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?

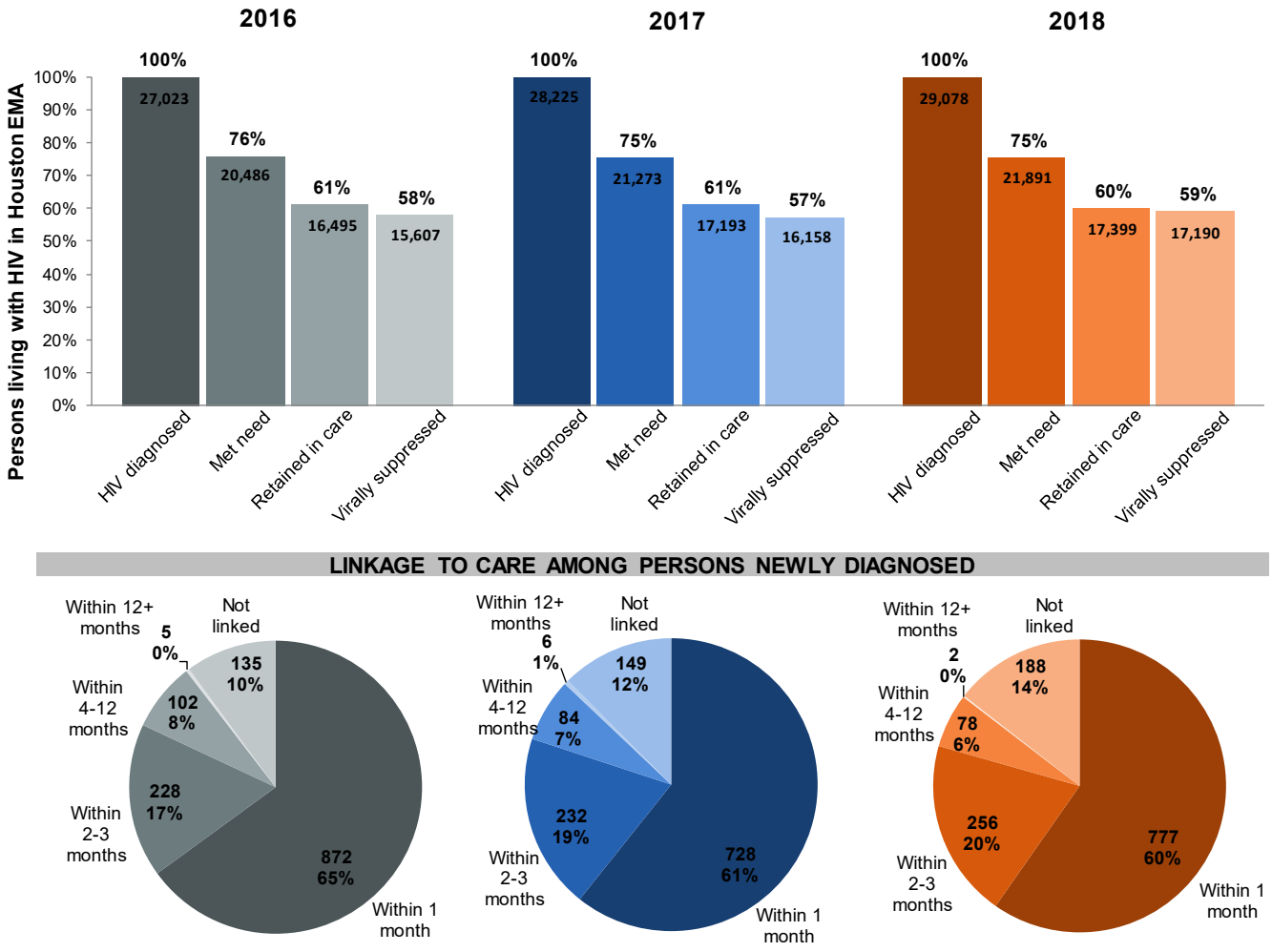
The HIV Care Continuum, previously known as a Treatment Cascade, was first released in 2012 by the Centers for Disease Control and Prevention (CDC). It represents the sequential stages of HIV care, from being diagnosed with HIV to suppressing the HIV virus through treatment. Ideally, the Care Continuum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

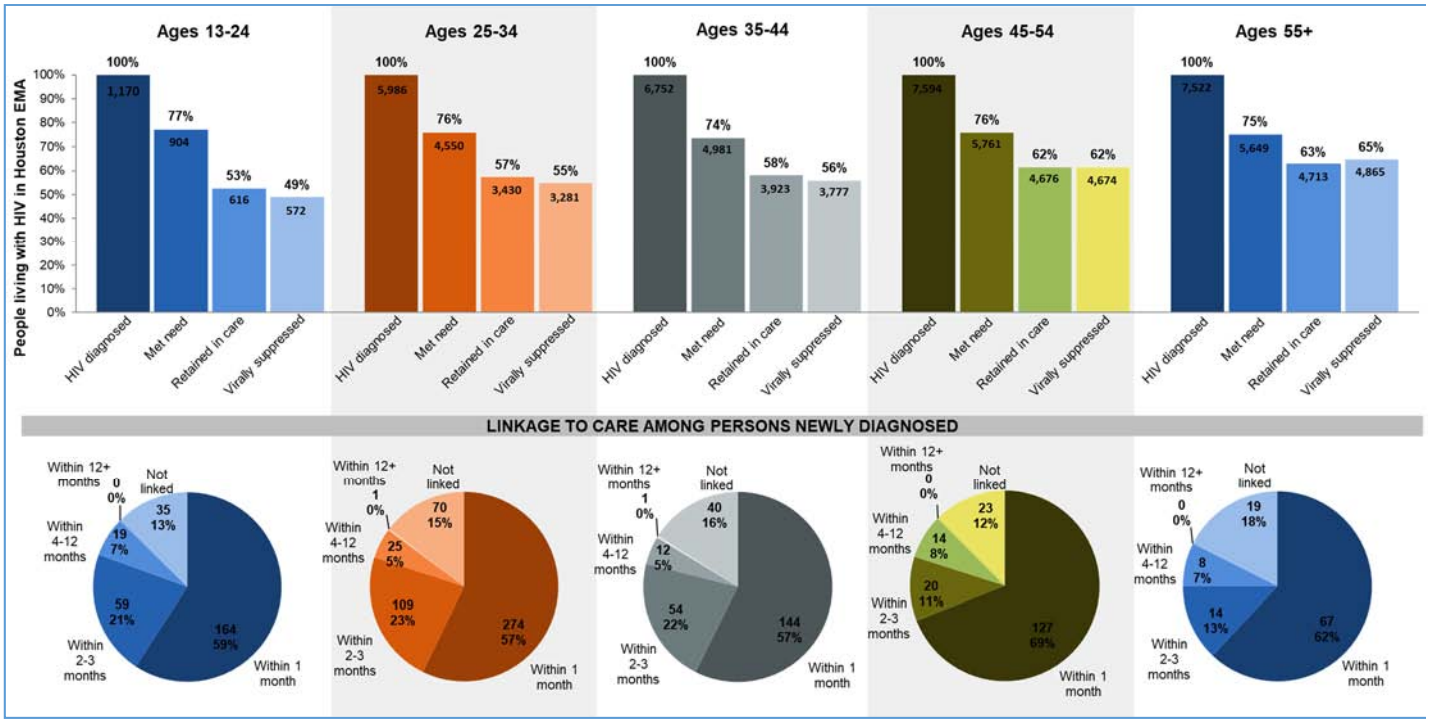
Disparities in Engagement among Key Populations

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.

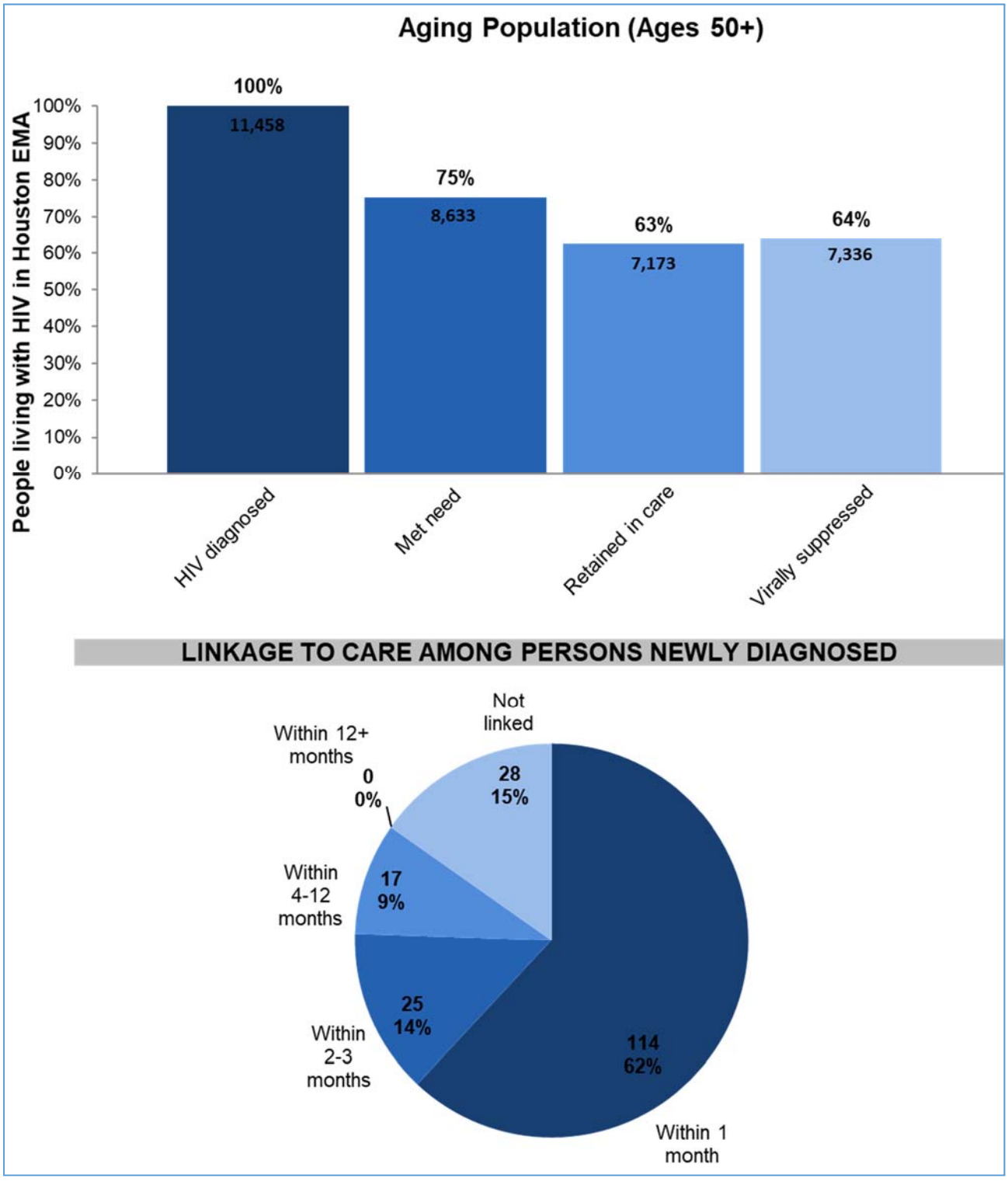
The Houston EMA Care Continuum, by Age

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**

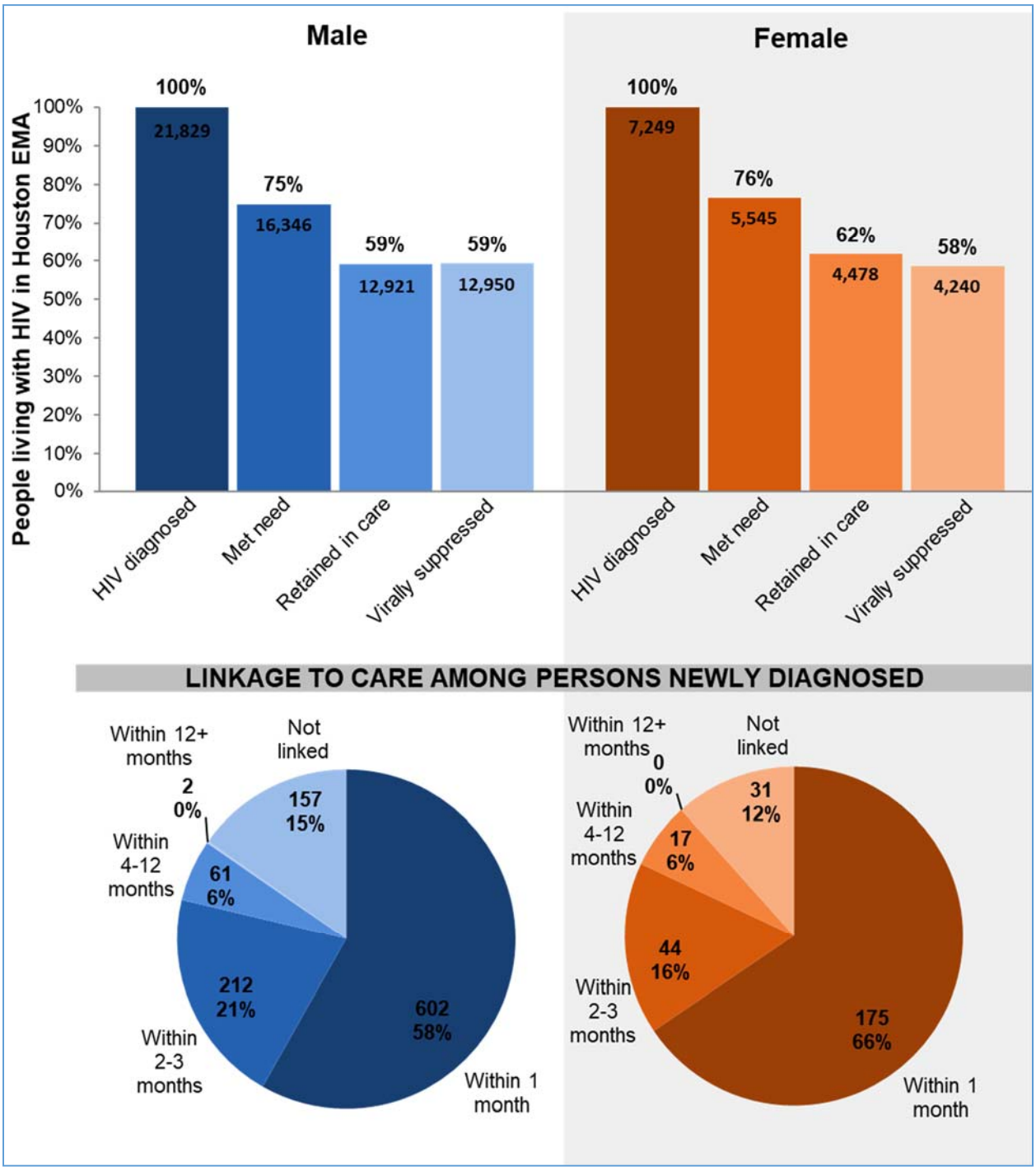


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- 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

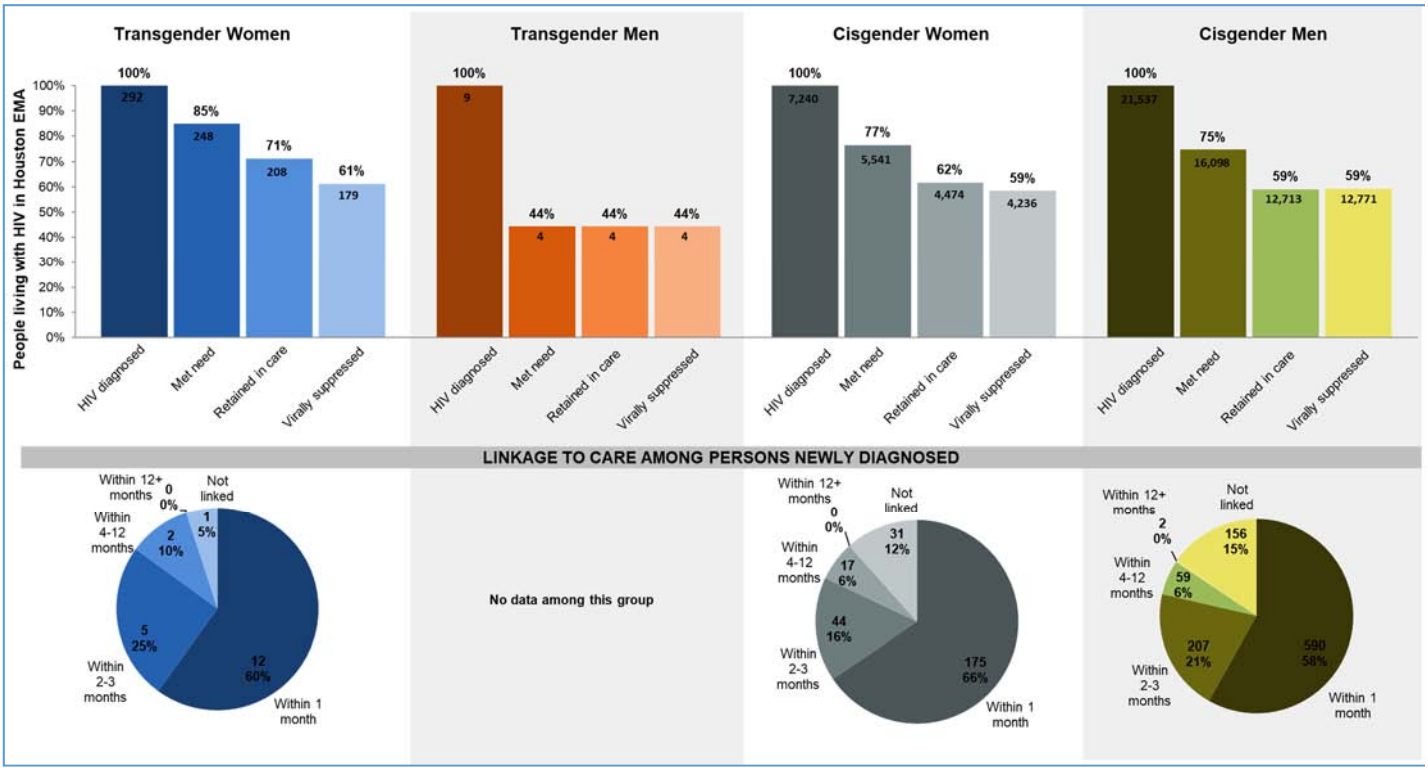
Figure 4: Houston EMA HIV Care Continuum by Sex Assigned at Birth, 2018**



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**

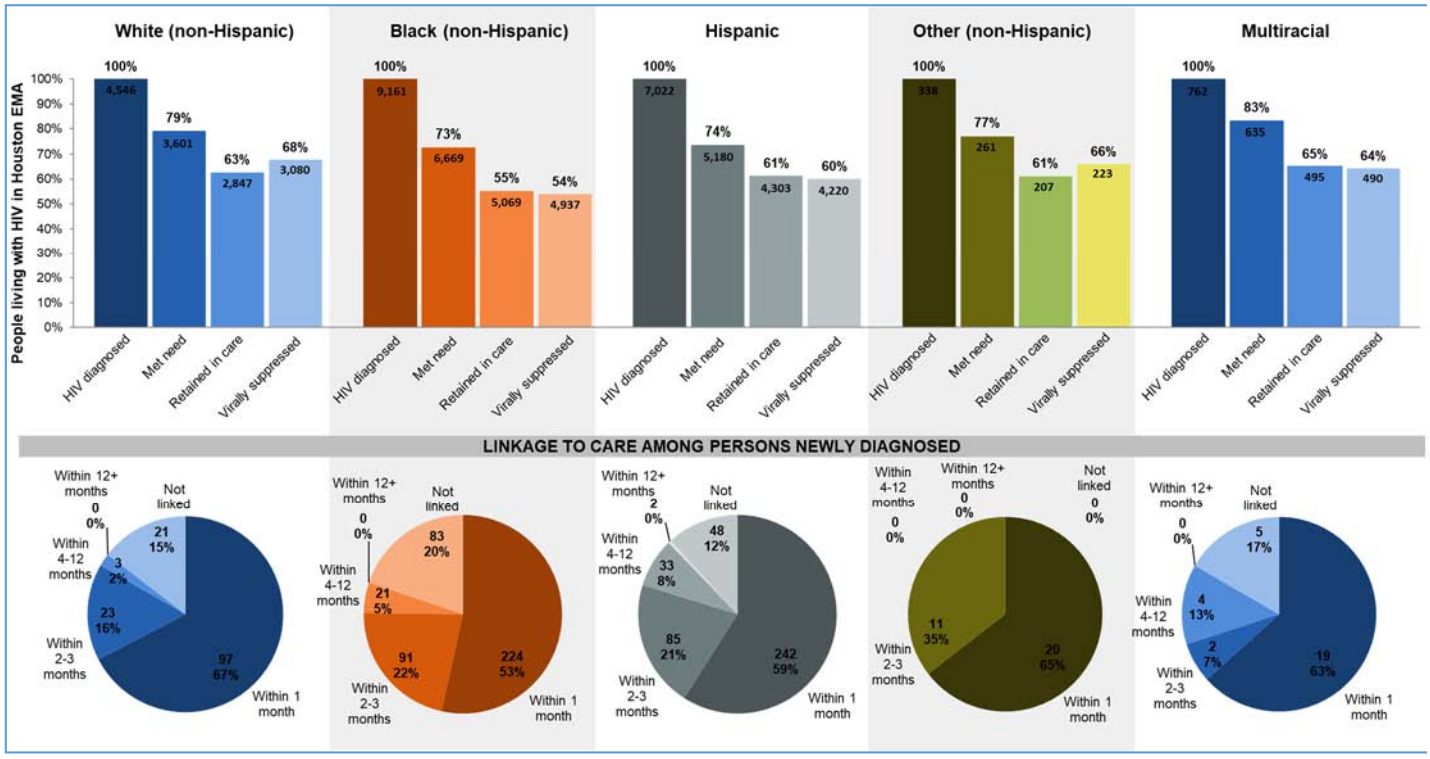


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- 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.

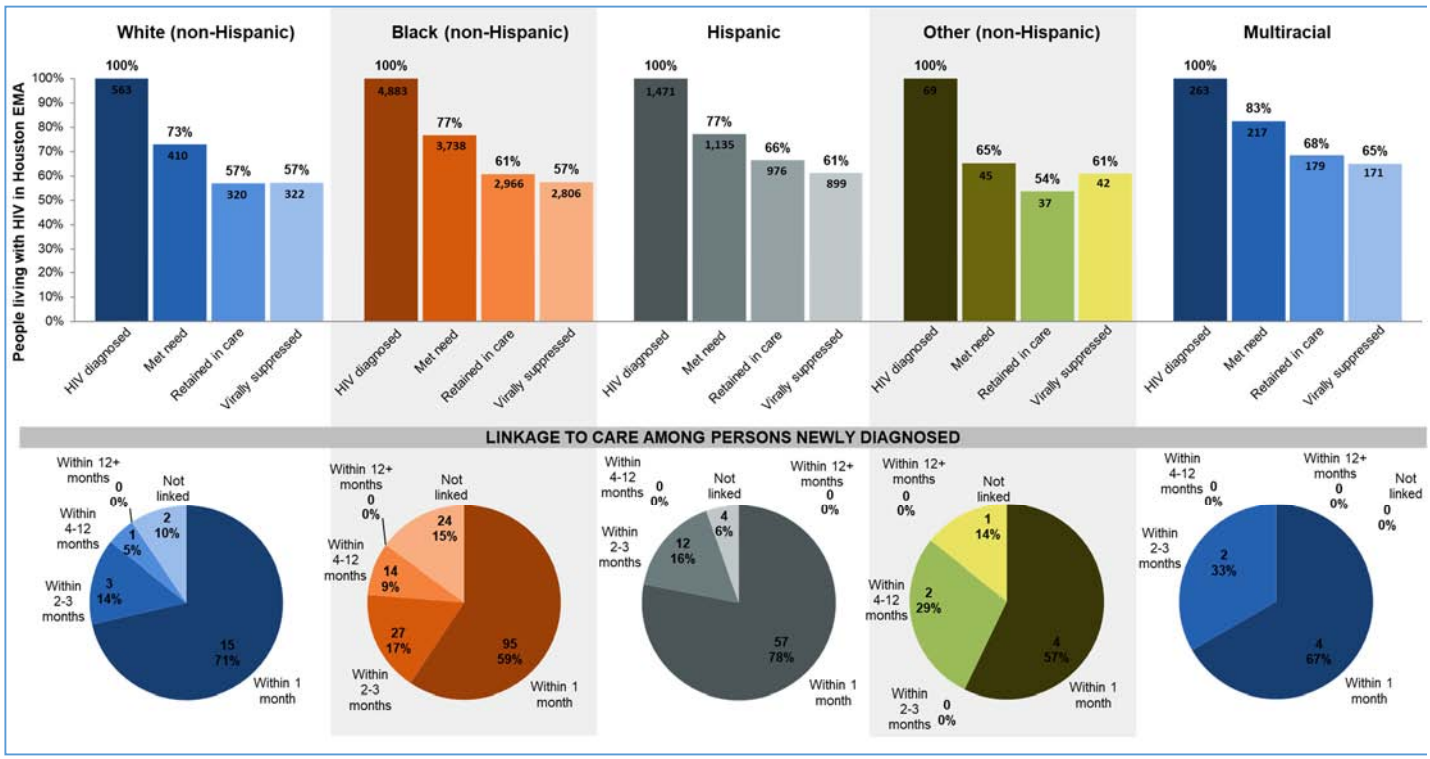
The Houston EMA Care Continuum, by Sex Assigned at Birth and Race/Ethnicity

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**



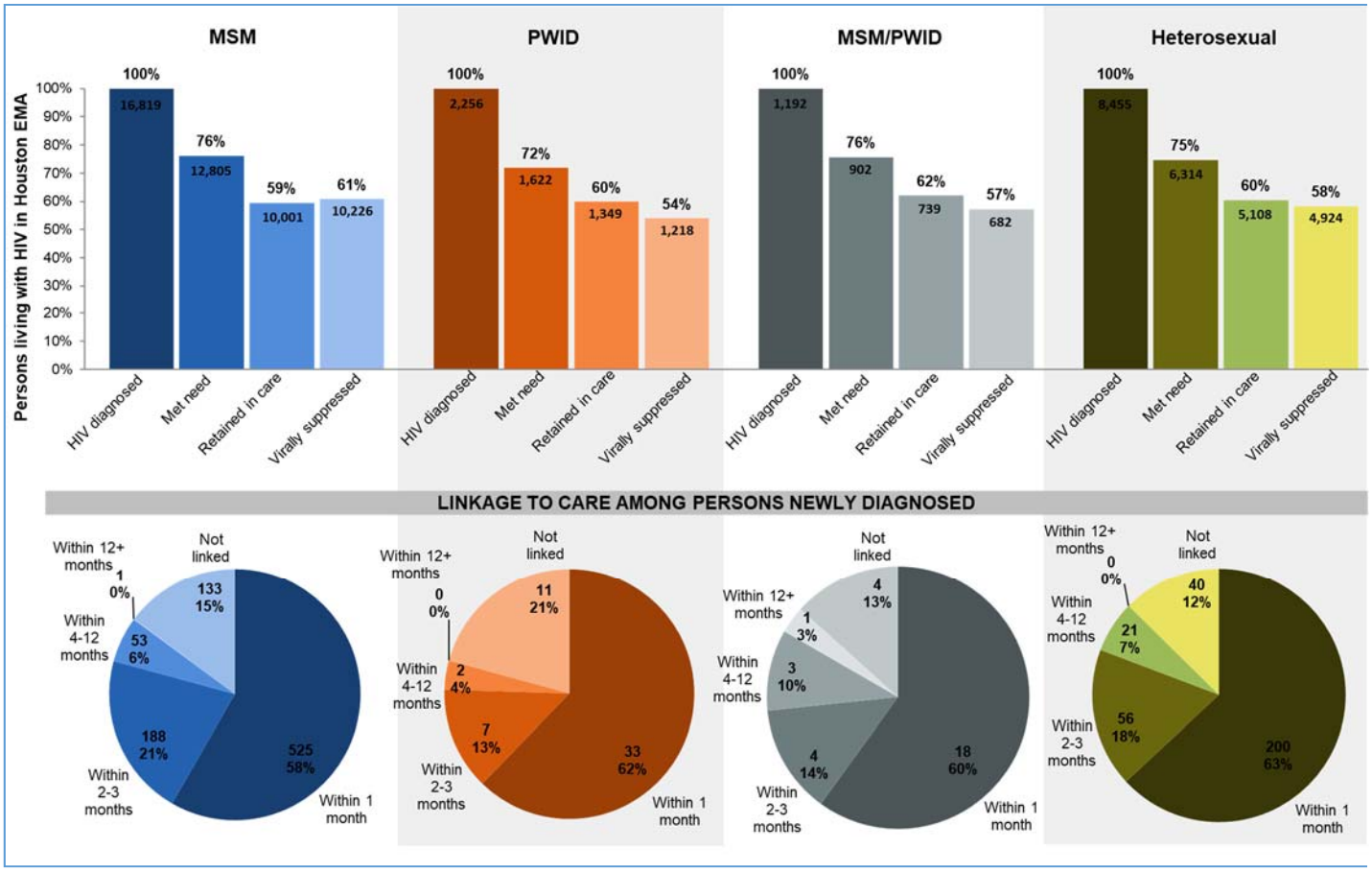
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- 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

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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

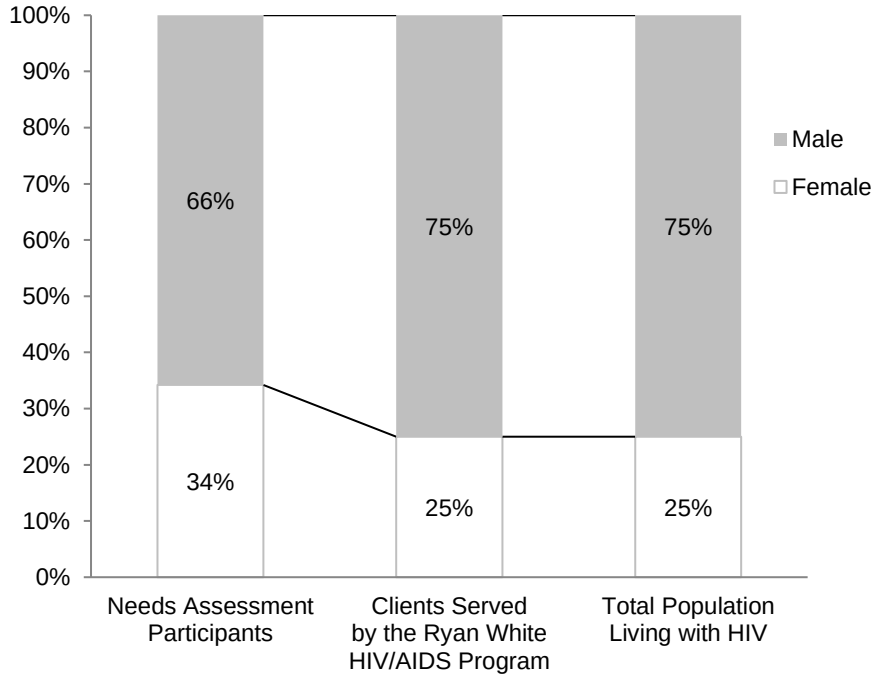
	No.	%
Young adult (18-24 years)	17	2.9%
Adult age 50+ years	353	59.9%
Homeless	65	11.1%
Unstably Housed	159	29.0%
People who inject drugs (PWID)*	47	8.2%
Male-male sexual contact (MSM)	238	40.5%
Out of care (last 12 months)	24	4.3%
Recently released from incarceration	65	11.6%
Rural (non-Harris County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



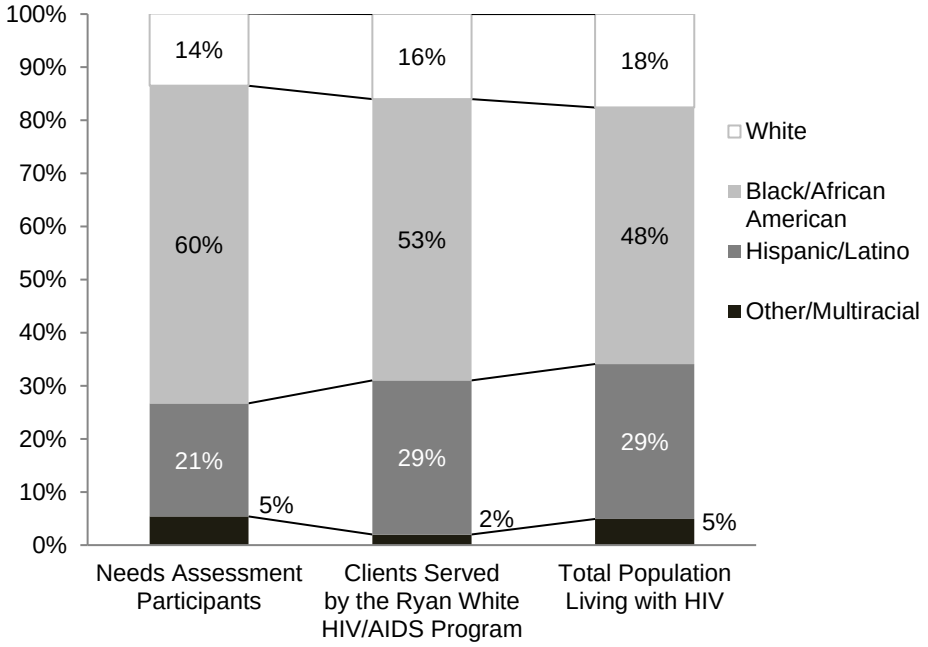
[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18.

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.

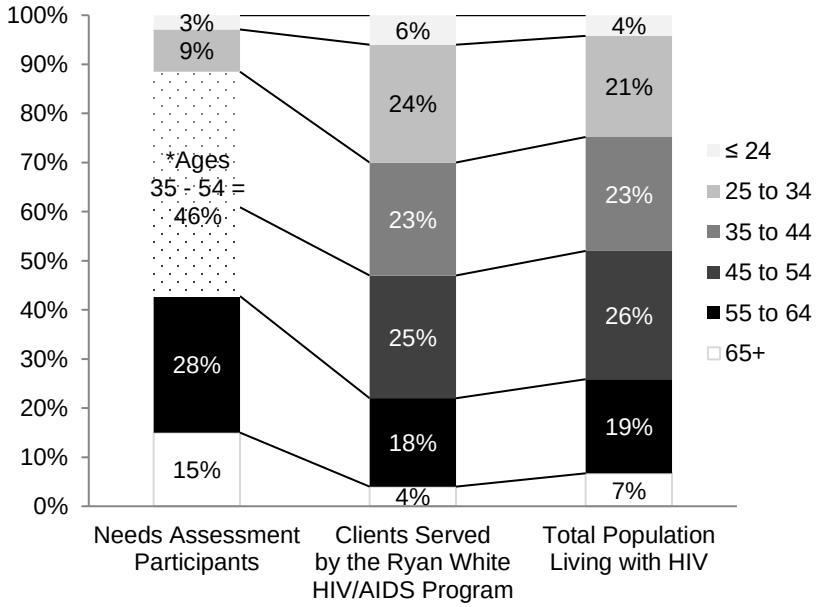
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Race/Ethnicity, 2018



[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.

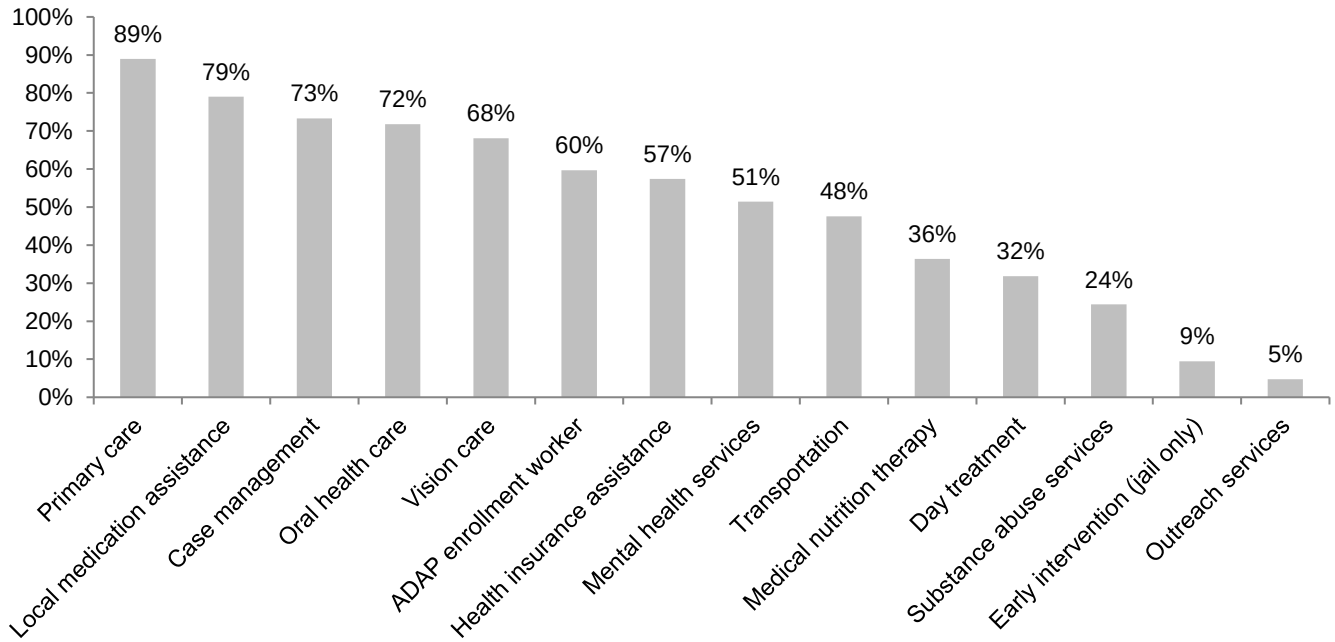
Overall Ranking of Funded Services, by Need

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

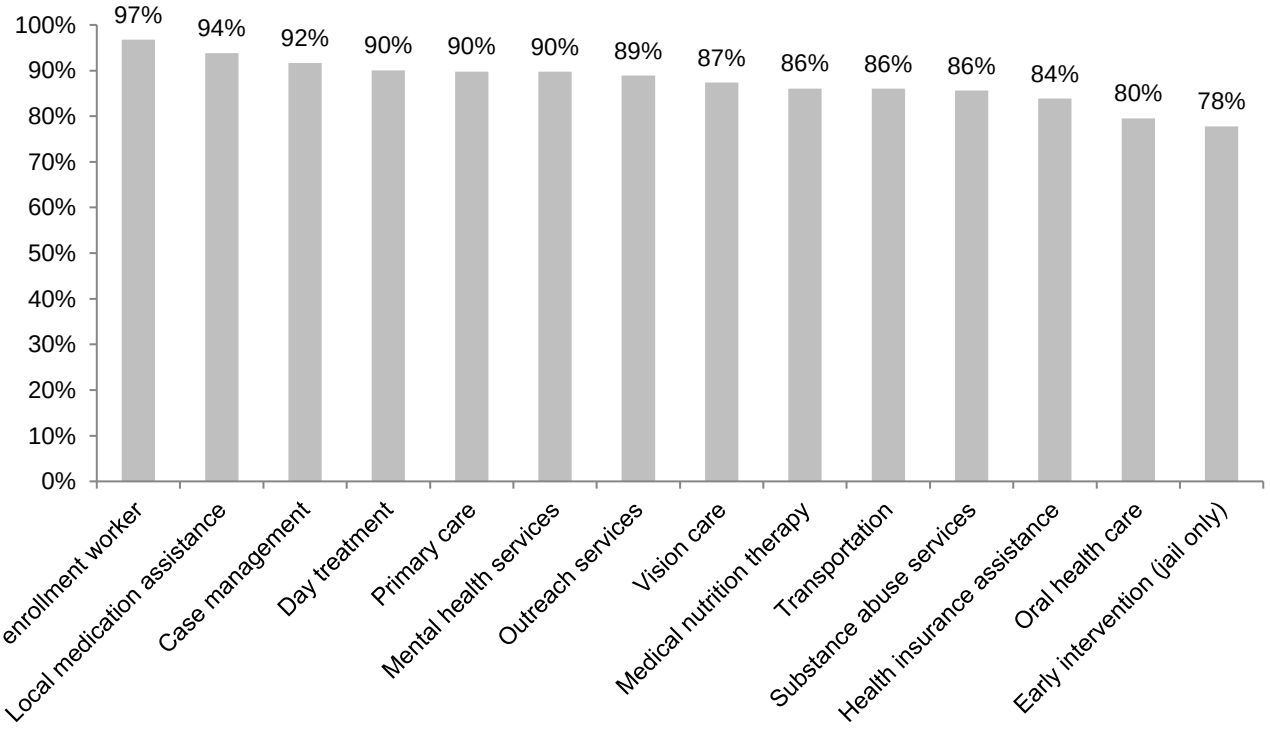
Participants were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both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

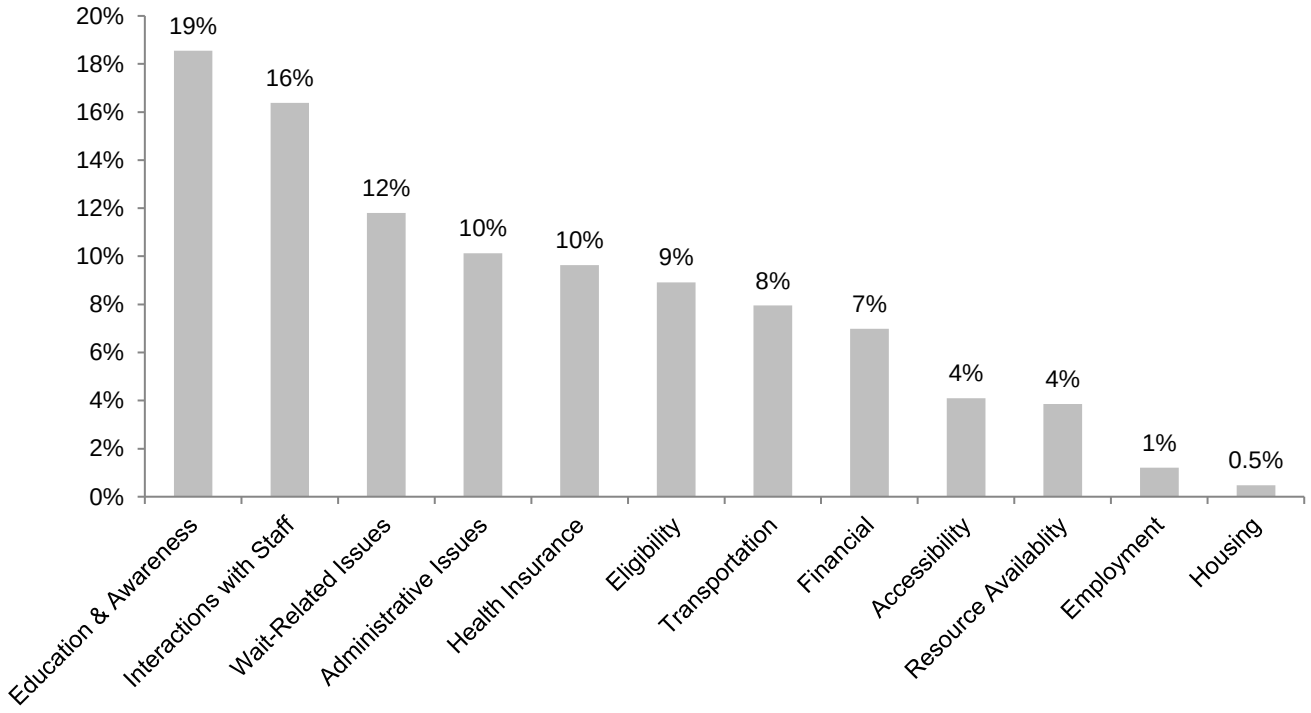
Since the 2016 Houston Area HIV Needs Assessment, participants who reported *difficulty* accessing needed services have been asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. In 2016, staff used recursive abstraction 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.

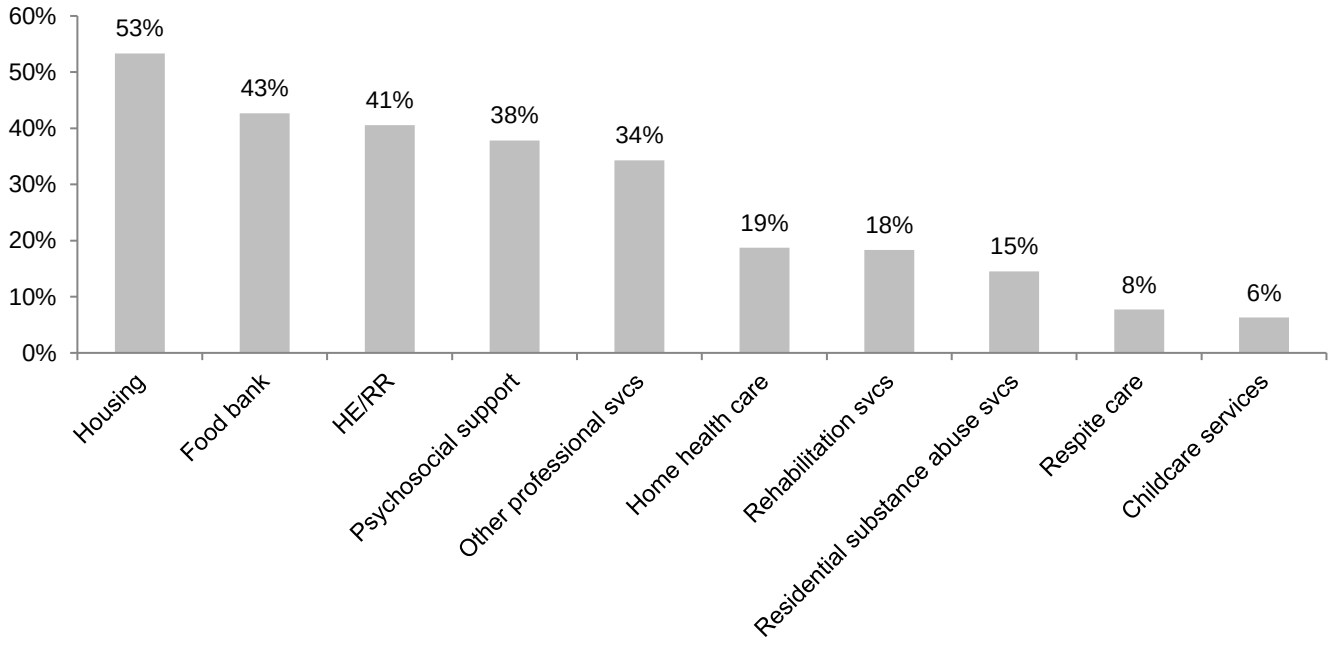
(**Graph 4**) At 53%, housing was the most needed unfunded service in the Houston Area, followed by food bank at 43%, health education/risk reduction at 41%, psychosocial support services at 38%, and other professional services at 34%. Of participants indicating a need for food bank, 69% reported needing 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

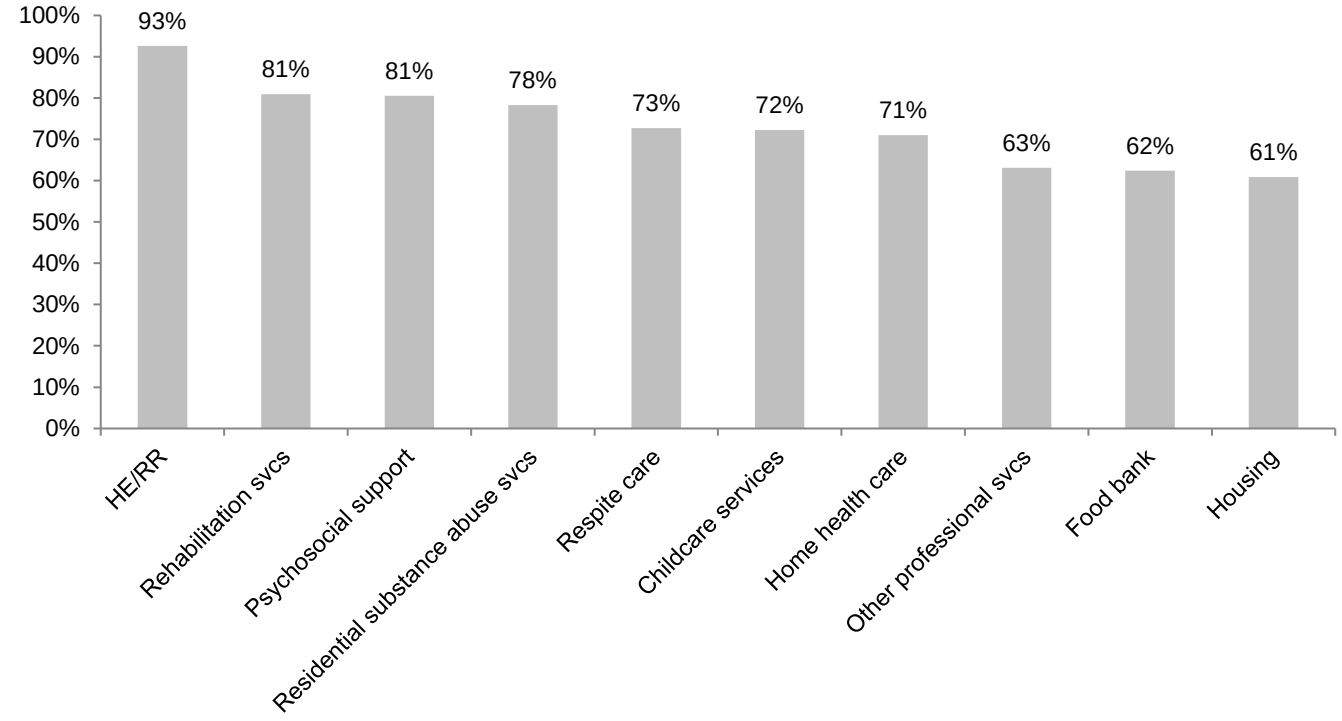
Participants were asked to indicate if each of the unfunded HIV services they needed in the past 12 months was easy or difficult for them to access.

(**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

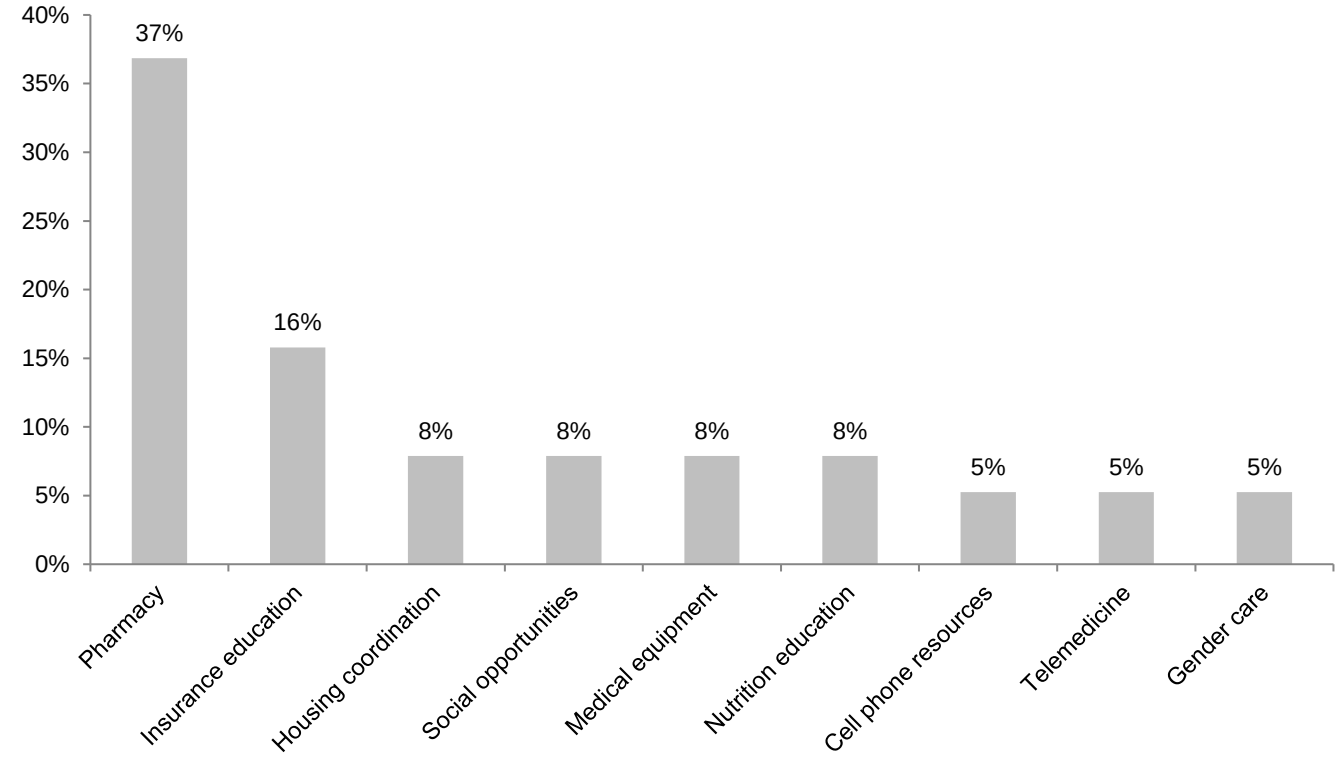
In addition to the allowable HIV services listed above, participants were also encouraged to write-in other types of needed services to gauge any new or emerging service needs in the community.

(**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



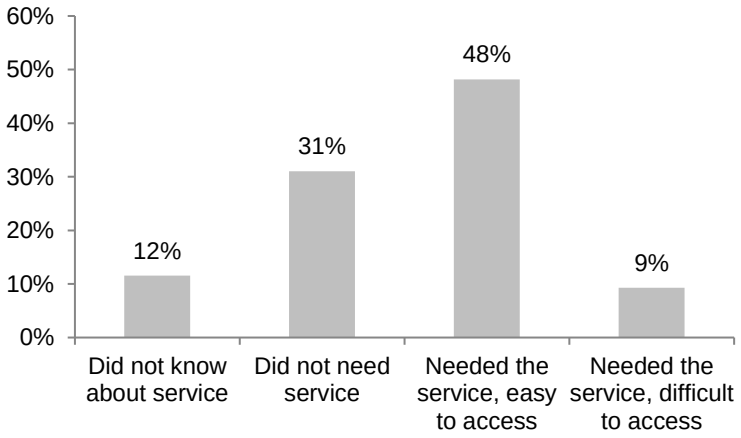
Service-Specific Fact Sheets

HEALTH INSURANCE ASSISTANCE

Health insurance assistance, also referred to as *health insurance premium and cost-sharing assistance*, provides financial assistance to persons living with HIV (PLWH) with third-party health insurance coverage (such as private insurance, ACA Qualified Health Plans, COBRA, or Medicare) so they can obtain or maintain health care benefits. This includes funding for premiums, deductibles, Advanced Premium Tax Credit liability, and co-pays for both medical visits and medication.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 57% of participants indicated a need for *health insurance assistance* in the past 12 months. 48% reported the service was easy to access, and 9% reported difficulty. 12% stated that they did not know the service was available.

GRAPH 1-Health Insurance Assistance, 2020



(**Table 1**) When barriers to *health insurance assistance* were reported, the most common barrier types were eligibility and financial (each 23%). Eligibility barriers reported include not meeting eligibility requirements, and redundant or complex processes for meeting/renewing eligibility, while financial barriers reported include inability to afford the service.

TABLE 1-Top 5 Reported Barrier Types for Health Insurance Assistance, 2020

		No.	%
1.	Eligibility (EL)	9	23%
2.	Financial (F)	9	23%
3.	Health Insurance Coverage (I)	7	18%
4.	Administrative (AD)	5	13%
5.	Education and Awareness (EA)	4	10%

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

- No difference in service accessibility by sex at birth.
- More white 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 transgender, homeless, MSM, and rural PLWH found the service difficult to access when compared to all participants.

TABLE 2-Health Insurance 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	12%	9%	15%	13%	8%	12%	0%	12%	11%
Did not need service	30%	34%	43%	29%	32%	12%	14%	30%	34%
Needed, easy to access	48%	48%	40%	48%	50%	58%	81%	47%	49%
Needed, difficult to access	9%	9%	3%	9%	10%	15%	5%	12%	6%

TABLE 3-Health Insurance Assistance, by Selected Special Populations, 2020

Experience with the Service	Homeles[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	21%	11%	16%	25%	17%	13%
Did not need service	32%	30%	42%	25%	23%	25%
Needed, easy to access	34%	47%	42%	43%	49%	33%
Needed, difficult to access	13%	12%	0%	8%	11%	29%

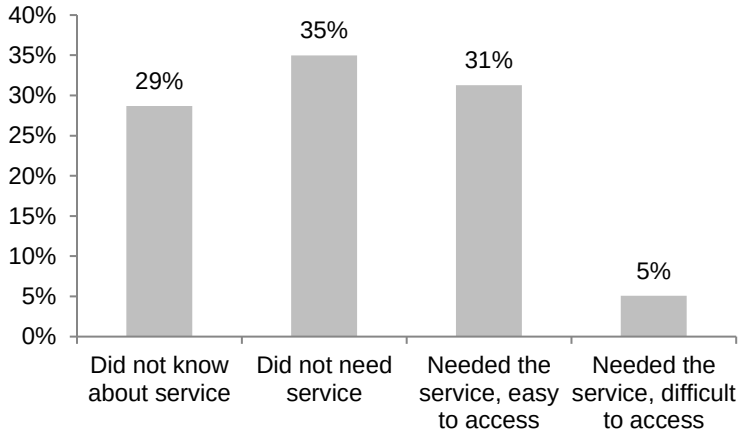
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

MEDICAL NUTRITION THERAPY

Medical nutrition therapy provides nutrition supplements and nutritional counseling to persons living with HIV (PLWH) outside of a primary care visit by a licensed registered dietician based on physician recommendation and a nutrition plan. The purpose of such services can be to address HIV-associated nutritional deficiencies or dietary needs as well as to mitigate medication side effects.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 36% of participants indicated a need for *medical nutrition therapy* in the past 12 months. 31% reported the service was easy to access, and 5% reported difficulty. 29% stated that they did not know the service was available.

GRAPH 1-Medical Nutrition Therapy, 2020



(**Table 1**) When barriers to *medical nutrition therapy* were reported, the most common barrier type was education and awareness (35%) Education and awareness barriers reported include lack of knowledge about service availability, what the service entails, and who to contact to access the service.

TABLE 1-Top 3 Reported Barrier Types for Medical Nutrition Therapy, 2020

	No.	%
1. Education and Awareness (EA)	8	35%
2. Eligibility (EL)	6	26%
3. Interactions with Staff (S)	4	17%

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

- More female than males found the service accessible.
- More Hispanic/Latino PLWH than other race/ethnicities found the service accessible.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Medical Nutrition Therapy, 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	29%	28%	24%	28%	31%	27%	19%	35%	20%
Did not need service	35%	33%	36%	35%	36%	27%	71%	30%	39%
Needed, easy to access	31%	33%	36%	31%	31%	38%	10%	29%	37%
Needed, difficult to access	5%	6%	4%	6%	2%	12%	0%	6%	4%

TABLE 3-Medical Nutrition Therapy, 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	29%	31%	35%	41%	43%	17%
Did not need service	37%	36%	45%	28%	40%	54%
Needed, easy to access	24%	29%	16%	30%	17%	29%
Needed, difficult to access	10%	4%	3%	2%	0%	0%

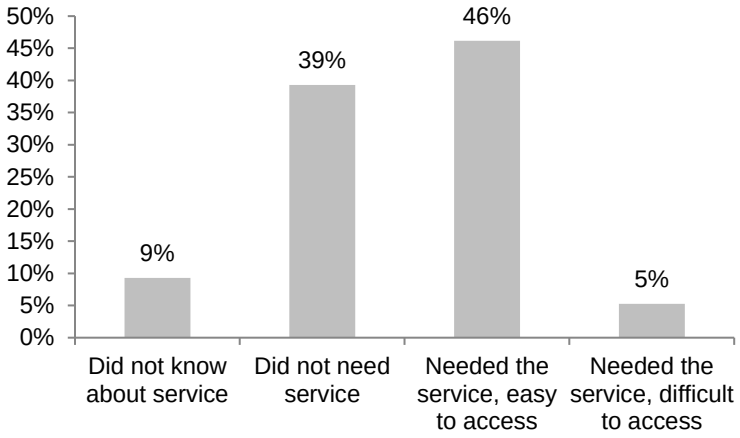
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

MENTAL HEALTH SERVICES

Mental health services, also referred to as *professional mental health counseling*, provides psychological counseling services for persons living with HIV (PLWH) who have a diagnosed mental illness. This includes group or individual counseling by a licensed mental health professional in accordance with state licensing guidelines.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 51% of participants indicated a need for *mental health services* in the past 12 months. 46% reported the service was easy to access, and 5% reported difficulty. 9% stated that they did not know the service was available.

GRAPH 1-Mental Health Services, 2020



(**Table 1**) When barriers to *mental health services* were reported, the most common barrier types were administrative, and education and awareness (each 22%). Administrative barriers reported include staff changes, hours of operation, client dismissal from the agency, and understaffing. Education and awareness barriers reported include lack of knowledge about service availability, where to go to access the service, and who to contact to access the service.

TABLE 1-Top 5 Reported Barrier Types for Mental Health Services, 2020

		No.	%
1.	Administrative (AD)	7	22%
2.	Education and Awareness (EA)	7	22%
3.	Health Insurance Coverage (I)	4	13%
4.	Interactions with Staff (S)	3	9%
5.	Transportation (T)	3	9%

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

- More males than females found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to24 found the service accessible than other age groups.
- In addition, more recently released, rural, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Mental Health 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	11%	5%	6%	10%	11%	12%	5%	12%	6%
Did not need service	39%	39%	35%	40%	42%	19%	43%	36%	44%
Needed, easy to access	46%	47%	47%	45%	45%	54%	52%	46%	45%
Needed, difficult to access	4%	8%	12%	5%	2%	12%	0%	5%	5%

TABLE 3-Mental Health 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	16%	9%	7%	11%	11%	8%
Did not need service	38%	38%	63%	25%	57%	54%
Needed, easy to access	39%	48%	30%	49%	17%	33%
Needed, difficult to access	7%	5%	0%	14%	11%	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

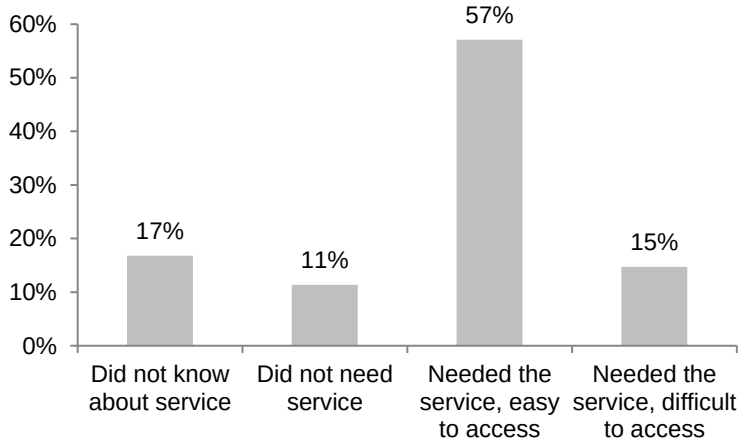
ORAL HEALTH CARE

Oral health care, or *dental services*, refers to the diagnostic, preventative, and therapeutic services provided to persons living with HIV (PLWH) by a dental health care professional (such as a dentist or hygienist). This includes examinations, periodontal services (such as cleanings and fillings), extractions and other oral surgeries, restorative dental procedures, and prosthodontics (or dentures).

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 72% of participants indicated a need for *oral health care* in the past 12 months. 57% reported the service was easy to access, and 15% reported difficulty. 17% stated that they did not know the service was available.

(**Table 1**) When barriers to *oral health care* were reported, the most common barrier type was wait-related issues (35%). Wait-related barriers reported include placement on a waitlist, long waits at appointments, and being told to call back as a wait list was full/unavailable. Of note, at least seven participants reported unprompted that their provider stated Ryan White does not cover prosthodontics, and that the participants would need to pay several hundred dollars out of pocket for treatment. Administrative agent and agency staff were notified immediately to resolve this issue.

GRAPH 1-Oral Health Care, 2020



(**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 *oral health care*, this analysis shows the following:

- More males than females found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 18 to 24 found the service accessible than other age groups.
- In addition, more out of care, recently released, and MSM found the service difficult to access when compared to all participants.

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

	No.	%
1. Wait (W)	20	22%
2. Interactions with Staff (S)	16	18%
3. Health Insurance Coverage (I)	12	13%
4. Education and Awareness (EA)	11	12%
5. Administrative (AD)	9	10%

TABLE 2-Oral Health 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	18%	12%	6%	19%	19%	15%	24%	22%	8%
Did not need service	11%	12%	22%	12%	8%	4%	14%	9%	14%
Needed, easy to access	57%	59%	49%	55%	63%	54%	52%	52%	65%
Needed, difficult to access	14%	17%	22%	14%	10%	27%	10%	17%	12%

TABLE 3-Oral Health 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	34%	15%	34%	20%	9%	8%
Did not need service	6%	10%	9%	11%	20%	13%
Needed, easy to access	45%	59%	34%	50%	69%	67%
Needed, difficult to access	15%	16%	22%	19%	3%	13%

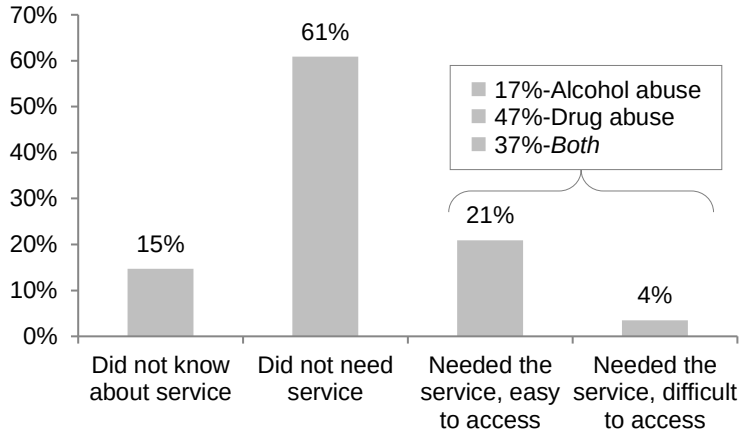
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

SUBSTANCE ABUSE SERVICES

Substance abuse services, also referred to as *outpatient alcohol or drug abuse treatment*, provides counseling and/or other treatment modalities to persons living with HIV (PLWH) who have a substance use disorder concern in an outpatient setting and in accordance with state licensing guidelines. This includes services for alcohol use and/or use of legal or illegal drugs.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 24% of participants indicated a need for *substance abuse services* in the past 12 months. 21% reported the service was easy to access, and 4% reported difficulty. 15% stated they did not know the service was available. When analyzed by type of substance concern, 17% of participants cited alcohol, 47% cited drugs, and 37% cited both.

GRAPH 1-Substance Abuse Services, 2020



(**Table 1**) When barriers to *substance use services* were reported, the most common barrier type was education and awareness (46%). Education and awareness barriers reported include lack of knowledge about service availability

TABLE 1-Top 2 Reported Barrier Types for Substance Abuse Services, 2020

	No.	%
1. Education and Awareness (EA)	4	46%
2. Transportation (T)	2	18%

(**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 *substance abuse services,* this analysis shows the following:

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

TABLE 2-Substance Abuse 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	17%	7%	12%	12%	18%	19%	43%	15%	12%
Did not need service	59%	68%	69%	63%	58%	58%	43%	59%	65%
Needed, easy to access	20%	23%	16%	21%	21%	23%	10%	22%	21%
Needed, difficult to access	4%	3%	3%	5%	2%	0%	5%	4%	2%

TABLE 3-Substance Abuse 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	13%	18%	16%	15%	23%	8%
Did not need service	55%	60%	61%	44%	71%	71%
Needed, easy to access	20%	18%	23%	24%	6%	17%
Needed, difficult to access	12%	3%	0%	18%	0%	4%

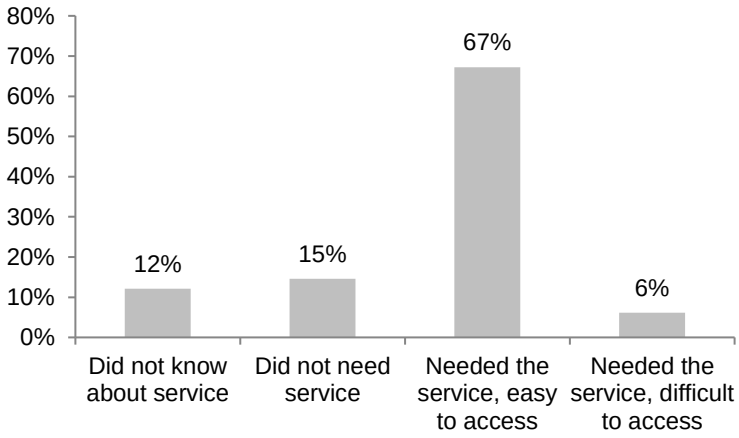
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

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

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.

TRG Consumer Engagement Feedback Results 2019

Feedback Period January 2019-December 2019

OVERVIEW

The Consumer Engagement Feedback Process is used by The Resource Group (TRG) to determine consumer experience and satisfaction accessing funded services. The process formally known as the consumer interview process has grown each year based on the lessons learned from implementation. The process and report system began in 2014 as a method of reporting feedback from consumers who received services within the reporting year. Consumer engagement is required as part of the TRG grant monitoring process at each Subrecipient in Houston and the fifty-one county areas of East Texas. The feedback was gathered through a variety of methods including but not limited to;

- Consumer Interviews
- Calls
- Meetings
- Survey
- Evaluations from Consumer Meetings/Events
- Advisory Board Feedback
- Client Concerns
- Follow up calls to consumers who had a client concern within the feedback period.

The barriers and challenges to obtaining feedback can range from consumer concerns including if the information will be utilized, who will have access to the statements, if the consumer is identified, and does their feedback matter. TRG has designed the process and reports to encourage feedback and recommendations. All experiences with TRG funded services are considered for the inclusion in this report. TRG provides this report at consumer meetings and other consumer engagement opportunities to show consumers their feedback is important. As a result of the efforts to address the challenges consumers have continued to more freely discuss their concerns and report dissatisfaction.

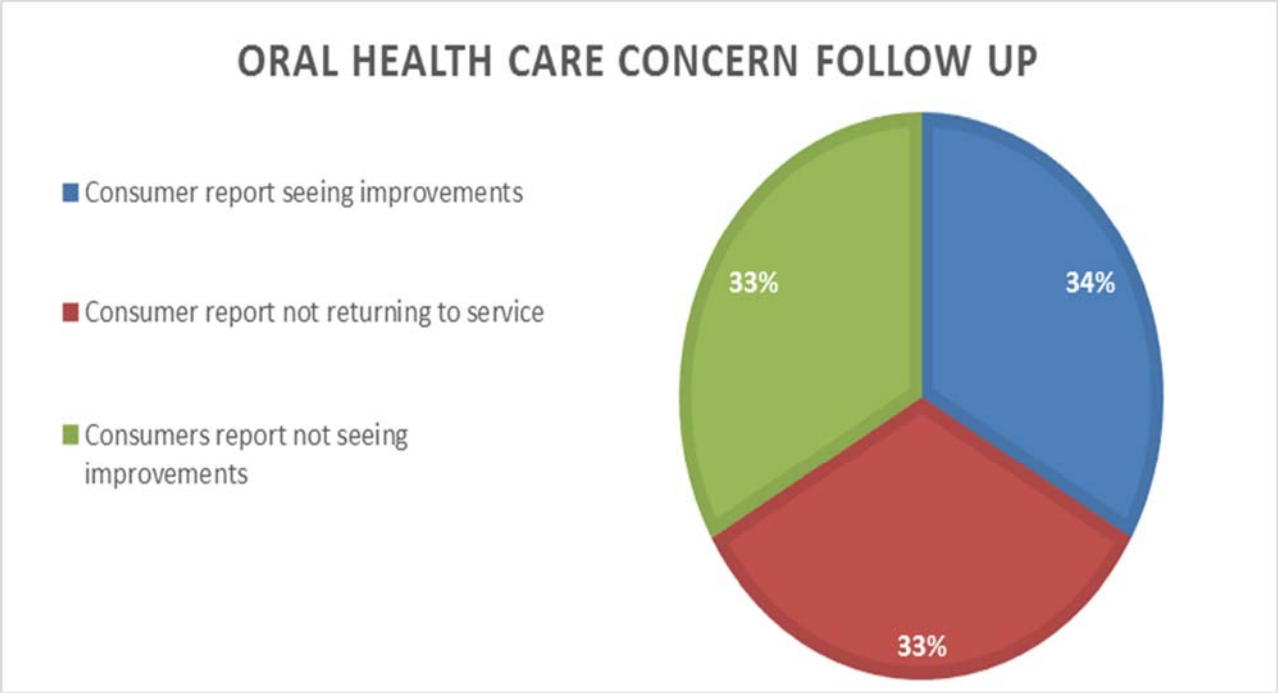
The purpose of the consumer engagement feedback process is to check the flow of information, gather feedback, identify trends and training needs of consumers related to services, programs, and funding updates. Each year TRG uses this report to assist with improvement planning. TRG identifies lessons learned and uses them to update the process and the questions asked during the next feedback period.

CROSS-SERVICE TRENDS

Overall, consumers reported satisfaction with the services they are receiving. Consumers, who are in care, feel comfortable and satisfied with their medical team and care process. The services which received the most feedback in 2019 were Oral Health Care (dental services) and Health Insurance Assistance (HIA). Oral Health Care received a low number of client concerns where consumers

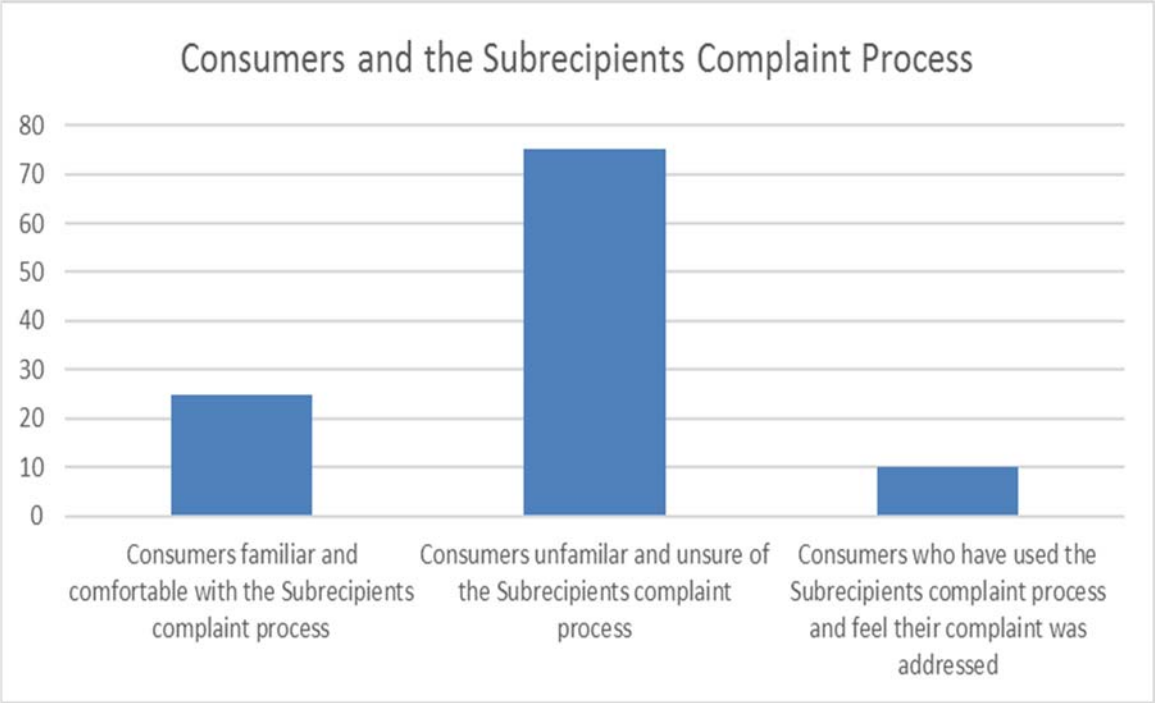
were willing to their give contact information for TRG to follow up. 75% of the consumers had concerns but did not wish to give their contact information for follow up purposes. All consumer concerns were addressed by TRG as part of the problem resolution process. Of the consumers who gave their consent to be contacted for follow up. 50% were unreachable through the contact information given to TRG. The chart and numbers below reflect the consumers who could be reached, TRG staff either spoke to the client or just left a message.

Comments from consumers who were reached as a follow up to concerns with dental service gave mixed reviews. Of those who contacted, 1/3 of the consumers who had a concern accessing service stated that they felt the Subrecipient made efforts to address their concern. 1/3 of the follow-up group of consumers stated they had not returned to the Subrecipient to seek services and were unsure if improvements had been made. 1/3 did not feel like enough improvements were in place and stated they still faced challenges. TRG staff informed consumers that the efforts to address their concerns would continue.



Consumers in Houston mentioned communication between staff and consumers at most Subrecipients needs improvement (i.e. calls not returned, difficulty reaching staff and difficulties navigating phone systems to reach a live person). Problems such as getting medication refills were discussed as problems and results of difficulties in communication with Subrecipients.

There is an ongoing disconnection between consumers and the Subrecipent complaint process or how concerns are resolved with the Subrecipent. Only 25% of consumers were familiar with the Subrecipient process and complaint forms. This discussion has continued for multiple years. Consumers who had complaints expressed their complaints have been addressed and resolved.



TRG continues to address concerns and bring reasonable solution between consumer and Subrecipient within the Ryan White Standards of Care. There are rare occasions where satisfaction cannot be achieved. This does not mean the concern is not documented. Each concern is documented and used to identify trends and best practices of resolution.

The lessons learned and new questions to be added to the interviews and feedback processes for 2020 include:

- TRG has begun to develop multiple Advisory Boards base on target populations and service-specific focuses. In 2019, TRG started a Reentry Advisory Board and hosted an Advisory Board for Clinical Trials related to HIV. TRG staff is also creating an Advisory Board for its Problem Resolution process.
- Service-specific/specific population questions
    - Based on client questions, comments and concerns related to Dental/Oral Health Services, TRG will focus on strategies to gather information, engage consumers and proactively address gaps in communication between the Oral Health Subrecipient consumers.
        a. To gather information; a dental survey has been developed and will be available in English and Spanish. The survey will available online and as a hard copy.
        b. To engage consumers; TRG will lead an Oral Health Advisory Board. A flyer has been created to recruit consumers to focus on reporting trends, progress, consumer feedback goals.
        c. To proactively assisting Oral Health Subrecipient in strengthening their communication efforts with consumers seeking and receiving Oral Health Services funded by TRG.

TRG efforts in obtaining consumer feedback identified the need for Subrecipients to create and facilitate Subrecipent specific/customized training for their consumers which may include but are not limited to:

- Consumers should review and provide feedback on Subrecipient policies and procedures which directly affect clients on an annual basis. TRG staff has provided onsite technical assistance (TA). This can be addressed on the Consumer Engagement Work Plan.
- Subrecipient should provide training on each service which are available to consumers and details to help consumers understand the length of processes for specific procedures or services. The Subrecipient Consumer Advisory Board quarterly meetings and host service-specific training or educational meetings for clients. This can be addressed on the Consumer Engagement Work Plan.

SERVICE-SPECIFIC TRENDS

Oral Health Care

Consumers in the local area have concerns about changes that affect access to this service. TRG has addressed concerns with the Subrecipients. TRG conducted follow-up efforts with consumers with concerns. This service has mixed reviews on the improvement efforts. TRG will continue to focus on addressing concerns with this service.

Mental Health Services

Consumers were satisfied with this service. There were no identified or reported issues related to this service.

Home and Community-Based Health Care Services

Consumers were satisfied with this service. Consumer's understanding of the service they are receiving has continued to improve over multiple years. There were no identified or reported issues related to this service.

Early Intervention Services – Incarcerated (EIS)

EIS consumers seem to be very knowledgeable and appreciative of access to service. The consumers were pleased to be referred to as experts and some inquired about learning more about the Ryan White system and how to participate upon release. There were no identified or reported issues related to this service.

Linguistic Services

There were no identified or reported issues related to this service.

Hospice Care Services

There were no identified or reported issues related to this service.

Health Insurance Assistance (HIA)

Consumers of this service are very knowledgeable about this service. HIA consumers were satisfied and appreciative of the availability of the service. Consumers stated that HIA was simple to get and easy to use. There were no identified or reported issues related to this service.

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	<u>Staff education on eligibility determination and fee schedule</u> 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	<u>Service Evaluation</u> 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	<u>Subcontractor Monitoring</u> 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	<u>Staff Guidelines</u> 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	<u>Intake</u> The agency conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions. In addition to office visits, client is provided alternatives such as conducting business by mail, online registration via the internet, or providing home visits, when necessary. Agency has established procedures for communicating with people with hearing impairments.	• Documentation in client record • Review of Agency's Policies and Procedures Manual indicates compliance
5.0	**Quality Management**	
5.1	<u>Continuous Quality Improvement (CQI)</u> Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum: • The Agency's QM Plan	• 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

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	Clients Referral and Tracking Agency receives referrals from a broad range of HIV service providers and makes appropriate referrals out when necessary.	• Documentation of referrals received • Documentation of referrals out • Staff reports indicate compliance
3.2	Prioritization of Service 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	Decreasing Barriers to Service 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

Medical Nutritional Therapy/Supplements

HRSA defines core Medical Nutrition Therapy as the provision of food, nutritional services and nutritional supplements provided outside of a primary care visit by a licensed registered dietician based on physician's recommendation and a nutritional plan developed by a licensed registered dietician. The Houston EMA Part A/B Medical Nutrition Therapy includes nutritional counseling, provision nutritional supplements (of up to 90 day supply) for eligible people living with HIV in the Houston EMA. Clients must have a written referral or prescription from a physician or physician extender and a written nutritional plan prepared by a licensed, registered dietician

1.0	**Services are individualized and tailored to client needs.**	
1.1	Education/Counseling – Clients Receiving New Supplements All clients receiving a supplement for the first time will receive appropriate education/counseling. This must include written information regarding supplement benefits, side effects and recommended dosage in client's primary language.	• Client record indicates compliance
1.2	Education/Counseling – Follow-Up Clients receive education/counseling regarding supplement(s) again at: • follow-up • when there is a change in supplements • at the discretion of the registered dietician if clinically indicated	• Client record indicates compliance
2.0	**Services adhere to professional standards and regulations.**	
2.1	Nutritional Supplement Formulary RW funded nutritional supplement disbursement for program eligible clients shall be based on the current RWGA nutritional supplement formulary. Ryan White funds may not be used for nutritional supplements not on the approved formulary. Providers wishing to prescribe/order other supplements 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/Department of Health and Human 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
2.2	Inventory Supplement inventory is updated and rotated as appropriate on a first-in, first-out basis, and shelf-life standards and applicable laws are observed.	• Review of agency's Policies & Procedures Manual indicates compliance • Staff interviews

2.3	Licensure Providers/vendors maintain proper licensure. A physician or physician extender (PE) with prescribing privileges at a Part A/B/C and/or MAI-funded agency or qualified primary care provider must write an order for Part A-funded nutritional supplements. A licensed registered dietician must provide an individualized nutritional plan including education/counseling based on a nutritional assessment	• Documentation of current licensure • Nutritional plan in client's record
2.4	Protocols Nutrition therapy services will use evidence-based guides, protocols, best practices, and research in the field of HIV including the *American Dietetic Association's HIV-related protocols in Medical Nutrition Therapy Across the Continuum of Care.*	• Chart Review shows compliance • Review of agency's Policies & Procedures Manual indicates compliance

Oral Health

Oral Health Care as "diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers". The Ryan White Part A/B oral health care services include standard preventive procedures, diagnosis and treatment of HIV-related oral pathology, restorative dental services, oral surgery, root canal therapy and oral medication (including pain control) for PLWH 15 years old or older based on a comprehensive individual treatment plan. Additionally, the category includes prosthodontics services (Part B) to people living with HIV including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.

1.0	**Staff HIV knowledge is based on documented training.**	
1.1	Continuing Education • Sixteen (16) hours of training in HIV and clinically-related issues is required every 2 years for licensed staff. (does not include any training requirements outlined in General Standards) • One (1) hour of training in HIV is required annually for all other staff. (does not include any training requirements outlined in General Standards)	• Materials for staff training and continuing education are on file • Documentation of continuing education in personnel file
1.2	Experience – HIV A minimum of one (1) year documented work experience with PLWH is preferred for licensed staff.	• Documentation of work experience in personnel file
1.3	Staff Supervision Supervision of clinical staff shall be provided by a practitioner with at least two years experience in dental health assessment and treatment of persons living 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 Policies & Procedures Manual indicates compliance
2.0	**Patient Care**	
2.1	HIV Primary Care Provider Contact Information Agency obtains and documents HIV primary care provider contact information for each client.	• Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number
2.2	Consultation for Treatment Agency consults with client's medical care providers when indicated.	• Documentation of communication in the client record
2.3	Health History Information	• Documentation of health history information in the client record. Reasons

	Agency collects and documents health history information for each client prior to providing care. This information should include, but not be limited to, the following: • A baseline (current within the last 12 months) CBC laboratory test results for all new clients, and an annual update thereafter, and when clinically indicated • Current (within the last 6 months) Viral Load and CD4 laboratory test results, when clinically indicated • Client's chief complaint, where applicable • Medication names • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis • Usual oral hygiene • Date of last dental examination • Involuntary weight loss or weight gain • Review of systems	for missing health history information are documented
2.4	<u>Client Health History Update</u> An update to the health history should be made, at minimum, every six (6) months or at client's next general dentistry visit whichever is greater.	• Documentation of health history update in the client record
2.5	<u>Comprehensive Periodontal Examination (Part B Only)</u> Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines	• Review of agency's Policies & Procedures Manual indicates compliance • Review of client records indicate compliance
2.6	<u>Treatment Plan</u> • A comprehensive, multidisciplinary Oral Health treatment plan will be developed in conjunction with the patient. • Patient's primary reason for dental visit should be addressed in treatment plan	• Treatment plan dated and signed by both the provider and patient in patient file • Updated treatment plan dated and signed by both the provider and patient in patient file

	• Patient strengths and limitations will be considered in development of treatment plan • Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions • Treatment plan will be updated as deemed necessary	
2.7	Annual Hard/Soft Tissue Examination The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan. Determination of clients needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all clients may not exceed two (2) years.	• Documentation in the client record • Review of agency's Policies & Procedures Manual indicates compliance
2.8	Oral Hygiene Instructions Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.	• Documentation in the client record

Substance Use Services

The Houston EMA Substance Abuse Treatment/Counseling service is an outpatient service providing treatment and/or counseling to people living with HIV who have substance use disorders. Services provided must be integrated with HIV-related issues that trigger relapse and must be coordinated with local TDSHS/SAS HIV Early Intervention funded programs. All services must be provided in accordance with the Texas Department of State Health Services/Substance Abuse services (TDSHS/SAS) Chemical Dependency Treatment Facility Standards as well as current treatment guidelines.

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	Comprehensive Assessment A comprehensive assessment including the following will be completed within ten (10 days) of intake or no later than and prior to the third therapy session. • Presenting Problem • Developmental/Social history • Social support and family relationships • Medical history • Substance use history • Psychiatric history • Complete mental status evaluation (including appearance and behavior, talk, mood, self attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory and language) Specific assessment tools such as the Addiction Severity Index(ASI) could be used for substance use and sexual history and the Mini Mental State Examination (MMSE) for cognitive assessment.	• Completed assessment in client's record
1.2	Psychosocial History A psychosocial history will be completed and must include: • Education and training • Employment • Military service • Legal history • Family history and constellation	• Completed assessment in client's record

	• Physical, emotional and/or sexual abuse history • Sexual and relationship history and status • Leisure and recreational activities • General psychological functioning	
1.3	Treatment Plan Treatment plans are developed jointly with the counselor and client and must contain all the elements set forth in the Texas Department of State Health Services Administrative code for substance abuse including: • Statement of the goal(s) of counseling • The plan of approach • Mechanism for review The plan must also address full range of substances the patient is abusing Treatment plans must be completed no later than five working days of admission. Individual or group therapy should be based on professional guidelines. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance use as clinically indicated.	• Completed treatment plan in client's record • Treatment Plan review documented in client's records
1.4	Treatment Plan Review In accordance with the Texas Department of State Health Services Administrative code on Substance Abuse, the treatment plan shall be reviewed at a minimum, midway through treatment and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures and must follow criteria outlined in the Administrative Code.	• Review of agency's Policy and Procedure Manual indicates compliance • Updated treatment plan in client's record
2.0	**Services are part of the coordinated continuum of HIV services.**	
2.1	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agency must have collaboration agreements with mental health and primary care providers or demonstrate that they offer these services on-site.	• Documentation of referrals received • Documentation of referrals out • Staff interviews indicate compliance • Collaborative agreements demonstrate that these services are offered on an off-site
2.2	Facility License	• Documentation of current agency licensure

	Agency is appropriately licensed by the Texas Department of State Health Services – Substance Abuse Services (TDSHS/SAS) with outpatient treatment designations.	
2.3	Minimum Qualifications All agency staff that provides direct client services must be properly licensed per current TDSHS/SAS requirements. Non-licensed staff must meet current TDSHS/SAS requirements.	• Documentation of current licensure in personnel files
3.0	**Staff HIV knowledge is based on documented training and experience.**	
3.1	Staff Training All agency staff, volunteers and students shall receive initial and subsequent trainings in accordance to the Texas Administrative Code, rule §448.603 (a), (c) & (d).	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines • Documentation of all trainings must be done in accordance with the Texas Administrative Code §448.603 (b)
3.2	Experience – HIV A minimum of one (1) year documented HIV work experience is required. Those who do not meet this requirement must be supervised by a staff member with at least 1 year of documented HIV work experience.	• Documentation of work experience in personnel file
4.0	**Service providers are knowledgeable, accepting, and respectful of the needs of individuals with HIV Staff efforts are compassionate and sensitive to client needs.**	
4.1	Staff Supervision The agency shall ensure that each substance abuse Supervisor shall, at a minimal, be a Masters level professional (e.g. LPC, LCSW, LMSW, LMFT, Licensed Clinical Psychologist, LCDC if applicable) and licensed by the State of Texas and qualified to provide supervision per applicable TDSHS/SAS licensure requirements. Professional staff must be knowledgeable of the interaction of drug/alcohol use and HIV transmission and the interaction of prescribed medication with other drug/alcohol use.	• Review of personnel files indicates compliance • Review of agency's Policy and Procedure Manual indicates compliance

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE

Definition:
Health Insurance Premium and Cost Sharing Assistance (Health Insurance Assistance or HIA) provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service **Health Insurance Assistance:** The Health Insurance Assistance (HIA) service category is intended to help individuals living with HIV maintain a continuity of medical benefits without gaps in health insurance coverage or discretion of treatment. This financial assistance program enables eligible individuals who are HIV positive to utilize their existing third party or public assistance (e.g. Medicare) medical insurance, not to exceed the cost of care delivery. Under this provision an agency can provide assistance with health insurance premiums, co-payments, co-insurance, deductibles, Medicare Part D premiums, and tax reconciliation. 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 is that 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. Tax Reconciliation: A refundable credit will be given on an individual's federal income tax return if the amount of advance-credit payments is *less* than the tax credit they should have received. Conversely, individuals will have to repay any excess advance payments with their tax returns if the advance payments for the year are *more* than the credit amount. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500. Income Guidelines: Marketplace (ACA) Plans: 100-400% of Federal Poverty Level All other plans: 0-400% of Federal Poverty Level Exception: Clients who were enrolled (and have maintained their plans without a break in coverage), prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Compliance with Regional Health Insurance Assistance Policy The Agency will establish and track all requirements outlined in the DSHS-approved Regional Health Insurance Assistance Policy (HIA-1701).	• Annual Review of agency shows compliance with established policy.
9.3	Clients Referral and Tracking Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary. Agencies must maintain referral relationships with organizations or individuals who can provide income tax preparation assistance.	• Documentation of referrals received • Documentation of referrals out • Staff reports indicate compliance
9.4	Ongoing Training Eight (8) hours annually of continuing education in HIV/AIDS related or other specific topics including a minimum of two (2) hours training in Medicare Part D is required. Minimum of two (2) hours training for all relevant staff on how to identify advance premium tax credits and liabilities.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
9.5	Staff Experience A minimum of (1) year documented HIV/AIDS work experience is preferred.	• Documentation of work experience in personnel file
9.6	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance
9.7	Program Policies Agency will develop policies and procedures regarding HIA assistance, cost-effectiveness and expenditure policy, and client contributions. Agencies must maintain policies on the assistance that can be offered for clients who are covered under a group policy. Agency must have P&P in place detailing the required process for reconciliation and documentation requirements. Agencies must maintain policies and procedures for the vigorous pursuit of excess premium tax credit from individual clients, to include measures to track vigorous pursuit performance; and vigorous pursuit of uninsured individuals to enroll in QHP via Marketplace.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of personnel files indicates training on the policies.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.8	Prioritization of Cost-Sharing Service Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agencies 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 3. Co-payments for provider visits (e.g. physician visit and/or lab copayments) 4. Medicare Part D (Rx) premiums 5. APTC Tax Liability 6. Out of Network out-of-pocket expenses	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.
9.9	Allowable Use of Funds 1. Health insurance premiums (COBRA, private policies, QHP, CHIP, Medicaid, Medicare, Medicare Supplemental) * 2. Deductibles 3. Medical/Pharmacy co-payments 4. Co-insurance, and 5. Tax reconciliation up to of 50% of the tax due up to a maximum of $500 6. Standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients (As of 4/1/2017)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.10	Restricted Use of Funds 1. Tax reconciliation due, if the client failed to submit the required documentation (life changes, i.e. marriage) during the enrollment period. 2. Funds may not be used to make Out of Packet payments for inpatient hospitalization, emergency department care or catastrophic coverage. 3. Funds may not be used for payment of services delivered by providers out of network. Exception: In-network provider is not available for HIV-related care only and/or appointment wait time for an in-network provider exceeds standards. Prior approval by AA (The Resource Group) is required for all out of network charges, including exceptions. 4. Payment can never be made directly to clients. 5. HIA funds may not be extended for health insurance plans with costs that exceed local benchmark costs unless special circumstances are present, but not without approval by AA. 6. Under no circumstances can funds be used to pay the fee for a client's failure to enroll in minimum essential coverage or any other tax liability owed by the client that is not directly attributed to the reconciliation of the premium tax credits. 7. HIA funds may not be used for COBRA coverage if a client is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price. 8. Life insurance and other elective policies are not covered.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.11	Health Insurance Premium Assistance The following criteria must be met for a health plan to be eligible for HIA assistance: 1. Health plan must meet the minimum standards for a Qualified Health Plan and be active at the time assistance is requested 1. Health Insurance coverage must be evaluated for cost effectiveness 2. Health insurance plan must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services. 3. COBRA plans must be evaluated based on cost effectiveness and client benefit. Additional Requirements for ACA plans: 1. If a client between 100%-250% FPL, only SILVER level plans are eligible for HIA payment assistance (unless client enroll prior to November 1, 2015). 2. Clients under 100% FPL, who present with an ACA plan, are NOT eligible for HIA payment assistance (unless enroll prior to November 1, 2015). 3. All clients who present with an ACA plan are required to take the ADVANCED Premium Tax Credit if eligible (100%-400% of FPL). All clients receiving HIA assistance must report any life changes such as income, family size, tobacco use or residence within 30 days of the reported change.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client records indicates compliance. • Agencies will ensure payments are made directly to the health or dental insurance vendor within five (5) business days of approved request.
9.12	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program to ensure 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 exchange.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.13	Client Education Education must be provided to clients specific to what is reasonably expected to be paid for by an eligible plan and what RWHAP can assist with to ensure healthcare coverage is maintained. **Cost Sharing Education** 1. Education is provided to clients, as applicable, regarding cost-sharing reductions to lower their out-of-pocket expenses. 2. Clients who are not eligible for cost-sharing reductions (i.e. clients under 100% FPL or above 400% FPL; clients who have minimum essential coverage other than individual market coverage and choose to purchase in the marketplace; and those who are ineligible to purchase insurance through the marketplace) are provided education on cost-effective resources available for the client's health care needs. **Premium Tax Credit Education** 1. Education should be provided to the client regarding tax credits and the requirement to file income tax returns 2. Clients must be provided education on the importance of reconciling any Advanced Premium Tax Credit (APTC) well before the IRS tax filing deadline.	• Documented evidence of education provided regarding cost sharing reductions as applicable, as indicated in the client's primary record. • Documented evidence of education provided regarding premium tax credits as indicated in the client's primary record.
9.14	Decreasing Barriers to Service Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse 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

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.15	Waiver Process In order to ensure proper program delivery, a waiver from the AA is required for the following circumstances: 1. HIA payment assistance will exceed benchmark for directly delivered services, 2. Providing payment assistance for out of network providers, 3. To fill prescriptions for drugs that incur higher co-pays or co-insurance because they are outside their health plans formulary, 4. Discontinuing HIA payment assistance due to client conduct or fraud, 5. Refusing HIA assistance for a client who is eligible and whom HIA provides a cost advantage over direct service delivery, 6. Services being postponed, denied, or a waitlisted and; 7. Assisting an eligible client with the entire cost of a group policy that includes coverage for persons not eligible for HIA payment assistance.	
9.16	Payer of Last Resort Agencies must assure that all clients are screened for potential third-party payers or other assistance programs, and that appropriate referrals are made to the provider who can assist clients in enrollment.	
9.17	Vigorous Pursuit All contracted agencies must vigorously pursue any excess premium tax credit received by the client from the IRS upon submission of the client's tax return. To meet the standard of "*vigorously pursue*", all clients receiving assistance through RW funded HIP assistance service category to pay for ACA QHP premiums must: 1. Designate premium tax credit be taken in advance during enrollment 2. Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual ACA open enrollment or renewal 3. Submit prior year tax information no later than May 31st. 4. Reconciliation of advance premium tax credits or liabilities.	

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.18	Prescription Eyewear Agency must keep documentation from physician stating that the eye condition is related to the client's HIV infection when HIA funds are used to cover co-pays for prescription eyewear.	• Percentage of client files with documented evidence, as applicable, of prescribing physician's order relating eye condition warranting prescription eyewear is medically related to the client's HIV infection as indicated in the client's primary record
9.19	Medical Visits Clients accessing health insurance premium and cost sharing assistance services should demonstrate adherence with their HIV medical care and have documented evidence of attendance of HIV medical appointments in the client's primary record. Note: For clients who use HIA to enable their use of medical care outside of the RW system: HIA providers are required to maintain documentation of client's adherence to Primary Medical Care (e.g. proof of MD visits) during the previous 12 months.	• Clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. (for clients with applicable data in ARIES or other data system used at the provider location) • Note: For clients who use HIA to enable their use of medical care outside of the RWHAP system: Documentation of the client's adherence to Primary Medical Care (e.g. proof of MD visits, insurance Explanation of Benefits, MD bill/invoice) during the previous 12 months
9.20	Viral Suppression Clients receiving Health Insurance Premium and Cost Sharing Assistance services have evidence of viral suppression as documented in viral load testing.	• For clients with applicable data in ARIES or other data system used at the provider location, percentage of clients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

References

TDSHS HIV/STD Ryan White Part B Program Universal Standards (pg. 30-31)
TDSHS HIV/STD Prevention and Care Branch, Policy 260.002. Health Insurance Assistance
HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 33-36.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 31-35.
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 16-02

HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 07-05
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 13-05
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 13-06
HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 14-01
TDSHS HIV/STD Ryan White Program Policies. DSHS Funds as Payment of Last Resort (Policy 590.001)
HRSA/HAB, Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Frequently Asked Questions (FAQ) for Standalone Dental Insurance (PDF)

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

Definition:
Mental Health Services are the provision of outpatient psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Work Agency will provide the following services: **Individual Therapy/counseling** is defined as 1-on-1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV positive or HIV/AIDS affected individual. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise HIV positive individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV positive person. Mental health services include Mental Health Assessment; Treatment Planning; Treatment Provision; Individual psychotherapy; Family psychotherapy; Conjoint psychotherapy; Group psychotherapy; Drop-In Psychotherapy Groups; and Emergency/Crisis Intervention. Also included are Psychiatric medication assessment, prescription and monitoring and Psychotropic medication management. General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for non-HIV infected family members or significant others. Mental health services can be delivered via Telehealth subject to federal guidelines, Texas State law, and DSHS policy	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client's primary record.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	Licensure Counselors must possess the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC, PhD, Licensed Clinical Psychologist or LMFT as authorized to provide mental health therapy in the relevant practice setting by their licensing authority). Bilingual English/Spanish licensed mental health practitioners must be available to serve monolingual Spanish-speaking clients.	• A file will be maintained on each professional counselor. Supportive documentation of credentials is maintained by the agency in each counselor's personnel file. • Review of Agency Policies and Procedures Manual indicates compliance. • Review of personnel files indicates compliance
9.3	Staff Orientation and Education Orientation must be provided to all staff providing direct services to patients within ninety (90) working days of employment, including at a minimum: • Referral for crisis intervention policy/procedures • Standards of Care • Confidentiality • Consumer Rights and Responsibilities • Consumer abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures • Data Management and record keeping; to include documenting in ARIES (or CPCDMS if applicable) Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate continuing education units (CEUs) based on license requirement for each licensed mental health practitioner.	• Personnel record will reflect all orientation and required continuing education training. • Review of Agency Policies and Procedures Manual indicates compliance. • Review of personnel files indicates compliance
9.4	Family Counseling Experience Professional counselors must have two years experience in family counseling if providing services to families.	• Experience is documented via resume or other method. Exceptions noted in personnel files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.5	Professional Liability Insurance Professional liability coverage of at least $300,000 for the individual or $1,000,000 for the agency is required.	• Documentation of liability insurance coverage is maintained by the agency.
9.6	Substance Abuse Assessment Training Professional counselors must receive training in assessment of substance abuse with capacity to make appropriate referrals to licensed substance abuse treatment programs as indicated within 60 days of start of contract or hire date.	• Documentation of training is maintained by the agency in each counselor's personnel file.
9.7	Crisis Situations and Behavioral Emergencies Agency has Policy and Procedures for handling/referring crisis situations and behavioral emergencies either during work hours or if they need after hours assistance, including but not limited to: • verbal intervention • non-violent physical intervention • emergency medical contact information • incident reporting • voluntary and involuntary inpatient admission • follow-up contacts Emergency/crisis intervention policy and procedure must also define emergency situations and the responsibilities of key staff are identified; there must be a procedure in place for training staff to respond to emergencies; and these procedures must be discussed with the client during the orientation process. In urgent, non-life-threatening circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within this time frame, the agency will offer to refer the client to another organization that can provide the requested services.	• Review of Agency Policies and Procedures Manual indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.8	Other Policies and Procedures The agency must develop and implement Policies and Procedures that include but are not limited to the following: • Client neglect, abuse and exploitation including but not limited to definition of terms; reporting to legal authority and funding source; documentation of incident; and follow-up action to be taken • Discharge criteria including but not limited to planned discharge behavior impairment related to substance abuse, danger to self or others (verbal/physical threats, self-discharge) • Changing therapists • Referrals for services the agency cannot perform and reason for referral, criteria for appropriate referrals, timeline for referrals. • Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active client at least once every 6 months.	• Review of Agency Policies and Procedures Manual indicates compliance.
9.9	In-Home Services Therapy/counseling and/or bereavement counseling may be conducted in the client's home.	• Program Policies and Procedures address the provision of home visits.
9.10	Client Orientation Orientation is provided to all new clients to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation will be provided to all clients and include written or verbal information on the following: • Services available • Clinic hours and procedures for after-hours emergency situations • How to reach staff member(s) as appropriate • Scheduling appointments • Client responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process	• Annual Client Interviews indicates compliance. • Percentage of new clients with documented evidence of orientation to services available in the client's primary record

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.11	Comprehensive Assessment A comprehensive assessment including a psychosocial history will be completed at intake (unless client is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History including HIV treatment and current medications, Death/Dying Issues, Mental Health Status Exam, Suicide/Homicide Assessment, Self-Assessment /Expectations, Education and Employment History, Military History, Parenthood, Alcohol/ Substance Abuse History, Trauma Assessment, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, HIV/STD Risk Assessment, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation.	• Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I. • Documentation in client record on the initial and comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the initial assessment will be recorded in the comprehensive client assessment. • Documentation of mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the client's primary record (If pressing mental health needs emerge during the mental health assessment requiring immediate attention that results in the assessment not being finalized by the third session, this must be documented in the client's primary record)
9.12	Treatment Plan Treatment plans are developed jointly with the counselor and client and must contain all the elements for mental health including: • Statement of the goal(s) of counseling and description of the mental health issue • Goals and objectives • The plan of approach and treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up • Mechanism for review	• Documentation of detailed treatment plan and documentation of services provided within the client's primary record. • Completed treatment plans and signed by the licensed mental health professional rendering services in the client's primary record. • Documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record. • Exceptions noted in client's primary record.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.12	Treatment Plan (Cont'd) Treatment plans must be completed within 30 days from the Mental Health Assessment. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance abuse, treatment adherence, development of social support systems, community resources, maximizing social and adaptive functioning, the role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals as clinically indicated. The treatment plan will be signed by the mental health professional rendering service.	
9.13	Treatment Plan Review Treatment plans are reviewed and modified at a minimum, midway through the number of determined sessions agreed upon for frequency of modality, or more frequently as clinically indicated. The plan must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures.	• Review of Agency Policies and Procedures Manual indicates compliance. • Documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.
9.14	Psychiatric Referral Clients are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the client's primary record.	• Documentation of need for psychiatric intervention are referred to services as evidenced in the client's primary record.
9.15	Psychotropic Medication Management: Psychotropic medication management services are available for all clients either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the client's concerns with the client about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively. *Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10*	• Clients accessing medication management services with documented evidence in the client's primary record of education regarding medications. • Documentation of clients with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the client's signed consent to share information, in the client's primary record.

9.16	Progress Notes Progress notes are completed according to the agency's standardized format, completed for each counseling session and must include: • Client name • Session date • Observations • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Assessment • Duration of session • Counselor signature and counselor authentication • Evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions and treatment adherence	• Legible, signed and dated documentation in client primary record. • Documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.
9.17	Coordination of Care Care will be coordinated across the mental health care coordination team members. The client is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the client, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for clients who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	• Percentage of agencies who have documented evidence in the client's primary record or care coordination, as permissible, of shared MH treatment adherence with the client's prescribing provider.
9.18	Referrals As needed, mental health providers will refer clients to full range of medical/mental health services including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the client's HIV diagnosis In urgent, non-life-threatening circumstances, an appointment will be made within one (1) business day. If an agency cannot provide the needed services, the agency	• Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.

	will offer to refer the client to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s).	
#	**STANDARD**	**MEASURE**
9.0 Service-Specific Requirements		
9.19	Discharge Services may be discontinued when the client has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period • Continual non-adherence to treatment plan • Chooses to terminate services • Unacceptable patient behavior • Death	• Agency will develop discharge criteria and procedures.
9.20	Discharge Summary Discharge summary is completed for each client after 30 days without client contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements • Date	• Percentage of clients with documentation of discharge planning when treatment goals being met as evidenced in the client's primary record. • Percentage of clients with documentation of case closure per agency non-attendance policy as evidenced in the client's primary record.
9.21	Supervisor Qualifications Supervision is provided by a clinical supervisor qualified by the State of Texas. The agency shall ensure that the Supervisor shall, at a minimal, be a State licensed Masters-level professional (e.g. LPC, LCSW, LMSW, LMFT, PhD, and Licensed Clinical Psychologist) qualified under applicable State licensing standards to provide supervision to the supervisee.	• Documentation of supervisor credentials is maintained by the agency.
9.22	Clinical Supervision A minimum of bi-weekly supervision is provided to counselors licensed less than three years. A minimum of monthly supervision is provided to counselors licensed three years or more.	• Documentation in supervision notes. • Each mental health service agency must have and implement a written policy for regular supervision of all licensed staff.

References

American Psychiatric Association. *The Practice Guideline for Treatment of Patients with HIV/AIDS*, Washington, DC, 2001.
HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April, 2013, page 17-18.
HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 17-18.
New York State Mental Health Standards of Care

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
ORAL HEALTH CARE SERVICES

Definition:
Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Work Oral Health Care as "diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers". The Ryan White Part A/B oral health care services include standard preventive procedures, routine dental examinations, diagnosis and treatment of HIV-related oral pathology, restorative dental services, root canal therapy, prophylaxis, x-rays, fillings, and basic oral surgery (simple extractions), endodontics and oral medication (including pain control) for HIV patients 15 years old or older based on a comprehensive individual treatment plan. Referral for specialized care should be completed if clinically indicated. Additionally, the category includes prosthodontics services including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs. Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a client's annual benefit balance. If a provider cannot provide adequate services for emergency care, the patient should be referred to a hospital emergency room. Limitations: Cosmetic dentistry for cosmetic purposes only is prohibited.	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
	Staff Qualifications All oral health care professionals, such as general dental practitioners, dental specialists, and dental hygienists shall be properly licensed by the State of Texas Board of Dental Examiners while performing tasks that are legal within the provisions of the Texas Dental Practice including satisfactory arrangements for malpractice insurance. Dental Assistants who make x-rays in Texas must register with the State Board of Dental Examiners. Dental hygienists and assistants will be supervised by a licensed dentist. Students enrolled in a College of Dentistry may perform tasks under the supervision	• Documentation of qualifications for each dental provider present in personnel file.
9.2	Continuing Education • Eight (8) hours of training in HIV/AIDS and clinically related issues is required annually for licensed staff. (does not include any training requirements outlined in General Standards) • One (1) hour of training in HIV/AIDS is required annually for all other staff. (does not include any training requirements outlined in General Standards)	• Materials for staff training and continuing education are on file • Documentation of continuing education in personnel file
9.3	Experience – HIV/AIDS Service provider should employ individuals experienced in dental care and knowledgeable in the area of HIV/AIDS dental practice. A minimum of one (1) year documented HIV/AIDS work experience is preferred for licensed staff.	• Documentation of work experience in personnel file
9.4	Confidentiality Confidentiality statement signed by dental employees.	• Signed statement in personnel file.
9.5	Universal Precautions All health care workers should adhere to universal precautions as defined by Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. It is strongly recommended that staff are aware of the following to ensure that all vaccinations are obtained, and precautions are met: • Health care workers who perform exposure-prone procedures should know their HIV antibody status • Health care workers who perform exposure-prone procedures and who do not have serologic evidence of immunity to HBV from vaccination or from previous infection should know their HBsAg status and, if that is positive, should also know their HBeAg status. • Tuberculosis tests at least every 12 months for all staff. • OSHA guidelines must be met to ensure staff and patient safety.	• Documentation of review in personnel file.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.6	Staff Supervision Supervision of clinical staff shall be provided by a practitioner with at least two years' experience in dental health assessment and treatment of persons living 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 Policies & Procedures Manual indicates compliance
9.7	Annual Cap on Services Maximum amount that may be funded by Ryan White/State Services per patient is $3,000/year. • In cases of emergency, the maximum amount may exceed the above cap • In cases where there is extensive care needed once the procedure has begun, the maximum amount may exceed the above cap. Dental providers must document ***via approved waiver*** the reason for exceeding the yearly maximum amount.	• Annual review of reimbursements indicates compliance • Signed waiver present in patient record for each patient.
9.8	HIV Primary Care Provider Contact Information Agency obtains and documents HIV primary care provider contact information for each client.	• Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number
9.9	Consultation for Treatment Agency consults with client's medical care providers when indicated.	• Documentation of communication in the client record
9.10	Dental and Medical History Information To develop an appropriate treatment plan, the oral health care provider should obtain complete information about the patient's health and medication status Provider obtains and documents HIV primary care provider contact information for each patient. Provider obtains from the primary care provider or obtains from the patient health history information with updates as medically appropriate prior to providing care. This information should include, but not be limited to, the following: • A baseline current (within in last 12 months) CBC laboratory test • Current (within the last 12 months) CD4 and Viral Load laboratory test results or more frequent when clinically indicated • Coagulants (PT/INR, aPTT, and if hemophiliac baseline deficient factor level (e.g., Factor VIII activity) and inhibitor titer (e.g., BIA) • Tuberculosis screening result • Patient's chief complaint, where applicable • Current Medications (including any osteoporotic medications) • Pregnancy status, where applicable	• Percentage of oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year. • Documentation of health history information in the client record. Reasons for missing health history information are documented

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
	Dental and Medical History Information (Cont'd) This information should include, but not be limited to, the following: • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis A, B, C status • Usual oral hygiene • Date of last dental examination • Involuntary weight loss or weight gain • Review of systems Any predisposing conditions that may affect the prognosis, progression and management of oral health condition	
9.11	Client Health History Update An update to the health history should be completed as medically indicated or at least annually.	• Documentation of health history update in the client's primary record at least once in the measurement year
9.12	Limited Physical Examination Initial limited physical examination should include, but shall not necessarily be limited to, blood pressure, and pulse/heart rate as may be indicated for each patient according to the Texas Board of Dental Examiners. Dental provider will obtain an initial baseline blood pressure/pulse reading during the initial limited physical examination of a dental patient. Dental practitioner should also record blood pressure and pulse heart rate as indicated for invasive procedures involving sedation and anesthesia. If the dental practitioner is unable to obtain a patient's vital signs, the dental practitioner must document in the patient's oral health care record an acceptable reason why the attempt to obtain vital signs was unsuccessful.	• Documented oral examination completed within the measurement year in the client's primary oral health record.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.13	Oral Examination Patient must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year such as: • D0150-Comprehensive oral evaluation, to include bitewing x-rays, new or established patient • D0120-Periodic Oral Evaluation to include bitewing x-rays, established patient, • D0160-Detailed and Extensive Oral Evaluation • D0170-Re-evaluation, limited, problem focused (established patient; not post-operative visit) • Comprehensive Periodontal Evaluation, new or established patient. Source: http://ada.org	• Documented oral examination completed within the measurement year in the client's primary oral health record.
9.14	Comprehensive Periodontal Examination Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines. Patient must have a periodontal screening once per year. A periodontal screen shall include the assessment of medical and dental histories, the quantity and quality of attached gingival, bleeding, tooth mobility, and radiological review of the status of the periodontium and dental implants. Comprehensive periodontal examination (ADA CDT D0180) includes: • Evaluation of periodontal conditions • Probing and charting • Evaluation and recording of the patient's dental and medical history and general health assessment. • It may include the evaluation and recording or dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. (Some forms of periodontal disease may be more severe in individuals affected with immune system disorders. Patients with HIV may have especially severe forms of periodontal disease. The incidence of necrotizing periodontal diseases may increase with patients with acquired immune deficiency syndrome).	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation of periodontal screen or examination as least once in the measurement year. (HRSA HAB Measure)

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.15	Treatment Plan A dental treatment plan should be developed appropriate for the patient's health status, financial status, and individual preference should be chosen. A comprehensive, multi-disciplinary Oral Health treatment plan will be developed and updated in conjunction with the patient. Patient's primary reason for dental visit should be addressed in treatment plan. Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions. A comprehensive dental treatment plan that includes preventive care, maintenance and elimination of oral pathology will be developed and updated annually. Various treatment options should be discussed and developed in collaboration with the patient. Treatment plan should include as clinically indicated: • Provision for the relief of pain • Elimination of infection • Preventive plan component • Periodontal treatment plan if necessary • Elimination of caries • Replacement or maintenance of tooth space or function • Consultation or referral for conditions where treatment is beyond the scope of services offered • Determination of adequate recall interval. • Invasive Procedure Risk Assessment (prior to oral surgery, extraction, or other invasive procedure) • Dental treatment plan will be signed by the oral care health professional providing the services. (*Electronic signatures are acceptable*)	• Treatment plan dated and signed by both the provider and patient in patient file • Dental treatment plan developed and/or updated at least once in the measurement year. (HRSA HAB Measure)
9.16	Phase 1 Treatment Plan In accordance with the National Monitoring Standards a Phase 1 treatment plan includes prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. Phase 1 treatment plan will be established and updated annually to include what diagnostic, preventative, and therapeutic services will be provided. Phase 1 treatment plan will be established within 12 months of initial assessment. Treatment plan should include as clinically indicated: • Restorative treatment • Basic periodontal therapy (non-surgical) • Basic oral surgery (simple extractions and biopsy) • Non-surgical endodontic therapy • Maintenance of tooth space • Tooth eruption guidance for transitional dentition	• Phase 1 Treatment plan dated and signed by both the provider and patient in patient file • Phase 1 treatment plan that is completed within 12 months. (HRSA HAB Measure)

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.17	Annual Hard/Soft Tissue Examination The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan. Determination of clients needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all clients may not exceed two (2) years.	• Documentation in the client record • Review of agency's Policies & Procedures Manual indicates compliance
9.18	Oral Health Education Oral health education may be provided and documented by a licensed dentist, dental hygienist, dental assistant and/or dental case manager. Provider must provide patient oral health education once each year which includes but is not limited to the following: • D1330 Oral hygiene instructions • Daily brushing and flossing (or other interproximal cleaning) and/or prosthetic care to remove plaque; • Daily use of over-the-counter fluorides to prevent or reduce cavities when appropriate and applicable to the patient. If deemed appropriate, the reason is stated in the patient's oral health record • D1320 Smoking/tobacco cessation counseling as indicated • Additional areas for instruction may include Nutrition (D1310). • For pediatric patients, oral health education should be provided to parents and caregivers and be age appropriate for pediatric patients.	• Documentation of oral health education at least once in the measurement year. (HRSA HAB Measure)
9.19	Oral Hygiene Instructions Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.	• Documentation in the client record
9.20	Referrals Referrals for other services must be documented in the patient's oral health care chart. Outcome of the referral will be documented in the patient's oral health care record.	• Documentation in the client record • Documented referrals provided have outcomes and/or follow-up documentation in the primary oral health care record.

References

- American Dental Association. Dental Practice Parameters. Patients requiring a comprehensive oral evaluation. Available at: http://www.ada.org/prof/prac/tools/parameters/eval_comprehensive.asp. Accessed on May 8, 2009.
- HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April, 2011, page 9-10.
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 9-10.
- Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Rule 7.Minimal Standards of Care. located at http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=5&ch=108&rl=7
- Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection, located at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.85.htm

RYAN WHITE PART B/DSHS STATE SERVICES
2021 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
NON-MEDICAL CASE MANAGEMENT TARGETING SUBSTANCE USE DISORDERS

Definition:
Non-Medical Case Management Services (N-MCM) Targeting Substance Use Disorders (SUD) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible PLWHs to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	Scope of Service The purpose of Non-Medical Case Management (N-MCM) Services targeting Substance Use Disorders (SUD) is to assist people living with HIV (PLWH) who are also facing the challenges of substance use disorder to procure needed services so that the problems associated with living with HIV and/or SUD are mitigated. N-MCM targeting SUD is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is community based (i.e. both office-based and field based). N-MCMs are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained	• Program's Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in primary client record.

#	STANDARD	MEASURE
9.1	alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are facing the challenges of SUD. Key activities include: • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Continuous monitoring to assess the efficacy of the care plan • Re-evaluation of the care plan at least every six (6) months with adaptations as necessary • Ongoing assessment of the PLWH's and other key family members' needs and personal support systems **Limitation: Direct Medical Costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.	
9.2	<u>Agency License</u> The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of substance use treatment/counseling.	• Review of agency
9.3	<u>Program Policies and Procedures</u> Agency will have a policy that: • Defines and describes N-MCM targeting SUD services (funded through Ryan White or other sources) that complies with the standards of care outlined in this document. • Specifies that services shall be provided in the office **and** in the field (i.e. community based). • Specifies required referral to and coordination with HIV medical services providers. • Requires referral to and coordination with providers of substance use treatment/counseling, as appropriate. • Requires monitoring of referrals into services.	• Program's Policies and Procedures indicate compliance with expectations.

#	STANDARD	MEASURE
9.4	Staff Qualifications Non-Medical Case Managers must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented work experience in providing services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Agency will provide Non-Medical Case Manager a written job description upon hiring.	• A file will be maintained on each non-medical case manager. Supportive documentation of credentials and job description are maintained by the agency and in each non-medical case manager's file. Documentation may include, but is not limited to, transcripts, diplomas, certifications and/or licensure. • Review of personnel files indicates compliance
9.5	Supervision A minimum of four (4) hours of supervision per month must be provided to each N-MCM 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.	• Program's Policies and Procedures indicate compliance with expectations. • Review of documentation indicates compliance.
9.6	Caseload Coverage – N-MCMs Supervisor ensures that there is coverage of the caseload in the absence of the N-MCM or when the position is vacant. N-MCM may assist PLWHs who are routinely seen by other CM team members in the absence of the PLWH's "assigned" case manager.	• Documentation of all service encounters in primary client record and in the Centralized Patient Care Data Management System
9.7	Case Reviews – N-MCMs Supervisor reviews a random sample equal to 10% of unduplicated PLWHs served by each N-MCM 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 primary client record, signed and dated by supervisor and/or quality assurance personnel and N-MCM
9.8	Client Eligibility N-MCM targeting SUD is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder.	• Documentation of eligibility is present in the PLWH's primary record. • Documentation in compliance with TRG SR-1801 Client Eligibility for Services.

#	STANDARD	MEASURE
9.9	<u>Initial Assessment</u> The Initial Assessment is required for PLWHs who are enrolled in Non-Medical Case Management (N-MCM) services. It expands upon the information gathered during the intake phase to provide the broader base of knowledge needed to address complex, longer- standing access and/or barriers to medical and/or psychosocial needs. The 30-day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information: a) PLWH's support service status and needs related to: • Nutrition/Food bank • Financial resources and entitlements • Housing • Transportation • Support systems • Partner Services and HIV disclosure • Identification of vulnerable populations in the home (i.e. children, elderly and/or disabled) and assessment of need (e.g. food, shelter, education, medical, safety (CPS/APS referral as indicated) • Family Violence • Legal needs (ex. Health care proxy, living will, guardianship arrangements, landlord/tenant disputes, SSDI applications) • Linguistic Services, including interpretation and translation needs • Activities of daily living • Knowledge, attitudes and beliefs about HIV disease • Sexual health assessment and risk reduction counseling • Employment/Education b) Additional information • PLWH strengths and resources • Other agencies that serve PLWH and household • Brief narrative summary of assessment session(s)	• Percentage of PLWHs who access N-MCM services that have a completed assessment within 30 calendar days of the first appointment to access N-MCM services and includes all required documentation. • Percentage of PLWHs that received at least one face-to-face meeting with the N-MCM staff that conducted the initial assessment. • Percentage of PLWHs who have documented Initial Assessment in the primary client record.

#	STANDARD	MEASURE
9.10	Care Planning The PLWH and the N-MCM will actively work together to develop and implement the care plan. Care plans include at a minimum: • Problem Statement (Need) • Goal(s) – suggest no more than three goals • Intervention o Task(s) o Assistance in accessing services (types of assistance) o Service Deliveries • Individuals responsible for the activity (N-MCM, PLWH, other team member, family) • Anticipated time for each task • PLWH acknowledgment The care plan is updated with outcomes and revised or amended in response to changes in access to care and services at a minimum every six (6) months. Tasks, types of assistance in accessing services, and services should be updated as they are identified or completed – not at set intervals.	• Percentage of non-medical case management PLWHs, regardless of age, with a diagnosis of HIV who had a non-medical case management care plan developed and/or updated two or more times in the measurement year. • Percentage of primary client records with documented follow up for issues presented in the care plan. • Percentage of Care Plans documented in the primary client record.
9.11	Assistance in Accessing Services and Follow-Up N-MCM will work with the PLWH to determine barriers to accessing services and will provide assistance in accessing needed services. N-MCM will ensure that PLWH are accessing needed services, and will identify and resolve any barriers PLWH may have in following through with their Care Plan. When PLWHs are provided assistance for services elsewhere, the referral should be documented and tracked. Referrals will be documented in the primary client record and, at a minimum, should include referrals for services such as: OAHS, MCM, Medical transportation, Mental Health, Substance Use Treatment, and any additional services necessary to help clients engage in their medical care. Referral Tracking All referrals made will have documentation of follow-up to the referral in the primary client record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the N-MCM offered to the PLWH.	• Percentage of N-MCM PLWHs with documented types of assistance provided that was initiated upon identification of PLWH needs and with the agreement of the PLWH. Assistance denied by the PLWH should also be documented in the primary client record system • Percentage of N-MCM PLWHs with assistance provided have documentation of follow up to the type of assistance provided.

#	STANDARD	MEASURE
9.12	Increase Health Literacy N-MCM assesses PLWH ability to navigate medical care systems and provides education to increase PLWH ability to advocate for themselves in medical care systems.	• Documentation of health literacy evaluation and education is present in the primary client record.
9.13	Transtheoretical Model of Change N-MCMs shall use the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change) to promote improved health outcomes and achievement of care plan goals.	• Documentation is present in the primary client record.
9.14	Overdose Prevention & SUD Reduction N-MCMs should provide activities, strategies and education that enhance the motivation of PLWH to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors.	• Documentation of activities, strategies and education is present in the primary client record.
9.15	Substance Use Treatment N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations.	• Documentation of discussion regarding treatment or other recovery support services is present in primary client record.Documentation of referrals and follow-up is present in the primary client record. •
9.16	Harm- and Risk-Reduction N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction.	• Documentation of tools and methods is present in the primary client record. • Review of agency tools • Review of agency training

#	STANDARD	MEASURE
9.17	Case Closure/Graduation PLWH who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. Common reasons for case closure include: • PLWH is referred to another case management program • PLWH relocates outside of service area • PLWH chooses to terminate services • PLWH is no longer eligible for services due to not meeting eligibility requirements • PLWH is lost to care or does not engage in service • PLWH incarceration greater than six (6) months in a correctional facility • Provider initiated termination due to behavioral violations • PLWH death Graduation criteria: • PLWH completed case management goals for increased access to services/care needs • PLWH is no longer in need of case management services (e.g. PLWH is capable of resolving needs independent of case management assistance) PLWH is considered non-compliant with care if three (3) attempts to contact PLWH (via phone, e-mail and/or written correspondence) are unsuccessful and the PLWH has been given 30 days from initial contact to respond. Discharge proceedings should be initiated by agency 30 days following the 3rd attempt. Make sure appropriate *Releases of Information and consents are signed by the PLWH and meet requirements of HB 300 regarding electronic dissemination of protected health information (PHI).* Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a PLWH, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300 regarding the electronic dissemination of protected health information (PHI).	• Percentage of PLWH with closed cases includes documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary). • Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable). • Percentage of PLWH notified (through face-to-face meeting, telephone conversation, or letter) of plans to discharge the PLWH from case management services. • Percentage of PLWH with written documentation explaining the reason(s) for discharge and the process to be followed if PLWH elects to appeal the discharge from service. • Percentage of PLWH with information about reestablishment shared with the PLWH and documented in primary client record system. • Percentage of PLWH provided with contact information and process for reestablishment as documented in primary client record system. • Percentage of PLWH with documented Case Closure/Graduation in the primary client record system.

9.18	Community-Based Service Provision N-MCM targeting SUD is a community-based service (i.e. both office-based and field based). Agency policies should support the provision of service outside of the office and/or medical clinic. Agencies should have systems in place to ensure the security of staff and the protections of PLWH information.	• Review of policies and/or procedures. • Review of primary client record indicates compliance with policies and/or procedures.

HIV and African Americans

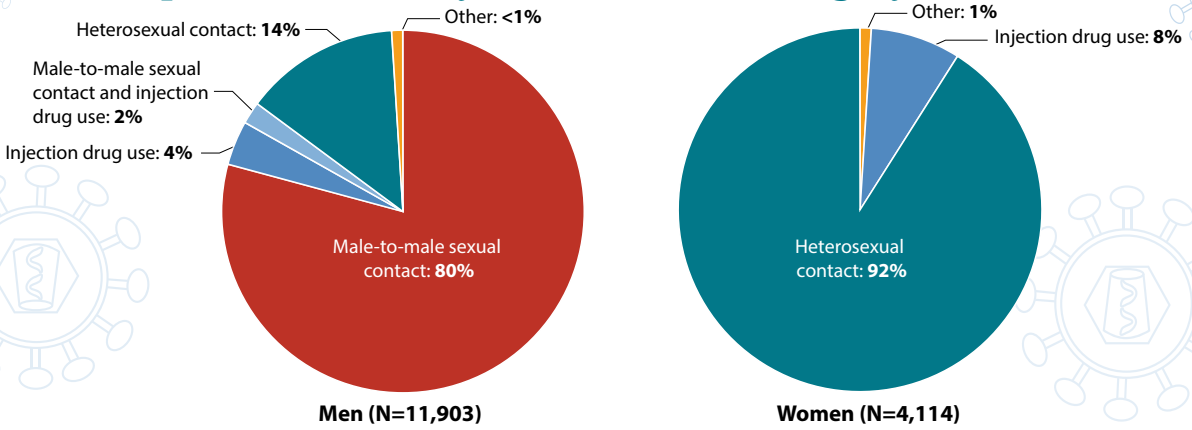
OF THE 37,832 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2018:

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



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.

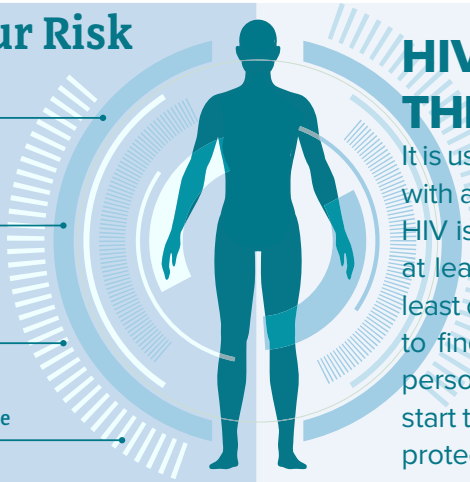
Reduce Your Risk

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.

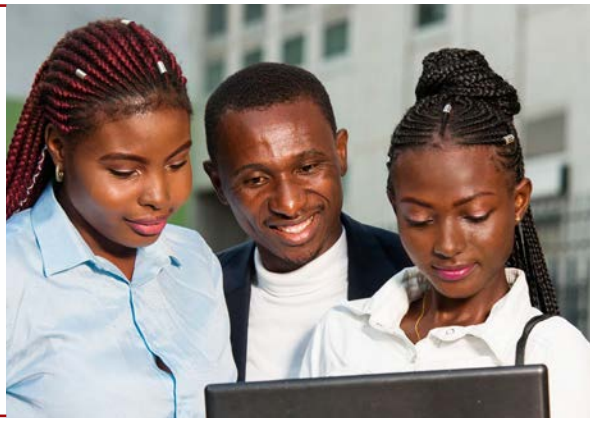
HRSA
Ryan White & Global HIV/AIDS Programs

HRSA's Ryan White HIV/AIDS Program

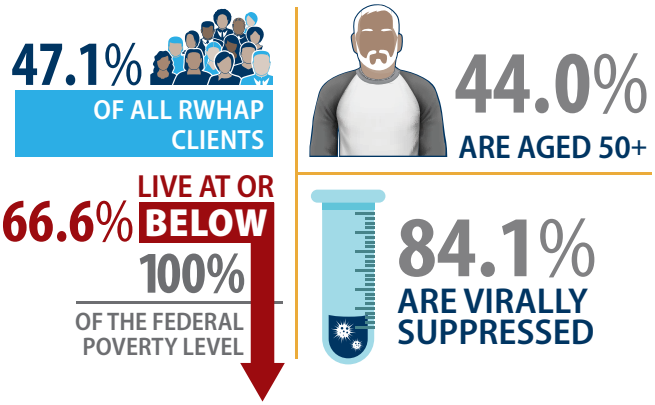
Black/African American Clients: Ryan White HIV/AIDS Program, 2018

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.

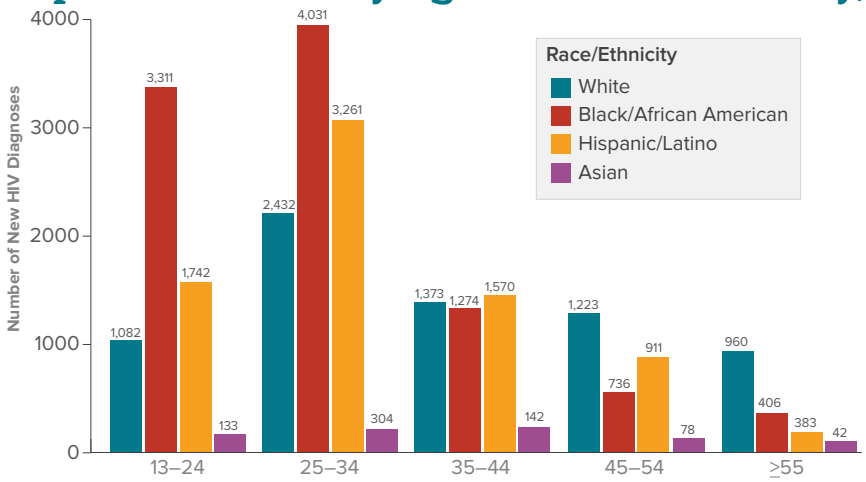
HIV and African American Gay and Bisexual Men

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.

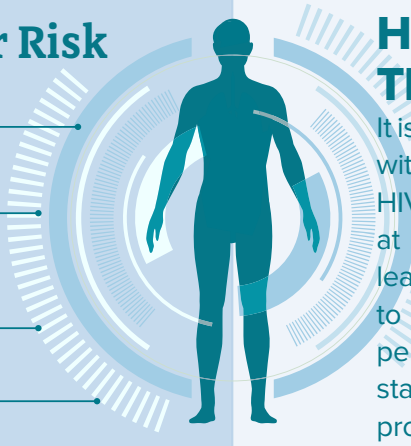
Reduce Your Risk

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

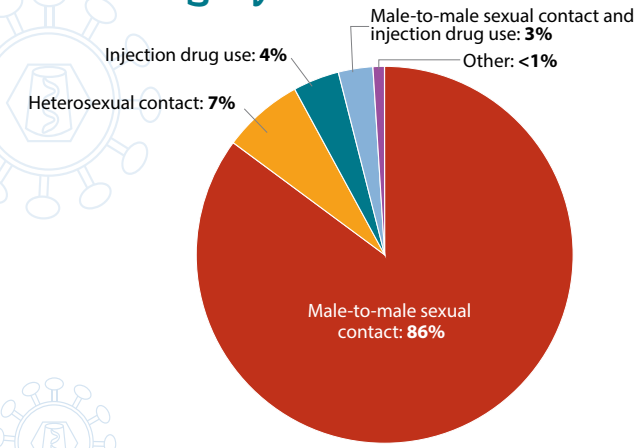
All content is based on the most recent data available in January 2020.

HIV and Hispanics/Latinos

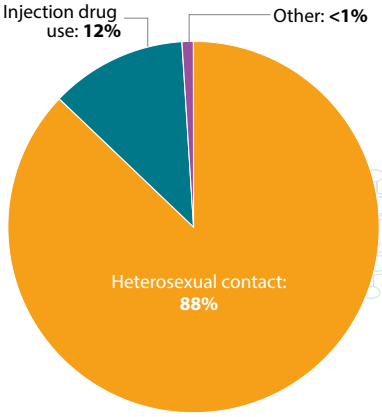
OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017:

- 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?

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Reduce Your Risk

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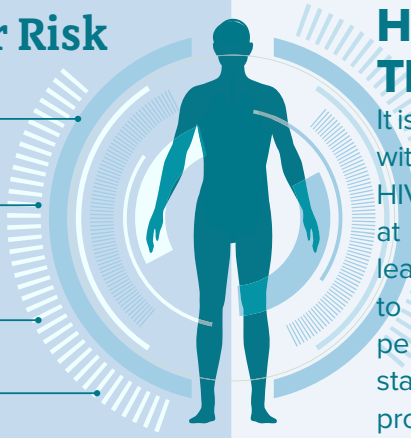
Taking medicine to prevent or treat HIV



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

For More Information

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

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

HRSA
Ryan White & Global HIV/AIDS Programs

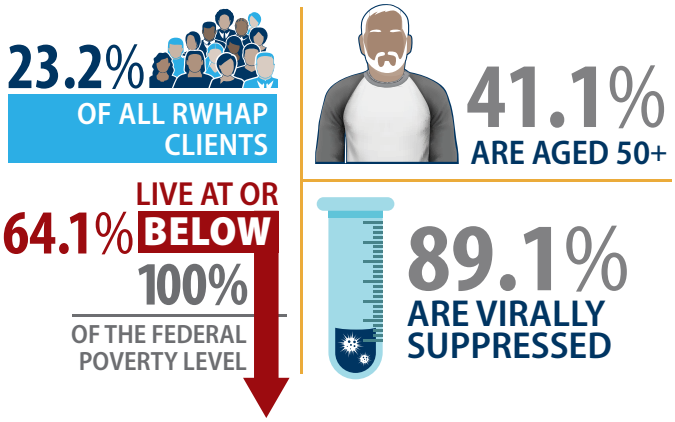
HRSA's Ryan White HIV/AIDS Program

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.

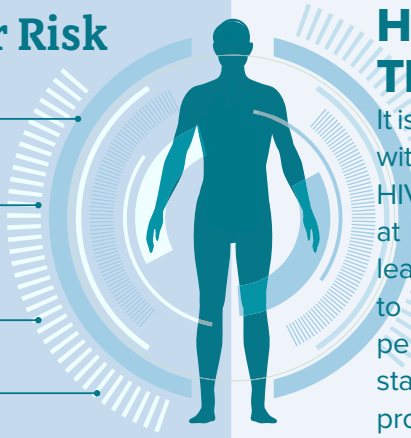
How is CDC making a difference?

- 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

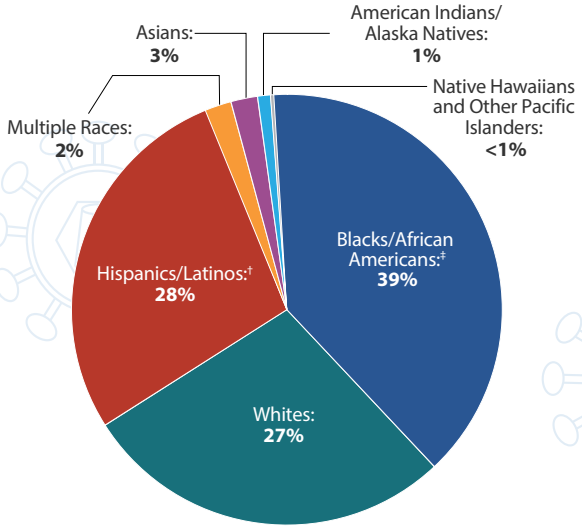
All content is based on the most recent data available in September 2019.

HIV and Men

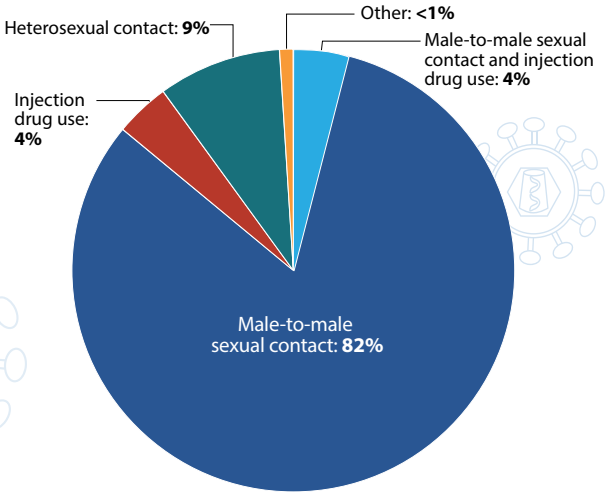
OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017,

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.

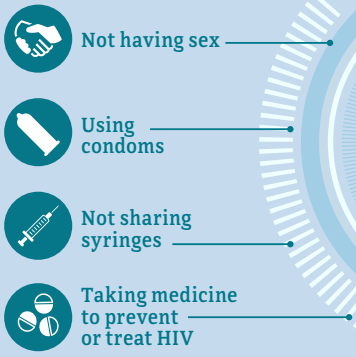
Supporting community organizations that increase access to HIV testing and care.

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



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.

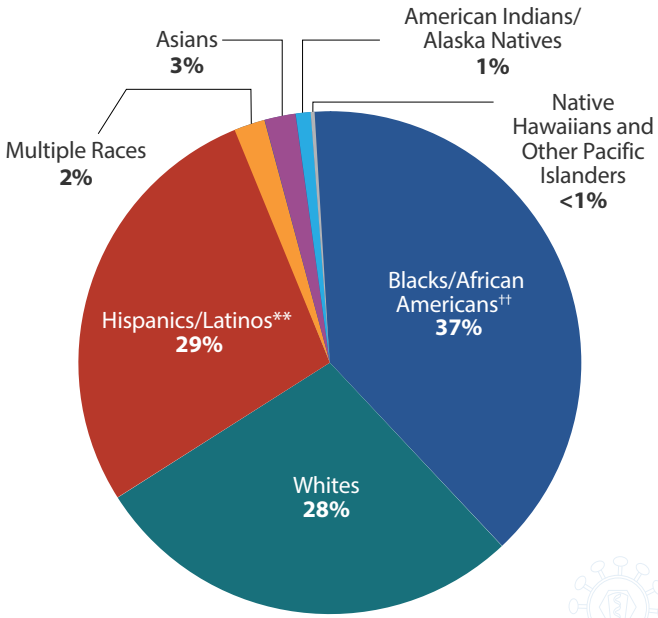
For More Information
Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

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.

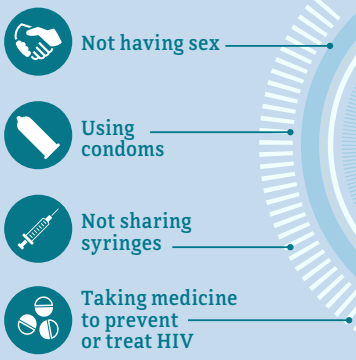
Conducting prevention research and providing guidance to those working in HIV prevention.

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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Visit www.cdc.gov/hiv

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Ryan White & Global HIV/AIDS Programs

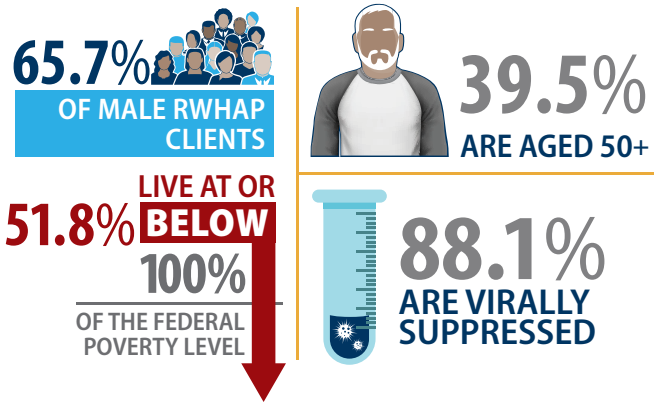
HRSA's Ryan White HIV/AIDS Program

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.

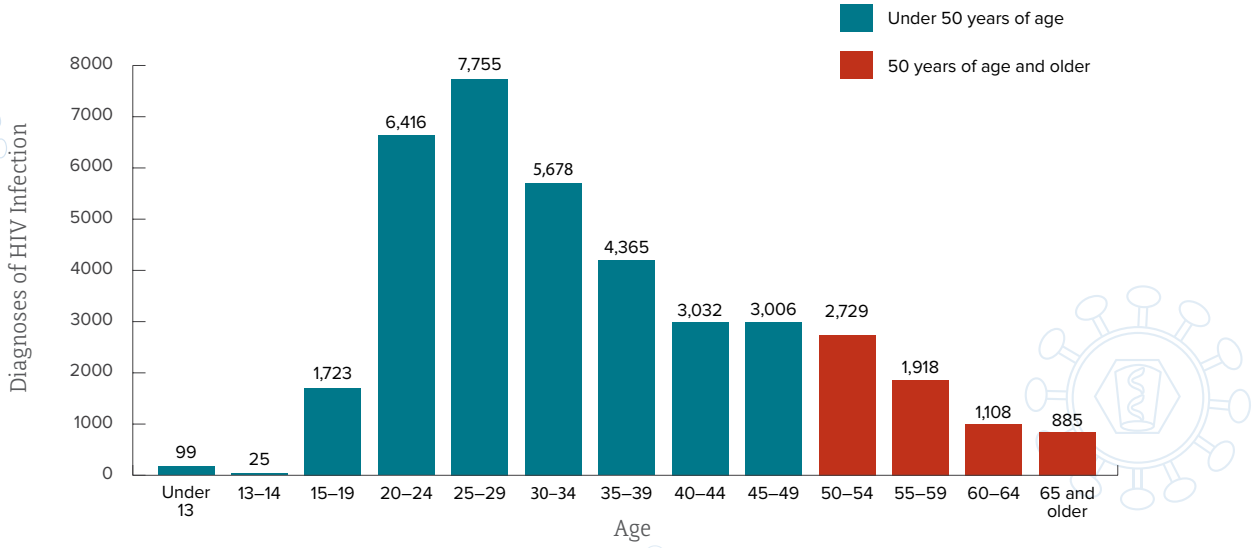
* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

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.

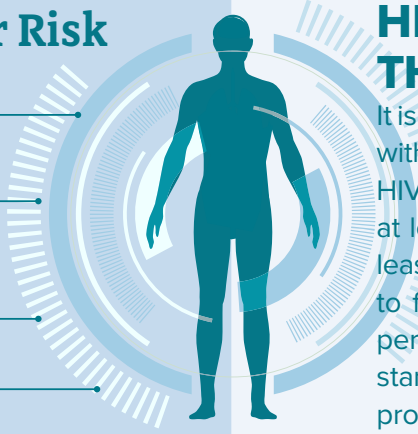
Reduce Your Risk

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

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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

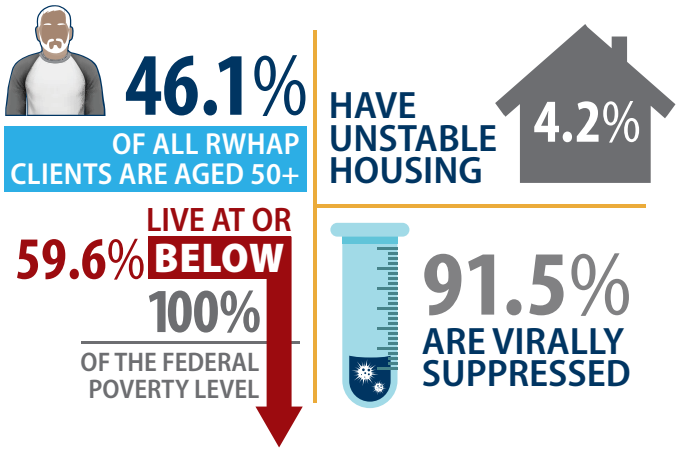
HRSA's Ryan White HIV/AIDS Program

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).

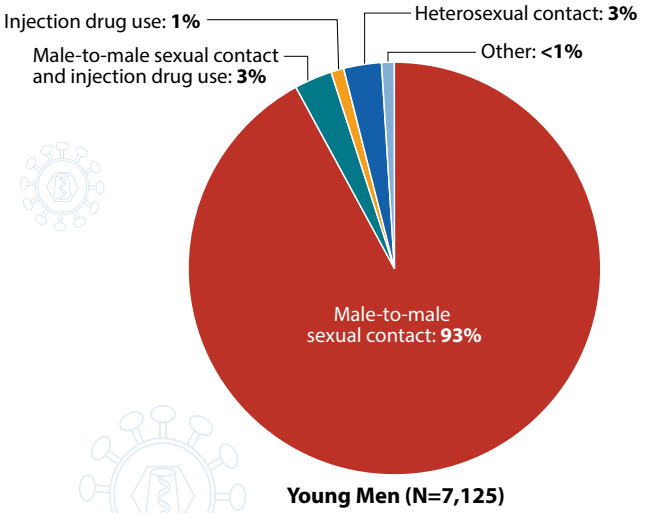
Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. In 2018, 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).

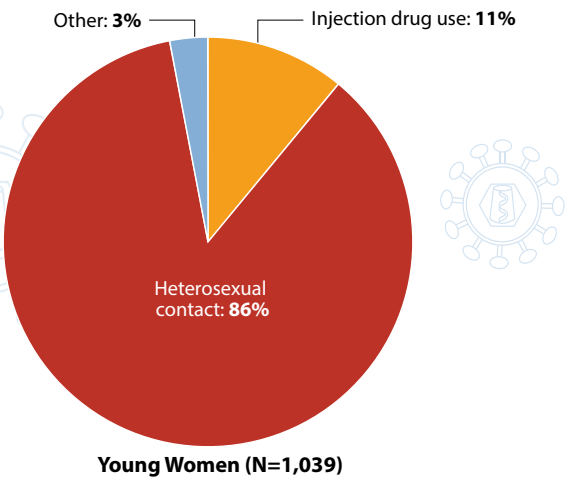
* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

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





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?

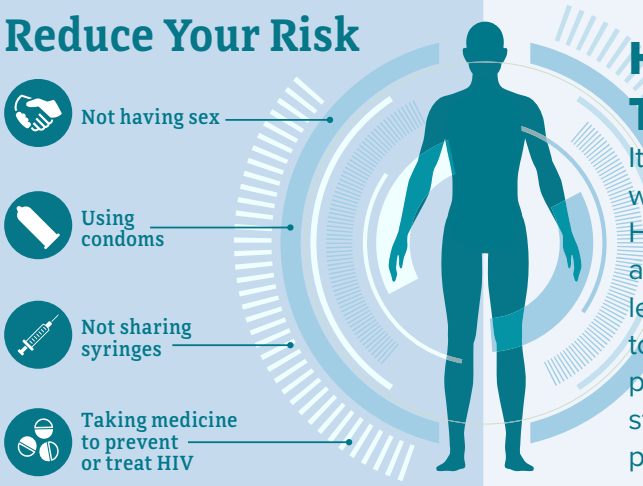
- Collecting and analyzing data and monitoring HIV trends among youth.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments, education agencies, and community organizations by funding HIV prevention work for youth and providing technical 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



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 April 2019.

HRSA
Ryan White & Global HIV/AIDS Programs

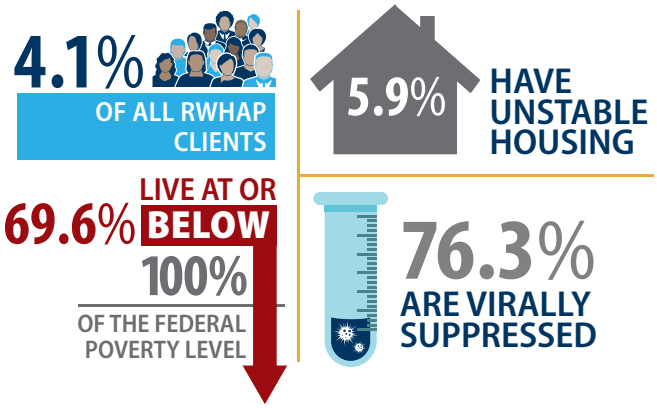
HRSA's Ryan White HIV/AIDS Program

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).

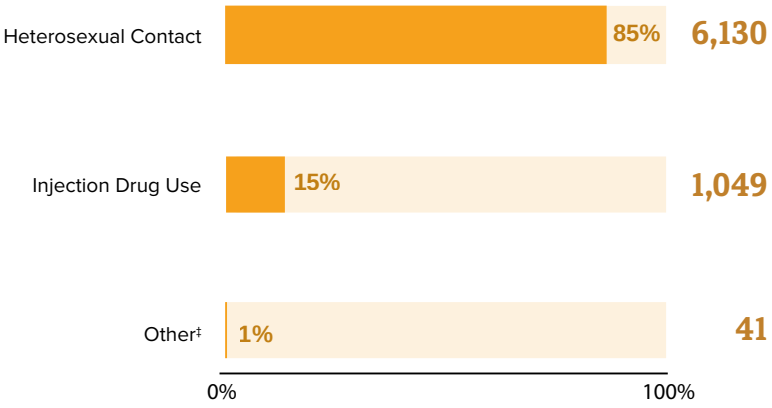
- 78.3 percent of young men who have sex with men (MSM) receiving RWHAP HIV medical care are virally suppressed.
- 74.8 percent of young black/African American MSM receiving RWHAP HIV medical care are virally suppressed.
- 72.1 percent of young black/African American women receiving RWHAP HIV medical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

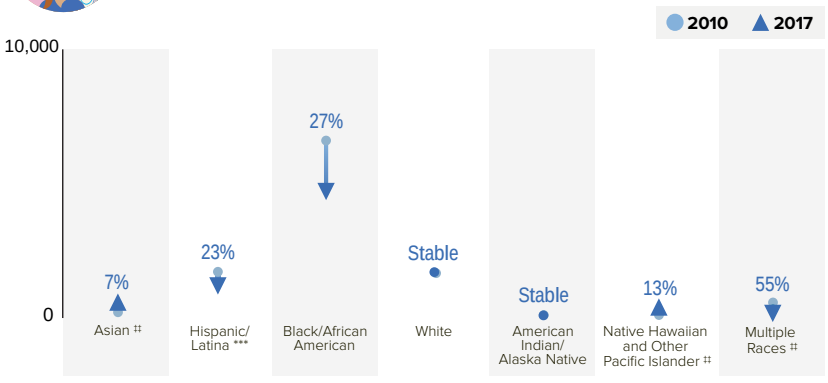
Of the **37,832 NEW HIV DIAGNOSES** in the US and dependent areas* in 2018, 19% were among women.†

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

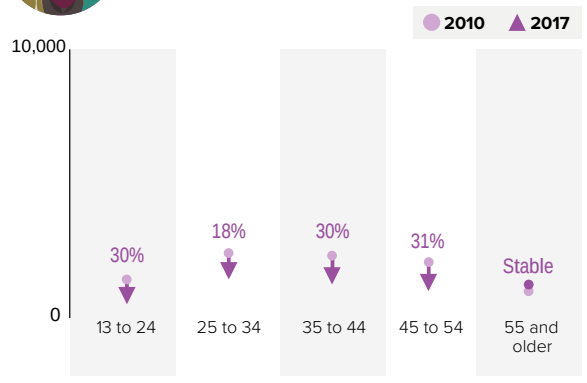


HIV diagnoses declined 23% among women overall from 2010 to 2017. ** Although trends varied for different groups of women, HIV diagnoses declined for groups most affected by HIV, including black/African American†† women and women aged 25 to 34.

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.

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

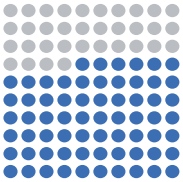
Women who don't know they have HIV cannot get the care and treatment they need to stay healthy.

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

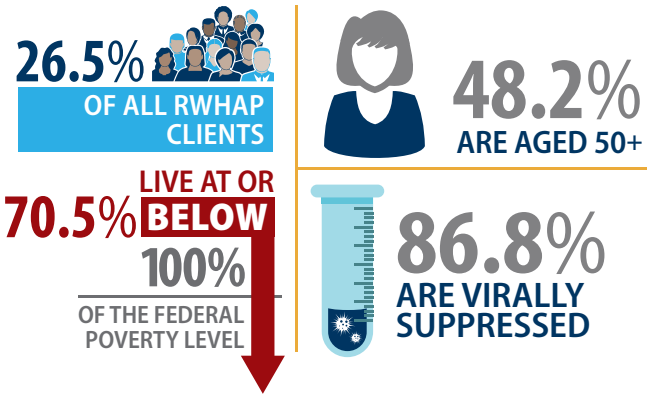
HRSA's Ryan White HIV/AIDS Program

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:

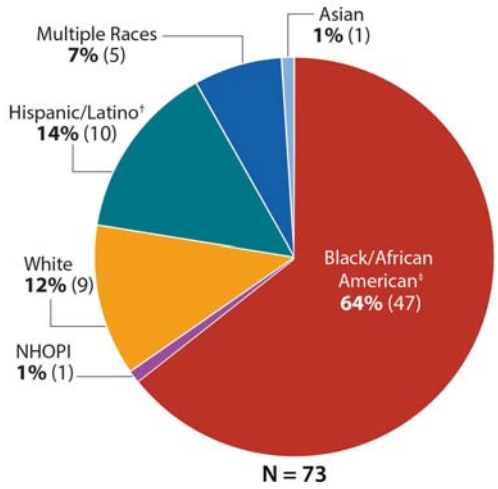
- **Takes HIV medicine daily as prescribed throughout pregnancy and childbirth.**
- **Gives HIV medicine to her baby for 4-6 weeks after giving birth.**
- **Does NOT breastfeed or pre-chew her baby's food.**

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.

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

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

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

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

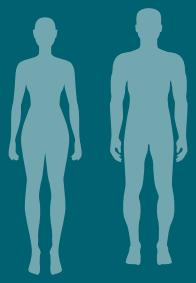
Why are pregnant women and their babies at risk?

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

How is CDC making a difference?

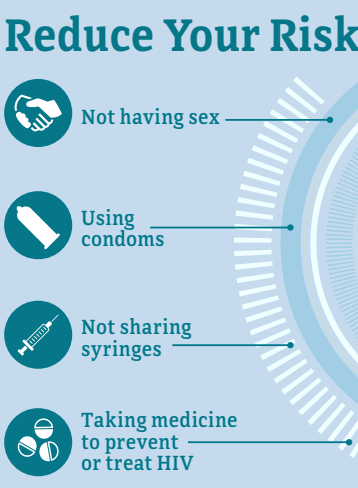
- CDC created a framework (www.cdc.gov/hiv/group/gender/pregnantwomen/emct.html) to help federal agencies and other groups lower the rate of perinatal HIV transmission to less than 1% and reduce the number of cases of perinatal HIV to less than one per 100,000 live births.
- CDC helps lead the Elimination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

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



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

Reduce Your Risk



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:

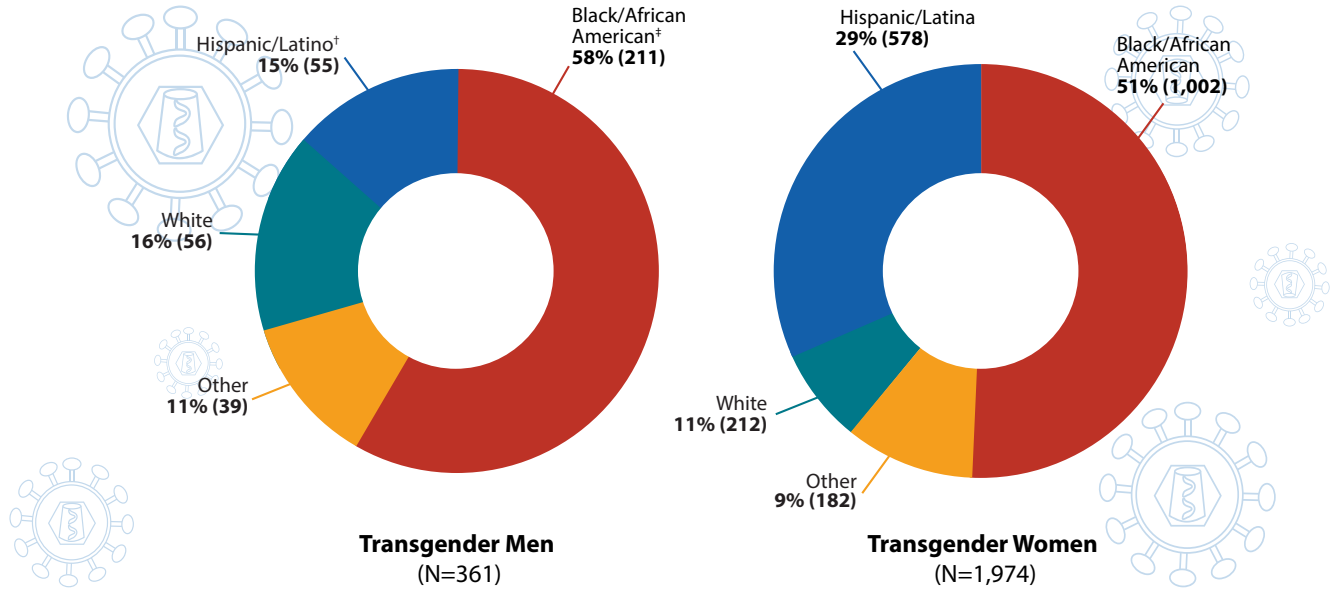
84% WERE TRANSGENDER WOMEN

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.

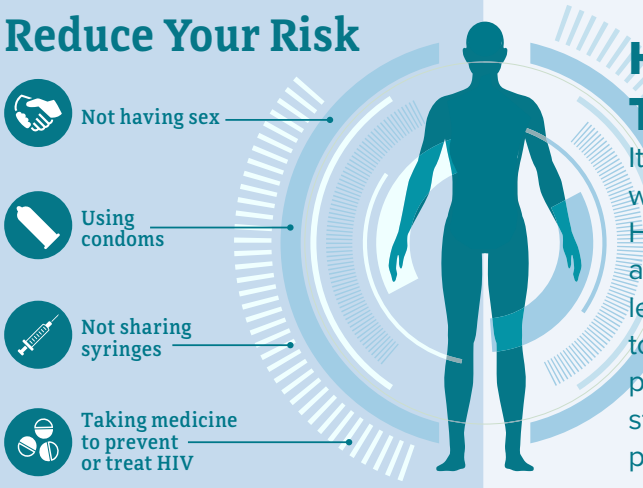
According to current estimates, about 14% of transgender women in the US have HIV.

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



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HRSA
Ryan White & Global HIV/AIDS Programs

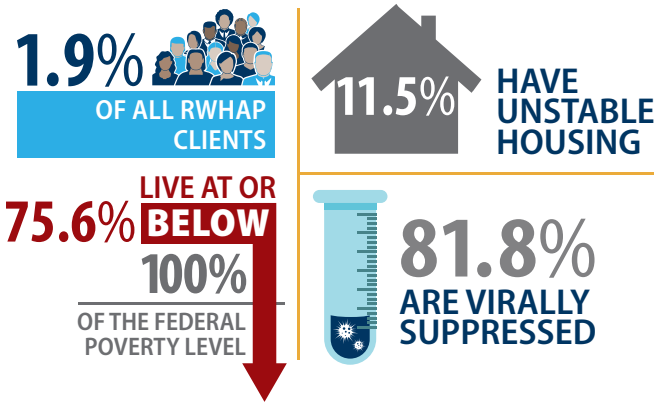
HRSA's Ryan White HIV/AIDS Program

Transgender 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: 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.

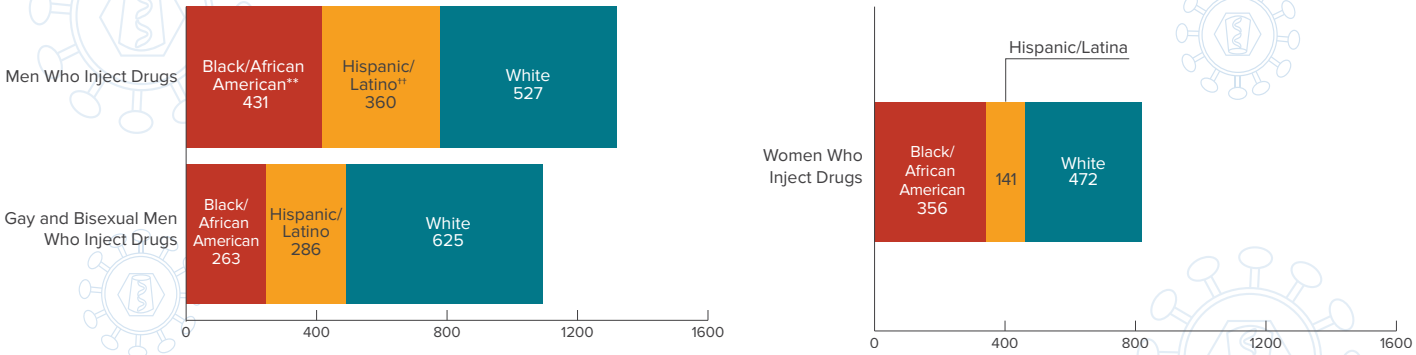
OF THE 38,739 HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017:

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.

†† 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 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.

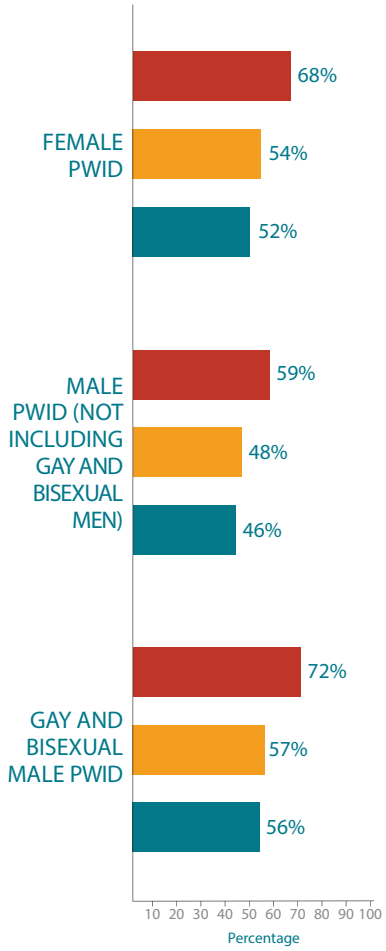
Conducting prevention research and providing guidance to those working in HIV prevention.

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

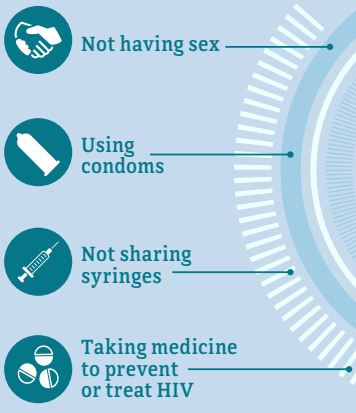
Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

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

HIV Care for PWID With HIV (2015)‡



Reduce Your Risk



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.