home health care, 7 respondents (15%) indicated not knowing where to refer clients. Approximately 10% (5 respondents) of providers did not know where to refer clients for assistance with HIV medications. A smaller percentage (4 or 8%) did not know where to refer clients for dental or oral health services. For both medical case management and alcohol/substance abuse treatment, three (6%) of respondents did not know where to refer clients for these services.

Support Services

The five support services with the lowest numbers of access attempts among all 764 client survey respondents were:

1. Developmental Assessment (6 client reports)
2. Child Welfare Services (9 client reports)
3. Day/Respite Care for Adults (19 client reports)
4. Permanency Planning (28 client reports)

5. Child Care Services (44 client reports)

Some of the aforementioned services are not funded by Ryan White resources in the HSDA, which may contribute to accessibility issues among clients. The table below outlines the percentage of providers that did not know where to refer clients for the five aforementioned support services only.

TABLE 41.8: REPORTED NUMBER OF SERVICE PROVIDERS THAT DO NOT KNOW WHERE TO REFER CLIENTS FOR LEAST ACCESSED SUPPORT SERVICES

Service	N	%
Permanency Planning	9	19%
Child Care Services	9	19%
Developmental Assessment	8	17%
Child Welfare Services	5	10%
Day/Respite Care for Adults	5	10%

Among the five services in the table above, permanency planning and child care services ranked highest as the services to which respondents did not know where to refer clients.

For developmental assessment services, 8 respondents (17%) indicated not knowing where to refer clients. Approximately 10% (5 respondents) of providers did not know where to refer clients for child welfare services. The same percentage did not know where to refer clients for day/respite care services for adults.

GAPS ANALYSIS: PREVENTION

The following charts summarize risky behaviors for the various sub-populations of the survey sample. Sub-populations of note are ones in which a higher proportion than that of the total sample reported the risk behavior. These sub-populations are highlighted and discussed below each chart. A sub-population of interest may be recommended for targeted HIV transmission and reinfection prevention activities, as deemed appropriate by the planning bodies.

TABLE 41.9: SUMMARY OF THOSE REPORTING SEX FOR DRUGS OR MONEY BY SUB-POPULATION

Sub-Population	Total # in Sub-Population	% of Total Sample	Reporting Sex for Drugs or Money	
			#	%
In Care	687	90%	44	6%
Out-of-Care	77	10%	12	16%
Men	507	66%	31	6%
Women	238	31%	24	10%
Youth ages 18 - 24	37	5%	4	11%
Blacks/African-Americans	429	56%	42	10%
Hispanics/Latinos	141	18%	3	2%
Whites	174	23%	11	6%
White MSM	102	13%	6	6%
MSM of Color	208	27%	17	8%
Substance Abuse	248	32%	45	18%
Mental Health Needs	452	59%	44	10%
Recently Released	119	16%	21	18%
Homeless	89	12%	13	15%
Total Sample	764	100%	56	7%

Seven percent (7%) of the overall population surveyed reported that they had exchanged sex for drugs or money in the previous 6 months. Eighteen percent (18%) of those recently released from jail or prison reported that they had exchanged sex for drugs or money, as did those who reported a history of substance abuse. Sixteen percent (16%) of those who were Out-of-Care reported exchanging sex for drugs or money, which contrasts with only 6% of those who are in care. Eleven percent (11%) of youth aged 18-24 reported exchanging sex for drugs or money. Ten percent (10%) of those reporting mental health needs also reported that they had exchanged sex for drugs or money in the previous 6 months.

TABLE 41.10: SUMMARY OF THOSE REPORTING ANONYMOUS SEX BY SUB-POPULATION

Sub-Population	Total # in Sub-Population	% of Total Sample	Reporting Anonymous Sex	
			#	%
In Care	687	90%	117	17%
Out-of-Care	77	10%	24	31%
Men	507	66%	111	22%
Women	238	31%	27	11%
Youth ages 18 - 24	37	5%	7	19%
Blacks/African-Americans	429	56%	79	18%
Hispanics/Latinos	141	18%	23	16%
Whites	174	23%	36	21%
White MSM	102	13%	29	28%
MSM of Color	208	27%	52	25%
Substance Abuse	248	32%	63	25%
Mental Health Needs	452	59%	104	23%
Recently Released	119	16%	27	23%
Homeless	89	12%	25	28%
Total Sample	764	100%	141	18%

Eighteen percent (18%) of the overall population surveyed reported that they had anonymous sex in the previous 6 months. Several populations reported a higher proportion of anonymous sex than that reported by the total sample.

Thirty one (31%) of those who are Out-of-Care, contrasted with 17% of those who are in care, reported that they had anonymous sex during the previous 6 months. Twenty eight percent (28%) of White MSM reported that they had anonymous sex, while 25% of MSM of color reported this risk factor. Twenty five percent (25%) of those reporting substance abuse also reported that they had anonymous sex in the past 6 months.

TABLE 41.11: SUMMARY OF THOSE REPORTING GREATER THAN 5 SEX PARTNERS BY SUB-POPULATION

Sub-Population	Total # in Sub-Population	% of Total Sample	Reporting Greater than 5 Sex Partners	
			#	%
In Care	687	90%	52	8%
Out-of-Care	77	10%	8	10%
Men	507	66%	53	10%
Women	238	31%	5	2%
Youth ages 18 - 24	37	5%	3	8%
Blacks/African-Americans	429	56%	26	6%
Hispanics/Latinos	141	18%	12	9%
Whites	174	23%	20	11%
White MSM	102	13%	17	17%
MSM of Color	208	27%	28	13%
Substance Abuse	248	32%	33	13%
Mental Health Needs	452	59%	46	10%
Recently Released	119	16%	16	13%
Homeless	89	12%	13	15%
Total Sample	764	100%	60	8%

Eight percent (8%) of the overall population surveyed reported that they had greater than 5 sex partners in the previous 6 months. Several populations reported a higher proportion of anonymous sex than that reported by the total sample.

Seventeen percent (17%) of White MSM reported that they had greater than 5 sex partners, while 13% of MSM of color did. Thirteen percent (13%) of those recently released from jail or prison and 13% substance abusers also reported that they had greater than 5 sex partners during the past 6 months.

TABLE 41.12: SUMMARY OF THOSE REPORTING UNPROTECTED SEX BY SUB-POPULATION

Sub-Population	Total # in Sub-Population	% of Total Sample	Reporting Unprotected Sex	
			#	%
In Care	687	90%	203	30%
Out-of-Care	77	10%	32	42%
Men	507	66%	158	31%
Women	238	31%	72	30%
Youth ages 18 - 24	37	5%	14	38%
Blacks/African-Americans	429	56%	140	33%
Hispanics/Latinos	141	18%	35	25%
Whites	174	23%	54	31%
White MSM	102	13%	31	30%
MSM of Color	208	27%	76	37%
Substance Abuse	248	32%	103	42%
Mental Health Needs	452	59%	155	34%
Recently Released	119	16%	39	33%
Homeless	89	12%	35	39%
Total Sample	764	100%	235	31%

Thirty one (31%) of the overall population surveyed reported that they had unprotected sex in the previous 6 months. Several populations reported a higher proportion of unprotected sex than that reported by the total sample.

Forty two (42%) of those who are out of care, contrasted with 30% of those who are in care, reported that they had unprotected sex during the previous 6 months. Forty two percent (42%) of substance abusers also reported unprotected sex. Thirty nine (39%) of homeless respondents reported unprotected sex. Thirty eight percent (38%) of youth reported unprotected sex, and 37% of MSM of color reported unprotected sex.

TABLE 41.13: SUMMARY OF THOSE REPORTING SHARED INJECTION EQUIPMENT BY SUB-POPULATION

Sub-Population	Total # in Sub-Population	% of Total Sample	Reporting Shared Injection Equipment	
			#	%
In Care	687	90%	9	1%
Out-of-Care	77	10%	3	4%
Men	507	66%	10	2%
Women	238	31%	2	1%
Youth ages 18 - 24	37	5%	1	3%
Blacks/African-Americans	429	56%	4	1%
Hispanics/Latinos	141	18%	2	1%
Whites	174	23%	6	3%
White MSM	102	13%	4	4%
MSM of Color	208	27%	2	1%
Substance Abuse	248	32%	10	4%
Mental Health Needs	452	59%	9	2%
Recently Released	119	16%	4	3%
Homeless	89	12%	4	4%
Total Sample	764	100%	12	2%

Twelve (12) of the total sample of 764 reported that they had shared injection equipment to inject a substance during the previous 6 months. Substances injected by those who shared injection equipment include cocaine (5), prescription testosterone (1), steroids (1), and multiple substances (1). Not everyone who shared injection equipment indicated what substance they were injecting. For the purposes of identifying risk of HIV transmission or reinfection, the most important thing to know is whether injection equipment is being shared. The substance being injected is important to know in order to target prevention activities to the activities in which people are practicing this risk behavior.

Two percent (2%) of the overall population reported that they had shared injection equipment. Those who did not meet HRSA's definition of being in care ("Out-of-Care") reported that they had shared injection equipment 4% of the time, as did White MSM and those who reported a history of substance abuse. Youth aged 18-24, whites, and those recently released from jail or prison reported that they had shared injection equipment 3% of the time.

TABLE 41.14: SUMMARY OF THOSE REPORTING SERODISCORDANT SEX PARTNER BY SUB-POPULATION

Sub-Population	Total # of Sub-Population	% of Total Sample	Reporting Serodiscordant Sex Partner	
			#	%
In Care	687	90%	104	15%
Out-of-Care	77	10%	7	9%
Men	507	66%	53	10%
Women	238	31%	56	24%
Youth ages 18 - 24	37	5%	14	38%
Blacks/African-Americans	429	56%	62	14%
Hispanics/Latinos	141	18%	20	14%
Whites	174	23%	23	13%
White MSM	102	13%	10	10%
MSM of Color	208	27%	20	10%
Substance Abuse	248	32%	28	11%
Mental Health Needs	452	59%	66	15%
Recently Released	119	16%	17	14%
Homeless	89	12%	11	12%
Total Sample	764	100%	111	15%

Fifteen percent (15%) of the overall population surveyed reported that they had an serodiscordant (HIV negative) sex partner. Only two populations exceeded the average.

Thirty eight percent (38%) of youth reported that they had an HIV negative sex partner, indicating that this population of PLWHA are not practicing serosorting as much as some other populations. It may also indicate that they are not transmitting their infections to their partner. Twenty four percent (24%) of women reported an HIV negative sex partner.

TABLE 41.15: HIV TRANSMISSION AND REINFECTION RISK BEHAVIOR IN CARE VERSUS OUT-OF-CARE

Risk Factor	In-Care (687) Reporting Risk Factor		Out-of-Care (77) Reporting Risk Factor	
	#	%	#	%
Sex for Drugs or Money	44	6%	12	16%
Anonymous Sex	117	17%	24	31%
More than 5 Sex Partners	52	8%	8	10%
Unprotected Sex	203	30%	32	42%
Shared Injection Equipment	9	1%	3	4%
Serodiscordant Sex Partner	104	15%	7	9%

For almost every risk category, those who met the HRSA definition of In Care reported less risky behavior than those who were Out-of-Care.

Eight percent (8%) of those who were in care reported that they had exchanged sex for drugs or money in the previous 6 months, while 16% of those who were Out-of-Care reported this risk factor. Seventeen percent (17%) of those who were in care reported that they had anonymous sex in the past 6 months, while 31% of those who were Out-of-Care reported this risk factor. Thirty percent (30%) of those who were in care reported that they had unprotected sex at least some of the time, while 42% of those who were Out-of-Care reported this risk behavior.

For nearly all of these risk behaviors, those who were Out-of-Care engaged in them at substantially higher proportions. This could be indicative of the many ways in which those who are Out-of-Care are marginalized. It could also indicate that being in care encourages a person to practice other healthier behaviors. More research with a larger sample size would be necessary to speculate further on the cause of this difference in risk behaviors.

TABLE 41.16: HIV TRANSMISSION AND REINFECTION RISK BEHAVIOR YOUTH (AGE 18 - 24) VERSUS THE TOTAL SAMPLE

Risk Factor	Youth, age 18 - 24 (37) Reporting Risk Factor		All Respondents (764) Reporting Risk Factor	
	#	%	#	%
Sex for Drugs or Money	4	11%	56	7%
Anonymous Sex	7	19%	141	18%
More than 5 Sex Partners	3	8%	60	8%
Unprotected Sex	14	38%	235	31%
Shared Injection Equipment	1	3%	12	2%
Serodiscordant Sex Partner	14	38%	111	15%

Youth aged 18-24 reported that they exchanged sex for drugs or money, had anonymous sex, had unprotected sex, shared injection equipment, and had an HIV negative partner at higher proportions than the overall sample.

While the sample size is small, this indicates that those youth who are living with HIV and AIDS may be engaging in behavior that puts them at risk for reinfection and transmitting infection at a higher rate than PLWHA in general. This may indicate a need for additional, or more tailored, prevention messages for youth living with HIV and AIDS.

TABLE 41.17: HIV TRANSMISSION AND REINFECTION RISK BEHAVIOR WHITE MSM VERSUS MSM OF COLOR

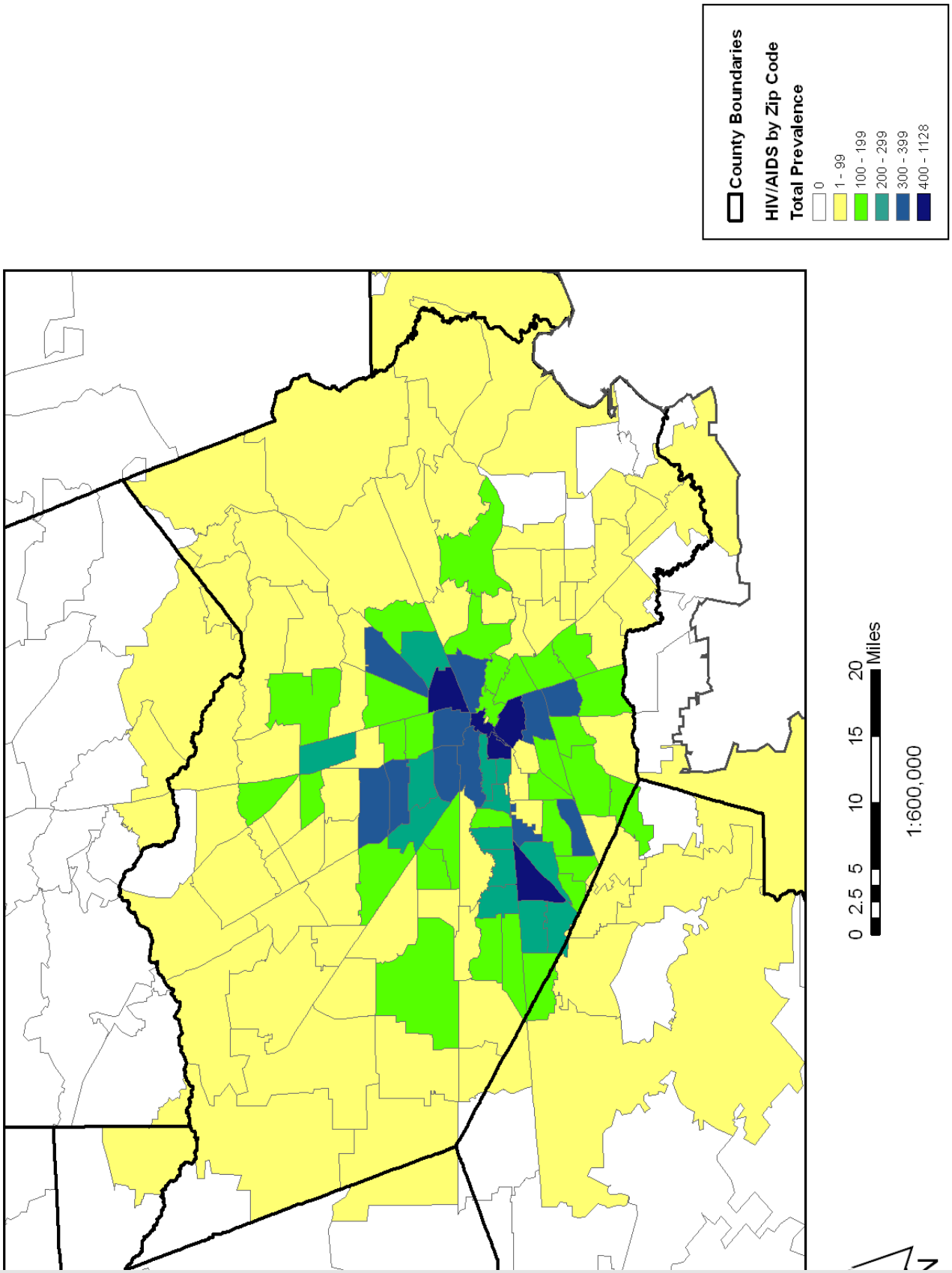
Risk Factor	White MSM (102) Reporting Risk Factor		MSM of Color (208) Reporting Risk Factor	
	#	%	#	%
Sex for Drugs or Money	6	6%	17	8%
Anonymous Sex	29	28%	52	25%
More than 5 Sex Partners	17	17%	28	13%
Unprotected Sex	31	30%	76	37%
Shared Injection Equipment	4	4%	2	1%
Serodiscordant Sex Partner	10	10%	20	10%

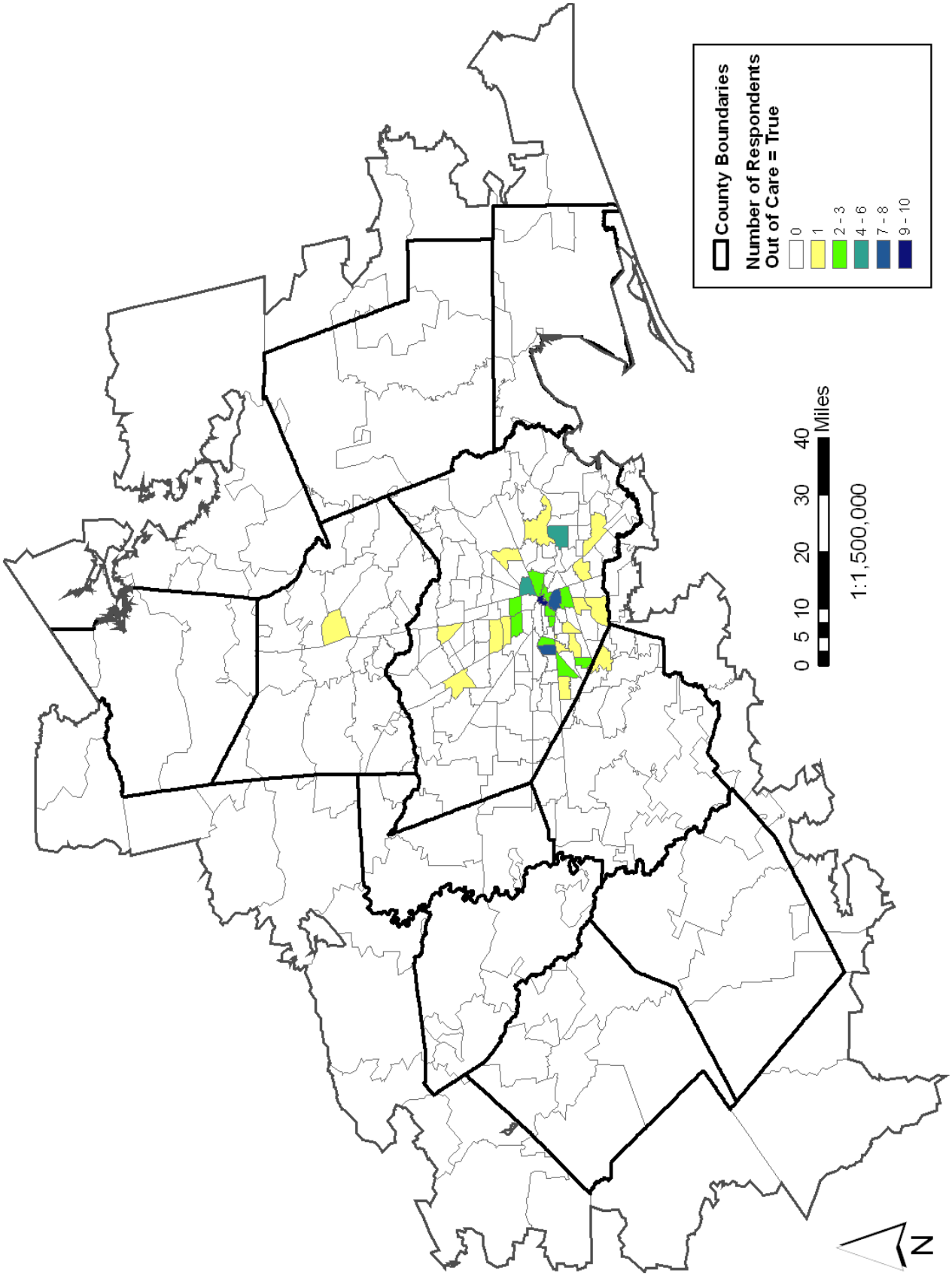
White MSM and MSM of Color do not report HIV transmission and reinfection risk behaviors in the same proportions. MSM of Color report higher proportions of sex for drugs or money and unprotected sex. White MSM report higher proportions of anonymous sex, having sex with more than 5 partners, and shared injection equipment.

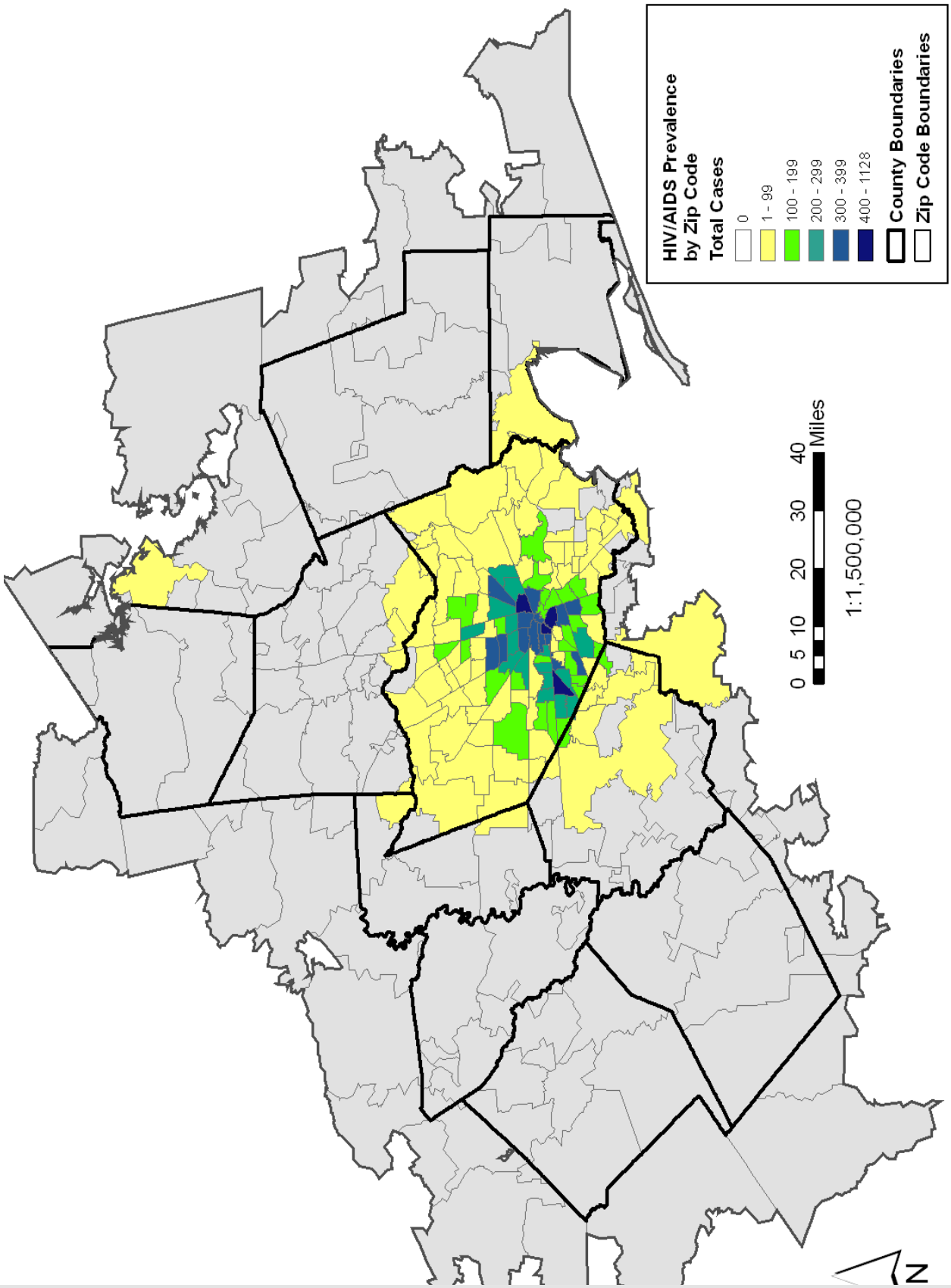
This further indicates the need for tailored prevention intervention activities for white MSM versus MSM of Color, rather than a “one size fits all” approach.

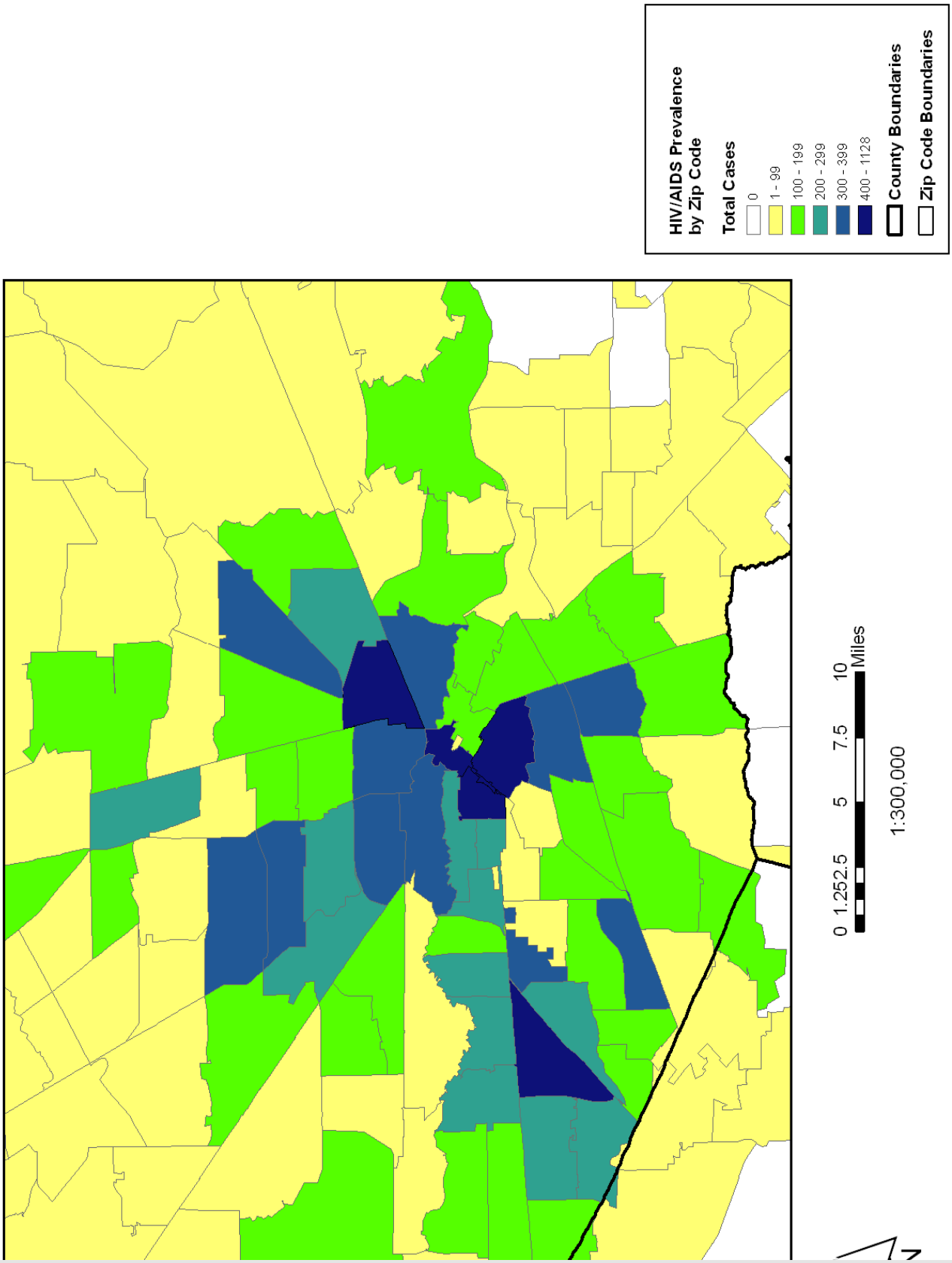
Geomapping

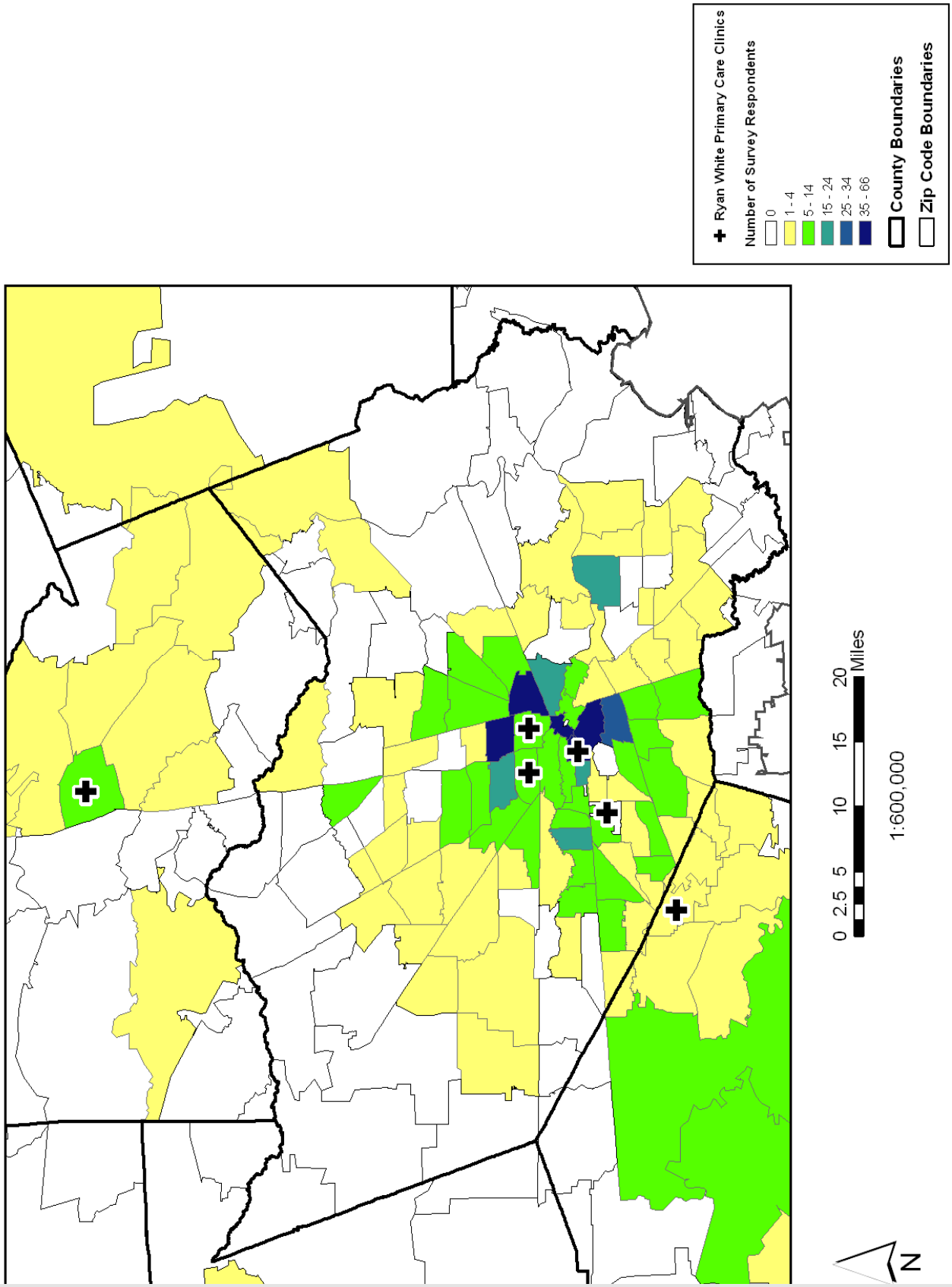
The maps on the following pages show the distributions of HIV/AIDS prevalence, as well as distributions of subpopulations within the total 764 survey respondents. These populations include the homeless and out-of-care, as well as comparisons of respondents in relation to locations of clinics.


County Boundaries
HIV/AIDS by Zip Code
Total Prevalence
0
1 - 99
100 - 199
200 - 299
300 - 399
400 - 1128
0 2.5 5 10 15 20
Miles
1:600,000


County Boundaries
Number of Respondents
Out of Care = True
0
1
2 - 3
4 - 6
7 - 8
9 - 10
0 5 10 20 30 40
Miles
1:1,500,000
N


HIV/AIDS Prevalence
by Zip Code
Total Cases
0
1 - 99
100 - 199
200 - 299
300 - 399
400 - 1128
County Boundaries
Zip Code Boundaries
0 5 10 20 30 40
Miles
1:1,500,000
N


HIV/AIDS Prevalence by Zip Code
Total Cases
0
1 - 99
100 - 199
200 - 299
300 - 399
400 - 1128
County Boundaries
Zip Code Boundaries
0 1.252.5 5 7.5 10
Miles
1:300,000


Ryan White Primary Care Clinics
Number of Survey Respondents
0
1 - 4
5 - 14
15 - 24
25 - 34
35 - 66
County Boundaries
Zip Code Boundaries
0 2.5 5 10 15 20
Miles
1:600,000
N

Lack of information and difficulties making or keeping appointments were among the top three barriers reported for both core and supportive services.

- Waiting times also ranked highly for core services.
- Lack of services close to survey respondents also ranked highly for supportive services.

For Further Study

It is impossible to administer a survey to all 18,109 PLWHA in the Houston HSDA. The NAG made many attempts to reach a representative sample of the PLWHA population – however, the following populations and service-related issues warrant further examination in future studies, projects and needs assessments:

IDU – Injection drug users living with HIV are a difficult population to target. Additional resources and dedicated time is required to identify and gather information from this population; however, there are little data existing for this population, so an increased understanding of the experiences and needs of this population would be well worth the additional resources and time required.

The Out-of-Care – The unmet need framework for the Houston EMA estimates approximately 7,000 (38%) PLWHA who meet the HRSA definition of out-of-care. This population is, for obvious reasons, a difficult population to reach – for that reason, the out-of-care should be a prioritized population in terms of future research or other projects.

White MSM – as with the previous Needs Assessment, white MSM were under-sampled in the current Needs Assessment. A future study might explore whether white MSM tend to receive primary medical care from private physicians, rather than publically funded Ryan White clinics, where most client surveys were administered.

Informational Barriers – A deeper exploration of factors that might explain why "I don't know where to get the services," or lack of information, remains a barrier for PLWHA would be useful when planning for services. Some examples of probing questions could include:

- Sources of information (i.e., resource guides, case managers, friends, media, etc);
- Decision-making processes when accessing services;
- The nature of the information needed – where to go? operating hours? phone number?

Experiences making or keeping appointments – clarification on the specific problems related to making or keeping appointments. For example, are the difficulties making appointments due to filled schedules at agencies, or simply getting through to a staff person over the phone? Are the problems keeping appointments due to transportation-related barriers, or personal obstacles such as conflicting work schedules, personal health issues, etc.

Alcohol Use and Abuse – Further examination of patterns in alcohol use and abuse among those living with HIV/AIDS, and how those behaviors affect utilization of services.

Blacks/African-Americans – Further study of the HIV/AIDS trends in the Black and African American communities is needed. Blacks/African-Americans had the highest rate of new HIV and new AIDS infections (106/100,000). This is four times greater than that of Latinos (27/100,000) and almost seven times that of Whites (15/100,000). Black/African-American women make up the largest percentage of newly diagnosed women in proportions that are significantly higher than those of whites and Latinos. Black/African-American youth are disproportionately affected by HIV and AIDS.

HIV/AIDS mortality trends –There was a decrease in the number of HIV deaths between 2000 and 2001; however, from 2002 to 2003, the number of deaths showed an increase. Mortality data for 2004 showed a slight decrease in the number of deaths. Future releases of these data should be monitored for any continuing trends in HIV/AIDS mortality.

Appendix A

SPECIAL STUDIES:

Access to Care among HIV+ Latino Immigrants
Approved December 2006 611

Barriers to Care among HIV+ Youth
Approved May 2006 631

Access to Care
among HIV+ Latino Immigrants

A special study of the
Comprehensive HIV Planning Committee
Houston Ryan White Planning Council

Approved
December 2006

Prepared by
Jen Haejin Kim, MPH
Health Planner
Ryan White Planning Council Office of Support

Introduction
In 2005, the Comprehensive HIV Planning Committee of the Houston Ryan White Planning Council commissioned three "special studies" focusing on populations of interest which were identified based on findings from the 2005 Needs Assessment and HIV/AIDS surveillance data. These populations were youth, MSM of color and Latino immigrants.

The purpose of this exploratory study was to better understand the factors that enhance or impede entry (and retention) into care for HIV+ Latino immigrants. The focus on entry to care was triggered by HRSA's unmet need initiative, and the Houston Ryan White Planning Council's efforts to bring HIV+ individuals into medical care. The findings in this study are based on the personal narratives of HIV+ Latino immigrants living in the Houston EMA. We chose to utilize one-on-one interviews in order to collect in-depth information not usually captured in quantitative surveys, and to give a direct voice to the experiences of HIV+ Latino immigrants.

Latinos in the Houston EMA & HSDA
An Eligible Metropolitan Area (EMA) is defined by the Health Resources Services Administration (HRSA) as an urban area hardest hit by the HIV/AIDS epidemic. These areas receive direct federal funds in the form of a Title I grant. The Houston EMA consists of six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery and Waller. Health Service Delivery Areas (HSDAs) are areas that receive Title II grants. Title II funds are awarded directly to states from HRSA, and distributed by the states to HSDAs. The Houston HSDA encompasses a total of ten counties. These ten counties consist of the six EMA counties plus Austin, Colorado, Walker and Wharton counties.

Hispanics/Latinos make up 30% of the EMA population and 32% of the state population. Twenty percent of EMA and HSDA residents were born outside the U.S. This compares to 14% in the state of Texas. These foreign born residents most frequently come from North, Central and South America. Mexico is the most frequent place of foreign birth, accounting for about half of those born outside the U.S.

Approximately one-third of EMA and HSDA residents are "linguistically isolated," meaning they speak English less than "very well." The predominant second language is Spanish.

HIV/AIDS among Latinos in the Houston EMA
During 2005, there were 7,406 living HIV cases (including 971 new HIV diagnoses) and 10,468 living AIDS cases (including 1,040 new AIDS diagnoses) in the six county Houston EMA. This included 214 new HIV diagnoses and 273 new AIDS diagnoses among Latinos.

In 2004, a total of 407 Hispanics were newly diagnosed with HIV or AIDS in the Houston HSDA. This total included 337 (83%) new cases among Hispanic men and 70 (17%) new cases among Hispanic women. As with other populations, the 25 to 44 year age group is the largest (n=300; 74%), but infections among youth 13 to 24 years of age are increasing. Nearly 18% of Hispanics living with HIV are youth, while 6% of those living with AIDS are youth between 13 and 24 years of age.

Sexual activity, either men who have sex with men (MSM) or heterosexual, was the transmission mode for almost all Hispanics diagnosed with HIV and those living with HIV or AIDS. MSM represented a higher percentage of those diagnosed with HIV (58%) than those diagnosed with AIDS (41%). Forty-five percent of Hispanics living with HIV and 50% of those living with AIDS report MSM as their transmission mode. Heterosexual contact is the transmission mode for 23% of Hispanics living with HIV and 24% of those living with AIDS. Among diagnosed AIDS cases, intravenous drug use (IDU) was attributed to 3% of new HIV cases and 6% of new AIDS cases. MSM/IDU transmission was attributed to less than 1% of new HIV cases, and 3% of new AIDS cases. Mothers at risk constituted 1% of new HIV cases. No new AIDS cases among Latinas in 2004 were attributed to mothers at risk.

Harris County is home to 96% of Hispanics living with HIV or AIDS. In addition, Harris County had the highest proportion of new HIV infections and diagnosed AIDS cases among Hispanics during 2004. There was also a small portion of cases in Fort Bend County, Liberty County, Montgomery County, and Waller County.

2005 Needs Assessment

In the 2005 Needs Assessment, Latinos comprised 22% of the survey sample, and 27% of these people, or 41 respondents, were out-of-care. Out-of-care Latino consumer survey participants have the same gender and age profiles as those receiving HIV medical care. With 55% working either full or part time, out-of-care Latinos are employed to a greater extent than both in-care Latinos and other groups of out-of-care consumers. Despite working, 87% are uninsured.

Out-of-care Latinos were relatively newly diagnosed with HIV. Almost all were diagnosed after 1995, and 73% were diagnosed between 2000 and 2004. After diagnosis, 83% of the out-of-care never received HIV medical care, and 33% reported they were not referred for services. Few out-of-care Latinos were treated for comorbid conditions in the last 12 months. Comorbidities identified included current IV drug use (18%), current street drug use (30%) and homelessness (15%).

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

- ♦ I do not believe I need medical care currently because I am not sick (54%);
- ♦ I do not believe medical care would do me any good (29%);
- ♦ I was worried someone would force me to take medication (17%);
- ♦ I was actively using (street drugs or alcohol) (17%); and
- ♦ I was worried someone might find out about my HIV status if I went there (17%).

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?", nearly 70% of Latino respondents identified "I'm afraid of others knowing I am HIV positive."

Other barriers were identified with the question, "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 (42%);
- ♦ Fear of being deported (42%); and
- ♦ I can't get services because of immigrant/legal status (27%).

Out-of-care Latino's ten most frequently identified unfulfilled needs include:

Service Category	Proportion of Latino participants identifying unfulfilled service need
Health Insurance	68%
Oral Health	61%
Primary Medical Care	54%
Utility Assistance	51%
Bus Pass	49%
Rental Assistance	48%
Vision Care	44%
Household Items	44%
Client Advocacy	44%
Food Bank	44%

Methodology
The findings of this study were based on 30 semi-structured one-on-one interviews with HIV+ Latino immigrants between the ages of 26 and 70. All participants received gift cards at the conclusion of each interview. All interviews were conducted in English by the Health Planner in the Ryan White Planning Council Office of Support, and interpreted by a Spanish-speaking consultant trained in medical translation and interpretation. Interviews were conducted at public clinics and community based organizations.

At the beginning of each interview, participants were informed that their participation was completely voluntary and that they could stop the interview at any time. A Research Assent form translated into Spanish, containing details of the study and assurances of confidentiality, was reviewed with each participant (see Appendix A). Upon receiving the participant's assent, a brief one-page questionnaire was administered by both the Health Planner and interpreter (see Appendix B).

To further protect confidentiality, first and last names were not collected during the course of the study; participants signed only their initials on the Research Assent and gift card receipt forms. A unique identification number was assigned to each participant for purposes of data entry and analysis.

Interview items were based on findings from a literature search on access to care among HIV+ Latino immigrants. Interviews lasted between 30 to 100 minutes. Interview questions were posed to the participant in English, and participant responded in Spanish, with the interpreter translating between the two. All interviews were recorded using a digital voice recorder, transcribed into Microsoft Word and coded and analyzed using AnSWR, a qualitative analysis program developed by the CDC.

Participants
Thirty (N=30) HIV positive Latino immigrants participated in one-on-one semi structured interviews. Fifteen (50%) were male and 15 (50%) were female. None of the participants identified as transgendered. Ages ranged from 26 to 70 years, with an average age of 42 yrs (sd = 11.0). Seventy percent (70%) of participants identified as heterosexual (n=21; 70%), 7(23%) gay, and 2 (7%) bisexual.

The majority of participants were undocumented immigrants (identified as "Other" on the pre-interview survey). Four (13%) were permanent residents, three (10%) were citizens and one (3%) was a visa holder. One of the participants was in the process of applying for asylum due to her HIV status.

Most participants originally came from Mexico (n=19; 63%), followed by Honduras (n=6; 20%), and El Salvador (n=3; 10%). Two came from Columbia and Ecuador. The average length of residency in the US was 11 years, ranging from 3 months to 48 years. The majority of participants (n=19; 63%) had been in the US for less than 10 years, and 8 (27%) had been in the US for less than 5 years.

The following table shows additional demographic information for the 30 participants.

Participant Background Information (N=30)

Gender	Male = 15 (50%) Female = 15 (50%)
Age	Range = 26 – 70 Average = 42 yrs (sd*=11.0)
Immigration Status	Citizen = 3 (10%) Permanent Resident = 4 (13%) Visa = 1 (3%) Other = 22 (73%)
Country of Origin	Mexico = 19 (63%) Honduras = 6 (20%) El Salvador = 3 (10%) Columbia = 1 (3%) Ecuador = 1 (3%)
Years in US	10 years or less = 19 (63%) 5 years or less = 8 (27%) Range = 3 months – 48 years Average = 11 years (sd=10.1)
Sexual Orientation	Straight = 21 (70%) Gay = 7 (23%) Bisexual = 2 (7%)
Marital Status	Married = 11 (37%) Never Married = 11 (37%) Divorced/Separated = 6 (20%) Widowed = 2 (7%)
Job Status	Full time = 1 (3%) Part time = 6 (20%) Temp/Odd Jobs = 6 (20%) Do not work = 17 (57%)
Monthly Income	Range = $0 - $2000 Average = $693 (sd=514.0)
Live Alone?	Yes = 10 (33%) No = 20 (67%); Average = 2 other people
Have Children?	No = 9 (30%) Yes = 21 (70%); Average = 2 children
Length of Diagnosis	Within past 4 years = 16 (53%)
Frequency of Doctor Visits (for HIV)	Range = 2x per month – every 6 months Average = Every 3 months (sd=1.1)
Taking HIV Meds?	No = 3 (10%) Yes = 27 (90%)
Taking non-HIV Meds?	No = 13 (43%) Yes = 17 (57%)

* sd = standard deviation

Limitations

It is important to note that interviews were conducted with HIV+ Latino immigrants who were willing and available to talk about their experiences. Since study recruitment was conducted through service providers, all participants were receiving medical or supportive services at the time of the interview. Therefore, the findings may not fully reflect the experiences of out-of-care HIV+ Latino immigrants.

These limitations may affect the generalizability of the findings.

In addition to participant names, the names of specific case managers, doctors and service providers have been removed.

Results

Reasons for immigrating

Financial opportunity was the most frequently reported reason for immigrating to the United States. Participants often stated they were seeking "a better life."

> *"I came here to work. I have better opportunities here than in my home country." Male participant*

> *"…I came to the US with my three sons so they could have a better life and education than I did." Female participant*

Six participants reported immigrating to the US to receive health care or other services related to being HIV positive. Of these six participants, two had received HIV tests prior to leaving their countries of origin. The remaining four were tested in the US, but stated they were ill and strongly suspected they were already infected.

> *"I was diagnosed here in the US. The reason I came to the US was because my husband died of AIDS, so we knew the symptoms, and I started to have the symptoms and I was becoming ill. So my mother contacted my sister who was here in the US, and it was recommended that I come to the US because they would not be able to send medications to my country." Female participant*

> *"The only person I knew who was HIV positive was my husband, who told me 3 months before he died. He died very quick, and I knew I was going to die too, which is why I came to the US because I didn't want to die alone." Female participant*

Participants described the differences between HIV-related care in Houston versus HIV-related care in their countries of origin. Availability of resources, stigma, medications and HIV knowledge of physicians were key differences.

> *"The difference would be that people with HIV are discriminated. People are so afraid of transmission, and their education on HIV is very poor. Another big difference is that there are no big clinics like there are here. If you have AIDS or HIV, you go to the general hospital or see general practitioners who don't know much about HIV. And you are given the message 'don't come back'." Female participant*

> *"After my husband died, everybody was talking about him and my dentist….told me not to come to her. She said 'I cannot help you anymore'…I was so shocked. I was too scared to see a doctor so I didn't get any medicine and I got very sick." Female participant*

HIV/AIDS Attitudes and Beliefs

Many participants reported that at the time of diagnosis, they believed that HIV was a "death sentence" with low chances of survival.

> *"The first time I went to [the public clinic], I thought I was going to die in two weeks. I thought I was going there to die and I would never come out." Male participant*

> *"My thought of HIV was people with thin arms and big stomachs and marks all over their skin.*

That was my idea of HIV." Male participant

"I went to support groups at [a Latino organization], and people there told me they had HIV for 25 years, and I told them they were lying to me to make me feel better." Female participant

"I thought I was going to die, and my son just cried and cried." Female participant

A few participants reported that they were unaware of HIV, or that it could affect them.

"I was surprised when the doctor suggested the HIV test, because I did not believe HIV was a real disease. Many people in my family said it did not exist. Yes, I did see promotions on TV, but I thought they were just promotions to help doctors become rich." Male participant

"I heard about AIDS, but I didn't think about Latinos with it. Because you only see African Americans and Anglos." Male participant

Basic HIV education messages are important during primary prevention. Many participants discussed the lack of basic HIV education in Latino communities. In addition to primary prevention, HIV education for HIV+ Latinos is also important. For example, a participant did not believe that her breast milk could transmit the virus to her child.

"My child, I was worried because he would not digest regular milk well, it would make him sick. He did take breast milk, and people they said 'no, no' and [told me] to keep taking my medicine. But I prayed to God to make him better, and it did make him stronger. That's why my child is healthy – he took my breast milk. Otherwise, he would have been HIV positive. That is why I am sure that breast milk is not bad milk when one is HIV positive. The people that think that drinking breast milk is bad for the child are mistaken." Female participant

<u>HIV Testing Experiences</u>

Most participants received their HIV diagnoses at public hospitals after seeking emergency care for severe symptoms, or at community clinics during prenatal care. Only three participants reported they initiated HIV tests as preventative measures. In most cases, post-test information was limited to a referral to the public clinic. A few participants reported that the Blue Book was a useful resource.

"They did not tell me much afterwards. Before I left, somebody gave me a piece of paper… they wrote the [name and address of the public clinic]." Female participant

"…a young man came who spoke Spanish, and he was Hispanic and said he had HIV for 10 years. And I didn't believe him that he had HIV for 10 years, but he said he did and that gave me hope. The young man gave me a Blue Book and told me to use it for services." Female participant

The majority of participants kept their HIV status a secret from friends and family. Less than five had disclosed their status to family members, and even fewer received positive support. Common reactions from friends and family members were denial, fear or rejection due to stigma and misunderstandings about transmission.

"My friend told me…he told me that I didn't have HIV, that it was a lie, and he didn't believe me so he didn't want to help me anymore… " Female participant

"Until this day, I have no idea if my husband ever took an HIV test or if he is HIV positive because we separated that day in the hospital." Female participant

"My brother, I used to take care of his children. But then he thought that I would infect his children. So he did not bring them to see me anymore." Female participant

"…all my sisters and brothers had a family meeting and decided that I had to be removed from the family circle. This was during the 9 days I was in the hospital. At the beginning, my sisters would be there and supportive of me. And when…all the doctors and nurses wore gloves and masks when they came into see me… that made my family believe even more that HIV was a contagious disease, even though the doctors told them that it was to protect me and not because other people were in danger." Female participant

"After I left the hospital, I went home to my family's house. And they were OK with it at first. But then [a Case Manager from a community organization] came to visit me at the house. After he left there was some anxiety again about my HIV and they didn't like that I was sharing the bathroom with our grandmother who had diabetes. And all the grandchildren were not allowed to come to the house while I was there. So eventually I was told to leave the house so I moved out and went to an apartment, and that was very difficult for me. It was like hell. [The Case Manager] offered to talk to them, but they just wanted to get as far away from me as possible." Female participant

Entry into Care

The average amount of time between diagnosis and self-reported entry into care was 5 days, with total times ranging from 1 day to 7 years. Those who delayed entry into care for more than one month reported fear or denial, lack of information, work-related barriers or other circumstances.

Some participants reported fear or denial about confirming their status.

"My husband died in 1997 but I did not get tested until 2002 because I was fearful. When my husband died of AIDS, everybody was talking, and I was afraid of rejection. And it was also part of my ignorance. But I got so ill that in order to be there for my children, I needed to come to the US because I knew in the US I would receive better treatment. So I came to the US and within the week my sister took me to the HIV clinic." Female participant

"My husband died 11 years ago. The reason I did not get treatment right away when I came to this country, was because I had forgotten that my husband died of AIDS. I told my son that his father had died of a heart condition." Female participant

"Me personally, I would not have wanted to know I was HIV, but I only knew because I was so ill. Female participant

After being diagnosed in the US, one participant did not seek services for 2 months because she feared rejection by service providers.

"I thought they would not treat me well, I thought they would reject me." Female participant

In one case, a participant's doctor in Houston did not test for HIV despite her symptoms and risk history.

"I was having fever and tenderness around my liver and I started to get spots on my arms. I was also having headaches. I went to a doctor that was recommended by my family members. He looked at my rash and said it was herpes related. I told him I had been raped once. Then he took my blood and said I just had high cholesterol. A month later I got the symptoms again and I went to [a public hospital], and that's where I learned I had HIV." Female participant

Another factor affecting entry into Houston's HIV care system was work-related barriers. Requesting time off from work for medical appointments was impossible for many participants. Many reported it as a reason for delayed entry into care.

"I was working for a woman from Chile, and she had two children and she was very strict and did not allow me to take any medical appointments. So without work I cannot make money. I have to work and make money so I can send it to my family, so my family can eat. I didn't follow up on medical because I didn't have any opportunities, and I fell ill because of that. And she fired me because I got ill." Female participant

"I went to a clinic and you have to wait for hours to see the doctor. But I would see the doctor standing around talking to people. And you have to understand, we have to take time off from work to go to the clinic, and to see the doctor standing around I did not like that. If I miss too much work then I will lose my job so I cannot spend all day at the clinic. And even though the clinic said they could mail the medication to me at my home, I still did not like that clinic so I did not go back." Female participant

One participant reported falling in and out of care due to violence and abuse from her husband.

"The first 6 months I lived with my husband [after HIV diagnosis], I lived in total fear. My husband was accusing me of having an affair with [my Case Manager], he was accusing that the staff at [the Latino organization] were raping me. Also, he wouldn't touch me or let me cook. And one of my sisters in law told him that I was a prostitute in Honduras… one time, I got lost on the Metro going to [the public clinic] so when I finally got to the clinic I spent three hours with [my Case Manager] because I was crying the whole time. And when I got home, my husband was drinking and he accused me again of having an affair with [my Case Manager] and threatened to kill us both by setting the apartment on fire." Female participant

Another participant reported that he did not enter Houston's HIV care system for two years because he was not informed of his status by the public hospital.

"In 2002, I found out I was already diagnosed in 2000, but I was never told about it. I went to [the public hospital] for a medical issue. I met the doctor, and the doctor opened my file and that's when I found out I had been diagnosed two years earlier. Many times prior to that day, I had been to [the public hospital] many times, but I was never informed that I was HIV positive. I feel that this was a very grave error because during those two years I could have been taking medications, because when I came to [a public clinic], my CD4 count was very low and I had an AIDS diagnosis." Male participant

Barriers to Care

Overall, participants were satisfied with their HIV medical care and the range of HIV services available in the Houston area. However, when discussing barriers to current systems of care, participants most often identified language and immigration status as the two top barriers.

Language barriers were identified throughout the course of treatment, starting from diagnosis. When bilingual translators were not available or offered by providers, family members stepped in. This dynamic affected the participant's right to confidentiality, when providers disclosed their HIV status to family members without their consent.

"When they called with the results, they asked to speak to my husband because he spoke English better than me. And they told him that they would not be able to see me there any longer because I was a carrier of AIDS, and they referred me to [a public clinic]." Female participant

"I arrived at the hospital…the doctor came and said I want to give you an HIV test because you show the symptoms. I signed the paper because I didn't think I had it, I wasn't expecting to have it. After that my husband's sister was there, and I was very ill. And my husband's sister

asked the doctor what's wrong with her? Is she going to die? And the doctor said, she has a mortal disease. She has AIDS. I heard the results of my HIV in front of my sister in law. The results were given to my sister in law in English by a doctor who did not speak Spanish. She did not try to give me the results in my language, privately. As the first sister in law was hearing the results, another sister in law was coming into the room…and the first sister in law said, "she has AIDS!" Then the second sister ran out of the room to call my husband's family and told them." Female participant

Several participants felt that they did not receive equal access to services because of their English abilities. They were frustrated by a system that they felt discriminated against non-English speakers.

"It is difficult to get services if you are Latino because, for example [a community organization] provides financial assistance, but they are only open for one hour a month, and only 20 people can get in. And if you don't speak English then it is difficult. That is why only the African Americans get services. It is hard for Latinos." Female participant

"More interpreters need to be available. So that we can be treated equally. Without interpreters we have to wait longer." Female participant

Participants also cited examples of how their language barriers prevented them from accessing services or information related to their medical care.

"I was never helped by anyone to help me understand the papers I was signing." Male participant

"I felt lost because I did not have someone to give me information in Spanish. I felt like when I was diagnosed I had no guidance as to other services, and I did not get a clear understanding of what medications to take and what the side effects were." Female participant

"When I was diagnosed, I didn't get much information from [the hospital] about HIV…I was in the hospital for three months and I did not get anyone who spoke Spanish to give me that information." Female participant

Although translators are often available to address language barriers, participants were often unsatisfied with the quality and skills of available translators. One such issue was related to "spontaneous translation," where staff untrained in translation or not fluent in Spanish were pulled in at a moment's notice.

"Generally, when a doctor does not speak Spanish then they try to make sure an interpreter is available. However, in other departments that are smaller and faster and less important, then they won't have an interpreter, like signing papers for the lab. Then they will just bring a secretary or somebody to translate." Male participant

"Sometimes I would get a translator that was not so good, they spoke what we'd call Spanglish, which is not really Spanish but a mixture of English and Spanish. The majority of interpreters that I saw were administrative staff. In the ER department, the interpreters I received seemed like real interpreters but in the specialty departments they did not seem like real interpreters." Male participant

Another issue was the proficiency of translators. Several participants described experiences with translators who did not speak Spanish fluently.

"You go into hospitals, and they say a bilingual person is here…but the only Spanish thing

about them is their last name because their Spanish is really, really bad. Or they speak 25% Spanish and 75% English. So you don't understand what they are saying… you need really good speaking people there for Spanish. Also because it's for health, because if there is something really wrong with you, and you don't understand, then that is bad." Male participant
"Sometimes they say, oh she speaks Spanish, but then when you try to speak Spanish then she doesn't even speak Spanish correctly. And you wonder why they told you she was bilingual but you cannot say anything." Male participant

Immigration status was also a common barrier identified by participants. Fear of deportation was one main concern related to immigration.

"I have definitely feared asking for services due to my immigration status. I don't want to be caught, and I don't want to be returned to Mexico because in Mexico I would only… my only option is to work in the fields, and I've done that, I've worked in the fields from 7am till 3pm and my average income for that work is 8 dollars a day… and so my great fear is that I get returned. And if I stay here, I can provide a better quality life for my children, because I want them to get the education that I didn't get. And so sometimes I think when I try to access, I get scared that they might send me back and that would mean I would be without income and also medicine for my HIV." Female participant

"Now as far as the fear of people…there is the fear that they will be sent back. That is the fear. Now I have never heard of a situation that someone tried to get a service and then was sent back, but that does not mean the fear is not there." Female participant

Participants also felt that the documentation required for services was difficult for many Latinos to produce.

"Many Latino immigrants do not have an ID or cannot get an ID, so the requirement of an ID can be a barrier for many folks." Female participant

"The most difficult paperwork is proof of income. I was able to get a job at a car wash and so I could get the Gold Card for 3 more months. One time I got the Red Card, but with the Red Card you have to pay for services." Female participant

"Sometimes they ask us to provide documentation of our employers, and not everyone works. Or they ask for a statement from someone supporting us, but not everyone wants to tell their family members they have HIV. So it is difficult for many people." Male participant

Other barriers to care identified by participants were cost of services and cultural attitudes.

"I think it's difficult for Latinos to access medical services in general, because services are very expensive." Female participant

"I would say another barrier is Machismo. We see Latino gays going in to access services, not a problem, we see women, we see children accessing services. Not a problem. But when we hear a woman say I am infected because my husband infected me, and we say please tell your husband to come in, she says, oh I can't tell my husband because he will kill me. Or he will say that if I am infected, I infected him. And he will not accept it because it's only for gay people." Male participant

"The Latino community in general has a difficult time accepting that Latino heterosexual men are also being infected. They are more accustomed to women now, but they are not questioning the population of straight men." Male participant

"I think that the US culture is different than the Mexican or Latino culture. In that in the US culture, I see a lot more acceptance of HIV. Everyone can have HIV now – women, men, children, everyone. Not just gays. All people can have it, and all people are accepted. But in the Latino culture or Mexican community that's not quite the case yet, so I think it's important for the Mexican community to realize that we're in the US now. We need to look more through the lenses of what the US culture looks through, how the US culture looks at HIV." Male participant

Reaching the Latino Community

When asked to recommend strategies for bringing HIV+ Latinos into care, participants said visibility and community education were the two most important approaches. Several participants who accessed services from Latino-specific organizations discussed the importance of receiving care in environments that were comfortable for them culturally and linguistically.

"When I was going to the other doctor, I would sit in the waiting room and I would see the other patients and they were white and spoke English. And I could not say hello or talk to them so I felt uncomfortable. They were Anglos, they were white people. And when I opened the door at [the Latino organization], I saw the population of people that were there. There were… mothers with children… young people and adults, and they were all Hispanics. So I immediately identified with them. It was not until then that I realized I was not the only Hispanic person with HIV." Female participant

"[At the Latino organization] I was told for the first time that I did not have AIDS, I was told the difference between HIV and AIDS…that was important for me to hear because when I was first told that I had AIDS my whole world came down and I was so stressed out and so desperate and when I heard more specifically that I had the initial stages of HIV it gave me a lot of hope and it helped me change my attitude about my health." Female participant

"While I was in the hospital…no one told me anything so I can't answer what medications I was on. I was not informed of any treatment they were giving me. It was not until I went to [the Latino organization] that I learned what a CD4 count or viral load was." Female participant

All participants said that increased outreach, education and publicity were needed to help bring more HIV+ Latinos into medical care. Many also felt that in addition to basic HIV education, outreach messages should address fears of anti-immigrant sentiment. Also, publicity should inform community members that they can receive services regardless of immigration status.

"Now, there are already advertisements, but they do not mention that they will provide services regardless of your immigration status. But I think that's one way to promote services." Female participant

"One time I heard on the radio a popular announcer talked about HIV and said it's not just gay people or white people, it's everyone who can get HIV. And then people started to call in and say my brother has HIV or my friend has HIV and that was good to hear it in Spanish on the radio because it was a popular radio show. But that was only one time and I don't hear that kind of thing on Spanish radio anymore." Male participant

"I think in order to get undocumented to access services for medical the important thing is publicity. Because the publicity we're getting in our community is exactly the opposite of the kind of publicity that would help the undocumented access services. Because if you look at the TV…if you're undocumented we have a law going on that you'll be taken away and you have no rights. We've been seeing more publicity against undocumented persons, so that is

giving the type of fear and effect that I don't have the right and they don't like me, so that makes it difficult for an undocumented immigrant to access medical services. And I think the popular Spanish news channels should say after news stories that you will not be deported if you access these services if you are undocumented. That does not take much time but it will be very important." Male participant

Conclusion

Based on the narratives collected in this study, several themes have emerged related to access to care for HIV+ Latino immigrants. Barriers most often faced by the participants were related to language and immigration status. Participants felt that not only were more translators needed, but the quality of the translations could be improved. Several participants felt that they did not receive equal access to services because of their English abilities. Although translators are often available to address language barriers, participants were often unsatisfied with the quality and skills of available translators. One such issue was related to "spontaneous translation," where staff untrained in translation or not fluent in Spanish were pulled in at a moment's notice. Another issue was the proficiency of translators. Several participants described experiences with translators who did not speak Spanish fluently.

Documentation required for some services were reported as difficult to obtain for those who were not permanent residents or citizens. Still, participants overall felt satisfied with the services they were receiving.

Money was the most frequently reported reason for immigrating to the United States. Participants often stated they were seeking "a better life" and described the differences between HIV-related care in Houston versus HIV-related care in their countries of origin.

Most participants received their HIV diagnoses at public hospitals after seeking emergency care for severe symptoms, or at community clinics during prenatal care. The majority of participants kept their HIV status a secret from friends and family. Common reactions from friends and family members were denial, fear or rejection due to stigma and misunderstandings about transmission.

The average amount of time between diagnosis and self-reported entry into care was 5 days, with total times ranging from 1 day to 7 years. Those who delayed entry into care for more than one month reported fear or denial, lack of information, work-related barriers or other circumstances.

When asked to recommend strategies for bringing HIV+ Latinos into care, participants said visibility and community education were the two most important approaches. Several participants who accessed services from Latino-specific organizations discussed the importance of receiving care in environments that were comfortable for them culturally and linguistically.

"I used to yell at [my Case Manager], why me? I am a good person, I just came here for the American dream, and look at what happened to me. And he said, you are living the American dream, because you are given medication, you are given medical care, that is the American dream, because you are able to stay healthy so that you can keep on your goal which is to work and provide a better life for your children. That is the American dream." Female – 10015

RESEARCH CONSENT FORM

Barriers to Care Among HIV Positive Latino Immigrants in the Houston Area

PURPOSE AND BACKGROUND

The Houston Ryan White Planning Council is conducting a research study to help understand the experiences of HIV positive Latino immigrants when accessing medical care.

PROCEDURES

If you agree to be in the study, the following will happen:

1. You will be asked to complete a brief one-page questionnaire about your basic background and demographic information. It should take approximately ten minutes to complete the questionnaire.

2. You will be interviewed by Jen Haejin Kim, Health Planner for Ryan White Planning Council Office of Support. The interview will cover various topics related to your experiences as an HIV+ Latino immigrant. The interview will be recorded, and is expected to last about 60 to 90 minutes.

3. These research activities will be done at various agencies and/or other agreed upon locations, and will take a total time of about one and a half hours.

4. Data collected from the questionnaires will be entered into a database for summary purposes. No identifying information will be collected on the questionnaires or stored in any database. All participation is confidential. All interviews will be transcribed and stored as word processing files. No identifying information will be included in the transcripts.

5. At the completion of this study, you are welcome to request copies of the final report and any presentations.

6. If at any time during the questionnaire and/or interview you would like to stop participating, just let Jen Haejin Kim know.

RISKS/DISCOMFORTS

Some of interview questions or topics may make you uncomfortable or upset, but you are free to decline to answer any questions you do not wish to answer or to leave the interview at any time.

BENEFITS

There will be no direct, immediate benefit to you from participating in this study. However, the information that you provide may help planning bodies, service providers and health professionals better understand the experiences HIV+ Latinos face when accessing medical care.

COSTS

There will be no costs to you as a result of taking part in this study.

PAYMENT

You will receive $30 in Wal-Mart or Kroger gift cards for your participation in the study.

QUESTIONS

If you have any questions or concerns about participation in this study, feel free to contact:

Jen Haejin Kim
Health Planner
(713) 572-3729 – voice
(713) 841 – 0738 – pager
Jennifer.Kim@hctx.net

or

Tori Williams
Manager
(713) 572-3724 – voice
Victoria.Williams@hctx.net

CONSENT

PARTICIPATION IN RESEARCH IS ALWAYS VOLUNTARY. You are free to decline to be in this study or to withdraw from it at any point.

You may also withdraw your authorization (consent) for this study by contacting Jen Haejin Kim to inform her of your decision.

If you wish to participate in this study, you should sign below. You will be given a copy of this consent form to keep for your records.

_____ _____

Date Subject's Signature for Consent

_____ _____

Date Signature of Person Obtaining Consent

FORMULARIO DE CONSENTIMIENTO PARA EFECTUAR EL ESTUDIO

Barreras en recibir cuidado por los inmigrantes Latinos VIH positivo en el área de Houston

PROPÓSITO E HISTORIAL

El Concilio de Planificación Ryan White de Houston está actualmente conduciendo una investigación a efecto de un mejor entendimiento sobre las experiencias de los inmigrantes Latinos VIH positivos cuando acceden al cuidado médico.

PROCEDIMIENTOS

Si usted acepta participar en el estudio, los procedimientos serán los siguientes:

1. Le pedirán que complete un cuestionario breve de una página referente a su antecedente básico e información demográfica. Tomará aproximadamente 10 minutos para completar el cuestionario.
2. Será entrevistado/a por Jen Haejin Kim, Planeadora de la Salud de la Oficina de Apoyo del Concilio de Planificación Ryan White. La entrevista cubrirá varios temas relacionados a su experiencia como inmigrante Latino con el VIH. Dicha entrevista será grabada y podría durar de 60 a 90 minutos.
3. Las actividades de la investigación tomarán lugar en varias agencias y/o en otras ubicaciones confirmadas en concordancia y con anticipación. Tomará un total de aproximadamente una hora y media.
4. La información reunida de los cuestionarios será introducida en una base de datos con el propósito de hacer un resumen. No se reunirá o almacenará en dicha base de datos ninguna información que identifique a la persona entrevistada. Toda participación es confidencial. Todas las entrevistas serán transcritas y almacenadas en los archivos del procesador de textos. No se incluirá información identificable en la trascripción.
5. Al término del estudio, podrá solicitar copias del reporte final y de cualquier otra presentación.
6. Si en cualquier momento durante el cuestionario y/o entrevista desea dejar de participar, simplemente avise a Jen Haejin Kim.

RIESGOS/INCOMODIDADES

Algunas de las preguntas o temas de la entrevista podrían incomodarlo/a o preocuparlo/a. Usted puede libremente rehusar contestar cualquier pregunta que lo/a incomode. Inclusive, tiene el derecho de retirarse de la entrevista en cualquier momento que lo desee.

BENEFICIOS

Usted no tendrá ningún beneficio directo o inmediato por la participación en este estudio. Sin embargo, la información que usted provea ayudará a los grupos de planificación, a los proveedores de servicios y a los profesionales de la salud para alcanzar un mejor entendimiento sobre las experiencias de los Latinos con el VIH cuando acceden al cuidado médico.

PRECIOS

No tendrá gasto alguno de su parte por participar en este estudio.

PAGO

Recibirá una tarjeta con un valor de $30 de Walmart o Kroger por haber participado en el estudio.

PREGUNTAS

Si tiene preguntas o preocupaciones concernientes a su participación en este estudio, por favor contáctese con:

Jen Haejin Kim
Health Planner
(713) 572-3729 – voice
(713) 841 – 0738 – pager
Jennifer.Kim@hctx.net

o

Tori Williams
Manager
(713) 572-3724 – voice
Victoria.Williams@hctx.net

CONSENTIMIENTO

LA PARTICIPACIÓN EN LA INVESTIGACIÓN ES SIEMPRE VOLUNTARIA. Usted tiene la libertad de rehusar de la participación o el derecho de retirarse en cualquier momento.

También puede retirar su autorización (consentimiento) contactando a Jen Haejin Kim e informándole de su decisión.

Si desea participar en este estudio, debe firmar en la línea a continuación. Se le proporcionará una copia de este consentimiento para su archivo personal.

_____ _____
Fecha Firma del Participante

_____ _____
Fecha Firma de la Persona Obteniendo el Consentimiento

APPENDIX B
PRE-INTERVIEW QUESTIONNAIRE

Gender:	Male Female Transgender
Age:	_____
Year of arrival to the US:	_____
Country of origin:	_____
Immigration status:	Citizen Permanent Resident Refugee Visa Other
Sexual Orientation:	Straight Gay Bisexual Lesbian Prefer not to say
Job Status	Work full-time Work part-time Temp work/Odd Jobs Do not work
Average monthly Income	_____
Marital Status	Married Never married Divorced Widowed
Do you live alone?	Yes No How many people do you live with? _____
Do you have any children?	Yes How many?_____ Do they live with you? _____ No
Date of HIV diagnosis:	_____
How often do you see a doctor for HIV?	_____
Are you currently taking any HIV medications?	Yes No
Are you currently taking any non-HIV medications?	Yes No

Acknowledgement of Receipt

I, _____, acknowledge that I received a $30 Wal-Mart/Kroger Gift Card (_____) in appreciation for participating in the Houston Ryan White Planning Council's Latino Study.

Initials of Participant: _____ Date: _____

Signature of Witness: _____ Date: _____

RWPC Copy

- -

Acknowledgement of Receipt

I, _____, acknowledge that I received a $30 Wal-Mart/Kroger Gift Card (_____) in appreciation for participating in the Houston Ryan White Planning Council's Latino Study.

Initials of Participant: _____ Date: _____

Signature of Witness: _____ Date: _____

Participant Copy

Barriers to Care among HIV+ Youth

A special study of the Comprehensive HIV Planning Committee Houston Ryan White Planning Council

Approved
May 2006

Prepared by
Jen Haejin Kim, MPH
Health Planner
Ryan White Planning Council Office of Support

Introduction

In 2005, the Comprehensive HIV Planning Committee of the Houston Ryan White Planning Council commissioned three "special studies" focusing on populations of interest, which were identified based on findings from the 2005 Needs Assessment, and HIV/AIDS surveillance data. The first of the special populations identified by the Committee was HIV positive youth.

The purpose of this study was to better understand the factors that enhance or impede entry (and retention) into care for HIV positive youth. The focus on entry to care was triggered by HRSA's unmet need initiative, and the Houston Ryan White Planning Council's efforts to bring HIV+ individuals into medical care. The findings in this study are based on the personal narratives of HIV+ youth living in the Houston EMA. We chose to utilize one on one interviews in order to collect in-depth information not usually captured in quantitative surveys, and to give a direct voice to the experiences of HIV+ youth.

HIV/AIDS among youth in the Houston EMA

During 2004, there were 7,093 living HIV cases (including 796 new HIV diagnoses) and 9,967 living AIDS cases (including 936 new AIDS diagnoses) in the six-county Houston EMA. A total of 229 youth between the ages of 13 and 24 were newly diagnosed with HIV or AIDS. The HIV infection rate among youth is higher than the AIDS infection rate, suggesting an increasing trend in new infections among this population. Youth aged 13 to 24 exhibited increasing infections with more than 2 times more HIV diagnoses per 100,000 than AIDS diagnoses.

Young women, age 13 to 24, were a significantly higher percentage of new HIV infections than women overall. They represented over 45% of new HIV diagnoses and 50% of living HIV/AIDS cases among 13 to 24 year olds.

Of 13 to 24 year old MSMs living with HIV, only 2% are white/Anglo and 10% are MSM of color. Representing 68% of new cases, black youth are disproportionately affected by HIV and AIDS. They are, by far, the largest group infected with HIV disease, comprising 69% of those living with either HIV or AIDS. This compares to 11% for white youth and 20% for Hispanic youth.

2005 Needs Assessment

Youth aged 13 to 24 years constituted only 10% of the total Needs Assessment sample (n=39); however, nearly 60% of those youth reported being out-of-care.

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

- 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%); and
- I was actively using (street drugs or alcohol) (23%).

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

- Food Bank
- Primary Medical Care
- Utility Assistance
- Rental Assistance
- Housing Related Services
- Health Insurance
- Medical Case Management
- Household Items
- Nutritional Supplements
- Oral Health

Methodology

The findings of this study were based on 23 semi-structured one-on-one interviews with HIV+ youth between the ages of 18 and 24. Although HRSA and HIV/AIDS surveillance data define youth as 13 to 24 year olds, this study limited interviews to youth 18 years and above due to research consent

issues for younger participants. Participants received gift cards at the conclusion of each interview. All interviews were conducted in English by the Health Planner in the Ryan White Planning Council Office of Support.

At the onset of each meeting, youth were informed that their participation was completely voluntary and that they could stop the interview at any time. A Research Assent form, containing details of the study and assurances of confidentiality, was reviewed with each participant (see Appendix A). Upon receiving the participant's assent, a brief one-page questionnaire was administered (see Appendix B).

To further protect confidentiality, first and last names were not collected during the course of the study, participants signed only their initials on the Research Assent and gift card receipt forms, and a unique identification number was assigned to each participant.

Interview items were based on findings from a literature search on access to care among HIV+ youth, and lasted between 30 to 100 minutes. All interviews were recorded using a digital voice recorder, transcribed into Microsoft Word and coded and analyzed using AnSWR, a qualitative analysis program developed by the CDC.

Participants

Twenty-three (N=23) HIV positive youth participated in one-on-one semi structured interviews. Ten (44%) were male and 13 (56%) were female. None of the participants identified as transgender. Ages ranged from 18 to 24 years, with an average age of 20.6 yrs (sd = 2.37). Ethnicity and race were collected as two separate variables. Four (17%) participants identified as Hispanic, 19 (83%) Black, 2 (9%) White and 2 (9%) identified as Other ("Mexican," "Puerto Rican"). Approximately half of the participants identified as heterosexual (n=12; 52%), 6(26%) gay, 3 (13%) bisexual and 2 (9%) preferred not to disclose. None of the participants identified as lesbian.

While the vast majority of participants (n=17; 74%) were not in school, five (22%) participants were full time students and 1 (4%) was a part time student. The majority of participants (n=17; 74%) did not work, one (4%) worked full time, 3 (13%) worked part time and 2 (9%) worked temp or odd jobs. Most participants (n=20; 87%) lived with an average of 3 other people. Five (22%) participants had children (average = 1.2), and three (13%) said their children lived with them.

The average length of time being positive averaged at 2.4 years, though time ranged from 6 years to as recent as 2 months. The average time since last doctor's visit averaged at 41 days, and the majority of participants reported that they were not taking HIV medications (n=14; 64%). Only two participants had private insurance (through family members), 7 (30%) were on Medicaid and 13 (61%) "Other" or "Don't Know." During the course of the interviews, many of these 13 participants reported using the Gold Card or CHIP.

The following table shows the demographic breakdown of the 23 youth participants.

Participant Background Information (N=23)

Characteristics	
Gender	
Male	10 (44%)
Female	13 (56%)
Age	Range 18-24; Avg = 20.6; (sd=2.37)
Age at diagnosis	Range 13-24; Avg = 18.0; (sd=3.18)
Number of years HIV+	Range 0-6; Avg = 2.4; (sd=1.89)
Time since last visit to the doctor	Range = 0-8 months; Avg = 41 days; (sd=70.18)
Taking HIV Medications?	
Yes	8 (36%)
No	14 (64%)
Insurance Status	
Private	2 (9%)
Medicaid	7 (30%)
Other/Don't Know	13 (61%) *(Other = Gold Card, CHIP)*
Hispanic	
Yes	4 (17%)
Race	
Black	19 (83%)
White	2 (9%)
Other:	2 (9%)
Sexual Orientation	
Heterosexual	12 (52%)
Gay	6 (26%)
Bisexual	3 (13%)
Prefer not to say	2 (9%)
Currently in school?	
Full time student	5 (22%)
Part time student	1 (4%)
Not currently in school	17 (74%)
Job Status	
Work full time	1 (4%)
Work part time	3 (13%)
Temp work/odd jobs	2 (9%)
Do not work	17 (74%)
Live Alone?	
Yes	3 (13%)
No	20 (87%)
- How many?	Range 1-6; Avg = 3.1; (sd=1.76)
Children?	
Yes	5 (22%)
- How many?	Range 1-2; Avg = 1.2; (sd=.44)
- Do they live with you?	Yes = 3 (13%)

* Some categories may not total 23 because demographic information was missing for one participant.

Limitations

It is important to note that interviews were conducted with HIV+ youth, between 18 and 24 years old, who were willing and available to talk about their experiences. None of the participants were infected through perinatal transmission. Additionally, since study recruitment was conducted through service

providers, all participants were receiving medical and supportive services at the time of the interview. Therefore, the findings may not fully reflect the experiences of out-of-care HIV+ youth, perinatally infected youth and youth under the age of 18 in the Houston area. These limitations may affect the generalizability of the findings.

In addition to participant names, the names of specific case managers, doctors and service providers have been removed.

Results

Sources of messages about HIV/AIDS

For most participants, sex and STDs – let alone HIV or AIDS – were rarely discussed amongst their families. A few did have parents or family members who provided them with in-depth information about HIV, but the majority of participants stated that issues related to sexuality were rarely discussed amongst their families.

> *"That's one problem we had in our family; we don't have good communication, so we were never able to talk real open about STD's or HIV or drugs at all." (Female, 18)*
>
> *"It wasn't really a talked about situation in our house." (Female, 18)*
>
> *"My house we just never really talked about, about stuff like that." (Male, 19)*

In some cases, sex and STD were mentioned rather than HIV or AIDS:

> *"…my whole family was giving me rubbers. They was like, protect yourself 'cause I don't want you getting pregnant and whatever 'cause they got a lot of disease, but my mama never named them to me." (Female, 18)*
>
> *"…they would say, you know, protect yourself if you're doing it but not any in depth conversation." (Male, 19)*
>
> *"My mom was always telling me use a condom, you know, she's always, you know, I don't want any babies, you know, so always use a condom, you know. She never really like said anything about it. Specifically, it wasn't something that we talked about. She was more worried about the other ones then she was about HIV." (Male, 24)*
>
> *"My mama, she never told me about HIV and if she did I probably wasn't paying attention. She only told me about STD's, Herpes and all that other stuff. She ain't never said nothing about HIV and I never heard of it." (Female, 18)*

School health classes were common sources of information about STDS.

> *"… it was hush, hush. You know, they don't talk about, you know, they talk about typical, gonorrhea and all this. They don't talk about HIV or AIDS. They don't talk about that, you know. They preach abstinence but of course, we're not doing, you know, you know they don't offer condoms. Only you can get condoms in the clinic if you can get in a clinic. But they didn't preach that. We didn't hear about that at school, you know, we heard the typical gonorrhea, chlamydia and all that and stuff but you didn't really hear HIV or AIDS." (Female, 24)*

Some participants said that the messages they got about HIV/AIDS were that it was scary and deadly.

> *"…it was bad, that if you had it you're a bad person and all that." (Female, 18)*
> *"it's something you get from, you know, having sex, unprotected and you could die from it." (Male, 22)*

Youth also talked about ignorance and stigma in the community regarding HIV/AIDS.

> *"…everybody say you dirty if you got AIDS." (Female, 18)*

"… you tell them [that you're positive] and they like, oh, get away from me…" (Female, 18)

"…I know ya'll are old and ya'll are set in your ways, and you don't want nobody with HIV to touch y'all or touch your silverware or anything like that because you think you're gonna get it because we done touched your silverware. And no, you're not gonna get it because we touched your silverware." (Male, 24)

"You know people think just because you have HIV you're nasty and you're dirty and all this stuff; that's not true…." (Female, 19)

HIV Testing Experiences

HIV testing sites utilized by participants included clinics (i.e., Planned Parenthood, mobile clinics, Live Clinic, People's Clinic, Houston Area Community Services (HACS), Kelsey Seybold, Montrose Clinic), hospitals (i.e., Ben Taub, Memorial Hermann, City of Houston) and jails/detention centers.

Some youth sought HIV tests as part of normal routine care.

"…I knew every year you go for your check-up, you know, every year you get a HIV test." (Female, 24)

"Oh, I always got tested. We had to all make sure we had, 'cause if you had sex you had to make sure you're healthy…I had gotten like gonorrhea like three times." (Female, 18)

"…. my wife. She had said, you know, I'm hungry they have some chips over there let's go get tested and get some food, you know, it was just like, you know, a playful thing, you know let's go get some chips and get some soda and take the test, you know. " (Male, 24)

The youth who received their diagnoses in hospitals were tested during prenatal care, childbirth or hospitalization.

"Because the doctor was wondering why I was having so many miscarriages and so he just put the test. That was one of the tests he wanted to run." (Female, 23)

"Oh, I had when I was pregnant and my baby died and that's how I found out 'cause they gave me a test," (Female, 18)

" I was pregnant and, I guess it was mandatory that when you're pregnant you have to get one." (Female, 18)

"…my knees were hurting and he tested my t-cell lymph nodes, said they were swollen and felt a couple different areas like under my arm pits and he suggested I get tested..." (Male, 22)

"I just gotten sick and they couldn't figure out what was wrong with me and I ended up having to take one." (Male, 22)

Other youth were tested following partner notification or blood donation.

"….a lady from high school said I had a note from the Texas Health Department saying call immediately. It was posted on my mail box and posted on my apartment door. So I called the woman…as soon as possible and she say…she say I'm sorry to tell you this but…you been named by someone that have it, that you should get checked immediately." (Female, 19)

"I used to donate plasma…and I think I went one day to donate and they gave me this piece of paper stating that I need to go get checked, so I went and got checked and that's how I got referred…" (Female, 22)

In most cases, participants tested outside of the jail system received referrals to case manager or a public clinic during their post-test counseling sessions. However, the youth did not seem to feel the post-test info was very useful.

"They just gave me papers so I can take to [a public clinic] and that's all they said. " (Male, 18)

"Well they give me that; I can go and get treated at this clinic…I can go get treated there and that was it. They gave me some 1-800 numbers to call if I needed somebody to talk to about it. That was it." (Male, 20)

"They really didn't give me any information. I didn't start getting information until I got with the people I'm with now. She just was, she just basically did the testing…." (Male, 19)

A few participants reported negative experiences after receiving their diagnoses.

"…they referred me to this counselor and she was like well, do you understand what HIV is and…you know, talking to me like I'm slow but then she, she went like if you had kept your legs closed then you wouldn't be in this predicament." (Female, 24)

"The director or whatever, he was, I just didn't like his attitude. He seemed like, you know, kind of like treated like you was diseased animal, you know, just the way he talked to you, his body language, he didn't care like he wouldn't try to help you, you know. He just give you all this information and then you sort it out it was like no comfort. When you hear something like that, you know, you want comfort, you know, you don't want sternness. " (Male, 24)

Family Support

Approximately half of the participants received positive support from family members, particularly their mothers, and disclosures to romantic partners were always positive. Other participants had not disclosed their status to their family members, or were met with silence and/or denial. Only a few participants reported negative or violent reactions from relatives.

"My family be doing talking trash to me, doing me wrong, but then I got to tell my family what if the shoe was on the other foot, what if you have HIV and I didn't, you know what I mean, what if the shoe was on the other foot; how would you like at them tables 'cause you wouldn't want me saying that type of stuff to you so why would you say that type of, that, that hurting things to me?" (Male, 20)

"My mama, she cried but she took care of me at that time but then she start changing on me. She didn't put me out she just started changing on me like being mean..." (Female, 18)

"…my mama girl friend beat me and left a little, what you call, a hickey on my head and I was bleeding everywhere so she told me to pick that blood up around her children." (Female, 18)

"…my daddy they know about it too and his wife tell me not to eat off the same plate as their children or nobody else. " (Female, 18)

Personal Reactions

Personal reactions to being diagnosed varied among the participants. Some reacted with extreme depression and self-isolation.

"I didn't believe, I was like, uh-uh, you wrong. " (Female, 18)

"…kind of feel like I let myself down and other people around me." (Male, 19)

"Suicide. I think about that all the time, I think about it…I cry and it hurt just to think about it and it really do, just to think about it." (Female, 18)

"…when I first caught this virus, I used to hide from people. I used to not want to come outside and play with my friends. I used to stay inside and hide and my mama used to come in my room and say, why you hiding? 'Cause I don't want my friends to laugh at me." (Female, 18)

"…every time I think about it, it scares me, it makes me cry…" (Female, 18)

"…I really didn't think I could make it. I didn't know if I was gonna wake up the next day…" (Female, 18)

"I cried myself to sleep like and I just like really couldn't believe that I had that. I didn't want to believe it but I know that it was true..." (Female, 19)

"I thought people wouldn't want be around me." (Female, 19)

"I think like my whole world, just like turned up side down, it was like, just, I can't even explain it, I was like so shocked and scared and worried and the angry and upset and frustrated and like just confused, you know, what the hell I was gonna do, I didn't know where I was going…I was like homeless so that added to the problems..." (Male, 24)

"I don't even talk about it. You know. The only time you know I think about it is when I start getting sick and then I get like depressed" (Male, 22)

"…when they first told me I had HIV I thought I was just, well that's the end of my life" (Female, 22)

"That's like the hardest thing I deal with day by day, my depression." (Female, 22)

Other participants responded positively to their diagnoses, viewing their HIV status as part of a larger purpose in life. It should be noted that these participants were actively involved in a youth support group.

"I wasn't ashamed. It helped me to bring out what used to be me and you know I used to have a picture say this used to be me before I got positive and this is me now. But it's different. It's a difference in my soul and difference in my being." (Female, 24)

"…I use that HIV thing for a motivation…as a blessing and a guidance for others, you know, to help other people." (Female, 24)

"…to me its like, its in my blood it's not me, it's me, it's my name, you know what I'm saying, but it's me, it's not, it's not….it's inside my blood, my blood red, it's just something I got, it's not going to define me…" (Female, 18)

"…I wasn't worried about it because if God puts it in my hands and says I want you to have this so you can go and tell your story to people, then that's His calling, there's nothing I can do for that. And that was His calling, I ended up getting it, but it's not a death sentence to me at all. It's more of a now you have something to go and tell people." (Male, 24)

"It's not a death sentence – look at me, I'm happy, I'm go lucky. You never see me in my room going I can't do nothing because I have HIV, I might as well sit here and let it take over me. Oh, no no no. I done have too many friends, people I've known throughout the years who get it and do that, sit back and I'm just gonna let it take over me, there's nothing I can do. Yeah, there's something you can do. Get up and be yourself. Go, go out and have some fun. You just a regular person. You just have a sickness. It's the same thing for people with high blood pressure, they don't sit there and say well I'm gonna let this blood pressure take over and let it kill me. No. Go out and have fun. Go do what you're supposed to be doing. Live your life like you're living it, like you lived it before you found out. That's how I am, I'm living my life like I did before I found out. Ain't nothing's stopped from what I used to do." (Male, 24)

Entry into Care

Virtually all participants reported seeking medical care no more than three weeks following their diagnosis. Only one participant was not immediately connected to medical care due to a miscommunication with her case manager. Youth who were diagnosed in hospitals or prison systems received immediate medical care, and those diagnosed in clinics or other testing sites sought medical care within a few days to three weeks following their diagnoses.

In most cases, participants were referred to specific medical care sites by their testing sites. In some cases, hospital staff contacted specific case managers, who then arranged transportation for the youth to and from a public clinic. Other youth reported local resource directories as very helpful referral sources.

Although all of the study participants were receiving medical care at the time of the interview, several reported going in and out of care in past years. Denial, pride, drug abuse, being busy and simply "not wanting it" were reasons for "falling" out of care.

> *"…I guess in between all that time I was in denial…I would act like I didn't know what was going on with me sometimes." (Female, 18)*
>
> *"…in the back of my mind I knew I had it but I just didn't, I was, I was living with my pride, you know, I mean, how would that look I'm going to the clinic, 'hey yo man, I'd like to checked up on my HIV positive', you know, I mean, that's, HIV is, that's a big worry, even though it's small that's a big word to some folks and that's a hard word, you know, that's what, I mean, that's what I was looking at my pride, you know." (Male, 20)*
>
> *"I started going back to drugs and stuff, so my main concern was not my health anymore basically, so I just stopped going to the doctors and I would go, I would go only when I didn't feel, when I felt like weak or something you know, I would tell my mama I think I need to go get my labs done so I could see that I'm not going into 200 or something, you know. That, that was the only other time I was concerned." (Female, 18)*
>
> *"…I was working and going to school and it got really busy and hectic and I just forgot all about the appointments. I done forgot that, like I was really sick…" (Female, 18)*
>
> *"I wasn't getting help because I didn't want it. I mean, at that time I didn't want it you know, I knew people to go to, you know. I had already met people to go to but it was my choice not to go back to them, you know." (Female, 18)*

During the interview, participants were asked to give their opinions on why some HIV+ youth might not be receiving adequate levels of appropriate medical care. Responses fell under three categories. Some participants felt that the cost of medication was to blame for inadequate levels of care among HIV+ youth.

> *"I think it's because they either first, they don't have Medicaid or they can't afford it." (Female, 19)*
>
> *"…us youth around here we, you have majority that's living like very poor and they can't afford medicines like that and it's hard to get help. So I think that's like basically their problem." (Female, 18)*

A few participants felt that the attitude of doctors played a role.

> *"…some doctors might not want to be around HIV person." (Female, 18)*

And other participants felt that the onus of receiving adequate medical care fell on the HIV+ youth. They suggested that youth might feel scared, in denial, concerned about confidentiality or simply not interested in seeking care.

> *"…young people aren't getting enough medical care because they don't feel there's any hope or they just gave up because there's no cure." (Male, 22)*
> *"Denial and they can't tell people. Some of them, you know, they probably on their parent's insurance and they just can't get up and go to the doctor." (Male, 19)*
>
> *"I'm thinking it's because sometimes they just don't want to come out and say they're HIV positive, so maybe they're not doing what they need to, to get the care that they want, or that*

they need. Because I believe, everywhere you go, you're gonna find doctors who go beyond that level to help HIV+ youth, just like they'd try to help the HIV+ adults, so I wouldn't necessarily put it on the doctors, I would put it on the youth…they need to carry out the initiative to go out and find some ways to get to doctors offices, to get the medical attention that they need…if you can't get your mom to take you, then get on the bus. That's all you have to do, get on the bus. I mean, we're in the city of Houston, Houston has one of the largest HIV/AIDS resources in the United States. So really, there is no excuse for youth in the City of Houston to say that they're not getting no medical attention because it's here. I'm getting it. It's really here. It's youth that really need to step up and do what they need to do." (Male, 24)

Service Providers

Participants were asked to describe traits of an "ideal" Case Manager. By far, most said they desired from their case managers a genuine sense of concern, friendliness and willingness to help.

"Every time I tell her I need something she try her best for me to get it." (Female, 23)

"Just a cool person…Just someone I could, like just to talk to…you know, someone I could talk to and relate to." (Male, 19)

"Somebody that tries to help me, somebody who honest that they gonna try to help me get on my meds and stuff like that and someone who cares about me." (Male, 18)

"Someone caring, someone that you can talk to not as a friend, well yes, as a friend, a mother, a counselor. I'm not looking for a friend but I want somebody to confide in. If I really have something on my, on my chest that I really need to tell someone and I don't want to tell my parents or my mom or my girlfriend or anything, I can come to you and I know you'll keep it confidential or you'll try to talk to me to help me out about it…I would want a social worker that will treat me the same way as they want to be treated, put it that way. I just want respect and understanding between each other. You understand where I'm coming from; I understand where you coming from." (Female, 22)

Based on the interviews, it appeared that there were three programs that worked collaboratively to coordinate entry into and retention in care for youth. These three programs consisted of a particular public clinic and two local agencies. A common "entry to care" scenario involved the participant being referred to the particular public clinic following diagnosis. Prior to, or during, the participant's first visit to that public clinic, a youth-designated case manager on site would meet with them and coordinate his or her medical and supportive care. This case manager would also connect the participant with one or both of the local agencies. One of the local agencies provided case management and a youth support group for all youth up to 24 years of age. The other agency provided case management only targeted to young MSM of color. There seemed to be a high level of coordination amongst these three agencies, and appeared seamless to the youth.

It was also clear that two specific case managers located at the particular public clinic and a local agency played an especially integral role in helping youth enter into care. These case managers work hand-in-hand, and rarely was one case manager's name mentioned without the other. The youth under their care often described them as a pair.

"You know them two…they're a good team and I like that. That's a good team 'cause they, they, they conference on things, they talk about patients that don't want to show up or don't want to come to the doctor, you know. They, they talk about it, you know, I mean, they, they a good team. They kind of like a Shaq and Kobe. A good thing." (Male, 20)

Every youth under the care of these case managers spoke of them very highly. They clearly valued not only the services provided by the case managers, but also the individual level of care and concern they received.

"…if I saw anybody who was just diagnosed and under the age limit I would refer them to [the Case Manager] because when I say that she is awesome, I say it from the bottom, not 'cause I like her, but from the bottom of my heart because she has done things that she didn't have to do, and that I have never seen anybody do." (Female, 24)

"…she tell you what you need to be told and she helps you when you need to be helped." (Female, 24)

"She act your second mama. She is there. She is good support. She should get like award or something 'cause she's really good. You call like 2 o'clock in the morning and just, man, you could talk to her all the time." (Female, 18)

"I didn't want to really go to [a public clinic]…she was telling me if you want me to I'll take you, she'll take you to [a public clinic] and get you information. She driving out her car. I don't think they pay her for that for her niceness. She drives out there on North Side, you know what I'm saying, so she cool, 'cause she cares. She really cares. She invite you to her church, she care, she really care…she ain't doing it for profit or kudos, she doing from her heart, so she's real like that." (Female, 18)

"…you can call her and talk to her about any problem. If she can help you, she will try her best to help you. If she can't she'll tell you she can't help you right then and, but she will try her best to help you…" (Male, 20)

"…she look out for us. She make sure we have our best, she look over us like we her own kids." (Female, 18)

"I never tell her when the appointments, she just finds, magically finds out herself, and she meets me up there. All I see is her sitting there before I get there." (Female, 18)

"[Case Manager A] know we young but [she] can relate to our level and that what make her so special because she can relate. She can relate to us; she can relate to everybody in her group…I give her the utmost respect, you know, because a lot of things…she shouldn't have to do, but I mean, she go out of her way to do 'em, you know what I mean, 'cause it's not that because that's her job, it's that because she, she want to see us get better in life…and even though some of us mess up, you know, some of us mess up, some of us don't mess up, you know what I mean, she still, even if we do mess up she still there, know what I'm saying, with an open hands, open arms, she still there. " (Male, 20)

Participants were also asked to describe traits of an ideal doctor. Common themes were patience, good listener, friendly, knowledgeable, caring, open, trustworthy and non-judgmental. Participants who were very satisfied with their current doctor referred to him/her as examples.

"…when I talk to her she doesn't interrupt me…she lets me get it all out, you know, so, I mean, that's what I look for, you know. " (Female, 18)

"…you feel like you can talk to her about anything." (Female, 23)

"She actually listens." (Female, 18)

"Knowledgeable, caring and understanding; understand the person where they coming from." (Female, 18)

"…they don't talk to you like you're beneath them. They talk to you like you're a human being and, you know, that's respect for you, you know. " (Male, 20)

"…they show that they really care, I mean, they're not just kind of doing because it's a job, that they really genuinely really care about each person." (Male, 20)

"When they be kind, courteous to their patients. Make their patients feel good about themselves. Help their patient out by you know, if their patient tell 'em like something they need

refer them to somebody they know that could help them out with that issue." (Female, 18)

"Her qualities is she doesn't look at us like, oh my god they have this, or oh my god they're young and they're just dumb and stupid because they have HIV now, no she doesn't look at us like that…she tries to help us out whenever we need help. She will always overstep her boundaries to get us help. She will. She will always overstep her boundaries to get us help. And whenever we need her, she's just a phone call away because we all have her cell phone number too. Most doctors won't even go that far to give you their cellphone numbers, she has given every single one of us her cellphone number, so we all have ways to get in contact with her whenever we have problems or questions or anything. And other qualities about her, she's caring, she's very caring. She's very caring. She loves the field she's in, and she loves dealing with her patients." (Male, 24)

"…somebody who you feel like you can see very easily and also treat you like you're a member of the family or has a…personable relationship with you, a very familiar relationship; spends more time with you…" (Male, 24)

"…they actually care about me and try to help me." (Female, 19)

"…she's always trying to call me and check on me so…makes me happy that somebody cares." (Female, 18)

"She explains everything and goes through everything and like she, she told me when I first met her she was like, now you're gonna have to listen to me and you're gonna have to just sit there and listen and if I keep repeating myself it's because you need to know, and every time she said something or she repeats everything she says like three or four times, and it's like okay I finally understand you can stop repeating yourself. But, it's good she's like that..." (Female, 19)

"Someone who is warm, down to earth, someone that…I don't have to actually necessarily look at them as the doctor, I can look at them as someone who can help me, and that is easy to talk to about the situation and is non-judgmental." (Male, 22)

"If they act like they on your level, they really understand you….more a friendship form than medically….." (Male, 22)

In addition to case managers and doctors, participants also described traits of an ideal HIV/AIDS agency. The most common trait was friendly staff. The vast majority of participants utilized medical and supportive services at a public clinic, and most rated their experiences there as very positive.

"I like the way the clinic is, the way the clinic run, you know, it's either with the nurses and the cashier, you know, they talk to you real nice…It's really, it's real wonderful. It's real site, a real good site." (Male, 20)

"…they nice and stuff. They treat you well. The doctors, the nurses are all nice. Nobody has a attitude, so it's really okay with me 'cause nobody don't treat you bad, make you feel down about yourself." (Female, 18)

"…they nice, they have a lot of stuff that you can do that they give out. A lot of stuff like clothes, food, stuff. They like every month, like whatever holiday, they always have something for the patient that come here, it's free. Medication's free." (Female, 18)

"I just want to have one doctor where I can just stick to one and that doctor will know what's going on with me instead of starting all over with another doctor and trying to communicate trying to have like, like a friendship with her instead of having to start all over and having different doctors." (Male, 18)

"I thought it was going to be a lot of sickly people and a lot of people in very, very bad situations I had to be around a lot of people on drugs and every thing like that, but it really wasn't like that at all. I was comfortable with the person I was working with. She made sure that, you know, I

did every thing correctly and, you know, I was, everybody was very nice. Everyone greeted me with a smile, warm smile; it was a great, you know, process." (Male, 22)

"I loved it there because it, everyone seemed helpful…everyone had a smile, they actually had me smiling and I felt, I felt horrible yesterday." (Female, 22)

" Everyone there helped me out. Everyone there has happy faces, their attitudes are nice, then everyone is up to par even if you go there feeling like you're down. You're not going to leave like that. Somebody gonna make you laugh before you leave." (Female, 22)

"I went from the first floor to the second floor, moved all around the second floor, moved back down to the first floor, went to the pharmacy and left. That's just how quick it was." (Female, 22)

"I have fun when I go there." (Male, 22)

However, some participants were not comfortable with the size of a public clinic, its designation as an HIV-specific site and inconsistency of providers.

"I haven't a stable doctor ever since I started with [a public clinic]…it's been different doctors. It hasn't been the same." (Male, 18)

"[a public clinic] was a little bit too big and busy." (Female, 18)

"I wouldn't want to see people look, seeing me and then after that they might say something to one of their friends, I saw this, this person at [a public clinic] and then the person tell the other person and it's going, everybody's going to know and I don't want that. 'Cause you know, somebody will say something to a friend and they gonna find out about you and I don't want that." (Male, 18)

"…if they're just a HIV clinic you automatically linked if you're in the area that you have HIV so, you know, I just better going to just a regular hospital then to go somewhere like that." (Male, 22)

Many participants attended one or both youth support groups offered at a public clinic and a local agency. When asked to describe what they valued about those support groups, participants emphasized the importance of the "safe space," confidentiality, openness and peer support they received through the groups. Several participants also described the groups as a "family."

"…it's been so confidential…what I say stays in there, and from what I see too, so, I mean, it's a…safe box that can always come to, you know, if I'm having trouble at home or something or something I can't talk about at home I can come here and talk…" (Female, 18)

"…to have a safe haven, you know, it's a difference that's unexplainable…" (Female, 24)

"Everybody is voicing their opinion and everybody comments and everybody tries to help you. If I bust out crying they gonna get up to console me, comfort me..." (Female, 24)

"You know, we help each other, we real positive role model to each other, you know, we help and we push and we motivate each other, so you know if they hear somebody that's gonna motivate them and help them and show them, they'll go to the doctor." (Female, 24)

"…what I like about it is you can come express your feelings and you can cry and you can do anything, everybody will support you and everybody will be there to help you 'cause we all in the same situation. " (Female, 19)

"…I rather would be around people that are diagnosed like me because they can understand where I'm coming from. They can understand my pain." (Female, 22)

"…we're a family. We all consider ourselves family." (Male, 24)

"… I felt depressed at the beginning 'cause I felt like I was by myself, but once the class had

ended I felt, I felt good. I felt real good. I felt like I was around people that I had known for years…I felt like I was around another family." (Female, 22)

Service Needs

These support groups were targeted to youth up to 24 years old. When asked about the importance of age-specific services, participants had mixed responses. While age may not be a universally valued factor in choosing and utilizing services, it is important to many of study participants. Unsurprisingly, the majority of study participants who attended the support groups favored services that targeted youth.

> *"I feel more comfortable here because I'm gonna listen to somebody who's my age." (Female, 18)*
>
> *"I feel comfortable with them 'cause they around my age group but I know that I'm not really like the only one that's eighteen that's HIV positive. For about half of the people is eighteen years old. So I really feel comfortable around them, like, if I was around the older age group; they're like, I think they look at me as I been too young to be having HIV and that be like; I don't know if they'd try to put me down but if I, I didn't know that everybody probably be like looking at me or whatever, like why's that little girl up in here? Like she's usually like too young to be going through what she's going through." (Female, 19)*
>
> *"It would be good for youth to have their own group, because some youth don't want to be in front of more older adults to tell them anything because I think it's a trust issue, I guess, because I can sit there and tell anybody about anything, but then there are some things that I won't tell an adult, but I'll tell somebody around my own age. Because if you tell an adult, sometimes if you tell an adult something, they'll look at you crazy because either they don't know what you're talking about, or they don't think that you should even be talking like that, or whatever, you know, they have their own agenda." (Male, 24)*

Other study participants stated that age did not play a role in their satisfaction with services – many stated, "age does not matter to me."

> *"it doesn't matter what age they are or anything like that. I sit in the room with anybody as long as you treat me the same way you want to be treated. It doesn't matter what age they are because you'd be surprised an old person can be a happy spirit as a young person." (Female, 22)*

When asked about needs not being met, participants listed housing, job assistance, rental assistance and day care. Participants also expressed a desire for more flexible eligibility requirements for services, more youth programs, community education and easier entry into care.

> *"…my one wish would be to have no requirements for medication; just sign up and you'll get service the next day. My second wish is that anyone that's sick and need, really need them, that they shouldn't be turned down, they should be, like I said before, get help. Basically, it really don't, I don't really need a second or third wish 'cause my main wish is no requirement that you should help them with no turn downs." (Female, 18)*
>
> *"if anything should change, it would be to come up with more youth programs for the city of Houston, because then it would make every youth in here not be afraid to go ahead and take that test…" (Male, 24)*
>
> *"…it'll be nice if they find a place, somebody tells you that you're positive, you immediately get them into counseling, you immediately try to help them, immediately try to offer them some assistance. That, that time is really the most critical time because they get to thinking crazy…" (Female, 24)*

Transportation is a frequently identified barrier to care in the Houston EMA; however, fewer study participants listed transportation as a barrier than expected. Many credited the bus passes and cab

assistance provided by various organizations. A few reported that their case managers drove them to and from medical appointments. Two participants said their case managers would drive 45 minutes each way to accompany them to appointments.

> *"…there's not a huge barrier now because I was recently given the little bus card which is very handy now, so I'm making it around on the bus..." (Male, 22)*
>
> *"…they have vouchers where you can catch the bus or they have cabs can pick you up take you to places…and even your doctor's appointment when you need them." (Female, 19)*
>
> *"…I'm riding the bus just like everybody else. And if you can't get your mom to take you, then get on the bus. That's all you have to do, get on the bus." (Male, 24)*
>
> *"[this program] was more helpful to me because they actually provide transportation and so that was our big thing so I think that's why we just really went for this program and didn't go for other ones…" (Male, 19)*

Still, participants acknowledged that without such assistance from these agencies, transportation would be a much larger issue. When asked about the hardest thing about finding services in Houston, one youth replied, "Getting there. Basically getting there." (Female, 19).

> *"I had to ride like four different buses just to get here. I don't think I'd be able to make it and I probably wouldn't be able to make some of my clinic appointments either if I didn't have the cab service…." (Female, 18)*

Conclusion

Based on the findings in this study, several themes emerged regarding entry to, and retention in, care among HIV+ youth. Satisfaction with service providers, the existence of a support network of some kind and access to transportation resources stood out as major factors influencing how HIV+ youth experienced care. And while not all youth reported age as an important factor in choosing services, youth-specific support groups were extremely important sources of emotional and peer support for many participants.

It is again important to note that interviews were conducted with HIV+ youth, between 18 and 24 years old, who were willing and available to talk about their experiences. None of the participants were infected through perinatal transmission. Additionally, since study recruitment was conducted through service providers, all participants were receiving medical and supportive services at the time of the interview. Therefore, the findings may not fully reflect the experiences of out-of-care HIV+ youth, perinatally infected youth and youth under the age of 18 in the Houston area. These limitations may affect the generalizability of the findings.

A number of participants reported that the first time they learned the facts about HIV/AIDS was after receiving their diagnoses. Many did not discuss issues of sex, STDs or HIV/AIDS with their families – and they did not feel susceptible to HIV. This suggests the need for additional prevention education efforts targeted to youth.

HIV testing sites were the first point of entry for most participants, which suggest that immediate linkage into medical care are crucial at time of diagnosis.

In a study by Flicker, et al (2005), youth identified a wide range of emotional response to their HIV status; however feelings of isolation, loneliness and hopelessness were dominant. According to Stein and Rotheram-Borus. (2004), coping styles among HIV positive youth were characterized as passive, depressive withdrawal, escapist and positive. Personal reactions to their HIV status varied among the participants from extreme depression and isolation to believing their HIV status was part of a larger purpose in life. Some participants responded positively to their diagnoses. It should be noted that these participants were actively involved in a youth support group. These findings suggest that mental

health services and treatment education are important in helping with feelings of depression or hopelessness following diagnosis.

Virtually all participants reported seeking medical care no more than three weeks following their diagnosis. Youth who were diagnosed in hospitals or prison systems received immediate medical care, and those diagnosed in clinics or other testing sites sought medical care within a few days to three weeks following their diagnoses.

In most cases, participants were referred to specific medical care sites by their testing sites. In some cases, hospital staff contacted specific case managers, who then arranged transportation for the youth to and from a public clinic. Other youth reported using resources books as referral resources.

Although all of the study participants were receiving medical care at the time of the interview, several reported going in and out of care in past years. Denial, pride, drug abuse, being busy and simply "not wanting it" were reasons for "falling" out of care.

During the interview, participants were asked to give their opinions on why some HIV+ youth might not be receiving adequate levels of appropriate medical care. Responses fell under three categories. Some participants felt that the cost of medication was to blame for inadequate levels of care among HIV+ youth. And other participants felt that the onus of receiving adequate medical care fell on the HIV+ youth. Some said that some youth may feel scared, are in denial, concerned about others finding out or simply not interested in seeking care.

Service Providers

Participants were asked to describe traits of an "ideal" case manager. By far, most said they desired from their case managers a genuine sense of concern, friendliness and willingness to help.

Based on the interviews, it appeared that there were three programs that worked collaboratively to coordinate entry into and retention in care for youth. These three programs consisted of a particular public clinic and two local agencies. A common "entry to care" scenario involved the participant being referred to the particular public clinic following diagnosis. Prior to, or during, the participant's first visit to that public clinic, a youth-designated case manager on site would meet with them and coordinate his or her medical and supportive care. This case manager would also connect the participant with one or both of the local agencies. One of the local agencies provided case management and a youth support group for all youth up to 24 years of age. The other agency provided case management only targeted to young MSM of color. There seemed to be a high level of coordination amongst these three agencies, and appeared seamless to the youth.
It was also clear that two specific case managers located at the particular public clinic and a local agency played an especially integral role in helping youth enter into care. These case managers work hand-in-hand, and rarely was one case manager's name mentioned without the other. The youth under their care often described them as a pair.

Participants were also asked to describe traits of an ideal doctor. Common themes were patience, good listener, friendly, knowledgeable, caring, open, trustworthy and non-judgmental. Participants who were very satisfied with their current doctor referred to him/her as examples.

In addition to case managers and doctors, participants also described traits of an ideal HIV/AIDS agency. The most common trait was friendly staff. The vast majority of participants utilized medical and supportive services at a public clinic, and most rated their experiences there as very positive. However, some participants were not comfortable with the size of a particular public clinic, its designation as an HIV-specific site and inconsistency of providers.

Many participants attended one or both youth support groups offered at a public clinic and a local CBO.

When asked to describe what they valued about those support groups, participants emphasized the importance of the "safe space," confidentiality, openness and peer support they received through the groups. Several participants also described the groups as a "family."

Service Needs

The support groups were targeted to youth up to 24 years old. When asked about the importance of age-specific services, participants had mixed responses. While age may not be a universally valued factor in choosing and utilizing services, it is important to many of study participants. Unsurprisingly, the majority of study participants who attended the support groups favored services that targeted youth. Other study participants stated that age did not play a role in their satisfaction with services – many stated, "age does not matter to me."

When asked about needs not being met, participants listed housing, job assistance, rental assistance and day care. Participants also expressed a desire for more flexible eligibility requirements for services, more youth programs, community education and easier entry into care.

Transportation is a frequently identified barrier to care in the Houston EMA; however, fewer study participants listed transportation as a barrier than expected. Many credited the bus passes and cab assistance provided by various organizations. A few reported that their case managers drove them to and from medical appointments. Two participants said their case managers would drive 45 minutes each way to accompany them to appointments.

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APPENDIX A

RESEARCH ASSENT FORM

Barriers to Care Among HIV Positive Youth in the Houston Area

PURPOSE AND BACKGROUND

The Houston Ryan White Planning Council is conducting a research study to help understand the experiences of HIV positive youth (ages 18-24) when accessing medical care. You are being asked to participate in this study because you are an eligible youth.

PROCEDURES

If you agree to be in the study, the following will happen:

1. You will be asked to complete a brief one-page questionnaire about your basic background and demographic information. It should take approximately ten minutes to complete the questionnaire.
2. You will be interviewed by Jen Haejin Kim, Health Planner for Ryan White Planning Council Office of Support. The interview will cover various topics related to your experiences as an HIV+ youth. The interview will be recorded, and is expected to last about 60 minutes.
3. These research activities will be done at various agencies and/or other agreed upon locations, and will take a total time of about one and a half hours.
4. Data collected from the questionnaires will be entered into a database for summary purposes. No identifying information will be collected on the questionnaires or stored in any database. All participation is confidential. All interviews will be transcribed and stored as word processing files. No identifying information will be included in the transcripts.
5. At the completion of this study, you are welcome to request copies of the final report and any presentations.
6. If at any time during the questionnaire and/or interview you would like to stop participating, just let Jen Haejin Kim know.

RISKS/DISCOMFORTS

Some of interview questions or topics may make you uncomfortable or upset, but you are free to decline to answer any questions you do not wish to answer or to leave the interview at any time.

BENEFITS

There will be no direct, immediate benefit to you from participating in this study. However, the information that you provide may help planning bodies, service providers and health professionals better understand the experiences HIV+ youth face when accessing medical care.

COSTS

There will be no costs to you as a result of taking part in this study.

PAYMENT

You will receive $30 in Wal-Mart gift cards for your participation in the study. You will receive the gift cards after completion of both the questionnaire and the interview.

QUESTIONS

If you have any questions or concerns about participation in this study, feel free to contact:

Jen Haejin Kim, MPH
Health Planner
(713) 572-3729 – voice
(713) 841-0738 – pager
Jennifer_Kim@itc.co.harris.tx.us

CONSENT

PARTICIPATION IN RESEARCH IS ALWAYS VOLUNTARY. You are free to decline to be in this study or to withdraw from it at any point.

You may also withdraw your authorization (consent) for this study by contacting Jen Haejin Kim to inform her of your decision.

If you wish to participate in this study, you should sign below. You will be given a copy of this consent form to keep for your records.

_____ _____

Date Subject's Signature for Consent

_____ _____

Date Signature of Person Obtaining Consent

APPENDIX B
PRE-INTERVIEW QUESTIONNAIRE

Gender:	Male Female Transgender
Age:	_____
Are you Hispanic?	Yes No
Race:	Black White Asian Native American/Pacific Islander
Sexual Orientation:	Straight Gay Bi Lesbian
Are you currently in school?	Yes, I'm a full-time student Yes, I'm a part-time student No, I am not currently in school
Job Status	Work full-time Work part-time Temp work/Odd Jobs Do not work
Do you live alone?	Yes No How many people do you live with? _____
Do you have any children?	Yes How many?_____ Do they live with you? _____ No
What is your Zip Code?	_____
What kind of insurance do you have?	Private Medicaid Other:_____ Do not know
How old were you when you were diagnosed?	_____
When was the last time you saw a doctor?	_____
Are you currently taking any HIV medications?	Yes No

Appendix B

Needs Assessment Tools:

Client Survey 653
Approved March 8, 2007

Cue Cards 665
Supportive Services list and Barriers list for first part of client survey

Provider Survey 667
Approved March 15, 2007

2008 Needs Assessment Consumer Survey

Council Approved: March 8, 2007

First, we'll ask you about services that are related to HIV/AIDS medical care		
Service	**In the past 12 months, did you have any difficulty getting this service?**	**If you had difficulty getting this service, please tell us why** ***(Use the list on the yellow sheet to write in the appropriate response number. If your difficulty is not listed, then please describe it below)***
Medical care visits with a doctor, nurse or physician assistant (PA)	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
HIV/AIDS medications	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
Dentist visits	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
Case Management services that help you <u>only</u> with medical care, substance abuse or mental health services	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
Home Health Care (administrator will provide more user-friendly definition)	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
Psychiatric services or medicine for mental health problems	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
Psychological counseling services	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
Alcohol or substance abuse treatment services (outpatient and inpatient)	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
Rehabilitation services (physical or speech therapy, low vision training) ordered by your doctor	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____

From the list on the yellow sheet, what are the FIVE (5) services that you think are most important in helping you cope with HIV/AIDS-related health issues?

Service	In the past 12 months, did you have any difficulty getting this service?	If you had difficulty getting this service, please tell us why *(Use the list on the yellow sheet to write in the appropriate response number. If your difficulty is not listed, then please describe it below)*
	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____
	I had some difficulty getting this service It was very easy to get this service I did not need this service	Barrier(s): _____ _____ _____ _____ _____ Other: _____

HIV TESTING & DIAGNOSIS HISTORY

1. **When were you diagnosed with HIV?** (month/year**)** _____

2. **Where did you receive your HIV diagnosis?**

Private doctor	HIV-specific testing site	Community testing location (bar, health fair, etc.)
Emergency Room	Public or community clinic	Alcohol or drug treatment facility
In hospital stay	Jail or prison	Other:_____

3. **When you received your diagnosis, did someone at the testing site help you get any of the following services? (Choose all that apply)**

Information about HIV/AIDS	Help with food or shelter	None of the above
Medical services	Alcohol or drug treatment services	
Counseling	Other:_____	

4. **What were the reasons you were tested for HIV? (Choose all that apply)**

A doctor or nurse recommended it	Felt sick	During pregnancy care
Had sex with someone who was HIV+	Engaged in risky behavior	Other:_____
Was in the emergency room/hospital	Was in prison or jail	

SERVICES

5. **After you were diagnosed with HIV, how much time passed before you saw a doctor for HIV?**

Less than 1 month	Between 6-12 months	I have never seen a doctor for HIV
Between 1-6 months	More than 12 months	

6. **If you waited more than 6 months before seeing a doctor for HIV, what were the reasons? (Choose all that apply)**

I was afraid	I didn't want to believe I was infected	I was depressed or had emotional problems
I didn't feel sick	I didn't want to take any medications	I didn't have a stable place to live
I was in jail/prison	I didn't have the money	Other:_____
I was doing drugs		

7. **After you were diagnosed with HIV, how much time passed before you had a CD4 or viral load test?**

Less than 1 month	Between 6-12 months	I have never had a CD4 or viral load test
Between 1-6 months	More than 12 months	

8. **If you waited more than 6 months before having a CD4 or viral load test, what were the reasons? (Choose all that apply)**

I was afraid	I didn't want to believe I was infected	I was depressed or had emotional problems
I didn't feel sick	I didn't want to take any medications	I didn't have a stable place to live
I was in jail/prison	I didn't have the money	Other:_____
I was doing drugs		

9. **After you first saw a medical provider for HIV, was there ever a time that you stopped going to the doctor for more than 6 months?** Yes No

If yes, **what were the reasons? (Choose all that apply)**

Case manager left	Did not want to take medications	Tired of regimen, wanted to take a break
Doctor left	Bad experience with provider	Felt fine, wasn't sick, no symptoms
Agency closed down	Lost stable housing	Worried about side effects from medications
Doing drugs, relapsed	Lost my job	Denial – didn't want to believe I was infected
Program closed down	Lost health insurance	Other:_____

10. **Where was the first place you received care from a doctor for HIV?**

Private clinic or doctor's office	Prison/Jail	Emergency Room/Hospital	I have not received care for HIV
Public clinic or community health center	VA Hospital	Other:_____	

11. **Where do you receive medical care most often?**

Private clinic or doctor's office	Prison/Jail	Emergency Room/Hospital	I have not received care for HIV
Public clinic or community health center	VA Hospital	Other:_____	

12. **In the past 6 months, have you gone to an emergency room because you felt sick?**
Yes No

13. **In the past 6 months, have you been admitted to a hospital for one or more nights?**
Yes No

14. **Is there a Case Manager, social worker or counselor (a specific person at a clinic, hospital or community organization) whose job it is to help you get services?**
Yes No Don't Know

15. **During the past month have you experienced any of the following? (Choose all that apply)**

Trouble with thinking, concentrating, or memory	Trouble with mouth or swallowing
Depressed or sad; trouble sleeping	Nausea, vomiting, diarrhea, abdominal pain
Aches, fatigue, lightheadedness, weak all over	Coughing, wheezing, or chest pain; trouble breathing
Fevers, chills, sweats	Rash, itch, herpes or other skin trouble
Poor appetite, weight loss	Numbness, tingling or pain in an arm or leg
Trouble with eyes or ears	None of the above
Trouble with nose or sinuses; headache	Other: _____

HIV/AIDS MEDICATIONS

16. **Are you currently taking medicine for HIV?** No Yes
    a. **If Yes, how many pills do you take in one day for HIV?** _____

17. **If you are currently taking meds, which of the following best describes you during the past month? (Choose all that apply)**

I have not missed any doses in the past month	I took about half of my doses
I have missed a few doses in the last month, but took nearly all my doses	I took some of my doses, but not half
I took more than half of my doses, but not nearly all	Other: _____

18. Has a nurse, doctor or case manager ever talked to you about ways to stay on schedule with your HIV medicine? Yes No

19. If you are not currently taking HIV medications, what are the reasons? (Choose all that apply)

There were too many unpleasant side effects
They were not effective for me
They were too difficult to take as prescribed
No doctor has ever offered them to me
I choose not to take them
My doctor did not think it was a good idea for me
t-cell count too high / still too healthy
Cannot pay for meds / don't have insurance for them
I don't want anyone to know I'm taking HIV medications
Other: _____

20. How many pills do you take in one day for conditions other than HIV? _____

21. Are you taking medicine for any of the following non-HIV conditions? (Choose all that apply)

Diabetes
High blood pressure
High cholesterol
Depression, emotional problems
None of the above
Other:_____

22. How often do you have trouble paying for these or other non-HIV medications?

Never Less than half the time More than half the time Always

HEALTH STATUS

23. How would you describe your health overall?

Excellent Good Fair Poor

24. During the past month, has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

No Yes, some of the time Yes, all of the time

25. When was the last time you saw a doctor, nurse or physician assistant (PA) for your HIV?

Within the last 6 months Between 6-12 months More than 1 year Never/Don't Know

26. When was the last time you had a viral load test?

Within the last 6 months Between 6-12 months More than 1 year Never/Don't Know

27. When was the last time you had a CD4 or T-Cell test?

Within the last 6 months Between 6-12 months More than 1 year Never/Don't Know

28. When was the last time you were prescribed medicine for HIV?

Within the last 6 months Between 6-12 months More than 1 year Never/Don't Know

29. When you first started getting care for HIV, what was your CD4 or t-cell count?

Less than 50 50-99 100-199 200-349 350-499 500+ Don't know/can't remember

30. What is your CD4 or t-cell count now?

Less than 50 50-99 100-199 200-349 350-499 500+ Don't know/can't remember

31. Since you were diagnosed with HIV, have you been tested for Hepatitis C?

Yes No Don't Know

32. Are you currently positive for Hepatitis C? Yes No Don't Know

33. Have you had a skin test for TB? No Yes

If Yes, what was the result? Positive Negative Don't Know

34. Have you ever been told that you have active TB? Yes No Don't Know

(If you had active TB, you would have been treated with 4 or 5 different TB medicines for a couple months (about 10 pills per day) and 2 or 3 medicines for another 4 months).

HOUSING

35. Where do you most often sleep?

Apartment/House Group home/halfway house Shelter Street Other:_____

36. Do you feel your housing situation is stable?

Yes No

37. In the past year, has your housing situation made it difficult for you to get HIV care?

Yes No

a. If yes, what were those difficulties? (Choose all that apply)

I could not keep my HIV status private

I didn't have a place to store my medications

I had to use my money for food

I had to use my money for rent

I had to use my money for utilities

I had to use my money for household supplies

Other: _____

MENTAL HEALTH

38. In the past month, have you experienced any of the following? (Choose all that apply)

Serious depression

Serious anxiety or tension

Hallucinations

Serious thoughts of suicide

Attempted suicide

Trouble understanding, concentrating or remembering

Psychiatric or emotional problems requiring medication

Wanted to hurt or harm yourself (including self-mutilation)

Seriously wanted to hurt or harm someone else

Trouble controlling anger that led to physical violence

39. Since being diagnosed with HIV, have you talked to a counselor, therapist or psychologist for help with depression or emotional problems? Yes No

40. Since being diagnosed with HIV, have you talked to a doctor or psychiatrist for medications to treat depression or emotional problems? Yes No

41. Since being diagnosed with HIV, have you participated in a support group? Yes No

SOCIAL SUPPORT

42. Of all the people you feel close to, how many have you told about being HIV positive?

All Some None

43. There are people I can depend on to help me if I really need it. Yes No

SUBSTANCE USE

44. Within the past year, have you used any of the following substances? (Choose all that apply)

Inhalants (poppers, glue, gasoline, nitrous, ethyl)	Marijuana, Hashish (grass, weed)
Street methadone (non-treatment)	Heroin
Other opiates (opium, Demerol, morphine, talwin, vicodin, dilaudid)	Cocaine (powder), Crack
Barbituates (seconal, tuinal, downers)	Ecstasy, X, MDA, GHB
Hypnotics/Sedatives/Tranquilizers (Valium, Librium, Xanax, Ativan)	Ketamine (K, Special K)
Hallucinogens/Acid (LSD, psychedelics, PCP, angel dust, mushrooms, peyote, wet, fry, illy)	Other: _____
Amphetamines (speed, uppers, crystal meth, ice, glass)	None

45. In the last year, have you ever drunk more than you meant to? Yes No

46. In the last year, have you felt you wanted or needed to cut down on your drinking?
Yes No

47. In the last year, have you ever used drugs more than you meant to? Yes No

48. In the last year, have you felt you wanted or needed to cut down on your drug use?
Yes No

FINANCIAL RESOURCES

49. What is your job status?

Full time job, more than 30 hrs/week	Temp/contract/odd jobs	Unemployed
Part time job	Not working due to disability	Retired

50. During the past 6 months, what has been your average monthly income? _____

51. How many people depend on this income? _____Of these, how many are children under 18? _____

52. During the past 6 months, what income or assistance have you been receiving? (Choose all that apply)

None	Supplemental Security Income (SSI)	Workers Comp	Other:_____
Hourly wages/Salary	TANF/AFDC	Unemployment	
SSDI	Food stamps	Private disability	
Social Security	Rental subsidy/Section 8	VA benefits	

53. How do you pay for your medical care?

I don't receive medical care because I can't pay for it	VA	Medicare	Gold Card/County
Private insurance or COBRA	Medicaid	Self-pay	Other: _____

54. If you had private health insurance during the past year, did you know that assistance with copays, deductibles and premiums was available? Yes No

55. During the past year, have you received any of the following assistance paying for health insurance costs? (Choose all that apply)

Copays	Deductibles	No, I have not received any insurance assistance
Premiums	Other:_____	

a. Have you had any difficulty getting assistance paying for health insurance costs?
(Choose all that apply)

The services are not in my area
I don't know where to get the services
I would have to wait too long to get the services
The services cost too much
I was told I am not eligible for this service
I don't think I'm eligible to get this service
The people who run the services are not friendly
It's hard to make or keep appointments
It's hard for me to get there
There is no one to watch my kids if I go there
I'm afraid someone will find out about my HIV
People at the agency don't speak my language
My jail/prison history makes it hard to get services
Other:_____

DEMOGRAPHICS

56. What zip code do you live in? _____

57. What is your gender?

Male
Female
Transgender – Male to Female
Transgender – Female to Male
Other: _____

58. If you are female, are you currently pregnant? Yes No Don't Know

59. How old are you? _____

60. Are you of Hispanic origin? Yes No

61. What is your race/ethnicity?

White
Black/African American
Asian
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander
Other:_____
Multi racial

62. How do you identify yourself?

Straight/Heterosexual Gay/Lesbian Bisexual Undecided Prefer not to say

63. What language are you most comfortable speaking at home, or with family and friends?
_____

64. What language are you most comfortable speaking when you see a doctor? _____

65. Were you born in the United States? Yes No → What year did you come to the US? _____

66. What is your immigration status?

Citizen
Permanent Resident
Visa (student, work, tourist, etc)
Prefer not to say
Other: _____

67. What is the highest level of education you have completed?

Less than high school degree
High school degree/GED
College degree
Graduate/professional degree
Some technical training
None

68. During the past year, have you been released from jail or prison? Yes No

69. Are you eligible for veteran benefits? Yes No Don't Know

RISK BEHAVIORS

70. Who do you have sex with? Choose all that apply

Men Women Transgender Male to Female Transgender Female to Male

71. In the last 6 months, how many people did you have sex with? _____

72. In the past 6 months, did you exchange sex for drugs or money?

Yes No Prefer not to say

73. In the last 6 months, about how many of the people who you had sex with were anonymous sex partners (that is, people whose name you didn't know)? _____

74. What is the HIV status of your main sex partner? A main sex partner would be someone you live with or see a lot and feel a special emotional commitment to.

I do not have a main sex partner HIV positive HIV negative I am not sure Prefer not to say

75. In the last 6 months, how frequently did you and the people you had sex with talk about the chances of giving each other HIV?

I did not have sex in the past 6 months

It was not discussed

I told my HIV status to **everyone** I had sex with

I told my HIV status to **some** of the people I had sex with

76. In the last 6 months, how frequently did you and the people you had sex with talk about the chances of giving each other STDs?

I did not have sex in the past 6 months

It was not discussed

I told my STD status to **everyone** I had sex with

I told my STD status to **some** of the people I had sex with

77. In the last 6 months, did any of the people you had sex with have HIV?

I did not have sex in the past 6 months

No, **nobody** I had sex with had HIV

Yes, at least **some** of the people I had sex with had HIV

I'm not sure if the people I had sex with had HIV

78. In the last 6 months, did any of the people you had sex with have another STD?

I did not have sex in the past 6 months

No, **nobody** I had sex with had an STD

Yes, at least **some** of the people I had sex with had an STD

I'm not sure if the people I had sex with had an STD

79. In the last 6 months, did you use a needle to inject any substance, including steroids, hormones, silicone, and ink under your skin or into a vein? ***Please check only one.***

No Yes (please specify substances)_____ I prefer not to answer

80. In the last 6 months, how often did you use a needle to inject any substance? ***Please check only one.***

Less than two times a **month** 2 to 8 times a **month** 2 to 7 times a **week** More than once a **day**

This question doesn't apply to me because I didn't inject any substance in the last 6 months

81. In the last 6 months, how often did you use needles or works that somebody else may have used? ***Please check only one.***

Never Less than half the time About half the time More than half the time Always

This question doesn't apply to me because I didn't inject any substance

82. In the last 6 months, how often did you clean your needles or works with bleach? ***Please check only one.***

Never Less than half the time About half the time More than half the time Always

This question doesn't apply to me because I didn't inject any substance or use any needle or works that may have been used by somebody else

83. In the last 6 months, how often did you have sex while intoxicated or high? ***Please check only one.***

Never Less than half the time About half the time More than half the time Always

I did not have sex in the past 6 months

84. In the last 6 months, how often did you have vaginal or anal sex without a barrier (condom or female condom)? ***Please check only one.***

Never Less than half the time About half the time More than half the time Always

This question doesn't apply to me because I didn't have vaginal or anal sex in the last 6 months

85. The <u>last</u> time you had <u>vaginal</u> or <u>anal</u> sex, did you use a condom or other barrier? ***Please check only one.*** Yes No

You're done! ☺

Thank you for completing the 2008 HIV/AIDS Needs Assessment survey!

Side 1: Cue card for survey
(Referred to as the yellow sheet)

BARRIERS

The services are not in my area

I don't know where to get the services

I would have to wait too long to get the services

The services cost too much

I was told I am not eligible for this service

I don't think I'm eligible to get the services

The people who run the services are not friendly

It's hard to make or keep appointments

It's hard for me to get there

There is no one to watch my kids if I go there

I'm afraid someone will find out about my HIV

People at the agency don't speak my language

My jail/prison history makes it hard to get services

Other:_____

Side 2: Cue card for survey
(Referred to as the yellow sheet)

SERVICES

Child Care Services

Child Welfare Services (parenting education, foster care, child placement assistance, parental rights, juvenile court, CPS)

Day/Respite Care for Adults

Developmental Assessment (assistance for affected infants and children in relation to the educational system)

Emergency Financial Assistance (short term assistance with utilities, food, housing)

Employment Assistance (i.e., finding or keeping a job)

Food Bank

HIV Education for HIV Positive Individuals

Rental Assistance, Shelter Vouchers

Housing-Related Services (help with finding housing and housing information)

Legal Services (non-criminal services)

Nutritional Counseling

Permanency Planning (wills)

Referrals to Services

Referral to Clinical Research

Support Groups

Translation/Interpretation

Transportation (van transportation, bus passes, gas vouchers, taxi vouchers)

Household Items

Other:_____

PROVIDER SURVEY - NAG APPROVED 3/15/07

Name of Agency: _____

Primary Location:

_____
STREET ADDRESS

_____
CITY STATE ZIP

_____
TELEPHONE FAX EMAIL

_____
CONTACT PERSON AND TITLE

1. Which of the following statements best describes the activities of your agency, program, or practice? **Check as many as needed but as few as possible.** (NOTE: If the choices provided do not describe your agency, choose other and describe your agency.)

   Type of Agency:

   - ❑ Hospital or university-based clinic
   - ❑ Publicly funded community health center
   - ❑ Publicly funded community mental health center
   - ❑ Other community-based service organization (CBO)
   - ❑ Health department
   - ❑ Substance abuse treatment center
   - ❑ Solo/group private medical practice
   - ❑ Agency reporting for multiple fee-for-service providers
   - ❑ PLWHA coalition
   - ❑ VA facility
   - ❑ Prison/Jail
   - ❑ Home Care Agency/Hospice
   - ❑ Religious-related services/Community centers
   - ❑ Other (Please Specify): _____

2. For which counties does your agency provide HIV/AIDS care-related services? **(Check all that apply)**

❑ Austin	❑ Chambers
❑ Colorado	❑ Fort Bend
❑ Harris	❑ Liberty
❑ Montgomery	❑ Walker
❑ Waller	❑ Wharton
❑ Other counties (please list): _____	❑ Other counties (please list):_____
❑ Other counties (please list): _____	❑ Other counties (please list): _____

3.How do you serve clients who do not speak English? **(Check all that apply)**

- ❑ By hiring staff who speak languages other than English
- ❑ By ensuring that translators/interpreters are available when needed
- ❑ By translating patient materials into different languages
- ❑ Other (Please Specify): _____
- ❑ Our agency is not able to serve clients who do not speak English

4. Please enter the year that your agency first began providing HIV/AIDS care-related services:_____

5. Do you specifically target a particular population?

- ❑ *No, we target all populations equally*
- ❑ **Yes, check all that apply in each section below**

a. Race
- ❑ American Indian/Alaska Native
- ❑ Asian
- ❑ Black/African-American
- ❑ Native Hawaiian/Pacific Islander
- ❑ White
- ❑ Other (Please Specify): _____

b. Gender
- ❑ Male
- ❑ Female
- ❑ Transgender M-F
- ❑ Transgender F-M
- ❑ Other (Please Specify): _____

c. Age Group
- ❑ Under 13
- ❑ 13-24
- ❑ 25-44
- ❑ 45-64
- ❑ 65+
- ❑ All of the Above

d. Sexual Orientation
- ❑ Heterosexual
- ❑ Gay
- ❑ Lesbian
- ❑ Bisexual
- ❑ All of the Above

c. Do you target people of Hispanic origin? ❑ No ❑ Yes

6. For the most recent calendar year (January - December) prior to this survey, **please provide, if known**:

Estimated number of patients/clients served: _____

The estimated number of HIV/AIDS patients/clients you served over this time period: _____

7. For the most recent calendar year (January - December) prior to this survey, **identify/estimate** the number of your client population who fall under the following categories:

Ethnic Background	**Number of Clients**	**Estimate or Number who are HIV positive**	**We do not ask HIV status**
Hispanic or Latino			
Not Hispanic or Latino			
Racial Background	**Number of Clients**	**Estimate or Number who are HIV positive**	**We do not ask HIV status**
American Indian or Alaska Native			
Asian			
Black or African American			
Native Hawaiian or Pacific Islander			
White			
Gender	**Number of Clients**	**Estimate or Number who are HIV positive**	**We do not ask HIV status**
Male			
Female			
Transgender M-F			
Transgender F-M			
Age	**Number of Clients**	**Estimate or Number who are HIV positive**	**We do not ask HIV status**
Under 13			
13-24			
24-44			
45-64			
65+			
Sexual Orientation	**Number of Clients**	**Estimate or Number who are HIV positive**	**We do not ask HIV status**
Heterosexual			
Gay			
Lesbian			
Bisexual			

8. How are the costs of HIV client services covered? (**Check all that apply)**

Funding Source	Amount of funding
Ryan White CARE Act (Title I/Part A)	$_____
Ryan White CARE Act (Title II/Part B)	$_____
Ryan White CARE Act (Title III/Part C)	$_____
Ryan White CARE Act (Title IV/Part D)	$_____
Other Ryan White Funding (SPNS/AETC/Part F)	$_____
HOPWA	$_____
CDC	$_____
DSHS	$_____
DSHS Substance Abuse Block Grants	$_____
Medicaid	$_____
Medicare	$_____
Private Insurance	$_____
Client Fees	$_____
Foundations	$_____
Corporate Contributions	$_____
Individual Contributions	$_____
United Way	$_____
City/County Grant	$_____
Endowment	$_____
SAMHSA	$_____
Office of Minority Health (OMH)	$_____
Other HUD	$_____
Publicly Funded Research (NIH)	$_____
Privately Funded Research	$_____
Other (Please Specify):_____	$_____

9. How many direct service staff are employed by your agency? (Write the total number of full time equivalent staff you have for each type of staff position listed. For example: If you had 5 half-time/ part-time case managers that would equal 2.5 FTE case managers.) Please include contractors in your estimate.

Personnel Category	Number of Staff that provide services for people with HIV/AIDS
Clinical Staff	
Physician	
Nurse	
Physician's Assistant	
Psychiatrist	
Psychologist	
Medical Case Manager	
Mental Health Provider	
Social Worker	
Other Clinical Staff:	
Program Staff	
Community/Social Case Manager	
Health Educator	
Outreach Worker	
Program Manager/Director	
Other Program Staff:	
Consultant/Contractual	
Interpreter Services	
Other Consultant:	

10. Have you experienced any limitations to providing services to People Living with HIV or AIDS (PLWHA)? ❑ No ❑ Yes, **check all that apply**

Limitations	Yes	No	Not Applicable
There is a lack of funding for our agency	❑	❑	❑
Our staff are not comfortable working with HIV+ clients	❑	❑	❑
There is a lack of transportation to our services.	❑	❑	❑
Shortage of community partnerships/linkages (affecting referrals, etc.).	❑	❑	❑
There is a lack of other services the client needs at our program site.	❑	❑	❑
We have problems with issues like licensure, facility permits, etc.	❑	❑	❑
We just started providing services for HIV+ individuals.	❑	❑	❑
The waiting lists are too long at our agency.	❑	❑	❑
The community doesn't want our services.	❑	❑	❑
We cannot provide services in appropriate languages.	❑	❑	❑
We have a lack of childcare.	❑	❑	❑
Clients are unable to afford our service(s).	❑	❑	❑
The community is unaware of the availability of services.	❑	❑	❑
Insufficient Staff	❑	❑	❑
Immigration Issues	❑	❑	❑
Other (Please Specify): _____	❑	❑	❑

11. Please give the following information about your agency locations.
Attach an additional sheet if necessary.

Primary Service Location

Address:_____

City_____ **County**_____ **Zip**_____

Populations targeted at this location:

_____

Hours of operation for services at this location:

_____

Secondary Service Location

Address:_____

City_____ **County**_____ **Zip**_____

Populations targeted at this location:

_____

Hours of operation for services at this location:

_____

Third Service Location

Address:_____

City_____ **County**_____ **Zip**_____

Populations targeted at this location:

_____

Hours of operation for services at this location:

_____

Please answer the questions for each service category:

	Does your agency provide any of the following services?	If your agency does not provide this service, do you know where to refer clients?	Availability at locations
Ambulatory/Outpatient Medical Care *(including OB/GYN, pediatrics, vision care)*	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Assistance with Medication Costs	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Mental Health Services	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Oral Health Services	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Case Management Services			
Social Case Management	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Medical Case Management	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Prevention Case Management	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Substance Abuse Services			
Outpatient Treatment	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Residential Treatment	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Health Insurance *(Assistance with premiums, copays, deductibles)*	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location

	Does your agency provide any of the following services?	If your agency does not provide this service, do you know where to refer clients?	Availability at locations
Early Intervention Services (HIV education, information, lab services, care coordination services)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Referral to Clinical Research	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Nutritional Counseling	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Child Care Services	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Child Welfare Services	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Client Advocacy	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Psychosocial Support Services			
Support Groups	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
EIS/Developmental Assessment (Educational Services for Children)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Day/Respite Care	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Emergency Financial Assistance	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Medication	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Utilities	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Food	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Housing	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Food Bank	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Nutritional Supplements	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Health Education/Risk Reduction	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location

	Does your agency provide any of the following services?	If your agency does not provide this service, do you know where to refer clients?	Availability at locations
Rehabilitation Services			
Physical Therapy	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Speech Pathology	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Low Vision Training	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Home Health Care	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Hospice	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Treatment Adherence Counseling	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Housing	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Rental Assistance	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Shelter Vouchers	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Housing Related Services	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Outreach	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Referral Services	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Transportation			
Van Transportation	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Bus Passes	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Gas Voucher	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Taxi Voucher	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location

	Does your agency provide any of the following services?	If your agency does not provide this service, do you know where to refer clients?	Availability at locations
Legal Services	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Permanency Planning	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
HIV testing	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Other Support Services	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Interpreter Services	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Employment Assistance	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Household Items	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location
Other (Please specify): _____	❑ Yes ❑ No	❑ Yes ❑ No	❑ Primary Location ❑ Secondary Location ❑ Third location

12. What could the local or area HIV agencies and planning bodies do to help your agency better coordinate services with other providers in the area?

_____

_____

_____

13. List up to five agencies that you work with the most.

_____

_____

_____

_____

_____

14. What else would you like to add that might be helpful to local HIV Services Planning Bodies or agencies?

_____

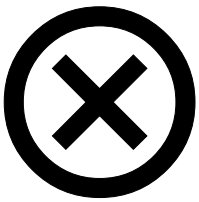
_____

_____

IF YOU PROVIDE PREVENTION SERVICES,

…Please continue to the next section.

IF YOU DO NOT PROVIDE PREVENTION SERVICES,



…You have completed the survey.

Thank you so much for your valuable time completing this survey! Please return your completed survey to:

Ryan White Planning Council
ATTN: DIANE BECK
2223 West Loop South, Suite 240
Houston, TX 77027

Or fax to: 713-572-3740

Prevention

1. Which of the following best describes your agency, program, or practice?
   (Check as many as needed, but as few as possible)
   - ❑ Hospital or university-based clinic
   - ❑ Publicly funded community health center
   - ❑ Publicly funded community mental health center
   - ❑ Other community-based service organization (CBO)
   - ❑ City health department or county health agency
   - ❑ Substance abuse treatment center
   - ❑ Solo/group private medical practice
   - ❑ Agency reporting for multiple fee-for-service providers
   - ❑ VA facility
   - ❑ Prison/Jail
   - ❑ Shelter, soup kitchen, or food bank
   - ❑ Home Care Agency/Hospice
   - ❑ Religious-related Community center/Service provider
   - ❑ Mobile testing unit
   - ❑ Mobile clinic
   - ❑ Other (Please Specify): _____

2. For which counties does your agency provide HIV prevention services? **(Check all that apply)**

- ❑ Austin
- ❑ Colorado
- ❑ Harris
- ❑ Montgomery
- ❑ Waller
- ❑ Other counties (please list): _____
- ❑ Chambers
- ❑ Fort Bend
- ❑ Liberty
- ❑ Walker
- ❑ Wharton
- ❑ Other counties (please list):_____

3. In what zip codes do you provide HIV prevention services?

_____

_____

4. How many staff who provide HIV prevention services are employed by your agency? (Write the total number of full time equivalent (FTE) staff you have for each type of position listed. Contractors being paid directly by your agency are considered paid staff. Please exclude administrative staff.)

_____Total

_____Licensed Medical Staff (MD, PA, NP, RN, LVN, etc)

_____Laboratory Staff

_____Counseling, Testing, Referral Staff

_____Outreach/ Recruitment Staff

_____Prevention case managers (non-licensed)

_____Social Workers (licensed)

_____Other *(please specify)*:_____

5. Do you provide post-exposure prophylaxis (PEP) at no charge or low cost to the client? **(Check all that apply)**

- ❑ No
- ❑ For victims of rape/ sexual assault
- ❑ No, but I know where to refer clients.
- ❑ For occupational exposure
- ❑ Upon request

6. Please give the following information about your agency locations: (attach an additional sheet if necessary)

Primary Service Location

Address:_____

City_____ County_____ Zip_____

Populations targeted at this location:

_____

Hours of operation for services at this location:

_____

Secondary Service Location

Address:_____

City_____ County_____ Zip_____

Populations targeted at this location:

_____

Hours of operation for services at this location:

_____

Third Service Location

Address:_____

City_____ County_____ Zip_____

Populations targeted at this location:

_____

Hours of operation for services at this location:

_____

7. Please check all of the following prevention services that your agency provides:
   - ❑ Targeted HIV screening
   - ❑ Protocol-Based Counseling (PBC)
   - ❑ Risk Assessment
   - ❑ Rapid and Conventional HIV antibody testing
   - ❑ Syphilis screening
   - ❑ Disclosure counseling
   - ❑ Post-disclosure counseling
   - ❑ Partner Counseling/Partner Elicitation (PCPE)
   - ❑ Testing in a traditional setting (clinic)
   - ❑ Testing in non-traditional settings (community, outreach, mass testing days, etc)
   - ❑ Social marketing
   - ❑ Prevention structural interventions
   - ❑ Comprehensive risk counseling services (CRCS)
   - ❑ HIV/STD Counseling Testing and Referral (CTR)
   - ❑ Health Education/ Risk Reduction (HE/RR)

8. Where are your HIV prevention services provided?
(Check all that apply)

- ❑ Primary and secondary schools
- ❑ Workplaces
- ❑ Street Outreach
- ❑ Homes
- ❑ Prisons/ jails
- ❑ Halfway house
- ❑ Shelters
- ❑ Bars/ Clubs
- ❑ Rural sites
- ❑ Commercial Sex Venues (bathhouses, adult bookstores, topless clubs, etc)
- ❑ Other (*Please specify*): _____
- ❑ Colleges and universities
- ❑ Churches/ Religious Sites
- ❑ Barber shops/ Beauty Parlors
- ❑ Housing Projects
- ❑ Drug rehabilitation centers
- ❑ Health fairs
- ❑ Hospitals/ Clinics
- ❑ Urban sites
- ❑ Public Sex Environments (parks, rest stops, beaches, parking lots, etc)
- ❑ Community Centers (YMCA, YWCA, Multi-service centers, gyms, etc)

9. Do you target a particular Behavioral Risk Group (BRG)/ Population of Special Need for Prevention Services? (**Check all that apply)**

- ❑ MSM ❑ FSM ❑ MSF ❑ M/IDU ❑ F/IDU ❑ SM/IDU
- ❑ Person Living with HIV/AIDS ❑ Youth (13-24) ❑ Transgender ❑ Incarcerated
- ❑ Recently released from Incarceration ❑ Sex Workers ❑ Pregnant women
- ❑ Victims of Rape or Sexual Violence ❑ Other (*please specify*): _____

10. From whom do you directly receive funds for your HIV prevention programs?

Federal

- ❑ CDC
- ❑ SAMHSA
- ❑ HRSA
- ❑ Other Federal: _____

State

- ❑ Department of State Health Services (DSHS)
- ❑ Other State: _____
- ❑ County
- ❑ City

- ❑ Non-governmental sources

11. Please provide a list of all HIV/AIDS-related prevention services funding received during the last three years. Include the funding source, amount and term (in fiscal years).

HIV/AIDS Prevention Services Funding (include all for the last three years)			
Funding Source	**Service**	**Amount**	**Term**

Appendix C

Official HRSA Service Definitions

2007 Service Category Definitions: From HRSA Ryan White Title I Manual and revised as necessary to reflect Care Act Data Report (CADR) definitions.

NOTE TO READERS:

The following list of HIV disease related service category definitions is the same list that has been adopted throughout the HIV/AIDS Bureau as a result of the CARE Act Data Report (CADR). The definitions are broad to accommodate the reporting requirements of all titles.

Grantees, planning councils, consortia, and service providers are reminded that per DSS Program Policy Guidance 2 (see Policies section of this manual):

> *"CARE Act funds are intended to support only the HIV disease related needs of eligible individuals. Grantees, planning councils, and consortia should be able to make an explicit connection between any service supported with CARE Act funds and the intended recipient's HIV status, or care-giving relationship to a person with HIV/AIDS."*

HEALTH CARE SERVICES

Ambulatory/Outpatient Medical Care. Provision of professional, diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient, community-based, and/or office-based setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care.

Primary Medical Care for the Treatment of HIV Infection includes the provision of care that is consistent with Public Health Service guidelines. Such care must include access to antiretrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Drug Reimbursement Program. Ongoing service/program to pay for approved pharmaceuticals and or medications for persons with no other payment source. Subcategories include:

- **State-Administered AIDS Drug Assistance Program (ADAP)**. Title II CARE Act-funded and administered program or other state-funded Drug Reimbursement Program.
- **Local/Consortium Drug Reimbursement Program**. A program established, operated, and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or to broaden eligibility beyond that established by a State-operated Title II or other State-funded Drug Reimbursement Program.
- **Medications** include prescription drugs provided through ADAP to prolong life or prevent the deterioration of health. The definition *does not include* medications that are dispensed or administered during the course of a regular medical visit or that are considered part of the services provided during that visit. If medications are paid for and dispensed as part of an *Emergency Financial Assistance Program*, they should be reported as such.

Health Insurance. A program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health-insurance program, including risk pools.

Home Health Care. Therapeutic, nursing, supportive and/or compensatory health services provided

by a licensed/certified home-health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case-management team that includes appropriate health-care professionals. Component services include:

- Durable medical equipment
- Homemaker or home-health aide services and personal care services
- Day treatment or other partial hospitalization services
- Intravenous and aerosolized drug therapy, including related prescription drugs
- Routine diagnostic testing administered in the home of the individual
- Appropriate mental health, developmental, and rehabilitation services

Home- and community-based care does not include inpatient hospital services or nursing home and other long-term care facilities.

Oral Health. Diagnostic, prophylactic, and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners.

Hospice Services:

Home-Based Hospice Care. Nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting.

Residential Hospice Care. Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

In-Patient Personnel Costs. Within the limitations of the legislation, up to ten percent of the total award is allowable for such costs, if it has been determined by the planning council that a shortage of inpatient personnel exists which has in turn resulted in inappropriate utilization of inpatient services.

Mental Health Services. Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental-health professional who is licensed or authorized within the State, including psychiatrists, psychologists, clinical-nurse specialists, social workers, and counselors.

Nutritional Counseling. Provision of nutrition education and/or counseling provided by a licensed/ registered dietitian outside of a primary care visit. Nutritional Counseling provided by other than a licensed/registered dietician should be provided under *Psychosocial support services*. Provision of food, meals, or nutritional supplements should be reported as a part of the subcategory, *Food and/ Home-Delivered Meals/Nutritional Supplements*, under Support Services.

Rehabilitation Services. Services provided by a licensed or authorized professional in accordance with an individualized plan of care which is intended to improve or maintain a client's quality of life and optimal capacity for self-care. This definition includes physical therapy, speech pathology, and low-vision training services.

Substance Abuse Services. Provision of treatment and/or counseling to address substance-abuse issues (including alcohol, legal and illegal drugs), provided in an outpatient or residential health service setting.

Treatment Adherence Services. Provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.

SUPPORT SERVICES

Child Care Services. The provision of care for the children of HIV positive clients while the clients are attending medical or other appointments. This does not include daycare while the client is at work.

Child Welfare Services. Assistance in placing children younger than 20 in temporary (foster care) or permanent (adoption) homes because their parents have died or are unable to care for them due to HIV-related illness.

Buddy/Companion Services. Activities provided by peers or volunteers to assist a client in performing household or personal tasks. Buddies also provide mental and social support to combat loneliness and isolation.

Case Management. A range of client-centered services that links clients with primary medical care, psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case-management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic reevaluation and revision of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.

Client Advocacy. Assessment of individual need, provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments.

Day or Respite Care. Home- or community-based non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of client or client's child.

Early Intervention Services (EIS). Counseling, testing, and referral services to PLWH who know their status but are not in primary medical care or who are recently diagnosed and are not in primary medical care for the purpose of facilitating access to HIV-related health services.

Emergency Financial Assistance. Provision of short-term payments for transportation, food, essential utilities, or medication assistance, which planning councils, Title II grantees, and consortia may allocate. These short-term payments must be carefully monitored to assure limited amounts, limited use, and for limited periods of time. Expenditures must be reported under the relevant service category.

Food Bank/Home Delivered Meals/Nutritional Supplements. Provision of food, meals, or nutritional supplements.

Health Education/Risk Reduction. (1) Provision of information, including the dissemination about medical and psychosocial support services and counseling or (2) preparation/distribution of materials in the context of medical and psychosocial support services to educate clients with HIV about methods to reduce the spread of HIV.

Housing Assistance. This assistance is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of Titles I, II and IV funds for short-term or emergency housing must be linked to medical and/or health-care services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

Housing Related Services. Includes assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State and Federal housing programs and how they can be accessed.

Legal Services. Legal services directly necessitated by a person's HIV status including: preparation of Powers of Attorney, Do Not Resuscitate Orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. See also, Permanency Planning and Child Welfare Services.

Outreach Services. Programs which have as their principal purpose identifying people with HIV disease, particularly those who know their HIV status so that they may become aware of and may be enrolled in ongoing HIV primary care and treatment. Outreach activities must be planned and delivered in coordination with State and local HIV-prevention outreach activities to avoid duplication of effort and to address a specific service need category identified through State and local needs assessment processes. Activities must be conducted in such a manner as to reach those known to have delayed seeking care. Outreach services should be continually reviewed and evaluated in order to maximize the probability of reaching individuals who do not know their HIV status or know their HIV status but are not actively in treatment. Broad activities that market the availability of health-care services for PLWH are not considered appropriate Title I outreach services.

Permanency Planning. The provision of social service counseling or legal counsel regarding:

- The drafting of wills or delegating powers of attorney
- The preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption

Psychosocial Support Services. Individual and/or group counseling, other than mental-health counseling, provided to clients, family, and/or friends by non-licensed counselors. May include psychosocial providers, peer counseling/support group services, caregiver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling, or education.

Referral. The act of directing a person to a service in-person or through telephone, written, or other forms of communication. Referral may be made formally from one clinical provider to another, within a case-management system by professional case managers, informally through support staff or as part of an outreach services program.

Transportation. Conveyance services provided to a client in order to access primary medical care or psychosocial support services. May be provided routinely or on an emergency basis.

Other Support Services. Direct support services not listed above, such as translation/ interpretation services.

Glossary

ADAP: AIDS Drug Assistance Program funded through Part B. Congress "earmarks" funds that must be used for ADAP, an important distinction since other Part B spending decisions are made locally.

AIDS: Acquired Immunodeficiency Syndrome. A clinical definition of illnesses caused by HIV: a CD4 count less than or equal to 200 or one of more diagnosed opportunistic infections.

Allocations: Refers to the distribution of dollar amounts or percentages of funding to established priorities – service categories, geographic areas, populations, or subpopulations. It does NOT involve contracting with or giving money to specific service providers.

ART: Antiretroviral therapy medication for treatment of HIV disease.

Centers for Disease Control and Prevention (CDC): The CDC is a Federal agency of the Department of Health and Human Services. Their 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.

CDC: See *Centers for Disease Control and Prevention*

CMV: Cytomegalovirus.

COBRA: The federal Consolidated Omnibus Budget Reconciliation Act gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

Commercial Sex Worker: Self-reported as having received money, drugs or favors in exchange for sex.

Community Planning: Steps taken and methods used by a community to gather information, interpret it, and produce a plan for rational decision-making.

Comorbid Condition: Non-HIV related health problem. A disease/condition, such as mental illness, substance abuse or hepatitis, co-existing with HIV.

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

EIS: Early Intervention Services.

EFA: Emergency Financial Assistance.

Eligible Metropolitan Area (EMA): A designation used by the Ryan White CARE Act to identify an area eligible for funds under Part A. It is 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: A disease that has spread rapidly among a large number of people within a short period of time.

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

Epidemiology: The study of the distribution and determinants of health-related states or events in specified populations and the application of this study to the control of health problems.

Ethnicity: A group of people who share the same place of origin, language or cultural ties.

GED: General Educational Development: high school equivalency diploma.

HCV: Hepatitis-C virus.

Health Resources and Services Administration (HRSA): HRSA directs national health programs that improve the nation's health by assuring equitable access to comprehensive, quality healthcare for all. HRSA works to improve and extend life for people living with HIV, provide primary health care to medically underserved people, serve women and children through state programs, and train a healthy workforce that is diverse and motivated to work in underserved communities. HRSA is responsible for administering the Ryan White CARE Act.

HIPAA: Health Insurance Portability and Accountability Act of 1996.

HIV: Human Immunodeficiency Virus, the virus that damages the immune system and causes AIDS.

HIV Services Delivery Area: A designation used by the Ryan White CARE Act to identify an area eligible for funds under Part B (formula funding to states and territories). There are six HSDAs in the East Texas Planning Area: Beaumont-Port Arthur (covering 3 counties), Galveston (covering 3 counties), Houston (covering 10 counties), Lufkin (covering 12 counties), Texarkana (covering 9 counties), and Tyler (covering 14 counties).

Homeless: Not having a stable residence in one's name. The term homeless applies equally to a person who has a temporary hotel room paid by a city program for indigents, a person sleeping in a shelter or in a car, and a person who is staying with a relative because she or he cannot afford to pay rent. It also refers to someone in temporary or transitional housing for substance abuse or other types of treatment.

HOPWA: Housing Opportunities for Persons with AIDS.

HRSA: See *Health Resources and Services Administration.*

HSDA: See *HIV Service Delivery Area.*

IDU: Injection drug use(r), the term used to refer to the people who or the act of injecting drugs using a needle or syringe.

In-Care: Self-reported as having had a CD4 test, viral load test or antiretroviral medication during the last 12 months.

Indigenous: A person currently living or working in the EMA and similar to the population studied.

Latino: Self-reported as Latino or Hispanic.

Mental Health Condition: Self-reported as having been treated for a mental disorder (such as depression, dementia or anxiety) in the past 12 months or unable to get needed services due to being "mentally impaired".

MCSM: Men of color who have sex with men exposure category.

MSM: Men who have sex with men exposure category.

NA: Narcotics Anonymous.

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

OB/GYN: Obstetrical/Gynecological services for women.

Out-of-Care: Self-reported as not having had a CD4 test, viral load test or antiretroviral medication during the last 12 months.

PLWHA: Person(s) Living with HIV or AIDS.

Prevalence: The rate or percentage of people living with an illness.

Primary Medical Care: Medical evaluation and clinical care that is consistent with U.S. Public Health Service guidelines for the treatment of HIV/AIDS.

Priorities: Refers to the formation of numerical priorities among various categories of services, such as primary care, case management, transportation, and among geographic areas, populations, or subpopulations if needed. The number one priority should reflect the service category or community considered the most critical for the use of funds.

Recently Released: Self-reported as having been released from jail/prison after being incarcerated during the past year.

Ryan White CARE Act: On August 18, 1990, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Reauthorized in 1996 and 2000, 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: Part A, Part B, Part C, Part AV, and Part F. The CARE Act is now the largest sole source of HIV funding in the Nation.

SAMHSA: Substance Abuse and Mental Health Services Administration.

SCSN: Statewide Coordinated Statement of Need.

Section 8: Federal housing assistance program.

Service Gap: All service needs not currently being met for all PLWHA, except for the need for primary health care, for individuals who know their status but are not in care. Service gaps include additional need for primary health care for those already receiving primary medical care ("in care"). They also include the need for supportive services for individuals not receiving primary medical care ("not in care").

Sexually Transmitted Infection (STI): Also known as Sexually Transmitted Disease (STD). An infection that is spread through intimate sexual contact. HIV, herpes, syphilis, and gonorrhea are commonly known STIs.

State Services: Formula funding from the State to support the care of people with HIV/AIDS. State-appropriated funds are used as partial matching for Ryan White Part B grants and are used for the same purposes.

STD: Sexually Transmitted Disease; see *Sexually Transmitted Infection.*

STI: See *Sexually Transmitted Infection.*
Substance Abuser: Self-reported as ever having a drug or alcohol problem.

Support Services: Those services that enable PLWHA to access and/or remain in primary medical care.

TB: Tuberculosis.

TDH: Texas Department of Health. See DSHS.

Part A: Under the Ryan White CARE Act, funding is given to eligible metropolitan areas hardest hit by the HIV epidemic. In the Houston EMA, Part A funding is given to the Harris County Judge, administered by the Harris County Health Department (HIV Services). The planning body for these funds is the Houston Area HIV Services Ryan White Planning Council.

Part B: 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 and families living with HIV/AIDS. There is an emphasis on rural populations. In Texas, funding is given to the Department of State Health Services.

Part C: Under the Ryan White CARE Act, funding is given to community-based organizations for outpatient early intervention services.

Part D: 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.

Unmet need: HRSA/HAB defines unmet need as the need for HIV-related health services by individuals with HIV who know their HIV status and are not receiving regular primary health care. Note: This definition differs from HRSA's definition of only primary medical care, defined as CD4 count, viral load test/HAART for those who know their HIV status.

VA: Department of Veterans Affairs.

WICY: Women, Infants, Children and Youth.

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