2020 Houston HIV Care Services Needs Assessment

A collaboration of:
Houston Area HIV Services Ryan White Planning Council
Houston HIV Prevention Community Planning Group
Harris County Public Health, Ryan White Grant Administration
Houston Health Department, Bureau of HIV/STD and Viral Hepatitis Prevention
Houston Regional HIV/AIDS Resource Group, Inc.
Harris Health System
People Living with HIV in the Houston Area and Ryan White HIV/AIDS Program Consumers

Approved July 9th, 2020

INTRODUCTION

What is an HIV needs assessment?

An HIV needs assessment is a process of collecting information about the needs of people living with HIV (**PLWH**) in a specific geographic area. The process involves gathering data *from multiple sources* on the number of HIV cases, the number of PLWH who are not in care, the needs and service barriers of PLWH, and current resources available to meet those needs. This information is then analyzed to identify what services are needed, what barriers to services exist, and what service gaps remain.

Special emphasis is placed on gathering information about the need for services funded by the Ryan White HIV/AIDS Program and on the socio-economic and behavioral conditions experienced by PLWH that may influence their need for and access to services both today and in the future.

In the Houston Area, data collected directly from PLWH in the form of a *survey* are the principal source of information for the HIV needs assessment process. Surveys are administered every three years to a representative sample of PLWH residing in the Houston Area.

How are HIV needs assessment data used?

Needs assessment data are integral to the information base for HIV services planning, and they are used in almost every decision-making process of the Ryan White Planning Council (**RWPC**), including setting priorities for the allocation of funds, designing services that fit the needs of local PLWH, developing the comprehensive plan, and crafting the annual implementation plan. The community also uses needs assessment data for a variety of *non*-Council purposes, such as in writing funding applications, evaluation and monitoring, and the improvement of services by individual providers.

In the Houston Area, HIV needs assessment data are used for the following purposes:

- Ensuring the consumer point-of-view is infused into all of the data-driven decision-making activities of the Houston Area RWPC.
- Revising local service definitions for HIV care, treatment, and support services in order to best meet the needs of PLWH in the Houston Area.
- Setting priorities for the allocation of Ryan White HIV/AIDS Program funds to specific services.
- Establishing goals for and then monitoring the impact of the Houston Area's comprehensive plan for improving the HIV prevention and care system.
- Determining if there is a need to target services by analyzing the needs of particular groups of PLWH.
- Determining the need for special studies of service gaps or subpopulations that may be otherwise underrepresented in data sources.
- By the Planning Council, other Planning Bodies, specific Ryan White HIV/AIDS Program Parts, providers, or community partners to assess needs for services.

Needs assessment data are specifically mandated for use during the Planning Council's *How to Best Meet the Need*, Priority & Allocations, and Comprehensive HIV Planning processes.

Because surveys are administered every three years, results are used in RWPC activities for a three year period. Other data sources produced during interim years of the cycle, such as epidemiologic data and estimates of unmet need, are used to provide additional context for and to better understand survey results.

Sources:

2020 Houston Area HIV Needs Assessment Group (NAG), Analysis Workgroup, Principles for the 2020 Needs Assessment Analysis. Approved 08-19-19.

U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Ryan White HIV/AIDS Program Part A Manual Revised 2013. Section XI, Ch 3: Needs Assessment.

METHODOLOGY

Needs Assessment Planning

Planning the 2020 Houston Area HIV Care Services Needs Assessment was a collaborative process between HIV prevention and care stakeholders, the Houston Area planning bodies for HIV prevention and care, all Ryan White HIV/AIDS Program Parts, and individual providers and consumers of HIV services. To guide the overall process and provide specific subject matter expertise, a series of Needs Assessment-related Workgroups reconvened under the auspices of the Ryan White Planning Council (**RWPC**):

- The Needs Assessment Group (**NAG**) provided overall direction to the needs assessment process. As such, the NAG consisted of voting members from each collaborating partner and from the following workgroups.
- The Epidemiology Workgroup developed the consumer survey sampling plan, which aimed at producing a representative sample of surveys.
- The Survey Workgroup developed the survey instrument and consent language.
- The Analysis Workgroup determined how survey data should be analyzed and reported in order to serve as an effective tool for HIV planning.

In total, 38 individuals in addition to staff participated in the planning process, of which at least 45% were people living with HIV (**PLWH**).

Survey Sampling Plan

Staff calculated the 2020 Houston Area HIV Care Services Needs Assessment sample size based on current total HIV prevalence for the Houston Eligible Metropolitan Area (**EMA**) (2017), with a 95% confidence interval, at both 3% and 4% margin of error. Respondent composition goals were proportional to demographic and geographic representation in total prevalence. Desired sample sizes for funded-agency representation were proportional to total client share for the most recent complete calendar year (2018). Efforts were also taken to over-sample out-of-care consumers and members of special populations. Regular reports of select respondent characteristics were provided to NAG, the Comprehensive HIV Planning Committee, and RWPC during survey administration to assess real-time progress toward attainment of sampling goals and to make sampling adjustments when necessary.

Survey Tool

Data for the 2020 Houston Area HIV Care Services Needs Assessment were collected using a 54-question paper or electronic survey of open-ended, multiple choice, and scaled questions addressing nine topic areas (in order):

- HIV services, needs, and barriers to care
- Communication with HIV medical providers
- HIV diagnosis history
- HIV care history including linkage to care
- Non-HIV co-occurring health concerns (incl. mental health)
- Substance use
- Housing, transportation, and social support
- Financial resources
- Demographics
- HIV prevention activities

The Survey Workgroup determined topics and questions, restructuring and expanding the 45-question 2016 needs assessment survey. Subject matter experts were also engaged to review specific questions. Consistency with the federally-mandated HIV prevention needs assessment for the Houston Area was assured through participation of Houston Health Department staff during the survey development process and alignment of pertinent questions such as those designed to gather demographic information and HIV prevention knowledge and behaviors. A cover sheet explained the purpose of the survey, risks and benefits, planned data uses, and consent. A double-sided tear-sheet of emergency resources and HIV service grievance/complaint process information was also attached, and liability language was integrated within the survey.

Data Collection

Surveys for the 2020 Houston Area HIV Care Services Needs Assessment were administered (1) in pre-scheduled group sessions at Ryan White HIV/AIDS Program providers, HIV Prevention providers, housing facilities, support groups, Harris County community centers, and specific community locations and organizations serving special populations; and (1) online via word of mouth, print, and social media advertising. Staff contacts at each physical location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through flyers, word of mouth, print advertisement, and staff promotion.

Inclusion criteria were an HIV diagnosis and residency in counties in the greater Houston Area. Participants were self-selected and self-identified according to these criteria. Surveys were self-administered in English, Spanish, and large-print formats, with staff and bilingual interpreters available for verbal interviewing.

Participation was voluntary, anonymous, and monetarily incentivized; and respondents were advised of these conditions verbally and in writing. Most surveys were completed in 30 to 40 minutes. Surveys were reviewed on-site by trained staff, interns, and interpreters for completion and translation of written comments; completed surveys were also logged in a centralized tracking database.

In total, 589 consumer surveys were collected from April 2019 to February 2020 during 47 survey sessions at 27 survey sites and online.

Data Management

Data entry for the current Houston Area HIV Care Services Needs Assessment was performed by trained staff and contractors at the RWPC Office of Support using simple numerical coding. Skip-logic questions were entered based on first-order responses; and affirmative responses only were entered for "check-all" questions. Additional variables were recoded during data entry and data cleaning. Surveys that could not be accurately entered by staff ere eliminated. Data are periodically reviewed for quality assurance, and a line-list level data cleaning protocol was applied prior to analysis. When data entry and cleaning are complete, a data weighting syntax will be created and applied to the sample for: sex at birth, primary race/ethnicity, and age group based on a three-level stratification of current HIV prevalence for the Houston EMA (2018). Missing or invalid survey entries will be excluded from analysis per variable; therefore, denominators vary across results. Also, proportions will not calculated with a denominator of the total number of completed surveys for every variable due to missing or "check-all" responses. Data entry for the 2020 Houston Area HIV Care Services Needs Assessment was performed by trained staff and contractors at the RWPC Office of Support using simple numerical coding. Skip-logic questions were entered based on first-order responses; and affirmative responses only were entered for "check-all" questions. Additional variables were recoded during data entry and data cleaning. Surveys that could not be accurately entered by staff or that were found to be duplicates were eliminated (n=11). Data were periodically reviewed for quality assurance, and a line-list level data cleaning protocol was applied prior to analysis. In addition, a data weighting syntax was created and applied to the sample for: sex at birth, primary race/ethnicity, and age group based on a three-level stratification of current HIV prevalence for the Houston EMA (2018), producing a total weighted sample size of 589 (8% in Spanish). Missing or invalid survey entries are excluded from analysis per variable; therefore, denominators vary across results. Also, proportions are not calculated with a denominator of 589 surveys for every variable due to missing or "check-all" responses. All data management and analysis was performed in IBM© SPSS© Statistics (v. 22) and QSR International© NVivo 10.

Limitations

The 2020 Houston Area HIV Care Services Needs Assessment produced data that are unique because they reflect the first-hand perspectives and lived experiences of PLWH in the Houston Area. However, there are limitations to the generalizability, reliability, and accuracy of the results that should be considered during their interpretation and use. These limitations are summarized below:

- *Convenience Sampling*. Multiple administrative methods were used to survey a representative sample of PLWH in the Houston Area proportional to geographic, demographic, transmission risk, and other characteristics. Despite extensive efforts, respondents were not randomly selected, and the resulting sample is not proportional to current HIV prevalence. To mitigate this bias, data were statistically weighted for sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2018). Results presented from Chapters 2 through the end of this report are proportional for these three demographic categories only. Similarly, the majority of respondents were Ryan White HIV/AIDS Program clients at the time of data collection, but may have received services outside the program that are similar to those currently funded. Therefore, it not possible to determine if results reflect non-Ryan White systems.
- *Margin of Error*. Staff met the minimum sampling plan goal of at least 588 valid surveys for a margin of error of 4.00%, based on a 95% confidence interval. This indicates that 95% of the time, the quantitative results reported this document are anticipated to be correct by a margin of 4 percentage points. For this reason, results reported in this document are statistically significant, generalizable, and are suitable for planning purposes to draw general conclusions about the overall needs and experiences of people living with HIV in the Houston area.
- *Reporting Bias*. Survey participants were self-selected and self-identified, and the answers they provided to survey questions were self-reported. Since the survey tool was anonymous, data could not be corroborated with medical or other records. Consequently, results

should not be used as empirical evidence of reported health or treatment outcomes. Other data sources should be used if confirmation of results is needed.

- *Instrumentation*. Full data accuracy cannot be assured due to variability in comprehension and completeness of surveys by individual respondents. Though trained staff performed real-time quality reviews of each survey, there were missing data as well as indications of misinterpretation of survey questions. It is possible that literacy and language barriers contributed to this limitation as well.
- *Data management*. The use of both staff and contractors to enter survey data could have produced transcription and transposition errors in the dataset. A line-list level data cleaning protocol was applied to help mitigate errors.

Data presented here represent the most current repository of *primary* data on PLWH in the Houston Area. With these caveats in mind, the results can be used to describe the experiences of PLWH in the Houston Area and to draw conclusions on how to best meet the HIV service needs of this population.

Sources:

Houston Area HIV Needs Assessment Group (NAG), Epidemiology Workgroup, 2019 Survey Sampling Principles and Plan, Approved 03-18-19.

Texas Department of State Health Services (DSHS) eHARS data through 12-31-2018, extracted as of spring 2020.

University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPPS Statistics 20, Post-stratification weights, 2009.

BACKGROUND

The Houston Area

Houston is the fourth largest city in the U.S., the largest city in the State of Texas, and as well as one of the most racially and ethnically diverse major American metropolitan area. Spanning 600 square miles, Houston is also the least densely populated major metropolitan area. Houston is the seat of Harris County, the most populous county in the State of Texas and the third most populous in the country. The United States Census Bureau estimates that Harris County has almost 4.7 million residents, around half of which live in the city of Houston.

Beyond Houston and Harris County, local HIV service planning extends to four geographic service areas in the greater Houston Area:

- *Houston/Harris County* is the geographic service area defined by the Centers for Disease Control and Prevention (**CDC**) for HIV prevention. It is also the local reporting jurisdiction for HIV surveillance, which mandates all laboratory evidence related to HIV/AIDS performed in Houston/Harris County be reported to the local health authority.
- The *Houston Eligible Metropolitan Area* (**EMA**) is the geographic service area defined by the Health Resources and Services Administration (**HRSA**) for the Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (**MAI**). The Houston EMA includes six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.
- The *Houston Health Services Delivery Area* (**HSDA**) is the geographic service area defined by the Texas Department of State Health Services (**TDSHS**) for the Ryan White HIV/AIDS Program Part B and the Houston Area's HIV service funds from the State of Texas. The HSDA includes the six counties in the EMA listed above plus four additional counties: Austin, Colorado, Walker, and Wharton.
- The *Houston Eligible Metropolitan Statistical Area* (**EMSA**) is the geographic service area defined by U.S. Department of Housing and Urban Development (**HUD**) for the Housing Opportunities for People with AIDS (**HOPWA**) program. The EMSA consists of the six counties in the EMA listed above plus Austin, Brazoria, Galveston, and San Jacinto Counties.

Together, these geographic service areas encompass 13 counties in southeast Texas, spanning from the Gulf of Mexico into the Texas Piney Woods.

HIV in the Houston Area

In keeping with national new HIV diagnosis trends, the number of new cases of HIV in the Houston Area has remained relatively stable; HIV-related mortality has steadily declined, and the number of people living with HIV has steadily increased. According to current disease surveillance data, there are 29,078 diagnosed people living with HIV in the Houston EMA (**Table 1**). The majority are male (75%), over the age of 45 (52%), and have MSM transmission risk (58%), while almost half are Black/African American (48%).

TABLE 1-Diagnosed People Living with HIV in the Houston EMA, 2018[a]

	#	%
Total	29,078	100.0%
Sex at Birth		
Male	21,829	75.1%
Female	7,249	24.9%
Race/Ethnicity		
White	5,109	17.6%
Black/African American	14,044	48.3%
Hispanic/Latino	8,493	29.2%
Other/Multiracial	1432	4.9%
Age		
0 - 12	54	0.2%
13 - 24	1,170	4.0%
25 - 34	5,986	20.6%
35 - 44	6,752	23.2%
45 - 54	7,594	26.1%
55 - 64	5,580	19.2%
65+	1,942	6.7%
Transmission Risk[b]		
Male-male sexual contact (MSM)	16,818	57.8%
Person who injects drugs (PWID)	2,256	7.8%
MSM/PWID	1,192	4.1%
Sex with Male/Sex with Female	8,455	29.1%
Perinatal transmission	340	1.2%
Adult other	17	0.1%

[a]Source: Texas eHARS, Diagnosed PLWH in the Houston EMA between 1/1/2018 and 12/31/2018

[b]Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification.

The CDC ranks the Houston Area (specifically, the Houston-Baytown-Sugarland, TX statistical area) 10th highest in the nation for new HIV diagnoses and 11th in cases of progressed/Stage 3 HIV (formerly known as AIDS). In February 2019, the U.S. Department of Health and Human Services (**HHS**) launched the cross-agency initiative *Ending the HIV Epidemic: A Plan for America* with an overarching goal to reduce new HIV transmission in the U.S. by 90% by 2030. This initiative identified Harris County as a priority county due to the high rate and number of new HIV diagnoses, and plans to introduce additional resources, technology, and technical assistance to support local HIV prevention and treatment activities. Of the 29,078 diagnosed PLWH in the Houston Area, 75% are in medical care for HIV, but only 59% have a suppressed viral load.

HIV Services in the Houston Area

Both governmental agencies and non-profit organizations provide HIV services in the Houston Area through direct HIV services provision and/or function as Administrative Agents which contract to direct service providers. The goal of HIV care in the Houston Area is to create a seamless system that supports people at risk for or living with HIV with a full array of educational, clinical, mental, social, and support services to prevent new infections and support PLWH with high-quality, life-extending care. In addition, two local HIV Planning Bodies provide mechanisms for those living with and affected by HIV to design prevention and care services. Each of the primary sources in the Houston Area HIV service delivery system is described below:

- Comprehensive HIV prevention activities in the Houston Area are provided by the Houston Health Department (**HHD**), a directly-funded CDC grantee, and the Texas Department of State Health Services (**DSHS**). Prevention activities include health education and risk reduction, HIV testing, disease investigation and partner services, linkage to care for newly diagnoses and out of care PLWH. The Houston Area HIV Prevention Community Planning Group provides feedback and to HHD in its design and implementation of HIV prevention activities.
- The Ryan White HIV/AIDS Program Part A and MAI provide core medical and support services for HIV-diagnosed residents of the Houston EMA. These funds are administered by the Ryan White Grant Administration of Harris County Public Health. The Houston Area Ryan White Planning Council designs Part A and MAI funded services for the Houston EMA.
- The Ryan White HIV/AIDS Program Parts B, C, D, and State Services provide core medical and support services for HIV-diagnosed residents of the Houston HSDA, with special funding provided to meet the needs of women, infants, children, and youth. The Houston Regional HIV/AIDS Resource Group (**TRG**) administers these funds. The Ryan White Planning Council also designs Part B and State Services for the Houston HSDA. Additional programs supported by TRG include reentry housing through HOPWA funds and support of the grassroots END HIV Houston coalition.
- HOPWA provides grants to community organizations to meet the housing needs of low-income persons living with HIV. HOPWA services include assistance with rent, mortgage, and utility payments, case management, and supportive housing. These funds are administered by the City of Houston Housing and Community Development for the Houston EMSA.

Together, these key agencies, the direct service providers that they fund, and the two local Planning Bodies ensure the greater Houston Area has a seamless system of prevention, care, treatment, and support services that best meets the needs of people at risk for or living with HIV.

Sources:

Centers for Disease Control and Prevention, *Diagnoses of HIV Infection in the United States and Dependent Areas, 2018*; vol. 30. Published November 2015. Accessed 03/06/2020. Available at: www.cdc.gov/hiv/topics/surveillance/resources/reports/.

U.S. Census Bureau, American FactFinder. Houston (city), Texas and Harris (county), Texas Accessed: 03/03/2020. Available at: https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

U.S. Department of Health and Human Services, *Ending the HIV Epidemic: A Plan for America*. February 2019.

Chapter 1: Demographics

PARTICIPANT COMPOSITION

The following summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2020 Houston HIV Care Services Needs Assessment provides both a "snapshot" of who is living with HIV in the Houston Area today as well as context for other needs assessment results.

(**Table 1**) Overall, 95% of needs assessment participants resided in Harris County at the time of data collection. The majority of participants were male (66%), African American/Black (63%), and heterosexual (57%). Over half (60%) were age 50 or over, with a median age of 50-54.

The average unweighted household income of participants was $13,493 annually, with the majority living below 100% of federal poverty (**FPL**). A majority of participants (63%) was not working at the time of survey, with 39% collecting disability benefits and 16% unemployed and seeking employment, and 9% retired. Most participants paid for healthcare using Medicaid/Medicare or assistance through Harris Health System (Gold Card).

TABLE 1-Select Participant Characteristics, Houston Area HIV Needs Assessment, 2020

	No.	%		No.	%		No.	%
County of residence			Age range (median: 50-54)			Sex at birth		
Harris	545	94.9%	13 to 17	0	-	Male	384	65.8%
Fort Bend	10	41.7%	18 to 24	17	2.9%	Female	200	34.2%
Liberty	3	0.5%	25 to 34	50	8.6%	Intersex	0	-
Montgomery	7	1.2%	35 to 49	160	27.6%	Transgender	22	3.9%
Other	9	1.6%	50 to 54	105	18.1%	Non-binary / gender fluid	8	1.4%
			55 to 64	161	27.8%	Currently pregnant*	4	2.0%
			65 to 74	79	13.6%	*All currently pregnant respondents reported being in care. The denominator is all respondents reporting female sex at birth		
			75+	8	1.4%			
			Youth (13 to 27)	17	2.9%			
			Seniors (≥50)	353	59.9%			
Primary race/ethnicity			Sexual orientation			Health insurance		
White	78	13.6%	Heterosexual	329	56.8%	Private insurance	53	9.1%
African American/Black	343	59.8%	Gay/Lesbian	176	30.4%	Medicaid/Medicare	388	66.7%
Hispanic/Latino	122	21.3%	Bisexual/Pansexual	52	9.0%	Harris Health System	168	30.1%
Asian American	4	0.7%	Other	22	3.8%	Ryan White Only	138	23.7%
Other/Multiracial	27	4.7%	MSM	238	40.5%	None	11	1.9%
Residency			Yearly income (average: $13,493)			Employment		
Born in the U.S.	511	87.8%	Federal Poverty Level (FPL)			Disabled	263	38.9%
Lived in U.S. > 5 years	58	10.0%	Below 100%	191	67.3%	Unemployed and seeking work	105	15.5%
Lived in U.S. < 5 years	8	1.4%	100%	54	19.0%	Employed (PT)	59	8.7%
In U.S. on visa	1	0.2%	150%	16	5.6%	Retired	59	8.7%
Prefer not to answer	4	0.7%	200%	15	5.3%	Employed (FT)	53	7.8%
			250%	2	0.7%	Self Employed	19	2.8%
			≥300%	6	2.1%	Other	118	17.5%

(**Table 2**) Certain subgroups of PLWH have been historically underrepresented in HIV data collection, thereby limiting the ability of local communities to address their needs in the data-driven decision-making processes of HIV planning. To help mitigate underrepresentation in Houston Area data collection, efforts were made during the 2020 needs assessment process to *oversample* PLWH who were also members of groups designated as "special populations" due to socio-economic circumstances or other sources of disparity in the HIV service delivery system.

The results of these efforts are summarized in Table 2.

TABLE 2-Representation of Special Populations, Houston Area HIV Needs Assessment, 2020

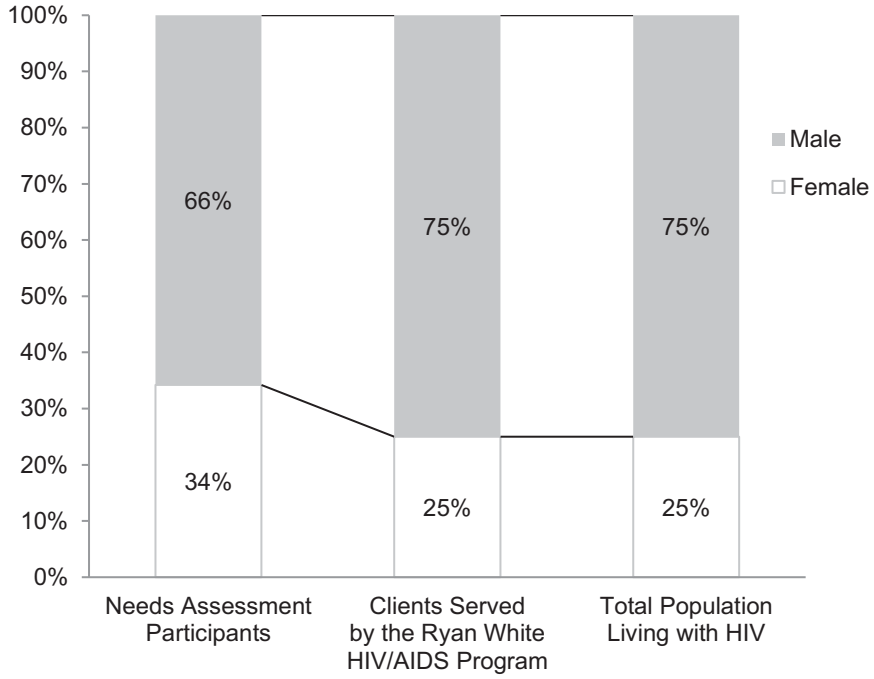
	No.	%
Young adult (18-24 years)	17	2.9%
Adult age 50+ years	353	59.9%
Homeless	65	11.1%
Unstably Housed	159	29.0%
People who inject drugs (PWID)*	47	8.2%
Male-male sexual contact (MSM)	238	40.5%
Out of care (last 12 months)	24	4.3%
Recently released from incarceration	65	11.6%
Rural (non-Harris County resident)	29	5.1%
Women of color	194	33.2%
Transgender	22	3.8%

*Includes self-administered medications, insulin, steroids, hormones, silicone, or drugs.

COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

HIV needs assessments generate information about the needs and service barriers of persons living with HIV (**PLWH**) in a specific geographic area to assist planning bodies and other stakeholders with designing HIV services that best meet those needs. As it is not be feasible to survey every PLWH in the Houston area, multiple administrative and statistical methods are used to generate a sample of PLWH that are reliably representative of *all* PLWH in the area. The same is true in regards to assessing the needs of clients of the Ryan White HIV/AIDS Program.

GRAPH 1-Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Sex at Birth, 2018



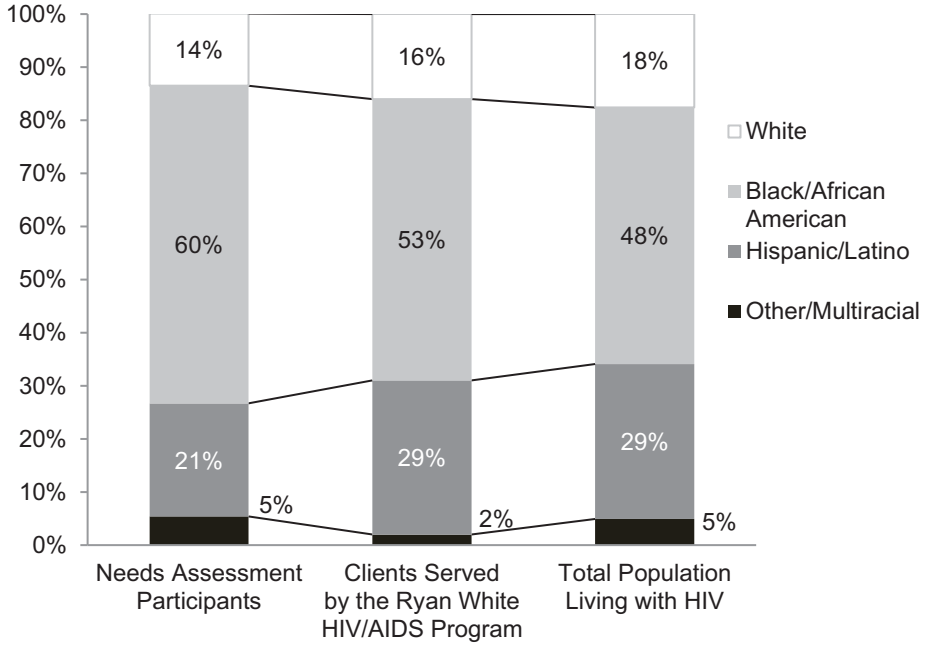
[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18.

As such, awareness of participant representation compared to the composition of both Ryan White HIV/AIDS Program clients and the total HIV diagnosed population is beneficial when reviewing needs assessment results to document actions taken to mitigate any disproportional results.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment males (sex at birth) comprised 66% of participants but 75% of all Ryan White clients, and all PLWH in the Houston Eligible Metropolitan Area (**EMA**). This indicates that male PLWH were underrepresented in the needs assessment sample, while female PLWH were overrepresented.

(**Graph 2**) Analysis of race/ethnicity composition also shows disproportionate representation between participants, all Ryan White clients, and all PLWH in the Houston EMA. Black/African American participants were overrepresented at 60% of participants when compared to the proportions of Black/African American Ryan White clients and PLWH. Conversely, White PLWH and Hispanic/Latino PLWH were slighly underrepresented in the needs assessment.

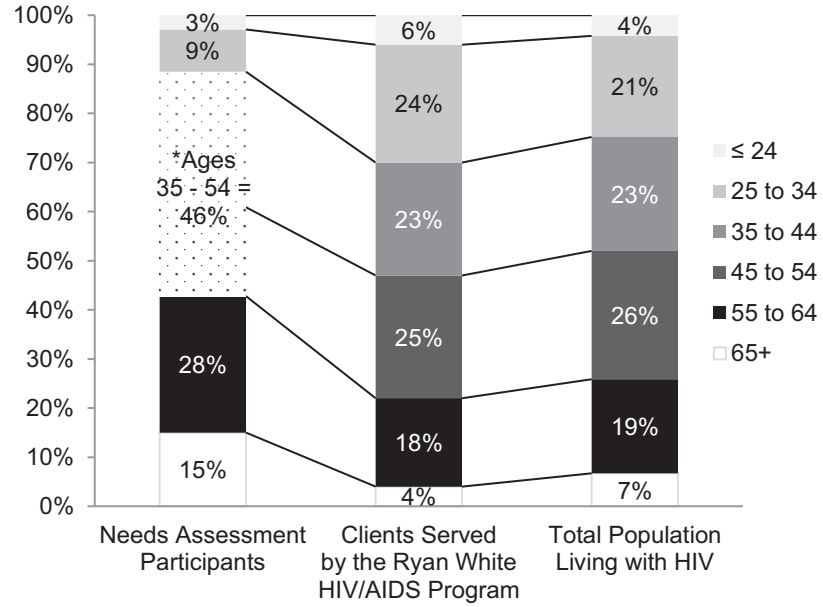
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Race/Ethnicity, 2018



[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18

(**Graph 3**) As referenced in Table 1, 60% of the total needs assessment sample was comprised of individuals age 50 and over. An analysis of age range shows that more needs assessment participants were older than Ryan White clients and PLWH in the Houston EMA. Among needs assessment participants, 28% were ages 55 to 64 and 15% age 65 years and over. Compared to Ryan White clients, 18% were ages 55 to 64 and 4% were 65 and over. Among all PLWH 19% and 7% were in these age groups, respectively. No adolescents (those age 13 to 17) were surveyed. This suggests that youth and young adult PLWH (those age 13 to 24) are generally underrepresented in the needs assessment, while older adults (those age 55 and above) are overrepresented.

GRAPH 3- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Age[c], 2018



[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18
[c]Excludes ages0-12
*Age ranges 35-44 and 45-54 combined due to differences in question structuring.

Weighting the Sample

Needs assessment data were statistically weighted by sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2018) *prior to* the analysis of results related to service needs and barriers. This was done because the demographic composition of 2020 Houston HIV Care Services Needs Assessment participants was *not* comparable to the composition of all PLWH in the Houston EMA. As such, the results presented in the remaining Chapters of this document are proportional for these three demographic categories only. Appropriate statistical methods were applied throughout the process in order to produce an accurately weighted sample, including a three-level stratification of prevalence data and subsequent data weighting syntax. Voluntary completion on the survey and non-applicable answers comprise the missing or invalid survey entries and are excluded in the statistical analysis; therefore, denominators will further vary across results. All data management and quantitative analysis, including weighting, was performed in IBM© SPSS© Statistics (v. 22). Qualitative analysis was performed in QSR International© NVivo 10.

Sources:

Texas Department of State Health Services (TDSHS) eHARS data through 12-31-2018.

University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPPS Statistics 20, Post-stratification weights, 2009.

Chapter 2:
Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

As payer of last resort, the Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to people living with HIV (**PLWH**) who may not have sufficient resources for managing HIV. The Houston Area HIV Services Ryan White Planning Council identifies, designs, and allocates funding to locally-provided HIV care services. Housing services for PLWH are provided through the federal Housing Opportunities for People with AIDS (**HOPWA**) program through the City of Houston Housing and Community Development Department and for PLWH recently released from incarceration through the Houston Regional HIV/AIDS Resource Group (**TRG**). The primary function of HIV needs assessment activities is to gather information about the need for and barriers to services funded by the local Houston Ryan White HIV/AIDS Program, as well as other HIV-related programs like HOPWA and the Houston Health Department's (**HHD**) prevention program.

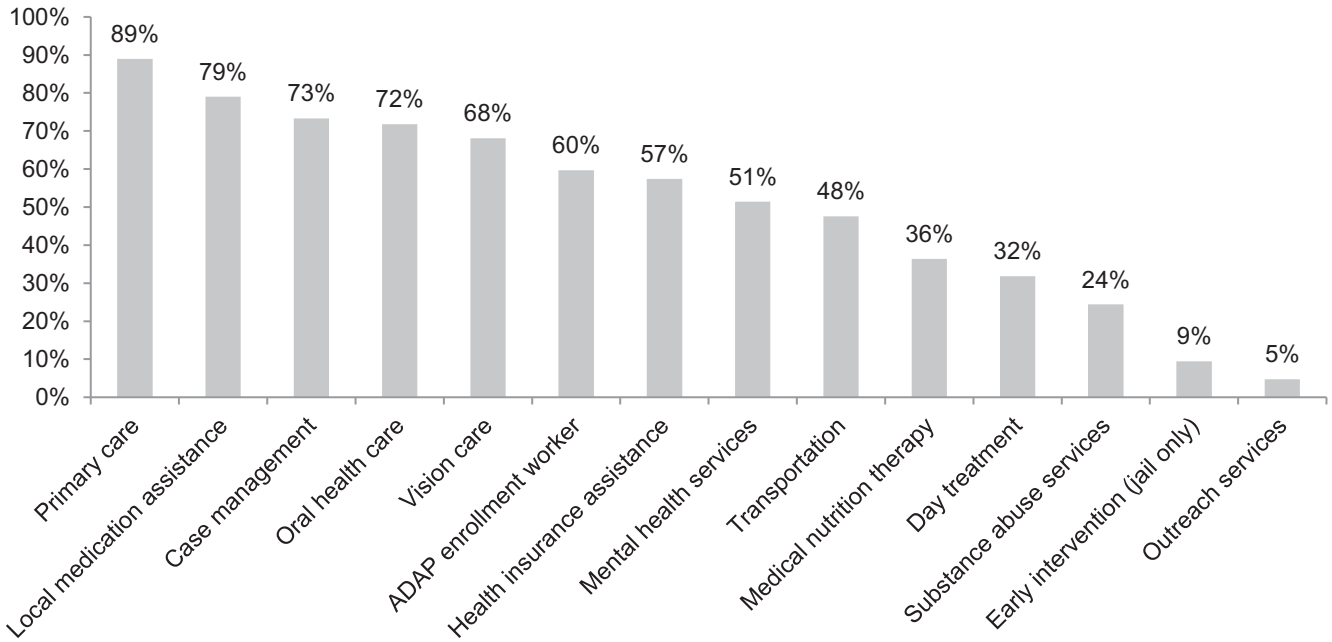
Overall Ranking of Funded Services, by Need

At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 1**) All funded services except hospice and linguistics were analyzed and received a ranking of need. Emergency financial assistance was merged with local medication assistance, and non-medical case management was merged with medical case management. At 89%, primary care was the most needed funded service in the Houston Area, followed by local medication assistance at 79%, case management at 73%, oral health care at 72%, and vision care at 68%. Primary care had the highest need ranking of any core medical service, while ADAP enrollment worker received the highest need ranking of any support service. Compared to the last Houston Area HIV needs assessment conducted in 2016, need ranking decreased for most services. The percent of needs assessment participants reporting need for a particular service decreased the most for case management and primary care, while the percent of those indicating a need for local medication assistance and early intervention services increased from 2016.

GRAPH 1-Ranking of HIV Services in the Houston Area, By Need, 2020

Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.
Denominator: 569-573 participants, varying between service categories



Overall Ranking of Funded Services, by Accessibility

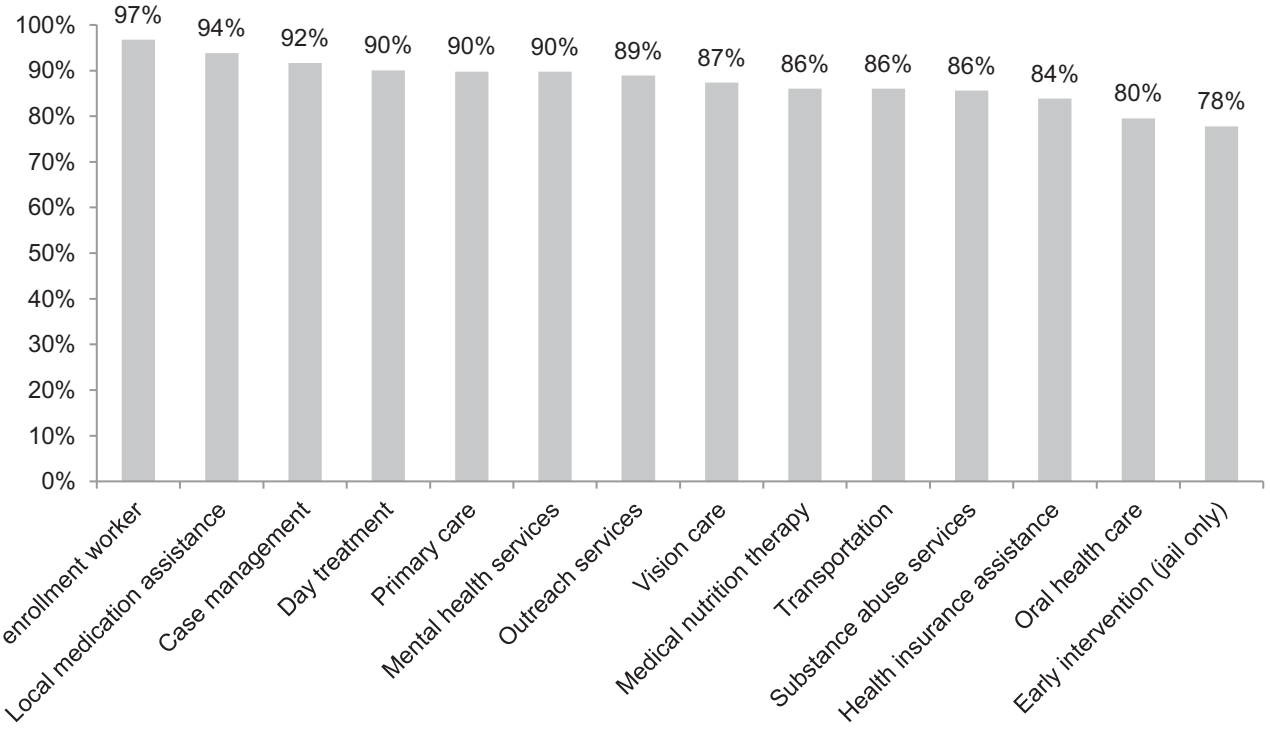
Participants were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both topics are presented below.

(**Graph 2**) All funded services except hospice and linguistics were analyzed and received a ranking of accessibility. The most accessible service was ADAP enrollment worker at 97% ease of access, followed by local medication assistance at 94% and case management at 92%. Local medication assistance had the highest accessibility ranking of any core medical service, while ADAP enrollment worker received the highest accessibility ranking of any support service. Compared 2016 needs assessment, reported accessibility on remained stable on average. The greatest increase in percent of participants reporting ease of access was observed in local medication assistance, while the greatest decrease in accessibility was reported for early intervention services.

GRAPH 2-Ranking of HIV Services in the Houston Area, By Accessibility, 2020

Definition: Of needs assessment participants stating they needed the service in the past 12 months, the percent stating it was easy to access the service.

Denominator: 569-573 participants, varying between service categories



Overall Ranking of Barriers Types Experienced by Consumers

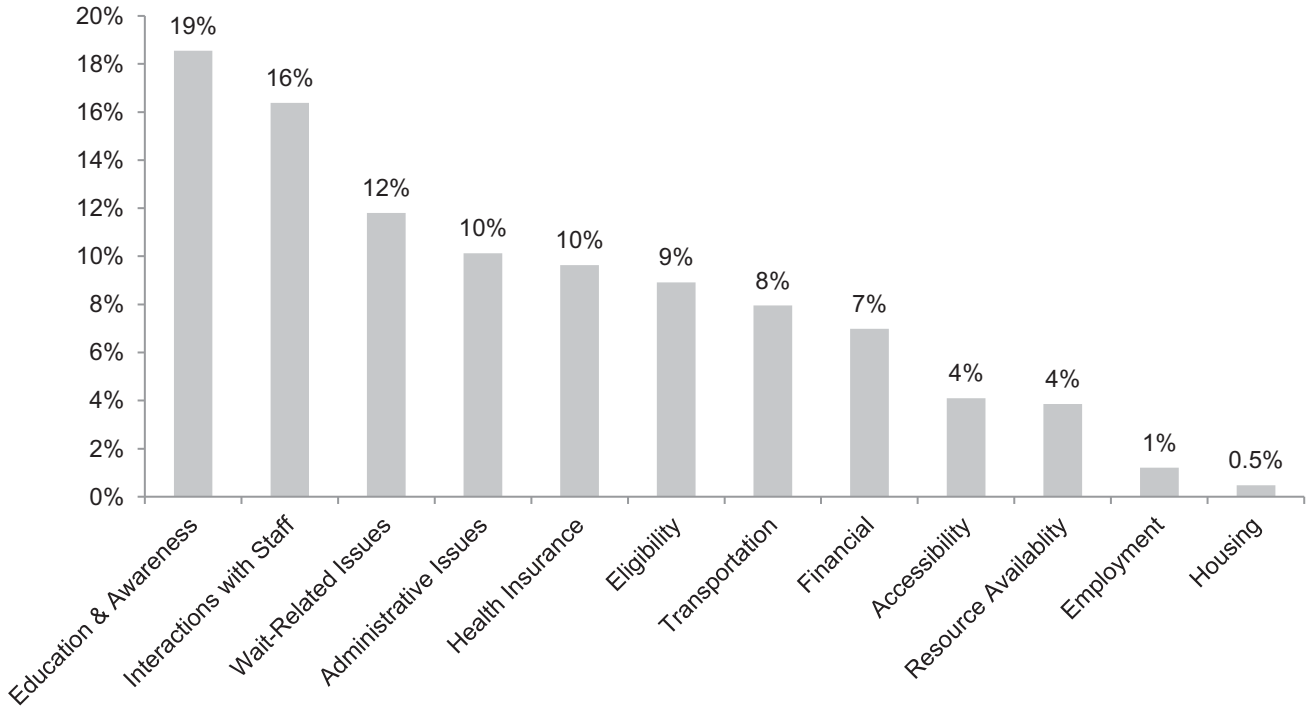
Since the 2016 Houston Area HIV Needs Assessment, participants who reported *difficulty* accessing needed services have been asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. In 2016, staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers, then grouped together into 12 nodes, or barrier types. This categorization schema was applied to reported barriers in the 2020 survey.

(**Graph 3**) Overall, fewer barriers were reported in 2020 (415 barrier reports) than in previous 2016 needs assessment (501 barrier reports), despite the increase in sample size in 2020. Across all funded services, the barrier types reported most often related to service education and awareness issues (19% of all reported barriers); interactions with staff (16%), wait-related issues (12%); administrative issues (10%); and issues relating to health insurance coverage (10%). Housing issues (homelessness or intimate partner violence) were reported least often as barriers to funded services (1%). Between the 2016 and 2020 HIV needs assessments, the percentage of barriers relating to interactions with staff increased by 3 percentage points, while wait-related issues decreased by 3 percentage points.

For more information on barrier types reported most often by service category, please see the Service-Specific Fact Sheets.

GRAPH 3-Ranking of Types of Barriers to HIV Services in the Houston Area, 2018

Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.
Denominator: 415 barrier reports



Descriptions of Barriers Encountered

All funded services were reported to have barriers, with an average of 35 reports of barriers per service. Participants reported the least barriers for Linguistic Services (one barrier) and the most barriers for Oral Health Care (90 barriers). In total, 415 reports of barriers across all services were indicated in the sample.

(**Table 1**) Within education and awareness, knowledge of the availability of the service and where to go to access the service accounted for 81% of barriers reported. Being put on a waitlist accounted for a majority (56%) of wait-related barriers. Poor communication and/or follow up from staff members when contacting participants comprised a majority (53%) of barriers related to staff interactions. Forty-five percent (45%) of eligibility barriers related to participants being told they did not meet eligibly requirements to receive the service while redundant or complex processes for renewing eligibility accounted for an additional 39% of eligibility barriers. Among administrative issues, long or complex processes required to obtain services sufficient to create a burden to access comprised most (57%) of the barriers reported.

A majority of health insurance-related barriers occurred because the participant was under-insured or experiencing coverage gaps for needed services or medications (55%) or they were uninsured (25%). The largest proportion (91%) of transportation-related barriers occurred when participants had no access to transportation. Inability to afford the service accounted for all barriers relating to participant financial resources. Services being offered at an inaccessible distance accounted for most (76%) of accessibility-related barriers, though it is noteworthy that low or no literacy accounted for 12% of accessibility-related barriers. Receiving resources that were insufficient to meet participant needs accounted for most resource availability barriers. Intimate partner violence accounted for both reports of housing-related barriers. Instances in which the participant's employer did not provide sufficient sick/wellness leave for attend appointments comprised most (80%) employment-related barriers.

TABLE 1-Barrier Proportions within Each Barrier Type, 2020					
Education & Awareness	%	Wait-Related Issues	%	Interactions with Staff	%
Availability (Didn't know the service was available)	51%	**Waitlist** (Put on a waitlist)	56%	**Communication** (Poor correspondence/ Follow up from staff)	53%
Definition (Didn't know what service entails)	2%	**Unavailable** (Waitlist full/not available resulting in client not being placed on waitlist)	22%	**Poor Treatment** (Staff insensitive to clients)	13%
Location (Didn't know where to go [location or location w/in agency])	30%	**Wait at Appointment** (Appointment visits take long)	12%	**Resistance** (Staff refusal/ resistance to assist clients)	6%
Contact (Didn't know who to contact for service)	16%	**Approval** (Long durations between application and approval)	10%	**Staff Knowledge** (Staff has no/ limited knowledge of service)	19%
				Referral (Received service referral to provider that did not meet client needs)	10%
Eligibility	%	Administrative Issues	%	Health Insurance	%
Ineligible (Did not meet eligibility requirements)	45%	**Staff Changes** (Change in staff w/o notice)	10%	**Uninsured** (Client has no insurance)	25%
Eligibility Process (Redundant process for renewing eligibility)	39%	**Understaffing** (Shortage of staff)	7%	**Coverage Gaps** (Certain services/medications not covered)	55%
Documentation (Problems obtaining documentation needed for eligibility)	16%	**Service Change** (Change in service w/o notice)	7%	**Locating Provider** (Difficulty locating provider that takes insurance)	18%
		Complex Process (Burden of long complex process for accessing services)	57%	**ACA** (Problems with ACA enrollment process)	3%
		Dismissal (Client dismissal from agency)	7%		
		Hours (Problem with agency hours of operation)	12%		
Transportation		Financial	%	Accessibility	%
No Transportation (No or limited transportation options)	91%	**Financial Resources** (Could not afford service)	100%	**Literacy** (Cannot read/difficulty reading)	12%
Providers (Problems with special transportation providers such as Metrolift or Medicaid transportation)	9%			**Spanish Services** (Services not made available in Spanish)	0%
				Released from Incarceration (Restricted from services due to probation, parole, or felon status)	12%
				Distance (Service not offered within accessible distance)	76%
Resource Availability	%	Housing	%	Employment	%
Insufficient (Resources offered insufficient for meeting need)	81%	**Homeless** (Client is without stable housing)	0%	**Unemployed** (Client is unemployed)	20%
Quality (Resource quality was poor)	19%	**IPV** (Interpersonal domestic issues make housing situation unsafe)	100%	**Leave** (Employer does not provide sick/wellness leave for appointments)	80%

NEEDS AND ACCESSIBILITY FOR UNFUNDED SERVICES

The Ryan White HIV/AIDS Program allows funding of 13 core medical services and 15 support services, though only 17 of these services were funded in the Houston area at the time of survey. For this first time, the 2020 Houston Area HIV Needs Assessment collected data on the need for and accessibility to services that are allowable under Ryan White, but not currently funded in the Houston area. While these services are not funded under Ryan White, other funding sources in the community may offer them.

Overall Ranking of Unfunded Services, by Need

Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of allowable but currently unfunded services they needed in the past 12 months.

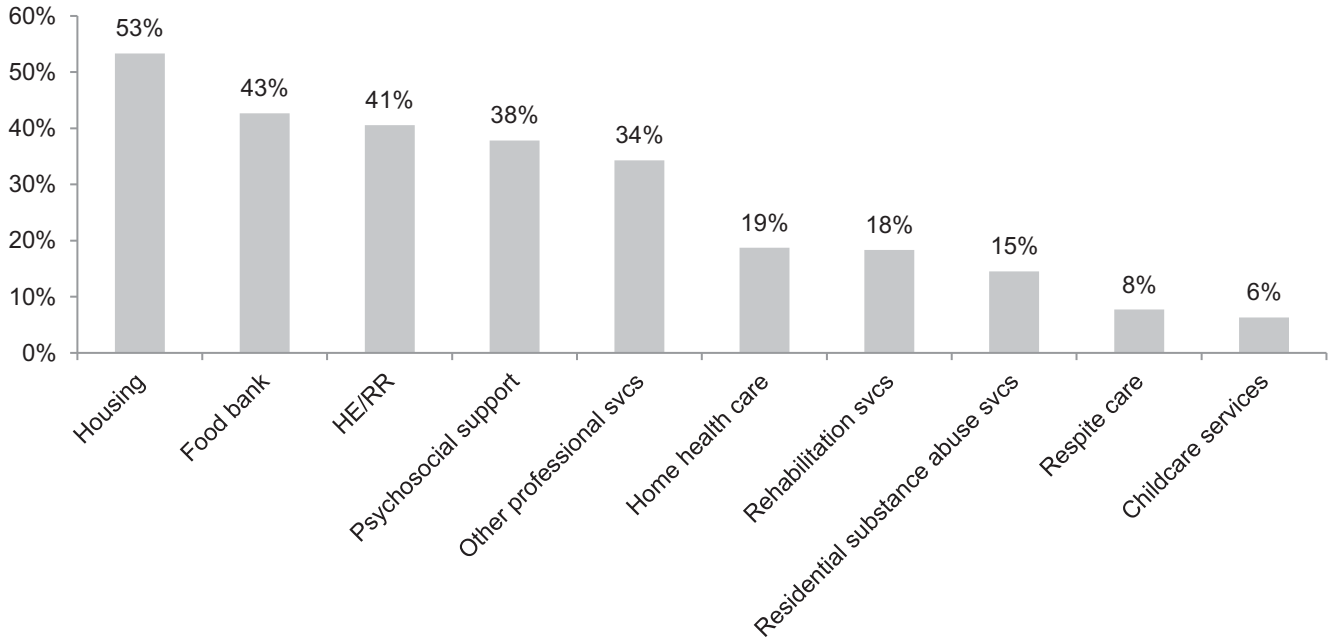
(**Graph 4**) At 53%, housing was the most needed unfunded service in the Houston Area, followed by food bank at 43%, health education/risk reduction at 41%, psychosocial support services at 38%, and other professional services at 34%. Of participants indicating a need for food bank, 69% reported needing services from a food bank, 6% reported needing home delivered meals, and 25% indicated need for both types of food bank service. Among participants indicating a need for psychosocial support services, 89% reported needing an in-person support group, 3% reported needing an online support group, and 8% indicated need for both types of psychosocial support.

Home health care had the highest need ranking of any unfunded core medical service, while housing received the highest need ranking of any unfunded support service.

GRAPH 4-Ranking of Unfunded HIV Services in the Houston Area, By Need, 2020

Definition: Percent of needs assessment participants stating they needed the unfunded service in the past 12 months, regardless of service accessibility.

Denominator: 569-572 participants, varying between service categories



Overall Ranking of Unfunded Services, by Accessibility

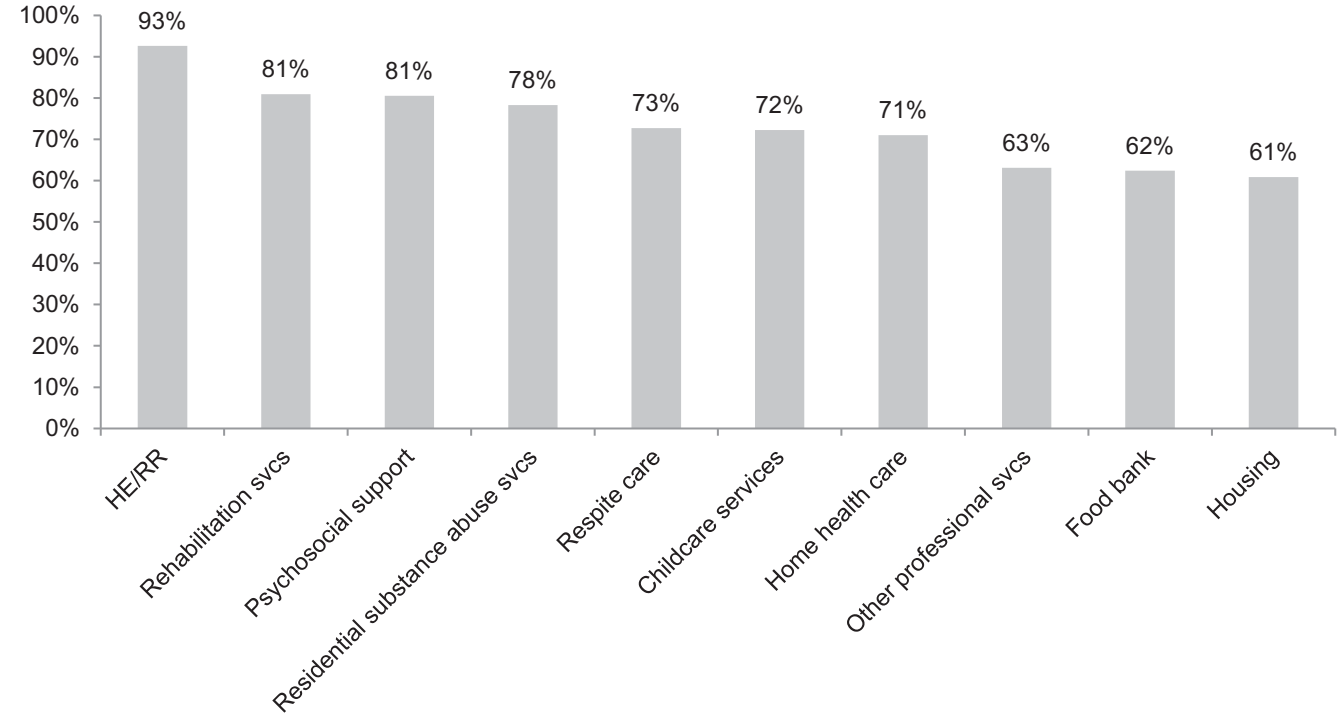
Participants were asked to indicate if each of the unfunded HIV services they needed in the past 12 months was easy or difficult for them to access.

(**Graph 5**) The most accessible unfunded service was health education/risk reduction at 93% ease of access, followed by rehabilitation services at 81%, psychosocial support services at 81%, residential substance abuse services at 78%, and respite care at 73%. The least accessible needed unfunded services was housing at 61%. Home health care had the highest accessibility ranking of any core medical service, while rehabilitation services received the highest accessibility ranking of any support service.

GRAPH 5-Ranking of Unfunded HIV Services in the Houston Area, By Accessibility, 2020

Definition: Of needs assessment participants stating they needed the unfunded service in the past 12 months, the percent stating it was easy to access the service.

Denominator: 569-572 participants, varying between service categories



Other Identified Needs

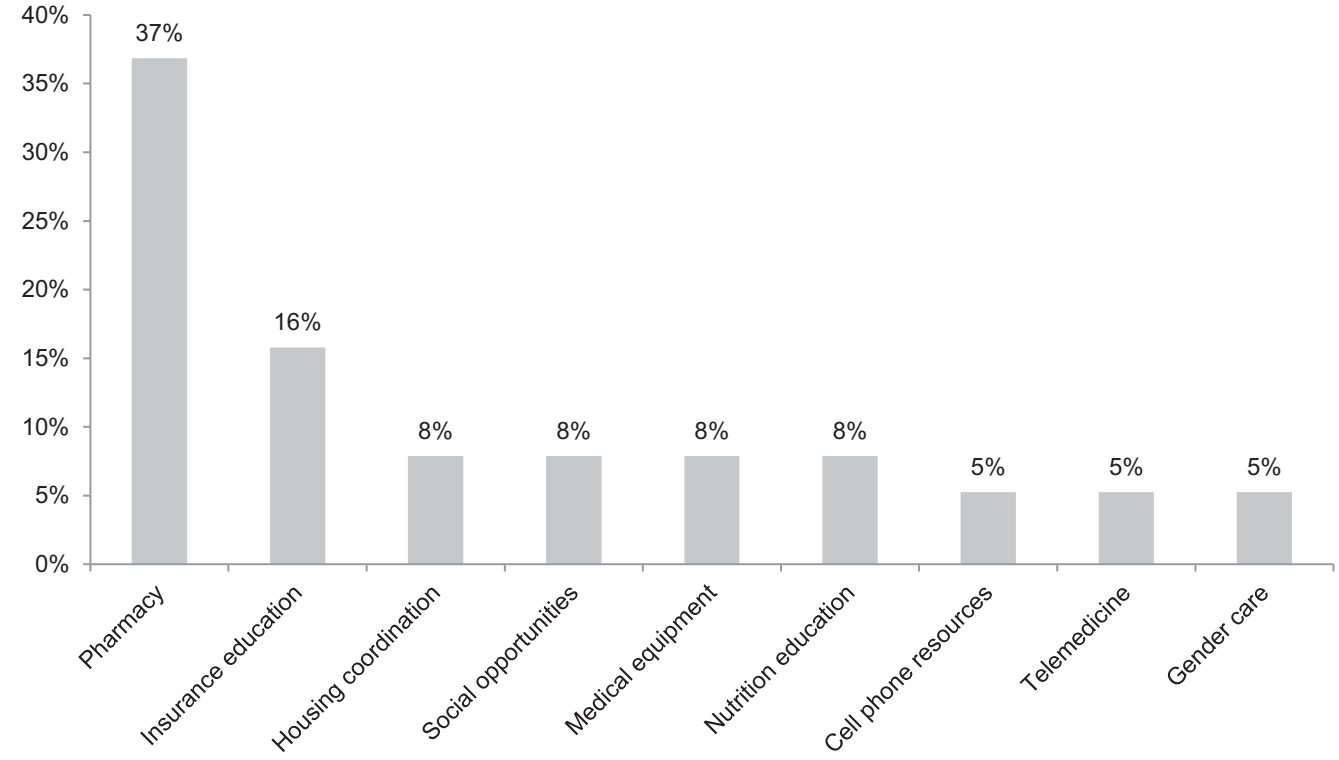
In addition to the allowable HIV services listed above, participants were also encouraged to write-in other types of needed services to gauge any new or emerging service needs in the community.

(**Graph 6**) Participants identified nine additional needs not otherwise described in funded and unfunded services above. The most common identified needs related to pharmacy, such as having medications delivered and automatic refills, at 37%. This was followed by insurance education at 16%, and housing coordination, social opportunities, coverage for medical equipment, and nutrition education, each at 8%.

GRAPH 6-Other Needs for HIV Services in the Houston Area, 2020

Definition: Percent of write-in responses by type for the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

Denominator: 38 write-in responses



Service-Specific Fact Sheets

ADAP ENROLLMENT WORKER

AIDS Drug Assistance Program (ADAP) enrollment worker, technically referred to as *referral for health care and support,* describes a service that helps people living with HIV (PLWH) access medication coverage by ensuring the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). ADAP enrollment workers meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, assist clients with the submission of complete, accurate ADAP applications, and submit annual re-certifications.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 60% of participants indicated a need for *ADAP enrollment worker* in the past 12 months. 58% reported the service was easy to access, and 2% reported difficulty. 12% stated they did not know the service was available.

(**Table 1**) When barriers to *ADAP enrollment worker* were reported, the most common barrier type was education and awareness (30%). Education and awareness barriers reported include lack of knowledge about service availability and who to contact to access the service.

GRAPH 1-ADAP Enrollment Worker, 2020

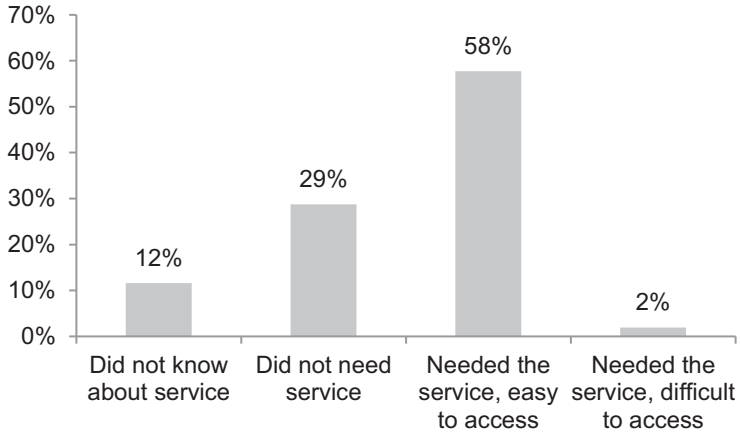


TABLE 1-Top 3 Reported Barrier Types for ADAP Enrollment Worker, 2020

	No.	%
1. Education and Awareness (EA)	3	30%
2. Administrative (AD)	2	20%
3. Eligibility (EL)	2	20%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *ADAP enrollment worker*, this analysis shows the following:

- More females than males found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.

In addition, more out of care, rural, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-ADAP Enrollment Worker, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	9%	8%	13%	12%	4%	12%	9%	8%
Did not need service	28%	31%	32%	36%	20%	12%	28%	31%	32%
Needed, easy to access	57%	58%	57%	50%	66%	77%	57%	58%	57%
Needed, difficult to access	2%	1%	3%	2%	1%	8%	2%	1%	3%

TABLE 3-ADAP Enrollment Worker, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	8%	6%	0%	5%	0%	18%
Did not need service	7%	12%	0%	0%	3%	9%
Needed, easy to access	76%	71%	100%	89%	91%	64%
Needed, difficult to access	10%	11%	0%	5%	6%	9%

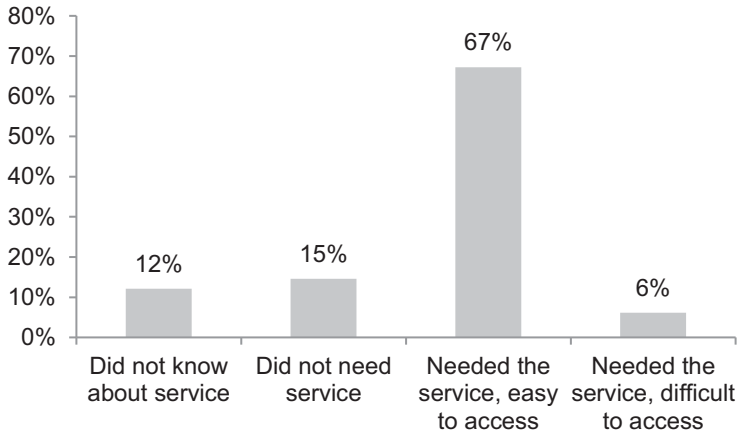
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

CASE MANAGEMENT

Case management, technically referred to as *medical case management, clinical case management, or service linkage*, describes a range of services that help connect persons living with HIV (PLWH) to HIV care, treatment, and support services and to retain them in care. Case managers assess client needs, develop service plans, and facilitate access to services through referrals and care coordination. Case management also includes treatment readiness and adherence counseling.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 73% of participants indicated a need for *case management* in the past 12 months. 67% reported the service was easy to access, and 6% reported difficulty. 12% stated they did not know the service was available.

GRAPH 1-Case Management, 2020



(**Table 1**) When barriers to *case management* were reported, the most common barrier type was interactions with staff (37%). Staff interaction barriers reported include poor correspondence or follow up, poor treatment, limited staff knowledge of services, and service referral to provider that did not meet client needs.

TABLE 1-Top 4 Reported Barrier Types for Case Management, 2020

	No.	%
1. Interactions with Staff (S)	13	37%
2. Education and Awareness (EA)	8	8%
3. Administrative (AD)	6	8%
4. Wait (4)	2	2%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *case management*, this analysis shows the following:

- More females than males found the service accessible.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.

In addition, more out of care, transgender, recently released from incarceration, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Case Management, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	7%	10%	11%	15%	4%	5%	15%	9%
Did not need service	59%	68%	22%	14%	13%	8%	29%	12%	17%
Needed, easy to access	20%	23%	64%	68%	66%	81%	52%	67%	69%
Needed, difficult to access	4%	3%	4%	7%	6%	8%	14%	6%	5%

TABLE 3-Case Management, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	10%	13%	13%	11%	37%	17%
Did not need service	13%	18%	16%	8%	9%	13%
Needed, easy to access	68%	63%	58%	71%	51%	58%
Needed, difficult to access	10%	6%	13%	11%	3%	13%

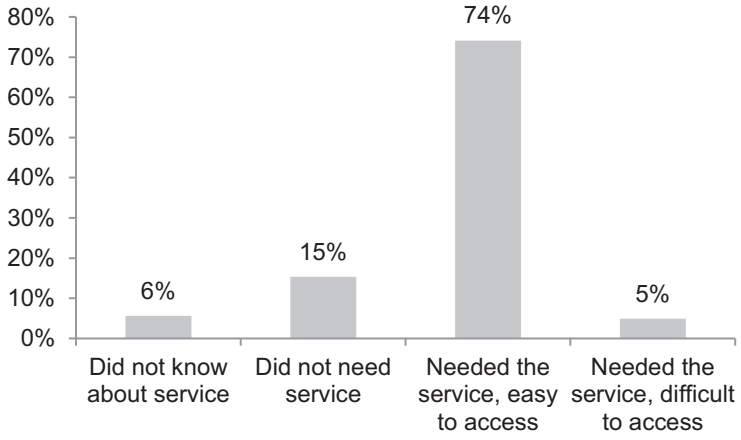
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

LOCAL HIV MEDICATION ASSISTANCE

Local HIV medication assistance, technically referred to as the *Local Pharmacy Assistance Program (LPAP)*, provides HIV-related pharmaceuticals to persons living with HIV (PLWH) who are not eligible for medications through other payer sources, including the state AIDS Drug Assistance Program (ADAP).

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 79% of participants indicated a need for *local HIV medication assistance* in the past 12 months. 74% reported the service was easy to access, and 5% reported difficulty. 6% stated that they did not know the service was available.

GRAPH 1-Local HIV Medication Assistance, 2020



(**Table 1**) When barriers to *local HIV medication assistance* were reported, the most common barrier type was eligibility (25%). Eligibility barriers reported include redundant or complex processes for meeting/renewing eligibility, problems obtaining documentation needed for eligibility and not meeting eligibility requirements.

TABLE 1-Top 5 Reported Barrier Types for Local HIV Medication Assistance, 2020

	No.	%
1. Eligibility (EL)	7	25%
2. Administrative (AD)	4	14%
3. Education and Awareness (EA)	4	14%
4. Health Insurance Coverage (I)	4	14%
5. Interactions with Staff (S)	3	11%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *local HIV medication assistance*, this analysis shows the following:

- More males than females found the service accessible.
- More White PLWH than other race/ethnicities found the service accessible.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, homeless, MSM, rural, and transgender PLWH found the service difficult to access when compared to all participants.

TABLE 2-Local HIV Medication Assistance, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	7%	2%	1%	5%	7%	8%	0%	6%	6%
Did not need service	16%	12%	29%	17%	10%	4%	14%	15%	16%
Needed, easy to access	73%	79%	69%	72%	76%	88%	81%	73%	75%
Needed, difficult to access	4%	7%	1%	5%	6%	4%	5%	6%	3%

TABLE 3-Local HIV Medication Assistance, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	11%	6%	10%	6%	6%	8%
Did not need service	15%	17%	20%	8%	17%	46%
Needed, easy to access	68%	71%	70%	83%	71%	42%
Needed, difficult to access	6%	6%	0%	3%	6%	4%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

OUTREACH SERVICES

Outreach services are provided for people living with HIV (PLWH) who have missed primary medical care appointments without rescheduling, and who may have other risk factors for falling out of care. The goal of *outreach services* is to support retention in care. Services are field-based, and include assistance with medical appointment setting and accessing supportive services, advocating on behalf of clients to decrease service gaps and remove barriers to services, and helping clients develop and utilize independent living skills and strategies.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 5% of participants indicated a need for *outreach services* in the past 12 months. 4% reported the service was easy to access, and 1% reported difficulty. 9% stated that they did not know the service was available.

(**Table 1**) When barriers to *outreach services* were reported, the most common barrier type was interactions with staff (71%). Interactions with staff barriers reported include poor correspondence or follow up.

GRAPH 1-Outreach Services, 2020

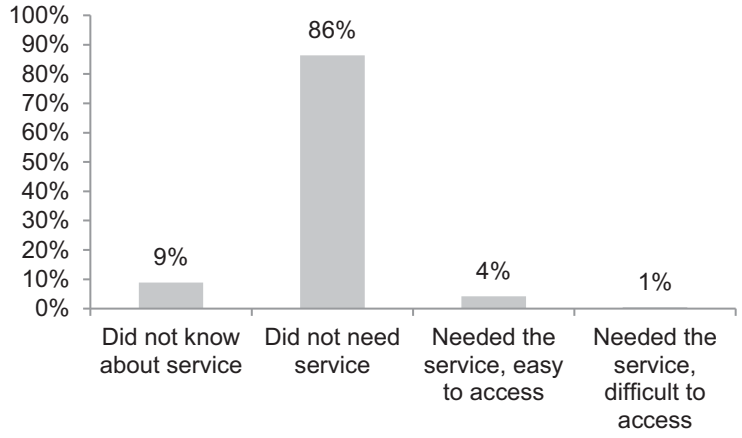


TABLE 1-Top Reported Barrier Type for Outreach Services, 2020

	No.	%
1. Interactions with Staff (S)	5	71%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *outreach services,* this analysis shows the following:

- More males than females found the service accessible.
- More Black/African American and Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more homeless, MSM, recently released, and transgender PLWH found the service difficult to access when compared to all participants.

TABLE 2-Outreach Services, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	22%	17%	22%	19%	22%	23%	57%	25%	11%
Did not need service	42%	40%	57%	45%	33%	38%	24%	34%	53%
Needed, easy to access	34%	40%	17%	34%	42%	38%	19%	37%	34%
Needed, difficult to access	3%	2%	4%	2%	2%	0%	5%	3%	1%

TABLE 3-Outreach Services, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	23%	23%	20%	28%	26%	21%
Did not need service	28%	42%	37%	30%	37%	42%
Needed, easy to access	37%	32%	43%	39%	37%	35%
Needed, difficult to access	12%	3%	0%	3%	0%	2%

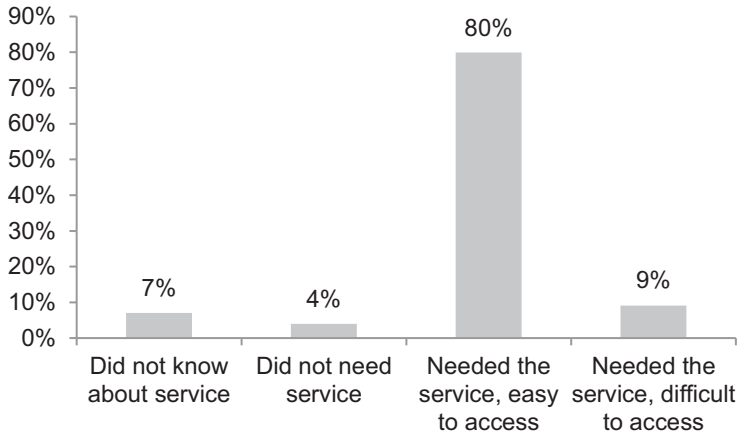
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

PRIMARY HIV MEDICAL CARE

Primary HIV medical care, technically referred to as *outpatient/ambulatory medical care*, refers to the diagnostic and therapeutic services provided to persons living with HIV (PLWH) by a physician or physician extender in an outpatient setting. This includes physical examinations, diagnosis and treatment of common physical and mental health conditions, preventative care, education, laboratory services, and specialty services as indicated.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 89% of participants indicated a need for *primary HIV medical care* in the past 12 months. 80% reported the service was easy to access, and 90% reported difficulty. 7% stated that they did not know the service was available.

GRAPH 1-Primary HIV Medical Care, 2020



(**Table 1**) When barriers to *primary HIV medical care* were reported, the most common barrier type was transportation (26%). Transportation barriers reported include having no or limited transportation options, and having problems with special transportation providers such as Metrolift or Medicaid transportation

TABLE 1-Top 5 Reported Barrier Types for Primary HIV Medical Care, 2020

	No.	%
1. Transportation (T)	11	26%
2. Education and Awareness (EA)	8	19%
3. Interactions with Staff (S)	8	19%
4. Eligibility	4	9%
5. Wait (W)	4	9%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *primary HIV medical care*, this analysis shows the following:

- More females than males found the service accessible.
- More White PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more rural, out of care, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Primary HIV Medical Care, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	8%	4%	1%	5%	12%	0%	0%	9%	5%
Did not need service	4%	4%	9%	3%	3%	0%	0%	2%	8%
Needed, easy to access	92%	85%	86%	83%	74%	92%	76%	79%	83%
Needed, difficult to access	9%	8%	4%	8%	12%	8%	24%	11%	5%

TABLE 3-Primary HIV Medical Care, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	10%	9%	19%	9%	3%	13%
Did not need service	2%	5%	10%	2%	0%	13%
Needed, easy to access	82%	77%	55%	83%	71%	75%
Needed, difficult to access	6%	10%	16%	6%	26%	0%

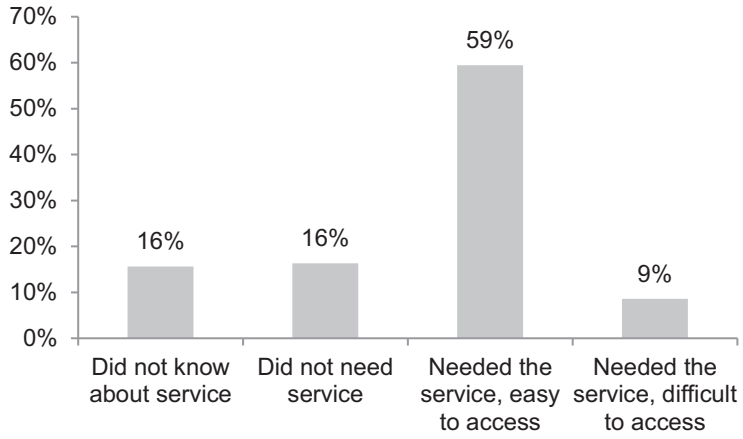
[a]Persons reporting current homelessnes [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

VISION CARE

Vision care, technically a subcategory of primary HIV medical care, provides optometric/ophthalmologic treatment, vision screening, and glasses to people living with HIV (PLWH). This does not include fitting of contact lenses.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 68% of participants indicated a need for *vision care* in the past 12 months. 59% reported the service was easy to access, and 9% reported difficulty. 16% stated they did not know the service was available.

GRAPH 1-Vision Care, 2020



(**Table 1**) When barriers to *vision care* were reported, the most common barrier type was wait-related issues. Wait-related barriers reported include scheduling appointments 2-3 months out, placement on a waitlist, being told to call back as a wait list was full/unavailable, and long waits at appointments.

TABLE 1-Top 5 Reported Barrier Types for Vision Care, 2020

	No.	%
1. Wait (W)	15	34%
2. Health Insurance Coverage (I)	8	18%
3. Education and Awareness (EA)	6	14%
4. Financial (F)	4	9%
5. Interactions with Staff (S)	3	7%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *vision care,* this analysis shows the following:

- More males than females found the service accessible.
- More Black/African American PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more homeless and out of care PLWH found the service difficult to access when compared to all participants.

TABLE 2-Vision Care, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	10%	12%	15%	15%	15%	14%	21%	8%
Did not need service	16%	18%	19%	21%	11%	4%	62%	15%	15%
Needed, easy to access	60%	58%	60%	56%	65%	69%	14%	56%	69%
Needed, difficult to access	7%	14%	9%	8%	9%	15%	14%	9%	8%

TABLE 3-Vision Care, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	20%	17%	10%	28%	6%	20%
Did not need service	16%	13%	10%	16%	20%	24%
Needed, easy to access	51%	63%	70%	47%	66%	56%
Needed, difficult to access	13%	7%	10%	9%	6%	0%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

Houston Area Integrated HIV Prevention and Care Plan

2022 - 2026

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Disclaimer:
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Vision

The Greater Houston area will become a community with an enhanced system of HIV prevention and care. New HIV infections will be reduced to zero. Should new HIV infections occur, every person, regardless of sex, race, color, ethnicity, national origin, age, familial status, marital status, military status, religion, disability, sexual orientation, genetic information, gender identity, pregnancy, or socio-economic circumstance, will have unfettered access to high-quality, life-extending care, free of stigma and discrimination.

Mission

The mission of the 2022-2026 Houston Area Integrated HIV Prevention & Care Services Plan is to work in partnership with the community to provide an effective system of HIV prevention and care services that best meets the needs of populations living with, affected by, or at risk for HIV.

SECTION I: EXECUTIVE SUMMARY OF INTEGRATED PLAN AND SCSN

(Provide a description of the Integrated Plan, including the SCSN and the approach the jurisdiction used to prepare and package requirements for submission.)

1. a. b. The mission of the 2022-2026 Houston Area Integrated HIV Prevention and Care Services Plan (**2022 Integrated Plan**) is to work in partnership with the community to provide an effective system of HIV prevention and care services that best meets the needs of populations living with, affected by, or at risk for HIV.

Houston is the fourth largest city in the U.S., the largest city in the State of Texas, and one of the most racially and ethnically diverse major American metropolitan areas. Spanning 600 square miles, Houston is also the least densely populated major metropolitan area. Houston is the seat of Harris County, the most populous county in the State of Texas and the third most populous in the country. The United States Census Bureau estimates that Harris County has almost 4.7 million residents, around half of which live in the city of Houston.

HIV prevention and care services are provided in the Houston Area throughout three distinctly defined service areas. The End the HIV Epidemic (**EHE**) geographic service area is Houston/Harris County. As of 2019, 92% of all diagnosed people living with HIV in the Houston Eligible Metropolitan Area and a majority of those in the Houston Health Services Delivery Area reside in Houston/Harris County. For this reason, much of the epidemiologic data presented for Houston/Harris County are considered representative of the larger areas, unless otherwise noted. This document provides information related to all three of the service areas described below:

- *The Houston Metropolitan Statistical Area (**MSA**)* includes Harris County and the cities of Houston, Baytown, and Sugarland, TX. The Centers for Disease Control and Prevention's (**CDC**) HIV prevention funding and activities are administered in the MSA.
- *The Houston Eligible Metropolitan Area (**EMA**)* is the geographic service area defined by the Health Resources and Services Administration (**HRSA**) for the Ryan White HIV Program Part A and Minority AIDS Initiative (**MAI**). It includes Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller Counties.
- *The Houston Health Services Delivery Area (**HSDA**)* includes the six counties of the Houston EMA plus four additional counties: Austin, Colorado, Walker, and Wharton. The Houston Regional HIV Resource Group (**TRG**) administers the Texas Department of State Health Services (**TDSHS**) Ryan White HIV Program Part B and State of Texas HIV care services funding and activities in the HSDA. Epidemiologic data for the HSDA are provided by TDSHS.

Because of these distinctly defined service areas, the 2022 Integrated Plan for HIV Prevention and Care Services is a collaborative project of the:

- Houston Health Department (**HHD**), Bureau of HIV/STD & Viral Hepatitis Prevention. The City of Houston is directly funded by CDC for HIV prevention and HIV Surveillance in the MSA.
- Houston HIV Prevention Community Planning Group (**CPG**), the HIV prevention planning body for the MSA.

- Harris County Public Health, Ryan White Grant Administration (**RWGA**), the Recipient for Ryan White Part A and Minority AIDS Initiative funding and the Cares Act (COVID) funding for the six-county EMA, as well as EHE funds for Harris County.
- Houston Regional HIV Resource Group (**TRG**), the recipient for Ryan White Part B and State Services funding in the 10-county HSDA.
- Ryan White Planning Council (**RWPC**), the HIV care planning body for the six-county EMA and the 10-county HSDA.

For this Plan, significant new information was collected from priority populations, as well as Ryan White and non-Ryan White funded stakeholders. Thus, many of the ideas and goals are new, and integrate new data into existing documents to create the 2022 Integrated Plan. The goals are also aligned with the *National HIV/AIDS Strategy (**NHAS**)*, *Fast Track Cities* and other comprehensive plans identified in the Houston Crosswalk of Comprehensive national, state and local plans. See Section III, page 24.

The 2022 Integrated Plan is intended for use by local HIV planning bodies, recipients and grantees, providers of HIV prevention and care services, both new and established community partners, the state in its Statewide Coordinated Statement of Need (**SCSN**), and other decision makers as they respond to the needs of people with or at-risk for HIV over the next five years. The 2022 Integrated Plan is organized into seven sections, which are summarized below.

Section II: Community Engagement and Planning Process
Since at least 1997, two HIV-related planning bodies have worked collaboratively to provide full coverage HIV prevention and care services planning. The prevention planning body is staffed by the City of Houston; Harris County administers the Ryan White Part A/MAI Program and provides staff for the HIV care planning body. Both planning bodies were key drivers in the formation of community trainings, data collection, development of the goals and objectives and they will be key drivers in implementing, monitoring and evaluating the 2022 Integrated Plan.

Over 580 people with HIV provided input on service needs, gaps and barriers as described in the 2020 Houston Area HIV Care Services Needs Assessment (**2020 NA**). In 2021 and 2022, staff focused on gathering information from populations that were selected by CPG and RWPC as Priority Populations based upon data from State and local sources. Focus groups with representatives of all priority populations included 117 participants. The purpose of the focus groups was to uncover unique ways to address HIV prevention and care services for these hard to reach populations.

Stakeholders in the 10-county service area were interviewed one on one for the most part. The intent was to learn from stakeholder's professional expertise and make it possible to compare suggestions from stakeholders against the lived experience of individuals in the focus groups. At least 126 individuals participated in stakeholder interviews, which included both focus groups and one-on-one interviews.

Section III: Data Sets and Assessments
This section contains a description of multiple databases available for planning HIV prevention and care services, a summary from the 2019 Epidemiological Profile as well as the 2022

Epidemiological Supplement to the Profile, an extensive Resource Inventory and a comparison of the 2020 HIV Care Services Needs Assessment and the 2022 HIV Prevention Needs Assessment. The Houston EMA HIV Care Continuum depicts the number and percentage of people with HIV in Harris, Fort Bend, Waller, Montgomery, Liberty and Chambers counties at each stage of HIV care, from being diagnosed with HIV to viral suppression and linkage to care. Stakeholders regularly use this analysis to measure the extent to which people with HIV have community-wide access to care and identify potential service gaps. The methodology follows the CDC definition for a diagnosis-based HIV care continuum.

Among 30,149 HIV-diagnosed individuals ages 13 years or older in the Houston EMA in 2019, 75% had receipt of care (at least one CD4/Viral Load test in year); 60% were retained in HIV care (at least two CD4/ Viral Load tests in a year, at least three months apart); 59% maintained or reached viral load suppression (≤200 copies/mL); and 63% among the newly diagnosed were linked to care.

As of 2019, in both Houston/Harris County and the Houston EMA, the rates of new HIV diagnoses and prevalence continue to exceed rates both for Texas and the U.S. The rate of new HIV diagnoses in Houston/Harris County is almost twice the rate for the U.S.

Section IV: Situational Analysis

From the 2020 NA, the 2022 HIV Prevention Needs Assessment, priority population focus groups, provider focus groups, stakeholder interviews, the 2022 crosswalk of comprehensive plans, community meetings, and other data sources, the following were selected as priority areas to emphasize within the 2022 Integrated Planning goals and objectives: 1) support for local and national EHE initiatives, 2) education and coordination, 3) access to care and medication, 4) quality of life issues and 5) policy issues.

Section V: Plan Goals and Objectives

The four pillars of the EHE were used to organize plan goals and objectives. The Houston/Harris County EHE goals are combined with the Integrated Plan goals for the 10-county area to demonstrate united purpose. Goals from the Integrated Plan are italicized to indicate the differently funded geographic areas. Both plans are considered “living” documents, and it is anticipated that more activities, strategies, and indicators will be added to each pillar as EHE and integrated planning implementation continues.

Since 2021, consumer representatives on the two Houston area planning bodies and others have been working to highlight quality of life issues for those living with HIV. Issues related to quality of life include stigma, housing, mental health, aging and other needs related to living and thriving with HIV. Quality of life issues have recently gained national significance, with inclusion in several comprehensive plans including the *2022 NHAS*. Additionally, the 2020 NA indicates the importance of quality of life issues. Of services that are needed and not funded by Ryan White, the top four include housing and food bank, since quality of life issues cannot be addressed through medical interventions alone.

Quality of life issues were addressed in stakeholder interviews and focus groups, when priority populations discussed how different services, including housing, mental health and substance use

treatment, influences their ability to access and be retained in care. To further quality of life efforts, a Greater Houston Area HIV Data Committee has been organized to identify and inventory all HIV data available in the 10-county area. The goal is to create tools to measure and address quality of life issues and to integrate the results of the tools into all Houston planning processes, share the tools with other communities, and encourage CDC and HRSA to add a fifth pillar that uses a variety of such tools to address quality of life concerns.

Education was identified as a pressing issue in the 2020 NA, where education and awareness issues were found to be the number one barrier to care. Further, according to the HHD 2022 HIV Prevention Needs Assessment, health education/risk reduction (HE/RR) is the number two reported need for people not living with HIV. From priority population focus groups, provider focus groups, community meetings, and stakeholder interviews, clearly priority populations and others lack knowledge about HIV prevention and care options. These findings led to the goal of creating a Houston Area HIV Education Council. Educational trainings will be divided into two categories: education for potential and existing service recipients and education for providers, with committees dedicated to meeting the needs of different priority populations.

For example, one committee will focus on the educational and service needs of adolescents while another committee will focus on the needs of individuals who were not born in the United States. Some of the education committees will interface with already established, longstanding groups such as the prevention task forces under CPG. All committees will report monthly to the Education Leadership Team, who will report to the CPG and RWPC.

Certain special populations indicate a high need for basic HIV education. For example, focus groups conducted with 43 college students found that they lack a basic understanding of HIV transmission. This led to designating college students as one of the populations of interest. College students will have a committee made up of students from different local universities along with professional educators who will work together to tailor a curriculum to increase knowledge of HIV and how to access local HIV prevention and care services, including mental health and substance use disorder services that are available on campus and off.

From focus groups with priority populations, it was determined that staff interactions with clients cause some to avoid service locations. This finding is supported by the 2020 NA, which indicates that interactions with staff is the number two barrier to care. Thus, a goal of the HIV Education Council will be to partner with the Houston AIDS Education and Training Center (AETC) to facilitate professional customer service trainings and yearly HIV service updates for staff, particularly front desk and eligibility personnel. Providers will also receive education on how to refer a client for services, as many respondents indicated they were unaware of how to navigate the jurisdiction's HIV prevention and care system.

Information from focus groups, stakeholders, community meetings, needs assessments, the crosswalk of comprehensive plans, and other data sources indicate that access to care remains a pressing issue. For example, the 2020 NA found that of 17 funded core and non-core services, primary medical care is the most needed Ryan White funded service in the jurisdiction. Although 50% of all individuals living with HIV in the 10-county area rely upon Ryan White funded services for care, there continue to be barriers that prevent some from accessing medical care, the most

common being education and awareness issues. Concerning education and awareness barriers, knowledge of the availability of the service and where to access the service accounted for 81% of barriers reported. And due to special limitations placed upon individuals with a history of a sexual offense, one goal of the 2022 Integrated Plan is to create a case manager position to help this particular population access HIV education, prevention, and care services. This goal is supported by stakeholders who state that this type of education is not being provided elsewhere.

Through interactions with stakeholders, it became clear that there are several pressing policy issues in the jurisdiction that require a deeper understanding. These issues include access to comprehensive harm reduction services, the distribution of condoms in jails and prisons, and efforts to transition Texas into a Medicaid expansion state. Interviews with substance use disorder stakeholders and with people who use drugs demonstrate the importance of comprehensive harm reduction to preventing the spread of HIV among people who use drugs. Stakeholder and consumer input revealed strong support for condom distribution in jails and prisons. But the focus group with members of the Serving the Incarcerated and Recently Released Partnership of Greater Houston (SIRR) emphasized that since it is against Texas State law to have sexual contact in jail or prison, condom distribution by staff is not legally permissible. And, the law against sex in prison is intended to prevent sexual assault. This supports the need for more complete education among stakeholders including elected and appointed officials. Additionally, many consumers, providers and stakeholders have worked for years to make Texas a Medicaid expansion state. It is important to understand how the HIV community can have a role in thoughtfully and effectively supporting this effort.

Section VI: Implementation, Monitoring and Jurisdictional Follow Up

Community partners will work collaboratively with members of the CPG and RWPC, health department staff, local educators and others to implement the goals and objectives of the 2022 Integrated Plan. Activities to monitor, evaluate, and disseminate 2022 Integrated Plan/EHE Plan implementation progress, as well as collect iterative feedback from stakeholders, will be conducted as follows:

- HHD Bureau of Epidemiology staff will update the Houston EMA Care Continuum, and planning body support staff will continue to link it to the RWPC website.
- Planning body support staff will review goals and objectives and inform responsible parties of the status of their assigned tasks. (Beginning January 2023; bi-annually thereafter)
- Both the RWPC and CPG will receive progress updates on 2022 Integrated Plan/EHE Plan goals and objectives (Beginning August 2023; bi-annually thereafter)
- The 2022 Integrated Plan/EHE Plan Evaluation Workgroup will convene on a regular basis to review the status of goals and objectives, provide explanation of outcomes, identify areas of course correction, assess direction of stated goals and objectives, and report findings to the planning bodies (Beginning at the all-day RWPC Orientation in January 2024; annually thereafter)
- Planning body support staff will conduct a document review and archive reports produced by responsible parties containing information about stated objectives and efforts (Beginning at the all-day RWPC Orientation in January 2024; annually thereafter)
- Planning body support staff will compile an evaluation report following the annual Evaluation Workgroup review process and present the report to planning bodies (Beginning at the all-day RWPC Orientation in January 2024; annually thereafter)

- Planning body support staff will update the 2022 Integrated Plan/EHE Plan Dashboard detailing progress on stated goals and objectives, which will be featured on the RWPC website (Beginning February 2024; annually thereafter)

Section VII: Letters of Concurrence
See the attached letters of concurrence. The letters are signed by the Co-Chairs of the Houston HIV Prevention Community Planning Group and the Chair of the Houston EMA Ryan White Planning Council. The planning bodies played the dual role of being the planning bodies for prevention and care services and the planning bodies for the development of the 2022 EHE and 2022 Integrated Plans. See Section VII, page 85.

DOCUMENTS SUBMITTED TO MEET CDC AND HRSA REQUIREMENTS:

Please use the links provided in this Plan to locate the following supporting documents:

Section II: Community Engagement and Planning Process. See link to the following document:
2022 Houston Area HIV Data Packet provided members of the CPG and the RWPC, as well as all participants in committee and community education and planning sessions, with an efficient, easy way to reference all data used to prepare the 2022 Integrated Plan. Per the Table of Contents, the packet contains a Summary of Group Interviews with All Priority Populations; Summary of Group Interviews with Special Populations; Interviews with Individual Stakeholders by Category of Expertise; the HIV Prevention, Care and Treatment Resource Inventory, the Houston Area Planning Crosswalk 2022-2026, which includes related goals and objectives for national and local ~~plans~~ HIV and non-HIV comprehensive plans; the Epidemiological Snapshot and more.
2016 - 2021 Roadmap to Ending the Houston HIV Epidemic, Houston's first Ending the HIV Epidemic Plan, which was funded by a grant from AIDS United.
2022 Ending the HIV Epidemic in Houston/Harris County, the CDC funded Houston/Harris County Ending the HIV Epidemic Plan.

Section III: Contributing Data Sets and Assessments. See links to the following documents, many of which provide pre-COVID data due to the unreliability of data during the COVID pandemic:
FY 2021 Crosswalk of National, State and Local Comprehensive Plans was a tool developed for this Plan.
FY 2020 Summary of Service Categories is updated and used annually during the Ryan White *How to Best Meet the Need*, priority setting and allocations process to justify decisions. The first 2 pages provide data on epidemiological trends, unmet need in HIV care and national, state, and local priorities. Starting on page 3, each funded Ryan White service has a separate page of data that includes a 10-year history of allocations and client utilization, current outcomes, needs assessment data and national, state, and local priorities for the service.
2019 Houston Area HIV Epidemiological Profile and the 2021 Houston Area HIV Epidemiological Supplement. This document includes the Executive Summaries from the two epidemiological reports. Complete data is available by using the links to the full reports.

Section V: Goals and Objectives. See links to the following documents:
Houston Area HIV Resource Directory "The Blue Book". Provided free of charge to people with HIV, in English and Spanish. Available online and in hard copy.
Mini Blue Book for the Harris County Sherriff's Office. Pocket sized version of the Blue Book distributed by medical staff to inmates living with HIV, available in English and Spanish.

Treat Committee

Goal 1C: Establish a Houston Area HIV Education Council by reaching out to colleges, consumers, in-person educators, youth, and professional healthcare workers in partnership with AETCs, the RW program, CPG, and city and county health departments to increase consumer input and participation into science-based health education and Houston Area HIV linkage to prevention and care services.

Goal 2A: Ensure 90% of clients are retained in care and virally suppressed.

Goal 2A.1: Ensure rapid linkage to HIV medical care and rapid ART initiation for all persons with newly diagnosed or re-engaging in care.

Key Activities:

- Increase retention in medical care through rapid treatment initiation.
  - *In FY 2020, the Ryan White Program, in partnership with South Central AETC, Baylor College of Medicine, and Harris County Public Health, launched Rapid Start Treatment Programs at Ryan White funded primary care sites. The next step is to increase outreach to priority populations and launch Rapid Start Treatment Programs at sites other than RWHAP-funded primary care sites.*
- Offer a 24-hour emotional support and resources line available with trauma informed staff considerate to the fact individuals are likely still processing a new diagnosis.
- Health literacy campaign to educate those diagnosed on benefits of rapid start and TasP.
- Support rapid antiretroviral therapy by providing ART "starter packs" for newly diagnosed clients and returning patients who have self-identified as being out of care for greater than 12 months.
- Expand community partnerships (e.g., churches and universities) to increase rapid linkage and ART availability at community-preferred gathering venues.
- Promote after-hour medical care to increase accessibility by partnering with providers currently offering expanded hours, like urgent care facilities.

- Develop a provider outreach program focused on best HIV treatment - related practices and emphasizing resources options for clients (Ryan White care system) as well as peer-to-peer support resources for providers (e.g., Project ECHO, AETC, UCSF).

Goal 2A.2: Support re-engagement and retention in HIV medical care, treatment, and viral suppression through improved treatment related practices, increased collaboration, greater service accessibility, and a whole-health emphasis.

Key Activities:

- Develop informative treatment navigation, viral suppression, and whole-health care program including regularly held community forums designed to maximize accessibility.
  - Partner with providers to expand hours and service location options based on community preferences (after-hours, mobile units, non-traditional settings).
  - Assess feasibility of expanded telehealth check-in options to enhance accessibility and promote bundling mobile care services (including ancillary services).
  - Increase the number of referrals and linkage to RW.
  - Increase integration, promotion, and the number of referrals to ancillary services (e.g., mental health, substance use, RW, and payment assistance) through expanded partnerships during service linkage.
  - Increase case management support capacity.
  - Develop system to monitor referrals to integrated health services.
  - Hire representative navigators, promote job openings in places where community members with relevant lived experience gather, and invest in programs such as the Community Health Worker Certification.
  - Survey users of services to evaluate additional service-based training needs.
- Conduct provider outreach (100 initial/100 follow-up visits) to improve multidisciplinary holistic health practices including importance of trauma-informed approach, motivational interview-based techniques, preferred language, culturally sensitive staff/setting, behavior-based risk vs demographic/race, and routine risk assessment screenings (mental health, gender-based or domestic violence, need for other ancillary services related to SDOH).
- Build and implement a mental health model for HIV treatment and care that includes routinizing screenings/opt-out integration into electronic health records.
- Source resources for referral/free initial mental health counseling sessions.
- Maintain at least one crisis intervention specialist on service link linkage staff.

- Partner community health workers with local community gathering places (e.g., churches) to recognize and reach individuals who may benefit from support and linkage to resources.
- Widely share analyses of collected data with emphasis on complete context and value to community, including annual science symposium; Allow opportunities for community to share their stories to illustrate the personal connection.
- Utilize a reporting system to endorse programs or environments that show training application and effort to end the epidemic. Conduct quarterly quality assurance checks after the secret shopper project established by END.
- Use the HIV system to fill gaps in healthcare by creating a grassroots initiative focused on social determinants of health.
- Increase access to quality health care through promoting FQHCs to reduce the number of uninsured to under 10% in the next 10 years.
- Revamp data-to-care to achieve full functionality

Goal 2A.3: Establish organized methods to raise widespread awareness on the importance of treatment.

Key Activities:

- Collaborate with CPG to gain real-time public input during meetings on preferred language and promotion of critical messages of Undetectable=Untransmittable (U=U) and Treatment as Prevention (TasP).
- Collaborate with CPG to regularly promote diversifying clinical trials.
- Increase education and awareness around the concept of U=U and TasP to reduce stigma, fear, and discrimination among PLWH.
- Implement community preferred social marketing strategies over multiple platforms to establish messaging on the benefits of rapid and sustained HIV treatment (include basic terminology, updates on treatment/progress advances, and consideration for generational understanding of information).

Goal 2A.4: Advance internal and external policies related to treatment.

Key Activities:

- Implement and monitor immediate ART with a standard of 72 hours of HIV diagnosis for Test and Treat protocols.
- Revise policies to simplify linkage through use of an encrypted universal technology such as patient portal and/or apps to easily share information across health systems, remove administrative (e.g., paperwork and registration) barriers, incorporate geo-fencing alerts and anonymous partner elicitation.
- Refresh policies to establish a retention/rewards program that empowers community to optimize health maintenance and encourages collaboration with health department services and resources.
- Focus on necessary requirements and reduce turnaround time from diagnosis to care (e.g., Change the 90-day window for Linkage Workers).

- Update prevention standards of care to reflect a person-centered approach.
- Develop standard of treatment and advocate for implementation for those incarcerated upon intake.
- Institute policies that require recurring trainings for staff/providers based on community feedback and focused on current preferred practices (emphasis on status-neutral approach, trauma-informed care, people first-language, cultural sensitivity, privacy/confidentiality, follow-up/follow-through).
- Revise funding processes and incentivize extended hours of operation to improve CBO workflow.

Goal 2B: ***Increase access to services that replace or provide identification documents so that lack of identification as a barrier will decrease regardless of immigration or legal status by working with identification providers including CBOs, NGOs, and government agencies.***

Goal 2C: ***Create a case manager job description and fund the position so that fewer people with a history of sexual offense will be lost to care by working with street outreach workers, harm reduction teams and others experienced working with people with a history of sexual offense by prioritizing this historically underserved population.***

Goal 2D: ***Gather information from RW-funded pharmacists, case managers, executive directors, and Coalition for the Homeless to create ease of access via phone provision for historically underserved communities and to mitigate challenges towards maintaining care. Have meetings to develop pros and cons and to synthesize information to develop a consensus decision by September 2024.***

Quality of Life and Social Determinants Committee

Goal 3B.3: Address social determinants through a multi-level approach that reduces new cases and sustains health equity.

Key Activities:

- Increase service provider knowledge and capability to assess those in need of ancillary services.
- Provide funded organizations with payment points for linking people to pre-exposure prophylaxis (PrEP), keeping appointments, and then linking people on PrEP to housing, transportation, food assistance, and other supportive services.
- Develop mental health and substance use campaigns to support self-efficacy/resiliency.
- Promote having health departments partner more with colleges and school districts, the Houston Health Department Bureau of Youth and Adolescent Health to create a tailored strategic plan that better engages adolescent Houstonians/ Harris Countians.
- Revitalize the Youth Task Force and seek funding for adolescent-focused initiatives.
- Engage healthcare programs regarding inclusion of all HIV prevention strategies in their curriculums to educate future practitioners (e.g., medical, nurse practitioner, nursing, and other healthcare programs).
- Reduce stigma and increase knowledge and awareness of PrEP and Treatment as Prevention (TasP) through a biannual inclusive public health campaign focused on all populations.
- Train the workforce on patient-centered (i.e., status-neutral and trauma informed) prevention approaches to build a quality care system.

Goal 5A: Improve quality of life for persons living with HIV by promoting unfettered access to high-quality, life-extending prevention and care services through the identification of the top three services people needed but couldn't access as well as the top three barriers. We will identify the number of people in need of service and who couldn't access it. This will decrease by focusing on the most needed and least accessible services and the populations benefiting least from these services by making services available, accessible and affordable for three years.

Goal 5B: **Increase the proportion of people with diagnosed HIV who report good or better health to 95% from a 2018 baseline of 71.5%.**

Activity: See Houston Medical Monitoring Project (HMMP).

Goal 5C: **Decrease by 50% the proportion of people with diagnosed HIV who report an unmet need for services from a mental health professional from a 2017 baseline of 24.2%.**

Activity: See Houston Medical Monitoring Project (HMMP).

Goal 5D: **Decrease by 50% the proportion of people with diagnosed HIV who report ever being hungry and not eating because there wasn't enough money for food from a 2017 baseline of 21.1%.**

Activity: See Houston Medical Monitoring Project (HMMP).

Goal 5E: **Decrease by 50% the proportion of people with diagnosed HIV who report being out of work from a 2017 baseline of 14.9%.**

Activity: See Houston Medical Monitoring Project (HMMP).

Goal 5F: **Decrease by 50% the proportion of people with diagnosed HIV who report being unstably housed or homeless from a 2018 baseline of 21.0%.**

Activity: See Houston Medical Monitoring Project (HMMP).

Goal 5G: **For 3 years, continue to host quarterly meetings of the Houston Area HIV Data Committee in order to (1) learn about the different data being collected; (2) create and maintain an inventory of HIV data being collected; and (3) distribute the resulting inventory of data to Houston area researchers, students, people living with HIV and others to maximize the use of these data to benefit people living with HIV.**

HIV and Aging Workgroup

Key Activities:

- *Continue to host Quality of Life workgroup meetings that started in Houston on 03/21/22 and were co-hosted by Community Planning Group (CPG) and the Ryan White Planning Council.*

Housing Workgroup

Key Activities:

- *To be determined.*

Racial and Social Justice Workgroup

Key Activities:

- *Continue to host Racial and Social Justice Workgroup meetings that started in Houston on 04/15/21 and were co-hosted by Community Planning Group (CPG) and the Ryan White Planning Council.*

Quality of Life VISION for PLHIV

All people living with HIV will have unfettered and 'hassle-free,' access to a full range of life-extending high quality culturally sensitive, gender affirming care and social support free from all stigma and discrimination that prioritizes our mental, emotional, and spiritual health as well as our financial wellbeing. People living with HIV are "people first" and our quality of life is not defined by our race, gender identity, sexual orientation, HIV status or measured solely by viral suppression.

Quality of Life THEMES

1. Intersectional stigma, discrimination, racial and social justice, human rights and dignity
2. Overall wellbeing, mental, emotional and spiritual health
3. Aging, comorbidities and life span (can include functionality, cognitive ability, geriatrics)
4. Healthcare services access, care and support
5. Economic justice, employment, stable and safe housing, food security
6. Policy and research

Quality of Life DEFINITION

We demand a quality of life that achieves the following:

1. Ensures that all people living with HIV thrive and live long healthy dignified lives.
2. Recognizes that HIV is a racial and social justice issue and works to dismantle the structural barriers that marginalize and diminish our quality of life.
3. Uplifts our humanity and dignity as human beings; we are people living with HIV and not a public health threat.
4. Values our emotional labor and personal stories as worthy of compensation and meaningfully involves people living with HIV as subject matter experts in all decisions that impact our lives as paid staff and consultants and not just as volunteers.
5. Recognizes that because we have a large number of people aging with HIV that include those born with HIV, long term survivors and people over the age of 50, we need for accessible services, support and care to ensure that we age with dignity
6. Understands that safe and stable housing, healthcare and financial security are basic human rights. We should not have to live in poverty to be eligible for services.
7. Recognizes that we are human beings entitled to live full rich pleasurable sexually active lives without fear of prosecution and understands the importance of social support networks to our overall well being.
8. Embraces our rich diversity in race, age, gender identity or expression, language, sexual orientation, income, ethnicity, country of origin or where we live and tells the full story of our resilience and not just our diagnosis.

THEME #1: Intersectional stigma, discrimination, racial and social justice, human rights and dignity

Strategy	Actions/Activities	Responsible Party	Year 1, 2, 3, 4 or 5
Reduce the impact of intersectional stigma for PLHIV and communities vulnerable to HIV	Implement new research tool developed by the Global Network of PLHIV called stigma index		
Ensure that all funding, policies, programs and decisions use an intersectional racial/social justice lens approach	Develop & apply racial/social justice lens to all decision making		
Implement/Operationalize MIPA throughout all service delivery	Integrate MIPA into RW planning councils		

THEME #2: Overall well-being, mental, emotional and spiritual health

Strategy	Actions/Activities	Responsible Party	Year 1, 2, 3, 4 or 5
Focus on “people first” rather than just treating HIV	Re-evaluate rapid start and other programs to ensure that services are person centered		
Eliminate use of stigmatizing language by organizations, services and throughout the workforce	Include people first language training requirement in all contracts and pay PLHIV to deliver trainings		
Increase the availability of social support services	Require all Part A providers to provide support groups led by PLHIV Develop at least 3 support groups by December 2023 for high priority populations Develop list of peer/PLHIV willing to lead support groups and be compensated		

THEME #3: Aging, comorbidities and life span (can include functionality, cognitive ability, geriatrics)

Strategy	Actions/Activities	Responsible Party	Year 1, 2, 3, 4 or 5
Reduce mortality rates for PLHIV	Develop data that more adequately reflects mortality and comorbidities of PLHIV		
Address aging needs of PLHIV	Develop aging related services for PLHIV at all health care providers Ensure that all demographics are represented in research Create a research CAB focused on aging issues Develop needs assessment to gather data to address the special needs of verticals		

NATIONAL HIV/AIDS STRATEGY

for the **United States**
2022–2025

THE WHITE HOUSE
WASHINGTON

Acknowledgments: The National HIV/AIDS Strategy (NHAS or Strategy) was developed by the White House Office of National AIDS Policy (ONAP) in collaboration with federal partners and with input from the HIV community across the country. Interested parties and organizations throughout the federal government and those engaged in work in many different communities have helped shape the goals, objectives, and strategies in the Strategy. ONAP extends the gratitude and appreciation of the White House to everyone who made thoughtful recommendations and recommitted to the Strategy's vision and goals. ONAP also offers thanks to the team at the Office of Infectious Disease and HIV/AIDS Policy in the U.S. Department of Health and Human Services for its many contributions to developing the Strategy.

Language used in the National HIV/AIDS Strategy: The Strategy honors the lived experiences and choices of all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance. To reflect this, authors made a concerted effort to use inclusive and person-first language throughout the strategy. Evidence-based, contemporary terminology is also used to convey respect and to reduce stigma faced by communities and populations disproportionately impacted by HIV. This approach is intended to reflect the administration's vision for a collective, inclusive, and respectful national response. Despite these efforts, in certain instances, for example to accurately convey scientific meaning, specific terminology or language may be unintentionally offensive or stigmatizing to some individuals or populations.

Additional information regarding the Strategy and associated activities may be accessed at the White House website.

Suggested citation: The White House. 2021. *National HIV/AIDS Strategy for the United States 2022–2025*. Washington, DC.

The National HIV/AIDS Strategy is not a budget document and does not imply approval for any specific action under Executive Order 12866 or the Paperwork Reduction Act. The Strategy will inform the Federal budget and regulatory development processes within the context of the goals articulated in the President's Budget. All activities included in the Strategy are subject to budgetary constraints and other approvals, including the weighing of priorities and available resources by the Administration in formulating its annual budget and by Congress in legislating appropriations.

VISION

The United States will be a place where new HIV infections are prevented, every person knows their status, and every person with HIV has high-quality care and treatment, lives free from stigma and discrimination, and can achieve their full potential for health and well-being across the lifespan.

This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.

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Download the full National HIV/AIDS Strategy 2022–2025 here:
https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf

EXECUTIVE SUMMARY

Building on lessons learned and progress made in the past 40 years, the United States now has the opportunity to end the HIV epidemic. This opportunity has been made possible by tireless advocacy, determined research, and dedicated delivery of diagnostic, prevention, care, treatment, and supportive services.

The nation's annual new HIV infections have declined from their peak in the mid-1980s, and people with HIV in care and treatment are living longer, healthier lives. In 2019, the estimated number of new HIV infections was 34,800 and 1.2 million people were living with HIV in the United States. However, not all groups have experienced decreases in HIV infections or improvements in health outcomes. Centers for Disease Control and Prevention data show that new HIV infections fell 8% from 2015 to 2019, after a period of general stability in new infections in the United States. This trend represents a hopeful sign of progress. But gains remain uneven, illuminating opportunities for geographic- and population-focused efforts to make more effective use of the powerful HIV prevention, care, and treatment tools now available.

This National HIV/AIDS Strategy (the Strategy), the nation's third national HIV strategy, updates the HIV National Strategic Plan (2021). The Strategy sets forth bold targets for ending the HIV epidemic in the United States by 2030, including a 75% reduction in new HIV infections by 2025 and a 90% reduction by 2030. For interested parties and organizations across the nation, the Strategy articulates goals, objectives, and strategies to prevent new infections, treat people with HIV to improve health outcomes, reduce HIV-related disparities, and better integrate and coordinate the efforts of all partners to achieve the bold targets for ending the epidemic. The Strategy also establishes evidence-based indicators to measure progress, with quantitative targets for each indicator, and designates priority populations.

The Strategy establishes the following vision:

The United States will be a place where new HIV infections are prevented, every person knows their status, and every person with HIV has high-quality care and treatment, lives free from stigma and discrimination, and can achieve their full potential for health and well-being across the lifespan.

This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.

The vision, goals, objectives, and other components of the Strategy were developed and approved by a dedicated Steering Committee, composed of subject matter experts from across the federal government, with input from numerous and varied interested parties and organizations in the field. The Strategy is designed to be accessible to and useful for a broad audience, including people working in public health, health care, government, community-based organizations, research, private industry, and academia. It serves as a roadmap for all sectors of society to guide development of policies, services, programs, initiatives, and other actions to achieve the nation's goal of ending the HIV epidemic by 2030.

The Strategy is designed to facilitate a whole-of-society national response to the HIV epidemic in the United States that accelerates efforts to end the HIV epidemic in the United States by 2030 while supporting people with HIV and reducing HIV-associated morbidity and mortality. While not every objective or strategy will speak to or be actionable by all readers, the intent is that individuals and organizations from all sectors of society can find opportunities

where they can support necessary scale-up, expansion, and refinement efforts. All communities, regardless of HIV prevalence, are vital to ending the HIV epidemic in this country and private- and public-sector partners must work together with community-based, faith-focused, and advocacy organizations; governmental public health; mental health and substance use disorder treatment services; the criminal justice system; and providers of housing, food and nutrition, education, and employment services because we all have a role in reducing new HIV infections, improving outcomes and quality of life for people with HIV, and eliminating HIV disparities.

Interwoven throughout the Strategy are approaches to address the individual, community, and structural factors and inequities that contribute to the spread of HIV, such as stigma and social determinants of health. The Strategy highlights opportunities to integrate HIV prevention, care, and treatment into prevention and treatment for sexually transmitted infections, viral hepatitis, mental health and substance use disorders, and other public health efforts by leveraging capacity and infrastructure across the domains and breaking down operational and funding silos. A recurring theme is the need to bring to scale innovative solutions and data-driven approaches to address the ongoing and emerging challenges to HIV prevention, care, and treatment, including expanding the types of community and clinical sites that address HIV to help reach and engage people in need of services; supporting retention in HIV prevention and care services; continuing research into development of better prevention tools, therapeutics, and vaccines; and understanding how to make best use of available tools in real-world settings. Throughout this document, the term "care" is used as an umbrella term meant to encompass holistic services including treatment and supportive services.

To ensure implementation and accountability, a Federal Implementation Plan that documents the specific actions that federal partners will take to achieve the Strategy's goals and objectives will be developed in early 2022. Progress toward meeting the Strategy's goals will be monitored and reported annually.

The Strategy and the *Ending the HIV Epidemic in the U.S.* (EHE) initiative are closely aligned and complementary, with EHE serving as a leading component of the work by the U.S. Department of Health and Human Services (HHS), in collaboration with local, state, tribal, federal, and community partners, to achieve the Strategy's goals. The EHE initiative focuses on scaling up four strategies in the communities most affected by HIV. The Strategy covers the entire country, has a broader focus across federal departments and agencies beyond HHS and all sectors of society, and addresses the integration of several key components that are vital to our collective work, including stigma, discrimination, and social determinants of health.

NHAS AT-A-GLANCE

This At-A-Glance section briefly summarizes the Goals, Objectives, and Strategies that are discussed in detail in the narrative that follows.

Goal 1: Prevent New HIV Infections

1.1 Increase awareness of HIV

1.1.1 Develop and implement campaigns, interventions, and resources to provide education about comprehensive sexual health; HIV risks; options for prevention, testing, care, and treatment; and HIV-related stigma reduction.

1.1.2 Increase knowledge of HIV among people, communities, and the health workforce in geographic areas disproportionately affected.

1.1.3 Integrate HIV messaging into existing campaigns and other activities pertaining to other parts of the syndemic, such as STIs, viral hepatitis, and substance use and mental health disorders, as well as in primary care and general wellness, and as part of annual reproductive health visits and wellness visits.

1.2 Increase knowledge of HIV status

1.2.1 Test all people for HIV according to the most current USPSTF recommendations and CDC guidelines.

1.2.2 Develop new and expand implementation of effective, evidence-based, or evidence-informed models for HIV testing that improve convenience and access.

1.2.3 Incorporate a status-neutral approach to HIV testing, offering linkage to prevention services for people who test negative and immediate linkage to HIV care and treatment for those who test positive.

1.2.4 Provide partner services to people diagnosed with HIV or other STIs and their sexual and/or syringe-sharing partners.

1.3 Expand and improve implementation of safe, effective prevention interventions, including treatment as prevention, PrEP, PEP, and SSPs, and develop new options

1.3.1 Engage people who experience risk for HIV in traditional public health and health care delivery systems, as well as in nontraditional community settings.

1.3.2 Scale up treatment as prevention (i.e., U=U) by diagnosing all people with HIV, as early as possible, and engaging them in care and treatment to achieve and maintain viral suppression.

1.3.3 Make HIV prevention services, including condoms, PrEP, PEP, and SSPs, easier to access and support continued use.

1.3.4 Implement culturally competent and linguistically appropriate models and other innovative approaches for delivering HIV prevention services.

1.3.5 Support research into the development and evaluation of new HIV prevention modalities and interventions for preventing HIV transmissions in priority populations.

1.3.6 Expand implementation research to successfully adapt evidence-based interventions to local environments to maximize potential for uptake and sustainability.

1.4 Increase the diversity and capacity of health care delivery systems, community health, public health, and the health workforce to prevent and diagnose HIV

1.4.1 Provide resources, incentives, training, and technical assistance to expand workforce and systems capacity to provide or link clients to culturally competent, linguistically appropriate, and accessible HIV testing, prevention, and supportive services especially in areas with shortages that are geographic, population, or facility based.

1.4.2 Increase the diversity of the workforce of providers who deliver HIV prevention, testing, and supportive services.

1.4.3 Increase the inclusion of paraprofessionals on prevention teams by advancing training, certification, supervision, financing, and team-based care service delivery.

1.4.4 Include comprehensive sexual health and substance use prevention and treatment information in curricula of medical and other health workforce education and training programs.

Goal 2: Improve HIV-Related Health Outcomes of People with HIV

2.1 Link people to care immediately after diagnosis and provide low-barrier access to HIV treatment

2.1.1 Provide same-day or rapid (within 7 days) start of antiretroviral therapy for persons who are able to take it; increase linkage to HIV health care within 30 days for all persons who test positive for HIV.

2.1.2 Increase the number of schools providing on-site sexual health services through school-based health centers and school nurses, and linkages to HIV testing and medical care through youth-friendly providers in the community.

2.2 Identify, engage, or reengage people with HIV who are not in care or not virally suppressed

2.2.1 Expand uptake of data-to-care models using data sharing agreements, integration and use of surveillance, clinical services, pharmacy, and social/support services data to identify and engage people not in care or not virally suppressed.

2.2.2 Identify and address barriers for people who have never engaged in care or who have fallen out of care.

2.3 Increase retention in care and adherence to HIV treatment to achieve and maintain long-term viral suppression and provide integrative HIV services for HIV-associated comorbidities, coinfections, and complications, including STIs

2.3.1 Support the transition of health care systems, organizations, and patients/clients to become more health literate in the provision of HIV prevention, care, and treatment services.

2.3.2 Develop and implement effective, evidence-based, or evidence-informed interventions and supportive services that improve retention in care.

2.3.3 Expand implementation research to successfully adapt effective evidence-based interventions, such as HIV telehealth, patient and peer navigators, accessible pharmacy services, community health workers, and others, to local environments to facilitate uptake and retention to priority populations.

2.3.4 Support ongoing clinical, behavioral, and other research to support retention in care, medication adherence, and durable viral suppression.

2.4 Increase the capacity of the public health, health care delivery systems, and health care workforce to effectively identify, diagnose, and provide holistic care and treatment for people with HIV

2.4.1 Provide resources, value-based and other incentives, training, and technical assistance to expand workforce and systems capacity to provide or link clients to culturally competent and linguistically appropriate care, treatment, and supportive services especially in areas with shortages that are geographic, population, or facility based.

2.4.2 Increase the diversity of the workforce of providers who deliver HIV care and supportive services.

2.4.3 Increase inclusion of paraprofessionals on teams by advancing training, certification, supervision, reimbursement, and team functioning to assist with screening/management of HIV, STIs, viral hepatitis, and mental and substance use disorders and other behavioral health conditions.

2.5 Expand capacity to provide whole-person care to older adults with HIV and long-term survivors

2.5.1 Identify, implement, and evaluate models of care that meet the needs of people with HIV who are aging and ensure quality of care across services.

2.5.2 Identify and implement best practices related to addressing psychosocial and behavioral health needs of older people with HIV and long-term survivors including substance use treatment, mental health treatment, and programs designed to decrease social isolation.

2.5.3 Increase HIV awareness, capability, and collaboration of service providers to support older people with HIV, including in settings such as aging services, housing for older adults, substance use treatment, and disability and other medical services.

2.5.4 Promote research, cross-agency collaborations, and sharing of research discoveries that address specific aging-related conditions in people with HIV, and other comorbidities and coinfections that can impact people with HIV of all ages.

2.5.5 Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing people living with HIV at various life stages to support healthy aging with HIV.

2.6 Advance the development of next-generation HIV therapies and accelerate research for HIV cure

2.6.1 Promote research and encourage public-private partnerships to accelerate new therapies to achieve sustained viral suppression and to address drug toxicity, viral resistance, adherence, and retention in care and stigma associated with ART use.

2.6.2 Increase investment in innovative basic and clinical research to inform and accelerate a research agenda to discover how to sustain viral suppression, achieve ART-free remission, reduce and eliminate viral reservoirs, and achieve HIV cure.

Goal 3: Reduce HIV-Related Disparities and Health Inequities

3.1 Reduce HIV-related stigma and discrimination

3.1.1 Strengthen enforcement of civil rights laws (including language access services and disability rights), promote reform of state HIV criminalization laws, and assist states in protecting people with HIV from violence, retaliation, and discrimination associated with HIV status, homophobia, transphobia, xenophobia, racism, substance use, and sexism.

3.1.2 Ensure that health care professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or who experience risk for HIV, including LGBTQI+ people, immigrants, people who use drugs, and people involved in sex work.

3.1.3 Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes.

3.1.4 Ensure resources are focused on the communities and populations where the need is greatest, especially Black, Latino, and American Indian/Alaska Native and other people of color, particularly those who are also gay and bisexual men, transgender people, people who use substances, sex workers, and immigrants.

3.1.5 Create funding opportunities that specifically address social and structural drivers of health as they relate to Black, Latino, and American Indian/Alaska Native and other people of color.

3.2 Reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum

3.2.1 Increase awareness of HIV-related disparities through data collection, analysis, and dissemination of findings.

3.2.2 Develop new and scale up effective, evidence-based or evidence-informed interventions to improve health outcomes among priority populations and other populations or geographic areas experiencing disparities.

3.3 Engage, employ, and provide public leadership opportunities at all levels for people with or who experience risk for HIV

3.3.1 Create and promote public leadership opportunities for people with or who experience risk for HIV.

3.3.2 Work with communities to reframe HIV services and HIV-related messaging so that they do not stigmatize people or behaviors.

3.4 Address social and structural determinants of health and co-occurring conditions that impede access to HIV services and exacerbate HIV-related disparities

3.4.1 Develop whole-person systems of care and wellness that address co-occurring conditions for people with or who experience risk for HIV.

3.4.2 Adopt policies that reduce cost, payment, coverage, and/or access barriers to improve the delivery and receipt of services for people with or who experience risk for HIV.

3.4.3 Improve screening and linkage to services for people with or who experience risk for HIV who are diagnosed with and/or are receiving services for co-occurring conditions.

3.4.4 Develop and implement effective, evidence-based and evidence-informed interventions that address social and structural determinants of health among people with or who experience risk for HIV including lack of continuous health care coverage, HIV-related stigma and discrimination in public health and health care systems, medical mistrust, inadequate housing and transportation, food insecurity, unemployment, low health literacy, and involvement with the justice system.

3.4.5 Increase the number of schools that have implemented LGBTQ-supportive policies and practices, including (1) having a Gay/Straight Alliance (GSA), Gender Sexuality Alliance, or similar clubs, (2) identifying safe spaces, (3) adopting policies expressly prohibiting discrimination and harassment based on sexual orientation or gender identity, (4) encouraging staff to attend professional development, (5) facilitating access to out-of-school health service providers, (6) facilitating access to out-of-school social and psychological service providers, and (7) providing LGBTQ-relevant curricula or supplementary materials.

3.4.6 Develop new and scale up effective, evidence-based or evidence-informed interventions that address intersecting factors of HIV, homelessness or housing instability, mental health and violence, substance use, and gender especially among cis- and transgender women and gay and bisexual men.

3.5 Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including health care workers, researchers, and community partners, particularly from underrepresented populations

3.5.1 Promote the expansion of existing programs and initiatives designed to increase the numbers of non-White research and health professionals.

3.5.2 Increase support for the implementation of mentoring programs for individuals from diverse cultural backgrounds to expand the pool of HIV research and health professionals.

3.5.3 Encourage the implementation of effective recruitment of community partners through community-based participatory research and social networking approaches.

3.6 Advance HIV-related communications to achieve improved messaging and uptake, as well as to address misinformation and health care mistrust

3.6.1 Develop and test strategies to promote accurate creation, dissemination, and uptake of information and to counter associated misinformation and disinformation.

3.6.2 Increase diversity and cultural competence in health communication research, training, and policy.

3.6.3 Expand community engagement in health communication initiatives and research.

3.6.4 Include critical analysis and health communication skills in HIV programs to provide participants with the tools to seek and identify accurate health information and to advocate for themselves and their communities.

3.6.5 Expand effective communication strategies between providers and consumers to build trust, optimize collaborative decision-making, and promote success of evidence-based prevention and treatment strategies.

Goal 4: Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties

4.1 Integrate programs to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence

4.1.1 Integrate HIV awareness and services into outreach and services for issues that intersect with HIV such as intimate partner violence, homelessness or housing instability, STIs, viral hepatitis, and substance use and mental health disorders.

4.1.2 Implement a no-wrong-door approach to screening and linkage to services for HIV, STIs, viral hepatitis, and substance use and mental health disorders across programs.

4.1.3 Identify and address funding, policy, data, workforce capacity, and programmatic barriers to effectively address the syndemic.

4.1.4 Coordinate and align strategic planning efforts on HIV, STIs, viral hepatitis, substance use disorders, and mental health care across national, state, and local partners.

4.1.5 Enhance the ability of the HIV workforce to provide naloxone and educate people on the existence of fentanyl in the drug supply to prevent overdose and deaths and facilitate linkage to substance use disorder treatment and harm reduction programs.

4.2 Increase coordination among and sharing of best practices from HIV programs across all levels of government (federal, state, tribal, local, and territorial) and with public and private health care payers, faith-based and community-based organizations, the private sector, academic partners, and the community

4.2.1 Focus resources including evidence-based and evidence-informed interventions in the geographic areas and priority populations disproportionately affected by HIV.

4.2.2 Enhance collaboration among local, state, tribal, territorial, national, and federal partners and the community to address policy and structural barriers that contribute to persistent HIV-related disparities and implement policies that foster improved health outcomes.

4.2.3 Coordinate across partners to quickly detect and respond to HIV outbreaks.

4.2.4 Support collaborations between community-based organizations, public health organizations, education agencies and schools, housing providers, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services.

4.3 Enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care continua data and social determinants of health data

4.3.1 Promote the collection, electronic sharing, and use of HIV risk, prevention, and care and treatment data using interoperable data standards, including data from electronic health records, in accordance with applicable law.

4.3.2 Use interoperable health information technology, including application programming interfaces (APIs), clinical decision support tools, electronic health records and health IT products certified by the Office of the National Coordinator's Health IT Certification Program, and health information exchange networks, to improve HIV prevention efforts and care outcomes.

4.3.3 Encourage and support patient access to and use of their individual health information, including use of their patient-generated health information and use of consumer health technologies in a secure and privacy supportive manner.

4.4 Foster private-public-community partnerships to identify and scale up best practices and accelerate HIV advances

4.4.1 Adopt approaches that incentivize the scale up of effective interventions among academic centers, health departments, community-based organizations, allied health professionals, people with HIV and their advocates, the private sector, and other partners.

4.4.2 Expand opportunities and mechanisms for information sharing and peer technical assistance within and across jurisdictions to move effective interventions into practice more swiftly.

4.4.3 Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing persons of all ages living with HIV.

4.5 Improve mechanisms to measure, monitor, evaluate, and use the information to report progress and course correct as needed in order to achieve the Strategy's goals

4.5.1 Streamline and harmonize reporting and data systems to reduce burden and improve the timeliness, availability, and usefulness of data.

4.5.2 Monitor, review, evaluate, and regularly communicate progress on the National HIV/AIDS Strategy.

4.5.3 Ensure that the National HIV/AIDS Strategy's goals and priorities are included in cross-sector federal funding requirements.

4.5.4 Strengthen monitoring and accountability for adherence to requirements, targets, and goals by funded partners.

4.5.5 Identify and address barriers and challenges that hinder achievement of goals by funded partners and other interested parties.

INDICATORS AT-A-GLANCE

Indicator 1: Increase knowledge of status to 95% from a 2017 baseline of 85.8%.

Indicator 2: Reduce new HIV infections by 75% from a 2017 baseline of 37,000.

Indicator 3: Reduce new HIV diagnoses by 75% from a 2017 baseline of 38,351.

Indicator 4: Increase PrEP coverage to 50% from a 2017 baseline of 13.2%.

Indicator 5: Increase linkage to care within 1 month of diagnosis to 95% from a 2017 baseline of 77.8%.

Indicator 6: Increase viral suppression among people with diagnosed HIV to 95% from a 2017 baseline of 63.1%.

- **Indicator 6a:** Increase viral suppression among MSM diagnosed with HIV to 95% from a 2017 baseline of 66.1%.
- **Indicator 6b:** Increase viral suppression among Black MSM diagnosed with HIV to 95% from a 2017 baseline of 58.4%.
- **Indicator 6c:** Increase viral suppression among Latino MSM diagnosed with HIV to 95% from a 2017 baseline of 64.9%.
- **Indicator 6d:** Increase viral suppression among American Indian/Alaska Native MSM diagnosed with HIV to 95% from a 2017 baseline of 67.3%.
- **Indicator 6e:** Increase viral suppression among Black women diagnosed with HIV to 95% from a 2017 baseline of 59.3%.
- **Indicator 6f:** Increase viral suppression among transgender women in HIV medical care to 95% from a 2017 baseline of 80.5%.
- **Indicator 6g:** Increase viral suppression among people who inject drugs diagnosed with HIV to 95% from a 2017 baseline of 54.9%.
- **Indicator 6h:** Increase viral suppression among youth aged 13-24 diagnosed with HIV to 95% from a 2017 baseline of 57.1%.

Indicator 7: Decrease stigma among people with diagnosed HIV by 50% from a 2018 baseline median score of 31.2 on a 10-item questionnaire.

Indicator 8: Reduce homelessness among people with diagnosed HIV by 50% from a 2017 baseline of 9.1%.

Indicator 9: Increase the median percentage of secondary schools that implement at least 4 out of 7 LGBTQ-supportive policies and practices to 65% from a 2018 baseline of 59.8%.

In addition, quality of life for people with HIV was designated as the subject for a developmental indicator, meaning that data sources, measures, and targets will be identified and progress monitored thereafter.

Harris County
Public Health
Building a Healthy Community

Ryan White Part A
Quality Management Program- Houston EMA
2021 Client Satisfaction Survey and Focus Group Report
Ryan White Grant Administration

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Overview

At the center of the Ryan White Service delivery system are ongoing efforts to obtain input from clients in the design and delivery of services. To keep the core focus of services on the client experience, the Ryan White Grant Administration Quality Management team collects client feedback to continuously improve services and understand how to best meet the needs of the clients. This process is a piece of an overall system of evaluation which strives to provide the highest quality services for Individuals living with HIV/AIDS.

Quantitative data was collected through Centralized Patient Care Data Management System Database (CPCDMS) online client satisfaction survey.

For the survey, data was collected using standardized client satisfaction surveys for each service provided through Part A of the Ryan White Program. The survey tools were developed to gather information on both service-specific and agency-focused topics. Each Part A service category utilizes a unique survey tool, with certain agency-focused questions being common to all surveys. This methodology allows for analysis of satisfaction with care using a standardized approach which ensures consistent comparisons across provider agencies and service areas. This also allows for examination of general trends in satisfaction each year. The results for all services surveyed in 2021 are attached.

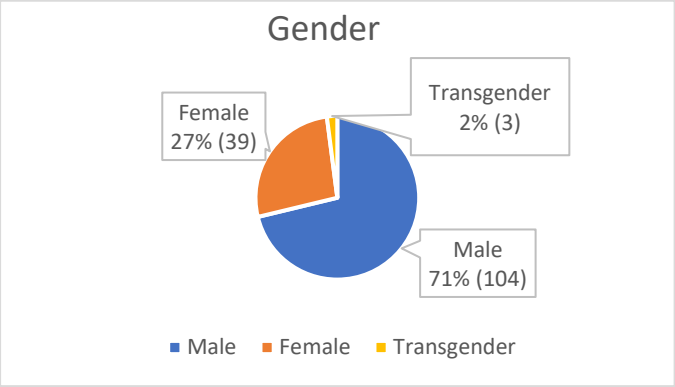
Ryan White Part-A funds an array of services allocated by the Ryan White Planning Council. The Services which were surveyed during the 2021 data collection period include outpatient/ambulatory care, case management, dental care, transportation, legal, local pharmacy assistance program, health insurance assistance, nutritional supplements, professional counseling, substance use disorder treatment, vision care, and rehabilitation. The service specific results presented in this report are limited to outpatient/ambulatory care and case management services as these are two of the most critical services provided to clients through Part A in the Houston EMA.

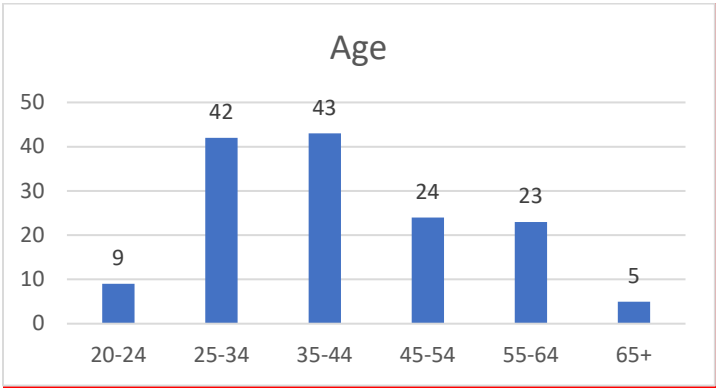
The Method

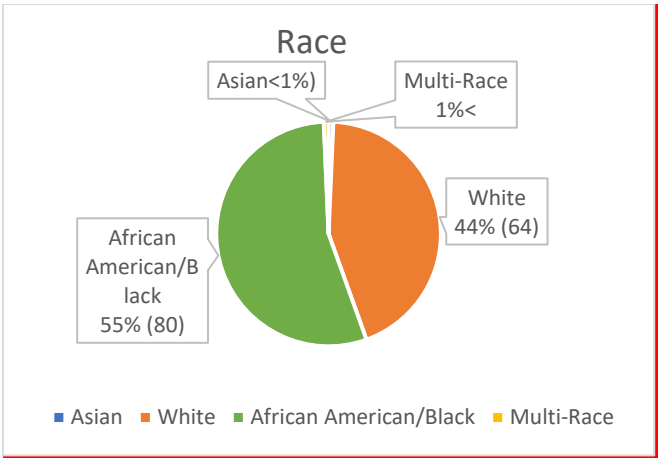
Ryan White Grant Administration in the Houston EMA conducted a web-based survey process through the CPCDMS to measure client satisfaction. Survey completion was conducted via two methods: 1) surveys were initiated by service providers reaching out to their client population to request participation; 2) Quality Management Development Project Coordinator was on-site at each agency to assist with survey collection and implementation of CPCDMS QR code. Instructions for access and completion of the survey was flexible for service providers so that they could best provide for their clients. The basics of needing to complete the survey were, 1) ensuring clients had the link, CPCDMS QR code, and instructions to complete the survey online 2) knowing their personal client access code needed to get the personalized survey questions 3) having internet or smartphone access to obtain the online survey. Case Managers generally know which of their clients have access to computers, internet, smartphones, or community resources. Agencies also had the option to provide a private location at their office with internet access where the client could complete the survey. During on-site visits, Quality Management Development Project Coordinator was provided a private space for clients needing additional assistance completing surveys.

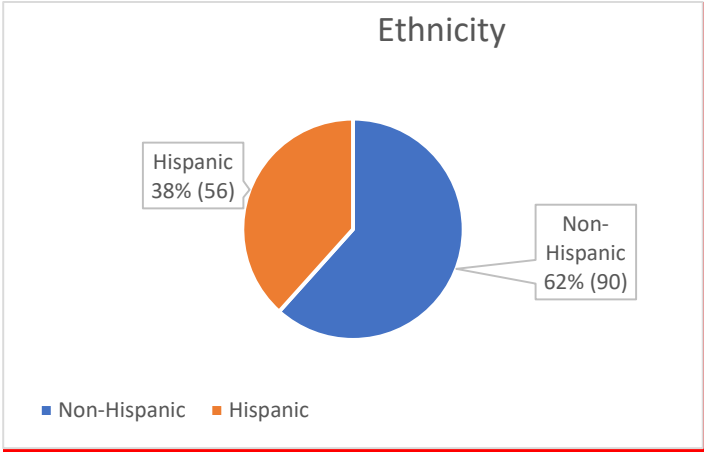
Survey Respondents Demographics

A convenience sample was used to obtain respondents. There was a total of 182 unduplicated clients that completed a survey. Data collection was February 1, 2022- February 28, 2022. Below is a cumulative summary of the respondents' demographic information:







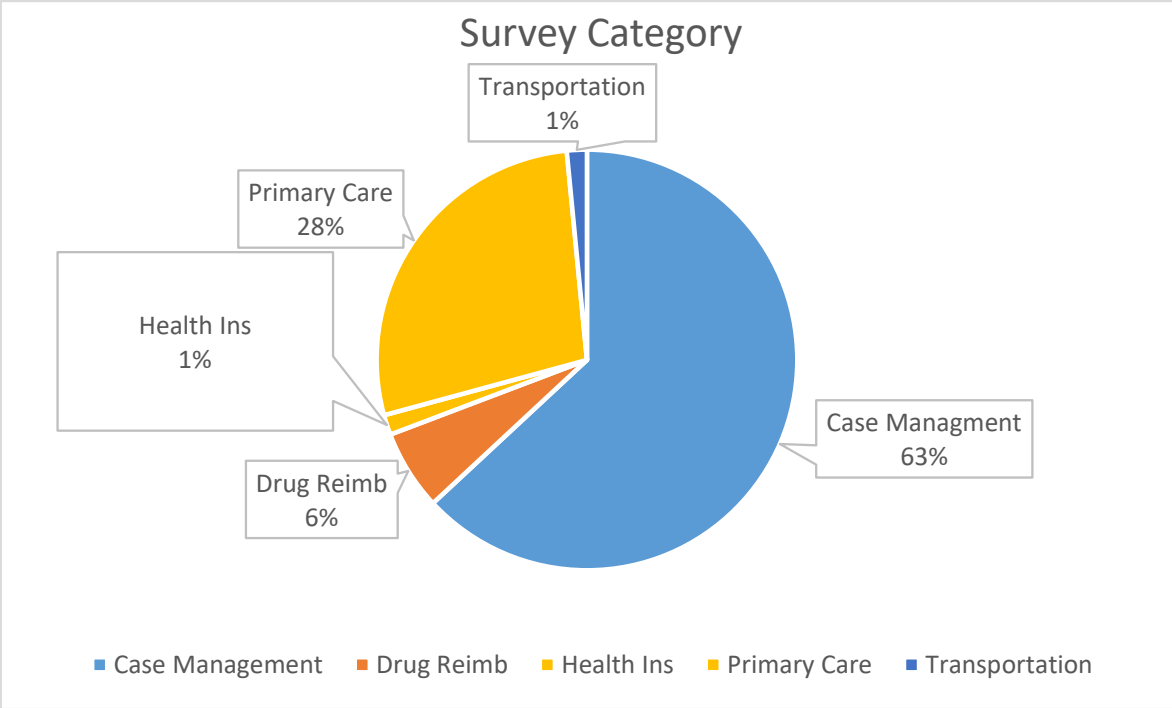


Cumulative Summaries

Service Areas Surveyed

Overall, Surveys were received for the following service areas:

- Drug Reimbursement Program
- Case Management
- Health Insurance Assistance
- Primary Care
- Transportation

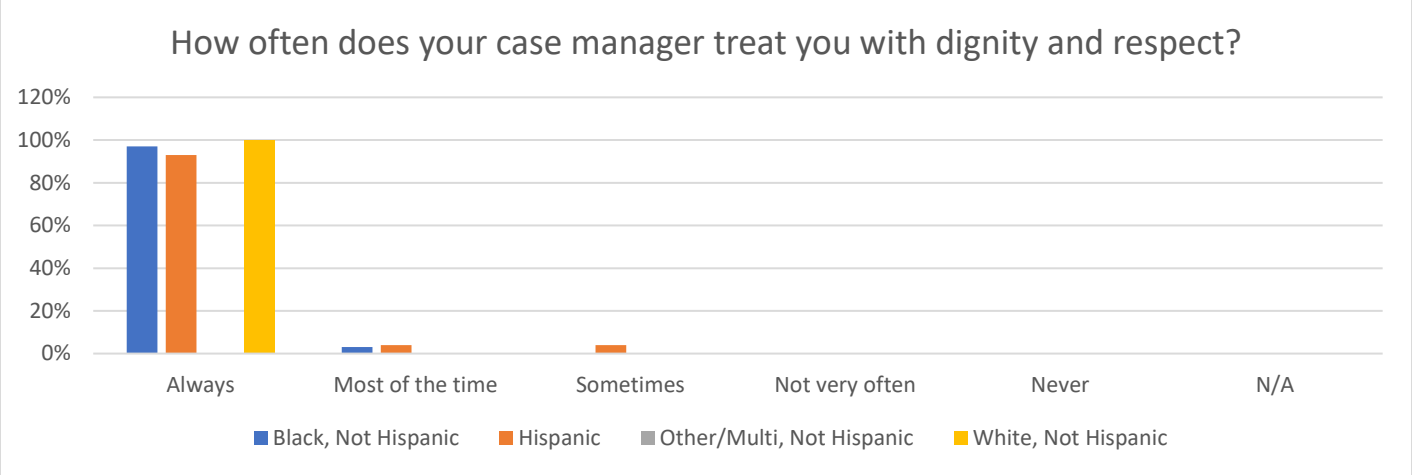


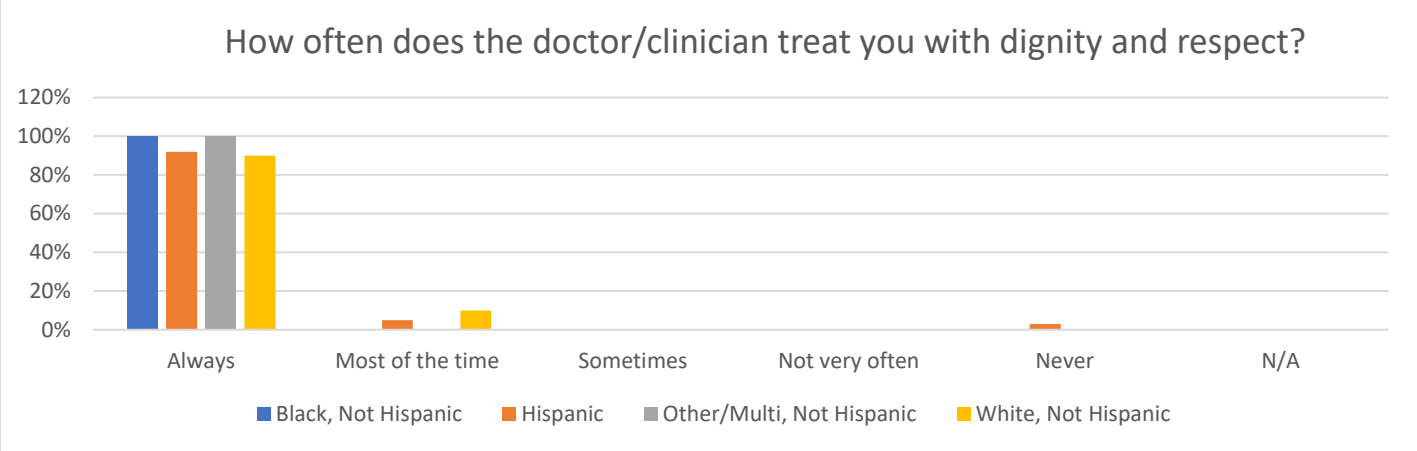
There was a total of 182 surveys taken. Several clients took more than one survey, but each survey was for a different service area. One-hundred forty-seven (147) of the total surveys were taken in English and thirty-five (35) were taken in Spanish.

Respondents were asked to rate their satisfaction with services on a scale of 1-6 with 1 being the best and 5 being the worst. 6 indicates “Not Applicable”.

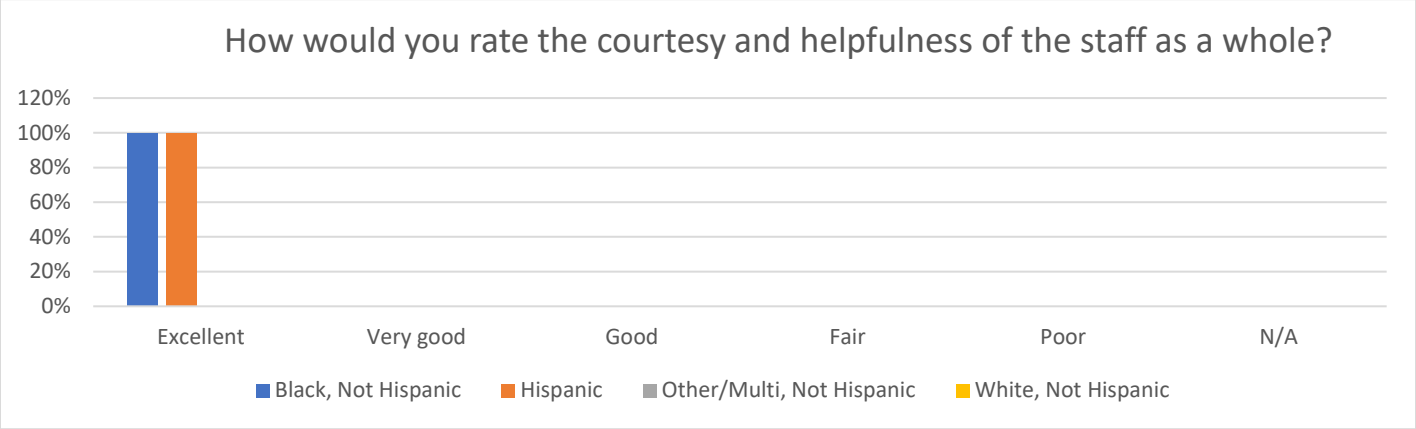
The graphs in the following sections show percentages broken out by race and ethnicity for all survey questions. They have been categorized into overall themes

Respect

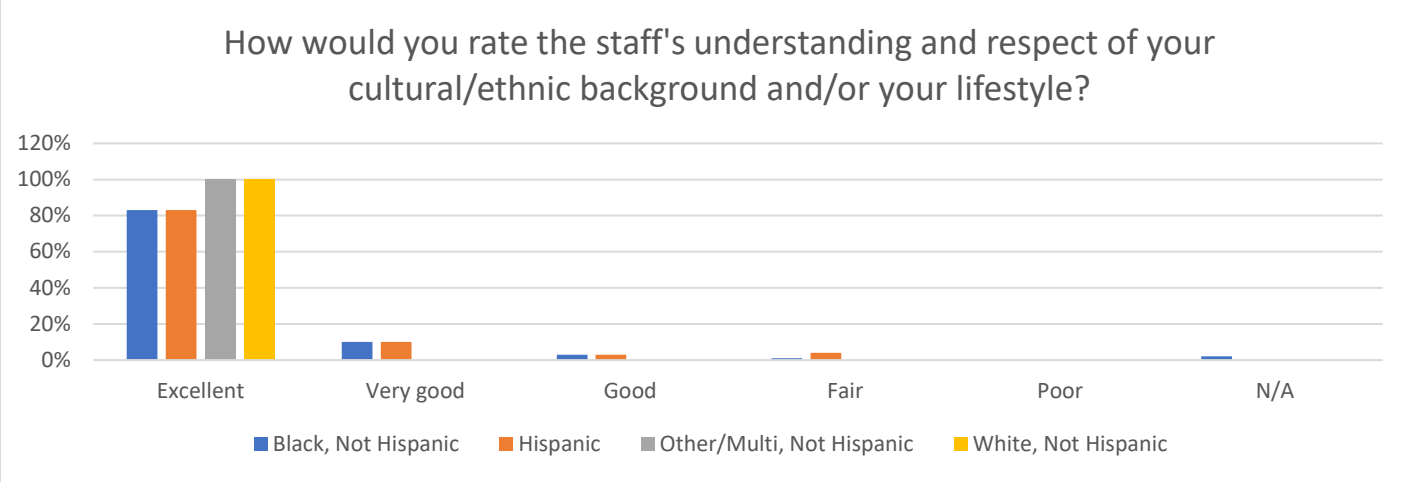

How often does your case manager treat you with dignity and respect?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

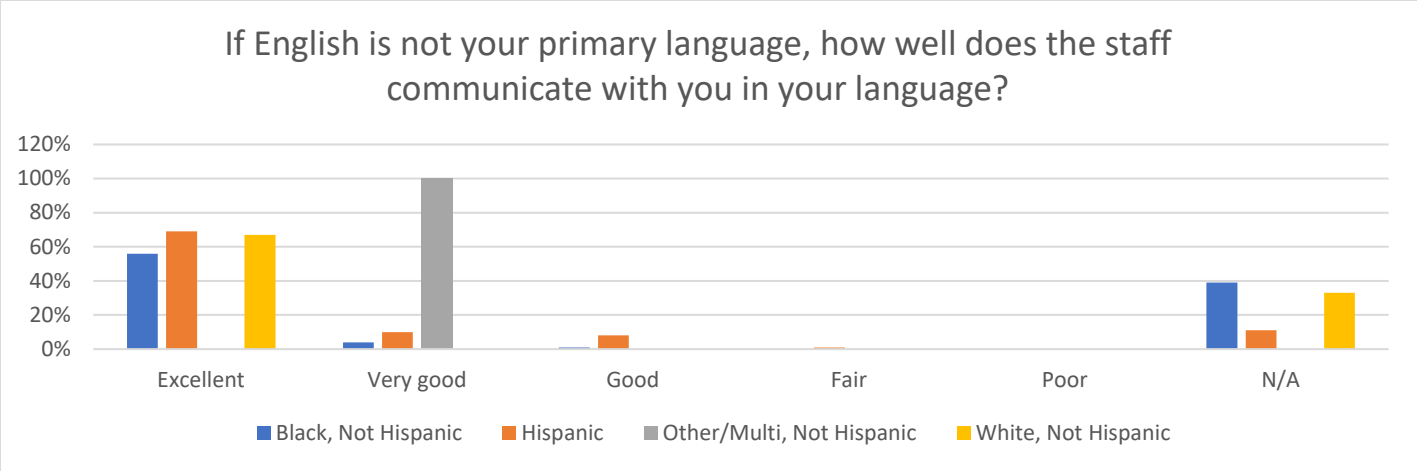

How often does the doctor/clinician treat you with dignity and respect?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

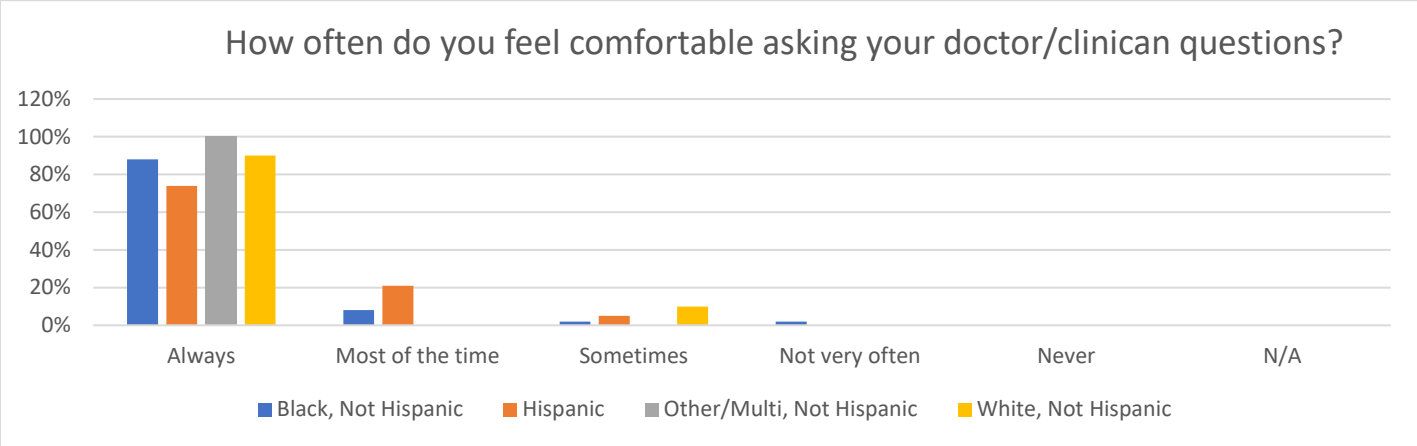

How often does pharmacy staff treat you with dignity and respect?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic



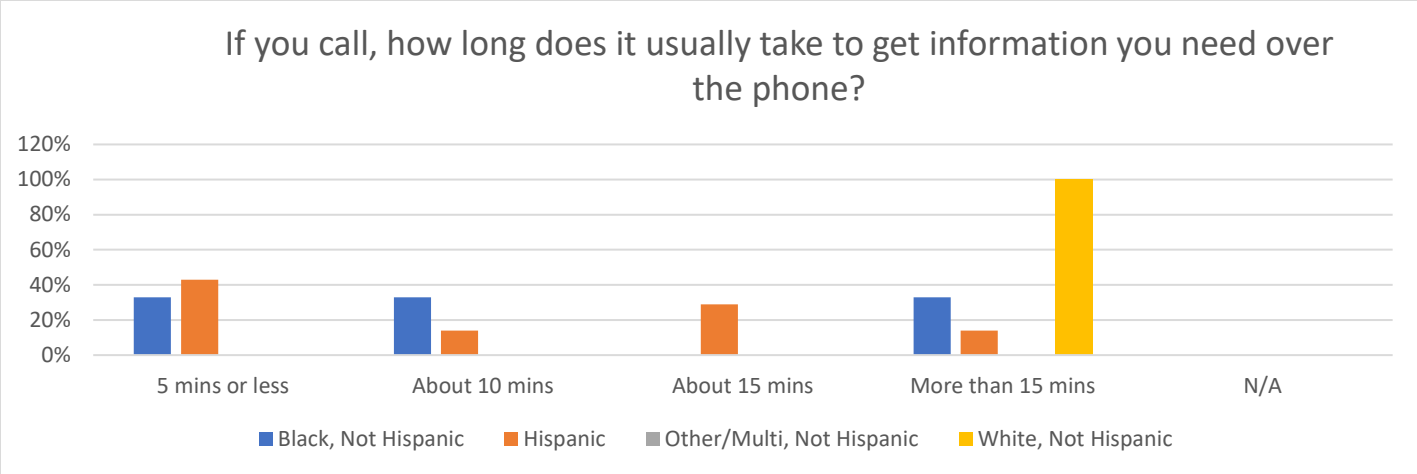
Culturally Responsive services

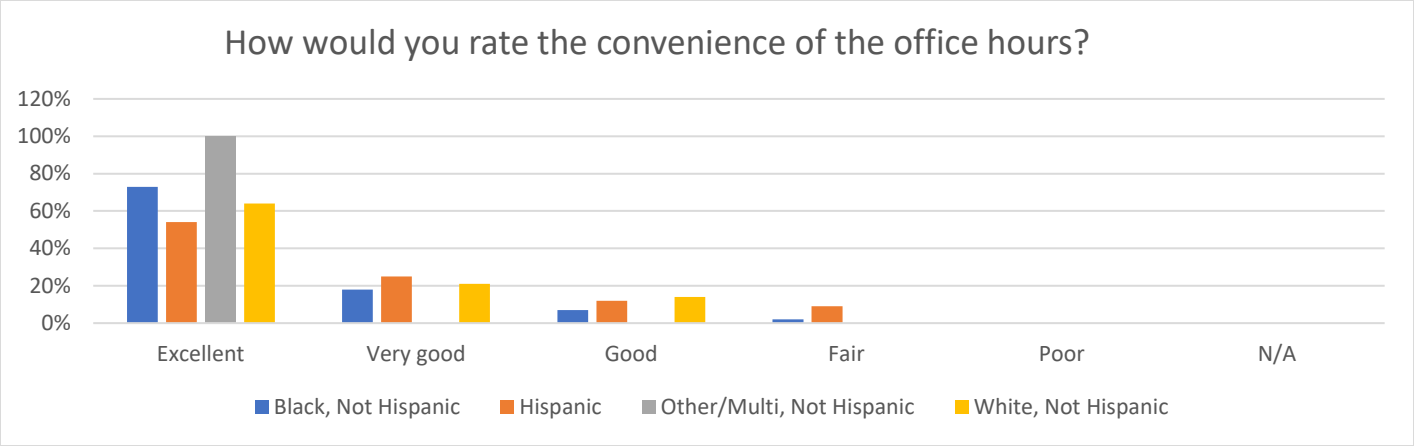


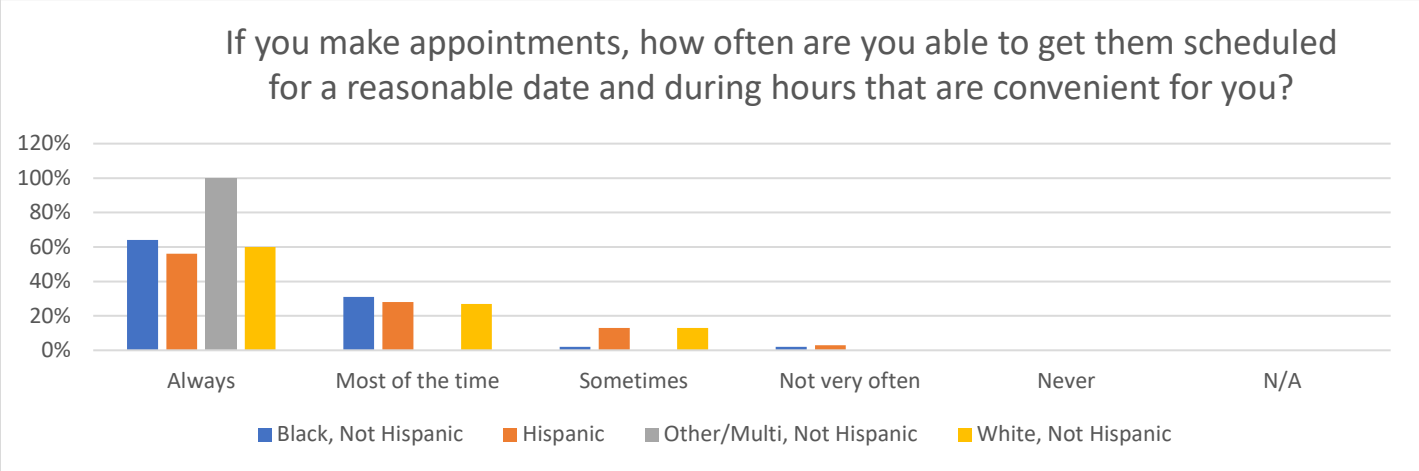


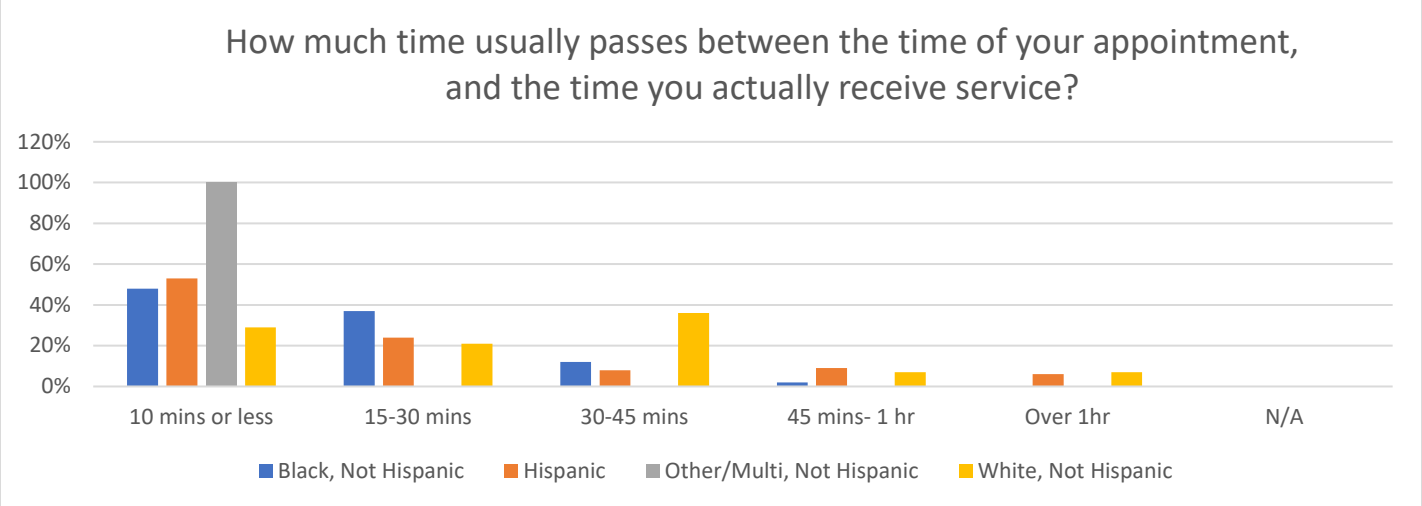


Convenience

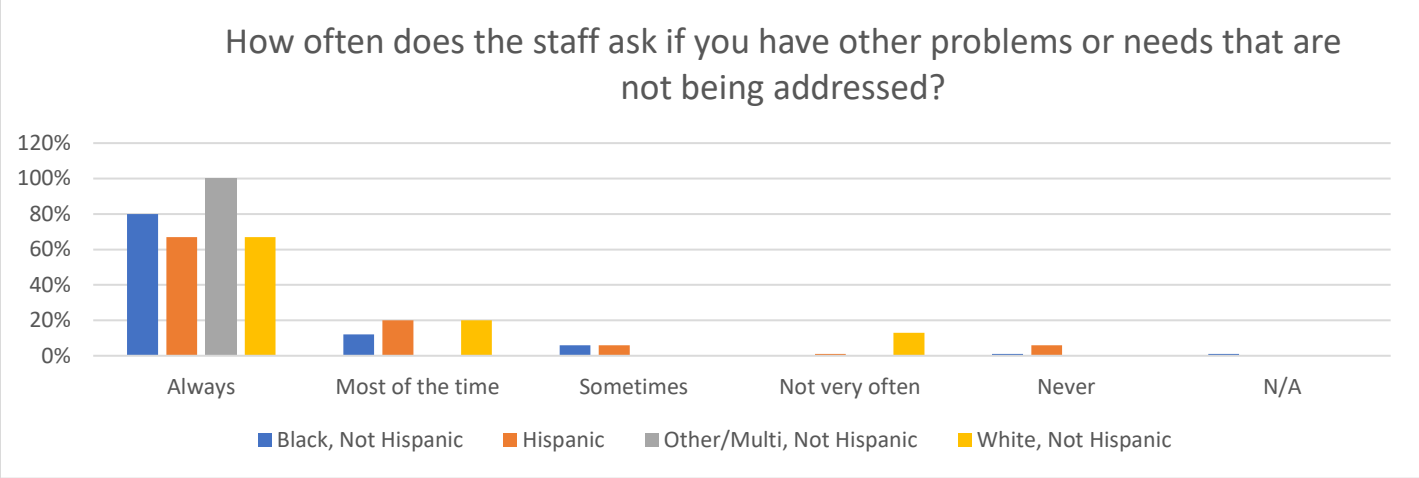


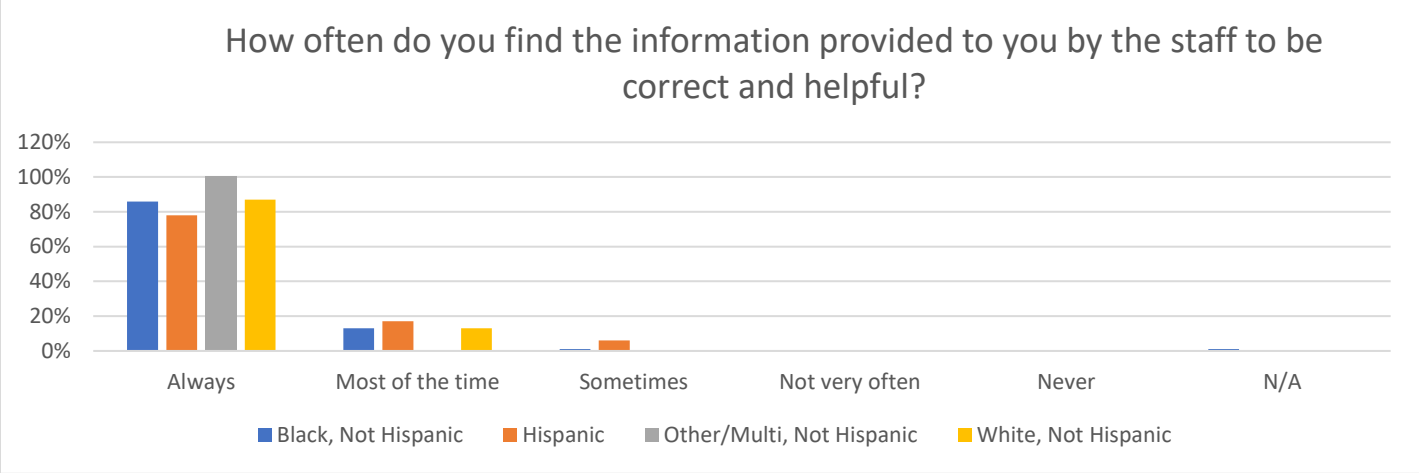

How would you rate the convenience of the office hours?
120%
100%
80%
60%
40%
20%
0%
Excellent
Very good
Good
Fair
Poor
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

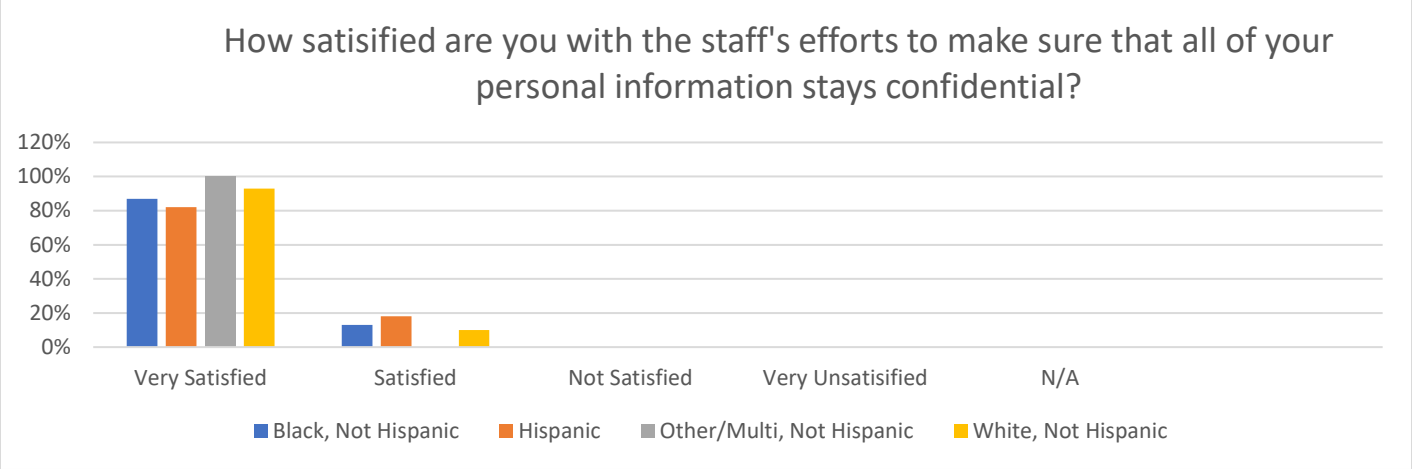

If you make appointments, how often are you able to get them scheduled for a reasonable date and during hours that are convenient for you?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

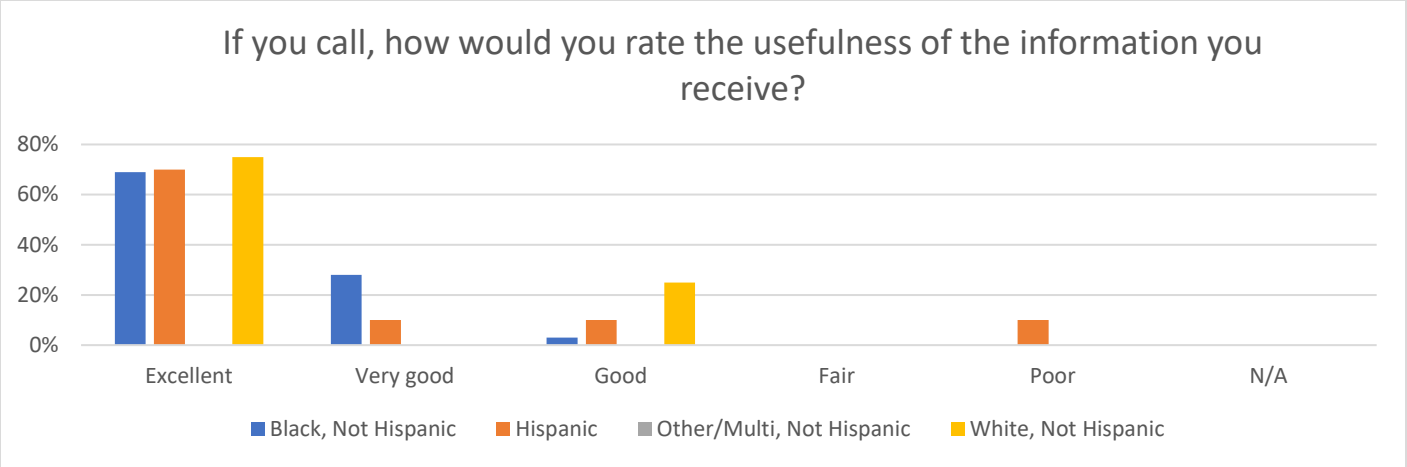

How much time usually passes between the time of your appointment, and the time you actually receive service?
120%
100%
80%
60%
40%
20%
0%
10 mins or less
15-30 mins
30-45 mins
45 mins- 1 hr
Over 1hr
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

Information and Communication

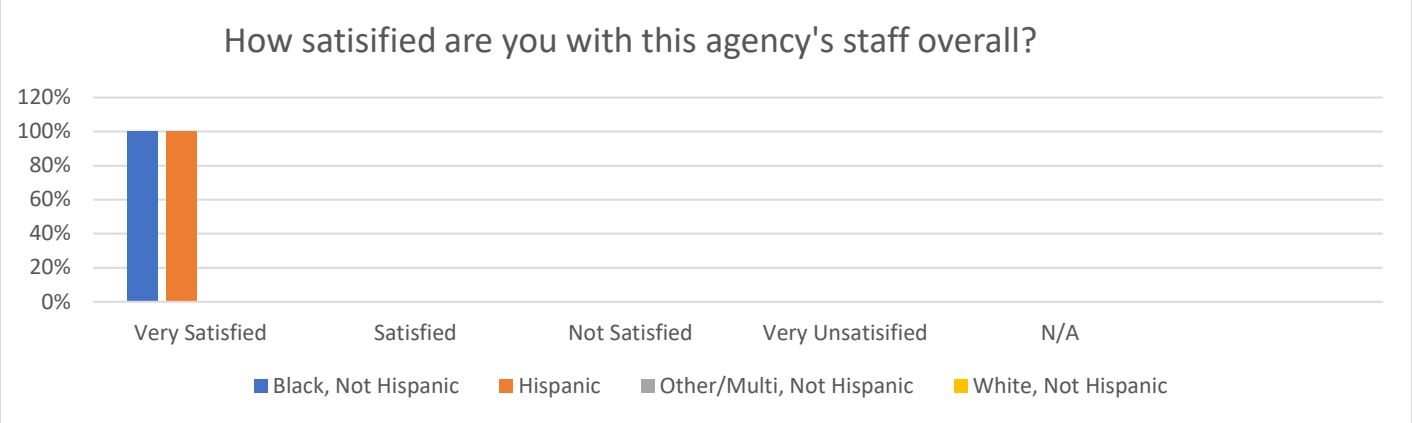


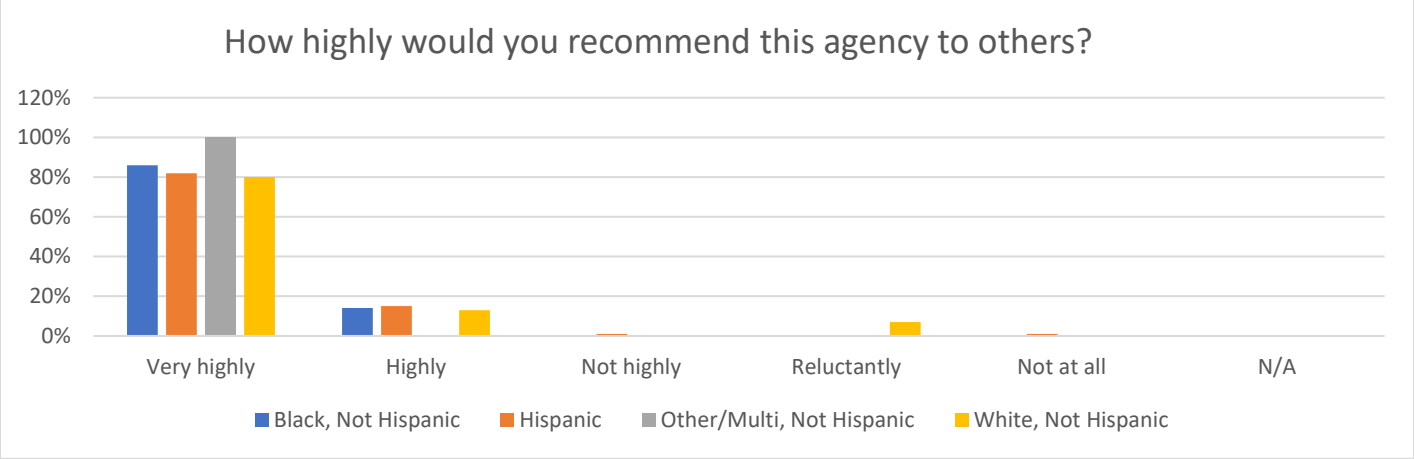


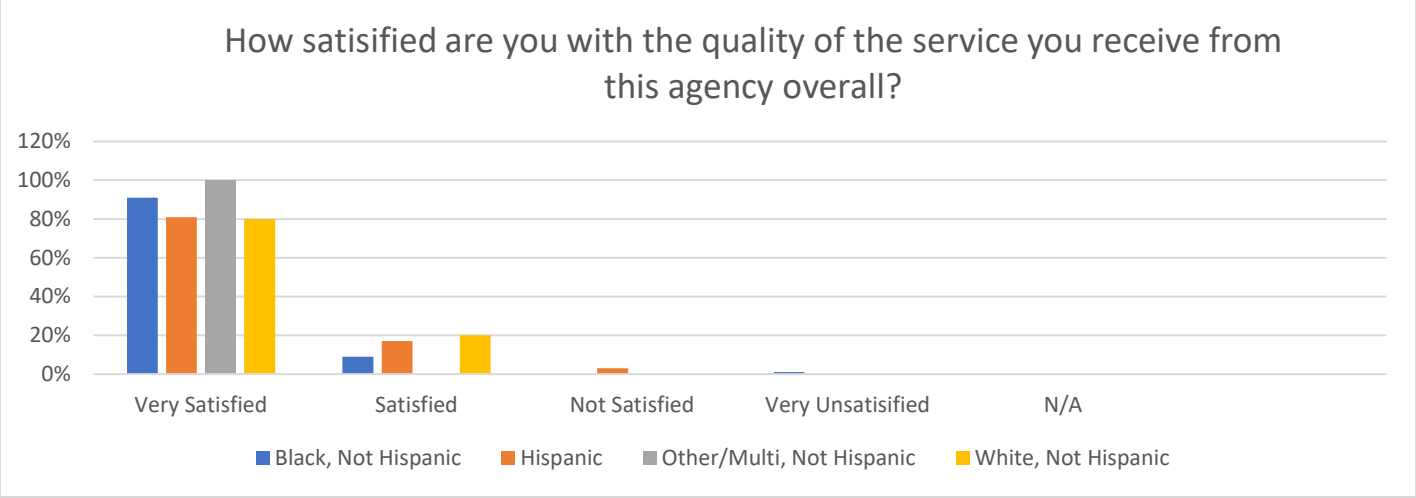



If you call, how would you rate the usefulness of the information you receive?
80%
60%
40%
20%
0%
Excellent
Very good
Good
Fair
Poor
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

Overall Satisfaction







Conclusion

The data collected represents a small sample of clients served in the Houston EMA and should not be generalized for the entire Ryan White population. But every individual's feedback is valuable and even with a small sample, the information should be considered seriously and incorporated into future conversations on improvement. Generally, most clients reported overall satisfaction with services received. Along with the positive feedback, there were areas that stood out as needing improvement.

The level of satisfaction was lower in areas focused on convenience of services. This included office hours, ability to get appointments, and wait times. Many clients also answered that they are not often asked if their needs are being met or if there is something else that they need.

Appendix **1 (survey data)**

Harris County Public Health and Environmental Services-Ryan White Grant Administration

Client Satisfaction Survey Results

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

Client Satisfaction Survey Results

Surveys record last update date between **3/1/21** and **2/28/22**
[Agency]: **ALL** [SLG#]: **(0) CLIENT SATIS - OUTPATIENT/AMBULAT CARE**
[Analysis Type]: **COMMON** [Question(s)]: **All**
[Sort]: **Race/Ethnicity** [Blanks]: **EXCLUDE**

Question Text	Answer Desc	Answer	Black, Not Hispanic	Hispanic	Other/Multi, Not Hispanic	White, Not Hispanic	Total
How often does your case manager treat you with dignity and respect?	Always,Siempre	1	50 98%	46 94%	0 0 %	8 100%	**104** **96%**
	La mayoría del tiempo,Most of the time	2	1 2%	2 4%	0 0 %	0 0%	**3** **3%**
	Sometimes	3	0 0%	1 2%	0 0 %	0 0%	**1** **1%**
			51	**49**		**8**	**108**
How often does the dentist treat you with dignity and respect?	Always	1	3 100%	0 0 %	0 0 %	0 0 %	**3** **100%**
			3				**3**
How often do you feel comfortable asking your dentist questions?	Always	1	3 100%	0 0 %	0 0 %	0 0 %	**3** **100%**
			3				**3**
How often does the doctor/clinician treat you with dignity and respect?	Always,Siempre	1	55 100%	42 93%	1 100%	10 83%	**108** **96%**
	La mayoría del tiempo,Most of the time	2	0 0%	2 4%	0 0%	2 17%	**4** **4%**
	Never	5	0 0%	1 2%	0 0%	0 0%	**1** **1%**

			55	**45**	**1**	**12**	**113**
How often does the optometrist/clinician treat you with dignity and respect?	Always	1	2 100%	0 %	0 %	0 %	**2** **100%**
			2				**2**
How often do you feel comfortable asking your optometrist/clinician questions?	Always	1	2 100%	0 %	0 %	0 %	**2** **100%**
			2				**2**
How often do you feel comfortable asking your doctor/clinician questions?	Always,Siempre	1	48 87%	32 73%	1 100%	11 92%	**92** **82%**
	La mayoría del tiempo,Most of the time	2	5 9%	10 23%	0%	0%	**15** **13%**
	A veces,Sometimes	3	1 2%	2 5%	0%	1 8%	**4** **4%**
	Not Very Often	4	1 2%	0%	0%	0%	**1** **1%**
			55	**44**	**1**	**12**	**112**
How often does pharmacy staff treat you with dignity and respect?	Always	1	4 100%	5 83%	0 %	1 100%	**10** **91%**
	A veces	3	0%	1 17%	0 %	0%	**1** **9%**
			4	**6**		**1**	**11**
How often does the staff treat you with dignity and respect?	Always	1	0 %	3 100%	0 %	0 %	**3** **100%**

How often does the staff treat you with dignity and respect?				**3**			**3**
How often does the staff treat you with dignity and respect?	Always	1	1 100%	0 %	0 %	0 %	**1** **100%**
			1				**1**
How would you rate the courtesy and helpfulness of the staff as a whole?	Excellent	1	1 100%	3 100%	0 %	0 %	**4** **100%**
			1	**3**			**4**
How would you rate the staff's understanding and respect of your cultural / ethnic background and/or your lifestyle?	Excelente,Excellent	1	96 84%	83 85%	1 100%	19 90%	**199** **85%**
	Muy buena,Very Good	2	12 11%	10 10%	0%	2 10%	**24** **10%**
	Buena,Good	3	3 3%	2 2%	0%	0%	**5** **2%**
	Fair,Regular	4	1 1%	3 3%	0%	0%	**4** **2%**
	Not Applicable	6	2 2%	0%	0%	0%	**2** **1%**
			114	**98**	**1**	**21**	**234**
If English is not your primary language, how well does the staff communicate with you in your language?	Excelentemente,Excellent	1	54 52%	64 65%	0%	11 61%	**129** **58%**
	Muy bién,Very Good	2	3 3%	12 12%	1 100%	0%	**16** **7%**

If English is not your primary language, how well does the staff communicate with you in your language?	Bién,Good	3	1 1%	7 7%	0%	1 6%	**9** **4%**
	Adecuadamente	4	0%	1 1%	0%	0%	**1** **0%**
	Not Applicable	6	46 44%	14 14%	0%	6 33%	**66** **30%**
			104	**98**	**1**	**18**	**221**
How often does the staff ask if you have other problems or needs that are not being addressed?	Always,Siempre	1	86 79%	69 71%	1 100%	14 67%	**170** **75%**
	La mayoría de tiempo,La mayoría del tiempo,Most of the time	2	14 13%	19 20%	0%	5 24%	**38** **17%**
	A veces,Sometimes	3	5 5%	4 4%	0%	0%	**9** **4%**
	Not Very Often	4	1 1%	1 1%	0%	2 10%	**4** **2%**
	Never,Nunca	5	2 2%	4 4%	0%	0%	**6** **3%**
	Not Applicable	6	1 1%	0%	0%	0%	**1** **0%**
			109	**97**	**1**	**21**	**228**
How satisfied are you with the staff's efforts to make sure that all of your personal information stays confidential?	Muy satisfecho/a,Very Satisfied	1	98 88%	84 84%	1 100%	19 90%	**202** **87%**

How satisfied are you with the staff's efforts to make sure that all of your personal information stays confidential?	Satisfecho/a,Satisfied	2	13 12%	16 16%	0%	2 10%	**31** **13%**
			111	**100**	**1**	**21**	**233**
How often do you find the information provided to you by the staff to be correct and helpful?	Always,Siempre	1	98 87%	80 81%	1 100%	17 81%	**196** **84%**
	La mayoría del tiempo,Most of the time	2	13 12%	14 14%	0%	4 19%	**31** **13%**
	A veces,Sometimes	3	1 1%	5 5%	0%	0%	**6** **3%**
	Not Applicable	6	1 1%	0%	0%	0%	**1** **0%**
			113	**99**	**1**	**21**	**234**
How satisfied are you with this agency's staff overall?	Very Satisfied	1	1 100%	3 100%	0 %	0 %	**4** **100%**
			1	**3**			**4**
If you call, how long does it usually take to get information you need over the phone?	5 min or less	1	2 50%	3 38%	0 %	0%	**5** **38%**
	About 10 min	2	1 25%	1 12%	0 %	0%	**2** **15%**
	About 15 min	3	0%	2 25%	0 %	0%	**2** **15%**
	Más de 15 min,Over 15 min	4	1 25%	2 25%	0 %	1 100%	**4** **31%**

If you call, how long does it usually take to get information you need over the phone?			**4**	**8**		**1**	**13**
If you call, how would you rate the usefulness of the information you receive?	Excelente,Excellent	1	35 70%	37 74%	0 %	7 88%	**79** **73%**
	Muy buena,Very Good	2	12 24%	6 12%	0 %	0%	**18** **17%**
	Buena,Good	3	1 2%	4 8%	0 %	1 12%	**6** **6%**
	Mala,Poor	5	1 2%	3 6%	0 %	0%	**4** **4%**
	Not Applicable	6	1 2%	0%	0 %	0%	**1** **1%**
			50	**50**		**8**	**108**
How much time usually passes between the time of your appointment, and the time you actually receive service?	10 min o menos,10 min or less	1	59 55%	45 49%	1 100%	9 45%	**114** **52%**
	15-30 min	2	35 32%	27 29%	0%	4 20%	**66** **30%**
	30-45 min	3	12 11%	10 11%	0%	5 25%	**27** **12%**
	45 min-1 hr,45 min-1hr	4	2 2%	6 7%	0%	1 5%	**9** **4%**

How much time usually passes between the time of your appointment, and the time you actually receive service?	Más de una hr,Over 1 hr	5	0%	4 4%	0%	1 5%	**5** **2%**
			108	**92**	**1**	**20**	**221**
How would you rate the convenience of the office hours here?	Excelente,Excellent	1	78 71%	59 63%	1 100%	13 65%	**151** **67%**
	Muy buena,Very Good	2	17 15%	21 22%	0%	4 20%	**42** **19%**
	Buena,Good	3	13 12%	8 9%	0%	3 15%	**24** **11%**
	Fair,Regular	4	2 2%	6 6%	0%	0%	**8** **4%**
			110	**94**	**1**	**20**	**225**
How would you rate the convenience of the location of this agency?	Very Good	2	1 100%	0 %	0 %	0 %	**1** **100%**
			1				**1**
If you make appointments, how often are you able to get them scheduled for a reasonable date and during hours that are convenient for you?	Always,Siempre	1	74 66%	54 57%	1 100%	14 67%	**143** **62%**
	La mayoría del tiempo,Most of the time	2	33 29%	28 29%	0%	5 24%	**66** **29%**
	A veces,Sometimes	3	3 3%	11 12%	0%	2 10%	**16** **7%**
	No muy seguido,Not Very Often	4	2 2%	2 2%	0%	0%	**4** **2%**

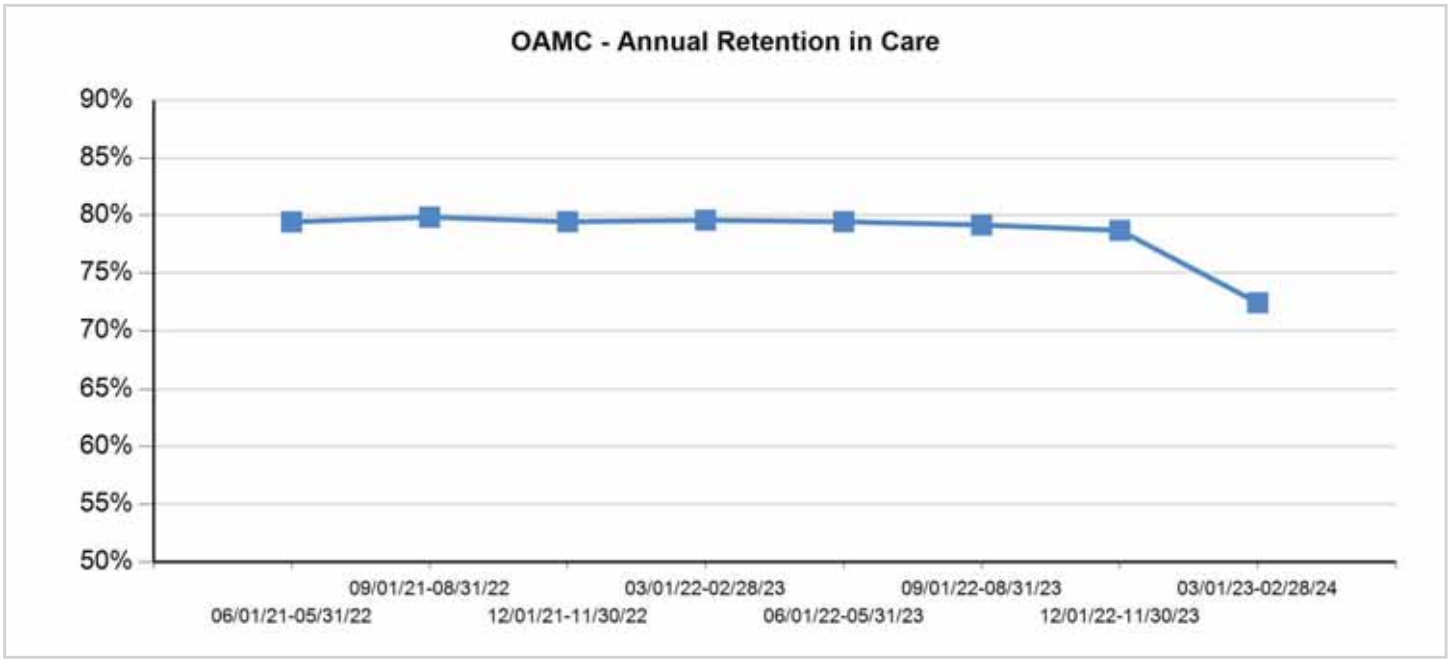
If you make appointments, how often are you able to get them scheduled for a reasonable date and during hours that are convenient for you?			**112**	**95**	**1**	**21**	**229**
How highly would you recommend this agency to others?	Muy buena,Very highly	1	99 88%	80 82%	1 100%	18 86%	**198** **85%**
	Buena,Highly	2	13 12%	15 15%	 0%	2 10%	**30** **13%**
	Not Highly,Regular	3	 0%	2 2%	 0%	 0%	**2** **1%**
	Reluctantly	4	1 1%	 0%	 0%	1 5%	**2** **1%**
	No daría	5	 0%	1 1%	 0%	 0%	**1** **0%**
			113	**98**	**1**	**21**	**233**
How satisfied are you with the quality of the service you receive from this agency overall?	Muy satisfecho/a,Very Satisfied	1	101 89%	81 82%	1 100%	18 86%	**201** **86%**
	Satisfecho/a,Satisfied	2	11 10%	16 16%	 0%	3 14%	**30** **13%**
	Insatisfecho/a,Not Satisfied	3	 0%	2 2%	 0%	 0%	**2** **1%**
	Very Unsatisfied	4	1 1%	 0%	 0%	 0%	**1** **0%**
			113	**99**	**1**	**21**	**234**

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

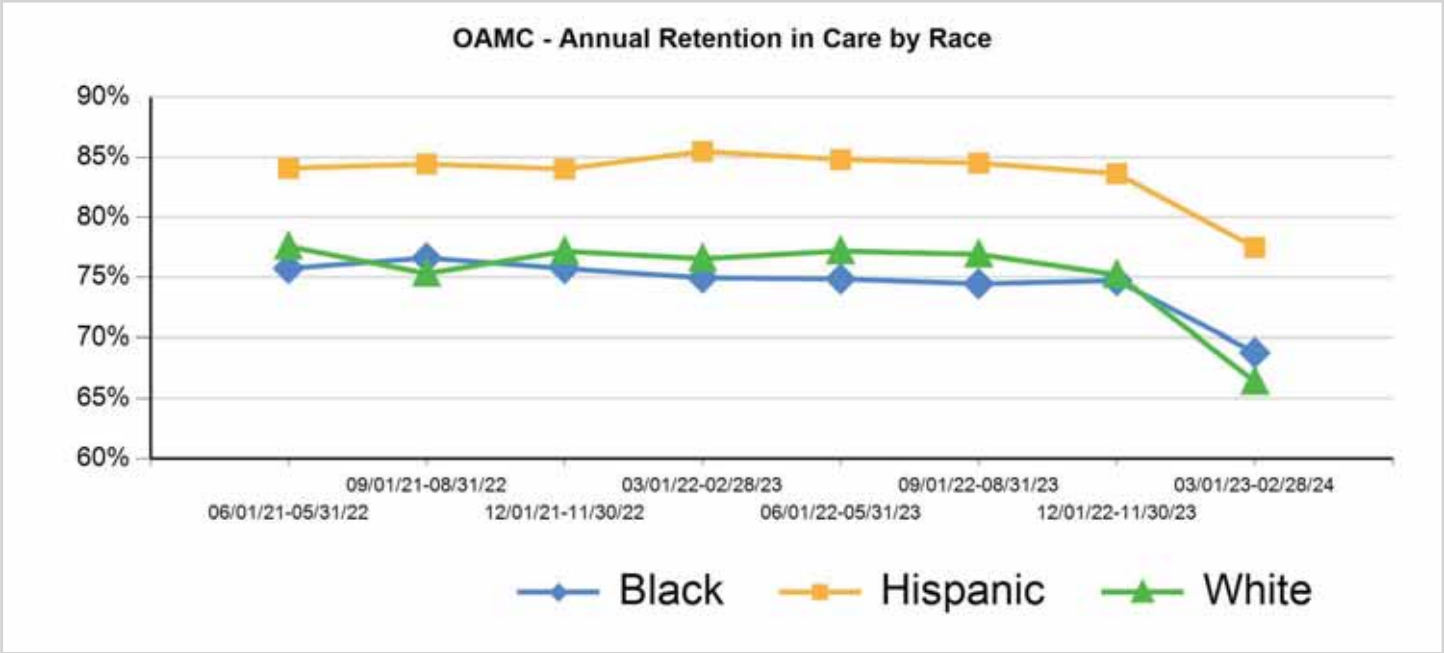
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **3/1/2023**

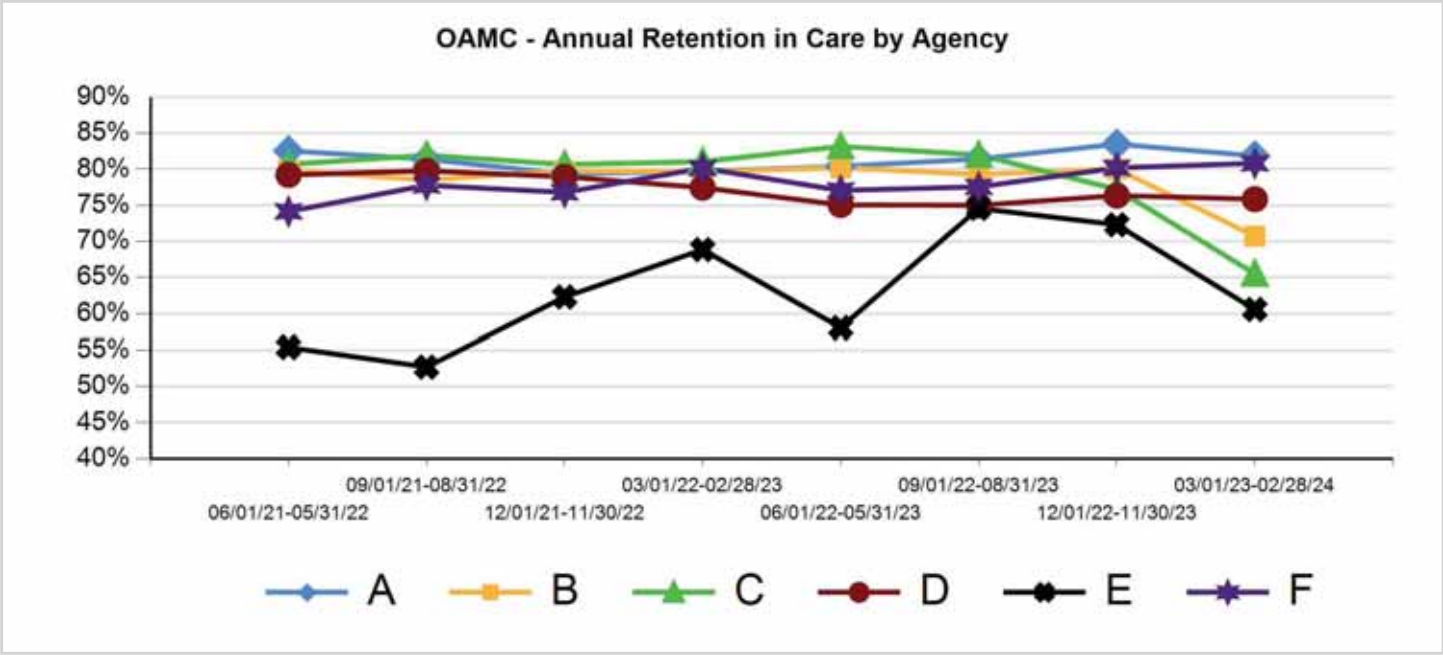
OAMC - Annual Retention in Care				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	6,849	6,896	6,915	6,156
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	8,620	8,710	8,786	8,501
Percentage	79.5%	79.2%	78.7%	72.4%
Change from Previous Quarter Results	-0.1%	-0.3%	-0.5%	-6.3%



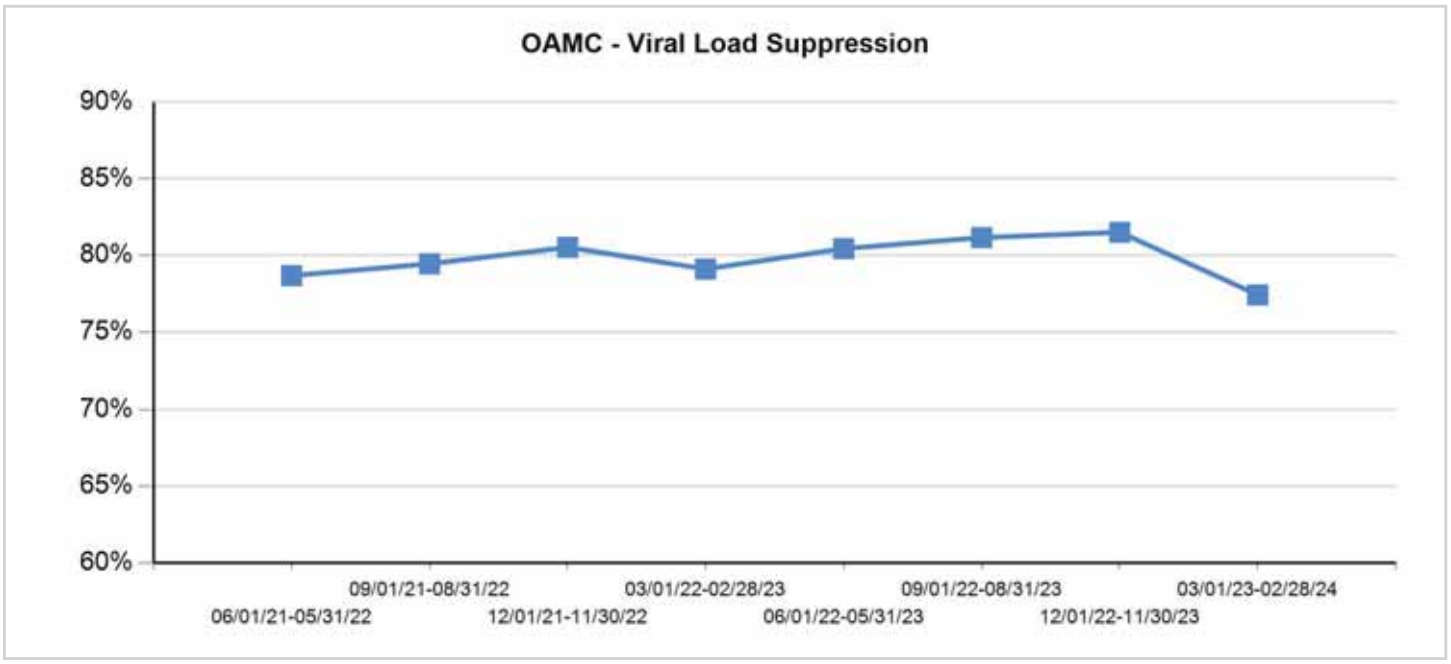
OAMC - Annual Retention in Care by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	2,919	3,147	686	2,902	3,194	683	2,554	2,899	585
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	3,920	3,724	892	3,883	3,819	908	3,712	3,741	881
Percentage	74.5%	84.5%	76.9%	74.7%	83.6%	75.2%	68.8%	77.5%	66.4%
Change from Previous Quarter Results	-0.4%	-0.3%	-0.3%	0.3%	-0.9%	-1.7%	-5.9%	-6.1%	-8.8%



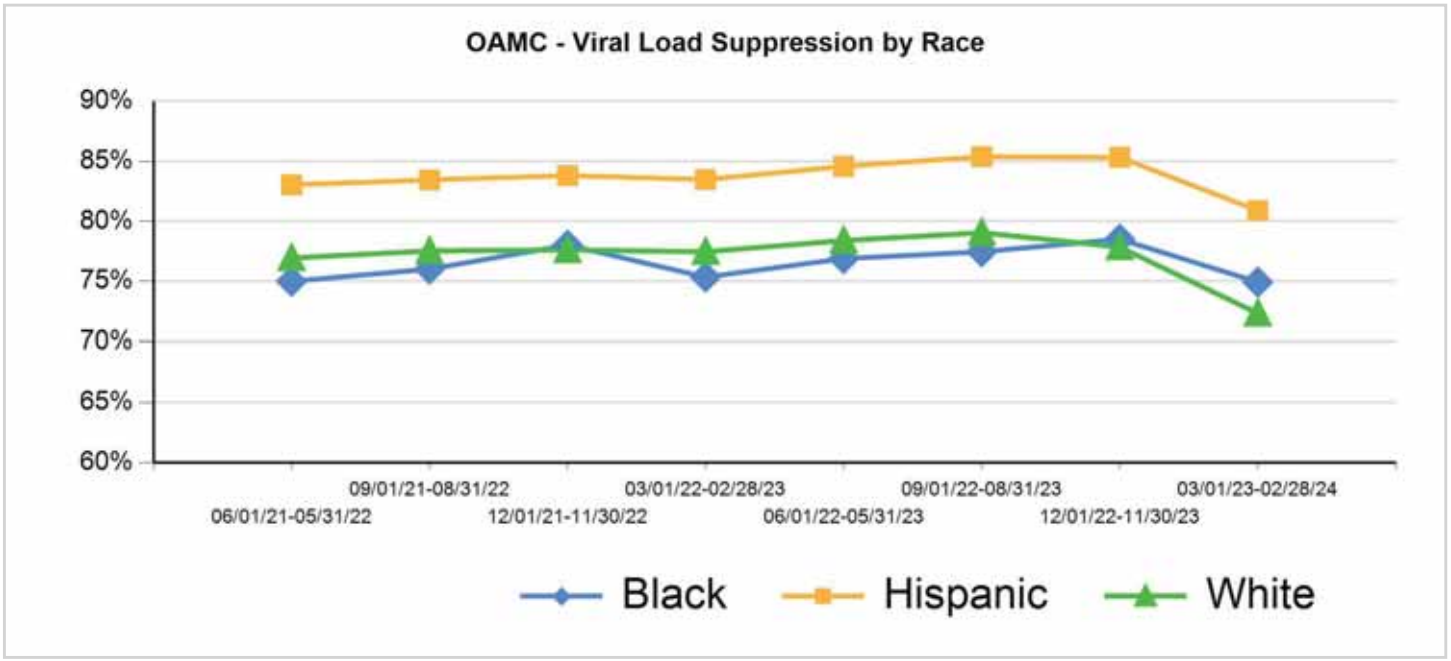
OAMC - Annual Retention in Care by Agency												
	12/01/22 - 11/30/23						03/01/23 - 02/28/24					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	733	1,766	2,211	1,502	47	753	695	1,454	1,833	1,433	43	759
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	878	2,206	2,863	1,967	65	939	849	2,056	2,798	1,889	71	939
Percentage	83.5%	80.1%	77.2%	76.4%	72.3%	80.2%	81.9%	70.7%	65.5%	75.9%	60.6%	80.8%
Change from Previous Quarter Results	2.1%	0.8%	-4.8%	1.4%	-2.3%	2.6%	-1.6%	-9.3%	-11.7%	-0.5%	-11.7%	0.6%



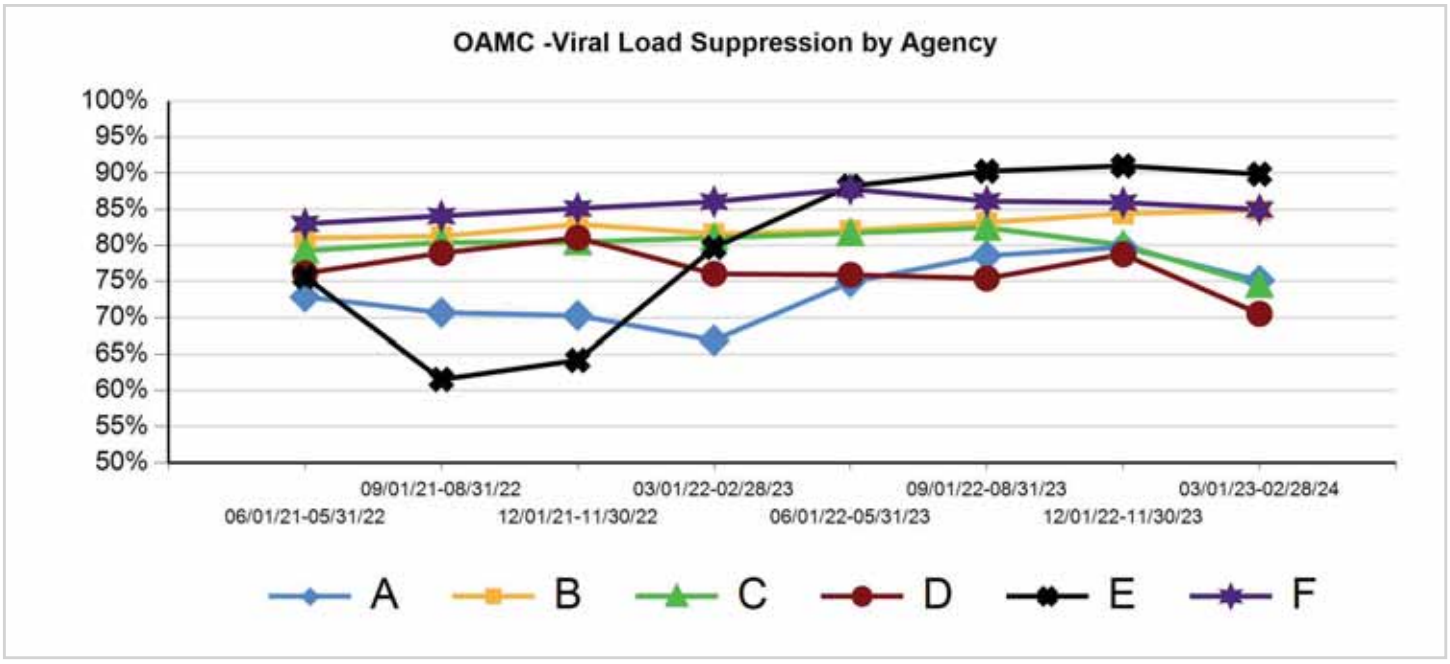
OAMC - Viral Load Suppression				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	7,620	7,780	7,859	7,144
Number of clients living with HIV, with at least one medical visit in the measurement year	9,473	9,586	9,642	9,227
Percentage	80.4%	81.2%	81.5%	77.4%
Change from Previous Quarter Results	1.3%	0.7%	0.3%	-4.1%



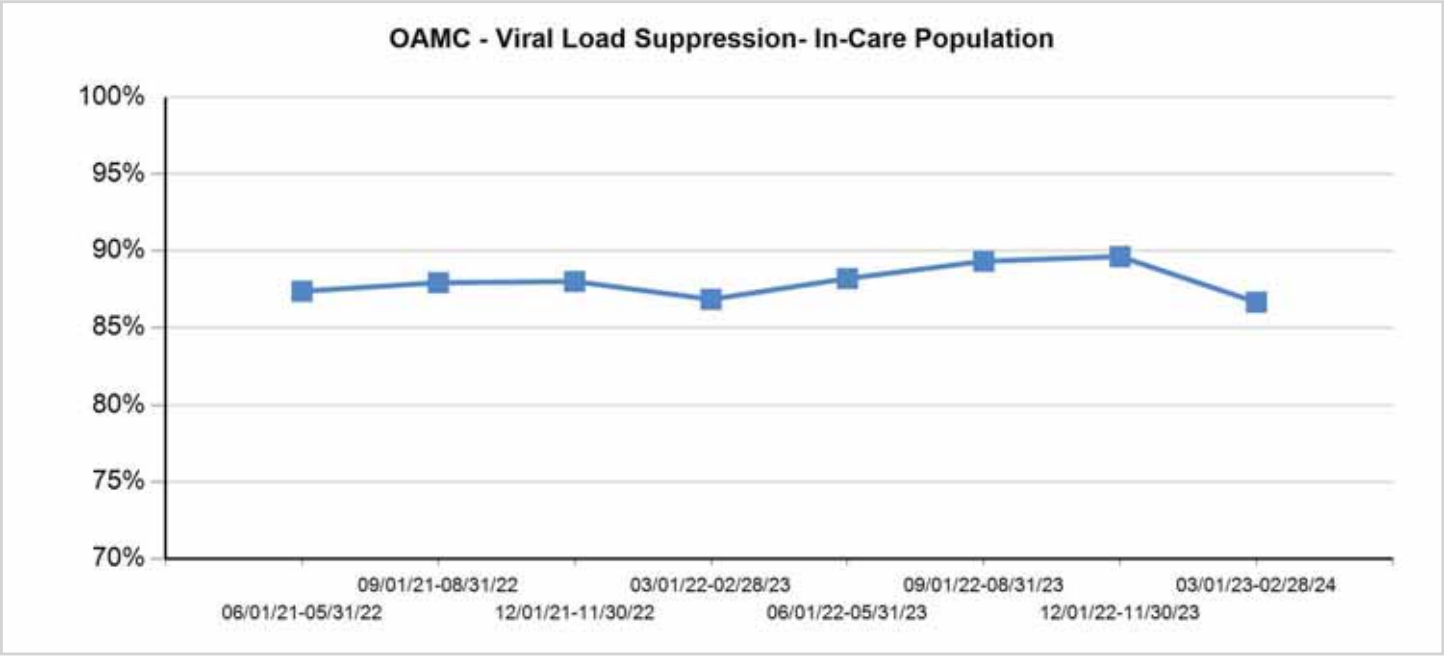
OAMC - Viral Load Suppression by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	3,340	3,498	781	3,364	3,568	766	3,029	3,281	685
Number of clients living with HIV, with at least one medical visit in the measurement year	4,312	4,097	988	4,285	4,182	984	4,042	4,056	947
Percentage	77.5%	85.4%	79.0%	78.5%	85.3%	77.8%	74.9%	80.9%	72.3%
Change from Previous Quarter Results	0.6%	0.8%	0.7%	1.0%	-0.1%	-1.2%	-3.6%	-4.4%	-5.5%



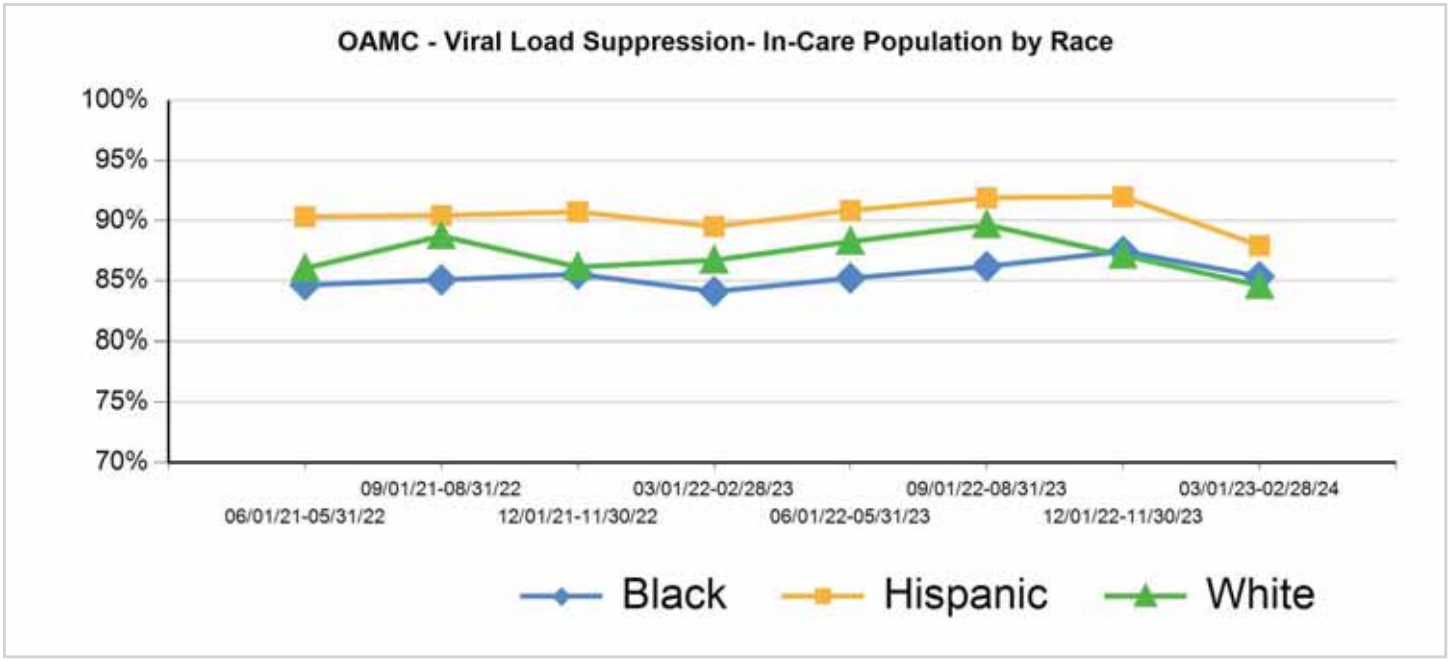
OAMC - Viral Load Suppression by Agency												
	12/01/22 - 11/30/23						03/01/23 - 02/28/24					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	732	2,000	2,528	1,661	71	984	671	1,843	2,272	1,430	71	944
Number of clients living with HIV, with at least one medical visit in the measurement year	918	2,370	3,159	2,109	78	1,145	893	2,172	3,049	2,028	79	1,111
Percentage	79.7%	84.4%	80.0%	78.8%	91.0%	85.9%	75.1%	84.9%	74.5%	70.5%	89.9%	85.0%
Change from Previous Quarter Results	1.2%	1.2%	-2.4%	3.3%	0.7%	-0.2%	-4.6%	0.5%	-5.5%	-8.2%	-1.2%	-1.0%



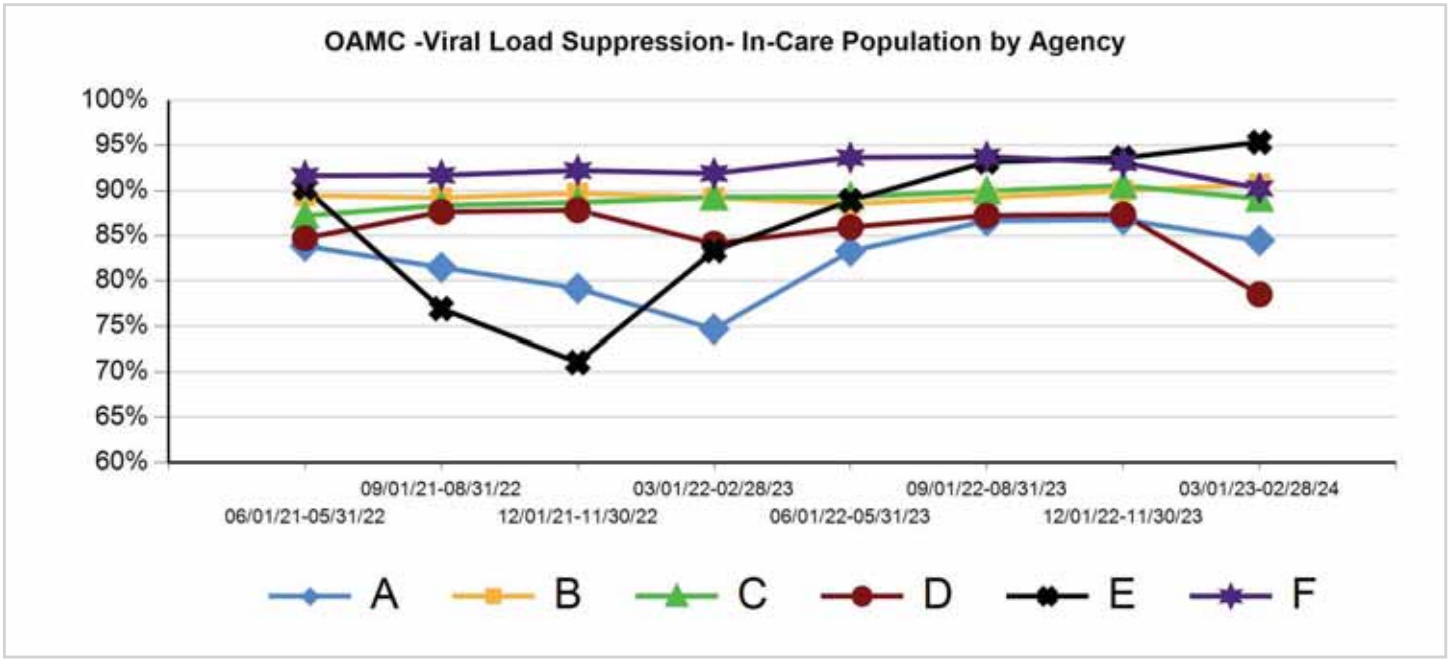
OAMC - Viral Load Suppression- In-Care Population				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	6,040	6,159	6,197	5,334
Number of clients living with HIV, with two or more medical encounters, 90 days apart, in an HIV care setting in the measurement year	6,849	6,896	6,915	6,156
Percentage	88.2%	89.3%	89.6%	86.6%
Change from Previous Quarter Results	1.4%	1.1%	0.3%	-3.0%



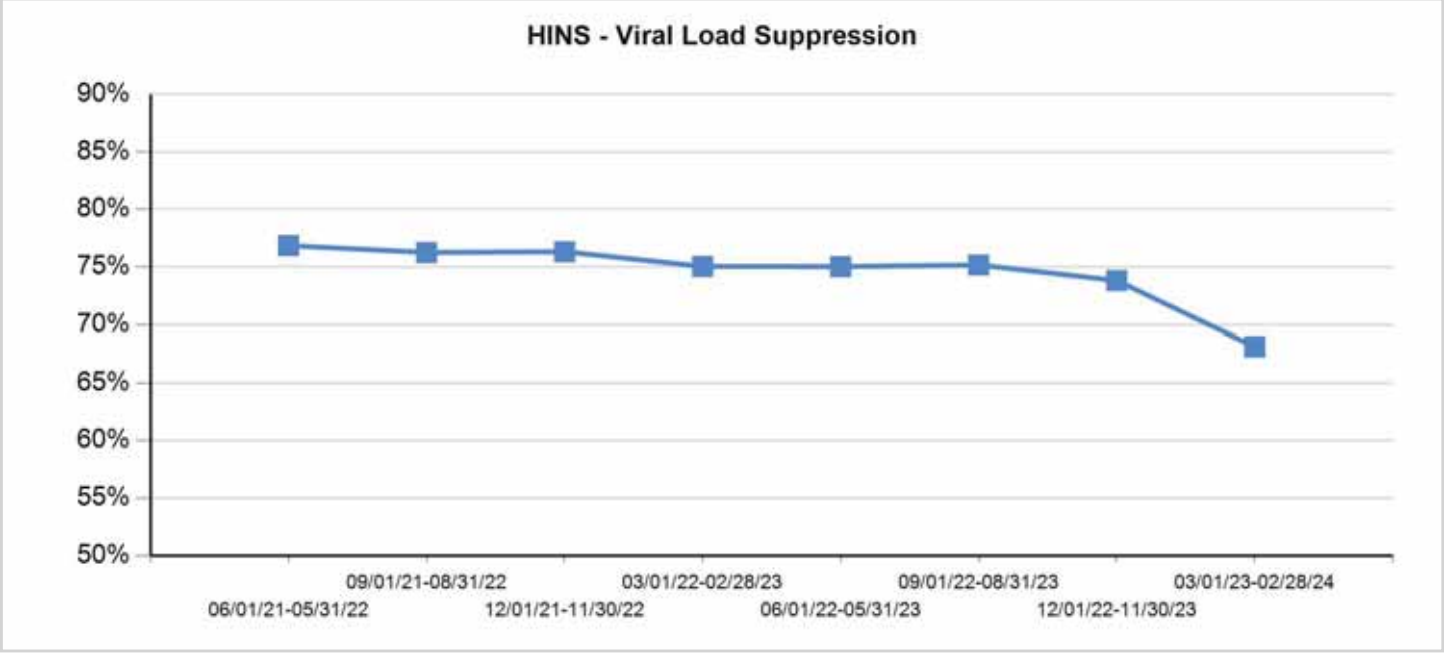
OAMC - Viral Load Suppression- In-Care Population by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	2,516	2,892	615	2,538	2,938	595	2,180	2,549	495
Number of clients living with HIV, with two or more medical encounters, 90 days apart, in an HIV care setting in the measurement year	2,919	3,147	686	2,902	3,194	683	2,554	2,899	585
Percentage	86.2%	91.9%	89.7%	87.5%	92.0%	87.1%	85.4%	87.9%	84.6%
Change from Previous Quarter Results	1.0%	1.1%	1.4%	1.3%	0.1%	-2.5%	-2.1%	-4.1%	-2.5%



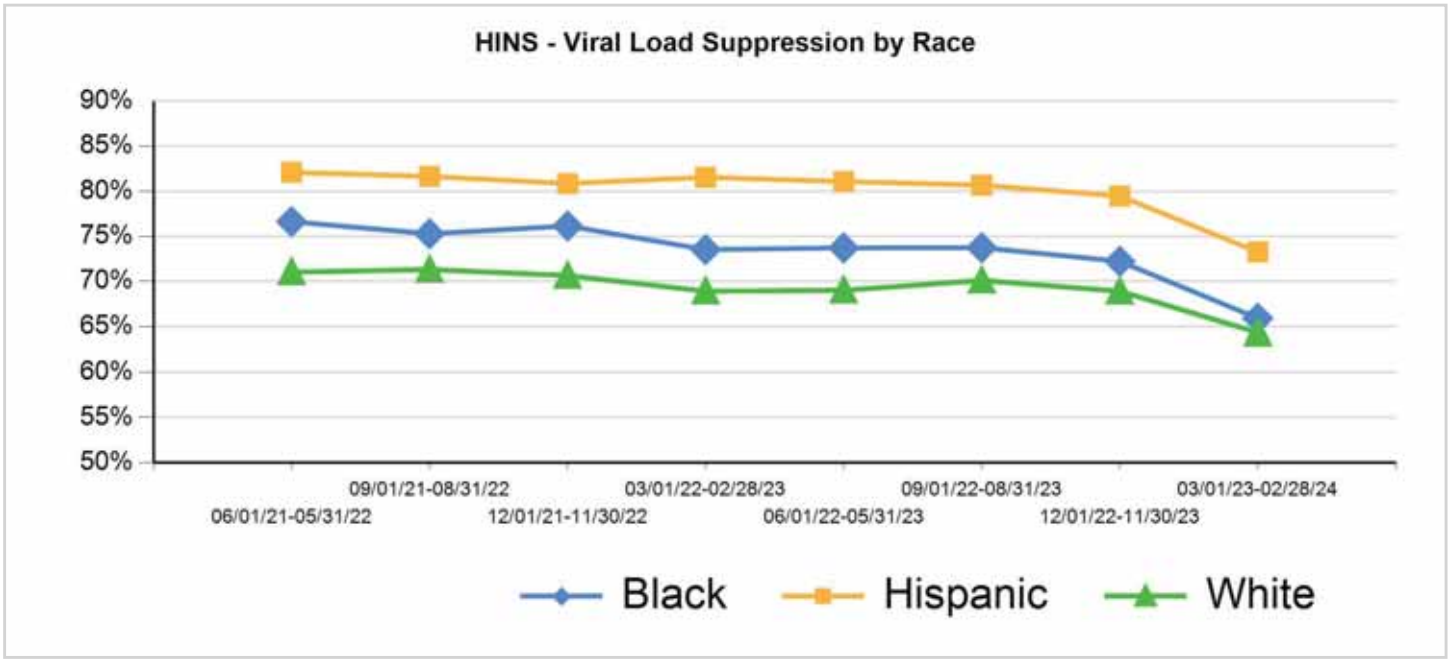
OAMC - Viral Load Suppression- In-Care Population by Agency												
	12/01/22 - 11/30/23						03/01/23 - 02/28/24					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	636	1,589	2,002	1,312	44	701	587	1,319	1,633	1,125	41	685
Number of clients living with HIV, with two or more medical encounters, 90 days apart, in an HIV care setting in the measurement year	733	1,766	2,211	1,502	47	753	695	1,454	1,833	1,433	43	759
Percentage	86.8%	90.0%	90.5%	87.4%	93.6%	93.1%	84.5%	90.7%	89.1%	78.5%	95.3%	90.3%
Change from Previous Quarter Results	0.1%	0.8%	0.6%	0.1%	0.4%	-0.7%	-2.3%	0.7%	-1.5%	-8.8%	1.7%	-2.8%



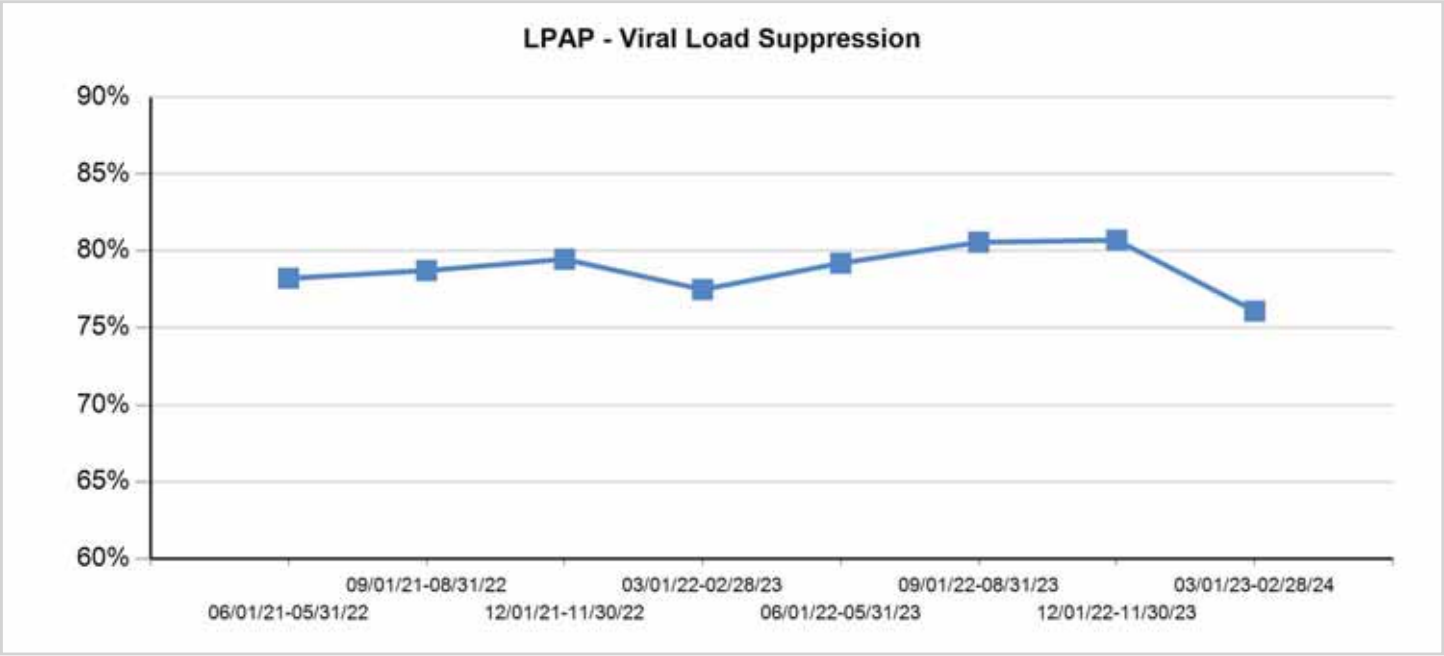
HINS - Viral Load Suppression				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	1,860	1,901	1,917	1,839
Number of clients living with HIV, with 1 or more Health Insurance Assistance encounters in the measurement year	2,479	2,529	2,597	2,700
Percentage	75.0%	75.2%	73.8%	68.1%
Change from Previous Quarter Results	0.0%	0.1%	-1.4%	-5.7%



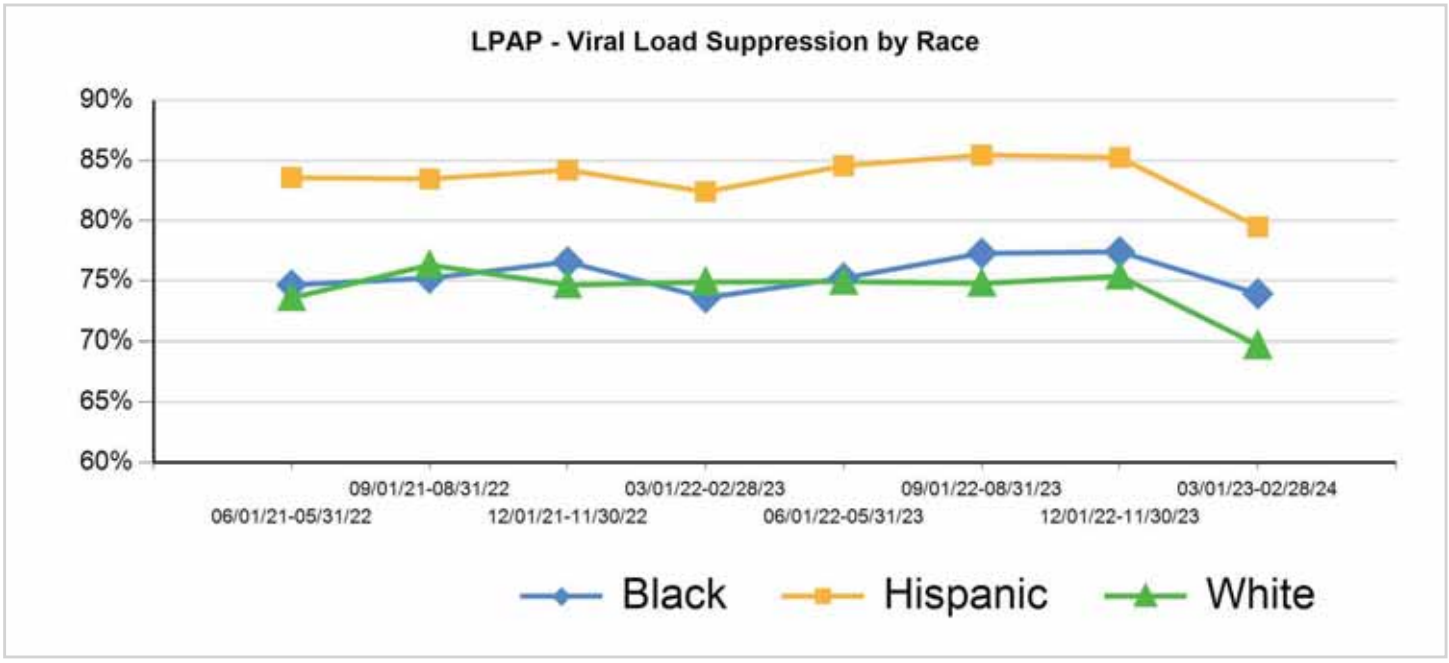
HINS - Viral Load Suppression by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	783	622	436	806	619	432	777	600	400
Number of clients living with HIV, with 1 or more Health Insurance Assistance encounters in the measurement year	1,062	771	622	1,116	779	627	1,179	819	622
Percentage	73.7%	80.7%	70.1%	72.2%	79.5%	68.9%	65.9%	73.3%	64.3%
Change from Previous Quarter Results	0.0%	-0.4%	1.1%	-1.5%	-1.2%	-1.2%	-6.3%	-6.2%	-4.6%



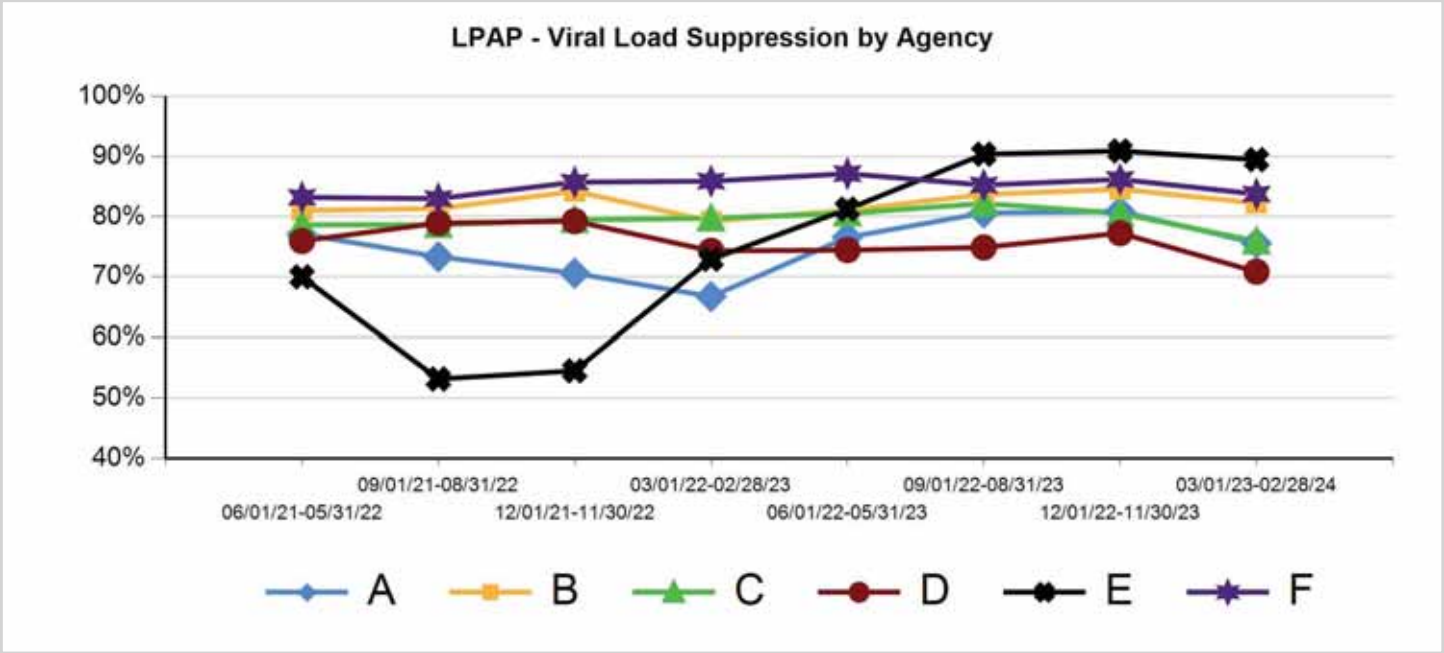
LPAP - Viral Load Suppression				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	5,278	5,406	5,452	4,926
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	6,665	6,711	6,757	6,476
Percentage	79.2%	80.6%	80.7%	76.1%
Change from Previous Quarter Results	1.7%	1.4%	0.1%	-4.6%



LPAP - Viral Load Suppression by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	2,317	2,367	593	2,317	2,415	591	2,076	2,224	510
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	2,998	2,770	793	2,993	2,833	784	2,808	2,798	732
Percentage	77.3%	85.5%	74.8%	77.4%	85.2%	75.4%	73.9%	79.5%	69.7%
Change from Previous Quarter Results	2.1%	0.9%	-0.2%	0.1%	-0.2%	0.6%	-3.5%	-5.8%	-5.7%



LPAP - Viral Load Suppression by Agency												
	12/01/22 - 11/30/23						03/01/23 - 02/28/24					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	448	701	2,264	1,438	50	668	424	617	2,053	1,269	51	624
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	554	829	2,811	1,861	55	775	561	750	2,704	1,791	57	745
Percentage	80.9%	84.6%	80.5%	77.3%	90.9%	86.2%	75.6%	82.3%	75.9%	70.9%	89.5%	83.8%
Change from Previous Quarter Results	0.2%	0.9%	-1.7%	2.4%	0.5%	0.9%	-5.3%	-2.3%	-4.6%	-6.4%	-1.4%	-2.4%



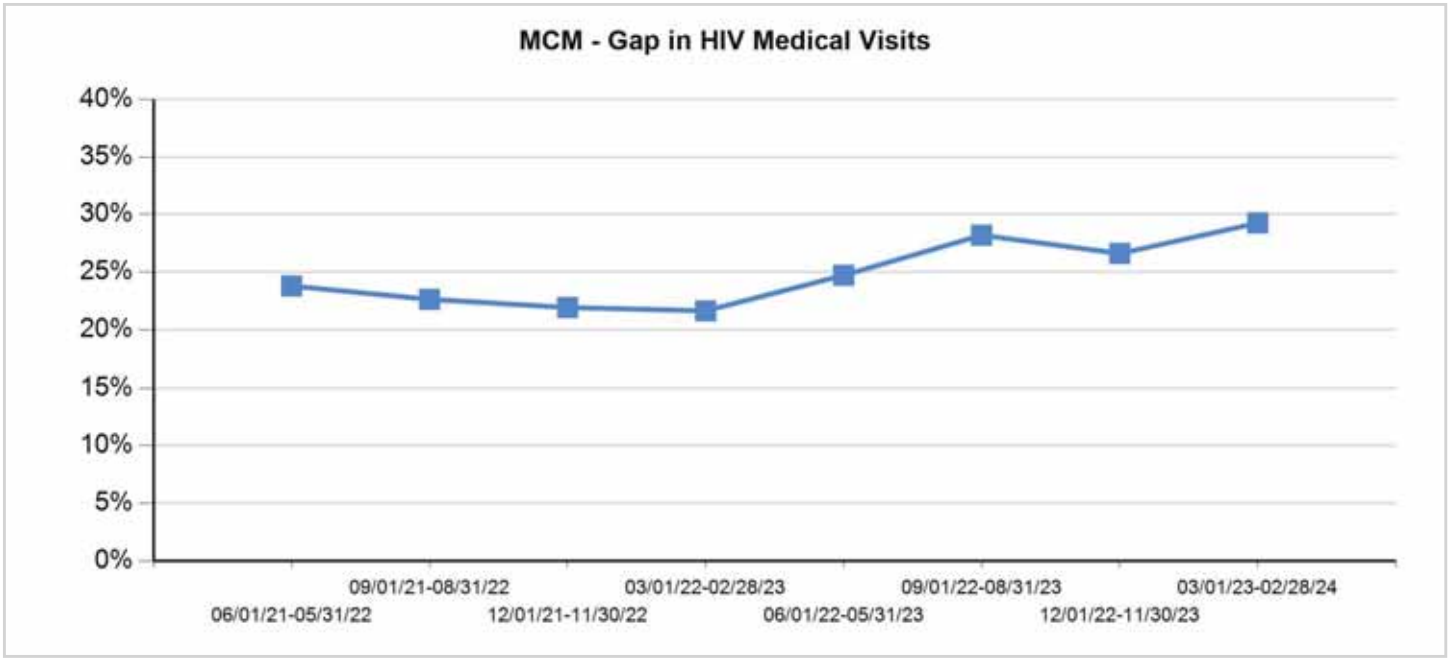
Footnotes:
1. Table/Chart data for this report run was taken from "ABR197 v1.1"

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

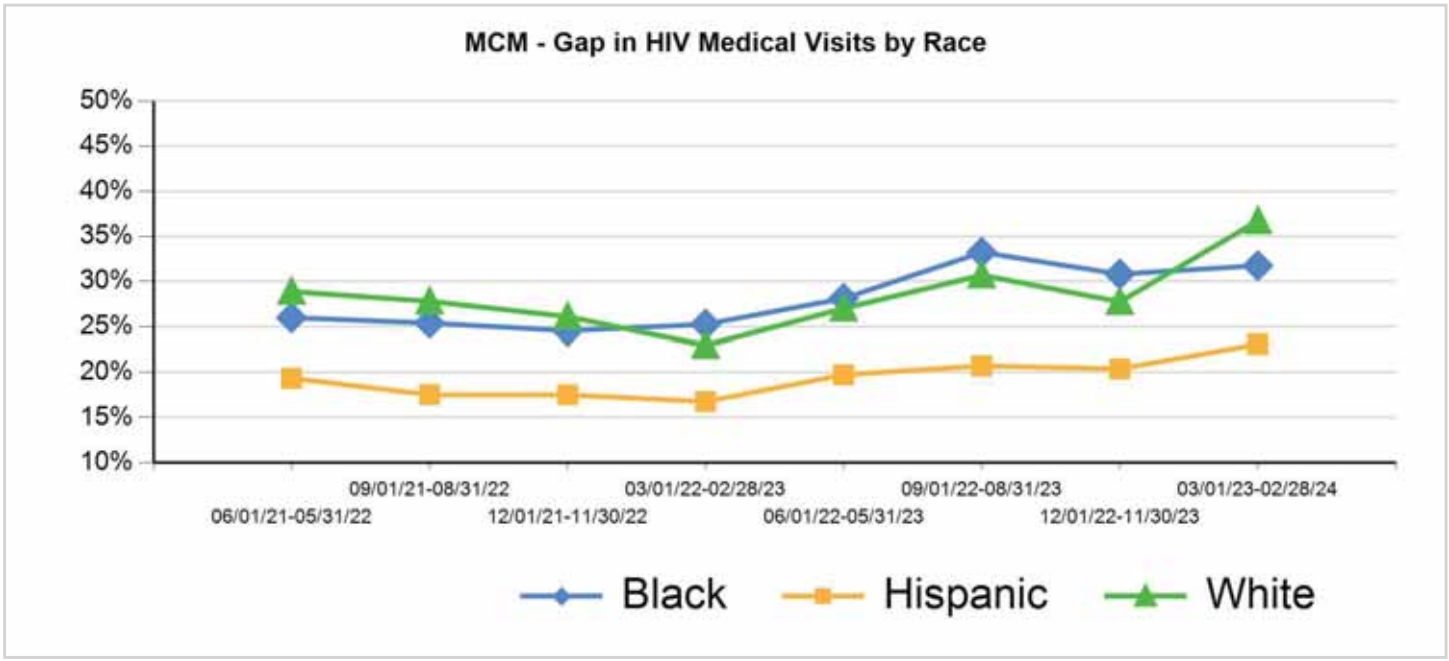
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **3/1/2023**

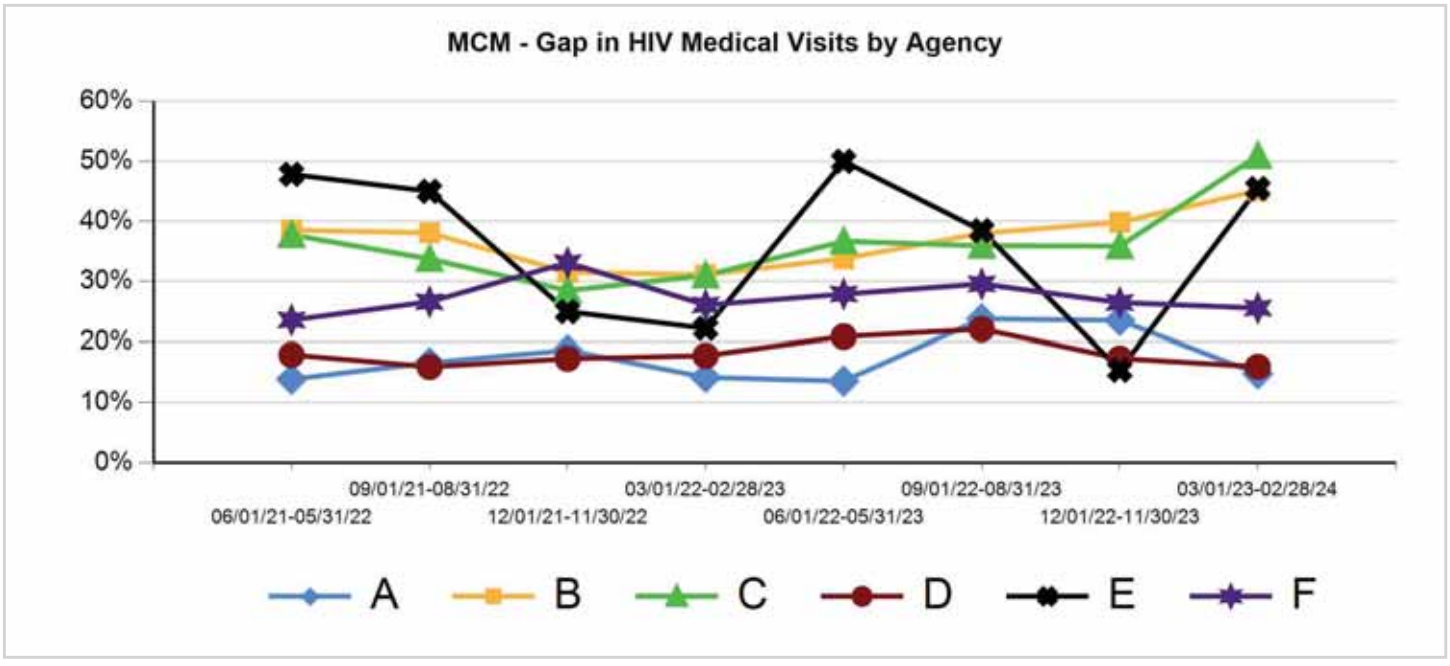
MCM - Gap in HIV Medical Visits				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	590	633	530	531
Number of medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	2,387	2,245	1,992	1,815
Percentage	24.7%	28.2%	26.6%	29.3%
Change from Previous Quarter Results	3.1%	3.5%	-1.6%	2.6%



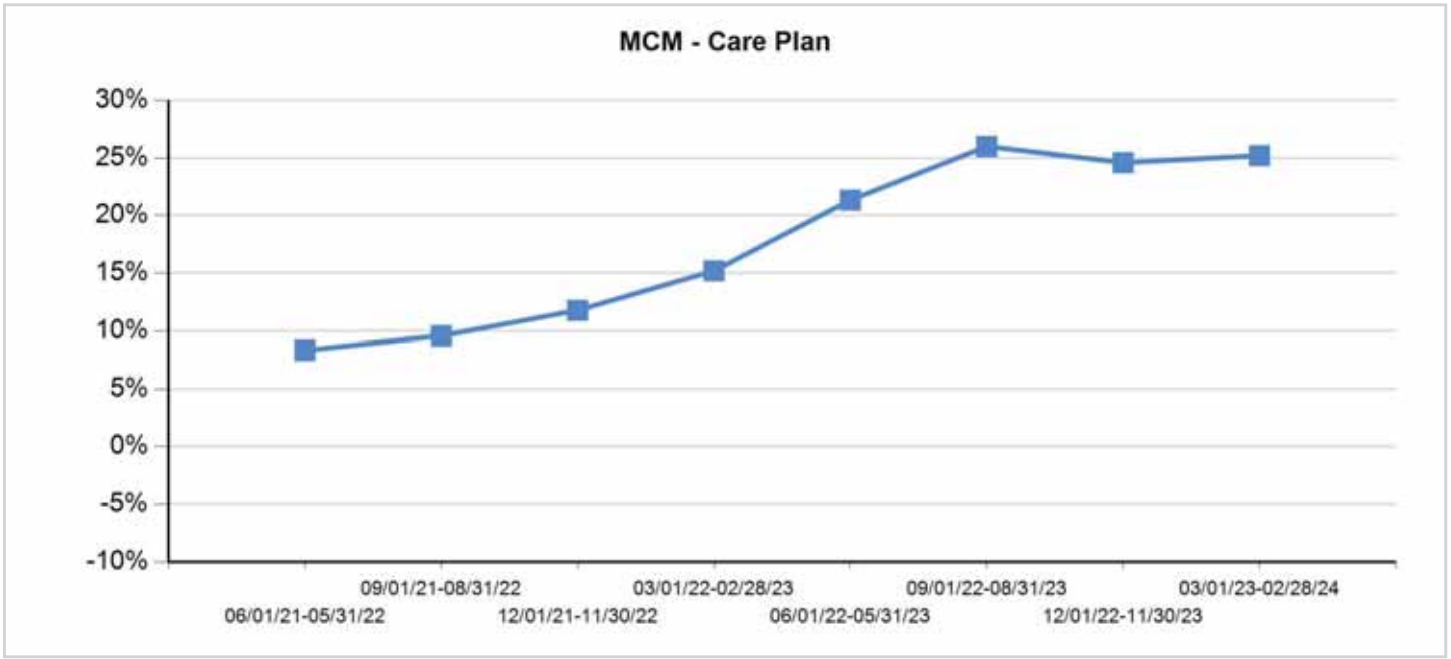
MCM - Gap in HIV Medical Visits by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	378	167	77	308	149	61	292	154	69
Number of medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	1,138	806	251	1,000	731	220	920	667	188
Percentage	33.2%	20.7%	30.7%	30.8%	20.4%	27.7%	31.7%	23.1%	36.7%
Change from Previous Quarter Results	5.1%	1.0%	3.7%	-2.4%	-0.3%	-3.0%	0.9%	2.7%	9.0%



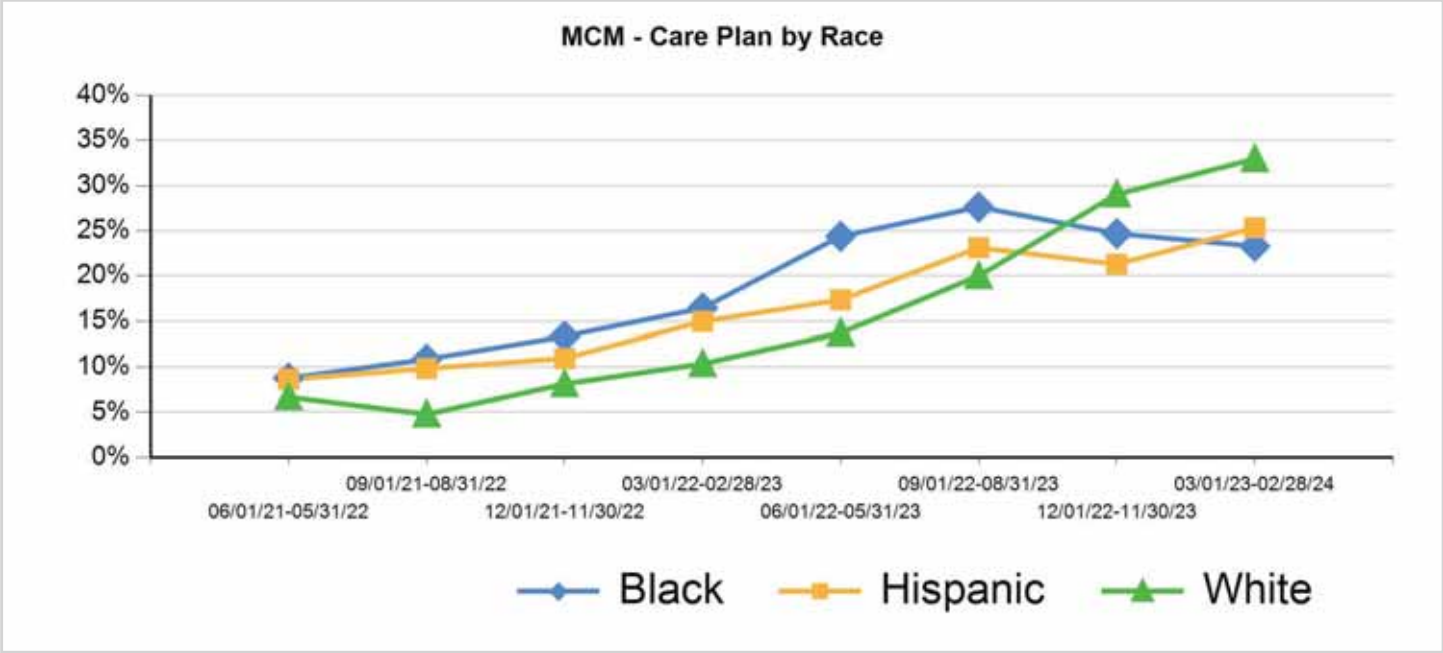
MCM - Gap in HIV Medical Visits by Agency												
	12/01/22 - 11/30/23						03/01/23 - 02/28/24					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	73	159	108	127	4	53	30	180	139	108	15	56
Number of medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	310	399	301	734	26	200	203	399	273	677	33	219
Percentage	23.5%	39.8%	35.9%	17.3%	15.4%	26.5%	14.8%	45.1%	50.9%	16.0%	45.5%	25.6%
Change from Previous Quarter Results	-0.2%	1.8%	-0.1%	-4.8%	-23.1%	-3.1%	-8.8%	5.3%	15.0%	-1.3%	30.1%	-0.9%



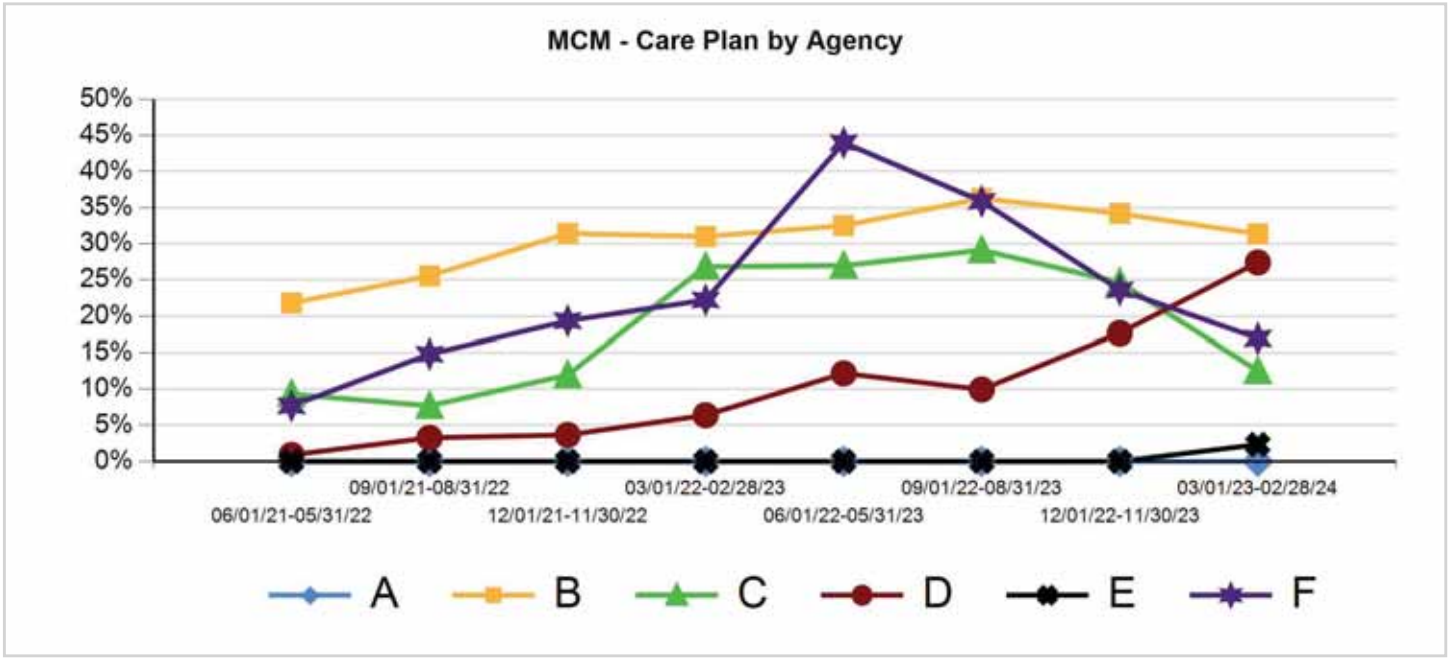
MCM - Care Plan				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator who had a medical case management care plan developed and/or updated two or more times at least three months apart in the measurement year	195	217	192	162
Number of medical case management clients living with HIV who had two or more medical case management encounters at least six months apart in the measurement year	914	835	781	643
Percentage	21.3%	26.0%	24.6%	25.2%
Change from Previous Quarter Results	6.1%	4.7%	-1.4%	0.6%



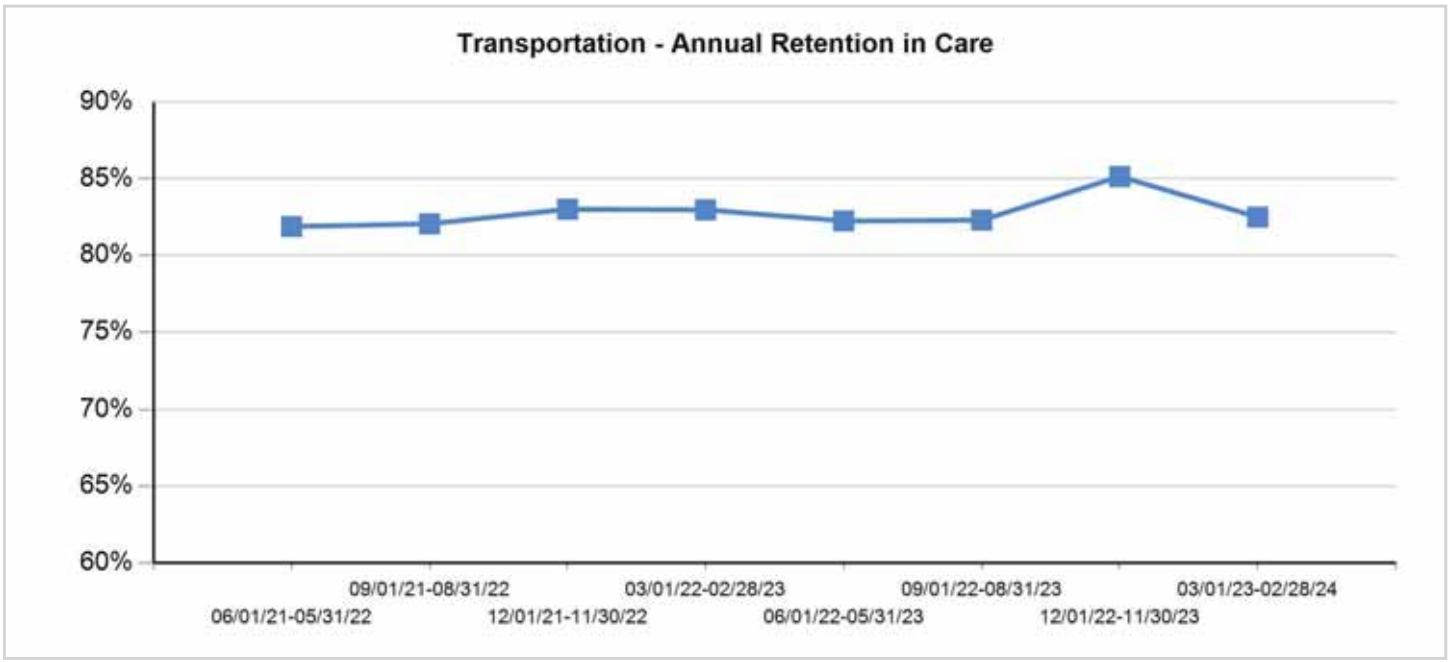
MCM - Care Plan by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who had a medical case management care plan developed and/or updated two or more times at least three months apart in the measurement year	137	49	22	117	43	27	91	40	28
Number of medical case management clients living with HIV who had two or more medical case management encounters at least six months apart in the measurement year	496	212	110	474	202	93	391	158	85
Percentage	27.6%	23.1%	20.0%	24.7%	21.3%	29.0%	23.3%	25.3%	32.9%
Change from Previous Quarter Results	3.2%	5.8%	6.3%	-2.9%	-1.8%	9.0%	-1.4%	4.0%	3.9%



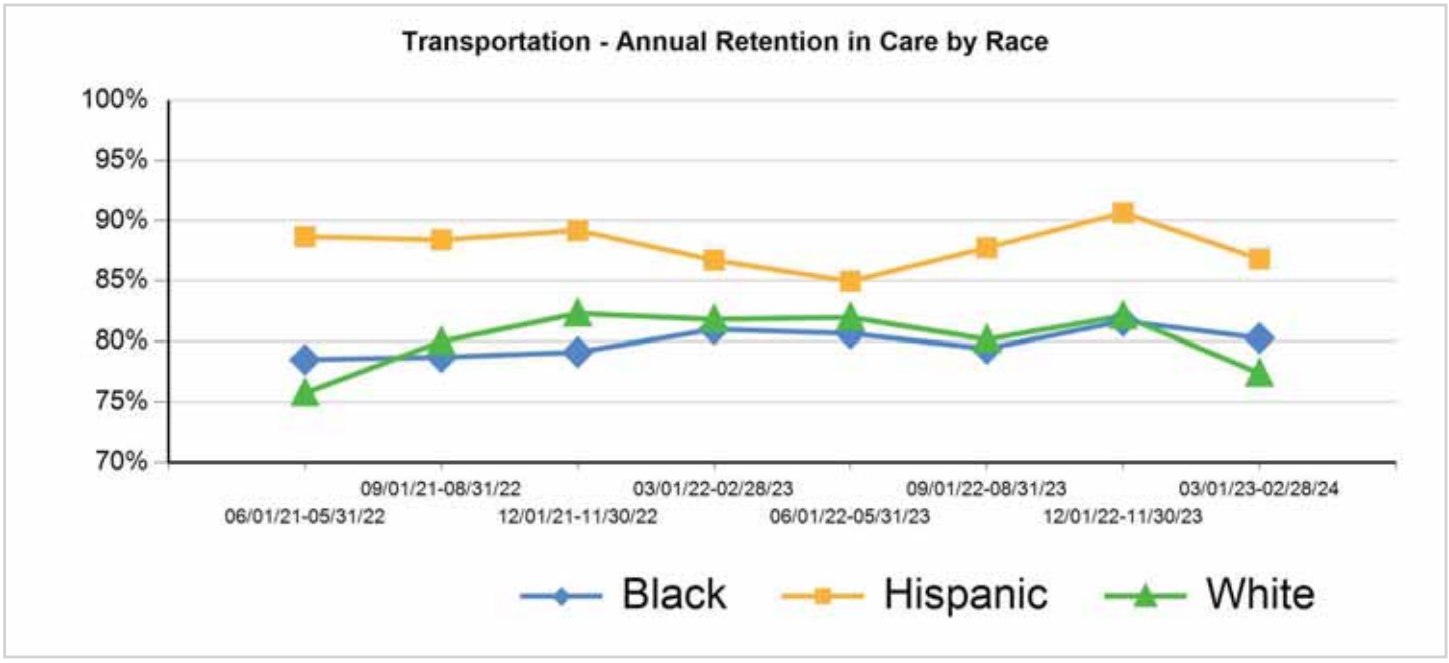
MCM - Care Plan by Agency												
	12/01/22 - 11/30/23						03/01/23 - 02/28/24					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who had a medical case management care plan developed and/or updated two or more times at least three months apart in the measurement year	0	94	17	35	0	17	0	85	3	37	1	10
Number of medical case management clients living with HIV who had two or more medical case management encounters at least six months apart in the measurement year	31	275	69	198	30	72	13	271	24	135	43	59
Percentage	0.0%	34.2%	24.6%	17.7%	0.0%	23.6%	0.0%	31.4%	12.5%	27.4%	2.3%	16.9%
Change from Previous Quarter Results	0.0%	-2.1%	-4.5%	7.7%	0.0%	-12.3%	0.0%	-2.8%	-12.1%	9.7%	2.3%	-6.7%



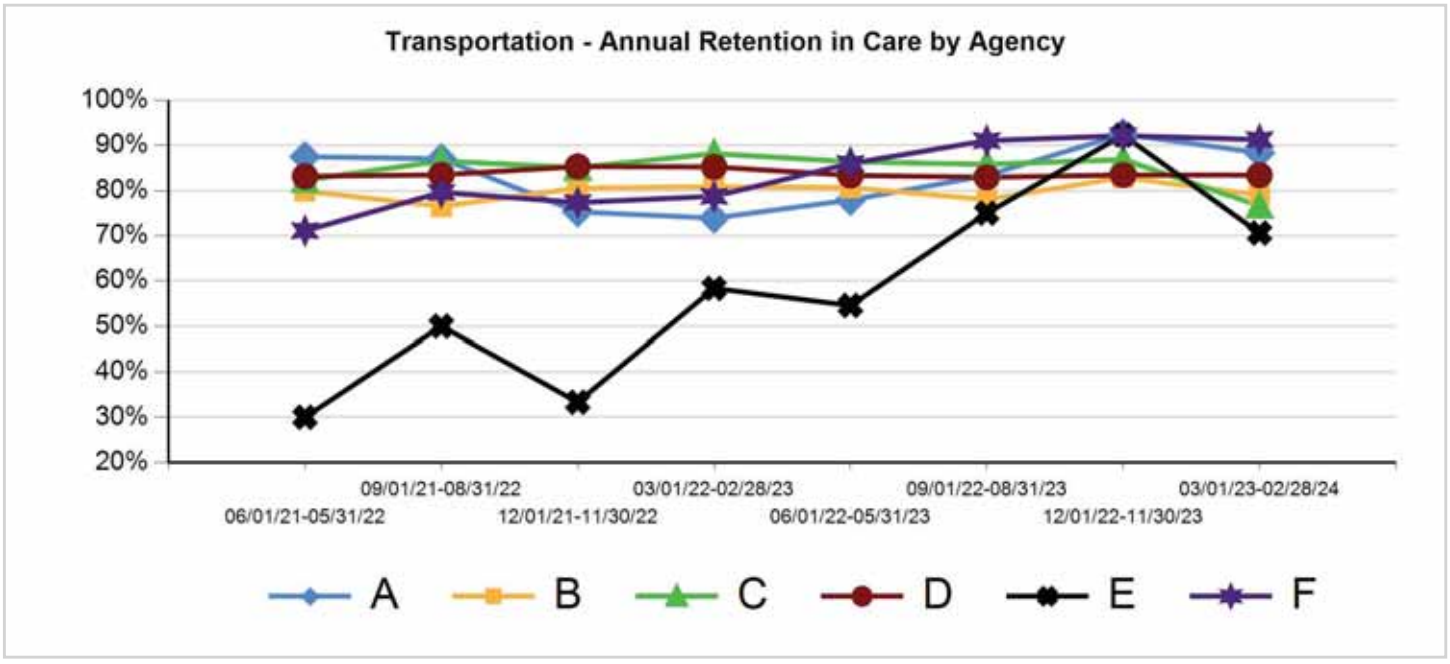
Transportation - Annual Retention in Care				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	1,005	939	854	773
Number of medical transportation clients living with HIV[1] who had at least one HIV medical encounter within the measurement year	1,222	1,141	1,003	937
Percentage	82.2%	82.3%	85.1%	82.5%
Change from Previous Quarter Results	-0.7%	0.1%	2.8%	-2.6%



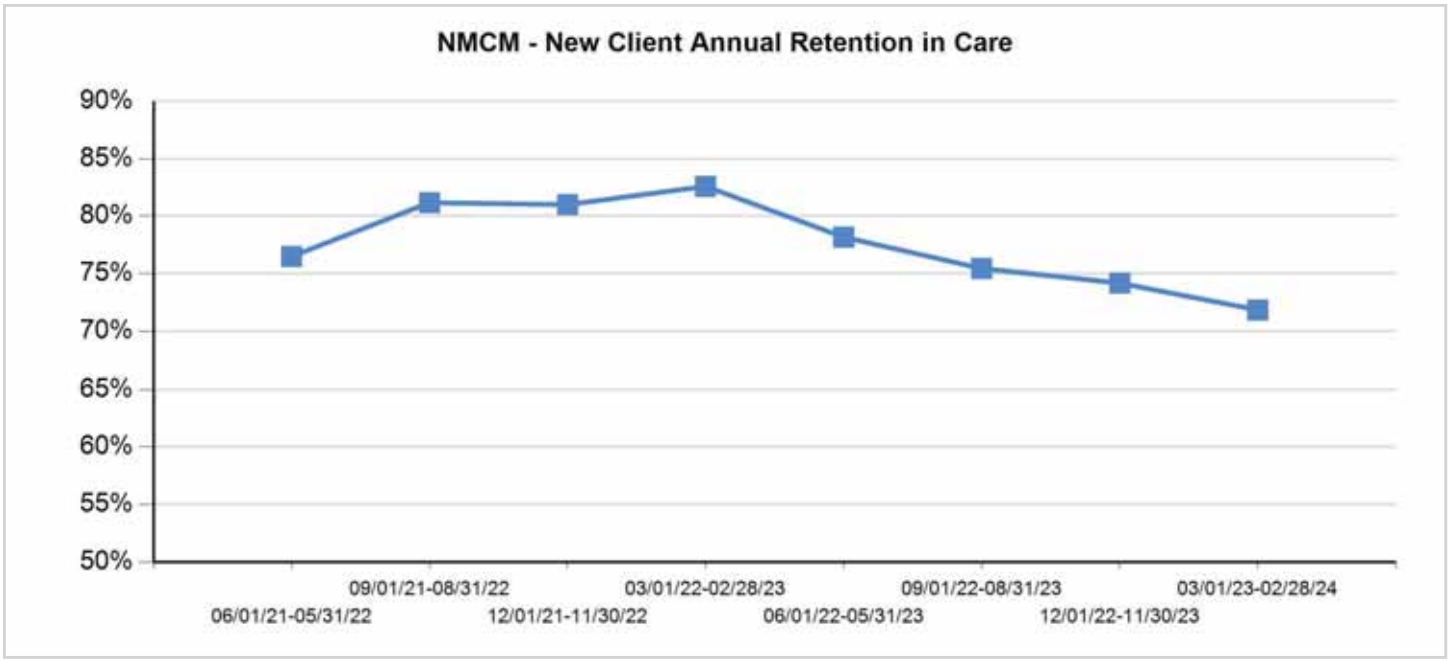
Transportation - Annual Retention in Care by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	486	344	89	437	320	78	399	290	65
Number of medical transportation clients living with HIV[1] who had at least one HIV medical encounter within the measurement year	612	392	111	535	353	95	497	334	84
Percentage	79.4%	87.8%	80.2%	81.7%	90.7%	82.1%	80.3%	86.8%	77.4%
Change from Previous Quarter Results	-1.3%	2.8%	-1.8%	2.3%	2.9%	1.9%	-1.4%	-3.8%	-4.7%



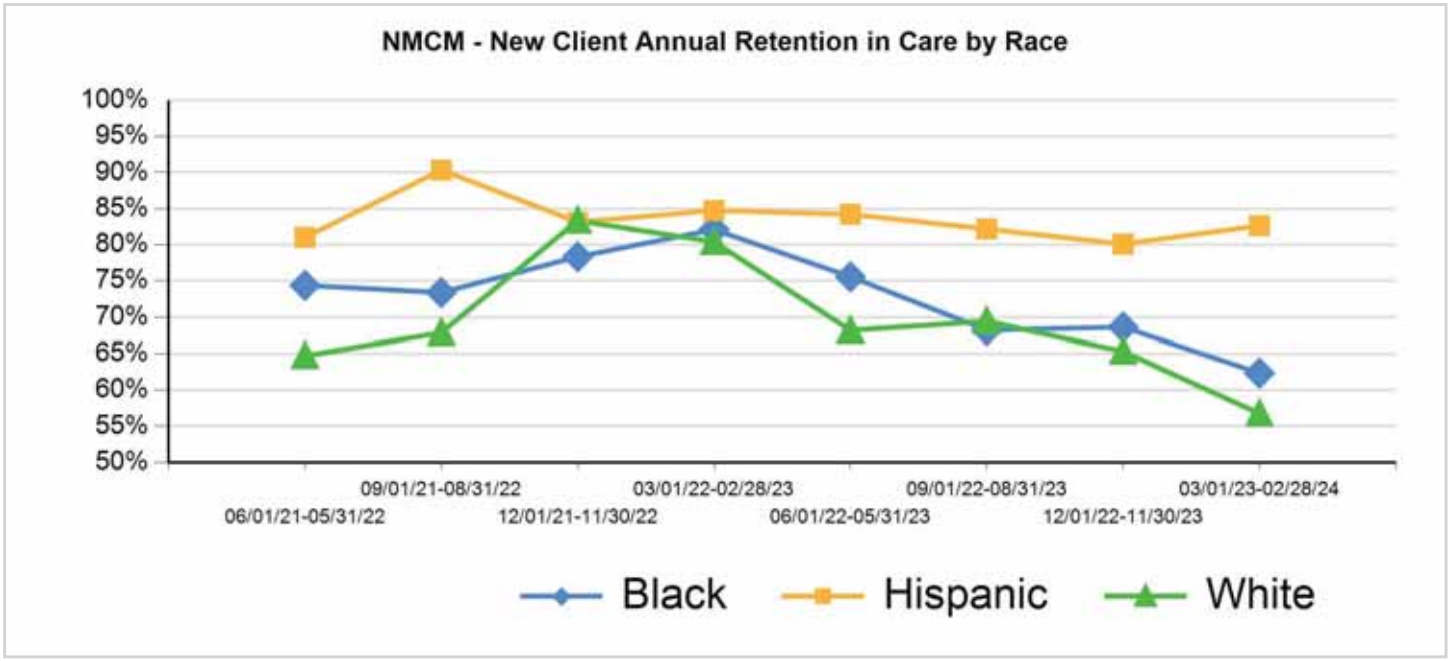
Transportation - Annual Retention in Care by Agency												
	12/01/22 - 11/30/23						03/01/23 - 02/28/24					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	62	282	119	338	12	47	53	237	82	347	12	42
Number of medical transportation clients living with HIV[1] who had at least one HIV medical encounter within the measurement year	67	340	137	405	13	51	60	300	107	416	17	46
Percentage	92.5%	82.9%	86.9%	83.5%	92.3%	92.2%	88.3%	79.0%	76.6%	83.4%	70.6%	91.3%
Change from Previous Quarter Results	9.2%	4.9%	1.1%	0.5%	17.3%	1.1%	-4.2%	-3.9%	-10.2%	0.0%	-21.7%	-0.9%



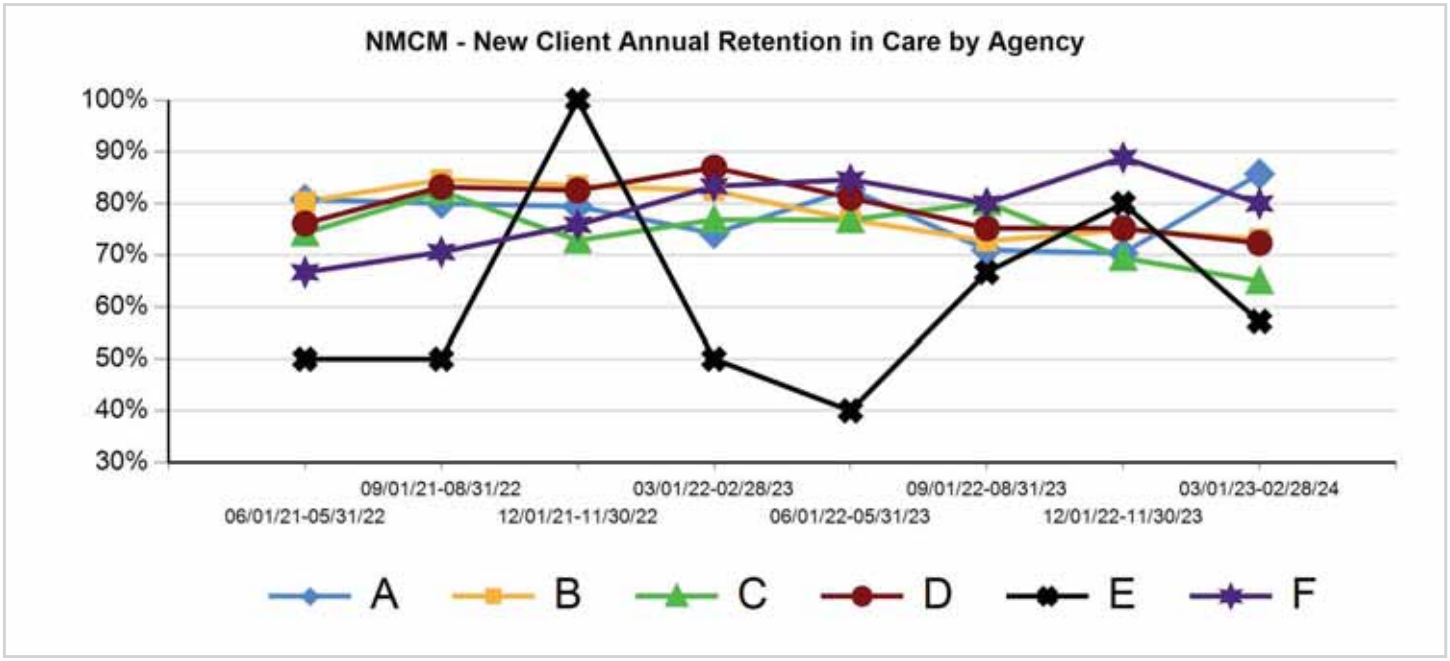
NMCM - New Client Annual Retention in Care				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	308	295	313	278
Number of non-medical case management clients living with HIV who had their first HIV medical encounter within the first six months of the measurement year	394	391	422	387
Percentage	78.2%	75.4%	74.2%	71.8%
Change from Previous Quarter Results	-4.4%	-2.7%	-1.3%	-2.3%



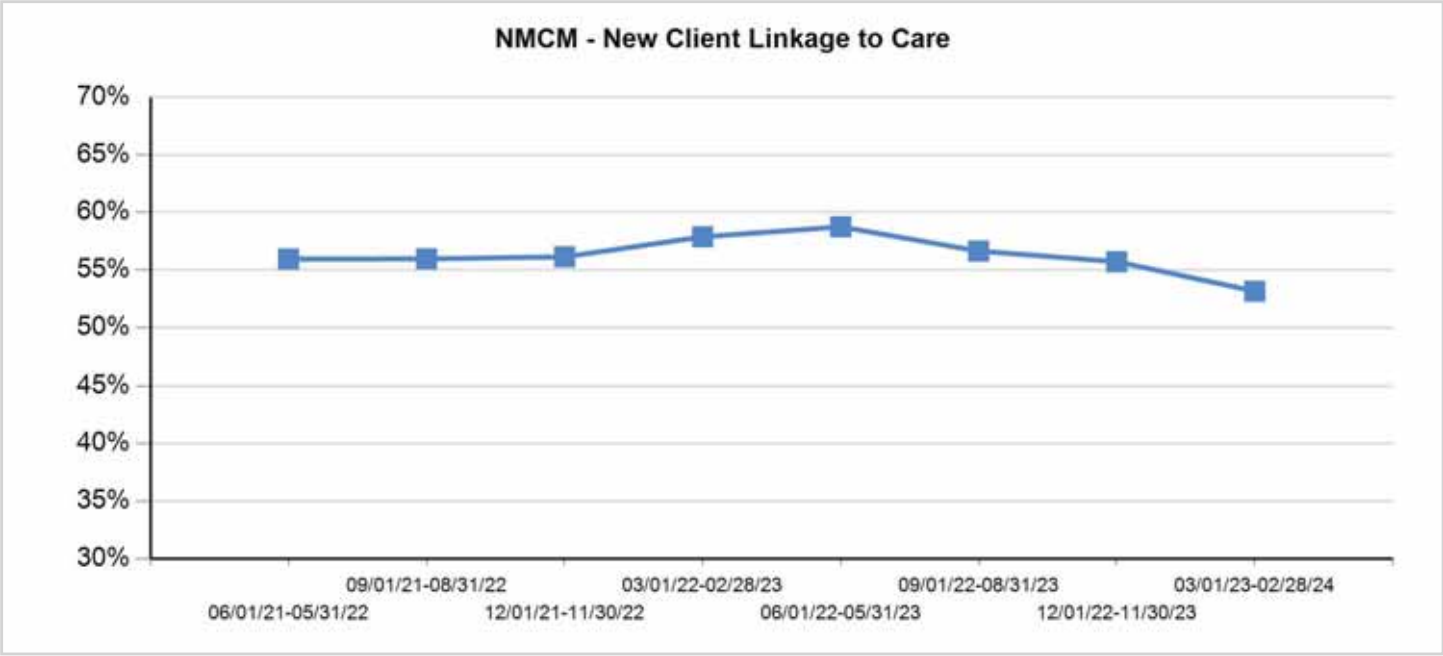
NMCM - New Client Annual Retention in Care by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	103	166	25	105	173	32	96	157	21
Number of non-medical case management clients living with HIV who had their first HIV medical encounter within the first six months of the measurement year	151	202	36	153	216	49	154	190	37
Percentage	68.2%	82.2%	69.4%	68.6%	80.1%	65.3%	62.3%	82.6%	56.8%
Change from Previous Quarter Results	-7.4%	-2.0%	1.3%	0.4%	-2.1%	-4.1%	-6.3%	2.5%	-8.5%



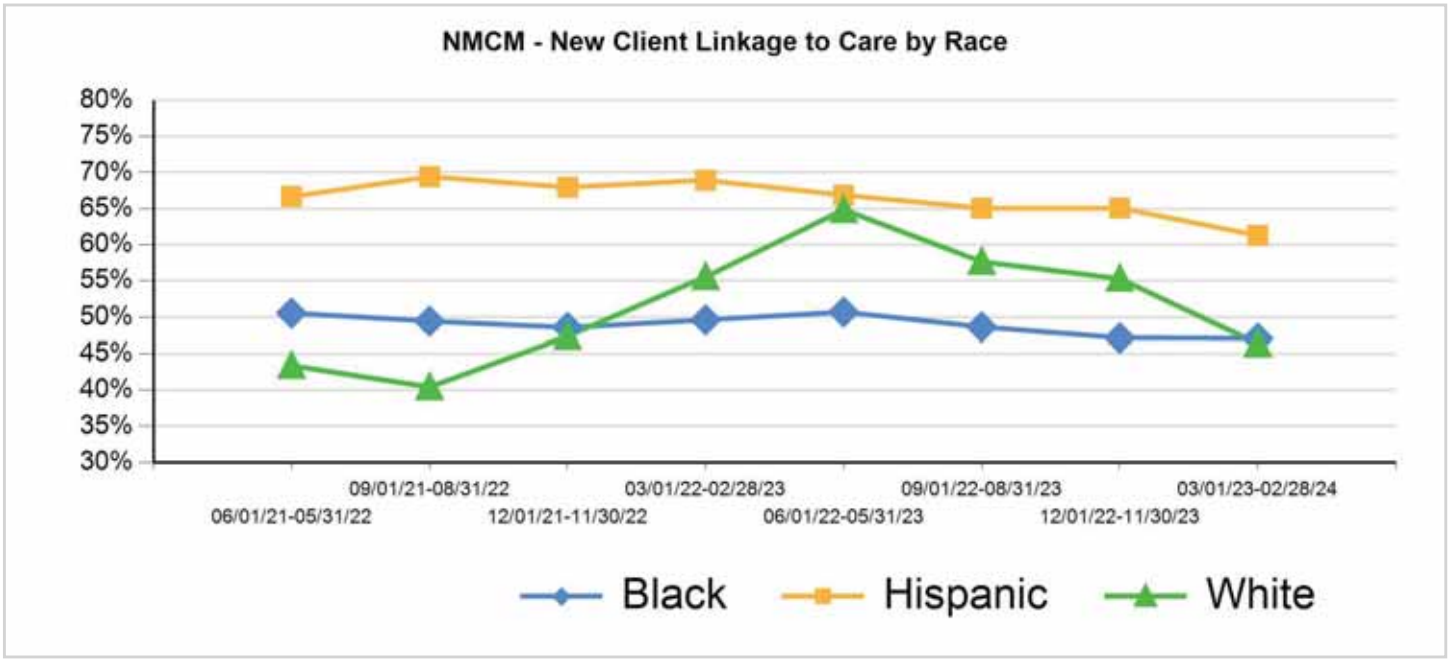
NMCM - New Client Annual Retention in Care by Agency												
	12/01/22 - 11/30/23						03/01/23 - 02/28/24					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	19	110	75	97	4	24	12	98	63	81	4	36
Number of non-medical case management clients living with HIV who had their first HIV medical encounter within the first six months of the measurement year	27	147	108	129	5	27	14	134	97	112	7	45
Percentage	70.4%	74.8%	69.4%	75.2%	80.0%	88.9%	85.7%	73.1%	64.9%	72.3%	57.1%	80.0%
Change from Previous Quarter Results	-0.6%	2.1%	-10.8%	0.0%	13.3%	8.9%	15.3%	-1.7%	-4.5%	-2.9%	-22.9%	-8.9%



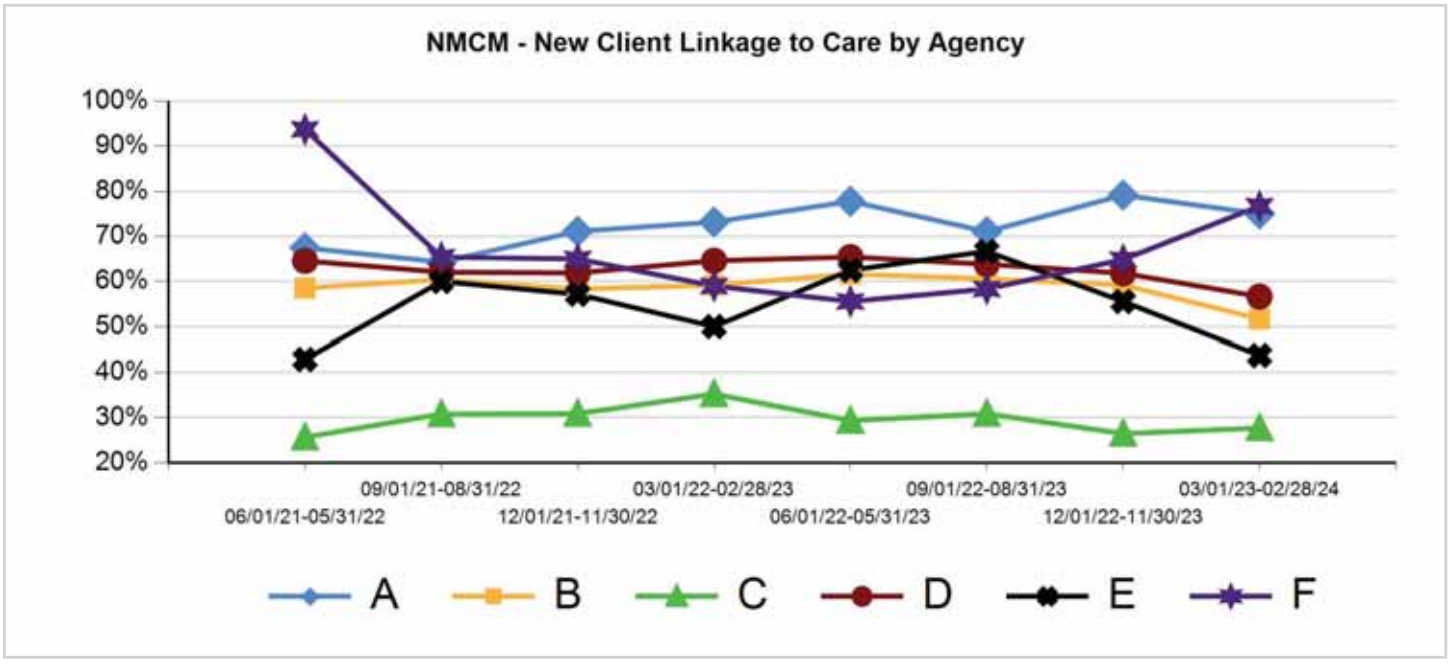
NMCM - New Client Linkage to Care				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator who attended a medical care visit within 30 days of a non-medical case management visit	467	448	434	422
Number of newly-enrolled clients living with HIV who had an initial non-medical case management encounter in the measurement year	795	791	779	794
Percentage	58.7%	56.6%	55.7%	53.1%
Change from Previous Quarter Results	0.9%	-2.1%	-0.9%	-2.6%



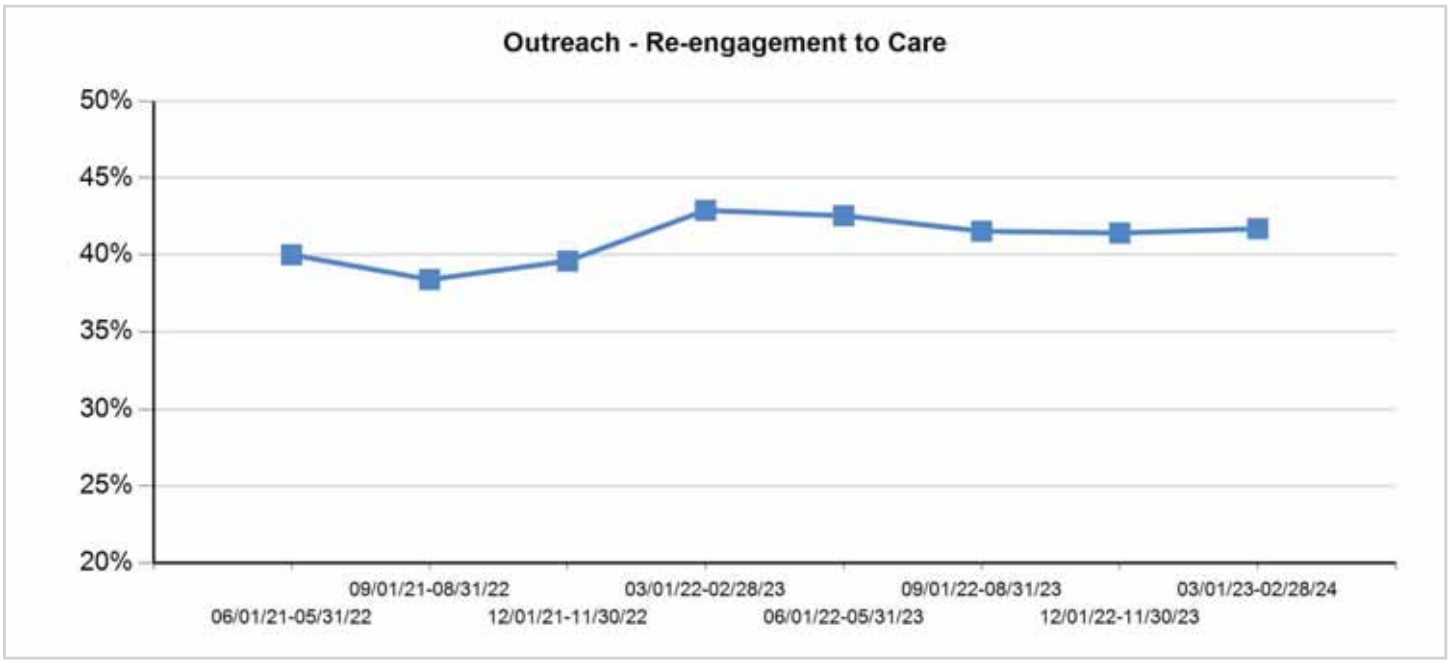
NMCM - New Client Linkage to Care by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who attended a medical care visit within 30 days of a non-medical case management visit	178	216	49	174	203	47	177	198	38
Number of newly-enrolled clients living with HIV who had an initial non-medical case management encounter in the measurement year	366	332	85	369	312	85	376	323	82
Percentage	48.6%	65.1%	57.6%	47.2%	65.1%	55.3%	47.1%	61.3%	46.3%
Change from Previous Quarter Results	-2.1%	-1.8%	-7.2%	-1.5%	0.0%	-2.4%	-0.1%	-3.8%	-9.0%



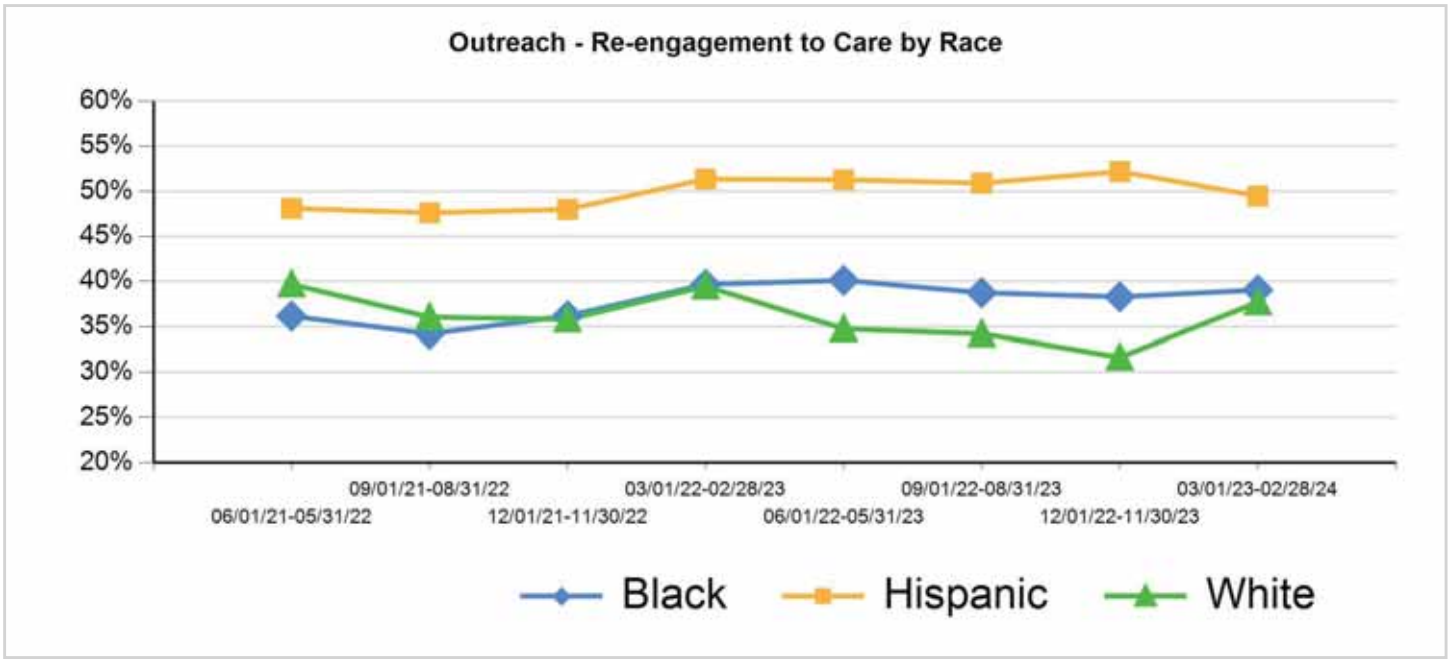
NMCM - New Client Linkage to Care by Agency												
	12/01/22 - 11/30/23						03/01/23 - 02/28/24					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who attended a medical care visit within 30 days of a non-medical case management visit	19	219	23	149	5	24	12	197	18	132	7	56
Number of newly-enrolled clients living with HIV who had an initial non-medical case management encounter in the measurement year	24	370	87	241	9	37	16	381	65	233	16	73
Percentage	79.2%	59.2%	26.4%	61.8%	55.6%	64.9%	75.0%	51.7%	27.7%	56.7%	43.8%	76.7%
Change from Previous Quarter Results	8.1%	-1.4%	-4.4%	-2.0%	-11.1%	6.5%	-4.2%	-7.5%	1.3%	-5.2%	-11.8%	11.8%



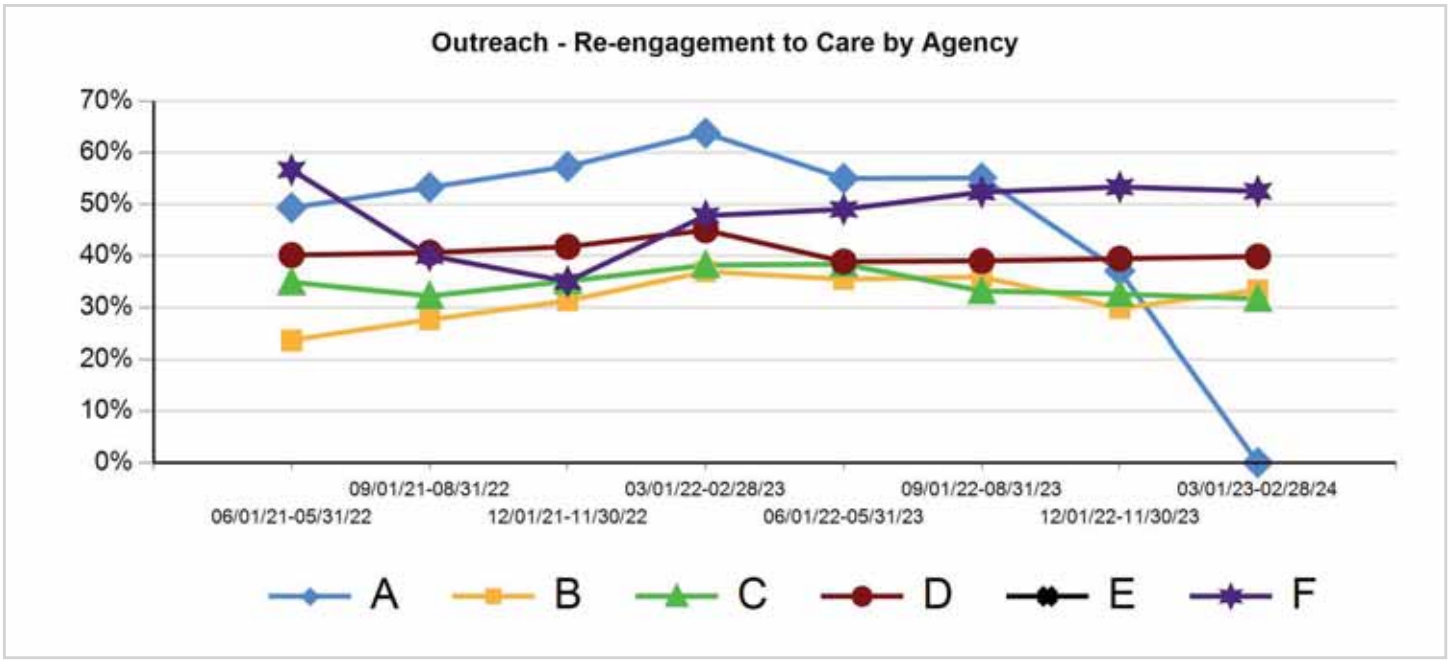
Outreach - Re-engagement to Care				
	06/01/22 - 05/31/23	09/01/22 - 08/31/23	12/01/22 - 11/30/23	03/01/23 - 02/28/24
Number of clients in the denominator who had at least one HIV medical care visit within 90 days of Outreach visit	391	427	408	304
Number of clients living with HIV who had at least one Outreach encounter within the measurement year	919	1,028	985	729
Percentage	42.5%	41.5%	41.4%	41.7%
Change from Previous Quarter Results	-0.4%	-1.0%	-0.1%	0.3%



Outreach - Re-engagement to Care by Race/Ethnicity									
	09/01/22 - 08/31/23			12/01/22 - 11/30/23			03/01/23 - 02/28/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who had at least one HIV medical care visit within 90 days of Outreach visit	239	142	39	237	132	31	178	93	26
Number of clients living with HIV who had at least one Outreach encounter within the measurement year	617	279	114	619	253	98	456	188	69
Percentage	38.7%	50.9%	34.2%	38.3%	52.2%	31.6%	39.0%	49.5%	37.7%
Change from Previous Quarter Results	-1.4%	-0.4%	-0.5%	-0.4%	1.3%	-2.6%	0.7%	-2.7%	6.0%



Outreach - Re-engagement to Care by Agency												
	12/01/22 - 11/30/23						03/01/23 - 02/28/24					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who had at least one HIV medical care visit within 90 days of Outreach visit	10	14	97	160	0	112	0	28	62	100	0	104
Number of clients living with HIV who had at least one Outreach encounter within the measurement year	27	47	298	406	0	210	1	84	196	251	0	198
Percentage	37.0%	29.8%	32.6%	39.4%	NaN	53.3%	0.0%	33.3%	31.6%	39.8%	NaN	52.5%
Change from Previous Quarter Results	-18.1%	-6.1%	-0.6%	0.4%	NaN	1.0%	-37.0%	3.5%	-0.9%	0.4%	NaN	-0.8%



Footnotes:
1. Table/Chart data for this report run was taken from "ABR197 v1.1"

2024-2025 HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE Care ACT PART A
STANDARDS OF CARE FOR HIV SERVICES
RYAN WHITE GRANT ADMINISTRATION SECTION
HARRIS COUNTY PUBLIC HEALTH (HCPH)

TABLE OF CONTENTS

Introduction

According to the Joint Commission (2008)[1], a standard is a "statement that defines performance expectations, structures, or processes that must be in place for an organization to provide safe, high-quality care, treatment, and services". Standards are developed by subject experts and are usually the minimal acceptable level of quality in service delivery. The Houston EMA Ryan White Grant Administration (RWGA) Standards of Care (SOCs) are based on multiple sources including RWGA on-site program monitoring results, consumer input, the US Public Health Services guidelines, Centers for Medicare and Medicaid Conditions of Participation (COP) for health care facilities, Joint Commission accreditation standards, the Texas Administrative Code, Center for Substance Abuse and Treatment (CSAT) guidelines and other federal, state and local regulations.

Purpose

The purpose of the Ryan White Part A SOCs is to determine the minimal acceptable levels of quality in service delivery and to provide a measurement of the effectiveness of services.

Scope

The Houston EMA SOCs apply to Part A funded HRSA defined core and support services including the following services in FY 2024-2025:

- *Primary Medical Care*
- *Vision Care*
- *Medical Case Management*
- *Clinical Case Management*
- *Local AIDS Pharmaceutical Assistance Program (LPAP)*
- *Oral Health*
- ***Health Insurance Assistance***
- Hospice Care
- Mental Health Services
- *Substance Abuse services*
- Home & Community Based Services (Facility-Based)
- Early Intervention Services
- *Medical Nutrition Supplement*
- *Outreach*
- *Non-Medical Case Management (Service Linkage)*
- *Transportation*
- Linguistic Services
- *Emergency Financial Assistance*
- *Emergency Financial Assistance (Other)*
- Referral for Healthcare & Support Services

Part A funded services
Combination of Parts A, B, and/or Services funding

Standards Development

The first group of standards was developed in 1999 following HRSA requirements for sub grantees to implement monitoring systems to ensure subcontractors complied with contract requirements. Subsequently, the RWGA facilitates annual work group meetings to review the standards and to make applicable changes. Workgroup participants include physicians, nurses, case managers and executive staff from subcontractor agencies as well as consumers.

Organization of the SOCs

The standards cover all aspect of service delivery for all funded service categories. Some standards are consistent across all service categories and therefore are classified under general standards. These include:

- Staff requirements, training and supervision
- Client rights and confidentiality
- Agency and staff licensure
- Emergency Management

The RWGA funds three case management models. Unique requirements for all three case management service categories have been classified under Service Specific SOCs "Case Management (All Service Categories)". Specific service requirements have been discussed under each service category. All new and/or revised standards are effective at the beginning of the fiscal year.

[1] The Joint Commission (formerly known as Joint Commission on Accreditation of Healthcare Organization (2008)). Comprehensive accreditation manual for ambulatory care; Glossary

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Review of personnel and/or volunteer files indicates compliance.
1.2	Initial Training: Staff/Volunteers Initial training includes eight (8) hours of: HIV basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers (e.g., job description), agency-specific information (e.g., Drug Free Workplace policy) and customer service training must be completed within 60 days of hire. https://www.sba.gov/course/customer-service/	• Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure. • Materials for staff training and continuing education are on file. • Staff interviews indicate compliance.
1.3	Staff Performance Evaluation Agency will perform annual staff performance evaluation.	• Completed annual performance evaluation kept in employee's file. • Signed and dated by employee and supervisor (includes electronic signature).
1.4	Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers All staff tenured 0 – 5 years with their current employer must receive four (4) hours of cultural competency training to include information on working with people of all races, ethnicities, nationalities, gender identities, and sexual orientations and an	• Documentation of training is maintained by the agency in the personnel file.

	additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire. All staff with greater than 5 years with their current employer must receive two (2) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually.	
1.5	Staff education on eligibility determination and fee schedule Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All new employees must complete within ninety (90) days of hire.	• Documentation of training in employee's record.
2.0	**Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.**	
2.1	Service Evaluation Agency has a process in place for the evaluation of client services.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Staff interviews indicate compliance.
2.2	Subcontractor Monitoring Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and standards Reviewed Annually	• Documentation of subcontractor monitoring. • Review of Agency's Policies and Procedures Manual indicates compliance.
2.3	Staff Guidelines Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and termination process, and position descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights; staff must review these guidelines annually.	• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed, and that the employee understands agency policies and procedures.

2.4	Work Conditions Staff/volunteers have the necessary tools, supplies, equipment, and space to accomplish their work.	• Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply. • Staff interviews indicate compliance.
2.5	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance. • Review of Agency's Policies and Procedures Manual indicates compliance.
2.6	Professional Behavior Staff must comply with written standards of professional behavior.	• Staff guidelines include standards of professional behavior. • Review of Agency's Policies and Procedures Manual indicates compliance. • Review of personnel files indicates compliance. • Review of agency's complaint and grievance files.
2.7	Communication There are procedures in place regarding regular communication with staff about the program and general agency issues.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation of regular staff meetings. • Staff interviews indicate compliance.
2.8	Accountability There is a system in place to document staff work time.	• Staff time sheets or other documentation indicate compliance.
2.9	Staff Availability Staff are present to answer incoming calls during agency's normal operating hours.	• Published documentation of agency operating hours. • Staff time sheets or other documentation indicate compliance.

3.0	**Clients Rights and Responsibilities**	
3.1	Clients Rights and Responsibilities Agency reviews Client Rights and Responsibilities Statement with each client in a language and format the client understands. Agency provides client with written copy of client rights and responsibilities, including: • Informed consent • Confidentiality • Grievance procedures • Duty to warn or report certain behaviors. • Scope of service • Criteria for end of services	• Documentation in client's record.
3.2	Confidentiality Agency maintains Policy and Procedure regarding client confidentiality in accordance with RWGA site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency. There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Client's interview indicates compliance. • Agency's structural layout and information management indicates compliance. • Signed confidentiality statement in each employee's personnel file.
3.3	Consents All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether or not HIV status is revealed.	• Agency Policy and Procedure and signed and dated consent forms in client record.
3.4	Up to date Release of Information Agency obtains an informed written consent of the client or legally responsible person prior to the disclosure or exchange of certain information about client's case to another party (including family members) in accordance with the RWGA Site Visit Guidelines, local, state and federal laws. The release/exchange consent form must contain:	• Current Release of Information form with all the required elements signed by client or authorized person in client's record.

	• Name of the person or entity permitted to make the disclosure. • Name of the client • The purpose of the disclosure • The types of information to be disclosed. • Entities to disclose to • Date on which the consent is signed. • The expiration date of client authorization (or expiration event) no longer than two years. • Signature of the client/or parent, guardian or person authorized to sign in lieu of the client. • Description of the *Release of Information*, its components, and ways the client can nullify it. Release/exchange of information forms must be completed entirely in the presence of the client. Any unused lines must have a line crossed through the space.	
3.5	<u>Grievance Procedure</u> Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to: • To whom complaints can be made. • Steps necessary to complain. • Form of grievance if any. • Timelines and steps taken by the agency to resolve the grievance. • Documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client. • All complaints or grievances initiated by clients are documented on the Agency's standardized form. • Resolution of each grievance/complaint is documented on the Standardized form and shared with client. • Confidentiality of grievance • Addresses and phone numbers of licensing authorities and funding sources.	• Signed receipt of agency Grievance Procedure, filed in client chart. • Review of Agency's Policies and Procedures Manual indicates compliance. • Review of Agency's Grievance file indicates compliance. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2

	• Language outlining that clients cannot be retaliated against for filing grievances.	
3.6	<u>Conditions Under Which Discharge/Closure May Occur</u> A client may be discharged from Ryan White funded services for the following reasons. • Death of the client • At the client's or legal guardian request • Changes in client's need which indicates services from another agency. • Fraudulent claims or documentation about HIV diagnosis by the client. • Client actions put the agency, case manager or other clients at risk. Documented supervisory review is required when a client is terminated or suspended from services due to behavioral issues. • Client moves out of service area, enters jail, or cannot be contacted for sixty (60) days. Agency must document three (3) attempts to contact clients by more than one method (e.g., phone, mail, email, text message, in person via home visit). • Client service plan is completed, and no additional needs are identified. Client must be provided a written notice prior to involuntary termination of services (e.g., due to dangerous behavior, fraudulent claims, or documentation, etc.).	• Documentation in client record and in the Centralized Patient Care Data Management System. • A copy of written notice and a certified mail receipt for involuntary termination.
3.7	<u>Client Closure</u> A summary progress note is completed in accordance with Site Visit Guidelines within three (3) working days of closure, including: • Date and reason for discharge/closure • Summary of all services received by the client and the client's response to services. • Referrals made and/or • Instructions given to the individual at discharge (when applicable).	• Documentation in client record and in the Centralized Patient Care Data Management System.
3.8	<u>Client Feedback</u> In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually). Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may	• Documentation of clients' evaluation of services is maintained. • Documentation of CAB and public meeting minutes.

	include client satisfaction surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB). • Agencies that serve an average of 100 or more unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.	• Documentation of existence and appropriateness of a suggestion box or other client input mechanism. • Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1
3.9	Patient Safety (Core Services Only) Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation *for Ambulatory Care* (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable: • "Improve the accuracy of patient identification. • Improve the safety of using medications. • Reduce the risk of healthcare-associated infections. • Accurately and completely reconcile medications across the continuum of care. • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (www.jointcommission.org)	• Review of Agency's Policies and Procedures Manual indicates compliance.
3.10	Client Records Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance.
4.0	**Accessibility**	
4.1	Cultural Competence Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals and people of all gender identities and sexual orientations.	• Agency has procedures for obtaining translation services. • Client satisfaction survey indicates compliance.

		• Policies and procedures demonstrate commitment to the community and culture of the clients. • Availability of interpretive services, bilingual staff, and staff trained in cultural competence. • Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record. • Agency has facilities available for consumers of all gender identities, including gender-neutral restrooms.
4.2	Client Education Agency demonstrates capacity for client education and provision of information on community resources.	• Availability of the blue book and other educational materials. • Documentation of educational needs assessment and client education in clients' records.
4.3	Special Service Needs Agency demonstrates a commitment to assisting individuals with special needs.	• Agency compliance with the Americans with Disabilities Act (ADA). • Review of Policies and Procedures indicates compliance. • Environmental Review shows a facility that is handicapped accessible.
4.4	Provision of Services for Low-Income Individuals Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low-income individuals.	• Facility is accessible by public transportation. • Review of Agency's Policies and Procedures Manual indicates compliance. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4

4.5	Proof of HIV Diagnosis Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services. An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3
4.6	Provision of Services Regardless of Current or Past Health Condition Agency must have Policies and Procedures in place to ensure that clients living with HIV are not denied services due to current or pre-existing health condition or non-HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	• Review of Policies and Procedures indicates compliance. • A file containing information on clients who have been refused services and the reasons for refusal. • Source Citation: HAB Program Standards; Section D: #1
4.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.) • Income no greater than 300% of the Federal Poverty level (unless otherwise indicated) • Proof of identification • Ineligibility for third party reimbursement	• Documentation of HIV+ status, residence, identification, and income in the client record. • Documentation of ineligibility for third party reimbursement. • Documentation of screening for Third Party Payers in accordance with RWGA site visit guidelines. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B: Eligibility Determination/Screening #1
4.8	Re-certification of Client Eligibility Appropriate documentation is required for changes in status and at least once a year (defined as a 12-month period) with renewed eligibility with the CPCDMS. At a minimum, agency confirms an individual's income, residency and re-screens, as appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance.	• Client record contains documentation of re-certification of client residence, income, and rescreening for third party payers at least every twelve (12) months. • Review of Policies and Procedures indicates compliance.

	Agency must ensure that Ryan White is the Payer of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance and other programs. Agency policy must also address coordination of benefits, billing and collection. Clients eligible for Department of Veterans Affairs (VA) benefits are duly eligible for Ryan White services and therefore exempted from the payer of last resort requirement. • Agency must verify 3rd party payment coverage for eligible services at every visit or monthly (whichever is less frequent).	• Information in client's files that includes proof of screening for insurance coverage (i.e., hard/scanned copy of results). • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B: Eligibility Determination/Screening #1 and #2 • Source Citation: HIV/AIDS Bureau (HAB) Policy Clarification Notice #13-02
4.9	<u>Charges for Services</u> Agency must institute Policies and Procedures for cost sharing including enrollment fees, premiums, deductibles, co-payments, co-insurance, sliding fee discount, etc. and an annual cap on these charges. Agency should not charge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross income level (GIL)is ≤ 100% of the Federal Poverty Level (FPL) as documented in the CPCDMS for any services provided. Clients whose gross income is between 101-300% may be charged annual aggregate fees in accordance with the legislative mandate outlined below: • 101%-200% of FPL---5% or less of GIL • 201%-300% of FPL---7% or less of GIL • >300% of FPL ---------10% or less of GIL Additionally, agency must implement the following: • Six (6) month evaluation of clients to establish individual fees and cap (i.e., the six (6) month CPCDMS registration or registration update.) • Tracking of charges • A process for alerting the billing system when the cap is reached so client will not be charged for the rest of the calendar year. • Documentation of fees	• Review of Policies and Procedures indicates compliance. • Review of system for tracking patient charges and payments indicate compliance. • Review of charges and payments in client records indicate compliance with annual cap. • Sliding fee application forms on client record is consistent with Federal guidelines.
4.9b	Provision of services regardless of an individual's ability to pay for the service. Subgrantee billing and collection policies and procedures do not: • Deny services for non-payment. • Deny payment for inability to produce income documentation. • Require full payment prior to service.	

	Include any other procedure that denies services for non-payment	
4.10	<u>Information on Program and Eligibility/Sliding Fee Schedule</u> Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update. Agency should maintain a file documenting promotion activity including copies of HIV program materials and information on eligibility requirements. Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	• Agency has a written substantiated annual plan to targeted populations. • Zip code data show provider is reaching clients throughout service area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5
4.11	<u>Linkage Into Core Services</u> Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.	• Documentation of client referral is present in client record. • Review of agency's policies & procedures' manual indicates compliance
4.12	<u>Wait Lists</u> It is the expectation that clients will not be put on a Wait List, nor will services be postponed or denied. Agency must notify the administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation that agency notified their Administrative Agency when

	which client information will be obtained and maintained to ensure that all clients that requested service(s) are contacted after service provision resumes. A wait list is defined as a roster developed and maintained by providers of patients awaiting a particular service when a demand for a service exceeds available appointments used on a first come next serviced method. The Agency will notify RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and a plan for resumption of service. The Agency's plan must address: • Action steps to be taken Agency to resolve the service shortfall; and • Projected date that services will resume. The Agency will report to RWGA in writing on a monthly basis while a client wait list is required with the following information: • Number of clients on the wait list. • Progress toward completing the plan for resumption of service. • A revised plan for resumption of service, if necessary.	funds for services were either low or exhausted.
4.13	<u>Intake</u> The agency conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions. In addition to office visits, client is provided alternatives such as conducting business by mail, online registration via the internet, or providing home visits, when necessary. Agency has established procedures for communicating with people with hearing impairments.	• Documentation in client record. • Review of Agency's Policies and Procedures Manual indicates compliance.
5.0	**Quality Management**	

5.1	Continuous Quality Improvement (CQI) Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum: • The Agency's QM Plan • Meeting agendas and/or notes (if applicable) • Project specific CQI Plans • Root Cause Analysis & Improvement Plans • Data collection methods and analysis • Work products • QM program evaluation • Materials necessary for QM activities	• Review of Agency's Policies and Procedures Manual indicates compliance. • Up-to-date QM Manual • Source Citation: HAB Universal Standards; Section F: #2
5.2	Data Collection and Analysis Agency demonstrates capacity to collect and analyze client level data including client satisfaction surveys and findings are incorporated into service delivery. Supervisors shall conduct and document ongoing record reviews as part of quality improvement activity.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Up to date QM Manual • Supervisors log on record reviews signed and dated. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2
6.0	**Point Of Entry Agreements**	
6.1	Points of Entry (Core Services Only) Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with HIV Services policy approved by HRSA for the Houston EMA.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation of formal agreements with appropriate Points of Entry. • Documentation of referrals and their follow-up.

7.0	**Emergency Management**	
7.1	Emergency Preparedness Agency leadership including medical staff must develop an Emergency Preparedness Plan modeled after the Joint Commission's regulations and/or Centers for Medicare and Medicaid guidelines for Emergency Management. The plan should, at a minimum utilize "all hazard approach" (hurricanes, floods, earthquakes, tornadoes, wide-spread fires, infectious disease outbreak and other public health threats, terrorist attacks, civil disturbances and collapse of buildings and bridges) to ensure a level of preparedness sufficient to support a range of emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergency. The agency shall communicate hazards identified with its community emergency response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	• Emergency Preparedness Plan • Review of Agency's Policies and Procedures Manual indicates compliance.
7.2	Emergency Management Training In accordance with the Department of Human Services recommendations, all applicable agency staff (such as, executive level, direct client services, supervisory staff) must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security: -IS-100.C: Introduction to the Incident Command System, ICS 100 -IS-200.C: Basic Incident Command System for Initial Response -IS-700.B: An Introduction to the National Incident Management System -IS-800.D: National Response Framework, An Introduction The above courses may be accessed at: training.fema.gov/nims/ . Agencies providing support services only may complete alternate courses listed for the above areas. All applicable new employees are required to complete the courses within 90 days of hire.	• Agency criteria used to determine appropriate staff for training requirement. • Documentation of all training including certificate of completion in personnel file.

7.3	Emergency Preparedness Plan The emergency preparedness plan shall address the six critical areas for emergency management including: • Communication pathways (for both clients and staff) • Essential resources and assets • patients' safety and security • staff responsibilities • Supply of key utilities such as portable water and electricity. • Patient clinical and support activities during emergency situations. (http://www.jointcommission.org/)	• Emergency Preparedness Plan
7.4	Emergency Management Drills Agency shall implement emergency management drills twice a year either in response to actual emergency or in a planned exercise. Completed exercise should be evaluated by a multidisciplinary team including administration, clinical and support staff. The emergency plan should be modified based on the evaluation results and retested.	• Emergency Management Plan • Review of Agency's Policies and Procedures Manual indicates compliance.
8.0	**Building Safety**	
8.1	Required Permits All agencies will maintain Occupancy and Fire Marshal's permits for the facilities.	• Current required permits on file.

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

Case management services in HIV care facilitate client access to health care services, assist clients to navigate through the wide array of health care programs, build rapport, provide supportive listening, and ensure coordination of services to meet the unique needs of People Living with HIV (PLWH). It also involves client assessment to determine client's needs and the development of individualized service plans in collaboration with the client to mitigate clients' needs. Ryan White Grant Administration funds three case management models i.e., one psychosocial and two clinical/medical models depending on the type of ambulatory service within which the case management service is located. The scope of these three case management models namely, Non-Medical, Clinical and Medical case management services are based on Ryan White HIV/AIDS Treatment Modernization Act of 2006 (HRSA)[2] definition for non-medical and medical case management services. Other resources utilized include the current *National Association of Social Workers (NASW) Standards for Social Work Case Management*[3]. Specific requirements for each of the models are described under each case management service category.

1.0	**Staff Training**	
1.1	Required Meetings Case Managers and Service Linkage Workers Case managers and Service Linkage Workers will attend on an annual basis a minimum of four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA. Case Managers and Service Linkage Workers will attend the "Joint Prevention and Care Coordination Meeting" held annually and facilitated by the RWGA and the City of Houston STD/HIV Bureau. Medical Case Management (MCM), Clinical Case Management (CCM) and Service Linkage Worker Supervisors will attend on an annual basis a minimum of five (5) of the six (6) bi-monthly Supervisor meetings facilitated by RWGA (in the event a MCM or CCM supervises SLW staff the MCM or CCM must attend the Supervisor meetings and may, as an option, attend the networking meetings)	• Agency will maintain verification of attendance (RWGA will also maintain sign-in logs).

1.2	Required Training for New Employees Within the first ninety (90) days of employment in the case management system, case managers will successfully complete HIV Care Coordination Training Curriculum, through the State of Texas TRAIN website https://www.dshs.texas.gov/hivstd/contractor/cm.shtm with a minimum of 70% accuracy. RWGA expects HIV Case Management 101 2013 Update, course completion to take no longer than 16 hours. Within the first six (6) months of employment, case managers will complete at least four (4) hours review of Community resources, and at least four (4) hours cultural competency training offered by RWGA. Mandatory Intimate Partner Violence Training is Required annually and during orientation for all Ryan White Part A funded, primary care co- located, case management staff (SLW, MCM, CCM). RWGA will host two (2) IPV training opportunities annually. Staff who provide field-based services should receive at least two (2) hours of field safety training within their first six (6) months of employment.	• Certificates of completion for applicable trainings in the case manager's file. • Sign-in sheets for agency-based trainings maintained by Agency. • RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum.
1.3	Certified Application Counselor (CAC) Training & Certification Within the first ninety (90) days of employment in the case management system, applicable case managers will successfully complete CAC training. Applicable case management staff must maintain CAC certification by their Certificated Application Counselor Designated Organization employer annually. RWGA expects CAC training completion to take no longer than 6 hours.	• Certificates of completion in case manager's file.
1.4	Case Management Supervisor Peer-led Training Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and Community (SLW) Case Managers must fully participate in the four (4) Case Management Supervisor Peer-Led three-hour training curriculum conducted by RWGA.	• Review of attendance sign-in sheet indicates compliance.

[2] US Department of Health and Human Services, Health Resources and Services Administration HIV or AIDS Bureau (2009). Ryan White HIV or AIDS Treatment Modernization Act of 2006: Definitions for eligible services

[3] National Association of Social Workers (2013). NASW standards for social work case management. Retrieved 12/28/2018 from https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3d&portalid=0

1.5	Child Abuse Screening, Documenting and Reporting Training Case Managers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient interaction.	• Documentation of staff training.
1.6	Warm Handoff Procedure Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e., medical case manager to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	• Agency has a warm handoff policy to specify procedures and appropriate patient population(s) for conducting a warm handoff.
2.0	**Timeliness of Services**	
2.1	Initial Case Management Contact Contact with client and/or referring agent is attempted within one working day of receiving a case assignment. If the case manager is unable to make contact within one (1) working day, this is documented and explained in the client record. Case manager should also notify their supervisor. All subsequent attempts are documented.	• Documentation in client record.
2.2	Progress Notes All case management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 business hours of their occurrence.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes.
2.3	Case Management Brief Intervention Case Management staff (Medical, Clinical and Service Linkage) will, on occasion, be called to assist a client with a low/intermittent need, (i.e., CPCDMS eligibility renewal, ADAP application renewal, bus pass renewal, or information about a service, etc.) and have no other needs. In this situation the staff may provide a brief intervention with the client. However, if during the visit the staff assesses the client may have further needs than originally presented, the appropriate staff will engage using an assessment (brief / comprehensive) appropriate to their service to better address the client's needs.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes.

2.4	<u>Client Referral and Tracking</u> Agency will have policies and procedures in place for referral and follow-up for clients with medical conditions, nutritional, psychological/social and financial problems. The agency will maintain a current list of agencies that provide primary medical care, prescription medications, assistance with insurance payments, dental care, transportation, nutritional counseling and supplements, support for basic needs (rent, food, financial assistance, etc.) and other supportive services (e.g., legal assistance, partner elicitation services and Client Risk Counseling Services (CRCS). The Case Manager will: • Initiate referrals within two (2) weeks of the plan being completed and agreed upon by the Client and the Case Manager. • Work with the Client to determine barriers to referrals and facilitate access to referrals. • Utilize a tracking mechanism to monitor completion of all case management referrals.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation of follow-up tracking activities in clients' records. • A current list of agencies that provide services including availability of the Blue Book.
2.5	<u>Client Notification of Service Provider Turnover</u> Client must be provided notice of assigned service provider's cessation of employment within 30 days of the employee's departure.	• Documentation in client record.
2.6	<u>Client Transfers between Agencies: Open or Closed less than One Year</u> The case manager should facilitate the transfer of clients between providers. All clients are transferred in accordance with Case Management Policy and Procedure, which requires that a "consent for transfer and release/exchange of information" form be completed and signed by the client, the client's record be forwarded to the receiving care manager within five (5) working days and a Request for Transfer form be completed for the client and kept on file with the receiving agency.	• Documentation in client record.
2.7	<u>Caseload</u> Case load determination should be based on client characteristics, acuity level and the intensity of case management activities.	• Review of the agency's policies and procedures for Staffing ratios.

Clinical Case Management Services

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines medical case management as "a range of client-centered services that link clients with health care, psychosocial, and other services" including coordination and follow-up of medical treatment and "adherence counseling to ensure readiness for and adherence to HIV complex treatments". The definition outlines the functions of the medical case manager as including assessments and reassessments, individualized comprehensive service planning, service plan implementation and periodic evaluation, client advocacy and services utilization review. The Ryan White Grant Administration categorizes medical case management services co-located in a Mental Health treatment/counseling and/or Substance Abuse treatment services as Clinical Case Management (CCM) services.
CCM services may be targeted to underserved populations such as Hispanics, African Americans, MSM, etc.

1.0	**Staff Requirements**	
1.1	Minimum Qualifications All clinical case managers must have a current and in good standing State of Texas license (LCSW, LPC, LMFT). LMSW, LPC-I, and LMFT-A may provide Clinical Case Management services with clinical supervision under a waiver agreement. Staff providing Clinical Case Management services with LBSW licensure must have accompanying LCDC, CI, Substance Abuse Counselor, or Addictions Counselor certification. Other training experiences may be considered under a waiver agreement.	• A file will be maintained on each clinical case manager. • Supportive documentation of credentials and job description is maintained by the agency in each clinical case manager file. Documentation should include transcripts and/or diplomas and proof of licensure
1.2	Scope of Services The clinical case management services will include at a minimum, comprehensive assessment including mental health and substance abuse/use; development, implementation and evaluation of care plans; follow-up; advocacy; direction of clients through the entire spectrum of health and support services and peer support. Other functions include facilitation and coordination of services from one service provider to another including mental health, substance abuse and primary medical care providers.	• Review of client records indicates compliance. • Agency Policy and Procedures indicates compliance.
1.3	Ongoing Education/Training for Clinical Case Managers After the first year of employment in the case management system each clinical case manager will obtain the minimum number of hours of continuing education to maintain his or her licensure and four (4) hours of training in current Community Resources conducted by RWGA.	• Certificates of completion are maintained by the agency. • Current License on case manager's file.

2.0	**Timeliness of Services/Documentation**	
2.1	<u>Client Eligibility</u> In addition to the general eligibility criteria, individuals must meet one or more of the following criteria in order to be eligible for clinical case management services: ● Individual living with HIV in mental health treatment/counseling and/or substance abuse treatment services or whose history or behavior may indicate the individual may need mental health and/or substance abuse treatment/counseling now or in the future. ● Clinical criteria for admission into clinical case management must include one of the following: ➢ Client is actively symptomatic with a DSM (most current, American Psychiatric Association approved) diagnosis, especially including substance-related disorders (abuse/dependence), mood disorders (Bipolar depression), depressive disorders, anxiety disorders, and other psychotic disorders; or DSM (most current, American Psychiatric Association approved) diagnosis personality disorders. ➢ Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services. ➢ Client is in mental health counseling or chemical dependency treatment.	• Documentation of HIV+ status, mental health and substance abuse status, residence, identification, and income in the client record.
2.2	<u>Discharge/Closure from Clinical Case Management Services</u> In addition to the general requirements, a client may be discharged from clinical case management services for the following reasons. • Client has achieved a sustainable level of stability and independence. ➢ Substance Abuse – Client has successfully completed an outpatient substance abuse treatment program. ➢ Mental Health – Client has successfully accessed and is engaged in mental health treatment and/or has completed mental health treatment plan objectives.	• Documentation in client record.

2. 3	<u>Coordination with Primary Medical Care and Medical Case Management Provider</u> Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White Part A funded Medical Case Management programs. Clinical Case Management services provided to clients accessing primary medical care from a Ryan White Part A funded primary medical care provider other than Agency will require Agency and Primary Medical Care/Medical Case Management provider to conduct regular multi-disciplinary case conferences to ensure effective coordination of clinical and psychosocial interventions. Case conferences must at a minimum include the clinical case manager; mental health/counselor and/or medical case manager and occur at least every six (6) months or more often if clinically indicated for the duration of Clinical Case Management services. Client refusal to provide consent for the clinical case manager to participate in multi-disciplinary case conferences with their Primary Medical Care provider must be documented in the client record.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Case conferences are documented in the client record.
2.4	<u>Assessment</u> Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Clinical Case Management will use a RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's Mental Health and/or Substance Abuse treatment program(s).	• Documentation in client record on the comprehensive client assessment form, signed and dated, or agency's equivalent form. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.5	<u>Reassessment</u> Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g., needing referral for services from other	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated.

	providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA approved reassessment form as applicable must be utilized.	
2.6	Service Plan Service planning begins at admission to clinical case management services and is based upon assessment. The clinical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short-term needs met before full-service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	• Documentation in client record on the clinical case management service plan or agency's equivalent form. • Service plan signed by client and the case manager.
3.0	**Supervision and Caseload**	
3.1	Clinical Supervision and Caseload Coverage The clinical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the clinical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision

Non-Medical Case Management Services (Service Linkage Worker)

Non-medical case management services (Service Linkage Worker (SLW) are co-located in ambulatory/outpatient medical care centers. HRSA defines non-medical case management services as the "provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services" and does not include coordination and follow-up of medical treatment. The Ryan White Part A/B SLW provides services to clients who do not require intensive case management services, and these include the provision of information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients to develop and utilize independent living skills and strategies.

1.0	**Staff Requirements**	
1.1	Minimum Qualifications Service Linkage Worker – unlicensed community case manager Service linkage workers must have a bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH may be substituted for the bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). Service linkage workers must have a minimum of 1-year paid work experience with PLWH. Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish. Agency will provide Service Linkage Worker a written job description upon hiring.	• A file will be maintained on service linkage worker. Supportive documentation of credentials and job description are maintained by the agency and in each service linkage worker's file. Documentation may include, but is not limited to, transcripts, diplomas, certifications and/or licensure.
2.0	**Timeliness of Services/Documentation**	
2.1	Client Eligibility – Service Linkage targeted to Not-in-Care and Newly Diagnosed (HHD Only) In addition to general eligibility criteria individuals must meet the following in order to be eligible for non-medical case management services: • Clients not receiving outpatient HIV primary medical care services within the previous 180 days as documented by the CPCDMS, or • Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care services as documented by the CPCDMS, or	• Documentation of HIV+ status, residence, identification, and income in the client record. • Documentation of "not in care" status through the CPCDMS.

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	• Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS.	
2.2	Service Linkage Worker Assessment Assessment begins at intake. The service linkage worker will provide client and, if appropriate, his/her personal support system information regarding the range of services offered by the case management program during intake/assessment. The service linkage worker will complete RWGA -approved brief assessment tool within five (5) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager.	• Documentation in client record on the brief assessment form, signed and dated. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.3	Service Linkage Worker Reassessment Clients on receiving services will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applicable must be utilized.	• Documentation in RWGA approved client reassessment form or agency's equivalent form, signed and dated.
2.4	Transfer of Not-in-Care and Newly Diagnosed Clients (HHD Only) Service linkage workers targeting their services to Not-in-Care and newly diagnosed clients will work with clients for a maximum of 90 days. Clients must be transferred to a Ryan White-funded primary medical care, clinical case management or medical case management program, or a private (non-Ryan White funded) physician within 90 days of the initiation of services. Those clients who chose to access primary medical care from a non-Ryan White funded source may receive ongoing service linkage services from provider or from a Ryan White-funded Clinic or Medical Case Management provider.	• Documentation in client record and in the CPCDMS.
2.5	Primary Care Newly Diagnosed and Lost to Care Clients Agency must have a written policy and procedures in place that address the role of Service Linkage Workers in the linking and re-engaging of clients into primary medical care. The policy and procedures must include at minimum: • Methods of routine communication with testing sites regarding newly diagnosis and referred individuals. • Description of service linkage worker job duties conducted in the field.	• Review of Agency's Policies and Procedures Manual indicates compliance.

	• Process for re-engaging agency patients lost to care (no primary care visit in 6 months)	
3.0	**Supervision and Caseload**	
3.1	Service Linkage Worker Supervision A minimum of four (4) hours of supervision per month must be provided to each service linkage worker by a master's level health professional.) At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ Date ➢ Name(s) of case manager(s) present. ➢ Topic(s) covered and/or client(s) reviewed. Plan(s) of action ➢ Supervisor's signature • Supervision notes are never maintained in the client record.
3.2	Caseload Coverage – Service Linkage Workers Supervisor ensures that there is coverage of the caseload in the absence of the service linkage worker or when the position is vacant. Service Linkage Workers may assist clients who are routinely seen by other CM team members in the absence of the client's "assigned" case manager.	• Documentation of all client encounters in client record and in the Centralized Patient Care Data Management System.
3.3	Case Reviews – Service Linkage Workers. Supervisor reviews a random sample equal to 10% of unduplicated clients served by each service linkage worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and SLW.

Medical Case Management

Similar to nonmedical case management services, medical case management (MCM) services are co-located in ambulatory/outpatient medical care centers (see clinical case management for HRSA definition of medical case management services). The Houston RWPA/B medical case management visit includes assessment, education and consultation by a licensed social worker within a system of information, referral, case management, and/or social services and includes social services/case coordination". In addition to general eligibility criteria for case management services, providers are required to screen clients for complex medical and psychosocial issues that will require medical case management services (see MCM SOC 2.1).

1.0	**Staff/Training**	
1.1	Qualifications/Training Minimum Qualifications - The program must utilize a Social Worker licensed by the State of Texas to provide Medical Case Management Services. A file will be maintained on each medical case manager. Supportive documentation of medical case manager credentials is maintained by the agency and in each medical case manager's file. Documentation may include, but is not limited to, transcripts, diplomas, certifications, and/or licensure.	• Documentation of credentials and job description in medical case manager's file.
1.2	Scope of Services The medical case management services will include at a minimum, screening of primary medical care patients to determine each patient's level of need for medical case management; comprehensive assessment, development, implementation and evaluation of medical case management service plan; follow-up; direction of clients through the entire spectrum of health and support services; facilitation and coordination of services from one service provider to another. Others include referral to clinical case management if indicated, client education regarding wellness, medication and health care compliance and peer support.	• Review of clients' records indicates compliance.
1.3	Ongoing Education/Training for Medical Case Managers After the first year of employment in the case management system each medical case manager will obtain the minimum number of hours of continuing education to maintain his or her licensure.	• Attendance sign-in sheets and/or certificates of completion are maintained by the agency.
2.0	**Timeliness of Service/Documentation** Medical case management for persons with HIV should reflect competence and experience in the assessment of client medical need and the development and monitoring of medical service delivery plans.	

2.1	<u>Screening Criteria for Medical Case Management</u> In addition to the general eligibility criteria, agencies are advised to use screening criteria before enrolling a client in medical case management. Examples of such criteria include the following: i. Newly diagnosed ii. New to ART iii. CD4<200 iv. VL>100,000 or fluctuating viral loads v. Excessive missed appointments vi. Excessive missed dosages of medications vii. Mental illness that presents a barrier to the patient's ability to access, comply or adhere to medical treatment viii. Substance abuse that presents a barrier to the patient's ability to access, comply or adhere to medical treatment ix. Housing issues x. Opportunistic infections xi. Unmanaged chronic health problems/injury/Pain xii. Lack of viral suppression xiii. Positive screening for intimate partner violence xiv. Clinician's referral Clients with one or more of these criteria would indicate need for medical case management services. The following criteria are an indication a client may be an appropriate referral for Clinical Case Management services. • Client is actively symptomatic with an axis I DSM (most current, American Psychiatric Association approved) diagnosis especially including substance-related disorders (abuse/dependence), mood disorders (major depression, Bipolar depression), anxiety disorders, and other psychotic disorders; or axis II DSM (most current, American Psychiatric Association approved) diagnosis personality disorders; • Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services;	• Review of agency's screening criteria for medical case management.

	• Client is in mental health counseling or chemical dependency treatment.	
2.2	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. Medical case managers will provide a comprehensive assessment at intake and at least annually thereafter. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Medical Case Management will use an RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's program needs.	• Documentation in client record on the comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.3	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g., needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA or TRG -approved reassessment form as applicable must be utilized.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated. • Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only).
2.4	Service Plan Service planning begins at admission to medical case management services and is based upon assessment. The medical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive	• Documentation in client's record on the medical case management service plan or agency's equivalent form. • Service Plan signed by the client and the case manager.

	client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short-term needs met before full-service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	
3.0	**Supervision and Caseload**	
3.1	<u>Clinical Supervision and Caseload Coverage</u> The medical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the medical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision.

Emergency Financial Assistance Program

Emergency Financial Assistance (EFA) is co-located in ambulatory medical care centers to provide short term (up to 30 days of medication) access to HIV pharmaceutical services to clients who have not yet completed eligibility determination for medications through Pharmaceutical Assistance Programs, State ADAP, State SPAP or other sources. EFA provides short-term (up to 30 days of medication) payments to assist clients with an emergent need for medication. HRSA requirements for EFA include a client enrollment process, uniform benefits for all enrolled clients, a record system for dispensed medications and a drug distribution system.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for EFA services: • Income no greater than 500% of the Federal poverty level for HIV medications	• Documentation of income in the client record.
1.2	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days. • Pharmacy will fill prescription within one (1) business day of approval.	• Documentation in the client record and review of pharmacy summary sheets • Review of agency's Policies & Procedures Manual indicates compliance.
1.3	Medication Formulary RW funded prescriptions for program eligible clients shall be based on current medications on the RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Any EFA service greater than 30 days of medication must also have prior waiver approval from RWGA. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Public Health Services guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of billing history indicates compliance. • Documentation in client's record.

2.0	**Staff HIV knowledge is based on documented training.**	
2.1	Orientation Initial orientation includes twelve (12) hours of HIV basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.	• Review of training curriculum indicates compliance. • Documentation of all training in personnel file. • Specific training requirements are specified in the staff guidelines.
2.2	Ongoing Training Sixteen (16) hours every two years of continuing education in PLWH related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	• Materials for staff training and continuing education are on file. • Staff interviews indicate compliance.
2.3	Pharmacy Staff Experience A minimum of one-year documented PLWH work experience is preferred.	• Documentation of work experience in personnel file
2.4	Pharmacy Staff Supervision Staff will receive at least two (2) hours of supervision per month to include client care, job performance and skill development.	• Review of personnel files indicates compliance. • Review of agency's Policies & Procedures Manual indicates compliance. • Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present.

Local Pharmacy Assistance Program

The Local Pharmacy Assistance Programs (LPAP) are co-located in ambulatory medical care centers and provide HIV and HIV-related pharmaceutical services to clients who are not eligible for medications through private insurance, Medicaid/Medicare, State ADAP, State SPAP or other sources. HRSA requirements for LPAP include a client enrollment process, uniform benefits for all enrolled clients, a record system for dispensed medications and a drug distribution system.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for LPAP services: • Income no greater than 500% of the Federal poverty level for HIV medications and no greater than 400% of the Federal poverty level for HIV-related medications	• Documentation of income in the client record.
1.2	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days. • Pharmacy will fill prescription within one (1) business day of approval.	• Documentation in the client record and review of pharmacy summary sheets. • Review of agency's Policies & Procedures Manual indicates compliance.
1.3	LPAP Medication Formulary RW funded prescriptions for program eligible clients shall be based on the current RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/HHS guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of billing history indicates compliance. • Documentation in client's record.

2.0	**Staff HIV knowledge is based on documented training.**	
2.1	Orientation Initial orientation includes twelve (12) hours of HIV basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.	• Review of training curriculum indicates compliance. • Documentation of all training in personnel file. • Specific training requirements are specified in the staff guidelines.
2.2	Ongoing Training Sixteen (16) hours every two years of continuing education in PLWH related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	• Materials for staff training and continuing education are on file. • Staff interviews indicate compliance.
2.3	Pharmacy Staff Experience A minimum of one-year documented PLWH work experience is preferred.	• Documentation of work experience in personnel file
2.4	Pharmacy Staff Supervision Staff will receive at least two (2) hours of supervision per month to include client care, job performance. and skill development.	• Review of personnel files indicates compliance. • Review of agency's Policies & Procedures Manual indicates compliance. • Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present.

Outreach Services

Outreach workers focus on locating clients who are on the cusp of falling out of care, for reengagement back into care. The Ryan White Part A Outreach Worker (OW) provides field-based services to clients based on criteria identified by each agency. These services include the provision of information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed and advocating on behalf of clients to decrease service gaps and remove barriers to services.

1.0	**Staff Training**	
1.1	**Minimum/Qualifications** Minimum Qualifications – High School Diploma or GED. Six months of working with or volunteering with PLWH.	• Documentation of credentials and job description in outreach worker's file. • Documentation includes, but is not limited to high school diploma, GED, and experience.
1.2	Scope of Services The OW will generate EMR reports to determine eligibility for services. Monthly, during OW-RWGA meetings OW will provide client status updates on engagement activities. Outreach workers are expected to document client's immediate needs and barriers to service in order to relink and reengage them back in to care. Upon successfully re-engaging clients back in to care, outreach workers will provide a warm handoff to a service linkage worker or medical case manager for additional assistance of the client's needs as necessary.	• Review of reporting records indicates compliance. • Monthly review of spreadsheet engagement activities. • Documentation of assessment will be maintained in the client file.
1.3	Ongoing Education/Training for Outreach Workers Staff who provide field-based services should receive at least two (2) hours of field safety training within their first six (6) months of employment. The Outreach Workers are required to attend a minimum of five (5) of the six (6) Outreach Worker meetings and four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA within the grant year, and one of the Joint Prevention and Care Collaborative Workshops presented by RGWA & HHD.	• Documentation of attendance will be maintained by the agency. RWGA will also maintain sign-in logs. • Review of reporting records indicates compliance. • Certificates of completion for applicable trainings in the outreach worker's file.

1.4	Outreach Brief Intervention Outreach staff will, on occasion, be called to assist a client with a low/intermittent need, (such as, CPCDMS eligibility renewal, ADAP application renewal, bus pass renewal, or information about a service, etc.) and have no other needs. In this situation the staff may provide a ***brief intervention*** with the client. However, if during the visit the staff assesses the client may have further needs than originally presented, the Outreach Worker will refer the client to the appropriate staff who will engage using an assessment (brief / comprehensive) to better address the client's needs.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes.
1.5	Documentation and Reporting Outreach Workers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with DSHS Child Abuse Screening, Documenting and Reporting Policy prior to interaction.	• Documentation of staff training in employee record.
1.6	Warm Handoff Procedure Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e., Outreach worker to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	• Agency has a warm handoff policy to specify procedures and appropriate patient population for conducting a warm handoff.
2.0	**Timeliness of Service/Documentation**	
2.1	**Progress Notes** All Outreach Worker activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 business hours of the occurrence.	• Documentation of client's needs and progress notes will be maintained in client's files. • Legible signed and dated in documentation in the client record.
2.2	Eligibility Criteria for Outreach Eligibility for outreach will vary and is specific to each agency. Criteria can include but is not limited to clients: • Who have missed 2 or more HIV-related medical appointments in the last 6 months, have one appointment scheduled in the next 3 weeks. • Missed 3 appointments in last 6 months and have one scheduled in next 3 weeks.	• Documentation of eligibility criteria will be maintained in client's files. • Legible signed and dated in documentation in the client record.

	• Clients who have not been seen in 4 months by their primary care provider; and/or • Three missed appointments in past 12 months (do not have to be consecutive).	
3.0	**Supervision**	
3.1	Outreach Worker Supervision Four (4) hours of supervision per month must be provided to each outreach worker. At least one (1) hour of supervision must be individual supervision. The remaining three (3) hours may be individual or group. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the outreach worker relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ Date & duration of time ➢ name(s) of outreach worker(s) present ➢ Topic(s) covered and/or client(s) reviewed. ➢ Plan(s) of action ➢ Supervisor's signature • Supervision notes are never maintained in the client record.
3.2	Case Reviews – Outreach Worker Supervisor reviews a random sample equal to 10% of unduplicated clients served by each Outreach Worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible and that services provided appropriately.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and Outreach Worker.

Primary Medical Care

The 2006 CARE Act defines Primary Medical Services as the "provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe Antiretroviral (ARV) therapy in an outpatient setting. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history tasking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions and referral to and provisions of specialty care".

The RW Part A primary care visit consists of a client examination by a qualified Medical Doctor, Nurse Practitioner, Clinical Nurse Specialist and/or Physician Assistant and includes all ancillary services such as eligibility screening, patient medication/treatment education, adherence education, counseling, and support; medication access/linkage; and as clinically indicated, OB/GYN specialty procedures, nutritional counseling, routine laboratory, and radiology. All primary care services must be provided in accordance with the current U.S. Department of Health and Human Services guidelines (HHS).

1.0	**Medical Care for persons with HIV should reflect competence and experience in both primary care and therapeutics known to be effective in the treatment of HIV infection and is consistent with the most current published HHS treatment guidelines**	
1.1	Minimum Qualifications Medical care for persons living with HIV shall be provided by MD, NP, CNS or PA licensed in the State of Texas and has at least two years paid experience in HIV care including fellowship.	• Credentials on file.
1.2	Licensing, Knowledge, Skills and Experience • All staff maintain current organizational licensure (and/or applicable certification) and professional licensure. • The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc. • Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (www.hivma.org): • Clinical management of at least 25 people living with HIV patients within the last year. • Maintain a minimum of 30 hours of HIV-specific CME (including a minimum of 10 hours related to antiretroviral therapy) every two years in accordance with State licensure renewal dates. Agencies using	• Documentation in personnel record.

	contractors must ensure that this requirement is met and must provide evidence at the annual program monitoring site visits. • Psychiatrists only: after the first biennium, psychiatrists must maintain a minimum of 10 hours of HIV-specific CME every two years in accordance with State licensure renewal dates. • Physician extenders must obtain this experience within six months of hire. • All staff receive professional supervision. • Staff show training and/or experience with the medical care of adults living with HIV.	
1.3	Peer Review Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e., MD, NP, PA).	• Provider will document peer review has occurred annually.
1.4	**Standing Delegation Orders (SDO)** Standing delegation orders provide direction to RNs, LVNs and, when applicable, Medical Assistants in supporting management of patients seen by a physician. Standing Delegation Orders must adhere to Texas Administrative Code, Title 22, Part 9; Chapter 193; Rule §193.1 and must be congruent with the requirements specified by the Board of Nursing (BON) and Texas State Board of Medical Examiners (TSBME).	• Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider. • Standing Delegation Orders will be reviewed, updated as needed and signed by the physician annually. • Use of standing delegation orders will be documented in patient's primary record
1.5	Primary Care Guidelines Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (http://www.aidsinfo.nih.gov/guidelines) and other nationally recognized evidence-based guidelines. Immunizations should be given according to the most current Advisory Committee on Immunization Practices (ACIP) guidelines.	• Documentation in client's record. • Exceptions noted in client's record.
1.6	Medical Evaluation/Assessment All people living with HIV receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination. The comprehensive assessment/evaluation will be completed by the MD, NP, CNS	• Completed assessment in client's record.

	or PA in accordance with professional and established HIV practice guidelines (www.hivma.org) within 3 weeks of initial contact with the client. A comprehensive reassessment shall be completed on an annual basis or when clinically indicated. The initial assessment and reassessment shall include at a minimum, general medical history, a comprehensive HIV related history and a comprehensive physical examination. Comprehensive HIV related history shall include: • Psychosocial history • HIV treatment history and staging • Most recent CD4 counts and VL test results. • Resistance testing and co receptor tropism assays as clinically indicated. • Medication adherence history • History of HIV related illness and infections • History of Tuberculosis • History of Hepatitis and vaccines • Psychiatric history • Transfusion/blood products history • Past medical care • Sexual history • Substance abuse history • Review of Systems	
1.7	Medical Records Medical Records should clearly document the following components, separate from progress notes: • A central "Problems List" which clearly prioritizes problems for primary care management, including mental health and substance use/abuse disorders (if applicable) • A vaccination record, including dates administered. • The status of routine screening procedures (i.e., pap smears, mammograms, colonoscopies).	• Documentation in client's record.

1.8	Plan of Care A plan of care shall be developed for each identified problem and should address diagnostic, therapeutic and educational issues in accordance with the current U.S. HHS treatment guidelines.	• Plan of Care documented in client's record.
1.9	Follow- Up Visits All patients shall have follow–up visits every three to six months or as clinically indicated for treatment monitoring and to detect any changes in the client's HIV status. At each clinic visit the provider will at a minimum: • Measure vital signs including height and weight. • Perform physical examination and update client history. • Measure CBC, CD4 and VL levels every 3-6 months or in accordance with current treatment guidelines. • Evaluate need for ART. • Resistance Testing if clinical indicated. • Evaluate need for prophylaxis of opportunistic infections. • Document current therapies on all clients receiving treatment or assess and reinforce adherence with the treatment plan. • Update problem list • Refer client for ophthalmic examination by an ophthalmologist every six months when CD4 count falls below 50CU/MM. • Refer Client for dental evaluation or care every 12 months. • Incorporate HIV prevention strategies into medical care for of persons living with HIV. • Screen for risk behaviors and provide education on risk reduction, including pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) for negative partners, and Undetectable Untransmutable. • Assess client comprehension of treatment plan and provide education/referral as indicated. • Refer for other clinical and social services where indicated.	• Content of Follow-up documented in client's record. • Documentation of specialist referral including dental in client's records.
1.10	Yearly Surveillance Monitoring and Vaccinations • All women living with HIV–should have regular pap tests ➢ An initial negative pap test should be followed with another pap test in 6-12 months and if negative, annually thereafter.	• Documentation in client's record.

	➢ If 3 consecutive pap tests are normal, follow-up pap tests should be done every 3 years. ➢ Women 30 years old and older may have pap test and HPV co-testing, and if normal, repeated every 3 years. ➢ A pap test showing abnormal results should be managed per guidelines. • Screening for anal cancer, if indicated. • Resistance Testing, if clinical indicated. • Chem. panel with LFT and renal function test • Influenza vaccination • Annual Mental Health Screening with standardized tool • TST or IGRA (this should be done in accordance with current U.S Public Health Service guidelines (US Public Health Service, Infectious Diseases Society of America. *Guidelines for preventing opportunistic infections among people living with HIV***)** (Available at aidsinfo.nih.gov/Guidelines/) • Annual STD testing including syphilis, gonorrhea and Chlamydia for those at risk, or more frequently as clinically indicated.	
1.11	Preconception Care for Women Living with HIV of Childbearing Age In accordance with the US Department of Health and Human Services recommendations (http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf), preconception care shall be a component of routine primary care for women of childbearing age living with HIV and should include preconception counseling. In addition to the general components of preconception counseling, health care providers should, at a minimum: • Assess women's pregnancy intentions on an ongoing basis and discuss reproductive options. • Offer effective and appropriate contraceptive methods to women who wish to prevent unintended pregnancy. • Counsel on safe sexual practices • Counsel on eliminating of alcohol, illicit drugs and smoking. • Educate and counsel on risk factors for perinatal HIV transmission, strategies to reduce those risks, and prevention and potential effects of HIV and treatment on pregnancy course and outcomes	• Documentation of preconception counseling and care at initial visit and annual updates in Client's record as applicable.

	• Inform women of interventions to prevent sexual transmission of HIV when attempting conception with a partner who does not have HIV. Other preconception care consideration should include: • The choice of appropriate antiretroviral therapy effective in treating maternal disease with no teratogenicity or toxicity should pregnancy occur. • Maximum suppression of viral load prior to conception.	
1.12	Obstetrical Care for Pregnant Women Living with HIV Obstetrical care for pregnant women living with HIV shall be provided by board certified obstetricians experienced in the management of high-risk pregnancy and has at least two years of experience in caring for pregnant women living with HIV. Antiretroviral therapy during ante partum, perinatal and postpartum should be based on the current HHS guidelines http://www.aidsinfo.nih.gov/Guidelines.	• Documentation in client's record.
1.13	Coordination of Services in Prenatal Care To ensure adherence to treatment, agency must ensure coordination of services among prenatal care providers, primary care and HIV specialty care providers, mental health and substance abuse treatment services and public assistance programs as needed.	• Documentation in client's records.
1.14	Care of and Infants, Children and Pre-pubertal Adolescents Care and monitoring of children exposed to HIV must be done in accordance with the HHS guidelines. Treatment of infants and children living with HIV should be managed by a specialist in pediatric and adolescent HIV infection. Where this is not possible, primary care providers must consult with such specialist. Providers must utilize current HHS Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Care (http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf) in providing and monitoring antiretroviral therapy in infants, children and pre pubertal adolescents. Patients should also be monitored for growth and development, drug toxicities, neurodevelopment, nutrition and symptoms management. A multidisciplinary team approach must be utilized in meeting clients' need and team should consist of physicians, nurses, case managers, pharmacists, nutritionists, dentists, psychologists and outreach workers.	• Documentation in client's record.

1.15	Patient Medication Education All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed and then documented in the patient record: the names, actions and purposes of all medications in the patient's regimen; the dosage schedule; food requirements, if any; side effects; drug interactions; and adherence. Patients must be informed of the following: how to pick up medications; how to get refills; and what to do and who to call when having problems taking medications as prescribed. Medication education must also include patient's return demonstration of the most current prescribed medication regimen. The program must utilize an RN, LVN, PA, NP, CNS, pharmacist or MD licensed by the State of Texas, who has at least one year of paid experience in HIV care, to provide the educational services.	• Documentation in the patient record. Documentation in patient record must include the clinic name; the session date and length; the patient's name, patient's ID number, or patient representative's name; the Educator's signature with license and title; the reason for the education (i.e., initial regimen, change in regimen, etc.) and documentation of all discussed education topics.
1.16	Adherence Assessment Agency will incorporate adherence assessment into primary care services. Clients who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. Adherence assessment shall be provided by an RN, LVN, PA, NP, CNS, Medical/Clinical Case Manager, pharmacist or MD licensed by the State of Texas. Agency must utilize the RWGA standardized adherence assessment tool. Case managers must refer clients with adherence issues beyond their scope of practice to the appropriate health care professional for counseling.	• Completed adherence tool in client's record. • Documentation of counseling in client records.
1.17	Documented Non-Adherence with Prescribed Medication Regimen The agency must have in place a written policy and procedure regarding client non-adherence with a prescribed medication regimen. The policy and procedure should address the agency's process for intervening when there is documented non-adherence with a client's prescribed medication regimen.	• Review of Policies and Procedures Manual indicates compliance.
1.18	Client Mental Health and Substance Use Policy The agency must have in place a written policy and procedure regarding client mental health and substance use. The policy and procedure should address: the agency's process for assessing clients' mental health and substance use; the treatment and referral of clients for mental illness and substance abuse; and care	• Review of Policies and Procedures Manual indicates compliance.

	Coordinator with mental health and/or substance abuse providers for clients who have mental health and substance abuse issues.	
1.19	Intimate Partner Violence Screening Policy The agency must have in place a written policy and procedure regarding client Intimate Partner Violence (IPV) Screening that is consistent with the Houston EMA IPV Protocol. The policy and procedure should address: • Process for ensuring clients are screened for IPV no less than annually • Intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management. • State reporting requirements associated with IPV. • Description of required medical record documentation. • Procedures for patient referral including available resources, procedures for follow-up and responsible personnel. Plan for training all appropriate staff (including non-RW funded staff)	• Review of Policies and Procedures Manual indicates compliance. • Documentation in patient record.
1.20	Patient Retention in Care The agency must have in place a written policy and procedure regarding client retention in care. The policy and procedure must include: • Process for client appointment reminders (e.g., timing, frequency, position responsible) • Process for contacting clients after missed appointments (e.g., timing, frequency, position responsible) • Measures to promote retention in care. Process for re-engaging those lost to care (no primary care visit in 6 months)	• Review of Agency's Policies and Procedures Manual indicates compliance.
2.0	**Psychiatric care for persons with HIV should reflect competence and experience in both mental health care and therapeutics known to be effective in the treatment of psychiatric conditions and is consistent with the most current published Texas Society of Psychiatric Physicians/American Psychiatric Association treatment guidelines.**	
2.1	Psychiatric Guidelines Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines (www.txpsych.org) and the American Psychiatric Association (www.psych.org/aids) guidelines.	• Documentation in patient record

3.0	**In addition to demonstrating competency in the provision of HIV specific care, HIV clinical service programs must show evidence that their performance follows norms for ambulatory care.**	
3.1	Access to Care Primary care providers shall ensure all new referrals from testing sites are scheduled for a new patient appointment within 15 working days of referral. (All exceptions to this timeframe will be documented) Agency must assure the time-appropriate delivery of services, with 24 hour on-call coverage including: • Mechanisms for urgent care evaluation and/or triage • Mechanisms for in-patient care • Mechanisms for information/referral to: ➢ Medical sub-specialties: Gastroenterology, Neurology, Psychiatry, Ophthalmology, Dermatology, Obstetrics and Gynecology and Dentistry ➢ Social work and case management services ➢ Mental health services ➢ Substance abuse treatment services ➢ Anti-retroviral counseling/therapy for pregnant women ➢ Local federally funded hemophilia treatment center for persons with inherited coagulopathies ➢ Clinical investigations	• Agency Policy and Procedure regarding continuity of care.
3.2	Continuity with Referring Providers Agency must have a formal policy for coordinating referrals for inpatient care and exchanging patient information with inpatient care providers.	• Review of Agency's Policies and Procedures Manual indicates compliance.
3.3	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agencies must implement tracking systems to identify clients who are out of care and/or need health screenings (e.g., Hepatitis b & c, cervical cancer screening, etc., for follow-up).	• Documentation of referrals out. • Staff interviews indicate compliance. • Established tracking systems
3.4	Client Notification of Service Provider Turnover Client must be provided notice of assigned service primary care provider's cessation of employment within 30 days of the employee's departure.	• Documentation in patient record

3.5	Recommended Format for Operational Standards Detailed standards and routines for program assessment are found in most recent Joint Commission performance standards.	• Ambulatory HIV clinical service should adopt and follow performance standards for ambulatory care as established by the Joint Commission.
3.6	Client Accommodation for Same Day Provider Cancellations Agency must have a policy in place that outlines a timeline for client notification of provider cancellations, and a protocol for how patients will be accommodated when they do not receive notification in advance of arriving to the clinic.	• Review of Agency's Policies and Procedures Manual indicates compliance.
3.7	Client Prescription Refill Policy Agency must have a policy in place that details short term prescription refill availability in when office visit is not feasible prior to patient depletion of medication.	• Review of Agency's Policies and Procedures Manual indicates compliance.

Vision Services

The Vision Services is an integral part of the Outpatient Ambulatory Medical Care Services. Primary Care Office/Clinic Vision Care consist of comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary. Allowable visits with a credentialed Ophthalmic Medical Assistant include routine and preliminary tests such as muscle balance test, Ishihara color test, Near Point of Conversion (NPC), visual acuity testing, visual field testing, Lensometry and glasses dispensing.

1.0	**Staff HIV knowledge is based on documented training.**	
1.1	Ongoing Training Four (4) hours of continuing education in vision-related or other specific topics is required annually.	• Documentation of all training in personnel file. • Staff interviews indicate compliance.
1.2	Staff Experience/Qualifications Minimum of one (1) year HIV work experience for paid staff (optometry interns exempt) is preferred. Provider must have a staff Doctor of Optometry licensed by the Texas Optometry Board as a Therapeutic Optometrist, or a medical doctor who is board certified in ophthalmology.	• Documentation of work experience in personnel file.
1.3	Staff Supervision Staff services are supervised by a paid coordinator or manager. Supervision of clinical staff shall be provided by a practitioner with at least two (2) years of experience in vision care and treatment of persons with HIV. All licensed personnel shall receive supervision consistent with the State of Texas license requirements.	• Review of personnel files indicates compliance. • Review of agency's Policy and Procedure Manual indicates compliance.
2.0	**Patient Care**	
2.1	Physician Contact Information Agency obtains and documents primary care physician contact information for each client. At minimum, agency should collect the physician's name and telephone number.	• Documentation of physician contact information in the client record.
2.2	Client Intake Agency collects the following information for all new clients: • Health history, • Ocular history,	• Documentation in the client record.

	• Current medications, • Allergies and drug sensitivities, • Reason for visit (chief complaint).	
2.3	<u>CD4/Viral Loads</u> When clinically indicated, current (within the last 6 months) CD4 and Viral Load laboratory test results for clients are obtained.	• Documentation in the client record.
2.4	<u>Comprehensive Eye Exam</u> The comprehensive eye exam will include documentation of the following: Visual acuity, refraction test, binocular vision muscle assessment, observation of external structures, Fundus/retina Exam, Dilated Fundus Exam (DFE) when clinically indicated, Glaucoma test, findings of exam - either normal or abnormal, written diagnoses where applicable, Treatment Plan. Client may be evaluated more frequently based on clinical indications and current US Public Health Service guidelines.	• Documentation in the client record.
2.5	<u>Lens Prescriptions</u> Clients who have clinical indications for corrective lens must receive prescriptions, and referrals for such services to ensure they are able to obtain their eyeglass.	• Documentation in the client record.

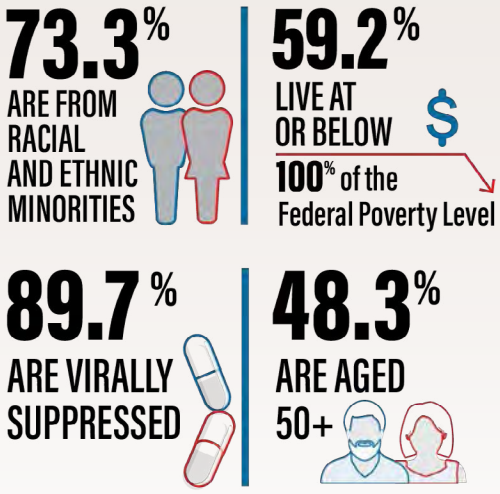
Overview of Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—more than 576,000 people in 2021—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission. For more than three decades, RWHAP has worked to stop HIV stigma and reduce health disparities by caring for the whole person and addressing their social determinants of health.

Ryan White HIV/AIDS Program Fast Facts: Program Clients



HRSA
Ryan White HIV/AIDS Program

Learn more about the people served by RWHAP:

- The majority of RWHAP clients are people with lower incomes. Data show that 59.2 percent of clients are people living at or below 100 percent of the federal poverty level (FPL), and 87.8 percent of RWHAP clients are people living at or below 250 percent of the FPL. Nearly all clients served have an income at or below 400 percent of the FPL.
- The RWHAP serves a diverse population. Nearly three-quarters of clients are people from racial and ethnic minorities. Data show that 45.8 percent of clients are Black/African American people and 24.1 percent of clients are Hispanic/Latino people.
- The majority of RWHAP clients are male. Among all clients served by RWHAP, 72.2 percent are male, 25.4 percent are female, and 2.4 percent are transgender.
- The RWHAP client population is aging. People aged 50 years and older account for 48.3 percent of all RWHAP clients.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication and reach and maintain viral suppression cannot sexually transmit the virus to their partner. According to 2021 data, 89.7 percent of RWHAP clients receiving HIV medical care are virally suppressed,* which is a significant increase from 69.5 percent virally suppressed in 2010.

The RWHAP delivers a range of support services to ensure that people with HIV are able to access and remain in care. The following are the most frequently utilized services:

- Outpatient ambulatory health services
- Medical case management, including treatment adherence services
- Non-medical case management services
- Food bank/home-delivered meals
- Oral health care
- Referral for health care and supportive services
- Health education/risk reduction
- Medical transportation
- Mental health services
- Emergency Financial Assistance

In addition, the RWHAP Part B AIDS Drug Assistance Program provides more than 300,000 clients with HIV-related medications and/or health care coverage assistance.

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

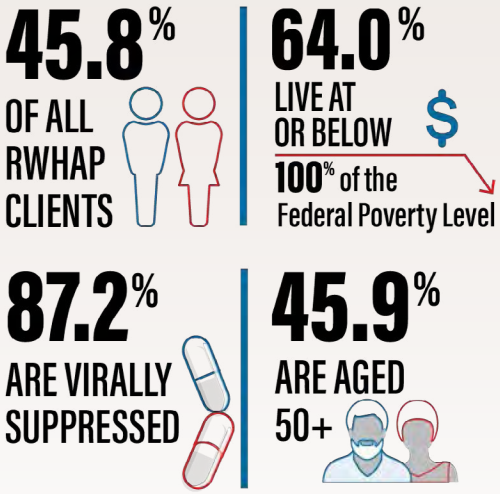
Black/African American Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—more than 576,000 people in 2021—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission. For more than three decades, RWHAP has worked to stop HIV stigma and reduce health disparities by caring for the whole person and addressing their social determinants of health.

Ryan White HIV/AIDS Program Fast Facts: Black/African American Clients



HRSA
Ryan White HIV/AIDS Program

Of the more than half a million clients served by RWHAP, 73.3 percent are people from racial and ethnic minorities; 45.8 percent of all RWHAP clients are Black/African American people.

Learn more about Black/African American clients served by RWHAP:

- The majority of Black/African American clients served by RWHAP are male. Data show that 63.6 percent of clients are male, 33.7 percent of clients are female, and 2.7 percent of clients are transgender. The proportion of Black/African American male clients is lower than the national RWHAP average (72.2 percent), whereas the proportion of Black/African American female clients is higher than the national RWHAP average (25.4 percent).
- The majority of Black/African American clients served by RWHAP are people with lower incomes. Data show that 64.0 percent of Black/African American clients are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (59.2 percent).
- Data show that 5.3 percent of RWHAP Black/African American clients experience unstable housing. This percentage is slightly higher than the national RWHAP average (5.0 percent).
- Black/African American RWHAP clients are aging. Data show that 45.9 percent of Black/African American RWHAP clients are aged 50 years and older.
- Among Black/African American male RWHAP clients, 59.5 percent are men who have sex with men (MSM). Among all men served by RWHAP, MSM account for 67.4 percent.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication as prescribed and reach and maintain viral suppression cannot sexually transmit the virus to their partner. According to 2021 data, 87.2 percent of Black/African American clients receiving RWHAP HIV medical care are virally suppressed,* which is lower than the national RWHAP average (89.7 percent).

- 86.5 percent of Black/African American men receiving RWHAP HIV medical care are virally suppressed.
- 89.0 percent of Black/African American women receiving RWHAP HIV medical care are virally suppressed.

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

2020 Houston HIV Care Services Needs Assessment: Profile of African American Men Who Have Sex with Men (MSM)

For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
Houston Area Ryan White Planning Council
Tel: (832) 927-7926
Web: rwpchouston.org

PROFILE OF AFRICAN AMERICAN MSM

A recent analysis of national HIV diagnosis rates revealed that the largest percentage of new HIV diagnoses in the south was among Black/African American men who have sex with men (**MSM**). (Center for Disease Control & Prevention, 2020). Though no single cause has been identified, intersections of high prevalence, decreased status awareness, stigma, racism and discrimination, and homophobia likely contribute to increased transmission vulnerability among African American MSM (Center for Disease Control & Prevention, 2020). A persistent challenge to designing HIV prevention and care services that meet the needs of Houston area people living with HIV (**PLWH**) is ensuring that services remain relevant and responsive to the needs of both the general population and groups with increased vulnerability to new transmissions and unmet need. Data about service needs and barriers African American MSM PLWH in the Houston area encounter is of particular importance to local HIV planning, as this information equips communities to design prevention and care services that meet the unique needs of disproportionately affected groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment, as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include African American MSM participants. This Profile highlights results *only* for participants who were African American MSM, as well as comparisons to the entire needs assessment sample.

Notes: This analysis defines African American MSM as PLWH who indicated they were cis-gender men with a primary race/ethnicity of black/African American, and self-identified as gay, bisexual, or pansexual. Results for participants who are transgender or gender non-conforming were reported in a separate profile available on the Houston Ryan White Planning Council website.

Data presented in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check-all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 103 participants in the 2020 Houston HIV Care Services Needs Assessment were African American MSM, comprising 17% of the entire sample.

Ninety-seven percent (97%) of African American MSM participants were residing in Houston/Harris County at the time of data collection. Compared to the total sample of the needs assessment participants, the majority of the respondents were between the ages of 35 to 64 (77%) and were born in the U.S. (98%). A third of African American MSM participants identified as gay (67%) or bisexual/pansexual (28%). Sixty percent (60%) of African American MSM participants had annual incomes below 100% of the Federal Poverty Level, and the average annual income for African American MSM participants was $15,127. Among African American MSM participants, thirty-nine (39%) had public health insurance coverage through Medicaid or Medicare, twenty-two (22%) had insurance coverage through Harris Health and twenty-one (21%) had Ryan White only.

Compared to all needs assessment participants, higher proportions of African American MSM participants were ages 55-64 (35% vs. 28%), identified as gay (67% vs. 30%) or bisexual/pansexual (27% vs 9%). The average income among African American MSM participants who reported income was larger than that of the total sample ($15,127 vs. $11,360). Lastly, a higher proportion of African American MSM participants did not have health insurance (5%) when compared to all needs assessment participants (2%).

Characteristics of African American MSM participants (as compared to all participants in general) can be summarized as follows:

- Residing in Houston/Harris County
- Adults between the ages of 35 and 64
- Self-identified as gay or bisexual
- Higher average annual income
- Higher proportion of having no health insurance

TABLE 1-Select Characteristics among African American MSM Participants, Houston Area HIV Needs Assessment, 2020

	No.	AA MSM %	Total %
County of residence			
Harris	84	97%	95%
Fort Bend	2	2%	2%
Other	1	1%	2%
Immigration status			
Born in the U.S.	88	98%	88%
Citizen > 5 years	0	-	10%
Citizen < 5 years	1	1%	1%
Visa (student, work, tourist, etc.)	0	-	0.2%
Prefer not to answer	1	1%	0.7%

	No.	AA MSM %	Total %
Age range (median: 50-54)			
13-17	0	-	-
18-24	5	6%	3%
25-34	9	10%	9%
35-49	26	30%	28%
50-54	11	13%	18%
55-64	31	35%	28%
≥65	6	7%	15%
Seniors (≥50)	48	26%	60%
Yearly income (average: $15,127)			
Federal Poverty Level (FPL)			
Below 100%	26	60%	67%
100%	9	21%	19%
150%	3	7%	6%
200%	2	5%	5%
250%	0	-	-
≥300%	3	7%	2%

	No.	AA MSM %	Total %
Sexual orientation (self-reported)			
Heterosexual	1	1%	57%
Gay	60	67%	30%
Bisexual / Pansexual	25	28%	9&
Undecided	4	4%	4%
Health insurance (multiple response)			
Private insurance	10	9%	9%
Medicaid/Medicare	44	39%	67%
Harris Health System	25	22%	29%
Ryan White Only	24	21%	24%
VA	3	3%	3%
None	6	5%	2%

BARRIERS TO RETENTION IN CARE

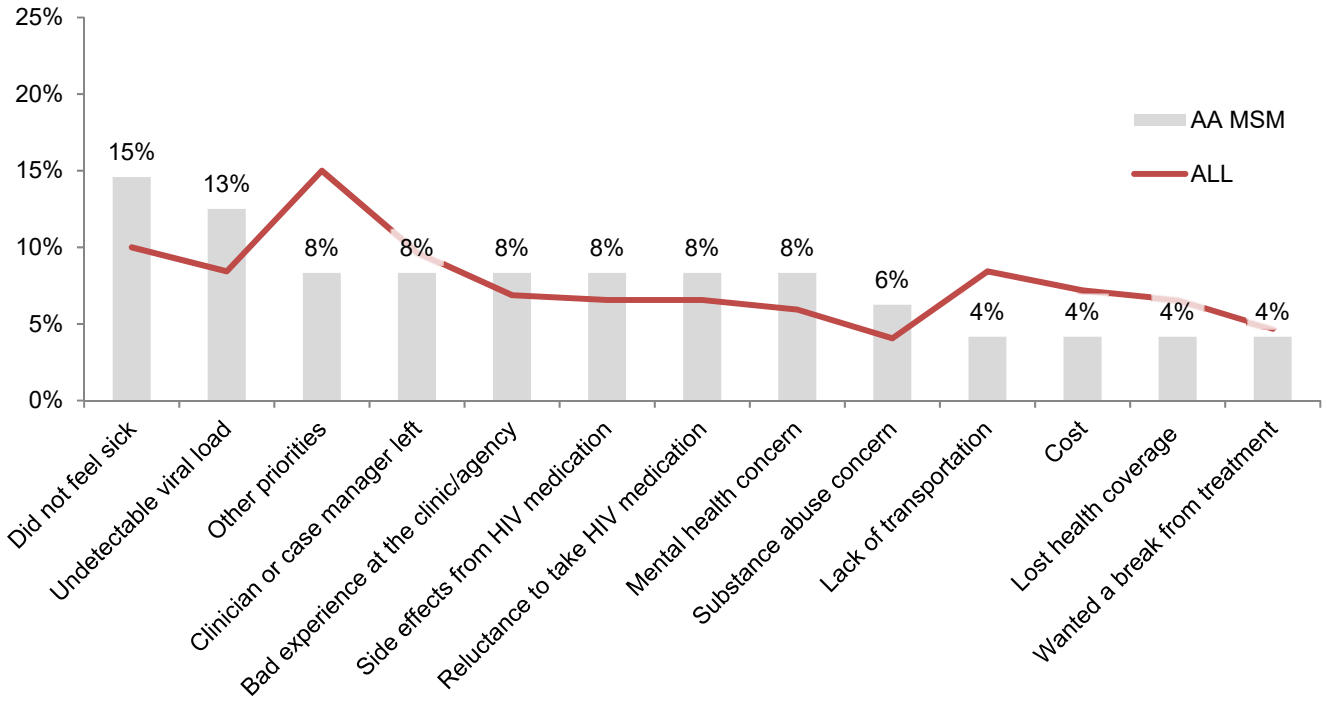
As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 31% of African American MSM participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey, and participants could select multiple reasons and write in their reasons.

(**Graph 1**) Among African American MSM participants, not feeling sick was the most cited reason for interruption in HIV medical care (15%), followed by having an undetectable viral load (13%). Additional reasons for falling out of HIV medical care reported by African American MSM respondents were the following: other priorities, clinician or case manager left, bad experience at the clinic/agency, side effects from HIV medication, reluctance to take HIV medication, and mental health concerns (all 8%). Compared to the total sample, a higher proportion of African American MSM participants reported not feeling sick (15% vs. 10%), and an undetectable viral load (13% vs 8%) as the reasons for the lapse in care. Lower proportions reported having other priorities (8% vs 15%), lack of transportation (4% vs 8%), and cost (4% vs 7%) as reasons for the lapse in care. Write in responses for this question reported they did not want family to know they were taking medication for HIV, were incarcerated, or did not know where to get services resulting in their lapse in HIV medical care.

GRAPH 1-Reasons for Falling Out of HIV Care among African American MSM PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by African American MSM needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



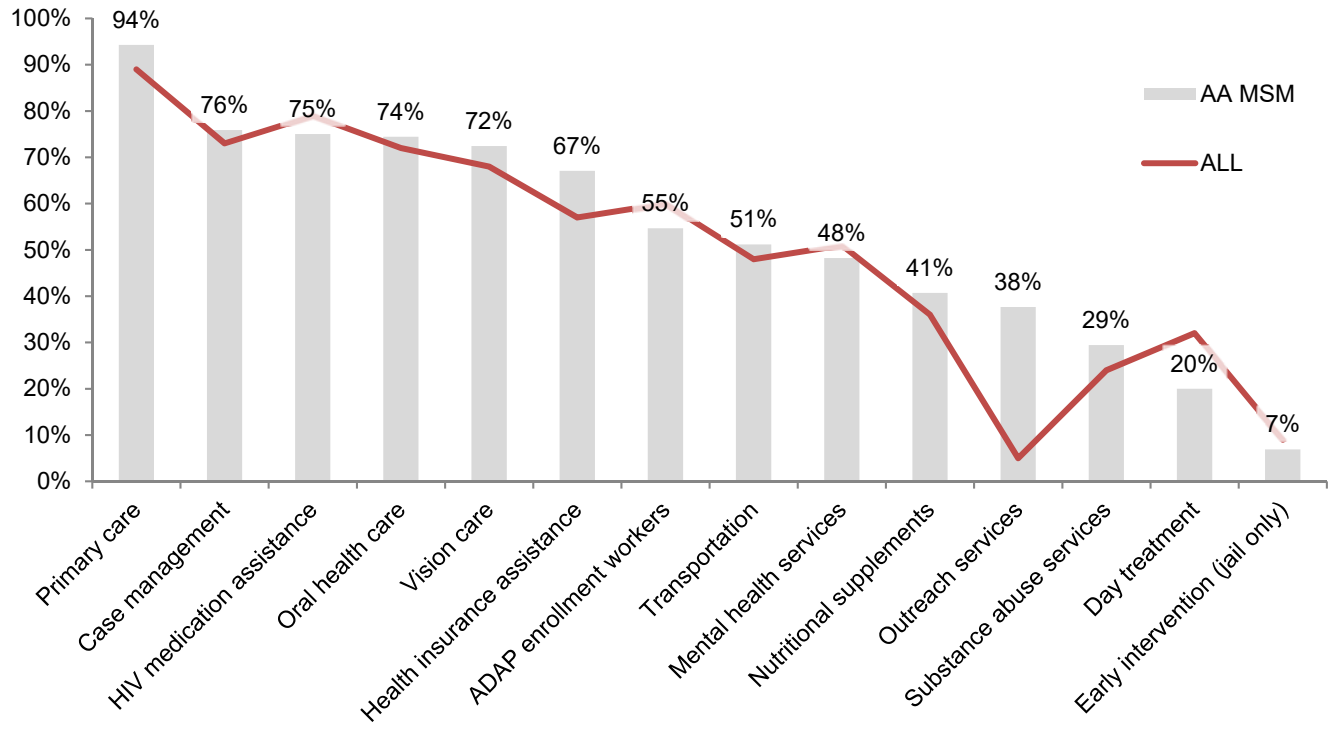
OVERALL RANKING OF FUNDED SERVICES, BY NEED

In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Among African American MSM participants, primary care was the most needed funded service at 94% of African American MSM participants reporting need, followed by case management (76%), HIV medication assistance (75%), oral health care (74%), vision care (72%), and health insurance assistance (67%). Compared to the total sample, higher proportion of African American MSM participants reported needing outreach services (38% vs 5%), health insurance assistance (67% vs 57%), primary care (94% vs 89%), nutritional supplements (41% vs 36), and substance abuse services (29% vs 24%). Lower proportions reported needing day treatment (20% vs 32%), ADAP enrollment workers (55% vs 60%), and HIV medication assistance (75% vs. 79%).

GRAPH 2-Ranking of HIV Services among African American MSM PLWH in the Houston Area, By Need, 2020

Definition: Percent of African American MSM needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



OTHER IDENTIFIED NEEDS

In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV-related services they needed in the past 12 months.

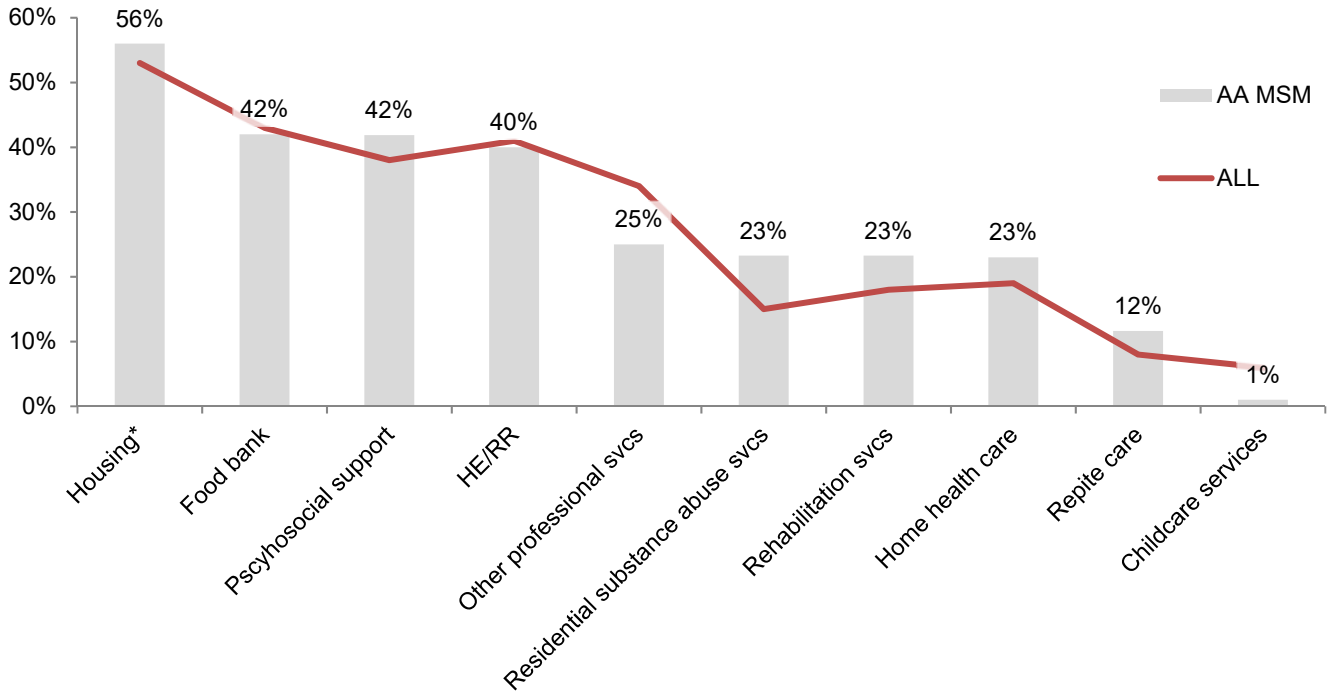
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, 56% of African American MSM reported housing as the most needed. Additionally, African American MSM participants reported a need for the following other/non-Ryan White funded HIV-related services: food bank (42%), psychosocial support (42%), and health education and risk reduction (HE/RR) (40%).

Compared to the total sample, higher proportions of African American MSM reported a need for residential substance abuse services (23% vs 15%), rehabilitation services (23% vs 18%), home health care (23% vs 19%), psychosocial support (42% vs 38%), and respite care (12% vs 8%). Lower proportions of participants reported needing the following other/non-Ryan White funded HIV-related services: professional services (25% vs 34%), and childcare services (1% vs 6%).

GRAPH 3-Other Needs for HIV Services among African American MSM PLWH in the Houston Area, 2020

Definition: Percent of African American MSM needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



OVERALL BARRIERS TO HIV CARE

The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 district barriers. These barriers were then grouped together into 12 nodes, or barrier types.

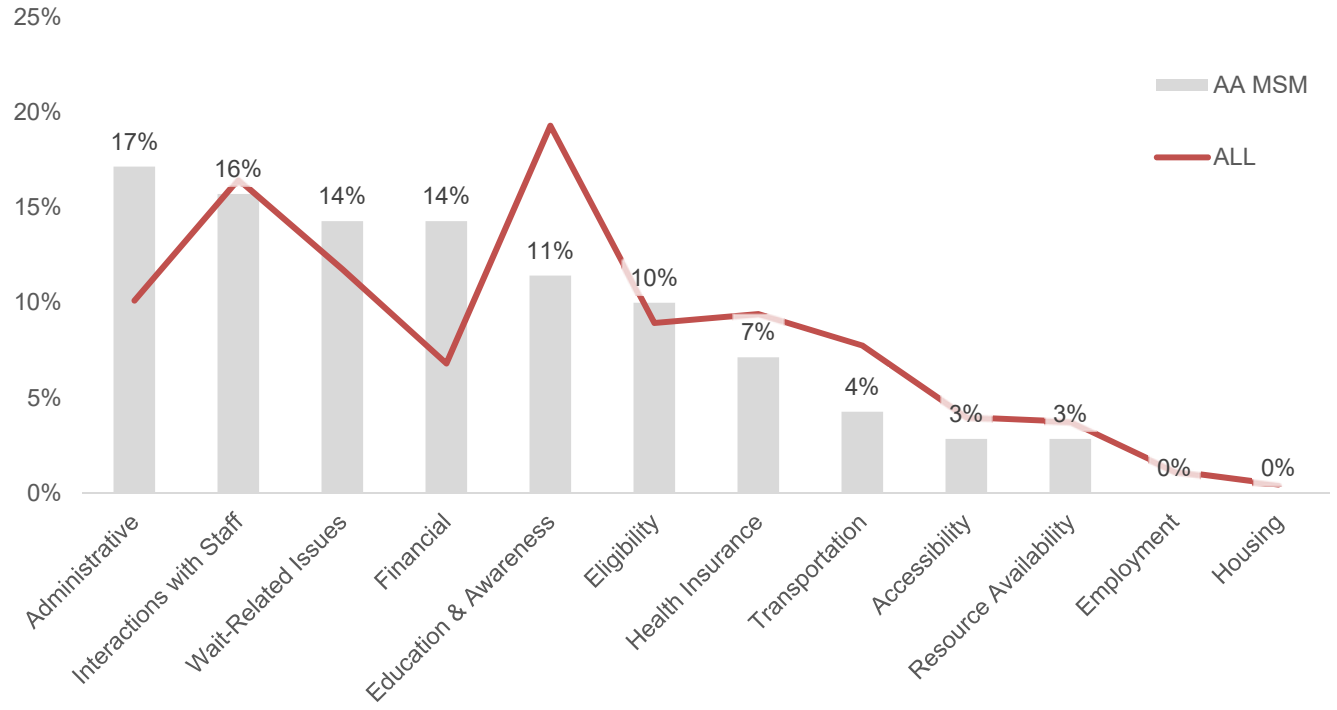
(**Graph 4**) Eighty-six (86) African American MSM participants cited barriers to Ryan White funded HIV care services. African American MSM participants most often cited barriers related to administrative issues (17%), interactions with staff (16%), wait related issues (14%), and financial barriers (14%).

Complex and lengthy processes needed to access services, changes in services and dismissal at agencies and clinics were administrative barriers reported by African American MSM respondents. Barriers reported by African American MSM respondents reporting interactions with staff as a barrier mentioned poor communication from staff, poor treatment by staff, lack of staff knowledge of services, and not receiving a referral to services as barriers.

Compared to the general sample, a greater proportion of African American MSM participants reported encountering administrative barriers (17% vs 10%), as well as barriers related to the participants finances (14% vs 7%). A lower proportion of African American MSM participants reported barriers related to education and awareness (11% vs 19%) as well as wait-related issues (14% vs 12%).

GRAPH 4-Ranking of Types of Barriers to HIV Services among African American MSM PLWH in the Houston Area, 2020

Definition: Percent of times each barrier type was reported by African American MSM needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



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Centers for Disease Control and Prevention. (2020, October 23). *HIV and African American Gay and Bisexual Men*. Retrieved from https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-31/index.html.

Hispanic/Latino Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

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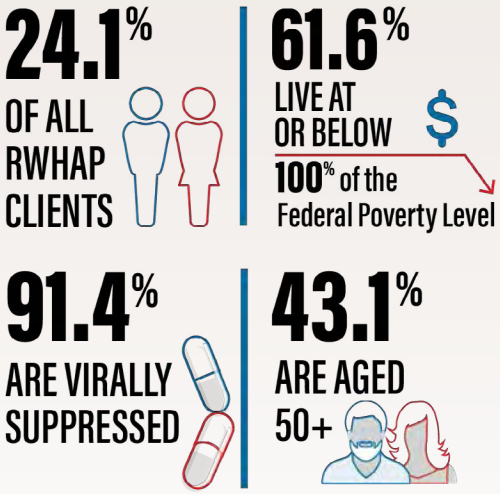
Ryan White HIV/AIDS Program Fast Facts: Hispanic/Latino Clients



HRSA Ryan White HIV/AIDS Program

Of the more than half a million clients served by RWHAP, 73.3 percent are people from racial and ethnic minorities; 24.1 percent of all RWHAP clients are Hispanic/Latino people.

Learn more about Hispanic/Latino clients served by RWHAP:

- The majority of Hispanic/Latino clients served by RWHAP are male. Data show that 76.2 percent of clients are male, 20.8 percent are female, and 2.9 percent are transgender.
- The majority of Hispanic/Latino clients served by RWHAP are people with lower incomes. Data show that 61.6 percent of Hispanic/Latino clients are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (59.2 percent).
- Data show that 4.4 percent of Hispanic/Latino RWHAP clients experience unstable housing. This percentage is slightly lower than the national RWHAP average (5.0 percent).
- Hispanic/Latino RWHAP clients are aging. Among all Hispanic/Latino RWHAP clients, 43.1 percent are aged 50 years and older.
- Among Hispanic/Latino male RWHAP clients, 68.2 percent are men who have sex with men. This percentage is slightly higher than the RWHAP national average (67.4 percent) of all male clients.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication as prescribed and reach and maintain viral suppression cannot sexually transmit the virus to their partner. According to 2021 data, 91.4 percent of Hispanic/Latino RWHAP clients receiving HIV medical care are virally suppressed,* which is higher than the national RWHAP average (89.7 percent).

- 91.5 percent of Hispanic/Latino men receiving RWHAP HIV medical care are virally suppressed.
- 91.5 percent of Hispanic/Latina women receiving RWHAP HIV medical care are virally suppressed.

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

2020 Houston HIV Care Services Needs Assessment: Profile of Hispanic/Latino Men Who Have Sex with Men (MSM)

For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
Houston Area Ryan White Planning Council
Tel: (832) 927-7926
Web: rwpchouston.org

PROFILE OF HISPANIC/LATINO MSM

An analysis conducted by the Centers for Disease Control & Prevention (**CDC**) showed that among all new HIV diagnoses in 2018 within the U.S., 21% were among Hispanic/Latino men who have sex with men (**MSM**) (Center for Disease Control & Prevention, 2020). Though no single cause has been identified, intersections of high prevalence, racism, discrimination, stigma, homophobia, and fear of disclosing their immigration status likely contribute to increased transmission vulnerability among Hispanic/Latino MSM (Center for Disease Control & Prevention, 2020). A persistent challenge to designing HIV prevention and care services that meet the needs of Houston area people living with HIV (**PLWH**) is ensuing that services remain relevant and responsive to the needs of both the general population and groups with increased vulnerability to new transmissions and unmet need. Data about service needs and barriers Hispanic/Latino MSM PLWH in the Houston area encounter is of particular importance to local HIV planning, as this information equips communities to design prevention and care services that meet the unique needs of disproportionately affected groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment, as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include Hispanic/Latino MSM participants. This Profile highlights results *only* for participants who were Hispanic/Latino MSM, as well as comparisons to the entire needs assessment sample.

Notes: This analysis defines Hispanic/Latino MSM as PLWH who indicated they were cis-gender men with a primary race/ethnicity of Hispanic/Latino, and self-identified as gay, bisexual, pansexual, or undecided. Results for participants who are transgender or gender non-conforming were reported in a separate profile available on the Houston Ryan White Planning Council website.

Data presented in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile. (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check-all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 44 participants in the 2020 Houston HIV Care Services Needs Assessment were Hispanic/Latino MSM, comprising 8% of the entire sample.

Ninety-three percent (93%) of Hispanic/Latino MSM participants were residing in Houston/Harris County at the time of data collection. Compared to the total sample of the needs assessment participants, the majority of the respondents were between the ages of 35 to 64 (84%), have been a citizen of the U.S. for more than 5 years (48%), and primarily had health insurance through public health insurance programs (82%); Medicaid/Medicare (27%), the Harris Health System (23%), and Ryan White (32%). Among Hispanic/Latino MSM needs assessment participants, 71% had annual incomes that were 100% below the Federal Poverty Level (**FPL**). The average annual income reported by Hispanic/Latino MSM was $10,871.

Compared to all needs assessment participants, higher proportions of Hispanic/Latino MSM participants were between the ages of 55 to 64 (36% vs 28%), were U.S. citizens for more than 5 years (48% vs 10%), and were 100% below the FPL, and had higher occurrences of having health insurance (7% vs 2%). Hispanic/Latino MSM participants who reported income had a lower average annual income when compared to the total sample of the needs assessment ($10,871 vs $11,360).

Characteristics of African American MSM participants (as compared to all participants in general) can be summarized as follows:

- Residing in Houston/Harris County
- Adults between the ages of 35 and 64
- Lower average annual income
- Higher proportion of having no health insurance or utilizing public health insurance program.

TABLE 1-Select Characteristics among Hispanic/Latino MSM Participants, Houston Area HIV Needs Assessment, 2020

	No.	H/L MSM %	Total %
County of residence			
Harris	41	93%	95%
Fort Bend	1	2%	2%
Montgomery	1	2%	1%
Other	1	2%	1.6%
Immigration status			
Born in the U.S.	18	41%	88%
Citizen > 5 years	21	48%	10%
Citizen < 5 years	5	11%	1%
Visa (student, work, tourist, etc.)	0	-	0.2%
Prefer not to answer	0	-	0.7%

	No.	H/L MSM %	Total %
Age range (median: 50-54)			
13-17	0	-	-
18-24	1	2%	3%
25-34	4	9%	9%
35-49	13	30%	28%
50-54	8	18%	18%
55-64	16	36%	28%
≥65	2	5%	15%
Seniors (≥50)	26	29%	60%
Yearly income (average: $10,871)			
Federal Poverty Level (FPL)			
Below 100%	12	71%	67%
100%	3	18%	19%
150%	2	12%	6%
200%	0	-	5%
250%	0	-	0.7%
≥300%	0	-	2%

	No.	H/L MSM %	Total %
Sexual orientation (self-reported)			
Heterosexual	39	93%	30%
Gay	3	7%	9%
Bisexual / Pansexual	0	0%	1%
Undecided	1	2%	2%
Health insurance (multiple response)			
Private insurance	6	10%	9%
Medicaid/Medicare	16	27%	67%
Harris Health System	14	23%	29%
Ryan White Only	19	32%	24%
VA	1	2%	3%
None	4	7%	2%

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighed using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

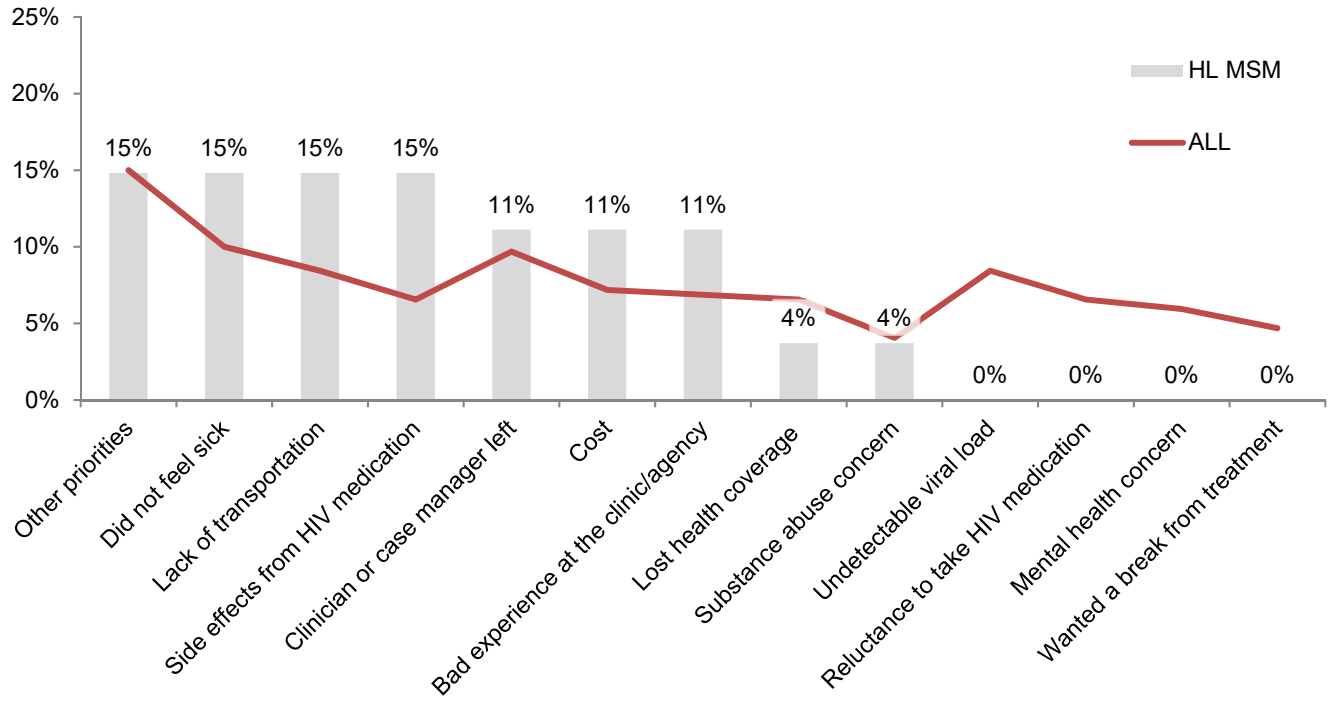
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months of more since their diagnosis, 81% of Hispanic/Latino MSM needs assessment participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey, and participants could provide multiple reasons. Participants could also write-in their reasons.

(**Graph 1**) Hispanic/Latino MSM needs assessment participants reported other priorities, not feeling sick, lack of transportation, and side effects from HIV medications (all 15%) as reasons for falling out of HIC medical care. Hispanic/Latino MSM also reported their clinician or case manager leaving, the cost of services, and bad experiences at the clinic/agency (all 11%) as reasons for falling out of HIV care.

Compared to the total sample, a higher proportion of Hispanic/Latino MSM participants reported having side effects from HIV medication (15% vs 7%), lack of transportation (15% vs 8%), and not feeling sick (15% vs 10%) as reasons for the lapse in HIV medical care. One write-in response was provided which reported "stupidity" as the reason for their lapse in HIV medical care.

GRAPH 1-Reasons for Falling Out of HIV Care among Hispanic/Latino MSM PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by Hispanic/Latino MSM needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



OVERALL RANKING OF FUNDED SERVICES, BY NEED

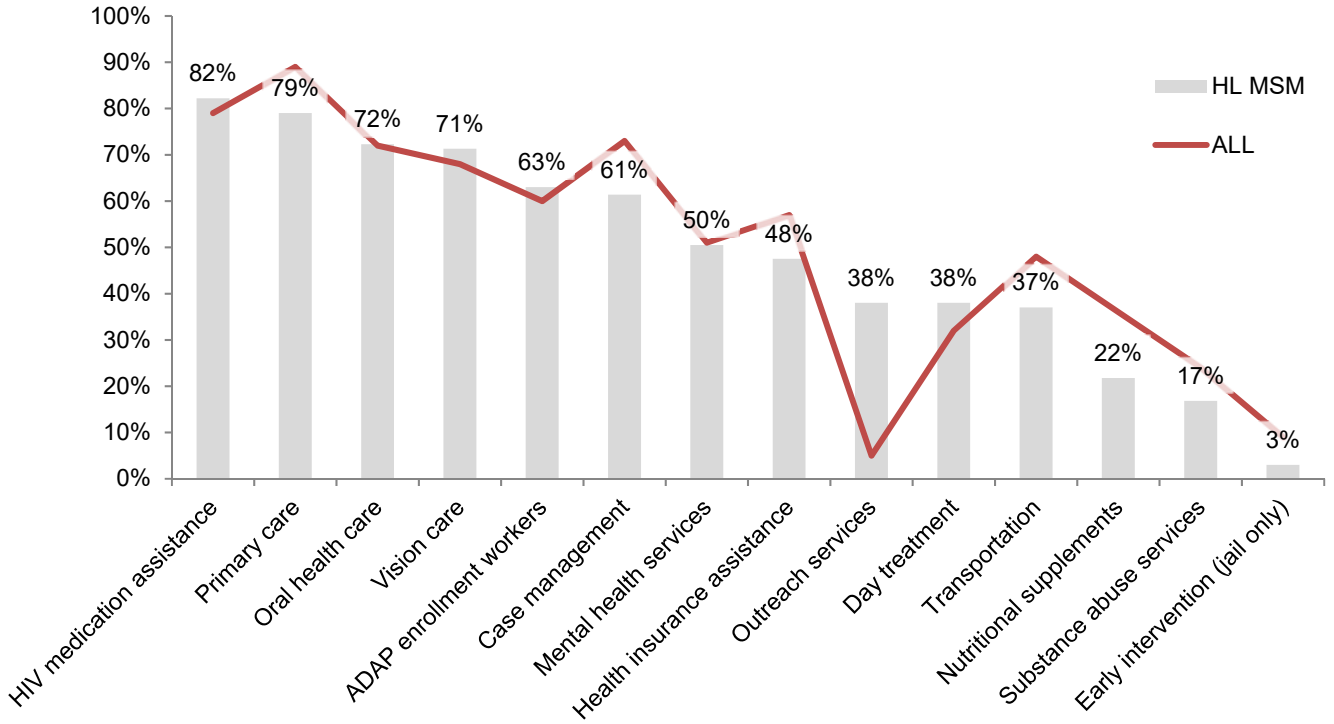
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Among Hispanic/Latino MSM participants, HIV medication assistance was the most needed funded service at 82% of Hispanic/Latino MSM participants reporting need. Hispanic/Latino MSM needs assessment participants also reported a need for primary care (79%), oral health care (72%) and vision care (71%).

Overall Hispanic/Latino MSM reported less need for funded services by the Houston Area Ryan White HIV/AIDS Program. However, Hispanic/Latino MSM did report a much greater need for outreach services when compared to the total sample (38% vs 5%). Lower proportions of Hispanic/Latino MSM reported needing nutritional supplements (22% vs 36%), case management (61% vs 73%), and transportation (37% vs 48%).

GRAPH 2-Ranking of HIV Services among Hispanic/Latino MSM PLWH in the Houston Area, By Need, 2020

Definition: Percent of Hispanic/Latino MSM needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



OTHER IDENTIFIED NEEDS

In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV-related services they needed in the past 12 months.

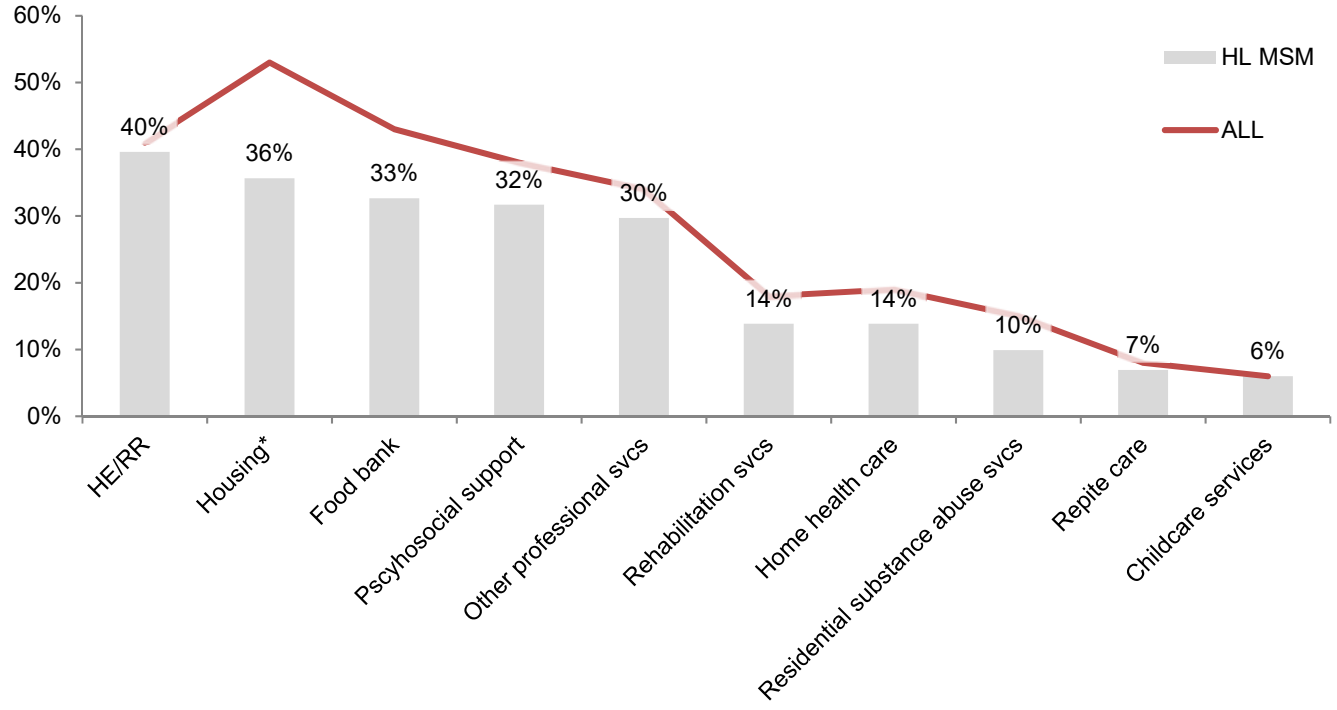
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, 40% of Hispanic/Latino MSM reported need for health education & risk reduction services as the most needed. Additionally, Hispanic/Latino MSM reported a need for housing (36%), food bank (33%), and psychosocial support services (32%).

Overall, Hispanic/Latino MSM reported a lower need for other/non-Ryan White Services in the 2020 Houston Care Services Needs Assessment. Compared to the total sample, lower proportions of Hispanic/Latino MSM reported need for housing (36% vs 53%), and food bank (33% vs 43%).

GRAPH 3-Other Needs for HIV Services among Hispanic/Latino MSM PLWH in the Houston Area, 2020

Definition: Percent of Hispanic/Latino MSM needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



OVERALL BARRIERS TO HIV CARE

The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

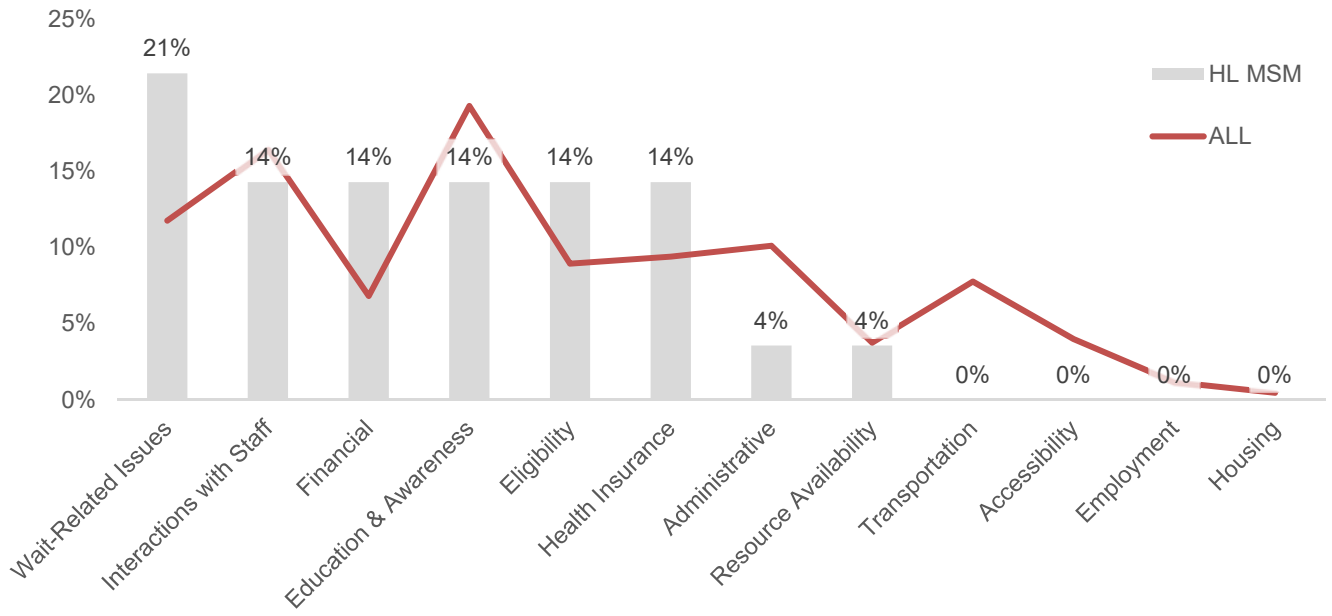
(**Graph 4**) Sixteen (16) Hispanic/Latino MSM participants cited barriers to Ryan White funded HIV care services. Hispanic/Latino MSM participants most often cited barriers related to wait issues (21%), interactions with staff at the agency or clinic, financial barriers, and education and awareness of services in the Houston area (all 14%).

Wait-related issues reported by Hispanic/Latino were related to being put on a waitlist, the service not being available due to a full waitlist, wait times at appointments, and approval of the application for the service. Issues related to interactions with staff reported by Hispanic/Latino MSM were that there was poor communication from staff, and providers not providing a referral for services. Barriers related to education and awareness of services were related to Hispanic/Latino MSM participants not knowing that a service was available.

Compared to the general sample, a greater proportion of Hispanic/Latino MSM participants reported encountering barriers that were wait-related (21% vs 12%), and related to finances or not being able to afford the service (14% vs 7%). Lower proportions of Hispanic/Latino MSM reported barriers related to transportation (0% vs 8%), and administrative issues (4% vs 10%) when compared to the total sample.

GRAPH 4-Ranking of Types of Barriers to HIV Services among Hispanic/Latino MSM PLWH in the Houston Area, 2020

Definition: Percent of times each barrier type was reported by Hispanic/Latino MSM needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



Works Cited

Centers for Disease Control and Prevention. (2020, May 7). *Diagnoses of HIV Infection in the United States and Dependent Areas, 2018*. Retrieved fromhttps://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-31/index.html.

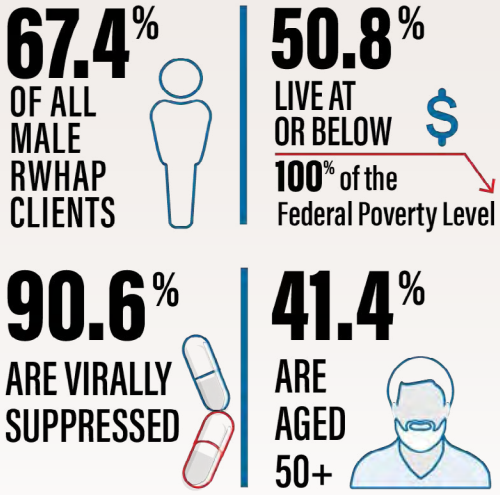
Gay, Bisexual, and Other Men Who Have Sex with Men (MSM) Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—more than 576,000 people in 2021—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission. For more than three decades, RWHAP has worked to stop HIV stigma and reduce health disparities by caring for the whole person and addressing their social determinants of health.

Ryan White HIV/AIDS Program Fast Facts: Gay, Bisexual, and Other Men Who Have Sex with Men Clients



HRSA
Ryan White HIV/AIDS Program

A significant proportion of RWHAP clients are men who have sex with men (MSM). Of the more than half a million clients served by RWHAP, 48.8 percent are MSM. Of male clients served by RWHAP, 67.4 percent are MSM.

Learn more about MSM clients served by RWHAP:

- The majority of MSM clients served by RWHAP are a diverse population. Data show that 65.5 percent of MSM RWHAP clients are people from racial and ethnic minorities. Among MSM RWHAP clients, 34.5 percent are white, 36.1 percent are Black/African American, and 25.7 percent are Hispanic/Latino.
- More than half of MSM clients served by RWHAP are people with lower incomes. Of the MSM RWHAP clients served, 50.8 percent are living at or below 100 percent of the federal poverty level, which is significantly lower than the national RWHAP average (59.2 percent).
- Among MSM RWHAP clients, 4.7 percent experience unstable housing. This percentage is slightly lower than the national RWHAP average (5.0 percent).
- MSM RWHAP clients are aging. MSM clients aged 50 years and older account for 41.4 percent of all MSM RWHAP clients. This percentage is lower than the national RWHAP average (48.3 percent).

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication as prescribed and reach and maintain viral suppression cannot sexually transmit the virus to their partner. According to 2021 data, 90.6 percent of MSM receiving RWHAP HIV medical care are virally suppressed,* which is slightly higher than the national RWHAP average (89.7 percent).

- 84.5 percent of young MSM (aged 13–24) receiving RWHAP HIV medical care are virally suppressed.
- 82.2 percent of young Black/African American MSM (aged 13–24) receiving RWHAP HIV medical care are virally suppressed.

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

2020 Houston HIV Care Services Needs Assessment: Profile of Men Who Have Sex with Men (MSM)

For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
Houston Area Ryan White Planning Council
Tel: (832) 927-7926
Web: rwpchouston.org

PROFILE OF MSM

An analysis conducted by the Centers for Disease Prevention & Control (**CDC**) in 2018 determined that 69% of all new diagnoses among adolescents and adults within the U.S. were individuals who identified as men who have sex with men (**MSM**) (Center for Disease Control & Prevention, 2020). No one cause has been identified for the large impact of HIV on MSM, high prevalence, being unaware of their status, stigma, and discrimination likely contribute to the increased transmission vulnerability among MSM (Center for Disease Control & Prevention, 2020). A persistent challenge to designing HIV prevention and care services that meet the needs of Houston area people living with HIV (**PLWH**) is ensuring that services remain relevant and responsive to the needs of both the general population and groups with increased vulnerability to new transmissions and unmet need. Data about service needs and barriers MSM PLWH in the Houston area encounter is of particular importance to local HIV planning, as this information equips communities to design prevention and care services that meet the unique needs of disproportionately affected groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment, as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include all MSM participants. This Profile highlights results *only* for participants who identified as MSM, as well as comparisons to the entire needs assessment sample

Notes: This analysis defines MSM as PLWH who indicated that they were cis-gender men who identified as gay, bisexual, or pansexual regardless of race/ethnicity. Results for participants who are African American/Black, Hispanic/Latino, and transgender or gender non-conforming were reported in separate profiles available on the Houston Ryan White Planning Council website.

Data presented in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing values or "check all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 238 participants in the 2020 Houston HIV Care Services Needs Assessment were MSM, comprising 41% of the entire sample.

Ninety-two percent (92%) of MSM participants were residing in Houston/Harris County at the time of data collection. Compared to the total sample of the needs assessment participants, the majority of respondents were between the ages of 35 to 64 (79%), primarily African American/Black (45%), and born in the U.S. (80%). MSM participants mostly self-reported sexual orientation as gay (77%); however, MSM participants also reported being bisexual (16%), pansexual (4%), and being undecided about their sexual orientation (3%). The majority of MSM needs assessment participants reported using public health insurance – such as Medicaid, Medicare, Ryan White, and the Harris Health System - to pay for HIV medical care (83%). Fifty-four percent (54%) of MSM participants had reported annual incomes 100% below the Federal Poverty Level (**FPL**), with the average annual income among MSM needs assessment participants being $15,225.

Compared to all needs assessment participants, higher proportions of MSM participants were white (25% vs 14%), used Ryan White only to pay for their HIV medical care (26% vs 24%), and had higher occurrences of having no health insurance (5% vs 2%). The average annual income reported by MSM participants who reported income was larger than that of the total sample ($15,225 vs $11,360).

Characteristics of African American MSM participants (as compared to all participants in general) can be summarized as follows:

- Residing in Houston/Harris County
- Adults between the ages of 35 and 64
- Self-identified as gay or bisexual
- Higher average annual income
- Higher proportion of having no health insurance

TABLE 1-Select Characteristics among MSM Participants, Houston Area HIV Needs Assessment, 2020

	No.	MSM %	Total %
County of residence			
Harris	197	92%	95%
Fort Bend	5	2%	2%
Montgomery	3	1%	1%
Liberty	2	1%	1%
Other	7	3%	2%
Sexual orientation (self-reported)			
Gay	163	77%	30%
Bisexual	34	16%	7%
Pansexual	8	4%	2%
Undecided	7	3%	1%
Immigration status			
Born in the U.S.	177	80%	88%
Citizen > 5 years	30	14%	10%
Citizen < 5 years	5	2%	1%
Visa (student, work, tourist, etc.)	9	4%	0%
Prefer not to answer	1	0%	1%

	No.	MSM %	Total %
Age range (median: 50-54)			
13-17	0	-	0%
18-24	11	5%	3%
25-34	22	11%	9%
35-49	60	30%	28%
50-54	34	17%	18%
55-64	65	32%	28%
≥65	10	5%	14%
Seniors (≥50)	169	88%	60%
Yearly income (average: $15,225)			
Federal Poverty Level (FPL)			
Below 100%	56	54%	67%
100%	20	19%	19%
150%	11	11%	6%
200%	7	7%	5%
250%	0	0%	1%
≥300%	9	9%	2%

	No.	MSM %	Total %
Primary race/ethnicity			
White	53	25%	14%
African American / Black	96	45%	60%
Hispanic/Latino	45	21%	21%
Asian American	4	2%	1%
Other/Multiracial	16	7%	5%
Health insurance (multiple response)			
Private insurance	27	10%	
Medicaid/Medicare	99	36%	
Harris Health System	58	21%	
Ryan White Only	71	26%	
VA	6	2%	
None	13	5%	

BARRIERS TO RETENTION IN CARE

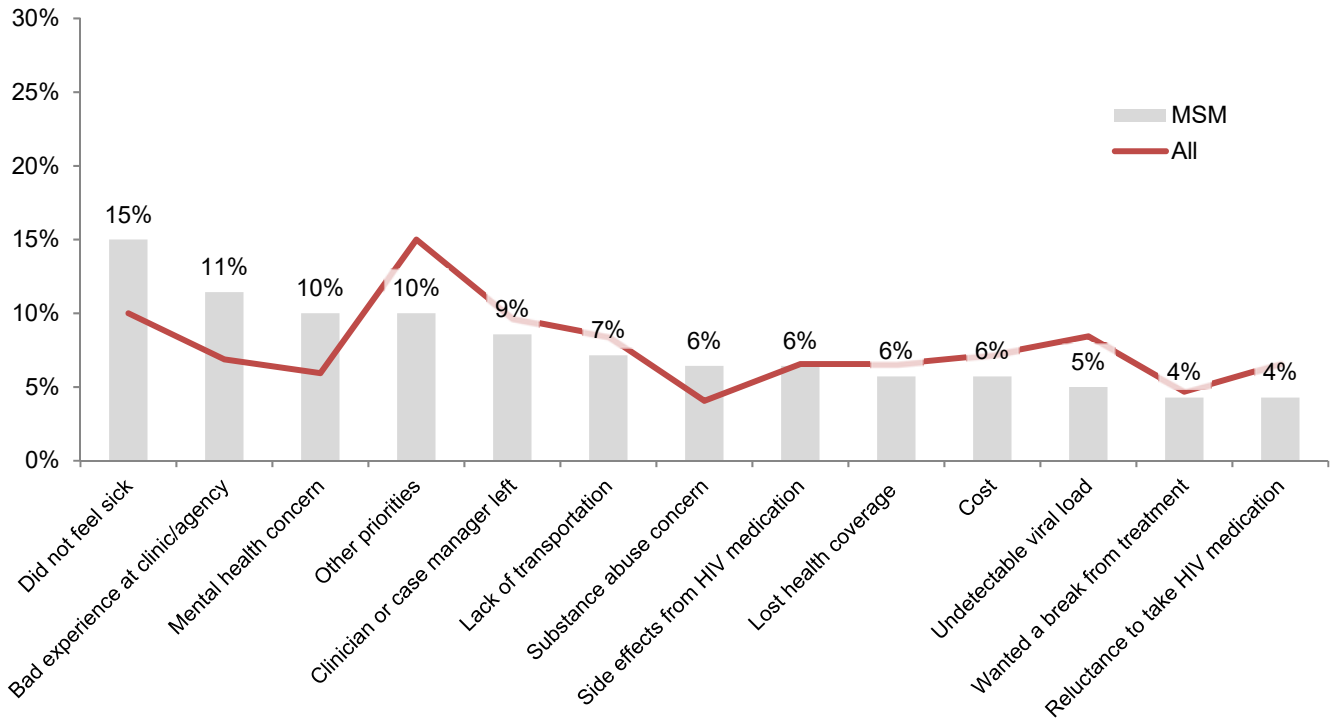
As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 70% of MSM participants reported no interruptions in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey, and participants could select multiple reasons and write in their reasons.

(**Graph 1**) Among MSM participants, not feeling sick was the most cited reason for interruption in HIV medical care (15%), followed by bad experiences at the clinic or agency (11%), mental health concerns (10%), and other priorities (10%). Compared to the total sample, a higher proportion of MSM participants reported not feeling sick (15% vs 10%), and bad experiences at the clinic or agency (11% vs 7%) as reasons for the lapse in care. Write in responses provided for this question varied with reasons reported by participants for lapses in HIV medical care being that they "didn't want to deal with it now", being homeless, not wanting family to know about their medications, being incarcerated, not knowing where to go to get care, and they weren't aware of the dates of their appointments.

GRAPH 1-Reasons for Falling Out of HIV Care among MSM PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by MSM needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



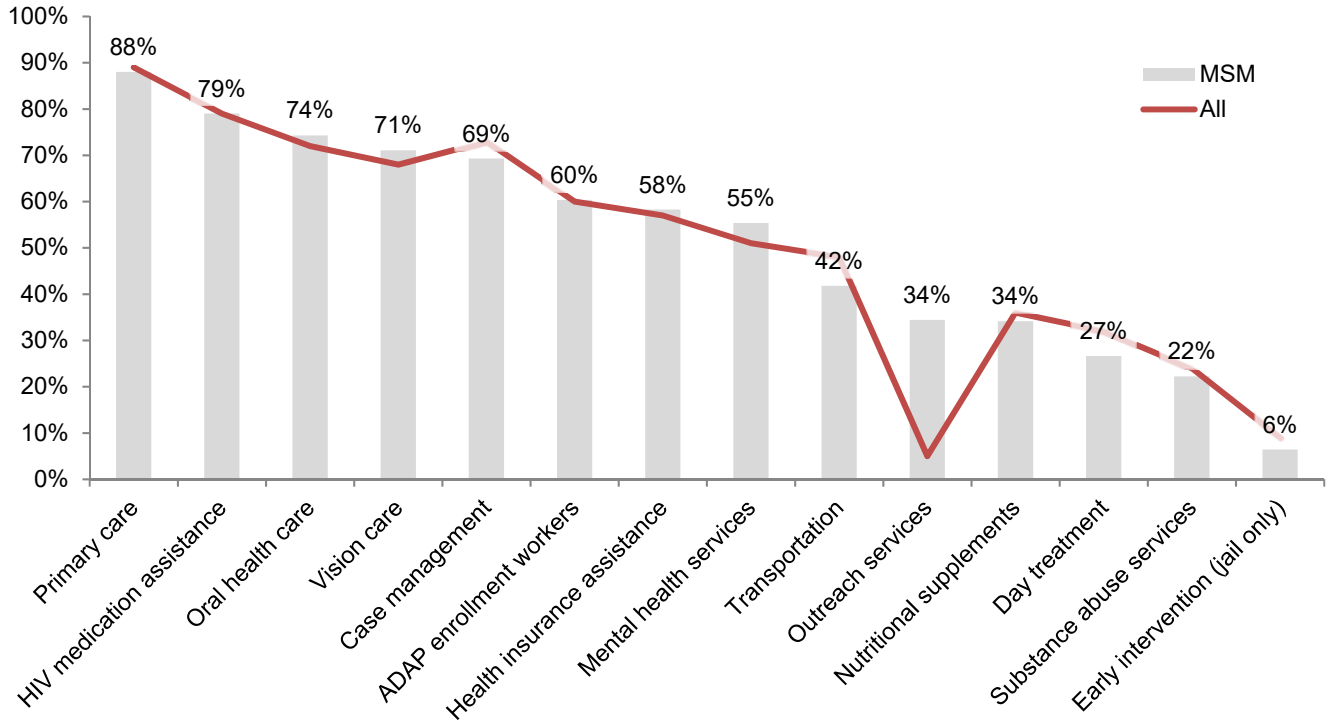
OVERALL RANKING OF FUNDED SERVICES, BY NEED

In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Among MSM participants, primary care was the most needed funded service at 88% of MSM participants reporting need, followed by HIV medication assistance (79%), oral health care (74%), and vision care (71%). When comparing need for HIV core medical and support services funded through the Houston Area Ryan White HIV/AIDS Program of MSM participants with the total sample, we see that the trends are similar, with the exception of one service. MSM participants reported a much higher proportion of need for outreach services when compared to the total sample (34% vs 5%).

GRAPH 2-Ranking of HIV Services among MSM PLWH in the Houston Area, By Need, 2020

Definition: Percent of MSM needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



OTHER IDENTIFIED NEEDS

In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV-related services they needed in the past 12 months.

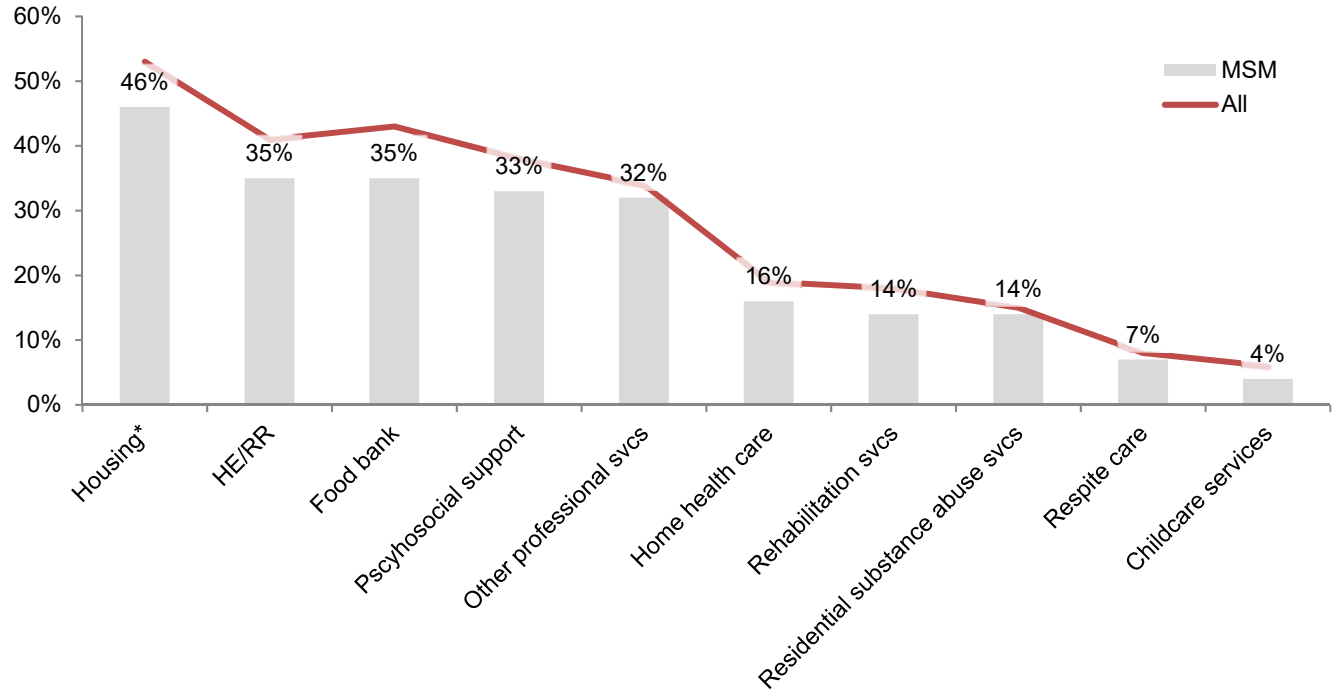
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, forty-six percent (46%) of MSM participants reported housing as the most needed. Additionally, MSM participants reported a need for health education & risk reduction (HE/RR) (35%), food bank (35%), and psychosocial support (33%).

Compared to the total sample, MSM participants reported lower need for all other/non-Ryan White funded HIV-related services. MSM participants reported lower proportions of need for food bank (35% vs 43%), housing (46% vs 53%), and health education & risk reduction (35% vs 41%).

GRAPH 3-Other Needs for HIV Services among MSM PLWH in the Houston Area, 2020

Definition: Percent of MSM needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



OVERALL BARRIERS TO HIV CARE

The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 district barriers. These barriers were then grouped together into 12 nodes, or barrier types.

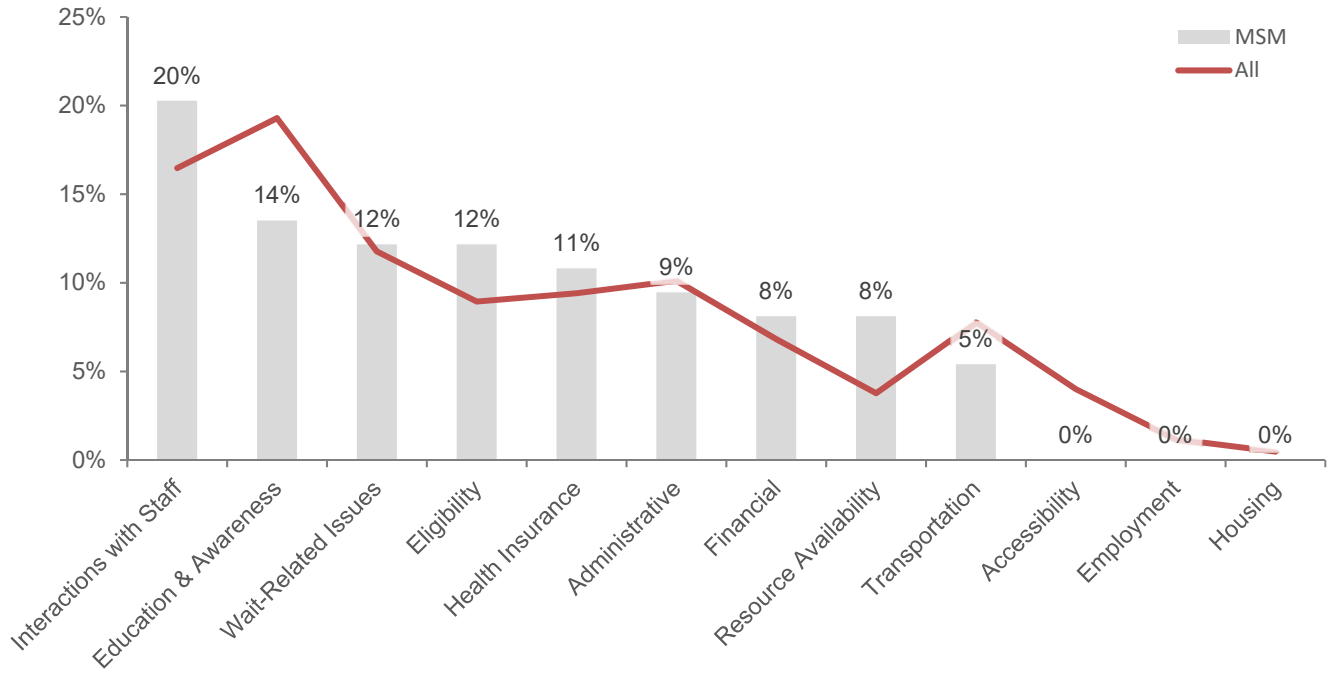
(**Graph 4**) Ninty (90) MSM participants cited barriers to Ryan White funded HIV care services. MSM participants most often cited interactions with staff (20%), service education & awareness (14%), as well as wait and eligibility related barriers (both 12%).

Poor treatment by staff, difficulty receiving a referral, and poor communication from staff were barriers related to interactions with staff reported by MSM participants. Not knowing a service was available, not knowing where to go, and not knowing who to contact for services were service education & awareness barriers reported by MSM participants. Being put on a waitlist, and redundant processes for service eligibility were the wait-related and eligibility related barriers reported by MSM participants.

Compared to the general sample, a greater proportion of MSM participants reported encountering barriers related to interactions with staff (20% vs 16%), and eligibility for services (12% vs 9%). Lower proportions of MSM participants reported barriers related to service education & awareness (14% vs 19%), and accessibility to services (0% vs 4%).

GRAPH 4-Ranking of Types of Barriers to HIV Services among MSM PLWH in the Houston Area, 2020

Definition: Percent of times each barrier type was reported by MSM needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



Works Cited

Centers for Disease Control and Prevention. (2020, May 7). *Diagnoses of HIV Infection in the United States and Dependent Areas, 2018*. Retrieved fromhttps://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-31/index.html.

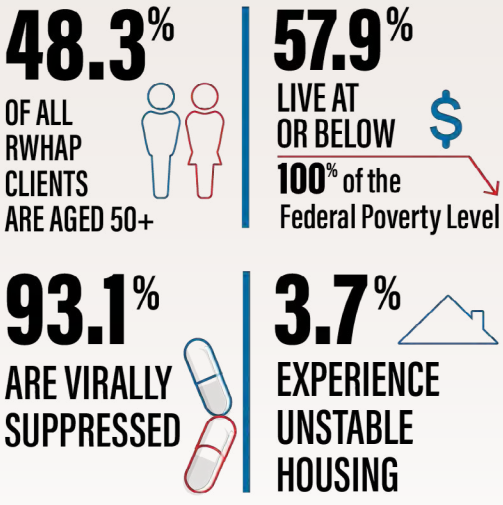
Older Adult Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—more than 576,000 people in 2021—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission. For more than three decades, RWHAP has worked to stop HIV stigma and reduce health disparities by caring for the whole person and addressing their social determinants of health.

Ryan White HIV/AIDS Program Fast Facts: Older Adult Clients



HRSA
Ryan White HIV/AIDS Program

RWHAP clients are aging. Of the more than half a million clients served by RWHAP, 48.3 percent are people aged 50 years and older.

Learn more about these clients served by RWHAP:

- The majority of RWHAP clients aged 50 years and older are a diverse population. Among RWHAP clients aged 50 years and older, 67.6 percent are people from racial and ethnic minorities; 43.4 percent of RWHAP clients in this age group are Black/African American people, which is lower than the national RWHAP average (45.8 percent). Additionally, 21.4 percent of RWHAP clients in this age group are Hispanic/Latino people, which is lower than the national RWHAP average (24.1 percent).
- The majority of RWHAP clients aged 50 years and older are male. Data show that approximately 70.7 percent of clients aged 50 years and older are male, 28.1 percent are female, and 1.2 percent are transgender.
- The majority of RWHAP clients aged 50 years and older are people with lower incomes. Among RWHAP clients aged 50 years and older, 57.9 percent are living at or below 100 percent of the federal poverty level, which is lower than the national RWHAP average (59.2 percent).
- Data show that 3.7 percent of RWHAP clients aged 50 years and older experience unstable housing. This percentage is lower than the national RWHAP average (5.0 percent).

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication as prescribed and reach and maintain viral suppression cannot sexually transmit the virus to their partner. According to 2021 data, 93.1 percent of clients aged 50 years and older receiving RWHAP HIV medical care are virally suppressed,* which is higher than the national RWHAP average (89.7 percent).

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

2020 Houston HIV Care Services Needs Assessment: Profile of Youth and Aging PLWH

For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
Houston Area Ryan White Planning Council
Tel: (832) 927-7926
Web: rwpchouston.org

PROFILE OF YOUTH AND AGING WITH HIV

While HIV may affect people of all ages, the impact of HIV varies across age groups. The Centers for Disease Control and Prevention (**CDC**) report that youth aged 12 to 24 accounted for 21% of new HIV diagnoses in 2018 with 92% of youth new diagnoses occurring among young men who have sex with men (**MSM**).[1] Locally, the HIV diagnosis rate for youth aged 12 to 24 in the Houston Eligible Metropolitan Area (**EMA**) was 32.6 new diagnoses per 100,000 population, 20% higher than the population as a whole.[2]

People Living with HIV (**PLWH**) ages 45 to 54 within the Houston EMA in 2019 had a prevalence rate of 386.2 diagnosed cases per 100,000 population. Data about the needs and experiences of youth and those aging with HIV in the greater Houston area are of particular importance to local HIV planning as this information equips communities to tailor HIV prevention and care services to meet the markedly different yet equally critical needs of these age groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were recently released. This profile highlights results *only* for participants who were youth or aging at the time of survey, as well as comparisons to the entire needs assessment sample.

Notes: "Youth" and "aging" are defined in this analysis as PLWH who indicated at survey that they were between 18 and 24 years of age for youth, and age 50 or over for aging. Data presented in this in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check-all" responses.

[1] https://www.cdc.gov/hiv/group/age/youth/index.html

[2] Texas Department of State Health Services

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 17 participants in the 2020 Houston HIV Care Services Needs Assessment were between the ages of 18 to 24 at the time of survey, while 353 were ages 50 and over. Youth comprised 3% of the total sample, while aging participants comprised 60%. This reflects the increasing number of aging PLLWH in the Houston area.

Eighty-nine percent (89%) of youth participants and 94% of aging participants were residing in Houston/Harris County at the time of data collection. As all needs assessment participants, the majority of youth and aging participants were male (84% and 66%) and African American/Black (53% and 62%). Among youth needs assessment participants, 19% reported not being retained in HIV care at the time of data collection. Among aging needs assessment participants, 13% reported not being retained in HIV medical care at the time of data collection.

Several differences were observed between these populations and the total sample. A greater proportion of youth participant's gender identities were reported as transgender/gender non-conforming (17% vs 4%), identified as multiracial (21% vs 4.7%), identified as gay/lesbian/bisexual/asexual (75% vs 39%). Compared to the total sample, a greater proportion of aging participants identified as heterosexual (61% vs 57%).

Several socio-economic characteristics of youth and aging participants were also different from all participants. No youth participants reported having private health insurance, and a smaller proportion reported utilizing Ryan White Program services to pay for medical care compared to the total sample (50% vs 24%). Youth needs assessment participants also showed a large proportion of having no insurance compared to the total sample (13% vs 2%). The average annual income among those reporting income for the total sample was $13,493, compared to $9,513 among youth participants and $12,011 among aging participants.

Characteristics of *youth* participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Gay/lesbian/bisexual/asexual
- Transgender/gender non-conforming
- With higher occurrences of no health insurance coverage, and lower average annual income.

Characteristics of *aging* participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Heterosexual
- With lower occurrences of no health insurance coverage, and slightly lower average annual income.

TABLE 1-Select Participant Characteristics among Youth (18-24) and Aging (50+) participants, Houston Area HIV Needs Assessment, 2016

	Youth %	Aging %	Total %
County of residence			
Harris	89%	94%	95%
Montgomery	5%	1%	1%
Walker	5%	0%	1%
Fort Bend	0%	2%	2%
Other	0%	3%	1.6%
Sexual orientation			
Heterosexual	22%	61%	57%
Gay/Lesbian	44%	28%	30%
Bisexual/Pansexual	28%	9%	9%
Other	6%	2%	3.8%
MSM	77%	37%	43%
Yearly income (average: $9,380)			
Yearly income – Youth (average: $12,017)			
Yearly income – Aging (average: $9,581)			
Federal Poverty Level (FPL)			
Below 100%	100 %	64%	67%
100%	0%	19%	19%
150%	0%	5%	6%
200%	0%	4%	5%
250%	0%	0%	0.7%
≥300%	0%	8%	2%

	Youth %	Aging %	Total %
Sex at birth			
Male	84%	66%	66%
Female	16%	34%	34%
Intesex	0%	0%	0%
Other	0%	0%	0%
Transgender/Gender Non-Conforming	17%	2%	4%
Currently pregnant	0%	0%	2%
Health insurance (multiple response)			
Private insurance	0%	7%	9%
Medicaid/Medicare	21%	56%	67%
Harris Health System	17%	21%	29%
Ryan White Only	50%	10%	24%
VA	0%	3%	3%

	Youth %	Aging %	Total %
Primary race/ethnicity			
White	11%	17%	14%
African American/Black	53%	62%	60%
Hispanic/Latino	5%	14%	21%
Asian American	5%	1%	1%
Native American or Native Alaskan	0%	1%	1%
Immigration status			
Born in the U.S.	100 %	89%	88%
Citizen > 5 years	0%	10%	10%
Citizen < 5 years	0%	1%	1%
Visa (student, work, tourist, etc.)	0%	0%	0.2%
Prefer not to answer	0%	3%	0.7%

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighed using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (see: *Methodology*, full document).

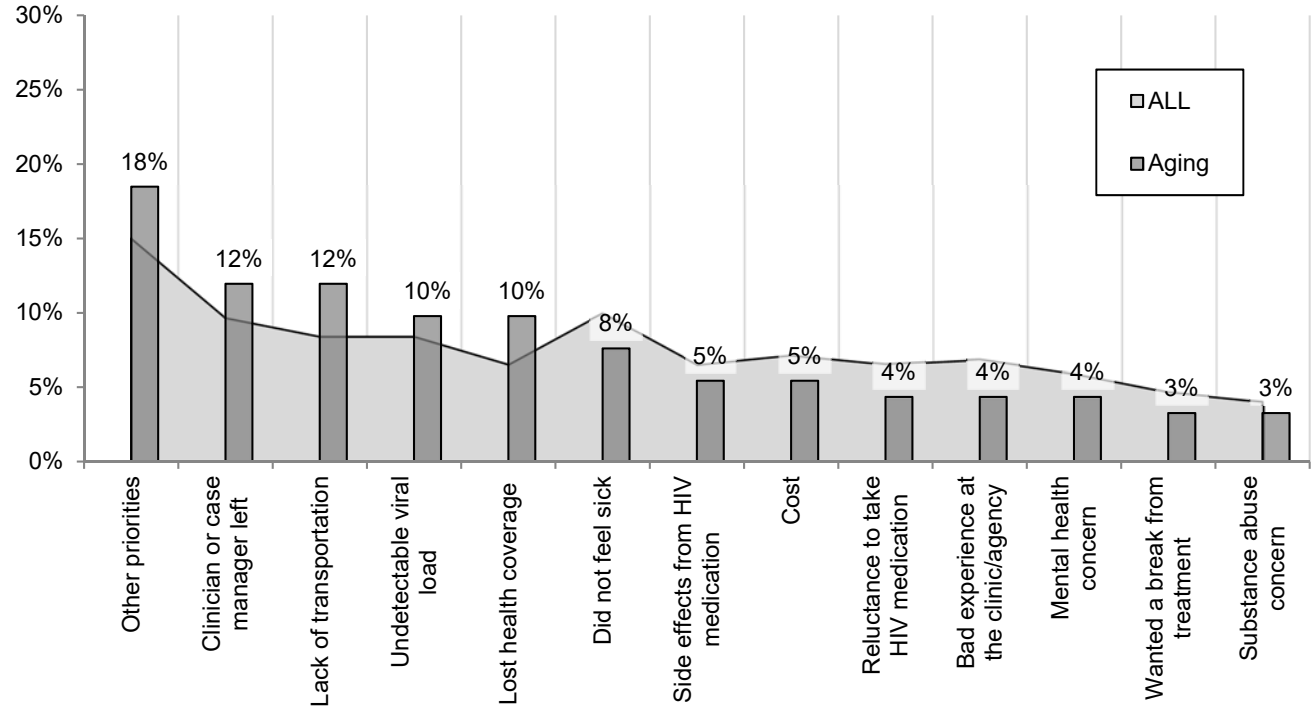
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 81% of youth and 70% of aging needs assessment participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey. Participants also had to the option to write in their reasons as well.

(**Graph 1**) The sample of youth participants with a history of interruption in care was too small to compare to the aging participants and the total sample and therefore are not reported on in this section. Among aging participants, other priorities were the most cited reason for a break in HIV medical care (18%). Other reasons for a break in HIV medical care were the clinician or case manager left the clinic/agency (12%), lack of transportation (12%), and having an undetectable viral load (10%).

Compared to the total sample, a greater proportion of aging needs assessment participants reported falling of care due to lack of transportation (12% vs 8%), other priorities (18% vs 15%), and loss of health coverage (10% vs 7%). Write-in responses that were provided by participants included being incarcerated, not wanting or being ready to start HIV medical care, it was hard to find a clinic or provider, and loss of loved ones as reported barriers to retention in HIV medical care.

GRAPH 1-Reasons for Falling Out of HIV Care among Aging PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by aging needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



OVERALL RANKING OF FUNDED SERVICES, BY NEED

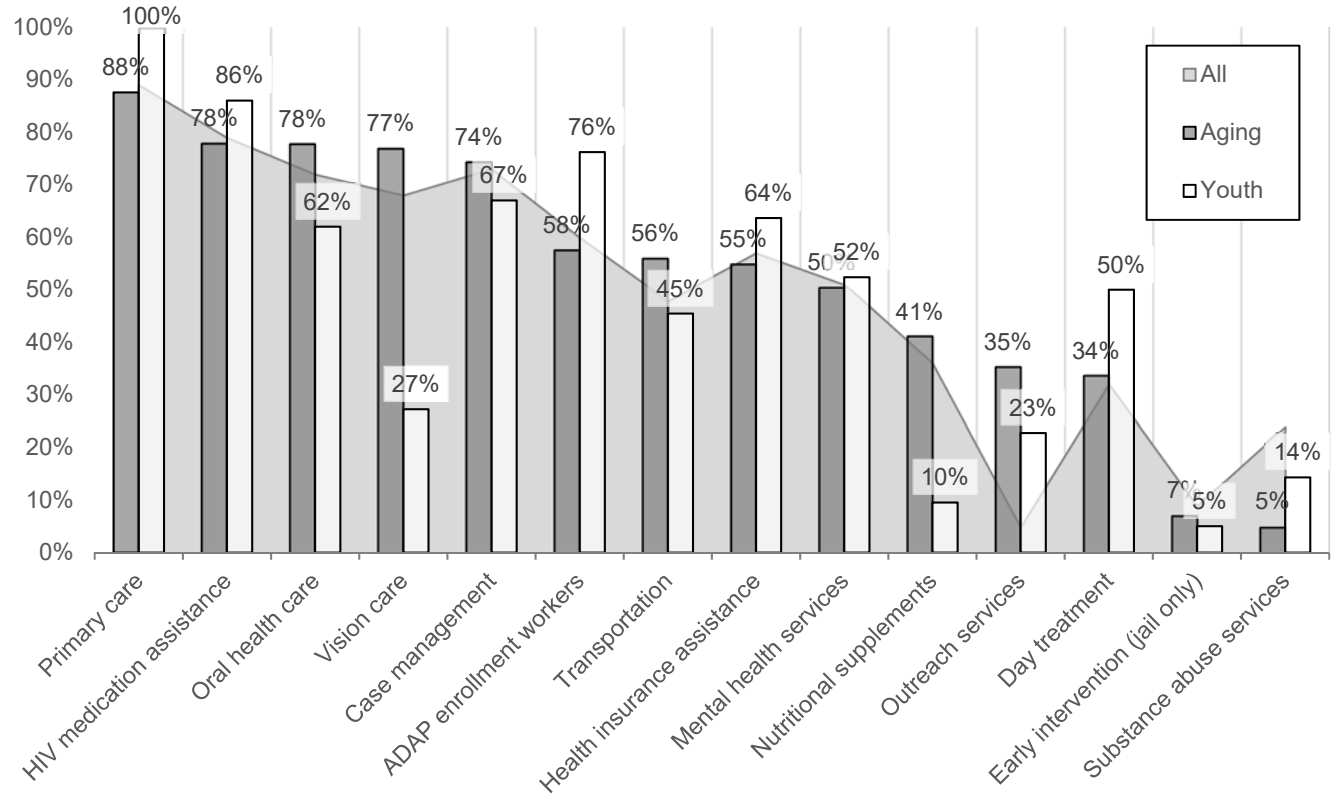
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Like the total sample, youth and aging needs assessment participants identified primary care as the most needed Ryan White funded service (100% of youth and 88% of aging participants). For youth, local HIV medication assistance (86%), ADAP enrollment workers (76%), and case management (67%) followed in ranking of need. For aging participants, local HIV medication assistance (78%), oral health care (78%), and vision care (78%) followed in ranking of need.

Compared to the total sample, higher proportions of youth participants indicated needing day treatment (50% vs 32%), outreach services (23% vs 5%), ADAP enrollment workers (76% vs 60%), primary care (100% vs 89%). Among aging needs assessment participants, a greater proportion indicated needing outreach services (35% vs 5%), vision care (77% vs 68%), and transportation (56% vs 48%).

GRAPH 2-Ranking of HIV Services among Youth (13-24) and Aging (60+) PLWH in the Houston Area, By Need, 2020

Definition: Percent of youth and aging needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

In 2020, 10 other/non-Ryan White funded HIV related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV related services they needed in the past 12 months.

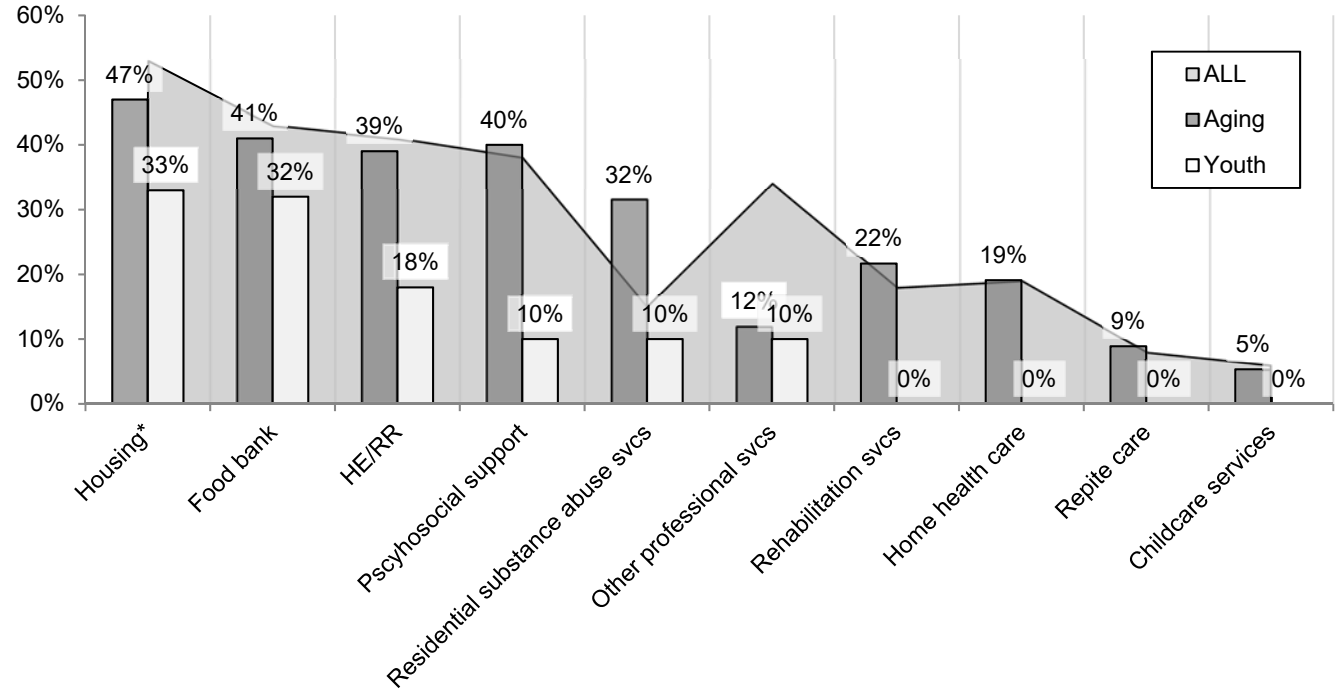
(**Graph 3**) From the 10 other/non-Ryan White funded HIV related services, the greatest proportion of youth participants reported needing housing (33%), food bank (32%), and health education and risk reduction services (18%). Among the aging needs assessment participants, the greatest reported non-Ryan White funded HIV related services were housing (47%), food bank (41%), and psychosocial support services (40%).

Aging participants reported comparable need for other services compared to the total sample, youth needs assessment participants expressed a lower need for other/non-Ryan White funded HIV-related services. Youth needs assessment participants reported a lower proportion of need for health education and risk reduction services (10% vs 41%), other professional services (10% vs 34%), and housing (33% vs 53%) when compared to the total sample.

GRAPH 3-Other Needs for HIV Services among Youth (13-24) and Aging (50+) PLWH in the Houston Area, 2020

Definition: Percent of youth and aging needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



OVERALL BARRIERS TO HIV CARE

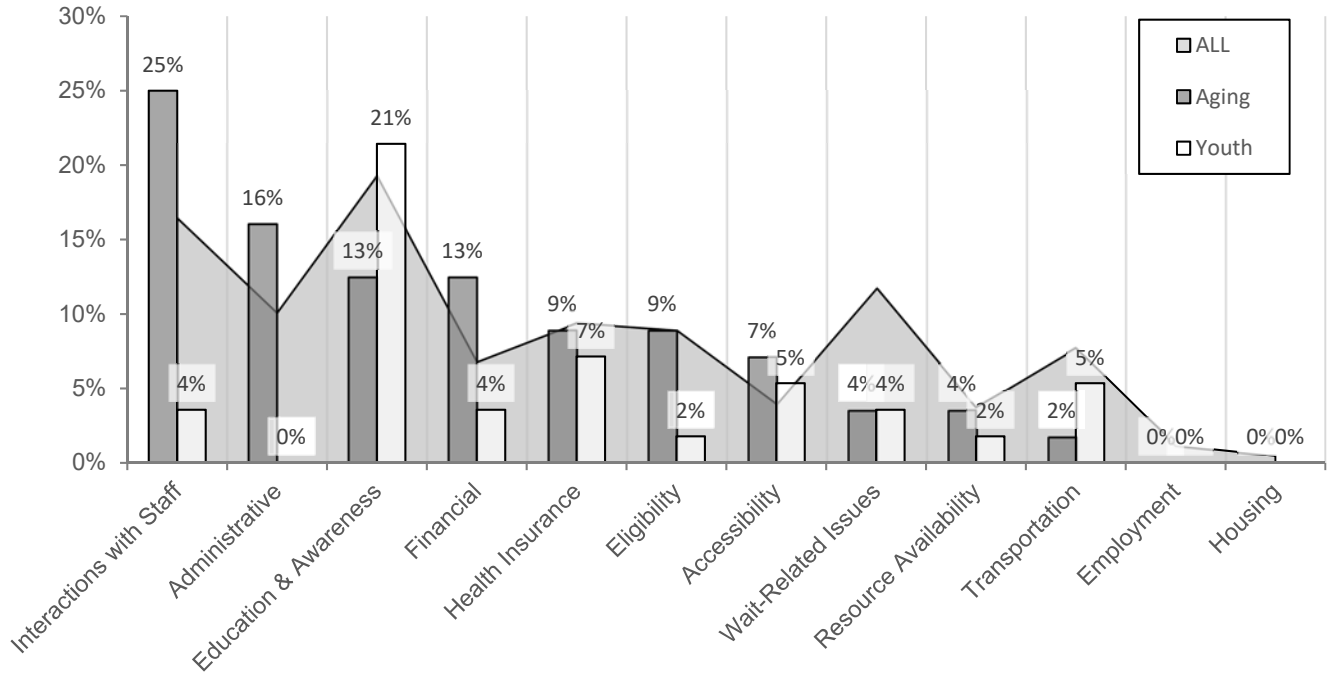
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 29 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

(**Graph 4**) Youth participants most often cited barriers related to service education and awareness issues (21%), and issues regarding health insurance (7%). Service education and awareness barriers among youth participants pertained mostly to not knowing who to contact for services, as well as not knowing that the service was available. While barriers related to health insurance among youth pertained mostly to health insurance gaps (certain services/medications not covered by the participants current health insurance) and being uninsured.

Aging needs assessment participants most often cited barriers related to interactions with staff (25%), administrative issues (16%), service education and awareness issues and issues related to finances (both 13%). Aging participants reported that issues relating to interactions with staff mainly pertained to poor treatment, staff having limited or no knowledge of services, and poor correspondence or follow-up from staff. Issues related to administrative issues reported by aging participants were complex processes at the clinic/agency, and understaffing. Education and awareness issues reported by aging participants were related to not knowing that a service was available.

GRAPH 4-Ranking of Types of Barriers to HIV Services among Youth (13-24) and Aging (50+) PLWH in the Houston Area, 2020

Definition: Percent of times each barrier type was reported by youth and aging needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



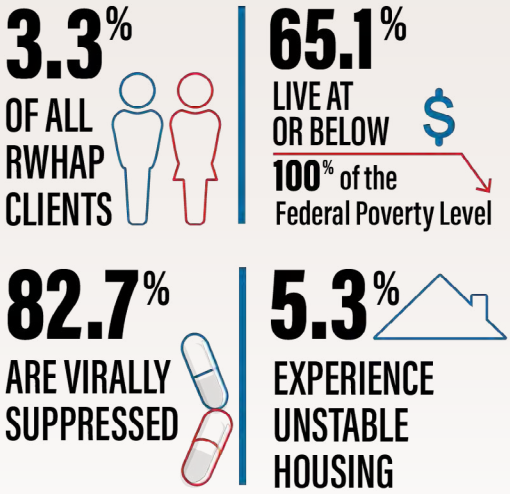
Youth and Young Adult Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—more than 576,000 people in 2021—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission. For more than three decades, RWHAP has worked to stop HIV stigma and reduce health disparities by caring for the whole person and addressing their social determinants of health.

Ryan White HIV/AIDS Program Fast Facts: Youth and Young Adult Clients



HRSA
Ryan White HIV/AIDS Program

Youth and young adults aged 13 to 24 years old represent 3.3 percent (more than 19,000 clients) of the more than half a million clients served by RWHAP.

Learn more about youth and young adult clients served by RWHAP:

- The majority of youth and young adult RWHAP clients aged 13–24 years are a diverse population. Among clients in this age group, 86.9 percent are people from racial and ethnic minorities. Data show that 58.2 percent of youth and young adult clients are Black/African American people, which is significantly higher than the national RWHAP average (45.8 percent). Hispanic/Latino people represent 24.2 percent of youth and young adult RWHAP clients, which is comparable to the national RWHAP average (24.1 percent).
- The majority of RWHAP clients aged 13–24 years are male. Data show that 75.2 percent of clients aged 13–24 years are male, 19.8 percent are female, and 4.9 percent are transgender.
- The majority of RWHAP clients aged 13–24 years are people with lower incomes. Among youth and young adult RWHAP clients, 65.1 percent are people living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (59.2 percent).
- Data show that 5.3 percent of RWHAP clients aged 13–24 years experience unstable housing. This percentage is slightly higher than the national RWHAP average (5.0 percent).

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication as prescribed and reach and maintain viral suppression cannot sexually transmit the virus to their partner. According to 2021 data, 82.7 percent of youth and young adult clients aged 13–24 years receiving RWHAP HIV medical care are virally suppressed,* which is significantly lower than the national RWHAP average (89.7 percent).

- 84.5 percent of young MSM receiving RWHAP HIV medical care are virally suppressed.
- 82.2 percent of young Black/African American MSM receiving RWHAP HIV medical care are virally suppressed.
- 78.6 percent of young Black/African American women receiving RWHAP HIV medical care are virally suppressed.
- 75.7 percent of transgender youth and young adults receiving RWHAP HIV medical care are virally suppressed.

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

Female Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

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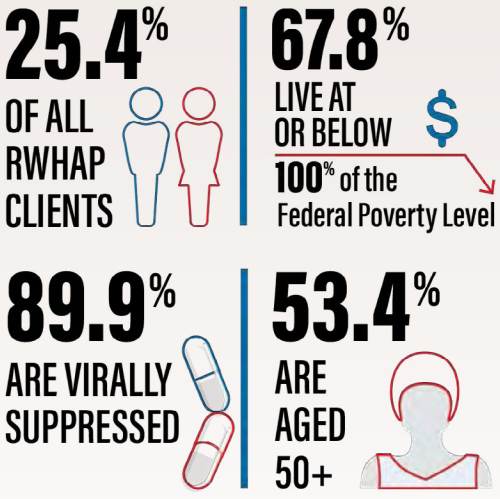
Ryan White HIV/AIDS Program Fast Facts: Female Clients



HRSA
Ryan White HIV/AIDS Program

Female clients comprise a substantial proportion of people served by RWHAP. Of the more than half a million clients served by RWHAP, 25.4 percent are female.

Learn more about these clients served by RWHAP:

- Female clients served by RWHAP are a diverse population. Data show that 83.3 percent of female clients are people from racial and ethnic minorities. 60.6 percent are Black/African American people, which is significantly higher than the national RWHAP average (45.8 percent), and 19.7 percent are Hispanic/Latina people, which is lower than the national RWHAP average (24.1 percent).
- The majority of female clients served by RWHAP are people with lower incomes. Among female clients served, 67.8 percent are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (59.2 percent).
- Data show that 3.7 percent of female RWHAP clients experience unstable housing. This percentage is slightly lower than the national RWHAP average (5.0 percent).
- RWHAP female clients are aging. Among female RWHAP clients served, 53.4 percent are aged 50 years and older, which is higher than the national average (48.3 percent). Only 2.6 percent of female RWHAP clients are aged 13–24 years.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication as prescribed and reach and maintain viral suppression cannot sexually transmit the virus to their partner. According to 2021 data, 89.9 percent of female clients receiving RWHAP HIV medical care are virally suppressed,* which is comparable to the national RWHAP average (89.7 percent).

- 89.0 percent of Black/African American women receiving RWHAP HIV medical care are virally suppressed.
- 91.5 percent of Hispanic/Latina women receiving RWHAP HIV medical care are virally suppressed.

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

Black Women and HIV in Texas

The Big Picture

Since 2012, the number of new HIV diagnoses among Black women living in Texas has decreased by 24 percent. Still, as of 2021, Black women have the highest rate of new HIV diagnoses compared to women of other races/ethnicities. In 2021, there were 11,788 Black women living with HIV in Texas. Although Black women make up only 13 percent of the Texas female population, they are 56 percent of women living with HIV. This shows the continued need to promote HIV prevention and education in Black women.

Black Women Living with HIV in Texas

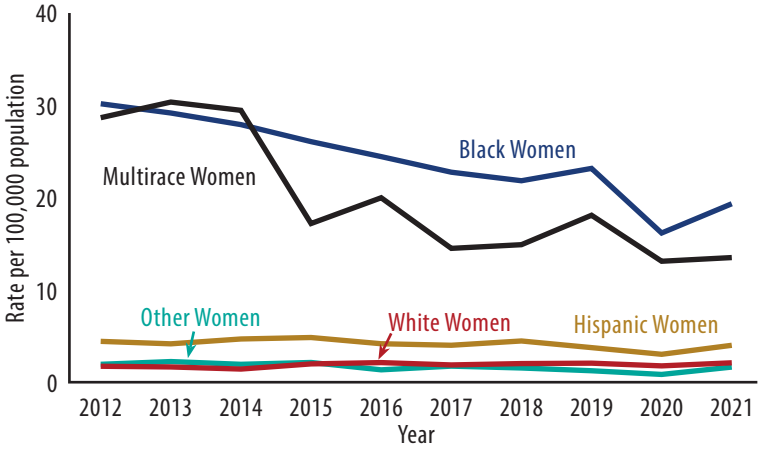
The rate of Black women living with HIV in Texas (631 per 100,000 population) is 6.9 times the rate of Hispanic women living with HIV and 13.6 times the rate of White women living with HIV.

The most common way Black women in Texas get HIV is through sex with a male living with HIV (83 percent).

An early diagnosis of HIV infection helps people get the care they need to stay healthy. Being diagnosed with HIV late (within a year of an AIDS diagnosis) reduces treatment effectiveness. In 2021, 25 percent of Black women diagnosed with HIV in Texas received a late diagnosis

One in every 156 Black women in Texas is living with HIV.

Rate of New HIV Diagnoses in Women by Race/Ethnicity, Texas, 2012-2021



Black Women Without HIV-Related Medical Care in 2021

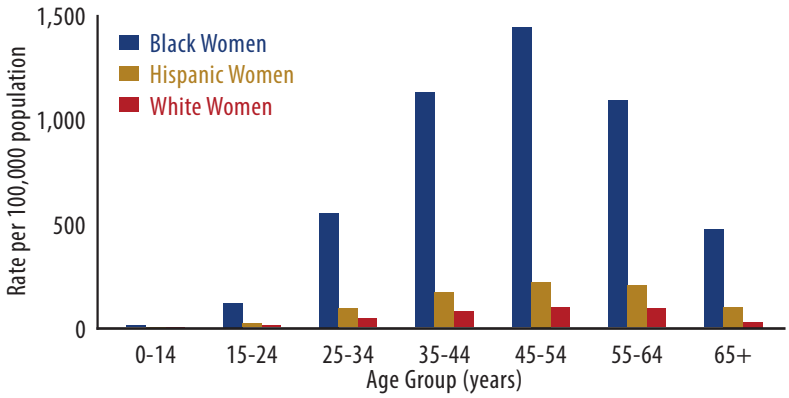
More than ever before, advances in medical care have enabled people with HIV to stay healthy and live longer. Some persons living with HIV may not seek care because they do not feel ill. Others may have problems affording or accessing health care. Still others may not seek medical care because of substance abuse, mental health issues, or HIV-related stigma.

More Black persons living with HIV (PLWH) (12,105) did not receive HIV medical care in 2021 compared to other racial and ethnic groups in Texas. **Nearly one in three** Black women living with HIV in **Texas** (3,572) were out of care in 2021.

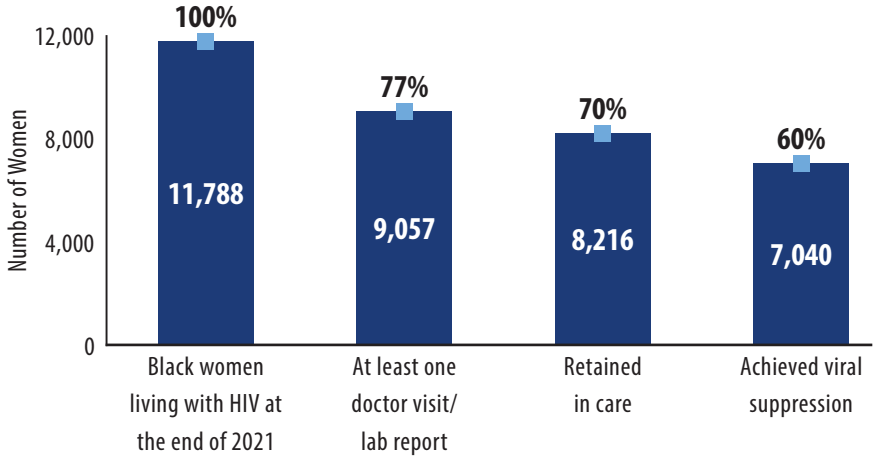
Of Black women living with HIV in Texas whose mode of HIV transmission was sex with males:

- 77 percent had at least one medical visit or lab test for their HIV infection,
- 70 percent had at least two medical visits or lab visits at least three months apart, and
- 60 percent achieved viral suppression.

Rate of Women Living with HIV by Age and Race/Ethnicity, Texas, 2021



HIV Treatment Cascade for Black Women in Texas, 2021



HIV Prevention for Black Women in Texas. What Can You Do?

Know the Facts! Early diagnosis and effective treatment of HIV will help reduce HIV transmission. Get tested. Know your partners HIV/STD status. Protect yourself by using condoms. Educate others about safe sex practices. Find out if PrEP is right for you.

To learn more about HIV prevention for Black women in Texas, contact the DSHS HIV/STD Section at hiv.std@dshs.texas.gov.

Texas Black Women's Initiative (TxBWI)

The mission of the Texas Black Women's Initiative (TxBWI) is to promote active, engaged, and empowered communities to address HIV disparity among Black women. TxBWI works to strengthen the ability of DSHS, local health departments, and community-based organizations to effectively implement HIV/AIDS programs focused on Black women. For more information, visit dshs.texas.gov/hivstd/TxBWI/.

More About Black Women and HIV in Texas

One in every 690 Texas Women have HIV
One in 156 Black Women
One in 1,080 Hispanic Women
One in 2,146 White Women

Since 2012, **51 percent** of new HIV diagnoses in Texas women under the age of 25 were among young Black women

The rate of new HIV diagnoses among Black women in Texas is **five times** the rate for Hispanic women and **ten times** the rate for White women

Black women have the highest case counts of gonorrhea and the second highest case counts of chlamydia and primary and secondary syphilis in Texas

DSHS HIV/STD Section

737-255-4300

dshs.texas.gov/hivstd/txbwi

Publication No. 13-13504
(Rev. 9/2023)

TEXAS Health and Human Services
Texas Department of State Health Services

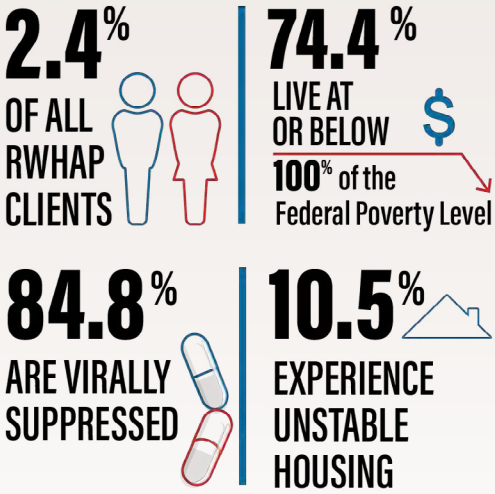
Transgender Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—more than 576,000 people in 2021—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission. For more than three decades, RWHAP has worked to stop HIV stigma and reduce health disparities by caring for the whole person and addressing their social determinants of health.

Ryan White HIV/AIDS Program Fast Facts: Transgender Clients



HRSA
Ryan White HIV/AIDS Program

Of the more than half a million clients served by RWHAP, 2.4 percent are transgender, representing approximately 14,000 clients.

Learn more about transgender clients served by RWHAP:

- **The majority of transgender clients served by RWHAP are a diverse population.** Among transgender clients, 85.7 percent are from racial and ethnic minorities: 51.1 percent of transgender clients are Black/African American people and 29.2 percent are Hispanic/Latino people—both percentages are higher than the national RWHAP averages (45.8 percent and 24.1 percent, respectively).
- **The majority of transgender clients served by RWHAP are people with lower incomes.** Among transgender RWHAP clients served, 74.4 percent are people living at or below 100 percent of the federal poverty level, which is much higher than the national RWHAP average (59.2 percent).
- **Data show that 10.5 percent of transgender clients served by RWHAP are people experiencing unstable housing.** This percentage is substantially higher than the national RWHAP average (5.0 percent).
- **Transgender clients are younger than the average RWHAP client population.** Approximately 23.9 percent of transgender RWHAP clients are aged 50 years and older, which is significantly lower than the national RWHAP average (48.3 percent).

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication as prescribed and reach and maintain viral suppression cannot sexually transmit the virus to their partner. According to 2021 data, 84.8 percent of transgender clients receiving RWHAP HIV medical care are virally suppressed,* which is lower than the national RWHAP average (89.7 percent).

* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

2020 Houston HIV Care Services Needs Assessment: Profile of Transgender and Gender Non-conforming Individuals

For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
Houston Area Ryan White Planning Council
Tel: (832) 927-7926
Web: rwpchouston.org

PROFILE OF TRANSGENDER AND GENDER NON-CONFORMING INDIVIDUALS

A persistent challenge to designing HIV prevention and care services that meet the needs of all Houston area people living with HIV (**PLWH**) is the lack of epidemiological and surveillance data that accurately reflect the burden of HIV among transgender and gender non-conforming PLWH. A 2013 meta-analysis indicated a heavily disproportionate HIV burden among transgender women in the United States, estimating that 21.7% (1 in 5) of transgender women are living with HIV (Baral, et al., 2013). While included in most state and national surveillance datasets, transgender women living with HIV are categorized as male and men who have sex with men (**MSM**) by sex at birth and risk factor. Transgender MSM are often categorized as female with heterosexual risk factor. Gender non-conforming or non-binary individuals are included, but are only represented by sex at birth, not current gender identity. Data about service needs and barriers transgender and gender non-conforming PLWH in the Houston area encounter is of particular importance to local HIV planning as this information equips communities to provide prevention and care services that meet the unique needs of disproportionately affected gender minority groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were transgender or gender non-conforming.. This Profile highlights results *only* for participants who were transgender or gender non-conforming, as well as comparisons to the entire needs assessment sample.

Notes: "Transgender" and "gender non-conforming" are defined in this analysis as PLWH who indicated having a primary gender identity or gender expression at the time of survey that differed from the participant's reported sex they were assigned at birth, including an option for "intersex". As such, participants who self-identify as transgender or gender non-conforming but who did not meet this analysis criterion may be excluded. Care should be taken in applying the results presented in this profile to the Houston area transgender and gender non-conforming PLWH population as a whole due to small sample size. Data presented in this in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check-all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 22 participants in the 2020 Houston HIV Care Services Needs Assessment were identified as transgender or gender non-conforming, comprising 4% of the total sample.

At the time of data collection, 91% of transgender and gender non-conforming participants lived within Houston/Harris County, 48% identified as Black/African American, and 41% were between the ages of 35-49. The majority of transgender and gender non-conforming participants were assigned male at birth (91%). Among the transgender and gender non-conforming participants sampled, 50% identified as transgender female, 9% identified as transgender male, and 36% identified as other/non-conforming. Seven percent (93%) of transgender and gender non-conforming participants reported being in HIV medical care, and the majority of had public health insurance through Medicaid or Medicare (37%), the Harris Health System (Gold Card) (27%), and the Ryan White Program (23%).

Compared to all needs assessment participants, a greater proportion of transgender and gender non-conforming participants displayed a wider variety in sexual orientation with "other" or write-in responses including "transgender", "human", "queer" and "transsexual" when compared to the total needs assessment sample (38% vs 3.8%).

A lower proportion of transgender and gender non-conforming participants were below 100% of the Federal Poverty Line (**FPL**), identified as Black/African American (48% vs 60%), and were seniors (greater than fifty years old) (11% vs 60%) when compared to the total sample of the needs assessment.

Though representing a very small overall number, the proportion of transgender and gender non-conforming participants recently released from incarceration was the same as when compared to the total sample (both 11%). Similarities between the total sample and transgender and gender non-conforming participants and the total sample were also seen in the proportion of participants that were not currently retained in care (both 7%).

Characteristics of transgender and gender non-conforming participants (as compared to all participants in general) can be summarized as follows:

- Residing in Houston/Harris County
- Male at birth
- Transgender female
- African American/Black
- Adults between the ages of 35 and 49
- Self-identified as a wide variety of other sexual identities
- Similar occurrences of recent release from incarceration and not being retained in care when compared to the total sample

TABLE 1-Select Characteristics among Transgender and Gender Non-Conforming Participants, Houston Area HIV Needs Assessment, 2020

	No.	TG / GN %	Total %
County of residence			
Harris	20	91%	95%
Fort Bend	1	5%	2%
Montgomery	1	5%	2%
Primary race/ethnicity			
White	3	14%	14%
African American/Black	10	48%	60%
Hispanic/Latino	5	24%	21%
Asian American	1	5%	0.7%
Other/Multiracial	2	10%	4.7%
Immigration status			
Born in the U.S.	17	77%	88%
Citizen > 5 years	4	18%	10%
Citizen < 5 years	0	-	1%
Undocumented	0	-	0.2%
Prefer not to answer	1	5%	0.7%
Other			1.8%

	No.	TG / GN %	Total %
Age range (median: 35-49)			
13 to 17	0	-	-
18 to 24	3	14%	3%
25 to 34	2	9%	9%
35 to 49	9	41%	28%
50 to 54	3	14%	18%
55 to 64	0	-	28%
≥65	5	23%	15%
Seniors (≥50)	8	11%	60%
Sexual orientation (self-reported)			
Heterosexual	4	19%	57%
Gay/Lesbian	6	29%	30%
Bisexual/Pansexual	3	14%	9%
Other	8	38%	3.8%
Yearly income (average: $6,688)			
Federal Poverty Level (FPL)			
Below 100%	8	53%	67%
100%	6	40%	19%
150%	0	-	6%
200%	0	-	5%
250%	0	-	-
≥300%	1	7%	2%

	No.	TG / GN %	Total %
Sex at birth			
Male	20	91%	57%
Female	2	9%	30%
Intersex	0	-	9%
Other	0	-	4%
Gender Identity			
Transgender Female	11	50.0%	
Transgender Male	2	9%	
Other/Non-conforming	8	36%	
Health insurance (multiple response)			
Private insurance	2	7%	9%
Medicaid/Medicare	11	37%	67%
Harris Health System	8	27%	29%
Ryan White Only	7	23%	24%
None	2	7%	3%

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of the Transgender and Gender Non-Conforming Needs Assessment Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

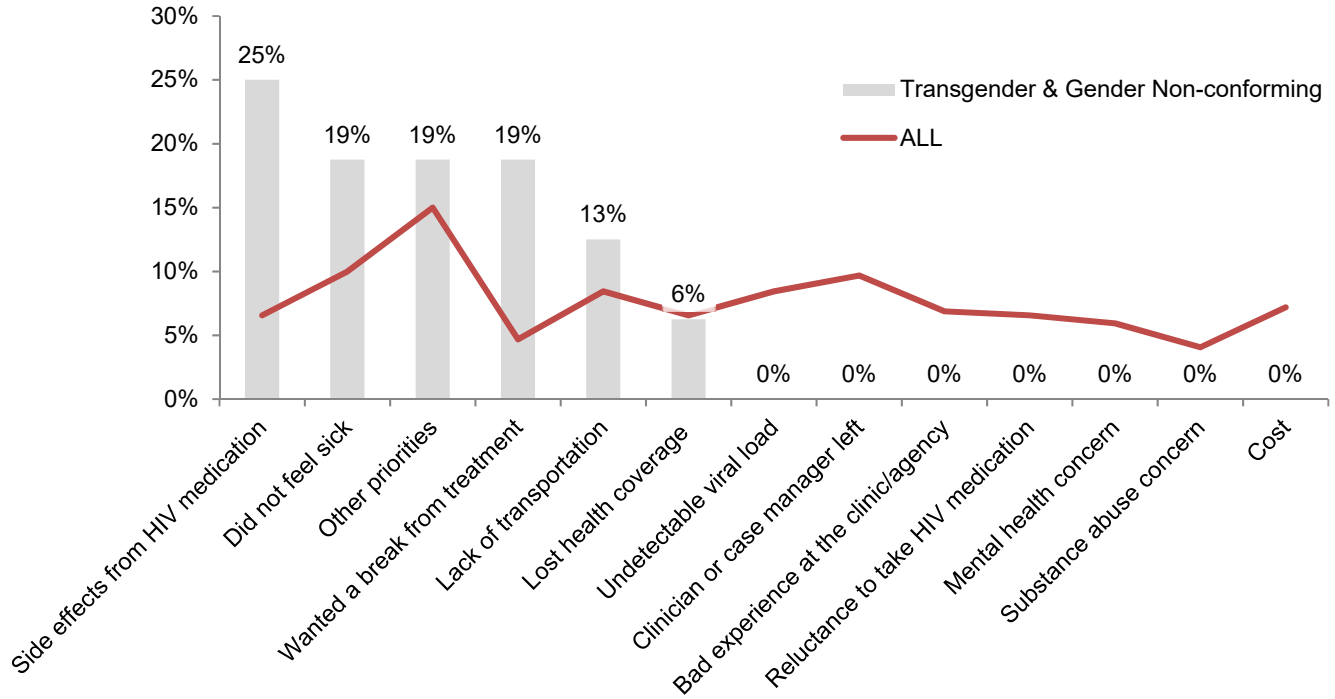
Though representing a very small overall number, the proportion of transgender and gender non-conforming participants reported a higher proportion of at least one interruption in their HIV medical care for 12 months or more since their diagnosis (42% vs 32%). Those who reported a break in HIV care for 12 month or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey, and participants could select multiple reasons. Participants could also write-in their reasons as well.

(**Graph 1**) Among transgender and gender non-conforming participants, side effects from HIV medication was cited most often as the reason for interruption in HIV medical care at 25% of reported reasons. Transgender and gender non-conforming participants also reported not feeling sick, other priorities, and wanting a break from treatment as common reasons for interruption in HIV medical care (all 19%).

The largest differences in reported barriers to retention in HIV medical care between transgender and gender non-conforming participants and the total sample were in the proportions of reports of side effects from HIV medication (25% vs 7%) and wanting a break from treatment (19% vs 5%). Transgender and gender non-conforming participants did not report undetectable viral load, clinician or case manager leaving, bad experiences at clinics/agencies, reluctance to take HIV medication, mental health concerns, substance abuse concerns, and cost as barriers to retention in HIV medical care. One of the write-in responses when asked to report barriers to retention in HIV medical care was the loss of a participant's child.

GRAPH 1-Reasons for Falling Out of HIV Care among Transgender and Gender Non-conforming PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by transgender and gender non-conforming needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



OVERALL RANKING OF FUNDED SERVICES, BY NEED

In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Among transgender and gender non-conforming participants, oral health care was the most needed Ryan White funded service at 79% of transgender and gender non-conforming participants reporting need, followed by primary care (75%), and case management (71%).

The greatest difference between transgender and gender non-conforming participants and the total sample were in the proportions reporting need for outreach services (56% vs 5%), and transportation (60% vs 48%). Transgender and gender non-conforming participants reported lower proportions of need for HIV medication assistance (46% vs 79%), primary care (46% vs 79%), and mental health services (38% vs 51%).

GRAPH 2-Ranking of HIV Services among Transgender and Gender Non-conforming PLWH in the Houston Area, By Need, 2020

Definition: Percent of transgender and gender non-conforming needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.

Other Identified Needs

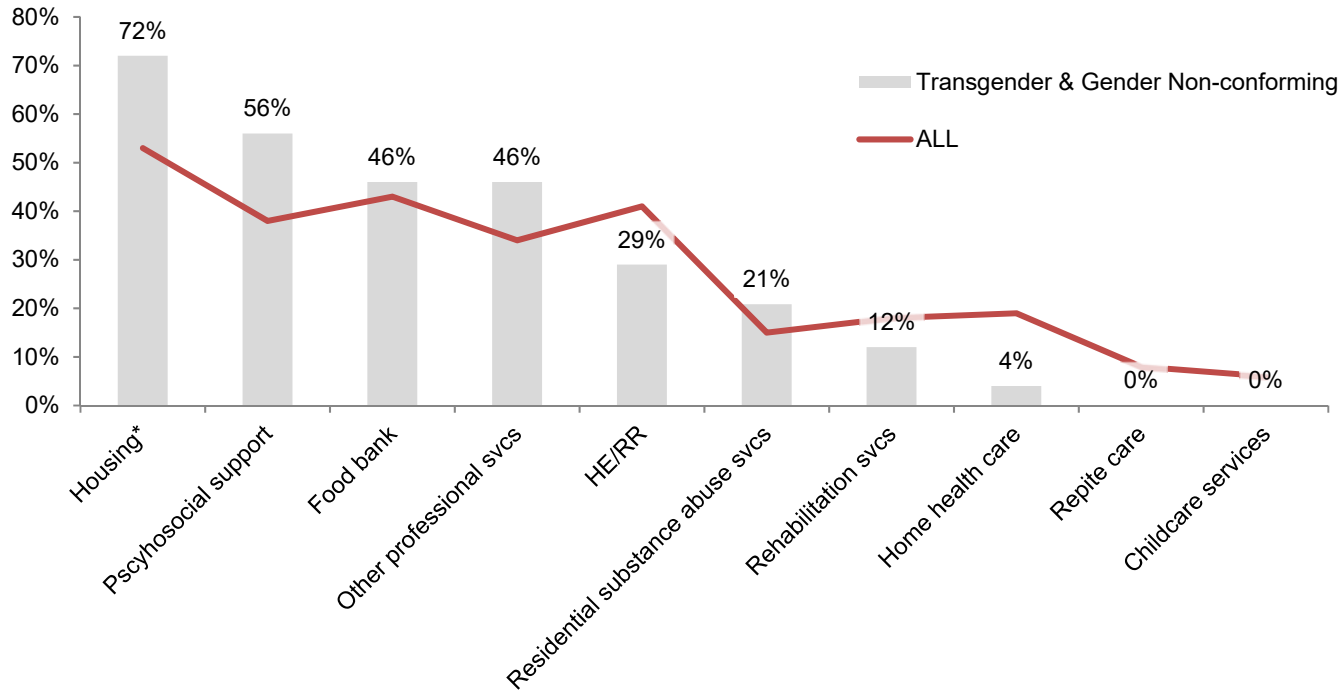
In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV-related services they needed in the past 12 months.

(**Graph 3**) In general, transgender and gender non-conforming participants reported a higher need for services skewed to meet psychological and safety needs like housing (72%), psychosocial support (56%), food bank (46%) and other professional services (46%). When compared to the reported other needs by the total sample, a greater proportion of transgender and gender non-conforming participants reported needing housing (72% vs 53%), psychosocial support (56% vs 28%), and other professional services (46% vs 34%). Lower proportions of transgender and gender non-conforming participants reported a need for home health care (4% vs 19%), and health education and risk reduction services (29% vs 41%).

GRAPH 3-Other Needs for HIV Services among Transgender and Gender Non-conforming PLWH in the Houston Area, 2020

Definition: Percent of transgender and gender non-conforming needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



OVERALL BARRIERS TO HIV CARE

The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 district barriers. These barriers were then grouped together into 12 nodes, or barrier types.

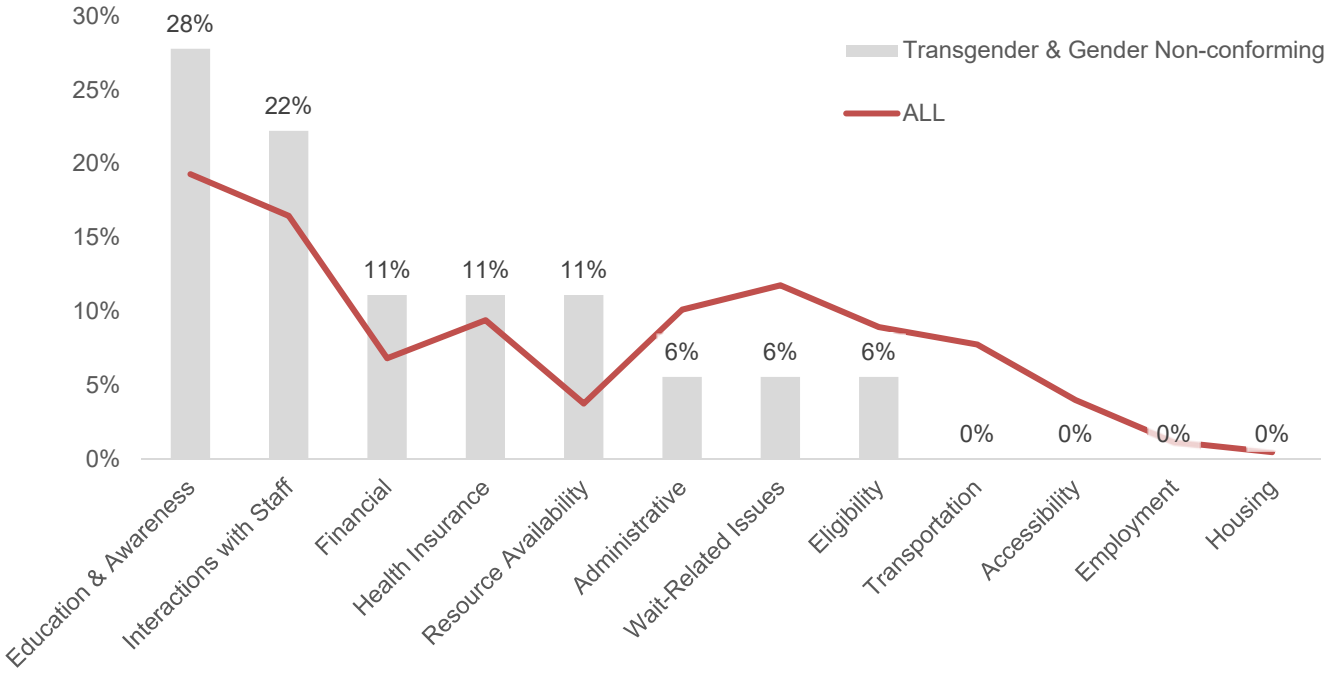
(**Graph 4**) Only 12 transgender and gender non-conforming participants cited barriers to HIV care services. As this group comprises only 50% of all transgender and gender non-conforming participants and 3.9% of the total sample, great care should be taken in applying data and conclusions from Graph 4 to the greater Houston area transgender and gender non-conforming PLWH populations.

Overall, the barrier types reported most often among transgender and gender non-conforming participants related to education and awareness (28%), and interactions with staff (22%). Transgender and gender non-conforming participants also reported interactions with staff, financial barriers, and health insurance (all 11%) as barriers to HIV medical care.

Due to the small number of transgender and gender non-conforming participants reporting barriers to HIV care services, comparison of barrier types between transgender and gender non-conforming participants and the total sample would not be generalizable and are not reported here.

GRAPH 4-Ranking of Types of Barriers to HIV Services among Transgender and Gender Non-conforming PLWH in the Houston Area, 2020

Definition: Percent of times each barrier type was reported by transgender and gender non-conforming needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



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Ryan White HIV/AIDS Program

HRSA's Ryan White HIV/AIDS Program

Addressing the HIV Care Needs of People With HIV in State Prisons and Local Jails

Technical Expert Panel Executive Summary

Policy Clarification Notice (PCN) 18-02 provides clarification to Ryan White HIV/AIDS Program (RWHAP) recipients and demonstrates the flexibility in the use of RWHAP funds to provide core medical services and support services (described in PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds) for people with HIV who are incarcerated or otherwise justice involved. There are differences between how an RWHAP recipient can collaborate with a federal or state facility versus a local correctional facility. These distinctions are based on the administrative entity (federal or state vs. local) relative to the payor of last resort statutory requirement for RWHAP recipients. The RWHAP statute specifies that payor of last resort applies to federal or state payers—like prisons operated by the Federal Bureau of Prisons or a state department of corrections. The provision does not mention local payors; as such, payor of last resort is not applicable. However, the RWHAP cannot duplicate existing services.

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB), which oversees the Ryan White HIV/AIDS Program (RWHAP), convened a Technical Expert Panel (TEP) in March 2020 to explore the HIV care needs of people with HIV in state prisons and local jails and the role the RWHAP can play in addressing these needs. The purpose of this panel was to identify supports and barriers to HIV care and treatment in correctional facilities, as well as community re-entry and current approaches and guidance under HAB Policy Clarification Notice (PCN) 18-02, The Use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living With HIV Who Are Incarcerated and Justice Involved. The term "justice involved" is used by U.S. government agencies to refer to any person who is engaged at any point along the continuum of the criminal justice system as a defendant (including arrest, incarceration, and community supervision).

- **Federal and State Prison Systems.** RWHAP recipients may provide RWHAP core medical and support services to people with HIV who are incarcerated in federal or state prisons on a transitional basis where those services are not provided by the correctional facility. HRSA HAB defers to recipients/subrecipients to define the time limitation, which generally is up to 180 days. RWHAP recipients/subrecipients work with the correctional systems/facilities to define both the nature of the services based on identified HIV-related needs and the duration for which the services are offered.

- **Other Correctional Systems.** RWHAP recipients may provide RWHAP core medical and support services to people with HIV who are incarcerated in other correctional facilities on a short-term or transitional basis. RWHAP recipients/subrecipients work with the correctional systems/facilities to define both the nature of the services based on identified HIV-related needs and the duration for which the services are offered, which may be the duration of incarceration. If core medical and support services are being provided on a short-term basis, HAB recommends that RWHAP recipients also provide services on a transitional basis. For these systems, RWHAP cannot duplicate existing services.

The following TEP Executive Summary includes the following sections:

- Considerations for Improving HIV Treatment for People With HIV Who Are Justice Involved
- Issues Related to Providing HIV Care and Treatment in Correctional Settings
- Issues Related to HIV Care During Re-Entry
- Data Considerations

CONSIDERATIONS FOR IMPROVING HIV TREATMENT FOR PEOPLE WITH HIV WHO ARE JUSTICE INVOLVED

Over the course of the discussion, multiple themes and strategies emerged that relate to the provision of services to people with HIV who are involved in the justice system—either during incarceration, upon release, or under community supervision.

Specific Issues

- **HIV-Related Stigma and Incarceration.** The impact of HIV-related stigma can be exacerbated by incarceration. Breaches of confidentiality, particularly related to HIV status, can constitute a safety risk. To minimize these risks, some facilities have segregated units for people with HIV, or people with HIV may be placed in solitary confinement. These practices have been found in some instances to be discriminatory. The U.S. Department of Justice works to address discrimination complaints from people with HIV in correctional facilities. These often relate to housing, unequal access to services, and access to treatment. Stigma and discrimination also are associated with incarceration. People with HIV who have been incarcerated also may experience the effects of incarceration-related stigma and/or discrimination upon release.

- **Impact of Comorbidities.** People with HIV often have comorbidities, which can make HIV treatment more difficult and create barriers to linkage to and retention in care once the patient re-enters the community. Substance use disorder (SUD) presents a significant challenge, and panelists emphasized the importance of access to treatment, especially medication-assisted treatment (MAT) for opioid use disorder. Other comorbidities include mental illness, hepatitis C, sexually transmitted infections, and chronic conditions, such as cardiovascular disease.

- **Holistic Services—Treating the Whole Person.** To ensure optimal health outcomes, people with HIV need comprehensive services both within the correctional facility and upon release. This includes a wide range of support services, including support from peer specialists. In particular, panelists emphasized the need for SUD treatment, mental health services, care for aging individuals, and care that addresses health issues other than HIV.

  Services should address not only HIV-related needs but also the social determinants of health—conditions in a person's life and environment that affect a wide range of outcomes and risks related to health, functioning, and quality of life. Challenges confronting this population include lack of a social support network, domestic violence, low levels of educational attainment, history of trauma, low health literacy, limited access to employment (especially post-incarceration), unstable housing, and a history of debt. Any one of these factors constitutes a barrier to engaging in care; combined, they present a significant challenge. Many of these issues predate incarceration and may have contributed to the person's becoming justice involved.

- **Multidisciplinary Care Team/Patient-Centered Care.** Key members of the team include a physician, nurse, social worker (behavioral/mental health), and case worker (support services). Other disciplines can augment the team. The patient is also an important member of the team.

- **Value of Lived Experience.** Peer support services can enhance the quality of care and are an important component for ensuring linkage to care in the community. Peer specialists serve in various positions, including navigator, recovery coach, re-entry coach, and community health worker.

- **Creating a Bridge Between Incarceration and Community.** Many barriers exist between correctional facilities and community providers, which can affect the care and services incarcerated people receive while in the facility and during their re-entry process. In some service models—such as the Hampden County Model—clinicians are dually based in correctional facilities and community health centers to help ensure that essential linkages are made and treatment is not interrupted.

- **Challenge of Recidivism.** Although multiple factors are related to recidivism, many TEP members expressed that justice-involved individuals often face insurmountable challenges upon their release due to community corrections policies, judicial mandates, and the stigma related to incarceration. These individuals also face limited options, especially related to housing and employment, which can contribute to recidivism.

ISSUES RELATED TO PROVIDING HIV CARE AND TREATMENT IN CORRECTIONAL SETTINGS

Uninterrupted access to antiretroviral medications and adherence to clinical treatment guidelines must be ensured to achieve optimal health outcomes, including viral suppression. Clinical treatment guidelines (e.g., U.S. Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV) apply to correctional facilities. Panelists expressed concern that these guidelines may not always be followed, particularly in situations where facilities contract out for medical services.

Specific Issues

- **Access to Medication Upon Entry to the Facility.** Newly incarcerated individuals may experience delays in obtaining medications for multiple reasons. Not all HIV medications may be available—this depends on the formulary—so patients may be provided a different antiretroviral medication. If patients transfer to another facility, a delay in access also may occur if they run out of medication before they are provided more in the new facility.

- **Access to Medication During Incarceration.** Processes for dispensing medication in a facility may result in missed doses. These treatment interruptions, whether one dose or more, can impact health outcomes. Long lines (e.g., 1–2 hours) for directly observed therapy can result in patients missing doses, because they may opt to skip the line if they have work duty or a visitor or must appear in court. Sometimes after waiting in line, medications may not be available. In addition, other circumstances in a facility, such as solitary confinement or lock downs, can reduce access to medications.

- **Access to Specialty Care.** Correctional systems have multiple facilities with multiple buildings. Specialty care, including infectious disease specialists, may not be available in every clinic, and transfers to these specialists may not occur.

Strategies for Improving HIV Treatment and Care in Correctional Settings

- Ensure uninterrupted access to antiretroviral medication, including access on entry, a process to track that medications are received, and such strategies as keep-on-person [KOP] medication.
- Treat comorbidities, including substance use disorder, mental illness, and hepatitis.
- Provide a multidisciplinary team—at a minimum, a physician, a nurse, and a social worker/case manager, with the patient as a partner.
- Ensure dually based physicians and case managers (i.e., providers who serve the patient in both the facility and the community).
- Use telehealth to facilitate access to HIV care and specialists, and maintain a connection to the same clinicians as the patient moves to different facilities.
- Identify champions to advocate for the needs of patients with HIV, in the correctional system/facility, the community, or both.
- Introduce patients to harm reduction strategies; provide services in a harm reduction framework.
- Provide education/training for administration and correctional officers, including stigma reduction training.
- Train clinical staff to ensure adherence to treatment guidelines.
- Build connections with community-based organizations and community-based services and allow them access to the facility (e.g., Alcoholics Anonymous/Narcotics Anonymous).
- Ensure that contracts for the provision of health care within correctional facilities are aligned with HIV treatment guidelines.
- Develop standard language for requests for proposals for contracted health care services based on U.S. Department of Health and Human Services guidelines and tied to performance measures that correctional systems can use in their procurement process.
- Collect data on access to care within facilities (e.g., type of care provided, access to specialty care, viral suppression rates).
- Encourage representation of both the department of corrections and individual facilities on RWHAP planning bodies.

- **Training.** The lack of HIV-related information and training for administrators and staff in correctional systems/facilities can affect the care of people with HIV. County managers and correctional facility administrators (i.e., wardens) make decisions related to the resources available to facilities and the policies within facilities that may limit access to or the quality of treatment for people with HIV in those facilities. More training is necessary for clinical staff, corrections officers, and administrators to ensure an understanding of the needs of incarcerated individuals with HIV, with a particular focus on reducing stigma and discrimination in facilities. Panelists also noted the need to educate those in the corrections community about the RWHAP and the resources available to patients with HIV.

ISSUES RELATED TO HIV CARE DURING RE-ENTRY

Panelists noted that patients face multiple challenges to continuity of care during re-entry. Some of these relate to the release process, whereas others relate to disconnects between correctional facilities and services within the community.

Specific Issues

- **Unpredictable Release Dates.** Release dates may change, frustrating efforts to ensure a "warm handoff." Sometimes release is scheduled for late at night, which can make coordination with community partners difficult. Unpredictable release also can result in a patient's leaving the facility without their medications.

- **Connecting With a Community-Based Health Care Provider.** Many jurisdictions have processes in place to ensure continuity of care. However, even for systems/facilities where this is the intention, it may not take place. Patients (and staff) must navigate the system, which may include multiple payers, requirements, and processes. For example, enrolling a patient in Medicaid or the RWHAP AIDS Drug Assistance Program may or may not be possible within the facility. Some community-based providers will not make an appointment unless the patient has active insurance or Medicaid, so the patient leaves the correctional facility with no appointment. The patient must contact the provider and make an appointment after release. The Health Insurance Portability and Accountability Act (HIPAA) also plays a role. Many community-based providers will not engage with the patient's clinician within the correctional facility until the patient is released, has accessed their organization, and has signed a HIPAA release. This policy makes advanced coordination impossible.

  Even if a community-based provider is selected prior to release, the process may not go smoothly. Many patients may not know where they will be living upon release and may select a provider and pharmacy that is not convenient to where they eventually live. Patients who are on Medicaid prior to release may be assigned to a provider who may not be the most appropriate to provide HIV-related care or be convenient to where the patient is living.

  Although the peer navigator is considered one of the most effective bridges to treatment, many community-based organizations (CBO) report challenges getting navigators into correctional facilities so they can facilitate a warm handoff. The issue is twofold: (1) Either the CBO or the facility may lack processes for CBO staff to enter the correctional facility; and (2) peer navigators, people with similar lived experience, may have a history of incarceration and have difficulty gaining approval to access the facility.

- **Access to Medications Upon Release.** Even if a patient is able to line up a community-based provider before release, ensuring ongoing access to medications can be a challenge. Patients may not have sufficient supply of medication upon release to last until their first appointment, and some retail pharmacies will not fill prescriptions from correctional facilities.

- **Followup.** Followup with patients is difficult. Often, patients leave facilities without a home address or telephone number. They are located only when and if they access care.

- **Exchange of Health Information.** Many systems/facilities do not have electronic health records (EHRs), which complicates the transfer of patient information; patients arrive at their new provider with paper records.

Strategies for Improving HIV Treatment and Care During Re-Entry

- Ensure a warm handoff (same clinician [dually based], clinician to clinician [face-to-face meeting before transfer], or establish a relationship with a new provider [via telephone]).
- Employ peer specialists to support re-entry (e.g., navigator, addiction coach, re-entry coach).
- Ensure that insurance/Medicaid/AIDS Drug Assistance Program is in place upon release.
- Ensure that the first appointment with a new clinic is in place on release.
- Follow up with patients to the extent possible, given challenges in tracking patients upon release.
- Connect patients with essential services, especially housing.
- Link patients to harm-reduction organizations, especially overdose prevention for the newly released.
- Help HIV-related community-based organizations connect with correctional facilities and organizations that serve incarcerated individuals (e.g., evangelical organizations).
- Educate correctional facilities about RWHAP.
- Engage formerly incarcerated people with HIV in the RWHAP planning process.

DATA CONSIDERATIONS

To improve the quality of patient care and data-driven decision-making, accurate data at the patient and facility levels need to be collected. At the patient level, health outcomes (e.g., viral suppression) need to be documented. At the facility level, quality indicators related to HIV testing, access to care, and access to antiretroviral treatment are needed. Sharable electronic health records and up-to-date data sets also are needed.

Providers also should collect data related to justice involvement, but these data need to be collected in a sensitive manner. Such information includes the date of release from most recent incarceration, length of most recent incarceration, number of previous incarcerations, and history of solitary confinement.

CONCLUSION

A knowledge gap remains on how RWHAP grant funds can be used to support people with HIV who are justice involved. Opportunities exist for RWHAP recipients and correctional facilities to collaborate and ensure that people with HIV who are justice involved receive needed care and treatment, both while incarcerated and upon release.

2020 Houston HIV Care Services Needs Assessment: Profile of the Recently Released

For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
Houston Area Ryan White Planning Council
Tel: (832) 927-7926
Web: rwpchouston.org

PROFILE OF THE RECENTLY RELEASED

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were recently released. This profile highlights results *only* for participants at the time of survey, as well as comparisons to the entire needs assessment sample.

Notes: "Recently released from incarcerations" and "recently released" are defined in this analysis as PLWH who indicated at survey that they were released from jail or prison within the past 12 months at the time of survey. Data presented in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 65 participants in the 2020 Houston HIV Care Services Needs Assessment were recently released from jail or prison within the 12 months prior to survey comprising 12% of the total sample.

Ninety-five percent (95%) of recently released participants were residing in Houston/Harris County at the time of data collection. Like all needs assessment participants, the majority of recently released participants were male (80%), African American (67%), and identified as heterosexual (60%). Among the recently released participants that were surveyed, 14% reported being out of HIV medical care, and the majority of the recently released participants had public health insurance through Medicaid or Medicare (37%), the Harris Health System (31%), and the Ryan White Program (25%).

Several differences were observed when comparing the recently released participants with the total sample of the 2020 Houston HIV Care Services Needs Assessment. Recently released participants had a higher proportion of males (80% vs 66%), individuals between the ages of 35-49 (37% vs 28%), and participants who identified as African American/Black (67% vs 60%) when compared to the total sample. Recently released participants had a lower proportion of participants who were females (20% vs 34%), participants ages 55-64 (20% vs 28%), and people who had health insurance through Medicare or Medicaid (37% vs 67%). The average annual among recently released participants who reported income was one-third less than the total sample ($8,974 vs $13,493).

Characteristics of recently released participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Adults between the ages of 35 and 49
- Heterosexual
- With higher occurrences of no health insurance coverage, and lower average annual income.

TABLE 1-Select Participant Characteristics for Recently Released Participants, Houston Area HIV Needs Assessment, 2020

	No.	Released %	Total %
County of residence			
Harris	58	95%	95%
Montgomery	2	3%	1%
Liberty	1	2%	1%
Other	4	7%	1.6%
Primary race/ethnicity			
White	13	20%	14%
African American/Black	43	67%	60%
Hispanic/Latino	3	5%	21%
Asian American	1	2%	0.7%
Other/Multiracial	4	6%	4.7%
Immigration status			
Born in the U.S.	2	2%	9%
Citizen > 5 years	35	37%	67%
Citizen < 5 years	29	31%	29%
Undocumented	24	25%	24%
Prefer not to answer	1	1%	3%
Other	4	4%	2%

	No.	Released %	Total %
Age range (median: 50-54)			
13 to 17	0	-	-
18 to 24	3	5%	3%
25 to 34	6	9%	9%
35 to 49	24	37%	28%
50 to 54	15	23%	18%
55 to 64	13	20%	28%
≥65	4	6%	15%
Seniors (≥50)	52	85%	3%
Sexual orientation			
Heterosexual	38	60%	57%
Gay/Lesbian	18	29%	30%
Bisexual	6	10%	9%
Other	1	2%	3.8%
MSM	27	42%	40%
Yearly income (average: $8,974)			
Federal Poverty Level (FPL)			
Below 100%	19	76%	67%
100%	3	12%	19%
150%	3	12%	6%
200%	0	-	5%
250%	0	-	-
≥300%	0	-	2%

	No.	Released %	Total %
Sex at birth			
Male	52	80%	66%
Female	13	20%	34%
Intersex	0	-	0%
Other	0	-	0%
Transgender	3	4.6%	4%
Currently pregnant	0	-	2%
Health insurance (multiple response)			
Private insurance	2	2%	9%
Medicaid/Medicare	35	37%	67%
Harris Health System	29	31%	29%
Ryan White Only	24	25%	24%
None	1	1%	3%

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

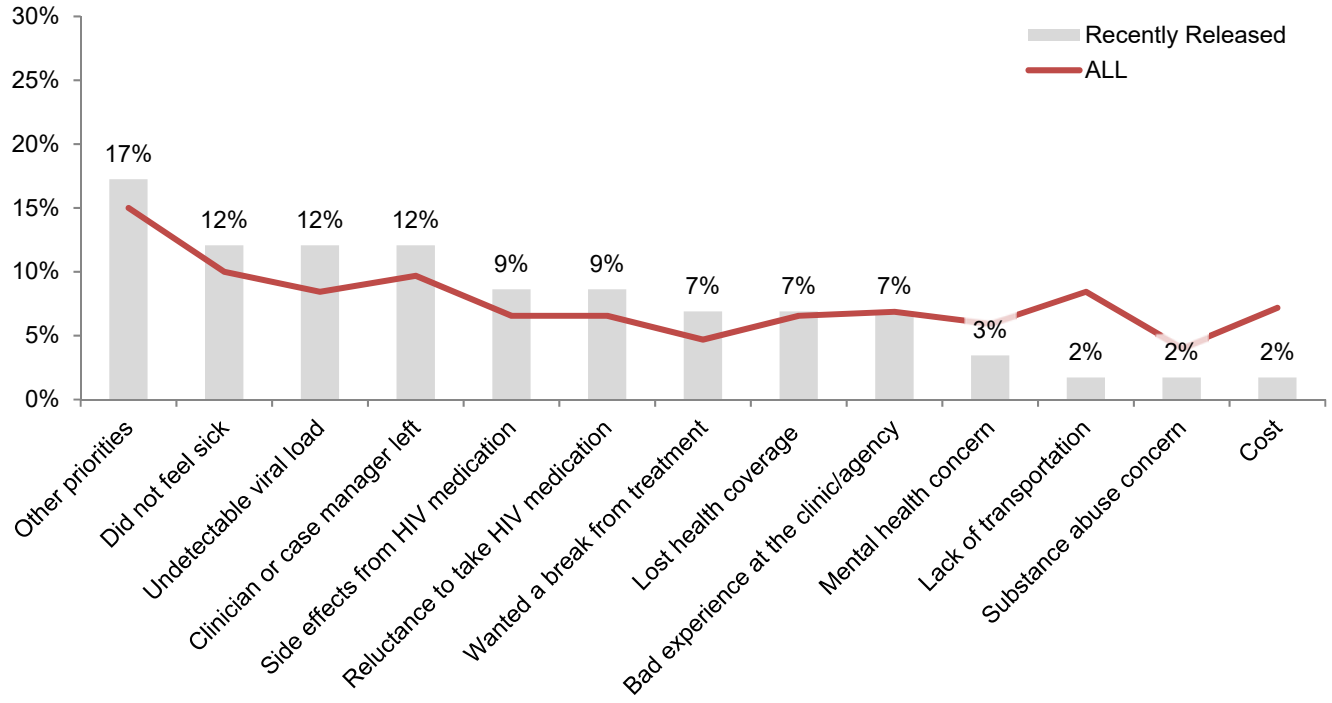
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 58% of recently released participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey. Participants could also write-in their reasons.

(**Graph 1**) Among recently released participants, other priorities was cited most often as the reason for interruption in HIV medical care at 17% of the reported reasons, followed by not feeling sick, undetectable viral load, and clinician or case manager leaving the clinic/agency (all 12%).

The greatest differences between recently released participants and the total sample were in the proportions reporting an undetectable viral load (12% vs 8%) as a reason for falling out of HIV medical care. Write-in responses for this question reported the following as reasons for falling out of HIV medical care – experiencing homelessness, being hospitalized, and the loss of family member.

GRAPH 1-Reasons for Falling Out of HIV Care among Recently Released PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by recently released needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



OVERALL RANKING OF FUNDED SERVICES, BY NEED

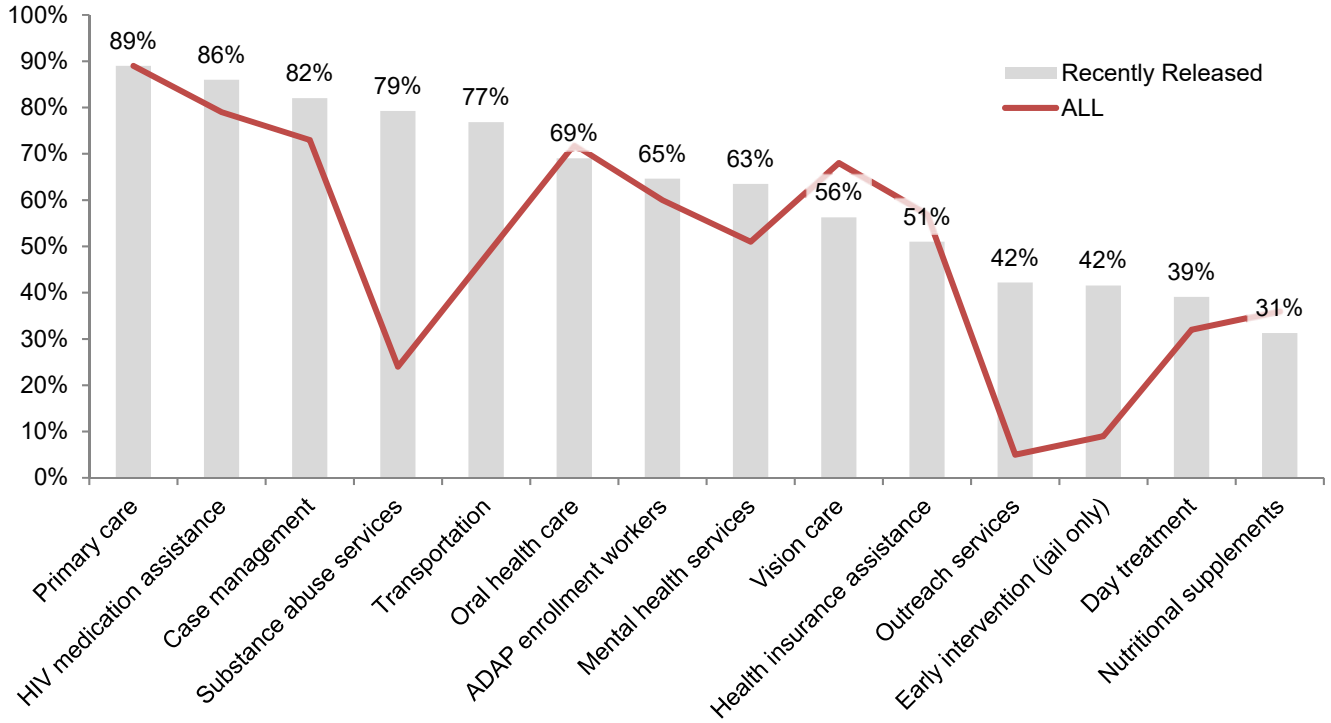
In 2020, 16 HIV care medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Among recently released participants, primary care was the most needed funded service at 89% of recently released participants reporting a need. Recently released participants also reported a need for HIV medication assistance (86%), case management (82%), and substance abuse services (79%).

The greatest differences between recently released participants and the total sample were in the proportions reporting need for outreach services (42% vs 5%), early intervention (jail only) services (42% vs 9%), transportation (66% vs 48%) and substance abuse services (79% vs 24%).

GRAPH 2-Ranking of HIV Services among Recently Released in the Houston Area, By Need, 2020

Definition: Percent of recently released needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants in the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other-non-Ryan White funded HIV-related services they needed in the past 12 months.

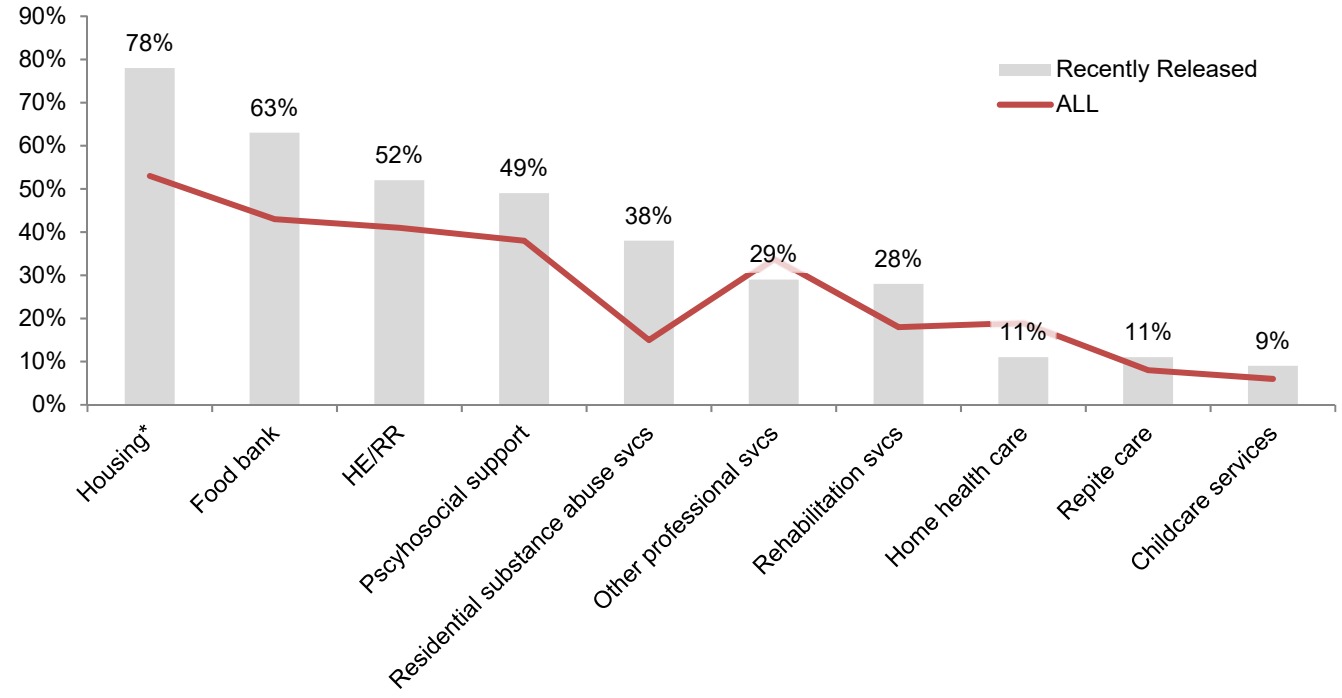
(**Graph 3**) From the 10 services options provided, the greatest proportion of recently released participants reported housing (78%) as the most needed service. This was followed by food bank (63%) and health education and risk reduction services (52%).

Compared to the total sample, a greater proportion of recently released participants reported needing housing services (78% vs 53%), food bank (63% vs 43%), and residential substance abuse services (38% vs 15%).

GRAPH 3-Other Needs for HIV Services among Recently Released PLWH in the Houston Area, 2020

Definition: Percent of recently released needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



OVERALL BARRIERS TO HIV CARE

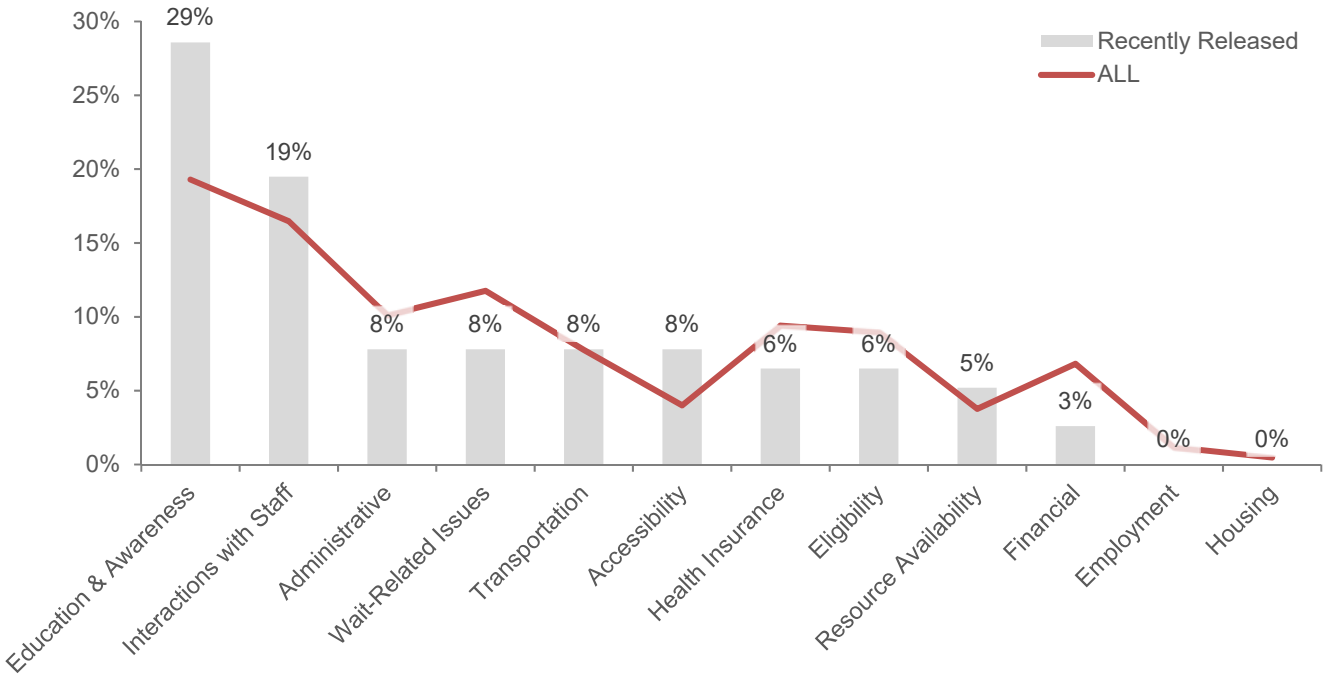
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

(**Graph 4**) Thirty-one (31) recently released participants cited barriers to Ryan White funded HIV care services. Recently released participants most often cited barriers related to service education & awareness (29%), and interactions with staff at the clinic/agency (19%).

Compared to the total sample, recently released participants reported greater proportions of service education & awareness barriers (29% vs 19%), with specific barriers reported being related to not knowing a service was available and not knowing the location of the service/where the service was available in an agency as specific barriers. Recently released participants also reported a greater proportion of barriers related to accessibility (8% vs 4%), with specific barriers reported being related to the former incarceration status, i.e. being restricted from services due to probation, parole, or felon status.

GRAPH 4-Ranking of Types of Barriers to HIV Services among Recently Released PLWH in the Houston Area, 2020

Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



HIV Care and Treatment in Rural Communities

HRSA's Ryan White HIV/AIDS Program, 2021

Rural Health Fact Sheet | November 2023

The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) provides support and resources to RWHAP recipients, including those in rural areas, to assist in the delivery of optimal care and treatment for all to end the HIV epidemic in the United States.[a] To that end, addressing HIV health disparities in engagement in care and viral suppression in rural communities is critical.[b] The RWHAP encourages innovative practices to best reach, meet the needs of, and retain in care people with HIV in rural communities. Although barriers remain, RWHAP providers[c] in rural areas have demonstrated success in such fields as telemedicine, rapid antiretroviral therapy, transportation services, and the use of community health workers.

[a] Klein PW, Geiger T, Chavis NS, et al. The Health Resources and Services Administration's Ryan White HIV/AIDS Program in rural areas of the United States: Geographic distribution, provider characteristics, and clinical outcomes. *PLOS ONE.* 2020;15(3): e0230121.

[b] HRSA. *Ending the HIV Epidemic in the U.S.* https://www.hrsa.gov/ending-hiv-epidemic.

[c] "RWHAP providers" refers to provider organizations that deliver direct care and support services to RWHAP clients.

HRSA
Ryan White HIV/AIDS Program

Among RWHAP providers in rural areas in 2021—

- 48.2% served more than 100 RWHAP clients.
- 43.4% were health departments.
- 84.6% received Public Health Service Act Section 330 funding, which supports HRSA-funded Health Centers.

The Top 10 Most Common Services[1] Delivered by RWHAP Providers in Rural Areas in 2021

1.	Medical case management	53.0%
2.	Medical transportation	43.6%
3.	Outpatient ambulatory health services	40.9%
4.	Oral health care	36.9%
5.	Non-medical case management	34.9%
6.	Emergency financial assistance	30.9%
7.	Food bank/home-delivered meals	22.1%
8.	Mental health services	21.5%
9.	Housing	18.1%
10.	Health insurance premium and cost-sharing assistance	14.8%

Ending the HIV Epidemic in the U.S.

The *Ending the HIV Epidemic in the U.S.* (EHE) initiative is an ongoing federal effort focused on increased linkage to, re-engagement in, and retention in HIV care and treatment. EHE provides priority jurisdictions with additional resources, technology, and expertise to expand HIV treatment and prevention activities. Funded jurisdictions include seven states with a disproportionate rural burden of HIV—Alabama, Arkansas, Kentucky,

RWHAP Clients Who Visited Rural Providers in 2021

90.4% of clients who received services from rural providers were virally suppressed, which is consistent with the national average (89.7%)

51.1% were aged 50 years and older

57.5% were from racial and ethnic minority groups

55.3% were living at or below 100% of the Federal Poverty Level

92.8% had stable housing

Mississippi, Missouri, Oklahoma, and South Carolina. The U.S. Department of Health and Human Services (HHS) leads the governmentwide effort, and HRSA has a key role in leading the implementation of EHE.

Rural Health and HIV Resources

The following resources describe promising practices, address training and technology needs, and review research and policy recommendations that are relevant to rural health and HIV.

RWHAP Part F AIDS Education and Training Center (AETC) Program. The RWHAP AETC Program is a network of HIV experts who provide education, training, and technical assistance on HIV care and prevention to health care team members and health care organizations serving people with or at risk of HIV.

RWHAP Best Practices Compilation. This resource gathers and disseminates interventions in RWHAP-funded settings, including those in rural areas, to improve outcomes for people with HIV and support replication by other RWHAP service providers.

TargetHIV. This website is the one-stop shop for technical assistance and training resources for the RWHAP community. Resources include webinars, tools, training materials, implementation manuals, and additional technical assistance resources, including resources dedicated to several key populations (e.g., rural populations).

AIDSVu. This interactive mapping tool visualizes HIV data from the Centers for Disease Control and Prevention's National HIV Surveillance System and other data sources, including data from rural counties. AIDSVu also provides tools and resources on HIV testing, pre-exposure prophylaxis, and other HIV service locations.

HIV Prevention and Treatment Challenges in Rural America: A Policy Brief and Recommendations to the Secretary. The National Advisory Committee on Rural Health and Human Services provides recommendations to the HHS Secretary on addressing HIV prevention and treatment challenges in rural communities.

Housing Opportunities for People With AIDS (HOPWA) Fact Sheet: Challenges in Rural Areas. This resource provides HOPWA program guidance and information about service area requirements. Additionally, it identifies challenges, suggests best practices to enhance housing operations, and provides program planning guidance.

National Rural Health Association (NRHA): Rural Health Resources and Best Practices. The NRHA provides free resources covering telehealth, policy, and leadership for rural communities and rural health.

Rural HIV/AIDS Planning Program Grantee Sourcebook: 2020–2021. This resource provides detailed descriptions of Rural HIV/AIDS Planning Program grant projects, including key EHE strategies, priority populations served, network development and planning activities, initial project planning outcomes, and sustainability strategies.

Rural HIV/AIDS Prevention and Treatment Toolkit. This toolkit contains modules that describe resources and provide information focused on developing, implementing, evaluating, and sustaining rural HIV programs.

Rural Residency Planning and Development Program. This program, a partnership between HRSA's Federal Office of Rural Health Policy and its Bureau of Health Workforce, provides funding to create new rural medical residency programs. The purpose is to improve access to health care by funding programs to train more physicians in rural communities.

Rural Telehealth Resource Centers (TRCs). This resource, developed by HRSA's Federal Office of Rural Health Policy, lists regional and national TRCs that provide technical assistance to states and territories concerning technology assessment and telehealth policy.

Reference

[1] Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds. PCN 16-02. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf.

2020 Houston HIV Care Services Needs Assessment: Profile of Rural PLWH

For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
Houston Area Ryan White Planning Council
Tel: (832) 927-7926
Web: rwpchouston.org

PROFILE OF RURAL AREAS

People living with HIV (**PLWH**) in rural areas experience the impact of HIV disproportionately and have specific HIV prevention and care needs that are much different than those seen in urban areas. The CDC estimates that 24% of all new diagnoses in the United States are within rural areas, which is more than any other region (Center for Disease Control & Prevention, 2019).

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment as well as focus targeting sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were currently living in rural areas within the Houston EMA at the time of data collection.

Note: Rural participants are defined in this analysis as PLWH who indicated at survey that they were currently residing in a county within the Houston EMA that is not Harris County. Data presented in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for each variable due to missing or "check all" responses within the survey.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 29 participants in the 2020 Houston HIV Care Services Needs Assessment reported currently residing in a rural county at the time of data collection comprising 5% off the total sample.

The majority of rural needs assessment participants resided within Fort Bend County (31%) at the time of survey. Rural needs assessment participants also reported living within Montgomery County (22%), and Liberty County (9%). Like all needs assessment participants, the majority of rural needs assessment participants were male (70%), and were between the ages of 35 to 64 (70%). While most rural needs assessment participants primarily identified as Black/African American (45%) and heterosexual (45%), a high proportion of rural needs assessment participants identified as White (41%) and gay/lesbian (45%). Among rural needs assessment participants, 87% reported being retained in HIV medical care at the time of the survey, and primarily paid for medical care through Medicaid, Medicare, and the Ryan White Program.

Several differences were observed when comparing the rural needs assessment participants with the total sample of the 2020 Houston HIV Care Services Needs Assessment. Rural needs assessment participants had a higher proportion of individuals between the ages of 25 to 34 (13% vs 9%), who are seniors (78% vs 3%), who identified as transgender (7% vs 4%), individuals who identified as White (41% vs 14%), and individuals who have Ryan White to pay for their HIV medical care (24% vs 24%). Rural needs assessment participants were also more likely to have no health insurance compared to the total sample (7% vs 2%).

Rural needs assessment participants had a lower proportion of participants who had insurance through Medicare or Medicaid (37% vs 67%) or the Harris Health System (12% vs 29%). The average yearly income reported by rural needs assessment participants was $13,544, which is slightly more than that of the total sample ($13,544 vs $13,493).

Characteristics of recently released participants (as compared to all participants) can be summarized as follows:

- Residing in Fort Bend County
- Male
- African American/Black as well as White
- Adults between the ages of 35 and 64
- Heterosexual as well as Gay/Lesbian
- With higher occurrences of no health insurance coverage, and use of public health insurance.

TABLE 1-Select Participant Characteristics for Rural Participants, Houston Area HIV Needs Assessment, 2020

	No.	Rural %	Total %
County of residence			
Fort Bend	10	31%	2%
Montgomery	7	22%	1%
Liberty	3	9%	0.5%
Other*	12	38%	1.6%
*Other includes: Colorado, Walker and Waller County			
Primary race/ethnicity			
White	12	41%	14%
African American/Black	13	45%	60%
Hispanic/Latino	3	10%	21%
Asian American	0	-	0.7%
Other/Multiracial	1	3%	4.7%
Immigration status			
Born in the U.S.	27	90%	88%
Citizen > 5 years	2	7%	10%
Citizen < 5 years	0	-	1%
Visa (student, work, tourist, etc.)	1	3%	0.2%
Prefer not to answer	0	-	0.7%
Born in the U.S.	27	90%	88%

	No.	Rural %	Total %
Age range (median: 50-54)			
13-17	0	-	-
18-24	2	7%	3%
25-34	4	13%	9%
35-49	8	27%	28%
50-54	4	13%	18%
55-64	9	30%	28%
≥65	3	10%	15%
Seniors (≥50)	21	78%	3%
Sexual orientation			
Heterosexual	13	45%	57%
Gay/Lesbian	13	45%	30%
Bisexual/Pansexual	3	10%	9%
Other	0	-	3.8%
MSM	`16	52%	41%
Yearly income (average: $13,544)			
Federal Poverty Level (FPL)			
Below 100%	4	33%	67%
100%	8	67%	19%
150%	0	-	6%
200%	0	-	5%
250%	0	-	-
≥300%	0	-	2%

	No.	Rural %	Total %
Sex at birth			
Male	21	70%	66%
Female	9	30%	34%
Intersex	0	-	0%
Other	0	-	0%
Transgender	2	6.7%	4%
Currently pregnant	0	0.0%	2%
Health insurance (multiple response)			
Private insurance	3	7%	9%
Medicaid/Medicare	15	37%	67%
Harris Health System	5	12%	29%
Ryan White Only	14	34%	24%
VA	1	2%	3%

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

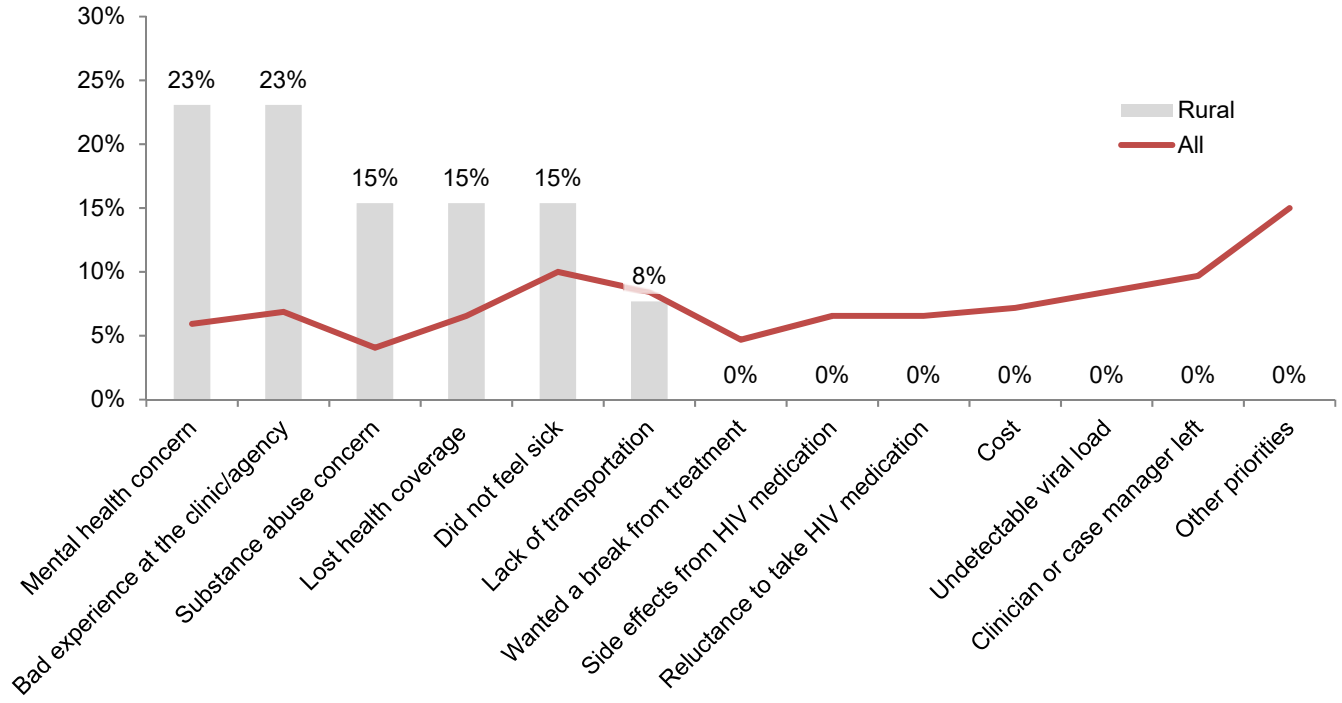
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 80% of rural participants reported no interruptions in their HIV care for 12 months or more since their diagnosis. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey. Participants could also write in their reasons.

(**Graph 1**) Among rural needs assessment participants, bad experiences at the clinic/agency and mental health concerns was the most cited most often as the reasons for interruption in HIV medical care both at 23% of the reported reasons. The next most cited reasons for interruptions in HIC medical care were not feeling sick, loss of health coverage, and substance abuse concerns (all 15%).

The greatest differences between rural needs assessment participants and the total sample were the proportions reporting mental health concerns (23% vs 6%), bad experiences at the clinic/agency (23% vs 7%), substance abuse concerns (15% vs 4%), loss of health care coverage (15% vs 7%), and not feeling sick (15% vs 10%) as reasons for interruption in HIV medical care. Rural needs assessment participants provided no write in responses.

GRAPH 1-Reasons for Falling Out of HIV Care among Rural PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by rural needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



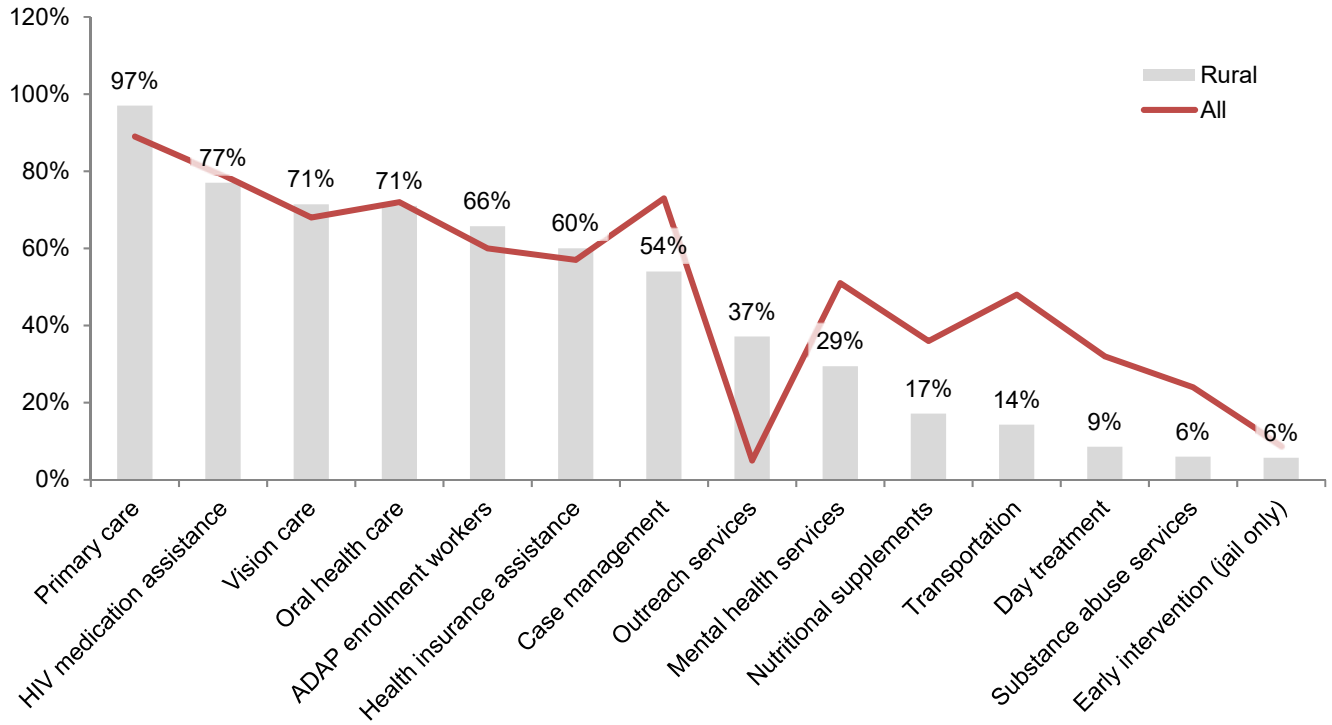
OVERALL RANKING OF FUNDED SERVICES, BY NEED

In 2020, 16 HIV care medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Among rural participants, primary care was the most needed funded service at 97% of rural participants reporting a need. Rural participants also indicated needs for local HIV medication assistance (77%), vision care (71%), and oral health care (71%). The greatest differences between rural needs assessment participants and the total sample were in the proportions reporting need for outreach services (37% vs 5%), primary care (97% vs 89%), ADAP enrollment workers (66% vs 60%), and vision care (71% vs 68%).

GRAPH 2-Ranking of HIV Services among Rural PLWH, By Need, 2020

Definition: Percent of rural needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

In 2020, 10 other/non-Ryan White Funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants in the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded services they needed in the past 12 months.

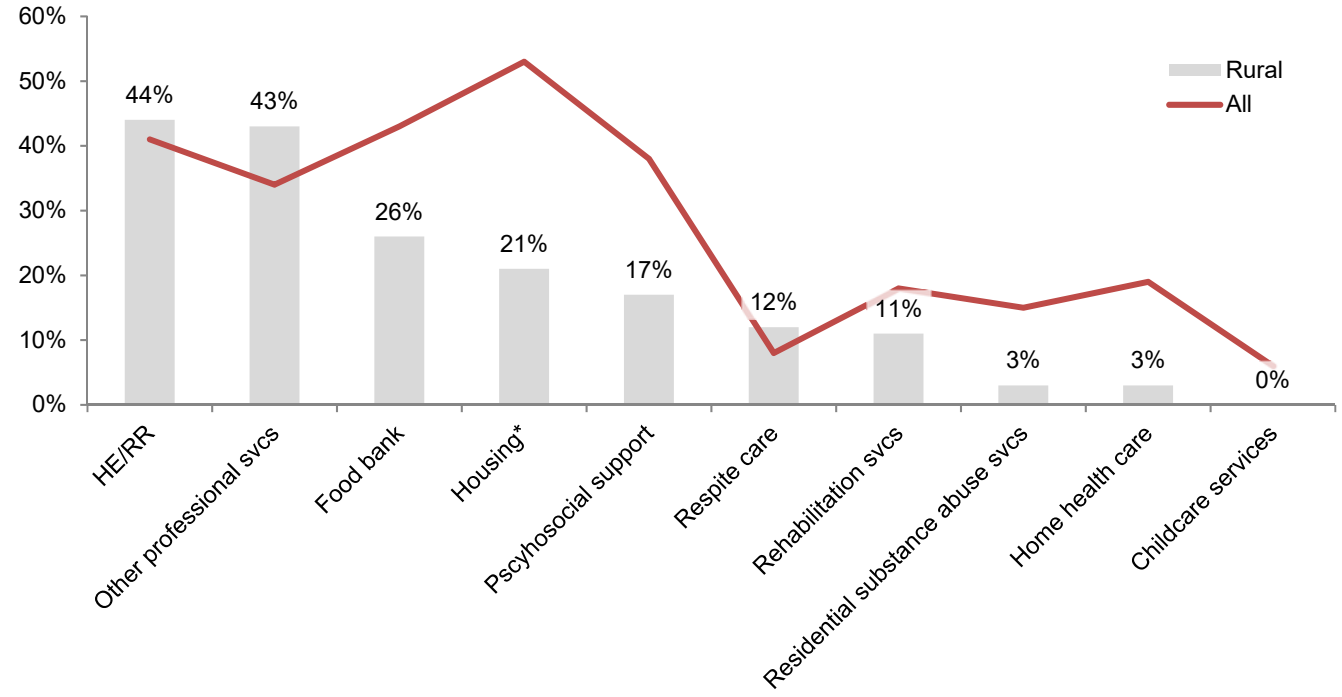
(**Graph 5**) From the 10 service options provided, rural needs assessment participants reported health education & risk reduction services (44%) as the most needed other/non-Ryan White Funded HIV-related service. Rural needs assessment participants also cited other professional services (43%), and food bank services (26%) as needed other/non-Ryan White Funded HIV-related services.

Overall when compared to the total sample rural needs assessment participants reported less need for other/non-Ryan White Funded HIV-related services; however, a greater proportion of rural needs assessment participants reported need for other professional services (43% vs 34%), respite care (12% vs 8%), and health education & risk reduction services (44% vs 41%).

GRAPH 3-Other Needs for HIV Services among Rural PLWH, 2020

Definition: Percent of rural needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



OVERALL BARRIERS TO HIV CARE

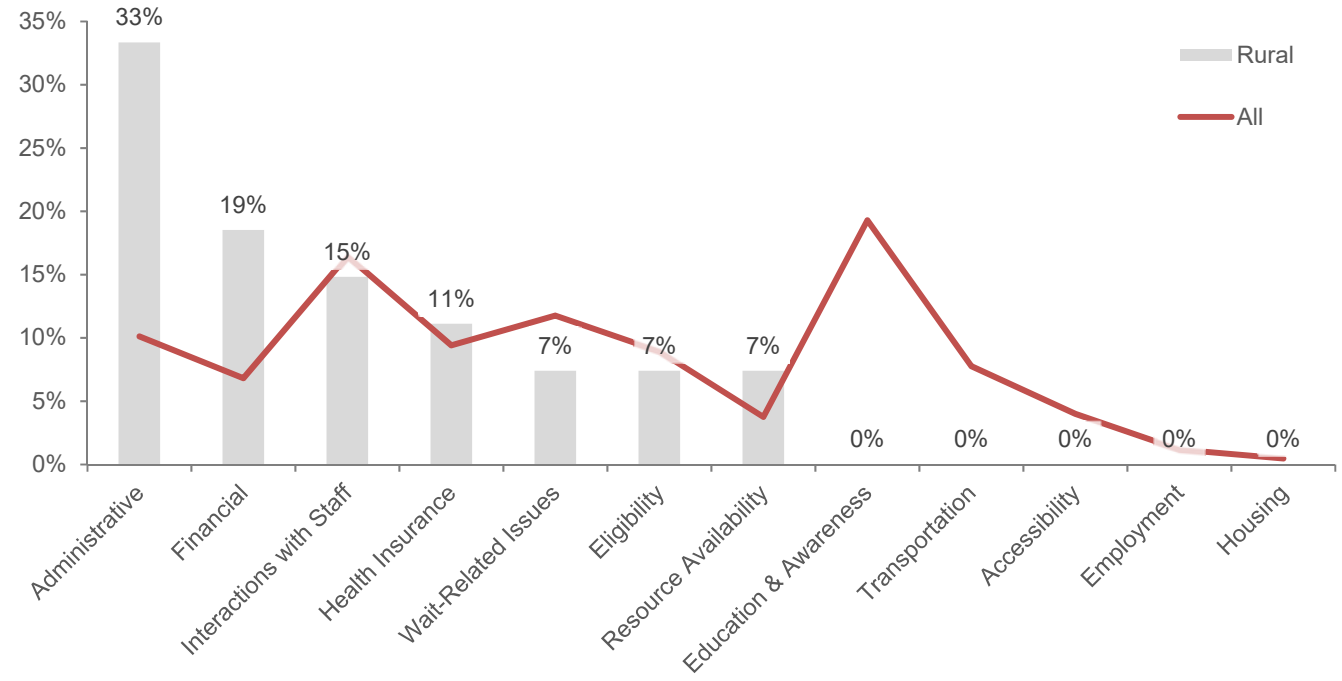
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers. These barriers were then groups together into 12 nodes, or barrier types.

(**Graph 4**) Thirteen (13) rural needs assessment participants cited barriers to Ryan White funded HIV care services. Rural needs assessment participants most cited barrier type was administrative related (33%); with complex processes, dismissal from the agency or clinic and understaffing being the barriers reported. Rural needs assessment participants also reported financial barriers (19%), not being able to pay for services, and interactions with staff (15%) as reported barrier types. Barriers related to interactions with staff reported by rural needs assessment participants were related to poor treatment by clinic or agency staff, and poor correspondence or follow from staff.

Compared to the total sample, rural needs assessment participants reported greater proportions of service administrative barriers (33% vs 10%), financial barriers (19% vs 7%), and barriers due to resource availability (7% vs 4%).

GRAPH 4-Ranking of Types of Barriers to HIV Services among Rural PLWH, 2020

Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



Works Cited

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