



2017 Austin Area HIV Needs Assessment

A collaboration of:

Austin Area Comprehensive HIV Planning Council

Austin HIV Needs Assessment Planning Work Groups

Ryan White funded service providers

People Living with HIV in the Austin Area and Ryan White
HIV/AIDS Program Clients

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Collaborating Partners:

The 2017 Austin Area HIV Needs Assessment is a collaboration of the following partners:

- ☐ Austin Area Comprehensive HIV Planning Council
- ☐ Austin HIV Needs Assessment Planning Work Groups
- ☐ Ryan White funded service providers
- ☐ People Living with HIV in the Austin Area and people who access Ryan White HIV/AIDS Program services

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EXECUTIVE SUMMARY

Introduction and Methods

The 2017 Austin Area HIV Needs Assessment identifies the HIV care and support services needed in the five-county Austin Transitional Grant Area (TGA). Service accessibility and service gaps are also explored—both overall and for particular populations. Programmatic and policy efforts can leverage this information to reduce HIV transmission and improve care for people living with HIV (PLWH).

A total of 445 PLWH who currently reside in the Austin TGA completed detailed needs assessment surveys. Surveys were administered at nine locations over a three month period, and were offered in English and Spanish.

HIV Service Needs in the Austin Area

Needs assessment participants were asked if they needed each of 13 HIV care and support services in the past 12 months, whether or not they received them.

The top five most needed services were:

1. HIV medical care
2. Medication assistance
3. Dental care
4. Case management
5. Foodbank

Service Accessibility and Gaps in the Austin Area

A service gap is defined as a service that is needed but not received by an individual. The largest service gaps were in dental care, outpatient substance use, and HIV support group services. Conversely, almost all survey participants who needed HIV medical appointments, medication assistance, and case management indicated that they were able to access these services.

Barriers to HIV Services in the Austin Area

Participants were asked to identify difficulties they experienced, if any, when accessing HIV care and support services.

The top three barriers to accessing services were:

1. Lack of knowledge about available resources
2. Transportation issues
3. Paperwork/enrollment processes at agencies

Additional analysis of barriers broken down by service category is available in Chapter 7: Service-Specific Fact Sheets.

HIV Care Continuum

Survey findings reflect the relatively high rates of linkage, retention and viral suppression of the Austin TGA. Most needs assessment participants (90%) reported being linked to care within 3 months of diagnosis, and 80% of participants reported no lapse in HIV medical care in the past 5 years. “Feeling fine” and “not feeling sick” were the most common reasons participants dropped out of medical care. 19% of survey participants indicated they missed three or more doses of anti-retroviral therapy (ART) medication in the past 30 days. Forgetting to take medications was the most common reason for non-adherence.

Co-Occurring Conditions

About half of PLHW reported having a co-occurring medical condition, and 1 in 3 PLWH indicated their co-occurring medical condition made it difficult for them to attend medical appointments or take ART medications. Most (62%) of survey participants reported having a current diagnosis for a mental health condition, and 1 in 4 participants indicated that their mental health made it difficult for them to attend medical appointments or take ART medications.

Social Determinants of Health

The 2017 Austin Area HIV Needs Assessment asked participants about their income, medical coverage, housing, transportation, and social support. Most (59%) of participants were worried about their ability to pay their monthly bills and housing costs. 1 in 4 participants currently have unstable housing, and 1 in 3 participants indicated that their transportation situation made it difficult for them to access HIV services.

HIV Prevention

Pre-exposure prophylaxis (PrEP) is a biomedical intervention, highly effective at preventing the transmission of HIV to HIV-negative sexual partners. Forty percent of survey participants did not know what PrEP was or where to access it. Consistency of condom use varied among participants. Commonly reported reasons for no or inconsistent condom use were monogamy, serosorting, and having an undetectable viral load.

Service-Specific Fact Sheets

Service-specific fact sheets detail the need for, and barrier to accessing, each HIV core medical and support service. This includes service needs by gender, race/ethnicity, and age group.

INTRODUCTION

What is an HIV needs assessment?

The Ryan White HIV/AIDS Program requires regular assessment of the care and support service needs of people living with HIV (PLWH) - both those in care and those not in care¹. Information on service categories funded by the Ryan White HIV/AIDS Program is emphasized in this report.

The needs assessment process identifies the services needed in a community and what service gaps exist, either overall or for particular populations. This information can then be used to advance programmatic and policy efforts to reduce HIV transmission and improve care for PLWH. Recognizing that HIV medical and support services are only a piece of an individual's holistic health and wellbeing, this needs assessment positions HIV service needs and gaps within a broad social determinants of health framework.

How are HIV needs assessment data used?

Needs assessment data are integral to HIV services planning, and are used in almost every decision-making process of the Austin Area Comprehensive HIV Planning Council (**Planning Council**).

In the Austin area, HIV needs assessment data are used for the following purposes:

- Ensuring the consumer point-of-view is incorporated into the data-driven decision-making activities of the Planning Council
- Setting priorities for the allocation of Ryan White HIV/AIDS Program Part A funds for specific services
- Developing and implementing a five year integrated HIV prevention and care plan for the Austin area
- Determining if there is a need for targeted services

- Determining the need for special studies of service gaps or subpopulations that may be otherwise underrepresented in data sources
- The community may also use needs assessment data for a variety of *non*-Council purposes, such as in developing funding applications, as well as program monitoring and evaluation

Austin Area HIV Needs Assessment Scope

Survey data collected from PLWH is the principle source of information for the Austin area HIV needs assessment process. Surveys are administered every three years to a representative sample of PLWH residing in the Austin transitional grant area (**TGA**). The Austin TGA encompasses five counties: Travis, Williamson, Hays, Bastrop and Caldwell.

Because surveys are administered every three years, results are used in Planning Council activities for a three year period. Data from other sources produced during interim years of the cycle, such as epidemiologic data and Ryan White utilization data, are used to provide additional context for survey results. Data from focus groups of PLWH, non-traditional partners, and other groups may be added as addendums to this report, to provide additional insight on findings.

Thematic Areas

The Planning Council prioritized four thematic areas to explore in the 2017 Austin Area HIV Needs Assessment:

1. HIV Service Needs and Barriers
2. Needs Across the Care Continuum
3. Social Determinants of Health
4. HIV Prevention

¹ U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau,

METHODOLOGY

Needs Assessment Planning

Planning for the 2017 Austin Area HIV Needs Assessment was a collaborative process, led by the Austin Area Comprehensive HIV Planning Council (**Planning Council**). An initial kick-off event was held on March 14, 2017, to gather input from HIV prevention and care service providers, PLWH and people who access Ryan White services, the Planning Council, and other interested community members. Twenty-four community stakeholders helped establish the goals and objectives of the needs assessment and identified key areas to be highlighted in the assessment. Participants in the kick-off and additional community members then divided into workgroups to develop the survey tool.

Survey Tool

Over a two month period, the survey tool was developed in community workgroups, chaired by Planning Council members, which focused on the key thematic areas of the survey: Demographics, Service Needs and Barriers, Needs across the Care Continuum, HIV Prevention, and Social Determinants of Health. These workgroups had conference calls and in-person meetings, utilizing Google Docs technology and call-in meetings to enable maximum community participation in the process. The workgroups used the Austin Transitional Grant Area's (**TGA**) 2014 needs assessment survey tool as well as resources and best practices from other Texas Ryan White jurisdictions to develop the survey.

The final tool was approved by Planning Council on May 23, 2017 (Appendix A). The tool has sixty-four questions and is available in print in English and Spanish, as well as online in English in Survey Monkey. Questions are self-report multiple choice, with options for write-in responses. Electronic surveys incorporated skip-logic, which automatically skipped questions that were not relevant to the individual taking the survey.

Survey Sampling Plan

To achieve a 95% confidence interval and a 5% margin of error, with a 2015 estimated PLWH population size of 5,521 (Department of State Health Services, 2015), it was estimated that a minimum of 360 valid responses should be collected to ensure a representative sample of PLWH in the Austin TGA. Adjustments were made to correct for incomplete surveys and some accidental duplication. A total of 445 valid survey responses were collected.

Data Collection

Survey Period: Surveys were collected between June 12 and August 22, 2017. Most people completed the survey in 10-20 minutes. All individuals who completed the survey were offered a small incentive to thank them for their participation.

Survey Formats: Surveys were self-administered and offered in online and paper formats. Online surveys were completed on touch-screen tablets with technical assistance provided, as necessary. Survey takers were given the option to have the survey read to them by a data collector, which was done in a private and secure setting. Where possible, both online and paper versions of the survey were offered. Of the 445 surveys completed, 268 surveys were completed online and 177 were completed on paper.

Data Collection Locations: Surveys were administered at a total of nine locations. To insure a representative sample of all Ryan White HIV/AIDS Program Part A clients, each Ryan White Part A funded service provider in the TGA was encouraged to collect surveys from their clients, in a number proportionate to the number of clients they serve. In addition to surveying "in care" PLWH, Health Resources and Services Administration (**HRSA**) guidance encourages assessment of individuals who are not in HIV medical care. To better sample out-of-care PLWH, an additional data collection site was added. This site provides case management for PLWH who are currently homeless or who are not in medical care.

Data Collectors: The responsible parties for data collection were determined based on the capacity of each site. Spanish speaking data collectors were available at almost all surveying events. In five of the

nine locations, HIV service provider staff administered the surveys to their clients directly. At the remaining four locations, Planning Council members, Planning Council support staff, and other Austin Public Health (APH) staff administered the surveys.

Limitations

1. *Convenience sampling:* Processes were designed to survey a representative sample of Ryan White clients, but this was not a random sample. Each Ryan White Part A service provider had a data collection goal proportionate to the number of PLWH they serve, and most locations were able to meet this goal. To avoid selection bias, all individuals were invited to take the survey upon entry into the survey location and Spanish surveys and Spanish speaking data collectors were available at almost every surveying event.
2. *Representative of the Austin TGA:* The demographics of survey respondents are similar to the demographics of Ryan White Part A clients. Out-of-care PLWH and PLWH who do not receive any Ryan White Part A services were under-represented in this survey. According to the Texas Department of State Health Services (DSHS), 15 percent of diagnosed PLWH are out of care in the Austin TGA². An additional survey location was added to reach individuals at risk of being out of care. Three percent of survey respondents self-reported to be out of care in the past 12 months, and 20% of respondents reported being out of care for at least one year in the past five years.
3. *Possibility of duplication:* All participants were asked to confirm that they had not taken the survey previously, but it is likely that some duplication did occur. Data collection occurred at multiple locations with many data collectors and, as a result, some potential participants were unsure if they had taken the survey previously or not. One Planning Council support staff member

consistently attended most survey collection sessions in an attempt to minimize duplication.

4. *Reporting bias:* Survey respondents were self-selected and self-identified. Surveys relied on self-reported measures of service use and need. The survey tool was anonymous, so answers could not be corroborated with AIDS Regional Information and Evaluation System (ARIES) data or other sources to confirm service use, viral suppression etc. Thus, results should be viewed as consumer perceptions of their experiences rather than as empirical evidence of health outcomes.
5. *Instrumentation:* A print but not an online version of the Spanish survey was available during data collection. Professional translation services were utilized to insure continuity between English and Spanish surveys.
6. *Data limitations:* Wherever possible, this document uses participant self-identified gender instead of sex at birth when analyzing survey results. The Texas Department of State Health Services does not currently report gender data, so sex at birth is used in sections of this report whenever comparisons to state data are needed.
Based on best practices from previous assessments, colloquial names for Ryan White service categories were used when asking about service needs and barriers. Thus, some questions do not completely align with Ryan White-funded service categories. For example, the survey asks about “case management”, but does not specify between medical and non-medical.

²Out of care defined as someone who has not received a medical visit, ART prescription, viral load test, or CD4 test in the past twelve month period.

BACKGROUND

The Austin Transitional Grant Area (TGA)

The Austin TGA is a five-county area (Travis, Williamson, Bastrop, Hays and Caldwell counties) in central Texas, with a rapidly growing population. The largest city, Austin, lies in Travis County, where the bulk of people living with HIV (**PLWH**) reside. Between 2010 and 2014, the general population of the Austin TGA grew by about 227,000 (13%)³. Currently, over 2 million people reside in the Austin TGA (2017)³. Most of the Austin TGA population is White (54%), followed by Hispanic (32%), and African American (7%)³.

HIV in the Austin Area

Mirroring national trends, the number of new cases of HIV in the Austin TGA has remained relatively stable; HIV-related mortality has steadily declined, and the number of people living with HIV has steadily increased⁴. Overall, the Austin TGA has higher rates of engagement along each stage of the HIV care continuum, from linkage to care to viral suppression, than all other Ryan White metropolitan jurisdictions in Texas⁵ (DSHS, 2016). According to the Texas Department of State Health Services (**DSHS**), of the 5,916 diagnosed PLWH living in the Austin Area in 2016, 80% (n=4,711) are retained in medical care, and 72% (n=4,262) are virally suppressed.

(**Table 1**) Demographic information for all PLWH in the Austin TGA is shown in Table 1. Most (86%) of PLWH are male. Forty-one percent of PLWH are White, 33% are Hispanic, and 21% are African American. Over half (55%) of PLWH are 45 years old or older, and 69% are men who have sex with men (**MSM**).

Table 1- Diagnosed People Living with HIV/AIDS in the Austin TGA, 2016

	#	%
Total	5,916	100.0%
Sex at birth		
Female	858	14.5%
Male	5,058	85.5%
Race/Ethnicity		
White, not Hispanic	2,450	41.4%
Black, not Hispanic	1,262	21.3%
Hispanic	1,932	32.7%
Other	78	1.3%
Unknown	194	3.3%
Age		
0-12	14	0.2%
13-24	249	4.2%
25-34	1,092	18.5%
35-44	1,311	22.2%
45-54	1,811	30.6%
55+	1,439	24.3%
Mode of Transmission		
Adult Other	2	0.0%
Heterosexual	892	15.1%
Injection Drug Use (IDU)	492	8.3%
Men who have sex with men (MSM)	4,096	69.2%
MSM/IDU	379	6.4%
Pediatric	55	0.9%

Source: Data Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services. Data run September 2017.

³ National Center for Health Statistics and results from the Census Bureau's American Community Survey (information collected across 2010-2014).

⁴ TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services (**DSHS**). Data run September 2017.

⁵ *ibid*

Disparities in the Austin Area

Austin has generally high levels of retention in medical care and viral suppression compared to other Texas cities. Despite this, disparities exist across the care continuum along the lines of race/ethnicity, age, gender, socio-economic status, geography, and mode of transmission. Detailed epidemiological data on disparities can be reviewed in the 2017-2021 Austin Area Integrated HIV Prevention and Care Plan*, and in the 2017 Austin HSDA Data Sheet. Below are a few data points from the Texas Department of State Health Services that highlight disparities among the following priority populations that were identified in the Integrated HIV Prevention and Care Plan: African American Women, African American MSM, Hispanic, Youth, and Injection Drug Users.

Disparities in diagnosis and health outcomes⁶:

- Most (61%) new diagnoses in 2016 were among people age 13-34.
- Over the past five years, an increasing percentage of new diagnoses are among Hispanics
- African Americans, who make up seven percent of the Austin TGA's total population, have HIV prevalence and incidence rates about four times higher compared to Whites.
- Young Hispanic MSM, African American MSM, and African American women are less likely to be retained in care than other groups
- African American women and African American MSM have lower rates of viral suppression than other groups

HIV Services in the Austin Area

HIV prevention and care services are provided to Austin TGA residents through a system of non-profit, private, and governmental institutions. The goal for HIV care in the Austin area is to create a seamless system that supports people at risk for or living with HIV with a full array of educational, clinical, mental, social, and support services.

Multiple funding sources are coordinated to provide care for low income PLWH in the Austin TGA. Some of these sources include: Ryan White HIV/AIDS Program Part A, Part B, Part C, Housing Opportunities for Persons with AIDS (**HOPWA**), Housing and Urban Development (**HUD**), Texas state services funding, Centers for Disease Control and Prevention (**CDC**), City of Austin General Fund, and other public grants and private funding.

The 2017-2021 Integrated HIV Prevention and Care Plan provides guidance for the planning, implementation and monitoring of HIV prevention and care services, with emphasis on services for low-income individuals.

*Note: 2017-2021 Integrated HIV Prevention and Care Plan, developed by the Austin Area Comprehensive HIV Planning Council, is available at www.austinhiv.com.

⁶ Austin HSDA Data Sheet Texas Department of State Health Services, HIV/STD Prevention and Care Branch, 2015



Chapter 1: Demographics

PARTICIPANT COMPOSITION

(Table 2) is an overview of select characteristics of the 445 individuals who completed the 2017 Austin Area HIV Needs Assessment Survey. Overall, most (74%) of participants identify as male, 21% as female, and 5% identify as transgender. Respondents were primarily African American (35%), Hispanic (31%) and White (26%). Most (89%) are fluent English speakers and 17% are fluent Spanish speakers. Greater than half (61%) of survey participants were age 45 or over. Forty-four percent of participants identify as gay, lesbian or homosexual, and 40% identify as straight or heterosexual. Ryan White was cited as the most common means of paying for HIV medical care (36%), followed by Medicare (30%), Medicaid (24%), and the Medical Access Program (MAP) (24%).

Table 2- Select Participant Characteristics, Austin HIV Needs Assessment, 2017

	#	%
Total	445	-
Gender*		
Male	324	74%
Female	93	21%
Transgender Male	11	3%
Transgender Female	8	2%
Other	2	<1%
Prefer not to Answer	1	<1%
Race/Ethnicity		
White, not Hispanic	136	26.4%
Black, not Hispanic	153	34.5%
Hispanic	117	30.7%
Multi-Racial	27	6.1%
Other	32	7.2%
Language		
English	394	89.3%
Spanish	76	17.2%
Other	12	2.7%
Age		
18-24	17	3.9%
25-34	60	13.6%
35-44	96	21.8%
45-54	143	32.4%
55-64	97	22.0%
65+	28	6.4%
Sexual Orientation		
Gay, lesbian or homosexual	194	44.3%
Straight or heterosexual	176	40.2%
Bisexual	42	9.6%
Something else	7	1.6%
Don't know	4	0.9%
Prefer not to answer	18	4.1%
Health Insurance		
Ryan White	160	36.2%
Medicare	131	29.6%
Medicaid	108	24.4%
Medical Access Program	108	24.4%
Obamacare/Affordable Care Act	21	4.8%
Insurance through employer	29	6.6%
Out of pocket	17	3.9%
I don't know	13	2.9%
Other	32	7.2%

*Respondents were asked, "What is your current gender identity?", and could select all options that apply from this list.

(Table 3) In this report, the Planning Council recognizes populations which have been historically underrepresented or misrepresented in HIV data collection, or that have unique or disproportionate barriers to care. To address these historical trends, special efforts were made in the 2017 needs assessment process to collect data for these groups. Spanish speaking survey collectors were available at almost all survey sessions to increase representation from individuals who may not be comfortable reading or speaking in English. Additionally, all participants were asked a two- part gender identity question to minimize accidentally miss-gendering participants. The representation of selected populations in the 2017 Austin Area Needs Assessment survey is summarized in Table 3.

Table 3- Representation of Selected Demographics, Austin HIV Needs Assessment, 2017

	#	%
Unstably Housed	106	24.4%
Injection Drug Users	47	11.2%
Out of Care- Current ^a	13	3.0%
Out of Care- Recent ^b	77	19.7%
Recently Released from Incarceration	9	2.1%
Transgender	19	4.3%
Monolingual Spanish Speakers	45	10.2%

^aDid not have at least one medical visit or ART prescription in the past 12 months. ^bSince 2012, participant indicated there was at least a twelve month period during which they did not have at least one medical visit or ART prescription.

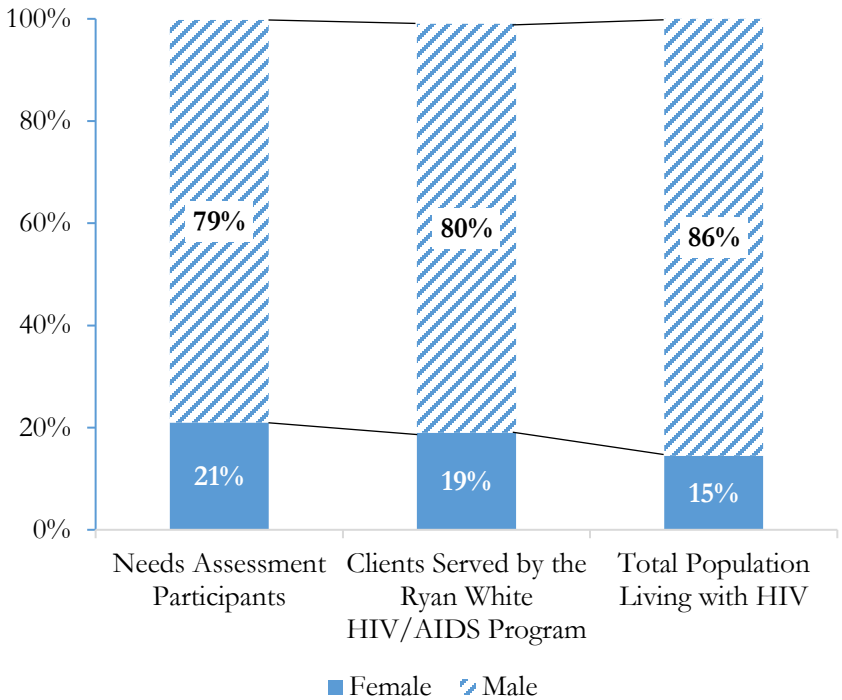
COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

The goal of the Austin Area HIV Needs Assessment is to provide an overview of the service needs and barriers for PLWH in the Austin Transitional Grant Area (**TGA**). As it is not feasible to survey all PLWH in the TGA, efforts were made to survey a representative sample that matched the Ryan White profile as closely as possible. It is important to note that demographics of Ryan White clients and all PLWH in the TGA are different, and emphasis was put on sampling PLWH who are eligible for Ryan White services. Participant representation is

compared to these larger populations in order to assess the generalizability of needs assessment findings. Overall, the demographic profile of needs assessment participants is similar to that of Ryan White clients. In general, data in this report are more accurately generalizable to the Ryan White client population than to all PLWH in the Austin TGA.

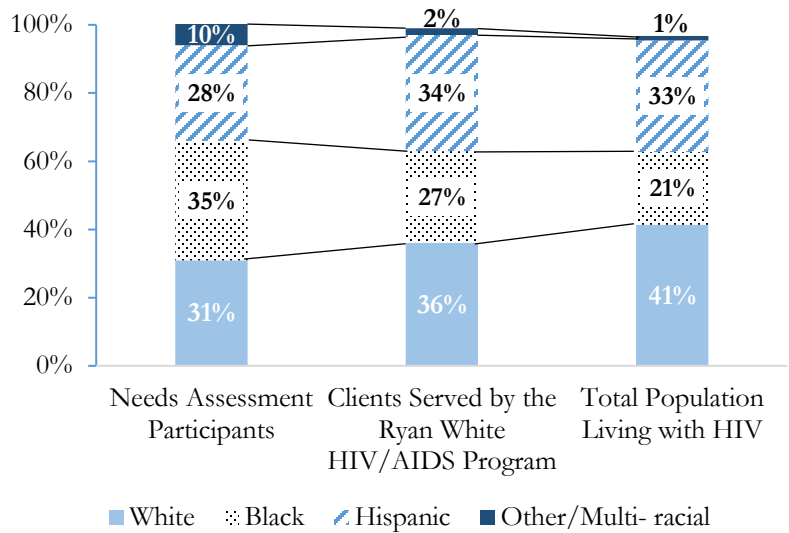
(**Figure 1**) In the 2017 Austin Area HIV Needs Assessment, males comprised 79% of needs assessment participants, compared to 80% of clients served by the Ryan White HIV/AIDS Program, and 86% of all PLWH in the Austin TGA. This indicates that males and females were proportionally represented in the needs assessment sample.

Figure 1- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients^a, and the Total PLWH Population^b, in the Austin TGA, By Sex at birth, 2016 & 2017



^aData Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services as of 12/31/16, Total number of clients served by the Ryan White HIV/AIDS Program ^bData Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services. Living cases as of 12/31/16

Figure 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients^a, and the Total PLWH Population^b, in the Austin TGA, By Race/Ethnicity, 2016 & 2017

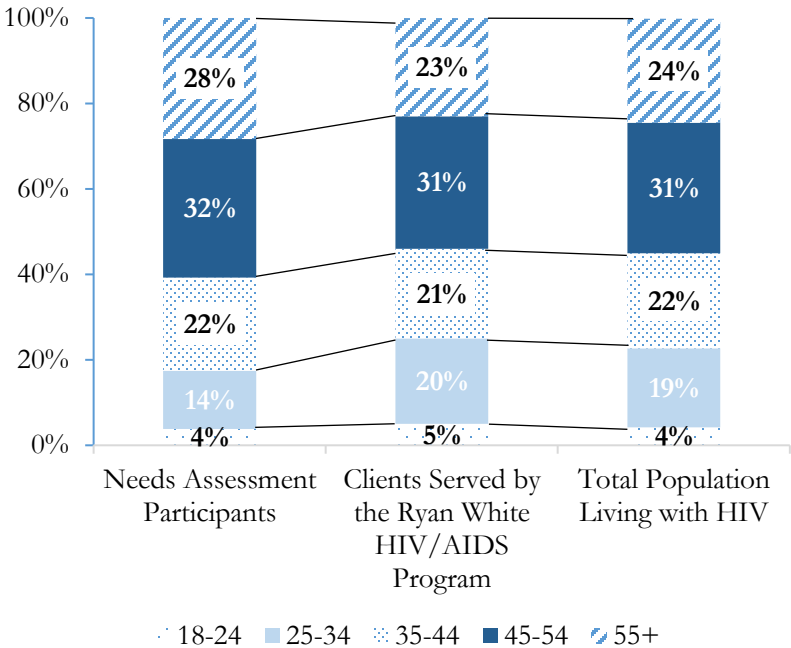


(Figure 2) Analysis of race/ethnicity composition shows a higher percentage of Black and Multi-racial/Other people took the survey compared to the overall Ryan White population. Conversely, White and Hispanic/Latino PLWH were slightly underrepresented in the sample compared to all Ryan White clients. These differences are greater when compared to all PLWH in the Austin TGA.

^aData Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services as of 12/31/16, Total number of clients served by the Ryan White HIV/AIDS Program ^bData Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services. Living cases as of 12/31/16

(Figure 3) Lastly, the age distribution of needs assessment participants varies slightly from the age distributions of Ryan White clients, and the total population of PLWH in the Austin TGA. The needs assessment over-surveyed people aged 55+ and under-surveyed people age 25-34. This reduced representation of younger voices is important to note, as new diagnosis increasingly occur in this younger population. Analysis of survey data should consider this distinction. Service category needs and barriers are assessed according to age category in Chapter 7, to insure needs of younger PLWH are identified.

Figure 3-Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients^a, and the Total PLWH Population^b, in the Austin TGA, By Age Group, 2016 & 2017



^aData Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services as of 12/31/16, Total number of clients served by the Ryan White HIV/AIDS Program ^bData Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services. Living cases as of 12/31/16



Chapter 2: Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

The Ryan White HIV/AIDS Program is a medical care safety net for low income people living with HIV (**PLWH**) who have no other means of acquiring medical services. The Ryan White HIV/AIDS Program also provides a variety of non-medical services which improve the quality of life of PLWH, and have shown to improve health outcomes. The Austin Area Comprehensive HIV Planning Council (**Planning Council**) is tasked with prioritizing these core medical and support services, and developing an annual Ryan White Part A funding allocation plan. Given resource limitations, the Planning Council regularly uses multiple mechanisms to evaluate which services are most needed in the community, and Ryan White consumer perspectives of their own needs is a key consideration.

The primary function of this section is to summarize feedback from PLWH in the Austin Transitional Grant Area (**TGA**) on their current need for HIV medical and support services, and any barriers they face to accessing these services. A detailed breakdown of need for, and barriers to, each service category by selected demographic characteristics is provided in Chapter 7: Service-Specific Fact Sheets.

Need for Ryan White Services in the Austin TGA

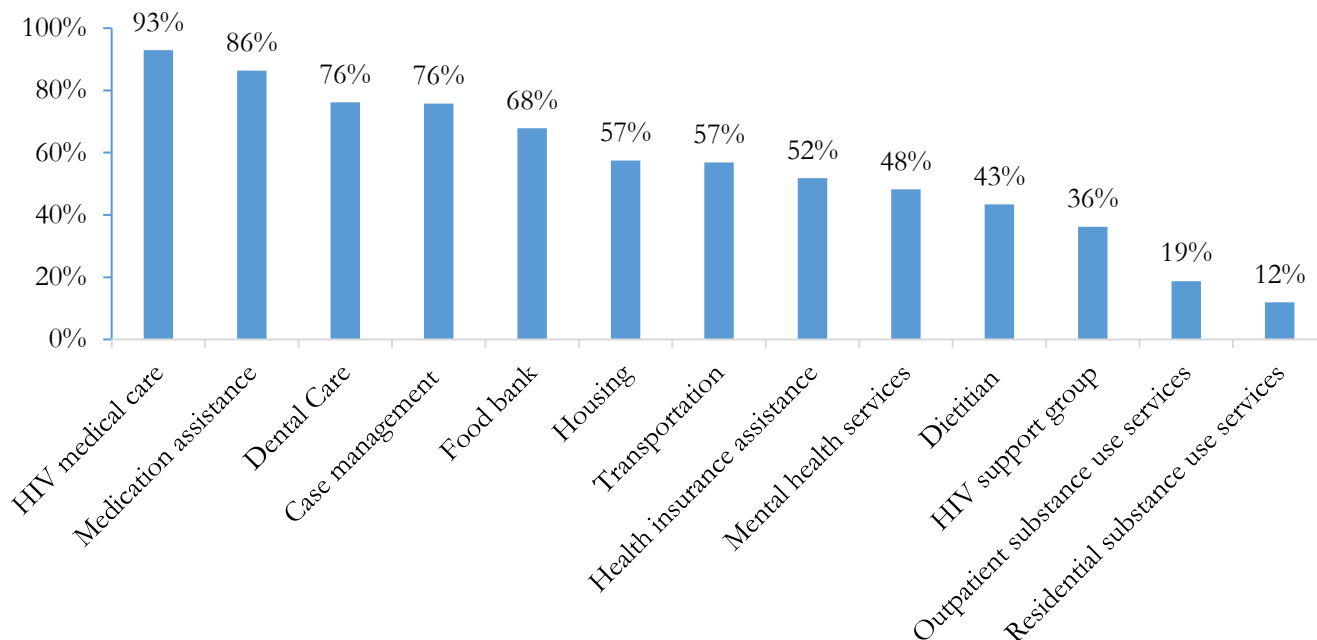
In 2017, eight core medical services and eight support services were funded by the Austin Area Ryan White HIV/AIDS Part A Program, which were condensed to 13 service types for the purposes of this assessment⁷. Participants of the 2017 Austin Area HIV Needs Assessment were asked to indicate which of these services they needed in the past 12 months.

(**Figure 4**) Figure 4 depicts the percent of participants who needed each service in the past 12 months. Almost all survey respondents (93%) indicated a need for HIV medical care. The second most highly needed service was assistance paying for HIV medications (86%), followed by dental care (76%).

HIV medical care, medication payment assistance, and dental care are the most needed services

Case management was the most needed support service at 76%, followed by food bank at 68%, and transportation at 57%. Over half (57%) of participants also indicated they needed help with housing in the past 12 months. These results are similar to those of the 2014 Austin HIV Needs Assessment, in which the six most needed services were (in order): medical care, food bank, case management, HIV medication assistance, dental care and transportation.

Figure 4- Need for HIV Services in the Austin TGA, 2017



Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility. *Denominator:* 396-411 participants, varying between service categories Survey Question: Did you need this service in the past 12 months- regardless of whether you received it.

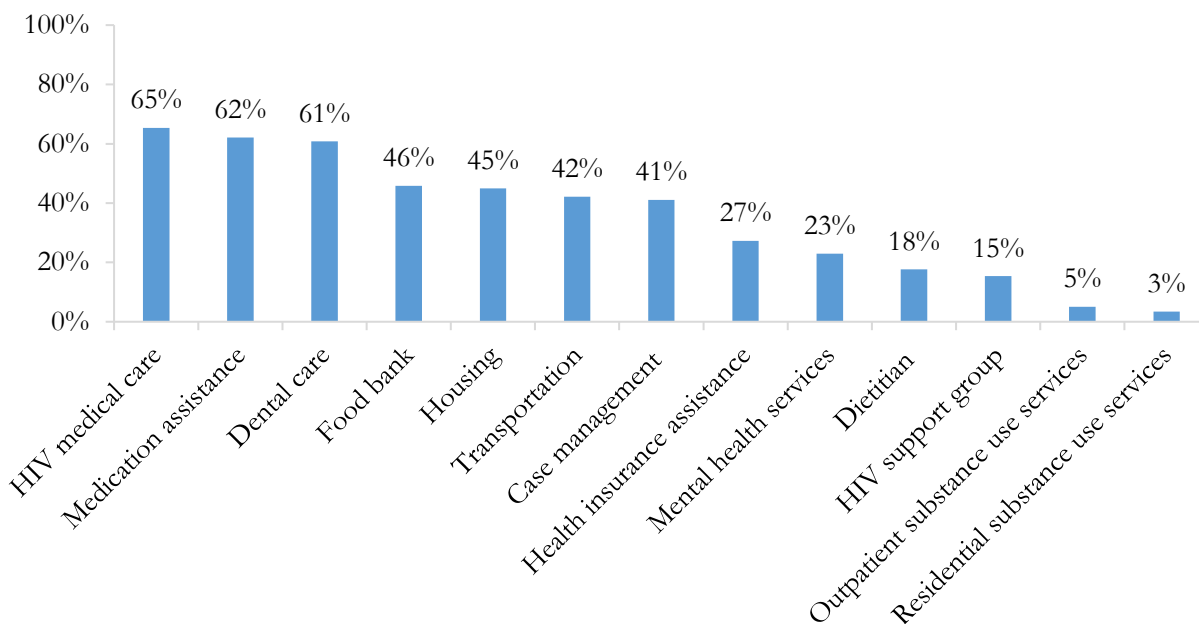
⁷ Housing is a support service provided by Ryan White Part A, but these funds are currently limited to medically assisted living programs, not traditional housing. Traditional housing services are provided by Housing Opportunities for People with AIDS (HOPWA). This survey did not discern between types of

housing assistance and simply asked participants if they needed “help with housing” in the past 12 months. Hospice service was discontinued in fiscal year (FY) 2017 and was not included in the assessment.

(**Figure 5**) Need was also evaluated using a second metric, where participants were asked to select the top five services they needed most. The three core medical services remained unchanged: 65% of participants indicated HIV medical care was one of their top five service needs, followed by medication

assistance at 62%, and dental care at 61%. The support services most frequently selected in participants' top five most needed services were food bank (46%), housing (45%), transportation (42%), and case management (41%).

Figure 5-Percent of Participants who Selected the Service as one of their Top 5 most Needed HIV Services, 2017



Denominator: 436 *Survey Question:* "Select the five services you need the most."

Need for Additional Services

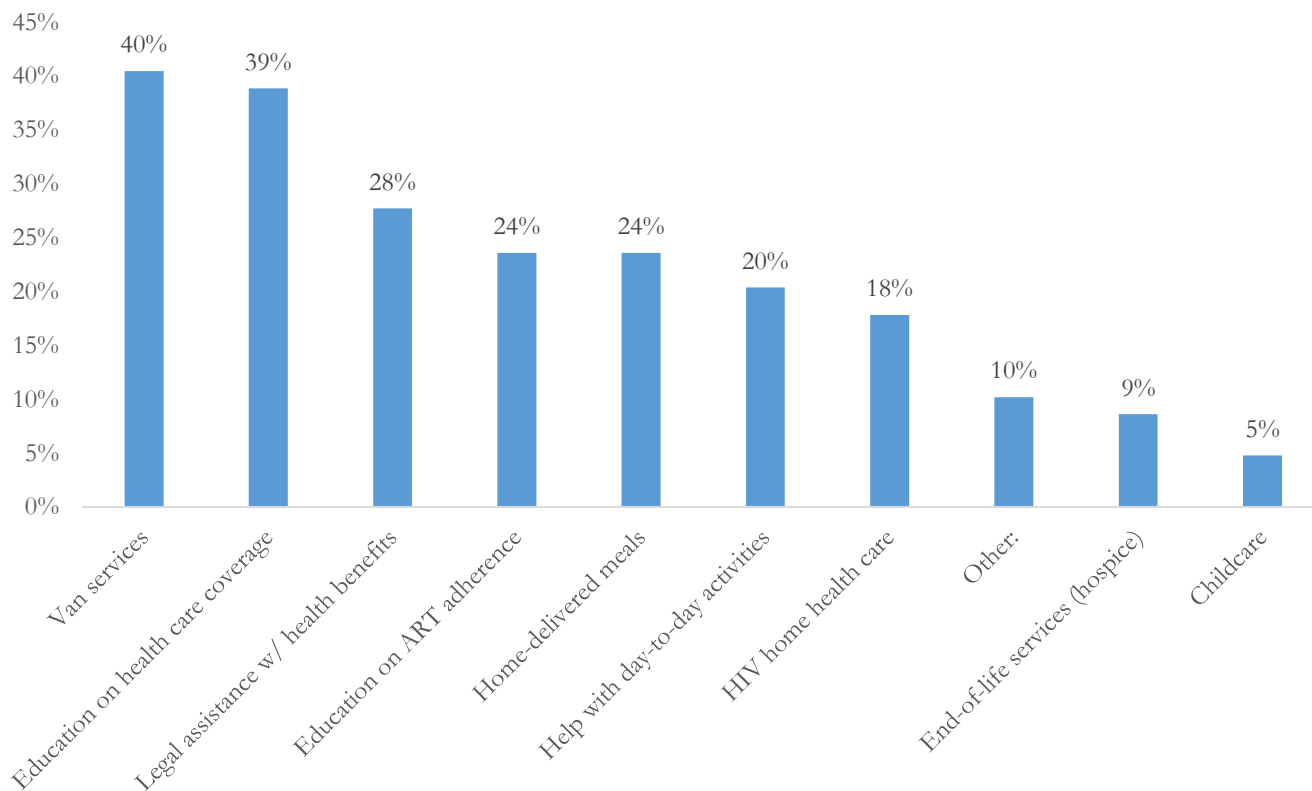
(**Figure 6**) In addition to the services currently funded by the Ryan White Program in the Austin TGA, participants were asked if they need any additional services, including currently unfunded Ryan White services. Participants could select from a list of services or write in their own service needs. The most needed additional service was transportation to and from medical appointments via van services, followed by education on health care coverage, and legal assistance regarding health benefits.

Van transportation, health care coverage information, and legal assistance were the top 3 additional needed services

Listed below are the write in responses to the question, “To help you stay healthy and manage your HIV, which of these do you need assistance with?” Text in [] is paraphrased.

- ADJ Bed
- Better times to visit with mental health issues
- Co-pay costs for cancer and long-term diabetic (type 1) complications
- Educate [HIV negative individuals] about HIV
- Health care groups
- Help with insurance co pays
- Housing. Living in a hotel is not helpful, or healthy for me.
- I call CARTS sometimes
- [Support while traveling]
- Job placement
- Job placement and training
- More case managers in Williamson Co
- Palliative care
- Rides to food pantries
- Set up a program for the deaf and hard of hearing that includes education, advocacy, housing, and more to help deaf people [living] with HIV
- Support group work

Figure 6- Responses to the question, “To help you stay healthy and manage your HIV, which of these do you need assistance with?”, among PLWH, 2017



Denominator: 314

Service Accessibility and Gaps in the Austin TGA

(Figure 7) HIV medical and support services were also ranked by accessibility. Accessibility is defined as: of the participants who indicated needing a service, the percent who actually accessed the service, through Ryan White-funded service providers or other mechanisms. HIV medical care, medication assistance, and case management were the most accessible services. Almost all (97%) of people who indicated they needed medical care also indicated that they received it. Medication assistance was accessed by 95% of people who needed it, and case management was accessed by 94% of people who needed it⁸.

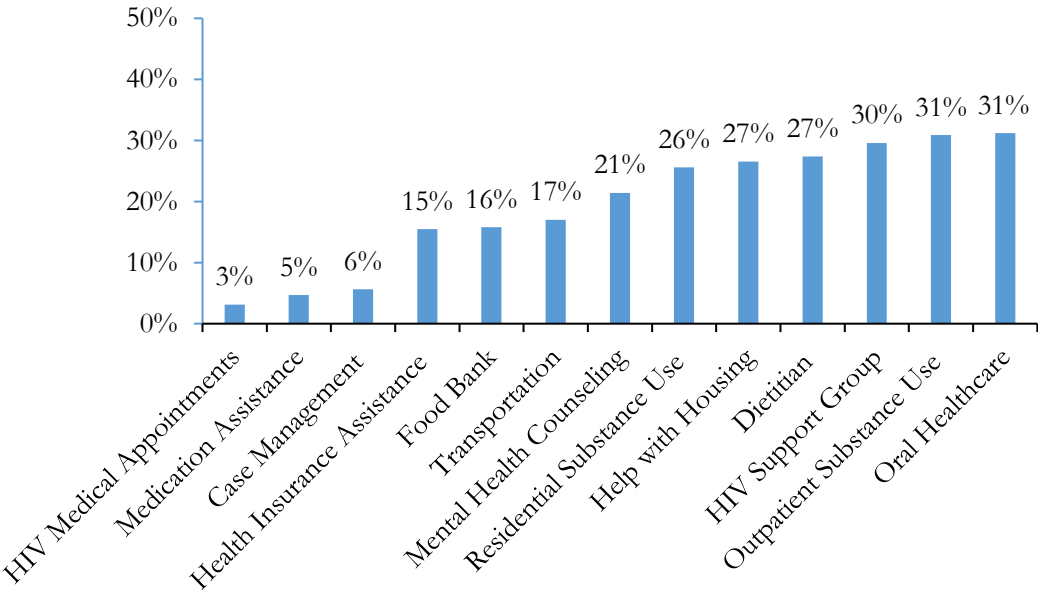
HIV medical care, medication assistance and case management were the most accessible services

The largest service gaps were in dental care, outpatient substance use treatment, and HIV support group services

A service gap is when a service is needed, but not received, by an individual. The largest service gaps were in dental care, outpatient substance use treatment, and HIV support group services. Of the 282 participants who indicated they needed dental care, almost one third (31%, n=88) did not receive it. Almost a third (31%, n=21) of PLWH who needed outpatient substance abuse services did not receive them, and 30% of PLWH who needed HIV support group services did not receive them. Reported barriers to accessing services are discussed later in this chapter and in Chapter 7.

Service gaps were identified and evaluated using different metrics than the 2014 Austin HIV Needs Assessment, so it is not possible to make a direct comparison or evaluate trends over time.

Figure 7-Service Gaps in the Austin TGA, 2017



Definition: Of needs assessment participants stating they needed the service in the past 12 months, the percent stating they did not receive the service. Source: 2017 Austin TGA HIV Needs Assessment. Denominator: 43-355 participants, varying between service categories.

⁸ *Note: The majority of surveys were administered at service provider sites, to individuals who were there to receive a

service. Thus, data may over-represent PLWH who are in care, receiving services.

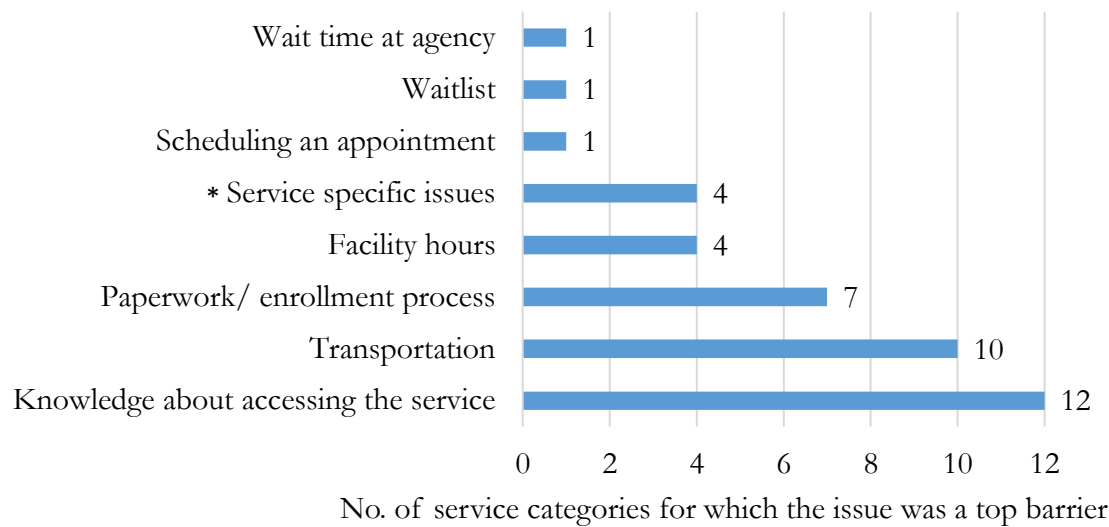
Service Barriers

Needs Assessment participants were asked to indicate if they experienced any barriers to accessing the HIV services they need. Participants were given a list of common barriers for each service category and could write in additional barriers*. The most common barriers for each individual service category are presented in detail in the Service-Specific Fact Sheets (Chapter 7). This section combines barrier information for all service categories, to show the overall barriers PLWH experience when accessing HIV medical and support services in the Austin TGA.

Top overall barriers to accessing services are 1) lack of knowledge about available services, 2) transportation, and 3) paperwork/enrolment processes

(Figure 8) The top three reported barriers for each of the 13 service categories were aggregated to see which barriers affected participants’ ability to access multiple services. For all services except one, lack of knowledge about the service was one of the top three reported barriers to accessing it. Transportation was one of the top three reported barriers for 10 out of the 13 service categories, and paperwork/enrollment processes was indicated as a top barrier for 7 out of 13 services.

Figure 8-Service Barriers Most Frequently Reported Across Multiple Service Categories, 2017



Denominators: Varied by service category, between 8 and 102 participants reported a barrier for each service.
* *Note:* Survey participants could indicated up to three barriers they face when accessing each of the 13 services. Chapter 7 reviews what the most commonly reported barriers are for each individual service. This graph shows how many times each barrier was one of the top three reported barriers for any of the 13 services.

* Note: Survey participants were given a list of commonly reported barriers for each service category. These lists were developed using data from the 2016 Houston Area HIV Care Services Needs Assessment, and input from the Austin

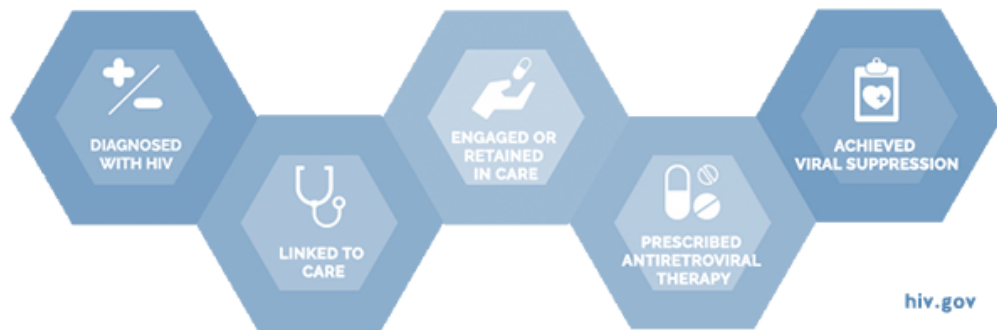
Area HIV Needs Assessment Planning Work Groups. Barrier lists for each service category are in Appendix A.



Chapter 3: HIV Care Continuum

HIV CARE CONTINUUM:

THE SERIES OF STEPS
A PERSON WITH HIV
TAKES FROM INITIAL
DIAGNOSIS THROUGH
THEIR SUCCESSFUL
TREATMENT WITH
HIV MEDICATION.



HIV CARE CONTINUUM

The HIV Care Continuum is the series of steps a person living with HIV (**PLWH**) takes, from initial diagnosis through their successful treatment with HIV medication.¹⁰ It shows the proportion of individuals living with HIV who are linked to care, engaged in care, prescribed antiretroviral therapy (**ART**), and are virally suppressed. Assessing engagement at each stage of the HIV Care Continuum can identify where gaps may exist in connecting PLWH to sustained, quality care. Planning Council and community groups can focus efforts on promoting movement from one stage of the continuum to the next.

The 2017 Austin Area HIV Needs Assessment was designed to assess barriers to engagement at each point along the HIV Care Continuum. This chapter first outlines care continuum data for the Austin Transitional Grant Area (**TGA**), and then presents

survey findings as they affect and inform each stage of the care continuum. Data are presented in the context of care continuum targets defined in the Austin 2017-2021 Integrated HIV Prevention and Care Plan.

Austin TGA Care Continuum

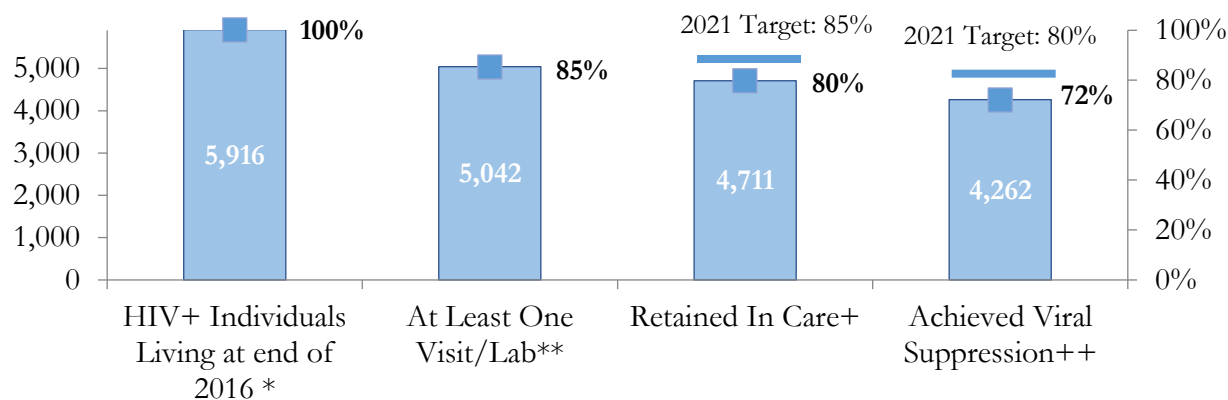
(**Figure 9**) Each year, the Austin TGA Care Continuum is updated using local epidemiological data. In 2016, 80% of the 5,916 PLWH in the Austin TGA were retained in care, and 72% achieved viral suppression.

(**Table 4**) Of the 295 new diagnoses in 2016, 64% were linked to care within 1 month of their HIV diagnosis, 26% were linked in 2-3 months, 3% were linked in 4-12 months, and 7% were not linked to care.

¹⁰ Health Resources and Services Administration (HRSA), Ryan White and Global HIV/AIDS Programs Retrieved

October 2016: <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/hiv-care-continuum#>

Figure 9-Care Continuum for the Austin TGA, 2016¹¹



Source: Enhanced HIV AIDS Reporting System as of July 23, 2017, Medicaid, ARIES, ADAP, and private payers. Texas Department of State Health Services, eHARS, August 2017

Table 4- Linkage to Care, 2016

	#	%	Target for 2021
Total New Diagnoses	295	100%	
Linked in 1 month	190	64%	75%
Linked in 2-3 months	76	26%	
Linked in 4-12 months	8	3%	
Linked in 12+ months	0	0%	
Not Linked	21	7%	

Source: Enhanced HIV AIDS Reporting System as of July 23, 2017, Medicaid, ARIES, ADAP, and private payers. Texas Department of State Health Services, eHARS, August 2017

¹¹ *Definitions:* *HIV+ Individuals at end of 2016 - No. of HIV+ individuals (alive) at the end of 2016.

**At Least One Visit in 2016 - No. of PLWH with a met need (at least one: medical visit, ART prescription, VL test, or CD4 test) in 2016. +Retained in Care is number of PLWH with at least 2 visits or labs, at least 3 months apart or suppressed at end of 2016. ++Achieved Viral Suppression at end of 2016 - No. of PLWH whose last viral load test value of 2016 was ≤ 200 copies/mL.

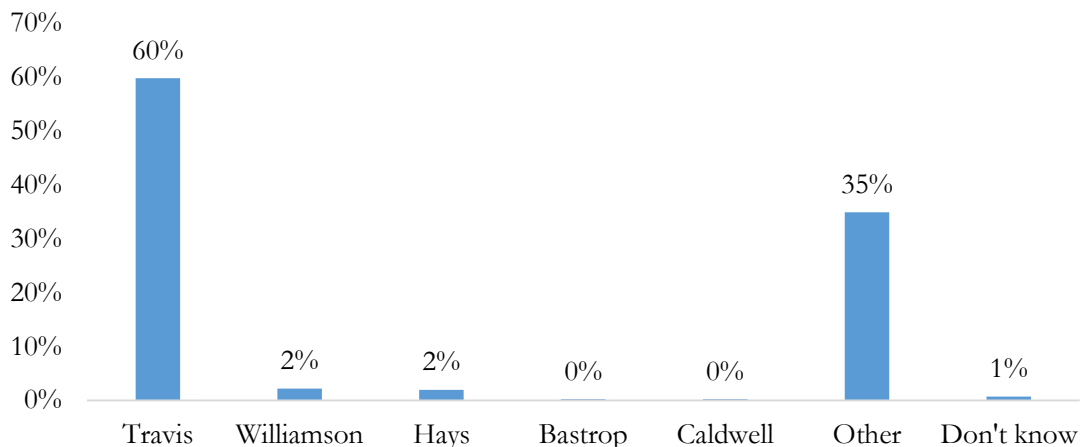
TESTING AND DIAGNOSIS

The Austin Integrated HIV Prevention and Care Plan targets a 25% reduction in new diagnoses in the Austin TGA by 2021. The plan also prioritizes HIV testing, to increase the percentage of PLWH who know their serostatus. The 2017 Austin Area HIV Needs Assessment asked participants to share some information about when they were first diagnosed.

(**Figure 10**) Most Needs Assessment participants were tested and diagnosed in Travis County. Only 4% were diagnosed in other counties within the TGA. About a third of respondents were diagnosed outside of the TGA.

Goal: Reduce new diagnoses by
25% by 2021

Figure 10-County of diagnosis for PLWH living in the Austin TGA, 2017

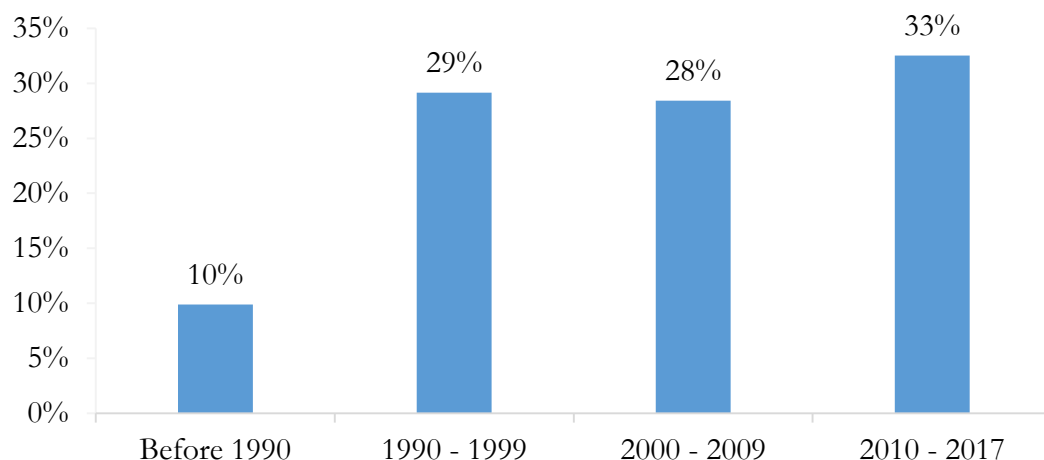


Denominator: 407

(**Figure 11**) About a third of all survey participants indicated they received an HIV diagnosis in the past 7 years (2010 or later). About forty percent of survey

participants indicated they were diagnosed with HIV prior to the year 2000.

Figure 11-Year of HIV Diagnosis for PLWH in the Austin TGA, 2017



Definition: Percent of participants who were first diagnosed with HIV in each time period.

Denominator: 415

LINKAGE TO CARE

(**Figure 12**) Rapid entry into HIV medical services after an HIV diagnosis can improve health outcomes, by reducing the period during which a person is not prescribed ART medication and is potentially not virally suppressed. The Austin Area Integrated HIV Prevention and Care Plan set a goal to increase the percent of PLWH who are linked to care within one month of diagnosis, from 60% in 2016, to at least 75% by 2021.

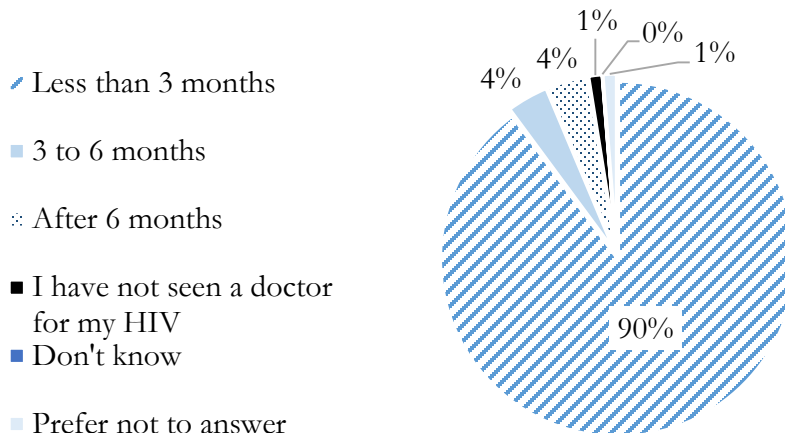
Needs assessment participants who indicated they were diagnosed in the Austin TGA in the last 5 years were asked about the time between their HIV diagnosis and when they entered care. Mirroring trends in the Austin TGA as a whole (Table 4), about 90% of respondents indicated they were linked to care within three months.

Goal: Increase the percent of PLWH who are linked to care within one month of diagnosis to 75% by 2021

Survey participants who did not see a doctor within three months of their diagnosis were asked if any specific barriers contributed to the delay in accessing medical care. A list of commonly reported barriers was provided. Participants could select multiple reasons for delayed entry or write in a response.

The most common reason for delaying initiation of HIV services was, “I felt fine, I was not sick”. Other barriers included not being able to get an appointment, not knowing where to go, and having other priorities.

**Figure 12-Austin HIV Needs Assessment
Participants' Linkage Experiences*, 2017**



Denominator: 79

*Excluded those not diagnosed in the Austin TGA and those diagnosed ≤ 2012

90% of participants indicated they were linked to care within 3 months

RETENTION IN CARE

The Austin Area Integrated HIV Prevention and Care Plan set a goal to increase the number of PLWH who are retained in care, from 80% in 2016, to at least 85% by 2021.

Only three percent of respondents indicated they did not receive any HIV medical care, including prescriptions for HIV medications, in the past 12 months. In comparison, 15% of all PLWH in the Austin TGA are estimated to be out of care (see Figure 9). The lower percentage for survey participants was anticipated because, while efforts were made to survey additional individuals outside of service provider locations, the majority of respondents were surveyed at Ryan White service provider locations. Thus, an additional indicator was used to understand the experiences of people who are currently in care but whose care had previously lapsed.

(Figure 13) Participants were asked if, in that past 5 years, there had been a period of at least 12 months when they did not see a doctor or get a prescription for HIV medications. Most (80%) of respondents reported no lapse in HIV medical services in the past 5 years. About 20% (n=77) of needs assessment

Goal: Increase the number of PLWH who are retained in care, from 80% in 2016, to at least 85% by 2021

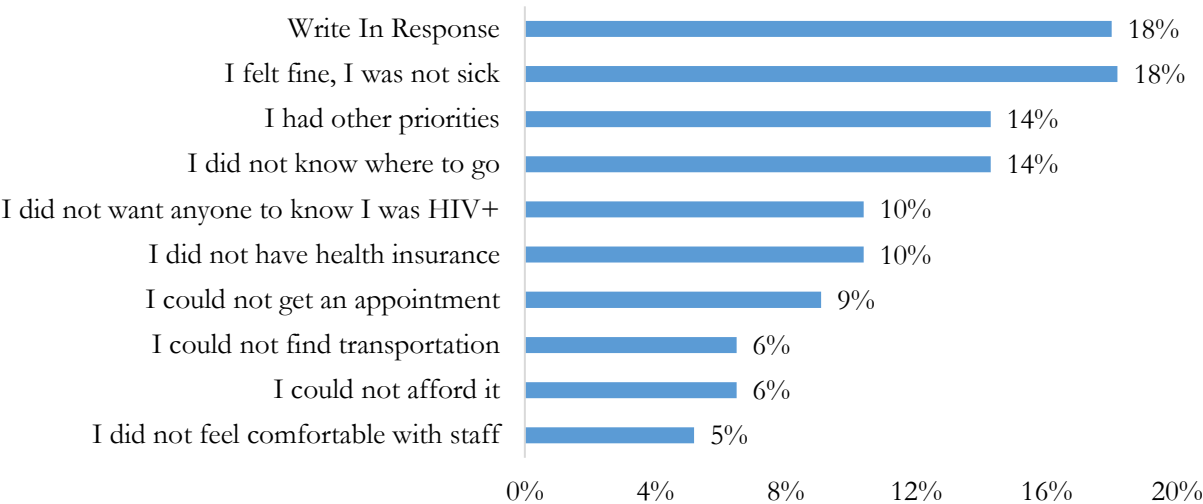
participants indicated their HIV medical care had lapsed for at least a year within the last five years.

Participants who indicated they were not retained in care at some point over the last five years were asked why they had fallen out of care during that period. A list of common barriers to accessing HIV medical services was provided. Participants could select multiple options or write in their own response. The most common response was that people dropped out of care because they felt fine and did not feel sick; this was also the most common response for delayed linkage to care. The next most common reason for falling out of care was that people had other priorities and/or they did not know where to go to receive services. Write-in responses included moving out of state, depression, alcohol or drug use, “did not care”, insurance changes, lack of appropriate language services, and forgetting appointments.

(80%) of respondents reported no lapse in HIV medical services in the past 5 years

Feeling fine/ not feeling sick was the most common reason participants dropped out of HIV medical care

Figure 13-Reasons for Falling out of HIV Care in the Austin area in the Past 5 Years, 2017



Denominator: 88 Definition: Of PLWH who have fallen out of care for at least 12 months in the past 5 years, percent who indicated various reasons for falling out.

(**Table 5**) In addition to the barriers listed above, the 2017 Needs Assessment asked how certain common determinants of health affect retention in HIV medical services. Most respondents indicated that the listed social determinants did not affect their ability to attend HIV medical appointments. About a third (32%) of respondents indicated that their transportation situation has made it difficult for them to attend HIV medical appointments in the past 12 months. About a quarter (24%) indicated that their co-occurring medical conditions made it difficult for them to attend medical appointments.

Transportation made it difficult for 1/3 of respondents to stay in care

Table 5-Percent of Needs Assessment Participants who had difficulty attending medical appointments due to other determinants of health in the past 12 months, 2017

	%	#	Denominator
Housing	17%	75	429
Transportation	32%	137	433
Co-occurring Medical Conditions	24%	56	233
Mental Health	15%	65	426
Alcohol or Drug Use	9%	40	423

HIV MEDICATION AND VIRAL SUPPRESSION

The Austin Area Integrated HIV Prevention and Care Plan set a goal to increase the number of PLWH who are virally suppressed, from 72% in 2016, to at least 80% by 2021. The Centers for Disease Control and Prevention states that PLWH who “keep an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative sexual partners”¹². Also commonly referred to as “Undetectable = Untransmittable” or “U=U”, this highlights the importance of viral suppression not only for the health of the individual living with HIV, but also as a way to prevent transmission of HIV to others.

Goal: Increase the number of PLWH who are virally suppressed, from 72% in 2016, to at least 80% by 2021

(Table 6) Needs Assessment participants were asked about their adherence to antiretroviral therapy (ART). About half indicated they were 100% adherent and took all medications as prescribed in the past 30 days. About a quarter of participants indicated they missed their medications one or two times. About 19% of respondents indicated they missed three or more doses of ART medication, and 5% of respondents indicated they did not take any HIV medication in the previous 30 days.

19% of respondents indicated they missed three or more doses of ART medication in the past 30 days

Forgetting to take medications was the most common reason indicated for non-adherence

Table 6-Adherence to Antiretroviral Therapy Medications, 2017

	%	#
I missed 0, I took it every day as prescribed	47%	205
I missed 1-2 times	27%	115
I missed 3-4 times	12%	53
I missed 5-10 times	4%	16
I missed 11-29 times	3%	12
I did not take any HIV medication in the last 30 days	5%	21
Not Sure	2%	10

Denominator: 432 Survey Question: In the last 30 days, about how many times have you missed taking your HIV medication?

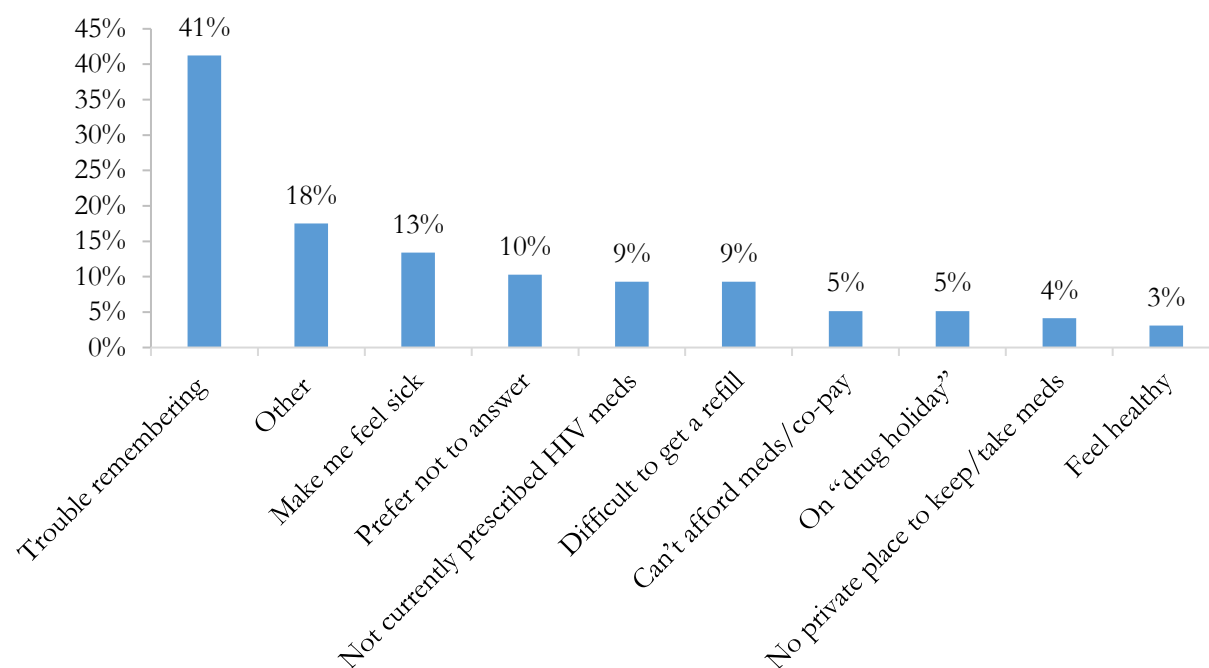
(Figure 14) People who missed at least three instances of taking ART were asked why they did not take their medications as prescribed. A list of common barriers to taking ART medications was provided. Participants could select multiple options and could write in their own response. Forgetting ART medications was the most common reason for not taking them. About 13% of respondents

indicated the ART medications made them feel sick, 9% indicated they were not currently prescribed ART, and 9% cited difficulty getting a refill. Of the 18% who wrote-in a different reason for why they missed 3 or more doses of ART medication, the most common reason was depression (n=4), followed by housing problems (n=3). Two respondents indicated their medicines had been stolen.

¹² “HIV Treatment as Prevention” Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and

Prevention Retrieved October 2017: <https://www.cdc.gov/hiv/risk/art/index.html>

Figure 14-Reasons for Not Adhering to Antiretroviral Therapy Medications, 2017



Definition: Percent of participants who missed HIV medication 3 or more times (including those 'Not Sure').
Denominator: 97

(**Table 7**) In addition to the barriers listed above, the 2017 Needs Assessment asked how certain common determinants of health affected the respondent's ability to take ART medications as prescribed. Most respondents indicated that the listed social determinants did not affect their ability to take their

ART medication as prescribed. Some respondents reported their housing situation (16%), their co-occurring medical conditions (15%), their mental health (15%), or their use of alcohol or drugs (11%) made it difficult for them to take their HIV medications.

Table 7-Percent of Needs Assessment Participants who had difficulty taking HIV medications as prescribed due to other determinants of health in the past 12 months, 2017

	%	#	Denominator
Housing	16%	67	429
Co-occurring Conditions	15%	35	233
Mental Health	15%	63	426
Alcohol or Drug Use	11%	45	423

AIDS Diagnosis

PLWH living with HIV who adhere to ART and maintain viral suppression may never progress to an AIDS diagnosis. About 60% of Needs Assessment participants indicated that they have never been

diagnosed with AIDS. About a third (37%) of respondents indicated that they had been diagnosed with AIDS at some point in their lifetime.



Chapter 4: Co-Occurring Conditions

INTRODUCTION

This chapter will focus on how persons living with HIV (**PLWH**) in the Austin area experience co-occurring medical and behavioral health conditions. The presence of additional medical conditions can complicate HIV treatment and potentially pose additional barriers to accessing services. Health conditions described in this chapter can be seen within the context of the social determinants of health, which are explored in the following chapter.

1 in 2 PLWH in this survey had a co-occurring health condition

CO-OCCURRING HEALTH CONDITIONS

In the 2017 Austin Area HIV Needs Assessment, participants were asked if they have any other medical issues that require ongoing treatment, in addition to HIV*. Over half (54%) of respondents reported that they do have other health issues that require ongoing treatment. Of the 243 participants who indicated they have additional medical conditions, two-thirds (65%) indicated that they receive adequate treatment for their other condition(s), while one third indicated they receive insufficient or no treatment for their other condition(s). Almost two-thirds (61%) of people with ongoing health issues indicated that they can receive care for those conditions and HIV care through the same medical provider.

A third (33%) of participants indicated that their co-occurring health condition(s) made it difficult for them to attend medical appointments and/or take their HIV medications in the past 12 months.

1 in 3 PLWH indicated their co-occurring medical condition(s) made it difficult for them to attend medical appointments or take ART medications

*Co-occurring medical conditions were not explicitly defined in the survey, but participants were given examples including heart disease, diabetes, chronic pain, cancer and arthritis. Behavioral health issues, including mental health and substance abuse were asked about elsewhere in the survey.

BEHAVIORAL HEALTH

Behavioral health is an umbrella term for any behavior-related health issues that affect mental or emotional wellbeing¹³. It includes mental health diagnosis, indicators of psychological distress, and substance use. The 2017 Austin Area HIV Needs Assessment asked participants about each of these behavioral health issues.

Mental Health Diagnosis

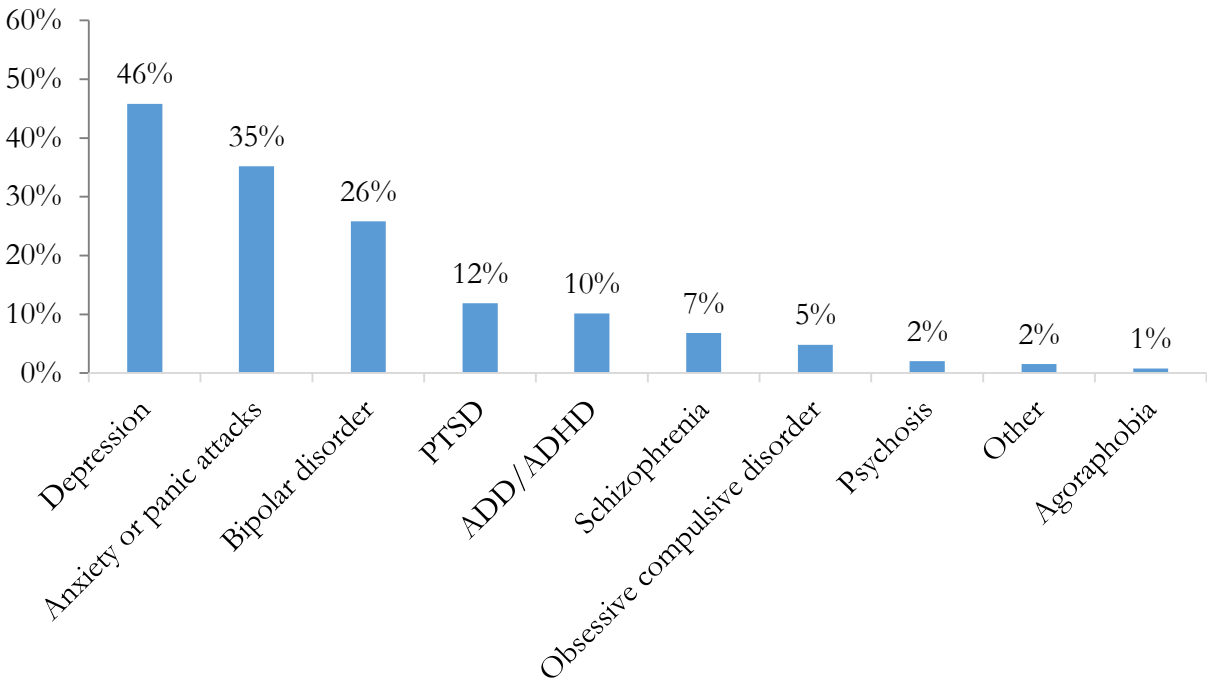
A co-occurring mental health issue may affect an individual’s progression along the HIV Care Continuum. Major stresses—like the death of a loved one, divorce, loss of a job, or moving—can have a major impact on mental health¹⁴. Having a serious medical condition, like HIV, can be another source of stress. Living with HIV may challenge one’s sense

of well-being or complicate existing mental health conditions¹⁵. HIV, and some opportunistic infections, can also affect the nervous system and can lead to changes in behavior¹⁶.

(Figure 15) Of needs assessment participants, 62% (n=244) reported having a current *diagnosis* of at least one mental health condition. The most frequently reported diagnosis was depression at 46%, followed by anxiety or panic attacks at 35%, and bipolar disorder at 26%.

62% of survey respondents have a current diagnosis for a mental health condition

Figure 15-Mental Health Diagnoses among PLWH in the Austin TGA, 2017



Denominator: 395

¹³ Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at: <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>.

¹⁴ HIV.gov Mental Health: Mental Health and HIV. Available at: <https://www.hiv.gov/hiv-basics/staying-in-hiv-care/other-related-health-issues/mental-health>

¹⁵ *ibid*

¹⁶ *ibid*

Mental/ Emotional Distress

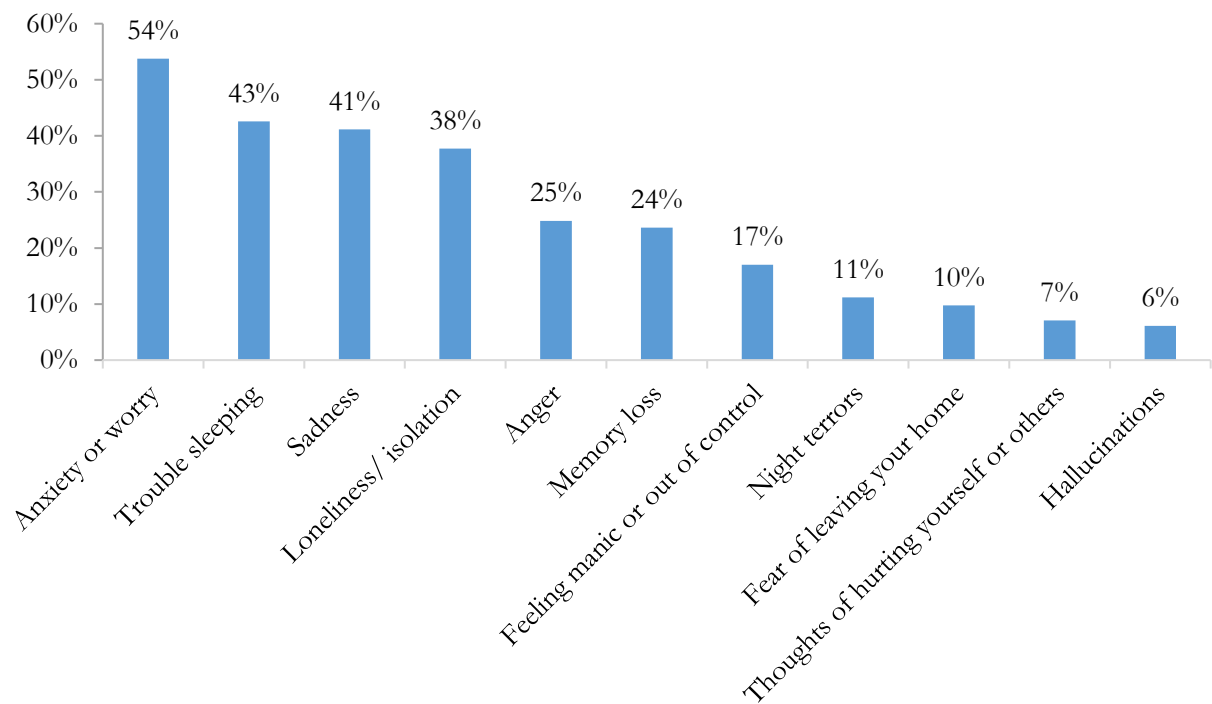
(Figure 16) In addition to mental health diagnosis, participants were also asked if they experienced any symptoms of mental /emotional distress in the past 12 months to *such a degree* that they thought they needed help.

72% of respondents reported at least one symptom of mental or emotional distress

Overall, 72% (n=299) of respondents reported at least one symptom of mental or emotional distress. The most commonly reported symptom of mental or emotional distress is anxiety or worry at 54%, followed by trouble sleeping at 43%, sadness at 41%, and loneliness or isolation at 38%. Less than 5% of respondents wrote in additional answers. The most common write in responses were depression and grief/ death of a partner.

About a quarter (22%) of participants indicated that their mental health made it difficult for them to attend medical appointments and/or take their HIV medications in the past 12 months.

Figure 16-Mental/Emotional Distress Symptoms among PLWH in the Austin TGA, 2017



Denominator: 411 *Definition:* Percent of needs assessment participants reporting having the following symptoms to such a degree that they desired professional help in the past 12 months, regardless of service accessibility.

1 in 4 participants indicated that their mental health made it difficult for them to attend medical appointments and/or take HIV medications

Substance Use

Alcohol and drug use can impair judgment and decision making, and may lead to risky sexual behavior that is often associated with HIV infection and transmission¹⁷. Most Needs Assessment participants (86%) indicated no alcohol or drug use related issues to accessing HIV services or medications. Fourteen percent of Needs Assessment participants indicated that their alcohol or drug use made it difficult for them to attend medical appointments and/or take their HIV medications in the past 12 months.

Injection drug use is a risk factor for acquiring HIV. In 2016, 8.3% of PLWH living in the Austin TGA had injection drug use as a risk factor, and 6.4% had injection drug use and MSM¹⁸. Of Needs Assessment respondents, 11% (n=47) indicated they have used injection drugs, other than those prescribed by a doctor, in the past 12 months. Of those who have injected drugs, a third (34%, n=16) said they shared needles or used a needle that may have been used by someone else. About half (51%, n=24) of people who reported injection drug use also reported they know how to access clean needles, and 39% (n=18) indicated they did not know how to access clean needles.

¹⁷ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and

Quality, December 1, 2010, The NSDUH Report: HIV/AIDS and Substance Use, Rockville, MD

¹⁸ Texas Department of State Health Services, eHARS, 2016



Chapter 5: Social Determinants of Health

INTRODUCTION TO SOCIAL DETERMINANTS OF HEALTH

An individual's health status, including their progression along the HIV Care Continuum, and any co-occurring medical and behavioral health conditions, is influenced by social determinants of health.

Social determinants (e.g., discrimination, income, education level) are complex, integrated, and overlapping social structures and economic systems that can create pathways to good or bad health¹⁹. Environmental factors, such as housing conditions, social networks, and social support may also influence an individual's progression along the HIV Care Continuum. The Austin HIV Planning Council is committed to going beyond addressing HIV on the individual level, to address other contributors to disease, including the social and environmental determinants of health.

The 2017 Austin Area HIV Needs Assessment evaluated some social determinants commonly experienced by people living with HIV (**PLWH**), and how these experiences affect health outcomes and access to HIV services. Data in this section can help communities better understand the needs of people living with HIV, beyond need for medical services. While some determinants of health can be addressed through Ryan White funded service categories, many exist outside the scope of Ryan White services. Understanding the presence of other personal, community, and societal level conditions is key to providing relevant care and collaborating with community partners to meet all needs of PLWH.

The 2017 Austin Area HIV Needs Assessment asked participants about their experience with the following social determinants of health: income, medical coverage, housing, transportation and social support.

¹⁹ Centers for Disease Control and Prevention. Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States. Atlanta

(GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; October 2010. The report is available at: www.cdc.gov/socialdeterminants

Household Income and Economic Stressors

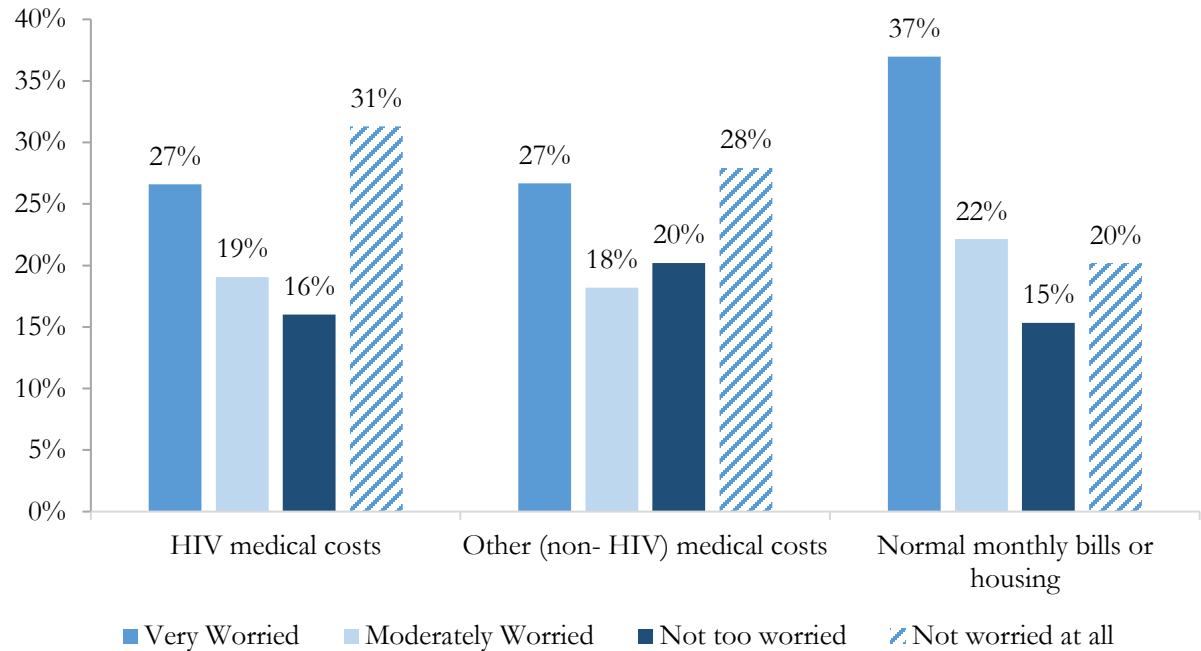
Income directly affects the ability to pay for health care. Of the 1,935 PLWH who received Ryan White Part A services in grant year 2016, approximately 86% (1,659) were below 200% of the federal poverty level (FPL)²⁰. Of all PLWH in the Austin TGA, about 35% are below 200% FPL, according to a U.S. Census Bureau poverty status report²¹.

indicated they were either moderately worried or very worried about their ability to pay for their HIV medical expenses, and 42% indicated they were either moderately worried or very worried about their ability to pay for other medical expenses. More than half of participants (59%) were worried about their ability to pay their monthly bills and housing expenses.

(Figure 17) As a gauge of economic stability, the Needs Assessment survey asked participants how confident they felt in their ability to pay for various expenses. Participants were asked if they were worried about their ability to pay for HIV medical expenses, non-HIV medical expenses, and normal monthly bills and housing. Almost half (43%)

59% of participants were worried about their ability to pay their monthly bills and housing expenses

Figure 17-Ability of PLWH in the Austin area to afford HIV medical expenses, non-HIV medical expenses, and monthly bills and housing, 2017



Definition: Percent of needs assessment participants who indicated each level of concern (from not worried at all to very worried) in regard to their ability to pay HIV medical expenses, other (non-HIV) medical expenses, and normal monthly bills or housing. Denominators range from 401 to 425.

²⁰ AIDS Regional Information and Evaluation System (ARIES) data report for the Austin TGA FY2016. Report run 7/18/2017

²¹ Census Bureau's March 2016 Current Population Survey (CPS: Annual Social and Economic Supplements)

Medical Care Coverage

Studies have shown that uninsured persons are less likely to have a regular source of health care, less likely to receive needed medical care, and more likely to die from health-related problems²². Chronically-ill uninsured adults may delay or forgo checkups and therapies, including medications. Uninsured PLWH are especially vulnerable to poor health outcomes, including an increased risk of death²³. The estimated percentage of PLWH who are uninsured in the Austin TGA is 45%, and approximately 28% of PLWH are covered by Medicaid or Medicare²⁴.

(**Table 8**): 2017 Needs Assessment participants were asked how their HIV medical care is paid for. Participants were given a list to choose from and could select all that applied. Participants indicated Ryan White, Medicare, Medicaid, and the Medical Assistance Program (**MAP**) are the most common payers for HIV services. Only 11% of the respondents indicated they have private insurance.

Table 8-Responses to the question, “How is your HIV medical care paid for” among PLWH, 2017

	#	%
Ryan White Program	160	37%
Medicare	131	30%
Medicaid	111	25%
Medical Assistance Program (MAP)	108	25%
Affordable Care Act Marketplace	21	5%
Insurance through employer	31	7%
Out of pocket	19	4%
I don’t know	13	3%
Other	6	1%

Denominator: 438

²² Bhattacharya, Jayanta & Goldman, Dana & Sood, Neera, "The link between public and private insurance and HIV-related mortality," Journal of Health Economics, Elsevier, vol. 22(6), pages 1105-1122, November 2003

²³ *ibid*

²⁴ Texas Department of State Health Services, eHARS, 2016

Housing

A study among housed and homeless PLWH found that homeless persons had poorer health status, were less adherent to medication regimens, were more likely to be uninsured, and were more likely to have been hospitalized²⁵. Needs assessment participants were asked about their housing situation, and how it has affected their ability to access HIV services. Approximately a quarter (24%) of participants said they felt their housing situation was not stable, that they did not have a safe, reliable place to live. Two-thirds (67%) said they did have stable housing, and 9% were not sure. AIDS Regional Information and Evaluation System (ARIES) reports indicate similar levels of housing instability in the Austin TGA overall. 2016 ARIES data show that 35% of all PLWH in the Austin TGA experienced unstable or temporary housing, including 4% who experienced homelessness.

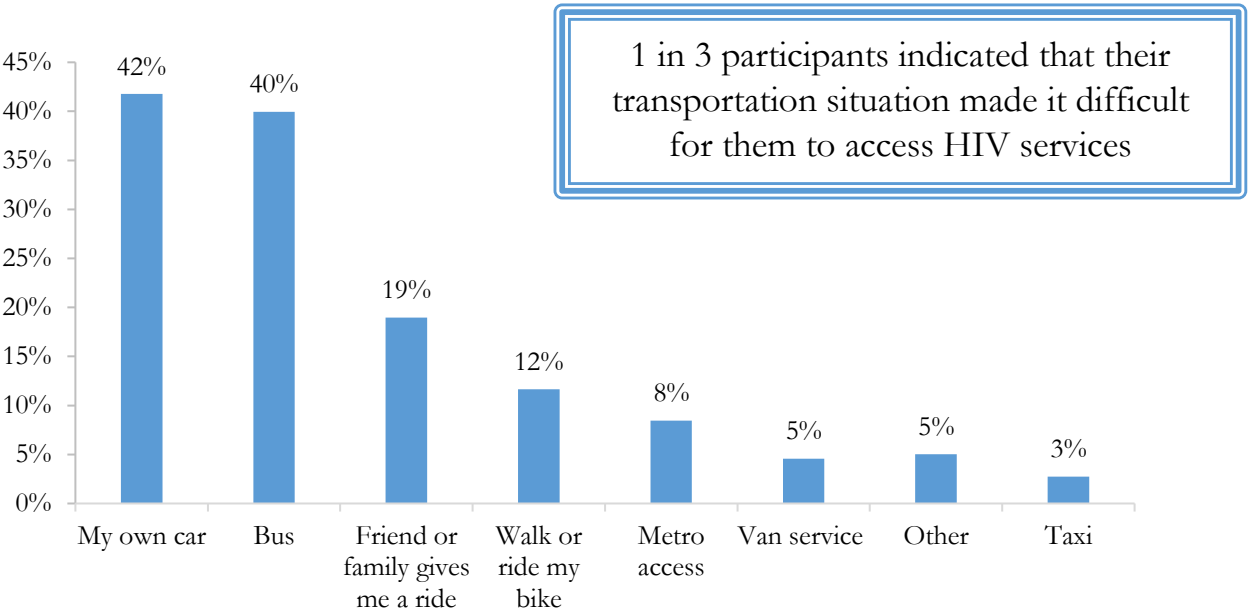
1 in 4 participants have unstable housing

Of all survey participants, 24% indicated their housing situation made it difficult for them to attend medical appointments or take HIV medications. Of people who indicated they did not have stable housing, 52% (n=55) indicated their housing situation was a barrier to either attend HIV medical appointments or take HIV medications.

Transportation

(Figure 18) The 2017 Austin Area HIV Needs Assessment asked individuals how they usually get to and from HIV services. Use of a personal vehicle was the most common means to get to HIV services at 42%, followed closely by taking the bus at 40%. Transportation with a case manager was the most common write-in response (n=14). Overall, about one-third (32%) of respondents indicated that their transportation situation made it difficult for them to get to HIV services.

Figure 18-Mode of transportation to and from HIV services for PLWH in the Austin area, 2017



Denominator: 438

²⁵ Centers for Disease Control and Prevention. Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States. Atlanta

(GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; October 2010. The report is available at: www.cdc.gov/socialdeterminants

Social Support

Participants were asked questions about the social support they receive from their family, friends and networks. When asked if they had enough people in their lives to provide emotional support, advice, and friendship, two thirds (68%) indicated they have enough, 27% indicated they did not have enough, and 5% were unsure. The majority of participants (78%) indicated they had a friend, family member or support group to talk with about their health and HIV status. Also, most (77%) indicated that HIV stigma or fear of discrimination has not kept them from getting services.

Exchanging Sex for Monetary and Non-monetary items

Persons who exchange sex for money, housing, drugs or other items are at increased risk of getting or transmitting HIV because they are more likely to engage in risky sexual behaviors (e.g., sex without a condom, sex with multiple partners) and substance use²⁶. There is a lack of population-level data on persons who exchange sex, which makes it difficult to develop targeted HIV prevention and care efforts²⁷. A small percentage (7%) of Needs Assessment participants indicated that they *received* money, gifts, housing, or drugs in exchange for sex in the last 12 months. Conversely, 6% of respondents indicated they have *given* someone money, gifts, housing or drugs in exchange for sex in the prior 12 months.

²⁶ Centers for Disease Control and Prevention. HIV Risk Among Persons Who Exchange Sex for Money or

Nonmonetary Items Retrieved October 2017: <https://www.cdc.gov/hiv/group/sexworkers.html>.

²⁷ *ibid*



Chapter 6: HIV Prevention

HIV PREVENTION

The Austin Integrated HIV Prevention and Care Plan targets a 25% reduction in new diagnoses by 2021. Supporting viral suppression for PLWH is a key component to achieving this goal, as persons living with HIV who have undetectable viral loads have effectively no risk of transmitting HIV to their sexual partners²⁸. Additional prevention efforts such as condom use and pre-exposure prophylaxis (**PrEP**) are needed to protect the sexual partners of PLWH who have not yet achieved viral suppression. An estimated 28% of people with an HIV diagnosis in the Austin area were not virally suppressed in 2016²⁹, and therefore are at elevated risk of transmitting HIV to their sexual partners. Thus PrEP and condom use are key components of HIV prevention.

This chapter reviews survey participants’ knowledge, attitudes and behaviors around PrEP and condom use as methods of HIV prevention. Viral suppression as HIV prevention was discussed in Chapter 3.

40% of participants are not knowledgeable about PrEP or where to access it

Pre-exposure Prophylaxis (PrEP)

(Table 9) PrEP is a biomedical intervention, highly effective at preventing the transmission of HIV to HIV-negative sexual partners. When needs assessment participants were asked about their knowledge of PrEP, one third (34%) indicated they know what PrEP is and where to access it. 15% indicated they know what PrEP is but not how to access it. About 40% of participants indicated they do not know what PrEP is nor where to access it. Among individuals who reported being sexually active in the past 12 months, 63% (n=156) indicated they know what PrEP is, and 43% (n=105) know where it is available.

Table 9-Knowledge of PrEP and knowledge of PrEP availability among PLWH in the Austin area, 2017

		"Do you know where PrEP is available?"			Total
		Yes	No	Not sure	
"Do you know what pre-exposure prophylaxis (PrEP) is?"	Yes	144 (34%)	62 (15%)	8 (2%)	214
	No	6 (1%)	172 (40%)	3(<1%)	181
	Not Sure	3 (<1%)	8 (2%)	20 (5%)	31

Denominator: 426

²⁸ “HIV Treatment as Prevention” Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and

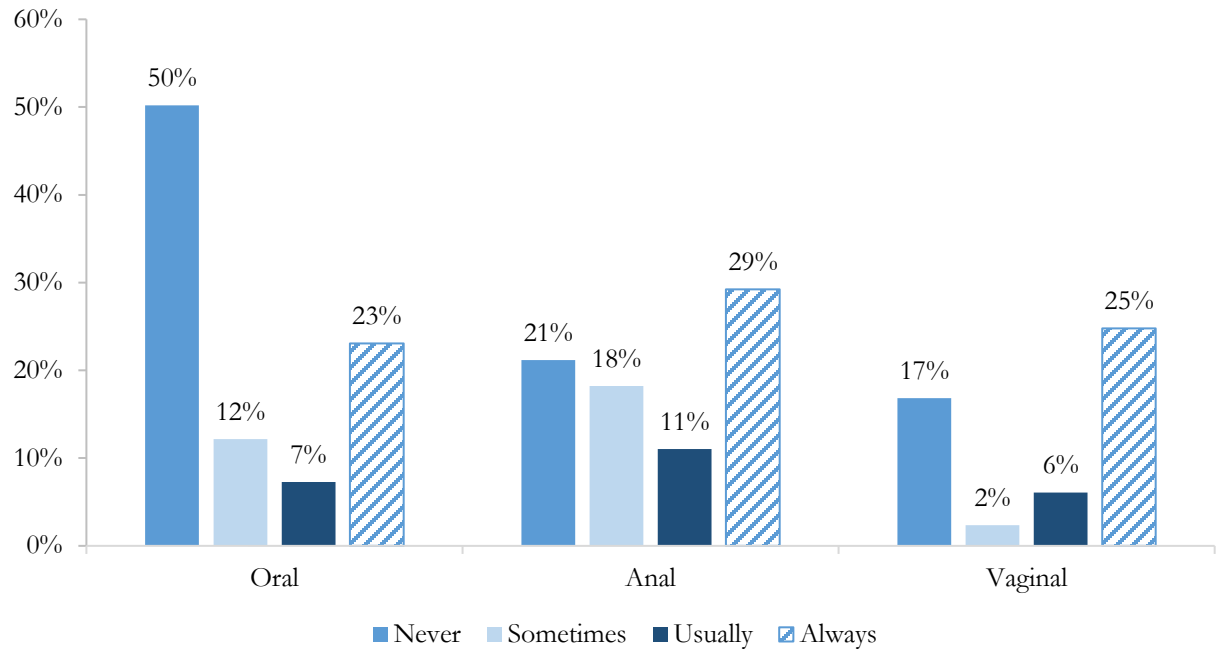
Prevention Retrieved October 2017:
<https://www.cdc.gov/hiv/risk/art/index.html>
²⁹ Texas Department of State Health Service, eHARS. Retrieved September 2017.

Condom Use

(**Figure 19**) Needs assessment participants were asked about their use of safer sex practices, particularly condom use, and barriers to consistent condom use. 23% of participants reported always

using condoms for oral sex, 29% for anal, and 25% for vaginal sex. Consistent condom use was lowest for oral sex, with 50% of participants reporting that they never use condoms during oral sex, 21% never use condoms during anal sex, and 17% never use condoms during vaginal sex.

Figure 19-Percent of survey participants who use condoms during sexual activity, 2017

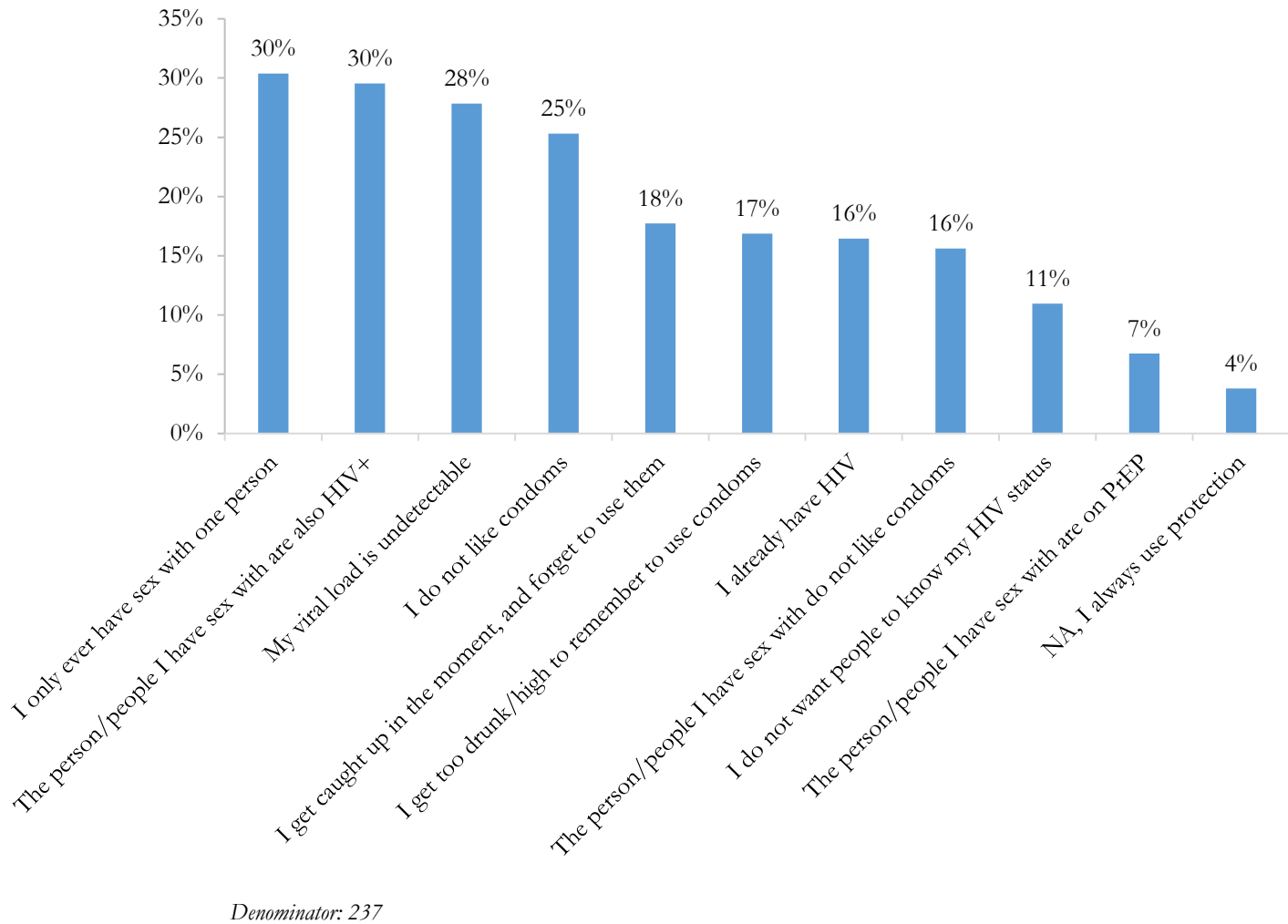


Denominator: 255

(**Figure 20**) Participants who reported inconsistent or no condom use in the past 12 months were asked to indicate their reason for not using condoms. Participants were provided a list of ten common reasons for not using condoms and could also write-in a response. Monogamy, serosorting (choosing partners with the same HIV status), and having an

undetectable viral load were the top reported reasons for not using condoms. About a quarter of respondents indicated they did not like condoms, 18% indicated they “get caught up in the moment and forget to use condoms”, and 17% indicated alcohol or drug use created a barrier to condom use.

Figure 20-Reasons for inconsistent or no condom use among PLWH in the Austin area, 2017





Chapter 7: Service-Specific Fact Sheets

BUS PASSES AND TAXI VOUCHERS

Bus passes and taxi vouchers (funded under Ryan White service category *Medical Transportation*) are distributed to eligible persons living with HIV (**PLWH**) to provide nonemergency transportation services to enable them to access or be retained in core medical and support services.

57% of participants needed bus passes or taxi vouchers

83% of participants who needed bus passes or taxi vouchers received them

In the 2017 Austin Area HIV Needs Assessment, 57% (n=231) of participants indicated a need for *bus passes or taxi vouchers* in the past 12 months. Of those who indicated a need for the service, 83% (n=176) indicated they received the service, while 17% (n=36) indicated they did not receive the service in the past 12 months.

(**Table 1**) Participants were asked to indicate if they experienced any barriers to accessing *bus passes or taxi vouchers*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 59 people who indicated a need for *bus passes or taxi vouchers* reported at

least one barrier. The most commonly reported barriers were lack of knowledge about the service, difficulty taking the bus while ill, and need to take multiple buses to get to services.

(**Table 2**) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed. Analysis of the *bus passes and taxi vouchers* data shows the following:

- A larger percentage of Black PLWH needed this service than PLWH of other races/ethnicities
- Female PLWH and PLWH age 55+ were more likely to need this service *but not receive it* compared to males and other age groups
- Out of care¹ PLWH were more likely to need the service compared to PLWH overall
- Monolingual Spanish speaking PLWH were less likely to need this service than PLWH overall
- 75% of transgender PLWH needed this service
- 1 in 4 transgender PLWH who needed this service *did not receive it*
- 1 in 4 unstably housed¹ PLWH who needed this service *did not receive it*

Table 1- Top 3 Reported Barriers to receiving Bus Passes or Taxi Vouchers, 2017

		No.	%
1.	Did not know how to get this service	19	35%
2.	Difficulty taking the bus while ill	9	15%
3.	Need to take multiple busses to get to services	7	12%

Table 2- Bus Passes or Taxi Vouchers, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	55%	165	59%	47	50%	64	76%	103	39%	43	63%	17	25%	4	57%	156	60%	67
Needed + Received	85%	132	79%	31	85%	53	81%	72	85%	33	82%	14	100%	4	84%	122	79%	46
Needed + Did Not Receive	15%	24	21%	8	15%	9	19%	17	15%	6	18%	3	0%	0	16%	24	21%	12

¹ *Definitions: Unstably housed:* Self-report of not having “stable housing, or a reliable, safe place to live”. *Out of care:* Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

CASE MANAGEMENT

Case management refers to two Ryan White service categories: *Medical case management* and *Non-medical case management*. In general, case management describes a range of services that help connect persons living with HIV (**PLWH**) to HIV care, treatment, and support services and to retain them in care. Case managers assess client needs, develop service plans, and facilitate access to services through referrals and care coordination. Medical case management also includes treatment readiness and adherence counseling. Non-medical case management services provide guidance and assistance in accessing medical, social, community, legal, financial and other needed services.

76% of participants needed case management

94% of participants who needed case management received it

In the 2017 Austin Area HIV Needs Assessment, 76% (n=307) of participants indicated a need for *case management* in the past 12 months. Of those who indicated a need for the service, 94% (n=267) indicated they received the service, while 6% (n=16) indicated they did not receive the service in the past 12 months.

(**Table 1**) Participants were asked to indicate if they experienced any barriers to receiving *case management*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 63 people who indicated a need for *case management* reported at least one

barrier. The most commonly reported barriers were transportation, lack of knowledge about the service, and paperwork or enrollment process.

(**Table 2**) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed.

Analysis of the *case management* data shows the following:

- A larger percentage of Hispanic PLWH needed this service than PLWH of other races/ethnicities
- Young (age 18-24) PLWH were less likely to need this service compared to other age groups
- 95% of transgender PLWH needed this service
- 100% of young PLWH and 100% transgender PLWH who needed the service received it
- Only 2% of female PLWH who needed this service *did not receive it*

Table 1- Top 3 Reported Barriers for Case Management , 2017

	No.	%
1. Transportation	14	22%
2. Did not know how to get this service	11	17%
3. Paperwork or enrollment process	7	11%

Table 2- Case Management, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	76%	227	73%	60	74%	96	73%	101	80%	86	77%	20	63%	10	76%	207	76%	87
Needed + Received	93%	200	98%	48	92%	85	94%	81	96%	77	95%	19	100%	10	94%	182	95%	72
Needed + Did Not Receive	7%	15	2%	1	8%	7	6%	5	4%	3	5%	1	0%	0	6%	12	5%	4

FOOD BANK

Food bank is the provision of food and/ or household items to persons living with HIV (**PLWH**). In the Austin Transitional Grant Area (**TGA**), the Ryan White service category *Food bank/Home Delivered Meals* is only used for food bank services.

68% of participants needed food bank services

84% of participants who needed food bank services received them

In the 2017 Austin Area HIV Needs Assessment, 68% (n=277) of participants indicated a need for *food bank services* in the past 12 months. Of those who indicated a need for the service, 84% (n=213) indicated they received the service, while 16% (n=40) indicated they did not receive the service in the past 12 months.

(**Table 1**) Participants were asked to indicate if they experienced any barriers to receiving *food bank services*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 71 people who indicated a need for *food bank services* reported at least one

barrier. The most commonly reported barriers were lack of knowledge about the service, transportation and the amount of food received.

(**Table 2**) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed.

Analysis of the *food bank services* data shows the following:

- A larger percentage of Black PLWH needed this service than PLWH of other races/ethnicities
- Young (age 18-24) PLWH were less likely to need this service compared to other age groups
- 77% of unstably housed¹ PLWH needed this service
- 78% of out of care¹ PLWH needed this service
- 86% of transgender PLWH needed this service
- 100% of multi-racial PLWH and of 100% transgender PLWH who needed this service received it

Table 1- Top 3 Reported Barriers for Food Bank Services, 2017

	No.	%
1. Did not know how to get this service	18	25%
2. Transportation	16	23%
3. Amount of food	8	11%

Table 2- Food Bank Services, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	65%	195	73%	61	68%	87	74%	103	62%	68	59%	16	25%	4	70%	193	68%	77
Needed + Received	80%	147	96%	47	75%	64	87%	75	92%	57	100%	16	100%	4	83%	149	85%	57
Needed + Did Not Receive	20%	37	4%	2	25%	21	13%	11	8%	5	0%	0	0%	0	17%	30	15%	10

¹ *Definitions: Unstably housed:* Self-report of not having “stable housing, or a reliable, safe place to live”. *Out of care:* Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

HEALTH INSURANCE ASSISTANCE

Health insurance assistance, refers to the Ryan White service category *health insurance premium and cost-sharing assistance*. This service provides financial assistance to persons living with HIV (PLWH) with third-party health insurance coverage (such as private insurance, ACA Qualified Health Plans, COBRA, or Medicare) so they can obtain or maintain medical, pharmacy and dental health care benefits. This includes funding for premiums, deductibles, and co-pays for both medical visits and medication.

52% of participants needed health insurance assistance

84% of participants who needed health insurance assistance received it

In the 2017 Austin Area HIV Needs Assessment, 52% (n=205) of participants indicated a need for *health insurance assistance* in the past 12 months. Of those who indicated a need for the service, 84% (n=152) indicated they received the service, while 16% (n=28) indicated they did not receive the service in the past 12 months.

(**Table 1**) Participants were asked to indicate if they experienced any barriers to receiving *health insurance assistance*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 59 people who indicated a need for *health insurance assistance*

reported at least one barrier. The most commonly reported barriers were lack of knowledge about the service, paperwork or enrollment process, and a co-pay or deductible the participant considered to be high.

(**Table 2**) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed. Analysis of the *health insurance assistance* data shows the following:

- A larger percentage of Hispanic PLWH needed this service than PLWH of other races/ethnicities
- Female PLWH were more likely to need this service *but not receive it* compared to males
- White PLWH were more likely to need this service *but not receive it* compared to other race/ethnicities
- Young (age 18-24) PLWH were more likely to need this service *but not receive it* compared to other age groups
- 60% of monolingual Spanish speaking PLWH needed this service
- 60% of transgender PLWH needed this service
- 1 in 5 out of care¹ PLWH who needed this service *did not receive it*

Table 1- Top 3 Reported Barriers for Health Insurance Assistance, 2017

	No.	%
1. Did not know how to get this service	20	34%
2. Paperwork or enrollment process	9	15%
3. High co-pay or deductible	9	15%

Table 2- Health Insurance Assistance, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	53%	154	48%	37	48%	59	51%	30	57%	62	45%	9	44%	7	53%	145	49%	51
Needed + Received	86%	122	74%	20	75%	41	85%	44	96%	51	89%	8	71%	5	85%	110	85%	35
Needed + Did Not Receive	14%	20	26%	7	25%	14	15%	8	4%	2	11%	1	29%	2	15%	20	15%	6

¹ *Definitions: Out of care:* Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

HIV MEDICAL CARE

HIV medical care refers to the Ryan White service category called *Outpatient/ Ambulatory Health Services*.

Outpatient/ Ambulatory Health Services are diagnostic and therapeutic services provided directly to persons living with HIV (**PLWH**) by a licensed healthcare provider in an outpatient medical setting. This includes physical examinations, laboratory testing, treatment of physical and behavioral health conditions, preventative care, prescriptions and other primary medical care services.

93% of participants needed Outpatient/ Ambulatory Health Services

97% of participants who needed Outpatient/ Ambulatory Health Services received them

In the 2017 Austin Area HIV Needs Assessment, 93% (n=381) of participants indicated a need for *Outpatient/ Ambulatory Health Services* in the past 12 months. Of those who indicated a need for the service, 97% (n=344) indicated they received the service, while 3% (n=11) indicated they did not receive the service in the past 12 months.

(**Table 1**) Participants were asked to indicate if they experienced any barriers to receiving *Outpatient/ Ambulatory Health Services*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 78 people who indicated a need for

Outpatient/ Ambulatory Health Services reported at least one barrier. The most commonly reported barriers were transportation, the paperwork or enrollment process, and lack of knowledge about the service.

(**Table 2**) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed. Analysis of the *Outpatient/ Ambulatory Health Services* data shows the following:

- Male PLWH were more likely to need this service *but not receive it* compared to females
- Black PLWH were more likely to need this service *but not receive it* compared to other races/ethnicities
- PLWH age 25-54 were more likely to need this service *but not receive it* compared to other age groups
- 7% of out of care¹ PLWH who needed this service *did not receive it*
- 11% of transgender PLWH who needed this service *did not receive it*

Table 1- Top 3 Reported Barriers for Outpatient/ Ambulatory Health Services , 2017

	No.	%
1. Transportation	20	26%
2. Paperwork or Enrollment Process	12	15%
3. Did not know how to get this service	6	8%

Table 2- Outpatient/ Ambulatory Health Services, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	94%	284	85%	69	94%	113	89%	123	95%	104	89%	25	88%	14	94%	263	91%	100
Needed + Received	97%	260	100%	61	98%	116	94%	101	99%	97	96%	23	100%	14	96%	239	99%	87
Needed + Did Not Receive	3%	8	0%	0	2%	2	6%	7	1%	1	4%	1	0%	0	4%	10	1%	1

¹ *Definitions: Out of care:* Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

HIV MEDICATION ASSISTANCE

HIV medication assistance refers to the Ryan White service category *Local AIDS Pharmaceutical Assistance (LPAP)* and to the state *AIDS Drug Assistance (ADAP)* program. ADAP is a state-administered program authorized under Ryan White Part B to provide FDA-approved medications to low-income persons living with HIV (PLWH) who have no coverage or limited health care coverage. LPAP is operated by a Ryan White Part A or B recipient or subrecipient as a supplemental means of providing medication assistance when ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria. For part of 2017, Emergency Financial Assistance was also used to fund HIV medications while ADAP applications were being processed.

86% of participants needed HIV medication assistance

95% of participants who needed HIV medication assistance received it

In the 2017 Austin Area HIV Needs Assessment, 86% (n=348) of participants indicated a need for *HIV medication assistance* in the past 12 months. Of those who indicated a need for the service, 95% (n=305) indicated they received the service, while 5% (n=15) indicated they did not receive the service in the past 12 months.

(Table 1) Participants were asked to indicate if they experienced any barriers to receiving *HIV medication assistance*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 56 people who indicated a need for *HIV medication*

assistance reported at least one barrier. The most commonly reported barriers were transportation, the paperwork or enrollment process, and lack of knowledge about the service.

(Table 2) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed. Analysis of the *HIV medication assistance* data shows the following:

- All races/ethnicities reported high rates for receiving the service
- A larger percentage of male PLWH needed this service compared to females
- A larger percentage of multi-racial and Hispanic PLWH needed this service compared to PLWH of other races/ethnicities
- A larger percentage of PLWH age 25-54 needed this service compared to other age groups
- White PLWH were more likely to need this service *but not receive it* compared to other races/ethnicities
- Young (age 18-24) PLWH were more likely to need this service *but not receive it* compared to other age groups
- 12% of out of care¹ PLWH who needed this service *did not receive it*

Table 1- Top 3 Reported Barriers for HIV Medication Assistance, 2017

	No.	%
1. Transportation	14	25%
2. Paperwork or Enrollment Process	11	20%
3. Did not know how to get this service	9	16%

Table 2- HIV Medication Assistance, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	87%	257	80%	65	85%	112	83%	109	88%	96	89%	25	69%	11	89%	247	82%	87
Needed + Received	95%	228	96%	55	93%	99	95%	88	98%	88	96%	23	73%	8	96%	222	96%	72
Needed + Did Not Receive	5%	12	4%	2	7%	7	5%	5	2%	2	4%	1	27%	3	4%	9	4%	3

¹ Definitions: Out of care: Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

HIV SUPPORT GROUP

In the Austin Transitional Grant Area, the Ryan White service category *Psychosocial Support Services* funds local *HIV Support Groups*. HIV support groups provide group support and counseling services to assist eligible persons living with HIV (**PLWH**) to address behavioral and physical health concerns.

36% of participants needed an HIV support group

70% of participants who needed an HIV support group received it

In the 2017 Austin Area HIV Needs Assessment, 36% (n=147) of participants indicated a need for an *HIV support group* in the past 12 months. Of those who indicated a need for the service, 70% (n=88) indicated they received the service, while 30% (n=37) indicated they did not receive the service in the past 12 months.

(**Table 1**) Participants were asked to indicate if they experienced any barriers to accessing an *HIV support group*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 34 people who indicated a need for an *HIV support group*

reported at least one barrier. The most commonly reported barriers were lack of knowledge about the service, group meeting times, and transportation.

(**Table 2**) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed. Analysis of the *HIV support group* data shows the following:

- A larger percentage of female PLWH needed this service compared to males
- A larger percentage of Black PLWH needed this service compared to PLWH of other races/ethnicities
- A larger percentage of PLWH age 55+ needed this service compared to other age groups
- White and multi-racial PLWH were more likely to need this service *but not receive it* compared to other races/ethnicities
- 43% of unstably housed¹ PLWH needed this service, and 37% of unstably housed PLWH who needed this service *did not receive it*
- 46% of out of care¹ PLWH needed this service
- 45% of transgender PLWH needed this service
- Half of monolingual Spanish speaking PLWH who needed this service *did not receive it*

Table 1- Top 3 Reported Barriers for HIV Support Groups , 2017

	No.	%
1. Did not know how to get this service	17	50%
2. Group meeting times	8	24%
3. Transportation	7	21%

Table 2- HIV Support Groups, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	32%	97	50%	39	25%	32	53%	72	29%	32	27%	7	19%	3	34%	93	43%	48
Needed + Received	66%	57	77%	23	50%	15	79%	44	74%	20	57%	4	33%	1	67%	56	78%	28
Needed + Did Not Receive	34%	29	23%	7	50%	15	21%	12	26%	7	43%	3	67%	2	33%	27	22%	8

¹ *Definitions: Unstably housed:* Self-report of not having “stable housing, or a reliable, safe place to live”. *Out of care:* Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

HOUSING ASSISTANCE

Housing assistance for persons living with HIV (PLWH) is provided by the Housing Opportunities for People Living with AIDs (HOPWA) program. Ryan White Part A also provides transitional, short-term, or emergency housing assistance for eligible PLWH and their families.

57% of participants needed housing assistance

73% of participants who needed housing assistance received it

In the 2017 Austin Area HIV Needs Assessment, 57% (n=235) of participants indicated a need for *housing assistance* in the past 12 months. Of those who indicated a need for the service, 73% (n=155) indicated they received the service, while 27% (n=56) indicated they did not receive the service in the past 12 months.

(Table 1) Participants were asked to indicate if they experienced any barriers to receiving *housing assistance*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 70 people who indicated a need for *housing assistance* reported at least one

barrier. The most commonly reported barriers were lack of knowledge about the service, waitlist, and paperwork/enrollment process. After indicating they did not qualify for housing assistance, one respondent wrote, "I guess I make too much [money]. I don't know how, when I have to choose between gas and food."

(Table 2) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed.

Analysis of the *housing assistance* data shows the following:

- A larger percentage of Black and multi-racial PLWH needed this service compared to PLWH of other races/ethnicities
- Female PLWH were more likely to need this service *but not receive it* compared to males
- 81% of unstably housed¹ PLWH needed this service, and 39% of unstably housed PLWH who needed this service *did not receive it*
- 71% of out of care¹ PLWH needed this service, and 31% of out of care PLWH who needed this service *did not receive it*
- 71% of transgender PLWH needed this service, and only 8% of transgender PLWH who needed this service *did not receive it*

Table 1- Top Reported Barriers for Housing Assistance, 2017

	No.	%
1. I did not know how to get this service	20	29%
2. Waitlist	24	34%
3. Paperwork	11	16%
4. I do not qualify for assistance	6	9%
4. Long wait at agency	6	9%

Table 2- Housing Assistance, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	57%	172	58%	46	55%	71	63%	88	49%	53	70%	19	31%	5	59%	163	57%	64
Needed + Received	73%	116	68%	25	75%	51	74%	53	72%	34	79%	15	100%	5	72%	108	77%	40
Needed + Did Not Receive	27%	42	32%	12	25%	17	26%	19	28%	13	21%	4	0%	0	28%	43	23%	12

¹ Definitions: *Unstably housed*: Self-report of not having "stable housing, or a reliable, safe place to live". *Out of care*: Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

INPATIENT SUBSTANCE USE PROGRAMS

Inpatient substance use programs, also called *residential substance abuse services*, refer to the treatment of drug or alcohol use disorders in a residential setting. Services include screening, assessment, diagnosis, and treatment of substance use disorders for persons living with HIV (PLWH).

12% of participants needed inpatient substance abuse services

74% of participants who needed inpatient substance abuse services received them

In the 2017 Austin Area HIV Needs Assessment, 12% (n=48) of participants indicated a need for *residential substance abuse services* in the past 12 months. Of those who indicated a need for the service, 74% (n=32) indicated they received the service, while 26% (n=11) indicated they did not receive the service in the past 12 months.

(Table 1) Participants were asked to indicate if they experienced any barriers to receiving *residential substance abuse services*.

Participants were given a list of common barriers (see Appendix A) or could write in a response. 8 people who indicated a need for

residential substance abuse services reported at least one barrier. The most commonly reported barriers were transportation, paperwork/enrollment process, and long wait at the agency.

(Table 2) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed. Analysis of the *residential substance abuse services* data shows the following:

- A larger percentage of multi-racial and Black PLWH needed this service compared to PLWH of other races/ethnicities
- A larger percentage of PLWH age 25-54 needed this service compared to other age groups
- Out of 42 monolingual Spanish speakers, none reported a need for this service
- 22% of unstably housed¹ PLWH needed this service, and 32% of unstably housed PLWH who needed this service *did not receive it*
- 19% of out of care¹ PLWH needed this service

Table 1- Top 3 Reported Barriers for Inpatient Substance Abuse Services, 2017

	No.	%
1. Did not know how to get this service	4	29%
2. Transportation	4	29%
3. Long wait at the agency	3	21%

Table 2- Inpatient Substance Abuse Services, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	12%	36	10%	8	13%	17	18%	24	5%	5	19%	5	0%	0	15%	40	6%	7
Needed + Received	74%	26	60%	3	71%	12	80%	16	75%	3	80%	4	-	-	69%	25	100%	6
Needed + Did Not Receive	26%	9	40%	2	29%	5	20%	4	25%	1	20%	1	-	-	31%	11	0%	0

¹ Definitions: *Unstably housed*: Self-report of not having “stable housing, or a reliable, safe place to live”. *Out of care*: Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

MENTAL HEALTH COUNSELING

Mental Health Counseling, also referred to as *Mental Health Services*, provides psychological and psychiatric screening, assessment, diagnosis, treatment and counseling services for persons living with HIV (PLWH). This includes group or individual counseling by a licensed mental health professional.

48% of participants needed mental health counseling

79% of participants who needed mental health counseling received it

In the 2017 Austin Area HIV Needs Assessment, 48% (n=198) of participants indicated a need for *mental health services* in the past 12 months. Of those who indicated a need for the service, 79% (n=143) indicated they received the service, while 21% (n=39) indicated they did not receive the service in the past 12 months.

(**Table 1**) Participants were asked to indicate if they experienced any barriers to receiving *mental health services*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 48 people who indicated a need for *mental health services* reported at

least one barrier. The most commonly reported barriers were lack of knowledge about the service, transportation, and paperwork/enrollment process.

(**Table 2**) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed.

Analysis of the *mental health services* data shows the following:

- A larger percentage of female PLWH needed this service compared to males
- A larger percentage of PLWH age 25-54 needed this service compared to other age groups
- Young (age 18-24) PLWH who needed this service were *less likely to receive it* compared to other age groups
- 62% of unstably housed¹ PLWH needed this service
- 60% of out of care² PLWH needed this service
- 75% of transgender PLWH needed this service

Table 1- Top Reported Barriers for Mental Health Counseling, 2017

	No.	%
1. Did not know how to get this service	17	35%
2. Transportation	14	29%
3. Paperwork or enrollment process	7	15%
4. Facility hours	6	13%
5. Waitlist	5	10%

Table 2- Mental Health Counseling, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	44%	133	57%	47	47%	63	51%	71	42%	46	46%	12	31%	5	52%	144	41%	47
Needed + Received	76%	97	82%	32	76%	48	81%	47	81%	35	75%	9	40%	2	78%	105	85%	34
Needed + Did Not Receive	24%	30	18%	7	24%	15	19%	11	19%	8	25%	3	60%	3	22%	30	15%	6

¹ Definition: *Unstably housed*: Self-report of not having “stable housing, or a reliable, safe place to live”.

² Definition: *Out of care*: Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

NUTRITION/DIETITIAN SERVICES

Nutrition/ Dietitian Services, also referred to as *Medical Nutrition Therapy*, includes nutrition assessment and screening, dietary/nutritional evaluation, food and/or nutritional supplements, and nutrition education and/or counseling for persons living with HIV (PLWH).

43% of participants needed medical nutrition therapy

73% of participants who needed medical nutrition therapy received it

In the 2017 Austin Area HIV Needs Assessment, 43% (n=176) of participants indicated a need for *medical nutrition therapy* in the past 12 months. Of those who indicated a need for the service, 73% (n=114) indicated they received the service, while 27% (n=43) indicated they did not receive the service in the past 12 months.

(**Table 1**) Participants were asked to indicate if they experienced any barriers to receiving *medical nutrition therapy*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 30 people who indicated a need for *medical nutrition therapy*

reported at least one barrier. The most commonly reported barriers were lack of knowledge about the service, transportation, and hours the dietitian is available.

(**Table 2**) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed. Analysis of the *medical nutrition therapy* data shows the following:

- A larger percentage of female PLWH needed this service compared to male PLWH
- A larger percentage of Black PLWH needed this service compared to PLWH of other races/ethnicities
- A larger percentage of PLWH age 55+ needed this service compared to other age groups
- Male PLWH who needed this service were *less likely to receive it* compared to females
- White PLWH who needed this service were *less likely to receive it* compared to other races/ethnicities
- 53% of unstably housed¹ PLWH needed this service, and 37% of unstably housed PLWH who needed this service *did not receive it*
- 65% of transgender PLWH needed this service
- 53% of out of care¹ PLWH needed this service

Table 1- Top 3 Reported Barriers for Medical Nutrition Therapy, 2017

	No.	%
1. Did not know how to get this service	16	53%
2. Transportation	6	20%
3. Hours dietitian is available	5	17%

Table 2- Medical Nutrition Therapy, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	41%	124	48%	38	36%	46	54%	74	43%	48	26%	7	25%	4	40%	110	54%	47
Needed + Received	69%	79	79%	23	53%	24	85%	51	72%	31	86%	6	50%	2	68%	68	83%	33
Needed + Did Not Receive	31%	36	21%	6	47%	21	15%	9	28%	12	14%	1	50%	2	32%	32	18%	7

¹ *Definitions: Unstably housed:* Self-report of not having “stable housing, or a reliable, safe place to live”. *Out of care:* Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

ORAL HEALTH CARE

Oral health care, or *dental care* services, provide outpatient diagnostic, preventative, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants for persons living with HIV (**PLWH**).

76% of participants needed oral health care

69% of participants who needed oral health care received it

In the 2017 Austin Area HIV Needs Assessment, 76% (n=307) of participants indicated a need for *oral health care* in the past 12 months. Of those who indicated a need for the service, 69% (n=194) indicated they received the service, while 31% (n=88) indicated they did not receive the service in the past 12 months.

(**Table 1**) Participants were asked to indicate if they experienced any barriers to receiving *oral health care*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 102 people who indicated a need for *oral health care*

reported at least one barrier. The most commonly reported barriers were lack of knowledge about the service, transportation, and difficulty scheduling an appointment.

(**Table 2**) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed.

Analysis of the *oral health care* data shows the following:

- A larger percentage of male PLWH needed this service compared to females
- A larger percentage of multi-racial PLWH needed this service compared to other races/ethnicities
- A larger percentage of PLWH age 25-54 needed this service compared to other age groups
- PLWH age 55+ who needed this service were *more likely to receive* compared to other age groups
- 85% of monolingual Spanish speaking PLWH needed this service
- 100% of transgender PLWH needed this service
- 45% of unstably housed¹ PLWH who needed this service *did not receive it*
- 42% of out of care¹ PLWH who needed this service *did not receive it*

Table 1- Top 3 Reported Barriers for Oral Health Care, 2017

		No.	%
1.	Did not know how to get this service	23	23%
2.	Transportation	15	15%
3.	Difficulty scheduling an appointment	14	14%

Table 2- Oral Health Care, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	76%	223	72%	60	76%	97	75%	103	77%	82	85%	23	50%	8	78%	213	75%	83
Needed + Received	68%	147	65%	30	61%	58	73%	63	79%	59	61%	14	63%	5	63%	126	83%	60
Needed + Did Not Receive	32%	68	35%	16	39%	37	27%	23	21%	16	39%	9	38%	3	37%	73	17%	12

¹ *Definitions: Unstably housed:* Self-report of not having “stable housing, or a reliable, safe place to live”. *Out of care:* Self-report in the past 5 years, there was a period of at least 12 months during which the survey respondent did not see a doctor or get a prescription for ART medications.

OUTPATIENT SUBSTANCE USE PROGRAMS

Outpatient substance use programs, also referred to as *substance abuse outpatient care*, is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include screening, assessment, diagnosis and treatment of substance use disorders for persons living with HIV (PLWH).

19% of participants needed substance abuse outpatient services

69% of participants who needed substance abuse outpatient services received them

In the 2017 Austin Area HIV Needs Assessment, 19% (n=76) of participants indicated a need for *substance abuse outpatient care* in the past 12 months. Of those who indicated a need for the service, 69% (n=47) indicated they received the service, while 31% (n=21) indicated they did not receive the service in the past 12 months.

(**Table 1**) Participants were asked to indicate if they experienced any barriers to receiving *substance abuse outpatient care*. Participants were given a list of common barriers (see Appendix A) or could write in a response. 14 people who indicated a need for *substance abuse outpatient care* reported at least one barrier. The most

commonly reported barriers were lack of knowledge about the service, transportation, and hours the service was available.

(**Table 2**) Table 2 identifies service needs and access by gender, race/ethnicity, and age. Additionally, service needs for monolingual Spanish speaking participants, transgender participants, unstably housed participants, and out of care participants were assessed.

Analysis of the *substance abuse outpatient care* data shows the following:

- A larger percentage of male PLWH needed this service compared to females
- A larger percentage of multi-racial and Black PLWH needed this service compared to PLWH of other races/ethnicities
- A larger percentage of PLWH age 25-54 needed this service compared to other age groups
- 26% of unstably housed¹ PLWH needed this service, and 50% of unstably housed PLWH who needed this service *did not receive it*
- Out of 43 monolingual Spanish speakers, none reported a need for this service

Table 1- Top 3 Reported Barriers for Outpatient Substance Abuse Services, 2017

	No.	%
1. Did not know how to get this service	4	29%
2. Transportation	4	29%
3. Hours the service is available	3	21%

Table 2- Outpatient Substance Abuse Services, by Selected Demographics 2017

	Gender				Race/ethnicity								Age Group					
	Male		Female		White		Black		Hispanic		Multi-Racial		18-24		25-54		55+	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Needed Service	20%	61	13%	10	20%	25	25%	34	9%	10	26%	7	6%	1	22%	60	13%	14
Needed + Received	70%	40	57%	4	63%	15	75%	21	67%	6	71%	5	100%	1	64%	35	91%	10
Needed + Did Not Receive	30%	17	43%	3	38%	9	25%	7	33%	3	29%	2	0%	0	36%	20	9%	1

¹ *Definitions: Unstably housed:* Self-report of not having “stable housing, or a reliable, safe place to live”.