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Needs Assessment for Greater Hampton Roads HIV Services Planning Council

Submitted to

The City of Norfolk

FINAL

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February 28, 2017

Acknowledgements

We would like to thank all the consumers, service providers and partners who participated in this assessment or supported its completion. We hope that this assessment enables the Greater Hampton Roads HIV Health Services Planning Council to better understand and address the needs of people living with diagnosed HIV or AIDS (PLWHA) in the area.

We would also like to thank those individuals who contributed their time and expertise to the development of the assessment and this document:

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This Needs Assessment was submitted to the QISP Committee for their approval on February 28, 2017.

Acronyms

ACA: Affordable Care Act
ACS: American Community Survey
ACCESS: Aids Care Center for Education and Support Services
ADAP: AIDS Drug Assistance Program
AIDS: Acquired Immune Deficiency Syndrome
ART/ARV: Antiretroviral medications/antiretroviral therapy to fight HIV
CD4: CD4 cells are white blood cells that fight infection. CD4 cell count provides an indication of immune system health. The higher a CD4 count, the better.
CDC: Centers for Disease Control & Prevention
CAREWare: Electronic System for HIV/AIDS Reporting and Evaluation
EIS: Early Intervention Services
EVMS: Eastern Virginia Medical School
FPL: Federal Poverty Level
FY: Fiscal Year
GHR: Greater Hampton Roads
GHRHSPC: Greater Hampton Roads HIV Health Services Planning Council
HIV: Human Immunodeficiency Virus
HRSA: U.S. Health Resources and Services Administration
IDU: Injection drug user
LGBT: Lesbian, Gay, Bisexual and Transgender
MASS: Minority Aids Support Services, Inc.
MSM: Men who have Sex with Men
Norfolk TGA: Norfolk Transitional Grant Area - area funded by Ryan White Grant (includes: Mathews, Gloucester, James City, Williamsburg, York, Poquoson, Newport News, Hampton, Norfolk, Portsmouth, Virginia Beach, Chesapeake, Suffolk and Isle of Wight in Virginia as well as Currituck County, North Carolina)
OOC: Out of Care
PLWHA: People living with diagnosed HIV or AIDS
QISP: Quality Improvement and Strategic Planning Committee
RW: Ryan White
SAMHSA: Substance Abuse and Mental Health Services Administration
STD/STI: Sexually Transmitted Disease/Infection
US: United States
VDH: Virginia Department of Health

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Executive Summary

This HIV Needs Assessment is a partnership activity between the Greater Hampton Roads HIV Health Services Planning Council (GHRHSPC) and the HIV Community. GHRHSPC will use the Needs Assessment for priority setting, resource allocation, and to guide decisions regarding HIV service delivery in the Norfolk Transitional Grant Area (TGA). The Needs Assessment will also be used to communicate the TGA's needs to the U.S. Health Resource and Service Administration (HRSA).

The Quality Improvement and Strategic Planning (QISP) Committee of the GHRHSPC contracted with toXcel, LLC and K.I. Services to conduct the HIV Needs Assessment for the Norfolk TGA. Its goal is to better understand the needs of people living with HIV/AIDS (PLWHA) in the Norfolk TGA who are out of care (OOC). For the purposes of this assessment, out of care is defined as persons who previously had a care marker but have had no evidence of care (CD4count, viral load, HIV medical care visit, or ART prescription) within a year of that date.

The Needs Assessment incorporates input from a variety of key stakeholders, including PLWHA who receive HIV services, PLWHA currently not receiving HIV services but who are aware of their HIV status, medical and support service providers, and Ryan White and Non-Ryan White funded providers in the TGA. In order to cast a wide net to increase our understanding of the unique circumstances that lead people to fall out of care and re-enter care, a consumer survey included a question about previous experience being out of care. Information was collected through focus groups and interviews as well as paper and online surveys. Extensive quantitative data analyses were also conducted.

To the extent possible, this Needs Assessment further explores the needs of certain vulnerable population groups, including: Transgender PLWHA, Young MSM (ages 13-24), African American MSM, African American females and Hispanic males and females.

Some of the recommendations identified through this process include:

- **Develop a more comprehensive system for establishing early care** that allows patients to immediately have appointments scheduled without wait time with additional follow-up services available if needed.
- **Strengthen patient support navigation services.** New patients need assistance negotiating medical care, including where to go and how to get there. For patients new to the HIV system of care, there is a lot of paperwork and a wide array of partners and services to navigate.
- **Develop a common protocol among medical and service providers for newly diagnosed HIV positive patients to provide information and connect them to services.** The initial information and referrals for those newly diagnosed varies greatly across testing locations.
- **Increase coordination of services among agencies.** Providers emphasized the need for decreased agency competition and better coordination across agencies. Co-locating or sharing spaces to provide services could be beneficial for providers and patients who wish to avoid the stigma of HIV-only services while accessing multiple services at one time.
- **Target HIV testing and outreach efforts in the emergency room (ER).** Offering rapid HIV testing in ERs could provide a way to identify more HIV positive people and re-engage OOC patients.
- **Expand opportunities for PLWHA to engage with each other beyond traditional support group meetings**. Consumers expressed feeling isolated from others and anxiety about being identified as HIV positive for coming in person to seek HIV-related services.
- **Strengthen the support system to address housing and transportation**. Housing and transportation needs continue to be major barriers to accessing care.

Introduction

The Norfolk Transitional Grant Area (TGA) Ryan White Part A Planning Council (also known as the Planning Council, Greater Hampton Roads HIV Health Services Planning Council, and GHRHSPC) is a federally mandated community group of dedicated volunteers appointed by the Mayor of the City of Norfolk, Virginia to plan the organization and delivery of Ryan White Part A HIV/AIDS services. The Planning Council is comprised of various shareholders in the community who directly or indirectly interact with the HIV/AIDS community and who have a vested interest to ensure that the best possible services are provided to ensure a positive healthy outcome for those served.

This HIV Needs Assessment will inform the work of the Planning Council and support it in targeting and prioritizing Ryan White Grant Funding throughout the Norfolk TGA) which includes the following areas and jurisdictions in Virginia and North Carolina: Mathews, Gloucester, James City, Williamsburg, York, Poquoson, Newport News, Hampton, Norfolk, Portsmouth, Virginia Beach, Chesapeake, Suffolk, Isle of Wight, and Currituck. These Hampton Roads communities have been identified as a metropolitan area to target for HIV prevention and intervention because of the growing rates of new and existing cases of HIV/AIDS in the area.

The goal of this Needs Assessment is to better understand the needs of people living with HIV/AIDS (PLWHA) in the Norfolk TGA who are out of care. For the purposes of this assessment, out of care (OOC) is defined as persons who previously had a care marker but have had no evidence of care (CD4 count, viral load, HIV medical care visit, or ART prescription) within a year of that date.

The Needs Assessment incorporates input from a variety of key stakeholders, including PLWHA who receive HIV services, PLWHA currently not receiving HIV services but who are aware of their HIV status, medical and support service providers, and Ryan White and Non-Ryan White funded providers in the TGA. In order to increase our understanding of the unique circumstances which lead people to fall out of care and re-enter care, a consumer survey asked PLWHA about previous experience being out of care for a year. Information was collected through focus groups and interviews as well as in-person, paper and online surveys. Extensive quantitative data analyses were also conducted.

To the extent possible, the assessment further explores the needs of certain vulnerable population groups, including:

- Transgender PLWHA
- Young MSM (Ages 13-24)
- African American MSM
- African American Females
- Hispanic Males and Females

This report is divided into four sections:

- **Section 1. Description of the HIV Population** - Reviews key characteristics of PLWHA in the Greater Hampton Roads area and populations disproportionately affected by HIV. It also describes characteristics specific to populations who are OOC.
- **Section 2. The Consumer Perspective: Accessibility and Quality of Care** - Provides an overview of the results from consumer surveys and stakeholder interviews. These results include the perspectives of PLWHA who are in and out of care. It discusses consumers' experiences with

service provision, their perceptions of quality of care and highlights barriers to and facilitators of care for PLWHA.

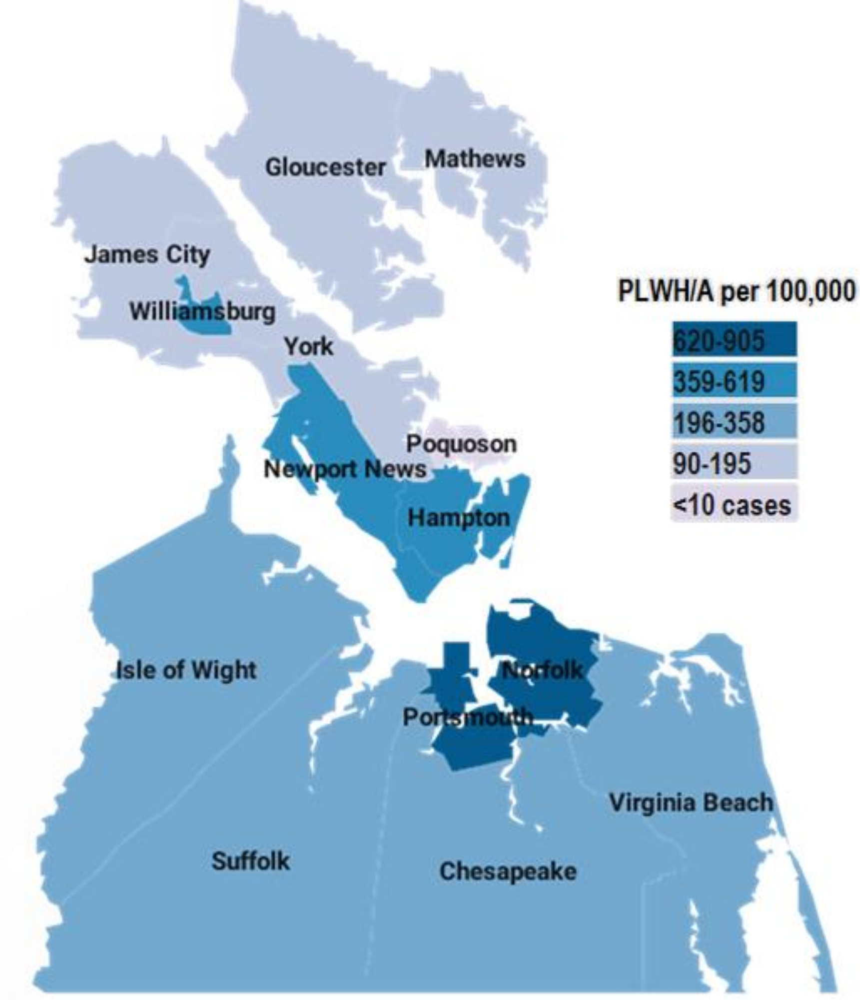
- **Section 3. The Provider Perspective: Service Needs and Utilization** - Highlights the provider perspective and shares the results from focus groups and online surveys with medical and support service providers, including Ryan White and Non-Ryan White funded providers in the Norfolk TGA.
- **Section 4. Recommendations and Next Steps** - Identifies recommendations based on findings across the three previous sections and discusses areas to prioritize moving forward in order to facilitate consumers' linkage to and retention in HIV primary care. Recommendations and insights for next steps are also included within each of the previous sections

The Needs Assessment was conducted by toXcel, in collaboration with K.I. Services, on behalf of the Planning Council at the request of its Quality Improvement and Strategic Planning (QISP) Committee.

Section 1. Description of the HIV Population

As of December 31, 2015 there were 7,284 people living with HIV/AIDS (PLWHA) in the Norfolk TGA (4,153 living with HIV only, and 3,131 living with AIDS). Figure 1 shows the geographic distribution of PLWHA in the Norfolk TGA.

Figure 1. Rate (per 100,000 population) of PLWHA as of December 31, 2015



In 2015, there were 280 newly diagnosed cases of HIV in the Norfolk TGA. While the 2015 rate (per 100,000 population) of PLWHA is higher for the Norfolk TGA (429.9[1]) than it is for the Eastern Health Region (416.8) and for the state of Virginia (298.5), the rate of newly diagnosed cases of HIV in the TGA has gradually decreased since 2013. Figure 2 show the counts and rates, respectively, of newly diagnosed cases of HIV in the Norfolk TGA from 2011 to 2015.

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[1] The rate for the Norfolk TGA was calculated using the US Census Bureau's 2015 American Community Survey (ACS) data (Count of PLWHA in TGA/Population of TGA based on 2015 ACS*100,000)

Figure 2. Count of Newly Diagnosed Cases in the Norfolk TGA (left) and Rate of Newly Diagnosed Cases of HIV in the Norfolk TGA[2], Eastern Health Region, and Virginia Statewide (right), 2011-2015

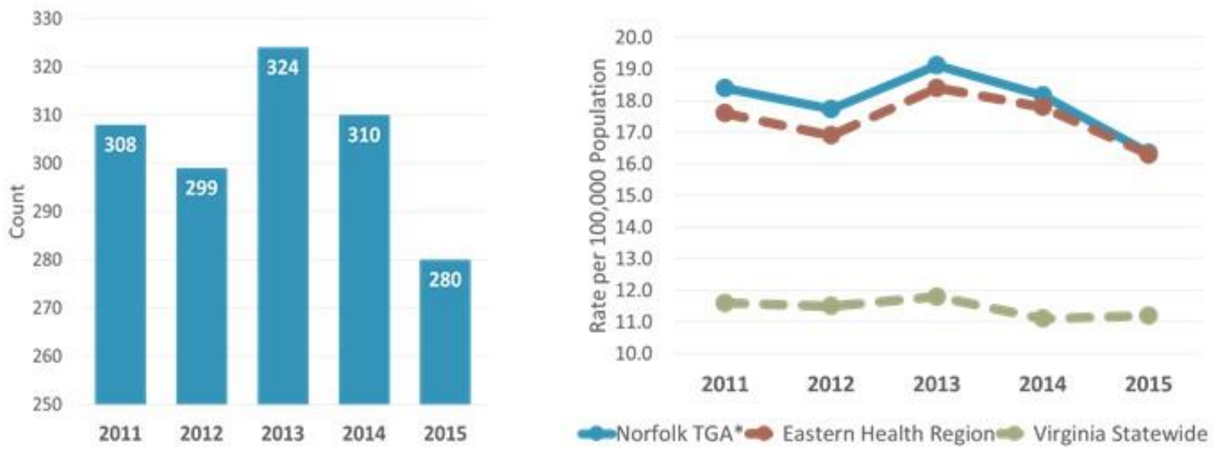
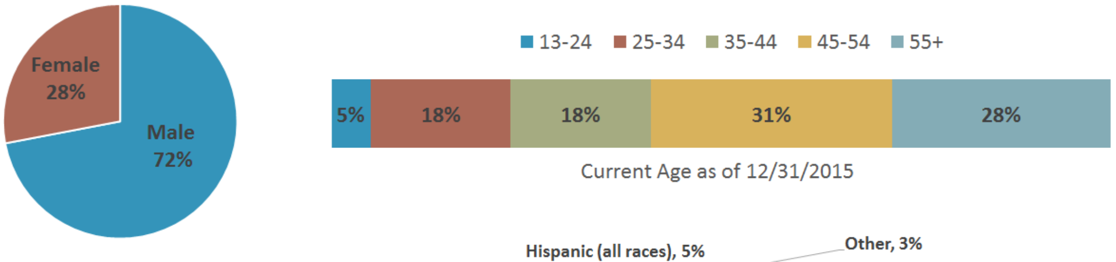
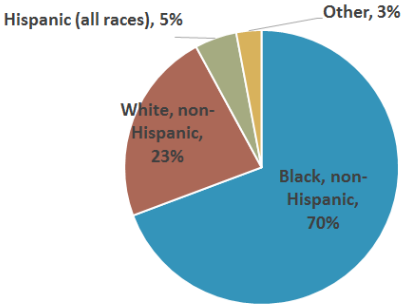


Figure 3 summarizes the demographics of the people living with HIV in the Norfolk TGA as of December 31, 2015. Later in this section, these demographics are compared to the demographics of both the Norfolk TGA general population and PLWHA in the Norfolk TGA who are out of care.

Figure 3. Demographic Characteristics of PLWHA in the Norfolk TGA as of December 31, 2015[3]



Transmission Category	Percent %
Male-to-male sexual contact (MSM)	44.0%
No risk factor reported or identified	25.0%
Heterosexual contact	18.0%
Injection Drug Use (IDU)	9.0%
MSM & IDU	3.0%
Other (pediatric and blood recipient)	1.0%



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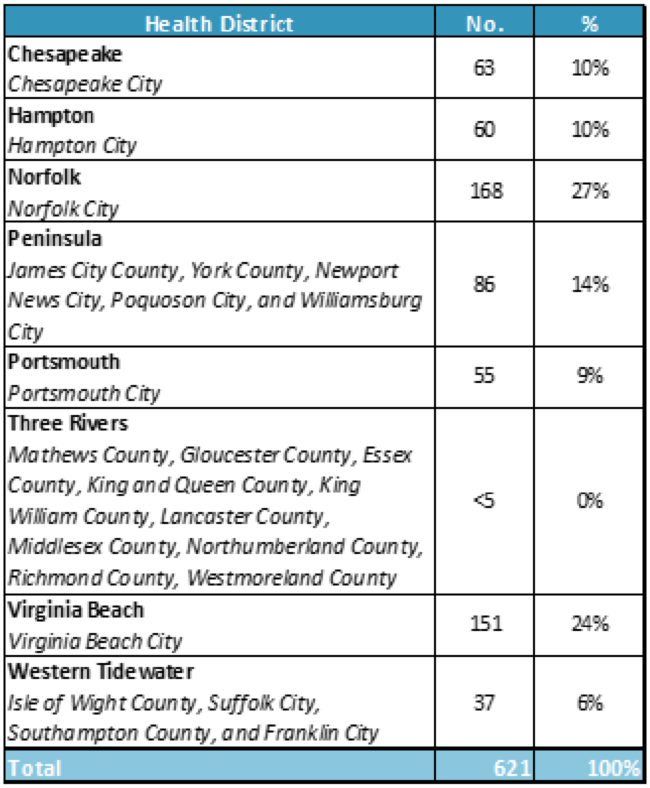
[2] Rates for Norfolk TGA were calculated using counts of newly diagnosed cases of HIV (Source: VDH Virginia HIV Surveillance Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report) and population estimates (source: US Census Bureau Annual Population Estimates). (Count of Newly Diagnosed Cases in Norfolk TGA/Norfolk TGA Population Estimate)*100,000 = Rate of Diagnoses

[3] Source: Virginia Department of Health. Data for 2015 is preliminary until certified by CDC in December 2016 and may be incomplete due to reporting delays. Data current as of December 2015.

Out-of-Care Persons

Data from the Virginia Department of Health indicate that there are 621 Out-of-Care (OOC) persons in the Norfolk TGA as of February 1, 2017. People are considered out-of-care if they had evidence of care (CD4 count, viral load, HIV medical care visit, or ART prescription) in 2015, but have not had any evidence of care within 1 year of the date the data list was generated (02/01/2017). Figure 4 shows the count of OOC Persons in the Norfolk TGA by Health District of Last Known Residence.

Figure 4. Out-of-Care Persons in the Norfolk TGA by Health District of Last Known Residence[4]



Health District	No.	%
Chesapeake *Chesapeake City*	63	10%
Hampton *Hampton City*	60	10%
Norfolk *Norfolk City*	168	27%
Peninsula *James City County, York County, Newport News City, Poquoson City, and Williamsburg City*	86	14%
Portsmouth *Portsmouth City*	55	9%
Three Rivers *Mathews County, Gloucester County, Essex County, King and Queen County, King William County, Lancaster County, Middlesex County, Northumberland County, Richmond County, Westmoreland County*	<5	0%
Virginia Beach *Virginia Beach City*	151	24%
Western Tidewater *Isle of Wight County, Suffolk City, Southampton County, and Franklin City*	37	6%
Total	621	100%

More than half of the OOC persons in the TGA come from Norfolk and Virginia Beach. Sixty-seven percent (67%) of these OOC persons are black (non-Hispanic) and 74% are males. Although the populations of PLWHA in the Norfolk TGA and OOC persons in the Norfolk TGA are demographically similar to each other in terms of gender and race/ethnicity, they are not similar to the general population of the Norfolk TGA. The figures below show that African Americans and males are disproportionately affected by HIV/AIDS in the Norfolk TGA and are subsequently found to be out-of-care in similar proportions.

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[4] Data reported to the Virginia Department of Health as of 2/1/2017.

Figure 5. Populations of the Norfolk TGA, PLWHA in the Norfolk TGA, and Out-of-Care Persons in the Norfolk TGA by Gender, 2015[5]

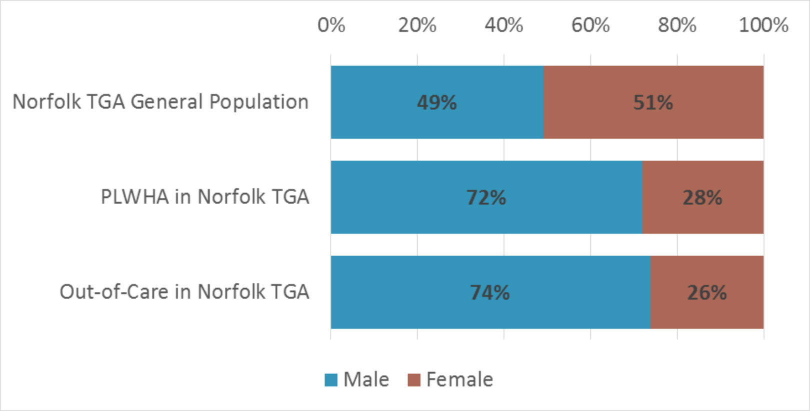
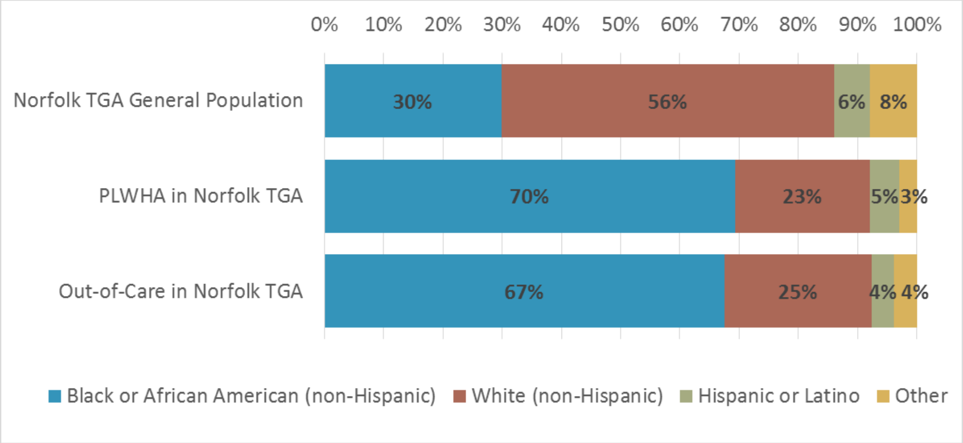


Figure 6. Populations of the Norfolk TGA, PLWHA in the Norfolk TGA, and Out-of-Care Persons in the Norfolk TGA by Race/Ethnicity, 2015



Note: "Other" includes Asian/Hawaiian/Pacific Islander, American Indian/Alaska Native and Multi-race/Unknown.

Additional demographics on PLWHA in the Norfolk TGA who are out-of-care can be found in Appendix A. This Appendix also includes other factors that may influence PLWHA ability or decision to stay in care.

Supplementary data on PLWHA and OOC persons in the Norfolk TGA was also retrieved through CAREWare[6]. Data from the Ryan White Part A (RWPA) Grantee Office indicates that 2,727 PLWHA in the Norfolk TGA received Ryan White funded services in fiscal year 2015 (referred to as RWPA FY2015 Clients in this section). There were also 39 people who were identified as out-of-care through CAREWare (referred to as RWPA Clients OOC in this section).

Of the 39 RWPA Clients who are OOC, approximately 89% do not have insurance as compared to the percentage of people in the entire Norfolk TGA who do not have insurance (11%) and the percent of Ryan White FY15 Clients without insurance (25%). Although the sample population for RWPA Clients OOC is

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[5] Sources: US Census Bureau, 2015 American Community Survey (ACS); Virginia Department of Health

[6] CAREWare is an electronic System for HIV/AIDS Reporting and Evaluation used by Ryan White grantees.

relatively low compared to those in-care, this could be an indication that lack of medical insurance is a potential factor in whether clients seek or get care.

Figure 7. Percent[7] of each Population (Norfolk TGA, RWPA FY2015 Clients, RWPA Clients Out-of-Care) without Health Insurance, 2015

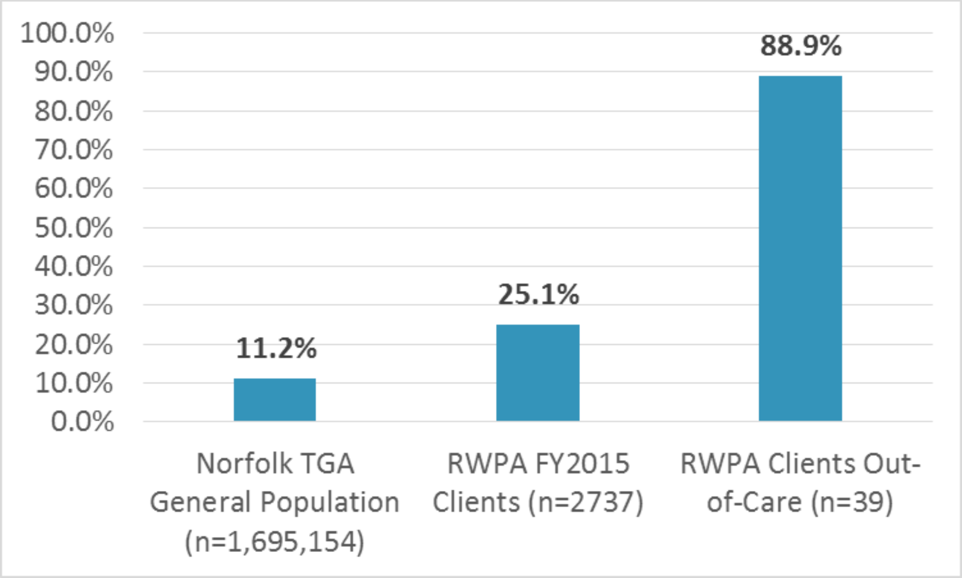

Figure 8 shows four different populations of PLWHA in the Norfolk TGA by gender. The proportions of males and females is similar for PLWHA in the Norfolk TGA and in both populations who were identified as being out-of-care (between 72% and 77% of each population is male). However, the population of PLWHA in the TGA who received Ryan White funded services in 2015 has only 30% males and 68% females. This is a potential indication that females are more likely to seek Ryan White services than their male counterparts.

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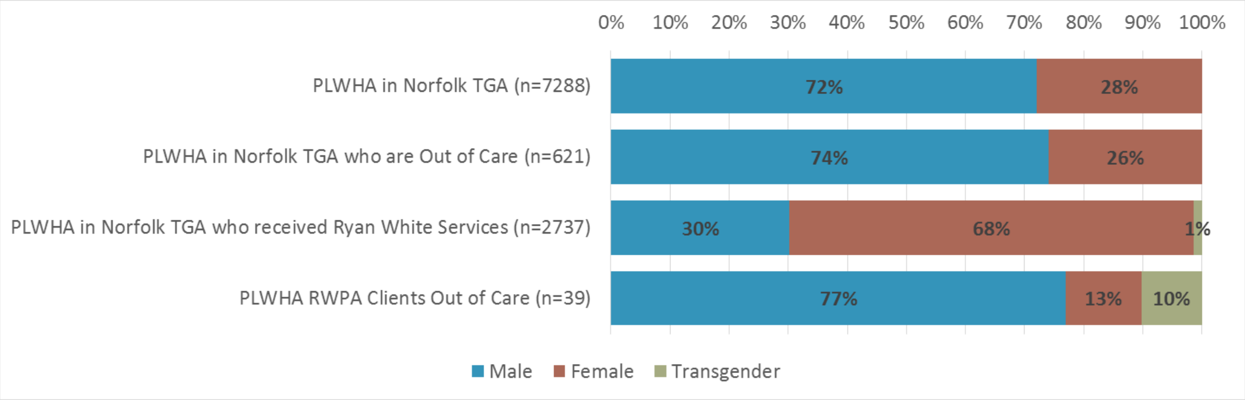
[7] Percent without Health Insurance for Norfolk TGA Overall was calculated using 2015 ACS data (Estimated Count of Civilian Noninstitutionalized Population without Health Insurance/Estimated Count of Civilian Noninstitutionalized Population). RWPA FY15 includes clients (<1%) with VA, Tricare, other Military Insurance.

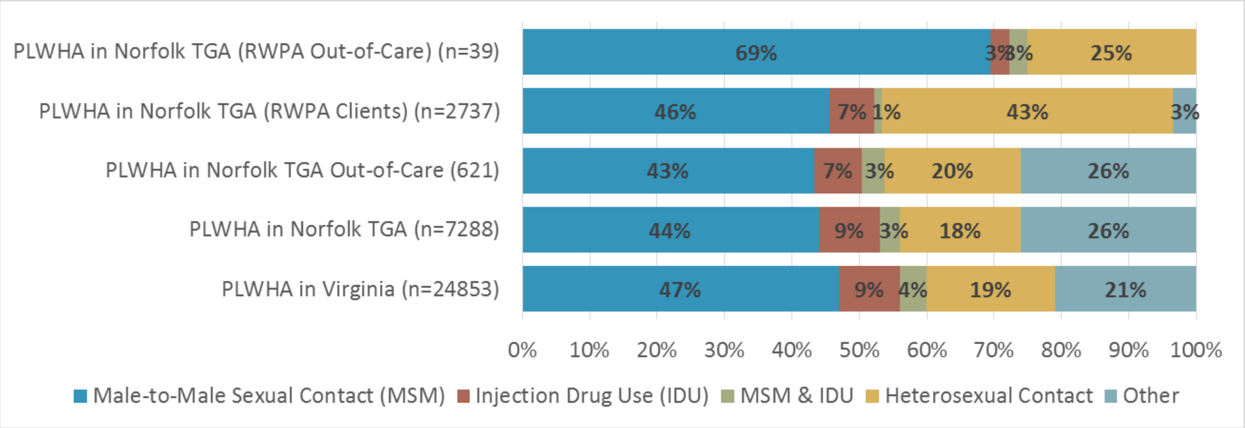
Figure 8. Populations of PLWHA in the Norfolk TGA by Gender[8]



Note: All data are for 2015, except for PLWHA in Norfolk TGA who are Out of Care, which is current as of 2/1/2017.

When looking at HIV risk factors and mode of transmission, most populations of PLWHA in the Norfolk TGA are proportional, with male-to-male sexual contact (MSM) being the primary risk factor. However, RWPA FY2015 Clients (who received Ryan White funded services in 2015) also have a high percentage of heterosexual contact as a risk factor when compared to the other populations (Figure 9).

Figure 9. Populations of PLWHA in the Norfolk TGA by HIV Risk Factor/Mode of Transmission



Note: Other includes pediatric/perinatal, blood recipient, and other/unknown

Figure 10 shows the age distribution of PLWHA in the Norfolk TGA and PLWHA who are OOC in the Norfolk TGA compared to the general population of the Norfolk TGA for 2015.

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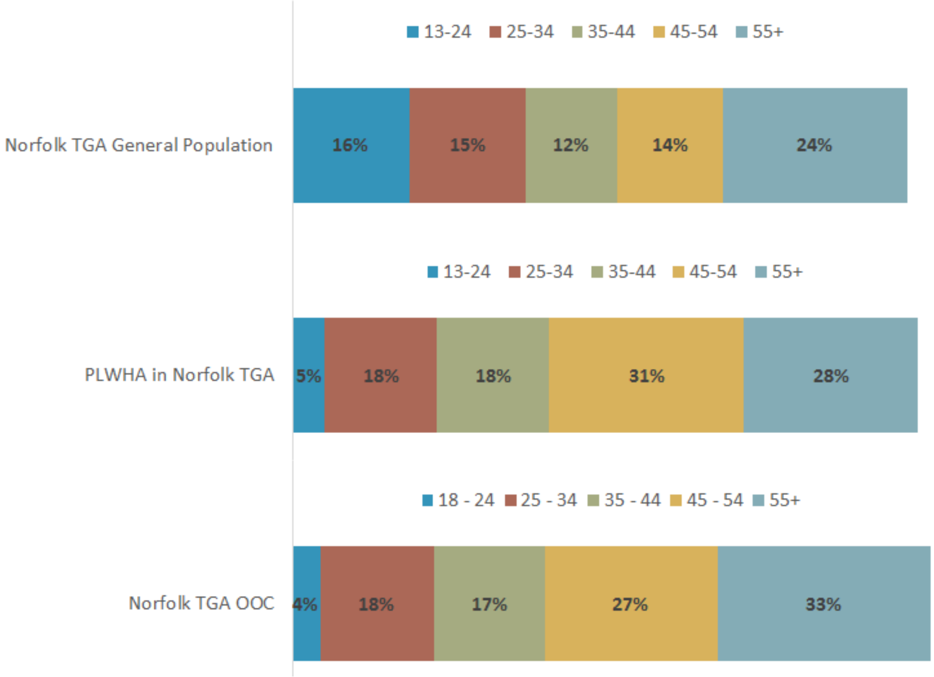
[8] Sources: PLWHA in Norfolk TGA – Virginia Department of Health (Data for 2015 is preliminary until certified by CDC in December 2016 and may be incomplete due to reporting delays. Data current as of December 2015.); PLWHA Norfolk TGA OOC – Virginia Department of Health (Data reported to as of 2/1/2017);

Figure 10. Populations of Norfolk TGA General Population, PLWHA in Norfolk TGA, and Out-of-Care Person in Norfolk TGA by Age Group, 2015



Note: The youngest age groups for Norfolk TGA OOC is 18-24 (instead of 13-24) because clients are not eligible for the out-of-care list if they are <18 years.

Section 2. The Consumer Perspective: Accessibility and Quality of Care

The degree to which consumers understand the importance of accessing services, are aware of those services, know how to access them and feel comfortable utilizing those services impacts their decision to stay in care. This section discusses consumers' experiences with service provision, their perceptions of quality of care and highlights barriers to and facilitators of staying in care for PLWHA. The results portrayed include the perspectives of PLWHA who are in and out of care.

Process

This section of the Needs Assessment shares data from two different sources – a widely circulated survey and key stakeholder interviews targeting OOC PLWHA who were identified as out of care through CAREWare.

The focus of the survey was to gain an understanding of how soon PLWHA sought care, how they initially received information about their disease, whether they had experienced a gap in services, the degree that they used existing services and the degree that they stayed in care with regards to managing their disease. The survey was available in paper copies and online, in English and Spanish. Ryan White Part A and Part C Grantees were asked to circulate the survey to their consumers and all grantees participated in the study to varying degrees. Additional outreach was done through homeless shelters, treatment and detox centers, mental health centers, churches, and social media. While there is no way to know that outreach in these locations reached OOC consumers, mental illness, substance abuse, and homelessness are three factors that play a role in PLWHA falling out of care. Churches and social media were identified as venues for information and support and thus potential opportunities to reach additional PLWHA who were OOC.

In total, there were 320 survey participants. The majority of them are currently in care; however, 21% reported that there had been a time period of over a year when they had not sought care.

There were nine key stakeholder interviews conducted with PLWHA who were identified as out of care through CAREWare. The CAREWare list was provided by the Quality Management Coordinator and included a total of 45 possible consumers who had no record of care for the last year since their last marker. A minimum of three calls were made to each person on the list. Of these, 10 phone numbers were no longer in service or could not receive incoming calls, 1 person was in prison, 3 people had moved out of state, 3 were still in care through private providers, 2 refused an interview, and others did not respond to the telephone calls or messages. Based on the information learned from consumers or their family through calling, 6 consumers were determined to either be in care or out of state and were removed from the data that was analyzed for this report. The data analysis only included 39 PLWHA who were OOC.

Of the stakeholders interviewed, 3 participants are out of care or had recently (within the last month) been out of care for more than a year, 1 participant had been out of care after diagnosis for more than a year but has re-entered care this year, and a fifth participant had been out of care for at least 6 months.

The perspectives of all 9 participants interviewed are summarized as part of this assessment. Of the participants interviewed, 5 identified as African American MSM, 1 identified as transgender, 1 was an African American female, and 1 was a Latino male.

The Virginia Department of Health (VDH) is also tracking PLWHA who are out of care and are in the process of launching a new program, called the Data to Care Initiative, to more proactively bring consumers back into care. However, given the timeframe of the assessment and their program launch, toXcel analysts were unable to access VDH's list. In the future, collaboration with VDH may prove a useful mechanism to reach the most vulnerable populations who have fallen out of care.

Consumer Survey Findings

Survey Participants

As stated previously, there were 320 total survey participants. Not every participant responded to each question so there are varying numbers of respondents to each question. Figure 11 shows the geographic distribution of survey responses within the Norfolk TGA, and Figure 12 shows how this compares to the geographic distribution of PLWHA in the Norfolk TGA.

Figure 11. Geographic Distribution of Survey Responses within the Norfolk TGA

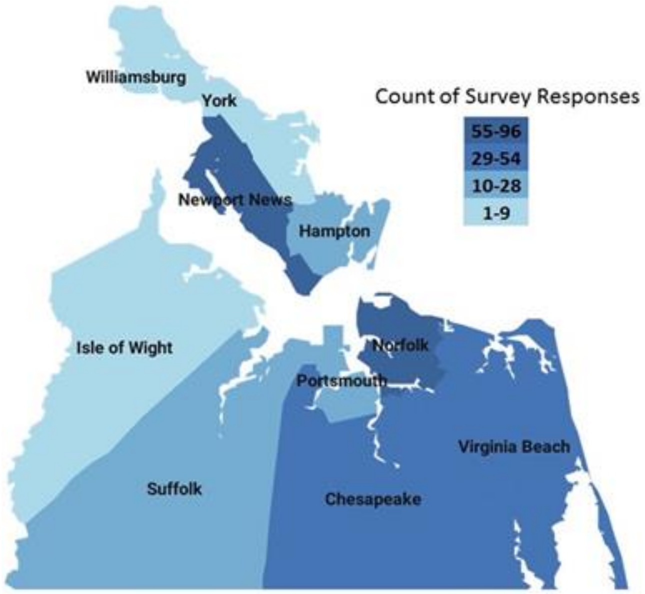
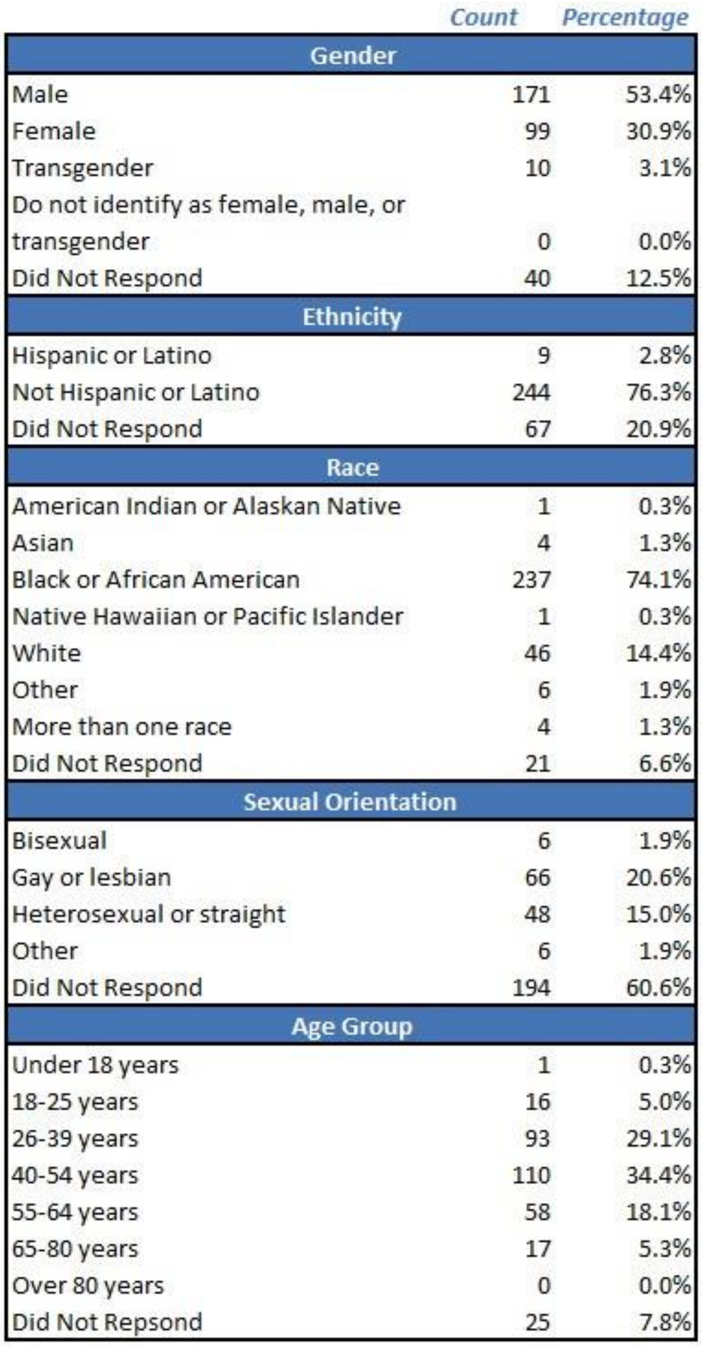


Figure 12. List of Survey Responses by Location and PLWHA in Norfolk TGA (2015) by Location

	Survey Respondents		PLWHA in Norfolk TGA 2015	
	Count	*Percent*	*Count*	*Percent*
Chesapeake	32	10.0%	667	9.2%
Hampton	22	6.9%	727	10.0%
Newport News	56	17.5%	952	13.1%
Norfolk	96	30.0%	2,221	30.5%
Poquoson	0	0.0%	9	0.1%
Portsmouth	21	6.6%	752	10.3%
Suffolk	13	4.1%	281	3.9%
Virginia Beach	38	11.9%	1,336	18.3%
Williamsburg	1	0.3%	53	0.7%
Gloucester County	0	0.0%	44	0.6%
Isle of Wight County	4	1.3%	79	1.1%
James City County	0	0.0%	77	1.1%
Mathews County	0	0.0%	12	0.2%
York County	3	0.9%	60	0.8%
Currituck County	0	0.0%	18	0.2%
Other/Unknown	34	10.6%	N/A	N/A
TOTAL	320	100.0%	7288	100.0%

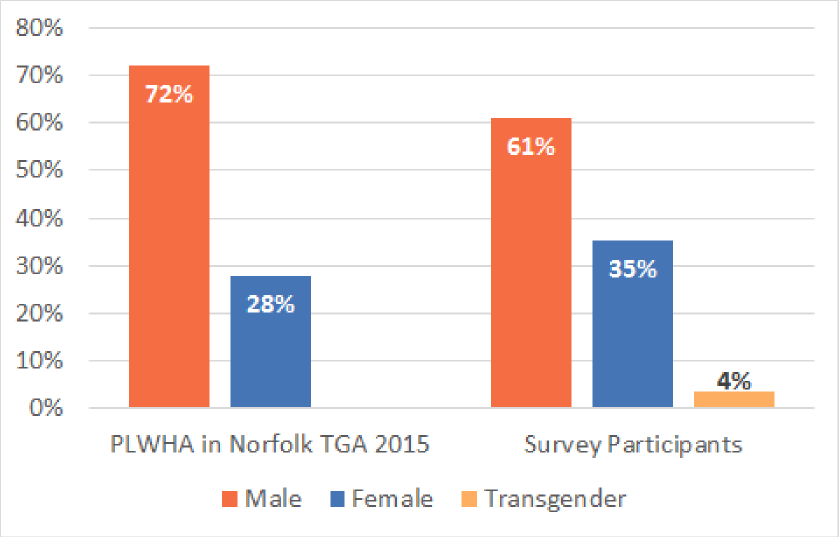
Figure 13 shows a summary of demographics for all survey participants, and Figures 14 and 15 show how the distribution of survey participants by race and gender, respectively, compared to the distributions of race and gender for all PLWHA in the Norfolk TGA (2015). Although the distributions of race/ethnicity and gender for the survey participants were similar to those of PLWHA in the Norfolk TGA, due to the survey sample size and subsequently low counts of responses for underrepresented populations, some demographic groups have been combined for analyses in the following sections.

Figure 13. Demographic Characteristics of the Survey Population



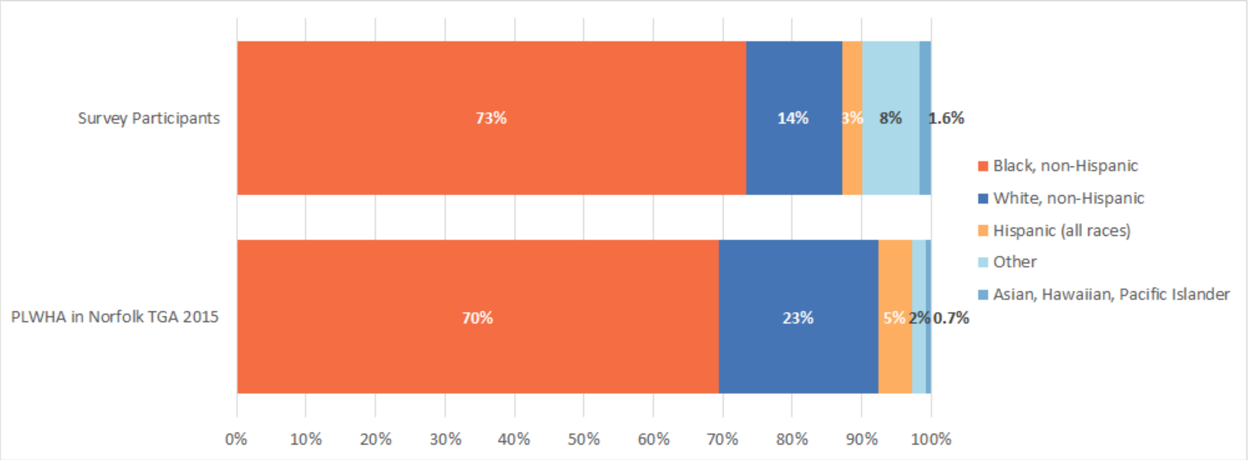
	Count	Percentage
Gender		
Male	171	53.4%
Female	99	30.9%
Transgender	10	3.1%
Do not identify as female, male, or transgender	0	0.0%
Did Not Respond	40	12.5%
Ethnicity		
Hispanic or Latino	9	2.8%
Not Hispanic or Latino	244	76.3%
Did Not Respond	67	20.9%
Race		
American Indian or Alaskan Native	1	0.3%
Asian	4	1.3%
Black or African American	237	74.1%
Native Hawaiian or Pacific Islander	1	0.3%
White	46	14.4%
Other	6	1.9%
More than one race	4	1.3%
Did Not Respond	21	6.6%
Sexual Orientation		
Bisexual	6	1.9%
Gay or lesbian	66	20.6%
Heterosexual or straight	48	15.0%
Other	6	1.9%
Did Not Respond	194	60.6%
Age Group		
Under 18 years	1	0.3%
18-25 years	16	5.0%
26-39 years	93	29.1%
40-54 years	110	34.4%
55-64 years	58	18.1%
65-80 years	17	5.3%
Over 80 years	0	0.0%
Did Not Repsond	25	7.8%

Figure 14. Survey Participants and PLWHA in Norfolk TGA by Gender



Note: Gender for Norfolk TGA is gender at birth. The percentages for Survey Participants only includes those who provided a response for Gender (n=280)

Figure 15. Survey Participants and PLWHA in Norfolk TGA by Race/Ethnicity



Note: Other race/ethnicity includes American Indian/Alaska Native and Multi-race/Unknown/Did Not Respond.

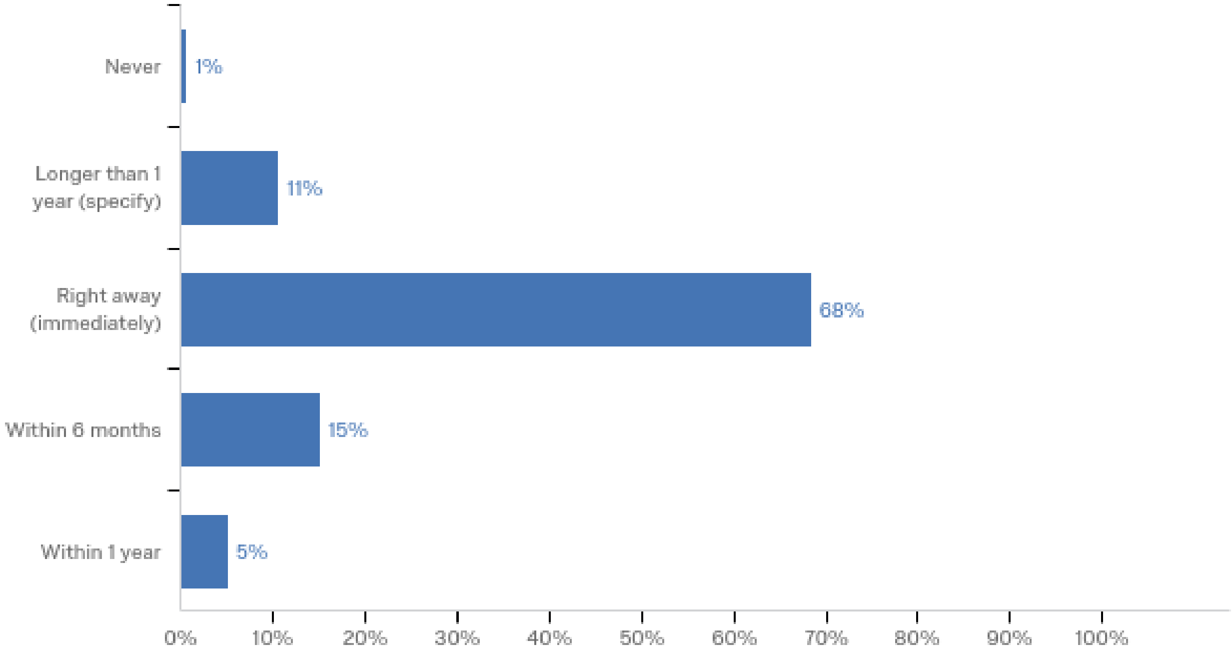
The majority of survey participants learned they were HIV positive after 2000. A breakdown of survey participants is included in Table 1.

Table 1. Count of Survey Participants by Year of Diagnosis

Year	1975-1979	1980-1989	1990-1999	2000-2009	2010-2016	Total
# of Participants	2	28	59	103	117	309

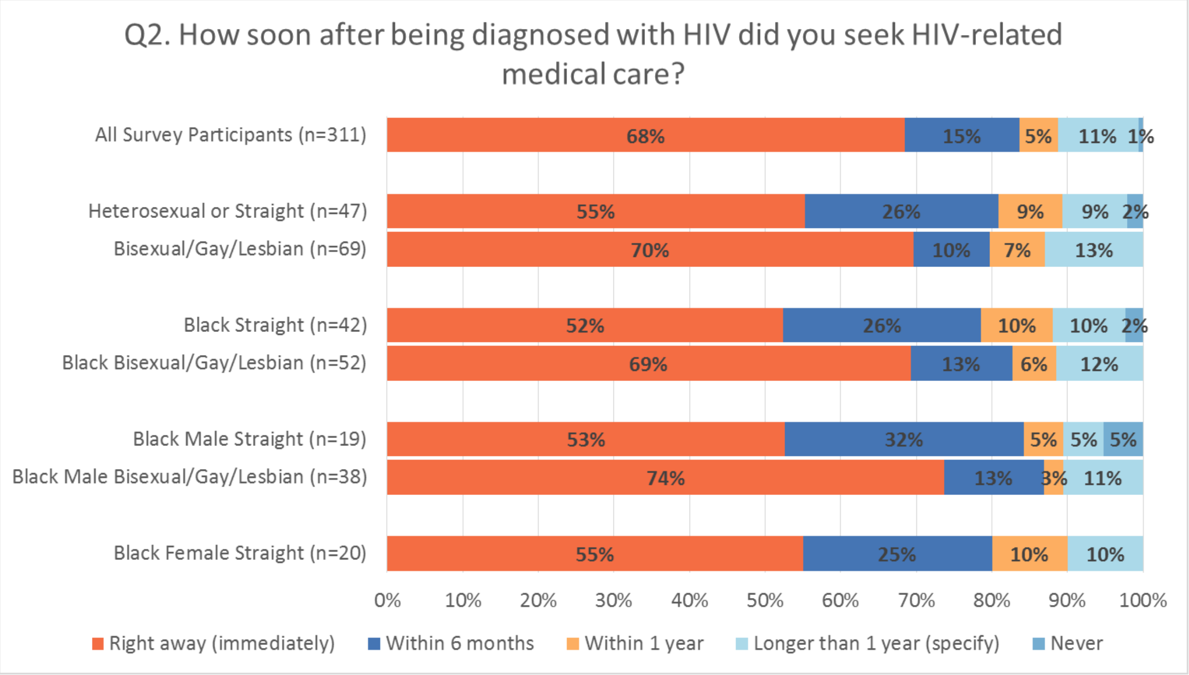
Of the survey participants who responded to the question about how quickly they sought medical care after their diagnosis, 68% sought HIV-related medical care right away and another 15% sought that care within the first 6 months. Only 11% reported that they waited longer than a year (see Figure 16).

Figure 16. Question 2. How soon after being diagnosed with HIV did you seek HIV-related medical care?



When looking at the responses for Question 2 by various demographic groups (see Figure 17), the heterosexual/straight demographic groups tend to report a lower percentage of "right away" responses and higher percentage of "within 6 months" responses than their bisexual/gay/lesbian counterparts (in terms of percentage of overall responses within each demographic groups).

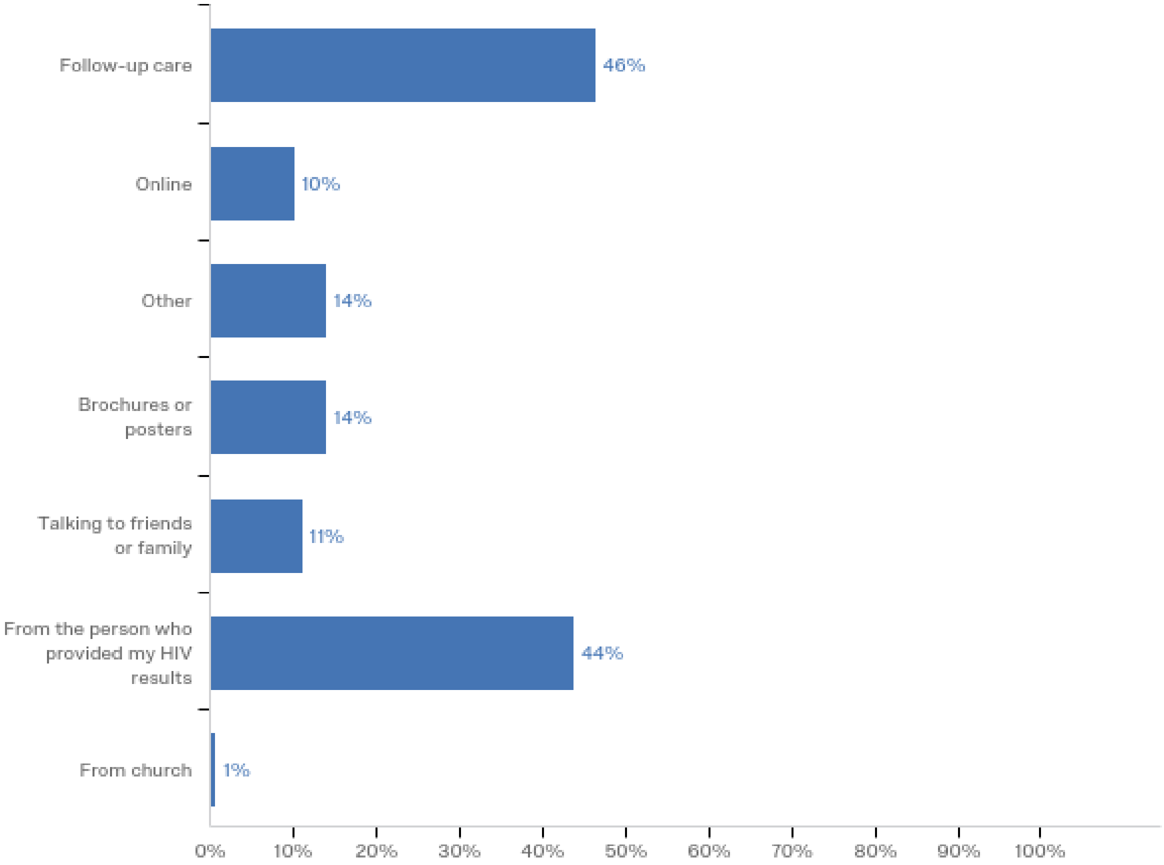
Figure 17. Question 2 Responses by Different Demographic Groups and Sub-groups



Note: There were not enough respondents to look at White, or Black Females Bisexual/Gay/Lesbian. Demographic groups with proportionally small sample sizes should be interpreted with caution.

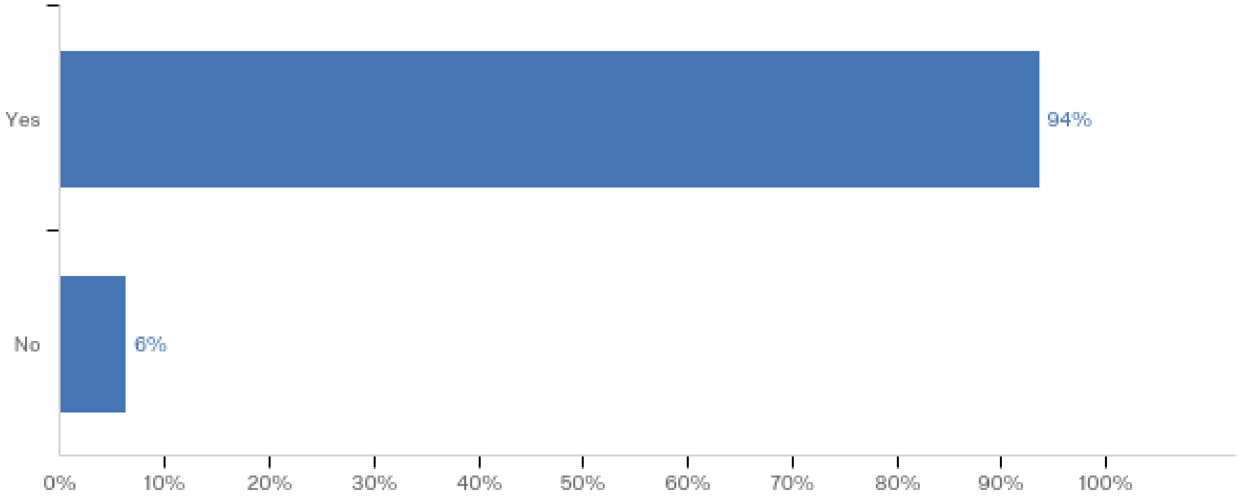
The vast majority of respondents received information about their disease during follow-up care (46%, N=145) or from the person who initially provided them their HIV results (44%, N=143). When asked in a separate question about where they learned of places to seek support for HIV, 46% (N=132) reported that they learned about places from their medical provider. According to 14% of survey participants, referrals from case managers and friends or family accounted for the next highest source of information. Other sources of referrals included Eastern Virginia Medical School (EVMS), other service providing organizations, health departments, ERs, Community Service Boards, churches or on their own.

Figure 18. Question 3. Where did you receive information to learn more about HIV and your HIV status?



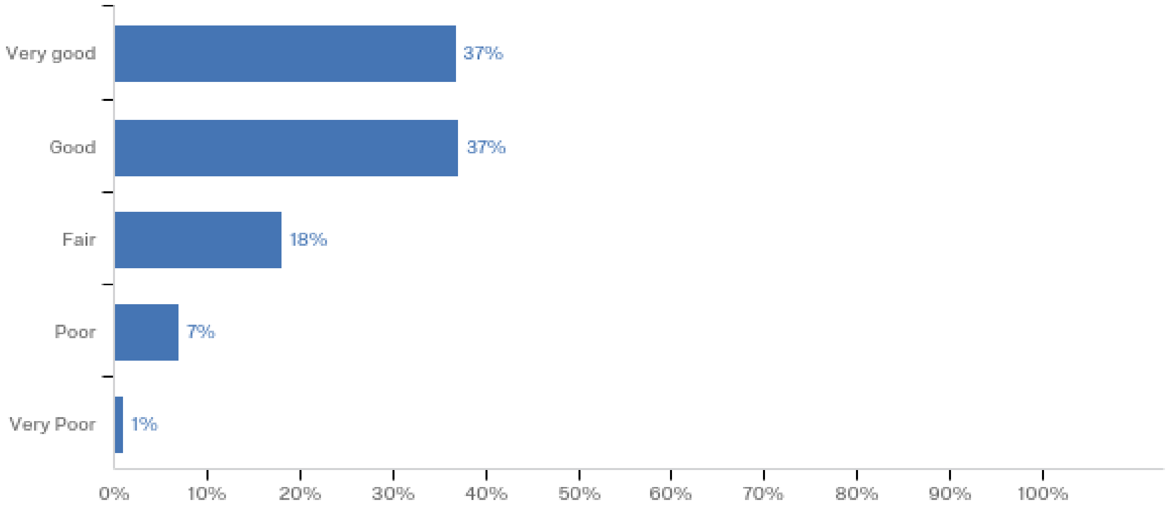
The majority of survey respondents (94%) reported that they are currently receiving medical care for their HIV (see Figure 19). Of participants who responded that they are in medical care, 185 (63%) identified EVMS as being their primary service provider. Participants also mentioned receiving care from health departments, the community health center, ACCESS, MASS, South Eastern Virginia Health systems, Sentara and Walmart. The high percentage of EVMS patients is expected given that nearly 40% of the surveys were completed through EVMS clinics. They are also the only Part C grantee in the Norfolk TGA.

Figure 19. Question 4. Are your currently seeking HIV medical care?



More than two-thirds of participants reported that they felt “good” or “very good” over the last three months (Figure 20). This is most likely a reflection of the large proportion of survey participants who reported being in care. The majority of participants who reported having “very good” or “good” health credited their health quality to taking their medications.

Figure 20. Question 8. Thinking about the last 3 months, how would you describe your personal health?



Service Utilization and Needs

The majority of participants who responded to the question about service usage indicated they use case management (84%) and dental care (58.5%) services. If they do not utilize these services, it is because they feel case management is not needed. Services related to transportation, food assistance, mental health, and housing are also used heavily. Many participants did not list a reason for not utilizing services. Housing may be a service that is underutilized for reasons such as participants not knowing about the service, how to utilize it, or being on the wait list. When asked which of these services were most important, 47% of respondents said case management. Housing (18%) and dental (17%) were also identified as important, followed by transportation (11%) and mental health (11%). More details on these finding can be found in Table 2.

Table 2. Question 9. Which of the following services have you used in the last 12 months? If no, why? Select all that apply.

		YES		NO		I don't need this service		I don't know about this service		I am unable to get an appointment or there is a wait list.		I don’t know who to contact	
#	**Service**	%	N	%	N	%	N	%	N	%	N	%	N
1	Case management	83.99%	236	14.59%	41	6.05%	17	0.00%	0	0.00%	0	0.71%	2
2	Dental care	58.50%	148	37.55%	95	13.44%	34	1.58%	4	0.79%	2	1.19%	3
3	Transportation	40.32%	102	55.34%	140	30.83%	78	1.19%	3	0.00%	0	0.40%	1
4	Food assistance	35.89%	89	59.27%	147	24.19%	60	6.05%	15	0.40%	1	3.23%	8
5	Mental health services	34.02%	83	61.89%	151	32.38%	79	1.64%	4	2.05%	5	0.82%	2
6	Housing assistance	28.40%	73	66.93%	172	28.02%	72	4.67%	12	5.45%	14	4.28%	11
7	Help paying my bills (e.g. rent, utilities)	21.16%	51	74.27%	179	28.22%	68	7.88%	19	0.83%	2	3.32%	8
8	Substance abuse help	11.64%	27	83.62%	194	46.12%	107	1.72%	4	0.43%	1	0.86%	2
9	Job training or job search help	11.11%	25	83.56%	188	42.67%	96	4.44%	10	0.44%	1	1.78%	4

From some of the comments that participants included on their survey when asked which service is most important, it is clear that they highly value these services. Some of the quotes are included below:

> *“Case management because it initiated my medication process.”*
> *“They help me to want to live a healthy life and can be normal and productive in making right choices and decisions.”*
> *“Case management, my case manager has never made me feel unfair about missing my meds and he is always sincere to help.”*
> *“Housing because I'm homeless and need to be off the streets.”*
> *“Case management because it helps manage my status and improves my quality of life.”*
> *“I am dealing with family issues. Those issues are… not being able to tell anyone of my status and I am very close to my family and they are close to me. So not being able to reach out because of so many reasons I stay highly depressed even thinking suicide from time to time: so mental health services and attending anything related to HIV/AIDS helps me.”*

When asked what other services they wished they had access to, the majority of respondents listed existing services. This may be due to the fact that certain services are unavailable in their area jurisdictions, they have been unable to access them for some reason, or they are unaware of their existence. Thirty-eight percent of respondents listed housing as an unmet need. Over 10% of respondents listed assistance with paying bills, food assistance, and dental services as unmet needs. Several respondents also listed other service needs, such as a program that provides eyeglasses, mental health services, job training (including college prep, career training, and training to keep a job), financial planning, and support groups.

Of the 175 participants who responded to a question asking about problems they encountered in accessing services, over half (53%, N=92) reported that they had experienced no problems. This indicates a high degree of service satisfaction among survey respondents. Ten percent of these respondents reported that housing, including a lack of housing and housing wait lists were an issue. Other problems that respondents identified included: waiting lists in general, costs for services, navigating red tape, transportation to and from medical appointments, difficulty being able to reach medical offices when they had questions, lack of programming (e.g., support groups), having no identification to be able to access services, and a lack of awareness of services.

Continuity of Care

The majority of respondents (over 90%) reported regularly seeing a doctor, completing HIV-related bloodwork, and being prescribed HIV medications (See Figures 21, 22 and 23)

Figure 21. Q 13. Have you seen a doctor in the last 12 months for HIV-related care?

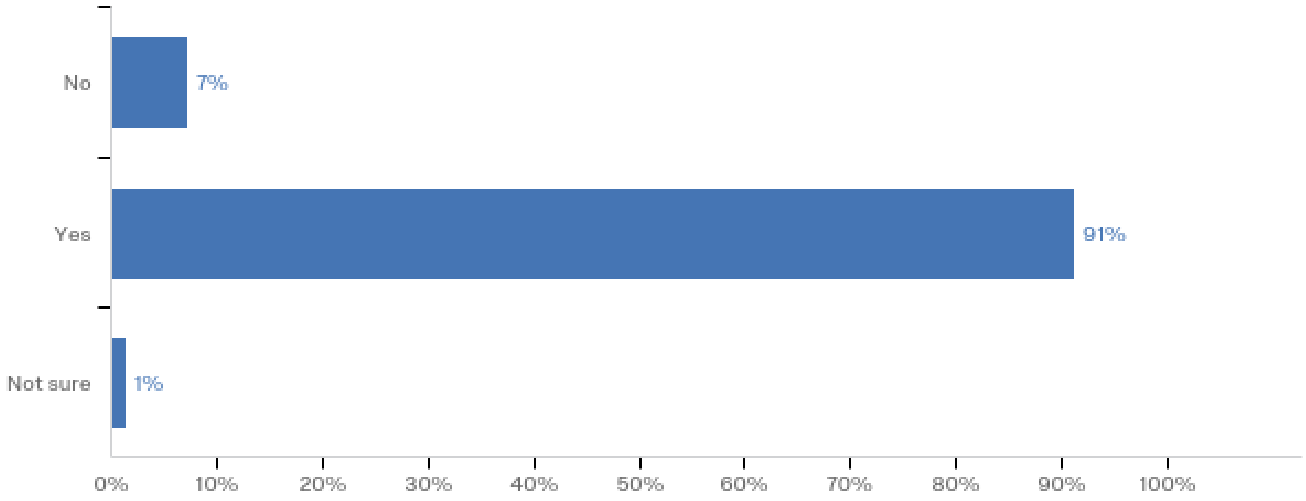


Figure 22. Q 14. Have you had HIV-related bloodwork done in the last 12 months?

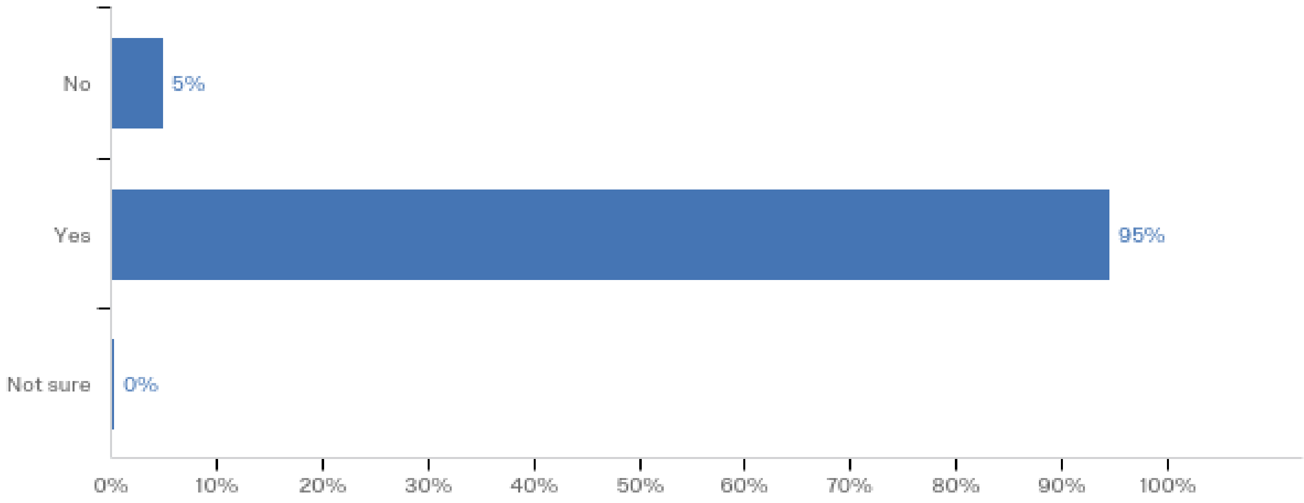
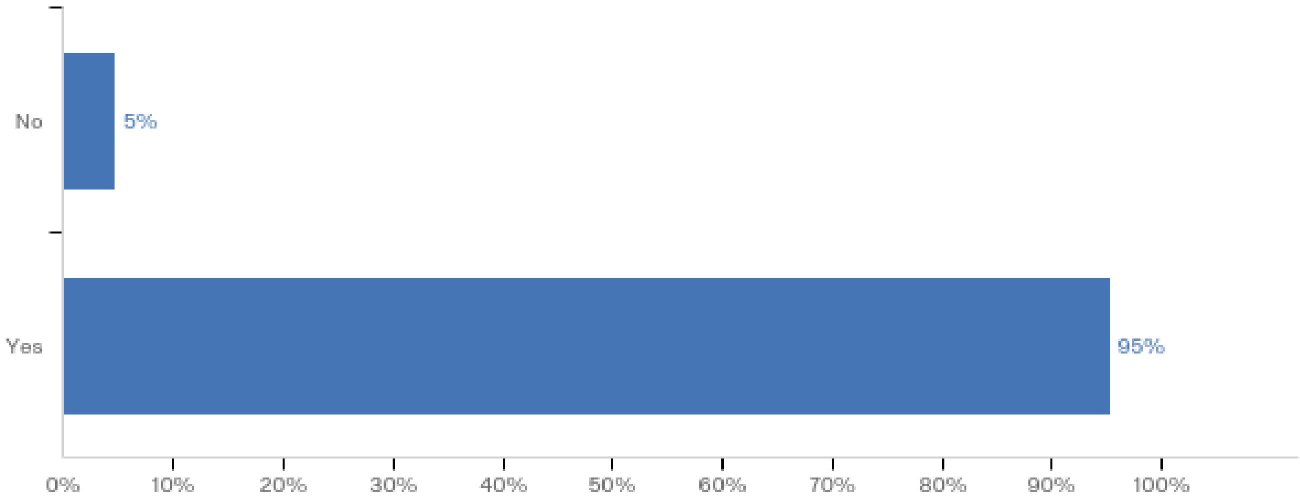


Figure 23. Q 15. Have you been prescribed HIV medications?



Only 84% of survey respondents reporting taking medications as prescribed over the last 12 months, but the majority of those respondents missing medications only missed them 1-3 times per month (see Figures 24 and 25).

Figure 24. Q27. If yes, have you taken the medications as prescribed in the last 12 months?

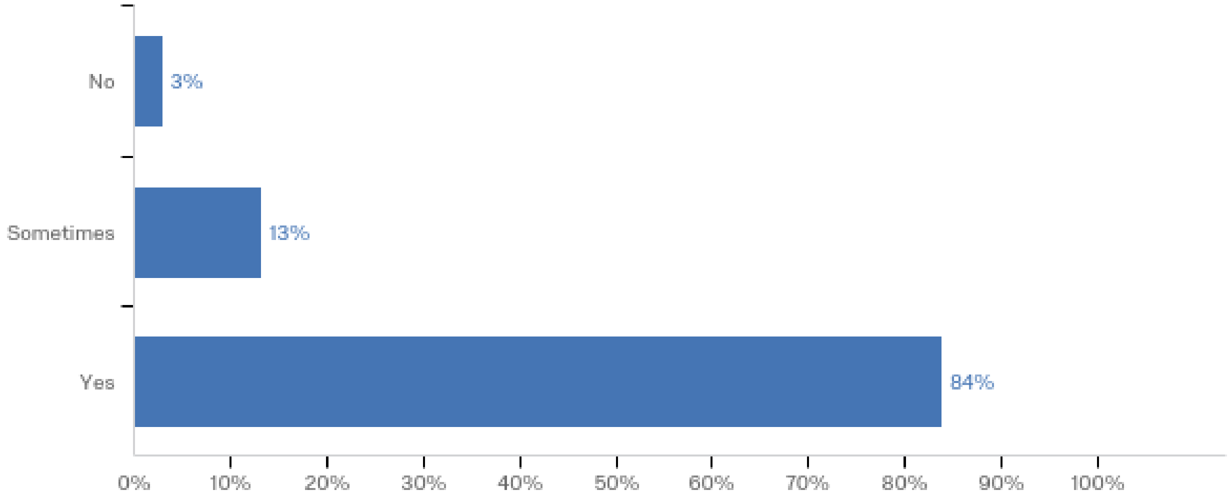
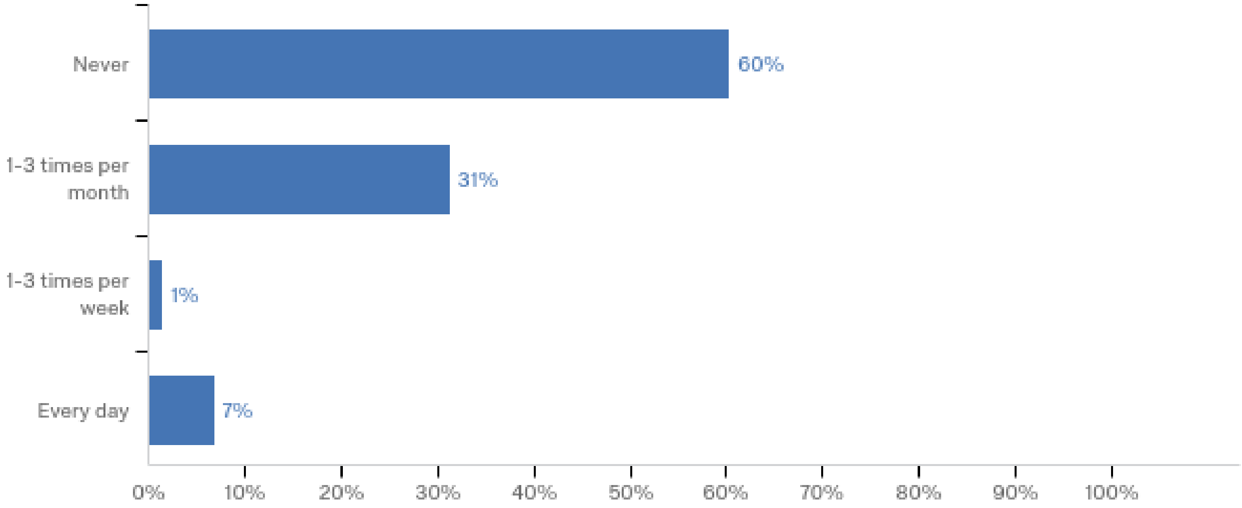
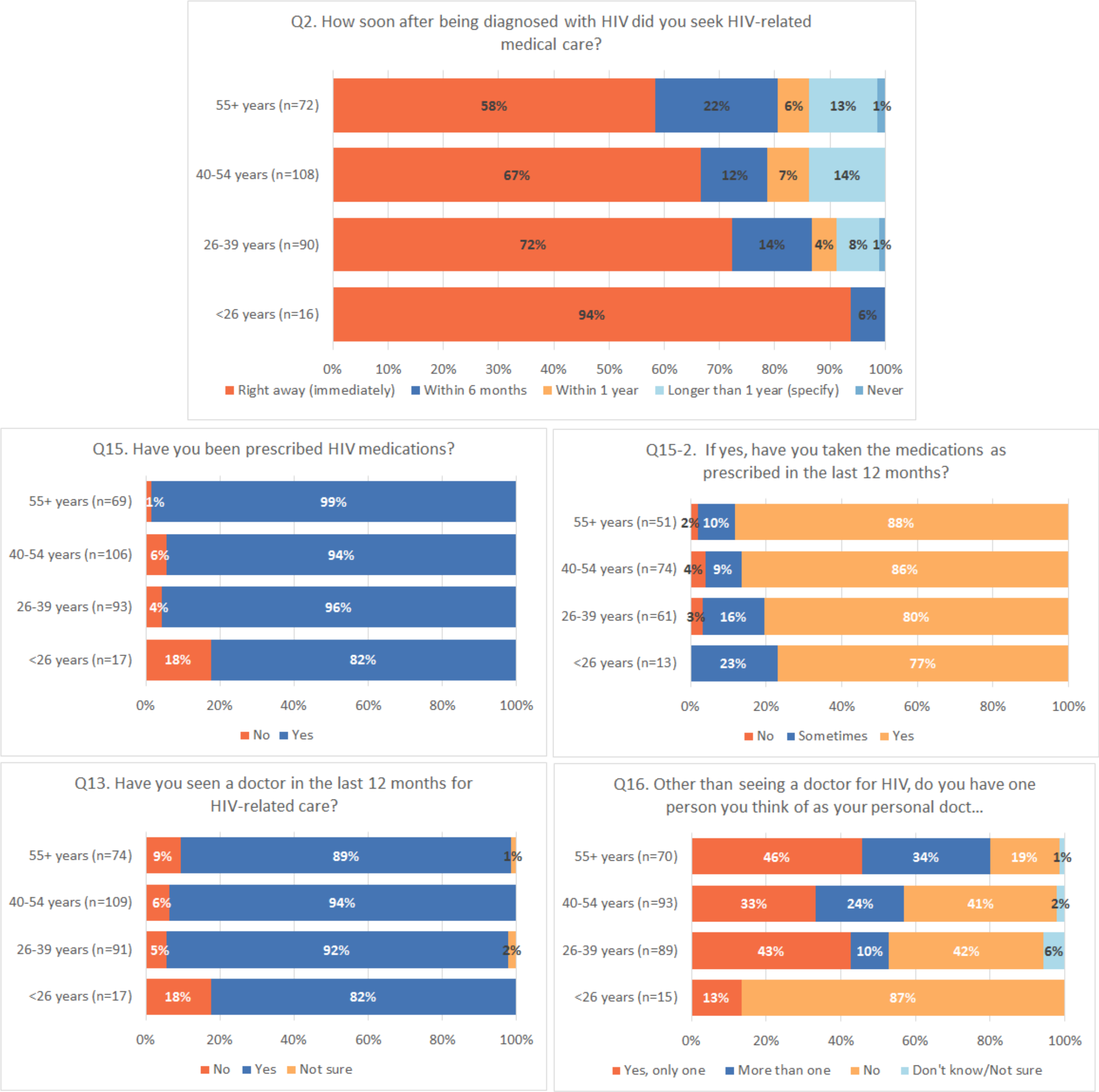


Figure 25. Q28. How frequently do you miss taking your medications?



One interesting trend that emerged when looking at responses to questions by different age groups is that the overall group of participants less than age 26 (N=17) tended to respond differently than older age groups to many questions. The younger age group is less likely to have seen a doctor for HIV care in the last 12 months, less likely to have been prescribed medications (or take them as directed), and less likely to have someone they think of as their personal doctor. However, they are more likely to report seeking treatment immediately after being diagnosed with HIV. In fact, the percentage of those seeking treatment immediately decreases as age group increases. These age-related trends are shown in Figure 26 below.

Figure 26. Responses of Different Age Groups for Questions 2, 13, 15, 15-2 and 16



Note: Due to the comparatively lower sample size of those <26 years, results should be interpreted with caution.

Thirty-seven percent of respondents reported not having another health care provider other than their HIV medical provider and 23% of respondents reported having no health insurance (see Figures 27 and 28). This is significant because these participants have a higher likelihood of going to the Emergency Room if they have a health concern and waiting longer than they might otherwise to address a health issue.

Figure 27. Q16. Other than seeing a doctor for HIV, do you have one person you think of as your personal doctor or health care provider?

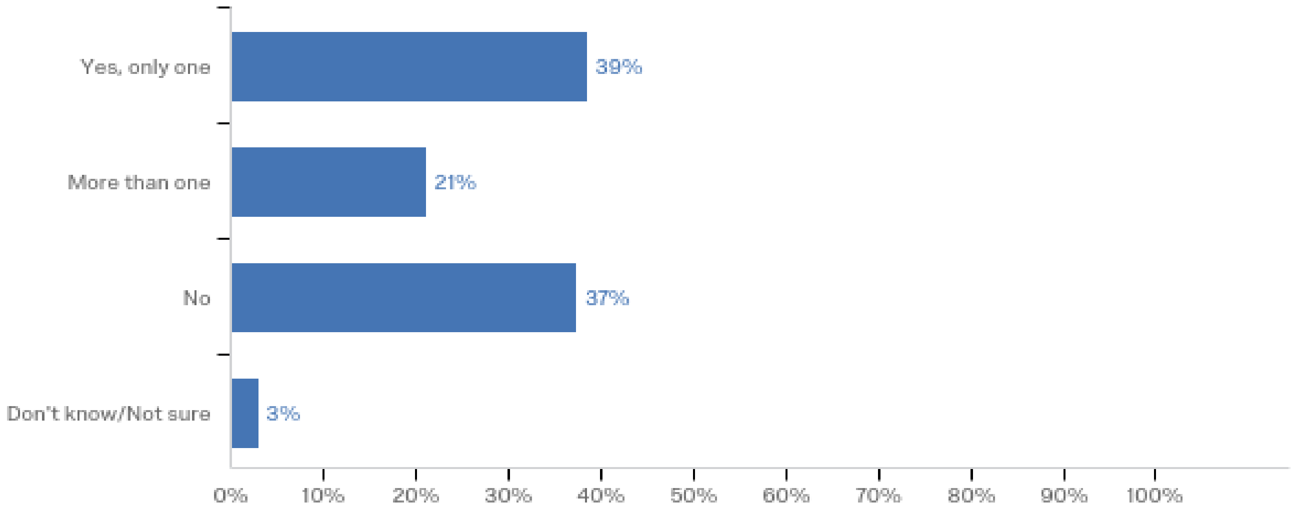
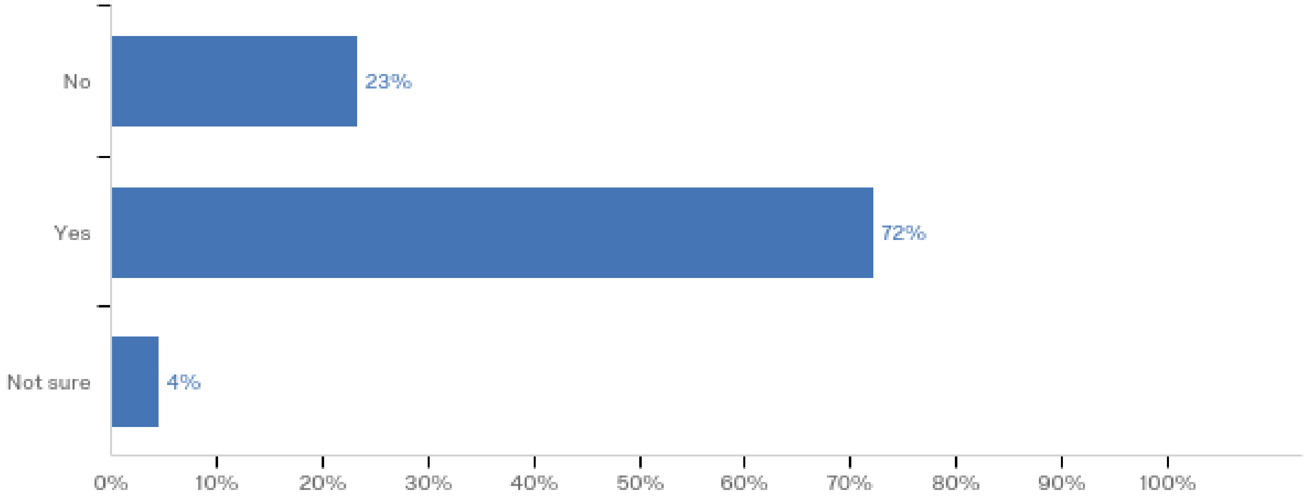
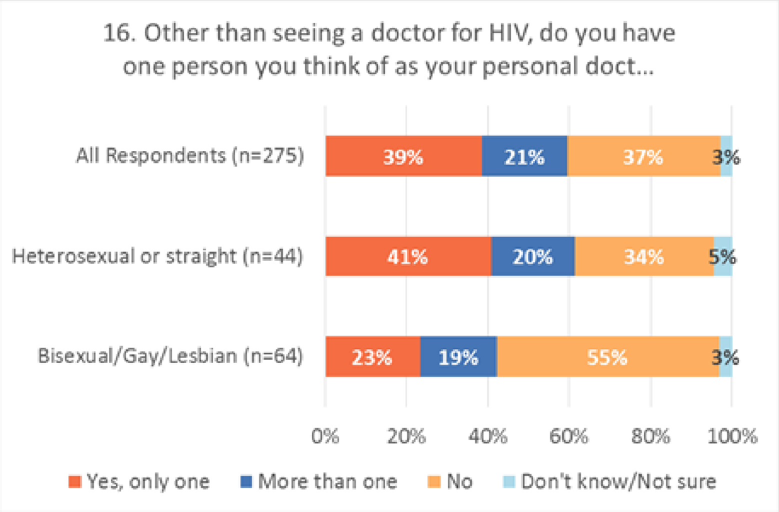


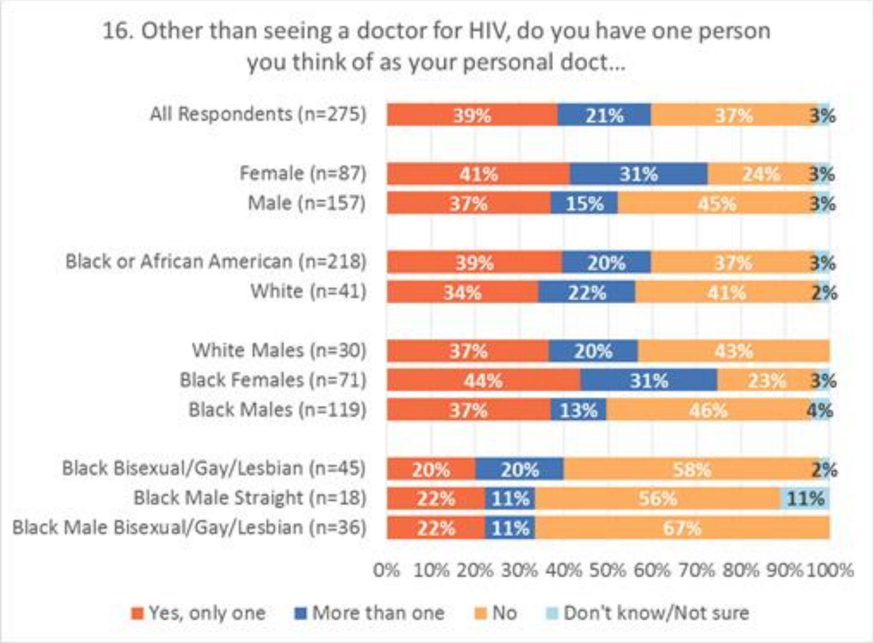
Figure 28. Q17. Do you have any health insurance such as Medicaid, Medicare, or private insurance?

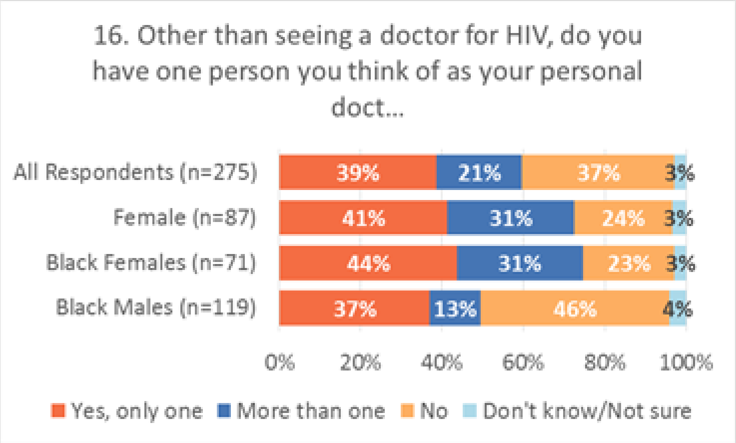


Of question respondents, males were more likely than females to report not having one person they think of as their personal doctor. African American males were least likely to report having a personal doctor. Bisexual or gay respondents also have a higher percentage of not having someone they think of as their personal doctor (see Figure 29).

Figure 29. Responses of Different Populations to Question 16







Out of Care Consumers

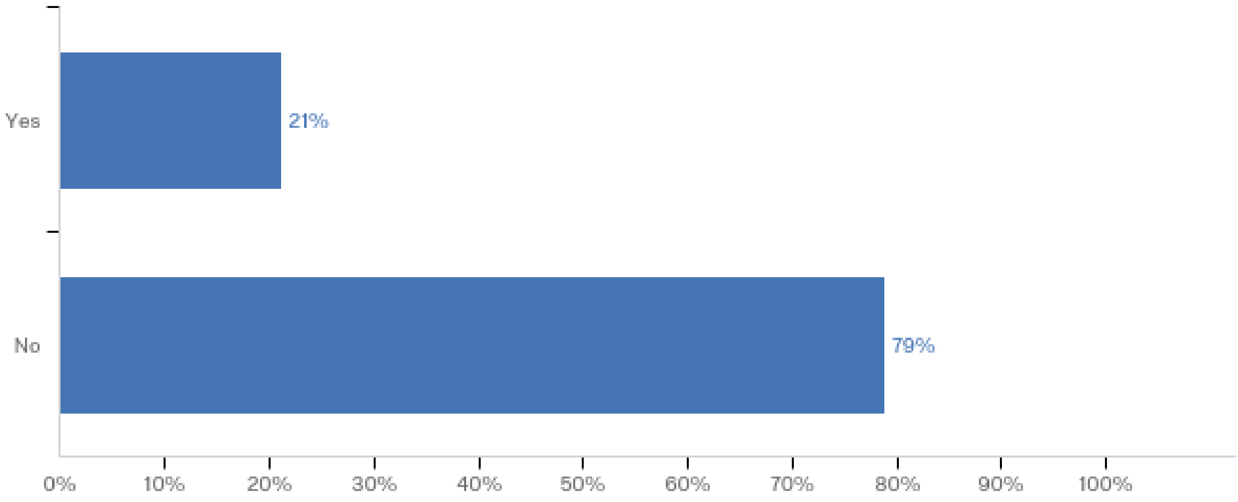
In order to gain a better understanding of what encourages PLWHA who are out of care to return to care, all survey participants were asked if they had ever been out of care for more than a year. Of survey participants, 21% (N=63) reported that there had been at least one year since being diagnosed with HIV during which they did not seek HIV-related services (Figure 30). Of those, 29% decided to seek care again because they wanted to stay or get healthy. Related, another 22% reported that they chose to seek care again because their health was declining or they were getting sick. Other reasons listed were that they wanted to stay alive; they were released from rehabilitation or recovered from an addiction; they were released from or entered prison; they started taking mental health medication again; they obtained insurance again or they were contacted by EVMS.

Below are some particularly illustrative quotes from respondents as to why they returned to care:

> *"Cause I got scared and I have a son to live for."*
> *"I wanted to live and got clean and sober."*
> *"I was without a home and had no access to getting meds and started to feel sick."*
> *"I stopped drinking and started taking care of myself."*
> *"I stopped for 2 years and almost died."*
> *"Because I was getting sick and I found my partner was sleeping around on me."*
> *"At the time I found out I was 8 1/2 months pregnant and I followed up with care provider my daughter did not contact HIV."*
> *"I wanted to take care of myself, gain control of my life back."*

The individualized nature of these statements underscore the difficulty in bringing consumers back into care. However, it also highlights the importance of mental health support and substance abuse treatment in supporting PLWHA to stay in care and re-enter care.

Figure 30. Question 6. Since being diagnosed, have you ever had a period of time (longer than 1 year) when you did not seek HIV-related services?



In addition, there were six survey respondents who identified as being out of care. These are participants who reported that:

- They have not seen a doctor in the last 12 months for HIV care.
- They have not had HIV bloodwork done in the last 12 months.
- They have not been prescribed HIV medications.

The majority of these participants sought care immediately and reported that they received information about their HIV status from the person who provided their HIV results. Five of the OOC participants are male and 1 identified as transgender. Four of the OOC participants were African American and two were white. Of the OOC participants, 50% (N=3) identified as gay or lesbian, 1 identified as bisexual and 2 identified as heterosexual or straight. The majority (50%. N=3) live with family, 2 are currently living in a homeless shelter and 1 owns or rents an apartment.

Commonalities and Differences among Vulnerable Populations

This section discusses the commonalities and differences in responses among some of the key vulnerable populations. The vulnerable populations discussed include:

- Transgender PLWHA
- Young MSM (Less than age 26)
- African American MSM
- African American Females
- Hispanic Males and Females

For several of these populations, there is insufficient data to make broad conclusions. However, for each population group, we discuss areas of differences and variances, which may be useful when considering opportunities for additional investigation or tailoring service delivery.

Transgender PLWHA

Of the 320 participants in the Needs Assessment survey, only 10 participants identified as transgender. Based on the small number of transgender participants, there is a limited ability to compare and contrast differences across populations and the margin of error is high. Many of the same trends among survey participants discussed throughout the findings sections are true for this population. The following differences identified by analysts are noted below.

Survey participants who identified as transgender were ***more*** likely to report that they:

- Waited longer than a year to seek HIV-related medical care
- Have not seen a doctor in the last 12 months for HIV-related care
- Have not had HIV-related bloodwork done
- Have not been prescribed HIV medications
- Have not taken those medications as prescribed
- Have received information about HIV or their HIV status from the person who provided their HIV results and through talking to friends or family rather than through other venues
- Sought job training or job search related services

Survey participants who identified as transgender were just as likely as other survey participants to report receiving the following services:

- Case management
- Housing assistance
- Transportation
- Mental health services
- Food assistance
- Dental care
- Substance abuse help

Young MSM (Less than age 26)

Of the 320 participants who responded to the Needs Assessment survey, only 126 identified their sexual preference, thus greatly reducing the level of generalizability. Of respondents who identified their sexuality, 58.7% (N=74) were male. Another layer of complexity is that MSMs, young or otherwise, do not necessarily identify as gay or bisexual.

As a result, there is a limited ability to compare and contrast differences across populations and the margin of error is high. Analysts compared responses and looked for trends from all participants who had identified sexual preferences, including males (N=166), males who were less than 26 years old (N=12), and males who were less than 26 years old and identified as bisexual or gay (N=5). Many of the same trends among participants discussed throughout the survey findings sections are true for this population. The following differences identified by analysts are noted below.

Survey participants who identified as young males who were bisexual or gay were *more* likely to report that they:

- Have not seen a doctor in the last 12 months for HIV-related care
- Have not had HIV-related bloodwork done
- Have not been prescribed HIV medications
- Sometimes did not take the medications as prescribed

Survey participants who identified as young males or young males who were bisexual or gay were *more* likely to report that they:

- Sought HIV-related medical care right away
- Received information to learn more about their HIV status online, through follow-up care, or through the person who diagnosed their HIV

Survey participants who identified as young males or young males who were bisexual or gay were *less* likely to report that they:

- Have had a period of time of more than a year where they did not receive HIV-related care
- Seek housing, transportation or job assistance
- Seek mental health services
- Seek substance abuse help
- Seek help paying bills

Survey participants who identified as young males or young males who were bisexual or gay were *just as likely* as other survey participants to report receiving the following service:

- Case management

African American MSM

The same data analysis complexities identified for the Young MSM category also apply to the African American MSM category. Since only 126 respondents identified their sexual preference, the level of generalizability is reduced. Also, remember that MSMs do not necessarily identify as gay or bisexual.

As a result, there is less ability to compare and contrast differences across populations and the margin of error is higher. Analysts compared responses and looked for trends among responses from all participants who had identified sexual preferences, including all males (N=166), African American males (N=125) and African American males who identified as bisexual or gay (N=38).

African American survey participants who identified as bisexual or gay were *more* likely to report that they:

- Received information to learn more about their HIV status online or by talking with friends or family

African American survey participants who identified as bisexual or gay were *less* likely to report that they:

- Seek housing or transportation assistance
- Seek mental health services
- Seek substance abuse help
- Seek help paying bills

African American survey participants who identified as bisexual or gay were *just as likely* as other survey participants to report that they:

- Have seen a doctor in the last 12 months for HIV-related care
- Have had HIV-related bloodwork done
- Have been prescribed HIV medications
- Take the medications as prescribed
- Utilize case management
- Seek food assistance
- Seek dental care
- Seek job training or job search assistance

African American males were least likely to report having a personal doctor. Bisexual or gay respondents also have a higher percentage of not having someone they think of as their personal doctor (see Figure 29). African American MSM are also less likely to be enrolled in the Ryan White Part A program and more likely to be OOC. This could indicate that they are seeking care at Urgent Care Centers or ERs, offering an opportunity for outreach and service referrals.

African American Females

Of the 320 participants who responded to the Needs Assessment survey, 79 identified as African American females. Unlike the other vulnerable populations, this sample size is larger and provides for better opportunities to compare and contrast differences and similarities across populations. However, a majority of the same trends among respondents discussed throughout the findings sections are true for African American females. The following comparisons identified by analysts are noted below.

African American females were *just as likely* as other survey participants to report that they:

- Have seen a doctor in the last 12 months for HIV-related care
- Have had HIV-related bloodwork done
- Have been prescribed HIV medications
- Take the medications as prescribed

African American females were *just as likely* as other survey participants to report receiving the following services:

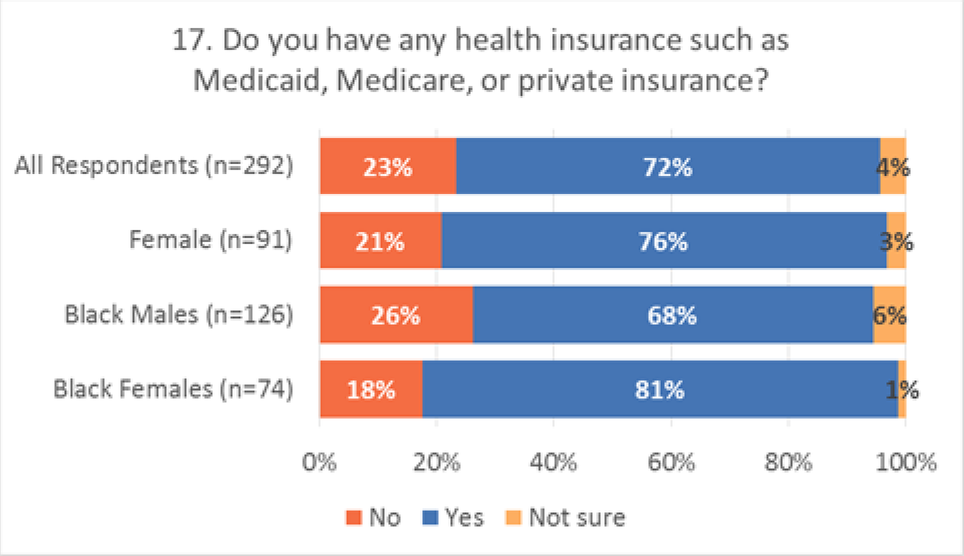
- Case management
- Transportation assistance
- Mental health services
- Substance abuse help
- Job training or job search help

African American females were *more* likely than other survey participants to report receiving the following services:

- Housing assistance
- Food assistance
- Dental care
- Help paying bills

African American females were also slightly more likely to report having health insurance as compared to the percentages of African American males, all females, and all respondents (see Figure 31).

Figure 31. Responses of All Respondents, Females, Black Males, and Black Females for Question 17



Hispanic Males and Females

Of the 320 survey participants, 20% opted not to identify their ethnicity. Of those who did, 3.6% (N=9) identified as Hispanic or Latino. Based on the small number of Latino participants, there is a limited ability to compare and contrast differences across populations and the margin of error is high. Many of the same trends among participants discussed throughout the survey findings sections are true for this population. The following differences identified by analysts are noted below.

Survey participants who identified as Latino were *just as likely* as other survey participants to report that they:

- Have seen a doctor in the last 12 months for HIV-related care
- Have had HIV-related bloodwork done
- Take the medications as prescribed

Survey participants who identified as Latino were *more* likely to report that they:

- Received information about HIV or their HIV status from the person who provided their follow-up care or online
- Rated their health as "fair" rather than "good" or "poor"
- Seek help paying bills

Survey participants who identified as Latino were *less* likely to report that they:

- Have been prescribed HIV medications
- Seek transportation assistance
- Seek mental health services
- Seek job training or job search related services

Survey participants who identified as Latino were *just as likely* as other survey participants to report receiving the following services:

- Case management
- Housing assistance
- Food assistance
- Dental care
- Seek substance abuse help

Stakeholder Interview Findings

This section describes the findings from key stakeholder interviews. As mentioned previously, of the 9 stakeholders interviewed, 3 participants are out of care or had recently (within the last month) been out of care for more than a year, 1 participant had been out of care after diagnosis for more than a year but re-entered care within the last year, and a fifth participant had been out of care for at least 6 months.

The perspectives of all of the vulnerable populations discussed in the previous section are represented in these interviews. Despite the diversity of race, gender, age and sexual preference among the participants, strong commonalities and themes in their experiences arose from the interviews. These themes include:

- Impact of stigma, including its impact on the quality of their lives as well as their willingness to seek services and their comfort (or lack of comfort) in receiving those services.

- Mental health and social support, including participants' emotional struggles with acceptance of their HIV status and their feelings of isolation.
- Quality of service matters, affecting both how comfortable participants feel using those services and whether they return to continue receiving services.
- Life transitions impact continuity of care.
- Lack of primary care.

This section also includes recommendations from participants about how to further support service delivery.

Impact of stigma

"You just see yourselves as three letters." The majority of participants discussed the perceptions and misconceptions related to HIV in their communities. These misconceptions made it more difficult for them to accept their own diagnosis and to feel comfortable revealing their HIV status.

> *"I really wish that it [HIV] didn't have such a powerful negative stigma. I don't know how to get people to understand that it's not anything to look down upon. Maybe there needs to be more exposure on people who are really dealing with it, handling and winning the battle against it. There is still a hard horrible stigma attached with it and I think that's coming from people who don't know the success stories behind it so they are afraid of it. So if someone finds out their status changes, they feel defeated because they don't understand it [HIV] is manageable."*
>
> *- PLWHA who is currently in care*

> *"I believe that the taboo and stigma of HIV is what makes people stay silent and that's why they end up dying silently. I've been trying to get my friend into treatment but he won't do it. I want to become a community advocate or something once I get my life together."*
>
> *- Previously out of care consumer*

In some cases, the negative stigma of HIV made participants feel uncomfortable while receiving services from an HIV or medical service provider. For example, one currently OOC participant voiced appreciation for services from ACCESS and the support he had received in getting to a doctor. At the same time, he felt uncomfortable going into their offices or seeking any more help because of the lack of privacy. He was concerned about someone coming in to ACCESS' offices and recognizing him. His concern with having to self-identify as having HIV also created discomfort when calling to seek other services and prevented him from reaching out for help. Another currently OOC consumer described feeling embarrassed just having to be in doctors' offices to receive HIV related care.

> *"I also think that the community needs more information in general about HIV. Lots of people are misinformed or don't know anything about the disease. They also don't understand that you can take medicine to prevent it and that you could get medicine at the health department. I also don't know about a lot of the services out there that might be helpful for me and I don't want to reach out and have to self-identify as having HIV."*
>
> *- PLWHA who is currently out of care*

Mental health and social support

Participants shared their challenges in accepting their HIV status and, in many cases, the isolation they felt not knowing others who were also HIV positive.

> *"I haven't had any barriers other than the ones I put up myself. The whole fear thing. When I found out [about being HIV positive], it was a complete and total devastating blow and then I sought care."*
>
> *- PLWHA who is currently in care*

> *"I think that if there were support groups for HIV that would have helped but people [her case manager] told me that no one came so I never showed up. I just didn't expect to be there [to be HIV positive]."*
>
> *- PLWHA who is currently out of care*

One previously OOC consumer had gone to the doctor again for the first time a day before the phone interview for this assessment. She credited the connection she had recently formed with her case worker, saying: *"I like talking to the person once a week and he gets me out of the house and away from depression. He really helps me keep my mood up."*

Quality of service matters

Unsurprisingly, the quality of the service provided makes a difference in whether consumers stay in care. Many of the participants who are currently in care had positive feedback related to services they received, specifically identifying that these agencies made it easy for them to stay enrolled and to receive the services they offered.

> *"ACCESS makes it easy, very easy. It's really helpful to people like me. My case manager is wonderful. I've heard other people being disappointed but I'd be dead if it weren't for my case manager. She deserves a raise."*
>
> *- PLWHA who is currently in care*
>
> *"I was previously at EVMS on Colley Ave. They were wonderful. My nurse was […] and she was amazing. They made everything so easy. Every year you could renew your application and they would let you know what you would need to bring in and they handled the rest."*
>
> *- PLWHA who is currently in care*
>
> *"The service at Sentara was so good that it was almost like having a magic wand. My case manager was magic. I could ask for nothing more. I enjoyed my time at Sentara – everything was very comfortable, bloodwork, doctor. I was truly blessed."*
>
> *- PLWHA who is currently in care*

At the same time, another consumer expressed frustration with social workers and nurses at the hospital where he was treated because they tried to talk to him about medical concerns in the lobby or out in a public clinic rather than waiting to have a private conversation in their offices.

Another consumer spent over a year out of care after his initial diagnosis because of a series of problems with the urgent care clinic who had completed his initial HIV testing.

> *"They [Patient First] just prescribed me medication – and kept billing me outrageous amounts and didn't refer me to EVMS or ACCESS… Then they referred me to [Dr. X] who was the worst doctor. And the pharmacies don't care what the situation is if you don't have insurance. He [the doctor] was the only person I knew to go to so I went untreated."*
>
> *- PLWHA who was previously out of care*

After not receiving information about HIV or any community referrals, this consumer did not enter care again until he was later hospitalized. In the hospital, he was connected with EVMS. From the same consumer: *"EVMS was the greatest help and compassionate and didn't let me leave until I understood what was going on and got me enrolled me in the Ryan White Program. If it weren't for EVMS then a lot more people would be dead."*

Life transitions

Life transitions impact continuity of care and consumers likelihood of staying in care. Three of the nine consumers interviewed had recently moved and two others described life changing transitions that impacted their care.

One of the consumers who had moved from another state described how easy it was to find care in the Hampton Roads area because of a referral made from his previous service provider. *"I was referred to Sentara by my Jacksonville provider and the next day I was referred a caseworker and everything was seamless. She made everything happen."*

Another consumer described leaving the area for six months and forgetting his medication: *"There was a six month state when I didn't have any meds at all for six months and it was hard to recover from that. And now slowly they [viral loads] are going down again."*

One participant currently out of care described the impact of moving quickly to another state. She did not have her medications, did not have a chance to change her address, and did not want to drive back to Hampton Roads for her doctor appointment. She was also unsure if she was still enrolled in Ryan White or how to reenroll if needed and where to seek services in her new location. While she was not averse to seeking treatment for her HIV and recognized that it was something she should probably do, there were a lot of barriers to her getting back into care and she was not sure where to start.

Lack of primary care

While a number of the consumers interviewed had jobs, no one interviewed had insurance or a medical home. If there was a non-HIV related illness, all participants said they would go to the ER.

Consumer Recommendations

A number of recommendations arose from the survey and the stakeholder interviews. The toXcel Team expanded on these consumer suggestions to provide additional insight into what their recommendations might mean for service delivery.

- **Develop a regional campaign to reduce the stigma of HIV in the Hampton Roads region.** The campaign would highlight how successful treatment can transform lives, raise awareness about the many success stories of PLWHA and decrease fear of the disease.
- **Increase awareness among providers and those most at risk of being infected with HIV of the free opportunities in the region to take a medication called "PrEP,"** which stands for **Pr**e-**E**xposure **P**rophylaxis. In taking PrEP, people who are at a very high risk of contracting HIV can prevent HIV infection by taking a daily pill. If someone who is taking PrEP is exposed to HIV through sexual contact or IDU, these medicines can work to prevent that person from contracting the virus. The use of PrEP can be a powerful prevention tool among the highest risk populations, especially when combined with condoms and other prevention methods. Currently, PrEP is being provided for free by several health departments across the Hampton Roads Region and is available to people who are most at risk for being infected. Additional coordination among service providers and health departments can raise awareness of opportunities to take PrEP and identify users who may most benefit from PrEP but do not know of its availability.
- **Improve transportation assistance or public transportation connections to support PLWHA in reaching appointments and other needed services.** Consumers surveyed and interviewed identified adequate transportation as a major barrier. Increasing the availability and awareness of transportation assistance, particularly targeting those more at risk for dropping out of care (e.g., PLWHA who do not have reliable transportation, do not have a support network, have a mental illness or abuse drugs), could reduce the number of consumers who drop out of care. An alternative to increasing transportation assistance would be to advocate for increased public transportation connections to key areas in the community where health services are provided. Service providers could also train administrative assistants who book appointments to be familiar with the public transportation systems and support consumers in booking appointments during times when transit is running more frequently to decrease the number of missed appointments.
- **Increase social media and online support for PLWHA to enhance social connections and information availability.** Consumers access services and information in different ways. Additional opportunities to provide information and services through social media could be developed to reach consumers who might benefit from these types of online connections. Support groups or web chats could be hosted for consumers who may not be ready to identify publicly as being HIV positive. In addition, establishing a web portal for consumers to see all the different kinds of services they can access and the eligibility requirements for those services would allow consumers to maintain their privacy and not have to call a service provider and identify themselves as having HIV to ask about services.
- **Increase opportunities for in-person social support**, particularly through support groups that connect people with similar interests together. Less traditional support groups could focus on healthy social activities and helping PLWHA get to know others who have shared experiences, thereby decreasing feelings of isolation.

- **Improve awareness, availability and accessibility of job seeking and job readiness programs.** Participants expressed the desire to be independent and to have jobs, but lack the skills or knowledge to find jobs and they need support in successfully moving through a job search.
- **Strengthen the housing assistance system.** Housing needs continue to be major issues that confront PLWHA and is a barrier to accessing care. Working with municipalities and affordable housing providers to develop stronger subsidized housing policies and transitional housing programs could support more people in accessing the services they need. The impact of lack of housing and homelessness were regular themes among PLWHA who participated in interviews and surveys. There were also many references to the long waiting lines for existing affordable housing programs, so much so that many did not even bother to apply.

Section 3. The Provider Perspective: Service Needs and Utilization

Service providers have a strong understanding of the strengths and weaknesses of the health system they work within and are able to offer an important perspective on the needs of consumers and the effectiveness of partner coordination in achieving quality care within the care network.

Process

This Needs Assessment incorporated the views of over 55 medical and service providers through focus groups, informal discussions and an online survey. The goal of the focus groups and the survey was to understand the state of services in the Greater Hampton Roads community and the degree to which clients are taking advantage of services. In particular, questions centered on factors that affect clients' decisions to seek services after diagnosis. Participants were also asked to identify unmet needs and strategies to improve access to and use of existing services.

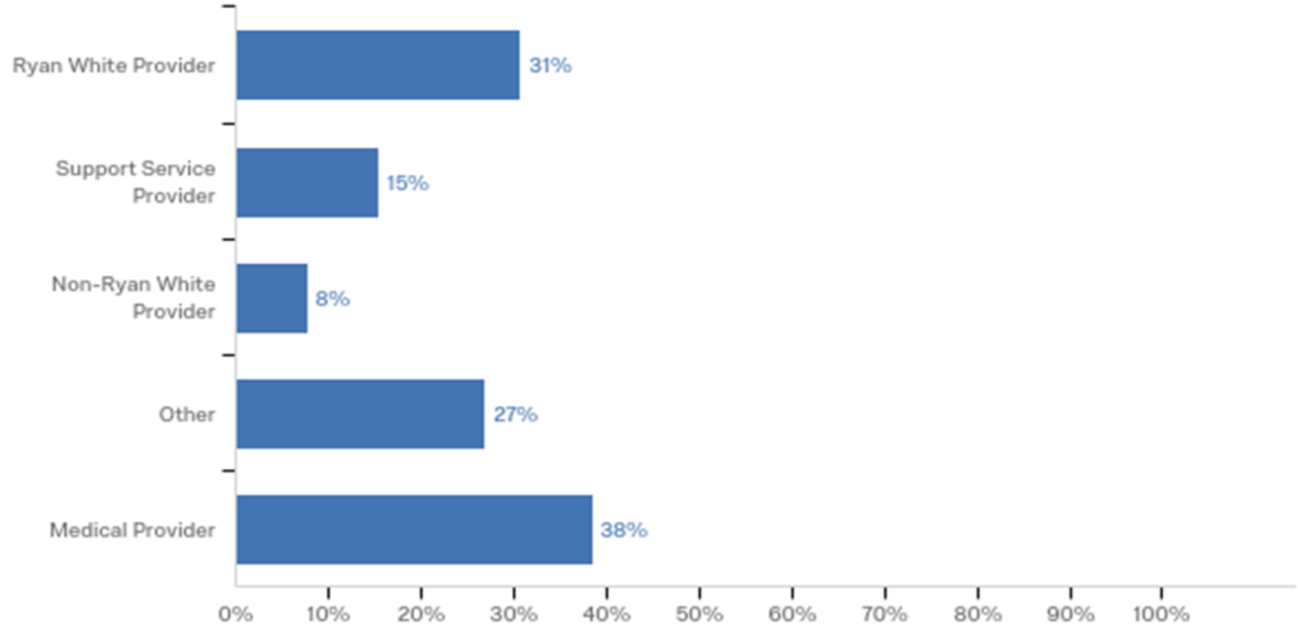
In November 2016, two focus groups were facilitated in conjunction with a required Ryan White grantee workshop. There were 29 participants representing 7 agencies; all of the participating agencies were Ryan White Part A grantees who provided services to a large number of PLWHA (at least 100+). The majority of the participants were case managers or worked with Early Intervention Services (EIS). Some medical and dental providers also participated in the focus groups.

In January 2017, an informal discussion was led with community health workers and patient navigators whose work focuses on drawing OOC consumers in to care. The focus of this conversation was to understand why this population may not be readily accessible.

In January and February 2017, a survey was also launched with providers to ensure that the views of medical providers and non-Ryan White grantees were adequately captured. Paper copies of the survey were circulated at a Bridges 757 event hosted by the Virginia Department of Health that focused on meeting the service needs of MSMs. The survey was also circulated electronically to mental health and medical providers as well as hospital networks within the Hampton Roads region, including local Community Services Boards and health departments, Sentara, Bon Secours, and the Eastern Virginia Medical School.

In total, there were 26 survey participants including medical providers, support service providers, Ryan White and non-Ryan White providers (Figure 32). Participants who identified themselves as 'other' were primarily either pharmacists or health care providers who worked at the community health center or EVMS satellite locations. All survey participants reported serving PLWHA and 61% reported serving more than 100 HIV patients in a year. In addition, the vast majority (88% or more) reported serving the vulnerable populations being targeted in this assessment – transgender, young MSM (Ages 13-24), African American MSM, African American females, and Hispanic males and females.

Figure 32. Description that best defines your role as a service provider



Findings from Focus Groups

The goal of the focus groups was to understand the state of services in the Norfolk TGA and the degree to which clients are taking advantage of services provided. In particular, the discussion focused on factors that affect clients' decisions to seek services after diagnosis. Participants also discussed any unmet needs and strategies to improve access to and use of existing services. Lastly, their feedback was sought in how to best engage clients in the Needs Assessment process. Some key themes included:

- Needs for newly diagnosed patients
- Barriers to initiating HIV-related medical care
- Factors that encourage OOC patients to seek care
- Barriers to accessing services and care
- Recommendations additional service needs

Needs for newly diagnosed patients

Focus group participants felt that the assurance of confidentiality, compassion, education and support as well as assistance in linking clients to care were critical components to care for newly diagnosed patients.

- **Confidentiality.** Clients need to feel that the information provided will be kept confidential and shared only with permission. Providers should be honest regarding who will receive the information, as required by state and federal laws.
- **Compassion and Care.** Clients should be involved in the creation of any treatment plan because it is their plan, not the providers. Participants felt that, initially, regular check-ins (at least weekly) helped show the client that their caseworker cared.
- **Education and support.** Clients need to understand what to expect at their first medical visit and what it means to be HIV positive. Their concerns and fears also need to be heard and listened to with an open mind.

- **Linkage to care.** A critical component is to assist clients in making the first medical appointment and ensuring that they attend. Clients also need to understand their eligibility for services and the application process.

Barriers to initiating HIV-related medical care

Focus group participants identified a number of factors that influence clients' decisions to continue to seek care. These include:

- **Negative stigma of HIV.** How HIV is perceived by their friends, family, and community has a huge influence on clients' willingness to seek care.
- **Perceived breach of confidentiality by providers.** Once trust is breached, especially when a patient is in a vulnerable state, it is hard to repair that relationship.
- **Competing priorities such as housing, finances and family.** There is little time and a lot of other priorities and sometimes clients decide not to prioritize their HIV treatment.
- **Denial.** Clients are not ready to accept an HIV diagnosis and are not ready to enter care.
- **Exclusive HIV service locations.** A place that is just servicing HIV clients and not serving others can be intimidating, as clients fear being identified as having HIV by others who might see them seeking services.
- **Inaccessibility.** The locations of medical services are not always accessible by public transportation or easy to reach. Office hours are not always convenient and clients are not able to access certain services after workday hours or during the weekends.
- **Citizenship status.** Immigration issues related to accessing services and fear of deportation.

Additional support and community services are also needed to ensure clients are linked to EIS services after initial testing.

- Peer support is critical in allowing clients to connect and talk with others who face similar issues. This mutual helping is healing, grounding and prevents isolation.
- Health literacy and understanding the medical language related to HIV is critical. Clients need to understand all the related terms and what it means to be HIV positive. Educational materials need to be readable and easily understood by clients with a lower literacy level.
- Clients need support in knowing their rights to receive services as outlined by Ryan White and their understanding should include what to do if those rights are taken away or challenged. Both provider and client should know their respective responsibilities relevant to receiving and giving services.
- Mental health counseling is an important component and not having it, especially when entering care, is a significant barrier to staying in care.

Factors that encourage OOC patients to seek care

Similarly, participants identified factors that influence OOC patients in their decision to re-enter medical care.

- **Fear of living with HIV/AIDS.** Clients are afraid of dying or their failing health and decide they would rather fight to live.
- **Availability of housing funds.** When clients are able to transition from homelessness or shelter life into a more stable environment, they are able to focus more of their attention and energy on self-care.

- **Early Intervention Services (EIS).** The ability of caseworkers with EIS to reconnect with clients, understand where they are coming from and help address some of the fears and concerns that led them out of care is critical. EIS plays an important role in re-entry into care.
- **Family priorities.** Clients decide that it is important to take care of themselves so that they can take care of their families.
- **Client-centered approach**. Using a method that centers around the client is critical in encouraging patients to understand their role in their care and to be empowered to make decisions about their medical treatment and seek the services they need.
- **Provider attitude.** Providers being optimistic and not negative about care. Clients need to understand what to expect, and they also should not fear care. They need to hear positivity and success stories from providers.

Barriers to accessing services and care

Focus group participants identified a number of barriers that negatively affected PLWHA trying to seek care.

- **A lack of mental health providers who offer services under Ryan White funding and those who accept Medicaid.** There are providers, but they are limited. Maintaining good mental health, being supported in accepting a new HIV diagnosis, and managing any number of issues related to existing mental illnesses are important to maintaining long-term HIV-related care.
- **Completing paperwork.** There is a large amount of paper work -- too much to complete for a new client who is already overwhelmed. Clients need assistance in completing the paperwork and it creates the perception of too much red tape.
- **Positive rapport with the case manager.** The relationship between a client and case manager is important. The quality of case managers can vary and some are more culturally competent than others.
- **Confusion about the roles and responsibilities of providers** (i.e., psychiatrist, case manager, EIS, etc.). There is a large network of providers who offer different services and have different eligibility requirements. It can be confusing to new clients trying to navigate the system, as well as to service providers who do not provide Ryan White funded services. Clients develop relationships with EIS for a short period of time only to be transitioned later to a case manager who then connects them to a network of other service providers. In addition, the variation of services offered by providers in different jurisdictions across the TGA can be confusing and overwhelming.
- **Confidentiality for active-duty clients.** Clients in the military are concerned about the degree of confidentiality and whether or not seeking care with service providers and non-profits in the TGA will then lead to the military learning of their status.
- **Lifeline.** Safe link phones provide needed access to resources but have their limits. Clients are requesting free phones through programs such as Safe link. These phones provide the client with telephone access to information and resources at no cost. Not having phones is a barrier to reaching others and staying in-touch with providers.
- **Denial** about the disease, particularly among young MSM, affect their willingness to seek care.

Focus Group Recommendations for Additional Service Needs

Focus group participants identified the following additional services and support needed by newly diagnosed patients to help them manage their HIV disease.

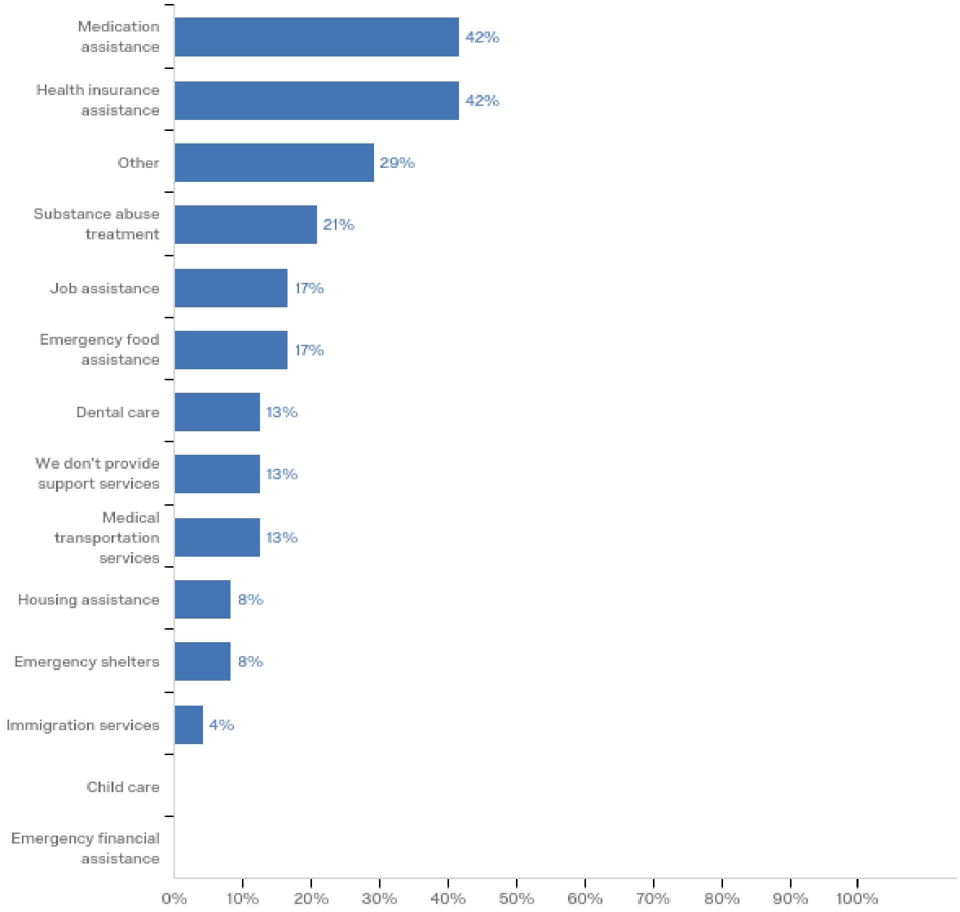
- **Networking with other agencies.** In order to provide the best services for the client, providers need to work together to meet the needs of clients instead of competing with each other based on numbers or funds. An example of this might be providing a referral to an agency who provides culturally competent services to transgender individuals because the referring organization does not have the staffing and services to meet the client's need.
- **Develop consistent policies and procedures** for collecting eligibility and client information required by agencies for clients to receive services (e.g., income verification, confirmation of homeless incidents).
- **Offer assistance negotiating medical care, including where to go and how to get there.** Peer educators play an important role in assisting newly diagnosed clients with navigating the process for receiving medical care, medication, insurance and other supportive services.
- **Provide increased access to transportation** in order to attend medical appointments and other HIV-related care.
- **Provide increased housing assistance** and other housing related programs that are available to assist clients with down payments of rent, getting into housing assistance programs, and maintaining their transitional programs.
- **Increase client-centered referrals.** Agencies need to understand their capabilities and limitations and make referrals accordingly that are in best interest of their client. Organizations should work to provide clients with the best services and programs. If they feel they do not have the internal cultural sensitivity or services to meet the needs of a given client then they should not allow the internal need to gather numbers for funding to interfere with service provision.
- **Limit the negative influence of funding requirements on service provision.** Providers are more interested in meeting the funder requirements rather than the need of the client. For example, if a client returns to care and requests support for transportation, the organization prioritizes medical care and instead of support services even if those support services would help prevent a client from falling out of care.
- **Increase the coordination of services among agencies to better serve clients.** Organizations need to work across the funding spectrum to provide the best services for clients. When one organization is funded for medical care and another for housing, both could work together to streamline the process for the client which would remove barriers to accessing those services.
- **Improve organizational capacity to provide client education.** Providers on all levels should educate the client about what services are available and how to access them.

Service Provider Survey Findings

Services Provided by Survey Participants

For the most part, survey participants had expansive experience working with PLWHA and a rich understanding of consumers' needs. Nearly half (48%) offered HIV testing. Participants also provided individual or group supporting counseling (40%), case management (36%), EIS (32%), mental health services (16%), emergency medical care (16%), or support with medication adherence. A number of the participants provided additional support services (see Figure 33).

Figure 33. Question 5. Please select which support services you provide (Please check all that apply)



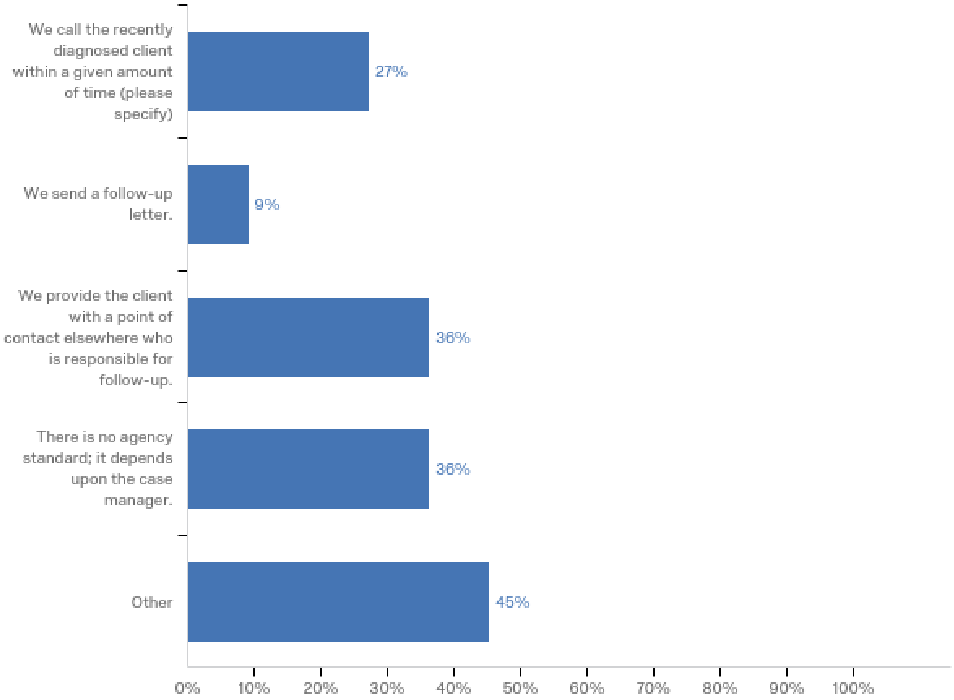
Barriers to Initiating and Accessing Care

Receiving HIV-positive testing results represents a critical moment in newly diagnosed HIV patients' lives when they can be referred to the right service and provider or alienated from care and left by themselves to figure out a complex system of medical needs (which many times means delayed entry into care). Making referrals and supporting follow-up care are critical ways to connect patients with care for their HIV when conveying positive test results.

Of the providers who responded, 54% (N=13) provide HIV testing. All of these participants described ways they connect clients who test positive to services. The approaches described ranged from reporting their status to the health department and directing patients to go there to making direct linkages to care networks and going with patients to their first appointment. The majority of respondents also provided some information about HIV, the importance of treatment, and available services. Some participants reported only giving patient's links and contact information to the Virginia Department of Health or HIV clinic.

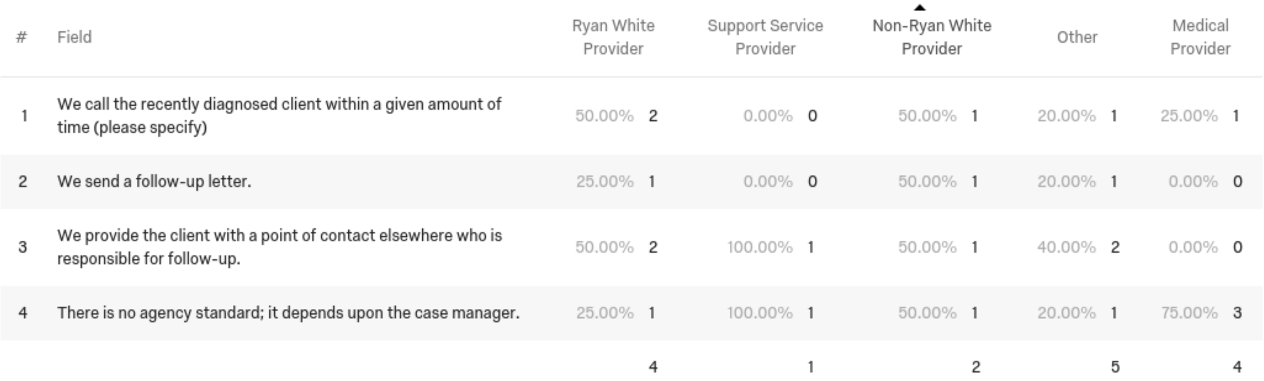
When asked about follow-up procedures when patients test positive for HIV, 36% (N=4) reported there was no agency standard and that it depended on case managers (Figure 34). "Other" responses that participants provided include giving in-house referrals, letting VDH take over, and being in contact with clients to support them keeping follow-up appointments. Of survey participants, medical providers were the most likely to report that there was no standard. While generalization about procedural processes is limited based on survey participation, these responses do identify an opportunity to support facilities that provide HIV testing in the region in developing high-quality procedures for follow-up after a patient tests positive with HIV, including linkages to care, understanding other services available and other HIV-related information.

Figure 34. Question 9. After a patient tests positive for HIV, what follow-up procedures has your agency established?



An additional breakdown of this question by the type of provider is included below in Figure 35.

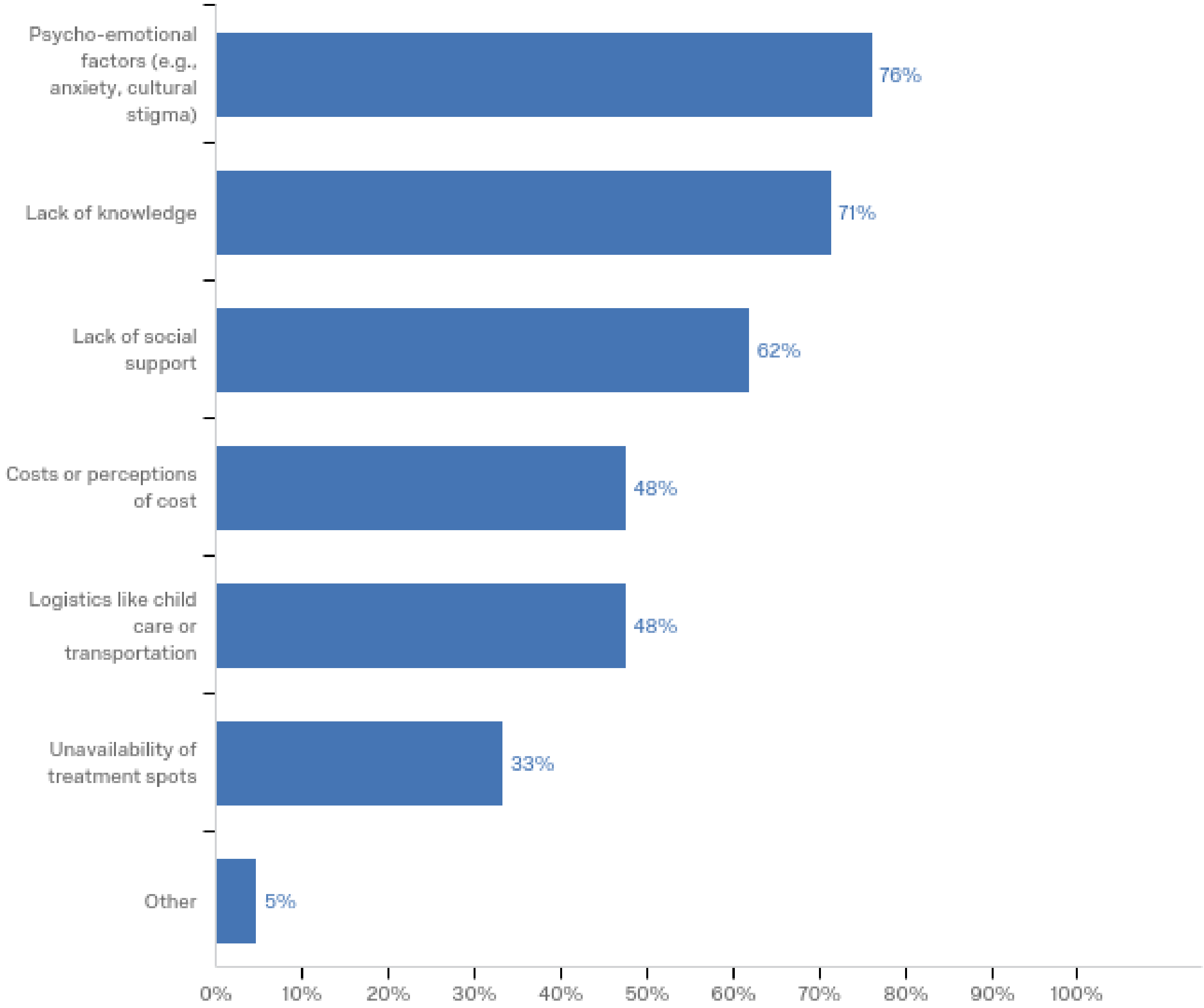
Figure 35. Question 9. After a patient tests positive for HIV, what follow-up procedures has your agency established? *(by provider response)*



#	Field	Ryan White Provider		Support Service Provider		Non-Ryan White Provider		Other		Medical Provider	
1	We call the recently diagnosed client within a given amount of time (please specify)	50.00%	2	0.00%	0	50.00%	1	20.00%	1	25.00%	1
2	We send a follow-up letter.	25.00%	1	0.00%	0	50.00%	1	20.00%	1	0.00%	0
3	We provide the client with a point of contact elsewhere who is responsible for follow-up.	50.00%	2	100.00%	1	50.00%	1	40.00%	2	0.00%	0
4	There is no agency standard; it depends upon the case manager.	25.00%	1	100.00%	1	50.00%	1	20.00%	1	75.00%	3
			4		1		2		5		4

The majority of providers agreed that psycho-emotional factors such as anxiety and cultural stigma as well as lack of knowledge and social support were the primary reasons that clients delayed seeking care after diagnosis (Figure 36).

Figure 36. Question 10. In your experience, what prevents clients from taking these steps initially after diagnosis?



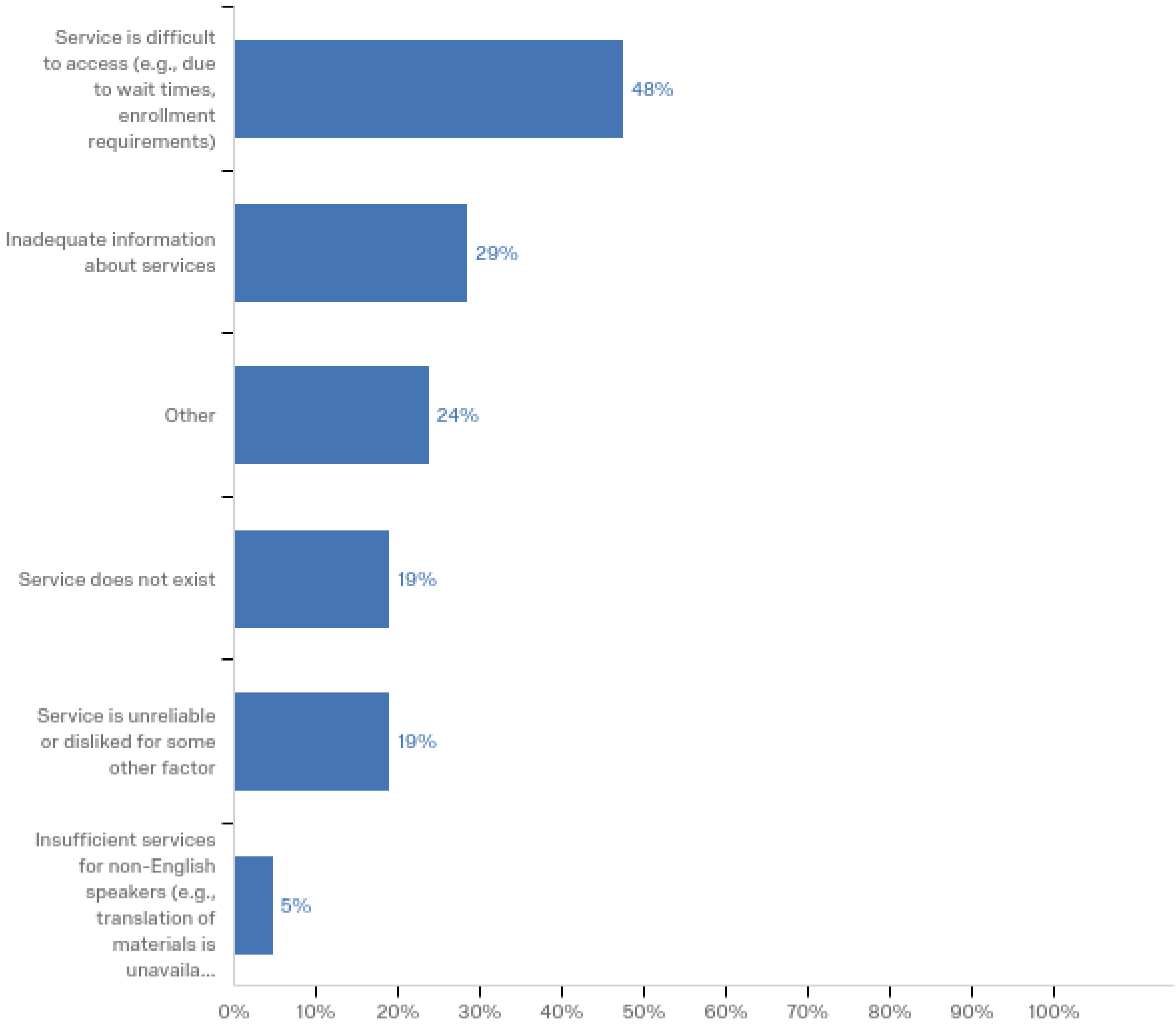
The majority of providers (over 65%) identified substance abuse and mental illness as factors that either most limited or very limited patients in seeking care (Figure 37). Poor insurance coverage, homelessness and difficulty finding transportation were also considered major barriers. Stigma was also considered a highly limiting factor.

Figure 37. Question 11. The following is a list of barriers to accessing care. Considering the clients that you have worked with in the last year, please rank the barriers that most limit seeking care (1=most limiting)

#	Question	(1=most limiting) %	N	2 %	N	3 %	N	4 %	N	(5=not as limiting) %	N	Total
1	Substance abuse	32%	7	45%	10	0%	0	14%	3	9%	2	22
2	Mental illness	23%	5	45%	10	14%	3	5%	1	14%	3	22
3	Poor or absent insurance coverage	48%	11	13%	3	9%	2	17%	4	13%	3	23
4	Homelessness	35%	8	26%	6	17%	4	13%	3	9%	2	23
5	Difficulty finding or using transportation	26%	6	35%	8	30%	7	0%	0	9%	2	23
6	Stigma	50%	9	22%	4	6%	1	22%	4	0%	0	18
7	Anxiety	20%	4	45%	9	10%	2	20%	4	5%	1	20
8	Unemployment or financial stresses	27%	6	23%	5	23%	5	23%	5	5%	1	22
9	Feel healthy	10%	2	30%	6	15%	3	40%	8	5%	1	20
10	Lack of child care	20%	4	10%	2	30%	6	25%	5	15%	3	20
11	Lack of food or nutritional support	14%	3	10%	2	24%	5	33%	7	19%	4	21
12	Immigration status	15%	3	5%	1	15%	3	30%	6	35%	7	20

In addition, providers felt that other factors such as services being difficult to access and inadequate information about services further prevented PLWHA from being able to overcome these barriers in order to access services (Figure 38). Other barriers mentioned included a lack of knowledge about the disease, stigma and the cost of medication.

Figure 38. Question 12. Considering the barriers mentioned above, what do you believe is the most common factor in not seeking services to overcome these barriers?

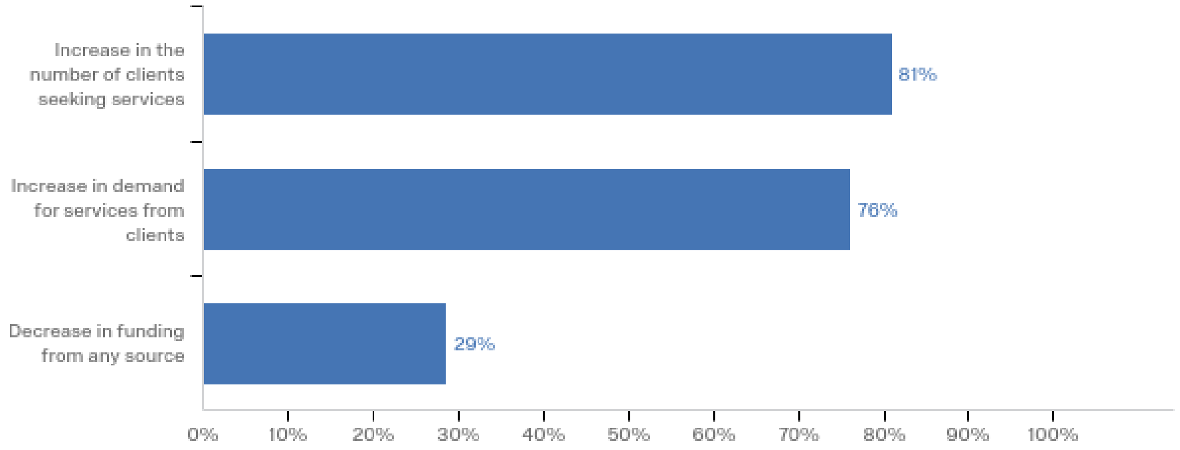


The majority of the providers surveyed believed that an OOC patient was most likely to seek care because of feeling ill or their declining medical condition. Other responses included improved mental health, coming to terms with their HIV status and understanding that medical services were free for the uninsured.

Improving Access to Care

The majority of those surveyed indicated an increase in the number of clients seeking services and an increase in the demand for services from clients (Figure 39). Focus group participants reported the same trends. This indicates that there is a rising demand for services and underlines the importance of identifying service and systemic changes that balance patient quality of care and the burden on the care giving system.

Figure 39. Question 6. Have any of the following occurrences taken place within your agency during the last year?



Service Provider Recommendations for Improved Service Delivery

The providers surveyed identified a number of possibilities to improve patient care, both on the provider and client side.

When asked what client-side change would most benefit the service delivery of newly diagnosed clients within the Norfolk TGA, providers had a number of suggestions:

- More patient navigation services for newly diagnosed patients.
- Better education prior to the point of diagnosis about HIV.
- Increase patients' health literacy.
- Provide access to quick care and ensure that clients receive a follow-up appointment immediately.
- Ensure adequate transportation to reach needed appointments.
- Change the stigma of HIV so that the community can better understand that it is a treatable disease and care can be available at free or low cost.

When asked what provider-side change would most benefit service delivery to newly diagnosed clients within the Norfolk TGA, providers offered the following suggestions:

- Offer staff-wide provider training. Specific topics suggested included training on the disease process, cultural sensitivity and resources available for PLWHA.
- Develop a more comprehensive system for establishing early care that allows patients to immediately have appointments scheduled without wait time with additional follow-up services available if needed.
- Implement an HIV testing and referral program in the ER.
- Improve effective communication and collaborations among system partners.

Section 4. Insights and Recommendations

This section weaves together the recommendations from the different sections and highlights additional focus areas.

Strengthen patient support navigation services. Patients need assistance negotiating medical care, including where to go and how to get there. For patients new to the HIV system of care, there is a lot of paperwork and a wide array of partners and services. Understanding how to use all the services that may be available, how to enroll and who to contact is overwhelming for newly diagnosed patients as well as those who have been in care. Many of the consumers who participated in the survey and who were interviewed reported having trouble identifying the service they needed or who to contact until they were connected with the right case manager.

Develop a more comprehensive system for establishing early care that allows patients to immediately have appointments scheduled without wait time with additional follow-up services available if needed. From a systems perspective, it would be easier for consumers if the partners could develop a system to streamline entry forms and eligibility questions by developing a "one stop shop" where consumers could go, find out what they were eligible for and submit the application forms all in the same place. Part of this process could include developing consistent policies and procedures required by agencies for clients to be eligible for and access services (i.e., income verification, confirmation of homeless incidents).

Increase coordination of services among agencies. Providers emphasized the need for agencies to better coordinate with each other and consumers expressed anxiety about being identified as being HIV positive when coming in to seek care in offices provided only HIV-related services. One way to address these challenges is by co-locating services and agencies so that consumers coming in for one service could access a number of them at the same time. The focus of the increased coordination should be among Ryan White service-providing organizations as well as non-Ryan White organizations. There should be particular focus on increasing service coordination with mental health agencies and substance abuse treatment centers given their role in supporting OOC clients return to care. Agencies working together to streamline the process for consumers can increase the number of consumers who seek care early and maintain that care longer. This kind of collaboration could be encouraged by adapting funding stream requirements to incentivize provider coordination and decrease barriers to working together.

Develop a common protocol among medical and service providers for providing newly diagnosed HIV positive patients with information and connecting them to services. Develop a protocol based on best practices that outlines steps that should be taken to support a newly diagnosed HIV patient, including a list of services offered and HIV medical providers. Urgent care and ERs are venues that might most benefit from this information and support given the care they provide to the uninsured and to those who do not have primary care providers. Urgent care and ERs also have longer hours and may be more accessible in the weekend and evenings, times outside of the normal service delivery times. These care providers are also less likely to be connected to the HIV Provider Network, have their staff fully trained on HIV care and HIV protocol and thus may lack an understanding on how to make referrals and what community support services are offered. The inclusion of non-Ryan White providers is essential to connecting patients to services. Having a concrete working relationship with Ryan White funded staff onsite, including monthly or quarterly meetings and staff-wide trainings, could assist in narrowing these barriers.

Target HIV testing and outreach efforts in the ER. Based on survey data and stakeholder interviews, some of the more vulnerable populations, African American males and gay or bisexual PLWHA, are more likely to go to the ER when they have non-HIV related health problems. Offering rapid HIV testing in ERs could provide a way to identify and engage more people who are HIV positive or re-engage a patient who is out of care. Developing and implementing a collaborative partnership with ER personnel will have a direct impact on streamlining care and have a positive impact on new clients and connecting OOC PLWHA with EIS and other medical care.

Expand opportunities for PLWHA to engage with each other. Consumers expressed feeling isolated from others and anxiety about being identified as HIV positive for coming in person to seek HIV-related services. Having additional ways to reach out and be involved or connected with the HIV community in more informal settings, whether it is in-person support groups or some other medium, could reduce their feeling of isolation. Peer educators could play an important role in assisting those who are newly diagnosed or those not attending appointments. Peer educators would work closely with case managers and medical providers to keep clients engaged.

Focus on transitions. Providers and consumers identified life transitions as key times when PLWHA may drop out of care. With the focus on other immediate needs related to a move or their livelihood, finding a provider or getting a prescription drops from the priority list. Providers and case managers can help patients anticipate this and offer to support them in developing a new network in their new location whether it be within the Norfolk TGA or out of state. This could reduce the number of patients who fall out of care. Establishing relationships and partnerships with other providers within Virginia and surrounding states is another element that could positively impact this transition.

Launch a campaign to address the stigma of HIV. The negative stigma of HIV has wide reaching affects. It affects how PLWHA see themselves, their ability and willingness to be tested or share the news with key support networks, and the community's perception of the disease. While a large task, working to change the stigma of HIV so that the community better understands what it means to be HIV positive can have a positive impact on the continuity of care. This includes promoting success stories increasing awareness that care can be available at free or low cost, and helping consumers and the community appreciate that HIV it is a treatable disease.

Strengthen the support system to address housing and transportation. Housing and transportation needs continue to be major issues confronted by PLWHA and barriers to their accessing care. Working with municipalities and health care providers to develop stronger subsidized housing policies and a better transportation network could support more people in accessing the services they need. The lack of adequate transportation to reach needed appointments and the impact of lack of housing or homelessness were regular themes in the feedback obtained from the survey and stakeholder meetings.

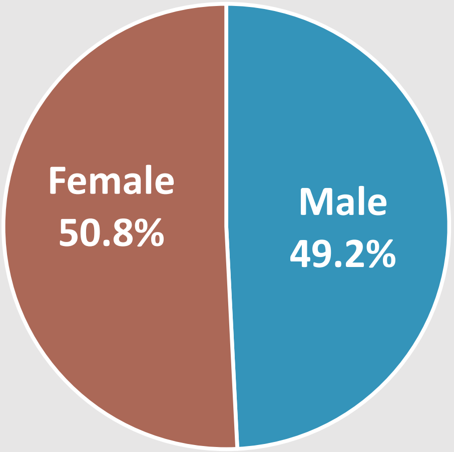
Offer increased training for providers. Providers underscored the need for additional training for all staff and not solely for identified (or interested) staff members. Specific topics suggested included training on the disease process, cultural sensitivity and resources available for PLWHA. Some participants discussed the need to have more focus groups or to bring providers together in a format where they are able to discuss concerns as well as successful and unsuccessful strategies for clients and providers in meeting the needs of clients who are in and out of care.

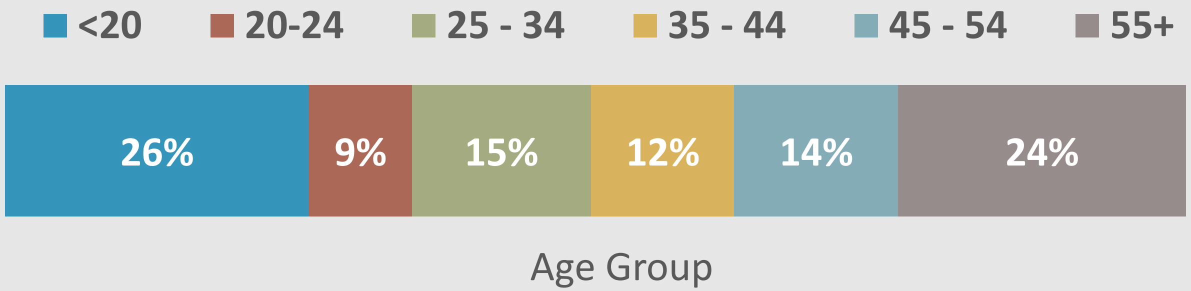
Appendix A – Quantitative Data

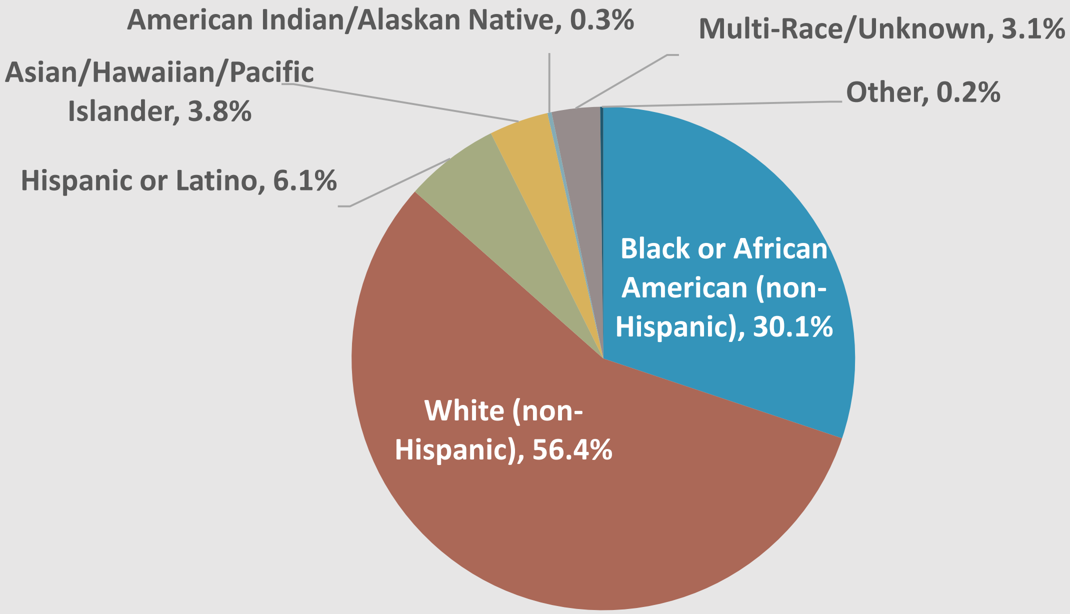
QUANTITATIVE DATA

NORFOLK TGA
GENERAL POPULATION

Norfolk TGA: General Population Demographics (2015)







Total Population of the Norfolk TGA: 1,695,154

Source: US Census Bureau, 2015 American Community Survey (ACS). Retrieved from American Fact Finder

Norfolk TGA: Poverty, Income, Employment Overview (2015)

	Norfolk TGA	Virginia
Unemployment Rate	7.9%[1]	6.5%
Median Household Income	$63,845[2]	$65,015
Mean Household Income	$77,095[2]	$88,955
Percent of Population without Health Insurance	11.2%[3]	11.4%
Average Percent of Families below Poverty Level	10.3%[4]	8.2%
Average Percent of People below Poverty Level	8.3%[4]	11.5%

[1] Unemployment Rate (16 years and over) = Estimated Count of Population in Civilian Labor Force Unemployed/Estimated Count of Civilian Labor Force.

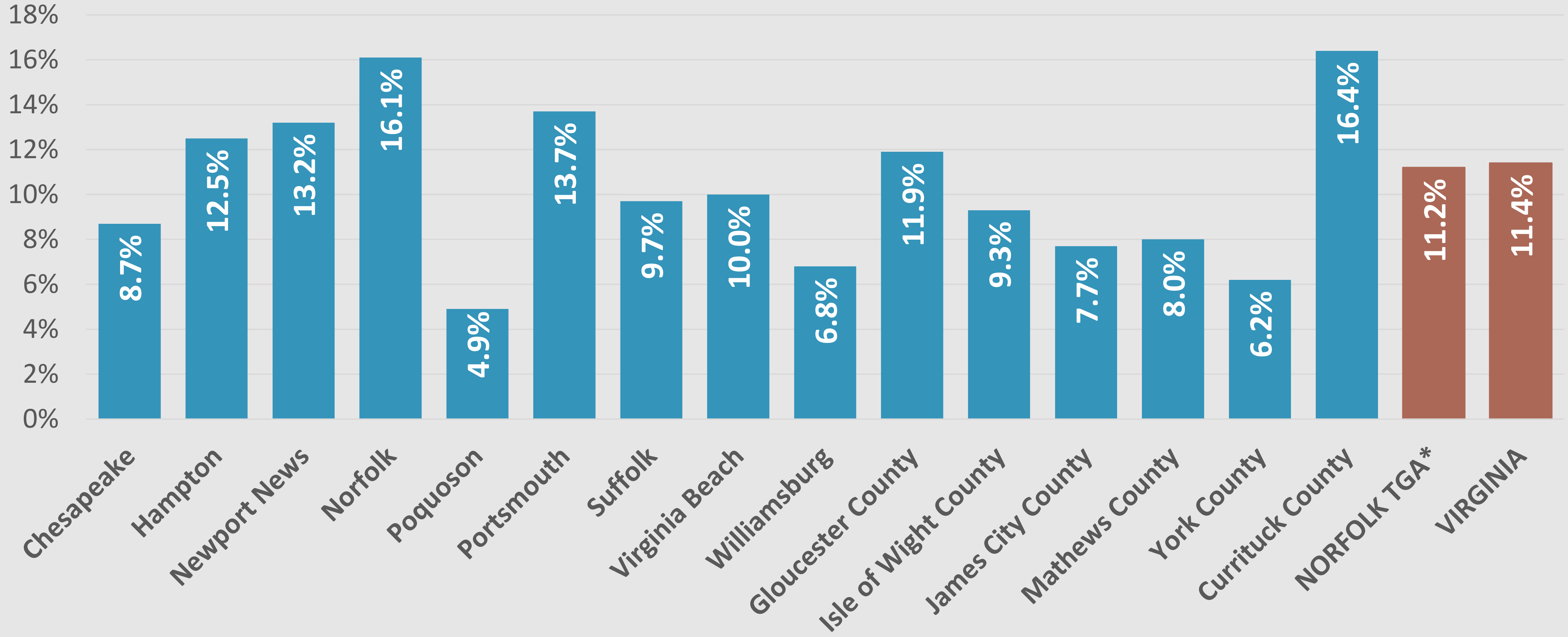
[2] Median and Mean Household Incomes for Norfolk TGA are averages (e.g. the Mean Household Income for the Norfolk TGA is the average of the Mean Household Incomes of all cities/counties within the TGA), and therefore should be interpreted with caution as averaging averages is not always completely accurate.

[3] Percent of Population without Health Insurance = Estimated Count of Civilian Noninstitutionalized Population without Health Insurance/Estimated Count of Civilian Noninstitutionalized Population.

[4] This was calculated by averaging the percentages for each city/county within the Norfolk TGA (as raw estimated counts were not available) and thus should be interpreted with caution.

Source: US Census Bureau, 2015 American Community Survey (ACS).

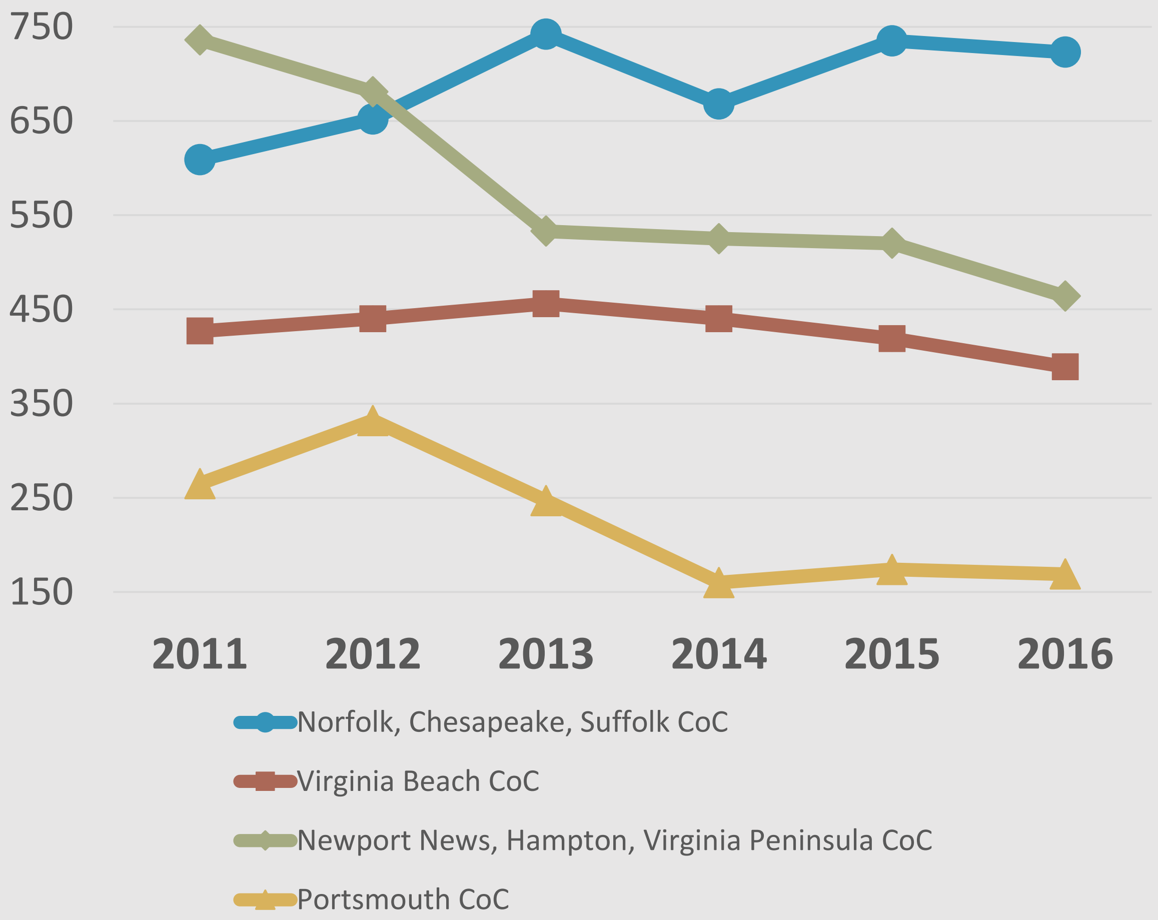
Norfolk TGA: Percent of Population with No Health Insurance Coverage - 2015



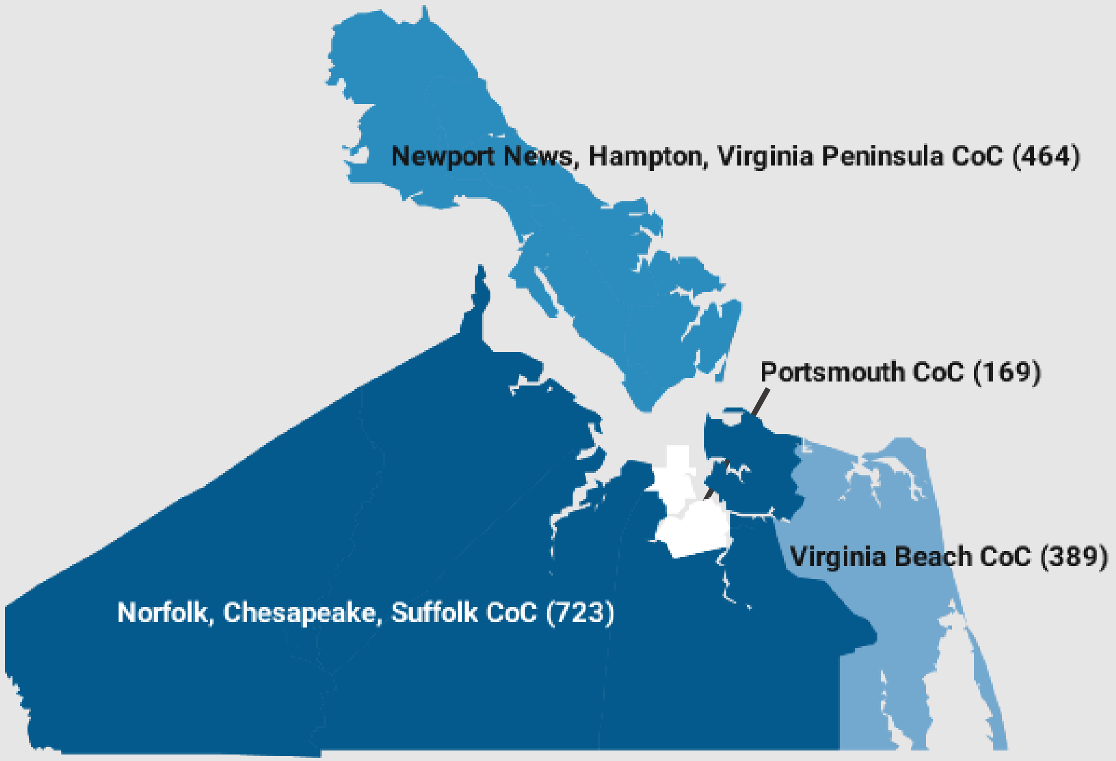
**Percent without Health Insurance for Norfolk TGA Overall was calculated using 2015 ACS data (Estimated Count of Civilian Noninstitutionalized Population without Health Insurance/Estimated Count of Civilian Noninstitutionalized Population).*

Source: US Census Bureau, 2015 American Community Survey (ACS). Retrieved from American Fact Finder

Homeless Point-in-Time (PIT) Estimates by Continua of Care (CoC)



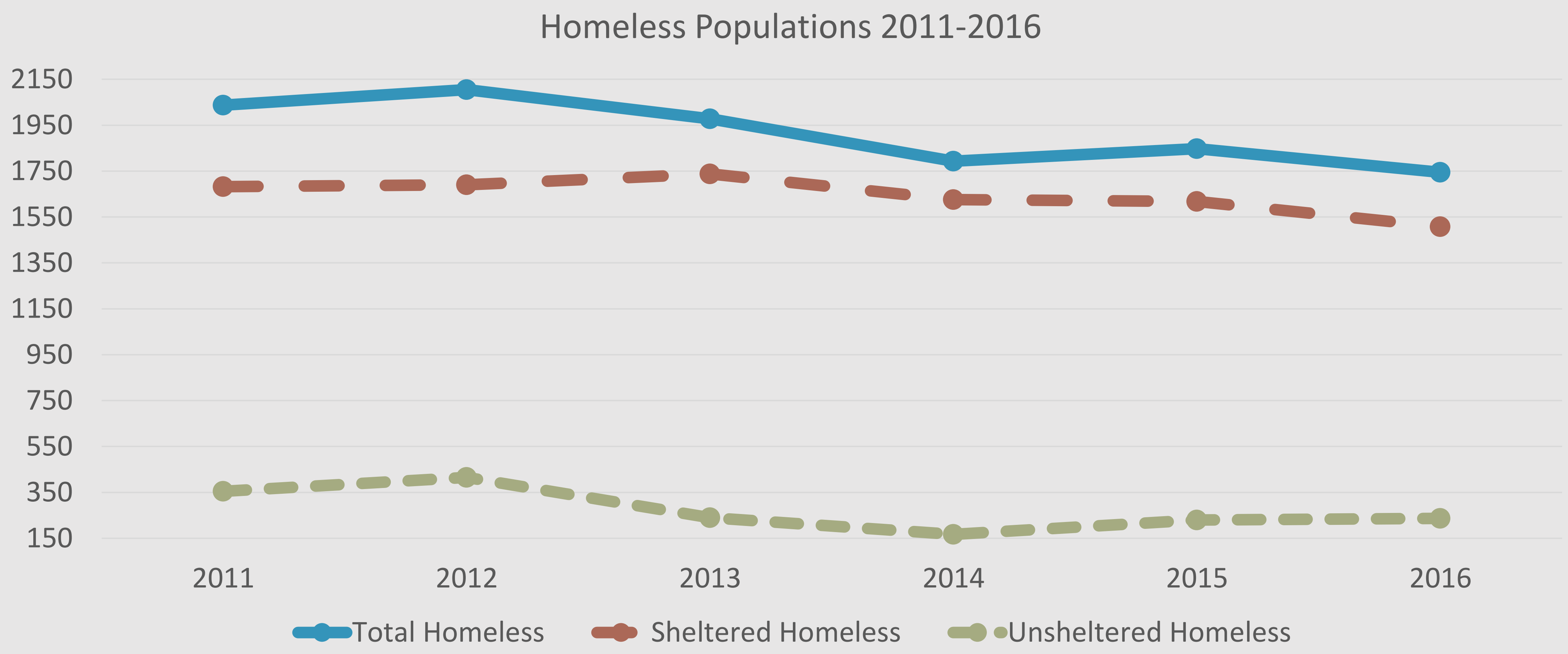
Total Homeless PIT Counts, 2016



Notes: Norfolk, Chesapeake, Suffolk CoC includes City of Chesapeake, City of Franklin, Isle of Wight, City of Norfolk, Southampton, City of Suffolk. Newport News, Hampton, Virginia Peninsula CoC includes City of Hampton, James City, City of Newport News, City of Poquoson, City of Williamsburg, York

Source: US Department of Housing and Urban Development, 2007-2016 PIT Counts by CoC, retrieved February 2017.

Norfolk TGA: Homeless Populations 2011-2016



**Percent without Health Insurance for Norfolk TGA Overall was calculated using 2015 ACS data (Estimated Count of Civilian Noninstitutionalized Population without Health Insurance/Estimated Count of Civilian Noninstitutionalized Population).*

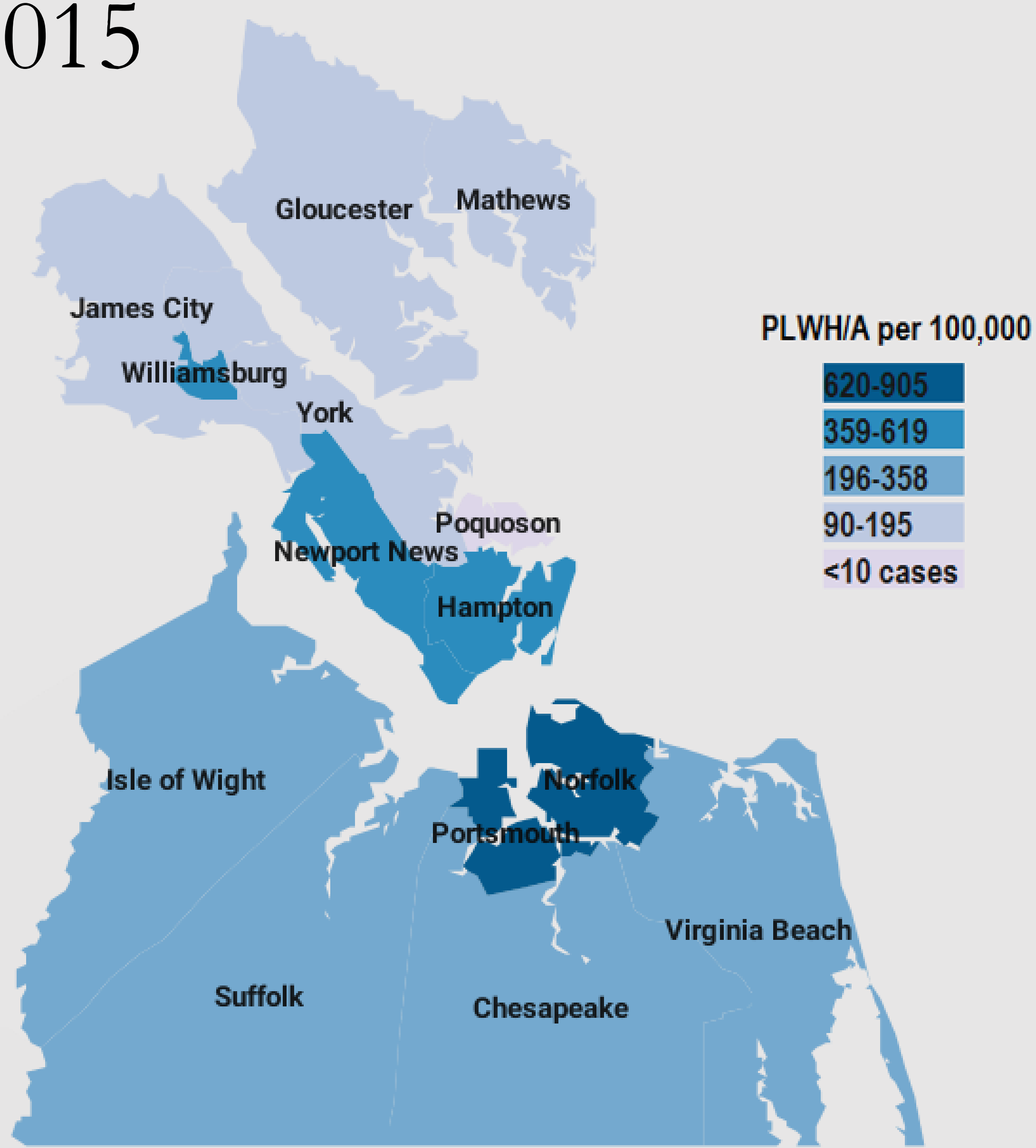
Source: US Census Bureau, 2015 American Community Survey (ACS). Retrieved from American Fact Finder

NORFOLK TGA
HIV PREVALENCE AND DIAGNOSES

PLWHA in Norfolk TGA - 2015

People Living with HIV/AIDS as of December 31, 2015

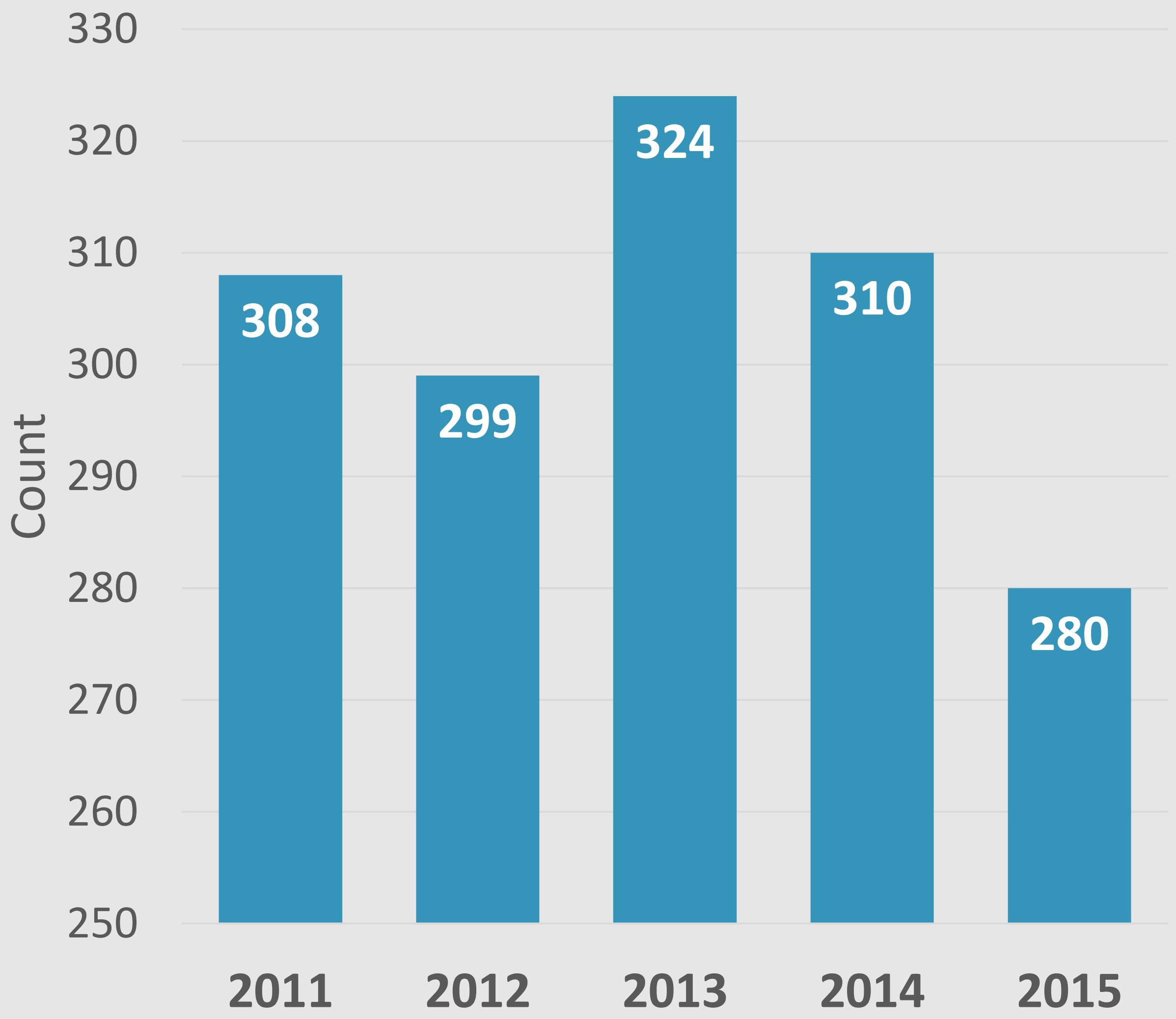
	Count	Rate (per 100,000)
Virginia	24,853	298.5
Eastern Health Region	7697	416.8
Norfolk TGA	7288	429.9*

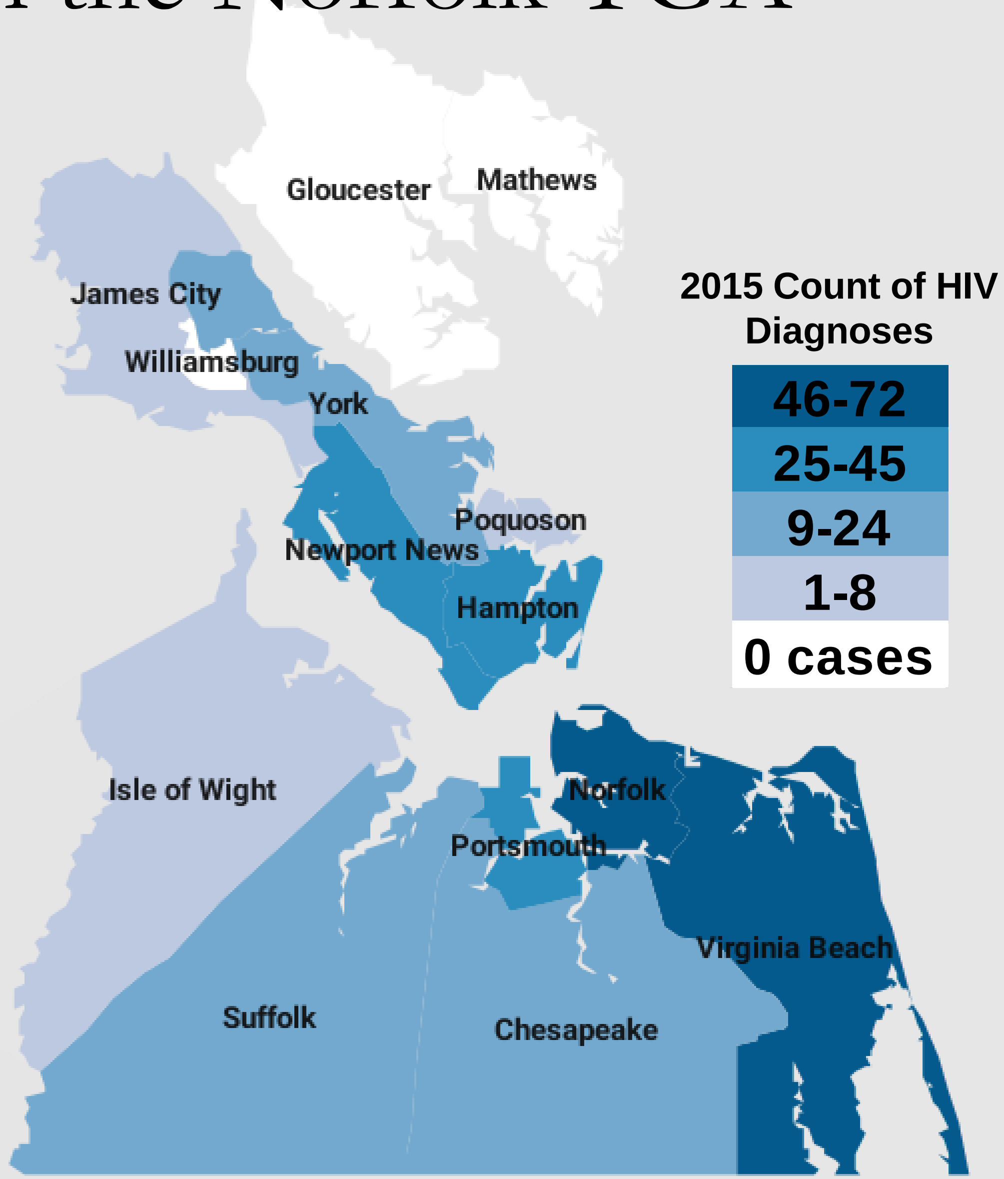


Rate for Norfolk TGA was calculated using US Census Bureau's 2015 ACS data (Count of PLWHA in TGA/Population of TGA based on 2015 ACS)

Sources: Virginia Department of Health HIV Surveillance Annual Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report

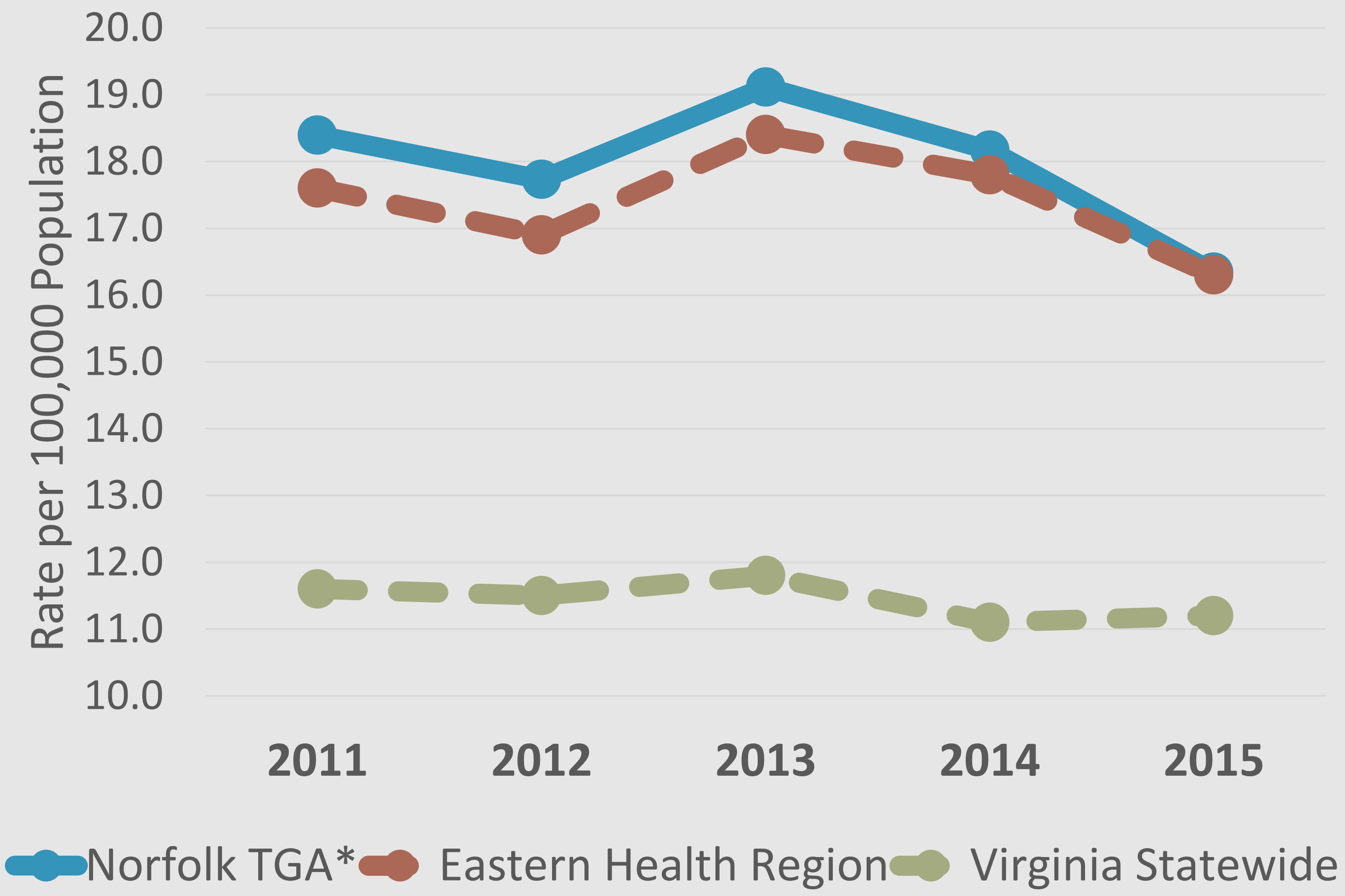
Newly Diagnosed Cases of HIV in the Norfolk TGA

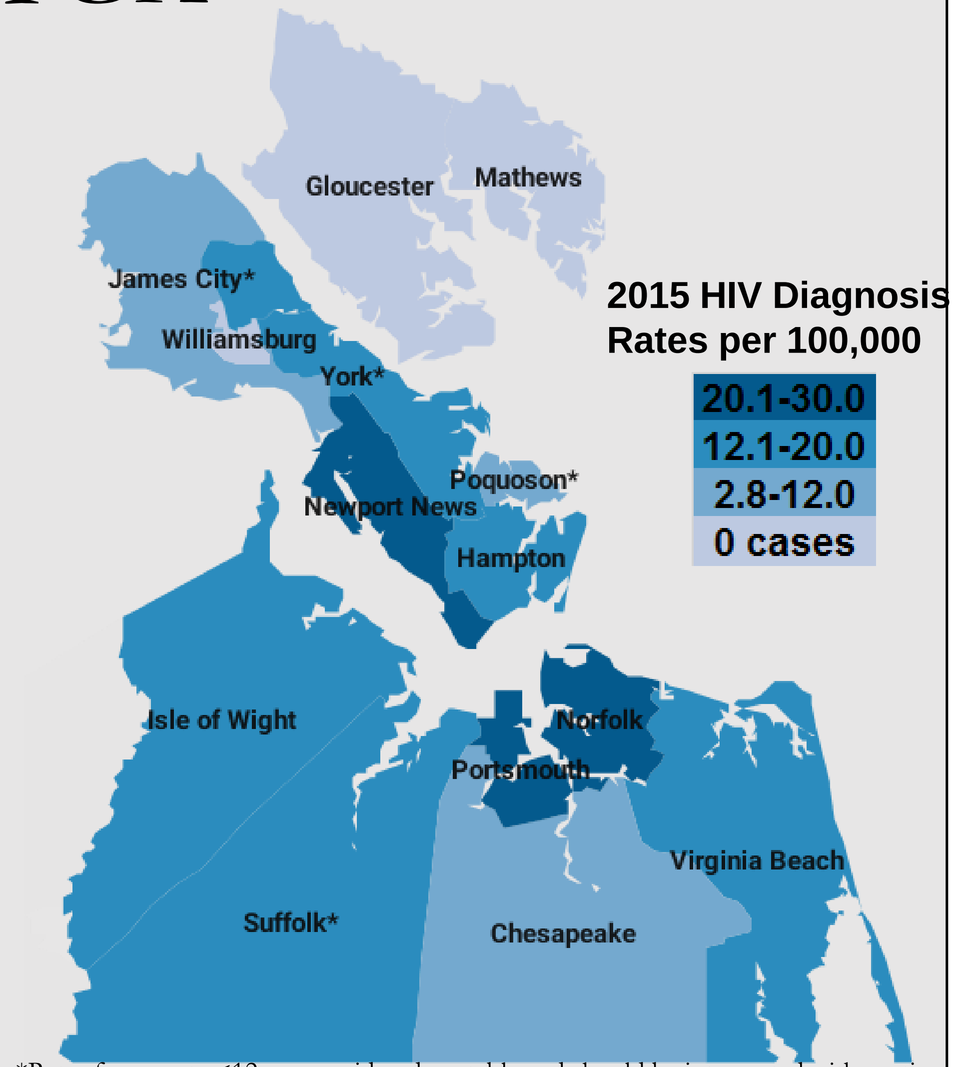




Source: Virginia Department of Health HIV Surveillance Annual Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report

Rate of HIV Diagnoses in Norfolk TGA



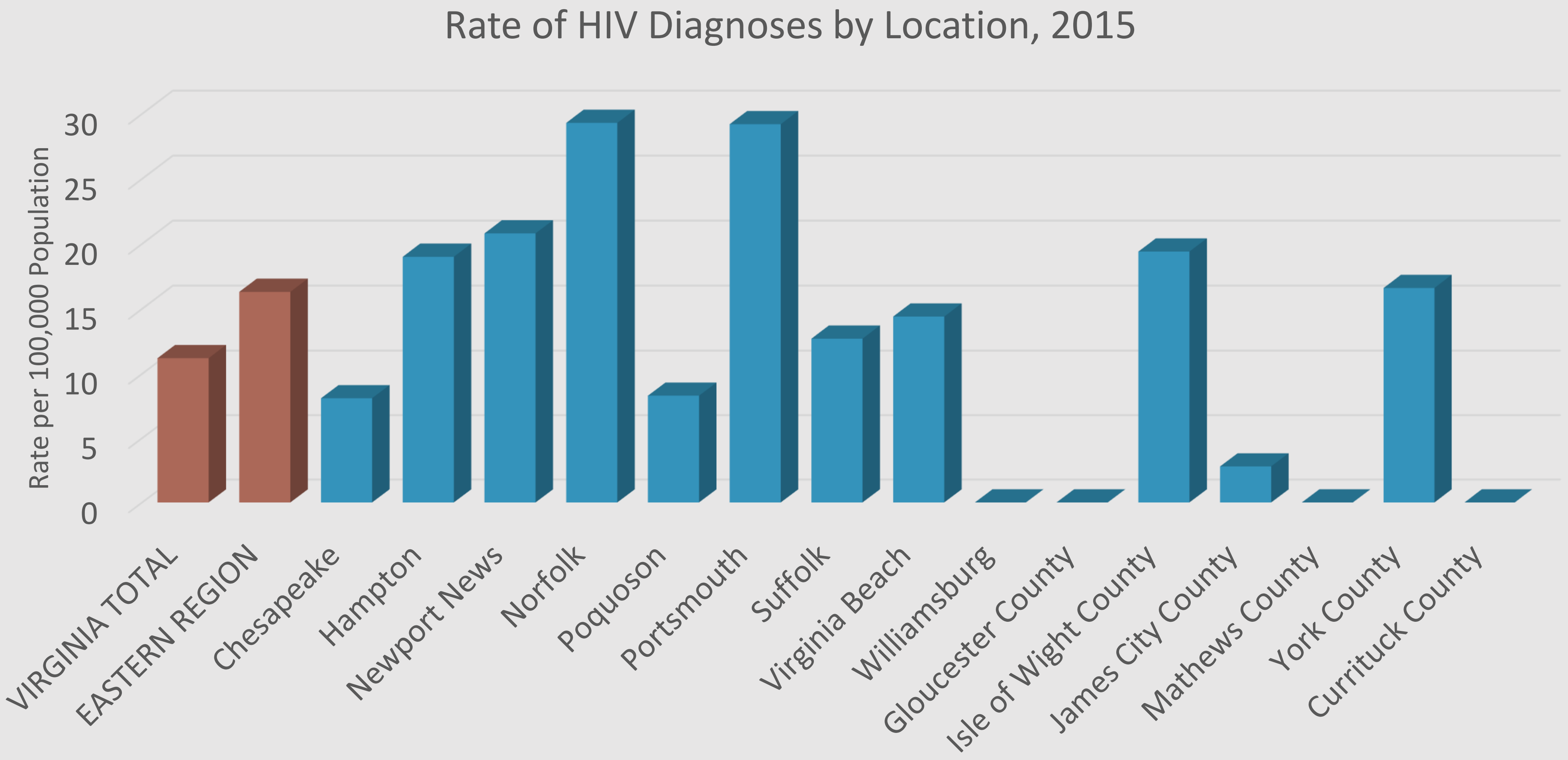


*Rates for counts <12 are considered unstable and should be interpreted with caution.

**Rates for Norfolk TGA were calculated using counts of newly diagnosed cases of HIV (Source: VDH Virginia HIV Surveillance Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report) and population estimates (source: US Census Bureau Annual Population Estimates). (Count of Newly Diagnosed Cases in Norfolk TGA/Norfolk TGA Population Estimate)*100000 = Rate of Diagnoses*

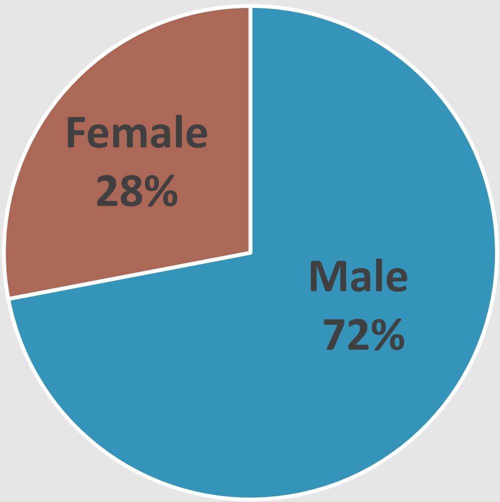
Sources: Virginia Department of Health HIV Surveillance Annual Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report; US Census Bureau's Annual Population Estimates via American Fact Finder

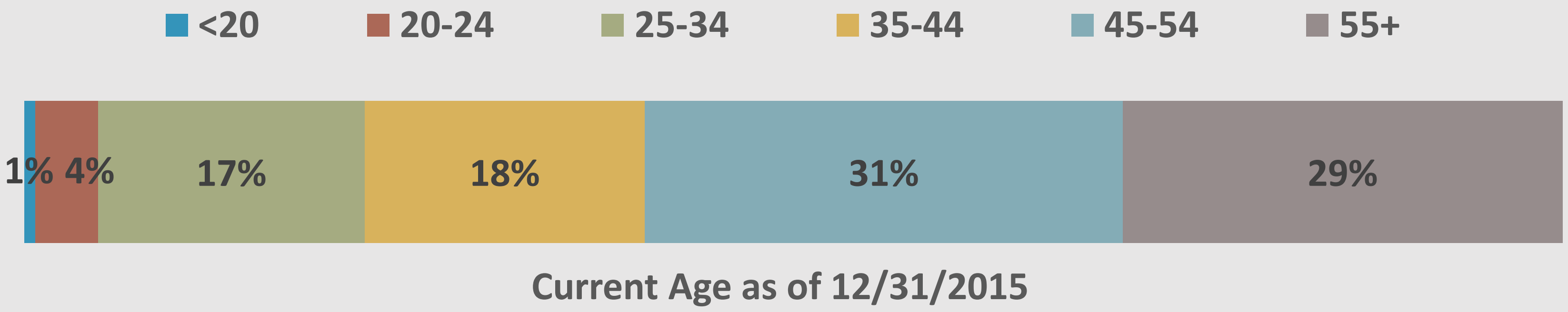
HIV Diagnoses



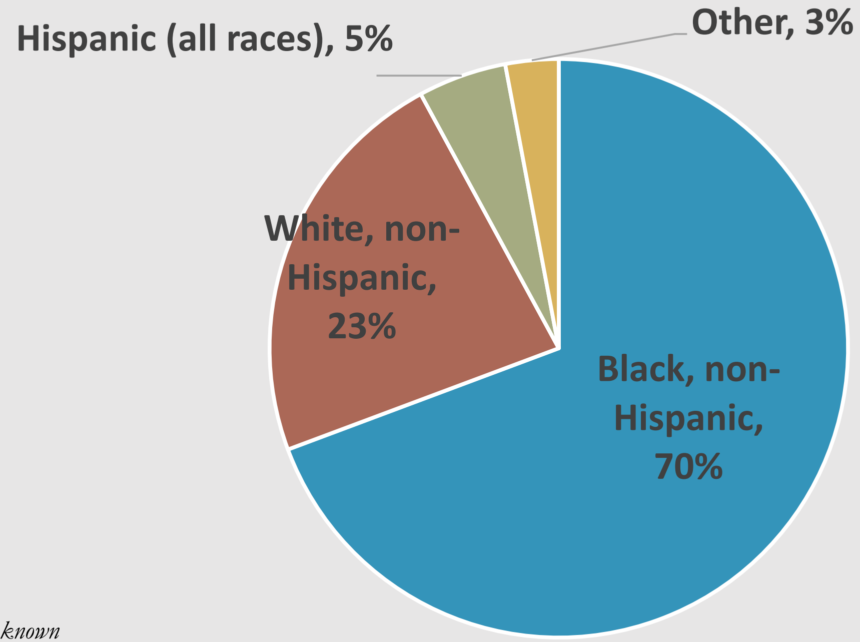
Sources: Virginia Department of Health HIV Surveillance Annual Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report

PLWHA in Eastern Health Region: 2015





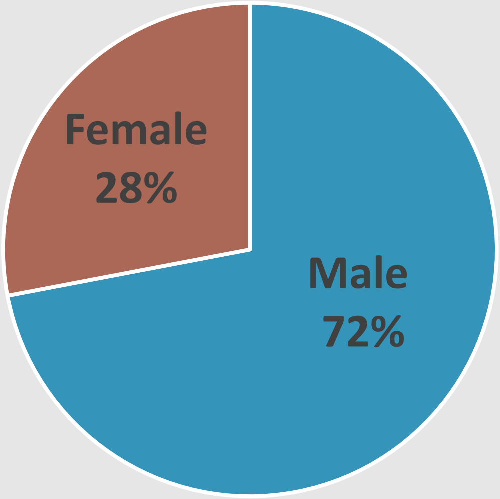
Transmission Category	Percent %
Male-to-male sexual contact (MSM)	44.0%
No risk factor reported or identified	25.0%
Heterosexual contact	19.0%
Injection Drug Use (IDU)	9.0%
MSM & IDU	3.0%
Pediatric	1.0%
Blood recipient	0.0%

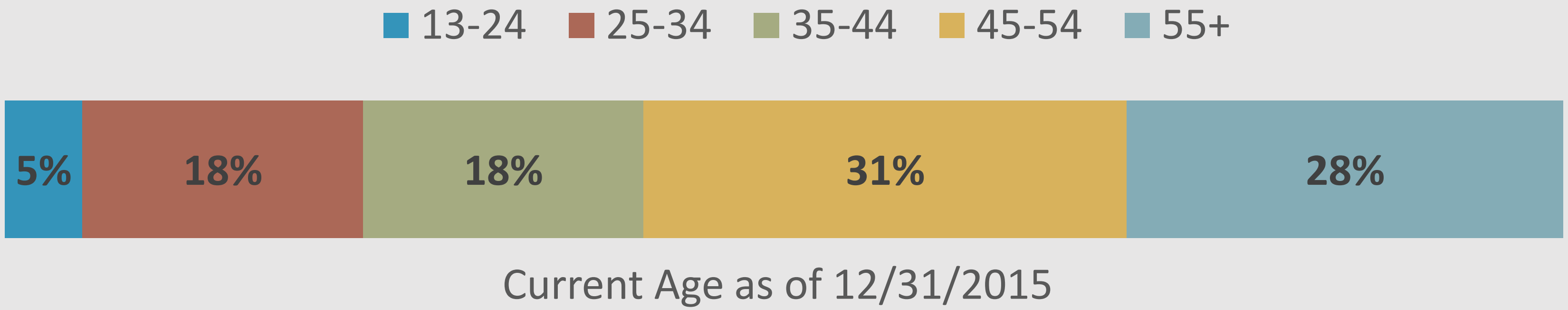


Note: Data as of December 31, 2015. Other race/ethnicity includes Asian/Hawaiian/Pacific Islander, American Indian/Alaska Native, and Multi-race/Unknown

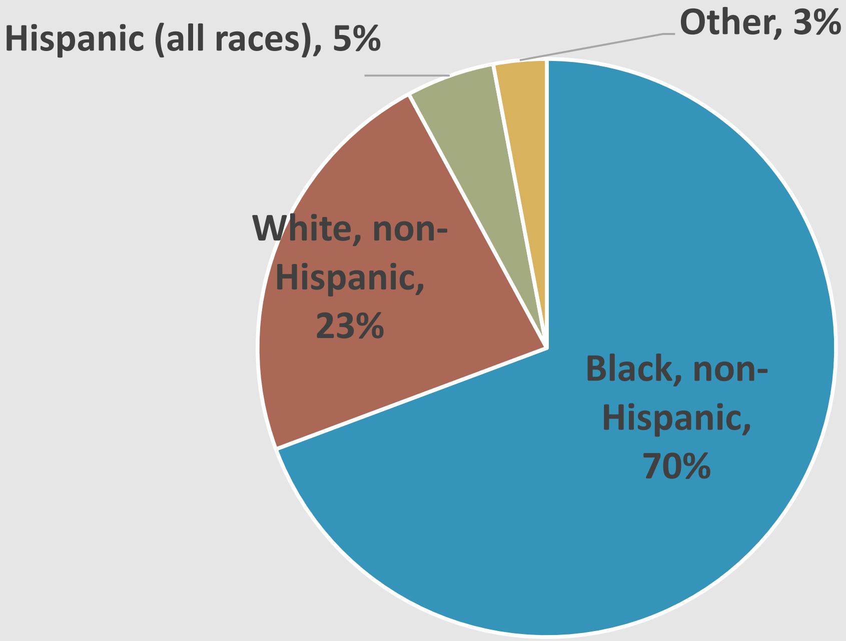
Sources: Virginia Department of Health HIV Surveillance Annual Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report.

PLWHA in Norfolk TGA: 2015





Transmission Category	Percent %
Male-to-male sexual contact (MSM)	44.0%
No risk factor reported or identified	25.0%
Heterosexual contact	18.0%
Injection Drug Use (IDU)	9.0%
MSM & IDU	3.0%
Other (pediatric and blood recipient)	1.0%

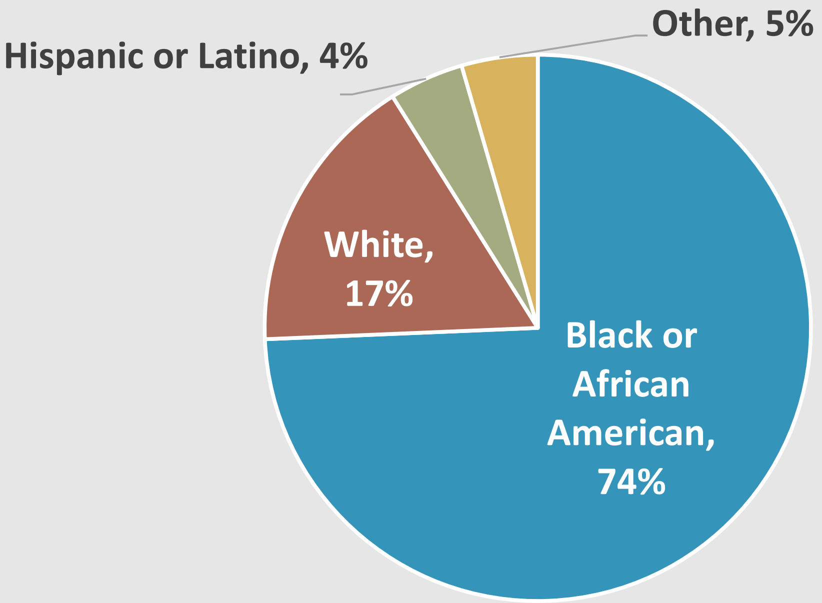


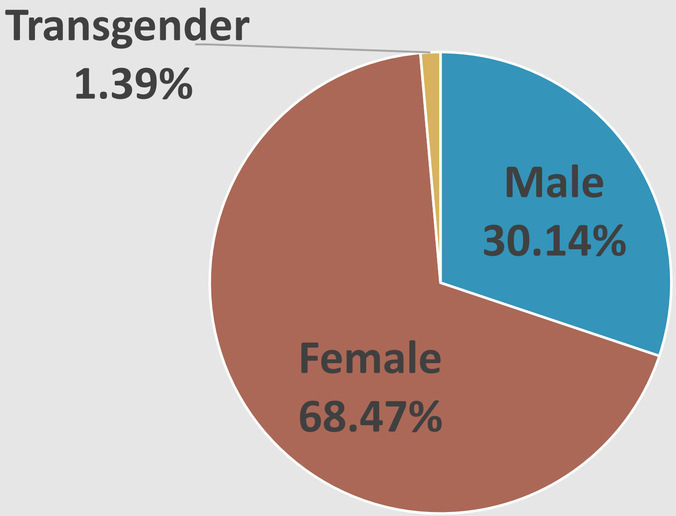
Note: Other race/ethnicity includes American Indian/Alaska Native and Multi-race/Unknown.

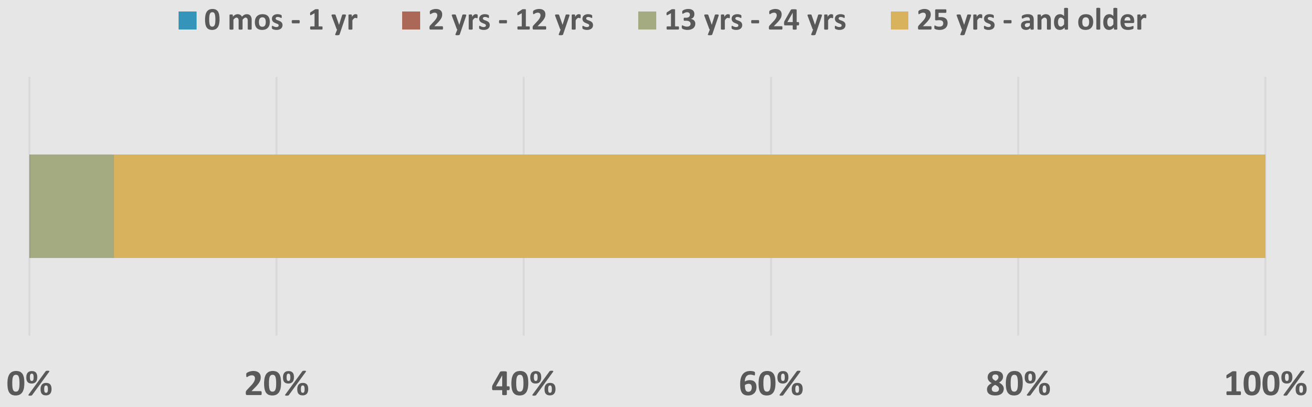
Sources: Virginia Department of Health. Data for 2015 is preliminary until certified by CDC in December 2016 and may be incomplete due to reporting delays. Data current as of December 2015.

PLWHA in Norfolk TGA who received Ryan White services in FY15

Mode of Transmission	Percent %
MSM	45.5%
Heterosexual Contact	43.2%
Injection Drug Use (IDU)	6.6%
Other/Undetermined/Not Specified/Unknown	1.5%
MSM & IDU	1.2%
Perinatal Transmission	1.2%
Transfusion	0.5%
Hemophilia / Coagulation disorder	0.3%



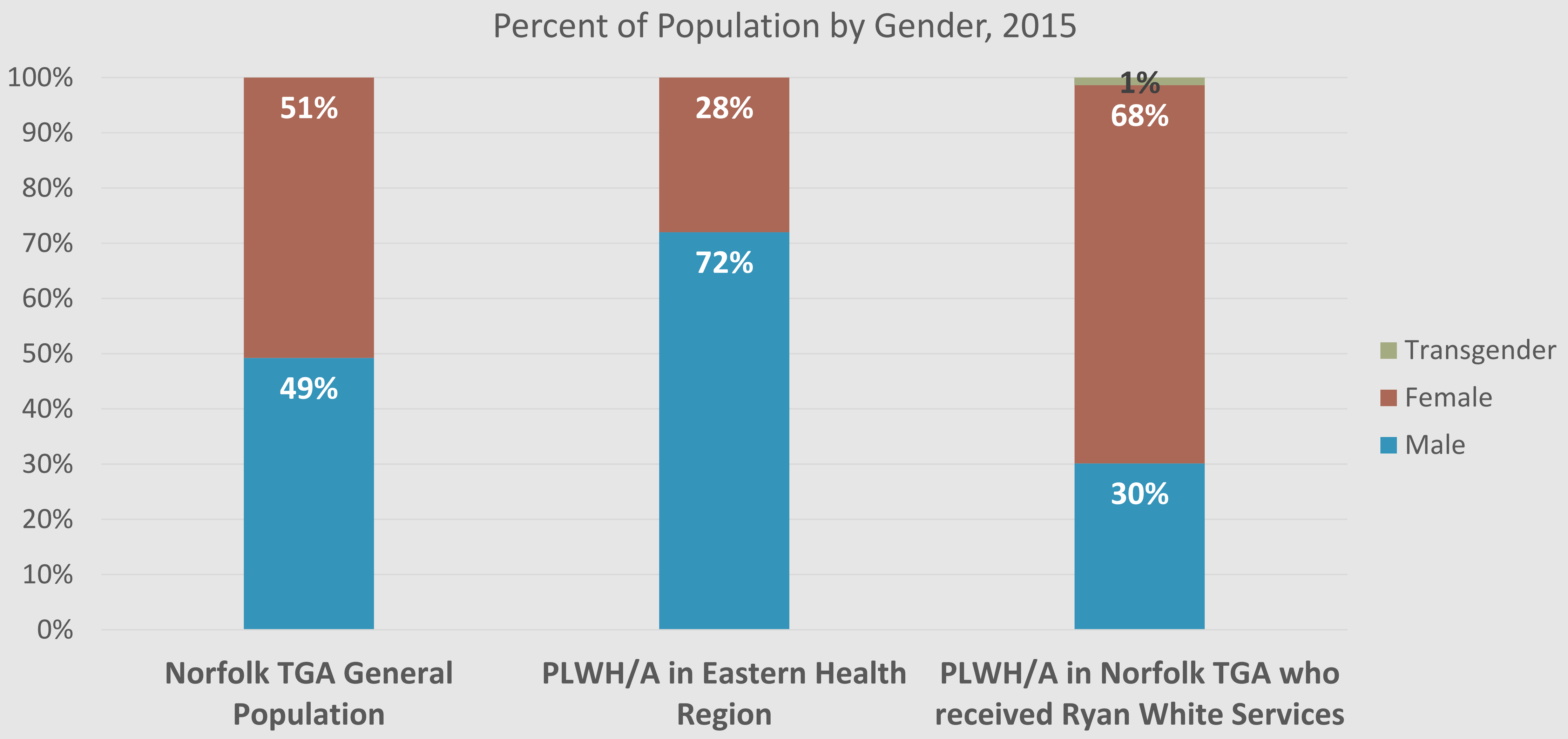




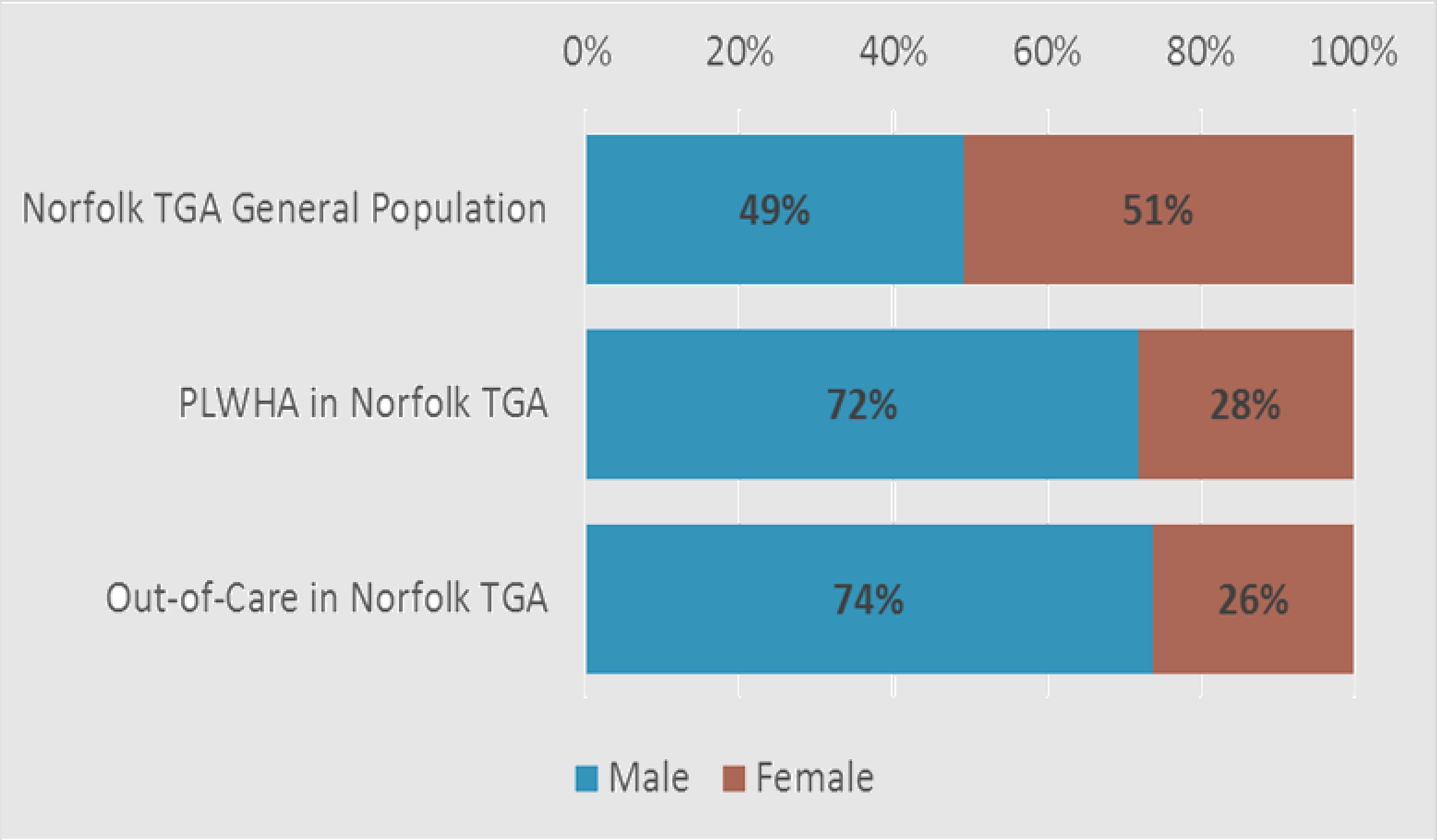
Note: Data is for those who received Ryan White funded services in fiscal year 2015. Other race/ethnicity includes Asian, Pacific Islander, American Indian, Multi-Race, Other, and Unknown/Not Specified.

Source: Data from the Ryan White Part A Grantee Office – Norfolk TGA Clients FY15.

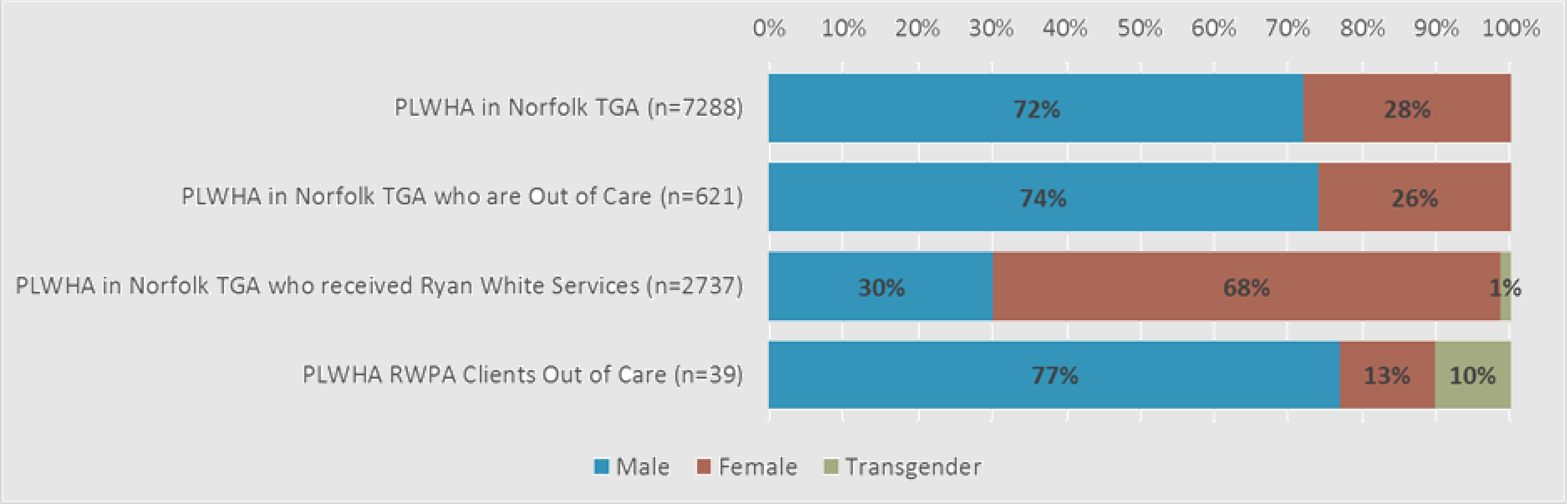
Populations of PLWHA by Gender



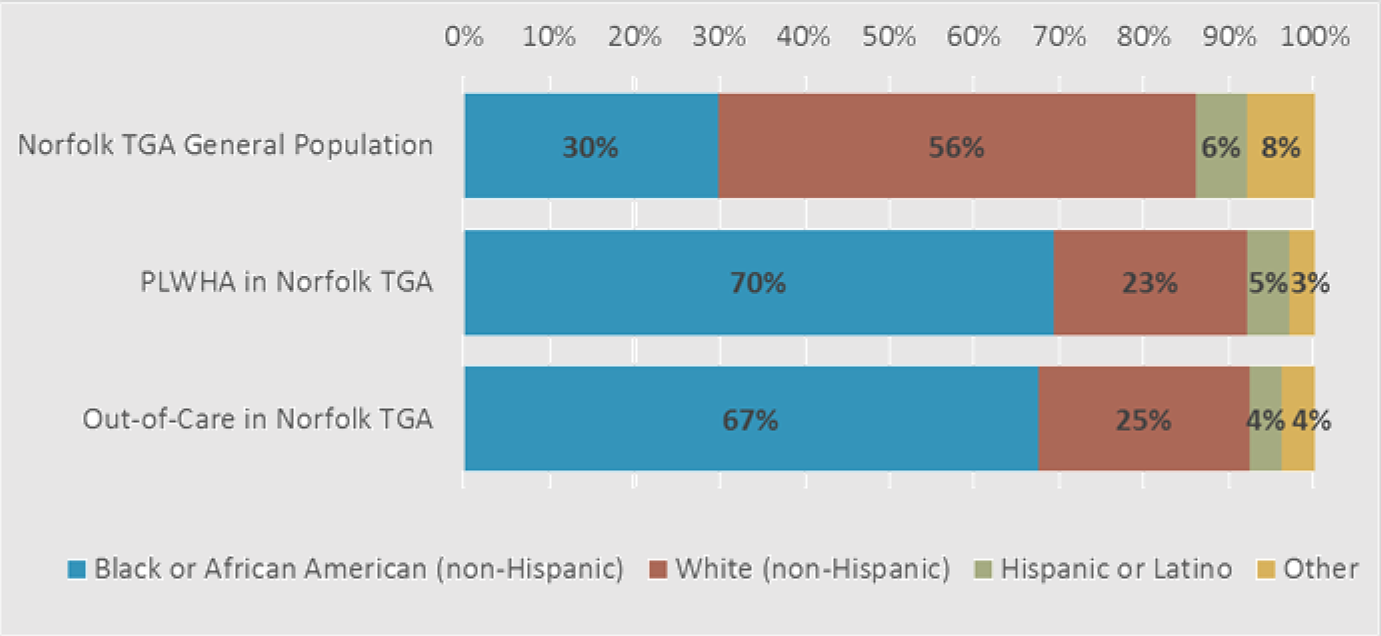
Norfolk TGA Population & Populations of PLWHA by Gender



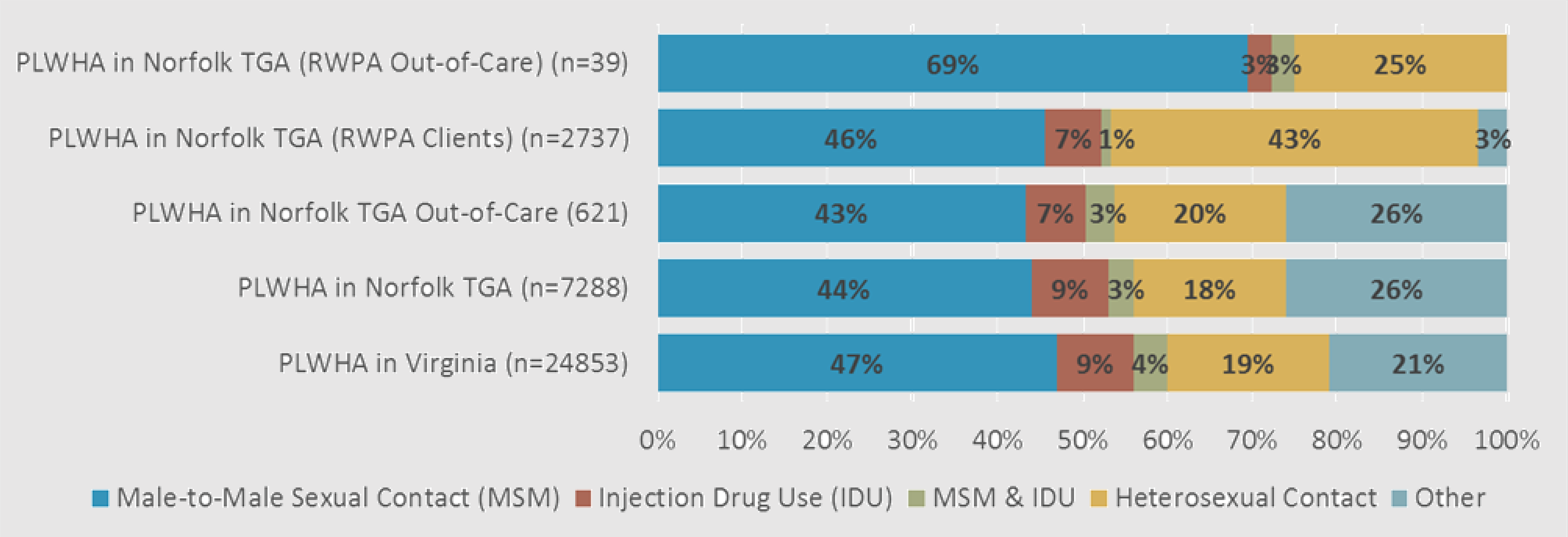
Populations of PLWHA by Gender



Norfolk TGA General Population & Populations of PLWHA by Race/Ethnicity

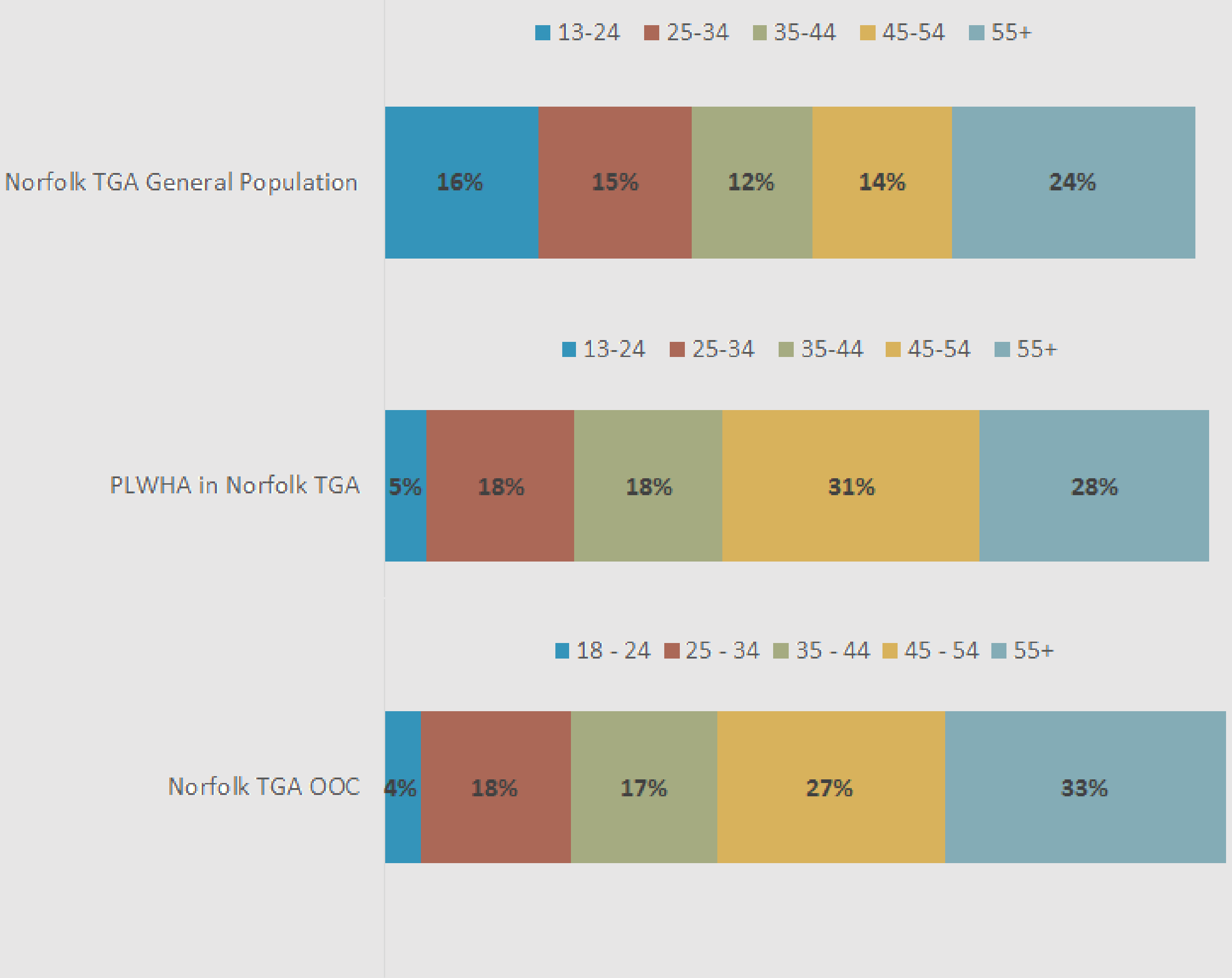


Populations of PLWHA in the Norfolk TGA by HIV Risk Factor/Mode of Transmission



Sources:

Norfolk TGA General Population an Populations of PLWHA in Norfolk TGA by Age Group

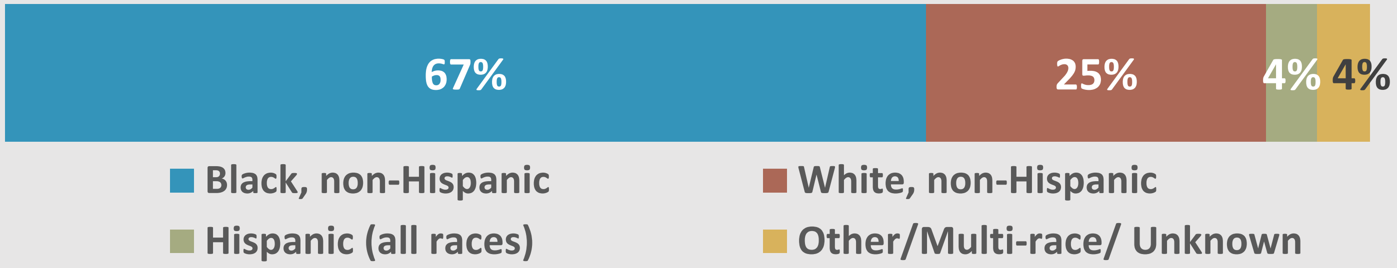


Sources:

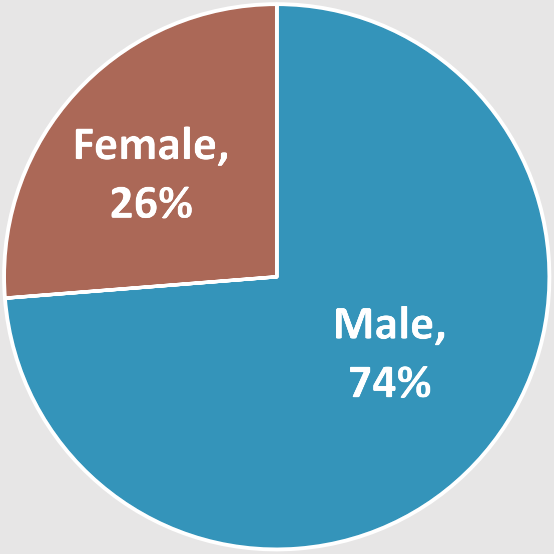
NORFOLK TGA

OUT-OF-CARE

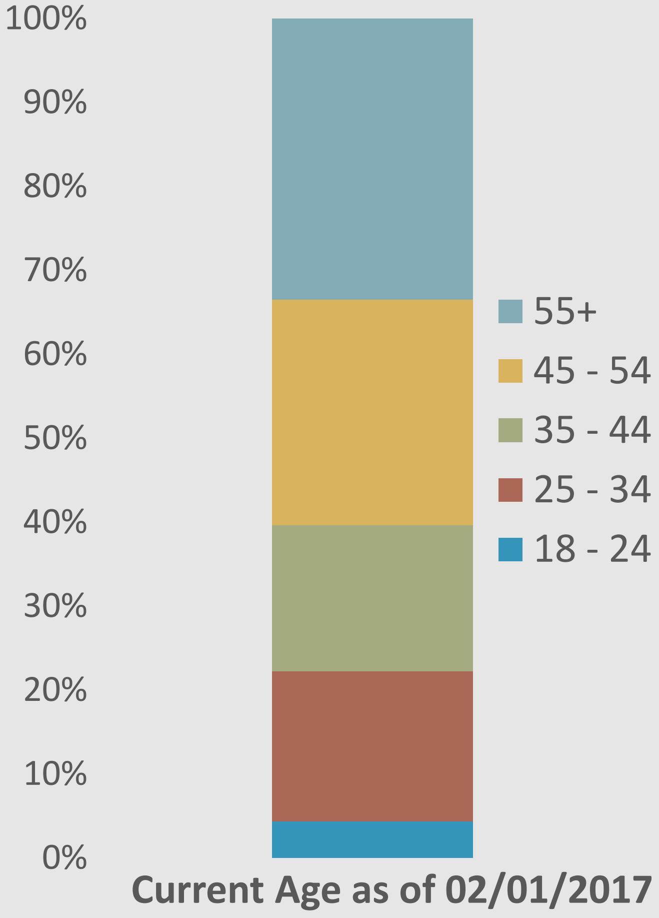
Norfolk TGA: Demographics for Persons Out of Care



Data from the Virginia Department of Health indicate that there are 621 Out-of-Care (OOC) persons in the Norfolk TGA as of February 1, 2017. People are considered out-of-care if they had evidence of care (CD4 count, viral load, HIV medical care visit, or ART prescription) in 2015, but have not had any evidence of care within 1 year of the date the data list was generated (02/01/2017).

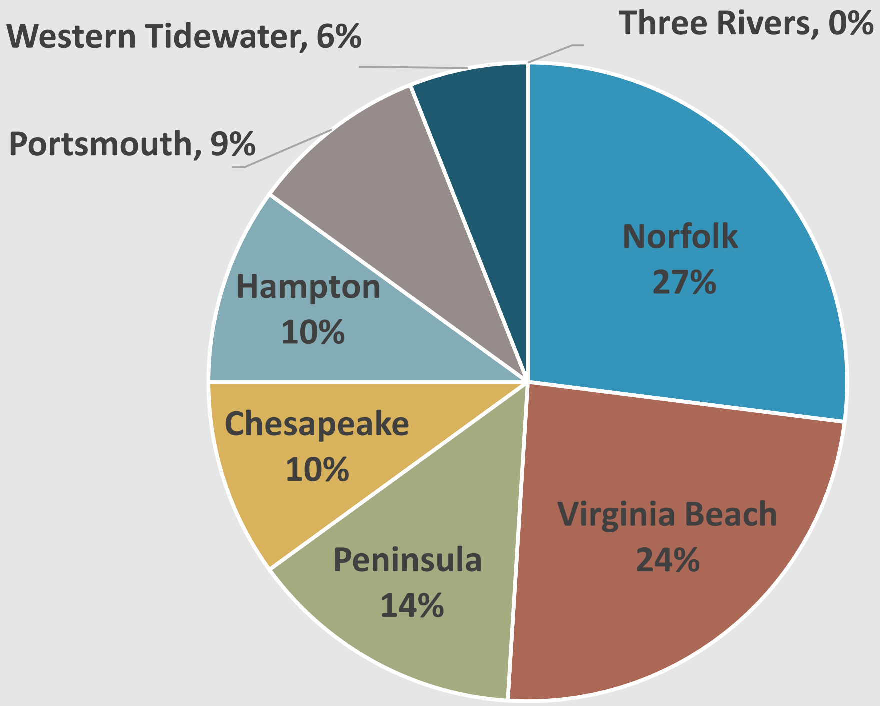


Transmission Risk	Percent %
Male-to-male sexual contact (MSM)	43%
No risk factor reported or identified	25%
Heterosexual contact	20%
Injection Drug Use (IDU)	7%
MSM & IDU	3%
Pediatric	1%



Source: Data reported to the Virginia Department of Health as of 2/1/2017

Out-of-Care Persons in the Norfolk TGA as of by Health District of Last Known Residence

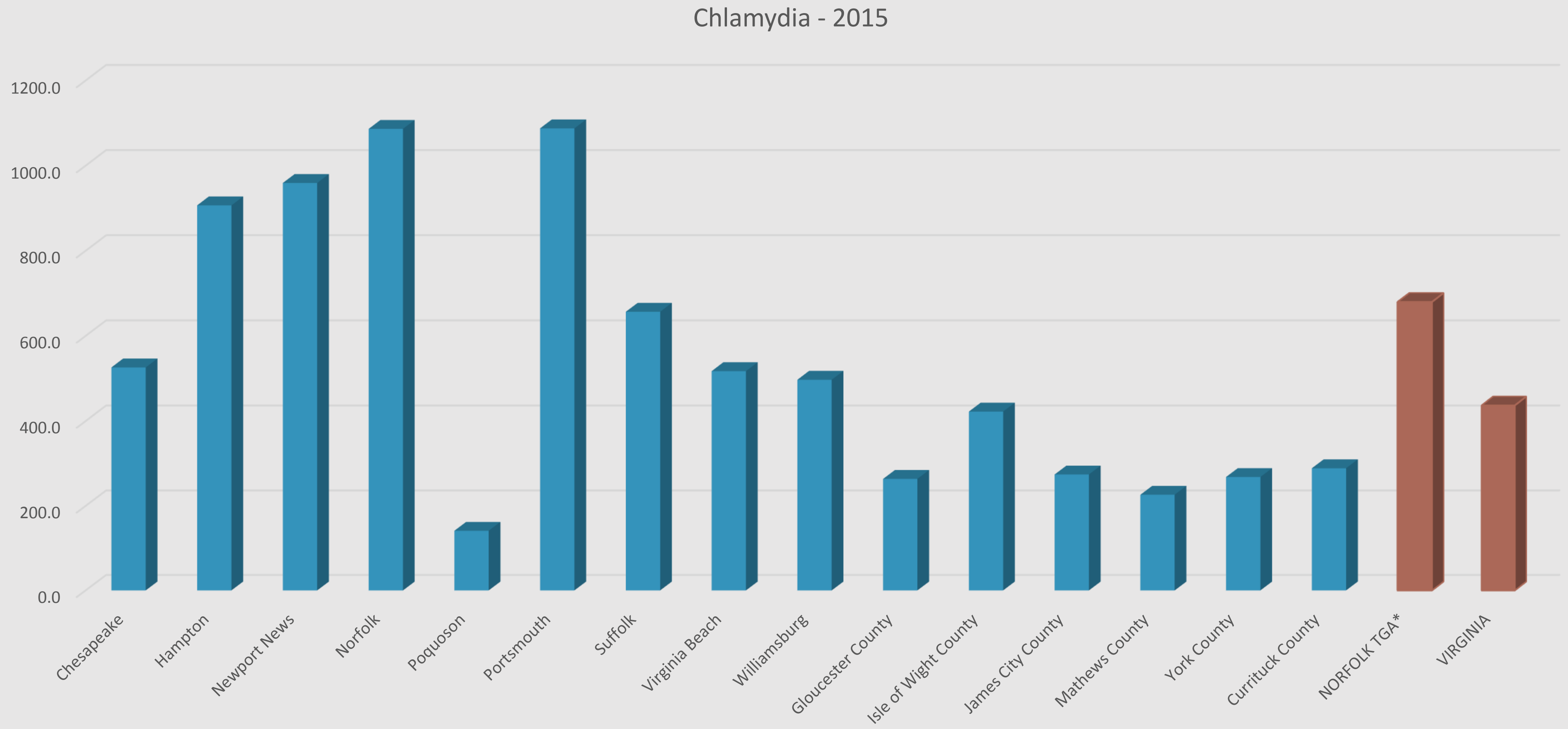


Source: Data reported to the Virginia Department of Health as of 2/1/2017

NORFOLK TGA

SEXUAL HEALTH

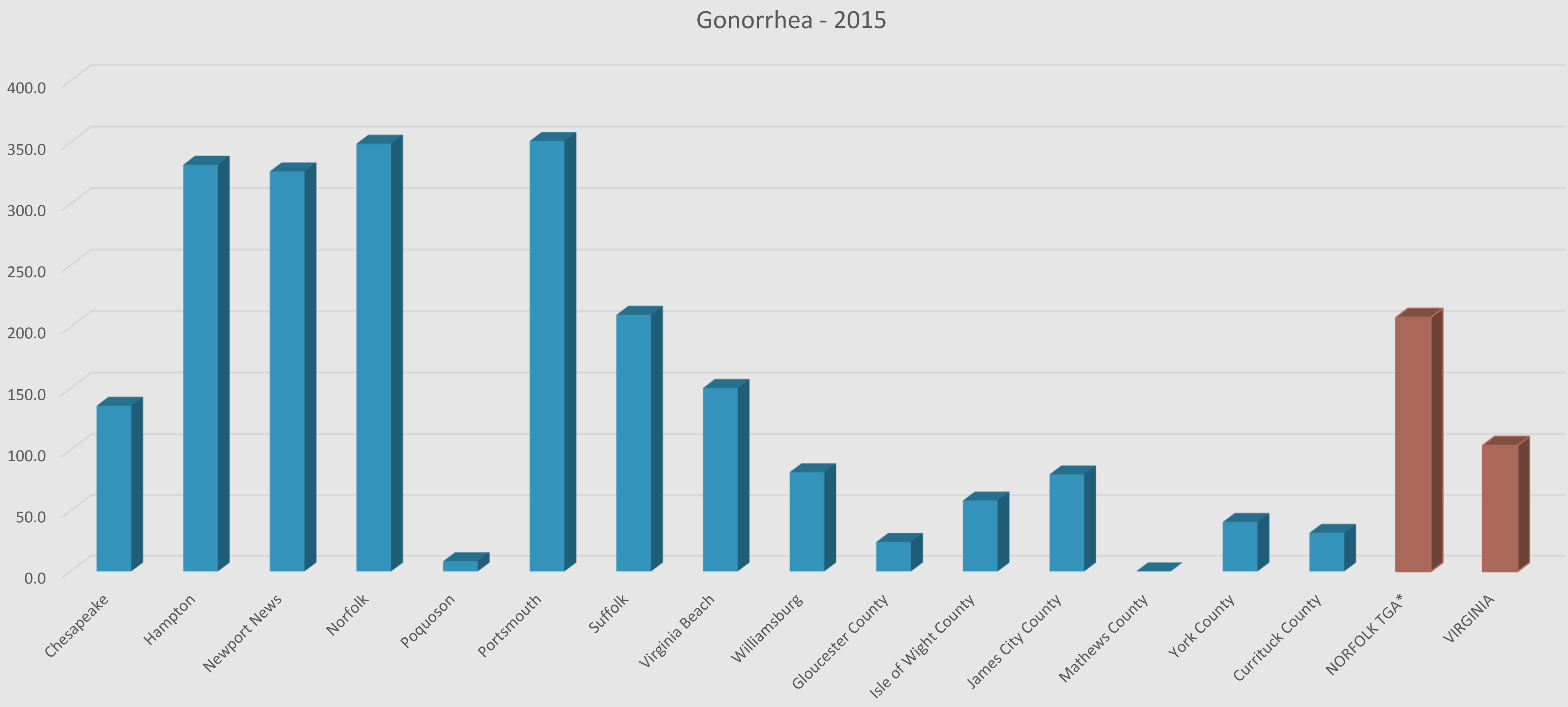
Chlamydia, Gonorrhea, Syphilis, etc.



**Rate for Norfolk TGA was calculated using counts of Chlamydia from the Virginia Department of Health Annual HIV Surveillance Report (2015), and Annual Population Estimates from the US Census Bureau.*

Sources: Virginia Department of Health STD Surveillance Annual Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report; US Census Bureau's Annual Population Estimates via American Fact Finder

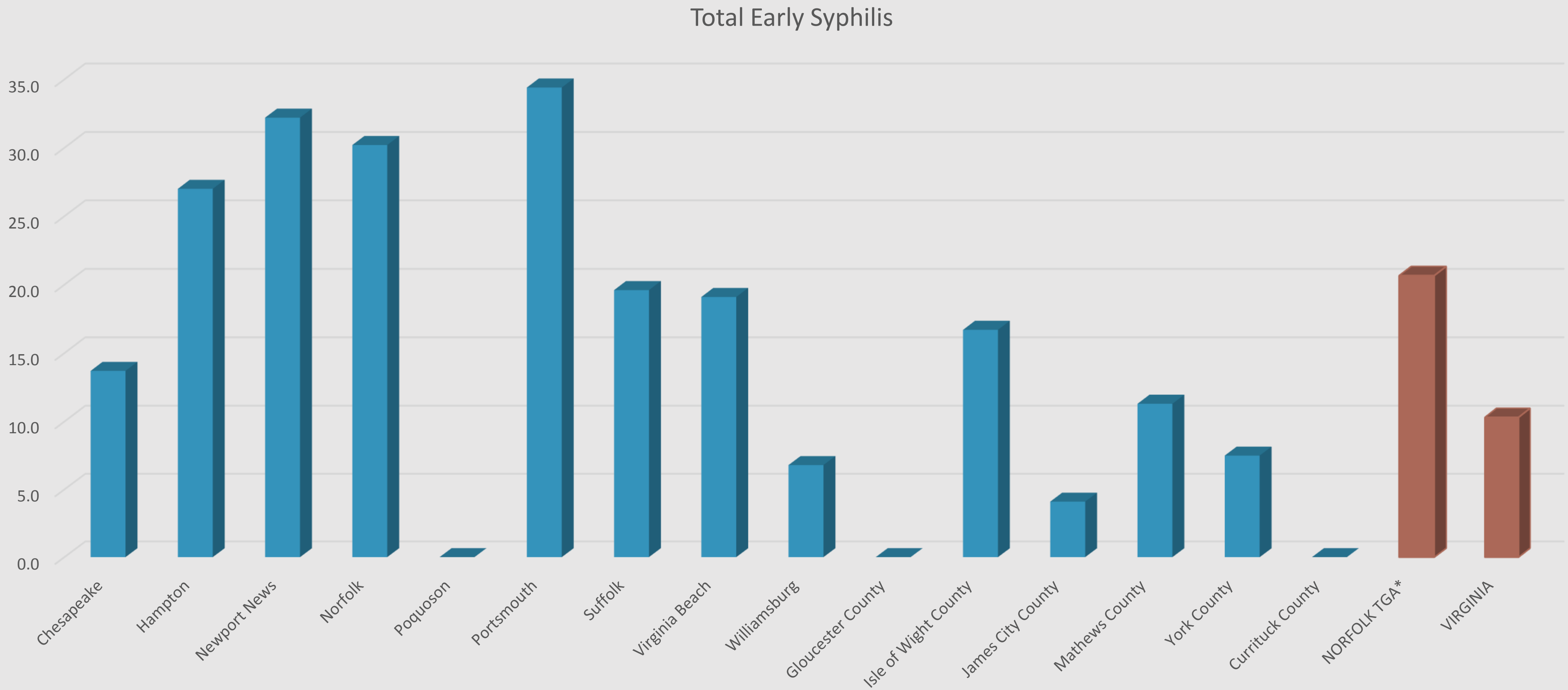
Chlamydia, Gonorrhea, Syphilis, etc.



**Rate for Norfolk TGA was calculated using counts of Gonorrhea from the Virginia Department of Health Annual HIV Surveillance Report (2015)/NC, and Annual Population Estimates from the US Census Bureau.*

Sources: Virginia Department of Health STD Surveillance Annual Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report; US Census Bureau's Annual Population Estimates via American Fact Finder

Chlamydia, Gonorrhea, Syphilis, etc.

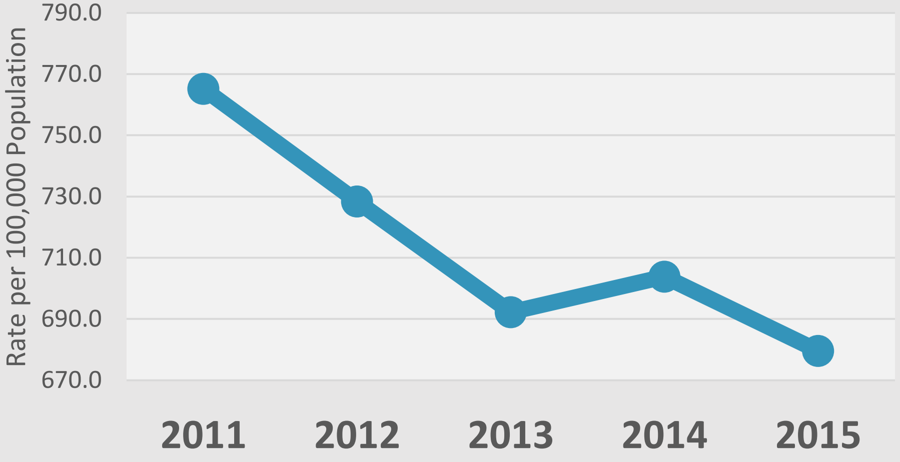


**Rate for Norfolk TGA was calculated using counts of Total Early Syphilis from the Virginia Department of Health Annual HIV Surveillance Report (2015)/NC, and Annual Population Estimates from the US Census Bureau.*

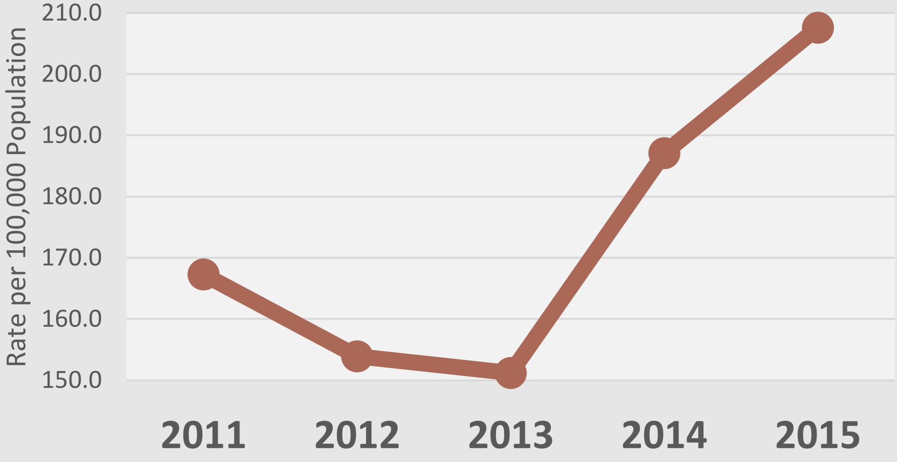
Sources: Virginia Department of Health STD Surveillance Annual Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report; US Census Bureau's Annual Population Estimates via American Fact Finder

Sexual Health Trends in the Norfolk TGA: 2011-2015

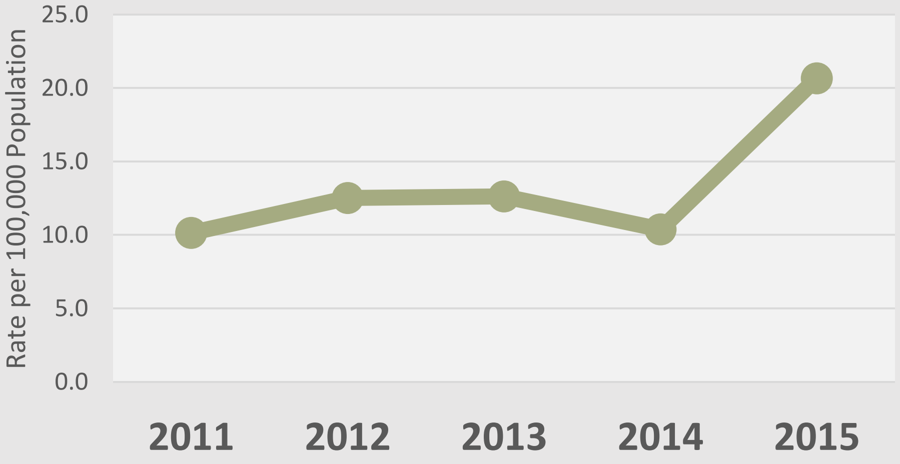
Chlamydia



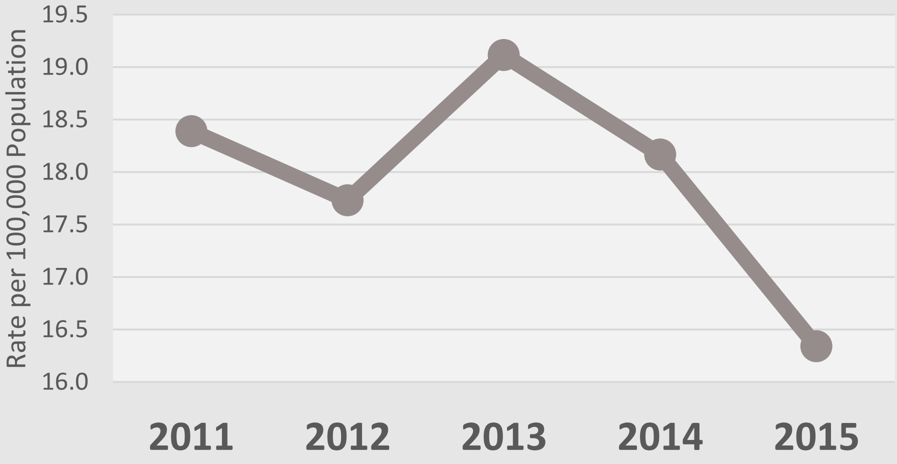
Gonorrhea



Total Early Syphilis



HIV



**Rates for Norfolk TGA were calculated using counts of STIs from the Virginia Department of Health and NC Division of Public Health, and Annual Population Estimates from the US Census Bureau. (Count of STIs for all cities and counties in TGA/Population of TGA*100000)*

Sources: Virginia Department of Health STD Surveillance Annual Reports; North Carolina Public Health HIV/STD Quarterly Surveillance Report; US Census Bureau's Annual Population Estimates via American Fact Finder