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Houston Area Integrated HIV Prevention and Care Plan

2022 - 2026

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Vision

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

Mission

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

SECTION I: EXECUTIVE SUMMARY OF INTEGRATED PLAN AND SCSN

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section IV: Situational Analysis

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

Section V: Plan Goals and Objectives

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

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

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

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

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

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

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

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

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

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

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

Section VI: Implementation, Monitoring and Jurisdictional Follow Up

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

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

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

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

DOCUMENTS SUBMITTED TO MEET CDC AND HRSA REQUIREMENTS:

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

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

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

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

Treat Committee

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

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

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

Key Activities:

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

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

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

Key Activities:

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

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

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

Key Activities:

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

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

Key Activities:

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

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

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

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

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

Quality of Life and Social Determinants Committee

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

Key Activities:

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

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

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

Activity: See Houston Medical Monitoring Project (HMMP).

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

Activity: See Houston Medical Monitoring Project (HMMP).

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

Activity: See Houston Medical Monitoring Project (HMMP).

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

Activity: See Houston Medical Monitoring Project (HMMP).

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

Activity: See Houston Medical Monitoring Project (HMMP).

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

HIV and Aging Workgroup

Key Activities:

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

Housing Workgroup

Key Activities:

- *To be determined.*

Racial and Social Justice Workgroup

Key Activities:

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

Quality of Life VISION for PLHIV

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

Quality of Life THEMES

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

Quality of Life DEFINITION

We demand a quality of life that achieves the following:

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

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

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

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

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

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

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

NATIONAL HIV/AIDS STRATEGY

for the **United States**
2022–2025

THE WHITE HOUSE
WASHINGTON

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

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

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

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

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

VISION

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

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

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

EXECUTIVE SUMMARY

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

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

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

The Strategy establishes the following vision:

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

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

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

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

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

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

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

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

NHAS AT-A-GLANCE

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

Goal 1: Prevent New HIV Infections

1.1 Increase awareness of HIV

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

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

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

1.2 Increase knowledge of HIV status

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Goal 3: Reduce HIV-Related Disparities and Health Inequities

3.1 Reduce HIV-related stigma and discrimination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.6.3 Expand community engagement in health communication initiatives and research.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INDICATORS AT-A-GLANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

HRSA Definition:
Hospice Services are end-of-life care services provided to PLWH in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling,
- Nursing care,
- Palliative therapeutics,
- Physician services, and
- Room and board.

Program Guidance: Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the state of Texas. Services must be provided with appropriate and valid licensure of provider as required by the State of Texas, as applicable. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under Texas Medicaid.

DSHS Definition:
Provision of end-of-life care provided by licensed hospice care providers to PLWH in the terminal stages of an HIV-related illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients.

Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are:

- Room
- Board
- Nursing care
- Mental health counseling, to include bereavement counseling
- Physician services
- Palliative therapeutics

Hospice services must have physician certification of the PLWH's terminally ill status as defined by Texas Medicaid documented in the primary service record.

Limitations: Ryan White Part B/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services. Services cannot be provided in skilled nursing facilities or nursing homes.

Local Definition:
Hospice services encompass palliative care for terminally ill PLWH and support services for PLWH and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a PLWH or a PLWH's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.

Scope of Services:
Hospice services encompass palliative care for terminally ill PLWH and support services for PLWH and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a PLWH or a PLWH's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.

Allowable services are:
- Room
- Board
- Nursing care
- Mental health counseling, to include bereavement counseling
- Physician services
- Palliative therapeutics

Services not allowed under this service:
- HIV medications under hospice care unless paid for by the PLWH.
- Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents.

- Funeral, burial, cremation, or related expenses.
- Nutritional services,
- Durable medical equipment and medical supplies.
- Case management services
- Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the PLWH's death and can be offered in a skilled nursing facility or nursing home, Ryan White funding cannot pay for these services per legislation.

Standard	Evidence
Program	
1.1 Physician Certification • The attending physician must certify that a PLWH is terminal, defined under Texas Medicaid hospice regulations as having a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification must specify that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification statement must be based on record review or consultation with the referring physician. • The referring provider must provide orders verbally and in writing to the Hospice provider prior to the initiation of care and act as that patient's primary care physician. Provider orders are transcribed and noted by attending nurse. • Must be reassessed by a physician every six (6) months. • Must first seek care from other facilities and denial must be documented in the resident's chart.	• Physician certification documented in the primary service record. • Reassessment documented in the primary service record.
1.2 Denial of Service The hospice provider may elect to refuse a referral for reasons which include, but are not limited to, the following: • There are no beds available • Level of patient's acuity and staffing limitations • Patient is aggressive and a danger to the staff • Patient is a "no show" Agency must develop and maintain s system to inform Administrative Agency regarding issue of long-term care facilities denying admission for PLWH based on	• Denial of Services documented in the primary service record. • Notification of the Administrative Agency regarding issue of denying admission for PLWH based on inability to provide appropriate level of skilled nursing care documented.

inability to provide appropriate level of skilled nursing care	
1.3 Intake Information Information will be obtained at intake (from the referral source, PLWH or other source) and will include, but is not limited to: • Contact and identifying information (name, address, phone, birth date, etc.) • Language(s) spoken • Literacy level (PLWH self-report) • Demographics • Emergency contact • Household members • Pertinent releases of information	• Intake information documented in the primary service record.
1.4 Comprehensive Health Assessment A comprehensive health assessment, including medical history, a psychosocial assessment and physical examination, is completed for each patient within 48 hours of admission and once every six months thereafter. Symptoms assessment (utilizing standardize tools), risk assessment for falls and pressure ulcers must be part of initial assessment and should be ongoing. Medical history should include the following components: • History of HIV infection and other co morbidities • Current symptoms • Systems review • Past history of other medical, surgical or psychiatric problems • Medication history • Family history • Social history • Identifies the patient's need for hospice services in the areas of medical, nursing, social, emotional, and spiritual care. • A review of current goals of care Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.	• Completed comprehensive health assessment document in the primary service record and dated within 48 hours of admission. • Required elements are included in the comprehensive health assessment.

Hospice provider documents each PLWH's scheduled medications, including dosage and frequency. • HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects. • Hospice provider documents as needed medications for PLWH and includes PLWH's name, dose, route, reason, and outcome.	
1.5 Care Plan Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient's priorities. These priorities should include culturally and linguistically appropriate goals. A written Plan of Care is completed for each patient within seven (7) calendar days of admission and reviewed monthly. Care Plans will be updated once every six (6) months thereafter or more frequently as clinically indicated. Hospice care should be based on the professional guidelines for supportive and palliative care. Hospice providers will maintain a consistent plan of care and communicate changes from the initial plan to the referring provider.	• Completed care plan based on physician's orders documented in the primary service record within 7 calendar days of admission. • Monthly care plan reviews documented in the primary service record. • Care Plan updates documented in the primary service record at least every 6 months.
1.6 Palliative Therapy Palliative therapy is designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure. Palliative therapy must be documented in the written plan of care with changes communicated to the referring provider	• Palliative therapy as ordered by the referring provider documented on the care plan in the primary service record. • Provision of palliative therapy documented in the primary service record.
1.7 Counseling Services for Family The need for counseling services for family members must be assessed and a referral made if requested. The need for counseling services for family members must be consistent with definition of mental health counseling.	• Assessment and referrals documented in the primary service record.
1.8 Bereavement Counseling The need for bereavement counseling services for family members must be consistent with the definition of mental health counseling.	• Discussion of bereavement counseling with family members upon admission to Hospice services documented in the primary service record.

Bereavement counseling must be provided. Bereavement counseling means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment. A hospice must have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. A hospice must: • Develop a bereavement plan of care that notes the kind of bereavement services to be offered to the patient's family and other persons and the frequency of service delivery, • Make bereavement services available to a patient's family and other persons in the bereavement plan of care for up to one year following the death of the patient, • Ensure that bereavement services reflect the needs of the bereaved. Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the patient's death and can be offered in a skilled nursing facility or nursing home, Ryan White funding cannot pay for these services in a skilled nursing facility or nursing home per legislation.	• Bereavement care plan documented in the primary services record. • Provision of bereavement counseling documented in the primary services record.
1.9 Mental Health Counseling Mental health counseling should be solution focused; outcomes oriented and time limited set of activities for the purpose of achieving goals identified in the patient's individual treatment plan. Mental Health Counseling is to be provided by a licensed Mental Health professional (see Mental Health Service Standard and Universal Standards for qualifications): • The patient's needs as identified in the patient's assessment • The patient's acceptance of these services	• Provision of mental health counseling documented in the primary service record. • Qualifications of mental health professional documented in personnel file.
1.10 Dietary Counseling Dietary counseling means education and interventions provided to a patient and family regarding appropriate nutritional intake as a hospice patient's condition progresses. Dietary	• Dietary counseling documented on the care plan in the primary service record. • Provision of dietary counseling documented in primary service record.

counseling, when identified in the plan of care, must be performed by a qualified person. A qualified person includes a dietitian, nutritionist, or registered nurse. A person that provides dietary counseling must be appropriately trained and qualified to address and assure that the specific dietary needs of a PLWH are met.	
1.11 Spiritual Counseling A hospice must provide spiritual counseling that meets the PLWH's and the family's spiritual needs in accordance with their acceptance of this service and in a manner consistent with their beliefs and desires. A hospice must: • Provide an assessment of the PLWH's and family's spiritual needs, • Make all reasonable efforts to the best of the hospice's ability to facilitate visits by local clergy, a pastoral counselor, or other persons who can support a PLWH's spiritual needs, and • Advise the PLWH and family of the availability of spiritual counseling services.	• Discussion of spiritual counseling with PLWH and family members upon admission to Hospice services documented in the primary service record. • Provision of spiritual counseling documented in the primary service record. • Referral to spiritual counseling documented.
1.12 Medical Social Services Medical social services must be provided by a qualified social worker. and is based on: • The PLWH's and family's needs as identified in the patient's assessment • The PLWH's and family's acceptance of these services	• Medical social services documented on the care plan in the primary service record. • Provision of medical social services documented in the primary service record.
1.13 Multidisciplinary Team Approach Programs must use a multidisciplinary team approach to ensure that patient and the family receive needed emotional, spiritual, physical, and social support. The multidisciplinary team may include physician, nurse, social worker, nutritionist, chaplain, patient, physical therapist, occupational therapist, care giver and others as needed. Team members must establish a system of communication to share information on a regular basis and must work together and with the patient and the family to develop goals for patient care.	• Multidisciplinary team documented in the primary service record. • Provision of multidisciplinary coordination documented in the primary service record.
1.14 Medication Administration Record Staff documents each patient's scheduled medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and	• Medication administration documented in the primary service record.

signature and title of staff. HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects.	
1.15 PRN Medication Record Staff documents each patient's PRN medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, outcome, and signature and title of staff.	• PRN medication administration documented in the primary service record.
1.16 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
1.17 Discharge An individual is deemed no longer to be in need of hospice services if one or more of these criteria is met: • Patient expires. • Patient's medical condition improves, and hospice care is no longer necessary, based on attending physician's plan of care and a referral to Medical Case Management or OAHS must be documented Patient elects to be discharged. • Patient is discharged for cause. • Patient is transferred out of provider's facility	• Discharge documented in primary service record. • One or more discharge criteria met.
Administrative	
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	• Program's Policies and Procedures document systems to comply with: • DSHS Universal Standards • TRG Contract and Attachments • Standards of Care • Collection of Performance Measures
2.1 Facility Licensure Agency is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation, or is certified as a Special Care Facility with Hospice designation	• License and/or certification available at the site(s) where services are provided. • License and/or certification posted in a highly visible place at site(s) where services are provided.
2.2 Services Requiring Licensed Personnel	• License documented in the personnel file.

All services requiring licensed personnel shall be provided by appropriate licensed personnel in accordance with State of Texas regulations. Hospice services must be provided under the delegation of an attending physician and/or registered nurse.	• Staff interviews document compliance.
<u>2.3 Staff Education</u> Agency shall employ staff who are trained and experienced in their area of practice and remain current in end of life issues as it relates to HIV. Staff shall maintain knowledge of psychosocial and end of life issues that may impact the needs of PLWH. Agency provides access to training activities, including but not limited to: • Updated HIV information, including current treatment methodologies and promising practices • In-service education • DSHS-sponsored trainings	• Agency documents the dissemination of HIV information and training activities relevant to the needs of PLWH to paid staff and volunteers. • Agency documents attendance at training activities. • Materials for training activities (agendas, handouts, etc.) are on file.
<u>2.4 Ongoing Staff Training</u> • Eight (8) hours of training in HIV 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.
<u>2.5 Staff Experience</u> A minimum of one-year documented hospice and/or HIV work experience is preferred	• Work experience documented in personnel file with exceptions to work experience noted.
<u>2.6 Staff Supervision</u> Staff services are supervised by a paid coordinator or manager. Professional supervision shall be provided by a practitioner with at least two years' experience in hospice care of persons with HIV. All licensed personnel shall receive supervision consistent with the State of Texas licensure requirements. Supervisory, provider or advanced practice registered nurses will document supervision over other staff members	• Work experience for professional supervisory providers documented in personnel file. • Supervision consistent with licensure documented. • Supervision of other staff members by supervisory provider or advanced practice registered nurse documented.
<u>2.7 Volunteer Assistance</u> Volunteers cannot be used to substitute for required personnel. They may however provide	• Policy and/or procedure documents duties and activities conducted by volunteers and oversight.

companionship and emotional/spiritual support to patients in hospice care. Volunteers providing patient care will: • Be provided with clearly defined roles and written job descriptions • Conform to policies and procedures	• Signed job descriptions documented in volunteer file. • Service provision by volunteers are documented in the primary service record.
2.8 Volunteer Training Volunteers may be recruited, screened, and trained in accordance with all applicable laws and guidelines. Unlicensed volunteers must have the appropriate State of Texas required training and orientation prior to providing direct patient care. Volunteer training must also address program-specific elements of hospice care and HIV. For volunteers who are licensed practitioners, training addresses documentation practices	• Trainings and education documented in volunteer file.
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. 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.
2.10 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.	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

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.	

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- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 16-18. Accessed on October 12, 2020 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. 15-17. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Texas Administrative code Title 40; Part 1; Chapter 97, Subchapter H Standards Specific to Agencies Licensed to Provide Hospice Services located at: https://hhs.texas.gov/laws-regulations/handbooks/texas-medicaid-hospice-program-standards-handbook/mhps- title-40-texas-administrative-code-chapter-30
- Texas Department of Aging and Disability Services Texas Medicaid Hospice Program Standards Handbook. Located at http://hhs.texas.gov/laws-regulations/handbooks/texas-medicaid-hospice-program-standards-handbook
- 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),

https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

- 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
HOSPICE SERVICES

1. Percentage of PLWH receiving Hospice services with attending physician certification of PLWH's terminal illness documented in the primary service record.
2. Percentage of PLWH receiving Hospice care with documentation in the primary record of all physician orders for initiation of care.
3. Percentage of PLWH in Hospice care with a documented comprehensive health assessment completed within 48 hours of admission in the primary service record.
4. Percentage of PLWH in Hospice care with documentation of all scheduled and as needed medications, including dosage and frequency, noted in the primary service record.
5. Percentage of PLWH in Hospice care with a written care plan based on physician's orders completed within seven calendar days of admission documented in the primary service record.
6. Percentage of PLWH in Hospice care with documented evidence of monthly care plan reviews completed in the primary service record.
7. Percentage of PLWH in Hospice care with a written care plan that documents palliative therapy as ordered by the referring provider documented in the primary service record.
8. Percentage of PLWH accessing Hospice care with documented evidence of bereavement counseling offered to family members upon admission to Hospice services in the primary service record.
9. Percentage of PLWH in Hospice care with documented evidence of dietary counseling provided, when identified in the written care plan, in the primary service record.
10. Percentage of PLWH in Hospice care that are offered spiritual counseling, as appropriate, documented in the written care plan in the primary service record.
11. Percentage of PLWH in Hospice care with documented evidence of mental health counseling offered, as medically indicated, in the primary service record.
12. Percentage of PLWH with documented evidence in the primary record of all refusals of attending physician referrals by hospice providers with evidence indicating an allowable reason for the refusal.
13. Percentage of PLWH in Hospice care with documented evidence of discharge status in the primary service record.

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

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

HRSA Definition:
Linguistic Interpretive Services include interpretation and translation activities, both oral and, written, to eligible people living with HIV (PLWH). These activities must be provided by a qualified linguistic services provider as a component of HIV service delivery between the healthcare provider and the PLWH. These services are to be provided when such services are necessary to facilitate communication between the provider and PLWH and/or support delivery of HRSA Ryan White HIV/AIDS Program (RWHAP) eligible services.

Program Guidance: Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). Linguistic services include sign language linguistics

DSHS Definition:
Linguistic services are provided as a component of HIV service delivery to facilitate communication between the PLWH and provider, as well as support service delivery in both group and individual settings. These standards ensure that language is not a barrier to any PLWH seeking HIV-related medical care and support, and that linguistic services are provided in a culturally appropriate manner.

Services are intended to be inclusive of all individuals and not limited to any population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations living with HIV receive quality, unbiased services.

Limitations: Linguistic services, including interpretation (oral) and translation (written) services, must be provided by a qualified linguistic provider.

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:
Support for Linguistic Interpretive Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the PLWH, when such services are necessary to facilitate communication between the provider and PLWH and/or support delivery of Ryan White-eligible services. Types of service include, but are not limited to, sign language for deaf and/or hard of hearing PLWH and native language interpretation for monolingual PLWH.

Scope of Services:
The agency will provide interpreter services including, but not limited to, sign language for deaf and/or hard of hearing and native language interpretation for monolingual PLWH. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.

Limitation: Eligible languages exclude Spanish as it is an expectation that all funded providers have the internal capacity to communicate with PLWH in English and Spanish.

Subcontractor Exclusion:
Due to the nature of service delivery, the staff training outlined in the Houston General Standards is not required for interpreters at subcontracted linguistic service agencies.

Standard	Evidence
Program	
1.1 Provision of Services Service referral will document assessment of need for linguistic services for interpretation and/or translation needs to communicate with the healthcare provider and/or receive appropriate services. Program shall provide translation and/or interpretation services for the date of scheduled appointment per request submitted and will document the type of linguistic service provided in the primary service record. Linguistic services may be provided in person or via telephonic or other electronic means (see telehealth/telemedicine information above). Program will offer services to the PLWH only in connection with other HRSA approved services (such as clinic visits).	• Referral for service documents need of linguistic services for interpretation and/or translation • Provision of linguistic services for interpretation and/or translation documented in primary service record.

Program will deliver services to the PLWH only to the extent that similar services are not available from another source (such as a translator employed by the clinic). This excludes use of family members of friends of the PLWH. Based on need, agency shall provide the following types of linguistic services in the PLWH's preferred language: • Oral interpretation • Written translation • Sign language	
1.2 Timeliness of Scheduling Program will schedule service within one (1) business day of the request.	• Request date documented. • Scheduling of service documented.
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, the scheduling of interpreters and process of utilizing the service. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Agency should have the ability to provide (or make arrangements for the provision of) translation services regardless of the language of the PLWH seeking assistance Agency will be able to provide interpretation/ translation in the languages needed based on the needs assessment for the area. 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 Staff Qualifications and Training To ensure highest quality of communication: • Oral and written translators will be certified by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of	• Program Policies and Procedures will ensure the contracted agency complies with Legislation and Regulations: • (Americans with Disabilities Act (ADA), Section 504 of the

Certification for Medical Interpreters (NBCMI). Where CCHI and NBCMI certification for a specific language do not exist, an equivalent certification (MasterWord, etc.) may be substituted for the CCHI and NBCMI certification. • Staff and volunteers who provide American Sign Language services must hold a certification from the Board of Evaluation of Interpreters (BEI), the Registry of Interpreters for the Deaf (RID), the National Interpreter Certification (NIC), or the State of Texas at a level recommended by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services. • Interpreter staff/agency will be trained and experienced in the health care setting.	Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act • Agency contracts with companies that maintain certified ASL interpreters on staff. • Agency scheduling documents appropriate levels of interpreters are requested.
2.6 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.	• Review of policies and procedures evidence incorporation of TIA. • Staff training is documented. • Systems and workflow revised to promote TISD.

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.	

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- Title VI of the Civil Rights Act of 1964 with respect to individuals with limited English proficiency (LEP). Located at: http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html
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- National Culturally and Linguistically Appropriate Services (CLAS) Standards: https://thinkculturalhealth.hhs.gov/clas/standards
- 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
LINGUISTIC INTERPRETIVE SERVICES

1. Percentage of PLWH with documented evidence of need of linguistic services as indicated in the service assessment.
2. Percentage of primary service records with documented evidence of interpretive/translation services provided for the date of service requested.

Harris County
Public Health
Building a Healthy Community

2025-2026
HOUSTON ELIGIBLE METROPOLITAN AREA
RYAN WHITE CARE ACT PART A
STANDARDS OF CARE
FOR HIV SERVICES
RYAN WHITE GRANT ADMINISTRATION
HARRIS COUNTY PUBLIC HEALTH (HCPH)

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Introduction

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

Purpose

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

Scope

The Houston EMA SOCs apply to Part A funded HRSA defined core and support services including the following services in FY 2025-2026:

Core Services

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

Support Services

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

Services are funded as follows:

Part A funded services

Combination of Parts A, B, and/or State Services funding

Standards Development

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

Organization of the SOCs

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

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

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

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

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application • Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Review of personnel and/or volunteer files indicates compliance.
1.2	Initial Training: Staff/Volunteers Initial training includes eight (8) hours of: HIV basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers (e.g., job description), agency-specific information (e.g., Drug Free Workplace policy) and customer service training must be completed within 60 days of hire. https://www.dshs.texas.gov/hivstd/contractor/casemanage	• Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure. • Materials for staff training and continuing education are on file. • Staff interviews indicate compliance.
1.3	Staff Performance Evaluation Agency will perform annual staff performance evaluation.	• Completed annual performance evaluation kept in employee's file. • Signed and dated by employee and supervisor (includes electronic signature).

1.4	<u>Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers</u> All staff tenured 0 – 5 years with their current employer must receive four (4) hours of cultural competency training to include information on working with people of all races, ethnicities, nationalities, gender identities, and sexual orientations and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire. All staff with greater than 5 years with their current employer must receive two (2) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually.	• Documentation of training is maintained by the agency in the personnel file.
1.5	<u>Staff education on eligibility determination and fee schedule</u> Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All new employees must complete within ninety (90) days of hire.	• Documentation of training in employee's record.
2.0	**Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.**	
2.1	Service Evaluation Agency has a process in place for the evaluation of client services.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Staff interviews indicate compliance.

2.2	Subcontractor Monitoring Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and	• Documentation of subcontractor monitoring. • Review of Agency's Policies and Procedures Manual indicates compliance.
2.3	Staff Guidelines Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and termination process, and position descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights; staff must review these guidelines annually.	• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed, and that the employee understands agency policies and procedures.
2.4	Work Conditions Staff/volunteers have the necessary tools, supplies, equipment, and space to accomplish their work.	• Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply. Staff interviews indicate compliance.
2.5	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance. • Review of Agency's Policies and Procedures Manual indicates compliance.

2.6	Professional Behavior Staff must comply with written standards of professional behavior.	• Staff guidelines include standards of professional behavior. • Review of Agency's Policies and Procedures Manual indicates compliance. • Review of personnel files indicates compliance. • Review of agency's complaint and grievance files.
2.7	Communication There are procedures in place regarding regular communication with staff about the program and general agency issues.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation of regular staff meetings. • Staff interviews indicate compliance.
2.8	Accountability There is a system in place to document staff time and effort commensurate to appropriate funding source.	• Staff time sheets or other documentation indicate compliance.
2.9	Staff Availability Staff are present to answer incoming calls during agency's normal operating hours.	• Published documentation of agency operating hours. • Staff time sheets or other documentation indicate compliance.

3.0	**Clients Rights and Responsibilities**	
3.1	Clients Rights and Responsibilities Agency reviews Client Rights and Responsibilities Statement with each client in a language and format the client understands. Agency provides client with written copy of client rights and responsibilities, including: • Informed consent • Confidentiality • Grievance procedures • Duty to warn or report certain behaviors. • Scope of service • Criteria for end of services	• Documentation in client's record.
3.2	Confidentiality Agency maintains Policy and Procedure regarding client confidentiality in accordance with RWGA site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency. There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Client's interview indicates compliance. • Agency's structural layout and information management indicates compliance. • Signed confidentiality statement in each employee's personnel file.
3.3	Consents All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether HIV status is revealed.	• Agency Policy and Procedure and signed and dated consent forms in client record.

3.4	<u>Up to date Release of Information</u> Agency obtains an informed written consent of the client or legally responsible person prior to the disclosure or exchange of certain information about client's case to another party (including family members) in accordance with the RWGA Site Visit Guidelines, local, state and federal laws. The release/exchange consent form must contain: • Name of the person or entity permitted to make the disclosure. • Name of the client • The purpose of the disclosure • The types of information to be disclosed. • Entities to disclose to • Date on which the consent is signed. • The expiration date of client authorization (or expiration event) no longer than two years. • Signature of the client/or parent, guardian or person authorized to sign in lieu of the client. • Description of the Release of Information, its components, and ways the client can nullify it. Release/exchange of information forms must be completed entirely in the presence of the client. Any unused lines must have a line crossed through the space.	• Current Release of Information form with all the required elements signed by client or authorized person in client's record.

3.5	Grievance Procedure Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to: • To whom complaints can be made. • Steps necessary to complain. • Form of grievance if any. • Timelines and steps taken by the agency to resolve the grievance. • Documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client. • All complaints or grievances initiated by clients are documented on the Agency's standardized form. • Resolution of each grievance/complaint is documented on the standardized form and shared with client. • Confidentiality of grievance. • Addresses and phone numbers of licensing authorities and funding sources. • Language outlining that clients cannot be retaliated against for filing grievances.	• Signed receipt of agency Grievance Procedure, filed in client chart. • Review of Agency's Policies and Procedures Manual indicates compliance. • Review of Agency's Grievance file indicates compliance. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2

3.6	<u>Conditions Under Which Discharge/Closure May Occur</u> A client may be discharged from Ryan White funded services for the following reasons. • Death of the client • At the client's or legal guardian request • Changes in client's need which indicates services from another agency. • Fraudulent claims or documentation about HIV diagnosis by the client. • Client actions put the agency, case manager or other clients at risk. Documented supervisory review is required when a client is terminated or suspended from services due to behavioral issues. • Client moves out of service area, enters jail, or cannot be contacted for sixty (60) days. Agency must document three (3) attempts to contact clients by more than one method (e.g., phone, mail, email, text message, in person via home visit). • Client service plan is completed, and no additional needs are identified. Client must be provided a written notice prior to involuntary termination of services (e.g., due to dangerous behavior, fraudulent claims, or documentation, etc.).	• Documentation in client record and in the Centralized Patient Care Data Management System. • A copy of written notice and a certified mail receipt for involuntary termination.
3.7	<u>Client Closure</u> A summary progress note is completed in accordance with Site Visit Guidelines within three (3) working days of closure, including: • Date and reason for discharge/closure. • Summary of all services received by the client and the client's response to services. • Referrals made and/or • Instructions given to the individual at discharge (when applicable).	• Documentation in client record and in the Centralized Patient Care Data Management System.

3.8	Client Feedback In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually). Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may include client satisfaction surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB). Agencies that serve an average of 100 or more unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.	• Documentation of clients' evaluation of services is maintained. • Documentation of CAB and public meeting minutes. • Documentation of existence and appropriateness of a suggestion box or other client input mechanism. • Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1

3.9	Patient Safety (Core Services Only) Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation *for Ambulatory Care* (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable: • "Improve the accuracy of patient identification. • Improve the safety of using medications. • Reduce the risk of healthcare-associated infections. • Accurately and completely reconcile medications across the continuum of care. • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (www.jointcommission.org)	• Review of Agency's Policies and Procedures Manual indicates compliance.
3.10	Client Records Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance.

4.0	**Accessibility**	
4.1	Cultural Competence Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals and people of all gender identities and sexual orientations.	• Agency has procedures for obtaining translation services. • Client satisfaction survey indicates compliance • Policies and procedures demonstrate commitment to the community and culture of the clients. • Availability of interpretive services, bilingual staff, and staff trained in cultural competence. • Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record. • Agency has facilities available for consumers of all gender identities, including gender-neutral restrooms.
4.2	Client Education Agency demonstrates capacity for client education and provision of information on community resources.	• Availability of the blue book and other educational materials. • Documentation of educational needs assessment and client education in clients' records.

4.3	Special Service Needs Agency demonstrates a commitment to assisting individuals with special needs.	• Agency compliance with the Americans with Disabilities Act (ADA). • Review of Policies and Procedures indicates compliance. • Environmental Review shows a facility that is handicapped accessible.
4.4	Provision of Services for Low-Income Individuals Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low-income individuals.	• Facility is accessible by public transportation. • Review of Agency's Policies and Procedures Manual indicates compliance. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4
4.5	Proof of HIV Diagnosis Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services. An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3

4.6	<u>Provision of Services Regardless of Current or Past Health Condition</u> Agency must have Policies and Procedures in place to ensure that clients living with HIV are not denied services due to current or pre-existing health condition or non- HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	• Review of Policies and Procedures indicates compliance. • A file containing information on clients who have been refused services and the reasons for refusal. • Source Citation: HAB Program Standards; Section D: #1
4.7	<u>Client Eligibility</u> In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.) • Income no greater than 300% of the Federal Poverty level (unless otherwise indicated) • Proof of identification • Ineligibility for third party reimbursement	• Documentation of HIV+ status, residence, identification, and income in the client record. • Documentation of ineligibility for third party reimbursement. • Documentation of screening for Third Party Payers in accordance with RWGA site visit guidelines. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B: Eligibility Determination/Screening #1

4.8	<u>Re-certification of Client Eligibility</u> Appropriate documentation is required for changes in status and at least once a year (defined as a 12-month period) with renewed eligibility with the CPCDMS. At a minimum, agency confirms an individual's income, residency and re- screens, as appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance. Agency must ensure that Ryan White is the Payer of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance and other programs. Agency policy must also address coordination of benefits, billing and collection. Clients eligible for Department of Veterans Affairs (VA) benefits are duly eligible for Ryan White services and therefore exempted from the payer of last resort requirement. • Agency must verify 3rd party payment coverage for eligible services at every visit or monthly (whichever is less frequent).	• Client record contains documentation of re-certification of client residence, income, and rescreening for third party payers at least every twelve (12) months. • Review of Policies and Procedures indicates compliance. • Information in client's files that includes proof of screening for insurance coverage (i.e., hard/scanned copy of results). • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B: Eligibility Determination/Screening #1 and #2 • Source Citation: HIV/AIDS Bureau (HAB) Policy Clarification Notice #13- 02

4.9	<u>Charges for Services</u> Agency must institute Policies and Procedures for cost sharing including enrollment fees, premiums, deductibles, co-payments, co-insurance, sliding fee discount, etc. and an annual cap on these charges. Agency should not charge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross income level (GIL)is ≤ 100% of the Federal Poverty Level (FPL) as documented in the CPCDMS for any services provided. Clients whose gross income is between 101-300% may be charged annual aggregate fees in accordance with the legislative mandate outlined below: • 101%-200% of FPL---5% or less of GIL • 201%-300% of FPL---7% or less of GIL • >300% of FPL ---------10% or less of GIL Additionally, agency must implement the following: • Six (6) month evaluation of clients to establish individual fees and cap (i.e., the six (6) month CPCDMS registration or registration update.) • Tracking of charges • A process for alerting the billing system when the cap is reached so client will not be charged for the rest of the calendar year. • Documentation of fees	• Review of Policies and Procedures indicates compliance. • Review of system for tracking patient charges and payments indicate compliance. • Review of charges and payments in client records indicate compliance with annual cap. • Sliding fee application forms on client record is consistent with Federal guidelines.
4.9b	<u>Provision of services regardless of an individual's ability to pay for the service.</u> Subgrantee billing and collection policies and procedures do not: • Deny services for non-payment. • Deny payment for inability to produce income documentation. • Require full payment prior to service. • Include any other procedure that denies services for non-payment.	

4.10	Information on Program and Eligibility/Sliding Fee Schedule Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update. Agency should maintain a file documenting promotion activity including copies of HIV program materials and information on eligibility requirements. Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	• Agency has a written substantiated annual plan to targeted populations. • Zip code data show provider is reaching clients throughout service area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record. Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5

4.11	<u>Linkage Into Core Services</u> Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.	• Documentation of client referral is present in client record. • Review of agency's policies & procedures' manual
4.12	<u>Wait Lists</u> It is the expectation that clients will not be put on a Wait List, nor will services be postponed or denied. Agency must notify the administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by which client information will be obtained and maintained to ensure that all clients that requested service(s) are contacted after service provision resumes. A wait list is defined as a roster developed and maintained by providers of patients awaiting a particular service when a demand for a service exceeds available appointments used on a first come next serviced method. The Agency will notify RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and a plan for resumption of service. The Agency's plan must address: • Action steps to be taken Agency to resolve the service shortfall; and • Projected date that services will resume. The Agency will report to RWGA in writing on a monthly basis while a client wait list is required with the following information: • Number of clients on the wait list. • Progress toward completing the plan for resumption of service. • A revised plan for resumption of service, if necessary.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted.

4.13	Intake The agency conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions. In addition to office visits, client is provided alternatives such as conducting business by mail, online registration via the internet, or providing home visits, when necessary. Agency has established procedures for communicating with people with hearing impairments.	• Documentation in client record. • Review of Agency's Policies and Procedures Manual indicates compliance.
5.0	**Quality Management**	
5.1	Continuous Quality Improvement (CQI) Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum: • The Agency's QM Plan • Meeting agendas and/or notes (if applicable) • Project specific CQI Plans • Root Cause Analysis & Improvement Plans • Data collection methods and analysis • Work products • QM program evaluation • Materials necessary for QM activities	• Review of Agency's Policies and Procedures Manual indicates compliance. • Up-to-date QM Manual • Source Citation: HAB Universal Standards; Section F: #2

5.2	Data Collection and Analysis Agency demonstrates capacity to collect and analyze client level data including client satisfaction surveys and findings are incorporated into service delivery. Supervisors shall conduct and document ongoing record reviews as part of quality improvement activity.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Up to date QM Manual • Supervisors log on record reviews signed and dated. • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2
6.0	**Point Of Entry Agreements**	
6.1	Points of Entry (Core Services Only) Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with HIV Services policy approved by HRSA for the Houston EMA.	• Review of Agency's Policies and Procedures Manual indicates compliance. • Documentation of formal agreements with appropriate Points of Entry. • Documentation of referrals and their follow-up.

7.0	**Emergency Management**	
7.1	Emergency Preparedness Agency leadership including medical staff must develop an Emergency Preparedness Plan modeled after the Joint Commission's regulations and/or Centers for Medicare and Medicaid guidelines for Emergency Management. The plan should, at a minimum utilize "all hazard approach" (hurricanes, floods, earthquakes, tornadoes, wide-spread fires, infectious disease outbreak and other public health threats, terrorist attacks, civil disturbances and collapse of buildings and bridges) to ensure a level of preparedness sufficient to support a range of emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergency. The agency shall communicate hazards identified with its community emergency response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	• Emergency Preparedness Plan • Review of Agency's Policies and Procedures Manual indicates compliance.

7.2	Emergency Management Training In accordance with the Department of Human Services recommendations, all applicable agency staff (such as, executive level, direct client services, supervisory staff) must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security: -IS-100.C: Introduction to the Incident Command System, ICS 100 -IS-200.C: 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

Emergency Financial Assistance Program (OTHER)

Emergency Financial Assistance (EFA) is to provide one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential housing, utilities, food (including groceries, and food vouchers), and transportation. Emergency Financial Assistance can occur as a direct payment to an agency or through a voucher program.

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	EFA funds may be used on the following essential items or services: • Housing for up to 14 days (limited to PLWH who are displaced from home due to acute housing needs). • Utilities (may include household utilities including gas, electricity, propane, water, and all required fees). • Telephone • Food (groceries or food vouchers) Other RWHAP allowable costs needed to improve health outcomes.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of billing history indicates compliance. • Documentation in the client chart.

1.2	Client Eligibility Applicants must demonstrate an urgent need resulting in their inability to pay their applicable bills without financial assistance for essential items or services necessary to improve health outcomes. Demonstrated need is made by the following: • A significant increase in bills • A recent decrease in income • High unexpected expenses on essential items • The cost of their shelter is more than 30% of the household income. • The cost of their utility consumption is more than 10% of the household income. • They are unable to obtain credit necessary to provide for basic needs and shelter. • A failure to provide emergency financial assistance will result in danger to the physical health of client or dependent children. Other emergency needs as deemed appropriate by the agency. • The invoice/bill which is to be paid with emergency financial assistance funds must be in the client's name. An exception may be made only in instances where it is documented that, although the service (e.g., utility) is in another person's name, it directly benefits the client.	• Documentation of client assessment • Copy of invoice/bill paid. • Copy of check for payment.
1.3	Client Confidentiality Payment for assistance made to service providers will protect client confidentiality through use of checks and envelopes that de-identify agency as an HIV/AIDS provider to protect client confidentiality.	• Agency financial records indicate compliance. • Documentation in the client chart.

1.4	Assessment • An assessment must demonstrate an urgent need resulting in their inability to pay their applicable bills without financial assistance for essential items or services necessary to improve health outcomes. • Client will be assessed for ongoing status and outcome of the emergency assistance. Referrals for services, as applicable, will be documented in the client file. • Emergent need must be documented each time funds are used.	• Documentation in the client chart.
1.5	Documentation • Plans are developed jointly with the client and must include an approach to mitigate the need in the future. • Client's chart contains documented plan for EFA that indicates emergent need, other resources pursued, and outcome of EFA provided.	• Documentation in the client chart.
1.6	Timeliness of Service Provision All completed requests for assistance shall be approved or denied within three (3) business days following the completed request.	• Documentation in the client chart.
2.0	**Agency requirements**	
2.1	Budget Requirements or Restrictions • Direct cash payments to clients are not permitted. • RWHAP funds will be the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. • At least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements.	• Documentation includes copies of checks paid and vouchers purchased. • Review of agency's Policies & Procedures Manual indicates compliance. • Documentation that at least 75% of the total amount of the budget must be solely allocated to the actual cost of disbursements.

2.1 cont.	• The agency must set priorities, delineate, and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary.	
2.2	Agency providing emergency financial assistance shall have procedures in place to ensure that funds are distributed fairly and consistently.	• Agency written procedure.
2.3	Agency must be dually awarded as HOWPA sub-recipient and work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. Agency must document procedures.	• Agency written procedure.

Legal Assistance - Expungement of Criminal Record

Ryan White allowable legal assistance in expungement of criminal record by an Attorney licensed to practice in Texas in accordance with 55.02, Texas Code of Criminal Procedure. https://statutes.capitol.texas.gov/Docs/CR/htm/CR.55.htm. Services include an assessment to determine the client's eligibility for expungement of criminal record.

1.0	**Services are part of the coordinated continuum of HIV/AIDS services.**	
1.1	Clients Referral and Tracking Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary.	• Documentation of referrals received
2.0	**Legal services adhere to professional standards and regulations.**	
2.1	Licensure Attorneys are licensed to practice law in the state of Texas and have a minimum educational level of a doctorate in Jurisprudence.	• Staff records indicate compliance
2.2	Non-Licensed Staff Non-licensed staff members are supervised by attorneys.	• Review of agency's Policies & Procedures Manual indicates compliance
3.0	**Service providers are knowledgeable, accepting and respectful of the needs of people living with HIV/AIDS.**	

3.1	Ongoing Staff Training Staff has access to appropriate training and resources needed to deliver services. Staff members are trained and knowledgeable and remain current in legal issues in accordance with the rules of the State Bar of Texas. Staff shall maintain knowledge of legal issues that may impact the legal assistance needs of PLWHA. Agency paid legal staff and contractors must complete two (2) hours of HIV-specific training annually. New agency paid legal staff and contractors must complete two (2) hours of HIV-specific training within 90 days of start date. Volunteer legal staffs are encouraged to complete HIV-specific legal training.	• Staff has attended and has continued access to training activities. • Staff has access to manuals and regulations. • Documentation of training on current applicable laws through the State Bar • Staff have access to updated HIV/AIDS information. • Agency maintains system for dissemination of HIV/AIDS information relevant to the legal assistance needs of PLWHA to paid staff and volunteers. • Staff interviews indicate compliance.
4.0	**Client is kept informed and participates in decisions about his/her case.**	
4.1	Service Agreement Clients are kept informed and work together with staff to determine the objective of the representation and to achieve expungement of criminal record.	• Copy of service agreement between client and agency is in client record.
4.2	Case Closure Agency will develop case closure criteria and procedures. Cases may be closed when the client's legal record is expunged, or when the client: is determined to be ineligible for criminal expungement has had no direct program contact for over six months is deceased no longer needs the service discontinues the service improperly utilizes the service has not complied with the client services agreement Agency will attempt to notify clients about case closure.	• Case closure criteria and procedures on file at provider agency. • Client chart will include attempts at notification and reason for case closure.

Transitional Housing - Temporary Assisted Living

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

1.0	**Service Specific Requirements**	
1.1	Services to be provided should be designed to support ongoing HIV care, increased functioning, and the return to self-sufficiency for PLWH through the provision of treatment and activities of daily living. Services must include: • Room and daily nutritious meals and snacks, • Skilled Nursing to include medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, ongoing monitoring of client's physical condition and communication with attending physician(s) and personal care team • Other Therapeutic Services including physical and occupational therapies.	• Review of agency's policies & procedures • Review of staff records

1.2	• Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant (PA), Nurse (RN, LVN), licensed Social Worker, or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed and then documented in the patient record: o the names, actions and purposes of all medications in the patient's regimen; the dosage schedule; o food requirements, if any; o side effects; o drug interactions; o and adherence. o Patients must be informed of the following: o how to pick up medications; o how to get refills; o and what to do and who to call when having problems taking medications as prescribed. o Medication education must also include patient's return demonstration of the most current prescribed medication regimen.	• Review of agency's policies & procedures • Review of staff records

2.0	**Staff Requirements**	
2.1	Staff must have all required federal, state and local licensure, certifications, permits and must comply with local, state, and federal regulations. The contractor is responsible for ensuring that services are provided by State licensed MDs, NPs, PAs, RNs, LVNs, social workers, and pharmacists.	• Staff records indicate compliance
2.2	The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV care, to provide the medication and adherence educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV care may also provide adherence education and counseling.	• Staff records indicate compliance
3.0	**Facility Requirements**	
3.1	Facility must have all required federal, state and local licenses, certifications and permits and must comply with local, state, and federal regulations.	• Records indicate compliance
4.0	**Client Eligibility and Referral**	
4.1	Eligibility: • Client must receive referral for service from an MD, NP, or PA. • Client must have a qualifying inpatient hospital stay of at least three (3) days in a row defined as the day of admission, but not counting the day of discharge. • Client must enter the facility within 30 days of discharge from a hospital.	• Review of agency's policies & procedures • Review of client's record
4.2	Services must be provided in accordance with doctor's referral. As part of the intake process, doctor's orders must be obtained to guide service provision to client.	• Review of agency's policies & procedures • Review of client's record

5.0	**Initial Assessment and Care Plan**	
5.1	A preliminary assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care. Client will be contacted within one (1) business day of the referral, and services should be initiated at the time specified by the primary medical care provider, or within thirty (30) days, whichever is earlier.	• Documentation of needs assessment completed in the client's primary service record • Documented evidence of a comprehensive evaluation completed in the client's primary service record.
5.2	<u>Comprehensive Assessment</u> A comprehensive assessment, including nursing, nutritional, therapeutic, and educational is completed for each client within seven (7) days of intake. A measure of the client's acuity will be incorporated into the assessment tool to track increased functioning. A comprehensive evaluation of the PLWH's health, psychosocial status, functional status, and home environment should be completed to include: • Assessment of PLWH's access to primary care • adherence to therapies, disease progression, symptom management and prevention • need for skilled nursing or rehabilitation services. Information to determine client's ability to perform activities of daily living and the level of attendant care assistance the client needs to maintain living independently.	• Review of PLWH's primary service record indicates compliance. • Acuity levels documented as part of assessment.
5.3	<u>Plan of Care</u> A written plan of care is completed for each client within seven (7) days of intake. Development of plan of care incorporates a multidisciplinary team approach.	

5.4	<u>Implementation of Care Plan</u> In coordination with the medical care coordination team, professional staff will: • Provide nursing and rehabilitation therapy care under the supervision and orders of the client's referring provider. • Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation. • Monitor changes in client's physical health and level of functionality. • Work closely with client's other health care providers and other members of the care team in order to effectively communicate and address client service-related needs, challenges and barriers. • Participate in the development of individualized care plan with members of the care team. • Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate. • Provide attendant care services which include taking vital signs if medically indicated • Assist with client's self-administration of medication. • Promptly report any problems or questions regarding the client's adherence to medication. • Report any changes in the client's condition and needs. • Current assessment and needs of the client, including activities of daily living needs (personal hygiene care, basic assistance with cleaning, and cooking activities) • Need for home and community-based health services. • Types, quantity and length of time services are to be provided.	• Documentation in the client's primary service record indicates services provided were consistent with the care plan. • Client record contains documented evidence of a care plan completed based on the primary medical care provider's order as indicated in the client's primary service record. • Documented evidence of care plans reviewed and/or updated as necessary in the client's primary service record.

5.5	Provision of Services/ Progress Notes Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of housing – temporary assisted living services. • Progress notes will be kept in the client's primary service record and must be written the day services are rendered. • Progress notes will then be entered into the client record within (5) working days. • The agency will maintain ongoing communication with the multidisciplinary medical care team in compliance with Texas Medicaid and Medicare Guidelines. • Care Team will document in the client's primary service record progress notes throughout the course of the treatment, including evidence that the PLWH is not in need of acute care.	• Documented evidence of completed progress notes in the client's primary service record • Documentation of on-going communication with primary medical care provider and care coordination team as indicated in the client's primary service record
6.0	**Billing Requirements**	
6.1	Agency must be able to bill Medicare, Medicaid, private insurance and/or other third-party payers.	• Client record shows evidence of third-party payor search • Billing records indicate compliance
	Restrictions • Housing activities cannot be in the form of direct cash payments to clients. • Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.	• Billing records and General Ledger indicate compliance
7.0	**Discharge**	
7.1	Services will end when one or more of the following takes place: • Referral period ends or thirty (days) pass without additional referral and approved waiver. • Client acuity indicates self-sufficiency and care plan goals completed. • Client expresses desire to discontinue/transfer services.	• Documentation of a discharge/transfer plan developed with client, as applicable, as indicated in the client's primary service record. • Copy of discharge letter in client record

	• Client has been referred on to a higher level of care (such as assisted living or skilled nursing facility). • Client is unable or unwilling to adhere to Care Plan. • Client is unable or unwilling to adhere to agency policies. • PLWH relocates out of the service delivery area. • When applicable, an employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a PLWH's home, in the company of an escort or not. The agency may discontinue services or refuse the PLWH for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within one (1) business day and followed by a written report. A copy of the police report is sufficient, if applicable.	
7.2	All services discontinued before completion of the client's Care Plan must be accompanied by a referral to an appropriate service provider agency.	• Documentation of a discharge/transfer plan developed with client, as applicable, as indicated in the client's primary service record. • Copy of discharge letter in client record

Transportation Services

The 2006 Care Act classifies Medical Transportation as a support service that provides conveyance services "directly or through voucher to a client so that he or she may access health care services". The Ryan White Part A transportation services include transportation to public and private outpatient medical care and physician services, Substance Use and mental health services, pharmacies and other services where eligible clients receive Ryan White-defined Core Services and/or medical and health-related care services, including clinical trials, essential to their well-being. All drivers utilized by the program must have a valid Texas Driver's license and must complete a "Safe Driving" course. The contractor must ensure that each vehicle has automobile liability insurance as required by the State and all vehicles have current Texas State Inspection.

1.0	**Transportation services are offered to eligible clients to ensure individuals most in need have access to services.**	
1.1	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/HSDA • Part A Urban Transportation limited to Harris County • Part A Rural/Part B Transportation are limited to Houston EMA/HSDA, as applicable. • Income no greater than 500% of the Federal Poverty level • Proof of identification • Documentation of ineligibility for Third Party Reimbursement	• Documentation of HIV+ status, identification, residence and income in the client record.

1.2	Voucher Guidelines (Distribution Sites) • Bus Card Voucher (Renewal): Eligible clients who reside in the METRO service area will be issued an initial METRO bus card voucher from any Ryan White subrecipient and annually thereafter, within 15 days of bus pass expiration. • Bus Card Voucher (Value-Based): Otherwise, eligible clients who are not eligible for a renewal bus card voucher may be issued a value- based bus card voucher per RWGA business rules. ➢ For an existing bus card client to renew their bus card (i.e., obtain another bus card voucher for all voucher types) there must be documentation that the client is engaged in ongoing primary medical care for treatment of HIV, or ➢ Documentation that the bus voucher is needed to ensure an out-of-care client is re-engaged in primary medical care. • Gas Card: Eligible clients in the rural area will receive gas cards from their Ryan White Part A/B rural case management provider or their rural primary care provider, if the client is not case managed, per RWGA business rules. • *Taxi Voucher: for emergencies, to access emergency shelter vouchers and to attend Social Security disability hearings only.*	• Client record indicates guidelines were followed; if not, an explanation is documented. • Documentation of the type of voucher(s) issued. • **Issuance of bus voucher must be entered into CPCDMS within 12 hours.** • Emergency necessitating taxi voucher is documented. • Ongoing current (within the last 12 months) medical care is documented in the CPCDMS OR A current (within the last 12 months) copy of client's Viral Load and/or CD4 lab work (preferred) or proof client is on ART (HIV medications) for clients in medical care with Ryan White or non-Ryan White funded providers in client record OR • Engagement/re-engagement in medical care is documented in client's case management assessment and service plan.

1.3	Eligibility for Van-Based Transportation (Urban Transportation Only) Written certification from the client's principal medical provider (e.g., medical care coordinator) is required to access van-based transportation and must be renewed every 180 days. All clients may receive a maximum of 4 non-certified round trips per year (includes taxi vouchers).	• Client record indicates compliance.
2.0	**ACCESSIBILITY** **Transportation services are offered in such a way as to overcome barriers to access and utilization.**	
2.1	Notification of Service Availability Prospective and current clients are informed of service availability, prioritization, and eligibility requirements.	• Program information is clearly publicized. • Availability of services, prioritization policy and eligibility
2.2	Access Clients must be able to initiate and coordinate their own services with the transportation providers in accordance with transportation system guidelines. This does not mean an advocate (e.g., social worker) for the client cannot assist the client in accessing transportation services. Agency must obtain a signed statement from clients regarding agreement on proper conduct of client in the vehicle. This statement should include the consequences of violating the agreement.	• Agency's policies and procedures for transportation services describe how the client can access the service. • Review of agency's complaint and grievances log. • Signed agreement in client's records.
2.3	Handicap Accessibility Transportation services are handicap accessible. Agency/Driver may refuse service to client with open sores/wounds or real exposure risk. Agency must have a policy in place regarding training for drivers on the proper boarding/unloading assistance of passengers with wheelchairs and other durable health devices.	• Agency compliance with the Americans with Disabilities Act (ADA) • Agency documentation of reason for refusal of service. • Documentation of training in personnel records.

2.4	EMA Accessibility Services are available throughout the Houston EMA as contractually defined in the RFP.	• Review of agency's Transportation Log and Monthly Activity Reports for compliance.
2.5	Service Availability The Contractor must ensure that general transportation service hours are from 7:00 AM to 10:00 PM on weekdays (non-holidays), and coverage must be available for medical and health-related appointments on Saturdays.	• Review of Transportation Logs. • Transportation services shall be available on Saturdays, by pre-scheduled appointment for core services. • Review of agency policy and procedure.
2.6	Service Capacity Agency will notify RWGA and other Ryan White providers when transportation resources are close to being maximized*. Agency will maintain documentation of clients who were refused services. * Maximized means the agency will not be able to provide service to client within the next 72 hours.	• RWGA will be contacted by phone/fax no later than twenty-four (24) working hours after services are maximized. • Agency will document all clients who were denied transportation or a voucher.
2.6	Service Capacity Agency will notify RWGA and other Ryan White providers when transportation resources are close to being maximized*. Agency will maintain documentation of clients who were refused services. * Maximized means the agency will not be able to provide service to client within the next 72 hours.	• RWGA will be contacted by phone/fax no later than twenty-four (24) working hours after services are maximized. • Agency will document all clients who were denied transportation or a voucher.

3.0	**Timeliness and Delays: Transportation services are provided in a timely manner**	
3.1	Timeliness There is minimal waiting time for vehicles and vans; appointments are kept. • Waiting times longer than 2 hours will also be documented in the client record. • If a cumulative incident of clients kept waiting for more than 2 hours reaches 75 clients in the contract year, this must be reported in writing within one business day to the administrative agent. Review of agency's complaint and grievance logs Client interviews and client satisfaction survey.	• Waiting times longer than 60 minutes will be documented in Delay Incident Log. • Review of Delay incident log. • Review of client's record.
3.2	Immediate Service Problems Clients are made aware of problems immediately (e.g., vehicle breakdown) and notification documented.	• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance. • Review of agency's complaint and grievance logs. • Client interviews and client satisfaction survey.
3.3	Future Service Delays Clients and Ryan White providers are notified of future service delays, changes in appointment or schedules as they occur.	• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance. • Review of agency's complaint and grievance logs. • Client interviews and client satisfaction survey. • Documentation exists in the client record.

3.4	<u>Confirmation of Appointments</u> Agency must allow clients to confirm appointments at least 48 hours in advance	• Review of agency's transportation policies and procedures indicates compliance. • Review of agency's complaint and grievance logs. • Client interviews and client satisfaction survey.
3.5	<u>"No Shows"</u> "No Shows" are documented in Transportation Log and client record. Passengers who do not cancel scheduled rides for two (2) consecutive times or who "no show" for two (2) consecutive times or three times within the contract year *may be* removed from the van/vehicle roster for 30 days. If client is removed from the roster, he or she must be referred to other transportation services. One additional no show and the client can be suspended from service for one (1) year.	• Review of agency's transportation policies and procedures indicates compliance. • Documentation on Transportation Log. Documentation in client record.
3.6	<u>System Abuse</u> If an agency has verified that a client has falsified the existence of an appointment in order to access transportation, the client can be removed from the agency roster. If a client cancels van/vehicle transportation appointments in excess of three (3) times per month, the client may be removed from the van/vehicle roster for 30 days. Agency must have published rules regarding the consequences to the client in situations of system abuse.	• Documentation in the client record of verification that an appointment did not exist. • Documentation in the client record of client cancellation of van/vehicle appointments. • Availability of agency's published rules Written documentation in the client record of specific instances of system abuse.

3.7	Documentation of Service Utilization Transportation Provider must ensure: • Follow-up verification between transportation provider and destination service program confirming use of eligible service(s) or • Client provides proof of service documenting use of eligible services at destination agency on the date of transportation or • Scheduling of transportation services by receiving agency's case manager or transportation coordinator • In order to mitigate Agency exposure to clients who may fail to follow through with obtaining the required proof of service, Agency is allowed to provide one (1) one-way trip per client per year without proof of service documentation. The content of the proof of service will include: • Agency's letter head • Date/Time • CPCDMS client code • Name and signature of Agency's staff who attended to client Agency's stamp	• Documentation of confirmation from destination agency in agency/client record. • Client's original receipt from destination agency in agency/client record. • Documentation in Case Manager's progress notes. Documentation in agency/client record of the one (1) allowable one-way trip per year without proof of service documentation.

4.0	**Safety/Vehicle Maintenance: Transportation services are safe**	
4.1	Vehicle Maintenance and Insurance Vehicles are in good repair and equipped for adverse weather conditions. All vehicles will be equipped with both a fire extinguisher and first aid and CPR kits. A file will be maintained on each vehicle and shall include but not be limited to- description of vehicle including year, make, model, mileage, as well as general condition and integrity and service records. Inspections of vehicle should be routine and documented not less than quarterly. Seat belts/restraint systems must be operational. When in place, child car seats must be operational and installed according to specifications. All lights and turn signals must be operational, brakes must be in good working order, tires must be in good condition and air conditioning/heating system must be fully operational. Driver must have radio or cell phone capability.	• Inspection of First Aid/CPR kits indicates compliance. • Review of vehicle file • Current vehicle State Inspection sticker. • Fire extinguisher inspection date must be current. Proof of current automobile liability and personal injury insurance in the amount of at least $300,000.00.
4.2	Emergency Procedures Transportation emergency procedures are in place (e.g., breakdown of agency vehicle). Written procedures are developed and implemented to handle emergencies. Each driver will be instructed in how to handle emergencies before commencing service and will be in-serviced annually.	A copy of each in-service and sign-in roster with names both printed and signed and maintained in the driver's personnel file.
4.3	Transportation of Children Children must be transported safely. When transporting children, the agency will adhere to the Texas Transportation code 545.412 child Passenger Safety Seat Systems. Information regarding this code can be obtained at http://www.statutes.legis.state.tx.us/docs/tn/htm/tn.545.htm. Necessity of a car seat should be documented on the Transportation Log by staff when appointment is scheduled. Children 15 years old or younger must be accompanied by an adult caregiver in order to be transported.	• Review of Transportation Log indicates compliance. • Review of client records indicates compliance. Review of agency policies and procedures.

4.2	Emergency Procedures Transportation emergency procedures are in place (e.g., breakdown of agency vehicle). Written procedures are developed and implemented to handle emergencies. Each driver will be instructed in how to handle emergencies before commencing service and will be in-serviced annually.	• A copy of each in-service and sign-in roster with names both printed and signed and maintained in the driver's personnel file.
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4.4	Staff Requirements • Picture identification of each driver must be posted in the vehicle utilized to transport clients. • Criminal background checks must be performed on all direct service transportation personnel prior to transporting clients. • Drivers must have annual proof of a safe driving record, including history of tickets, DWI/DUI, or other traffic violations. • Conviction on more than three (3) moving violations within the past year will disqualify the driver. Conviction of one (1) DWI/DUI within the past three (3) years will disqualify the driver.	• Documentation in vehicle. Documentation in personnel file.
5.0	**Records Administration: Transportation services are documented consistently and appropriately**	
5.1	Transportation Consent Prior to receiving transportation services, clients must read and sign the Transportation Consent.	Review of client records indicates compliance.

5.2	Van/Vehicle Transportation Agency must document daily transportation services on the Transportation Log.	• Review of agency files indicates compliance. Log must contain driver's name, client's name or identification number, date, destinations, time of arrival, and type of appointment.
5.3	Mileage Documentation Agency must document the mileage between Trip Origin and Trip Destination (e.g., where client is transported to access eligible service) per a standard Internet-based mapping program (e.g., Yahoo Maps, Map Quest, Google Maps) for all clients receiving Van-based transportation services.	Map is printed out and filed in client chart

Overview of Clients:

HRSA's Ryan White HIV/AIDS Program, 2022

Population Fact Sheet | April 2024

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—nearly 567,000 people in 2022—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission. For more than three decades, RWHAP has worked to stop HIV stigma and reduce health disparities by caring for the whole person and addressing their social determinants of health.

Ryan White HIV/AIDS Program Fast Facts: Program Clients

74.2% ARE FROM RACIAL AND ETHNIC MINORITY GROUPS

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

89.6% ARE VIRALLY SUPPRESSED

48.2% ARE AGED 50+

HRSA
Ryan White HIV/AIDS Program

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

- **The majority of RWHAP clients are people with lower incomes.** Data show that 58.6 percent of clients are people living at or below 100 percent of the federal poverty level (FPL), and 86.9 percent of RWHAP clients are people living at or below 250 percent of the FPL. Nearly all clients served have an income at or below 400 percent of the FPL.
- **The RWHAP serves a diverse population.** Nearly three-quarters of clients are people from racial and ethnic minority groups. Data show that 44.5 percent of clients are Black/African American people and 25.3 percent of clients are Hispanic/Latino people.
- **The majority of RWHAP clients are male.** Among all clients served by RWHAP, 72.1 percent are male, 25.2 percent are female, and 2.8 percent are transgender.
- **The RWHAP client population is aging.** In 2022, people aged 50 years and older account for 48.2 percent of all RWHAP clients, which is a significant increase from 31.6 percent of RWHAP clients aged 50 years and older in 2010.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take their medication as prescribed and are virally suppressed cannot sexually transmit HIV to their partners and can live longer and healthier lives. According to 2022 data, **89.6 percent of RWHAP clients receiving HIV medical care are virally suppressed,*** which is a significant increase from 69.5 percent virally suppressed in 2010.

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

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

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

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

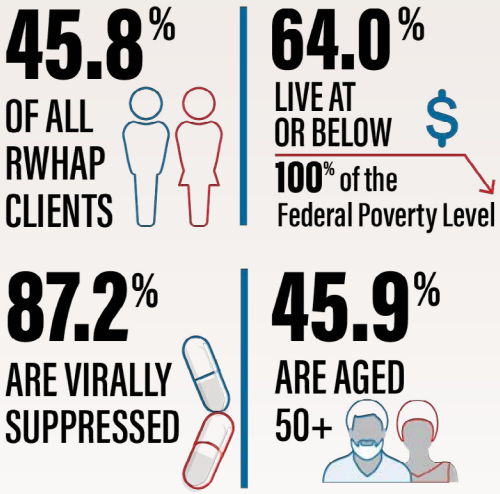
Black/African American Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

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

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



HRSA
Ryan White HIV/AIDS Program

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

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

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

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

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

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

The Impact of HIV on Black People in the United States

Published: Sep 09, 2024

Key Facts

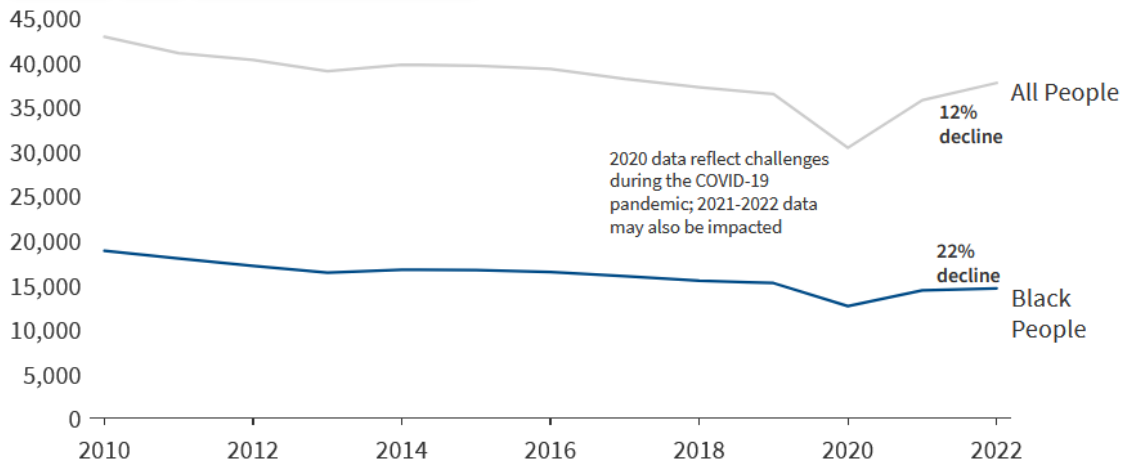
- Black people in the U.S. have been disproportionately affected by HIV since the epidemic's beginning, and that disparity has deepened over time.
- Although they represent only 12% of the U.S. population, Black people account for a much larger share of HIV diagnoses (39%), people living with HIV (40%),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

Figure 1

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

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

Overall | Sex | Transmission Categories



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

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

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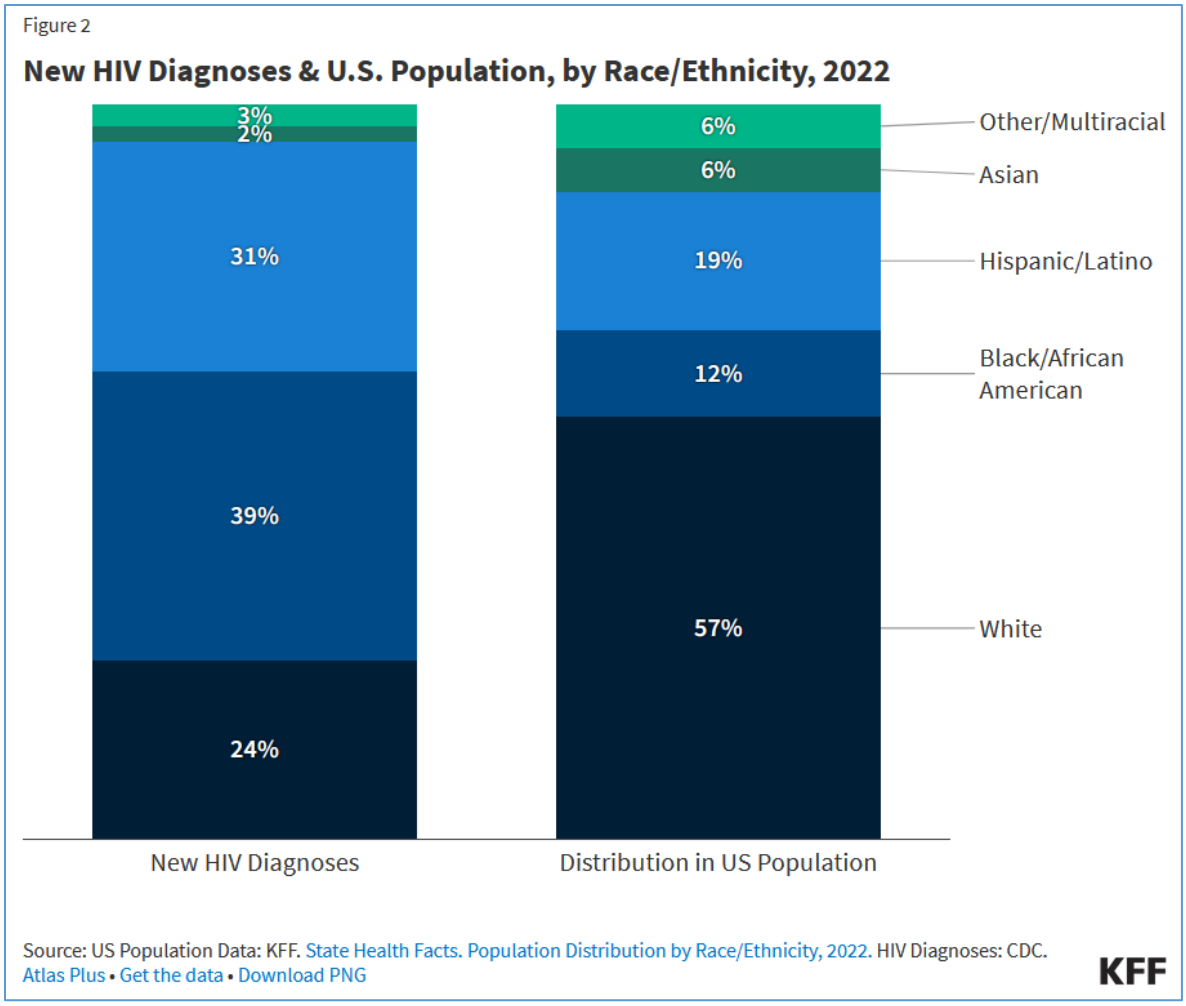
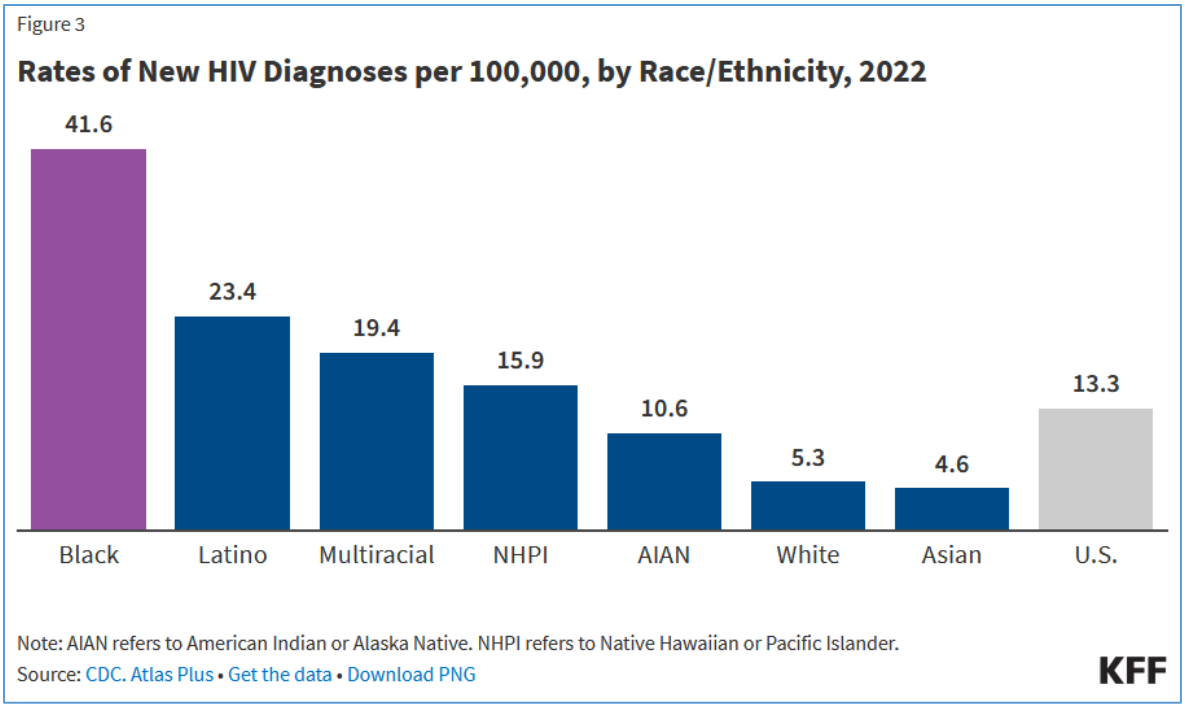
Overview

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



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



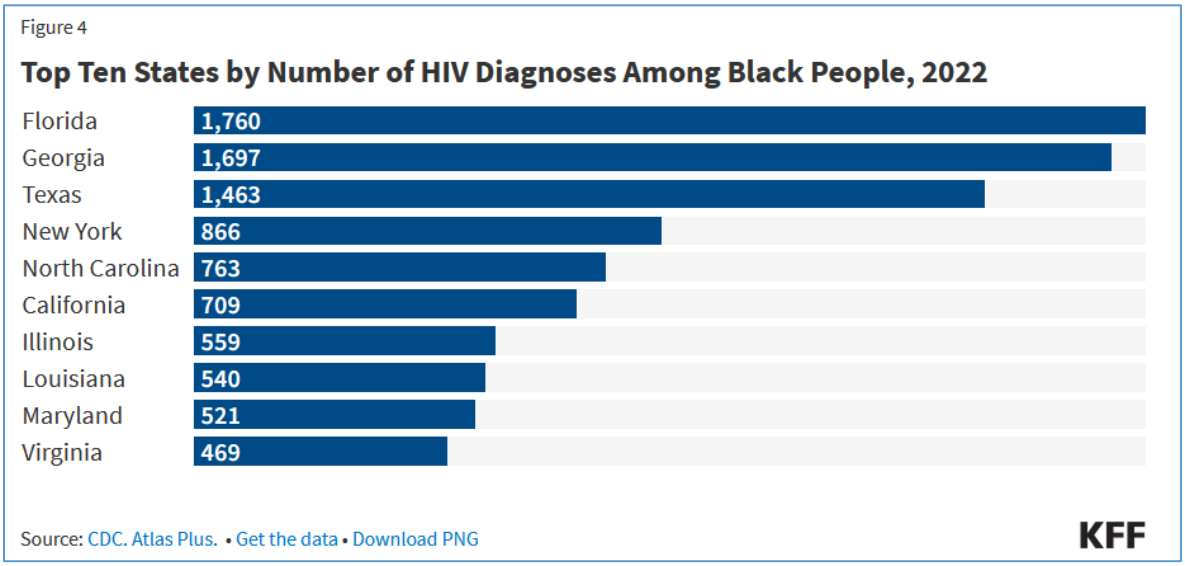
- Black people accounted for more than 4 in 10 (43%) deaths among people with an HIV diagnosis (deaths may be due to any cause) in 2022. The number of deaths among Black individuals with an HIV diagnosis decreased 13% between 2010 and 2018 but then increased more recently, by 15% between 2018 and 2022.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

Transmission

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

Geography

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



Women

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

Young People

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

Gay and Bisexual Men

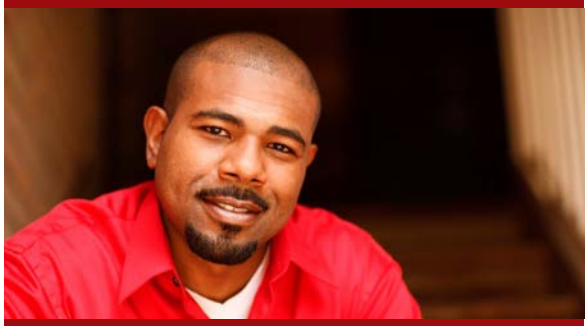
- Black gay and bisexual men accounted for almost half (49%) of Black people living with HIV and 30% of gay and bisexual men living with HIV.
- Among Black people, male-to-male sexual contact accounted for more than half (63%) of HIV diagnoses in 2022 and a majority (82%) of diagnoses among Black men.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

HIV Testing and Access to Prevention & Care

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

Hispanic/Latino Clients:

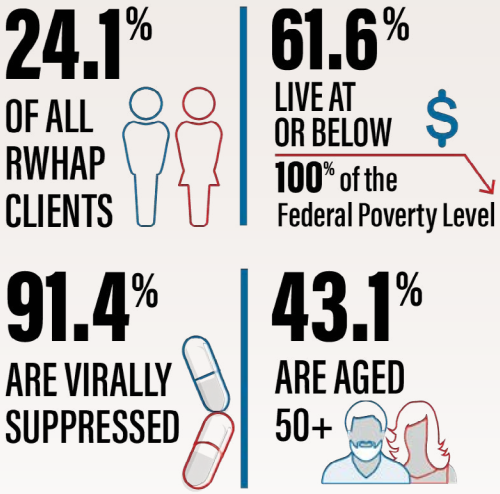
HRSA's Ryan White HIV/AIDS Program, 2021



Population Fact Sheet | March 2023

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

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



HRSA Ryan White HIV/AIDS Program

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

Learn more about Hispanic/Latino clients served by RWHAP:

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

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

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

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

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

Published: Oct 15, 2024

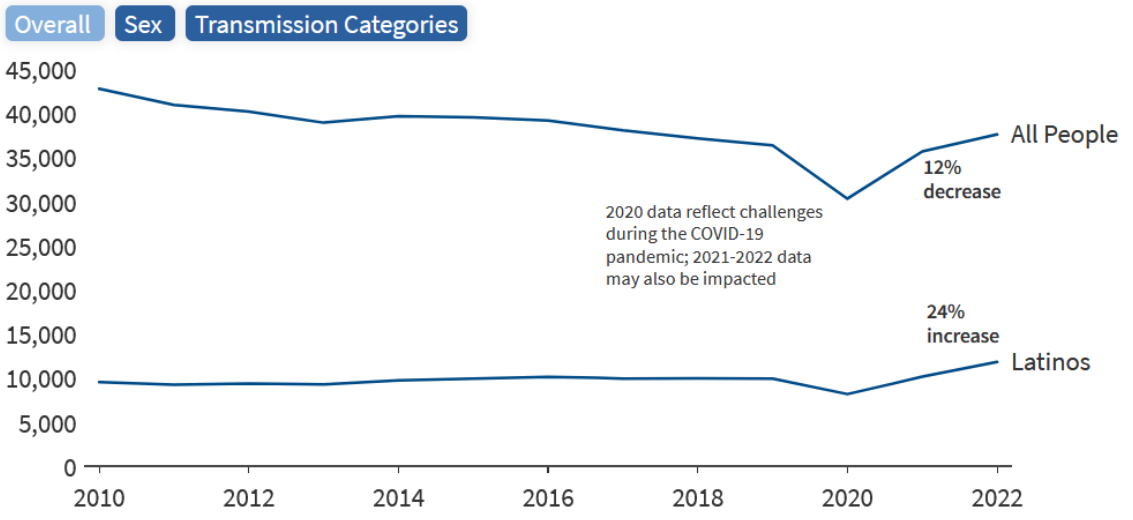
Key Facts

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

Figure 1

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

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



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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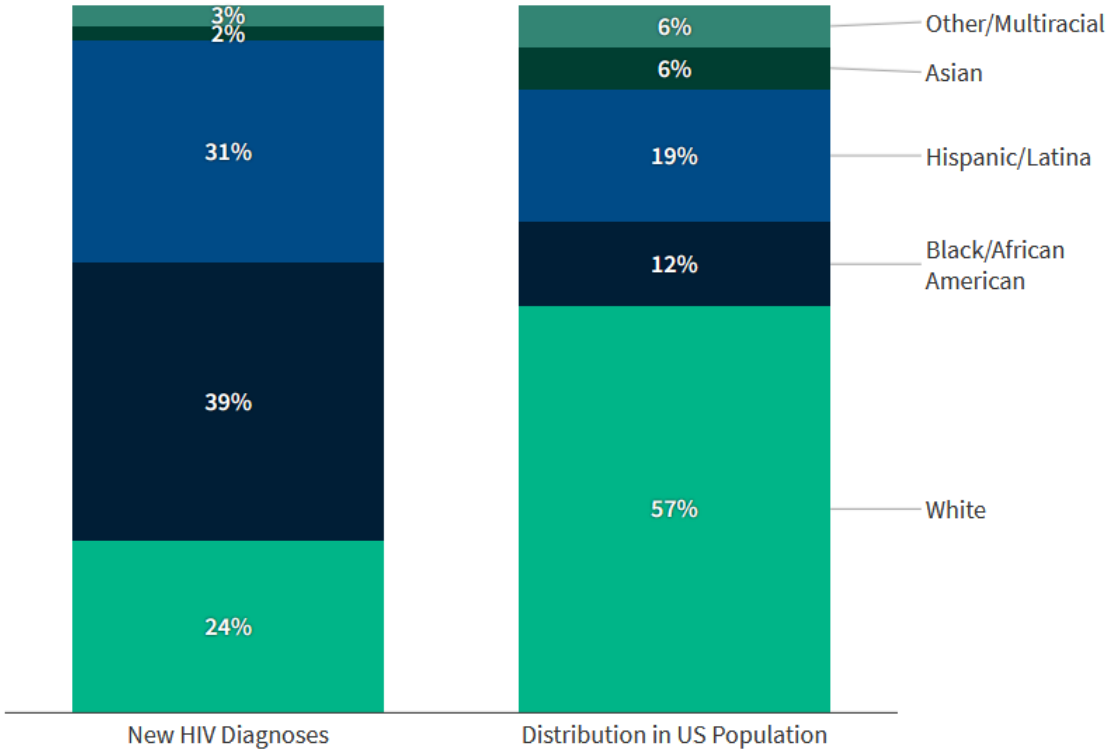
Overview

- 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.

Figure 2

New HIV Diagnoses Among Women and Girls Compared to US Female Population, 2022



Source: US Population Data: KFF. State Health Facts. Population Distribution by Race/Ethnicity, 2022. HIV Diagnoses: CDC. Atlas Plus • Get the data • Download PNG

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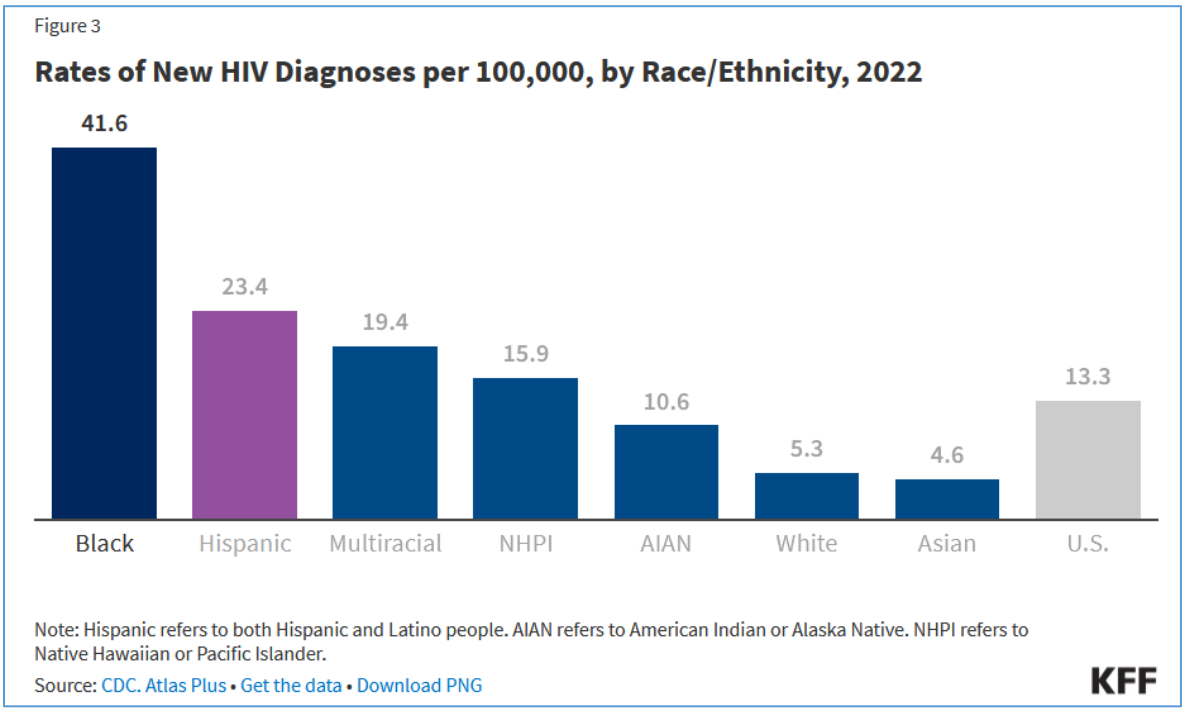
- The rate of new HIV diagnoses per 100,000 among adult and adolescent Hispanic/Latino people (23.4) was over 4 times that of White people (5.3) but about half that of Black people (41.6) in 2022 (see Figure 3). Looking by sex and race, the rate for Hispanic/Latino men (40.8) was the second highest of 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).



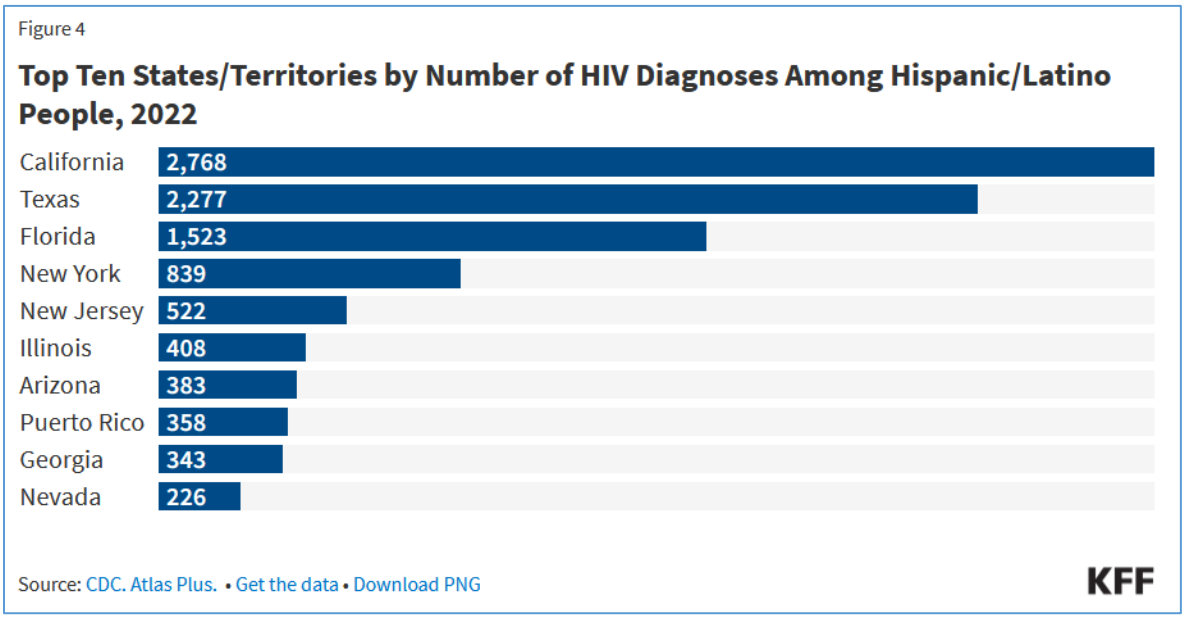
- Hispanic/Latino people accounted for almost 1 in 5 (17%) deaths among people with an HIV diagnosis (deaths may be due to any cause) in 2022. The number of deaths among Latino individuals with an HIV diagnosis increased 24% between 2010 and 2022.
- Rates for deaths where HIV was indicated as the leading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

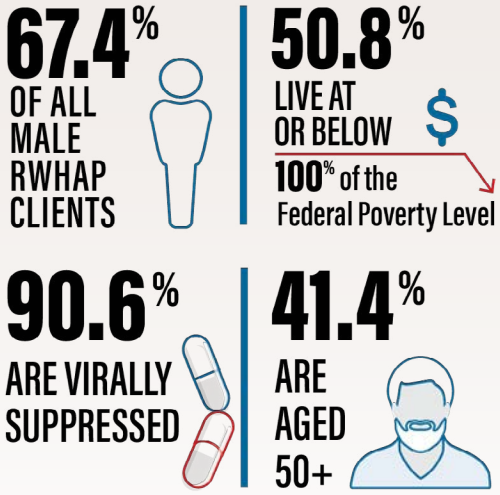
Gay, Bisexual, and Other Men Who Have Sex with Men (MSM) Clients:

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.

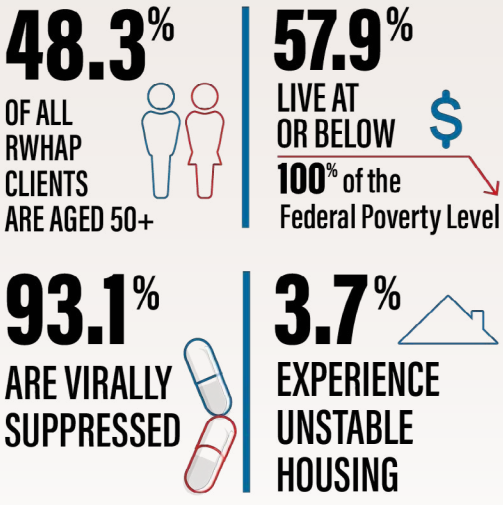
Older Adult Clients:

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.

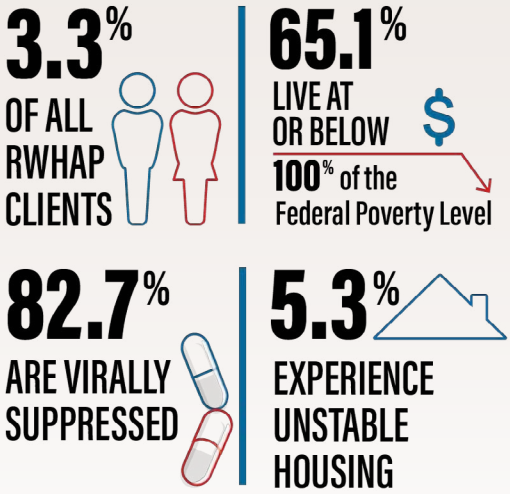
Youth and Young Adult Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

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

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



HRSA
Ryan White HIV/AIDS Program

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

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

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

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

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

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

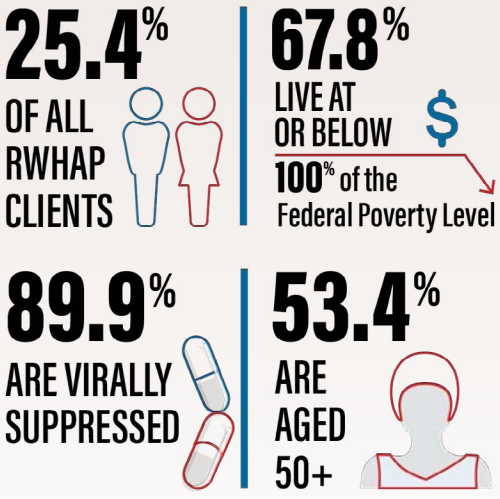
Female Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

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

Ryan White HIV/AIDS Program Fast Facts: Female Clients



HRSA
Ryan White HIV/AIDS Program

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

Learn more about these clients served by RWHAP:

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

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

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

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

Black Women and HIV in Texas

The Big Picture

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

Black Women Living with HIV in Texas

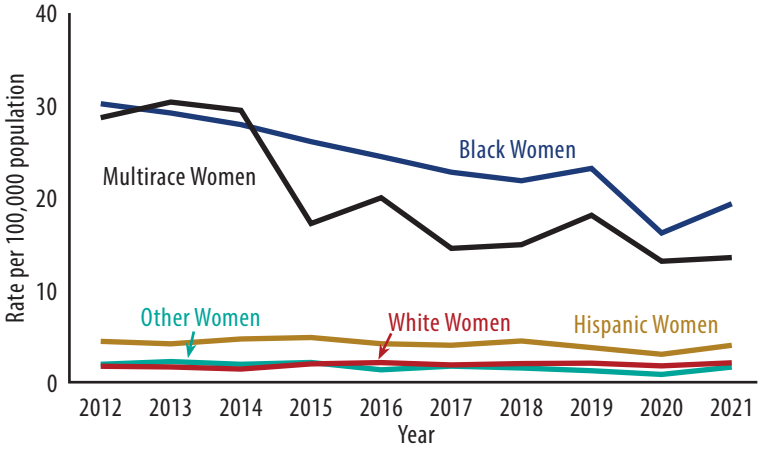
The rate of Black women living with HIV in Texas (631 per 100,000 population) is 6.9 times the rate of Hispanic women living with HIV and 13.6 times the rate of White women living with HIV.

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

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

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

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



Black Women Without HIV-Related Medical Care in 2021

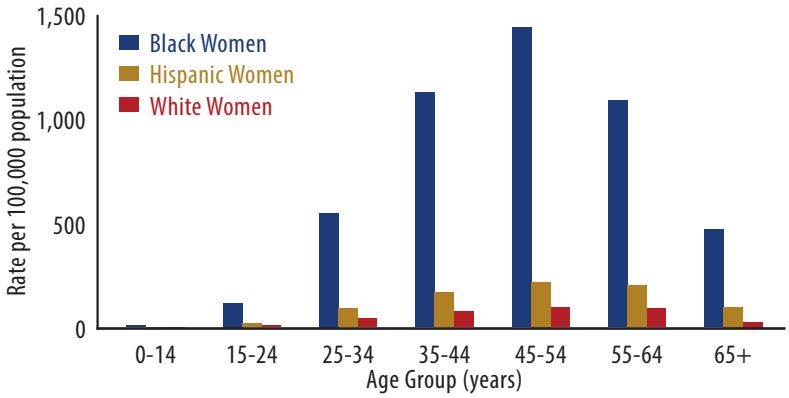
More than ever before, advances in medical care have enabled people with HIV to stay healthy and live longer. Some persons living with HIV may not seek care because they do not feel ill. Others may have problems affording or accessing health care. Still others may not seek medical care because of substance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

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

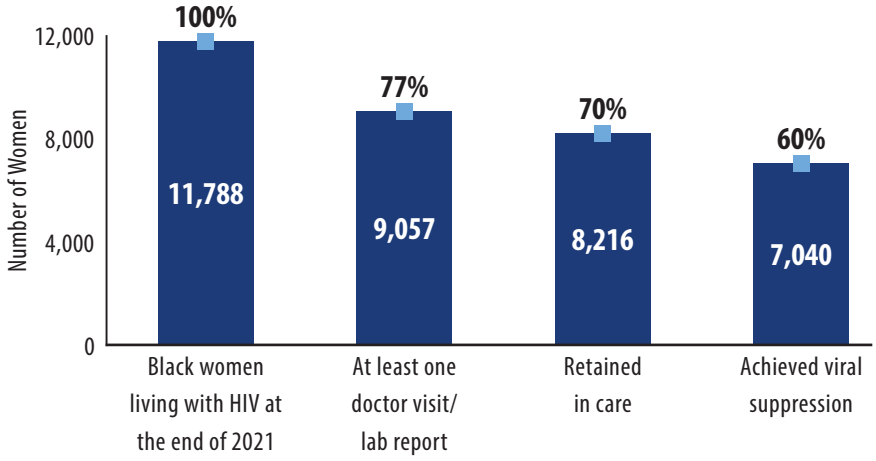
Of Black women living with HIV in Texas whose mode of HIV transmission was sex with males:

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

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



HIV Treatment Cascade for Black Women in Texas, 2021



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

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

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

Texas Black Women's Initiative (TxBWI)

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

More About Black Women and HIV in Texas

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

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

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

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

DSHS HIV/STD Section

737-255-4300

dshs.texas.gov/hivstd/txbwi

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

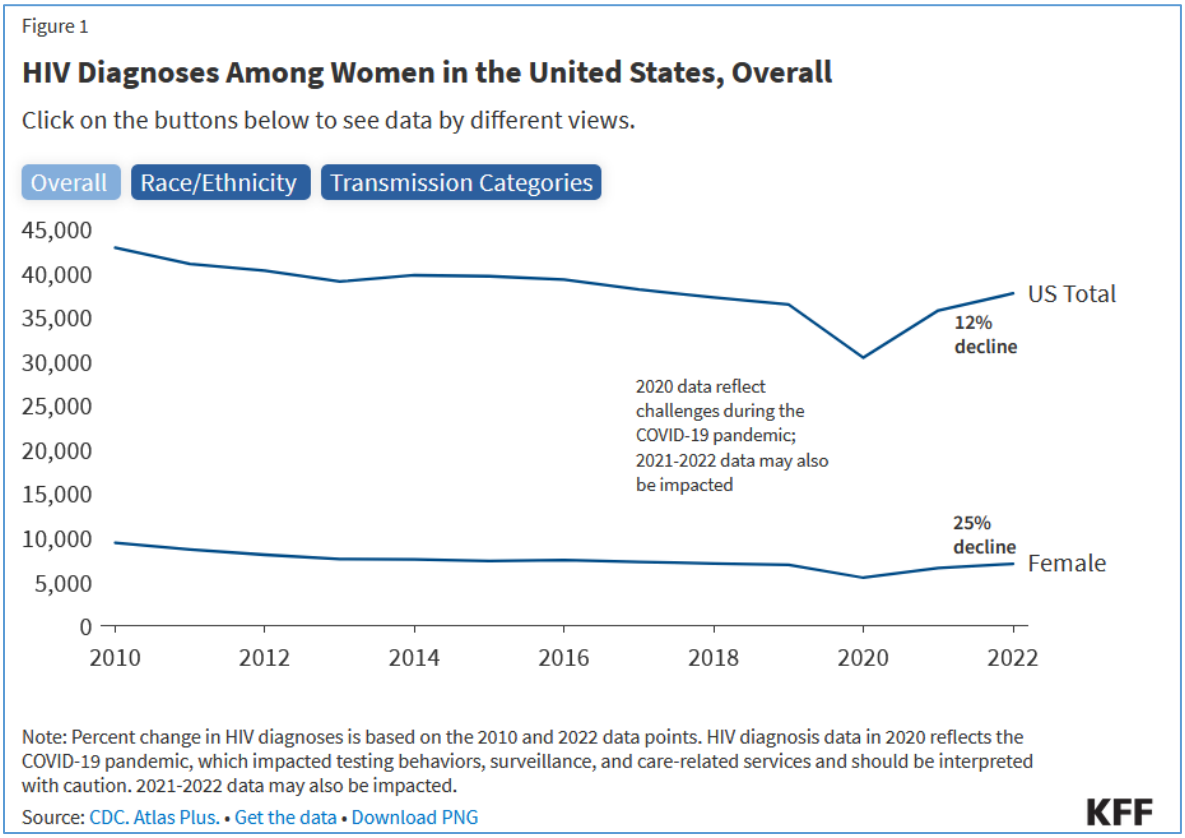
TEXAS Health and Human Services
Texas Department of State Health Services

The Impact of HIV on Women in the United States

Published: Dec 16, 2024

Key Facts

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



Overview

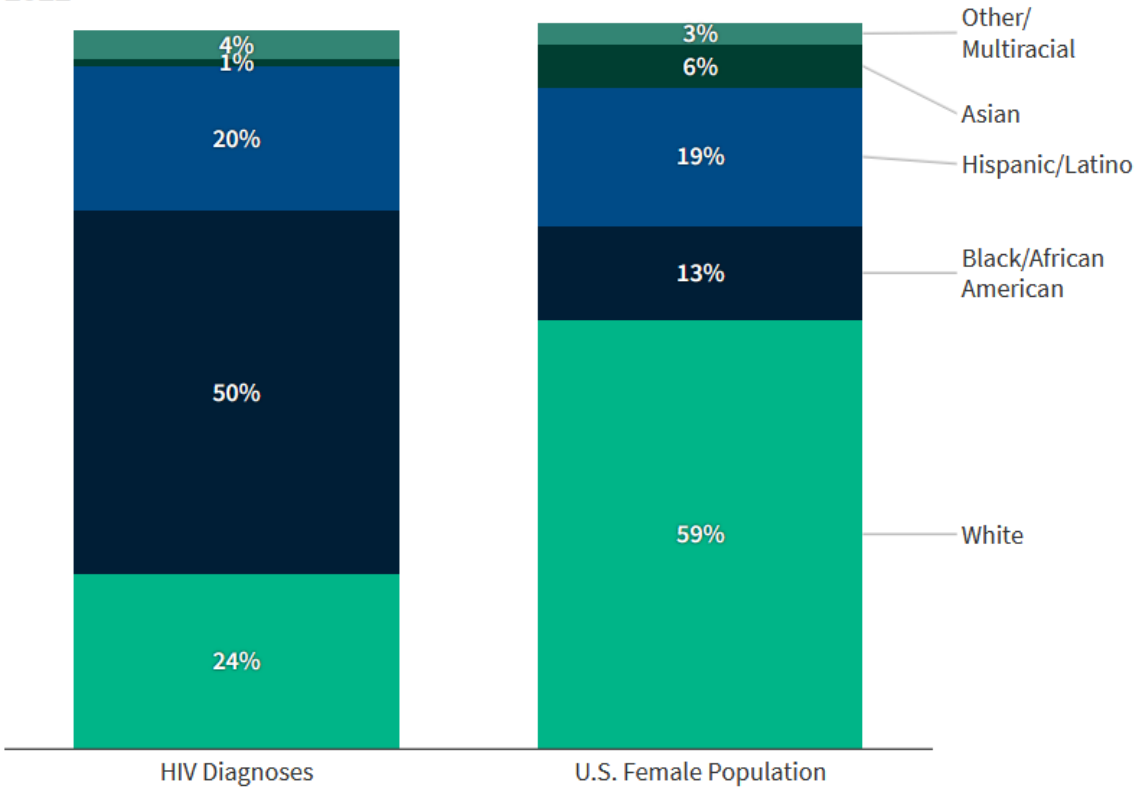
- Today, there are more than 1.2 million people estimated to be living with HIV in the U.S., including 268,800 (22%) who are women.
- Women accounted for 19% of the 6,980 new HIV diagnoses in 2022 and are diagnosed with HIV at slightly older ages than men are.
- Between 2010-2022, while HIV diagnoses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

Race/Ethnicity

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

Figure 2

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



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

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

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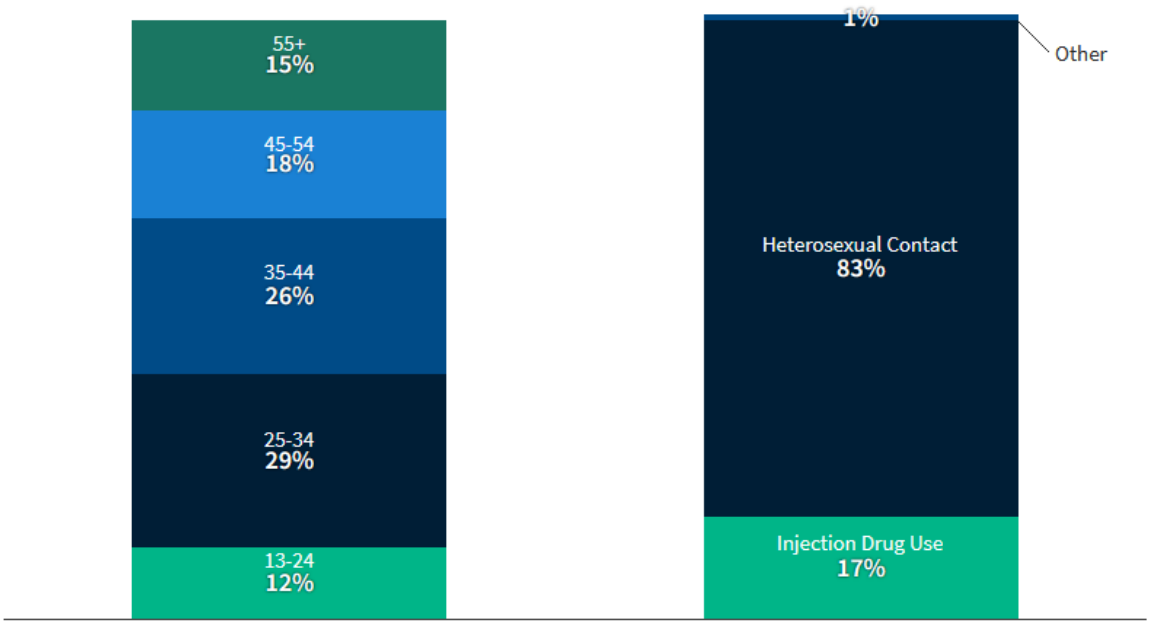
Age

- 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

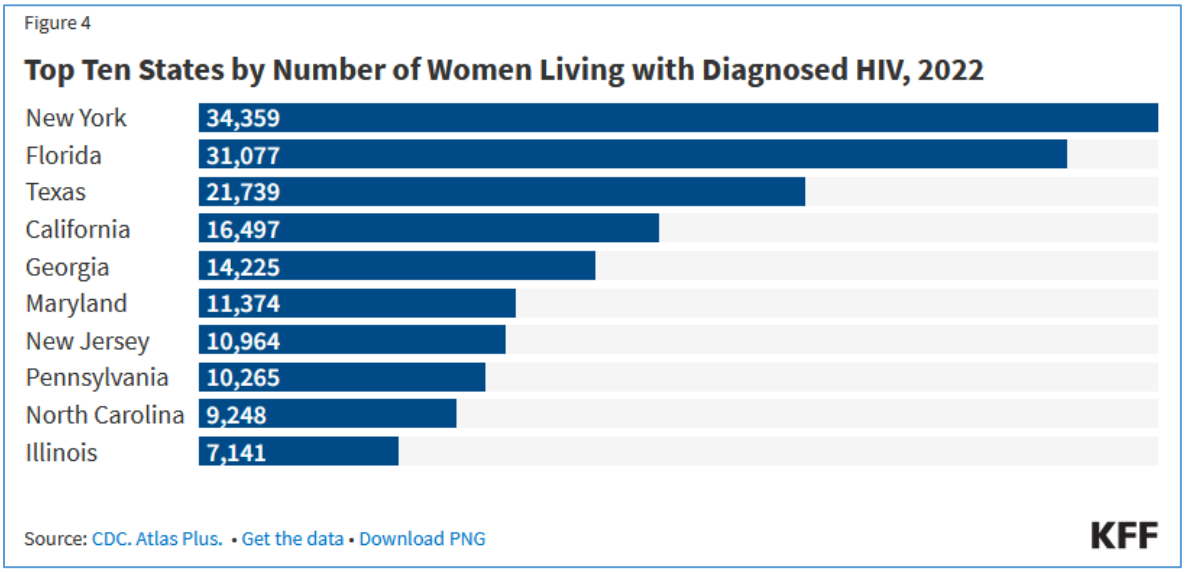
- In 2022, HIV diagnoses among women were mostly attributed to heterosexual sex (83%), followed by injection drug use (17%), and 1% were attributed to other causes. Heterosexual transmission accounts for a greater share of HIV diagnoses among Black and Hispanic/Latina women (90% and 87%, respectively)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

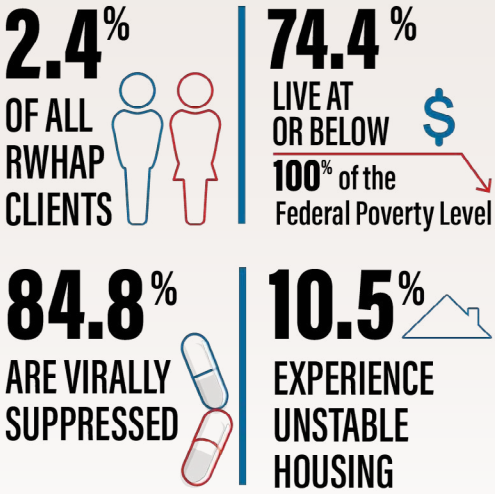
Transgender Clients:

HRSA's Ryan White HIV/AIDS Program, 2021

Population Fact Sheet | March 2023

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

Ryan White HIV/AIDS Program Fast Facts: Transgender Clients



HRSA
Ryan White HIV/AIDS Program

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

Learn more about transgender clients served by RWHAP:

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

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

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

Ryan White HIV/AIDS Program

HRSA's Ryan White HIV/AIDS Program

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

Technical Expert Panel Executive Summary

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

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

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

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

The following TEP Executive Summary includes the following sections:

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

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

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

Specific Issues

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

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

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

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

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

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

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

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

ISSUES RELATED TO PROVIDING HIV CARE AND TREATMENT IN CORRECTIONAL SETTINGS

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

Specific Issues

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

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

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

Strategies for Improving HIV Treatment and Care in Correctional Settings

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

- **Training.** The lack of HIV-related information and training for administrators and staff in correctional systems/facilities can affect the care of people with HIV. County managers and correctional facility administrators (i.e., wardens) make decisions related to the resources available to facilities and the policies within facilities that may limit access to or the quality of treatment for people with HIV in those facilities. More training is necessary for clinical staff, corrections officers, and administrators to ensure an understanding of the needs of incarcerated individuals with HIV, with a particular focus on reducing stigma and discrimination in facilities. Panelists also noted the need to educate those in the corrections community about the RWHAP and the resources available to patients with HIV.

ISSUES RELATED TO HIV CARE DURING RE-ENTRY

Panelists noted that patients face multiple challenges to continuity of care during re-entry. Some of these relate to the release process, whereas others relate to disconnects between correctional facilities and services within the community.

Specific Issues

- **Unpredictable Release Dates.** Release dates may change, frustrating efforts to ensure a "warm handoff." Sometimes release is scheduled for late at night, which can make coordination with community partners difficult. Unpredictable release also can result in a patient's leaving the facility without their medications.

- **Connecting With a Community-Based Health Care Provider.** Many jurisdictions have processes in place to ensure continuity of care. However, even for systems/facilities where this is the intention, it may not take place. Patients (and staff) must navigate the system, which may include multiple payers, requirements, and processes. For example, enrolling a patient in Medicaid or the RWHAP AIDS Drug Assistance Program may or may not be possible within the facility. Some community-based providers will not make an appointment unless the patient has active insurance or Medicaid, so the patient leaves the correctional facility with no appointment. The patient must contact the provider and make an appointment after release. The Health Insurance Portability and Accountability Act (HIPAA) also plays a role. Many community-based providers will not engage with the patient's clinician within the correctional facility until the patient is released, has accessed their organization, and has signed a HIPAA release. This policy makes advanced coordination impossible.

  Even if a community-based provider is selected prior to release, the process may not go smoothly. Many patients may not know where they will be living upon release and may select a provider and pharmacy that is not convenient to where they eventually live. Patients who are on Medicaid prior to release may be assigned to a provider who may not be the most appropriate to provide HIV-related care or be convenient to where the patient is living.

  Although the peer navigator is considered one of the most effective bridges to treatment, many community-based organizations (CBO) report challenges getting navigators into correctional facilities so they can facilitate a warm handoff. The issue is twofold: (1) Either the CBO or the facility may lack processes for CBO staff to enter the correctional facility; and (2) peer navigators, people with similar lived experience, may have a history of incarceration and have difficulty gaining approval to access the facility.

- **Access to Medications Upon Release.** Even if a patient is able to line up a community-based provider before release, ensuring ongoing access to medications can be a challenge. Patients may not have sufficient supply of medication upon release to last until their first appointment, and some retail pharmacies will not fill prescriptions from correctional facilities.

- **Followup.** Followup with patients is difficult. Often, patients leave facilities without a home address or telephone number. They are located only when and if they access care.

- **Exchange of Health Information.** Many systems/facilities do not have electronic health records (EHRs), which complicates the transfer of patient information; patients arrive at their new provider with paper records.

Strategies for Improving HIV Treatment and Care During Re-Entry

- Ensure a warm handoff (same clinician [dually based], clinician to clinician [face-to-face meeting before transfer], or establish a relationship with a new provider [via telephone]).
- Employ peer specialists to support re-entry (e.g., navigator, addiction coach, re-entry coach).
- Ensure that insurance/Medicaid/AIDS Drug Assistance Program is in place upon release.
- Ensure that the first appointment with a new clinic is in place on release.
- Follow up with patients to the extent possible, given challenges in tracking patients upon release.
- Connect patients with essential services, especially housing.
- Link patients to harm-reduction organizations, especially overdose prevention for the newly released.
- Help HIV-related community-based organizations connect with correctional facilities and organizations that serve incarcerated individuals (e.g., evangelical organizations).
- Educate correctional facilities about RWHAP.
- Engage formerly incarcerated people with HIV in the RWHAP planning process.

DATA CONSIDERATIONS

To improve the quality of patient care and data-driven decision-making, accurate data at the patient and facility levels need to be collected. At the patient level, health outcomes (e.g., viral suppression) need to be documented. At the facility level, quality indicators related to HIV testing, access to care, and access to antiretroviral treatment are needed. Sharable electronic health records and up-to-date data sets also are needed.

Providers also should collect data related to justice involvement, but these data need to be collected in a sensitive manner. Such information includes the date of release from most recent incarceration, length of most recent incarceration, number of previous incarcerations, and history of solitary confinement.

CONCLUSION

A knowledge gap remains on how RWHAP grant funds can be used to support people with HIV who are justice involved. Opportunities exist for RWHAP recipients and correctional facilities to collaborate and ensure that people with HIV who are justice involved receive needed care and treatment, both while incarcerated and upon release.

HIV Care and Treatment in Rural Communities

HRSA's Ryan White HIV/AIDS Program, 2021

Rural Health Fact Sheet | November 2023

The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) provides support and resources to RWHAP recipients, including those in rural areas, to assist in the delivery of optimal care and treatment for all to end the HIV epidemic in the United States.[a] To that end, addressing HIV health disparities in engagement in care and viral suppression in rural communities is critical.[b] The RWHAP encourages innovative practices to best reach, meet the needs of, and retain in care people with HIV in rural communities. Although barriers remain, RWHAP providers[c] in rural areas have demonstrated success in such fields as telemedicine, rapid antiretroviral therapy, transportation services, and the use of community health workers.

[a] Klein PW, Geiger T, Chavis NS, et al. The Health Resources and Services Administration's Ryan White HIV/AIDS Program in rural areas of the United States: Geographic distribution, provider characteristics, and clinical outcomes. *PLOS ONE*. 2020;15(3): e0230121.

[b] HRSA. *Ending the HIV Epidemic in the U.S.* https://www.hrsa.gov/ending-hiv-epidemic.

[c] "RWHAP providers" refers to provider organizations that deliver direct care and support services to RWHAP clients.

HRSA
Ryan White HIV/AIDS Program

Among RWHAP providers in rural areas in 2021—

- 48.2% served more than 100 RWHAP clients.
- 43.4% were health departments.
- 84.6% received Public Health Service Act Section 330 funding, which supports HRSA-funded Health Centers.

The Top 10 Most Common Services[1] Delivered by RWHAP Providers in Rural Areas in 2021

1.	Medical case management	53.0%
2.	Medical transportation	43.6%
3.	Outpatient ambulatory health services	40.9%
4.	Oral health care	36.9%
5.	Non-medical case management	34.9%
6.	Emergency financial assistance	30.9%
7.	Food bank/home-delivered meals	22.1%
8.	Mental health services	21.5%
9.	Housing	18.1%
10.	Health insurance premium and cost-sharing assistance	14.8%

Ending the HIV Epidemic in the U.S.

The *Ending the HIV Epidemic in the U.S.* (EHE) initiative is an ongoing federal effort focused on increased linkage to, re-engagement in, and retention in HIV care and treatment. EHE provides priority jurisdictions with additional resources, technology, and expertise to expand HIV treatment and prevention activities. Funded jurisdictions include seven states with a disproportionate rural burden of HIV—Alabama, Arkansas, Kentucky,

RWHAP Clients Who Visited Rural Providers in 2021

90.4% of clients who received services from rural providers were virally suppressed, which is consistent with the national average (89.7%)

51.1% were aged 50 years and older

57.5% were from racial and ethnic minority groups

55.3% were living at or below 100% of the Federal Poverty Level

92.8% had stable housing

Mississippi, Missouri, Oklahoma, and South Carolina. The U.S. Department of Health and Human Services (HHS) leads the governmentwide effort, and HRSA has a key role in leading the implementation of EHE.

Rural Health and HIV Resources

The following resources describe promising practices, address training and technology needs, and review research and policy recommendations that are relevant to rural health and HIV.

RWHAP Part F AIDS Education and Training Center (AETC) Program. The RWHAP AETC Program is a network of HIV experts who provide education, training, and technical assistance on HIV care and prevention to health care team members and health care organizations serving people with or at risk of HIV.

RWHAP Best Practices Compilation. This resource gathers and disseminates interventions in RWHAP-funded settings, including those in rural areas, to improve outcomes for people with HIV and support replication by other RWHAP service providers.

TargetHIV. This website is the one-stop shop for technical assistance and training resources for the RWHAP community. Resources include webinars, tools, training materials, implementation manuals, and additional technical assistance resources, including resources dedicated to several key populations (e.g., rural populations).

AIDSVu. This interactive mapping tool visualizes HIV data from the Centers for Disease Control and Prevention's National HIV Surveillance System and other data sources, including data from rural counties. AIDSVu also provides tools and resources on HIV testing, pre-exposure prophylaxis, and other HIV service locations.

HIV Prevention and Treatment Challenges in Rural America: A Policy Brief and Recommendations to the Secretary. The National Advisory Committee on Rural Health and Human Services provides recommendations to the HHS Secretary on addressing HIV prevention and treatment challenges in rural communities.

Housing Opportunities for People With AIDS (HOPWA) Fact Sheet: Challenges in Rural Areas. This resource provides HOPWA program guidance and information about service area requirements. Additionally, it identifies challenges, suggests best practices to enhance housing operations, and provides program planning guidance.

National Rural Health Association (NRHA): Rural Health Resources and Best Practices. The NRHA provides free resources covering telehealth, policy, and leadership for rural communities and rural health.

Rural HIV/AIDS Planning Program Grantee Sourcebook: 2020–2021. This resource provides detailed descriptions of Rural HIV/AIDS Planning Program grant projects, including key EHE strategies, priority populations served, network development and planning activities, initial project planning outcomes, and sustainability strategies.

Rural HIV/AIDS Prevention and Treatment Toolkit. This toolkit contains modules that describe resources and provide information focused on developing, implementing, evaluating, and sustaining rural HIV programs.

Rural Residency Planning and Development Program. This program, a partnership between HRSA's Federal Office of Rural Health Policy and its Bureau of Health Workforce, provides funding to create new rural medical residency programs. The purpose is to improve access to health care by funding programs to train more physicians in rural communities.

Rural Telehealth Resource Centers (TRCs). This resource, developed by HRSA's Federal Office of Rural Health Policy, lists regional and national TRCs that provide technical assistance to states and territories concerning technology assessment and telehealth policy.

Reference

[1] Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds. PCN 16-02. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf.