2012-2014

HOUSTON AREA COMPREHENSIVE HIV PREVENTION AND CARE SERVICES PLAN

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

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 2nd half of the year after also having at least 1 visit for HIV primary care in the 1st 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)