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

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	<u>Subcontractor Monitoring</u> 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	<u>Staff Guidelines</u> 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	<u>Work Conditions</u> 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	<u>Staff Supervision</u> 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	<u>Client Feedback</u> In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually). Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may 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	<u>Information on Program and Eligibility/Sliding Fee Schedule</u> Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update. Agency should maintain a file documenting promotion activity including copies of HIV program materials and information on eligibility requirements. Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	• Agency has a written substantiated annual plan to targeted populations. • Zip code data show provider is reaching clients throughout service area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record. Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5

4.11	<u>Linkage Into Core Services</u> Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.	• Documentation of client referral is present in client record. • Review of agency's policies & procedures' manual
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

Health Insurance Premium and Cost Sharing Assistance

The Health Insurance Premium and Cost Sharing Assistance service category is intended to help PLWH continue medical care without gaps in health insurance coverage or discretion of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance, and deductibles to enable eligible individuals with HIV to utilize their existing third party or public assistance (e.g., Medicare) medical insurance. Agency may provide help with client co-payments, co-insurance, deductibles, and Medicare Part D premiums.

Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost- sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription. Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy.

1.0	**Staff/Training**	
1.1	Ongoing Training Eight (8) hours annually of continuing education in HIV related or other specific topics including a minimum of two (2) hours training in Affordable Care Act is required as needed.	• Materials for staff training and continuing education are on file. • Staff interviews indicate compliance.
1.2	Staff Experience A minimum of one-year documented HIV work experience is preferred.	• Documentation of work experience in personnel file.
2.0	**Client Eligibility**	
2.1	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program as needed to ensure that these funds are used as a last resort in order for the client to utilize their existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health insurance marketplace.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance.

2.2	<u>Advance Premium Tax Credit Reconciliation</u>
	Agency will ensure all clients receiving assistance for Marketplace QHP premiums:
	• Designate Premium Tax Credit to be taken in advance during Marketplace Insurance enrollment.
	• Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual Marketplace open enrollment or Marketplace renewal periods.
	• Submit prior year tax information no later than May 31st. Tax information must include:
	  • Federal Marketplace Form 1095-A
	  • IRS Form 8962
	  • IRS Form 1040 (excludes 1040EZ)
	• Reconciliation of APTC credits or liabilities
		• Review of client record.

3.0	**Client Access**	
3.1	<u>Clients Referral and Tracking</u> Agency receives referrals from a broad range of HIV service providers and makes appropriate referrals out when necessary.	• Documentation of referrals received. • Documentation of referrals out. Staff reports indicate compliance.

3.2	Prioritization of Service Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agency use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistance (in descending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles (all other allowable HIV- related medications) 3. Doctor visit co-pays/deductibles (physician visit and/or lab copayments) Medicare Part D (Rx) premiums	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.
3.3	Decreasing Barriers to Service Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance use provider agencies to enable clients of these agencies to enroll in Health Insurance Assistance at their primary care, mental health or substance use provider site. (i.e., No need for client to physically present to Health Insurance Assistance provider.)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance.

Home Delivered Meals

Home delivered meals are the provision of prepared meals or food vouchers for prepared meals to clients who are homebound or require special dietary support in meeting nutritional outcomes based on dietary needs to improve and enhance their HIV care. This service includes the provision of both frozen and hot meals.

1.0	**Services are individualized and tailored to client needs.**	
1.1	Eligibility Persons with HIV living within the Houston Eligible Metropolitan Area (EMA) or HIV Service Delivery Area (HSDA) who are homebound or require special dietary support in meeting nutritional outcomes based on dietary needs to improve and enhance their HIV care including persons with compromised nutritional status and limited ability to prepare his/her own meals. The client is actively enrolled in primary medical care along with the referral from the client's Primary Care provider's registered dietician or nutritionist.	• Client record indicates compliance • Documentation in client's record
1.2	Culturally Competent Home-delivered meals should be culturally representative and best meet the eligible client's traditional food options and have the ability to supply a variety of meal options with daily, weekly or on an as-needed basis delivery. The contractor must incorporate practices that honor clients' beliefs, being sensitive to cultural diversity and diverse cultural and ethical backgrounds, including supporting clients with limited English proficiency or disabilities, and regardless of gender, sexual orientation, or gender identity. This includes fostering attitudes and interpersonal communication styles in staff and providers which respect recipients' cultural backgrounds.	• Client record indicates compliance. • Review of agency's Policies & Procedures Manual indicates compliance.

2.0	**Services adhere to professional standards and regulations.**	
2.1	Referrals and Consultation The prepared meals should be nutritious and individualized to client's dietary needs, and shall be based on current federal dietary guidelines (Dietary Guidelines for Americans, 2020-2025 and Online Materials | Dietary Guidelines for Americans). All meal plans must be reviewed and approved by a registered dietician. Subrecipient shall receive consultation from a registered and/or licensed dietitian regarding the nutrition, caloric needs, and other dietary issues of people with HIV, and has incorporated that guidance into its food pantry and/or home-delivered meals program. Consultation should be done on an annual basis and must be documented.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record
2.2	Regulations Subrecipient shall comply with local, state, and federal food safety, sanitization, and safety regulations.	• Review of agency's Policies & Procedures Manual indicates compliance • Staff interviews
2.3	Licensure Subrecipient shall comply with the USDA Department of Agriculture food handling guidelines. Staff members packaging bulk foods shall have current and valid food handling permits or license.	• Documentation of current licensure • Staff Permits/license on file at agency • Nutritional plan in client's record
2.4	Inspections Subrecipient shall maintain and show evidence that all required inspections are current and resulted in acceptable findings.	• Chart Review shows compliance • Review of agency's Policies & Procedures Manual indicates compliance

2.5	Facility Subrecipient shall provide adequate space and equipment to store food in a sanitary manner.	• Appropriate space and equipment available upon inspection/observation.
2.6	Procurement Subrecipient shall comply with procedures for purchasing, receiving, sorting, issuing, preparing, and service of safe food and beverage products.	• Review of agency's Policies & Procedures Manual indicates compliance
2.7	New Staff Training All new staff members shall attend educational seminars regarding food safety within three months of hire, and annually thereafter.	• Education certificates on file at provider agency for each staff member
3.0	**Food Processing & Delivery**	
3.1	Condition of Food Items • All milk and cheese products shall have the word pasteurized on the label. • Fresh food such as bread shall be free of any mold. • Fruits and vegetables shall be free from insects and mold. • All packaged products shall be labeled properly, and within the expiration period as stated on the product in accordance with FDA regulations. • Frozen foods shall be packaged, kept completely frozen and stored in a proper freezer at 0° Fahrenheit or below.	• Evident at food-processing facility inspection
3.2	Delivery vehicle and driver • Vehicle will be insured. • Driver will be free of past moving violations.	• Review of agency's Policies & Procedures Manual indicates compliance. • Documentation in personnel record
3.3	Delivery of meals • Delivered timely at proper temperature. • Delivery must be directly to client or authorized representative.	• Review of agency's Policies & Procedures Manual indicates compliance. • Documentation in client's record

4.0	**Client Eligibility**	
4.1	Client Screening • Agencies shall ensure that clients have exhausted access through other funding sources prior to issuing a food voucher. • Agencies shall receive consultation from a registered and/or licensed dietitian regarding the nutrition, caloric needs, and other dietary issues of people with HIV. Agencies shall incorporate such guidance into its home-delivered meals program. Consultations should be done on a quarterly basis and must be documented.	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in client's record
5.0	**Discharge**	
5.1	Clients may be discharged from home delivered meals services when the client: • Has achieved all goals listed in the Nutritional Care Plan • Has become ineligible for services • Has relocated out of the service area • Is incarcerated • Is deceased • Decides to discontinue services • Is found to be improperly utilizing the service and/or is asked to leave the agency.	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in client's record
5.2	The client will be notified in writing of termination from home-delivered meals services including the reason indicated for discharge.	• A copy of the letter is present in client record.

Medical Nutritional Therapy/Supplements

HRSA defines core Medical Nutrition Therapy as the provision of food, nutritional services and nutritional supplements provided outside of a primary care visit by a licensed registered dietician based on physician's recommendation and a nutritional plan developed by a licensed registered dietician. The Houston EMA Part A/B Medical Nutrition Therapy includes nutritional counseling, provision nutritional supplements (of up to 90-day supply) for eligible people living with HIV in the Houston EMA. Clients must have a written referral or prescription from a physician or physician extender and a written nutritional plan prepared by a licensed, registered dietician.

1.0	**Services are individualized and tailored to client needs.**	
1.1	Education/Counseling – Clients Receiving New Supplements All clients receiving a supplement for the first time will receive appropriate education/counseling. This must include written information regarding supplement benefits, side effects and recommended dosage in client's primary language.	• Client record indicates compliance.
1.2	Education/Counseling – Follow-Up Clients receive education/counseling regarding supplement(s) again at: • Follow-up • When there is a change in supplements. • At the discretion of the registered dietician if clinically indicated.	• Client record indicates compliance.
2.0	**Services adhere to professional standards and regulations.**	
2.1	Nutritional Supplement Formulary RW funded nutritional supplement disbursement for program eligible clients shall be based on the current RWGA nutritional supplement formulary. Ryan White funds may not be used for nutritional supplements not on the approved formulary. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Department of Health and Human 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

2.2	Inventory Supplement inventory is updated and rotated as appropriate on a first-in, first-out basis, and shelf-life standards and applicable laws are observed.	• Review of agency's Policies & Procedures Manual indicates compliance. • Staff interviews
2.3	Licensure Providers/vendors maintain proper licensure. A physician or physician extender (PE) with prescribing privileges at a Part A/B/C and/or MAI-funded agency or qualified primary care provider must write an order for Part A- funded nutritional supplements. A licensed registered dietician must provide an individualized nutritional plan including education/counseling based on a nutritional assessment.	• Documentation of current licensure. • Nutritional plan in client's record.
2.4	Protocols Nutrition therapy services will use evidence-based guides, protocols, best practices, and research in the field of HIV including the *American Dietetic Association's HIV-related protocols in Medical Nutrition Therapy Across the Continuum of Care.*	• Chart Review shows compliance. • Review of agency's Policies & Procedures Manual indicates compliance.

Oral Health

Oral Health Care as "diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers". The Ryan White Part A/B oral health care services include standard preventive procedures, diagnosis and treatment of HIV-related oral pathology, restorative dental services, oral surgery, root canal therapy and oral medication (including pain control) for PLWH 15 years old or older based on a comprehensive individual treatment plan. Additionally, the category includes prosthodontics services (Part B) to people living with HIV including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.

1.0	**Staff HIV knowledge is based on documented training.**	
1.1	Continuing Education • Sixteen (16) hours of training in HIV and clinically related issues is required every 2 years for licensed staff. (Does not include any training requirements outlined in General Standards.) • One (1) hour of training in HIV is required annually for all other staff. (Does not include any training requirements outlined in General Standards.)	• Materials for staff training and continuing education are on file. • Documentation of continuing education in personnel file.
1.2	Experience – HIV A minimum of one (1) year documented work experience with PLWH is preferred for licensed staff.	• Documentation of work experience in personnel file
1.3	Staff Supervision Supervision of clinical staff shall be provided by a practitioner with at least two years of experience in dental health assessment and treatment of persons living 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 Policies & Procedures Manual indicates compliance.

2.0	**Patient Care**	
2.1	HIV Primary Care Provider Contact Information Agency obtains and documents HIV primary care provider contact information for each client.	• Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number.
2.2	Consultation for Treatment Agency consults with client's medical care providers when indicated.	• Documentation of communication in the client record.
2.3	Health History Information Agency collects and documents health history information for each client prior to providing care. This information should include, but not be limited to, the following: • A baseline (current within the last 12 months) CBC laboratory test results for all new clients, and an annual update thereafter, and when clinically indicated. • Current (within the last 6 months) Viral Load and CD4 laboratory test results, when clinically indicated. • Client's chief complaint, where applicable • Medication names • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis • Usual oral hygiene • Date of last dental examination • Involuntary weight loss or weight gain • Review of systems	• Documentation of health history information in the client record. Reasons for missing health history information are documented.

2.4	Client Health History Update An update to the health history should be made, at minimum, every six (6) months or at client's next general dentistry visit whichever is greater.	• Documentation of health history update in the client record.
2.5	Comprehensive Periodontal Examination (Part B Only) Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client records indicate compliance.
2.6	Treatment Plan • A comprehensive, multidisciplinary Oral Health treatment plan will be developed in conjunction with the patient. • Patient's primary reason for dental visit should be addressed in treatment plan. • Patient strengths and limitations will be considered in development of treatment plan. • Treatment priority should be given to pain management, infection, traumatic injury, or other emergency conditions. • Treatment plan will be updated as deemed necessary.	• Treatment plan dated and signed by both the provider and patient in patient file. • Updated treatment plan dated and signed by both the provider and patient in patient file.
2.7	Annual Hard/Soft Tissue Examination The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record: • Charting of caries • X-rays • Periodontal screening • Written diagnoses, where applicable • Treatment plan Determination of clients needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all clients may not exceed two (2) years.	• Documentation in the client record. • Review of agency's Policies & Procedures Manual indicates compliance.
2.8	Oral Hygiene Instructions Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.	• Documentation in the client record.

Substance Use Outpatient Care

The Houston EMA Substance Abuse Treatment/Counseling service is an outpatient service providing treatment and/or counseling to people living with HIV who have substance use disorders. Services provided must be integrated with HIV-related issues that trigger relapse and must be coordinated with local TDSHS/SAS HIV Early Intervention funded programs. All services must be provided in accordance with the Texas Department of State Health Services/Substance Use services (TDSHS/SAS) Chemical Dependency Treatment Facility Standards as well as current treatment guidelines.

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	Comprehensive Assessment A comprehensive assessment including the following will be completed within ten (10 days) of intake or no later than and prior to the third therapy session. • Presenting Problem • Developmental/Social history • Social support and family relationships • Medical history • Substance use history • Psychiatric history • Complete mental status evaluation (including appearance and behavior, talk, mood, self-attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory and language) Specific assessment tools such as the Addiction Severity Index (ASI) could be used for substance use and sexual history and the Mini Mental State Examination (MMSE) for cognitive assessment.	• Completed assessment in client's record.

1.2	Psychosocial History A psychosocial history will be completed and must include: • Education and training • Employment • Military service • Legal history • Family history and constellation • Physical, emotional and/or sexual abuse history • Sexual and relationship history and status • Leisure and recreational activities • General psychological functioning	• Completed assessment in client's record.
1.3	Treatment Plan Treatment plans are developed jointly with the counselor and client and must contain all the elements set forth in the Texas Department of State Health Services Administrative code for Substance Use including: • Statement of the goal(s) of counseling • The plan of approach • Mechanism for review The plan must also address full range of substances the patient is abusing. Treatment plans must be completed no later than five working days of client assessment. Individual or group therapy should be based on professional guidelines. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance use as clinically indicated.	• Completed treatment plan in client's record. • Treatment Plan review documented in client's records.

1.4	Treatment Plan Review In accordance with the Texas Department of State Health Services Administrative code on Substance Use, the treatment plan shall be reviewed at a minimum, midway through treatment and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures and must follow criteria outlined in the Administrative Code.	• Review of agency's Policy and Procedure Manual indicates compliance. • Updated treatment plan in client's record
2.0	**Services are part of the coordinated continuum of HIV services.**	
2.1	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agency must have collaboration agreements with mental health and primary care providers or demonstrate that they offer these services on-site.	• Documentation of referrals received. • Documentation of referrals out. • Staff interviews indicate compliance. • Collaborative agreements demonstrate that these services are offered on an off-site.
2.2	Facility License Agency is appropriately licensed by the Texas Department of State Health Services – Substance Use Services (TDSHS/SAS) with outpatient treatment designations.	• Documentation of current agency licensure.
2.3	Minimum Qualifications All agency staff that provides direct client services must be properly licensed per current TDSHS/SAS requirements. Non-licensed staff must meet current TDSHS/SAS requirements.	• Documentation of current licensure in personnel files.

3.0	**Staff HIV knowledge is based on documented training and**	
3.1	Staff Training All agency staff, volunteers and students shall receive initial and subsequent trainings in accordance with the Texas Administrative Code, rule §448.603 (a), (c) & (d).	• Review of training curriculum indicates compliance. • Documentation of all training in personnel file. • Specific training requirements are specified in the staff guidelines. • Documentation of all trainings must be done in accordance with the Texas Administrative Code §448.603 (b).
3.2	Experience – HIV A minimum of one (1) year documented HIV work experience is required. Those who do not meet this requirement must be supervised by a staff member with at least 1 year of documented HIV work experience.	• Documentation of work experience in personnel file.
4.0	**Service providers are knowledgeable, accepting, and respectful of the needs of individuals with HIV Staff efforts are compassionate and sensitive to client needs.**	
4.1	Staff Supervision The agency shall ensure that each Substance Use Supervisor shall, at a minimal, be a master's level professional (e.g., LPC, LCSW, LMSW, LMFT, Licensed Clinical Psychologist, LCDC if applicable) and licensed by the State of Texas and qualified to provide supervision per applicable TDSHS/SAS licensure requirements. Professional staff must be knowledgeable of the interaction of drug/alcohol use and HIV transmission and the interaction of prescribed medication with other drug/alcohol use.	• Review of personnel files indicates compliance. • Review of agency's Policy and Procedure Manual indicates compliance.

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE

Effective Date: April 1, 2024/September 1, 2024

HRSA Definition:
Health Insurance Premium and Cost Sharing Assistance (Health Insurance Assistance or HIA) provides financial assistance for eligible people living with HIV (PLWH) to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services (OAHS), and pharmacy benefits that provide a full range of HIV medications for eligible PLWH; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible PLWH; and/or
- Paying cost sharing on behalf of PLWH.

To use HRSA Ryan White HIV/AIDS Program (RWHAP) funds for health insurance premium and cost sharing assistance (not standalone dental insurance assistance), a HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- PLWH obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate Outpatient/Ambulatory Health Services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate OAHS.

To use funds for standalone dental insurance premium assistance, agencies must implement a methodology that incorporates the following requirement:

- Agencies must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate and allocate funding to HIA only when determined to be cost effective.

Program Guidance:
Traditionally, RWHAP funding supports health insurance premiums and cost sharing assistance. The following DSHS policies/standards and HRSA Policy Clarification Notices (PCNs) provide additional clarification for allowable uses of this service category:

- DSHS Policy 260.002 (Revised 11/2/2015): Health Insurance Assistance,

- DSHS HIV/STD Ryan White Part B Program Universal Standards: Health Insurance Premium and Cost Sharing Assistance,
- PCN 07-05: Program Part B ADAP Funds to Purchase Health Insurance,
- PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance,
- PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid,
- PCN 14-01 (Revised 4/3/2015): Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act, and
- PCN 16-02: Eligible Individuals & Allowable Uses of Funds and FAQ for Standalone Dental Insurance

DSHS Definition:
The provision of financial assistance for eligible PLWH to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes out-of-pocket costs such as premium payments, co-payments, coinsurance, and deductibles. Please refer to Texas Department of State Health Services (DSHS) Policy 260.002 (Health Insurance Assistance) for further clarification and guidance.

The cost of insurance plans must be lower than the cost of providing health services through grant-supported direct delivery (be "cost-effective"), including costs for participation in the Texas AIDS Drug Assistance Program (ADAP). Please refer to Texas Department of State Health Services (DSHS) Policy 270.001

(Calculation of Estimated Expenditures on Covered Clinical Services) for further clarification and guidance. Additionally, an annual cost-effective analysis can be located as an attachment to the aforementioned policy.

HIA may be extended for job or employer-related health insurance coverage and plans on the individual and group market, including plans available through the federal Health Insurance Marketplace (Marketplace). HIA funds may also be used towards premiums and out-of-pocket payments on Medicare plans and supplemental insurance policies if the primary purpose of the supplemental policy is to assist with HIV-related outpatient care.

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies, telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance

Local Definition:
Health Insurance Premium and Cost Sharing Assistance (Health Insurance Assistance or HIA) provides financial assistance for eligible PLWH to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program.

Allowable Use of Funds:
1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental) that provides comprehensive primary care and pharmacy benefits for PLWH that provide a full range of HIV medications
2. Paying co-pays for medical and dental plans on behalf of PLWH including:
    a. Deductibles
    b. Medical/Pharmacy co-payments
    c. Co-insurance, and
    d. Tax reconciliation up to of 50% of the tax due up to a maximum of $500
    e. Standalone dental insurance premiums to provide comprehensive oral health care services for eligible PLWH (As of 4/1/2017)
    f. Medicare Part D true out-of-pocket (TrOOP) costs,

Restricted Use of Funds:
1. HIA excludes plans that do not cover HIV-treatment drugs; specifically, insurance plans must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services to be eligible for premium payments under HIA.
2. HIA excludes any cost associated with liability risk pools.
3. Tax reconciliation due, if the PLWH failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period.
4. HIA funds may not be used to support Out of Pocket payments for inpatient hospitalization, emergency department care or catastrophic coverage.
5. HIA funds may not be used to support plans that offer only catastrophic coverage or supplemental insurance that assists only with hospitalization.
6. Funds may not be used for payment of services delivered by providers out of network. Exception: When an in-network provider is not available for HIV-related care only and/or appointment wait time for an in-network provider exceeds standards. Prior approval by AA (The Resource Group) is required for all out of network charges, including exceptions.
7. HIA cannot be in the form of direct cash payments to PLWH.
8. HIA funds may not be extended for health insurance plans with costs that exceed local benchmark costs unless special circumstances are present, but not without approval by AA.
9. HIA funds may not be used to pay fines or tax obligations incurred by PLWH for not maintaining health insurance coverage required by the Affordable Care Act (ACA).
10. HIA must not be extended for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage
11. HIA funds may not be used for COBRA coverage if a PLWH is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price.
12. HIA funds cannot be used to cover costs associated with Social Security.
13. Life insurance and other elective policies are not covered.
14. HIA funds may not be used if a PLWH is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price.

Scope of Services:
The Health Insurance Assistance (HIA) service category is intended to help PLWH maintain a continuity of medical benefits without gaps in health insurance coverage or discretion of treatment. This financial assistance program enables eligible individuals who are HIV positive to utilize their existing third party or public assistance (e.g. Medicare) medical insurance, not to exceed the cost of care delivery. Under this provision an agency can provide assistance with health insurance premiums, standalone dental insurance, co-payments, co-insurance, deductibles, Medicare Part D premiums, and tax reconciliation.

Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement is that requirement that requires the insured to pay a percentage of costs for covered services/prescription. Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Tax Reconciliation: A refundable credit will be given on an individual's federal income tax return if the amount of advance-credit payments is *less* than the tax credit they should have received. Conversely, individuals will have to repay any excess advance payments with their tax returns if the advance payments for the year are *more* than the credit amount. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500.

Income Guidelines:
- Marketplace (ACA) Plans: 100-400% of Federal Poverty Level
- All other plans: 0-400% of Federal Poverty Level

Exception: PLWH who were enrolled (and have maintained their plans without a break in coverage), prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.

Program	
1.1 Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine eligibility for this program to ensure that these funds are used as a last resort in order for the PLWH to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health exchange.	• Comprehensive Intake/Assessment documented in the primary services record.
1.2 Cost Effectiveness Assessment The cost of insurance plans must be lower than the cost of providing health services through DSHS-funded delivery of care including costs for participation in the Texas AIDS Drug Assistance Program (ADAP). Agency must	• Cost effectiveness Assessment and results documented in the primary service record.

implement a methodology that incorporates the following requirement: 1. Health Insurance Premium: Agency must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services and only provide assistance when determined to be cost effective. 2. Standalone Dental Premium: Agency must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and only provide assistance when determined to be cost effective	
<u>1.3 Health Insurance Plan Assessment</u> The following criteria must be met for a health plan to be eligible for HIA assistance: 1. Health plans must meet the minimum standards for a Qualified Health Plan and be active at the time assistance is requested. 2. Health Insurance coverage must be evaluated for cost effectiveness. 3. Health insurance plans must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services. 4. COBRA plans must be evaluated based on cost effectiveness and PLWH benefit. Additional Requirements for ACA plans: 1. If a PLWH is between 100%-250% FPL, only SILVER level plans are eligible for HIA payment assistance (unless PLWH enroll prior to November 1, 2015). 2. PLWH under 100% FPL, who present with an ACA plan, are NOT eligible for HIA payment assistance (unless enroll prior to November 1, 2015). 3. All PLWH who present with an ACA plan are required to take the Advanced Premium Tax Credit if eligible (100%-400% of FPL).	• Health Insurance Plan Assessment and results documented in the primary service record.

All PLWH receiving HIA assistance must report any life changes such as income, family size, tobacco use or residence within 30 days of the reported change	
1.4 Payment of Last Resort PLWH accessing services are screened for potential third-party payers or other assistance programs, and that appropriate referrals are made to the provider who can assist PLWH in enrollment.	• Third-party payment screening documented in the primary service record.
1.5 Co-payments, Premiums, Deductibles and Co-Insurance Eligible PLWH with job or employer-based insurance coverage, Qualified Health Plans (QHP), or Medicaid plans, can be assisted in offsetting any cost-sharing programs may impose. PLWH must be educated on the cost and their responsibilities to maintaining medical adherence. Agencies will ensure payments are made directly to the health or dental insurance vendor within five (5) business days of approved request.	• Provision of cost sharing assistance documented in the primary service record • Payments completed and documented in the primary service record within the established timeframe.
1.6 Education Education must be provided to PLWH specific to what is reasonably expected to be paid for by an eligible plan and what RWHAP can assist with to ensure healthcare coverage is maintained. Cost Sharing Education 1. Education is provided to PLWH, as applicable, regarding cost-sharing reductions to lower their out-of-pocket expenses. 2. PLWH who are not eligible for cost-sharing reductions (i.e. PLWH under 100% FPL or above 400% FPL; PLWH who have minimum essential coverage other than individual market coverage and choose to purchase in the marketplace; and those who are ineligible to purchase insurance through the marketplace) are provided education on cost-effective resources available for the PLWH's health care needs. Premium Tax Credit Education 1. Education should be provided to the PLWH regarding tax credits and the requirement to file income tax returns.	• Education, including but not limited to Cost-Sharing and Premium Tax Credit education documented in the primary service record.

2. PLWH must be provided education on the importance of reconciling any Advanced Premium Tax Credit (APTC) well before the IRS tax filing deadline	
1.7 Prescription Eyewear Documentation from physician must be obtained stating that the eye condition is related to the PLWH's HIV infection when HIA funds are used to cover co-pays for prescription eyewear	• Physician statement that the eye condition is related to HIV documented in primary service record.
1.8 Medical Visits PLWH accessing health insurance premium and cost sharing assistance services should demonstrate adherence with their HIV medical or dental care and have documented evidence of attendance of HIV medical or dental appointments in the primary service record. Note: For PLWH who use HIA to enable their use of medical or dental care outside of the RW system: HIA providers are required to maintain documentation of PLWH's adherence to Primary Medical Care (e.g. proof of MD visits) during the previous 12 months	• At least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits documented for PLWH with applicable data in TCT or other data system used at the provider location. • Adherence to Primary Medical Care (e.g. proof of MD visits, insurance Explanation of Benefits, MD bill/invoice) during the previous 12 months documented for PLWH who use HIA to enable their use of medical care outside of the RWHAP system.
1.9 Viral Suppression PLWH receiving Health Insurance Premium and Cost Sharing Assistance services have evidence of viral suppression as documented in viral load testing. *NOTE: Achieving viral suppression is not required to access HIA.*	• Viral Suppression via HIV viral load test during the measurement year documented for PLWH with applicable data in TCT or other data system used at the provider location, percentage of PLWH, regardless of age.
1.10 Referrals and Tracking Program receives referrals from a broad range of HIV service providers, community stakeholders and clinical providers. Program makes appropriate referrals out when necessary.	• Referral source documented in the primary service record. • Referrals made documented in the primary service record
1.11 Waiver Process Waivers from the AA is required for the following circumstances: 1. HIA payment assistance will exceed benchmark for directly delivered services, 2. Providing payment assistance for out of network providers, 3. To fill prescriptions for drugs that incur higher co-pays or co-insurance because they are outside their health plans formulary,	• Approved waiver documented in the primary service record.

4. Discontinuing HIA payment assistance due to PLWH conduct or fraud, 5. Refusing HIA assistance for a PLWH who is eligible and whom HIA provides a cost advantage over direct service delivery, 6. Services being postponed, denied, or a waitlisted, and 7. Assisting an eligible PLWH with the entire cost of a group policy that includes coverage for persons not eligible for HIA payment assistance	
1.12 Vigorous Pursuit Program must vigorously pursue any excess premium tax credit received by the PLWH from the IRS upon submission of the PLWH's tax return. To meet the standard of "*vigorously pursue*", PLWH receiving assistance through RW funded HIP assistance service category to pay for ACA QHP premiums must: 1. Designate premium tax credit be taken in advance during enrollment. 2. Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual ACA open enrollment or renewal. 3. Submit prior year tax information no later than May 31st. 4. Reconciliation of advance premium tax credits or liabilities	• Efforts to conduct vigorous pursuit documented in the primary service record.
Administrative	
2.1 Program Policies and/or Procedures Program will develop and maintain policies and/or procedures that outline the delivery of HIA service including, but not limited to, the marketing of service to applicable community stakeholders, cost-effectiveness and expenditure policy, and PLWH contributions. Program must maintain policies on the assistance that can be offered for PLWH who are covered under a group policy. Program must have P&P in place detailing the required process for reconciliation and documentation requirements. Program must maintain policies and procedures for the vigorous pursuit of excess premium tax credit from individual PLWH, to include measures to track vigorous pursuit performance; and vigorous pursuit of uninsured individuals to enroll in QHP via Marketplace. Program will disseminate policies and/or procedures to providers seeking to utilize the service.	• Program's Policies and Procedures document systems to comply with: ▪ DSHS Universal Standards ▪ TRG Contract and Attachments ▪ Regional Health Insurance Assistance Policy ▪ Standards of Care ▪ Collection of Performance Measures

Additionally, Program will have policies and procedures that comply with applicable DSHS Universal Standards	
2.2 Regional Health Insurance Assistance Policy Program will establish and track all requirements outlined in the DSHS-approved Regional Health Insurance Assistance Policy (HIA-1701).	• Program policies and/or procedures document compliance with Regional HIA Policy. • Program Review documents compliance with Regional HIA Policy.
2.3 Ongoing Staff Training Eight (8) hours annually of continuing education in HIV related or other specific topics including a minimum of two (2) hours training in Affordable Care Act is required, as needed.	• Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.
2.4 Staff Experience A minimum of (1) year documented HIV/AIDS work experience is preferred.	• Work experience documented in personnel file with exceptions to work experience noted.
2.5 Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Supervision of staff members by coordinator or manager documented.
2.6 Decreasing Barriers to Care Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable PLWH of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (I.e. No need for PLWH to physically present to Health Insurance provider.)	• Policies and/or procedure document compliance. • Review of primary service records document compliance. • Staff interviews
2.7 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. Subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

3.8 Trauma-Informed Service Delivery (TISD) Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can exacerbate the physical, mental, and behavioral manifestations of trauma. Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues." Trauma-informed service delivery (TISD) requires that: • Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services. • Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors. • Systems and workflows should be altered to support the environment that promotes trauma-informed care.	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

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- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses

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- Trauma Informed Care: https://www.traumapolicy.org/topics/trauma-informed-care and https://www.nih.gov/

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 QUALITY ASSURANCE MEASURES
HEALTH INSURANCE ASSISTANCE

1. Percentage of PLWH with documented evidence of health care coverage that includes at least one drug in each class of core ART from HHS treatment guidelines along with OAHS and Oral Health Care services that meet the requirements of the ACA law for essential health benefits as indicated in the primary service record.
2. Percentage of PLWH with documented evidence of education provided regarding reasonable expectations of assistance available through RWHAP Health Insurance to assist with healthcare coverage as indicated in the primary service record.
3. Percentage of PLWH with documented evidence of insurance payments made to the vendor within five (5) business days of the approved request.
4. Percentage of PLWH with documented evidence of education provided regarding cost sharing reductions as applicable, as indicated in the primary service record.
5. Percentage of PLWH with documented evidence of education provided regarding premium tax credits as indicated in the primary service record.
6. Percentage of PLWH files with documented evidence, as applicable, of prescribing physician's order relating eye condition warranting prescription eyewear is medically related to the PLWH's HIV as indicated in the primary service record.
7. or PLWH with applicable data in TCT or other data system used at the provider location, percentage of PLWH, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. (HRSA HAB Measure)
8. For PLWH who use HIA to enable their use of medical care outside of the RWHAP system, percentage of PLWH with documentation of PLWH's adherence to Primary Medical Care (e.g. proof of MD visits, insurance Explanation of Benefits, MD bill/invoice) during the previous 12 month.
9. For PLWH with applicable data in TCT or other data system used at the provider location, percentage of PLWH, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.
10. Percentage of PLWH accessing HIA with premium assistance that have activities to comply with the standards of "vigorous pursuit" documented in the primary service record.
11. Percentage of PLWH accessing HIA with cost-sharing services delivered in accordance with the approved prioritization of services documented in the primary service record.

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

Effective Date: April 1, 2024/September 1, 2024

HRSA Definition:
Mental Health (MH) Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to people living with HIV (PLWH). Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized with the state to render such services. Such professionals typically include psychiatrists, advanced practice nurses, psychologists, licensed professional counselors, and licensed clinical social workers.

Limitations: Mental Health Services are allowable only for PLWH who are eligible for HRSA Ryan White HIV/AIDS Program (RWHAP) services.

DSHS Definition:
Mental health counseling services include outpatient mental health therapy and counseling provided solely by mental health practitioners licensed in the State of Texas.

Mental health services include:
- Mental health assessment
- Treatment planning
- Treatment provision
- Individual psychotherapy
- Conjoint psychotherapy
- Group psychotherapy
- Psychiatric medication assessment, prescription, and monitoring
- Psychotropic medication management
- Drop-in psychotherapy groups
- Emergency/crisis intervention

All mental health interventions must be based on proven clinical methods and in accordance with legal, licensing, and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on federal, state, and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI).

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies,

telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance

Local Definition:
Mental Health Services are the provision of outpatient psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers. Mental Health Services include:

- Individual Therapy/counseling is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible PLWH.
- Family/Couples Therapy/Counseling is defined as crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to a family or couple (opposite-sex, same-sex, transgendered or non-gender conforming) that includes an eligible PLWH.
- Support Groups are defined as professionally led (licensed therapists or counselor) groups that comprise PLWH, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for PLWH.

Scope of Services:
Mental health services include mental health assessment; treatment planning; treatment provision; individual psychotherapy; family psychotherapy; conjoint psychotherapy; group psychotherapy; drop-in psychotherapy groups; and emergency/crisis intervention. also included are psychiatric medication assessment, prescription and monitoring and psychotropic medication management.

General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for affected family members or significant others.

Therapy/counseling and/or bereavement counseling may be conducted in the PLWH's home.

Program	
1.1 Orientation Orientation is provided to PLWH who access services to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation will include written or verbal information on the following: • Services available	• Orientation documented in the primary service record • Annual PLWH feedback documents compliance.

• Clinic hours and procedures for after-hours emergency situations • How to reach staff member(s) as appropriate • Scheduling appointments • PLWH responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process	
<u>1.2 Comprehensive Assessment</u> A comprehensive assessment including a psychosocial history will be completed at intake (unless PLWH is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History including HIV treatment and current medications, Death/Dying Issues, Mental Health Status Exam, Suicide/Homicide Assessment, Self-Assessment /Expectations, Education and Employment History, Military History, Parenthood, Alcohol/ Substance Abuse History, Trauma Assessment, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, HIV/STD Risk Assessment, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation. The assessment must document DSM-IV diagnosis or diagnoses, utilizing at least Axis I. The initial and comprehensive PLWH assessment (or agency's equivalent) forms must be signed and dated. Updates to the information included in the initial assessment will be recorded in the comprehensive PLWH assessment.	• Documentation of mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the primary service record • If pressing mental health needs emerge during the mental health assessment requiring immediate attention results in the assessment not being finalized by the third session, the exception must be documented in the primary services record.
<u>1.3 Treatment Plan</u> Treatment plans are developed jointly with the counselor and PLWH and must contain all the elements for mental health including: • Description of the diagnosed mental health issue • Statement of the goal(s) and objectives of counseling • The plan of approach and treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date	• Treatment plan that meets the established criteria documented in the primary service record. • Treatment plans signed by the licensed mental health professional rendering services documented in the primary service record. • Exceptions noted in the primary service record.

• Any recommendations for follow up • Mechanism for review Treatment plans must be completed within 30 days from the Mental Health Assessment. Supportive and educational counseling should include prevention of HIV related risk behaviors including risk reduction and health promotion, substance abuse, treatment adherence, development of social support systems, community resources, maximizing social and adaptive functioning, the role of spirituality and religion in a PLWH's life, disability, death and dying and exploration of future goals as clinically indicated. Treatment plans should include culturally and linguistically appropriate goals. The treatment plan must be signed by the mental health professional rendering service. Electronic signatures are acceptable.	
1.4 Treatment Plan Review Treatment plans are reviewed and modified at a minimum, midway through the number of determined sessions agreed upon for frequency of modality, or more frequently as clinically indicated. The plan must reflect ongoing reassessment of PLWH's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures	• Evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality documented in the primary service record. • Exceptions noted in the primary service record.
1.5 Psychiatric Referral PLWH are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the primary service record.	• Referrals for psychiatric intervention documented in the primary service record.
1.6 Psychotropic Medication Management Psychotropic medication management services are available for all PLWH either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professionals will discuss the PLWH's concerns with the PLWH about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professionals will encourage the PLWH to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health	• Education regarding medications documented in the primary service record. • Changes to psychotropic/ psychoactive medications documented in the primary service record. • Changes to medications shared with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.

professional is not the prescribing clinician) so that medications can be managed effectively. *Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10*	
1.7 Provision of Service/Progress Notes Services will be provided according to the individual's treatment plan and documented in the primary service record. Progress notes are completed according to the agency's standardized format, completed for each counseling session, and must include: • PLWH name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment • Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence	• Service provision in accordance with the individual's treatment plan documented in the primary service record. • Signed progress notes documented in primary service record.
1.8 Coordination of Care Care will be coordinated across the mental health care coordination team members. The PLWH is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the PLWH, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for PLWH who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	• Coordination of care with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.
1.9 Referrals As needed, mental health providers will refer PLWH to full range of medical/mental health services including: • Psychiatric evaluation	• Referrals made documented in the primary service record.

• Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the PLWH's HIV diagnosis In urgent, non-life-threatening circumstances, an appointment will be made within one (1) business day. If an agency cannot provide the needed services, the agency will offer to refer the PLWH to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s)	
1.10 Discharge Services may be discontinued when the PLWH has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period • Continual non-adherence to treatment plan • Chooses to terminate services • Unacceptable patient behavior • Death Discharge planning will be done with each PLWH when treatment goals are met or when PLWH has discontinued therapy either by initiating closure or as evidenced by non-attendance of scheduled appointments, as applicable.	• Discharge reason meeting the established criteria documented in primary service record. • Exceptions documented in the primary service record.
1.11 Discharge Summary Discharge summary is completed for each PLWH after 30 days without PLWH contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements • Date	•
Administrative	
2.1 Program Policies and/or Procedures Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to	• Program's Policies and Procedures document systems to comply with: • DSHS Universal Standards • TRG Contract and Attachments

applicable community stakeholders and process of utilizing Hospice services. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards. The agency must develop and implement Policies and Procedures that include but are not limited to the following: • PLWH neglect, abuse and exploitation including but not limited to definition of terms; reporting to legal authority and funding source; documentation of incident; and follow-up action to be taken • Discharge criteria including but not limited to planned discharge behavior impairment related to substance abuse, danger to self or others (verbal/physical threats, self-discharge) • Changing therapists • Referrals for services the agency cannot perform and reason for referral, criteria for appropriate referrals, timeline for referrals. • Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active PLWH at least once every 6 months.	• Standards of Care • Collection of Performance Measures
<u>2.2 Crisis Situations and Behavioral Emergencies</u> Agency has Policy and Procedures for handling/referring crisis situations and behavioral emergencies either during work hours or if they need after hours assistance, including but not limited to: • verbal intervention • non-violent physical intervention • emergency medical contact information • incident reporting • voluntary and involuntary inpatient admission • follow-up contacts Emergency/crisis intervention policy and procedure must also define emergency situations and the responsibilities of key staff are identified; there must be a procedure in place for training staff to respond to emergencies; and these procedures must be discussed with the PLWH during the orientation process.	• Agency Policy and/or procedure meets established criteria. • Staff Training on the policy is documented. • Crisis situations and behavioral emergencies documented in primary service record.

In urgent, non-life-threatening circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within this time frame, the agency will offer to refer the PLWH to another organization that can provide the requested services.	
2.3 Services Requiring Licensed Personnel Counselors must possess the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC, PhD, Licensed Clinical Psychologist or LMFT as authorized to provide mental health therapy in the relevant practice setting by their licensing authority). Bilingual English/Spanish licensed mental health practitioners must be available to serve monolingual Spanish-speaking PLWH.	• License documented in the personnel file. • Staff interviews document compliance.
2.4 Supervisor Qualifications Supervision is provided by a clinical supervisor qualified by the State of Texas. The agency shall ensure that the Supervisor shall, at a minimal, be a State licensed Masters-level professional (e.g. LPC, LCSW, LMSW, LMFT, PhD, and Licensed Clinical Psychologist) qualified under applicable State licensing standards to provide supervision to the supervisee.	• Clinical supervision qualifications documented in personnel file.
2.5 Family Counseling Experience Professional counselors must have two years' experience in family counseling if providing services to families.	• Work experience documented in personnel file with exceptions to work experience noted.
2.6 Staff Orientation and Education Orientation must be provided to all staff providing direct services to patients within ninety (90) working days of employment, including at a minimum: • Referral for crisis intervention policy/procedures • Standards of Care • Confidentiality • Consumer Rights and Responsibilities • Consumer abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures • Data Management and record keeping; to include documenting in ARIES (or CPCDMS if applicable) Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate continuing education units (CEUs) based on license requirement for each licensed mental health practitioner.	• Completion of orientation documented in personnel file. • Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.

2.7 Substance Abuse Assessment Training Professional counselors must receive training in assessment of substance abuse with capacity to make appropriate referrals to licensed substance abuse treatment programs as indicated within 60 days of start of contract or hire date.	• Assessment documented in personnel file. • Training per assessment documented in personnel file.
2.8 Professional Liability Insurance Professional liability coverage of at least $300,000 for the individual or $1,000,000 for the agency is required.	• Professional Liability Insurance documented. • Annual Reviews documents compliance.
2.9 Clinical Supervision A minimum of bi-weekly supervision is provided to counselors licensed less than three years. A minimum of monthly supervision is provided to counselors licensed three years or more.	• Agency policy documents clinical supervision provided to staff. • Supervision of staff documented.
2.10 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. Subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.
2.7 Trauma-Informed Service Delivery (TISD) Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can exacerbate the physical, mental, and behavioral manifestations of trauma. Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues." Trauma-informed service delivery (TISD) requires that: • Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services. • Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors. • Systems and workflows should be altered to support the environment that promotes trauma-informed care.	

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- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 17-18. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
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- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm

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- Trauma Informed Approaches: https://www.traumapolicy.org/topics/trauma-informed-care
- Trauma Informed Care: https://www.traumapolicy.org/topics/trauma-informed-care and https://www.nih.gov/

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 QUALITY ASSURANCE MEASURES
MENTAL HEALTH SERVICES

1. Percentage of new PLWH with documented evidence of orientation to services available in the primary service record.
2. Percentage of PLWH with documented mental health assessment completed by the third counseling session, unless otherwise noted, in the primary service record.
3. Percentage of PLWH with documented detailed treatment plan and documentation of services provided within the primary service record.
4. Percentage of PLWH with treatment plans completed and signed by the licensed mental health professional rendering services in the primary service record.
5. Percentage of PLWH with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the primary service record.
6. Percentage of PLWH with documented need for psychiatric intervention are referred to services as evidenced in the primary service record.
7. Percentage of PLWH accessing medication management services with documented evidence in the primary service record of education regarding medications.
8. Percentage of PLWH with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.
9. Percentage of PLWH with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the primary service record.
10. Percentage of PLWH who have documented evidence in the primary service record of care coordination, as permissible, of shared mental health treatment adherence with the PLWH's prescribing provider.
11. Percentage of PLWH with documented referrals, as applicable, for other medical/mental health services in the primary service record.
12. Percentage of PLWH with documentation of discharge planning when treatment goals being met as evidenced in the primary service record.
13. Percentage of PLWH with documentation of case closure per agency non-attendance policy as evidenced in the primary service record.

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES TARGETING SPECIAL POPULATIONS

Effective Date: April 1, 2024/September 1, 2024

HRSA Definition:
Mental Health (MH) Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to people living with HIV (PLWH). Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized with the state to render such services. Such professionals typically include psychiatrists, advanced practice nurses, psychologists, licensed professional counselors, and licensed clinical social workers.

Limitations: Mental Health Services are allowable only for PLWH who are eligible for HRSA Ryan White HIV/AIDS Program (RWHAP) services.

DSHS Definition:
Mental health counseling services include outpatient mental health therapy and counseling provided solely by mental health practitioners licensed in the State of Texas.

Mental health services include:
- Mental health assessment
- Treatment planning
- Treatment provision
- Individual psychotherapy
- Conjoint psychotherapy
- Group psychotherapy
- Psychiatric medication assessment, prescription, and monitoring
- Psychotropic medication management
- Drop-in psychotherapy groups
- Emergency/crisis intervention

All mental health interventions must be based on proven clinical methods and in accordance with legal, licensing, and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on federal, state, and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI).

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies,

telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance

Local Definition:
Mental Health Services are the provision of outpatient psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers. Mental Health Services include:

- Individual Therapy/counseling is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible PLWH.
- Family/Couples Therapy/Counseling is defined as crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to a family or couple (opposite-sex, same-sex, transgendered or non-gender conforming) that includes an eligible PLWH.
- Support Groups are defined as professionally led (licensed therapists or counselor) groups that comprise PLWH, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for PLWH.

These targeted mental health services should be delivered to people living with HIV and affected family/partners living within the Houston HIV Service Delivery Area (HSDA). PLWH should also be a member of the following special populations: Transgender persons (emphasizing those who are LatinX/Black and/or under the age of 25), individuals who exchange sex for money, and individuals born outside the US.

Scope of Services:
Mental health services include mental health assessment; treatment planning; treatment provision; individual psychotherapy; family psychotherapy; conjoint psychotherapy; group psychotherapy; drop-in psychotherapy groups; and emergency/crisis intervention. Also included are psychiatric medication assessment, prescription and monitoring and psychotropic medication management.

General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for affected family members or significant others.

Therapy/counseling and/or bereavement counseling may be conducted in the PLWH's home.

Program	
1.1 Orientation	• Orientation documented in the primary service record

Orientation is provided to PLWH who access services to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation will include written or verbal information on the following: • Services available • Clinic hours and procedures for after-hours emergency situations • How to reach staff member(s) as appropriate • Scheduling appointments • PLWH responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process	• Annual PLWH feedback documents compliance.
1.2 Comprehensive Assessment A comprehensive assessment including a psychosocial history will be completed at intake (unless PLWH is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History including HIV treatment and current medications, Death/Dying Issues, Mental Health Status Exam, Suicide/Homicide Assessment, Self-Assessment /Expectations, Education and Employment History, Military History, Parenthood, Alcohol/ Substance Abuse History, Trauma Assessment, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, HIV/STD Risk Assessment, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation. The assessment must document DSM-IV diagnosis or diagnoses, utilizing at least Axis I. The initial and comprehensive PLWH assessment (or agency's equivalent) forms must be signed and dated. Updates to the information included in the initial assessment will be recorded in the comprehensive PLWH assessment.	• Documentation of mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the primary service record • If pressing mental health needs emerge during the mental health assessment requiring immediate attention results in the assessment not being finalized by the third session, the exception must be documented in the primary services record.
1.3 Treatment Plan Treatment plans are developed jointly with the counselor and PLWH and must contain all the elements for mental health including: • Description of the diagnosed mental health issue • Statement of the goal(s) and objectives of counseling	• Treatment plan that meets the established criteria documented in the primary service record. • Treatment plans signed by the licensed mental health professional rendering services documented in the primary service record.

• The plan of approach and treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up • Mechanism for review Treatment plans must be completed within 30 days from the Mental Health Assessment. Supportive and educational counseling should include prevention of HIV related risk behaviors including risk reduction and health promotion, substance abuse, treatment adherence, development of social support systems, community resources, maximizing social and adaptive functioning, the role of spirituality and religion in a PLWH's life, disability, death and dying and exploration of future goals as clinically indicated. Treatment plans should include culturally and linguistically appropriate goals. The treatment plan must be signed by the mental health professional rendering service. Electronic signatures are acceptable.	• Exceptions noted in the primary service record.
<u>1.4 Treatment Plan Review</u> Treatment plans are reviewed and modified at a minimum, midway through the number of determined sessions agreed upon for frequency of modality, or more frequently as clinically indicated. The plan must reflect ongoing reassessment of PLWH's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures	• Evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality documented in the primary service record. • Exceptions noted in the primary service record.
<u>1.5 Psychiatric Referral</u> PLWH are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the primary service record.	• Referrals for psychiatric intervention documented in the primary service record.
<u>1.6 Psychotropic Medication Management</u> Psychotropic medication management services are available for all PLWH either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services.	• Education regarding medications documented in the primary service record. • Changes to psychotropic/ psychoactive medications

Mental health professional will discuss the PLWH's concerns with the PLWH about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the PLWH to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively. *Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10*	documented in the primary service record. • Changes to medications shared with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.
1.7 Provision of Service/Progress Notes Services will be provided according to the individual's treatment plan and documented in the primary service record. Progress notes are completed according to the agency's standardized format, completed for each counseling session, and must include: • PLWH name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment • Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence	• Service provision in accordance with the individual's treatment plan documented in the primary service record. • Signed progress notes documented in primary service record.
1.8 Coordination of Care Care will be coordinated across the mental health care coordination team members. The PLWH is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the PLWH, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for PLWH who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding	• Coordination of care with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.

medication management, interactions, and treatment adherence.	
1.9 Referrals As needed, mental health providers will refer PLWH to full range of medical/mental health services including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the PLWH's HIV diagnosis In urgent, non-life-threatening circumstances, an appointment will be made within one (1) business day. If an agency cannot provide the needed services, the agency will offer to refer the PLWH to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s)	• Referrals made documented in the primary service record.
1.10 Discharge Services may be discontinued when the PLWH has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period • Continual non-adherence to treatment plan • Chooses to terminate services • Unacceptable patient behavior • Death Discharge planning will be done with each PLWH when treatment goals are met or when PLWH has discontinued therapy either by initiating closure or as evidenced by non-attendance of scheduled appointments, as applicable.	• Discharge reason meeting the established criteria documented in primary service record. • Exceptions documented in the primary service record.
1.11 Discharge Summary Discharge summary is completed for each PLWH after 30 days without PLWH contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements	•

• Date	
Administrative	
2.1 Program Policies and/or Procedures Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing Hospice services. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards. The agency must develop and implement Policies and Procedures that include but are not limited to the following: • PLWH neglect, abuse and exploitation including but not limited to definition of terms; reporting to legal authority and funding source; documentation of incident; and follow-up action to be taken • Discharge criteria including but not limited to planned discharge behavior impairment related to substance abuse, danger to self or others (verbal/physical threats, self-discharge) • Changing therapists • Referrals for services the agency cannot perform and reason for referral, criteria for appropriate referrals, timeline for referrals. • Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active PLWH at least once every 6 months.	• Program's Policies and Procedures document systems to comply with: • DSHS Universal Standards • TRG Contract and Attachments • Standards of Care • Collection of Performance Measures
2.2 Crisis Situations and Behavioral Emergencies Agency has Policy and Procedures for handling/referring crisis situations and behavioral emergencies either during work hours or if they need after hours assistance, including but not limited to: • verbal intervention • non-violent physical intervention • emergency medical contact information • incident reporting • voluntary and involuntary inpatient admission • follow-up contacts	• Agency Policy and/or procedure meets established criteria. • Staff Training on the policy is documented. • Crisis situations and behavioral emergencies documented in primary service record.

Emergency/crisis intervention policy and procedure must also define emergency situations and the responsibilities of key staff are identified; there must be a procedure in place for training staff to respond to emergencies; and these procedures must be discussed with the PLWH during the orientation process. In urgent, non-life-threatening circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within this time frame, the agency will offer to refer the PLWH to another organization that can provide the requested services.	
2.3 Services Requiring Licensed Personnel Counselors must possess the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC, PhD, Licensed Clinical Psychologist or LMFT as authorized to provide mental health therapy in the relevant practice setting by their licensing authority). Bilingual English/Spanish licensed mental health practitioners must be available to serve monolingual Spanish-speaking PLWH.	• License documented in the personnel file. • Staff interviews document compliance.
2.4 Supervisor Qualifications Supervision is provided by a clinical supervisor qualified by the State of Texas. The agency shall ensure that the Supervisor shall, at a minimal, be a State licensed Masters-level professional (e.g. LPC, LCSW, LMSW, LMFT, PhD, and Licensed Clinical Psychologist) qualified under applicable State licensing standards to provide supervision to the supervisee.	• Clinical supervision qualifications documented in personnel file.
2.5 Family Counseling Experience Professional counselors must have two years' experience in family counseling if providing services to families.	• Work experience documented in personnel file with exceptions to work experience noted.
2.6 Staff Orientation and Education Orientation must be provided to all staff providing direct services to patients within ninety (90) working days of employment, including at a minimum: • Referral for crisis intervention policy/procedures • Standards of Care • Confidentiality • Consumer Rights and Responsibilities • Consumer abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures	• Completion of orientation documented in personnel file. • Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.

• Data Management and record keeping; to include documenting in ARIES (or CPCDMS if applicable) Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate continuing education units (CEUs) based on license requirement for each licensed mental health practitioner.	
2.7 Substance Abuse Assessment Training Professional counselors must receive training in assessment of substance abuse with capacity to make appropriate referrals to licensed substance abuse treatment programs as indicated within 60 days of start of contract or hire date.	• Assessment documented in personnel file. • Training per assessment documented in personnel file.
2.8 Professional Liability Insurance Professional liability coverage of at least $300,000 for the individual or $1,000,000 for the agency is required.	• Professional Liability Insurance documented. • Annual Reviews documents compliance.
2.9 Clinical Supervision A minimum of bi-weekly supervision is provided to counselors licensed less than three years. A minimum of monthly supervision is provided to counselors licensed three years or more.	• Agency policy documents clinical supervision provided to staff. • Supervision of staff documented.
2.10 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. All AAs and subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.
2.11 Trauma-Informed Service Delivery (TISD) Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

exacerbate the physical, mental, and behavioral manifestations of trauma. Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues." Trauma-informed service delivery (TISD) requires that: • Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services. • Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors. • Systems and workflows should be altered to support the environment that promotes trauma-informed care.	
2.12 Collaborative Relationships The agency must develop collaborative relationships with community partners that serve each of the identified special populations. These relationships should be documented via Memoranda of Understanding. MOUs will be submitted to TRG for review each year. Referrals should be tracked to evidence the success of these MOUs. Referrals will be reviewed by TRG on an annual basis.	• Executed MOUs are submitted for review to TRG. • Referrals are documented and tracked by the agency. Referral tracking is available for review by TRG and meets expectations.
2.13 Specialized Training Staff should be adequately trained and/or experienced with each of the identified special populations. Training and/or experience should be documented. This documentation will be reviewed by TRG on an annual basis.	• Staff training is documented, available for review by TRG and meets expectations.
2.14 Community Based Approach Services are strongly encouraged to be community based where counseling can be provided in a safe and secure location. Services should be provided on days and at	• Policies and procedures support a community-based approach.

times that are conducive for participation of the identified special populations.	• Primary service records document when services are provided in the community.

References

- American Psychiatric Association. The Practice Guideline for Treatment of Patients with HIV/AIDS, Washington, DC, 2001. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/hivaids.pdf
- American Psychiatric Association. Guideline Watch: Practice Guideline for the Treatment of Patients with HIV/AIDS, Washington, DC, 2006. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/hivaids-watch.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 17-18. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 17-18. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18). Available at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm
- New York State Department of Health, Mental Health Standards of Care, Delivery of Care. Available at: https://www.health.ny.gov/diseases/aids/providers/standards/mental_health/delivery_of_care.htm
- Trauma Informed Approaches: https://www.traumapolicy.org/topics/trauma-informed-care
- Trauma Informed Care: https://www.traumapolicy.org/topics/trauma-informed-care and https://www.nih.gov/

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 QUALITY ASSURANCE MEASURES
MENTAL HEALTH SERVICES

1. Percentage of new PLWH with documented evidence of orientation to services available in the primary service record.
2. Percentage of PLWH with documented mental health assessment completed by the third counseling session, unless otherwise noted, in the primary service record.
3. Percentage of PLWH with documented detailed treatment plan and documentation of services provided within the primary service record.
4. Percentage of PLWH with treatment plans completed and signed by the licensed mental health professional rendering services in the primary service record.
5. Percentage of PLWH with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the primary service record.
6. Percentage of PLWH with documented need for psychiatric intervention are referred to services as evidenced in the primary service record.
7. Percentage of PLWH accessing medication management services with documented evidence in the primary service record of education regarding medications.
8. Percentage of PLWH with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the PLWH's signed consent to share information, in the primary service record.
9. Percentage of PLWH with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the primary service record.
10. Percentage of PLWH who have documented evidence in the primary service record of care coordination, as permissible, of shared mental health treatment adherence with the PLWH's prescribing provider.
11. Percentage of PLWH with documented referrals, as applicable, for other medical/mental health services in the primary service record.
12. Percentage of PLWH with documentation of discharge planning when treatment goals being met as evidenced in the primary service record.
13. Percentage of PLWH with documentation of case closure per agency non-attendance policy as evidenced in the primary service record.

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
ORAL HEALTH CARE

Effective Date: April 1, 2024/September 1, 2024

HRSA Definition:
Oral Health Care (OH) activities include outpatient diagnostics, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

DSHS Definition:
Services will include routine dental examinations, prophylaxes, radiographs, restorative therapies, basic oral surgery (e.g., extractions and biopsy), endodontics, and prosthodontics. Referral for specialized care should be completed if clinically indicated.

Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a PLWH's annual benefit balance.

Oral health services are an allowable core service with an expenditure cap of $3,000/PLWH per calendar year. Local service regions may set additional limitations on the type or number of procedures covered and/or may set a lower expenditure cap, so long as such criteria are applied equitably across the region and the limitations do not restrict eligible individuals from receiving needed oral health services outlined in their individualized dental treatment plan.

In the cases of emergency need and/or where extensive care is needed, the maximum amount may exceed the above cap. Dental providers are required to document the reason for exceeding the yearly maximum amount and must have documented approval from the local Administrative Agency (AA) for the purposes of funds only, but not the appropriateness of the clinical procedure.

Limitations: Cosmetic dentistry for cosmetic purposes only is prohibited.

Local Definition:
Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Scope of Services:
Oral Health Care as "diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers". The Ryan White Part A/B oral health care services include standard preventive procedures, routine dental examinations, diagnosis and treatment of HIV-related oral pathology, restorative dental services, root canal therapy, prophylaxis, x-rays, fillings, and basic oral surgery (simple extractions), endodontics and oral medication (including pain control) for HIV PLWH 15 years old or older based on a comprehensive individual treatment plan. Referral for specialized care should be completed if clinically indicated.

Additionally, the category includes prosthodontics services including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.

Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a PLWH's annual benefit balance. If a provider cannot provide adequate services for emergency care, the PLWH should be referred to a hospital emergency room.

Limitations:
Cosmetic dentistry for cosmetic purposes only is prohibited.

Tele-dentistry allowable per H.B. 2056 as of September 1, 2021 and subject to applicable rules and guidance from the Board (see References).

Standard	Evidence
Program	
1.1 Dental and Medical History To develop an appropriate treatment plan, the oral health care provider should obtain complete information about the PLWH's health and medication status. Provider obtains and documents HIV primary care provider contact information for each PLWH. Provider obtains from the primary care provider or obtains from the health history information with updates as medically appropriate prior to providing care. This information should include, but not be limited to, the following: • A baseline current (within in last 12 months) CBC laboratory test • Current (within the last 12 months) CD4 and Viral Load laboratory test results or more frequent when clinically indicated • Coagulants (PT/INR, aPTT, and if hemophiliac baseline deficient factor level (e.g., Factor VIII activity) and inhibitor titer (e.g., BIA) • Tuberculosis screening result • PLWH's chief complaint, where applicable • Current Medications (including any osteoporotic medications) • Pregnancy status, where applicable • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis A, B, C status • Usual oral hygiene	• Dental and medical health history per established criteria documented in primary service record. • Health history update per established timeframe documented in primary service record.

• Date of last dental examination • Involuntary weight loss or weight gain • Review of systems • Any predisposing conditions that may affect the prognosis, progression and management of oral health condition. An update to the health history should be completed as medically indicated or at least annually.	
1.2 Limited Physical Exam Initial limited physical examination should include, but shall not necessarily be limited to, blood pressure, and pulse/heart rate as may be indicated for each PLWH according to the Texas Board of Dental Examiners. Dental provider will obtain an initial baseline blood pressure/pulse reading during the initial limited physical examination of a PLWH. Dental practitioner should also record blood pressure and pulse heart rate as indicated for invasive procedures involving sedation and anesthesia. If the dental practitioner is unable to obtain a PLWH's vital signs, the dental practitioner must document in the primary service record an acceptable reason why the attempt to obtain vital signs was unsuccessful.	• Limited physical examination per established criteria documented in the primary service record. • Exceptions documented in the primary service record.
1.3 Oral Examination PLWH must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year such as: • D0150-Comprehensive oral evaluation, to include bitewing x-rays, new or established PLWH • D0120-Periodic Oral Evaluation to include bitewing x-rays, established PLWH, • D0160-Detailed and Extensive Oral Evaluation • D0170-Re-evaluation, limited, problem focused (established PLWH; not post-operative visit) • Comprehensive Periodontal Evaluation, new or established PLWH. Source: http://ada.org	• Oral examination per established criteria documented in the primary service record. • Exceptions documented in the primary service record.
1.4 Comprehensive Periodontal Examination Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines. PLWH must have a periodontal screening once per year. A periodontal screen shall include the assessment of medical and dental histories, the quantity and quality of attached gingival, bleeding, tooth mobility, and radiological review of the status of the periodontium and dental implants.	• Agency policies and/or procedures document when a comprehensive periodontal examination should occur. • Comprehensive periodontal examination per established criteria documented in the primary service record. • Exceptions documented in the primary service record.

Comprehensive periodontal examination (ADA CDT D0180) includes: • Evaluation of periodontal conditions • Probing and charting • Evaluation and recording of the PLWH's dental and medical history and general health assessment. • It may include the evaluation and recording or dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. (Some forms of periodontal disease may be more severe in individuals affected with immune system disorders. PLWH may have especially severe forms of periodontal disease. The incidence of necrotizing periodontal diseases may increase with PLWH).	
<u>1.5 Treatment Plan</u> A dental treatment plan should be developed appropriate for the PLWH's health status, financial status, and individual preference should be chosen. A comprehensive, multi-disciplinary treatment plan will be developed and updated in conjunction with the PLWH. PLWH's primary reason for dental visit should be addressed in treatment plan. Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions. A comprehensive dental treatment plan that includes preventive care, maintenance and elimination of oral pathology will be developed and updated annually. Various treatment options should be discussed and developed in collaboration with the PLWH. The plan should include culturally and linguistically appropriate goals. Treatment plan should include as clinically indicated: • Provision for the relief of pain • Elimination of infection • Preventive plan component • Periodontal treatment plan if necessary • Elimination of caries • Replacement or maintenance of tooth space or function • Consultation or referral for conditions where treatment is beyond the scope of services offered • Determination of adequate recall interval. • Invasive Procedure Risk Assessment (prior to oral surgery, extraction, or other invasive procedure) • Dental treatment plan will be signed by the oral care health professional providing the services. (*Electronic signatures are acceptable*) Dental treatment plan will be updated annually.	• Treatment plan per established criteria documented in primary service record. • Updated dental treatment plan per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.

1.6 Phase 1 Treatment Plan In accordance with the National Monitoring Standards a Phase 1 treatment plan includes prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. Phase 1 treatment plan will be established and updated annually to include what diagnostic, preventative, and therapeutic services will be provided. Phase 1 treatment plan will be established within 12 months of initial assessment. The plan should include culturally and linguistically appropriate goals. Treatment plan should include as clinically indicated: • Restorative treatment • Basic periodontal therapy (non-surgical) • Basic oral surgery (simple extractions and biopsy) • Non-surgical endodontic therapy • Maintenance of tooth space • Tooth eruption guidance for transitional dentition The Phase 1 treatment plan, if the care was completed on schedule, is completed within 12 months of initiating treatment.	• Phase 1 treatment plan per stablished criteria documented in the primary service record. • Phase 1 treatment plan per established timeframe documented in the primary service record. • Completion of Phase 1 treatment plan per established timeframe documented in the primary service record. • Updated Phase 1 treatment plan per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.
1.7 ~~Annual~~ Hard/Soft Tissue Examination The following elements are part of each PLWH's annual hard/soft tissue examination and are documented in the primary service record: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan. Determination of PLWH needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all PLWH may not exceed two (2) years.	• Hard/soft tissue examination per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.
1.8 Oral Health Education Oral health education may be provided and documented by a licensed dentist, dental hygienist, dental assistant and/or dental case manager. Provider must provide oral health education once each year which includes but is not limited to the following: • D1330 Oral hygiene instructions • Daily brushing and flossing (or other interproximal cleaning) and/or prosthetic care to remove plaque; • Daily use of over-the-counter fluorides to prevent or reduce cavities when appropriate and applicable to the	• Oral health education per established criteria documented in the primary service record. • Oral health education per established timeframe documented in the primary services record. • Exceptions documented in the primary service record.

PLWH. If deemed appropriate, the reason is stated in the primary service record • D1320 Smoking/tobacco cessation counseling as indicated • Additional areas for instruction may include Nutrition (D1310). • For pediatric PLWH, oral health education should be provided to parents and caregivers and be age appropriate for pediatric PLWH. The content of the oral health education will be documented in the primary service record.	
1.9 Referrals and Tracking Referrals for other services must be documented in the primary service record. Outcome of the referral will be documented in the primary service record.	• Referrals made documented in the primary service record. • Outcome of referrals documented in primary service record.
1.10 Coordination of Care The provider will consult with PLWH's medical care providers when indicated. Consultations will be documented in the primary service record.	• Consultations documented in the primary service record.
1.12 Annual Cap of Charges Maximum amount that may be funded by Ryan White/State Services per PLWH is $3,000/year. • In cases of emergency, the maximum amount may exceed the above cap • In cases where there is extensive care needed once the procedure has begun, the maximum amount may exceed the above cap. • Dental providers must document ***via approved waiver*** the reason for exceeding the yearly maximum amount.	• Approved waiver for charges exceeding annual cap documented in the primary service record.
1.10 Explanation of Charges As part of the delivery of services, any charges that need to be paid by the PLWH should be explained. It is preferred that the PLWH is given the explanation of charges in writing as well as providing it verbally. All explanations of charges should include the explanation that services may not be denied due to an inability to pay.	• Documentation of the explanation of charges present in primary service records reviewed. • PLWH interviews indicate compliance. • Staff interviews indicate compliance.
Administrative	

2.1 Program Policies and/or Procedures
Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing the service. Agency will disseminate policies and/or procedures to providers seeking to utilize the service.
 	
Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards
	• Program's Policies and Procedures document systems to comply with:
	  • DSHS Universal Standards
	  • TRG Contract and Attachments
	  • Standards of Care
	  • Collection of Performance Measures

2.2 Services Requiring Licensed Personnel	• License documented in the personnel file.

All oral health care professionals, such as general dental practitioners, dental specialists, and dental hygienists shall be properly licensed by the State of Texas Board of Dental Examiners while performing tasks that are legal within the provisions of the Texas Dental Practice including satisfactory arrangements for malpractice insurance. Dental Assistants who make x-rays in Texas must register with the State Board of Dental Examiners. Dental hygienists and assistants will be supervised by a licensed dentist. Students enrolled in a College of Dentistry may perform tasks under the supervision.	• Staff interviews document compliance.
2.3 Continuing Education • Eight (8) hours of training in HIV/AIDS and clinically related issues is required annually for licensed staff. • One (1) hour of training in HIV/AIDS is required annually for all other staff.	• Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.
2.4 Staff Experience Service provider should employ individuals experienced in dental care and knowledgeable in the area of HIV/AIDS dental practice. A minimum of one (1) year documented HIV/AIDS work experience is preferred for licensed staff.	• Work experience documented in personnel file with exceptions to work experience noted.
2.5 Supervisor Qualifications Supervision of clinical staff shall be provided by a practitioner with at least two years' experience in dental health assessment and treatment of persons living with HIV.	• Clinical supervision qualifications documented in personnel file.
2.6 Staff Supervision All licensed personnel shall receive supervision consistent with the State of Texas license requirements.	• Agency policy documents clinical supervision provided to staff. • Supervision of staff documented.
2.7 Confidentiality Each dental employee will sign a confidentiality statement.	• Signed Confidentiality Statement documented in personnel file.
2.8 Universal Precautions All health care workers should adhere to protective practices as defined by Texas Administrative Code, Title 22, Part 5, Chapter 108, Subchapter B, Rule §108.25, and OSHA Standards for Bloodborne Pathogens (29 CFR 1910.1030), and OSHA Personal Protective Equipment (29 CFR 1910 Sub Part 1.	• Staff training documented in personnel file. • Staff interviews document compliance.
2.9 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

Subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	
2.10 Trauma-Informed Service Delivery (TISD) Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can exacerbate the physical, mental, and behavioral manifestations of trauma. Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues." Trauma-informed service delivery (TISD) requires that: • Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services. • Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors. • Systems and workflows should be altered to support the environment that promotes trauma-informed care.	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

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- HB2056: https://capitol.texas.gov/BillLookup/History.aspx?LegSess=87R&Bill=HB2056
- Trauma Informed Approaches: https://www.traumapolicy.org/topics/trauma-informed-care
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RYAN WHITE PART B/DSHS STATE SERVICES
24-25 QUALITY ASSURANCE MEASURES
ORAL HEALTH CARE

1. Percentage of PLWH with documented evidence that oral health care services provided met the specific limitations or caps as set forth for dollar amount and any additional limitations as set regionally for type of procedure, limits on number of procedures or combination of these.
2. Percentage of PLWH with documented evidence if the cost of dental care exceeded the annual maximum amount for Ryan White/State Services funding, reason is documented in the primary service record.
3. Percentage of PLWH who had a dental and medical health history (initial or updated) at least once in the measurement year.
4. Percentage of PLWH with a documented limited physical examination completed in the primary service record.
5. Percentage of PLWH with a documented oral examination completed within the measurement year in the primary service record.
6. Percentage of PLWH who had a periodontal screen or examination as least once in the measurement year.
7. Percentage of oral health PLWH who had a dental treatment plan developed and/or updated at least once in the measurement year.
8. Percentage of PLWH with a Phase 1 treatment plan that is completed within 12 months.
9. Percentage of PLWH who received oral health education at least once in the measurement year.
10. Percentage of PLWH with documented referrals provided have outcomes and/or follow-up documentation in the primary service record.

RYAN WHITE PART B/DSHS STATE SERVICES
24-25 HOUSTON HSDA STANDARDS OF CARE
NON-MEDICAL CASE MANAGEMENT TARGETING
SUBSTANCE USE DISORDERS

Effective Date: April 1, 2024/September 1, 2024

HRSA Definition:
Non-Medical Case Management Services (NMCM) is the provision of a range of person-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM services may also include assisting eligible people living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. health insurance Marketplace plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

DSHS Definition:
Non-Medical Case Management is a service based on need and is not appropriate or necessary for every PLWH accessing services. Non-Medical Case Management is designed to serve individuals who are unable to access, and maintain in, systems of care on their own (medical and social). Non-Medical Case Management should not be used as the only access point for medical care and other agency services. People living with HIV (PLWH) who do not need guidance and assistance in improving/gaining access to needed services should not be enrolled in NMCM services. When PLWH can maintain their care, PLWH should be graduated. PLWH with ongoing existing needs due to impaired cognitive functioning, legal issues, or other documented concerns meet the criteria for NMCM services.

Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

Services: Non-Medical Case Management services provide guidance and assistance to PLWH to help them to access needed services (medical, social, community, legal, financial, and other needed services), but may not analyze the services to enhance their care toward improving their health outcomes.

Key activities include:
- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Individualized advocacy and/or review of utilization of services

- Continuous monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every six (6) months with adaptations as necessary
- Ongoing assessment of the PLWH's and other key family members' needs and personal support systems

In addition to providing the psychosocial services above, Non-Medical Case Management may also provide benefits counseling by assisting eligible PLWH in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges)

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies, telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance.

Local Definition:
Non-Medical Case Management Services (N-MCM) Targeting Substance Use Disorders (SUD) provides guidance and assistance in accessing medical, social, community, legal, financial, and other needed services to eligible PLWHs facing the challenges of substance use disorder. Non-Medical Case management services may also include assisting PLWHs to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program.

Scope of Service
The purpose of Non-Medical Case Management (N-MCM) Services targeting Substance Use Disorders (SUD) is to assist people living with HIV (PLWH) who are also facing the challenges of substance use disorder to procure needed services so that the problems associated with living with HIV and/or SUD are mitigated.

N-MCM targeting SUD is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is community based (i.e. both office-based and field based). N-MCMs are expected to coordinate activities with referral sources where newly diagnosed PLWH or PLWH who have disengaged from care may be identified, including

substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes activities to re-engage PLWH who have disengaged from care. PLWHs who have disengaged from care are those who have not returned for scheduled appointments with a medical and/or the NMCM provider. NMCM must document efforts to re-engage PLWH who have disengaged from care prior to closing PLWH on their caseload. There are many reasons why PLWH disengage from care. NMCM should partner with the PLWH to determine how to address those reasons as part of re-engagement. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are facing the challenges of SUD.

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every six (6) months with adaptations as necessary
- Ongoing assessment of the PLWH's and other key family members' needs and personal support systems

Non-Medical Case Management is a service based on need and is not appropriate or necessary for every PLWH accessing services. Non-Medical Case Management is designed to serve individuals who are unable to access, and maintain in, systems of care on their own (medical and social). Non-Medical Case Management **should not** be used as the only access point for medical care and other agency services. PLWH who do not need guidance and assistance in improving/gaining access to needed services **should not** be enrolled in NMCM services. When PLWH can maintain their care, they should be graduated. PLWH with ongoing existing needs due to impaired cognitive functioning, legal issues, or other documented concerns meet the criteria for NMCM services.

Case Management services provided via telehealth platforms are eligible for reimbursement.

Limitations:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes. Non-Medical Case Management services **do not** involve coordination and follow up of medical treatments.

Direct Medical Costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.

Standard	Evidence
Program	
1.1 Eligibility for Services N-MCM targeting SUD is intended to serve eligible PLWH who are also facing the challenges of substance use disorder	• Additional eligibility criteria documented in primary service record.

1.2 Initial Assessment The Initial Assessment is required for PLWHs who are enrolled in Non-Medical Case Management (N-MCM) services. It expands upon the information gathered during the intake phase to provide the broader base of knowledge needed to address complex, longer- standing access and/or barriers to medical and/or psychosocial needs. The thirty (30) day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information: b) PLWH's support service status and needs related to: • Nutrition/Food bank • Financial resources and entitlements • Housing • Transportation • Support systems • Partner Services and HIV disclosure • Identification of vulnerable populations in the home (i.e. children, elderly and/or disabled) and assessment of need (e.g. food, shelter, education, medical, safety (CPS/APS referral as indicated) • Family Violence • Legal needs (ex. Health care proxy, living will, guardianship arrangements, landlord/tenant disputes, SSDI applications) • Linguistic Services, including interpretation and translation needs • Activities of daily living • Knowledge, attitudes and beliefs about HIV disease • Sexual health assessment and risk reduction counseling • Employment/Education c) Additional information • PLWH strengths and resources • Other agencies that serve PLWH and household • Brief narrative summary of assessment session(s) Reassessments should be conduct at least annually for PLWH remaining in case management services.	• Completed Initial Assessment is documented in the primary service record. • Assessment completed within thirty (30) days of the initiation of case management services. • Any special circumstances for not completing the Initial Assessment with thirty (30) day timeframe are noted in the primary service record. • Annual Reassessments are documented in the primary service record.
1.3 Care Planning The PLWH and the N-MCM will actively work together to develop and implement the care plan. Care plans include at a minimum: • Problem Statement (Need)	• Completed initial Care Plan documented in the primary service record. • Updated Care Plans documented in the primary service record.

• Goal(s) – suggest no more than three goals
• Intervention
  o Task(s)
  o Assistance in accessing services (types of assistance)
  o Service Deliveries
• Individuals responsible for the activity (N-MCM, PLWH, other team member, family)
• Anticipated time for each task
• PLWH acknowledgment
 	
The care plan is updated with outcomes and revised or amended in response to changes in access to care and services at a minimum every six (6) months. Tasks, types of assistance in accessing services, and services should be updated as they are identified or completed – not at set intervals. Discharge plans should have culturally and linguistically appropriate goals.	

<u>1.4 Transtheoretical Model of Change</u> N-MCMs shall use the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change) to promote improved health outcomes and achievement of care plan goals.	• Stage of Change documented in the primary service record. • Incorporation of Stage of Change incorporated into the Care Plans in the primary service record.
<u>1.5 Referrals and Tracking</u> N-MCM will work with the PLWH to determine barriers to accessing services and will assist in accessing needed services. N-MCM will ensure that PLWH are accessing needed services and will identify and resolve any barriers PLWH may have in following through with their Care Plan. When PLWHs are assisted with referral for services, the referral should be documented and tracked. Referrals will be documented in the primary service record and, at a minimum, should include referrals for services such as: OAHS, MCM, Medical transportation, Mental Health, Substance Use Treatment, and any additional services necessary to help PLWH engage in their medical care. All referrals made will have documentation of follow-up in the primary service record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the N-MCM offered to the PLWH.	• Referrals to service are documented in the primary service record. • Referral follow-up and outcome documented in the primary service record.

1.6 Increase Health Literacy N-MCM assesses PLWH ability to navigate medical care systems and provides education to increase PLWH ability to advocate for themselves in medical care systems.	• Health Literacy assessment documented in the primary service record. • Health Literacy education documented in the primary service record • Knowledge, Attitudes, and Practice (KAP) evaluation documented in the primary service record.
1.7 Overdose Prevention & SUD Reduction N-MCMs should provide activities, strategies and education that enhance the motivation of PLWH to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors.	• Provision of overdose prevention and SUD reduction education and activities documented in primary service record.
1.8 Substance Use Treatment N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations.	• Treatment or other recovery support services discussion and education documented in primary service record. • Referrals to treatment or other recovery support services documented in the primary service record. • Referral follow-up documented in the primary service record.
1.9 Harm- and Risk-Reduction N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction.	• Harm- and Risk-Reduction evaluation, methods and activities documented in the primary service record.
1.10 Case Closure/Graduation PLWH who are no longer actively accessing case management services should have their cases closed	• Case Closure per established criteria documented in the primary service record.

based on the criteria and protocol outlined below. Common reasons for case closure include: • PLWH is referred to another case management program • PLWH relocates outside of service area • PLWH chooses to terminate services • PLWH is no longer eligible for services due to not meeting eligibility requirements • PLWH is no longer actively accessing service • PLWH incarceration greater than six (6) months in a correctional facility • Provider initiated termination due to behavioral violations • PLWH death Graduation criteria: • PLWH completed case management goals for increased access to services/care needs • PLWH is no longer in need of case management services (e.g. PLWH is capable of resolving needs independent of case management assistance) NMCM should attempt to contact PLWH who disengaged from service at least three (3) times via phone, e-mail and/or written correspondence. If these attempts are unsuccessful, the PLWH has been given at least thirty (30) days from initial contact to respond. Case closure can be initiated thirty (30) days following the 3rd attempt. All attempts to re-engage the PLWH should be documented in the primary service record. Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a PLWH, as appropriate. Agencies must ensure that they have signed releases of information and consent forms that meet the requirements of HB 300 regarding the electronic dissemination of protected health information (PHI) NMCM should complete a case closure summary/progress note to provide a brief overview of the activities conducted with the PLWH and the reason why the case is being closed.	• Discharge summary per established criteria documented in the primary service record. •
1.11 Community-Based Service Provision N-MCM targeting SUD is a community-based service (i.e. both office-based and field based). Agency policies should support the provision of service outside of the	• Agency policies and/or procedures allow and support community-based service provision

office and/or medical clinic. Agencies should have systems in place to ensure the security of staff and the protections of PLWH information.	• Community-based service provision documented in primary service record.
Administrative	
2.1 Program Policies and Procedures Program will have a policy that: • Defines and describes N-MCM targeting SUD services (funded through Ryan White or other sources) that complies with the standards of care outlined in this document. • Specifies that services shall be provided in the office and in the field (i.e. community based). • Specifies required referral to and coordination with HIV medical services providers. • Requires referral to and coordination with providers of substance use treatment/counseling, as appropriate. • Requires monitoring of referrals into services Additionally, Program will have policies and procedures that comply with applicable DSHS Universal Standards.	• Program's Policies and Procedures address systems to comply with ▪ Scope of Services ▪ TRG Contract and Attachments ▪ Performance Measures ▪ Standards of Care
2.2 Agency Licensure The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of substance use treatment/counseling	• Copy of Agency Licensure and/or Certification provided as part of Contract Submissions Process
2.3 Staff Qualifications Non-Medical Case Managers must have at a minimum a bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented work experience in providing services to PLWH may be substituted for the bachelor's degree requirement on a 1:1 basis (1 year of documented experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Agency will provide Non-Medical Case Manager a written job description upon hiring.	• Degree documented in personnel file. • Work experience documented in personnel file. • Signed job description documented in personnel file.
2.4 Staff Training Staff must complete the following trainings: • Within thirty (30) days of hire, complete HHS-mandated Cybersecurity training and DSHS Data Security and Confidentiality training (or approved equivalent) • Within sixty (60) days of hire, complete TRG Standards of Care orientation.	• Certificates of completion and/or attendance documented in the staff personnel file. • Any special circumstances for not meeting the timeframes are noted in the staff personnel file.

• Within six (6) months of hire, complete the DSHS HIV Care Coordination Training Curriculum (https://www.dshs.texas.gov/hivstd/contractor/cm.shtm) • After first year, a minimum of 12 hours of continuing education in relevant topics annually.	
2.5 Supervision A minimum of four (4) hours of supervision per month must be provided to each N-MCM by a master's level health professional. At least one (1) hour of supervision must be individual supervision. Supervision activities 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	• Supervision activities documented and provided for review during the Quality Compliance Review
2.6 Caseload Coverage – N-MCMs Supervisor ensures that there is coverage of the caseload in the absence of the N-MCM or when the position is vacant. N-MCM may assist PLWHs who are routinely seen by other CM team members in the absence of the PLWH's "assigned" case manager.	• • Assignment of case coverage documented in supervisory records. • Activities conducted by staff providing case coverage documented in primary service record.
2.7 Case Reviews – N-MCMs Supervisor reviews a random sample equal to 10% of unduplicated PLWHs served by each N-MCM 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.	• Case reviews documented in primary service record, signed and dated by supervisor and/or quality assurance personnel and N-MCM
2.8 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. Subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

organizations' planning and operations.	
2.9 Trauma-Informed Service Delivery (TISD) Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can exacerbate the physical, mental, and behavioral manifestations of trauma. Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues." Trauma-informed service delivery (TISD) requires that: • Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services. • Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors. • Systems and workflows should be altered to support the environment that promotes trauma-informed care.	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

References:

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- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Trauma Informed Approaches: https://www.traumapolicy.org/topics/trauma-informed-care
- Trauma Informed Care: https://www.traumapolicy.org/topics/trauma-informed-care and https://www.nih.gov/

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 QUALITY ASSURANCE MEASURES
NON-MEDICAL CASE MANAGEMENT TARGETING
SUBSTANCE USE DISORDERS

1. Percentage of PLWHs who access N-MCM services that have a completed assessment within 30 calendar days of the first appointment to access N-MCM services and includes all required documentation.
2. Percentage of PLWHs that received at least one face-to-face meeting with the N-MCM staff that conducted the initial assessment.
3. Percentage of PLWHs who have documented Initial Assessment in the primary service record.
4. Percentage of non-medical case management PLWHs, regardless of age, with a diagnosis of HIV who had a non-medical case management care plan developed and/or updated two or more times in the measurement year.
5. Percentage of primary service records with documented follow up for issues presented in the care plan.
6. Percentage of Care Plans documented in the primary service record.
7. Percentage of N-MCM PLWHs with documented types of assistance provided that was initiated upon identification of PLWH needs and with the agreement of the PLWH. Assistance denied by the PLWH should also be documented in the primary service record system
8. Percentage of N-MCM PLWHs with assistance provided have documentation of follow up to the type of assistance provided.
9. Percentage of N-MCM PLWHs assessed for health literacy.
10. Percentage of PLWH with closed cases includes documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary).
11. Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable).
12. Percentage of PLWH notified (through face-to-face meeting, telephone conversation, or letter) of plans to discharge the PLWH from case management services.
13. Percentage of PLWH with written documentation explaining the reason(s) for discharge and the process to be followed if PLWH elects to appeal the discharge from service.
14. Percentage of PLWH with information about reestablishment shared with the PLWH and documented in primary service record system.
15. Percentage of PLWH provided with contact information and process for reestablishment as documented in primary service record system.
16. Percentage of PLWH with documented Case Closure/Graduation in the primary service record system

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.

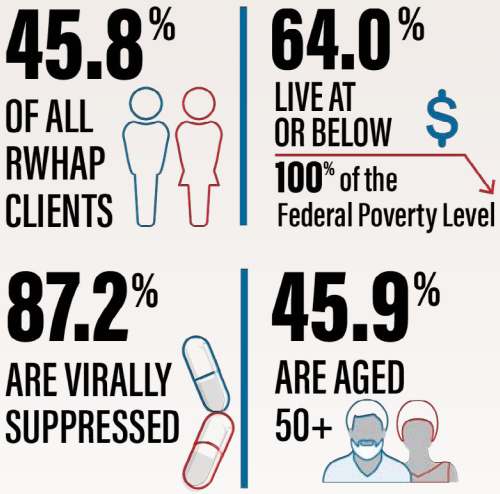
Black/African American Clients:

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

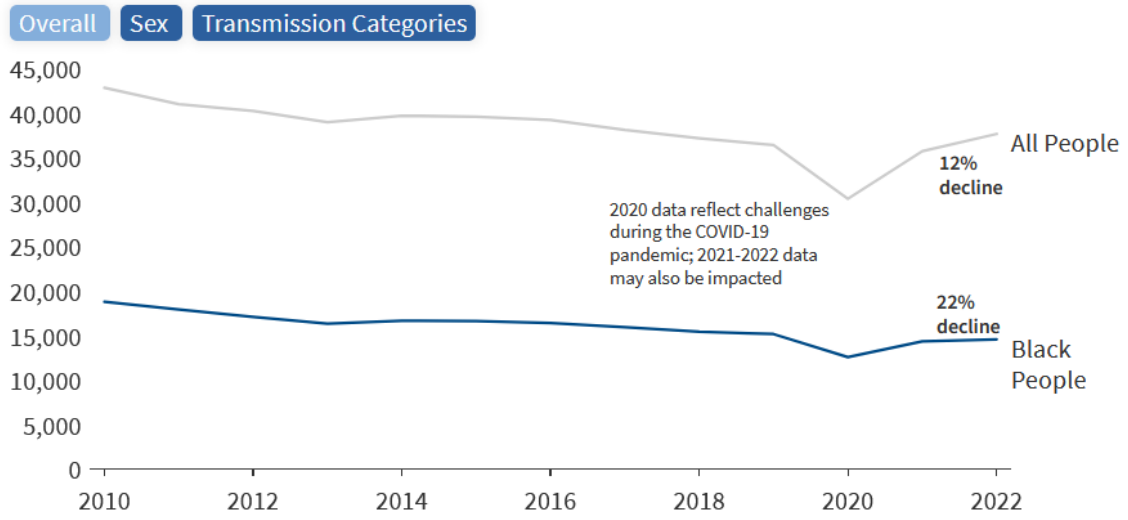
Key Facts

- 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.



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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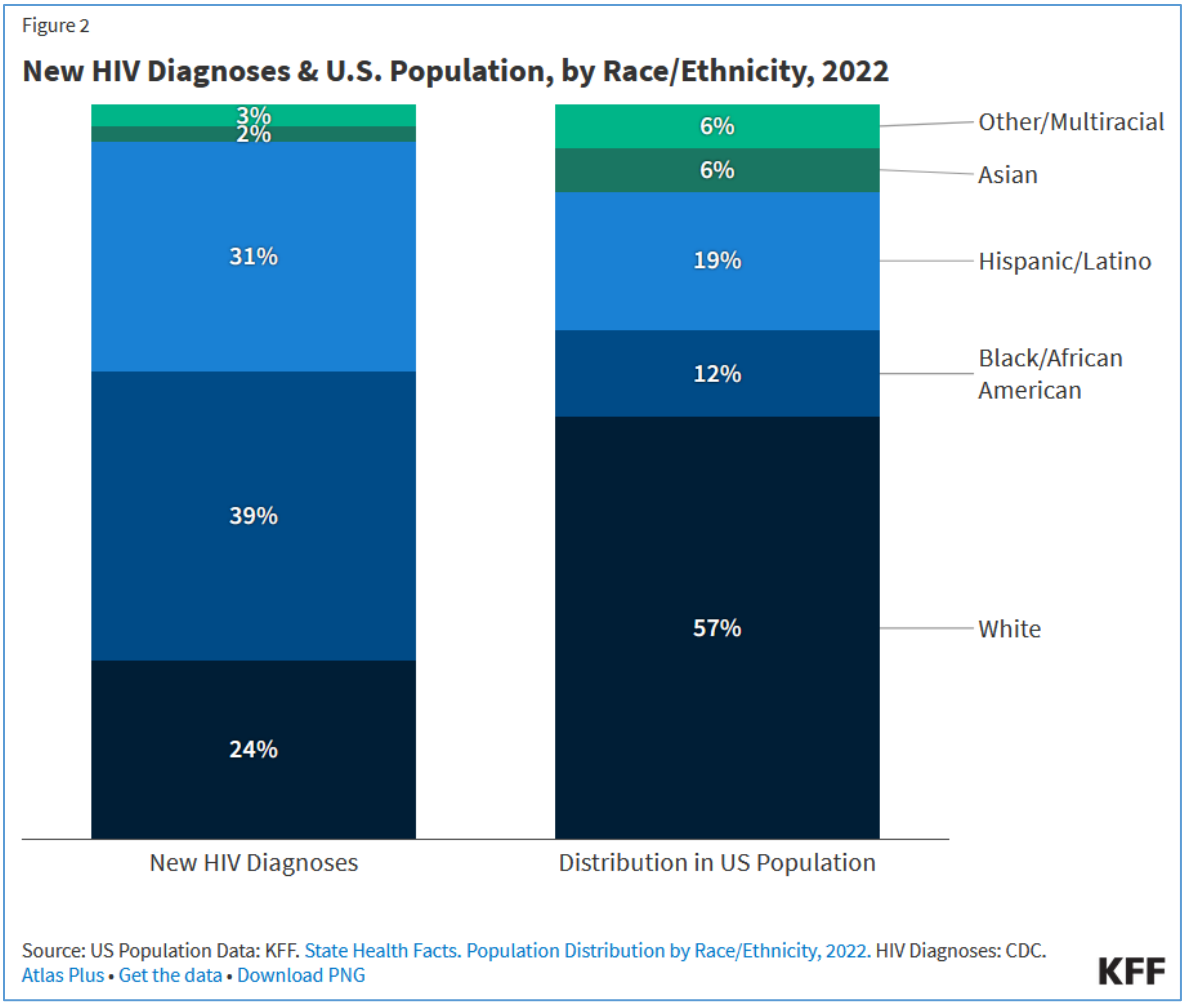
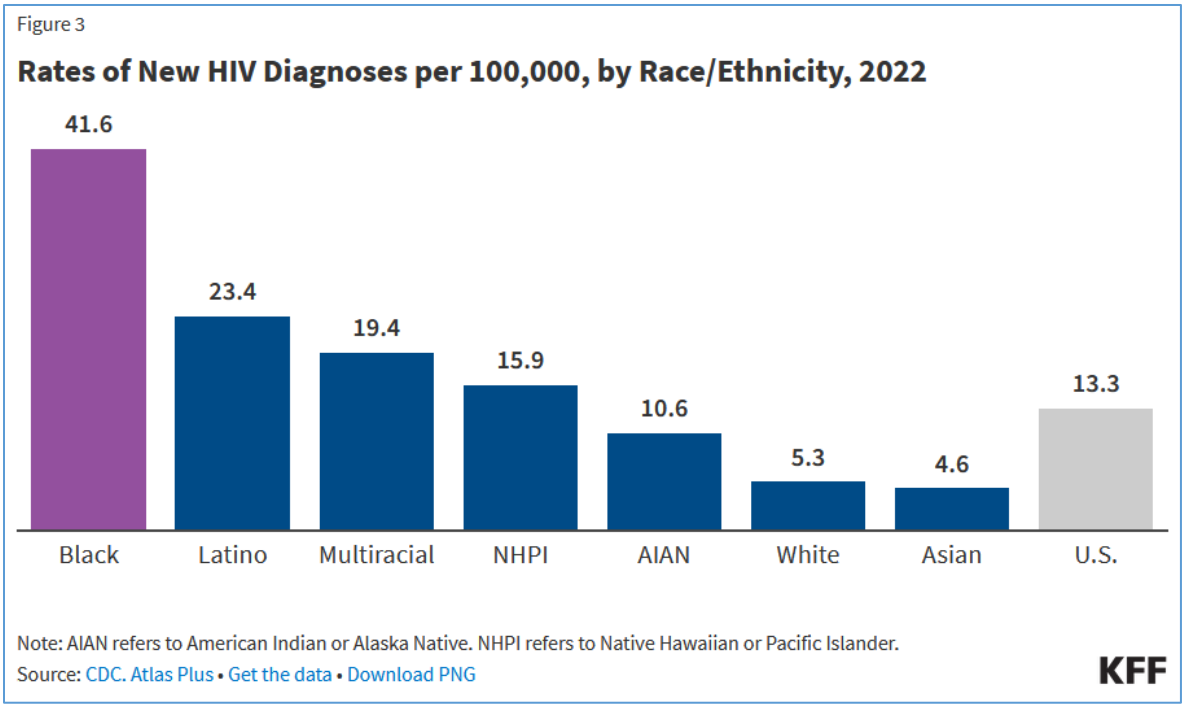
Overview

- 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

Figure 2



- 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.



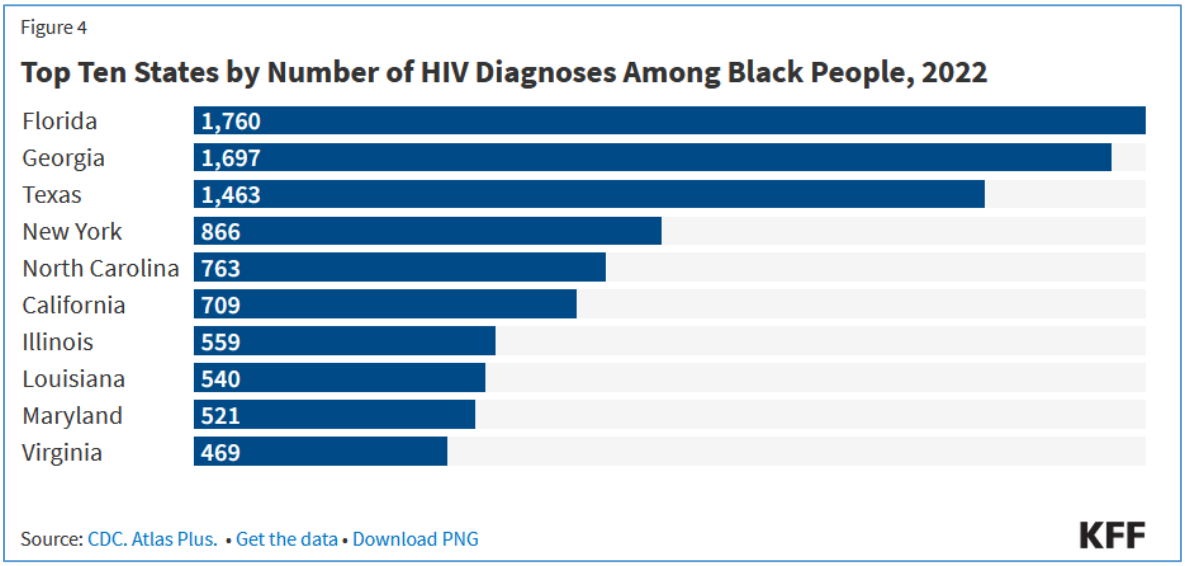
- Black people accounted for more than 4 in 10 (43%) deaths among people with an HIV diagnosis (deaths may be due to any cause) in 2022. The number of deaths among Black individuals with an HIV diagnosis decreased 13% between 2010 and 2018 but then increased more recently, by 15% between 2018 and 2022.
- 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

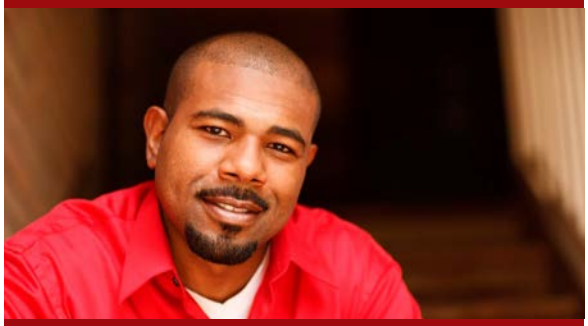
- Black gay and bisexual men accounted for almost half (49%) of Black people living with HIV and 30% of gay and bisexual men living with HIV.
- Among Black people, male-to-male sexual contact accounted for more than half (63%) of HIV diagnoses in 2022 and a majority (82%) of diagnoses among Black men.
- 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:

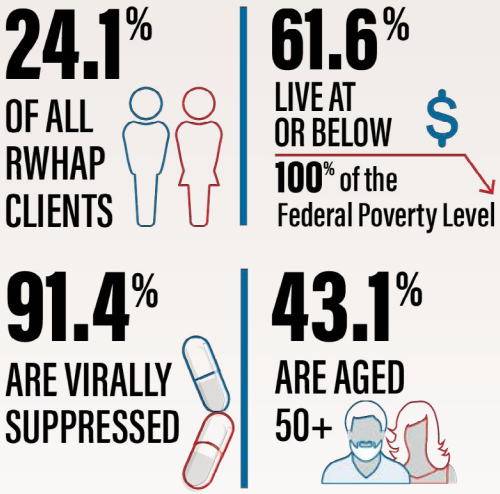
HRSA's Ryan White HIV/AIDS Program, 2021



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

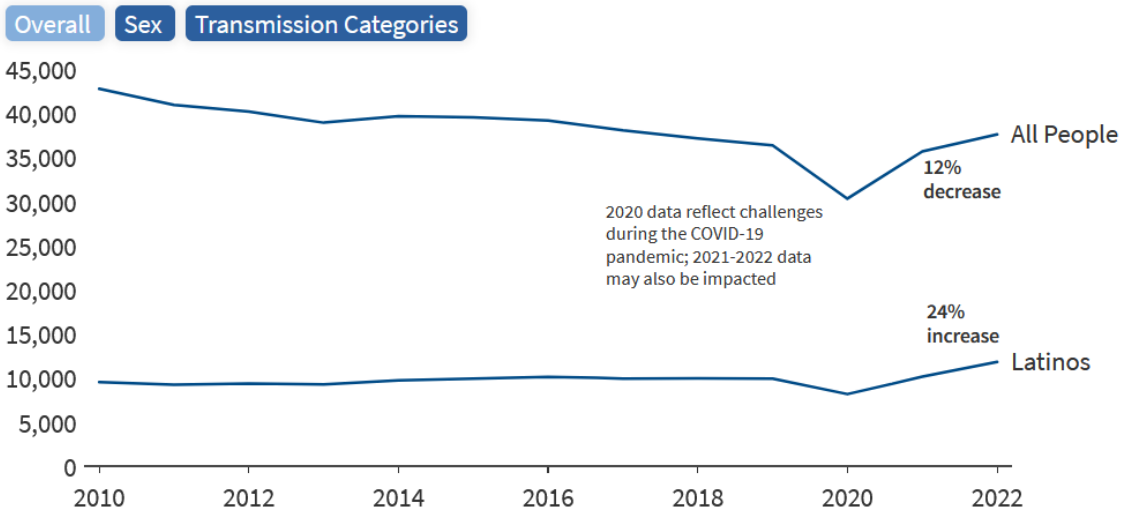
Key Facts

- 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.



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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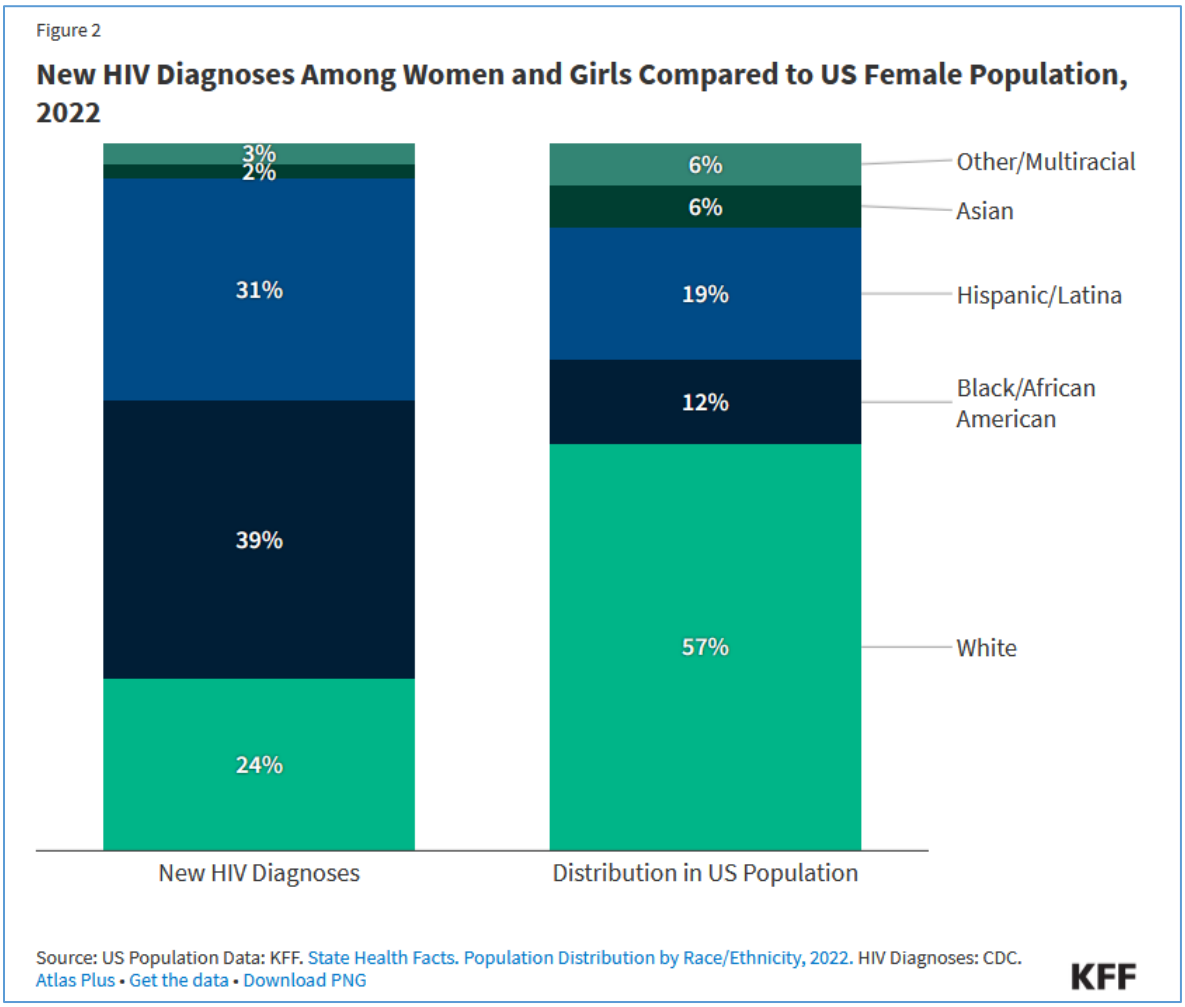
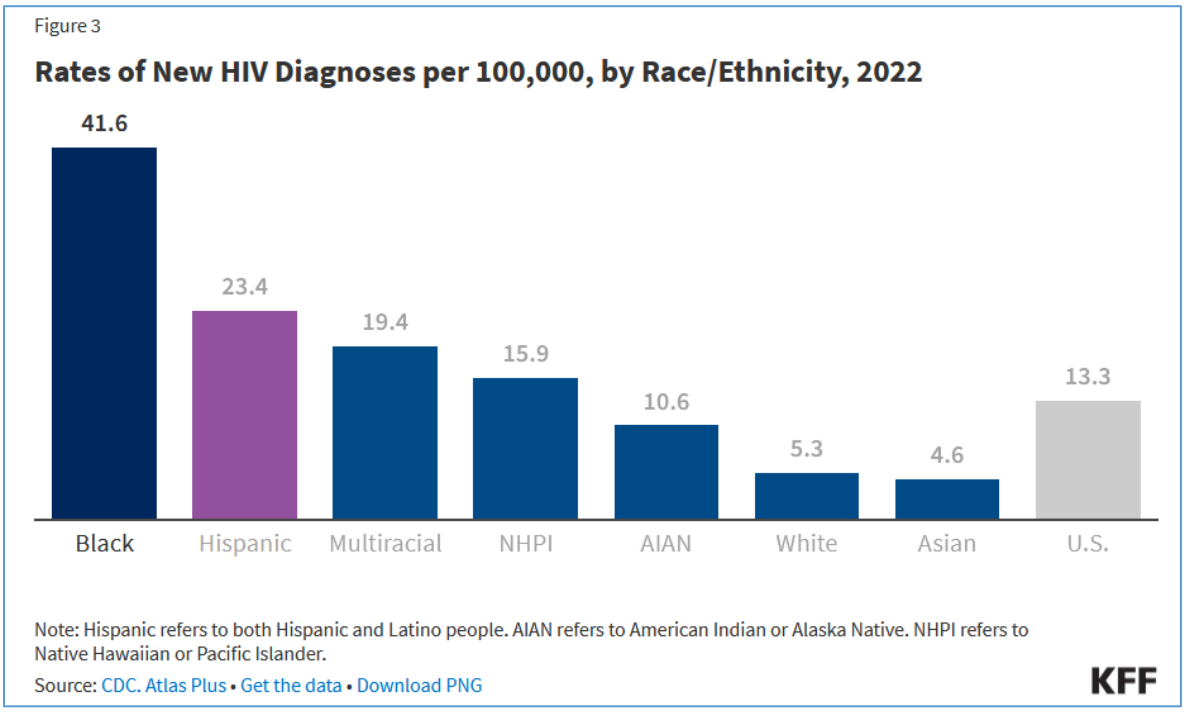
Overview

- 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).



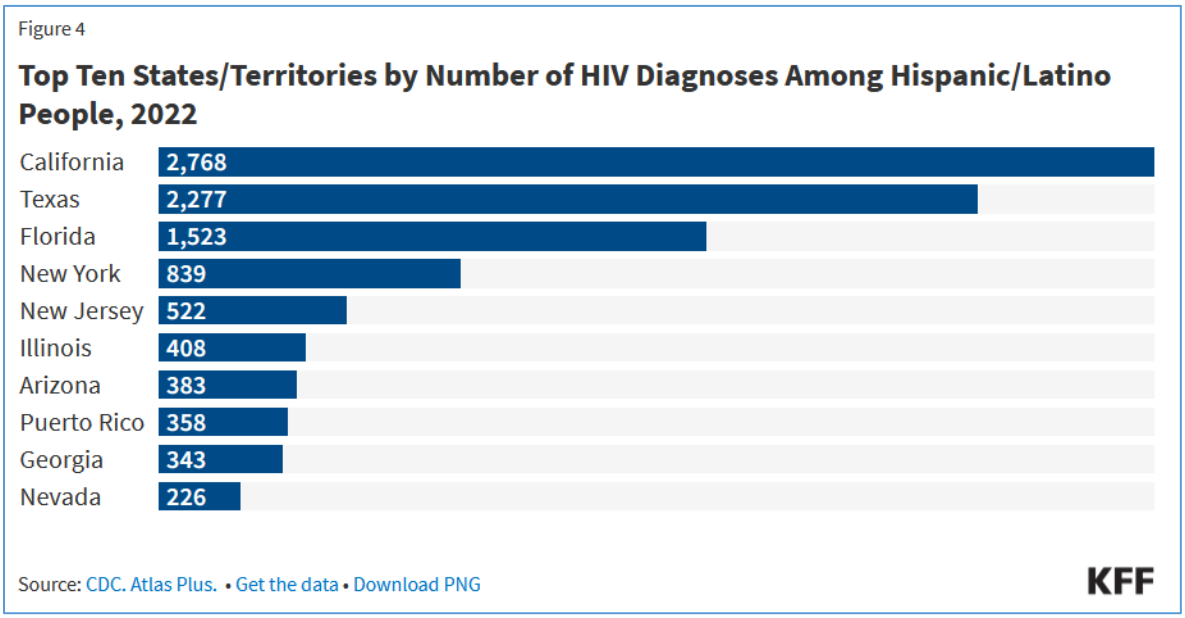
- Hispanic/Latino people accounted for almost 1 in 5 (17%) deaths among people with an HIV diagnosis (deaths may be due to any cause) in 2022. The number of deaths among Latino individuals with an HIV diagnosis increased 24% between 2010 and 2022.
- Rates for deaths where HIV was indicated as the leading 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).



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.

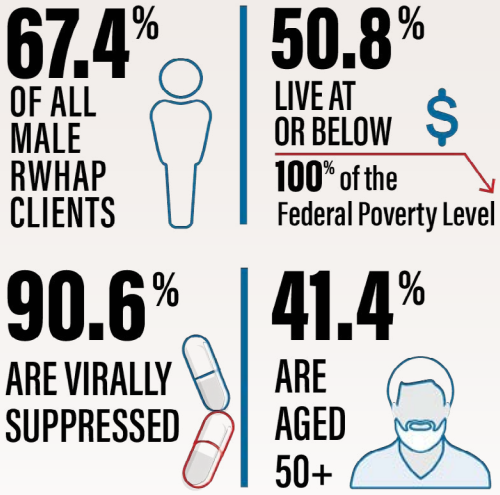
Gay, Bisexual, and Other Men Who Have Sex with Men (MSM) Clients:

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.

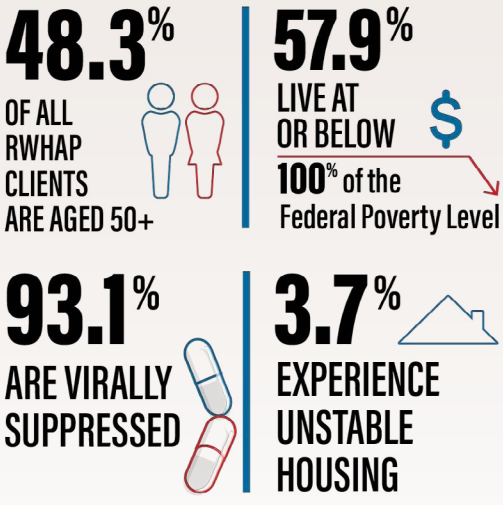
Older Adult Clients:

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



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

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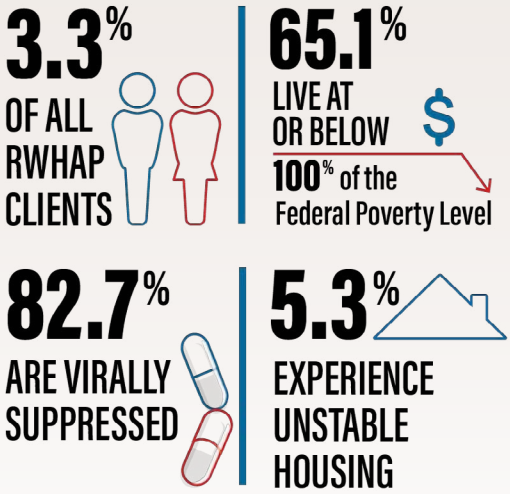
Ryan White HIV/AIDS Program Fast Facts: Youth and Young Adult Clients



HRSA Ryan White HIV/AIDS Program

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

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

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

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

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

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

Female Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

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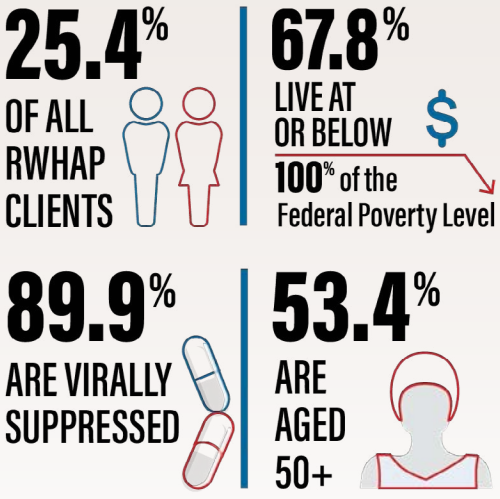
Ryan White HIV/AIDS Program Fast Facts: Female Clients



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Ryan White HIV/AIDS Program

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

Learn more about these clients served by RWHAP:

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

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

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

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

Black Women and HIV in Texas

The Big Picture

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

Black Women Living with HIV in Texas

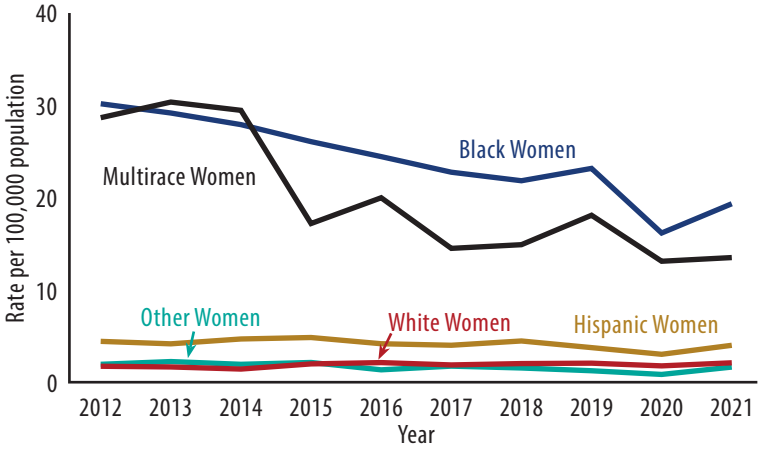
The rate of Black women living with HIV in Texas (631 per 100,000 population) is 6.9 times the rate of Hispanic women living with HIV and 13.6 times the rate of White women living with HIV.

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

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

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

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



Black Women Without HIV-Related Medical Care in 2021

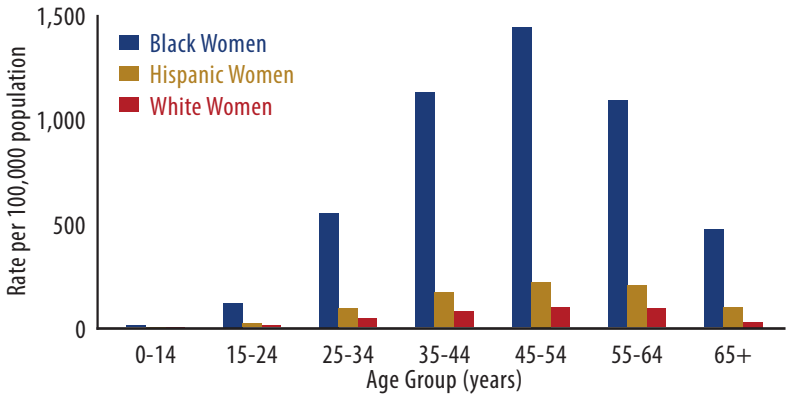
More than ever before, advances in medical care have enabled people with HIV to stay healthy and live longer. Some persons living with HIV may not seek care because they do not feel ill. Others may have problems affording or accessing health care. Still others may not seek medical care because of substance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

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

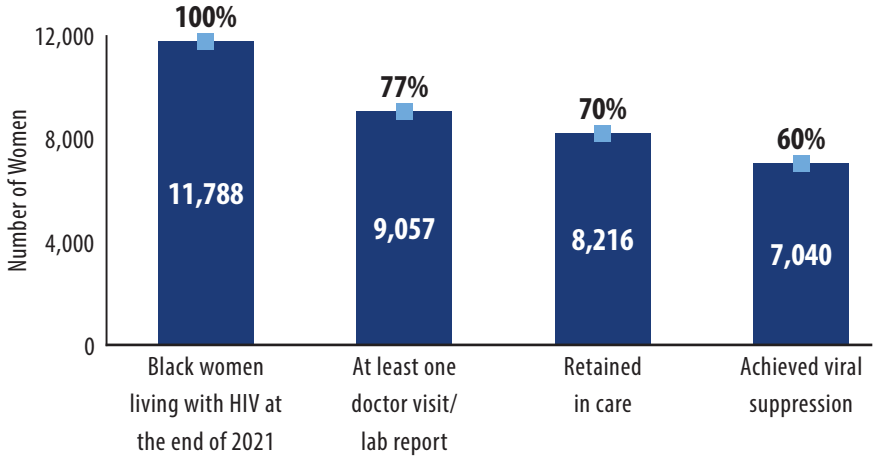
Of Black women living with HIV in Texas whose mode of HIV transmission was sex with males:

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

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



HIV Treatment Cascade for Black Women in Texas, 2021



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

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

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

Texas Black Women's Initiative (TxBWI)

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

More About Black Women and HIV in Texas

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

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

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

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

DSHS HIV/STD Section

737-255-4300

dshs.texas.gov/hivstd/txbwi

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

TEXAS Health and Human Services
Texas Department of State Health Services

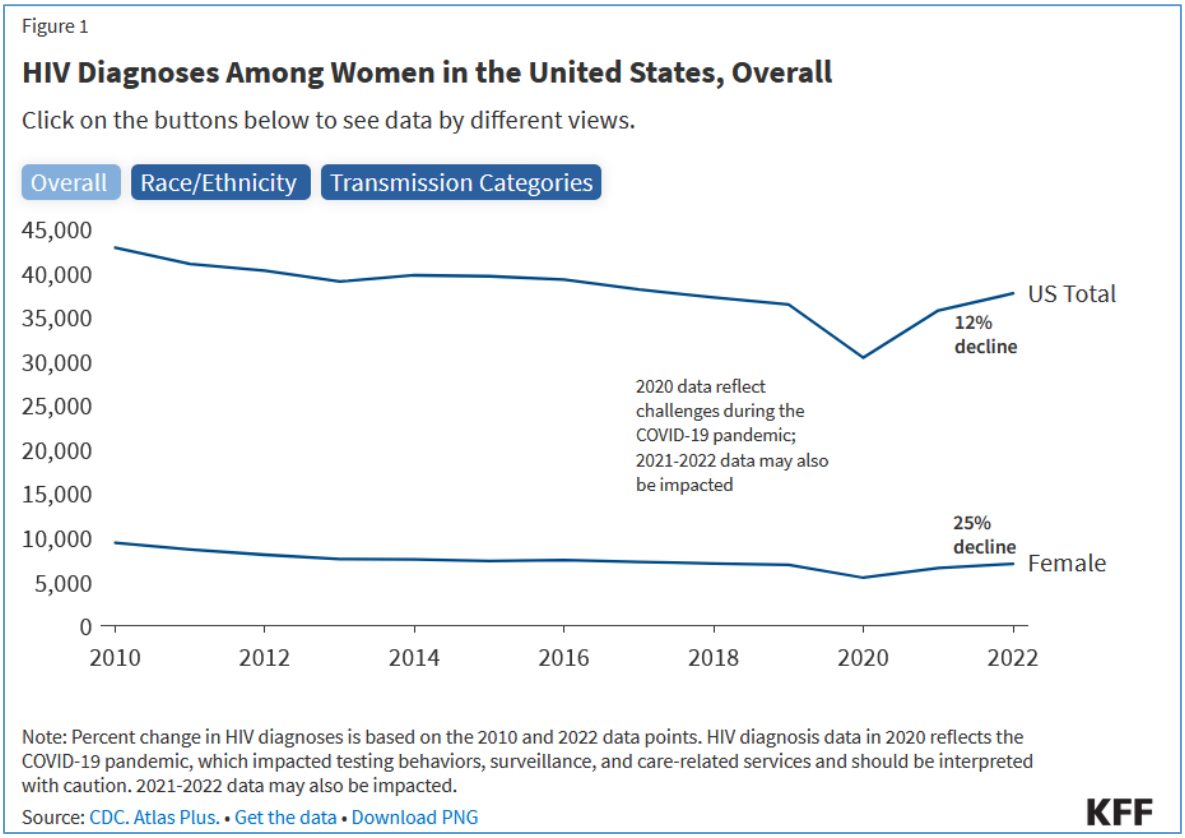
The Impact of HIV on Women in the United States

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.

Figure 1



Overview

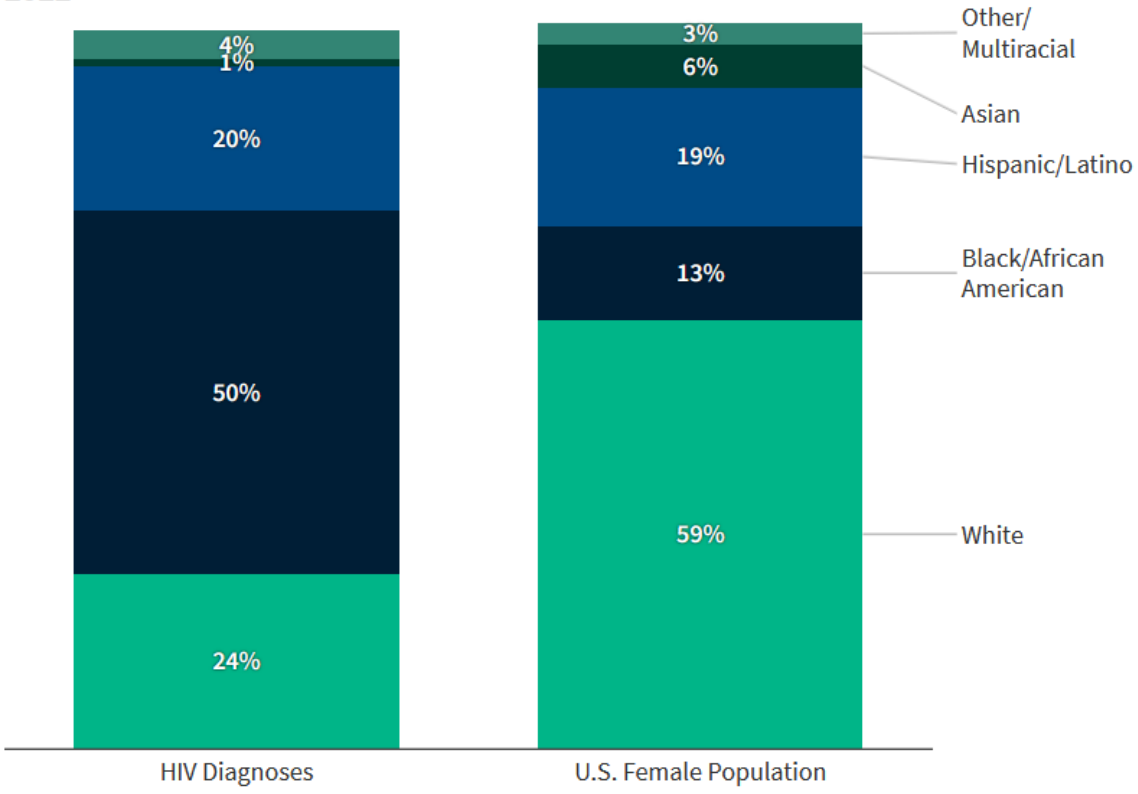
- Today, there are more than 1.2 million people estimated to be living with HIV in the U.S., including 268,800 (22%) who are women.
- Women accounted for 19% of the 6,980 new HIV diagnoses in 2022 and are diagnosed with HIV at slightly older ages than men are.
- Between 2010-2022, while HIV diagnoses 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

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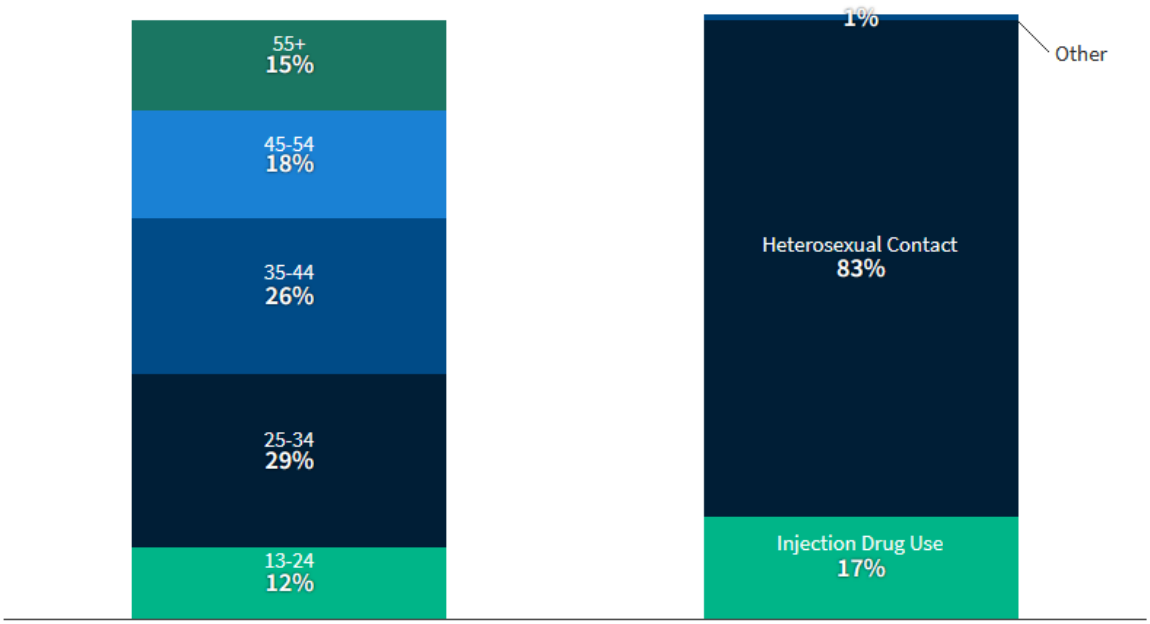
Age

- 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

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Transmission

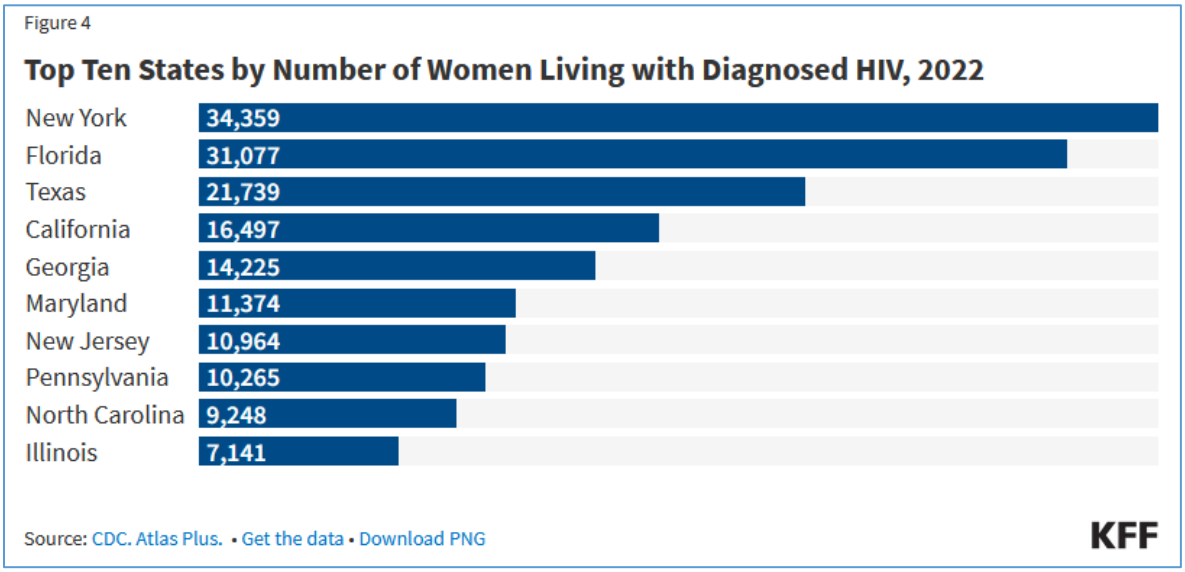
- In 2022, HIV diagnoses among women were mostly attributed to heterosexual sex (83%), followed by injection drug use (17%), and 1% were attributed to other causes. Heterosexual transmission accounts for a greater share of HIV diagnoses among Black and Hispanic/Latina women (90% and 87%, respectively) 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

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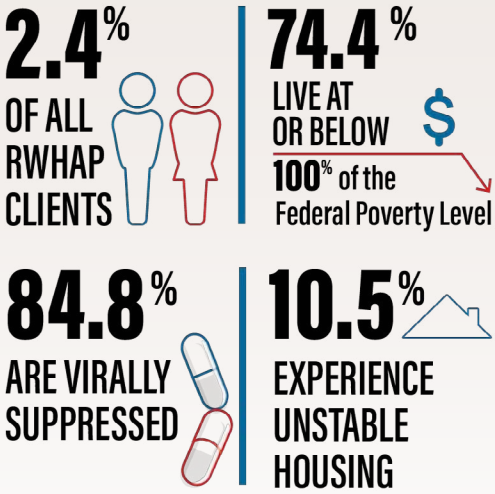
Ryan White HIV/AIDS Program Fast Facts: Transgender Clients



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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.

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.

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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.