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?

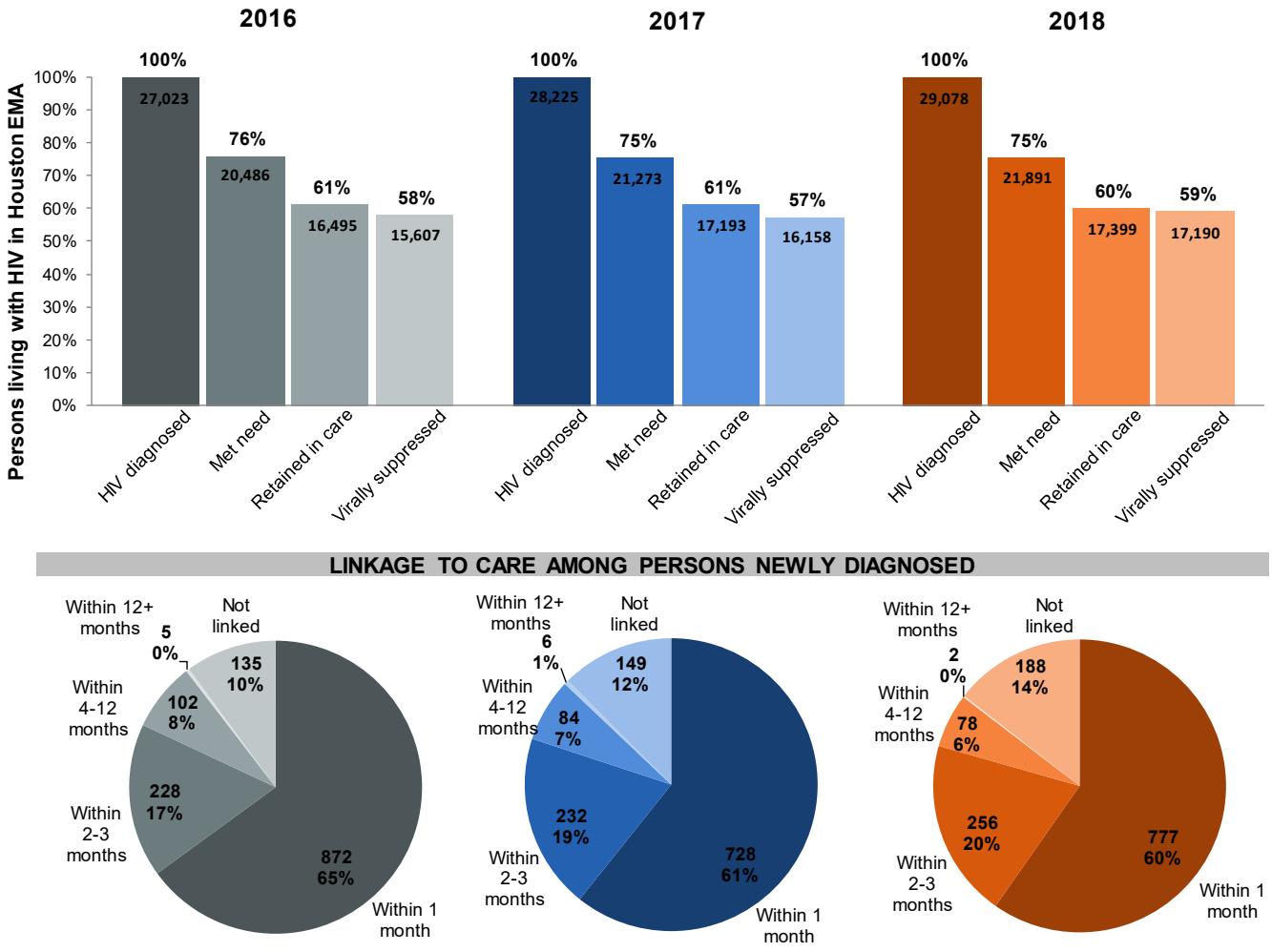
The HIV Care Continuum, previously known as a Treatment Cascade, was first released in 2012 by the Centers for Disease Control and Prevention (CDC). It represents the sequential stages of HIV care, from being diagnosed with HIV to suppressing the HIV virus through treatment. Ideally, the Care Continuum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

Figure 1: Houston EMA HIV Care Continuum, 2016-2018**



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

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 2016-2018, 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 from 65% to 60% from 2016 to 2018.

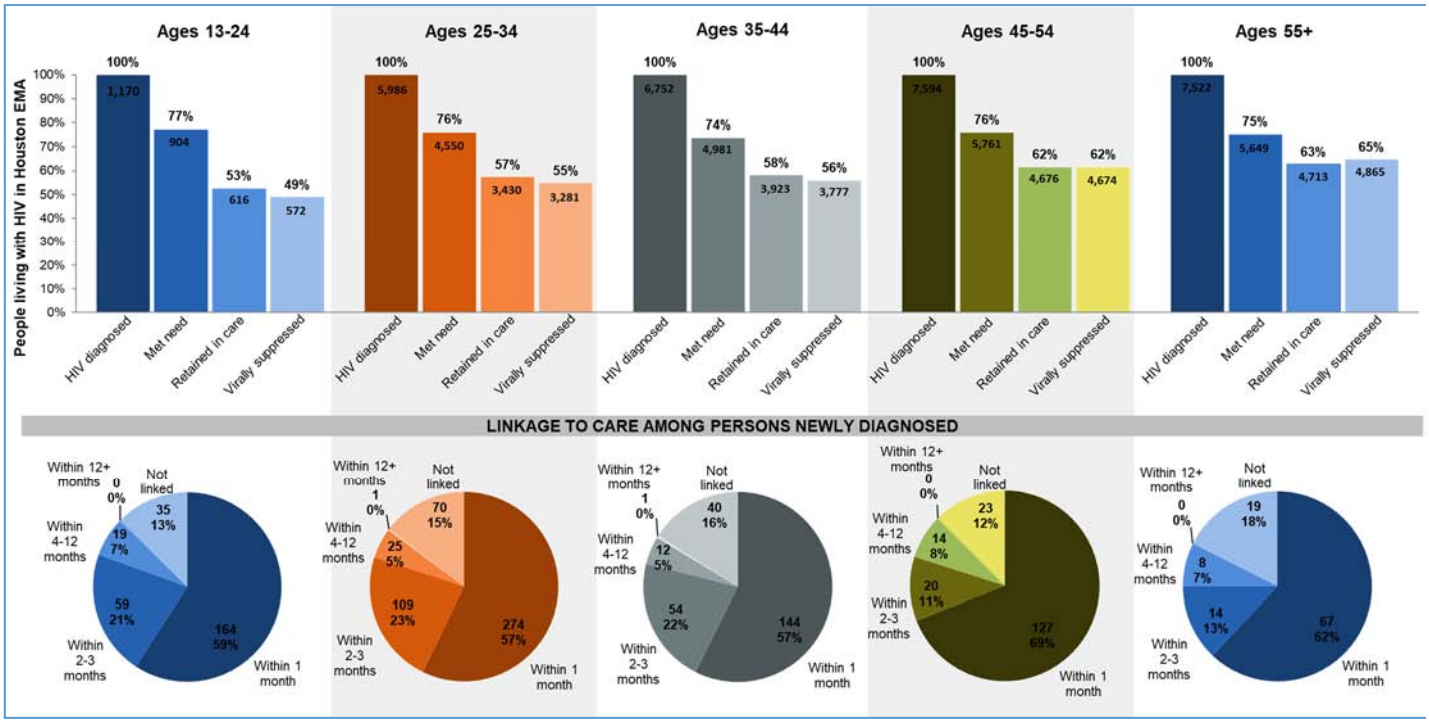
Disparities in Engagement among Key Populations

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 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.

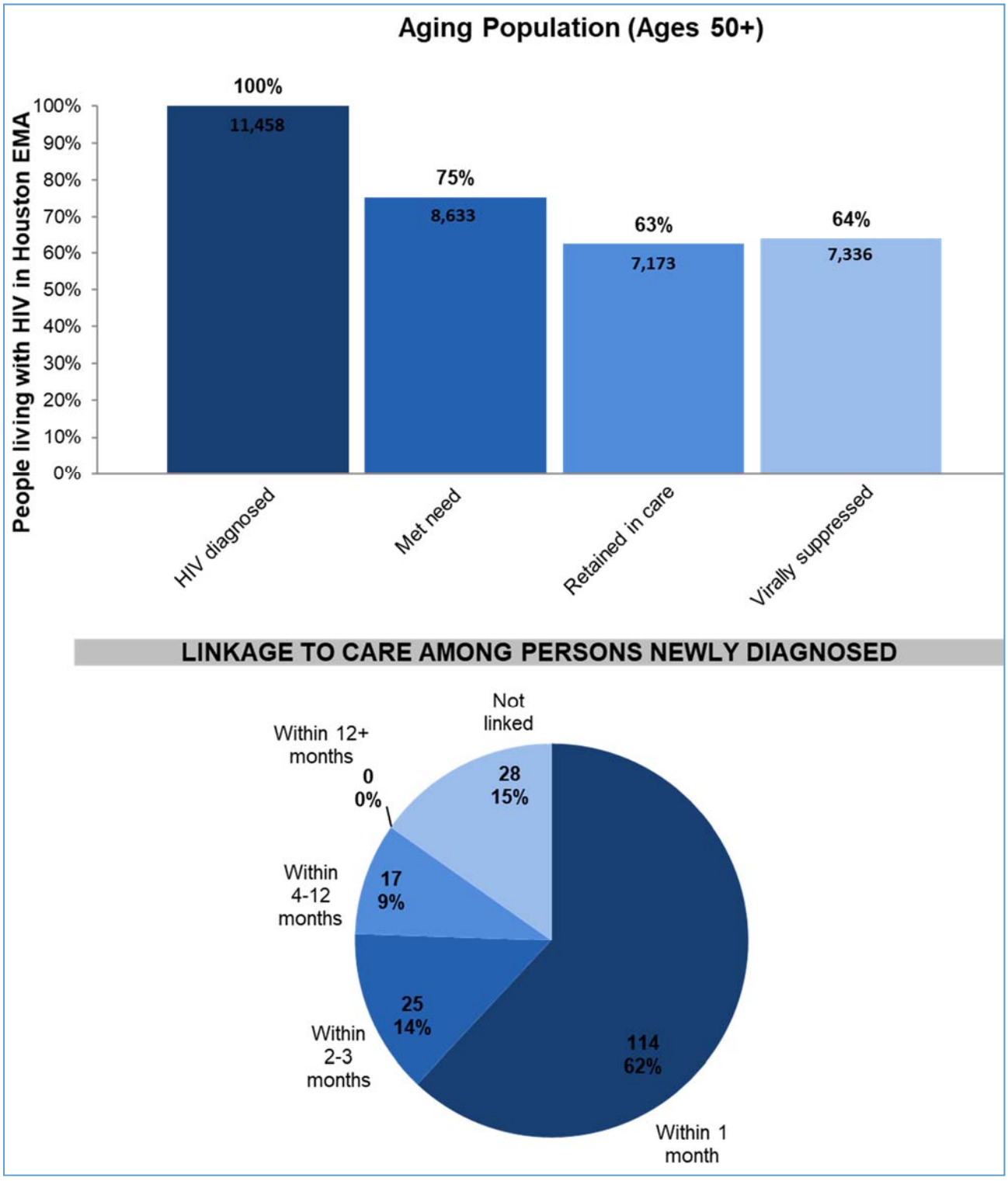
The Houston EMA Care Continuum, by Age

Figure 2: Houston EMA HIV Care Continuum by Age Group, 2018**



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

Figure 3: Houston EMA HIV Care Continuum by Age Group, 2018**

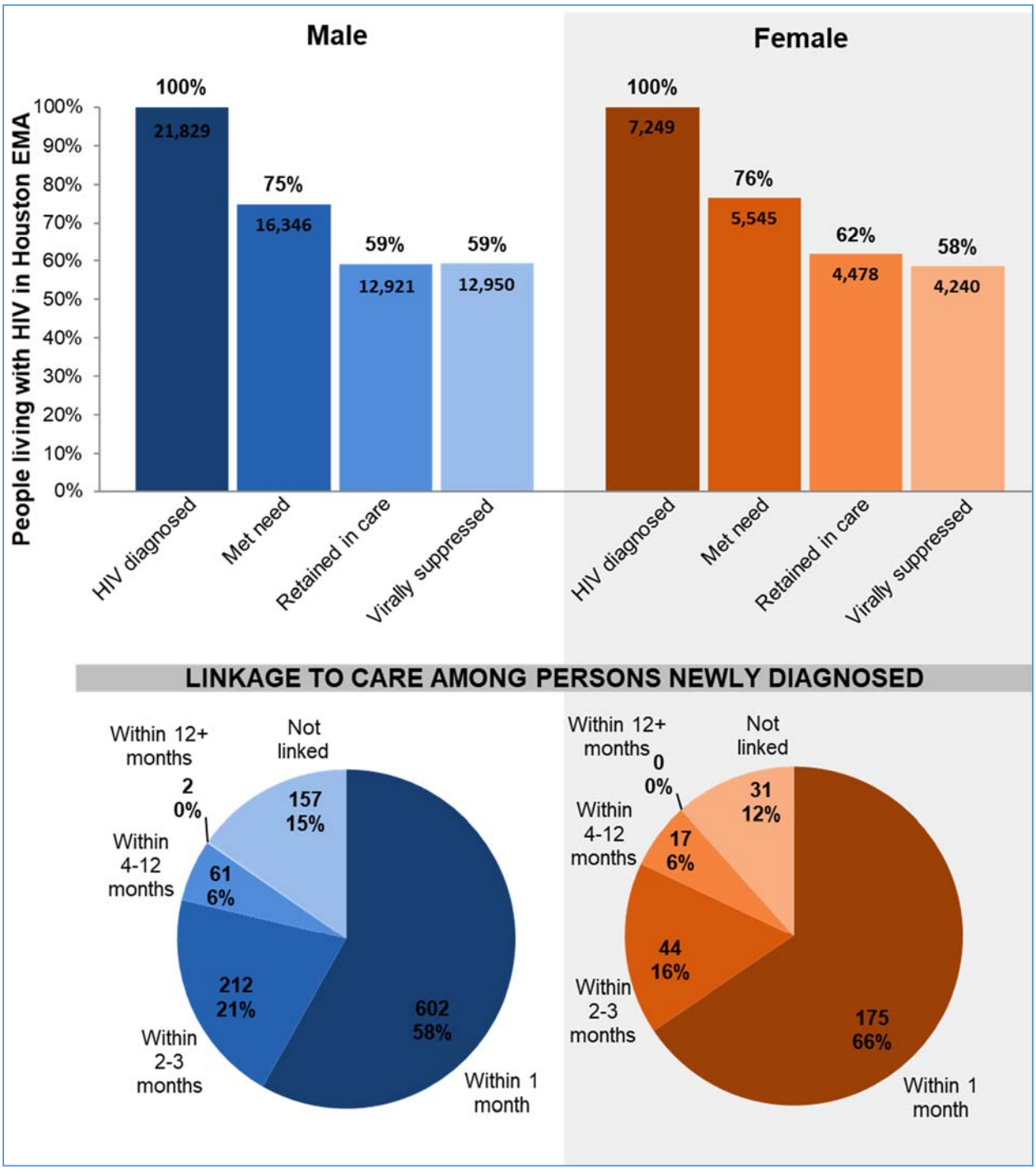


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- Younger adults had lower percentages of retention and viral suppression compared to older adults.
- Middle age adults (25-44 years old) had the lowest proportion of newly diagnosed PLWH who were linked to care within one month of diagnosis when compared to other age groups.

The Houston EMA Care Continuum, by Sex Assigned at Birth/Current Gender

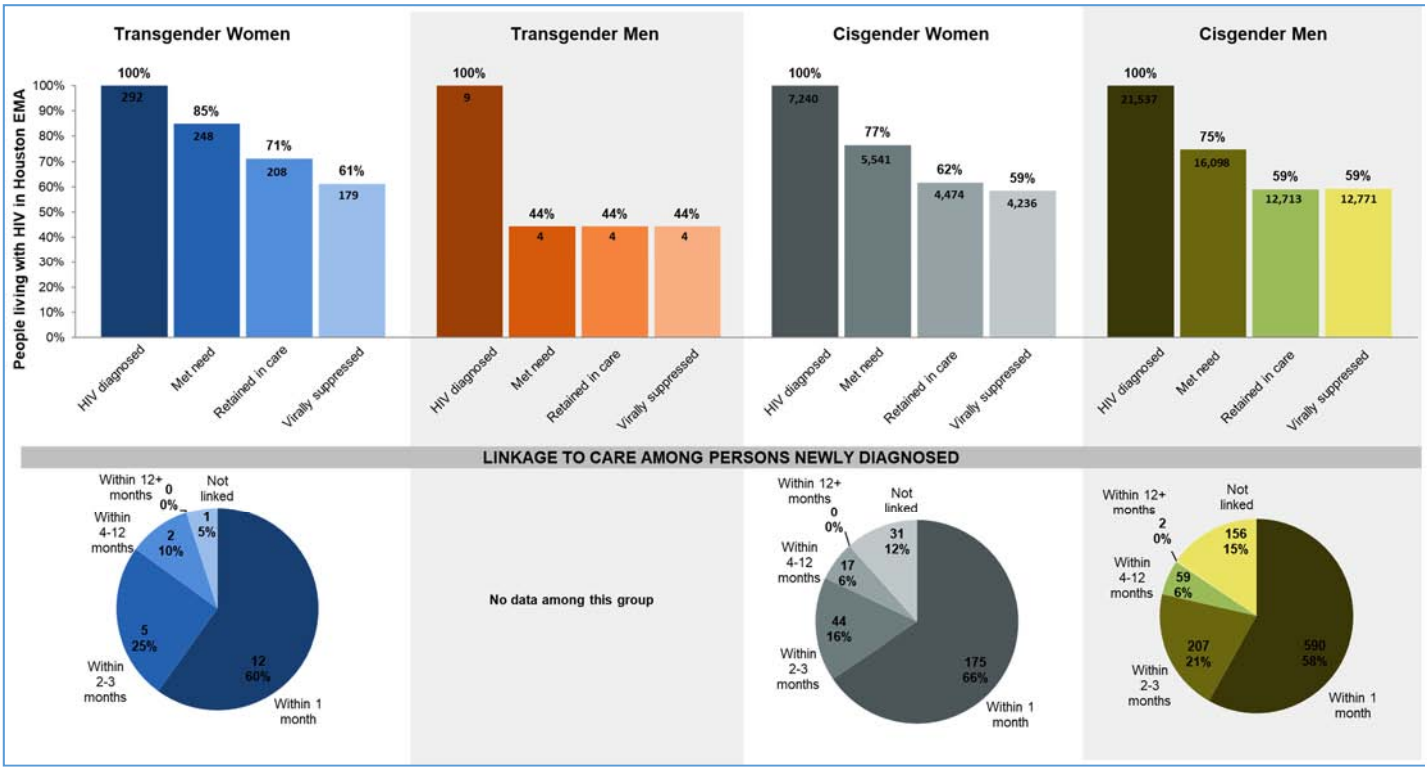
Figure 4: Houston EMA HIV Care Continuum by Sex Assigned at Birth, 2018**



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- Females living with HIV in the Houston EMA in 2018 had a slightly 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 females linked to care within the first month after diagnosis was higher than males (66% vs. 58%).

Figure 5: Houston EMA HIV Care Continuum by Current Gender, 2018**

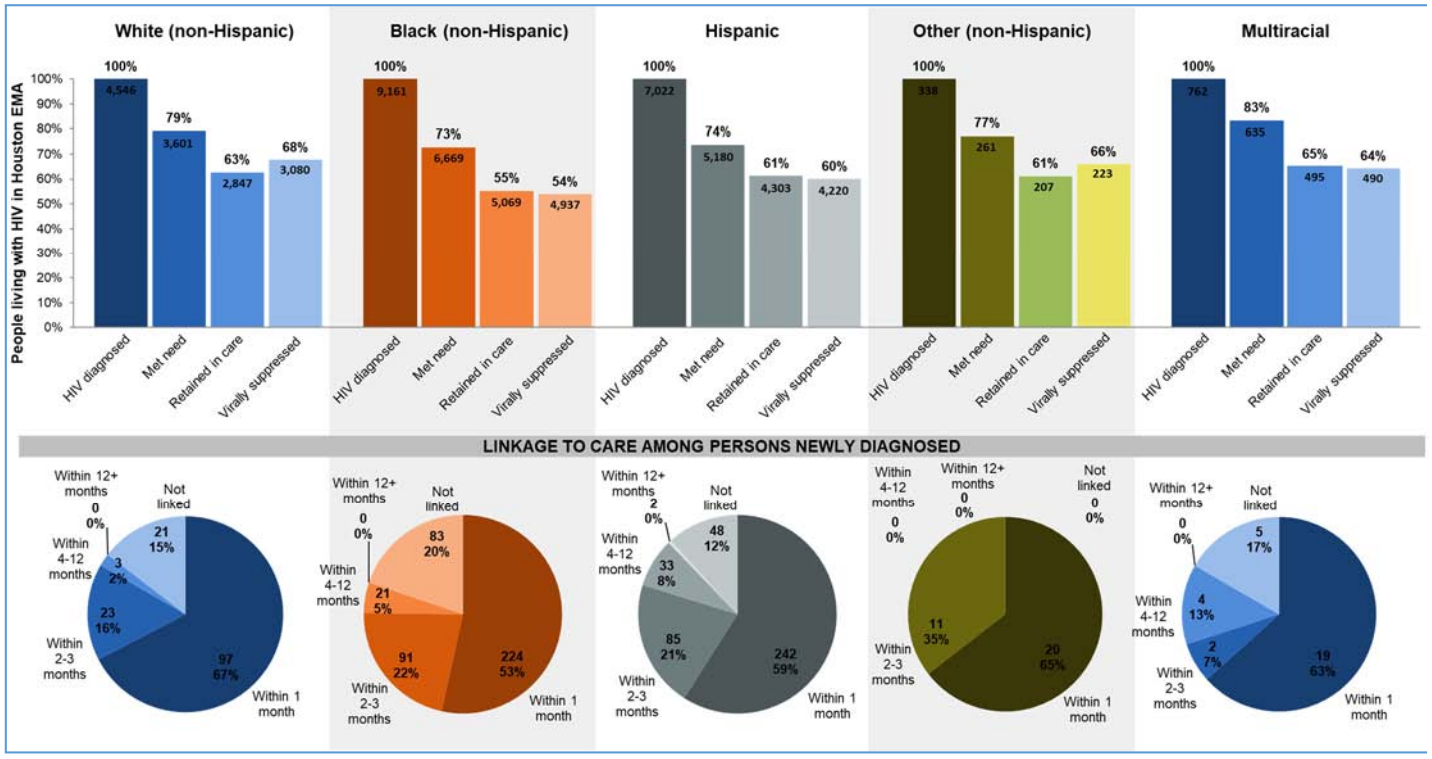


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- Transgender women living with HIV in the Houston EMA in 2018 had the highest proportion of individuals with met need, retention in care, and viral suppression.
- Transgender men living with HIV in the Houston EMA in 2018 had the lowest proportion of individuals with met need, retention in care, and viral suppression. Extreme 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 lower for transgender women compared to cisgender women. However, there were few transgender individuals represented in the data and percentages can vary widely with small increases/decreases.

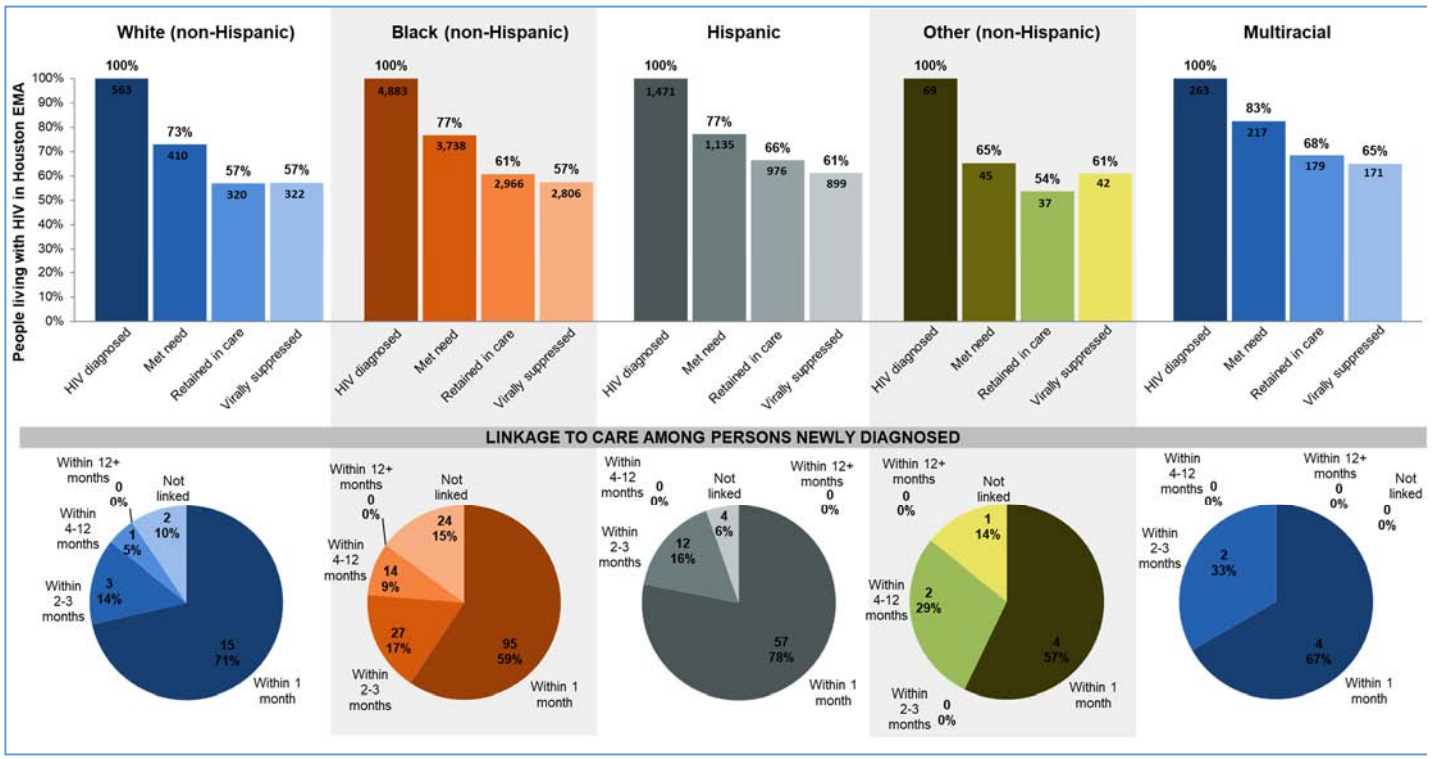
The Houston EMA Care Continuum, by Sex Assigned at Birth and Race/Ethnicity

Figure 6: Houston EMA HIV Care Continuum by Sex Assigned at Birth = Male and Race/Ethnicity, 2018**



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

Figure 7: Houston EMA HIV Care Continuum by Sex Assigned at Birth = Female and Race/Ethnicity, 2018**



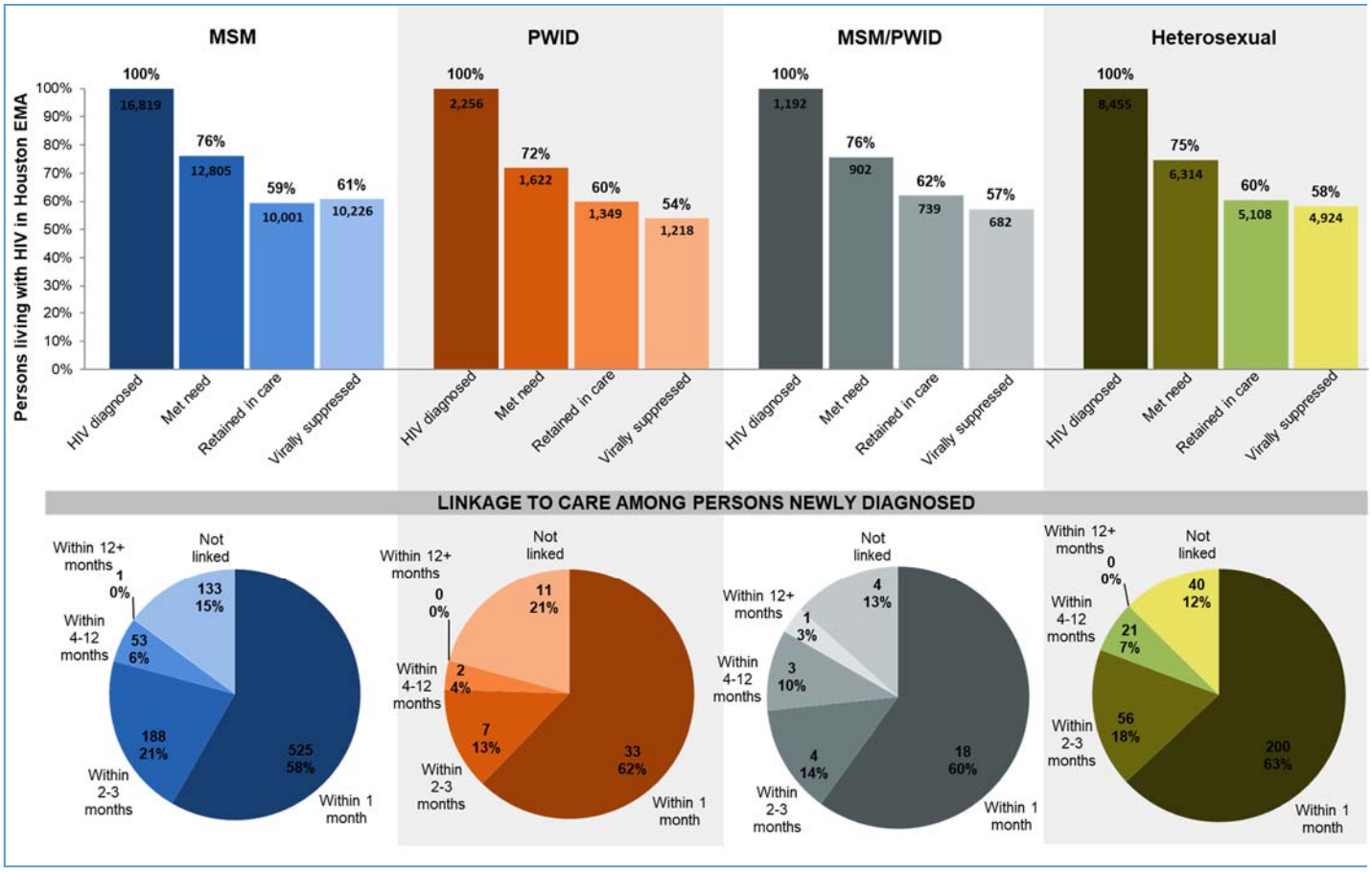
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- Compared to White (non-Hispanic) and multiracial males, all other males living with HIV had lower proportions of met need, retention in care, and viral suppression in 2018.
- Among females, Other (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of met need and retention in care while Black and White (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 and Black (non-Hispanic) males 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. White (non-Hispanic) males living with HIV had the highest proportion of individuals virally suppressed.

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), people who inject drugs (PWID), MSM who also inject drugs (MSM/PWID), and heterosexual exposure.*

Figure 8: Houston EMA HIV Care Continuum by Transmission Risk, 2018**



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- Although MSM have a higher number 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 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. Those with a transmission risk factor of heterosexual contact had the highest proportion of people linked to care within one month of initial diagnosis.
- Overall, PWID as a primary transmission risk factor exhibited the lowest proportions of individuals with met need and viral suppression.

*** 2018 data should be used with caution -- it may be underrepresented due to unforeseen data importing issues at Texas DSHS. Updates to 2018 data will occur in the future.*

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

★ 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

2020 Houston HIV Care Services Needs Assessment

A collaboration of:
Houston Area HIV Services Ryan White Planning Council
Houston HIV Prevention Community Planning Group
Harris County Public Health, Ryan White Grant Administration
Houston Health Department, Bureau of HIV/STD and Viral Hepatitis Prevention
Houston Regional HIV/AIDS Resource Group, Inc.
Harris Health System
People Living with HIV in the Houston Area and Ryan White HIV/AIDS Program Consumers

Approval: Pending

INTRODUCTION

What is an HIV needs assessment?

An HIV needs assessment is a process of collecting information about the needs of people living with HIV (**PLWH**) in a specific geographic area. The process involves gathering data *from multiple sources* on the number of HIV cases, the number of PLWH who are not in care, the needs and service barriers of PLWH, and current resources available to meet those needs. This information is then analyzed to identify what services are needed, what barriers to services exist, and what service gaps remain.

Special emphasis is placed on gathering information about the need for services funded by the Ryan White HIV/AIDS Program and on the socio-economic and behavioral conditions experienced by PLWH that may influence their need for and access to services both today and in the future.

In the Houston Area, data collected directly from PLWH in the form of a *survey* are the principal source of information for the HIV needs assessment process. Surveys are administered every three years to a representative sample of PLWH residing in the Houston Area.

How are HIV needs assessment data used?

Needs assessment data are integral to the information base for HIV services planning, and they are used in almost every decision-making process of the Ryan White Planning Council (**RWPC**), including setting priorities for the allocation of funds, designing services that fit the needs of local PLWH, developing the comprehensive plan, and crafting the annual implementation plan. The community also uses needs assessment data for a variety of *non*-Council purposes, such as in writing funding applications, evaluation and monitoring, and the improvement of services by individual providers.

In the Houston Area, HIV needs assessment data are used for the following purposes:

- Ensuring the consumer point-of-view is infused into all of the data-driven decision-making activities of the Houston Area RWPC.
- Revising local service definitions for HIV care, treatment, and support services in order to best meet the needs of PLWH in the Houston Area.
- Setting priorities for the allocation of Ryan White HIV/AIDS Program funds to specific services.
- Establishing goals for and then monitoring the impact of the Houston Area's comprehensive plan for improving the HIV prevention and care system.
- Determining if there is a need to target services by analyzing the needs of particular groups of PLWH.
- Determining the need for special studies of service gaps or subpopulations that may be otherwise underrepresented in data sources.
- By the Planning Council, other Planning Bodies, specific Ryan White HIV/AIDS Program Parts, providers, or community partners to assess needs for services.

Needs assessment data are specifically mandated for use during the Planning Council's *How to Best Meet the Need*, Priority & Allocations, and Comprehensive HIV Planning processes.

Because surveys are administered every three years, results are used in RWPC activities for a three year period. Other data sources produced during interim years of the cycle, such as epidemiologic data and estimates of unmet need, are used to provide additional context for and to better understand survey results.

Sources:

2020 Houston Area HIV Needs Assessment Group (NAG), Analysis Workgroup, Principles for the 2020 Needs Assessment Analysis. Approved 08-19-19.

U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Ryan White HIV/AIDS Program Part A Manual Revised 2013. Section XI, Ch 3: Needs Assessment.

METHODOLOGY

Needs Assessment Planning

Planning the 2020 Houston Area HIV Care Services Needs Assessment was a collaborative process between HIV prevention and care stakeholders, the Houston Area planning bodies for HIV prevention and care, all Ryan White HIV/AIDS Program Parts, and individual providers and consumers of HIV services. To guide the overall process and provide specific subject matter expertise, a series of Needs Assessment-related Workgroups reconvened under the auspices of the Ryan White Planning Council (**RWPC**):

- The Needs Assessment Group (**NAG**) provided overall direction to the needs assessment process. As such, the NAG consisted of voting members from each collaborating partner and from the following workgroups.
- The Epidemiology Workgroup developed the consumer survey sampling plan, which aimed at producing a representative sample of surveys.
- The Survey Workgroup developed the survey instrument and consent language.
- The Analysis Workgroup determined how survey data should be analyzed and reported in order to serve as an effective tool for HIV planning.

In total, 38 individuals in addition to staff participated in the planning process, of which at least 45% were people living with HIV (**PLWH**).

Survey Sampling Plan

Staff calculated the 2020 Houston Area HIV Care Services Needs Assessment sample size based on current total HIV prevalence for the Houston Eligible Metropolitan Area (**EMA**) (2017), with a 95% confidence interval, at both 3% and 4% margin of error. Respondent composition goals were proportional to demographic and geographic representation in total prevalence. Desired sample sizes for funded-agency representation were proportional to total client share for the most recent complete calendar year (2018). Efforts were also taken to over-sample out-of-care consumers and members of special populations. Regular reports of select respondent characteristics were provided to NAG, the Comprehensive HIV Planning Committee, and RWPC during survey administration to assess real-time progress toward attainment of sampling goals and to make sampling adjustments when necessary.

Survey Tool

Data for the 2020 Houston Area HIV Care Services Needs Assessment were collected using a 54-question paper or electronic survey of open-ended, multiple choice, and scaled questions addressing nine topic areas (in order):

- HIV services, needs, and barriers to care
- Communication with HIV medical providers
- HIV diagnosis history
- HIV care history including linkage to care
- Non-HIV co-occurring health concerns (incl. mental health)
- Substance use
- Housing, transportation, and social support
- Financial resources
- Demographics
- HIV prevention activities

The Survey Workgroup determined topics and questions, restructuring and expanding the 45-question 2016 needs assessment survey. Subject matter experts were also engaged to review specific questions. Consistency with the federally-mandated HIV prevention needs assessment for the Houston Area was assured through participation of Houston Health Department staff during the survey development process and alignment of pertinent questions such as those designed to gather demographic information and HIV prevention knowledge and behaviors. A cover sheet explained the purpose of the survey, risks and benefits, planned data uses, and consent. A double-sided tear-sheet of emergency resources and HIV service grievance/complaint process information was also attached, and liability language was integrated within the survey.

Data Collection

Surveys for the 2020 Houston Area HIV Care Services Needs Assessment were administered (1) in pre-scheduled group sessions at Ryan White HIV/AIDS Program providers, HIV Prevention providers, housing facilities, support groups, Harris County community centers, and specific community locations and organizations serving special populations; and (1) online via word of mouth, print, and social media advertising. Staff contacts at each physical location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through flyers, word of mouth, print advertisement, and staff promotion.

Inclusion criteria were an HIV diagnosis and residency in counties in the greater Houston Area. Participants were self-selected and self-identified according to these criteria. Surveys were self-administered in English, Spanish, and large-print formats, with staff and bilingual interpreters available for verbal interviewing.

Participation was voluntary, anonymous, and monetarily incentivized; and respondents were advised of these conditions verbally and in writing. Most surveys were completed in 30 to 40 minutes. Surveys were reviewed on-site by trained staff, interns, and interpreters for completion and translation of written comments; completed surveys were also logged in a centralized tracking database.

In total, 589 consumer surveys were collected from April 2019 to February 2020 during 47 survey sessions at 27 survey sites and online.

Data Management

Data entry for the current Houston Area HIV Care Services Needs Assessment was performed by trained staff and contractors at the RWPC Office of Support using simple numerical coding. Skip-logic questions were entered based on first-order responses; and affirmative responses only were entered for "check-all" questions. Additional variables were recoded during data entry and data cleaning. Surveys that could not be accurately entered by staff ere eliminated. Data are periodically reviewed for quality assurance, and a line-list level data cleaning protocol was applied prior to analysis. When data entry and cleaning are complete, a data weighting syntax will be created and applied to the sample for: sex at birth, primary race/ethnicity, and age group based on a three-level stratification of current HIV prevalence for the Houston EMA (2018). Missing or invalid survey entries will be excluded from analysis per variable; therefore, denominators vary across results. Also, proportions will not calculated with a denominator of the total number of completed surveys for every variable due to missing or "check-all" responses. Data entry for the 2020 Houston Area HIV Care Services Needs Assessment was performed by trained staff and contractors at the RWPC Office of Support using simple numerical coding. Skip-logic questions were entered based on first-order responses; and affirmative responses only were entered for "check-all" questions. Additional variables were recoded during data entry and data cleaning. Surveys that could not be accurately entered by staff or that were found to be duplicates were eliminated (n=11). Data were periodically reviewed for quality assurance, and a line-list level data cleaning protocol was applied prior to analysis. In addition, a data weighting syntax was created and applied to the sample for: sex at birth, primary race/ethnicity, and age group based on a three-level stratification of current HIV prevalence for the Houston EMA (2018), producing a total weighted sample size of 589 (8% in Spanish). Missing or invalid survey entries are excluded from analysis per variable; therefore, denominators vary across results. Also, proportions are not calculated with a denominator of 589 surveys for every variable due to missing or "check-all" responses. All data management and analysis was performed in IBM© SPSS© Statistics (v. 22) and QSR International© NVivo 10.

Limitations

The 2020 Houston Area HIV Care Services Needs Assessment produced data that are unique because they reflect the first-hand perspectives and lived experiences of PLWH in the Houston Area. However, there are limitations to the generalizability, reliability, and accuracy of the results that should be considered during their interpretation and use. These limitations are summarized below:

- *Convenience Sampling*. Multiple administrative methods were used to survey a representative sample of PLWH in the Houston Area proportional to geographic, demographic, transmission risk, and other characteristics. Despite extensive efforts, respondents were not randomly selected, and the resulting sample is not proportional to current HIV prevalence. To mitigate this bias, data were statistically weighted for sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2018). Results presented from Chapters 2 through the end of this report are proportional for these three demographic categories only. Similarly, the majority of respondents were Ryan White HIV/AIDS Program clients at the time of data collection, but may have received services outside the program that are similar to those currently funded. Therefore, it not possible to determine if results reflect non-Ryan White systems.
- *Margin of Error*. Staff met the minimum sampling plan goal of at least 588 valid surveys for a margin of error of 4.00%, based on a 95% confidence interval. This indicates that 95% of the time, the quantitative results reported this document are anticipated to be correct by a margin of 4 percentage points. For this reason, results reported in this document are statistically significant, generalizable, and are suitable for planning purposes to draw general conclusions about the overall needs and experiences of people living with HIV in the Houston area.
- *Reporting Bias*. Survey participants were self-selected and self-identified, and the answers they provided to survey questions were self-reported. Since the survey tool was anonymous, data could not be corroborated with medical or other records. Consequently, results

should not be used as empirical evidence of reported health or treatment outcomes. Other data sources should be used if confirmation of results is needed.

- *Instrumentation*. Full data accuracy cannot be assured due to variability in comprehension and completeness of surveys by individual respondents. Though trained staff performed real-time quality reviews of each survey, there were missing data as well as indications of misinterpretation of survey questions. It is possible that literacy and language barriers contributed to this limitation as well.
- *Data management*. The use of both staff and contractors to enter survey data could have produced transcription and transposition errors in the dataset. A line-list level data cleaning protocol was applied to help mitigate errors.

Data presented here represent the most current repository of *primary* data on PLWH in the Houston Area. With these caveats in mind, the results can be used to describe the experiences of PLWH in the Houston Area and to draw conclusions on how to best meet the HIV service needs of this population.

Sources:

Houston Area HIV Needs Assessment Group (NAG), Epidemiology Workgroup, 2019 Survey Sampling Principles and Plan, Approved 03-18-19.

Texas Department of State Health Services (DSHS) eHARS data through 12-31-2018, extracted as of spring 2020.

University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPPS Statistics 20, Post-stratification weights, 2009.

BACKGROUND

The Houston Area

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

Beyond Houston and Harris County, local HIV service planning extends to four geographic service areas in the greater Houston Area:

- *Houston/Harris County* is the geographic service area defined by the Centers for Disease Control and Prevention (**CDC**) for HIV prevention. It is also the local reporting jurisdiction for HIV surveillance, which mandates all laboratory evidence related to HIV/AIDS performed in Houston/Harris County be reported to the local health authority.
- The *Houston Eligible Metropolitan Area* (**EMA**) is the geographic service area defined by the Health Resources and Services Administration (**HRSA**) for the Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (**MAI**). The Houston EMA includes six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.
- The *Houston Health Services Delivery Area* (**HSDA**) is the geographic service area defined by the Texas Department of State Health Services (**TDSHS**) for the Ryan White HIV/AIDS Program Part B and the Houston Area's HIV service funds from the State of Texas. The HSDA includes the six counties in the EMA listed above plus four additional counties: Austin, Colorado, Walker, and Wharton.
- The *Houston Eligible Metropolitan Statistical Area* (**EMSA**) is the geographic service area defined by U.S. Department of Housing and Urban Development (**HUD**) for the Housing Opportunities for People with AIDS (**HOPWA**) program. The EMSA consists of the six counties in the EMA listed above plus Austin, Brazoria, Galveston, and San Jacinto Counties.

Together, these geographic service areas encompass 13 counties in southeast Texas, spanning from the Gulf of Mexico into the Texas Piney Woods.

HIV in the Houston Area

In keeping with national new HIV diagnosis trends, the number of new cases of HIV in the Houston Area has remained relatively stable; HIV-related mortality has steadily declined, and the number of people living with HIV has steadily increased. According to current disease surveillance data, there are 29,078 diagnosed people living with HIV in the Houston EMA (**Table 1**). The majority are male (75%), over the age of 45 (52%), and have MSM transmission risk (58%), while almost half are Black/African American (48%).

TABLE 1-Diagnosed People Living with HIV in the Houston EMA, 2018[a]

	#	%
Total	29,078	100.0%
Sex at Birth		
Male	21,829	75.1%
Female	7,249	24.9%
Race/Ethnicity		
White	5,109	17.6%
Black/African American	14,044	48.3%
Hispanic/Latino	8,493	29.2%
Other/Multiracial	1432	4.9%
Age		
0 - 12	54	0.2%
13 - 24	1,170	4.0%
25 - 34	5,986	20.6%
35 - 44	6,752	23.2%
45 - 54	7,594	26.1%
55 - 64	5,580	19.2%
65+	1,942	6.7%
Transmission Risk[b]		
Male-male sexual contact (MSM)	16,818	57.8%
Person who injects drugs (PWID)	2,256	7.8%
MSM/PWID	1,192	4.1%
Sex with Male/Sex with Female	8,455	29.1%
Perinatal transmission	340	1.2%
Adult other	17	0.1%

[a]Source: Texas eHARS, Diagnosed PLWH in the Houston EMA between 1/1/2018 and 12/31/2018

[b]Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification.

The CDC ranks the Houston Area (specifically, the Houston-Baytown-Sugarland, TX statistical area) 10th highest in the nation for new HIV diagnoses and 11th in cases of progressed/Stage 3 HIV (formerly known as AIDS). In February 2019, the U.S. Department of Health and Human Services (**HHS**) launched the cross-agency initiative *Ending the HIV Epidemic: A Plan for America* with an overarching goal to reduce new HIV transmission in the U.S. by 90% by 2030. This initiative identified Harris County as a priority county due to the high rate and number of new HIV diagnoses, and plans to introduce additional resources, technology, and technical assistance to support local HIV prevention and treatment activities. Of the 29,078 diagnosed PLWH in the Houston Area, 75% are in medical care for HIV, but only 59% have a suppressed viral load.

HIV Services in the Houston Area

Both governmental agencies and non-profit organizations provide HIV services in the Houston Area through direct HIV services provision and/or function as Administrative Agents which contract to direct service providers. The goal of HIV care in the Houston Area is to create a seamless system that supports people at risk for or living with HIV with a full array of educational, clinical, mental, social, and support services to prevent new infections and support PLWH with high-quality, life-extending care. In addition, two local HIV Planning Bodies provide mechanisms for those living with and affected by HIV to design prevention and care services. Each of the primary sources in the Houston Area HIV service delivery system is described below:

- Comprehensive HIV prevention activities in the Houston Area are provided by the Houston Health Department (**HHD**), a directly-funded CDC grantee, and the Texas Department of State Health Services (**DSHS**). Prevention activities include health education and risk reduction, HIV testing, disease investigation and partner services, linkage to care for newly diagnoses and out of care PLWH. The Houston Area HIV Prevention Community Planning Group provides feedback and to HHD in its design and implementation of HIV prevention activities.
- The Ryan White HIV/AIDS Program Part A and MAI provide core medical and support services for HIV-diagnosed residents of the Houston EMA. These funds are administered by the Ryan White Grant Administration of Harris County Public Health. The Houston Area Ryan White Planning Council designs Part A and MAI funded services for the Houston EMA.
- The Ryan White HIV/AIDS Program Parts B, C, D, and State Services provide core medical and support services for HIV-diagnosed residents of the Houston HSDA, with special funding provided to meet the needs of women, infants, children, and youth. The Houston Regional HIV/AIDS Resource Group (**TRG**) administers these funds. The Ryan White Planning Council also designs Part B and State Services for the Houston HSDA. Additional programs supported by TRG include reentry housing through HOPWA funds and support of the grassroots END HIV Houston coalition.
- HOPWA provides grants to community organizations to meet the housing needs of low-income persons living with HIV. HOPWA services include assistance with rent, mortgage, and utility payments, case management, and supportive housing. These funds are administered by the City of Houston Housing and Community Development for the Houston EMSA.

Together, these key agencies, the direct service providers that they fund, and the two local Planning Bodies ensure the greater Houston Area has a seamless system of prevention, care, treatment, and support services that best meets the needs of people at risk for or living with HIV.

Sources:

Centers for Disease Control and Prevention, *Diagnoses of HIV Infection in the United States and Dependent Areas, 2018*; vol. 30. Published November 2015. Accessed 03/06/2020. Available at: www.cdc.gov/hiv/topics/surveillance/resources/reports/.

U.S. Census Bureau, American FactFinder. Houston (city), Texas and Harris (county), Texas Accessed: 03/03/2020. Available at: https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

U.S. Department of Health and Human Services, *Ending the HIV Epidemic: A Plan for America*. February 2019.

Chapter 1: Demographics

PARTICIPANT COMPOSITION

The following summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2020 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, 95% of needs assessment participants resided in Harris County at the time of data collection. The majority of participants were male (66%), African American/Black (63%), and heterosexual (57%). Over half (60%) were age 50 or over, with a median age of 50-54.

The average unweighted household income of participants was $13,493 annually, with the majority living below 100% of federal poverty (**FPL**). A majority of participants (63%) was not working at the time of survey, with 39% collecting disability benefits and 16% unemployed and seeking employment, and 9% retired. Most participants paid for healthcare using Medicaid/Medicare or assistance through Harris Health System (Gold Card).

TABLE 1-Select Participant Characteristics, Houston Area HIV Needs Assessment, 2020

	No.	%		No.	%		No.	%
County of residence			Age range (median: 50-54)			Sex at birth		
Harris	545	94.9%	13 to 17	0	-	Male	384	65.8%
Fort Bend	10	41.7%	18 to 24	17	2.9%	Female	200	34.2%
Liberty	3	0.5%	25 to 34	50	8.6%	Intersex	0	-
Montgomery	7	1.2%	35 to 49	160	27.6%	Transgender	22	3.9%
Other	9	1.6%	50 to 54	105	18.1%	Non-binary / gender fluid	8	1.4%
			55 to 64	161	27.8%	Currently pregnant*	4	2.0%
			65 to 74	79	13.6%	*All currently pregnant respondents reported being in care. The denominator is all respondents reporting female sex at birth		
			75+	8	1.4%			
			Youth (13 to 27)	17	2.9%			
			Seniors (≥50)	353	59.9%			
Primary race/ethnicity			Sexual orientation			Health insurance		
White	78	13.6%	Heterosexual	329	56.8%	Private insurance	53	9.1%
African American/Black	343	59.8%	Gay/Lesbian	176	30.4%	Medicaid/Medicare	388	66.7%
Hispanic/Latino	122	21.3%	Bisexual/Pansexual	52	9.0%	Harris Health System	168	30.1%
Asian American	4	0.7%	Other	22	3.8%	Ryan White Only	138	23.7%
Other/Multiracial	27	4.7%	MSM	238	40.5%	None	11	1.9%
Residency			Yearly income (average: $13,493)			Employment		
Born in the U.S.	511	87.8%	Federal Poverty Level (FPL)			Disabled	263	38.9%
Lived in U.S. > 5 years	58	10.0%	Below 100%	191	67.3%	Unemployed and seeking work	105	15.5%
Lived in U.S. < 5 years	8	1.4%	100%	54	19.0%	Employed (PT)	59	8.7%
In U.S. on visa	1	0.2%	150%	16	5.6%	Retired	59	8.7%
Prefer not to answer	4	0.7%	200%	15	5.3%	Employed (FT)	53	7.8%
			250%	2	0.7%	Self Employed	19	2.8%
			≥300%	6	2.1%	Other	118	17.5%

(**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 2020 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, 2020

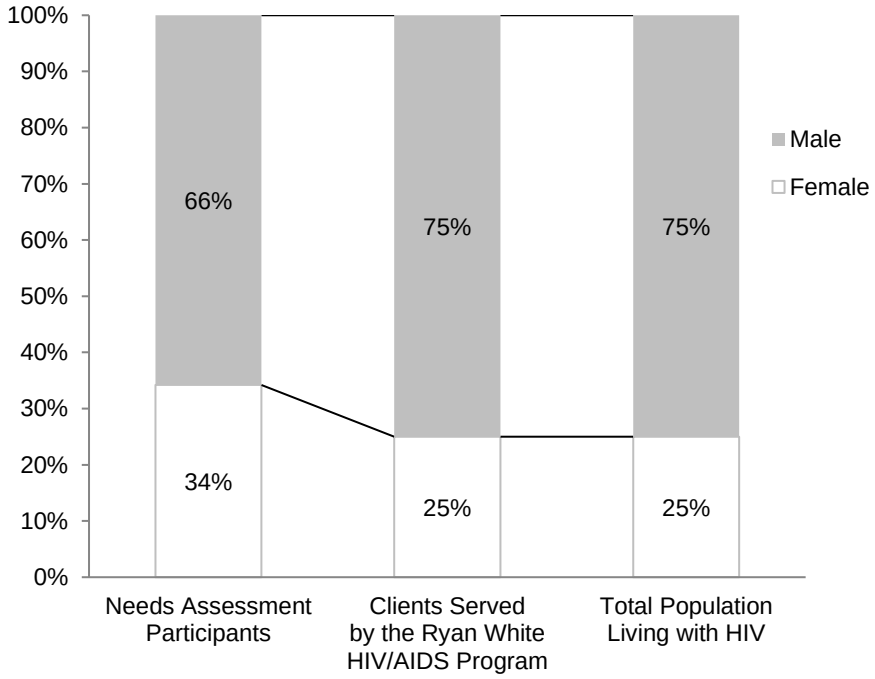
	No.	%
Young adult (18-24 years)	17	2.9%
Adult age 50+ years	353	59.9%
Homeless	65	11.1%
Unstably Housed	159	29.0%
People who inject drugs (PWID)*	47	8.2%
Male-male sexual contact (MSM)	238	40.5%
Out of care (last 12 months)	24	4.3%
Recently released from incarceration	65	11.6%
Rural (non-Harris County resident)	29	5.1%
Women of color	194	33.2%
Transgender	22	3.8%

*Includes self-administered medications, insulin, steroids, hormones, silicone, or drugs.

COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

HIV needs assessments generate information about the needs and service barriers of persons living with HIV (**PLWH**) in a specific geographic area to assist planning bodies and other stakeholders with designing HIV services that best meet those needs. As it is not be feasible to survey every PLWH in the Houston area, multiple administrative and statistical methods are used to generate a sample of PLWH that are reliably representative of *all* PLWH in the area. The same is true in regards to assessing the needs of clients of the Ryan White HIV/AIDS Program.

GRAPH 1-Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Sex at Birth, 2018



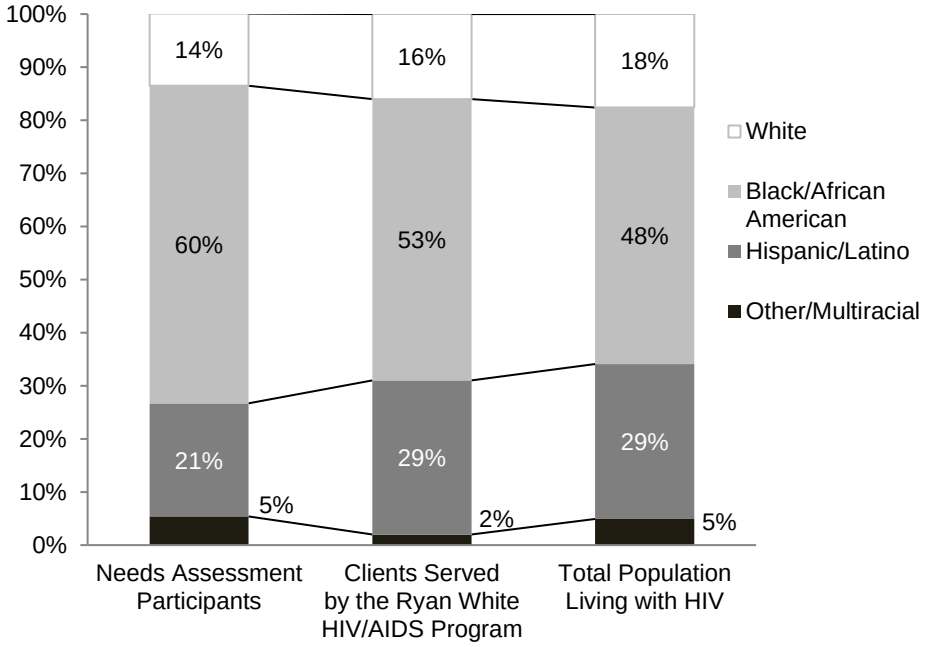
[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18.

As such, awareness of participant representation compared to the composition of both Ryan White HIV/AIDS Program clients and the total HIV diagnosed population is beneficial when reviewing needs assessment results to document actions taken to mitigate any disproportional results.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment males (sex at birth) comprised 66% of participants but 75% of all Ryan White clients, and all PLWH in the Houston Eligible Metropolitan Area (**EMA**). This indicates that male PLWH were underrepresented in the needs assessment sample, while female PLWH were overrepresented.

(**Graph 2**) Analysis of race/ethnicity composition also shows disproportionate representation between participants, all Ryan White clients, and all PLWH in the Houston EMA. Black/African American participants were overrepresented at 60% of participants when compared to the proportions of Black/African American Ryan White clients and PLWH. Conversely, White PLWH and Hispanic/Latino PLWH were slighly underrepresented in the needs assessment.

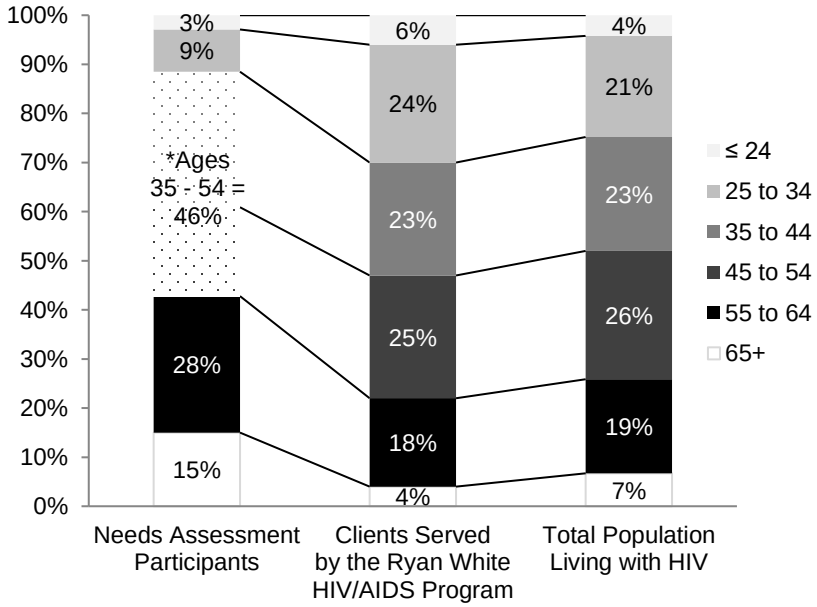
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Race/Ethnicity, 2018



[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18

(**Graph 3**) As referenced in Table 1, 60% of the total needs assessment sample was comprised of individuals age 50 and over. An analysis of age range shows that more needs assessment participants were older than Ryan White clients and PLWH in the Houston EMA. Among needs assessment participants, 28% were ages 55 to 64 and 15% age 65 years and over. Compared to Ryan White clients, 18% were ages 55 to 64 and 4% were 65 and over. Among all PLWH 19% and 7% were in these age groups, respectively. No adolescents (those age 13 to 17) were surveyed. This suggests that youth and young adult PLWH (those age 13 to 24) are generally underrepresented in the needs assessment, while older adults (those age 55 and above) are overrepresented.

GRAPH 3- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Age[c], 2018



[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18
[c]Excludes ages0-12
*Age ranges 35-44 and 45-54 combined due to differences in question structuring.

Weighting the Sample

Needs assessment data were statistically weighted by sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2018) *prior to* the analysis of results related to service needs and barriers. This was done because the demographic composition of 2020 Houston HIV Care Services Needs Assessment participants was *not* comparable to the composition of all PLWH in the Houston EMA. As such, the results presented in the remaining Chapters of this document are proportional for these three demographic categories only. Appropriate statistical methods were applied throughout the process in order to produce an accurately weighted sample, including a three-level stratification of prevalence data and subsequent data weighting syntax. Voluntary completion on the survey and non-applicable answers comprise the missing or invalid survey entries and are excluded in the statistical analysis; therefore, denominators will further vary across results. All data management and quantitative analysis, including weighting, was performed in IBM© SPSS© Statistics (v. 22). Qualitative analysis was performed in QSR International© NVivo 10.

Sources:

Texas Department of State Health Services (TDSHS) eHARS data through 12-31-2018.

University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPPS Statistics 20, Post-stratification weights, 2009.

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. 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 and for PLWH recently released from incarceration through the Houston Regional HIV/AIDS Resource Group (**TRG**). 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.

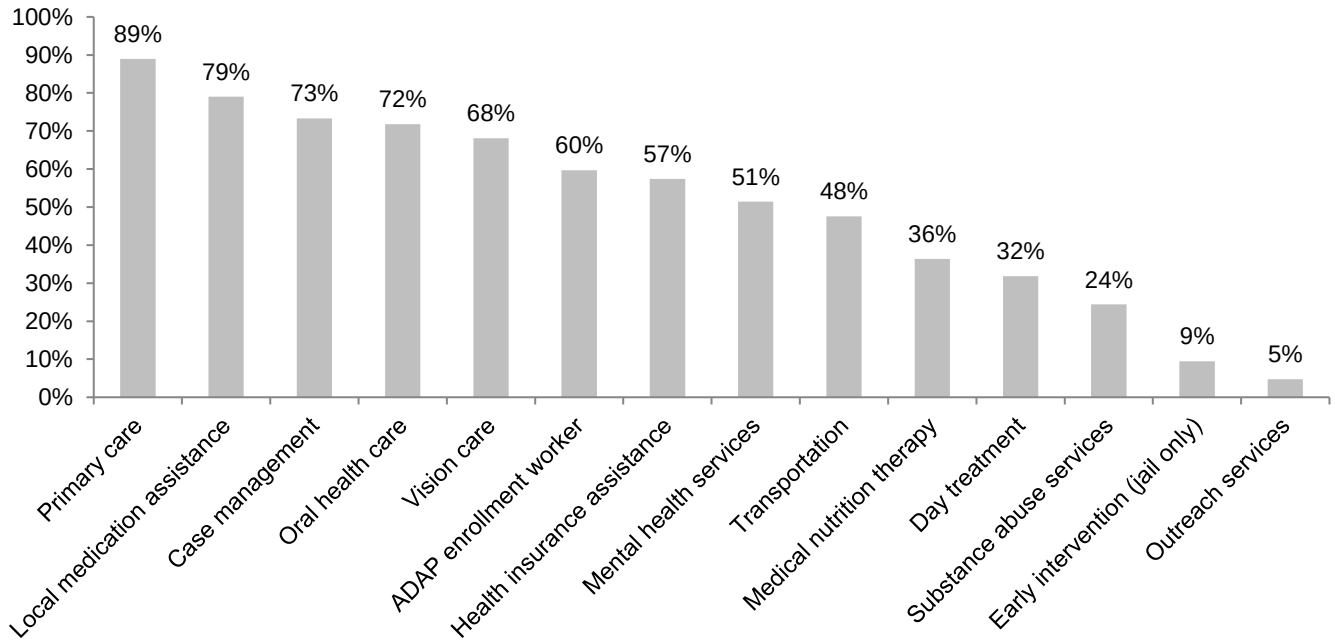
Overall Ranking of Funded Services, by Need

At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. Participants of the 2020 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. Emergency financial assistance was merged with local medication assistance, and non-medical case management was merged with medical case management. At 89%, primary care was the most needed funded service in the Houston Area, followed by local medication assistance at 79%, case management at 73%, oral health care at 72%, and vision care at 68%. Primary care had the highest need ranking of any core medical service, while ADAP enrollment worker received the highest need ranking of any support service. Compared to the last Houston Area HIV needs assessment conducted in 2016, need ranking decreased for most services. The percent of needs assessment participants reporting need for a particular service decreased the most for case management and primary care, while the percent of those indicating a need for local medication assistance and early intervention services increased from 2016.

GRAPH 1-Ranking of HIV Services in the Houston Area, By Need, 2020

Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.
Denominator: 569-573 participants, varying between service categories



Overall Ranking of Funded Services, by Accessibility

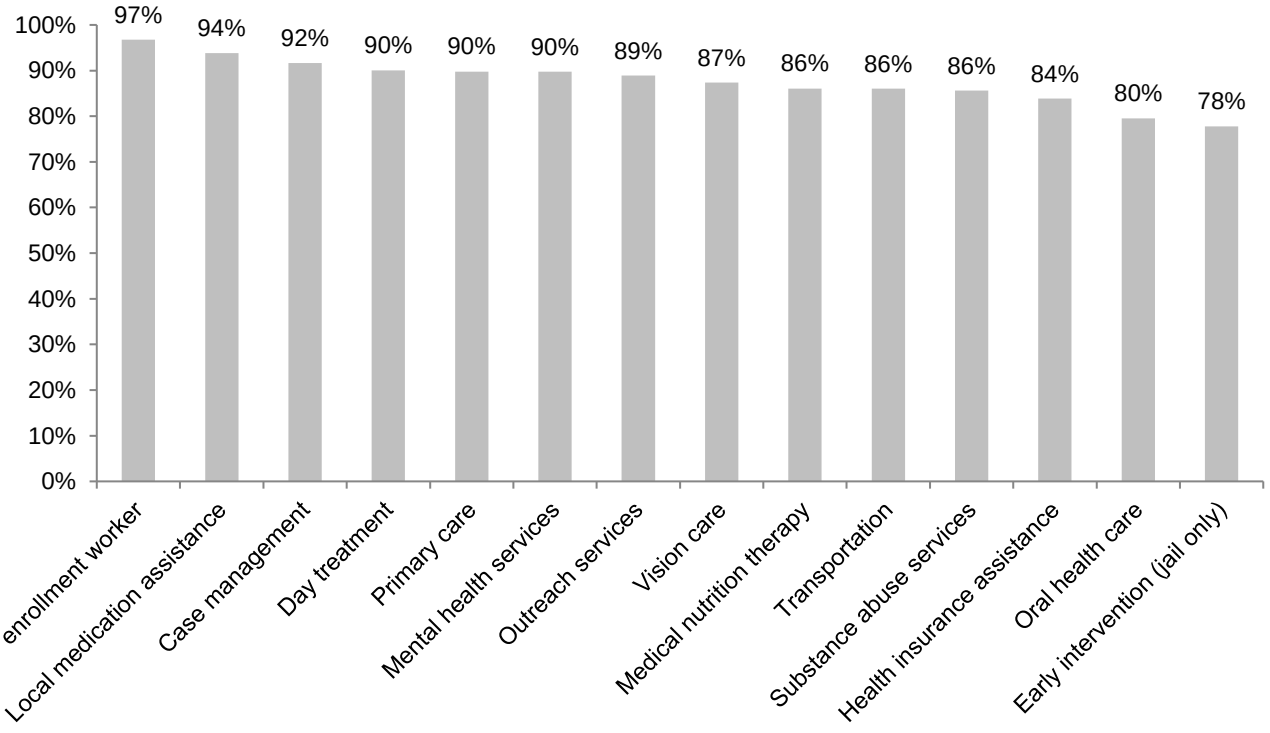
Participants were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both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

(**Graph 2**) All funded services except hospice and linguistics were analyzed and received a ranking of accessibility. The most accessible service was ADAP enrollment worker at 97% ease of access, followed by local medication assistance at 94% and case management at 92%. Local medication assistance had the highest accessibility ranking of any core medical service, while ADAP enrollment worker received the highest accessibility ranking of any support service. Compared 2016 needs assessment, reported accessibility on remained stable on average. The greatest increase in percent of participants reporting ease of access was observed in local medication assistance, while the greatest decrease in accessibility was reported for early intervention services.

GRAPH 2-Ranking of HIV Services in the Houston Area, By Accessibility, 2020

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.

Denominator: 569-573 participants, varying between service categories



Overall Ranking of Barriers Types Experienced by Consumers

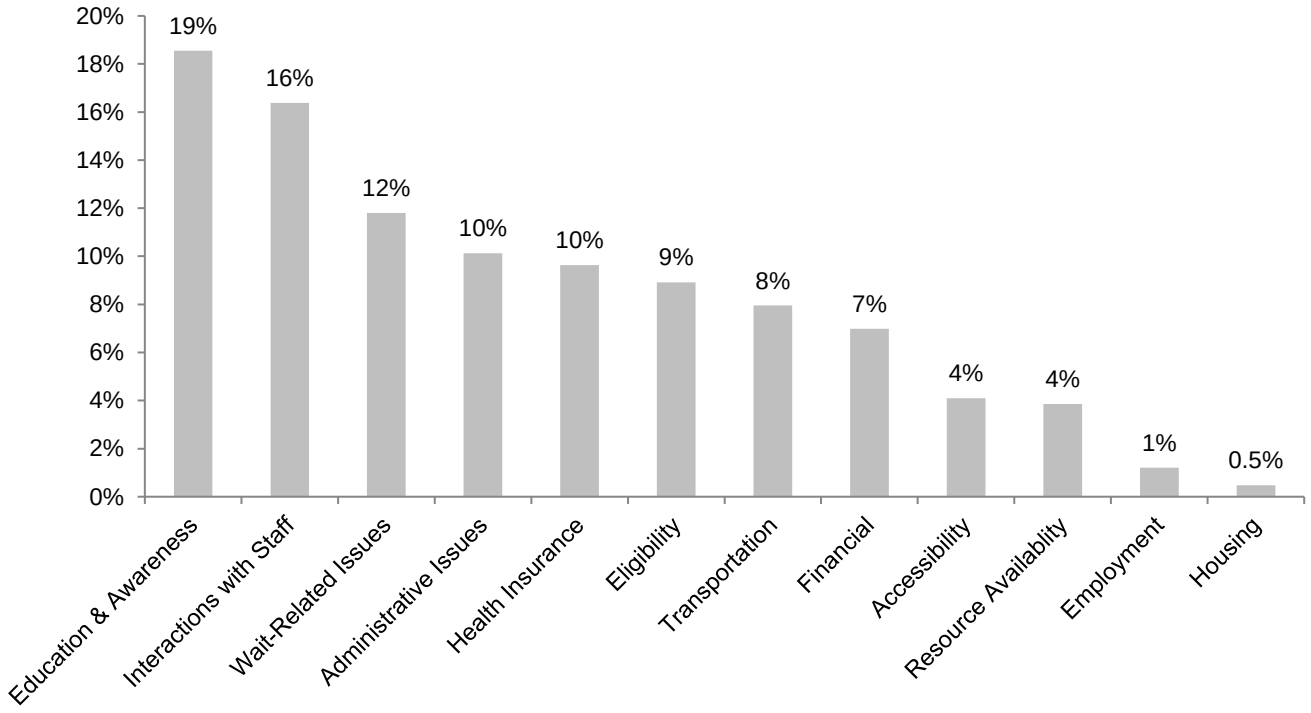
Since the 2016 Houston Area HIV Needs Assessment, participants who reported *difficulty* accessing needed services have been asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. In 2016, staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers, then grouped together into 12 nodes, or barrier types. This categorization schema was applied to reported barriers in the 2020 survey.

(**Graph 3**) Overall, fewer barriers were reported in 2020 (415 barrier reports) than in previous 2016 needs assessment (501 barrier reports), despite the increase in sample size in 2020. Across all funded services, the barrier types reported most often related to service education and awareness issues (19% of all reported barriers); interactions with staff (16%), wait-related issues (12%); administrative issues (10%); and issues relating to health insurance coverage (10%). Housing issues (homelessness or intimate partner violence) were reported least often as barriers to funded services (1%). Between the 2016 and 2020 HIV needs assessments, the percentage of barriers relating to interactions with staff increased by 3 percentage points, while wait-related issues decreased by 3 percentage points.

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, 2018

Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.
Denominator: 415 barrier reports



Descriptions of Barriers Encountered

All funded services were reported to have barriers, with an average of 35 reports of barriers per service. Participants reported the least barriers for Linguistic Services (one barrier) and the most barriers for Oral Health Care (90 barriers). In total, 415 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 81% of barriers reported. Being put on a waitlist accounted for a majority (56%) of wait-related barriers. Poor communication and/or follow up from staff members when contacting participants comprised a majority (53%) of barriers related to staff interactions. Forty-five percent (45%) of eligibility barriers related to participants being told they did not meet eligibly requirements to receive the service while redundant or complex processes for renewing eligibility accounted for an additional 39% of eligibility barriers. Among administrative issues, long or complex processes required to obtain services sufficient to create a burden to access comprised most (57%) of the barriers reported.

A majority of health insurance-related barriers occurred because the participant was under-insured or experiencing coverage gaps for needed services or medications (55%) or they were uninsured (25%). The largest proportion (91%) of transportation-related barriers occurred when participants had no access to transportation. Inability to afford the service accounted for all barriers relating to participant financial resources. Services being offered at an inaccessible distance accounted for most (76%) of accessibility-related barriers, though it is noteworthy that low or no literacy accounted for 12% of accessibility-related barriers. Receiving resources that were insufficient to meet participant needs accounted for most resource availability barriers. Intimate partner violence accounted for both reports of housing-related barriers. Instances in which the participant's employer did not provide sufficient sick/wellness leave for attend appointments comprised most (80%) employment-related barriers.

TABLE 1-Barrier Proportions within Each Barrier Type, 2020					
Education & Awareness	%	Wait-Related Issues	%	Interactions with Staff	%
Availability (Didn't know the service was available)	51%	**Waitlist** (Put on a waitlist)	56%	**Communication** (Poor correspondence/ Follow up from staff)	53%
Definition (Didn't know what service entails)	2%	**Unavailable** (Waitlist full/not available resulting in client not being placed on waitlist)	22%	**Poor Treatment** (Staff insensitive to clients)	13%
Location (Didn't know where to go [location or location w/in agency])	30%	**Wait at Appointment** (Appointment visits take long)	12%	**Resistance** (Staff refusal/ resistance to assist clients)	6%
Contact (Didn't know who to contact for service)	16%	**Approval** (Long durations between application and approval)	10%	**Staff Knowledge** (Staff has no/ limited knowledge of service)	19%
				Referral (Received service referral to provider that did not meet client needs)	10%
Eligibility	%	Administrative Issues	%	Health Insurance	%
Ineligible (Did not meet eligibility requirements)	45%	**Staff Changes** (Change in staff w/o notice)	10%	**Uninsured** (Client has no insurance)	25%
Eligibility Process (Redundant process for renewing eligibility)	39%	**Understaffing** (Shortage of staff)	7%	**Coverage Gaps** (Certain services/medications not covered)	55%
Documentation (Problems obtaining documentation needed for eligibility)	16%	**Service Change** (Change in service w/o notice)	7%	**Locating Provider** (Difficulty locating provider that takes insurance)	18%
		Complex Process (Burden of long complex process for accessing services)	57%	**ACA** (Problems with ACA enrollment process)	3%
		Dismissal (Client dismissal from agency)	7%		
		Hours (Problem with agency hours of operation)	12%		
Transportation		Financial	%	Accessibility	%
No Transportation (No or limited transportation options)	91%	**Financial Resources** (Could not afford service)	100%	**Literacy** (Cannot read/difficulty reading)	12%
Providers (Problems with special transportation providers such as Metrolift or Medicaid transportation)	9%			**Spanish Services** (Services not made available in Spanish)	0%
				Released from Incarceration (Restricted from services due to probation, parole, or felon status)	12%
				Distance (Service not offered within accessible distance)	76%
Resource Availability	%	Housing	%	Employment	%
Insufficient (Resources offered insufficient for meeting need)	81%	**Homeless** (Client is without stable housing)	0%	**Unemployed** (Client is unemployed)	20%
Quality (Resource quality was poor)	19%	**IPV** (Interpersonal domestic issues make housing situation unsafe)	100%	**Leave** (Employer does not provide sick/wellness leave for appointments)	80%

NEEDS AND ACCESSIBILITY FOR UNFUNDED SERVICES

The Ryan White HIV/AIDS Program allows funding of 13 core medical services and 15 support services, though only 17 of these services were funded in the Houston area at the time of survey. For this first time, the 2020 Houston Area HIV Needs Assessment collected data on the need for and accessibility to services that are allowable under Ryan White, but not currently funded in the Houston area. While these services are not funded under Ryan White, other funding sources in the community may offer them.

Overall Ranking of Unfunded Services, by Need

Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of allowable but currently unfunded services they needed in the past 12 months.

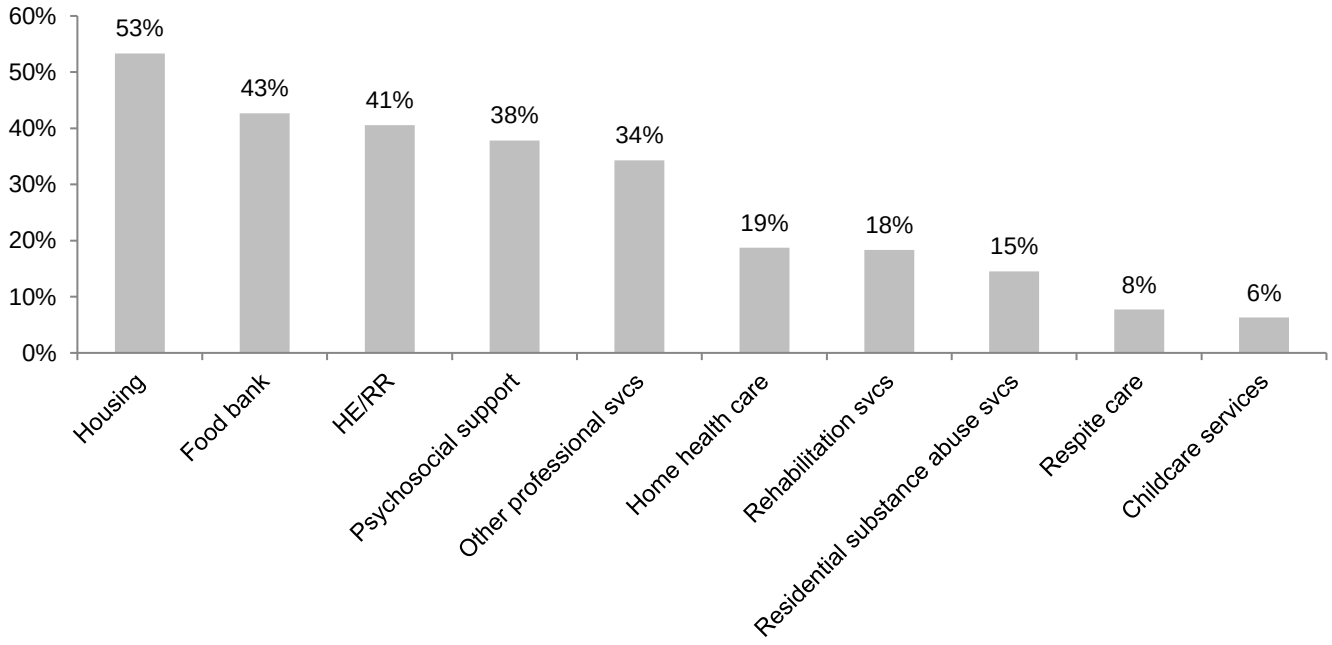
(**Graph 4**) At 53%, housing was the most needed unfunded service in the Houston Area, followed by food bank at 43%, health education/risk reduction at 41%, psychosocial support services at 38%, and other professional services at 34%. Of participants indicating a need for food bank, 69% reported needing services from a food bank, 6% reported needing home delivered meals, and 25% indicated need for both types of food bank service. Among participants indicating a need for psychosocial support services, 89% reported needing an in-person support group, 3% reported needing an online support group, and 8% indicated need for both types of psychosocial support.

Home health care had the highest need ranking of any unfunded core medical service, while housing received the highest need ranking of any unfunded support service.

GRAPH 4-Ranking of Unfunded HIV Services in the Houston Area, By Need, 2020

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

Denominator: 569-572 participants, varying between service categories



Overall Ranking of Unfunded Services, by Accessibility

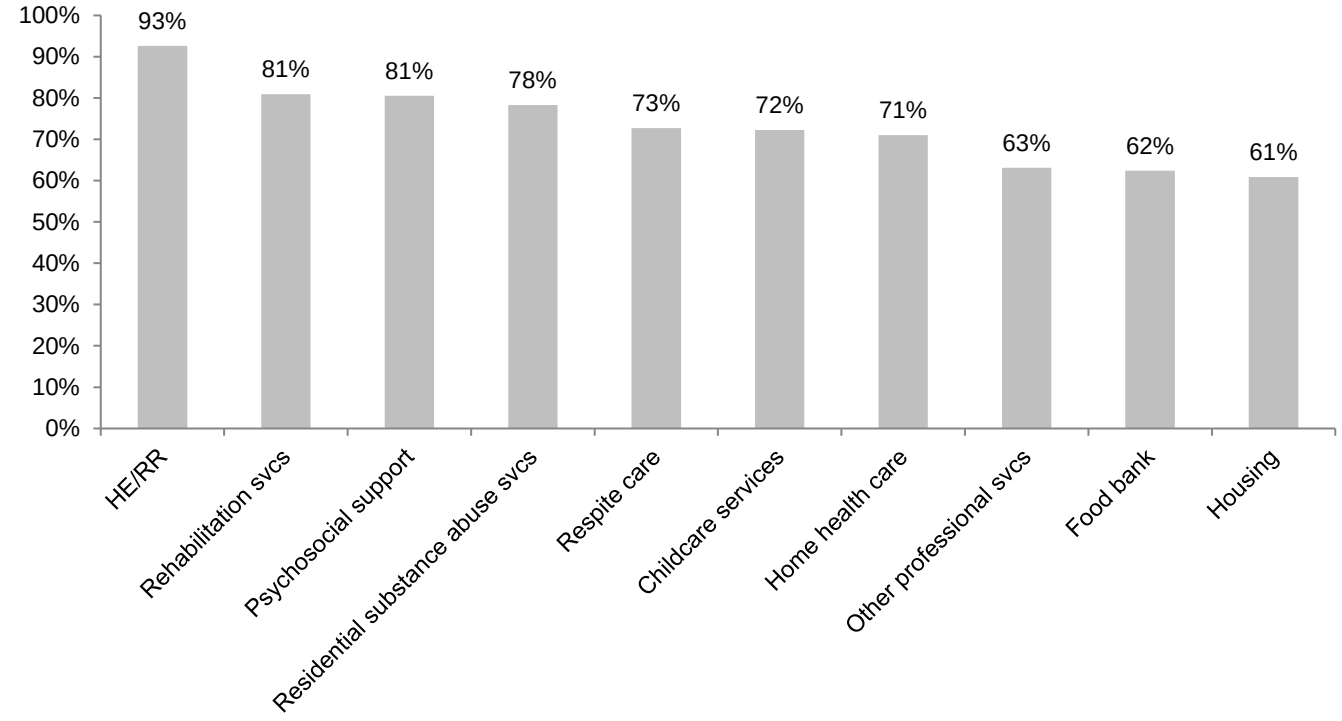
Participants were asked to indicate if each of the unfunded HIV services they needed in the past 12 months was easy or difficult for them to access.

(**Graph 5**) The most accessible unfunded service was health education/risk reduction at 93% ease of access, followed by rehabilitation services at 81%, psychosocial support services at 81%, residential substance abuse services at 78%, and respite care at 73%. The least accessible needed unfunded services was housing at 61%. Home health care had the highest accessibility ranking of any core medical service, while rehabilitation services received the highest accessibility ranking of any support service.

GRAPH 5-Ranking of Unfunded HIV Services in the Houston Area, By Accessibility, 2020

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

Denominator: 569-572 participants, varying between service categories



Other Identified Needs

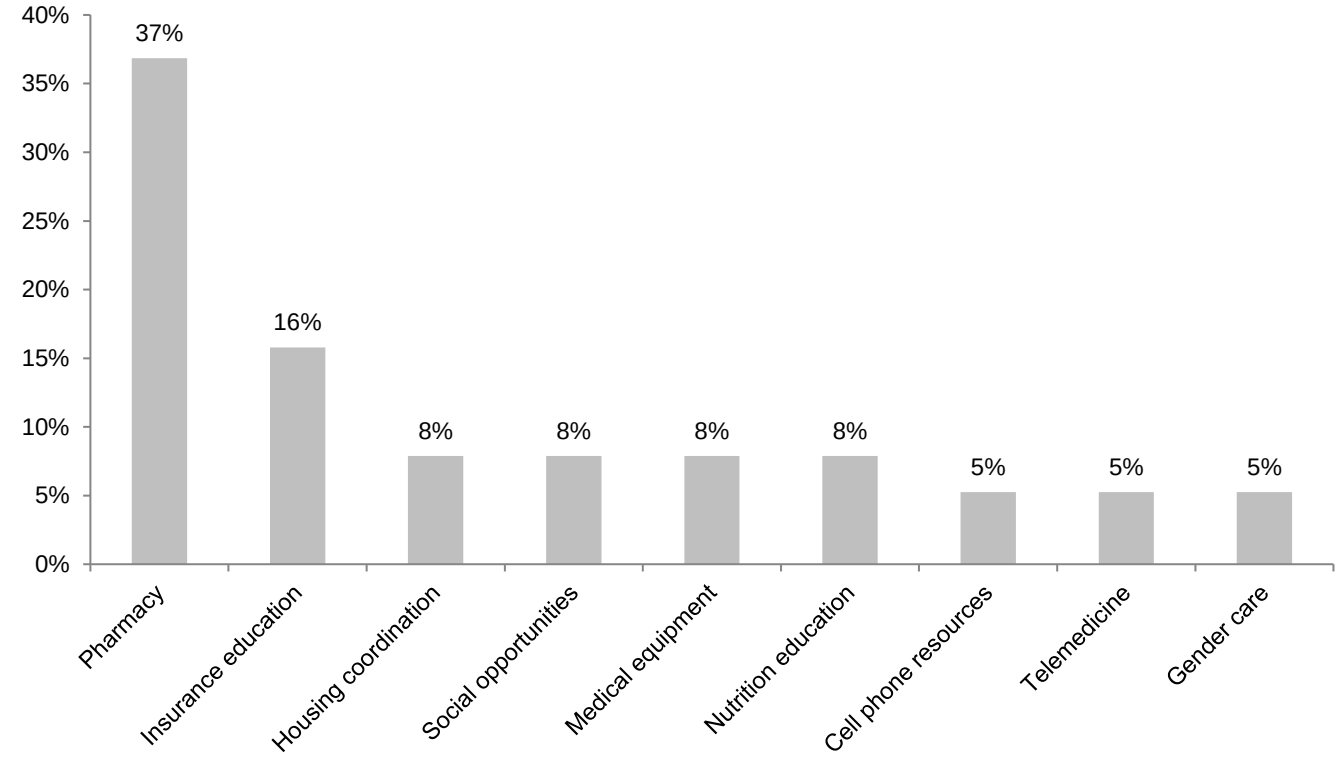
In addition to the allowable HIV services listed above, participants were also encouraged to write-in other types of needed services to gauge any new or emerging service needs in the community.

(**Graph 6**) Participants identified nine additional needs not otherwise described in funded and unfunded services above. The most common identified needs related to pharmacy, such as having medications delivered and automatic refills, at 37%. This was followed by insurance education at 16%, and housing coordination, social opportunities, coverage for medical equipment, and nutrition education, each at 8%.

GRAPH 6-Other Needs for HIV Services in the Houston Area, 2020

Definition: Percent of write-in responses by type for the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

Denominator: 38 write-in responses



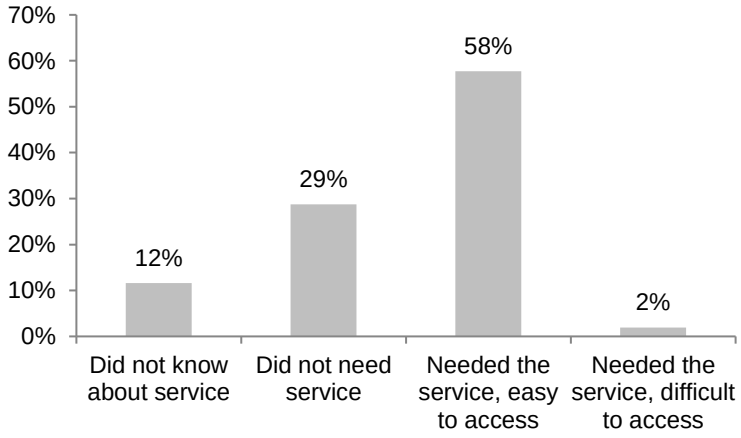
Service-Specific Fact Sheets

ADAP ENROLLMENT WORKER

AIDS Drug Assistance Program (ADAP) enrollment worker, technically referred to as *referral for health care and support,* describes a service that helps people living with HIV (PLWH) access medication coverage by ensuring the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). ADAP enrollment workers meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, assist clients with the submission of complete, accurate ADAP applications, and submit annual re-certifications.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 60% of participants indicated a need for *ADAP enrollment worker* in the past 12 months. 58% reported the service was easy to access, and 2% reported difficulty. 12% stated they did not know the service was available.

GRAPH 1-ADAP Enrollment Worker, 2020



(**Table 1**) When barriers to *ADAP enrollment worker* were reported, the most common barrier type was education and awareness (30%). Education and awareness barriers reported include lack of knowledge about service availability and who to contact to access the service.

TABLE 1-Top 3 Reported Barrier Types for ADAP Enrollment Worker, 2020

	No.	%
1. Education and Awareness (EA)	3	30%
2. Administrative (AD)	2	20%
3. Eligibility (EL)	2	20%

(**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 *ADAP enrollment worker*, this analysis shows the following:

- More females than males found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.

In addition, more out of care, rural, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-ADAP Enrollment Worker, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	9%	8%	13%	12%	4%	12%	9%	8%
Did not need service	28%	31%	32%	36%	20%	12%	28%	31%	32%
Needed, easy to access	57%	58%	57%	50%	66%	77%	57%	58%	57%
Needed, difficult to access	2%	1%	3%	2%	1%	8%	2%	1%	3%

TABLE 3-ADAP Enrollment Worker, by Selected Special Populations, 2020

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

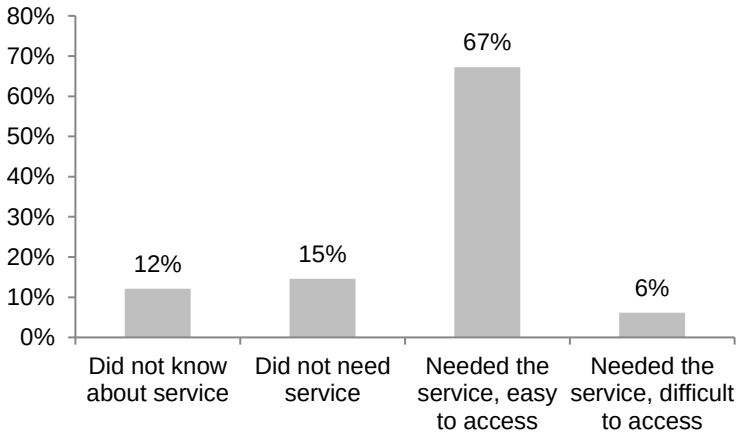
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

CASE MANAGEMENT

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

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 73% of participants indicated a need for *case management* in the past 12 months. 67% reported the service was easy to access, and 6% reported difficulty. 12% stated they did not know the service was available.

GRAPH 1-Case Management, 2020



(**Table 1**) When barriers to *case management* were reported, the most common barrier type was interactions with staff (37%). Staff interaction barriers reported include poor correspondence or follow up, poor treatment, limited staff knowledge of services, and service referral to provider that did not meet client needs.

TABLE 1-Top 4 Reported Barrier Types for Case Management, 2020

	No.	%
1. Interactions with Staff (S)	13	37%
2. Education and Awareness (EA)	8	8%
3. Administrative (AD)	6	8%
4. Wait (4)	2	2%

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

- More females than males found the service accessible.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.

In addition, more out of care, transgender, recently released from incarceration, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Case Management, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	7%	10%	11%	15%	4%	5%	15%	9%
Did not need service	59%	68%	22%	14%	13%	8%	29%	12%	17%
Needed, easy to access	20%	23%	64%	68%	66%	81%	52%	67%	69%
Needed, difficult to access	4%	3%	4%	7%	6%	8%	14%	6%	5%

TABLE 3-Case Management, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	10%	13%	13%	11%	37%	17%
Did not need service	13%	18%	16%	8%	9%	13%
Needed, easy to access	68%	63%	58%	71%	51%	58%
Needed, difficult to access	10%	6%	13%	11%	3%	13%

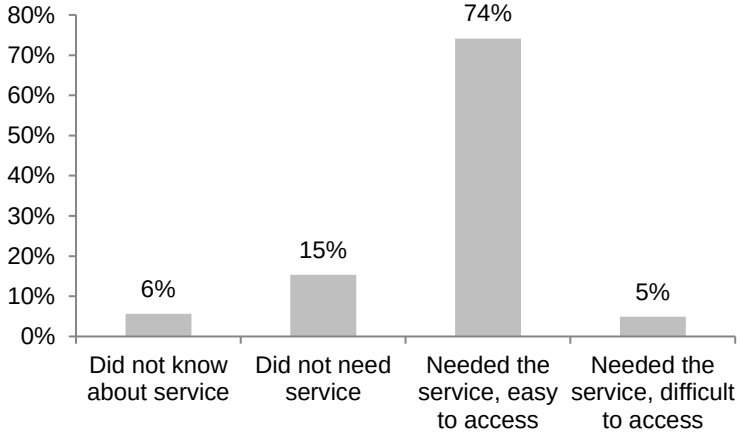
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

LOCAL HIV MEDICATION ASSISTANCE

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

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 79% of participants indicated a need for *local HIV medication assistance* in the past 12 months. 74% reported the service was easy to access, and 5% reported difficulty. 6% stated that they did not know the service was available.

GRAPH 1-Local HIV Medication Assistance, 2020



(**Table 1**) When barriers to *local HIV medication assistance* were reported, the most common barrier type was eligibility (25%). Eligibility barriers reported include redundant or complex processes for meeting/renewing eligibility, problems obtaining documentation needed for eligibility and not meeting eligibility requirements.

TABLE 1-Top 5 Reported Barrier Types for Local HIV Medication Assistance, 2020

	No.	%
1. Eligibility (EL)	7	25%
2. Administrative (AD)	4	14%
3. Education and Awareness (EA)	4	14%
4. Health Insurance Coverage (I)	4	14%
5. Interactions with Staff (S)	3	11%

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

- More males than females found the service accessible.
- More White PLWH than other race/ethnicities found the service accessible.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, homeless, MSM, rural, and transgender PLWH found the service difficult to access when compared to all participants.

TABLE 2-Local HIV Medication Assistance, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	7%	2%	1%	5%	7%	8%	0%	6%	6%
Did not need service	16%	12%	29%	17%	10%	4%	14%	15%	16%
Needed, easy to access	73%	79%	69%	72%	76%	88%	81%	73%	75%
Needed, difficult to access	4%	7%	1%	5%	6%	4%	5%	6%	3%

TABLE 3-Local HIV Medication Assistance, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	11%	6%	10%	6%	6%	8%
Did not need service	15%	17%	20%	8%	17%	46%
Needed, easy to access	68%	71%	70%	83%	71%	42%
Needed, difficult to access	6%	6%	0%	3%	6%	4%

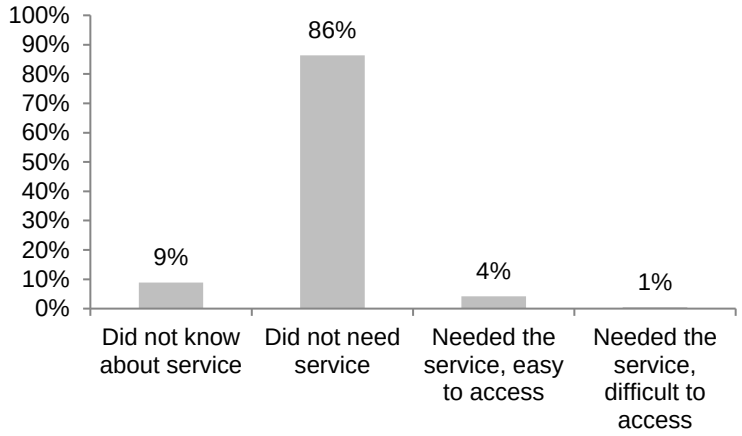
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

OUTREACH SERVICES

Outreach services are provided for people living with HIV (PLWH) who have missed primary medical care appointments without rescheduling, and who may have other risk factors for falling out of care. The goal of *outreach services* is to support retention in care. Services are field-based, and include assistance with medical appointment setting and accessing supportive services, advocating on behalf of clients to decrease service gaps and remove barriers to services, and helping clients develop and utilize independent living skills and strategies.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 5% of participants indicated a need for *outreach services* in the past 12 months. 4% reported the service was easy to access, and 1% reported difficulty. 9% stated that they did not know the service was available.

GRAPH 1-Outreach Services, 2020



(**Table 1**) When barriers to *outreach services* were reported, the most common barrier type was interactions with staff (71%). Interactions with staff barriers reported include poor correspondence or follow up.

TABLE 1-Top Reported Barrier Type for Outreach Services, 2020

	No.	%
1. Interactions with Staff (S)	5	71%

(**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 *outreach services,* this analysis shows the following:

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

TABLE 2-Outreach Services, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	22%	17%	22%	19%	22%	23%	57%	25%	11%
Did not need service	42%	40%	57%	45%	33%	38%	24%	34%	53%
Needed, easy to access	34%	40%	17%	34%	42%	38%	19%	37%	34%
Needed, difficult to access	3%	2%	4%	2%	2%	0%	5%	3%	1%

TABLE 3-Outreach Services, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	23%	23%	20%	28%	26%	21%
Did not need service	28%	42%	37%	30%	37%	42%
Needed, easy to access	37%	32%	43%	39%	37%	35%
Needed, difficult to access	12%	3%	0%	3%	0%	2%

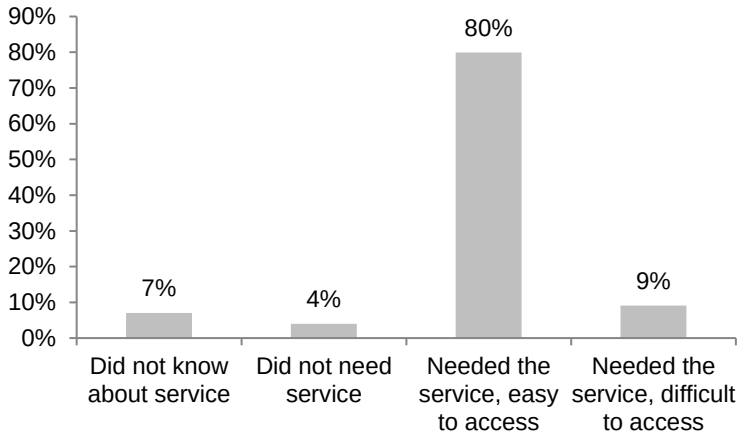
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

PRIMARY HIV MEDICAL CARE

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

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 89% of participants indicated a need for *primary HIV medical care* in the past 12 months. 80% reported the service was easy to access, and 90% reported difficulty. 7% stated that they did not know the service was available.

GRAPH 1-Primary HIV Medical Care, 2020



(**Table 1**) When barriers to *primary HIV medical care* were reported, the most common barrier type was transportation (26%). Transportation barriers reported include having no or limited transportation options, and having problems with special transportation providers such as Metrolift or Medicaid transportation

TABLE 1-Top 5 Reported Barrier Types for Primary HIV Medical Care, 2020

	No.	%
1. Transportation (T)	11	26%
2. Education and Awareness (EA)	8	19%
3. Interactions with Staff (S)	8	19%
4. Eligibility	4	9%
5. Wait (W)	4	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 *primary HIV medical care*, this analysis shows the following:

- More females than males found the service accessible.
- More White PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more rural, out of care, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Primary HIV Medical Care, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	8%	4%	1%	5%	12%	0%	0%	9%	5%
Did not need service	4%	4%	9%	3%	3%	0%	0%	2%	8%
Needed, easy to access	92%	85%	86%	83%	74%	92%	76%	79%	83%
Needed, difficult to access	9%	8%	4%	8%	12%	8%	24%	11%	5%

TABLE 3-Primary HIV Medical Care, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	10%	9%	19%	9%	3%	13%
Did not need service	2%	5%	10%	2%	0%	13%
Needed, easy to access	82%	77%	55%	83%	71%	75%
Needed, difficult to access	6%	10%	16%	6%	26%	0%

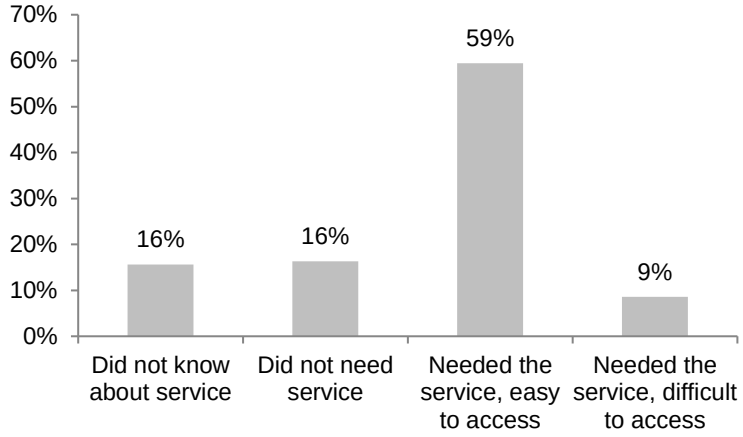
[a]Persons reporting current homelessnes [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

VISION CARE

Vision care, technically a subcategory of primary HIV medical care, provides optometric/ophthalmologic treatment, vision screening, and glasses to people living with HIV (PLWH). This does not include fitting of contact lenses.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 68% of participants indicated a need for *vision care* in the past 12 months. 59% reported the service was easy to access, and 9% reported difficulty. 16% stated they did not know the service was available.

GRAPH 1-Vision Care, 2020



(**Table 1**) When barriers to *vision care* were reported, the most common barrier type was wait-related issues. Wait-related barriers reported include scheduling appointments 2-3 months out, placement on a waitlist, being told to call back as a wait list was full/unavailable, and long waits at appointments.

TABLE 1-Top 5 Reported Barrier Types for Vision Care, 2020

	No.	%
1. Wait (W)	15	34%
2. Health Insurance Coverage (I)	8	18%
3. Education and Awareness (EA)	6	14%
4. Financial (F)	4	9%
5. Interactions with Staff (S)	3	7%

(**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 *vision care,* this analysis shows the following:

- More males than females found the service accessible.
- More Black/African American PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more homeless and out of care PLWH found the service difficult to access when compared to all participants.

TABLE 2-Vision Care, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	10%	12%	15%	15%	15%	14%	21%	8%
Did not need service	16%	18%	19%	21%	11%	4%	62%	15%	15%
Needed, easy to access	60%	58%	60%	56%	65%	69%	14%	56%	69%
Needed, difficult to access	7%	14%	9%	8%	9%	15%	14%	9%	8%

TABLE 3-Vision Care, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	20%	17%	10%	28%	6%	20%
Did not need service	16%	13%	10%	16%	20%	24%
Needed, easy to access	51%	63%	70%	47%	66%	56%
Needed, difficult to access	13%	7%	10%	9%	6%	0%

[a]Persons reporting current homelessness [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

The Positive VIBE Project Funding (Houston)

1. Medical Services Subtotal	**$310,129**
a. Outpatient /Ambulatory Health Services	$20,707
b. AIDS Pharmaceutical Assistance (local)	$0
c. Oral Health Care	$0
d. Home Health Care	$0
e. Home and Community-based Health Services	$0
f. Hospice Services	$0
g. Mental Health Services	$18,066
h. Medical Nutrition Therapy	$0
i. Medical Case Management (including Treatment Adherence)	$271,356
j. Substance Abuse Services - Outpatient	$0
2. Support Services Sub-total	**$231,503**
a. Case Management (non-Medical)	$128,931
b. Child Care Services	$0
c. Early Intervention Services	$0
d. Emergency Financial Assistance	$0
e. Food Bank/Home-Delivered Meals	$0
f. Health Education/Risk Reduction	$35,454
g. Legal Services	$0
h. Linguistics Services	$0
i. Medical Transportation Services*	$16,000
j. Outreach Services	$51,118
k. Permanency Planning	$0
l. Psychosocial Support Services	$0
m. Referral for Health Care/Supportive Services	$0
n. Rehabilitation Services	$0
o. Respite Care	$0
p. Treatment Adherence Counseling	$0
Total Service Allocations	**$541,632**

*Agency Specific funding

FROM HRSA

Coronavirus 2019 (COVID-19) Frequently Asked Questions

Updated 3/31/2020

HRSA recognizes the important work Ryan White HIV/AIDS Program recipients, subrecipients, and stakeholders are doing in response to the coronavirus 2019 (COVID-19) public health emergency. HRSA's Ryan White HIV/AIDS Program recipients provide a comprehensive system of HIV primary medical care, medication, and essential support services to the most vulnerable people with HIV, and many play an important role in delivering critical services and assisting local communities during an emergency. HRSA understands Ryan White HIV/AIDS Program recipients are coordinating with existing partners at the state, regional, and local level, while also maintaining ongoing access to HIV care and treatment services and medication to their patients. We are updating this page regularly as information becomes available.

Are RWHAP recipients allowed to use RWHAP funds to purchase pre-paid cell phones for clients who may need them to support remote service provision? ***(Added: 3/25/2020)***

Emergency Financial Assistance (EFA) is the RWHAP service category that may be used to provide pre-paid cell phones for RWHAP clients. To leverage scarce resources, the recipient should also coordinate with existing partners at the state, regional, and local level in advance to identify and define appropriate roles and responsibilities in the event of an emergency. This includes establishing relationships with local hospitals, health departments, and other large community health care providers.

NEW **We've heard from several Ryan White HIV/AIDS Program providers that food on shelves at grocery stores is low, and they would like to be able to support clients' meals using RWHAP emergency financial assistance (EFA) funding. Would our case management agency in eastern Idaho be allowed to use EFA to support meals through Grub Hub and local restaurants that are offering take out options?** ***(Added 3/31/2020)***

PCN #16-02 (PDF - 173 KB) allows for Emergency Financial Assistance to be used as one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a

voucher program. Standards are determined by RWHAP recipients, however, they must be equitably applied.

NEW **Can Ryan White HIV/AIDS Program Part A Planning Councils (PC) buy phones, electronic devices help PC members with connectivity during this emergency so members can attend meetings? Also, can consumers who are not voting members of the PC, but on the consumer committee be provided with electronic devices so they will be able to fully participate in meetings?** ***(Added 3/31/2020)***

Emergency Financial Assistance (EFA) is the RWHAP service category that may be used to provide pre-paid cell phones for RWHAP clients. To leverage scarce resources, the recipient should also coordinate with existing partners at the state, regional, and local level in advance to identify and define appropriate roles and responsibilities in the event of an emergency. This includes establishing relationships with local hospitals, health departments, and other large community health care providers.

NEW **Can a Ryan White HIV/AIDS Program Part A funded Food Bank Program pay for grocery delivery? Prior to the COVID-19 emergency, this provider had done distributed food vouchers, which they plan to go back to after the emergency is over.** ***(Added 3/31/2020)***

HRSA HAB encourages promoting access to and continuity of care in a safe way during social distancing PCN #16-02 (PDF - 173 KB) allows for Emergency Financial Assistance to be used as one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program. Standards are determined by RWHAP recipients, however, they must be equitably applied.

Harris County
Public Health
Building a Healthy Community

Ryan White Part A
Quality Management Program
Clinical Quality Management Quarterly Report

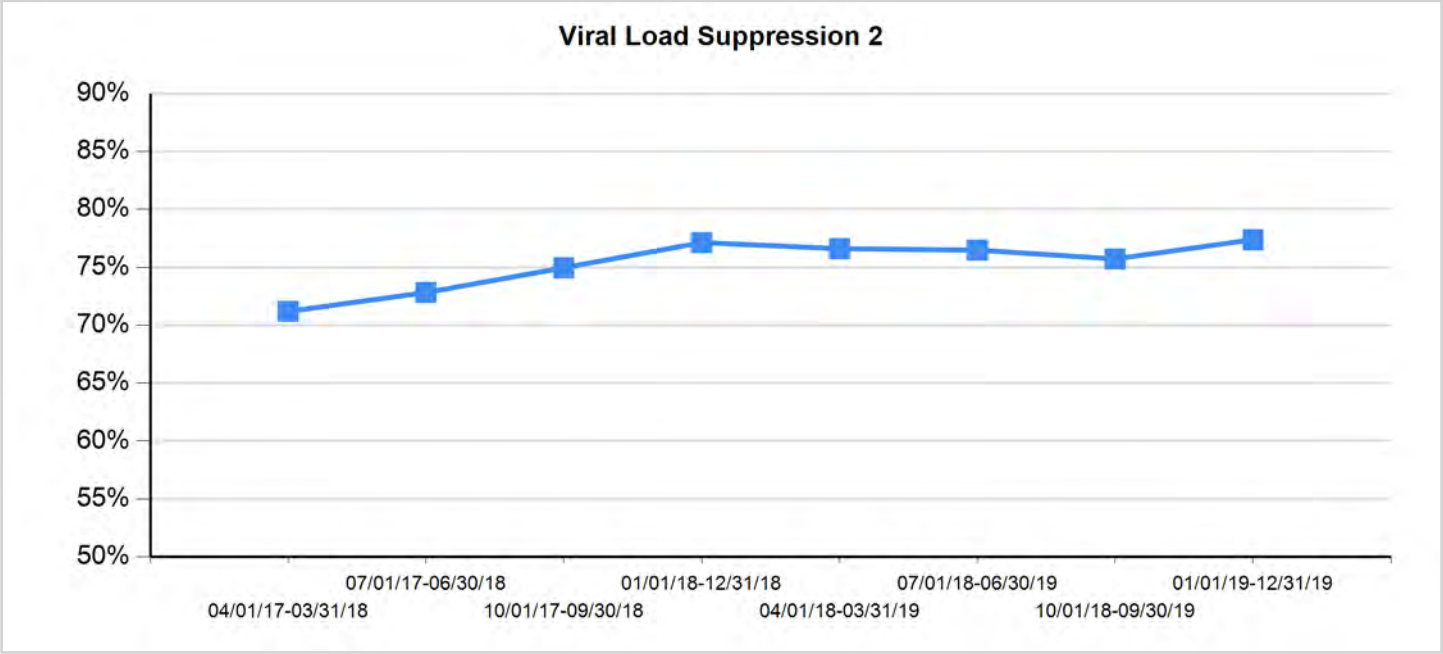
Table of Contents

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

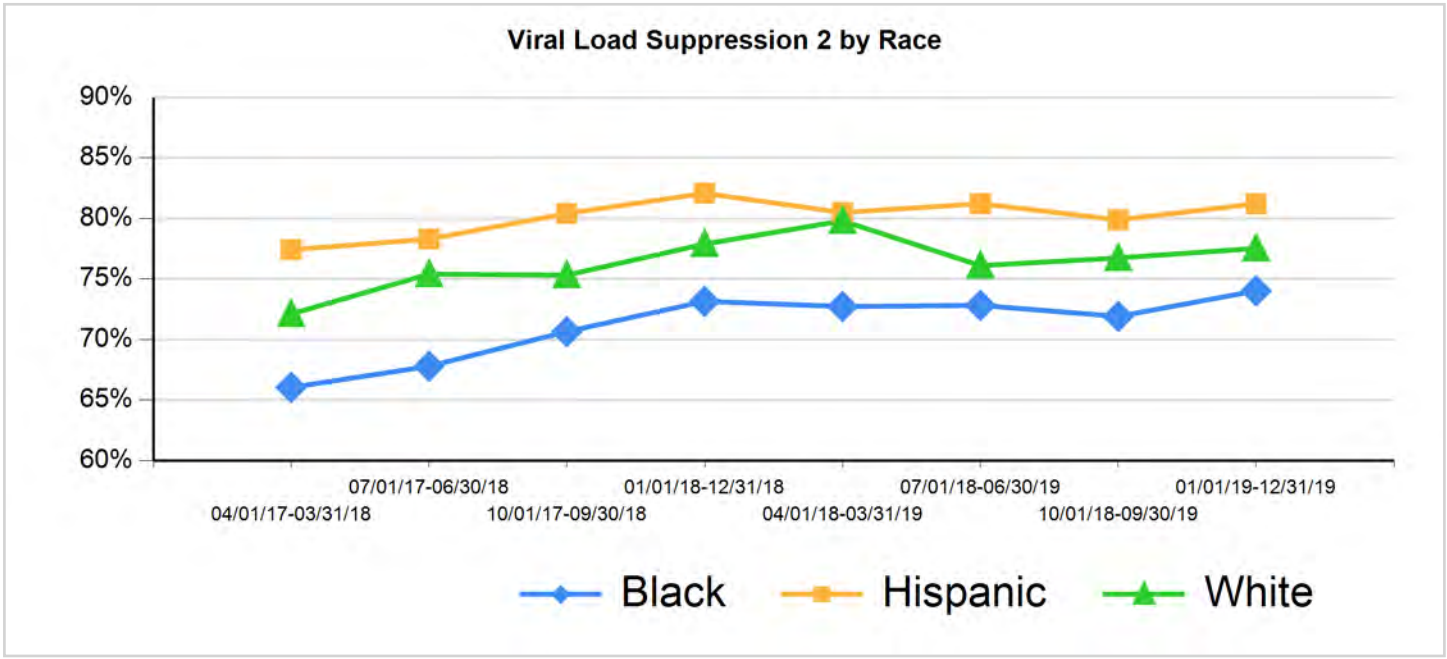
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **1/1/2019**

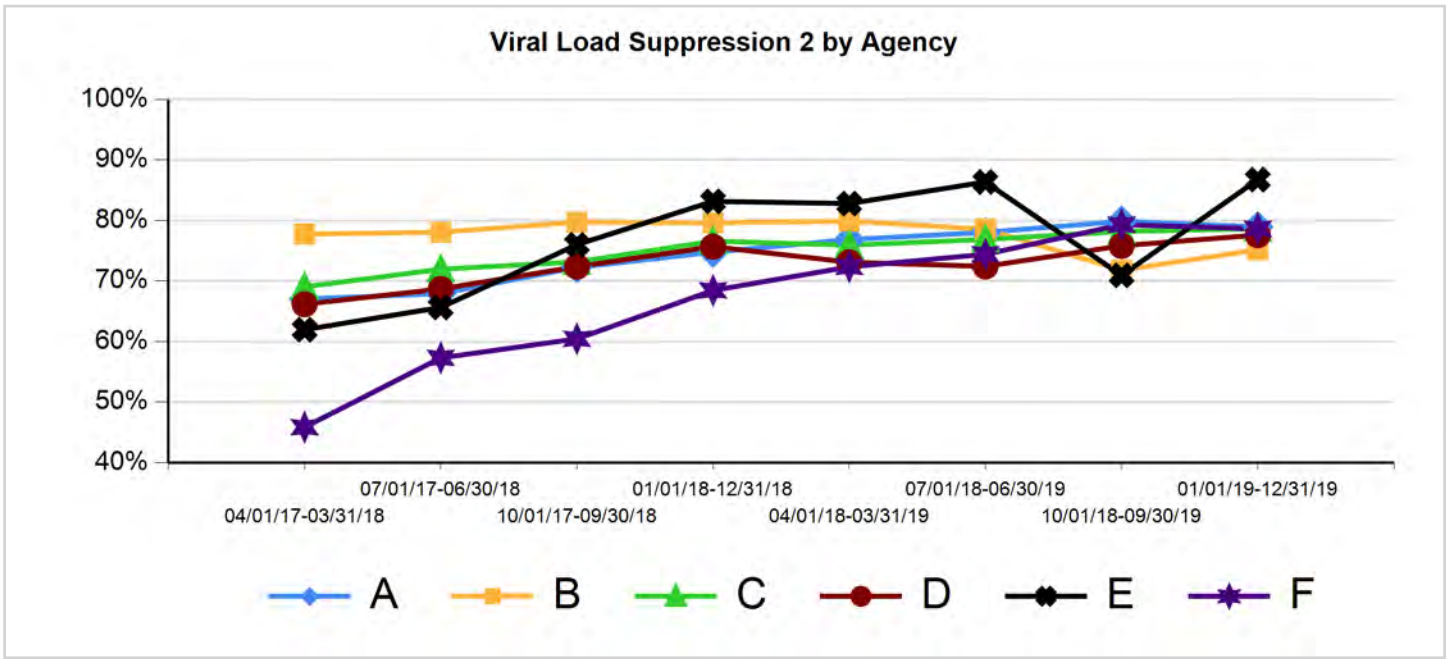
Viral Load Suppression 2- HAB Measure				
	04/01/18 - 03/31/19	07/01/18 - 06/30/19	10/01/18 - 09/30/19	01/01/19 - 12/31/19
Number of clients who have a viral load of <200 copies/ml during the measurement year	6,209	6,325	6,418	6,642
Number of clients who have had at least 1 medical visit with a provider with prescribing privileges	8,105	8,270	8,476	8,583
Percentage	76.6%	76.5%	75.7%	77.4%
Change from Previous Quarter Results	-0.5%	-0.1%	-0.8%	1.7%



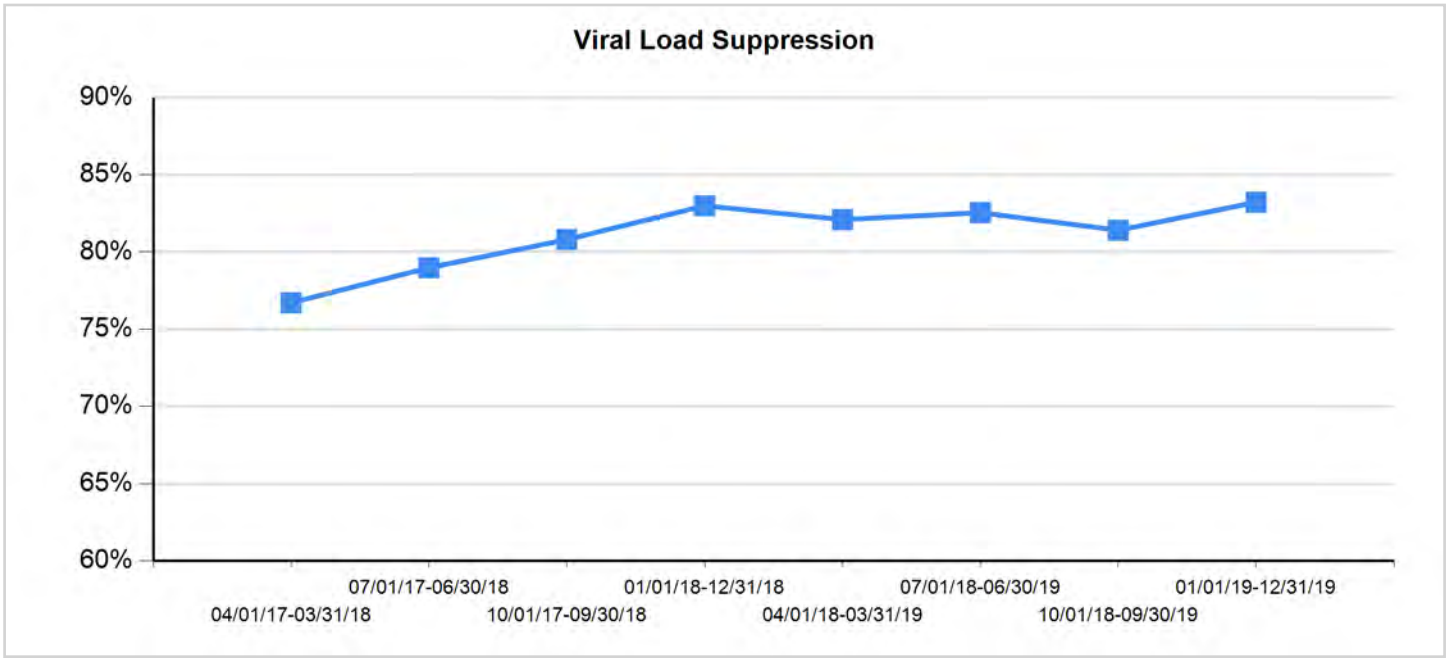
VL Suppression 2 by Race/Ethnicity									
	07/01/18 - 06/30/19			10/01/18 - 09/30/19			01/01/19 - 12/31/19		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	2,915	2,461	793	2,938	2,495	818	3,049	2,602	828
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	4,003	3,030	1,042	4,086	3,123	1,066	4,119	3,204	1,068
Percentage	72.8%	81.2%	76.1%	71.9%	79.9%	76.7%	74.0%	81.2%	77.5%
Change from Previous Quarter Results	0.1%	0.7%	-3.7%	-0.9%	-1.3%	0.6%	2.1%	1.3%	0.8%



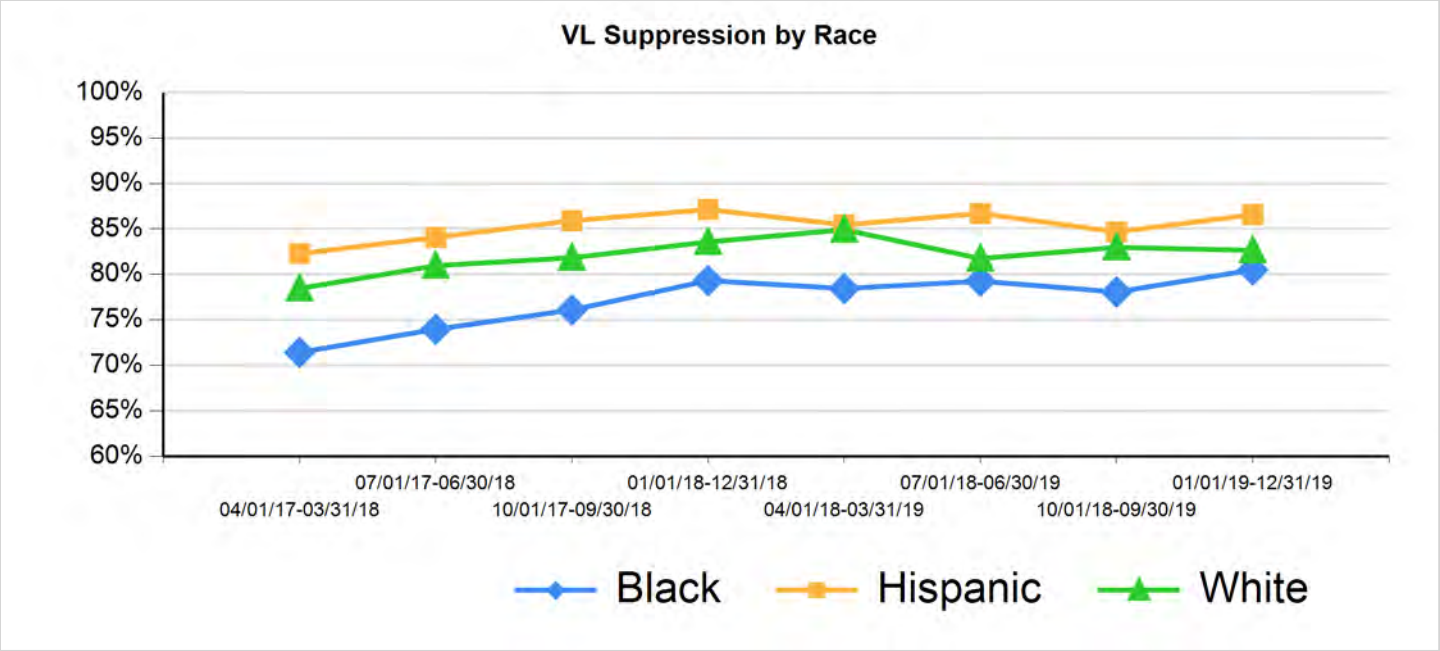
Viral Load 2 Suppression by Agency												
	10/01/18 - 09/30/19						01/01/19 - 12/31/19					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load of <200 copies/ml during the measurement year	567	1,993	2,076	1,530	61	299	544	2,077	2,132	1,607	72	331
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	710	2,776	2,655	2,018	86	377	689	2,764	2,711	2,071	83	421
Percentage	79.9%	71.8%	78.2%	75.8%	70.9%	79.3%	79.0%	75.1%	78.6%	77.6%	86.7%	78.6%
Change from Previous Quarter Results	1.8%	-6.8%	1.3%	3.4%	-15.4%	4.9%	-0.9%	3.4%	0.5%	1.8%	15.8%	-0.7%



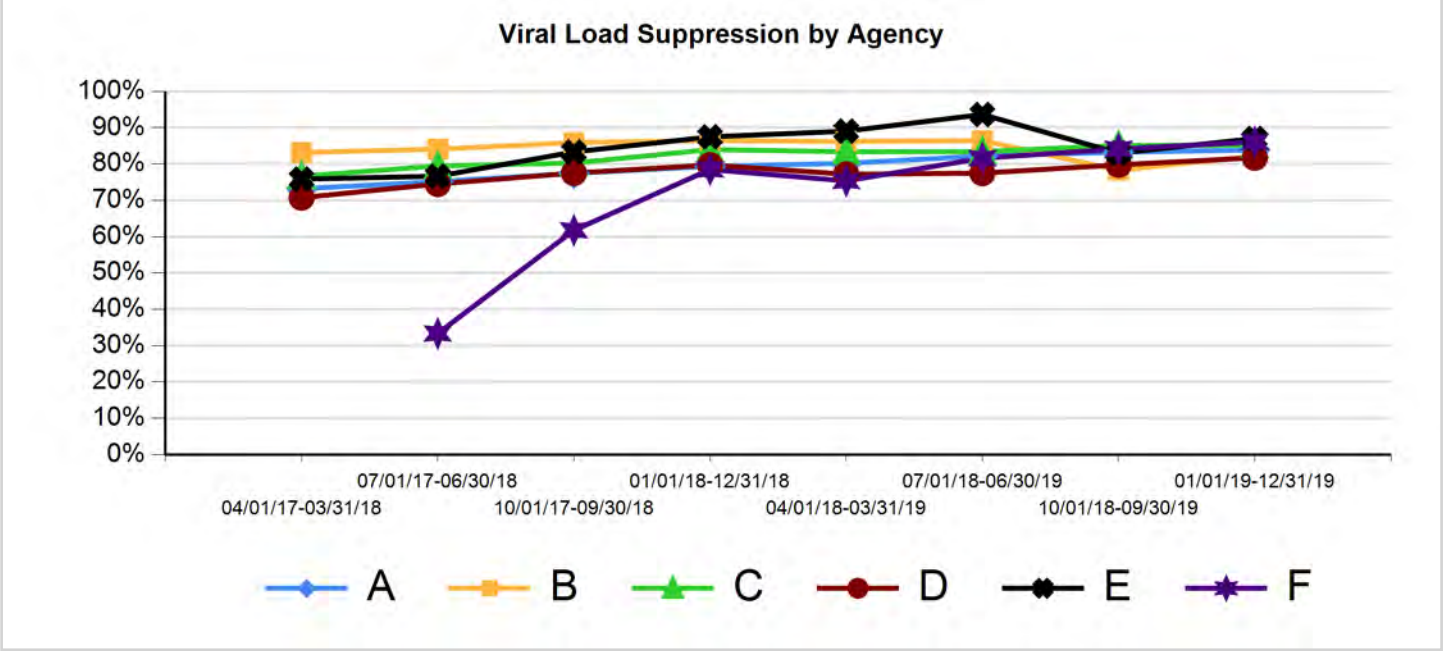
Viral Load Suppression				
	04/01/18 - 03/31/19	07/01/18 - 06/30/19	10/01/18 - 09/30/19	01/01/19 - 12/31/19
Number of clients who have a viral load of <200 copies/ml during the measurement year	4,705	4,829	4,873	5,084
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	5,731	5,850	5,986	6,109
Percentage	82.1%	82.5%	81.4%	83.2%
Change from Previous Quarter Results	-0.9%	0.4%	-1.1%	1.8%



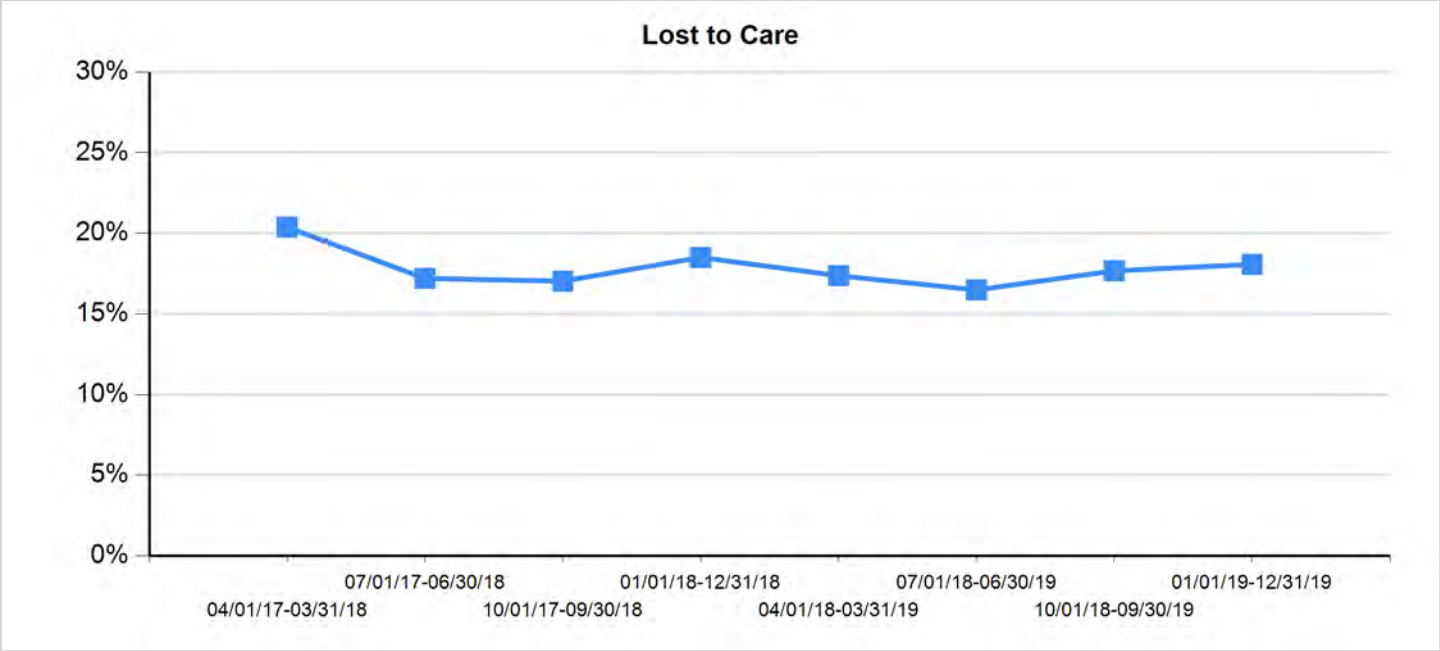
VL Suppression by Race/Ethnicity									
	07/01/18 - 06/30/19			10/01/18 - 09/30/19			01/01/19 - 12/31/19		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	2,163	1,944	609	2,192	1,950	609	2,299	2,037	624
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	2,729	2,242	745	2,808	2,303	734	2,856	2,353	755
Percentage	79.3%	86.7%	81.7%	78.1%	84.7%	83.0%	80.5%	86.6%	82.6%
Change from Previous Quarter Results	0.8%	1.3%	-3.2%	-1.2%	-2.0%	1.2%	2.4%	1.9%	-0.3%



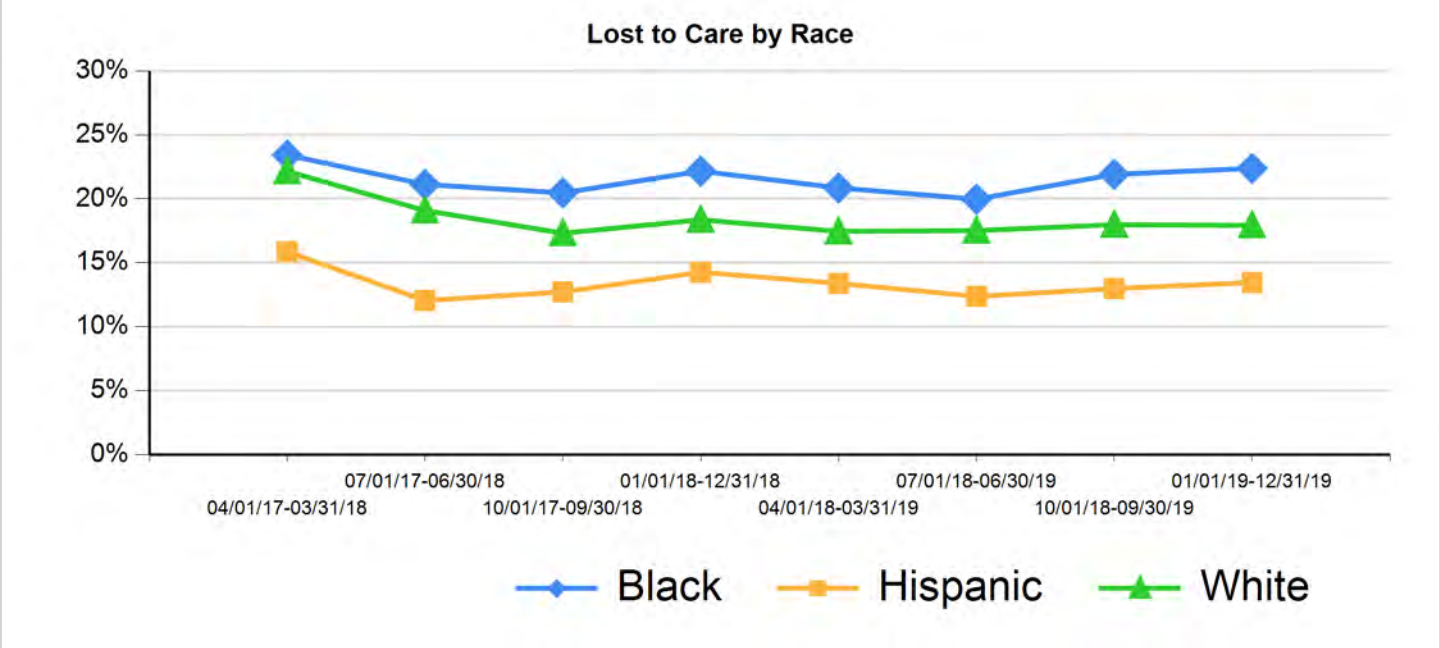
VL Suppression by Agency												
	10/01/18 - 09/30/19						01/01/19 - 12/31/19					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load of <200 copies/ml during the measurement year	498	1,423	1,453	1,310	44	170	479	1,492	1,539	1,392	47	186
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	598	1,817	1,707	1,642	53	202	571	1,815	1,806	1,703	54	216
Percentage	83.3%	78.3%	85.1%	79.8%	83.0%	84.2%	83.9%	82.2%	85.2%	81.7%	87.0%	86.1%
Change from Previous Quarter Results	1.0%	-8.1%	1.7%	2.3%	-10.6%	2.5%	0.6%	3.9%	0.1%	2.0%	4.0%	2.0%



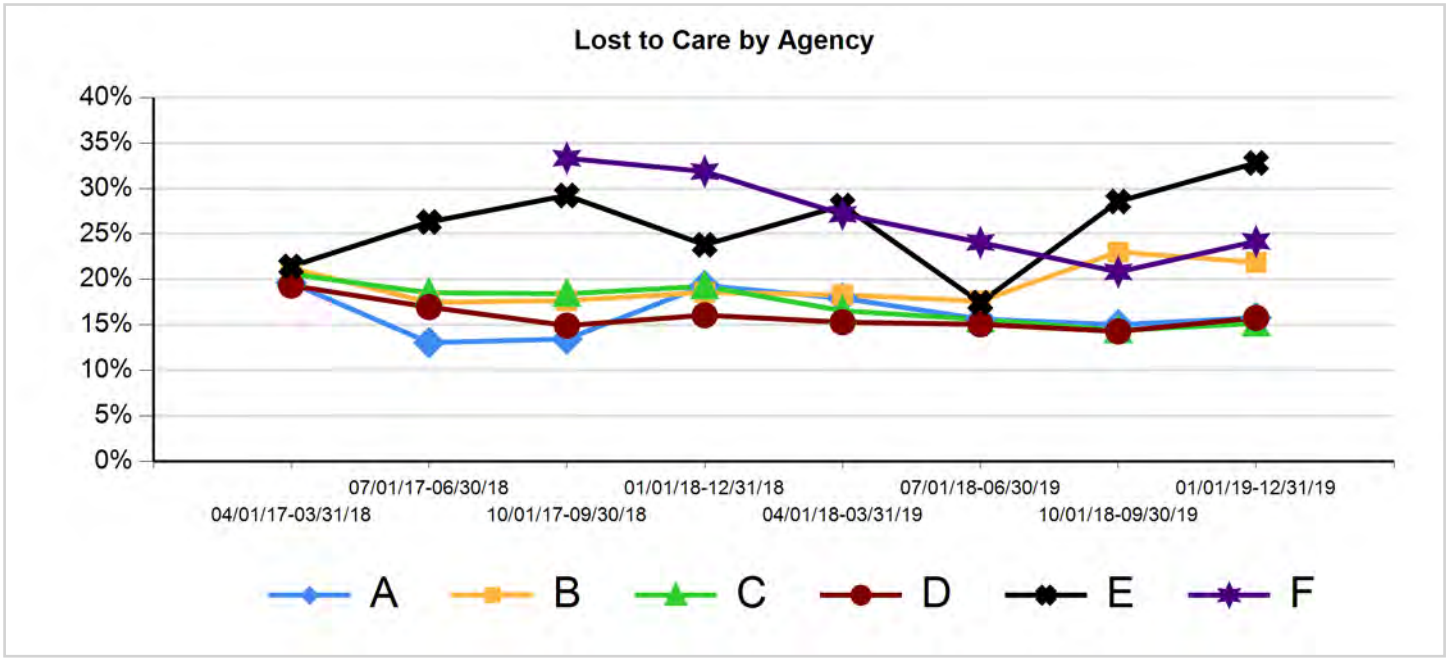
Lost to Care				
In+Care Campaign Gap Measure				
	04/01/18 - 03/31/19	07/01/18 - 06/30/19	10/01/18 - 09/30/19	01/01/19 - 12/31/19
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	991	937	1,050	1,120
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	5,705	5,683	5,941	6,198
Percentage	17.4%	16.5%	17.7%	18.1%
Change from Previous Quarter Results	-1.1%	-0.9%	1.2%	0.4%



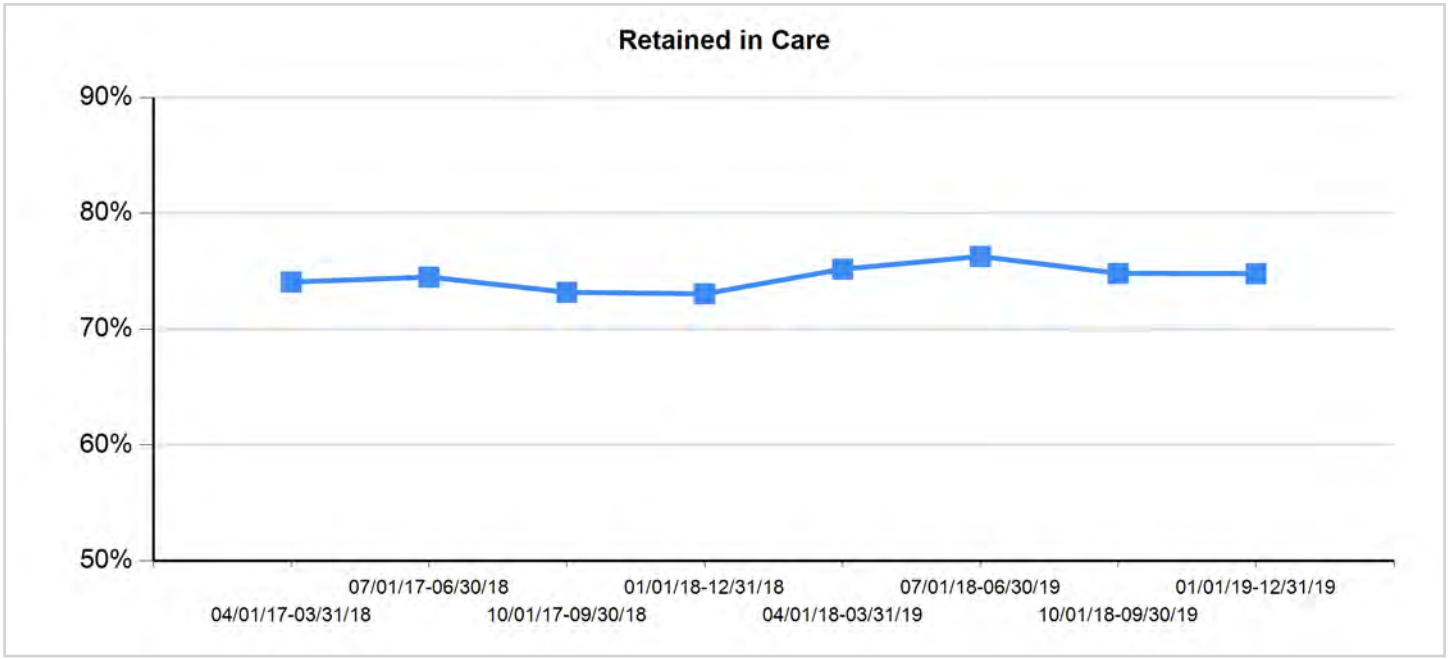
Lost to Care by Race/Ethnicity									
	07/01/18 - 06/30/19			10/01/18 - 09/30/19			01/01/19 - 12/31/19		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	524	275	124	605	301	131	644	325	136
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	2,624	2,223	708	2,761	2,320	729	2,878	2,415	759
Percentage	20.0%	12.4%	17.5%	21.9%	13.0%	18.0%	22.4%	13.5%	17.9%
Change from Previous Quarter Results	-0.9%	-1.0%	0.1%	1.9%	0.6%	0.5%	0.5%	0.5%	-0.1%



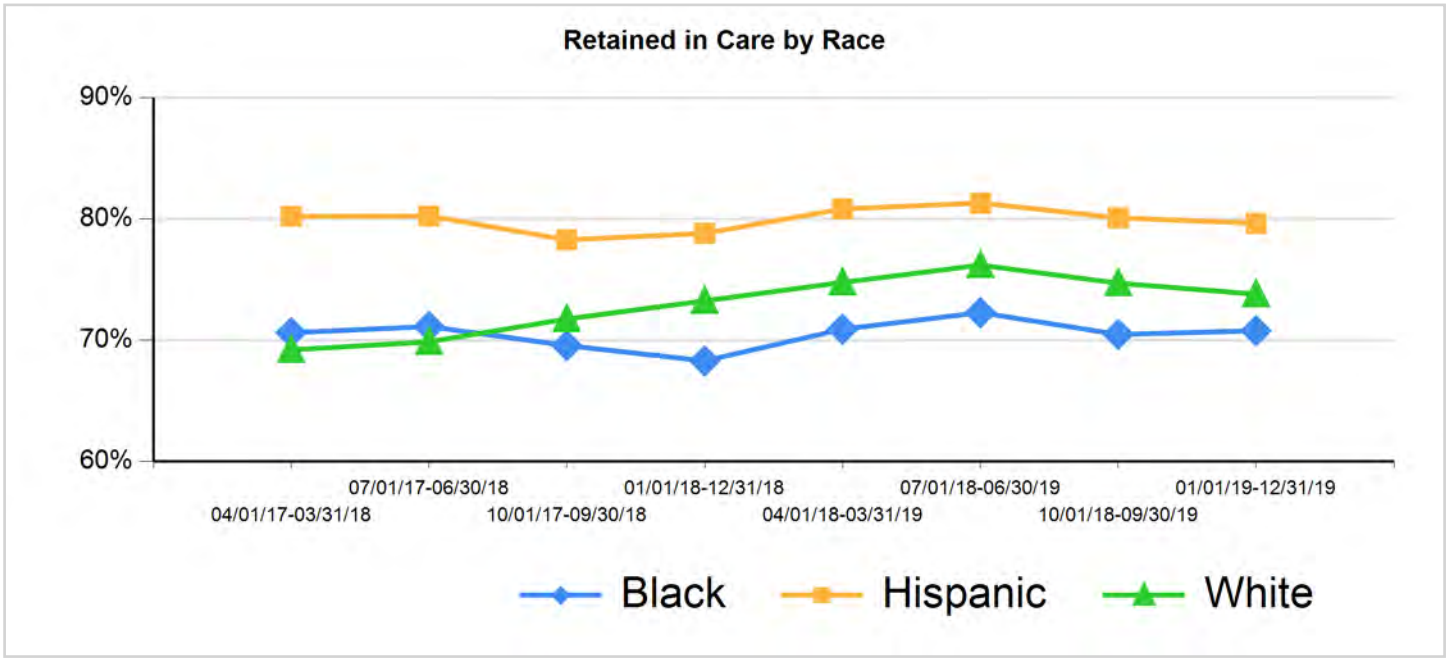
Lost to Care by Agency												
	10/01/18 - 09/30/19						01/01/19 - 12/31/19					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	83	453	248	207	18	46	89	444	275	240	21	60
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	553	1,968	1,723	1,450	63	221	564	2,030	1,814	1,522	64	248
Percentage	15.0%	23.0%	14.4%	14.3%	28.6%	20.8%	15.8%	21.9%	15.2%	15.8%	32.8%	24.2%
Change from Previous Quarter Results	-0.6%	5.4%	-1.2%	-0.8%	11.1%	-3.2%	0.8%	-1.1%	0.8%	1.5%	4.2%	3.4%



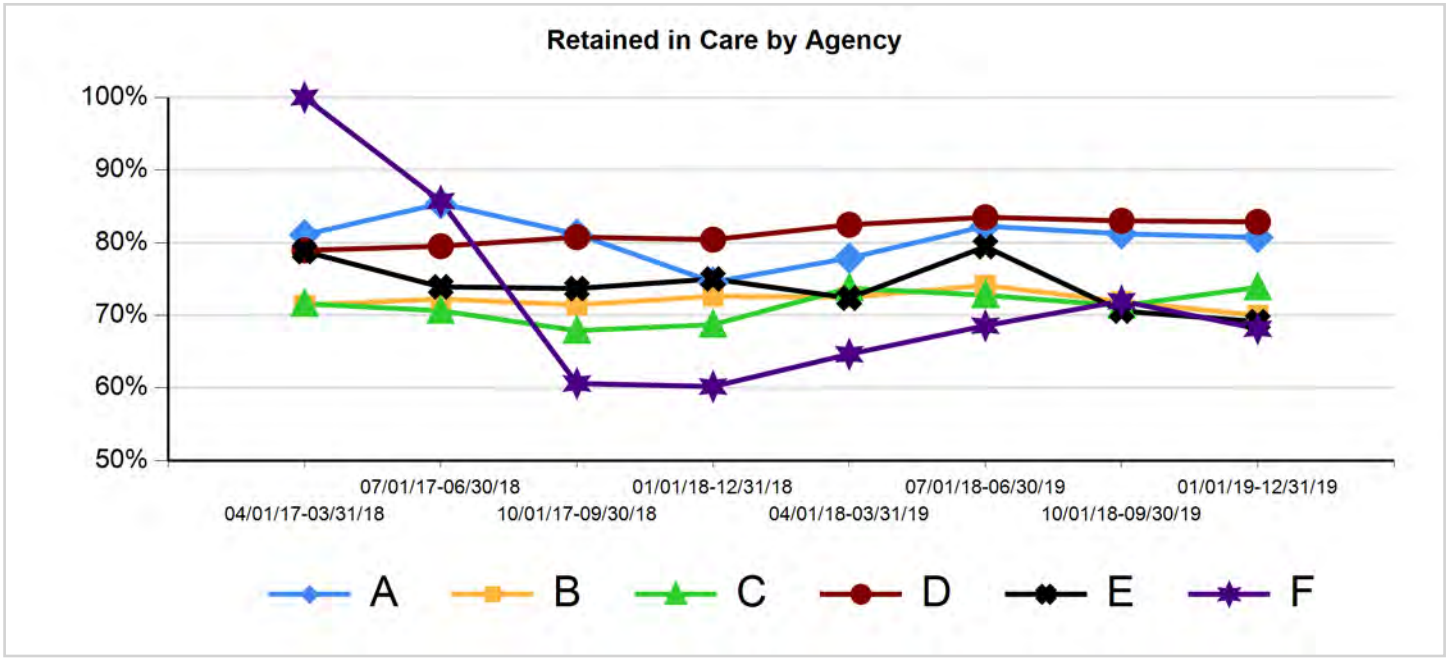
Retained in Care				
Houston EMA Medical Visits Measure				
	04/01/18 - 03/31/19	07/01/18 - 06/30/19	10/01/18 - 09/30/19	01/01/19 - 12/31/19
Number of clients who had 2 or more medical visits at least 3 months apart during the measurement year*	4,663	4,706	4,808	4,947
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	6,202	6,169	6,426	6,614
Percentage	75.2%	76.3%	74.8%	74.8%
Change from Previous Quarter Results	2.1%	1.1%	-1.5%	0.0%
* Not newly enrolled in care				



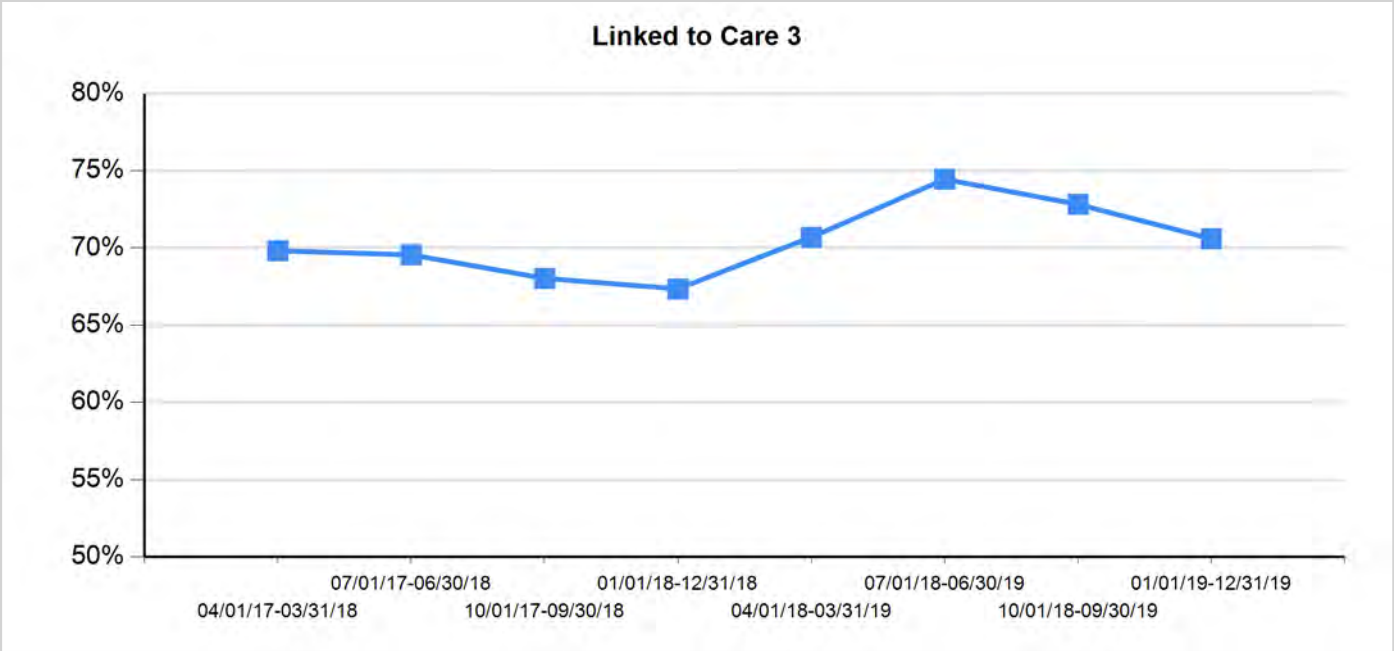
Retained in Care by Race/Ethnicity									
	07/01/18 - 06/30/19			10/01/18 - 09/30/19			01/01/19 - 12/31/19		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had 2 or more medical visits at least 3 months apart during the measurement year	2,089	1,909	598	2,137	1,958	599	2,200	2,017	605
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	2,891	2,348	785	3,033	2,445	802	3,109	2,533	820
Percentage	72.3%	81.3%	76.2%	70.5%	80.1%	74.7%	70.8%	79.6%	73.8%
Change from Previous Quarter Results	1.4%	0.5%	1.4%	-1.8%	-1.2%	-1.5%	0.3%	-0.5%	-0.9%



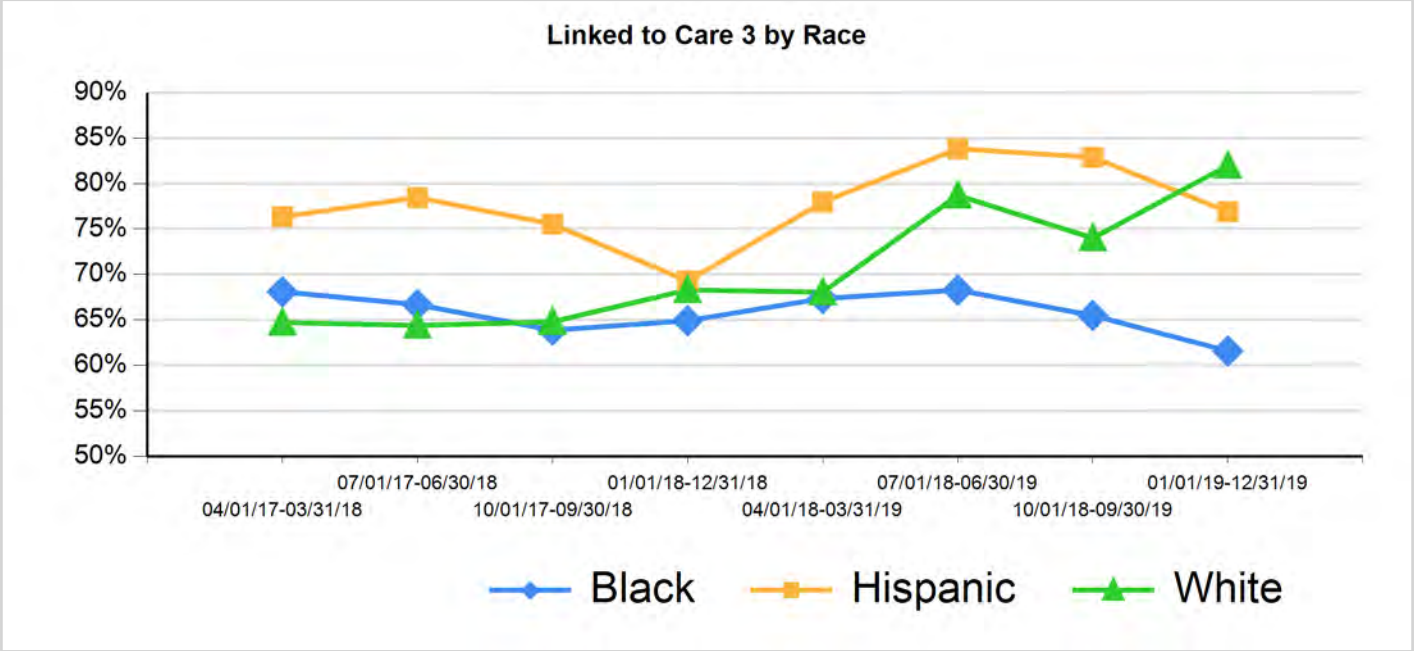
Retained in Care by Agency												
	10/01/18 - 09/30/19						01/01/19 - 12/31/19					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who had 2 or more medical visits at least 3 months apart during the measurement year	476	1,510	1,384	1,334	48	177	486	1,493	1,486	1,383	47	184
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	586	2,101	1,941	1,607	68	246	602	2,133	2,012	1,669	68	270
Percentage	81.2%	71.9%	71.3%	83.0%	70.6%	72.0%	80.7%	70.0%	73.9%	82.9%	69.1%	68.1%
Change from Previous Quarter Results	-1.0%	-2.3%	-1.5%	-0.5%	-8.9%	3.4%	-0.5%	-1.9%	2.6%	-0.1%	-1.5%	-3.8%



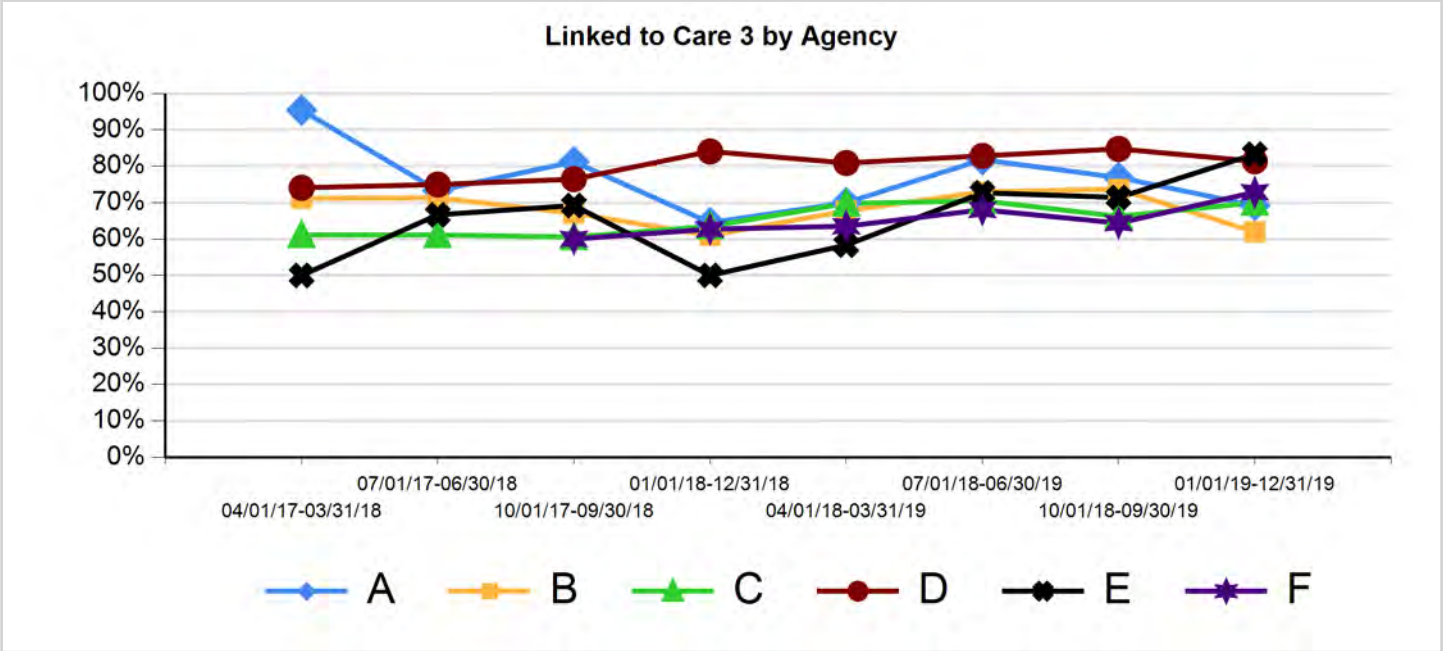
Linked to Care 3				
Medical Visits for Newly Enrolled Clients				
	04/01/18 - 03/31/19	07/01/18 - 06/30/19	10/01/18 - 09/30/19	01/01/19 - 12/31/19
Number of clients who had a medical visit with a provider at least once in the last 6 months of the measurement period	427	408	394	377
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 6 months of the measurement period	604	548	541	534
Percentage	70.7%	74.5%	72.8%	70.6%
Change from Previous Quarter Results	3.3%	3.8%	-1.6%	-2.2%



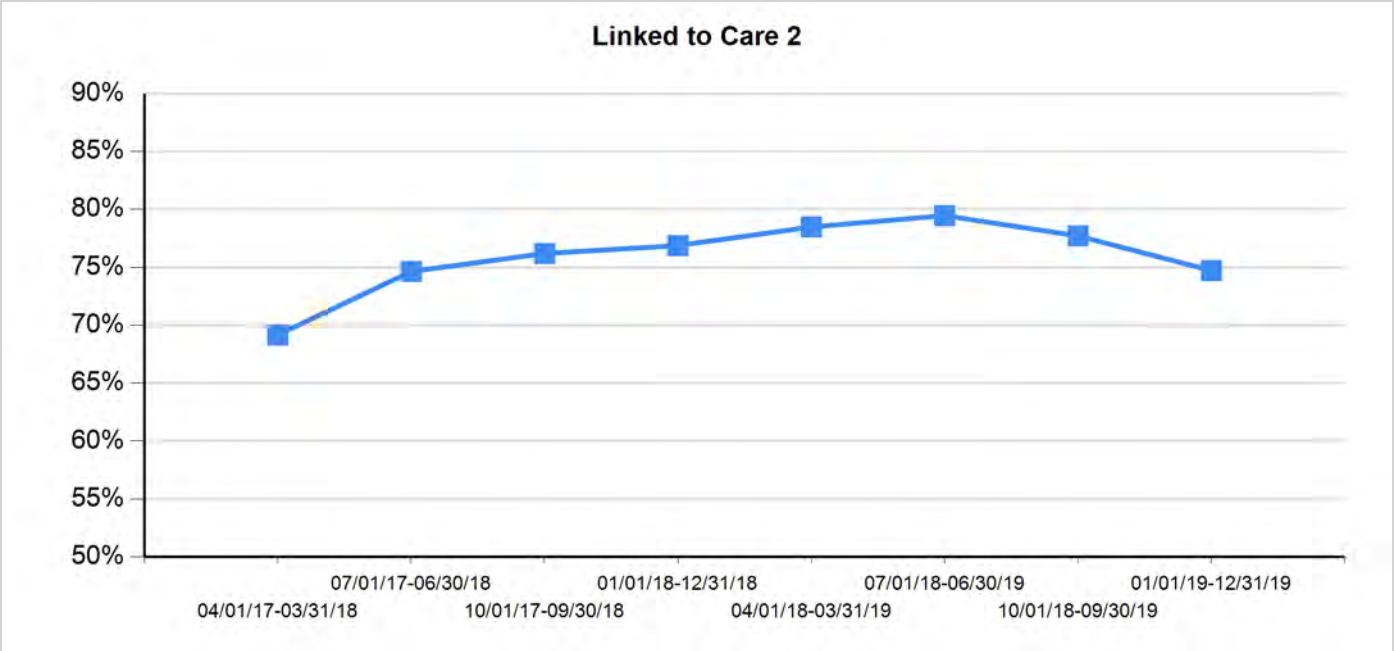
Linked to Care 3 by Race/Ethnicity									
	07/01/18 - 06/30/19			10/01/18 - 09/30/19			01/01/19 - 12/31/19		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had a medical visit with a provider at least once in the last 6 months of the measurement period	198	145	48	184	155	37	149	163	50
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 6 months of the measurement period	290	173	61	281	187	50	242	212	61
Percentage	68.3%	83.8%	78.7%	65.5%	82.9%	74.0%	61.6%	76.9%	82.0%
Change from Previous Quarter Results	0.9%	5.9%	10.6%	-2.8%	-0.9%	-4.7%	-3.9%	-6.0%	8.0%



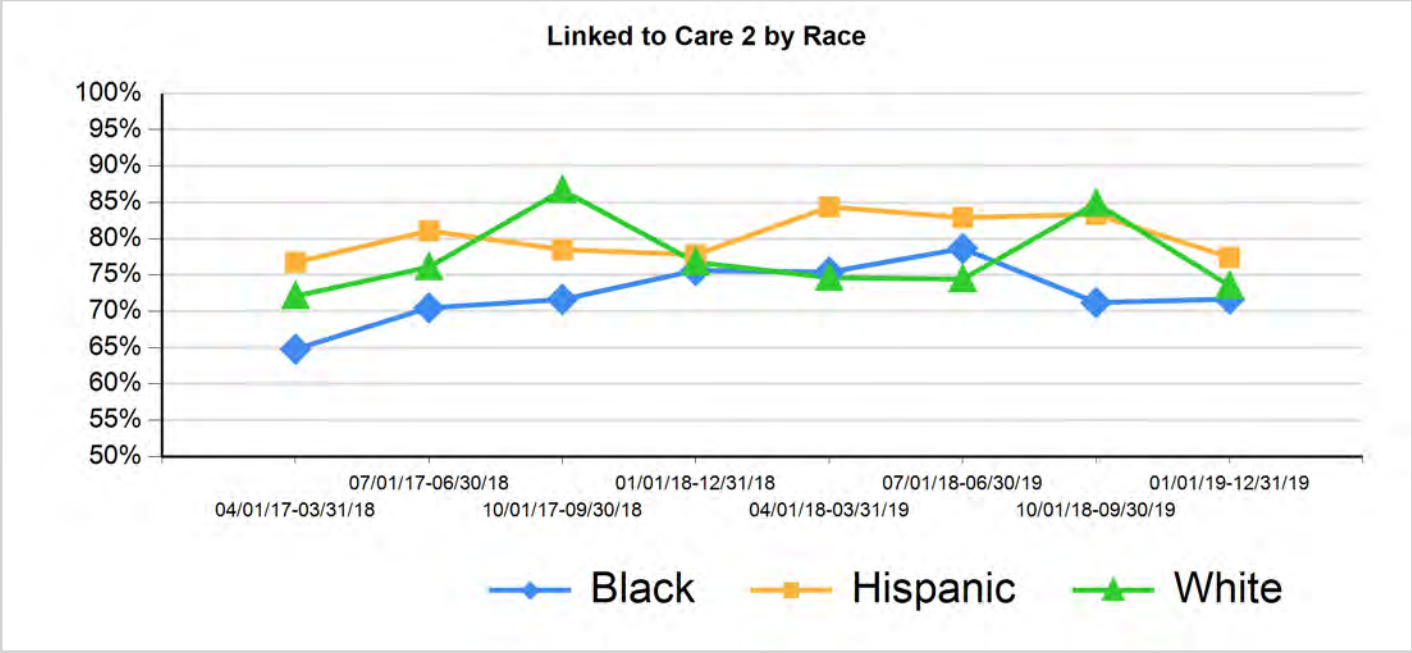
Linked to Care 3 by Agency												
	10/01/18 - 09/30/19						01/01/19 - 12/31/19					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who had a medical visit with a provider at least once in the last 6 months of the measurement period	20	115	104	106	5	47	18	93	119	105	5	43
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 6 months of the measurement period	26	156	157	125	7	73	26	150	170	129	6	59
Percentage	76.9%	73.7%	66.2%	84.8%	71.4%	64.4%	69.2%	62.0%	70.0%	81.4%	83.3%	72.9%
Change from Previous Quarter Results	-4.9%	0.7%	-4.3%	1.9%	-1.3%	-3.7%	-7.7%	-11.7%	3.8%	-3.4%	11.9%	8.5%



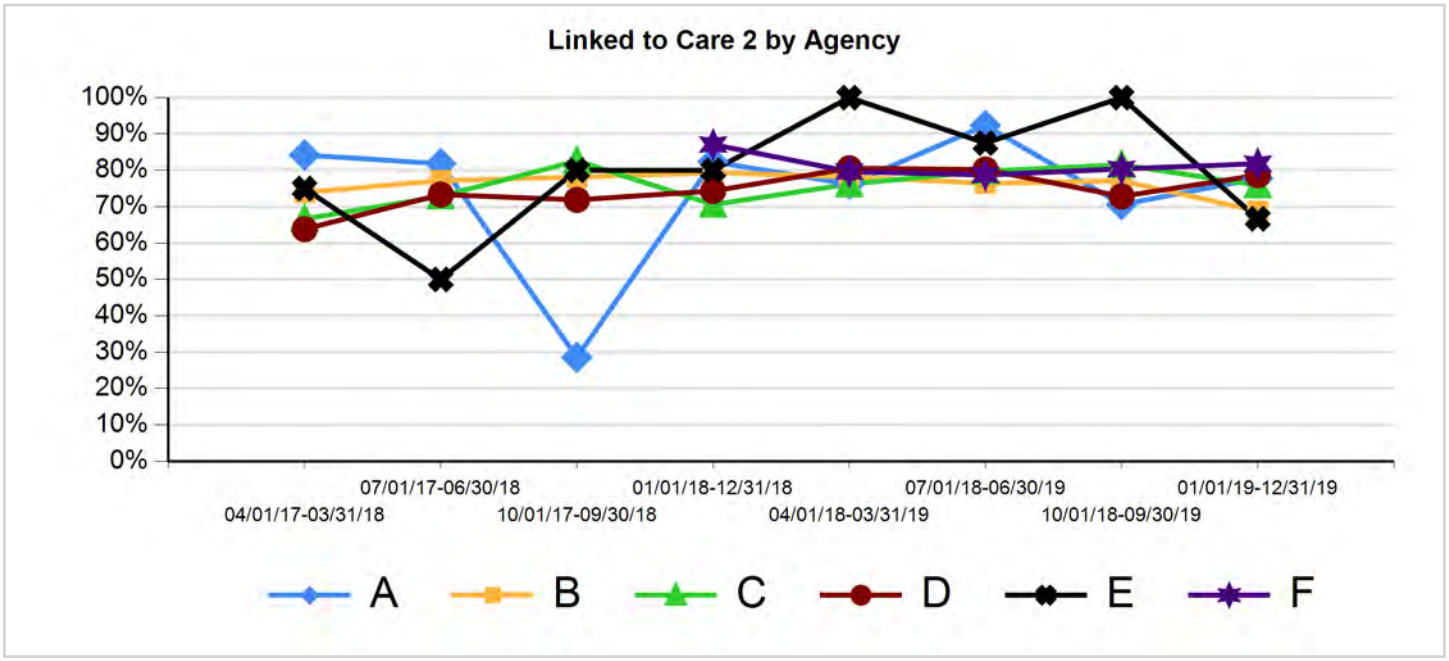
Linked to Care 2				
Viral Load Suppression Measure for Newly Enrolled Clients				
	04/01/18 - 03/31/19	07/01/18 - 06/30/19	10/01/18 - 09/30/19	01/01/19 - 12/31/19
Number of clients who have a viral load <200 copies/ml at last viral load in the measurement period	310	294	265	266
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 4 months of the measurement period	395	370	341	356
Percentage	78.5%	79.5%	77.7%	74.7%
Change from Previous Quarter Results	1.6%	1.0%	-1.7%	-3.0%



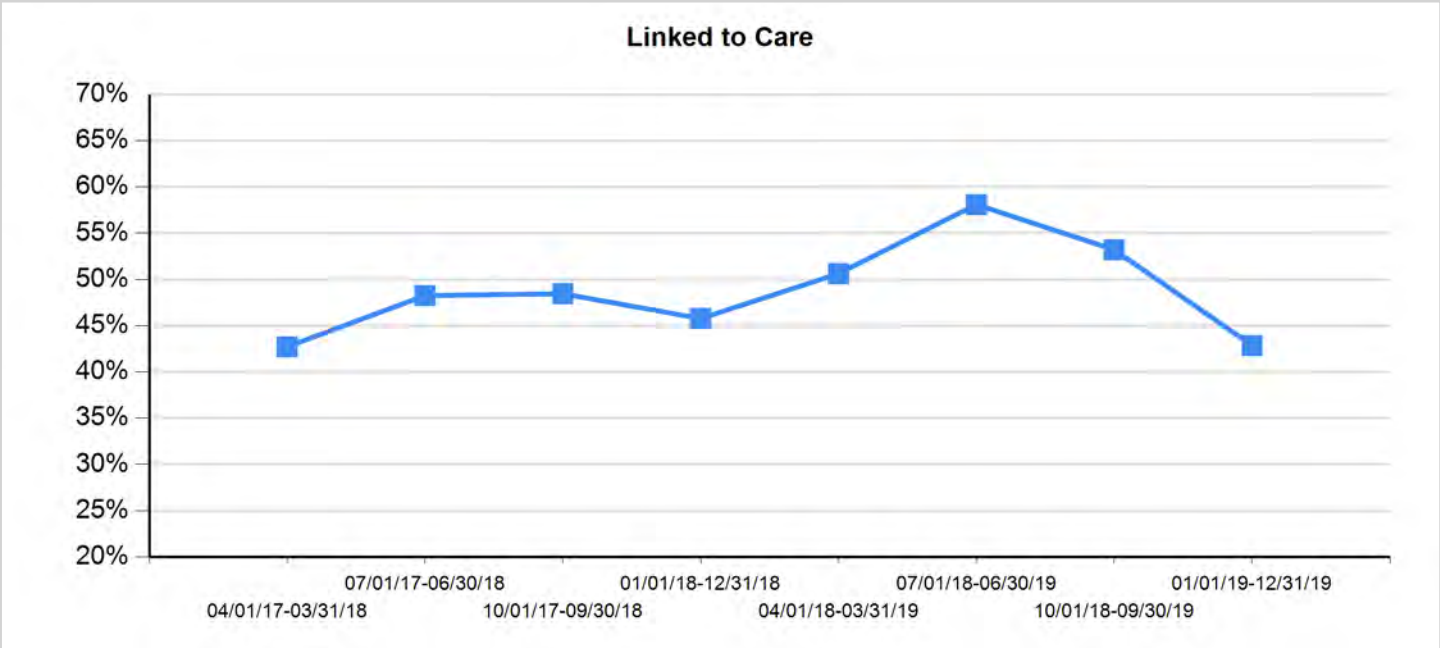
Linked to Care 2 by Race/Ethnicity									
	07/01/18 - 06/30/19			10/01/18 - 09/30/19			01/01/19 - 12/31/19		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load <200 copies/ml at last viral load in the measurement period	151	97	32	131	90	28	124	103	25
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 4 months of the measurement period	192	117	43	184	108	33	173	133	34
Percentage	78.6%	82.9%	74.4%	71.2%	83.3%	84.8%	71.7%	77.4%	73.5%
Change from Previous Quarter Results	3.3%	-1.5%	-0.2%	-7.5%	0.4%	10.4%	0.5%	-5.9%	-11.3%



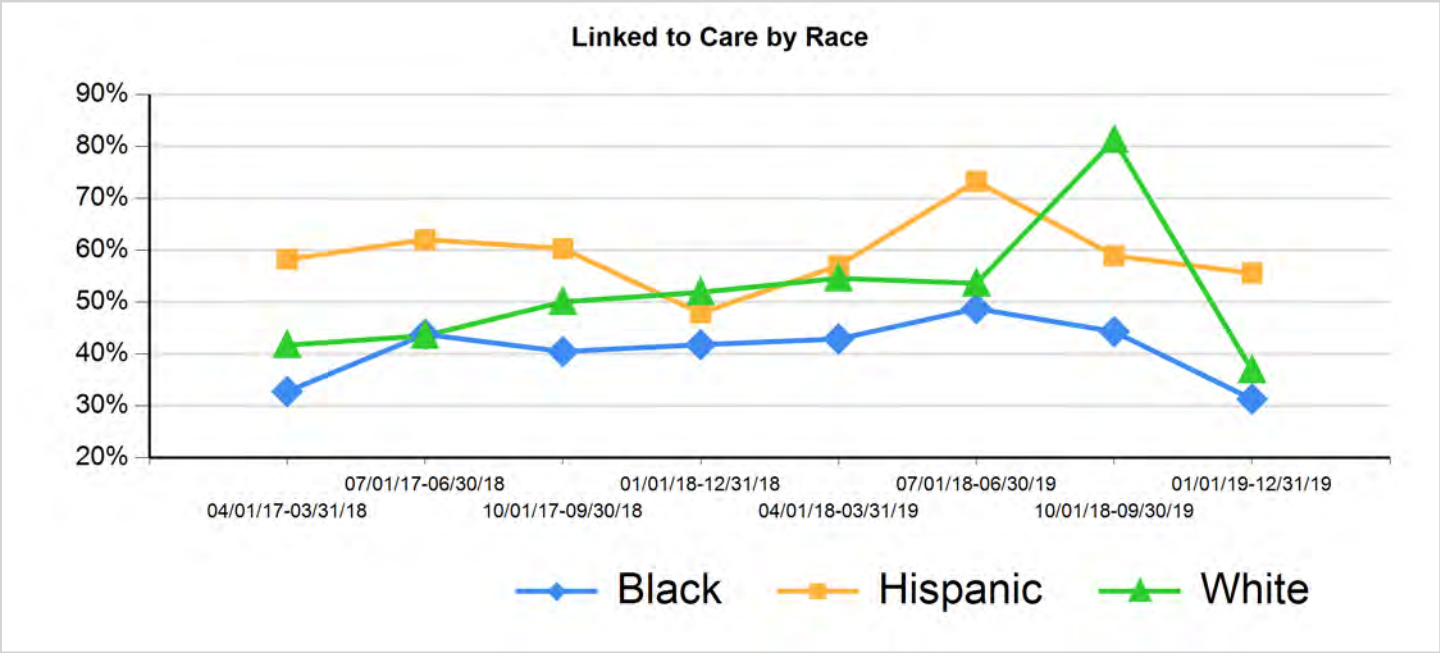
Linked to Care 2 by Agency												
	10/01/18 - 09/30/19						01/01/19 - 12/31/19					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load <200 copies/ml at last viral load in the measurement period	12	74	75	59	5	41	14	75	82	59	4	36
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 4 months of the measurement period	17	96	92	81	5	51	18	109	108	75	6	44
Percentage	70.6%	77.1%	81.5%	72.8%	100.0 %	80.4%	77.8%	68.8%	75.9%	78.7%	66.7%	81.8%
Change from Previous Quarter Results	-21.7%	0.7%	1.7%	-7.4%	12.5%	1.7%	7.2%	-8.3%	-5.6%	5.8%	-33.3%	1.4%



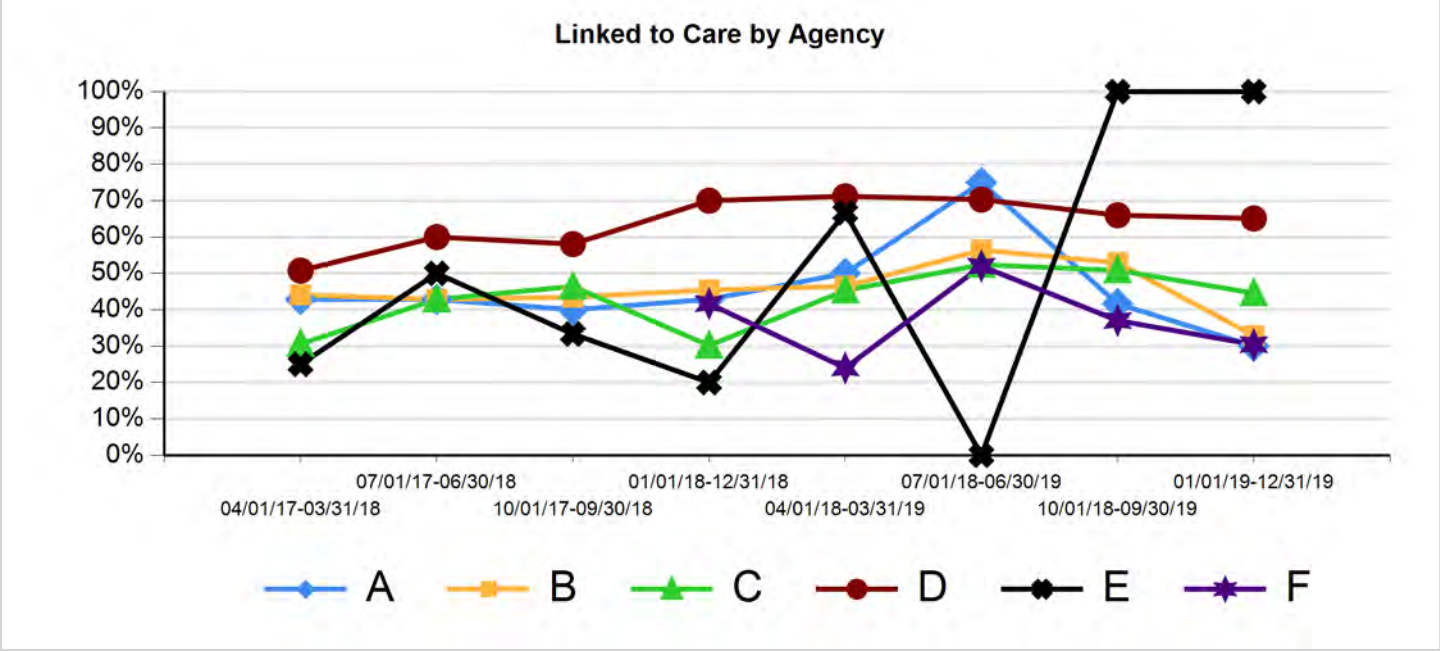
Linked to Care				
In+Care Campaign clients Newly Enrolled in Medical Care Measure				
	04/01/18 - 03/31/19	07/01/18 - 06/30/19	10/01/18 - 09/30/19	01/01/19 - 12/31/19
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	121	140	116	99
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	239	241	218	231
Percentage	50.6%	58.1%	53.2%	42.9%
Change from Previous Quarter Results	4.9%	7.5%	-4.9%	-10.4%
* exclude if vl<200 in 1st 4 months				



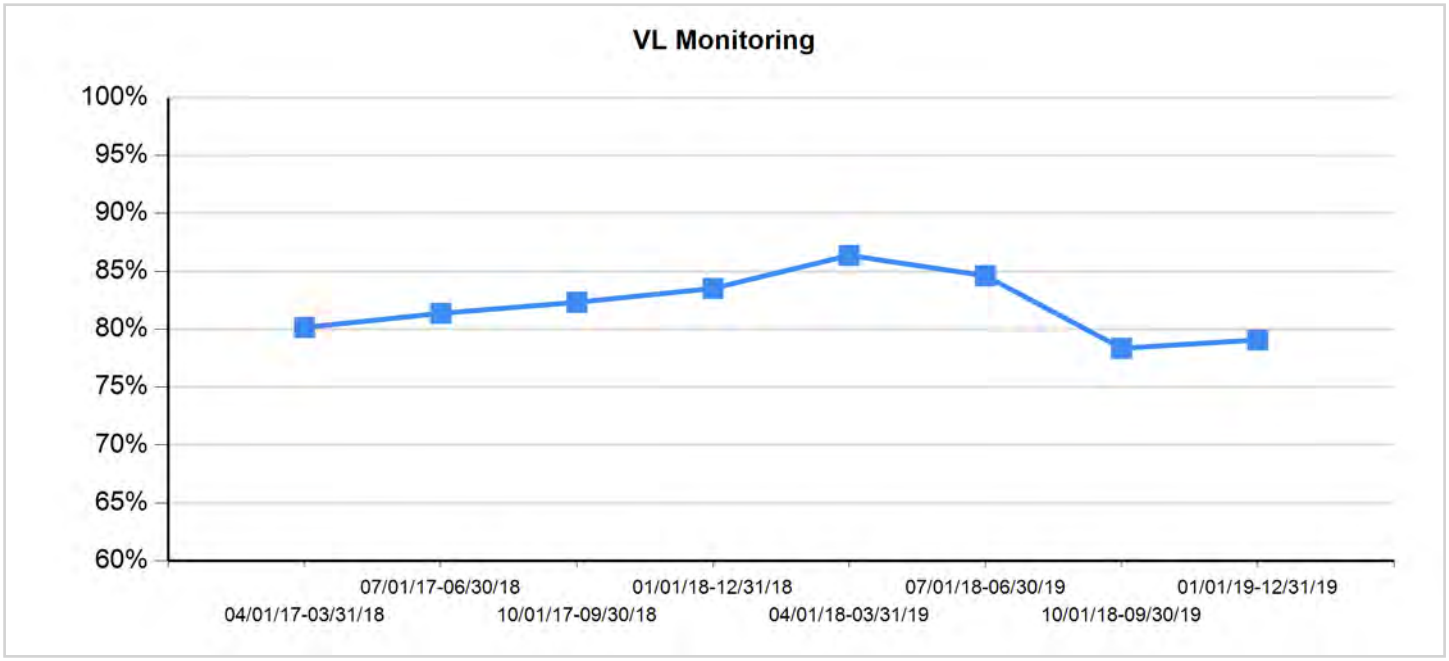
Linked to Care by Race/Ethnicity									
	07/01/18 - 06/30/19			10/01/18 - 09/30/19			01/01/19 - 12/31/19		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	56	63	15	54	43	13	35	50	7
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	115	86	28	122	73	16	112	90	19
Percentage	48.7%	73.3%	53.6%	44.3%	58.9%	81.3%	31.3%	55.6%	36.8%
Change from Previous Quarter Results	5.8%	16.3%	-1.0%	-4.4%	-14.4%	27.7%	-13.0%	-3.3%	-44.4%
* exclude if vl<200 in 1st 4 months									



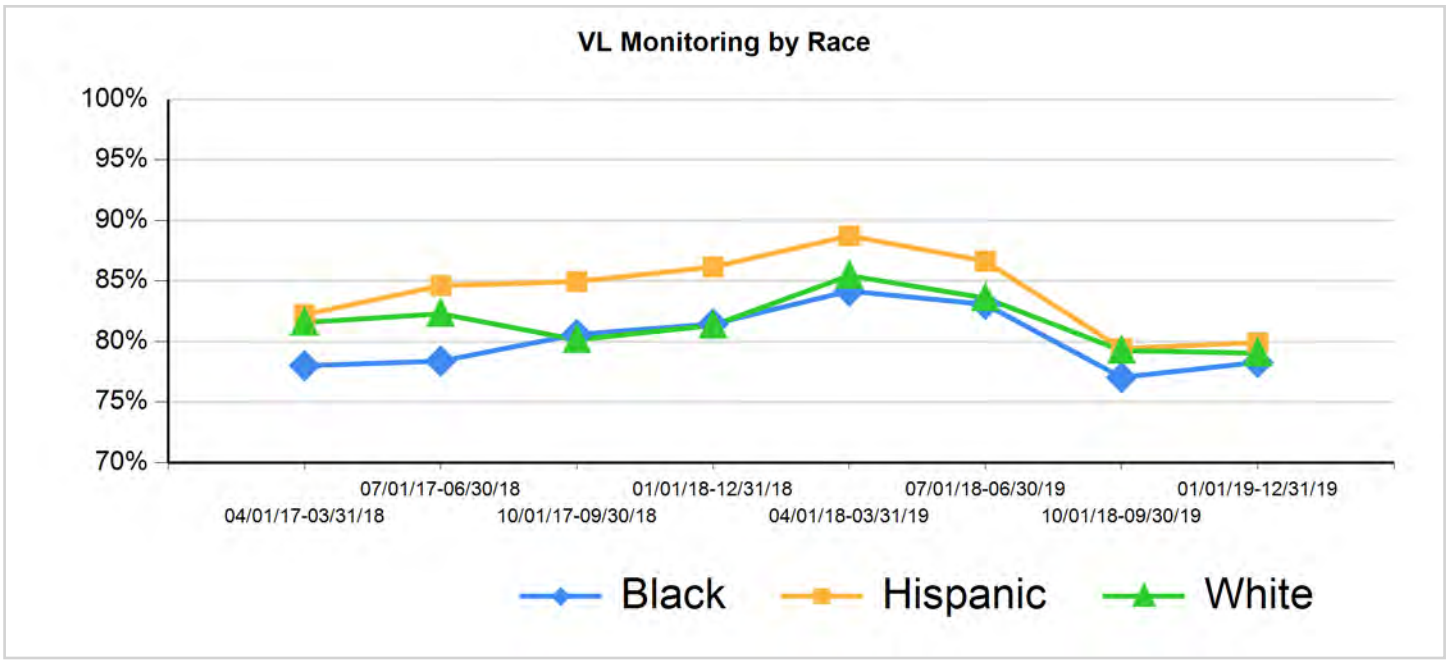
Linked to Care by Agency												
	10/01/18 - 09/30/19						01/01/19 - 12/31/19					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	5	36	30	33	2	10	3	26	33	28	4	7
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	12	68	59	50	2	27	10	79	74	43	4	23
Percentage	41.7%	52.9%	50.8%	66.0%	100.0 %	37.0%	30.0%	32.9%	44.6%	65.1%	100.0 %	30.4%
Change from Previous Quarter Results	-33.3%	-3.5%	-1.5%	-4.3%	100.0 %	-15.0%	-11.7%	-20.0%	-6.3%	-0.9%	0.0%	-6.6%
* exclude if vl<200 in 1st 4 months												



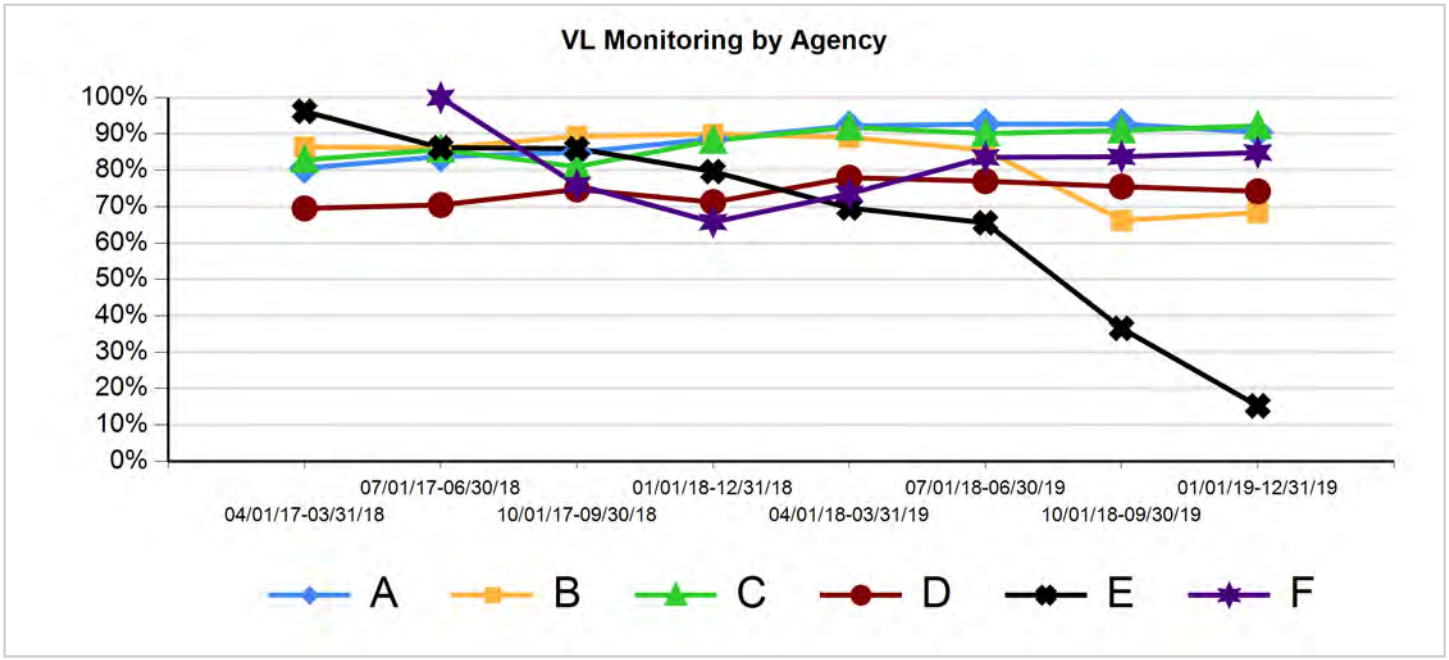
Viral Load Monitoring				
	04/01/18 - 03/31/19	07/01/18 - 06/30/19	10/01/18 - 09/30/19	01/01/19 - 12/31/19
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	4,322	4,295	4,054	4,179
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	5,004	5,076	5,174	5,285
Percentage	86.4%	84.6%	78.4%	79.1%
Change from Previous Quarter Results	2.8%	-1.8%	-6.3%	0.7%



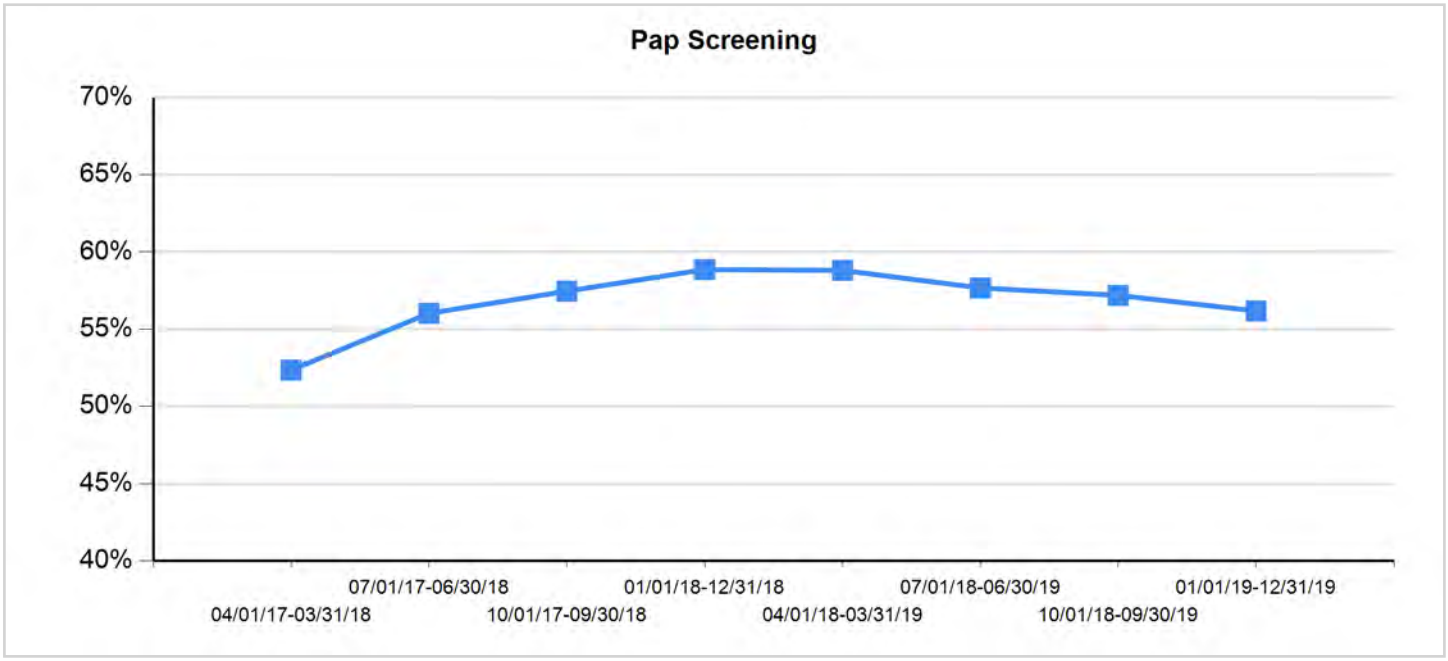
VL Monitoring Data by Race/Ethnicity									
	07/01/18 - 06/30/19			10/01/18 - 09/30/19			01/01/19 - 12/31/19		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	1,889	1,763	540	1,781	1,663	504	1,856	1,707	509
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	2,274	2,035	646	2,312	2,094	636	2,371	2,136	644
Percentage	83.1%	86.6%	83.6%	77.0%	79.4%	79.2%	78.3%	79.9%	79.0%
Change from Previous Quarter Results	-1.1%	-2.1%	-1.9%	-6.0%	-7.2%	-4.3%	1.2%	0.5%	-0.2%



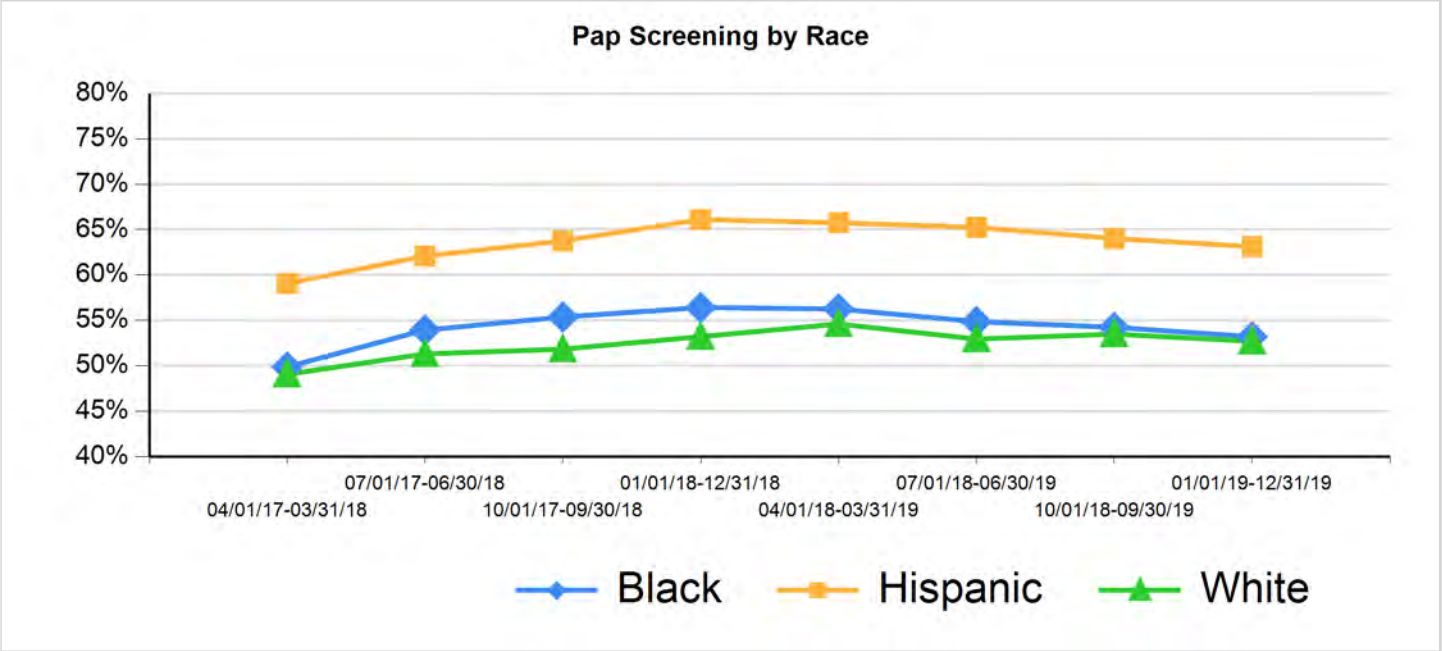
VL Monitoring by Agency												
	10/01/18 - 09/30/19						01/01/19 - 12/31/19					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	459	1,036	1,342	1,047	19	139	447	1,047	1,425	1,068	7	163
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	495	1,564	1,475	1,386	52	166	494	1,531	1,545	1,439	46	192
Percentage	92.7%	66.2%	91.0%	75.5%	36.5%	83.7%	90.5%	68.4%	92.2%	74.2%	15.2%	84.9%
Change from Previous Quarter Results	0.0%	-19.3%	0.9%	-1.5%	-29.0%	0.2%	-2.2%	2.1%	1.2%	-1.3%	-21.3%	1.2%



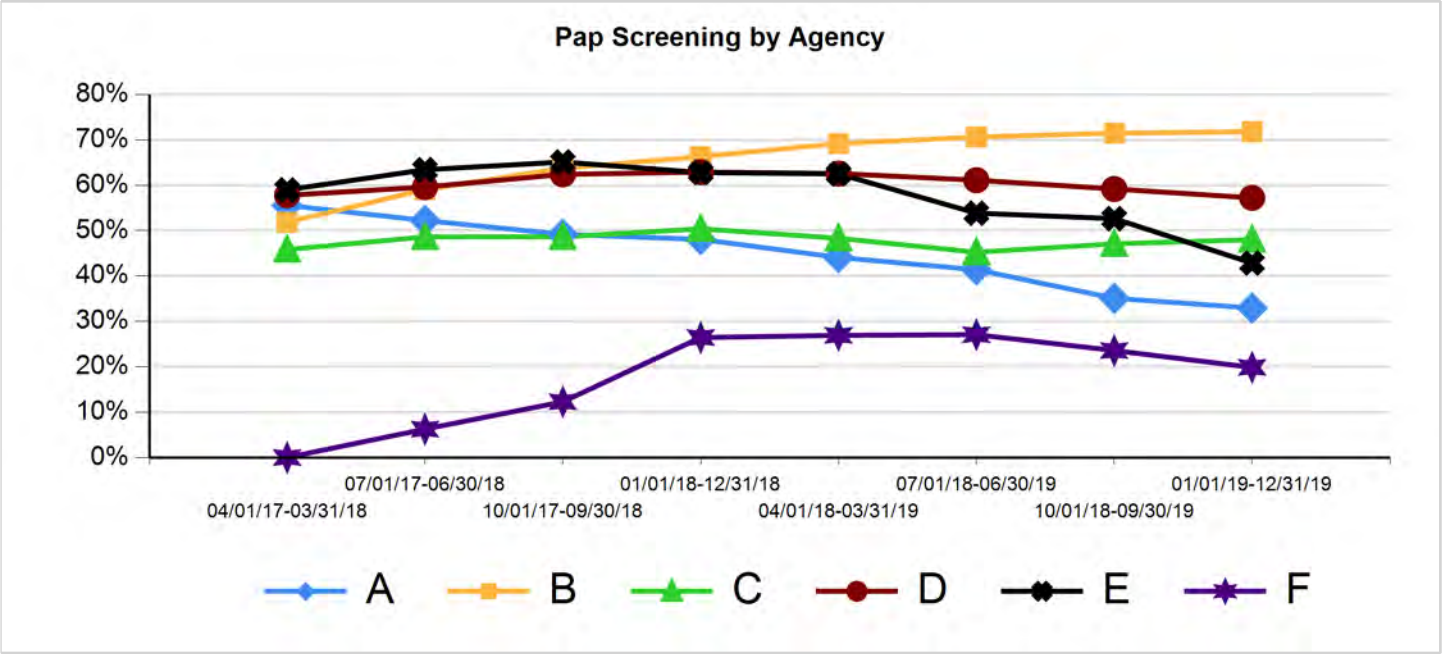
Cervical Cancer Screening				
	04/01/18 - 03/31/19	07/01/18 - 06/30/19	10/01/18 - 09/30/19	01/01/19 - 12/31/19
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	1,165	1,154	1,173	1,159
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,981	2,001	2,051	2,063
Percentage	58.8%	57.7%	57.2%	56.2%
Change from Previous Quarter Results	-0.1%	-1.1%	-0.5%	-1.0%



Cervical Cancer Screening Data by Race/Ethnicity									
	07/01/18 - 06/30/19			10/01/18 - 09/30/19			01/01/19 - 12/31/19		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	672	366	90	679	372	92	674	368	88
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,225	561	170	1,252	581	172	1,267	583	167
Percentage	54.9%	65.2%	52.9%	54.2%	64.0%	53.5%	53.2%	63.1%	52.7%
Change from Previous Quarter Results	-1.4%	-0.5%	-1.7%	-0.6%	-1.2%	0.5%	-1.0%	-0.9%	-0.8%



Cervical Cancer Screening by Agency												
	10/01/18 - 09/30/19						01/01/19 - 12/31/19					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	60	609	186	609	20	33	56	611	193	297	15	29
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	171	852	395	507	38	140	170	851	402	519	35	146
Percentage	35.1%	71.5%	47.1%	59.2%	52.6%	23.6%	32.9%	71.8%	48.0%	57.2%	42.9%	19.9%
Change from Previous Quarter Results	-6.3%	0.9%	1.9%	-1.9%	-1.2%	-3.5%	-2.1%	0.3%	0.9%	-1.9%	-9.8%	-3.7%



Footnotes:
1. Table/Chart data for this report run was taken from "ABR152 v5.0 5/2/19 [MAI=ALL]", "ABR076A v1.4.1 10/15/15 [ExcludeVL200=yes]", and "ABR163 v2.0.6 4/25/13"
   A. OPR Measures used for the ABR152 portions: "Viral Load Suppression", "Linked to Care", "CERV", "Medical Visits - 3 months", and "Viral Load Monitoring"

Harris County
Public Health
Building a Healthy Community

2020-2021 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)

TABLE OF CONTENTS

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 2020-2021:

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

Organization of the SOCs

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

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

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

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

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel and/or volunteer files indicates compliance
1.2	Initial Training: Staff/Volunteers Initial training includes eight (8) hours of: HIV basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers (e.g. job description), agency-specific information (e.g. Drug Free Workplace policy) and customer service training must be completed within 60 days of hire. https://www.sba.gov/course/customer-service/	• 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	Required trainings offered through RWGA For required trainings that RWGA offers (IPV, Cultural Competency, and Field Safety), Agency must request a waiver for agency-based training alternative that meets or exceeds the RWGA requirements.	• RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum
1.6	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	• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed and that the

	termination process, and position descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights; staff must review these guidelines annually	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 • Name of the client • The purpose of the disclosure • The types of information to be disclosed • Entities to disclose to • Date on which the consent is signed • The expiration date of client authorization (or expiration event) no longer than two years • Signature of the client/or parent, guardian or person authorized to sign in lieu of the client. • Description of the *Release of Information*, its components, and ways the client can nullify it Release/exchange of information forms must be completed entirely in the presence of the client. Any unused lines must have a line crossed through the space.	• Current Release of Information form with all the required elements signed by client or authorized person in client's record
3.5	Grievance Procedure Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to: • to whom complaints can be made • steps necessary to complain • form of grievance, if any • 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	• 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

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

3.8	Client Feedback In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually), Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may include client satisfaction surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB). • Agencies that serve an average of 100 or more unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.	• Documentation of clients' evaluation of services is maintained • Documentation of CAB and public meeting minutes • Documentation of existence and appropriateness of a suggestion box or other client input mechanism • Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1
3.9	Patient Safety (Core Services Only) Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation *for Ambulatory Care* (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable: • "Improve the accuracy of patient identification • Improve the safety of using medications • Reduce the risk of healthcare-associated infections • Accurately and completely reconcile medications across the continuum of care • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (www.jointcommission.org)	• Review of Agency's Policies and Procedures Manual indicates compliance
3.10	Client Records Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance

4.0	**Accessibility**	
4.1	Cultural Competence Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals and people of all gender identities and sexual orientations	• Agency has procedures for obtaining translation services • Client satisfaction survey indicates compliance • Policies and procedures demonstrate commitment to the community and culture of the clients • Availability of interpretive services, bilingual staff, and staff trained in cultural competence • Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record • Agency has facilities available for consumers of all gender identities, including gender-neutral restrooms.
4.2	Client Education Agency demonstrates capacity for client education and provision of information on community resources	• Availability of the blue book and other educational materials • Documentation of educational needs assessment and client education in clients' records
4.3	Special Service Needs Agency demonstrates a commitment to assisting individuals with special needs	• Agency compliance with the Americans with Disabilities Act (ADA). • Review of Policies and Procedures indicates compliance • Environmental Review shows a facility that is handicapped accessible
4.4	Provision of Services for low-Income Individuals Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low income individuals.	• Facility is accessible by public transportation • Review of Agency's Policies and Procedures Manual indicates compliance

		• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4
4.5	Proof of HIV Diagnosis Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services. An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03 • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3
4.6	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	• Client record contains documentation of re-certification of client residence,

	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. 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)	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) • 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 must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	• Agency has a written substantiated annual plan to targeted populations • Zip code data show provider is reaching clients throughout service area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5
4.11	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. 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	• 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

	that requested service(s) are contacted after service provision resumes. A wait list is defined as a roster developed and maintained by providers of patients awaiting a particular service when a demand for a service exceeds available appointments used on a first come next serviced method. The Agency will notify RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and A plan for resumption of service. The Agency's plan must address: • Action steps to be taken Agency to resolve the service shortfall; and • Projected date that services will resume. The Agency will report to RWGA in writing on a monthly basis while a client wait list is required with the following information: • Number of clients on the wait list. • Progress toward completing the plan for resumption of service. • A revised plan for resumption of service, if necessary.	
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	• Review of Agency's Policies and Procedures Manual indicates compliance • Up to date QM Manual • Source Citation: HAB Universal Standards; Section F: #2

	• Meeting agendas and/or notes (if applicable) • Project specific CQI Plans • Root Cause Analysis & Improvement Plans • Data collection methods and analysis • Work products • QM program evaluation • Materials necessary for QM activities	
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	• Emergency Preparedness Plan • Review of Agency's Policies and Procedures Manual indicates compliance

	emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergency. The agency shall communicate hazards identified with its community emergency response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	
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: training.fema.gov/nims/ . Agencies providing support services only may complete alternate courses listed for the above areas All applicable new employees are required to complete the courses within 90 days of hire.	• Agency criteria used to determine appropriate staff for training requirement • Documentation of all training including certificate of completion in personnel file
7.3	Emergency Preparedness Plan The emergency preparedness plan shall address the six critical areas for emergency management including • Communication pathways • 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	• Emergency Management Plan • Review of Agency's Policies and Procedures Manual indicates compliance

	support staff. The emergency plan should be modified based on the evaluation results and retested.	
8.0	**Building Safety**	
8.1	Required Permits All agencies will maintain Occupancy and Fire Marshal's permits for the facilities.	• Current required permits on file

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

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

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

[2] US Department of Health and Human Services, Health Resources and Services Administration HIV or AIDS Bureau (2009). Ryan White HIV or AIDS Treatment Modernization Act of 2006: Definitions for eligible services
[3] National Association of Social Workers (2013). NASW standards for social work case management. Retrieved 12/28/2018 from https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3d&portalid=0

1.2	Required Training for New Employees Within the first ninety (90) days of employment in the case management system, case managers will successfully complete HIV Case Management 101 2013 Update, through the State of Texas TRAIN website (https://tx.train.org) with a minimum of 70% accuracy. RWGA expects HIV Case Management 101 2013 Update, course completion to take no longer than 16 hours. Within the first six (6) months of employment, case managers will complete at least four (4) hours review of Community resources, and at least four (4) hours cultural competency training offered by RWGA. Mandatory Intimate Partner Violence Training is Required annually and during orientation for all Ryan White Part A funded, primary care co-located, case management staff (SLW, MCM, CCM). RWGA will host two (2) IPV training opportunities annually. Staff who provide field-based services should receive at least two (2) hours of field safety training within their first six (6) months of employment. For required trainings that RWGA offers (IPV, Cultural Competency, and Field Safety), Agency must request a waiver for agency based training alternative that meets or exceeds the RWGA requirements for the first year training for case management staff.	• Certificates of completion for applicable trainings in the case manager's file • Sign-in sheets for agency based trainings maintained by Agency • RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum
1.3	Certified Application Counselor (CAC) Training & Certification Within the first ninety (90) days of employment in the case management system, applicable case managers will successfully complete CAC training. Applicable case management staff must maintain CAC certification by their Certificated Application Counselor Designated Organization employer annually. RWGA expects CAC training completion to take no longer than 6 hours.	• Certificates of completion in case manager's file
1.4	Case Management Supervisor Peer-led Training Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and Community (SLW) Case Managers must fully participate in the four (4) Case Management Supervisor Peer-Led three-hour training curriculum conducted by RWGA.	• Review of attendance sign-in sheet indicates compliance
1.5	Child Abuse Screening, Documenting and Reporting Training Case Managers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in	• Documentation of staff training

	accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient interaction.	
1.6	Warm Handoff Procedure Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e. medical case manager to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	• Agency has a warm handoff policy to specify procedures and appropriate patient population(s) for conducting a warm handoff
2.0	**Timeliness of Services**	
2.1	Initial Case Management Contact Contact with client and/or referring agent is attempted within one working day of receiving a case assignment. If the case manager is unable to make contact within one (1) working day, this is documented and explained in the client record. Case manager should also notify their supervisor. All subsequent attempts are documented.	• Documentation in client record
2.2	Progress Notes All case management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 business hours of their occurrence.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes
2.3	Client Referral and Tracking Agency will have policies and procedures in place for referral and follow-up for clients with medical conditions, nutritional, psychological/social and financial problems. The agency will maintain a current list of agencies that provide primary medical care, prescription medications, assistance with insurance payments, dental care, transportation, nutritional counseling and supplements, support for basic needs (rent, food, financial assistance, etc.) and other supportive services (e.g. legal assistance, partner elicitation services and Client Risk Counseling Services (CRCS). The Case Manager will: • Initiate referrals within two (2) weeks of the plan being completed and agreed upon by the Client and the Case Manager • Work with the Client to determine barriers to referrals and facilitate access to referrals • Utilize a tracking mechanism to monitor completion of all case	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of follow-up tracking activities in clients records • A current list of agencies that provide services including availability of the Blue Book

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

Clinical Case Management Services

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

1.0	**Staff Requirements**	
1.1	Minimum Qualifications All clinical case managers must have a current and in good standing State of Texas license (LCSW, LPC, LPC-I, LMFT, LMFT-A). Staff providing Clinical Case Management services with LBSW or LMSW licensure must have accompanying LCDC, CI, Substance Abuse Counselor, or Addictions Counselor certification. Other training experiences may be considered under a waiver agreement. LMSWs receiving clinical supervision hours towards LCSW requirements may provide Clinical Case Management services under a waiver agreement.	• A file will be maintained on each clinical case manager • Supportive documentation of credentials and job description is maintained by the agency in each clinical case manager file. Documentation should include transcripts and/or diplomas and proof of licensure
1.2	Scope of Services The clinical case management services will include at a minimum, comprehensive assessment including mental health and substance abuse/use; development, implementation and evaluation of care plans; follow-up; advocacy; direction of clients through the entire spectrum of health and support services and peer support. Other functions include facilitation and coordination of services from one service provider to another including mental health, substance abuse and primary medical care providers.	• Review of client records indicates compliance • Agency Policy and Procedures indicates compliance
1.3	Ongoing Education/Training for Clinical Case Managers After the first year of employment in the case management system each clinical case manager will obtain the minimum number of hours of continuing education to maintain his or her licensure and four (4) hours of training in current Community Resources conducted by RWGA	• Certificates of completion are maintained by the agency • Current License on case manager's file
2.0	**Timeliness of Services/Documentation**	

2.1	Client Eligibility In addition to the general eligibility criteria, individuals must meet one or more of the following criteria in order to be eligible for clinical case management services: ● Individual living with HIV in mental health treatment/counseling and/or substance abuse treatment services or whose history or behavior may indicate the individual may need mental health and/or substance abuse treatment/counseling now or in the future. ● Clinical criteria for admission into clinical case management must include one of the following: ➢ Client is actively symptomatic with a DSM (most current, American Psychiatric Association approved) diagnosis, especially including substance-related disorders (abuse/dependence), mood disorders (Bipolar depression), depressive disorders, anxiety disorders, and other psychotic disorders; or DSM (most current, American Psychiatric Association approved) diagnosis personality disorders. ➢ Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services. ➢ Client is in mental health counseling or chemical dependency treatment.	• Documentation of HIV+ status, mental health and substance abuse status, residence, identification, and income in the client record
2.2	Discharge/Closure from Clinical Case Management Services In addition to the general requirements, a client may be discharged from clinical case management services for the following reasons. • Client has achieved a sustainable level of stability and independence. ➢ Substance Abuse – Client has successfully completed an outpatient substance abuse treatment program. ➢ Mental Health – Client has successfully accessed and is engaged in mental health treatment and/or has completed mental health treatment plan objectives.	• Documentation in client record.
2. 3	Coordination with Primary Medical Care and Medical Case Management Provider Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White Part A funded Medical Case Management programs.	• Review of Agency's Policies and Procedures Manual indicates compliance

	Clinical Case Management services provided to clients accessing primary medical care from a Ryan White Part A funded primary medical care provider other than Agency will require Agency and Primary Medical Care/Medical Case Management provider to conduct regular multi-disciplinary case conferences to ensure effective coordination of clinical and psychosocial interventions. Case conferences must at a minimum include the clinical case manager; mental health/counselor and/or medical case manager and occur at least every three (3) months for the duration of Clinical Case Management services. Client refusal to provide consent for the clinical case manager to participate in multi-disciplinary case conferences with their Primary Medical Care provider must be documented in the client record.	• Case conferences are documented in the client record
2.4	<u>Assessment</u> Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Clinical Case Management will use a RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's Mental Health and/or Substance Abuse treatment program(s).	• Documentation in client record on the comprehensive client assessment form, signed and dated, or agency's equivalent form. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
2.5	<u>Reassessment</u> Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA approved reassessment form as applicable must be utilized.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated

2.6	Service Plan Service planning begins at admission to clinical case management services and is based upon assessment. The clinical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short term needs met before full service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	• Documentation in client record on the clinical case management service plan or agency's equivalent form • Service plan signed by client and the case manager
3.0	**Supervision and Caseload**	
3.1	Clinical Supervision and Caseload Coverage The clinical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the clinical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision

Non-Medical Case Management Services (Service Linkage Worker)

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

1.0	**Staff Requirements**	
1.1	Minimum Qualifications Service Linkage Worker – unlicensed community case manager Service linkage workers must have a bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH may be substituted for the bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). Service linkage workers must have a minimum of 1 year paid work experience with PLWH. Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish. Agency will provide Service Linkage Worker a written job description upon hiring.	• A file will be maintained on service linkage worker. Supportive documentation of credentials and job description are maintained by the agency and in each service linkage worker's file. Documentation may include, but is not limited to, transcripts, diplomas, certifications and/or licensure.
2.0	**Timeliness of Services/Documentation**	
2.1	Client Eligibility – Service Linkage targeted to Not-in-Care and Newly Diagnosed (HHD Only) In addition to general eligibility criteria individuals must meet the following in order to be eligible for non-medical case management services: • Clients not receiving outpatient HIV primary medical care services within the previous 180 days as documented by the CPCDMS, or • Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care services as documented by the CPCDMS, or	• Documentation of HIV+ status, residence, identification and income in the client record • Documentation of "not in care" status through the CPCDMS

	• Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS	
2.2	Service Linkage Worker Assessment Assessment begins at intake. The service linkage worker will provide client and, if appropriate, his/her personal support system information regarding the range of services offered by the case management program during intake/assessment. The service linkage worker will complete RWGA -approved brief assessment tool within five (5) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager.	• Documentation in client record on the brief assessment form, signed and dated • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
2.3	Service Linkage Worker Reassessment Clients on receiving services will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applicable must be utilized.	• Documentation in RWGA approved client reassessment form or agency's equivalent form, signed and dated
2.4	Transfer of Not-in-Care and Newly Diagnosed Clients (HHD Only) Service linkage workers targeting their services to Not-in-Care and newly diagnosed clients will work with clients for a maximum of 90 days. Clients must be transferred to a Ryan White-funded primary medical care, clinical case management or medical case management program, or a private (non-Ryan White funded) physician within 90 days of the initiation of services. Those clients who chose to access primary medical care from a non-Ryan White funded source may receive ongoing service linkage services from provider or from a Ryan White-funded Clinic or Medical Case Management provider.	• Documentation in client record and in the CPCDMS
2.5	Primary Care Newly Diagnosed and Lost to Care Clients Agency must have a written policy and procedures in place that address the role of Service Linkage Workers in the linking and re-engaging of clients into primary medical care. The policy and procedures must include at minimum: • Methods of routine communication with testing sites regarding newly diagnosis and referred individuals • Description of service linkage worker job duties conducted in the field	• Review of Agency's Policies and Procedures Manual indicates compliance.

	• Process for re-engaging agency patients lost to care (no primary care visit in 6 months)	
3.0	**Supervision and Caseload**	
3.1	Service Linkage Worker Supervision A minimum of four (4) hours of supervision per month must be provided to each service linkage worker by a master's level health professional.) At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ date ➢ name(s) of case manager(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature • Supervision notes are never maintained in the client record
3.2	Caseload Coverage – Service Linkage Workers Supervisor ensures that there is coverage of the caseload in the absence of the service linkage worker or when the position is vacant. Service Linkage Workers may assist clients who are routinely seen by other CM team members in the absence of the client's "assigned" case manager.	• Documentation of all client encounters in client record and in the Centralized Patient Care Data Management System
3.3	Case Reviews – Service Linkage Workers. Supervisor reviews a random sample equal to 10% of unduplicated clients served by each service linkage worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and SLW

Medical Case Management

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

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

2.1	<u>Screening Criteria for Medical Case Management</u> In addition to the general eligibility criteria, agencies are advised to use screening criteria before enrolling a client in medical case management. Examples of such criteria include the following: i. Newly diagnosed ii. New to ART iii. CD4<200 iv. VL>100,000 or fluctuating viral loads v. Excessive missed appointments vi. Excessive missed dosages of medications vii. Mental illness that presents a barrier to the patient's ability to access, comply or adhere to medical treatment viii. Substance abuse that presents a barrier to the patient's ability to access, comply or adhere to medical treatment ix. Housing issues x. Opportunistic infections xi. Unmanaged chronic health problems/injury/Pain xii. Lack of viral suppression xiii. Positive screening for intimate partner violence xiv. Clinician's referral Clients with one or more of these criteria would indicate need for medical case management services. The following criteria are an indication a client may be an appropriate referral for Clinical Case Management services. • Client is actively symptomatic with an axis I DSM (most current, American Psychiatric Association approved) diagnosis especially including substance-related disorders (abuse/dependence), mood disorders (major depression, Bipolar depression), anxiety disorders, and other psychotic disorders; or axis II DSM (most current, American Psychiatric Association approved) diagnosis personality disorders; • Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services;	• Review of agency's screening criteria for medical case management

	• Client is in mental health counseling or chemical dependency treatment.	
2.2	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. Medical case managers will provide a comprehensive assessment at intake and at least annually thereafter. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Medical Case Management will use an RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's program needs.	• Documentation in client record on the comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.3	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA or TRG -approved reassessment form as applicable must be utilized.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated • Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only)
2.4	Service Plan Service planning begins at admission to medical case management services and is based upon assessment. The medical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive	• Documentation in client's record on the medical case management service plan or agency's equivalent form • Service Plan signed by the client and the case manager

	client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short term needs met before full service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	
3.0	**Supervision and Caseload**	
3.1	<u>Clinical Supervision and Caseload Coverage</u> The medical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the medical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision

Emergency Financial Assistance Program

Emergency Financial Assistance (EFA) is co-located in ambulatory medical care centers to provide short term (up to 30 days of medication) access to HIV pharmaceutical services to clients who have not yet completed eligibility determination for medications through Pharmaceutical Assistance Programs, State ADAP, State SPAP or other sources. EFA provides short-term (up to 30 days of medication) payments to assist clients with an emergent need for medication. HRSA requirements for EFA include a client enrollment process, uniform benefits for all enrolled clients, a record system for dispensed medications and a drug distribution system.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for EFA services: • Income no greater than 500% of the Federal poverty level for HIV medications	• Documentation of income in the client record.
1.2	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days • Pharmacy will fill prescription within one (1) business day of approval	• Documentation in the client record and review of pharmacy summary sheets • Review of agency's Policies & Procedures Manual indicates compliance
1.3	Medication Formulary RW funded prescriptions for program eligible clients shall be based on current medications on the RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Any EFA service greater than 30 days of medication must also have prior waiver approval from RWGA. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Public Health Services guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record
2.0	**Staff HIV knowledge is based on documented training.**	

2.1	Orientation Initial orientation includes twelve (12) hours of HIV basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines
2.2	Ongoing Training Sixteen (16) hours every two years of continuing education in PLWH related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
2.3	Pharmacy Staff Experience A minimum of one year documented PLWH work experience is preferred.	• Documentation of work experience in personnel file
2.4	Pharmacy Staff Supervision Staff will receive at least two (2) hours of supervision per month to include client care, job performance and skill development.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance • Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present

Health Insurance Assistance

The Health Insurance Premium and Cost Sharing Assistance service category is intended to help PLWH continue medical care without gaps in health insurance coverage or discretion of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Agency may provide help with client co-payments, co-insurance, deductibles, and Medicare Part D premiums.

Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription. Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy.

1.0	**Staff/Training**	
1.1	Ongoing Training Eight (8) hours annually of continuing education in HIV related or other specific topics including a minimum of two (2) hours training in Affordable Care Act is required as needed.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.2	Staff Experience A minimum of one year documented HIV work experience is preferred.	• Documentation of work experience in personnel file
2.0	**Client Eligibility**	
2.1	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program as needed to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health insurance marketplace.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance
2.2	Advance Premium Tax Credit Reconciliation Agency will ensure all clients receiving assistance for Marketplace QHP premiums: • Designate Premium Tax Credit to be taken in advance during Marketplace Insurance enrollment	• Review of client record

	• Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual Marketplace open enrollment or Marketplace renewal periods • Submit prior year tax information no later than May 31st. Tax information must include: o Federal Marketplace Form 1095-A o IRS Form 8962 o IRS Form 1040 (excludes 1040EZ) • Reconciliation of APTC credits or liabilities	
3.0	**Client Access**	
3.1	<u>Clients Referral and Tracking</u> 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
3.2	<u>Prioritization of Service</u> Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agency use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistance (in descending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles (all other allowable HIV-related medications) 3. Doctor visit co-pays/deductibles (physician visit and/or lab copayments) Medicare Part D (Rx) premiums	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance
3.3	<u>Decreasing Barriers to Service</u> Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance use provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance use provider site. (i.e. No need for client to physically present to Health Insurance provider.)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance

Local Pharmacy Assistance Program

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

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for LPAP services: • Income no greater than 500% of the Federal poverty level for HIV medications and no greater than 400% of the Federal poverty level for HIV-related medications	• Documentation of income in the client record.
1.2	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days • Pharmacy will fill prescription within one (1) business day of approval	• Documentation in the client record and review of pharmacy summary sheets • Review of agency's Policies & Procedures Manual indicates compliance
1.3	LPAP Medication Formulary RW funded prescriptions for program eligible clients shall be based on the current RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/HHS guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record
2.0	**Staff HIV knowledge is based on documented training.**	

2.1	Orientation Initial orientation includes twelve (12) hours of HIV basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines
2.2	Ongoing Training Sixteen (16) hours every two years of continuing education in PLWH related or medication/pharmacy – related topics is required for pharmacist and pharmacy tech staff.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
2.3	Pharmacy Staff Experience A minimum of one year documented PLWH work experience is preferred.	• Documentation of work experience in personnel file
2.4	Pharmacy Staff Supervision Staff will receive at least two (2) hours of supervision per month to include client care, job performance and skill development.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance • Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present

Outreach Services

Outreach workers focus on locating clients who are on the cusp of falling out of care, for reengagement back into care. The Ryan White Part A Outreach Worker (OW) provides field-based services to clients based on criteria identified by each agency. These services include the provision of information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed and advocating on behalf of clients to decrease service gaps and remove barriers to services.

1.0	**Staff Training**	
1.1	**Minimum/Qualifications** Minimum Qualifications – High School Diploma or GED. Six months of working with or volunteering with PLWH.	• Documentation of credentials and job description in outreach worker's file • Documentation includes, but is not limited to high school diploma, GED and experience
1.2	Scope of Services The OW will generate EMR reports to determine eligibility for services. Monthly, during OW-RWGA meetings OW will provide client status updates on engagement activities. Outreach workers are expected to document client's immediate needs and barriers to service in order to relink and reengage them back in to care. Upon successfully re-engaging clients back in to care, outreach workers will provide a warm handoff to a service linkage worker or medical case manager for additional assistance of the client's needs as necessary.	• Review of reporting records indicates compliance • Monthly review of spreadsheet engagement activities • Documentation of assessment will be maintained in the client file
1.3	Ongoing Education/Training for Outreach Workers Staff who provide field-based services should receive at least two (2) hours of field safety training within their first six (6) months of employment. The Outreach Workers are required to attend a minimum of five (5) of the six (6) Outreach Worker meetings and four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA within the grant year, and one of the Joint Prevention and Care Collaborative Workshops presented by RGWA & HHD.	• Documentation of attendance will be maintain by the agency. RWGA will also maintain sign-in logs • Review of reporting records indicates compliance • Certificates of completion for applicable trainings in the outreach worker's file •
1.4	Documentation and Reporting Outreach Workers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with DSHS Child Abuse Screening, Documenting and Reporting Policy prior to interaction.	• Documentation of staff training in employee record

1.5	Warm Handoff Procedure Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e. Outreach worker to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	• Agency has a warm handoff policy to specify procedures and appropriate patient population for conducting a warm handoff.
2.0	**Timeliness of Service/Documentation**	
2.1	**Progress Notes** All Outreach Worker activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 business hours of the occurrence.	• Documentation of client's needs and progress notes will be maintained in client's files • Legible signed and dated in documentation in the client record
2.2	Eligibility Criteria for Outreach Eligibility for outreach will vary and is specific to each agency. Criteria can include but is not limited to clients: • Who have missed 2 or more HIV-related medical appointments in the last 6 months, have one appointment scheduled in the next 3 weeks; • Missed 3 appointments in last 6 months and have one scheduled in next 3 weeks; • Clients who have not been seen in 4 months by their primary care provider; and/or • Three missed appointments in past 12 months (do not have to be consecutive).	• Documentation of eligibility criteria will be maintained in client's files • Legible signed and dated in documentation in the client record
3.0	**Supervision**	
3.1	Outreach Worker Supervision Four (4) hours of supervision per month must be provided to each outreach worker. At least one (1) hour of supervision must be individual supervision. The remaining three (3) hours may be individual or group. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the outreach worker relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments	• Documentation in supervision notes, which must include: ➢ Date & duration of time ➢ name(s) of outreach worker(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature

		Supervision notes are never maintained in the client record
3.2	Case Reviews – Outreach Worker Supervisor reviews a random sample equal to 10% of unduplicated clients served by each Outreach Worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible and that services provided appropriately.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and Outreach Worker.

Primary Medical Care

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

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

1.0	**Medical Care for persons with HIV should reflect competence and experience in both primary care and therapeutics known to be effective in the treatment of HIV infection and is consistent with the most current published HHS treatment guidelines**	
1.1	Minimum Qualifications Medical care for persons living with HIV shall be provided by MD, NP, CNS or PA licensed in the State of Texas and has at least two years paid experience in HIV care including fellowship.	• Credentials on file
1.2	Licensing, Knowledge, Skills and Experience • All staff maintain current organizational licensure (and/or applicable certification) and professional licensure • The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc. • Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (www.hivma.org): • Clinical management of at least 25 people living with HIV patients within the last year • Maintain a minimum of 30 hours of HIV-specific CME (including a minimum of 10 hours related to antiretroviral therapy) every two years in accordance with State licensure renewal dates. Agencies using	• Documentation in personnel record

	contractors must ensure that this requirement is met and must provide evidence at the annual program monitoring site visits. • Psychiatrists only: after the first biennium, psychiatrists must maintain a minimum of 10 hours of HIV-specific CME every two years in accordance with State licensure renewal dates • Physician extenders must obtain this experience within six months of hire • All staff receive professional supervision • Staff show training and/or experience with the medical care of adults living with HIV	
1.3	Peer Review Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e. MD, NP, PA).	• Provider will document peer review has occurred annually
1.4	**Standing Delegation Orders (SDO)** Standing delegation orders provide direction to RNs, LVNs and, when applicable, Medical Assistants in supporting management of patients seen by a physician. Standing Delegation Orders must adhere to Texas Administrative Code, Title 22, Part 9; Chapter 193; Rule §193.1 and must be congruent with the requirements specified by the Board of Nursing (BON) and Texas State Board of Medical Examiners (TSBME).	• Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider. • Standing Delegation Orders will be reviewed, updated as needed and signed by the physician annually. • Use of standing delegation orders will be documented in patient's primary record system.
1.5	Primary Care Guidelines Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (http://www.aidsinfo.nih.gov/guidelines/) and other nationally recognized evidence-based guidelines. Immunizations should be given according to the most current Advisory Committee on Immunization Practices (ACIP) guidelines.	• Documentation in client's record • Exceptions noted in client's record
1.6	Medical Evaluation/Assessment All people living with HIV receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination. The comprehensive assessment/evaluation will be completed by the MD, NP, CNS	• Completed assessment in client's record

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

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

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

	• Inform women of interventions to prevent sexual transmission of HIV when attempting conception with a partner who does not have HIV Other preconception care consideration should include: • The choice of appropriate antiretroviral therapy effective in treating maternal disease with no teratogenicity or toxicity should pregnancy occur • Maximum suppression of viral load prior to conception	
1.12	Obstetrical Care for Pregnant Women Living with HIV Obstetrical care for pregnant women living with HIV shall be provided by board certified obstetricians experienced in the management of high risk pregnancy and has at least two years experience in caring for pregnant women living with HIV. Antiretroviral therapy during ante partum, perinatal and postpartum should be based on the current HHS guidelines http://www.aidsinfo.nih.gov/Guidelines.	• Documentation in client's record
1.13	Coordination of Services in Prenatal Care To ensure adherence to treatment, agency must ensure coordination of services among prenatal care providers, primary care and HIV specialty care providers, mental health and substance abuse treatment services and public assistance programs as needed.	• Documentation in client's records.
1.14	Care of and Infants, Children and Pre-pubertal Adolescents Care and monitoring of children exposed to HIV must be done in accordance to the HHS guidelines. Treatment of infants and children living with HIV should be managed by a specialist in pediatric and adolescent HIV infection. Where this is not possible, primary care providers must consult with such specialist. Providers must utilize current HHS Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Care (http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf) in providing and monitoring antiretroviral therapy in infants, children and pre pubertal adolescents. Patients should also be monitored for growth and development, drug toxicities, neurodevelopment, nutrition and symptoms management. A multidisciplinary team approach must be utilized in meeting clients' need and team should consist of physicians, nurses, case managers, pharmacists, nutritionists, dentists, psychologists and outreach workers.	• Documentation in client's record

1.15	Patient Medication Education All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed and then documented in the patient record: the names, actions and purposes of all medications in the patient's regimen; the dosage schedule; food requirements, if any; side effects; drug interactions; and adherence. Patients must be informed of the following: how to pick up medications; how to get refills; and what to do and who to call when having problems taking medications as prescribed. Medication education must also include patient's return demonstration of the most current prescribed medication regimen. The program must utilize an RN, LVN, PA, NP, CNS, pharmacist or MD licensed by the State of Texas, who has at least one year paid experience in HIV care, to provide the educational services.	• Documentation in the patient record. Documentation in patient record must include the clinic name; the session date and length; the patient's name, patient's ID number, or patient representative's name; the Educator's signature with license and title; the reason for the education (i.e. initial regimen, change in regimen, etc.) and documentation of all discussed education topics.
1.16	Adherence Assessment Agency will incorporate adherence assessment into primary care services. Clients who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. Adherence assessment shall be provided by an RN, LVN, PA, NP, CNS, Medical/Clinical Case Manager, pharmacist or MD licensed by the State of Texas. Agency must utilize the RWGA standardized adherence assessment tool. Case managers must refer clients with adherence issues beyond their scope of practice to the appropriate health care professional for counseling.	• Completed adherence tool in client's record • Documentation of counseling in client records
1.17	Documented Non-Adherence with Prescribed Medication Regimen The agency must have in place a written policy and procedure regarding client non-adherence with a prescribed medication regimen. The policy and procedure should address the agency's process for intervening when there is documented non-adherence with a client's prescribed medication regimen.	• Review of Policies and Procedures Manual indicates compliance.
1.18	Client Mental Health and Substance Use Policy The agency must have in place a written policy and procedure regarding client mental health and substance use. The policy and procedure should address: the agency's process for assessing clients' mental health and substance use; the treatment and referral of clients for mental illness and substance abuse; and care	• Review of Policies and Procedures Manual indicates compliance.

	coordination with mental health and/or substance abuse providers for clients who have mental health and substance abuse issues.	
1.19	Intimate Partner Violence Screening Policy The agency must have in place a written policy and procedure regarding client Intimate Partner Violence (IPV) Screening that is consistent with the Houston EMA IPV Protocol. The policy and procedure should address: • process for ensuring clients are screened for IPV no less than annually • intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management • State reporting requirements associated with IPV • Description of required medical record documentation • Procedures for patient referral including available resources, procedures for follow-up and responsible personnel Plan for training all appropriate staff (including non-RW funded staff)	• Review of Policies and Procedures Manual indicates compliance. • Documentation in patient record
1.20	Patient Retention in Care The agency must have in place a written policy and procedure regarding client retention in care. The policy and procedure must include: • process for client appointment reminders (e.g. timing, frequency, position responsible) • process for contacting clients after missed appointments (e.g. timing, frequency, position responsible) • measures to promote retention in care process for re-engaging those lost to care (no primary care visit in 6 months)	• Review of Agency's Policies and Procedures Manual indicates compliance •
2.0	**Psychiatric care for persons with HIV should reflect competence and experience in both mental health care and therapeutics known to be effective in the treatment of psychiatric conditions and is consistent with the most current published Texas Society of Psychiatric Physicians/American Psychiatric Association treatment guidelines.**	
2.1	Psychiatric Guidelines Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines (www.txpsych.org) and the American Psychiatric Association (www.psych.org/aids) guidelines.	• Documentation in patient record
3.0	**In addition to demonstrating competency in the provision of HIV specific care, HIV clinical service programs must show evidence that their performance follows norms for ambulatory care.**	

3.1	<u>Access to Care</u> Primary care providers shall ensure all new referrals from testing sites are scheduled for a new patient appointment within 15 working days of referral. (All exceptions to this timeframe will be documented) Agency must assure the time-appropriate delivery of services, with 24 hour on-call coverage including: • Mechanisms for urgent care evaluation and/or triage • Mechanisms for in-patient care • Mechanisms for information/referral to: ➢ Medical sub-specialties: Gastroenterology, Neurology, Psychiatry, Ophthalmology, Dermatology, Obstetrics and Gynecology and Dentistry ➢ Social work and case management services ➢ Mental health services ➢ Substance abuse treatment services ➢ Anti-retroviral counseling/therapy for pregnant women ➢ Local federally funded hemophilia treatment center for persons with inherited coagulopathies ➢ Clinical investigations	• Agency Policy and Procedure regarding continuity of care.
3.2	<u>Continuity with Referring Providers</u> Agency must have a formal policy for coordinating referrals for inpatient care and exchanging patient information with inpatient care providers.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.3	<u>Clients Referral and Tracking</u> Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agencies must implement tracking systems to identify clients who are out of care and/or need health screenings (e.g. Hepatitis b & c, cervical cancer screening, etc., for follow-up).	• Documentation of referrals out • Staff interviews indicate compliance • Established tracking systems
3.4	<u>Client Notification of Service Provider Turnover</u> Client must be provided notice of assigned service primary care provider's cessation of employment within 30 days of the employee's departure.	• Documentation in patient record
3.5	<u>Recommended Format for Operational Standards</u> Detailed standards and routines for program assessment are found in most recent Joint Commission performance standards.	• Ambulatory HIV clinical service should adopt and follow performance standards for ambulatory care as established by the Joint Commission

3.6	Client Accommodation for Same Day Provider Cancellations Agency must have a policy in place that outlines a timeline for client notification of provider cancellations, and a protocol for how patients will be accommodated when they do not receive notification in advance of arriving to the clinic.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.7	Client Prescription Refill Policy Agency must have a policy in place that details short term prescription refill availability in when office visit is not feasible prior to patient depletion of medication.	• Review of Agency's Policies and Procedures Manual indicates compliance

Vision Services

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

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

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

HIV and African Americans

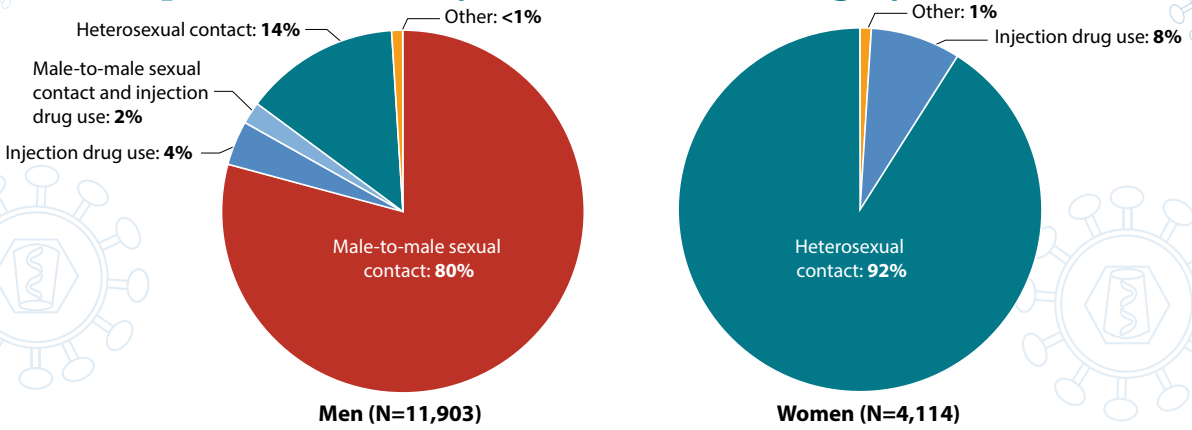
OF THE 37,832 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2018:

42% WERE AMONG ADULT AND ADOLESCENT BLACKS/ AFRICAN AMERICANS†

31% WERE AMONG BLACK/ AFRICAN AMERICAN MEN

11% WERE AMONG BLACK/ AFRICAN AMERICAN WOMEN

New HIV Diagnoses Among Blacks/African Americans in the US and Dependent Areas by Transmission Category and Sex, 2018



Men (N=11,903) **Women (N=4,114)**

Totals may not equal 100% due to rounding.

From 2010 to 2017, HIV diagnoses decreased 15% among blacks/African Americans overall.‡ But trends varied for different groups of blacks/African Americans:

Women: **down 27%**

Heterosexual men: **down 32%**

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

Gay and bisexual men by age:††

- 13 to 24: **down 11%**
- 25 to 34: **up 42%**
- 35 to 44: **down 21%**
- 45 to 54: **down 36%**
- 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 the District of Columbia.

** This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who have sex with men.

†† 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.

AT THE END OF 2016, AN ESTIMATED
476,100
BLACKS/AFRICAN AMERICANS HAD HIV.

6 in 7
KNEW THEY HAD THE VIRUS.‡

For every 100 blacks/African Americans with HIV in 2016:‡

- **61** received some HIV care
- **47** were retained in care
- **48** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

What places some African Americans at higher risk for HIV?

Knowledge of HIV Status

Some African Americans do not know their HIV status. People who do not know they have HIV can't get the care they need and may transmit HIV to others without knowing it.

Sexually Transmitted Diseases (STDs)

African Americans have higher rates of some STDs. Having another STD can increase a person's chance of getting or transmitting HIV.

Socioeconomic Issues

The poverty rate is high among African Americans. The issues associated with poverty, including limited access to HIV prevention and care services, may increase the risk for HIV.

Stigma and Discrimination

Stigma, fear, discrimination, and homophobia may place some African Americans at higher risk for HIV.

How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Conducting prevention research and providing guidance to those working in HIV prevention.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

Supporting community organizations that increase access to HIV testing and care.

Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

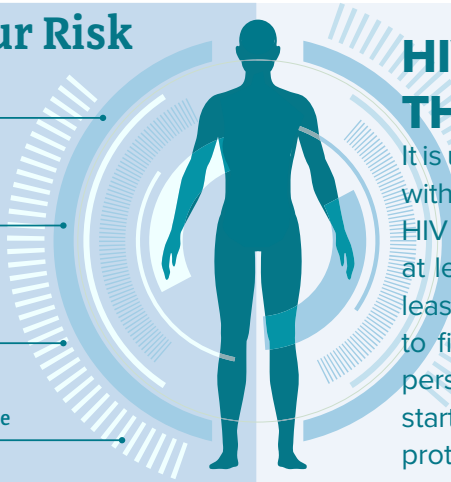
Reduce Your Risk

Not having sex

Using condoms

Not sharing syringes

Taking medicine to prevent or treat HIV



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 January 2020.

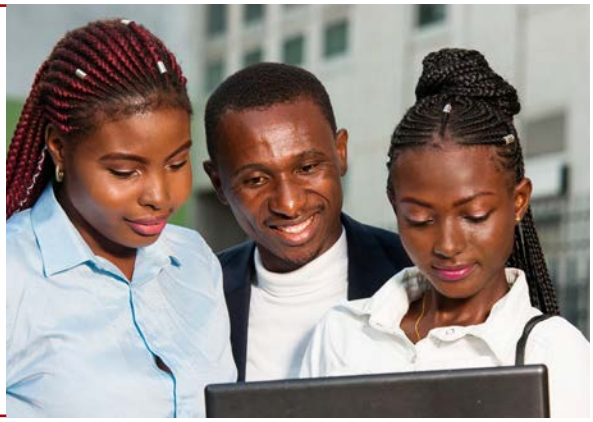
HRSA
Ryan White & Global HIV/AIDS Programs

HRSA's Ryan White HIV/AIDS Program

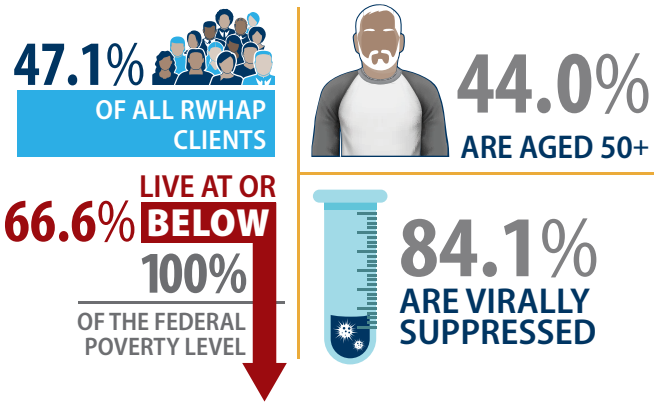
Black/African American Clients: Ryan White HIV/AIDS Program, 2018

Population Fact Sheet | January 2020

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.



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



Of the more than half a million clients served by RWHAP, 73.7 percent are from racial/ethnic minority populations, with 47.1 percent of all RWHAP clients identifying as black/African American.

More details about this RWHAP client population are outlined below:

- The majority of black/African American clients served by RWHAP are low income. Data show that 66.6 percent of black/African American clients are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (61.3 percent).
- The majority of black/African American clients served by RWHAP are male. Data show that 62.9 percent of clients are male, 35.0 percent of clients are female, and 2.2 percent of clients are transgender. The proportion of black/African American males is lower than the national RWHAP average (72.0 percent), whereas the proportion of black/African American females is higher than the national RWHAP average (26.1 percent).
- One in seven black/African American clients served by RWHAP has temporary or unstable housing. Among black/African American clients served by RWHAP, 8.3 percent have temporary housing, and 5.9 percent have unstable housing.
- The black/African American RWHAP client population is aging. Black/African American clients aged 50 years and older account for 44.0 percent of all black/African American RWHAP clients.
- Among black/African American male RWHAP clients, 56.3 percent are men who have sex with men (MSM). Among all males served by RWHAP, MSM account for 65.7 percent.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, approximately 84.1 percent of black/African American clients receiving RWHAP HIV medical care are virally suppressed,* which is lower than the national RWHAP average (87.1 percent).

- 83.3 percent of black/African American men receiving RWHAP HIV medical care are virally suppressed.
- 85.7 percent of black/African American women receiving RWHAP HIV medical care are virally suppressed.

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

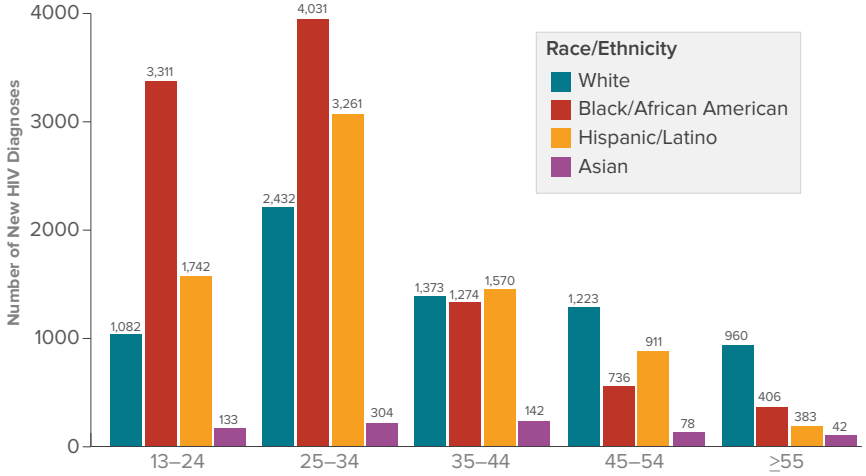
HIV and African American Gay and Bisexual Men

OF THE 37,832 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2018,
9,756 WERE AMONG ADULT AND ADOLESCENT BLACK/AFRICAN AMERICAN† GAY AND BISEXUAL MEN.‡ **

BLACK/AFRICAN AMERICAN GAY AND BISEXUAL MEN MADE UP 37% 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 TO 34

New HIV Diagnoses Among Gay and Bisexual Men in the US and Dependent Areas By Age and Race/Ethnicity, 2018



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 2017, 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 by age‡

- 13 to 24: **down 11%**
- 25 to 34: **up 42%**
- 35 to 44: **down 21%**
- 45 to 54: **down 36%**
- 55 and older: **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).
** This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who have sex with men.
†† In 50 states and the 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.

AT THE END OF 2016, AN ESTIMATED

225,200

BLACK/AFRICAN AMERICAN GAY AND BISEXUAL MEN HAD HIV.

8 in 10

KNEW THEY HAD THE VIRUS.‡‡

For every 100 black/African American gay and bisexual men with HIV in 2016:***

- **75** received some HIV care
- **59** were retained in care
- **57** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

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

Delay in Linkage to HIV Medical Care

Not all African American gay and bisexual men with newly and previously diagnosed HIV are linked to care within 90 days of the diagnosis.

Lower Viral Suppression Percentages

African American gay and bisexual men have lower percentages of viral suppression than gay and bisexual men of other races/ethnicities.

Socioeconomic Factors

Issues such as limited access to quality health care, lower income, and education may place some African American gay and bisexual men at higher risk for HIV.

Stigma

Stigma, homophobia, and discrimination may affect whether African American gay and bisexual men seek or receive high-quality health services.

How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Supporting community organizations that increase access to HIV testing and care.

Conducting prevention research and providing guidance to those working in HIV prevention.

Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

‡‡ Includes infections attributed male-to-male sexual contact only. Among black/African American men with HIV infection attributed to male-to-male sexual contact and injection drug use, 94% knew they had HIV.
*** In 41 states and the District of Columbia.

Reduce Your Risk

- Not having sex
- Using condoms
- Not sharing syringes
- Taking medicine to prevent or treat HIV

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

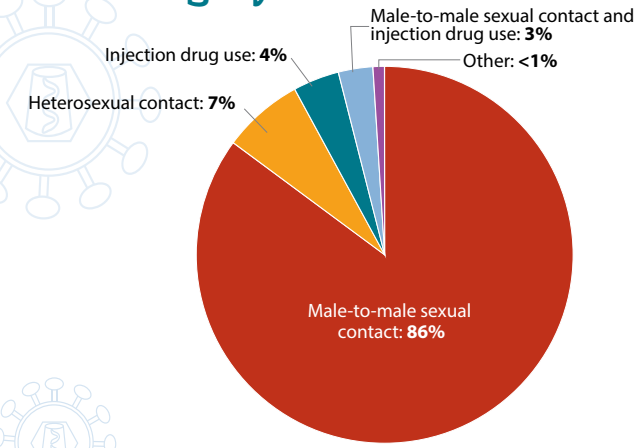
All content is based on the most recent data available in January 2020.

HIV and Hispanics/Latinos

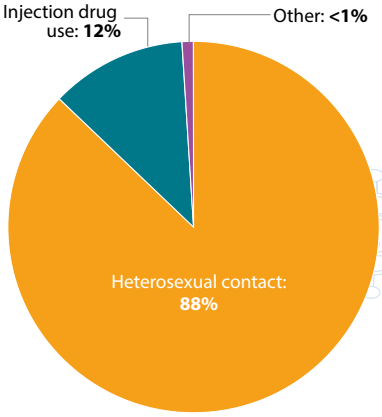
OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017:

- 26% WERE AMONG ADULT AND ADOLESCENT HISPANICS/ LATINOS†
- 22% WERE AMONG HISPANIC/ LATINO MEN
- 3% WERE AMONG HISPANIC WOMEN/LATINAS

New HIV Diagnoses Among Hispanics/Latinos by Transmission Category and Sex in the US and Dependent Areas, 2017



Hispanic/Latino Men (N= 8,686)



Hispanic Women/Latinas (N=1,203)

From 2010 to 2016, HIV diagnoses increased 6% among Hispanics/Latinos overall.‡ But trends varied by transmission category:

Hispanic/Latino men by transmission category:	Hispanic women/Latinas by transmission category:
Male-to-male sexual contact: **up 21%**	Heterosexual contact: **down 20%**
Injection drug use: **down 39%**	Injection drug use: **down 25%**
Male-to-male sexual contact and injection drug use: **down 21%**	
Heterosexual contact: **down 17%**	

* 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.
‡ In 50 states and the 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.

AT THE END OF 2016, AN ESTIMATED **254,600** HISPANICS/LATINOS HAD HIV.‡

5 in 6 KNEW THEY HAD THE VIRUS.

For every 100 Hispanics/Latinos with HIV in 2016:‡

- **60** received some HIV care
- **49** were retained in care
- **51** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

What places some Hispanics/Latinos at higher risk?

Knowledge of HIV Status

Many Hispanics/Latinos do not know their HIV status. People who do not know they have HIV can't get the care they need and may pass HIV to others without knowing it.

Stigma and Discrimination

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.

Sexually Transmitted Diseases (STDs)

Hispanics/Latinos have higher rates of some STDs. Having another STD can increase a person's chance of getting or transmitting HIV.

Access to HIV Prevention and Care

Immigration status, poverty, migration patterns, lower educational level, and language barriers may make it harder for some Hispanics/Latinos to get HIV testing and care.

How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Supporting community organizations that increase access to HIV testing and care.

Conducting prevention research and providing guidance to those working in HIV prevention.

Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

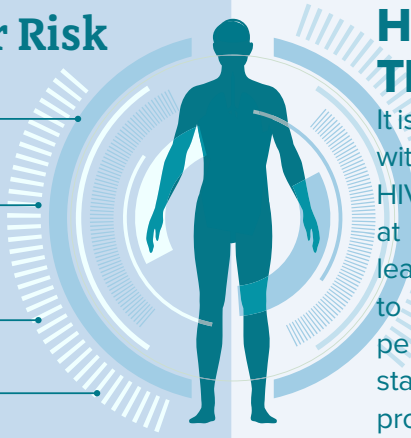
Reduce Your Risk

Not having sex

Using condoms

Not sharing syringes

Taking medicine to prevent or treat HIV



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

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Visit www.cdc.gov/hiv

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

HRSA
Ryan White & Global HIV/AIDS Programs

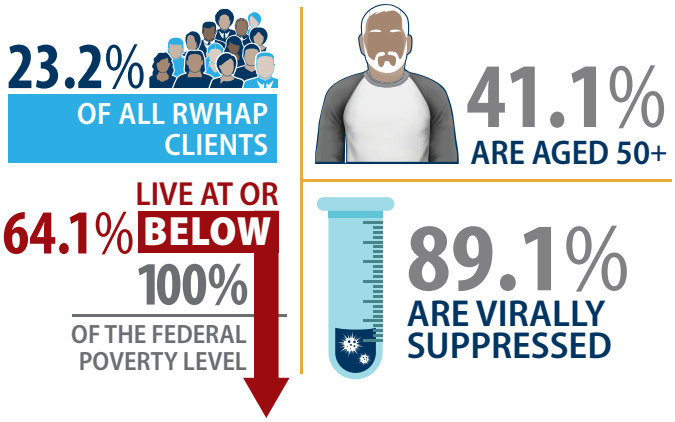
HRSA's Ryan White HIV/AIDS Program

Hispanic/Latino Clients: Ryan White HIV/AIDS Program, 2018

Population Fact Sheet | January 2020

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

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



Of the more than half a million clients served by RWHAP, 73.7 percent are from racial/ethnic minority populations, with 23.2 percent of all RWHAP clients identifying as Hispanic/Latino. Below are more details about this RWHAP client population:

- The majority of Hispanic/Latino clients served by RWHAP are low income. Data show that 64.1 percent of Hispanic/Latino clients are living at or below 100 percent of the federal poverty level, which is slightly higher than the national RWHAP average (61.3 percent).
- The majority of Hispanic/Latino clients served by RWHAP are male. Data show that 75.9 percent of clients are male, 21.7 percent are female, and 2.4 percent are transgender.
- Data show that 4.7 percent of Hispanic/Latino RWHAP clients have unstable housing. This percentage is slightly lower than the national RWHAP average (5.3 percent).
- The Hispanic/Latino RWHAP client population is aging. Hispanic/Latino clients aged 50 years and older account for 41.1 percent of all Hispanic/Latino RWHAP clients.
- Among Hispanic/Latino male RWHAP clients, 65.8 percent are men who have sex with men (MSM). This percentage is consistent with the RWHAP national average (65.7 percent).

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, approximately 89.1 percent of Hispanic/Latino RWHAP clients receiving HIV medical care are virally suppressed,* which is slightly higher than the national RWHAP average (87.1 percent).

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

HIV and Hispanic/Latino Gay and Bisexual Men

OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017:

7,722 WERE AMONG ADULT AND ADOLESCENT HISPANIC/LATINO† GAY AND BISEXUAL MEN‡ **

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

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

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

From 2010 to 2016, HIV diagnoses increased 18% among Hispanic/Latino gay and bisexual men overall.†† But trends varied by age:

Hispanic/Latino gay and bisexual men by age

- **13 to 24: up 17%**
- **25 to 34: up 34%**
- **35 to 44: stable**
- **45 to 54: up 14%**
- **55 and older: up 10%**

* 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.
‡ Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).
** This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who have sex with men.
†† In 50 states and the 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.

AT THE END OF 2016, AN ESTIMATED

168,400

HISPANIC/LATINO GAY AND BISEXUAL MEN HAD HIV.††

4 in 5

KNEW THEY HAD THE VIRUS.‡‡

For every 100 Hispanic/Latino gay and bisexual men with HIV in 2016:***

- **76** received some HIV care
- **62** were retained in care
- **61** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

What places some Hispanic/Latino gay and bisexual men at higher risk?

Knowledge of HIV Status

People who don't know they have HIV can't get the care they need and may pass HIV to others without knowing it.

Low PrEP Use

A small number of Hispanic/Latino gay and bisexual men reported using using pre-exposure prophylaxis (PrEP). If taken daily, PrEP is highly effective for preventing HIV.

Older Sex Partners

Hispanic/Latino gay and bisexual men are more likely to report that their last sex partner was older. Having older partners may increase the likelihood of being exposed to HIV.

Access to HIV Prevention and Treatment Services

Immigration status, poverty, migration patterns, lower educational level, and language barriers may make it harder for some Hispanic/Latino gay and bisexual men to access HIV services.

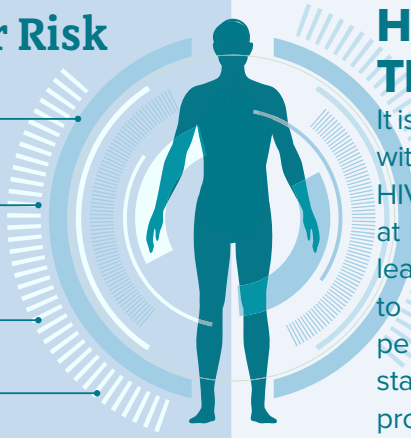
How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends.
- Supporting community organizations that increase access to HIV testing and care.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.
- Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

‡‡ Includes infections attributed to male-to-male sexual contact only. Among Hispanic/Latino men with HIV infection attributed to male-to-male sexual contact *and* injection drug use, 91% knew they had HIV.
*** In 41 states and the District of Columbia.

Reduce Your Risk

- Not having sex
- Using condoms
- Not sharing syringes
- Taking medicine to prevent or treat HIV



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

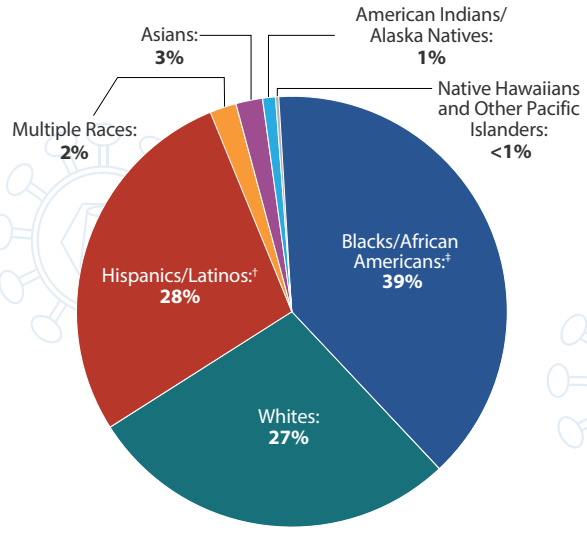
All content is based on the most recent data available in September 2019.

HIV and Men

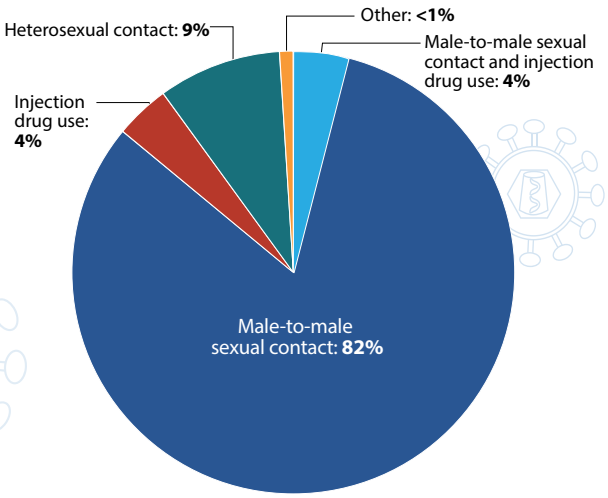
OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017,

31,239 (81%) WERE AMONG MEN.

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



New HIV Diagnoses Among Men by Transmission Category in the US and Dependent Areas, 2017



From 2010 to 2016, HIV diagnoses decreased 6% among men overall.** But trends varied for different groups of men:

- **Black/African American:** down 7%
- **Hispanic/Latino:** up 11%
- **Asian:** up 45%
- **White:** down 15%
- **Other Races/ Ethnicities:** down 31%

Men by transmission category

- Male-to-male sexual contact: **stable**
- Injection drug use: **down 37%**
- Male-to-male sexual contact and injection drug use: **down 23%**
- Heterosexual contact: **down 21%**

Men by age

- 13 to 24: **stable**
- 25 to 34: **up 23%**
- 35 to 44: **down 27%**
- 45 to 54: **down 28%**
- 55 and older: **down 5%**

* 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.
‡ *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 the 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.

AT THE END OF 2016, AN ESTIMATED **882,300** **MEN** HAD HIV.**

6 in 7 KNEW THEY HAD THE VIRUS.

For every 100 men with HIV in 2016:

- **63** received some HIV care
- **49** were retained in care
- **53** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

What places some men at higher risk?

Knowledge of HIV Status

People who don't know they have HIV can't get the care they need and may pass HIV to others without knowing it.

Sexual Behaviors

Most men get HIV through sexual contact, especially anal sex. Anal sex is the riskiest type of sex for getting or transmitting HIV.

Sexually Transmitted Diseases (STDs)

Having another STD can greatly increase the chance of getting or transmitting HIV.

Injection Drug Use

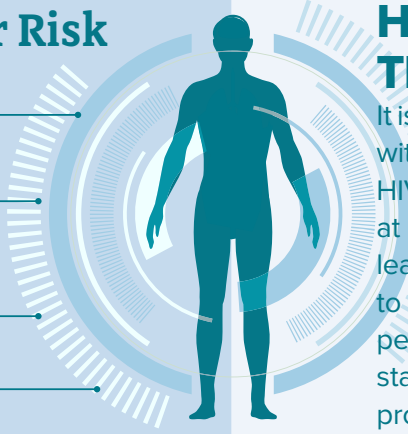
Sharing needles, syringes, and other injection drug equipment puts people at risk for HIV.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends.
- Supporting community organizations that increase access to HIV testing and care.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.
- Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

Reduce Your Risk

- Not having sex
- Using condoms
- Not sharing syringes
- Taking medicine to prevent or treat HIV



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

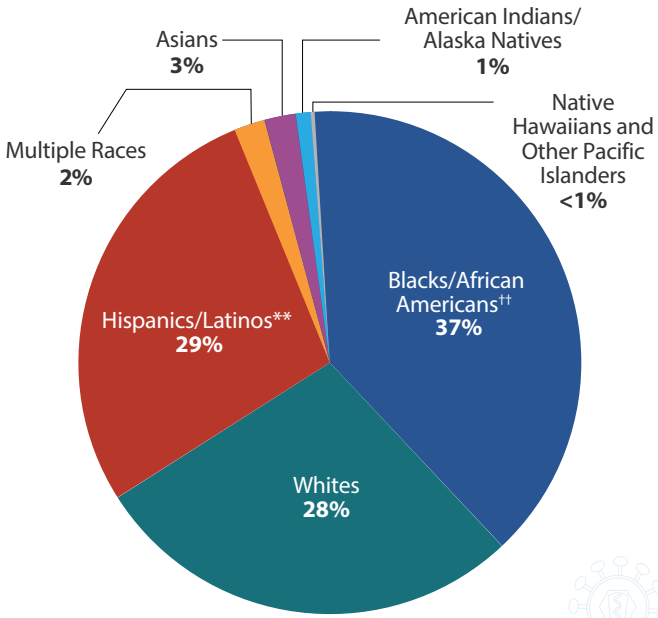
Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

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

HIV and Gay and Bisexual Men

OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017,
27,000 (70%) WERE AMONG ADULT AND ADOLESCENT GAY AND BISEXUAL MEN.† ‡

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



From 2010 to 2016, HIV diagnoses remained stable among gay and bisexual men overall.⌗ But trends varied for different groups of gay and bisexual men:

Gay and bisexual men by race/ethnicity

- Black/African American: **stable**
- Hispanic/Latino: **up 18%**
- Asian: **up 52%**
- White: **down 16%**

Gay and bisexual men by age

- 13 to 24: **stable**
- 25 to 34: **up 26%**
- 35 to 44: **down 24%**
- 45 to 54: **down 23%**
- 55 and older: **up 5%**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).
‡ This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who have sex with men.
** Hispanics/Latinos 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 the 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.

AT THE END OF 2016, AN ESTIMATED **707,100** GAY AND BISEXUAL MEN HAD HIV.‡‡

5 in 6 KNEW THEY HAD THE VIRUS.***

For every 100 gay and bisexual men with HIV in 2016:‡‡

- **72** received some HIV care
- **57** were retained in care
- **58** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

What places some gay and bisexual men at higher risk?

Knowledge of HIV Status

People who don't know they have HIV can't get the care they need and may pass HIV to others without knowing it.

Sexual Behaviors

Most gay and bisexual men get HIV from having anal sex without a condom or taking medicine to prevent or treat HIV.

Sexually Transmitted Diseases (STDs)

Having another STD can greatly increase the chance of getting or transmitting HIV.

Stigma

Stigma, homophobia, and discrimination may affect whether gay and bisexual men seek or receive high-quality health services.

How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Supporting community organizations that increase access to HIV testing and care.

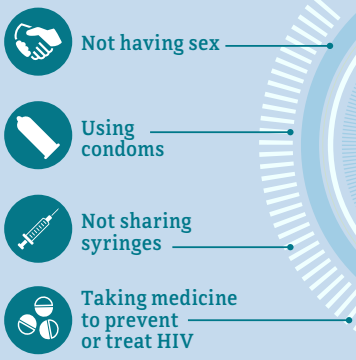
Conducting prevention research and providing guidance to those working in HIV prevention.

Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

*** Includes infections attributed to male-to-male sexual contact *only*. Among men with HIV infection attributed to male-to-male sexual contact *and* injection drug use, 92% knew they had HIV.

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

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Ryan White & Global HIV/AIDS Programs

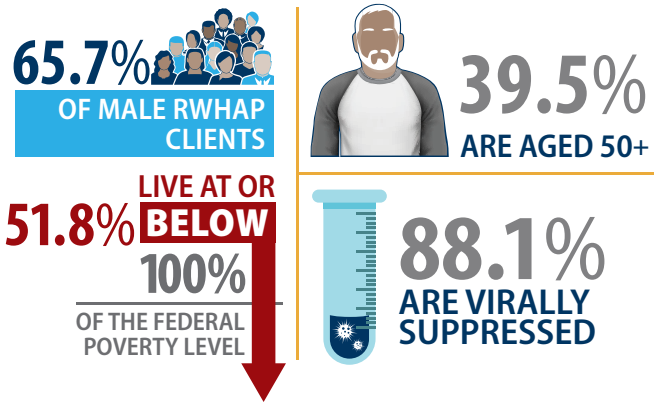
HRSA's Ryan White HIV/AIDS Program

Gay, Bisexual, and Other Men Who Have Sex with Men (MSM) Clients: Ryan White HIV/AIDS Program, 2018

Population Fact Sheet | January 2020

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

Ryan White HIV/AIDS Program Fast Facts: Gay, Bisexual, and Other Men Who Have Sex with Men (MSM) Clients



A significant proportion of RWHAP clients are men who have sex with men (MSM). Of the more than half a million clients served by RWHAP, 47.3 percent are MSM. Of male clients served by RWHAP, 65.7 percent are MSM. More details about this RWHAP client population are outlined below:

- The majority of MSM clients served by RWHAP are from racial/ethnic minority populations. Data show that 63.7 percent of MSM RWHAP clients served are from racial/ethnic minority populations. Among MSM, 36.3 percent identify as white, 35.0 percent identify as black/African American, and 25.2 percent identify as Hispanic/Latino.
- More than half of MSM clients served by RWHAP are low income. Of the MSM RWHAP clients served, 51.8 percent are living at or below 100 percent of the federal poverty level, which is lower than the national RWHAP average (61.3 percent).
- Among the MSM RWHAP clients, 4.6 percent have unstable housing. This percentage is slightly lower than the national RWHAP average (5.3 percent).
- The MSM RWHAP client population is aging. MSM clients aged 50 years and older account for 39.5 percent of all RWHAP MSM clients. This percentage is lower than the national RWHAP average (46.1 percent).

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, approximately 88.1 percent of MSM receiving RWHAP HIV medical care are virally suppressed,* which is slightly higher than the national RWHAP average (87.1 percent).

- 78.3 percent of young MSM (aged 13–24) receiving RWHAP HIV medical care are virally suppressed.
- 74.8 percent of young black/African American MSM (aged 13–24) receiving RWHAP HIV medical care are virally suppressed.

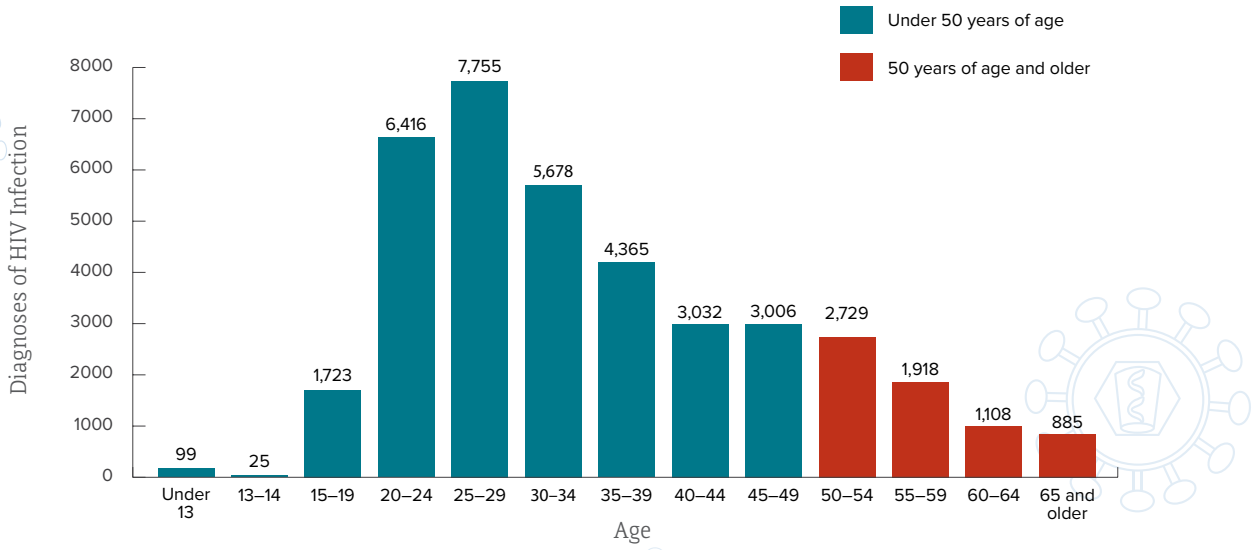
* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

HIV and Older Americans

OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017, 6,640 WERE AMONG PEOPLE AGED 50 AND OLDER. OF THESE:

2,731 WERE AMONG BLACKS/AFRICAN AMERICANS† | **2,343 WERE AMONG WHITES** | **1,288 WERE AMONG HISPANICS/LATINOS‡**

New HIV Diagnoses in the US and Dependent Areas by Age, 2017



From 2012 to 2016, HIV diagnoses remained stable overall among people aged 50 and older.
But trends varied by transmission category:

All people aged 50 and older: stable

Men by transmission category:	Women by transmission category:
Male-to-male sexual contact: **stable**	Heterosexual contact: **down 8%**
Injection drug use: **down 17%**	Injection drug use: **down 18%**
Male-to-male sexual contact and injection drug use: **down 12%**	
Heterosexual contact: **down 9%**	

* 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.
‡ Hispanics/Latinos can be of any race.
** In 50 states and the 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.

AT THE END OF 2016, AN ESTIMATED **327,000** PEOPLE AGED 55 AND OLDER HAD HIV.

9 in 10 KNEW THEY HAD THE VIRUS.**

For every 100 people aged 55 and older with HIV in 2016:**

- **69** received some HIV care
- **56** were retained in care
- **60** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

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.

What places some older Americans at higher risk?

Delayed Treatment

Older people in the US are more likely to have late-stage HIV when diagnosed, start treatment late, and suffer more immune system damage.

Knowledge of HIV Prevention

Older people may not be as knowledgeable about prevention and sexual risk including having multiple sex partners.

Stigma

Older people may already face isolation due to illness or loss of family and friends.

Fewer Discussions with Doctors

Older people may visit their doctors more often, but are less likely to discuss sexual and drug use behaviors.

How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Supporting community organizations that increase access to HIV testing and care.

Conducting prevention research and providing guidance to those working in HIV prevention.

Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

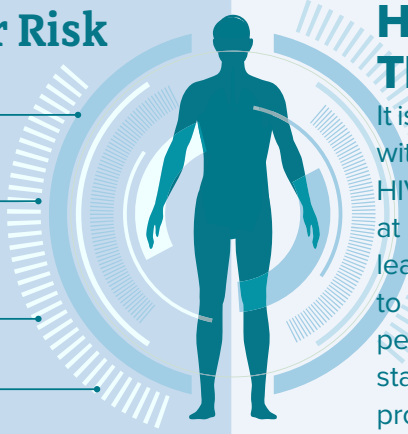
Reduce Your Risk

Not having sex

Using condoms

Not sharing syringes

Taking medicine to prevent or treat HIV



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 2019.

HRSA
Ryan White & Global HIV/AIDS Programs

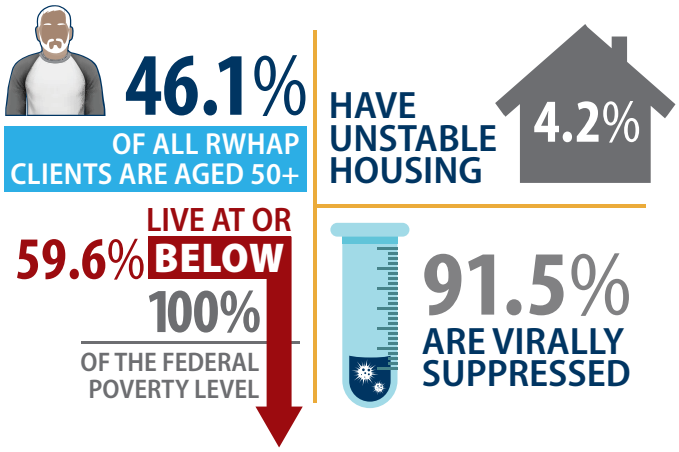
HRSA's Ryan White HIV/AIDS Program

Older Adult Clients: Ryan White HIV/AIDS Program, 2018

Population Fact Sheet | January 2020

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

Ryan White HIV/AIDS Program Fast Facts: Older Adult Clients



The RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older. Below are more details about this RWHAP client population:

- The majority of RWHAP clients aged 50 years and older are from racial/ethnic minority populations. Among RWHAP clients aged 50 years and older, 68.2 percent are from racial/ethnic minority populations; 44.9 percent of RWHAP clients in this age group identify as black/African American, which is slightly lower than the national RWHAP average (47.1 percent). Additionally, 20.6 percent of RWHAP clients in this age group identify as Hispanic/Latino, which is slightly lower than the national RWHAP average (23.2 percent).
- The majority of RWHAP clients aged 50 years and older are male. Data show approximately 71.3 percent of clients aged 50 years and older are male, 27.7 percent are female, and 1.0 percent are transgender.
- The majority of RWHAP clients aged 50 years and older are low income. Among RWHAP clients aged 50 years and older, 59.6 percent are living at or below 100 percent of the federal poverty level, which is lower than the national RWHAP average (61.3 percent).
- Data show 4.2 percent of RWHAP clients aged 50 years and older have unstable housing. This percentage is slightly lower than the national RWHAP average (5.3 percent).

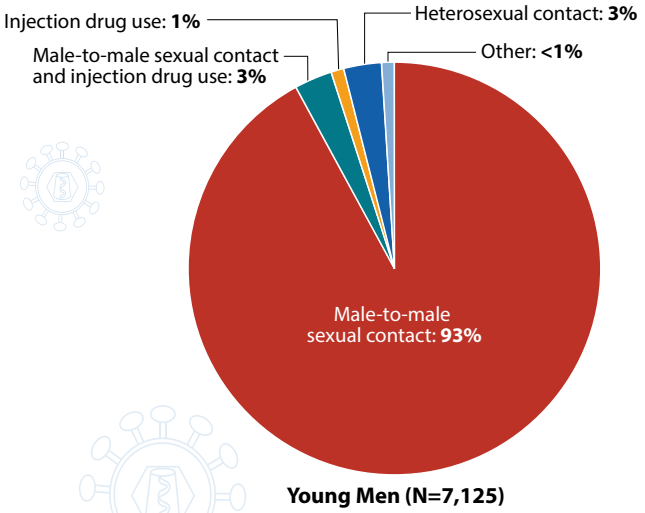
Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, 91.5 percent of clients aged 50 years and older receiving RWHAP HIV medical care are virally suppressed,* which is higher than the national RWHAP average (87.1 percent).

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

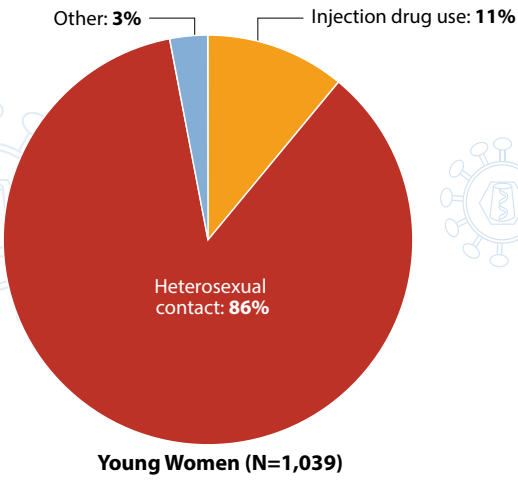
HIV and Youth

OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017,
8,164 (21%) WERE AMONG YOUTH AGED 13 TO 24.†

New HIV Diagnoses Among Youth by Transmission Category and Sex in the US and Dependent Areas, 2017



Young Men (N=7,125)



Young Women (N=1,039)

From 2010 to 2016, HIV diagnoses decreased 6% among youth overall.‡ But trends varied for different groups of youth.

Youth overall: down 6%

Young women: down 32%

Young men: remained stable

Young gay and bisexual men by race/ethnicity:**

- **Black/African American: down 5%††**
- **Hispanic/Latino: up 17%‡‡**
- **White: down 6%**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Unless otherwise noted, persons aged 13 to 24 are referred to as *youth* or *young* in this fact sheet.
‡ 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).
†† *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.
‡‡ 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 2016, AN ESTIMATED **50,900** **YOUTH** HAD HIV.‡

ONLY 56% KNEW THEY HAD 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 health-related 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.
- Young people may be uninsured or on their parent's insurance making it difficult to access or use medicines to prevent or treat HIV due to cost, perceived stigma, and privacy concerns.
- 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 *Let's Stop HIV Together* (formerly *Act Against AIDS*).

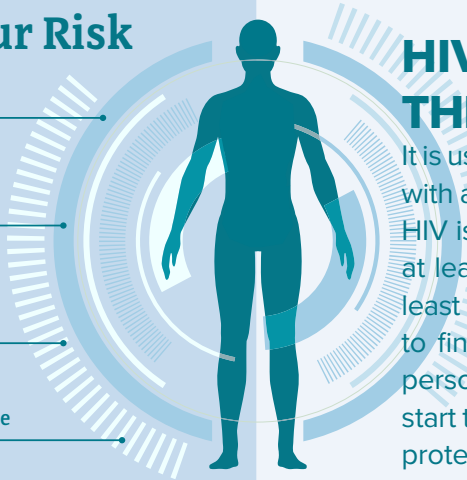
Visit **www.cdc.gov/hiv** and **www.cdc.gov/healthyyouth** for more information about CDC's HIV prevention activities among youth.

FOR EVERY 100 YOUTH WITH HIV IN 2015:‡

- **36** received some HIV care
- **27** were retained in care
- **25** were virally suppressed

Reduce Your Risk

- Not having sex
- Using condoms
- Not sharing syringes
- Taking medicine to prevent or treat HIV



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

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

HRSA
Ryan White & Global HIV/AIDS Programs

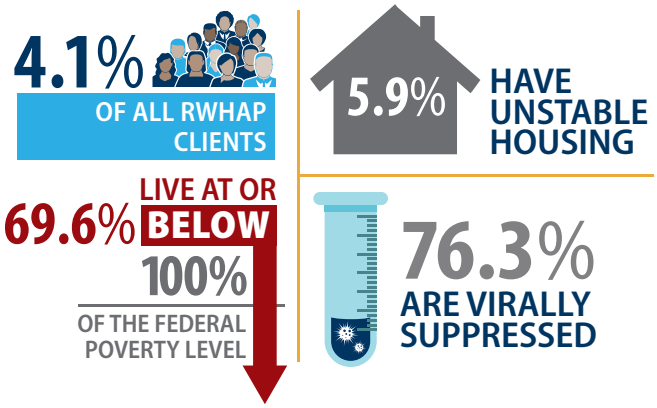
HRSA's Ryan White HIV/AIDS Program

Youth and Young Adult Clients: Ryan White HIV/AIDS Program, 2018

Population Fact Sheet | January 2020

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

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



Youth and young adults aged 13–24 years represent 4.1 percent (nearly 22,000 clients) of the more than half a million RWHAP clients. Below are more details about this RWHAP client population:

- The majority of RWHAP clients aged 13–24 years are from racial/ethnic minority populations. Among clients in this age group, 87.1 percent are from racial/ethnic minority populations. Nearly two-thirds (61.4 percent) of youth and young adult clients identify as black/African American, which is higher than the national RWHAP average (47.1 percent). Hispanics/Latinos represent 21.6 percent of youth and young adult RWHAP clients, which is slightly lower than the national RWHAP average (23.2 percent).
- The majority of RWHAP clients aged 13–24 years are male. Data show that 73.6 percent of clients aged 13–24 years are male, 23.3 percent are female, and 3.1 percent are transgender.
- The majority of RWHAP clients aged 13–24 years are low income. Of youth and young adult RWHAP clients, 69.6 percent are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (61.3 percent).
- Data show that 5.9 percent of RWHAP clients aged 13–24 years have unstable housing. This percentage is slightly higher than the national RWHAP average (5.3 percent).

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, 76.3 percent of clients aged 13–24 years receiving RWHAP HIV medical care are virally suppressed,* which is significantly lower than the national RWHAP average (87.1 percent).

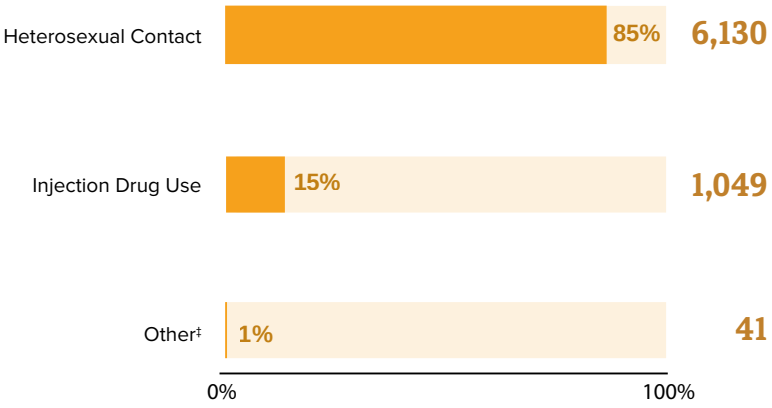
- 78.3 percent of young men who have sex with men (MSM) receiving RWHAP HIV medical care are virally suppressed.
- 74.8 percent of young black/African American MSM receiving RWHAP HIV medical care are virally suppressed.
- 72.1 percent of young black/African American women receiving RWHAP HIV medical care are virally suppressed.
- 68.0 percent of transgender youth and young adults receiving RWHAP HIV medical care are virally suppressed.

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

HIV and Women

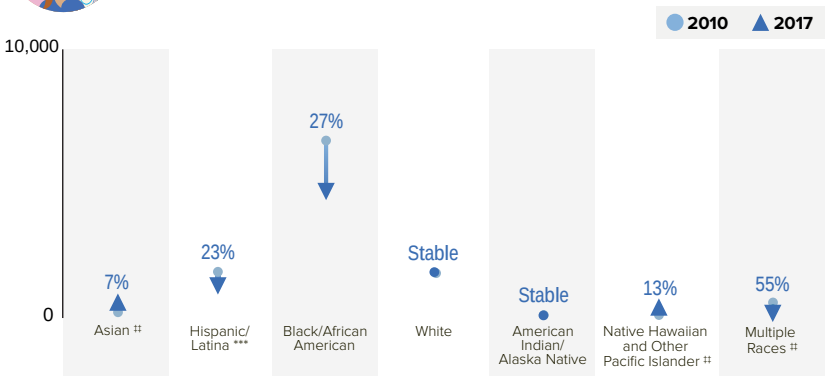
Of the **37,832 NEW HIV DIAGNOSES** in the US and dependent areas* in 2018, 19% were among women.†

Most of the new HIV diagnoses among women were attributed to heterosexual contact.

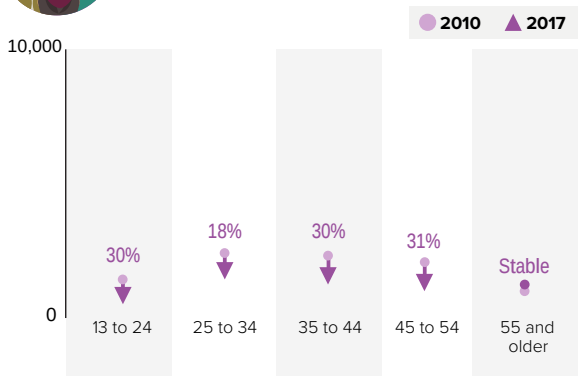


HIV diagnoses declined 23% among women overall from 2010 to 2017. ** Although trends varied for different groups of women, HIV diagnoses declined for groups most affected by HIV, including black/African American†† women and women aged 25 to 34.

Trends by Race and Ethnicity



Trends by Age



* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Adult and adolescent women aged 13 and older.
‡ Includes hemophilia, blood transfusion, perinatal exposure, and risk factors not reported or not identified.
** In 50 states and the District of Columbia.
†† *Black* refers to people having origins in any of the black racial groups of Africa. *African American* is a term often used for Americans of African descent with ancestry in North America.
⌗ Changes in subpopulations with fewer HIV diagnoses can lead to a large percentage increase or decrease.
*** Hispanic women/Latinas can be of any race.

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Division of HIV/AIDS Prevention

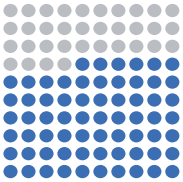
Women who don't know they have HIV cannot get the care and treatment they need to stay healthy.

At the end of 2016, an estimated **1.1 MILLION PEOPLE** had HIV.** Of those, 258,000 were women.

8 in 9 women knew they had the virus.

It is important for women to know their HIV status so they can take medicine to treat HIV if they have the virus. Taking HIV medicine every day can make the viral load undetectable. Women who get and keep an undetectable viral load (or stay virally suppressed) have effectively no risk of transmitting HIV to HIV-negative sex partners.

When compared to people overall with HIV, women have about the same viral suppression rates. But more work is needed to increase these rates. In 2016, for **every 100 women with HIV**: **



66 received some HIV care

51 were retained in care

53 were virally suppressed

For comparison, for every **100 people overall** with HIV, **64 received some HIV care**, **49 were retained in care**, and **53 were virally suppressed**.

There are several challenges that place women at higher risk for HIV.

Other Sexually Transmitted Diseases (STDs)

Having another STD, such as gonorrhea and syphilis, can increase the chance of getting or transmitting HIV.

Unaware of Partner's Risk Factors

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 protection (like condoms or medicine to prevent HIV).

Risk of Exposure

Because receptive sex is riskier than insertive sex, women have a higher risk of getting HIV during vaginal or anal sex than their sex partner.

History of Sexual Abuse

Women who have been sexually abused are more likely to engage in risky behaviors like exchanging sex for drugs or having multiple sex partners.

How is CDC making a difference for women?

- Collecting and analyzing data and monitoring HIV trends.
- Supporting community organizations that increase access to HIV testing and care.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.
- Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.
- Strengthening successful HIV prevention programs and supporting new efforts funded through the *Ending the HIV Epidemic* initiative.

For more information about HIV surveillance data and how it is used, read the "Technical Notes" in the HIV surveillance reports at www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

For more information visit www.cdc.gov/hiv

All content is based on the most recent data available in March 2020.

HRSA
Ryan White & Global HIV/AIDS Programs

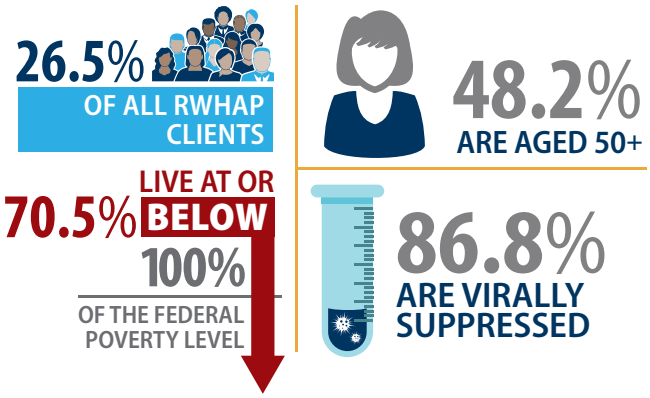
HRSA's Ryan White HIV/AIDS Program

Female Clients: Ryan White HIV/AIDS Program, 2018

Population Fact Sheet | January 2020

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half the people with diagnosed HIV in the United States—approximately 519,000 people in 2018—receive services through RWHAP each year. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

Ryan White HIV/AIDS Program Fast Facts: Female Clients



Females comprise a substantial proportion of RWHAP clients. Of the more than half a million clients served by RWHAP, 26.5 percent are female.

More details about this RWHAP client population are outlined below:

- The majority of female clients served by RWHAP are from racial/ethnic minority populations. The data show that 84.0 percent of female clients are from racial/ethnic minority populations. 62.1 percent of female clients identify as black/African American, which is higher than the national RWHAP average (47.1 percent), and 19.0 percent of female clients identify as Hispanic/Latino, which is lower than the national RWHAP average (23.2 percent).
- The majority of female clients served by RWHAP are low income. Among female clients served, 70.5 percent are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (61.3 percent).
- The data show that 4.2 percent of female RWHAP clients have unstable housing. This is slightly lower than the national RWHAP average (5.3 percent).
- The RWHAP female client population is aging. Among female RWHAP clients served, 48.2 percent are aged 50 years and older, whereas only 3.6 percent of female RWHAP clients are aged 13–24 years.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, approximately 86.8 percent of female clients receiving RWHAP HIV medical care are virally suppressed,* which is slightly lower than the national RWHAP average (87.1 percent).

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

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:

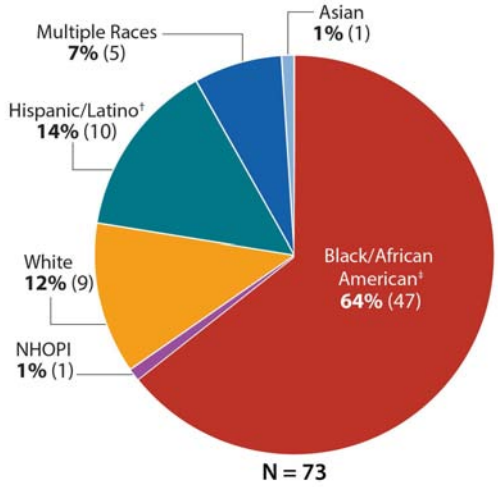
- **Takes HIV medicine daily as prescribed throughout pregnancy and childbirth.**
- **Gives HIV medicine to her baby for 4-6 weeks after giving birth.**
- **Does NOT breastfeed or pre-chew her baby's food.**

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.

† Hispanics/Latinos 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.

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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.

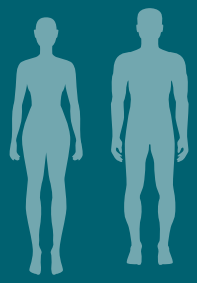
Why are pregnant women and their babies at risk?

- 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?

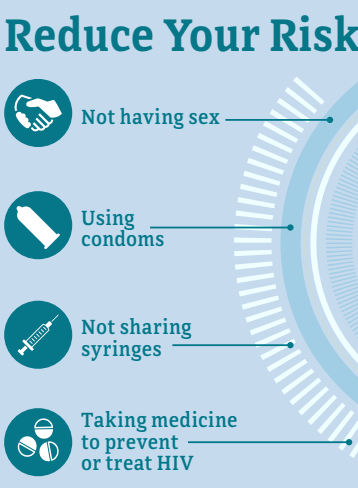
- CDC created a framework (www.cdc.gov/hiv/group/gender/pregnantwomen/emct.html) to help federal agencies and other groups lower the rate of perinatal HIV transmission to less than 1% and reduce the number of cases of perinatal HIV to less than one per 100,000 live births.
- CDC helps lead the Elimination 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



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 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.

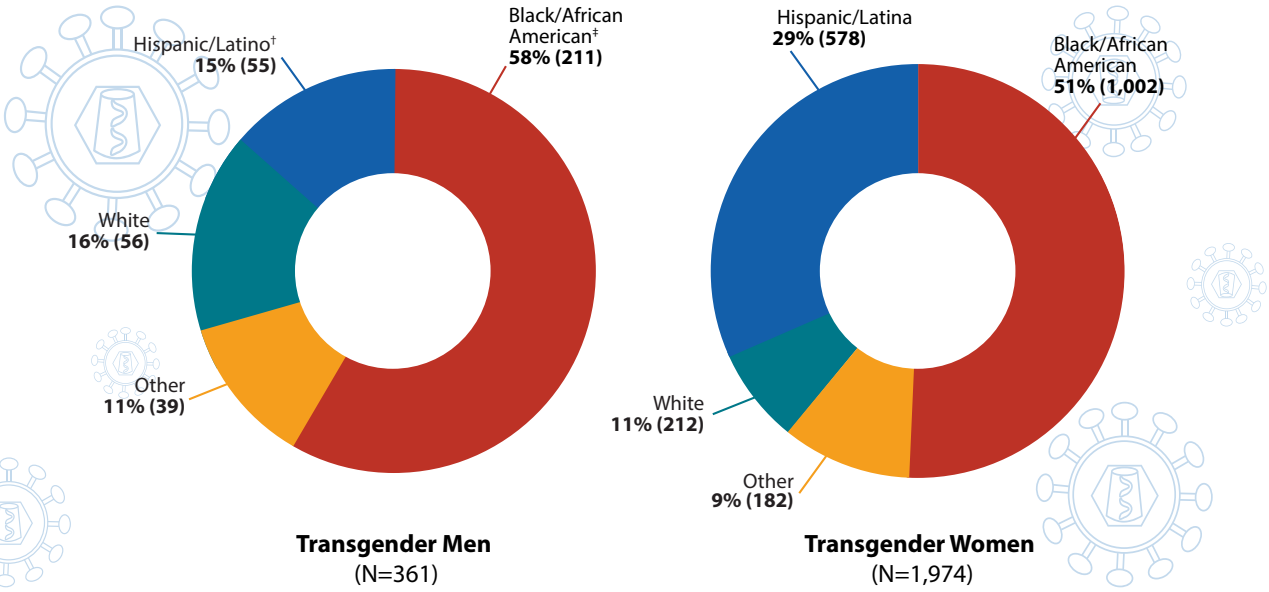
Gender identity: person's internal understanding of their own gender.

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



* Less than 1% had another gender identity.

† Hispanics/Latinos 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.

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.

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, having anal or vaginal sex without protection** (like a condom or medicine to prevent or treat HIV), and sharing needles, syringes, or other equipment to inject hormones or drugs. Other factors may include commercial sex work, mental health issues, high levels of substance misuse, homelessness, and unemployment.
- 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 knowledgeable about transgender issues, this can be a barrier for transgender people with HIV who are looking for treatment and care.
- Due to certain barriers transgender men and women face, current testing programs may not reach enough people in this population.
- The sexual health of transgender men and transgender and gender minority youth has not been well studied. More research is needed to understand their HIV risk behaviors.
- Transgender women and men might not fully engage in medical care.

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 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.

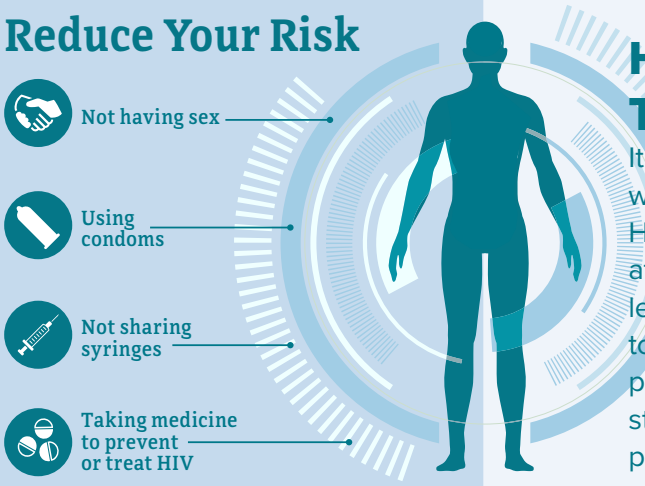
According to current estimates, about 14% of transgender women in the US have HIV.

An estimated 44% of black/African American transgender women have HIV—the highest percentage among all transgender women.††

** It is important to avoid assumptions regarding the types of sexual activity that transgender people engage in or how they may refer to their body parts.

†† Estimate for transgender women overall includes laboratory-confirmed infections only. Estimates by race/ethnicity include laboratory-confirmed and self-reported infections.

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

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Ryan White & Global HIV/AIDS Programs

HRSA's Ryan White HIV/AIDS Program

Transgender Clients: Ryan White HIV/AIDS Program, 2018

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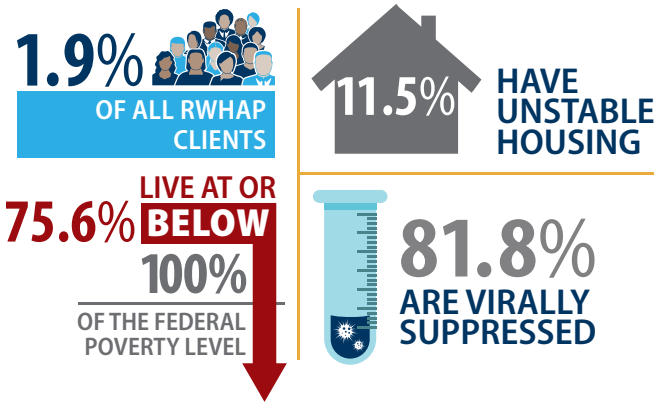
Ryan White HIV/AIDS Program Fast Facts: Transgender Clients



Of the more than half a million clients served by RWHAP, 1.9 percent are transgender, representing approximately 10,200 clients. Below are more details about this RWHAP client population:

- The majority of transgender clients served by RWHAP are from racial/ethnic minority populations. Among the transgender clients served, 88.1 percent are from racial/ethnic minority populations; 54.0 percent of transgender clients identify as black/African American and 29.4 percent identify as Hispanic/Latino, both of which are higher than the national RWHAP averages (47.1 percent and 23.2 percent, respectively).
- The majority of transgender clients served by RWHAP are low income. Among transgender RWHAP clients served, 75.6 percent live at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (61.3 percent).
- Data show that 11.5 percent of transgender RWHAP clients have unstable housing. This percentage is substantially higher than the national RWHAP average (5.3 percent).
- The transgender client population is younger than the average for RWHAP clients. Approximately 25.1 percent of RWHAP transgender clients are aged 50 years and older.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. Among the transgender clients receiving RWHAP HIV medical care in 2018, 81.8 percent are virally suppressed,* which is lower than the national RWHAP average (87.1 percent).

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

HIV and People Who Inject Drugs

People who inject drugs (PWID) are at high risk for getting HIV if they use needles, syringes, or other injection equipment–for example, cookers–that someone with HIV has used.

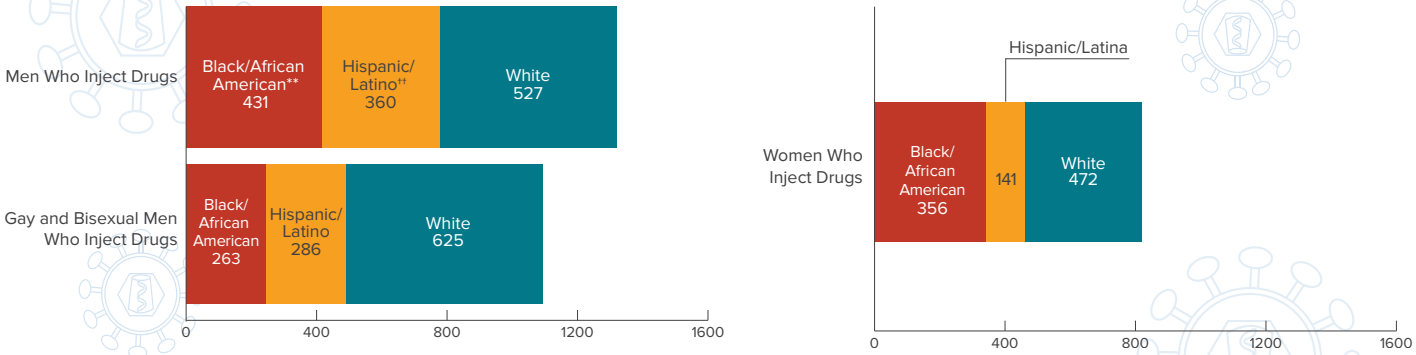
OF THE 38,739 HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017:

1 IN 10 (3,641) WERE AMONG PWID

2,625 WERE AMONG MEN WHO INJECT DRUGS†

1,016 WERE AMONG WOMEN WHO INJECT DRUGS

New HIV Diagnoses Among People Who Inject Drugs in the US and Dependent Areas, 2017



This chart does not include subpopulations representing 2% or less of all PWID who received an HIV diagnosis in 2017.

From 2010 to 2016, HIV diagnoses decreased 31% among PWID overall.† ‡ But trends varied by race/ethnicity.

PWID overall: down 31%

By race/ethnicity:

- **Black/African American: down 52%**
- **Hispanic/Latino: down 30%**
- **White: remained stable**

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

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

** *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.

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‡ In 50 states and the District of Columbia.

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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.

People with HIV who take HIV medicine as prescribed and get and keep an undetectable viral load (or stay virally supressed) have effectively no risk of transmitting HIV to their HIV-negative sexual partners.

Keeping an undetectable viral load likely reduces the risk of transmitting HIV through shared syringes or other injection equipment. But we don't know how much it reduces the risk.

At the end of 2016, an estimated **189,600 PWID had HIV**.‡ Of these, **93%** knew they had the virus.

What places some PWID at higher risk?

Opioid Crisis

Prescription opioid and heroin crisis in nonurban areas leading to more people injecting and new populations being at risk. These areas have limited access to HIV services and substance use disorder treatment.

Socioeconomic Factors

Social and economic factors like homelessness or not having health insurance. These make it harder for some PWID to access HIV services.

Lack of Sterile Equipment

Low access to sterile injection equipment in the US.

Lack of Treatment

Lack of access to treatment for drug addiction or substance use disorder, including medication-assisted treatment (MAT).

Other Diseases

Blood-borne diseases such as viral hepatitis and other sexually transmitted diseases (STDs). Having another STD can greatly increase the chance of getting or transmitting HIV through sex.

How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Supporting responses for HIV outbreaks traced to injection drug use.

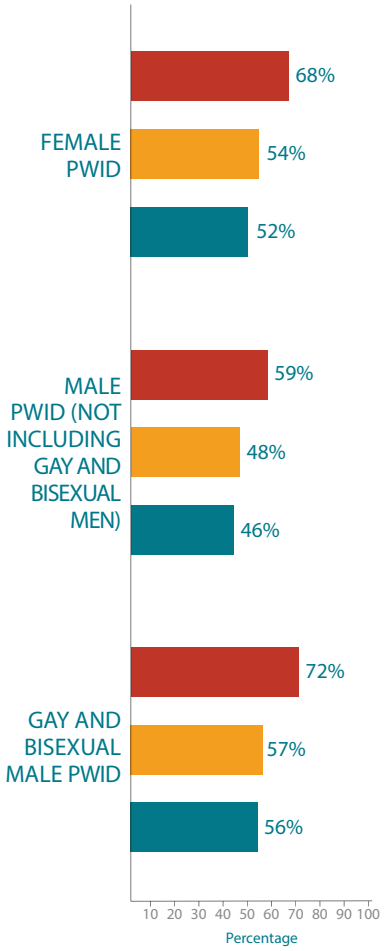
Conducting prevention research and providing guidance to those working in HIV prevention.

Providing guidance and technical assistance to programs on how CDC funding supports implementation of syringe service programs.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

HIV Care for PWID With HIV (2015)‡



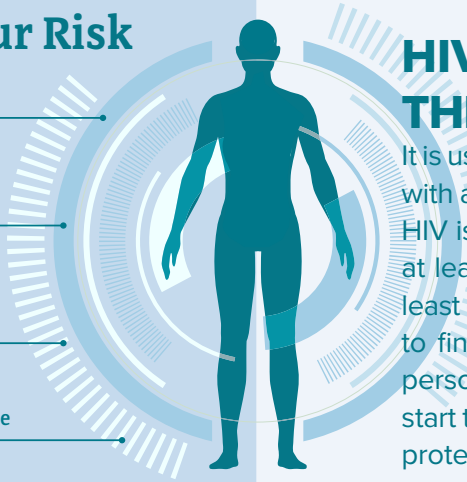
Reduce Your Risk


Not having sex


Using condoms


Not sharing syringes


Taking medicine to prevent or treat HIV



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 August 2019.