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 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		

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.*

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
2022 Client Satisfaction Survey 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 2022 are attached.

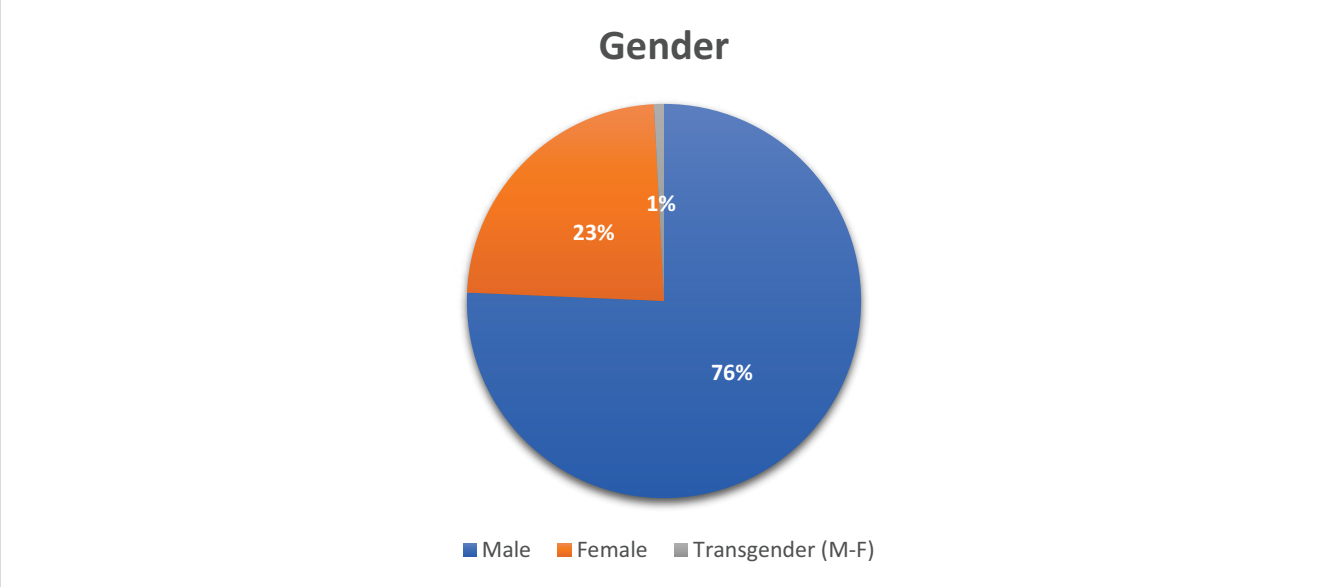
Ryan White Part-A funds an array of services allocated by the Ryan White Planning Council. The Services which were surveyed during the 2022 data collection period include outpatient/ambulatory care, case management, dental care, transportation, legal, local pharmacy assistance program, health insurance 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.

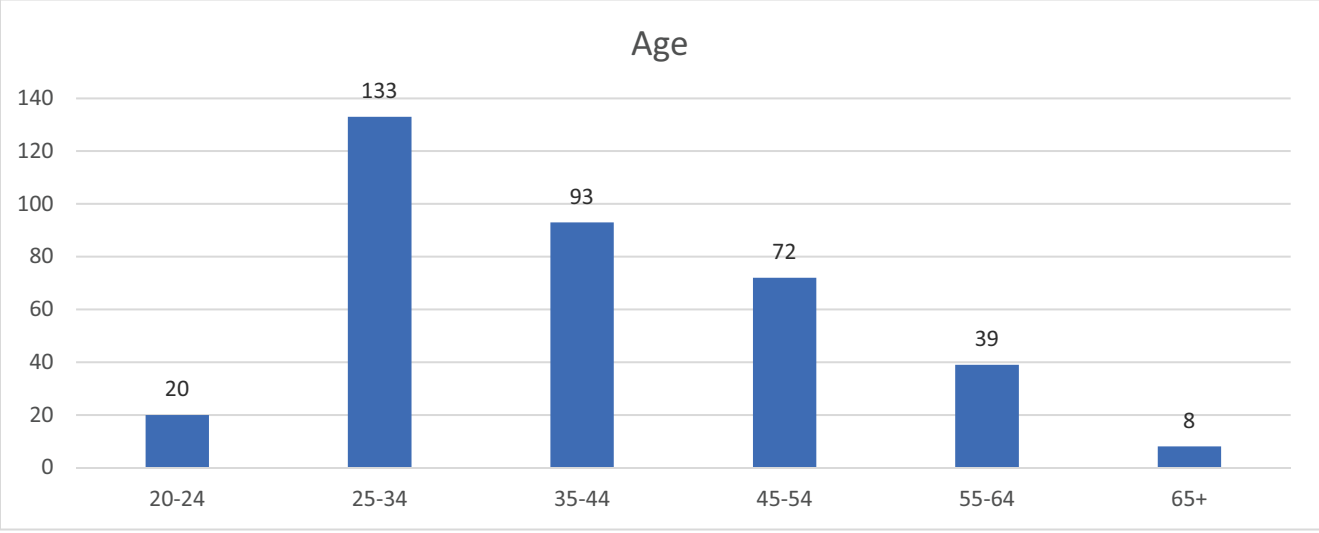
The Method

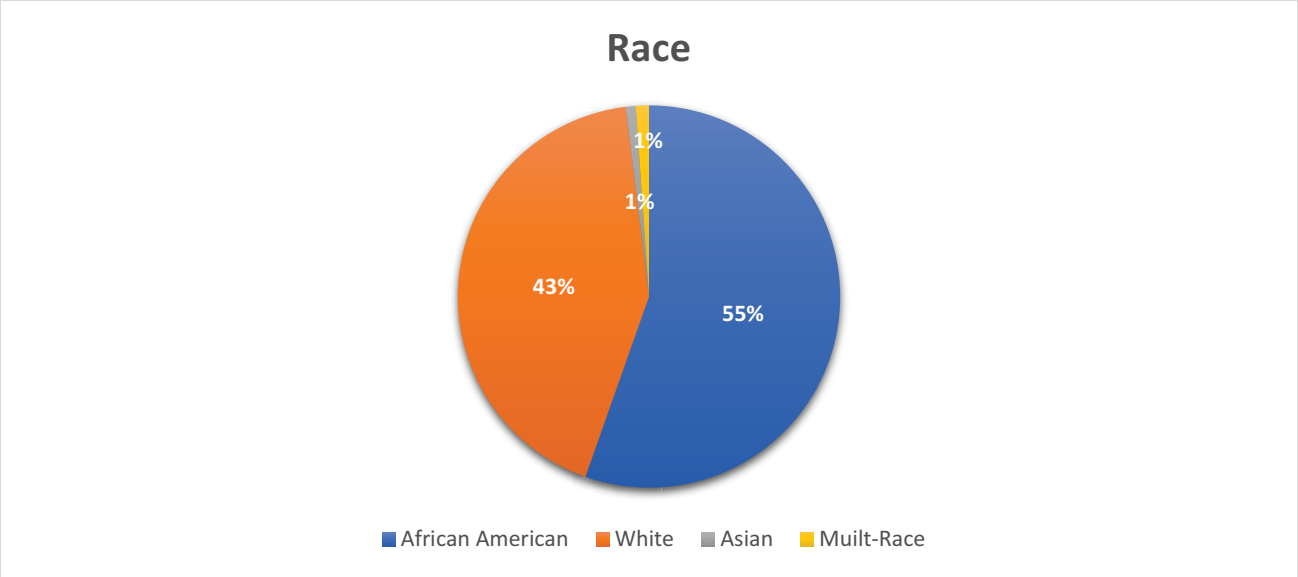
Ryan White Grant Administration in the Houston EMA conducted a web-based survey process through the CPCDMS to measure client satisfaction. Survey completion was conducted via two methods: 1) surveys were initiated by service providers reaching out to their client population to request participation; 2) utilization 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.

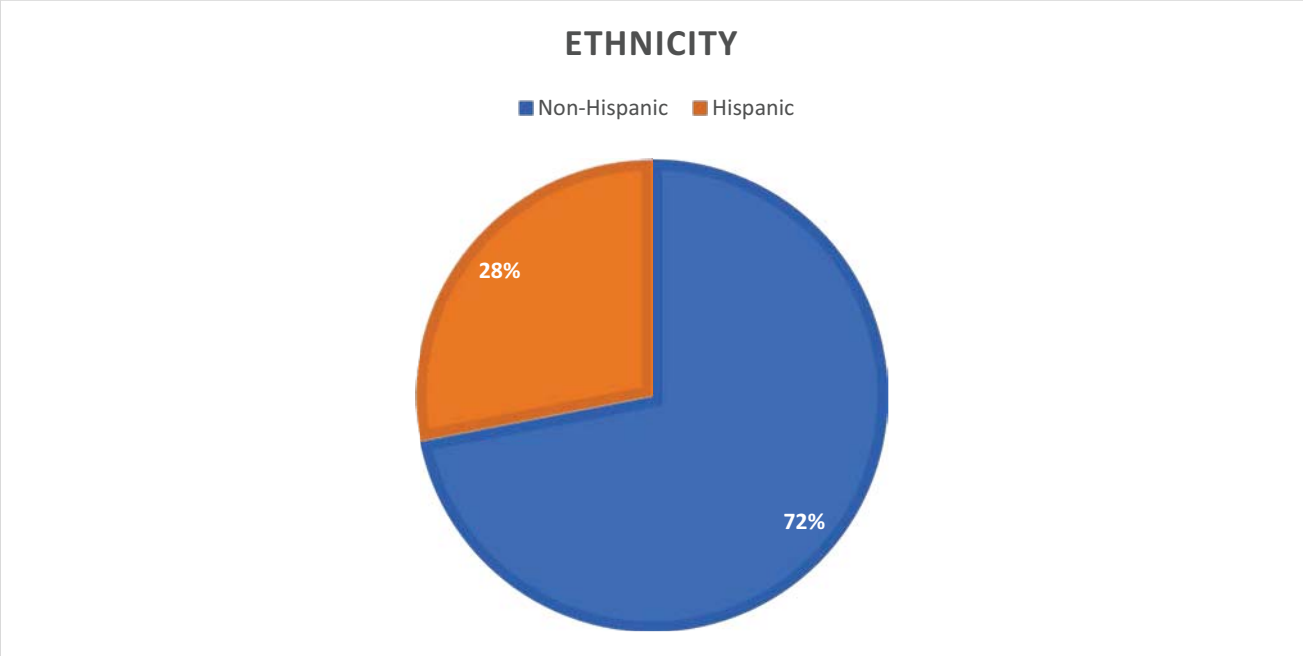
Survey Respondents Demographics

A convenience sample was used to obtain respondents. There was a total of 555 unduplicated clients that completed a survey. Data collection was March 1, 2022- February 28, 2023. Below is a cumulative summary of the respondents' demographic information:






Race
1%
1%
43%
55%
African American
White
Asian
Muilt-Race

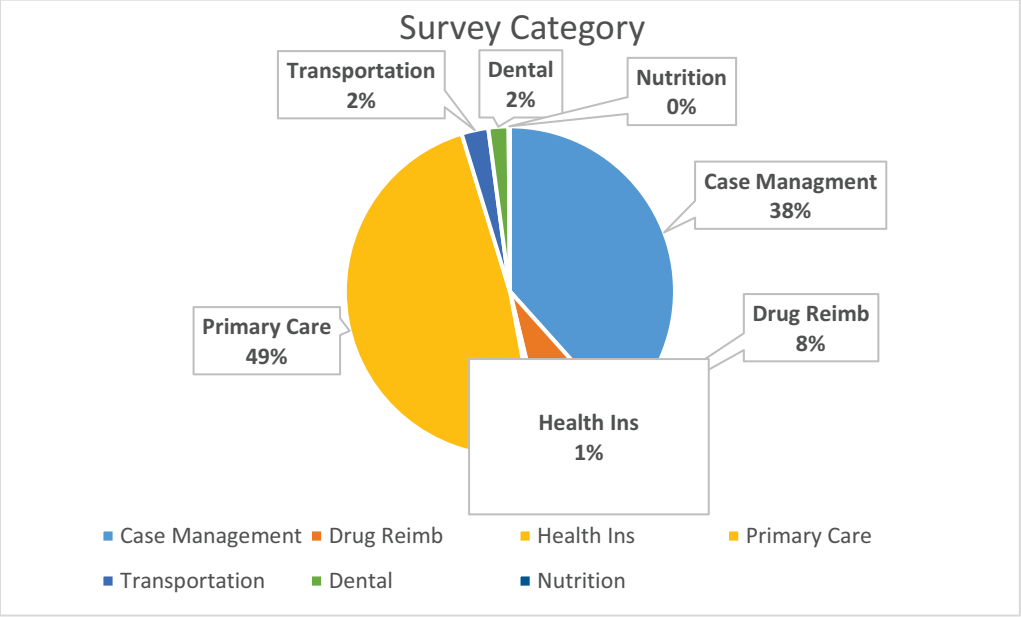

ETHNICITY
Non-Hispanic
Hispanic
28%
72%

Cumulative Summaries

Service Areas Surveyed

Overall, Surveys were received for the following service areas:

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

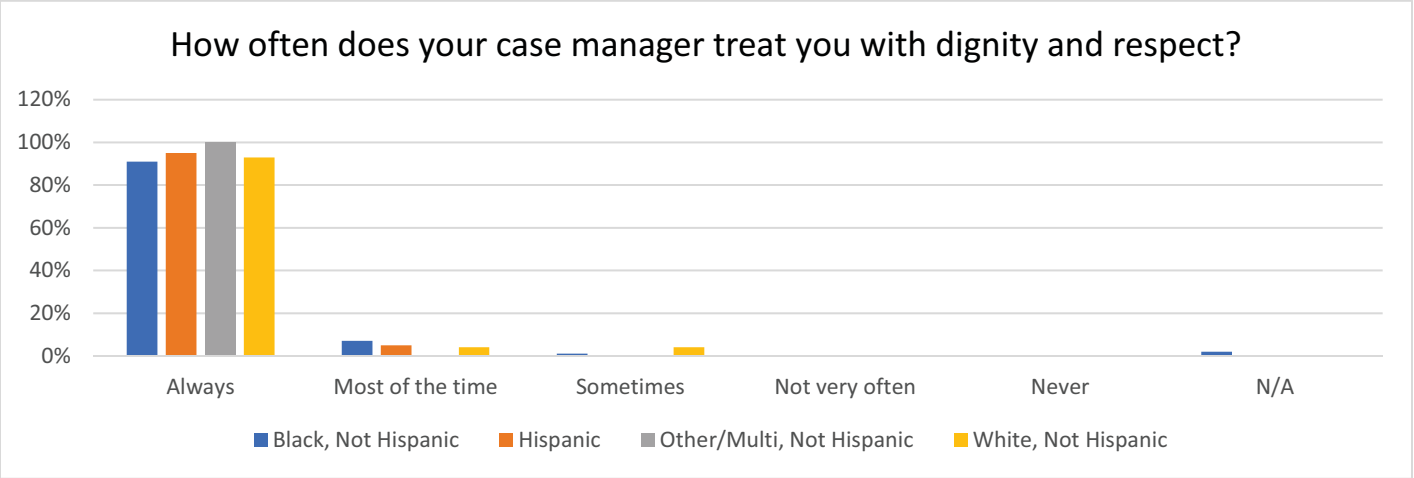


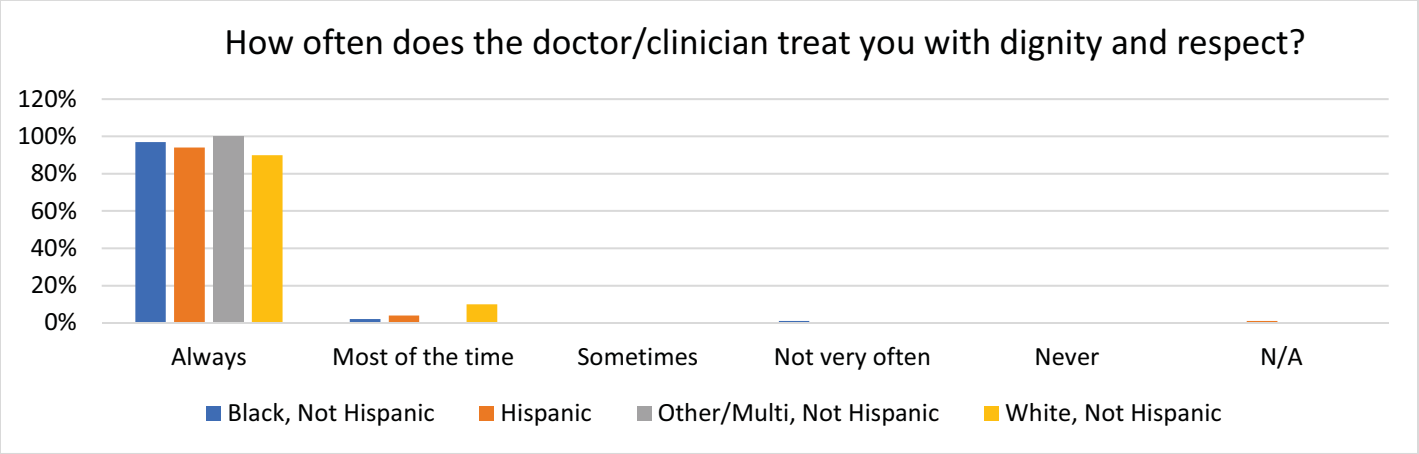
As of 3/1/23, there were a total of 555 surveys taken. Several clients took more than one survey, but each survey was for a different service area. Four-hundred eighty-nine (509) of the total surveys were taken in English and forty-six (46) were taken in Spanish.

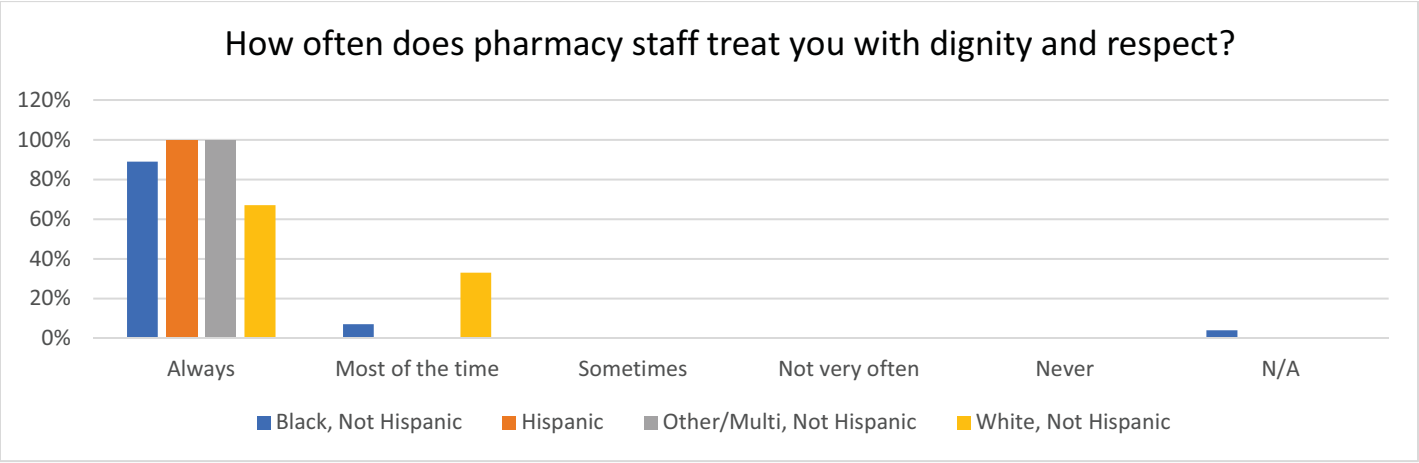
Respondents were asked to rate their satisfaction with services on a scale of 1-6 with 1 being the best and 5 being the worst. 6 indicates “Not Applicable”.

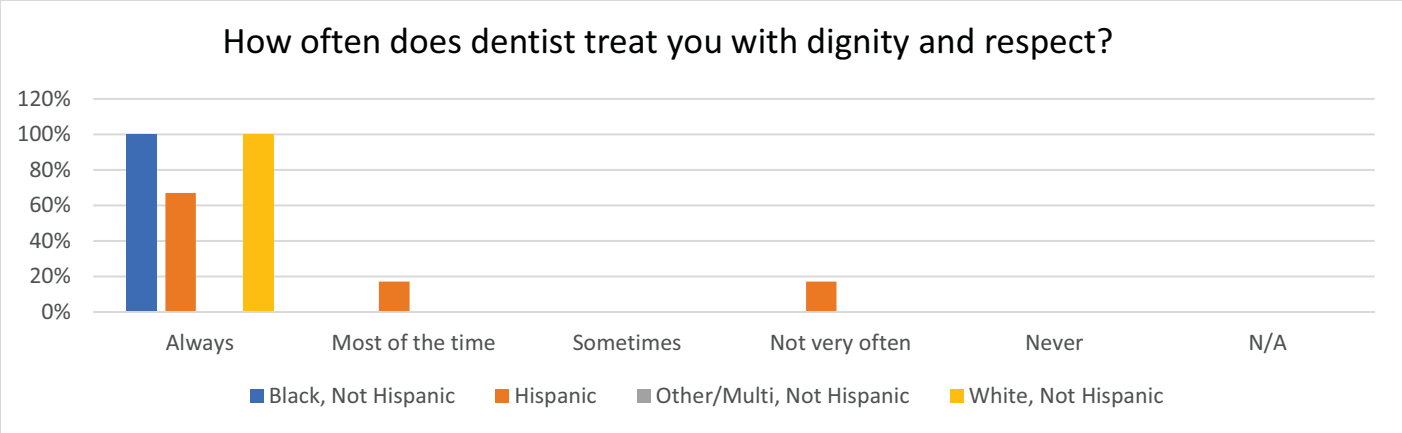
The graphs in the following sections show percentages broken out by race and ethnicity for all survey questions. They have been categorized into overall themes

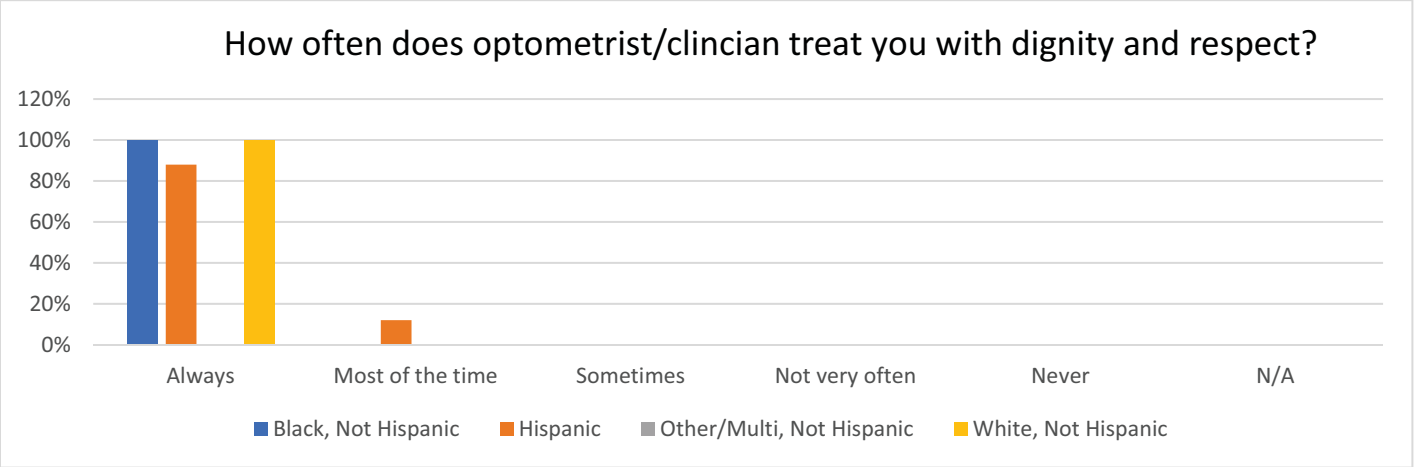
Respect

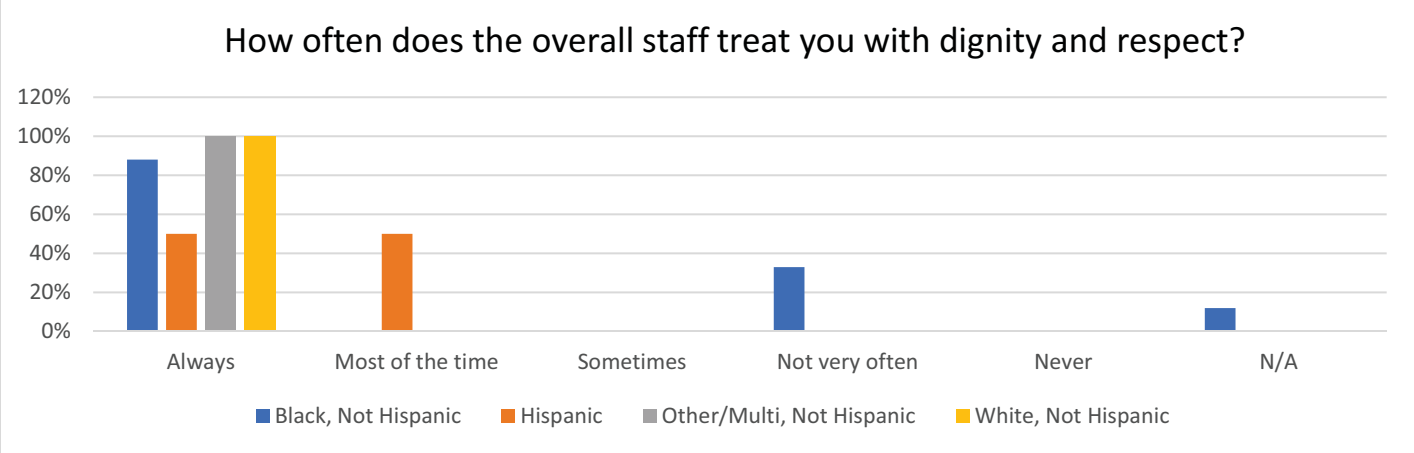

How often does your case manager treat you with dignity and respect?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

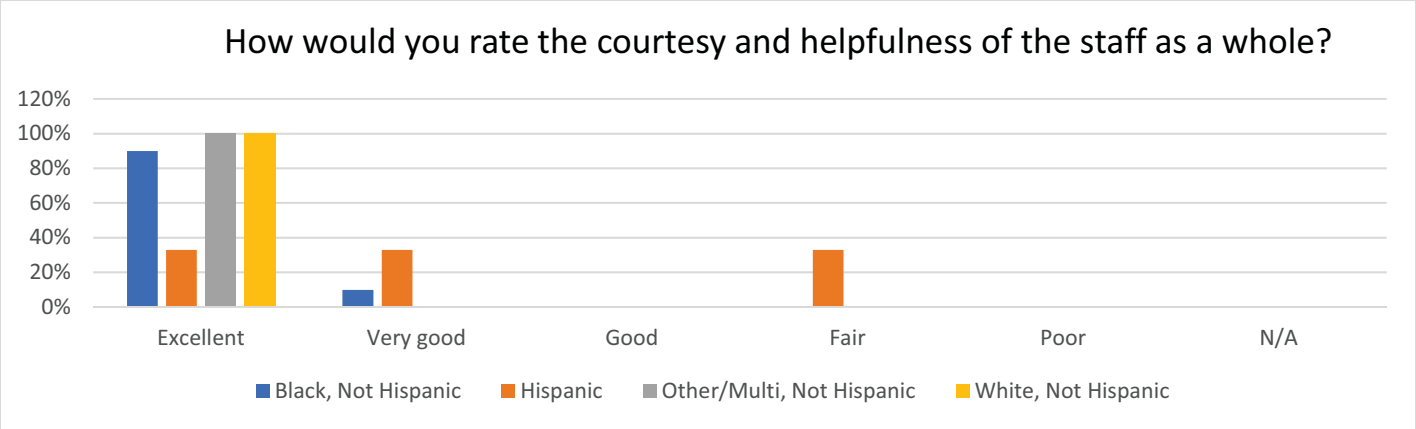

How often does the doctor/clinician treat you with dignity and respect?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic


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

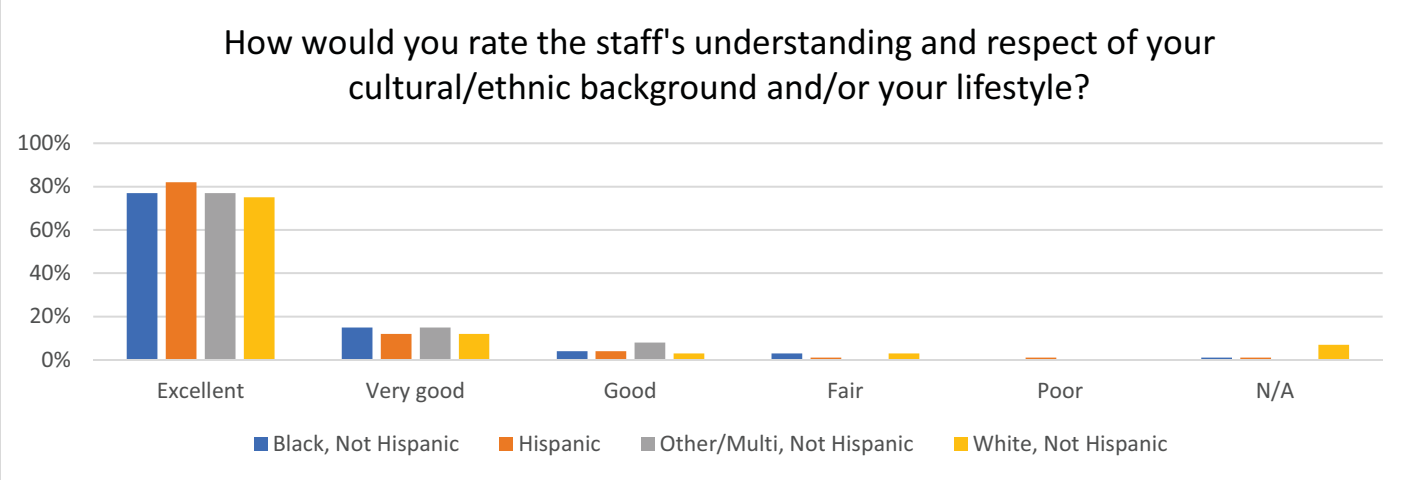

How often does dentist treat you with dignity and respect?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

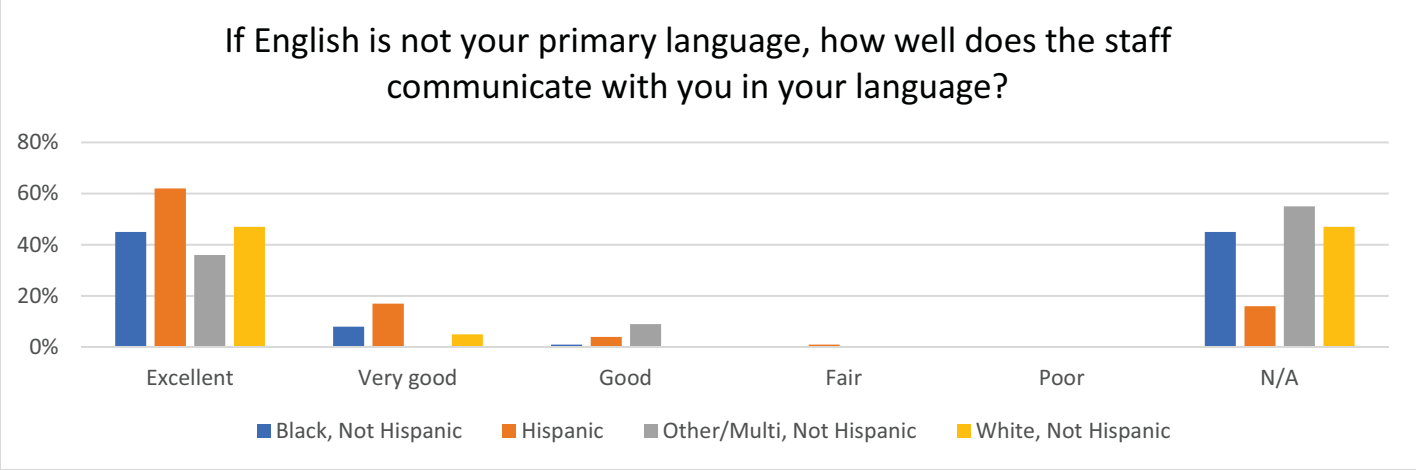

How often does optometrist/clincian treat you with dignity and respect?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

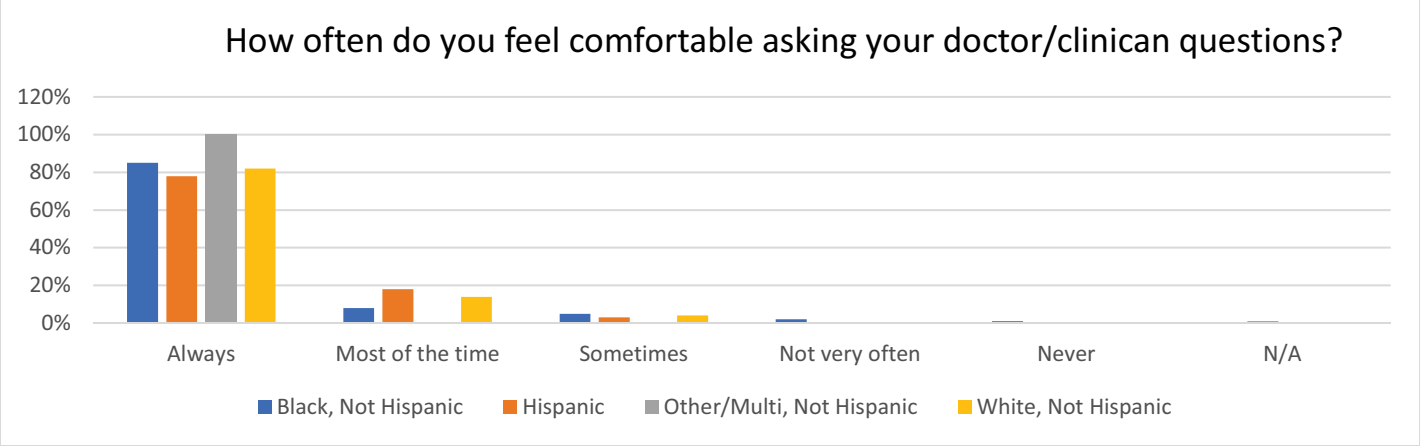

How often does the overall staff treat you with dignity and respect?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

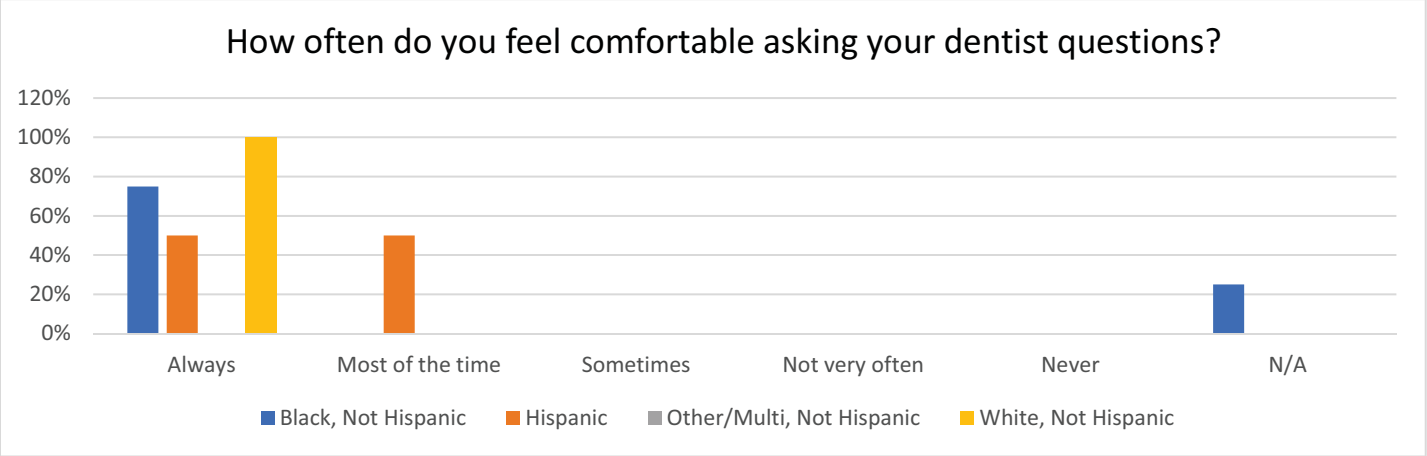


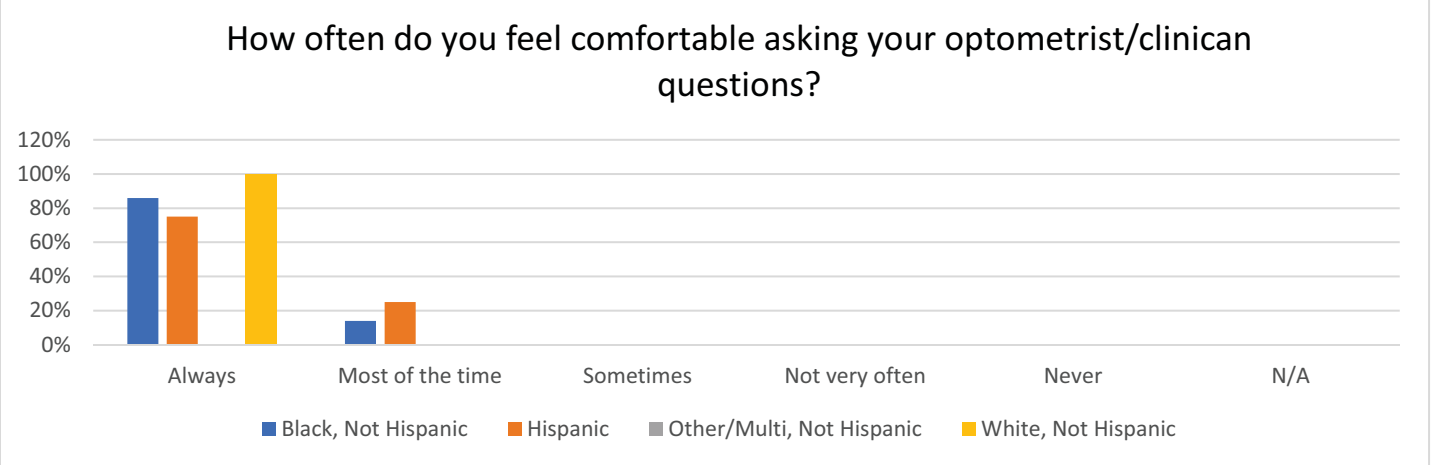
Culturally Responsive services



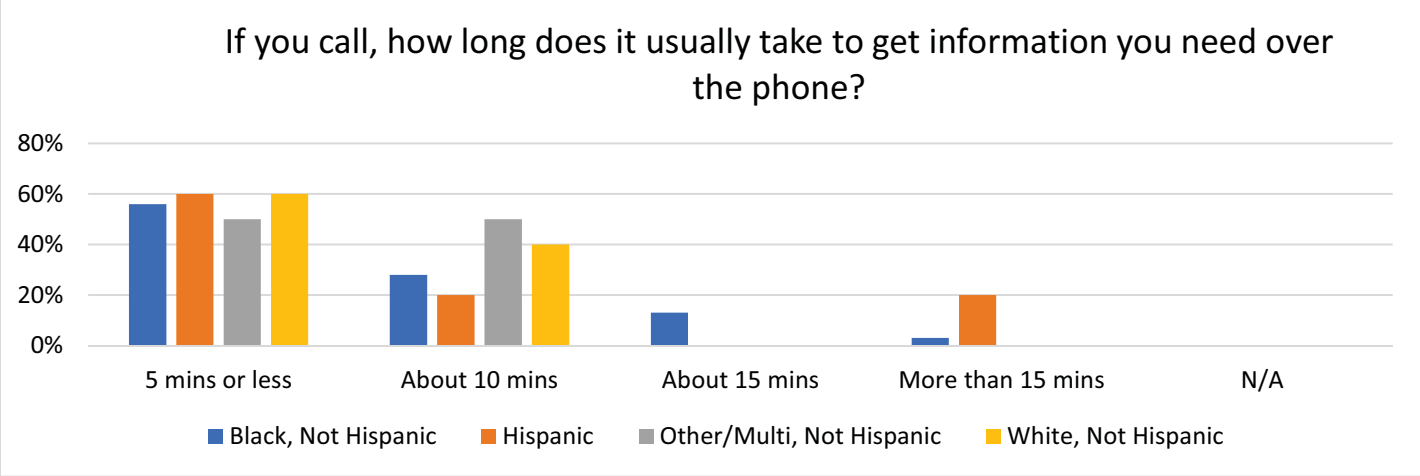


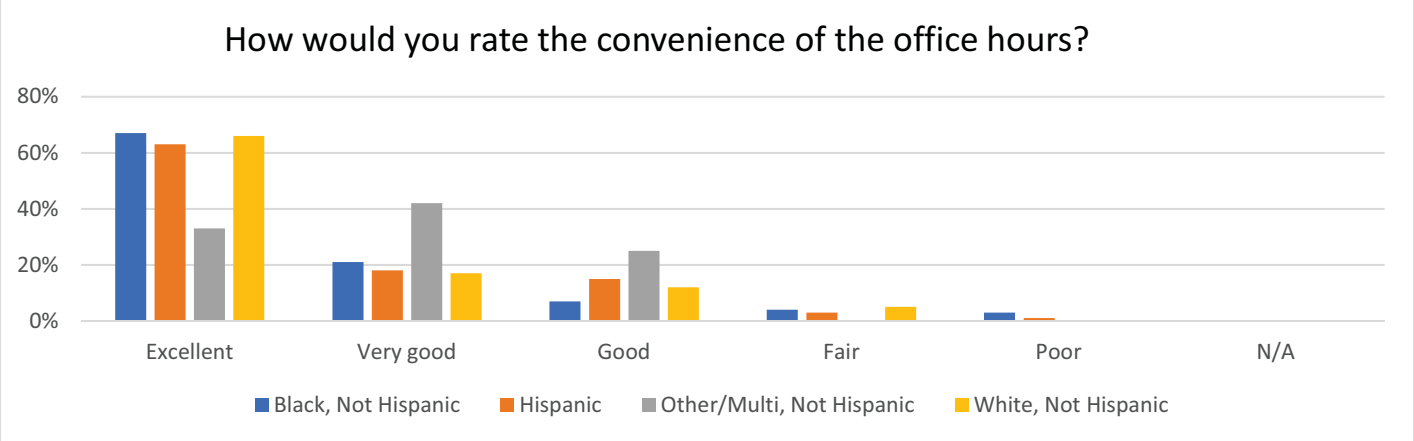

How often do you feel comfortable asking your doctor/clinican questions?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

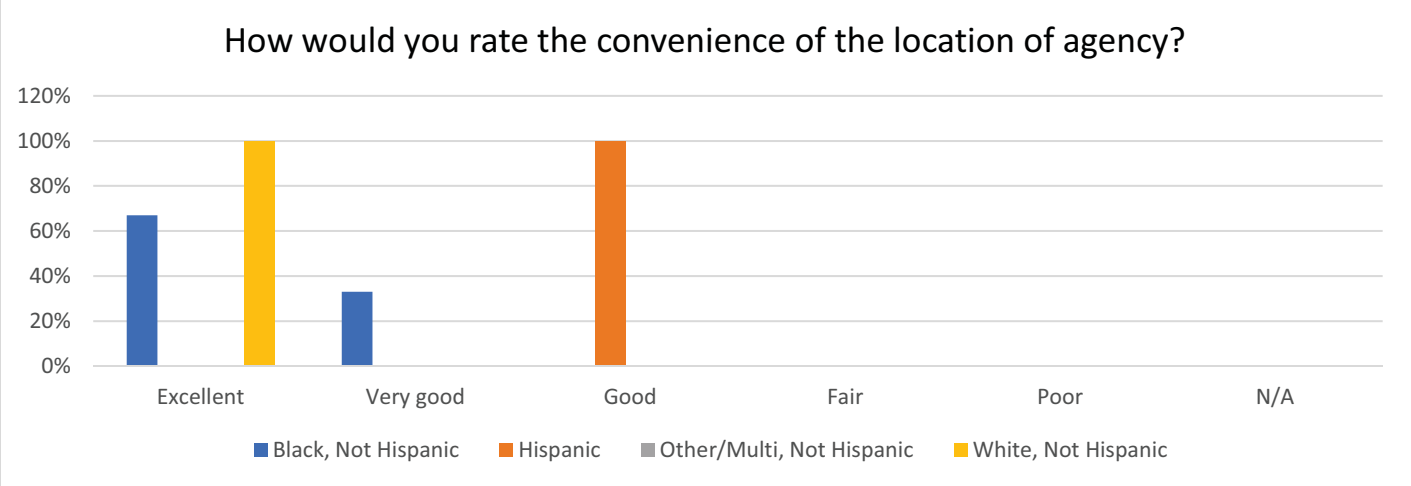

How often do you feel comfortable asking your dentist questions?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

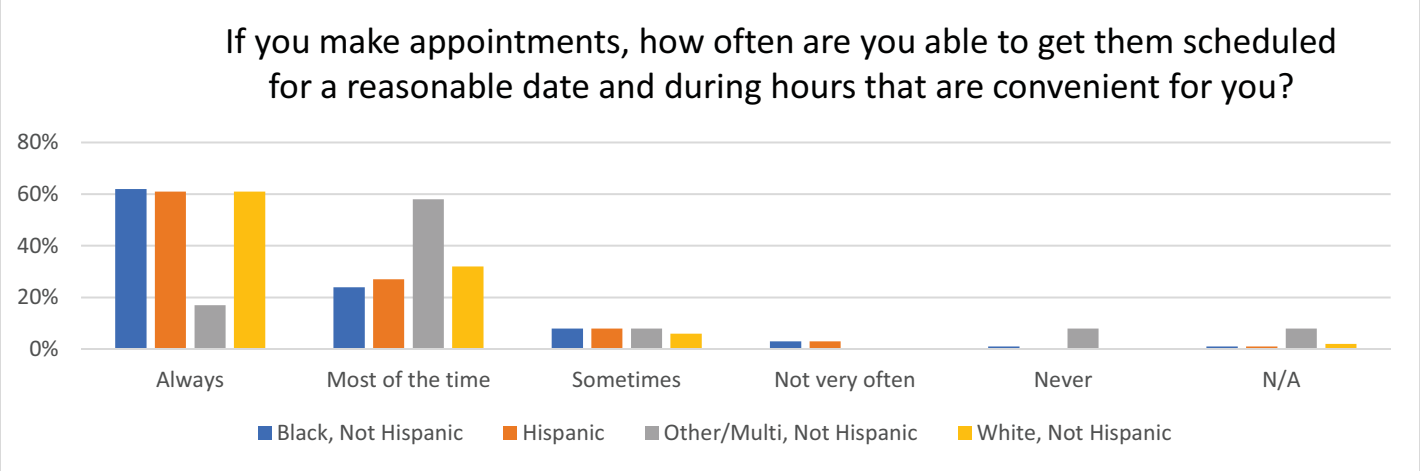

How often do you feel comfortable asking your optometrist/clinican questions?
120%
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

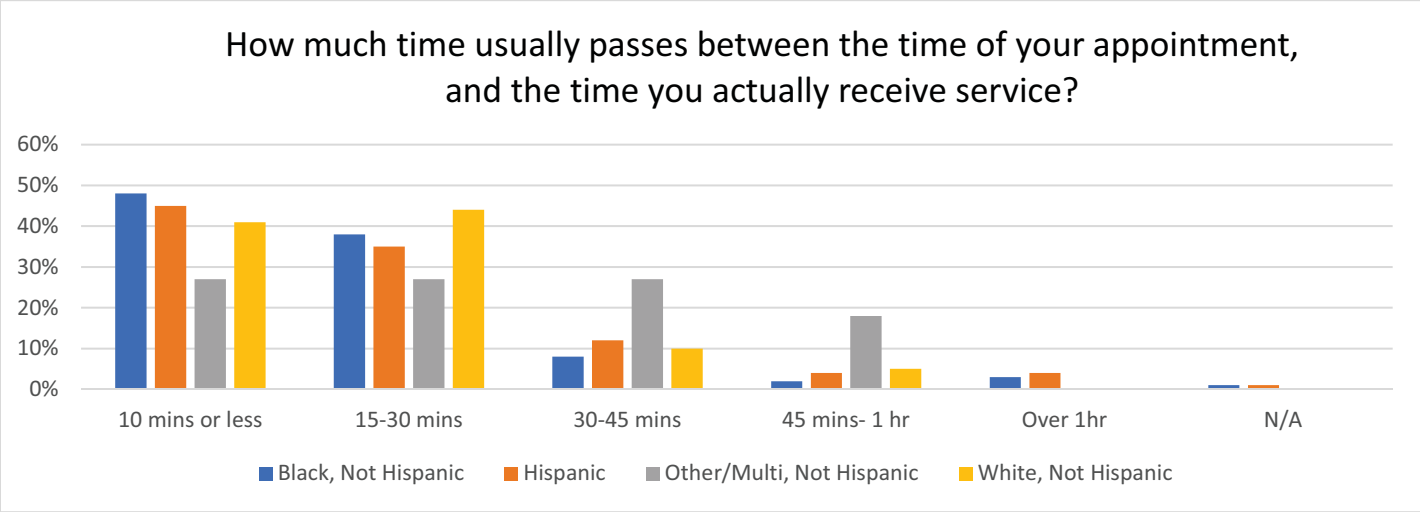
Convenience



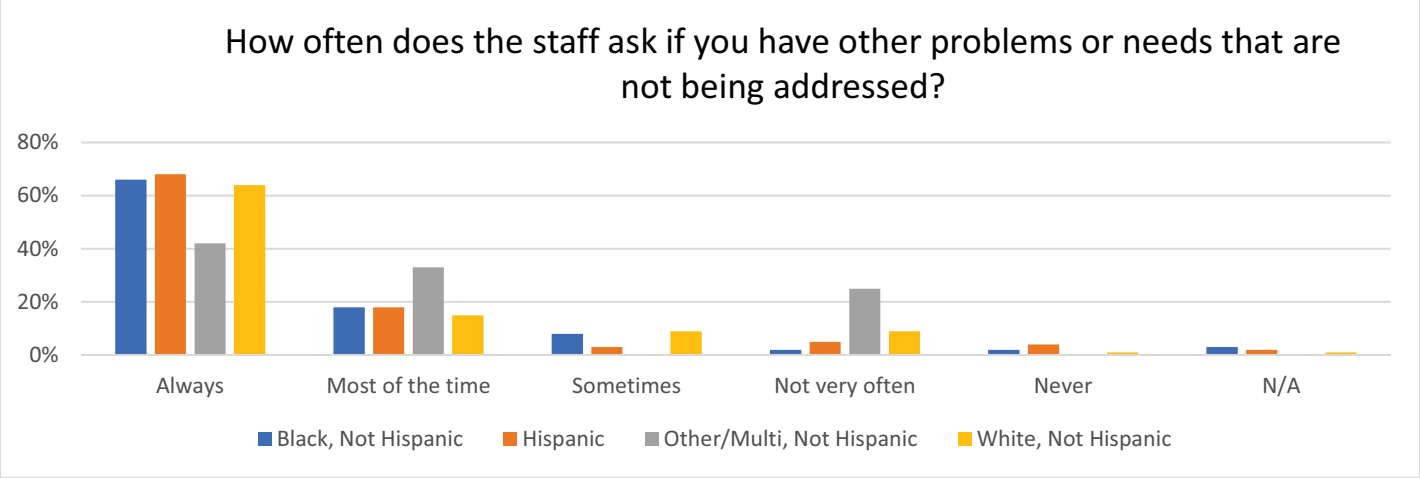


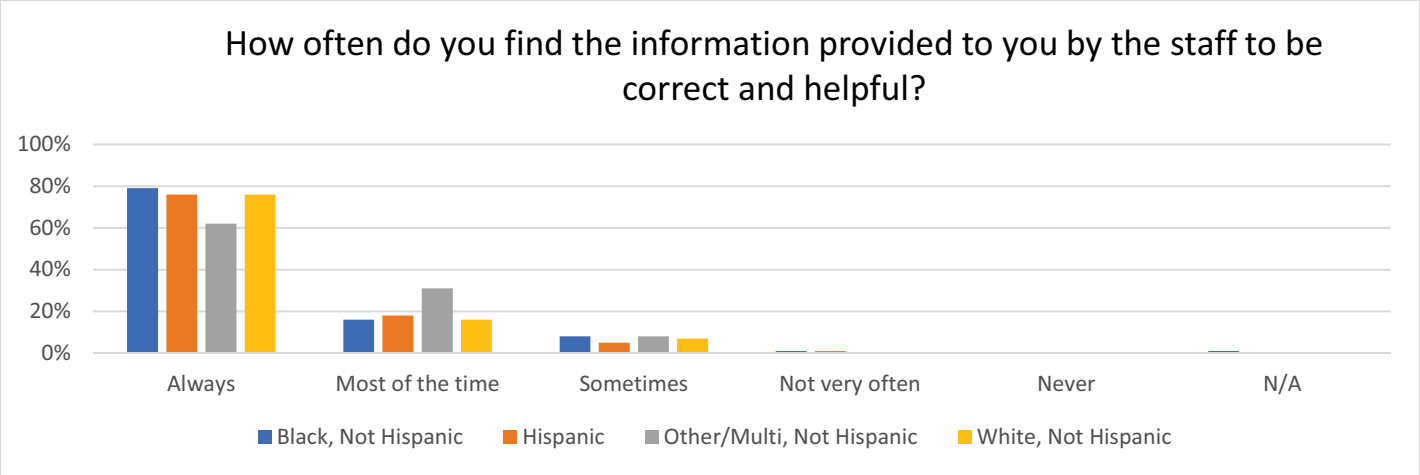


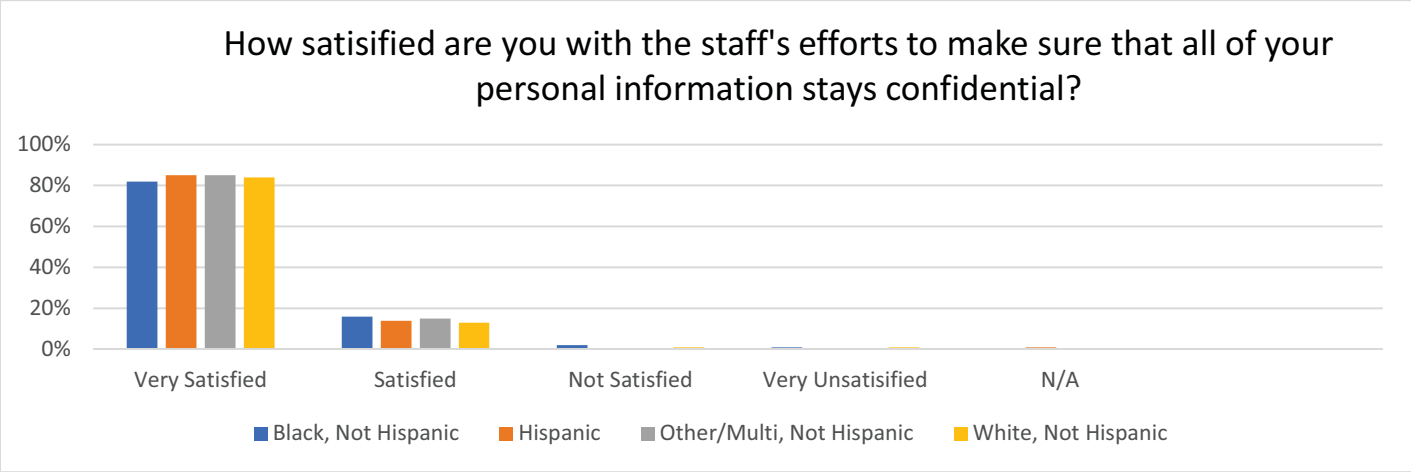


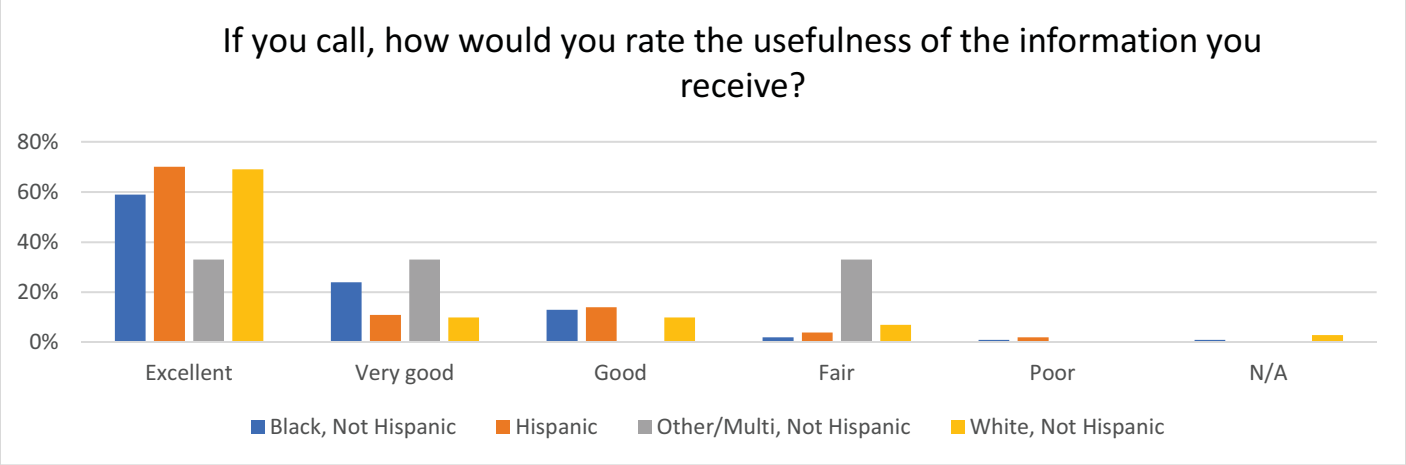


Information and Communication

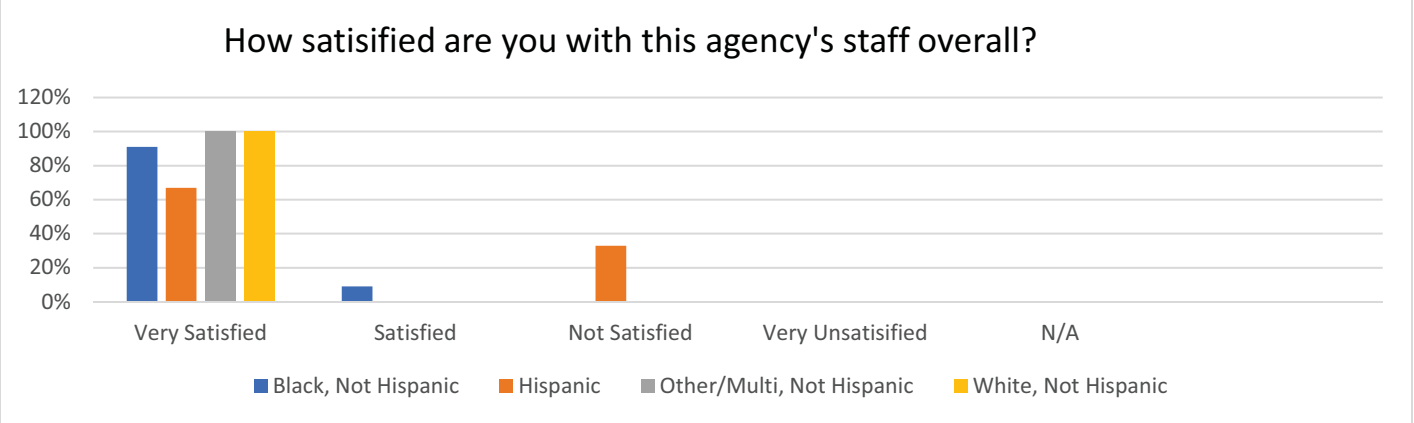


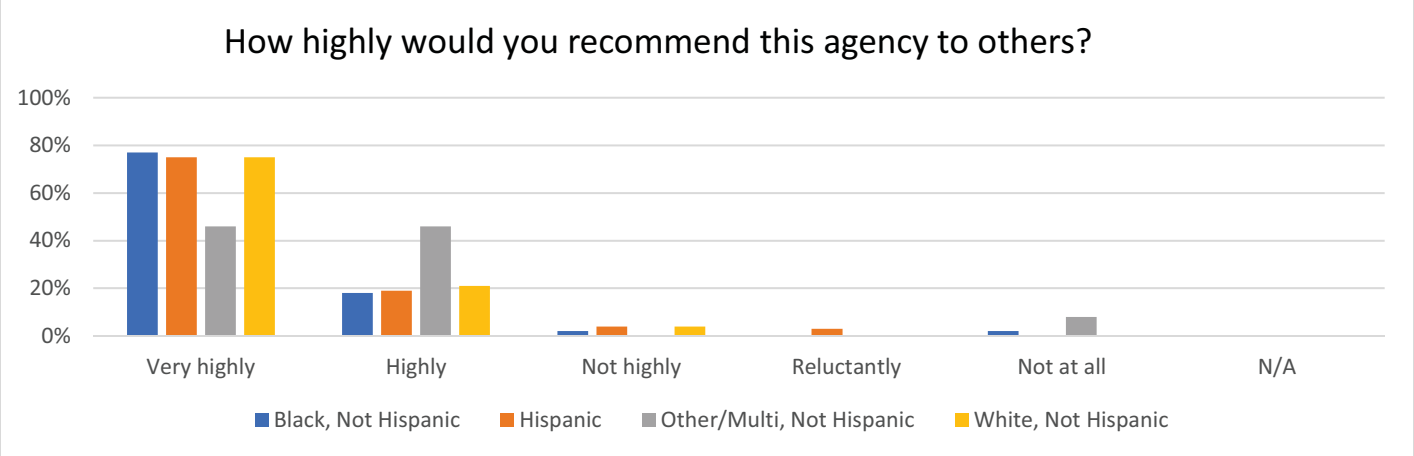

How often do you find the information provided to you by the staff to be correct and helpful?
100%
80%
60%
40%
20%
0%
Always
Most of the time
Sometimes
Not very often
Never
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

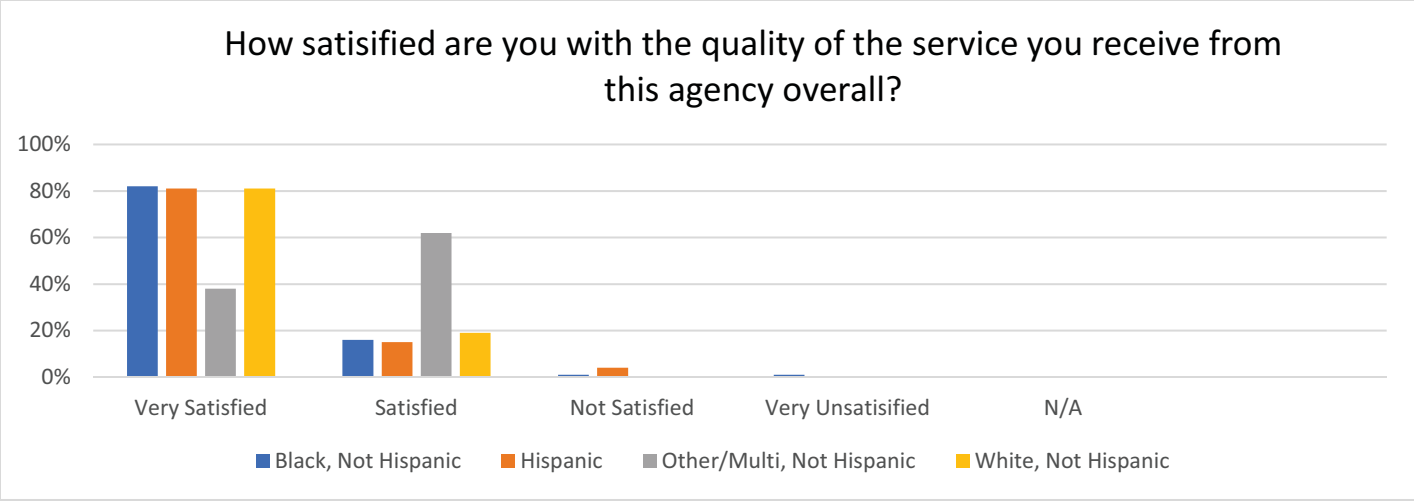

How satisified are you with the staff's efforts to make sure that all of your personal information stays confidential?
100%
80%
60%
40%
20%
0%
Very Satisfied
Satisfied
Not Satisfied
Very Unsatisified
N/A
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic


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. 80% of clients are satisfied with the quality of service received for HIV care. Less than 20% are reluctant to recommend Ryan White funded agencies. Along with the positive feedback, there were areas that stood out as needing improvement.

The level of satisfaction is consistently lower in areas focused on convenience of services. This included office hours, ability to get appointments, and wait times. Many clients continue to respond that are not often asked if their needs are being met or if there is something else that they need. Highlighting the importance of utilizing the case management brief and comprehensive assessments to identify client needs. 2022 surveys show an increase in dissatisfaction with the level of respect and dignity clients feel they received from health care teams. Data also suggest a need for improvement in providing useful information and resources during, or after, encounters with health care teams.

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 **3/1/22** and **3/1/23**
[Agency]: **ALL** [SLG#]: **(0) CLIENT SATIS - CASE MGMT**
[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	111 91%	58 95%	5 100%	26 93%	**200** **93%**
	La mayoría del tiempo,Most of the time	2	8 7%	3 5%	0%	1 4%	**12** **6%**
	Sometimes	3	1 1%	0%	0%	1 4%	**2** **1%**
	Not Applicable	6	2 2%	0%	0%	0%	**2** **1%**
			122	**61**	**5**	**28**	**216**
How often does the dentist treat you with dignity and respect?	Always	1	3 100%	4 67%	0 %	2 100%	**9** **82%**
	La mayoría del tiempo	2	0%	1 17%	0 %	0%	**1** **9%**
	Not Very Often	4	0%	1 17%	0 %	0%	**1** **9%**
			3	**6**		**2**	**11**
How often do you feel comfortable asking your dentist questions?	Always	1	3 75%	3 50%	0 %	2 100%	**8** **67%**

	La mayoría del tiempo,Most of the time	2	0%	3 50%	0 %	0%	**3 25%**
	Not Applicable	6	1 25%	0%	0 %	0%	**1 8%**
			4	**6**		**2**	**12**
How often does the doctor/clinician treat you with dignity and respect?	Always,Siempre	1	119 97%	69 95%	5 100%	26 90%	**219 95%**
	La mayoría del tiempo,Most of the time	2	3 2%	3 4%	0%	3 10%	**9 4%**
	Not Very Often	4	1 1%	0%	0%	0%	**1 0%**
	Not Applicable	6	0%	1 1%	0%	0%	**1 0%**
			123	**73**	**5**	**29**	**230**
How often does the optometrist/clinician treat you with dignity and respect?	Always,Siempre	1	14 100%	7 88%	0 %	6 100%	**27 96%**
	La mayoría del tiempo	2	0%	1 12%	0 %	0%	**1 4%**
			14	**8**		**6**	**28**
How often do you feel comfortable asking your optometrist/clinician questions?	Always,Muy satisfecho/a	1	12 86%	6 75%	0 %	6 100%	**24 86%**

How often do you feel comfortable asking your optometrist/clinician questions?	Most of the time,Satisfecho/a	2	2 14%	2 25%	0 %	0%	**4** **14%**
			14	**8**		**6**	**28**
How often do you feel comfortable asking your doctor/clinician questions?	Always,Siempre	1	102 85%	56 78%	6 100%	23 82%	**187** **83%**
	La mayoría del tiempo,Most of the time	2	9 8%	13 18%	0%	4 14%	**26** **12%**
	A veces,Sometimes	3	6 5%	2 3%	0%	1 4%	**9** **4%**
	Not Very Often	4	2 2%	0%	0%	0%	**2** **1%**
	Never	5	1 1%	0%	0%	0%	**1** **0%**
	Not Applicable	6	0%	1 1%	0%	0%	**1** **0%**
			120	**72**	**6**	**28**	**226**
How often does pharmacy staff treat you with dignity and respect?	Always,Siempre	1	25 89%	16 100%	1 100%	2 67%	**44** **92%**
	Most of the time	2	2 7%	0%	0%	1 33%	**3** **6%**
	Not Applicable	6	1 4%	0%	0%	0%	**1** **2%**
			28	**16**	**1**	**3**	**48**

How often does the staff treat you with dignity and respect?	Always	1	7 88%	1 50%	1 100%	1 100%	**10** **83%**
	Most of the time	2	0%	1 50%	0%	0%	**1** **8%**
	Not Applicable	6	1 12%	0%	0%	0%	**1** **8%**
			8	**2**	**1**	**1**	**12**
How often does the staff treat you with dignity and respect?	Always	1	2 67%	0%	0 %	1 100%	**3** **60%**
	Most of the time	2	0%	1 100%	0 %	0%	**1** **20%**
	Not Very Often	4	1 33%	0%	0 %	0%	**1** **20%**
			3	**1**		**1**	**5**
How would you rate the courtesy and helpfulness of the staff as a whole?	Excellent	1	9 90%	1 33%	1 100%	2 100%	**13** **81%**
	Very Good	2	1 10%	1 33%	0%	0%	**2** **12%**
	Fair	4	0%	1 33%	0%	0%	**1** **6%**
			10	**3**	**1**	**2**	**16**
How would you rate the staff's understanding and respect of your cultural / ethnic background and/or your lifestyle?	Excelente,Excellent	1	226 77%	130 82%	10 77%	52 75%	**418** **78%**

	Muy buena,Very Good	2	43 15%	19 12%	2 15%	8 12%	**72** **13%**
	Buena,Good	3	11 4%	7 4%	1 8%	2 3%	**21** **4%**
	Fair,Regular	4	10 3%	1 1%	0%	2 3%	**13** **2%**
	Poor	5	1 0%	1 1%	0%	0%	**2** **0%**
	Not Applicable	6	2 1%	1 1%	0%	5 7%	**8** **1%**
			293	**159**	**13**	**69**	**534**
If English is not your primary language, how well does the staff communicate with you in your language?	Excelentemente,Excellent	1	123 45%	97 62%	4 36%	28 47%	**252** **51%**
	Muy bién,Very Good	2	21 8%	26 17%	0%	3 5%	**50** **10%**
	Bién,Good	3	4 1%	7 4%	1 9%	0%	**12** **2%**
	Fair	4	0%	1 1%	0%	0%	**1** **0%**
	Not Applicable	6	123 45%	25 16%	6 55%	28 47%	**182** **37%**
			271	**156**	**11**	**59**	**497**

How often does the staff ask if you have other problems or needs that are not being addressed?	Always,Siempre	1	190 66%	104 68%	5 42%	43 64%	**342** **66%**
	La mayoría de tiempo,La mayoría del tiempo,Most of the time	2	52 18%	27 18%	4 33%	10 15%	**93** **18%**
	A veces,Sometimes	3	22 8%	5 3%	0%	6 9%	**33** **6%**
	No muy seguido,Not Very Often	4	7 2%	7 5%	3 25%	6 9%	**23** **4%**
	Never,Nunca	5	7 2%	6 4%	0%	1 1%	**14** **3%**
	No aplica,Not Applicable	6	10 3%	3 2%	0%	1 1%	**14** **3%**
			288	**152**	**12**	**67**	**519**
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	239 82%	133 85%	11 85%	58 84%	**441** **83%**
	Satisfecho/a,Satisfied	2	46 16%	22 14%	2 15%	9 13%	**79** **15%**
	Not Satisfied	3	5 2%	0%	0%	1 1%	**6** **1%**
	Very Unsatisfied	4	1 0%	0%	0%	1 1%	**2** **0%**
	Not Applicable	5	1 0%	2 1%	0%	0%	**3** **1%**

			292	**157**	**13**	**69**	**531**
How often do you find the information provided to you by the staff to be correct and helpful?	Always,Siempre	1	232 79%	119 76%	8 62%	52 76%	**411** **78%**
	La mayoría de tiempo,La mayoría del tiempo,Most of the time	2	47 16%	29 18%	4 31%	11 16%	**91** **17%**
	A veces,Sometimes	3	9 3%	8 5%	1 8%	5 7%	**23** **4%**
	No muy seguido,Not Very Often	4	2 1%	1 1%	0%	0%	**3** **1%**
	Not Applicable	6	2 1%	0%	0%	0%	**2** **0%**
			292	**157**	**13**	**68**	**530**
How satisfied are you with this agency's staff overall?	Very Satisfied	1	10 91%	2 67%	1 100%	2 100%	**15** **88%**
	Satisfied	2	1 9%	0%	0%	0%	**1** **6%**
	Not Satisfied	3	0%	1 33%	0%	0%	**1** **6%**
			11	**3**	**1**	**2**	**17**
If you call, how long does it usually take to get information you need over the phone?	5 min o menos,5 min or less	1	22 56%	10 62%	1 50%	3 60%	**36** **58%**

If you call, how long does it usually take to get information you need over the phone?	About 10 min,Como 10 min	2	11 28%	3 19%	1 50%	2 40%	**17** **27%**
	About 15 min	3	5 13%	0%	0%	0%	**5** **8%**
	Over 15 min	4	1 3%	3 19%	0%	0%	**4** **6%**
			39	**16**	**2**	**5**	**62**
If you call, how would you rate the usefulness of the information you receive?	Excelente,Excellent	1	75 60%	41 69%	2 33%	21 70%	**139** **63%**
	Muy buena,Very Good	2	29 23%	6 10%	2 33%	3 10%	**40** **18%**
	Buena,Good	3	16 13%	9 15%	0%	3 10%	**28** **13%**
	Fair	4	4 3%	2 3%	2 33%	2 7%	**10** **5%**
	Mala,Poor	5	1 1%	1 2%	0%	0%	**2** **1%**
	Not Applicable	6	1 1%	0%	0%	1 3%	**2** **1%**
			126	**59**	**6**	**30**	**221**
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	121 48%	62 45%	3 27%	26 41%	**212** **46%**

How much time usually passes between the time of your appointment, and the time you actually receive service?	15-30 min	2	96 38%	48 35%	3 27%	28 44%	**175** **38%**
	30-45 min	3	20 8%	16 12%	3 27%	6 10%	**45** **10%**
	45 min-1 hr,45 min-1hr	4	4 2%	6 4%	2 18%	3 5%	**15** **3%**
	Más de una hr,Over 1 hr	5	7 3%	6 4%	0%	0%	**13** **3%**
	Not Applicable	6	3 1%	1 1%	0%	0%	**4** **1%**
			251	**139**	**11**	**63**	**464**
How would you rate the convenience of the office hours here?	Excelente,Excellent	1	176 67%	91 63%	4 33%	43 66%	**314** **65%**
	Muy buena,Very Good	2	53 20%	26 18%	5 42%	11 17%	**95** **20%**
	Buena,Good	3	18 7%	22 15%	3 25%	8 12%	**51** **11%**
	Fair,Regular	4	10 4%	4 3%	0%	3 5%	**17** **4%**
	Poor	5	7 3%	1 1%	0%	0%	**8** **2%**
			264	**144**	**12**	**65**	**485**

How would you rate the convenience of the location of this agency?	Excellent	1	2 67%	0% 	0 % 	1 100%	**3** **60%**
	Very Good	2	1 33%	0% 	0 % 	0% 	**1** **20%**
	Good	3	0% 	1 100%	0 % 	0% 	**1** **20%**
			3	**1**		**1**	**5**
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	174 62%	93 61%	2 17%	40 61%	**309** **61%**
	La mayoría de tiempo,La mayoría del tiempo,Most of the time	2	67 24%	42 27%	7 58%	21 32%	**137** **27%**
	A veces,Sometimes	3	22 8%	12 8%	1 8%	4 6%	**39** **8%**
	No muy seguido,Not Very Often	4	8 3%	5 3%	0% 	0% 	**13** **3%**
	Never	5	4 1%	0% 	1 8%	0% 	**5** **1%**
	Not Applicable	6	4 1%	1 1%	1 8%	1 2%	**7** **1%**
			279	**153**	**12**	**66**	**510**
How highly would you recommend this agency to others?	Muy buena,Very highly	1	222 77%	116 75%	6 46%	51 75%	**395** **75%**
	Buena,Highly	2	53 18%	29 19%	6 46%	14 21%	**102** **19%**

	Not Highly	3	6 2%	6 4%	0%	3 4%	**15** **3%**
	Indeciso,Reluctantly	4	1 0%	4 3%	0%	0%	**5** **1%**
	Not At All	5	5 2%	0%	1 8%	0%	**6** **1%**
	Not Applicable	6	1 0%	0%	0%	0%	**1** **0%**
			288	**155**	**13**	**68**	**524**
How satisfied are you with the quality of the service you receive from this agency overall?	Muy satisfecho/a,Very Satisfied	1	238 82%	126 81%	5 38%	54 81%	**423** **81%**
	Satisfecho/a,Satisfied	2	46 16%	23 15%	8 62%	13 19%	**90** **17%**
	Not Satisfied	3	4 1%	6 4%	0%	0%	**10** **2%**
	Very Unsatisfied	4	2 1%	0%	0%	0%	**2** **0%**
			290	**155**	**13**	**67**	**525**

NOTE: An answer of dash one (-1) indicates the number of clients who completed other questions on this survey, but who skipped that particular question.

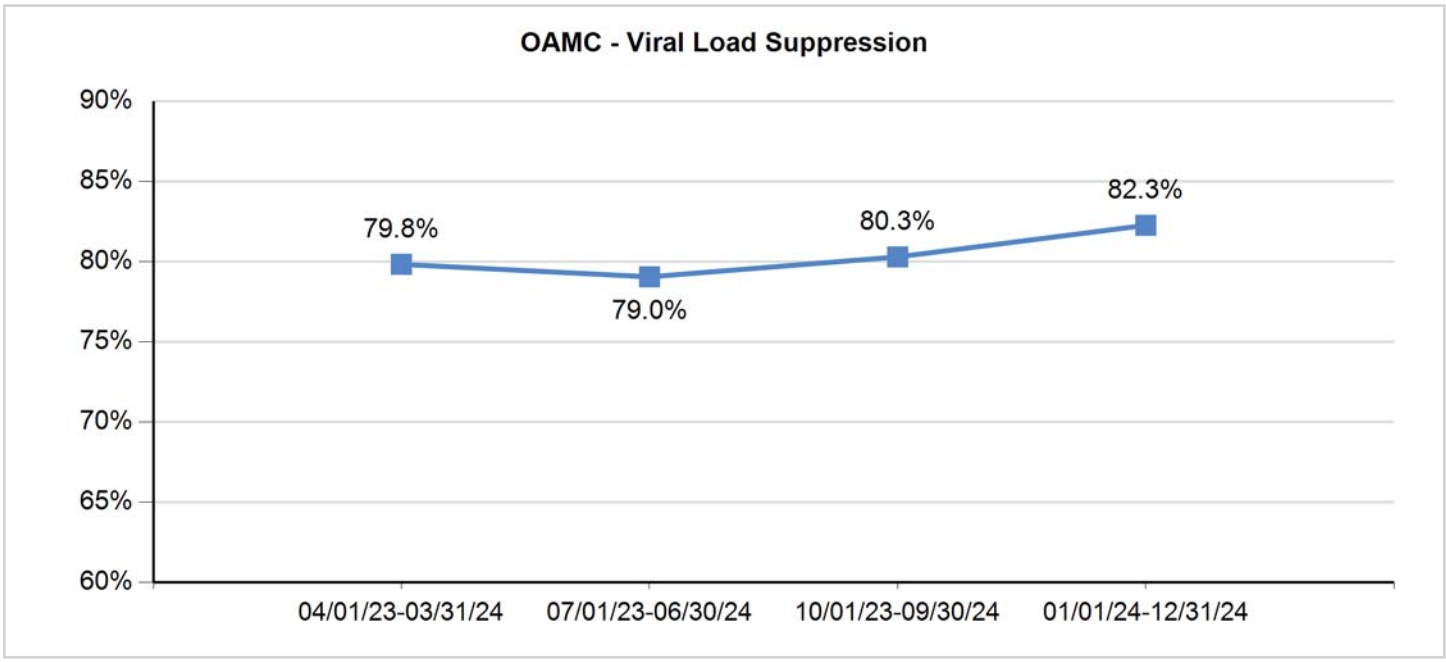
Survey ID **Survey Name**

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

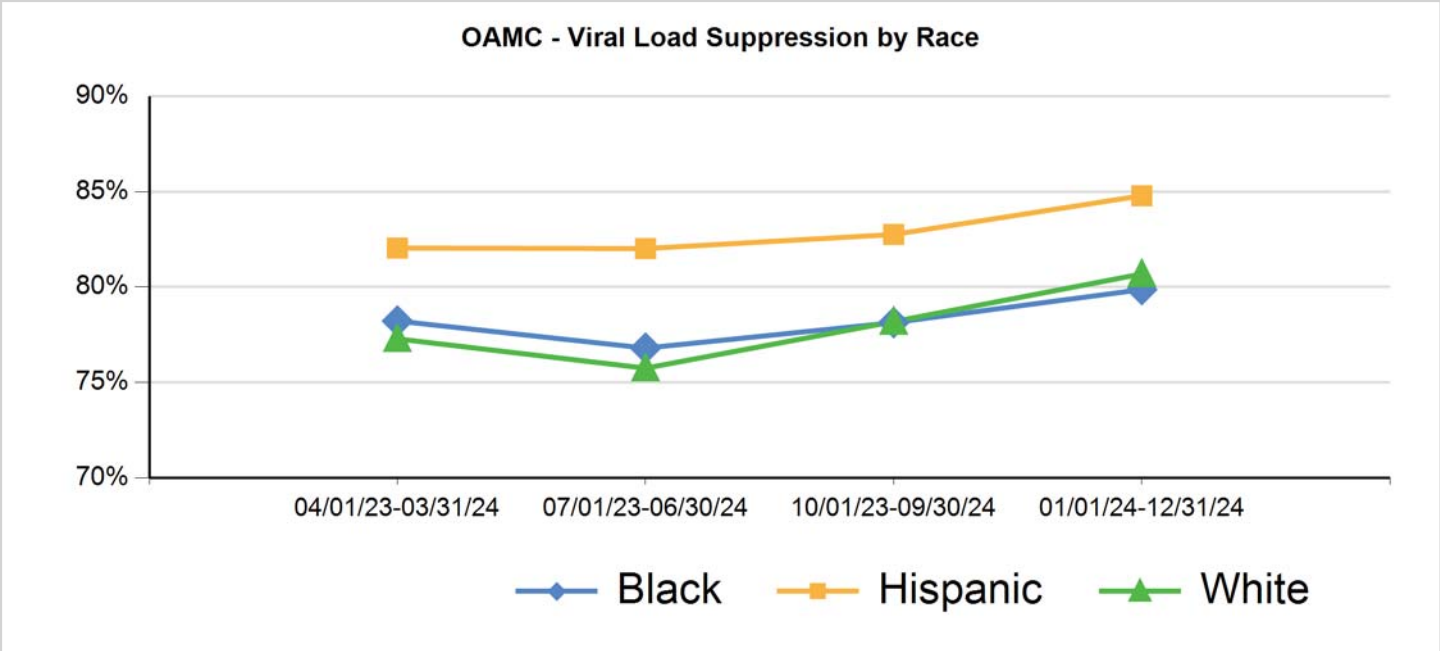
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: 1/1/2024
Agency: ALL

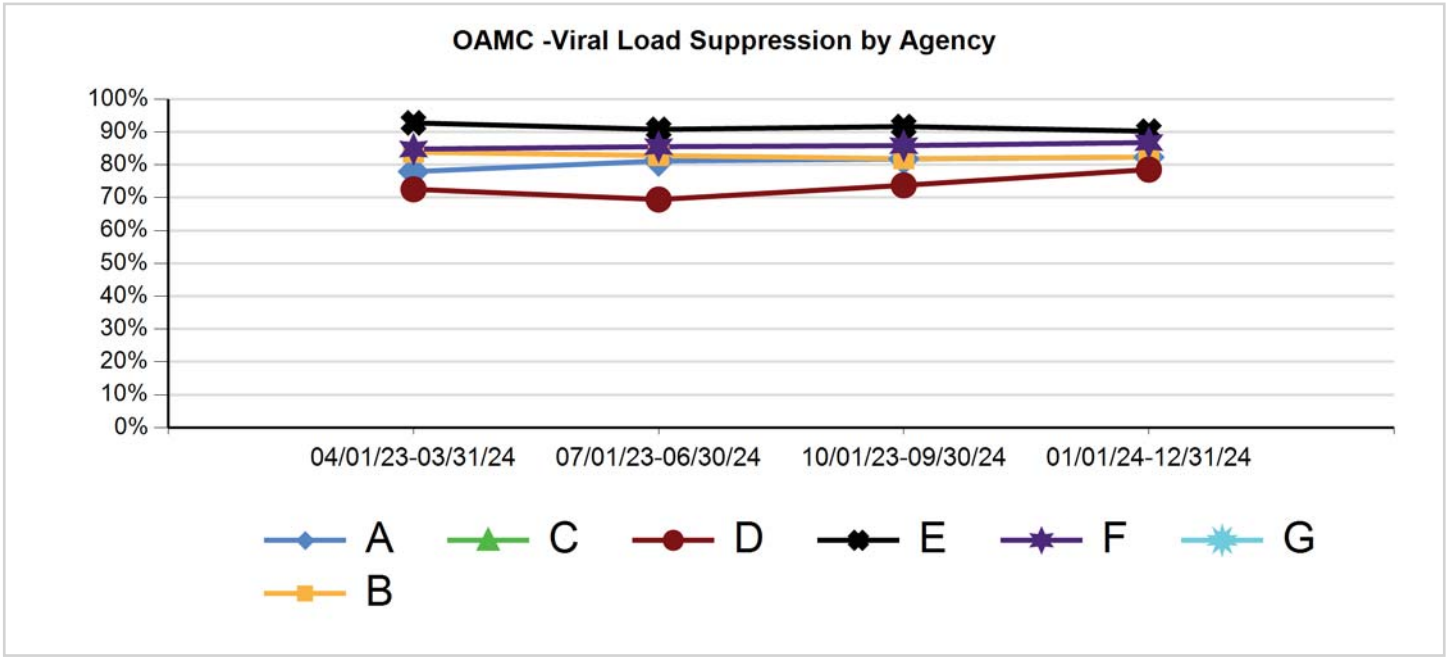
OAMC - Viral Load Suppression				
	04/01/23 - 03/31/24	07/01/23 - 06/30/24	10/01/23 - 09/30/24	01/01/24 - 12/31/24
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	5,199	5,157	5,218	5,211
Number of clients living with HIV, with at least one medical visit in the measurement year	6,513	6,524	6,499	6,335
Percentage	79.8%	79.0%	80.3%	82.3%
Change from Previous Quarter Results	-3.2%	-0.8%	1.2%	2.0%



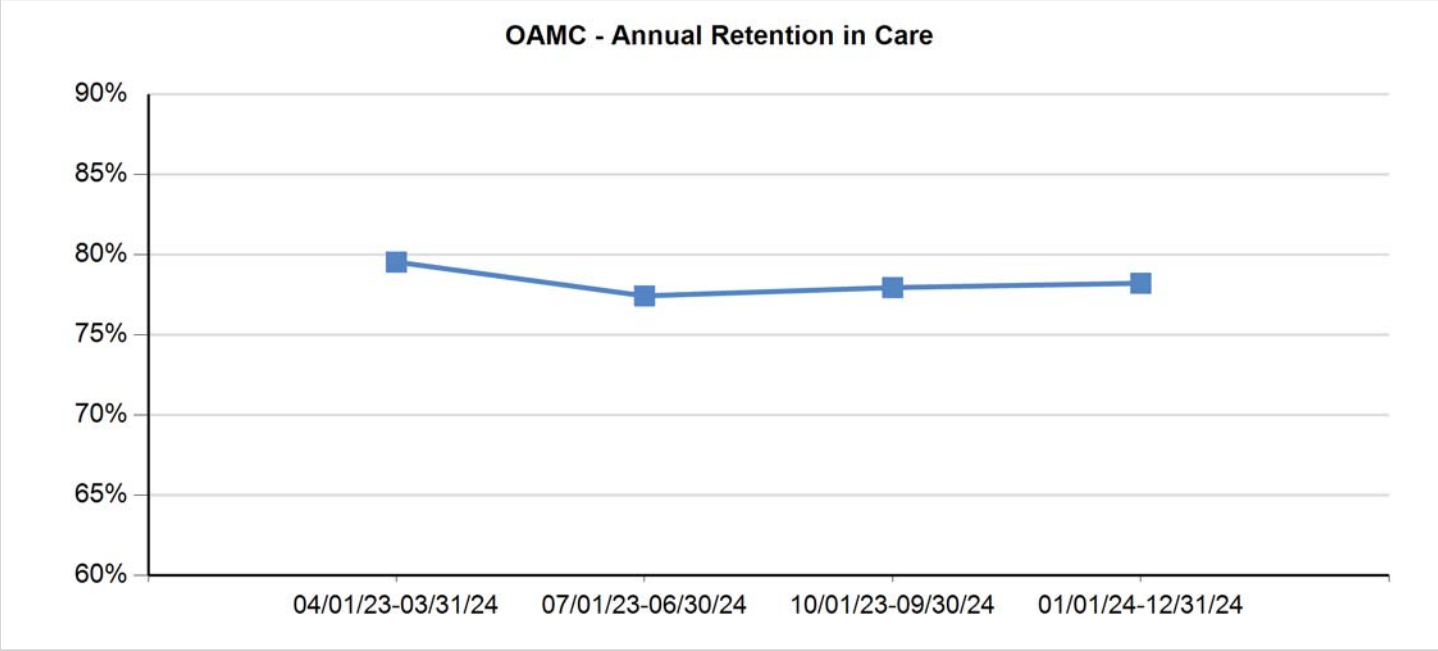
OAMC - Viral Load Suppression by Race/Ethnicity									
	07/01/23 - 06/30/24			10/01/23 - 09/30/24			01/01/24 - 12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	2,264	2,394	406	2,269	2,442	405	2,257	2,446	401
Number of clients living with HIV, with at least one medical visit in the measurement year	2,948	2,919	536	2,904	2,951	518	2,826	2,885	497
Percentage	76.8%	82.0%	75.7%	78.1%	82.8%	78.2%	79.9%	84.8%	80.7%
Change from Previous Quarter Results	-1.4%	0.0%	-1.5%	1.3%	0.7%	2.4%	1.7%	2.0%	2.5%



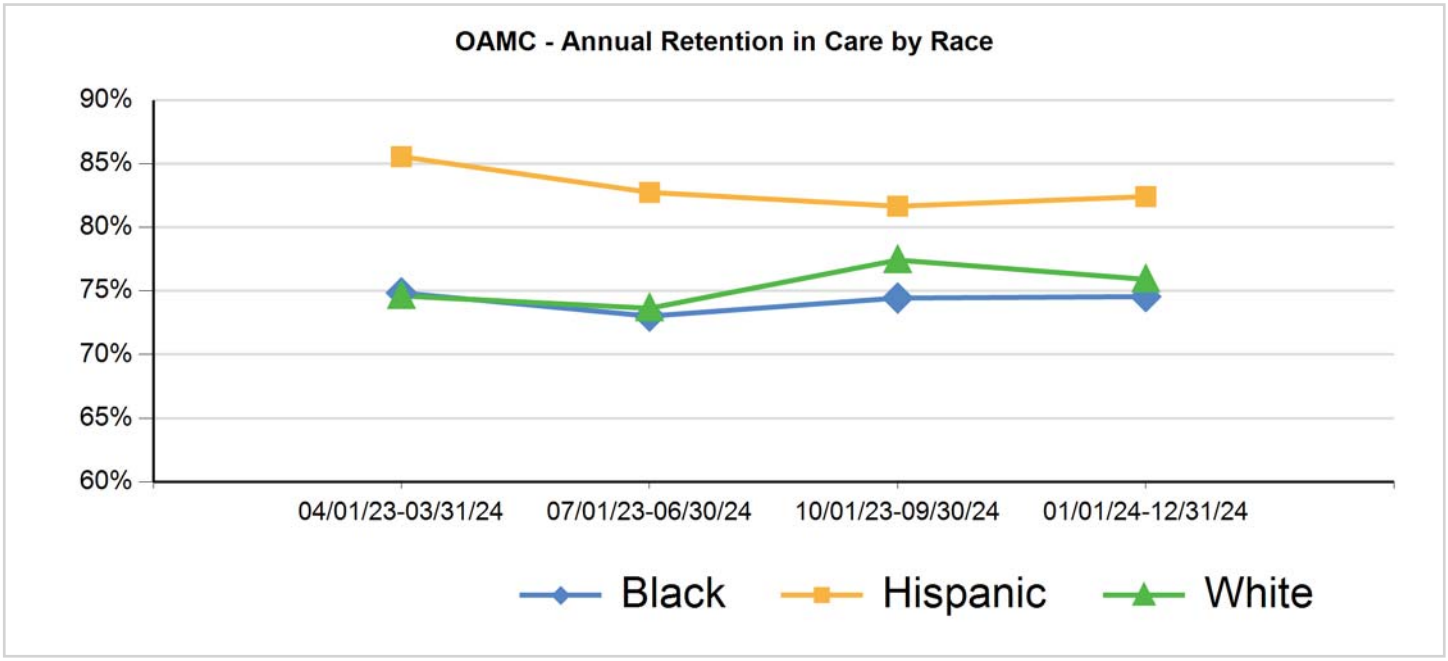
OAMC - Viral Load Suppression by Agency														
	10/01/23 - 09/30/24							01/01/24 - 12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	719	1,911	0	1,443	77	1,099	0	704	1,850	0	1,495	74	1,116	0
Number of clients living with HIV, with at least one medical visit in the measurement year	879	2,334	0	1,956	84	1,280	0	855	2,246	0	1,903	82	1,286	0
Percentage	81.8%	81.9%	NaN	73.8%	91.7%	85.9%	0.0%	82.3%	82.4%	NaN	78.6%	90.2%	86.8%	0.0%
Change from Previous Quarter Results	0.6%	-1.0%	NaN	4.3%	0.9%	0.3%	NaN	0.5%	0.5%	NaN	4.8%	-1.4%	0.9%	NaN



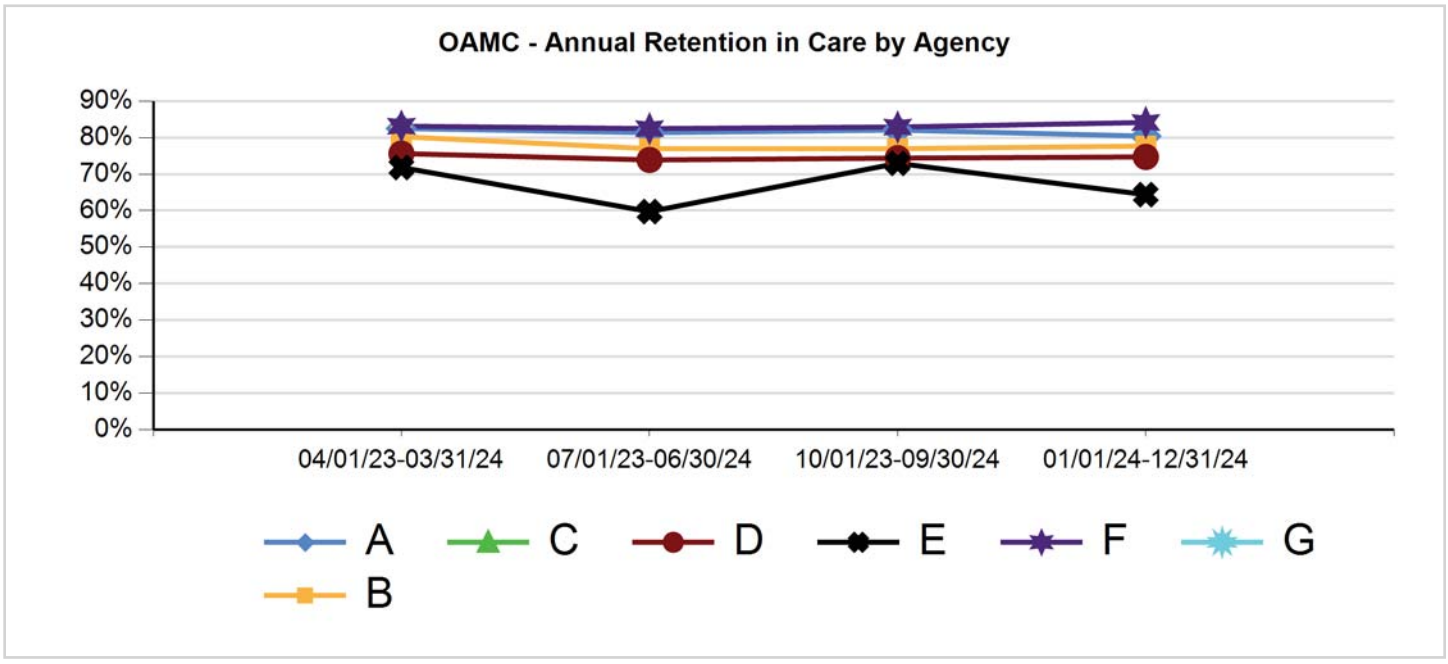
OAMC - Annual Retention in Care				
	04/01/23 - 03/31/24	07/01/23 - 06/30/24	10/01/23 - 09/30/24	01/01/24 - 12/31/24
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year.	4,725	4,643	4,678	4,594
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	5,941	5,997	6,002	5,874
Percentage	79.5%	77.4%	77.9%	78.2%
Change from Previous Quarter Results	-0.7%	-2.1%	0.5%	0.3%



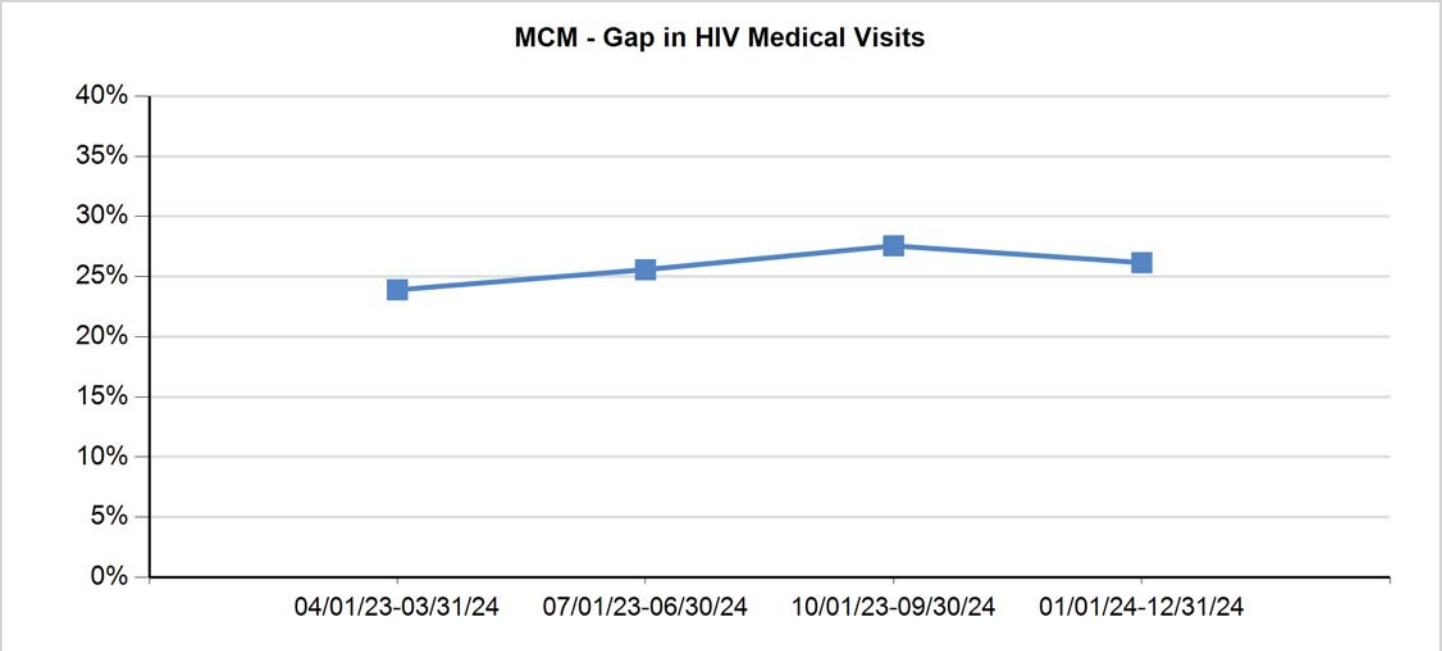
OAMC - Annual Retention in Care by Race/Ethnicity									
	07/01/23 - 06/30/24			10/01/23 - 09/30/24			01/01/24 - 12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year.	1,979	2,217	366	1,984	2,235	374	1,937	2,227	353
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	2,710	2,679	497	2,665	2,737	483	2,598	2,702	465
Percentage	73.0%	82.8%	73.6%	74.4%	81.7%	77.4%	74.6%	82.4%	75.9%
Change from Previous Quarter Results	-1.8%	-2.8%	-1.0%	1.4%	-1.1%	3.8%	0.1%	0.8%	-1.5%



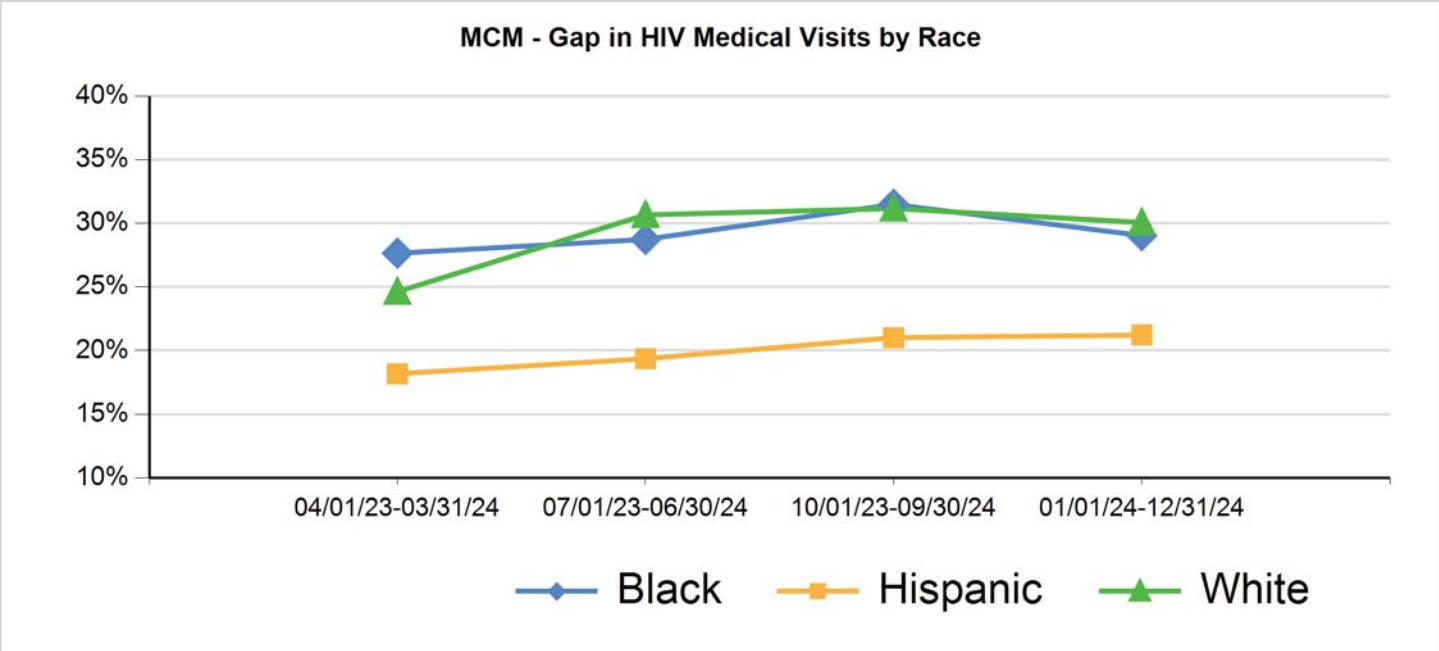
OAMC - Annual Retention in Care by Agency														
	10/01/23 - 09/30/24							01/01/24 - 12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year.	701	1,689	0	1,380	54	878	0	665	1,650	0	1,357	47	903	0
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	854	2,194	0	1,855	74	1,059	0	827	2,124	0	1,816	73	1,073	0
Percentage	82.1%	77.0%	NaN	74.4%	73.0%	82.9%	0.0%	80.4%	77.7%	NaN	74.7%	64.4%	84.2%	0.0%
Change from Previous Quarter Results	0.7%	0.0%	NaN	0.5%	13.2%	0.4%	NaN	-1.7%	0.7%	NaN	0.3%	-8.6%	1.2%	NaN



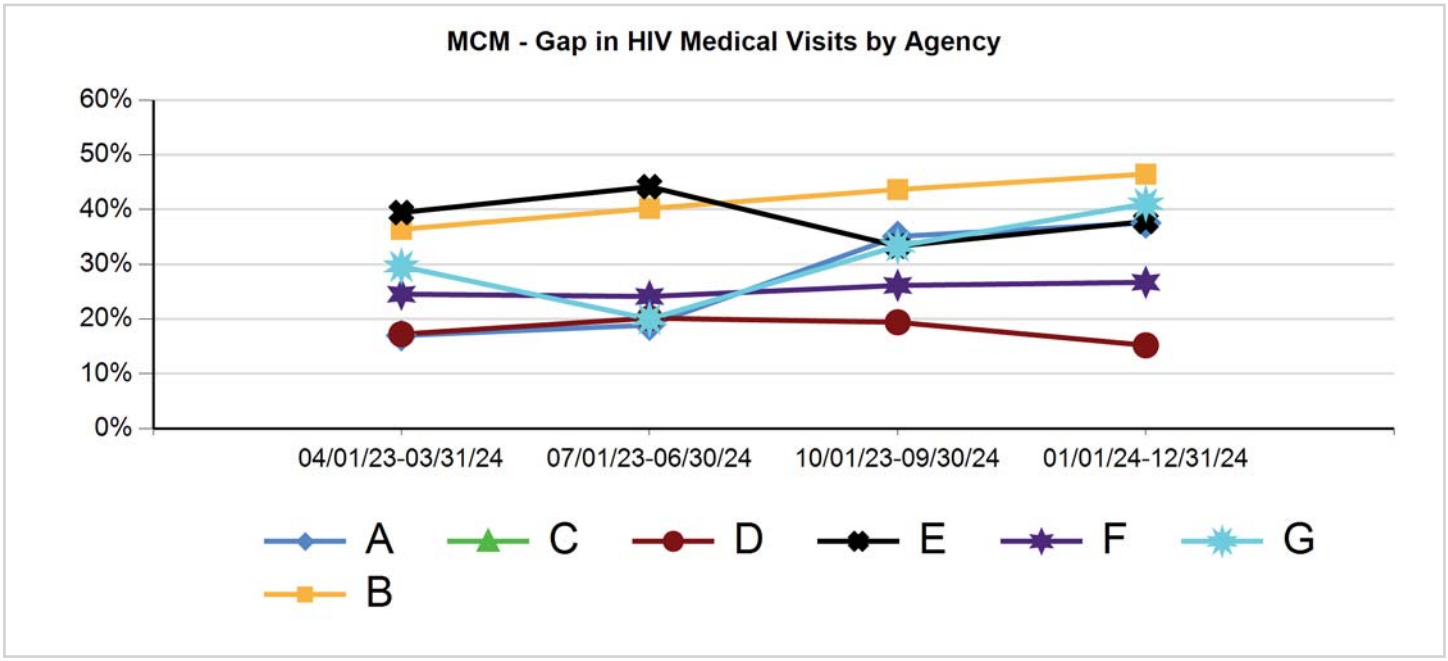
MCM - Gap in HIV Medical Visits				
	04/01/23-03/31/24	07/01/23-06/30/24	10/01/23-09/30/24	01/01/24-12/31/24
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	358	421	458	423
Number of medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	1,498	1,646	1,662	1,617
Percentage	23.9%	25.6%	27.6%	26.2%
Change from Previous Quarter Results	-0.9%	1.7%	2.0%	-1.4%



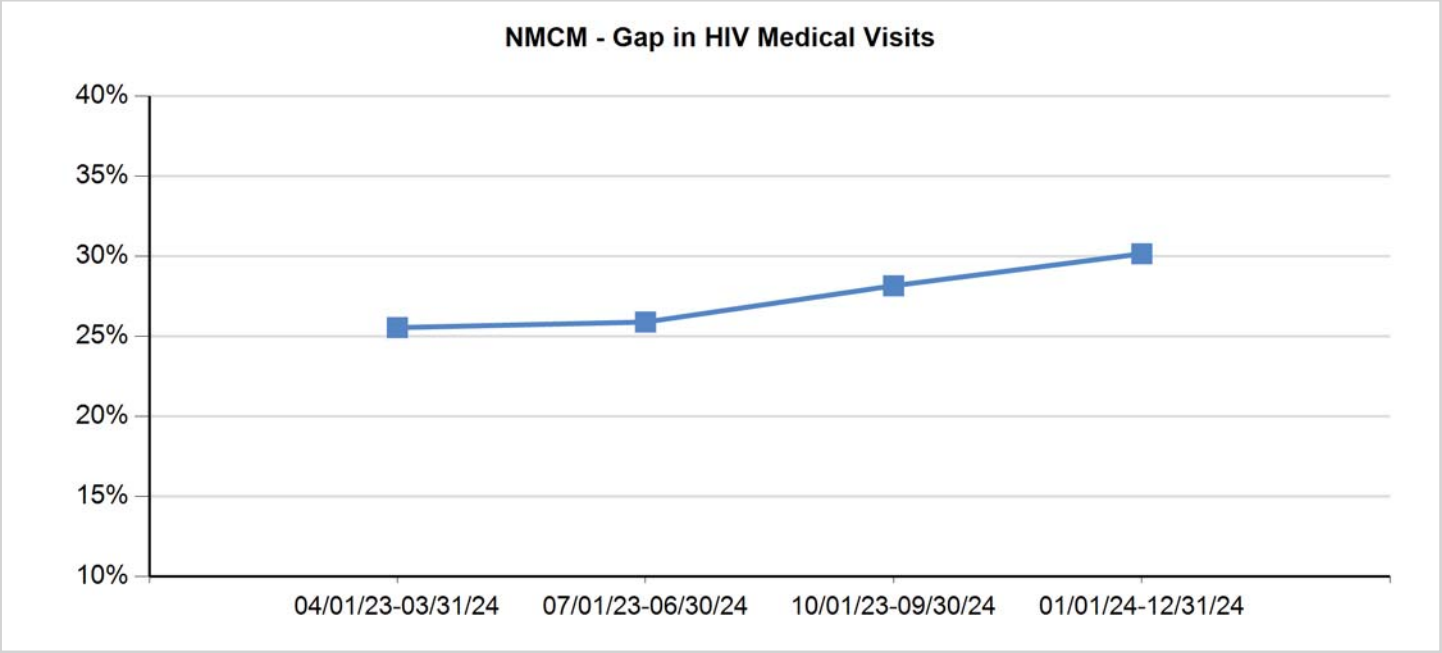
MCM - Gap in HIV Medical Visits by Race/Ethnicity									
	07/01/23-06/30/24			10/01/23-09/30/24			01/01/24-12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	240	122	46	268	132	48	239	132	46
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	835	630	150	851	628	154	823	622	153
Percentage	28.7%	19.4%	30.7%	31.5%	21.0%	31.2%	29.0%	21.2%	30.1%
Change from Previous Quarter Results	1.1%	1.2%	6.0%	2.7%	1.7%	0.5%	-2.5%	0.2%	-1.1%



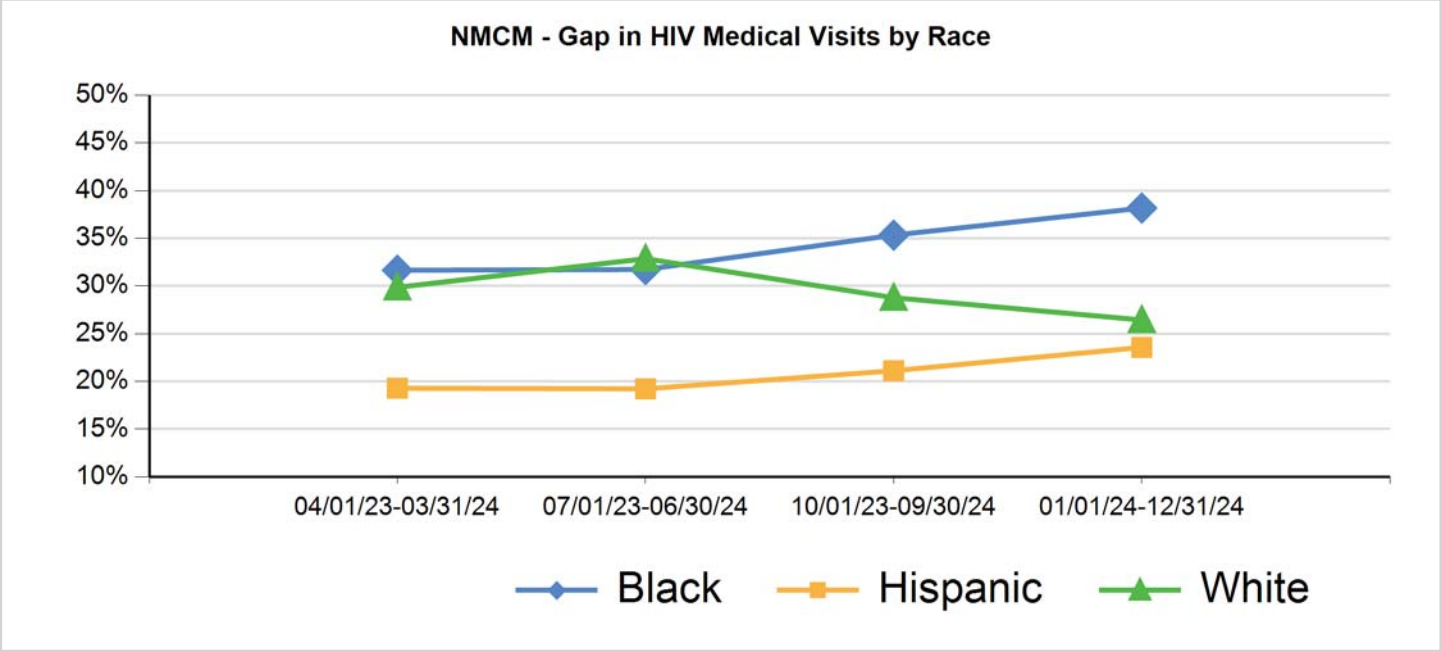
MCM - Gap in HIV Medical Visits by Agency														
	10/01/23 - 09/30/24							01/01/24 - 12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	53	159	0	162	13	68	17	59	146	0	131	14	62	23
Number of medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	151	364	0	834	39	260	51	157	314	0	861	37	232	56
Percentage	35.1%	43.7%	NaN	19.4%	33.3%	26.2%	33.3%	37.6%	46.5%	NaN	15.2%	37.8%	26.7%	41.1%
Change from Previous Quarter Results	16.2%	3.5%	NaN	-0.8%	-10.9%	2.0%	13.3%	2.5%	2.8%	NaN	-4.2%	4.5%	0.6%	7.7%



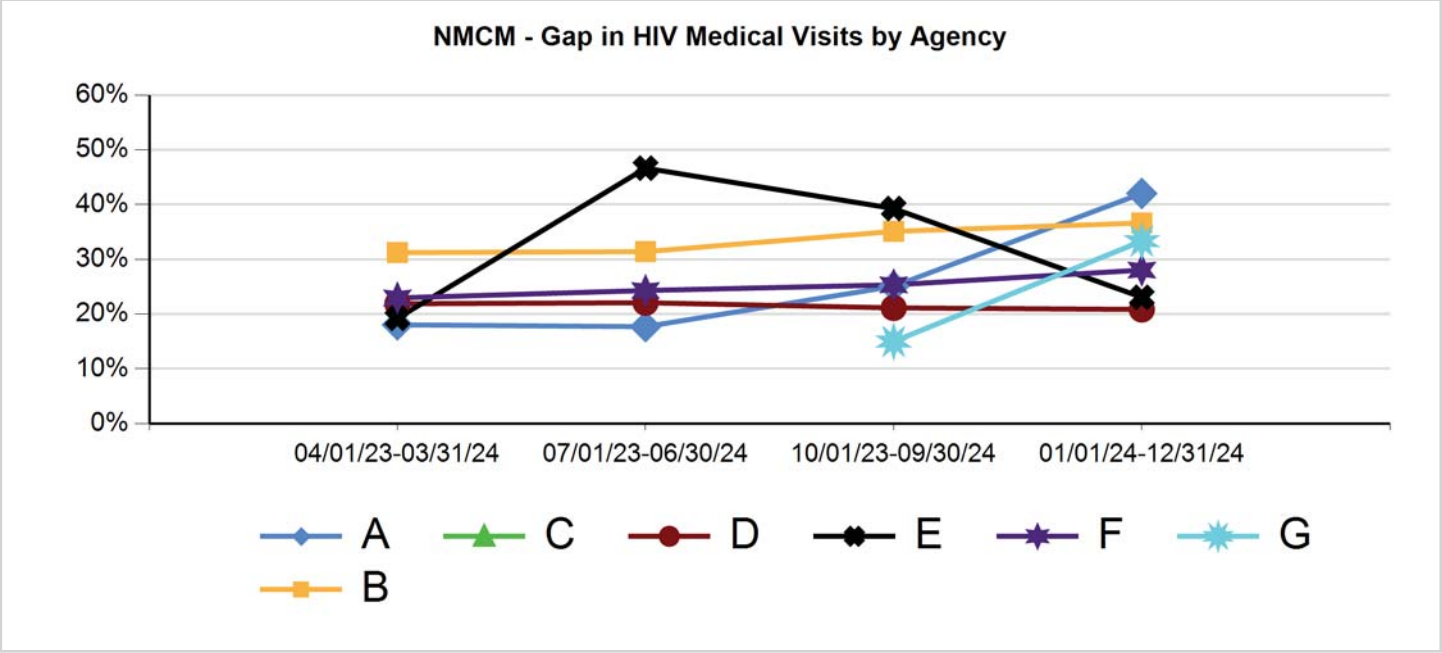
NMCM - Gap in HIV Medical Visits				
	04/01/23 - 03/31/24	07/01/23 - 06/30/24	10/01/23 - 09/30/24	01/01/24 - 12/31/24
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	903	899	991	1,020
Number of non medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	3,536	3,473	3,520	3,383
Percentage	25.5%	25.9%	28.2%	30.2%
Change from Previous Quarter Results	-1.1%	0.3%	2.3%	2.0%



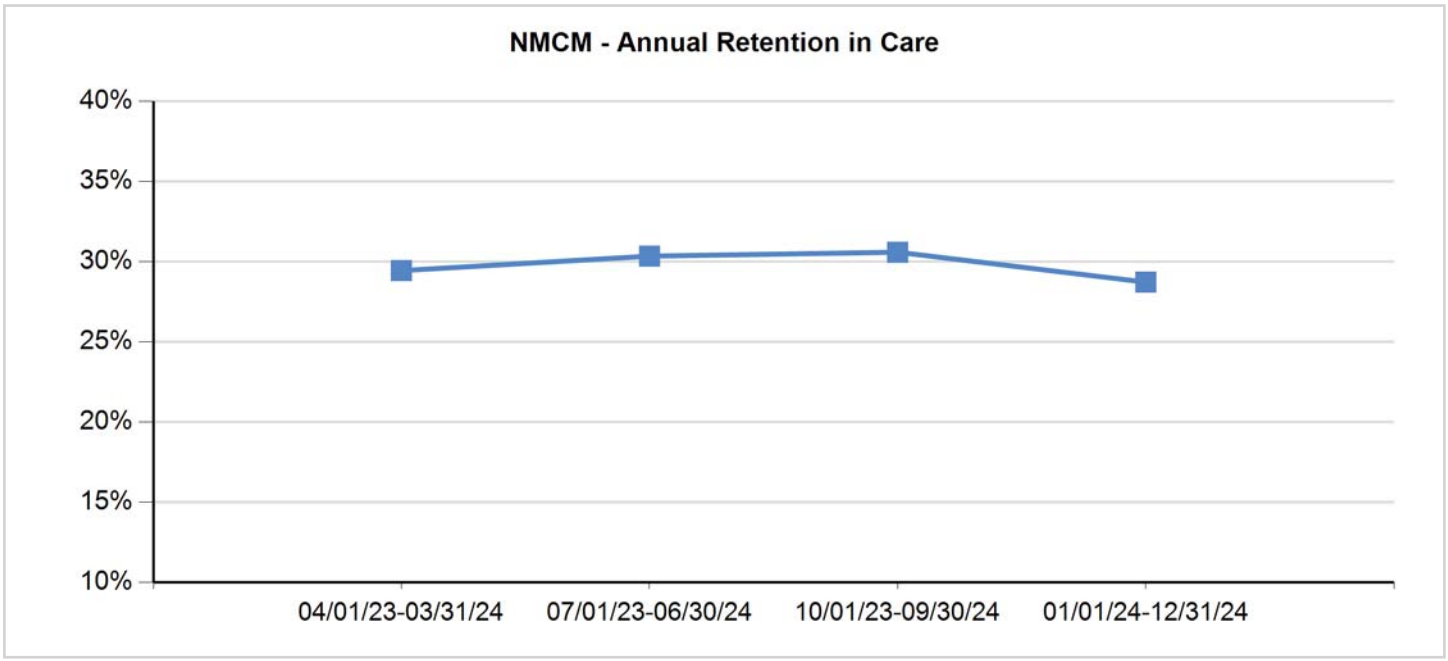
NMCM - Gap in HIV Medical Visits by Race/Ethnicity									
	07/01/23 - 06/30/24			10/01/23 - 09/30/24			01/01/24 - 12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	475	313	93	531	352	82	542	386	69
Number of non medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	1,497	1,628	283	1,503	1,667	285	1,420	1,638	261
Percentage	31.7%	19.2%	32.9%	35.3%	21.1%	28.8%	38.2%	23.6%	26.4%
Change from Previous Quarter Results	0.1%	-0.1%	3.0%	3.6%	1.9%	-4.1%	2.8%	2.4%	-2.3%



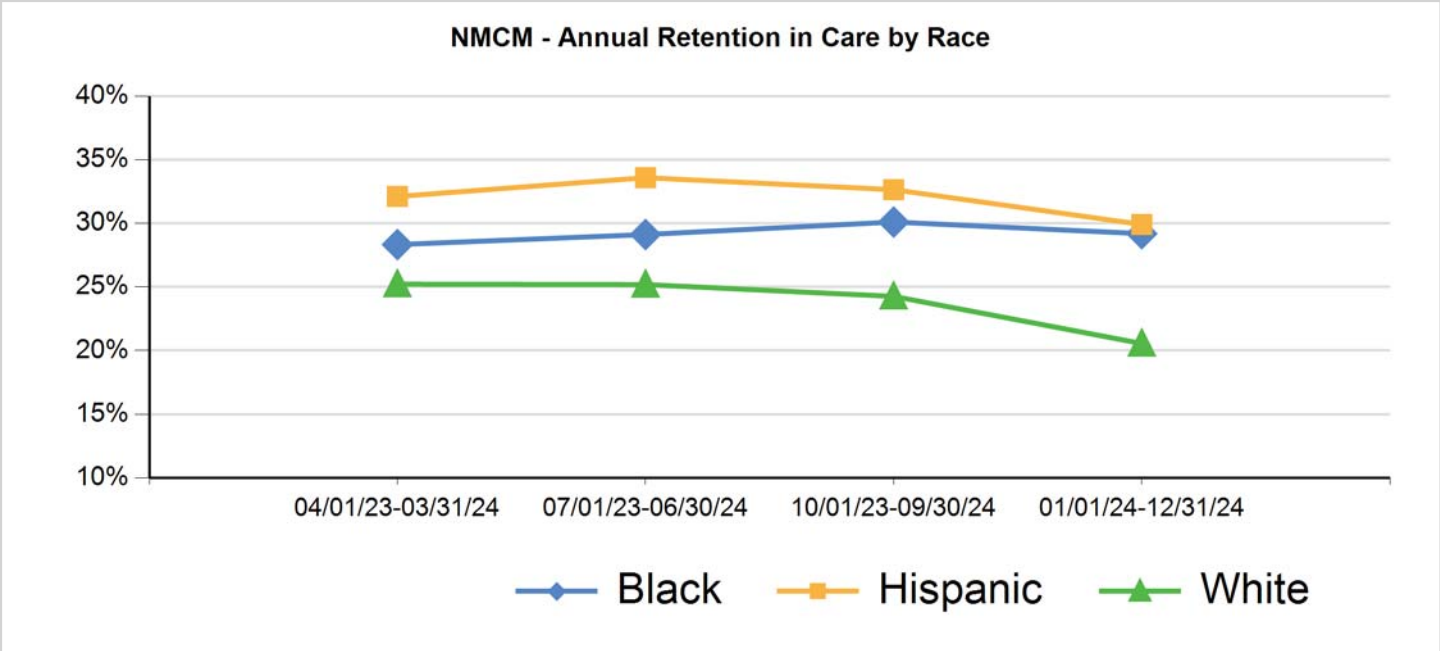
NMCM - Gap in HIV Medical Visits by Agency														
	10/01/23 - 09/30/24							01/01/24 - 12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	74	554	0	309	11	74	3	111	557	0	293	6	76	17
Number of non medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	295	1,578	0	1,462	28	292	20	264	1,520	0	1,405	26	271	51
Percentage	25.1%	35.1%	NaN	21.1%	39.3%	25.3%	15.0%	42.0%	36.6%	NaN	20.9%	23.1%	28.0%	33.3%
Change from Previous Quarter Results	7.4%	3.7%	NaN	-0.9%	-7.4%	1.0%	NaN	17.0%	1.5%	NaN	-0.3%	-16.2%	2.7%	18.3%



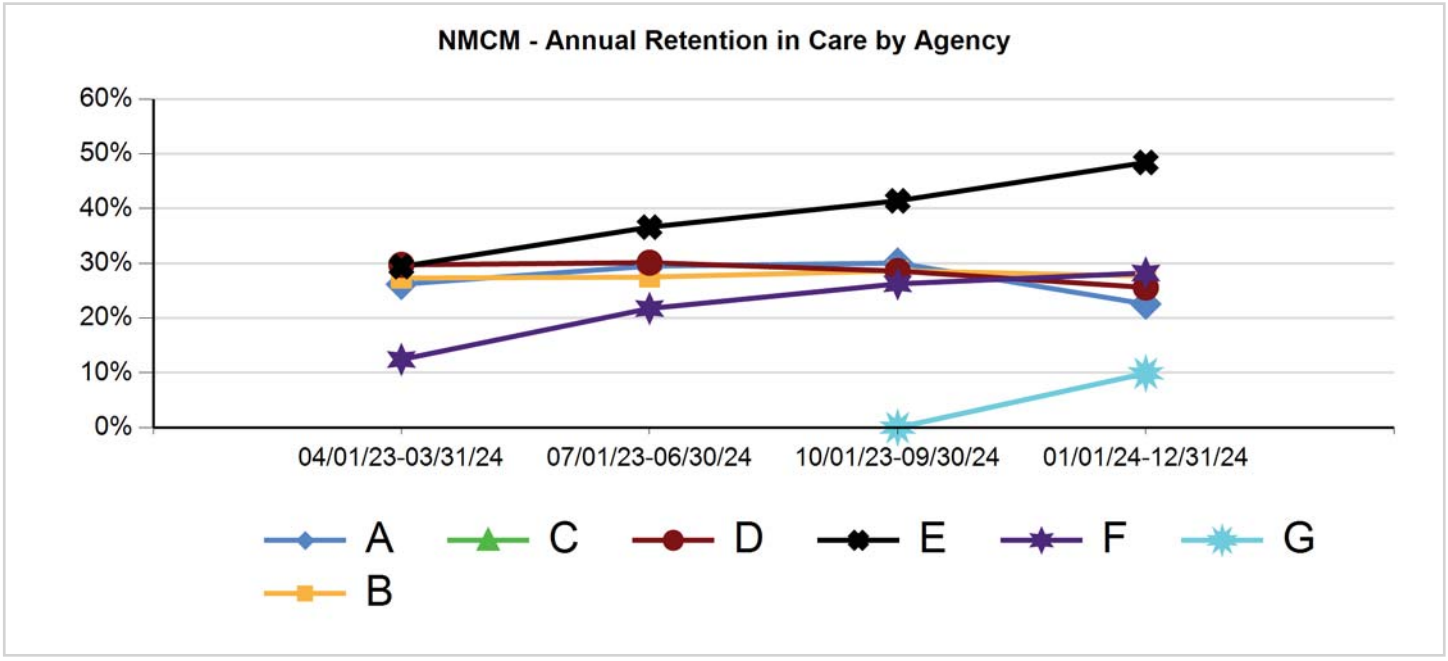
NMCM - Annual Retention in Care				
	04/01/23 - 03/31/24	07/01/23 - 06/30/24	10/01/23 - 09/30/24	01/01/24 - 12/31/24
Number of clients in the denominator who had at least two encounters at least 90 days apart within the measurement year.	2,184	2,228	2,186	2,025
Number of clients living with HIV who receive NMCM and had at least one encounter within the measurement year	7,420	7,344	7,148	7,052
Percentage	29.4%	30.3%	30.6%	28.7%
Change from Previous Quarter Results	0.3%	0.9%	0.2%	-1.9%



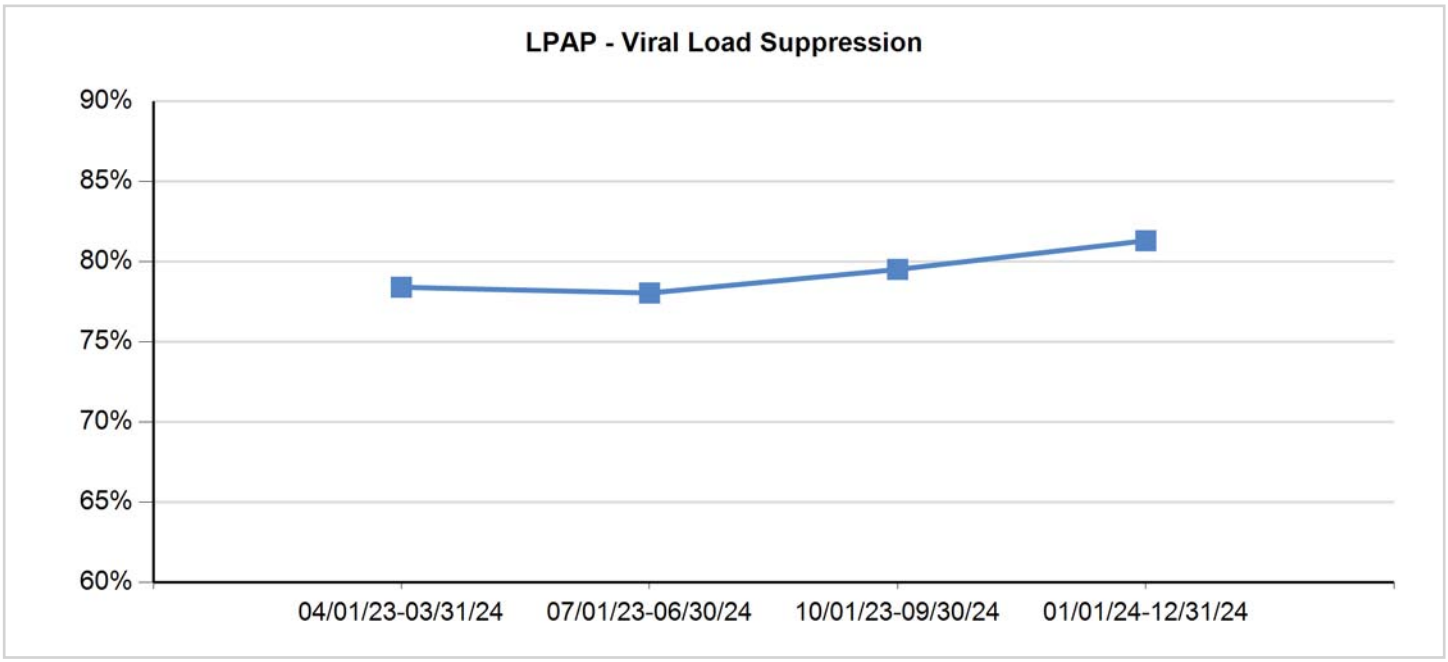
NMCM - Annual Retention in Care by Race/Ethnicity									
	07/01/23 - 06/30/24			10/01/23 - 09/30/24			01/01/24 - 12/31/24		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients in the denominator who had at least two encounters at least 90 days apart within the measurement year.	1,121	909	164	1,120	875	148	1,069	788	126
Number of clients living with HIV who receive NMCM and had at least one encounter within the measurement year	3,849	2,706	651	3,720	2,680	610	3,662	2,634	613
Percentage	29.1%	33.6%	25.2%	30.1%	32.6%	24.3%	29.2%	29.9%	20.6%
Change from Previous Quarter Results	0.8%	1.5%	0.0%	1.0%	-0.9%	-0.9%	-0.9%	-2.7%	-3.7%



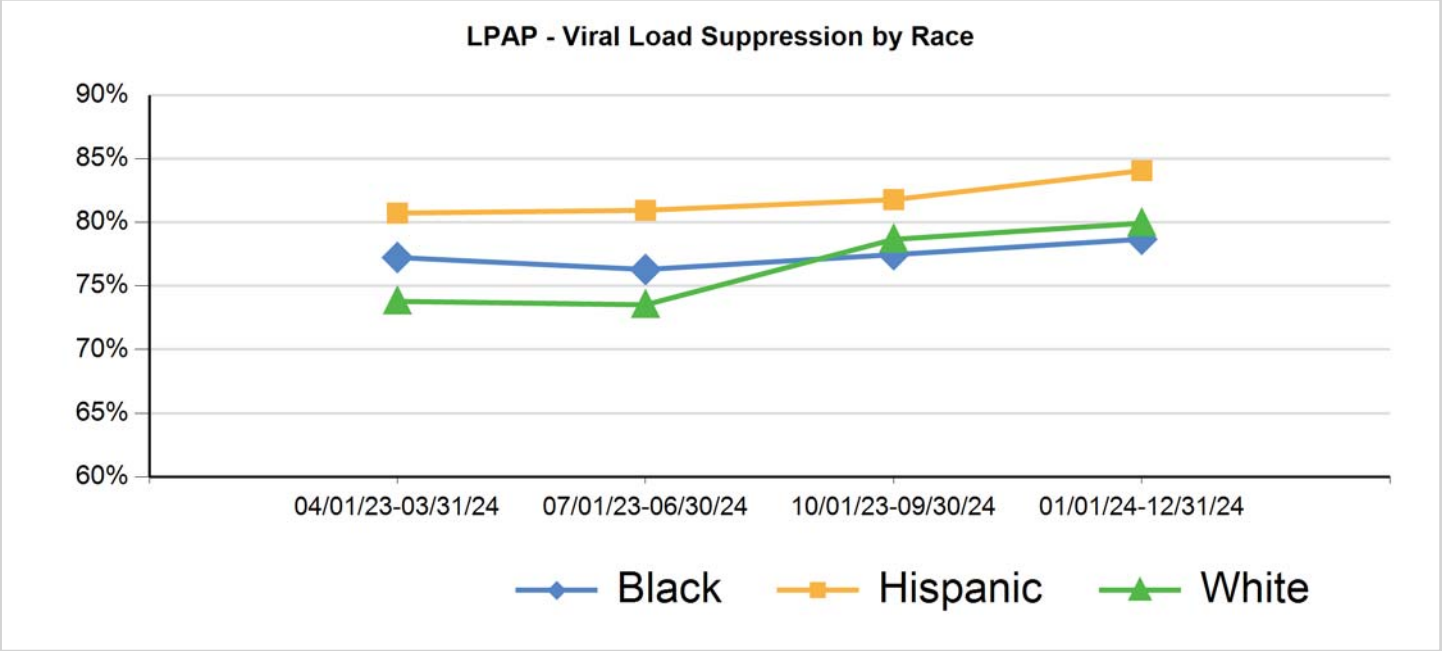
NMCM - Annual Retention in Care by Agency														
	10/01/23 - 09/30/24							01/01/24 - 12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Number of clients in the denominator who had at least two encounters at least 90 days apart within the measurement year.	116	1,042	0	793	29	125	0	86	997	0	675	31	135	12
Number of clients living with HIV who receive NMCM and had at least one encounter within the measurement year	386	3,638	0	2,772	70	476	44	381	3,601	0	2,637	64	478	121
Percentage	30.1%	28.6%	NaN	28.6%	41.4%	26.3%	0.0%	22.6%	27.7%	NaN	25.6%	48.4%	28.2%	9.9%
Change from Previous Quarter Results	0.6%	1.1%	NaN	-1.5%	4.8%	4.5%	NaN	-7.5%	-1.0%	NaN	-3.0%	7.0%	2.0%	9.9%



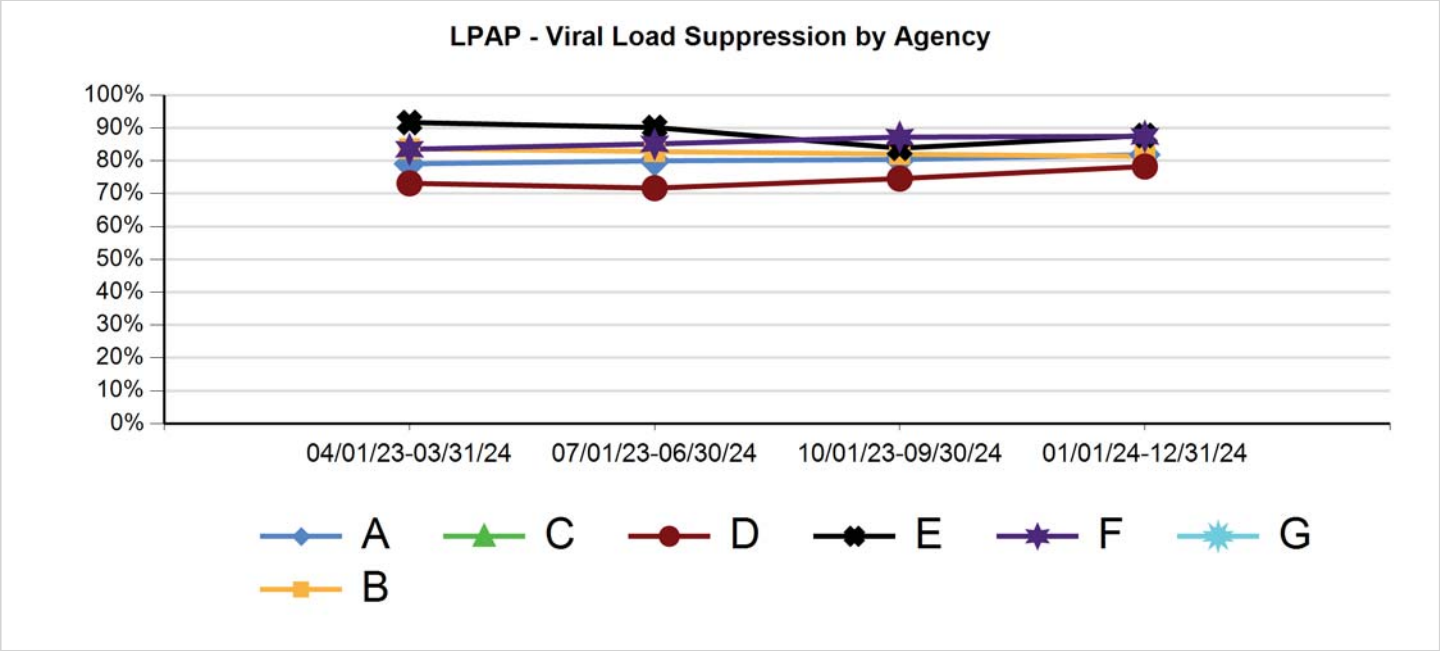
LPAP - Viral Load Suppression				
	04/01/23-03/31/24	07/01/23-06/30/24	10/01/23-09/30/24	01/01/24-12/31/24
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	3,117	3,134	3,119	3,117
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	3,976	4,016	3,923	3,834
Percentage	78.4%	78.0%	79.5%	81.3%
Change from Previous Quarter Results	-3.1%	-0.4%	1.5%	1.8%



LPAP - Viral Load Suppression by Race/Ethnicity									
	07/01/23-06/30/24			10/01/23-09/30/24			01/01/24-12/31/24		
	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	1,413	1,428	236	1,375	1,446	236	1,332	1,483	239
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	1,852	1,764	321	1,775	1,768	300	1,693	1,764	299
Percentage	76.3%	81.0%	73.5%	77.5%	81.8%	78.7%	78.7%	84.1%	79.9%
Change from Previous Quarter Results	-0.9%	0.2%	-0.3%	1.2%	0.8%	5.1%	1.2%	2.3%	1.3%



LPAP - Viral Load Suppression by Agency														
	10/01/23-09/30/24							01/01/24-12/31/24						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
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	435	717	0	1,268	52	718	0	425	725	0	1,297	50	691	0
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	541	874	0	1,700	62	823	0	519	891	0	1,657	57	790	0
Percentage	80.4%	82.0%	NaN	74.6%	83.9%	87.2%	0.0%	81.9%	81.4%	NaN	78.3%	87.7%	87.5%	0.0%
Change from Previous Quarter Results	0.4%	-0.8%	NaN	2.9%	-6.3%	2.1%	NaN	1.5%	-0.7%	NaN	3.7%	3.8%	0.2%	NaN



Harris County
Public Health
Building a Healthy Community

2025-2026

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

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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 2025-2026:

Core Services

- *Clinical Case Management*
- ***Health Insurance Premium and Cost Sharing Assistance***
- Hospice Care
- *Local AIDS Pharmaceutical Assistance Program (LPAP)*
- *Medical Case Management*
- *Medical Nutrition Therapy Supplements*
- Mental Health Services
- ***Oral Health***
- *Primary Medical Care (Ambulatory/ Outpatient Primary Care)*
- *Substance Use Outpatient Services*

Support Services

- *Emergency Financial Assistance (Other)*
- *Emergency Financial Assistance (Prescriptions)*
- Food Bank / Home Delivered Meals
- Legal Services
- Linguistic Services
- *Medical Transportation*
- Mental Health Services
- ***Non-Medical Case Management (Service Linkage)***
- *Outreach Services*
- Referral for Healthcare & Support Services
- *Vision Care*

Services are funded as follows:

Part A funded services

Combination of Parts A, B, and/or State 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.dshs.texas.gov/hivstd/contractor/casemanage	• 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	<u>Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers</u> 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 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.	• Documentation of training is maintained by the agency in the personnel file.
1.5	<u>Staff education on eligibility determination and fee schedule</u> 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	• 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 time and effort commensurate to appropriate funding source.	• 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 HIV status is revealed.	• Agency Policy and Procedure and signed and dated consent forms in client record.

3.4	<u>Up to date Release of Information</u> 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: • 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.	• Current Release of Information form with all the required elements signed by client or authorized person in client's record.

3.5	Grievance Procedure 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. • Language outlining that clients cannot be retaliated against for filing grievances.	• 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

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	Client Feedback 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 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 clients' evaluation of services is maintained. • Documentation of CAB and public meeting minutes. • 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	<u>Provision of Services Regardless of Current or Past Health Condition</u> 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	<u>Client Eligibility</u> 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	<u>Re-certification of Client Eligibility</u> 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. 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).	• 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. • 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	<u>Provision of services regardless of an individual's ability to pay for the service.</u> 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	Information on Program and Eligibility/Sliding Fee Schedule 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
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 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.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted.

4.13	Intake 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	<u>Emergency Preparedness</u> 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: ICS for Single Resources and Initial Action Incidents -IS-700.B: National Incident Management System, An Introduction -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 <u>Case Managers and Service Linkage Workers</u> 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 non-medical (SLW) Case Managers must fully participate in at least four (4) of the five (5) Case Management Supervisor/Peer-Led two -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, and external service providers. 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. • Documentation of handoff in client record.
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

2.3	<u>Case Management Brief Intervention</u> 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 Case Management Provider Turnover</u> Client must be provided notice of assigned case manager service provider's cessation of employment within 30 days 2 weeks 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	Client Eligibility 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 diagnosis (most current, American Psychiatric Association approved), especially including substance-related disorders (abuse/dependence), mood disorders (Bipolar depression), depressive disorders, anxiety disorders, and other psychotic disorders; or DSM diagnosis (most current, American Psychiatric Association approved) personality disorders. ➢ Client has a mental health condition or substance abuse pattern that interferes with their 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, their 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, past or present 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 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.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated.

2.6	<u>Service Plan</u> 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	<u>Clinical Supervision and Caseload Coverage</u> 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 minimum of 1-year work experience with PLWH, or a community health worker/patient navigator. 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 hire.	• 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.
2.0	**Timeliness of Services/Documentation**	
2.1a	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 • Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS.	• Documentation of HIV+ status, residence, identification, and income in the client record. • Documentation of "not in care" status through the CPCDMS.

2.2	Service Linkage Worker Assessment Assessment begins at intake. The service linkage worker will provide client and, if appropriate, their 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.
2.4a	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.

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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. • Process for re-engaging agency patients lost to care (no primary care visit in 6 months)	• Review of Agency's Policies and Procedures Manual indicates compliance.
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 services 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 n umber 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**	
2.1	Screening Criteria for Medical Case Management 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	• Review of agency's screening criteria for medical case management.

2.1 cont.	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 diagnosis (most current, American Psychiatric Association approved) especially including substance-related disorders (abuse/dependence), mood disorders (major depression, bipolar disorder), anxiety disorders, and other psychotic disorders; or axis II DSM diagnosis (most current, American Psychiatric Association approved) personality disorders; • Client has a mental health condition or substance abuse pattern that interferes with their 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.	• Review of agency's screening criteria for medical case management.

2.2	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, their 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 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's record on the medical case management service plan or agency's equivalent form. • Service Plan signed by the client and the case manager.
3.0	**Supervision and Caseload**	
3.1	Clinical Supervision and Caseload Coverage 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.

4.0	**Geriatric Medical Case Management**	
4.1	**Criteria for Geriatric Medical Case Management** Clients living with HIV/AIDS, ages 60 and older.	• Review of clients' records indicates compliance.
4.2	Service Provisions Oriented to Geriatric Clients • Provide support, education, and established goal-directed medical interventions to achieve optimal treatment outcomes and improve quality of life. • Conduct comprehensive assessments to determine each client's level of need for medical case management and health literacy. • Develop and implement a service plan for each client and provide an ongoing assessment of its efficacy. • Monitor the service plan to ensure its implementation. • Maintain regular contact with each client to monitor response to treatment and identify new needs. • Coordinate access to medically appropriate levels of health and support services, including facilitating and coordinating services from one service provider to another. • Coordinate and track referrals to internal and external services and programs. • Provide or refer to a licensed medical provider assessment involving ADL abilities, cognitive functioning, vision, hearing, nutrition, fall prevention, incontinence, Osteoporosis, and medication contraindications. • Provide treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, particularly in areas involving geriatric-related issues. • Provide treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, particularly in areas involving geriatric-related issues. • Provide benefits counseling by assisting clients in obtaining access to other public and private programs for which they may be eligible. • Provide advocacy on behalf of clients. • Provide emotional support on behalf of clients. • Provide liaison services with medical providers on behalf of the client.	• Review of clients' records indicates compliance. • Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated. • 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.

Emergency Financial Assistance (Prescriptions)

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.**	
1.1a	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.
1.2a	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 that are available over the counter (OTC) without a prescription, or drugs not on the approved formulary. Any EFA service greater than 30 days of medication must also have prior waiver approval from RWGA. If multiple waivers are required, they do not need to be submitted consecutively. 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 services are supervised by a paid coordinator or manager.	• 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 500% of the Federal poverty level for HIV-related medications Move above	• 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, that are available over the counter (OTC) without a prescription. 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 (in accordance with the period of their licensure) 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

Providing allowable Ryan White Program outreach and service linkage activities to PLWH who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, 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 develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care 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 (cross reference with service def to ensure this is accurate) 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. • Documentation of warm handoff in the client record.
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 m u s t include: Cusp of Falling Out of Care 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. • 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). Lost-to-Care Clients: • (HRSA) Lost to care definition. Newly Diagnosed Clients: • Applies to clients with a diagnosis within the last 12 months but have not engaged in care.	• Documentation of eligibility criteria will be maintained in client's files. • Legible signed and dated in documentation in the client record.

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	<u>Minimum Qualifications</u> Medical care for persons living with HIV shall be provided by MD, NP, DO, 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 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.	• Documentation in personnel record.

1.3	Peer Review Agency/Provider will conduct peer review for all levels of licensed /credentialed providers (i.e., MD, DO, CNS, 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 system.
1.5	Primary Care Guidelines Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (https://clinicalinfo.hiv.gov/en/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 a	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 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	• Completed assessment in client's record.

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	<u>Yearly Surveillance Monitoring and Vaccinations</u> • 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. ➢ 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 <u>https://clinicalinfo.hiv.gov/en/guidelines</u>) ➢ Annual STD testing including syphilis, gonorrhea and Chlamydia for those at risk, or more frequently as clinically indicated.	• Documentation in client's record.

1.11	Preconception Care for Women Living with HIV of Childbearing Age In accordance with the US Department of Health and Human Services recommendations (https://clinicalinfo.hiv.gov/en), 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 • 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.	• Documentation of preconception counseling and care at initial visit and annual updates in Client's record as applicable.

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 https://clinicalinfo.hiv.gov/en	• 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 (https://clinicalinfo.hiv.gov/en) 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	<u>Patient Medication Education</u> 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, DO, CNS 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 Coordinator with mental health and/or substance abuse providers for clients who have mental health and substance abuse issues.	• Review of Policies and Procedures Manual indicates compliance.

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 (by a health care provider, e.g. MA, RN, NP, PA, MD, DO, CNS, etc.). • 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 (https://www.psychiatry.org/psychiatrists/practice/professional-interests/hiv-psychiatry 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 14 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 cl inical 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, • Current medications, • Allergies and drug sensitivities, • Reason for visit (chief complaint).	• Documentation in the client record.
2.3	CD4/Viral Loads 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	Comprehensive Eye Exam 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	Lens Prescriptions 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, 2022

Population Fact Sheet | April 2024

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—nearly 567,000 people in 2022—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

74.2% ARE FROM RACIAL AND ETHNIC MINORITY GROUPS

58.6% LIVE AT OR BELOW **100%** of the **Federal Poverty Level**

89.6% ARE VIRALLY SUPPRESSED

48.2% ARE AGED 50+

HRSA Ryan White HIV/AIDS Program

Learn more about clients served by the Ryan White HIV/AIDS Program (RWHAP):

- **The majority of RWHAP clients are people with lower incomes.** Data show that 58.6 percent of clients are people living at or below 100 percent of the federal poverty level (FPL), and 86.9 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 minority groups. Data show that 44.5 percent of clients are Black/African American people and 25.3 percent of clients are Hispanic/Latino people.
- **The majority of RWHAP clients are male.** Among all clients served by RWHAP, 72.1 percent are male, 25.2 percent are female, and 2.8 percent are transgender.
- **The RWHAP client population is aging.** In 2022, people aged 50 years and older account for 48.2 percent of all RWHAP clients, which is a significant increase from 31.6 percent of RWHAP clients aged 50 years and older in 2010.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take their medication as prescribed and are virally suppressed cannot sexually transmit HIV to their partners and can live longer and healthier lives. According to 2022 data, **89.6 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
- Health education/risk reduction
- Oral health care
- Medical transportation
- Referral for health care and supportive services
- Mental health and substance use disorder services
- Emergency financial assistance

In addition, the RWHAP Part B AIDS Drug Assistance Program provides HIV-related medications and/or health care coverage assistance to nearly 290,000 clients.

* 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.

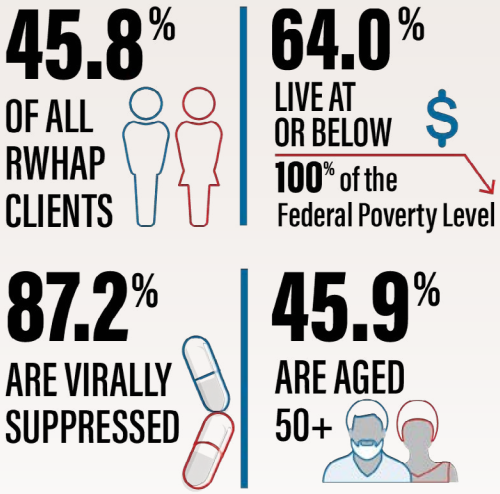
Black/African American Clients:

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.

The Impact of HIV on Black People in the United States

Published: Sep 09, 2024

Key Facts

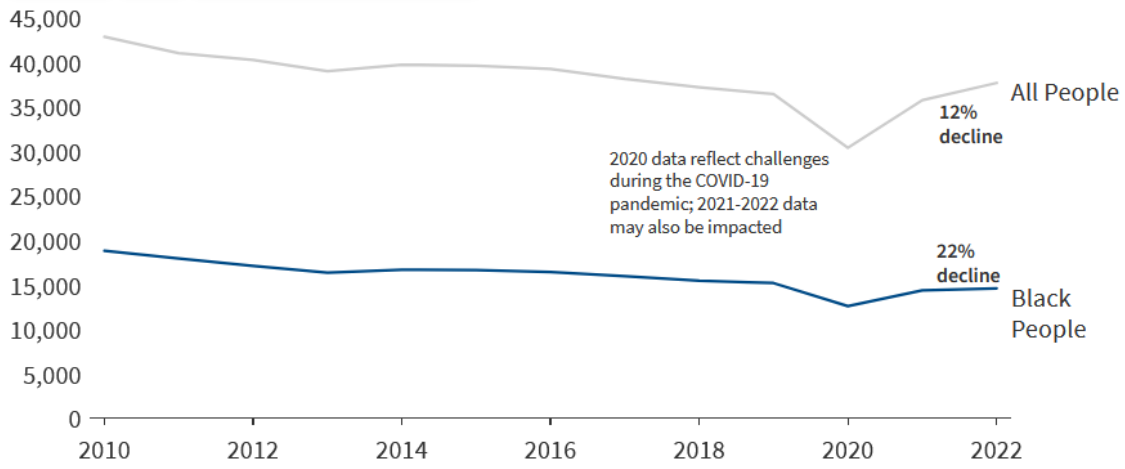
- Black people in the U.S. have been disproportionately affected by HIV since the epidemic's beginning, and that disparity has deepened over time.
- Although they represent only 12% of the U.S. population, Black people account for a much larger share of HIV diagnoses (39%), people living with HIV (40%), and deaths among people with HIV (43%) than any other racial/ethnic group in the U.S.
- Among Black Americans, Black women, youth, and gay and bisexual men have been disproportionately impacted by HIV.
- Several challenges contribute to the epidemic among Black people, including experiences with stigma and discrimination, higher rates of poverty, lack of access to health care, higher rates of some sexually transmitted infections, and lower awareness of HIV status..
- Recent data indicate some encouraging trends, including declining new HIV diagnoses among Black people overall, especially among women, and a leveling off of new diagnoses among Black gay and bisexual men (see Figure 1). However, given the epidemic's continued and disproportionate impact on Black people, continued focus on this population is key to addressing HIV in the United States.

Figure 1

HIV Diagnoses in the United States, Overall and Among Black People

Click on the buttons below to see data by different views.

Overall | Sex | Transmission Categories



Note: Percent change in HIV diagnoses is based on the 2010 and 2022 data points. HIV diagnosis data in 2020 reflects the COVID-19 pandemic, which impacted testing behaviors, surveillance, and care-related services and should be interpreted with caution. 2021-2022 data may also be impacted.

Source: CDC. Atlas Plus. • Get the data • Download PNG

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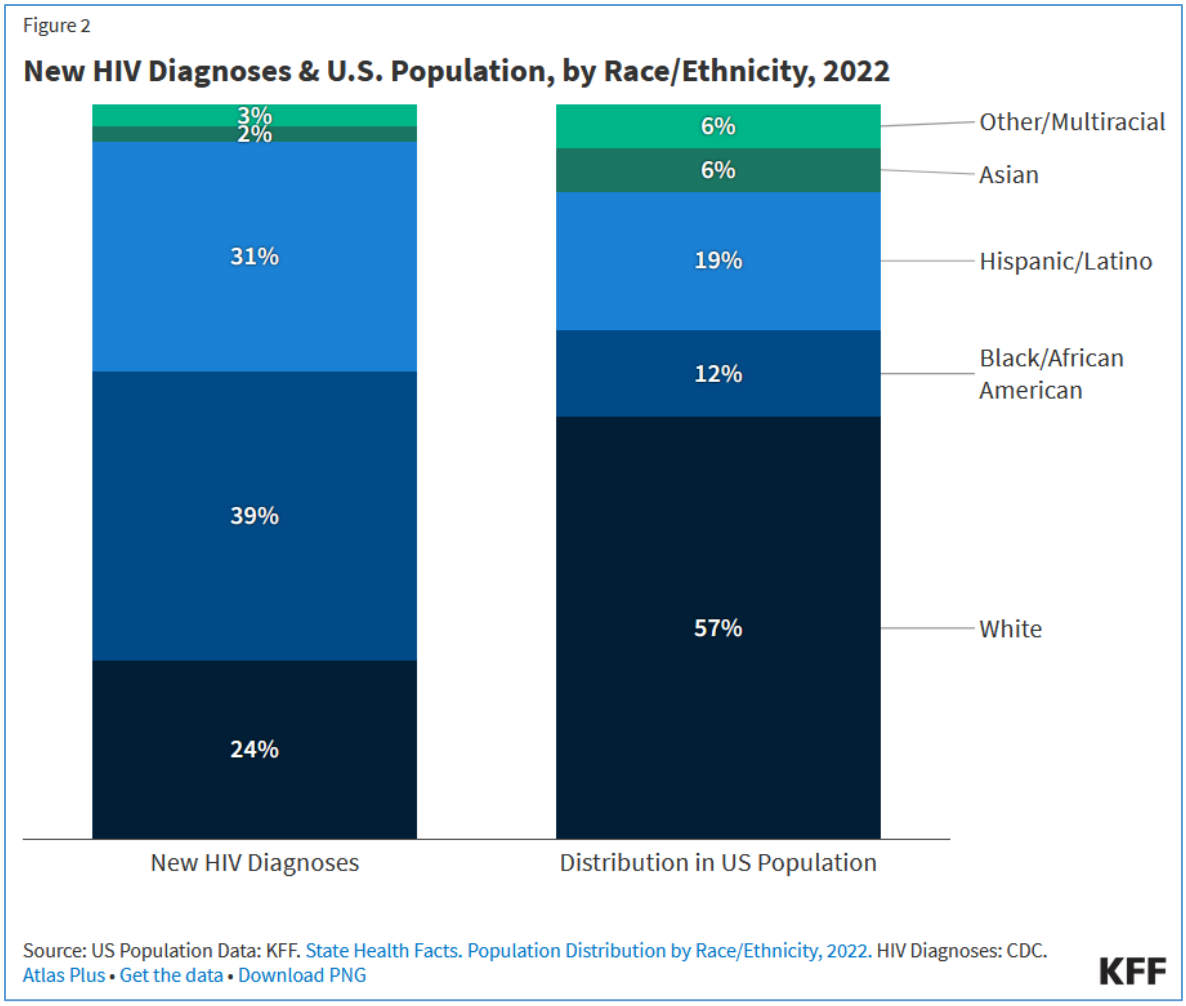
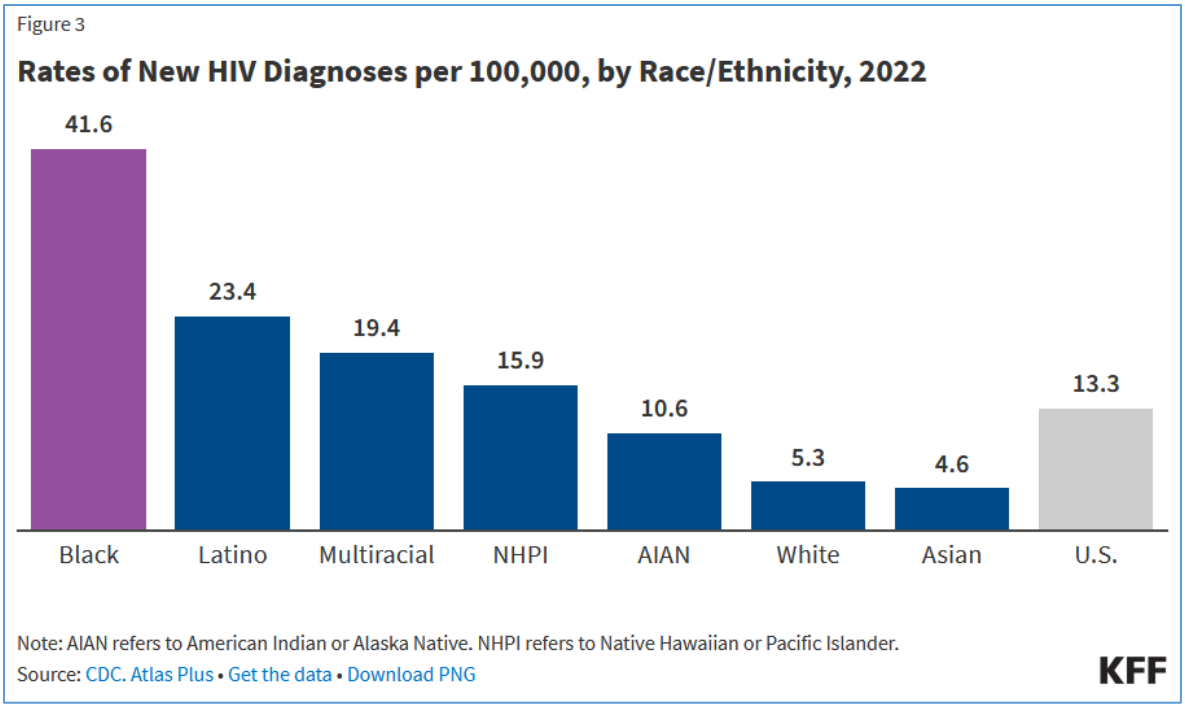
Overview

- Today, there are more than 1.2 million people living with HIV in the U.S., 40% of whom (489,200) are Black.
- The latest data indicate declines in both the number and rate of annual new diagnoses among Black people in recent years, including among both men and women (see Figure 1). However disparities persist in HIV prevention, treatment, and outcomes.
- Although Black people represent only 12% of the U.S. population, they accounted for 39% of new HIV diagnoses in 2022 (see Figure 2). Bureaucratic



- The rate of new HIV diagnoses per 100,000 among Black adults/adolescents (41.6) was about 8 times that of White people (5.3) and twice that of Latinos (23.4) in 2022 (see Figure 3). The rate for Black men (66.3) was the highest of any race/ethnicity and gender, followed by Latino men (40.8), the second highest group. Black women (19.2) had the highest rate among women.



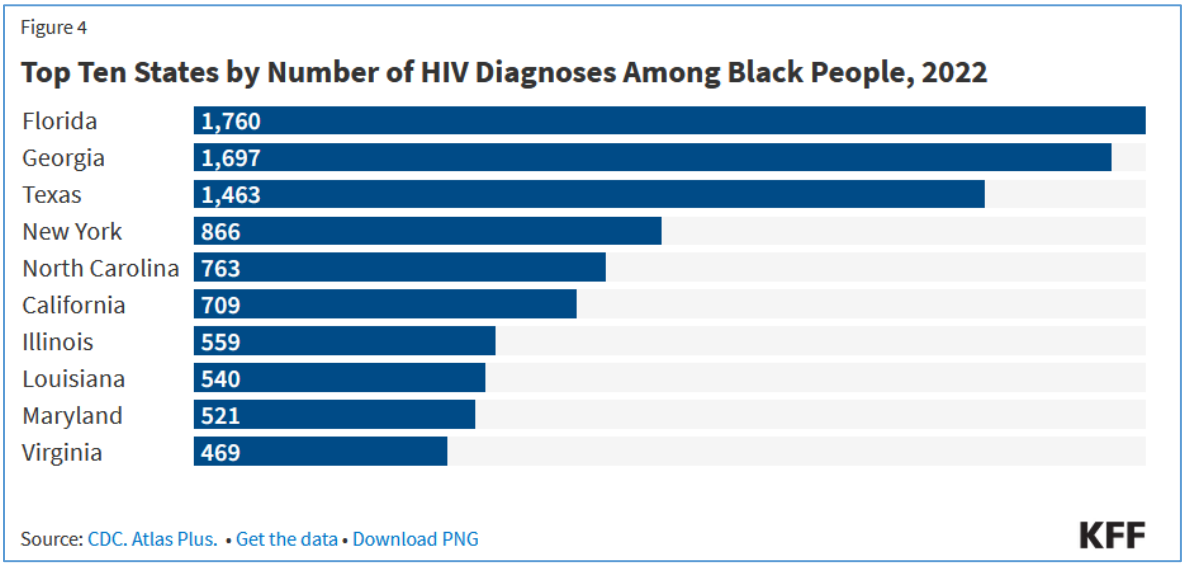
- Black people accounted for more than 4 in 10 (43%) deaths among people with an HIV diagnosis (deaths may be due to any cause) in 2022. The number of deaths among Black individuals with an HIV diagnosis decreased 13% between 2010 and 2018 but then increased more recently, by 15% between 2018 and 2022.
- HIV death rates (deaths for which HIV was indicated as the leading cause of death) are highest among Black people compared to people of other race/ethnicities. In 2022, Black people had the highest age-adjusted HIV death rate per 100,000 – 5.9, compared to 0.6 per 100,000 White persons.
- In addition, in 2021 HIV was the 8th leading cause of death for Black men and for Black women ages 25-34.

Transmission

- Transmission patterns vary by race/ethnicity. While male-to-male sexual contact accounts for the largest share of HIV cases among both Black and White people, proportionately, fewer Black people contract HIV this way. Heterosexual sex accounts for a greater proportion of HIV cases among Black people than White people.
- Among Black people, 63% of HIV diagnoses in 2022 were attributable to male-to-male sexual contact and 32% were attributable to heterosexual sex; among White people, 70% of new HIV diagnoses in 2022 were attributable to male-to-male sexual contact and 16% were attributable to heterosexual sex. The remainder of HIV diagnoses in each group were attributable to other causes, including injection drug use.
- Most HIV positive Black women acquired HIV through heterosexual transmission and a smaller share of HIV infections are attributable to injection drug use among Black women compared to White women (15% v 32%).

Geography

- Although HIV diagnoses among Black people have been reported throughout the country, the impact of the epidemic is not uniformly distributed.
- Regionally, the South accounts for both the majority of Black people newly diagnosed with HIV (52% in 2022) and the majority living with HIV at the end of 2022 (46%).
- HIV diagnoses among Black people are concentrated in a handful of states. The top 10 states, 7 of which are in the South, account for 64% of all HIV diagnoses among Black people (see Figure 4).



Women

- Black women account for the largest share of new HIV diagnoses among women (3,523 or 50% in 2022) as well as the largest share of all women living with HIV. The rate of new diagnoses among Black women (19.2) is 10 times the rate among White women (1.9) and 3 times the rate among Latinas (5.5).
- Although new HIV diagnoses continue to occur disproportionately among Black women, data show a 39% decrease in new diagnoses for Black women between 2010 and 2022. More recently though, from 2018 to 2022, new HIV diagnoses among Black women were essentially flat, decreasing by just 1%.
- In 2022, Black women represented about one quarter (24%) of new HIV diagnoses among all Black people – a higher share than Latinas and White women (who represented 12% and 18% of new diagnoses among their respective racial/ethnic groups).

Young People

- In 2022, half (50%) of HIV diagnoses among all young people ages 13-24 were among Black people.
- More than half (53%) of gay and bisexual teens and young adults with HIV were Black in 2022.
- In 2023, 10% of Black high school students report having ever been tested for HIV compared to 5% of White students but that share is down from 20% of Black students in 2013.

Gay and Bisexual Men

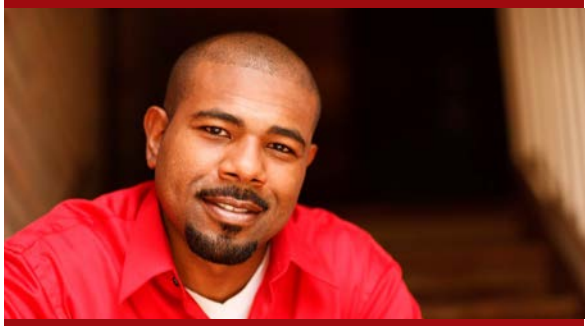
- Black gay and bisexual men accounted for almost half (49%) of Black people living with HIV and 30% of gay and bisexual men living with HIV.
- Among Black people, male-to-male sexual contact accounted for more than half (63%) of HIV diagnoses in 2022 and a majority (82%) of diagnoses among Black men.
- Young Black gay and bisexual men are particularly affected. Black gay and bisexual men are younger than their White counterparts, with those ages 13-24 accounting for 32% of new HIV diagnoses among Black gay and bisexual men in 2022, compared to 12% among White gay and bisexual men.

HIV Testing and Access to Prevention & Care

- In 2022, over half (57%) of Black adults reported ever having been tested for HIV, a greater share than among Latino or White adults (44% and 32%, respectively).
- One-in-five (20%) Black people with HIV tested positive late in their illness – that is, were diagnosed with AIDS at the time of testing positive for HIV; similar to the share among White (21%) and Latino (21%) people.
- Looking across the care continuum, Black people face disparities related to linkage to care and viral suppression. At the end of 2022, 88% of Black people with HIV were diagnosed, 64% were linked to care, and 53% were virally suppressed. In comparison, 89% of White people with HIV were diagnosed, 70% were linked to care, and 63% were virally suppressed.

Hispanic/Latino Clients:

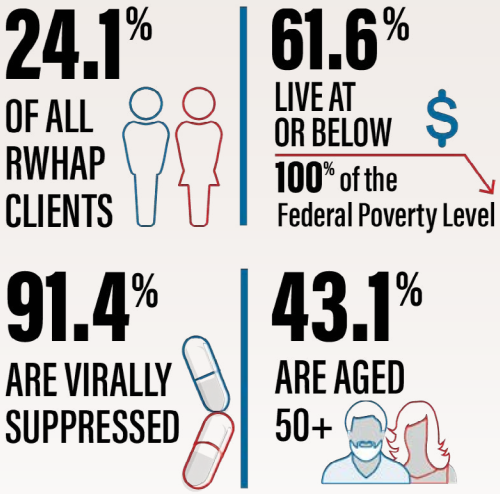
HRSA's Ryan White HIV/AIDS Program, 2021



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: 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.

The Impact of HIV on Hispanic/Latino People in the United States

Published: Oct 15, 2024

Key Facts

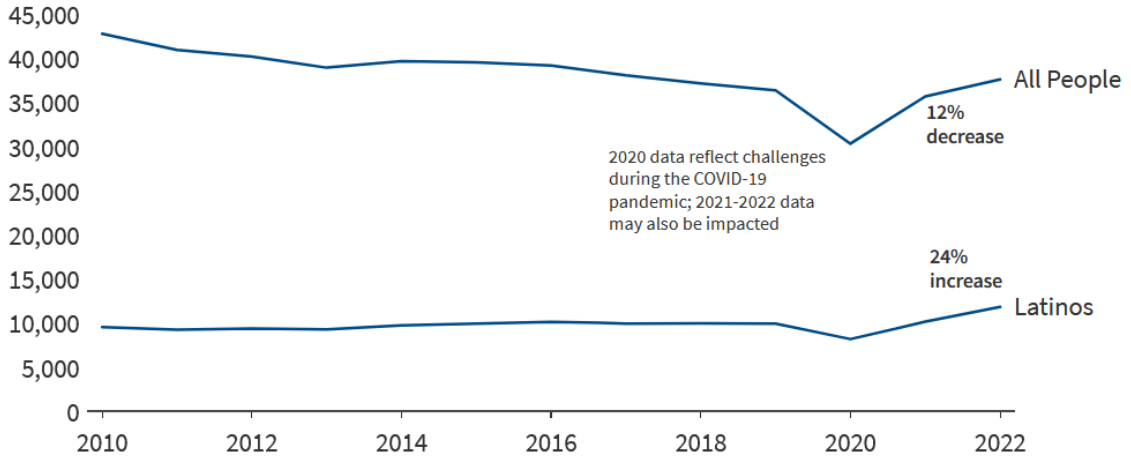
- Hispanic/Latino people have been disproportionately affected by HIV/AIDS since the epidemic's beginning, and that disparity has deepened over time.
- Between 2010-2022, while HIV diagnoses decreased by 12% overall, Hispanic/Latino people saw a 24% increase.
- Although they represent only 19% of the U.S. population, Hispanic/Latino people account for a larger share of HIV diagnoses (31%) and people estimated to be living with HIV (26%) compared to their population size.[1]
- Among Hispanic/Latino people, youth and gay and bisexual men have been disproportionately impacted by HIV.
- Several challenges contribute to the epidemic among Hispanic/Latino people, including poverty, limited access to health care and insurance, lower awareness of HIV status, stigma, and language or cultural barriers in health care settings.
- Recent data indicates mixed trends, including increasing new HIV diagnoses among Hispanic/Latino people overall, especially among men, but a leveling off among women (see Figure 1), largely related to transmission patterns: HIV diagnoses attributed to male-to-male sexual contact increased but those attributed to heterosexual sex and injection drug use decreased.
- As the largest and one of the fastest growing ethnic minority groups in the U.S., and one of the only groups to see an increase in HIV diagnoses in recent years, addressing HIV in the Hispanic/Latino community takes on increased importance in efforts to address the epidemic across the country.

Figure 1

HIV Diagnoses in the United States, 2010-2022: Hispanic/Latino People Saw a 24% Increase in Diagnoses Compared to the 12% Decrease Seen Overall

Click on the buttons below to see data by different views.

Overall | Sex | Transmission Categories



Note: Percent change in HIV diagnoses is based on the 2010 and 2022 data points. HIV diagnosis data in 2020 reflects the COVID-19 pandemic, which impacted testing behaviors, surveillance, and care-related services and should be interpreted with caution. 2021-2022 data may also be impacted.

Source: CDC. Atlas Plus. • Get the data • Download PNG

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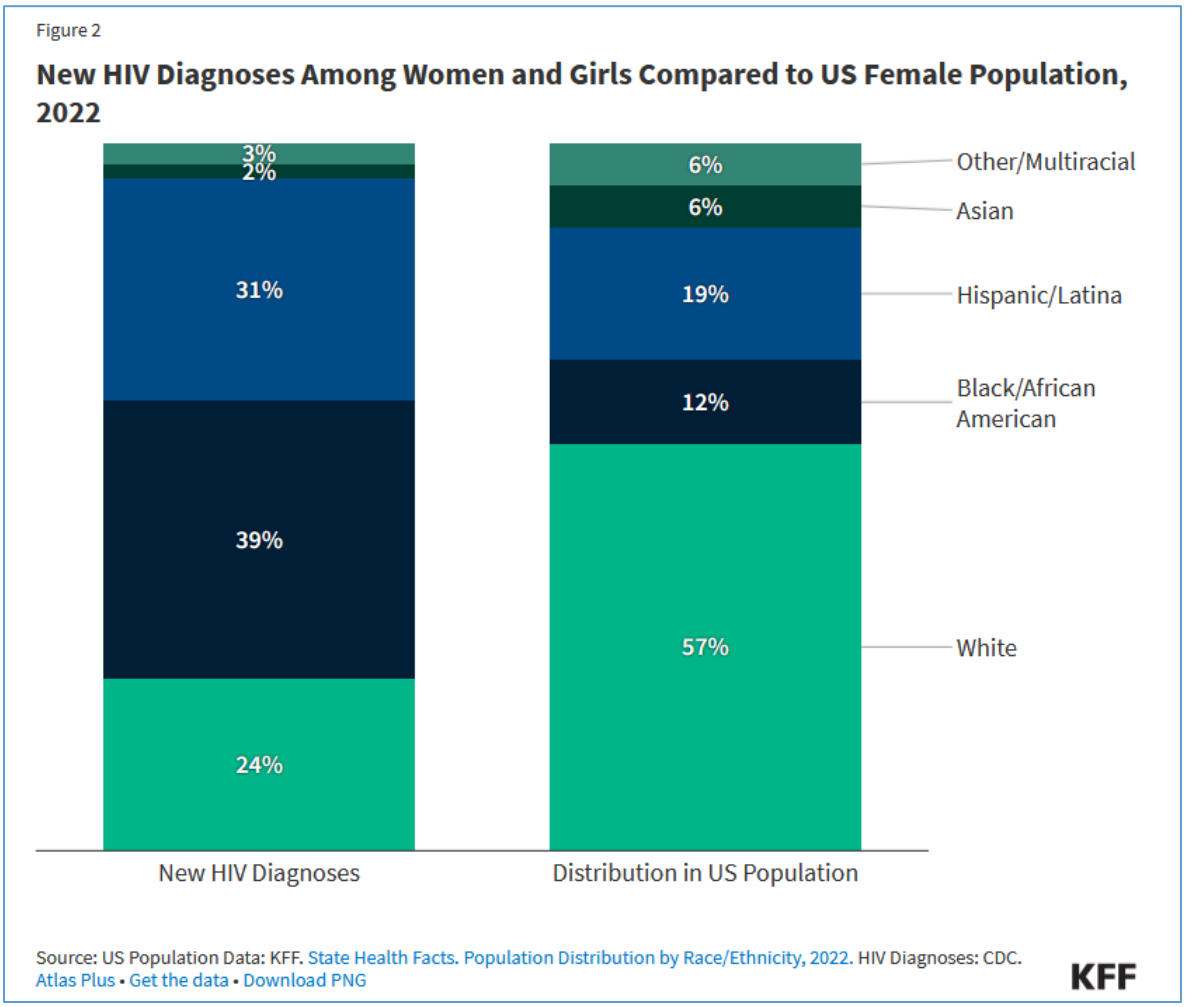
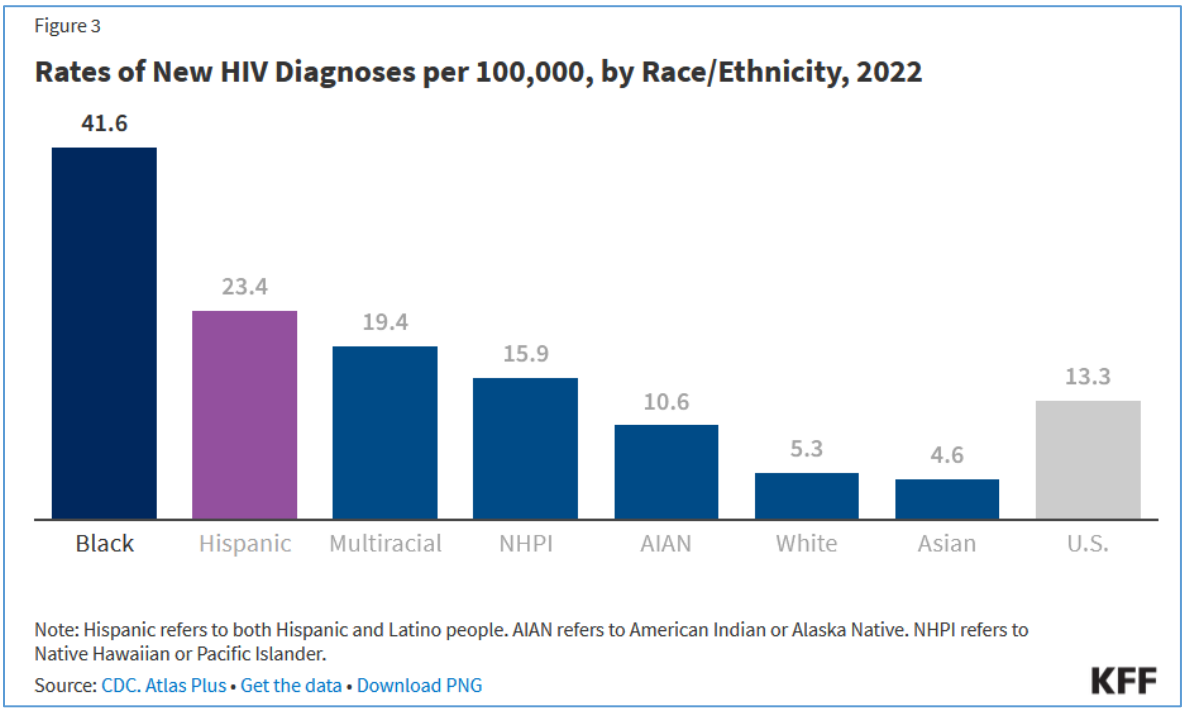
Overview

- Today, there are more than 1.2 million people estimated to be living with HIV in the U.S., including 316,900 who are Hispanic/Latino.
- Although Hispanic/Latino people represent only 19% of the U.S. population, they accounted for 31% of new HIV diagnoses in 2022 (see Figure 2) and an estimated 26% of people estimated to be living with HIV.
- Disparities persist in awareness of HIV status, linkage to care, and viral suppression between Hispanic/Latino people and White people.
- Between 2010-2022, while HIV diagnoses decreased by 12% overall, Hispanic/Latino people saw a 24% increase.
- The increase in the number of annual HIV diagnoses among Hispanic/Latino people in recent years was concentrated among men who accounted for almost nine in ten new diagnoses (88%) in 2022 (See Figure 1).
- Of the 10,426 new HIV diagnoses among Hispanic/Latino men in 2022, 91% were attributable to diagnoses among gay and bisexual Hispanic/Latino men.



- The rate of new HIV diagnoses per 100,000 among adult and adolescent Hispanic/Latino people (23.4) was over 4 times that of White people (5.3) but about half that of Black people (41.6) in 2022 (see Figure 3). Looking by sex and race, the rate for Hispanic/Latino men (40.8) was the second highest of any group after Black men (66.3) and over 4 times that of White men (8.7). Latina women (5.5) had the third highest rate among women (tied with American Indian/Alaska Native women) after Multiracial women (8.2) and Black women (19.2).



- Hispanic/Latino people accounted for almost 1 in 5 (17%) deaths among people with an HIV diagnosis (deaths may be due to any cause) in 2022. The number of deaths among Latino individuals with an HIV diagnosis increased 24% between 2010 and 2022.
- Rates for deaths where HIV was indicated as the leading cause of death are second highest among Hispanic/Latino people (after Black people) compared to people of other race/ethnicities. Hispanic/Latino people had the second highest age-adjusted HIV death rate per 100,000 – 1.4 compared to 0.6 per 100,000 White persons.

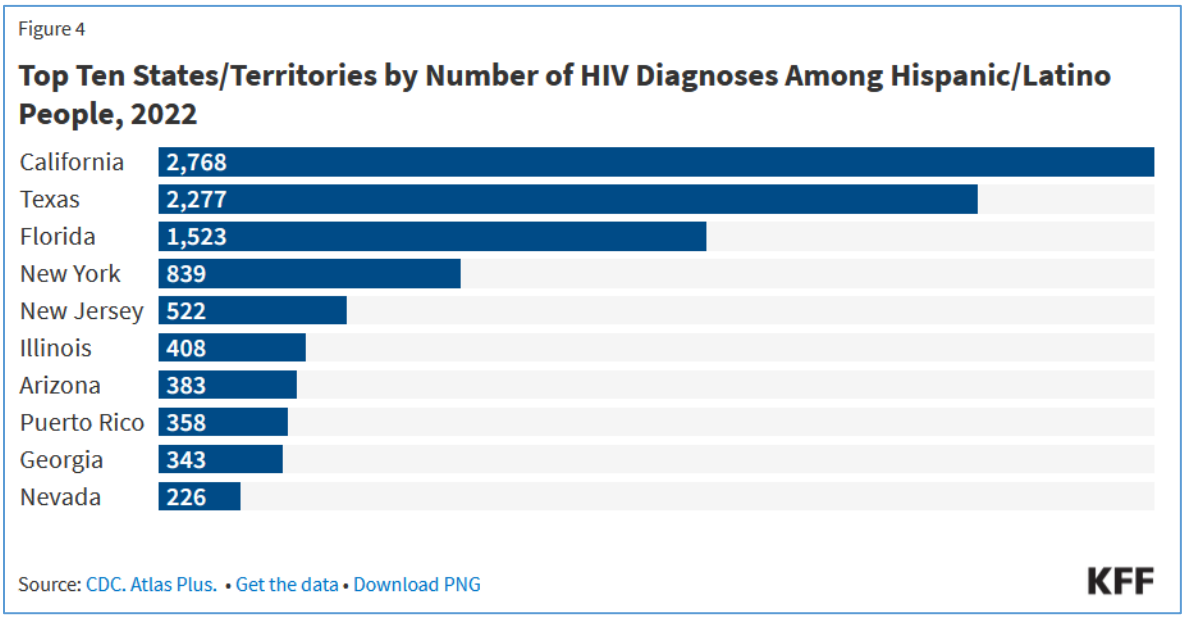
Transmission

- Transmission patterns vary by race/ethnicity. While male-to-male sexual contact accounts for the largest share of HIV cases across racial/ethnic groups, proportionately, more Hispanic/Latino people contract HIV this way. Heterosexual sex accounts for a smaller proportion of HIV cases among Hispanic/Latino people than White people.
- Among Hispanic/Latino people, 78% of new HIV diagnoses in 2022 were attributable to male-to-male sexual contact, with an additional 3% attributable to male-to-male sexual contact and injection drug use. 15% were attributable to heterosexual sex and the remainder of HIV diagnoses were attributable injection drug use only. This differs from transmission patterns among White people. Among White people, 63% of new HIV diagnoses in 2022 were attributable to male-to-male sexual contact with an additional 7% attributable to male-to-male sexual contact and injection drug use and 16% were attributable to heterosexual sex. The remainder were attributable injection drug use only.
- Nearly 9 in 10 (87%) HIV diagnoses among Hispanic/Latina women are attributed to heterosexual contact and a smaller share of HIV are attributable to injection drug use compared to White women.

Geography

- Although HIV diagnoses among Hispanic/Latino people have been reported throughout the country, the impact of the epidemic is not uniformly distributed.
- In 2022, Hispanic/Latino people made up an estimated 19% of all people in the South, but accounted for a greater share of new diagnoses (42%) and estimated people living with HIV (34%) in that region.
- HIV diagnoses among Hispanic/Latino people are concentrated in a handful of states. The top 10 states account for 82% of all HIV diagnoses among Hispanic/Latino people (see Figure 4).

Figure 4



Women

- Hispanic/Latina women accounted for 1 in 5 (20%) new HIV diagnoses among women as well as 1 in 5 (20%) women estimated to be living with HIV. The rate of new diagnoses among Latina women (5.5) is nearly 3 times the rate among White women (1.9) but less than the rate among Black women (19.2).
- After several years of decreases, new HIV diagnoses among Hispanic/Latina women increased by 16% between 2018 and 2022.
- In 2022, Hispanic/Latina women represented 12% of new HIV diagnoses among all Hispanic/Latino people – a smaller share than White and Black women (who represented 18% and 24% of new diagnoses among their respective racial/ethnic groups).

Young People

- In 2022, 30% of HIV diagnoses among young people ages 13-24 were among Hispanic/Latino people.
- Looking at young people (those ages 13-24) by race/ethnicity, Hispanic/Latino youth, had the second highest number and rate of HIV diagnoses (2,124 and 16.3 per 100,000, respectively) after Black youth (3,555 and 48.7); the rate for Hispanic/Latino people was 4.5 times greater than that of White youth (3.6).

- Hispanic/Latino gay and bisexual teens and young adults are especially impacted. Among all gay and bisexual teens and young adults diagnosed with HIV in 2022, 32% were Hispanic/Latino.

Gay and Bisexual Men

(Data in this section are based on individuals who acquired HIV through male-to-male sexual contact or male-to-male sexual contact and injection drug use.)

- Between 2010 and 2022, HIV diagnoses among Hispanic/Latino people attributable to male-to-male sexual contact increased by 43%, including a 23% increase between 2018 to 2022.
- Among Hispanic/Latino people, gay and bisexual men accounted for 85% those estimated to be living with HIV and 30% of all gay and bisexual men estimated to be living with HIV.
- Young Hispanic/Latino gay and bisexual men are particularly affected, with those ages 13-24 accounting for 20% of new HIV diagnoses among Hispanic/Latino gay and bisexual men in 2022, higher than the share among White gay and bisexual men (12%).

HIV Testing and Access to Prevention & Care

- In 2022, nearly one half (44%) of Hispanic/Latino adults reported ever having been tested for HIV, compared to a third of those who were White (32%).
- Among those who are HIV positive, 21% of Hispanic/Latino people were diagnosed with HIV late – that is, were diagnosed with AIDS within 3 months of testing positive for HIV; similar to the share among White (21%) and Black (20%) people.
- Looking across the care continuum, Hispanic/Latino people face disparities related to diagnosis, linkage to care and viral suppression. At the end of 2022, it was estimated that 84% of Hispanic/Latino people with HIV were diagnosed, 62% were linked to care, and 54% were virally suppressed. In comparison, an estimated 89% of White people with HIV were diagnosed, 70% were linked to care, and 63% were virally suppressed.

Endnotes

1. Unless otherwise noted, HIV data come from KFF analysis of the Centers for Disease Control and Prevention (CDC) data in the CDC's National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention tool: Atlas Plus. https://www.cdc.gov/nchhstp/about/atlasplus.html.

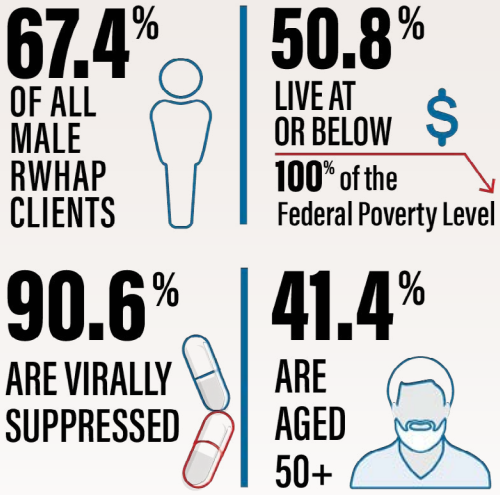
Gay, Bisexual, and Other Men Who Have Sex with Men (MSM) Clients:

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.

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

48.3% OF ALL RWHAP CLIENTS ARE AGED 50+

57.9% LIVE AT OR BELOW **100%** of the Federal Poverty Level

93.1% ARE VIRALLY SUPPRESSED

3.7% EXPERIENCE UNSTABLE HOUSING

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.

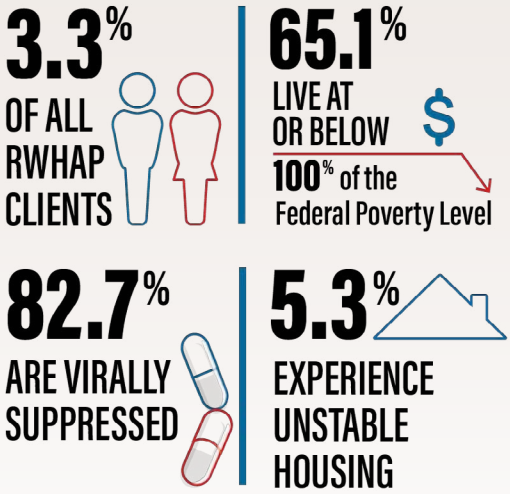
Youth and Young Adult Clients:

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.

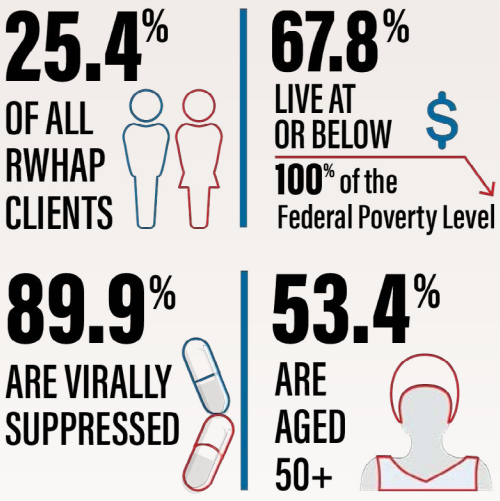
Female Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

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: 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

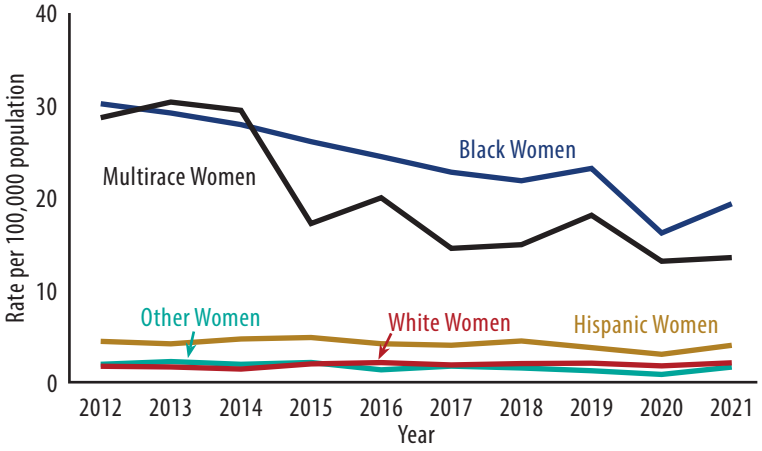
The rate of Black women living with HIV in Texas (631 per 100,000 population) is 6.9 times the rate of Hispanic women living with HIV and 13.6 times the rate of White women living with HIV.

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.

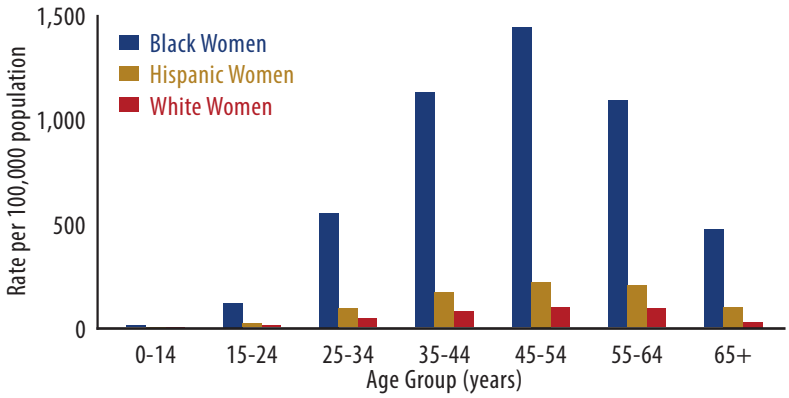
More Black persons living with HIV (PLWH) (12,105) did not receive HIV medical care in 2021 compared to other racial and ethnic groups in Texas. **Nearly one in three** Black women living with HIV in **Texas** (3,572) were out of care in 2021.

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

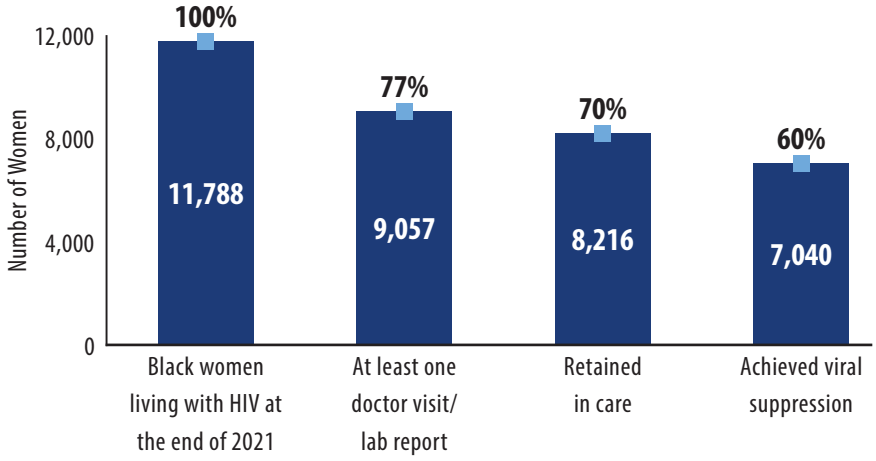
- 77 percent had at least one medical visit or lab test for their HIV infection,
- 70 percent had at least two medical visits or lab visits at least three months apart, and
- 60 percent achieved viral suppression.

TEXAS Health and Human Services | Texas Department of State Health Services

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)

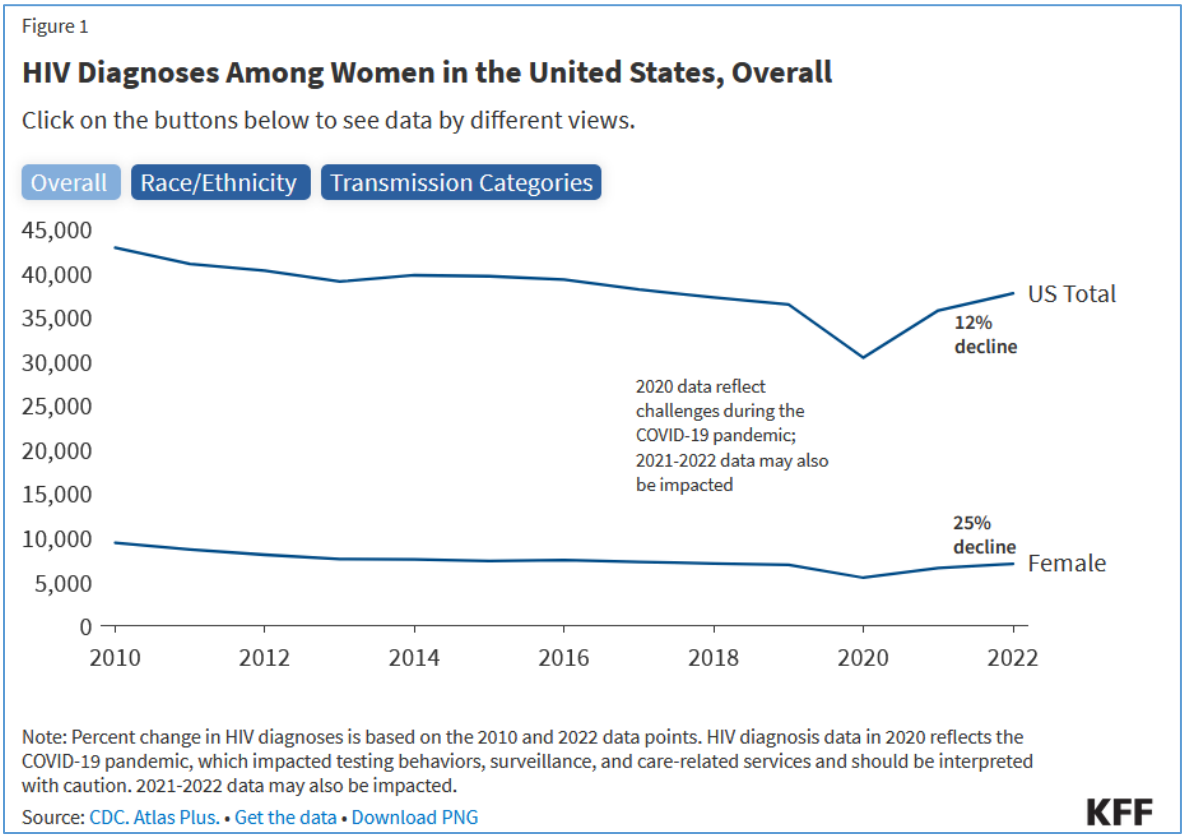
TEXAS Health and Human Services
Texas Department of State Health Services

The Impact of HIV on Women in the United States

Published: Dec 16, 2024

Key Facts

- Women have been affected by HIV since the beginning of the epidemic and face unique challenges in accessing optimal prevention, care, and treatment resources.1
- In 2022, women accounted for about 1 in 5 (19%) new HIV diagnoses in the U.S.[2]
- Women of color, particularly Black women, have been disproportionately impacted and represent the majority of women living with HIV, as well as the majority of new diagnoses among women.
- Recent data indicates that HIV diagnoses among women fell 25% between 2010 and 2022, compared to a 12% decline across the population overall. Decreases in HIV diagnoses have occurred for nearly every racial/ethnic group besides White women (Figure 1). However, rates of HIV diagnoses among women of color are much higher.



Overview

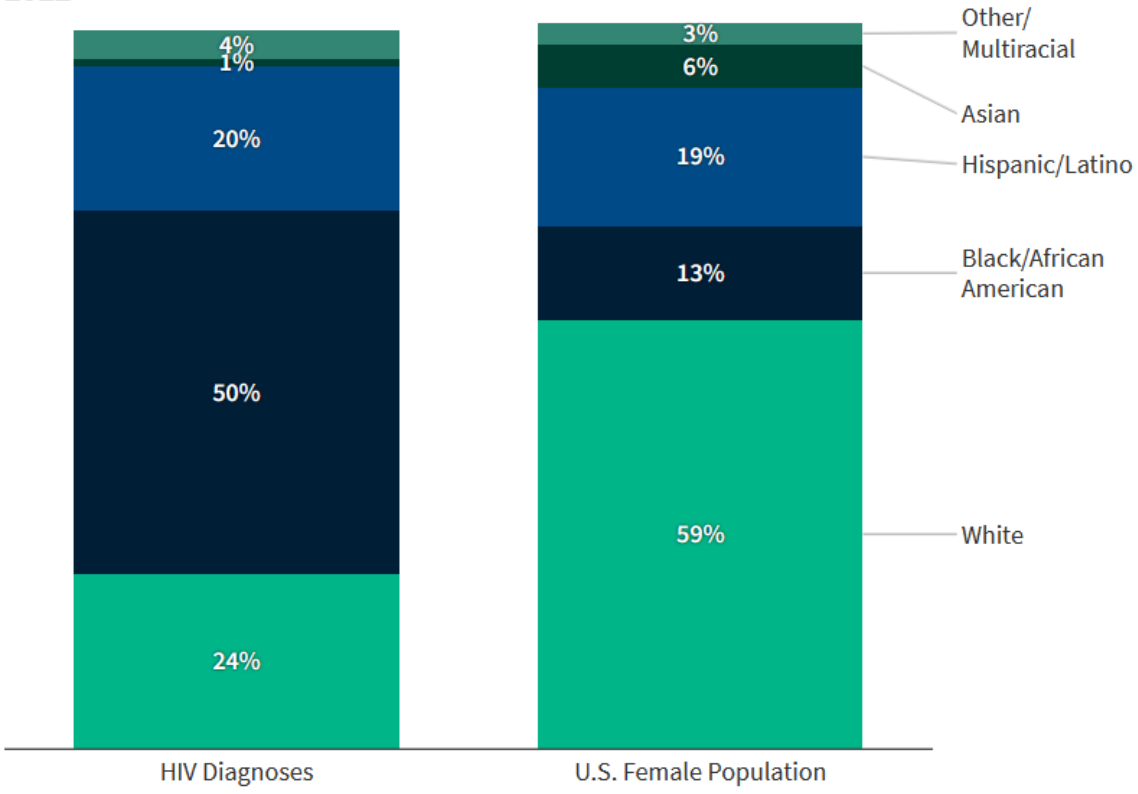
- Today, there are more than 1.2 million people estimated to be living with HIV in the U.S., including 268,800 (22%) who are women.
- Women accounted for 19% of the 6,980 new HIV diagnoses in 2022 and are diagnosed with HIV at slightly older ages than men are.
- Between 2010-2022, while HIV diagnoses decreased by 12% among the population overall, the decline was twice as large among women (25%). Decreases in HIV diagnoses have occurred for nearly every racial/ethnic group besides White women (Figure 1). However, rates of HIV diagnoses among women of color are much higher.
- Of new HIV diagnoses among women in 2022, 83% were attributable to heterosexual sex, 17% were attributable to injection drug use, and 1% were attributed to other causes.
- Women with and at risk for HIV face several challenges to getting the services and information they need, including socio-economic and structural barriers such as poverty, cultural inequities, and intimate partner violence (IPV).

Race/Ethnicity

- Women of color, particularly Black women, are disproportionately affected by HIV, accounting for the majority of new HIV diagnoses, the majority of women living with HIV, and highest rates of HIV-related deaths among women with HIV in the U.S.
- In 2022, Black women accounted for half (50%) of HIV diagnoses among women, while only accounting for 13% of the U.S. female population. White women accounted for 24% and Hispanic/Latina women accounted for 20% of HIV diagnoses among women (Figure 2).
- HIV diagnoses decreased 58% among Multiracial women, 39% among Black women, 9% among Hispanic/Latina women, and 3% among Asian women between 2010 and 2022. In this same timeframe, HIV diagnoses increased 21% among White women.
- Rates of new HIV diagnoses are much higher for Black, Multiracial, and Hispanic/Latina women than for White women. In 2022, the rate of new HIV diagnoses for Black women was 10 times higher than the rate for White women (19.2 per 100,000 compared to 1.9); the rate for Multiracial women (8.2) was 4 times higher; the rates for Hispanic/Latina women (5.5) and American Indian/Alaska Native women (5.5) were nearly 3 times higher; the rate for Native Hawaiian/Other Pacific Islander women (4.6) was more than 2 times higher. The rate of new HIV diagnoses among Asian women (1.1) was less than that of White women (1.9).
- In 2021, HIV was the 9th leading cause of death for Black women ages 25-34, behind diabetes. Black women accounted for the greatest share of deaths (of any cause) among women with diagnosed HIV in 2022 (57%), followed by White women (20%), and Hispanic/Latina women (15%).

Figure 2

New HIV Diagnoses Among Women & U.S. Female Population, by Race/Ethnicity, 2022



Note: Data are estimates among those ages 13 and older. Percentages may not sum to 100 due to rounding. U.S. female population data is from the U.S. Census Bureau's Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States: April 1, 2020 to July 1, 2023.

Source: US Population Data: U.S. Census Bureau, Annual Estimates April 1, 2020 to July 1, 2023. HIV Diagnoses: CDC. Atlas Plus. • Download PNG

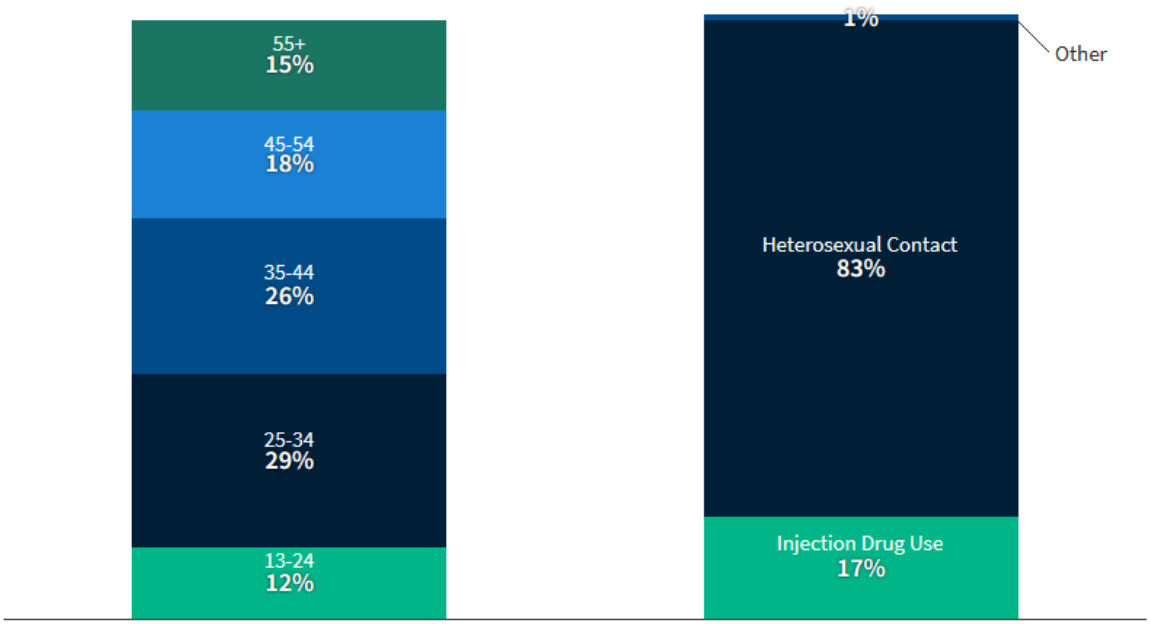
KFF

Age

- Women ages 25-34 accounted for the largest share (29%) of HIV diagnoses among women in 2022, followed by those ages 35-44 (26%). (Figure 2).
- Women are diagnosed with HIV at slightly older ages than men are. Women 35 years old and older accounted for 58% of new diagnoses among women in 2022. Comparatively, men in this age group accounted for 41% of diagnoses among men.

Figure 3

New HIV Diagnoses Among Women & Girls, by Age and Transmission Category, 2022



Note: Data are estimates among those ages 13 and older. Distribution by transmission category includes all women and girls. "Other" includes hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or identified. Percentage may not sum to 100% due to rounding; total percentage for those Ages 35+ do not sum to 58% as stated in the text due to rounding.

Source: CDC. Atlas Plus. • Get the data • Download PNG

KFF

Transmission

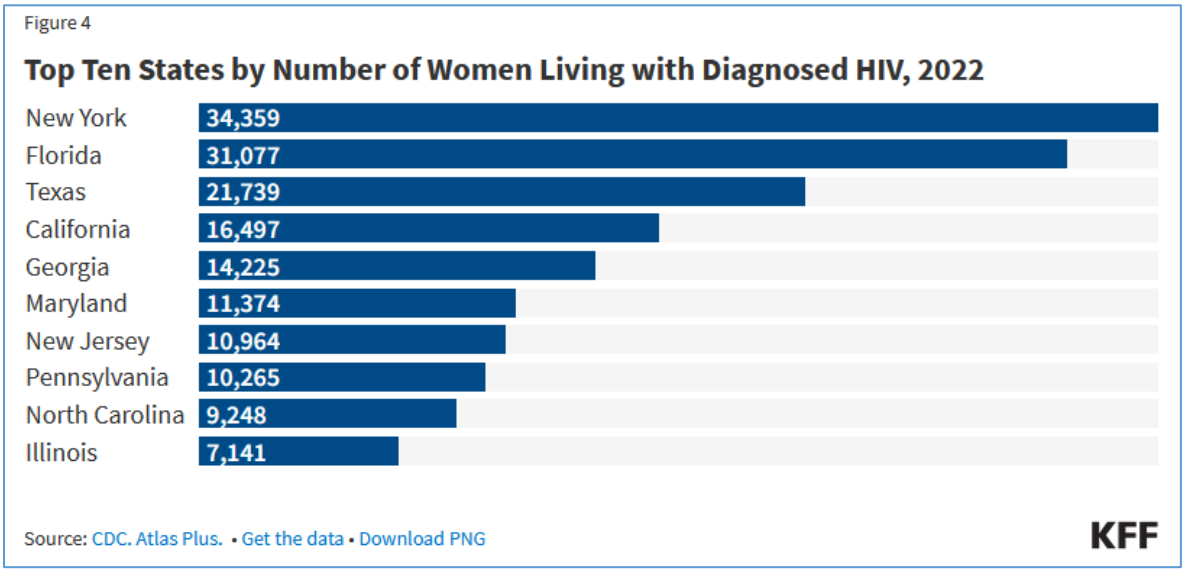
- In 2022, HIV diagnoses among women were mostly attributed to heterosexual sex (83%), followed by injection drug use (17%), and 1% were attributed to other causes. Heterosexual transmission accounts for a greater share of HIV diagnoses among Black and Hispanic/Latina women (90% and 87%, respectively) compared to White women (64%). Among White women, injection drug use accounts for a greater share of diagnoses (36%), relative to Black and Hispanic/Latina women (9%, 12%). (See Figure 3.)
- Mother-to-child transmission of HIV in the U.S. has decreased dramatically since its peak in 1991 due to antiretroviral therapy (ART), which significantly reduces the risk of transmission from a woman to her baby (to 1% or less). Still, some perinatal infections occur each year, the majority of which are among Black women, and there continues to be missed opportunities for preventing mother-to-child transmissions, such as testing late in pregnancy. Of the 42 infants born with HIV in 2022, two-thirds (67%) were Black.

Geography

- Although HIV diagnoses among women have been reported throughout the country, the impact of the epidemic is not uniformly distributed.
- Ten states account for two-thirds of women living with diagnosed HIV (67% in 2022); with 5 states accounting for nearly half (47%) (Figure 4). While the District of Columbia ranked 18th

among states in terms of the number of women living with diagnosed HIV (3,629 in 2022), the rate per 100,000 women living with an HIV diagnosis was the highest, nearly 7 times the national rate for women (1,189 per 100,000 compared to 174 per 100,000 nationally), similar to the share in other high populous urban areas.

- Thirty-five counties account for almost half (46%) of all women living with an HIV diagnosis in the U.S., with Bronx County, New York having the greatest number (9,454) and highest rate (1,552 per 100,000) of women living with an HIV diagnosis.



Transgender Women

- Transgender women are disproportionately affected by HIV and face stigma, discrimination, and exclusion in accessing testing, treatment, and health care, relative to other women.
- Since the beginning of the HIV epidemic, national surveillance of and research on the impacts of HIV on transgender women, as well as transgender and gender-diverse people more broadly, has been limited.
- Although transgender women account for a small share of people estimated to be living with HIV (1%) among transgender women, 14% are estimated to be living with HIV.
- In 2022, transgender women accounted for 87% of 994 new HIV diagnoses among transgender and gender-diverse people. Among transgender women, looking across race/ethnicity, Black transgender women had the highest share of HIV diagnoses (41%), followed by Hispanic/Latina transgender women (39%), whereas White transgender women accounted for 13% of diagnoses. HIV diagnoses among transgender women were mostly attributed to sexual contact (89%).
- Among transgender women, 83% received care for HIV, while 67% were virally suppressed, similar to the share in the overall population of people with HIV.

Sexual and Reproductive Health

- HIV interacts with women's reproductive health on many levels, impacting menstruation, reducing fertility, and predisposing pregnant people to greater risk of complications. In addition, antiretroviral therapy may impact contraceptive efficacy. During pregnancy, people with HIV can take additional measures to prevent mother-to-child-transmission of HIV such as adherence to antiretroviral regimens and labor and delivery procedures.

- Mothers living with HIV can reduce the risk of transmission to their babies via breastfeeding to less than 1% through antiretroviral therapy.
- Women with other sexually transmitted infections (STIs) are at increased risk for contracting HIV. Women with HIV are at increased risk for developing or contracting a range of conditions, including human papillomavirus (HPV), which can lead to cervical cancer, and severe pelvic inflammatory disease.
- Sexual and reproductive health clinics provide an important entry point for reaching women at risk for and living with HIV. Nearly two-thirds (63%) of women receiving care at sexual and reproductive health clinics report it as their usual source of medical care.
- Research efforts are exploring a number of new HIV prevention technologies which could be particularly beneficial for women, such as cervical barriers and microbicides. The long-acting injectable lenacapavir has also been shown to be highly effective in preventing HIV among women but is not yet approved in the U.S. Once approved, this will be an important addition to the prevention toolkit for women, particularly given its relatively low burden of twice annual injections.

Intimate Partner Violence (IPV) and HIV

- Women living with HIV are disproportionately affected by intimate partner violence (IPV), including physical, sexual, and emotional abuse compared to the general population. Intimate partner violence (IPV), sometimes referred to as domestic violence, has been shown to be associated with increased risk for HIV among women, as well as poorer treatment outcomes for those who are already positive.
- In the U.S., 35% of women living with HIV experienced physical (i.e. non-sexual) IPV in their lifetime, compared to 24% of men living with HIV.
- In many cases, the factors that put women at risk for HIV are similar to those that make them vulnerable to experiencing trauma or IPV: women in violent relationships are at a greater risk for contracting STIs, including HIV, than women in non-violent relationships, and women who experience IPV are more likely to report risk factors for HIV. These experiences are interrelated and can become a cycle of violence, HIV risk, and HIV acquisition.
- Women may also be at increased risk of experiencing violence upon disclosure of their HIV status to partners.

HIV Prevention

- The CDC recommends routine HIV screening for all adults, including women, ages 13-64, in health care settings, as well as repeat screening at least annually for those at high risk. The CDC also separately recommends that all pregnant women be screened for HIV, and that those at high-risk for HIV have repeat HIV screening in the third trimester. Testing of newborns is also recommended if the mother's HIV status is unknown.
- Additionally, the United States Preventive Services Task Force (USPSTF) recommends HIV testing (including specifically for pregnant women), IPV screening, many STI screenings, and pre-exposure prophylaxis (PrEP) which means that most insurers are required to cover these services without cost-sharing.
- Despite these recommendations, only 37% of women in the U.S. ages 18-64 report having been tested for HIV at some point. Black women are much more likely to report having been tested in the past year compared to White women (21% compared to 6%).

- PrEP is a safe and highly effective preventive medication that reduces the risk of acquiring HIV through sex by 99%. Women have been underrepresented in PrEP uptake and use and not all forms of PrEP are approved for people assigned female at birth. Recent developments in PrEP research have shown lenacapavir to be highly effective in preventing HIV among cisgender and transgender women.

Access to Care & Treatment

- As is the case for all people, there are several sources of care and treatment for women living with and at risk for HIV in the U.S., including government programs such as Medicaid, Medicare, and the Ryan White Program for those who are eligible.
- Looking across the care continuum, women see progress but continue to face challenges related to diagnosis, linkage to care, and viral suppression. At the end of 2022, among all women living with HIV, 90% were diagnosed, 48% were retained in care, and 57% were virally suppressed, similar to the shares among men.
- Among women with HIV, 21% were diagnosed late – that is, were diagnosed with AIDS within 3 months of testing positive for HIV, the same share as among men. This suggests that one in five women are not adequately being served by HIV testing services and are not getting into care within ideal timeframes.

Endnotes

1. Unless otherwise noted, the term "women" in this factsheet refers to sex assigned at birth.
2. Unless otherwise noted, HIV data come from KFF analysis of the Centers for Disease Control and Prevention (CDC) data in the CDC's National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention tool: Atlas Plus. https://www.cdc.gov/nchhstp/about/atlasplus.html

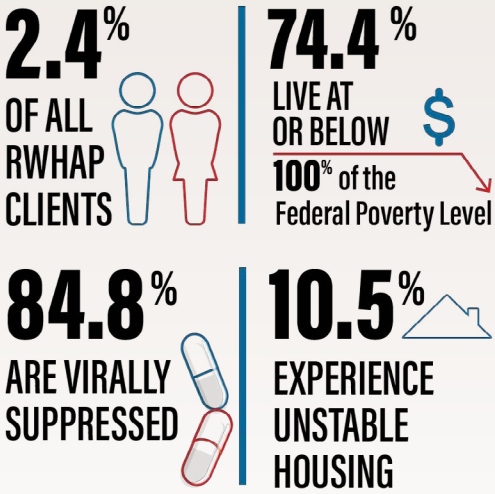
Transgender Clients:

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.

HRSA 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.

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.