# The Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 through 2014

Capturing the community's vision for an ideal system of HIV prevention and care for the Houston Area

**Funding acknowledgment:**
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**Photography acknowledgment:**
Photography generously donated by Barbara Lynn Garvin.

**Disclaimer:**
This document was developed from September 2011 to April 2012 and submitted to the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) on May 21, 2012. Its contents reflect the information and data that were available during that timeframe. New information and data on the topics addressed in this document may have become available since the time of publication. Moreover, activities put forth in this document may have been completed or altered during implementation.

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## Vision

The greater Houston Area will become a community with a coordinated system of HIV prevention and care, where new HIV infections are rare, and, when they do occur, where every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high-quality, life-preserving care, free of stigma and discrimination.

## Mission

The mission of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 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 infected with, affected by, or at risk for HIV.

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### HIV Planning Guidance Pre-Decisional Draft, March 2012

*The Jurisdictional HIV Prevention Plan should include:*



## Health Resources and Services Administration (HRSA)
### 2012 Comprehensive Plan Instructions - Part A, March 20, 2011

*The 2012 Comprehensive Plans for Ryan White HIV/AIDS Program Part A and B grants should include:*



*Continued on reverse*

HARRIS COUNTY TEXAS

Ed Emmett

COUNTY JUDGE

Dear Elected Officials and All Concerned Citizens:

As the Chief Elected Official of the Houston EMA, Part A, Ryan White Program, I am pleased to provide this letter of support and concurrence with the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014.

Every three years, jurisdictions that receive federal HIV dollars are required to assess the current system of HIV services in their community, and then identify essential steps for improving the system. To accomplish this, local HIV Planning Councils develop comprehensive HIV plans using a collaborative community-based process. For the first time, the Houston Area has produced a joint plan for both HIV prevention and HIV care, which, when implemented, will improve the entire continuum of HIV services, from education and awareness to life-preserving care and treatment.

More than 100 individuals, including representatives of 56 agencies, people living with and at risk for HIV/AIDS and other concerned community members, shared their expertise over the course of eight months to develop this joint document. They identified the key issues facing the Houston Area, which include preventing new infections, ensuring access to care, and reducing disparities. They identified solutions for filling gaps in services, increasing collaboration, and meeting the needs of special populations. They also looked to the future of health services and identified steps to ready our HIV system for health care reform. Lastly, they defined how success will be measured and attained.

I want to commend the individuals who participated in this process for their hard work and dedication, especially those who served in leadership roles by chairing workgroups and other planning teams. I also want to encourage my fellow elected officials and policy makers, as well as all local service providers and stakeholders, to use this document as a tool in their own decisions regarding priorities for health services in the Houston Area.

Great inroads have been made in addressing the HIV epidemic and ensuring that all people living with HIV/AIDS have the opportunity to enjoy long, healthy, and productive lives. We can have an even greater impact if we work together and use the 2012 - 2014 Comprehensive HIV Prevention and Care Services Plan as our guide. I look forward to continuing my partnership with the community as we work toward this important goal.

Sincerely,

Ed Emmett
County Judge

ADMINISTRATION BUILDING 1001 PRESTON, SUITE 911 HOUSTON, TEXAS 77002 (713) 755-4000 (713) 755-8379

**HOUSTON HIV PREVENTION PLANNING GROUP**

May 4, 2012



CDC
Grants Management Officer
Grants Management Branch, Procurement and Grants Office
Funding Opportunity Announcement PS12-1201
Centers for Disease Control and Prevention, MS E-15
2920 Brandywine Road, Room 300
Atlanta, GA 30341-4146

Dear Ms. Erica Dunbar:

The Houston HIV Prevention Planning Group (HHPPG) concurs with the following submission of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 through 2014, (Comprehensive Plan):

- The HHPPG reviewed this Joint Comprehensive Plan, which will be submitted to the Centers of Disease Control and Prevention (CDC), and concurs that the goals, solutions, activities, and benchmarks for the strategies identified in the plan are responsive to the needs of those priority populations and communities with the greatest burden of HIV. Furthermore, the HHPPG concurs that the plan demonstrates alignment with the goals of the National HIV/AIDS Strategy (NHAS) and the Enhanced Comprehensive HIV Prevention Planning (ECHPP) Project for this jurisdiction.

The process used to develop this Jurisdictional HIV Prevention Comprehensive Plan did include the involvement of the HHPPG. HHPPG Committees for Resources & Needs, Quality Assurance, and Prioritization were suspended; thereby allowing members to re-direct participation to serve as members of specific Workgroups and/or to serve as Workgroup Co-Chairs for the duration of this joint planning process. Workgroup meetings were held on a monthly basis.

Based on the review of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 through 2014, the HHPPG reached consensus and concurrence with the priorities and strategies proposed in this joint comprehensive plan.

The Community Co-Chair and the Governmental Co-Chair have been designated as signatories to this letter of concurrence.

Sincerely,

Brenda Chapman
Governmental Co-Chair

05/07/12
Date

Cristan Williams
Community Co-Chair

5/4/12
Date

**Houston Area HIV Services Ryan White Planning Council**
**2223 West Loop South, Suite 240, Houston, Texas 77027**
**713 572-3724 telephone; 713 572-3740 fax**
**www.rwpc.org**

April 26, 2012

Dear Friends and Colleagues,

As Chair of the Houston Ryan White Planning Council, I am pleased to add our letter of concurrence to this three-year Comprehensive HIV Prevention and Care Services Plan. Our diverse partners in the creation of this document included representatives from the local HIV prevention and care service communities, people at risk for and living with HIV/AIDS, consumers of HIV prevention and care services and other important stakeholders.

I want to extend special thanks to our friends at the HIV Prevention Group for working side by side with the Ryan White Planning Council to create this important document. We look forward to deepening our working relationship as we implement this plan so that, together with all of our partners, we can realize our community's vision for an ideal system of HIV prevention and care in the Houston Area.

Sincerely,

Morénike Giwa

Morénike Giwa
Chair
Houston Ryan White Planning Council

THE RESOURCE GROUP

April 24, 2012

Houston Ryan White Planning Council
2223 West Loop South #240
Houston, Texas 77027

Dear Colleagues,

As an Administrator of Ryan White Part B, C, D and State HIV Services funding, The Houston Regional HIV/AIDS Resource Group, Inc. extends our concurrence with the 2012-2014 Houston Area Comprehensive HIV Prevention and Care Services Plan. We recognize the importance of this comprehensive plan in directing both prevention and care services to individuals at risk, infected, and affected by HIV/AIDS. We are particularly appreciative of your efforts to include the Part D targeted populations of Women and Youth in the comprehensive planning process.

The planning process for this year's plan was notable for its inclusiveness of groups and individuals who had previously been missing "from the table." We congratulate the Prevention Planning Group, the Ryan White Planning Council, and specifically, the Planning Council Office of Support for the increased efforts to bring participants with unique perspectives into the planning process. The final product reflects these efforts in the creation of a strong vision and set of implementable strategies that will help Houston meet the expectations of the Federal and State governments as well as the National AIDS Strategy.

We look forward to continuing our partnership with community in target our services to meet the goals and objectives of this comprehensive plan.

Sincerely,

Yvette Garvin
Executive Director
The Resource Group

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.

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Texas
77006

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May 1, 2012

Dear Colleagues;

I am pleased to provide this letter of support for the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014.

Ryan White Grant Administration (RWGA) is the Ryan White HIV/AIDS Program Part A grantee for the Houston Eligible Metropolitan Area (EMA). As such, we have been involved in comprehensive HIV services planning for over 20 years. This year's process was unlike those in the past. For the first time, the Houston Area HIV Planning Group (HPG) for HIV prevention and the Ryan White Planning Council (RWPC) for HIV care joined together to produce a *single* plan for HIV prevention *and* care, with the intent of improving the entire continuum of HIV services.

RWGA staff and providers were integral partners in this process, alongside over 100 other individuals and agencies, including some that had never before participated in comprehensive HIV planning in the Houston Area. Our office would like to commend all those who contributed to this process for their hard work and dedication to improving HIV services in our community.

To accomplish the solutions put forth in this document, we know that continued partnership, collaboration, and coordination between agencies and programs will be essential. RWGA is committed to our role in the implementation of this plan, and we look forward to strengthening our partnerships with the Ryan White HIV/AIDS Program and with local HIV Prevention efforts as a result.

Thank you for the opportunity to participate in this process and to provide this letter of support.

Sincerely,

Charles Henley, LCSW

Charles Henley, LCSW
Manager
Ryan White Grant Administration
Harris County Public Health & Environmental Services

**Harris County Hospital District**

service FIRST

*We will create a healthier community and be recognized as one of America's best community-owned healthcare systems.*

P.O. BOX 66769, Houston, TX 77266-6769 *www.hchdonline.com*

May 2012

Ryan White Planning Council
2223 West Loop South, Suite 240
Houston, Texas 77027

Dear Colleagues:

Once again, the Harris County Hospital District is pleased to have been a part of developing the HIV/AIDS Comprehensive Plan for the Houston EMA. As the grantee of Ryan White Part C funds for Harris County, we recognize every day the value of working in concert with other grantees and providers in the area to ensure the best possible focus of our efforts.

We look forward to continued opportunities for working with the Planning Council and the HIV Prevention Planning Group to plan and provide services to those living with HIV and AIDS in Harris County.

Sincerely,

Nancy Miertschin

Nancy P. Miertschin, MPH
Project Manager
HIV Services

# CITY OF HOUSTON

Department of Health and Human Services

**Annise D. Parker**
Mayor

Stephen L. Williams, M.Ed., M.P.A.
Director
Houston Department of Health
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May 1, 2012

Houston Ryan White Planning Council
2223 West Loop South, Suite 240
Houston, Texas 77027

Dear Colleagues and Community Members,

The Houston Department of Health and Human Services, Bureau of HIV/STD and Viral Hepatitis Prevention is pleased to provide our support and concurrence with the 2012-2014 Houston Area Comprehensive HIV Prevention and Care Services Plan.

Although the community planning process has been essential in developing a comprehensive prevention plan for HIV since 1994, this is the first year that the Houston Area brought together stakeholders and community to *jointly* create a plan for both prevention and care. We commend the engagement process that took place to include over 100 individuals in this process, including those living with HIV/AIDS. Furthermore, the strategies identified in the Plan align with the vision and goals of the National HIV/AIDS Strategy (NHAS) and the Enhanced Comprehensive HIV Prevention Planning (ECHPP) Project. Local implementation of the NHAS necessitates that prevention and care activities are identified, prioritized, and evaluated by data-driven decision making. The measurable benchmarks associated with each goal in the Plan will ensure that success is guided by sound scientific principles.

We look forward to working with the community and with our partners in HIV care to achieve the goals identified in the 2012-2014 Houston Area Comprehensive HIV Prevention and Care Services Plan. Once achieved, the Houston Area will benefit from a more coordinated and seamless response that will promote the health of all residents at risk for or living with HIV.

Sincerely,

Marlene McNeese-Ward
Bureau Chief
Bureau of HIV/STD and Viral Hepatitis Prevention

**CITY OF HOUSTON**
Housing and Community Development Department

**Annise D. Parker**
Mayor

Neal Rackleff
Interim Director
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Houston, Texas 77007

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May 8, 2012

Ladies and Gentlemen:

On behalf of the City of Houston (City) through its Housing and Community Development Department (HCDD), I am pleased to provide this letter of support for the *2012 Houston Area Comprehensive HIV Prevention and Care Services Plan.*

HCDD is the administrator of the Housing Opportunities for Persons with AIDS (HOPWA) program for the Houston Eligible Metropolitan Statistical Area (EMSA), a ten county geographical area. The Houston EMSA consists of the cities of Houston, Baytown, and Pasadena; and Austin, Brazoria, Champers, Fort Bend Galveston, Harris, Liberty, Montgomery, San Jacinto and Waller counties. The HOPWA program provides the following activities for low- to moderate-income persons living with HIV/AIDS:

- Operating Costs - Housing (including maintenance), security, operation, insurance, utilities, furnishings, equipment, supplies, and other incidental costs. This activity is limited to persons of 50% of the medium income or below.
- Supportive Services - Including, but not limited to, health services, mental health services, assessment, permanent housing, drug and alcohol abuse treatment and counseling, day care, personal assistance, and nutritional services.
- Technical Assistance/Housing - Housing information services including, but not limited to, counseling, information, and referral services to assist an eligible person to locate, acquire, finance and maintain housing. This may also include fair housing counseling for eligible persons that encounter discrimination on the basis of race, color, religion, sex, age, national origin, family status, or handicap.
- Resource Identification - To establish, coordinate and develop housing assistance resources.
- Tenant Based Rental Assistance (TBRA) - Payment vouchers for stable housing. This activity is limited to persons of 50% medium income or below.
- Short-Term Rent, Mortgage, & Utility Assistance (STRMU) - To prevent the homelessness of the tenant or mortgagor of a dwelling.

According to the most recent Needs Assessment of People Living with HIV/AIDS (PLWHA) in the Houston Area, 28% are facing housing insecurity, 9% are homeless, and 37% have interrupted their HIV care due to unstable housing issues. The *2012 Houston Area Comprehensive HIV Prevention and Care Services Plan* includes specific strategies and activities to address these concerns. Alongside over 100 individuals and agencies, HOPWA staff and providers, in cooperation with more than 100 individuals and agencies, were integral partners in the development of these solutions. We believe that the implementation of this plan will not only improve housing access among PLWHA in our community, thereby helping individuals remain in continuous HIV care, but it will also increase access to HIV prevention and care services overall.

To accomplish these important goals, ongoing partnership, collaboration, and coordination between agencies and programs will be essential. We are committed to helping with the implementation of this plan that will strengthen ongoing connections between HOPWA, the Ryan White HIV/AIDS Program, and local HIV Prevention efforts.

Thank you for the opportunity to participate in this process and to provide this letter of support.

Sincerely,

Neal Rackleff
Interim Director

## Contributors

This document is the result of countless hours of participation and effort by members of the Houston Area community who are committed to improving the system of HIV prevention and care. Individuals who contributed their time and expertise include people at risk for and living with HIV/AIDS, consumers of HIV prevention and care services, providers of HIV prevention and care services, providers of other health, public health, and social services in the Houston Area, and other concerned stakeholders and community members. The diversity of the Houston Area community in terms of geography, age, sex, race/ethnicity, sexual orientation, gender identity, and socio-economic circumstance is well reflected in this list as well. Many volunteered their time while others were compensated by their agencies to provide subject matter expertise or administrative support to the process. They are listed below.

David Garner, *Co-Chair*
Tam Kiehnhoff, *Co-Chair*
Cristan Williams, *Co-Chair*

Sherifat Akorede
Gayle Alstot
Roberto Andrade
Kristina Arscott
Jacquelyn Baldwin
Ben Barnett
Melody Barr
Diane Beck
Jeffrey Benavides
David Benson
Nike Blue
Francis Bueno
Katy Caldwell
Giovanna Castro
Jeffrey Campbell
Brenda Chapman
Ron Cookston
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Roy Delesbore
Jackie Eaton
Pat Eldridge
Hickmon Friday
Joe C. Fuentes, Jr.
Yvette Garvin
Joaquin Garza
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Rose Haggerty
Camden Hallmark
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Dwayne Haught
Lisa Marie Hayes
King Hiller
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Linda Hollins
Deundra Johnson
J. Hoxi Jones
Heather Keizman
Florida Kweekeh
John La Fleur
Anna Langford
Michael Lawson
Januari Leo
Amy Leonard
Solomon Lopez
Ken Malone
Carin Martin
Patrick Martin
Aundrea Matthews
Marlene McNeese-Ward
Dawn Meade
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Erik Soliz
Lupita Thornton
Amana Turner
C. Bruce Turner
Steven Vargas
Barbara Walker
David Watson
Ray E. Watts
Maggie White
Cathy Wiley
Lena Williams
Tori Williams
Biru Yang

*Client listening session participants from:*
AIDS Foundation Houston Project LifeRoad
Harris County Jail

## Agency Participation

The development of this document was informed by the experience and expertise of a diverse cross-section of health, public health, and social services agencies from the Houston Area, including those that provide HIV prevention and care services. The list of participating agencies includes representation from all sectors and from several non-traditional partners, some of whom had never before participated in HIV prevention and care services planning in the Houston Area. There are funded and non-funded HIV prevention and care services providers on this list, providers of other health, public health, and social services, Federally Qualified Health Centers (FQHCs) and hospital systems, various task forces and coalitions dedicated to advocating on behalf of people at risk for or living with HIV/AIDS, and the two local HIV Planning Bodies, under whose leadership this document was developed. They are listed below:

- AIDS Clinical Trials Group
- AIDS Education and Training Center
- AIDS Foundation Houston
- AIDS Vaccine Project
- African American State of Emergency Task Force
- Area Agency on Aging, Houston-Galveston Area Council
- Association for the Advancement of Mexican-Americans, Inc.
- Bee Busy, Inc.
- City of Houston Housing and Community Development, Housing Opportunities for People with AIDS
- Center for AIDS Information and Advocacy
- Change Happens!
- Coalition for the Homeless of Houston/ Harris County
- Covenant House
- El Centro De Corazon
- Gateway to Care
- Goodwill – Project Hope
- HIV FOCUS, Gilead Sciences, Inc.
- Harris County Hospital District
- Harris County Jail
- Harris County Medical Society
- Harris County Public Health Services, Family Planning Services
- Harris County Public Health Services, Ryan White Grant Administration
- Healthcare for the Homeless
- Hepatitis C Task Force
- Hepatitis Stakeholders Group
- Houston Area Ryan White Planning Council
- Houston Area Community Services, Inc.
- Houston Department of Health and Human Services, Bureau of HIV/STD and Viral Hepatitis Prevention
- Houston Department of Health and Human Services, Bureau of Epidemiology
- Houston Enriches Rice Education Project
- Houston HIV Planning Group
- Houston Regional HIV/AIDS Resource Group, Inc.
- Houston Independent School District
- International Maternal Pediatric Adolescent AIDS Clinical Trials Group
- Latino HIV Task Force
- Legacy Community Health Services, Inc.
- Living Without Limits Living Large Inc.
- M-Pact (the MSM Task Force)
- Montrose Counseling Center
- Partners for Community Health
- Pink Rose-Saving Our Community Kids…Seniors
- Planned Parenthood Gulf Coast, Inc.
- Positive Playdates
- St. Hope Foundation
- St. John's Church, AIDS Ministry
- St. Luke's Texas Liver Coalition
- Serving the Incarcerated and Recently Released Partnership
- Texas HIV/AIDS Coalition
- Texas HIV Medication Program
- Texas HIV Medication Program Advisory Committee
- Texas Children's Hospital
- Texas Department of State Health Services
- Texas Health and Human Services Commission
- Thomas Street Health Center
- Transgender Foundation of America
- Transgender Center
- Triangle AIDS Network
- Urban AIDS Ministry
- Youth Task Force
- Vertex Pharmaceuticals
- Walgreens

## HIV Leader Profiles

Though a comprehensive jurisdictional plan may describe the community's current system of HIV prevention and care services as well as its vision for an ideal system, it may not fully convey the spirit and motivation of the individuals and agencies that helped build the current system and who have been integral contributors to the new and compelling image of the future of HIV prevention and care that the plan describes.

To fill this gap in the Houston Area plan, six individuals – *all diverse in terms of their experience with HIV, all leaders in HIV prevention and/or care in the Houston Area, all integrally involved in the development of this document* – were willing to be interviewed, photographed, and have their stories told. Our hope with this process is to better convey the face of the Houston Area and its response to the HIV epidemic, to spotlight the enduring commitment and passion of these individuals to addressing HIV in their communities, and to inspire those who read this document to do the same. The following profiles are included throughout the document as indicated:


Chair, 2012, Houston Area Ryan White Planning Council, international advocate for HIV clinical trials research, and the founder of Positive Playdates, a non-profit organization for HIV positive children and families


Community Co-Chair, 2012, Houston HIV Planning Group (HPG), founder of the Transgender Center and Transgender Archive, and the Executive Director of the Transgender Foundation of America


Senior Public Health Investigator at the Houston Department of Health and Human Services and the coordinator of the AIDS Ministry for St. John's Church in Downtown Houston


Medical Case Management Coordinator at The Triangle AIDS Network, the only HIV services provider in the "Golden Triangle" Beaumont/Port Arthur/Orange area of rural Southeast Texas


Member, 2003 to 2012, Houston Area Ryan White Planning Council, Member, 2012, Texas HIV Medication Program Advisory Committee, member of M-Pact (the MSM Task Force), and HIV+ since 1989


Case Manager at the Association for the Advancement of Mexican-Americans (AAMA), member of the Hepatitis C Task Force and the Latino HIV Task Force, and selected for the 2012 Dennis DeLeon Sustainable Leadership Institute

Photographs by Barb Garvin

# Morénike Giwa

*"Children with HIV have just as much of a right to a family as any other child."*

Photograph by Barb Garvin

*Morénike Giwa knew early in life about HIV and the stigma it can cause.*

Growing up in a Nigerian family that travelled regularly to the country, she gained a global perspective on life at an early age. Her visits taught her the importance of building bridges between different points of view. Morénike's grandfather was also a missionary and her mother a nurse, reflecting her family's long tradition of caring for others. Each year, Morénike's family would watch a television movie about Ryan White on World AIDS Day.

Morénike was in college before she met a person living with HIV for the first time, someone she still considers a friend today. What she remembers most from that first meeting is how her friend just wanted to be herself, not defined by HIV. Morénike knew that fighting stigma against those living with the disease would play a central role in her life as well. She joined a group on campus called UNITY, which worked to bridge multicultural alliances between different racial groups.

After college, Morénike began working with refugees, and she noticed that some of the children were HIV positive. One child in particular was orphaned after a grandmother died of AIDS. The child's grandmother refused to take medications, feeling too stigmatized for being HIV positive. Morénike took steps to gain custody of the child at which point she experienced stigma herself. She says, "this was my first experience with how negatively people perceive you for even being affiliated with HIV."

Yet Morénike persisted. She advocated for HIV positive children from around the world and adopted a second HIV positive child. She says, "children with HIV have just as much of a right to a family as any other child."

Today she lives this belief by running a grassroots effort called Positive Playdates, which seeks to connect refugee children living with HIV in the Houston area. Morénike is also the Chair of the Houston Area Ryan White Planning Council and a member of the AIDS Clinical Trials Group in addition to being a graduate student and mother. Asked about what she wants others to gain from her story, she says she hopes "someone will look at me and see that they can do this, too."

MORÉNIKE GIWA

Chair, 2012, Houston Area Ryan White Planning Council
*Co-Chair, Operations Committee, 2010*
*Co-Chair, Quality Assurance Committee, 2010*

AIDS Clinical Trials Group (ACTG)
*Member, Global Community Advisory Board*
*Member, Underrepresented Populations Committee*
*Member, HIV Prevention Trails Network*

Community Liaison to the
International Maternal Pediatric Adolescent AIDS Clinical Trials Group (IMPAACT)

Member, Eliminate Mother to Child Transmission Working Group,
Centers for Disease Control and Prevention

Founder, Positive Playdates

## Introduction

"H-I-V. Alone, these are three simple letters. Put them together and they identify a disease with an impact of extraordinary proportions. What was once a relatively unknown and concentrated disease has evolved into an epidemic reaching all corners of the globe. It knows no national boundary or division of race, ethnicity, age, sex, or socioeconomic status...

Countless individuals, organizations, and communities the world over have responded admirably to the challenge of fighting the HIV epidemic. This document represents the continuing efforts of one local community, the greater Houston, Texas area, to prevent the spread of HIV and care for those who are living with HIV and their families."

*-- The 2009 Comprehensive HIV Services Plan for the Houston Area*

**Who We Are: The Greater Houston Area Community.** With a population of almost 2.1 million,[1] the city of Houston is the fourth largest city in the nation[2] and the most racially and ethnically diverse major metropolitan area.[3] It is also the least densely populated major metropolitan area in the country, spanning 600 square miles.[1] Houston is the population center of Harris County, the most populous county in Texas and the third most populous in the nation.[4] Currently, Harris County has close to 4.1 million residents,[4] over half of which live in the city of Houston. [1]

Houston and Harris County residents are also unique in terms of their social and demographic characteristics as well as their overall health status, particularly in comparison to the state of Texas as a whole. For example:

- Larger proportions of Houston and Harris County residents are African American, Hispanic, and Asian American than the rest of the state. [1,4]
- A larger percentage of Houston and Harris County residents is foreign-born, as is the percentage of people who report speaking a language other than English in the home. [1,4]
- While the median household income for Harris County is higher than the state, Houston's median household income is almost $7,000 lower; [1] similarly, the percentage of people living below the federal poverty level in Houston is higher than both Harris County and Texas. [1,4]
- Both Houston and Harris County have lower percentages of people who have graduated from high school than the state as whole. [1,4]

According to recent estimates, Texas has the highest percentage of residents lacking health insurance in the nation; however, the percentage of people uninsured in the Houston and Harris County area is even higher.[5] The impact of these socio-economic disparities can already be seen in the overall health status of most residents. Harris County residents have a lower average life expectancy[6] than the nation as a whole as well as statistically higher rates of death from cardiovascular disease, stroke, and certain cancers than the rest of Texas. [7] Moreover, a higher percentage of residents, almost 20 percent, describe their overall health as only "fair or poor." [6]

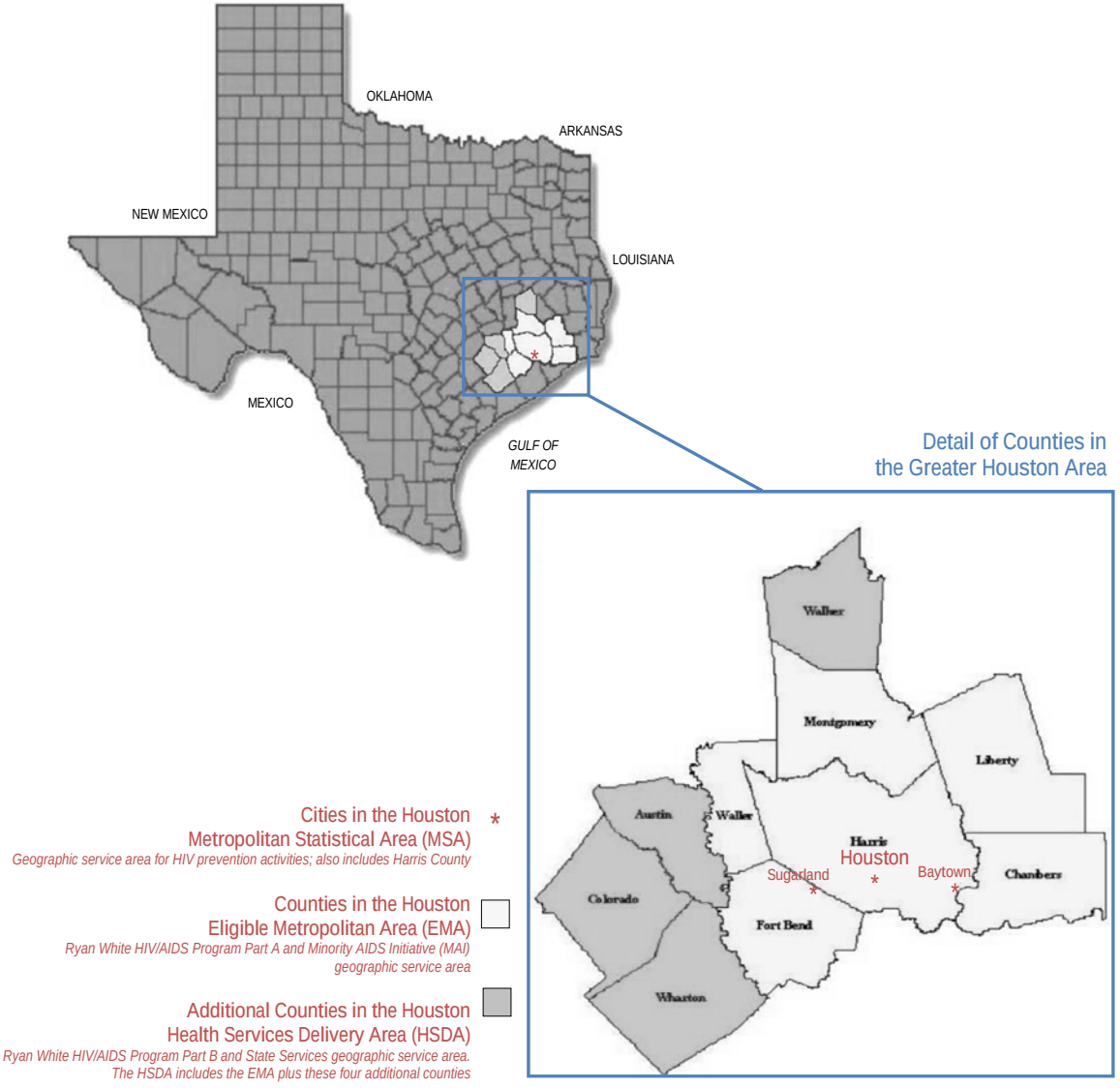
In the context of the HIV epidemic, Houston and Harris County face comparable challenges. According to the Centers for Disease Control and Prevention (CDC), the Houston-Baytown-Sugarland, TX area ranks 12th highest in the nation for rate of AIDS diagnoses.[8] In 2010, an estimated 1,430 cases of HIV were diagnosed in the area, and 21,170 people were estimated to be living with HIV at the end of 2009. [8] As a result, the Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) has designated the Houston-Baytown-Sugarland, TX area as the 8th most HIV/AIDS-impacted local jurisdiction in the country. [9]

Though they serve as its population center, the greater Houston Area extends beyond Houston and Harris County for the purposes of HIV prevention and care services. In fact, there are three distinct service designations in the greater Houston Area for HIV prevention and care (Figure 1):

- *The Houston Metropolitan Statistical Area (MSA)* that includes Harris County and the cities of Houston, Baytown, and Sugarland, TX.
- *The Houston Eligible Metropolitan Area (EMA)* that includes six counties in the area: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.
- *The Houston Health Services Delivery Area (HSDA)* that includes the six counties of the Houston EMA plus four additional counties: Austin, Colorado, Walker, and Wharton.

Together, the Houston MSA, EMA, and HSDA cover 9,415 square miles of southeast Texas or 3.5 percent of the entire state.[5] They are home to more than 4.3 million residents, the vast majority of which (98 percent) reside in Houston and Harris County.[5]

Figure 1: Greater Houston Area Geographic Service Designations for HIV Prevention and Care



**Where We've Been: The Houston Area's Response to the HIV Epidemic.** In 1981, when the first known cases of AIDS were reported, the national *and local* response to the disease was lead by small grassroots organizations and individual advocates. Over time, this community-based effort evolved into a coordinated international movement recently culminating in the release of the first-ever National HIV/AIDS Strategy for the U.S., the United Nations' new framework for attaining "zero new HIV infections," and the 30th anniversary of those first known cases of HIV/AIDS. In the Houston Area, the response to the epidemic has followed a similar course:

- *Early 1980s.* Local grassroots organizations such as the Montrose Clinic (now Legacy Community Health Services, Inc.), Montrose Counseling Center, and KS AIDS Foundation (now AIDS Foundation Houston) were at the helm of the Houston Area response to HIV/AIDS. Mid-decade, a privately-owned hospital corporation opened the Institute for Immunology in Houston, becoming the first hospital in the country dedicated to HIV. Unfortunately, the Institute closed after one year, and patients without health insurance were referred to the Harris County Hospital District, the Houston Area's indigent hospital system. As a result, the District gained over 700 new HIV patients *overnight*. By 1989, the District had established the Thomas Street Health Center, a publicly-funded outpatient HIV medical home still considered one of the best in the nation today.

- *Mid-1980s.* State and federal funding for HIV prevention was beginning in earnest in the Houston Area. The Texas Department of Health (now the Texas Department of State Health Services or DSHS) and the Centers for Disease Control (now the Centers for Disease Control and Prevention or CDC) began funding HIV case surveillance. A limited amount of funding was dedicated to HIV testing, counseling, and education. In 1988, the City of Houston (now the Houston Department of Health and Human Services or HDHHS) was funded by the CDC for a pilot perinatal HIV prevention program; and, in 1989, became one of only six cities in the nation to receive funding for a community-wide HIV prevention program.

"A coordinated federally-funded HIV prevention program has been in the Houston Area for 23 years. The Ryan White HIV/AIDS Program for HIV care, treatment, and support services has been in the Houston Area for 22 years."

- *Late 1980s.* Services for HIV care, treatment, and support in the Houston Area were still limited. AIDS Foundation Houston remained the primary source of social support for people living with HIV/AIDS. In 1987, DSHS used a general appropriation from their state budget to support small grants to community-based organizations in the highest infection areas, including Houston. In 1988, then County Judge Jon Lindsay announced the formation of the Greater Houston HIV/AIDS Alliance, a private corporation of public and private AIDS-service providers. The first federal demonstration grant for HIV case management was awarded to Harris County in 1989. It was not until 1990 that the first federal funding for HIV care, treatment, and support services became widely available.

- *1990.* The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was passed into law by Congress to provide for HIV/AIDS care, treatment, and support services in areas most severely impacted by HIV, including the Houston Area. The Ryan White HIV/AIDS Program has been reauthorized by Congress four times and is now called the Ryan White HIV/AIDS Treatment Extension Act, administered by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) and comprised of five funding components or Parts (formerly Titles) allocated to specific geographic service designations, populations, and purposes. The Houston Area has received Ryan White HIV/AIDS

Program funds since the program's inception. Also in 1990, the National Affordable Housing Act established the Housing Opportunities for People with AIDS (HOPWA) Program, which was also awarded to the Houston Area.

- *Late 1990s.* It had become clear that communities of color, and African Americans in particular, were being disproportionately impacted by HIV/AIDS. In 1999, as a result of a Congressional Black Caucus initiative, a Ryan White HIV/AIDS Program "set-aside" for HIV care services for minority communities was established. Today, it is the Minority AIDS Initiative (MAI). Also in 1999, then County Judge Robert Eckels and then Mayor Lee Brown declared an HIV "State of Emergency" in the Houston Area African American community.

- *The 2000s and today.* The Houston Area response to the HIV epidemic has transformed into a coordinated effort of public and private organizations utilizing state and federal HIV prevention and care resources to implement a comprehensive continuum of care. Houston and Harris County remain a CDC direct-funded grantee for HIV prevention and surveillance, and the Houston Area has retained its designation as a most impacted EMA, thereby continuing to qualify for formula-based direct funds from HRSA for the Ryan White HIV/AIDS Program. Throughout the 2000s, additional initiatives to accelerate the local response to HIV have also taken place. In 2006, the Houston Area was awarded the Expanded Testing Initiative (ETI) to establish routine, opt-out HIV screening in hospitals and community health centers. In 2010, as a result of the National HIV/AIDS Strategy, the Houston Area was selected for ECHPP, the *Enhanced Comprehensive HIV Prevention Planning* project to enhance HIV prevention efforts in the most HIV/AIDS impacted cities. A year later, the Houston EMA embarked on HRSA's EIIHA initiative, the *Early Identification of Individuals with HIV/AIDS*, which seeks to improve linkage to care for the newly-diagnosed.

**Where We're Going: A New Approach for HIV Prevention and Care Planning.** Jurisdictions like the Houston Area that receive federal HIV prevention and care dollars are required to ensure extensive collaboration and consultation with the community on the use of these funds, particularly from people living with HIV/AIDS and from consumers of services. Most jurisdictions have established volunteer committees for this purpose called Planning Bodies. In the Houston Area, there are two local Planning Bodies:

"Jurisdictions like the Houston Area that receive federal HIV dollars must ensure extensive collaboration and consultation with the community on the use of funds, particularly from people living with HIV/AIDS."

- *The Houston HIV Planning Group (HPG, formerly the Community Planning Group or CPG)* a volunteer body of up to 35 members selected to represent the demographics of the Houston Area HIV epidemic. The HPG is responsible for prioritizing populations and interventions for Houston Area HIV prevention activities funded by the Centers for Disease Control and Prevention (CDC); and

- *The Houston Area HIV Services Ryan White Planning Council (RWPC)* a 38-person body appointed by the Harris County Judge, who serves as the CEO for the Houston Area Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (MAI). The RWPC is responsible for prioritizing and allocating funds for HIV care, treatment, and support services provided under Part A and MAI as well as for making recommendations regarding services provided under Part B and State Services, the matching funds from the state of Texas.

An additional core function of local Planning Bodies is to articulate the community's vision for how best to deliver HIV prevention and care services long-term – a process commonly referred

to as *comprehensive jurisdictional HIV planning* – which culminates in the development of multi-year plans for HIV prevention and HIV care services. Comprehensive jurisdictional planning became a mandate for HIV prevention and the HPG beginning in 1993; the RWPC launched its first comprehensive HIV services planning process in 1999. Ever since, each Planning Body has produced separate three-year jurisdictional plans for HIV prevention and HIV care services.

"The Houston Area HIV Planning Group and the Ryan White Planning Council set into motion a plan to create the first-ever *joint* comprehensive jurisdictional HIV prevention *and* HIV care services plan."

Though the Houston Area has a long history of conducting other comprehensive jurisdictional HIV planning activities as joint efforts between HIV prevention and HIV care, by 2011, the community had yet to produce a *joint* comprehensive jurisdictional plan for HIV services. Since 2004, the Houston Area's HIV/AIDS Epidemiological Profile has been an integrated document for use in both prevention and care planning, and, beginning in 2002, the area's needs assessment of people living with HIV/AIDS measured needs, barriers, and gaps in both prevention and care. When the time came to begin the next cycle of comprehensive jurisdictional HIV planning for the Houston Area, it was in light of this recent history that the decision to produce the first-ever *joint* plan was made. There were several additional reasons for this new approach:

- The National HIV/AIDS Strategy's "call to action" for increased collaboration among all AIDS-service providers, including within and between HIV prevention and HIV care.
- Despite separate funding sources and administration, HIV prevention and HIV care services are part of a single continuum of care for people at risk for or infected with HIV.
- HIV prevention and HIV care service-providers are often reaching the same clients, high risk populations, and underserved communities.
- A joint plan offers the opportunity to engage new partners, strengthen existing relationships, and gain increased community-wide ownership for addressing the HIV epidemic.
- More and diverse sets of experience and expertise will ultimately lead to a more comprehensive and representative plan for the Houston Area.

As a result, the Houston Area HIV prevention and care Planning Bodies, grantees, service-providers, and stakeholders set into motion a plan to create the first-ever *joint* Comprehensive HIV Prevention and Care Services Plan for the Houston Area.

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## Engagement Plan: The Process for Developing the 2012 Comprehensive Plan

The Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 (Comprehensive Plan) is the Houston Area's *first-ever* joint jurisdictional plan for HIV prevention and HIV care. The process used to develop this document was also unique and is described in detail below.

**Design of the Process (Creating a "Plan for Planning") and Determining Who to Engage.** When the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) issued its guidance for comprehensive HIV services planning for 2012, it included several areas for local jurisdictions to consider in regards to improving and filling gaps in their current continuum of care.[1] At a minimum, jurisdictions were expected to:

- Articulate the community's vision and values regarding how best to deliver HIV services.
- Evaluate their most recent comprehensive plan to identify successes and challenges.
- Address the needs of individuals *unaware* of their HIV status; individuals *aware* of their HIV status, but who are not in care; and members of special populations, including but not limited to, adolescents, injection drug users, homeless, and transgender.
- Propose goals and solutions to fill gaps in care.
- Propose efforts to improve coordination *within* the Ryan White HIV/AIDS Program, *between* the AIDS-service community and other public and private health care providers, *between* HIV prevention and HIV care, and in anticipation of changes that will occur with the implementation of the *Patient Protection and Affordable Care Act of 2010*.
- Demonstrate alignment of the new plan with other local, state, and national initiatives, with special attention to the National HIV/AIDS Strategy, *Healthy People 2020*, the Statewide Coordinated Statement of Need (SCSN), *Enhanced Comprehensive HIV Prevention Planning* (ECHHP); and the *Early Identification of Individuals with HIV/AIDS* (EIIHA).
- Include extensive consultation and collaboration with the community.

The process used to develop the Comprehensive Plan (i.e., the "plan for planning") was a reflection of this guidance. Building on six overarching themes from the guidance – *community involvement, evaluation, prevention and early identification, filling gaps and reaching the out-of-care, and coordination* – a new organizational structure, separate from the two local HIV Planning Bodies, was adopted and then populated with both prevention and care stakeholders. This structure included five topic-specific Workgroups based on the HRSA guidance themes and a Leadership Team to oversee the process as a whole (Figure 1). The HRSA guidance also provided the main criteria for determining *who* to engage in this new structure. Representation in the planning process was sought from:

- The two local Planning Bodies, the Ryan White Planning Council (RWPC) and the HIV Planning Group (HPG).
- The Houston Area's directly-funded Centers for Disease Control and Prevention (CDC) HIV prevention grantee; directly-funded HRSA Ryan White HIV/AIDS Program grantees (Part A, C, D); and Ryan White HIV/AIDS Program Part B and State Services provider.
- Other federally-funded HIV programs in the Houston Area (e.g., Housing Opportunities for People with AIDS, CDC Division of Adolescent and School Health grantee).
- AIDS-service providers in both HIV prevention and care from both the urban Eligible Metropolitan Area (EMA) and the rural Health Service Designation Area (HSDA).
- Individual or agency representation on the needs of the special populations of adolescents, injection drug users, homeless, and transgender.
- Entities and sectors indicated as priorities for enhanced coordination of effort with HIV (e.g., private providers, substance abuse, Medicaid, and Community Health Centers, etc.).

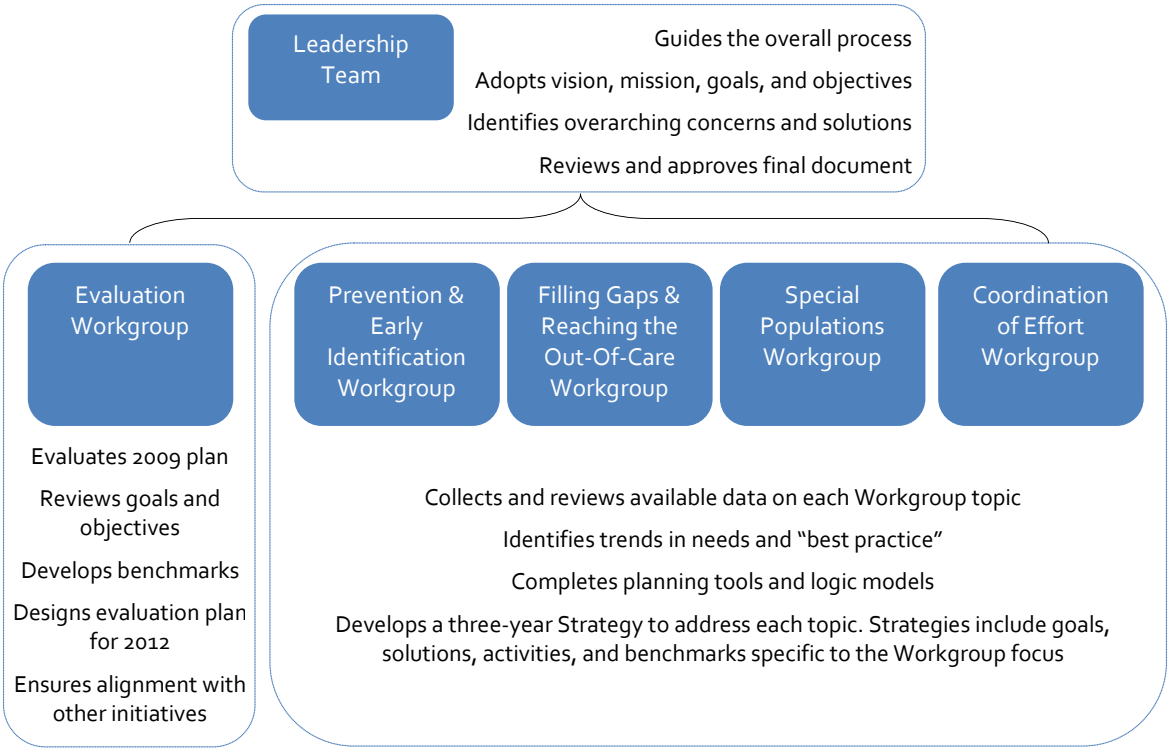
- Experts in evaluation, outcomes measures, performance measures, and benchmarking.
- Individuals infected with, at risk for, or affected by HIV, including consumers of HIV prevention and care services.

Once engaged on specific Workgroups, participants were tasked with determining the goals of the plan, and each produced a three-year strategy containing specific goals, solutions, activities, and benchmarks specific to their Workgroup topic.

The leadership for each Workgroup and the Leadership Team was also strategically identified. For the former, a person living with HIV/AIDS and an additional subject matter expert were identified and appointed to serve as Co-Chairs. The latter was chaired by three representatives: (1) of the RWPC, to represent Ryan White HIV/AIDS Program Part A; (2) of the Ryan White HIV/AIDS Program Part B, with an emphasis on representation from the rural areas of the Houston jurisdiction; and (3) of the HPG, to represent HIV prevention. Each Workgroup Co-Chair also served as an executive on the Leadership Team.

In addition, specific offices were identified to provide staff to the process. These included: (1) the RWPC Office of Support, to represent Ryan White HIV/AIDS Program Part A; (2) The Houston Regional HIV/AIDS Resource Group, Inc. (TRG), to represent Ryan White HIV/AIDS Program Part B and State Services; and (3) the Houston Department of Health and Human Services (HDHHS), to represent HIV prevention and HPG.

Figure 1: Structure Used to Develop the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 - 2014



**Partner Recruitment, Engagement, and Retention in the Process.** Ten core strategies were utilized throughout the planning process to recruit, engage, and retain both previous partners and new partnering agencies in the design of the Comprehensive Plan. Each is described below:

1. *At-A-Glance and Role Descriptions*. A written At-A-Glance of the goals, opportunity, structure, and timeline of the 2012 comprehensive planning process as well as role descriptions specific to the Leadership Team and each topic-specific Workgroups were created and disseminated.
2. *Community Presentations*. Multiple formal presentations about the process and opportunities for involvement were made at meetings of relevant community groups and coalitions, including at the RWPC, HPG, HIV prevention and care contractor meetings, HIV prevention and care frontline staff trainings, and community events such as health fairs. The latter was used as a specific recruitment site for HIV infected individuals and consumers.
3. *Targeted Outreach*. To ensure representation from priority groups and particularly from those populations and/or sectors identified in the HRSA guidance, specific individuals and/or agencies were contacted directly using existing staff relationships. As needed, outreach to new partnering agencies was conducted via "cold call."
4. *Redirection of Planning Resources*. Meetings of the standing comprehensive HIV planning committees of the RWPC and HPG were suspended for the duration of the process, thereby allowing members to re-direct participation to the 2012 planning structure.
5. *Formal Appointments*. The leadership of the two Planning Bodies made formal appointments of individuals to specific roles in the 2012 planning structure. These included appointments to serve as members of specific Workgroups and/or to serve as Workgroup Co-Chairs.
6. *Formal Workgroup Meeting Schedules*. The Leadership Team and Workgroups maintained a set monthly in-person meeting schedule. Meeting packets were disseminated via email, and options were made available to accommodate scheduling conflicts, such as teleconferencing. Meeting packets were also made available on the RWPC website.
7. *Meeting Facilitation Methods*. Though formal decisions of the Leadership Team and Workgroup were made using parliamentary procedure (e.g., approval of minutes), methods to encourage open dialogue and consensus during meetings were used throughout the process.
8. *General Feedback Methods*. In addition to attendance at standing monthly meetings, opportunities for input and feedback on the direction of the comprehensive plan were made available throughout the process. Input could be provided via email, through direct contact with staff, and during the formal Public Comment and Concurrence Processes.
9. *Planning Updates*. Each month, a summary of activities was developed and disseminated both within the planning structure and through the formal lines of communication of the Planning Bodies. Updates included summaries of overall participation, evaluation activities, Leadership Team and Workgroup activities, and other notable milestones in the process.
10. *Acknowledgments*. As significant milestones in the process were reached, partners and participants were publicly acknowledged for their contribution. Activities were also identified to formally recognize participants at the conclusion of the process as well as to officially release the plan to the Houston Area community as a whole.

"As a result of engagement strategies, 71 individuals and 56 agencies participated in planning meetings. Of these, 23% were persons living with HIV/AIDS (PLWHA). Moreover, 62% of the leadership for the process was PLWHA."

As a result of these strategies, a total of 71 individuals and 56 agencies participated in either a Leadership Team or a Workgroup process.

**Ensuring Participation by People Living with HIV/AIDS (PLWHA).** The structure adopted to develop the Comprehensive Plan included specific roles for HIV infected individuals and consumers of HIV services in the Houston Area. As described above, it was required that a person living with HIV/AIDS be appointed as at least one of the two Co-Chairs of each Workgroup and, if possible, as at least one of the three chairs of the Leadership Team. In addition, the recruitment, engagement, and retention strategies described above were applied to HIV infected individuals and consumers as well as to previous partners and new partnering agencies. As a result, 23 percent (or 16) of the individuals who participated in either a Leadership Team or Workgroup process were people living with HIV/AIDS (PLWHA). Within the leadership of the process, 62 percent (or eight) of all Co-Chairs were also PLWHA.

**Building the Plan.** The Leadership Team and topic-specific Workgroups formed for the purpose of 2012 comprehensive planning (Figure 1) were tasked with developing the content that would form the basis of specific required sections of the Comprehensive Plan: [1]

- *Section II: Where Do We Need to Go?* describes the community's vision for an ideal, high quality, comprehensive continuum of HIV prevention and care services for the Houston Area and outlines the overarching issues, opportunities, goals and objectives, and other elements that shape this ideal system;
- *Section III: How Will We Get There?* outlines the specific strategies, solutions, and activities needed to achieve specified goals and meet identified challenges toward the development of an ideal system of HIV prevention and care in the Houston Area; and
- *Section IV: How Will We Monitor Progress?* describes the means by which progress will be measured in achieving goals, reaching benchmarks, and implementing strategies.

The Leadership Team and Evaluation Workgroup convened at least monthly for seven months (September 2011 through March 2012); while topic-specific Workgroups met monthly for five months (September 2011 through January 2012). In total, 36 planning meetings were held during the process. To facilitate an efficient process for each group, staff designed and utilized the following planning tools:

"The Leadership Team and Evaluation Workgroup convened at least monthly for seven months; while topic-specific Workgroups met monthly for five months. In total, 36 planning meetings were held during the process."

1. *Mind-Mapping Tool.* A Venn diagram was used to map overarching issues, concerns, and key research questions about each Workgroup topic as identified through initial brainstorming. Based on the results, data collection packets on each topic were compiled. Primary sources of data were secondary data collection and data mining; anecdotal and/or qualitative data provided by participants; and extensive document review and archiving.
2. *Logic Models.* A series of three progressive macro-to-micro level logic models was used in topic-specific Workgroups to link overarching issues, concerns, and key research questions to goals, solutions, and benchmarks; population focus and activities; and outputs, timeframe, and responsible parties.
3. *Coordination of Effort Tools.* Two matrices were developed specifically for the Coordination of Effort Workgroup to document both current collaborative activities and opportunities for new collaborations within the HIV system of prevention and care and between the HIV system and other priority sectors and groups identified in the HRSA guidance.
4. *Inventories.* Written inventories of vision statements, mission statements, goals, objectives, performance measures, and priority populations from 17 local, regional, state, national, and

global HIV-related strategic plans and other documents were developed and referenced by the Leadership Team and Workgroups.

5. *Benchmarking and Alignment Tool.* A matrix was developed to track process and outcome measures per goal per Workgroup topic. The tool served as a compendium for data sources, baseline data, distal and proximal targets, and assurance of alignment with key regional and national initiatives and plans. This tool was used solely by the Evaluation Workgroup.
6. *Strategy Compendium.* Also used by the Evaluation Workgroup was a matrix of all proposed goals, solutions, activities, and benchmarks per Workgroup topic.

At key points during the Workgroup process, two foundational draft products were reviewed: (1) a draft *macro*-level Strategy for each Workgroup topic summarizing overarching themes, goals, solutions, and benchmarks; and (2) a draft *micro*-level Strategy for each Workgroup topic outlining activities, timeframes, and responsible parties. Once reviewed and approved by the Workgroups, these documents were also reviewed and approved by the Leadership Team. In addition, as drafts of each narrative section of the Comprehensive Plan were developed by staff, they, too were reviewed by the Leadership Team and members of Workgroups also serving on that body. A complete draft of Section IV was also reviewed by the Evaluation Workgroup.

As needed throughout the planning process, additional tools were created to help members of the Leadership Team and Workgroups to better understand the process itself. For example, a series of models, entitled *Synergy Models*, was created to visually describe the relationship between the Leadership Team and Workgroups; and a metric showing visually how the final products will interconnect, entitled *Putting it All Together: A Map of the Plan*, was also developed. Lastly, a series of tools was designed and utilized by the Evaluation Workgroup to conduct the required evaluation of the 2009 Comprehensive Plan.

**The Public Comment Process.** Though multiple methods were used during the comprehensive planning process to garner input from stakeholders and community members on the content of the Comprehensive Plan, an additional mixed-method approach and timeframe was designated as a formal Public Comment Process. From January 19, 2012 to March 2, 2012, the following methods were applied to generate additional feedback from key stakeholders, community members, and people living with HIV/AIDS:

It is "a sound, collaboratively developed plan for implementing coordinated prevention and care services in the Houston metro area."
*– Public Comment Process Survey Respondent*

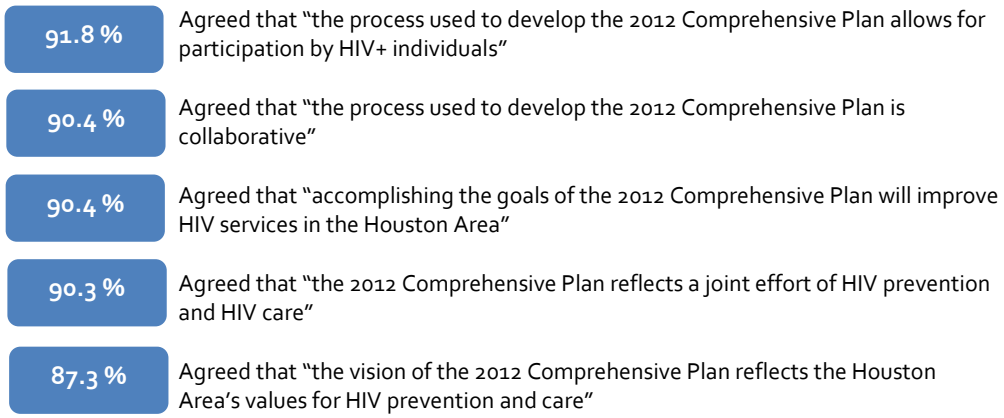
- *Key Informant Interviews.* In-person guided key informant interviews were conducted with representatives of 13 Houston Area agencies. These included large facility-based AIDS-service providers funded by the Ryan White HIV/AIDS Program, agencies serving the special populations identified in HRSA guidance, and agencies indicated as priorities for enhanced coordination of effort. Priority was placed on agencies that were under-represented in the planning process.
- *Group Presentations.* Formal presentations were given at meetings of nine community groups and coalitions. Attendance at presentations ranged in size from less than five to 40. The presentation included an overview of the planning process, the structure of the Comprehensive Plan, the vision statement, overarching concerns and solutions, goals and objectives, and priority populations.
- *Surveys.* An 11-point survey of agree-disagree statements using a simple Likert scale was made available in paper-and-pencil and electronic formats. The survey was disseminated via email

with a self-study presentation about the Comprehensive Plan and distributed at the conclusion of group presentations. A total of 84 respondents completed the survey.

- *Focus Groups.* One client focus group and one provider focus group were held with individuals representing the special populations of the homeless and the incarcerated, respectively. Interviews with incarcerated clients and with their care providers were also conducted.

Results of the Public Comment Process were used to assess the extent of achievement of specific expected attributes of the planning process per HRSA guidance (Figure 2) as well as to affirm the proposed direction of the plan and identify remaining gaps. Respondents were also asked to provide recommendations for effective implementation and to share how they intend to use the plan as individuals and/or agencies.

Figure 2: Percent of Survey Respondents in Agreement with Selected Statements about 2012 Comprehensive Plan Attributes




**Synergy with the Local Planning Bodies and Other Planning Efforts.** It is the intent of the Houston Area community that this Comprehensive Plan serve as the jurisdictional plan for Houston Area HIV prevention and HIV care geographic service designations, thereby meeting the expectations of respective funding sources for jurisdictional planning as follows:

- The Centers for Disease Control and Prevention (CDC)'s jurisdictional HIV prevention planning for the Houston-Baytown-Sugarland, TX Metropolitan Statistical Area (MSA);[2] and
- The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB)'s plan for the organization and delivery of health and support services for Ryan White HIV/AIDS Program Part A and B grantees for the Houston Eligible Metropolitan Area (EMA) and Health Service Designation Area (HSDA), respectively.[1]

Both the process used to develop the Comprehensive Plan and its final content and structure have been designed to ensure compliance with the jurisdictional planning guidance provided by these entities. The Comprehensive Plan has also been reviewed by both local Planning Bodies: (1) the HPG, which provides concurrence for HIV prevention activities; and (2) the RWPC, which provides concurrence for Ryan White HIV/AIDS Program Part A. The Administrative Agent for Ryan White HIV/AIDS Program Part B has provided concurrence as well.

The comprehensive planning process occurred simultaneously with the planning activities of several other local, regional, and statewide entities and initiatives. As a result, the goals and solutions put forth in this document are coordinated, aligned, and, in some cases, infused into the goals and solutions of other Houston Area jurisdictional plans (Section IV: How the Plan Aligns).

**Maintaining the Partner Relationships.** Five core strategies have been identified to maintain relationships with previous partners and new partnering agencies upon completion of the Comprehensive Plan. Each is described below:

1. *Ongoing Engagement Activities*. The *Strategy to Improve Coordination of Effort and Prepare for Health Care System Changes* (Section III) outlines the goals, solutions, activities, and timelines that the Houston Area HIV community has identified for increasing coordination within HIV programs (i.e., prevention, care, treatment) across the state and jurisdiction to reduce rates of new HIV infection. It also lists the specific high priority fields, sectors, and agencies to target for new engagement activities as a component of plan implementation, and it includes quantifiable measures of coordination of effort success.
2. *Implementation Plan*. Each of the four strategies developed by topic-specific Workgroups for the Comprehensive Plan (Section III) includes an implementation plan. For each proposed activity, the implementation plan states at least one responsible party and a timeline for completion. Responsible parties reflect both previous and new partnering agencies.
3. *Monitoring Progress.* An Evaluation and Monitoring Plan for the Comprehensive Plan has been developed (Section IV). In addition, the Evaluation Workgroup formed for the 2012 comprehensive planning process will be maintained during plan implementation. Their role will be to review data, assess the status of proposed activities and benchmarks, provide explanation of outcomes, identify areas of course correction, and report findings to the local Planning Bodies. Membership on the Evaluation Workgroup will include previous and new partnering agencies, and their reports of findings will be shared with all engaged partners.
4. *Public Comment Process and "How to Use the Plan."* During the Public Comment Process described above, participants were asked how they intend to use the Comprehensive Plan as individuals and/or agencies. Their responses formed the basis of the section of the document entitled, *How to Use The Plan*, which will be used during plan implementation as an ongoing engagement strategy with both previous and new partnering agencies.
5. *Assessment of the Process*. After completion of the Comprehensive Plan, staff will evaluate the process with all participants. Lessons learned from the process will be gathered for use in the next jurisdictional planning period, and partners will be queried on their readiness for ongoing engagement, their needs for continued involvement, and possible "best practices" for maintaining partner relationships throughout the implementation of a joint plan.

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## Executive Summary

The mission of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 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 infected with, affected by, or at risk for HIV.

The purpose of the plan is to: (1) describe the *current* system of HIV prevention and care services in the Houston Area; (2) describe an *ideal* system of HIV prevention and care services; (3) outline the specific activities needed to make progress toward an ideal system; and (4) describe how progress will be measured.

The plan is intended for use by local HIV Planning Bodies, Administrative Agents and grantees, providers of HIV prevention and care services, and other decision-makers as they respond to the needs of people at risk for or infected with HIV for the next three years. The plan is organized into four sections summarized below.

**Section I: Where Are We Now?** The Houston Area includes three geographic service areas specific to HIV prevention and care:

- *The Metropolitan Statistical Area (MSA)*, which includes Harris County and the cities of Houston, Baytown, and Sugarland, TX and serves as the jurisdiction for HIV prevention activities.
- *The Eligible Metropolitan Area (EMA)*, which includes the six counties of Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller and serves as the jurisdiction for HIV care services funded by the Ryan White HIV/AIDS Program Part A and the Minority AIDS Initiative (MAI).
- *The Houston Health Services Delivery Area (HSDA)*, which includes the six counties of the Houston EMA plus the four additional counties of Austin, Colorado, Walker, and Wharton and serves as the jurisdiction for HIV care services funded by the Ryan White HIV/AIDS Program Part B and State Services.

Together, these service areas cover 9,415 square miles of southeast Texas and are home to over 4.3 million residents, the vast majority of which reside in Houston/Harris County.

According to the Houston Area's most recently published epidemiological profile, there are 20,190 people currently living with HIV/AIDS in the area, and 1,903 new cases of HIV/AIDS were diagnosed in the most recently published reporting year. Over the past five years, the rate of *new* HIV infections in the Houston Area has increased as have the rates of living HIV/AIDS cases. The most commonly-reported risk category for HIV/AIDS in the Houston Area is male-to-male sexual practices (or MSM). It is further estimated that an additional 5,306 people in the Houston EMA are currently HIV positive but unaware of their status and that an additional 6,287 individuals *are* aware of their HIV positive status but are not in HIV care.

Since 1999, the Houston Area has maintained a Continuum of Care conceptualized as a rail system of five tracks, with each track representing a stage in the progression of HIV disease – *from having no awareness of the disease to end-of-life* – and then including examples of the HIV prevention and care services indicated for each stage. Two federal funding sources support the majority of the HIV prevention and care services indicated on the Continuum:

- *The Centers for Disease Control and Prevention (CDC)*, which supports HIV prevention activities in the Houston MSA and HIV surveillance activities for Houston and Harris County; and
- *The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB)*, which supports HIV care, treatment, and support services in the Houston EMA and Houston HSDA through the Ryan White HIV/AIDS Program.

A combination of public and non-profit Houston Area agencies are competitively-awarded these funds and either provide direct services or function as Administrative Agents that contract to direct service providers.

**Section II: Where Do We Need to Go?** In the time since the last Comprehensive Plan for the Houston Area was developed, several local

initiatives were launched to accelerate HIV prevention and care outcomes. Therefore, where the Houston Area "needs to go" in terms of improving the HIV system is to complement recent initiatives by identifying specific strategies to *sustain*, *scale-up*, *shift* (in terms of new priorities or needs), or that will *shore-up* the entire system.

The vision for this process is that the *"greater Houston Area will become a community with a coordinated system of HIV prevention and care, where new HIV infections are rare, and, when they do occur, where every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high-quality, life-preserving care, free of stigma and discrimination."*

To make progress toward this vision, several influences must be addressed including: resources that do not keep pace with need, continued disparities in HIV/AIDS infection, the presence of co-occurring conditions and behavioral health concerns among people living with HIV/AIDS, and the impact of health care reform on HIV services.

In light of these factors, the Houston Area has identified six goals for the HIV system over the next three years:

1. *Mobilize the greater Houston Area community around HIV*
2. *Prevent new HIV infections through both prevention and treatment strategies*
3. *Ensure that all people living with or at risk for HIV have access to early and continuous HIV prevention and care services*
4. *Reduce the effect of co-occurring conditions that hinder prevention behaviors and adherence to care*
5. *Reduce disparities in the HIV epidemic and address the needs of vulnerable populations*
6. *Achieve a more coordinated and expansive HIV system prepared for health care system changes*

**Section III: How Will We Get There?** There are several cross-cutting high-impact solutions for achieving system-wide improvements in HIV prevention and care services in the Houston Area. They include: structural interventions such as policy change, HIV testing, engagement and retention in continuous HIV care, technology, and improved coordination of effort among current and new partners. These solutions and others have been incorporated into four strategies:

1. *Strategy for prevention and early identification*
2. *Strategy to fill gaps in care and reach the out-of-care*
3. *Strategy to address the needs of special populations*
4. *Strategy to improve coordination of effort and prepare for health care system changes*

Each strategy includes specific activities to be conducted over the next three years in order to make progress toward long-range goals.

**Section IV: How Will We Monitor Progress?** Progress toward the vision and goals of the Comprehensive Plan will be measured by the extent of achievement of stated objectives, activities, and benchmarks, including specific long-range measures of success:

1. *Reduce the number of new HIV infections by 25% (from 1,029 to 771).*
2. *Maintain and, if possible, increase the percentage of HIV+ individuals who are aware of their status (from 92.9% to 100%).*
3. *Increase the proportion of newly-diagnosed individuals linked to HIV care within three months of diagnosis to 85% (from 65.1%).*
4. *Reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year by 25% (from 36% to 27%).*
5. *Increase the percentage of Ryan White HIV/AIDS Program clients who are in continuous HIV care to 80% (from 78%).*
6. *Reduce the proportion of individuals who are HIV+ but not in HIV care by 0.8% each year (beginning at 30.1%).*
7. *Increase the proportion of Ryan White HIV/AIDS Program clients with undetectable viral load by 10% (from 57% to 62.7%).*
8. *Reduce the number of reports of barriers to Ryan White HIV/AIDS Program-funded Mental Health Services and Substance Abuse Services by 27.3% and 43.7%, respectively.*

In its vision, goals, and measures of success, the Comprehensive Plan is aligned with other local, regional, state, and national initiatives.

# Cristan Williams

*"HIV prevention is more than just telling someone how to use a condom."*

Photograph by Barb Garvin

*After years of searching for a place to belong, Cristan Williams created one for herself and for other transgender people in Houston.*

Cristan was raised in Pasadena, Texas by her mother who, despite bouts of depression and drug use, was an early source of nurturing and support, in contrast to what Cristan saw around her. Cristan lived on the same street as KKK headquarters, and she was acutely aware of their beliefs about gays and lesbians. She saw the anti-gay literature they passed around in her neighborhood and understood their hatred to be a serious threat.

Cristan was in high school when she first tried to come out as transgender. When she told her guidance counselor, she was met with misunderstanding. Her counselor told her to "read the Bible more," suggested she move to San Francisco, and then removed her from school. But Cristan persevered. She attended community college to earn her GED and entered a twelve step program to overcome a drug addiction that began when she was younger. Not only did twelve step help Cristan end her drug use, it also helped her find her calling. She started chairing meetings for groups at age 15 and became the area's representative for statewide meetings. It was also during this time that Cristan first met and cared for someone who was dying of AIDS.

Clean and sober, she took a job at a warehouse to experience what she calls "man school," a place where she could learn to "live as a man." She says her time at the warehouse made her feel

like an anthropologist, studying how men behave, but also repressing her gender identity. She ultimately decided to transition from male to female. There were still times, however, when Cristan struggled; she was homeless and denied assistance from shelters because of her gender identity. This led her to start organizing. She founded the first transgender homeless program, several transgender social service programs, and a unique space called the Transgender Center.

Today, the Center is a major resource for transgender people across the county. It provides health information for the transgender community, including information about HIV, as well as educates people about transgender history and helps other transgender individuals, like Cristan, realize they are not alone. Addressing the HIV epidemic in Houston, Cristan says, "is more than just telling someone how to use a condom….it also means helping people improve their overall circumstances, from education to housing." And having a place to belong.

CRISTAN WILLIAMS

Community Co-Chair, 2012, Houston Area HIV Planning Group (HPG)

2012 Houston Area Comprehensive HIV Prevention and Care Services Plan
*Co-Chair, Leadership Team*

Executive Director, Transgender Foundation of America

Founder, Transgender Center and Transgender Archive

Board of Directors, Bee Busy Wellness Center, Inc.

# Section I: Where Are We Now?

The purpose of this section is to describe the current state of HIV/AIDS in the Houston Area, including trends in HIV/AIDS epidemiology and service delivery as well as needs, gaps, and barriers to HIV prevention and care. It also provides an overview of the current system of HIV prevention and care services in the Houston Area and summarizes progress made since the 2009 Comprehensive Plan.

Section Contents

# HIV/AIDS IN THE HOUSTON AREA: INCIDENCE, PREVALENCE, AND MORTALITY

## The "Epi Profile"

Jurisdictions in receipt of federal funding for HIV prevention or care are expected to be able to describe and understand the local HIV/AIDS epidemic in their local jurisdiction and to use this information to inform decisions on HIV prevention and care services. *Integrated HIV/AIDS Epidemiologic Profiles for HIV Prevention and Ryan White CARE Act (sic) Community Planning* (commonly referred to as "Epi Profiles") are jurisdiction-specific documents designed to meet this goal. They are intended to describe HIV/AIDS disease trends in defined geographic areas and then to serve as a source of quantitative data from which HIV prevention and care priorities can be identified based on the burden of disease. Epidemiological profiles include data on HIV/AIDS incidence, prevalence, mortality, service utilization, socio-demographics, and other information for various populations, including the general population, the HIV-infected population, the non-infected (and untested) population whose behavior places them at risk for HIV, and other special or emerging populations as determined by local HIV Planning Bodies.

Below is a summary of key findings from the current Houston Area "Epi Profile" (published March 2011). The following considerations should be made when reviewing these data:

- Data selected for presentation are the epidemiological analyses most commonly used to describe the current burden of a disease in a community and that offer comparability to other jurisdictions and nationwide: *incidence, prevalence, and mortality*. They are intended to provide a broad perspective on "where we are now" in the HIV/AIDS epidemic in the Houston Area. They are not intended to be representative of the full body of data collected, analyzed, and presented in the complete Houston Area epidemiological profile. A complete profile can found at the following address: *http://www.rwpchouston.org/Publications/publication_listing.htm.*
- In order to be representative of the greater Houston Area as a whole, the data presented here are for the largest of the HIV prevention and care geographic service designations, the Houston Health Services Delivery Area (HSDA), comprised of the counties of Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton and *encompassing* both the Houston Metropolitan Statistical Area (MSA) and the Houston Eligible Metropolitan Area (EMA).
- Data presented here are drawn directly from the current *published* epidemiologic profile for the Houston Area, which utilized confirmed HIV/AIDS case surveillance data for the reporting periods of calendar years 2008 and 2007. Though more current data may be available for some geographic service areas, they are not presented here in order to remain consistent with current published epidemiologic reports for the Houston Area.
- Because the data presented here are from the current *published* epidemiologic profile for the Houston Area, they also retain that originating document's limitations in regards to data collection and analysis. Of note is the lack of data analyzed by current gender identity in addition to sex. As a result, HIV/AIDS incidence, prevalence, and mortality are not available for the Houston Area transgender population.

## New HIV/AIDS Cases (*Incidence*) in the Houston Area

Incidence is an epidemiological term used to refer to newly diagnosed cases of disease. Incidence data for HIV in the Houston Area includes all new HIV cases reported in the time period; while incidence data for AIDS includes both previously diagnosed HIV cases that progressed to AIDS

during the reporting period as well as newly reported AIDS cases that were not previously reported as HIV cases. Key findings in incidence in the Houston Area are as follows (Table 1):

- 1,903 cases of HIV and AIDS were newly diagnosed in the Houston Area in 2008; of those, 1,029 were newly diagnosed HIV (not yet progressed to AIDS), and 874 were new AIDS.
- The HIV infection rate for the Houston Area in 2008 was 19.7 cases per 100,000 population, and the AIDS infection rate was 16.7 cases per 100,000 population. During the five year period of 2003 - 2008, the rate of new HIV infection in the Houston Area *increased* by 15 percent while the rate of new AIDS *decreased* by the same percentage.
- Blacks/African Americans had the highest rate of new HIV infection in the Houston Area in 2008 (65.2 cases per every 100,000 population of blacks/African Americans), which is almost six times greater than the rate for Hispanics and seven times greater than the rate for whites.

Table 1: New Cases (Incidence) of HIV/AIDS in the Houston HSDA, 2008
Data source: Texas Department of State Health Services Enhanced HIV/AIDS Reporting System (eHARS)

| | New HIV | | | New AIDS | | | New HIV/AIDS | | |
|---|---|---|---|---|---|---|---|---|---|
| | # | % | Rate[1] | # | % | Rate[1] | # | % | Rate[1] |
| **Total** | 1,029 | 100.0 | 19.7 | 874 | 100.0 | 16.7 | 1,903 | 100.0 | 36.4 |
| **Sex** | | | | | | | | | |
| Male | 771 | 74.9 | 29.3 | 621 | 71.1 | 23.6 | 1,392 | 73.1 | 52.9 |
| Female | 258 | 25.1 | 9.9 | 253 | 28.9 | 9.7 | 511 | 26.9 | 19.6 |
| **Race/Ethnicity** | | | | | | | | | |
| White, non-Hispanic | 187 | 18.2 | 9.2 | 160 | 18.3 | 7.9 | 347 | 18.2 | 17.2 |
| Black/African American | 598 | 58.1 | 65.2 | 484 | 55.4 | 52.8 | 1,082 | 56.9 | 118.0 |
| Hispanic/Latino | 221 | 21.5 | 11.5 | 214 | 24.5 | 11.1 | 435 | 22.9 | 22.6 |
| Other | 23 | 2.2 | 6.2 | 16 | 1.8 | 4.3 | 39 | 2.0 | 10.5 |
| **Age (years)** | | | | | | | | | |
| 0-1 | 2 | 0.2 | 1.1 | 0 | 0.0 | 0.0 | 2 | 0.1 | 1.1 |
| 2-12 | 1 | 0.1 | 0.1 | 0 | 0.0 | 0.0 | 1 | 0.1 | 0.1 |
| 13-24 | 239 | 23.2 | 25.3 | 61 | 7.0 | 6.5 | 300 | 15.8 | 31.8 |
| 25-34 | 324 | 31.5 | 38.9 | 259 | 29.6 | 31.1 | 583 | 30.6 | 69.9 |
| 35-44 | 264 | 25.7 | 33.4 | 288 | 33.0 | 36.4 | 552 | 29.0 | 69.8 |
| 45-54 | 147 | 14.3 | 20.1 | 183 | 20.9 | 25.0 | 330 | 17.3 | 45.1 |
| 55+ | 52 | 5.1 | 5.7 | 83 | 9.5 | 9.1 | 135 | 7.1 | 14.8 |
| **Transmission Mode** | | | | | | | | | |
| Men Who Have Sex with Men (MSM) | 450 | 43.7 | * | 310 | 35.5 | * | 760 | 39.9 | * |
| Injection Drug Use (IDU) | 28 | 2.7 | * | 86 | 9.8 | * | 114 | 6.0 | * |
| MSM and IDU | 8 | 0.8 | * | 36 | 4.1 | * | 44 | 2.3 | * |
| Heterosexual Contact | 197 | 19.1 | * | 231 | 26.4 | * | 428 | 22.5 | * |
| Perinatal Exposure | 2 | 0.2 | * | 4 | 0.5 | * | 6 | 0.3 | * |
| No Identified Risk (NIR)/ No Reported Risk (NRR) | 344 | 33.4 | * | 207 | 23.7 | * | 551 | 29.0 | * |
| Other | 0 | 0 | * | 0 | 0 | * | 0 | 0 | * |
| **Location** | | | | | | | | | |
| Houston/Harris County | 953 | 92.6 | 24.0 | 794 | 90.8 | 20.0 | 1,747 | 91.8 | 44.1 |
| Non-Harris County | 76 | 7.4 | 6.0 | 80 | 9.2 | 6.3 | 156 | 8.2 | 12.3 |

[1]per 100,000 population *Rate not available due to lack of population estimates

- No Identified Risk (NIR) and No Reported Risk (NRR) were high among the newly diagnosed; however, of cases *with* reported risk, 43.7 percent of new HIV was among Men Who Have Sex with Men (MSM), and 19.1 percent was attributed to heterosexual contact.
- Harris County remained the epicenter of new cases with 92.6 percent and 90.8 percent of newly diagnosed HIV and AIDS cases, respectively.

## People Living with HIV/AIDS (*Prevalence*) in the Houston Area

While incidence is an analysis of new cases of disease, prevalence is an analysis of the total number of people who currently have a disease. In the case of HIV/AIDS, prevalence is the total number of People Living with HIV or AIDS (PLWHA). Key findings in prevalence in the Houston Area are as follows (Table 2):

Table 2: People Living with HIV/AIDS (Prevalence) in the Houston HSDA, 2008
Data source: Texas Department of State Health Services Enhanced HIV/AIDS Reporting System (eHARS)

| | Living w/ HIV | | | Living w/ AIDS | | | Living w/ HIV/AIDS | | |
|---|---|---|---|---|---|---|---|---|---|
| | # | % | Rate[1] | # | % | Rate[1] | # | % | Rate[1] |
| **Total** | 8,481 | 100.0 | 162.1 | 11,709 | 100.0 | 223.8 | 20,190 | 100.0 | 385.8 |
| **Sex** | | | | | | | | | |
| Male | 5,897 | 69.5 | 224.2 | 8,921 | 76.2 | 339.2 | 14,818 | 73.4 | 563.4 |
| Female | 2,584 | 30.5 | 99.3 | 2,788 | 23.8 | 107.1 | 5,372 | 26.6 | 206.4 |
| **Race/Ethnicity** | | | | | | | | | |
| White, non-Hispanic | 2,228 | 26.3 | 110.2 | 3,540 | 30.2 | 175.1 | 5,768 | 28.6 | 285.2 |
| Black/African American | 4,500 | 53.1 | 490.7 | 5,381 | 46.0 | 586.8 | 9,881 | 48.9 | 1,077.5 |
| Hispanic/Latino | 1,627 | 19.2 | 84.7 | 2,657 | 22.7 | 138.3 | 4,284 | 21.2 | 223.0 |
| Other | 126 | 1.5 | 33.9 | 131 | 1.1 | 35.2 | 257 | 1.3 | 69.0 |
| **Age (years)** | | | | | | | | | |
| 0-1 | 5 | 0.1 | 2.9 | 1 | 0.0 | 0.6 | 6 | 0.0 | 3.4 |
| 2-12 | 87 | 1.0 | 10.3 | 10 | 0.1 | 1.2 | 97 | 0.5 | 11.4 |
| 13-24 | 701 | 8.3 | 74.3 | 253 | 2.2 | 26.8 | 954 | 4.7 | 101.1 |
| 25-34 | 2,226 | 26.2 | 267.0 | 1,508 | 12.9 | 180.9 | 3,734 | 18.5 | 447.8 |
| 35-44 | 2,690 | 31.7 | 340.0 | 3,797 | 32.4 | 479.9 | 6,487 | 32.1 | 820.0 |
| 45-54 | 1,974 | 23.3 | 269.9 | 4,105 | 35.1 | 561.3 | 6,079 | 30.1 | 831.2 |
| 55+ | 798 | 9.4 | 87.5 | 2,035 | 17.4 | 223.2 | 2,833 | 14.0 | 310.8 |
| **Transmission Mode** | | | | | | | | | |
| Men Who Have Sex with Men (MSM) | 3,422 | 40.3 | * | 5,169 | 44.1 | * | 8,591 | 42.6 | * |
| Injection Drug Use (IDU) | 643 | 7.6 | * | 1,380 | 11.8 | * | 2,023 | 10.0 | * |
| MSM and IDU | 288 | 3.4 | * | 739 | 6.3 | * | 1,027 | 5.1 | * |
| Heterosexual Contact | 2,076 | 24.5 | * | 2,867 | 24.5 | * | 4,943 | 24.5 | * |
| Perinatal Exposure | 149 | 1.8 | * | 81 | 0.7 | * | 230 | 1.1 | * |
| No Identified Risk (NIR)/ No Reported Risk (NRR) | 1,890 | 22.3 | * | 1,445 | 12.3 | * | 3,335 | 16.5 | * |
| Other | 13 | 0.2 | * | 28 | 0.2 | * | 41 | 0.2 | * |
| **Location** | | | | | | | | | |
| Houston/Harris County | 7,962 | 93.9 | 200.8 | 10,996 | 93.9 | 277.3 | 18,958 | 93.9 | 478.0 |
| Non-Harris County | 519 | 6.1 | 41.0 | 713 | 6.1 | 56.3 | 1,232 | 6.1 | 97.2 |

[1]per 100,000 population *Rate not available due to lack of population estimates

- 20,190 people were living with either HIV or AIDS in the Houston Area in 2008; of these, 8,481 were HIV positive (not progressed to AIDS), and 11,709 had progressed to AIDS.
- The HIV prevalence rate in the Houston Area in 2008 was 162.1 people per 100,000 population, and the AIDS prevalence rate was 223.8 people per 100,000 population. During the five year period of 2003 - 2008, the rate of living HIV cases *and* of living AIDS cases increased in the Houston Area, by 5 percent and 13 percent, respectively.
- Blacks/African Americans had the highest HIV/AIDS prevalence rate in the Houston Area in 2008 (1,078 cases per every 100,000 population of blacks/African Americans), which is five times greater than the rate for Hispanics and four times greater than the rate for whites.
- No Identified Risk (NIR) and No Reported Risk (NRR) were also high among living cases; for example, 22.3 percent of living HIV cases had no reported risk behavior. However, of cases *with* reported risk, 42.6 percent of people living with HIV/AIDS were Men Who Have Sex with Men (MSM), and 24.5 percent was heterosexual.
- As with new infections, Harris County was home to the majority of people living with HIV/AIDS; 93.9 percent of living HIV cases *and* of living AIDS cases were in Harris County.

### Deaths among People with HIV/AIDS (*Mortality*) in the Houston Area

Mortality rate refers to the number of deaths due to a specific disease that occur among the total number of people living with that disease. In the case of HIV/AIDS, however, death may be due to HIV/AIDS as well as to other causes when the individual is also HIV-infected. In addition, reporting of deaths for HIV/AIDS requires additional data cleaning procedures to confirm the presence of HIV disease. Therefore, HIV mortality data are delayed by an additional reporting calendar year. Key findings in mortality in the Houston Area are as follows (Table 3):

- 540 total deaths occurred among people living with HIV or AIDS in the Houston Area in 2007; of these, 73 were among people with HIV, and 467 were among people with AIDS.
- The HIV/AIDS mortality rate in the Houston Area in 2008 was 10.5 deaths per every 100,000 cases of HIV/AIDS and was stable for the five year period of 2003 - 2008.
- Blacks/African Americans had the highest HIV/AIDS mortality rate in the Houston Area in 2008 (34.4 deaths per 100,000 cases of HIV/AIDS in blacks/African Americans), which is nine times greater than the rate for Hispanics and five times greater than the rate for whites.
- No Identified Risk (NIR) and No Reported Risk (NRR) continued to account for a large proportion of HIV/AIDS-related deaths (16.9 percent). However, of cases of death *with* reported risk, the highest proportion was among Men Who Have Sex with Men (MSM) at 32.8 percent followed by heterosexual contact at 27.0 percent.
- Again, the majority of HIV/AIDS deaths (94.6 percent) occurred in Harris County. At 13 deaths per 100,0000 cases, the Harris County HIV/AIDS mortality rate is higher than the HIV/AIDS mortality rate for the greater Houston Area overall.

Table 3: Deaths Among People with HIV/AIDS (Mortality) in the Houston HSDA, 2007

Data source: Texas Department of State Health Services Enhanced HIV/AIDS Reporting System (eHARS)

| | HIV Deaths | | | AIDS Deaths | | | HIV/AIDS Deaths | | |
|---|---|---|---|---|---|---|---|---|---|
| | # | % | Rate[1] | # | % | Rate[1] | # | % | Rate[1] |
| **Total** | 73 | 100.0 | 1.4 | 467 | 100.0 | 9.1 | 540 | 100.0 | 10.5 |
| **Sex** | | | | | | | | | |
| Male | 59 | 80.8 | 2.3 | 343 | 73.4 | 13.3 | 402 | 74.4 | 15.6 |
| Female | 14 | 19.2 | 0.5 | 124 | 26.6 | 4.9 | 138 | 25.6 | 5.4 |
| **Race/Ethnicity** | | | | | | | | | |
| White, non-Hispanic | 26 | 35.6 | 1.3 | 126 | 27.0 | 6.2 | 152 | 28.1 | 7.5 |
| Black/African American | 40 | 54.8 | 4.4 | 272 | 58.2 | 30.0 | 312 | 57.8 | 34.4 |
| Hispanic/Latino | 7 | 9.6 | 0.4 | 65 | 13.9 | 3.6 | 72 | 13.3 | 3.9 |
| Other | 0 | 0.0 | 0.0 | 4 | 0.9 | 1.1 | 4 | 0.7 | 1.1 |
| **Age (years)** | | | | | | | | | |
| 0-1 | 0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 2-12 | 0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 13-24 | 3 | 4.1 | 0.3 | 6 | 1.3 | 0.6 | 9 | 1.7 | 1.0 |
| 25-34 | 6 | 8.2 | 0.7 | 54 | 11.6 | 6.7 | 60 | 11.1 | 7.4 |
| 35-44 | 15 | 20.5 | 1.9 | 150 | 32.1 | 19.3 | 165 | 30.6 | 21.2 |
| 45-54 | 27 | 37.0 | 3.7 | 180 | 38.5 | 25.0 | 207 | 38.3 | 28.7 |
| 55+ | 22 | 30.1 | 2.5 | 77 | 16.5 | 8.8 | 99 | 18.3 | 11.3 |
| **Transmission Mode** | | | | | | | | | |
| Men Who Have Sex with Men (MSM) | 19 | 26.0 | * | 158 | 33.8 | * | 177 | 32.8 | * |
| Injection Drug Use (IDU) | 11 | 15.1 | * | 73 | 15.6 | * | 84 | 15.6 | * |
| MSM and IDU | 4 | 5.5 | * | 37 | 7.9 | * | 41 | 7.6 | * |
| Heterosexual Contact | 13 | 17.8 | * | 133 | 28.5 | * | 146 | 27.0 | * |
| Perinatal Exposure | 0 | 0.0 | * | 0 | 0.0 | * | 0 | 0.0 | * |
| No Identified Risk (NIR)/ No Reported Risk (NRR) | 25 | 34.2 | * | 66 | 14.1 | * | 91 | 16.9 | * |
| Other | 1 | 1.4 | * | 0 | 0.0 | * | 1 | 0.2 | * |
| **Location** | | | | | | | | | |
| Houston/Harris County | 67 | 91.8 | 1.7 | 444 | 95.1 | 11.4 | 511 | 94.6 | 13.1 |
| Non-Harris County | 6 | 8.2 | 0.5 | 23 | 4.9 | 1.9 | 29 | 5.4 | 2.4 |

[1]per 100,000 population *Rate not available due to lack of population estimates

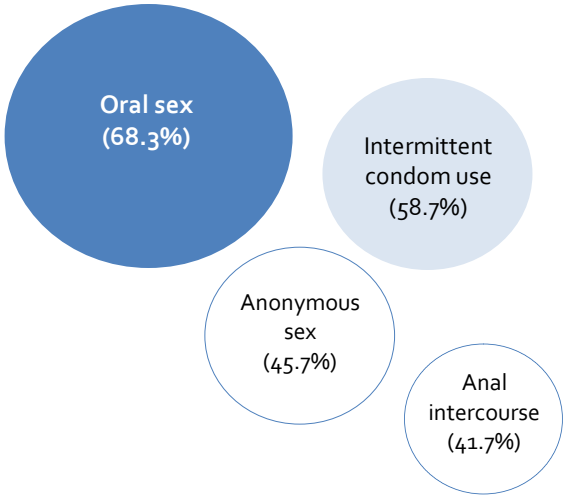
# HIV/AIDS In the Houston Area: Risk, Testing, Awareness of Status, and Linkage to Care

## HIV Risk in the Houston Area

Incidence, prevalence, and mortality data provide important information about risk for HIV infection in the Houston Area. As described previously, when a risk factor *is* identified for new infections and living cases of HIV/AIDS in the Houston Area, it is most commonly male-to-male sexual practices or Men Who Have Sex With Men (MSM) followed by heterosexual contact. Together, these two transmission modes accounted for 62.4 percent of new HIV/AIDS cases and 67.1 percent of all living HIV/AIDS cases in the most recently published reporting period. Moreover, 59.8 percent of deaths among people with HIV/AIDS were individuals in these two categories. However, additional analyses of *specific* behaviors that increase risk for HIV infection within these broader groups are also necessary in order to target risk reduction and other HIV prevention and care services.

A recent analysis of risk behaviors among 974 individuals who tested newly positive for HIV in Houston and Harris County revealed that, in the past 12 months, the most commonly cited specific risk behaviors related to HIV infection are: (1) oral sex (reported 68.3 percent of the time by the newly diagnosed), (2) intermittent condom use (58.7 percent), (3) anonymous sex (45.7 percent), and (4) anal intercourse (41.7 percent) (Figure 1):

Figure 1: Most Commonly-Reported Risk Behaviors among New HIV Positive Individuals in Houston/Harris County, 2010[1]




Spatial clustering of HIV diagnoses has also produced maps of relative risk for HIV infection according to Houston Area zip codes. Geographic overlays of rates of new HIV infection and rates of other STDs (Chlamydia, gonorrhea, and primary and secondary syphilis) have revealed specific zip codes in the Houston Area that bear an excess of burden of HIV/STD infection. According to these analyses, the neighborhoods of Sunnyside/South Park, Greater Fifth Ward, Acres Homes, Sharpstown/Southwest, and Montrose currently have the highest rates of HIV and other STDs in Houston and Harris County.[2]

STD infection itself has also been shown to increase the risk for acquisition of HIV among HIV negative individuals.[3] Therefore, monitoring trends in reportable STDs, namely Chlamydia, gonorrhea, and primary and secondary syphilis, provide useful information about overall HIV

risk in a community. Brief information about trends in these three STDs for Houston and Harris County is as follows:

- *Chlamydia*. Since 2005, the rate of Chlamydia has been increasing steadily in Houston and Harris County.[4] The current rate is 510.30 cases per 100,000 population,[4] which exceeds the current national rate of 426.0 reported cases per 100,000 people.[5]
- *Gonorrhea*. Unlike Chlamydia, gonorrhea has been experiencing a steady decrease over the past 10 years of approximately 0.6 percent annually.[4] The current rate is 149.05 cases per 100,000 population.[4] Despite the declining trend, the Houston and Harris County rate continues to exceed the current national rate of 100.8 reported cases per 100,000 people.[5]
- *Primary and Secondary (P&S) Syphilis*. P&S syphilis in Houston and Harris County peaked in 2007 at 11.0 cases per 100,000 population, but has since been on a general decline.[4] The current rate is 6.42 cases per 100,000 population. [4] Again, despite the declining trend, the Houston and Harris County rate continues to exceed the current national rate of 4.5 reported cases per 100,000 people.[5]

## HIV Testing and Awareness of Status in the Houston Area

The Houston Area places a high priority on widespread access to HIV testing in both targeted and non-targeted settings, using all available technologies. The Houston Department of Health and Human Services (HDHHS) Expanded Testing Initiative (ETI) supports routine opt-out HIV screening at local emergency rooms; and several state and local funding sources support community-based organizations to provide targeted testing to those at highest risk. In 2010, 104,415 HIV tests were funded by the HDHHS in both targeted and non-targeted settings. Of these, 1.5 percent (or 1,587) of tests was positive; of positive tests, 92.6 percent were informed of their positive status (Table 4).

Table 4: HIV Testing, Positivity, and Awareness of Status in Houston/Harris County, 2010
Data source: Houston Department of Health and Human Services (HDHHS) Houston and Harris County, Funded Agencies

| | Targeted Testing* | | Non-Targeted Testing** | | Total Testing | |
|---|---|---|---|---|---|---|
| | # | % | # | % | # | % |
| HIV tests provided | 12,447 | | 91,968 | | 104,415 | |
| Of those tested, individuals informed of test result | 11,193 | 89.9 | 1,285 | 1.4 | 12,478 | 12.0 |
| Of those tested, individuals NOT informed of test result | 1,254 | 10.1 | 90,683 | 98.6 | 91,937 | 88.0 |
| Positive HIV tests | 202 | 1.6 | 1,385 | 1.5 | 1,587 | 1.5 |
| Of positive tests, individuals informed of positive status | 185 | 91.6 | 1,285 | 92.8 | 1,470 | 92.6 |
| Of positive tests, individuals NOT informed of positive status | 17 | 8.4 | 100 | 7.2 | 117 | 7.4 |
| Negative HIV tests | 12,245 | 98.4 | 90,583 | 98.5 | 102,828 | 98.5 |
| Of negative tests, individuals informed of negative status | 11,008 | 89.9 | 0 | 0.0 | 11,008 | 10.7 |
| Of negative tests, individuals NOT informed of negative status | 1,237 | 10.1 | 90,583 | 100.0 | 91,820 | 89.3 |

*Targeted testing includes all traditional publically-funded testing settings required to collect all data elements such as informed of test results (negative or positive)
**Non-targeted testing includes publically-funded testing by systems that are not required to collect all data elements such as informed of tests results (negative or positive). These are most commonly settings in which testing is offered in a routine, opt-out model.

Though over 1,400 individuals were tested *and* informed of their HIV positive status in one year alone in the Houston Area, it is estimated that a notable proportion of HIV infected individuals remain unaware of their positive status *and* untested as occurs nationwide. [6] Using an equation derived by the Health Resources and Services Administration (HRSA) and the Centers for

Disease Control and Prevention (CDC) called the Estimated Back Calculation (EBC), it is possible to approximate the number and demographic characteristics of individuals in the Houston Area who are HIV positive, living, and unaware of their positive status. Using this calculation with the most current reporting year of HIV surveillance data (calendar year 2009) for the Houston Area, findings are as follows:

- The number of HIV positive status-unaware individuals in the Houston Area is estimated to be 5,306 and has increased by 1.6 percent from the prior year.[7]
- Individuals unaware of their status in the Houston Area are more often male, black/African American, and in the exposure category of MSM and heterosexual contact.[7] They also tend to be in the older age category of 35 to 54 years.[7]

### Linkage to Care for the Newly Diagnosed in the Houston Area

The Houston Area has also placed a high priority on ensuring early linkage into HIV clinical care and treatment for those newly diagnosed through widespread HIV testing and awareness efforts. For example, a unique local service category within the Ryan White HIV/AIDS Program for linking the newly diagnosed into HIV clinical care (e.g., Service Linkage Workers) was created in 2008. Current estimates of those linked to care in the Houston Area are as follows:

- Of newly diagnosed HIV infected individuals diagnosed in the Houston Area, 65.1 percent[8] is linked to HIV clinical care within the national standard[9] of three months following diagnosis. The Houston Area rate falls below the average for the state of Texas as a whole (68.6 percent)[8] as well as the national target (85.0 percent).[9]
- There are certain demographic groups in the Houston Area with lower than community-wide aggregate linkage to care rates as well. Men, blacks/African Americans, and Injection Drug Users (IDU) all have linkage to care rates below the Houston Area average.[8] Those in the age category of 13 to 24 years also have a lower than average linkage to care rate.[8]

# THE CURRENT SYSTEM OF HIV PREVENTION AND CARE SERVICES IN THE HOUSTON AREA

## The Houston Area Continuum of Care for HIV Prevention and Care Services

A continuum of care is a visual representation of how a community is using or would like to use health resources in order to effectively meet community needs. In the HIV field, a continuum of care is an "integrated service network that guides and tracks clients through a comprehensive array of clinical, mental, and social services in order to maximize access and outcomes."[10] In 1999, the Houston Area HIV community revised its continuum of care for the Houston Area into a structure, theory, and series of attributes that remain in place today. In 1999, the continuum was re-conceptualized as a "rail system" containing five tracks. Each track represents a stage in the progression of HIV disease – *from having no awareness of the disease to end-of-life* – and then provides examples of the HIV prevention and care services indicated at each stage in order to attain desired health outcomes (Figure 2):

"A continuum of care designed as *tracks* is inclusive of people both at risk for and infected with HIV. It also shows how individuals can move seamlessly within the local HIV system"

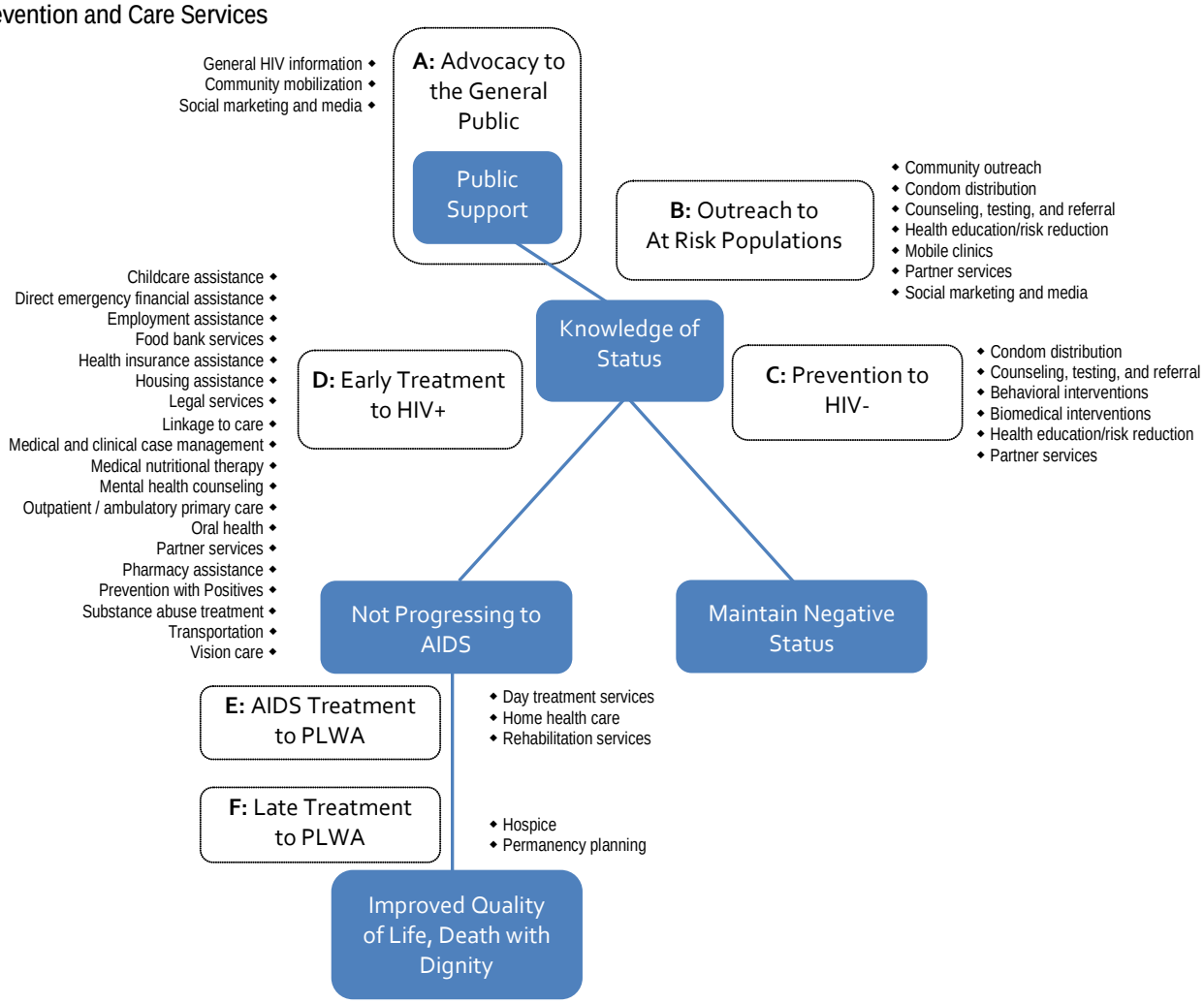
- Track A is intended for the general public that may have no awareness of HIV. The goal of this track is to build public support for HIV through the provision of HIV information.
- Track B is intended for individuals at high-risk of HIV infection and includes outreach and HIV testing. The goal of this track is to make people aware of their HIV status.
- Track C is intended for HIV negative individuals and includes audience-specific behavioral interventions. The goal of this track is to help individuals maintain their negative HIV status.
- Track D is intended for individuals who are HIV positive and includes a variety of HIV care, treatment, and support services. The goal of this track is to help people living with HIV remain in care, maintain their health status, and prevent progression to AIDS.
- Tracks E and F are intended for HIV infected individuals who progress to AIDS. The goal of these tracks is to maintain quality of life and, as necessary, prepare for end-of-life care.

The intent of a paradigm of a continuum of care as a series of tracks based on disease progression, including the *absence* of disease, is to describe a model local HIV system that is inclusive of individuals both infected with and at risk for HIV. It is also intended to indicate how individuals can move within the system, by entering, transitioning, and exiting tracks seamlessly over time as their awareness of, risk for, and/or stage of HIV disease evolve over time.

The Houston Area has also adopted five principles *or attributes* for how the HIV prevention and care services in each track are to be provided. Often referred to as "The Five As," these are the guidelines according to which the Houston Area HIV community is expected to select, design, and provide the HIV prevention and care services on each track and for the system as a whole. The five attributes are: (1) availability, (2) accessibility, (3) affordability, (4) appropriateness, and (5) accountability. Decisions regarding the selection and design of HIV prevention and care services for each track are to be made in ways that ensure these attributes are met.

The Houston Area Continuum of Care is implemented by a combination of governmental and non-profit organizations that provide direct services and/or function as Administrative Agents that contract to direct service providers. Two Planning Bodies provide the opportunity for extensive collaboration and consultation with the community on the effective implementation of the continuum. The major components of this system are described below.

Figure 2: Model of the Houston Area Continuum of Care for HIV Prevention and Care Services

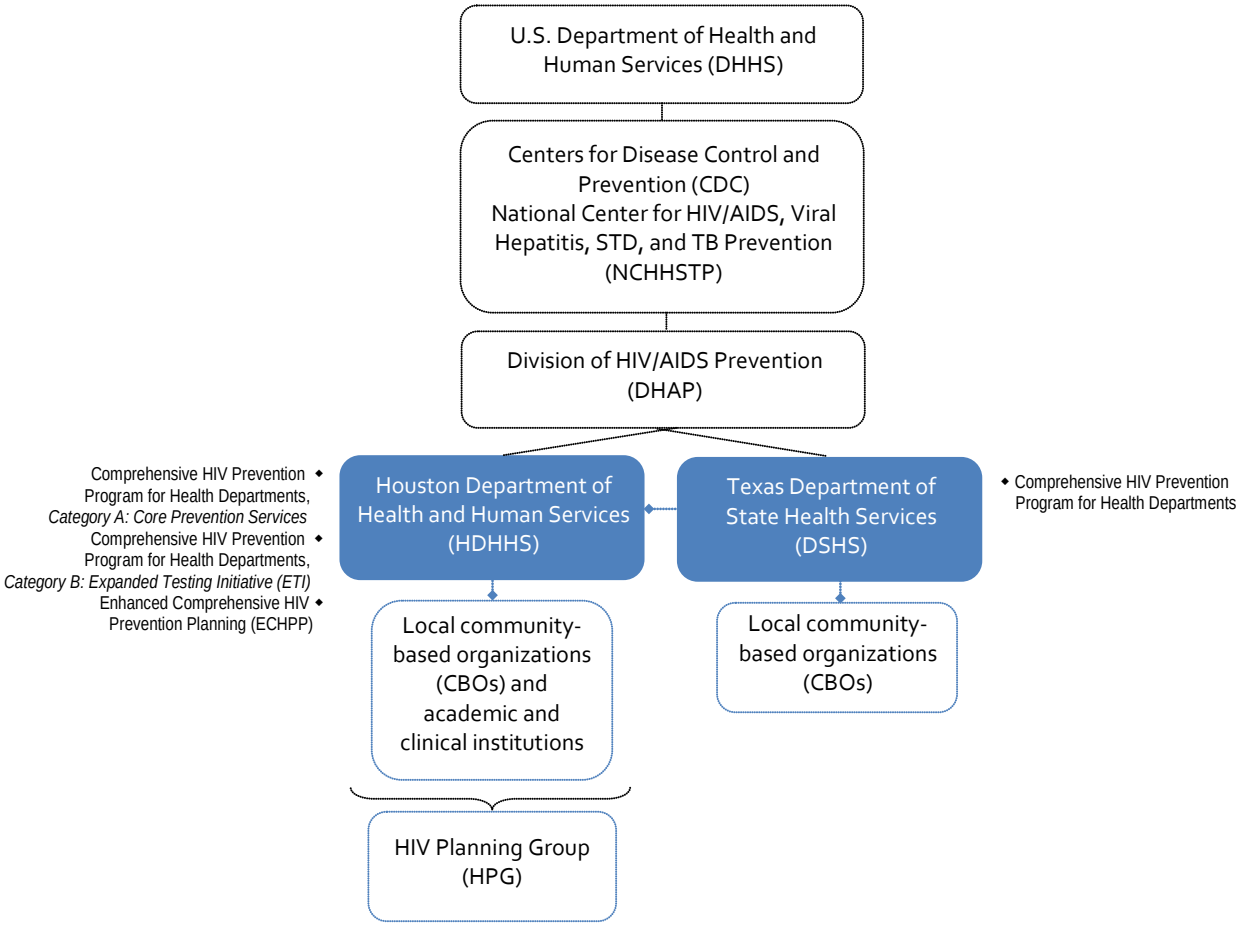



## HIV Prevention Services in the Houston Area

The Centers for Disease Control and Prevention (CDC) supports HIV prevention and intervention activities in the Houston and Harris County jurisdiction through cooperative agreements with the Houston Department of Health and Human Services (HDHHS) and the Texas Department of State Health Services (DSHS) (Figure 3). The HDHHS is also directly-funded by CDC for the three-year demonstration project ECHPP, *Enhanced Comprehensive HIV Prevention Planning*, designed to accelerate the goals of the National HIV/AIDS Strategy in the Metropolitan Statistical Areas (MSAs) with the highest number of people living with HIV/AIDS. The Houston MSA includes Harris County and the cities of Houston, Baytown, and Sugarland, TX. Core HIV prevention and intervention services conducted by the HDHHS are as follows:

- **HIV Counseling, Testing, and Referral (CTR).** The HDHHS provides confidential name-based and anonymous HIV Counseling, Testing, and Referral (CTR) services in both clinical and non-traditional settings. Testing is provided at the HDHHS Family Planning, Maternity, and STD Clinics as well as at the Harris County Jail and Harris County Juvenile Detention Center, through a mobile testing unit, and at the annual mass testing event, *HIP HOP for HIV Awareness*. All targeted testing provided through the HDHHS utilizes Protocol Based Prevention Counseling (PBC), a guided pre- and post-test counseling method developed by

Figure 3: Structure of HIV Prevention Services in the Houston Area




DSHS based on proven effective individual-level behavioral interventions developed by the CDC. The HDHHS also supports routine, non-targeted, opt-out HIV screening in local emergency departments, community health centers, and Federally-Qualified Health Centers (FQHCs) through the Expanded Testing Initiative (ETI). Laboratory functions for HIV targeted testing are provided through the HDHHS Bureau of Laboratory Services.

- **Disease Intervention Specialists (DIS) and Partner Services (PS).** As the local health jurisdiction for Houston and Harris County, all laboratory evidence of HIV or AIDS is reported to the HDHHS. HDHHS Disease Intervention Specialists (DIS) investigate all newly-reported cases of HIV or AIDS for public health follow-up. This includes results notification (if applicable) and prevention counseling, as well as Partner Counseling and Referral Services (PCRS) for sex- and needle-sharing partners. Partner notification is also conducted using the internet through a locally-designed program called PENSHouston
- **Health Education and Risk Reduction (HE/RR).** The HDHHS supports implementation of Effective Behavioral Interventions (EBIs) at the individual-, group-, and community-levels, targeting high-risk HIV-negative individuals as well as people living with HIV/AIDS and their partners. These interventions include a school-based HIV/STD prevention curriculum for grades 7 – 8, as well as an intervention targeted to incarcerated individuals and/or individuals recently released from a correctional institution. Current EBIs include: (1) Focus on Youth, (2) SISTA, (3) Street Smart, (4) Voices/VOCES, and (5) Community PROMISE. The HDHHS also operates an HIV/STD information hotline and coordinates mass condom distribution efforts with traditional and non-traditional community partners such as bars,

record stores, beauty salons, barber shops, and other local businesses. Male, female, and specialty condoms, dental dams, and lube are included.

- **Community-Based Organization (CBO) Contractors.** The HDHHS contracts with direct service community-based organizations (CBOs) to provide HIV Counseling, Testing, and Referral (CTR), Comprehensive Risk Counseling Services (CRCS), and Health Education/Risk Reduction (HE/RR) using Effective Behavioral Interventions (EBIs) to high-risk populations. The HDHHS serves as an administrative agent to these CBOs, providing monitoring, evaluation, capacity building, and technical assistance. The HDHHS Training Unit is dedicated to enhancing the knowledge and skills of CBO contractors.
- **Social Marketing and Media**. The HDHHS conducts community-wide social marketing and media campaigns designed to alter HIV testing and risk reduction behaviors, correct misperceptions and misinformation about HIV in the community, and reduce stigma and discrimination against people living with HIV/AIDS. Campaign strategies include brochures, posters, billboards, transit advertisements, radio spots, and branded promotional items such as the "Houston….We Have A Condom." The HDHHS also participates in HIV awareness days and commemorations such as World AIDS Day and exhibits at various community-wide events and health fairs.
- **Community Mobilization**. Using geographic mapping of HIV and STD diagnoses, the HDHHS has identified specific zip codes in the Houston Area with the greatest HIV/STD morbidity and has targeted them for intensive prevention and intervention activities. The SAFER Initiative (Strategic AIDS/HIV Focused Emergency Response Initiative) aims to mobilize residents, leaders, business owners, and elected officials in these local neighborhoods around HIV prevention, testing, and linkage to care. The HDHHS also supports the prevention and testing activities of community-based Task Forces focused on specific high-risk populations.
- **Service Linkage**. The HDHHS is funded by the Ryan White HIV/AIDS Program to employ Service Linkage Workers (SLW) who connect newly-diagnosed individuals to Ryan White HIV/AIDS Program-funded primary HIV medical care. SLWs at the HDHHS are also cross-trained in disease investigation and can provide partner services for the newly-diagnosed. SLWs also provide referrals to non-HIV related services such as those for co-morbid conditions, behavioral health concerns, and social support services including housing, food, employment, transportation, and child care.
- **Jurisdictional HIV Prevention Planning.** Recipients of federal HIV prevention funds are required to have in place a prevention planning process that includes the development of a jurisdictional HIV prevention plan and the establishment of a local HIV Planning Group (HPG, formerly the Community Planning Group or CPG). The HDHHS coordinates the HPG for the Houston Area and an HDHHS staff person serves as a group Co-Chair.

The HDHHS has scaled-up several core HIV prevention and intervention activities as a result of the ECHPP demonstration project. Scaled-up activities include Counseling, Testing, and Referral (CTR) in both routine and targeted settings, Social Marketing, Community Mobilization, and a portfolio of efforts focused on enhancing linkage to, retention in, and re-engagement in HIV care for people living with HIV/AIDS.

In addition to HDHHS activities, DSHS also contracts with community-based organizations (CBOs) in the Houston Area to provide core HIV prevention and intervention services, including Counseling, Testing, and Referral (CTR) and Effective Behavioral Interventions (EBIs).

## HIV Care Services in the Houston Area: The Ryan White HIV/AIDS Program

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) supports HIV care, treatment, and support services in the Houston Area through the Ryan White HIV/AIDS Program, the largest federally funded HIV/AIDS-specific program in the country.[11] The Ryan White HIV/AIDS Program is an "umbrella" program administered in a series of Parts distributed according to geographic service areas, populations, and purposes:

- **Part A** provides funds to Eligible Metropolitan Areas (EMAs), i.e., geographic regions with more than 2,000 total reported AIDS cases over the most recent five year period, and to Transitional Grant Areas (TGAs), i.e., geographic regions with 1,000 – 1,999 reported AIDS cases over the most recent five year period. The Houston Area is an EMA, which includes the six counties of Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller. Part A also includes the **Minority AIDS Initiative (MAI)**.
- **Part B** provides funds to all 50 states and territories, including the AIDS Drug Assistance Program (ADAP). Locally, funds are awarded according to Health Services Delivery Areas (HSDA). The Houston HSDA includes the six counties of the Houston EMA plus the four additional counties of Austin, Colorado, Walker, and Wharton.
- **Part C** provides funds directly to public and private organizations for early intervention services and capacity development and planning.
- **Part D** provides funds directly to public and private organizations for services to women, infants, children, and youth living with HIV.
- **Part F** provides funds for the following special initiatives: AIDS Education and Training Centers (AETC); Dental Programs; and Special Projects of National Significance (SPNS) for demonstration or research projects benefiting HIV/AIDS services.

The overall intent of the Ryan White HIV/AIDS Program is to ensure the provision of Core Medical and Support Services, which are defined by HRSA, for the management of HIV disease. HRSA-defined Core Medical and Support Services are as follows:

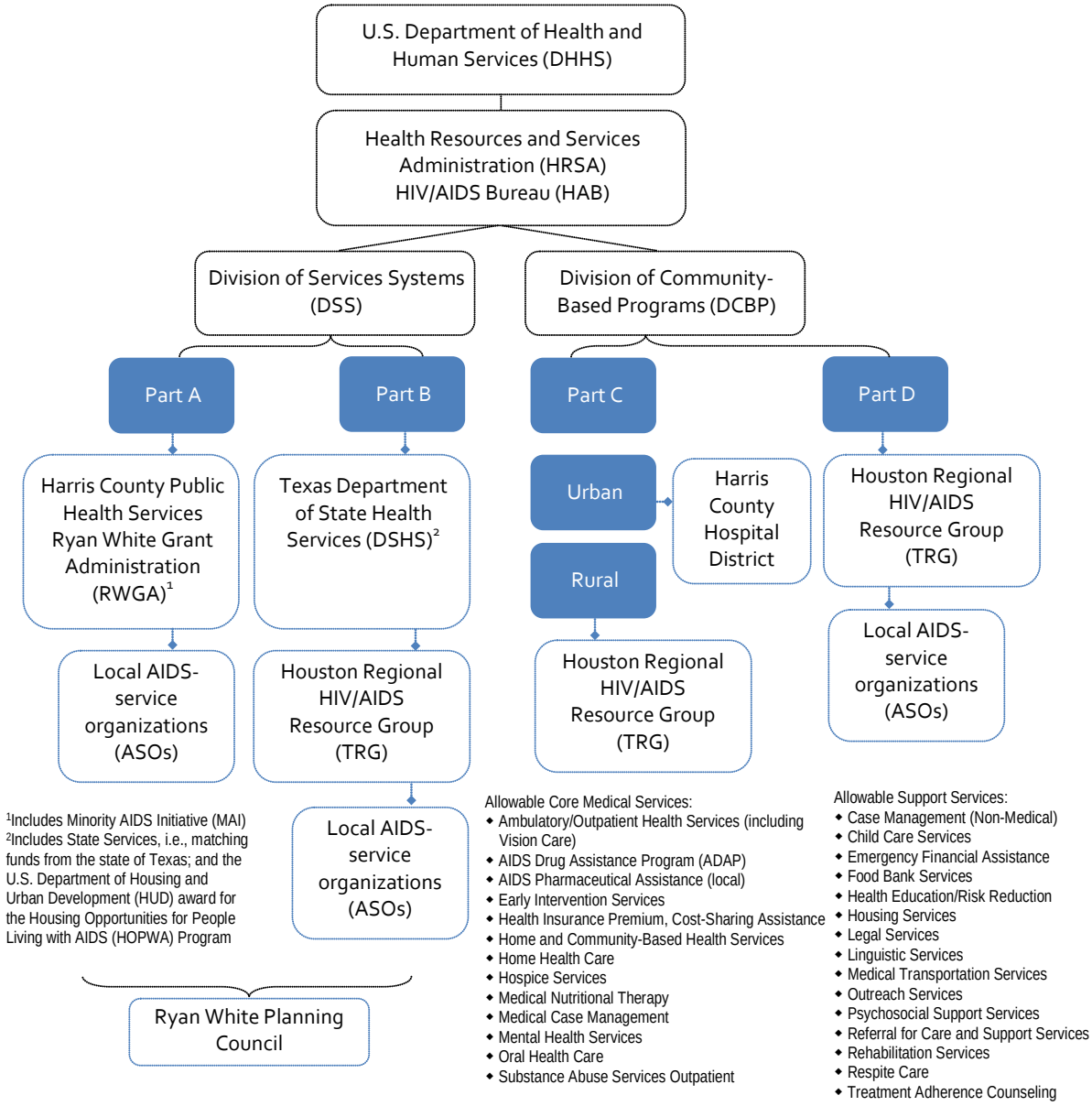
**Core Medical Services**

1. Ambulatory/Outpatient Health Services (including Vision Care)
2. AIDS Drug Assistance Program (ADAP)
3. AIDS Pharmaceutical Assistance (local)
4. Early Intervention Services
5. Health Insurance Premium and Cost-Sharing Assistance
6. Home and Community-Based Health Services
7. Home Health Care
8. Hospice Services
9. Medical Case Management
10. Medical Nutritional Therapy
11. Mental Health Services
12. Oral Health Care
13. Substance Abuse Services Outpatient

**Support Services**

1. Case Management (Non-Medical)
2. Child Care Services
3. Emergency Financial Assistance (EFA)
4. Food Bank Services
5. Health Education/Risk Reduction
6. Housing Services
7. Legal Services
8. Linguistic Services
9. Medical Transportation Services
10. Outreach Services
11. Psychosocial Support Services
12. Referral for Health Care and Supportive Services
13. Rehabilitation Services
14. Respite Care
15. Treatment Adherence Counseling

Figure 4: Structure of HIV Care Services in the Houston Area




Determinations of which of the above HRSA-defined services to provide in a geographic service area, at what funding level and with what population focus, if any, is a local jurisdictional decision made by the administrators of Ryan White HIV/AIDS Program funds in collaboration with people living with HIV/AIDS and consumers of services via the local HIV Planning Body.

For both Houston Area geographic service designations for HIV care, a combination of public and non-profit Houston Area agencies serve as either directly-funded, direct providers of Core Medical and Support Services, or as directly or competitively-funded Administrative Agents that contract to direct providers of Core Medical and Support Services, again according to geographic service areas and Parts (Figure 4). Each is described below:

- **Part A and the Minority AIDS Initiative (MAI)** are administered by the Ryan White Grant Administration (RWGA) of Harris County Public Health Services for the Houston EMA. The RWGA is a directly-funded HRSA HAB grantee and serves as the Administrative Agent

for Part A and MAI funds. RWGA contracts with local AIDS-service organizations (ASOs) to provide direct services. *Services currently funded by Part A include: ambulatory/outpatient health services (including vision care), AIDS pharmaceutical assistance (local), case management (non-medical), hospice services, legal services, medical case management, medical nutritional therapy, medical transportation services, oral health care, and substance abuse services outpatient. Services funded by MAI include: ambulatory/outpatient health services.*

- Part B, AIDS Drug Assistance Program (ADAP) is administered statewide by the Texas Department of State Health Services (DSHS). Remaining Part B funds are administered by the Houston Regional HIV/AIDS Resource Group, Inc. (TRG) for the Houston HSDA through a competitive DSHS process. TRG serves as the Administrative Agent for Part B funds and contracts to local ASOs to provide direct services. *Services currently funded by Part B include: ambulatory/outpatient health services, health insurance premium and cost-sharing assistance, home and community-based health services, medical case management, and oral health care.*
- Part C, Urban is administered by the Harris County Hospital District (for Harris County) and Part C, Rural by TRG (for non Harris County) both as directly-funded, direct service providers. *Services currently funded by Part C Urban include early intervention services, and, by Part C Rural, a Rural Primary Care Network.*
- Part D is administered by TRG for the Houston Area as a directly-funded HRSA HAB grantee. TRG serves as the Administrative Agent for Part D funds and contracts to local ASOs to provide direct services. *Services currently funded by Part D include: Core Medical and Support Services targeted to women, infants, children, and youth living with HIV/AIDS.*
- Part F, AIDS Education and Training Center (AETC). The Harris County Hospital District serves as the local performance site for AETC.

The Houston Area also receives state of Texas matching funds for Core Medical and Support Services. These funds, commonly-referred to as State Services, are awarded to DSHS, which, in turn, competes them for administration in local HSDAs. TRG is the current Administrative Agent of State Services funds for the Houston HSDA and contracts to local ASOs to provide direct services. *Services currently funded by State Services include: food bank services, health insurance premium and cost-sharing assistance, hospice services, legal services, linguistic services, and mental health services.* State Services funds are also used for *early intervention services* in the Harris County Jail for the purpose of linking HIV positive individuals released from the jail system into HIV care upon re-entry into the community.

The Houston Area has tailored other Ryan White HIV/AIDS Program service categories in order to increase service delivery efficiency and better meet the needs of people living with HIV/AIDS. For example, several Core Medical Services are bundled in Part A contracts to local ASOs. These include Ambulatory/Outpatient Health Services, AIDS Pharmaceutical Assistance (local), and Medical Case Management, thereby creating "one stop shops" for consumers. The Houston Area has also adapted the Case Management (Non-Medical) service category for the purpose of linking the newly-diagnosed into primary HIV medical care. Defined locally as Community-Based (Non-Medical) Case Management, services provided under this adapted category are called Service Linkage, and Service Linkage Workers (SLW) are often co-located at HIV testing sites. Other Ryan White HIV/AIDS Program services are also co-located at funded provider sites, such as Mental Health Services and Substance Abuse Services Outpatient, as many clients are in need of both services concurrently.

The Houston Area Ryan White HIV/AIDS Program Part A also supports the HRSA initiative, EIIHA, *Early Identification of Individuals with HIV/AIDS*, designed to accelerate local efforts to identify individuals who are unaware of their positive HIV status and link them into HIV primary

care. The Houston Area EIIHA Strategy is a collaboration with other Ryan White HIV/AIDS Program Parts and HIV prevention and includes enhanced efforts around HIV testing, public health follow-up, and linkage and referral of newly-diagnosed individuals to HIV primary care.

### Other HIV Programs in the Houston Area

In addition to the HIV-*specific* prevention and care services programs described above, the Houston Area system also includes programs targeting people living with HIV/AIDS for *non*-HIV prevention and care needs as well as overall reproductive and sexual health promotion programs targeting populations at high risk for HIV, other STDs, and unintended pregnancy:

- Housing Opportunities for Persons with AIDS (HOPWA). The U.S. Department of Housing and Urban Development (HUD) provides funds to the City of Houston Housing and Community Development Department to serve as the Administrative Agent for HOPWA in the Houston Eligible Metropolitan Statistical Area (EMSA). The Houston EMSA consists of the cities of Houston, Baytown, and Pasadena, TX; and the counties of Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, San Jacinto, and Waller. Current Houston Area HOPWA services include: Community Residences (CR), Short-Term Rent, Mortgage, and Utility Assistance (STRMU) for up to 21 weeks, Tenant-Based Rental Assistance (TBRA) for 12 to 24 months, and Support Services. Additional HOPWA funds are awarded to Texas Department of State Health Services (DSHS), which contracts them locally to the Houston Regional HIV/AIDS Resource Group, Inc. (TRG).
- STD and Viral Hepatitis Prevention. The Centers for Disease Control and Prevention (CDC) supports prevention and intervention activities for non-HIV STDs in the state of Texas through a cooperative agreement with DSHS, which, in turn, contracts with the Houston Department of Health and Human Services (HDHHS) for activities in Houston and Harris County. Core STD prevention activities include STD testing and treatment, disease investigation services, surveillance, and syphilis elimination. All activities are implemented with community input, specifically through collaboration with public and private providers.
- School District HIV, STD, and Unintended Pregnancy Prevention. The Houston Independent School District (HISD) is one of 24 city school districts directly funded by the CDC's Division of Adolescent and School Health to conduct HIV, STD, and unintended pregnancy prevention activities with students. The HISD program includes the Youth Risk Behavior Survey (YRBS), which queries middle and high school student behaviors related to sexual activity, implementation of an HISD-developed HIV prevention curriculum in middle and high schools, HIV prevention professional development for educators, and student engagement activities, including an annual HIV Prevention Parent/Teen Health Summit.
- Texas Department of Criminal Justice (TDCJ). The Texas Department of Criminal Justice operates TCOOMI, the Texas Correctional Office on Offenders with Medical or Mental Impairments. In addition to providing HIV care and treatment to HIV positive individuals in the Texas prison system, TCOOMI also assists offenders pre- and post-release with continuity of HIV care, including discharge planning, assistance with application to the AIDS Drug Assistance Program (ADAP), coordination with local AIDS-service providers, and re-entry case management through a voluntary re-entry and integration program.

### Inventory of HIV Prevention and Care Services: The "Blue Book"

Biennially, the Houston Area community participates in a comprehensive resource inventory of all HIV prevention and care services in the Houston Area, including: (1) agencies funded through the Ryan White HIV/AIDS Program, Centers for Disease Control and Prevention, and Texas Department of State Health Services; (2) non-publically funded agencies providing HIV

prevention, care, treatment, and support services; and (3) a selection of non-HIV related health and social services that may be of interest to people living with HIV/AIDS. This inventory is then published as a resource guide commonly referred to as the "Blue Book."

- The current Houston Area resource inventory or "Blue Book" can found at the following address: *http://www.rwpchouston.org/Blue_Book/10-11/10-11_blue_book_MAIN.htm*

### The Houston Area HIV Planning Bodies

The Houston Area Continuum of Care for HIV prevention and care services is supported by two local HIV Planning Bodies, one for HIV prevention and one for HIV care, treatment, and support services. Together, they ensure the opportunity for extensive collaboration and consultation with the community on the use of federal HIV prevention and care funds:

- *The Houston HIV Planning Group (HPG, formerly the Community Planning Group or CPG)* is a volunteer body of up to 35 members selected to represent the demographics of the Houston Area HIV epidemic. The HPG is responsible for prioritizing populations and interventions for Houston Area HIV prevention activities funded by the Centers for Disease Control and Prevention (CDC); and
- *The Houston Area HIV Services Ryan White Planning Council (RWPC)*, a 38-person body appointed by the Harris County Judge, who serves as the CEO for the Houston Area Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (MAI). The RWPC is responsible for prioritizing and allocating funds for HIV care, treatment, and support services provided under Part A and MAI as well as for making recommendations regarding services provided under Part B and State Services, the matching funds from the state of Texas.

Membership on both Planning Bodies includes people living with HIV/AIDS, consumers of HIV prevention and care services, representation from populations most impacted by the local HIV epidemic, representation from local AIDS-service organizations (ASOs), and subject matter experts. For the RWPC in particular, a certain number of voting member positions is reserved for representation from ASOs funded through non-Ryan White HIV/AIDS Program sources. These entities participate equally with Ryan White HIV/AIDS Program-funded ASOs in annual Planning Body processes. As a result, the RWPC provides a mechanism for Ryan White HIV/AIDS Program-funded care and services to interact with *non*-Ryan White HIV/AIDS Program-funded care and services for the purpose of ensuring effective implementation of the Houston Area Continuum of Care.

To ensure that people living with HIV/AIDS and consumers are serving on local Planning Bodies, Ryan White HIV/AIDS Program Part A supports an annual training program unique to the Houston Area called Project LEAP (Learning, Empowerment, Advocacy, and Participation). Project LEAP teaches HIV infected individuals, consumers, and affected others the knowledge, skills, and abilities needed to serve on the HPG or RWPC.

The HPG also coordinates opportunities for enhanced community involvement in local HIV planning through Task Forces focused on populations most impacted by the Houston Area HIV epidemic. Current Task Forces include: *African American State of Emergency Task Force (AASOE), Hepatitis C Task Force, Latino HIV Task Force, M-Pact (the MSM Task Force), Syphilis Elimination Advisory Council (SEAC), Urban AIDS Ministry, Youth Task Force, and Transgender Task Force.*

# HIV Care Service Utilization trends and Unmet Need

## Patterns of HIV Care Service Utilization: Key Findings from the "Epi Profile"

In addition to analyses of epidemiological trends in HIV/AIDS, such as incidence, prevalence, and mortality, *Integrated HIV/AIDS Epidemiologic Profiles for HIV Prevention and Ryan White CARE Act (sic) Community Planning* ("Epi Profiles") also summarize patterns in the utilization of Ryan White HIV/AIDS Program-funded HIV care, treatment, and support services by people living with HIV/AIDS (PLWHA) in a local jurisdiction.

Below is a summary of key findings from the current Houston Area "Epi Profile" of the analysis of HIV care service utilization. The analysis was conducted by comparing the demographic composition of living HIV/AIDS cases in the Houston Area to those of individuals utilizing each of five specific Ryan White HIV/AIDS Program Core Medical Services. The goal of the analysis is to identify patterns of alignment or misalignment between prevalence and service usage.

### AIDS Drug Assistance Program (ADAP)

- ADAP in the Houston Area is being accessed proportionately according to age and sex.
- Hispanic PLWHA appear to be overrepresented in this service category while white, non-Hispanic PLWHA appear to be underrepresented, both when compared to their overall proportions of living HIV/AIDS cases.

### Ambulatory/Outpatient Health Services

- Ambulatory/Outpatient Health Services in the Houston Area are being accessed proportionately according to age and sex.
- White, non-Hispanic PLWHA appear to be underrepresented in this service category when compared to their overall proportion of living HIV/AIDS cases.

### Medical Case Management

- Medical Case Management in the Houston Area is being accessed proportionately according to age and sex.
- White, non-Hispanic PLWHA appear to be underrepresented in this service category, while black/African American PLWHA are overrepresented, both when compared to their overall proportions of living HIV/AIDS cases.

### Mental Health Services

- White, non-Hispanic PLWHA account for a higher proportion of Mental Health Services in the Houston Area when compared to their overall proportion of living HIV/AIDS cases.
- Black/African American PLWHA appear to be underrepresented in this service category when compared to their overall proportion of living HIV/AIDS cases.
- Data also show an increase in representation among urban clients accessing Mental Health Services.
- There also appears to be in increase in Men Who Have Sex With Men (MSM) accessing this service and a decrease in usage among those who report heterosexual contact.

### Oral Health Services

- There is disproportionately higher use of Oral Health Services in the Houston Area by older PLWHA (55+), as would be expected.
- Black/African-American PLWHA appear to be underrepresented in this service category while Hispanics appear to be slightly overrepresented, both when compared to their overall proportions of living HIV/AIDS cases.
- Data also show an increase in representation among rural clients accessing Oral Health Services.

Detailed discussions of service utilization can be found in the complete Houston Area "Epi Profile" available at: *http://www.rwpchouston.org/Publications/publication_listing.htm.*

## Unmet Need in the Houston Area

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) has developed a replicable methodology for estimating the number of people diagnosed with HIV/AIDS who have unmet need for HIV care, treatment, and support services in a local jurisdiction (i.e., are out-of-care).[7] Commonly-referred to as the Ryan White HIV/AIDS Program Unmet Need Framework, the methodology applies the HRSA definition of being out-of-care to local HIV surveillance and service utilization databases.[7] According to the HRSA definition, an individual is "out-of-care" if any of the following occur in a 12 month period:

No evidence of a CD4 count;
No evidence of a viral load test;
No evidence of the use of antiretroviral therapy (ART); or
No evidence of an outpatient/ambulatory health services visit

If there is evidence in an HIV service utilization database that an individual diagnosed with HIV/AIDS in that jurisdiction had any one of these four services in the specified 12 month period, then the individual is considered to have their HIV medical needs met and to be "in care." Using this methodology, it is possible to approximate the number and demographic characteristics of individuals in a local jurisdiction who have unmet need for HIV medical care.

Using Houston Area data for calendar year 2010,[7] the Ryan White HIV/AIDS Program Unmet Need Framework calculation produces the following results:

- **Population Estimates for Total Living Cases.** The total number of people living with HIV in the Houston Area is 8,965, and the total number of people living with AIDS in the Houston Area is 11,910. Combined, there are 20,875 people living HIV or AIDS in the Houston Area.
- **Estimates of People in Care.** The total number of people living with HIV who are in HIV medical care is 5,641, or 63 percent of total living HIV cases. The total number of people living with AIDS who are in HIV medical care is 8,947, or 75 percent of total living AIDS cases. The total number of people living with HIV/AIDS in the Houston Area who are in HIV medical care is 14,588 (or 70 percent of the total number of living HIV/AIDS cases).
- **Estimates of People Out-of-Care, or Unmet Need.** An estimated 3,324 people living with HIV are out-of-care; this represents 37 percent of total living HIV cases in the Houston Area. An estimated 2,963 people living with AIDS are out-of-care; this represents 25 percent of total living AIDS cases in the Houston Area. Together, the HIV/AIDS unmet need estimate for the Houston Area is 30.1 percent, or approximately 6,287 diagnosed individuals who are out-of-care according to the HRSA definition.

Further analysis by demographic characteristics shows that individuals with unmet need in the Houston Area are more often male, black/African American or Hispanic, and in the transmission mode of Injection Drug Use (IDU).[7]

Though close to one-third of people living with HIV/AIDS in the Houston Area is estimated to be out-of-care, this percent has been on the decline. Between 2008 and 2010, unmet need in the Houston Area decreased by 2 percent (from 32 percent to 30 percent).[12]

# Special Considerations in the Houston Area Continuum of Care

## Current Priorities for the Allocation of Ryan White HIV/AIDS Program Funds

The level of need for HIV care, treatment, and support services has always exceeded available resources.[9] Therefore, the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) mandates jurisdictions in receipt of Ryan White HIV/AIDS Program funds to "complete an annual priority setting process that weighs needs against available resources and informs the resource allocation process."[13] In the Houston Area, Ryan White HIV/AIDS Program service categories are defined, prioritized, and funds allocated by the local HIV Planning Body for HIV care, the Ryan White Planning Council, according to size, demographics, and needs of people living with HIV/AIDS.

The Ryan White Planning Council also maintains a ranking of funding priorities, which reflects the ongoing support for and transition to HIV medical care and treatment as the primary focus of Ryan White HIV/AIDS Program funds. In its priority ranking, the Houston Area has honored the HRSA "75/25 Rule," which states that 75 percent of Ryan White HIV/AIDS Program funds in a local jurisdiction should be applied to Core Medical Services, while the remaining 25 percent may be applied to Support Services. [13] The Priority Ranking is further delineated by demographic categories. For example, Ambulatory/Outpatient Health Services and Medical Case Management targeting African Americans, Hispanics, women, and pediatrics are awarded to AIDS-service organizations (ASOs) specializing in the unique HIV care needs of these highly-impacted groups.

In the Houston Area, a unique prioritization model has also been adopted to maximize scarce resources. Ambulatory/Outpatient Health Services, Medical Case Management, AIDS Pharmaceutical Assistance (local), and Case Management (Non-Medical) – known locally as Service Linkage – are a "bundled" service category in the Houston Area, requiring ASOs that compete for funds in these categories to provide all three services cohesively. Bundling of these Core Medical Services and key Support Services ensures the services are co-located within funded agencies, thereby creating "one stop shops" for consumers. It also facilitates medical teams and case managers within agencies to work collaboratively to achieve client outcomes.

## Recent Funding Trends in the Ryan White HIV/AIDS Program and How Services Were Adapted

Like other highly-impacted major metropolitan areas directly funded for the Ryan White HIV/AIDS Program, the Houston Area is subject to HRSA's Hold Harmless provision, which guarantees that no "dramatic shifts" occur between grant cycles based on formula changes in the epidemiological profile of a jurisdiction. However, the Houston Area has experienced notable increases in living HIV/AIDS cases in the time of the Hold Harmless provision; for example, between Fiscal Years 2005 and 2011, the Houston Area saw an increase of 4,240 (25 percent) in diagnosed HIV/AIDS cases and an increase of 1,774 (22 percent) in net unduplicated clients served by Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (MAI).[7] However, the Houston Area also experienced a net decrease of 1.4 percent in Part A and MAI funding. The result of these concurrent trends has been a reduction in funding per living case of 21 percent (from $1,197 per living case in 2005 to $946 per living case in 2011).[7] In the most recent funding cycle, the Houston Area was awarded an increase in Part A and MAI funding (less than 2 percent). However, the amount of the increase did not make up for several prior years of reductions, and funding for the current year remains less than it was only two years ago.[7]

In addition, efforts such as the Expanded Testing Initiative (ETI) to promote routine, opt-out HIV testing in general health care settings and the HRSA-funded *Early Identification of Individuals with HIV/AIDS* (EIIHA) to accelerate the identification of individuals unaware of their HIV status have resulted in an increased volume of newly-diagnosed HIV infected individuals entering the HIV care system. Local HIV systems have adjusted service priorities and allocations in order to accommodate new positives. As these initiatives continue, local HIV systems must also take steps to accurately estimate and plan for future influxes of new consumers, while continuing to manage Hold Harmless provisions and reductions in per-client funding. In the Houston Area, a precedent has been established to respond to these conditions by transferring allocations from Support Services to Core Medical Services for the newly-diagnosed.

### Strategy to Respond to Future Funding Reductions

The Houston Area has developed a structured annual process to respond to changes in local, state, or federal funding for the Ryan White HIV/AIDS Program as well as other changes in the health care system that may impact access to HIV care, treatment, and support services by people living with HIV/AIDS. These two processes are described below:

- **How to Best Meet the Need (HTBMTN)**. The Houston Area conducts a process each year to develop justifications for service categories to be funded by the Ryan White HIV/AIDS Program. Called How to Best Meet the Need (HTBMTN), the process takes place prior to the mandated Priorities and Allocations process of the Ryan White Planning Council and includes a series of public workshops focused on each service category. During the workshops, data are reviewed per service category in response to six criteria, including documentation of need, how the service assists individuals who are out-of-care to access care, the presence of non-Ryan White HIV/AIDS Program funding sources for the service, and options for service delivery, such as "bundling." The criteria also include methods to assess for and prevent duplication of services, thereby helping to ensure that Ryan White HIV/AIDS Program remains the "payer of last resort" and that services provided through the funds are coordinated. Data from multiple sources are utilized for the HTBMTN process, including Epidemiological Profiles, Needs Assessments, Clinical Outcome Measures, and Comprehensive HIV Services Plans. Following the HTBMTN workshops, a public televised community forum is held to gather additional feedback from the larger Houston Area community on proposed service category definitions.

- **Increase/Decrease Funding Scenarios**. The Houston Area has also adopted a series of scenarios to be applied when Ryan White HIV/AIDS Program Part A, Part B, or State Services funds are increased or decreased. These funding scenarios outline specific dollar amounts, percentages, and service categories to receive the increase or decrease in a ranked order. For example, the current funding scenarios for Part A outline the following: (1) in a decrease funding scenario, all service categories will be decreased by the same percent; and (2) in an increase funding scenario, the first $165,000 will be allocated to Ambulatory/ Outpatient Health Services, the next $100,000 to AIDS Pharmaceutical Assistance (local), and so on. As a result of these scenarios, planning for future potential decreases or increases in Ryan White HIV/AIDS Program funds can occur in advance of Notices of Grant Award. To prepare for the national health care system changes that will occur with full implementation of the *Patient Protection and Affordable Care Act of 2010*, a third scenario has been proposed for development, one that will estimate the increase in public health insurance coverage among Ryan White HIV/AIDS Program clients through health care reform so that projected unspent or unallocated funds can be planned in anticipation of the transition of clients to other public health insurance programs.

## NEEDS, GAPS, AND BARRIERS TO HIV PREVENTION SERVICES IN THE HOUSTON AREA

Every five years, in response to the Centers for Disease Control and Prevention (CDC)'s Funding Opportunity Announcement (FOA) for comprehensive HIV prevention programs for local health departments, the Houston Department of Health and Human Services (HDHHS), the local health jurisdiction for Houston and Harris County, conducts an inventory of all HDHHS-funded HIV prevention activities in the Houston Area. During this process, an environmental scan and key informant interviews are conducted to identify needs, gaps, and barriers to HIV prevention services. This process was last conducted in August 2011.

In addition, the HDHHS and the Houston HIV Planning Group (HPG) periodically conduct a comprehensive Community Services Assessment (CSA) of HIV prevention activities and community needs in the Houston Area. The CSA is a compilation of multiple data collection methods including epidemiologic studies, focus groups and key informant interviews with HIV prevention services providers, a resource inventory, a client survey, and a gaps analysis identifying areas of disconnect between needs and resources. The last CSA was conducted in 2009.

Below are key findings identified from these two sources as current needs, gaps, or barriers to HIV prevention services in the Houston Area:

- **Access to Testing and Prevention Services.** Due to the National HIV/AIDS Strategy and its focus on the 12 cities with the highest cumulative AIDS cases, the Houston Area has received incremental increases for HIV prevention activities, such as funding through ECHPP, *the Enhanced Comprehensive HIV Prevention Planning* project, that began in 2010. However, as demonstrated by the continued rate of new diagnoses in the Houston Area, these increases fail to keep pace with need. Greater access to both routine and targeted HIV testing, particularly in the geographic areas of Houston and Harris County with the highest HIV/STD morbidity, is needed to ensure that acute infections are identified and the proportion of those unaware of status decreases. Scaling up of other prevention interventions, such as social marketing, is also needed to increase awareness of testing and other services, promote engagement in care, and reduce stigma. For example, client surveys from the 2009 CSA revealed a significant lack of knowledge of some available HIV prevention services in the community, such as counseling on how to inform partners of a positive HIV result. Increased access to condoms in a wider variety of venues throughout the jurisdiction has also been cited as a current gap in services.

- **Prevention Data Collection, Management, and Dissemination.** Though HIV prevention and care data management systems contribute information to a single continuum of care, they have historically been unable to interface. HIV prevention databases centralize information on HIV screening and testing, new infections, and partners while HIV care databases centralize information on HIV medical care, treatment, and support services including health outcomes. Lack of interface between these systems has limited the ability of providers to ensure linkages of infected person from diagnosis to HIV medical care. In order to address this need, a new Internet-based data system developed by HDHHS, branded as ECLIPS (Electronic Client-Level Integrated Prevention System) will interface with the Houston Area's HIV care data management system, the Centralized Patient Care Data Management System (CPCDMS) to ensure referral linkages into HIV primary care. Currently there are four HDHHS data systems that will be combined and replaced by ECLIPS.

- **Surveillance Data Collection, Management, and Dissemination.** HIV surveillance data can assist in determining the optimal combination of HIV prevention activities by identifying the populations and geographic areas with the highest HIV/STD morbidity. However, there is currently limited capacity for using HIV/STD surveillance data for this purpose. For example, statewide policy changes in January 2010 ensured that all viral load and CD4 results are reportable to local health jurisdictions by Texas law. Additional staff capacity in the HDHHS to assess completeness of this new reporting is still needed. The HDHHS utilizes electronic laboratory reporting of positive HIV tests, CD4, and viral load data from several large facility providers. However, the data systems currently utilized for surveillance need to be replaced in order to maximize the use of electronic laboratory reporting. The Texas Department of State Health Services (DSHS) is currently in the planning phase of building a combined HIV/STD/TB data system that would meet this need.

- **STD Clinic Resources.** Currently, clients in HDHHS STD clinics may have excessive wait times, and the clinic registration structure occasionally results in clients being turned away because medical providers are only able to see a limited number of clients per day. In order to increase the number of clients receiving testing in the STD clinics, HDHHS plans to implement an automated self-registration and risk assessment system. Automated registration kiosks will be placed in the three STD clinics, and clients will self-register for HIV/STD testing and clinical services as well as complete a risk assessment questionnaire. Key clinic staff will be able to access this information quickly via computer. This system will expedite rapid HIV testing as well as testing for other STDs including "stat" syphilis tests, rapid Hepatitis C (HCV) tests and testing for gonorrhea and Chlamydia infection. Test results for HIV and syphilis will be provided during the same-day clinic visit. Wait times and visit lengths will be reduced, which will increase the capacity for additional clients to receive HIV/STD testing services.

- **Screening the Incarcerated.** Voluntary HIV screening is offered in the Harris County Jail under a contract with DSHS. Screening occurs during the inmate medical assessment, which takes place within 10-14 days of incarceration. If an inmate is released prior to the time of medical assessment, however, then screening for HIV does not occur. Inmates who test positive for HIV are then counseled and offered partner services by HDHHS Disease Intervention Specialists (DIS) assigned to the jail. HDHHS is working with DSHS to encourage Harris County Jail to adopt routine HIV and syphilis screening earlier than the standard medical assessment. Gonorrhea and Chlamydia testing is only available in this setting upon request or if symptoms are present. Currently, additional HIV/STD screening at time of release does not occur.

- **Syringe Exchange.** Texas law does not allow for the implementation of syringe exchange programs, which include the distribution of sterile needles, syringes, and other sterile injection supplies. Under Chapter 481.125 of the Texas Health and Safety Code, a person commits an offense if the person knowingly or intentionally uses or delivers, or possesses with intent to use or deliver, drug paraphernalia that can be used to inject a controlled substance into the human body. The punishment for one of these offenses ranges from a Class C misdemeanor to a state jail felony. HDHHS created a Hepatitis C Task Force that has established a Harm Reduction Workgroup to discuss how to best meet the needs of those who continue to be at risk for contracting HCV and HIV through unsafe injection practices in light of these prohibitions.

# NEEDS, GAPS, AND BARRIERS TO HIV CARE SERVICES IN THE HOUSTON AREA

## Client Level Needs, Gaps, and Barriers to Care: Key Findings from the 2011 HIV/AIDS Needs Assessment

A needs assessment produces detailed information about service usage for a defined population and, as a result, is an essential tool for planning service delivery in a community. Every three years, a needs assessment of people living with HIV/AIDS (PLWHA) in the Houston Area is conducted. Its purpose is to gather information on the HIV-related services that PLWHA in the Houston Area use, their barriers to services, and their continued areas of service need.

For the 2011 Houston Area HIV/AIDS Needs Assessment, 924 PLWHA were surveyed from the Houston Health Services Delivery Area (HSDA). Survey participants were queried on 11 topics related to HIV prevention and care services, including service usage history for Ryan White HIV/AIDS Program Core Medical and Support Services, perception of ease or difficulty accessing services, barriers to seeking or receiving services, and co-occurring health conditions. Their responses were analyzed by demographic characteristics, risk factors for HIV/AIDS, and other conditions that can impact access to HIV care, such as being homeless, living in a rural location, or being recently released from the criminal justice system.

Below is a summary of key findings from the 2011 Needs Assessment. Key findings presented here have been selected as the best available measures of current needs, gaps, and barriers to HIV care. They are not intended to be representative of the full body of data collected, analyzed, or presented in the 2011 Needs Assessment. The complete document can be found at the following address: *http://www.rwpchouston.org/Publications/publication_listing.htm*.

**Diagnosis.** Needs assessment participants were asked about their experience with HIV testing:

- "Feeling sick" was the most commonly cited reason for seeking an HIV test (25 percent of respondents), followed by having sex with someone with HIV (19 percent), testing as part of a routine check-up (19 percent), and engaging in risky behavior (18 percent).
- The most commonly reported location for the HIV test was a public or community clinic (40 percent), followed by jail/prison (16 percent). Less than half of survey respondents (48 percent) said they received information about HIV medical services at the time of their diagnosis, and 19 percent stated they received no information at all.

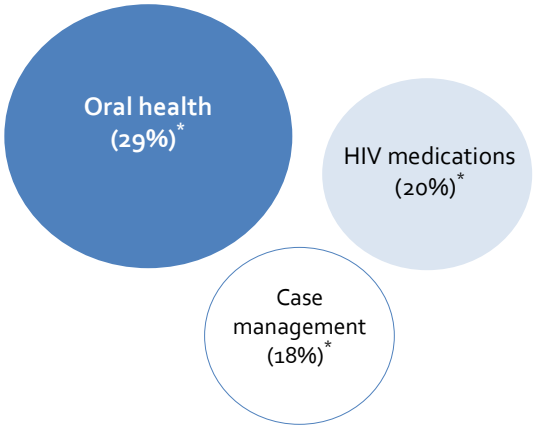
**First Medical Visit.** Needs assessment participants were asked about the time between their HIV diagnosis and their first HIV medical visit.

- Half of respondents (50 percent) reported seeing a doctor for HIV within one month of their diagnosis, while 14 percent waited more than 12 months, and 2 percent said they had never seen a doctor for HIV.
- PLWHA who more often reported waiting longer than 12 months to see a doctor for HIV were those with a history of being out-of-care (35 percent of respondents) or who were still out-of-care (21 percent) as well as White Men Who Have Sex with Men (MSM) (19 percent).
- The most commonly-cited reason for delaying care was fear (42 percent), followed by denial (35 percent) and not feeling sick (34 percent). As with testing, the most commonly-reported location for the first HIV medical visit was a public or community clinic (54 percent).

**Access to Core Medical Services.** Needs assessment participants were asked about their experience seeking each of the Ryan White HIV/AIDS Program Core Medical Services currently available in the Houston Area.

- Some respondents stated that they did not need Core Medical Services, but, of those that did, services overall were reportedly "very easy to get."
- For all respondents, the top three "very easy to get" Core Medical Services in the Houston Area were primary medical care visits (74 percent), HIV medications (68 percent), and case management (63 percent).
- The top three Core Medical Services in the Houston Area that respondents reported "some difficulty getting" were oral health visits (29 percent), HIV medications (20 percent), and case management (18 percent) (Figure 5).

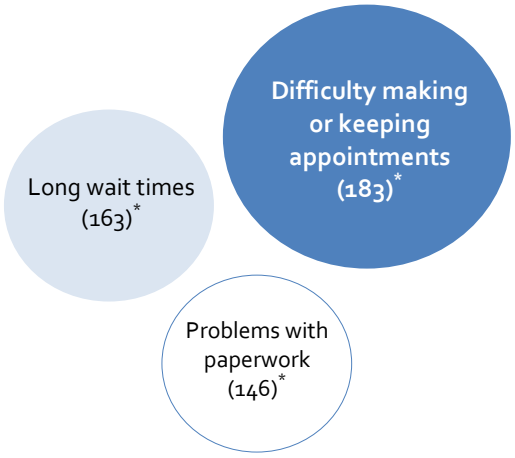
Figure 5: Top Three Core HIV Medical Services Reported as "Difficult" to Access in the Houston Area




*Percentage of respondents in the 2011 Houston Area HIV/AIDS Needs Assessment that reported having "some difficulty getting" this service.

- Though certain Core Medical Services ranked at the top of both lists, certain subgroups of PLWHA reported divergent experiences. In general, PLWHA who were not in regular HIV care or who were homeless had difficulty accessing services that others perceived as "easy."
- When respondents reported having "some difficulty" accessing a service, they were also asked to identify why, using a list of possible barriers. The three most commonly-reported barriers to accessing Core Medical Services were difficulty making or keeping appointments (183 reports of barriers), long wait times (163 reports), and problems with paperwork (146 reports) (Figure 6).

Figure 6: Top Three Barriers to Core HIV Medical Services in the Houston Area



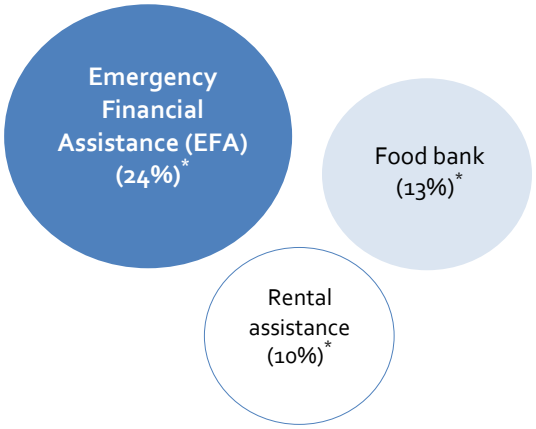

*Number of reports of barriers to this service cited by respondents in the 2011 Houston Area HIV/AIDS Needs Assessment.

- A majority of respondents (78 percent) reported being on HIV medications at the time of the assessment. Hispanics reported HIV medication usage the most while those that were homeless reported it the least. Overall, the most commonly-cited reason for not taking HIV medications was a T-cell count being too high. About one-quarter (26 percent) of participants reported stopping their HIV medications at some point in time due to side effects. Fifteen percent (15 percent) reported difficulty paying for medications.

**Access to Support Services.** Needs assessment participants were asked about their experience seeking each of the Ryan White HIV/AIDS Program Support Services currently available in the Houston Area.

- Of available Support Services, respondents stated that the three most useful services were Emergency Financial Assistance (EFA), or short-term payments for transportation, food, utilities, or medication (50 percent), followed by food bank services for meals or nutritional supplements (50 percent) and transportation services to access primary medical care or psychosocial support (43 percent).
- Though ranked first and second in importance for PLWHA, EFA and food bank services were also cited as the most difficult-to-access of the Support Services with 24 percent and 13 percent of respondents stating "some difficulty getting" the service. Third was rental assistance and/or shelter vouchers for short-term assistance to support temporary and/or transitional housing to access medical care at 10 percent (Figure 7).

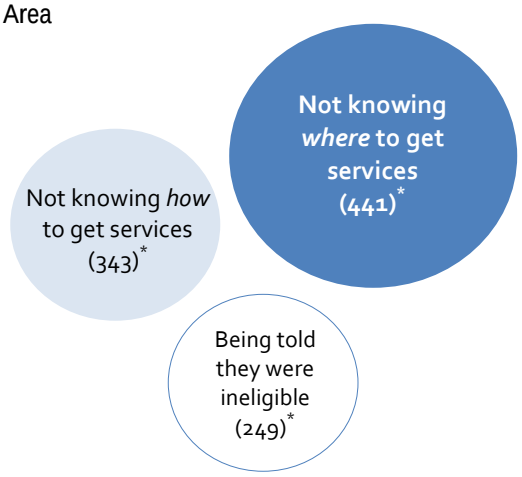
Figure 7: Top Three HIV Support Services Reported as "Difficult" to Access in the Houston Area




*Percentage of respondents in the 2011 Houston Area HIV/AIDS Needs Assessment that reported having "some difficulty getting" this service.

- When respondents reported having "some difficulty" accessing a Support Service, they were also asked to identify why, using a list of possible barriers. The three most commonly-reported barriers to accessing Support Services were "not knowing where to get services" (441 reports of barriers), "not knowing how to get services" (343 reports), and being told they were not eligible for the service (249 reports) (Figure 8).

Figure 8: Top Three Barriers to HIV Support Services in the Houston Area




*Number of reports of barriers to this service cited by respondents in the 2011 Houston Area HIV/AIDS Needs Assessment.

- Respondents were also asked about sources for social support for their HIV. The most commonly-cited source was family (35 percent of respondents), followed by other PLWHA (34 percent), and doctors, nurses, or agency staff (33 percent).

**Co-Concurring Conditions.** Needs assessment participants were also asked about the presence of certain other health conditions that could impact their ability to seek HIV care.

- One-quarter of respondents reported Hepatitis C co-infection, 11 percent reported a history of active TB, and 31 percent reported taking high blood pressure medication.

- A majority of respondents (63 percent) reported having at least one mental health condition during the previous month, with "serious anxiety/tension" reported most often (52 percent).
- Respondents were also asked about drug and alcohol use. Overall, about one-third (36 percent) showed an indication of alcohol abuse, 25 percent reported using marijuana, 21 percent reported using cocaine, and 5 percent reported using amphetamines.

**Characteristics of PLWHA Who Are Out-of-Care.** Needs assessment results were analyzed according to HIV care status using the Health Resources and Services Administration (HRSA) definition of in-care/out-of-care described above. Using this definition, seven percent (or 66) respondents in the assessment were out-of-care. Those who fell into this category tended to be male, 45 years of age or older, black/African American, and heterosexual.

- The out-of-care were least likely to have received information about HIV medical services at the time of their HIV diagnosis. They were also more likely to delay entry into care for more than 12 months. The most common reason for not being in care was that they "felt fine."
- Those who were out-of-care were more likely to report not having a case manager or to be unsure if they had a case manager.
- Half of those who were out-of-care (50 percent) reported having no source of social support compared to 19 percent of all respondents.
- Those who were out-of-care were more likely to report EFA as an important Support Service. They also more frequently reported not knowing where or how to get Support Services as a barrier.

Overall, over one quarter of all respondents (26 percent) reported stopping their HIV care for one year or more at some point in their history. The most common reasons for falling out of care were drug use (50 percent), loss of stable housing (37 percent) and "not wanting HIV medication" (36 percent).

### Provider, Program, and System Level Needs, Gaps, and Barriers to Care

Provider, program, and system level needs, gaps, and barriers to HIV care, treatment, and support services in the Houston Area stem primarily from its population size and geographic density (including the presence of a large rural community) as well as from the socio-economic conditions experienced by people living with HIV/AIDS, many of whom represent communities that are historically underserved.

As previously described, the Houston Area has a large and multi-tiered health care system administered by city, county, and state officials as well as by private and non-profit organizations, including the "largest medical center in the world." The size and complexity of this system can create challenges for *individuals* seeking health care as well as for *providers* seeking to coordinate care. Again, as described previously, the Houston Area is also the least densely populated major metropolitan area in the nation. Relatively long distances must be travelled to seek services even within the urban center. This creates challenges for providers attempting to reach individuals for HIV follow-up. In rural Houston Area locations, even longer distances must often be travelled to reach HIV medical services. The lack of HIV medical homes in many rural parts of the Houston Area further exacerbates this barrier to care.

Confounding these logistical challenges are socio-economic barriers often faced by communities at high-risk for HIV and by those residing in rural areas, such as low levels of education, unemployment, unstable housing, low health literacy, and poverty.

## EVALUATION OF THE 2009 COMPREHENSIVE PLAN

### Methodology

In September 2011, as the process for developing the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 was beginning, its Evaluation Workgroup was tasked with conducting an evaluation of the 2009 Houston Area Comprehensive HIV Services Plan (2009 Comprehensive Plan) in order to identify major successes and continued areas of challenge that would inform current planning activities. The methodology adopted for the evaluation relied on available secondary data, convenience proxy measures of impact and outcomes, and internal subject matter expertise. The following methods were applied:

"Five major successes and six continued areas of challenge were revealed through an evaluation of the 2009 Comprehensive Plan."

- *Impact Evaluation*. Five community-level indicators were selected to serve as measures of the extent of achievement of the vision and mission of the 2009 Comprehensive Plan. Special attention was paid to any goals in the document that included a directional outcome (e.g., Goal 8: Prevent youth from becoming HIV positive).
- *Outcome Evaluation*. Two outcome-level indicators were included in the 2009 Comprehensive Plan: (1) Reduce by 10 percent annually the number [of people living with HIV/AIDS] not in care; and (2) reduce the impact of stigma and increase retention in care by 10 percent. These were assessed using available data points/sources at both baseline and actual.
- *Process Evaluation*. One process-level indicator was included in the 2009 Comprehensive Plan: (1) Increase the provision of education and advocacy events by 25 percent. In addition, each action step in the 2009 Comprehensive Plan was assessed for completion/non-completion to serve as measures of the extent of achievement of this target.

The evaluation process revealed five major successes and six continued areas of challenge since the time of 2009 Comprehensive Plan implementation (2009 to 2011).[14] These findings reflect the results of data analysis on impact, outcome, and process indicators as well as conclusions drawn by members of the Evaluation Workgroup and other key stakeholders in the planning process.

### Major Successes

- **Health outcomes for people living with HIV/AIDS (PLWHA) are improving**. An important measure of HIV-related health status for PLWHA is viral load. According to two data sources reviewed for the evaluation, viral load among PLWHA in the Houston area has notably improved since implementation of the 2009 Comprehensive Plan.[15] Between 2008 and 2011, the percent of Ryan White HIV/AIDS Program Part A clients with an undetectable viral load increased 70.6 percent (from 34 percent with an undetectable viral load in 2008 to 58 percent at the time of the evaluation in 2011). In addition, the average viral load of Part A clients (including those with undetectable viral load) also decreased (11.7 percent). Noteworthy is that the increase in undetectable viral load seen in Houston Area Part A clients far exceeds comparable national targets.[16]

- **PLWHA are entering care sooner after diagnosis**. Reducing the time between HIV diagnosis and entry into care contributes to earlier treatment and, ultimately, improved health outcomes. According to data sources reviewed for the evaluation, PLWHA in the Houston Area appear to be entering care sooner after diagnosis. [15] This was measured using self-reported data from PLWHA on the time between diagnosis and first medical visit. Between 2008 and 2011, the percent of PLWHA reporting their first medical visit *less than one* month after diagnosis increased 1.0 percent, and the percent reporting their first medical visit *one to*

*six* months after diagnosis increased 2.0 percent. It is noteworthy, however, that self-reported initial CD4 count at first medical visit did not show comparable improvements, suggesting that PLWHA may be being diagnosed later in their disease.

- **HIV testing has become increasingly widespread.** During the time of 2009 Comprehensive Plan implementation, multiple efforts were launched to increase HIV testing in non-traditional settings and using a routine, opt-out screening model. For example, the number of publicly-funded HIV tests in the Houston area increased 61 percent between 2009 and 2010 with an average of 151, 870 tests provided each year.[17] Of that, approximately 85,000 tests each year were conducted routinely.[17] In addition, an average of 12,300 tests was provided yearly at the mass multi-site testing event, *HIP HOP for HIV Awareness.*[17]

- **More PLWHA are becoming aware of their status.** HIV/AIDS incidence is a measure of new cases diagnosed in a specific time period. The following are HIV/AIDS incidence rates for the Houston Area for each year of 2009 Comprehensive Plan implementation:

| | 2008 | 2009 | 2010 |
|---|---|---|---|
| HIV/AIDS Incidence[15] | 20.0 per 100,000 | 25.4 per 100,000 | 24.7 per 100,000 |

As described above, HIV testing experienced a significant scale-up in the Houston Area during this time. The anticipated epidemiological outcome of a scale-up in testing is a sharp increase in incidence followed by gradual decreases over time. This is due to the increase in the number of previously unaware positives found through increased testing followed by declines in new positives as testing becomes normalized. Taken together, HIV testing and incidence suggest that the Houston Area has been experiencing this epidemiological trend.

- **The community has responded well to the needs of PLWHA recently released from jail or prison.** The 2009 Comprehensive Plan included 11 action steps specific to the population of PLWHA recently released from jail or prison. During the three-year timeframe of the 2009 Comprehensive Plan, significant community mobilization occurred to meet the needs of this population. As a result, all but one of the action steps was completed, including the formation of a new community coalition focused on this group.

### Continued Areas of Challenge

- **The HIV system of care still needs additional capacity to accommodate new positives.** As described above, the impact of a large scale-up in HIV testing is an increase in the number of positives diagnosed in a community. The Houston Area was successful in identifying more positives during the time of plan implementation. However, the HIV care system continues to need capacity to serve new positives. According to data analyzed for the evaluation, the percent of diagnosed PLWHA who were out of care (i.e., the Ryan White HIV/AIDS Program Unmet Need Framework) increased 4.4 percent between 2008 and 2011 with the greatest increase occurring between 2008 and 2009, the year that routine HIV testing began.[18] The number of out-of-care then dropped between 2009 and 2010 by about 1 percent. Like incidence, the impact of increased testing on unmet need may be a sharp increase followed by gradual decreases as system capacity is adjusted to meet need.

- **Retention in care is steady, but not increasing.** Retaining individuals in continuous HIV care contributes to improved disease management and, ultimately, better health outcomes. According to data generated for this evaluation, PLWHA in the Ryan White HIV/AIDS Program Part A system are being retained in primary medical care at a steady, but not increasing, rate.[18] The percent of PLWHA retained in care using a federally-defined metric

was 76 percent for the first defined time period in 2008 compared to 75 percent for the most recent defined time period in 2011. In the interim, the percentage fluctuated as low as 52 percent retained; however, beginning in late 2010, the rate began and has continued to rise.

- **Incidence in youth continues to increase.** As described above, the anticipated epidemiological outcome of a large scale-up in HIV testing is a sharp increase in incidence followed by gradual decreases over time. This trend has not yet been observed for youth aged 13 – 24 in the Houston Area as 2009 planners had desired. Instead, as shown below, youth incidence experienced a sharp increase between 2008 and 2009, the year that routine HIV testing began, followed by another, albeit slight, rise between 2009 and 2010:

| | 2008 | 2009 | 2010 |
|---|---|---|---|
| HIV/AIDS Incidence Youth age 13 - 24[15] | 25.8 per 100,000 | 31.3 per 100,000 | 31.4 per 100,000 |

- **Actions are needed to address the needs of specific populations.** The 2009 Comprehensive Plan included action steps specific to several subpopulations of PLWHA. A large proportion of these activities were completed or at least started during implementation. However, activities identified for some groups were not completed in full. These include: bisexually-identified individuals, substance abusers, and some activities targeting youth and women.

- **Information is needed about non-traditional HIV service providers.** The majority of action steps in the 2009 Comprehensive were known to be undertaken by "traditional" HIV prevention and care providers, i.e., Ryan White HIV/AIDS Program providers, HIV prevention funded by the Centers for Disease Control and Prevention (CDC), etc. Little was known about the HIV activities of: non-Ryan White HIV/AIDS Program, non-CDC, and other public, private, or faith-based providers in the Houston Area.

- **Future HIV planning goals and objectives need greater specificity.** Evaluation Workgroup members encountered difficulty conducting the evaluation of the 2009 Comprehensive Plan due to the lack of specificity and measurability in its goals, objectives, and action steps. It is recommended that future planning follow the principles below:

  1. Each proposed goal is coupled with at least one measurable benchmark.
  2. Each proposed objective and action step is SMART (Specific, Measurable, Achievable, Realistic, and Time-Phased) and includes specifics in regards to anticipated outputs and timeframes.
  3. Terminology used in goals, objectives, action steps, and benchmarks is standardized and/or defined.
  4. Only benchmarks with verifiable baseline data are used. Moreover, benchmarks are aligned with other local, state, and national targets.

### Plan to Meet Continued Areas of Challenges in the 2012 Comprehensive Plan

Results of the evaluation of the 2009 Comprehensive Plan were communicated to participants of the 2012 comprehensive HIV prevention and care services planning process. Participants were encouraged to identify goals, solutions, strategies, and activities that would meet continued areas of challenge and could be included in the 2012 Comprehensive Plan. As a result, each continued area of challenge remaining from the 2009 Comprehensive Plan has been addressed for the 2012 – 2014 planning period as summarized on the following page.

| Continued Area of Challenge from the Evaluation of the 2009 Comprehensive Plan | Plan to Meet the Challenge in the 2012 Comprehensive Plan |
|---|---|
| The HIV system of care still needs additional capacity to accommodate new positives | The Strategy to Improve Coordination of Effort and Prepare for Health Care System Changes (Section III) includes goals, solutions, and activities specific to this challenge:<br>• Goal #2: Increase the Availability of HIV Prevention and Care Services and Providers<br>• Solution #1: Launch proactive efforts to unify stakeholders and to engage new and non-traditional partners in achieving the HIV prevention and care mission<br>• Solution #2: Intensify technical assistance and training to current and potential AIDS-service organizations (ASOs) and providers |
| Retention in care is steady, but not increasing | The 2012 Comprehensive Plan includes a system-level objective specific to this challenge (Section II):<br>• Increase the percentage of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) to 80 percent (from 78 percent).<br>To accomplish this objective, the following Strategies include goals, solutions, and activities for improving retention in care (Section III):<br>• Strategy for Prevention and Early Identification; and<br>• Strategy to Fill Gaps in Care and Reach the Out-Of-Care. |
| Incidence in youth continues to increase | The 2012 Comprehensive Plan has included "youth age 13-24" as a Priority Population for the Houston Area (Section II); and "adolescents age 13-17" as a Special Population for the Houston Area (Section II).<br>The Strategy to Address the Needs of Special Populations (Section III) includes goals, solutions, and activities specific to adolescents. |
| Actions are needed to address the needs of specific populations | The 2012 Comprehensive Plan has included several of the populations identified as having continued need as Priority Populations and/or Special Populations (Section II), including:<br>• Injection Drug users (IDU)<br>• Transgender<br>• Women, incl. pregnant women and those of childbearing age<br>• Youth (age 13 – 24), incl. Adolescents (age 13 -17)<br>The Strategy to Address the Needs of Special Populations (Section III) includes goals, solutions, and activities specific to IDU, transgender, and adolescents. |
| Information is needed about non-traditional HIV service providers | The Strategy to Improve Coordination of Effort and Prepare for Health Care System Changes (Section III) includes goals, solutions, and activities specific to improving coordination and communication with non-traditional HIV services providers, including other public providers and private providers. |
| Future HIV planning goals and objectives need greater specificity | The 2012 Comprehensive Plan participants adopted the recommendations listed under this continued area of challenge as Planning Principles for the process (Section IV). These recommendations were also incorporated into the Guiding Principles for the document (Section II). |

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# Amber David

*"There was a time when there were no formal programs for HIV. We had to be resourceful. We built it ourselves."*

Photograph by Barb Garvin

*From a young age, Amber David was fighting for his survival.*

As a child growing up in Baytown, Texas, Amber remembers being taunted by other kids for being gay, and he remembers his grandmother teaching him to defend himself. He was the youngest in a large African American family and often identified with "other lonely kids" that he saw on television, particularly Michael Jackson. As a teen, Amber was a talented dancer, just like his role-model, and won a number of dance competitions. He later joined the school band. Eventually he discovered that, when others respected his creative talents, it would most often lead them to respect him as a person as well.

As a young man, Amber became active in the Montrose neighborhood in Houston. He was a drag queen and worked at a flower shop alongside other gay men. Though his new community staved off the loneliness he had felt as a child, it also introduced him to drugs and alcohol. It was during this period that Amber became infected with HIV. He compares the epidemic at the time to an image from the Bible of "smoke coming down on the firstborn" in Egypt taking everyone in its path. Amber discovered quickly that HIV was a way "to learn who your friends are and who you can trust." HIV positive and still an addict, Amber cared for friends and fellow users who were battling the disease.

Today, Amber is a Senior Public Health Investigator with the Houston Department of Health and Human Services, where he helps locate those newly-diagnosed with HIV and link them into care. For well over a decade, Amber has coordinated monthly HIV testing at a local Downtown Houston, primarily African American church where he also leads an AIDS Ministry. He speaks before the congregation on national HIV/AIDS awareness days to keep them informed about the local HIV epidemic. Amber is also the captain of the largest faith-based team at the annual AIDS Walk Houston.

When asked about what he has learned from this experience, Amber tells a story about building a kite with his nephew. When his nephew asked Amber why they didn't just buy a kite in the store, Amber told him that they needed "to know that they can make one if there are no more to buy." In a time when there were no formal programs or services for those living with HIV, Amber and his community bound together to help others fight for their survival; they built it themselves.

AMBER DAVID

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# Section II: Where Do We Need to Go?

The purpose of this section is to describe the community's vision for an ideal, high quality, comprehensive continuum of HIV prevention and care services for the Houston Area and to outline the overarching issues, opportunities, goals, objectives, and other elements that shape this ideal system.

Section Contents

## Our Approach: Sustain, Scale-up, Shift, and Shore-Up

Since 2008, when the last comprehensive HIV services plan for the Houston Area was developed, the HIV prevention and care landscape has experienced a transformation. The National HIV/AIDS Strategy, health insurance reform, the most promising HIV prevention research in decades, a greater understanding of the socio-ecological factors that influence HIV, and new initiatives designed to accelerate HIV prevention and care in the most impacted communities have all taken root since the last time Houston's HIV community gathered to articulate its vision for an ideal HIV system. In this new landscape, the approach to designing an ideal system for the Houston Area was also transformed.

"The goal is to present current initiatives as part of an overall system plan for the Houston Area and then complement them by identifying specific strategies to *sustain*, *scale-up*, *shift*, or *shore-up* the entire system."

For the first time in the Houston Area's history, HIV prevention planning and HIV care planning joined together to produce an *integrated* jurisdictional HIV prevention and care services plan. This integrated planning process was then also purposely designed to consider national system changes; it sought to ensure that the resulting document would be in alignment with the National HIV/AIDS Strategy (as well as with other federal plans and statewide efforts) and be inclusive of the Houston Area iterations of the national acceleration initiatives ECHPP (*Enhanced Comprehensive HIV Prevention Planning*) and EIIHA (*Early Identification of Individuals with HIV/AIDS*).

As a result, the aim of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 (Comprehensive Plan) is not to re-design the already fully-realized initiatives that have occurred since 2008. Instead, its aim is to present these initiatives as part of an overall system plan for the Houston Area and then complement them by identifying specific strategies to *sustain*, *scale-up*, *shift* (in terms of new priorities or needs) or *shore-up* the entire system in order to fully realize Houston's vision for an ideal continuum of HIV prevention and care.

## "A Living Document"

Planning has been imperative to the Houston Area HIV community since the beginning of the epidemic. Unfortunately, funding for HIV prevention and care has rarely kept pace with need, and the needs themselves have changed over time in response to disease trends and new science. These conditions have heightened the role and responsibility of the Houston Area HIV community to make sound real-time decisions regarding service priorities and resource-allocations. The 2012 Comprehensive Plan is intended to serve as a roadmap for this year-round process. Its intent is to assist the Houston Area HIV planning community, including Planning Bodies, programs, and providers, in their ongoing decision-making on the design and implementation of the local HIV prevention and care system.

"The plan is meant to inform real-time local decision-making, but it is also meant to *be* informed by real-time local decision-making and continually reviewed and updated."

*However*….just as the Comprehensive Plan is meant to inform real-time local decision-making, it is also meant to *be* informed by real-time local decision-making. Therefore, this plan should be viewed as a *living* document and be continually reviewed and updated as activities are completed, as critical and emerging new areas of need are identified, as progress is made toward goals and benchmarks, and as lessons are learned about how to best implement HIV prevention and care services for the Houston Area. The Comprehensive Plan must also be reviewed and updated in

response to ongoing changes in the HIV prevention and care landscape, in health care service-delivery, and in the Houston Area community as a whole. If health insurance reform takes a different course, if new HIV initiatives are launched, or if unanticipated changes occur in resources for HIV prevention or care in the Houston Area, then the goals, solutions, and activities proposed in the Comprehensive Plan may need to be reworked and efforts redirected. All of this is possible with a living document.

## Vision

The Greater Houston Area will become a community with a coordinated system of HIV prevention and care, where new HIV infections are rare, and, when they do occur, where every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high-quality, life-preserving care, free of stigma and discrimination.

## Mission

The mission of the 2012 Comprehensive HIV Prevention and 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 infected with, affected by, or at risk for HIV.

## Guiding Principles

The development of the 2012 Houston Area Comprehensive HIV Prevention and Care Services Plan was guided by 10 core principles; that the plan and planning process would:

1. Fully integrate the perspectives, needs, and priorities of both HIV prevention and HIV care and, within the HIV care community, all Ryan White HIV/AIDS Program components.
2. Align with local, state, and national HIV prevention and care plans and initiatives, including the National HIV/AIDS Strategy, *Healthy People 2020*, the Centers for Disease Control and Prevention (CDC)'s plan for High-Impact HIV Prevention, and the local acceleration initiatives, the CDC's ECHPP (*Enhanced Comprehensive HIV Prevention Planning*) and the Health Resources and Services Administration (HRSA)'s EIIHA (*Early Identification of Individuals with HIV/AIDS*).
3. Be cognizant of changes occurring in the national health care delivery system resulting from the *Patient Protection and Affordable Care Act of 2010* and the Ryan White HIV/AIDS Treatment Extension Act.
4. Assess strategies, including those used internationally, that have effectively reduced HIV infection and could be implemented locally.
5. Assure that federal expectations for Houston Area comprehensive planning and the required deliverables of funded agencies are met while still allowing new or emerging critical areas of need and innovation to be considered.
6. Produce Specific, Measurable, Achievable, Realistic, and Time-phased (SMART) goals and solutions that can be used to guide priority-setting, resource allocation, scopes of work, quality assurance, and other decision-making activities of the Houston Area planning bodies and administrative agents.
7. Balance the need to be comprehensive, data-driven, and reflective of new science, theory, and models with the need for efficiency in regards to resources and timelines.
8. Recognize the importance of and provide opportunities for participation by non-AIDS-service organizations and other non-traditional partners.
9. Honor the populations most impacted by HIV, including the underserved in response to the epidemic's impact on minority and hard-to-reach populations, and those who are uniquely vulnerable to HIV infection due to social, economic, cultural, or structural barriers.
10. Engage with and ensure that people living with and at risk for HIV as well as consumers of prevention and care services have a central voice, clear understanding, and full involvement throughout the process.

## THE PROBLEM STATEMENT: OVERARCHING COMMUNITY CONCERNS IN THE HOUSTON AREA

Over a six-month period, from September 2011 to February 2012, 71 individuals, including representatives of 56 agencies and groups, people living with and at risk for HIV/AIDS, and other concerned community members convened at least monthly to discuss the essential elements of an ideal system of HIV prevention and care services for the Houston Area. Throughout the process, they also identified a series of trends – *in the field, in the epidemic, and in the community-at-large* – that are influencing the current HIV system and that must be addressed if progress toward an ideal system is to be made. Together, these trends describe the most pressing concerns facing the Houston Area HIV prevention and care community today. In other words, they are the "problem statement" that the goals, solutions, and activities contained in the remainder of this plan will ultimately seek to solve.

"A series of trends – *in the field, in the epidemic, and in the community-at-large* – are influencing the current HIV system and must be addressed if progress toward an ideal system is to be made."

- **Dedicated HIV funding in the Houston Area has not kept pace with need.** Federal funding for HIV has increased significantly over the course of the epidemic.[1] However, many local jurisdictions have seen funding decline or remain level over time due to the application of formula-based allocations.[2] As business costs rise, level funding can translate into fewer dollars for direct services. In the Houston Area, Ryan White HIV/AIDS Program funding for HIV care services increased slightly in the most recent funding cycle (by less than 2 percent), but the amount of the increase did not make up for several prior years of reductions, and funding for the current Fiscal Year remains less than it was only two years ago.[3] Despite this, the number of people living with HIV/AIDS continues to grow, both nationally and locally.[4] The number of people who are HIV positive in the U.S. is now at nearly 1.2 million;[4] in the Houston Area, it is over 20,000 with over 1,000 new HIV infections diagnosed each year through public and private efforts.[5] This places the Houston Area 12th highest in the nation for rate of AIDS diagnoses[6] and 1st in the state of Texas for number of people living with the disease.[7] Due to the National HIV/AIDS Strategy and its focus on the 12 cities with the highest cumulative AIDS cases, the Houston Area has received incremental increases in funding for HIV prevention activities. However, as demonstrated by the rate of new diagnoses, these increases fail to keep pace with need.[8]

- **Certain populations and communities continue to bear the greatest burden of disease.** Not every person or group has an equal chance of becoming infected with HIV.[9] Nationally, certain groups are at the highest risk and bear a disproportionate burden of the disease: Men Who Have Sex with Men (MSM), African Americans, Hispanics, and substance abusers, particularly those who inject drugs (IDU).[9] In the Houston Area, trends are comparable: 44 percent of new HIV infections and 43 percent of all people living with HIV/AIDS are MSM.[5] African Americans also have the highest rate of new HIV infections (65 per 100,000, or seven times the rate among whites) and of people living with HIV/AIDS (1,078 per 100,000, four times the rate among whites).[5] Certain Houston Area communities are also more impacted than others. The neighborhoods of Sunnyside/South Park, Greater Fifth Ward, Acres Homes, Sharpstown/Southwest, and Montrose have the highest rates of HIV and other STDs in the city.[10] It is also often the case that HIV affects the most disenfranchised individuals, i.e., those who have less access to services or are facing other

social problems.[9] This is true in the Houston Area as well: 28 percent of people living with HIV/AIDS (PLWHA) report unstable housing, and 35 percent are unemployed.[11] There are also other populations that may not show the greatest burden of disease (and/or there is insufficient data to determine burden) but whose unique circumstances make them particularly vulnerable to HIV. Those who are homeless, incarcerated or recently released from the criminal justice system, and transgender individuals may not yet have the highest HIV incidence or prevalence in the Houston Area, but may be at high-risk for HIV infection and for being out of HIV medical care if there were sufficient data to analyze.[11]

- **Stigma, bias, and discrimination against people with HIV persist.** Though over 30 years have passed since HIV was first brought to the public's attention, it continues to be highly stigmatized.[9] PLWHA can still face insensitivity, differential treatment, outright refusal of services, and even hostile environments or harassment because of their HIV status. Fear of discrimination keeps many people from learning their HIV status, disclosing their status, or seeking HIV medical care.[9] Many of the population groups that are most impacted by HIV may also experience bias based on other factors, such as race/ethnicity, sexual orientation, gender identity, or economic or legal circumstance. It is also well documented that the U.S. health care system as a whole continues to harbor inequities based on culture and language.[12] In the Houston Area, several large-scale efforts have been undertaken to reduce the stigma around HIV and facilitate a supportive environment for people who are HIV positive.[13] Despite this, almost 20 percent of PLWHA in the Houston Area still report having no source of social support for living with the disease.[11]

- **Continuous HIV care has proven health benefits, yet close to one-third of PLWHA in the Houston Area are out-of-care.** Advances in the treatment of HIV, namely antiretroviral therapy (ART), have vastly extended the length and quality of life for people living with HIV/AIDS. Today, most HIV-positive individuals receiving combination ART can achieve an undetectable level of HIV RNA,[14] which is strongly associated with better health status and reduced mortality.[15] New research is now showing that a consistently suppressed viral load is also associated with a lower chance of transmitting HIV to sex partners.[15] Sustained engagement in HIV care is essential to all of these outcomes.[14] In the Houston Area, being in HIV care has had clear benefits for persons living with HIV/AIDS. Currently, over 90 percent of PLWHA in care through the Ryan White HIV/AIDS Program decreased or maintained their viral load.[16] For over half of all clients (57 percent), their viral load is currently undetectable, and this percentage has been increasing.[17] Despite these outcomes, there are many HIV-positive individuals, both locally and nationally, who are not in care. In the Houston Area, it is estimated that 30 percent of people with an HIV or AIDS diagnosis are currently out of care,[18] and 25 percent of all PLWHA have been out-of-care at some point during their diagnosis.[11] Moreover, only 65 percent of individuals enter care within three months of their diagnosis,[19] thereby delaying treatment.

- **There is more to be done to integrate HIV prevention and care as well as HIV and other STDs.** New research about the impact of ART on suppressed viral load and prevention of secondary transmission has further solidified the connection between HIV prevention and HIV care. Actively facilitating newly-diagnosed individuals into care has become a prevention priority;[13] and the early identification of people with HIV/AIDS through testing and disease investigation has become a priority for the Ryan White HIV/AIDS Program as well.[20] Despite such recognitions that HIV prevention and HIV care are intricately connected, the vast majority of HIV prevention and HIV care planning, programming, service delivery, and data collection in the Houston Area continues to occur separately. Moreover, many HIV

efforts continue to operate separately from those that address other STDs, including Hepatitis B and C that either increase the probability of HIV infection or impact the efficacy of HIV care.[21] Fully integrated messaging, interventions, screening, investigation, and treatment for all STDs remain a long-term goal.

- **Syndemic public health problems (such as substance abuse and mental health concerns) are impacting the Houston Area PLWHA population.** The term "syndemic" refers to the phenomenon of linked epidemics, or when two or more diseases or other health problems occur simultaneously in a population leading to an additional burden of each condition.[22] Syndemics are often referred to as co-occurring epidemics or co-morbidities.[22] Research has shown a consistently syndemic relationship occurring between substance abuse, intimate partner violence, poor mental health, and HIV infection, particularly among specific vulnerable populations.[22] Therefore, as each of these conditions occurs in a population, the other conditions follow, and all are magnified. Data for the Houston Area suggest that syndemic public health problems such as these may be occurring in the local PLWHA population. For example, 36 percent of people living with HIV/AIDS in the Houston Area report an indication of alcohol abuse; 25 percent report an indication of drug abuse; and 63 percent report at least one mental health concern.[11] The impact of these co-morbidities on HIV can be significant; not only might they contribute to increased transmission risk, but they can also impede access to and retention in care.

- **The public *and providers* must be re-engaged in the HIV mission.** The public's sense of urgency around HIV has been on the decline for decades, and they are hearing about HIV less and less.[23] In the Houston Area, a recent survey of over 2,000 young adults attending a mass HIV event showed that only about half (56 percent) believe HIV is a "major health issue."[24] Lack of exposure to HIV information can have serious health implications. A recent national opinion poll revealed that one in three Americans does not know the facts about how HIV is transmitted.[23] The National HIV/AIDS Strategy aims to reinvigorate the public's response to HIV by providing concise and strategic direction for preventing new infections and ensuring access to care, but its success is *predicated* on all individuals having a common baseline of awareness about HIV.[9] Providers play a critical role in this as well. AIDS-service organizations alone have never been able to reach all people who are in need, and, nationally, there are indications of an impending shortage in HIV providers.[9] Fewer providers able to address HIV could lead to an even wider gap in public awareness. In the Houston Area, there have also been reports that many PLWHA are unaware of the resources available to them for their HIV care.

- **The HIV system must ready itself for health care reform.** The *Patient Protection and Affordable Care Act of 2010* will restructure the way that many individuals access health care services in the U.S., including those at risk for or infected with HIV.[25] Experts predict that thousands of currently uninsured people at risk for or living with HIV will become newly covered under Medicaid; however, debate continues about what HIV-related services and medications, if any, will become part of the Essential Health Benefits package for public and private health insurance.[26] Though there is general agreement that publicly-funded HIV programs will remain an integral component of this new system, it is unclear what the exact role of these programs and of the Ryan White HIV/AIDS Program in particular will be in 2014 if health care reform is fully implemented.[26] For now, the AIDS-service community must continue to gain understanding of – and prepare itself for – this new health care system landscape.

## CROSS CUTTING SOLUTIONS: BEST PRACTICES FOR THE HOUSTON AREA

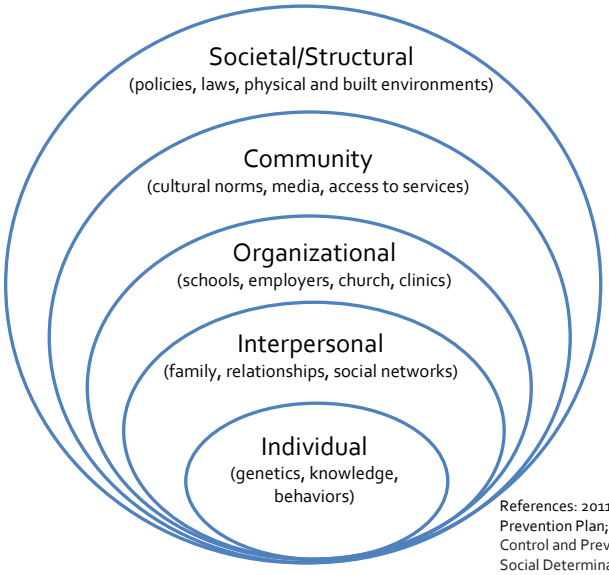
As trends in the HIV field, epidemic, and community-at-large were being identified and discussed during Houston Area comprehensive planning meetings, so were potential *solutions*. During the five-month planning period, over thirty working meetings were held; inventories of local, regional, state, national, and even global "best practices" for HIV prevention and care were reviewed as were over 100 other data sources. Whether the discussion turned to preventing new infections, reaching the out-of-care, addressing co-occurring conditions, or meeting the needs of vulnerable populations, a series of common approaches began to emerge. At the end of the process, 10 overarching solutions cut across the discussion and the data. Together, they represent the local "best practices" for HIV prevention and care for the Houston Area.

"At the end of the process, 10 overarching solutions cut across the discussion and the data. Together, they represent the local *best practices* for HIV prevention and care for the Houston Area."

- **High-impact structural interventions, such as policy, systems, and environmental change**

  It is now widely understood that the factors that influence risk for and protection from disease are not limited to individual characteristics such as genetics or behavior.[27] Instead, determinants of health occur at the interpersonal, organizational, community, and even societal levels as well. [27] This approach to health is also commonly referred to as the socio-ecological framework (Figure 1); and its application often results in a continuum of activities that addresses all levels of risk and protective factors. The use of this model has also lead to the recognition that societal-level interventions have the potential to improve the health of entire populations while also changing individual behavior.[27] Societal-level interventions are also known as structural interventions and include policy, systems, and environmental change. Structural interventions have become a promising new direction for HIV prevention and care.[28, 29]

  Figure 1: The Socio-Ecological Framework

  References: 2011 Texas HIV/STD Prevention Plan; and Centers for Disease Control and Prevention, White Paper on Social Determinants of Health, 2010

  In the Houston Area, efforts are underway to change public policies that inhibit access to HIV information or tools (e.g., condoms or syringes) and to improve transportation, housing, and other social and economic conditions that can serve as barriers to HIV prevention and access to care. Intervening at the structural level ultimately benefits all people at risk for or living with HIV.

- **Changing community norms around HIV through education at both the individual and population levels**

  Community norms are the prevailing group attitudes of what is acceptable and unacceptable in terms of behavior.[30] In general, the extent to which a behavior is perceived as the "norm" is positively correlated with the likelihood of an individual adopting it. Therefore, changing community norms can have a direct and powerful impact on health. To change norms, factual information about the issue must be widespread, and misinformation must be corrected.[30] Unfortunately, many community norms around HIV do not yet support healthy behaviors such as risk reduction, regular HIV testing, and continuous HIV care. In fact, the National HIV/AIDS Strategy is *predicated* on all Americans gaining a common baseline of factual information about HIV.[9]

  The Houston Area has a long history of effective activities to influence HIV community norms. Houston's annual mass testing event, *HIP HOP for HIV Awareness*, helps make HIV testing more acceptable among youth, and many of Houston's health education and risk reduction interventions train community leaders to influence the attitudes of their peers toward HIV. Plans are also underway to scale-up population-level activities (e.g., social marketing) that change perceptions of HIV community-wide. Efforts are still needed, however, to make early entry into and retention in HIV care a widespread community norm among the Houston Area's PLWHA population.

- **HIV testing and increasing awareness of HIV status**

  Central to reducing new HIV infections and creating unfettered access to HIV care is individuals knowing their HIV status. The CDC estimates that 20 percent of HIV infected individuals in the U.S. are unaware of their infection[31] and may be unknowingly transmitting HIV to others.[32] Those unaware of their status account for a higher proportion of HIV transmission than those who are aware.[33] Studies also show that individuals will take steps to prevent transmission when they know they have HIV. [9] Furthermore, only when individuals know their status can they begin to access HIV care. A negative HIV test is also an opportunity for health education. For these reasons, the CDC recommends that HIV testing be routinely performed for all patients aged 13 to 64 in all healthcare settings and that people at increased risk for HIV be tested at least annually.[32]

  The Houston Area places a high priority on widespread access to HIV testing in both targeted and routine settings, using all available technologies. The Expanded Testing Initiative (ETI) supports routine opt-out HIV screening at local emergency rooms; and community-based organizations provide targeted counseling and testing to those at high risk. Of all publicly-funded HIV tests offered in the Houston Area in 2010, 1.2 percent were positive, which translates into almost 600 HIV+ individuals who became aware of their status in that year alone.[34]

- **Application of the engagement in care continuum, including linkage to care, retention in care, and finding and engaging the out-of-care**

  As noted above, continuous HIV care has significant benefits, yet a less than optimal proportion of HIV+ individuals is in continuous care for HIV. In 2011, two national estimates were released of the number and percentage of Americans infected, diagnosed, and participating in HIV care.[14, 15] Both studies were based on a model of the HIV care continuum that outlines the spectrum of HIV care engagement, from being undiagnosed and not in care to having entered and remained in care without interruption (Figure 2, a). The less than optimal estimates of individuals at the fully engaged end of the spectrum have

Figure 2 (a): The Engagement in Care Continuum

Reference: Gardner, E., et al, The Spectrum of Engagement in HIV Care and Its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection, Clinical Infectious Diseases, 2011, 52(6): 793-800.

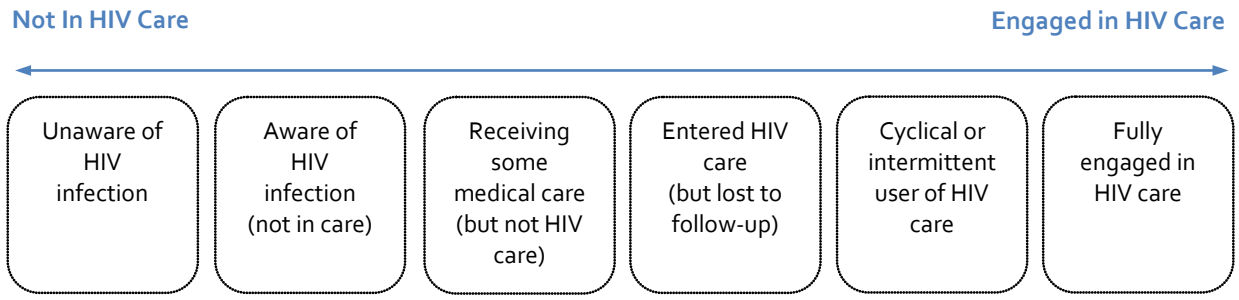
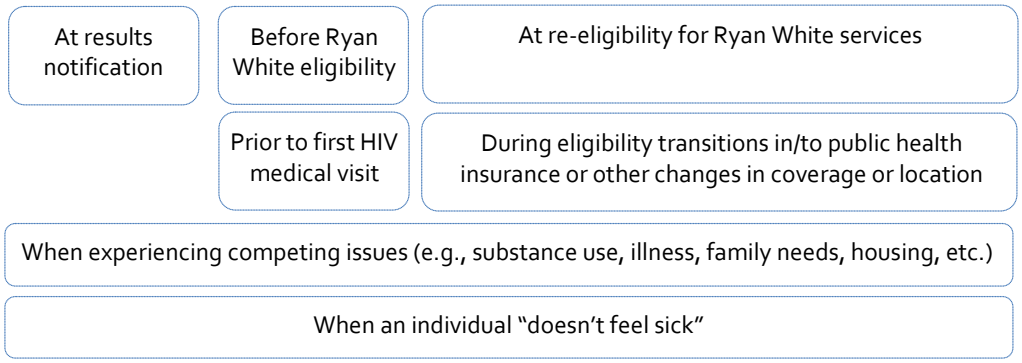



Figure 2 (b): Vulnerable Places for Falling Out-Of-Care




brought renewed attention to the application of the model and to identifying the best ways to retain clients in care. Nationally, HRSA now requires all jurisdictions funded for HIV care services to implement a strategy to refer the newly-diagnosed into care (EIIHA) and, in 2011, launched their first retention in care campaign (in+care).

The Houston Area has been at the forefront of retention efforts as well. Not only are the services proven to improve retention (e.g., case management, mental health services, transportation, etc.)[14] prioritized in the HIV care funding allocations process, but a unique local service definition for linking the newly-diagnosed into care (e.g., Service Linkage Workers) was also created in 2008. Future application of linkage activities will explore vulnerable places in the care continuum (Figure 2, b).

- **Treatment adherence and Prevention with Positives**

  A key outcome of continuous HIV care is the opportunity for viral load suppression via antiretroviral therapy (ART). Research shows that a consistently suppressed viral load not only reduces the risk for opportunistic infection but also for clinical progression from HIV to AIDS.[35] As the efficacy of ART has improved, most HIV+ individuals receiving ART can reach undetectable virology at lower levels of adherence.[14] Accordingly, ART for eligible clients is a national guideline for HIV clinical care,[36] a required core performance measure for all Ryan White HIV/AIDS Programs,[37] and a local standard of care for the Houston Area. In fact, pharmacy assistance is second only to primary care as the highest priority for funding allocations for HIV care in the Houston Area. In 2011, the potential health benefits of ART and suppressed viral load gained even more attention. Named the scientific breakthrough of the year, [38] the HPTN 052 study confirmed the correlation between viral load suppression via ART and a reduction in HIV transmission at a population-level. Additional studies on the use

of ART to prevent HIV infections were released in 2010-2011 as well.[39] Moreover, communities with lower *average* viral loads have been shown to have fewer new HIV infections as well.[9] As the practical implications of this new research continue to be explored, strategies to prevent secondary transmission with HIV+ individuals or "prevention with positives" remain important prevention tools.

Houston Area practitioners are exploring the range of new opportunities to convey prevention messages to HIV+ individuals, including the role of ART.

- **Tailored interventions**

  As noted above, certain populations continue to bear the greatest burden of HIV disease, both nationally and locally. Not only does this mean that certain populations are in the greatest need of HIV prevention and care services, but also that HIV prevention and care services tailored to these populations can have greater success in preventing new infections and increasing access to care than those focused on the *general* population. The guidance is clear that population segmentation and subsequent targeting of interventions is necessary to make progress toward national goals.[4, 9] Moreover, because HIV has been concentrated in historically underserved populations, focusing resources on the most affected groups can also help reduce health disparities and improve healthy equity.[9] This is especially true when services are culturally and linguistically tailored.

  Tailoring of HIV interventions is occurring in both HIV prevention and HIV care in the Houston Area. The majority of evidence-based interventions (EBIs) approved for replication locally are designed to motivate a specific audience or target population to change behavior.[40] Local task forces have been formed to mobilize specific high-risk groups around HIV.[13] HRSA has designated certain funding streams for HIV care services targeting racial/ethnic minority groups (the Minority AIDS Initiative) as well as women, infants, children, and youth (Part D). Several additional Houston Area initiatives are targeting communities based on other defining characteristics such as zip code (The SAFER Initiative) or incarceration status (Part C). Some local agencies are even piloting tailored service-delivery models (e.g., mobile services, after-hours clinics, "fast-tracking" HIV appointments, etc.).

- **Advancing the HIV medical home**

  Though HIV medical care has improved dramatically since the epidemic began, it has also become increasingly complex. New combinations of ART, the growth in co-occurring conditions such as substance abuse and mental illness, and the aging of the HIV+ population have all broadened the needs of HIV patients into the full range of medical, behavioral, and psychosocial services.[36] Integrated service-delivery in which primary and specialty care as well as psychological and social support services are coordinated by the HIV primary care team has proven to be an effective model in light of these increasingly complex needs.[41] This type of service-delivery model is also commonly referred to as a "medical home."[41] The Ryan White HIV/AIDS Program has ascribed to this model since the early 1990s.[41] In fact, HRSA-funded HIV care providers are required to demonstrate client outcomes beyond HIV, including oral health, STD co-infection, substance abuse and mental illness, wellness, and chronic conditions.[37] Measures for all of the above have been incorporated into the Houston Area Standards of Care and funded accordingly. This holistic approach to HIV helps to ensure that all co-occurring health needs of HIV infected clients are met, which is particularly critical as those living with HIV experience age-related health concerns. This approach also has the potential to improve HIV care retention rates by preventing patients from falling out-

of-care due to other health concerns.[41] With the advent of health care reform, the medical home model for HIV may expand even further.

The Houston Area AIDS-service community can be impactful in ensuring that Federally-Qualified Health Centers (FQHCs) and FQHC "look-alikes" have the capacity to serve as HIV medical homes; and that all HIV care providers, particularly in the rural areas, have the capacity to adopt the model as well.

- **Health information technology and new media**

  It is difficult to summarize the full extent to which technology has changed since the last Houston Area Comprehensive Plan was developed, much less since the beginning of the HIV epidemic.[42] Mobile devices and new media have altered day-to-day life for the majority of Americans including how they access health information. Today, 59 percent of all U.S. adults go online for health information; and 15 percent use their mobile devices for health information.[43] The ways in which health information is conveyed have also expanded. Today's new media includes all forms of internet-based communication, including websites, email, text messaging, social networks, RSS feeds, blogs, wikis, mobile apps, geolocation, cloud computing, and more.[44] The HIV field has made considerable use of new media for some time: GPS-enabled websites direct users to real-time HIV testing locations, virtual HIV town halls are held via Facebook, national HIV campaigns rely on video and photosharing, and the Office of National AIDS Policy blogs to advance the National HIV/AIDS Strategy.[42] National conferences are now held to discuss how individuals use new media to engage in HIV-related risk behaviors.

  In addition to consumer-driven technologies, health information technology in the healthcare setting has also grown. Electronic Medical Records (EMR) and Electronic Laboratory Reporting (ELR) are increasing at the facility-level, and interfaces within disease surveillance systems and between client-level enterprise databases are becoming more common.

  The Houston Area has been on the forefront of data integration. The Centralized Patient Care Data Management System (or CPCDMS) for Ryan White HIV/AIDS Program providers has been in place since 1999. Soon, client-level data collected via HIV prevention contractors will interface with CPCDMS as well. Despite this, there is more the Houston Area can do to capitalize on technology for both HIV prevention and care.

- **Unification of stakeholders and non-traditional partners**

  The application of the socio-ecological framework extends beyond improving our understanding of what places people at risk for disease. When the framework is fully applied, it also sheds light on the full range of sectors, fields, and organizations that influence health outcomes; sectors such as education, housing, transportation, agriculture, and environment become important health allies.[27] This is true in terms of HIV as well. In fact, as its fourth and final goal, the National HIV/AIDS Strategy calls for increased coordination of effort in responding to HIV across all Federal agencies, all levels of government, with external partners, and throughout the health care system.[9]

  In the Houston Area, collaboration between all levels and types of AIDS-service organizations has long been codified through contracts, data sharing, community planning, and community-wide events. Allied agencies such as Medicaid and Housing Opportunities for People with AIDS (HOPWA) have dedicated seats on the Ryan White Planning Council; and both Planning Bodies encourage *non*-AIDS-service organizations to participate. However, as the needs of people at risk for and living with HIV evolve, as our understanding

of what can influence HIV infection and access to care grows, *and* as the universe of potential HIV providers diversifies, engaging even more non-traditional partners becomes an important "best practice" for the Houston Area.

- Application of national, state, and regional initiatives and plans
  Significant, long-term investments of data analysis, planning, and community participation went into the development of the National HIV/AIDS Strategy, its local acceleration initiatives, ECHPP and EIIHA, and other newly-released national, state, and regional initiatives and plans. As a result, they represent the "gold standard" of the current science and practice for HIV prevention and care, both nationally and locally. As the Houston Area moves forward to reduce new HIV infections and create unfettered access to HIV care, these other regional, state, and national initiatives and plans will be important resources for the ongoing identification of solutions, interventions, and activities for the Houston Area.

## GOALS

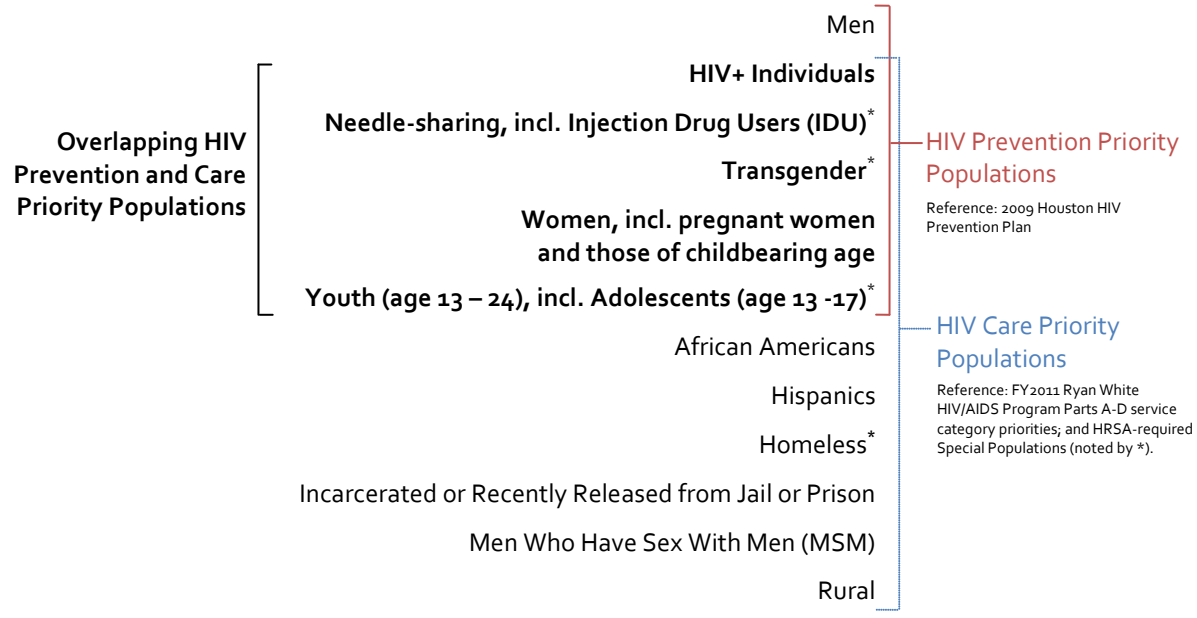
To make progress toward our vision of an ideal system of HIV prevention and care for the Houston Area, we must:

1. Mobilize the Greater Houston Area Community Around HIV
2. Prevent New HIV Infections Through Both Prevention and Treatment Strategies
3. Ensure that All People Living With or At Risk for HIV Have Access to Early and Continuous HIV Prevention and Care Services
4. Reduce the Effect of Co-Occurring Conditions that Hinder HIV Prevention Behaviors and Adherence to Care
5. Reduce Disparities in the Houston Area HIV Epidemic and Address the Needs of Vulnerable Populations
6. Achieve a More Coordinated and Expansive HIV System that is Prepared for Health Care System Changes

## PRIORITY POPULATIONS

As discussed above, HIV infection continues to occur disproportionately in certain population groups and geographic communities. As a result, HIV prevention and care services are needed most *by* certain populations and communities. Though a comprehensive plan for HIV prevention and care for a jurisdiction is intended to describe an entire HIV system for all residents, it must also respond to where the epidemic is actually occurring and take steps to ensure that the HIV prevention and care services needs of those who are impacted most will be met; in other words, it must identify *priorities* for the entire system. Figure 3 shows the priority populations for HIV prevention and care services for the Houston Area for the next three years. The intent of this list is that, as the goals, solutions, activities, and efforts outlined in this document are implemented, these populations will be their highest priority.

Figure 3: Priority Populations for the 2012 Houston Area HIV Prevention and Care Services Plan



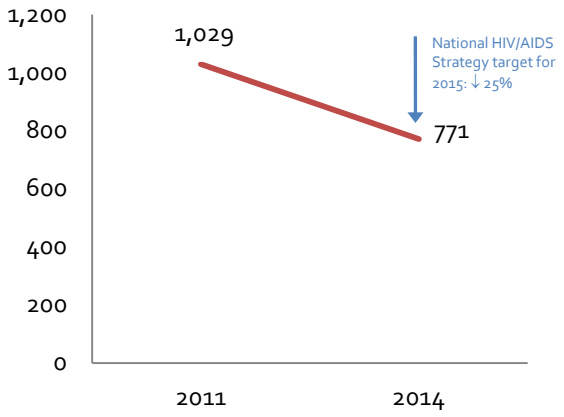
*There is a caveat*….in some cases, the populations and communities in greatest need of HIV prevention and those in need of HIV care will differ as trends in risk, new infections, and persons living with the disease change over time. At the same time, those at risk for and those living with HIV in the Houston Area more often than not share the same demographic and geographic characteristics and also have common service needs. In light of this, the priority populations list below allows for all three distinctions to be made: (1) priority populations for HIV prevention; (2) priority populations for HIV care; and (3) priority populations for *both* prevention and care. Furthermore, these distinctions have been based on the priority populations already identified by the year-round HIV prevention and care services planning work of the two local Planning Bodies. As a result, the priority populations list for the 2012 Comprehensive Plan is both integrated and distinct; it allows for current service-delivery to continue as well as for new service-delivery to have clear direction; and it is consistent with the year-round planning activities of the HIV community-at-large.

## OBJECTIVES

### By 2014, we hope to accomplish the following:

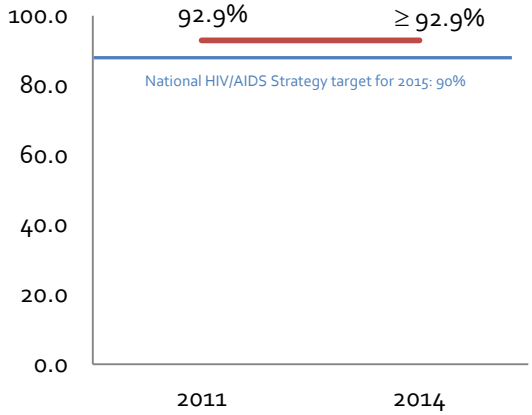
1. Reduce the number of new HIV infections diagnosed in the Houston Area by 25 percent (from 1,029 to 771).
2. Maintain and, if possible, increase the percentage of individuals with a positive HIV test result identified through *targeted* HIV testing who are informed of their HIV+ status (beginning at 92.9 percent with the goal of 100 percent).
3. Increase the proportion of newly-diagnosed individuals linked to clinical HIV care within three months of their HIV diagnosis to 85 percent (from 65.1 percent).
4. Reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year by 25 percent (from 36.0 percent to 27.0 percent).
5. Increase the percentage of Ryan White HIV/AIDS Program clients who are in continuous HIV care (at least two visits for HIV medical care in 12 months at least three months apart) to 80 percent (from 78.0 percent).
6. Reduce the proportion of individuals who have tested positive for HIV but who are not in HIV care by 0.8 percent each year (beginning at 30.1 percent) as determined by the Ryan White HIV/AIDS Program Unmet Need Framework.
7. Increase the proportion of Ryan White HIV/AIDS Program clients with undetectable viral load by 10 percent (from 57.0 percent to 62.7 percent).
8. Reduce the number of reports of barriers by People Living with HIV/AIDS to accessing Ryan White HIV/AIDS Program-funded Mental Health Services and Substance Abuse Services by 27.3 percent and 43.7 percent, respectively (from 117 reports to 85 reports for Mental Health Services; and from 58 reports to 32 reports for Substance Abuse Services).

## Number of New HIV Infections Diagnosed in the Houston Area



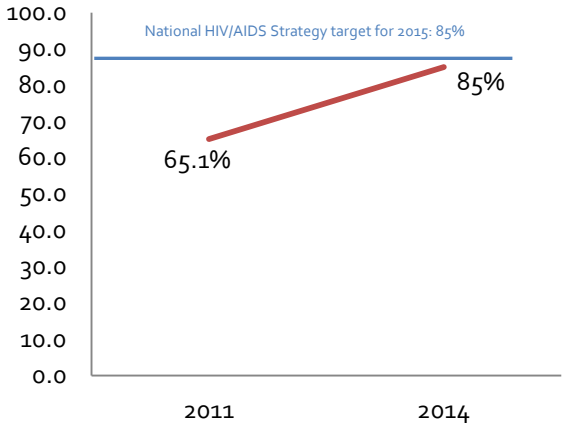

Data source: Texas Department of State Health Services eHARS
Reported in: 2011 Integrated Epidemiological Profile for HIV/AIDS Prevention and Care Planning for the Houston HSDA and EMA (Released March 2011)
Baseline: New HIV infections, CY2008, HSDA
Target: Nationally-defined: By 2015, lower the annual number of new infections by 25% (National HIV/AIDS Strategy)

## Percentage of Individuals with a Positive HIV Test Result* Informed of Their HIV+ Status in the Houston Area



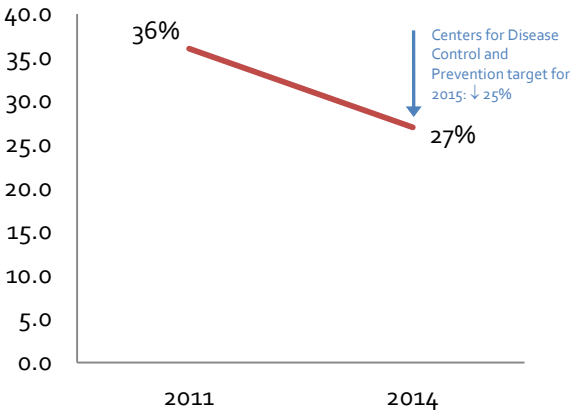

*When testing though targeted HIV testing only*
Data source: Texas Department of State Health Services
Reported in: HIV Testing & Awareness Data, Ryan White HIV/AIDS Program Part A FOA (Released September 2011)
Baseline: Percentage of individuals tested through targeted HIV testing who have a positive HIV test result and who were informed of their positive status, CY2010, EMA
Target: Locally-defined: baseline exceeds national target; aim is to maintain current percentage (92.9%) and, if possible, increase to 100%

## Proportion of Newly HIV Diagnosed Linked to Clinical Care within 3 Months in the Houston Area



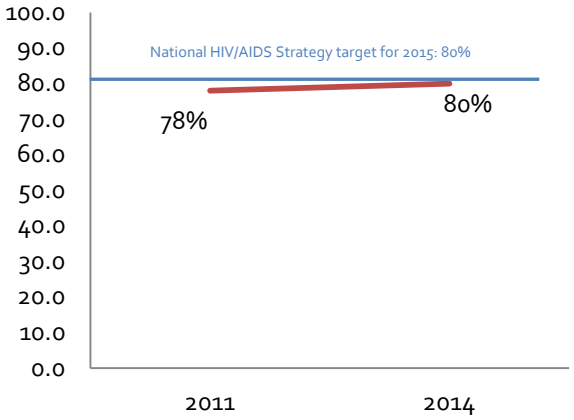

Data source: Texas Department of State Health Services
Reported in: Linkage to Care Estimates for 2010 Newly Diagnosed Individuals in Texas, EMA/TGA data (Released August 2011)
Baseline: Newly-diagnosed individuals linked to primary care or medical/clinical case management within three months of their HIV diagnosis, CY2010, EMA
Target: Nationally-defined: By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85% (National HIV/AIDS Strategy)

## Percentage of New HIV Diagnoses with an AIDS Diagnosis within 1 Year in the Houston Area



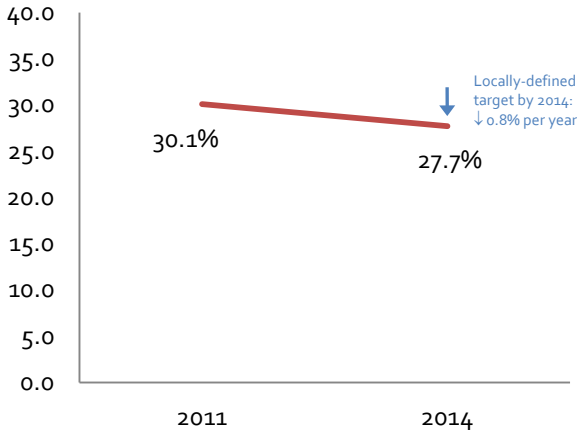

Data source: Texas Department of State Health Services
Reported in: 2010 Texas Integrated Epidemiologic Profile for HIV/AIDS Prevention and Services Planning (Released December 1, 2011)
Baseline: Percent of new HIV diagnoses with an AIDS diagnosis within one year, average of CY2003-CY2009, EMA
Target: Nationally-defined: By 2015, increase the percentage of people diagnosed with HIV infection at earlier stages of disease (not stage 3: AIDS) by 25% (Centers for Disease Control and Prevention)

Proportion of Ryan White HIV/AIDS Program Clients in Continuous Care in the Houston Area



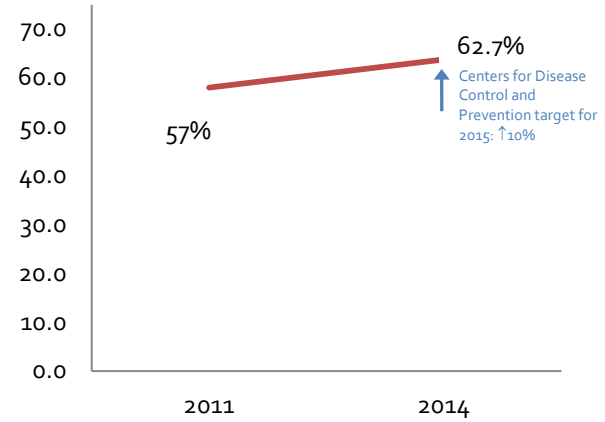

Data source: Centralized Patient Care Data Management System (CPCDMS)
Reported in: N/a (Generated January 2012)
Baseline: Percentage of Ryan White HIV/AIDS Program Part A clients with 2 or more medical visits in the time period at least 3 months apart and not newly enrolled in care, CY 2010 and 2011, EMA
Target: Nationally-defined: By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80% (National HIV/AIDS Strategy)

Proportion of Individuals Who Have Tested Positive for HIV but Are Not in HIV Care in the Houston Area



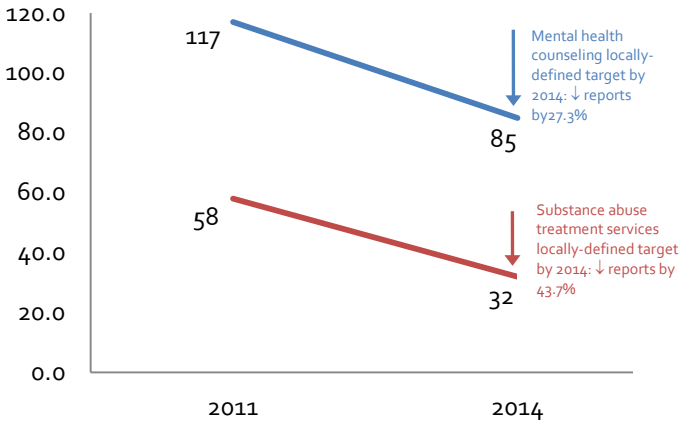

Data source: Texas Department of State Health Services
Reported in: Unmet Need Analysis through 2010 (Released September 2011)
Baseline: Percentage of people meeting HRSA out-of-care definition utilizing data from eHARS, ADAP, ELR, ARIES, Medicaid, private providers, and Houston VA, CY2010, EMA
Target: Locally-defined: average yearly reduction of 0.8% observed from CY2008- CY2010. Target reflects 0.8% reduction per year for CY2012-CY2041

Proportion of Ryan White HIV/AIDS Program Clients with Undetectable Viral Load in the Houston Area




Data source: Centralized Patient Care Data Management System (CPCDMS)
Reported in: N/a (Generated October 2011)
Baseline: Percentage of Ryan White HIV/AIDS Program Part A clients meeting laboratory guidelines for undetectable viral load (viral load of 50 or less) from 1/1/11 to 12/31/11, EMA
Target: Nationally-defined: By 2015, increase by 10% the percentage of HIV-diagnosed persons in care whose most recent viral load test in the past 12 months was undetectable (Centers for Disease Control and Prevention)

Reports of Barriers to Ryan White-funded Mental Health Counseling and Substance Abuse Treatment Services by PLWHA in the Houston Area




Data source: 2011 HIV/AIDS Needs Assessment
Reported in: 2011 HIV/AIDS Needs Assessment (Released February 2011)
Baseline: Number of reports of barriers by survey respondents (n=924) to "professional mental health counseling" and "outpatient alcohol or drug abuse treatment services," HSDA
Target: Locally-defined: percent change was observed between 2008 and 2011 needs assessment results for each measure.

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# Tam Kiehnhoff

*"Planning forces you to look beyond the 'whack a mole' approach to responding to problems by examining the entire system."*

Photograph by Barb Garvin

*Tam Kiehnhoff grew up in the Midwest in a politically progressive Catholic family.*

Her grandmother was a social worker in Chicago who wrote textbooks about her work and became Tam's first role model. Tam went to Catholic school where she was encouraged to become involved in the Civil Rights movement, and she remembers her class sending money to the Freedom Riders in Mississippi. She later attended Webster University in St. Louis, a liberal arts college where she studied psychology and English.

Tam met and married her husband, Tom while he attended law school in St. Louis and moved to his home state of Colorado where they lived for 15 years and had two sons. Later Tom took the position of Assistant U.S. Attorney and the family relocated to Beaumont, Texas. Not long after the move to Texas, Tam felt the need to find other like-minded people who shared her beliefs about social justice, so she started volunteering at the Triangle AIDS Network in Beaumont. Shortly thereafter, Triangle AIDS Network received funding from the Ryan White HIV/AIDS Program, and her volunteer position became the job of coordinating the case management program that she has held for the past 21 years.

Triangle AIDS Network (TAN) is the only HIV services provider in the "Golden Triangle" Beaumont/Port Arthur/Orange corner of Southeast Texas. Although the single point-of-entry system makes it easy for clients to access care at TAN, its smaller community also allows stigma

to remain a powerful force. Tam knows that some clients are afraid to seek services. "Some people," she says, "who might come to a larger agency in a city like Houston, may be afraid to come to an agency in Beaumont, because they might see someone who knows them."

As a leader in a major AIDS-service organization in the East Texas region, Tam has also been integrally involved in comprehensive HIV services planning for many years. She is a Co-Chair of the Leadership Team that oversaw the development of the Comprehensive HIV Prevention and Care Services Plan for 2012. When asked why she remains involved, she says, "planning forces you to look beyond the 'whack a mole' approach to responding to problems by examining the entire system."

Moving forward, Tam sees her activism expanding beyond HIV. She would like to see her son who has brain cancer have the same client-centered system as people living with HIV, and she is equally passionate about the opportunity of national health care reform to expand access to health care for all who need it, a vision that her grandmother would surely support.

TAM KIEHNHOFF

Medical Case Management Coordinator, Triangle AIDS Network

Co-Chair, Leadership Team, 2012 Houston Area Comprehensive HIV Prevention and Care Services Plan

# Section III: How Will We Get There?

The purpose of this section is to outline the specific strategies, solutions, and activities needed to achieve specified goals and meet identified challenges toward the development of an ideal system of HIV prevention and care in the Houston Area.

Section Contents

## Our Structure: *The Four Cornerstones*

### Filling Gaps in the Houston Area Continuum of Care for HIV Prevention and Care Services

A continuum of care is a visual representation of how a community is using or would like to use health resources in order to effectively meet community needs. The Houston Area Continuum of Care for HIV prevention and care services (Figure 1) represents how the Houston Area HIV community intends to use HIV prevention and care resources to meet the needs of individuals at risk for or living with HIV/AIDS. Designed as a "rail system," the Houston Area continuum contains five tracks each representing a stage in the progression of HIV disease – *from having no awareness of the disease to end-of-life* – and then provides examples of the HIV prevention and care services indicated at each stage in order to attain desired health outcomes:

- Track A is intended for the general public that may have no awareness of HIV. The goal of this track is to build public support for HIV through the provision of HIV information.
- Track B is intended for individuals at high-risk of HIV infection and includes outreach and HIV testing. The goal of this track is to make people aware of their HIV status.
- Track C is intended for HIV negative individuals and includes audience-specific behavioral interventions. The goal of this track is to help individuals maintain their negative HIV status.
- Track D is intended for individuals who are HIV positive and includes a variety of HIV care, treatment, and support services. The goal of this track is to help people living with HIV remain in care, maintain their health status, and prevent progression to AIDS.
- Tracks E and F are intended for HIV infected individuals who progress to AIDS. The goal of these tracks is to maintain quality of life and, as necessary, prepare for end-of-life care.

The Houston Area continuum is implemented by a combination of governmental and non-profit organizations that provide direct services and/or function as Administrative Agents that contract to direct service providers. Two local Planning Bodies provide the opportunity for extensive collaboration and consultation with the community on the effective implementation of the continuum. Year-round, these two Planning Bodies, alongside Administrative Agents, AIDS-service organizations (ASOs), and other stakeholders, conduct activities to ensure the continuum is implemented effectively. Every three years, when a new comprehensive jurisdictional HIV services plan is developed, there is the opportunity to identify how the continuum *itself* can be improved, how gaps can be filled, how needs can be better met as they have evolved and changed over time, and how progress can be made toward the community's vision of an ideal HIV system.

When the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) issued its guidance for comprehensive jurisdictional HIV services planning for 2012 – 2014, it included several areas for local jurisdictions to consider in regards to improving their continuum of care. At a minimum, jurisdictions were expected to:

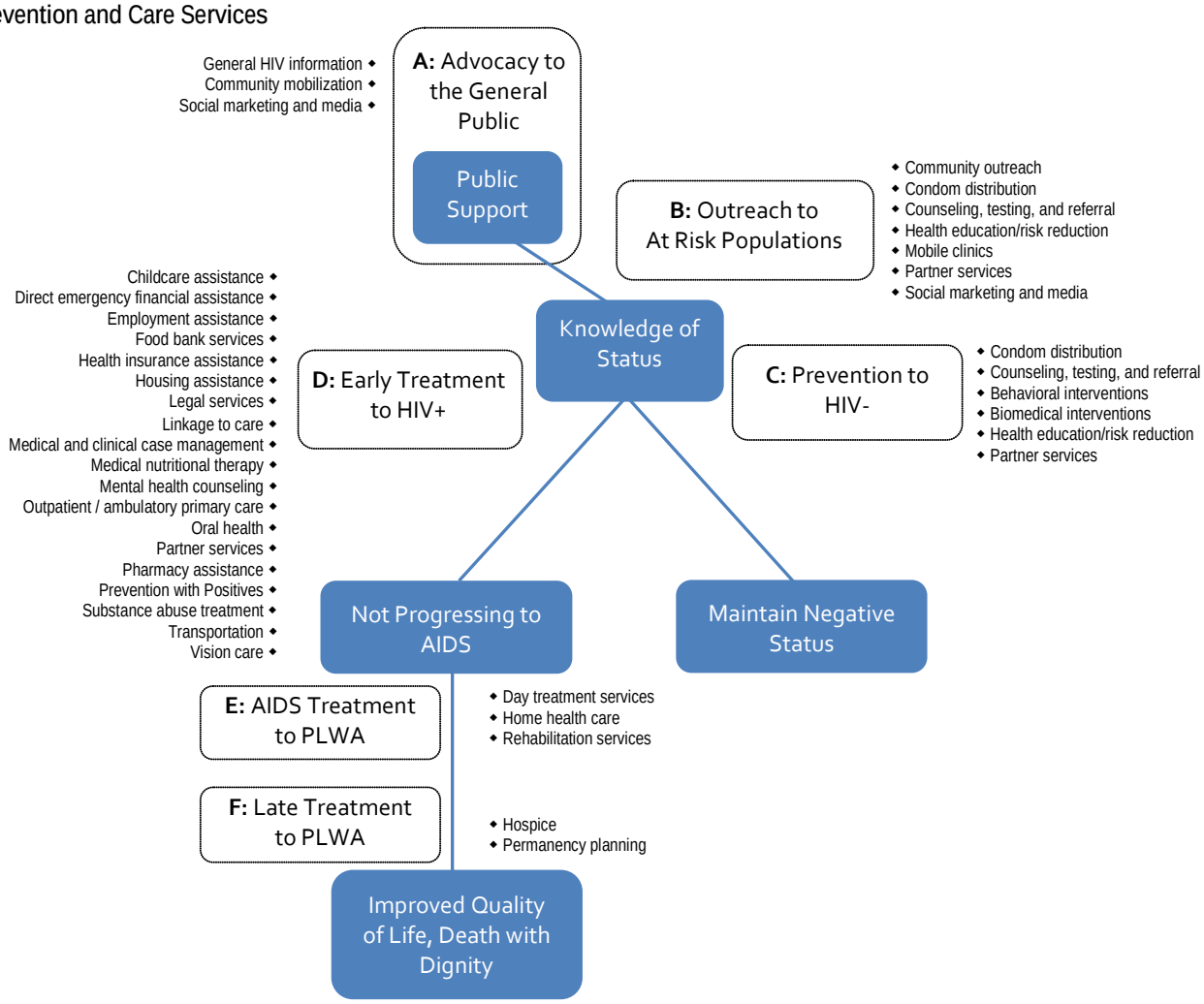
- Address the needs of individuals who are *unaware* of their HIV status;
- Address the needs of individuals *aware* of their HIV status, but not in care;
- Address the needs of special populations, including but not limited to, adolescents, injection drug users, homeless, and transgender; and
- Address the need to improve coordination *within* the Ryan White HIV/AIDS Program, *between* the AIDS-service community and other public and private health care providers, *between* HIV prevention and care, and in anticipation of changes that will occur with the implementation of the *Patient Protection and Affordable Care Act of 2010*.

The process used to develop the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 was a reflection of this guidance. Workgroups were formed in response to each of the four HRSA topics. They were then populated with HIV prevention and

care stakeholders, and each produced a written Strategy of goals, solutions, activities, responsible parties, timelines, and benchmarks specific to their topic. These four Strategies are:

1. Strategy for Prevention and Early Identification
2. Strategy to Fill Gaps in Care and Reach the Out-Of-Care
3. Strategy to Address the Needs of Special Populations
4. Strategy to Improve Coordination of Effort and Prepare for Health Care System Changes

Figure 2: Model of the Houston Area Continuum of Care for HIV Prevention and Care Services




Section II of this document describes where the Houston Area "needs to go" in terms of an ideal, high quality, comprehensive continuum of HIV prevention and care services; taken together, these four Strategies describe "how we will get there."

However, these four Strategies are not intended to, *nor could they*, be an exhaustive list of all activities needed to address HIV in the Houston Area. They do represent concise plans for each of the four topics. They include priorities and action steps tied to measurable outcomes for each topic; they can be utilized independently or as a group (activities that address more than one topic are included in multiple Strategies); and they have already been used to develop the long-range system-wide goals and objectives for the Houston Area outlined in Section II. They are *the four cornerstones* for how the Houston Area will improve and fill gaps throughout the continuum of care and, in so doing, accomplish its long-range goals.

## Key to Responsible Parties

### Houston Department of Health and Human Services

| | |
|---|---|
| Full agency name: | Houston Department of Health and Human Services (HDHHS), Bureau of HIV/STD and Viral Hepatitis Prevention |
| Funding source(s): | Centers for Disease Control and Prevention (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP); and Texas Department of State Health Services (DSHS) HIV/STD Prevention and Care Branch |
| Purpose of funding: | HIV prevention |
| Jurisdiction: | Houston Metropolitan Statistical Area (MSA). Harris County and the cities of Houston, Baytown, and Sugarland, TX |

### Ryan White Grant Administration

| | |
|---|---|
| Full agency name: | Harris County Public Health Services (HCPHS), Ryan White Grant Administration (RWGA) |
| Funding source(s): | Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Division of Service Systems (DSS) |
| Purpose of funding: | Administrative Agent for Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (MAI) |
| Jurisdiction: | Houston Eligible Metropolitan Area (EMA). Counties of Harris, Ft. Bend, Waller, Montgomery, Liberty, and Chambers |

### The Resource Group

| | |
|---|---|
| Full agency name: | The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) |
| Funding source(s): | Texas Department of State Health Services (DSHS) HIV/STD Prevention and Care Branch; and Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Division of Community-Based Programs (DCBP) |
| Purpose of funding: | Administrative Agent for Ryan White HIV/AIDS Program Part B, Part C, and Part D, State Services, and Housing Opportunities for People with AIDS (HOPWA) |
| Jurisdiction: | Houston Health Services Delivery Area (HSDA). Counties of Harris, Ft. Bend, Waller, Montgomery, Liberty, Chambers, Wharton, Colorado, Austin, and Walker |

### HIV Planning Group

The Houston HIV Planning Group (HPG, formerly the Community Planning Group or CPG) is a volunteer body of up to 35 members selected to represent the demographics of the Houston Area HIV epidemic. The HPG is responsible for prioritizing populations and interventions for Houston Area HIV prevention activities funded by the Centers for Disease Control and Prevention (CDC).

### Ryan White Planning Council

The Houston Area HIV Services Ryan White Planning Council (RWPC) is a 38-person body appointed by the Harris County Judge, who serves as the CEO for the Houston Area Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (MAI). The RWPC is responsible for prioritizing and allocating funds for HIV care services provided by Part A and MAI and for making recommendations for services provided by Part B and the Texas Department of State Health Services (DSHS).

### Ryan White Planning Council/Office of Support

The Ryan White Planning Council/Office of Support (RWPC/OS) supplies the administrative infrastructure for the Ryan White Planning Council. The RWPC/OS is funded through the Ryan White HIV/AIDS Program Part A, and the staff are employees of the Harris County Judge's Office.

# STRATEGY 1:
# STRATEGY FOR PREVENTION AND EARLY IDENTIFICATION

"After three decades of fighting HIV in the United States,
we now have more prevention tools with proven effectiveness than ever."
Centers for Disease Control and Prevention
August 2011

The Centers for Disease Control and Prevention (CDC) estimates that HIV prevention efforts have averted at least 350,000 new HIV infections in the United States alone since the beginning of the epidemic.[1] There is now a significant body of research on the effectiveness of HIV prevention strategies, including behavioral interventions, structural interventions, and, more recently, antiretroviral prophylaxis. [1] Despite these strides, approximately 50,000 Americans continue to become infected with HIV each year[1] (including, on average, approximately 870 Houstonians annually)[2] and, though this number appears to be stabilizing, the population living with HIV continues to grow.[1] Such conditions reinforce the importance of applying scientifically proven, cost-effective primary prevention strategies with the greatest probability of success in the populations and communities in greatest need.[3, 4] It also reinforces the need for scaled-up prevention efforts with those who are infected.[3,4] As more is also learned about the relationship between HIV treatment and secondary transmission, the more the early identification of HIV+ individuals and linkage to HIV care become a core prevention method as well. [3, 4]

The *Prevention and Early Identification Strategy* of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 outlines the goals, solutions, and activities that the Houston Area HIV community has identified to improve the continuum of care specific to preventing new HIV infections and linking the newly-diagnosed into care. It is intended to address the needs of individuals who are *unaware* of their HIV+ status, those newly-aware but not yet in care, those who are living with HIV and want to reduce their risk for transmitting the disease to others, and those who are HIV negative but at continued high risk for HIV infection.

REFERENCES


(1) Centers for Disease Control and Prevention, High-Impact HIV Prevention, CDC's Approach to Reducing HIV Infection in the United States, August 2011.

(2) Texas Department of State Health Services, HIV (non-AIDS) Prevalence, AIDS Prevalence and Three-Year AIDS Incidence, Houston EMA, Texas eHARS data as of July 2011, September 2011.

(3) U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, *Strategic Plan 2011 through 2015*. August 2011.

(4) U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. 2020 Topics and Objectives – HIV. Washington, DC. Available at http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=22. Accessed February 13, 2012.

**Goals**

1. Reduce New HIV Infections
2. Increase Awareness of HIV
3. Increase Awareness of HIV Status
4. Ensure Early Entry Into Care
5. Maximize Adherence to Antiretroviral Therapy
6. Address the HIV Prevention Needs of High Incidence Communities
7. Reduce Population Risk Factors for HIV Infection

**Solutions**

1. Adopt high-impact structural interventions such as governmental policy change and population-based efforts that normalize HIV risk reduction and help create unfettered access to HIV information and proven prevention tools
2. Expand opportunities for HIV testing for the general public and in high-incidence populations and communities
3. Increase the timeliness of the linkage to care system for newly-diagnosed HIV+ individuals
4. Intensify prevention with positives including treatment adherence, HIV prophylaxis, and behavior change interventions for HIV+ individuals and their partners
5. Expand the HIV prevention knowledge base to include behavioral surveillance and measures of community-wide HIV health

**Activities (Responsible Party, Timeline)**

1. Educate public officials on changing governmental policies that create barriers to HIV prevention information and tools (e.g., repeal the ban on syringe access, adopt comprehensive sexuality education in schools, etc.) (Houston Department of Health and Human Services; 2012-2014)
2. Sustain condom distribution for: (a) the general public and (b) for high-risk populations and communities (Houston Department of Health and Human Services; 2012-2014)
3. Expand social marketing and other mass education activities focused on raising HIV awareness and increasing HIV testing (e.g., *HIP HOP for HIV Awareness*, Testing Makes Us Stronger, Greater Than AIDS, etc.) (Houston Department of Health and Human Services; 2012-2014)
4. Sustain *targeted* HIV testing by community-based organizations to high-risk populations (Houston Department of Health and Human Services; 2012-2014)
5. Expand *non-targeted* routine, opt-out HIV testing in facilities serving high-risk populations (Houston Department of Health and Human Services; 2012-2014)
6. Document and present outcomes of the Expanded Testing Initiative (ETI) to encourage other hospital systems, private medical providers, and Federally Qualified Health Centers (FQHCs) to begin routine HIV testing in their facilities; cost benefit analysis and leveraging public/private collaboration should be emphasized (Houston Department of Health and Human Services; 2012)
7. Intensify combination HIV prevention in high-risk communities (Houston Department of Health and Human Services; 2012-2014)
8. Implement training to Counseling, Testing, and Referral (CTR) providers on integrating HIV testing with testing for other (non-HIV) STDs and Viral Hepatitis (Houston Department of Health and Human Services; 2013)

**Activities (Responsible Party, Timeline) Con't**

9. Implement training to CTR providers about their role in encouraging entry into care beginning at post-test counseling/results notification; and establish linkage to care performance measures for CTR providers (Houston Department of Health and Human Services; 2012)
10. Implement training to Ryan White HIV/AIDS Program funded case managers on Partner Services (Houston Department of Health and Human Services; Ryan White Grant Administration; 2012)
11. Expand Disease Intervention Specialist (DIS) activities to include a readiness for HIV care assessment at the time of DIS interview as a means of assisting with linkage to care efforts (Houston Department of Health and Human Services; 2013)
12. Re-develop the Ryan White HIV/AIDS Program Service Category definition for Case Management (Non-Medical) (i.e., Service Linkage) during the *How to Best Meet the Need* process to improve linkage to care rates (Ryan White Planning Council; 2012)
13. Identify and disseminate a model protocol for a layperson system navigator program to assist newly-diagnosed HIV infected individuals to enter HIV care (Ryan White Planning Council/Office of Support; 2013)
14. Develop a toolkit for private medical doctors for how to link newly-diagnosed HIV infected individuals into the Ryan White HIV/AIDS Program (Ryan White Planning Council/Office of Support; 2013)
15. Expand the provision of Partner Services to HIV infected individuals (e.g. identification, notification, counseling and testing, and linkage to care for partners) (Houston Department of Health and Human Services; 2012-2014)
16. Sustain evidence-based behavioral interventions (EBIs)* for HIV infected individuals and their partners (Houston Department of Health and Human Services; 2012-2014) *Refer to the 2011 Texas HIV/STD Prevention Plan for a list of approved EBIs for use in the Houston Area.
17. Form a Scientific Advisory Council for the Houston Area that will use scientific expertise to advise on HIV prevention activities and research questions (Houston Department of Health and Human Services; 2012)
18. Support ongoing efforts of local HIV clinical trial networks (Ryan White Planning Council, HIV Planning Group; 2012-2014)
19. Develop community-wide guidelines for the use of Pre-exposure Prophylaxis (PrEP) and for Non-Occupational Post-Exposure Prophylaxis (nPEP) (Houston Department of Health and Human Services; 2013)
20. Launch a Ryan White HIV/AIDS Program clinical quality management initiative focused on retention in care (Ryan White Grant Administration/Clinical Quality Management Committee; The Resource Group; 2012)
21. Establish a mechanism for tracking medication adherence among Ryan White HIV/AIDS Program clients (Ryan White Grant Administration; 2012)
22. Establish a baseline for Houston Area community viral load of individuals in HIV care (Houston Department of Health and Human Services; 2014)

**Benchmarks**

1. Reduce the number of new HIV infections diagnosed in the Houston Area by 25 percent (from 1,029 to 771)
2. Maintain the number of HIV/STD brochures distributed at 86,389 annually
3. Maintain the mean number of calls per day to the local HIV prevention hotline at 6.2

**Benchmarks Con't**

4. Increase the number of persons reached each year with an HIV awareness message via the *HIP HOP for HIV Awareness* Radio One advertising campaign by 3.2 percent (from 1,231,400 to 1,353,438)
5. Maintain the percentage of individuals at *HIP HOP for HIV Awareness* that agree "HIV/AIDS is a major health problem for my peers" at 55.9 percent
6. Maintain the mean score on the *HIP HOP for HIV Awareness* individual HIV/STD knowledge test at 10.9 correct answers (out of 14)
7. Maintain the number of publicly-funded HIV tests at 165,076 annually
8. Increase the positivity rate for *targeted* HIV testing to 2 percent (from 1.7 percent) to demonstrate maximization of HIV testing resources in high risk populations
9. Reduce the positivity rate for *non-targeted* routine, opt-out HIV testing to 1 percent (from 1.2 percent) to demonstrate maximized identification of new positives
10. Maintain and, if possible, increase the percentage of individuals with a positive HIV test result identified through *targeted* HIV testing who are informed of their HIV+ status (from 92.9 percent to the goal of 100 percent)
11. Reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year by 25 percent (from 36.0 percent to 27.0 percent)
12. Increase the proportion of newly-diagnosed individuals linked to clinical care within three months of their HIV diagnosis to 85 percent (from 65.1 percent)
13. Increase the proportion of Ryan White HIV/AIDS Program clients with undetectable viral load by 10 percent (from from 57.0 percent to 62.7 percent)
14. Reduce the number of new HIV infections in high HIV/STD morbidity zip codes targeted for intervention by 25 percent (from 33 to 24)
15. Reduce or maintain the rate of STD infection per 100,000 population (Chlamydia = Maintain at 510.0, Gonorrhea = Reduce by 0.6% annually to 146.0; Primary and Secondary Syphilis = Reduce to 6.0)
16. Maintain the number of condoms distributed at 380,000 annually
17. Maintain the number of high-risk individuals receiving information on HIV risk reduction through community outreach at 9,000 annually
18. Maintain the number of high-risk individuals that completes an evidence-based behavioral intervention to reduce risk for HIV at 3,288 annually

## STRATEGY 2:
## STRATEGY TO FILL GAPS IN CARE AND REACH THE OUT-OF-CARE

"Being linked to care is not enough.
It is estimated that as many as 30 percent of people diagnosed with HIV are not accessing care.
There is a need to re-engage people diagnosed with HIV who have never been in care
or who have subsequently fallen out of care."
National HIV/AIDS Strategy
July 2010

The benefit of early and continuous HIV medical care and treatment on length and quality of life for a person who is HIV+ cannot be underestimated. One national study showed that HIV care and treatment reduces HIV morbidity and mortality by as much as 80 percent.[1] Significant national public investments have been made in health care services for HIV in order to fully realize this potential.[2] The Houston Area is no exception. As described in Section I, the Houston Area maintains an extensive infrastructure of HIV medical care and treatment services for people living with HIV/AIDS. There is no wait list for HIV medication assistance (via the Texas Drug Assistance Program), most agencies funded by the Ryan White HIV/AIDS Program also function as HIV medical homes, and special initiatives are in place to serve populations with unique access to care barriers, such as living in a rural area or being incarcerated. Despite this, and mirroring trends nationally, 30 percent of people with an HIV diagnosis in the Houston Area are not in HIV care;[3] and 25 percent of people living with HIV/AIDS report being without HIV care at some point since their diagnosis.[4] Such conditions reinforce the importance of identifying and fortifying specific places in the HIV care system where people are *more likely* to fall out of care…or to never begin care at all. It reinforces the need to equip HIV clients with the knowledge and tools they need to stay in care and be medication adherent; and it draws attention to the need for scaled-up efforts to locate and engage those who are not in care.

The *Strategy to Fill Gaps in Care and Reach the Out-of-Care* of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 outlines the goals, solutions, and activities that the Houston Area HIV community has identified to improve the continuum of care specific to core HIV medical and supportive services, including linkage to care, early entry into care, and retention in care. It is intended to address the needs of individuals who are *aware* of their HIV status but not yet in care, those who *are* in care but who may be vulnerable to falling out-of-care, those experiencing *gaps in care*, and those who have *been in care* and need to be re-engaged.

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(1) Gallant, J. E., Adimora, A.A., Carmichael, J.K., Horberg, M., Kitahata, M., Quinlivan E. B., Raper, J.L., Selwyn, P., and Williams, S.B., Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition, Clinical Infectious Diseases Advance Access Published October 20, 2011.
(2) The White House Office of National AIDS Policy, National HIV/AIDS Strategy for the United States, July 2010.
(3) Texas Department of State Health Services, Unmet Need Analysis Through 2010, Utilizing data from eHARS, ADAP, ELR, ARIES, Medicaid, private providers, and Houston VA, September 2011.
(4) 2011 Houston Area HIV/AIDS Needs Assessment, April 2011.

**Goals**

1. Reduce Unmet Need
2. Ensure Early Entry Into Care
3. Increase Retention in Continuous Care
4. Improve Health Outcomes for People Living with HIV/AIDS (PLWHA)

**Solutions**

1. Target linkage to care efforts to vulnerable points in the HIV system (e.g., at initial diagnosis, before the first medical visit, after the initial visit, etc.) where individuals are more likely to not seek care or to fall out of care, particularly *newly-diagnosed* PLWHA
2. Intensify retention and engagement activities with *currently in-care* PLWHA, focusing on community education, system enhancements, and health literacy
3. Adopt strategies to re-engage *out-of-care* PLWHA and other "prior positives" to return to care

**Activities (Responsible Party, Timeline)**

1. Implement training to Counseling, Testing, and Referral (CTR) providers about their role in encouraging entry into care beginning at post-test counseling/results notification; and establish linkage to care performance measures for CTR providers (Houston Department of Health and Human Services; 2012)
2. Expand Disease Intervention Specialist (DIS) activities to include a readiness for HIV care assessment at the time of DIS interview as a means of assisting with linkage to care efforts (Houston Department of Health and Human Services; 2013)
3. Re-develop the Ryan White HIV/AIDS Program Service Category definition for Case Management (Non-Medical) (i.e., Service Linkage) during the *How to Best Meet the Need* process to improve linkage to care rates (Ryan White Planning Council; 2012)
4. Identify and disseminate a model protocol for a layperson system navigator program to assist newly-diagnosed HIV infected individuals to enter and be retained in HIV care (Ryan White Planning Council/Office of Support; 2013)
5. Develop a toolkit for private medical doctors for how to link newly-diagnosed HIV infected individuals into the Ryan White HIV/AIDS Program (Ryan White Planning Council/Office of Support; 2013)
6. Launch a Ryan White HIV/AIDS Program clinical quality management initiative focused on retention in care (Ryan White Grant Administration Clinical Quality Management Committee; The Resource Group; 2012)
7. Integrate messaging on the importance of retention in care for health outcomes and secondary prevention into evidence-based behavioral interventions (EBIs) targeting HIV infected individuals and their partners (Houston Department of Health and Human Services; 2012-2014)
8. Add to the Ryan White HIV/AIDS Program Standards of Care that funded primary care providers will have in place a client reminder system that reflects client preferences (Ryan White Grant Administration, The Resource Group; 2013)

**Activities (Responsible Party, Timeline) Con't**

9. Expand health literacy programming for people living with and/or affected by HIV/AIDS with attention to the impact of the *Patient Protection and Affordable Care Act* (The Resource Group, Ryan White Planning Council/Office of Support Project LEAP; 2012-2014)
10. Re-asses Ryan White HIV/AIDS Program Service Category definitions during the *How to Best Meet the Need* process for ways to address the emotional/social support needs of PLWHA (Ryan White Planning Council; 2012)
11. Sustain required annual training for Ryan White HIV/AIDS Program funded case managers on effective client engagement (e.g., motivational interviewing, rapport development, assessment skills, etc.) (Ryan White Grant Administration, The Resource Group; 2012-2014)
12. Facilitate technical assistance and training to funded AIDS-service organizations in rural counties to aid in the transition into HIV medical homes using annual resource inventories (The Resource Group; 2012-2014)
13. Establish a mechanism for tracking medication adherence among Ryan White HIV/AIDS Program clients (Ryan White Grant Administration; 2012)
14. Launch a re-linkage to care project using data matching algorithms between client-level HIV surveillance (eHARS) and client-level HIV care databases (CPCDMS) (Houston Department of Health and Human Services; 2012-2014)
15. Re-assess the Ryan White HIV/AIDS Program Standards of Care for "lost to care" clients for the purpose of increasing the number of individuals returned to HIV care (Ryan White Grant Administration, The Resource Group; 2012)
16. Establish partnerships with existing community-wide outreach opportunities to locate PLWHA who are out-of-care particularly among Priority Populations, Special Populations, and other high-risk sub-populations (Ryan White Planning Council/Office of Support; 2012-2014)

**Benchmarks**

1. Reduce the proportion of individuals who have tested positive for HIV but who are not in care by 0.8 percent each year (using the Ryan White HIV/AIDS Program Unmet Need Framework) beginning at 30.1 percent
2. Reduce the percentage of PLWHA reporting being currently out-of-care (i.e., no evidence of HIV medications, viral load test, or CD4 test in 12 months) by 3.0 percent (from 7.1 percent to 4.1 percent)
3. Prevent the percentage of PLWHA reporting a prior history of being out-of-care from increasing above 26.0 percent
4. Increase the proportion of newly-diagnosed individuals linked to clinical care within three months of their HIV diagnosis to 85 percent (from 65.1 percent)
5. Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care to 80 percent (from 78.0 percent) (i.e., at least 2 visits for routine HIV medical care in 12 months at least 3 months apart)
6. Prevent the proportion of Ryan White HIV/AIDS Program clients who are retained in care from falling below 75.0 percent (i.e., at least 1 visit for HIV primary care in the 2$^{nd}$ half of the year after also having at least 1 visit for HIV primary care in the 1$^{st}$ half of the year)
7. Increase the proportion of Ryan White HIV/AIDS Program clients with undetectable viral load by 10 percent (from from 57.0 percent to 62.7 percent)

# STRATEGY 3:
# STRATEGY TO ADDRESS THE NEEDS OF SPECIAL POPULATIONS

"Improving access to quality health care for populations disproportionately affected by HIV… is a fundamental public health strategy[.]"
Healthy People 2020

Since the beginning of the HIV epidemic, certain populations have born a disproportionate burden of HIV disease.[1] "Best practice" in both HIV prevention and care has been to direct resources to the highest-incident populations in response to their greater need.[2,3] In the Houston Area, HIV prevention and care services are targeted according to age, sex, race/ethnicity, geography, and risk factors using local epidemiology.[4] However, some populations and communities may not yet have the greatest burden of disease in a local area (and/or there is insufficient local data to determine burden), but have behavioral, socio-economic, or legal circumstances that place them at particularly high-risk for HIV infection and for being out-of-care in ways that other population groups do not.[5] In its guidance for comprehensive jurisdictional HIV services planning for 2012, the Health Resources and Services Administration (HRSA) defined such groups as "special populations" and called on local jurisdictions to develop strategies, plans, and activities to address their needs.[6] Four populations were specifically required by HRSA in its guidance; others could be added in response to local trends.[6]

The *Strategy to Address the Needs of Special Populations* of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 outlines the goals, solutions, and activities that the Houston Area HIV community has identified to improve the continuum of care for both HRSA-required special populations and those identified in response to local need:

- **Adolescents** aged 13 to 17
- **Homeless** defined as individuals who lack a fixed, regular, and adequate nighttime residence, including those who live in locations not meant for human habitation such as public parks and streets, those who live in or are transitioning from temporary housing or shelters, and those who have persistent housing instability
- **Incarcerated or Recently Released (IRR)** defined as individuals who are currently incarcerated in the jail or prison system or have been released from jail or prison within the past 12 months
- **Injection Drug Users (IDU)** defined as individuals who inject medications or drugs, including illegal drugs, hormones, and cosmetics
- **MSM** or Men who Have Sex with Men, defined as men who engage in male-to-male sexual practices and identify as gay or bisexual, those who engage in male-to-male sexual practices and do not identify as gay or bisexual, and those who engage in gay or bisexual male culture regardless of gender identity (i.e., male-to-female transgender)
- **Transgender** or individuals who cross or transcend culturally-defined categories of gender

Note: Adolescents, homeless, IDU, and transgender are special populations required by HRSA; IRR and MSM were added by participants following analysis of epidemiological, needs assessment, and service utilization data. All definitions were developed by participants using various sources.

Though each of these populations is unique, they share common experiences in regards to HIV, including bias, stigma, and discrimination, lack of data, and lack of tailored interventions and services. Moreover, many individuals meet more than one special population definition. Therefore, the goals, solutions, and activities outlined in this strategy aim to address gaps in the continuum of care that occur *across* special populations. As a result, the HIV prevention and care needs of all vulnerable groups, both HRSA- and Houston Area-defined, will be improved.

## References


(1) The White House Office of National AIDS Policy, National HIV/AIDS Strategy for the United States, July 2010.

(2) U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, *Strategic Plan 2011 through 2015*. August 2011.

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## Goals

1. Prevent New HIV Infections among the Special Populations of Adolescents, Homeless, Incarcerated and Recently Released (IRR) from jail or prison, Injection Drug Users (IDU), MSM (Men who Have Sex with Men), and Transgender
2. Reduce Barriers to HIV Prevention and Care for the Special Populations of Adolescents, Homeless, IRR from jail or prison, IDU, MSM, and Transgender
3. Strengthen the Cultural and Linguistic Competence of the HIV Prevention and Care System

## Solutions

1. Infuse the HIV prevention and care system with policies, procedures, and other structural solutions that ensure equal treatment of all people living with or at risk for HIV
2. Fill gaps in targeted interventions and services to better meet the HIV prevention and care needs of vulnerable populations
3. Improve data management systems to better reveal information on the HIV epidemiology, risks, outcomes, and needs of historically under-sampled populations

## Activities (Responsible Party, Timeline)

1. Develop and adopt a universal statement about non-discrimination toward Special Populations in the provision of HIV prevention and care services (Ryan White Planning Council, HIV Planning Group; 2012)
2. Establish or maintain formal partnerships between the Houston Area HIV Planning Bodies and agencies or individuals representing Special Populations; and through these partnerships, seek technical assistance and training on how the needs of Special Populations can be advanced (Ryan White Planning Council, HIV Planning Group; 2012-2014)
3. Sustain community-based Task Forces and Coalitions focused on Special Populations (e.g., *Serving the Incarcerated and Recently Released Partnership/SIRR*, HIV Planning Group Task Forces, etc.) (HIV Planning Group, The Resource Group; 2012-2014)
4. Sustain training on Special Populations in current capacity-building efforts for frontline HIV prevention and care staff (Ryan White Grant Administration, The Resource Group, Houston Department of Health and Human Services; 2012-2014)
5. Require cultural competence training for frontline HIV prevention and care staff to have: (a) standard minimum training topics; and (b) methods for measuring change in knowledge, skill, and ability (Ryan White Grant Administration, The Resource Group, Houston Department of Health and Human Services; 2012-2014)
6. Ensure data on Special Populations are included in the annual process for determining Ryan White HIV/AIDS Program Part A, B, and State Services funded services, priorities and allocations (i.e., *How to Best Meet the Need* and Priorities & Allocations) (Ryan White Planning Council/Office of Support; 2012-2014)
7. Sustain HIV care services to specific Special Populations through the Ryan White HIV/AIDS Program Part A, B, State Services, and the Minority AIDS Initiative (MAI) (Ryan White Planning Council; 2012-2014)

**Activities (Responsible Party, Timeline) Con't**

8. Sustain HIV care services to specific Special Populations through the Ryan White HIV/AIDS Program Part D (The Resource Group, if funded; 2012-2014)
9. Re-assess the Houston Area *Early Identification of Individuals with HIV/AIDS* (EIIHA) Strategy to ensure inclusion of Special Populations and any additional high-risk sub-populations (Ryan White Planning Council Ad Hoc EIIHA Committee; 2012)
10. Sustain HIV prevention services to specific Special Populations through contracted community-based organizations (Houston Department of Health and Human Services; 2012-2014)
11. Explore how to address bias, stigma, and discrimination against Special Populations in social marketing and other mass education activities (e.g., *HIP HOP for HIV Awareness*, School Health Summit), including data collection methods (Houston Department of Health and Human Services, Houston Independent School District; 2012-2014)
12. Alter data collection and reporting methods in current local data collection systems (e.g., Testing 4 Tickets, ECLIPS, CPCDMS, etc.) to provide information on Special Populations, in particular, Homeless, IRR, and Transgender, including standard definitions for data collection and reporting requirements (Ryan White Grant Administration, Houston Department of Health and Human Services; 2013)
13. Develop baselines and targets for each Special Population lacking benchmark data; this may develop into Special Studies on certain populations (Ryan White Planning Council/Office of Support; 2012-2014)

**Benchmarks**

1. Reduce the number of new HIV infections diagnosed among each Special Population by 25 percent:
   *Adolescents, from 18 to 13*
   *Homeless, from 172 to 132*
   *IRR from jail, from 1,097 to 822*
   *IRR from prison, from 137 to 102*
   *IDU, from 38 to 28*
   *MSM, from 563 to 422*
   *Transgender, from 7 to 5*
2. Increase the proportion of newly-diagnosed individuals within each Special Population linked to HIV clinical care within three months of their HIV diagnosis to at least 85 percent:
   *Adolescents, baseline to be developed*
   *Homeless, baseline to be developed*
   *Incarcerated in jail, maintain at 100 percent; recently released from jail, from 62.0 percent to 85 percent*
   *IRR from prison, baseline to be developed*
   *IDU, from 51.1 percent to 85 percent*
   *MSM, from 65.2 percent to 85 percent*
   *Transgender, baseline to be developed*
3. Prevent increases in the proportion of individuals within each Special Population who have tested positive for HIV but who are not in care (Ryan White HIV/AIDS Program Unmet Need Framework):
   *Adolescents, baseline to be developed*
   *Homeless, baseline to be developed*
   *IRR from jail, baseline to be developed*
   *IRR from prison, baseline to be developed*
   *IDU, maintain at 37.6 percent*
   *MSM, maintain at 33.7 percent*
   *Transgender, baseline to be developed*
4. Maintain the percentage of frontline HIV prevention and care staff receiving annual cultural competence training at 100 percent

# STRATEGY 4:
# STRATEGY TO IMPROVE COORDINATION OF EFFORT AND PREPARE FOR HEALTH CARE SYSTEM CHANGES

"[W]hat is needed at this time is an enhanced focus on coordinating our efforts across [...] agencies, across all levels of government, with external partners, and throughout the health care system."
National HIV/AIDS Strategy
July 2010

The HIV system in the U.S. is complex. Services to individuals at risk for or infected with HIV are provided by a variety of agencies and organizations through equally various funding sources and mandates.[1] The result can sometimes be a confusing and overwhelming system for clients to navigate. Not to mention, the system itself is changing.[2] Many individuals at risk for or infected with HIV seek and receive HIV services through non-AIDS-service organizations, including other public health insurance programs such as Medicaid, Federally Qualified Health Centers, and in the private sector.[1] The *Patient Protection and Affordable Care Act of 2010* is expected to further expand the numbers of individuals eligible for services under these types of programs.[2] It also incentivizes opportunities for AIDS-service organizations (ASOs) to serve clients who are *not* HIV infected. These conditions reinforce the importance of coordination among current ASOs as well as *between* ASOs and other health and human service providers, including those in the private sector;[1] the latter of which can help the HIV system better meet the needs of people at risk for or living with HIV as well as reduce duplication or overlaps in care. These conditions also draw attention to the need for capacity-building for ASOs and non-ASOs alike to ready themselves for health care system changes and to ensure sustained high quality medical homes for HIV clients regardless of their source of coverage or the location of their care.[3] Lastly, it highlights the need to prepare clients to transition into and navigate their new system.

The *Strategy to Improve Coordination of Effort and Prepare for Health Care System Changes* of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 outlines the goals, solutions, activities, and timelines that the Houston Area HIV community has identified to improve the continuum of care through coordination of effort among HIV providers and partners. It is intended to improve the seamlessness of the current HIV prevention and care system, facilitate partnerships that will increase access to services for people at risk or living with HIV, and assist the entire HIV system to ready for and interface with health insurance reform.

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## Goals

1. Increase Awareness of HIV among all Greater Houston Area Health and Human Service Providers
2. Increase the Availability of HIV Prevention and Care Services and Providers
3. Reduce Barriers to HIV Prevention and Care
4. Partner to Address Co-Occurring Public Health Problems that Inhibit Access to Care
5. Prepare for State and National-Level Changes in the Health Care System

## Solutions

1. Launch proactive efforts to unify stakeholders and to engage new and non-traditional partners in achieving the HIV prevention and care mission
2. Intensify technical assistance and training to current *and potential* AIDS-service organizations (ASOs) and providers
3. Maximize the use of media to (re) mobilize the public and providers around HIV
4. Maximize the use of technology to (a) link people at risk for or living with or HIV/AIDS (PLWHA) with resources and (b) assist providers with real-time referrals for clients to needed HIV prevention and care services
5. Intensify coordination of data systems within the HIV care system; between HIV prevention and care; and between AIDS-service organizations and the broader health care delivery system

## Proposed Coordinating Efforts (Responsible Party, Timeline)

<u>To Support the Entire HIV System</u>

1. Engage broad-based Houston Area health, social service, and community coalitions in order to engage new and non-traditional partners in supporting the HIV prevention and care mission (Ryan White Planning Council, HIV Planning Group; 2013)
2. Adopt a process to develop a Houston Area HIV media and marketing plan that encapsulates priority audiences, messages, products, outlets, and outcomes for engaging earned media on HIV prevention and care issues (Ryan White Planning Council, HIV Planning Group; 2013)
3. Explore the feasibility and practicality of developing a clearinghouse of available funding opportunities to support Strategy implementation (Ryan White Planning Council/Office of Support; 2013)
4. Translate the Houston Area HIV/AIDS Resource Guide into a real-time web- and phone-based resource locator with accompanying mobile applications (if feasible) accessible by clients and providers (Ryan White Planning Council/Office of Support; 2013)

<u>Within the Ryan White HIV/AIDS Program, including Part A, B, C, D, F, AIDS Drug Assistance Program, and State Services</u>

1. Facilitate technical assistance and training for Administrative Agents and funded ASOs to prepare for health care system changes (e.g., client pool/eligibility changes, reimbursement procedures, Medicaid/Medicare benefits coverage, Electronic Medical Records, medical home models, quality measures, fiscal diversification and sustainability, etc.) (Ryan White Grant Administration, The Resource Group; 2012-2014)

**Proposed Coordinating Efforts (Responsible Party, Timeline) Con't**

Within the Ryan White HIV/AIDS Program, including Part A, B, C, D, F, AIDS Drug Assistance Program, and State Services Con't

2. Create an "increased public health insurance coverage scenario" for Ryan White Part A, B, and State Services funding allocations in anticipation of expansions in coverage occurring through health care reform (Ryan White Planning Council; 2014)
3. Facilitate educational opportunities and provide materials for consumers about the impact of the *Patient Protection and Affordable Care Act* on HIV services (Ryan White Planning Council/Office of Support, Ryan White Grant Administration; 2014)

Between HIV Prevention and Care, including Partner Notification and Prevention with Positives Initiatives and STD Programs

1. Continue to conduct core comprehensive HIV planning processes jointly between the Ryan White Planning Council and the HIV Planning Group (Ryan White Planning Council, HIV Planning Group; 2012-2014)
2. Fully implement Phase One of the roll-out of collecting client-level HIV prevention data (ECLIPS) and linking to HIV care data (CPCDMS) (Ryan White Grant Administration, Houston Department of Health and Human Services; 2012)
3. Support ongoing regional efforts to operationalize HIV prevention and care integration as outlined by *Enhanced Comprehensive HIV Prevention Planning* (ECHPP) and *Early Identification of Individuals with HIV/AIDS* (EIIHA) (Houston Department of Health and Human Services, Ryan White Grant Administration; 2012-2014)
4. Support ongoing statewide efforts for increased integration of HIV prevention and care as outlined in the *Texas HIV/STD Prevention Plan*, *Texas Jurisdictional Plan*, and the *Texas Program Collaboration, Service Integration* (PCSI) Plan (Ryan White Planning Council, HIV Planning Group; 2012-2014)

Between ASOs and other Priority Sectors/Groups

*Other Public Health Care Providers, including Medicare, Medicaid, CHIP, and Community Health Centers*

1. Make available technical assistance and training for potential new ASOs such as Federally Qualified Health Centers (FQHCs) and Medicaid providers on the core elements of HIV care service delivery (Ryan White Grant Administration, The Resource Group; 2012-2014)
2. Target potential new ASOs such as FQHCs and Medicaid Managed Care Organizations (MCOs) for coordination of effort activities (Ryan White Planning Council/Office of Support; 2012-2014)
3. Work with Ryan White HIV/AIDS Program funded primary care providers to develop implementation plans for federally-compliant Electronic Medical Records platforms for HIV infected clients (Ryan White Grant Administration, The Resource Group; 2014)
4. Explore the feasibility of partnering with Area Agencies on Aging and Aging and Disability Resource Centers (ADRC) to provide public health insurance benefits counseling to newly eligible HIV infected consumers (Ryan White Planning Council/Office of Support; 2014)
5. Support ongoing statewide efforts to improve Medicaid access for people living with HIV as outlined in the *Texas State SHARP Report* (Ryan White Planning Council, HIV Planning Group; 2012-2014)

*Private Providers*

1. Target Houston Area medical professional associations, medical societies, and practice groups for coordination of effort activities (Ryan White Planning Council/Office of Support; 2012-2014)

**Proposed Coordinating Efforts (Responsible Party, Timeline) Con't**

Between ASOs and other Priority Sectors/Groups Con't

*Private Providers Con't*

2. Implement plans to conduct a survey of the HIV testing and linkage to care activities of private providers in the Houston Area (Houston Department of Health and Human Services; 2012)

*Substance Abuse Treatment Programs/Facilities*

1. Target local and regional alcohol and drug abuse providers and coalitions for coordination of effort activities (Ryan White Planning Council/Office of Support; 2012-2014)
2. Develop a methodology for determining the need for and use of alcohol treatment services vs. drug treatment services among Ryan White HIV/AIDS Program clients (Ryan White Planning Council/Office of Support, Ryan White Grant Administration, The Resource Group; 2012)

*Other Community Agencies and Non-Traditional Partners*

1. Sustain formal partnerships with the Housing Opportunities for People with AIDS (HOPWA) program and other housing and homelessness prevention coalitions and groups to address housing instability among PLWHA (Ryan White Planning Council; 2012-2014)
2. Partner with the AIDS Education and Training Center (AETC) to target medical and nursing education providers to promote the opportunity of HIV-related training and employment (Ryan White Planning Council/Office of Support; 2012)
3. Target the following for coordination of effort activities (Ryan White Planning Council/Office of Support; 2012-2014):
    a) Aging (e.g., assisted living, home health care, hospice, etc.) to address the needs of seniors who are PLWHA
    b) Business community and Chambers of Commerce to identify partnership opportunities that reach customers and employees with HIV information
    c) Community centers to identify opportunities to reach the general community with HIV information
    d) Chronic disease prevention, screening, and self-management programs to address co-occurring chronic conditions among PLWHA
    e) Mental health (e.g., counseling associations, treatment programs and facilities, etc.) to address co-occurring mental health, illness, and disabilities among PLWHA
    f) Philanthropic organizations to encourage charitable giving to ASOs using proven strategies outlined in the *Funders Guide to the National HIV/AIDS Strategy*
    g) Primary education, including schools and school districts, to increase access to HIV education services and to help campuses develop supportive environments for HIV+ students
    h) Secondary education, including researchers, instructors, and student groups, to create "pipelines" for HIV workforce development and volunteers, increase awareness of HIV among on local campuses, and establish new research efforts on HIV
    i) Workforce Solutions and other vocational training and rehabilitation programs to address underling economic conditions of and employment opportunities for PLWHA

**Benchmarks**

1. Increase the number of non-ASOs serving as members of the Ryan White Planning Council each year (baseline is 10)
2. Increase the number of non-ASOs requesting information about HIV services each year (baseline is 42)
3. Maintain the number of agencies listed in Houston Area HIV/AIDS Resource Guide at 187
4. Reduce the number of reports of barriers to Ryan White HIV/AIDS Program Core Medical Services by 27.2 percent (from 1,397 to 1,017 reports)
5. Reduce the number of reports of barriers to Ryan White HIV/AIDS Program Support Services by 12.7 percent (from 2,151 to 1,878 reports)
6. Reduce the number of reports of barriers by PLWHA to accessing Ryan White HIV/AIDS Program-funded Mental Health Services by 27.3 percent (from 117 to 85 reports)
7. Reduce the number of reports of barriers by PLWHA to accessing Ryan White HIV/AIDS Program-funded Substance Abuse Services by 43.7 percent (from 58 to 32 reports)
8. Prevent the percentage of PLWHA reporting housing instability from increasing above 22.2 percent
9. Prevent the percentage of PLWHA reporting seeking no medical care due to inability to pay from increasing above 8 percent
10. Maintain the number of individuals working for ASOs who receive training on health insurance reform at 200 each year
11. Track the percentage of Ryan White HIV/AIDS Program clients with Medicaid enrollment (baseline is 16.7 percent)

# C. Bruce Turner

*"Active, able, aging, and alive."*

Photograph by Barb Garvin

*Asked to describe himself, Bruce Turner says he is a hermit…and an activist.*

Growing up "on the poor side" in a rural Pennsylvania community, Bruce often felt alienated from those around him. With two older sisters and a younger brother in the house, he often found refuge with his grandfather who gave him a safe place to be himself and, in the process, became Bruce's childhood role-model. Bruce channeled his feelings into reading and attended the University of Akron where he studied English Literature.

College is where Bruce's activism came alive. He joined nearby Kent State University's Gay Liberation Front and staged sit-ins of restaurants and bars to protest their poor treatment of LGBTQ customers. As a graduate student, Bruce occasionally taught the novels of James Baldwin, which tell of the disenfranchisement and liberation experienced by African Americans, in a Black American Literature course, filling in when the main instructor was away. Of his activism at the time, he says "it certainly raised awareness in *some* people's eyes."

By the time Bruce was diagnosed with HIV in 1989, there was a national discourse taking place about the LGBTQ community as well as widespread misinformation and fear about HIV. Bruce can recall a time in Houston when people brought their own glasses to the gay bars because they feared they could be infected with HIV simply from sharing cups. When Bruce's partner was

diagnosed, Bruce felt it was "just a matter of time" before he would have HIV, too. In fact, it was his anger and guilt about the death of his partner that inspired Bruce to become an activist again…this time, for the needs of people living with HIV.

Although Bruce describes himself as a "hermit," he has come to know almost everyone in the HIV community. He has served on the Houston Area Ryan White Planning Council for over eight years, is a graduate of Project LEAP, the Houston Area's empowerment course for HIV consumers, and even conducted grant reviews for a local Administrative Agent. Recently, Bruce completed his term with the Houston HIV Planning Group (HPG) and was also appointed to the Texas HIV Medication Program Advisory Committee.

At 63, Bruce sees advocating for seniors living with HIV as the next stage in his activism. For himself, he simple wants to be known as "active, able, aging, and alive."

C. BRUCE TURNER

Member, 2003 - 2012, Houston Area Ryan White Planning Council
*Co-Chair, 2012, Ad Hoc Committee for the Early Identification of Individuals with HIV/AIDS (EIIHA) Strategy*

Member, 2012, Texas HIV Medication Program Advisory Committee

2012 Houston Area Comprehensive HIV Prevention and Care Services Plan
*Co-Chair, Workgroup on Coordination of Effort*

Member, 2011, Houston HIV Planning Group (HPG)

Member, M-pact (the MSM Task Force)

# Section IV: How Will We Monitor Progress?

The purpose of this section is to describe how progress will be measured in achieving goals, reaching benchmarks, and implementing strategies toward the development of an ideal system of HIV prevention and care in the Houston Area. It also outlines plans for improved data collection and for the use of data in monitoring service utilization and outcomes. It also describes how the Houston Area plan is aligned with selected other local, state, and national initiatives.

Section Contents

## Introduction: *An Emphasis on Evaluation*

In its guidance for comprehensive jurisdictional HIV services planning for 2012, the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) emphasized the importance of monitoring and evaluation for 2012 plans and required, for the first time, that local jurisdictions begin their planning process by evaluating their expiring jurisdictional plans.[1] HRSA's emphasis on evaluation in *jurisdictional* HIV services planning is reflective of a *national* call for increased accountability, careful monitoring, and constant re-evaluation of how scarce HIV resources are allocated and of the impact they are making on the HIV epidemic.[2] When designing its approach to the Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 (Comprehensive Plan), the Houston Area HIV community was careful to heed this call as well. Four strategies were employed to provide evaluation activities throughout the comprehensive planning process and to ensure that the resulting document would be SMART (Specific, Measurable, Achievable, Realistic, and Time-Phased) and that it would have clear quantifiable measures of the impact it intends to make on the Houston Area HIV epidemic:

"When designing an approach to comprehensive HIV planning for 2012, the Houston Area HIV community was careful to heed the national call…for increased accountability, monitoring, and evaluation of our impact on the HIV epidemic."

- **2012 Comprehensive Plan Evaluation Workgroup.** A 13-member Evaluation Workgroup oversaw all components of the 2012 comprehensive jurisdictional HIV planning process related to evaluation. The Workgroup conducted the formal evaluation of the 2009 Comprehensive Plan, identifying areas of success and of continued challenge. They developed data collection and decision-making methodologies for use by other planning participants and groups, and they developed the process and outcome measures for all proposed activities, including identifying replicable data sources, baselines, and short-term and long-term targets. They also assisted in assuring alignment with the goals, objectives, and targets outlined in other local, state, regional, national, and global initiatives and plans. Workgroup membership included subject matter experts in epidemiology, disease surveillance, research methods, strategic planning, and HIV-related outcome measures in both prevention and care.

- **Planning Principles.** Among the key findings from the 2009 Comprehensive Plan evaluation was that future HIV planning goals and objectives for the Houston Area need greater specificity in order to meaningfully measure impact on the local epidemic. In fact, the Evaluation Workgroup encountered difficulty conducting the evaluation of the 2009 plan due to the lack of specificity and measurability in its goals, objectives, and action steps. In the development of the 2012 Comprehensive Plan, four principles were applied to the planning process in order to remedy this challenge:
  1. Each proposed goal will be measurable through at least one quantitative benchmark;
  2. Benchmarks will have replicable data sources and existing baselines, and either national or locally-defined targets based on historical data will be used;
  3. Each proposed activity will name a responsible party and timeline; and
  4. Terminology used in goals, objectives, activities, and benchmarks will be standardized and/or defined.

- **Benchmarking Tool.** To help ensure the application of the planning principles listed above, a written benchmarking tool was utilized by the Evaluation Workgroup throughout the

planning process. Designed as a matrix, the tool consolidates all process and outcome measures identified for each goal of the Comprehensive Plan as well as their data sources, baselines, and proximal and distal targets. It also notes alignment of targets, where applicable, with local and national initiatives and plans. Through this process, a total of 56 benchmarks were identified to measure the impact of the Comprehensive Plan on the Houston Area epidemic. Those lacking existing data sources and baseline data were additionally included as a new data collection activity.

- **Inventories.** To ensure alignment with other local, state, regional, national, and global HIV prevention and care initiatives and plans throughout the planning process, written inventories of vision statements, mission statements, goals, objectives, performance measures, and priority populations in these key documents were developed and referenced by planning participants. The following sources were included in these inventories:
  1. National HIV/AIDS Strategy
  2. *Healthy People 2020* Vision, Mission, Overarching Goals, and HIV Objectives
  3. Health Resources and Services Administration (HRSA) and the HIV/AIDS Bureau (HAB) Goals, Principles, Vision, and Mission
  4. Centers for Disease Control and Prevention (CDC) *High-Impact HIV Prevention: The CDC's Approach to Reducing HIV Infection in the United States*
  5. Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention (DHAP) Strategic Plan, 2011 – 2015
  6. UNAIDS World AIDS Day Report, 2011
  7. Texas Integrated Epidemiologic Profile for HIV/AIDS Prevention and Services Planning, 2010
  8. Texas Statewide Plan for Delivery of HIV Medical and Psychosocial Support Services, 2009 – 2011
  9. 2008 – 2010 Texas Statewide Coordinated Statement of Need (SCSN)
  10. Texas Statewide HIV/STD Prevention Plan, 2011
  11. Integrated Epidemiological Profile for HIV/AIDS Prevention and Care Planning for the Houston HSDA and EMA, 2011
  12. Comprehensive HIV Services Plan for the Houston Area, 2009
  13. Comprehensive Services Plan for the East Texas HIV Administrative Services Area, 2011 Update
  14. Houston HIV Prevention Community Planning Group Comprehensive Plan, 2007 and 2009 Updates
  15. Houston Independent School District HIV, STD, and Unintended Pregnancy Prevention Plan, 2010
  16. City of Houston Housing and Community Development Department Consolidated Plan and Action Plan, 2010 – 2014
  17. *Early Identification of Individuals with HIV/AIDS* (EIIHA) Strategy, 2010
  18. *Enhanced Comprehensive HIV Prevention Planning* (ECHPP) Workbook for Houston Baytown-Sugarland, June 2011

## Current Evaluation Methods in Comprehensive HIV Planning

Though comprehensive jurisdictional HIV services plans are developed only once every three years per federal requirements, planning for HIV prevention and care services is conducted *throughout each year* through the work of the local Planning Bodies. Data on the HIV system in the Houston Area is collected or compiled and then analyzed for these interim processes as well.

Three sources of information about the Houston Area HIV system are produced regularly to assist the Planning Bodies in completing short-term planning tasks:

- Integrated HIV/AIDS Epidemiological Profile (yearly). The integrated HIV/AIDS epidemiologic profile describes HIV disease trends in a defined geographic area; as a result, it serves as a source of quantitative data from which HIV prevention and care priorities can be identified based on the burden of disease. Epidemiological profiles describe HIV/AIDS incidence, prevalence, mortality, service-utilization, socio-demographics, and other disease trends for various populations, including the general population, the HIV-infected population, and the non-infected (and untested) population whose behavior places them at risk for HIV. The Houston Area epidemiologic profile also features analyses of HIV/AIDS trends in special or emerging populations as determined by the Planning Bodies.

- Needs Assessment of People Living with HIV/AIDS (every three years). The HIV/AIDS needs assessment produces detailed information about service utilization from the perspective of people living with HIV/AIDS (PLWHA); as a result, it serves as a source of quantitative data from which trends in use of, gaps in, and barriers to HIV prevention and care services can be identified. Needs assessments describe the use of Ryan White HIV/AIDS Program Core Medical Services and Supportive Services by PLWHA, their perceived barriers to accessing these services, and continued areas of service need. Needs assessment also query perceived general health status, the presence of co-morbidities, history of service utilization, and social determinants factors, such as housing, employment, and income. The Houston Area needs assessment also features analyses of data for special or emerging populations as determined by the Planning Bodies.

- Special Studies (as needed). In the Houston Area, when a specific HIV-related topic or population requires additional data collection or a further exploration of available data, a special study may be conducted at the request of the local Planning Body. Often, the outcome of a special study is to over-sample a particular special or emerging population in order to reveal details of their disease burden or need for services. Past examples include *Access to Care Among HIV+ Latino Immigrants* and *Barriers to Care Among HIV+ Youth*.

# 2012 – 2014 Evaluation and Monitoring Plan

## The goal of the evaluation plan is:

To determine the impact of the Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 as measured by the extent of achievement of the following stated objectives:

1. Reduce the number of new HIV infections diagnosed in the Houston Area by 25 percent (from 1,029 to 771).
2. Maintain and, if possible, increase the percentage of individuals with a positive HIV test result identified through *targeted* HIV testing who are informed of their HIV+ status (beginning at 92.9 percent with the goal of 100 percent).
3. Increase the proportion of newly-diagnosed individuals linked to clinical HIV care within three months of their HIV diagnosis to 85 percent (from 65.1 percent).
4. Reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year by 25 percent (from 36.0 percent to 27.0 percent)
5. Increase the percentage of Ryan White HIV/AIDS Program clients who are in continuous HIV care (at least two visits for HIV medical care in 12 months at least three months apart) to 80 percent (from 78.0 percent).
6. Reduce the proportion of individuals who have tested positive for HIV but who are not in HIV care by 0.8 percent each year (beginning at 30.1 percent) as determined by the Ryan White HIV/AIDS Program Unmet Need Framework.
7. Increase the proportion of Ryan White HIV/AIDS Program clients with undetectable viral load by 10 percent (from 57.0 percent to 62.7 percent)
8. Reduce the number of reports of barriers by People Living with HIV/AIDS to accessing Ryan White HIV/AIDS Program-funded Mental Health Services and Substance Abuse Services by 27.3 percent and 43.7 percent, respectively (from 117 reports to 85 reports for Mental Health Services; and from 58 reports to 32 reports for Substance Abuse Services).

## To conduct the evaluation of the plan, we will undertake the following activities:

- Convene the 2012 Comprehensive Plan Evaluation Workgroup annually to review data, assess direction of stated objectives, provide explanation of outcomes, and report findings to the Planning Bodies (Beginning December 2012; annually thereafter)
- Update the 2012 Comprehensive Plan Dashboard annually (Beginning December 2012, annually thereafter)

## The goal of the monitoring plan is:

To monitor the implementation of the Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 as measured by:

1. The extent of achievement of stated activities and efforts (Section III); and
2. The extent of achievement of stated benchmarks (Section III).

## To monitor implementation of the plan, we will undertake the following activities:

- Conduct a biannual document review and archiving of reports produced by responsible parties containing information about stated activities and efforts (Beginning December 2012; biannually thereafter)
- Convene the 2012 Comprehensive Plan Evaluation Workgroup biannually to review the status of activities, provide explanation of outcomes, identify areas of course correction, and report findings to the Planning Bodies (Beginning December 2012; biannually thereafter)

## 2012 – 2014 DATA COLLECTION ACTIVITIES

Fifty-six benchmarks have been identified to measure the impact of the Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 (Comprehensive Plan) on the local HIV epidemic. Those lacking existing data sources and baseline data have been additionally included as an activity in relevant Comprehensive Plan Strategies. Several additional activities in the Strategies will also result in new or data for use in HIV prevention and care services planning. The data collection activities proposed by the Comprehensive Plan are summarized below:

- Develop baselines and targets for each Special Population in the Comprehensive Plan lacking benchmark data; this may develop into Special Studies on certain populations.
- Alter data collection and reporting methods in current local data collection systems to provide information on Special Populations, in particular, the homeless, the incarcerated or recently released from jail or prison, and transgender, including standard definitions for data collection and reporting requirements.
- Develop a methodology for determining the need for and use of alcohol treatment services vs. drug treatment services in the Ryan White HIV/AIDS Program client population.
- Establish a mechanism for tracking medication adherence among Ryan White HIV/AIDS Program clients.
- Establish a baseline for Houston Area community viral load of individuals in HIV care.
- For required cultural competence training for frontline HIV prevention and care staff, develop: (a) standard minimum training topics; and (b) methods for measuring change in knowledge, skill, and ability.
- Implement plans to conduct a survey on the HIV testing and linkage to care activities of private providers in the Houston Area.

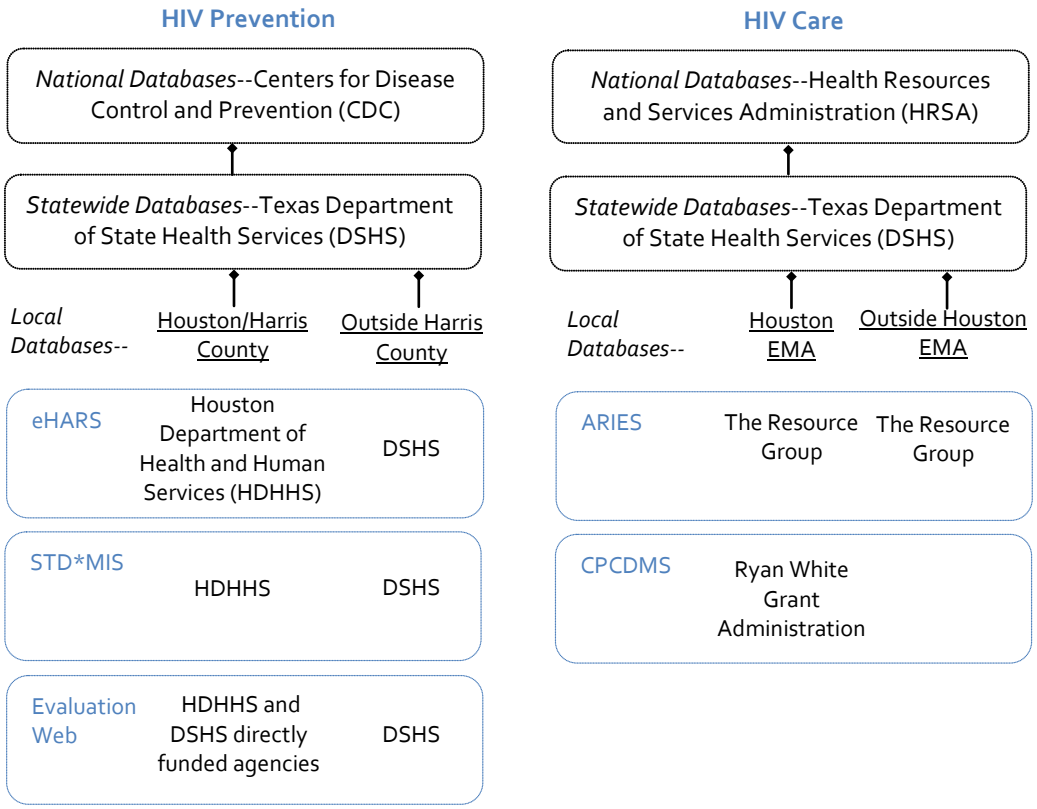
# USE OF CLIENT LEVEL DATA IN THE HOUSTON AREA

## Current Client Level Data Systems

The Houston Area HIV prevention and care system operates standard client level HIV/AIDS surveillance and care databases as well as data collection platforms uniquely designed and built for the jurisdiction. There are currently five major data systems in place in the Houston Area administered by specific agencies at the local, state, and national level according to jurisdiction (Figure 1); all collect client level data related to HIV/AIDS prevention or care:

- eHARS.[3] The Enhanced HIV/AIDS Reporting System (eHARS) is a browser-based HIV/AIDS surveillance system deployed at all state and local health departments. Its purpose is to serve as a comprehensive centralized source for the ongoing, systematic collection and dissemination of data on HIV/AIDS in a local jurisdiction. All evidence of HIV/AIDS disease is entered into the eHARS system using case reports and laboratory reports. On a monthly basis, health departments submit de-identified data electronically to the national HIV/AIDS database at the Centers for Disease Control and Prevention (CDC). eHARS is the real-time source for HIV and AIDS incidence, prevalence, and mortality in a local jurisdiction. For Houston/Harris County, eHARS is administered by the Houston Department of Health and Human Services (HDHHS) Bureau of HIV/STD and Viral Hepatitis Prevention; for counties outside of Harris, the system is managed by the Texas Department of State Health Services (DSHS) HIV/STD Prevention and Care Branch.

Figure 1: Model of Client Level Data Systems in the Houston Area



- **STD*MIS.**[4] The Sexually Transmitted Disease Management Information System (STD*MIS) is an application provided by the CDC to state and local health departments for surveillance of sexually transmitted diseases (STD). Its purpose is to enable local STD programs to manage evidence of reportable STDs received from laboratories, health care providers, facilities, and Disease Intervention Specialists (DIS). In jurisdictions where STD*MIS is in use for this purpose, it can serve as a real-time source for STD incidence in a local jurisdiction as eHARS does for HIV/AIDS. STD*MIS also has the capacity to serve as a case management database for tracking treatment, partner services, and other public health follow-up activities. The HDHHS administers STD*MIS for STD surveillance in Houston/Harris County; they also use the application for HIV case management functions. For counties outside of Harris, STD*MIS is managed by the DSHS.

- **Evaluation Web.**[5] Formerly the Program Evaluation and Monitoring System (PEMS), Evaluation Web is a national web-based client-level HIV prevention data collection system supported by CDC for the collection of HIV prevention data variables, such as Counseling, Testing, and Referral (CTR) services. Its purpose is to enable HIV prevention providers and the CDC to monitor and report on HIV prevention service utilization, behavior change outcomes, and attainment of HIV prevention program performance indicators. In the Houston Area, all entities receiving CDC HIV prevention funds either directly or through a contract with a directly-funded state or local agency enter data into Evaluation Web through an upload from another data system.

- **ARIES.**[6] The AIDS Regional Information and Evaluation System (ARIES) was developed by the states of Texas and California and the Counties of San Diego and San Bernardino to serve as a centralized data collection system for client data, service details, and agency and staff information for services funded by HRSA's HIV/AIDS Bureau (HAB) (i.e., the Ryan White HIV/AIDS Program) in those jurisdictions. The primary goal of ARIES is to enhance services for clients by helping local providers automate, plan, manage, and report on client data in real-time. ARIES further provides a mechanism for funded agencies to submit required HRSA HAB reporting via the annual CARE Act Data Report (CADR). In the Houston Area, all entities receiving HRSA HAB funds for HIV/AIDS care services other than Part D rely on the CPCDMS (*see below*) for primary data entry. These data are then uploaded from CPCDMS to ARIES, thereby ensuring data are entered once even if shared by multiple grantees. Part D funded agencies enter data into ARIES manually or through an upload from another data system. For the Houston Area, ARIES is managed by the Houston Regional HIV/AIDS Resource Group, the Administrative Agent for Ryan White HIV/AIDS Program Part B and State Services and the grantee of Part C and D services. The DSHS administers ARIES for the state of Texas.

- **CPCDMS.** The Centralized Patient Care Data Management System (CPCDMS) is a browser-based encrypted, real-time, de-identified client level database unique to the Houston Area. It links all Ryan White HIV/AIDS Program Part A, B, and C funded agencies as well as other local AIDS service providers on specific data variables, including registration, encounter, medical update information, demographic, co-morbidity, biological marker, service utilization, outcomes survey, and assessment data for each client served. Its purpose is to manage and produce real-time client level data for tracking service utilization, planning for services, and quality improvement of services for all Ryan White HIV/AIDS Program services community-wide. For example, CPCDMS data are used to generate quarterly service utilization reports, to monitor the health needs of a specific demographic served by the program, to assess health status indicators of the overall client population, and to generate

population samples for annual clinical chart review. All entities in the Houston Area receiving HRSA HAB funds for HIV/AIDS care services other than Part D enter data into CPCDMS. CPCDMS is administered by Harris County Public Health Services Ryan White Grant Administration, the Administrative Agent for Ryan White HIV/AIDS Program Part A and the Minority AIDS Initiative (MAI).

### Plans for Improved Use of Client Level Data

Though the Houston Area maintains a robust client level data management system as described above, plans are in place to improve the use of these data through the development of additional jurisdiction-specific data platforms and increased capacity for interfaces with current systems:

- **ECLIPS.** The Electronic Client-Level Integrated Prevention System (ECLIPS) is in development by the HDHHS as a mechanism for tracking HIV prevention activities including HIV testing and as a replacement for the local instance of PEMS. In its full iteration, ECLIPS will also interface directly with the CPCDMS and eHARS. The goal of this interface is to seamlessly track referrals from initial HIV test to engagement in primary medical care or case management for newly-diagnosed HIV positive individuals. Once implemented, HIV prevention staff will have the capacity to make referrals directly into the HIV care data system and to receive electronic verification from the provider of the client's completed visit. Through this integration, it will be possible to track referrals of newly-diagnosed individuals, confirm that linkage to care has occurred, and assess the time elapsed from results notification to confirmed entry into care. Also in its full iteration, ECLIPS is slated to replace the HDHHS Contractor Compliance database described in the next section. It will also have the capacity to upload data directly into Evaluation Web, the national client-level HIV prevention data collection system for HIV prevention described above.

- **Maven.** Also in development by the HDHHS is Maven, a modifiable electronic tool for disease surveillance, case management, and reporting. In January 2010, Texas State Law was amended to require mandated reporting of all viral load and CD4 tests to local health jurisdictions. Currently, the HDHHS Bureau of Epidemiology is receiving these newly-mandated test results from several large laboratories and hospital providers via Electronic Laboratory Reporting (ELR). However, neither eHARS nor STD*MIS can accept ELR. This has necessitated the development of a separate new data platform in order for these tests to be fully collected and analyzed. The proposed Maven system will have the capacity to accept ELR for CD4, viral load, and other HIV-related testing; it may also have the necessary functionality to be used for HIV/AIDS surveillance and case management in place of and with an interface to eHARS, thereby consolidating all HIV/AIDS case data in Houston/Harris County into a single data management system. In the short-term, the Maven case management platform will make it possible to better describe CD4 and viral load trends community-wide.

## USE OF DATA IN MONITORING HIV PREVENTION AND CARE SERVICE UTILIZATION

### In HIV Prevention

The Houston Department of Health and Human Services (HDHHS) Bureau of HIV/STD and Viral Hepatitis Prevention is responsible for monitoring the HIV prevention services provided by HIV prevention contractors, with a focus on the core HIV prevention activities of Counseling, Testing, and Referral (CTR) and Health Education/ Risk Reduction (HE/RR). The HDHHS maintains a Contractor Compliance database to monitor contractor activities and to produce service utilization reports as follows:

- **Activity Report.** Monthly activity reports summarize CTR and HE/RR units of service provided per HIV prevention contractor per month as well as track percent of progress made toward yearly contractor service goals. Examples of activities summarized in these reports include number of HIV tests provided, number of individuals post test counseled, rate of return for HIV test results, number of interventions delivered to individuals (ILI) and to groups, and number of persons who completed the intended number of intervention sessions
- **Budget Report.** A comparison of billed vs. actual CTR and HE/RR units of service provided per HIV prevention contractor is produced quarterly and annually. Cost per unit of CTR and HE/RR service is also generated in the budget report.
- **All Agency Report.** A summary of CTR and HE/RR activities for all HIV prevention contractors is also produced. This report gives a broad overview of service utilization of CTR and HE/RR for the HIV prevention system as a whole.

In addition, the HDHHS conducts a compliance check of CTR activities reported by HIV prevention contractors compared to data entered into the Program Evaluation and Monitoring System (PEMS) system described above.

### In HIV Care

As described above, the AIDS Regional Information and Evaluation System (ARIES) and the Centralized Patient Care Data Management System (CPCDMS) are used to monitor service utilization of Ryan White HIV/AIDS Program-funded Core Medical and Supportive Services in the Houston Area. Reports of service utilization are produced and used as follows:

- **Quarterly Report.** Service utilization reports for each Core Medical and Supportive Service are produced quarterly for review by the Ryan White Planning Council. These reports summarize goals for the numbers of unduplicated clients to be served per service category, actual numbers of unduplicated clients served per category, and demographic characteristics.
- **Multi-Year Report.** Multi-year service utilization reports are compiled for the Planning Council's annual How To Best Meet the Need process, during which epidemiological, needs assessment, and service utilization data are reviewed systematically to determine which Ryan White HIV/AIDS Program service categories are needed to meet the needs of people living with HIV/AIDS in the Houston Area. Annual service utilization data reports are also used during the Planning Council's annual Priorities and Allocations process. These reports allow the Planning Council to evaluate trends in the use of funded services over time. Because CPCDMS and ARIES client level data also includes the sex/gender and race/ethnicity of clients, Planning Council members can monitor utilization to ensure that services are being allocated to consumers at a rate that reflects their proportion of the local HIV epidemic.

The Houston Regional HIV/AIDS Resource Group and the Harris County Public Health Services Ryan White Grant Administration provide the above service utilization reports for Ryan White HIV/AIDS Program Part A, B, and State Services via ARIES and CPCDMS, respectively.

# MEASUREMENT OF CLINICAL OUTCOMES AND PERFORMANCE MEASURES

## In HIV Prevention

In addition to monitoring activities of HIV prevention contractors, the Houston Department of Health and Human Services (HDHHS) Bureau of HIV/STD and Viral Hepatitis Prevention establishes and assesses minimum HIV prevention performance standards. The purpose of the HIV/STD Prevention Services Standards is to determine the minimal acceptable levels of quality in the delivery of HIV/STD Counseling, Testing, and Referral (CTR) services and Health Education/Risk Reduction (HE/RR) services as well as provide a measurement for the effectiveness of and/or need for HIV/STD prevention services in the jurisdiction. The HDHHS standards outline methods for measurement, required documentation, and the location of records as proof of documentation in each of the following domains for both CTR and HE/RR services:

1. Staffing and Training
2. Testing Requirements
3. HE/RR Requirements
4. Client Referral and Tracking
5. Client Rights/Responsibilities
6. Protocol Based Counseling (PBC) Process and Risk Reduction
7. CTR in Non-Traditional Settings
8. CTR in Traditional Settings
9. Prioritization
10. Documentation of Services
11. Recruitment

The following structure is used to monitor attainment of the standards by HIV prevention contractors:

- Program Unit. The HDHHS Bureau of HIV/STD and Viral Hepatitis Prevention maintains a Program Unit staffed by Program Liaisons, one of whom is assigned to each HDHHS-funded HIV prevention contractor. The Program Liaison serves as the primary contact from the HDHHS to the assigned contractor for all HIV prevention activities including attainment of the prevention standards. The Liaisons conduct monitoring activities as well as assess capacity building needs and opportunities for quality improvement.

- Fiscal Unit. The HDHHS Bureau of HIV/STD and Viral Hepatitis Prevention maintains a Fiscal Unit staffed by Fiscal Liaisons. Like Program Liaisons, one Fiscal Liaison is assigned to each HDHHS-funded HIV prevention contractor. Fiscal Liaisons review budgets and monthly invoices for appropriate spending patterns and allowable expenses. The Fiscal Unit is also responsible for fiscal audits of each HIV prevention contractor.

- City of Houston Bureau of Quality Assurance (BQM). The City of Houston BQM conducts site visits twice a year with all HDHHS contractors, including those contracted though for HIV prevention activities. The purpose of the visits is to conduct an in-depth review of the contractor's financial records and to ensure overall contract compliance. The BQM also meets quarterly with contractors to discuss changes in policies and procedures or other topics relevant to contract requirements. Should an audit finding occur of an HIV prevention contractor through the BQM process, the HDHHS Bureau of HIV/STD and Viral Hepatitis Prevention's Program and Fiscal Units will meet with contractors to attain resolution. The

Program and Fiscal Units also provides ongoing technical assistance to contractors to ensure compliance with policies, procedures and guidelines set forth by the BQM.

- **Joint Meetings.** The Program and Fiscal Units meet annually to review HIV prevention contractor documentation and to ascertain that all invoices, correspondence, and other important documents are filed appropriately for each contractor.

### In HIV Care

In addition to monitoring service utilization, the client level data collected in the Centralized Patient Care Data Management System (CPCDMS) is an integral part of the development and monitoring of clinical outcomes and performance measures for HIV care services in the Houston Area. As the administrator of CPCDMS, the Harris County Public Health Services Ryan White Grant Administration (RWGA) oversees clinical outcomes and performance measures data collection and reporting for Ryan White HIV/AIDS Program-funded service categories in the jurisdiction. CPCDMS-generated clinical outcomes and performance measures data are also supplemented by self-administered pre- and post-tests and standardized service provider assessments. The jurisdiction's data collection system is monitored regularly to ensure provider agencies are entering clinical outcomes and performance measures data as required. The following clinical outcomes and performance measures are monitored as part of this system:

- **Clinical Outcomes Measures.** A logic model of initial, intermediate, and long term clinical client outcomes are applied to Houston Area HIV care services in the following domains:
  1. Health outcomes such as changes in CD4 counts, viral load, and stage of illness;
  2. KAP (knowledge, attitudes, and practices) outcomes such as changes in service utilization rates and adherence to drug treatment regimens;
  3. Cost-effectiveness outcomes such as utilization of pharmaceutical assistance programs to mitigate costs of medications; and
  4. Quality of life outcomes such as increased ability to perform activities of daily living.

  Clinical outcomes data are monitored, analyzed, and reported semi-annually to the Ryan White Planning Council and service providers. They are also incorporated into annual planning for quality improvement activities system-wide.

- **Performance Measures.** HRSA HIV/AIDS Bureau (HAB) HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents and the Institute for Health Care Improvement's performance measures for HIV/AIDS quality of care are used to measure performance of service providers. Examples of current performance measures include:
  1. Clients with HIV infection will have two or more medical visits in an HIV care setting.
  2. HIV-infected female clients who were ≥18 years old or reported having a history of sexual activity will have pap screening.
  3. HIV-infected clients who have been enrolled in care at least six months and have had 2 or more medical visits will have a viral load of <200 copies/mL.
  4. 90 percent of HIV-infected oral health clients will have treatment plan developed or updated at least once.
  5. HIV-infected oral health clients will receive oral health education at least once.
  6. HIV-infected oral health clients will receive periodontal screening or examination at least once.
  7. Clients will utilize Part A, B, C, or D primary care two or more times at least three months apart after accessing medical case management services.
  8. Medical case management clients will have service plans developed/or updated two or more times at least three months apart.

9. Nutritional supplements clients will report increased or maintained knowledge of the usage, dosing and side effects of the prescribed supplement(s).
10. HIV positive vision care patients/clients with CD4 counts of $<50/mm^3$ will have documented CMV screening during the measurement year.

Performance measures are monitored continuously through annual chart reviews and analysis of data in CPCDMS. They are revised annually to reflect identified needs, changes to Public Health Services (PHS) guidelines, and best practice. Ryan White HIV/AIDS Program-funded service providers are also required to implement quality improvement projects to better facilitate attainment of performance measures system-wide.

To monitor clinical outcomes and performance measures of HIV care services in the Houston Area, the following activities are conducted:

- **Clinical Chart Reviews.** Chart abstractions are performed on an annual basis for each primary medical care and selected health-related service-delivery agency. Annual reports summarizing agency level findings are distributed to the respective providers. An aggregate report of jurisdiction-wide findings is shared with all quality management stakeholders. Chart review results are also used to assist in the development of agency-specific quality management plans described below. Agencies review the results from their chart reviews and identify areas in need of improvement. They then develop plans to address identified needs.

- **Quality Management (QM) Plans.** Each Ryan White HIV/AIDS Program-funded service provider must maintain an annual QM plan. The QM plan must include applicable jurisdiction-wide performance measures selected for improvement based on chart review results and clinical outcomes data. Providers are also required to evaluate their internal service delivery systems and processes to identify areas for improvement. Quarterly updates to the QM plan are required and must include the results of the provider's internal assessment activities. Technical support and guidance is provided to funded-service providers as they develop and update their QM plans. Annual site visits are conducted at all agencies to evaluate their QM programs and provide technical assistance.

- **Client Satisfaction Surveys.** A client satisfaction survey tool is administered year-round to consumers of Ryan White HIV/AIDS Program services in the Houston Area. The survey queries satisfaction with specific services, service providers, and the Houston Area Continuum of Care as a whole. The tool is available in both paper-and-pencil and electronic formats and can be submitted ongoing by consumers for "real time" client input. Focus groups with consumers are also conducted at each funded primary medical care agency to solicit additional client satisfaction input. A report of key findings from the client satisfaction process is provided annually to the Ryan White Planning Council for review.

The Houston Area also maintains two quality management oversight bodies:

- **Clinical Quality Management (CQM) Committee.** The membership of the CQM Committee reflects the diversity of disciplines involved in HRSA defined Core Medical and Supportive Services in the Houston Area. Currently, the committee structure consists of Ryan White HIV/AIDS Program-funded providers in the following disciplines:
  1. Two Physicians/One Dentist (1 HIV Specialist to serve as Chairperson)
  2. Two Nurses
  3. One Medical/Clinical Case Manager
  4. One Pharmacist

5. One Nutritionist
6. Two Program Administrators
7. One Quality Management Coordinator
8. One HIV Prevention Specialist
9. One Data Manager

The CQM committee is responsible for assisting with the following activities:

1. Quarterly meetings to review system-wide CQM issues/challenges and the development of strategies to improve care.
2. Annual meetings to:
   a. Review chart review and clinical outcome measures reports and other relevant data;
   b. Determine system-wide quality initiatives and performance indicators and goals;
   c. Review and recommend revisions to the Standards of Care to reflect current US Health and Human Services (HHS) Treatment guidelines as well as federal and state regulations for HIV care and services; and
   d. Review and revise assessment and data collection tools/protocols as necessary.
3. Establish subcommittees as needed to address service specific quality issues.
4. Plan and develop educational strategies for Ryan White HIV/AIDS Program-funded service providers which may include grand rounds for HIV care and clinical updates according to federal guidelines.
5. Annually review and update the quality management plan.
6. Provide input into an annual evaluation of the quality management system.

- Ryan White Planning Council Quality Assurance (QA) Committee. The QA Committee operates as a formal committee of the Ryan White Planning Council. All annual chart review and client satisfaction survey reports, semi-annual clinical outcomes measures reports, service utilization reports, and annual revisions to standards of care are disseminated to the QA Committee at appropriate intervals during the grant year. Members of the QA Committee collaborate with quality management staff to address matters identified through the reports described above. Committee members evaluate and share the information with the Planning Council, which in turn uses the data during its annual How to Best Meet the Need process to evaluate funded service categories and make funding allocations decisions.

The section above describes the overall approach to measuring clinical outcomes and performance of Ryan White HIV/AIDS Program-funded service providers in the Houston Area. Implementation of this process will differ according to Ryan White HIV/AIDS Program Part and funding provider. As such, quality management for Part A and the Minority AIDS Initiative (MAI) is implemented by the Harris County Public Health Services Ryan White Grant Administration (RWGA); and by the Houston Regional HIV/AIDS Resource Group, Inc. for Part B, C, D, and State Services.

## Maximizing the HIV Prevention Portfolio for the Houston Area

With increased national attention to maximizing the efficacy of HIV prevention strategies,[2] the Houston Department of Health and Human Services (HDHHS) Bureau of HIV/STD and Viral Hepatitis Prevention has launched specific science-based strategies to determine the optimal *local* combination of HIV prevention activities for the Houston/Harris County area. Examples of these strategies include:

- Strengthening the infrastructure of client level data management systems via the Electronic Client-Level Integrated Prevention System (ECLIPS) and Maven, as described above;
- Geocoding HIV and (non-HIV) STD incidence in the Houston/Harris County area to strategically direct prevention resources to geographic areas with the greatest burden of and risk for HIV; and
- As a component of ECHPP (*Enhanced Comprehensive HIV Prevention Planning*), determining the scalability of required and recommended HIV prevention activities for the jurisdiction.

"Strengthening the scientific basis for Houston Area HIV prevention activities will better ensure that a portfolio of interventions is selected that maximizes impact on the local HIV epidemic."

The HDHHS Bureau of HIV/STD and Viral Hepatitis Prevention has also convened a panel of experts in the fields of epidemiology, health economics, biostatistics, infectious disease, virology, and behavioral sciences to serve as a Scientific Advisory Council for HIV prevention activities in the Houston Area. The Council has been tasked with making recommendations to the HDHHS Bureau of HIV/STD and Viral Hepatitis Prevention regarding its portfolio of HIV prevention activities based on an ongoing examination of cost-effectiveness and scalability. In the long-term, strengthening the scientific basis for Houston Area HIV prevention activities will better ensure that a portfolio of interventions is selected that maximizes impact on the local epidemic.

## Assessing the Impact of the *Early Identification of Individuals with HIV/AIDS* (EIIHA) Strategy

The Ad Hoc EIIHA Strategy Committee (AHEC) was established by the Ryan White Planning Council to oversee the design, implementation, evaluation, and *re-evaluation* of the EIIHA Strategy for the Houston Area. Membership on the AHEC includes HIV prevention stakeholders, HIV care stakeholders, individuals at risk or infected with HIV, and consumers of HIV prevention and care services. Beginning in 2012, the AHEC will be tasked with assessing the impact of the EIIHA Strategy on identifying, informing, linking, and referring the newly diagnosed into HIV care. Two primary sources of data will be available to the AHEC to determine impact:

- **Benchmarks.** As noted above, 56 process and outcome level benchmarks have been identified to assess the impact of the 2012 Houston Area Comprehensive HIV Prevention and Care Services Plan on the local HIV epidemic. Benchmarks related to HIV testing, notification of status, and linkage to care can be used concurrently to assess EIIHA impact.
- **Clinical Outcome Measures.** Also as noted above, a logic-based set of client level clinical outcome measures are used to evaluate the Houston Area Ryan White HIV/AIDS Program as a whole. Clinical outcome measures related to medical and non-medical case management (or Service Linkage Workers) can be used concurrently to assess EIIHA impact.

Because the EIIHA Strategy began prior to 2012, however, assessing its full impact will require a review of data on relevant benchmarks and clinical outcome measures prior to EIIHA. As available, data on these relevant measures pre-, during, and post-EIIHA will also be assessed.

## How the Plan Aligns with Select Local, State, and National Initiatives and Plans

### Ensuring Alignment

In addition to emphasizing monitoring and evaluation in its guidance for 2012 comprehensive jurisdictional HIV services planning, the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) also outlined expectations of jurisdictions to be cognizant of and responsive to the changing context of HIV prevention and care and of health care service delivery as a whole at both the local and national level. Comprehensive jurisdictional HIV plans for 2012 – 2014 are the first to be developed since the landscape of HIV prevention and care was strategically re-directed through the release of the National HIV/AIDS Strategy and its local acceleration initiatives, ECHPP (*Enhanced Comprehensive HIV Prevention Planning*) and EIIHA (*Early Identification of Individuals with HIV/AIDS*). They are also the first to be developed since the passing of the *Patient Protection and Affordable Care Act of 2010*. From the beginning of the planning process, the Houston Area HIV community utilized multiple strategies to ensure the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 (Comprehensive Plan) was in alignment with these HIV prevention and care "game-changers." In particular, attention was paid to aligning Houston Area planning efforts with the following local, regional, state, and national initiatives and plans:

"From the beginning of the planning process, the Houston Area used multiple strategies to ensure the Comprehensive Plan was in alignment with national HIV prevention and care *game-changers*."

1. National HIV/AIDS Strategy
2. The Centers for Disease Control and Prevention (CDC)'s: (a) Division of HIV/AIDS Prevention (DHAP) Strategic Plan (2011 – 2015); and (b) *High-Impact HIV Prevention: The CDC's Approach to Reducing HIV Infections in the U.S.*
3. *Healthy People 2020*
4. *Patient Protection and Affordable Care Act of 2010*
5. Statewide Coordinated Statement of Need (SCSN) for the State of Texas
6. *Enhanced Comprehensive HIV Prevention Planning* (ECHPP) for the Metropolitan Statistical Areas Most Affected by HIV/AIDS (Houston-Baytown-Sugarland, TX)

Though the specific ways in which the Comprehensive Plan aligns with each of the above may differ depending on the specific nature of the initiative or plan, three general strategies were applied throughout the planning process to ensure synergy in planning outcomes:

- **Partner Engagement.** Individuals representing the agencies responsible for, to be impacted by, and/or with subject matter expertise in each of the above initiatives and plans were strategically identified and recruited for participation in the comprehensive planning structure, as staff to the process, and/or during Public Comment.

- **Reference and Data Sources.** As described above, written inventories of vision statements, mission statements, goals, objectives, performance measures, and priority populations drawn from relevant initiatives and plans were developed and referenced by planning participants throughout the process. Eighteen different local, regional, state, national, and international documents, including the plans listed above, were included in the inventories. In many cases, initiatives and plans in their entirety were also used as data sources for topic-specific Workgroup discussion, and copies were made available during Workgroup meetings. As a

result, virtually all of the above documents are cited as references in the Houston Area Comprehensive Plan.

- **Vision, Goal, Target, and Activity Selection**. Whenever possible, the goals, objectives, and targets identified for the Comprehensive Plan were selected from the relevant *national* initiatives and plans listed above. The identification of locally-replicable benchmarks was a primary task of the 2012 Evaluation Workgroup. Also where applicable, the activities proposed in the Comprehensive Plan were selected from among the *local* initiatives and plans listed above. As a result, the implementation of the Comprehensive Plan will help to advance national goals, objectives, and targets at a local level and will also encapsulate local initiative activities as part of overall system improvement.

Specific ways in which these strategies resulted in the alignment of the Comprehensive Plan with selected local, regional, state, and national initiatives and plans are presented in the following sections. Alignment is itemized for core planning elements, such as vision, goals, priority populations, targets, crosscutting issues, and interventions.

## The National HIV/AIDS Strategy

The Comprehensive Plan is aligned with the National HIV/AIDS Strategy (NHAS) through its vision, goals, priority populations, and targets. As summarized below, the vision for the NHAS was tailored to serve as the vision statement for the Houston Area's response to the local HIV epidemic. Some NHAS goals were also replicated for the Houston Area approach. Moreover, the Houston Area's priority populations for HIV prevention and care include all of those identified in NHAS. Lastly, where alignment occurred most frequently is in the Houston Area's adoption of NHAS targets for local replicable measures of success.

| Element | National HIV/AIDS Strategy[7] | Houston Area Comprehensive Plan |
|---|---|---|
| **Vision** | The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination. | The Greater Houston Area will become a community with a coordinated system of HIV prevention and care, where new HIV infections are rare, and, when they do occur, where every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high-quality, life-preserving care, free of stigma and discrimination. |
| **Goals** | 1-Reducing New HIV Infections<br><br>2-Increasing Access to Care and Improving Health Outcomes for People Living with HIV<br><br>3-Reducing HIV-Related Disparities and Health Inequities<br><br>4-Achieving a More Coordinated National Response to the HIV Epidemic | 2-Prevent New HIV Infections Through Both Prevention and Treatment Strategies<br><br>3-Ensure that All People Living With or At Risk for HIV Have Access to Early and Continuous HIV Prevention and Care Services<br><br>5-Reduce Disparities in the Houston Area HIV Epidemic and Address the Needs of Vulnerable Populations<br><br>6-Achieve a More Coordinated and Expansive HIV System that is Prepared for Health Care System Changes |
| **Priority Populations** | Gay and Bisexual Men<br>Blacks<br>Latinos | Men Who Have Sex With Men (MSM)<br>African Americans<br>Hispanics |
| **Targets** | 1-By 2015, lower the annual number of new infections by 25% (from 56,300 to 42,225).<br><br>3-By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people).<br><br>4-By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85% (from 26,824 to 35,078 people).<br><br>5-By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80% (or 237,924 people in continuous care to 260,739 people in continuous care). | 1-By 2014, reduce the number of new HIV infections diagnosed in the Houston Area by 25 percent (from 1,029 to 771).<br><br>2-By 2014, maintain and, if possible, increase the percentage of individuals with a positive HIV test result through targeted HIV testing who are informed of their HIV+ status (beginning at 92.9 percent with the goal of 100 percent).<br><br>3-By 2014, increase the proportion of newly-diagnosed individuals linked to clinical care within three months of their HIV diagnosis to 85 percent (from 65.1 percent).<br><br>5-By 2014, increase the percentage of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) to 80 percent (from 78 percent). |

## Centers for Disease Control and Prevention (CDC)

Because the Comprehensive Plan and the Centers for Disease Control and Prevention (CDC)'s Division of HIV/AIDS Prevention (DHAP) Strategic Plan (2011 – 2015) are both in alignment with the NHAS, they, by definition, align with each other via specific goals, priority populations, and targets, summarized below. However, certain targets selected for the Comprehensive Plan are aligned only with DHAP objectives, as comparable measures were not included in the NHAS.

| Element | CDC Division of HIV/AIDS Prevention (DHAP) Strategic Plan[2] | Houston Area Comprehensive Plan |
|---|---|---|
| Goals | A: HIV INCIDENCE—Prevent New Infections | 2-Prevent New HIV Infections Through Both Prevention and Treatment Strategies |
| | B: PREVENTION AND CARE—Increase Linkage to and Impact of Prevention and Care Services with People Living with HIV/AIDS | 3-Ensure that All People Living With or At Risk for HIV Have Access to Early and Continuous HIV Prevention and Care Services |
| | C: HEALTH DISPARITIES—Reduce HIV-Related Disparities | 5-Reduce Disparities in the Houston Area HIV Epidemic and Address the Needs of Vulnerable Populations |
| Priority Populations | Gay and Bisexual Men<br>Blacks<br>Latinos | Men Who Have Sex With Men (MSM)<br>African Americans<br>Hispanics |
| Targets | A1- By 2015, reduce the annual number of new HIV infections by 25%. | 1-By 2014, reduce the number of new HIV infections diagnosed in the Houston Area by 25 percent (from 1,029 to 771). |
| | A2-By 2015, increase the percentage of people living with HIV who know their serostatus to 90%. | 2-By 2014, maintain and, if possible, increase the percentage of individuals with a positive HIV test result through targeted HIV testing who are informed of their HIV+ status (beginning at 92.9 percent with the goal of 100 percent). |
| | A 3-By 2015, increase the percentage of people diagnosed with HIV infection at earlier stages of disease (not stage 3: AIDS), by 25%. | 4-By 2014, reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year by 25 percent (from 36 percent to 27 percent). |
| | B2-By 2015, increase the percent-age of persons diagnosed with HIV who are linked to clinical care as evidenced by having a CD4 count or viral load measure within 3 months of HIV diagnosis to 85%. | 3-By 2014, increase the proportion of newly-diagnosed individuals linked to clinical care within three months of their HIV diagnosis to 85 percent (from 65.1 percent). |
| | B3-By 2015, increase by 10% the percentage of HIV-diagnosed persons in care whose most recent viral load test in the past 12 months was undetectable. | 7-By 2014, increase the proportion of Ryan White HIV/AIDS Program clients with undetectable viral load by 10 percent (from 57 percent to 62.7 percent). |

In addition to being aligned with the DHAP Strategic Plan, the Comprehensive Plan is also in alignment with CDC's other strategic HIV prevention document, *High-Impact HIV Prevention: The CDC's Approach to Reducing HIV Infections in the U.S.*[8] For example, several of the proven, cost-effective approaches to reducing the risk of HIV infection identified in this CDC document are also put forth in the Comprehensive Plan (e.g., HIV testing, linkage to care, treatment adherence, prevention with positives, etc.). Its philosophy of maximizing HIV prevention resources using scientifically-proven combinations of interventions is echoed throughout the Comprehensive Plan as well. The Comprehensive Plan also shares comparable priority populations.

## Healthy People 2020

The Comprehensive Plan is aligned with *Healthy People 2020* through its proposed use of specific objectives comparable to those included in the *Healthy People 2020* Chapter 22—HIV as local measures of success, summarized below. However, the Comprehensive Plan is also aligned with *Healthy People 2020* in its overall approach to identifying solutions for HIV prevention and care in the Houston Area. Both documents are cognizant of the social determinants of health and have applied the socio-ecological model to identifying effective strategies. The Comprehensive Plan has also identified health information technology as an overarching solution for HIV prevention and care in the Houston Area, which is a component of the *Healthy People 2020* framework.

| Element | Healthy People 2020[9] | Houston Area Comprehensive Plan |
|---|---|---|
| Targets | HIV–2: (Developmental) Reduce new (incident) HIV infections among adolescents and adults. | 1-By 2014, reduce the number of new HIV infections diagnosed in the Houston Area by 25 percent (from 1,029 to 771). |
| | HIV–9: (Developmental) Increase the proportion of new HIV infections diagnosed before progression to AIDS. | 4-By 2014, reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year by 25 percent (from 36 percent to 27 percent). |
| | HIV–13: Increase the proportion of people living with HIV who know their serostatus. | 2-By 2014, maintain and, if possible, increase the percentage of individuals with a positive HIV test result through targeted HIV testing who are informed of their HIV+ status (beginning at 92.9 percent with the goal of 100 percent). |

## The *Patient Protection and Affordable Care Act of 2010*

The *Patient Protection and Affordable Care Act of 2010* (ACA) will restructure the way that many individuals access health care services in the U.S., Texas, and in the Houston Area, including those at risk for or infected with HIV. If fully implemented, it is predicted that significantly more people living with HIV/AIDS in the Houston Area who currently access services through the Ryan White HIV/AIDS Program will become eligible for other public health insurance programs, namely Medicaid, and be required to seek services at Medicaid providers that may not be traditional AIDS-service organizations (ASOs). It is also possible that the essential benefits for people with HIV in these new public programs will be insufficient for their care. What is also known is that the ACA has incentivized opportunities for ASOs to serve clients in their communities who are *not* HIV infected, which has an impact on business models, client compositions, and workforce development needs. The ACA has also supported the expansion of other publicly-funded community-based health care models, such as Federally Qualified Health Centers (FQHCs), in the same underserved communities served by traditional ASOs. In light of these and other potential changes to the HIV system in the Houston Area, several steps were taken during the planning process to ensure the goals, solutions, and activities put forth in the Comprehensive Plan would be in coordination with *and help ready the Houston Area* for the implementation of this new law.

Partners with subject matter expertise in health care system models, public health insurance programs such as Medicaid and Medicare, and the ACA at a state and national legislative level were recruited into the comprehensive planning process. One of the topic-specific Workgroups established for the process was tasked with identifying goals, solutions, activities, and efforts that will prepare the Houston Area for ACA implementation. Additional stakeholders were also identified and interviewed about the document's alignment with the ACA during the Public

Comment Process. Ultimately, the aims of the activities identified for the Houston Area HIV community in regards to local ACA implementation are to:

- Prepare the Ryan White HIV/AIDS Program as a system, including Administrative Agents, contracted ASOs, and Planning Bodies, for health care system changes.
- Expand partnerships between the AIDS-service community and potential new providers of HIV care, such as the private sector, Medicaid, and Medicare.
- Prepare potential new providers of HIV care to provide HIV services based on proven models and standards of care.
- Ensure that services to HIV positive consumers of health care are sustained at current standards of care and that consumers benefit from system improvements.
- Ready current consumers of Ryan White HIV/AIDS Program-services to understand the changes that will occur in 2014 and to effectively navigate new systems of health care.

All of the ways in which the Comprehensive Plan is coordinated with implementation of the ACA are summarized below.

| Element | How the Houston Area Comprehensive Plan Coordinates with Implementation of the ACA |
|---|---|
| Goal | 6-Achieve a More Coordinated and Expansive HIV System that is Prepared for Health Care System Changes |
| Strategy | Strategy to Improve Coordination of Effort and Prepare for Health Care System Changes |
| Activities | Activity (Responsible Party, Timeline)<br>• Facilitate technical assistance and training for Administrative Agents and funded AIDS-service organizations (ASOs) to prepare for health care system changes (e.g., client pool/eligibility changes, reimbursement procedures, Medicaid/Medicare benefits coverage, medical home models, quality measures, fiscal diversification and sustainability, etc.) (Ryan White Grant Administration, The Resource Group; 2012-2014)<br>• Make available technical assistance and training for potential new ASOs such as Federally Qualified Health Centers (FQHCs) and Medicaid providers on core elements of HIV care (Ryan White Grant Administration, The Resource Group; 2012-2014)<br>• Target potential new ASOs such as FQHCs and Medicaid Managed Care Organizations (MCOs) for coordination of effort activities (Ryan White Planning Council/Office of Support; 2012-2014)<br>• Support ongoing statewide efforts to improve Medicaid access for People Living with HIV/AIDS (PLWHA) as outlined in the *Texas SHARP Report* (Ryan White Planning Council, HIV Planning Group; 2012-2014)<br>• Expand health literacy programming for people living with and/or affected by HIV/AIDS with attention to the impact of the *Patient Protection and Affordable Care Act* (The Resource Group, Ryan White Planning Council/Office of Support Project LEAP; 2012-2014)<br>• Facilitate technical assistance and training to funded ASOs in rural counties to aid in the transition into HIV medical homes using annual resource inventories (The Resource Group; 2012-2014)<br>• Create an "increased public health insurance coverage scenario" for Ryan White HIV/AIDS Program Part A, B, and State Services funding allocations in anticipation of expansions in coverage occurring through health care reform (Ryan White Planning Council; 2013)<br>• Facilitate educational opportunities and provide materials for consumers about the impact of the *Patient Protection and Affordable Care Act* on HIV services (Ryan White Planning Council/Office of Support, Ryan White Grant Administration, The Resource Group; 2014)<br>• Work with Ryan White HIV/AIDS Program funded primary care providers to develop implementation plans for federally-compliant Electronic Medical Records (EMR) platforms (Ryan White Grant Administration, The Resource Group; 2014)<br>• Explore the feasibility of partnering with Area Agencies on Aging and Aging and Disability Resource Centers (ADRC) to provide public health insurance benefits counseling to newly eligible HIV+ consumers (Ryan White Planning Council/Office of Support; 2014) |
| Benchmarks | • Maintain the number of individuals working for ASOs who receive training on health insurance reform at 200 each year<br>• Track the percentage of Ryan White HIV/AIDS Program clients with Medicaid enrollment (baseline is 16.7 percent) |

## Statewide Coordinated Statement of Need (SCSN) for the State of Texas

A Statewide Coordinated Statement of Need (SCSN) for the State of Texas for the current planning cycle is in the process of development. However, the Comprehensive Plan is aligned with the SCSN for 2008 – 2010. As summarized below, comparable crosscutting issues have been identified in both documents. The goals, solutions, activities, and efforts identified in the Comprehensive Plan are in direct response to these overarching concerns. The two documents are also aligned in their long-term goals.

| Element | Statewide Coordinated Statement of Need[10] | Houston Area Comprehensive Plan |
|---|---|---|
| Crosscutting Issues | The incidence of early syphilis among previously HIV positive MSM is increasing, especially in major urban centers. | There is more to be done to integrate HIV prevention and care as well as HIV and other STDs. |
| | The effect of substance abuse on entry and maintenance in care; and the effect of mental health issues on entry and maintenance in care. | Syndemic public health problems (such as substance abuse and mental health concerns) are impacting the Houston Area PLWHA population. |
| | African Americans continue to be disproportionately affected by HIV/AIDS. | Certain populations and communities continue to bear the greatest burden of disease. |
| | Not feeling sick or not believing medical care was necessary are the most common reasons cited for clients not accessing care or coming late to care. | Continuous HIV care has proven health benefits, yet close to one-third of PLWHA in the Houston Area are out-of-care |
| | The effect of stigma for PLWHA creates barriers to access for care | Stigma, bias, and discrimination against people with HIV persist |
| | Poor health literacy affects access and adherence to medical care and is associated with disparities in health outcomes. | Continuous HIV care has proven health benefits, yet close to one-third of PLWHA in the Houston Area is out-of-care |
| Goals | 1- Increase the proportion of HIV-infected adolescents and adults who know their status and receive care for HIV/AIDS. | 3-Ensure that All People Living With or At Risk for HIV Have Access to Early and Continuous HIV Prevention and Care Services |
| | 3- Ensure that local care systems facilitate access to care for populations experiencing disparities such as substance abuse, mental health, and recently incarcerated populations and includes mechanisms to treat co-morbid conditions such as tuberculosis, hepatitis, and those conditions associated with aging. | 4-Reduce the Effect of Co-Occurring Conditions that Hinder HIV Prevention Behaviors and Adherence to Care; and<br>5-Reduce Disparities in the Houston Area HIV Epidemic and Address the Needs of Vulnerable Populations |
| | 5-Ensure local and state administrative systems provide consistent and effective oversight and technical assistance to ensure that the use of Ryan White and HOPWA funds is responsive to locally assessed need and supports a system of care that address the health care needs of PLWHA, reduces barriers to service, and facilitates entry and maintenance in high-quality care that meets or exceeds minimum public health standards. | 6-Achieve a More Coordinated and Expansive HIV System that is Prepared for Health Care System Changes |

## Enhanced Comprehensive HIV Prevention Planning (ECHPP) for the Metropolitan Statistical Areas Most Affected by HIV/AIDS (Houston-Baytown-Sugarland, TX)

The Comprehensive Plan is aligned with Houston-Baytown-Sugarland, TX *Enhanced Comprehensive HIV Prevention Planning* (ECHPP) project. As summarized below, the majority of the Required and Recommended Interventions intended for scale-up as part of Houston Area ECHPP are reflected in the solutions, activities, and efforts of specific Comprehensive Plan Strategies. Both documents also share local targets and measures of success, drawn primarily from the NHAS.

| Element | Enhanced Comprehensive HIV Prevention Planning (ECHPP) Houston-Baytown-Sugarland, TX[11] | Houston Area Comprehensive Plan |
|---|---|---|
| Required Interventions | 1-Routine, Opt-Out HIV Screening | Prevention and Early Identification Strategy |
| | 2-HIV Testing in Non-Clinical Settings | Prevention and Early Identification Strategy |
| | 3-Condom Distribution for HIV Positive Persons | Prevention and Early Identification Strategy |
| | 4-Post-Exposure Prophylaxis (PEP) | Prevention and Early Identification Strategy |
| | 5-Structures, Policies, Barriers to Optimal HIV Efforts | Prevention and Early Identification Strategy |
| | 6-Linkage for HIV Positives Not In Care | Prevention and Early Identification Strategy; and Strategy to Fill Gaps in Care and Reach the Out-of-Care |
| | 7-Retention and Re-engagement for HIV Positive Persons | Strategy to Fill Gaps in Care and Reach the Out-of-Care |
| | 8-Antiretroviral Treatment for HIV Positive Persons | Strategy to Fill Gaps in Care and Reach the Out-of-Care |
| | 9-Adherence to ART for HIV Positive Persons | Prevention and Early Identification Strategy |
| | 12-Partner Services | Prevention and Early Identification Strategy |
| | 13-Behavioral Risk Screening, Risk Reduction for HIV Positive Persons | Prevention and Early Identification Strategy |
| | 14-Implement linkage to other medical and social services for HIV-positive persons | Prevention and Early Identification Strategy; and Strategy to Fill Gaps in Care and Reach the Out-of-Care |
| Recommended Interventions | 15-Condom Distribution for General Population | Prevention and Early Identification Strategy |
| | 16-Social Marketing Campaigns | Prevention and Early Identification Strategy |
| | 17-Clinic-wide or Provider-delivered Prevention Interventions | Prevention and Early Identification Strategy |
| | 18-Community Interventions | Prevention and Early Identification Strategy |
| | 20-Integrated Hepatitis, TB, STD Services | Prevention and Early Identification Strategy |
| | 21-Targeted Use of Surveillance Data | Strategy to Improve Coordination of Effort and Prepare for Health Care System Changes |
| | 24-Community Mobilization | Strategy to Improve Coordination of Effort and Prepare for Health Care System Changes |

| | | |
|---|---|---|
| Targets | 1- Reduce the annual number of new HIV infections by 25% and reduce the HIV transmission rate by 30%. | 1-By 2014, reduce the number of new HIV infections diagnosed in the Houston Area by 25 percent (from 1,029 to 771). |
| | 2-Increase the percentage of people living with HIV who know their serostatus to 90%. | 2-By 2014, maintain and, if possible, increase the percentage of individuals with a positive HIV test result through targeted HIV testing who are informed of their HIV+ status (beginning at 92.9 percent with the goal of 100 percent). |
| | 7-Reduce AIDS diagnoses by 25%. | 4-By 2014, reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year by 25 percent (from 36 percent to 27 percent). |
| | 8-Increase the percentage of persons diagnosed with HIV who are linked to clinical care as evidenced by having a CD4 count or viral load measure within 3 months of HIV diagnosis to 85%. | 3-By 2014, increase the proportion of newly-diagnosed individuals linked to clinical care within three months of their HIV diagnosis to 85 percent (from 65.1 percent). |
| | 9-Increase by 10% the percentage of HIV-diagnosed persons in care whose most recent viral load test in the past 12 months was undetectable. | 7-By 2014, increase the proportion of Ryan White HIV/AIDS Program clients with undetectable viral load by 10 percent (from 57 percent to 62.7 percent). |
| | 11-By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least two visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80%. | 5-By 2014, increase the percentage of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) to 80 percent (from 78 percent). |

In addition to ensuring alignment of comprehensive HIV planning efforts with planning conducted through ECHPP, the Ryan White HIV/AIDS Program has also collaborated on the *implementation* of ECHPP interventions in the Houston Area. The Houston Department of Health and Human Services (HDHHS) is the directly-funded grantee for the Houston-Baytown-Sugarland, TX ECHPP initiative. The Ryan White HIV/AIDS Program Part A has partnered with the HDHHS to implement specific ECHPP components:

- Service Linkage Workers (SLW). The Ryan White HIV/AIDS Program Part A contracts with the HDHHS to place SLW at HDHHS locations where individuals are newly-diagnosed, including routine HIV testing sites and public STD clinics, for the purpose of linking these individuals to HIV care, treatment, and support services (ECHPP Required Intervention #6). SLW provide targeted, non-medical community-based case management, including active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing. The SLW Outcome Measure requires each newly-diagnosed client to be linked to a Ryan White HIV/AIDS Program-funded primary medical care or case management provider within 120 days of contact.

- Case Management (CM). The Ryan White HIV/AIDS Program Part A also places CM in locations where newly-diagnosed or out-of-care individuals interact with the HIV system, including HDHHS-funded locations, for the purpose of promoting retention in or re-engagement in care (ECHPP Required Intervention #7). In addition to making active referrals to services, CM includes coordination of medical appointments, treatment plans, and medication adherence to ensure improved health outcomes. CM is evaluated on specific Outcome Measures related to CD-4, viral load, and stage of illness.

Though not a Required or Recommended Intervention within the ECHPP model, ongoing data systems collaboration between the HDHHS and the Ryan White HIV/AIDS Program will ultimately support evaluation and monitoring of ECHHP implementation. As described above, the HDHHS is in the process of implementing a client-level data system called ECLIPS, which, in its full iteration, will bi-directionally communicate electronically with the Houston Area's client-level HIV care data system on linkage to care, service utilization, and health outcome data.

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# Steven Vargas

*"It falls on us, the children, the current survivors of this epidemic, to pick up the torch, not let the flag hit the ground."*

Photograph by Barb Garvin

*There was a time when Steven Vargas felt like HIV was closing in around him.*

Raised in a "mixed race, mixed religious beliefs, mixed sexual orientation family," Steven had many role models for tolerance, embracing difference, and what it means to have a healthy relationship. He also attended a local performing arts high school that was both affirming for him as a Latino gay man and inspiring for him in his love of art and music. There, Steven was a first chair horn player and even received a music scholarship to DePaul University but chose instead to enter the workforce. His motto at the time? "Don't let school get in the way of your education."

Then, as Steven describes it, HIV started to close in around him. First, friends of his family became infected, then more distant relatives, and then he learned that both of his parents were HIV positive. His mother encouraged Steven to become an activist against the disease, but, after finding out that he too, was positive, he felt that HIV infection was "inevitable." It was only later, after continuing to hear about HIV spreading into the heterosexual community, that Steven felt compelled to act.

Today, Steven works as a Case Manager for the Minorities Action Program at the Association for the Advancement of Mexican Americans (AAMA) where he helps spread life-saving messages

about HIV to Houston's Latino community. He has also served on the Houston Area Ryan White Planning Council and will soon become a member of the Houston HIV Planning Group.

Despite this, he still wishes there was no longer a need for his work. He says, "I've lived to see the turn of a millennium, an openly gay Mayor of Houston, an African American President. I really was not certain I would see these things in my lifetime," and so he remains hopeful that he will also live to see a cure for HIV. Until that day, Steven says, remembering his own parents, "it falls on us, the children, the current survivors of this epidemic, to pick up the torch, not let the flag hit the ground."

STEVEN VARGAS

Case Manager, Minorities Action Program,
Association for the Advancement of Mexican-Americans, Inc. (AAMA)

Houston Area Ryan White Planning Council
*Co-Chair, 2011, Comprehensive HIV Planning Committee*

2012 Houston Area Comprehensive HIV Prevention and Care Services Plan
*Co-Chair, Evaluation Workgroup*

Member, 2012, Dennis DeLeon Sustainable Leadership Institute

Member
*Hepatitis C Task Force*
*Latino HIV Task Force*
*M-Pact (the MSM Task Force)*

## Conclusion: How to Use the Plan

Comprehensive jurisdictional HIV prevention and care services plans are roadmaps for the design and delivery of activities and services to meet the needs of individuals at risk for, infected with, or affected with HIV/AIDS. As the roadmap for the Houston Area, the Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 (Comprehensive Plan) describes both the *destination* of an ideal system of HIV prevention and care services for the Houston Area as well as the *direction* needed in order to make progress toward this ideal. It outlines global concerns, solutions, and long-range goals and objectives for the Houston Area *as a whole*, and it designates specific activities and efforts for key HIV prevention and care stakeholders in the community. The combination of agency-specific solutions and system-wide goals allows the Comprehensive Plan to serve as a roadmap for those already engaged in HIV prevention and care services and for the Houston Area community as a whole.

While the goals and action steps of the Comprehensive Plan are extensive and represent the input of over 100 subject matter experts and agencies, they are not intended to, *nor could they be,* an exhaustive list of all activities needed to address HIV in the Houston Area. Attaining the vision of an ideal system of HIV prevention and care services will require the continued partnership, collaboration, and coordination of numerous individuals, groups, organizations, and programs. Below are specific ways in which some of these groups and organizations can use the Comprehensive Plan in their work and in their community to help make progress toward an ideal system of HIV prevention and care services:

### Planning Bodies

- Use the plan to orient new and potential new Planning Body members about the current system of HIV prevention and care in the Houston Area (Section I)
- Use the plan's list of Priority Populations (Section II) when determining a population focus for HIV prevention and care services
- Use the plan's list of crosscutting solutions (Section II) when prioritizing HIV prevention and care services
- Use the plan's dashboard (Section II) as a way to assess community-wide HIV health status in the Houston Area
- Implement assigned activities within each Strategy (Section III); and become engaged in Strategy implementation by other stakeholders
- If needed, establish a mechanism within the Planning Body structure to ensure effective implementation of the plan
- Disseminate the plan to other HIV prevention and care jurisdictions as a model for collaboration and joint comprehensive HIV planning

### People Living with HIV/AIDS (PLWHA), Consumers, and Concerned Community Members

- Use the plan as a source of information about local HIV prevention and care services and providers (Section I)
- Review the plan for ways that PLWHA and consumers can become involved in local HIV decision-making, such as through the Planning Bodies (Section I)
- Review each Strategy (Section III) in the plan for activities designed for PLWHA and consumers
- Consider how PLWHA, consumers, and other concerned community members can participate in Strategy implementation (Section III)
- Become a plan "champion," be trained to speak about the plan to interested groups, and promote the plan to peers, providers, and other networks

### AIDS-Service Organizations (ASOs)

- Align agency-level strategic plans and business plans with the vision, mission, goals, and objectives of the Comprehensive Plan (Section II)

- Use the plan as a reference for program development and when determining new target populations, services, or initiatives (Section II) for the agency
- Review each Strategy (Section III) in the plan for activities targeted to ASOs
- Adopt specific activities within the Strategies (Section III) to complete at the agency-level; and participate in Strategy implementation by other stakeholders
- Reference the plan in grant-writing and marketing efforts
- Disseminate the plan to leadership and staff; and use it in workforce development
- Designate a plan "champion"

### Other Community-Based Organizations (CBOs) and Coalitions

- Use the plan as a reference for information about HIV in the Houston Area (Section I)
- Disseminate the plan to staff, leadership, and members as an educational tool. Invite a plan "champion" to speak at an agency or coalition meeting.
- Review agency-level strategic plans and business plans for opportunities to align with the vision, mission, goals, and objectives of the Comprehensive Plan (Section II)
- Review each Strategy (Section III) in the plan for activities targeted to potential new AIDS-service providers and community groups and coalitions
- Consider how the agency or coalition might be able to participate in Strategy implementation (Section III)

### Medical Professionals

- Use the plan as a tool to educate providers about needs, gaps, and barriers for people at risk for or infected with HIV (Section I)
- Use the plan as a reference for information about the HIV prevention and care services system in the Houston Area (Section I)
- Use the plan's list of crosscutting solutions (Section II) as a guide for delivering HIV services in the medical setting (e.g., routine HIV screening, linkage to care, HIV medical homes, etc.)
- Apply the plan's dashboard (Section II) as internal benchmarks for HIV patients; and consider how facility-level data might be incorporated into community-wide data management systems (Section IV)
- Review each Strategy (Section III) for activities targeting medical professionals

### Media Professionals

- Use the plan as a reference when determining new media stories
- Use the plan as documentation for the need for media coverage of HIV related issues and concerns
- Review each Strategy (Section III) in the plan for activities related to media and marketing

### Researchers

- Use the plan as a reference when determining new research efforts on HIV
- Review the plan's goals for new data collection (Section IV) for potential collaboration
- Facilitate opportunities for students to participate in research and evaluation activities related to plan implementation
- Reference the plan in research proposals and grant-writing
- Align long-term research aims with the plan's vision, mission, goals, and objectives (Section II) and short-term research aims with the benchmarks contained in each Strategy (Section III)

### Policy-Makers

- Use the plan as a reference for information about HIV in the Houston Area (Section I)
- Disseminate the plan as an educational tool to other policy- and decision-makers. Invite a plan "champion" to speak to a group.
- Use the plan as documentation for the need to prioritize HIV concerns in local health policy. Include HIV in policy agendas.
- Review each Strategy (Section III) in the plan for activities related to policy change.
- If applicable, consider making charitable giving or other funding decisions that support plan implementation.
- Review the plan's vision, mission, goals, and objectives (Section II) for alignment with other strategic plans, business plans, and community development plans for the Houston Area.

# Leadership Team

Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014

Photograph by Barb Garvin

Joint Meeting with the Ryan White Planning Council Comprehensive HIV Planning Committee, March 26, 2012, Houston TX. *Top row (L-R):* Nancy Miertschin, Morénike Giwa, Diane Beck, Erik Soliz, Pam Green, David Garner, Jennifer Hadayia, David Benson, Charles Henley, Amber David, Larry Woods, and Cristan Williams. *Middle row (L-R):* Camden Hallmark, Cecilia Smith-Ross, Bruce Turner, Jerry Garza, Jeff Benavides, Maggie White, Jonathan Post, Tori Williams, and Roy Delesbore. *Front row (L-R):* Anna Langford, Frances Bueno, Florida Kweekah, Edith Curry-Moore, Michael Bass, and Steven Vargas

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