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?

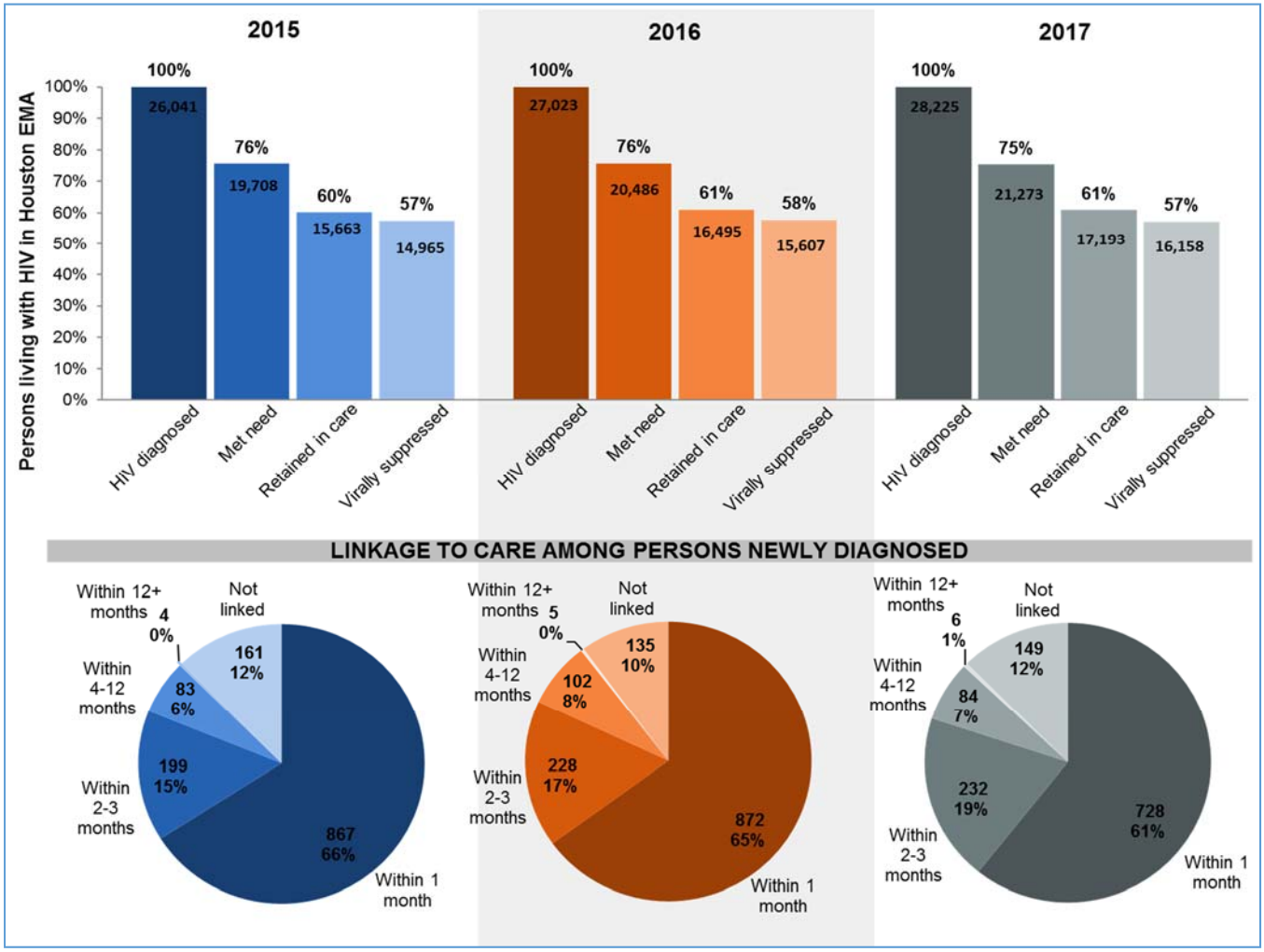
The HIV Care Continuum, previously known as a Treatment Cascade, was first released in 2012 by the Centers for Disease Control and Prevention (CDC). It represents the sequential stages of HIV care, from being diagnosed with HIV to suppressing the HIV virus through treatment. Ideally, the Care Continuum 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

Figure 1: Houston EMA HIV Care Continuum, 2015-2017



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

Measure	Description	Data source
HIV diagnosed	No. of persons 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 DSHS HIV Unmet Need Project (incl. eHARS, ELR, ARIES, ADAP, Medicaid, private payer data)
Linked 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

From 2015-2017, the total number of persons diagnosed with HIV increased each year and the percentage of those with met need, retention, and viral suppression remained relatively constant.

- The percentage of newly diagnosed PLWH linked to care within one month of diagnosis decreased by 5% from 2015 to 2017.

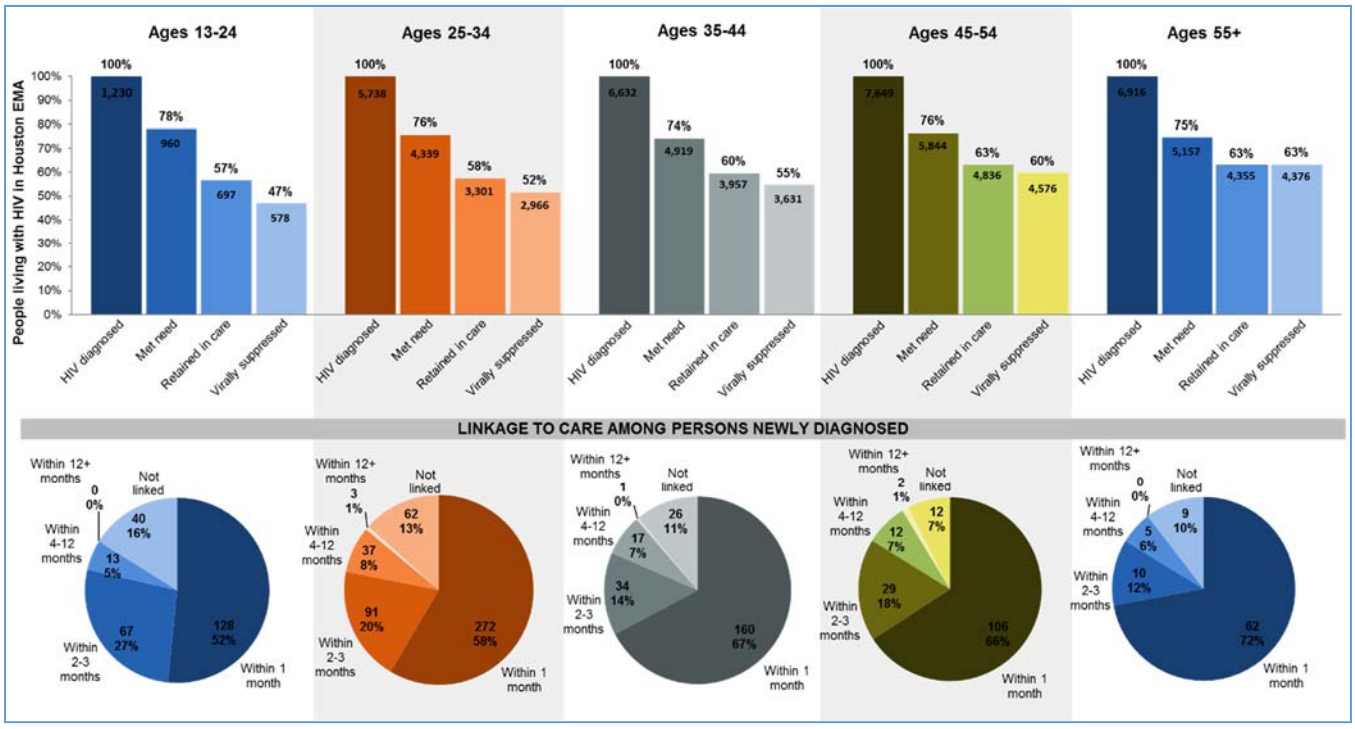
Disparities in Engagement among Key Populations

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 intersex, experiencing homelessness, or those recently released from incarceration.

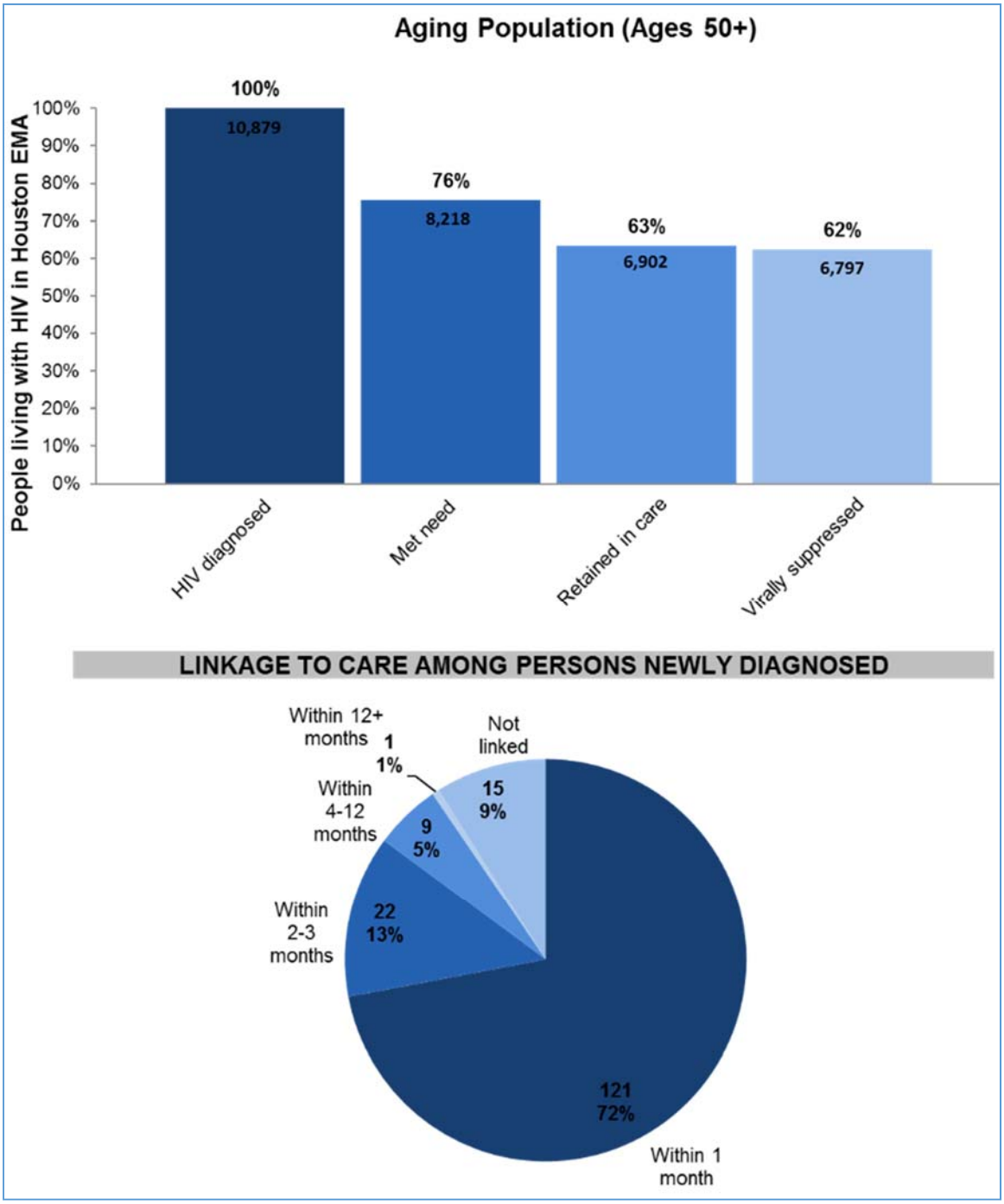
The Houston EMA Care Continuum, by Age

Figure 2: Houston EMA HIV Care Continuum by Age Group, 2017



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

Figure 3: Houston EMA HIV Care Continuum by Aging Population 50+, 2017



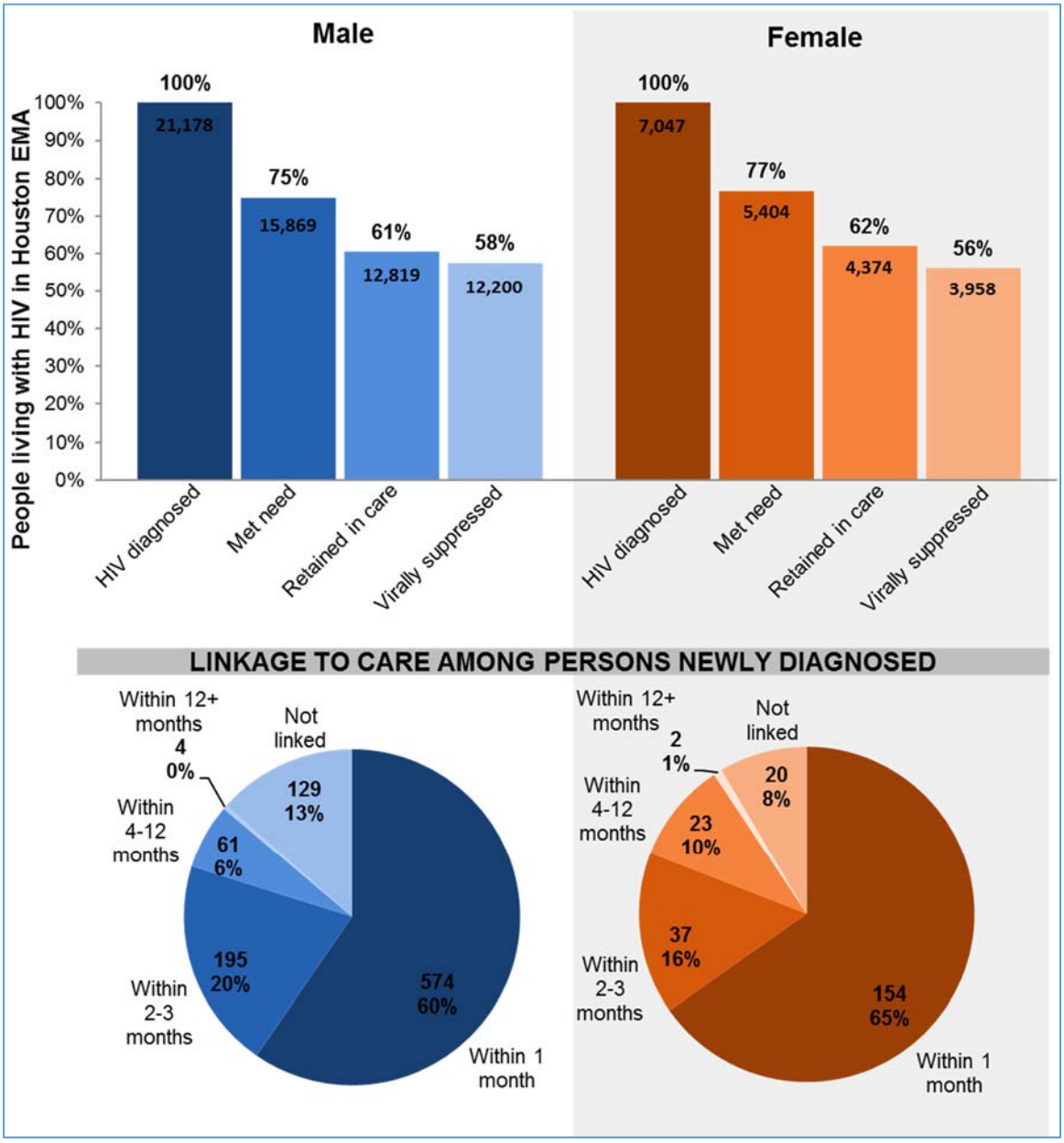
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

- Younger adults had lower percentages of retention and viral suppression compared to older adults.
- Youth and young adults (13-24 years old) had the highest percentage of met need.

- Youth to middle age adults (13-34 years old) 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 Assigned at Birth/Current Gender

Figure 4: **Houston EMA HIV Care Continuum by Sex Assigned at Birth, 2017**

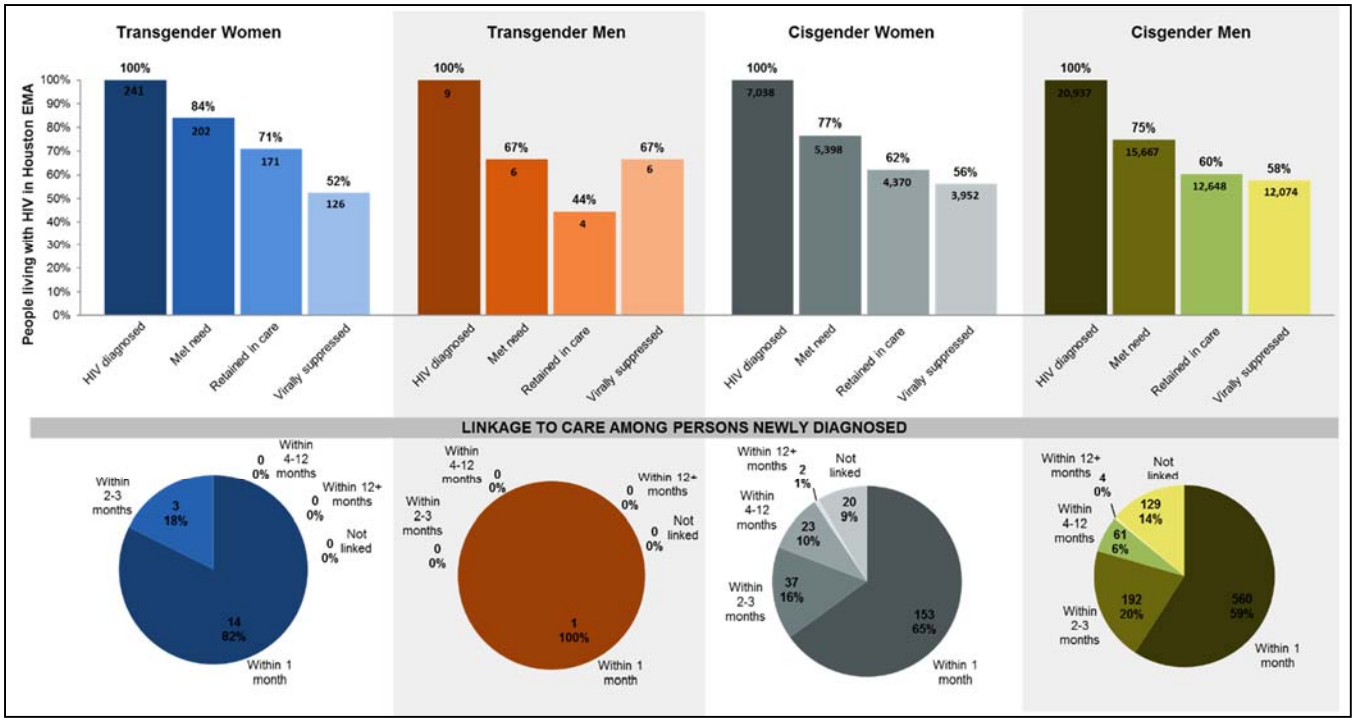


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

- Females living with HIV in the Houston EMA in 2017 had a higher proportion of individuals with met need and retention in care than males living with HIV, although females had a slightly smaller proportion of viral suppression.

- The proportion of newly diagnosed female PLWH linked to care within the first month after diagnosis was 5% higher than males.

Figure 5: Houston EMA HIV Care Continuum by Current Gender, 2017

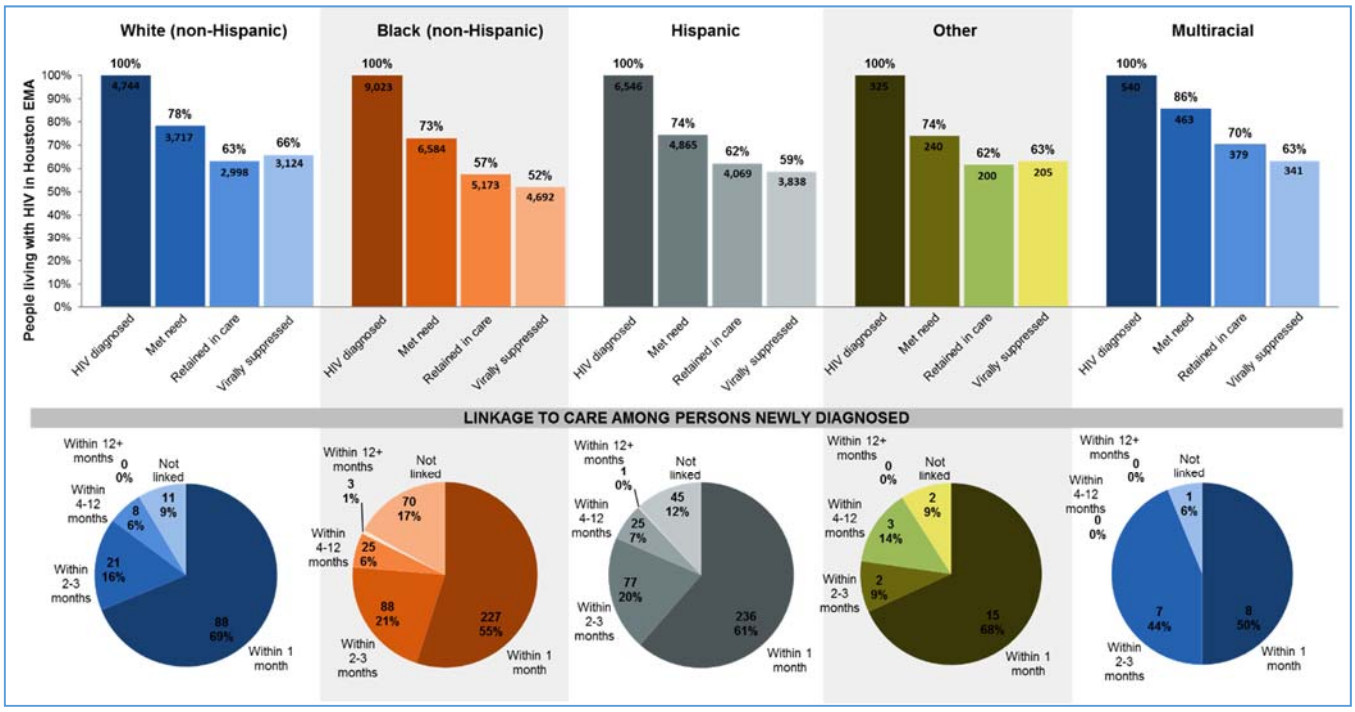


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

- Transgender women living with HIV in the Houston EMA in 2017 had the highest proportion of individuals with met need and retention in care. However, they had the lowest proportion of viral suppression.
- Transgender men living with HIV in the Houston EMA in 2017 had the lowest proportion of individuals retained in care but had the highest viral suppression. Caution should be exercised in interpretation, however, due to the very small numbers of transgender men represented in this data.
- The proportion of newly diagnosed people linked to care within the first month after diagnosis was higher for transgender people compared to cisgender people. However, the transgender groups had few individuals and percentages can vary widely with small increases/decreases.

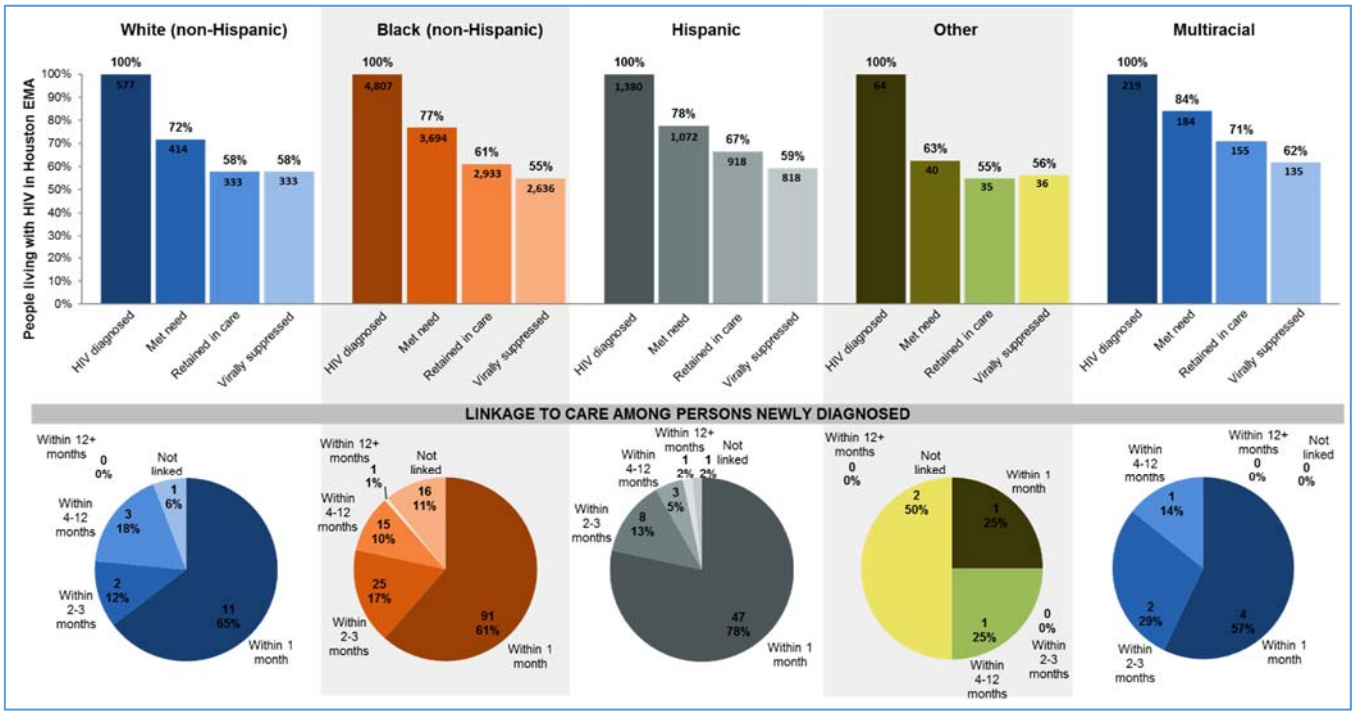
The Houston EMA Care Continuum, by Sex Assigned at Birth and Race/Ethnicity

Figure 6: Houston EMA HIV Care Continuum by Sex Assigned at Birth=Male and Race/Ethnicity, 2017



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

Figure 7: Houston EMA HIV Care Continuum by Sex Assigned at Birth=Female and Race/Ethnicity, 2017



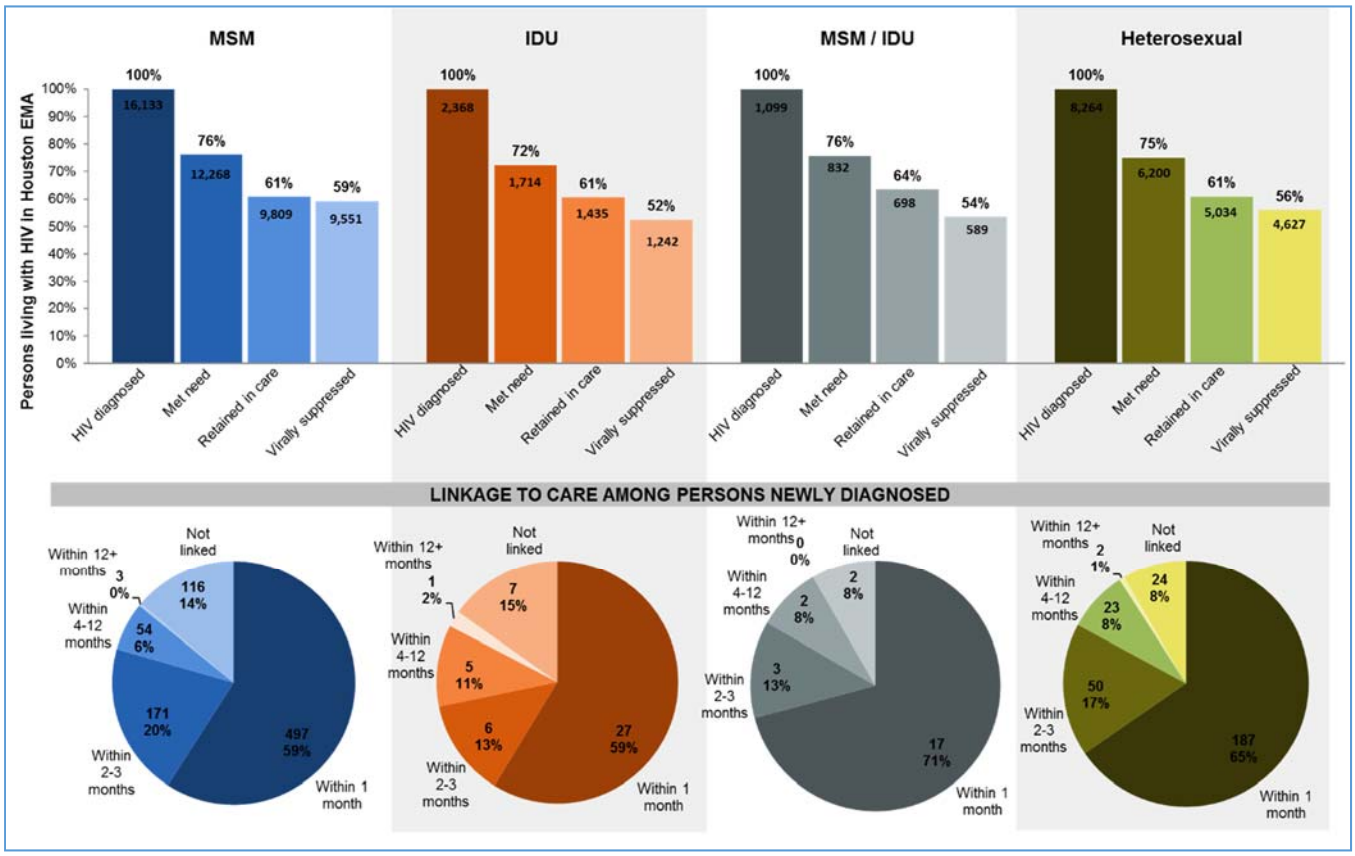
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

- Compared to White and multiracial males, all other males living with HIV had lower proportions of met need, retention in care, and viral suppression in 2017.
- Among females, Other (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of met need and retention in care while Black (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of viral suppression.
- Among those newly diagnosed with HIV, Hispanic females and White (non-Hispanic) males had the highest proportion linked to care within 1 month of diagnosis.
- Overall, Other (non-Hispanic) females living with HIV had the lowest proportion of individuals with met need across all birth sex and race/ethnicity groups. However, this group had few individuals and percentages can vary widely with small increases/decreases. White (non-Hispanic) females living with HIV had the next lowest proportion of individuals with met need.
- Overall, Other (non-Hispanic) females living with HIV had the lowest proportion of individuals retained in care across all birth sex and race/ethnicity groups. However, this group had few individuals and percentages can vary widely with small increases/decreases. Black (non-Hispanic) males living with HIV had the next lowest proportion of individuals retained in care.
- Overall, Black (non-Hispanic) males living with HIV had the lowest proportion of individuals virally suppressed across all birth sex and race/ethnicity groups

The Houston EMA Care Continuum, by Transmission Risk Factor*

**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.*

Figure 8: Houston EMA HIV Care Continuum by Transmission Risk, 2017



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

- Although MSM have higher numbers of PLWH than the other risk groups, the proportion of diagnosed MSM living with HIV with evidence of met need and retention in care is similar to those observed for other risk groups.
- MSM also have 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 one month of initial diagnosis.
- Overall, PLWH with IDU as a primary transmission risk factor exhibited the lowest proportions of individuals in each care continuum stage.

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

Houston HSDA

Houston HSDA Counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton

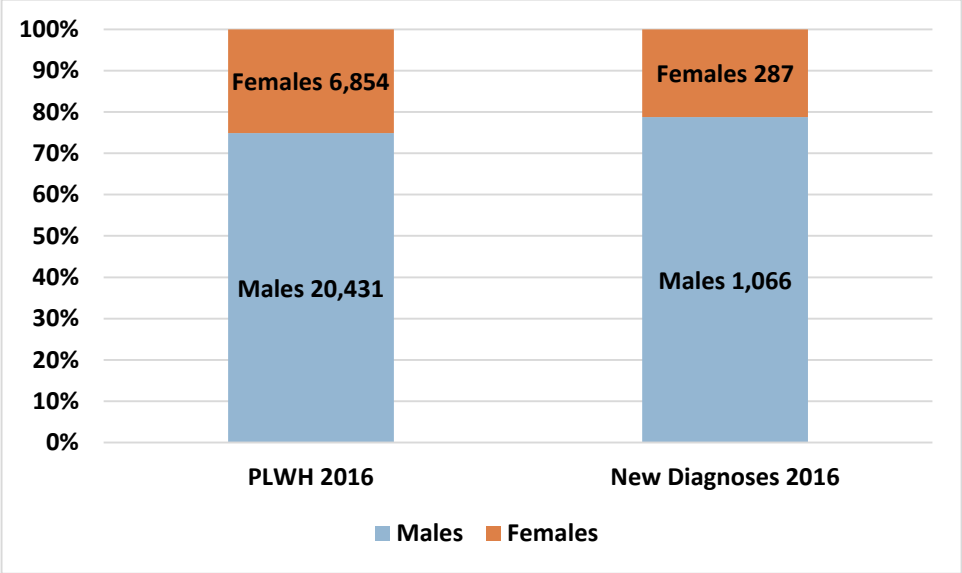
Epi Profile

In the Houston HSDA, the number of new diagnoses has remained flat and stable for the past several years.

There were **27,285 people living with HIV (PLWH)** in this area as of the end of 2016. This includes only people with diagnosed infections with a current address in this area. People with undiagnosed HIV are not included. In 2016, **1,353 people were newly diagnosed with HIV**.

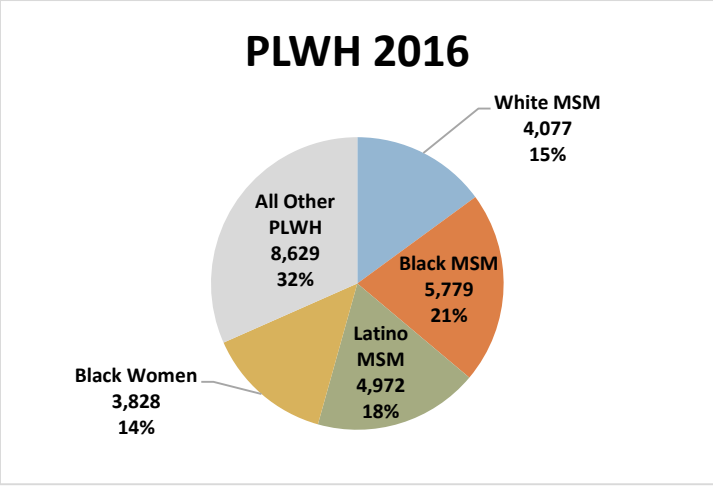
Gender

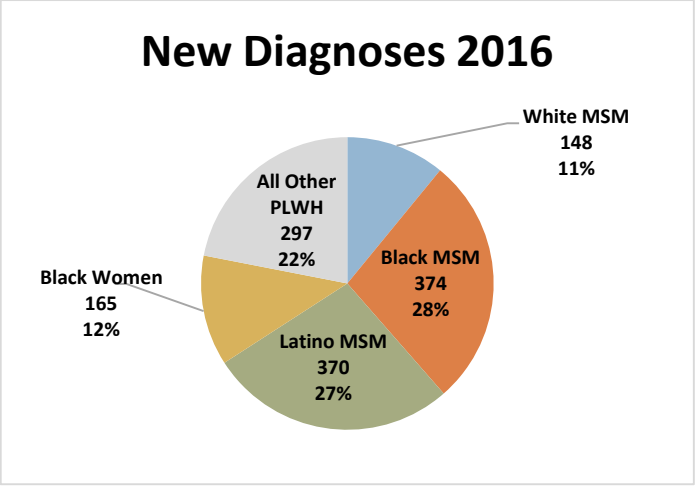
Men make up the majority of PLWH and the majority of new diagnoses.



Priority Populations (68% of total PLWH, 78% of new diagnoses)

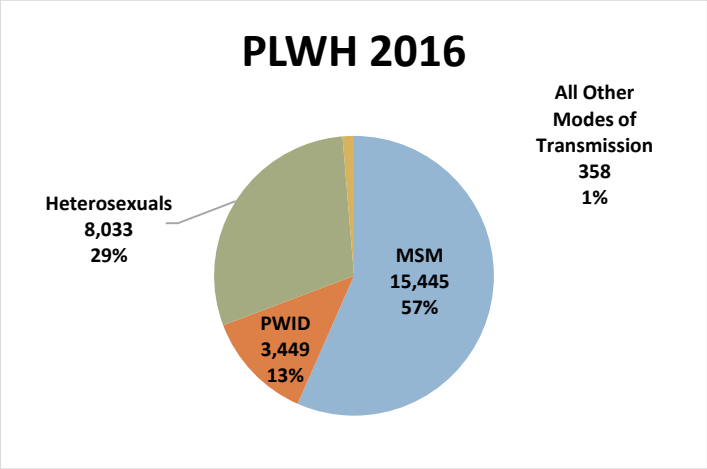
Priority populations make up the majority of PLWH and the majority of new diagnoses. Black MSM are the largest priority population among PLWH and among new diagnoses.

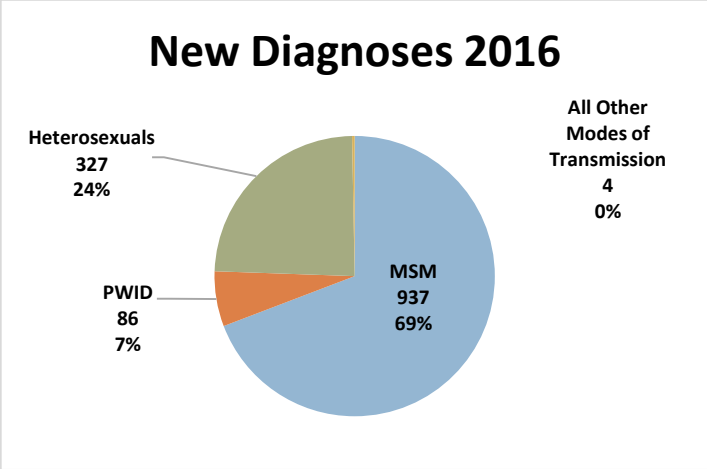




Mode of Exposure

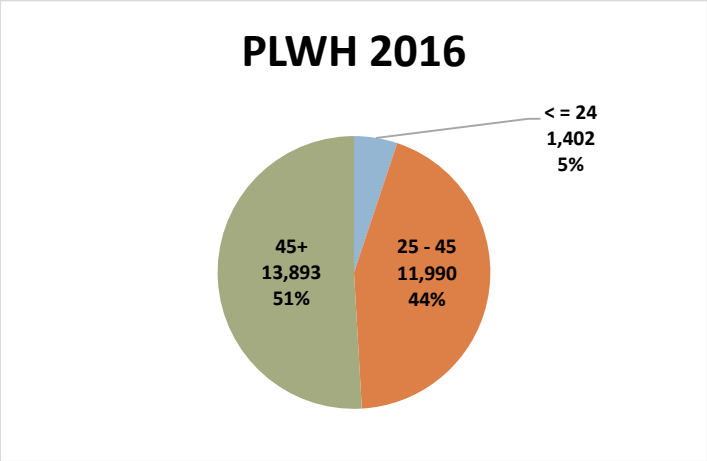
MSM makes up the primary mode of exposure among PLWH and among new diagnoses.

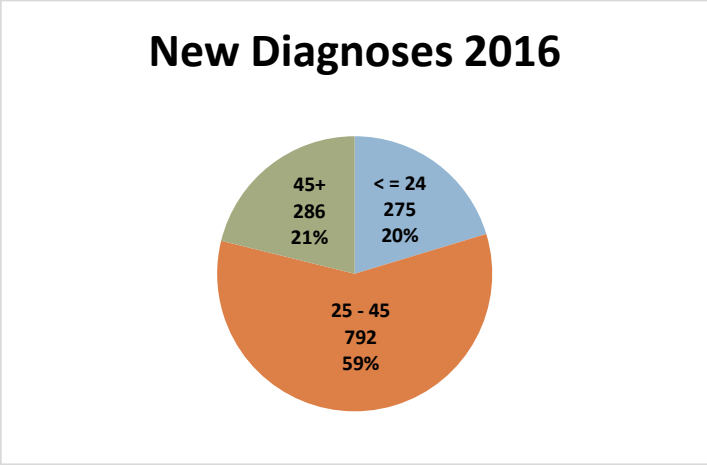




Age

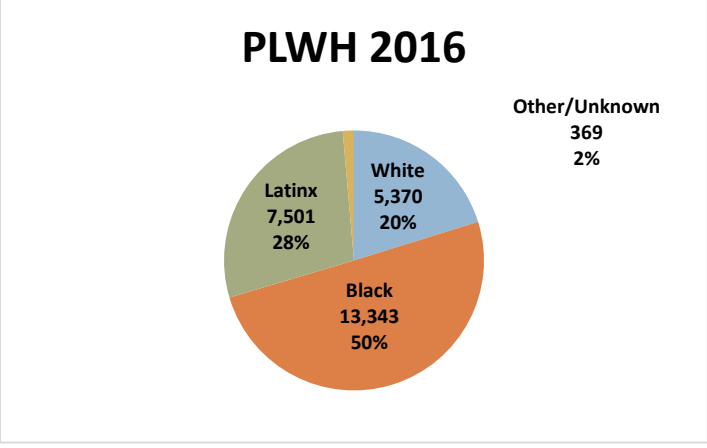
The majority of PLWH are 45 and older; the majority of new diagnoses are among people 25-45.

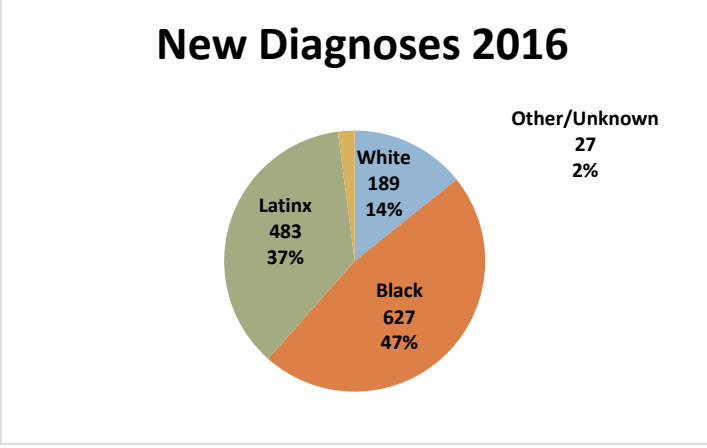




Race/Ethnicity

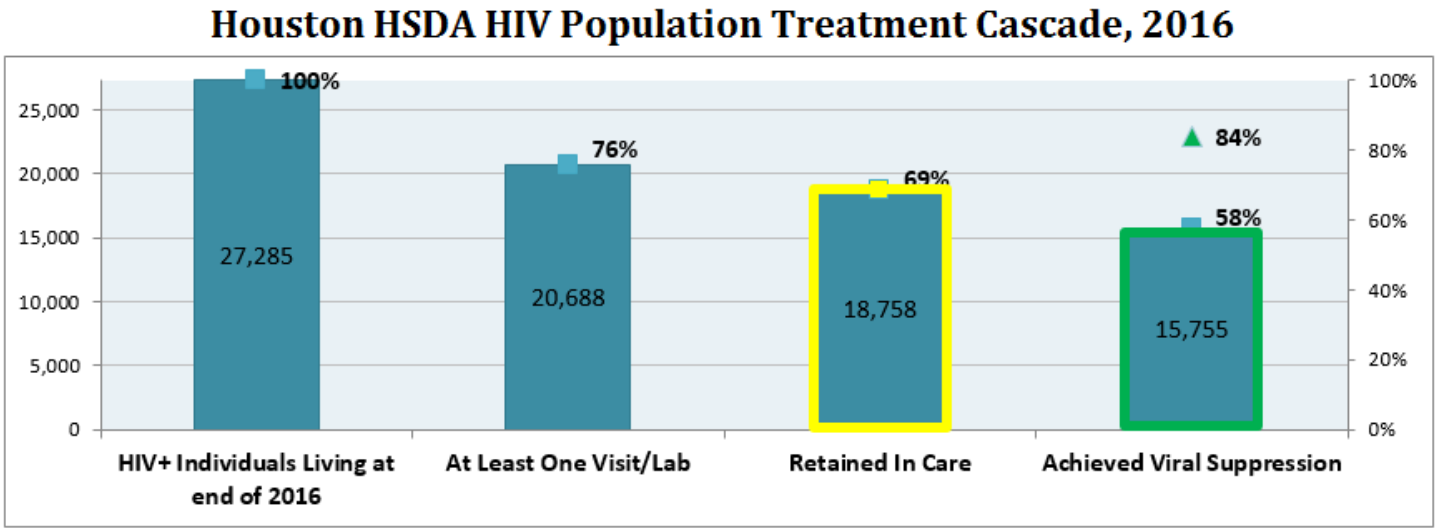
The majority of PLWH and the majority of new diagnoses are among Black individuals.





2016 Care Continuum

When people are able to achieve retention in care, they are able to achieve viral suppression. In the Houston HSDA, 58% of total PLWH have achieved viral suppression, and 84% of PLWH who are retained in care achieved viral suppression. Retention in care is a priority area.



76% of PLWH had at least one episode of HIV care & treatment. This means roughly 8 out of 10 PLWH were in care.

69% of PLWH were retained in care (2 episodes of HIV care & treatment across the year). This means that roughly 7 out of 10 PLWH were retained in care

58% of PLWH were virally suppressed. This means that roughly 6 out of 10 PLWH were virally suppressed

Of those 7 out of 10 PLWH who were retained in care, 84%, or roughly 6 of those 7 PLWH, were virally suppressed.

2016 Continuum of Care, Parity Table

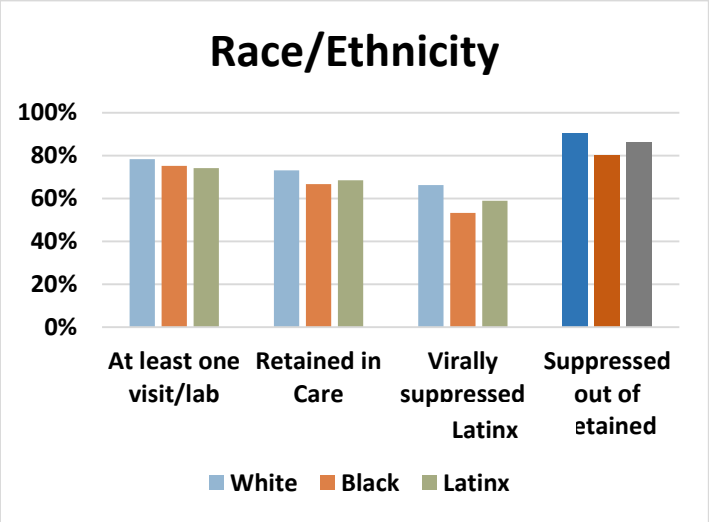
All communities who are retained in care are able to achieve viral suppression goals, except for people under the age of 35 and People Who Inject Drugs (PWID).
Communities with the fewest opportunities to achieve retention are people under the age of 45, People Who Inject Drugs (PWID), Heterosexuals, Men and Black PLWH, specifically Black MSM.

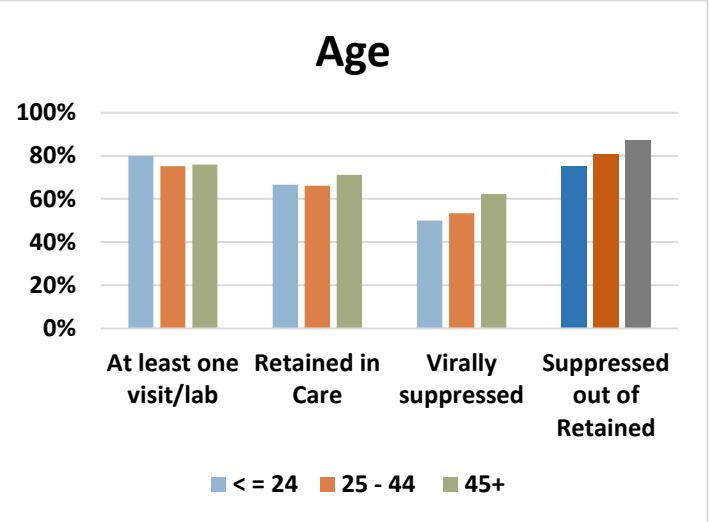
85% PLWH retained in HIV care and treatment

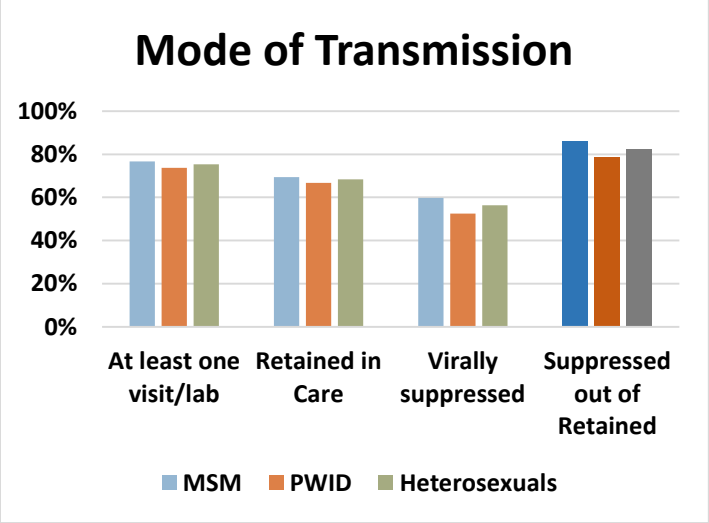
80% Of those retained are virally suppressed

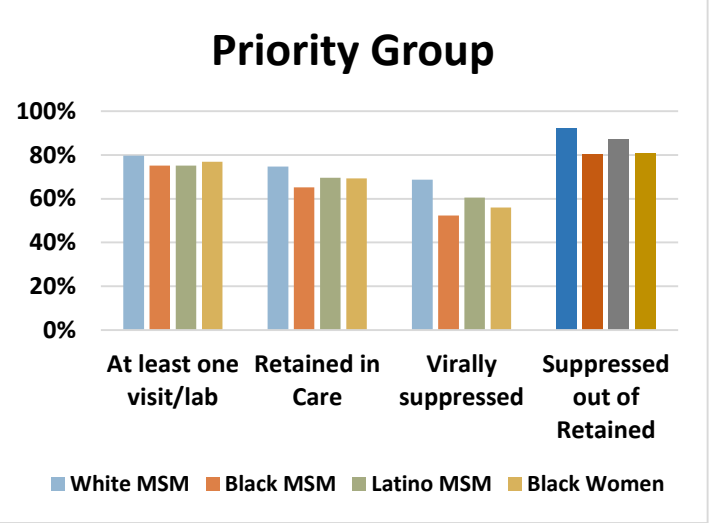
	PLWH		At least one visit		Retained in Care		% retained if any care	Suppressed		% suppressed of those retained
	#	%	#	%	#	%	%	#	%	%
All PLWH	**27,285**	**100%**	**20,688**	**76%**	**18,758**	**69%**	**91%**	**15,755**	**58%**	**84%**
Female	6,854	25%	5,296	77%	4,792	70%	90%	3,887	57%	81%
Male	20,431	75%	15,392	75%	13,966	68%	91%	11,868	58%	85%
White	5,370	20%	4,206	78%	3,297	73%	78%	3,553	66%	90%
Black	13,343	49%	10,037	75%	8,896	67%	89%	7,106	53%	80%
Latinx	7,501	27%	5,562	74%	5,140	69%	92%	4,422	59%	86%
<=24	1,402	5%	1,121	80%	933	67%	83%	700	50%	75%
25 – 34	5,491	20%	4,176	76%	3,567	65%	85%	2,804	51%	79%
35 – 44	6,499	24%	4,836	74%	4,369	67%	90%	3,597	55%	82%
45+	13,893	51%	10,555	76%	9,889	71%	94%	8,654	62%	88%
MSM	15,445	57%	11,834	77%	10,724	69%	91%	9,236	60%	86%
PWID	3,449	13%	2,542	74%	2,301	67%	91%	1,811	53%	79%
Heterosexual	8,033	29%	6,052	75%	5,495	68%	91%	4,532	56%	82%
White MSM	4,077	15%	3,250	80%	3,045	75%	94%	2,802	69%	92%
Black MSM	5,779	21%	4,344	75%	3,771	65%	87%	3,028	52%	80%
Latino MSM	4,972	18%	3,735	75%	3,459	70%	93%	3,012	61%	87%
Black Women	3,828	14%	2,942	77%	2,654	69%	90%	2,143	56%	81%

2016 Continuum of Care, Parity Bar Charts









Targets

Among priority populations, the community with the greatest need for new opportunities to achieve retention are Black MSM.

85% PLWH retained in HIV care and treatment

80% Of those retained are virally suppressed

	PLWH		Retained in Care		*85% retained goal*	Gap	Suppressed	*80% suppressed goal*	Gap
	#	%	#	%	#	#	#	#	#
All PLWH	**27,285**	**100%**	**18,758**	**69%**	***23,192***	***4,434***	**15,755**	***18,554***	***2,799***
Female	6,854	25%	4,792	70%	*5,826*	*1,034*	3,887	*4,661*	*774*
Male	20,431	75%	13,966	68%	*17,366*	*3,400*	11,868	*13,893*	*2,025*
White	5,370	20%	3,297	73%	*4,565*	*638*	3,553	*3,652*	*99*
Black	13,343	49%	8,896	67%	*11,342*	*2,446*	7,106	*9,074*	*1,968*
Latinx	7,501	27%	5,140	69%	*6,376*	*1,236*	4,422	*5,101*	*679*
<=24	1,402	5%	933	67%	*1,192*	*259*	700	*953*	*253*
25 – 34	5,491	20%	3,567	65%	*4,667*	*1,100*	2,804	*3,734*	*930*
35 – 44	6,499	24%	4,369	67%	*5,524*	*1,155*	3,597	*4,419*	*822*
45+	13,893	51%	9,889	71%	*11,809*	*1,920*	8,654	*9,447*	*793*
MSM	15,445	57%	10,724	69%	*13,128*	*2,404*	9,236	*10,502*	*1,266*
PWID	3,449	13%	2,301	67%	*2,932*	*631*	1,811	*2,346*	*535*
Heterosexual	8,033	29%	5,495	68%	*6,828*	*1,333*	4,532	*5,462*	*930*
White MSM	4,077	15%	3,045	75%	*3,465*	*420*	2,802	*2,772*	*-30*
Black MSM	5,779	21%	3,771	65%	*4,912*	*1,141*	3,028	*3,930*	*902*
Latino MSM	4,972	18%	3,459	70%	*4,226*	*767*	3,012	*3,381*	*369*
Black Women	3,828	14%	2,654	69%	*3,254*	*600*	2,143	*2,603*	*460*

★ ROADMAP ★

TO ENDING THE HIV EPIDEMIC IN HOUSTON

~December 2016~

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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 2016~

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.

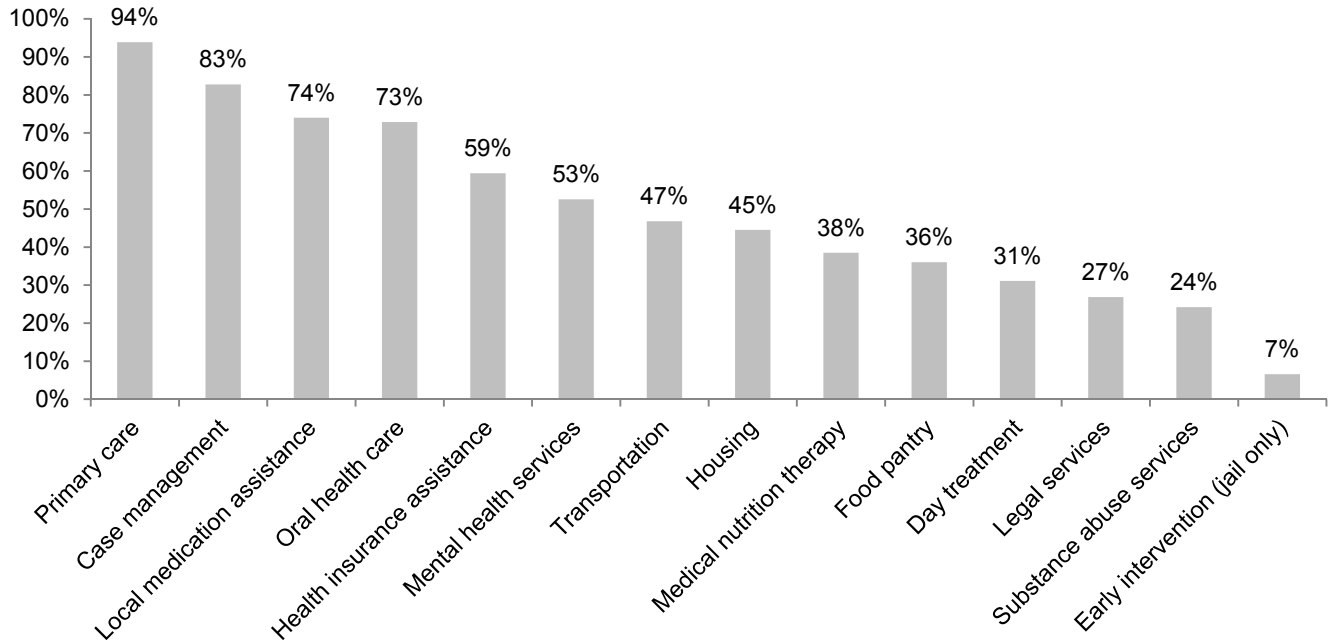
Overall Ranking of Funded Services, by Need

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:



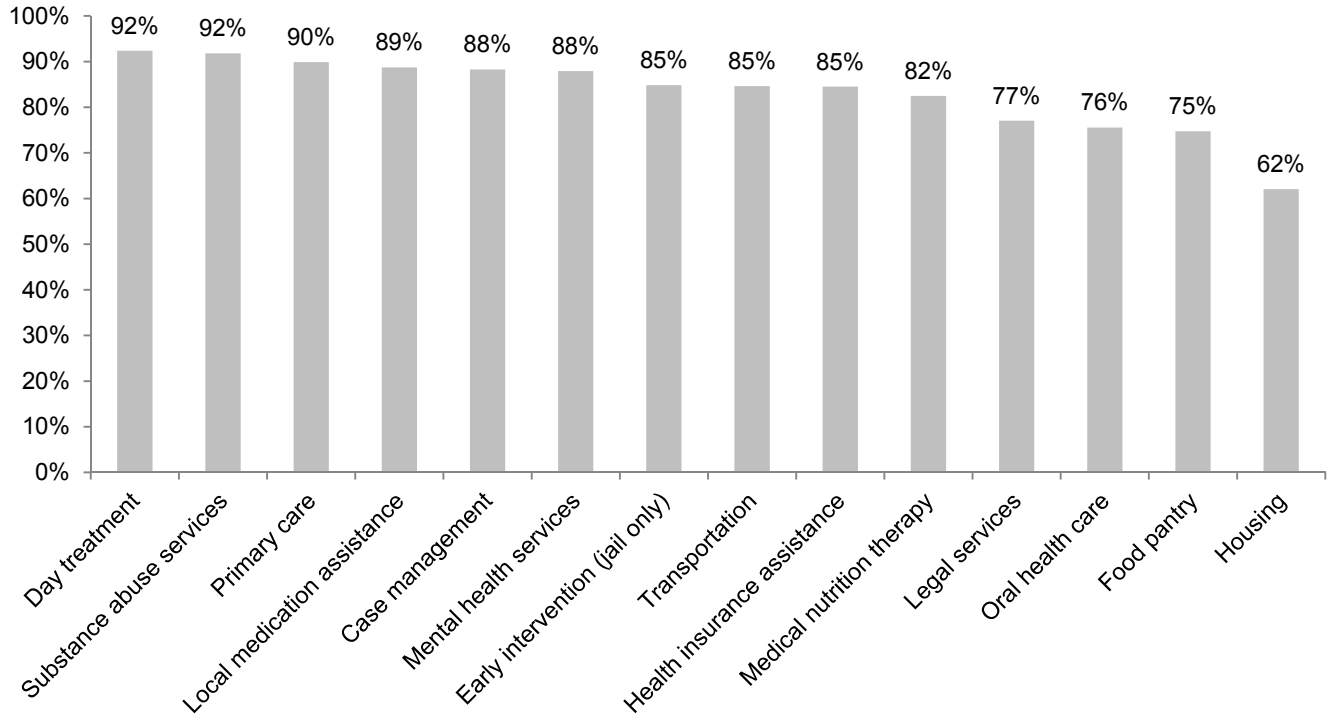
Overall Ranking of Funded Services, by Accessibility

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

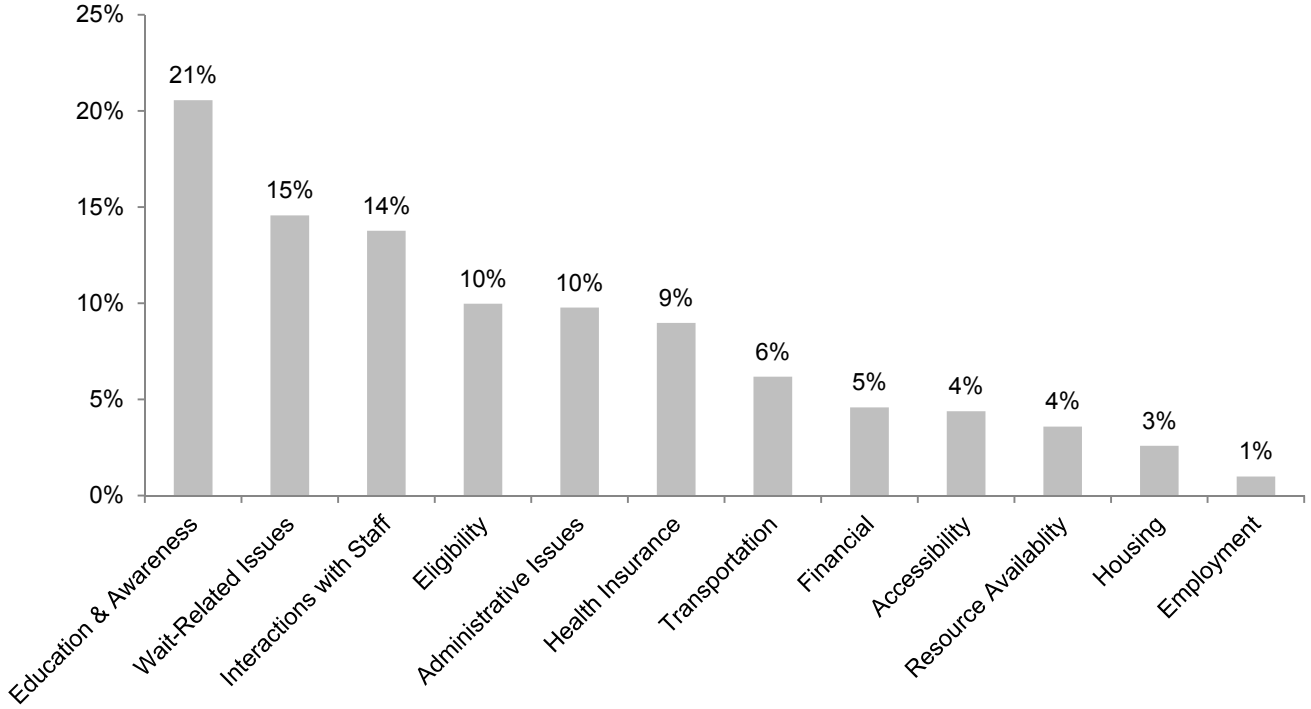
For the first time in the Houston Area HIV Needs Assessment process, participants who reported *difficulty* accessing needed services were asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Recursive abstraction was used 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%

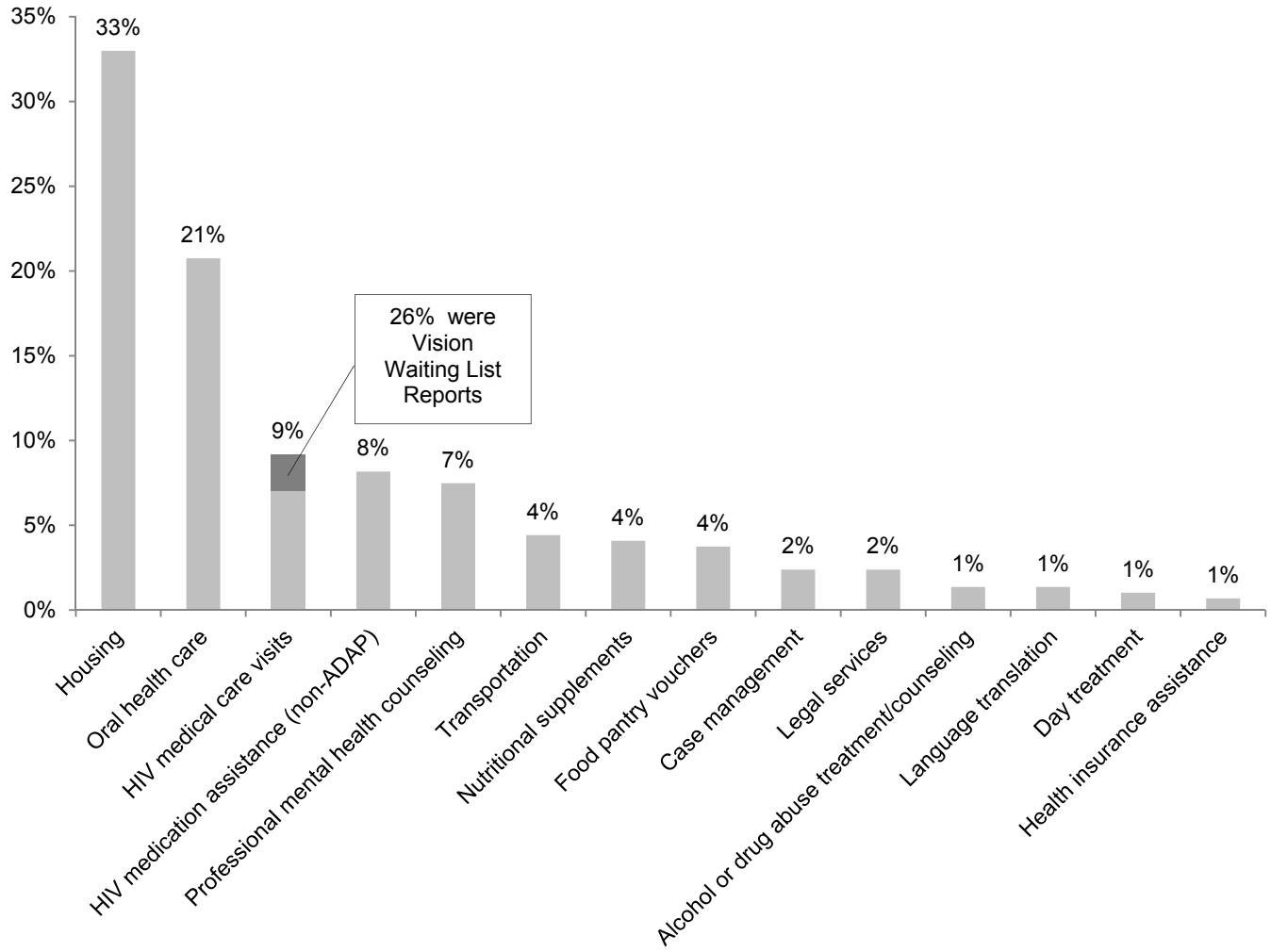
Waiting List Barriers and Experiences

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.

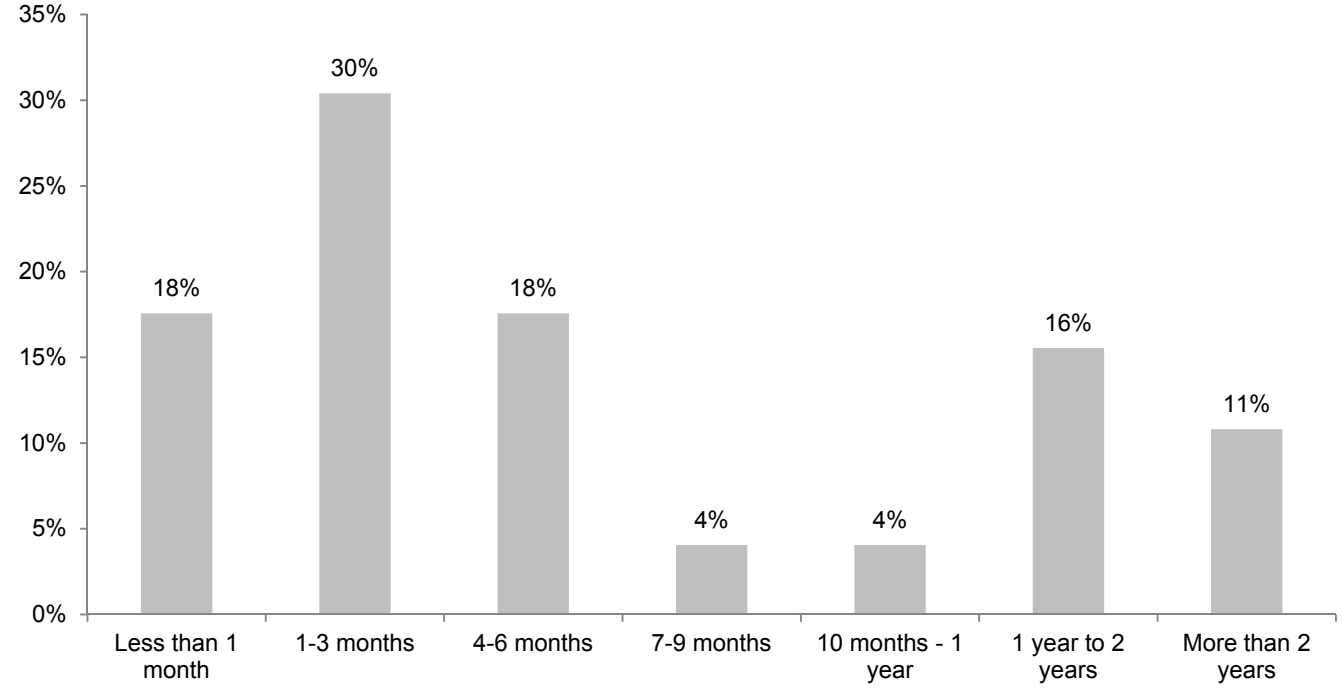


(**Graph 5**) Participant reports of time elapsed from the initial request for a service until receipt of the service vary from 1 day to over 2 years. The greatest number of reports of time elapsed occurred for wait times between one and three months (30%), followed by less than one month (18%) and four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

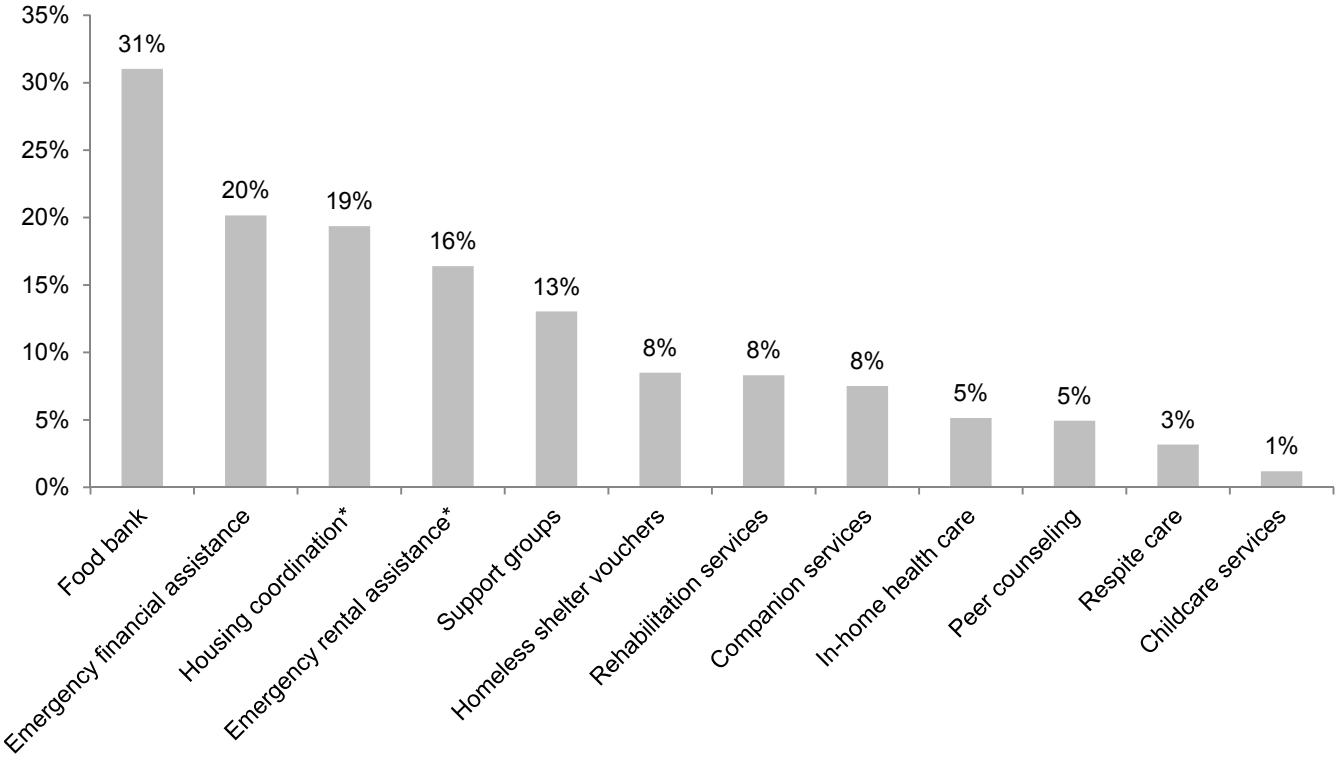
In addition to the HIV services listed above, there are other services allowable for funding by the Ryan White HIV/AIDS Program in local communities if there is a demonstrated need. Several of these other services have been funded by the Ryan White Program in the Houston Area in the past. The 2016 Houston 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?"



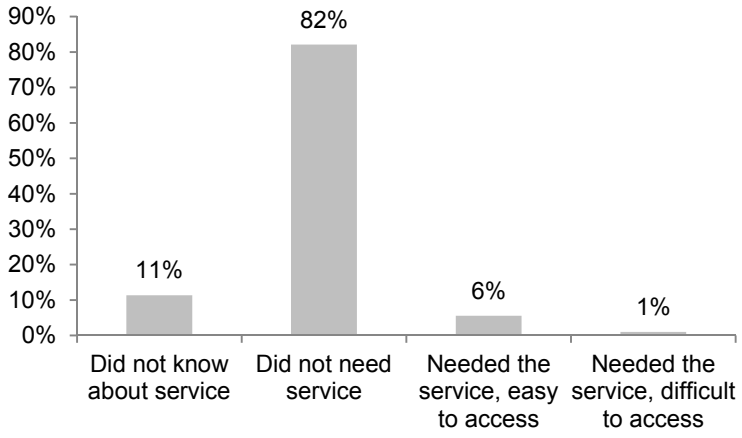
*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.

EARLY INTERVENTION (JAIL ONLY)

Early intervention services (EIS) refers to the provision of HIV testing, counseling, and referral in the Ryan White HIV/AIDS Program setting. In the Houston Area, the Ryan White HIV/AIDS Program funds EIS to persons living with HIV (PLWH) who are incarcerated in the Harris County Jail. Services focus on post-incarceration care coordination to ensure continuity of primary care and medication adherence post-release.

(**Graph 1**) In the 2014 Houston Area HIV needs assessment, 7% of participants indicated a need for *early intervention services* in the past 12 months. 6% reported the service was easy to access, and 1% reported difficulty. 11% stated that they did not know the service was available.

GRAPH 1-Early Intervention (Jail Only), 2016



(**Table 1**) When barriers to *early intervention services* were reported, the most common barrier type was accessibility (40%). Accessibility barriers reported include release from incarceration.

TABLE 1-Top 4 Reported Barrier Types for Early Intervention (Jail Only), 2016

	No.	%
1. Accessibility (AC)	2	40%
2. Interactions with Staff (S)	1	20%
3. Resource Availability (R)	1	20%
4. Transportation (T)	1	20%
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(**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 *early intervention services*, this analysis shows the following:

- More males than females 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 recently release and unstably housed PLWH found the service difficult to access when compared to all participants.

TABLE 2-Early Intervention (Jail Only), 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	12%	8%	13%	13%	7%	14%	4%	15%	7%
Did not need service	81%	86%	86%	80%	88%	43%	96%	77%	88%
Needed, easy to access	6%	5%	1%	6%	5%	43%	0%	6%	5%
Needed, difficult to access	1%	2%	0%	2%	0%	0%	0%	1%	1%

TABLE 3-Early Intervention (Jail Only), 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	11%	12%	0%	26%	0%	9%
Did not need service	78%	82%	100%	26%	97%	86%
Needed, easy to access	9%	6%	0%	42%	3%	5%
Needed, difficult to access	2%	1%	0%	5%	0%	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

DAY TREATMENT

Day treatment, technically referred to as *home and community-based health services*, provides therapeutic nursing, support services, and activities for persons living with HIV (PLWH) at a community-based location. This service does not currently include in-home health care, in-patient hospitalizations, or long-term nursing facilities.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 31% of participants indicated a need for *day treatment* in the past 12 months. 29% reported the service was easy to access, and 2% reported difficulty. 18% stated that they did not know the service was available.

(**Table 1**) When barriers to *day treatment* were reported, the most common barrier types were administrative (complex processes), eligibility (ineligible), health insurance-related (being uninsured), interactions with staff (poor communication or follow up), transportation (lack of transportation).

GRAPH 1-Day Treatment, 2016

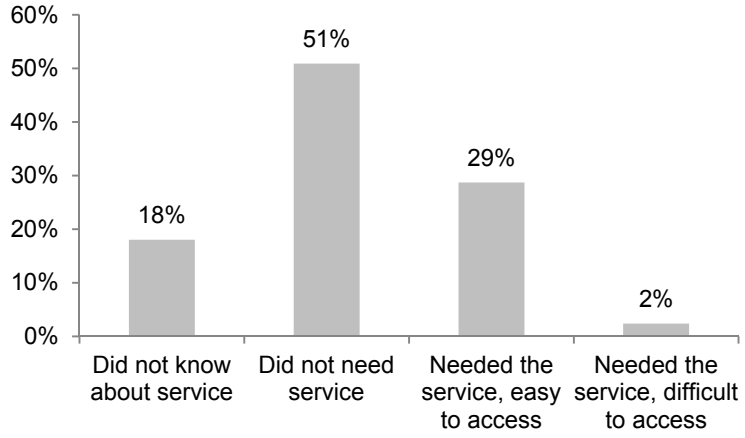

TABLE 1-Top 5 Reported Barrier Types for Day Treatment, 2016

	No.	%
1. Administrative (AD)	1	17%
2. Eligibility (EL)	1	17%
3. Health Insurance Coverage (I)	1	17%
4. Interactions with Staff (S)	1	17%
5. Transportation (T)	1	17%

(**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 *day treatment*, this analysis shows the following:

- More males than females 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 unstably housed PLWH found the service difficult to access when compared to all participants.

TABLE 2- Day Treatment, 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	18%	18%	28%	17%	15%	0%	30%	20%	12%
Did not need service	49%	56%	56%	49%	50%	53%	52%	45%	61%
Needed, easy to access	30%	23%	13%	33%	31%	47%	17%	32%	24%
Needed, difficult to access	2%	3%	3%	1%	5%	0%	0%	2%	3%

TABLE 3- Day Treatment, 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	27%	19%	50%	24%	32%	18%
Did not need service	38%	49%	50%	38%	50%	27%
Needed, easy to access	32%	30%	0%	38%	18%	55%
Needed, difficult to access	3%	2%	0%	0%	0%	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

HOSPICE

Hospice is end-of-life care for persons living with HIV (PLWH) who are in a terminal stage of illness (defined as a life expectancy of 6 months or less). This includes room, board, nursing care, mental health counseling, physician services, and palliative care.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 7% of participants indicated a need for *hospice* in the past 12 months. 7% reported the service was easy to access, and 0.1% reported difficulty. 16% stated that they did not know the service was available.

(**Table 1**) When barriers to *hospice* were reported, the only barrier type identified was education and awareness (lack of knowledge about the availability the service)

TABLE 1- Reported Barrier Type for Hospice, 2016

	No.	%
1. Education and Awareness (EA)	2	100%
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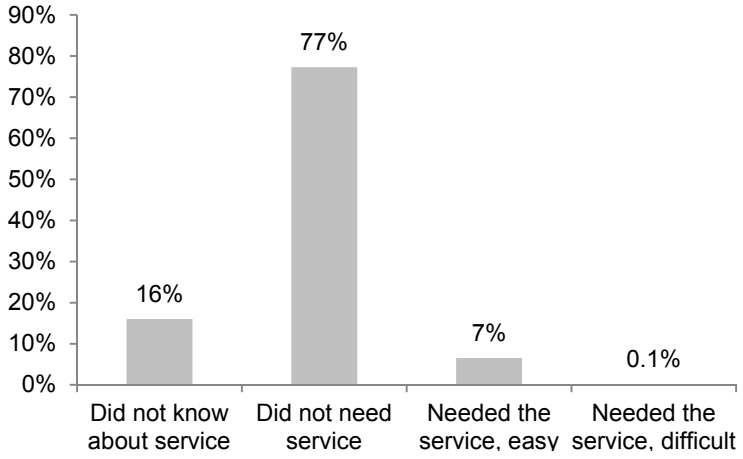
GRAPH 1-Hospice, 2016



(**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 *hospice*, this analysis shows the following:

- More males than females found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 50+ found the service accessible than other age groups.
- No PLWH in special populations found the service difficult to access compared to all participants.

TABLE 2-Hospice, 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	16%	17%	10%	16%	20%	0%	21%	18%	12%
Did not need service	77%	77%	84%	75%	74%	13%	75%	77%	78%
Needed, easy to access	7%	6%	6%	8%	5%	87%	4%	5%	11%
Needed, difficult to access	0%	0%	0%	0%	0%	0%	0%	0%	0%

TABLE 3- Hospice, 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	20%	13%	50%	21%	15%	14%
Did not need service	74%	80%	50%	74%	79%	77%
Needed, easy to access	6%	7%	0%	5%	6%	9%
Needed, difficult to access	0%	0%	0%	0%	0%	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

TRANSPORTATION

Transportation services provides transportation to persons living with HIV (PLWH) to locations where HIV-related care is received, including pharmacies, mental health services, and substance abuse services. The service can be provided in the form of public transportation vouchers (bus passes), gas vouchers (for rural clients), taxi vouchers (for emergency purposes), and van-based services as medically indicated.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 47% of participants indicated a need for *transportation services* in the past 12 months. 40% reported the service was easy to access, and 7% reported difficulty. 10% stated they did not know the service was available. When analyzed by type transportation assistance sought, 84% of participants needed bus passes, 10% needed van services, and 6% needed both forms of assistance.

(**Table 1**) When barriers to *transportation services* were reported, the most common barrier type was transportation (28%). Transportation barriers reported include both lack of transportation and difficulty with special transportation providers.

GRAPH 1-Transportation Services, 2016

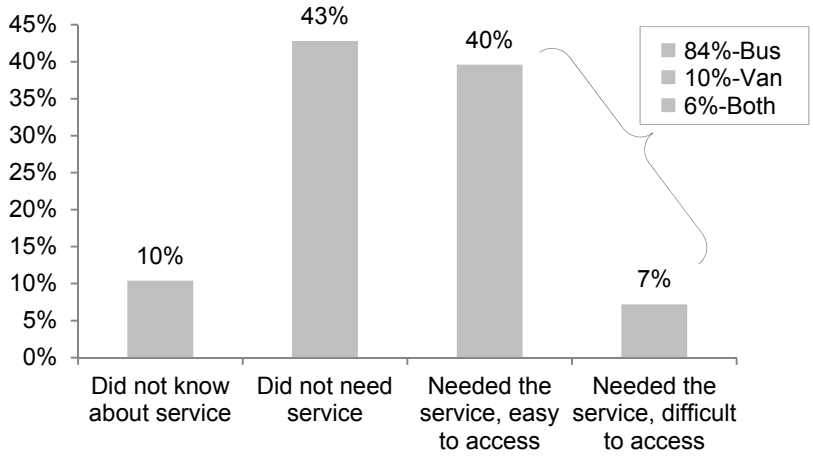


TABLE 1-Top 5 Reported Barrier Types for Transportation Services, 2016

		No.	%
1.	Transportation (T)	9	28%
2.	Education and Awareness (EA)	6	19%
3.	Eligibility (EL)	4	13%
4.	Accessibility (AC)	3	9%
5.	Resource Availability (R)	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 *transportation services,* this analysis shows the following:

- More females than males found the service accessible..
- More African American/black PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more transgender, recently released, unstably housed, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Transportation Services, 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	11%	8%	7%	9%	15%	13%	22%	10%	9%
Did not need service	47%	31%	55%	36%	41%	87%	43%	44%	40%
Needed, easy to access	35%	55%	27%	48%	38%	0%	30%	38%	44%
Needed, difficult to access	8%	6%	10%	8%	5%	0%	4%	8%	7%

TABLE 3-Transportation Services, 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	17%	13%	50%	8%	6%	14%
Did not need service	27%	49%	50%	22%	72%	18%
Needed, easy to access	46%	31%	0%	59%	16%	50%
Needed, difficult to access	10%	8%	0%	11%	6%	18%

[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

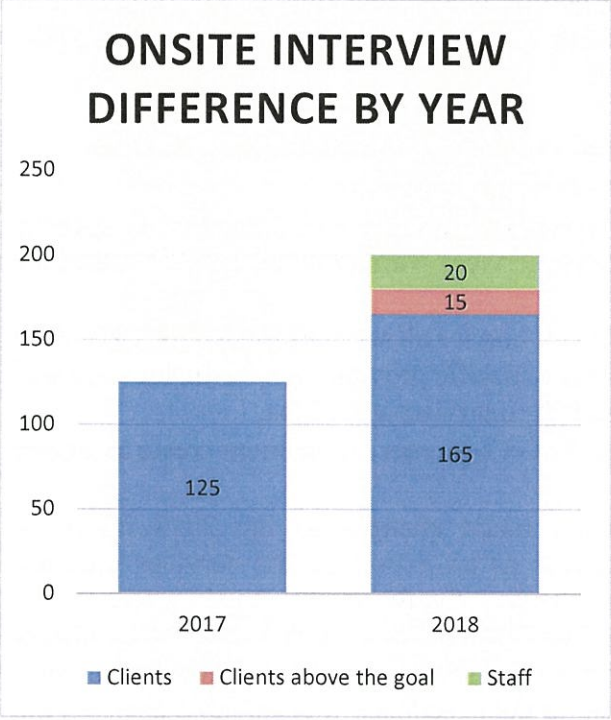
TRG Consumer Interview Results 2018

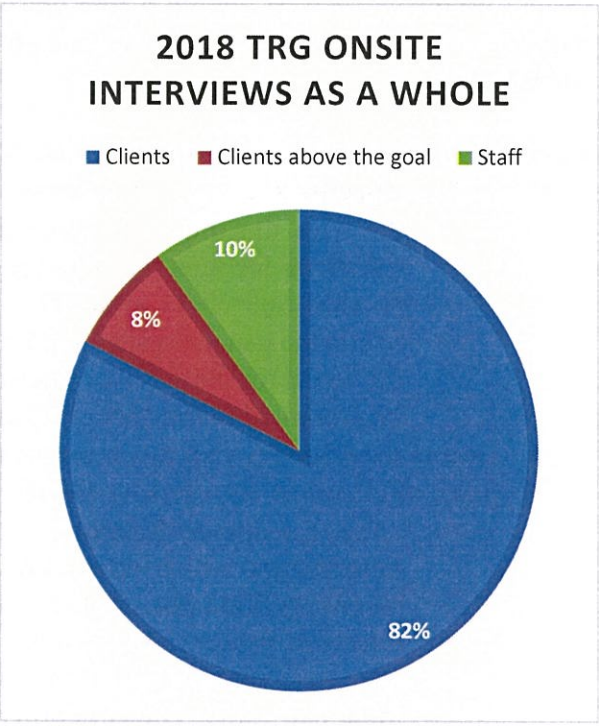
Interview and Feedback Period October 2018-December 2018

Overview

The Consumer Interview Process is used by The Resource Group (TRG) to determine consumer experience, satisfaction and collect additional feedback from consumers. Consumer interviews are required as part of TRG grant monitoring process at each agency in Houston and the fifty-one county areas of East Texas. The process which reviews consumer engagement is called the Onsite Interview (OI) Process. During the 2018 OI process one hundred and eighty (180) Consumer participated in the interview process. HIV positive consumers have been in care ranging from two weeks though thirty years. Sessions conducted were individual, couples, random pairs and as group interviews. Below is a comparison between the 2017 and 2018 reporting process showing an increase in participation. A goal was set for one hundred and sixty-five (165) for the 2018 reporting period. One hundred and sixty-five (165) would yield a 32% increase however, one hundred and eighty (180) clients participated is a 44% increase.

In 2018, staff interviews were formalized as a part of the Onsite Interview Process, to get a foster the relationship TRG expects its Subrecipients to have with consumers. Twenty (20) provider staff was interviewed or given onsite technical assistance (TA) to help improve the efforts of overall consumer engagement. The total interviews were two hundred (200).





CROSS-SERVICE TRENDS

Overall, consumers reported satisfaction with the services they are receiving. Consumers, who are in care, feel comfortable and satisfied with their medical team and care process. A high percentage of consumers felt they were leaders on their health care team or an important team member of their team. Consumers stated the medical staff answer questions and explain the things the consumer does not understand. Case managers were described as "good at helping and explaining things".

Consumers in Houston and throughout East Texas mentioned general communication between staff and consumers at most service agencies needs improvement. Consumers continue to become more open about discussing concerns and reporting dissatisfaction for improvement purposes. There is an ongoing disconnection between consumers and the agency complaint process or how concerns are resolve at some agencies. Some consumers continue to report they were not aware of the complaint process for problems with services. Some consumers were familiar with the agency process and complaint forms. This discussion has continued multiple years.

There was an increase in statements and conversations related to services. Services which received the most detailed comments were Oral Health Care. In previous years, having online surveys available for consumers who may not have the time during their day to complete a survey has been suggested.

From year to year consumers only a select few are familiar with the complaint process at the agencies they are receiving services from. Consumers who had complaints expressed their complaints have been addressed and resolved. While a few consumers worried that if they complained, it may affect their service or that it may take them longer to get an appointment. Phone system problems such as getting a live person and getting medication refills were discussed as problems. In 2017 a client suggests an exit survey to ask about any complaints or comments at the end of a visit.

The lessons learned and questions which will be added to the questionnaire for 2019 include:

- Service specific/specific population questions to all some services
  - As with the introduction of dental specific questions and incarcerated specific questions for interviews in the jail, other services warrant some specific questions to encourage client feedback.
  - While the general questionnaire will have a box for all services funded by TRG, only the boxes for the services funded through a specific provider or specific location will be presented to the service agencies staff as interview questions.
- During a HRSA TA visit it was recommended TRG Consumer Department create an expert panel of clients as an Advisory Board.
  - The Consumer Relations Coordinator made changes to the 2018 interview introduction which now identifies clients as an expert on the services they are receiving. This change has been empowering for the clients participating in the interview process. An example in the Early Intervention Service received by clients who were incarcerated at the time of the interview, allowed the clients to feel their input had value. The possibility of feeling their feedback was valuable changed the

mood of the interviews and increased the clients willing ness to share their experience. This was the same occurrence during all the consumer interviews.

- The Contact Consent form will serve as an assessment of clients' interest in participating in feedback/consumer engagement opportunities as well as a skill assessment the form is voluntary to complete, and the consumer has the right to refuse. The form gives the client's consent to be contacted about only the topics the have selected. This form was very useful to check on the safety and communicate with some consumers during and after Hurricane Harvey. TRG staff was able to communicate via cell phone with Houston and Beaumont consumers. A few clients who were evacuated were able to stay connected to information and updates on where to get service and medications.

The client satisfaction questions will be reviewed by various groups of TRG consumers and feedback is utilized to improve the evaluation process. The Onsite Interview Process has identified the need for Ryan White agencies to create and facilitate agency specific/customized trainings for their consumers which may include but are not limited to:

- Consumers reviewing and providing feedback on agency policies and procedures. This has been recommended for the previous years. During the interviewing process of 2018 The Consumer Relations Coordinator provided onsite technical assistance. The TA recommended the service provider utilize the agencies Consumer Advisory Board to review policy and procedures which directly affect clients on an annual basis. This can be addressed on the Consumer Engagement Work Plan.
- Consumer trainings on each service which the agency provides and details to help consumers understand the length of processes for specific procedures or service. This has been recommended for the previous years. During the interviewing process of 2018 The Consumer Relations Coordinator provided onsite technical assistance. The TA recommended the service provider utilize the agencies Consumer Advisory Board quarterly meetings and host service specific trainings or educational meetings for clients. This can be addressed on the Consumer Engagement Work Plan.
- Based on feedback, conversations and identified interest TRG will develop multiple Advisory Boards base on target populations and service specific focuses.

SERVICE-SPECIFIC TRENDS

Oral Health Care

Consumers in the local area have concerns about changes which affect accesses to this service. TRG is working with Subrecipients to address client concerns and provide Service update written materials and update meetings to consumers receiving or seeking this service.

For most rural area services, consumers were satisfied with this service. And very knowledgeable of this service and how to access the service.

For a few remote rule areas consumers expressed a need to have this service closer to their home. Clients expressed they were not satisfied with how for the must travel to receive the service. The concerns have been documented. For the specific areas discussed. The consumers were informed that there are were no providers closer to provide the service. The clients statements were they preferred to have it closer but, they were willing to travel to have access to the service.

Part D Patient Navigation Services
Consumers were satisfied with this service. Consumers stated that the service was useful and needed.

Mental Health Services
Consumers were satisfied with this service. Many consumers expressed satisfaction with the selection process of pairing a client with an appropriate therapist through this service. Many consumers expressed interest in learning more and understanding this service. TRG has begun to address this by creating a booklet on "Understanding Mental Health Services".

Home and Community-Based Health Care Services
Consumers were satisfied with this service. Consumers expressed satisfaction with the socialization and activities available through this service. Day treatment consumers understanding of the service they are receiving has continued to improve from the previous years. The TRG recommendations have been utilized and continually administered to day treatment consumers.

Early Intervention Services – Incarcerated (EIS)
EIS consumers seem to be very knowledgeable and appreciative of access to service. The consumers were pleased to be referred to as experts and some inquired about learning more about the Ryan White system and how to participate upon release. For this service 50% of clients were diagnosed during their current incarceration. Some clients had been newly diagnosed about month.

Linguistic Services
There were no issues related to this service and due to the nature of the service delivered, there are no Consumer interviews conducted for this service.

Hospice Care Services
There were no issues of note related to this service and due to the nature of the service delivered; Consumer interviews were not conducted for this service.

Health Insurance Premium (HIP)
HIP consumers were satisfied and appreciative for the availability of the service. Consumers stated that HIP was simple to get and easy to use. Consumers of this service are very knowledgeable of this service.

RYAN WHITE PART B/DSHS STATE SERVICES
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EARLY INTERVENTION SERVICES FOR THE INCARCERATED

Definition:
Early Intervention Services are designed to bring people living with HIV into Outpatient Ambulatory Medical Care through counseling, testing, and referral activities.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service The goal of Early Intervention Services (EIS) is to decrease the number of underserved people living with HIV(PLWH) by increasing access to care, educating and motivating PLWHs on the importance and benefits of getting into care, through expanding key points of entry. The provision of EIS includes: • HIV Testing and Targeted counseling** • Referral services • Linkage to care • Health education and literacy training that enable PLWHs to navigate the HIV system of care EIS for the Incarcerated specifically includes the connection of incarcerated PLWH in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the PLWH, provision of education regarding disease and treatment, education and skills building to increase PLWH's health literacy, establishment of THMP/ADAP eligibility (as applicable), care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning. **Limitation: Funds can only be used for HIV testing as necessary to supplement, ***not supplant***, existing funding.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in primary client record.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Agency License The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services.	• Review of agency
9.3	Program Policies and Procedures Agency will have a policy that: • Defines and describes EIS services (funded through Ryan White or other sources) that include and are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for PLWHs to help them navigate the HIV care system • Specifies that services shall be provided at specific points of entry • Specifies required coordination with HIV prevention efforts and programs • Requires coordination with providers of prevention services • Requires monitoring and reporting on the number of HIV tests conducted and the number of PLWH found • Requires monitoring of referrals into care and treatment	• Program's Policies and Procedures indicate compliance with expectations.
9.4	Staff Qualifications All agency staff that provide direct-care services shall possess: • Advanced training/experience in the area of HIV/infectious disease • HIV early intervention skills and abilities as evidenced by training, certification, and/or licensure, and documented competency assessment • Skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel. Supervisors must possess a degree in a health/social service field or equivalent experience.	• Review of personnel files indicates compliance
9.5	Continuing Education Each staff will complete a minimum of (12) hours of training annually to remain current on HIV care.	• Evidence of training will be documented in the staff personnel records.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.6	Supervision Each agency must have and implement a written plan for supervision of all Early Intervention staff. Supervisors must review a 10 percent sample of each staff member's primary client records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. Each supervisor must maintain a file on each staff supervised and hold supervisory sessions on at least a monthly basis. The file must include, at a minimum: • Date, time, and content of the supervisory sessions • Results of the supervisory case review addressing at a minimum completeness and accuracy of records, compliance with standards, and effectiveness of service.	• Program's Policies and Procedures indicate compliance with expectations. • Review of documentation indicates compliance.
9.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • Documentation of HIV diagnosis • Language(s) spoken and Literacy level (client self-report) *Due to PLWH's state of incarceration, this service is excluded from the requirement to document income and residency.*	• Documentation of HIV status is present in the primary client record. • Documentation in compliance with TRG Policies for Documentation of HIV Status.
9.8	CPCDMS Update/Registration As part of intake into service, staff will register new PLWHs into the CPCDMS data system (to the extent possible) and update CPCDMS registration for existing PLWHs.	• Current registration for PLWH is present in CPCDMS.
9.9	Assessment of Client Staff will complete an intake assessment form for all PLWHs served. The assessment will include identified needs upon release, assessment of support system upon release, and desired provider to receive referral information on.	• Intake assessment form is present in the primary client record.
9.10	Provision of Education/Counseling Staff provide PLWH with education regarding the disease and its management, risk reduction, medication adherence and other health-related education. The provision education will include: • Health Education regarding HIV • Risk Reduction counseling • Maintenance of immune system • Disclosure to partners and support systems • Importance of accessing medical care and medications	• Documentation of education is present in the primary client record.

#	STANDARD	MEASURE
9.11	Increase Health Literacy Staff assesses PLWH's ability to navigate medical care systems and provides education to increase PLWH's ability to advocate for themselves in medical care systems.	• Documentation of health literacy evaluation and education is present in the primary client record.
9.12	Coordination of Care Staff assists in the coordination of PLWH's medical care while incarcerated including, but not limited to, medical appointments with a prescribing provider and medications.	• Documentation of coordination of care is present in the primary client record.
9.13	Medication Regimen Establishment/Transition Staff assists PLWH to become eligible for THMP/ADAP medication program prior to release. Staff assists PLWH with transition of medication from correctional facility to outside pharmacy.	• Documentation of THMP/ADAP application and its submission is present in primary client record. • Documentation of connection/referral to outside pharmacy.
9.14	Transitional Team Multidisciplinary (TTMD) Review Staff creates opportunities for MDT review with all involved agencies to discuss PLWH's case.	• Schedule of available times for TTMD reviews with involved agencies available for review. • Documentation of TTMD reviews present in primary client record.
9.15	Discharge/Care Planning Staff conducts discharge planning into Houston HIV Care Continuum. Discharge/Care planning should include but is not limited to: • Review of core medical and other supportive services available upon release, and • Needs identified through the assessment should document referral (as applicable) either through resources within the incarceration program or upon discharge • Creation of a discharge/care plan. • Discharge/Care plan should clearly identify individuals responsible for the activity (i.e. EIS Staff, MAI, MHMR, DSHS Prevention)	• Documentation of review of services present in primary client record. • Documentation of discharge/care plan is present in primary client record. • Documentation of applicable referrals (internal/external) with follow-up in the primary client record
9.16	Progress Note Progress notes will be maintained in each primary client record with documentation of the assistance the EIS staff provided to the PLWH to help achieve applicable goals, including successful linkage to OAHS services.	• Documented progress notes showing assistance provided to the PLWH in the primary client record.
9.17	HIV Testing and Targeted Counseling According to the HRSA National Monitoring Standards all four components must be present. ~~Part B~~ Funds can only be used for HIV testing to supplement, not supplant, existing funding. If ~~Ryan White Part B~~ funds are used for HIV testing, agency must submit a waiver to TRG and document the reason(s) necessary to supplement existing funding.	• Review of monthly expenses indicates compliance • Waiver are present when funds are utilized for testing

#	STANDARD	MEASURE
9.18	Referral Process Referrals will be documented in the primary client record and, at a minimum, should include referrals for services such as: • OAHS • MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable Any additional services necessary to help PLWHs engage in their medical care.	• Documentation of referral present in primary client record • Documentation of referral feedback present in primary client record. • Copy of "known to me as" letter present in primary client record.
9.19	Referral Packet Staff makes referrals to agencies for all PLWHs to be released from Harris County Jail. The referral will include a packet with a. A copy of the Harris County Jail Intake/Assessment Form, b. Proof of HIV diagnosis, c. A list of current medications, and d. Provide ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV services in the community.	•
9.20	Referral Outcome All referrals made will have documentation of follow-up to the referral in the primary client record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS staff offered to the PLWH.	•
9.21	Case Closure PLWHs who are released from Harris County Jail must have their cases closed with a case closure summary narrative documenting the reason for closure (i.e. transferring care, release, PLWH chooses to discontinue services), linkage to care (OAHS, MCM) and referral outcome summary (if applicable).	• Closed cases that include documentation stating the reason for closure and a closure summary in the primary client record system. • Documentation of supervisor signature/approval on closure summary (electronic review is acceptable).

#	STANDARD	MEASURE
9.22	MOUs with Core Medical Services The Agency must maintain MOUs with a continuum of core medical service providers. MOUs should be targeted at increasing communication, simplifying referrals, and decreasing other barriers to successfully connecting PLWHs into ongoing care.	• Review of MOUs at annual quality compliance reviews. • Documentation of communication and referrals with agencies covered by MOUs is present in primary client record.

References

DSHS HIV/STD Policy #2013.02, *"The Use of Testing Technology to Detect HIV Infection"* http://www.dshs.texas.gov/hivstd/policy/policies/2013-02.shtm.
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RYAN WHITE PART B/DSHS STATE SERVICES
1920 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
COMMUNITY-BASED HEALTH SERVICES

Definition:
Home and Community-Based Health Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Services Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of PLWHs through the provision of treatment and activities of daily living. Services must include: **Skilled Nursing** including medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient care techniques, ongoing monitoring of patients' physical condition and communication with attending physician(s), personal care, and diagnostics testing; **Other Therapeutic Services** including recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation; **Nutrition** including evaluation and counseling, supplemental nutrition, and daily nutritious meals; and **Education** including instructional workshops of HIV related topics and life skills. Services will be available at least Monday through Friday for a minimum of 10 hours/day.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in primary client record.
9.2	Licensure Agency must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider. Agency maintains other certification for facilities and personnel, if applicable. Services are provided in accordance with Texas State regulations.	• Documentation of license and/or certification posted in a highly-visible place at the site where services are provided to PLWHs.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.3	Services Requiring Licensed Personnel All services requiring licensed personnel shall be provided by Registered Nurses/Licensed Vocational Nurses or appropriate licensed personnel in accordance with State of Texas regulations. Other Therapeutic Services are provided by paraprofessionals, such as an activities coordinator, and counselors (LPC, LMSW, LMFTA). Nutritional Services are provided by a Registered Dietician and food managers. Education Services are provided by a health educator.	• Documentation of qualification in personnel file
9.4	Staff Qualifications All personnel providing care shall have (or receive training) in the following minimum qualifications: • Ability to work with diverse populations in a non-judgmental way • Working knowledge of: ➢ HIV and its diverse manifestations ➢ HIV transmission and effective methods of reducing transmission ➢ current treatment modalities for HIV and co-morbidities ➢ HIV continuum of care ➢ diverse learning and teaching styles ➢ the impacts of mental illness and substance use on behaviors and adherence to treatment ➢ crisis intervention skills ➢ the use of individualized plans of care in the provision of services and achievement of goals • Effective crisis management skills • Effective assessment skills	• Personnel Qualification on file • Documentation of orientation of file
9.5	Doctor's Order Community-based Health Services must be provided in accordance with doctor's orders. As part of the intake process, doctor's orders must be obtained to guide service provision to the PLWH.	• Review of primary client record indicates compliance.
9.6	Billing Requirement Home and Community Based Home Health agency must be able to bill Medicare, Medicaid, private insurance and/or other third-party payers.	• Provider will provide evidence of third-party billing.

#	STANDARD	MEASURE
9.7	Initial Client Assessment A preliminary assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care. PLWH will be contacted within one (1) business day of the referral, and services should be initiated at the time specified by the primary medical care provider, or within two (2) business days, whichever is earlier.	• Documentation of needs assessment completed in the primary client record • Documented evidence of a comprehensive evaluation completed in the primary client record.
9.8	Comprehensive Client Assessment A comprehensive client assessment, including nursing, therapeutic, and educational is completed for each PLWH within seven (7) days of intake and every six (6) months thereafter. A measure of client acuity will be incorporated into the assessment tool to track PLWH's increased functioning. A comprehensive evaluation of the PLWH's health, psychosocial status, functional status, and home environment should be completed to include: • Assessment of PLWH's access to primary care, adherence to therapies, disease progression, symptom management and prevention, and need for skilled nursing or rehabilitation services. • Information to determine PLWH's ability to perform activities of daily living and the level of attendant care assistance the PLWH needs to maintain living independently.	• Review of primary client record indicates compliance. • Acuity levels documented as part of assessment.
9.8	Nutritional Evaluation Each PLWH shall receive a nutritional evaluation within 15 days of initiation of care.	• Documentation is completed and maintained in the primary client record.
9.9	Meal Plan Staff will maintain signed and approved meal plans.	• Written documentation of plans is on file and posted in serving area.
9.10	Plan of Care A written plan of care is completed for each PLWH within seven (7) days of intake and updated at least every sixty (60) calendar days thereafter. Development of plan of care incorporates a multidisciplinary team approach.	• Review of primary client record indicates compliance

#	STANDARD	MEASURE
9.11	Implementation of Care Plan In coordination with the medical care coordination team, professional staff will: • Provide nursing and rehabilitation therapy care under the supervision and orders of the client's primary medical care provider. • Monitor the progress of the care plan by reviewing it regularly with the PLWH and revising it as necessary based on any changes in the PLWH's situation. • Advocate for the PLWH when necessary (e.g., advocating for the PLWH with a service agency to assist the PLWH in receiving necessary services). • Monitor changes in PLWH's physical and mental health, and level of functionality. • Work closely with PLWH's other health care providers and other members of the care team in order to effectively communicate and address service related needs, challenges and barriers. • Participate in the development of individualized care plan with members of the care team. • Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate. • Provide attendant care services which include taking vital signs if medically indicated • Assist with PLWH's self-administration of medication. • Promptly report any problems or questions regarding the PLWH's adherence to medication. • Report any changes in the PLWH's condition and needs. • Current assessment and needs of the PLWH, including activities of daily living needs (personal hygiene care, basic assistance with cleaning, and cooking activities) • Need for home and community-based health services • Types, quantity and length of time services are to be provided Care plan is updated at least every sixty (60) calendar days	• Documentation in the primary client record indicates services provided were consistent with the care plan. • Documentation in the primary client record indicates services provided were consistent with the care plan. • Percentage of PLWHs with documented evidence of a care plan completed based on the primary medical care provider's order as indicated in the primary client record. • Percentage of PLWHs with documented evidence of care plans reviewed and/or updated as necessary based on changes in the PLWH's situation at least every sixty (60) calendar days as evidenced in the primary client record.

#	STANDARD	MEASURE
9.12	Provision of Services/ Progress Notes Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community-based health services. • Progress notes will be kept in the primary client record and must be written the day services are rendered. • Progress notes will then be entered into the primary client record within (14) working days. • The agency will maintain ongoing communication with the multidisciplinary medical care team in compliance with Texas Medicaid and Medicare Guidelines. • The Home and Community-Based Provider will document in the primary client record progress notes throughout the course of the treatment, including evidence that the PLWH is not in need of acute care.	• Documented evidence of completed progress notes in the primary client record • Documentation of on-going communication with primary medical care provider and care coordination team as indicated in the primary client record
9.13	Coordination of Services/Referrals If referrals are appropriate or deemed necessary, the agency will: • Ensure that service for PLWHs will be provided in cooperation and in collaboration with other agency services and other community HIV service providers to avoid duplication of efforts and encouraging PLWH access to integrated health care. • Consistently report referral and coordination updates to the multidisciplinary medical care team. • Assist PLWHs in making informed decisions on choices of available service providers and resources.	• Documentation of referrals (as applicable) to other services as indicated, with follow-up in the primary client record.
9.14	Refusal of referral The home or community-based health service agency may refuse a referral for the following reasons only: • Based on the agency's perception of the PLWH's condition, the PLWH requires a higher level of care than would be considered reasonable in a home/community setting. The agency must document the situation in writing and immediately contact the client's primary medical care provider.	• Documentation in the primary client record will indicate the reason for refusal

#	STANDARD	MEASURE
9.15	Completion of Services/Discharge Services will end when one or more of the following takes place: • Client acuity indicates self-sufficiency and care plan goals completed; • PLWH expresses desire to discontinue/transfer services; • PLWH is not seen for ninety (90) days or more; and • PLWH has been referred on to a higher level of care (such as assisted living or skilled nursing facility) • PLWH is unable or unwilling to adhere to agency policies. • PLWH relocates out of the service delivery area • When applicable, an employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a PLWH's home, in the company of an escort or not. The agency may discontinue services or refuse the PLWH for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within one (1) business day and followed by a written report. A copy of the police report is sufficient, if applicable. All services discontinued under above circumstances (if applicable) must be accompanied by a referral to an appropriate service provider agency.	• Documentation of a discharge/transfer plan developed with PLWH, as applicable, as indicated in the primary client record.

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 14-16.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 13-15.
Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS Standards of Care for HIV/AIDS Services 2009.
San Francisco EMA Home-Based Home Health Care Standards of Care February 2004.
Texas Administrative Code, Title 40, Part 1, Chapter 97, Subchapter B, Rule 97.211.
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 16-02

RYAN WHITE PART B/DSHS STATE SERVICES
1920 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HOSPICE SERVICES

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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service Hospice services encompass palliative care for terminally ill PLWHs and support services for PLWHs and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a PLWH or a PLWH's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in primary client record.

#	STANDARD	MEASURE
9.2	Scope of Service (Cont'd) Services NOT allowed under this category: • HIV medications under hospice care unless paid for by the PLWH. • Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents. • Funeral, burial, cremation, or related expenses. • Nutritional services, • Durable medical equipment and medical supplies. • Case management services • Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the patient's death, Ryan White funding cannot pay for these services beyond the patient's death per legislation.	
9.3	Client Eligibility In addition to general eligibility criteria, individuals must meet the following criteria in order to be eligible for services. The PLWH's eligibility must be recertified for the program every six (6) months. • Referred by a licensed physician • Certified by his or her physician that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course • Must be reassessed by a physician every six (6) months. • Must first seek care from other facilities and denial must be documented in the resident's primary client record.	• Documentation of elgibility in the primary client record. • Documentation in primary client record that an attempt has been made to place Medicaid/Medicare eligible PLWHs in another facility prior to admission.
9.4	Referral and Tracking Agency receives referrals from a broad range of HIV service providers and makes appropriate referrals out when necessary.	• Documentation of referrals received. • Documentation of referrals out • Staff reports indicate compliance
9.5	Staff Education Agency shall employ staff who are trained and experienced in their area of practice and remain current in end of life issues as it relates to HIV. Staff shall maintain knowledge of psychosocial and end of life issues that may impact the needs of persons living with HIV.	• Staff will attend and has continued access to training activities: • Staff has access to updated HIV information • Agency maintains system for dissemination of HIV information relevant to the needs of PLWH to paid staff and volunteers. • Agency will document provision of in-service education to staff regarding current treatment methodologies and promising practices.

#	STANDARD	MEASURE
9.6	Ongoing Staff Training • Eight (8) hours of training in HIV and clinically-related issues is required annually for licensed staff (in addition to training required in General Standards). • One (1) hour of training in HIV is required annually for all other staff (in addition to training required in General Standards).	• Materials for staff training and continuing education are on file • Documentation of training in personnel file
9.7	Staff Credentials & Experience All hospice care staff who provide direct-care services and who require licensure or certification, must be properly licensed or certified by the State of Texas. A minimum of one year documented hospice and/or HIV work experience is preferred.	• Personnel files reflect requisite licensure or certification. • Documentation of work experience in personnel file
9.8	Staff Requirements Hospice services must be provided under the delegation of an attending physician and/or registered nurse.	• Review of personnel file indicates compliance • Staff interviews indicate compliance.
9.9	Volunteer Assistance Volunteers cannot be used to substitute for required personnel. They may however provide companionship and emotional/spiritual support to patients in hospice care. Volunteers providing patient care will: • Be provided with clearly defined roles and written job descriptions • Conform to policies and procedures	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation of all training in volunteer files • Signed compliance by volunteer
9.10	Volunteer Training Volunteers may be recruited, screened, and trained in accordance with all applicable laws and guidelines. Unlicensed volunteers must have the appropriate State of Texas required training and orientation prior to providing direct patient care. Volunteer training must also address program-specific elements of hospice care and HIV. For volunteers who are licensed practitioners, training addresses documentation practices.	• Review of training curriculum indicates compliance • Documentation of all training in volunteer files
9.11	Staff Supervision Staff services are supervised by a paid coordinator or manager. Professional supervision shall be provided by a practitioner with at least two years experience in hospice care of persons with HIV. All licensed personnel shall receive supervision consistent with the State of Texas licensure requirements. Supervisory, provider or advanced practice registered nurses will document supervision over other staff members	• Review of personnel files indicates compliance. • Review of agency's Policies & Procedures Manual indicates compliance. • Review of documentation that supervisory provider or advanced practice registered nurse provided supervision over other staff members

#	STANDARD	MEASURE
9.12	Facility Licensure Agency/provider is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation or is certified as a Special Care Facility with Hospice designation.	• License and/or certification will be posted in a conspicuous place at the site where services are provided to patients. • Documentation of license and/or certification is available at the site where services are provided to PLWHs
9.13	Denial of Service The hospice provider may elect to refuse a referral for reasons which include, but are not limited to, the following: • There are no beds available • Level of patient's acuity and staffing limitations • Patient is aggressive and a danger to the staff • Patient is a "no show" Agency must develop and maintain s system to inform Administrative Agency regarding issue of long term care facilities denying admission for people living with HIV based on inability to provide appropriate level of skilled nursing care.	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation of notification is available for review.
9.14	Multidisciplinary Team Care Agency must use a multidisciplinary team approach to ensure that patient and the family receive needed emotional, spiritual, physical and social support. The multidisciplinary team may include physician, nurse, social worker, nutritionist, chaplain, patient, physical therapist, occupational therapist, care giver and others as needed. Team members must establish a system of communication to share information on a regular basis and must work together and with the patient and the family to develop goals for patient care.	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in primary client records
9.15	Medication Administration Record Agency documents each patient's scheduled medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff. HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects.	• Documentation in primary client record
9.16	PRN Medication Record Agency documents each patient's PRN medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, outcome, and signature and title of staff.	• Documentation in primary client record

#	STANDARD	MEASURE
9.17	Physician ~~Orders~~ Certification • The attending physician must certify that a PLWH is terminal, defined under Texas Medicaid hospice regulations as having a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification must specify that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification statement must be based on record review or consultation with the referring physician. • The referring provider must provide orders verbally and in writing to the Hospice provider prior to the initiation of care and act as that patient's primary care physician. Provider orders are transcribed and noted by attending nurse.	• Documentation of attending physician certification of PLWH's terminal illness documented in the primary client record. • Documentation in the primary record of all physician orders for initiation of care.
9.18	Intake and Service Eligibility Agency will receive referrals from a broad range of HIV service providers. Information will be obtained from the referral source and will include: • Contact and identifying information (name, address, phone, birth date, etc.) • Language(s) spoken • Literacy level (client self-report) • Demographics • Emergency contact • Household members • Pertinent releases of information • Documentation of insurance status • Documentation of income (including a "zero income" statement) • Documentation of state residency • Documentation of HIV diagnosis • Photo ID or two other forms of identification • Acknowledgement of client's rights	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in primary client records

#	STANDARD	MEASURE
9.19	Comprehensive Health Assessment A comprehensive health assessment, including medical history, a psychosocial assessment and physical examination, is completed for each patient within 48 hours of admission and once every six months thereafter. Symptoms assessment (utilizing standardize tools), risk assessment for falls and pressure ulcers must be part of initial assessment and should be ongoing. Medical history should include the following components: • History of HIV disease progression and other co morbidities • Current symptoms • Systems review • Past history of other medical, surgical or psychiatric problems • Medication history • Family history • Social history • Identifies the patient's need for hospice services in the areas of medical, nursing, social, emotional, and spiritual care. • A review of current goals of care Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.	• Documentation of comprehensive health assessment completed within 48 hours of admission in the primary client record.
9.20	Plan of Care Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient's priorities. A written Plan of Care is completed for each patient within ~~48 hours~~ seven (7) calendar days of admission and reviewed monthly. Care Plans will be updated once every six months thereafter or more frequently as clinically indicated. Hospice care should be based on the USPHS guidelines for supportive and palliative care for people living with HIV (http://hab.hrsa.gov/tools/palliative/contents.html) and professional guidelines. Hospice provider will maintain a consistent plan of care and communicate changes from the initial plan to the referring provider.	• Documentation in primary client record • Written care plan based on physician's orders completed within seven calendar days of admission documented in the primary client record. • Documented evidence of monthly care plan reviews completed in the primary client record.

#	STANDARD	MEASURE
9.21	Counseling Services The need for counseling services for family members must be assessed and a referral made if requested. The need for bereavement and counseling services for family members must be consistent with definition of mental health counseling.	• Documentation in primary client record
9.22	Bereavement Counseling Bereavement counseling must be provided. Bereavement counseling means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment. A hospice must have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. A hospice must: • Develop a bereavement plan of care that notes the kind of bereavement services to be offered to the patient's family and other persons and the frequency of service delivery; • Make bereavement services available to a patient's family and other persons in the bereavement plan of care for up to one year following the death of the patient; • Extend bereavement counseling to residents of a skilled nursing facility, a nursing facility, or an intermediate care facility for individuals with an intellectual disability or related conditions when appropriate and as identified in the bereavement plan of care; • Ensure that bereavement services reflect the needs of the bereaved.	• Referral and/or service provision documented. • Documented evidence of bereavement counseling offered to family members upon admission to Hospice services in the primary client record.
9.23	Dietary Counseling Dietary counseling must be provided. Dietary counseling means education and interventions provided to a patient and family regarding appropriate nutritional intake as a hospice patient's condition progresses. Dietary counseling, when identified in the plan of care, must be performed by a qualified person. • A qualified person includes a dietitian, nutritionist, or registered nurse. A person that provides dietary counseling must be appropriately trained and qualified to address and assure that the specific dietary needs of a PLWH are met.	• Referral and/or service provision documented. • Documented evidence of dietary counseling provided, when identified in the written care plan, in the primary client record.

#	STANDARD	MEASURE
9.24	Mental Health Counseling Mental health counseling must be provided. Mental health counseling should be solution focused; outcomes oriented and time limited set of activities for the purpose of achieving goals identified in the patient's individual treatment plan. Mental Health Counseling is to be provided by a licensed Mental Health professional (see Mental Health Service Standard and Universal Standards for qualifications): • The patient's needs as identified in the patient's psychosocial assessment • The patient's acceptance of these services	• Referral and/or service provision documented. • Documented evidence of mental health counseling offered, as medically indicated, in the primary client record.
9.25	Spiritual Counseling A hospice must provide spiritual counseling that meets the patient's and the family's spiritual needs in accordance with their acceptance of this service and in a manner consistent with their beliefs and desires. A hospice must: • Provide an assessment of the PLWH's and family's spiritual needs; • Make all reasonable efforts to the best of the hospice's ability to facilitate visits by local clergy, a pastoral counselor, or other persons who can support a PLWH's spiritual needs; and • Advise the PLWH and family of the availability of spiritual counseling services.	• Referral and/or service provision documented. • Spiritual counseling, as appropriate, documented in the written care plan in the primary client record.
9.26	Palliative Therapy Palliative therapy is care designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure. Palliative therapy must be documented in the written plan of care with changes communicated to the referring provider.	• Written care plan that documents palliative therapy as ordered by the referring provider documented in the primary client record.
9.27	Medical Social Services Medical social services must be provided by a qualified social worker. and is based on: • The patient's and family's needs as identified in the patient's psychosocial assessment • The patient's and family's acceptance of these services.	• Assessment present in the primary client record. • Documentation in primary client records.

#	STANDARD	MEASURE
9.28	Discharge An individual is deemed no longer to be in need of hospice services if one or more of these criteria is met: • Patient expires. • Patient's medical condition improves, and hospice care is no longer necessary, based on attending physician's plan of care (a referral to Medical Case Management or OAHS must also be documented) • Patient elects to be discharged. • Patient is discharged for cause. • Patient is transferred out of provider's facility.	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation in primary client records. • Percentage of PLWHs in Hospice care with documented evidence of discharge status in the primary client record.

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 16-18.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 15-17.
Texas Administrative code Title 40; Part 1; Chapter 97, Subchapter H Standards Specific to Agencies Licensed to Provide Hospice Services
Texas Department of Aging and Disability Services Texas Medicaid Hospice Program Standards Handbook
HRSA Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds, June 2017

RYAN WHITE PART B/DSHS STATE SERVICES
1920 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC SERVICES

Definition:
Support for Linguistic Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the person living with HIV, when such services are necessary to facilitate communication between the provider and person living with HIV and/or support delivery of Ryan White-eligible services.

#	STANDARD	MEASURE
9.1	Scope of Service The agency will provide interpreter services including, but not limited to, sign language for deaf and/or hard of hearing and native language interpretation for monolingual people living with HIV (PLWH). Services are intended to be inclusive of all cultures and sub-cultures and not limited to any population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by HIV receive quality unbiased services. Due to Ryan White expectations, Services exclude Spanish Translation Services.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in primary client records.
9.2	Staff Qualifications and Training • Oral and written translators will be certified by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of Certification for Medical Interpreters (NBCMI). Staff and volunteers who provide American Sign Language services must hold a certification from the Board of Evaluation of Interpreters (BEI), the Registry of Interpreters for the Deaf (RID), or the National Interpreter Certification (NIC) at a level recommended by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services. • Interpreter staff/agency will be trained and experienced in the health care setting	• Program Policies and Procedures will ensure the contracted agency is in compliance with legislation/regulations • Legislation and Regulations • (Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act
9.3	Program Policies Agency will develop policies and procedures regarding the scheduling of interpreters and process of utilizing the service. Agency will disseminate policies and procedures to providers seeking to utilize the service.	• Review of Program Policies.

#	STANDARD	MEASURE

9.4	Provision of Services
	• Agencies shall provide translation/interpretation services for the date of scheduled appointment per request submitted and will document the type of linguistic service provided in the primary client record.
	• Agency/providers will offer services to the PLWH only in connection with other HRSA approved services (such as clinic visits).
	• Providers will deliver services to the PLWH only to the extent that similar services are not available from another source (such as a translator employed by the clinic). This excludes use of family members of friends of the PLWH
	• Based on provider need, agency shall provide the following types of linguistic services in the PLWH's preferred language:
	  • Oral interpretation
	  • Written translation
	  • Sign language
	• Agency/providers should have the ability to provide (or make arrangements for the provision of) translation services regardless of the language of the PLWH seeking assistance
	• Agency will be able to provide interpretation/ translation in the languages needed based on the needs assessment for the area
		• Review of Program's Policies and Procedures indicate compliance.
		• Documentation that linguistic services are being provided as a component of HIV service delivery between the provider and the PLWH, to facilitate communication between the PLWH and provider and the delivery of RW-eligible services in both group and individual settings.
		• Documented evidence of need of linguistic services as indicated in the PLWH's assessment.
		• Percentage of primary client records with documented evidence of interpretive/translation services provided for the date of service requested.

9.5	Timeliness of Scheduling Agency will schedule service within one (1) business day of the request.	• Review of primary client records indicates compliance.
9.6	Interpreter Certifications All American Sign Language interpreters will be certified in the State of Texas. Level II and III interpreters are recommended for medical interpretation.	• Agency contracts with companies that maintain certified ASL interpreters on staff. • Agency requests denote appropriate levels of interpreters are requested.
9.7	Subcontractor Exclusion: Due to the nature of subcontracts under this service category, the staff training outlined in the General Standards are excluded from being required for interpreters.	• No Measure

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 37-38.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 37-38.
Title VI of the Civil Rights Act of 1964 with respect to individuals with limited English proficiency (LEP).
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 16-02

2019-2020 HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE CARE ACT PART A
STANDARDS OF CARE FOR HIV SERVICES
RYAN WHITE GRANT ADMINISTRATION SECTION
HARRIS COUNTY PUBLIC HEALTH (HCPH)

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Introduction

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

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

Scope
The Houston EMA SOCs apply to Part A funded HRSA defined core and support services including the following services in FY 2019-2020:

- *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
- *Medical Nutrition Supplement*
- *Outreach*
- *Non-Medical Case Management (Service Linkage)*
- *Transportation*
- Linguistic Services
- *Emergency Financial Assistance*
- Referral for Healthcare & Support 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

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

applicable changes. Workgroup participants include physicians, nurses, case managers and executive staff from subcontractor agencies as well as consumers.

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

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

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

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 sixteen (8) hours HIV 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://www.train.org/texas/course/1078713/	• 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 to include information on working with people of all races, ethnicities, nationalities, gender identities, and sexual orientations and an	• Documentation of training is maintained by the agency in the personnel file

	additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire. All staff with greater than 5 years with their current employer must receive two (2) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually.	
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, and position 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	Clients Rights and Responsibilities Agency reviews Client Rights and Responsibilities Statement with each client in a language and format the client understands. Agency provides client with written copy of client rights and responsibilities, including: • Informed consent • Confidentiality • Grievance procedures • Duty to warn or report certain behaviors • Scope of service • Criteria for end of services	• Documentation in client's record
3.2	Confidentiality Agency maintains Policy and Procedure regarding client confidentiality in accordance with RWGA site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency. There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.	• Review of Agency's Policies and Procedures Manual indicates compliance • Clients interview indicates compliance • Agency's structural layout and information management indicates compliance • Signed confidentiality statement in each employee's personnel file
3.3	Consents All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether or not HIV status is revealed.	• Agency Policy and Procedure and signed and dated consent forms in client record
3.4	Up to date Release of Information 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	Conditions Under Which Discharge/Closure May Occur 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	Client Closure A summary progress note is completed in accordance with Site Visit Guidelines within three (3) working days of closure, including: • Date and reason for discharge/closure • Summary of all services received by the client and the client's response to services • Referrals made and/or • Instructions given to the individual at discharge (when applicable)	• Documentation in client record and in the Centralized Patient Care Data Management System
3.8	Client Feedback In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually), Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may include client satisfaction surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a	• Documentation of clients' evaluation of services is maintained • Documentation of CAB and public meeting minutes • Documentation of existence and appropriateness of a suggestion box or other client input mechanism

	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 content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1
3.9	Patient Safety (Core Services Only) Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation *for Ambulatory Care* (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable: • "Improve the accuracy of patient identification • Improve the safety of using medications • Reduce the risk of healthcare-associated infections • Accurately and completely reconcile medications across the continuum of care • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (www.jointcommission.org)	• Review of Agency's Policies and Procedures Manual indicates compliance
3.10	Client Records Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance
4.0	**Accessibility**	
4.1	Cultural Competence Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals and people of all gender identities and sexual orientations	• Agency has procedures for obtaining translation services • Client satisfaction survey indicates compliance • Policies and procedures demonstrate commitment to the community and culture of the clients

		• Availability of interpretive services, bilingual staff, and staff trained in cultural competence • Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record • Agency has facilities available for consumers of all gender identities, including gender-neutral restrooms.
4.2	Client Education Agency demonstrates capacity for client education and provision of information on community resources	• Availability of the blue book and other educational materials • Documentation of educational needs assessment and client education in clients' records
4.3	Special Service Needs Agency demonstrates a commitment to assisting individuals with special needs	• Agency compliance with the Americans with Disabilities Act (ADA). • Review of Policies and Procedures indicates compliance • Environmental Review shows a facility that is handicapped accessible
4.4	Provision of Services for low-Income Individuals Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low income individuals.	• Facility is accessible by public transportation • Review of Agency's Policies and Procedures Manual indicates compliance • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4
4.5	Proof of HIV Diagnosis Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services.	• 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 clients living with HIV are not denied services due to current or pre-existing health condition or non-HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	• Review of Policies and Procedures indicates compliance • A file containing information on clients who have been refused services and the reasons for refusal • Source Citation: HAB Program Standards; Section D: #1
4.7	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 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 status and at least once a year (defined as a 12-month period) with renewed eligibility with the CPCDMS.	• 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 coverage (i.e. hard/scanned copy of results)

	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)	• 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 should maintain a file documenting promotion activities including copies of HIV program materials and information on eligibility requirements.	• Agency has a written substantiated annual plan to targeted populations • Zip code data show provider is reaching clients throughout service area (as applicable to specific service category).

	Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	• Agency 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 that agency notified their Administrative Agency when funds for services were either low or exhausted

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

	• 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 (such as, executive level, direct client services, supervisory staff) must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security: • IS -100.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.	• Agency criteria used to determine appropriate staff for training requirement • Documentation of all training including certificate of completion in personnel file
7.3	Emergency Preparedness Plan The emergency preparedness plan shall address the six critical areas for emergency management including • Communication pathways • 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

Transportation Services

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

1.0	**Transportation services are offered to eligible clients to ensure individuals most in need have access to services.**	
1.1	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/HSDA • Part A Urban Transportation limited to Harris County • Part A Rural/Part B Transportation are limited to Houston EMA/HSDA, as applicable • Income no greater than 300% of the Federal Poverty level • Proof of identification • Documentation of ineligibility for Third Party Reimbursement	• Documentation of HIV+ status, identification, residence and income in the client record
1.2	Voucher Guidelines (Distribution Sites) • Bus Card Voucher (Renewal): Eligible clients who reside in the Metro service area will be issued a Metro bus card voucher by the client's record-owning agency for an annual bus card upon new registration and annually thereafter, within 15 days of bus pass expiration • Bus Card Voucher (Value-Based): Otherwise eligible clients who are not eligible for a renewal bus card voucher may be issued a value-based bus card voucher per RWGA business rules ➢ In order for an existing bus card client to renew their bus card (i.e. obtain another bus card voucher for all voucher types) there must be documentation that the client is engaged in ongoing primary medical care for treatment of HIV, or ➢ Documentation that the bus voucher is needed to ensure an out-of-care client is re-engaged in primary medical care	• Client record indicates guidelines were followed; if not, an explanation is documented • Documentation of the type of voucher(s) issued • Emergency necessitating taxi voucher is documented • Ongoing current **(within the last 180 days)** medical care is documented in the CPCDMS OR • A current (within the last 180 days) copy of client's Viral Load and/or CD4 lab work (preferred) or proof client is on ART (HIV medications) for clients in medical care

	• Gas Card: Eligible clients in the rural area will receive gas cards from their Ryan White Part A/B rural case management provider or their rural primary care provider, if the client is not case managed, per RWGA business rules • Taxi Voucher: for emergencies, to access emergency shelter vouchers and to attend Social Security disability hearings only	with Ryan White or non-Ryan White funded providers in client record OR • Engagement/re-engagement in medical care is documented in client's case management assessment and service plan.
1.3	<u>Eligibility for Van-Based Transportation (Urban Transportation Only)</u> Written certification from the client's principal medical provider (e.g. medical care coordinator) is required to access van-based transportation and must be renewed every 180 days. All clients may receive a maximum of 4 non-certified round trips per year (includes taxi vouchers).	• Client record indicates compliance
2.0	**ACCESSIBILITY** **Transportation services are offered in such a way as to overcome barriers to access and utilization.**	
2.1	<u>Notification of Service Availability</u> Prospective and current clients are informed of service availability, prioritization and eligibility requirements.	• Program information is clearly publicized • Availability of services, prioritization policy and eligibility requirements are defined in the information publicized
2.2	<u>Access</u> Clients must be able to initiate and coordinate their own services with the transportation providers in accordance with transportation system guidelines. This does not mean an advocate (e.g. social worker) for the client cannot assist the client in accessing transportation services. Agency must obtain a signed statement from clients regarding agreement on proper conduct of client in the vehicle. This statement should include the consequences of violating the agreement.	• Agency's policies and procedures for transportation services describe how the client can access the service • Review of agency's complaint and grievances log • Signed agreement in client's records
2.3	<u>Handicap Accessibility</u> Transportation services are handicap accessible. Agency/Driver may refuse service to client with open sores/wounds or real exposure risk.	• Agency compliance with the Americans with Disabilities Act (ADA) • Agency documentation of reason for refusal of service • Documentation of training in personnel records

	Agency must have a policy in place regarding training for drivers on the proper boarding/unloading assistance of passengers with wheel chairs and other durable health devices.	
2.4	EMA Accessibility Services are available throughout the Houston EMA as contractually defined in the RFP.	• Review of agency's Transportation Log and Monthly Activity Reports for compliance
2.5	Service Availability The Contractor must ensure that general transportation service hours are from 7:00 AM to 10:00 PM on weekdays (non-holidays), and coverage must be available for medical and health-related appointments on Saturdays.	• Review of Transportation Logs • Transportation services shall be available on Saturdays, by pre-scheduled appointment for core services • Review of agency policy and procedure
2.6	Service Capacity Agency will notify RWGA and other Ryan White providers when transportation resources are close to being maximized*. Agency will maintain documentation of clients who were refused services. * Maximized means the agency will not be able to provide service to client within the next 72 hours.	• RWGA will be contacted by phone/fax no later than twenty-four (24) working hours after services are maximized • Agency will document all clients who were denied transportation or a voucher
3.0	**Timeliness and Delays: Transportation services are provided in a timely manner**	
3.1	Timeliness There is minimal waiting time for vehicles and vans; appointments are kept • Waiting times longer than 2 hours will also be documented in the client record • If a cumulative incident of clients kept waiting for more than 2 hours reaches 75 clients in the contract year, this must be reported in writing within one business day to the administrative agent • Review of agency's complaint and grievance logs Client interviews and client satisfaction survey	• Waiting times longer than 60 minutes will be documented in Delay Incident Log. • Review of Delay incident log • Review of client's record
3.2	Immediate Service Problems Clients are made aware of problems immediately (e.g. vehicle breakdown) and notification documented.	• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance • Review of agency's complaint and grievance logs

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

3.7	Documentation of Service Utilization Transportation Provider must ensure: • Follow-up verification between transportation provider and destination service program confirming use of eligible service(s) or • Client provides proof of service documenting use of eligible services at destination agency on the date of transportation or • Scheduling of transportation services by receiving agency's case manager or transportation coordinator • In order to mitigate Agency exposure to clients who may fail to follow through with obtaining the required proof of service, Agency is allowed to provide one (1) one-way trip per client per year without proof of service documentation. The content of the proof of service will include: • Agency's letter head • Date/Time • CPCDMS client code • Name and signature of Agency's staff who attended to client • Agency's stamp	• Documentation of confirmation from destination agency in agency/client record • Client's original receipt from destination agency in agency/client record • Documentation in Case Manager's progress notes • Documentation in agency/client record of the one (1) allowable one-way trip per year without proof of service documentation
4.0	**Safety/Vehicle Maintenance: Transportation services are safe**	
4.1	Vehicle Maintenance and Insurance Vehicles are in good repair and equipped for adverse weather conditions. All vehicles will be equipped with both a fire extinguisher and first aid and CPR kits. A file will be maintained on each vehicle and shall include but not be limited to: description of vehicle including year, make, model, mileage, as well as general condition and integrity and service records. Inspections of vehicle should be routine, and documented not less than quarterly. Seat belts/restraint systems must be operational. When in place, child car seats must be operational and installed according to specifications. All lights and turn signals must be operational, brakes must be in good working order, tires must be in good condition and air conditioning/heating system must be fully operational.	• Inspection of First Aid/CPR kits indicates compliance • Review of vehicle file • Current vehicle State Inspection sticker. • Fire extinguisher inspection date must be current • Proof of current automobile liability and personal injury insurance in the amount of at least $300,000.00

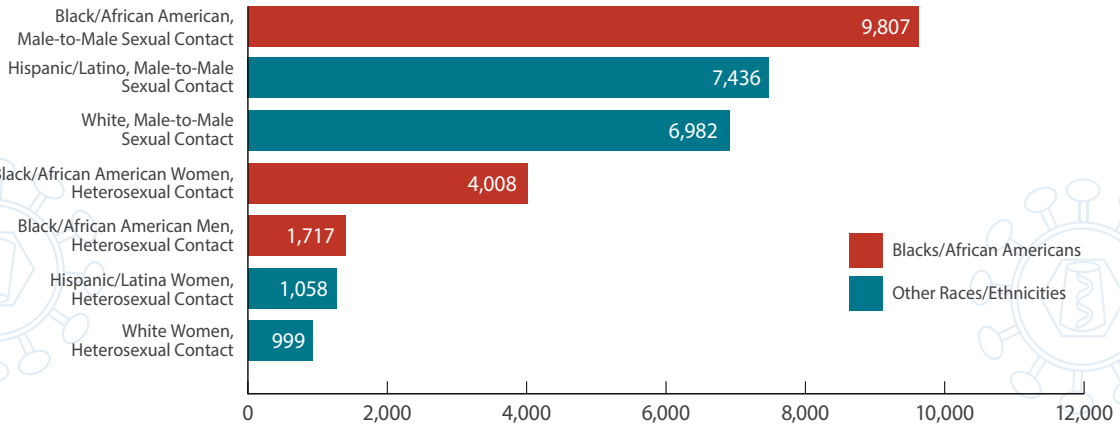
	Driver must have radio or cell phone capability.	
4.2	Emergency Procedures Transportation emergency procedures are in place (e.g. breakdown of agency vehicle). Written procedures are developed and implemented to handle emergencies. Each driver will be instructed in how to handle emergencies before commencing service, and will be in-serviced annually.	• A copy of each in-service and sign-in roster with names both printed and signed and maintained in the driver's personnel file
4.3	Transportation of Children Children must be transported safely. When transporting children, the agency will adhere to the Texas Transportation code 545.412 child Passenger Safety Seat Systems. Information regarding this code can be obtained at http://www.statutes.legis.state.tx.us/docs/tn/htm/tn.545.htm. Necessity of a car seat should be documented on the Transportation Log by staff when appointment is scheduled. Children 15 years old or younger must be accompanied by an adult caregiver in order to be transported.	• Review of Transportation Log indicates compliance • Review of client records indicates compliance • Review of agency policies and procedures
4.4	Staff Requirements Picture identification of each driver must be posted in the vehicle utilized to transport clients. Criminal background checks must be performed on all direct service transportation personnel prior to transporting clients Drivers must have annual proof of a safe driving record, including history of tickets, DWI/DUI, or other traffic violations Conviction on more than three (3) moving violations within the past year will disqualify the driver Conviction of one (1) DWI/DUI within the past three (3) years will disqualify the driver.	• Documentation in vehicle • Documentation in personnel file
5.0	**Records Administration: Transportation services are documented consistently and appropriately**	
5.1	Transportation Consent Prior to receiving transportation services, clients must read and sign the Transportation Consent.	• Review of client records indicates compliance
5.2	Van/Vehicle Transportation Agency must document daily transportation services on the Transportation Log.	• Review of agency files indicates compliance

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

HIV and African Americans

Of the 38,739 new HIV diagnoses in the US and dependent areas* in 2017,
16,694 (43%) were among blacks/African Americans.**

New HIV Diagnoses in the US and Dependent Areas for the Most-Affected Subpopulations, 2017



Hispanics/Latinos can be of any race. Subpopulations representing 2% or less of HIV diagnoses are not reflected in this chart.

From 2010 to 2016, HIV diagnoses decreased 12% among blacks/African Americans overall.† But trends varied for different groups of blacks/African Americans.

Women: **decreased 25%**

Heterosexual men: **decreased 26%**

Gay and bisexual men overall: **remained stable**§

Gay and bisexual men by age:§

- 13 to 24: **decreased 5%**
- 25 to 34: **increased 40%**
- 35 to 44: **decreased 21%**
- 45 to 54: **decreased 30%**
- 55 and older: **remained stable**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

** *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether. This fact sheet uses *African American*, unless referencing surveillance data.

† In 50 states and District of Columbia.

§ Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around 1.1 million people are living with HIV in the US.† People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

AT THE END OF 2015, AN ESTIMATED

468,800

BLACKS/AFRICAN AMERICANS HAD HIV.†

6 in 7

KNEW THEY HAD THE VIRUS.

Why are African Americans at higher risk?

- 1 in 7 blacks/African Americans with HIV are unaware they have it. People who do not know they have HIV cannot take advantage of HIV care and treatment and may unknowingly pass HIV to others.
- Some African American communities continue to experience higher rates of other sexually transmitted diseases (STDs) when compared to other races/ethnicities. Having another STD can significantly increase a person's chance of getting or transmitting HIV.
- Limited access to quality health care, lower income and educational levels, and higher rates of unemployment may place some African Americans at higher risk for HIV.
- Stigma, fear, discrimination, and homophobia may also place many African Americans at higher risk for HIV.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among African Americans.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for African Americans and providing technical assistance.
- Supporting community organizations that can increase access to HIV testing and care and other services for African Americans.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

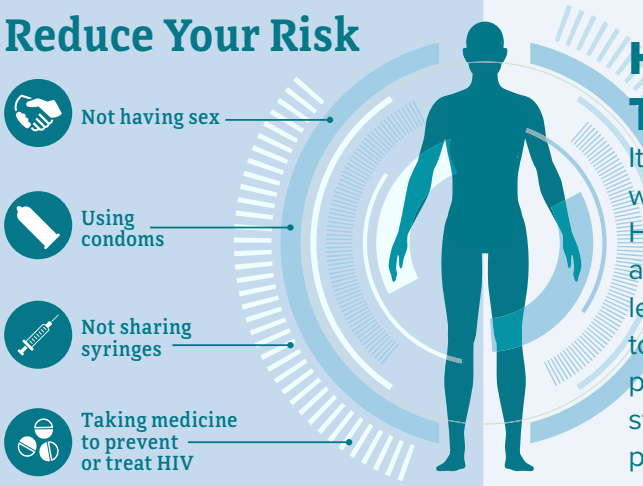
FOR EVERY 100 BLACKS/AFRICAN AMERICANS **WITH HIV IN 2015:**†

60 received some HIV care

46 were retained in care

46 were virally suppressed

Reduce Your Risk



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in February 2019.

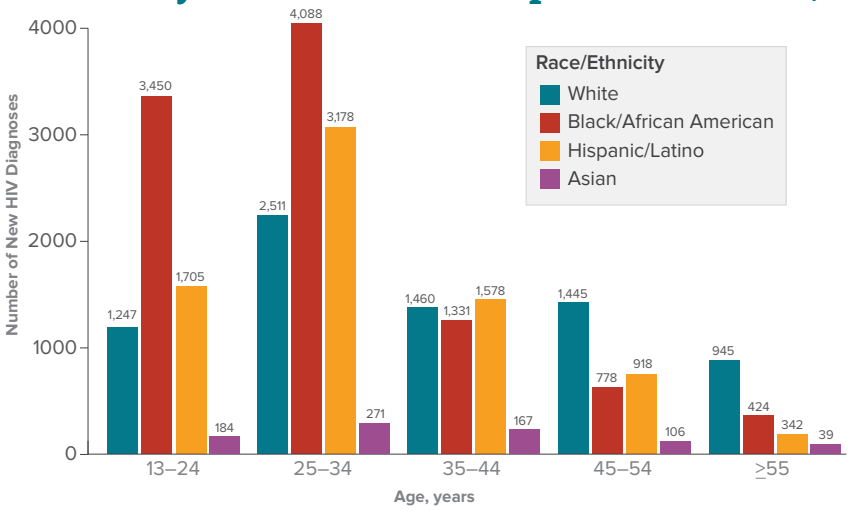
HIV and African American Gay and Bisexual Men

Of the 38,739 new HIV diagnoses in the US and dependent areas* in 2017,
10,070 (26%) were among black/African American gay and bisexual men.*****

Black/African American gay and bisexual men made up 34% of HIV diagnoses among all gay and bisexual men

3 out of 4 black/African American gay and bisexual men who received an HIV diagnosis were aged 13 - 34

New HIV Diagnoses Among Gay and Bisexual Men by Age and Race/Ethnicity in the US and Dependent Areas, 2017***



Subpopulations representing 2% or less of HIV diagnoses among gay and bisexual men are not reflected in this chart. Hispanics/Latinos can be of any race.

From 2010 to 2016, HIV diagnoses remained stable overall among black/African American gay and bisexual men.*** † But trends varied by age.

Black/African American gay and bisexual men overall: **remained stable**	By age:
	13 to 24: **decreased 5%**
	25 to 34: **increased 40%**
	35 to 44: **decreased 21%**
	45 to 54: **decreased 30%**
	55 and older: **remained stable**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

** *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether. This fact sheet uses *African American*, unless referencing surveillance data.

*** Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).

† In 50 states and District of Columbia.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around 1.1 million people are living with HIV in the US.† People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

What places some African American gay and bisexual men at higher risk?

- Many African American gay and bisexual men do not know their HIV status. People who do not know they have HIV cannot get the treatment they need and may pass the infection to others without knowing it.
- African American gay and bisexual men have lower rates of viral suppression compared to gay and bisexual men of other races/ethnicities. Because of the low rates of viral suppression, greater number of people with HIV in that population, and the greater likelihood of having sex partners of the same race, compared with other races/ethnicities, African American gay and bisexual men have a greater chance of coming in contact with HIV.
- Limited access to quality health care, lower income and educational levels, and higher rates of unemployment and incarceration may place some African American gay and bisexual men at higher risk for HIV.
- Stigma, homophobia, and discrimination put gay and bisexual men of all races/ethnicities at risk for many health issues and may affect whether they are able to get quality health care.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among African American gay and bisexual men.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for African American gay and bisexual men and providing technical assistance.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS.*

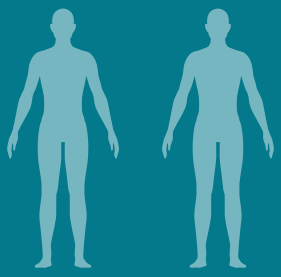
† In 50 states and District of Columbia.

†† "4 in 5" (80%) includes infections attributed to male-to-male sexual contact. Among men with HIV infection attributed to male-to-male sexual contact *and* injection drug use, 95% knew they had HIV.

AT THE END OF 2015, AN ESTIMATED

218,600

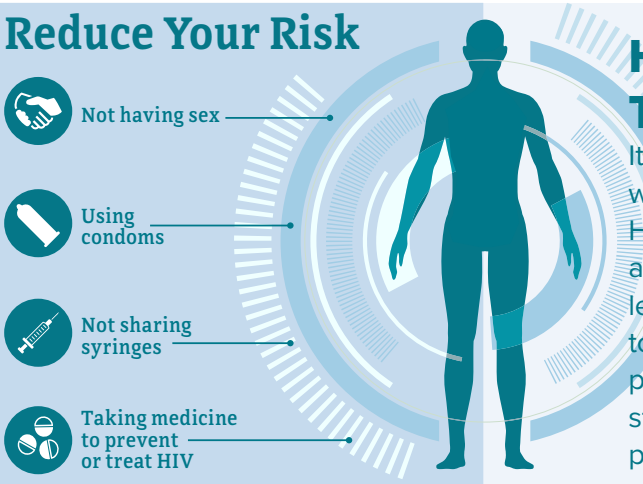
BLACK/AFRICAN AMERICAN GAY AND BISEXUAL MEN HAD HIV.†



4 in 5

KNEW THEY HAD THE VIRUS.††

Reduce Your Risk



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in February 2019.

HIV and Hispanics/Latinos

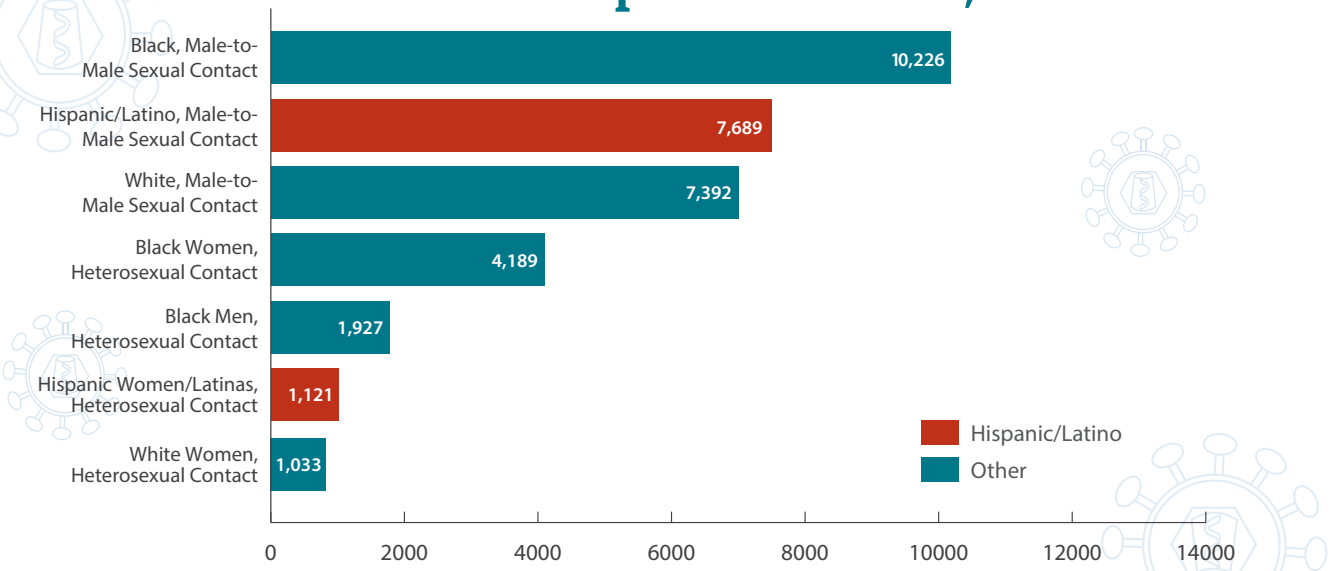
OF THE 40,324 HIV DIAGNOSES IN THE US AND 6 DEPENDENT AREAS IN 2016:*

10,292 (26%) WERE AMONG HISPANICS/ LATINOS**

8,999 (22%) WERE AMONG HISPANIC/ LATINO MEN

1,277 (3%) WERE AMONG HISPANIC WOMEN/LATINAS

HIV Diagnoses Among the Most-Affected Subpopulations in the US and 6 Dependent Areas, 2016



From 2011 to 2015, HIV diagnoses remained stable among all Hispanics/Latinos.

HIV diagnoses fell **14%** among Hispanic women/Latinas.

HIV diagnoses increased **13%** among all Hispanic/ Latino gay and bisexual men.

HIV diagnoses increased **19%** among young Hispanic/Latino gay and bisexual men aged 13 - 24.

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
** Hispanics/Latinos can be of any race.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around 1.1 million people have HIV in the US.† People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

AT THE END OF 2015, AN ESTIMATED **252,400** **HISPANICS/LATINOS** HAD HIV.†

5 in 6 KNEW THEY HAD THE VIRUS.

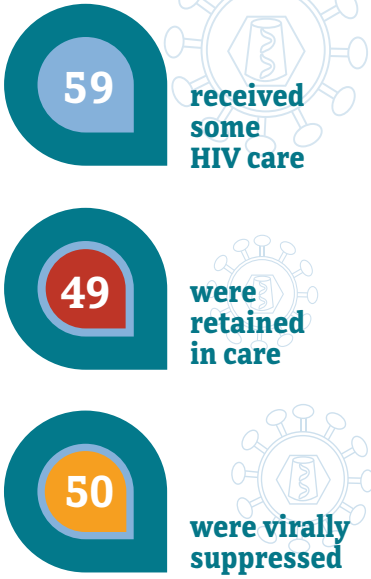
What places some Hispanics/Latinos at higher risk?

- Many Hispanics/Latinos do not know their HIV status. People who do not know they have HIV cannot get the treatment they need and may pass the infection to others without knowing it.
- More Hispanics/Latinos have HIV compared to some other races/ethnicities. Therefore, Hispanics/Latinos have an increased chance of having an HIV-positive partner if they have other Hispanic/Latino partners.
- Hispanics/Latinos have higher rates of some STDs. Having another STD can increase a person's chance of getting or transmitting HIV.
- Poverty, migration patterns, lower educational level, and language barriers may make it harder for some Hispanics/Latinos to get HIV testing and care.
- Stigma, fear, discrimination, and homophobia may impact the lives of some Hispanics/Latinos. These issues may put some Hispanics/Latinos at higher risk for HIV infection.

How is CDC making a difference?

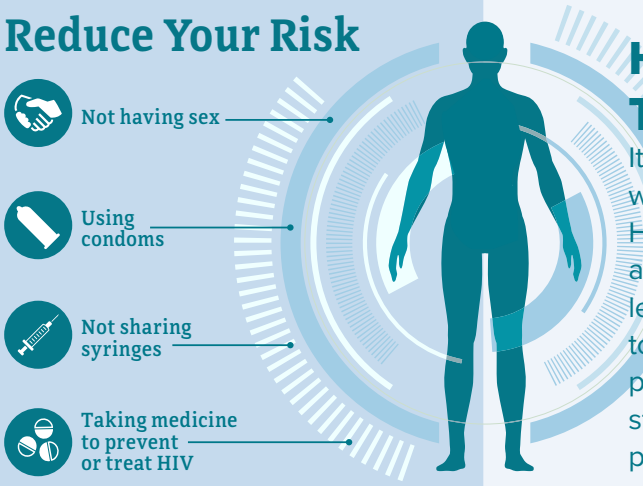
- Collecting and analyzing data and monitoring HIV trends among Hispanics/Latinos.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for Hispanics/Latinos and providing technical assistance.
- Supporting community organizations that can increase access to HIV testing and care and other services for Hispanics/Latinos.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS.*

FOR EVERY 100 HISPANICS/LATINOS **WITH HIV IN 2015:†**



† In 50 states and District of Columbia.

Reduce Your Risk



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in October 2018.

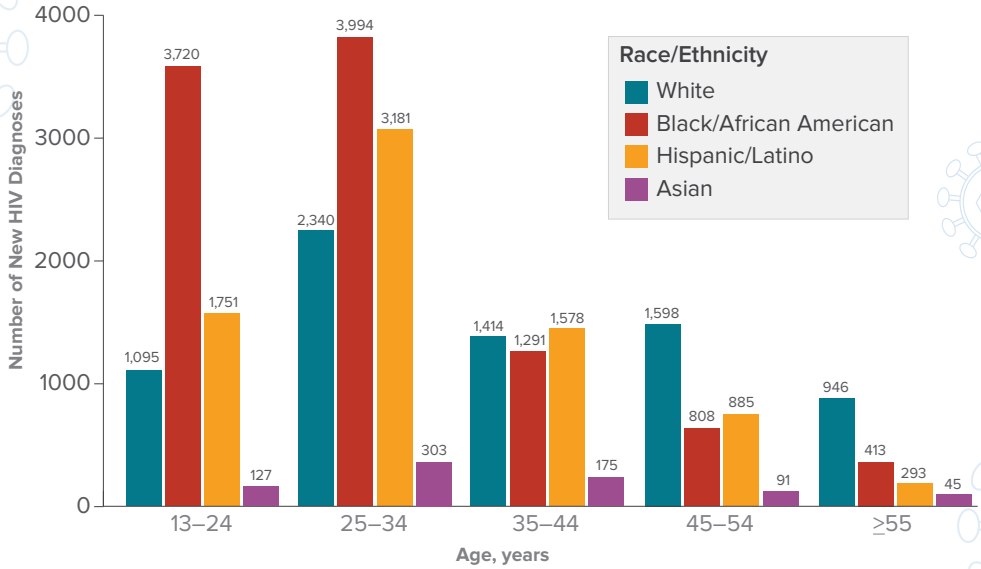
HIV and Hispanic/Latino Gay and Bisexual Men

OF THE 40,324 HIV DIAGNOSES IN THE US AND 6 DEPENDENT AREAS IN 2016:*
7,689 (19%) WERE AMONG HISPANIC/LATINO GAY AND BISEXUAL MEN**

HISPANIC/LATINO GAY AND BISEXUAL MEN ACCOUNTED FOR 29% OF HIV DIAGNOSES AMONG ALL GAY AND BISEXUAL MEN

ABOUT 2 OUT OF 3 HISPANIC/LATINO GAY AND BISEXUAL MEN WHO RECEIVED AN HIV DIAGNOSIS WERE AGED 13 - 34

HIV Diagnoses Among Gay and Bisexual Men by Age and Race/Ethnicity in the US and 6 Dependent Areas, 2016



Subpopulations representing 2% or less of HIV diagnoses among gay and bisexual men are not reflected in this chart.

HIV Diagnoses From 2011 to 2015

Increased **13%** among Hispanic/ Latino gay and bisexual men

Increased **19%** among Hispanic/ Latino gay and bisexual men aged 13 to 24

Increased **21%** among Hispanic/ Latino gay and bisexual men aged 25 to 34

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
** Hispanics/Latinos can be of any race.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around 1.1 million people are living with HIV in the US.[†] People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

AT THE END OF 2015, AN ESTIMATED

151,200

HISPANIC/LATINO GAY AND BISEXUAL MEN

HAD HIV.[†]

4 in 5

KNEW THEY HAD THE VIRUS.

Why are some Hispanic/Latino gay and bisexual men at higher risk?

- An estimated 80% of Hispanic/Latino gay and bisexual men with HIV know they have it.[†] People who do not know they have HIV cannot get the treatment they need and may transmit HIV to others without knowing it.
- Hispanic/Latino gay and bisexual men are more likely to report that their last sex partner was older, compared to white or African American gay and bisexual men. Having older male partners may increase the likelihood of being exposed to HIV.
- Overall, a very small number of Hispanic/Latino gay and bisexual men reported using PrEP, and a much lower number than white gay and bisexual men.
- Poverty, migration patterns, lower educational level, and language barriers may make it harder for Hispanic/Latino gay and bisexual men to get HIV testing and care.
- Immigration status of some Hispanic/Latino gay and bisexual men may make them less likely to use HIV prevention services, get tested, or get treated if they have HIV because of lack of access.
- Stigma, homophobia, and discrimination put gay and bisexual men of all races/ethnicities at risk for many health issues and may affect whether they are able to get quality health care.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among Hispanic/Latino gay and bisexual men.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for Hispanic/Latino gay and bisexual men and providing technical assistance.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

FOR EVERY 100 HISPANIC/LATINO GAY AND BISEXUAL MEN **WHO RECEIVED AN HIV DIAGNOSIS IN 2013 OR EARLIER:**[‡]

71 received some HIV care

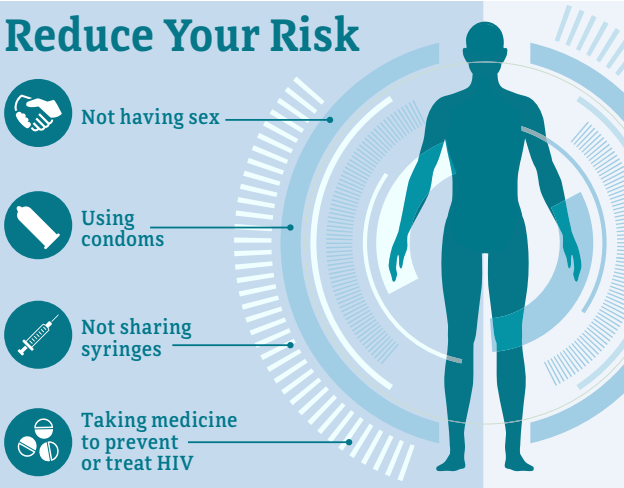
58 were retained in care

61 were virally suppressed

[†] In 50 states and District of Columbia

[‡] In 37 states and District of Columbia. These jurisdictions are included because they had complete reporting of CD4 and viral load results to CDC.

Reduce Your Risk



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

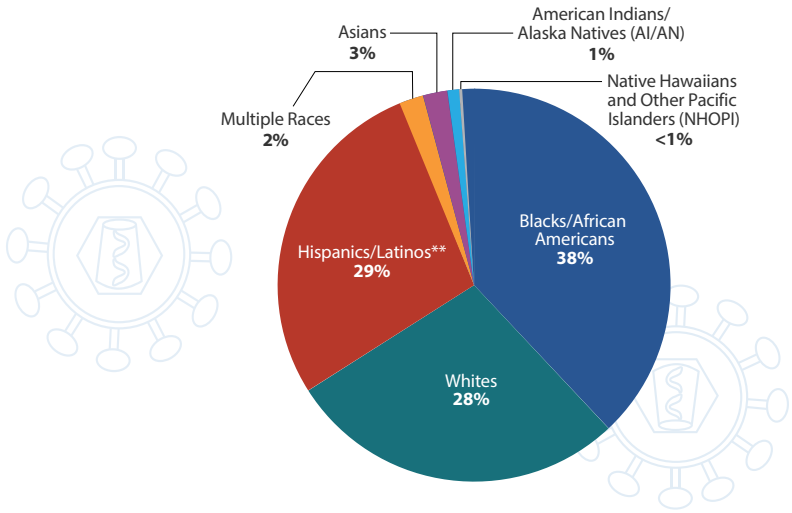
All content is based on the most recent data available in September 2018.

HIV and Gay and Bisexual Men

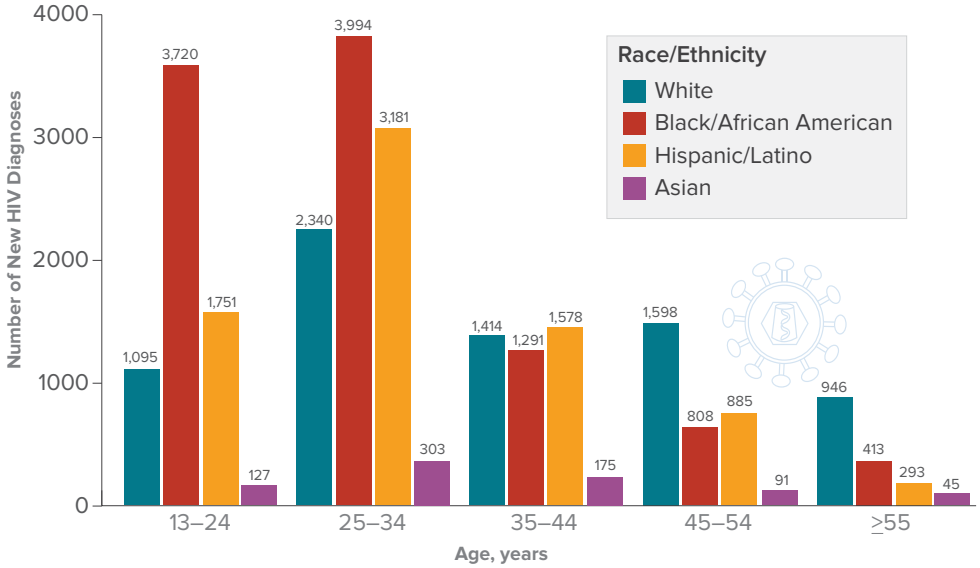
OF THE 40,324 HIV DIAGNOSES IN THE US AND 6 DEPENDENT AREAS IN 2016:*

26,844 (67%) WERE AMONG GAY AND BISEXUAL MEN

HIV Diagnoses Among Gay and Bisexual Men by Race/Ethnicity in the US and 6 Dependent Areas, 2016



HIV Diagnoses Among Gay and Bisexual Men by Age and Race/Ethnicity in the US and 6 Dependent Areas, 2016



Subpopulations representing 2% or less of HIV diagnoses among gay and bisexual men are not reflected in this chart.

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
** Hispanics/Latinos can be of any race.

From 2011 to 2015, HIV diagnoses remained stable among all gay and bisexual men.

HIV diagnoses increased **13%** among Hispanic/Latino gay and bisexual men.

HIV diagnoses increased **21%** among gay and bisexual men aged 25 - 34.

HIV diagnoses increased **35%** among Asian gay and bisexual men.

HIV diagnoses remained stable among young gay and bisexual men aged 13 - 24.

HIV diagnoses fell **15%** among gay and bisexual men aged 35 - 44.

HIV diagnoses fell **10%** among white gay and bisexual men.

Around 1.1 million people are living with HIV in the US.† People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

AT THE END OF 2015, AN ESTIMATED

632,300

GAY AND BISEXUAL MEN

HAD HIV.†

5 in 6

KNEW THEY HAD THE VIRUS.

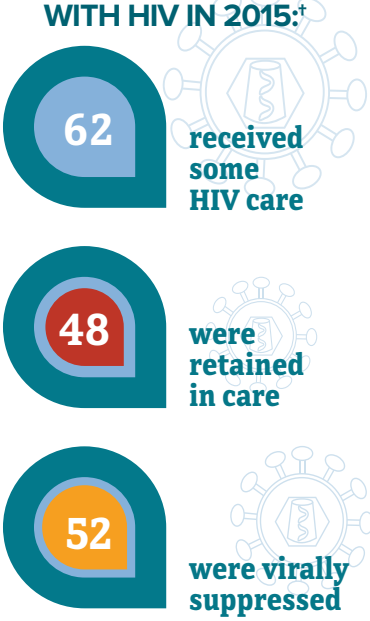
What places some gay and bisexual men at higher risk?

- More gay and bisexual men have HIV compared to any other group in the United States. Therefore, gay and bisexual men have a higher chance of having an HIV-positive partner.
- 1 in 6 gay and bisexual men with HIV are unaware they have it. People who do not know they have HIV cannot get the treatment they need and may pass the infection to others without knowing it. Among African American gay and bisexual men with HIV, a lower percentage know their status compared to HIV-positive gay and bisexual men of some other races/ethnicities.
- Most gay and bisexual men get HIV through having anal sex without condoms or medicines to prevent or treat HIV. Anal sex is the riskiest type of sex for getting or transmitting HIV.
- Gay and bisexual men are at increased risk for STDs, like syphilis, gonorrhea, and chlamydia. Having another STD can significantly increase a person's chance of getting or transmitting HIV.
- Stigma, homophobia, and discrimination put gay and bisexual men of all races/ethnicities at risk for many health issues and may affect whether they are able to get quality health care.

How is CDC making a difference?

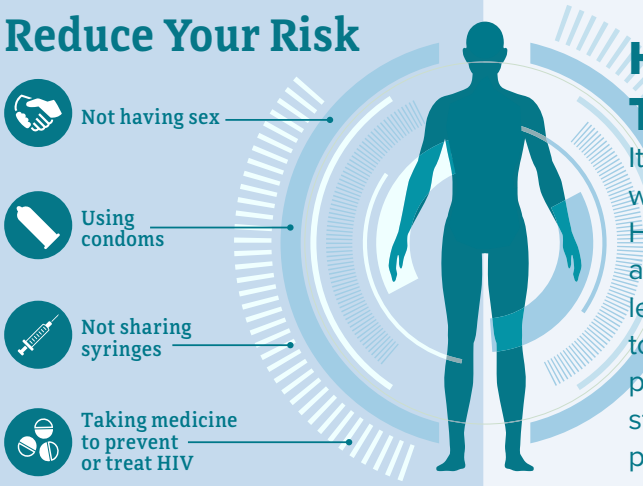
- Collecting and analyzing data and monitoring HIV trends among gay and bisexual men.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for gay and bisexual men and providing technical assistance.
- Supporting community organizations that can increase access to HIV testing and care and other services for gay and bisexual men.
- Promoting testing, prevention, and treatment through *Act Against AIDS* campaigns that feature gay and bisexual men, such as *Start Talking. Stop HIV., Doing It,* and *HIV Treatment Works*.

FOR EVERY 100 GAY AND BISEXUAL MEN WITH HIV IN 2015:†



† In 50 states and District of Columbia.

Reduce Your Risk



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in September 2018.

HIV and Older Americans

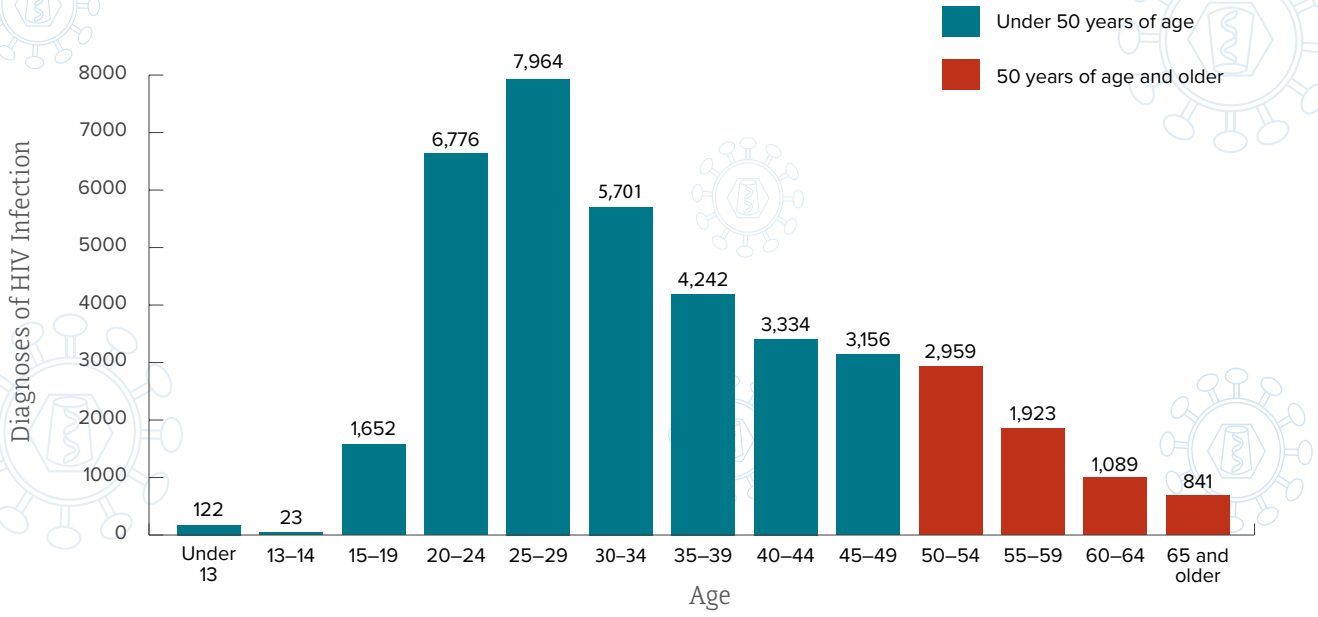
OF THE 39,782 HIV DIAGNOSES IN THE US IN 2016:

6,812 (17%) WERE AGED 50 AND OLDER.

Among people aged 50 and older who received an HIV diagnosis:

- 49% were gay and bisexual men
- 15% were heterosexual men
- 24% were heterosexual women
- 12% were people who inject drugs*

HIV Diagnoses by Age, 2016, United States



From 2011 to 2015 HIV diagnoses among all people aged 50 and older decreased by 7%.

* *People who inject drugs* includes infections attributed to injection drug use and other sexual risk factors.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around 1.1 million people are living with HIV in the US. People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

A person living with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to a negative partner.

Aging with HIV infection presents special challenges for preventing other diseases because both age and HIV increase risk for heart disease, bone loss, and certain cancers.

Unfortunately, thousands of Americans still die each year from HIV. In 2015, 2,749 people aged 55 and older died from HIV disease.

AT THE END OF 2015, AN ESTIMATED

298,200

PEOPLE OVER 55

HAD HIV.

95%

KNEW THEY HAD HIV

Why are older Americans at risk?

- Older people in the United States are more likely than younger people to have AIDS at the time of diagnosis, which means they start treatment late and may suffer more immune-system damage.
- Older people have the same HIV risk factors as younger people, but may not be as knowledgeable about prevention.
- Although they visit their doctors more often, older people are less likely than younger people to talk about their sexual or drug use behaviors with their doctors.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among older Americans.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments, education agencies, and community organizations by funding HIV prevention work for older Americans and providing technical assistance.
- Promoting testing, prevention and treatment through campaigns like *Act Against AIDS*.

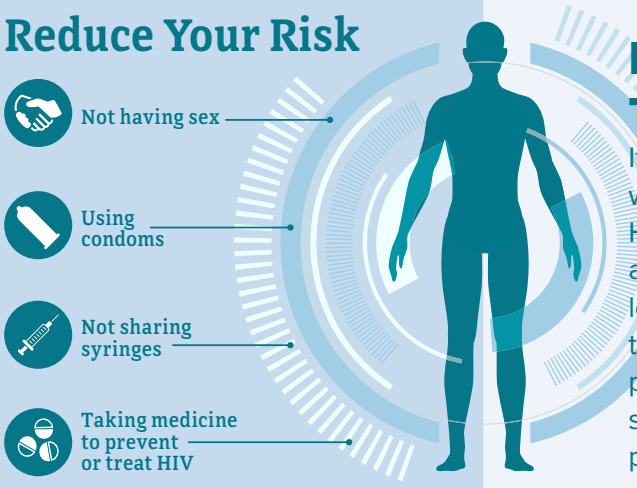
FOR EVERY 100 PEOPLE AGED 55 AND OLDER LIVING WITH HIV IN THE US IN 2015:

69 received some HIV care

56 were retained in care

60 were virally suppressed

Reduce Your Risk



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in September 2018.

HIV and Youth

OF THE 39,782 HIV DIAGNOSES IN 2016:

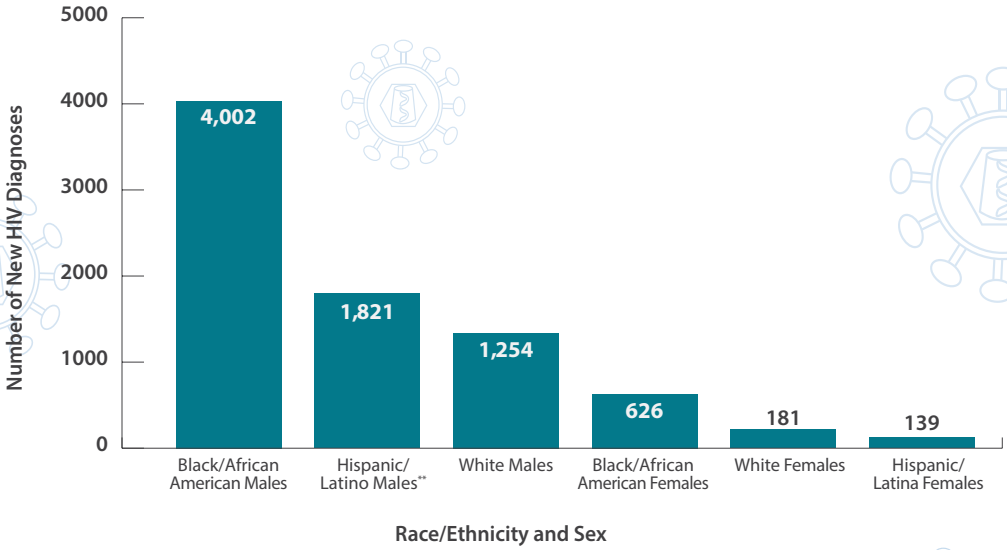
8,451 WERE AMONG YOUTH* AGED 13 - 24

6,848 WERE AMONG YOUNG GAY AND BISEXUAL MEN

4 OUT OF 5 YOUTH DIAGNOSED WITH HIV WERE AGED 20 - 24

21% OF ALL NEW HIV DIAGNOSES IN THE US WERE AMONG YOUTH

HIV Diagnoses Among Youth in the United States, by Race/Ethnicity and Sex, 2016



Subpopulations representing 2% or less of all people who received an HIV diagnosis in 2016 are not represented in this chart.

From 2011 to 2015, HIV diagnoses among youth remained stable overall.***

- remained stable among young African American and white gay and bisexual men
- increased 19% among young Hispanic/ Latino gay and bisexual men
- fell 25% among young women
- remained stable among young people who inject drugs

* Unless otherwise noted, people aged 13 to 24 are referred to as *youth* or *young* in this fact sheet.

** Hispanics/Latinos can be of any race.

*** From 2010 to 2015, new HIV infections (incidence) fell 24% among youth. Incidence data includes the number of people who get HIV (both diagnosed and undiagnosed) each year. Diagnosis data includes the number of people receiving an HIV diagnosis each year (regardless of the year they were infected). In general, any difference between an incidence trend and a diagnosis trend can be attributed to HIV testing and diagnosis.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around 1.1 million people are living with HIV in the US. People living with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable. A person living with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

Unfortunately, thousands of Americans still die each year from HIV. In 2015, 100 youth aged 15 to 24 died from HIV disease.

AT THE END OF 2015, AN ESTIMATED

60,300

YOUTH WERE LIVING WITH HIV.

1 in 2

DIDN'T KNOW THEY WERE LIVING WITH THE VIRUS

What places some young people at higher risk?

- Many students are not getting the sexual health education they need, and sex education is not starting early enough.
- Certain risk behaviors put youth at higher risk for HIV, including low HIV testing rates, substance use, low rates of condom use, and multiple sex partners. Research has also shown that young gay and bisexual men who have sex with older partners are at a greater risk for HIV infection.
- Youth aged 20 to 24, especially youth of color, have some of the highest STD rates. Having another STD can significantly increase a person's chance of getting or transmitting HIV.
- Many young people avoid talking about HIV with their sex partners.
- Stigma, fear, homophobia, isolation, and lack of support may also place many youth at higher risk for HIV.

How is CDC making a difference?

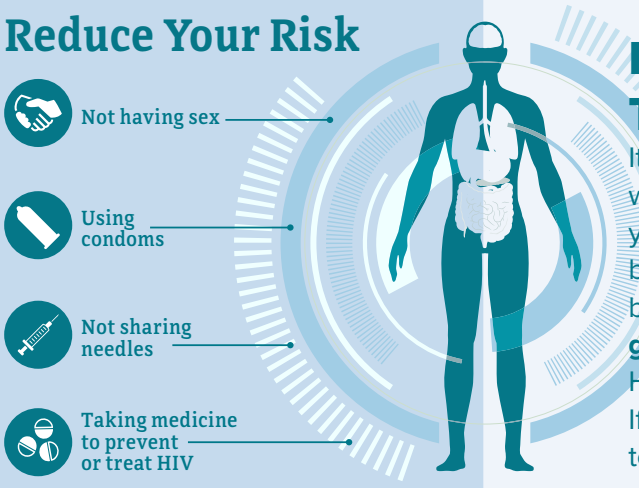
- Collecting and analyzing data and monitoring HIV trends among youth.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments, education agencies, and community organizations by funding HIV prevention work for youth and providing technical assistance.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

Visit **www.cdc.gov/hiv** and **www.cdc.gov/healthyyouth** for more information about CDC's HIV prevention activities among youth.

FOR EVERY 100 YOUNG PEOPLE LIVING WITH HIV IN 2014:

- **41** received some HIV care
- **31** were retained in care
- **27** were virally suppressed

Reduce Your Risk



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing needles with a person who is living with HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you are living with HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

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Visit www.cdc.gov/hiv

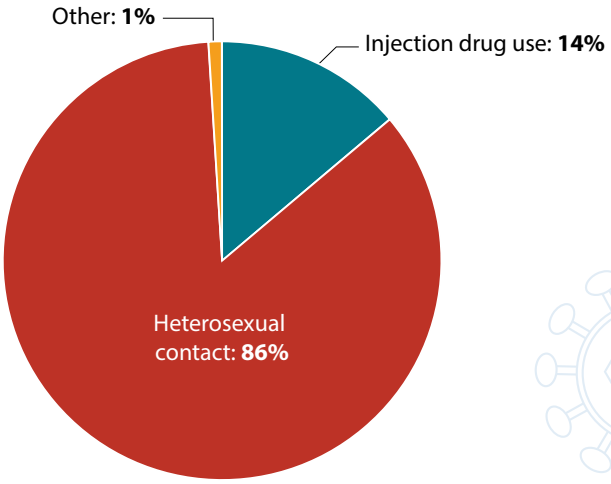
All content is based on the most recent data available in April 2018.

HIV and Women

OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017,
7,401 (19%) WERE AMONG WOMEN.

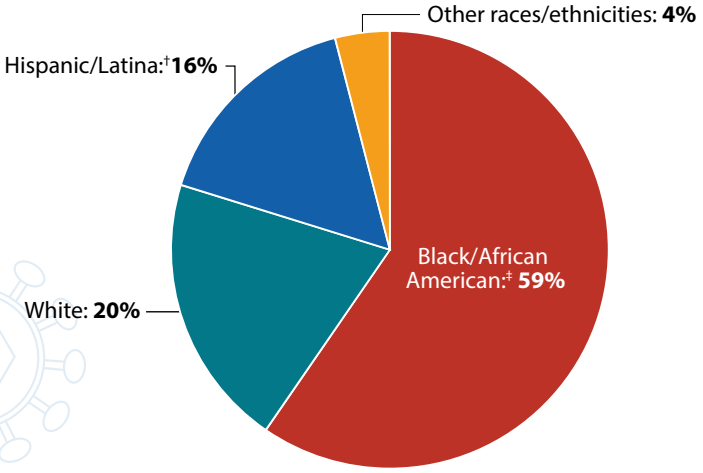
New HIV Diagnoses Among Women in the US and Dependent Areas in 2017

By Transmission Category



Total may not equal 100% due to rounding.

By Race/Ethnicity



Total may not equal 100% due to rounding.

From 2010 to 2016, HIV diagnoses decreased 21% among women overall.**
But trends varied for different groups of women.

Women overall: down 21%

Black/African American: down 25%

Hispanic/Latina: down 20%

White: remained stable

Women by age:
13 to 24: **down 32%**
25 to 34: **down 13%**
35 to 44: **down 27%**
45 to 54: **down 27%**
55 and older: **remained stable**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Hispanics/Latinas can be of any race.
‡ *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether.
** In 50 states and District of Columbia.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Around 1.1 million people are living with HIV in the US.** People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

AT THE END OF 2016, AN ESTIMATED

258,000

WOMEN HAD HIV.**

8 in 9

KNEW THEY HAD THE VIRUS.

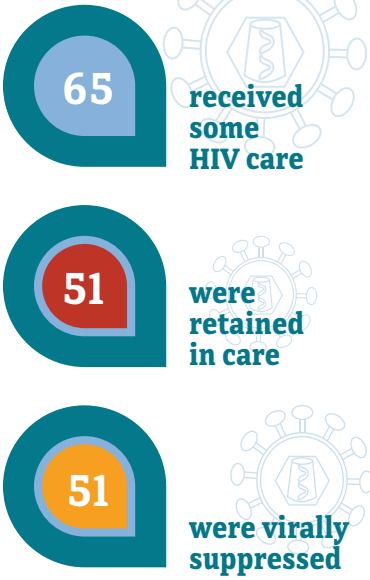
What places some women at higher risk?

- 1 in 9 women with HIV are unaware they have it. People who do not know they have HIV cannot take advantage of HIV care and treatment and may unknowingly pass HIV to others.
- Sexually transmitted diseases, like gonorrhea and syphilis, may place some women at higher risk for HIV.
- Some women don't know their male partner's risk factors for HIV (such as injection drug use or having sex with men) and may not use condoms or medicines to prevent HIV.
- Women have a higher risk for getting HIV during vaginal or anal sex than their sex partners. The riskiest behavior for getting HIV is receptive anal sex.
- Women who have been sexually abused may be more likely to engage in risky behaviors like exchanging sex for drugs, having multiple sex partners, or having sex without a condom.

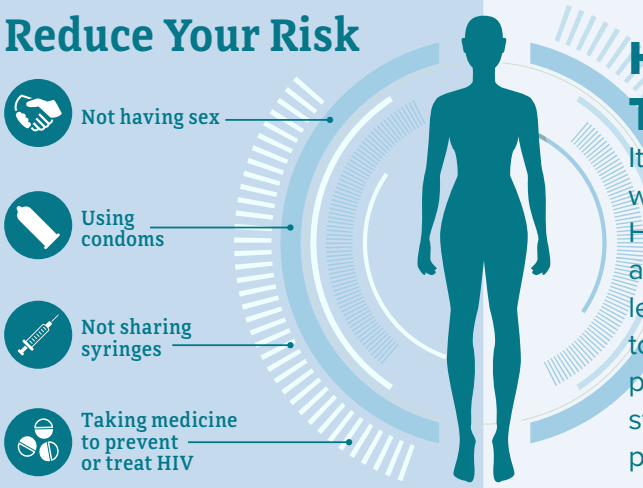
How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among women.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for women and providing technical assistance.
- Supporting community organizations that can increase access to HIV testing and care and other services for women.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

FOR EVERY 100 WOMEN WITH HIV IN 2015:**



Reduce Your Risk



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in March 2019.

HIV and Pregnant Women, Infants, and Children

HIV can be passed from mother to child anytime during pregnancy, childbirth, and breastfeeding. This is called *perinatal* transmission.

BUT THERE IS GOOD NEWS:

For a woman with HIV, the risk of transmitting HIV to her baby can be **1% OR LESS** if she:

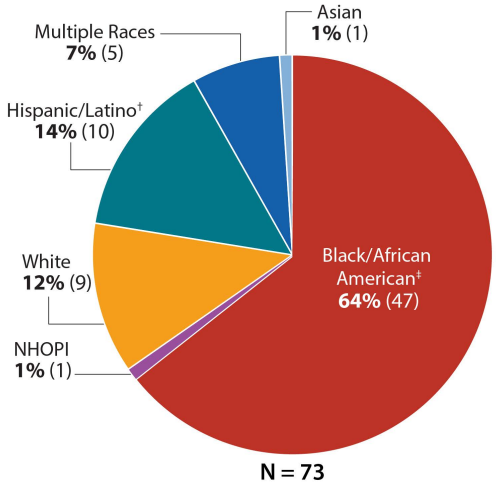
- **Takes HIV medicine daily as prescribed throughout pregnancy and childbirth.**
- **Gives HIV medicine to her baby for 4-6 weeks after giving birth.**
- **Does NOT breastfeed or pre-chew her baby's food.**

If you are pregnant or planning to get pregnant, **get tested for HIV** as soon as possible. If you have HIV, the sooner you start treatment the better—for your health and your baby's health and to prevent transmitting HIV to your sexual partner.

73 diagnoses of perinatal HIV in the US in 2017*

From 2012 to 2016, perinatal diagnoses: **decreased 41%**

Diagnoses of Perinatal HIV Infections in the US and Dependent Areas by Race/Ethnicity, 2017



* Unless otherwise noted, the term *United States* (US) includes the 50 states, the District of Columbia, and the 6 dependent areas of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

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National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Women who are pregnant or trying to get pregnant should encourage their partner to get tested for HIV also. If either partner has HIV, that partner should take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

HIV-negative women who have a partner with HIV should ask their doctor about taking HIV medicine daily, called pre-exposure prophylaxis (PrEP), to protect themselves and their baby.

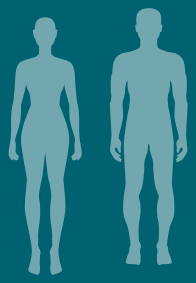
Why are pregnant women and their babies at risk?

- Preconception care and family planning services are often not provided in HIV care settings.
- Women with HIV may not know they are pregnant, how to prevent or safely plan a pregnancy, or what they can do to reduce the risk of transmitting HIV to their baby.
- The risk of transmitting HIV to the baby is much higher if the mother does not stay on HIV treatment throughout pregnancy and childbirth, or if HIV medicine is not provided to her baby. The risk is also higher if she gets HIV during pregnancy.
- Social and economic factors, especially poverty, may make it harder for some women with HIV to access health care and stay on treatment.

How is CDC making a difference?

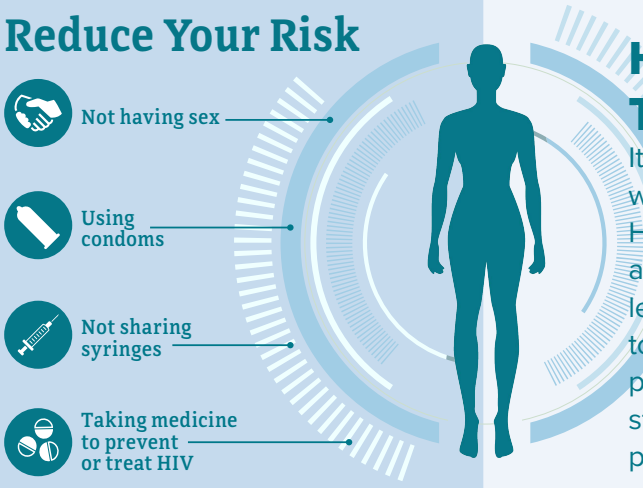
- CDC created a framework (www.cdc.gov/hiv/group/gender/pregnantwomen/emct.html) to help federal agencies and other groups lower the rate of perinatal HIV transmission to less than 1% and reduce the number of cases of perinatal HIV to less than one per 100,000 live births.
- CDC helps lead the Elimination of Mother-to-Child HIV Transmission Stakeholders Group, a group that develops and implements strategies to advance the elimination of perinatal HIV.
- CDC collaborated with and funded partners to develop a continuous quality improvement method that helps local health systems address missed prevention and treatment opportunities for pregnant women with HIV.
- CDC funds perinatal HIV prevention through Integrated Human Immunodeficiency Virus Surveillance and Prevention Programs for Health Departments (www.cdc.gov/hiv/funding/announcements/ps18-1802), and promotes HIV testing and treatment for pregnant women.

By the end of 2016 in the US, 11,915 people were living with HIV they got through perinatal transmission.



1,814 of them were children under the age of 13.

Reduce Your Risk



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For More Information

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HIV and Transgender People

HIV Diagnoses in the US, 2009-2014

2,351 TRANSGENDER PEOPLE RECEIVED AN HIV DIAGNOSIS. OF THESE:

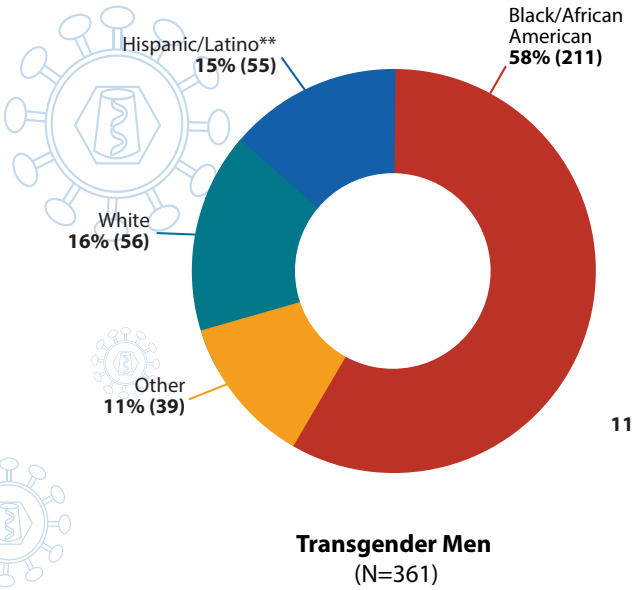
84% WERE TRANSGENDER WOMEN

15% WERE TRANSGENDER MEN*

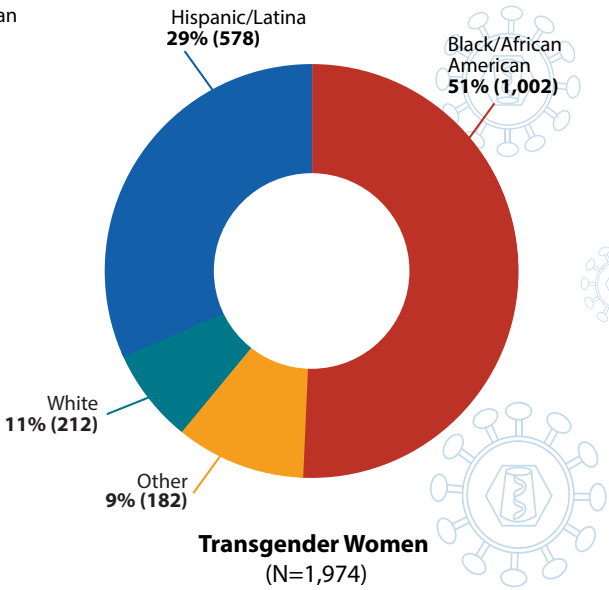
ABOUT HALF LIVED IN THE SOUTH

- ***Transgender:*** people whose gender identity or expression is different from their sex assigned at birth.
- ***Gender identity:*** person's internal understanding of their own gender.
- ***Gender expression:*** person's outward presentation of their gender (example, how they dress).
- ***Transgender women:*** people who were assigned the male sex at birth but identify as women.
- ***Transgender men:*** people who were assigned the female sex at birth but identify as men.

HIV Diagnoses Among Transgender People in the United States by Race/Ethnicity, 2009-2014



Transgender Men
(N=361)



Transgender Women
(N=1,974)

* Less than 1% had another gender identity
** Hispanics/Latinos can be of any race

Around 1.1 million people are living with HIV in the US. People living with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable. A person living with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

Why are transgender people at higher risk?

- Some things that may put transgender people at higher risk for getting or transmitting HIV include multiple sexual partners, anal or vaginal sex without condoms or medicines to prevent or treat HIV, and sharing syringes to inject hormones or drugs.
- Many transgender people face stigma, discrimination, social rejection, and exclusion. These factors may affect their well-being and put them at increased risk for HIV.
- HIV prevention programs designed for other at-risk groups may not address all the needs of transgender people.
- When health care providers are not sensitive to transgender issues, this can be a barrier for transgender people living with HIV and looking for treatment and care.
- Current HIV testing programs may not be enough to reach transgender women and men.

How is CDC making a difference?

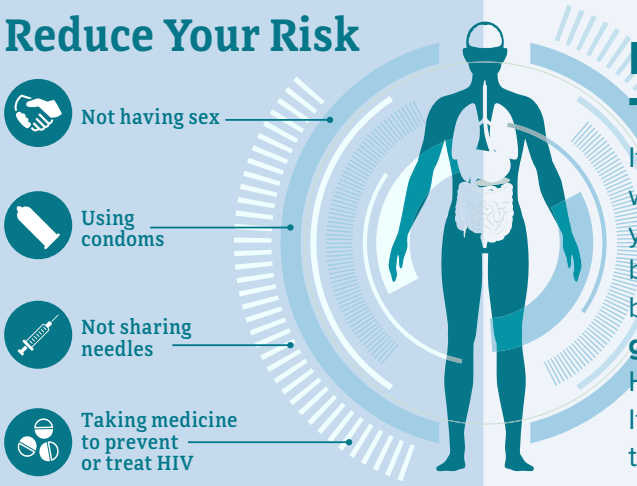
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for transgender people and providing technical assistance.
- Helping health care providers improve care for transgender people living with HIV.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

Visit **www.cdc.gov/hiv** for more information about CDC's HIV prevention activities among transgender people.

According to current estimates, around a quarter (22-28%) of transgender women are living with HIV.

An estimated 56% of black transgender women were living with HIV—the highest percentage among all transgender women.

Reduce Your Risk



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All content is based on the most recent data available in April 2018.

TEXAS Health and Human Services

Texas Department of State Health Services

2016 HIV Surveillance Data among PLWH who are Transgender

Jie Deng
Epidemiology and Supplemental Projects Group
TB/HIV/STD Epidemiology and Surveillance Branch
April, 2017

Introduction

- **Preliminary** HIV surveillance data overview among PLWH who are transgender
- Data update regarding gender identity in HIV surveillance system is still in progress
- Since this data is fairly new, it's important to remember that we are likely undercounting the true number. **The numbers in this slide set are provisional**

Overview

New HIV diagnoses, People Living with HIV, and Deaths among PLWH who are Transgender in Texas

- In 2016, there were 683 Transgender Women and 88 Transgender Men living with HIV in Texas. That year, 73 Transgender Women and 13 Transgender Men were newly diagnosed with HIV.
- 10 Transgender Women living with HIV died in 2014.

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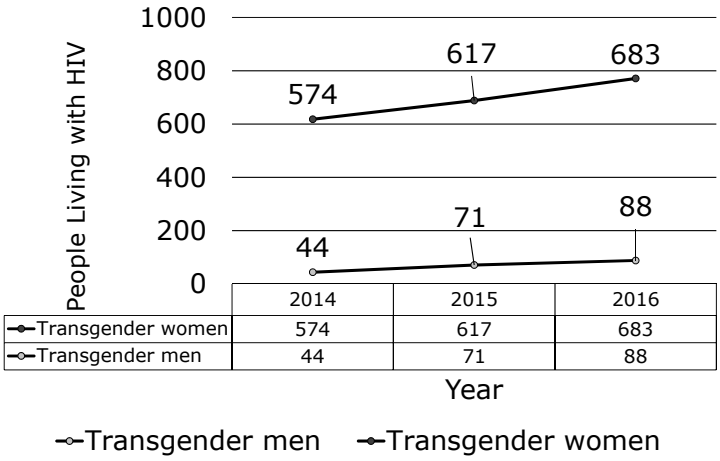
People Living with HIV who are Transgender



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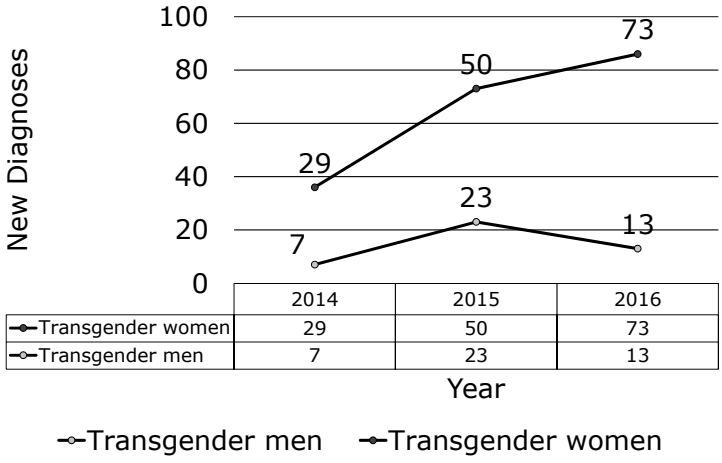
New HIV Diagnoses among PLWH who are Transgender



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Deaths among People Living with HIV who are Transgender

Death year	Current Gender	
	Transgender Men	Transgender Women
2014	0	10

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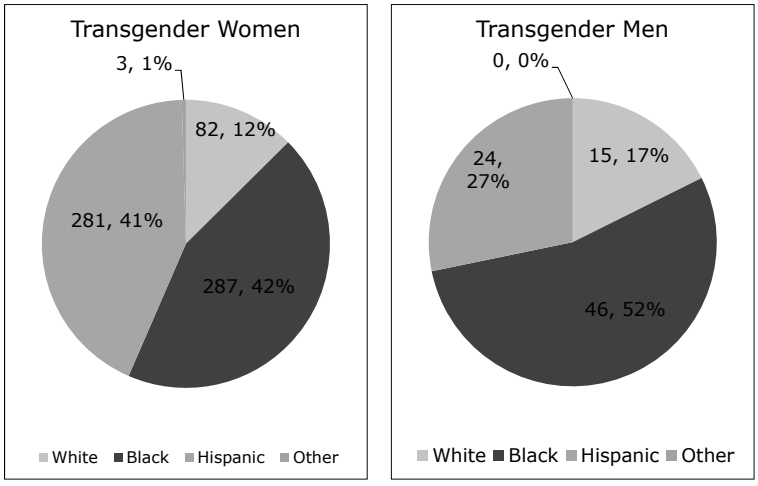
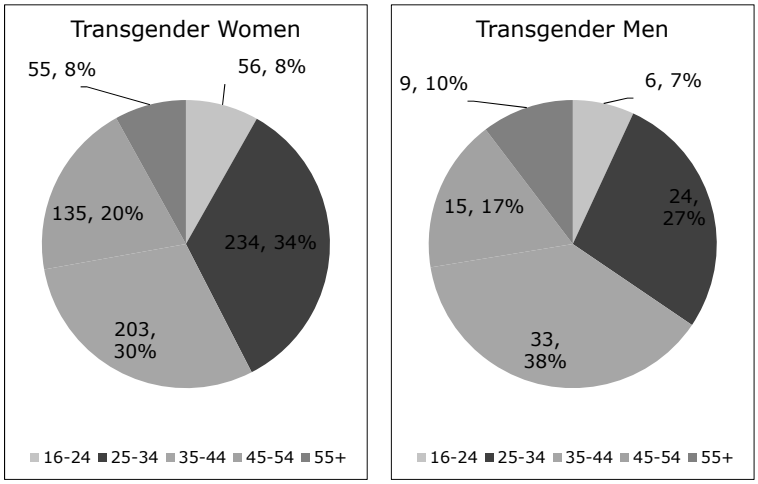
HIV Prevalence in Texas among People who are Transgender

PLWH who are Transgender by Race/Ethnicity, 2016



PLWH who are Transgender by Age, 2016



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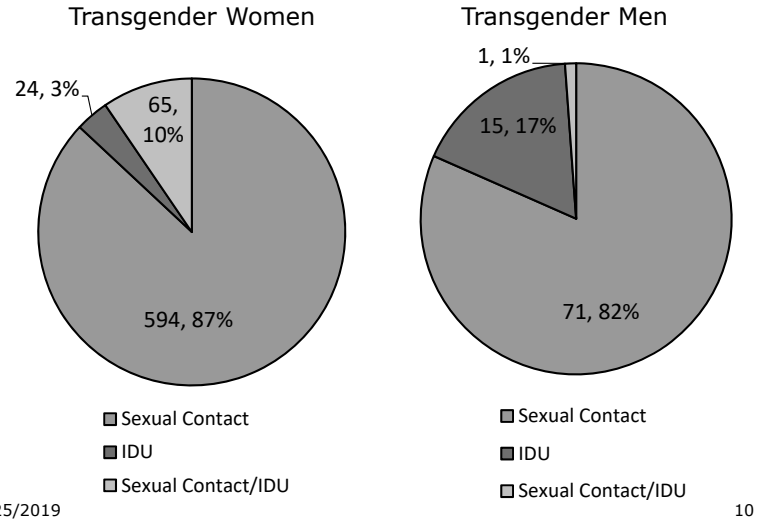
PLWH among Transgender by Mode of Transmission, 2016



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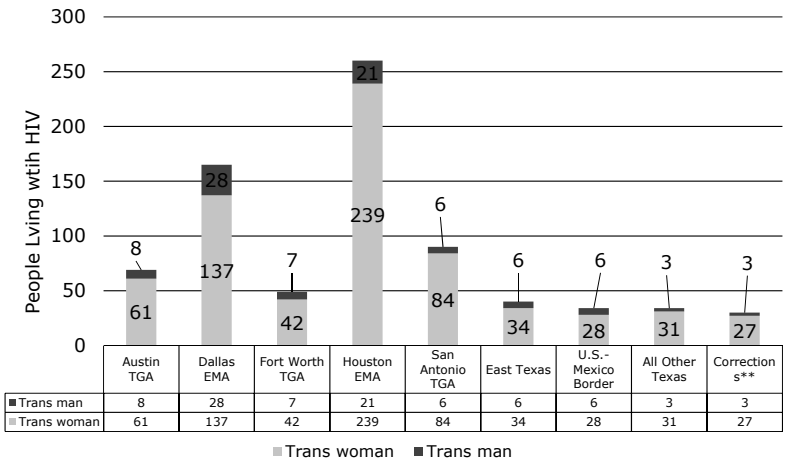
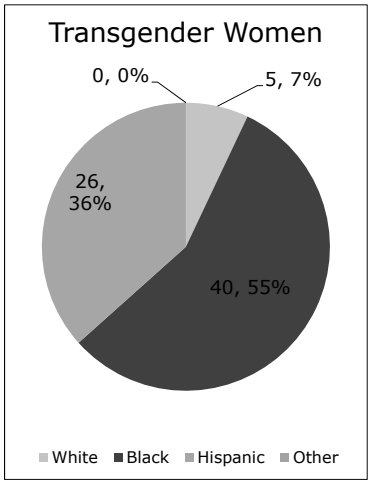
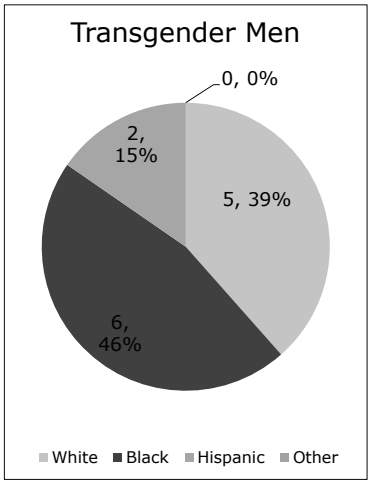
PLWH among Transgender by EMA/TGA, 2016



New HIV Diagnoses among PLWH who are Transgender

New HIV Diagnoses among Trans by Race/Ethnicity, 2016





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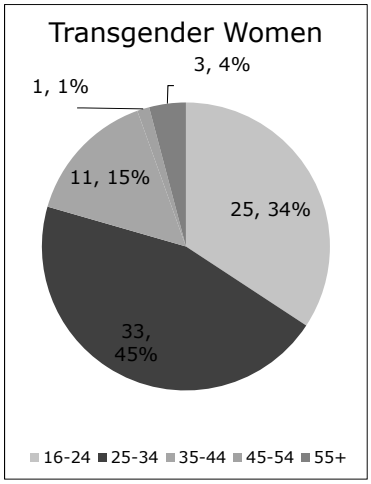
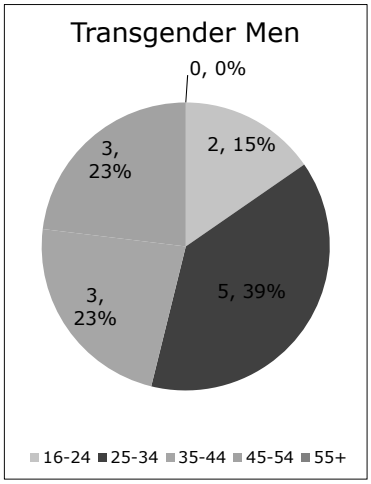
New HIV Diagnoses among Trans by Age, 2016





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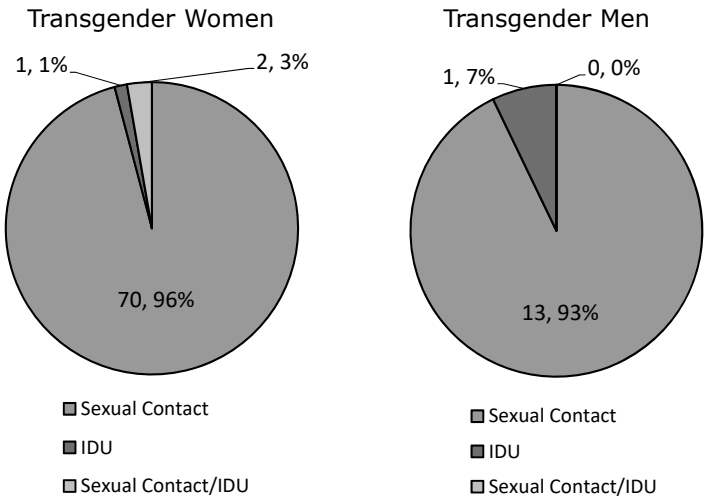
New HIV Diagnoses among Trans by Mode of Transmission, 2016



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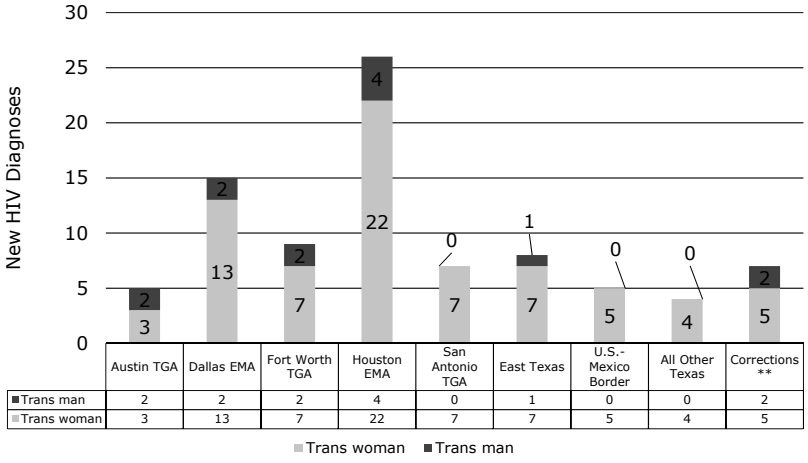
New HIV Diagnoses among Trans by EMA/TGA*, 2016



	Austin TGA	Dallas EMA	Fort Worth TGA	Houston EMA	San Antonio TGA	East Texas	U.S.-Mexico Border	All Other Texas	Corrections **
Trans man	2	2	2	4	0	1	0	0	2
Trans woman	3	13	7	22	7	7	5	4	5

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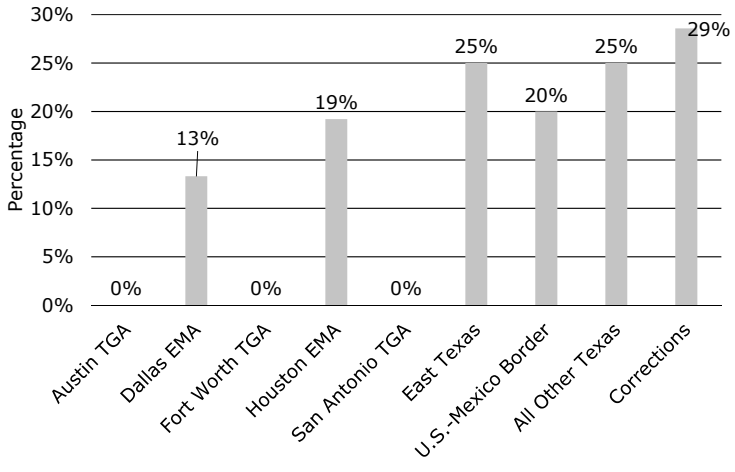
Stage 3 HIV (AIDS)

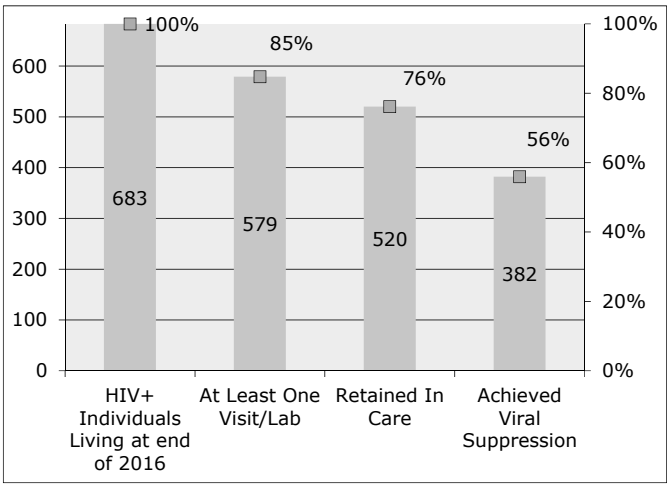
HIV infection, stage 3 (AIDS), defined by Centers for Disease Control and Prevention*:

- CD4 count <200 cells/μL
- CD4 percentage of total lymphocytes <14%
- Documentation of an AIDS-defining condition

Late Diagnoses* as Percentage of Total HIV Diagnoses among Trans 2016



Care Continuum among Transgender Women, 2016



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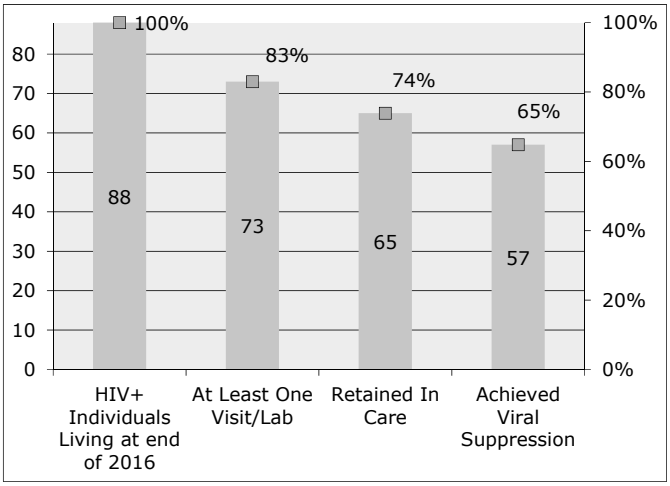
Care Continuum among Transgender Men, 2016



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Summary

- More HIV cases among transgender women compared to transgender men;
- Black transgender men and Hispanic/Latinx transgender women were accounted for larger proportions for either new HIV cases or living cases;
- Potential shorter life expectancy among transgender people living with HIV;

Summary

- Houston EMA and Dallas EMA had the highest numbers of transgender HIV cases;
- Proportions of late HIV diagnoses among transgender PLWH were higher in rural areas but generally lower than the statewide averages;
- Generally, the HIV treatments among transgender PLWH were better than the statewide averages.

Thank you

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