



# Norfolk TGA

In Care, Newly Diagnosed & Out of Care Needs Assessment

Report of Findings | June 2011

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## EXECUTIVE SUMMARY

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The Norfolk Transitional Grant Area (TGA) has a population of 1,801,073 (U.S. Census 2009). The TGA includes the Virginia cities of Chesapeake, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach and Williamsburg; the Virginia counties of Gloucester, Isle of Wight, James City, Mathews and York; and Currituck County in North Carolina. The TGA's racial composition consists of 60% White, 31% Black/African-American, 3% Hispanic, 3% Asian and 3% other (includes Native, Pacific Islander and Multi-Races). The TGA, bordered by the Chesapeake Bay and the Atlantic Ocean, has a large military presence, is home to the largest naval station in the world, is one of the top ten seaports in the U.S. and is a major tourist destination. The TGA's transient population contributes to the local epidemic (owing to the military, ports and tourism industry).

The inherent diversity of the Norfolk TGA poses substantial challenges for planners as they strive to create a system that provides accessible and high quality primary medical care and supportive services for all PLWHA in the Planning Area. The Norfolk TGA's continuum of care has evolved into a robust and responsive medical model of HIV care and services delivery. Primary medical care is supported by a strong HIV medication infrastructure and by a wide range of medically and socially supportive services, including mental health and substance abuse treatment services, medical and social services case management, emergency financial assistance, oral health care, transportation, outreach/case finding and other services essential to facilitating optimal access to and retention in HIV primary medical care.

All of these services exist in the context of the five key goals of the U.S. Health Resources and Services Administration (HRSA): 1) improve access to care, 2) eliminate health disparities, 3) improve the quality of care, 4) assure cost effectiveness, and 5) improve health outcomes.

In order to comprehensively inform the 2012 services planning and resource allocation process, the Greater Hampton Roads HIV Health Services Planning Council commissioned three needs assessment studies in 2011:

- 1) An 'In Care' PLWHA survey study to ascertain the emerging service needs, uses, barriers and gaps for the 2011 population of PLWH/A in Ryan White funded services;
- 2) A 'Newly Diagnosed/New to Care' PLWH/A study of those individuals who had recently been diagnosed and entered care and services within the past year; and
- 3) An 'Out of Care' survey study of those PLWH/A who have been out of care for one year or longer or who have never entered care and services to ascertain the emerging service needs, gaps and barriers for the 2011 population of PLWH/A with unmet need.

## RELEVANCE OF PLWH/A NEEDS ASSESSMENT STUDY

There are over 1.8 million people residing in the fourteen Virginia locations and one North Carolina location that comprise the Norfolk TGA. Of those, 31% are non-White/African-American. Approximately one quarter, or 450,000 residents live at or below 200% of the federal poverty level. The primary industries in the Norfolk TGA include military, technology, government and the services sector. As of December 31, 2009, there were 6,548 PLWHA in the Norfolk TGA. Of those, 2,832 (43%) were PLWA and 3,716 were PLWH (non-AIDS) (57%). AIDS prevalence in the TGA is notable in that males represent 73% of living AIDS cases; Blacks represent 67%; MSM represent 42% and the City of Norfolk has the highest AIDS prevalence of the 15 localities. By age group, 80% of the PLWA are 20-44 year olds, and 4% are in the 13-19 age range.

During the reporting period of January 1, 2008 to December 31, 2009, there were 205 new AIDS cases reported and 637 new HIV cases, representing an 11% increase in new HIV cases. Males represent 67% of AIDS incidence in 2008-2009 (reduced from 72% of the AIDS incidence in 2007-2008), evidencing recent increases in advancing disease among women, and especially women of color in the TGA. Blacks had almost 4 times higher the number of newly reported AIDS cases than whites (N=151 versus 39). MSM represented 29% of new AIDS cases while Heterosexuals represented 17% of new AIDS cases. Males represent 76% of new HIV cases, Blacks were diagnosed with HIV at a 76% rate, and MSM had the highest incidence of new HIV cases at 43% (an increase of 9% over the last reporting period), followed by Heterosexuals at 9%.

## DISPROPORTIONATE IMPACT OF HIV/AIDS ON CERTAIN POPULATIONS

The specific impact or disparity for all groups in the Norfolk TGA is noted below. Bold font that is shaded in Columns D indicates the extent of the disparity for 'new' HIV and AIDS cases. The same display denotes the scale of disparity for PLWHA in Column E.

DISPROPORTIONATE IMPACT OF HIV/AIDS IN NORFOLK TGA, 2009...CHART CONTINUES ON PG. 5

SERVICE CATEGORY DESCRIPTION	A	B	C	D	E
GROUP IN NORFOLK, VA TGA	GENERAL POPULATION	NEW CASES	PLWHA	NEW DISPARITY	EXISTING DISPARITY

### RACE/ETHNIC GROUP

African American	31%	77%	71%	46%	40%
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SERVICE CATEGORY DESCRIPTION	A	B	C	D	E
Asian	3%	1.0%	<1%		
Latino/a	3%	4%	3%	1%	
Other	3%	1%	1%		
White	60%	17%	24%		
GENDER					
Male	49%	74%	72%	25%	23%
Female	51%	26%	28%		
AGE GROUP					
0-12	14%	0.34%	1%		
13-19	6%	7%	4.1%	1%	
20-44	46%	78%	86%	32%	40%
45+	34%	15%	8.4%		

Sources: Column A. US Census Bureau, 2008;

Columns B & C: Virginia Department of Health (VDH)/North Carolina Division of Public Health (NCDPH); 2009

The level of disproportionate impact in the TGA was derived by comparing the proportion of the HIV infected population to the general population in the TGA. African Americans, Males and the age group of 20-44 years display a disproportionate impact for people living with the disease. African American women are 20 times more likely to be diagnosed with HIV/AIDS than white women in Virginia. (VDH, 2009) A group with a slight disparity of note is Youth, 13-19 years of age, with 1% higher proportion of new HIV cases than their percentage in the populace. Youth ages 20-29 years are an emerging population of concern in the TGA, comprising 221 or 39% of the 574 new HIV cases and 15.4% of the new AIDS cases reported in the TGA in 2008 (Special Report on Youth ages 13-29 years, Norfolk TGA, VDH, 2008).

## DISPARITIES AMONG SPECIAL POPULATIONS

For every 5 Virginians diagnosed with HIV infection, approximately 4 are men; 3 are Black; 3 live in the Eastern or Northern region; 3 are men who have sex with other men; and 2 are ages 20 to 34 at diagnosis (2009 Virginia Department of Health (VDH) Epidemiologic Profile).

## BEHAVIORAL RISK DISPARITIES

Men who have Sex with Men (MSM): MSM constitute 52% of all living HIV/AIDS cases with a known risk residing within the TGA. From 1/1/08 to 12/31/09, there were 64 new MSM AIDS cases (31%) and 278 new 'MSM HIV cases (44%) reported to the Center for Disease Control & Prevention (CDC). MSM comprise 14% of the Out of Care population of PLWHA with unmet need and account for 42% of the 'unaware' proportion in the TGA (2008 Unmet Need Estimate, & Unaware HIV Estimated Cases in Norfolk TGA, 2010).

## RACIAL/ETHNICITY DISPARITIES

A total of 83% of all emergent cases of HIV/AIDS in the TGA occurred among racial/ethnic minorities, as compared to their combined 2009 prevalence of 76%. Disparate impact among minority populations is most pronounced among non-Hispanic African Americans. Currently, the emergent HIV/AIDS rate among African Americans in Virginia is more than 4 times that of white Non-Hispanics (2009 VDH Epidemiologic Profile).

## AFRICAN AMERICAN NON-HISPANICS

The majority of new HIV infection diagnoses in Virginia are among persons who are Black (62% from 2004-2008). Black persons comprise only 20% of Virginia's population; however, they represent nearly 2 out of 3 new cases of HIV infection (66%). Black females were 21 times more likely to be diagnosed than White females and Black males 7 times more likely compared to White males. The highest rate of newly diagnosed cases of HIV infection occurred among Black males ages 20-24. Black males ages 20-24 are 17 times more likely to be diagnosed with HIV infection than their White counterparts (2009 VDH Epidemiologic Profile). African Americans comprise 76% of all new HIV/AIDS diagnoses in the TGA and 70% of all PLWHA residing in the TGA as of 12/09.

## HISPANICS

In Virginia, for every 5 Hispanic/Latino Virginians diagnosed with HIV infection, approximately 4 are men; 4 live in the Eastern or Northern region; and 3 are men who have sex with men. Hispanic/Latino men are 3 times more likely to be diagnosed with HIV infection than White men. Hispanic/Latina women are 8 times more likely to be diagnosed with HIV infection than White women. Hispanics/Latinos tend to be diagnosed with HIV infection at a later age compared to the general population (2009 VDH Epidemiologic Profile). Hispanics make up 3.4% and 4.4% of the new AIDS cases and new HIV cases, respectively, in the Norfolk TGA.

## GENDER DISPARITIES

### AFRICAN AMERICAN FEMALES

HIV infection in Virginia is predominantly among MSM, but Black women are increasingly bearing the burden of infection. For every 5 women in Virginia diagnosed with HIV infection, approximately: 4 are Black; 4 were exposed through heterosexual contact; and 2 are ages 25-34 at diagnosis. In 1983, Black females represented 7% of the total diagnosed cases of HIV infection while White MSM represented 51%. By 2009, the percent of Black females grew to 20% while the percent of White MSM decreased to 16%. Black females are 20 times more likely to be diagnosed than White females. In the Norfolk TGA, females comprised 33% of the new AIDS cases, 24% of the new HIV cases, and 29% of all living HIV/AIDS cases in 2009 (2009 VDH Epidemiologic Profile).

## AGE DISPARITIES

The 20-44 age bracket evidences a disparity for both new and existing cases of HIV/AIDS. The large combined 'young to middle aged group, 20-44 years', has a large (32 percentage point) disparity in new cases and a substantial (40 percentage points) disparity for existing cases. The Youth age bracket of 13-19 years evidences an emerging disparity (1%) among new cases of HIV/AIDS .

### POPULATIONS OF PLWHA IN THE TGA THAT ARE UNDERREPRESENTED IN RYAN WHITE-FUNDED SYSTEM OF HIV/AIDS OUTPATIENT/AMBULATORY MEDICAL CARE...CHART CONTINUES ON PG. 8

UNDER-REPRESENTATION IN O/AMC IN NORFOLK TGA: FY 2008-2009							
RACE, GENDER AND RISK GROUP	TOTAL PREVALENCE 12/31/09		PART A OAMC UTILIZATION FY 2008		PART A OAMC UTILIZATION FY09		OVER/ UNDER/ PARITY UTILIZATION
	#	%	#	%	#	%	
RACE							
Black	4,566	70%	751	74%	734	70.8%	parity
White	1,595	24%	172	17%	189	18%	under
Hispanic	257	4%	30	3%	51	4.92%	parity
Asian/Pacific Islander	51	<1%	3	<1%	6	<1%	parity
Native American	13	<1%	5	<1%	2	<1%	parity

	#	%	#	%	#	%	
Multi-race/ Other/Unknown	43	<1%	50	5%	54	5.2%	over
<b>TOTAL</b>	<b>6,548</b>	<b>100%</b>	<b>1011</b>	<b>100%</b>	<b>1,036</b>	<b>100%</b>	
<b>GENDER</b>							
Male	4,688	72%	637	63%	707	68.2%	under
Female	1,860	28%	354	35%	314	30.3%	over
Transgender/ Unknown	UNK	-	20	2%	15	1.5%	parity
<b>TOTAL</b>	<b>6,548</b>	<b>100%</b>	<b>1011</b>	<b>100%</b>	<b>1036</b>	<b>100%</b>	
<b>AGE</b>							
Youth, 13-24	-	-	75	7.4%	99	10%	under
Youth, 13-24	-	-	75	7.4%	99	10%	under
<b>TOTAL</b>	<b>-</b>	<b>-</b>	<b>1011</b>	<b>100%</b>	<b>1036</b>	<b>100%</b>	
<b>RISK BEHAVIOR</b>							
	<b>ALL PART A SERVICES</b>			<b>PART A OAMC ONLY</b>			
MSM	2,498	38%	827	36%	438	42.3%	under/ parity
IDU	703	11%	280	12%	88	8.5%	under
MSM/IDU	231	3.5%	48	2%	19	1.8%	under
Heterosexual	1209	18.5%	1059	46%	447	43.2%	over
Blood Recipient	14	<1%	2	<1%	3	<1%	parity
Perinatal	81	2%	27	1%	8	<1%	under
RNR/ Undetermined/ Unknown	1,792	27%	60	3%	33	3.2%	parity
<b>TOTAL</b>	<b>6,548</b>	<b>100%</b>	<b>2,311</b>	<b>100%</b>	<b>1036</b>	<b>100%</b>	

As evidenced in the table above, the groups of PLWHA who are underrepresented in Ryan White funded HIV outpatient/ambulatory medical care services include: Whites, Males, Youth, IDU and MSM/IDU. Each of the special populations of MSM, Youth and Hispanics access outpatient/ ambulatory medical care in greater proportions in 2009 as compared to 2008.

## OVERVIEW OF 2011 IN CARE PLWH/SURVEY FINDINGS

A total of 229 In Care PLWH/A participated in the 2011 needs assessment process. All SNGs were well represented in the In Care survey. Overall, when compared to the 2008 Needs Assessment findings, there is greater reported need for Employment Assistance (perhaps related to recent economic challenges) and Housing Assistance is identified by the In Care, New to Care and Out of Care as the #1 ranking service Gap.

### 2011 ALL PLWH/A USE, NEED, BARRIER, GAP MATRIX...CHART CONTINUES ON PG. 10

SERVICE CATEGORY DESCRIPTION	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
Medication Assistance	1	2	2	2
Ambulatory Outpatient Medical Care	2	1	10 tie	9
Housing Assistance	3	7	1	1
Nutrition Assistance	4	6	6 tie	5
Mental Health/Support Groups	5	5	5	6
Medical Transportation	6	4	3	3
Other: Employment Assistance	7 tie	13 tie	9	12 tie
Health Education/Peer Educators	7 tie	10	NR	13
Health Insurance/Premium Assistance	8	9	4	4
Emergency Financial Assistance	9	13 tie	7	8
Medical Case Management	10	3	NR	15

SERVICE CATEGORY DESCRIPTION	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
Oral Health Care	11	8	6 tie	7
Substance Abuse Services	12	12	NR	17
HIV Prevention/Condoms	13	13 tie	NR	NR
Other (list): Clothing	14	11	NR	16
Outreach	15 tie	13 tie	NR	NR
Other: Vision Care	15 tie	NR	8 tie	14
Other: Medical/Surgical/ GYN Specialty Care	NR	NR	8 tie	14
Other: Disability Assistance/SSI/Medicaid	NR	NR	10 tie	10
Other: Help with Medical & MH co-pays	NR	NR	11	11

**THE TOP 12 RANKING SERVICE NEEDS OF THE 2011 NORFOLK TGA 'IN CARE' SURVEY RESPONDENT GROUP:**

1. Medication Assistance
2. Ambulatory Outpatient Medical Care
3. Housing Assistance
4. Nutrition Assistance
5. Mental Health/Support Groups
6. Medical Transportation
7. Other: Employment/Job Assistance
8. Health Insurance/Premium Assistance
9. Emergency Financial Assistance
10. Medical Case Management
11. Oral Health Care &
12. Substance Abuse Services

## THE TOP 12 RANKING SERVICE USES OF THE 2011 NORFOLK TGA 'IN CARE' SURVEY RESPONDENT GROUP:

1. Ambulatory Outpatient Medical Care
2. Medication Assistance
3. Medical Case Management
4. Medical Transportation
5. Mental Health/Support Groups
6. Nutrition Assistance
7. Housing Assistance
8. Oral Health Care
9. Health Insurance/Premium Assistance
10. Health Education/Peer Educators
11. Other-Clothing Assistance
12. Substance Abuse Services

## THE TOP 12 RANKING SERVICE GAPS OF THE 2011 NORFOLK TGA 'IN CARE' SURVEY RESPONDENT GROUP:

1. Housing Assistance
2. Medication Assistance
3. Medical Transportation
4. Health Insurance/Premium Assistance
5. Mental Health/Support Groups
6. Oral Health Care tied with Nutrition Assistance
7. Emergency Financial Assistance
8. Other: Vision Care tied with Other Medical/Surgical/GYN Specialty Care
9. Other: Employment Assistance
10. Other: Disability Assistance tied with AOMC
11. Other: Help with Medical & MH Co-Pays
12. NR

## THE TOP 12 RANKING SERVICE BARRIERS OF THE 2011 NORFOLK TGA 'IN CARE' SURVEY RESPONDENT GROUP:

1. Housing Assistance
2. Medication Assistance
3. Medical Transportation
4. Health Insurance/Premium Assistance
5. Nutrition Assistance
6. Mental Health/Support Groups
7. Oral Health Care
8. Emergency Financial Assistance
9. AOMC
10. Other: Disability Assistance
11. Other: Help with Medical/MH Co-Pays
12. Other: Vision Care tied with Employment Assistance

## OVERVIEW OF 2011 NEWLY DIAGNOSED PLWH/SURVEY FINDINGS

The Newly Diagnosed Respondents ranged in age from 18 to 50 years of age with the average age reported as 28 years. By gender, 44% of the New to Care are males; 53% females; and 3% Transgender. The vast majority are African American (87%) with 13% reporting their race/ethnicity as Caucasian. Over 1/3 report their transmission risk mode as MSM (36%); 52% report Heterosexual sex; and 7% report IDU. The majority report a diagnosis of HIV only/not AIDS, with 14% reporting the receipt of an AIDS diagnosis.

2011 ALL NEWLY DIAGNOSED PLWH/A USE, NEED, BARRIER, GAP MATRIX...CHART  
CONTINUES ON PG. 13

SERVICE CATEGORY DESCRIPTION	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
Ambulatory Outpatient Medical care	1	1	NR	NR
Medication Assistance	2	5 tie	3 tie	1
Housing Assistance	3	5 tie	1	3
Health Education/Peer Educator	4	6 tie	NR	NR

SERVICE CATEGORY DESCRIPTION	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
Mental Health/Support Groups	5 tie	4	3 tie	5 tie
Nutrition Assistance	5 tie	8 tie	3 tie	6 tie
Medical Transportation	6 tie	3	NR	5 tie
HIV Prevention/Condoms	6 tie	7	NR	NR
Other: Employment Assistance	7	NR	NR	NR
Health Insurance Assistance	8	NR	4 tie	5 tie
Emergency Financial Assistance	9	NR	NR	NR
Medical Case Management	10 tie	2	NR	6 tie
Substance Abuse Services-Outpatient	10 tie	NR	NR	NR
Oral Health Care	NR	6 tie	3 tie	2
Other: Vision Care	NR	8 tie	2	4 TIE
Other: Medical Specialty Care	NR	NR	4 tie	NR
Other: Disability Assistance/Medicaid	NR	NR	NR	4 TIE
Other: "Knowing where to go/what to do"	NR	NR	NR	6 TIE

**THE TOP 10 RANKING SERVICE NEEDS OF THE 2011 NORFOLK TGA 'NEWLY DIAGNOSED' SURVEY RESPONDENT GROUP INCLUDE:**

1. AOMC
2. Medication Assistance
3. Housing Assistance
4. Health Education/Peer Educator

5. Mental Health/Support Groups tied with Nutrition Assistance
6. Medical Transportation tied with HIV Prevention/Condoms
7. Other: Employment Assistance
8. Health Insurance Assistance
9. Emergency Financial Assistance
10. Medical Case Management tied with Substance Abuse Services-Outpatient

### **THE TOP RANKING SERVICE USES OF THE 2011 NORFOLK TGA 'NEWLY DIAGNOSED' SURVEY RESPONDENT GROUP INCLUDE**

1. AOMC
2. Medical Case Management
3. Medical Transportation
4. Mental Health/Support Groups
5. Medication Assistance tied with Housing Assistance
6. Health Education/Peer Educator tied with Oral Health Care
7. HIV Prevention/Condoms
8. Nutrition Assistance tied with Other: Vision Care

### **THE TOP RANKING SERVICE GAPS OF THE 2011 NORFOLK TGA 'NEWLY DIAGNOSED' SURVEY RESPONDENT GROUP INCLUDE**

1. Housing Assistance
2. Other: Vision Care
3. Medication Assistance tied with Mental Health/Support Groups tied with Nutrition Assistance tied with Oral Health Care
4. Health Insurance Assistance tied with Other: Medical Specialty Care

### **THE TOP RANKING SERVICE BARRIERS OF THE 2011 NORFOLK TGA 'NEWLY DIAGNOSED' SURVEY RESPONDENT GROUP INCLUDE**

1. Medication Assistance
2. Oral Health Care
3. Housing Assistance

4. Other: Vision Care tied with Disability Assistance
5. Mental Health/Support Groups tied with Medical Transportation tied with Health Insurance Assistance
6. Nutrition Assistance tied with Medical Case Management tied with “Knowing where to go/what to do”

## OVERVIEW OF 2011 OUT OF CARE PLWH/SURVEY FINDINGS

REASONS FOR OOC STATUS...CHART CONTINUES ON PG. 16

IF YOU HAVE NOT HAD MEDICAL CARE IN MORE THAN 6 MONTHS FOR YOUR HIV, PLEASE TELL US WHY. (PLEASE CHECK ALL THAT APPLY.)		
ANSWER OPTIONS	PERCENT	COUNT
I am undetectable	37.5%	3
I do not think I need medical care now because I am not sick	37.5%	3
I get anxious about going to a doctor or nurse about HIV	25.0%	2
Not applicable, I have received medical care w/in the past 6 mos	25.0%	2
I feel better than I did	25.0%	2
I have not found a place that I feel comfortable going	12.5%	1
I don't have transportation to get to medical care appointments	12.5%	1
I do not know where to go for medical care	12.5%	1
I can't afford medical care now	12.5%	1
I don't have the money for parking/lunch	12.5%	1
I was told to take a break	0.0%	0
I do not think medical care would do me any good	0.0%	0
I have not found a doctor or nurse who I want to treat me	0.0%	0

**IF YOU HAVE NOT HAD MEDICAL CARE IN MORE THAN 6 MONTHS FOR YOUR HIV, PLEASE TELL US WHY. (PLEASE CHECK ALL THAT APPLY.)**

I don't have child care when I go for medical care	0.0%	0
I do not want to receive medical care	0.0%	0
I use alternative treatments	0.0%	0
I don't want anyone to know	0.0%	0
I had problems with medications	0.0%	0
Other (please specify): Mental health; Got 'cocky'; every time I go, either the doctor isn't there or I am too late to be seen	37.5%	3

**ANSWERED QUESTION 8**

The major reasons supplied by the OOC respondents to explain their absence from medical care include: “Am undetectable”; “Don’t need it because I am not sick”; “I get anxious about going”; “I feel better than I did”; while less frequently reported reasons include: lack transportation, can’t afford it and don’t know where to go for medical care. Several of these reasons that keep PLWH/A from medical care would appear to be positively impacted through better HIV education of the benefits of regular care and treatment.

**PROMPTS FOR OOC TO RETURN TO CARE...CHART CONTINUES ON PG. 17**

**IF YOU HAVEN'T RECEIVED MEDICAL CARE IN THE LAST 6 MONTHS, WHICH OF THE FOLLOWING THINGS WOULD HELP YOU GET TO A DOCTOR? (PLEASE CHECK ALL THAT APPLY.)**

ANSWER OPTIONS	PERCENT	COUNT
TRANSPORTATION	33.3%	3
MORE OUTREACH SERVICES	33.3%	3
FREE MEDICAL CARE	33.3%	3
PEER SUPPORT/SOMEONE TO HELP ME UNDERSTAND	22.2%	2
NOT APPLICABLE AS I AM RECEIVING MEDICAL CARE	22.2%	2
MORE INFORMATION ABOUT THE SERVICES	22.2%	2

**IF YOU HAVEN'T RECEIVED MEDICAL CARE IN THE LAST 6 MONTHS, WHICH OF THE FOLLOWING THINGS WOULD HELP YOU GET TO A DOCTOR? (PLEASE CHECK ALL THAT APPLY.)**

LOWER COST OF MEDICAL CARE/MEDICINES	22.2%	2
INSURANCE TO PAY FOR DOCTOR AND MEDS	22.2%	2
HOUSING	22.2%	2
FINANCIAL CONCERNS	22.2%	2
SUBSTANCE USE TREATMENT	11.1%	1
REFERRALS OR ADVICE FROM SOMEONE I TRUST	11.1%	1
OTHER (PLEASE SPECIFY): CASE MANAGER	11.1%	1
NOTHING	11.1%	1
NOT HAVING TO WAIT SO LONG FOR APPOINTMENTS	11.1%	1
MORE GOVERNMENT SERVICES	11.1%	1
EMPLOYMENT OPPORTUNITIES	11.1%	1
BETTER TRAINED DOCTORS AND NURSES	11.1%	1
<b>ANSWERED QUESTION 9</b>		

Transportation assistance, more outreach services and free medical care are the top services that this cohort of PLWH/A with unmet/under-met need for medical care report as prompts to their returning to care. Peer support, more information about the services available and how to access them, lower cost of medical care/medicines, housing assistance and assistance with financial concerns, and health insurance to pay for doctors and meds are the next most frequently reported prompters to seeking and remaining in primary medical care. The other prompters to return to care include reported by the OOC respondents include: substance abuse treatment, advice from trusted referral sources, a case manager, shorter appointment wait times, more government services, employment opportunities and better trained doctors and nurses.

## REASONS WHY OOC PLWH/A DON'T GET HIV MEDICAL CARE

WHY DO YOU THINK PEOPLE DON'T GET MEDICAL CARE FOR HIV? (PLEASE CHECK ALL THAT APPLY.)		
ANSWER OPTIONS	PERCENT	COUNT
WORRIED THAT OTHER PEOPLE WILL FIND OUT/ FEAR OF TELLING	66.7%	6
FEEL HEALTHY	44.4%	4
DRUGS	33.3%	3
DON'T HAVE TRANSPORTATION	33.3%	3
DON'T BELIEVE THEY ARE HIV POSITIVE	33.3%	3
CAN'T AFFORD IT	33.3%	3
OTHER (PLEASE SPECIFY): NO SIGNS OR SYMPTOMS, GET ANXIOUS, DON'T CARE	22.2%	2
DON'T WANT TO TAKE HIV MEDICATIONS	11.1%	1
COULDN'T GET AN APPOINTMENT	0.0%	0
CANNOT SPEAK ENGLISH VERY WELL	0.0%	0
ANSWERED QUESTION 9		

When asked why PLWH/A do not get medical care for their HIV disease, the majority of the OOC respondents reported “Worried that others will find out/fear of divulging their HIV status”. The next most frequently cited reason is “Feel healthy”, followed by drug use, lack of transportation, don’t believe they are HIV positive, and can’t afford it. Less frequently reported reasons include the lack of signs or symptoms of disease, get anxious going to doctors, don’t care about getting treatment and don’t want to take HIV medications.

## SERVICES THAT WOULD PROMPT RE-ENTRY INTO HIV MEDICAL CARE- OOO SERVICE NEEDS

- Case management
- Transportation
- Case manager’s encouragement

- Strong doctor
- Help from agency like ACCESS AIDS care
- Housing
- Employment
- Schools
- Medicaid
- Support
- Needing to see a doctor

## OOO SERVICES NEEDED BUT CAN'T GET- SERVICE GAPS

1. Housing Assistance
2. Nutrition Assistance tied with Medical Transportation tied with Oral Health Care
3. ADAP/Medications
4. Health Insurance tied with AOMC
5. Other: Employment Assistance/Job tied with Medicaid/SSI/Disability Assistance tied with Clothing tied with “things not covered by RW, i.e., surgery
6. Health Information/HIV Education tied with Vision Care tied with EFA

The service Gap/Barrier rankings for the In Care, Newly Diagnosed and Out of Care PLWHA listed in the tables below deserve special attention in the priority setting and resource allocation planning and decision making processes for the TGA.

### SUMMARY OF BARRIER RANKINGS BY IN CARE, NEWLY DIAGNOSED & OUT OF CARE... CHART CONTINUES ON PG. 20

RANKING	IN CARE BARRIERS	NEWLY DIAGNOSED BARRIERS	OUT OF CARE BARRIERS
1	Housing Assistance	Medication Assistance	Fear of disclosure
2	Medication Assistance	Oral Health Care	Feel healthy/Don't recognize benefits of treatment
3	Medical Transportation	Housing Assistance	Drug use tied with lack of transportation tied with lack of finances

<b>RANKING</b>	<b>IN CARE BARRIERS</b>	<b>NEWLY DIAGNOSED BARRIERS</b>	<b>OUT OF CARE BARRIERS</b>
4	Health Insurance/ Premium Assistance	Other: Vision Care tied with Disability Assistance	Anxiety about going to the doctor/lack of concern/don't care
5	Nutrition Assistance	Mental Health/Support Groups tied with Medical Transportation tied with Health Insurance Assistance	Don't want to take medicines
6	Mental Health/ Support Groups	Nutrition Assistance tied with Medical Case Management tied with "Knowing where to go/ what to do"	NR

SUMMARY OF GAP RANKINGS BY IN CARE, NEWLY DIAGNOSED & OUT OF CARE...CHART CONTINUES ON PG. 21

<b>RANKING</b>	<b>IN CARE BARRIERS</b>	<b>NEWLY DIAGNOSED BARRIERS</b>	<b>OUT OF CARE BARRIERS</b>
1	Housing Assistance	Housing Assistance	Housing Assistance
2	Medication Assistance	Other: Vision Care	Nutrition Assistance tied with Medical Transportation tied with Oral Health Care
3	Medical	Medication Assistance tied with Mental Health/Support Groups tied with Nutrition Assistance tied with Oral Health Care	ADAP/Medications
4	Health Insurance/ Premium Assistance	Health Insurance Assistance tied with Other: Medical Specialty Care	Health Insurance tied with AOMC

RANKING	IN CARE BARRIERS	NEWLY DIAGNOSED BARRIERS	OUT OF CARE BARRIERS
5	Mental Health/ Support Groups	NR	Other: Employment Assistance/Job tied with Medicaid/SSI/ Disability Assistance tied with Clothing tied with “things not covered by RW, i.e., surgery
6	Oral Health Care tied with Nutrition Assistance	NR	Health Information/ HIV Education tied with Other: Vision Care tied with EFA

## CHAPTER 1: INTRODUCTION

Three TGA localities (Norfolk, Virginia Beach and Newport News) were among the top 7 cities/counties in Virginia with the greatest burden of all HIV infection diagnoses between 2004-2008. The City of Norfolk has the highest number of PLWHA in the region (2,277 or 35% of total) and is the epidemic center. HIV/AIDS services tend to be concentrated in the denser urban and suburban areas. PLWHA must travel long distances to access services. The abundance of regional waterways requires a complex system of bridges and tunnels that impede access to services. The TGA divides major population centers by Peninsula and Southside locations.

The Norfolk TGA has a geographically dispersed network of providers in a geographically challenging area. The inherent diversity of the Norfolk TGA poses substantial challenges for planners as they strive to create a system that provides primary medical care and supportive services that are responsive to the needs of all PLWHA in the Planning Area.

Annual Needs Assessments are special studies in time conducted to determine the priority service needs, barriers, and gaps in the continuum of care for People Living with HIV/AIDS (PLWH/A). Results of this client-centered activity are used to establish service priorities, document the need for specific services, determine barriers to accessing care, provide baseline data for comprehensive planning including capacity building, and help providers improve the accessibility, acceptability quality of services delivered, especially to the designated ‘Severe Need Groups/Special Populations’.

The Norfolk TGA’s continuum of care has evolved into an increasingly robust and responsive medical model of HIV care and services delivery. Primary medical care is supported by a strong HIV medication infrastructure and by a wide range of medically and socially supportive services, including substance abuse and mental health treatment services, medical and social services case management, emergency financial assistance, oral health care, transportation, outreach/case finding and other services essential to facilitating

PLWH/A access to and retention in HIV primary medical care. The Norfolk TGA's ideal continuum of care facilitates optimal access to and full utilization of medical and supportive services. All of these services exist in the context of the five key goals of the U.S. Health Resources and Services Administration (HRSA): 1) improve access to care, 2) eliminate health disparities, 3) improve the quality of care, 4) assure cost effectiveness, and 5) improve health outcomes.

In order to inform the 2012 services planning and resource allocation process, the Greater Hampton Roads HIV Health Services Planning Council commissioned three needs assessment studies in 2011:

1) An "In Care" PLWHA survey study to ascertain the emerging service needs, uses, barriers and gaps for the 2011 population of PLWH/A in Ryan White funded services; 2) A "Newly Diagnosed/New to Care" PLWH/A study of those individuals who had recently been diagnosed and entered care and services within the past year; and 3) An "Out of Care" survey study of those PLWH/A who have been out of care for one year or longer or who have never entered care and services, to ascertain the emerging service needs, gaps and barriers for the 2011 population of PLWH/A with unmet need.

## RELEVANCE OF THE PART A COMPREHENSIVE NEEDS ASSESSMENTS

The targeted special population groups, their sub-populations and the TGA's severe needs groups remain a major focus of study for the Planning Area. The Planning Council is continuously challenged in identifying the changing needs of the PLWH/A community in order to best facilitate access, engagement and retention in care for all those living with HIV/AIDS in the service area.

Based upon their disproportionate impact within the TGA, the needs assessment survey process and resulting report highlights the differing needs, uses, gaps and barriers to HIV primary medical care experienced by severe need groups of African Americans, MSM, Women of Color, Substance Abusers/IDU, Rural PLWH/A, Veterans/Military, and Youth, ages 13-24 years. In addition to the "In Care" and "Out of Care" needs assessments, efforts were made to canvass the "Newly Diagnosed/New to Care" PLWH/A, in order to better understand how the TGA may reduce the proportion of Unaware and strengthen linkages and engagement in primary medical care and services.

## ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV

A total of 3,716 persons living with HIV have been reported in the Norfolk TGA as of 12/31/09, an increase of 2% since the last report.

## ESTIMATED NUMBER OF PEOPLE LIVING WITH AIDS

A total of 2,832 persons living with AIDS have been reported in the Norfolk TGA as of 12/31/09, representing an 8% increase over last year.

As of December 31, 2009, there were 6,548 PLWHA reported as living in the TGA, representing a 4.4% increase from 2008 (6,271). The TGA comprises over 31% of the total living cases reported throughout the state of Virginia as of 12/2009 (N=21,071). Of the 6,548 PLWHA, 3,716 (56.8%) are PLWH and 2,832 are PLWA (43.2%). The increase in prevalence rates appears to be due to the efficacy of multi-drug treatments for HIV infection, which have sharply reduced HIV-related death (2010 VDH Epidemiologic Profile)

## NUMBER OF NEW AIDS CASES

The number of new AIDS cases among TGA residents reported to the CDC during 2008 to 2009 was 205, a decrease from the previous reporting period when 338 new AIDS cases were reported, but representing a continuing expansion of newly diagnosed AIDS cases over the last three reporting periods. Increases in the proportion of new AIDS cases occurred among men, persons ages 45+, MSM and IDU from 2008 to 2009. Of the 205 new cases of AIDS reported in 2008-2009, African Americans comprise 74%; males constitute 67%; 45+ year olds comprise 33%, and the combined 20-44 age bracket constitutes 61% of all new AIDS cases. Among those persons with known risk, MSM constitute 57%; Heterosexuals comprise 31%; and IDU comprise 12% of all new AIDS cases. The proportion of 'Risk Not Identified/Not Reported among new AIDS cases is over 45%. Locations with the highest rates of new AIDS cases in 2008 were Norfolk (13.2 per 100,000), Hampton (9.6 per 100,000), Newport News (8.4 per 100,000), and Chesapeake (7.3 per 100,000). Norfolk's rate of new AIDS cases was higher than both the Commonwealth of Virginia (8.2) and the U.S. rates (12.5) for new AIDS cases.

## HIV INCIDENCE

Of the 637 new HIV cases reported in 2008-2009, (representing a substantial 11% increase over 2007-2008 new HIV cases), 76% are among African Americans; 76% males; 9% 13-19 year olds; and 68% 20-44 year olds. When the numbers of new HIV cases among the "No Identified Risk category is subtracted (44%), MSM comprise 78%; Heterosexuals constitute 15.5%; and IDU make up 5.3% of those with a known risk category. Increases in the proportion of new HIV cases occurred among males, Hispanics, the multi-racial, persons ages 45+, MSM, IDU and MSM/IDU from 2008 to 2009. Locations with the highest rates of new HIV (not-AIDS) in 2008 were Norfolk (40.1, increased from 34.8 per 100,000 in 2007) Portsmouth (30.8 per 100,000), Newport News (27.8, increased from 19.2 per 100,000), and Hampton (21.3 per 100,000) substantially exceeding rates among both the state and the nation (2009 VA/NC HARS, 2008 Population Estimates, US Census Bureau).

## PREVALENT HIV/AIDS CASES:

Males, men who have sex with men (MSM), African-Americans, adults ages 20-44, people from urban areas, and those living in poverty are disproportionately infected with HIV/AIDS in the Norfolk TGA. Men who have sex with men (MSM) represented 47% of AIDS prevalence and 39% of HIV (not-AIDS) prevalence in the TGA. African-Americans reported 72% of HIV (not-AIDS) and are over 67% of people living with AIDS; and adults ages 20-44 represented 79% of the TGA's total living HIV/AIDS epidemic. Of all high-risk groups, male and female African-Americans, MSM, and PLWH ages 20-29 years and PLWA ages 30-49 tend to be the most disproportionately impacted by HIV-disease in the Norfolk TGA. Among those with reported risk, approximately 57% of all PLWHA are Men who have sex with men (MSM) and MSM/IDU; with African-Americans comprising a large portion of the MSM population. In addition, the Norfolk TGA is witnessing an increase in HIV-disease among women of childbearing age, youth ages 13-29 years and aging PLWHA, 45+ years of age and older.

One of the most significant differences among locations in the TGA is population size. According to the 2008 United States Census Populations Estimate data, population ranges in size from 9,038 (Mathews) to 433,746 (Virginia Beach). Virginia/North Carolina HIV/AIDS Reporting System (HARS) data indicates that urban areas within the TGA are disproportionately impacted by HIV disease. The City of Norfolk—

the urban epicenter of the TGA—reported the largest number of living HIV/AIDS cases for the 2008-2009 time period (2,277 or 35%, with a rate of 980 per 100,000) followed by Virginia Beach, with 1,156 PLWHA (226 per 100,000); Newport News has 873 PLWHA (rate of 487); and Portsmouth, reporting 662 PLWHA, has a rate of 649 per 100,000.

Approximately 75% of all HIV and AIDS living cases are in Southside localities. Norfolk, Portsmouth and Newport News demonstrate disproportionately high rates of overall HIV-disease prevalence (HIV and AIDS), at 2.5-3.5 times the rates of Virginia (270 per 100,000). The Planning Council took this information into account during the resource allocation and priority setting process and in the TGA's Comprehensive Plan.

## **DISPROPORTIONATE IMPACT OF HIV/AIDS ON CERTAIN POPULATIONS**

A disproportionate impact of HIV/AIDS is evident for populations determined to be nationally undercounted in recent CDC incidence estimates announced August 2, 2008. Using new technology called Serological Testing Algorithm for Recent HIV Seroconversion (STARHS) that distinguishes recent from longstanding HIV infections, CDC estimates that 56,300 new HIV infections occurred in the United States in 2006. These estimates show that two groups, both of which dominate the epidemiology profile for existing and new cases in the Norfolk TGA, are higher than previously expected for new infections. Gay and bisexual men of all races account for 53% of new infections and African Americans for 43% of national cases. African Americans continue to have an incidence rate 7 times that of whites and 3 times higher than Latinos.

The level of disproportionate impact in the TGA was derived by comparing the proportion of the HIV infected population to the general population in the TGA. African Americans, Males and the age group of 20-44 years display a disproportionate impact for people living with the disease. African American women are 20 times more likely to be diagnosed with HIV/AIDS than white women in Virginia. (VDH, 2009) A group with a slight disparity of note is Youth, 13-19 years of age, with 1% higher proportion of new HIV cases than their percentage in the populace. Youth ages 20-29 years are an emerging population of concern in the TGA, comprising 221 or 39% of the 574 new HIV cases and 15.4% of the new AIDS cases reported in the TGA in 2008 (Special Report on Youth ages 13-29 years, Norfolk TGA, VDH, 2008). The specific impact or disparity for all groups in the Norfolk TGA is noted below. Bold font that is shaded in Columns D indicates the extent of the disparity for 'new' HIV and AIDS cases. The same display denotes the scale of disparity for PLWHA in Column E.

*DISPROPORTIONATE IMPACT OF HIV/AIDS IN NORFOLK TGA, 2009*

<b>% GENERAL POPULATION V. HIV+</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>
<b>GROUP IN NORFOLK, VA TGA</b>	<b>GENERAL POPULATION</b>	<b>NEW CASES</b>	<b>PLWHA</b>	<b>NEW DISPARITY</b>	<b>EXISTING DISPARITY</b>
<b>RACE/ETHNIC GROUP</b>					
<b>AFRICAN AMERICAN</b>	31%	77%	71%	46%	40%
<b>ASIAN</b>	3%	1.0%	<1%		
<b>LATINO/A</b>	3%	4%	3%	1%	
<b>OTHER</b>	3%	1%	1%		
<b>WHITE</b>	60%	17%	24%		
<b>GENDER</b>					
<b>MALE</b>	49%	74%	72%	25%	23%
<b>FEMALE</b>	51%	26%	28%		
<b>AGE GROUP</b>					
<b>0-12</b>	14%	0.34%	1%		
<b>13-19</b>	6%	7%	4.1%	1%	
<b>20-44</b>	46%	78%	86%	32%	40%
<b>45+</b>	34%	15%	8.4%		

Sources: Column A. US Census Bureau, 2008;

Columns B & C: Virginia Department of Health (VDH)/North Carolina Division of Public Health (NCDPH); 2009

## DISPARITIES AMONG SPECIAL POPULATIONS

For every 5 Virginians diagnosed with HIV infection, approximately 4 are men; 3 are Black; 3 live in the Eastern or Northern region; 3 are men who have sex with other men; and 2 are ages 20 to 34 at diagnosis (2009 Virginia Department of Health (VDH) Epidemiologic Profile).

## **MEN WHO HAVE SEX WITH MEN (MSM)**

MSM constitute 52% of all living HIV/AIDS cases with a known risk residing within the TGA. From 1/1/08 to 12/31/09, there were 64 new MSM AIDS cases (31%) and 278 new 'MSM HIV cases (44%) reported to the Center for Disease Control & Prevention (CDC). MSM comprise 14% of the Out of Care population of PLWHA with unmet need and account for 42% of the 'unaware' proportion in the TGA (2008 Unmet Need Estimate, & Unaware HIV Estimated Cases in Norfolk TGA, 2010).

## **RACIAL/ETHNICITY DISPARITIES**

A total of 83% of all emergent cases of HIV/AIDS in the TGA occurred among racial/ethnic minorities, as compared to their combined 2009 prevalence of 76%. Disparate impact among minority populations is most pronounced among non-Hispanic African Americans. Currently, the emergent HIV/AIDS rate among African Americans in Virginia is more than 4 times that of white Non-Hispanics (2009 VDH Epidemiologic Profile).

## **AFRICAN AMERICAN NON-HISPANICS**

The majority of new HIV infection diagnoses in Virginia are among persons who are Black (62% from 2004-2008). Black persons comprise only 20% of Virginia's population; however, they represent nearly 2 out of 3 new cases of HIV infection (66%). Black females were 21 times more likely to be diagnosed than White females and Black males 7 times more likely compared to White males. The highest rate of newly diagnosed cases of HIV infection occurred among Black males ages 20-24. Black males ages 20-24 are 17 times more likely to be diagnosed with HIV infection than their White counterparts (2009 VDH Epidemiologic Profile). African Americans comprise 76% of all new HIV/AIDS diagnoses in the TGA and 70% of all PLWHA residing in the TGA as of 12/09.

## **HISPANICS**

In Virginia, for every 5 Hispanic/Latino Virginians diagnosed with HIV infection, approximately 4 are men; 4 live in the Eastern or Northern region; and 3 are men who have sex with men. Hispanic/Latino men are 3 times more likely to be diagnosed with HIV infection than White men. Hispanic/Latina women are 8 times more likely to be diagnosed with HIV infection than White women. Hispanics/Latinos tend to be diagnosed with HIV infection at a later age compared to the general population (2009 VDH Epidemiologic Profile). Hispanics make up 3.4% and 4.4% of the new AIDS cases and new HIV cases, respectively, in the Norfolk TGA.

## **GENDER DISPARITIES/AFRICAN AMERICAN FEMALES**

HIV infection in Virginia is predominantly among MSM, but Black women are increasingly bearing the burden of infection. For every 5 women in Virginia diagnosed with HIV infection, approximately: 4 are Black; 4 were exposed through heterosexual contact; and 2 are ages 25-34 at diagnosis. In 1983, Black females represented 7% of the total diagnosed cases of HIV infection while White MSM represented 51%. By 2009, the percent of Black females grew to 20% while the percent of White MSM decreased to 16%.

Black females are 20 times more likely to be diagnosed than White females. In the Norfolk TGA, females comprised 33% of the new AIDS cases, 24% of the new HIV cases, and 29% of all living HIV/AIDS cases in 2009 (2009 VDH Epidemiologic Profile).

## AGE DISPARITIES

The 20-44 age bracket evidences a disparity for both new and existing cases of HIV/AIDS. The large combined 'young to middle aged group, 20-44 years', has a large (32 percentage point) disparity in new cases and a substantial (40 percentage points) disparity for existing cases. The Youth age bracket of 13-19 years evidences an emerging disparity (1%) among new cases of HIV/AIDS.

As evidenced in the table below, the groups of PLWHA who are underrepresented in Ryan White funded HIV outpatient/ambulatory medical care services include: Whites, Males, Youth, IDU and MSM/IDU. Each of the special populations of MSM, Youth and Hispanics accessed outpatient/ ambulatory medical care in greater proportions in 2009 as compared to 2008.

## POPULATIONS OF PLWHA IN THE TGA THAT ARE UNDERREPRESENTED IN RYAN WHITE-FUNDED SYSTEM OF HIV/AIDS OUTPATIENT/AMBULATORY MEDICAL CARE...CHART CONTINUES ON PG. 28

UNDER-REPRESENTATION IN O/AMC IN NORFOLK TGA: FY 2008-2009							
RACE, GENDER AND RISK GROUP	TOTAL PREVALENCE 12/31/09		PART A OAMC UTILIZATION FY 2008		PART A OAMC UTILIZATION FY09		OVER/ UNDER/ PARITY UTILIZATION
	#	%	#	%	#	%	
RACE							
Black	4,566	70%	751	74%	734	70.8%	parity
White	1,595	24%	172	17%	189	18%	under
Hispanic	257	4%	30	3%	51	4.92%	parity
Asian/Pacific Islander	51	<1%	3	<1%	6	<1%	parity
Native American	13	<1%	5	<1%	2	<1%	parity
Multi-race/Other/ Unknown	43	<1%	50	5%	54	5.2%	over
<b>TOTAL</b>	<b>6,548</b>	<b>100%</b>	<b>1011</b>	<b>100%</b>	<b>1,036</b>	<b>100%</b>	

	#	%	#	%	#	%	
GENDER							
Male	4,688	72%	637	63%	707	68.2%	under
Female	1,860	28%	354	35%	314	30.3%	over
Transgender/ Unknown	UNK	-	20	2%	15	1.5%	parity
<b>TOTAL</b>	<b>6,548</b>	<b>100%</b>	<b>1011</b>	<b>100%</b>	<b>1036</b>	<b>100%</b>	
AGE							
Youth, 13-24	-	-	75	7.4%	99	10%	under
Youth, 13-24	-	-	936	92.6%	937	90%	over
<b>TOTAL</b>	<b>-</b>	<b>-</b>	<b>1011</b>	<b>100%</b>	<b>1036</b>	<b>100%</b>	
RISK BEHAVIOR							
	ALL PART A SERVICES			PART A OAMC ONLY			
MSM	2,498	38%	827	36%	438	42.3%	under/parity
IDU	703	11%	280	12%	88	8.5%	under
MSM/IDU	231	3.5%	48	2%	19	1.8%	under
Heterosexual	1209	18.5%	1059	46%	447	43.2%	over
Blood Recipient	14	<1%	2	<1%	3	<1%	parity
Perinatal	81	2%	27	1%	8	<1%	under
RNR/ Undetermined/ Unknown	1,792	27%	60	3%	33	3.2%	parity
<b>TOTAL</b>	<b>6,548</b>	<b>100%</b>	<b>2,311</b>	<b>100%</b>	<b>1036</b>	<b>100%</b>	

## IMPACT OF CO-MORBIDITIES ON COST AND COMPLEXITY OF CARE

There are substantial levels of co-morbidities reported across numerous categories that seriously complicate the cost of care for PLWHA in the TGA.

## STI (SEXUALLY TRANSMITTED INFECTION) RATES

All Sexually Transmitted Infection (STI) statistical data is from Virginia Department of Health and North Carolina Department of Public Health, unless noted otherwise.

According to data from the Virginia Department of Health (VDH) and North Carolina Division of Public Health (NCDPH), there were 12,100 cases of Chlamydia, 3,666 cases of gonorrhea and 179 cases of total early syphilis reported in the Norfolk TGA for 2009. These figures represent modest increases in each of these sexually transmitted diseases after dramatic escalation from 2007 to 2008. As evidenced in the table below, there is wide variation in the case rates throughout the TGA, with those most disproportionately impacted inclusive of Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, and Virginia Beach.

### CHLAMYDIA: THE NORFOLK TGA REPORTED 12, 100 CHLAMYDIA CASES IN 2009, A LEVELING OFF OF THE DRAMATIC UPSWING FROM 2007 TO 2008

The majority of reported Chlamydia diagnoses were females (75%), 20 to 29 years (55%), Black (51%), and lived in the Eastern region of the Norfolk TGA (39%). Among Virginians, females are 3 times more likely to be diagnosed with Chlamydia than males, and Blacks are 9 times more likely than Whites. Black females are 8 times more likely to be diagnosed with Chlamydia than White females, and Hispanic females are 3 times more likely than White females. Black males are 13 times more likely to be diagnosed with Chlamydia than White males, and Hispanic males are 3 times more likely than White males (VDH, 2009). It is unknown how many PLWHA are infected with Chlamydia each year, however Eastern Virginia Medical School, (the largest OAMC provider in the TGA), estimates that 15% of the living population was currently infected with one or more STIs.

### GONORRHEA

During 2008, the number of Gonorrhea almost doubled; from 6,258 cases in 2007 to 10,337 cases in 2008. This dramatic increase subsided in 2009 with 7,809 total cases reported in Virginia. The Norfolk TGA remained responsible for 47% of total cases in the state. The majority of reported Gonorrhea diagnoses were Black (71%), females (57%), and 15 to 24 years old (64%). Gonorrhea remains the sexually transmitted disease with the largest racial health disparity in Virginia. Black females account for 39% of the total reported Gonorrhea cases, and Black males accounted for 32%. A comparison of age groups indicates the highest gonorrhea incidence rate is among the 20-29 year age group (306/100,000), followed by the 10-19 group (177/100,000) (VDH, 2009).

### SYPHILIS

In 2008, the Virginia reported Total Early Syphilis (TES) diagnoses increased by 23%, from 407 in 2007 to 499 cases in 2008, with slight further increase to 546 in 2009. The incidence rate of TES cases reported in Virginia more than doubled since 2002, from 2.3 to 6.4 per 100,000 population in 2008. TES cases reported in Virginia were among males (86%), Black (67%), 20 to 29 years old (41%), and lived in the Eastern region (33%) or the Norfolk TGA (23%). Black males were two thirds of the total reported cases (65%). Approximately 50% of reported cases among Black males were 15 to 24 years old.

## SEXUALLY TRANSMITTED INFECTIONS AND RATES IN THE NORFOLK TGA, 2009

		CHLAMYDIA		GONORRHEA		TOTAL EARLY SYPHILIS Z	
NORFOLK TGA	POPULATION	CASES	RATES	CASES	RATES	CASES	RATES
CHESAPEAKE	222,455	1,267	569.6	369	165.9	15	6.7
GLOUCESTER	39,184	80	204.2	17	43.4	1	2.6
HAMPTON	144,236	1,394	966.5	395	273.9	14	9.7
ISLE OF WRIGHT	35,877	167	465.5	21	58.5	4	11.1
JAMES CITY	63,735	112	175.7	12	18.8	1	1.6
MATHEWS	8,984	21	233.7	1	11.1	0	0.0
NEWPORT NEWS	193,172	2,123	1099.0	574	297.1	26	13.5
NORFOLK	233,333	2,880	1234.3	1,059	453.9	53	22.7
POQUOSON	11,794	18	152.6	2	17.0	0	0.0
PORTSMOUTH	99,321	1,132	1139.7	489	492.3	21	21.1
SUFFOLK	83659	593	708.8	125	149.4	5	6.0
VIRGINIA BEACH	433575	2,025	467.0	545	125.7	37	8.5
WILLIAMSBURG	12729	88	691.3	15	117.8	1	7.9
YORK	61,140	167	273.1	30	49.1	1	1.6
CURRITUCK, NC	24,216	33	137.7	12	50.1	0	0
<b>TOTAL TGA</b>	<b>1,667,410</b>	<b>12,100</b>	<b>725.7</b>	<b>3,666</b>	<b>219.9</b>	<b>179</b>	<b>10.7</b>
<b>VA TOTAL</b>	<b>7882590</b>	<b>31,220</b>	<b>396.1</b>	<b>7,809</b>	<b>99.1</b>	<b>546</b>	<b>6.9</b>

Re-infection risk, transmission of both HIV and STIs to sero-negative partners and increased health impairment due to immunodeficiency are among the determinants that adversely impact the HIV/STI co-infected in the Norfolk TGA.

## TUBERCULOSIS (TB)

Mycobacterium tuberculosis is both a clinical antecedent to and exacerbated by HIV-disease. In 2009, there were 37 cases of TB-disease (infectious stage of TB) (2.1 per 100,000) reported in the Norfolk TGA, representing 14% of all TB cases reported state-wide. Fourteen of the 37 cases in 2009 were reported among the foreign-born. Only two cases of HIV/TB co-infection was reported from the TGA in 2009. TB infection predisposes those with decreased immunity to greater morbidity and higher risk of transmission. There is a wide range of case rates throughout the TGA, ranging from lows of 0.0 to 25.4 per 100,000.

### TUBERCULOSIS CASES AND RATES IN THE NORFOLK TGA, 2009

NORFOLK TGA LOCALITY	2008 TB CASES	2008 TB RATES	2009 TB CASES	2009 TB RATES
CHESAPEAKE	2	0.9	6	2.7
GLOUCESTER	2	5.2	1	2.6
HAMPTON	6	4.1	3	2.1
ISLE OF WRIGHT	2	5.8	1	2.8
JAMES CITY	0	0.0	0	0.0
MATHEWS	0	0.0	0	0.0
NEWPORT NEWS	6	3.4	5	2.6
NORFOLK	5	2.2	5	2.1
POQUOSON	0	0.0	0	0.0
PORTSMOUTH	4	3.9	2	2.0
SUFFOLK	2	2.5	1	1.2
VIRGINIA BEACH	11	2.5	13	3.0
WILLIAMSBURG	3	25.4	0	0.0
YORK	0	0.0	0	0.0
<b>TOTAL TGA</b>	<b>43</b>	<b>2.7</b>	<b>37</b>	<b>2.1</b>
<b>VA TOTAL</b>	<b>292</b>	<b>3.8</b>	<b>273</b>	<b>3.5</b>

## HOMELESSNESS

After two years of declining numbers, Norfolk’s 2009 homeless population is growing. The most recent Point in Time count found 577 people living on the streets or in shelters in January 2009, about a 15 % increase over 2008’s count of 502 (South Hampton Roads Regional Taskforce on Ending Homelessness, 2009.)

The total population of homeless people in Norfolk declined from 665 in 2006 to 502 in 2008. In addition to the 69% decline in the number of unsheltered homeless people, chronic homelessness (long-term or repeated homelessness experienced by those with a disability) decreased by almost 40 percent, credited to implementation of Norfolk’s Ten Year Plan to End Homelessness.

Since the inception of the plan in 2005, Norfolk has increased permanent supportive housing units by 65% with an estimated 1,224 people placed in housing. Norfolk, Virginia Beach and Portsmouth pooled their resources to provide funding and rental subsidies for regionally-supported efficiency apartments for homeless single adults. Services provide residents with access to employment skills training, literacy classes, and substance abuse recovery programs.

### 2009 HOMELESSNESS BY CITY IN THE NORFOLK TGA

PROFILE	REGION	NORFOLK	VIRGINIA BEACH	PORTSMOUTH	WCHESAPEAKE	WESTERN
SINGLE	873	428	215	194	13	23
FAMILY	542	149	218	109	24	42

*(2009 Regional Needs Assessment/Point in Time Count. Regional Taskforce to End Homelessness)*

Although there now exists an extensive and dedicated network of agencies and nonprofit service providers throughout the region, the numbers of individuals becoming or remaining homeless for extended periods of time rivals the numbers found in other metropolitan areas in Virginia. Of the individuals found and counted in January, thirty percent (30%) are unsheltered, 35% meet the federal definition of chronically homeless, 70% have mental illness and/or substance abuse disorders, 38% are families with children, and 21% are veterans (Homelessness in Hampton Roads, 2010).

Homeless PLWHA deserve special attention due to high morbidity and mortality, numerous barriers to care, and challenges to adherence. According to the 2008 ‘In Care’ Needs Assessment, fully 44% of the “In Care” survey respondent group (N=134 of 304) reports a current or previous period of homelessness, indicating a severe degree of housing instability within this consumer group.

Over 10% of the 2008 In Care respondents reported current homelessness; 13% have been homeless in the past two years but not now; and 21% have been homeless longer than two years ago but not now. Half of the Out of Care are currently homeless, with a total of 80% reporting current or prior homelessness (2007 Needs Assessment). These findings indicate high level challenge in successfully facilitating entry and retention in HIV primary care and services, with moderate risk for impending homelessness. Homelessness

often predisposes PLWHA to other high-risk behaviors, including prostitution and substance use. For homeless persons, healthcare access may be limited and is often superseded by needs for food and shelter.

## MENTAL ILLNESS

By applying prevalence rates from national epidemiological studies and the 2009 National Household Survey of Drug Use and Health to 2009 Population by Age and Sex estimates, the Weldon Cooper Center for Public Services at the University of Virginia, the Virginia Department of Behavioral Health and Developmental Services estimates that:

- Approximately 316,552 adults have had a serious mental illness during the past year.
- Between 85,129 and 104,046 children and adolescents have a serious emotional disturbance, with between 47,294 and 66,211 exhibiting extreme impairment.

### NORFOLK TGA/REGION 5: MENTAL ILLNESS, 2009

PERCENTAGE OF REGION 5 POPULATION:	18 OR OLDER	18-25 YEARS
SERIOUS PSYCHOLOGICAL DISTRESS	10.6%	19.9%
HAVING AT LEAST ONE MAJOR DEPRESSIVE EPISODE	7.1%	10.9%

Source: NSDUH/SAMHSA, 2009 (National Survey of Drug Use and Health by the Substance Abuse & Mental Health Services Administration)

The average percentage of Region 5 residents in the Norfolk TGA who experienced “Serious Psychological Distress” in the past year is 10.6% (increasing to 20% among Youth, ages 18-25 years). Those reporting at least one major depressive episode in the past year is estimated to be 7.1% (increasing to 11% among youth, ages 18-25 years) (NSDUH, 2008, SAMHSA).

The estimated prevalence of Serious Mental Illness includes Hampton-Newport News (12,968); Virginia Beach (17,185); Chesapeake (8,670); Norfolk (9,422); Portsmouth (3,895); and Peninsula (5,969) (2009 Prevalence Estimates by Virginia Community Service Boards by Region, Comprehensive State Plan 2010-2016).

A recent US Department of Defense (DOD) study of the mental health needs of service members returning from Iraq and Afghanistan asserts that “combat imposes a psychological burden that affects all combatants, not only those vulnerable to emotional disorders or those who sustain physical wounds” (DOD, Defense Health Board, 2009). Half of military veterans and their families face significant mental health challenges. Based on current rates of diagnosis reported by the Veterans Administration (VA) for recently discharged veterans seeking care, if historic trends in the Norfolk TGA continue, Norfolk could face a 15-20% surge in those seeking behavioral health services over current levels (Virginia Department of Behavioral Health and Developmental Services, Comprehensive State Plan 2010-2016.)

Nationally, only 12% of persons with SMI receive treatment for mental illness (SAMHSA, 2009.) Over half, or fifty five percent (55%) of PLWHA respondents to the 2008 Needs Assessment (N=167 of 304) reported a history of mental health issues, and most reported more than one disorder. Sixty five percent (65%) of PLWHA survey respondents affirmed medical treatment for their mental health disorders. Thirty five percent (35%) reported that they were not currently receiving treatment and/or taking medication(s) for their mental health disorders. This data may be interpreted to infer that lack of treatment represents a mental health care access issue.

## SUBSTANCE USE/INJECTION DRUG USE

Based upon the National Survey of Drug Use and Health, among persons aged 12 or older in the Eastern Region of Virginia, the percentage of the population that is alcohol dependent in the past year is 3.2% and those with any illicit drug dependence in the past year is approximately 2% in Region 5/Norfolk TGA (NSDUH, 2009).

When dependence on or abuse of any illicit drug or alcohol in the past year is considered, the proportion of the population increases to 7.9%. According to the 2009 Report of Community Service Board (CSB) Substance Abuse Services, the numbers of prevalent drug and alcohol dependence in the Norfolk TGA compared to the numbers served evidences substantial disparity.

### PREVALENCE OF SUBSTANCE ABUSE IN THE NORFOLK TGA BY CSB AREA, 2009

REGION 5	DRUG & ALCOHOL DEPENDENCE PREVALENCE	UNDUPLICATED # SERVED-2009
CHESAPEAKE	5,829	1,246
HAMPTON-NEWPORT NEWS	8,618	1,938
PENINSULA	3,923	1,000
NORFOLK	6,197	2,185
PORTSMOUTH	2,572	1,164
VIRGINIA BEACH	11,447	1,021
<b>TOTAL</b>	<b>38,586</b>	<b>8,554</b>

Source: NSDUH/SAMHSA, 2009

As evidenced in the above table, approximately 22% of those individuals deemed dependent on alcohol and/or drugs actually received treatment in the past year. For those needing but not receiving treatment for alcohol or illicit drug use is considered, fully 6.10% and 2.60% of the residents in the Norfolk TGA are considered to have an immediate unmet need for treatment (NSDUH, 2009).

Based on previous needs assessments, at least 40% of the PLWHA in the Norfolk TGA are estimated to be substance abusers. (Annual Needs Assessments, 2005-2008, Norfolk TGA) Data also purports that a substantial minority of the general population and a large proportion of our HIV-infected population has some history of injection drug use. Data collected from the Drug Enforcement Agency (DEA) indicated that the use of Cocaine “crack”, Heroin, and Marijuana are the major illicit drugs in the Eastern Virginia Region. (DEA, 2006)

It is estimated that HIV infection via injection drug use is on the rise and represents 19% of AIDS-prevalence and 12% of HIV prevalence in the Norfolk TGA, (when cases of IDU & MSM/IDU are considered) (VDH, 2010). Survey results from IDU who participated in the 2005 Needs Assessment (NA) study indicated that 75% of IDU/SA had dropped out of care. When asked the “reasons for dropping out of care”, results analyzed from focus group transcripts indicated that the most common reason was active substance use.

One fifth or 20% of the 2008 ‘Out of Care’ survey respondents, with unmet need for Outpatient/ Ambulatory Medical Care, reported IDU as their risk exposure mode, and fully 85% reported the active use of substances. The estimated cost of treating drug abusers is highly dependent upon whether treatment is rendered in an outpatient or residential setting. Based upon the NSDUH estimate of 2.6% with unmet need, approximately 170 PLWHA are estimated to have an unmet need for drug treatment. On an outpatient basis, it would cost about \$2,426/case for treatment for a total cost of \$412,420 (Norfolk TGA Expenditure Data, 2009). This is a fraction of the cost of treatment in a supportive transitional housing setting.

## UNINSURED

According to America’s Health Rankings, Virginia has a high rate of uninsured population at 13.6 percent in 2009 (United Health Foundation, 2009). According to the Community Health Solutions report, over 175,992 (greater than 11%) people are uninsured in the Norfolk TGA. This figure reflects uninsured estimates for the cities of Chesapeake, Hampton, Newport News, Norfolk, Poquoson, Portsmouth and Virginia Beach. It is estimated that 24% of the Currituck, North Carolina residents are uninsured (Annual Report, NC HD, 2009). The percentage of the general population in the Norfolk TGA receiving Medicaid benefits is approximately 8.9% (US Census Bureau, 2009). According to CAREWare data, 67% of PLWHA in 2009 reported no insurance, with high reliance on Ryan White funded services. Of the minority reporting some form of health insurance benefit, 12.5% reported Medicaid benefits; and 10.8 % reported Medicare benefits, with almost 8% reporting private insurance.

## POVERTY

In Virginia, the average proportion of residents who live at or below the poverty level in metropolitan areas is 12% as compared to 25% for those residing in non-metropolitan areas. Blacks in Virginia are the most impoverished, with over 24% living at or below 100% FPL. (Kaiser Family Foundation State Health Facts, 2009) Data from the U.S. Census Bureau indicates that greater than 450,000 or approximately twenty-five percent of the TGA’s population live at or below 300% of poverty.

Fully 22.7% of Norfolk’s families live at or below the federal poverty level (Institute for Children and

Poverty, Virginia, 2010) Twenty-five percent of African Americans in the TGA live in high poverty census tracts, compared to 6% or less of all other racial and ethnic groups. One in 565 homes in Virginia is in foreclosure (compared to 1 in 411 nationally) ranking Virginia #18 for its level of house foreclosures.

While the precipitous nature of poverty effects all populations. PLWHA face unique challenges and increased health disparities due to poverty. Homelessness, missed appointments, poor nutrition, transportation difficulties, and inability to pay rent or household utilities were among the major results of poverty. According to 2009 CAREWare data, the Part A PLWHA are an impoverished group: 100% report incomes at or below 300% FPL; 75% of the PLWHA report incomes at or below 100% FPL; and 94% <200% FPL. Foreign-Born: The Federation for American Immigration Reform (F.A.I.R) estimates that 98,675 or 6% of the Norfolk-Virginia Beach-Newport News, Virginia MSA is foreign-born, with a 9.9% share of immigrant stock.

In summary, according to the local area statistics and the results of the 2008 Comprehensive Needs Assessment Survey (N=304 PLWHA Respondents) the PLWHA residing in the TGA evidenced high levels of co-morbidities, including

- 60% other chronic illness;
- 55% diagnosis/ treatment of mental health disorder;
- 44% diagnosis/ treatment of substance abuse disorder;
- 44% current or previous homelessness;
- 42% previous STI; and
- 10.7% recent incarceration in the past year.

*These data evidence the substantial impact of co-morbidities on the cost of care for PLWHA in the TGA.*

## ASSESSMENT OF SEVERE NEED GROUPS

Six (6) special populations and the emerging population of Youth, ages 13-29 years comprise the Severe Need Groups (SNGs) within the service area, and are designated based upon their respective size in the Norfolk TGA PLWHA community, their disproportionate incidence or prevalence of HIV/AIDS given their size in the overall population, and their high percentage in the Out of Care group.

The SNGs currently include: African Americans, MSM, Women of Color, Substance Abusers/IDU, Rural PLWH/A, Veterans/Military, and the emerging population of Youth, ages 13-29 years. A full description of these six (6) severe need groups along with the emerging population of Youth, ages 13-29 years follows.

SPECIAL POPULATIONS V. GENERAL POPULATION V. OOC V. IN CARE, 2009

SPECIAL POPULATION	OVERALL % IN PLWHA	COMPARISON TO GENERAL POPULATION %	ESTIMATED COMPOSITION IN OUT OF CARE GROUP	PROPORTION OF TGA PMC CLIENTS 2009
1) AFRICAN AMERICAN	New AIDS 74% New HIV 76% PLWA 67% PLWH 72%	34%	18%	71%
2) MEN WHO HAVE SEX WITH MEN	New AIDS 29% New HIV 43% PLWA 42% PLWH 36%	MSM highest exposure group	14%	42%
3) WOMEN OF COLOR	New AIDS 30% New HIV 34% PLWA 27% PLWH 30%	13%	12%	24%
4) SUBSTANCE USERS/ INJECTION DRUG USE	New AIDS 6% New HIV 3% PLWA 14% PLWH 9%	SA: 32% IDU: 3%	33%	8.5%
5) RURAL	1.9% Peninsula locations except Newport News and Hampton	19.4%	6.5%	unk%
6) VETERANS/ MILITARY	PLWA 8.3% PLWH 5.4%	33% of general population has a military affiliation	Est. 16%*	unk%
7) EMERGING POPULATION: YOUTH, AGES 13-19 & 20-29	New AIDS: 17.4% New HIV: 49%	19%	UNK	9.5% (13-24 years)

(Sources: Column B: VA/NC HARS data, 2009; Column C – U.S. Census Bureau and VA/NC HARS data, 2008; Column D: 2008 Unmet Need Estimate)\* estimated that change in eligibility related to a stricter definition of ‘disabled’ enacted in 2004, that this figure could easily be as high as 23% due to PLWHA no longer eligible for military or veterans benefits. Column E: CAREWare data, 2009.)

## (1) AFRICAN AMERICANS:

*Unique Challenges:* The largest group in terms of AIDS incidence and prevalence, this group is highly interconnected with the MSM special population. An increasingly impacted community, due to bisexual practice and failure to disclose to heterosexual partners, are African American women. MSM-Blacks represent the highest HIV-epidemic among all identified special populations in the Norfolk TGA, especially younger MSM-blacks. Qualitative needs assessment and focus group data (collected annually from 2005 through 2008) demonstrate that this population experiences a significant degree of poverty, social stigma, familial isolation, homelessness, and cultural and religious barriers. In addition, surveys from the same focus group study indicate that 57% of MSM-black participants reported having “dropped out of outpatient/ ambulatory medical care” during the duration of their disease. As of December 31, 2009, African Americans comprise 72% of HIV prevalence, 67% of AIDS prevalence, 76% of HIV incidence and 74% of all AIDS incidence in the Norfolk TGA. In 2008, 18% of all African American PLWHA had unmet need (2008 Unmet Need Estimate), and comprise 70% or 1,167 of the 1,667 HIV unaware in the TGA. (2010 HIV Unaware Estimate, Norfolk TGA).

Means to retain in care: 1) Sensitivity to stigma by Case managers and Medical care providers related to sexual orientation and disclosure issues; 2) Significant issues related to skepticism about antiretroviral medications, side effects and medication adherence; 3) Need to jointly address substance use issues and HIV disease.

Part A Proportion/Out of Care profile: African Americans comprised almost 71% of the total 2009 Part A OAMC client profile (reduced from 74% in 2008), and 71% of the total Part A OAMC costs but only comprised a total of 734 PMC clients of all Part A clients (or 43.6% of the total Part A population). Equally composed of MSM and Substance Users is an estimated 18% of African Americans that are Out of Care (2008 Unmet Need Estimate.) *African Americans are estimated to comprise 70% of the HIV unaware proportion in the TGA (2010 HIV Unaware Estimate, Norfolk TGA).*

## (2) MEN WHO HAVE SEX WITH MEN:

*Unique Challenges:* MSM constitute the largest exposure group, with a majority presence of Black MSM. Issues with non-disclosure, presenting late to care and bisexual transmission affect this special needs group. Epidemiologically, when ‘any’ MSM are considered, MSM & MSM/IDU comprise 47% of AIDS prevalence; 39% of HIV prevalence; 44% of HIV incidence; and 31% of AIDS prevalence. MSM-Whites report a consistent decline in HIV-infection in the Norfolk TGA compared to MSM-African Americans.

Education, income, and presence of supportive social networks are among the variables that positively affect the outcomes of this population. However, when controlled for age, substance use, homelessness and mental health, the needs of this population increase, exponentially. Data from the 2005 and 2008 Needs Assessments indicated that active substance use, mental health issues, homelessness and young age positively correlate with increased acuity within the MSM population. Not only do these conditions impact on the physical health of the individual, but they also increase the propensity to engage in high-risk behaviors. The cost of providing care to this population is heavily contingent upon the availability of mental health and substance abuse services to meet the co-morbid conditions.

Means to retain in care: 1) Focus on young (20-29) Black and Anglo MSM experiencing spikes in incidence; 2) Jointly addressing HIV and substance use; 3) Further refining pre-release protocols to deal with significant incarcerated population and aid with community re-entry. In Part A OAMC/Out of Care profile: MSM comprise 42.28% of 2009 PMC clients by risk exposure group. (CAREWare, 2009) A high percentage with majority using substances or incarcerated with estimate of 14% MSM that are out of care. (2008 Unmet Need Estimate) MSM represent 38% of the HIV unaware in the TGA (*2010 HIV Unaware Estimate, Norfolk TGA*).

### **(3) WOMEN OF COLOR:**

*Unique Challenges.* This special group of PLWHA is primarily composed of African American (non-Latino) women of childbearing years. The epidemic of HIV-disease in the Norfolk TGA evidences a disparate increase in cases among women of color. Of the 3,235 newly diagnosed HIV/AIDS cases in Virginia between 2008 and 2009, 76 percent were African American and 26 percent were women. African American women are 20 times more likely to be diagnosed with HIV/AIDS than white women in Virginia. (VDH, 2010) In 2009, women represented 32.7% of new AIDS cases; 23.9% of new HIV cases; over 27% of AIDS prevalence and over 29% of HIV (not-AIDS). Determinants identified in the TGA which significantly impact the HIV-disease epidemic among women are: 1) lack of self-efficacy with negotiating condom use; 2) unknowingly becoming infected during a marriage or long-term relationship with an infected male partner; 3) commercial sex behaviors; 4) history of injection drug use; 5) history of multiple sex partners; and, 6) lack of prevention education. Furthermore, it is estimated that >50% of all women with HIV-disease in the Norfolk TGA are single heads of household. According to results from the 2005-2008 Needs Assessment surveys, an average of 40% of our female samples reported a history of substance use. In addition to substance use, gynecologic issues significantly impact upon the cost of providing care to women in the Norfolk TGA. In 2008 women represented 78% of all Chlamydia (CT) cases and 57% of all Gonorrhea (GC) cases in the Norfolk TGA. (VDH Surveillance Data, 2009) Although the TGA has been extremely proactive in reducing the rates of sexually transmitted disease along with perinatal transmission, it is imperative that primary care visits not only address HIV/STI-related issues; but family planning, contraception, and risk reduction. According to our largest health care provider (EVMS), it is estimated that over 30% of HIV-positive women have co-infection with HPV, which impacts the cost of care to this population. Many women in the TGA report co-morbidity with mental health issues. Similar to the barriers associated with substance abuse, women with acute and chronic mental health issues (primarily depression) reported that they were less likely to adhere to medical care and were more likely to engage in risky behaviors. Means to retain in care: 1) Continue to develop more female-friendly care protocols specifically addressing broader family planning/gynecologic and related care; 2) Ensure sensitivity of case managers to issues related to women ranging from child care concerns to family-friendly housing to need to address broader family including financial management, educational concerns and care plan addressing female health; 3) Continue to address issue of transportation to medical and oral health care services through advance scheduling of appointments; and, 4) Expand women-specific social support groups for female PLWHA who report high levels of isolation and marginalization owing to their HIV disease. Out of Care profile. Women of color comprised 24% of 2009 Part A OAMC clients, as compared to their higher proportions in the local epidemic. With late presentation in advanced form of disease, many were unaware that they had been exposed or were at risk. Once entering care, compliance levels are high (based on QM audits of Primary Care Providers). The 2008 unmet need study estimates that 12% of Women are out of care. Women are estimated to comprise 28% of the HIV unaware proportion in the TGA (*2010 HIV Unaware Estimate, Norfolk TGA*).

#### **(4) SUBSTANCE USERS/INJECTION DRUG USERS:**

*Unique Challenges:* IDU currently comprise 6% of new AIDS cases, 3% of new HIV cases, 14% of PLWA and 9% of PLWH. When the total IDU risk is considered (combining IDU and MSM/IDU), the total proportion attributable to IDU increases to over 18% among PLWA and increases to over 11% among PLWH. Even larger is the issue is non-injection substance abuse with estimates of 44% PLWHA who are actively using illicit substances (2008 TGA Needs Assessment). Unique challenges of providing services to this population are the high propensity for non-adherence to medical treatment; and the reluctance (or inability) to abstain from substance use. Survey results from IDU who participated in the OOC NA study indicated that 75% of IDU/SA had dropped out of care. When asked the “*reasons for dropping out of care*”, results analyzed from focus group transcripts indicated that the most common reason was active substance use. The Norfolk TGA used these findings to improve outreach-case finding and services among IDU.

The challenge for the HIV service system with providing care to this population is treating the substance use (including injection drug use) before/or in tandem with providing HIV-care. This impacts the cost of providing care to this population. It is clear that active addiction can be challenging to adherence to HIV medical care. Although there are significant costs associated with substance abuse treatment (especially methadone programs for heroin) it must be in combination with HIV-Outpatient/ Ambulatory Medical Care to reduce the morbidity within the population. Means to retain in care: 1) Develop harm reduction models of housing and case management with re-education of PLWHA with substance use issues of availability of such services 2) Enhance treatment adherence protocols and peer support for HIV medication adherence.

*Out of Care profile:* IDU constitute 9% of Part A funded OAMC services in 2009, according to CAREWare. IDU/Substance Users constitute the highest estimated percentage (33%) of Out of Care (2008 Unmet Need Estimate), and are estimated to comprise 15% of the HIV unaware, when ‘any’ IDU are considered. (2010 HIV Unaware Estimate, Norfolk TGA)

#### **(5) RURAL PLWHA:**

*Unique Challenges:* The total population of the rural areas is approximately 317,467 with an estimated 347 People Living With HIV/AIDS (based upon an analysis performed in 2007). This equates to a 109.3 HIV/AIDS case rate compared to the urban areas with an overall population of 1,322,845; 4,897 PLWHA and a case rate of 370.2. While it is not a surprise that the urban case rate is over three times that of rural areas, key non-metropolitan localities (i.e. Newport News, Portsmouth, and Chesapeake) exceed the Virginia and U.S. PLWHA case rates. Though improving, this is an issue of concern since transportation is such a barrier in the TGA. Outpatient/ Ambulatory Medical Care services are now offered in a branch setting located in Williamsburg, and efforts have been successful in enhancing locally-based services, inclusive of medical case management, oral health care and outreach services. The delivery of oral health services on the Peninsula is greatly equalizing geographic parity.

*Means to retain in care:* A key issue is the continued emphasis on further augmenting transportation to medical care and services, and maintaining access to expanding satellite services in the rural areas. Out of Care profile: Rural PLWHA are estimated to compose 7% of out of care. (2008 Unmet Need Estimate)

## **(6) VETERANS/MILITARY**

*Unique Challenges:* Due to Norfolk's high concentration of active and retired military, an accurate count of HIV-positive is difficult, compounded by the 'don't ask, don't tell' policy for gays in the military. Successful efforts were rewarded with preliminary data on active military receiving medical care for HIV from the Department of Defense. Over 2% of the 2009 Part A clients report other public benefits, including VA benefits.

*Means to retain in care:* 1) Coordination of benefits with Department of Defense and Veterans Administration officials given high proportion of retired military in the Norfolk general population and the TGA. 2) Maintain/expand implementation of Health Insurance Premium Payments and Continuation to ensure coverage of PLWHA.

*Out of Care profile:* Veterans are increasingly seeking assistance from the Ryan White Part A program. Current estimates are that 16% of veterans are out of care, but further study needs to occur in the context of an out of care study, with focus on this special population (2008 Unmet Need Analysis).

*The emerging population of Youth, ages 13-29 years: Youth, ages 13-29 years comprised 49% of the emergent HIV infection reported in 2007-2008, and comprise growing numbers of PLWHA. In 2009, Youth ages 13 to 19 years comprised 6% of AIDS incidence; 9% of HIV incidence; 7% of HIV prevalence; and 4% of AIDS prevalence.*

With the exception of a few "teen clinic programs" in local health departments (Norfolk, Portsmouth, Hampton, Newport News and Virginia Beach) and Planned Parenthood of Southeastern Virginia, most youth receive health care through private or public health providers. The downside to this infrastructure is the issue of parental involvement, and less youth autonomy regarding sexual health care. Analysis of focus group data indicated that approximately one-third (25.7%) were diagnosed with HIV or AIDS between the ages of 16 and 24. Due to the clinical spectrum of infection, it is deduced that these individuals were diagnosed between ages 20-29 were infected during their teen years. The cost of providing care to this population centers on creating a "youth-friendly" infrastructure to address the unique needs of youth and aggressively providing outreach-case finding services to infected youth to facilitate access to and retention in care. Youth represented only 6.45% of all Part A clients and 7.42% of all Part A funded Outpatient/Ambulatory Medical Care services in 2008, but in 2009 the number of Youth ages 13-24 years increased 29%, increasing access from 77 to 99. If 'behaviorally infected' (the majority), the 'adult-only' Ryan White Part A providers now serve persons that are younger than 18; removing barriers to care for this population.

*Project Design for the 'In Care', 'Newly Diagnosed' and 'Out of Care' PLWH/A Needs Assessment Studies*

## TARGET SAMPLE SETS

TOTAL PLWHA	IN CARE	OUT OF CARE	NEWLY DIAGNOSED
6,548	4,532	2,016	872
327 surveys to complete	227 surveys to complete	100 surveys to complete	44 surveys to complete (sub set of the 327 surveys)
271 completed (83% of goal)	229 completed (101% of goal)	42 completed (42% of goal)	45 completed (102% of goal)

The objective of the comprehensive ‘In Care’ Needs Assessment Study was to identify the extent and types of service Uses, Needs, Gaps and Barriers among PLWH/A participating in Ryan White funded services in the Norfolk TGA service area. The survey process was designed to target as high a level of participation as possible among the severe needs groups (N=227). The actual participation rate for ‘In Care’ survey respondents was 229 participants in the 2011 Needs Assessment process (101% of goal). Survey sources evidenced a balanced representation among Primary Medical Care and Medical Case Management providers.

The objective of the comprehensive ‘Newly Diagnosed’ Needs Assessment Study was to identify the demographics and characteristics of the Newly Diagnosed/New to Care PLWH/A, including their prevention and service needs and perceived barriers to testing and care, which may help the TGA to increase engagement with and retention in care while reducing the fractions of unmet need and Unaware in the service delivery area, and meet the HRSA EIIHA mandate. All AOMC clients who had entered care over the previous year were offered the opportunity to participate in the survey process. A total of 45 PLWH/A participated in the 2011 Newly Diagnosed survey process (102% of goal).

The objective of the ‘Out of Care’ Needs Assessment study was to better understand the evolving service Needs, Gaps and Barriers among OOC PLWH/A in the Norfolk TGA service area. A total of 42 PLWH/A with unmet need participated in the 2011 Out of Care survey process (42% of goal).

## CHAPTER 2: ‘IN CARE’ SURVEY FINDINGS

### INTRODUCTION

As of December 31, 2009, there were 6,548 PLWHA reported as living in the TGA, representing a 4.4% increase from 2008 (6,271). The TGA comprises over 31% of the total living cases reported throughout the state of Virginia as of 12/2009 (N=21,071). Of the 6,548 PLWHA, 3,716 (56.8%) are PLWH and 2,832 are PLWA (43.2%). The increase in prevalence rates appears to be due to the efficacy of multi-drug treatments for HIV infection, which have sharply reduced HIV-related death (2010 VDH Epidemiologic Profile)

Surveys were conducted throughout the TGA from February to June of 2011. The objective of the comprehensive ‘In Care’ Needs Assessment Study was to identify the extent and types of service Uses, Needs, Gaps and Barriers among PLWH/A in the Norfolk TGA service area. Additional reasons for conducting the needs assessment process were to:

- inform the FY 2012 Priority Setting and Resource Allocation;
- inform the TGA’s FY 2012 Comprehensive Plan;
- inform the FY 2012 Part A Grant Application; and
- guide service delivery decisions throughout the TGA

## DEMOGRAPHICS

### GENDER & RACE/ETHNICITY

A total of 229 PLWH/A participated in the 2011 ‘In Care’ needs assessment process. The demographic profile of the 2011 ‘In Care’ Survey Respondents reflects the local TGA’s PLWH/A epidemiologic profile and includes:

- 62% male, 35% female, 2% transgender (all male to female)
- 75% African American, 17% White, 4% Hispanic, 0.4% respectively American Indian & Asian/Pacific Islander, 2% Multi-racial, 0.4% Other (Dominican

### COMPARISON OF SURVEY RESPONDENTS’ DEMOGRAPHIC PROFILE COMPARED TO EPIDEMIOLOGIC TRENDS...CHART CONTINUES ON PG. 44

CATEGORY	IN CARE-2011	EPI	% DIFFERENCE
AGE	42	43	-1 year from EPI
GENDER	62% Male 35% Female 2% TG	71% Male, 29% Female	Slightly higher male
RACE/ETHNIC	75% African American, 17% White, 4% Hispanic, 2% Multiracial	70% African American, 24% White, 4% Hispanic, 2% Multiracial	Slightly higher AA, Slightly lower White, Equal Hispanic & Multiracial

CATEGORY	IN CARE-2011	EPI	% DIFFERENCE
TRANSMISSION	37% MSM, 34% Heterosexual, 12% IDU	38% MSM, 19% Hetero, 11% IDU, 4% MSM/IDU, 27% NIRR	Close on MSM, Higher Hetero response, Close on IDU
HIV STATUS	84% HIV, 16% AIDS	57% HIV, 43% AIDS	Much higher HIV response (could be self reporting error)

## AGE RANGES OF 2011 SURVEY RESPONDENTS

The 2011 Norfolk TGA survey respondent group is primarily a middle-aged to older group of PLWH/A, but includes strong representation from the emerging population of Youth, ages 20-29 years (N=43), comprising almost 20% of the entire respondent group.

## AGE RANGES OF 2011 PLWH/A SURVEY RESPONDENTS

AGE RANGE	NUMBER	PERCENT
0-12 YEARS	0	0%
13-19 YEARS	3	1.3%
20-29 YEARS	43	19%
30-39 YEARS	40	18%
40-49 YEARS	76	33%
50-59 YEARS	48	21%
60-69 YEARS	15	7%
70+ YEARS	3	1.3%
<b>TOTAL</b>	<b>228</b>	<b>100%</b>

## SEXUAL ORIENTATION

The majority of the 2011 respondents report their sexual orientation as straight or heterosexual; 30% identify as gay and 10% identify their sexual orientation as bi-sexual. Almost 5% of the respondents declined to answer the question and 2% reported 'other', indicating transgender.

## RISK TRANSMISSION MODE

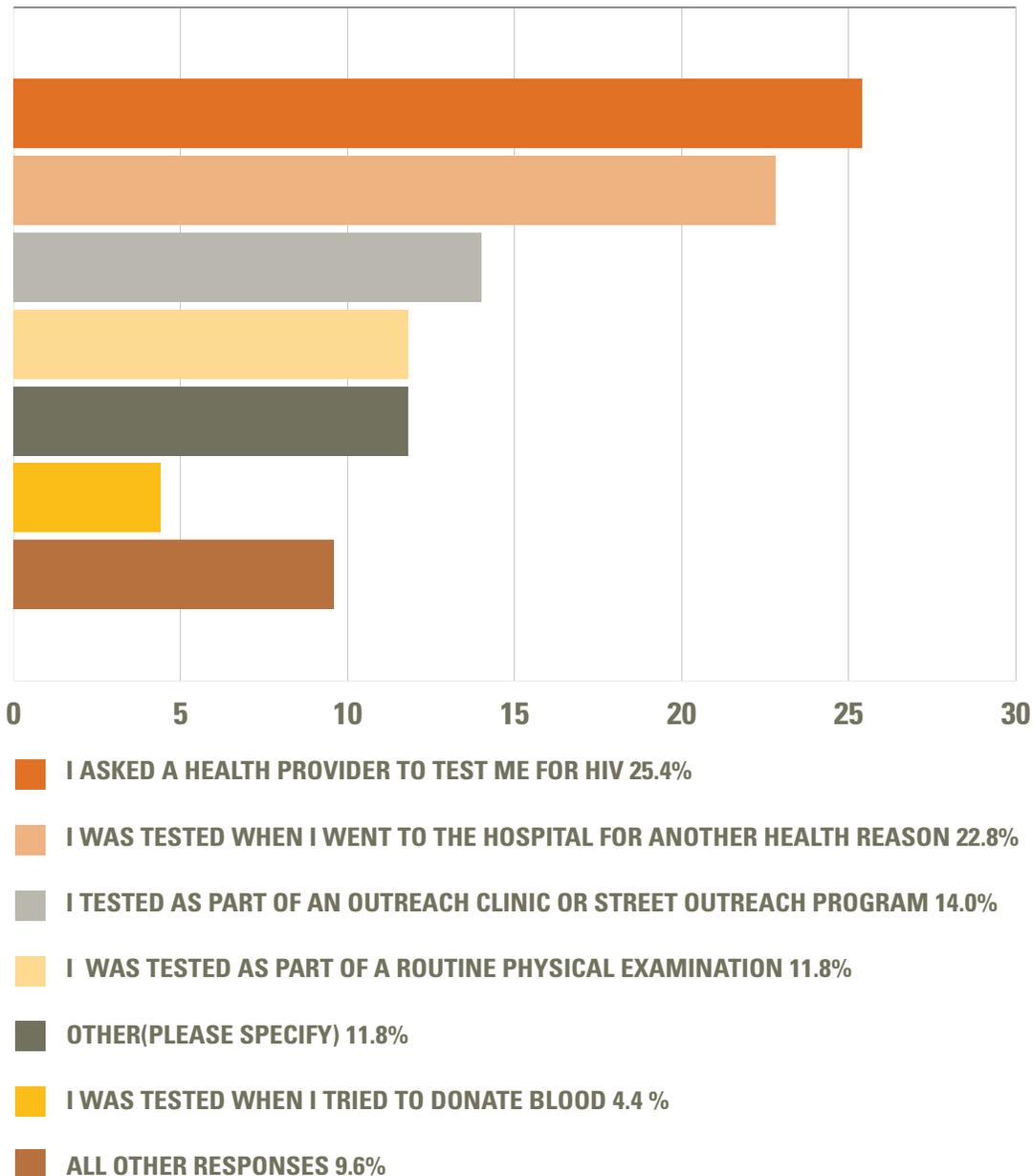
As evidenced below, MSM is the most frequently reported HIV risk behavior at 37%, followed by Heterosexual sex (34%), and IDU (12%). A higher than desired proportion report that they do not know how they acquired HIV (12%), and an additional 8% reports sex with a drug user as their risk exposure mode. The remaining respondents identified Mother with HIV/AIDS (1%), sexual assault (2%), prison (1%) and transfusion (0.5%) as their risk exposure modes. The six respondents reporting "other", sited prostitution, female sex with female, "husband had it", and "no protection" for their means of acquiring HIV.

DO YOU KNOW HOW YOU MAY HAVE ACQUIRED HIV/AIDS? (PLEASE CHECK ALL THAT APPLY.)		
ANSWER OPTIONS	PERCENT	COUNT
MALE SEX W/ MALE	36.8%	77
HETEROSEXUAL SEX	34.4%	72
INJECTION DRUG USE	12.4%	26
HEALTH CARE WORKER	0.0%	0
SEX W/ DRUG USER	7.7%	16
MOTHER W/ HIV/AIDS	1.4%	3
SEXUAL ASSAULT	1.9%	4
PRISON	1.4%	3
TRANSFUSION	0.5%	1
UNKNOWN	12.0%	25
OTHER (PLEASE SPECIFY)	2.9%	6
ANSWERED QUESTION 209		

## TESTING CIRCUMSTANCES

Fully one-quarter of the 2011 respondents were tested upon a voluntary request. Fourteen percent were tested as part of an outreach testing program. Almost another 25% were tested when in the hospital or ER for treatment of another condition. Almost 12% report being tested as part of routine medical care and another 4% report testing as part of their routine prenatal care. Over 4% report being tested at the request of a partner/friend/family member. The remaining 12% of respondents offered numerous other reasons for being tested for HIV, including: 12 respondents were tested while in jail or prison; “child born positive” (1); “got sick and asked for test” (1); “one of my partners died from AIDS” (1) “STD” (3); “tested for military” (3); “the person I had been with told me” (1); “tested because of work” (1); “tested at methadone clinic” (1); “tested because of rape at 12 years of age” (1); and “testing as part of the partner notification process”(1).

## HOW DID YOU FIND OUT YOU WERE HIV POSITIVE



## LOCATION OF HIV DIAGNOSIS

The majority of all of the 2011 PLWH/A survey respondents (N=156 or 80%) reported learning their HIV or AIDS status in Virginia, with the majority of those reporting Norfolk, VA as the location of HIV diagnosis (N=60); followed by Virginia Beach, VA (19); Newport News, VA (18); Portsmouth, VA (10); Chesapeake, VA (9); Richmond, VA (13); Suffolk, VA (7); Hampton, VA (6); with 14 others reporting various other Virginia locations. Approximately 20% (or 40) of all the respondents reports the receipt of their first HIV/AIDS diagnosis *in a state or location other than Virginia*. The cities/states most frequently identified included: Georgia (2); Maryland (3); Florida (5); North Carolina (3); Connecticut (2); California (3); New Jersey (3); New York (6); Ohio (2); Pennsylvania (1); South Carolina (2); Virgin Islands (1); Washington, DC (3); and West Virginia (2). Two respondents report first learning their HIV status in Africa

## EVER HOMELESS

ARE YOU NOW OR HAVE YOU EVER BEEN HOMELESS?		
ANSWER OPTIONS	PERCENT	COUNT
NEVER	53.4%	94
CURRENTLY HOMELESS	11.4%	20
BEEN HOMELESS IN PAST 2 YEARS, BUT NOT NOW	18.8%	33
BEEN HOMELESS LONGER THAN PAST 2 YEARS, BUT NOT NOW	16.5%	29
ANSWERED QUESTION 176		

A high proportion of the 2011 In Care respondent group reports current homelessness (11%) or previous homelessness (19% in past two years but not now) and 17% report a period of homelessness longer than two years ago but not now, *yielding a 36% previous rate of homelessness and a 47% rate of ever homeless*. This indicates a high level of fragility and challenges for these PLWH/A in maintaining an active In Care status.

## CURRENT HOUSING SITUATION

DO YOU CURRENTLY?		
ANSWER OPTIONS	PERCENT	COUNT
OWN YOUR HOME	6.6%	13
RENT	54.1%	106
LIVE WITH A FRIEND/ RELATIVE	30.1%	59
STAY IN A SHELTER	4.6%	9
OTHER (PLEASE SPECIFY): LIVE W/PARTNER; HALFWAY HOUSE; PUBLIC HOUSING; HOMELESS; AND DID NOT SPECIFY	4.6%	9
ANSWERED QUESTION 196		

The majority of the In Care respondents reports renting their home (54%), while a sizeable minority (30%) report temporary housing, living with a friend or relative. A small minority--almost 7% report owning their home, while almost 5% report that they currently stay in a shelter. The 'other' responses evidence a high degree of housing instability, with reports of homelessness, staying in a halfway house or residing in public housing. Twenty nine percent (29%) of the 2011 respondents report the receipt of housing/rent assistance, and cite the various sources of support, including: ACCESS, friends and family, Home and Health Support, HUD, Housing Solutions, Parents and Partners, Planning Council, Section 8, SSI, TACT, and Urban League.

## ZIP CODE OF RESIDENCE

The 2011 respondents report numerous zip codes of residence across the service delivery area. The top reported zip codes of residence for the 2011 respondents include the following: 23434 (10); 23453 (13); 23462 (11); 23503 (17); 23504 (27); 23508 (9); 23513 (9); 23607 (22); and 23669 (13).

## EMPLOYMENT & INCOME

Over 42% of the In Care respondents reports being currently employed, however the vast majority of respondents (85%) report incomes at or below \$19,999 annually. Many PLWH/A respondents report that at least 2-3 persons are supported by this level of income, with an average report of 1.64 persons in the household who are supported by the stated income.

## EDUCATION LEVEL

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?		
ANSWER OPTIONS	PERCENT	COUNT
GRADE SCHOOL	3.6%	7
SOME HIGH SCHOOL	24.4%	47
HIGH SCHOOL DEGREE/ GED	34.7%	67
SOME COLLEGE	22.3%	43
COLLEGE DEGREE	9.8%	19
SOME GRADUATE SCHOOL	0.5%	1
GRADUATE SCHOOL DEGREE	4.7%	9
ANSWERED QUESTION 193		

As evidenced in the table above, over one-quarter of the 2011 In Care respondents reports some high school or grade school. Over 1/3 or 35% report a high school diploma or GED. Over 1.5 of the respondents reports some college and almost 10% report a college degree. Almost 5% report the acquisition of a graduate level degree.

## RECENT JAIL OR PRISON STAY

HAVE YOU BEEN IN JAIL OR PRISON IN THE PAST 6 MONTHS?		
ANSWER OPTIONS	PERCENT	COUNT
YES	10.7%	19
NO	89.3%	159
ANSWERED QUESTION 178		

A sizeable minority of the 2011 Norfolk TGA In Care respondents (11%) reports a recent stay in jail or prison over the past 6 months.

## HEALTH INSURANCE STATUS

DO YOU CURRENTLY HAVE HEALTH INSURANCE?		
ANSWER OPTIONS	PERCENT	COUNT
PRIVATE HEALTH INSURANCE (HUMANA, AETNA, ETC.)	9.0%	19
MEDICARE	7.6%	16
MEDICAID	14.8%	31
VA	0.5%	1
NONE	56.2%	118
OTHER (PLEASE SPECIFY): PRIMARILY MEDICARE & MEDICAID IN COMBINATION	11.9%	25
ANSWERED QUESTION 178		

Over half of the 2011 In Care respondents report a lack of health insurance (56%). Almost 15% report Medicaid benefits; 8% report Medicare; and 9% report private health insurance. The 12% reporting 'other' cited a combination of Medicaid and Medicare for their health care coverage.

## HIV/AIDS STATUS

### LOCATION OF HIV PRIMARY CARE PROVIDER

WHAT CLINIC/DOCTOR'S OFFICE DO YOU GO TO FOR YOUR HIV CARE?		
ANSWER OPTIONS	PERCENT	COUNT
EVMS	38.3%	79
PICH	13.6%	28
PORTSMOUTH NAVAL	0.0%	0
VA	4.4%	9
HEALTH UNIT (PRISON)	0.0%	0
NDPH	1.9%	4
NCHC	18.4%	38
HEALTH DEPARTMENT	14.6%	30
OTHER (PLEASE SPECIFY): PRIVATE PRACTICE; EVMS & HD;EVMS & PORTSMOUTH NAVAL; ID SPECIALIST; EVMS & PARK PLACE CENTER	8.7%	18
ANSWERED QUESTION 206		

### PRIMARY CARE VISIT AND LAB MONITORING INDICATORS OF “IN CARE” STATUS

The majority of the 2011 PLWH/A respondents evidence an excellent active “In Care” status, with 200 (or 88% of the respondents) reporting having seen their physician within the past 1-6 months; and 178 and 175, respectively, reported receiving CD4 cell count and viral load measures within the past six months or less.

It is notable that a minority of the ‘In Care’ respondents report an “erratically” In care status, having been to see their physician 7-12 months ago. (N=9 or 4% of the total number of respondents.)

Seven respondents (N=7 or 3%) of the total respondent group report a technically ‘Out of Care’ status for greater than one year.

## LAST DOCTOR VISIT AND LAST LAB MONITORING VISIT PATTERN

VISIT TIME FRAME	DOCTOR	CD4	VIRAL LOAD
PAST 3-4 MONTHS 1/11-4/11 (IDEAL 'IN CARE' STATUS)	143	123	120
PAST 4-6 MONTHS 10/10-12/10 (SATISFACTORY 'IN CARE' STATUS)	57	55	55
PAST 7-9 MONTHS 7/10-9/10 (ERRATICALLY 'IN CARE' STATUS)	5	7	7
PAST 10-12 MONTHS 4/10-6/10 (ERRATICALLY 'IN CARE' STATUS- AT RISK OF UNMET NEED)	4	3	4
<b>TOTAL 'IN CARE'</b>	<b>209</b>	<b>188</b>	<b>186</b>
TECHNICALLY 'OUT OF CARE' UNMET NEED IN 2010-11,	2	0	0
OUT OF CARE > ONE YEAR (OOC SINCE 2008 OR BEFORE)	5	3	0
NEVER IN CARE	0	0	0
TOTAL OUT OF CARE	7	3	0
<b>GRAND TOTAL</b>	<b>216</b>	<b>191</b>	<b>186</b>

## ART

Over  $\frac{3}{4}$  or 77% of the 2011 In Care respondents reports the current receipt of antiretroviral therapy.



Almost 2/3 of the 2011 respondents (63%) report the use/abuse of alcohol and other substances. As evidenced in the figure above, a minority of PLWH/A report the regular daily use of alcohol (N=7), Marijuana (N=5) of heroin (N=1).

The weekly reports of substance use increase to 27 persons for alcohol and remain steady for marijuana and heroin (5 and 1, respectively).

Cocaine is reportedly used weekly by two respondents and crack is reported as used weekly by one respondent. Additional respondents report the monthly average use of alcohol (10); cocaine (2); crack (2); and marijuana (2).

None of the 2011 In Care respondents admits to injection drug use at the present time, but 19% report the previous practice. Only two respondents reported sharing works previously, one “always disinfecting” and one “sometimes disinfecting” their works prior to sharing needles.

## SEXUALLY TRANSMITTED INFECTIONS

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR SEXUALLY TRANSMITTED DISEASES (STD)?		
ANSWER OPTIONS	PERCENT	COUNT
YES	56.0%	122
NO	43.6%	95
DON'T KNOW	0.5%	1
ANSWERED QUESTION 218		
IF YOU ANSWERED YES, WHICH STD?		
ANSWER OPTIONS	PERCENT	COUNT
GONORRHEA	49.6%	61
SYPHILIS	28.5%	35
CHLAMYDIA	27.6%	34
ANSWERED QUESTION 123		

As evidenced above, almost half of the ‘In Care’ respondents who answered this question report a history of Gonorrhea; with 29% reporting treatment for syphilis and 28% reporting treatment for Chlamydia. “Other” reports of STIs included: Crabs, genital warts (N=5), genital herpes (N=6), PID, Trichomonas, Hepatitis C, and yeast infections.

## DIAGNOSIS & TREATMENT FOR OTHER ILLNESSES/CHRONIC CONDITIONS

Over one-quarter or 28% of the 2011 In Care respondents reports having been diagnosed and/or treated for other conditions including:

### OTHER ILLNESSES/CHRONIC CONDITIONS

- Arthritis, allergies
- Cancer
- Cervical Cancer
- Cryptococcus
- Diabetes and HTN (3)
- Diabetes, Heart Problems, High Blood Pressure, High Cholesterol, Lung/Breathing Problems, Neuropathy
- Problems with Thought/Memory
- GERD
- End Stage Renal Disease-Kidney failure
- HEP B (6)
- HEP C (6)
- Hepatitis, High Blood Pressure, High Cholesterol, and Stroke
- Hepatitis, Liver Problems, PCP Pneumonia, and Emotional Problems
- Herpes (2)
- High Blood Pressure and Thyroid Disease
- High Blood Pressure, Diabetes
- Hypertension and Hypoglycemia
- Insomnia
- Mononucleosis
- Sickle Cell Disease

### USE, NEED, BARRIER & GAP RANKING

A Need, Use, Barrier and Gap ranking was developed for all Norfolk TGA survey respondents, with rankings developed for each special population. The 2011 HIV/AIDS Needs Assessment provides a “snapshot” of community service uses, needs, barriers, and gaps as expressed by consumers of HIV related services in the service area. The rankings of the Needs Assessment are displayed for all ‘In Care’ respondents, with separation by Special Population, and are defined as:

## USE NEED BARRIER GAP

- Number of 'In Care' client survey respondents who indicated service use in the past year
- Number of 'In Care' client survey respondents who stated "I currently need this service."
- Number of 'In Care' client survey respondents who indicated that a service is 'Hard to Get'.
- Sum of 'In Care' client survey respondents who answered 'Yes' to Need and 'No' to availability of that service

2011 ALL IN CARE PLWH/A USE, NEED, BARRIER, GAP MATRIX (N=229)...CHART  
CONTINUES ON PG. 57

SERVICE CATEGORY DESCRIPTION	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
MEDICATION ASSISTANCE	1	2	2	2
AMBULATORY OUTPATIENT MEDICAL CARE	2	1	10 tie	9
HOUSING ASSISTANCE	3	7	1	1
NUTRITION ASSISTANCE	4	6	6 tie	5
MENTAL HEALTH/SUPPORT GROUPS	5	5	5	6
MEDICAL TRANSPORTATION	6	4	3	3
OTHER: EMPLOYMENT ASSISTANCE	7 tie	13 tie	9	12 tie
HEALTH EDUCATION/PEER EDUCATORS	7 tie	10	NR	13
HEALTH INSURANCE/ PREMIUM ASSISTANCE	8	9	4	4
EMERGENCY FINANCIAL ASSISTANCE	9	13 tie	7	8
MEDICAL CASE MANAGEMENT	10	3	NR	15
ORAL HEALTH CARE	11	8	6 tie	7

SERVICE CATEGORY DESCRIPTION	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
SUBSTANCE ABUSE SERVICES	12	12	nr	17
HIV PREVENTION/ CONDOMS	13	13 tie	NR	nR
*OTHER : CLOTHING	14	11	NR	16
OUTREACH	15 tie	13 tie	NR	NR
OTHER: VISION CARE	15 tie	NR	8 tie	12 tie
OTHER: MEDICAL/ SURGICAL/GYN SPECIALTY CARE	NR	NR	10 tie	14
OTHER: DISABILITY ASSISTANCE/SSI/MEDICAID	NR	NR	10 tie	10
OTHER: HELP WITH MEDICAL & MH CO-PAYS	NR	NR	11	11

### THE TOP 12 RANKING SERVICE NEEDS OF THE 2011 NORFOLK TGA 'IN CARE' SURVEY RESPONDENT GROUP:

1. Medication Assistance
2. Ambulatory Outpatient Medical Care
3. Housing Assistance
4. Nutrition Assistance
5. Mental Health/Support Groups
6. Medical Transportation
7. Other: Employment/Job Assistance
8. Health Insurance/Premium Assistance
9. Emergency Financial Assistance
10. Medical Case Management
11. Oral Health Care &
12. Substance Abuse Services

## THE TOP 12 RANKING SERVICE USES OF THE 2011 NORFOLK TGA 'IN CARE' SURVEY RESPONDENT GROUP:

1. Ambulatory Outpatient Medical Care
2. Medication Assistance
3. Medical Case Management
4. Medical Transportation
5. Mental Health/Support Groups
6. Nutrition Assistance
7. Housing Assistance
8. Oral Health Care
9. Health Insurance/Premium Assistance
10. Health Education/Peer Educators
11. Other-Clothing Assistance
12. Substance Abuse Services

## THE TOP 12 RANKING SERVICE GAPS OF THE 2011 NORFOLK TGA 'IN CARE' SURVEY RESPONDENT GROUP:

### HOUSING ASSISTANCE

1. Medication Assistance
2. Medical Transportation
3. Health Insurance/Premium Assistance
4. Mental Health/Support Groups
5. Oral Health Care tied with Nutrition Assistance
6. Emergency Financial Assistance
7. Other: Vision Care tied with Other Medical/Surgical/GYN Specialty Care
8. Other: Employment Assistance
9. Other: Disability Assistance tied with AOMC
10. Other-help with Medical & MH Co-Pays
11. NR

## THE TOP 12 RANKING SERVICE BARRIERS OF THE 2011 NORFOLK TGA 'IN CARE' SURVEY RESPONDENT GROUP:

1. Housing Assistance
2. Medication Assistance
3. Medical Transportation
4. Health Insurance/Premium Assistance
5. Nutrition Assistance
6. Mental Health/Support Groups
7. Oral Health Care
8. Emergency Financial Assistance
9. AOMC
10. Other: Disability Assistance
11. Other- Help with Medical/MH Co-Pays
12. Other: Vision Care tied with Employment Assistance

## NEED, USE, GAP AND BARRIER RANKINGS BY SPECIAL POPULATION GROUP

AFRICAN AMERICANS PLWH/A SERVICE NEEDS, USES, GAPS AND BARRIERS MATRIX (N=171)...CHART CONTINUES ON PG. 60

SERVICE CATEGORY	TOTAL 2011 PLWH/A NEED RANK	AA NEED RANK	AA USE RANK	AA GAP RANK	AA BARRIER RANK
MEDICATION ASSISTANCE	1	2	3	3	2
AMBULATORY OUTPATIENT MEDICAL CARE	2	1	1	9 TIE	6 TIE
HOUSING ASSISTANCE	3	3	7	1	1
NUTRITION ASSISTANCE	4	4	6	6 TIE	4
MENTAL HEALTH/SUPPORT GROUPS	5	6	5	5	5 TIE

SERVICE CATEGORY	TOTAL 2011 PLWH/A NEED RANK	AA NEED RANK	AA USE RANK	AA GAP RANK	AA BARRIER RANK
MEDICAL TRANSPORTATION	6	5	4	2	6 TIE
OTHER: EMPLOYMENT ASSISTANCE	7 tie	7	13 tie	8 tie	6 tie
HEALTH EDUCATION/ PEER EDUCATION	7 tie	8	9	NR	9 tie
HEALTH INSURANCE ASSISTANCE	8	9	10	4	3
EMERGENCY FINANCIAL ASSISTANCE	9	10	11 tie	7 tie	7
MEDICAL CASE MANAGEMENT	10	11	2	NR	9 tie
ORAL HEALTH CARE	11	13	8	6 tie	5 tie
SUBSTANCE ABUSE SERVICES	12	14	13 tie	NR	NR
HIV PREVENTION/ CONDOMS	13	12 tie	11 tie	NR	NR
*OTHER (LIST): CLOTHING	14	12 tie	NR	NR	9 tie
OUTREACH	15 tie	15 tie	13 tie	NR	NR
OTHER: VISION CARE	15 tie	15 tie	NR	7 tie	8
OTHER: MEDICAL/ SURGICAL/GYN SPECIALTY CARE	NR	15 tie	NR	9 tie	10
OTHER: DISABILITY ASSISTANCE/SSI/ MEDICAID	NR	15 tie	12	8 tie	6 TIE
OTHER: HELP WITH MEDICAL & MH CO-PAYS	NR	15 tie	NR	NR	NR

## DISCUSSION OF AFRICAN AMERICAN PLWH/A SERVICE NEEDS, USES, GAPS AND BARRIERS

The top ranking Service Needs of the special population of African Americans mirrors those of the entire respondent group. The African Americans PLWH/A Service Use rankings compare with their Need rankings, except for Housing and Nutrition Assistance. This finding indicates that a service gap exists between need and use, which is confirmed in the Service Gap rankings below.

### THE TOP RANKING SERVICE GAPS FOR AFRICAN AMERICAN PLWH/A IN THE SERVICE AREA INCLUDE:

1. Housing Assistance;
2. Medical Transportation
3. Medications
4. Insurance Assistance
5. Mental Health/Support Groups
6. Oral Health Care tied with Nutrition Assistance
7. Emergency Financial Assistance tied with Other: Vision Care
8. Other: Employment Assistance tied with Disability Assistance
9. AOMC tied with GYN Care tied with Other: Specialty Care

### AA REASONS FOR SERVICE GAPS INCLUDE:

- Can't afford
- No insurance
- Funding cuts
- Need more counselors
- Hard to get people to help you
- Not sure what is available
- Don't qualify
- Not sure what is available
- Income too high
- Pre-existing condition
- No access
- Don't know where to go or what to do
- No car
- Services not covered by RW
- No information about services
- No transportation
- Social security not yet approved so is hard to get further help

**THE TOP RANKING SERVICE BARRIERS FOR AFRICAN AMERICAN PLWH/A INCLUDES A COMBINATION OF CORE AND SUPPORT SERVICES, INCLUDING MANY OF THE SAME SERVICES IDENTIFIED AS SERVICE GAPS:**

1. Housing Assistance;
2. Medication Assistance;
3. Insurance Assistance
4. Nutrition Assistance
5. Oral Health Care tied with Mental Health/Support Groups
6. AOMC (some mentioned co-pays) tied with Disability Assistance
7. Emergency Financial Assistance
8. Other: Vision Care
9. Medical Case Management tied with Health Education/Information tied with Other: Clothing
10. Other: General Medical Care

**AA REASONS FOR SERVICE BARRIERS INCLUDE:**

- Availability in area
- Case Management Overload
- Budget cuts
- No license
- Cut is funding for transportation
- My age
- Access to services
- My lab values are too good
- Service hours
- Lack of knowledge
- Being sent to too many people
- Not in my area
- Long waits for appointments
- Not sure what is available
- Poorly trained doctors
- Too much income
- Don't know the resources

MSM PLWH/A SERVICE NEEDS, USES, GAPS AND BARRIERS MATRIX (N=77)...CHART  
CONTINUES ON PG. 64

SERVICE CATEGORY DESCRIPTION	2011 TOTAL PLWH/A NEED RANK	MSM NEED RANK	MSM USE RANK	MSM GAP RANK	MSM BARRIER RANK
MEDICATION ASSISTANCE	1	1	3	2	1
AMBULATORY OUTPATIENT MEDICAL CARE	2	2	1	6 tie	4 tie
HOUSING ASSISTANCE	3	3	6	1	2
NUTRITION ASSISTANCE	14	4	5 tie	5 tie	5 tie
MENTAL HEALTH/ SUPPORT GROUPS	5	5	8	6 tie	3
MEDICAL TRANSPORTATION	6	7	4	5 tie	5 tie
OTHER: EMPLOYMENT ASSISTANCE	7 tie	6	12tie	5 tie	7 tie
HEALTH EDUCATION/ PEER EDUCATION	7 tie	8	10 tie	NR	NR
HEALTH INSURANCE ASSISTANCE	8	9 tie	9	4	4 tie
EMERGENCY FINANCIAL ASSISTANCE	9	9 tie	11	NR	6 tie
MEDICAL CASE MANAGEMENT	10	12	2	3	7 tie
ORAL HEALTH CARE	11	13	7	NR	5tie
SUBSTANCE ABUSE SERVICES	12	NR	12 tie	NR	NR
HIV PREVENTION/ CONDOMS	13	10	10 tie	NR	NR
*OTHER (LIST): CLOTHING	14	11	NR	NR	NR

SERVICE CATEGORY DESCRIPTION	2011 TOTAL PLWH/A NEED RANK	MSM NEED RANK	MSM USE RANK	MSM GAP RANK	MSM BARRIER RANK
OUTREACH	15 tie	NR	NR	NR	NR
*OTHER: VISION CARE	15 tie	NR	NR	6 tie	6 tie
*OTHER :MEDICAL/ SURGICAL/GYN SPECIALTY CARE	NR	NR	NR	5 tie	7 tie
*OTHER: DISABILITY ASSISTANCE/SSI/ MEDICAID	NR	NR	NR	5 tie	4 tie
*OTHER: HELP WITH MEDICAL & MH CO-PAYS	NR	NR	NR	NR	NR

## DISCUSSION OF MSM PLWH/A SERVICE NEEDS, USES, GAPS AND BARRIERS

The top MSM Service Need rankings generally reflect those of the larger PLWH/A population, although the MSM respondent group ranks Nutrition Assistance substantially higher than the total PLWH/A group and ranks HIV Prevention/Condoms higher than the total group of In Care respondents.

The top ranking MSM Service NEEDS include: 1) Medications; 2) AOMC; 3) Housing Assistance; 4) Nutrition Assistance; 5) Mental Health/Support Groups; 6) Other: Employment Assistance; 7) Medical Transportation; 8) Health Education/Peer Education; 9) EFA tied with Health Insurance Assistance; 10) HIV Prevention/Condoms; 11) Other: Clothing; 12) Medical Case Management; and 13) Oral Health Care.

The MSM Service Use rankings indicate that Housing Assistance is utilized less often than needed, confirmed by a #1 Service Gap ranking.

### THE TOP RANKING MSM SERVICE USES INCLUDE:

1. AOMC
2. Medical Case Management
3. Medications
4. Medical Transportation
5. Nutrition Assistance
6. Housing Assistance
7. Oral Health Care
8. Mental health/Support Groups

9. Insurance Assistance
10. Health Education tied with HIV Prevention/Condoms
11. Emergency Financial Assistance
12. Employment Assistance tied with Substance Abuse Treatment

### **FOLLOWING THE #1 GAP RANKING FOR HOUSING ASSISTANCE, THE NEXT HIGHEST MSM SERVICE GAP RANKINGS INCLUDE:**

1. Medications;
2. Oral Health Care;
3. Insurance Assistance;
4. Other: Employment Assistance tied with Disability Assistance tied with Medical Transportation tied with Specialty Care;
5. Mental Health/Support Groups tied with Other: Vision care and AOMC.

### **MSM SERVICE GAP REASONS INCLUDE:**

- No income as a student to qualify for assistance
- No housing
- No medical insurance
- Not enough government programs
- I do not qualify
- State does not have the money
- Lack of funding
- Income too high
- No money
- Lab values are good

### **MSM'S HIGHEST RANKING SERVICE BARRIERS ARE SIMILAR TO THOSE OF THE ENTIRE RESPONDENT GROUP AND INCLUDE:**

1. Medications;
2. Housing Assistance;
3. Mental Health/Support Groups;
4. AOMC tied with Insurance Assistance tied with Other: Disability Assistance;
5. Oral Health Care tied with Nutrition Assistance tied with Medical Transportation;
6. EFA tied with Other: Vision care;
7. Other: General non-HIV Health Care tied with Employment Assistance tied with Specialty Care.

## MSM SERVICE BARRIER REASONS INCLUDE:

- Budget cuts
- Unemployment is up
- Cuts in funding for transportation
- My lab values are not good
- Don't qualify for help
- Wait lists
- Limited resources for co-pay assistance
- My age
- State funds have run out
- Certain organizations show favoritism with grants

WOMEN OF COLOR SERVICE NEEDS, USES, GAPS AND BARRIER S MATRIX (N=71)...  
CHART CONTINUES ON PG. 67

SERVICE CATEGORY DESCRIPTION	2011 TOTAL NEED RANK	WOMEN NEED RANK	WOMEN USE RANK	WOMEN GAP RANK	WOMEN BARRIER RANK
MEDICATION ASSISTANCE	1	2	2	3 tie	2
AMBULATORY OUTPATIENT MEDICAL CARE	2	1	1	nr	Nr
HOUSING ASSISTANCE	3	3	5 tie	1	1
NUTRITION ASSISTANCE	4	5	7 tie	5 tie	4
MENTAL HEALTH/SUPPORT GROUPS	5	4	4	3 tie	3
MEDICAL TRANSPORTATION	6	6	5 tie	5 tie	8 tie
OTHER: EMPLOYMENT ASSISTANCE	7 tie	8	8 tie	4 tie	5
HEALTH EDUCATION/PEER EDUCATION	7 tie	7	7tie	NR	9
HEALTH INSURANCE ASSISTANCE	8	9	7 tie	2	6 tie
EMERGENCY FINANCIAL ASSISTANCE	9	11	7 tie	4 tie	7 tie

SERVICE CATEGORY DESCRIPTION	2011 TOTAL NEED RANK	WOMEN NEED RANK	WOMEN USE RANK	WOMEN GAP RANK	WOMEN BARRIER RANK
MEDICAL CASE MANAGEMENT	10	12 tie	3	NR	10 tie
ORAL HEALTH CARE	11	10	5 tie	6 tie	6 tie
SUBSTANCE ABUSE SERVICES	12	NR	7 tie	NR	NR
HIV PREVENTION/ CONDOMS	13	12 tie	8 tie	NR	NR
OTHER (LIST): CLOTHING	14	13 tie	nr	NR	NR
OUTREACH	15 tie	13 tie	8 tie	NR	NR
OTHER: VISION CARE	15 tie	NR	NR	4 tie	7 tie
OTHER : MEDICAL/ SURGICAL/GYN SPECIALTY CARE	NR	13 tie	8 tie	4 tie	10 tie
OTHER: DISABILITY ASSISTANCE/SSI/MEDICAID	NR	13 tie	6	6 tie	8 tie
OTHER: HELP WITH MEDICAL & MH CO-PAYS	NR	13 tie	NR	NR	NR

## DISCUSSION OF SERVICE NEEDS, USES, GAPS AND BARRIERS FOR WOMEN OF COLOR

The Service Need rankings for the Women of Color are highly similar to those of the entire respondent group, and include: 1) AOMC; 2) Medications; 3) Housing Assistance; 4) Mental Health/Support Groups; 5) Nutrition Assistance; 6) Medical Transportation; 7) Health Education; 8) Other: Employment Assistance; 9) Insurance Assistance; and 10) Oral Health Care.

Top ranking Service Uses reported by Women include: 1) AOMC; 2) Medications; 3) Medical Case Management; 4) Mental Health/Support Groups; 5) Housing Assistance tied with Medical Transportation tied with Oral Health Care; 6) Other: Disability Assistance; 7) EFA tied with Insurance Assistance tied with Health Education tied with Substance Abuse Treatment; 8) Other: Employment Assistance tied with HIV Prevention/Condoms tied with Other: Specialty Care services.

## **HOUSING ASSISTANCE IS CITED AS THE #1 TOP RANKING SERVICE GAP BY WOMEN. THE NEXT HIGHEST SERVICE GAPS INCLUDED:**

1. Insurance Assistance;
2. Medications tied with Mental Health/Support Groups;
3. Other: Employment Assistance tied with Specialty Care services tied with EFA tied with Vision Care;
4. Nutrition Assistance tied with Medical Transportation;
5. Other: Disability Assistance tied with Oral Health Care.

## **WOMEN'S SERVICE GAP REASONS INCLUDE:**

- Lack of money
- No insurance
- Need more counselors
- No job
- No transportation
- Not eligible for Medicaid
- Not sure what is available
- Insurance refusal

## **THE TOP RANKING SERVICE BARRIERS FOR WOMEN INCLUDE:**

1. Housing Assistance;
2. Medications;
3. Mental Health/Support Groups;
4. Nutrition Assistance;
5. Employment Assistance;
6. Oral Health care tied with Insurance Assistance;
7. Vision Care tied with EFA;
8. Disability Assistance tied with Medical Transportation;
9. Health Education;
10. Medical case management tied with GYN/Specialty Care

## **WOMEN'S SERVICE BARRIER REASONS INCLUDE:**

- Availability
- Access to services
- Service hours
- Cost/eligibility

- Because you are infected
- Currently pregnant
- Being sent to too many people
- Funding cuts
- Lack of Case managers
- Live in low income housing
- No information
- Case management overload
- My age
- Lab levels
- Not in my area
- Too much income

**SUBSTANCE USERS/IDU NEEDS, USES, GAPS AND BARRIERS MATRIX (N=26)...CHART CONTINUES ON PG. 70**

SERVICE CATEGORY DESCRIPTIONW	2011 TOTAL PLWH/A NEED RANK	SA/IDU NEED RANK	SA/IDU USE RANK	SA/IDU GAP RANK	SA/IDU BARRIER RANK
MEDICATION ASSISTANCE	1	1	2	NR	2
AMBULATORY OUTPATIENT MEDICAL CARE	2	2	1	NR	NR
HOUSING ASSISTANCE	3	3	8 tie	2 tie	4 tie
NUTRITION ASSISTANCE	4	4	6	2 tie	3 tie
MENTAL HEALTH/ SUPPORT GROUPS	5	5	4	2 tie	NR
MEDICAL TRANSPORTATION	6	6	5	2 tie	3 tie
OTHER: EMPLOYMENT ASSISTANCE	7 tie	8 tie	8 tie	NR	3 tie
HEALTH EDUCATION	7 tie	7 tie	8 tie	NR	NR

SERVICE CATEGORY DESCRIPTIONW	2011 TOTAL PLWH/A NEED RANK	SA/IDU NEED RANK	SA/IDU USE RANK	SA/IDU GAP RANK	SA/IDU BARRIER RANK
HEALTH INSURANCE ASSISTANCE	8	9 tie	8 tie	3 TIE	NR
EMERGENCY FINANCIAL ASSISTANCE	9	8 tie	8 tie	1 tie	3 tie
MEDICAL CASE MANAGEMENT	10	NR	3	NR	NR
ORAL HEALTH CARE	11	9 tie	NR	1 tie	1
SUBSTANCE ABUSE SERVICES	12	9 tie	7 tie	NR	4 tie
HIV PREVENTION/ CONDOMS	13	NR	7 tie	NR	NR
OTHER (LIST): CLOTHING	14	7 tie		NR	NR
OUTREACH	15 tie	NR	NR	NR	NR
OTHER: VISION CARE	15 tie	NR	NR	1 tie	3 tie
OTHER :MEDICAL/ SURGICAL/GYN SPECIALTY CARE	NR	9 tie	NR	3 tie	3 tie
OTHER: DISABILITY ASSISTANCE/SSI/ MEDICAID	NR	NR	NR	3 tie	4 tie
OTHER: HELP WITH MEDICAL & MH CO-PAYS	NR	NR	NR	3 tie	3 tie

## DISCUSSION OF SA/IDU NEEDS, USES, GAPS AND BARRIERS

The Substance Users'/IDU's Service Need rankings reflect those of the larger group, except for the notably higher Need ranking for Substance Abuse treatment services (ranked as the #9 Need and # 7 Service Use among SA/IDU, (as compared to the #12 Need and #12 Use rankings by the total respondent group) along with a considerably higher Need ranking for clothing assistance (#7 as compared to the #14 Need by the total respondent group).

**The SA/IDU Need rankings include:** 1) Medications; 2) AOMC; 3) Housing Assistance; 4) Nutrition Assistance; 5) Mental Health/Support Groups; 6) Medical Transportation; 7) Health Education tied with Other: Clothing; 8) Emergency Financial Assistance tied with Other: Employment Assistance; and 9) Oral Health Care tied with Insurance Assistance tied with Other: General Medical and Specialty Care services.

### **THE TOP RANKING SERVICE USES FOR SA/IDU INCLUDE:**

1. AOMC;
2. Medications;
3. Medical Case Management;
4. Mental Health/Support Groups;
5. Medical Transportation;
6. Nutrition Assistance;
7. HIV Prevention/Condoms tied with Substance Abuse Treatment; and
8. Insurance Assistance tied with EFA tied with Housing Assistance tied with Health Education.

### **THE TOP RANKING SERVICE GAPS FOR SA/IDU INCLUDE:**

1. Oral Health Care tied with EFA tied with Other: Vision care;
2. Housing Assistance tied with Medical Transportation tied with Nutrition Assistance tied with Mental Health/Support Groups;
3. Other: Disability Assistance tied with Insurance Assistance tied with Other: General Medical and Specialty Services.

### **SA/IDU SERVICE GAP REASONS INCLUDE:**

- “Hard to get people to help you”
- “I have no medical insurance”
- “Lack of funds”
- “No money”
- “Not approved”
- “No transportation”
- “Services not covered by RW CARE Act”
- “My SS benefits haven’t been approved, which makes it harder to obtain further assistance”

**THE SA/IDU RESPONDENT GROUP RANKS MANY OF THE SAME SERVICES AS SERVICE GAPS (PERCEIVED AS ‘UNAVAILABLE’) AS THEY RANK THEM AS ‘HARD TO GET’, INDICATED BY THEIR TOP RANKING SERVICE BARRIERS WHICH INCLUDE:**

1. Oral Health Care;
2. Medications;
3. Other: Vision Care tied with Other: Medical Appointment Co-pay Assistance tied with EFA, Medical Transportation, Nutrition Assistance and Other: Employment Assistance;
4. Other: Disability Assistance tied with Other: General Medical and Specialty care, Substance Abuse Treatment, Housing Assistance and Other: Clothing.

**SA/IDU SERVICE BARRIER REASONS INCLUDE:**

- “Lack of funds”
- “Can’t be paid out of RW”
- “Lack of money”
- “There’s nowhere to go”
- “Not funded”

RURAL PLWH/A SERVICE NEEDS, USES, GAPS AND BARRIER MATRIX (N=10)...CHART CONTINUES ON PG. 73

SERVICE CATEGORY DESCRIPTION	2011 TOTAL NEED RANK	RURAL NEED RANK	RURAL USE RANK	RURAL GAP RANK	RURAL BARRIER RANK
MEDICATION ASSISTANCE	1	2	3 tie	1 tie	1 tie
AMBULATORY OUTPATIENT MEDICAL CARE	2	1	1	NR	NR
HOUSING ASSISTANCE	3	3 tie	NR	NR	1 tie
NUTRITION ASSISTANCE	4	3 tie	NR	NR	NR
MENTAL HEALTH/ SUPPORT GROUPS	5	4	NR	NR	1 tie
MEDICAL TRANSPORTATION	6	6 tie	2 tie	1 tie	NR

SERVICE CATEGORY DESCRIPTION	2011 TOTAL NEED RANK	RURAL NEED RANK	RURAL USE RANK	RURAL GAP RANK	RURAL BARRIER RANK
OTHER: EMPLOYMENT ASSISTANCE	7 tie	5 tie	NR	NR	1 tie
HEALTH EDUCATION/ PEER EDUCATION	7 tie	6 tie	NR	1 tie	NR
HEALTH INSURANCE ASSISTANCE	8	5 tie	3 tie	NR	NR
EMERGENCY FINANCIAL ASSISTANCE	9	6 tie	3 tie	NR	NR
MEDICAL CASE MANAGEMENT	10	NR	2 tie	NR	NR
ORAL HEALTH CARE	11	NR	NR	1 tie	NR
SUBSTANCE ABUSE SERVICES	12	NR	NR	NR	NR
HIV PREVENTION/ CONDOMS	13	NR	NR	NR	NR
OTHER (LIST): CLOTHING	14	NR	NR	NR	NR
OUTREACH	15 tie	NR	NR	NR	NR
OTHER: VISION CARE	15 tie	NR	NR	NR	NR
OTHER: MEDICAL/ SURGICAL/GYN SPECIALTY CARE	NR	NR	NR	NR	NR
OTHER: DISABILITY ASSISTANCE/SSI/ MEDICAID	Nr	NR	NR	NR	NR
OTHER: HELP WITH MEDICAL & MH CO-PAYS	NR	NR	NR	NR	NR

## DISCUSSION OF RURAL PLWH/A SERVICE NEEDS, USES, GAPS AND BARRIERS

The Service Need rankings of Rural PLWH/A are less similar than those of other special population groups when compared to the larger Norfolk respondent group. *Of note is the fact that Rural PLWH/A rank Health Insurance Assistance and Emergency Financial Assistance substantially higher than the respondent group as a whole.*

### RURAL PLWH/A'S TOP FIVE SERVICE USES INCLUDE:

1. AOMC;
2. Medical Case Management tied with Medical Transportation;
3. Medications tied with EFA and Health Insurance Assistance.

### THE TOP RANKING SERVICE GAPS FOR RURAL PLWH/A (ALL RANKED AS #1) INCLUDE:

1. Medications tied with Oral Health Care tied with Insurance Assistance tied with Employment Assistance.

### THE RURAL PLWH/A SERVICE GAP REASONS INCLUDE:

1. Was told I did not qualify
2. No funding
3. Ask the person who handles ADAP

### THE RURAL PLWH/A RESPONDENT GROUP'S TOP SERVICE BARRIER RANKINGS, INCLUDE:

1. Mental Health/Support Groups tied with Housing Assistance tied with Medications tied with Employment Assistance.

### THE RURAL PLWH/A SERVICE BARRIER REASONS INCLUDE:

- Too much income
- Only the State knows

**VETERAN/MILITARY PLWH/A:** *As only four PLWH/A could be definitely identified as a Veteran/Military participant, based upon health insurance and/or HIV primary care home, it is recommended that the Planning Council conduct a special study of HIV+ military (active duty and retired). This study will require significant inroads and a focused approach with the VA and Portsmouth Naval Hospital.*

## DISCUSSION OF 2011 VETERAN/MILITARY PLWH/A SERVICE NEEDS, USES, GAPS AND BARRIERS

The top ranking Service Needs of the 2011 Veteran/Military PLWH/A include four equally ranked top services: 1) AOMC tied with Medications Assistance tied with Nutrition Assistance tie with Mental Health/Support Group services.

### THE TOP RANKING SERVICE USES REPORTED BY THE 2011 VETERAN/MILITARY PLWH/A INCLUDE:

1. AOMC;
2. MCM tied with Medication Assistance;
3. Personal Aid.

The top ranking **Service Barrier** is identified as a single service category: Oral Health Care. The Veteran/Military PLWH/A identify the reason for this service barrier as lack of available funding.

*The 2011 Veteran/Military PLWH/A did not report any service as a Gap.*

Because there were so few Veteran/Military PLWH/A who participated in the 2011 Needs Assessment process, the 2008 Needs Assessment findings are included here for reference (wherein 56 Veteran/Military PLWH/A participated).

The **Service Needs** of 2008 Veteran/Military PLWH/A included: 1) AOMC; 2) Housing Assistance; 3) MCM; 4) Medications Assistance; and 5) Mental Health Services tied with EFA. Their reported 2008 **Service Uses** include: 1) AOMC; 2) MCM; 3) Medication Assistance; 4) Medical Transportation; and 5) Mental Health Services.

The 2008 Veteran/Military PLWH/A top ranking **Service Gaps** include: 1) Housing Assistance; 2) Oral Health Care; 3) Medical Transportation; 4) EFA; and 5) 'Other', including Coordination of benefits with VA/Military, Eyeglasses and General Medical Care other than HIV care.

The top ranking 2008 **Service Barriers** cited by the Veteran/Military PLWH/A respondent group are similar to those of the entire respondent group and include: 1) Medical Transportation; 2) Oral Health Care; 3) Substance Abuse services; 4) EFA; and 5) Medication Assistance.

VETERAN/MILITARY PLWH/A SERVICE NEEDS, USES, GAPS AND BARRIERS MATRIX  
(N=4)...CHART CONTINUES ON PG. 77

SERVICE CATEGORY DESCRIPTION	2011 TOTAL NEED RANK	VET/MIL NEED RANK	VET/MIL USE RANK	VET/MIL GAP RANK	VET/MIL BARRIER RANK
MEDICATION ASSISTANCE	1	1 tie	2 tie	NR	NR
AMBULATORY OUTPATIENT MEDICAL CARE	2	1 tie	1	NR	NR
HOUSING ASSISTANCE	3	NR	NR	NR	NR
NUTRITION ASSISTANCE	4	1 tie	NR	NR	NR
MENTAL HEALTH/ SUPPORT GROUPS	5	1 tie	NR	NR	NR
MEDICAL TRANSPORTATION	6	NR	NR	NR	NR
OTHER: EMPLOYMENT ASSISTANCE	7 tie	NR	NR	NR	NR
HEALTH EDUCATION/PEER EDUCATION	7 tie	NR	NR	NR	NR
HEALTH INSURANCE ASSISTANCE	8	NR	NR	NR	NR
EMERGENCY FINANCIAL ASSISTANCE	9	NR	NR	NR	NR
MEDICAL CASE MANAGEMENT	10	NR	2 tie	NR	NR
ORAL HEALTH CARE	11	NR	NR	NR	1

SERVICE CATEGORY DESCRIPTION	2011 TOTAL NEED RANK	VET/MIL NEED RANK	VET/MIL USE RANK	VET/MIL GAP RANK	VET/MIL BARRIER RANK
SUBSTANCE ABUSE SERVICES	12	NR	NR	NR	NR
HIV PREVENTION/ CONDOMS	13	NR	NR	NR	NR
OTHER (LIST): CLOTHING	14	NR	NR	NR	NR
OUTREACH	15 tie	NR	NR	NR	NR
OTHER: VISION CARE	15 tie	NR	NR	NR	NR
OTHER: MEDICAL/ SURGICAL/GYN SPECIALTY CARE	nr	NR	NR	NR	NR
OTHER: DISABILITY ASSISTANCE/SSI/ MEDICAID	NR	NR	NR	NR	NR
OTHER: HELP WITH MEDICAL & MH CO-PAYS	NR	NR	NR	NR	NR
OTHER: PERSONAL AID	NR	NR	3	NR	NR

**ADDITIONAL INFORMATION: SURGE IN MENTAL HEALTH SERVICE NEEDS FORECASTED FOR MILITARY PERSONNEL**

A recent US Department of Defense (DOD) study of the mental health needs of military service members returning from Iraq and Afghanistan asserts that “combat imposes a psychological burden that affects all combatants, not only those vulnerable to emotional disorders or those who sustain physical wounds” (DOD, Defense Health Board, 2009). Half of military veterans and their families face significant mental health challenges. Based on current rates of diagnosis reported by the Veterans Administration (VA) for recently discharged veterans seeking care, if historic trends in the Norfolk TGA continue, *Norfolk could face a 15-20% surge in those seeking behavioral health services over current levels (Virginia Department of Behavioral Health and Developmental Services, Comprehensive State Plan 2010-2016.)*

## YOUTH AS AN EMERGING SPECIAL POPULATION

Youth represent a newly emerging special population of significance in the Norfolk TGA, which has not previously been targeted for a comprehensive assessment of need. Strictly speaking, the local epidemiologic data supports Youth, ages 13-19 years, and Youth, ages 20-24 years as important populations in the Norfolk TGA.

The epidemiologic data and local wisdom both support the fact that older youth/young adults ages 25-39 were most likely infected at a younger age. In order to ensure the widest and most accurate representation of the relative needs, uses, gaps and barriers experienced by infected youth, the following age groups were delineated for inclusion in the 2011 comprehensive needs assessment study:

### SUB-POPULATIONS OF YOUTH RESPONDENTS

BIRTH RANGE	AGE	TERM	# STUDY PARTICIPANTS
1999-2011	0-12	Child	0
1998-1992	13-19	Adolescent	3
1991-1987	20-24	Young Adult	26
			29
1986-1982	25-29	Recent Youth	17
			46

### DISCUSSION OF YOUTH'S SERVICE NEEDS, USES, GAPS AND BARRIERS

The **Service Need rankings** of Youth evidence a relatively greater need for Health Education/Peer Education, HIV Prevention/Condoms and Other: Disability Assistance as compared to the entire respondent group.

The top five ranked **Service Uses** of Youth include 1) AOMC; 2) Medical Case Management; 3) Medical Transportation; 4) Medications; 5) Mental Health/Support Group services.

*The number one ranking Service Gaps expressed by Young PLWH/A includes Medications tied with Housing Assistance; followed by: 2) Health Insurance Assistance; 3) Nutrition Assistance; 4) Oral Health Care tied with AOMC tied with Other: Disability Assistance; 5) Other: Employment Assistance tied with Vision Care.*

## YOUTH GAP REASONS INCLUDE:

- “I don’t know, but they are hard to get”
- “I have no income as a student to qualify for assistance with food in order to eat healthfully”
- “I was told I don’t qualify”
- “No access”
- “No money”
- “No insurance”
- “Not accepted”
- “No job”
- “Not enough government programs”

*It is notable that Youth rank access to AOMC as a higher ranking Barrier (#6 tie) and Gap (#4) than the PLWH/A group as a whole, who provided #10 and #9 Gap and Barrier rankings, respectively, for AOMC. The top ranking Service Barriers cited by PLWH/A Youth include: 1) Medications; 2) Housing Assistance; 3) Health Insurance Assistance tied with Other: Disability Assistance; 4) Nutrition Assistance; 5) Other: Employment Assistance; 6) Mental Health/Support Group services tied with Oral Health Care tied with AOMC tied with Other: Vision Care.*

## YOUTH BARRIER REASONS INCLUDE:

- “I don’t qualify for help”
- “Funding”
- “State funds have run out”
- “Lack of knowledge”
- “Unemployment”
- “Limited resources for co-pay”
- “Knowing where to go and what to do”

## YOUTH SERVICE NEEDS, USES, GAPS AND BARRIERS MATRIX (N=46)...CHART CONTINUES ON PG. 80

SERVICE CATEGORY DESCRIPTION	2008 TOTAL PLWH/A NEED RANK	YOUTH NEED RANK	YOUTH USE RANK	YOUTH GAP RANK	YOUTH BARRIER RANK
MEDICATION ASSISTANCE	1	2	4	1 tie	1
AMBULATORY OUTPATIENT MEDICAL CARE	2	1	1	4 tie	6 tie
HOUSING ASSISTANCE	3	3	6 tie	1 tie	2
NUTRITION ASSISTANCE	4	4	8 tie	3	4

SERVICE CATEGORY DESCRIPTION	2008 TOTAL PLWH/A NEED RANK	YOUTH NEED RANK	YOUTH USE RANK	YOUTH GAP RANK	YOUTH BARRIER RANK
MENTAL HEALTH/ SUPPORT GROUPS	5	7 tie	5	NR	6 tie
MEDICAL TRANSPORTATION	6	6	3	NR	NR
OTHER: EMPLOYMENT ASSISTANCE	7 tie	8 tie	NR	5 tie	5
HEALTH EDUCATION/ PEER EDUCATOR	7 tie	5	7	NR	NR
HEALTH INSURANCE ASSISTANCE	8	7 tie	6 tie	2	3 tie
EMERGENCY FINANCIAL ASSISTANCE	9	9	NR	NR	NR
MEDICAL CASE MANAGEMENT	10	10 tie	2	NR	NR
ORAL HEALTH CARE	11	NR	8 tie	4 tie	6 tie
SUBSTANCE ABUSE SERVICES	12	NR	NR	NR	NR
HIV PREVENTION/ CONDOMS	13	8 tie	8 tie	NR	NR
OTHER (LIST): CLOTHING	14	NR	NR	NR	NR
OUTREACH	15 tie	NR	NR	NR	NR
OTHER: VISION CARE	15 tie	NR	NR	5 tie	6 tie
OTHER : MEDICAL/ SURGICAL/GYN SPECIALTY CARE	NR	NR	NR	NR	NR
OTHER: DISABILITY ASSISTANCE/SSI/ MEDICAID	NR	NR	8 tie	4 tie	3 tie
OTHER: HELP WITH MEDICAL & MH CO-PAYS	NR	NR	NR	NR	NR

- *Other: GED-#10 tie Need*

# CHAPTER 3: NEWLY DIAGNOSED SURVEY FINDINGS

## INTRODUCTION

A special focus of the Norfolk TGA Planning Council in 2011 was to better understand and respond to the complex HIV prevention and service needs of the emerging Severe Need Group: the Newly Diagnosed/New to Care PLWHA. The newly diagnosed cases of HIV/AIDS continue to grow at alarming rates, and therefore, represent a population of substantial concern to the Greater Hampton Roads HIV Services Planning Council.

This special needs assessment study was undertaken to determine the priority service needs, barriers, and gaps in the continuum of care for “Newly Diagnosed/New to Care” PLWHA. A special focus of this needs assessment study was to perform an in-depth survey of the HIV risk behaviors and prevention needs of this SNG population, along with survey items intended to clarify what system level changes may be necessary in order to strengthen the prevention-to testing-to care linkages, so that persons living with HIV disease and Unaware may learn their HIV status and be assisted in entering care at earlier stages in their disease process.

A comprehensive assessment of the HIV care and prevention service needs, gaps and barriers of the emerging population of ‘Newly Diagnosed/New to Care’ PLWHA within the Norfolk TGA was conducted in the spring of 2011. This assessment of need included a qualitative survey of the ‘Newly Diagnosed’ (defined as having received a first diagnosis of HIV or AIDS in past year). A new and comprehensive survey tool was developed, inclusive of detailed survey items relative to the complex HIV prevention and care needs, uses, barriers and gaps for the Newly Diagnosed/New to Care PLWHA in the TGA. The results of the study were performed to meet HRSA’s EIIHA mandate and are intended to better inform planners of improved strategies to reach and serve the Unaware of HIV diagnosis in the service area. The current “Unaware” estimates are depicted in the table below, with the greatest frequency occurring among black males, ages 13-19 and 20-44 years of age, with MSM and heterosexual risk.

CHART CONTINUES ON PG. 82

UNAWARE ESTIMATE FOR NORFOLK, VIRGINIA TGA, AS OF DECEMBER 31, 2008		
UNAWARE HIV ESTIMATED CASES IN NORFOLK TGA - 2010	CASE COUNT	REGION PROPORTION
ESTIMATED TOTAL PERSONS UNAWARE OF HIV INFECTION	1,667	.21/.79 * 6,271
PERSONS UNAWARE OF HIV INFECTION BY GENDER		
MALES	1,200	72%

**UNAWARE ESTIMATE FOR NORFOLK, VIRGINIA TGA, AS OF DECEMBER 31, 2008**

<b>FEMALES</b>	<b>467</b>	<b>28%</b>
<b>PERSONS UNAWARE OF HIV INFECTION BY AGE</b>		
<b>AGE &lt;13 YEARS</b>	<b>17</b>	<b>1%</b>
<b>AGE 13-19</b>	<b>100</b>	<b>6%</b>
<b>AGE 20-44</b>	<b>1,317</b>	<b>79%</b>
<b>AGE 45+</b>	<b>233</b>	<b>14%</b>
<b>PERSONS UNAWARE OF HIV INFECTION BY RACE/ETHNICITY</b>		
<b>WHITE NON-HISPANIC</b>	<b>400</b>	<b>24%</b>
<b>BLACK NON-HISPANIC</b>	<b>1,167</b>	<b>70%</b>
<b>HISPANIC</b>	<b>67</b>	<b>4%</b>
<b>ASIAN/PACIFIC ISLANDER NON-HISPANIC</b>	<b>17</b>	<b>1%</b>
<b>AMERICAN INDIAN/ ALASKA NATIVE NON- HISPANIC</b>	<b>0</b>	<b>0%</b>
<b>MULTI-RACE/OTHER RACE/ UNKNOWN</b>	<b>17</b>	<b>1%</b>
<b>PERSONS UNAWARE OF HIV INFECTION BY REPORTED RISK</b>		
<b>MSM</b>	<b>633</b>	<b>38%</b>
<b>IDU</b>	<b>183</b>	<b>11%</b>
<b>MSM/IDU</b>	<b>67</b>	<b>4%</b>
<b>HETEROSEXUAL</b>	<b>383</b>	<b>23%</b>
<b>BLOOD EXPOSURE/OTHER</b>	<b>3</b>	<b>0%</b>
<b>MATERNAL VERTICAL TRANSMISSION</b>	<b>0</b>	<b>0%</b>
<b>NO REPORTED RISK/ UNKNOWN RISK</b>	<b>407</b>	<b>27%</b>

The target sample size for the Newly Diagnosed survey population was 40-50 PLWHA diagnosed in the past year with representation from the entire Norfolk TGA. While the Newly Diagnosed respondents were challenging to identify and recruit due to stigma, shock with their diagnosis, and difficulty understanding use of the data, over a three-month period there were 45 respondents who participated in the survey. Incentives were offered for completion of the survey in the amount of a \$10 gift certificate.

## THE SURVEY INSTRUMENT REQUESTED INFORMATION ON EIGHT (8) DIFFERENT CATEGORIES:

- Demographics
- HIV Acquisition
- HIV Testing
- HIV Disclosure
- Delay of Entry Into Testing/HIV Medical Care
- HIV Pathway To Care & Supportive Services
- Current 'In Care' Practice and CD4 At Diagnosis
- Risk Reduction

Results of this client-centered activity will be used to establish Ryan White funded service priorities, document the need for specific prevention and care services, determine barriers to accessing HIV testing and care, provide baseline data for comprehensive prevention and care planning including capacity building, and help providers improve the accessibility, acceptability and quality of both prevention and care services that are delivered to this special population'.

## EPIDEMIOLOGY OF NEWLY INFECTED PLWHA

During the reporting period of January 1, 2008 to December 31, 2009, there were 205 new AIDS cases reported and 637 new HIV cases, representing an 11% increase in new HIV cases. Males represent 67% of AIDS incidence in 2008-2009 (reduced from 72% of the AIDS incidence in 2007-2008), evidencing recent increases in advancing disease among women, and especially women of color in the TGA. Blacks had almost 4 times higher the number of newly reported AIDS cases than whites (N=151 versus 39). MSM represented 29% of new AIDS cases while Heterosexuals represented 17% of new AIDS cases. Males represent 76% of new HIV cases, Blacks were diagnosed with HIV at a 76% rate, and MSM had the highest incidence of new HIV cases at 43% (an increase of 9% over the last reporting period), followed by Heterosexuals at 9%.

The respondents to the newly diagnosed survey comprised approximately 19% of newly diagnosed (N=842) within the past year.

<b>% GENERAL POPULATION V. HIV+</b>	<b>A</b>	<b>B</b>	<b>C</b>
<b>GROUP IN NORFOLK, VA TGA</b>	<b>GENERAL POPULATION</b>	<b>NEW CASES</b>	<b>PLWHA</b>
<b>RACE/ETHNIC GROUP</b>			
<b>AFRICAN AMERICAN</b>	<b>31%</b>	<b>77%</b>	<b>71%</b>
<b>ASIAN</b>	<b>3%</b>	<b>1.0%</b>	<b>&lt;1%</b>
<b>LATINO/A</b>	<b>3%</b>	<b>4%</b>	<b>3%</b>
<b>OTHER</b>	<b>3%</b>	<b>1%</b>	<b>1%</b>
<b>WHITE</b>	<b>60%</b>	<b>17%</b>	<b>24%</b>
<b>GENDER</b>			
<b>MALE</b>	<b>49%</b>	<b>74%</b>	<b>72%</b>
<b>FEMALE</b>	<b>51%</b>	<b>26%</b>	<b>28%</b>
<b>AGE GROUP</b>			
<b>0-12</b>	<b>14%</b>	<b>0.34%</b>	<b>1%</b>
<b>13-19</b>	<b>6%</b>	<b>7%</b>	<b>4.1%</b>
<b>20-44</b>	<b>46%</b>	<b>78%</b>	<b>86%</b>
<b>45+</b>	<b>34%</b>	<b>15%</b>	<b>8.4%</b>

Sources: Column A. US Census Bureau, 2008;

Columns B & C: Virginia Department of Health (VDH)/North Carolina Division of Public Health (NCDPH); 2009

DEMOGRAPHICS OF 2011 NEWLY DIAGNOSED/NEW TO CARE...CHART CONTINUES ON PG. 85

<b>AGE RANGE</b>	<b>NUMBER</b>	<b>PERCENT</b>
<b>0-12 YEARS</b>	<b>0</b>	<b>0%</b>
<b>13-19 YEARS</b>	<b>2</b>	<b>4.4%</b>
<b>20-29 YEARS</b>	<b>22</b>	<b>48%</b>

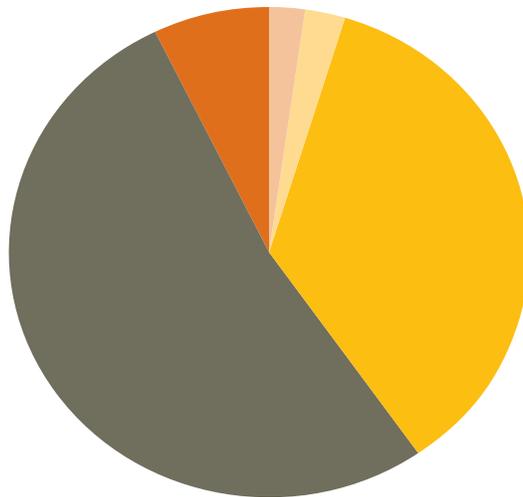
AGE RANGE	NUMBER	PERCENT
30-39 YEARS	11	24%
40-49 YEARS	7	16%
50-59 YEARS	1	2%
<b>TOTAL</b>	<b>45</b>	<b>100%</b>

## GENDER & RACE OF NEWLY DIAGNOSED

- 44% Male; 53% Female; 2% Transgender
- 87% African American; 13% White

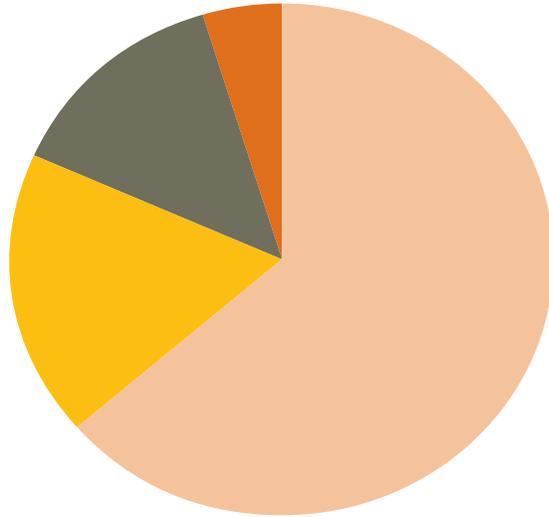
## RISK EXPOSURE MODE

The majority of the 2011 Newly Diagnosed reports heterosexual sex as their risk exposure mode (>52%), with 36% reporting MSM as their transmission risk mode. A significant minority report IDU (7%), and 2% respectively, report Mother with HIV/AIDS and Sex with Drug User as the way they became infected with HIV.



- MALE SEX W/MALE 35.7 %
- INJECTION DRUG USER 7.1%
- SEX W/DRUG USER 2.4%
- MOTHER W/HIV/AIDS 2.4 %
- HETEROSEXUAL SEX 52.4%

## HEALTH INSURANCE COVERAGE

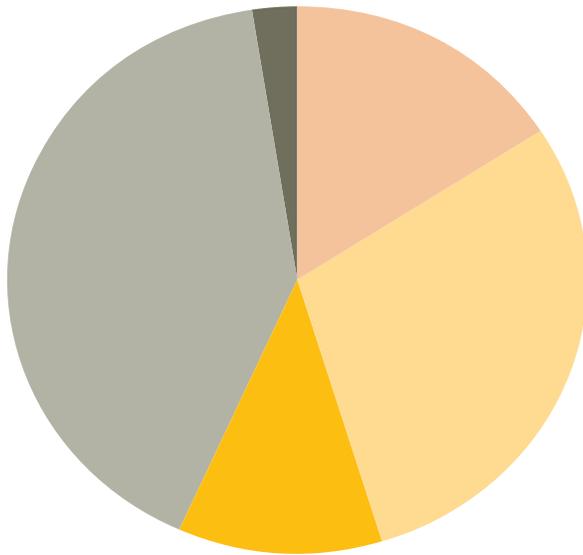


- PRIVATE HEALTH INSURANCE 18.2 %
- MEDICARE 13.6%
- VA BENEFITS 4.5%
- NONE 63.6%

Almost 2/3 of the 2011 Newly Diagnosed respondents report a lack of health insurance coverage, while 18% report private health insurance, 14% report Medicaid benefits, and 5% report VA benefits.

## YEAR OF DIAGNOSIS AND HIV/AIDS STATUS

100% of the Newly Diagnosed PLWH/A received their diagnosis within the past year. The vast majority (86%) report an HIV- not AIDS diagnosis and 14% report the receipt of an AIDS diagnosis.



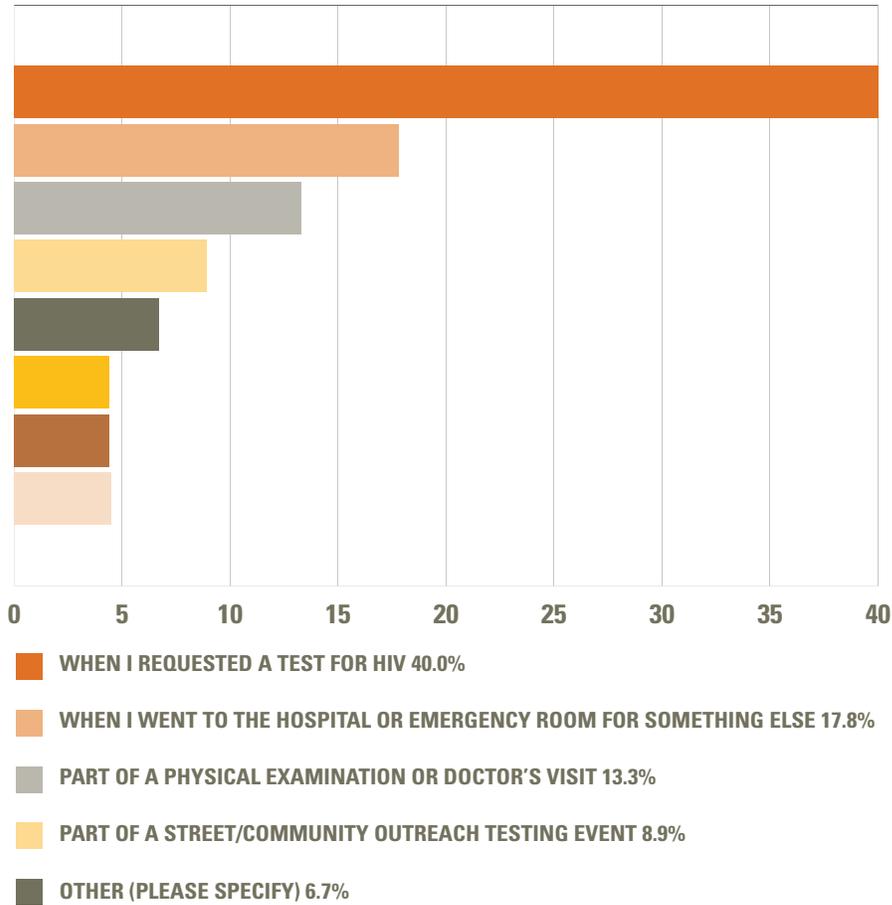
- > 500 15.9%
- I DON'T KNOW 40.9%
- BETWEEN 200-500 29.5%
- I HAVEN'T HAD LABS YET 2.3%
- <200 11.4%

### INITIAL CD4 CELL COUNT

While only 14% of the Newly Diagnosed report the formal receipt of an AIDS diagnosis, only 16% report their initial CD4 cell count was greater than 500. Thirty percent (30%) report varying levels of immune system decline with CD4 cell counts ranging between 200-500 cells. Over 40% report that they do not know what their initial CD4 cell count was, a disturbing finding. Over 1/3 report the active receipt of ART (37%).

## TESTING CIRCUMSTANCES

### HOW DID YOU FIND OUT YOU WERE HIV POSITIVE



Over half of the Newly Diagnosed respondents reported that they wanted to know their status (17 or 52%) and 18 PLWH/A voluntarily requested HIV testing. However, almost 18% were diagnosed in the ER/ Hospital while being treated for something else. Almost 1/3 or 27% were tested as part of routine health care, whether during a doctor visit, through perinatal care or upon blood donation.

### REASONS FOR HIV TESTING...CHART CONTINUES ON PG. 89

IF YOU VOLUNTARILY REQUESTED A TEST FOR HIV, WHAT PROMPTED YOU TO GET TESTED FOR HIV?		
ANSWER OPTIONS	PERCENT	COUNT
I WANTED TO KNOW MY STATUS	51.5%	17
I DID NOT FEEL WELL AND THOUGHT I SHOULD GET TESTED FOR HIV	21.2%	7
I HAD UNPROTECTED SEX WITH SOMEONE WHO WAS HIV POSITIVE	15.2%	5

**IF YOU VOLUNTARILY REQUESTED A TEST FOR HIV, WHAT PROMPTED YOU TO GET TESTED FOR HIV?**

I NEEDED SCREENING AND/OR TREATMENT FOR AN STD	9.1%	3
A FRIEND TESTED POSITIVE	9.1%	3
MY PARTNER TESTED POSITIVE	9.1%	3
I WANTED TO CONFIRM MY SUSPICION THAT I WAS POSITIVE	3.0%	1
DRUG USE	0.0%	0
MY PARTNER ASKED ME TO GET TESTED	0.0%	0
OTHER (PLEASE SPECIFY): IN HOSPITAL	3.0%	1
ANSWERED QUESTION 33		

REFERRALS FOR AOMC & OTHER HIV SERVICES...CHART CONTINUES ON PG. 90

**AT THE TIME OF YOUR HIV DIAGNOSIS, WERE YOU REFERRED FOR ANY OF THE FOLLOWING SERVICES?**

ANSWER OPTIONS	PERCENT	COUNT
MEDICAL CARE RELATED TO HIV DIAGNOSIS	65.9%	29
MEDICAL CARE FOR CONDITION OTHER THAN HIV	9.1%	4
CASE MANAGEMENT	68.2%	30
SUBSTANCE ABUSE COUNSELING SERVICE	4.5%	2
MENTAL HEALTH SERVICES (OTHER THAN SUBSTANCE ABUSE COUNSELING)	15.9%	7
IF PREGNANT, OB/GYN CARE	4.5%	2
HEALTH/HIV EDUCATION CLASS	6.8%	3

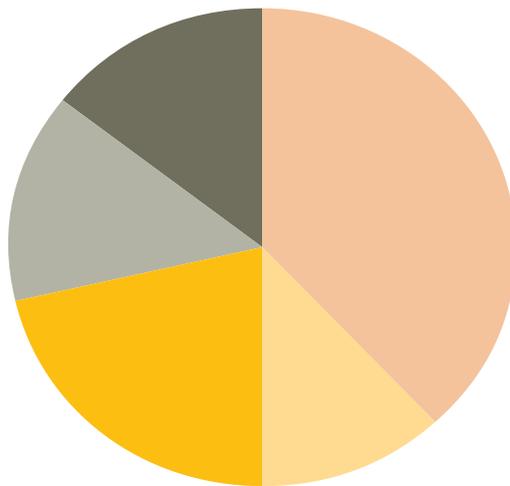
**AT THE TIME OF YOUR HIV DIAGNOSIS, WERE YOU REFERRED FOR ANY OF THE FOLLOWING SERVICES?**

I WAS NOT REFERRED FOR SERVICES	4.5%	2
DON'T REMEMBER	6.8%	3
OTHER (PLEASE SPECIFY): CALLED ON MY OWN; MAI	4.5%	22
<b>ANSWERED QUESTION 44</b>		

The majority of the Newly Diagnosed (66%) report the receipt of a referral into HIV medical care and 68% report a referral into case management. A substantial minority were referred for mental health services (16%) and 5% were referred for substance abuse services. It is notable that 5% of the Newly Diagnosed were referred for OB/perinatal services because they were pregnant. Only 5% report NOT being referred for any services and another 7% report not remembering whether they were referred for care and services upon diagnosis.

**FREQUENCY OF HIV TESTS PRIOR TO DIAGNOSIS**

The greatest proportion of Newly Diagnosed received their HIV status report upon their very first test (38%). Another 21% reported testing every year or so and another 12% reported getting tested every six months at the frequency recommended by the CDC for high risk MSMs. Fourteen percent (14%) reported “other”, stating: “tested every two years or so” and another 14% reported the following: “one other time in 2009”; “4 years ago”; “tested one time years ago”; and “tested one time before”.

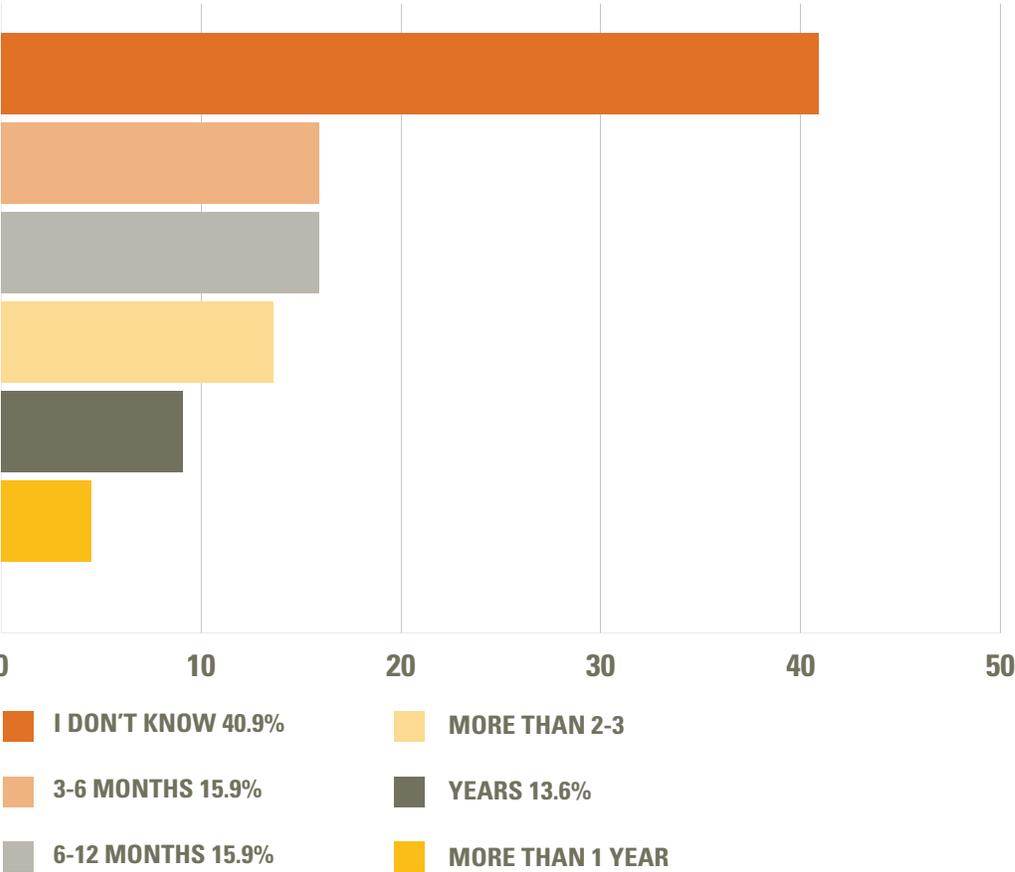


- I HAD NOT BEEN TESTED BEFORE 38.1%
- I GENERALLY GOT TESTED EVERY SIX MONTHS OR SO 11.9%
- I GENERALLY GOT TESTED ON AN ANNUAL BASIS OR SO 21.4%
- I GOT TESTED EVERY TWO YEARS OR SO 14.3%
- OTHER (PLEASE SPECIFY) 14.3%

### ESTIMATE OF TIME LIVING WITH HIV PRIOR TO DIAGNOSIS

When asked to estimate the amount of time they thought they had been living with HIV prior to learning their status, the majority of the Newly Diagnosed respondents reported “not knowing” (41%). The smallest proportion estimated only 1-3 months ( 5%); followed by 9% who estimated more than one year; followed by 14% who believed they had been living with HIV at least 2-3 years prior to diagnosis; and 16% who believed it had been only 3-6 months.

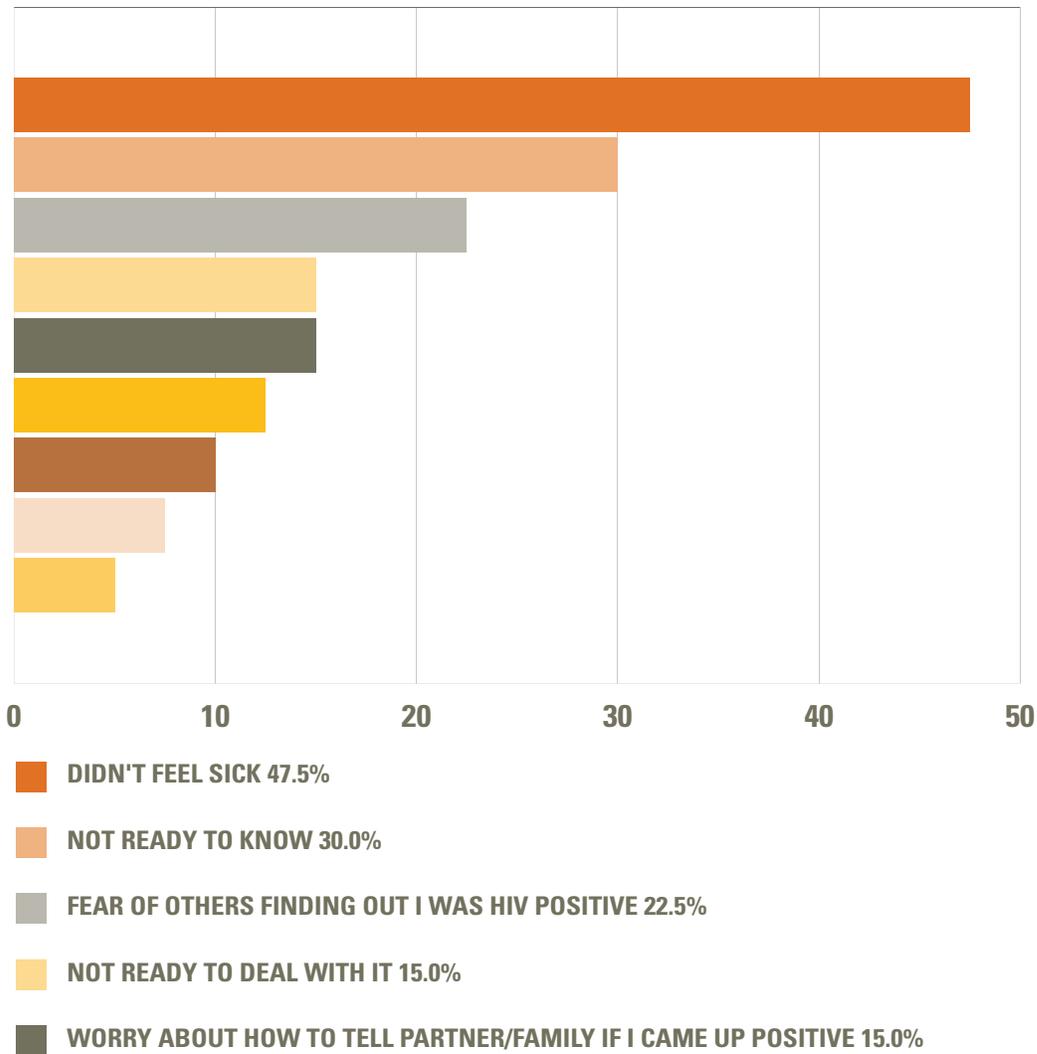
### HOW LONG DO YOU THINK YOU MAY HAVE BEEN HIV POSITIVE (LIVING WITH HIV) BEFORE YOU RECEIVED YOUR FIRST POSTIVE TEST?



### REASONS FOR NOT GETTING TESTED

The most frequently reported reason to support their delay in getting tested for HIV included “Didn’t feel sick” (48%), followed by “Not ready to know (30%); and “Fear of others finding out” (23%). Less frequently reported reasons for delaying testing included: “Not ready to deal with it” (15%) and “Worry about how to tell partner/family” (15%), followed by general stigma surrounding HIV disease (13%) and concerns about confidentiality/privacy (8%). The least reported reason was lack of insurance (5%).

IF YOU DELAYED GETTING TESTED FOR HIV, WHAT WERE YOUR REASONS FOR NOT GETTING TESTED?



PROMPTS TO EARLIER TESTING

The greatest number of Newly Diagnosed (45%) reported that more information/health education about HIV testing would have likely prompted them to seek testing sooner.

CHART CONTINUES ON PG. 93

WHAT WOULD HAVE HELPED YOU TO GET TESTED FOR HIV SOONER? (PLEASE CHECK ALL THAT APPLY.)		
ANSWER OPTIONS	PERCENT	COUNT
MORE INFORMATION/HEALTH EDUCATION ABOUT HIV TESTING	44.7%	17
AN ADVOCATE TO COME WITH ME TO MY TEST	18.4%	7

**WHAT WOULD HAVE HELPED YOU TO GET TESTED FOR HIV SOONER? (PLEASE CHECK ALL THAT APPLY.)**

A PEER TO TALK WITH ABOUT GETTING TESTED FOR HIV	15.8%	6
BEING CLEAN AND SOBER	15.8%	6
MENTAL HEALTH COUNSELING AT THE POINT OF TESTING	10.5%	4
TRANSPORTATION ASSISTANCE TO TESTING SITE	5.3%	2
OTHER (PLEASE SPECIFY): MORE DOCTOR VISITS	2.6%	1
<b>ANSWERED QUESTION 38</b>		

Other strategies that this cohort of Newly Diagnosed report as helpful to encouraging earlier HIV testing include: “an advocate to accompany them to take the test” (18%), followed by “a peer to talk with about getting tested” (16%) and “being clean and sober” (16%). Less frequently recommended supports to testing included: “Mental health counseling available at the point of testing” (11%), transportation assistance (5%) and “more doctor visits” (3%).

## **PARTNER NOTIFICATION SERVICES**

The majority of the Newly Diagnosed respondents affirm the receipt of partner notification services at the point of testing positive (71%), while 7% deny the receipt of an offer. A sizeable minority of the Newly Diagnosed respondents did not know or did not remember whether they had been offered partner notification services (21%) at the point of initial diagnosis. The majority (66%) report they encourage their sexual partners to be tested and 96% state that they know where to get free condoms.

## **EXPOSURE TO HIV PREVENTION MESSAGES PRIOR TO TESTING**

The vast majority of the 2011 Newly Diagnosed respondents (86%) report they had previously been exposed to HIV prevention messages while 14% reported they had not. The most frequently reported vehicle for the successful receipt of HIV prevention messages was TV or radio (56%) followed by books and magazines/newspapers (53%); doctor’s/health care providers’ office (50%); and billboards (47%). One quarter (25%) of the Newly Diagnosed respondents reported receiving HIV prevention messages via internet web sites; 16% through friends; with 11% reporting the exposure to HIV prevention messages via internet chat rooms and bars, respectively.

**IF YES, WHERE DID YOU SEE/HEAR THESE HIV PREVENTION MESSAGES? (PLEASE CHECK ALL THAT APPLY.)**

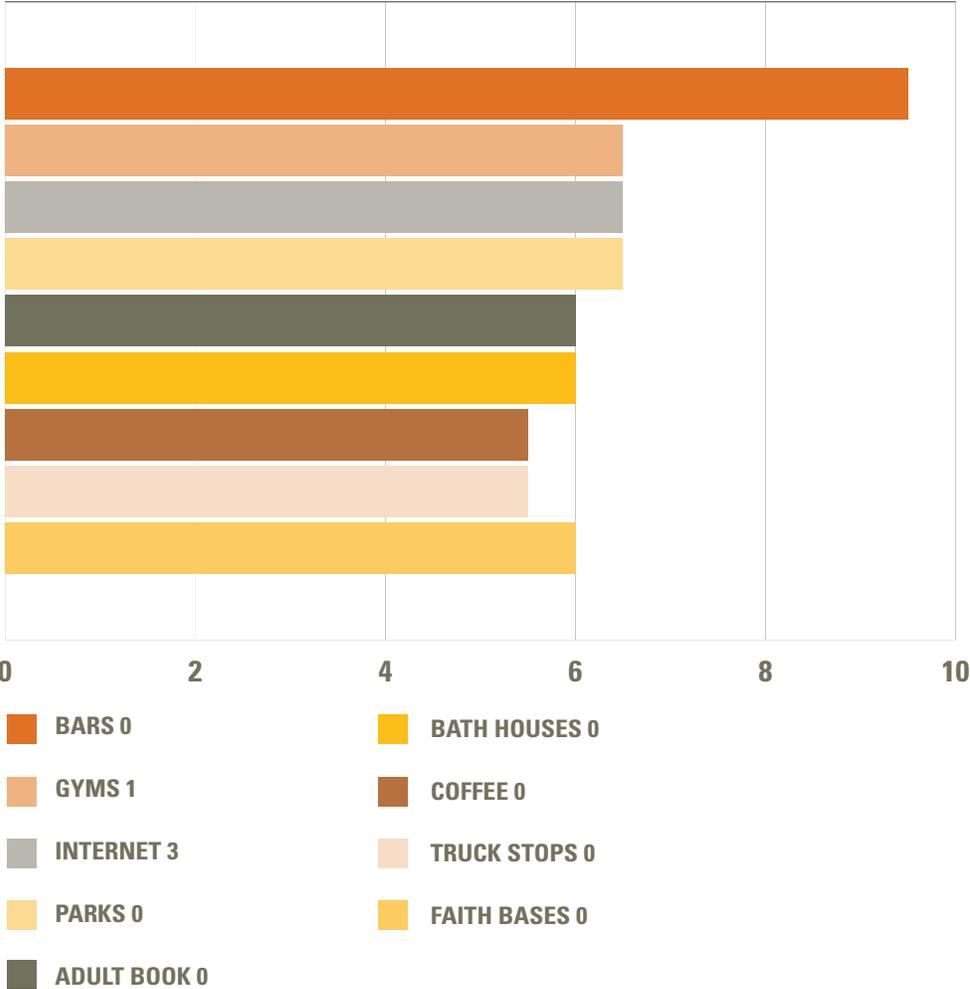
<b>ANSWER OPTIONS</b>	<b>PERCENT</b>	<b>COUNT</b>
TV OR RADIO	55.6%	20
BOOKS, MAGAZINES, NEWSPAPERS	52.8%	19
MY DOCTOR OR HEALTH CARE PROVIDER'S OFFICE	50.0%	18
BILLBOARDS	47.2%	17
INTERNET WEB SITES	25.0%	9
FRIENDS	16.7%	6
INTERNET CHAT ROOMS	11.1%	4
BARS	11.1%	4
<b>ANSWERED QUESTION 36</b>		

### **SEEKING OUT SEXUAL PARTNERS SINCE HIV DIAGNOSIS**

Only a minority (25%) of the Newly Diagnosed report actively seeking new sexual partners since their diagnosis. It is not known how many are already partnered or have spouses. Seven percent (7%) preferred to not answer the question.

# FREQUENTING OF VARIOUS LOCATIONS TO MEET SEXUAL PARTNERS

NORFOLK NEWLY DIAGNOSED



A minority of the Newly Diagnosed respondents report seeking out sexual partners on a daily basis at the gym or internet (one and one respondent, respectively). Three respondents report seeking sexual partners on a weekly basis via the internet and one respondent reports seeking partners on a weekly basis at the gym.

## MENTAL HEALTH & SUBSTANCE ABUSE CO-MORBIDITIES

29% report previous diagnosis and/or treatment for mental health issues and 11% report diagnosis and/or treatment for a substance abuse disorder.

## STI CO-MORBIDITY

As evidenced in the table on the following page, there is a significant level of reported sexually transmitted disease in this cohort of Newly Diagnosed respondents. Over 1/3 report a previous diagnosis of Chlamydia (36%); ¼ report Gonorrhea (25%); 16% report syphilis and 14% report genital herpes.

<b>HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR SEXUALLY TRANSMITTED DISEASES (STD)?</b>		
<b>ANSWER OPTIONS</b>	<b>PERCENT</b>	<b>COUNT</b>
CHLAMYDIA	36.4%	16
GONORRHEA	25.0%	11
SYPHILIS	15.9%	7
GENITAL HERPES	13.6%	6
GENITAL WARTS	0.0%	0
NOT APPLICABLE	40.9%	18
<b>ANSWERED QUESTION 44</b>		

### **OTHER CHRONIC ILLNESS**

The 2011 Newly Diagnosed respondents report a fair amount of other chronic illness, with 29% reporting the previous diagnosis and treatment of Diabetes, Hypertension, high cholesterol, TB, Sickle cell disease, and Hepatitis C.

### **LOCATION OF PRIMARY MEDICAL CARE PROVIDER...CHART CONTINUES ON PG. 97**

<b>WHAT CLINIC/DOCTOR'S OFFICE DO YOU GO TO FOR YOUR HIV?</b>		
<b>ANSWER OPTIONS</b>	<b>PERCENT</b>	<b>COUNT</b>
EVMS	61.4%	27
PICH	13.6%	6
VA	9.1%	4
HEALTH DEPARTMENT	4.5%	2
PORTSMOUTH NAVAL	0.0%	0

WHAT CLINIC/DOCTOR'S OFFICE DO YOU GO TO FOR YOUR HIV?		
HEALTH UNIT (PRISON)	0.0%	0
OTHER (PLEASE SPECIFY): NCHC (4); DR. KLUGER	11.4%	5
ANSWERED QUESTION 44		

The vast majority of this cohort of Newly Diagnosed PLWH/A identify EVMS as their HIV primary care home. PICH is next most frequently reported (14%), followed by VA (9%) and Health Department (5%), and NCHC (9%).

### PATTERN OF AOMC ENGAGEMENT

As evidenced in the table below, the vast majority of the Newly Diagnosed evidences a strong initial engagement in Ambulatory Outpatient Medical Care (AOMC). All but one respondent has had an AOMC visit in the past 3-6 months. The remaining single respondent reports an out of care status with the last reported AOMC visit in 2008.

### LAST DOCTOR VISIT PATTERN TRENDS...CHART CONTINUES ON PG. 98

VISIT TIME FRAME	DOCTOR
PAST 3-4 MONTHS 1/11-4/11 (IDEAL 'IN CARE' STATUS)	22
PAST 4-6 MONTHS 10/10-12/10 (SATISFACTORY 'IN CARE' STATUS)	14
PAST 7-9 MONTHS 7/10-9/10 (ERRATICALLY 'IN CARE' STATUS)	0
PAST 10-12 MONTHS 4/10-6/10 (ERRATICALLY 'IN CARE' STATUS- AT RISK OF UNMET NEED)	0
<b>TOTAL 'IN CARE'</b>	<b>36</b>

VISIT TIME FRAME	DOCTOR
TECHNICALLY 'OUT OF CARE' UNMET NEED IN 2010-11,	0
OUT OF CARE > ONE YEAR (OOC SINCE 2008 OR BEFORE)	1
NEVER IN CARE	0
<b>TOTAL OUT OF CARE</b>	<b>1</b>
<b>GRAND TOTAL</b>	<b>37</b>

## USE, NEED, BARRIER & GAP RANKING

A Need, Use, Barrier and Gap ranking was developed for all Norfolk TGA Newly Diagnosed survey respondents, with rankings developed for each special population. The 2011 HIV/AIDS Needs Assessment provides a “snapshot” of community service uses, needs, barriers, and gaps as expressed by consumers of HIV related services in the service area. The rankings of the Needs Assessment are displayed for all ‘Newly Diagnosed/New to Care’ respondents.

<b>USE</b>	Number of ‘New to Care’ client survey respondents who indicated service use in the past year
<b>NEED</b>	Number of ‘New to Care’ client survey respondents who stated “I currently need this service.”
<b>BARRIER</b>	Number of ‘New to Care’ client survey respondents who indicated that a service is ‘Hard to Get’.
<b>GAP</b>	Sum of ‘New to Care’ client survey respondents who answered ‘Yes’ to Need and ‘No’ to availability of that service

2011 ALL NEWLY DIAGNOSED PLWH/A USE, NEED, BARRIER, GAP MATRIX...CHART  
CONTINUES ON PG. 100

SERVICE CATEGORY DESCRIPTION	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
AMBULATORY OUTPATIENT MEDICAL CARE	1	1	NR	NR
MEDICATION ASSISTANCE	2	5 tie	3 tie	1
HOUSING ASSISTANCE	3	5 tie	1	3
HEALTH EDUCATION/ PEER EDUCATOR	4	6 tie	NR	NR
MENTAL HEALTH/ SUPPORT GROUPS	5 tie	4	3 tie	5 tie
NUTRITION ASSISTANCE	5 tie	8 tie	3 tie	6 tie
MEDICAL TRANSPORTATION	6 tie	3	NR	5 tie
HIV PREVENTION/ CONDOMS	6 tie	7	NR	NR
OTHER: EMPLOYMENT ASSISTANCE	7	NR	NR	NR
HEALTH INSURANCE ASSISTANCE	8	NR	4 tie	5 tie
EMERGENCY FINANCIAL ASSISTANCE	9	NR	NR	NR
MEDICAL CASE MANAGEMENT	10 tie	2	NR	6 tie
SUBSTANCE ABUSE SERVICES- OUTPATIENT	10 tie	NR	NR	NR
ORAL HEALTH CARE	NR	6 tie	3 tie	2
OTHER: VISION CARE	NR	8 tie	2	4 tie

SERVICE CATEGORY DESCRIPTION	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
OTHER: MEDICAL SPECIALTY CARE	NR	NR	4 tie	NR
OTHER: DISABILITY ASSISTANCE/ MEDICAID	NR	NR	NR	4 tie
OTHER: "KNOWING WHERE TO GO/WHAT TO DO"	NR	NR	NR	6 tie

**THE TOP 10 RANKING SERVICE NEEDS OF THE 2011 NORFOLK TGA NEWLY DIAGNOSED SURVEY RESPONDENT GROUP INCLUDE:**

1. AOMC
2. Medication Assistance
3. Housing Assistance
4. Health Education/Peer Educator
5. Mental Health/Support Groups tied with Nutrition Assistance
6. Medical Transportation tied with HIV Prevention/Condoms
7. Employment Assistance
8. Health Insurance Assistance
9. Emergency Financial Assistance
10. Medical Case Management tied with Substance Abuse Services-Outpatient

**THE TOP RANKING SERVICE USES OF THE 2011 NORFOLK TGA NEWLY DIAGNOSED SURVEY RESPONDENT GROUP INCLUDE:**

1. AOMC
2. Medical Case Management
3. Medical Transportation
4. Mental Health/Support Groups
5. Medication Assistance tied with Housing Assistance
6. Health Education/Peer Educator tied with Oral Health Care
7. HIV Prevention/Condoms
8. Nutrition Assistance tied with Other: Vision Care

## THE TOP RANKING SERVICE GAPS OF THE 2011 NORFOLK TGA NEWLY DIAGNOSED SURVEY RESPONDENT GROUP INCLUDE:

1. Housing Assistance
2. Other: Vision Care
3. Medication Assistance tied with Mental Health/Support Groups tied with Nutrition Assistance tied with Oral Health Care
4. Health Insurance Assistance tied with Other: Medical Specialty Care

## THE TOP RANKING SERVICE BARRIERS OF THE 2011 NORFOLK TGA NEWLY DIAGNOSED SURVEY RESPONDENT GROUP INCLUDE:

1. Medication Assistance
2. Oral Health Care
3. Housing Assistance
4. Other: Vision Care tied with Disability Assistance
5. Mental Health/Support Groups tied with Medical Transportation tied with Health Insurance Assistance
6. Nutrition Assistance tied with Medical Case Management tied with “Knowing where to go/what to do”

## CHAPTER 4: OUT OF CARE SURVEY FINDINGS

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### INTRODUCTION

*Estimates of Unmet Need:* Calculated results of the HRSA/HAB Framework indicated that approximately 736 (28%) of PLWA-aware and 1,280 (34%) of PLWH-aware had “unmet need” The combined total of PLWHA-aware with “unmet need” in the Norfolk TGA is 2,016/6,344 or 31%, a slight improvement from the figure of 37% in 2006.

#### THREE-YEAR TREND OF UNMET NEED IN NORFOLK TGA, 2007-2009

2007	2008	2009	% CHANGE 07-09
2,086 (37%)	2,101 (34%)	2,016 (31%)	-70 PLWHA; 37 TO 31%

## OUT OF CARE DEMOGRAPHICS

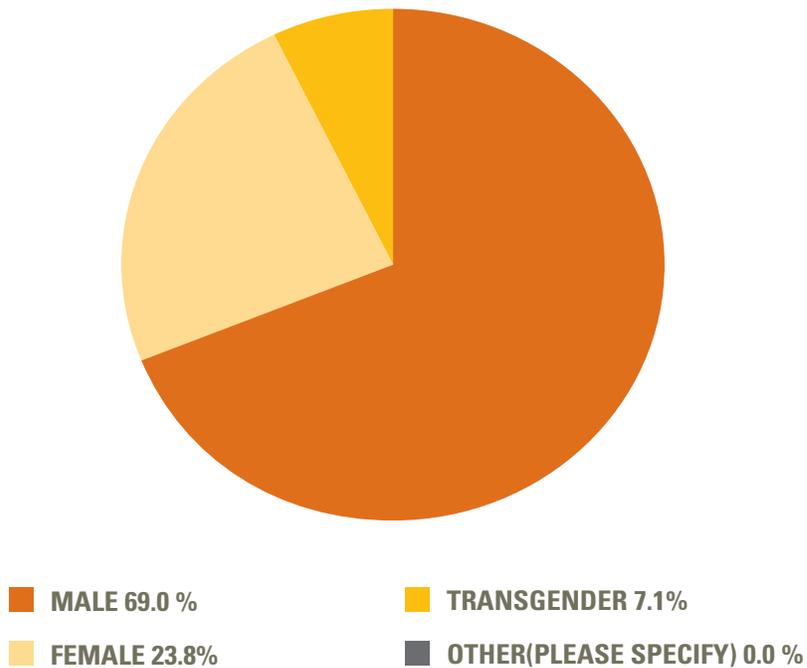
A total of 42 PLWH/A participated in the 2011 Out of Care survey.

### AGE

The ages of the OOC ranged from 19 to 63 years, with the average age reported as 39 years of age.

### GENDER

#### NORFOLK OUT OF CARE



Over 2/3 of the OOC respondents are male; 24% female; and 7% transgender.

## RACE/ETHNICITY

WHAT RACE DO YOU CONSIDER YOURSELF?		
ANSWER OPTIONS	PERCENT	COUNT
AFRICAN AMERICAN	83.3%	35
CAUCASIAN	7.1%	3
HISPANIC/LATINO	7.1%	3
AMERICAN INDIAN	0.0%	0
ASIAN PACIFIC ISLANDER	0.0%	0
OTHER (PLEASE SPECIFY)	0.0%	0
ANSWERED QUESTION 42		

100% of the OOC respondents report US Citizenship, with English reported as their first language.

## SEXUAL ORIENTATION

WHAT IS YOUR SEXUAL ORIENTATION?		
ANSWER OPTIONS	PERCENT	COUNT
GAY	41.5%	17
BISEXUAL	7.3%	3
STRAIGHT	43.9%	18
PREFER NOT TO ANSWER	2.4%	1
OTHER (PLEASE SPECIFY): TRANSGENDER	4.9%	2
ANSWERED QUESTION 41		

The OOC respondents' reports of sexual orientation evidence nearly equal proportions of those identifying as gay (42%) or straight (44%), with over 7% reporting bisexuality and 5% reporting transgender.

Of the nine respondents who answered the question regarding relationship status, 7 reported single, 1 reported partnered, and one reported divorced.

## EDUCATION LEVEL

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?		
ANSWER OPTIONS	PERCENT	COUNT
GRADE SCHOOL	4.9%	2
SOME HIGH SCHOOL	17.1%	7
HIGH SCHOOL DEGREE/GED	43.9%	18
SOME COLLEGE	24.4%	10
COLLEGE DEGREE	7.3%	3
SOME GRADUATE SCHOOL	0.0%	0
GRADUATE SCHOOL DEGREE	2.4%	1
ANSWERED QUESTION 41		

There is wide variation in the education levels reported by the OOC respondents. Almost 44% of the OOC respondents report a high school diploma or GED. Over 1/5 or 22% report only some high school or grade school education, while over 24% report some college and over 7% report a college degree. One PLWH/A reports the attainment of a graduate level degree.

## CURRENT LIVING SITUATION

DO YOU CURRENTLY?		
ANSWER OPTIONS	PERCENT	COUNT
OWN YOUR HOME	2.4%	1
RENT	39.0%	16
LIVE WITH A FRIEND/RELATIVE	43.9%	18
STAY IN A SHELTER	9.8%	4
OTHER (PLEASE SPECIFY): HOMELESS	4.9%	2
ANSWERED QUESTION 41		

The greatest proportion of OOC PLWH/A report a temporary housing status, “living with friends/relatives”, and another 10% reports current homelessness, “staying in a shelter”. Almost 40% report renting their current home and a small minority report that they own their residence (2%).

## HIV /AIDS STATUS

The vast majority of the OOC respondents report an HIV-not AIDS diagnosis (85%) with 12% reporting an AIDS diagnosis and 2% reporting that they do not know their status.

The OOC respondents report the year of diagnosis, ranging from 1980 to 2010, with the most frequently reported year of diagnosis as the year 2000 (median value).

All but three of the OOC respondents report learning their status when living in Virginia. The three others report living in Washington, DC, North Carolina and New York at the time of their diagnosis.

## TESTING CIRCUMSTANCES...CHART CONTINUES ON PG. 106

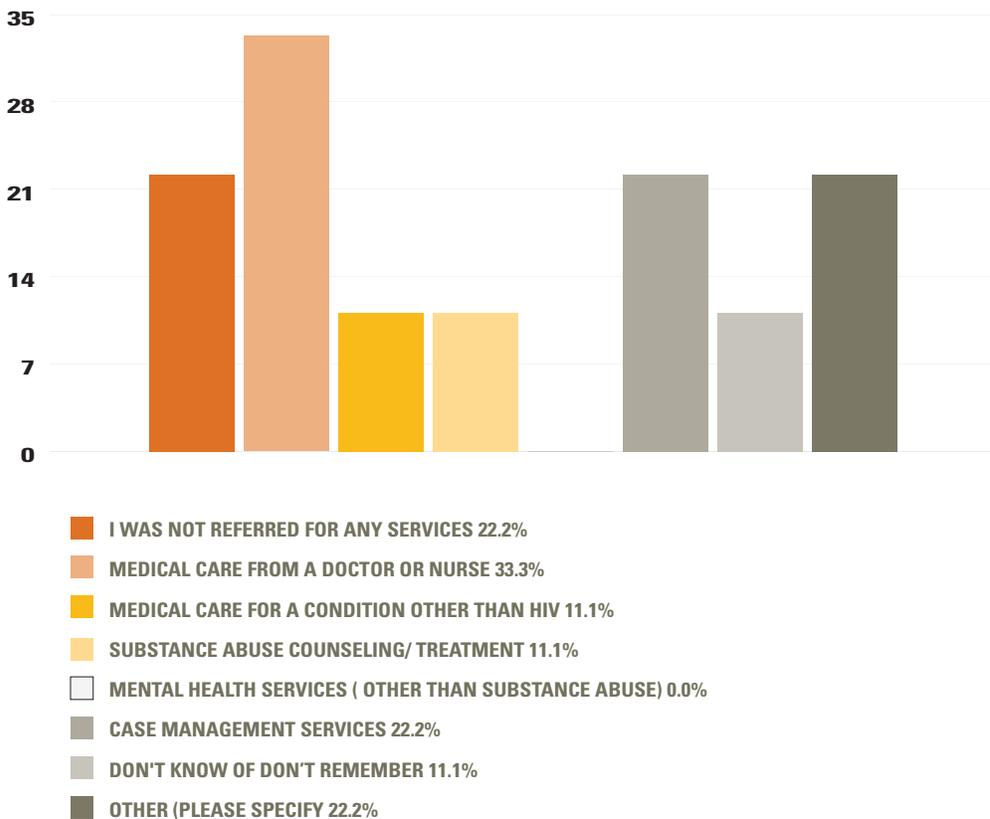
WHY WERE YOU GETTING TESTED FOR HIV WHEN YOU LEARNED YOU WERE POSITIVE?		
ANSWER OPTIONS	PERCENT	COUNT
I WAS TESTED WHEN I WENT TO THE HOSPITAL FOR ANOTHER HEALTH CARE REASON	21.4%	9
I ASKED A HEALTH CARE PROVIDER TO TEST ME FOR HIV	19.0%	8
I TESTED AS PART OF AN OUTREACH CLINIC OR STREET OUTREACH PROGRAM THAT OFFERED HIV TESTING	19.0%	8
I WAS TESTED AS PART OF A ROUTINE PHYSICAL EXAMINATION	9.5%	4
I WAS TESTED WHEN I TRIED TO DONATE BLOOD	7.1%	3
I WAS TESTED AS PART OF ROUTINE CARE WHILE PREGNANT (FOR WOMEN)	4.8%	2
I WAS TESTED BECAUSE MY PARTNER/SOMEONE ASKED ME TO TEST	4.8%	2

## WHY WERE YOU GETTING TESTED FOR HIV WHEN YOU LEARNED YOU WERE POSITIVE?

I WAS TESTED BY THE COURTS	0.0%	0
OTHER (PLEASE SPECIFY): TESTED BY ARMY; JAIL (2); HD; TESTED BECAUSE OF RAPE; FEMALE PARTNER DIAGNOSED	14.3%	6
ANSWERED QUESTION 42		

Over 1/5 of the OOC respondents report being tested when they were in the hospital for another reason (21%). Another 19% report voluntarily seeking testing and 19% were tested as part of an outreach testing program. Almost 10% were tested as part of a routine health exam. Seven percent were tested when they donated blood and almost 5% were tested as a routine part of their perinatal care. Another 5% sought testing because their partner or friend asked them to be tested. Other reasons for testing are listed in the table above.

## REFERRAL FOR SERVICES



*As evidenced above, over 1/5 of the OOC respondents reports the lack of any referrals for care and services upon being diagnosed HIV positive (22%). One third report a referral for HIV primary care (33%) and 22% report a case management referral. Eleven percent (11%) of the respondents reports a substance abuse referral, with none of the OOC respondents reporting a mental health referral. Another 11% don't remember or they don't know whether they received referrals for care and services upon diagnosis.*

#### LENGTH OF TIME FROM TESTING TO CARE

HOW SOON AFTER YOU FOUND OUT ABOUT BEING HIV POSITIVE DID YOU RECEIVE MEDICAL CARE?		
ANSWER OPTIONS	PERCENT	COUNT
IMMEDIATELY	66.7%	6
WITHIN 3-6 MONTHS	11.1%	1
WITHIN 6-12 MONTHS	22.2%	2
LONGER THAN 1 YEAR	0.0%	0
LONGER THAN 2-3 YEARS	0.0%	0
I HAVE NEVER RECEIVED MEDICAL CARE FOR MY HIV	0.0%	0
ANSWERED QUESTION 9		

For those who delayed their entry into care, the primary reason was “I was depressed”, indicating that the availability of mental health treatment at the point of testing may be a help in reducing the level of unmet need in the TGA.

LAST DOCTOR VISIT PATTERNTER

VISIT TIME FRAME	DOCTOR	VIRAL LOAD
PAST 3-4 MONTHS 1/11-4/11 (IDEAL 'IN CARE' STATUS/ JUST RETURNED TO CARE)	19	23
PAST 4-6 MONTHS 10/10-12/10 (SATISFACTORY RECENT RETURN TO 'IN CARE' STATUS)	6	5
PAST 7-9 MONTHS 7/10-9/10 (ERRATICALLY 'IN CARE' STATUS)	4	4
PAST 10-12 MONTHS 4/10-6/10 (ERRATICALLY 'IN CARE' STATUS- AT RISK OF UNMET NEED)	3	3
<b>TOTAL SATISFACTORY RETURN TO CARE 'IN CARE'</b>	<b>25</b>	<b>28</b>
<b>TOTAL ERRATICALLY 'IN CARE'/NOT STRONGLY ENGAGED</b>	<b>7</b>	<b>7</b>
TECHNICALLY 'OUT OF CARE' UNMET NEED IN 2010-11,	2	1
OUT OF CARE > ONE YEAR (OOC SINCE 2008 OR BEFORE)	5	3
NEVER IN CARE	0	0
<b>TOTAL ERRATICALLY IN/OUT OF CARE</b>	<b>14</b>	<b>11</b>
<b>GRAND TOTAL</b>	<b>39</b>	<b>35</b>

These medical and lab service visit patterns reported by the 2011 OOC PLWH/A evidence an excessively 'erratic in care' pattern coupled with a substantial number who have just returned to care from an unknown length of time spent in an absence from care. Of the OOC respondents who reported the last date they took ART, one reported 2001; one reported 2005; three reported 2010; and eight reported 2011 (presumably those who have just recently returned to care).

CHART CONTINUES ON PG. 110

<b>IF YOU HAVE NOT HAD MEDICAL CARE IN MORE THAN 6 MONTHS FOR YOUR HIV, PLEASE TELL US WHY. (PLEASE CHECK ALL THAT APPLY.)</b>		
<b>ANSWER OPTIONS</b>	<b>PERCENT</b>	<b>COUNT</b>
I AM UNDETECTABLE	37.5%	3
I DO NOT THINK I NEED MEDICAL CARE NOW BECAUSE I AM NOT SICK	37.5%	3
I GET ANXIOUS ABOUT GOING TO A DOCTOR OR NURSE ABOUT HIV	25.0%	2
NOT APPLICABLE, I HAVE RECEIVED MEDICAL CARE W/IN THE PAST 6 MOS	25.0%	2
I FEEL BETTER THAN I DID	25.0%	2
I HAVE NOT FOUND A PLACE THAT I FEEL COMFORTABLE GOING	12.5%	1
I DON'T HAVE TRANSPORTATION TO GET TO MEDICAL CARE APPOINTMENTS	12.5%	1
I DO NOT KNOW WHERE TO GO FOR MEDICAL CARE	12.5%	1
I CAN'T AFFORD MEDICAL CARE NOW	12.5%	1
I DON'T HAVE THE MONEY FOR PARKING/LUNCH	12.5%	1
I WAS TOLD TO TAKE A BREAK	0.0%	0
I DO NOT THINK MEDICAL CARE WOULD DO ME ANY GOOD	0.0%	0
I HAVE NOT FOUND A DOCTOR OR NURSE WHO I WANT TO TREAT ME	0.0%	0

**IF YOU HAVE NOT HAD MEDICAL CARE IN MORE THAN 6 MONTHS FOR YOUR HIV, PLEASE TELL US WHY. (PLEASE CHECK ALL THAT APPLY.)**

I DON'T HAVE CHILD CARE WHEN I GO FOR MEDICAL CARE	0.0%	0
I DO NOT WANT TO RECEIVE MEDICAL CARE	0.0%	0
I USE ALTERNATIVE TREATMENTS	0.0%	0
I DON'T WANT ANYONE TO KNOW	0.0%	0
I HAD PROBLEMS WITH MEDICATIONS	0.0%	0
OTHER (PLEASE SPECIFY): MENTAL HEALTH; GOT 'COCKY'; EVERY TIME I GO, EITHER THE DOCTOR ISN'T THERE OR I AM TOO LATE TO BE SEEN	37.5%	3
<b>ANSWERED QUESTION 8</b>		

The major reasons supplied by the OOC respondents to explain their absence from medical care include: “Am undetectable”; “Don’t need it because I am not sick”; “I get anxious about going”; “I feel better than I did”; while less frequently reported reasons include: lack transportation, can’t afford it and don’t know where to go for medical care. Several of these reasons that keep PLWH/A from medical care would appear to be positively impacted through better HIV education of the benefits of regular care and treatment.

**PROMPTS TO RETURN TO CARE...CHART CONTINUES ON PG. 111**

**IF YOU HAVEN'T RECEIVED MEDICAL CARE IN THE LAST 6 MONTHS, WHICH OF THE FOLLOWING THINGS WOULD HELP YOU GET TO A DOCTOR? (PLEASE CHECK ALL THAT APPLY.)**

<b>ANSWER OPTIONS</b>	<b>PERCENT</b>	<b>COUNT</b>
TRANSPORTATION	33.3%	3
MORE OUTREACH SERVICES	33.3%	3
FREE MEDICAL CARE	33.3%	3
PEER SUPPORT/SOMEONE TO HELP ME UNDERSTAND	22.2%	2

**IF YOU HAVEN'T RECEIVED MEDICAL CARE IN THE LAST 6 MONTHS, WHICH OF THE FOLLOWING THINGS WOULD HELP YOU GET TO A DOCTOR? (PLEASE CHECK ALL THAT APPLY.)**

NOT APPLICABLE AS I AM RECEIVING MEDICAL CARE	22.2%	2
MORE INFORMATION ABOUT THE SERVICES	22.2%	2
LOWER COST OF MEDICAL CARE/MEDICINES	22.2%	2
INSURANCE TO PAY FOR DOCTOR AND MEDS	22.2%	2
HOUSING	22.2%	2
FINANCIAL CONCERNS	22.2%	2
SUBSTANCE USE TREATMENT	11.1%	1
REFERRALS OR ADVICE FROM SOMEONE I TRUST	11.1%	1
OTHER (PLEASE SPECIFY): CASE MANAGER	11.1%	1
NOTHING	11.1%	1
NOT HAVING TO WAIT SO LONG FOR APPOINTMENTS	11.1%	1
MORE GOVERNMENT SERVICES	11.1%	1
EMPLOYMENT OPPORTUNITIES	11.1%	1
BETTER TRAINED DOCTORS AND NURSES	11.1%	1
<b>ANSWERED QUESTION 9</b>		

*Transportation assistance, more outreach services and free medical care are the top services that this cohort of PLWH/A with unmet/under-met need for medical care report as prompts to their returning to care.*

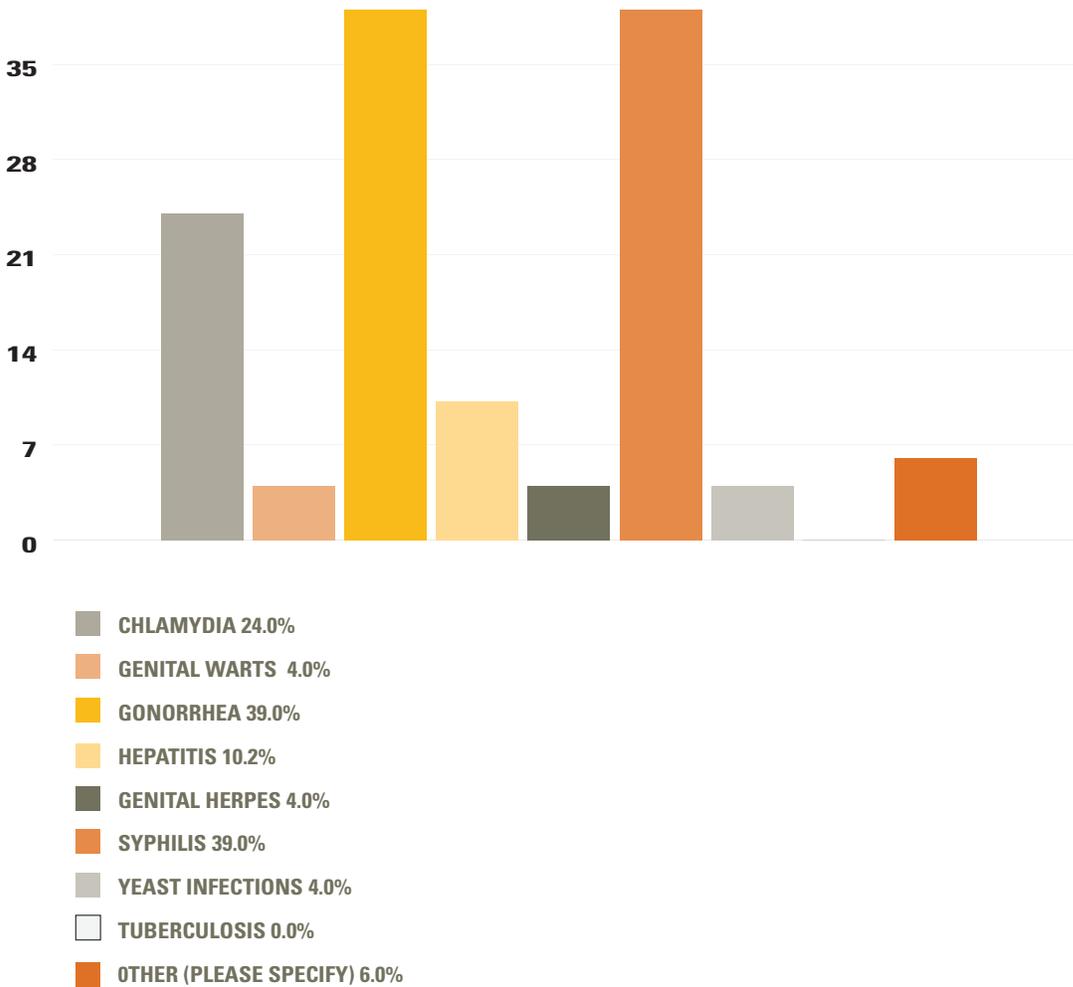
*Peer support, more information about the services available and how to access them, lower cost of medical care/medicines, housing assistance and assistance with financial concerns, and health insurance to pay for doctors and meds are the next most frequently reported prompters to seeking and remaining in primary medical care. The other prompters to return to care include reported by the OOC respondents include: substance abuse treatment, advice from trusted referral sources, a case manager, shorter appointment wait times, more government services, employment opportunities and better trained doctors and nurses.*

## REASONS WHY PLWH/A DON'T GET HIV MEDICAL CARE

IF YOU HAVEN'T RECEIVED MEDICAL CARE IN THE LAST 6 MONTHS, WHICH OF THE FOLLOWING THINGS WOULD HELP YOU GET TO A DOCTOR? (PLEASE CHECK ALL THAT APPLY.)		
ANSWER OPTIONS	PERCENT	COUNT
WORRIED THAT OTHER PEOPLE WILL FIND OUT/ FEAR OF TELLING	66.7%	6
FEEL HEALTHY	44.4%	4
DRUGS	33.3%	3
DON'T HAVE TRANSPORTATION	33.3%	3
DON'T BELIEVE THEY ARE HIV POSITIVE	33.3%	3
CAN'T AFFORD IT	33.3%	3
OTHER (PLEASE SPECIFY): NO SIGNS OR SYMPTOMS, GET ANXIOUS, DON'T CARE	22.2%	2
Don't want to take HIV medications	11.1%	1
Couldn't get an appointment	0.0%	0
Cannot speak English very well	0.0%	0
ANSWERED QUESTION 9		

When asked why PLWH/A do not get medical care for their HIV disease, the majority of the OOC respondents reported “Worried that others will find out/fear of divulging their HIV status”. The next most frequently cited reason is “Feel healthy”, followed by drug use, lack of transportation, don’t believe they are HIV positive, and can’t afford it. Less frequently reported reasons include the lack of signs or symptoms of disease, get anxious going to doctors, don’t care about getting treatment and don’t want to take HIV medications.

## SEXUALLY TRANSMITTED ILLNESSES (STIS)



Overall, this cohort of OOC respondents reports high levels of STIs, including almost 40% levels of reported Syphilis and Gonorrhea; 24% Chlamydia; over 10% Hepatitis A,B and/or C; and lesser amounts of reported genital herpes or warts or yeast infections.

## OTHER CHRONIC ILLNESSES...CHART CONTINUES ON PG. 114

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?		
ANSWER OPTIONS	PERCENT	COUNT
EMOTIONAL PROBLEMS	8.8%	3
PROBLEMS WITH THOUGHT OR MEMORY	5.9%	2

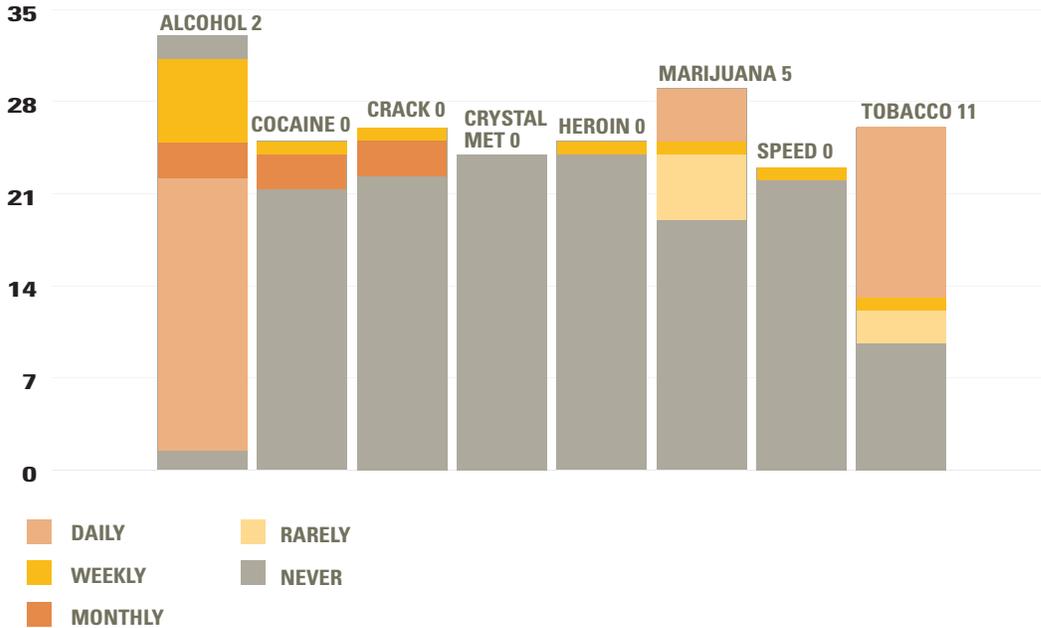
<b>HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?</b>		
<b>DRUGS</b>	<b>33.3%</b>	<b>3</b>
<b>OTHER (PLEASE SPECIFY): STROKE, HYPERTENSION, HYPOGLYCEMIA</b>	<b>5.9%</b>	<b>2</b>
<b>LIVER PROBLEMS</b>	<b>5.9%</b>	<b>2</b>
<b>HIGH CHOLESTEROL</b>	<b>5.9%</b>	<b>2</b>
<b>HIGH BLOOD PRESSURE</b>	<b>5.9%</b>	<b>2</b>
<b>Lung/breathing problems</b>	<b>2.9%</b>	<b>1</b>
<b>Kidney problems</b>	<b>2.9%</b>	<b>1</b>
<b>Cancer (lymphoma, sarcoma, etc)</b>	<b>2.9%</b>	<b>1</b>
<b>PCP Pneumonia</b>	<b>0.0%</b>	<b>0</b>
<b>Neuropathy</b>	<b>0.0%</b>	<b>0</b>
<b>Heart problems</b>	<b>0.0%</b>	<b>0</b>
<b>Diabetes</b>	<b>0.0%</b>	<b>0</b>
<b>None</b>	<b>82.4%</b>	<b>28</b>
<b>ANSWERED QUESTION 34</b>		

The vast majority of OOC respondents deny other chronic illnesses (82%-but it is unknown if this is because of a lack of medical care or a true reflection of health status). For those reporting other illnesses, the most frequently noted is emotional problems, followed by problems with thought or memory, liver problems, high cholesterol, high blood pressure and other (stroke, hypertension, hypoglycemia). The least frequently reported illnesses include lung or kidney problems and cancer. It is interesting to note that 56% of this OOC respondent sample reports the receipt of other drugs for treatment of illnesses other than HIV.

## SUBSTANCE USE

The majority (83%) of the OOC respondents admits to substance use in one form or another. Substances used on a daily basis include tobacco, alcohol and marijuana. Weekly use of alcohol, cocaine, crack, heroin, and marijuana and tobacco is reported by a minority of the OOC respondents. None of the respondents currently injects drugs, however 7% report the previous practice.

## NORFOLK OUT OF CARE



## SERVICES THAT WOULD PROMPT RE-ENTRY INTO HIV MEDICAL CARE-SERVICE NEEDS

- Case management
- Transportation
- Case manager's encouragement
- Strong doctor
- Help from agency like ACCESS AIDS care
- Housing
- Employment
- Schools
- Medicaid
- Support

## SERVICES NEEDED BUT CAN'T GET- SERVICE GAPS

1. Housing
2. Nutrition Assistance tied with Medical Transportation tied with Oral Health Care
3. ADAP/Medications
4. Health Insurance tied with AOMC
5. Employment Assistance/Job tied with Medicaid/SSI/Disability Assistance tied with Clothing tied with “things not covered by RW, i.e., surgery
6. Health Information/HIV Education tied with Vision care tied with EFA

## CHAPTER 5: RECOMMENDATIONS FOR COMPREHENSIVE PLAN

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### IN CARE PLWH/A

#### I. ADDRESS THE TOP RANKING SERVICE GAPS OF THE SPECIAL POPULATIONS

NORFOLK TGA: ALL PLWHA VERSUS SPECIAL POPULATION SERVICE GAPS...CHART CONTINUES ON PG. 117 & 118 & 119

SERVICE CATEGORY TOP RANKING NEEDS-ALL	SERVICE CATEGORY TOP RANKING GAPS-ALL	AA GAPS	MSM GAPS	WOMEN OF COLOR GAPS
MEDICATION ASSISTANCE	2	3	2	3 tie
AOMC	10 tie	9 tie	6 tie	NR
HOUSING ASSISTANCE	1	1	1	1
NUTRITION ASSISTANCE	6 tie	6 tie	5 tie	5 tie
MENTAL HEALTH/ SUPPORT GROUPS	5	5	6 tie	3 tie

SERVICE CATEGORY TOP RANKING NEEDS-ALL	SERVICE CATEGORY TOP RANKING GAPS-ALL	AA GAPS	MSM GAPS	WOMEN OF COLOR GAPS
MEDICAL TRANSPORTATION	3	2	5 tie	5 tie
OTHER: EMPLOYMENT ASSISTANCE	9	8 tie	5 tie	4 tie
HEALTH EDUCATION/ PEER EDUCATORS	NR	NR	NR	NR
HEALTH INSURANCE/ PREM ASSISTANCE	4	4	4	2
EFA	7	7 tie	NR	4 tie
MEDICAL CASE MANAGEMENT	NR	NR	Nr	NR
ORAL HEALTH CARE	6 tie	6 tie	3	6 tie
SUBSTANCE ABUSE SERVICES	NR	Nr	NR	NR
HIV PREVENTION/ CONDOMS	NR	NR	NR	NR
*OTHER : CLOTHING	NR	NR	NR	NR
OUTREACH	NR	NR	NR	NR
OTHER: VISION CARE	8 tie	7 tie	6 tie	4 tie
OTHER: SPECIALTY CARE	8 tie	9 tie	5 tie	4 tie
OTHER: DISABILITY ASSISTANCE	10 tie	8 tie	5 tie	6 tie
OTHER: HELP CO- PAYS	11	Nr	NR	NR

NORFOLK TGA: ALL PLWHA VERSUS SPECIAL POPULATION SERVICE GAPS CONTINUED

SERVICE CATEGORY TOP RANKING NEEDS-ALL	RURAL GAPS	SA/IDU GAPS	YOUTH GAPS	VET/MIL GAPS
MEDICATION ASSISTANCE	1 tie	NR	1 tie	NR
AOMC	NR	NR	4 tie	NR
HOUSING ASSISTANCE	NR	2 tie	1 tie	NR
NUTRITION ASSISTANCE	NR	2 tie	3	NR
MENTAL HEALTH/ SUPPORT GROUPS	NR	2 tie	NR	NR
MEDICAL TRANSPORTATION	NR	2 tie	NR	NR
OTHER: EMPLOYMENT ASSISTANCE	1 tie	NR	5 tie	NR
HEALTH EDUCATION/ PEER EDUCATORS	NR	NR	NR	NR
HEALTH INSURANCE/ PREM ASSISTANCE	1 tie	3 tie	2	NR
EFA	NR	1 tie	NR	NR
MEDICAL CASE MANAGEMENT	NR	NR	NR	NR
ORAL HEALTH CARE	1 tie	1 tie	4 tie	1
SUBSTANCE ABUSE SERVICES	NR	Nr	NR	NR
HIV PREVENTION/ CONDOMS	NR	NR	NR	NR
*OTHER : CLOTHING	NR	NR	NR	NR

SERVICE CATEGORY TOP RANKING NEEDS-ALL	RURAL GAPS	SA/IDU GAPS	YOUTH GAPS	VET/MIL GAPS
OUTREACH	NR	NR	NR	NR
OTHER: VISION CARE	NR	1 tie	1 tie	NR
OTHER: SPECIALTY CARE	NR	3 tie	3 tie	NR
OTHER: DISABILITY ASSISTANCE	NR	3 tie	3 tie	NR
OTHER: HELP CO- PAYS	NR	3 tie	3 tie	NR

## 2. ADDRESS THE TOP RANKING SERVICE BARRIERS OF THE SPECIAL POPULATIONS

NORFOLK TGA: ALL PLWHA VERSUS SPECIAL POPULATION SERVICE BARRIERS .....  
 CHART CONTINUES ON PG. 120 & 121 & 122

SERVICE CATEGORY TOP RANKING NEEDS-ALL	TOP RANKING SERVICE BARRIERS - ALL	AA BARRIERS	MSM BARRIERS	MINORITY WOMEN BARRIERS
MEDICATION ASSISTANCE	2	2	1	2
AMBULATORY OUTPATIENT MEDICAL CARE	9	6 tie	4 tie	NR
HOUSING ASSISTANCE	1	1	2	1
NUTRITION ASSISTANCE	5	4	5 tie	4
MENTAL HEALTH/ SUPPORT GROUPS	6	5 tie	3	3

SERVICE CATEGORY TOP RANKING NEEDS-ALL	TOP RANKING SERVICE BARRIERS - ALL	AA BARRIERS	MSM BARRIERS	MINORITY WOMEN BARRIERS
MEDICAL TRANSPORTATION	3	6 tie	5 tie	8 tie
OTHER: EMPLOYMENT ASSISTANCE	12 tie	6 tie	7 tie	5
HEALTH EDUCATION/ PEER EDUCATORS	13	9 tie	NR	9
HEALTH INSURANCE/ PREM ASSISTANCE	4	3	4 tie	6 tie
EFA	8	7	6 tie	7 tie
MEDICAL CASE MANAGEMENT	15	9 tie	7 tie	10 tie
ORAL HEALTH CARE	7	5 tie	5 tie	6 tie
SUBSTANCE ABUSE SERVICES	17	NR	NR	NR
HIV PREVENTION/ CONDOMS	NR	NR	NR	NR
*OTHER : CLOTHING	16	9 tie	NR	NR
OUTREACH	NR	NR	NR	NR
OTHER: VISION CARE	12 tie	8	6 tie	7 tie
OTHER: SPECIALTY MEDICAL CARE	14	10	7 tie	10 tie
OTHER: DISABILITY ASSISTANCE	10	6 tie	4 tie	8 tie
OTHER: HELP WITH MEDICAL CO-PAYS	11	NR	NR	NR

NORFOLK TGA: ALL PLWHA VERSUS SPECIAL POPULATION SERVICE BARRIERS  
CONTINUED

SERVICE CATEGORY TOP RANKING NEEDS-ALL	RURAL BARRIERS	SA/IDU BARRIERS	YOUTH BARRIERS	VET/MIL BARRIERS
MEDICATION ASSISTANCE	1 tie	2	1	NR
AMBULATORY OUTPATIENT MEDICAL CARE	NR	NR	6 tie	NR
HOUSING ASSISTANCE	1 tie	4 tie	2	NR
NUTRITION ASSISTANCE	NR	3 tie	4	NR
MENTAL HEALTH/ SUPPORT GROUPS	1 tie	NR	6 tie	NR
MEDICAL TRANSPORTATION	NR	3 tie	NR	NR
OTHER: EMPLOYMENT ASSISTANCE	1 tie	3 tie	5	NR
HEALTH EDUCATION/ PEER EDUCATORS	NR	NR	NR	NR
HEALTH INSURANCE/ PREM ASSISTANCE	NR	NR	3 tie	NR
EFA	NR	3 tie	NR	NR
MEDICAL CASE MANAGEMENT	NR	NR	Nr	NR
ORAL HEALTH CARE	NR	1	6 tie	1
SUBSTANCE ABUSE SERVICES	NR	4 tie	NR	NR
HIV PREVENTION/ CONDOMS	NR	NR	NR	NR
*OTHER : CLOTHING	NR	NR	NR	NR
OUTREACH	NR	NR	NR	NR

SERVICE CATEGORY TOP RANKING NEEDS-ALL	RURAL BARRIERS	SA/IDU BARRIERS	YOUTH BARRIERS	VET/MIL BARRIERS
OTHER: VISION CARE	NR	3 tie	6 tie	NR
OTHER: SPECIALTY MEDICAL CARE	NR	3 tie	NR	NR
OTHER: DISABILITY ASSISTANCE	NR	4 tie	3 tie	NR
OTHER: HELP WITH MEDICAL CO-PAYS	NR	3 tie	NR	NR

## NEWLY DIAGNOSED PLWH/A

The 2010 National HIV/AIDS Strategy for the United States (US) identified three major goals: reducing the number of new HIV infections, increasing access to care and optimizing health outcomes for people living with HIV, and reducing health-related disparities. The Strategy outlines actions to achieve these goals, including increased HIV screening and creation of a seamless system to link newly diagnosed individuals to medical care immediately when they learn they are infected with HIV. (*Office of National AIDS Policy (2010) National HIV/AIDS Strategy for the United States. ONAP, The White House*)

To support this action, the Strategy recommends that HIV resources be targeted to support linkage coordinators in settings where at risk populations receive health and social services. The Strategy is consistent with the aims of the 2009 reauthorization of the Ryan White HIV/AIDS Program that emphasized the need to examine the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status, as well as the needs of individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services; and linking them to care. (*The Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87)*).

## HIV ACQUISITION

MSM behavior consistently continues to be the predominant means of acquiring the virus amongst newly diagnosed throughout the Norfolk TGA (55%). It is imperative that education, prevention and risk reduction strategies be tailored to positively impact these individuals and that they be successfully disseminated to this population. EIS initiatives should continue to aggressively address this issue.

## HIV TESTING

The majority of respondents learned of their HIV status through a voluntary request for testing, participating in outreach testing programs or by requesting to be tested by their providers. It is strongly

recommended that medical providers consider making HIV testing a universal screening item within routine medical visit and laboratory exams and consider implementing the ‘opt out’ model. Such a model will ensure that more individuals know their status, addressing firsthand the issue the unknown/unaware. The way a substantial minority of respondents learned of their status was through an emergency room visit for the treatment of another condition. The TGA should consider collaborating with AOMC providers to develop a sensitive risk screening tool for use in the Emergency Rooms in the TGA, in order to target high risk individuals for testing. Another recommendation is to consider funding Medical Case Management via a pilot study in the highest incidence areas and seek creative ways to collaborate with the emergency room staff to ensure necessary systems are in place for testing and linking newly diagnosed individuals into the service delivery system. Another useful means of reaching and testing persons at high risk for HIV disease is to offer HIV testing within the Ryan White funded clinics and case management offices, with offers of free testing to partners, friends and spouses of positive patients/clients. Placement of EIS funded Part A Disease Intervention Specialists within STD clinics should yield an increased number of new HIV diagnoses among those persons with high STI co-morbidity. Expanded use of peer outreach/peer mentors is also recommended, given the survey findings and effectiveness of this model. Finally, enhancing the existing linkages between Counseling/Testing sites and AOMC and medical case management providers is recommended to strengthen the linkages to care.

## **HIV DISCLOSURE**

While the majority of respondents were offered partner notification services and most PLWH/A report that they encourage their partners to get tested and know their status, additional assurances can be implemented amongst providers to ensure that newly diagnosed individuals understand the importance of disclosing their status and using safer sex methods for the protection of self and others. It is recommended that the Newly Diagnosed survey data be utilized to help craft population-specific and targeted prevention messages as well as improved messages regarding the benefits of HIV testing, care and treatment. Given the high frequency of internet use among PLWHA, implementation of an internet-based chat room for peer outreach to MSM, offering anonymous testing and offers to accompany individuals for testing should be piloted. Efforts to “normalize” HIV as a treatable chronic illness may help reduce the continuing perception of HIV as stigmatizing.

## **DELAY OF ENTRY INTO MEDICAL CARE**

While the majority of respondents do access medical care upon learning of their positive status, a minority of the newly diagnosed respondents have been given an AIDS diagnosis and many already had decreasing CD4 T-cell counts in the 200-500 cell count range upon their initial diagnosis. These findings indicate that the disease has progressed while going undiagnosed for an undetermined period of time. Increased testing throughout primary care settings and community-wide initiatives as well as education regarding the benefits of testing and earlier diagnosis coupled with disease de-stigmatization strategies will ensure additional individuals are aware of their status and begin treatment earlier in their disease process.

## PATHWAY INTO CARE AND SUPPORTIVE SERVICES

Following identification of young racial/ethnic minority HIV-positive MSM and other newly identified PLWH/A through outreach, linkage to HIV care activities should be undertaken to help engage them rapidly in medical care. A recent study indicated that the newly diagnosed may be assisted to schedule their initial medical visits, arrange for transportation to appointments, place reminder telephone calls to ensure appointments are kept, and conduct case finding for clients that miss appointments. In addition, it is recommended, based on the study success, that outreach workers escort individuals identified through outreach to their initial medical visits. Outreach workers may provide ongoing linkage activities to ensure that their clients are engaged and retained in care. In addition to accompanying clients to medical visits, they may help them navigate the health care system, coordinate services with case managers, conduct support groups, organize social and educational events, and offer peer support in initiating HIV medications. (*Julia Hidalgo, et al. Roles and Challenges of Outreach Workers in HIV Clinical and Support Programs Serving Young Racial/Ethnic Minority Men Who Have Sex with Men, AIDS PATIENT CARE & STDs, July 2011*)

Survey findings reflect a solid system for linkage to care throughout the Norfolk TGA. However, it is recommended that the Planning Council determine the “continuum of care” for the Newly Diagnosed in order to ensure capacity to meet the high ranking needs of this increasing population. All three groups (In Care, Newly Diagnosed and Out of care) evidence high levels of co-morbidity with mental health disorders, STIs and other chronic illness. These findings, coupled with the high levels of un-insurance among LWH/A in the service area renders it important for the TGA to address how such services will be rendered in a cost effective and dignified manner to these individuals. Given the high co-morbidity of these disorders among the PLWHA population in the service area, in combination with the reported transportation barriers, it would be ideal if the mental health and substance abuse treatment services may be co-located within primary medical care and case management service sites to the fullest extent possible.

## OUT OF CARE PLWH/A

### 1. ADDRESS THE SERVICE BARRIERS OF OOC PLWH/A

The major reasons supplied by the OOC respondents to explain their absence from medical care include: “Am undetectable”; “Don’t need it because I am not sick”; “I get anxious about going”; “I feel better than I did”; while less frequently reported reasons include: lack transportation, can’t afford it and don’t know where to go for medical care. Several of these reasons that keep PLWH/A from medical care would appear to be positively impacted through more widespread marketing of available services and better HIV education of the benefits of regular care and treatment.

PROMPTS TO RETURN TO CARE

IF YOU HAVEN'T RECEIVED MEDICAL CARE IN THE LAST 6 MONTHS, WHICH OF THE FOLLOWING THINGS WOULD HELP YOU GET TO A DOCTOR? (PLEASE CHECK ALL THAT APPLY.)

ANSWER OPTIONS	PERCENT	COUNT
TRANSPORTATION	33.3%	3
MORE OUTREACH SERVICES	33.3%	3
FREE MEDICAL CARE	33.3%	3
PEER SUPPORT/SOMEONE TO HELP ME UNDERSTAND	22.2%	2
NOT APPLICABLE AS I AM RECEIVING MEDICAL CARE	22.2%	2
MORE INFORMATION ABOUT THE SERVICES	22.2%	2
LOWER COST OF MEDICAL CARE/MEDICINES	22.2%	2
INSURANCE TO PAY FOR DOCTOR AND MEDS	22.2%	2
HOUSING	22.2%	2
FINANCIAL CONCERNS	22.2%	2
SUBSTANCE USE TREATMENT	11.1%	1
REFERRALS OR ADVICE FROM SOMEONE I TRUST	11.1%	1
OTHER (PLEASE SPECIFY): CASE MANAGER	11.1%	1
NOTHING	11.1%	1
NOT HAVING TO WAIT SO LONG FOR APPOINTMENTS	11.1%	1
MORE GOVERNMENT SERVICES	11.1%	1
EMPLOYMENT OPPORTUNITIES	11.1%	1
BETTER TRAINED DOCTORS AND NURSES	11.1%	1
ANSWERED QUESTION 9		

Transportation assistance, more outreach services and free medical care are the top services that this cohort of PLWH/A with unmet/under-met need for medical care report as prompts to their returning to care. Peer support, more information about the services available and how to access them, lower cost of medical care/medicines, housing assistance and assistance with financial concerns, and health insurance to pay for doctors and meds are the next most frequently reported prompters to seeking and remaining in primary medical care. The other prompters to return to care include reported by the OOC respondents include: substance abuse treatment, advice from trusted referral sources, a case manager, shorter appointment wait times, more government services, employment opportunities and better trained doctors and nurses.

## REASONS WHY PLWH/A DON'T GET HIV MEDICAL CARE

<b>WHY DO YOU THINK PEOPLE DON'T GET MEDICAL CARE FOR HIV? (PLEASE CHECK ALL THAT APPLY.)</b>		
<b>ANSWER OPTIONS</b>	<b>PERCENT</b>	<b>COUNT</b>
<b>WORRIED THAT OTHER PEOPLE WILL FIND OUT/FEAR OF TELLING</b>	<b>66.7%</b>	<b>6</b>
<b>FEEL HEALTHY</b>	<b>44.4%</b>	<b>4</b>
<b>DRUGS</b>	<b>33.3%</b>	<b>3</b>
<b>DON'T HAVE TRANSPORTATION</b>	<b>33.3%</b>	<b>3</b>
<b>DON'T BELIEVE THEY ARE HIV POSITIVE</b>	<b>33.3%</b>	<b>3</b>
<b>CAN'T AFFORD IT</b>	<b>33.3%</b>	<b>3</b>
<b>OTHER (PLEASE SPECIFY): NO SIGNS OR SYMPTOMS, GET ANXIOUS, DON'T CARE</b>	<b>22.2%</b>	<b>2</b>
<b>DON'T WANT TO TAKE HIV MEDICATIONS</b>	<b>11.1%</b>	<b>1</b>
<b>COULDN'T GET AN APPOINTMENT</b>	<b>0.0%</b>	<b>0</b>
<b>CANNOT SPEAK ENGLISH VERY WELL</b>	<b>0.0%</b>	<b>0</b>
<b>ANSWERED QUESTION 9</b>		

When asked why PLWH/A do not get medical care for their HIV disease, the majority of the OOC respondents reported “Worried that others will find out/fear of divulging their HIV status”. The next most frequently cited reason is “Feel healthy”, followed by drug use, lack of transportation, don’t believe they are HIV positive, and can’t afford it.

Less frequently reported reasons include the lack of signs or symptoms of disease, get anxious going to doctors, don’t care about getting treatment and don’t want to take HIV medications.

## 2. ADDRESS SERVICE GAPS OF OOC PLWH/A

1. Housing Assistance
2. Nutrition Assistance tied with Medical Transportation tied with Oral Health Care
3. ADAP/Medication Assistance
4. Health Insurance tied with AOMC
5. Other: Employment Assistance/Job tied with Other: Medicaid/SSI/Disability Assistance tied with Other: Clothing tied with “Things not covered by RW, i.e., surgery
6. Health Information/HIV Education tied with Other: Vision Care tied with EFA

## APPENDIX

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