Houston Area Comprehensive HIV Prevention and Care Services Plan 2017 - 2021

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

HOUSTON EMA HIV CARE CONTINUUM

What is the Care Continuum?

The HIV Care Continuum, previously known as a Treatment Cascade, was first released in 2012 by the Centers for Disease Control and Prevention (CDC). It represents the sequential stages of HIV care, from being diagnosed with HIV to suppressing the HIV virus through treatment. Ideally, the Care Continuum describes a seamless system of HIV prevention and care services, in which people living with HIV (PLWH) receive the full benefit of HIV treatment by being diagnosed, linked to care, retained in care, and taking HIV medications as prescribed to achieve viral suppression.

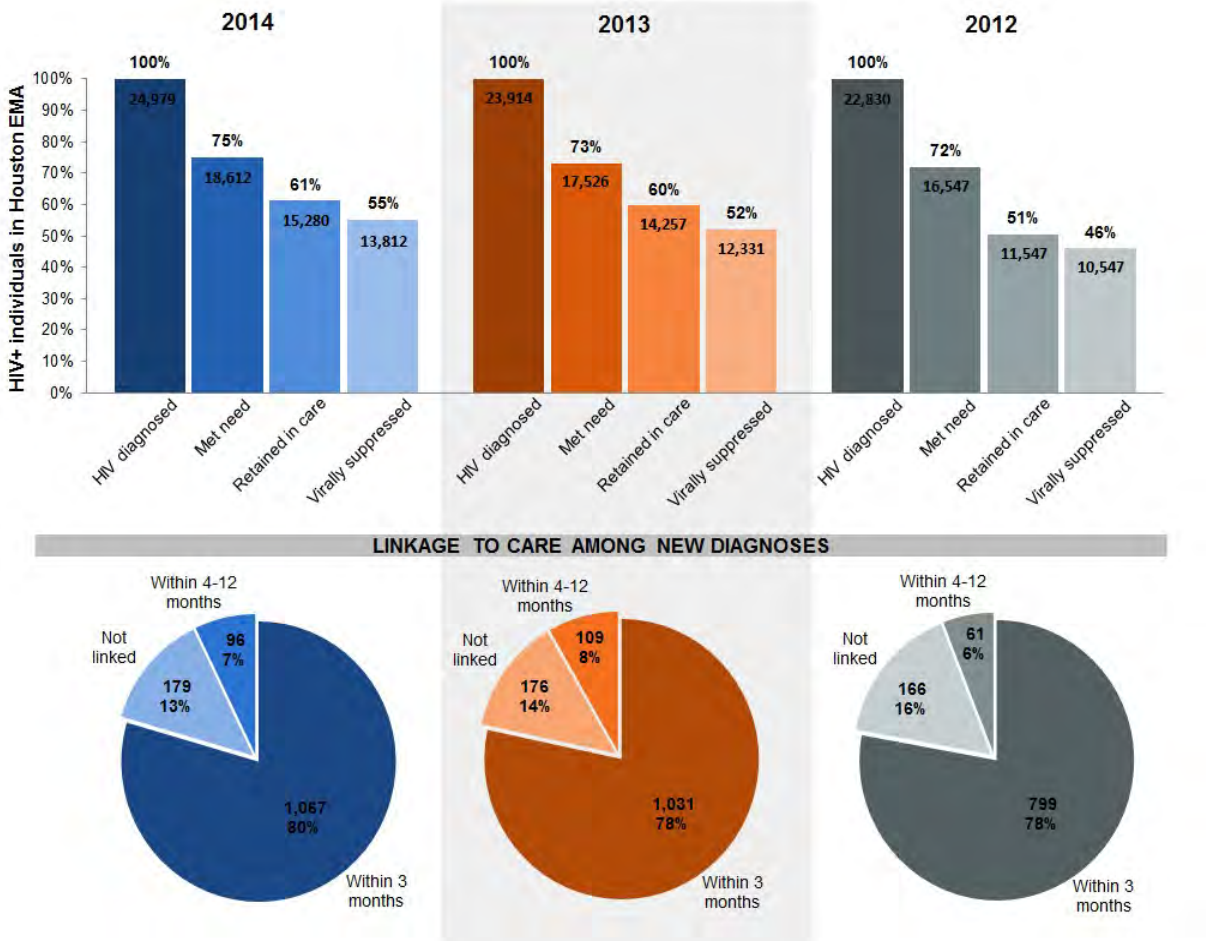
The Houston EMA Care Continuum (HCC)

The HCC is a diagnosis-based continuum. The HCC reflects the number of PLWH who have been diagnosed ("HIV diagnosed"); and among the diagnosed, the numbers and proportions of PLWH with records of engagement in HIV care ("Met need"), retention in care ("Retained in care"), and viral suppression ("Virally suppressed") within a calendar year. Although retention in care is a significant factor for PLWH to achieve viral suppression, 'Virally suppressed' also includes those PLWH in the Houston EMA whose most recent viral load test of the calendar year was <200 copies/mL but who did not have evidence of retention in care.

Linking newly diagnosed individuals into HIV medical care as quickly as possible following initial diagnosis is an essential step to improved health outcomes. In the HCC, initial linkage to HIV medical care ("Linkage to care") is presented separately as the proportion of *newly* diagnosed PLWH in the Houston EMA who were successfully linked to medical care within three months or within one year after diagnosis.

Please see the last page for the Methodology used to develop the Houston EMA HIV Care Continuum.

Figure 1: Houston EMA HIV Care Continuum, 2012-2014



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

From 2012-2014, the total number of HIV diagnosed increased each year, but the percentage of those with met need, retained in care, and virally suppressed also increased.

- There was a 10% increase in the percentage of persons retained in care over the course of three years, with the greatest increase from 2012-2013.
- There was a 9% increase in the percentage of those virally suppressed from 2012 to 2014.
- The percentage of those with met need and those linked within 3 months was relatively stable, with a change of 2% or less between each year.

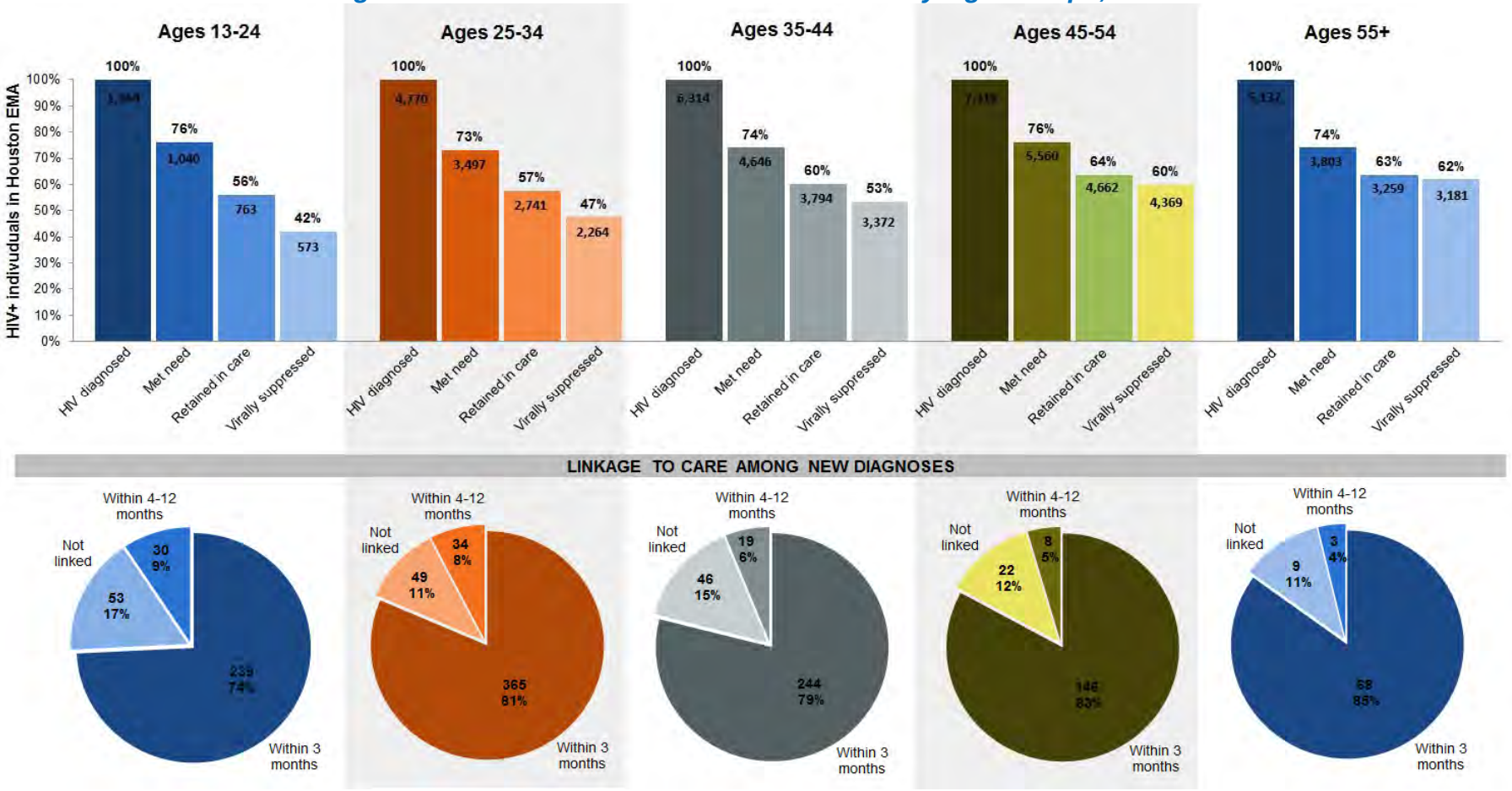
Disparities in Engagement among Key Populations

Multiple versions of the HCC have been created to illustrate engagement disparities and service gaps that key populations encounter in the Houston EMA.

It is important to note that available data used to construct each version of the Houston EMA HCC do not portray the need for activities to increase testing, linkage, retention, ART access, and viral suppression among many other at-risk key populations, such as those who are transgender or gender non-conforming, intersex, experiencing homelessness, or those recently released from incarceration

The Houston EMA Care Continuum, by Age

Figure 2: Houston EMA HIV Care Continuum by Age Groups, 2014



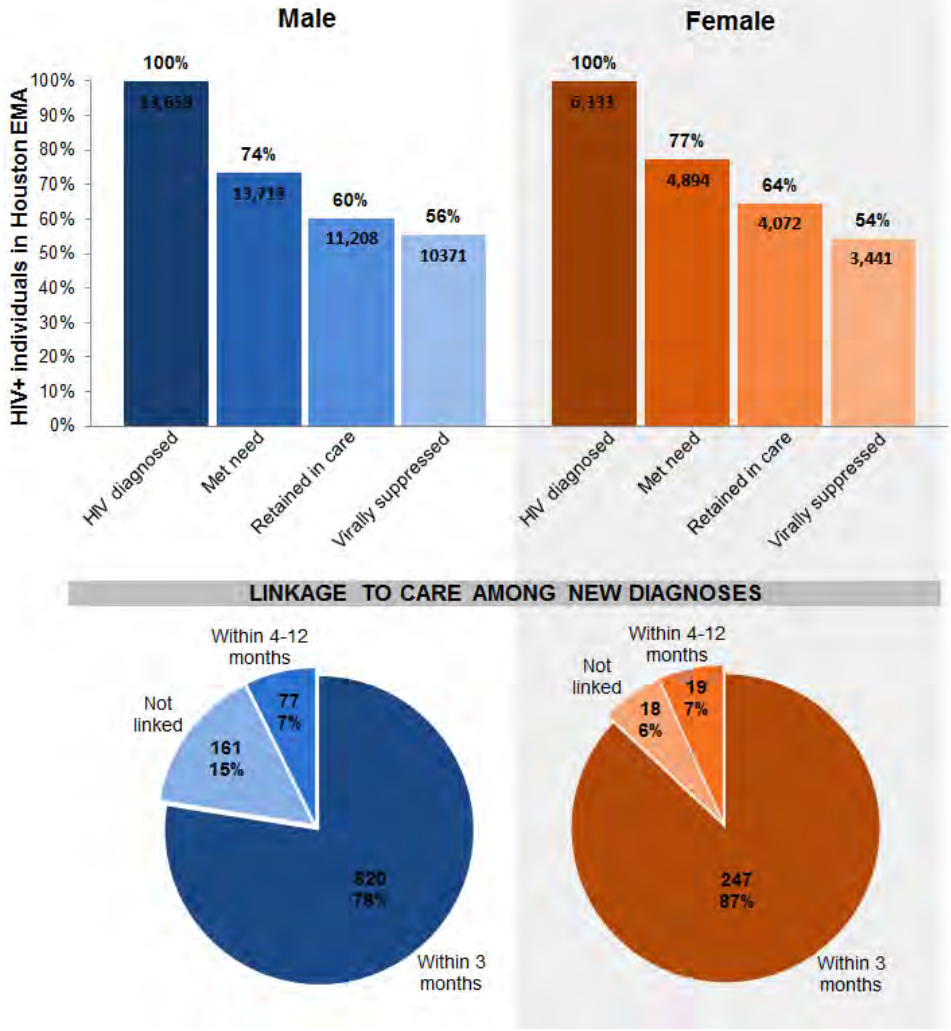
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

- Younger adults had lower percentages of retention and viral suppression compared to the older adult age groups.

- Youth and young adults (13-24 years old) also had the lowest proportion of newly diagnosed PLWH who were linked within three months of diagnosis when compared to the older adult age groups.

The Houston EMA Care Continuum, by Sex at Birth

Figure 3: Houston EMA HIV Care Continuum by Sex at Birth, 2014

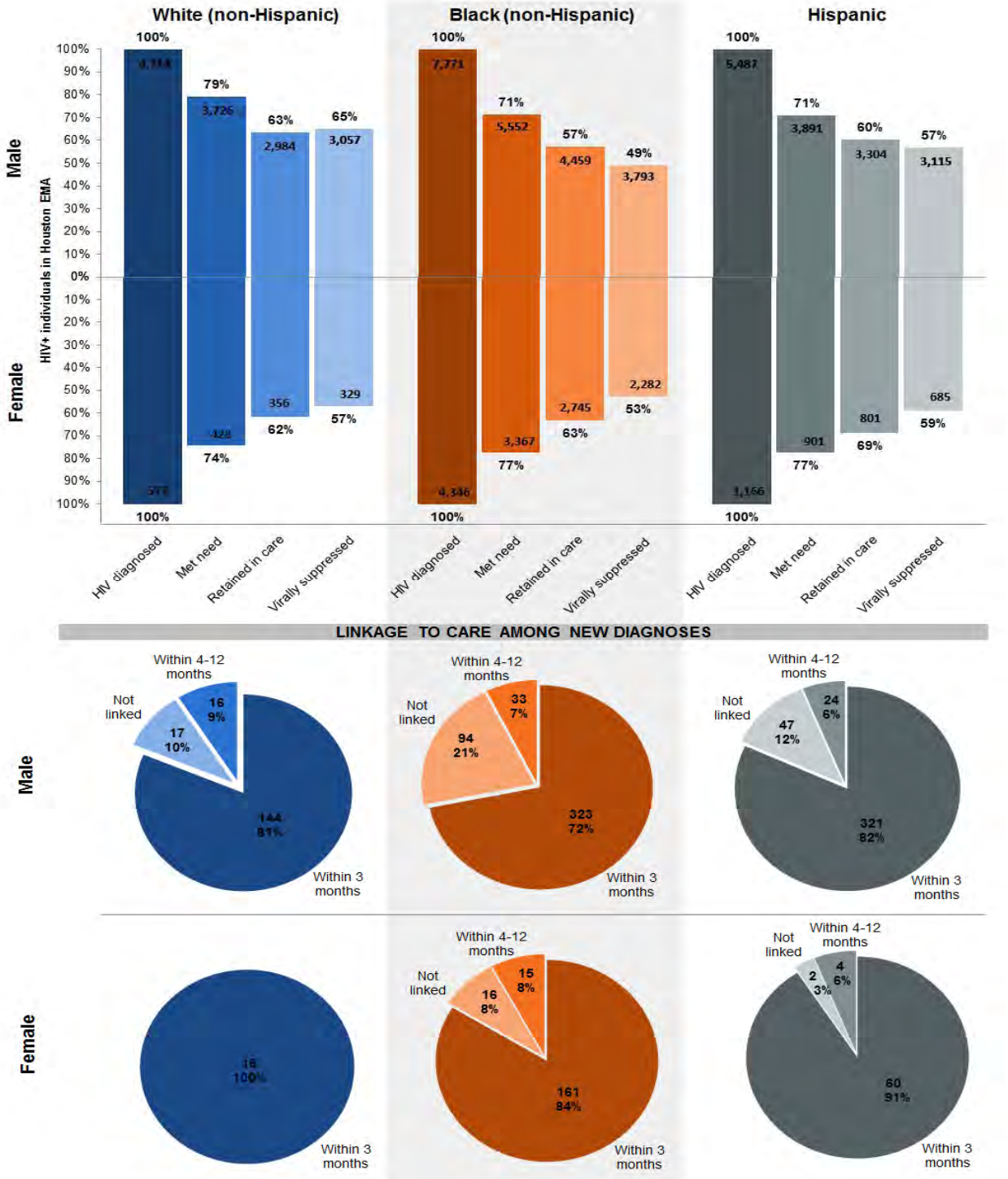


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

- Females living with HIV in the Houston EMA in 2014 had a higher proportion of individuals with met need and retention in care than males living with HIV, although females had a smaller proportion of viral suppression.
- The proportion of newly diagnosed female PLWH linked to care within the first three months after diagnosis was almost 10% higher among females than males.

The Houston EMA Care Continuum, by Sex at Birth and Race/Ethnicity in 2014

Figure 4: Houston EMA HIV Care Continuum by Sex at Birth and Race/Ethnicity, 2014



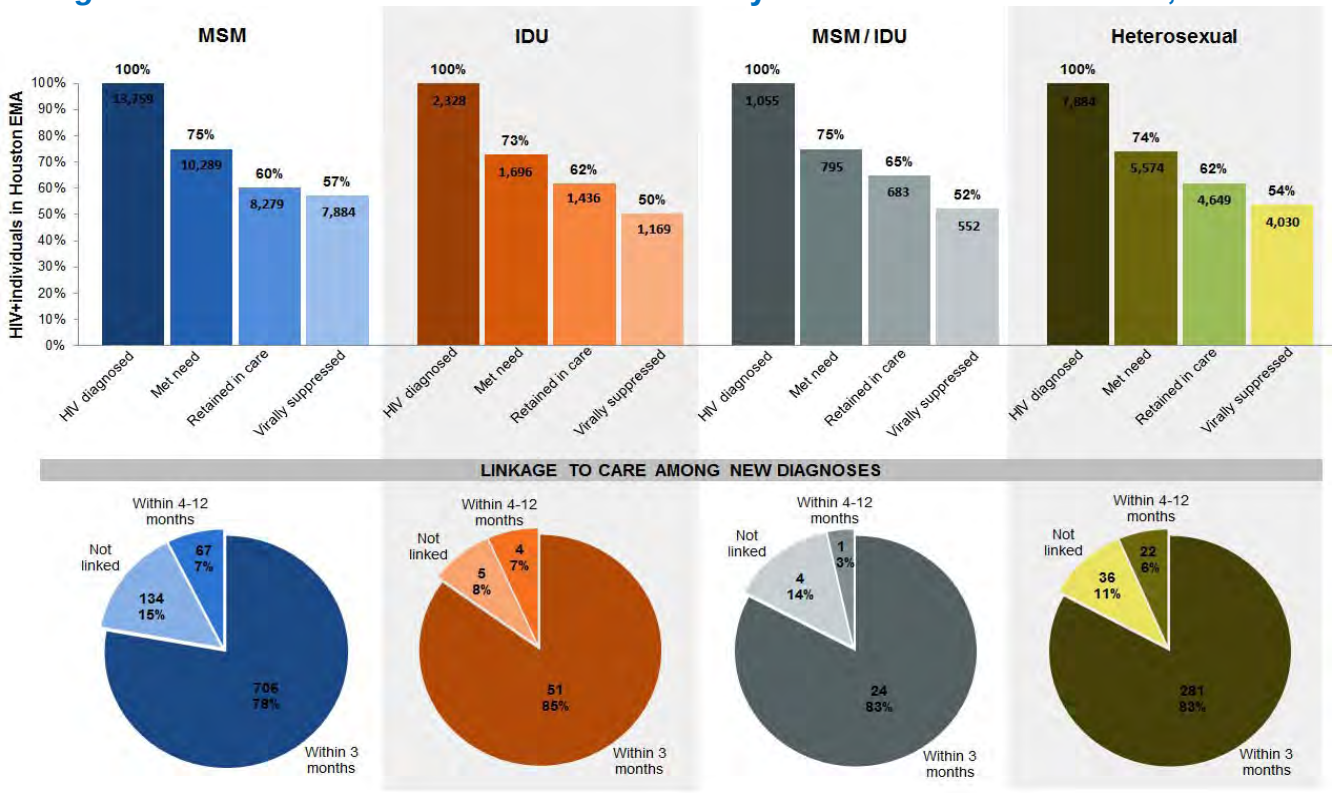
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

- Hispanic and Black (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of met need, retention in care, and viral suppression among males in 2014.

- Among females, White (non-Hispanic) and Black (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of retention in care and viral suppression in 2014.
- Overall, Black (non-Hispanic) males living with HIV had the lowest proportion of individuals in each care continuum stage across all birth sex and race/ethnicity groups.

The Houston EMA Care Continuum, by Transmission Risk Factor in 2014

Figure 5: Houston EMA HIV Care Continuum by Transmission Risk Factor, 2014



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

Transmission risk factors that are associated with increased risk of HIV exposure and transmission include Men who have Sex with Men (MSM), injection drug use (IDU), MSM who also practice IDU (MSM/IDU), and heterosexual exposure.

- Although MSM have higher numbers of PLWH than the other risk groups, the proportion of diagnosed MSM living with HIV show evidence of met need and retention in care similar to those observed for other risk groups.
- MSM also has a higher proportion of diagnosed PLWH who are virally suppressed, but a lower proportion of newly diagnosed PLWH who were successfully linked to care within three months of initial diagnosis.
- Those with IDU as a primary transmission risk factor exhibited the lowest proportions of both met need and viral suppression.

Questions about the Houston EMA HIV Care Continuum can be directed to: Amber Harbolt, Health Planner in the Office of Support.

The methodology used to develop the Houston EMA Care Continuum:

Measure	Definition	Data Source(s)
HIV diagnosed	No. of persons diagnosed and living with HIV (PLWH) residing in Houston EMA through end of year (alive)	Texas eHARS data
Met need	No. (%) of PLWH in Houston EMA with met need (at least one: medical visit, ART prescription, or CD4/VL test) in year.	Texas Department of State Health Services HIV Unmet Need Project (incl. eHARS, ELR, ARIES, ADAP, Medicaid, private payer data)*
Linkage to care (pie chart)	No. (%) of **newly diagnosed** PLWH in Houston EMA who were linked to medical care ("Met need") within N months of their HIV diagnosis	
Retained in care	No. (%) of PLWH in Houston EMA with at least 2 medical visits, ART prescriptions, or CD4/VL tests in year, at least 3 months apart	
Virally suppressed	No. (%) of PLWH in Houston EMA whose last viral load test of the year was <200 copies/mL	Texas ELRs, ARIES labs, ADAP labs

★ ROADMAP ★

TO ENDING THE HIV EPIDEMIC IN HOUSTON

~December 2016~

TABLE OF CONTENTS

Access to Care

ACCESS TO CARE

The vision of the access to care work group is to ensure all residents of the Houston Area receive proactive and timely access to comprehensive and non-discriminatory care to prevent new diagnoses, and for those living with HIV/AIDS to achieve and maintain viral suppression.

Recommendation 1: Enhance the health care system to better respond to the HIV/AIDS epidemic

The ability of the local health care system to appropriately respond to the HIV/AIDS epidemic is a crucial component to ending the epidemic in Houston. FQHCs, in particular, represent a front line for providing comprehensive and appropriate access to care for people living with HIV/AIDS. While we acknowledge the commitment of many medical providers to provide competent care, ending the epidemic will require a more coordinated and focused response.

Ending the epidemic will require a more coordinated and focused response.

Some specific actions include:

- Develop a more coordinated and standard level of HIV prevention services and referrals for treatment, so that patients receive the same type and quality of services no matter where care is accessed.
- Integrate a women-centered care model approach to increase access to sexual and reproductive health services. Women-centered care meets the unique needs of women living with HIV and provides care that is non-stigmatizing, holistic, integrated, and gender-sensitive.
- Train more medical providers on the Ryan White care system.
- Explore feasibility of implementing a pilot rapid test and treat model, in which treatment would start immediately upon receipt of a positive HIV test.
- Better equip medical providers and case managers with training on best practices, latest developments in care and treatment, and opportunities for continuing education credits.
- Increase use of METRO Q® Fare Cards, telemedicine, mobile units, and other solutions to transportation barriers.
- Develop performance measures to improve community viral load as a means to improve health outcomes and decrease HIV transmission.
- Integrate access to support services such as Women, Infants and Children (WIC), food stamps, Children's Health Insurance Program (CHIP), and health literacy resources in medical settings.

Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.

Recommendation 2: Improve cultural competency for better access to care

Lack of understanding of the social and cultural norms of the community is one of the most cited barriers to care. These issues include race, culture, ethnicity, religion, language, poverty, sexual orientation and gender identity. Issues related to the lack of cultural competency are more often experienced by members of the very communities most impacted by HIV. Medical providers must improve their cultural understanding of the communities they serve in order to put the "care" back in health care. Individuals will not seek services in facilities they do not feel are designed for them or where they receive insensitive treatment from staff.

Some specific actions include:

- Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.
- Include training on interventions for trauma-informed care and gender-based violence. This type of care is a treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma that contribute to mental health issues including substance abuse, domestic violence, and child abuse.
- Establish measures to evaluate effectiveness of training.
- Revise employment applications to include questions regarding an applicant's familiarity with the community being served. New hires with lack of experience working with certain communities should receive training prior to interacting with the community.

Recommendation 3: Increase access to mental health services and substance abuse treatment

Access to behavioral health and substance abuse treatment are two of the most critical unmet needs in the community. Individuals have difficulty staying in care and adhering to medication without access to mental health and substance abuse treatment. Comprehensive HIV/AIDS care must address the prevalence of these conditions.

Increase the availability of mental health services and substance abuse treatment.

Some specific actions include:

- Perform mental health assessments on newly diagnosed persons to determine readiness for treatment, the existence of an untreated mental health disorders, and need for substance abuse treatment.
- Increase the availability of mental health services and substance abuse treatment, including support groups and peer advocacy programs.
- Implement trauma-informed care in health care settings to respond to depression and post-traumatic stress disorders.

Recommendation 4: Improve health outcomes for people living with HIV/AIDS with co-morbidities

Because of recent scientific advances, people living with HIV/AIDS, who have access to antiretroviral therapy, are living long and healthy lives. HIV/AIDS is now treated as a manageable chronic illness and is no longer considered a death sentence. However, these individuals are developing other serious health conditions that may cause more complications than the virus. Some of these other conditions include Hepatitis C, hypertension, diabetes, and certain types of cancer. When coupled with an HIV diagnosis, these additional conditions are known as co-morbidities. HIV treatment must address the impact of co-morbidities on treatment of HIV/AIDS.

Some specific actions include:

- Utilize a multi-disciplinary approach to ensure that treatment for HIV/AIDS is integrated with treatment for other health conditions.
- Develop treatment literacy programs and medication adherence support programs for people living with HIV/AIDS to address co-morbidities.

Recommendation 5: Develop and publicize complete and accurate data for transgender people and those recently released from incarceration

There is insufficient data to accurately measure the prevalence and incidence of HIV among transgender individuals. In addition, there appears to be a lack of data on those recently released from incarceration. We need to develop data collection protocols to improve our ability to define the impact of the epidemic on these communities.

Recommendation 6: Streamline the Ryan White eligibility process for special circumstances

The Ryan White program is an important mechanism for delivering services to individuals living with HIV/AIDS. In order to increase access to this program, we must remove barriers to enrollment for qualified individuals experiencing special situations. We recommend creating a fast track process for Ryan White eligibility determinations for special circumstances, such as when an individual has recently relocated to Houston and/or has fallen out of care.

Recommendation 7: Increase access to care for diverse populations

According to the 2016 Kinder Houston Area Survey, the Houston metropolitan area has become "the single most ethnically and culturally diverse urban region in the entire country." Between 1990 and 2010, the Hispanic population grew from 23% to 41%, and Asians and others from 4% to 8%. It is imperative that we meet the needs of an increasingly diverse populace.[10]

Some specific actions include:

- Train staff and providers on culturally competent care.
- Hire staff who represent the communities they serve.
- Increase access to interpreter services.
- Develop culturally and linguistically appropriate education materials.
- Market available services directly to immigrant communities.

[10] https://kinder.rice.edu/uploadedFiles/Center_for_the_Study_of_Houston/53067_Rice_HoustonAreaSurvey2016_Lowres.pdf

ROADMAP TO ENDING THE HIV EPIDEMIC IN HOUSTON

-December 2018-

endhivhouston.org

PARTICIPANT COMPOSITION

The following summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2016 Houston HIV Care Services Needs Assessment provides both a "snapshot" of who is living with HIV in the Houston Area today as well as context for other needs assessment results.

(**Table 1**) Overall, 93% of needs assessment participants resided in Harris County at the time of data collection. The majority of participants were male (67%), African American/Black (63%), and heterosexual (54%). Greater than half were age 50 or over, with a median age of 50-54.

The average unweighted household income of participants was $9,380 annually, with the majority living below 100% of federal poverty (**FPL**). Most participants paid for healthcare using Medicaid/Medicare and assistance through Harris Health System (Gold Card).

TABLE 1-Select Participant Characteristics, Houston Area HIV Needs Assessment, 2016

	No.	%		No.	%		No.	%
County of residence			Age range (median: 50-54)			Sex at birth		
Harris	464	93.4%	13 to 17	1	0.2%	Male	341	67.3%
Fort Bend	21	4.2%	18 to 24	17	3.4%	Female	166	37.7%
Liberty	1	0.2%	25 to 49	219	43.2%	Intersex	0	-
Montgomery	6	1.2%	50 to 54	123	24.3%	Transgender	20	3.9%
Other	5	1.0%	55 to 64	133	26.2%	Currently pregnant	1	0.2%
			≥65	14	2.8%			
			Seniors (≥50)	270	53.3%			
Primary race/ethnicity			Sexual orientation			Health insurance		
White	60	11.8%	Heterosexual	274	54.0%	Private insurance	53	8.6%
African American/Black	318	62.7%	Gay/Lesbian	171	33.7%	Medicaid/Medicare	307	49.8%
Hispanic/Latino	121	23.9%	Bisexual	39	7.7%	Harris Health System	146	23.7%
Asian American	5	1.0%	Other	23	4.5%	Ryan White	105	17.0%
Other/Multiracial	3	0.6%	MSM	216	42.6%	None	6	1.0%
Immigration status			Yearly income (average: $9,380)					
Born in the U.S.	427	84.6%	Federal Poverty Level (FPL)					
Citizen > 5 years	33	6.5%	Below 100%	278	78.8%			
Citizen < 5 years	4	0.8%	100%	45	12.7%			
Undocumented	10	2.0%	150%	13	3.7%			
Prefer not to answer	22	4.4%	200%	10	2.8%			
Other	9	1.8%	250%	2	0.6%			
			≥300%	5	1.4%			

(**Table 2**) Certain subgroups of PLWH have been historically underrepresented in HIV data collection, thereby limiting the ability of local communities to address their needs in the data-driven decision-making processes of HIV planning. To help mitigate underrepresentation in Houston Area data collection, efforts were made during the 2016 needs assessment process to *oversample* PLWH who were also members of groups designated as "special populations" due to socio-economic circumstances or other sources of disparity in the HIV service delivery system.

The results of these efforts are summarized in Table 2.

TABLE 2-Representation of Special Populations, Houston Area HIV Needs Assessment, 2016

	No.	%
Unstable Housing	142	28.0%
Injection drug users (IDU)*	8	1.6%
Men who have sex with men (MSM)	216	42.6%
Not retained in care (last 6 months)	4	0.8%
Recently released from incarceration	41	8.1%
Rural (non-Harris County resident)	33	6.4%
Transgender	20	3.9%

*See Limitations section for further explanation of identification of IDU

Chapter 2:
Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

As payer of last resort, the Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to people living with HIV (**PLWH**) who may not have sufficient resources for managing HIV disease. The Houston Area HIV Services Ryan White Planning Council identifies, designs, and allocates funding to locally-provided HIV care services. Housing services for PLWH are provided through the federal Housing Opportunities for People with AIDS (**HOPWA**) program through the City of Houston Housing and Community Development Department. The primary function of HIV needs assessment activities is to gather information about the need for and barriers to services funded by the local Houston Ryan White HIV/AIDS Program, as well as other HIV-related programs like HOPWA and the Houston Health Department's (**HHD**) prevention program.

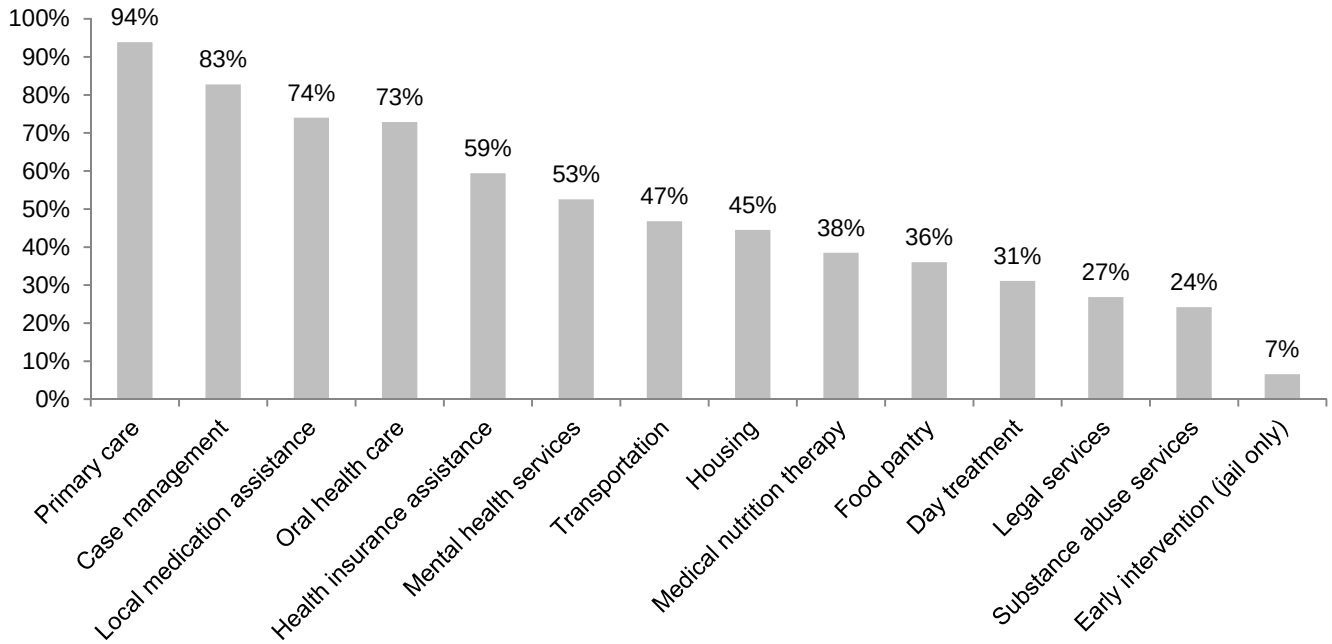
Overall Ranking of Funded Services, by Need

In 2016, 15 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Though no longer funded through the Ryan White HIV/AIDS Program, Food Pantry was also assessed. Participants of the 2016 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 1**) All funded services except hospice and linguistics were analyzed and received a ranking of need. At 94%, primary care was the most needed funded service in the Houston Area, followed by case management at 83%, local medication assistance at 74%, and oral health care at 73%. Primary care had the highest need ranking of any core medical service, while transportation received the highest need ranking of any support service. Compared to the last Houston Area HIV needs assessment conducted in 2014, need ranking increased for many core medical services, and decreased for most support services. The percent of needs assessment participants reporting need for a particular service decreased the most for food pantry, housing, and medical nutrition therapy, while the percent of those indicating a need for health insurance assistance increased 12 percentage points from 2014, the most of any service measured.

GRAPH 1-Ranking of HIV Services in the Houston Area, By Need, 2016

Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.
Denominator:



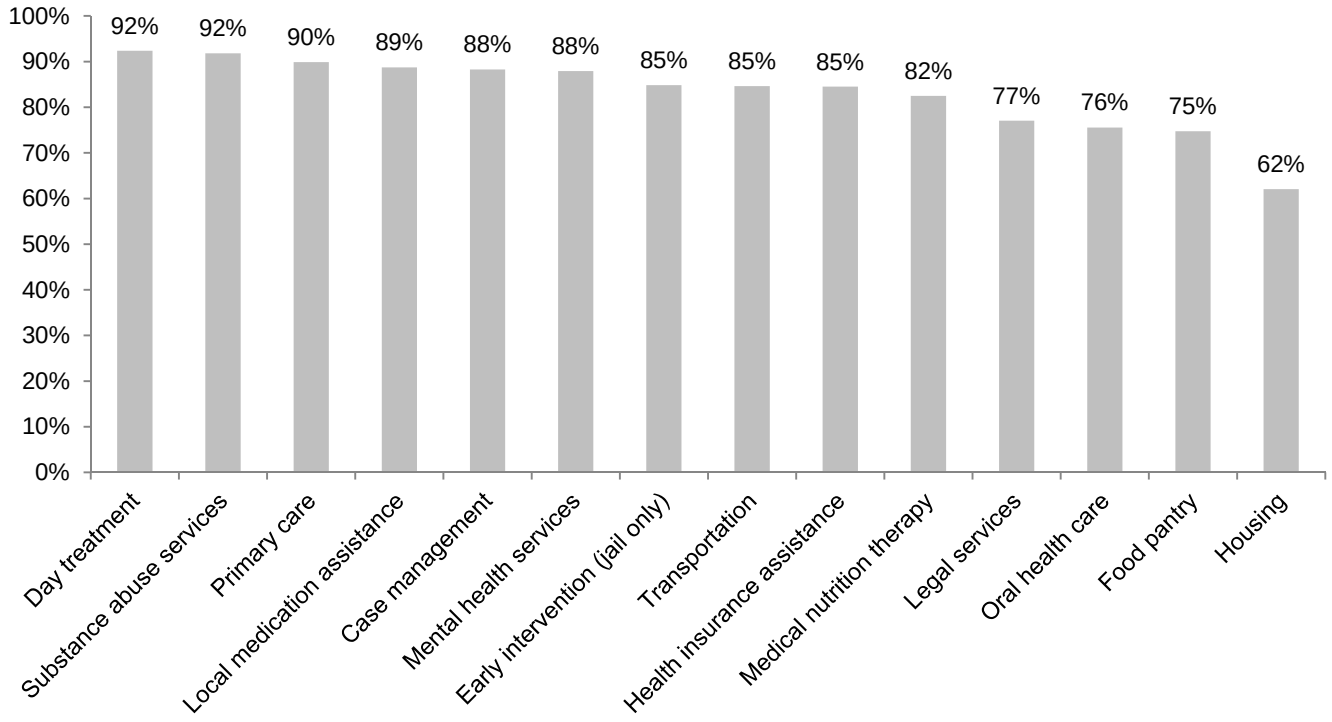
Overall Ranking of Funded Services, by Accessibility

Participants of the 2016 Houston HIV Care Services Needs Assessment were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both topics are presented below.

(**Graph 2**) All funded services except hospice and linguistics were analyzed and received a ranking of accessibility. The two most accessible services were day treatment and substance abuse services at 92% ease of access, followed by primary care at 90% and local medication assistance at 89%. Day treatment had the highest accessibility ranking of any core medical service, while transportation received the highest accessibility ranking of any support service. Compared 2014 needs assessment, reported accessibility increased for each service category, with an average increase of 9 percentage points. The greatest increase in percent of participants reporting ease of access was observed in early intervention services, while transportation experienced the lowest increase in accessibility.

GRAPH 2-Ranking of HIV Services in the Houston Area, By Accessibility, 2016

Definition: Of needs assessment participants stating they needed the service in the past 12 months, the percent stating it was easy to access the service.



Overall Ranking of Barriers Types Experienced by Consumers

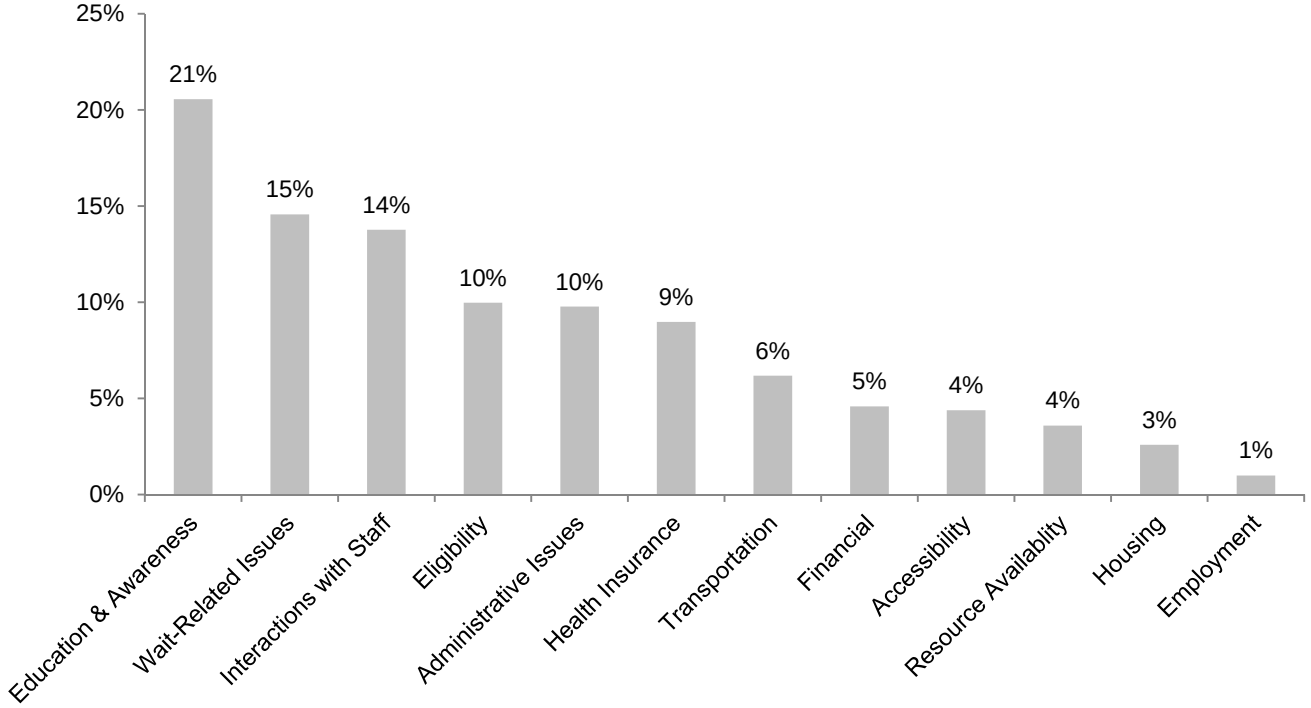
For the first time in the Houston Area HIV Needs Assessment process, participants who reported *difficulty* accessing needed services were asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Recursive abstraction was used to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

(**Graph 3**) Overall, the barrier types reported most often related to service education and awareness issues (21% of all reported barriers); wait-related issues (15%); interactions with staff (14%); eligibility issues (10%); and administrative issues (10%). Employment concerns were reported least often (1%). Due to the change in methodology for barrier assessment between the 2014 and 2016 HIV needs assessments, a comparison of the change in number of reports of barriers will not be available until the next HIV needs assessment.

For more information on barrier types reported most often by service category, please see the Service-Specific Fact Sheets.

GRAPH 3-Ranking of Types of Barriers to HIV Services in the Houston Area, 2016

Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



Descriptions of Barriers Encountered

All funded services were reported to have barriers, with an average of 33 reports of barriers per service. Participants reported the least barriers for Hospice (two barriers) and the most barriers for Oral Health Care (86 barriers). In total, 525 reports of barriers across all services were indicated in the sample.

(**Table 1**) Within education and awareness, knowledge of the availability of the service and where to go to access the service accounted for 82% barriers reported. Being put on a waitlist accounted for a majority (66%) of wait-related issues barriers. Poor communication and/or follow up from staff members when contacting participants comprised a majority (51%) of barriers related to staff interactions. Almost all (86%) of eligibility barriers related to participants being told they did not meet eligibly requirements to receive the service or difficulty obtaining the required documentation to establish eligibility. Among administrative issues, long or complex processes required to obtain services sufficient to create a burden to access comprised most (59%) the barriers reported.

Most (84%) of health insurance-related barriers occurred because the participant was uninsured or underinsured and experiencing coverage gaps for needed services or medications. The largest proportion (81%) of transportation-related barriers occurred when participants had no access to transportation. It is notable that multiple participants reported losing bus cards and the difficulty of replacing the cards presented a barrier to accessing other services. Inability to afford the service accounted for all barriers relating to participant financial resources. The service being offered at a distance that was inaccessible to participants or being recently released from incarceration accounted for most (77%) of accessibility-related barriers, though it is worth note that low or no literacy accounted for 14% of accessibility-related barriers. Receiving resources that were insufficient to meet participant needs accounted for most resource availability barriers. Homelessness accounted for virtually all housing-related barriers. Instances in which the participant's employer did not provide sufficient sick/wellness leave for attend appointments comprised most (60%) employment-related barriers.

TABLE 1-Barrier Proportions within Each Barrier Type, 2016					
Education & Awareness	%	Wait-Related Issues	%	Interactions with Staff	%
Availability (Didn't know the service was available)	50%	**Waitlist** (Put on a waitlist)	66%	**Communication** (Poor correspondence/ Follow up from staff)	51%
Definition (Didn't know what service entails)	7%	**Unavailable** (Waitlist full/not available resulting in client not being placed on waitlist)	15%	**Poor Treatment** (Staff insensitive to clients)	17%
Location (Didn't know where to go [location or location w/in agency])	32%	**Wait at Appointment** (Appointment visits take long)	7%	**Resistance** (Staff refusal/ resistance to assist clients)	13%
Contact (Didn't know who to contact for service)	11%	**Approval** (Long durations between application and approval)	12%	**Staff Knowledge** (Staff has no/ limited knowledge of service)	7%
				Referral (Received service referral to provider that did not meet client needs)	17%
Eligibility	%	Administrative Issues	%	Health Insurance	%
Ineligible (Did not meet eligibility requirements)	48%	**Staff Changes** (Change in staff w/o notice)	12%	**Uninsured** (Client has no insurance)	53%
Eligibility Process (Redundant process for renewing eligibility)	16%	**Understaffing** (Shortage of staff)	2%	**Coverage Gaps** (Certain services/medications not covered)	31%
Documentation (Problems obtaining documentation needed for eligibility)	38%	**Service Change** (Change in service w/o notice)	10%	**Locating Provider** (Difficulty locating provider that takes insurance)	13%
		Complex Process (Burden of long complex process for accessing services)	59%	**ACA** (Problems with ACA enrollment process)	17%
		Dismissal (Client dismissal from agency)	4%		
		Hours (Problem with agency hours of operation)	16%		
Transportation		Financial	%	Accessibility	%
No Transportation (No or limited transportation options)	81%	**Financial Resources** (Could not afford service)	100%	**Literacy** (Cannot read/difficulty reading)	14%
Providers (Problems with special transportation providers such as Metrolift or Medicaid transportation)	19%			**Spanish Services** (Services not made available in Spanish)	9%
				Released from Incarceration (Restricted from services due to probation, parole, or felon status)	32%
				Distance (Service not offered within accessible distance)	45%
Resource Availability	%	Housing	%	Employment	%
Insufficient (Resources offered insufficient for meeting need)	56%	**Homeless** (Client is without stable housing)	100%	**Unemployed** (Client is unemployed)	40%
Quality (Resource quality was poor)	44%	**IPV** (Interpersonal domestic issues make housing situation unsafe)	0%	**Leave** (Employer does not provide sick/wellness leave for appointments)	60%

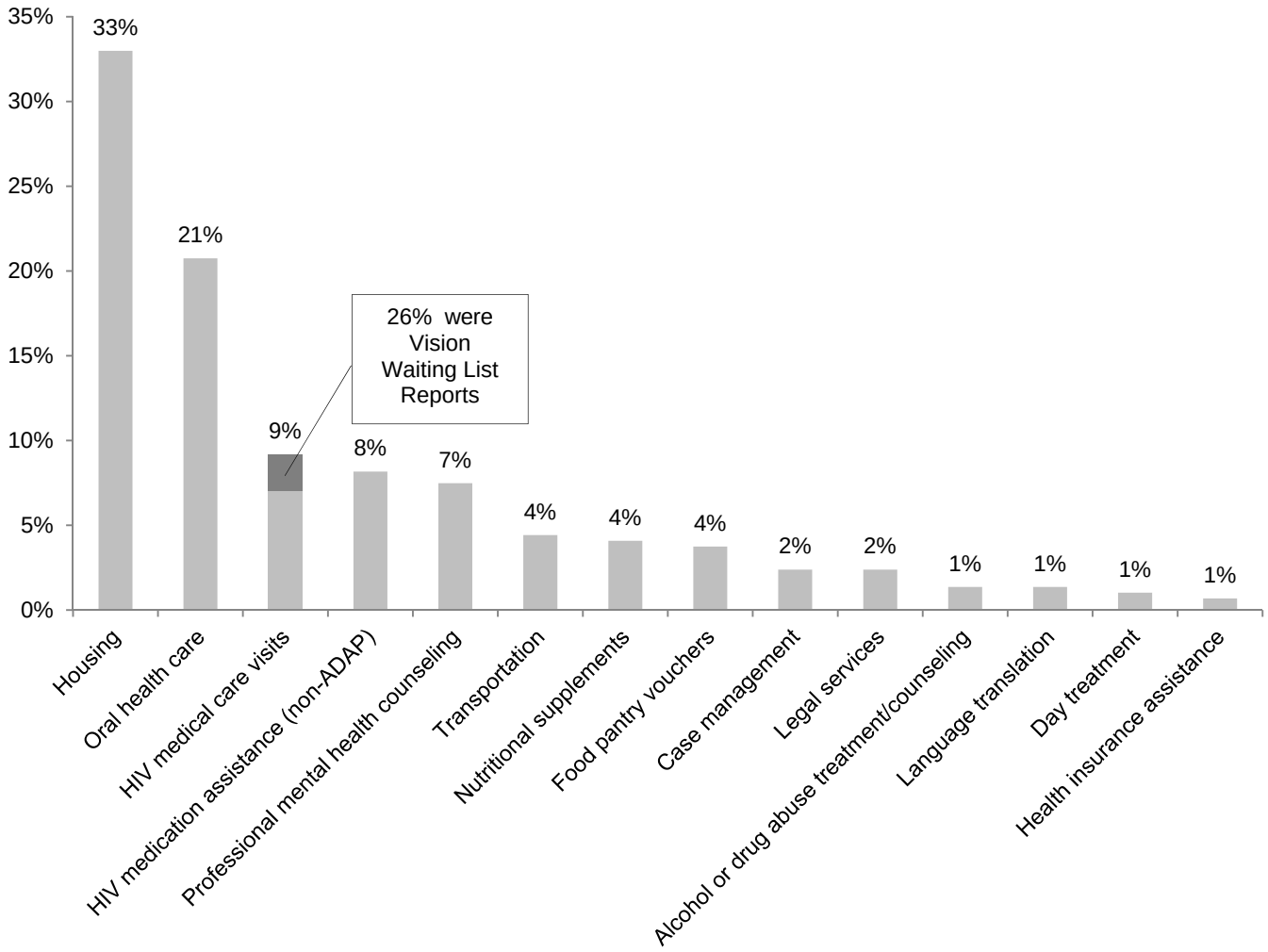
Waiting List Barriers and Experiences

In February 2014, the Ryan White Planning Council formed the ad-hoc Waiting List Workgroup to evaluate the extent to which waiting and waitlists impact the receipt of HIV care and treatment services in the Houston Area, and propose ways to address wait-related issues through changes to the HIV care and treatment system. With input from the Waiting List Workgroup, the 2016 Houston HIV Care Services Needs Assessment included questions specifically designed to elicit information from participants about which services they had been placed on a waiting list for in the past 12 months, the time period between first request for a service and eventual receipt of the service, awareness of other providers of waitlisted services, and services for which clients reported being placed on a waitlist more than once. Thirty-nine percent (39%) of participants indicated that they had been placed on a waiting list for at least one service in the past 12 months.

(**Graph 4**) A third of participant reports of being on a waiting list were for housing services. This was followed by oral health care (21%), HIV medical care (9%), local medication assistance (8%), and professional mental health counseling (7%). Of all participants reporting being on a wait list for HIV medical care visits, 26% indicated being placed on a waiting list specifically for vision services. There were no reports of participants being placed on a wait list for hospice or pre-discharge planning.

GRAPH 4-Percentage of Waiting List Reports by Service, 2016

Definition: Percent of times needs assessment participants reported being on a waiting list for each service.

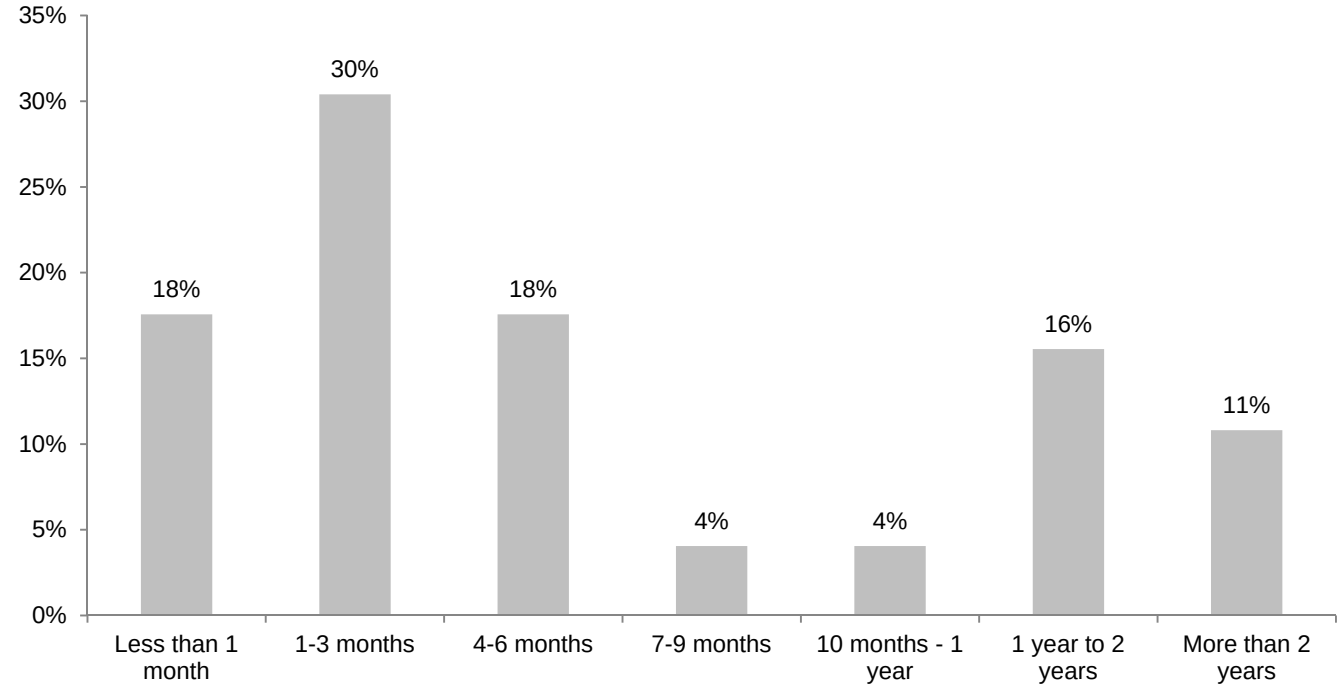


(**Graph 5**) Participant reports of time elapsed from the initial request for a service until receipt of the service vary from 1 day to over 2 years. The greatest number of reports of time elapsed occurred for wait times between one and three months (30%), followed by less than one month (18%) and four to six months 18%).

Most wait times reported for housing services occurred for one to three months (26%), one to two years (26%), or 10 months to one year (18%). It is worth noting that 8% of participants reporting a wait time for housing services had over two years elapse between first request and receipt of service, with several expressing that they were on a housing wait list at the time of survey. Most reports of wait times for oral health care were less than one month (26%) or four to six months (26%). However, 14% of participants indicating a wait time for oral health care services reported wait times of over one year. Finally, most participants (64%) indicating wait times for HIV medical care including vision services reported waiting one to three months.

GRAPH 5-Percentage of Wait Times Reports, 2016

Definition: Percent of times needs assessment participants reported time elapsed from the initial request for a service until receipt of the service each time period.



Awareness of other providers for services operating waiting lists can offer timely service to consumers with acute needs and reduce wait times for those remaining on wait lists. A majority (83%) of participants who reported being on a wait list for at least one in the past 12 months stated that they were not aware of another provider of the service for which they were waiting, or did not remember if they were aware of another provider. Of the remaining 35% of participants who were aware of another provider, over half (59%) reported not seeking service from the alternative provider.

Nearly one-third of participants who reported being placed on a wait list in the past 12 months also reported having been placed on a wait list for the service more than once. This was observed primarily for among participants reporting being placed on a wait list for housing services (34%) and oral health care (29%).

Other Identified Needs

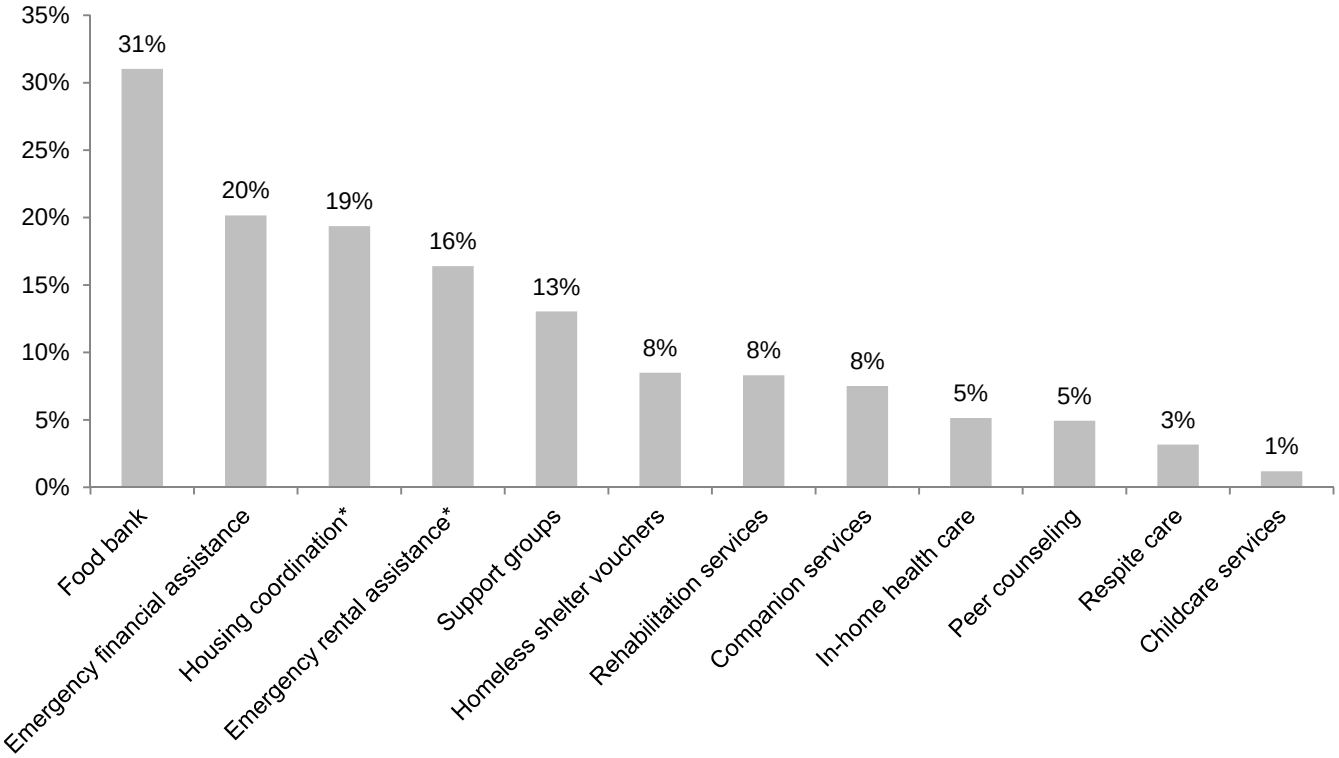
In addition to the HIV services listed above, there are other services allowable for funding by the Ryan White HIV/AIDS Program in local communities if there is a demonstrated need. Several of these other services have been funded by the Ryan White Program in the Houston Area in the past. The 2016 Houston HIV Care Services Needs Assessment measured the need for these services to order to gauge any new or emerging service needs in the community. In addition, some of these services are currently funded through other HIV-specific non-Ryan White sources, namely housing-related services provided by the Housing Opportunities with People with AIDS (HOPWA) program, as indicated.

(**Graph 6**) Twelve other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for Houston Area PLWH. Participants were also encouraged to write-in other types of needed services. Of the 12 services options provided, 31% of participant selected food bank was needed services, a decrease of 14 percentage points from the 2014 needs assessment. Emergency financial assistance was selected second (20%), followed by housing-related services cited third (20%) and fourth (16%), and support groups cited fifth (13%).

Services that were written-in most often as a need (and that are not currently funded by Ryan White) were (*in order*): employment assistance and job training, vision hardware/glasses, and services for spouses/partners.

GRAPH 6-Other Needs for HIV Services in the Houston Area, 2016

Definition: Percent of needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"



*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.

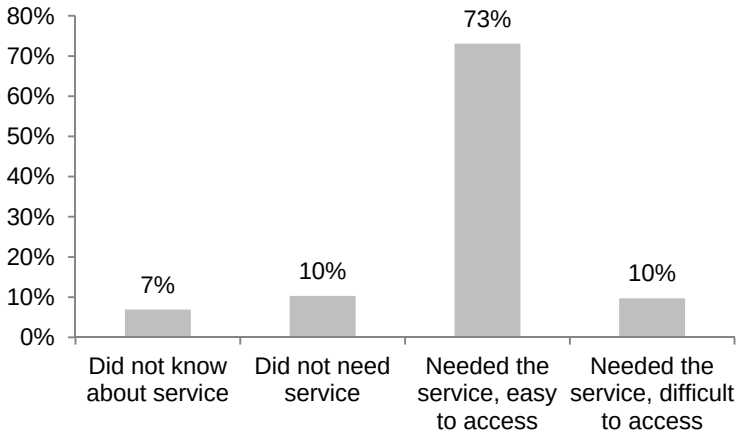
Service-Specific Fact Sheets

CASE MANAGEMENT

Case management, technically referred to as *medical case management, clinical case management, or service linkage*, describes a range of services that help connect persons living with HIV (PLWH) to HIV care, treatment, and support services and to retain them in care. Case managers assess client needs, develop service plans, and facilitate access to services through referrals and care coordination. Case management also includes treatment readiness and adherence counseling.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 83% of participants indicated a need for *case management* in the past 12 months. 73% reported the service was easy to access, and 10% reported difficulty. 7% stated they did not know the service was available.

GRAPH 1-Case Management, 2016



(**Table 1**) When barriers to *case management* were reported, the most common barrier type was interactions with staff (54%). Staff interaction barriers reported include poor correspondence or follow up, poor treatment, limited staff knowledge of services, and service referral to provider that did not meet client needs.

TABLE 1-Top 5 Reported Barrier Types for Case Management, 2016

	No.	%
1. Interactions with Staff (S)	19	54%
2. Education and Awareness (EA)	6	17%
3. Administrative (AD)	5	14%
4. Resource Availability (R)	2	6%
5. Eligibility (EL)	1	3%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *case management*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.

In addition, more MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Case Management, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	7%	8%	1%	9%	7%	13%	13%	7%	7%
Did not need service	11%	8%	10%	11%	11%	0%	13%	7%	16%
Needed, easy to access	73%	76%	72%	73%	72%	87%	75%	76%	68%
Needed, difficult to access	10%	9%	17%	7%	11%	0%	0%	11%	9%

TABLE 3-Case Management, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	8%	6%	0%	5%	0%	18%
Did not need service	7%	12%	0%	0%	3%	9%
Needed, easy to access	76%	71%	100%	89%	91%	64%
Needed, difficult to access	10%	11%	0%	5%	6%	9%

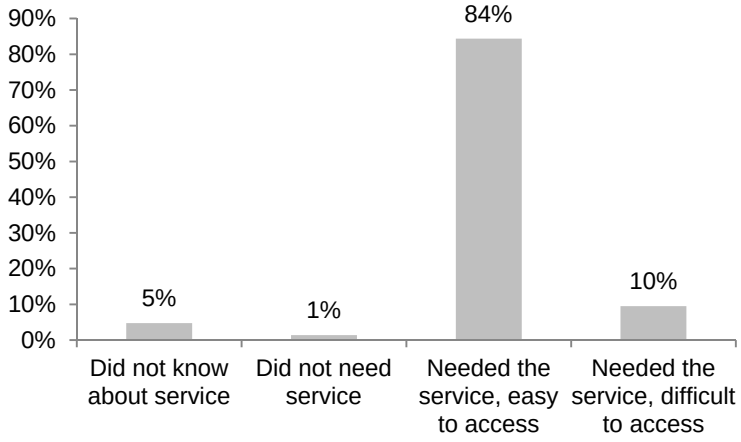
[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

PRIMARY HIV MEDICAL CARE

Primary HIV medical care, technically referred to as *outpatient/ambulatory medical care*, refers to the diagnostic and therapeutic services provided to persons living with HIV (PLWH) by a physician or physician extender in an outpatient setting. This includes physical examinations, diagnosis and treatment of common physical and mental health conditions, preventative care, education, laboratory services, and specialty services as indicated.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 94% of participants indicated a need for *primary HIV medical care* in the past 12 months. 84% reported the service was easy to access, and 10% reported difficulty. 5% stated that they did not know the service was available.

GRAPH 1-Primary HIV Medical Care, 2016



(**Table 1**) When barriers to *primary HIV medical care* were reported, the most common barrier type was administrative (19%). Administrative barriers reported include complex processes, staff, hours of operation, understaffing, and service changes without client notification.

TABLE 1-Top 5 Reported Barrier Types for Primary HIV Medical Care, 2016

	No.	%
1. Administrative (AD)	8	19%
2. Interactions with Staff (S)	6	14%
3. Transportation (T)	6	14%
4. Wait (W)	6	14%
5. Education and Awareness (EA)	4	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *primary HIV medical care*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH and whites found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more out of care, rural, transgender, recently released, and unstably housed PLWH found the service difficult to access when compared to all participants.

TABLE 2-Primary HIV Medical Care, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	5%	3%	5%	4%	6%	0%	0%	6%	4%
Did not need service	1%	2%	0%	2%	2%	0%	0%	2%	2%
Needed, easy to access	84%	86%	83%	85%	85%	87%	83%	83%	86%
Needed, difficult to access	10%	9%	12%	9%	8%	13%	17%	10%	9%

TABLE 3-Primary HIV Medical Care, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	7%	4%	0%	11%	0%	14%
Did not need service	0%	1%	0%	0%	0%	0%
Needed, easy to access	81%	85%	67%	79%	79%	73%
Needed, difficult to access	12%	10%	33%	11%	21%	14%

[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

LOCAL HIV MEDICATION ASSISTANCE

Local HIV medication assistance, technically referred to as the *Local Pharmacy Assistance Program (LPAP)*, provides HIV-related pharmaceuticals to persons living with HIV (PLWH) who are not eligible for medications through other payer sources, including the state AIDS Drug Assistance Program (ADAP).

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 74% of participants indicated a need for *local HIV medication assistance* in the past 12 months. 66% reported the service was easy to access, and 8% reported difficulty. 10% stated that they did not know the service was available.

(**Table 1**) When barriers to *local HIV medication assistance* were reported, the most common barrier type was related to health insurance coverage (24%). Health insurance-related barriers reported include having coverage gaps and being uninsured.

GRAPH 1-Local HIV Medication Assistance, 2016

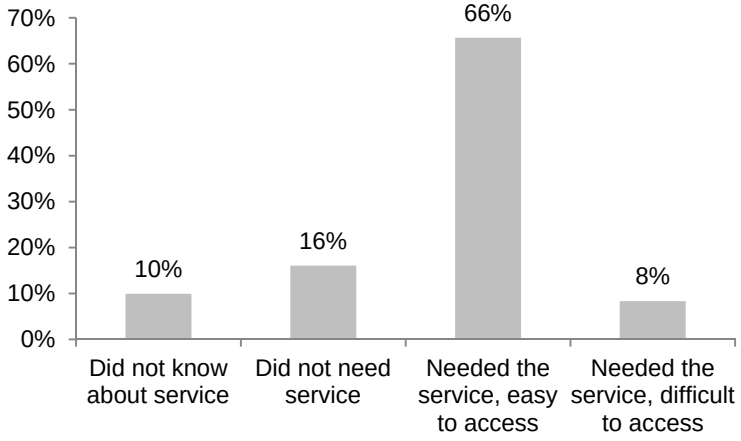


TABLE 1-Top 5 Reported Barrier Types for Local HIV Medication Assistance, 2016

	No.	%
1. Health Insurance Coverage (I)	8	24%
2. Administrative (AD)	4	12%
3. Education and Awareness (EA)	3	9%
4. Eligibility (EL)	3	9%
5. Financial (F)	3	9%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *local HIV medication assistance*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH than other race/ethnicities found the service accessible.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, rural and recently released PLWH found the service difficult to access when compared to all participants.

TABLE 2-Local HIV Medication Assistance, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	10%	9%	7%	12%	9%	0%	5%	11%	8%
Did not need service	18%	11%	16%	17%	11%	53%	14%	14%	20%
Needed, easy to access	65%	68%	71%	62%	73%	33%	76%	66%	64%
Needed, difficult to access	7%	11%	7%	9%	7%	13%	5%	8%	8%

TABLE 3-Local HIV Medication Assistance, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	12%	8%	100%	13%	0%	14%
Did not need service	19%	18%	0%	3%	12%	14%
Needed, easy to access	61%	67%	0%	74%	73%	71%
Needed, difficult to access	8%	8%	0%	11%	15%	0%

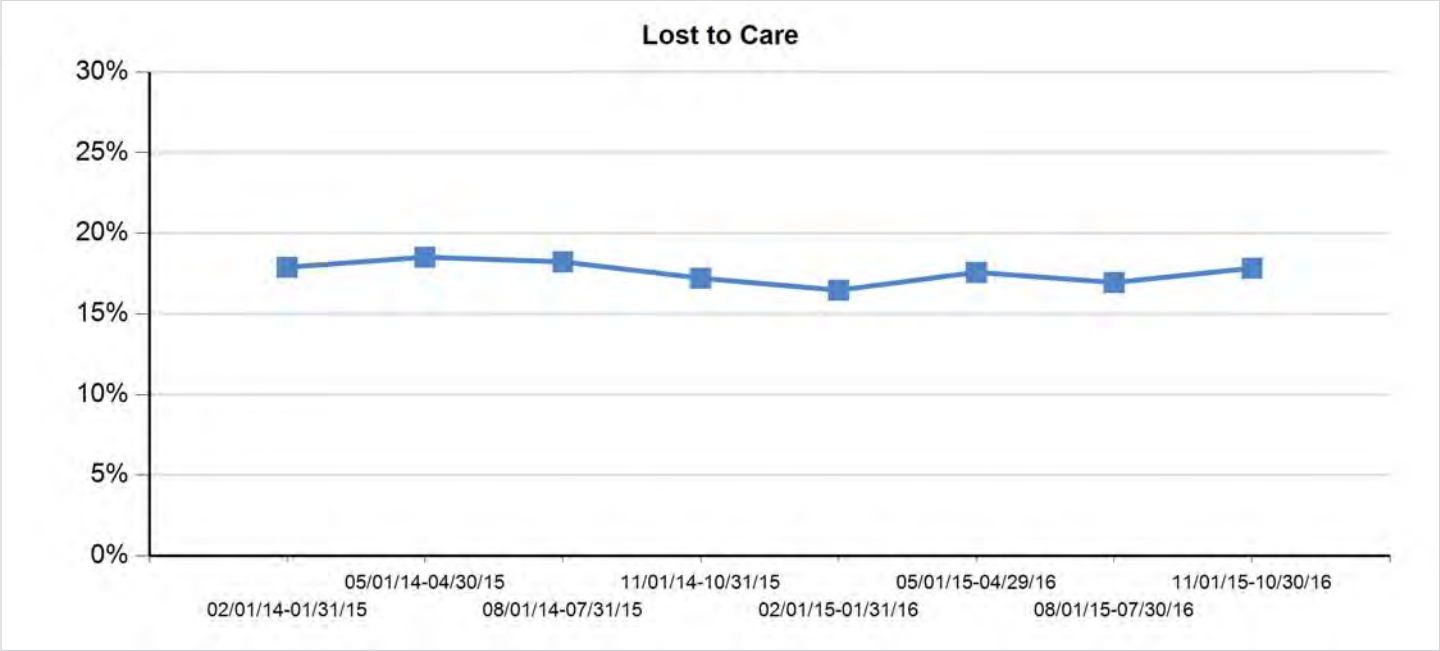
[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

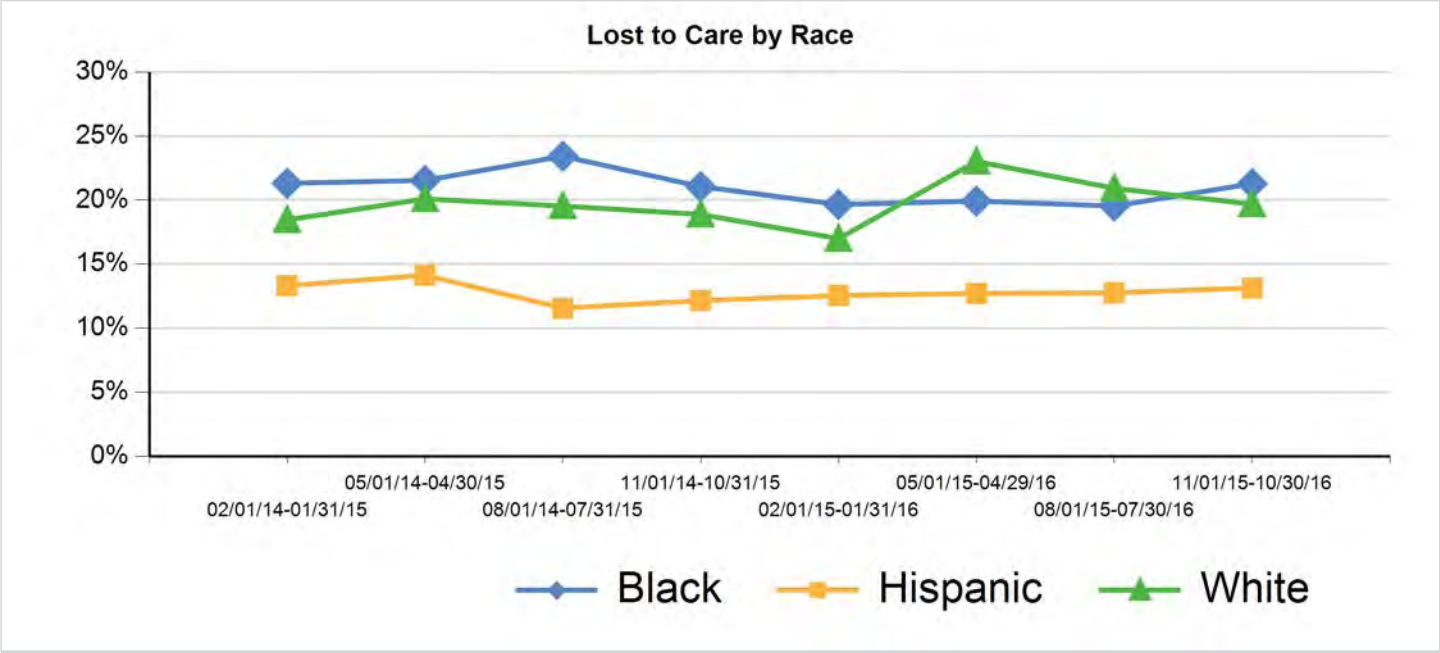
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **11/1/2015**

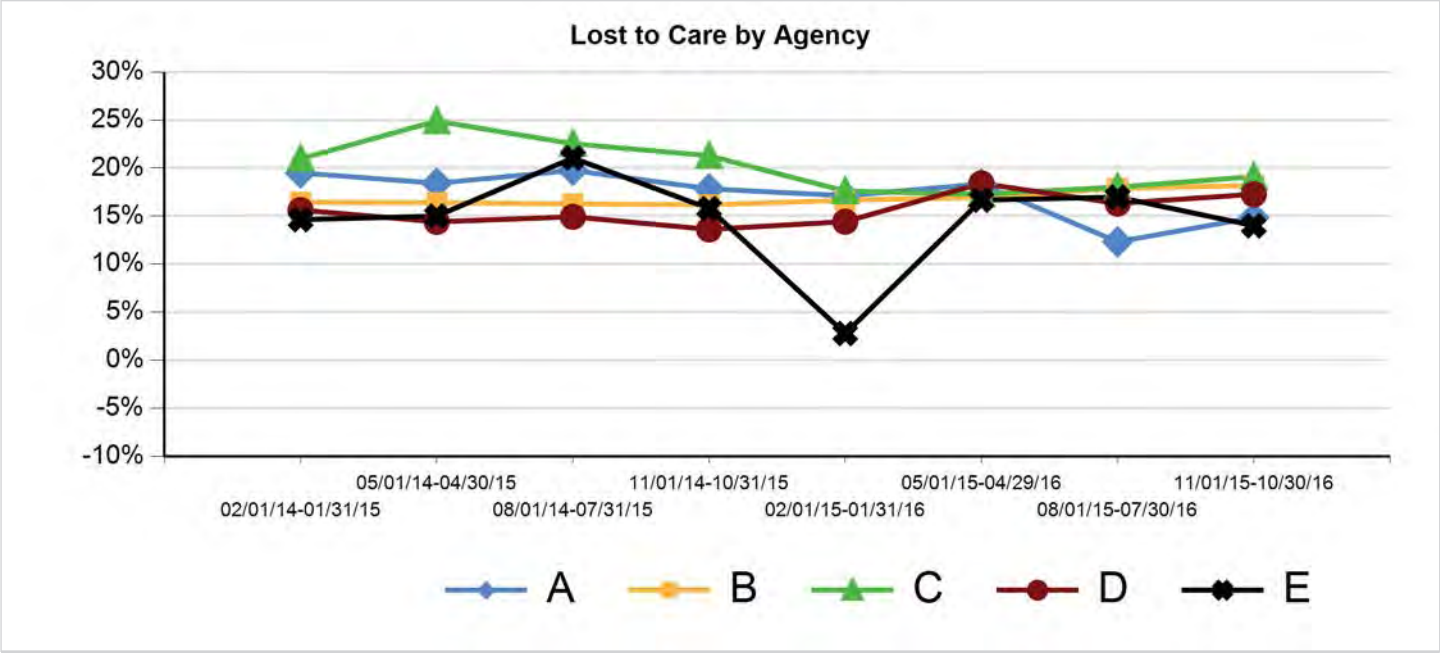
Lost to Care				
In+Care Campaign Gap Measure				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	776	845	821	892
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	4,712	4,807	4,845	5,001
Percentage	16.5%	17.6%	16.9%	17.8%
Change from Previous Quarter Results	-0.7%	1.1%	-0.6%	0.9%



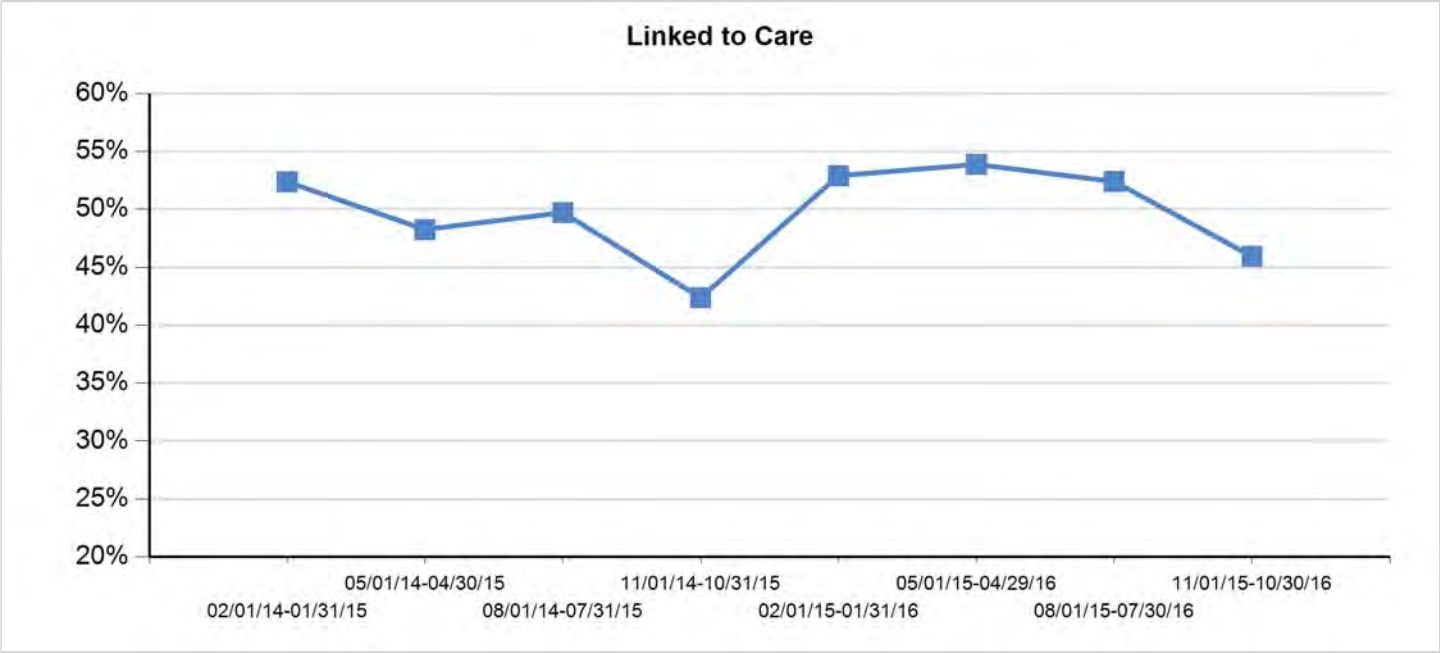
Lost to Care by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	452	229	148	446	235	132	506	249	124
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	2,269	1,803	643	2,283	1,842	631	2,378	1,895	630
Percentage	19.9%	12.7%	23.0%	19.5%	12.8%	20.9%	21.3%	13.1%	19.7%
Change from Previous Quarter Results	0.3%	0.2%	6.0%	-0.4%	0.1%	-2.1%	1.7%	0.4%	-1.2%



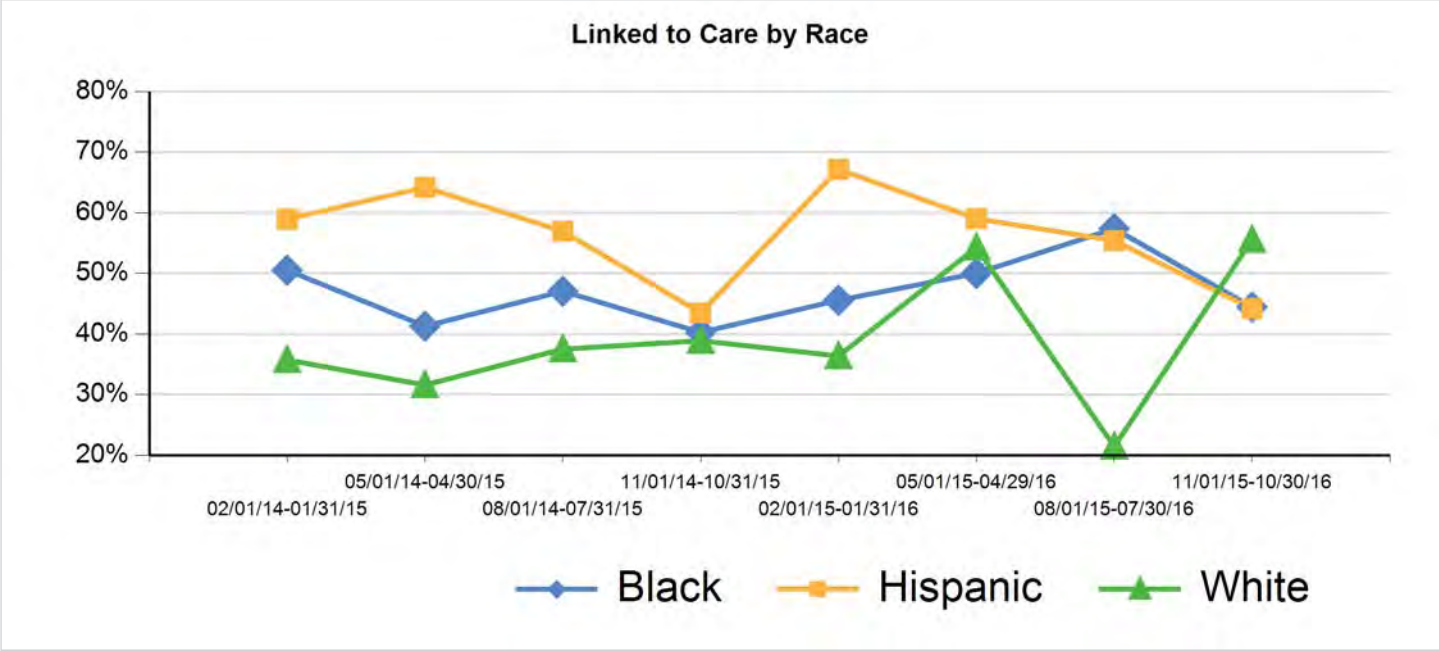
Lost to Care by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of uninsured HIV-infected clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	79	346	225	163	9	97	346	261	185	7
Number of uninsured HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	641	1,935	1,249	999	53	653	1,902	1,366	1,071	50
Percentage	12.3%	17.9%	18.0%	16.3%	17.0%	14.9%	18.2%	19.1%	17.3%	14.0%
Change from Previous Quarter Results	-6.0%	0.9%	0.7%	-2.1%	0.3%	2.5%	0.3%	1.1%	1.0%	-3.0%



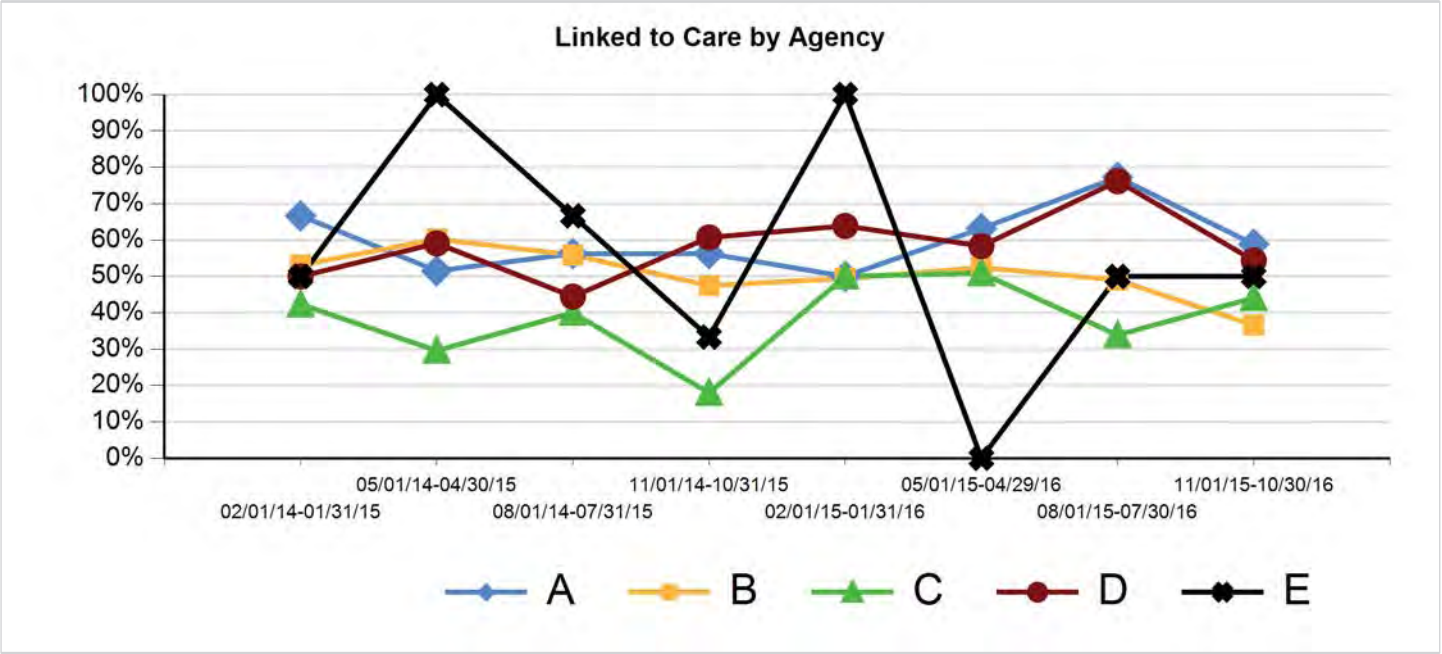
Linked to Care				
In+Care Campaign clients Newly Enrolled in Medical Care Measure				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of newly enrolled HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	91	111	120	96
Number of newly enrolled HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	172	206	229	209
Percentage	52.9%	53.9%	52.4%	45.9%
Change from Previous Quarter Results	10.5%	1.0%	-1.5%	-6.5%
* exclude if vl<200 in 1st 4 months				



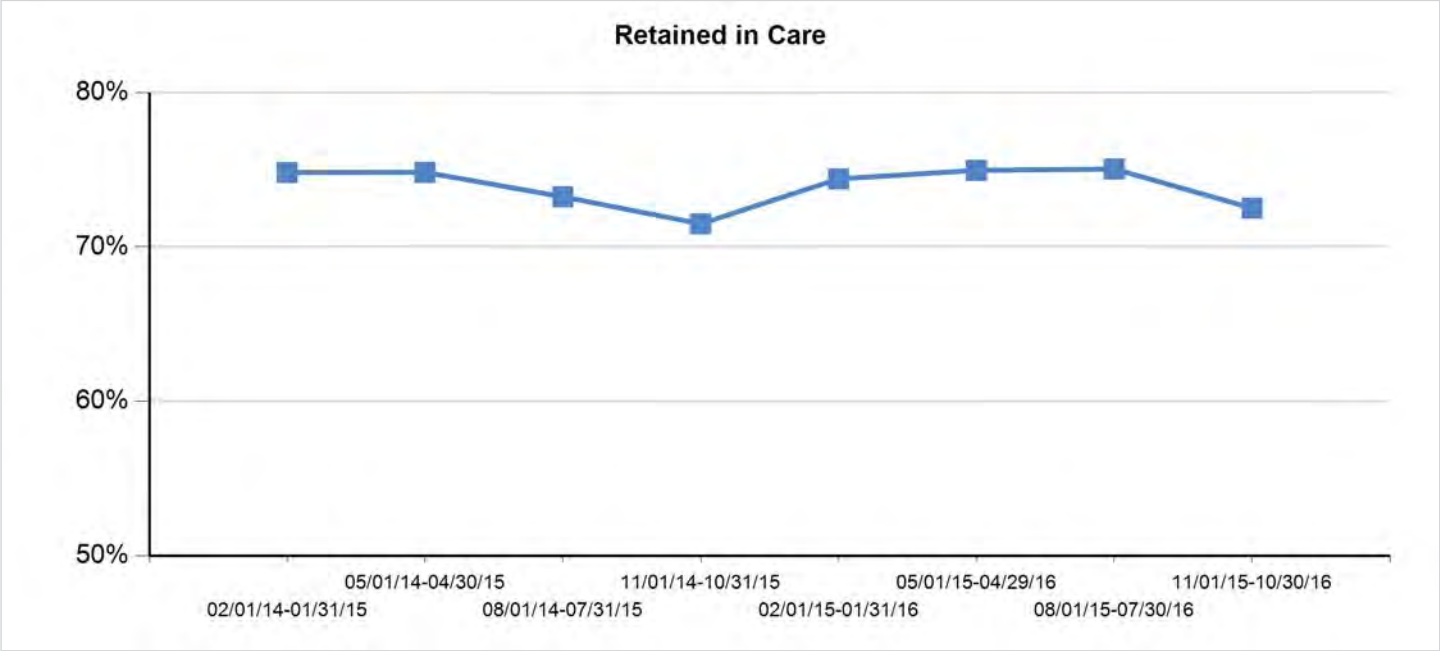
Linked to Care by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of newly enrolled HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	53	36	19	70	41	6	48	34	10
Number of newly enrolled HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	106	61	35	122	74	28	108	77	18
Percentage	50.0%	59.0%	54.3%	57.4%	55.4%	21.4%	44.4%	44.2%	55.6%
Change from Previous Quarter Results	4.4%	-8.1%	17.9%	7.4%	-3.6%	-32.9%	-12.9%	-11.2%	34.1%
* exclude if vl<200 in 1st 4 months									



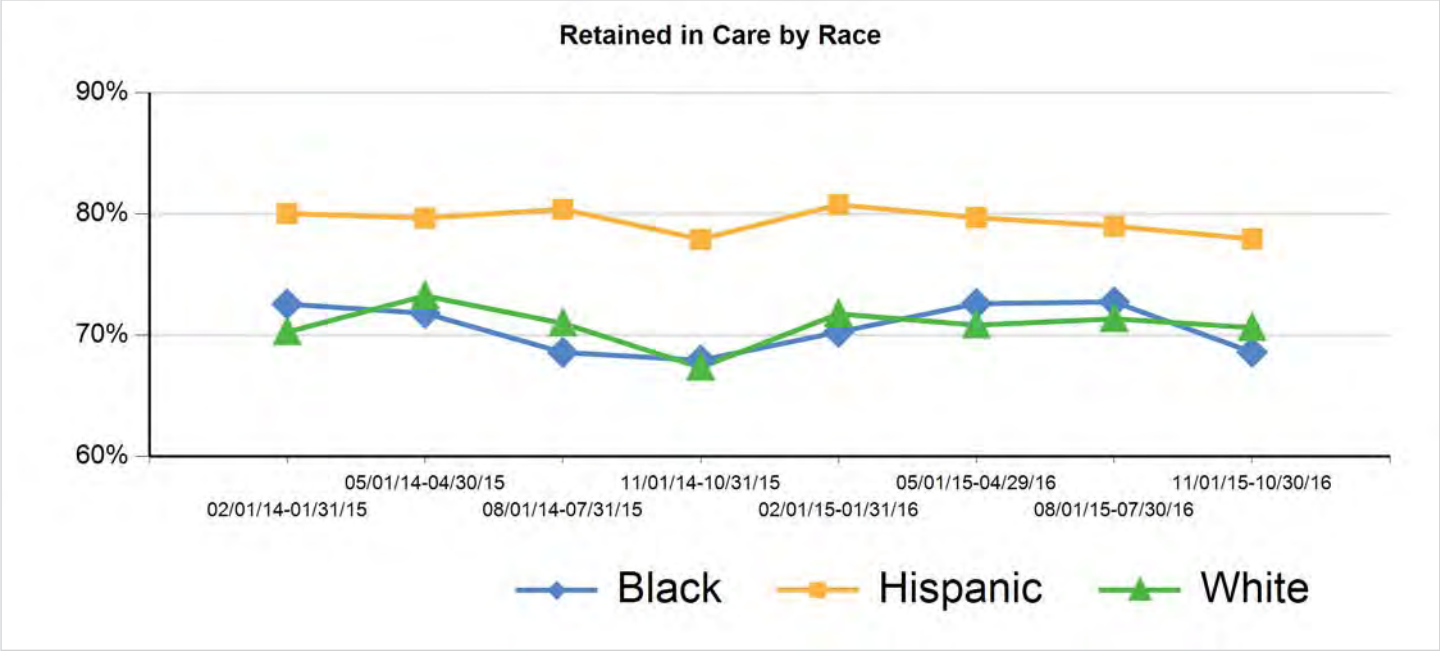
Linked to Care by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of newly enrolled HIV-infected clients who had at least one medical visit in each of the 4-month periods of the measurement year	17	49	21	32	2	10	26	26	31	3
Number of newly enrolled HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	22	100	62	42	4	17	71	59	57	6
Percentage	77.3%	49.0%	33.9%	76.2%	50.0%	58.8%	36.6%	44.1%	54.4%	50.0%
Change from Previous Quarter Results	14.1%	-3.4%	-17.0%	17.9%	50.0%	-18.4%	-12.4%	10.2%	-21.8%	0.0%
* exclude if vl<200 in 1st 4 months										



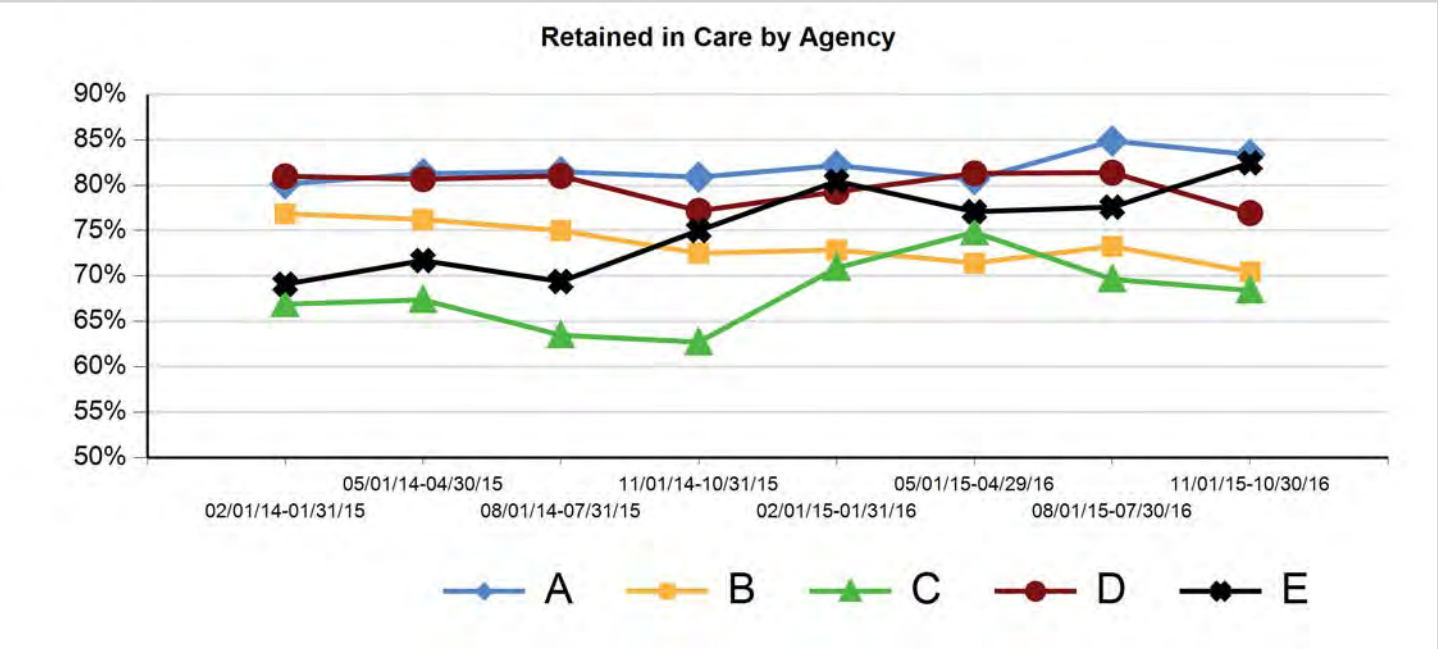
Retained in Care				
Houston EMA Medical Visits Measure				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year*	3,946	4,015	4,103	4,063
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	5,303	5,356	5,467	5,603
Percentage	74.4%	75.0%	75.1%	72.5%
Change from Previous Quarter Results	2.9%	0.6%	0.1%	-2.5%
* Not newly enrolled in care				



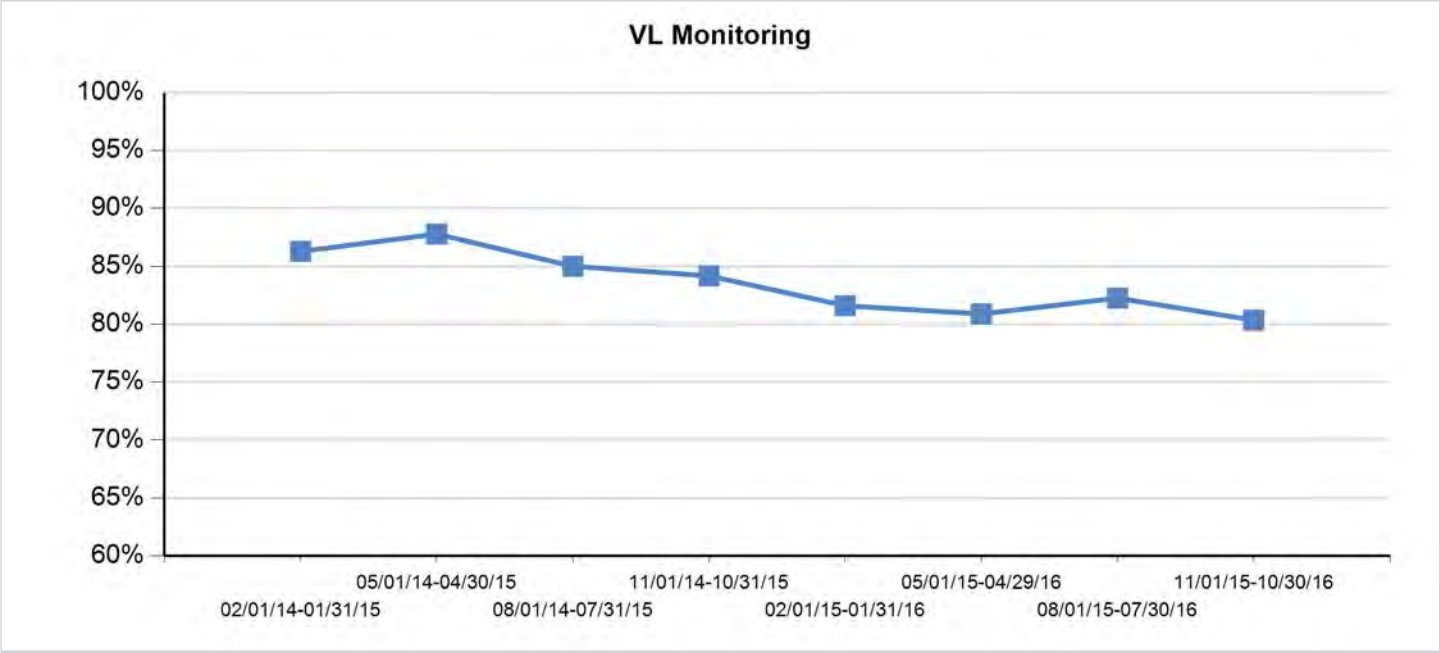
Retained in Care by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year	1,853	1,561	524	1,904	1,581	530	1,853	1,606	514
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	2,553	1,959	740	2,618	2,002	743	2,702	2,061	728
Percentage	72.6%	79.7%	70.8%	72.7%	79.0%	71.3%	68.6%	77.9%	70.6%
Change from Previous Quarter Results	2.3%	-1.1%	-0.9%	0.1%	-0.7%	0.5%	-4.1%	-1.0%	-0.7%



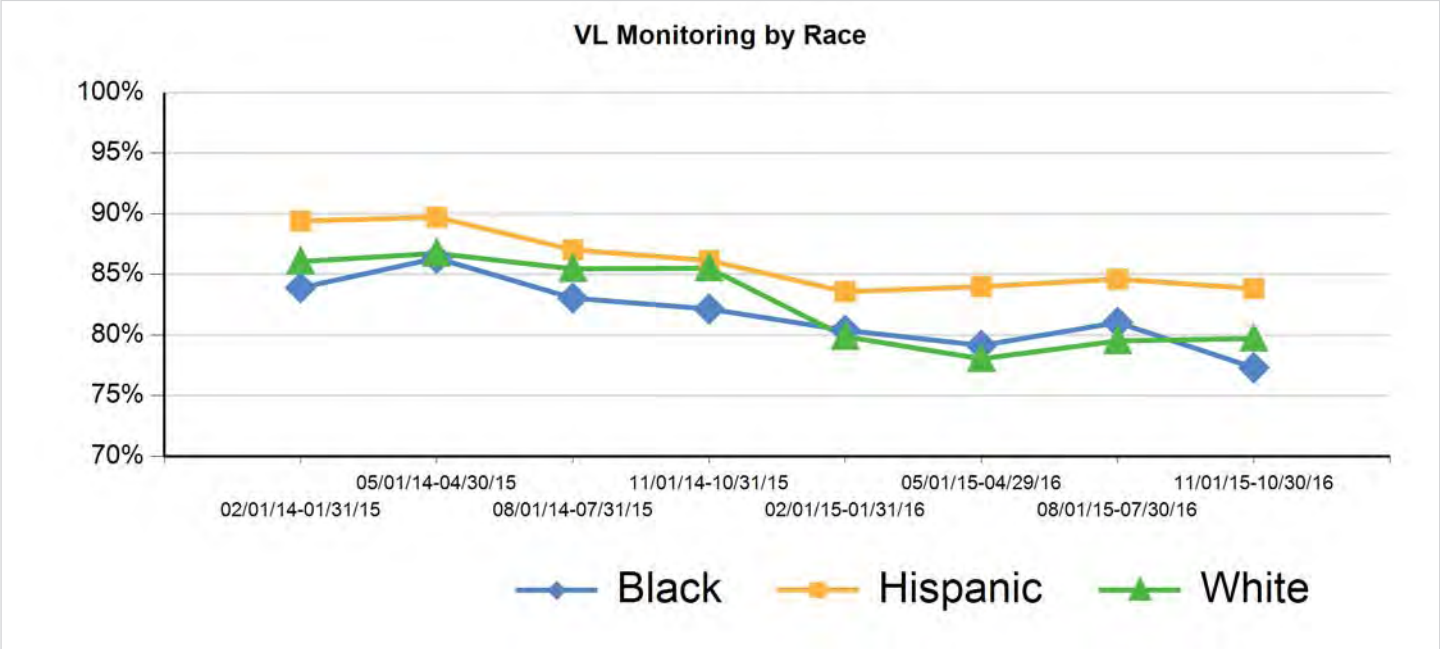
Retained in Care by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart during the measurement year	600	1,559	1,064	940	45	592	1,468	1,117	947	47
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	707	2,128	1,528	1,155	58	710	2,084	1,633	1,231	57
Percentage	84.9%	73.3%	69.6%	81.4%	77.6%	83.4%	70.4%	68.4%	76.9%	82.5%
Change from Previous Quarter Results	4.3%	1.8%	-5.2%	0.1%	0.5%	-1.5%	-2.8%	-1.2%	-4.5%	4.9%



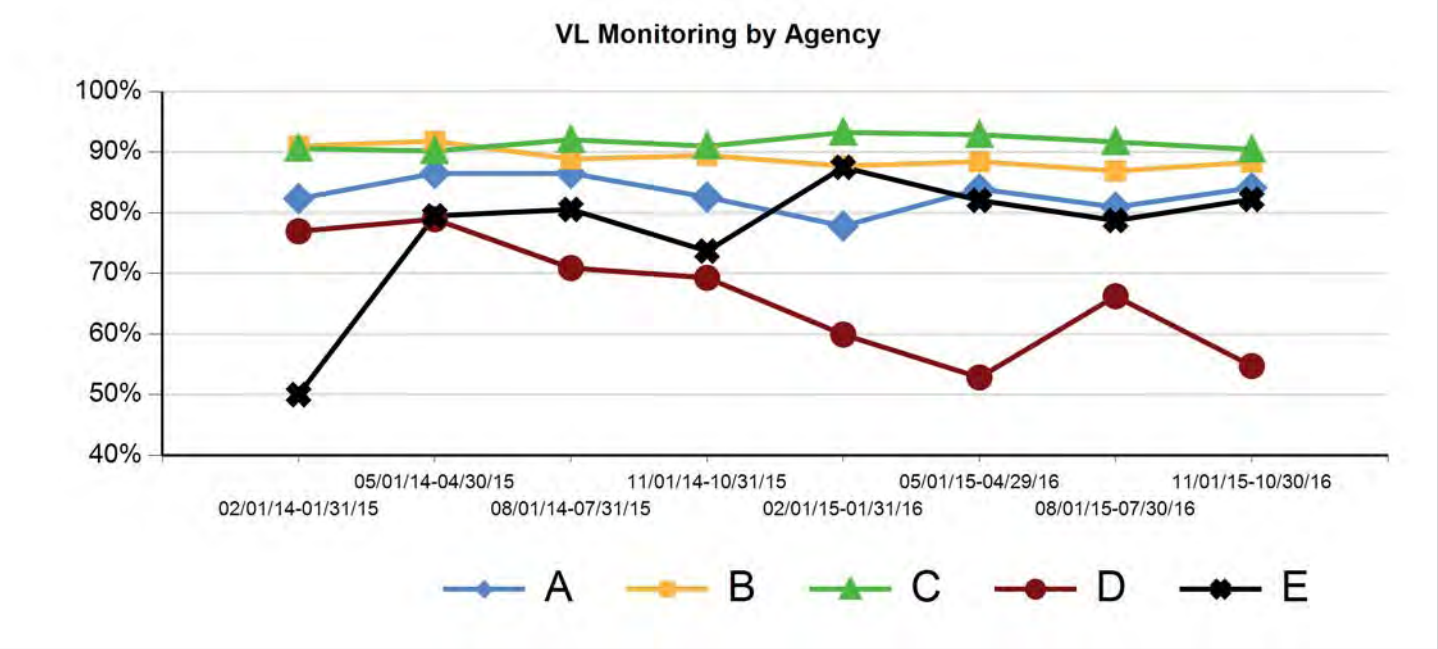
Viral Load Monitoring				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	3,493	3,470	3,628	3,514
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	4,281	4,290	4,411	4,374
Percentage	81.6%	80.9%	82.2%	80.3%
Change from Previous Quarter Results	-2.6%	-0.7%	1.4%	-1.9%



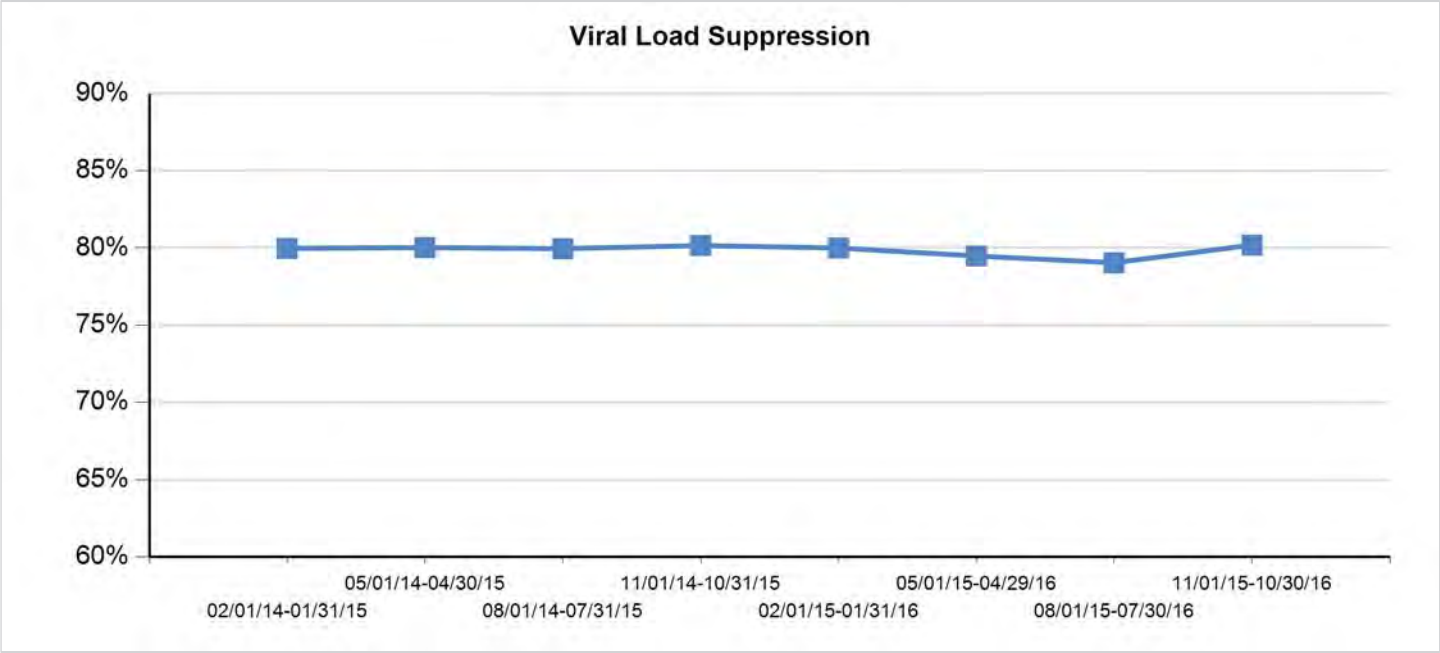
VL Monitoring Data by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	1,574	1,390	437	1,670	1,429	450	1,560	1,425	444
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	1,989	1,655	560	2,061	1,689	566	2,018	1,700	557
Percentage	79.1%	84.0%	78.0%	81.0%	84.6%	79.5%	77.3%	83.8%	79.7%
Change from Previous Quarter Results	-1.3%	0.4%	-1.8%	1.9%	0.6%	1.5%	-3.7%	-0.8%	0.2%



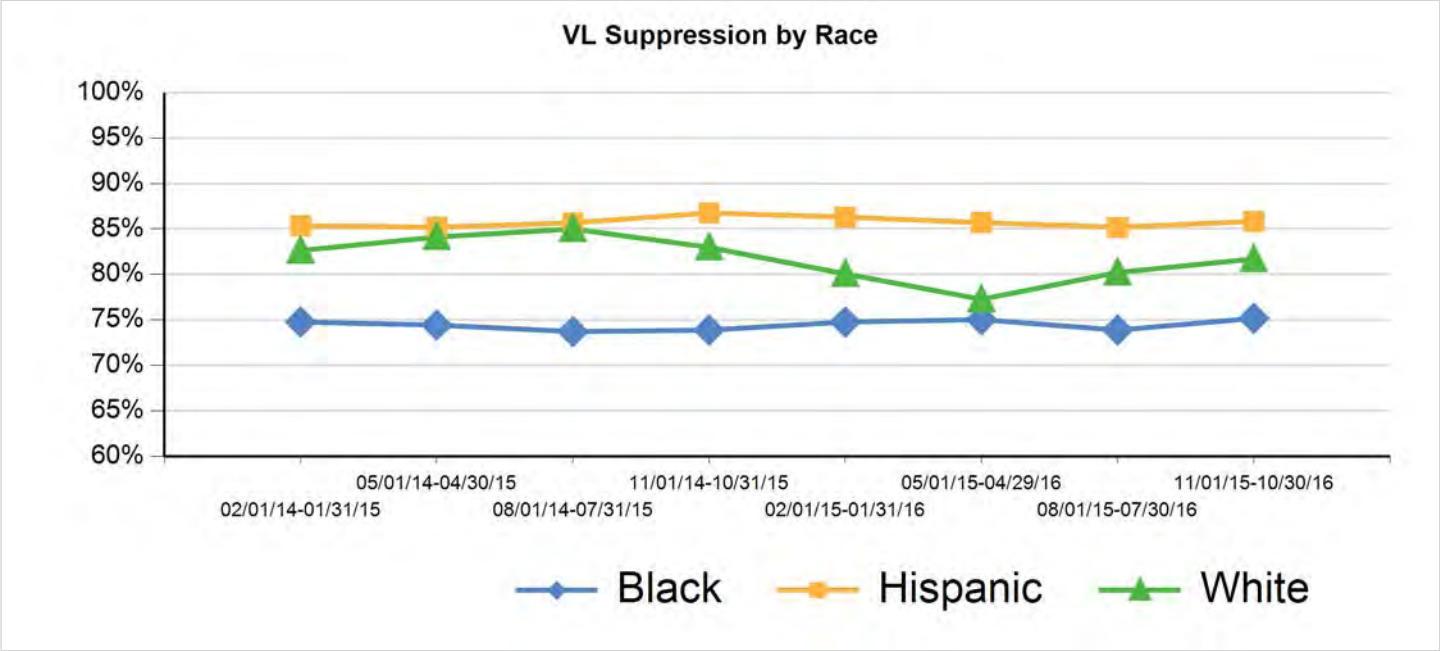
VL Monitoring by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	497	1,418	1,015	653	37	509	1,365	1,041	545	37
Number of HIV-infected clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	614	1,632	1,107	986	47	605	1,545	1,151	996	45
Percentage	80.9%	86.9%	91.7%	66.2%	78.7%	84.1%	88.3%	90.4%	54.7%	82.2%
Change from Previous Quarter Results	-3.0%	-1.6%	-1.2%	13.4%	-3.3%	3.2%	1.5%	-1.2%	-11.5%	3.5%



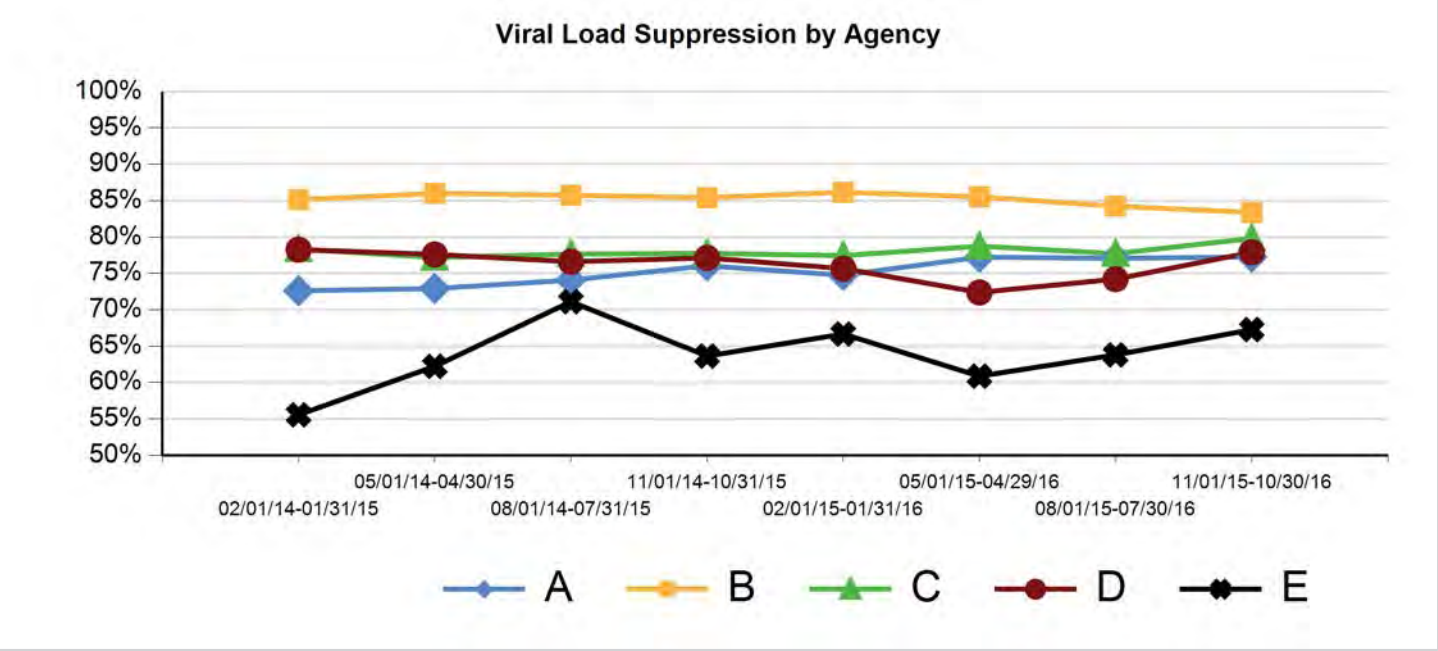
Viral Load Suppression				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	3,956	3,997	4,051	4,148
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	4,945	5,029	5,125	5,173
Percentage	80.0%	79.5%	79.0%	80.2%
Change from Previous Quarter Results	-0.2%	-0.5%	-0.4%	1.1%



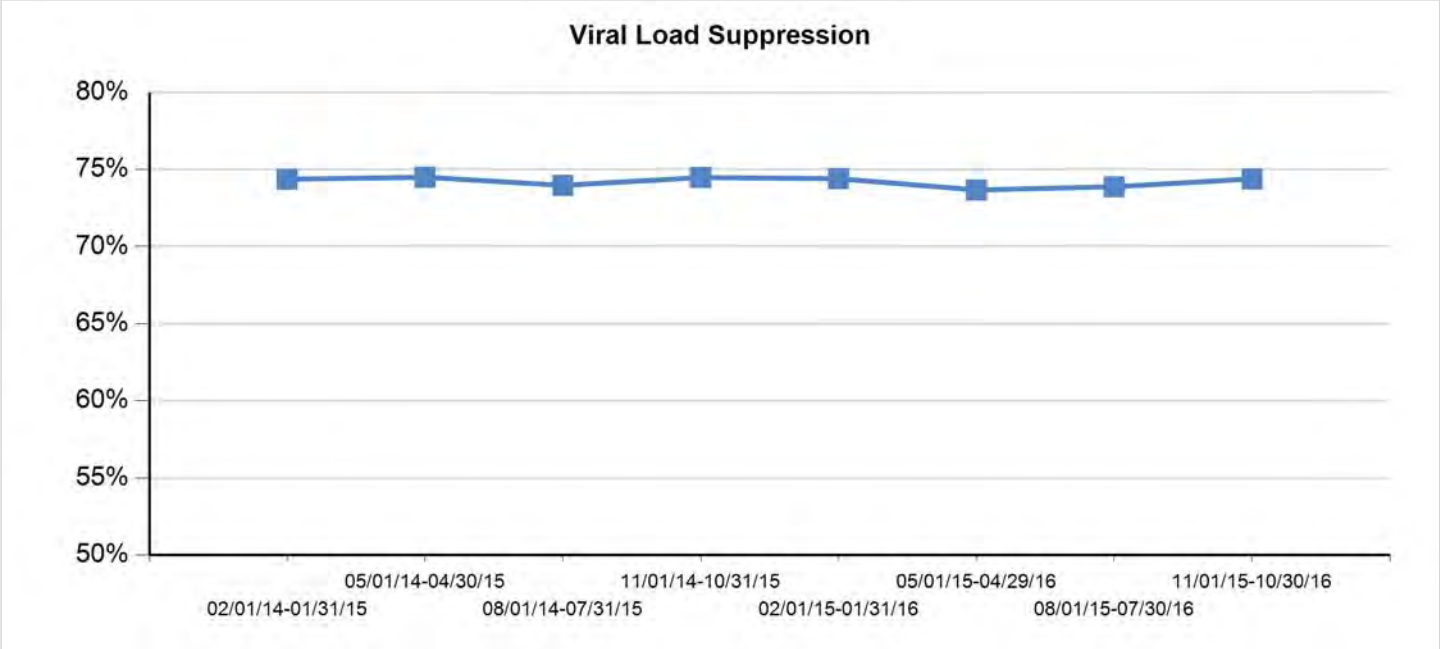
VL Suppression by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	1,811	1,576	530	1,835	1,598	531	1,864	1,642	549
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	2,414	1,839	686	2,484	1,876	662	2,480	1,913	672
Percentage	75.0%	85.7%	77.3%	73.9%	85.2%	80.2%	75.2%	85.8%	81.7%
Change from Previous Quarter Results	0.3%	-0.6%	-2.8%	-1.1%	-0.5%	3.0%	1.3%	0.7%	1.5%



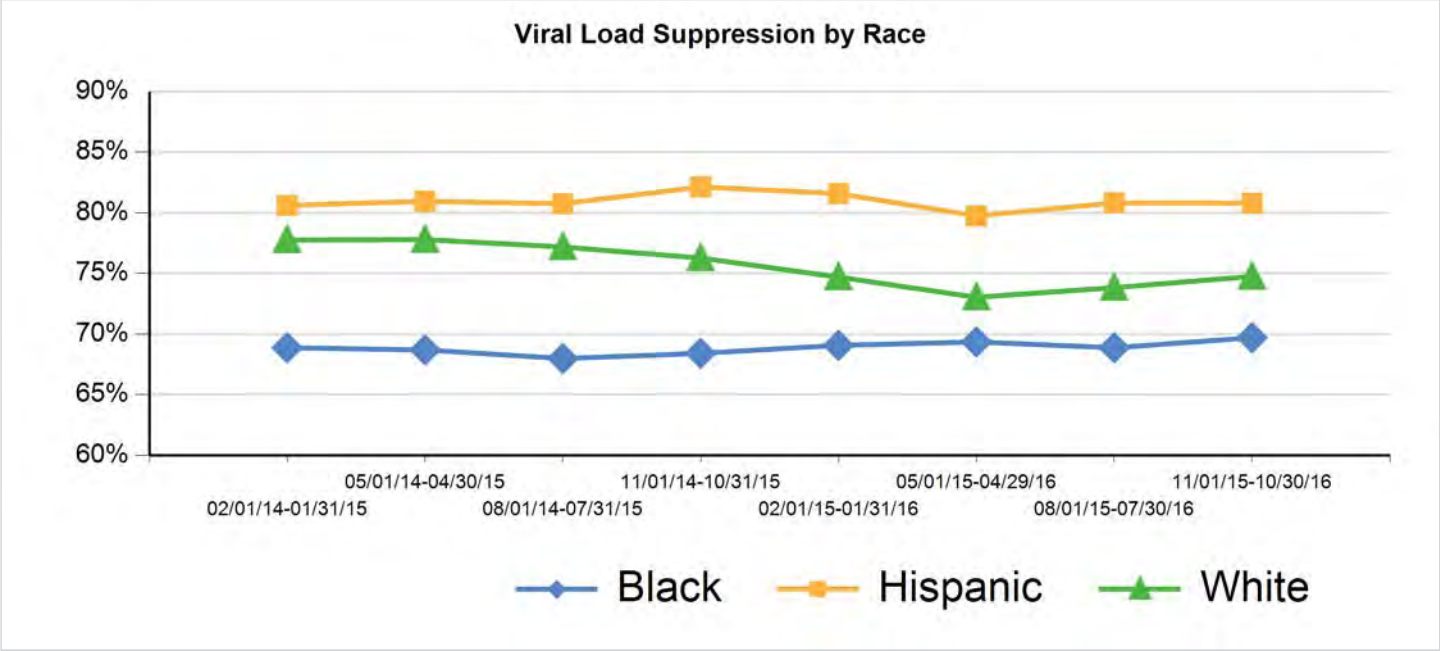
VL Suppression by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	538	1,625	1,036	849	37	547	1,524	1,115	938	37
Number of HIV-infected clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	698	1,929	1,333	1,144	58	708	1,828	1,397	1,204	55
Percentage	77.1%	84.2%	77.7%	74.2%	63.8%	77.3%	83.4%	79.8%	77.9%	67.3%
Change from Previous Quarter Results	-0.2%	-1.3%	-1.0%	1.8%	2.9%	0.2%	-0.9%	2.1%	3.7%	3.5%



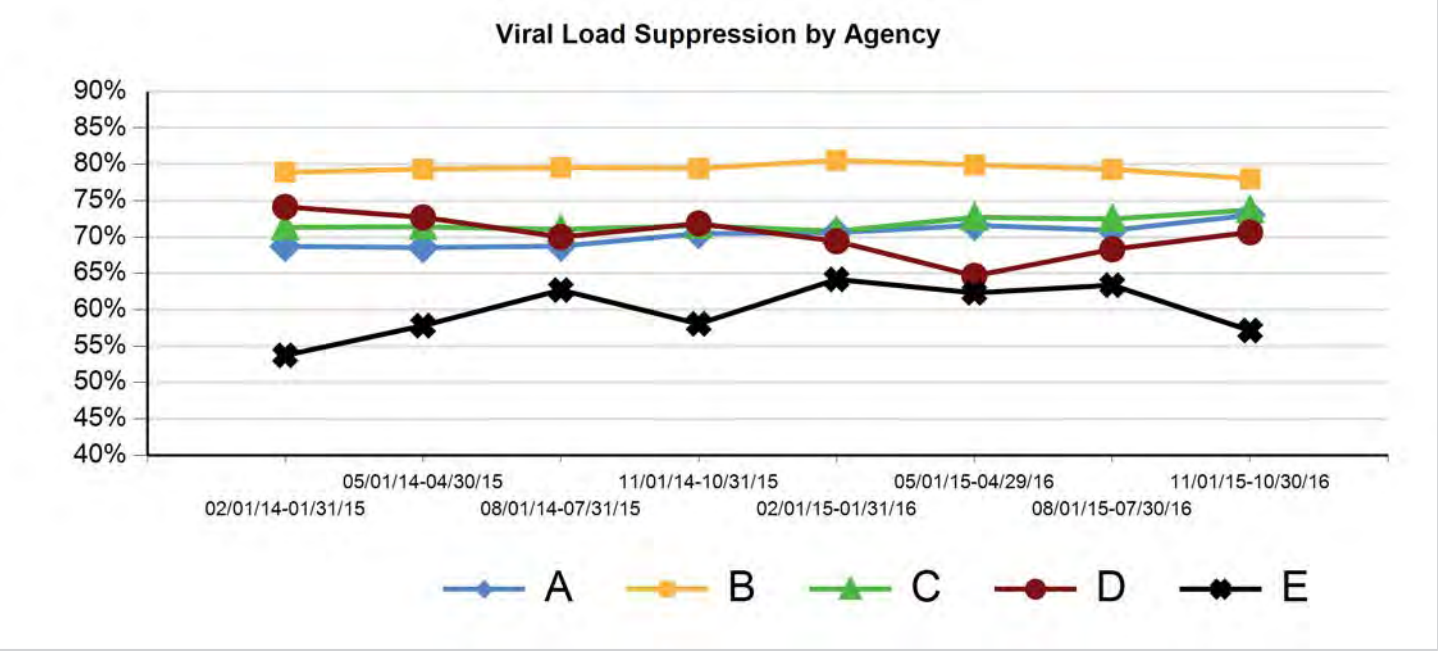
Viral Load Suppression 2- HAB Measure				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	5,192	5,220	5,310	5,502
Number of HIV-infected clients who have had at least 1 medical visit with a provider with prescribing privileges	6,978	7,085	7,187	7,396
Percentage	74.4%	73.7%	73.9%	74.4%
Change from Previous Quarter Results	-0.1%	-0.7%	0.2%	0.5%



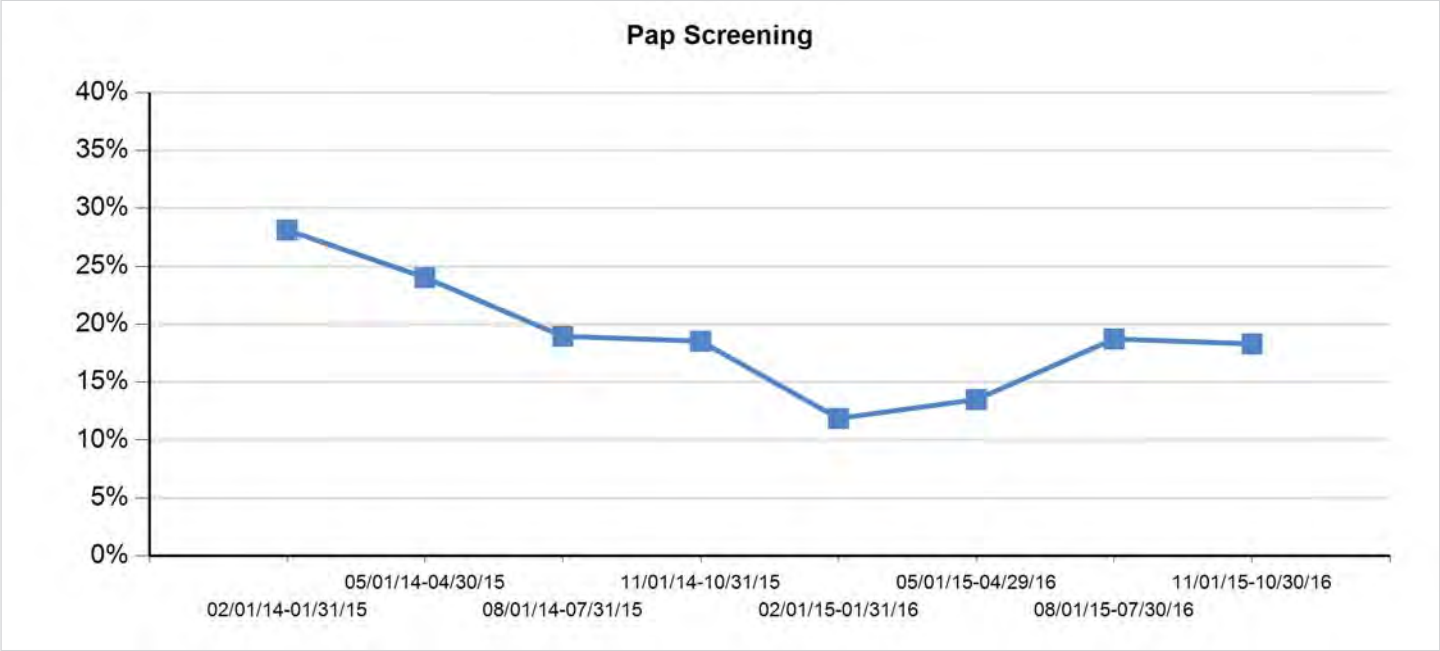
VL Suppression by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	2,416	1,992	704	2,457	2,017	722	2,569	2,082	731
Number of HIV-infected clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	3,484	2,498	964	3,568	2,496	978	3,686	2,577	978
Percentage	69.3%	79.7%	73.0%	68.9%	80.8%	73.8%	69.7%	80.8%	74.7%
Change from Previous Quarter Results	0.3%	-1.8%	-1.7%	-0.5%	1.1%	0.8%	0.8%	0.0%	0.9%



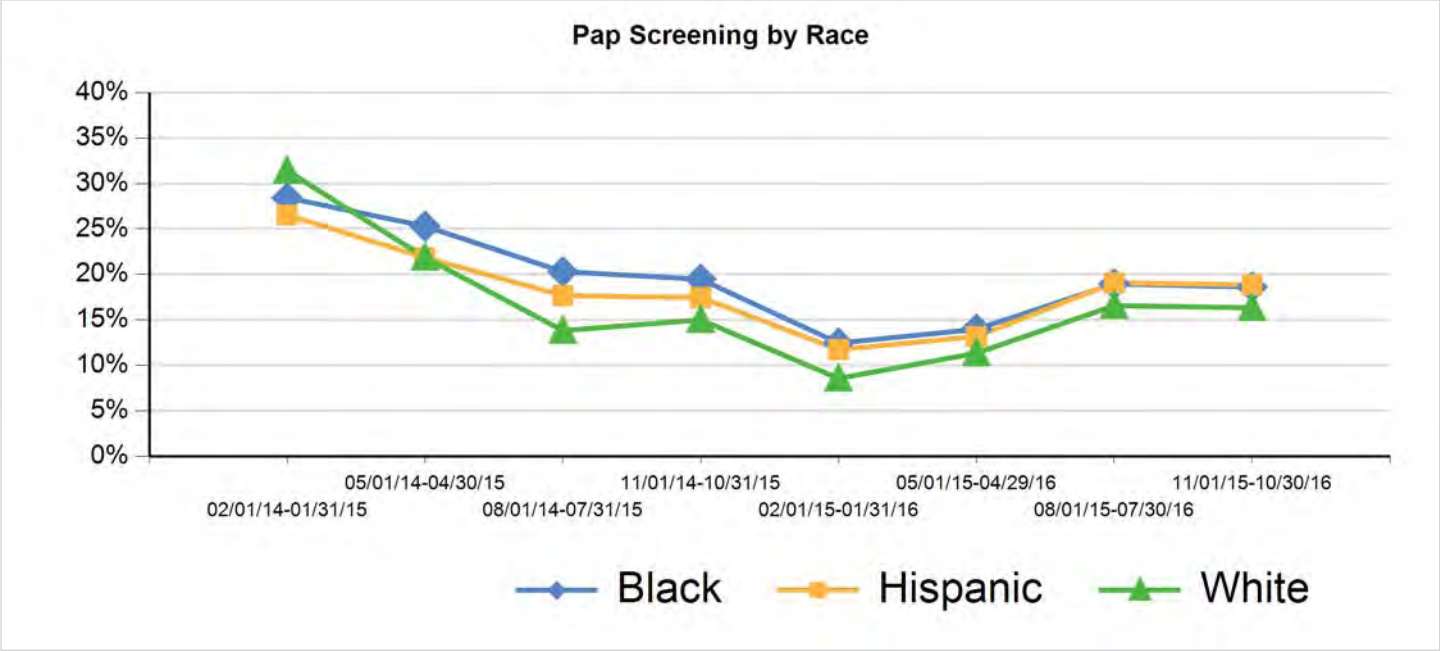
Viral Load Suppression by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected clients who have a viral load of <200 copies/ml during the measurement year	610	2,158	1,533	1,052	45	641	2,120	1,637	1,156	40
Number of HIV-infected clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	860	2,721	2,115	1,540	71	878	2,717	2,221	1,636	70
Percentage	70.9%	79.3%	72.5%	68.3%	63.4%	73.0%	78.0%	73.7%	70.7%	57.1%
Change from Previous Quarter Results	-0.7%	-0.6%	-0.2%	3.6%	1.1%	2.1%	-1.3%	1.2%	2.3%	-6.2%



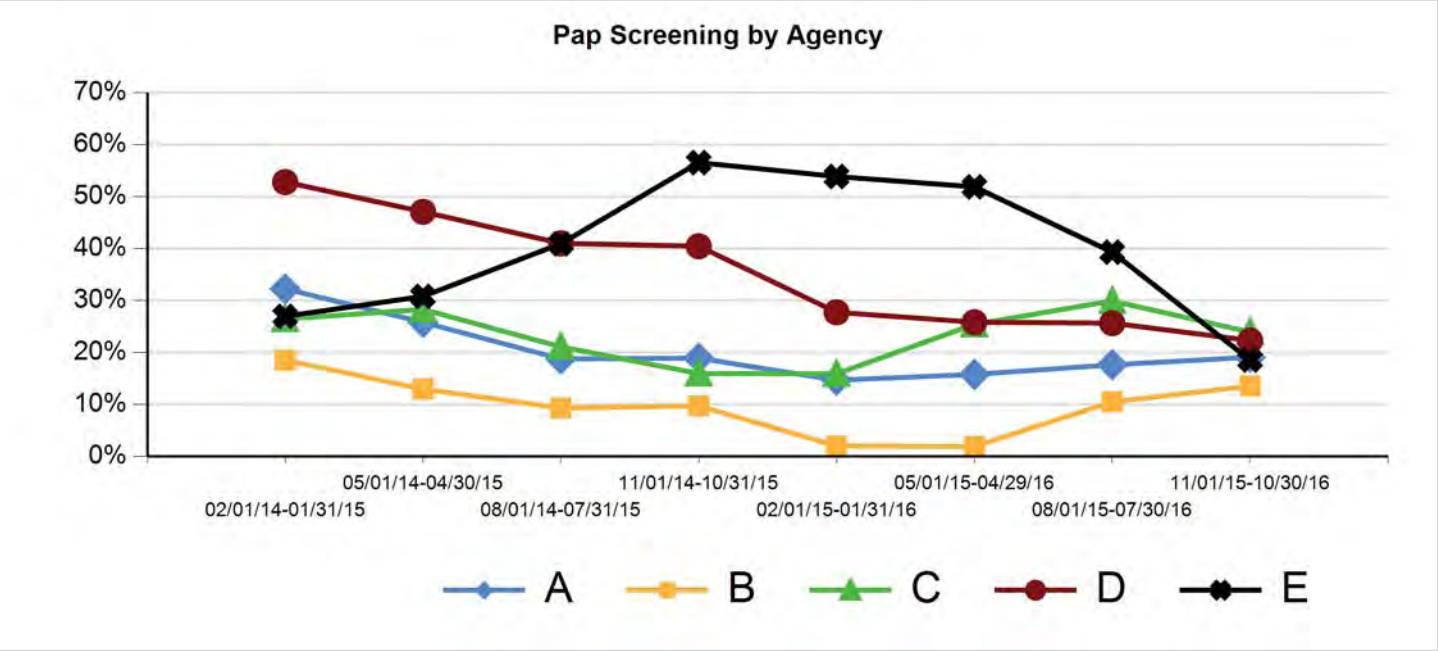
Cervical Cancer Screening				
	02/01/15 - 01/31/16	05/01/15 - 04/29/16	08/01/15 - 07/30/16	11/01/15 - 10/30/16
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	213	245	343	340
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,796	1,816	1,832	1,858
Percentage	11.9%	13.5%	18.7%	18.3%
Change from Previous Quarter Results	-6.7%	1.6%	5.2%	-0.4%



Cervical Cancer Screening Data by Race/Ethnicity									
	05/01/15 - 04/29/16			08/01/15 - 07/30/16			11/01/15 - 10/30/16		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	161	64	17	222	91	25	222	91	24
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,153	486	150	1,171	477	151	1,193	483	147
Percentage	14.0%	13.2%	11.3%	19.0%	19.1%	16.6%	18.6%	18.8%	16.3%
Change from Previous Quarter Results	1.5%	1.4%	2.8%	5.0%	5.9%	5.2%	-0.3%	-0.2%	-0.2%



Pap Smear Screening by Agency										
	08/01/15 - 07/30/16					11/01/15 - 10/30/16				
	A	B	C	D	E	A	B	C	D	E
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	44	88	104	103	11	48	112	87	94	5
Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	250	841	348	402	28	252	829	364	422	27
Percentage	17.6%	10.5%	29.9%	25.6%	39.3%	19.0%	13.5%	23.9%	22.3%	18.5%
Change from Previous Quarter Results	1.9%	8.6%	4.5%	-0.2%	-12.6%	1.4%	3.0%	-6.0%	-3.3%	-20.8%



Footnotes:
1. Table/Chart data for this report run was taken from "ABR152 v3.3.1 9/2/15", "ABR076A v1.4.1 10/15/15 [ExcludeVL200=yes]", and "ABR163 v2.0.6 4/25/13"
A. OPR Measures used for the ABR152 portions: "Viral Load Suppression", "Linked to Care", "CERV", "Medical Visits - 3 months", and "Viral Load Monitoring"

2017-2018 HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE CARE ACT PART A/B

STANDARDS OF CARE FOR HIV SERVICES

RYAN WHITE GRANT ADMINISTRATION SECTION
HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES (HCPHES)

TABLE OF CONTENTS

Introduction

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

Purpose

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

Scope

The Houston EMA SOCs apply to Part A, Part B and State Services, funded HRSA defined core and support services including the following services in FY 2015-2016:

- *Primary Medical Care*
- *Vision Care*
- *Medical Case Management*
- *Clinical Case Management*
- *Local AIDS Pharmaceutical Assistance Program (LPAP)*
- *Oral Health*
- ***Health Insurance Assistance***
- Hospice Care
- Mental Health Services
- *Substance Abuse services*
- Home & Community Based Services (Facility-Based)
- Early Intervention Services
- *Legal Services*
- *Medical Nutrition Supplement*
- *Non-Medical Case Management (Service Linkage)*
- *Transportation*
- Linguistic Services

Part A funded services
Combination of Parts A, B, and/or Services funding

Standards Development

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

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

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

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

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

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel and/or volunteer files indicates compliance
1.2	Initial Training: Staff/Volunteers Initial training includes eight (8) hours HIV/AIDS basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers, agency-specific information (e.g. Drug Free Workplace policy) and customer service training must be completed within 60 days of hire. https://tx.train.org/DesktopShell.aspx	• Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure • Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.3	Staff Performance Evaluation Agency will perform annual staff performance evaluation.	• Completed annual performance evaluation kept in employee's file • Signed and dated by employee and supervisor (includes electronic signature)
1.4	Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers All staff tenured 0 – 5 year with their current employer must receive four (4) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire.	• Documentation of training is maintained by the agency in the personnel file

	All staff with greater than 5 years with their current employer must receive two (2) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually.	
1.5	Staff education on eligibility determination and fee schedule Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All new employees must complete within ninety (90) days of hire.	Documentation of training in employee's record
2.0	**Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.**	
2.1	Service Evaluation Agency has a process in place for the evaluation of client services.	• Review of Agency's Policies and Procedures Manual indicates compliance • Staff interviews indicate compliance.
2.2	Subcontractor Monitoring Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and standards Reviewed Annually	• Documentation of subcontractor monitoring • Review of Agency's Policies and Procedures Manual indicates compliance
2.3	Staff Guidelines Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and termination process, job descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights. Reviewed Annually	• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed and that the employee understands agency policies and procedures

2.4	Work Conditions Staff/volunteers have the necessary tools, supplies, equipment and space to accomplish their work.	• Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply • Staff interviews indicate compliance
2.5	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance • Review of Agency's Policies and Procedures Manual indicates compliance
2.6	Professional Behavior Staff must comply with written standards of professional behavior.	• Staff guidelines include standards of professional behavior • Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel files indicates compliance • Review of agency's complaint and grievance files
2.7	Communication There are procedures in place regarding regular communication with staff about the program and general agency issues.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of regular staff meetings • Staff interviews indicate compliance
2.8	Accountability There is a system in place to document staff work time.	• Staff time sheets or other documentation indicate compliance
2.9	Staff Availability Staff are present to answer incoming calls during agency's normal operating hours.	• Published documentation of agency operating hours • Staff time sheets or other documentation indicate compliance
3.0	**Clients Rights and Responsibilities**	

3.1	<u>Clients Rights and Responsibilities</u> Agency has a Client Rights and Responsibilities Statement that is reviewed with each client in a language and format the client can understand. Agency will provide client with written copy of client rights and responsibilities, including: • Informed consent • Confidentiality • Grievance procedures • Duty to warn or report certain behaviors • Scope of service • Criteria for end of services	• Documentation in client's record
3.2	<u>Confidentiality</u> Agency has Policy and Procedure regarding client confidentiality in accordance with RWGA /TRG site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency. There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.	• Review of Agency's Policies and Procedures Manual indicates compliance • Clients interview indicates compliance • Agency's structural layout and information management indicates compliance • Signed confidentiality statement in each employee's personnel file
3.3	<u>Consents</u> All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether or not HIV status is revealed.	• Agency Policy and Procedure and signed and dated consent forms in client record
3.4	<u>Up to date Release of Information</u> Agency obtains an informed written consent of the client or legally responsible person prior to the disclosure or exchange of certain information about client's case to another party (including family members) in accordance with the RWGA Site Visit Guidelines, local, state and federal laws. The release/exchange consent form must contain: • Name of the person or entity permitted to make the disclosure	• Current Release of Information form with all the required elements signed by client or authorized person in client's record

	• Name of the client • The purpose of the disclosure • The types of information to be disclosed • Entities to disclose to • Date on which the consent is signed • The expiration date of client authorization (or expiration event) no longer than two years • Signature of the client/or parent, guardian or person authorized to sign in lieu of the client. • Description of the *Release of Information*, its components, and ways the client can nullify it Release/exchange of information forms must be completed entirely in the presence of the client. Any unused lines must have a line crossed through the space.	
3.5	<u>Grievance Procedure</u> Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to: • to whom complaints can be made • steps necessary to complain • form of grievance, if any • time lines and steps taken by the agency to resolve the grievance • documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client • all complaints or grievances initiated by clients are documented on the Agency's standardized form • resolution of each grievance/complaint is documented on the Standardized form and shared with client • confidentiality of grievance • addresses and phone numbers of licensing authorities and funding sources	• Signed receipt of agency Grievance Procedure, filed in client chart • Review of Agency's Policies and Procedures Manual indicates compliance • Review of Agency's Grievance file indicates compliance, • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2

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

	least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB). • Agencies that serve an average of 100 or more unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.	• Documentation of existence and appropriateness of a suggestion box or other client input mechanism • Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1
3.9	Patient Safety (Core Services Only) Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation *for Ambulatory Care* (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable: • "Improve the accuracy of patient identification • Improve the safety of using medications • Reduce the risk of healthcare-associated infections • Accurately and completely reconcile medications across the continuum of care • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (www.jointcommission.org)	• Review of Agency's Policies and Procedures Manual indicates compliance
3.10	Client Records Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance
4.0	**Accessibility**	
4.1	Cultural Competence Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals.	• Agency has procedures for obtaining translation services • Client satisfaction survey indicates compliance

		• Policies and procedures demonstrate commitment to the community and culture of the clients • Availability of interpretive services, bilingual staff, and staff trained in cultural competence • Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record
4.2	Client Education Agency demonstrates capacity for client education and provision of information on community resources	• Availability of the blue book and other educational materials • Documentation of educational needs assessment and client education in clients' records
4.3	Special Service Needs Agency demonstrates a commitment to assisting individuals with special needs	• Agency compliance with the Americans with Disabilities Act (ADA). • Review of Policies and Procedures indicates compliance • Environmental Review shows a facility that is handicapped accessible
4.4	Provision of Services for low-Income Individuals Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low income individuals.	• Facility is accessible by public transportation • Review of Agency's Policies and Procedures Manual indicates compliance • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4
4.5	Proof of HIV Diagnosis Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services.	• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03

	An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3
4.6	Provision of Services Regardless of Current or Past Health Condition Agency must have Policies and Procedures in place to ensure that HIV+ clients are not denied services due to current or pre-existing health condition or non-HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	• Review of Policies and Procedures indicates compliance • A file containing information on clients who have been refused services and the reasons for refusal • Source Citation: HAB Program Standards; Section D: #1
4.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.) • Income no greater than 300% of the Federal Poverty level (unless otherwise indicated) • Proof of identification • Ineligibility for third party reimbursement	• Documentation of HIV+ status, residence, identification and income in the client record • Documentation of ineligibility for third party reimbursement • Documentation of screening for Third Party Payers in accordance with TRG Policy SG-06 Documentation of Third Party Payer Eligibility or RWGA site visit guidelines • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1
4.8	Re-certification of Client Eligibility Agency conducts six (6) month re-certification of eligibility for all clients. At a minimum, agency confirms an individual's income, residency and re-screens, as appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance. At one of the two required re-certifications during a year, agency may accept client self-attestation for verifying that an individual's income, residency, and insurance status complies with the RWGA eligibility requirements. Appropriate documentation is required for changes in	• Client record contains documentation of re-certification of client residence, income and rescreening for third party payers at least every six (6) months • Review of Policies and Procedures indicates compliance • Information in client's files that includes proof of screening for insurance

	status and at least once a year (defined as a 12-month period) with renewed eligibility with the CPCDMS. Agency must ensure that Ryan White is the Payer of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance and other programs. Agency policy must also address coordination of benefits, billing and collection. Clients eligible for Department of Veterans Affairs (VA) benefits are duly eligible for Ryan White services and therefore exempted from the payer of last resort requirement • Agency must verify 3rd party payment coverage for eligible services at every visit or monthly (whichever is less frequent)	coverage (i.e. hard/scanned copy of results) • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1 and #2 • Source Citation: HIV/AIDS Bureau (HAB) Policy Clarification Notice #13-02
4.9	Charges for Services Agency must institute Policies and Procedures for cost sharing including enrollment fees, premiums, deductibles, co-payments, co-insurance, sliding fee discount, etc. and an annual cap on these charges. Agency should not charge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross income level (GIL)is ≤ 100% of the Federal Poverty Level (FPL) as documented in the CPCDMS for any services provided. Clients whose gross income is between 101-300% may be charged annual aggregate fees in accordance with the legislative mandate outlined below: • 101%-200% of FPL---5% or less of GIL • 201%-300% of FPL---7% or less of GIL • >300% of FPL ---------10% or less of GIL Additionally, agency must implement the following: • Six (6) month evaluation of clients to establish individual fees and cap (i.e. the six (6) month CPCDMS registration or registration update.) • Tracking of charges • A process for alerting the billing system when the cap is reached so client will not be charged for the rest of the calendar year. • Documentation of fees	• Review of Policies and Procedures indicates compliance • Review of system for tracking patient charges and payments indicate compliance • Review of charges and payments in client records indicate compliance with annual cap • Sliding fee application forms on client record is consistent with Federal guidelines
4.10	Information on Program and Eligibility/Sliding Fee Schedule Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update.	• Agency has a written substantiated annual plan to targeted populations • Zip code data show provider is reaching clients throughout service

	Agency should maintain a file documenting promotion activities including copies of HIV program materials and information on eligibility requirements. Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5
4.11	Linkage Into Core Services Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.	• Documentation of client referral is present in client record • Review of agency's policies & procedures' manual indicates compliance
4.12	Wait Lists It is the expectation that clients will not be put on a Wait List nor will services be postponed or denied due to funding. Agency must notify the Administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by which client information will be obtained and maintained to ensure that all clients that requested service(s) are contacted after service provision resumes. A wait list is defined as a roster developed and maintained by providers of patients awaiting a particular service when a demand for a service exceeds available appointments used on a first come next serviced method.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of compliance with TRG's Policy SG-19 Client Wait Lists • Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted

	The Agency will notify The Resource Group (TRG) or RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and A plan for resumption of service. The Agency's plan must address: • Action steps to be taken Agency to resolve the service shortfall; and • Projected date that services will resume. The Agency will report to TRG or RWGA in writing on a monthly basis while a client wait list is required with the following information: • Number of clients on the wait list. • Progress toward completing the plan for resumption of service. • A revised plan for resumption of service, if necessary.	
4.13	<u>Intake</u> The agency conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions. In addition to office visits, client is provided alternatives such as conducting business by mail, online registration via the internet, or providing home visits, when necessary. Agency has established procedures for communicating with people with hearing impairments.	• Documentation in client record • Review of Agency's Policies and Procedures Manual indicates compliance
5.0	**Quality Management**	
5.1	<u>Continuous Quality Improvement (CQI)</u> Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum: • The Agency's QM Plan • Meeting agendas and/or notes (if applicable) • Project specific CQI Plans • Root Cause Analysis & Improvement Plans • Data collection methods and analysis	• Review of Agency's Policies and Procedures Manual indicates compliance • Up to date QM Manual • Source Citation: HAB Universal Standards; Section F: #2

	• Work products • QM program evaluation • Materials necessary for QM activities	
5.2	Data Collection and Analysis Agency demonstrates capacity to collect and analyze client level data including client satisfaction surveys and findings are incorporated into service delivery. Supervisors shall conduct and document ongoing record reviews as part of quality improvement activity.	• Review of Agency's Policies and Procedures Manual indicates compliance • Up to date QM Manual • Supervisors log on record reviews signed and dated • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2
6.0	**Point Of Entry Agreements**	
6.1	Points of Entry (Core Services Only) Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with HIV Services policy approved by HRSA for the Houston EMA.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of formal agreements with appropriate Points of Entry • Documentation of referrals and their follow-up
7.0	**Emergency Management**	
7.1	Emergency Preparedness Agency leadership including medical staff must develop an Emergency Preparedness Plan modeled after the Joint Commission's regulations and/or Centers for Medicare and Medicaid guidelines for Emergency Management. The plan should, at a minimum utilize "all hazard approach" (hurricanes, floods, earthquakes, tornadoes, wide-spread fires, infectious disease outbreak and other public health threats, terrorist attacks, civil disturbances and collapse of buildings and bridges) to ensure a level of preparedness sufficient to support a range of emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergency. The agency shall communicate hazards identified with its community emergency	• Emergency Preparedness Plan • Review of Agency's Policies and Procedures Manual indicates compliance

	response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	
7.2	Emergency Management Training In accordance with the Department of Human Services recommendations, all applicable agency staff must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security: • IS -100.HC – Introduction to the Incident command system for healthcare/hospitals • IS-200.HC- Applying ICS to Healthcare organization • IS-700.A-National Incident Management System (NIMS) Introduction • IS-800.B National Response Framework (management) The above courses may be accessed at:www.training.fema.gov. Agencies providing support services only may complete alternate courses listed for the above areas All applicable new employees are required to complete the courses within 90 days of hire.	• Documentation of all training including certificate of completion in personnel file
7.3	Emergency Preparedness Plan The emergency preparedness plan shall address the six critical areas for emergency management including • Communication pathways • Essential resources and assets • patients' safety and security • staff responsibilities • Supply of key utilities such as portable water and electricity • Patient clinical and support activities during emergency situations. (www.jointcommission.org)	• Emergency Preparedness Plan
7.4	Emergency Management Drills Agency shall implement emergency management drills twice a year either in response to actual emergency or in a planned exercise. Completed exercise should be evaluated by a multidisciplinary team including administration, clinical and support staff. The emergency plan should be modified based on the evaluation results and retested.	• Emergency Management Plan • Review of Agency's Policies and Procedures Manual indicates compliance

8.0	**Building Safety**	
8.1	Required Permits All agencies will maintain Occupancy and Fire Marshal's permits for the facilities.	• Current required permits on file

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

Case management services in HIV care facilitate client access to health care services, assist clients to navigate through the wide array of health care programs and ensure coordination of services to meet the unique needs of PLWHA. It also involves client assessment to determine client's needs and the development of individualized service plans in collaboration with the client to mitigate clients' needs. Ryan White Grant Administration funds three case management models i.e. one psychosocial and two clinical/medical models depending on the type of ambulatory service within which the case management service is located. The scope of these three case management models namely, Non-Medical, Clinical and Medical case management services are based on Ryan White HIV/AIDS Treatment Modernization Act of 2006 (HRSA)[2] definition for non-medical and medical case management services. Other resources utilized include the current *National Association of Social Workers (NASW) Standards for Social Work Case Management*[3]. Specific requirements for each of the models are discussed under each case management service category.

1.0	**Staff Training**	
1.1	Required Meetings Case Managers and Service Linkage Workers Case managers and Service Linkage Workers will attend on an annual basis a minimum of four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA. Case Managers and Service Linkage Workers will attend the "Joint Prevention and Care Coordination Meeting" held annually and facilitated by the RWGA and the City of Houston STD/HIV Bureau. Medical Case Management (MCM), Clinical Case Management (CCM) and Service Linkage Worker Supervisors will attend on an annual basis a minimum of five (5) of the six (6) bi-monthly Supervisor meetings facilitated by RWGA (in the event a MCM or CCM supervises SLW staff the MCM or CCM must attend the Supervisor meetings and may, as an option, attend the networking meetings)	• Agency will maintain verification of attendance (RWGA will also maintain sign-in logs)

[2] US Department of Health and Human Services, Health Resources and Services Administration HIV/AIDS Bureau (2009). Ryan White HIV/AIDS Treatment Modernization Act of 2006: Definitions for eligible services

[3] National Association of Social Workers (1992). NASW standards for social work case management. Retrieved 02/9/2009 from www.socialworkers.org/practice/standards/sw_case_mgmt.asp

1.2	Required Training for New Employees Within the first ninety (90) days of employment in the case management system, case managers will successfully complete HIV Case Management 101 2013 Update, through the State of Texas TRAIN website (https://tx.train.org) with a minimum of 70% accuracy. RWGA expects HIV Case Management 101 2013 Update, course completion to take no longer than 16 hours. Within the first six (6) months of employment, case managers will complete at least four (4) hours review of Community resources, and at least four (4) hours cultural competency training offered by RWGA. For cultural competency training only, Agency may request a waiver for agency based training alternative that meets or exceeds the RWGA requirements for the first year training for case management staff.	• Certificates of completion for applicable trainings in the case manager's file • Sign-in sheets for agency based trainings maintained by Agency • RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum
1.3	Certified Application Counselor (CAC) Training & Certification Within the first ninety (90) days of employment in the case management system, case managers will successfully complete CAC training and maintain CAC certification by their Certificated Application Counselor Designated Organization employer. RWGA expects CAC training completion to take no longer than 6 hours.	• Certificates of completion in case manager's file
1.4	Case Management Supervisor Peer-led Training Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and Community (SLW) Case Managers must fully participate in the four (4) Case Management Supervisor Peer-Led three-hour training curriculum conducted by RWGA.	• Review of attendance sign-in sheet indicates compliance
1.5	Child Abuse Screening, Documenting and Reporting Training Case Managers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient interaction.	• Documentation of staff training
2.0	**Timeliness of Services**	

2.1	Initial Case Management Contact Contact with client and/or referring agent is attempted within one working day of receiving a case assignment. If the case manager is unable to make contact within one (1) working day, this is documented and explained in the client record. Case manager should also notify their supervisor. All subsequent attempts are documented.	• Documentation in client record
2.2	Acuity The case manager should use an acuity scale or other standardized system as a measurement tool to determine client needs (applies to TDSHS funded case managers only).	• Completed acuity scale in client's records
2.3	Progress Notes All case management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 hours of their occurrence.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes
2.4	Client Referral and Tracking Agency will have policies and procedures in place for referral and follow-up for clients with medical conditions, nutritional, psychological/social and financial problems. The agency will maintain a current list of agencies that provide primary medical care, prescription medications, assistance with insurance payments, dental care, transportation, nutritional counseling and supplements, support for basic needs (rent, food, financial assistance, etc.) and other supportive services (e.g. legal assistance, partner elicitation services and Client Risk Counseling Services (CRCS). The Case Manager will: • Initiate referrals within two (2) weeks of the plan being completed and agreed upon by the Client and the Case Manager • Work with the Client to determine barriers to referrals and facilitate access to referrals • Utilize a tracking mechanism to monitor completion of all case management referrals	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of follow-up tracking activities in clients records • A current list of agencies that provide services including availability of the Blue Book
2.5	Client Notification of Service Provider Turnover	• Documentation in client record

	Client must be provided notice of assigned service provider's cessation of employment within 30 days of the employee's departure.	
2.6	<u>Client Transfers between Agencies: Open or Closed less than One Year</u> The case manager should facilitate the transfer of clients between providers. All clients are transferred in accordance with Case Management Policy and Procedure, which requires that a "consent for transfer and release/exchange of information" form be completed and signed by the client, the client's record be forwarded to the receiving care manager within five (5) working days and a Request for Transfer form be completed for the client and submitted to RWGA by the receiving agency.	• Documentation in client record
2.7	<u>Caseload</u> Case load determination should be based on client characteristics, acuity level and the intensity of case management activities.	• Review of the agency's policies and procedures for Staffing ratios

Clinical Case Management Services

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines medical case management as "a range of client-centered services that link clients with health care, psychosocial, and other services" including coordination and follow-up of medical treatment and "adherence counseling to ensure readiness for and adherence to HIV complex treatments". The definition outlines the functions of the medical case manager as including assessments and reassessments, individualized comprehensive service planning, service plan implementation and periodic evaluation, client advocacy and services utilization review. The Ryan White Grant Administration categorizes medical case management services co-located in a Mental Health treatment/counseling and/or Substance Abuse treatment services as Clinical Case Management (CCM) services.
CCM services may be targeted to underserved populations such as Hispanics, African Americans, MSM, etc.

1.0	**Staff Requirements**	
1.1	Minimum Qualifications All clinical case managers must have a current and in good standing State of Texas license (LBSW, LMSW, LCSW, LPC, LPC-I, LMFT, LMFT-A).	• A file will be maintained on each clinical case manager • Supportive documentation of credentials and job description is maintained by the agency in each clinical case manager file. Documentation should include transcripts and/or diplomas and proof of licensure
1.2	Scope of Services The clinical case management services will include at a minimum, comprehensive assessment including mental health and substance abuse/use; development, implementation and evaluation of care plans; follow-up; advocacy; direction of clients through the entire spectrum of health and support services and peer support. Other functions include facilitation and coordination of services from one service provider to another including mental health, substance abuse and primary medical care providers.	• Review of client records indicates compliance • Agency Policy and Procedures indicates compliance
1.3	Ongoing Education/Training for Clinical Case Managers After the first year of employment in the case management system each clinical case manager will obtain the minimum number of hours of	• Certificates of completion are maintained by the agency • Current License on case manager's file

	continuing education to maintain his or her licensure and four (4) hours of training in current Community Resources conducted by RWGA	
2.0	**Timeliness of Services/Documentation**	
2.1	<u>Client Eligibility</u> In addition to the general eligibility criteria, individuals must meet one or more of the following criteria in order to be eligible for clinical case management services: • HIV+ individual in mental health treatment/counseling and/or substance abuse treatment services or HIV+ individual whose history or behavior may indicate the individual may need mental health and/or substance abuse treatment/counseling now or in the future. • Clinical criteria for admission into clinical case management must include one of the following: ➢ Client is actively symptomatic with a DSM (most current, American Psychiatric Association approved) diagnosis, especially including substance-related disorders (abuse/dependence), mood disorders (Bipolar depression), depressive disorders, anxiety disorders, and other psychotic disorders; or DSM (most current, American Psychiatric Association approved) diagnosis personality disorders. ➢ Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services. ➢ Client is in mental health counseling or chemical dependency treatment.	• Documentation of HIV+ status, mental health and substance abuse status, residence, identification, and income in the client record
2.2	<u>Discharge/Closure from Clinical Case Management Services</u> In addition to the general requirements, a client may be discharged from clinical case management services for the following reasons. • Client has achieved a sustainable level of stability and independence.	• Documentation in client record.

	➢ Substance Abuse – Client has successfully completed an outpatient substance abuse treatment program. ➢ Mental Health – Client has successfully accessed and is engaged in mental health treatment and/or has completed mental health treatment plan objectives.	
2. 3	<u>Coordination with Primary Medical Care and Medical Case Management Provider</u> Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White **Part A/B**-funded Medical Case Management programs. Clinical Case Management services provided to clients accessing primary medical care from a Ryan White **Part A/B**-funded primary medical care provider other than Agency will require Agency and Primary Medical Care/Medical Case Management provider to conduct regular multi-disciplinary case conferences to ensure effective coordination of clinical and psychosocial interventions. Case conferences must at a minimum include the clinical case manager; mental health/counselor and/or medical case manager and occur at least every three (3) months for the duration of Clinical Case Management services. Client refusal to provide consent for the clinical case manager to participate in multi-disciplinary case conferences with their Primary Medical Care provider must be documented in the client record.	• Review of Agency's Policies and Procedures Manual indicates compliance • Case conferences are documented in the client record
2.4	<u>Assessment</u> Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk	• Documentation in client record on the comprehensive client assessment form, signed and dated, or agency's equivalent form. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate

	behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Clinical Case Management will use a RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's Mental Health and/or Substance Abuse treatment program(s).	
2.5	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA or TRG -approved reassessment form as applicable must be utilized.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated • Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only)
2.6	Service Plan Service planning begins at admission to clinical case management services and is based upon assessment. The clinical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short term needs met before full service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care,	• Documentation in client record on the clinical case management service plan or agency's equivalent form • Service plan signed by client and the case manager

	mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	
3.0	**Supervision and Caseload**	
3.1	Clinical Supervision and Caseload Coverage The clinical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the clinical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision

Non-Medical Case Management Services (Service Linkage Worker)

Non-medical case management services (Service Linkage Worker (SLW) is co-located in ambulatory/outpatient medical care centers. HRSA defines Non-Medical case management services as the "provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services" and does not include coordination and follow-up of medical treatment. The Ryan White Part A/B SLW provides services to clients who do not require intensive case management services and these include the provision of information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients to develop and utilize independent living skills and strategies.

1.0	**Staff Requirements**	
1.1	Minimum Qualifications Service Linkage Worker – unlicensed community case manager Service linkage workers must have a bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). Service linkage workers must have a minimum of 1 year paid work experience with PLWHA. Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish. Agency will provide Service Linkage Worker a written job description upon hiring.	• A file will be maintained on service linkage worker. Supportive documentation of credentials and job description are maintained by the agency and in each service linkage worker's file. Documentation may include, but is not limited to, transcripts, diplomas, certifications and/or licensure.
2.0	**Timeliness of Services/Documentation**	
2.1	Client Eligibility – Service Linkage targeted to Not-in-Care and Newly Diagnosed (COH Only) In addition to general eligibility criteria individuals must meet the following in order to be eligible for non-medical case management services: • HIV+ and not receiving outpatient HIV primary medical care services within the previous 180 days as documented by the CPCDMS, or	• Documentation of HIV+ status, residence, identification and income in the client record • Documentation of "not in care" status through the CPCDMS

	• Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care services as documented by the CPCDMS, or • Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS	
2.2	Service Linkage Worker Assessment Assessment begins at intake. The service linkage worker will provide client and, if appropriate, his/her personal support system information regarding the range of services offered by the case management program during intake/assessment. The service linkage worker will complete RWGA -approved brief assessment tool within five (5) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager. **Low-need, non-primary care clients who have only an intermittent need for information about services may receive brief SLW services without being placed on open status**.	• Documentation in client record on the brief assessment form, signed and dated • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
2.3	Service Linkage Worker Reassessment Clients on **open status** will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applicable must be utilized.	• Documentation in RWGA approved client reassessment form or agency's equivalent form, signed and dated
2.4	Transfer of Not-in-Care and Newly Diagnosed Clients (COH Only) Service linkage workers targeting their services to Not-in-Care and newly diagnosed clients will work with clients for a maximum of 90 days. Clients must be transferred to a Ryan White-funded primary medical care, clinical case management or medical case management program, or a private (non-Ryan White funded) physician within 90 days of the initiation of services.	• Documentation in client record and in the CPCDMS

	Those clients who chose to access primary medical care from a non-Ryan White funded source may receive ongoing service linkage services from provider or from a Ryan White-funded Clinic or Medical Case Management provider.	
2.5	<u>Primary Care Newly Diagnosed and Lost to Care Clients</u> Agency must have a written policy and procedures in place that address the role of Service Linkage Workers in the linking and re-engaging of clients into primary medical care. The policy and procedures must include at minimum: • Methods of routine communication with testing sites regarding newly diagnosis and referred individuals • Description of service linkage worker job duties conducted in the field • Process for re-engaging agency patients lost to care (no primary care visit in 6 months)	• Review of Agency's Policies and Procedures Manual indicates compliance.
3.0	**Supervision and Caseload**	
3.1	<u>Service Linkage Worker Supervision</u> A minimum of four (4) hours of supervision per month must be provided to each service linkage worker by a master's level health professional.) At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ date ➢ name(s) of case manager(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature • Supervision notes are never maintained in the client record
3.2	<u>Caseload Coverage – Service Linkage Workers</u> Supervisor ensures that there is coverage of the caseload in the absence of the service linkage worker or when the position is vacant. Service Linkage Workers may assist clients who are routinely seen by other CM team members in the absence of the client's "assigned" case manager.	• Documentation of all client encounters in client record and in the Centralized Patient Care Data Management System

3.3	<u>Case Reviews – Service Linkage Workers.</u> Supervisor reviews a random sample equal to 10% of unduplicated clients served by each service linkage worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and SLW

Medical Case Management

Similarly to nonmedical case management services, medical case management (MCM) services are co-located in ambulatory/outpatient medical care centers (see clinical case management for HRSA definition of medical case management services). The Houston RWPA/B medical case management visit includes assessment, education and consultation by a licensed social worker within a system of information, referral, case management, and/or social services and includes social services/case coordination,". In addition to general eligibility criteria for case management services, providers are required to screen clients for complex medical and psychosocial issues that will require medical case management services (see MCM SOC 2.1).

1.0	**Staff/Training**	
1.1	Qualifications/Training Minimum Qualifications - The program must utilize a Social Worker licensed by the State of Texas to provide Medical Case Management Services. A file will be maintained on each medical case manager. Supportive documentation of medical case manager credentials is maintained by the agency and in each medical case manager's file. Documentation may include, but is not limited to, transcripts, diplomas, certifications, and/or licensure.	• Documentation of credentials and job description in medical case manager's file
1.2	Scope of Services The medical case management services will include at a minimum, screening of primary medical care patients to determine each patient's level of need for medical case management; comprehensive assessment, development, implementation and evaluation of medical case management service plan; follow-up; direction of clients through the entire spectrum of health and support services; facilitation and coordination of services from one service provider to another. Others include referral to clinical case management if indicated, client education regarding wellness, medication and health care compliance and peer support.	• Review of clients' records indicates compliance
1.3	Ongoing Education/Training for Medical Case Managers After the first year of employment in the case management system each medical case manager will obtain the minimum number of hours of continuing education to maintain his or her licensure.	• Attendance sign-in sheets and/or certificates of completion are maintained by the agency

2.0	**Timeliness of Service/Documentation** Medical case management for persons with RWGA disease should reflect competence and experience in the assessment of client medical need and the development and monitoring of medical service delivery plans.	
2.1	<u>Screening Criteria for Medical Case Management</u> In addition to the general eligibility criteria, agencies are advised to use screening criteria before enrolling a client in medical case management. Examples of such criteria include the following: i. Newly diagnosed ii. New to ART iii. CD4<200 iv. VL>100,000 or fluctuating viral loads v. Excessive missed appointments vi. Excessive missed dosages of medications vii. Mental illness that presents a barrier to the patient's ability to access, comply or adhere to medical treatment viii. Substance abuse that presents a barrier to the patient's ability to access, comply or adhere to medical treatment ix. Housing issues x. Opportunistic infections xi. Unmanaged chronic health problems/injury/Pain xii. Lack of viral suppression xiii. Positive screening for intimate partner violence xiv. Clinician's referral Clients with one or more of these criteria would indicate need for medical case management services. Clients enrolling in medical case management services should be placed on "open" status in the CPCDMS. The following criteria are an indication a client may be an appropriate referral for Clinical Case Management services. • Client is actively symptomatic with an axis I DSM (most current, American Psychiatric Association approved) diagnosis especially including substance-related disorders (abuse/dependence), mood disorders (major depression, Bipolar depression), anxiety disorders, and other	• Review of agency's screening criteria for medical case management

	psychotic disorders; or axis II DSM (most current, American Psychiatric Association approved) diagnosis personality disorders; • Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services; • Client is in mental health counseling or chemical dependency treatment.	
2.2	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. Medical case managers will provide a comprehensive assessment at intake and at least annually thereafter. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Medical Case Management will use an RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's program needs.	• Documentation in client record on the comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.3	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other providers, increased	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated

	risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA or TRG -approved reassessment form as applicable must be utilized.	• Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only)
2.4	<u>Service Plan</u> Service planning begins at admission to medical case management services and is based upon assessment. The medical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short term needs met before full service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	• Documentation in client's record on the medical case management service plan or agency's equivalent form • Service Plan signed by the client and the case manager
2.5	<u>Brief Interventions</u> Clients who are not appropriate for medical case management services may still receive brief interventions. In lieu of completing the comprehensive client re-assessment, the medical case manager should complete the brief re-assessment and service plan and document in the progress notes. Any referrals made should be documented, including their outcomes in the progress notes.	• Documentation in the progress notes reflects a brief re-assessment and plan (referral) • Documentation in client record on the brief re-assessment form • Documentation of referrals and their outcomes in the progress notes • Documentation of brief interventions in the progress notes.
3.0	**Supervision and Caseload**	

3.1	Clinical Supervision and Caseload Coverage The medical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the medical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision

Local Pharmacy Assistance Program

The Local Pharmacy Assistance Programs (LPAP) are co-located in ambulatory medical care centers and provide HIV/AIDS and HIV-related pharmaceutical services to clients who are not eligible for medications through private insurance, Medicaid/Medicare, State ADAP, State SPAP or other sources. HRSA requirements for LPAP include a client enrollment process, uniform benefits for all enrolled clients, a record system for dispensed medications and a drug distribution system.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV/AIDS.**	
1.1	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for LPAP services: • Income no greater than 500% of the Federal poverty level for HIV medications and no greater than 300% of the Federal poverty level for HIV-related medications	• Documentation of income in the client record.
1.2	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days • Pharmacy will fill prescription within one (1) business day of approval	• Documentation in the client record and review of pharmacy summary sheets • Review of agency's Policies & Procedures Manual indicates compliance
1.3	LPAP Medication Formulary RW funded prescriptions for program eligible clients shall be based on the current RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Public Health Services guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record

2.0	**Staff HIV/AIDS knowledge is based on documented training.**	
2.1	Orientation Initial orientation includes twelve (12) hours of HIV/AIDS basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines
2.2	Ongoing Training Eight (8) hours annually of continuing education in HIV/AIDS related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
2.3	Pharmacy Staff Experience A minimum of one year documented HIV/AIDS work experience is preferred.	• Documentation of work experience in personnel file
2.4	Pharmacy Staff Supervision Staff will receive at least two (2) hours of supervision per month to include client care, job performance and skill development.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance • Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present

Primary Medical Care

The 2006 CARE Act defines Primary Medical Services as the "provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe Antiretroviral (ARV) therapy in an outpatient setting….. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history tasking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions and referral to and provisions of specialty care".

The RW Part A primary care visit consist of a client examination by a qualified Medical Doctor, Nurse Practitioner, Clinical Nurse Specialist and/or Physician Assistant and includes all ancillary services such as eligibility screening, patient medication/treatment education, adherence education, counseling and support; medication access/linkage; and as clinically indicated, OB/GYN specialty procedures, nutritional counseling, routine laboratory and radiology. All primary care services must be provided in accordance with the current U.S. Department of Health and Human Services guidelines (HHS)

1.0	**Medical Care for persons with HIV disease should reflect competence and experience in both primary care and therapeutics known to be effective in the treatment of HIV infection and is consistent with the most current published HHS treatment guidelines**	
1.1	Minimum Qualifications Medical care for HIV infected persons shall be provided by MD, NP, CNS or PA licensed in the State of Texas and has at least two years paid experience in HIV/AIDS care including fellowship.	• Credentials on file
1.2	Licensing, Knowledge, Skills and Experience • All staff maintain current organizational licensure (and/or applicable certification) and professional licensure • The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc. • Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (www.hivma.org): • Clinical management of at least 25 HIV-infected patients within the last year	• Documentation in personnel record

	• Maintain a minimum of 15 hours of HIV-specific CME (including a minimum of 5 hours related to antiretroviral therapy) per year. Agencies using contractors must ensure that this requirement is met and must provide evidence at the annual program monitoring site visits. • Physician extenders must obtain this experience within six months of hire • All staff receive professional supervision • Staff show training and/or experience with the medical care of adults with HIV	
1.3	Peer Review Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e. MD, NP, PA).	• Provider will document peer review has occurred annually
1.4	**Standing Delegation Orders (SDO)** Standing delegation orders provide direction to RNs, LVNs and, when applicable, Medical Assistants in supporting management of patients seen by a physician. Standing Delegation Orders must adhere to Texas Administrative Code, Title 22, Part 9; Chapter 193; Rule §193.1 and. must be congruent with the requirements specified by the Board of Nursing (BON) and Texas State Board of Medical Examiners (TSBME).	• Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider. • Standing Delegation Orders will be reviewed , updated as needed and signed by the physician annually. • Use of standing delegation orders will be documented in patient's primary record system.
1.5	Primary Care Guidelines Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (**http://www.aidsinfo.nih.gov/guidelines/**) and other nationally recognized evidence-based guidelines. Immunizations should be given according to the most current Advisory Committee on Immunization Practices (ACIP) guidelines. .	• Documentation in client's record • Exceptions noted in client's record
1.6	Medical Evaluation/Assessment All HIV infected clients receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical	• Completed assessment in client's record

	examination. The comprehensive assessment/evaluation will be completed by the MD, NP, CNS or PA in accordance with professional and established HIV practice guidelines (www.hivma.org) within 3 weeks of initial contact with the client. A comprehensive reassessment shall be completed on an annual basis or when clinically indicated. The initial assessment and reassessment shall include at a minimum, general medical history, a comprehensive HIV related history and a comprehensive physical examination. Comprehensive HIV related history shall include: • Psychosocial history • HIV treatment history and staging • Most recent CD4 counts and VL test results • Resistance testing and co receptor tropism assays as clinically indicated • Medication adherence history • History of HIV related illness and infections • History of Tuberculosis • History of Hepatitis and vaccines • Psychiatric history • Transfusion/blood products history • Past medical care • Sexual history • Substance abuse history • Review of Systems	
1.7	Medical Records Medical Records should clearly document the following components, separate from progress notes: • A central "Problems List" which clearly prioritizes problems for primary care management, including mental health and substance use/abuse disorders (if applicable) • A vaccination record, including dates administered • The status of routine screening procedures (i.e., pap smears, mammograms, colonoscopies)	• Documentation in client's record

1.8	Plan of Care A plan of care shall be developed for each identified problem and should address diagnostic, therapeutic and educational issues in accordance with the current U.S. HHS treatment guidelines.	• Plan of Care documented in client's record
1.9	Follow- Up Visits All patients shall have follow –up visits every three to six months or as clinically indicated for treatment monitoring and also to detect any changes in the client's HIV status. At each clinic visit the provider will at a minimum: • Measure vital signs including height and weight • Perform physical examination and update client history • Measure CBC, CD4 and VL levels every 3-6 months or in accordance with current treatment guidelines, • Evaluate need for ART • Resistance Testing if clinical indicated • Evaluate need for prophylaxis of opportunistic infections • Document current therapies on all clients receiving treatment or assess and reinforce adherence with the treatment plan • Update problem list • Refer client for ophthalmic examination by an ophthalmologist every six months when CD4 count falls below 50CU/MM • Refer Client for dental evaluation or care every 12 months • Incorporate HIV prevention strategies into medical care for of persons living with HIV • Screen for risk behaviors and provide education on risk reduction • Assess client comprehension of treatment plan and provide education/referral as indicated • Refer for other clinical and social services where indicated	• Content of Follow-up documented in client's record • Documentation of specialist referral including dental in client's records
1.10	Yearly Surveillance Monitoring and Vaccinations • All HIV–infected women should have regular pap tests	• Documentation in client's record

	➢ An initial negative pap test should be followed with another pap test in 6-12 months and if negative, annually thereafter. ➢ If 3 consecutive pap tests are normal, follow-up pap tests should be done every 3 years ➢ Women 30 years old and older may have pap test and HPV co-testing, and if normal, repeated every 3 years ➢ A pap test showing abnormal results should be managed per guidelines • Screening for anal cancer, if indicated • Resistance Testing if clinical indicated • Chem. panel with LFT and renal function test • Influenza vaccination • Annual Mental Health Screening with standardized tool • TST or IGRA (this should be done in accordance with current U.S Public Health Service guidelines (US Public Health Service, Infectious Diseases Society of America. *Guidelines for preventing opportunistic infections among HIV-infected persons***)** (Available at aidsinfo.nih.gov/Guidelines/) • Annual STD testing including syphilis, gonorrhea and Chlamydia for those at risk, or more frequently as clinically indicated	
1.11	<u>Preconception Care for HIV Infected Women of Child Bearing Age</u> In accordance with the US Department of Health and Human Services recommendations (http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf), preconception care shall be a component of routine primary care for HIV infected women of child bearing age and should include preconception counseling. In addition to the general components of preconception counseling, health care providers should, at a minimum: • Assess women's pregnancy intentions on an ongoing basis and discuss reproductive options • Offer effective and appropriate contraceptive methods to women who wish to prevent unintended pregnancy	• Documentation of preconception counseling and care at initial visit and annual updates in Client's record as applicable

	• Counsel on safe sexual practices • Counsel on eliminating of alcohol, illicit drugs and smoking • Educate and counsel on risk factors for perinatal HIV transmission, strategies to reduce those risks, and prevention and potential effects of HIV and treatment on pregnancy course and outcomes • Inform women of interventions to prevent sexual transmission of HIV when attempting conception with an HIV-uninfected partner Other preconception care consideration should include: • The choice of appropriate antiretroviral therapy effective in treating maternal disease with no teratogenicity or toxicity should pregnancy occur • Maximum suppression of viral load prior to conception	
1.12	Obstetrical Care for HIV Infected Pregnant Women Obstetrical care for HIV infected pregnant women shall be provided by board certified obstetrician experienced in the management of high risk pregnancy and has at least two years experience in the care of HIV infected pregnant women. Antiretroviral therapy during ante partum, perinatal and postpartum should be based on the current HHS guidelines http://www.aidsinfo.nih.gov/Guidelines.	• Documentation in client's record
1.13	Coordination of Services in Prenatal Care To ensure adherence to treatment, agency must ensure coordination of services among prenatal care providers, primary care and HIV specialty care providers, mental health and substance abuse treatment services and public assistance programs as needed.	• Documentation in client's records.
1.14	Care of HIV-Exposed and HIV- Infected Infants, Children and Pre-pubertal Adolescents Care and monitoring of HIV-exposed children must be done in accordance to the HHS guidelines. Treatment of HIV infected infants and children should be managed by a specialist in pediatric and adolescent HIV infection. Where this is not possible, primary care providers must consult with such specialist. Providers must utilize current HHS Guidelines for the Use	• Documentation in client's record

	of Antiretroviral Agents in Pediatric HIV Infection (http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf) in providing and monitoring antiretroviral therapy in infants, children and pre pubertal adolescents. Patients should also be monitored for growth and development, drug toxicities, neurodevelopment, nutrition and symptoms management. A multidisciplinary team approach must be utilized in meeting clients' need and team should consist of physicians, nurses, case managers, pharmacists, nutritionists, dentists, psychologists and outreach workers.	
1.15	Patient Medication Education All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed and then documented in the patient record: the names, actions and purposes of all medications in the patient's regimen; the dosage schedule; food requirements, if any; side effects; drug interactions; and adherence. Patients must be informed of the following: how to pick up medications; how to get refills; and what to do and who to call when having problems taking medications as prescribed. Medication education must also include patient's return demonstration of the most current prescribed medication regimen. The program must utilize an RN, LVN, PA, NP, CNS, pharmacist or MD licensed by the State of Texas, who has at least one year paid experience in HIV/AIDS care, to provide the educational services.	• Documentation in the patient record. Documentation in patient record must include the clinic name; the session date and length; the patient's name, patient's ID number, or patient representative's name; the Educator's signature with license and title; the reason for the education (i.e. initial regimen, change in regimen, etc.) and documentation of all discussed education topics.
1.16	Adherence Assessment Agency will incorporate adherence assessment into primary care services. Clients who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. Adherence assessment shall be provided by an RN, LVN, PA, NP, CNS, Medical/Clinical Case Manager, pharmacist or MD licensed by the State of Texas. Agency must utilize the RWGA standardized adherence assessment tool. Case managers must refer clients with adherence issues beyond their scope of practice to the appropriate health care professional for counseling.	• Completed adherence tool in client's record • Documentation of counseling in client records

1.17	Documented Non-Compliance with Prescribed Medication Regimen The agency must have in place a written policy and procedure regarding client non-compliance with a prescribed medication regimen. The policy and procedure should address the agency's process for intervening when there is documented non-compliance with a client's prescribed medication regimen.	• Review of Policies and Procedures Manual indicates compliance.
1.18	Client Mental Health and Substance Use Policy The agency must have in place a written policy and procedure regarding client mental health and substance use. The policy and procedure should address: the agency's process for assessing clients' mental health and substance use; the treatment and referral of clients for mental illness and substance abuse; and care coordination with mental health and/or substance abuse providers for clients who have mental health and substance abuse issues.	• Review of Policies and Procedures Manual indicates compliance.
1.19	Intimate Partner Violence Screening Policy The agency must have in place a written policy and procedure regarding client Intimate Partner Violence (IPV) Screening that is consistent with the Houston EMA IPV Protocol. The policy and procedure should address: • process for ensuring clients are screened for IPV no less than annually • intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management • State reporting requirements associated with IPV • Description of required medical record documentation • Procedures for patient referral including available resources, procedures for follow-up and responsible personnel • Plan for training all appropriate staff (including non-RW funded staff)	• Review of Policies and Procedures Manual indicates compliance. • Documentation in patient record
1.20	Patient Retention in Care The agency must have in place a written policy and procedure regarding client retention in care. The policy and procedure must include:	• Review of Agency's Policies and Procedures Manual indicates compliance

	• process for client appointment reminders (e.g. timing, frequency, position responsible) • process for contacting clients after missed appointments (e.g. timing, frequency, position responsible) • measures to promote retention in care • process for re-engaging those lost to care (no primary care visit in 6 months)	
2.0	**Psychiatric care for persons with HIV disease should reflect competence and experience in both mental health care and therapeutics known to be effective in the treatment of psychiatric conditions and is consistent with the most current published Texas Society of Psychiatric Physicians/American Psychiatric Association treatment guidelines**	
2.1	Psychiatric Guidelines Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines (www.txpsych.org) and the American Psychiatric Association (www.psych.org/aids) guidelines.	• Documentation in patient record
3.0	**In addition to demonstrating competency in the provision of HIV disease specific care, HIV clinical service programs must show evidence that their performance follows norms for ambulatory care.**	
3.1	Access to Care Primary care providers shall ensure all new referrals from testing sites are scheduled for a new patient appointment within 15 working days of referral. (All exceptions to this timeframe will be documented) Agency must assure the time-appropriate delivery of services, with 24 hour on-call coverage including: • Mechanisms for urgent care evaluation and/or triage • Mechanisms for in-patient care • Mechanisms for information/referral to: ➢ Medical sub-specialties: Gastroenterology, Neurology, Psychiatry, Ophthalmology, Dermatology, Obstetrics and Gynecology and Dentistry ➢ Social work and case management services ➢ Mental health services	• Agency Policy and Procedure regarding continuity of care.

	➢ Substance abuse treatment services ➢ Anti-retroviral counseling/therapy for pregnant women ➢ Local federally funded hemophilia treatment center for persons with inherited coagulopathies ➢ Clinical investigations	
3.2	<u>Continuity with Referring Providers</u> Agency must have a formal policy for coordinating referrals for inpatient care and exchanging patient information with inpatient care providers.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.3	<u>Clients Referral and Tracking</u> Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agencies must implement tracking systems to identify clients who are out of care and/or need health screenings (e.g. Hepatitis b & c, cervical cancer screening, etc., for follow-up).	• Documentation of referrals out • Staff interviews indicate compliance • Established tracking systems
3.4	<u>Client Notification of Service Provider Turnover</u> Client must be provided notice of assigned service primary care provider's cessation of employment within 30 days of the employee's departure.	• Documentation in patient record
3.5	<u>Recommended Format for Operational Standards</u> Detailed standards and routines for program assessment are found in most recent Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) performance standards.	• Ambulatory HIV clinical service should adopt and follow performance standards for ambulatory care as established by the Joint Commission on the Accreditation of Healthcare Organizations.

Vision Services

The Vision Services is an integral part of the Outpatient Ambulatory Medical Care Services. Primary Care Office/Clinic Vision Care consist of comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary. Allowable visits with a credentialed Ophthalmic Medical Assistant include routine and preliminary tests such as muscle balance test, Ishihara color test, Near Point of Conversion (NPC), visual acuity testing, visual field testing, Lensometry and glasses dispensing.

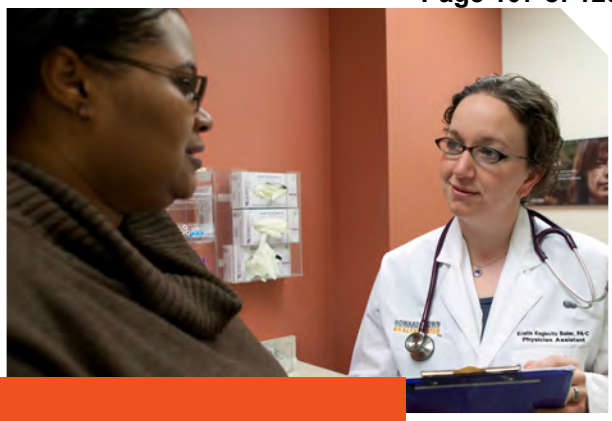
1.0	**Staff HIV/AIDS knowledge is based on documented training.**	
1.1	Ongoing Training Four (4) hours of continuing education in vision-related or other specific topics is required annually.	• Documentation of all training in personnel file • Staff interviews indicate compliance
1.2	Staff Experience/Qualifications Minimum of one (1) year HIV/AIDS work experience for paid staff (optometry interns exempt) is preferred. Provider must have a staff Doctorate of Optometry licensed by the Texas Optometry Board as a Therapeutic Optometrist, or a medical doctor who is board certified in ophthalmology.	• Documentation of work experience in personnel file
1.3	Staff Supervision Staff services are supervised by a paid coordinator or manager. Supervision of clinical staff shall be provided by a practitioner with at least two (2) years experience in vision care and treatment of persons with HIV. All licensed personnel shall receive supervision consistent with the State of Texas license requirements.	• Review of personnel files indicates compliance • Review of agency's Policy and Procedure Manual indicates compliance
2.0	**Patient Care**	
2.1	Physician Contact Information Agency obtains and documents primary care physician contact information for each client. At minimum, agency should collect the physician's name and telephone number.	• Documentation of physician contact information in the client record
2.2	Client Intake Agency collects the following information for all new clients: Health history;	• Documentation in the client record

	Ocular history; Current medications; Allergies and drug sensitivities; Reason for visit (chief complaint).	
2.3	<u>CD4/Viral Loads</u> When clinically indicated, current (within the last 6 months) CD4 and Viral Load laboratory test results for clients are obtained.	• Documentation in the client record
2.4	<u>Comprehensive Eye Exam</u> The comprehensive eye exam will include documentation of the following: Visual acuity, refraction test, binocular vision muscle assessment, observation of external structures, Fundus/retina Exam, Dilated Fundus Exam (DFE) when clinically indicated, Glaucoma test, findings of exam - either normal or abnormal, written diagnoses where applicable, Treatment Plan. Client may be evaluated more frequently based on clinical indications and current US Public Health Service guidelines.	• Documentation in the client record
2.5	<u>Lens Prescriptions</u> Clients who have clinical indications for corrective lens must receive prescriptions, and referrals for such services to ensure they are able to obtain their eyeglass.	• Documentation in the client record

HRSA Ryan White & Global HIV/AIDS Programs

Ryan White HIV/AIDS Program

March 2016



Black/African American Clients, 2014

Ryan White HIV/AIDS Program Black/African American Client Fast Facts

47.2% OF ALL RWHAP CLIENTS.

79.8% ARE RETAINED IN HIV MEDICAL CARE.

69.2% LIVE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL.

77.1% ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

RWHAP serves a significant proportion of black/African American clients living with HIV. In 2014, 73 percent of the more than half a million clients served by the Program were from racial or ethnic minority populations, with approximately 47 percent of all RWHAP clients identifying as black/African American. Below are more details about this RWHAP client population:

- **The majority of black/African American clients served by RWHAP are low income.** More than 69 percent of black/African American clients are living at or below 100 percent of the federal poverty level, which is slightly higher than the national RWHAP average (64 percent at or below 100 percent of the federal poverty level).
- **The majority of black/African American clients are male.** More than 62 percent of clients are male, nearly 37 percent are female, and just over 1 percent of clients are transgender. The proportion of black/African American males to females is slightly less than the national RWHAP average (nearly 71 percent males and 28 percent females).
- **One in six black/African American clients have temporary or unstable housing.** More than 11 percent of black/African American clients served by RWHAP have temporary housing and more than 5 percent have unstable housing.
- **Lack of health care coverage continues to impact black/African American clients served by RWHAP.** Nearly 27 percent of black/African American clients have no health care coverage, which is slightly higher than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. Nearly 80 percent of black/African American clients receiving HIV medical care are retained in HIV medical care. About 77 percent of black/African American clients receiving HIV medical care are virally suppressed, which is slightly lower than the national RWHAP average (more than 80 percent retained in care and more than 81 percent virally suppressed).[1]

- More than 78 percent of black/African American males receiving HIV medical care are retained in care and more than 76 percent are virally suppressed.
- Approximately 82 percent of black/African American females receiving HIV medical care are retained in care and 78 percent are virally suppressed.

[1]Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

HRSA Ryan White & Global HIV/AIDS Programs

Ryan White HIV/AIDS Program

May 2016

Gay, Bisexual, and Other Men Who Have Sex with Men (MSM), 2014

Ryan White HIV/AIDS Program Gay, Bisexual, and Other MSM Fast Facts

44.9% OF ALL RWHAP CLIENTS.

79.4% ARE RETAINED IN HIV MEDICAL CARE.

25.4% HAVE NO HEALTH CARE COVERAGE.

82.8% ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A significant proportion of RWHAP clients are men who have sex with men (MSM). In 2014, nearly 45 percent of the more than 461,000 clients with transmission risk information served by RWHAP were MSM. Below are more details about this RWHAP client population:

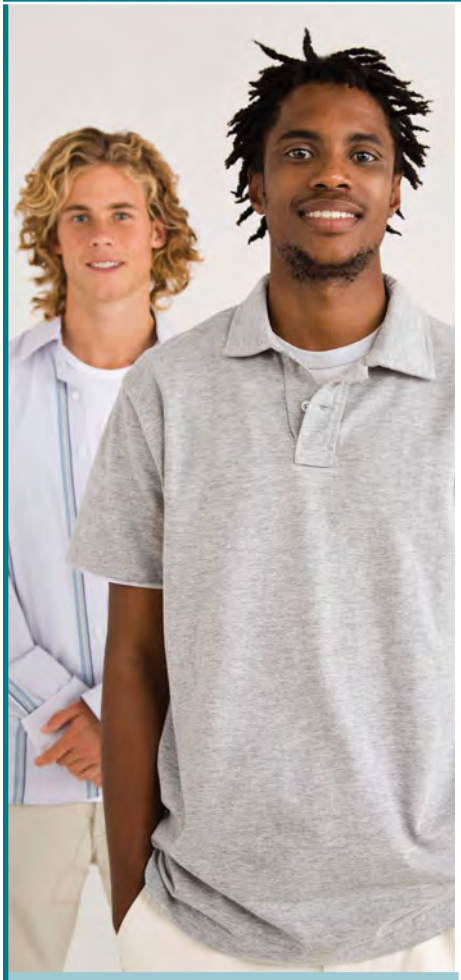
- **61 percent of MSM served by RWHAP are racial and ethnic minorities.** Approximately 34 percent of MSM identify as black/African American, which is less than the national RWHAP average (approximately 47 percent). Approximately 22 percent of men identify as Hispanic/Latino, which is equal to the national RWHAP average (22 percent). Approximately 39 percent of MSM identify as white, which is significantly greater than the national RWHAP average (about 27 percent).
- **The RWHAP MSM client population continues to increase in age.** Half of MSM are aged 45 years and older.
- **More than half (55 percent) of clients aged 13 to 24 years are MSM.** These youth and young adults represent about 7 percent of all MSM served by RWHAP.
- **About 4 percent of MSM have unstable housing situations.** This is slightly less than the national RWHAP average (about 5 percent).
- **Lack of health care coverage continues to affect MSM served by RWHAP.** Approximately 28 percent of MSM have no health care coverage, which is slightly greater than the national RWHAP average (25 percent).

Medical care and treatment improves health and decreases transmission of HIV. About 79 percent of MSM receiving RWHAP HIV medical care are retained in care, which is slightly less than the national RWHAP average (approximately 80 percent). Nearly 83 percent of MSM receiving RWHAP HIV medical care are virally suppressed, which is slightly greater than the national RWHAP average (81 percent).[1]

- Approximately 72 percent of young MSM (aged 13–24) receiving HIV medical care are retained in care, and more than 65 percent are virally suppressed.
- Approximately 72 percent of young, black/African American MSM (aged 13–24) receiving HIV medical care are retained in care, and 62 percent are virally suppressed.

[1] Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

HIV and Young Men Who Have Sex with Men



Many young people in the United States remain at risk for HIV infection. An estimated 47,500 Americans were newly infected with HIV[1] in 2010. Of these, 26%—about 12,200—were adolescents or young adults aged 13–24 years.[1] Young men who have sex with men (YMSM),[a] especially black/African American[b] YMSM, are at highest risk. The ongoing risk for HIV infection among YMSM underscores the need to reach each new generation with effective HIV prevention messages and services. Schools and education agencies are important partners in this effort.

Fast Facts

HIV disproportionately affects young men who have sex with men (YMSM).

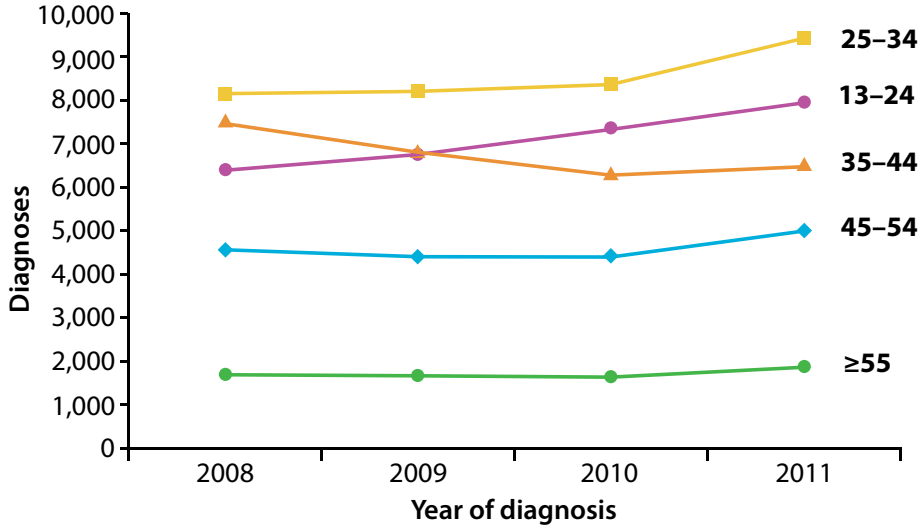
YMSM:

- In 2011, among adolescent males aged 13–19 years, approximately 93% of all diagnosed HIV infections were from male-to-male sexual contact.[2]
- From 2008–2011, YMSM aged 13–24 years had the greatest percentage increase (26%) in diagnosed HIV infections.[3] (Figure 1)

Black and Hispanic/Latino[c] YMSM:

- In 2011, among all YMSM aged 13–24 years with HIV infection, an estimated 58% were black; 20% were Hispanic/Latino.[3]
- Black YMSM also experienced the largest increase of all racial/ethnic groups in diagnosed HIV infections—from 3,762 diagnoses in 2008 to 4,619 diagnoses in 2011.[3] (Figure 2)

Figure 1. Diagnoses of HIV Infection among Men Who Have Sex with Men, by Age Group, 2008–2011—United States and 6 Dependent Areas

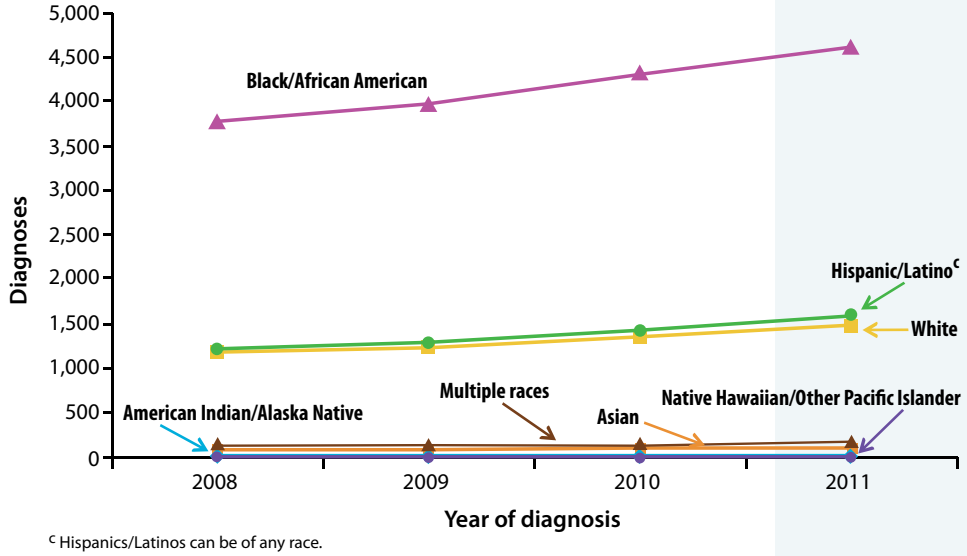


[a] CDC uses the term men who have sex with men (MSM) in its surveillance systems. MSM indicates the behaviors that transmit HIV infection, rather than how individuals self-identify in terms of their sexuality.

[b] Black/African American: Referred to as black in this fact sheet.

[c] Hispanics/Latinos can be of any race.

Figure 2. Diagnoses of HIV Infection Among Men Who Have Sex with Men Aged 13–24 Years, by Race/Ethnicity, 2008–2011—United States and 6 Dependent Areas

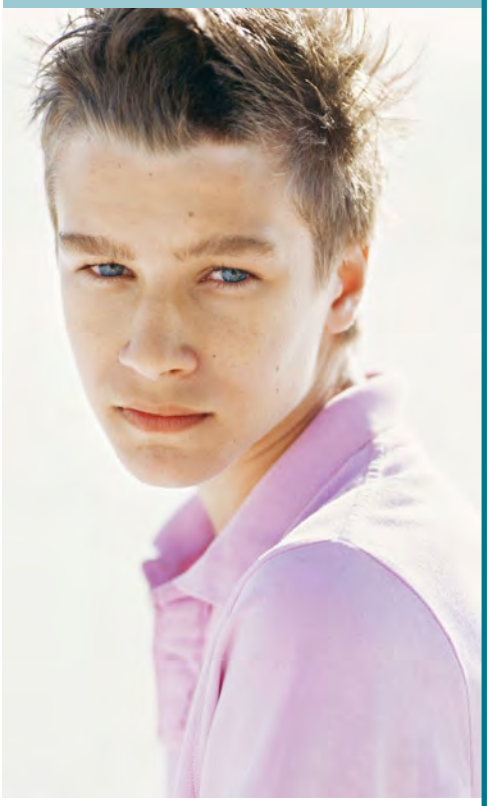


[c] Hispanics/Latinos can be of any race.

HIV Prevention Challenges

The reasons for disparities in HIV infection are varied and not well understood. These disparities do not appear to reflect individual racial or ethnic differences in risk behaviors.[4] Possible factors to explain these disparities may include the following:

- **Inadequate HIV prevention education and interventions.** Sex education programs that are not sensitive and appropriate to the needs of YMSM might not be effective in reducing sexual risk behaviors among those students.[5]
- **Limited awareness of infection.** Some HIV-infected men who have sex with men (MSM) may not know they are infected, especially MSM of color and YMSM.[6] Those who do not know they are infected might be less likely to take measures to keep from spreading the virus to others. Getting tested for HIV is an important part of prevention.
- **Low perception of risk.** Improved treatment for HIV has helped many people with HIV infection live longer and healthier lives. YMSM, who did not witness the toll of AIDS in the early years of the epidemic, might view HIV as less dangerous and disregard risks and important prevention practices.[7]
- **Alcohol and illegal drug use.** Alcohol, methamphetamine (commonly known as "meth" or "crystal meth"), and other "party drug" use is common among some YMSM. Alcohol and drug use can lead to risky sexual behavior.[7]
- **Feelings of rejection and isolation.** Bullying, harassment, family disapproval, social isolation, and sexual violence are experienced frequently by YMSM and other sexual minority youth.[d] These experiences can cause poor self-esteem and feelings of shame and can lead to more emotional distress, suicide attempts, substance use, and risky sexual behavior.[8-10]



[d] Those who identify as gay, lesbian, or bisexual or who have sexual contact with persons of the same or both sexes.

School-Based Strategies for Addressing HIV Among YMSM

CDC funds state and local education and health agencies to help schools implement policies and practices to reduce health risks among sexual minority youth, including YMSM. Because black and Hispanic/Latino YMSM are at especially high risk of HIV infection, CDC collaborates with local education agencies and national nongovernmental organizations to reduce HIV and other sexually transmitted diseases (STDs) among this population. These partners are collaborating with local community-based organizations, health departments, and other health care organizations to collect data, promote safe and supportive environments, increase HIV/STD testing and treatment in schools and school-based health centers, refer students to youth-friendly health services, and implement evidence-based HIV/STD education and prevention activities.

Collect and use health risk behavior data.

Many states and large urban school districts use CDC's Youth Risk Behavior Survey (YRBS) data to monitor health risk behaviors and selected health outcomes among sexual minority students. In addition, starting in 2015, the national YRBS questionnaire and the state/local standard questionnaire will include questions about sexual identity and sex of sexual contacts. By documenting that some youth do engage in same-sex sexual activity and various health risk behaviors, YRBS data can help confirm the value of addressing the health needs of sexual minority youth in schools, adjust intervention priorities, and monitor health outcomes.

More information is available at www.cdc.gov/yrbs.

Establish safe and supportive school environments.

HIV prevention activities are more likely to have an impact if they address the challenges YMSM face at school, especially verbal harassment related to their sexual orientation.[11] For lesbian, gay, bisexual, or transgender students, having a safe and supportive school environment has been associated with decreases in depression, suicidal feelings, substance use, and unexcused school absences.[12,13] To help establish supportive school environments for YMSM, schools can address bullying and sexual harassment, help students feel cared for and valued, and foster parent engagement.

Provide key sexual health services.

Linking YMSM to HIV testing and treatment is key to preventing the spread of HIV and AIDS. Confidential clinical services can help prevent new cases of HIV by increasing testing and treating HIV and other STDs. Schools can help youth access key preventive sexual health services such as HIV and STD testing, counseling, and referral, either by providing these services at schools or connecting students with community providers.[14]

Implement exemplary sexual health education.[e]

Because sexual health education programs that ignore issues in the lives of YMSM might not work effectively, schools and education agencies should ensure that health education curricula include evidence-based prevention information relevant to this population. Professional development training can help school staff understand the health needs of YMSM and shape health messages accordingly.

[e] Sexual health education programs that are medically accurate, consistent with scientific evidence, and tailored to students' contexts; and that use effective classroom instructional methods.

HIV and YMSM Resources

- Evidence-based HIV prevention interventions:
  www.cdc.gov/healthyyouth/adolescenthealth/registries.htm
- Specific CDC-funded YMSM program activities:
  www.cdc.gov/healthyyouth/disparities/ymsm/
- CDC resources on school connectedness and parent engagement in school health:
  www.cdc.gov/healthyyouth/adolescenthealth/protective.htm
- Parental influence on sexual minority youth:
  www.cdc.gov/healthyyouth/protective/positiveparenting/parents_influence.htm

Getting tested for HIV is a critical part of prevention.

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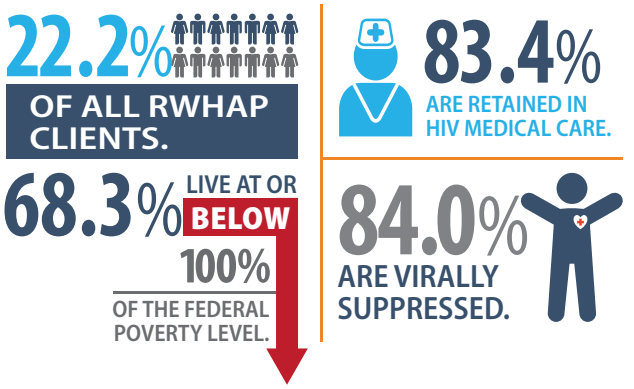
Ryan White HIV/AIDS Program

May 2016

Hispanic/Latino Clients, 2014

Ryan White HIV/AIDS Program Hispanic/Latino Client Fast Facts



The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

RWHAP serves a significant population of Hispanic/Latino clients living with HIV. In 2014, 73 percent of the more than half a million clients served by the Program were from racial or ethnic minority populations, and approximately 22 percent of all RWHAP clients identified as Hispanic/Latino. Below are more details about this RWHAP client population:

- **The majority of Hispanic/Latino clients are low-income.** More than 68 percent of Hispanic/Latino clients served by RWHAP live at or below 100 percent of the federal poverty level. This is greater than the national RWHAP average (64 percent).
- **The majority of Hispanic/Latino clients are male.** About 74 percent of Hispanic/Latino clients are male, about 25 percent are female, and slightly more than 1 percent of Hispanic/Latino clients are transgender. The proportion of Hispanic/Latino males compared to females is slightly higher than the national RWHAP average (about 71 percent males and 28 percent females).
- **The RWHAP Hispanic/Latino client population continues to increase in age.** About 36 percent of Hispanic/Latino clients are aged 50 years and older. An additional 16 percent are aged 40 to 49 years old.
- **About 4 percent of Hispanic/Latino clients have unstable housing situations.** This is slightly less than the national RWHAP average (about 5 percent).
- **Approximately 45 percent of all Hispanic/Latino clients are men who have sex with men (MSM).** This is the national RWHAP average of MSM clients (about 45 percent).
- **Lack of health care coverage continues to affect Hispanic/Latino clients served by RWHAP.** More than 31 percent of Hispanic/Latino clients have no health care coverage, which is higher than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. More than 83 percent of Hispanic/Latino clients receiving HIV medical care are retained in care, which is higher than the national RWHAP average (approximately 80 percent). About 84 percent of Hispanic/Latino clients receiving HIV medical care are virally suppressed, which also is higher than the national RWHAP average (81 percent).[1]

[1] Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

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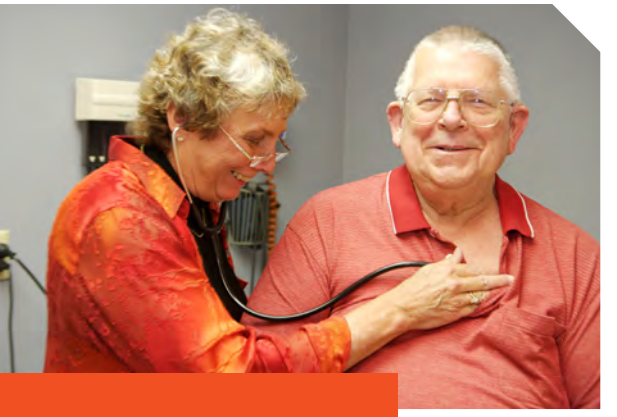
Ryan White HIV/AIDS Program

May 2016



Older Adults, 2014

Ryan White HIV/AIDS Program Clients Aged 50 Years and Older—Fast Facts

40.4% OF ALL RWHAP CLIENTS.

83.7% ARE RETAINED IN HIV MEDICAL CARE.

60.6% LIVE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL.

87.6% ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A significant proportion of RWHAP clients are aged 50 years and older. In 2014, more than 40 percent of the more than half a million clients served by the Program were aged 50 and older. Below are more details about this RWHAP client population:

- **The majority of RWHAP clients aged 50 and older are racial and ethnic minorities.** About 68 percent of clients aged 50 and older are from racial and ethnic minority populations. More than 45 percent of clients in this age group identify as black/African American, which is less than the national RWHAP average (approximately 47 percent). More than 19 percent identify as Hispanic/Latino, which is less than the national RWHAP average (22 percent).
- **The majority of clients aged 50 and older are low-income.** Nearly 61 percent of people aged 50 and older served by RWHAP live at or below 100 percent of the federal poverty level. This is less than the national RWHAP average (64 percent).
- **The majority of RWHAP clients aged 50 and older are male.** Nearly 72 percent of clients aged 50 and older are male, more than 27 percent are female, and 0.5 percent of clients aged 50 and older are transgender. The ratio of males to females in the older population is comparable to the national RWHAP average (71 percent males, 28 percent females, and 1 percent transgender).
- **About 4 percent of clients aged 50 and older have unstable housing situations.** This is slightly less than the national RWHAP average (about 5 percent).
- **Lack of health care coverage continues to affect older clients served by RWHAP.** More than 16 percent of clients aged 50 and older have no health care coverage, which is significantly less than the national RWHAP average (about 25 percent), likely because they are eligible for Medicare.

Medical care and treatment improves health and decreases transmission of HIV. Nearly 84 percent of clients aged 50 and older receiving HIV medical care are retained in care, which is greater than the national RWHAP average (approximately 80 percent). More than 87 percent of clients aged 50 and older receiving HIV medical care are virally suppressed, which is also greater than the national RWHAP average (81 percent).[1]

[1] Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

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Youth and Young Adults, 2014

Ryan White HIV/AIDS Program Youth and Young Adults Fast Facts

5.8% OF ALL RWHAP CLIENTS.

75.1% ARE RETAINED IN HIV MEDICAL CARE.

76.0% LIVE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL.

64.6% ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A significant proportion of RWHAP clients are youth and young adults. In 2014, more than 29,500 (nearly 6 percent) of the more than half a million clients served by the Program were between the ages of 13 and 24 years old. Below are more details about this RWHAP client population:

- **The majority of RWHAP clients between the ages of 13 and 24 are racial and ethnic minorities.** Approximately 63 percent of these clients identify as black/African American, which is more than the national RWHAP average (approximately 47 percent). About 19 percent of clients in this age group identify as Hispanic/Latino, which is lower than the national RWHAP average (22 percent).
- **The majority of RWHAP clients between the ages of 13 and 24 are low-income.** Seventy-six percent of these clients live at or below 100 percent of the federal poverty level. This is significantly greater than the national RWHAP average (64 percent).
- **The majority of RWHAP clients between the ages of 13 and 24 are male.** About 70 percent of clients in this age group are male, 29 percent are female, and about 1.5 percent are transgender. The proportions of male, female, and transgender clients in the youth and young adult population are similar to the national RWHAP averages (71 percent male, 28 percent female, and 1 percent transgender).
- **About 5 percent of RWHAP clients between the ages of 13 and 24 have unstable housing situations.** This is comparable to the national RWHAP average (about 5 percent).
- **Lack of health care coverage continues to affect youth and young adult clients served by RWHAP.** Approximately 33 percent of these clients have no health care coverage, which is significantly higher than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. Approximately 75 percent of RWHAP clients between the ages of 13 and 24 who receive HIV medical care are retained in care, which is less than the national RWHAP average (approximately 80 percent). About 64 percent of RWHAP clients in this age group who receive HIV medical care are virally suppressed, which is significantly less than the national RWHAP average (81 percent).[1]

- Seventy-two percent of young men having sex with men (MSM) receiving HIV medical care are retained in care, and 65 percent receiving HIV medical care are virally suppressed.
- Seventy-two percent of young black MSM receiving HIV medical care are retained in care, and approximately 62 percent receiving HIV medical care are virally suppressed.
- Seventy-nine percent of young black women receiving HIV medical care are retained in care, and 60 percent receiving HIV medical care are virally suppressed.

[1]Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

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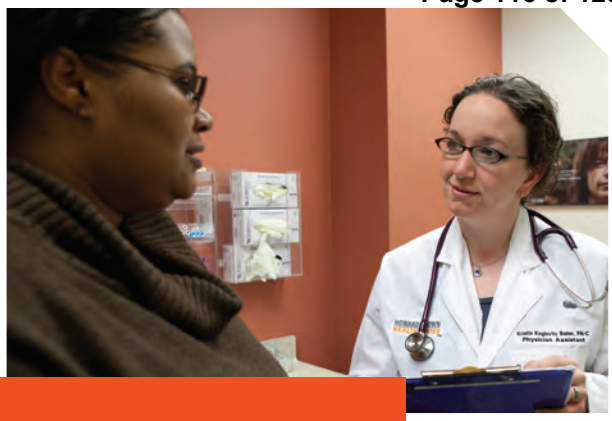
Ryan White HIV/AIDS Program

April 2016



Female Clients, 2014

Ryan White HIV/AIDS Program Female Clients Fast Facts

28.2% OF ALL RWHAP CLIENTS.

82.4% ARE RETAINED IN HIV MEDICAL CARE.

72.5% LIVE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL.

80.1% ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller, but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

RWHAP serves a significant proportion of female clients living with HIV. In 2014, more than 28 percent of the more than half a million clients served by the Program were female. Below are more details about this RWHAP client population:

- **The majority of female clients served by RWHAP are racial and ethnic minorities.** About 84 percent of female clients are from racial and ethnic minority populations. Approximately 61 percent of female clients identify as black/African American, which is higher than the national RWHAP average (approximately 47 percent). Approximately 19 percent identify as Hispanic/Latina, which is slightly lower than the national RWHAP average (22 percent identify as Hispanic/Latino).
- **The majority of female clients are age 45 and above.** Nearly 39 percent of female clients served by RWHAP are 50 and older. Approximately 14 percent of clients are age 29 or younger.
- **The majority of female clients are low income.** 72 percent of female clients served by RWHAP live at or below 100 percent of the federal poverty level (FPL). This is above the national RWHAP average (64 percent).
- **Lack of health care coverage continues to impact female clients served by RWHAP.** Approximately 23 percent of female clients have no health care coverage, which is slightly lower than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. About 82 percent of female clients receiving HIV medical care are retained in care, which is slightly higher than the national RWHAP average (approximately 80 percent retained in care). Approximately 80 percent of female clients receiving HIV medical care are virally suppressed, which is slightly lower than the national RWHAP average (81 percent virally suppressed).[1]

- Approximately 82 percent of black/African American females receiving HIV medical care are retained in care, and 78 percent are virally suppressed.
- Approximately 86 percent of Hispanic/Latina females receiving HIV medical care are retained in care, and 82 percent are virally suppressed.

[1] Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

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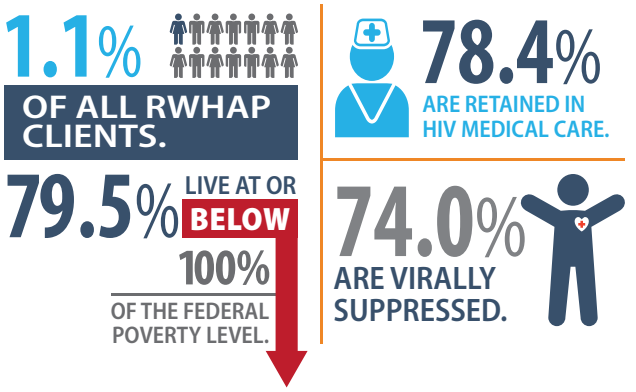
Ryan White HIV/AIDS Program

May 2016

Transgender Clients, 2014

Ryan White HIV/AIDS Program Transgender Client Fast Facts



The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A critical population served by RWHAP is transgender individuals. In 2014, approximately 1.1 percent of the more than half a million clients served by the Program were transgender. Below are more details about this RWHAP client population:

- **The majority of transgender clients served by RWHAP are racial and ethnic minorities.** Approximately 88 percent of transgender clients are from racial and ethnic minority populations. About 53 percent of transgender clients identify as black/African American, which is greater than the national RWHAP average (47 percent). About 30 percent identify as Hispanic/Latino, which is also greater than the national RWHAP average (approximately 22 percent).
- **The RWHAP transgender client population continues to increase in age.** One in five RWHAP transgender clients is aged 50 and older. An additional 28 percent are aged 40 to 49 years old.
- **About 10 percent of transgender clients have unstable housing situations.** This is greater than the national RWHAP average (about 5 percent).
- **The majority of transgender clients are low income.** More than 79 percent of transgender clients served by RWHAP live at or below 100 percent of the federal poverty level. This is significantly greater than the national RWHAP average (64 percent).
- **Lack of health care coverage affects transgender clients served by RWHAP.** Approximately 27 percent of transgender clients have no health care coverage, which is greater than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. 78 percent of transgender clients receiving HIV medical care are retained in care, which is slightly less than the national RWHAP average (approximately 80 percent). 74 percent of transgender clients receiving HIV medical care are virally suppressed, which is significantly less than the national RWHAP average (81 percent).[1]

[1] Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

HIV Among Incarcerated Populations

July 2015

Fast Facts

- HIV is a serious health issue for correctional facilities and their incarcerated populations.
- Most incarcerated people with HIV got the virus before entering a correctional facility.
- HIV testing at a correctional facility may be the first time incarcerated people are tested and diagnosed with HIV.

More than 2 million people in the United States are incarcerated in federal, state, and local correctional facilities on any given day. In 2010, the rate of diagnosed HIV infection among inmates in state and federal prisons was more than five times greater than the rate among people who were not incarcerated. Most inmates with HIV acquire it in their communities, before they are incarcerated.

The Numbers

- In 2012, 1.57 million people were incarcerated in state and federal prisons and at midyear 2013 there were 731,208 people detained in local jails.[1]
- In 2010, there were 20,093 inmates with HIV/AIDS in state and federal prisons with 91% being men.
- Among state and federal jurisdictions reporting in 2010[2] there were 3,913 inmates living with an AIDS diagnosis.
- Rates of AIDS-related deaths among state and federal prisoners declined an average of 16% per year between 2001 and 2010, from 24 deaths/100,000 in 2001 to 5/100,000 in 2010.
- Among jail populations, African American men are 5 times as likely as white men, and twice as likely as Hispanic/Latino men, to be diagnosed with HIV.
- Among jail populations, African American women are more than twice as likely to be diagnosed with HIV as white or Hispanic/Latino women.

Prevention Challenges

- Lack of awareness about HIV and lack of resources for HIV testing and treatment in inmates' home communities. Most inmates with HIV become infected in their communities, where they may engage in high-risk behaviors or be unaware of available prevention and treatment resources.
- Lack of resources for HIV testing and treatment in correctional facilities. Prison and jail administrators must weigh the costs of HIV testing and treatment against other needs, and some correctional systems may not provide such services. HIV testing can identify inmates with HIV before they are released. Early diagnosis and treatment can potentially reduce the level of HIV in communities to which inmates return.
- Rapid turnover among jail populations. While most HIV programs in correctional facilities are in prisons, most incarcerated people are detained in jails. Nine out of ten jail inmates are released in under 72 hours, which makes it hard to test them for HIV and help them find treatment.
- Inmate concerns about privacy and fear of stigma. Many inmates do not disclose their high-risk behaviors, such as anal sex or injection drug use, because they fear being stigmatized. Health care providers should keep inmate's health care information confidential, know the public health confidentiality and reporting laws, and inform inmates about them.

What CDC Is Doing

Funding state, local, and territorial health departments. This is CDC's largest investment in HIV prevention. CDC funds health departments and community-based organizations (CBOs) to provide HIV prevention services in many settings, including prisons and jails.

- CDC funded selected state health departments to conduct voluntary rapid HIV testing in jails, identify previously undiagnosed cases, and refer inmates to medical care. Of the 33,211 inmates tested, 409 (1.2%) tested positive, and 269 (0.8%) undiagnosed cases of HIV were detected, many among people who had not disclosed their risk behaviors.

[1] Jails are short-term facilities that are usually run by a local law enforcement agency. Jail sentences may range from a few hours up to one year. Compared with jail facilities, prisons are longer-term facilities owned by a state or by the federal government that typically hold people sentenced to more than one year.

[2] State and federal jurisdictions reporting in 2010 included 37 states and the Bureau of Federal Prisons.

Funding community-based pilot projects. CDC has joined with universities, CBOs, and other partners to find out which HIV prevention interventions are most effective among incarcerated populations and how they can be applied to other settings.

- CDC supported Project START (https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/Interventions/ProjectSTART.aspx), a pre-release HIV intervention for young men. Project participants reduced their HIV risk behaviors after their release back into the community.
- CDC funded the University of North Carolina to evaluate Project POWER (http://www.ncbi.nlm.nih.gov/pubmed/23631715), an HIV intervention among women in state correctional facilities. Six months after release, participants reported significantly greater condom use than nonparticipants. Participants also reported greater HIV knowledge, and more social support.
- CDC partnered with Emory University to adapt and evaluate an HIV intervention program for African American girls aged 13-17 in a juvenile detention center. Three months after the intervention, participants reported greater condom use, HIV/STD prevention knowledge, and condom use skills.
- CDC joined with Morehouse Medical School to counsel African American male jail inmates about high-risk sexual behaviors and ways to reduce them. After six months, participants reported significantly more condom use during vaginal or anal sex than nonparticipants. Participants 14-18 years old reported significantly more condom use at last sex with a non-main female sex partner than nonparticipants.

Voluntary rapid HIV testing. CDC partnered with Emory University to support voluntary rapid HIV testing at a large county jail located in a community with a high prevalence of HIV. The jail's nursing staff provided more than 12,000 tests, and 52 cases of HIV infection were newly diagnosed.

CDC has published HIV testing guidance for correctional facilities (https://www.cdc.gov/hiv/pdf/group/cdc-hiv-correctional-settings-guidelines.pdf) which recommends testing inmates when they enter correctional facilities, during incarceration, and just prior to release. CDC also recommends medical treatment and counseling to educate inmates about HIV risk behaviors. HIV prevention education should address male to male sex, tattooing, injection drug use, and other high risk behaviors that occur during and after incarceration.

CDC recommends that condom distribution programs be evaluated for use in prisons and jails in the United States. The World Health Organization recommends such programs (http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf?ua=1) as an effective way to reduce HIV among incarcerated populations.

The National Center for HIV/AIDS, Hepatitis, STD and TB Prevention, (NCHHSTP) Corrections Workgroup addresses the prevention and control of HIV, STDs, Viral hepatitis, and TB among incarcerated people. The workgroup includes experts in epidemiology, criminology, and corrections issues, and works to reduce health disparities among incarcerated populations.

CDC scientists edited a special issue of the journal Women & Health, "Infectious and Other Disease Morbidity and Health Equity among Incarcerated Adolescent and Adult Women," in November 2014, which focused on the health challenges, including HIV, faced by incarcerated women.

For more information on this topic visit www.cdc.gov/hiv/group/correctional.html.

Additional Resources

CDC-INFO
1-800-CDC-INFO (232-4636)
www.cdc.gov/info

CDC HIV Website
www.cdc.gov/hiv

CDC Act Against AIDS Campaign
www.cdc.gov/actagainstaids

Sociocultural dimensions of HIV/AIDS among Middle Eastern immigrants in the US: bridging culture with HIV/AIDS programmes

Authors

Parvaneh Ehsanzadeh-Cheemeh
MD, Institute of Community Health, College of Pharmacy, University of Houston, US
The University of Texas – Health Science Center at Houston, Medical School, Houston, US

Abul Sadeque
MD, MA, MPH, DrPH, The University of Texas – Health Science Center at Houston, Medical School, Houston, US

Richard M Grimes
PhD, The University of Texas – Health Science Center at Houston, Medical School, Houston, US

E James Essien
MD, DrPH, Institute of Community Health, College of Pharmacy, University of Houston, US

Corresponding author:
Parvaneh Ehsanzadeh-Cheemeh, MD, Institute of Community Health, College of Pharmacy, University of Houston, Suite 118, 1441 Moursund Street, Houston, TX 77030, US
Tel: (713) 795-8321
Fax: (713) 795-8383
Email: pehsanza@central.uh.edu

Key words

HIV risk factors; sociocultural factors; immigrants; Middle Easterners; health disparity

Abstract

The population of Middle Eastern immigrants in the US has been increasing dramatically over the past 30 years, growing from 200,000 in 1970 to 1.5 million in 2000. These immigrants and their descendants constitute an important new population of interest for public health and other social programmes. With this addition to the cultural diversity of American society, it is important for healthcare programmes to be responsive to the unique cultural needs of those of Middle Eastern origin and to include them in healthcare curricula. This need is particularly imperative for human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) intervention programmes, where the reduction of risky behaviours is essential to controlling the epidemic. When Middle Easterners emigrate to the US they must adjust to the American culture, which leads to preservation of some aspects of their culture and adjustment of behaviors to match American customs. This article aims to present sociocultural factors of HIV risk behaviours that are specific to Middle Eastern culture. The article also provides recommendations for HIV/AIDS-culturally appropriate intervention programmes.

INTRODUCTION

Middle Eastern and HIV/AIDS epidemics

One of the fastest growing populations in the US is the Middle Eastern immigrant population, having increased from 200,000 in 1970 to 1.5 million in the 2000 census.[1] Recent statistics show that 40% of the Middle Eastern immigrant population in the US comes from Arab countries.[1] In addition, a sizable portion of Middle Easterners come from non-Arab countries, including Iran, Israel, Turkey and Pakistan.[1] For the purposes of this paper, the Middle East is defined as a region including Afghanistan, Bahrain, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates and Yemen (Figure 1), with a population of about 460 million.[2,3] While immigrants from this region are quite diverse in their heritage, history and languages, most Middle Easterners share a set of beliefs that are rooted in Islam.

This is an important group to investigate with regard to HIV/AIDS because, according to one study of foreign and US-born populations in Los Angeles, HIV prevalence was highest among North African/Middle Easterners compared to other immigrant populations (3.3%), with North Africa/Middle Eastern males having a prevalence of 4.1%. The same study concluded that there is a need to develop HIV-prevention materials and treatment programmes that are sensitive to the needs of Middle Eastern immigrants, since the disease affects their communities so strongly.[4]

BACKGROUND

Middle Eastern immigrants: preservation or disintegration of cultural identities?

An individual's cultural beliefs and sexual behaviours are important risk factors for HIV-acquisition.[5,6,7] Like other immigrants, Middle Easterners find it necessary to adjust to Western

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Figure 1

Middle East

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culture over time, leading to their traditional values being challenged by new cultural norms.[7,8,9,10] The degree of adaptation and change varies within various cultural groups.[11,12] For example, among Middle Eastern immigrants in the US, social attitudes of Arab immigrants have been found to be less Americanized than their Iranian counterparts who come from a non-Arab culture.[11] In addition, the degree to which previous generations of Middle Eastern immigrants acculturated in the past may be very different from newer generations.[8,13] New generations may not preserve the customs and traditions of their forefathers while they are living in the US or travelling back to their home countries.

Furthermore, the mobility and growth of a population impacts on the overall spread of HIV among both immigrants and non-immigrants. It has also been shown that immigrants are more likely to engage in risky sexual behaviour than non-immigrants.[14,15] Studies of some immigrant groups have suggested that the majority of the foreign-born HIV-infected patients were infected after immigration to the US.[15,16] This aspect of behaviour among immigrants has not been studied in the Middle Eastern immigrant population. Therefore it is important to examine the behaviours and beliefs that might facilitate or retard risky behaviours in Middle Eastern immigrants.

Middle Eastern immigrants, particularly Arabs, usually tend to maintain their traditional customs as they explore new opportunities and take pride in their cultural heritage and identity.[8,13,17] National origin, *per se*, does not automatically make someone more or less at risk of HIV infection. Behaviours associated with certain cultural beliefs or values may make a person more or less likely to be at risk of infection. Several features of the immigration process can affect HIV risk behaviours in this population. Immigration tends to be dominated by males and often leaves the migrant with poor prospects for marriage within his cultural group. Also the control of behaviour that is often exercised in tight-knit communities where individuals are monitored by family and neighbours is lost when one is submerged in a large foreign culture.

There is no published study on risky behaviours with regard to HIV/AIDS among Middle Eastern immigrants in the US. In addition, no culturally appropriate HIV/AIDS educational programmes for this population were found to have been developed. This may be due to the fact that most HIV educators are not familiar with the sociocultural norms, beliefs and stigmas that may increase the risk of HIV transmission in this population. Therefore this paper has been prepared to review sociocultural factors and their potential impact on risky behaviours. These include norms with regard to sexual intercourse, drug use and perinatal behaviours that might result in HIV transmission, and attitudes towards health. Understanding these cultural beliefs is crucial in order for healthcare providers to design culturally appropriate programmes for these clients.

SEXUAL TRANSMISSION

Religious culture

Islam is the fastest growing faith worldwide and in the US. It is also the second largest religion worldwide and

the dominant religion in the Middle East.[18,19] According to the US Census Bureau, in the year 2000, 73% of Middle Eastern immigrants to the US were Muslims, with a faster population growth rate than non-Muslim Middle Easterners.[1] Decades of Islamic domination and culture have influenced the Middle Eastern way of life.[20] HIV/AIDS challenges the religious beliefs of Middle Easterners due to the nature of the leading mode of transmission, which is sexual intercourse. Islam commands that followers practice a sexually healthy lifestyle, male circumcision and purification rituals.[18] Furthermore, Islam orders that believers avoid alcohol consumption, extra- and premarital sex, anal sex, homosexuality and vaginal sex during menses.[18] Adherence to these religious constraints constitutes behaviours consistent with reducing the incidence of HIV. As a result, it has been hypothesized that Islamic religious adherence is negatively related to HIV infection.[21] Conversely, polygamy and an attitude opposed to condom use appear to increase the risks of HIV.[20] In addition, some sects of the Muslim faith allow the practice of 'Nikah mut'ah', which allows temporary marriage and sexual intercourse with the temporary spouse.[20] This marriage has a preset duration, which may be as little as one hour. After the preset time period has ended, the marriage is automatically dissolved. Multiple, sequential, temporary marriages are allowed.[22]

Condom use

Condom use is seen as a sign of embarrassment, immorality and corruption in Middle Eastern culture. Embarrassment with regard to condoms in particular is a barrier to condom use.[23,24] Condoms are allowed only within legal marriages[18,25] and are intended for family planning.[20] The importance of fertility, particularly the importance of having male children,[20,26] is deeply ingrained in Middle Eastern culture, which hinders condom use even among married people. Hence, AIDS education programmes must be sensitive to these beliefs. Therefore when educating this population, safe sex with condom use as an HIV prevention message – particularly for singles – must be done within this cultural context.

Homosexuality

The practice of homosexuality is culturally and religiously prohibited, and if discovered may lead to community chastisement, rejection or a death sentence.[18,27] Despite the strong prohibition and social stigma, there is an increasingly visible presence of homosexuality among Middle Easterners around the world.[28,29] Unfortunately the fear of the disease along with societal rejection, denial and lack of education makes Middle Easterners who engage in male-to-male sex a particularly vulnerable population.

Sex industry

Approximately 50,000 people a year, most of them women and children, are trafficked to the US for illegitimate purposes including commercial sex work.[30] Although commercial sex is not culturally condoned, the sex industry has established itself as a mainstream business among Middle Easterners.[31,32] The practice of Islamic religious customs of polygamy and temporary marriages can result in promiscuity, especially among immigrants who are living far from their families. Some immigrants develop 'parallel lives' when they move out of their home country. Being away from their families, friends and communities allows them a certain degree of freedom which, if taken advantage of, can lead to promiscuity.[20] These are populations that need to be targeted with prevention programmes. However, it must be recognized that to be seen listening to these messages is stigmatizing; it may be seen as a violation of religious and cultural norms. Even where AIDS prevention programmes and care services exist, individuals whose culture condemns those practices (in the US or their home countries) may be reluctant to participate in programmes.

Cultural beliefs and taboos on sexuality

Sexual issues and sex education are considered shameful and therefore are not discussed in families or between sexual partners.[7, 33,34] Cultural taboos and shame of talking openly about sex inhibit conservative families from seeking information concerning safe sex.[7,35] Despite the important role of family communication, Middle Easterners seem less likely to supply their children with critical sexual information and HIV/AIDS education, and parents may themselves be uninformed or misinformed. School-based, in-depth, culturally sensitive programmes on sexual education and HIV/AIDS (preferably in the presence of parents or guardians) could be used to accurately and appropriately address sexuality and HIV-related risks.

Female virginity is a social value. However, the tradition surrounding it is a taboo discussion topic among Middle Easterners.[20] Because the bride-price for virgins is higher than for non-virgins, the social authorities or family members may impose a virginity examination.[20,36] The prominent sign of virginity is the release of blood due to the breaking of the hymen; this evidence on a white sheet may be used later for further investigation. The absence of bleeding is considered a sign of disgrace for the bride's family and may result in shame, and in some sub-cultures, the bride's suicide or murder.[36,37,38] To avoid the stigma attached to losing her virginity, a woman can try alternative sex like oral or anal sex. She may also attempt to 'restore' her virginity through hymenoplasty, which if performed using non-sterile techniques can lead to increased HIV risk and significant risk of other infections like hepatitis B.[20]

Sexual subordination

The culture of patriarchy is not limited to Middle Easterners, but is highly visible and valued among them.[39,40] Strong male authority forces women to be dependent upon the men.[34,41] Women should be obedient to husbands and if a woman suspects that her husband has been unfaithful, she may be in danger of divorce if she voices her suspicions, initiates safe-sex practices or discusses HIV/AIDS.[34,41,42,43] In Middle Eastern culture, sexual satisfaction is considered a priority for men, although this is largely unrecognized and even considered

inappropriate for women.[35,44] Divorce is taboo, especially for women. If a divorced woman wishes to remarry, many sub-cultures will limit remarriage to an older man or a married man as his second wife.[45,46]

Although increasingly common, sexual activity outside of marriage is decisively negative and stigmatizes a female's reputation.[20,34,47] The fear of being judged or discriminated against due to immoral behaviour adds another level of distress. Additionally, a mother and her child without a legally recognized father would face shame, social neglect and ridicule. Sexual liaisons resulting in unwanted pregnancies therefore contribute to illegal abortions.[20] Women's risk of HIV infection is affected by sociocultural values, economic need and poor access to HIV/AIDS education.[35,44,48] Even where sex education exists, Arab Americans tend to preserve cultural taboos on female sexuality and HIV/AIDS, which makes it more difficult for HIV/AIDS educational programmes to reach these women.[49] Most Middle Eastern Muslim women prefer or expect to have minimal casual contact with the opposite sex.[13,50,51] The conservative culture of the Middle East can either increase women's vulnerabilities to HIV/AIDS by deterring them from seeking safe sex, or it may protect them from unsafe sex due to its conservative nature.

BLOOD-BORNE TRANSMISSION

Information on Middle Eastern immigrants' drug use and HIV transmission through injection drug users (IDUs) in the US is unavailable.[20] The Joint United Nations Programme on HIV/AIDS (UNAIDS) has reported that sexual intercourse is the main transmission route of HIV infection in the Middle East, followed by IDUs.[52] There is also a high rate of drug trafficking from heroin-producing countries to Middle Eastern countries. There are approximately 400,000 IDUs in Arab countries and about 200,000 of these in Iran.[52] According to Islam, mind-altering substances including alcohol and injection drugs are prohibited.[18] Therefore information regarding needle-replacement or needle-cleaning practices needs to be transmitted in a fashion that avoids stigmatization.

Cutting one's skin is another traditional rite that is believed to improve one's health,[53] cure diseases and/or furnish heavenly rewards.[20] This is akin to bleeding practices that were practiced in Western countries in the early 20th century. These traditional practices are possible routes of HIV transmission when conducted with non-sterile or shared devices.

ABORTION AND PERINATAL TRANSMISSION

Islam like all of the major world religions forbids abortion. Therapeutic abortion is allowed under certain conditions such as AIDS but only if carried out before four months of gestation and only after that to save the life of the mother.[54] This in turn means that Islam does not permit abortion under normal health conditions, and considers it an elaborate act of killing an innocent human being, which is a crime under any law. Those who seek illegal abortions for unwanted pregnancies are highly stigmatized.[20] As a result, unsafe abortions performed by untrained persons and/or in improperly equipped institutions occur. These carry a high risk of death or disability for the woman and may increase the risk of HIV infection due to the unsterile circumstances of the procedure.

Anti-retroviral therapy for an HIV-positive mother and baby before, during and after delivery can drastically reduce the risk of HIV transmission to the neonate. Fortunately, Islam does not forbid taking medication to treat life-threatening diseases. So health professionals can explain the advantages and disadvantages of anti-retroviral treatments to their Middle Eastern patients in a manner that is similar to non-Muslims. However, while avoidance of breastfeeding can reduce mother-to-child transmission, there are strong Middle Eastern cultural and Islamic commands for breastfeeding that may make this preventive practice difficult.[18] Healthcare providers need to provide their patients with alternative explanations for not breastfeeding.

HEALTH AND DISEASE BELIEFS

Expression of health, diseases and death are influenced by cultural norms.[11,55,56] Commonly, Arabs tend to underutilize health services.[57,58] Muslims may believe that disease is a punishment from God due to sin and this is particularly true of AIDS.[18] This punitive belief may prevent Muslims from seeking HIV-related services including testing, treatment and counselling. This failure to seek care and health information may even carry over to more acculturated Arabs.

Middle Easterners generally value family ties and hold family institutions in high regard; the protection of and support for families is a matter of civil, moral and spiritual value.[59,60,61] In the Middle East, people who are ill habitually turn to their family members first for comfort, prayer and advice. Families are expected to help each other[41] and be engaged in the patient's treatment and support.[62] At least one family member usually accompanies the patient to a medical centre. It is common for a family member to stay with the patient when they are being seen by a physician to help answer questions. In Middle Eastern healthcare situations patients are only told the good news about their ailment. Physicians would normally report the significance of illnesses and consequences to a chosen family member. In the event of death or the immediate prospect of death, a guardian is designated to take care of the will and religious customs associated with burial. In the US, however, medical professionals are trained to talk frankly and directly with patients. This may have to be done more discreetly with Muslim patients and particular care must be exercised in stigmatized conditions such as HIV/AIDS. Clinicians should also be aware that if using an interpreter, their direct discussions of illnesses and their prognoses might not be accurately translated. For one thing, Middle Eastern cultural norms – particularly Islam – do not allow the discussion of certain fastidious sexual matters.[63] In addition, specific cultural concepts are not easily translated from one language to another.[64]

In Middle Eastern culture, prayer and spirituality are believed to enhance recovery and give comfort to patients and their families.[59] When patients are admitted to hospital, there is a social obligation for friends and family to visit them. This custom may be in conflict with hospital rules about number of visitors, hours of visiting, etc. Immigrants who have lived in the US for an extended time may understand these rules, reflecting the role of acculturation. However, new immigrants or the poorly acculturated may find this difficult. As a result, Middle Eastern people may postpone seeking professional treatment because they perceive that traditional methods bring psychological relief for patients and that their families may be denied to them. Therefore training and linking community leaders and traditional healers to modern health facilities is essential.[55,60,65]

CONCLUSION

Middle Easterners are one of the fastest growing immigrant populations in the US. Lack of valid, reliable information is a major barrier to providing effective HIV/AIDS prevention and treatment for this growing population, both in their homeland and in the US. Sex and IDU are the main HIV transmission routes, yet these are culturally and religiously stigmatized. Due to language and cultural barriers, immigrant populations may be less able to seek HIV educational information and access proper care.

It is important to highlight to Western hosts that the main HIV/AIDS risk factors (non-marital sex and IDU) are sins or against the law in most of the Middle Eastern countries. Consequently, Middle Easterners may be unwilling to disclose HIV risk behaviours. Finally, existing American HIV/AIDS intervention programmes and sexual orientation messages may not be culturally and religiously appropriate for Middle Easterners. It is strongly recommended that Middle Easterners be involved in the preparation of culturally sensitive curricula for these populations. It is particularly important to encourage religious and community leaders to take part in the development of such programmes. These individuals will differ from community to community among immigrants of various different countries of origin (e.g. Iranians versus Saudi Arabians).

The population of Middle Easterners in the US is rapidly growing. Lack of knowledge and an unwillingness to confront detested truths are harming people by perpetuating the stigma attached to HIV/AIDS. In order to combat the HIV/AIDS epidemic effectively, it is important to understand the sociocultural risk predictors of HIV/AIDS and address them through culturally competent programmes.

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