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?

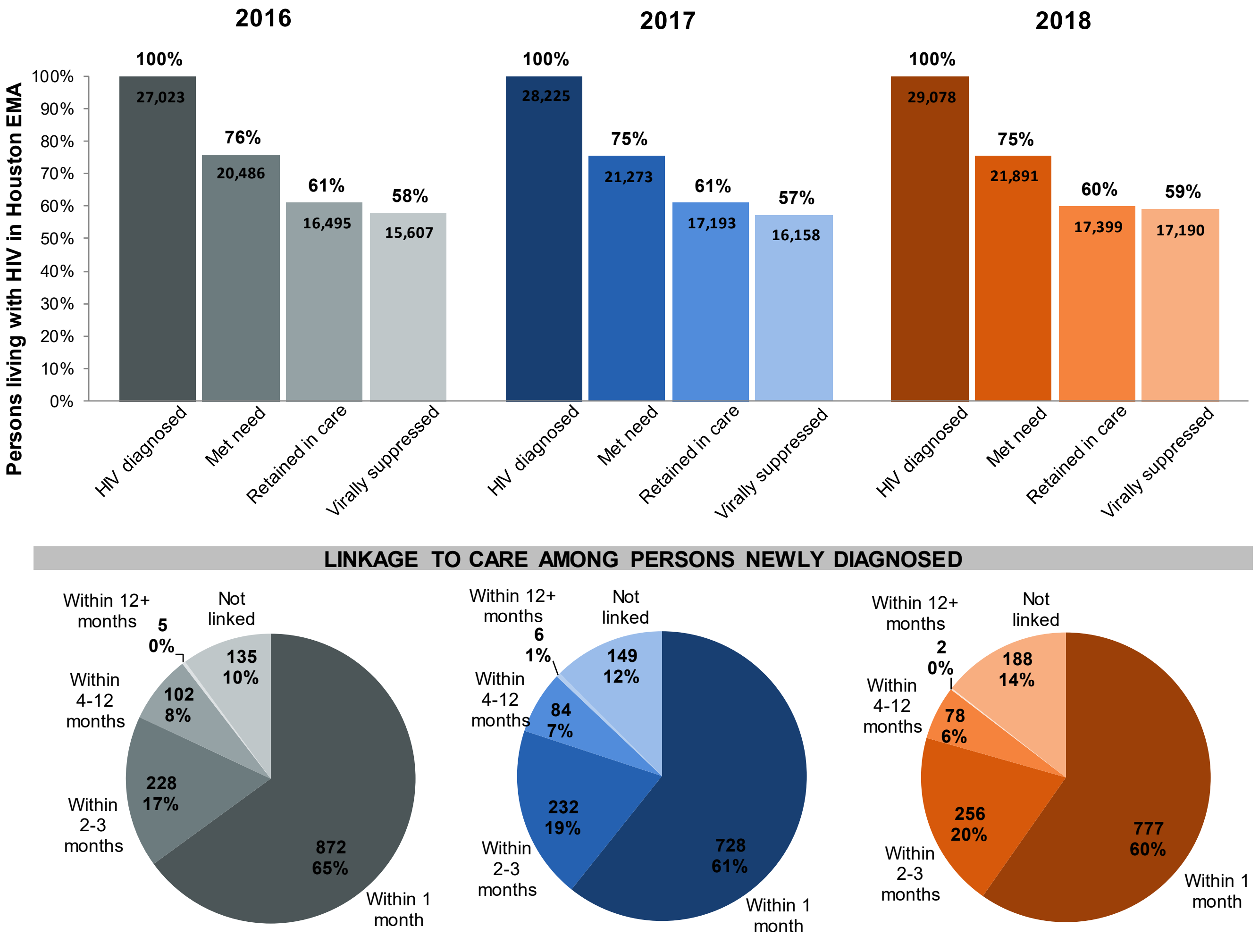
The HIV Care Continuum, previously known as a Treatment Cascade, was first released in 2012 by the Centers for Disease Control and Prevention (CDC). It represents the sequential stages of HIV care, from being diagnosed with HIV to suppressing the HIV virus through treatment. Ideally, the Care Continuum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

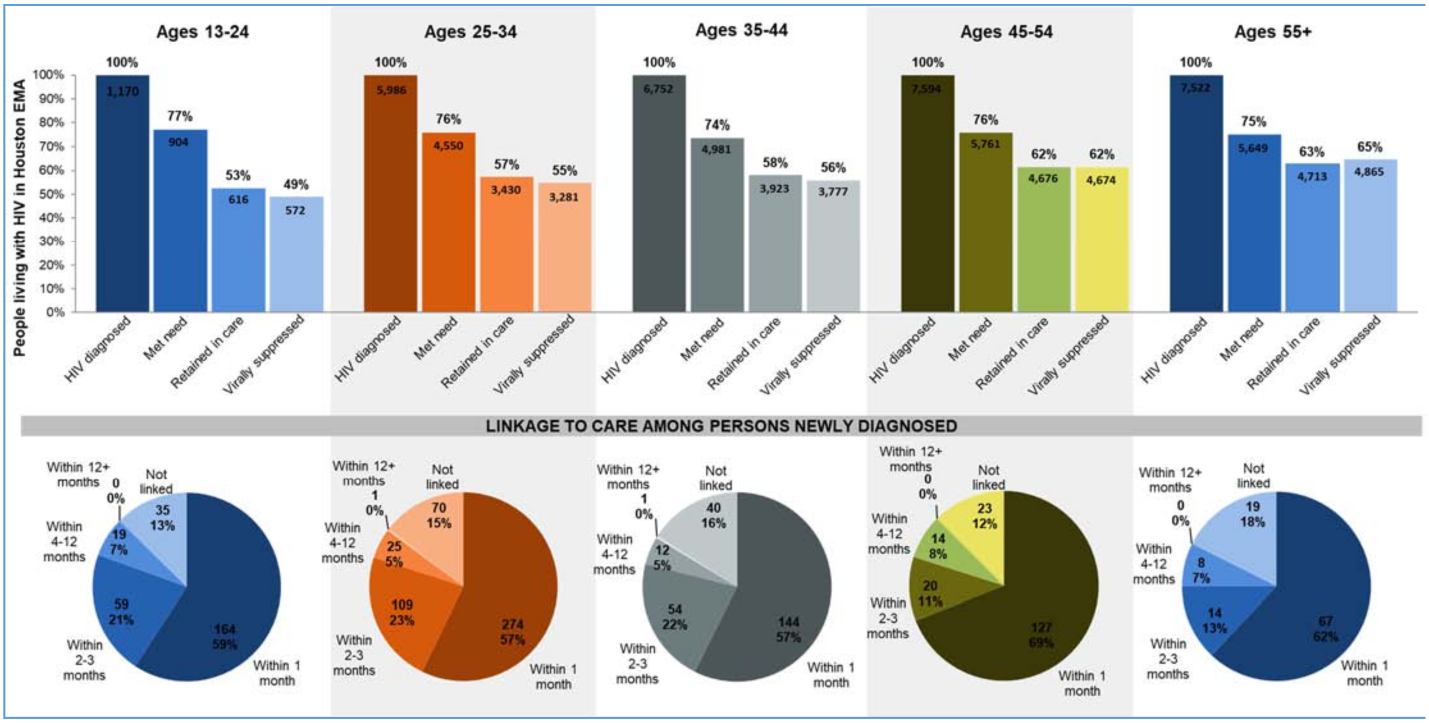
Disparities in Engagement among Key Populations

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.

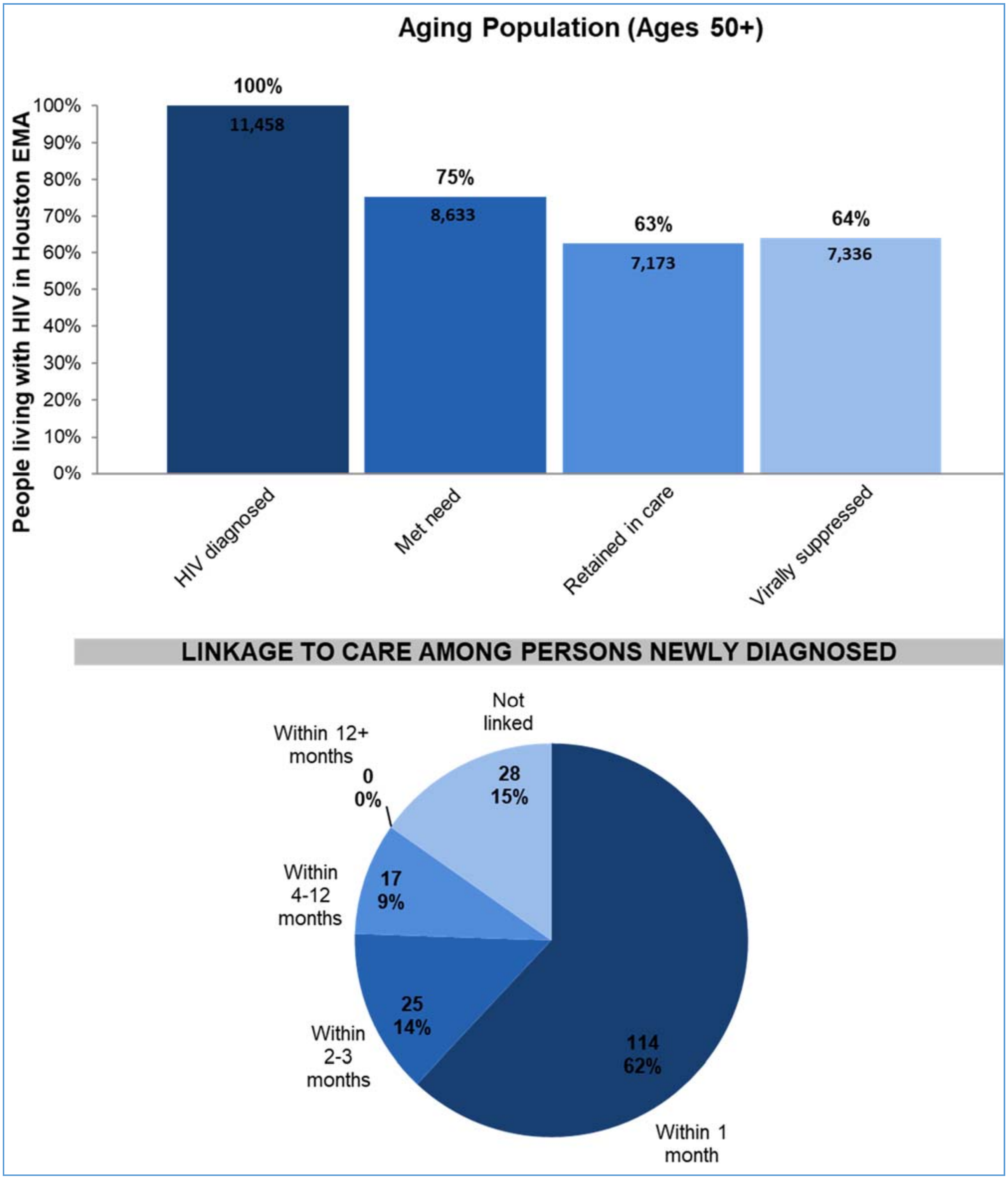
The Houston EMA Care Continuum, by Age

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**

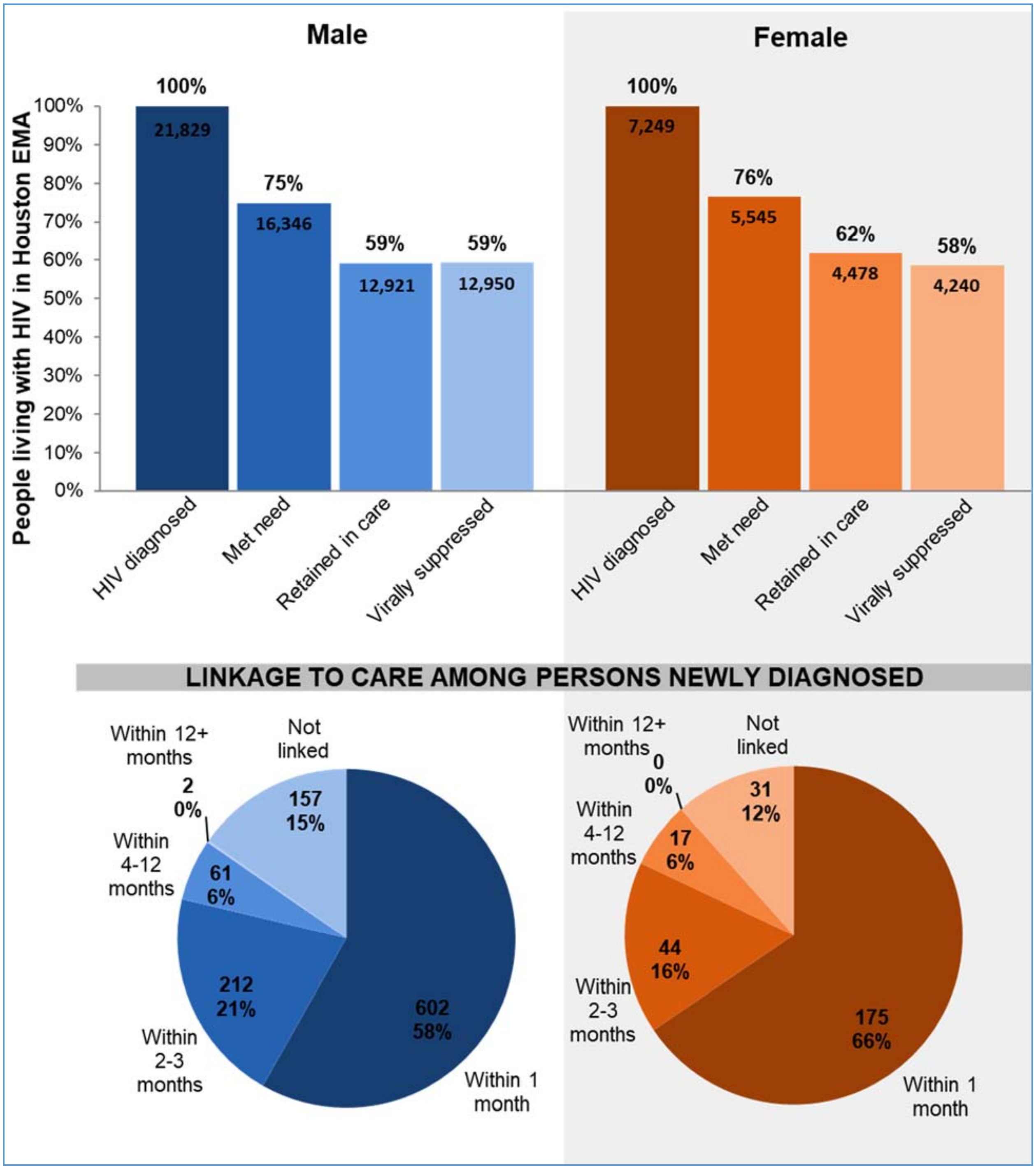


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- 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

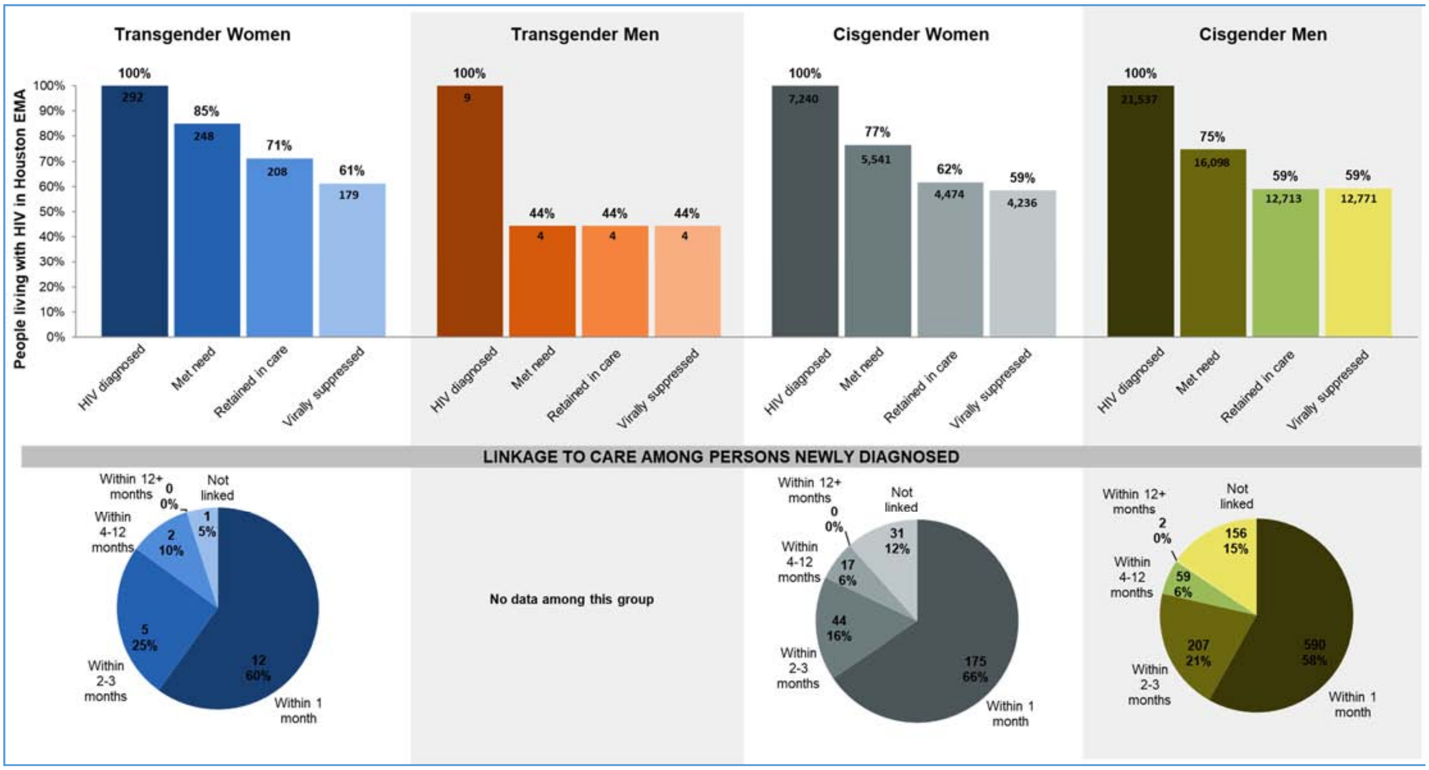
Figure 4: Houston EMA HIV Care Continuum by Sex Assigned at Birth, 2018**



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****

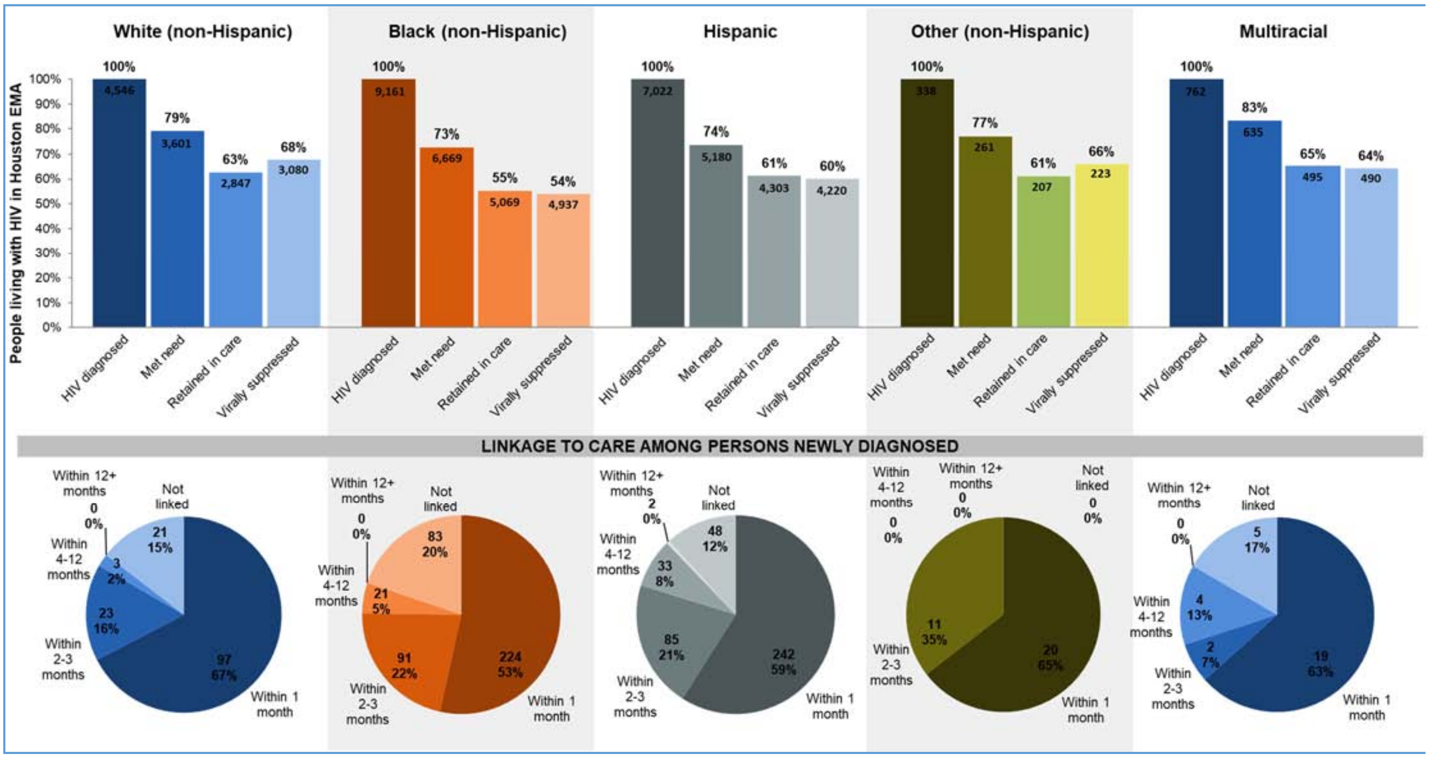


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- 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.

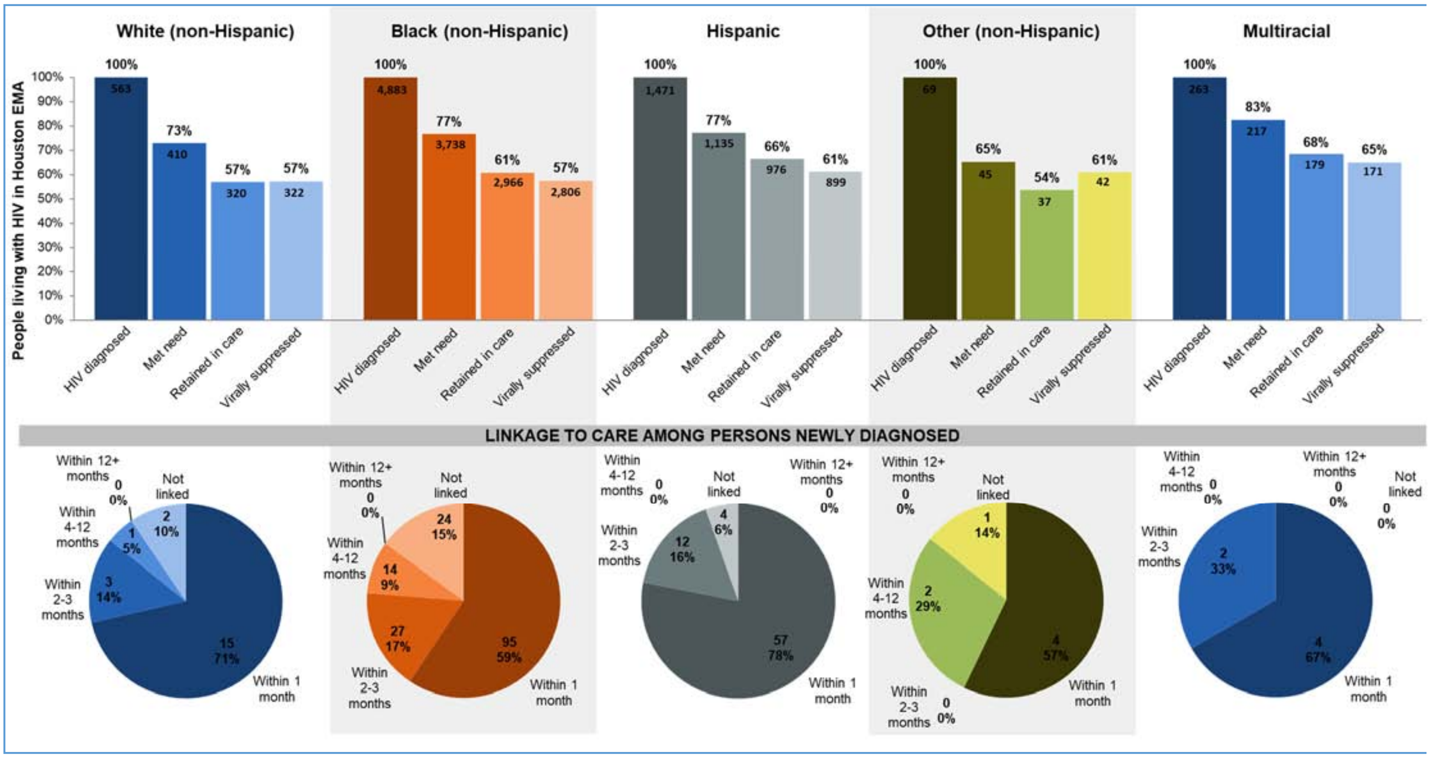
The Houston EMA Care Continuum, by Sex Assigned at Birth and Race/Ethnicity

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**



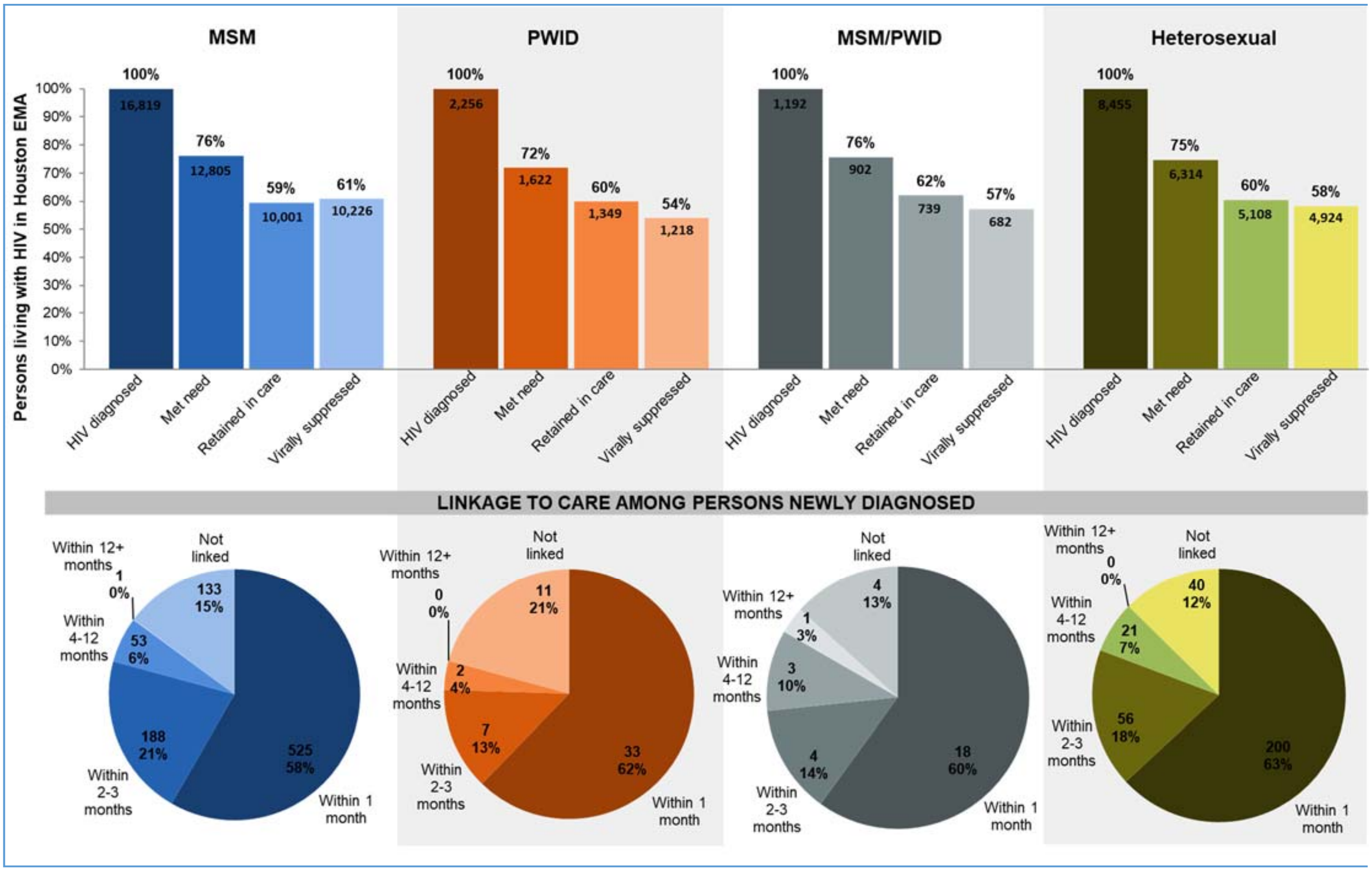
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2020

- 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~

Excerpt for How to Best Meet the Needs
Full document available at www.endhivhouston.org

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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.

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[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

Approved July 9th, 2020

INTRODUCTION

What is an HIV needs assessment?

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

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

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

How are HIV needs assessment data used?

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

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

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

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

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

Sources:

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

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

METHODOLOGY

Needs Assessment Planning

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

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

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

Survey Sampling Plan

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

Survey Tool

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

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

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

Data Collection

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

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

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

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

Data Management

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

Limitations

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

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

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

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

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

Sources:

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

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

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

BACKGROUND

The Houston Area

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

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

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

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

HIV in the Houston Area

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

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

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

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

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

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

HIV Services in the Houston Area

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

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

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

Sources:

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

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

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

Chapter 1: Demographics

PARTICIPANT COMPOSITION

The following summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2020 Houston HIV Care Services Needs Assessment provides both a "snapshot" of who is living with HIV in the Houston Area today as well as context for other needs assessment results.

(**Table 1**) Overall, 95% of needs assessment participants resided in Harris County at the time of data collection. The majority of participants were male (66%), African American/Black (63%), and heterosexual (57%). Over half (60%) were age 50 or over, with a median age of 50-54.

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

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

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

(**Table 2**) Certain subgroups of PLWH have been historically underrepresented in HIV data collection, thereby limiting the ability of local communities to address their needs in the data-driven decision-making processes of HIV planning. To help mitigate underrepresentation in Houston Area data collection, efforts were made during the 2020 needs assessment process to *oversample* PLWH who were also members of groups designated as "special populations" due to socio-economic circumstances or other sources of disparity in the HIV service delivery system.

The results of these efforts are summarized in Table 2.

TABLE 2-Representation of Special Populations, Houston Area HIV Needs Assessment, 2020

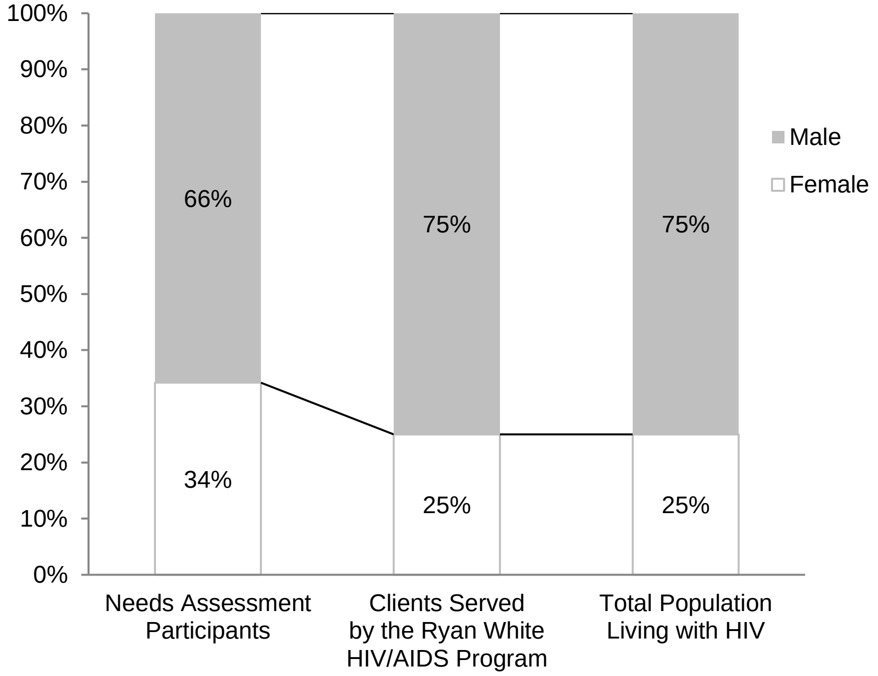
	No.	%
Young adult (18-24 years)	17	2.9%
Adult age 50+ years	353	59.9%
Homeless	65	11.1%
Unstably Housed	159	29.0%
People who inject drugs (PWID)*	47	8.2%
Male-male sexual contact (MSM)	238	40.5%
Out of care (last 12 months)	24	4.3%
Recently released from incarceration	65	11.6%
Rural (non-Harris County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

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

COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

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

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



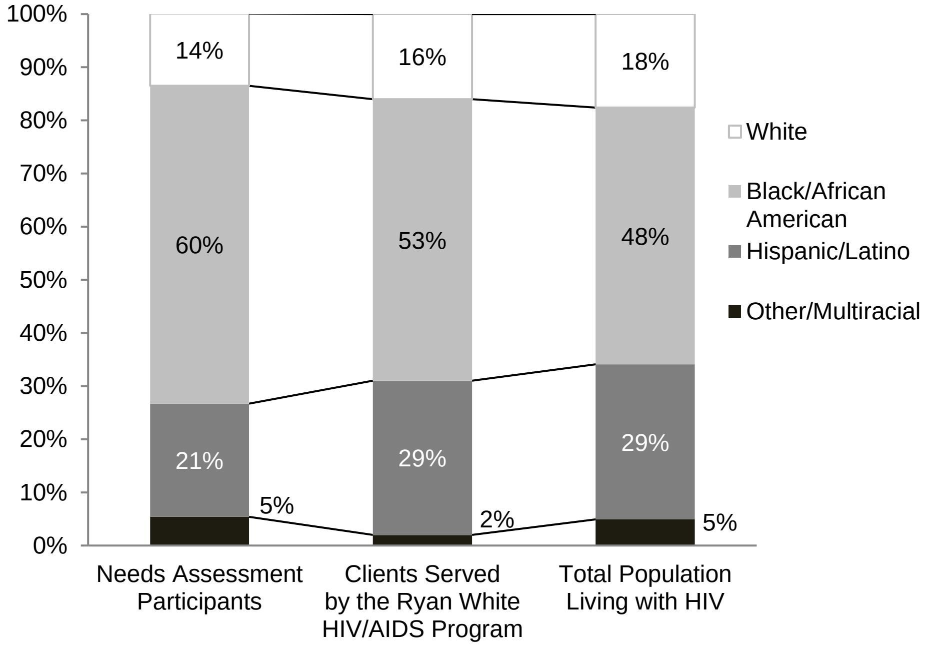
[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18.

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

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

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

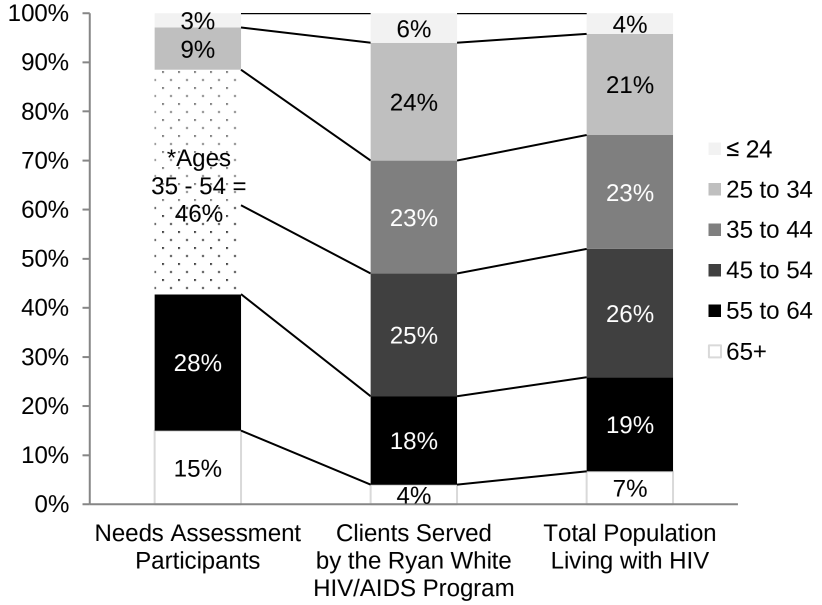
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Race/Ethnicity, 2018



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

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

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



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

Weighting the Sample

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

Sources:

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

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

Chapter 2:
Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

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

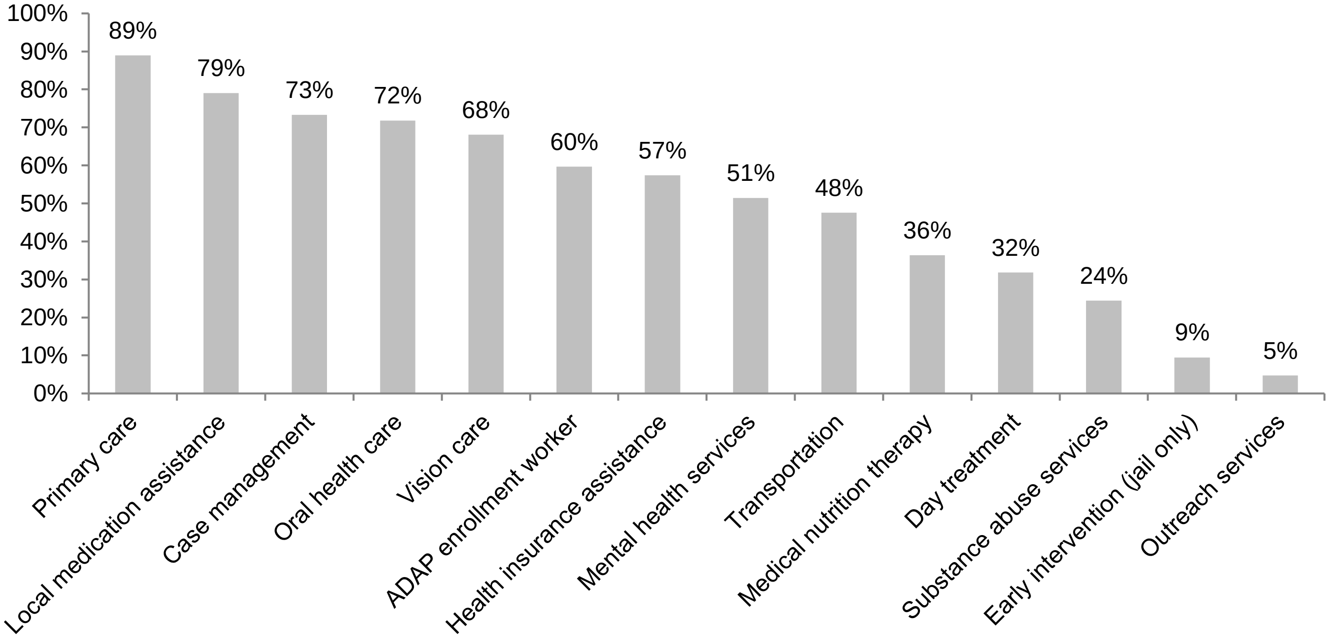
Overall Ranking of Funded Services, by Need

At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 1**) All funded services except hospice and linguistics were analyzed and received a ranking of need. Emergency financial assistance was merged with local medication assistance, and non-medical case management was merged with medical case management. At 89%, primary care was the most needed funded service in the Houston Area, followed by local medication assistance at 79%, case management at 73%, oral health care at 72%, and vision care at 68%. Primary care had the highest need ranking of any core medical service, while ADAP enrollment worker received the highest need ranking of any support service. Compared to the last Houston Area HIV needs assessment conducted in 2016, need ranking decreased for most services. The percent of needs assessment participants reporting need for a particular service decreased the most for case management and primary care, while the percent of those indicating a need for local medication assistance and early intervention services increased from 2016.

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

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



Overall Ranking of Funded Services, by Accessibility

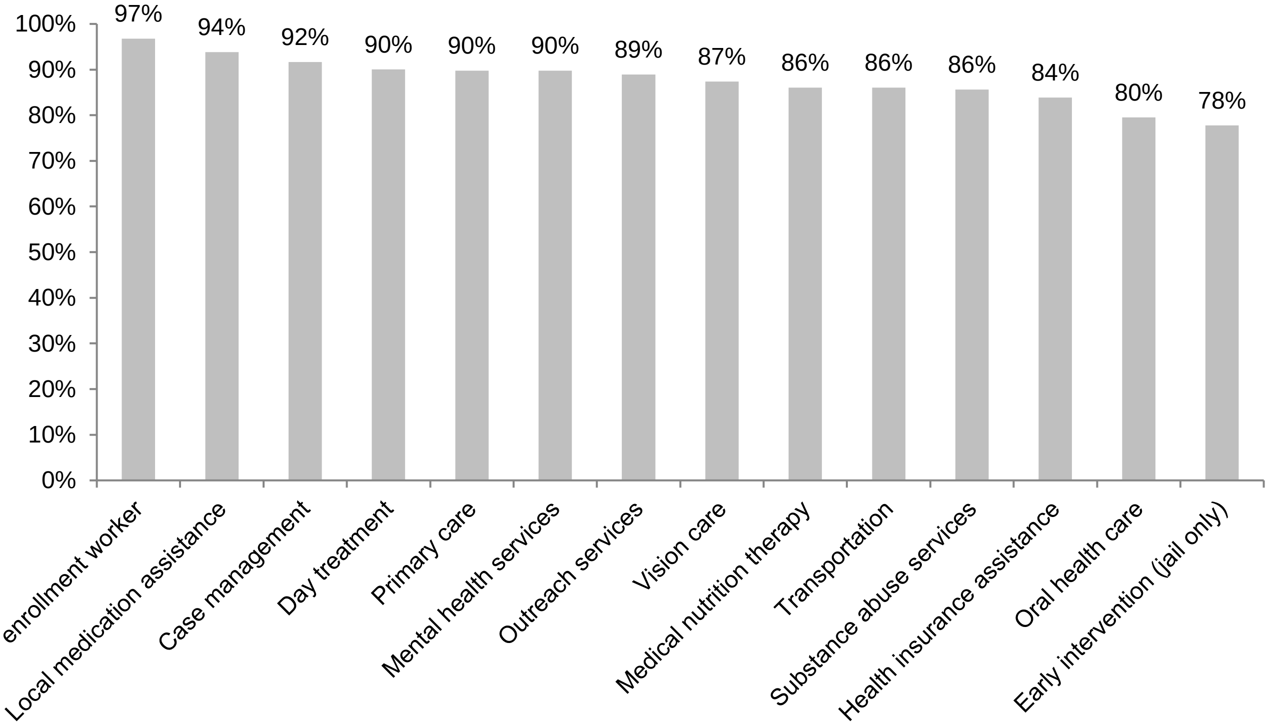
Participants were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both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

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

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

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

Denominator: 569-573 participants, varying between service categories



Overall Ranking of Barriers Types Experienced by Consumers

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

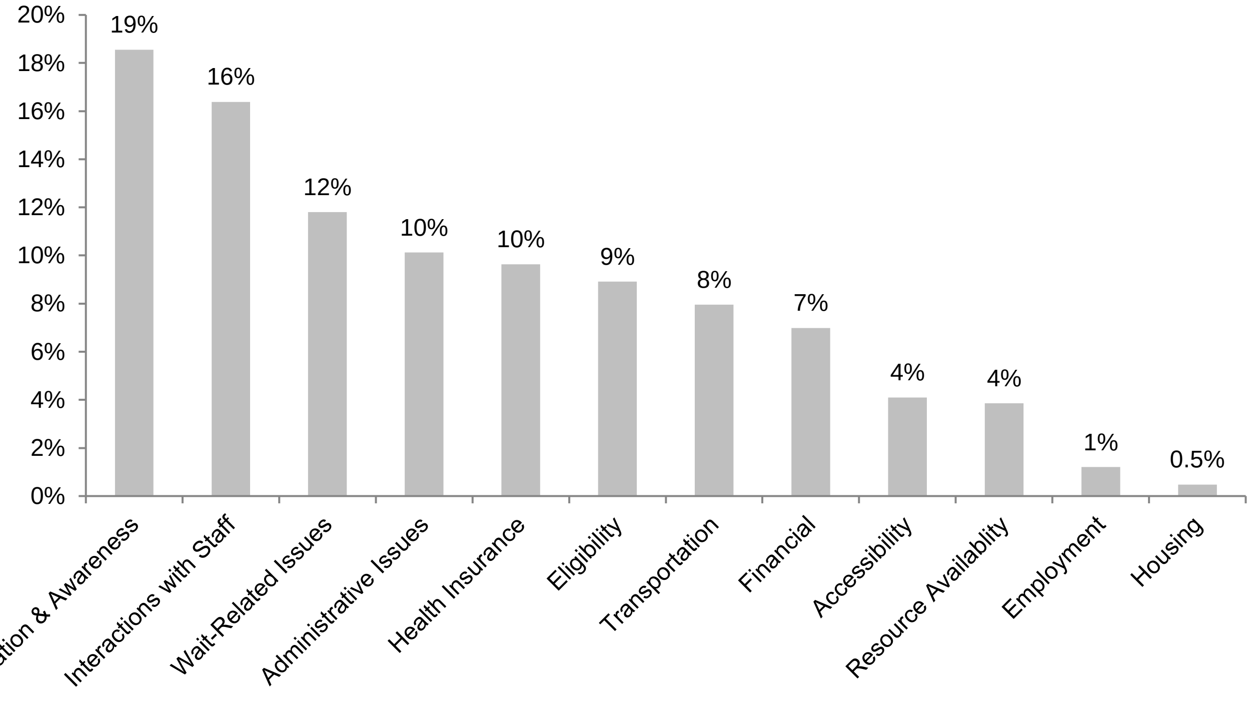
(**Graph 3**) Overall, fewer barriers were reported in 2020 (415 barrier reports) than in previous 2016 needs assessment (501 barrier reports), despite the increase in sample size in 2020. Across all funded services, the barrier types reported most often related to service education and awareness issues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

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

GRAPH 3-Ranking of Types of Barriers to HIV Services in the Houston Area, 2018

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

Denominator: 415 barrier reports



Descriptions of Barriers Encountered

All funded services were reported to have barriers, with an average of 35 reports of barriers per service. Participants reported the least barriers for Linguistic Services (one barrier) and the most barriers for Oral Health Care (90 barriers). In total, 415 reports of barriers across all services were indicated in the sample.

(**Table 1**) Within education and awareness, knowledge of the availability of the service and where to go to access the service accounted for 81% of barriers reported. Being put on a waitlist accounted for a majority (56%) of wait-related barriers. Poor communication and/or follow up from staff members when contacting participants comprised a majority (53%) of barriers related to staff interactions. Forty-five percent (45%) of eligibility barriers related to participants being told they did not meet eligibly requirements to receive the service while redundant or complex processes for renewing eligibility accounted for an additional 39% of eligibility barriers. Among administrative issues, long or complex processes required to obtain services sufficient to create a burden to access comprised most (57%) of the barriers reported.

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

TABLE 1-Barrier Proportions within Each Barrier Type, 2020

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

NEEDS AND ACCESSIBILITY FOR UNFUNDED SERVICES

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

Overall Ranking of Unfunded Services, by Need

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

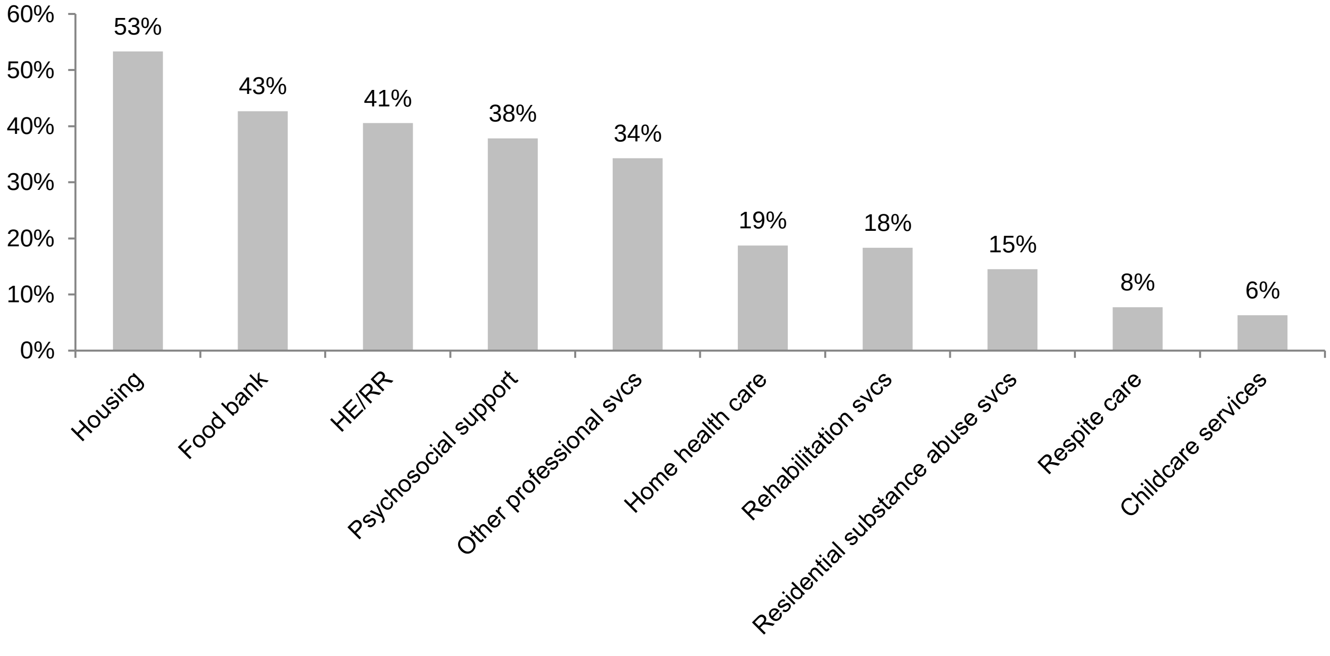
(**Graph 4**) At 53%, housing was the most needed unfunded service in the Houston Area, followed by food bank at 43%, health education/risk reduction at 41%, psychosocial support services at 38%, and other professional services at 34%. Of participants indicating a need for food bank, 69% reported needing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

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

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

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

Denominator: 569-572 participants, varying between service categories



Overall Ranking of Unfunded Services, by Accessibility

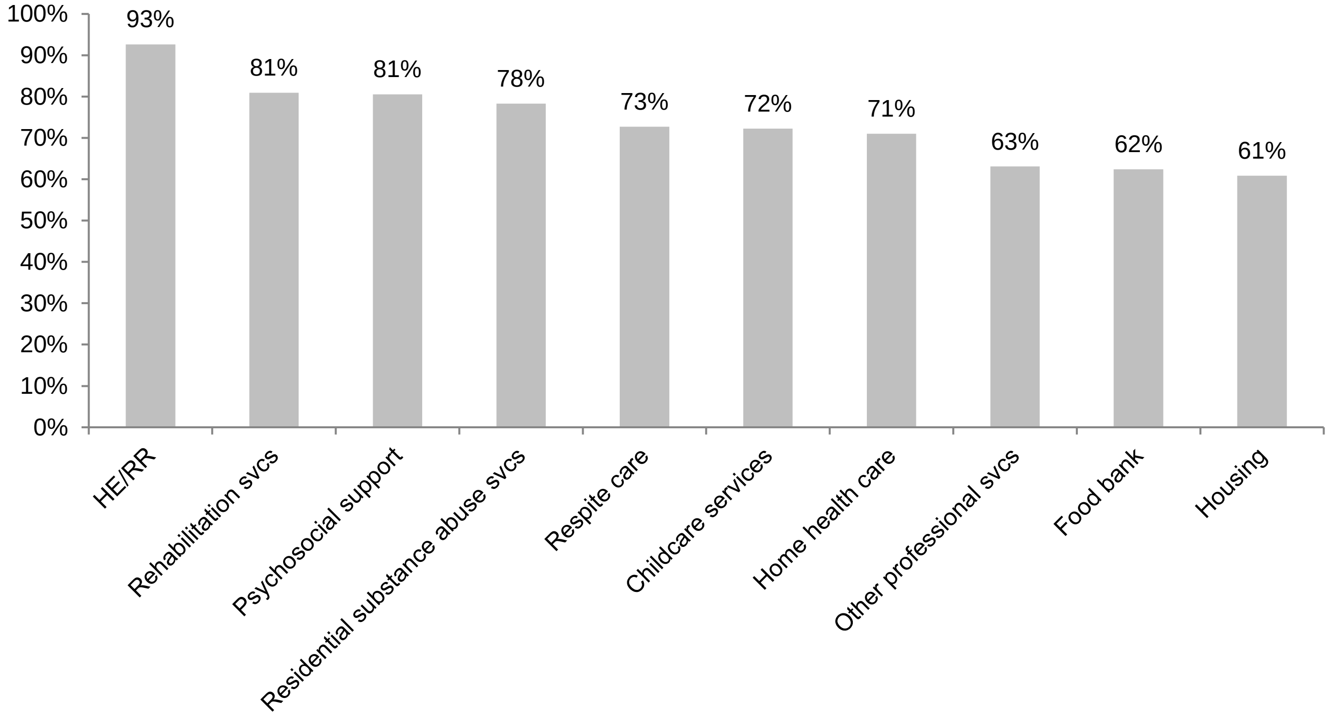
Participants were asked to indicate if each of the unfunded HIV services they needed in the past 12 months was easy or difficult for them to access.

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

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

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

Denominator: 569-572 participants, varying between service categories



Other Identified Needs

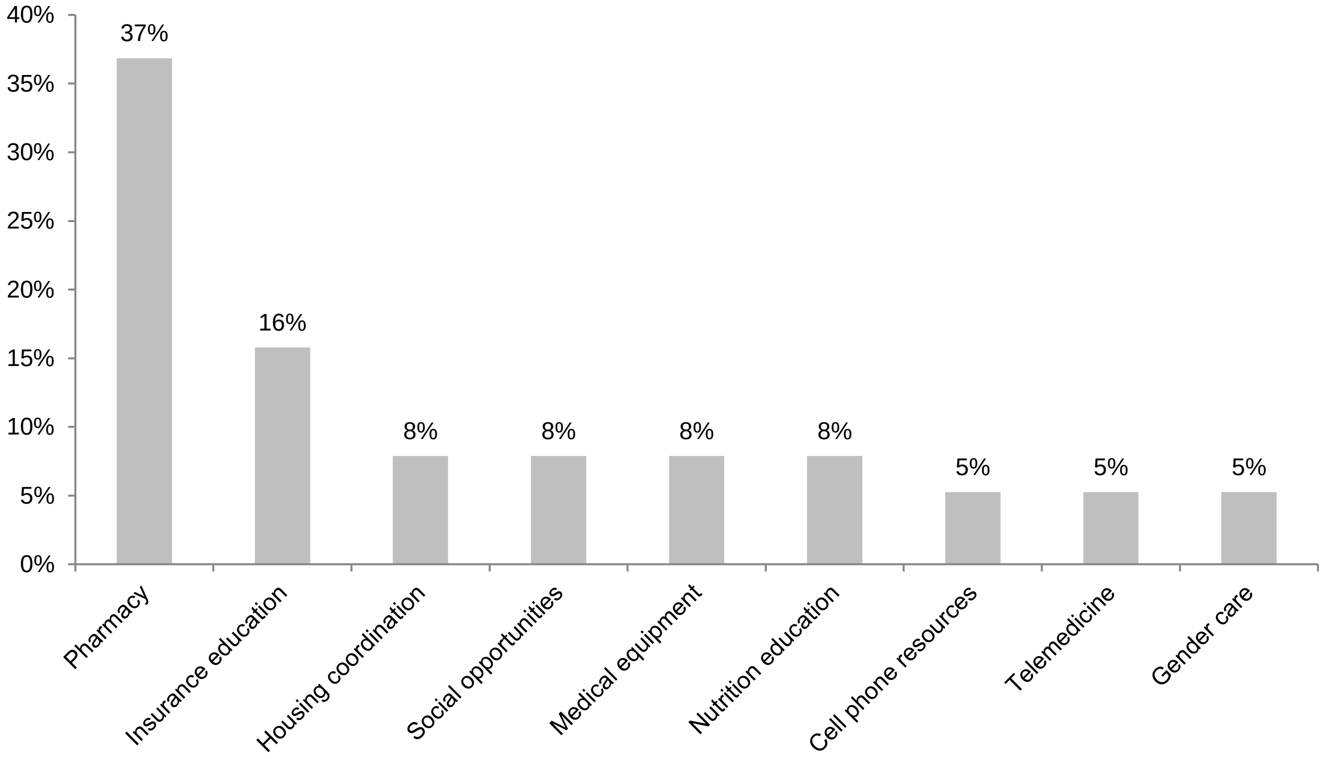
In addition to the allowable HIV services listed above, participants were also encouraged to write-in other types of needed services to gauge any new or emerging service needs in the community.

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

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

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

Denominator: 38 write-in responses



Service-Specific Fact Sheets

ADAP ENROLLMENT WORKER

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

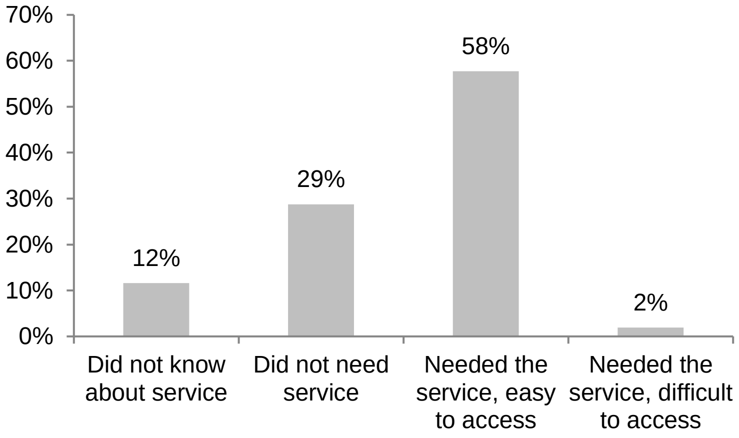
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 60% of participants indicated a need for *ADAP enrollment worker* in the past 12 months. 58% reported the service was easy to access, and 2% reported difficulty. 12% stated they did not know the service was available.

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

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

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

GRAPH 1-ADAP Enrollment Worker, 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 *ADAP enrollment worker*, this analysis shows the following:

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

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

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

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

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

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

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

CASE MANAGEMENT

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

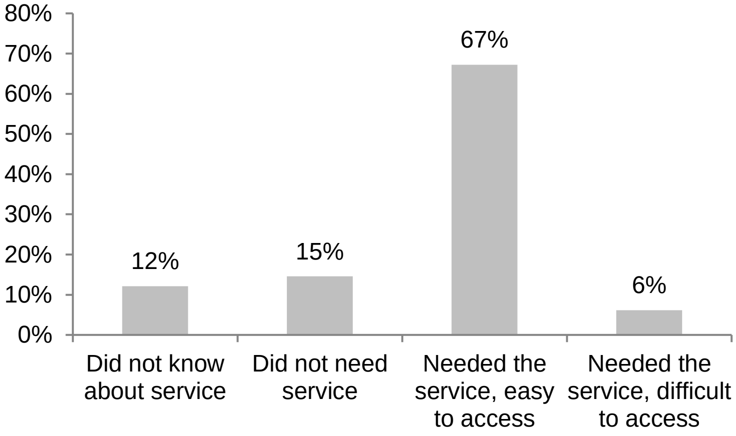
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 73% of participants indicated a need for *case management* in the past 12 months. 67% reported the service was easy to access, and 6% reported difficulty. 12% stated they did not know the service was available.

(**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%

GRAPH 1-Case Management, 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 *case management*, this analysis shows the following:

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

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

TABLE 2-Case Management, by Demographic Categories, 2020

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

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

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

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

LOCAL HIV MEDICATION ASSISTANCE

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

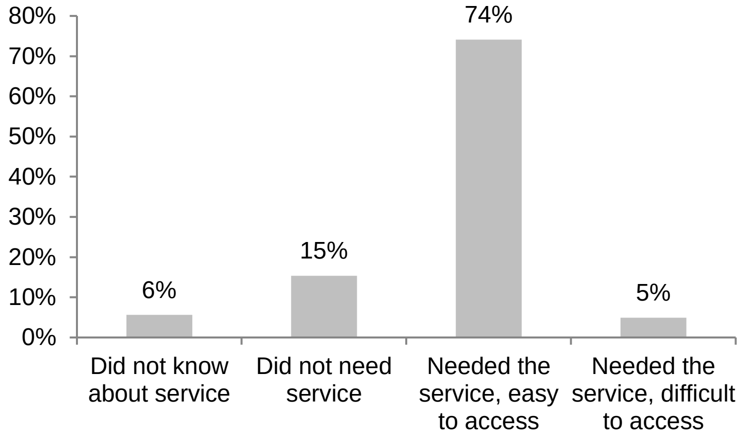
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 79% of participants indicated a need for *local HIV medication assistance* in the past 12 months. 74% reported the service was easy to access, and 5% reported difficulty. 6% stated that they did not know the service was available.

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

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

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

GRAPH 1-Local HIV Medication Assistance, 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 *local HIV medication assistance*, this analysis shows the following:

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

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

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

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

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

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

OUTREACH SERVICES

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

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

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

GRAPH 1-Outreach Services, 2020

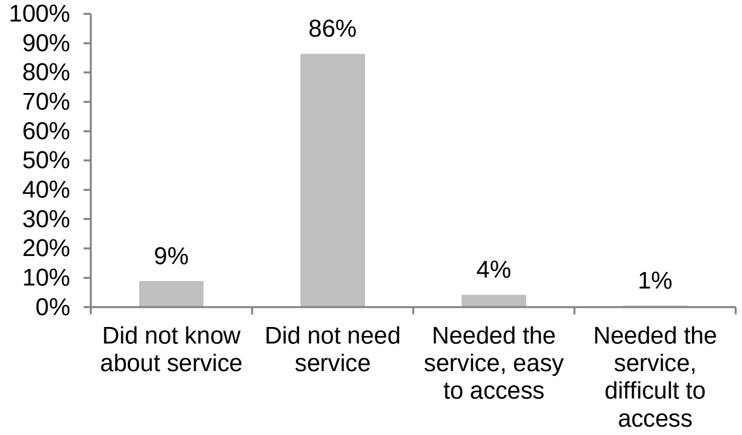


TABLE 1-Top Reported Barrier Type for Outreach Services, 2020

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

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

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

TABLE 2-Outreach Services, by Demographic Categories, 2020

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

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

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

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

PRIMARY HIV MEDICAL CARE

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

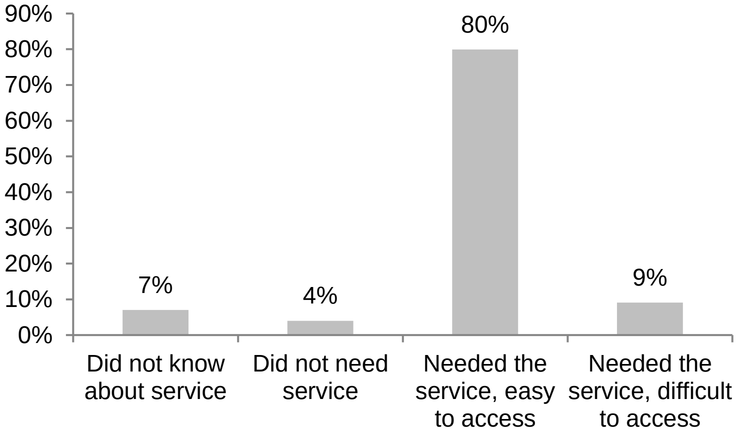
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 89% of participants indicated a need for *primary HIV medical care* in the past 12 months. 80% reported the service was easy to access, and 90% reported difficulty. 7% stated that they did not know the service was available.

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

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

	No.	%
1. Transportation (T)	11	26%
2. Education and Awareness (EA)	8	19%
3. Interactions with Staff (S)	8	19%
4. Eligibility	4	9%
5. Wait (W)	4	9%

GRAPH 1-Primary HIV Medical 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 *primary HIV medical care*, this analysis shows the following:

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

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

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

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

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

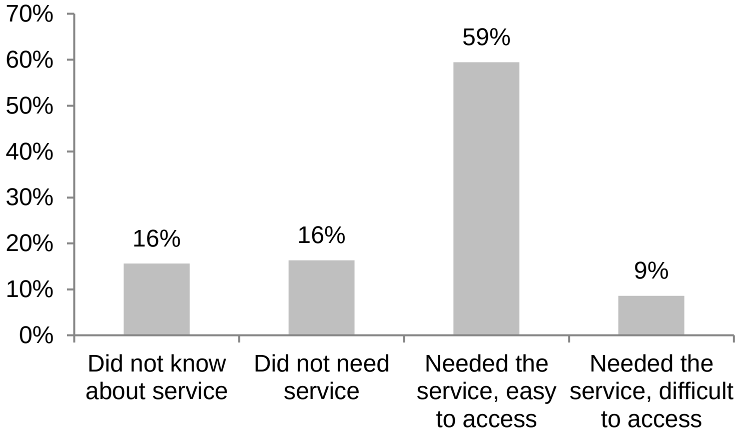
[a] Persons reporting current homelessnes [b] Men who have sex with men [c] Persons with no evidence of HIV care for 12 mo.
[d] Persons released from incarceration in the past 12 mo. [e] Non-Houston/Harris County residents [f] Persons with discordant sex assigned at birth and current gender

VISION CARE

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

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

GRAPH 1-Vision Care, 2020



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

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

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

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

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

TABLE 2-Vision Care, by Demographic Categories, 2020

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

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

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

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

2122 Positive VIBE Project Funding (Houston)

1. Medical Services Subtotal	**$240,107**
a. Outpatient /Ambulatory Health Services	$23,895
b. AIDS Pharmaceutical Assistance (local)	$0
c. Oral Health Care	$0
d. Home Health Care	$0
e. Home and Community-based Health Services	$0
f. Hospice Services	$0
g. Mental Health Services	$24,797
h. Medical Nutrition Therapy	$0
i. Medical Case Management (CC)	$191,415
j. Substance Abuse Services - Outpatient	$0
2. Support Services Sub-total	**$263,173**
a. Case Management (non-Medical) (CC)	$140,815
b. Child Care Services	$0
c. Early Intervention Services	$0
d. Emergency Financial Assistance	$0
e. Food Bank/Home-Delivered Meals	$0
f. Health Education/Risk Reduction (CC)	$29,506
g. Legal Services	$0
h. Linguistics Services	$0
i. Medical Transportation Services*	$19,000
j. Outreach Services (CC)	$15,408
k. Permanency Planning	$0
l. Psychosocial Support Services	$0
m. Referral for Health Care/Supportive Services (CC)	$58,444
n. Rehabilitation Services	$0
o. Respite Care	$0
p. Treatment Adherence Counseling	$0
Total Service Allocations	**$503,280**

*Agency Specific funding

CC = Care Coordination (bundles service interventions for PLWH at a single-point of delivery.)

NMCM includes Non-Medical Case Management and Patient Navigation service interventions.

March 11, 2021

Dear Ryan White Planning Council,

I am writing to secure a commitment from our Council to continue the path our community forged in developing our END HIV Houston plan and use a racial and social justice approach in development of our next Integrated HIV Prevention and Care Plan.

In the June 17, 2020, letter from both Laura Cheever and Eugene MCCray, we were encouraged to ***incorporate our community engagement for the EHE plans and integrated planning activities to the extent that is helpful***. In the same letter, and repeated in the February 2021 letter, we are told our Integrated HIV Prevention and Care Plan will be the umbrella plan for all of our HIV-related resources and activities and the EHE plan should work in conjunction as a subset of focused resources and activities. **This focused subset of resources and activities should take a racial and social justice approach in their development to strengthen the alignment with the EHE and END HIV Houston plan.** The approach is both innovative and disruptive, as we were invited to be in developing our EHE Plan by Dr. Redfield. My evidence for both is two-fold:

a. According to the HHD, their EHE Plan submission to the CDC was the only one taking a racial and social justice approach, which I take as a testament to our foresight and innovation .
b. Dr. Fauci stated in an interview with Terry Gross the mistake, or lost opportunity, made years ago was not addressing HIV via a racial lens and that the same mistake has been repeated with our response to COVID. We can correct this mistake by continuing the community's charge to address our HIV epidemic through a racial and social justice lens. Here is a link to that interview: https://www.npr.org/sections/health-shots/2021/02/04/963943156/fauci-on-vaccinations-and-bidens-refreshing-approach-to-covid-19?sc=18&f=

During the first day of the PACHA meeting, several speakers (Dr. Laura Cheever, Harold Phillips, and Dr. Daskalakis) spoke to the need to be intentional about advancing racial equity and support for underserved communities. A racial and social justice approach will help us accomplish this goal and possibly assist with creating opportunities to discover and/or develop a means to further President Biden's Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. We are practically being invited to continue the path our community forged in the development of the END HIV Plan, a document which infused the Houston Health Department's EHE Plan. https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

As a reminder, Houston created a combined HIV prevention and care services plan about 5 years prior to the Feds mandating it. Four years later, our community prophetically created a *racial and social justice infused community driven plan to end HIV*, about four years before the Feds aired any idea of ending HIV with funding attached to it. On both counts, we did not wait to be told but took advantage of invitations to create our community vision to end HIV in Houston. We should continue leading and not be afraid to commit to taking a racial and social justice approach. As they have demonstrated, HRSA and the CDC eventually catch up when we act as they have done now.

Thank you,

Steven Vargas, (pronouns: He, Him, His, Él)

BRIEFING ROOM

Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government

JANUARY 20, 2021 • PRESIDENTIAL ACTIONS

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered:

Section 1. Policy. Equal opportunity is the bedrock of American democracy, and our diversity is one of our country's greatest strengths. But for too many, the American Dream remains out of reach. Entrenched disparities in our laws and public policies, and in our public and private institutions, have often denied that equal opportunity to individuals and communities. Our country faces converging economic, health, and climate crises that have exposed and exacerbated inequities, while a historic movement for justice has highlighted the unbearable human costs of systemic racism. Our Nation deserves an ambitious whole-of-government equity agenda that matches the scale of the opportunities and challenges that we face.

It is therefore the policy of my Administration that the Federal Government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Affirmatively advancing equity, civil rights, racial justice, and equal opportunity is the responsibility of the whole of our Government. Because advancing equity requires a systematic approach to embedding fairness in decision-making processes, executive departments and agencies (agencies) must recognize and work to redress inequities in their policies and programs that serve as barriers to equal opportunity.

By advancing equity across the Federal Government, we can create opportunities for the improvement of communities that have been historically underserved, which benefits everyone. For example, an analysis shows that closing racial gaps in wages, housing credit, lending opportunities, and access to higher education would amount to an additional $5 trillion in gross domestic product in the American economy over the next 5 years. The Federal Government's goal in advancing equity is to provide everyone with the opportunity to reach their full potential. Consistent with these aims, each agency must assess whether, and to what extent, its programs and policies perpetuate systemic barriers to opportunities and benefits for people of color and other underserved groups. Such assessments will better equip agencies to develop policies and programs that deliver resources and benefits equitably to all.

Sec. 2. Definitions. For purposes of this order: (a) The term "equity" means the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

(b) The term "underserved communities" refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of "equity."

Sec. 3. Role of the Domestic Policy Council. The role of the White House Domestic Policy Council (DPC) is to coordinate the formulation and implementation of my Administration's domestic policy objectives. Consistent with this role, the DPC will coordinate efforts to embed equity principles, policies, and approaches across the Federal Government. This will include efforts to remove systemic barriers to and provide equal access to opportunities and benefits, identify communities the Federal Government has underserved, and develop policies designed to advance equity for those communities. The DPC-led interagency process will ensure that these efforts are made in coordination with the directors of the National Security Council and the National Economic Council.

Sec. 4. Identifying Methods to Assess Equity. (a) The Director of the Office of Management and Budget (OMB) shall, in partnership with the heads of agencies, study methods for assessing whether agency policies and actions create or exacerbate barriers to full and equal participation by all eligible individuals. The study should aim to identify the best methods, consistent with applicable law, to assist agencies in assessing equity with respect to race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability.

(b) As part of this study, the Director of OMB shall consider whether to recommend that agencies employ pilot programs to test model assessment tools and assist agencies in doing so.

(c) Within 6 months of the date of this order, the Director of OMB shall deliver a report to the President describing the best practices identified by the study and, as appropriate, recommending approaches to expand use of those methods across the Federal Government.

Sec. 5. Conducting an Equity Assessment in Federal Agencies. The head of each agency, or designee, shall, in consultation with the Director of OMB, select certain of the agency's programs and policies for a review that will assess whether underserved communities and their members face systemic barriers in accessing benefits and opportunities available pursuant to those policies and programs. The head of each agency, or designee, shall conduct such review and within 200 days of the date of this order provide a report to the Assistant to the President for Domestic Policy (APDP) reflecting findings on the following:

(a) Potential barriers that underserved communities and individuals may face to enrollment in and access to benefits and services in Federal programs;

(b) Potential barriers that underserved communities and individuals may face in taking advantage of agency procurement and contracting opportunities;

(c) Whether new policies, regulations, or guidance documents may be necessary to advance equity in agency actions and programs; and

(d) The operational status and level of institutional resources available to offices or divisions within the agency that are responsible for advancing civil rights or whose mandates specifically include serving underrepresented or disadvantaged communities.

Sec. 6. Allocating Federal Resources to Advance Fairness and Opportunity. The Federal Government should, consistent with applicable law, allocate resources to address the historic failure to invest sufficiently, justly, and equally in underserved communities, as well as individuals from those communities. To this end:

(a) The Director of OMB shall identify opportunities to promote equity in the budget that the President submits to the Congress.

(b) The Director of OMB shall, in coordination with the heads of agencies, study strategies, consistent with applicable law, for allocating Federal resources in a manner that increases investment in underserved communities, as well as individuals from those communities. The Director of OMB shall report the findings of this study to the President.

Sec. 7. Promoting Equitable Delivery of Government Benefits and Equitable Opportunities. Government programs are designed to serve all eligible individuals. And Government contracting and procurement opportunities should be available on an equal basis to all eligible providers of goods and services. To meet these objectives and to enhance compliance with existing civil rights laws:

(a) Within 1 year of the date of this order, the head of each agency shall consult with the APDP and the Director of OMB to produce a plan for addressing:

(i) any barriers to full and equal participation in programs identified pursuant to section 5(a) of this order; and

(ii) any barriers to full and equal participation in agency procurement and contracting opportunities identified pursuant to section 5(b) of this order.

(b) The Administrator of the U.S. Digital Service, the United States Chief Technology Officer, the Chief Information Officer of the United States, and the heads of other agencies, or their designees, shall take necessary actions, consistent with applicable law, to support agencies in developing such plans.

Sec. 8. Engagement with Members of Underserved Communities. In carrying out this order, agencies shall consult with members of communities that have been historically underrepresented in the Federal Government and underserved by, or subject to discrimination in, Federal policies and programs. The head of each agency shall evaluate opportunities, consistent with applicable law, to increase coordination, communication, and engagement with community-based organizations and civil rights organizations.

Sec. 9. Establishing an Equitable Data Working Group. Many Federal datasets are not disaggregated by race, ethnicity, gender, disability, income, veteran status, or other key demographic variables. This lack of data has cascading effects and impedes efforts to measure and advance equity. A first step to promoting equity in Government action is to gather the data necessary to inform that effort.

(a) Establishment. There is hereby established an Interagency Working Group on Equitable Data (Data Working Group).

(b) Membership.

(i) The Chief Statistician of the United States and the United States Chief Technology Officer shall serve as Co-Chairs of the Data Working Group and coordinate its work. The Data Working Group shall include representatives of agencies as determined by the Co-Chairs to be necessary to complete the work of the Data Working Group, but at a minimum shall include the following officials, or their designees:

(A) the Director of OMB;

(B) the Secretary of Commerce, through the Director of the U.S. Census Bureau;

(C) the Chair of the Council of Economic Advisers;

(D) the Chief Information Officer of the United States;

(E) the Secretary of the Treasury, through the Assistant Secretary of the Treasury for Tax Policy;

(F) the Chief Data Scientist of the United States; and

(G) the Administrator of the U.S. Digital Service.

(ii) The DPC shall work closely with the Co-Chairs of the Data Working Group and assist in the Data Working Group's interagency coordination functions.

(iii) The Data Working Group shall consult with agencies to facilitate the sharing of information and best practices, consistent with applicable law.

(c) Functions. The Data Working Group shall:

(i) through consultation with agencies, study and provide recommendations to the APDP identifying inadequacies in existing Federal data collection programs, policies, and infrastructure across agencies, and strategies for addressing any deficiencies identified; and

(ii) support agencies in implementing actions, consistent with applicable law and privacy interests, that expand and refine the data available to the Federal Government to measure equity and capture the diversity of the American people.

(d) OMB shall provide administrative support for the Data Working Group, consistent with applicable law.

Sec. 10. Revocation. (a) Executive Order 13950 of September 22, 2020 (Combating Race and Sex Stereotyping), is hereby revoked.

(b) The heads of agencies covered by Executive Order 13950 shall review and identify proposed and existing agency actions related to or arising from Executive Order 13950. The head of each agency shall, within 60 days of the date of this order, consider suspending, revising, or rescinding any such actions, including all agency actions to terminate or restrict contracts or grants pursuant to Executive Order 13950, as appropriate and consistent with applicable law.

(c) Executive Order 13958 of November 2, 2020 (Establishing the President's Advisory 1776 Commission), is hereby revoked.

Sec. 11. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) Independent agencies are strongly encouraged to comply with the provisions of this order.

(d) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

JOSEPH R. BIDEN JR.

THE WHITE HOUSE,
January 20, 2021.

America: Equity and Equality in Health 3

Structural racism and health inequities in the USA: evidence and interventions

Zinzi D Bailey, Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, Mary T Bassett

Despite growing interest in understanding how social factors drive poor health outcomes, many academics, policy makers, scientists, elected officials, journalists, and others responsible for defining and responding to the public discourse remain reluctant to identify racism as a root cause of racial health inequities. In this conceptual report, the third in a Series on equity and equality in health in the USA, we use a contemporary and historical perspective to discuss research and interventions that grapple with the implications of what is known as structural racism on population health and health inequities. Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources. We argue that a focus on structural racism offers a concrete, feasible, and promising approach towards advancing health equity and improving population health.

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See **Editorial** page 1369

See **Comment** pages 1376 and 1378

This is the third in a **Series** of five papers about equity and equality in health in the USA

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Introduction

Racial and ethnic inequalities, including health inequities, are well documented in the USA (table),[1–5] and have been a part of government statistics since the founding of colonial America.[6–8] However, controversies abound over explanations for these inequities.[6–8] In this report, we offer a perspective not often found in the medical literature or taught to students of health sciences, by focusing on structural racism (panel 1)[9–11] as a key determinant of population health.[9,10,12,13] To explore this determinant of health and health equity, we examine a range of disciplines and sectors, including but not limited to medicine, public health, housing, and human resources. Our focus is the USA.

Although there is growing interest in understanding how social factors drive poor health outcomes,[14] and directed investigation in social science and social epidemiology into the interconnected systems of discrimination,[9,10,12,13] many academics, policy makers, scientists, elected officials, and others responsible for defining and responding to the public discourse remain resistant to identify racism as a root cause of racial health inequities.[9,10,13] For example, in a Web of Science search done on Sept 7, 2016, with the term “race” in conjunction with “health”, “disease”, “medicine”, or “public health”, 47 855 articles were retrieved. However, when “race” was replaced by “racial discrimination”, only 2061 articles were located, and only 1996 articles were found when it was replaced by “racism”. Furthermore, when “race” was replaced by “structural or systematic racism”, only 195 articles were identified (ie, 0·4% of those identified with the search term “race”).

To date, the small body of empirical research on racial discrimination and health has focused primarily on the stress of perceived unfair treatment as experienced by individuals (interpersonal racism).[9,10,12,15–18] Such inequitable suffering matters, but a broad, societal view—one that identifies and seeks to alter how such racism contributes to poor health—is required to understand, prevent, and address the harms related to structural racism. There is a rich social science literature conceptualising structural racism,[8–10,19] but this research has not been adequately integrated into medical and scientific literature geared towards clinicians and other health professionals.[9,10,12,13] In this report, we examine what constitutes structural racism, explore evidence of how it harms health, and provide examples of interventions that can reduce its impact. Our central argument is that a focus on structural racism is essential to advance health equity and improve population health.

Structural racism: a brief introduction

Any account of structural racism within the USA must start with the experiences of black people and the Indigenous people of North America. It was on these two groups that the initial colonisers of North America (the English, French,

Search strategy and selection criteria

An overarching search strategy was not used; instead, we drew on our collective experience and specific searches for different sections to update or amplify the completeness of our review of the published literature. To identify review articles on racism and health, we searched Web of Science, PubMed, and Google Scholar using the search terms “racism AND health” or “racial discrimination AND health” or “structural racism AND health”. Only review articles published in English between Jan 1, 2000, and Feb 23, 2016, were considered. We identified additional sources by performing selected searches in the databases listed above and the Google and DuckDuckGo search engines. These searches were further supplemented from our own knowledge of this subject.

Key messages

- Racial/ethnic health inequities in the USA are well documented, but controversies over explanations of these inequities persist.
- To date, in the small body of empirical research on racism and health, most studies have focused on interpersonal racial/ethnic discrimination, with comparatively less emphasis on investigating the health effects of structural racism.
- Structural racism involves interconnected institutions, whose linkages are historically rooted and culturally reinforced. It refers to the totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable systems (in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, and so on) that in turn reinforce discriminatory beliefs, values, and distribution of resources, which together affect the risk of adverse health outcomes.
- One example of structural racism pertains to the ongoing residential segregation of black Americans, which is associated with adverse birth outcomes, increased exposure to air pollutants, decreased longevity, increased risk of chronic disease, and increased rates of homicide and other crime. Residential segregation also systematically shapes health-care access, utilisation, and quality at the neighbourhood, health-care system, provider, and individual levels.
- Several avenues exist for potentially efficacious solutions, including the use of a focused external force that acts on multiple sectors at once (eg, place-based multisector initiatives such as Purpose Built Communities, Promise Neighborhoods, and Choice Neighborhoods), disruption of leverage points within a sector that might have ripple effects in the system (eg, reforming drug policy and reducing excessive incarceration), and divorcing institutions from the racial discrimination system (eg, by training the next generation of health professionals about structural racism).
- A focus on structural racism offers a concrete, feasible, and promising approach towards advancing health equity and improving population health. Without a vision of health equity and the commitment to tackle structural racism, health inequities will persist.

Dutch, and Spanish) first promulgated genocide and enslavement, and created both legal and tacit systems of racial oppression.[8,20,21] Our report focuses primarily on the experiences of black Americans, since most research on racism and health has focused on this racialised group. We recognise, however, that Native Americans and other people of colour in the USA—including Latinos, Asian Americans, and Pacific Islanders—have also been the target of health-harming racial discrimination, combined with anti-immigrant and religious (eg, anti-Muslim) discrimination.[8] Although issues of immigration and nativism are beyond the scope of this report, our analysis is applicable to the structural discrimination experienced not only by these groups but also by societally defined and racialised groups in other countries with systems of oppression that have led to health inequities.[9,14,16,22]

Racial ideology and the categorisation of racialised social groups

As with many other race-conscious societies, the USA has a long history as a slaveholding republic and as a colonial-settler nation.[8,19–21] The modern concept of "race" emerged at the cusp of the country's nationhood, as early European settlers sought to preserve an economy largely on the basis of the labour of enslaved African people and their descendants while upholding the universal rights of "man".[6,8,19,23,24] To reconcile this contradiction, the colonists established legal categories based on the premise that black and Native American individuals were different, less than human, and innately, intellectually, and morally inferior—and therefore subordinate—to white individuals.[8,19–21,23] Buttressing this concept of racial classification has been a long legacy of now discredited scientific theory and inquiry, constructed around the primary assumption that "race" was an innate and fixed characteristic and an inherently hierarchical category.[6,8,9,19,23] This manufactured concept of race used ostensibly visible phenotypic characteristics and ancestry to justify systems of oppression and privilege.[6,8,19] Similar processes in other racialised societies, such as those of South Africa and Brazil, have produced country-specific racial hierarchies, which ascribe human value on the basis of proximity to whiteness.[22] Furthermore, since the 18th century, scientific racism rooted in Aryan or white supremacy became a blueprint for many other manifestations of society-specific scientific racism around the world.[6,22,25]

The continuing role of ostensibly colour-blind laws and policies

In the USA, since the passage of the 1960s civil rights laws,[8,20] government complicity in the promotion of racial discrimination is typically viewed as belonging to the past. Examples of such de jure discrimination include the legalisation and enforcement of slavery, the Jim Crow laws enacted in the 1870s (which legalised racial discrimination in reaction to the civil rights and social gains attained by the newly freed black population in the short Reconstruction period after the US Civil War), the forcible removal of Indigenous people from their lands, and the forcible transfer of Indigenous children from their families to punitive so-called boarding schools designed to strip them of their culture.[8,19–21,26,27]

However, this standard view overlooks the long reach of past practices and the impact of contemporary practices of institutional racism in both the public and private sector; such practices have been and continue to be realised by purportedly colour-blind policies that do not explicitly mention "race" but bear racist intent or consequences, or both.[28–30] Institutional racism in one sector reinforces it in other sectors, forming a large, interconnected system of structural racism whereby unfair discriminatory practices and inequities in the health and criminal justice systems and in labour and housing markets bolster unfair discriminatory practices and inequities in the educational system, and vice versa.[10] One key example, with ongoing intergenerational effects, is the historic Social Security Act of 1935, which created an important system of employment-based old-age insurance and unemployment compensation.[8,20] The Act also, however, deliberately excluded agricultural workers and domestic servants—occupations largely held by black men and women. This accommodation was made to secure the votes of Democrats in the South and thus ensure passage of the

	Total	White non-Hispanic	Asian*	Hispanic or Latino	Black non-Hispanic†	Native American or Alaska Native
Wealth: median household assets (2011)	$68 828	$110 500	$89 339	$7683	$6314	NR
Poverty: proportion living below poverty level, all ages (2014); children <18 years (2014)	14·8%; 21·0%	10·1%; 12·0%	12·0%; 12·0%	23·6%; 32·0%	26·2%; 38·0%	28·3%; 35·0%
Unemployment rate (2014)	6·2%	5·3%	5·0%	7·4%	11·3%	11·3%
Incarceration: male inmates per 100 000 (2008)	982	610	185	836	3611	1573
Proportion with no health insurance, age <65 years (2014)	13·3%	13·3%	10·8%	25·5%	13·7%	28·3%
Infant mortality per 1000 livebirths (2013)	6·0	5·1	4·1	5·0	10·8	7·6
Self-assessed health status (age-adjusted): proportion with fair or poor health (2014)	8·9%	8·3%	7·3%	12·2%	13·6%	14·1%
Potential life lost: person-years per 100 000 before the age of 75 years (2014)	6621·1	6659·4	2954·4	4676·8	9490·6	6954·0
Proportion reporting serious psychological distress‡ in the past 30 days, age ≥18 years, age-adjusted (2013–14)	3·4%	3·4%	3·5%	1·9%	4·5%	5·4%
Life expectancy at birth (2014), years	78·8	79·0	NR	81·8	75·6	NR
Diabetes-related mortality: age-adjusted mortality per 100 000 (2014)	20·9	19·3	15·0	25·1	37·3	31·3
Mortality related to heart disease: age-adjusted mortality per 100 000 (2014)	167·0	165·9	86·1	116·0	206·3	119·1

NR=not reported. *Economic data and data on self-reported health and psychological distress are for Asians only; all other health data reported combine Asians and Pacific Islanders. †Wealth, poverty, and potential life lost before the age of 75 years are reported for the black population only; all other data are for the black non-Hispanic population. ‡Serious psychological distress in the past 30 days among adults aged 18 years and older is measured using the Kessler 6 scale (range=0–24; serious psychological distress: ≥13). Sources: wealth data taken from the US Census;[1] poverty data for adults taken from the National Center for Health Statistics,[2] and poverty data for children taken from the National Center for Education Statistics;[3] unemployment data taken from the US Bureau of Labor Statistics;[4] incarceration data taken from the Kaiser Family Foundation;[5] data on uninsured individuals taken from the National Center for Health Statistics;[2] data on infant mortality, self-assessed health status, potential life lost, serious psychological distress, life expectancy, diabetes-related mortality, and mortality related to heart disease taken from the National Center for Health Statistics.[2]

***Table*: Social and health inequities in the USA**

Act. This racially motivated exclusion afforded the primarily white recipients additional opportunities to acquire wealth and pass it on to their children, while those excluded were unable to do so and instead often became dependent on their children after retirement, thereby further curtailing the intergenerational accumulation of assets.[8,20] The net result has been an entrenchment of racial economic inequities that persist to this day.[8,10,20,29,30]

Another example is the War on Drugs and tough-on-crime policies enacted in the 1970s and 1980s (labelled "The new Jim Crow").[28] Without ever referring to "race" by itself, these policies stereotyped black Americans as drug addicts—despite similar prevalence of illicit drug use among white Americans—and disproportionately targeted black people for incarceration.[28,30] The legacy of these policies is that the annual rate of incarceration of black men is 3·8–10·5 times greater than that of white men, across all age groups;[31] moreover, in 2014, almost 3% of all black men in the USA were serving sentences of at least 1 year in prison.[31]

Panel 1: Definitions of structural racism and institutional racism

Many academics use structural racism and institutional racism interchangeably, but we consider these terms as two separate concepts.

Structural racism refers to "the totality of ways in which societies foster [racial] discrimination, via mutually reinforcing [inequitable] systems...(eg, in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc) that in turn reinforce discriminatory beliefs, values, and distribution of resources", reflected in history, culture, and interconnected institutions.[9] This definition is similar to the "über discrimination" described by Reskin.[10]

Within this comprehensive definition, institutional racism refers specifically to racially adverse "discriminatory policies and practices carried out...[within and between individual] state or non-state institutions" on the basis of racialised group membership.[9]

Some of these institutional policies and practices explicitly name race (eg, de jure Jim Crow laws, which required schools and medical facilities to be racially segregated, and restricted certain neighbourhoods to be white-only), but many do not (eg, employer practices of screening applications on seemingly neutral codes, such as telephone area codes or ZIP codes, because of presumptions about which racial groups live where).[11]

Structural racism in the private sector

Institutional racism also continues unabated in the private sector, especially in housing and employment, underpinning the structural racism of the ostensibly colour-blind policies in the public sector.[32–34] In their review of the evidence on discrimination in four domains (employment, housing, credit markets, and consumer markets), Pager and Shepherd[33] argue that discrimination in the rental and housing markets against black and Latino communities remains pervasive, even though intentional redlining is no longer legal (the term redlining is derived from the legal practice initiated in 1934 by the Federal Housing Administration, which involved marking maps with red lines to delineate neighbourhoods where mortgages were denied to marginalised, racialised groups to steer them away from

Panel 2: Pathways between racism and health[9,12,13,16–18]

Economic injustice and social deprivation[8,9,12,32–35]

Examples include residential, educational, and occupational segregation of marginalised, racialised groups to low-quality neighbourhoods, schools, and jobs (both historical de jure discrimination and contemporary de facto discrimination), reduced salary for the same work, and reduced rates of promotion despite similar performance evaluations

Environmental and occupational health inequities[9,36–38]

Examples include strategic placement of bus garages and toxic waste sites in or close to neighbourhoods where marginalised, racialised groups predominantly reside, selective government failure to prevent lead leaching into drinking water (as in Flint, MI, in 2015–16), and disproportionate exposure of workers of colour to occupational hazards

Psychosocial trauma[9,15,16,18]

Examples include interpersonal racial discrimination, micro-aggressions (small, often unintentional racial slights and insults, such as a judge asking a black defence attorney "Can you wait outside until your attorney gets here?"), and exposure to racist media coverage, including social media

Targeted marketing of health-harming substances[9,30,39]

Examples include legal substances such as cigarettes and sugar-sweetened beverages, and illegal substances such as heroin and illicit opioids

Inadequate health care[9,17,40–45]

Examples include inadequate access to health insurance and health-care facilities, and substandard medical treatment due to implicit or explicit racial bias or discrimination

State-sanctioned violence and alienation from property and traditional lands[9,21,30,46–48]

Examples include police violence, forced so-called urban renewal (the use of eminent domain to force the relocation of urban communities of colour), and the genocide and forced removal of Native Americans

Political exclusion[49,50]

Examples include voter restrictions (eg, for former felons and through identification requirements)

Maladaptive coping behaviours[9,16,18]

Examples include increased tobacco and alcohol consumption on the part of marginalised, racialised groups

Stereotype threats[15–18]

Examples include stigma of inferiority, leading to physiological arousal, and an impaired patient–provider relationship

white neighbourhoods). Additionally, strong evidence from experimental audit studies reveals continued racial discrimination in hiring decisions. In one study that used identical résumés, which differed only in the name of the applicant, hiring managers called back those with traditionally white names (eg, Brad or Emily) 50% more often than those with traditionally black names (eg, Jamal or Lakisha).[33] In another study that used mailed résumés, white applicants with criminal records were called back more often than were black applicants without criminal records.[33] Ongoing de facto racial segregation in the workforce is partly why black Americans, on average, have lower wages than those of white Americans.[35]

As this brief summary suggests, structural racism is an ongoing—and not just historical—concern across multiple systems. We next consider the implications of such systemic racism on population health.

Health consequences of structural racism: evidence and evidence gaps

Contemporary scholarship has established multiple pathways by which racism harms health, involving adverse physical, social, and economic exposures, as well as maladaptive coping behaviours and stereotype threats (panel 2).[9,12,13,15–18,21,30,32–50] Typically concurrent, these exposures can accumulate over the life course and across generations.

To date, research on racial discrimination and health has focused primarily on interpersonal discrimination as a psychosocial stressor.[9,16–18] The strongest evidence in the scientific literature is for adverse effects on psychological wellbeing, mental health, and related health practices (eg, sleep disturbance, eating patterns, and the consumption of psychoactive substances, including cigarettes, alcohol, and drugs), as summarised in panel 3.[9,12,15,16,18,35,51–58] Furthermore, growing research is linking interpersonal racism to various biomarkers of disease and wellbeing, including allostatic load, inflammatory markers, and hormonal dysregulation.[16,18]

Here, we focus instead on adverse health effects of structural racism through two distinct but related pathways emphasised in the literature: residential segregation and health-care quality and access.[9,12,13,18] Both of these pathways include actionable leverage points to reduce exposure and promote health equity. A third relevant pathway, discriminatory incarceration,[28,30,35] is only briefly mentioned since it is discussed elsewhere in this Series by Wildeman and Wang.[59]

Residential segregation

As a reflection and reinforcement of structural and institutional racism, most residents in the USA have grown up in, and continue to live in, racialised and economically segregated neighbourhoods.[29,33,34,60] Analysis of 2010 US Census data has found that "the average white person in metropolitan America lives in a neighborhood that is 75% white", whereas "a typical African American lives in a neighborhood that is only 35% white (not much different from 1940) and as much as 45% black".[61] The literature on racial residential segregation and poor health[32,34,36,37,62–68] examines several direct and indirect pathways through which structural racism harms health, including the high concentration of dilapidated housing in neighbourhoods that people of colour reside in,[62,63] the substandard quality of the social[64] and built[65] environment, exposure to pollutants and toxins,[36,37,65] limited opportunities for high-quality education and decent employment,[34,66] and restricted access to quality health care.[65] Health outcomes associated with residential segregation documented

Panel 3: Dominant approaches to studying racial discrimination as a psychosocial stressor and associated adverse health outcomes, with counterexamples of research on measures of structural racism

Racism and stress

To date, racism has primarily been conceptualised as a psychosocial stressor in the health science literature, and the strongest and most consistent evidence of its adverse health effects concerns mental health, as detailed in several comprehensive, systematic reviews.[9,12,15,16,18] In one such review,[16] published in 2015, the authors found that self-reported racism was positively associated with increased levels of negative mental health, including all individual mental health outcomes except for positive affect (eg, depression, anxiety, distress, psychological stress, negative affect, and post-traumatic stress), and negatively associated with positive mental health (eg, self-esteem, life satisfaction, control and mastery, and wellbeing). After adjusting for publication bias, the association between reported racism and mental health remained twice as large as that for physical health, which was driven primarily by obesity outcomes. There is growing evidence that experiences of racism are associated with poor sleep outcomes, which could be linked to both mental and physical health.[51]

Stress pathways

Much of the research on interpersonal racism and health has posited that racism is a social stressor that operates through diverse stress pathways, including physiological, psychological, and behavioural pathways. Experiences that are perceived as racist act as social stressors, which can initiate a set of neurobiological and behavioural responses (ie, coping behaviours) that can affect mental and physical health. These experiences can be chronic and include everyday hassles of receiving poor service at restaurants, being followed or not helped in stores, and generally being treated with less respect and consideration than others. Acute experiences of violence, harassment, and other threatening behaviour are also included in this category. However, although such exposures are most likely to garner media attention, the common, chronic experiences of discrimination are more consistently associated with poor health outcomes than are acute experiences,[9,15,16,18] probably reflecting how brain chemistry and general metabolism change in response to chronic stressors.[15] There is burgeoning evidence linking experiences of discrimination to biomarkers of disease and wellbeing, including allostatic load, telomere length, cortisol dysregulation, and inflammatory markers.[9,16,18]

Reliance on self-reports of exposure to racial discrimination

Most of the research on racial discrimination and health has relied on self-reported measures, although some studies have used vignettes or experimental situations. Evidence suggests that because of well known cognitive biases, including social desirability, self-reported data are likely to provide an underestimate of actual exposure, leading to underestimates of the magnitude of the association of racial discrimination with, and its impact on, adverse health outcomes.[9,18] Some immigrant groups, moreover, might be less likely than others to recognise racist interactions, or less likely to attribute discriminatory behaviour to racism as opposed to language skills, immigration status, or chance.[9,52]

Counterexamples of research on measures of structural racism

Although small in comparison with psychosocial approaches, an emerging body of research has begun to investigate the relationship between health and four domains of state-level structural racism: political participation, employment and job status, educational attainment, and judicial treatment, including incarceration.[9,12,16,35,53–58] Black people living in states with higher levels of structural racism in these domains were more likely than those living in states with lower levels of structural racism to self-report a myocardial infarction in the previous year; meanwhile, the same association for white people was null or protective.[57] Another study that used the same measures found a positive association between structural racism at the state level and the odds of births that were small for gestational age in both black and white women.[58] Such measures could be used to build the evidence base regarding the connections between structural and institutional racism and health, and highlight areas for intervention. Priority should be given to expanding this type of research.

among black Americans include adverse birth outcomes,[32] increased exposure to air pollutants,[36] decreased longevity,[34,66] increased risk of chronic disease,[32,34,64] and increased rates of homicide and other crime.[66,67] These adverse outcomes far outweigh any benefits deriving from social support or political power that accrue from the clustering of black Americans (or other oppressed racialised groups) in adjoining neighbourhoods.[63,68] Residential segregation is thus a foundation of structural racism and contributes to racialised health inequities.

Moreover, analysis of residential segregation requires addressing the intertwined occurrences of residential segregation by both racialised group and class.[60,69,70] In the USA there has been a shift from macrosegregation to microsegregation, whereby "blacks and whites became more evenly distributed across states and counties during the first two-thirds of the twentieth century, [and]…less evenly distributed at the city and neighborhood levels".[60] Highlighting the need to think about smaller geographies, researchers have also noted that, as income inequality has increased, people at the top and bottom of the socioeconomic distribution have increasingly become spatially isolated,[69,70] such that "middle-class blacks are less able than their white counterparts to translate their higher economic status into desirable residential conditions".[34]

In recognition of the trend towards microsegregation and increased social polarisation, public health researchers have recently begun to use the Index of Concentration at the Extremes (ICE).[70] This measure was introduced into the sociological literature in 2001[69] and was designed to measure economic polarisation—the extent to which a population is concentrated into the extremes of wealth or impoverishment—by taking the difference between the number of affluent and poor households in an area and dividing it by the total number of households in the area.[70] Moreover, these areas can be measured at multiple levels (eg, census tract, city neighbourhood, and county). New innovations include the development of an ICE for racialised economic segregation, which uses data on the joint distribution of income and race/ethnicity. Research done in New York City, for example, has shown that ICE measures that captured both income and racialised group yielded larger risk ratios, at both the neighbourhood and census tract levels, for infant mortality, premature mortality, and diabetes mortality than an ICE solely for income or the poverty level.[70]

Underscoring the need for explicit analysis of the health burden of residential segregation (regardless of how it is measured) and neighbourhood disinvestment, there is evidence to suggest that these structurally driven, place-based exposures harm economic opportunity and, when coupled with inadequate gun control, contribute to the lethal burden of gun violence and crime in predominantly black and Latino neighbourhoods[71,72] and in impoverished Native American reservations.[21] In turn, the violence and crime in these neighbourhoods reinforces the intergenerational legacy of racialised punitive policing,[8,20,21,28,31] perpetuating vicious cycles of further community depletion and adverse health outcomes.[8,9,28,30,31,35,59]

Discriminatory incarceration

The penal institutions that constitute the US criminal justice system—police departments, court systems, correctional agencies, parole and probation departments, and sentencing boards—have established policies and practices that are ostensibly colour-blind yet they criminalise communities of colour (eg, through day-to-day practices such as stop and frisk) and disproportionately incarcerate black men, women, and children.[30] As reviewed in this Series by Wildeman and Wang,[59] each component of the criminal justice continuum—from arrest to re-entry—carries various health consequences, and a growing body of literature has documented severe adverse health outcomes associated with incarceration on the individual, their families, and neighbourhoods. What should not be lost in the explication of these outcomes is their roots in structural racism; the present disproportionate representation of black people in the penal system is reminiscent of the Black Codes and convict leasing practices from the colonial period.[8,26] New freedoms afforded to black people following the US Civil War were promptly undone by laws that selectively criminalised unemployment, vagrancy, and loitering.[26] The resultant prison population effectively re-established free labour for Southern states to rebuild infrastructure.[73] The effects of mass incarceration, as traced by Wildeman and Wang[59] from the 1970s, are best understood as a continuation of racialised imprisonment[8,10,20] rather than as an emergent process.[28] Moreover, as noted previously, strong feedback mechanisms exist between inequities in incarceration, employment, and health on a population level.[30,35,59]

Health-care quality and access

Interpersonal racism, bias, and discrimination in health-care settings can directly affect health through poor health care. Almost 15 years ago, the Institute of Medicine Report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*[40] documented systematic and pervasive bias in the treatment of people of colour, resulting in substandard care. Evidence continues to support this finding.[41–44]

However, it would be short sighted to view these problems solely as a matter of institutional and interpersonal discrimination within health-care settings.[17,40–44] Instead, it is essential to understand the broad context within which health-care systems operate, including the potentially disparate settings in which health-care professionals and their patients reside. Specifically, residential segregation systematically shapes health-care access, utilisation, and quality at the neighbourhood, health-care system, provider, and individual levels.[45] The socioeconomic disadvantage resulting from systematic disinvestment in public and private sectors renders it difficult to attract primary-care providers and specialists to predominantly black neighbourhoods.[40,45] Likewise, health-promoting resources are inadequately invested into these neighbourhoods. Health-care infrastructure and services are inequitably distributed, resulting in predominantly black neighbour hoods having lower-quality facilities with fewer clinicians than those in other neighbourhoods. Moreover, most of these clinicians have lower clinical and educational qualifications than those in other neighbourhoods. This inequitable system is likely to disproportionately expose black residents to racially biased services.[45]

Addressing structural racism to advance health equity

Although efforts to counter institutional racism and residential segregation in the housing market and medical care system require initiatives focused on these institutions, such initiatives are not sufficient. Also needed is intersectoral work, especially that which is guided by transdisciplinary frameworks and action. Analytical insights derived from a systems perspective suggest several avenues for efficacious solutions, including the use of a focused external force that acts on multiple subsystems (ie, sectors) at once, disruption of leverage points (ie, key points of intervention within a sector that could be important for maintenance of the system, both within and outside the particular sector in question), and divorcing institutions from the racial discrimination system.[10] We highlight some promising, concrete, intersectoral examples of each of these types of solutions, which have the potential to reduce, if not remove, the burden of structural racism on population health.

Place-based, multisector, equity-oriented initiatives

Health and health equity are substantially influenced by the places where people live, work, play, and pray.[14] Yet, the USA has high levels of racialised economic segregation.[69,70] Within this context, multisector, place-based partnerships focusing on equity can be an effective means of placing pressure on the systems of structural racism operating in a specific geographical region. Place-based initiatives create structures for reinvesting in neighbourhoods that have long been sidelined. Several initiatives have combined public and private partners from multiple sectors to achieve community-specific changes.[74] These community-specific, multisector interventions that seek neighbourhood-wide coverage have thus far focused primarily on predominantly black and Latino neighbourhoods, and also on Native American reservations, that have experienced high levels of poverty, health-limiting built environments, and substandard resources for schools and housing as a result of generations of structural racism.

Established in 2009, Purpose Built Communities is exploring the redevelopment of more than 20 high-need neighbourhoods with the use of a model based on their original 1995 development site: the East Lake neighbourhood of Atlanta, GA.[74] About 20 years ago, a private philanthropist partnered with the president of the Atlanta Housing Authority, a resident leader, and several community business leaders to revitalise the area by razing a violent, poorly maintained public housing development and rebuilding a new mixed-income development, which involved temporary displacement of residents during construction. Unlike other attempts at rebuilding public housing, this development's planning and rollout was organised and backed by a dedicated non-profit and focused on high-quality construction and on safe walkways and streets. The effort included a cradle-to-college educational curriculum, and a combination of facilities, programmes, and services prioritised by community residents to promote healthy behaviours, create jobs, and reduce crime in the short term, and break the cycle of intergenerational poverty concentrated in this community in the long term.[74]

With active involvement of community residents, by 2015, crime had declined by 95% (compared with a 50% overall decline in Atlanta), the employment rate among families in public housing increased from 13% to 70%, capital investments increased from no investment (over the course of 30 years before the project) to US$123 million, property values in the surrounding area increased, and new grocery stores, banks, and other businesses opened.[74] The evidence of changes in the social determinants related to health inequities is striking; to date, no health impact assessment has been done, although it is clearly warranted. Future place-based interventions should build in health equity impact assessments from the start. Two federal initiatives launched in 2010 have followed similar principles: the US Department of Education's Promise Neighborhood initiative and the US Department of Housing and Urban Development's Choice Neighborhood initiative. Results of health impact assessments are eagerly awaited.

For more on **Promise Neighhorhoods** see https://www2.ed.gov/programs/promiseneighborhoods/index.html

For more on **Choice Neighborhoods** see https://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/ph/cn

Short of full-scale community redevelopment, data suggest that improvements in housing lead to improvements in health. In New York City, individuals and families on a low income are able to enter lotteries for affordable housing units. Data from the New York City Housing and Neighborhood Study,[75] which assessed the impact of re-housing on those who won the lottery compared with those who did not, showed reductions in depression and asthma exacerbations. Although results among adolescents were mixed, findings from the Moving to Opportunity study,[76,77] in which vouchers for housing were randomly allocated, suggest that housing mobility policies that enable voluntary movement out of deprived neighbourhoods can result in long-term improvements in health and social outcomes.

Building government and public support for large-scale initiatives to counter structural racism is both necessary and possible. In May, 2016, the Government Alliance for Race and Equity (GARE) and the non-profit Living Cities jointly launched Racial Equity Here, a $3 million initiative to help five cities (Albuquerque, NM, Austin, TX, Grand Rapids, MI, Louisville, KY, and Philadelphia, PA) improve racial equity, building on approaches such as Seattle's Race and Social Justice Initiative, which has explicitly recognised the links between racial equity and health equity.[78] As the Mayor of Austin, Steve Adler, noted, "Government helped create a lot of the inequities, it institutionalized them. It's important for the government, the city government to address racial inequity, not just because of the conditions, but also because we helped create it."[78]

For more on **Seattle's Race and Social Justice Initiative** see http://www.seattle.gov/rsji

Advocating for policy reform

With the recognition that mass incarceration is a system used to subordinate black people,[10,28,30] efforts to reduce discriminatory criminal sanctions on drug use (a leverage point) are also beginning to gain traction. From the 1980s to 2010, the federal government sentencing guidelines mandated penalties for crimes related to crack cocaine (a cheaper formulation more common in black communities than in other communities) that were 100 times harsher than sentences for crimes involving the pharmacologically identical substance in powder form, effectively targeting black people for prolonged prison sentences.[30] In the first sentencing breakthrough in decades—the Fair Sentencing Act of 2010—the crack-to-powder penalty ratio was reduced to 18:1, shrinking the disparity but not eliminating it.[30] Meanwhile, prescription opioids, which are fuelling the current opioid epidemic among white people, have been relatively unregulated. It was not until opioid addicts from white communities started being incarcerated and dying in large numbers that the national narrative shifted from penalisation to treatment—a clear demonstration of the racialised nature of the War on Drugs.[79]

The past decade has also witnessed new bipartisan efforts, across the country, to reduce the number of people who are imprisoned. For example, California has sought to address its unconstitutionally overcrowded prisons through several legislative initiatives, including Proposition 47.[80] This ballot initiative, passed in November, 2014, commutes drug possession felonies (and a few minor offenses) to misdemeanours. It also allows people serving a sentence for an eligible felony conviction to petition the court for resentencing. With the disproportionate impact of drug arrests, prosecutions, and convictions on black and Latino men and women, Proposition 47 is likely to reduce racial inequities in sentencing. Since 2014, more than 4000 people have been released under this initiative and California has reduced overcrowding in prisons; however, racial inequities and health effects have not yet been assessed.[81]

Training the next generation of health professionals

Structural racism has developed over centuries and is deeply embedded in the thoughts and behaviours of people in the USA and other countries,[6,8,10,22,25] with its influence extending to how health sciences are taught and the routine practices of health agencies and health-care providers.[6,7,13,82–85] An analysis of structural racism is required to recognise these problems and change them. Fortunately, a new wave of public health and medical students, galvanised by protests over police killings and the Black Lives Matter movement, have been advocating to ensure that medical and public health schools incorporate essential pedagogy about racism and health into standard coursework, as one step towards divorcing medical and public health institutions from their supportive roles in the system of structural racism.[13,82–84,86] Similarly, several public health agencies have begun to reform their institutional structure and organisational culture.

The standard practice for teaching about race and health in medical and public health schools is one in which race is often discussed, but conversations about racism are sidelined, with scant hours (if any) devoted to social epidemiologists, medical anthropologists, social scientists, or historians who focus on racism and health.[82–84] Few scientific and medical textbooks include discussions of how racism affects the conceptualisation of race or an analysis of racial inequality in relation to health and other outcomes.[85] Although many medical schools now include diversity training and provide instruction on cultural competency, such instruction is often brief (and sometimes delivered online). Moreover, the programmes typically focus on individual responsibility to counteract interpersonal discrimination; the goal is for individuals to increase their sensitivity to, and knowledge about, other racial/ethnic groups.[87,88] The emphasis is therefore on “others”, in a way that could inadvertently contribute to racial stereotyping, as opposed to critical self-reflection about the participants’ positions in their societies’ race relations.

By contrast, approaches based on structural competency,[83] cultural humility,[89] and cultural safety[46,90,91]—which have been implemented in health professionals’ training in several countries such as Canada and New Zealand—encourage a lifelong commitment to self-reflection and mutual exchange in engaging power imbalances along the lines of cultural differences. These approaches emphasise the value of gaining knowledge about structural racism, internalised scripts of racial superiority and inferiority, and the cultural and power contexts of health professionals and their patients or clients. Tying interactions between patients and health-care providers to population-level inequalities requires skilled instruction and considerable time, far beyond that patched together for short training courses in cultural competency.[83] These approaches also require that health professionals be informed by scholarship from diverse disciplines about the origins and perpetuation of—as well as remedies to counter—structural racism. It remains the charge of those committed to exploring and reversing structural racism to connect how these forms of social inequality translate into health and health-care inequities, within and across generations.[9,13,82,86]

Professional education about structural racism after graduate school also matters, especially for clinical and public health practitioners whose decisions affect peoples’ health daily.[13,92] As Hardeman and colleagues[13] advocate, health professionals already practising in the field can still “learn, understand, and accept” the contemporary and historical basis of structural racism in the USA, understand how structural racism shapes our overarching narrative around inequities, define and call out racism when it is present, and contribute to the understanding of equity through clinical care and health research from the perspective of marginalised groups and with a healthy dose of cultural humility. Several local health departments have already incorporated anti-racism training into staff professional development, and introduced internal reforms to drive organisational change.[92,93] For example, in the mid-1990s the Alameda County Public Health Department began to place neighbourhood offices in areas with poor health outcomes. Over time, these offices drove changes in the department, including additional community involvement, staff trainings on anti-racism, a new unit and a strategic plan to incorporate equity into their work, and an increased presence of the health department in local activism.[92] The Boston Public Health Commission has also engaged in organisational change, launching a Racial Justice and Health Equity Initiative that incorporates an anti-racism advisory committee, the development of a health equity framework, anti-racism training and professional development, and a forthcoming evaluation of its activities.[93] As institutional reform is closely associated with other models of productive practices—including quality improvement, collective impact, community engagement, and community mobilisation—application of an anti-racism lens should not only be judged on its moral merits but also on its contributions to organisational effectiveness. We anticipate that forthcoming evidence will continue to support the view that removing racism from institutions is essential to protect and promote the health of our increasingly diverse communities.

Conclusion

Since the American colonial period, public and private institutions have reinforced each other, maintaining racial hierarchies that have allowed white Americans, across generations, to earn more and consolidate more wealth than non-white Americans, and maintain political dominance. This structural racism has had a substantial role in shaping the distribution of social determinants of health and the population health profile of the USA, including persistent health inequities. The stark reality is that research investigating the relationship between structural racism and population health outcomes has been scant, and even less work has been done to assess the health impacts of the few interventions and policy changes that could help dismantle structural racism.

We can, however, look to history as a guide. Notably, the handful of studies on the impact of the abolition of Jim Crow laws have consistently shown improvements in mortality in the black community, and converging mortality between black and white communities in the 15 years after the passage of the 1964 Civil Rights Act.[53–56] We recognise that efforts to implement reforms to dismantle structural racism have repeatedly encountered serious obstacles and backlash from institutions, communities, and individuals seeking to preserve their racial privilege.[8,20,26,30] However, as Frederick Douglass famously said in his 1857 address on the struggle against slavery in the USA, the West India emancipation, and the backlash that ensued: "Power concedes nothing without a demand."[94]

Without a vision of health equity and the commitment to tackle structural racism, health inequities will persist, thwarting efforts to eliminate disparities and improve the health of all groups—the overarching goals for US health policy as enunciated by the official Healthy People 2020 objectives. The challenge is great, but rising to this challenge lies at the heart of our mission and our commitment, as health professionals, to prevent avoidable suffering, care for those who are unwell, and create conditions in which all can truly thrive.

For more on **Healthy People 2020** see https://www.healthypeople.gov/2020/About-Healthy-People

Contributors

All authors contributed to the conceptualisation of the manuscript, literature search, and writing of this report. ZDB, NK, and MTB took the lead in ensuring coherence of the text, including the selection of appropriate data, and in data interpretation.

Declaration of interests

We declare no competing interests.

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Health Equity, Social Justice, and HIV in Rhode Island: A Contemporary Challenge

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ABSTRACT

From its beginning, HIV has primarily affected marginalized populations, such as injection drug users, gay, bisexual and other men who have sex with men (GBMSM), and minority racial and ethnic groups. HIV is a disease that, from the start, has been strongly influenced by issues related to social justice and health equity due to its intersection with behaviors among at-risk populations. While some of the risks associated with HIV have been successfully mitigated through social justice initiatives related to needle exchange programs and routine HIV testing of pregnant women, Rhode Island remains confronted with the health equity challenges of preventing HIV transmission and ensuring access to HIV care/treatment, especially for Black/African Americans, Hispanics, and GBMSM.

KEYWORDS: HIV, Social Justice, Health Equity, Rhode Island

HIV IN A SOCIAL CONTEXT

In 1981, human immunodeficiency virus (HIV) was first identified in the United States among non-immunosupressed injection drug users and gay men who were diagnosed with a rare form of pneumonia caused by *Pneumocystis jirovecii*. Prior to this time, *Pneumocystis* infections were only known to occur in people with compromised immune systems. Untreated, HIV leads to acquired immune deficiency syndrome (AIDS) and death. Since its emergence in 1981, the HIV/AIDS pandemic has had a major impact on morbidity and mortality across the world.

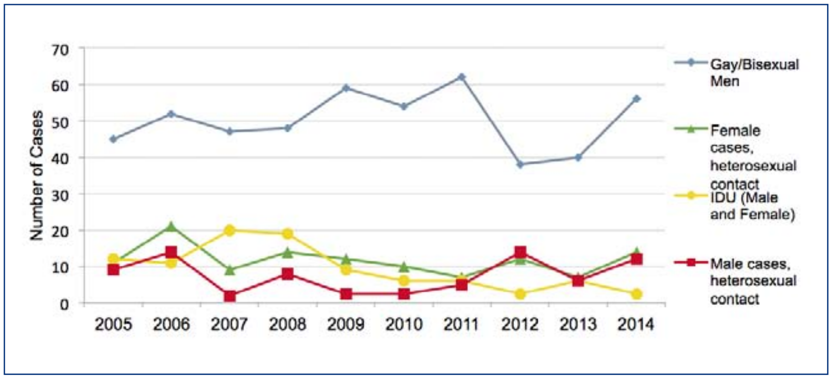
Even though HIV/AIDS is an infectious disease, it has had a remarkable impact on politics, education, the media, social movements, the entertainment industry, and professional sports in a manner unlike any other disease in modern history. Its societal impact has evolved in response to its shifting epidemiology, as well as advances in medicine and technology that have made HIV testing more accessible and new medications that are highly effective in managing – and most recently preventing – the disease (pre-exposure prophylaxis or PrEP).

What makes HIV/AIDS historically stand apart from other diseases is its impact on a diverse subset of specific populations, including persons who inject drugs, gay, bisexual, and other men who have sex with men (GBMSM), minority racial and ethnic populations, children born to HIV-positive mothers, incarcerated populations, hemophiliacs, and foreign-born individuals from endemic countries. These groups have historically experienced societal marginalization, discrimination, and isolation that directly contributes to their disproportionate burden of HIV. (**See Figure 1**.)

Commenting on the HIV epidemic among African Americans, Dr. Jonathan Mermin, director of the CDC's Division on HIV/AIDS Prevention, stated that "there is nothing biological that has caused African Americans to have such a disproportionate rate of HIV infection. It's the social, it's the economic, and it's the epidemiological environment in which people live."[1]

As an outgrowth of the HIV epidemic, both nationally and internationally, many groups have mobilized social movements to advocate not only for affordable access to HIV treatment and care, but also for housing, employment, and education to help stem the incidence of HIV within their communities. Such groups include AIDS Coalition to Unleash Power (ACT UP), National Association for the Advancement of Colored People (NAACP), Black Church and HIV, and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Often framing their advocacy through a social justice lens, these groups frequently include a focus on improving conditions related to social determinants of health for the communities they represent.

Figure 1. Newly-Diagnosed Cases of HIV by Exposure Mode, Rhode Island, 2005–2014



HIV AND SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are typically defined as a person's social environment, physical environment, and their access to health services.[2] These factors cannot be changed with differences in behavior, but can greatly affect the individual's environment, and their health outcomes. Some of the most salient social determinants of health include poverty, homelessness, unequal access to healthcare, incarceration, lack of education, stigma, homophobia, sexism and racism.

Socioeconomic status and HIV are closely linked. Socioeconomic status can affect HIV status, and vice versa. Individuals who have low socioeconomic resources are more likely to practice riskier behaviors, which may make them more susceptible to HIV. Some of these riskier behaviors may include earlier sexual debut and inconsistent condom use. It has been observed that the most substantial social determinants of health in relation to HIV/AIDS are education, employment, housing, income and insurance status. While all of these factors are significant predictors of HIV status, research indicates that education and housing status are the strongest predictors.[3] It has been demonstrated that those who experience unstable housing are more likely to have condomless sex, use drugs, and share syringes.

An HIV diagnosis may negatively impact someone's socioeconomic status by diminishing their capacity to work and earn income. The percentage of HIV-positive individuals who are unemployed is high compared to their seronegative counterparts. This is partially due to work responsibilities competing with healthcare needs, as well as difficulty in maintaining typical work hours due to fatigue.[4]

HIV SUCCESSES IN RHODE ISLAND: HIV TESTING OF PREGNANT WOMEN AND NEEDLE EXCHANGE PROGRAMS

While many social determinants of health represent significant barriers toward reducing HIV risk, two public health interventions have proven successful as HIV prevention strategies in Rhode Island and in other jurisdictions across the nation: routine HIV testing of pregnant women and syringe exchange programs for injecting drug users.

In 1994 it was discovered that the administration of zidovudine (AZT) during pregnancy and childbirth reduced the chance of a child being born HIV positive to an infected mother by two-thirds. In 1999, the Institute of Medicine recommended "adoption of a national policy of universal HIV testing, with patient notification, as a routine component of prenatal care."[5]

In accordance with Rhode Island General Laws 23-6.3-3, enacted in 2009, HIV opt-out screening is incorporated into prenatal testing for all pregnant women as early and often as appropriate during each pregnancy.[6] Newborns are tested as soon as possible after delivery if the mother's HIV status is not documented (the mother's consent is not needed). In Rhode Island, there has been only one case of mother-to-child transmission of HIV in the last five years.

Needle exchange programs, also known as "syringe services" programs, generally provide a full spectrum of services to individuals who inject drugs, including exchange of used syringes for clean ones, naloxone distribution, counseling, condoms, rapid HIV and hepatitis C testing, and referrals to mental health and social services. Since the inception of the needle exchange program in Rhode Island in 1994, there has been a precipitous drop in new cases of HIV identified among injecting drug users, with fewer than six cases reported annually from 2009–2014.

AIDS Care Ocean State (ACOS) operates Rhode Island's needle exchange program, which started as one fixed site in Providence in 1994. In 2002, ACOS expanded their services to include mobile sites in Woonsocket and Newport, then expanded their services to street outreach in 2008, and home delivery in 2012. In total, ACOS provides services through three fixed sites, a mobile/street-based exchange unit, and home delivery in five cities: Providence, Woonsocket, Newport, Pawtucket, and Central Falls.[7] Clean syringes can also be bought without prescription at retail pharmacies in Rhode Island.

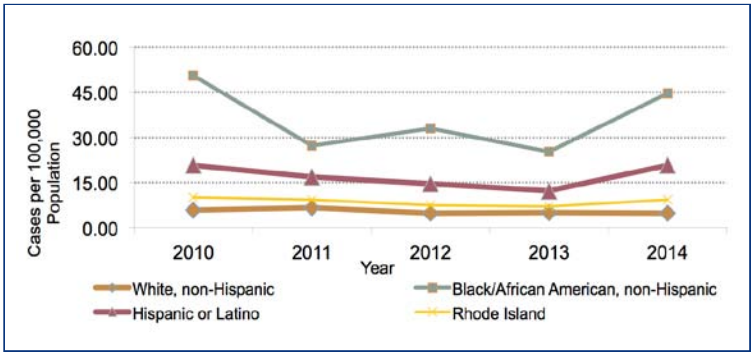
HIV EPIDEMIOLOGY AND RACE/ETHNICITY

In a state with a population that is between 75% and 80% White, the rates of Black/African American males living with an HIV diagnosis is five times that of white males. Further, Black/African American females have rates that are 17 times that of their white counterparts. Black Americans represent only 12% of the United States population, but they account for 44% of individuals living with HIV.[8] In Rhode Island, the rate of HIV in the Black/African American population is roughly 10 times that of White, non-Hispanic individuals. The rate for Hispanic or Latino individuals is five times that of non-Hispanic Whites. (**See Figure 2.**)

HIV EPIDEMIOLOGY AND SEXUAL ORIENTATION

According to the Centers for Disease Control and Prevention, GBMSM comprised 83% of new HIV diagnoses among

Figure 2. Rates of Newly-Diagnosed Cases of HIV by Race/Ethnicity, Rhode Island, 2010–2014

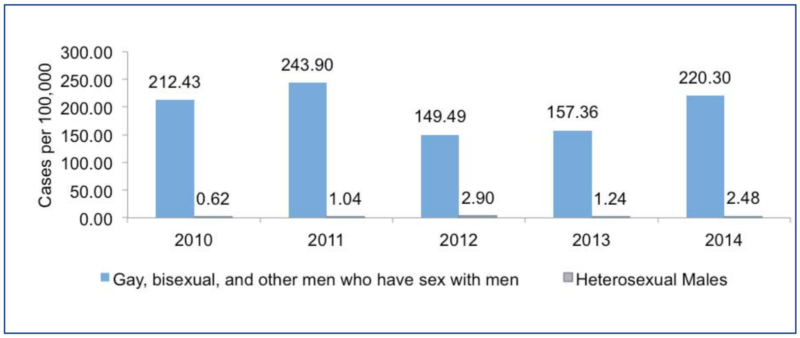


males age 13 and older in 2014. Furthermore, it is estimated in the United States that 15% of all GBMSM are HIV-infected.[9] A major barrier to testing and screening globally is that one-third of countries around the world criminalize same-sex conduct, thus restricting the rights of GBMSM and the lesbian/gay/transgender community. In these countries, GBMSM are less likely to access services, fearing prosecution.

The South (Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia) is home to 37% of the United States population, but more than 50% of newly-diagnosed HIV cases.[10] There are many contributing factors to this disproportionate epidemic in the South, including poverty, stigma, racism, and homophobia. Further contributing to these factors is "abstinence-only" education in schools, as well as limited Medicaid expansion by these Southern states.[11] Social stigma related to the GBMSM population is further exacerbated by race, as African American GBMSM are stigmatized not only because of sexual preference, but also due to race.[12]

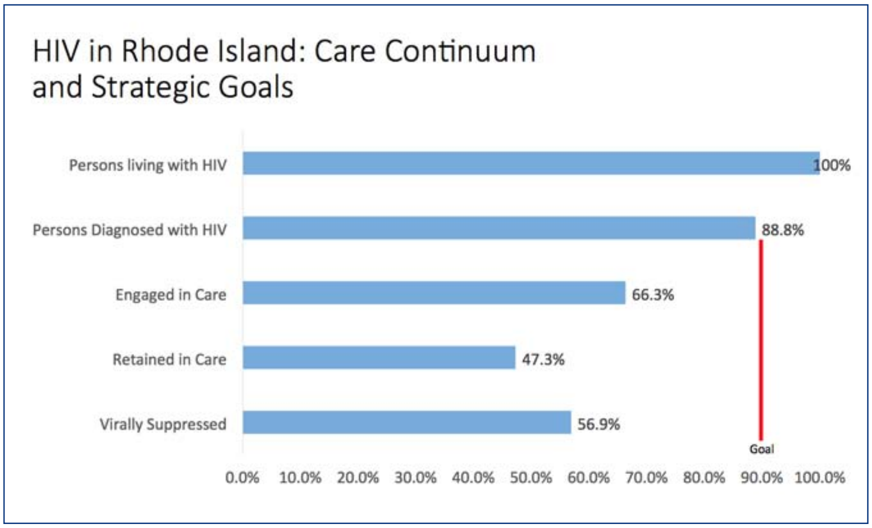
The rate of new HIV infections in 2014 in Rhode Island was 89 times higher in GBMSM than heterosexual men. While most of the cases of HIV among GBMSM in years past have been concentrated in men in ages 30–49, there has been a recent shift toward younger men (in their 20s). The majority of GBMSM diagnosed with HIV reside in Providence County. (**See Figure 3.**)

Figure 3. Rates of Newly-Diagnosed HIV among Males* by Sexual Orientation, Rhode Island, 2010–2014



*Denominator data to estimate the GBMSM population is derived from the Rhode Island Behavioral Risk Factor Surveillance System and Lieb et al., "Statewide Estimation of Racial/Ethnic Population of Men Who Have Sex with Men in the U.S." *Public Health Reports* 126(2011): 60-72

Figure 4. Rhode Island's Progress towards reaching set targets.



A recent advancement in addressing HIV prevention among GBMSM is PrEP. Taken once a day by HIV-negative individuals, PrEP can effectively prevent HIV infection. Studies suggest that PrEP is >90% effective in preventing HIV. Currently, The Miriam Hospital STD Clinic has prescribed PrEP to more than 200 patients and is taking referrals.

ACHIEVING HEALTH EQUITY IN RHODE ISLAND

With the goal of scaling up HIV testing and treatment efforts and achieving health equity for individuals at-risk for – and impacted by – HIV, Rhode Island officially adopted the UNAIDS "90-90-90" initiative at the Rhode Island Statehouse *World AIDS Day* event in December 2015. The goals of this global initiative for the year 2020 include: 1) 90% of people living with HIV know their HIV status; 2) 90% of people who know their HIV-positive status access treatment; and 3) 90% of people in treatment have suppressed viral loads. **Figure 4** illustrates Rhode Island's progress towards these targets.

The cornerstone of Rhode Island's 90-90-90 initiative is a commitment not only to address the medical needs of individuals at-risk for and living with HIV, but also their social and economic needs, including issues related to discrimination, housing, education, and employment. Accordingly, partnerships and planning groups have been formed that include social service agencies, AIDS service organizations, municipal governments, community-based organizations, and other state agencies.

While medical advances have led to tremendous successes in HIV prevention and care, Rhode Island's current challenge is to combine these advancements with improvements in local environments and communities in which at-risk groups and people living with HIV live, grow, work, and learn. This comprehensive approach is intended to be a foundation on which Rhode Island hopes to be the first state in the nation to "get to zero."

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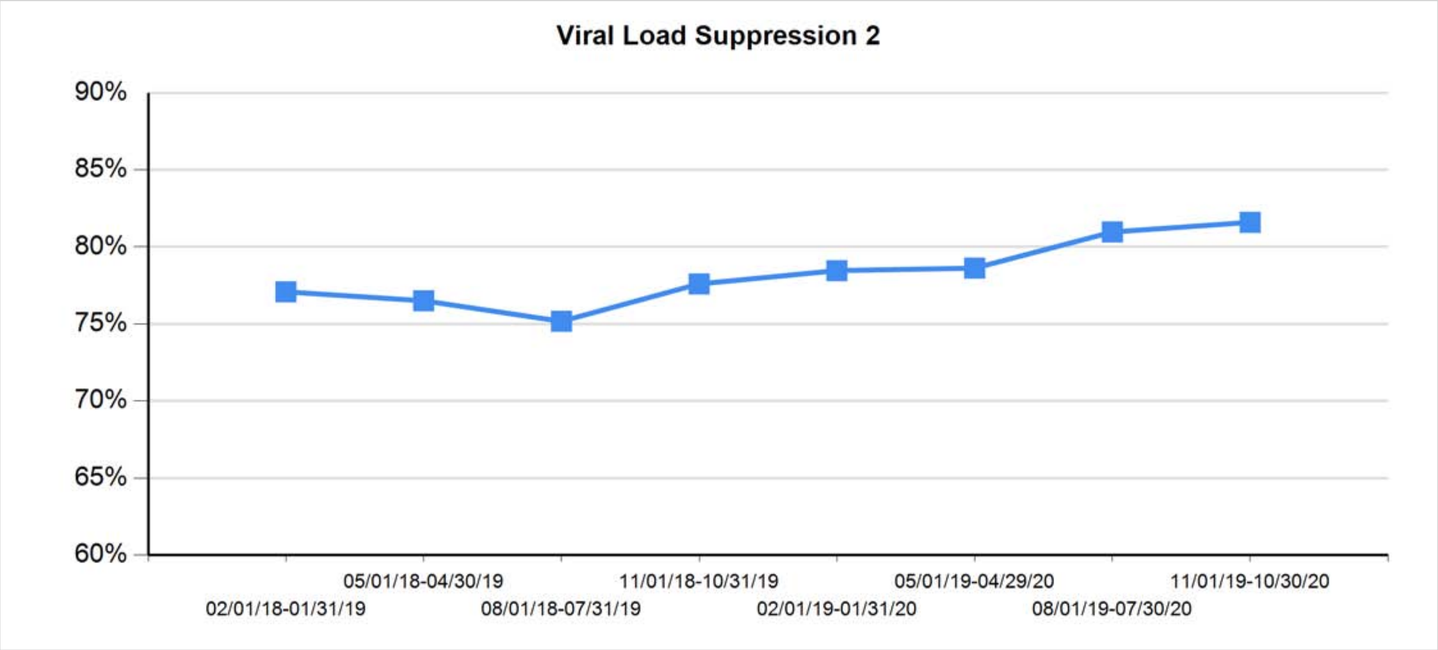
HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

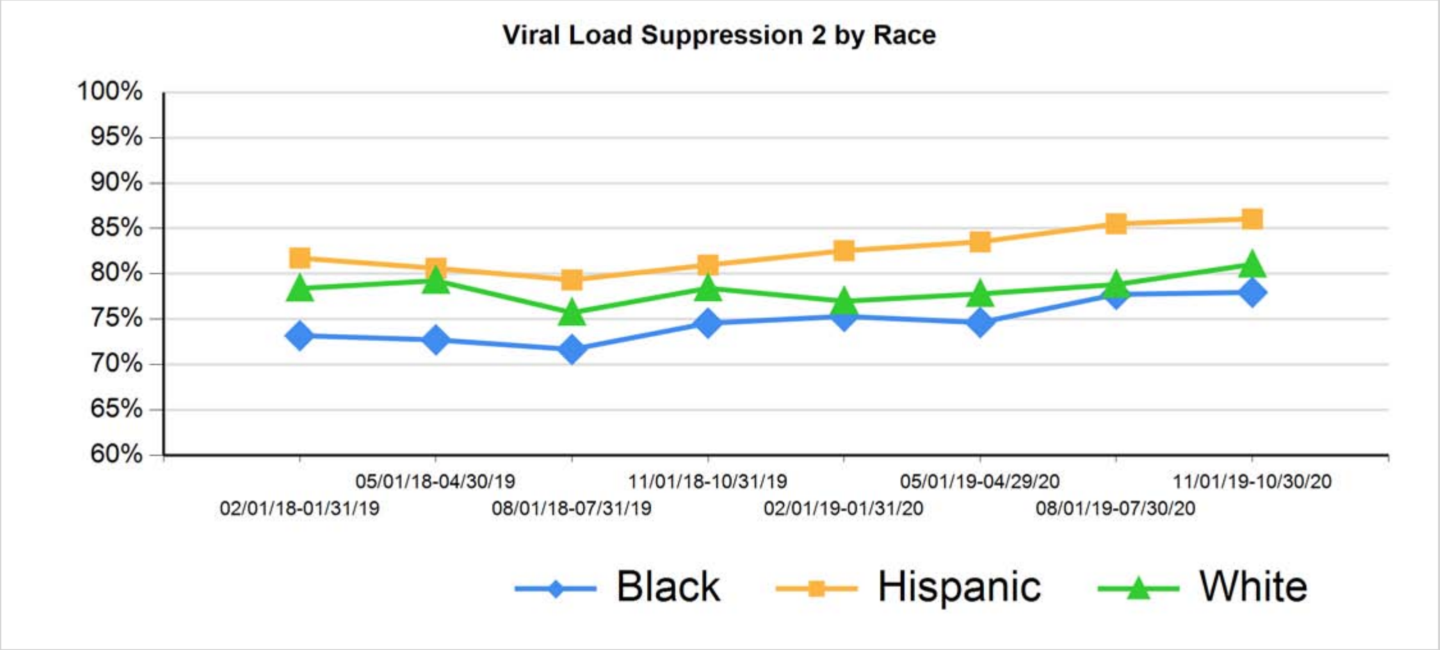
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **11/1/2019**

Viral Load Suppression 2- HAB Measure				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who have a viral load of <200 copies/ml during the measurement year	6,736	6,830	6,995	6,970
Number of clients who have had at least 1 medical visit with a provider with prescribing privileges	8,585	8,687	8,639	8,542
Percentage	78.5%	78.6%	81.0%	81.6%
Change from Previous Quarter Results	0.9%	0.2%	2.3%	0.6%

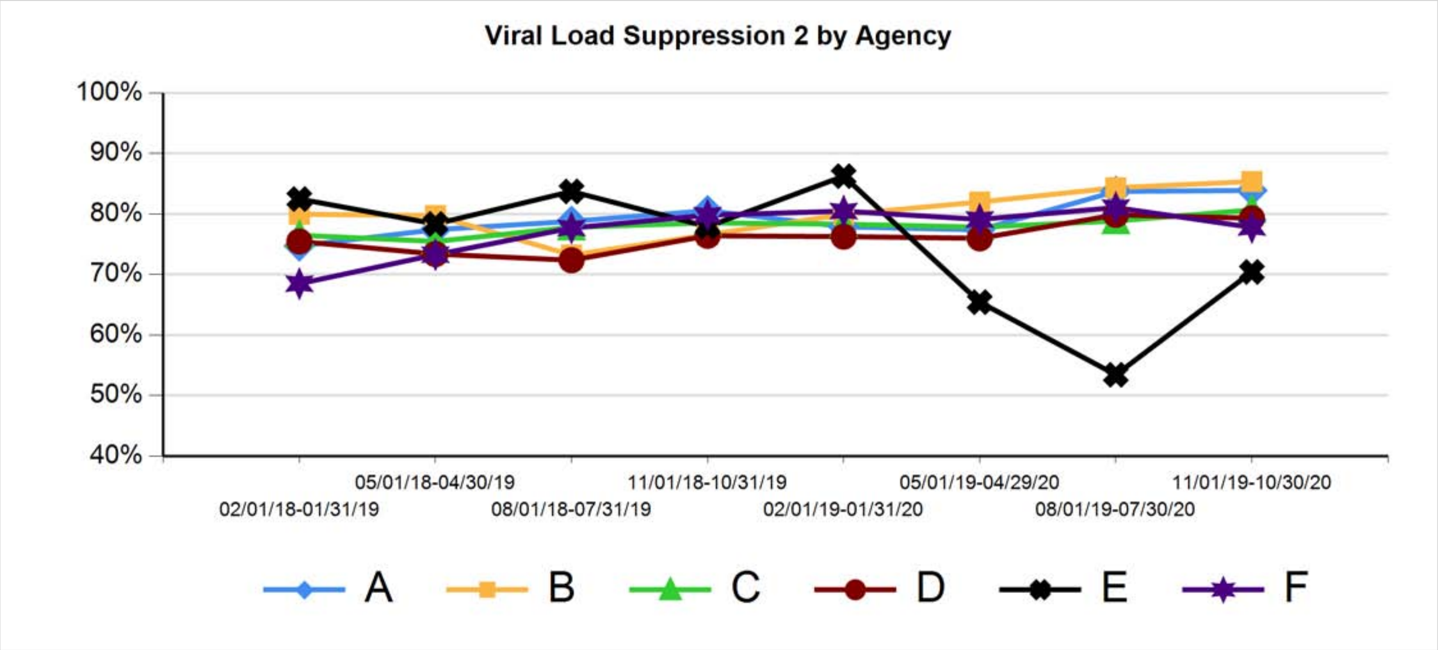


VL Suppression 2 by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	3,088	2,736	844	3,172	2,814	852	3,165	2,775	876
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	4,138	3,276	1,085	4,081	3,291	1,081	4,060	3,225	1,081
Percentage	74.6%	83.5%	77.8%	77.7%	85.5%	78.8%	78.0%	86.0%	81.0%
Change from Previous Quarter Results	-0.7%	1.0%	0.8%	3.1%	2.0%	1.0%	0.2%	0.5%	2.2%

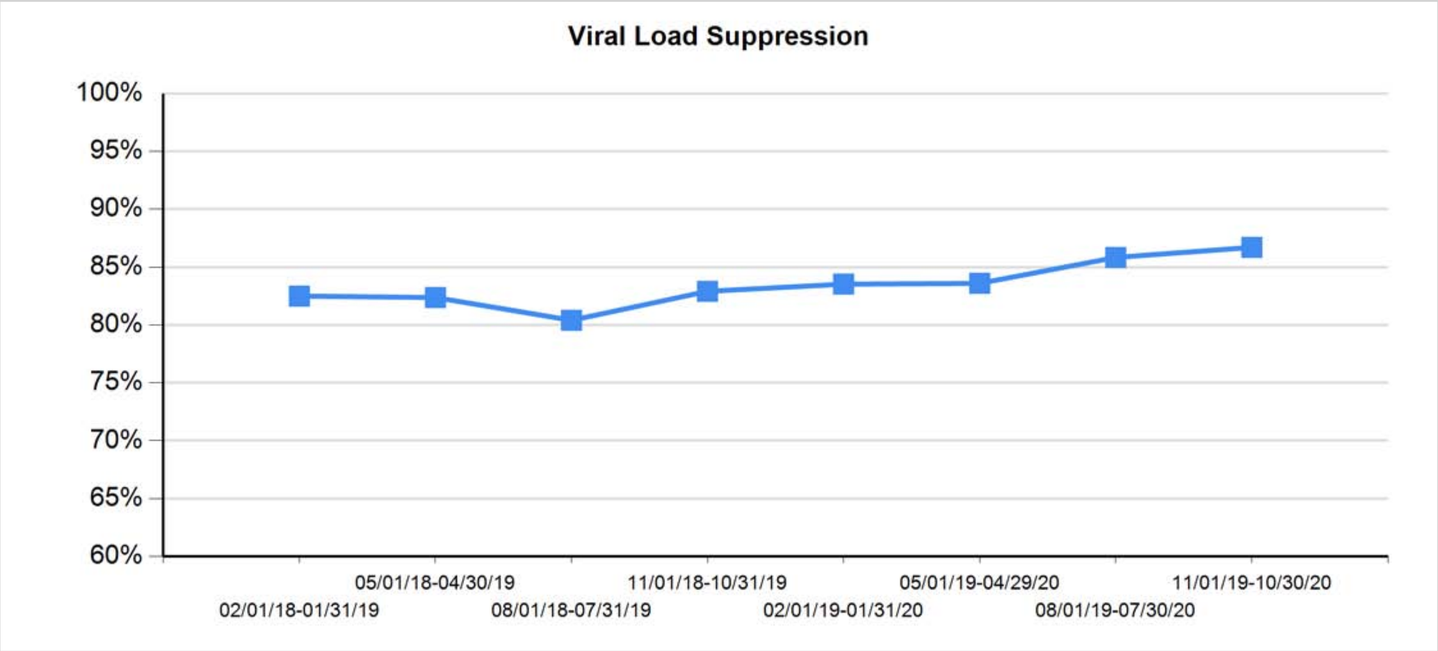


Viral Load 2 Suppression by Agency

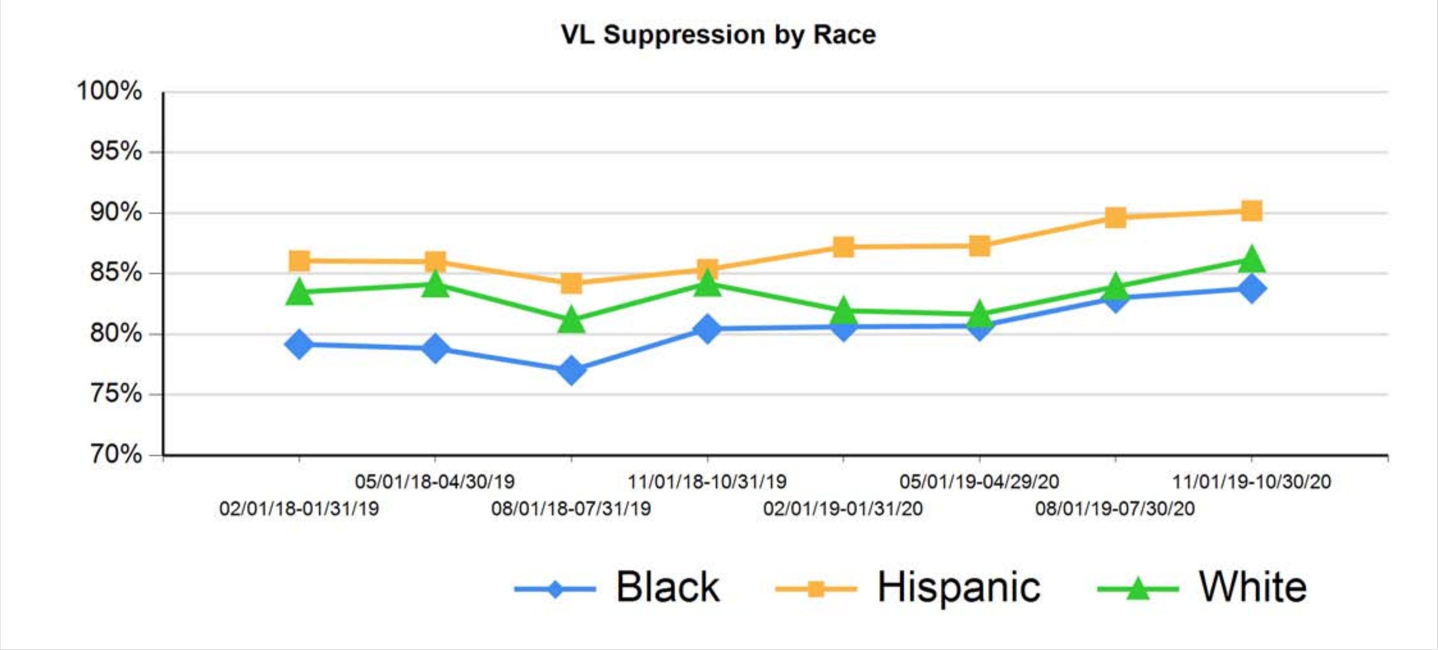
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load of <200 copies/ml during the measurement year	561	2,213	2,220	1,677	39	398	557	2,135	2,274	1,651	50	413
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	670	2,624	2,816	2,100	73	491	664	2,501	2,819	2,082	71	531
Percentage	83.7%	84.3%	78.8%	79.9%	53.4%	81.1%	83.9%	85.4%	80.7%	79.3%	70.4%	77.8%
Change from Previous Quarter Results	6.4%	2.4%	1.0%	3.9%	-12.0%	2.0%	0.2%	1.0%	1.8%	-0.6%	17.0%	-3.3%



Viral Load Suppression				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who have a viral load of <200 copies/ml during the measurement year	5,130	5,162	5,150	5,073
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	6,142	6,175	6,000	5,851
Percentage	83.5%	83.6%	85.8%	86.7%
Change from Previous Quarter Results	0.6%	0.1%	2.2%	0.9%

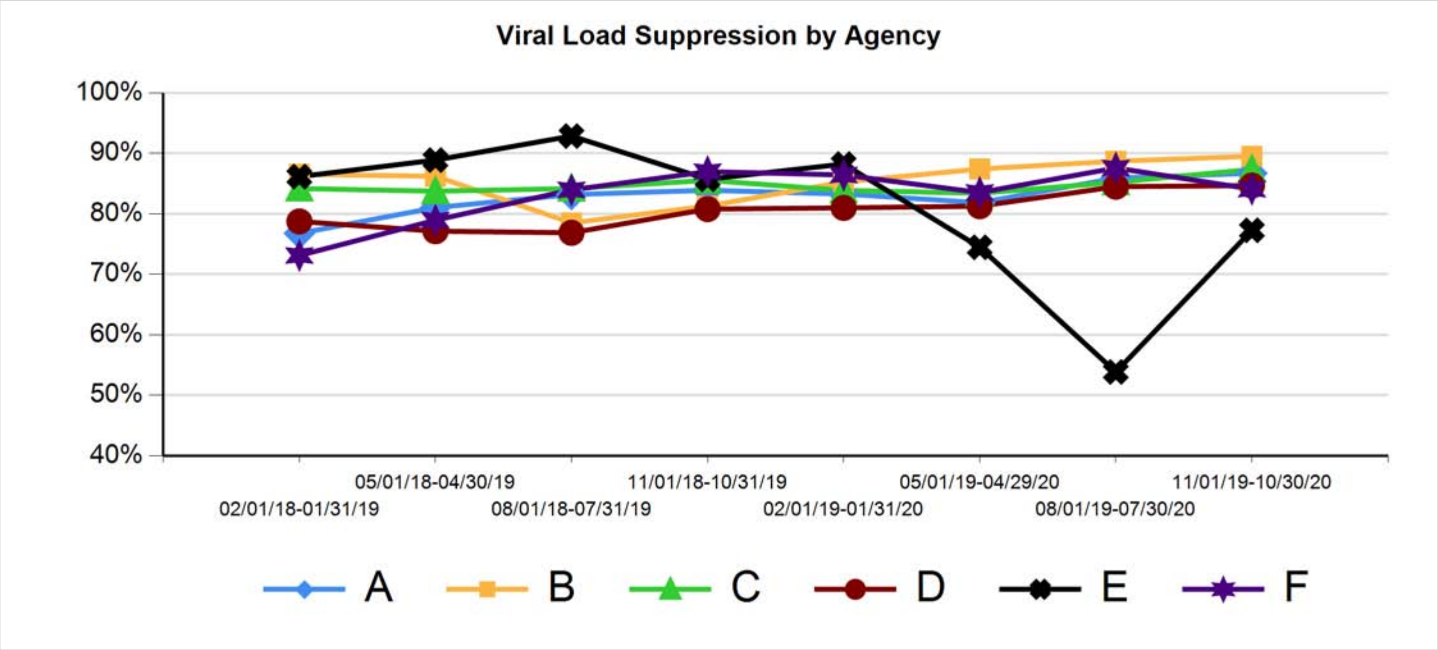


VL Suppression by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	2,305	2,103	623	2,312	2,107	611	2,289	2,077	605
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	2,857	2,409	763	2,786	2,351	728	2,732	2,303	702
Percentage	80.7%	87.3%	81.7%	83.0%	89.6%	83.9%	83.8%	90.2%	86.2%
Change from Previous Quarter Results	0.1%	0.1%	-0.3%	2.3%	2.3%	2.3%	0.8%	0.6%	2.3%

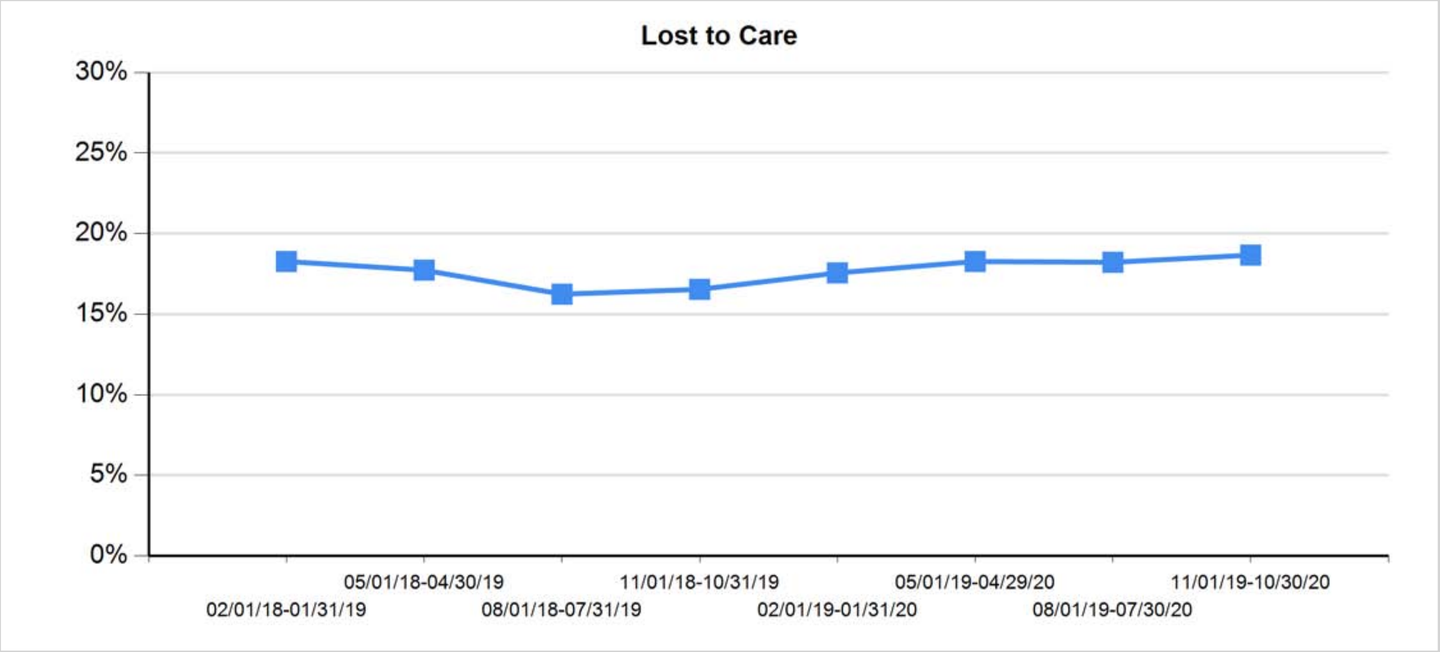


VL Suppression by Agency

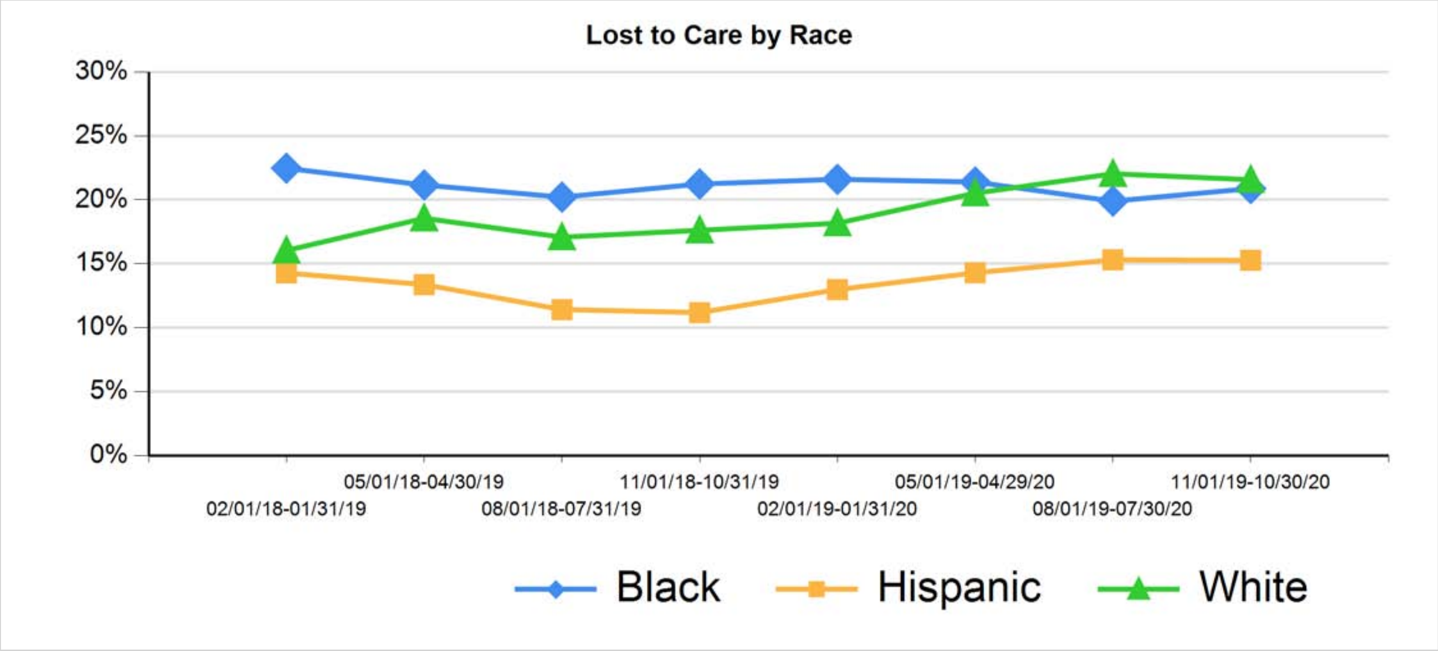
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load of <200 copies/ml during the measurement year	481	1,413	1,532	1,476	21	268	483	1,324	1,506	1,481	34	280
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	560	1,593	1,798	1,747	39	306	557	1,479	1,724	1,749	44	333
Percentage	85.9%	88.7%	85.2%	84.5%	53.8%	87.6%	86.7%	89.5%	87.4%	84.7%	77.3%	84.1%
Change from Previous Quarter Results	4.1%	1.3%	1.8%	3.2%	-20.6%	4.1%	0.8%	0.8%	2.1%	0.2%	23.4%	-3.5%



Lost to Care				
In+Care Campaign Gap Measure				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	1,079	1,148	1,139	1,168
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	6,144	6,284	6,251	6,258
Percentage	17.6%	18.3%	18.2%	18.7%
Change from Previous Quarter Results	1.0%	0.7%	0.0%	0.4%

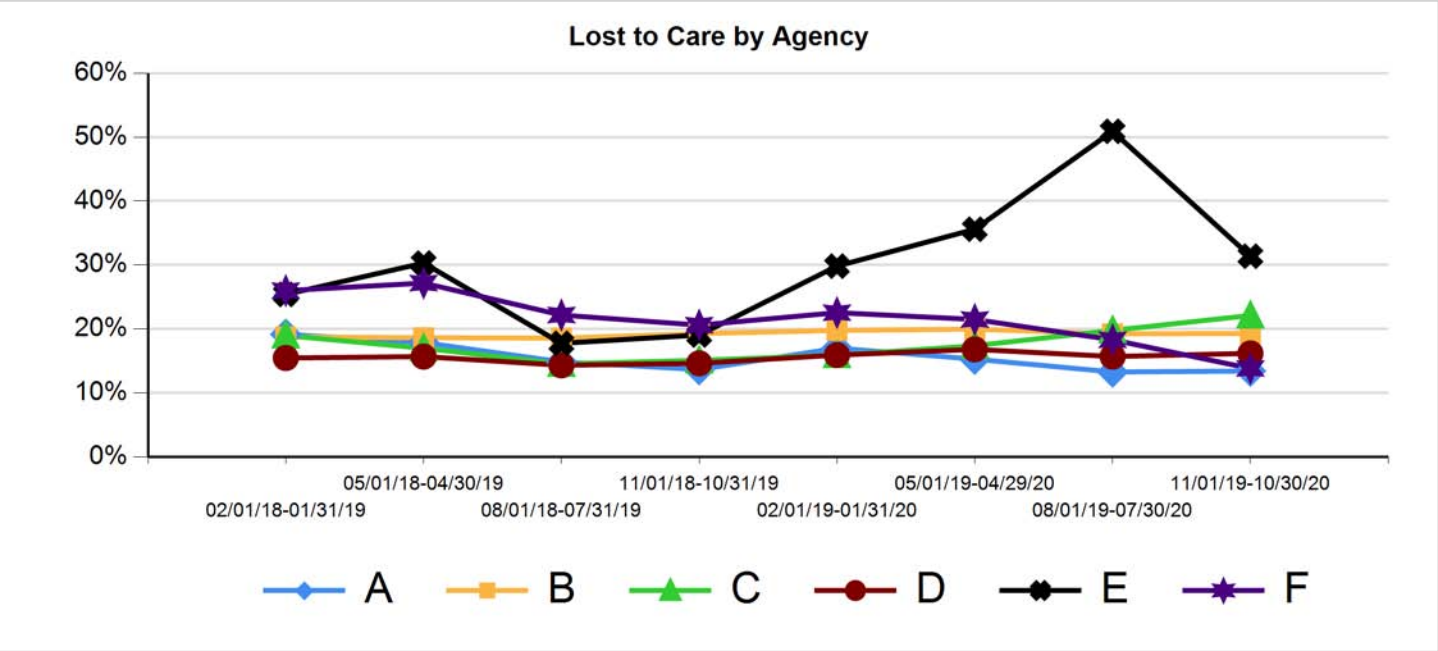


Lost to Care by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	615	355	159	560	386	171	597	382	165
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	2,875	2,484	775	2,815	2,522	776	2,859	2,502	765
Percentage	21.4%	14.3%	20.5%	19.9%	15.3%	22.0%	20.9%	15.3%	21.6%
Change from Previous Quarter Results	-0.2%	1.3%	2.3%	-1.5%	1.0%	1.5%	1.0%	0.0%	-0.5%

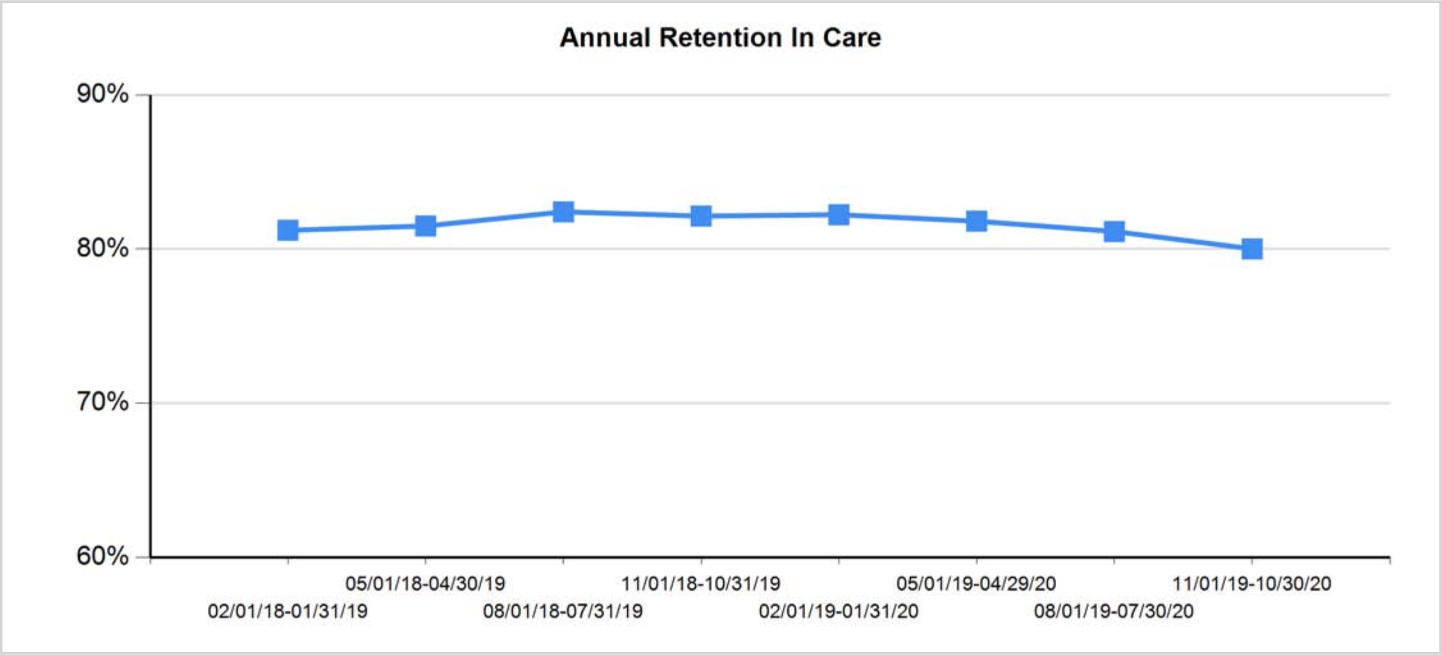


Lost to Care by Agency

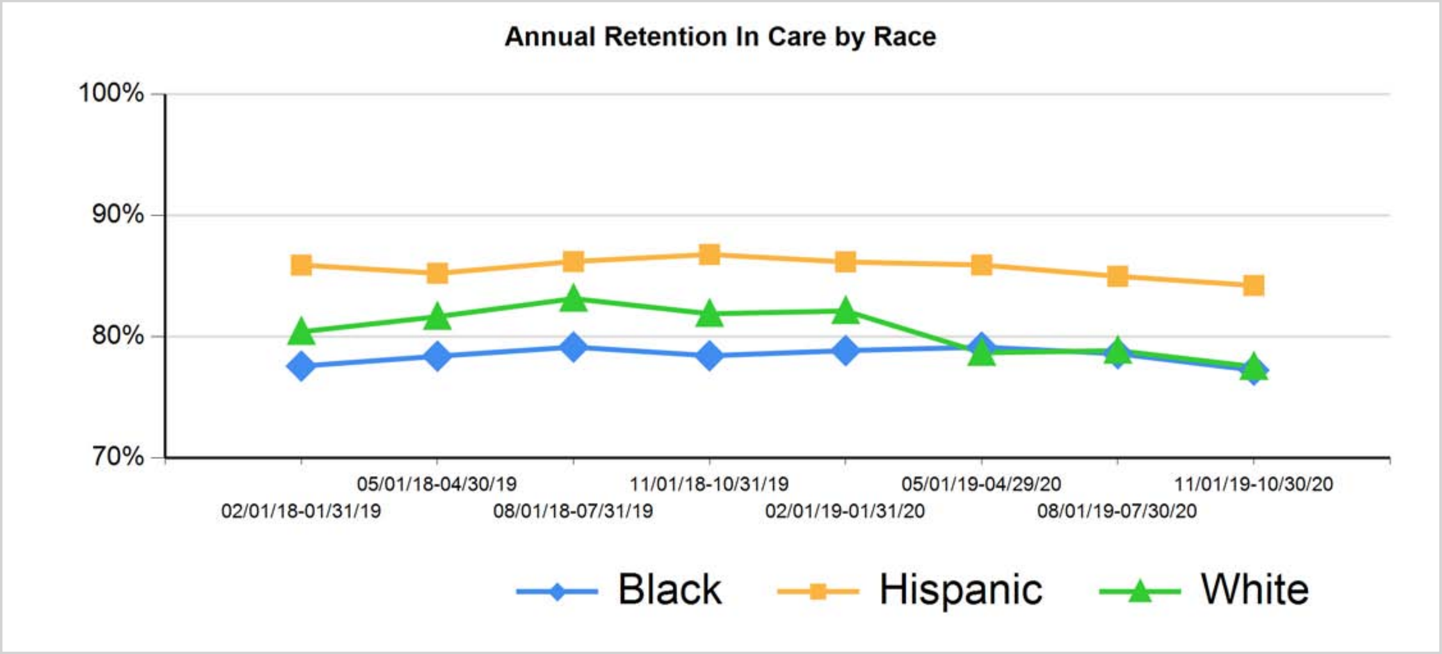
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	69	367	376	251	28	58	70	357	423	264	16	46
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	520	1,909	1,902	1,601	55	317	522	1,851	1,914	1,632	51	333
Percentage	13.3%	19.2%	19.8%	15.7%	50.9%	18.3%	13.4%	19.3%	22.1%	16.2%	31.4%	13.8%
Change from Previous Quarter Results	-2.0%	-0.7%	2.4%	-1.1%	15.3%	-3.2%	0.1%	0.1%	2.3%	0.5%	-19.5%	-4.5%



Annual Retention In Care				
Houston EMA Medical Visits Measure				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year*	6,400	6,485	6,445	6,306
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	7,783	7,927	7,943	7,881
Percentage	82.2%	81.8%	81.1%	80.0%
Change from Previous Quarter Results	0.1%	-0.4%	-0.7%	-1.1%
* Not newly enrolled in care				

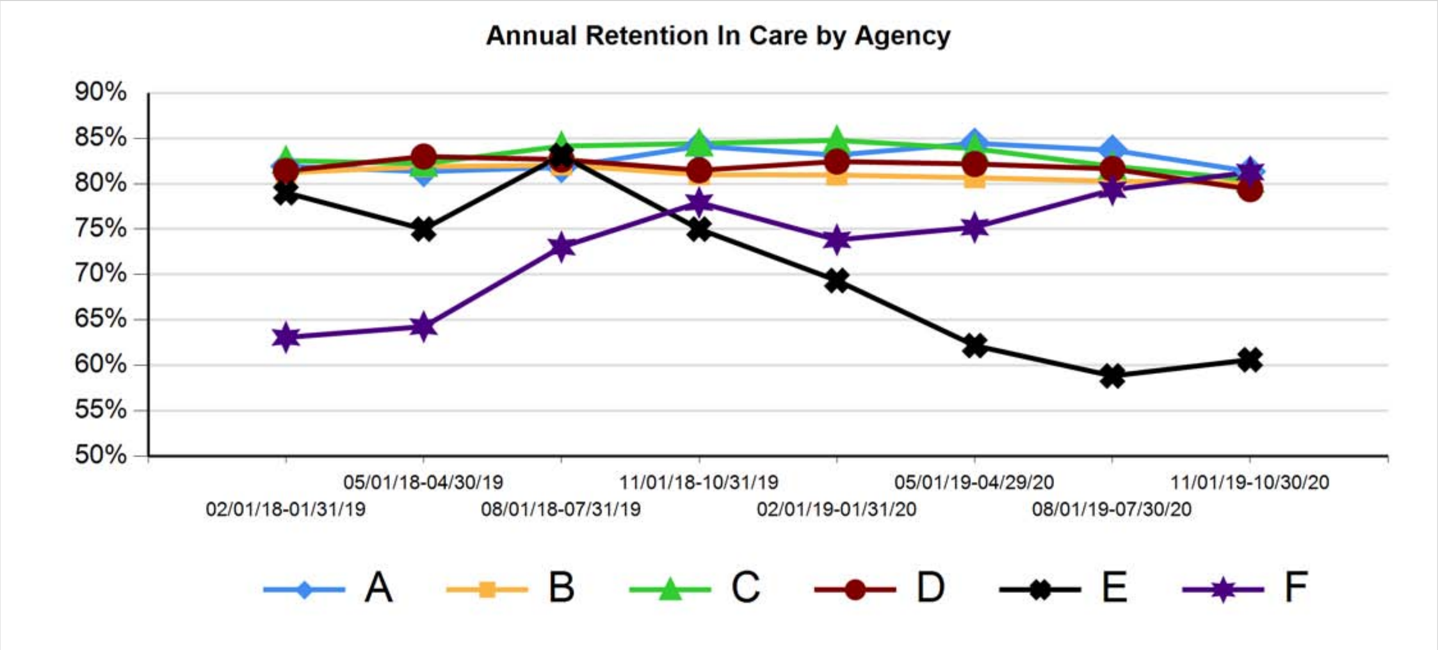


Annual Retention In Care by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year	2,975	2,589	763	2,942	2,588	771	2,892	2,523	758
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	3,760	3,014	970	3,744	3,046	978	3,745	2,996	978
Percentage	79.1%	85.9%	78.7%	78.6%	85.0%	78.8%	77.2%	84.2%	77.5%
Change from Previous Quarter Results	0.3%	-0.3%	-3.4%	-0.5%	-0.9%	0.2%	-1.4%	-0.8%	-1.3%

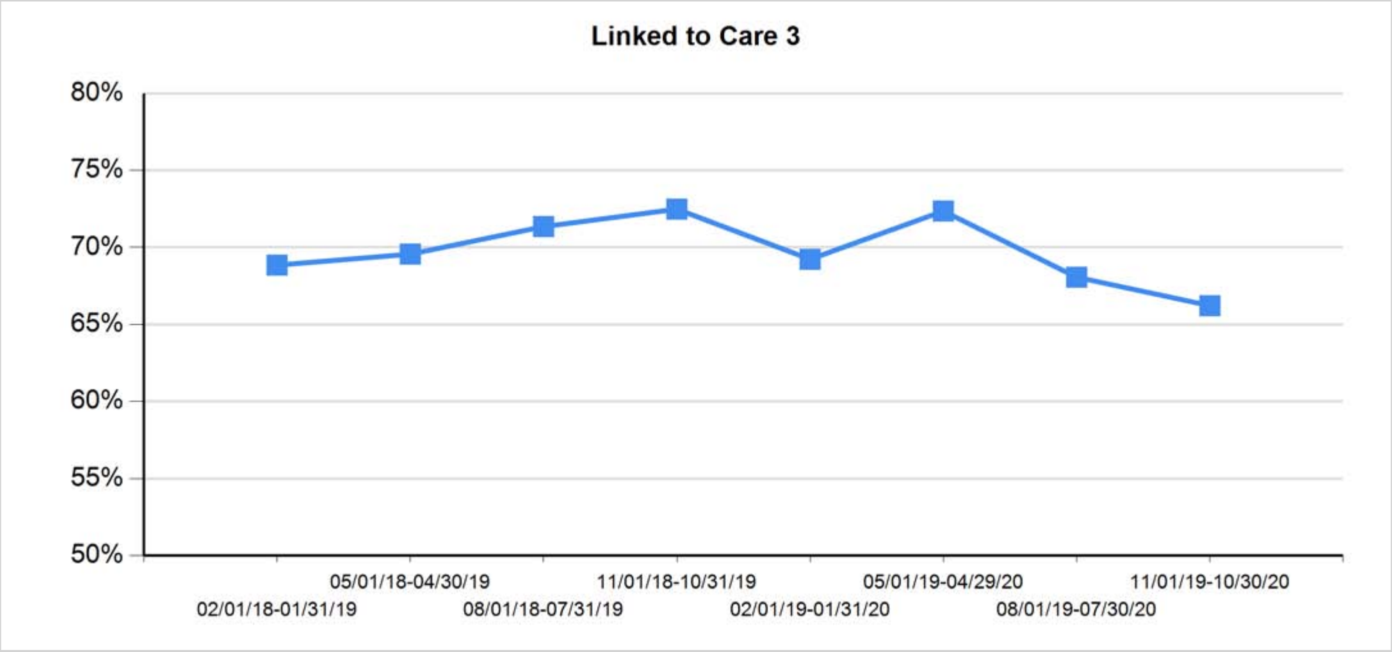


Annual Retention In Care by Agency

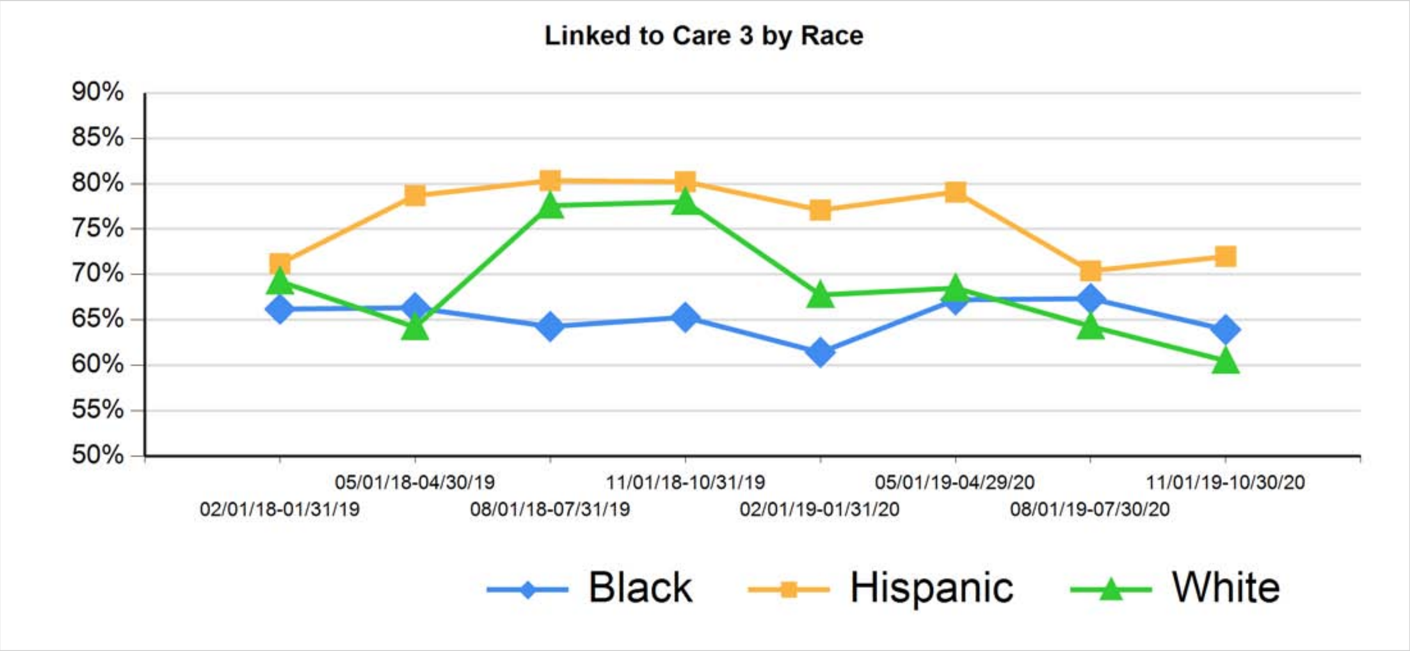
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year	539	1,967	2,089	1,601	40	307	519	1,871	2,058	1,557	40	343
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	644	2,450	2,550	1,961	68	387	638	2,336	2,558	1,961	66	422
Percentage	83.7%	80.3%	81.9%	81.6%	58.8%	79.3%	81.3%	80.1%	80.5%	79.4%	60.6%	81.3%
Change from Previous Quarter Results	-0.8%	-0.4%	-1.9%	-0.5%	-3.3%	4.1%	-2.3%	-0.2%	-1.5%	-2.2%	1.8%	2.0%



Linked to Care 3				
Medical Visits for Newly Enrolled Clients				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who had a medical visit with a provider at least once in the last 6 months of the measurement period	378	411	373	345
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 6 months of the measurement period	546	568	548	521
Percentage	69.2%	72.4%	68.1%	66.2%
Change from Previous Quarter Results	-3.3%	3.1%	-4.3%	-1.8%

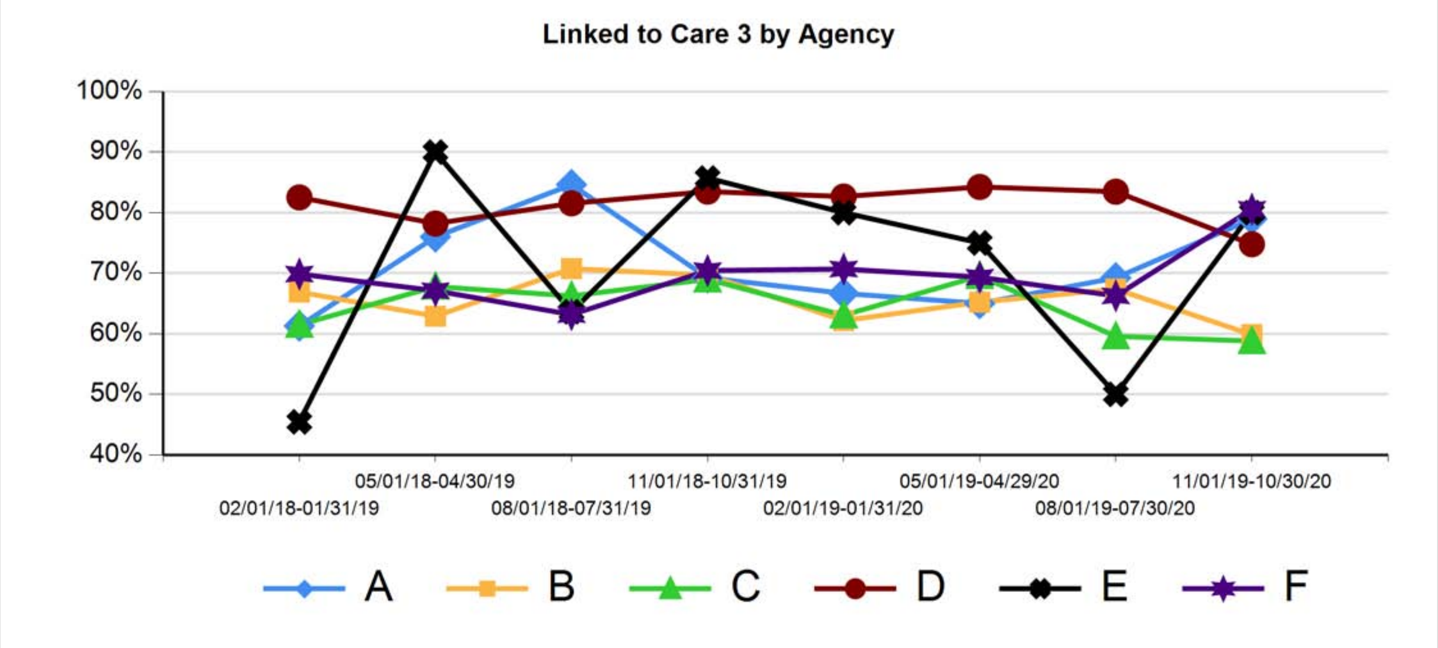


Linked to Care 3 by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had a medical visit with a provider at least once in the last 6 months of the measurement period	164	189	50	167	145	54	163	131	49
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 6 months of the measurement period	244	239	73	248	206	84	255	182	81
Percentage	67.2%	79.1%	68.5%	67.3%	70.4%	64.3%	63.9%	72.0%	60.5%
Change from Previous Quarter Results	5.8%	2.0%	0.8%	0.1%	-8.7%	-4.2%	-3.4%	1.6%	-3.8%

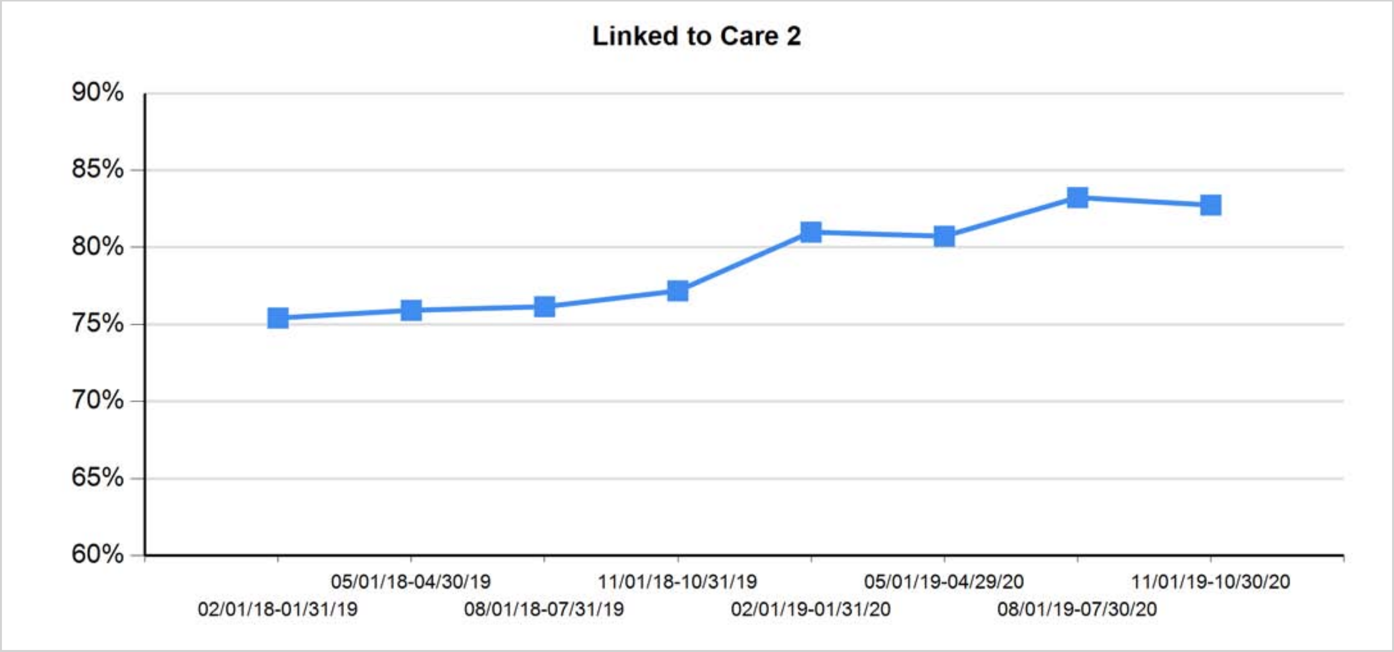


Linked to Care 3 by Agency

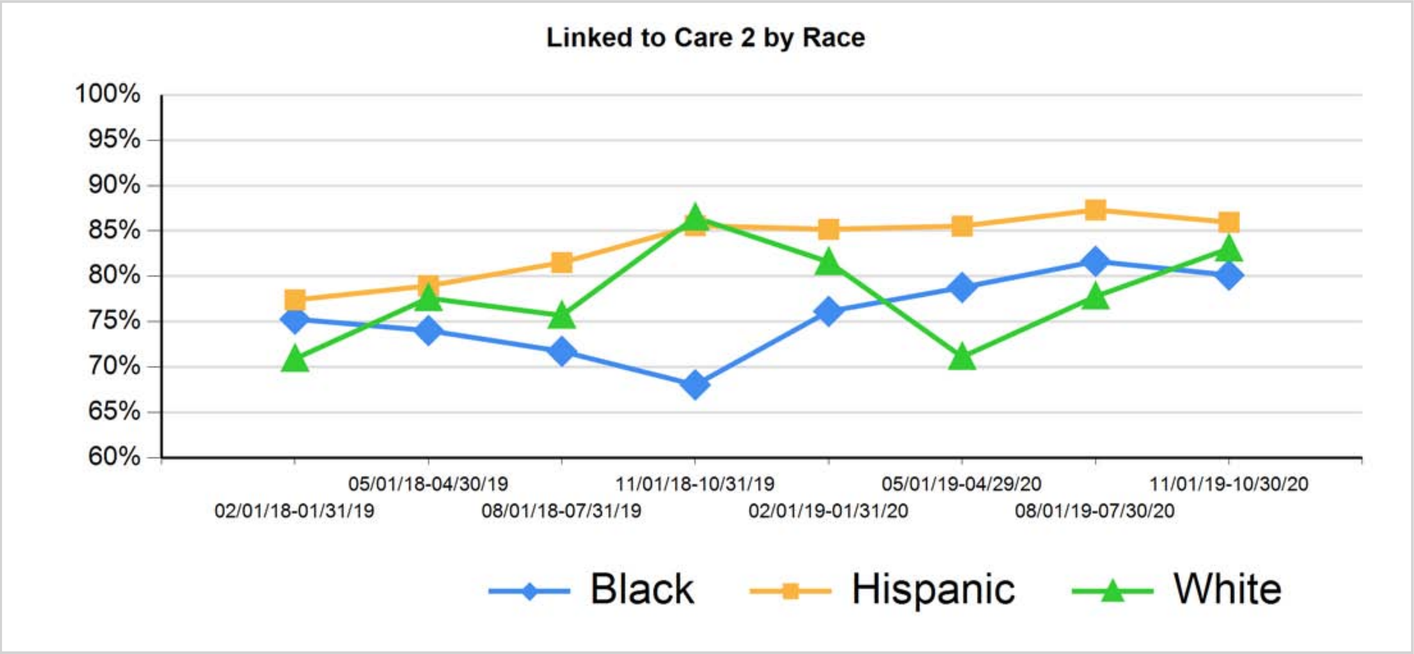
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who had a medical visit with a provider at least once in the last 6 months of the measurement period	9	95	112	106	2	53	15	79	107	86	4	58
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 6 months of the measurement period	13	141	188	127	4	80	19	132	182	115	5	72
Percentage	69.2%	67.4%	59.6%	83.5%	50.0%	66.3%	78.9%	59.8%	58.8%	74.8%	80.0%	80.6%
Change from Previous Quarter Results	4.2%	2.2%	-10.0%	-0.8%	-25.0%	-3.1%	9.7%	-7.5%	-0.8%	-8.7%	30.0%	14.3%



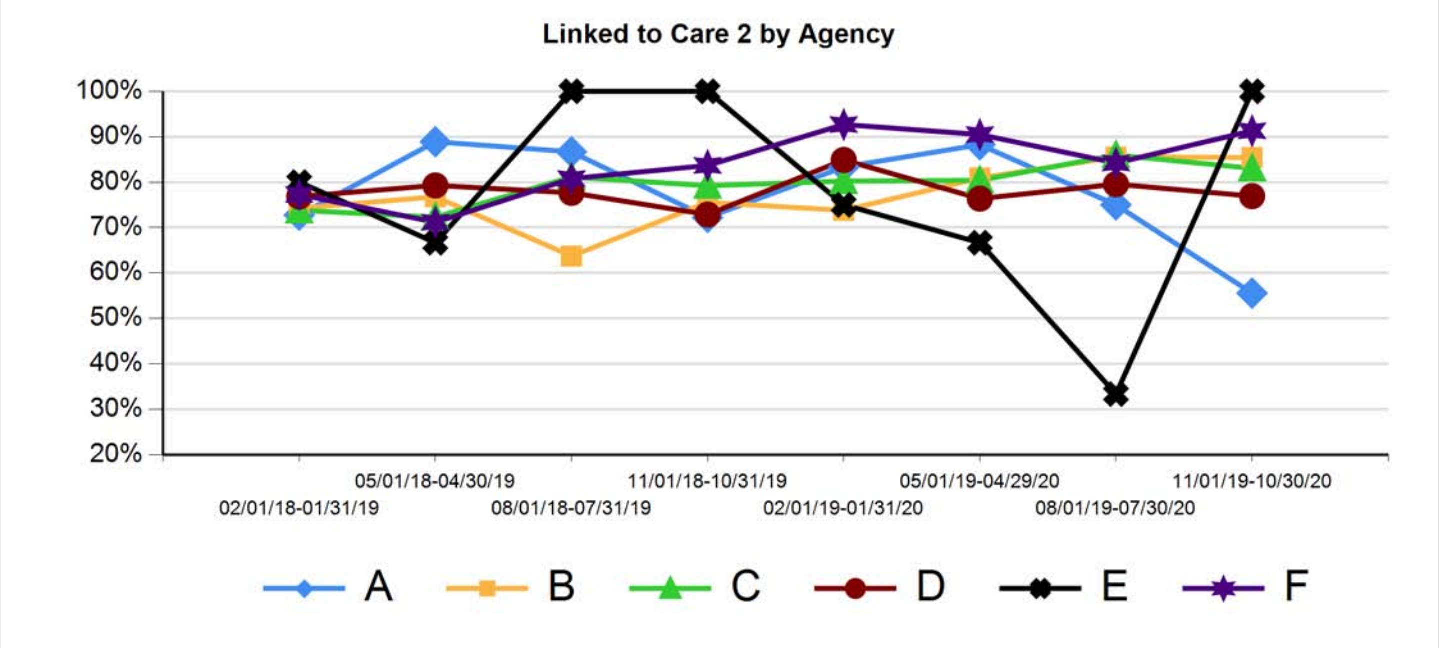
Linked to Care 2				
Viral Load Suppression Measure for Newly Enrolled Clients				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who have a viral load <200 copies/ml at last viral load in the measurement period	277	289	288	283
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 4 months of the measurement period	342	358	346	342
Percentage	81.0%	80.7%	83.2%	82.7%
Change from Previous Quarter Results	3.8%	-0.3%	2.5%	-0.5%



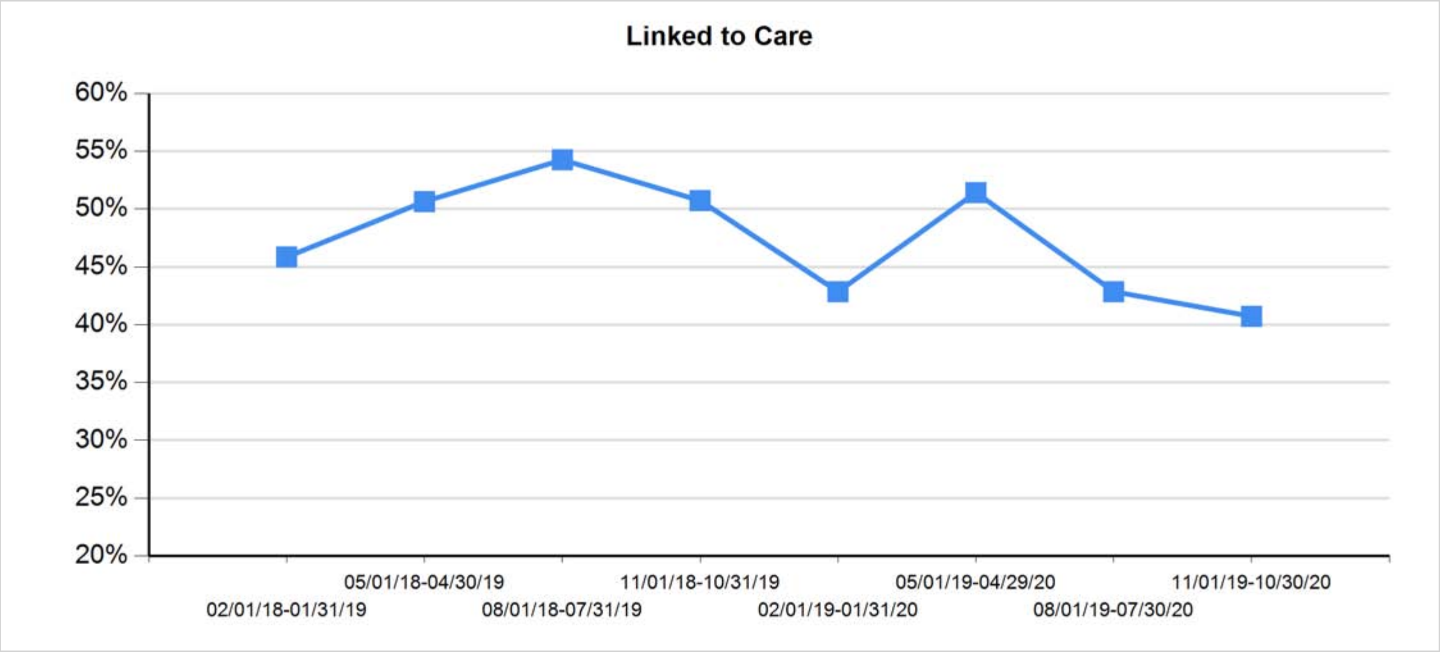
Linked to Care 2 by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load <200 copies/ml at last viral load in the measurement period	115	136	32	129	117	35	129	104	49
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 4 months of the measurement period	146	159	45	158	134	45	161	121	59
Percentage	78.8%	85.5%	71.1%	81.6%	87.3%	77.8%	80.1%	86.0%	83.1%
Change from Previous Quarter Results	2.6%	0.3%	-10.5%	2.9%	1.8%	6.7%	-1.5%	-1.4%	5.3%



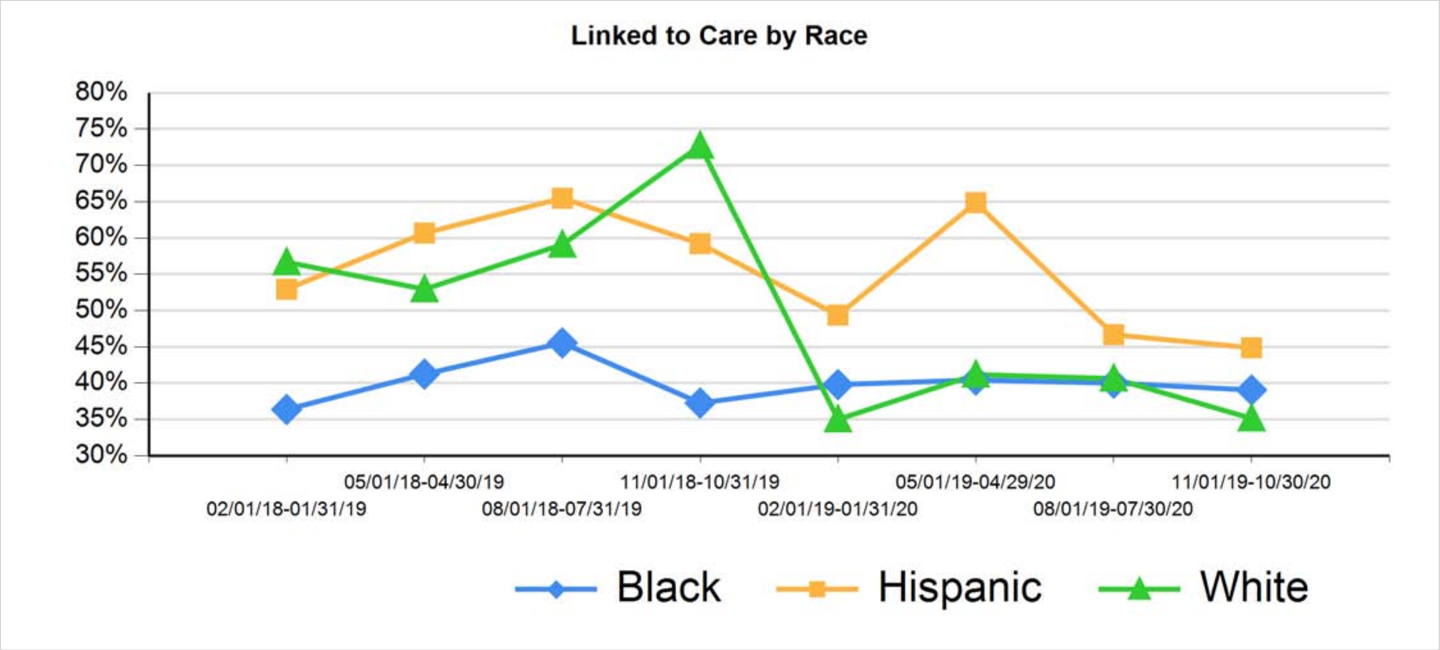
Linked to Care 2 by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load <200 copies/ml at last viral load in the measurement period	3	71	98	70	1	48	5	82	93	60	3	42
Number of newly enrolled clients who had a medical visit with a provider at least once in the first 4 months of the measurement period	4	83	114	88	3	57	9	96	112	78	3	46
Percentage	75.0%	85.5%	86.0%	79.5%	33.3%	84.2%	55.6%	85.4%	83.0%	76.9%	100.0%	91.3%
Change from Previous Quarter Results	-13.2%	4.6%	5.6%	3.2%	-33.3%	-6.3%	-19.4%	-0.1%	-2.9%	-2.6%	66.7%	7.1%



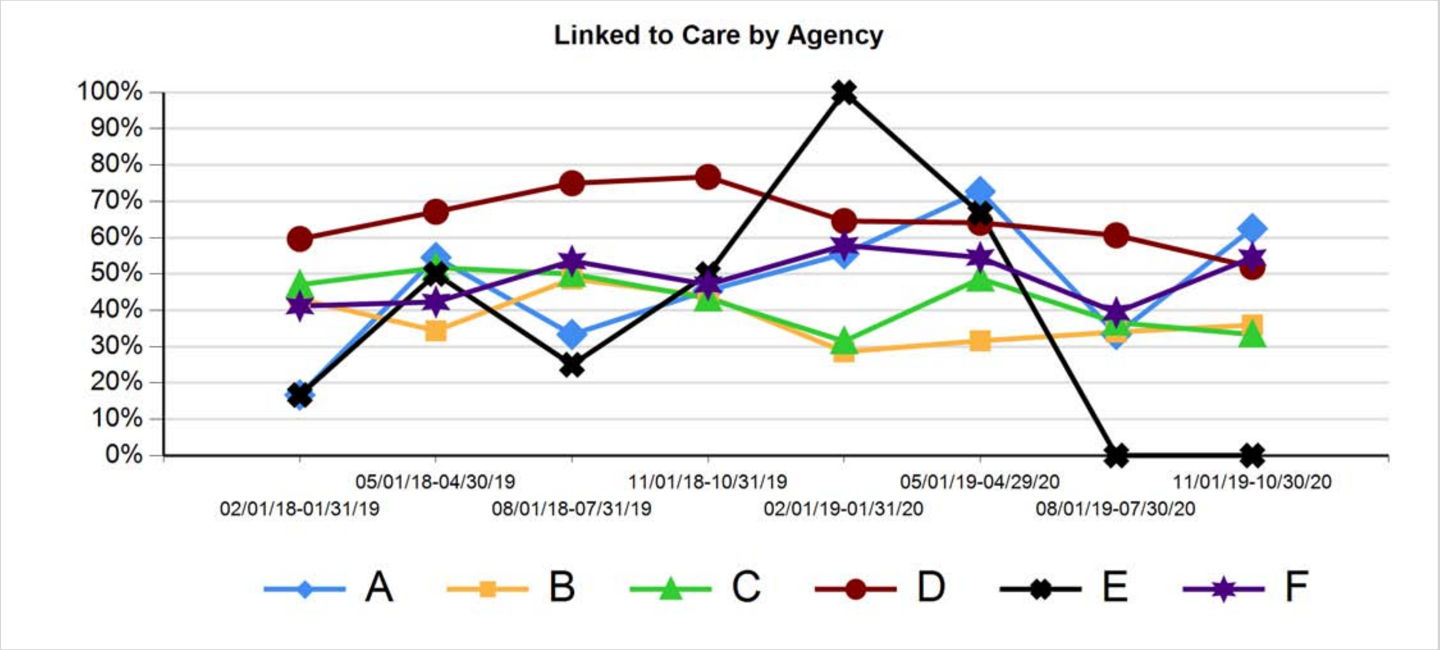
Linked to Care				
In+Care Campaign clients Newly Enrolled in Medical Care Measure				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	87	126	93	90
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	203	245	217	221
Percentage	42.9%	51.4%	42.9%	40.7%
Change from Previous Quarter Results	-7.9%	8.6%	-8.6%	-2.1%
* exclude if vl<200 in 1st 4 months				



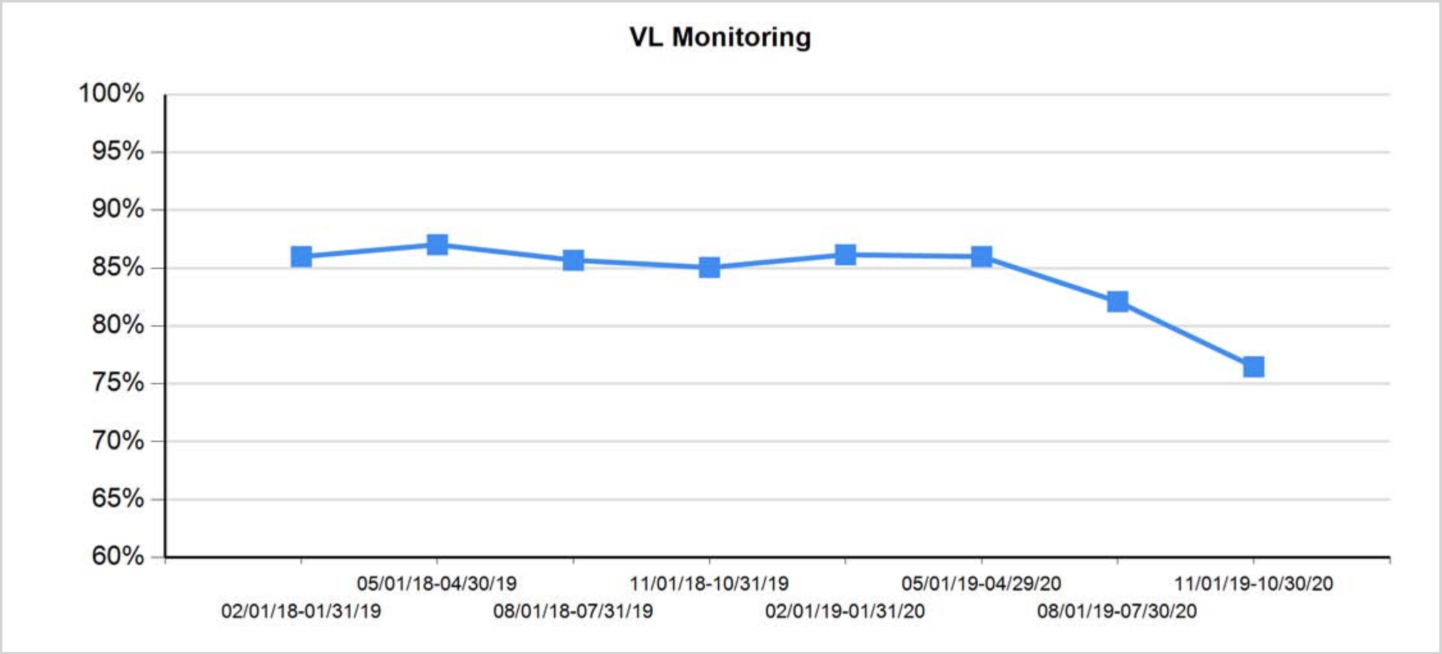
Linked to Care by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	38	72	14	36	42	13	41	35	13
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	94	111	34	90	90	32	105	78	37
Percentage	40.4%	64.9%	41.2%	40.0%	46.7%	40.6%	39.0%	44.9%	35.1%
Change from Previous Quarter Results	0.6%	15.5%	6.2%	-0.4%	-18.2%	-0.6%	-1.0%	-1.8%	-5.5%
* exclude if vl<200 in 1st 4 months									



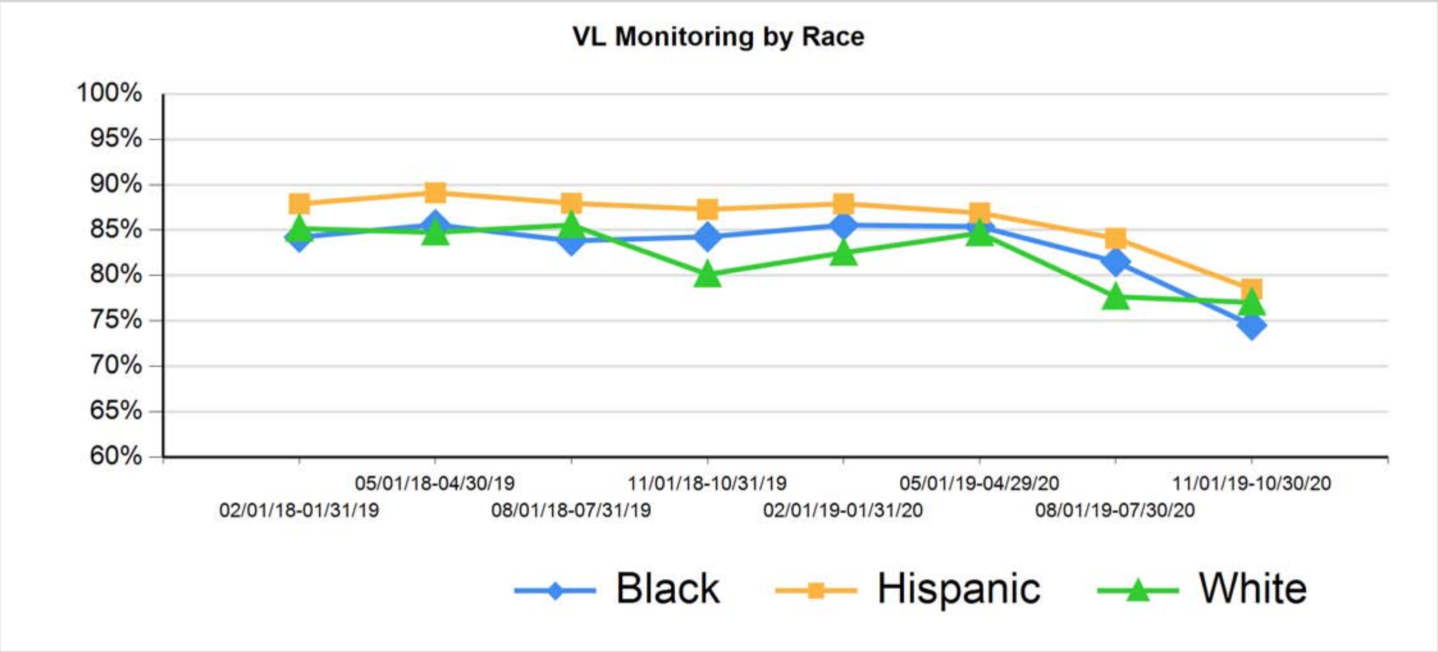
Linked to Care by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	1	17	26	37	0	13	5	23	25	27	0	12
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	3	50	71	61	1	33	8	64	75	52	2	22
Percentage	33.3%	34.0%	36.6%	60.7%	0.0%	39.4%	62.5%	35.9%	33.3%	51.9%	0.0%	54.5%
Change from Previous Quarter Results	-39.4%	2.4%	-12.1%	-3.4%	-66.7%	-15.2%	29.2%	1.9%	-3.3%	-8.7%	0.0%	15.2%
* exclude if vl<200 in 1st 4 months												



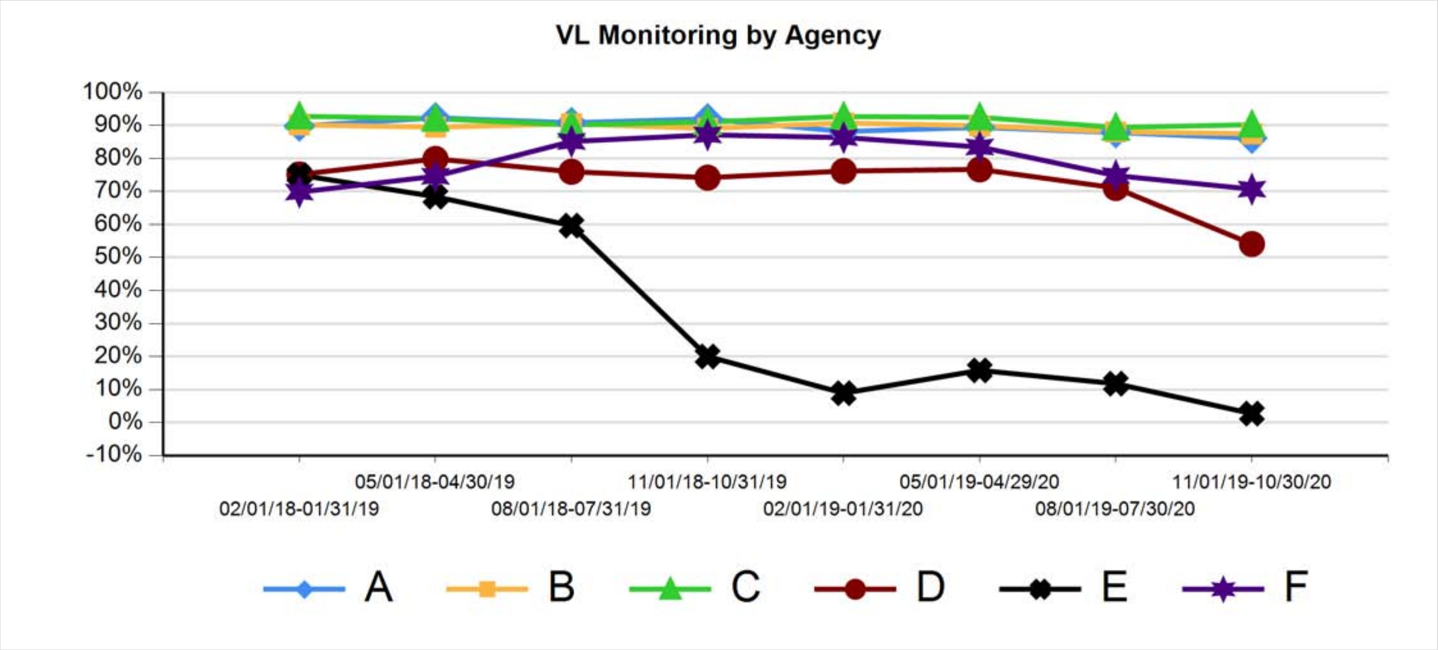
Viral Load Monitoring				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	4,598	4,597	4,233	3,802
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	5,337	5,346	5,156	4,972
Percentage	86.2%	86.0%	82.1%	76.5%
Change from Previous Quarter Results	1.1%	-0.2%	-3.9%	-5.6%



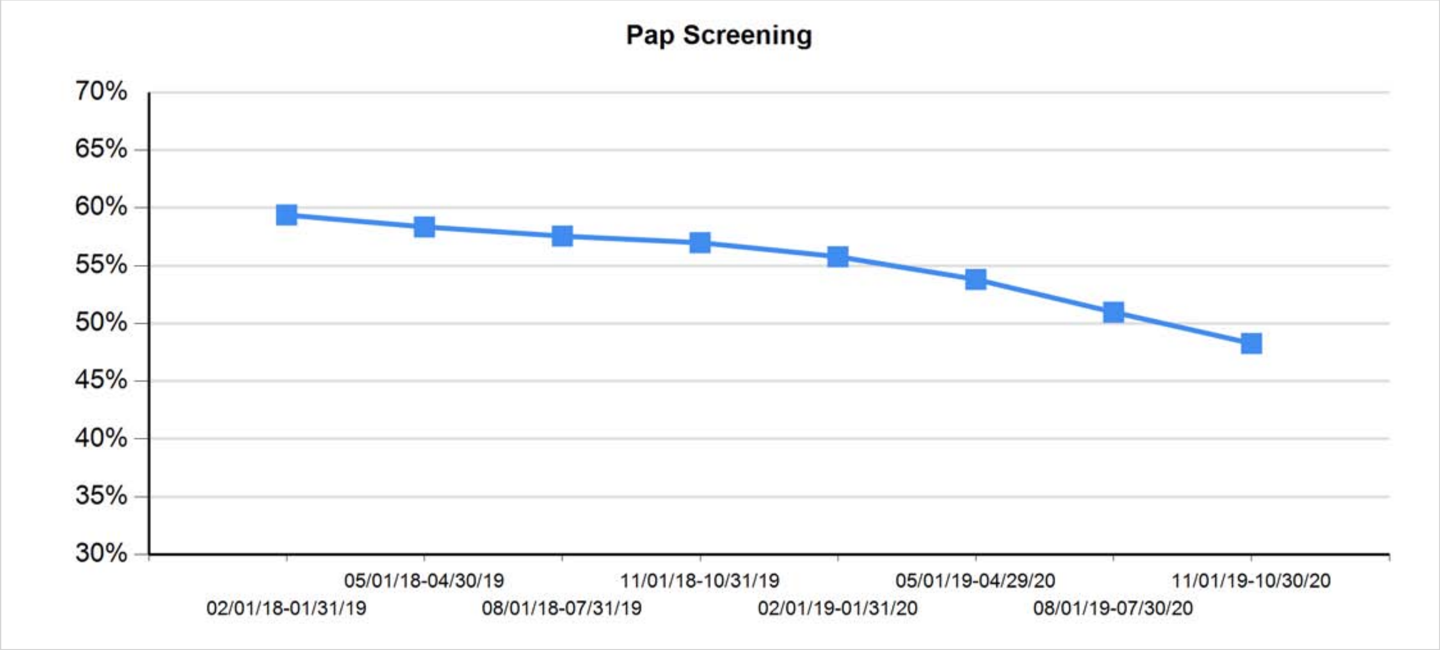
VL Monitoring Data by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	2,045	1,896	541	1,896	1,754	483	1,670	1,610	446
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	2,395	2,182	639	2,326	2,086	622	2,241	2,051	579
Percentage	85.4%	86.9%	84.7%	81.5%	84.1%	77.7%	74.5%	78.5%	77.0%
Change from Previous Quarter Results	-0.2%	-1.0%	2.2%	-3.9%	-2.8%	-7.0%	-7.0%	-5.6%	-0.6%



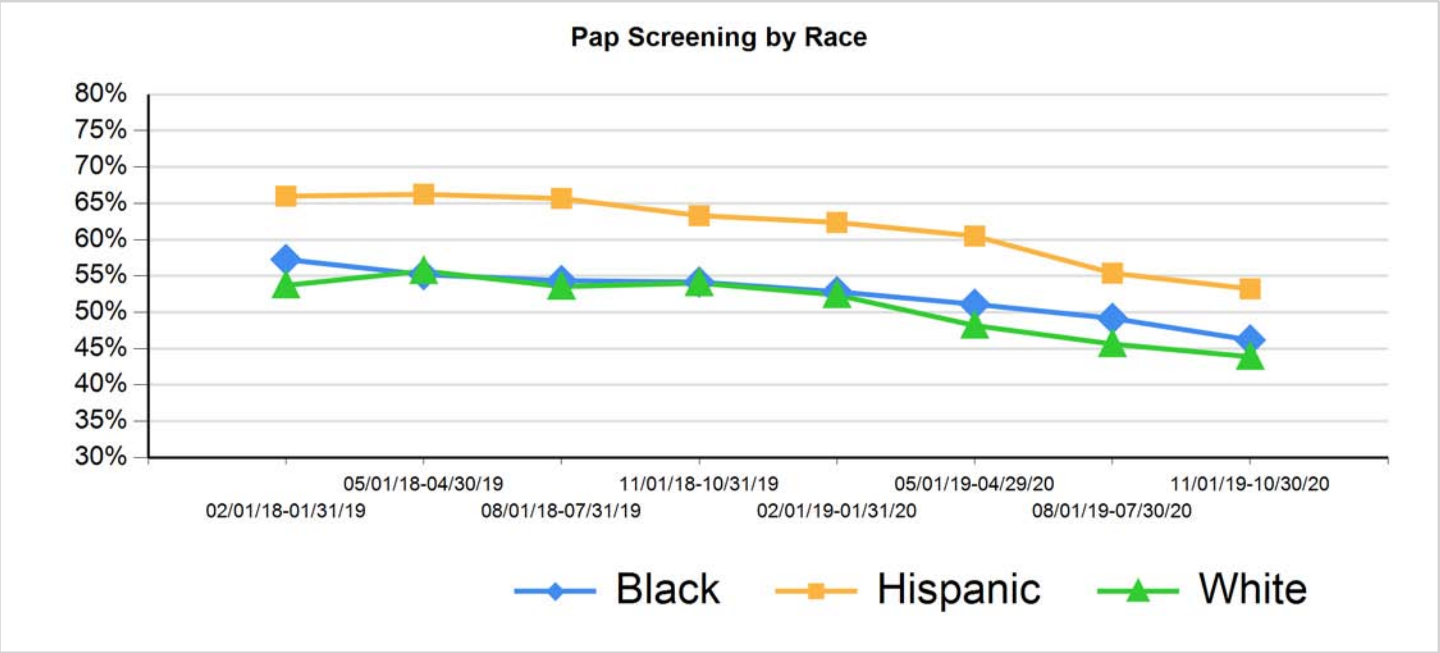
VL Monitoring by Agency												
	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	419	1,136	1,381	1,078	4	202	404	1,042	1,329	801	1	210
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	477	1,290	1,545	1,517	34	270	469	1,191	1,473	1,481	37	297
Percentage	87.8%	88.1%	89.4%	71.1%	11.8%	74.8%	86.1%	87.5%	90.2%	54.1%	2.7%	70.7%
Change from Previous Quarter Results	-1.6%	-1.8%	-3.1%	-5.6%	-4.0%	-8.7%	-1.7%	-0.6%	0.8%	-17.0%	-9.1%	-4.1%



Cervical Cancer Screening				
	02/01/19 - 01/31/20	05/01/19 - 04/29/20	08/01/19 - 07/30/20	11/01/19 - 10/30/20
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	1,149	1,116	1,049	975
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	2,060	2,074	2,058	2,020
Percentage	55.8%	53.8%	51.0%	48.3%
Change from Previous Quarter Results	-1.2%	-2.0%	-2.8%	-2.7%

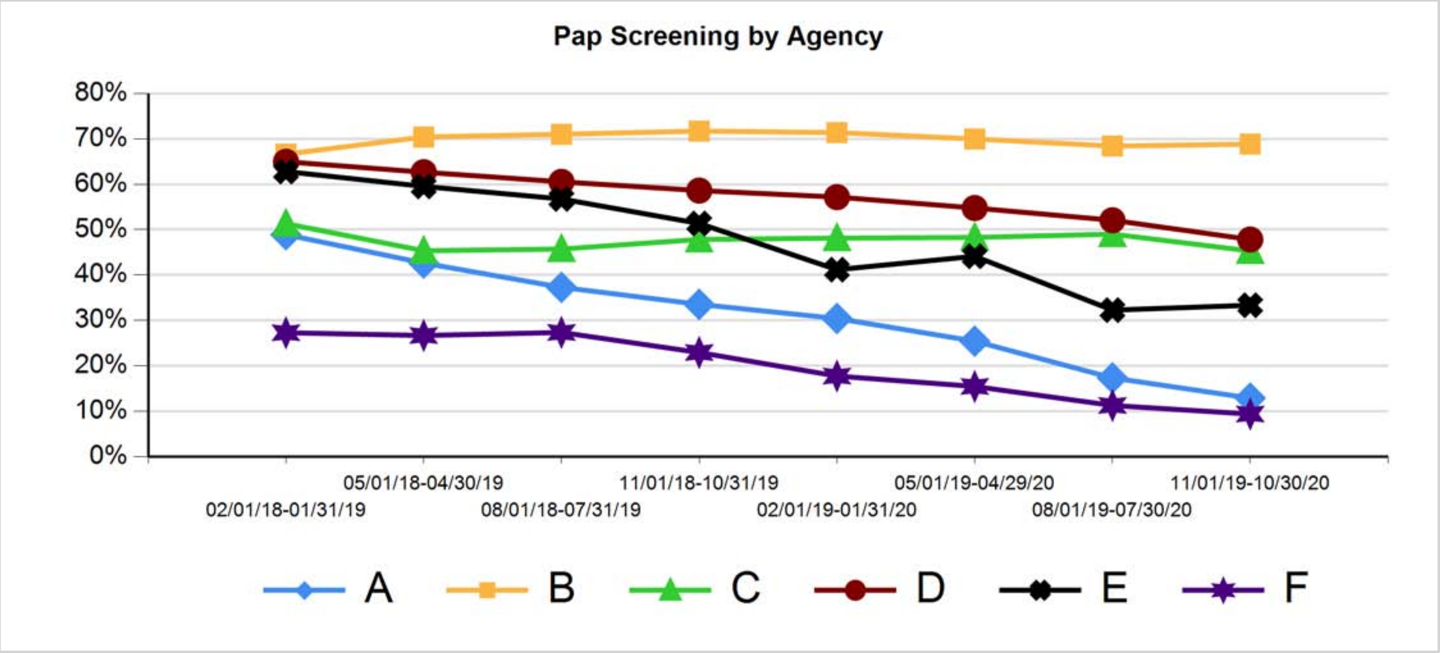


Cervical Cancer Screening Data by Race/Ethnicity									
	05/01/19 - 04/29/20			08/01/19 - 07/30/20			11/01/19 - 10/30/20		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	647	363	79	617	334	73	573	313	68
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,266	600	164	1,255	603	160	1,241	588	155
Percentage	51.1%	60.5%	48.2%	49.2%	55.4%	45.6%	46.2%	53.2%	43.9%
Change from Previous Quarter Results	-1.7%	-1.9%	-4.2%	-1.9%	-5.1%	-2.5%	-3.0%	-2.2%	-1.8%



Cervical Cancer Screening by Agency

	08/01/19 - 07/30/20						11/01/19 - 10/30/20					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	31	563	196	563	10	18	22	530	188	241	11	16
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	179	823	400	509	31	160	171	770	415	504	33	171
Percentage	17.3%	68.4%	49.0%	52.1%	32.3%	11.3%	12.9%	68.8%	45.3%	47.8%	33.3%	9.4%
Change from Previous Quarter Results	-8.1%	-1.6%	0.7%	-2.7%	-11.9%	-4.2%	-4.5%	0.4%	-3.7%	-4.2%	1.1%	-1.9%



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

Harris County
Public Health
Building a Healthy Community

2021-2022 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

Service Specific Standards

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 2021-2022:

- *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*
- *Emergency Financial Assistance (Other)*
- 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

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

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

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

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

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

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel and/or volunteer files indicates compliance
1.2	Initial Training: Staff/Volunteers Initial training includes 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	Intake The agency conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions. In addition to office visits, client is provided alternatives such as conducting business by mail, online registration via the internet, or providing home visits, when necessary. Agency has established procedures for communicating with people with hearing impairments.	• Documentation in client record • Review of Agency's Policies and Procedures Manual indicates compliance
5.0	**Quality Management**	
5.1	Continuous Quality Improvement (CQI) Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum: • The Agency's QM Plan	• Review of Agency's Policies and Procedures Manual indicates compliance • Up to date QM Manual • Source Citation: HAB Universal Standards; Section F: #2

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

	emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergency. The agency shall communicate hazards identified with its community emergency response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	
7.2	<u>Emergency Management Training</u> 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	<u>Emergency Preparedness Plan</u> The emergency preparedness plan shall address the six critical areas for emergency management including • Communication pathways (for both clients and staff) • 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. <u>(www.jointcommission.org)</u>	• Emergency Preparedness Plan
7.4	<u>Emergency Management Drills</u> Agency shall implement emergency management drills twice a year either in response to actual emergency or in a planned exercise. Completed exercise should be evaluated by a multidisciplinary team including administration, clinical and	• Emergency Management Plan • Review of Agency's Policies and Procedures Manual indicates compliance

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

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

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

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

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

[3] National Association of Social Workers (2013). NASW standards for social work case management. Retrieved 12/28/2018 from https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3d&portalid=0

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

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

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

Clinical Case Management Services

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

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

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

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

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

Non-Medical Case Management Services (Service Linkage Worker)

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

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

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

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

Medical Case Management

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

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

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

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

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

Emergency Financial Assistance Program

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

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

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

Local Pharmacy Assistance Program

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

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

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

Outreach Services

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

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

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

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

Primary Medical Care

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

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

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

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

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

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

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

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

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

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

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

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

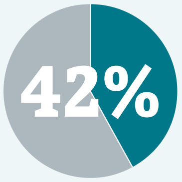
Vision Services

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

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

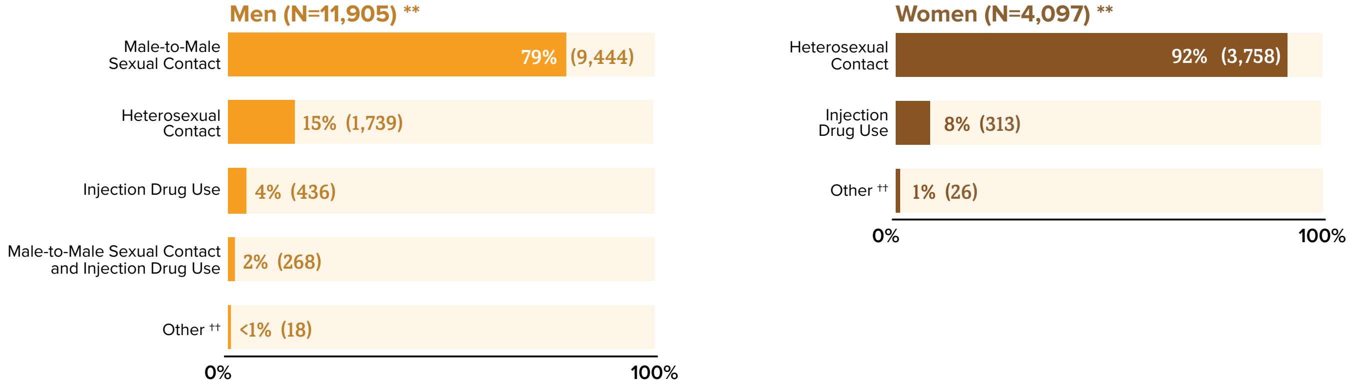
	Current medications; Allergies and drug sensitivities; Reason for visit (chief complaint).	
2.3	CD4/Viral Loads When clinically indicated, current (within the last 6 months) CD4 and Viral Load laboratory test results for clients are obtained.	• Documentation in the client record
2.4	Comprehensive Eye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

HIV and African American People



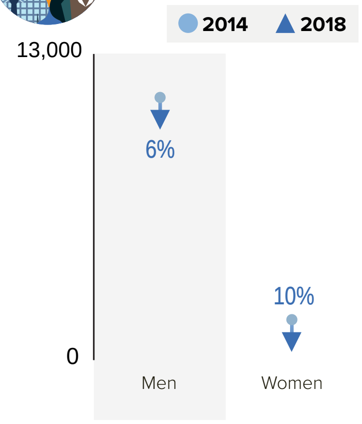
Black/African American[*] people made up 42% (16,002)[†] of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas[‡] in 2018.

Among Black/African American people, most new HIV diagnoses were among men.

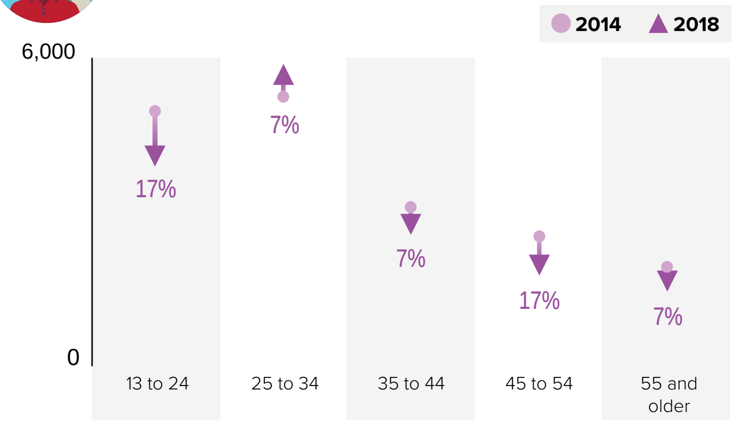


Good progress has been made with reducing HIV diagnoses among most age groups, with HIV diagnoses decreasing 7% among Black/African American people overall from 2014 to 2018.

Trends by Sex



Trends by Age [‡‡]



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[*] *Black* refers to people having origins in any of the Black racial groups of Africa. *African American* is a term often used for people of African descent with ancestry in North America. This fact sheet uses *African American*, unless referencing surveillance data.

[†] Adult and adolescent Black/African American people aged 13 and older.

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

[**] Based on sex assigned at birth and includes transgender people.

[††] Includes perinatal exposure, blood transfusion, hemophilia, and risk factors not reported or not identified.

[‡‡] Does not include *perinatal* and *other* transmission categories.

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Black/African American people who don't know they have HIV can't get the care and treatment they need to stay healthy.

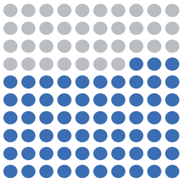
At the end of 2018, an estimated **1.2 MILLION PEOPLE** had HIV. Of those, 482,900 were among Black/African American people. ***

6 in 7

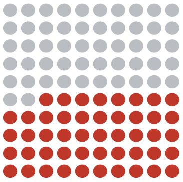
Black/African American people knew they had the virus.

It is important for Black/African American people 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. People who get and keep an undetectable viral load (or remain virally suppressed) can stay healthy for many years and have effectively no risk of transmitting HIV to their sex partners.

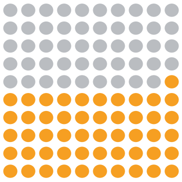
Compared to all people with HIV, Black/African American people have lower viral suppression rates. More work is needed to increase these rates. For **every 100 Black/African American people with HIV in 2018:**



63 received some HIV care



48 were retained in care



51 were virally suppressed

For comparison, for every **100 people overall** with HIV, **65 received some HIV care**, **50 were retained in care**, and **56 were virally suppressed**.

There are several challenges that place some African American people at higher risk for HIV.

Knowledge of HIV Status

Some African American people don't know their 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.

Sexually Transmitted Diseases (STDs)

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

Racism, HIV Stigma, and Homophobia

Racism, HIV stigma, and homophobia can negatively impact risk-taking behaviors, knowledge of HIV status, HIV care, and other needed services for many African American people.

Social and Economic Issues

African American people experiencing poverty may find it harder to get HIV prevention and care services.

How is CDC making a difference for African American people?

- 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.

*** In 50 states and the District of Columbia..

For more information about HIV surveillance data, 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 January 2021.

HRSA
Ryan White & Global HIV/AIDS Programs

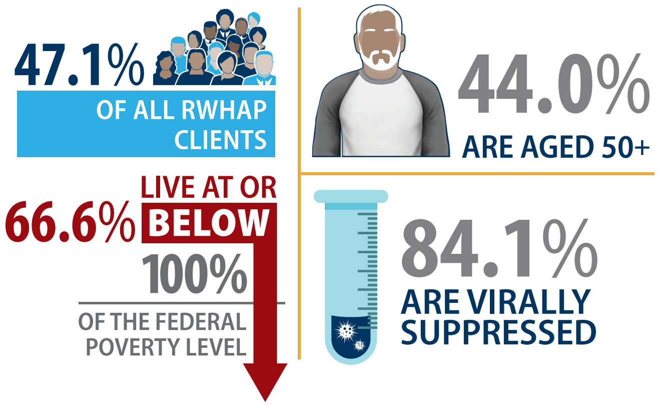
HRSA's Ryan White HIV/AIDS Program

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.

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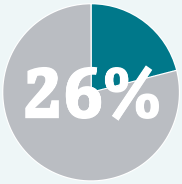
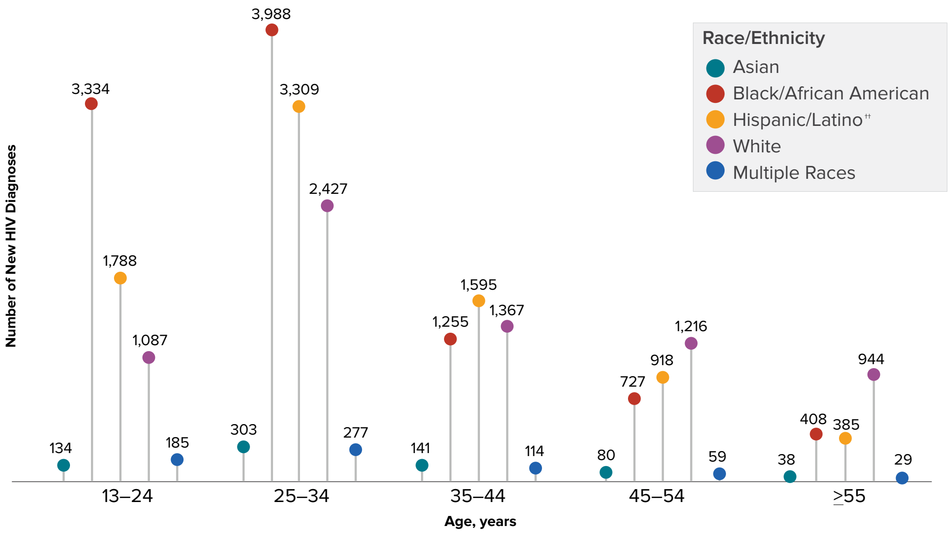
* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

HIV and African American Gay and Bisexual Men



Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas* in 2018, 26% were among Black/African American† gay and bisexual men. ‡ **

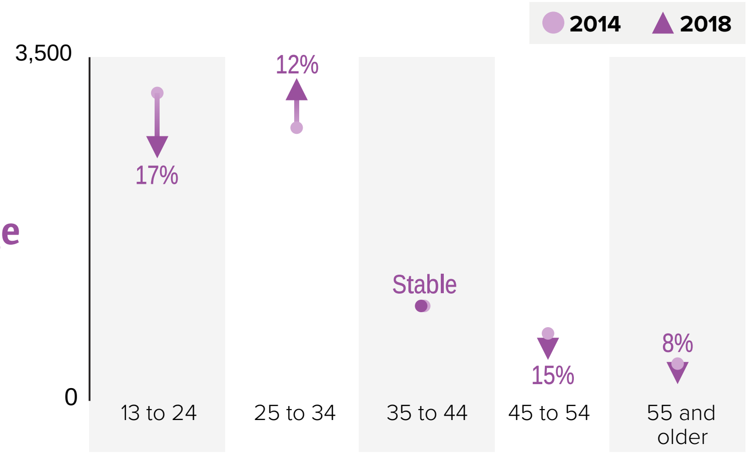
About 3 out of 4 Black/African American gay and bisexual men who received an HIV diagnosis were aged 13 to 34.



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

From 2014 to 2018, HIV diagnoses remained stable among Black/African American gay and bisexual men. ** But trends varied by age.

Trends by Age



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* 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. *African American* is a term often used for Americans of African descent with ancestry in North America. This fact sheet uses African American, unless referencing surveillance data.

‡ This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who reported male-to-male sexual contact aged 13 and older.

** Includes infections attributed to male-to-male sexual contact *and* injection drug use.

†† Hispanics /Latinos can be of any race.

‡‡ In 50 states and the District of Columbia.

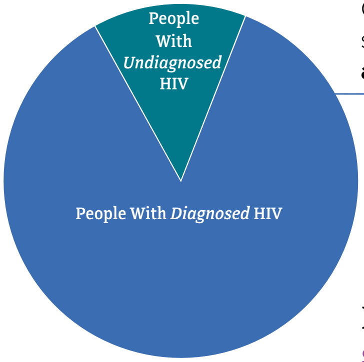
Black/African American gay and bisexual men who don't know they have HIV cannot get the care and treatment they need to stay healthy.

At the end of 2018, an estimated **1.2 MILLION AMERICANS** had HIV. [‡‡]
Of those, 235,100 were Black/African American gay and bisexual men.

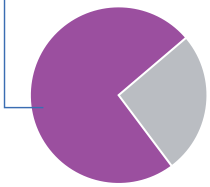
4 in 5

Black/African American gay and bisexual men knew they had the virus.[***]

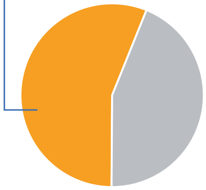
It is important for Black/African American gay and bisexual men to know their HIV status so they can take medicine to treat HIV if they have the virus. Taking HIV medicine every day can make the viral load undetectable. People who get and keep an undetectable viral load (or stay virally suppressed) can live a long and healthy life. They also have effectively no risk of transmitting HIV to HIV-negative sex partners.



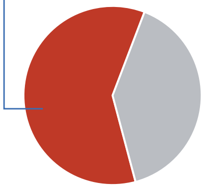
Compared to all people with *diagnosed* HIV, Black/African American gay and bisexual men have lower viral suppression rates. More work is needed to increase these rates. For every **100 Black/African American gay and bisexual men with *diagnosed* HIV** in 2018:[†††]



75 received some HIV care



56 were retained in care



61 were virally suppressed

For comparison, for every 100 people overall with *diagnosed* HIV, 76 received some HIV care, 58 were retained in care, and 65 were virally suppressed.[‡‡‡]

There are several challenges that place some African American gay and bisexual men at higher risk for HIV.

Delay in Linkage to HIV Medical Care

Not all African American gay and bisexual men with 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

Higher poverty rates among some African American gay and bisexual men can mean limited access to quality health care, HIV prevention education, and lower income, placing them at higher risk for HIV.

Racism, HIV Stigma, and Homophobia

Racism, HIV stigma, and homophobia can negatively impact risk-taking behaviors, knowledge of HIV status, HIV care, and other needed services for many African American gay and bisexual men.

How is CDC making a difference for African American gay and bisexual men?

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.

[***] Includes infections attributed male-to-male sexual contact only. Among Black/African American men with HIV attributed to male-to-male sexual contact and injection drug use, 94% knew they had HIV.

[†††] In 41 states and the District of Columbia.

[‡‡‡] Learn more about CDC's different HIV care continuum approaches at www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf. 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 October 2020.

2020 Houston HIV Care Services Needs Assessment: Profile of African American Men Who Have Sex with Men (MSM)

PROFILE OF AFRICAN AMERICAN MSM

A recent analysis of national HIV diagnosis rates revealed that the largest percentage of new HIV diagnoses in the south was among Black/African American men who have sex with men (**MSM**). (Center for Disease Control & Prevention, 2020). Though no single cause has been identified, intersections of high prevalence, decreased status awareness, stigma, racism and discrimination, and homophobia likely contribute to increased transmission vulnerability among African American MSM (Center for Disease Control & Prevention, 2020). A persistent challenge to designing HIV prevention and care services that meet the needs of Houston area people living with HIV (**PLWH**) is ensuring that services remain relevant and responsive to the needs of both the general population and groups with increased vulnerability to new transmissions and unmet need. Data about service needs and barriers African American MSM PLWH in the Houston area encounter is of particular importance to local HIV planning, as this information equips communities to design prevention and care services that meet the unique needs of disproportionately affected groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment, as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include African American MSM participants. This Profile highlights results *only* for participants who were African American MSM, as well as comparisons to the entire needs assessment sample.

Notes: This analysis defines African American MSM as PLWH who indicated they were cis-gender men with a primary race/ethnicity of black/African American, and self-identified as gay, bisexual, or pansexual. Results for participants who are transgender or gender non-conforming were reported in a separate profile available on the Houston Ryan White Planning Council website.

Data presented in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check-all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 103 participants in the 2020 Houston HIV Care Services Needs Assessment were African American MSM, comprising 17% of the entire sample.

Ninety-seven percent (97%) of African American MSM participants were residing in Houston/Harris County at the time of data collection. Compared to the total sample of the needs assessment participants, the majority of the respondents were between the ages of 35 to 64 (77%) and were born in the U.S. (98%). A third of African American MSM participants identified as gay (67%) or bisexual/pansexual (28%). Sixty percent (60%) of African American MSM participants had annual incomes below 100% of the Federal Poverty Level, and the average annual income for African American MSM participants was $15,127. Among African American MSM participants, thirty-nine (39%) had public health insurance coverage through Medicaid or Medicare, twenty-two (22%) had insurance coverage through Harris Health and twenty-one (21%) had Ryan White only.

Compared to all needs assessment participants, higher proportions of African American MSM participants were ages 55-64 (35% vs. 28%), identified as gay (67% vs. 30%) or bisexual/pansexual (27% vs 9%). The average income among African American MSM participants who reported income was larger than that of the total sample ($15,127 vs. $11,360). Lastly, a higher proportion of African American MSM participants did not have health insurance (5%) when compared to all needs assessment participants (2%).

Characteristics of African American MSM participants (as compared to all participants in general) can be summarized as follows:

- Residing in Houston/Harris County
- Adults between the ages of 35 and 64
- Self-identified as gay or bisexual
- Higher average annual income
- Higher proportion of having no health insurance

TABLE 1-Select Characteristics among African American MSM Participants, Houston Area HIV Needs Assessment, 2020

	No.	AA MSM %	Total %		No.	AA MSM %	Total %		No.	AA MSM %	Total %
County of residence				**Age range** (median: 50-54)				**Sexual orientation** (self-reported)			
Harris	84	97%	95%	13-17	0	-	-	Heterosexual	1	1%	57%
Fort Bend	2	2%	2%	18-24	5	6%	3%	Gay	60	67%	30%
Other	1	1%	2%	25-34	9	10%	9%	Bisexual / Pansexual	25	28%	9&
				35-49	26	30%	28%	Undecided	4	4%	4%
				50-54	11	13%	18%				
				55-64	31	35%	28%				
				≥65	6	7%	15%				
				Seniors (≥50)	48	26%	60%				
Immigration status				**Yearly income** (average: $15,127)				**Health insurance** (multiple response)			
Born in the U.S.	88	98%	88%	**Federal Poverty Level (FPL)**				Private insurance	10	9%	9%
Citizen > 5 years	0	-	10%	Below 100%	26	60%	67%	Medicaid/Medicare	44	39%	67%
Citizen < 5 years	1	1%	1%	100%	9	21%	19%	Harris Health System	25	22%	29%
Visa (student, work, tourist, etc.)	0	-	0.2%	150%	3	7%	6%	Ryan White Only	24	21%	24%
Prefer not to answer	1	1%	0.7%	200%	2	5%	5%	VA	3	3%	3%
				250%	0	-	-	None	6	5%	2%
				≥300%	3	7%	2%				

BARRIERS TO RETENTION IN CARE

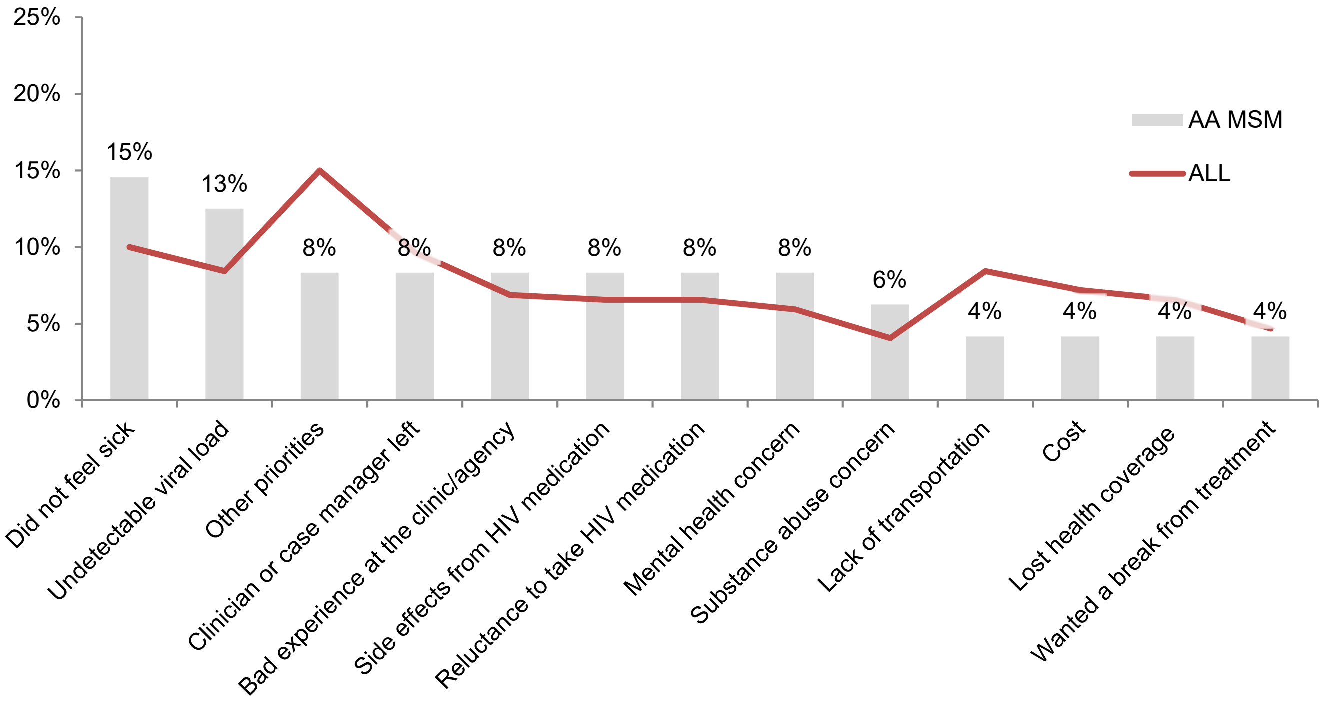
As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 31% of African American MSM participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey, and participants could select multiple reasons and write in their reasons.

(**Graph 1**) Among African American MSM participants, not feeling sick was the most cited reason for interruption in HIV medical care (15%), followed by having an undetectable viral load (13%). Additional reasons for falling out of HIV medical care reported by African American MSM respondents were the following: other priorities, clinician or case manager left, bad experience at the clinic/agency, side effects from HIV medication, reluctance to take HIV medication, and mental health concerns (all 8%). Compared to the total sample, a higher proportion of African American MSM participants reported not feeling sick (15% vs. 10%), and an undetectable viral load (13% vs 8%) as the reasons for the lapse in care. Lower proportions reported having other priorities (8% vs 15%), lack of transportation (4% vs 8%), and cost (4% vs 7%) as reasons for the lapse in care. Write in responses for this question reported they did not want family to know they were taking medication for HIV, were incarcerated, or did not know where to get services resulting in their lapse in HIV medical care.

GRAPH 1-Reasons for Falling Out of HIV Care among African American MSM PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by African American MSM needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



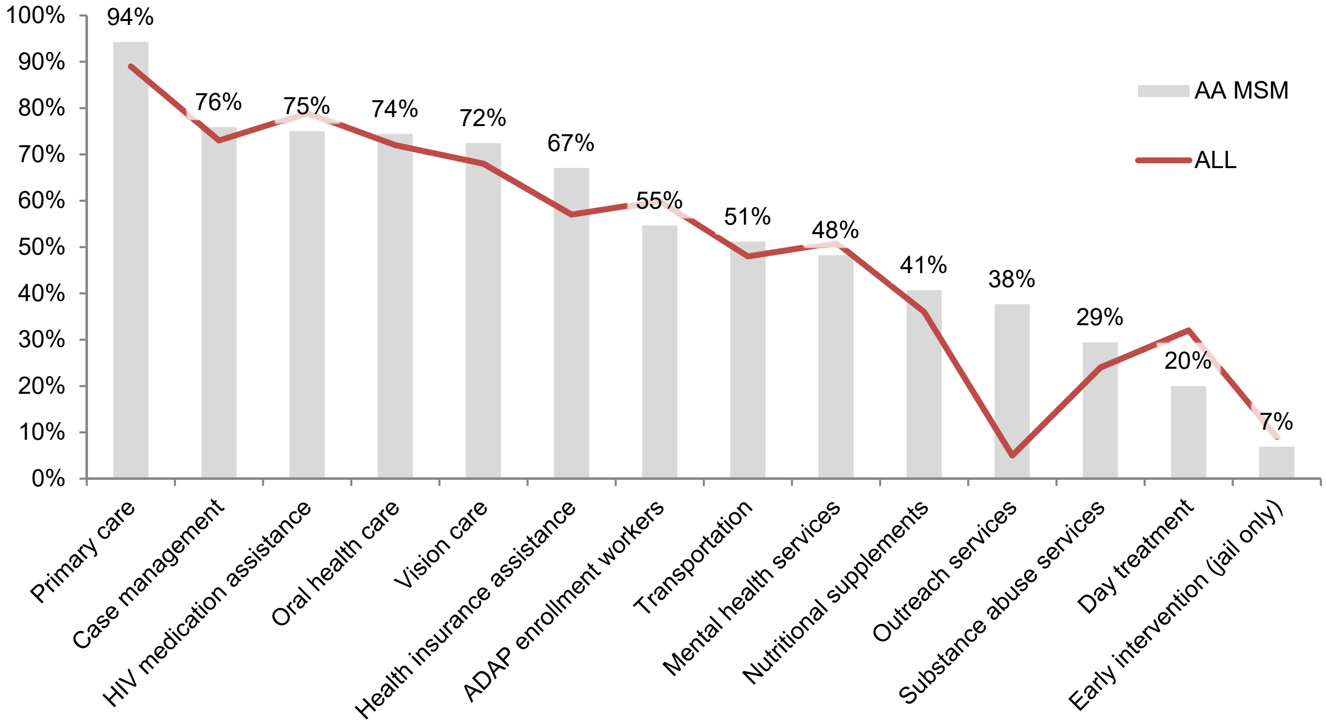
OVERALL RANKING OF FUNDED SERVICES, BY NEED

In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. 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 2**) Among African American MSM participants, primary care was the most needed funded service at 94% of African American MSM participants reporting need, followed by case management (76%), HIV medication assistance (75%), oral health care (74%), vision care (72%), and health insurance assistance (67%). Compared to the total sample, higher proportion of African American MSM participants reported needing outreach services (38% vs 5%), health insurance assistance (67% vs 57%), primary care (94% vs 89%), nutritional supplements (41% vs 36), and substance abuse services (29% vs 24%). Lower proportions reported needing day treatment (20% vs 32%), ADAP enrollment workers (55% vs 60%), and HIV medication assistance (75% vs. 79%).

GRAPH 2-Ranking of HIV Services among African American MSM PLWH in the Houston Area, By Need, 2020

Definition: Percent of African American MSM needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



OTHER IDENTIFIED NEEDS

In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV-related services they needed in the past 12 months.

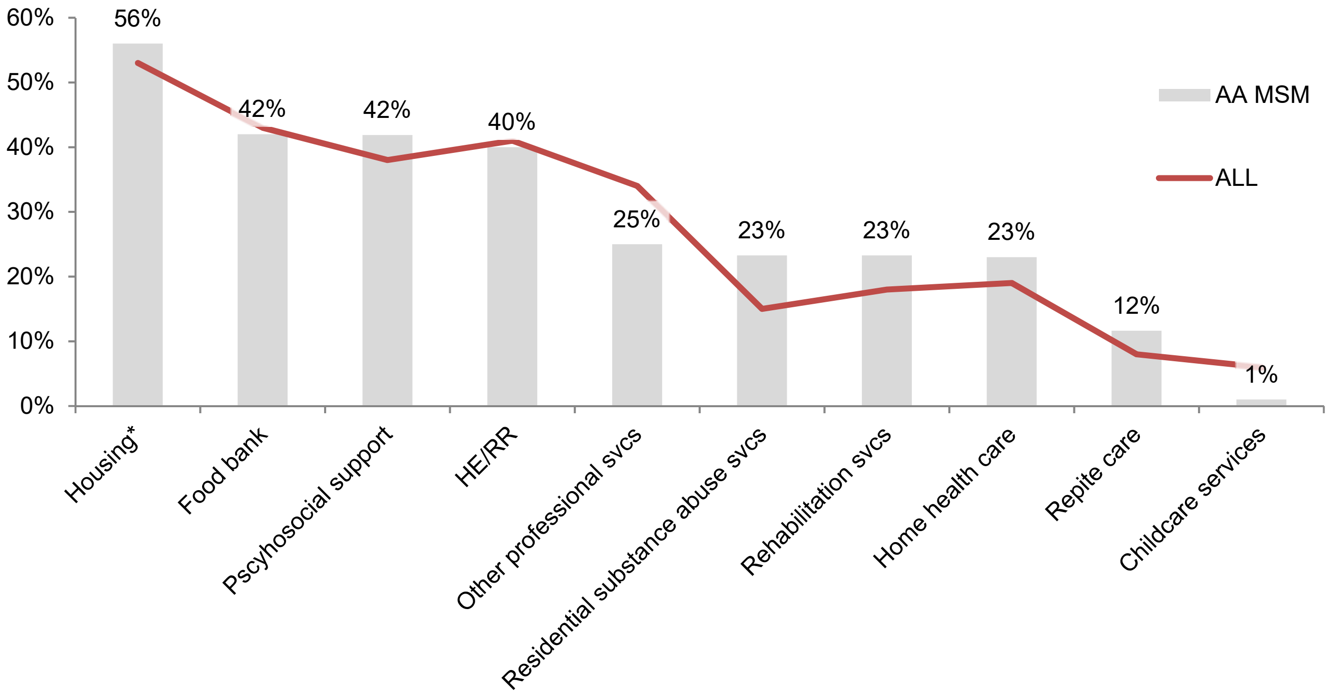
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, 56% of African American MSM reported housing as the most needed. Additionally, African American MSM participants reported a need for the following other/non-Ryan White funded HIV-related services: food bank (42%), psychosocial support (42%), and health education and risk reduction (HE/RR) (40%).

Compared to the total sample, higher proportions of African American MSM reported a need for residential substance abuse services (23% vs 15%), rehabilitation services (23% vs 18%), home health care (23% vs 19%), psychosocial support (42% vs 38%), and respite care (12% vs 8%). Lower proportions of participants reported needing the following other/non-Ryan White funded HIV-related services: professional services (25% vs 34%), and childcare services (1% vs 6%).

GRAPH 3-Other Needs for HIV Services among African American MSM PLWH in the Houston Area, 2020

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

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



OVERALL BARRIERS TO HIV CARE

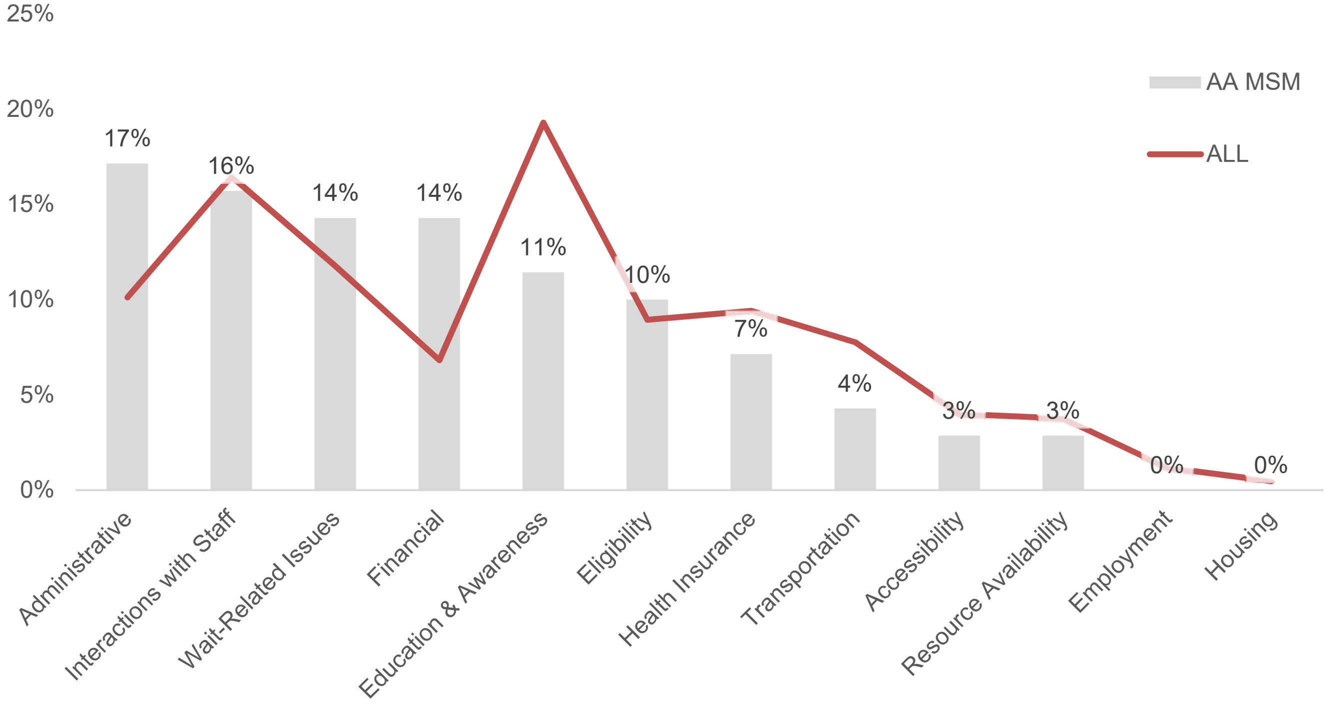
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 district barriers. These barriers were then grouped together into 12 nodes, or barrier types.

(**Graph 4**) Eighty-six (86) African American MSM participants cited barriers to Ryan White funded HIV care services. African American MSM participants most often cited barriers related to administrative issues (17%), interactions with staff (16%), wait related issues (14%), and financial barriers (14%).

Complex and lengthy processes needed to access services, changes in services and dismissal at agencies and clinics were administrative barriers reported by African American MSM respondents. Barriers reported by African American MSM respondents reporting interactions with staff as a barrier mentioned poor communication from staff, poor treatment by staff, lack of staff knowledge of services, and not receiving a referral to services as barriers.

Compared to the general sample, a greater proportion of African American MSM participants reported encountering administrative barriers (17% vs 10%), as well as barriers related to the participants finances (14% vs 7%). A lower proportion of African American MSM participants reported barriers related to education and awareness (11% vs 19%) as well as wait-related issues (14% vs 12%).

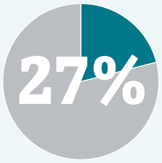
GRAPH 4-Ranking of Types of Barriers to HIV Services among African American MSM PLWH in the Houston Area, 2020
Definition: Percent of times each barrier type was reported by African American MSM needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



Works Cited

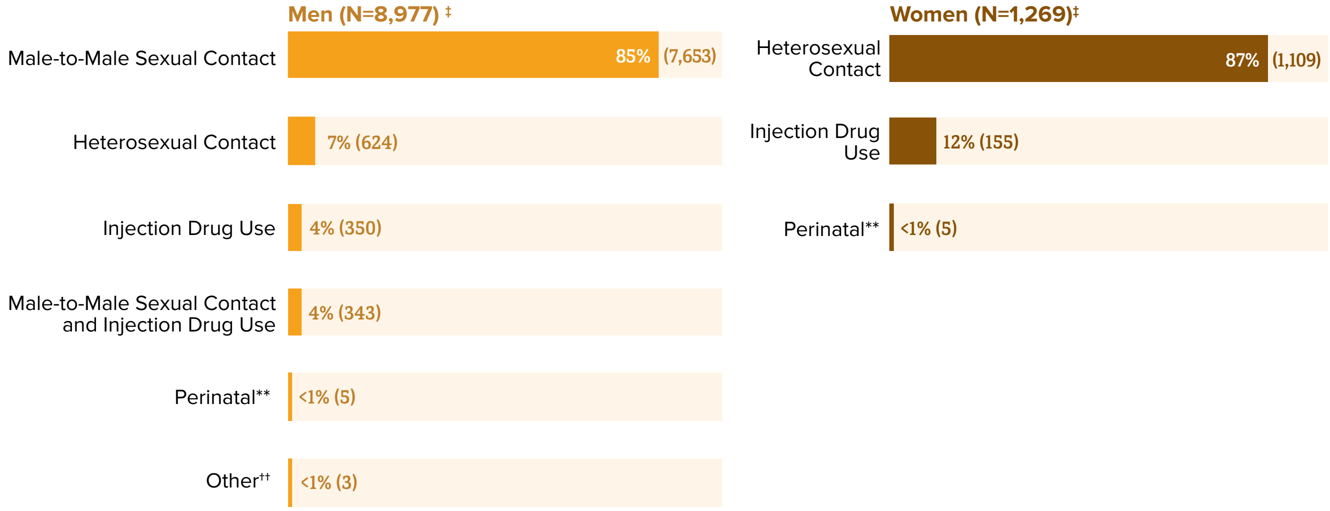
Centers for Disease Control and Prevention. (2020, October 23). *HIV and African American Gay and Bisexual Men*. Retrieved from https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-31/index.html.

HIV and Hispanics/Latinos



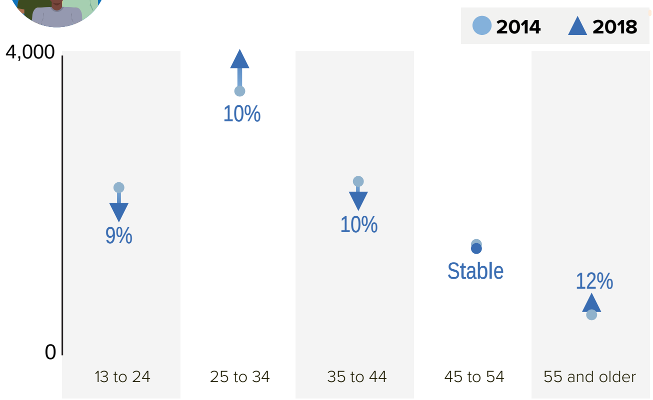
Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2018, 27% were among Hispanics/Latinos.[†]

Most new HIV diagnoses among Hispanics/Latinos were among gay and bisexual men.

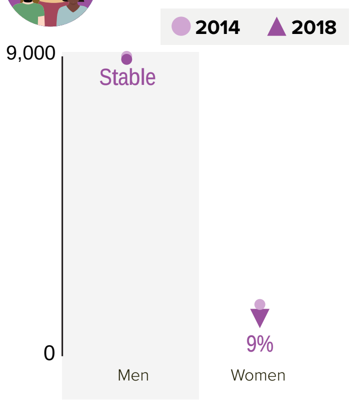


From 2014 to 2018, HIV diagnoses remained stable among Hispanics/Latinos overall. Although trends varied for different groups of Hispanics/Latinos, HIV diagnoses declined for some groups, including Hispanic women/Latinas and young Hispanics/Latinos aged 13 to 24.

Trends by Age[‡‡]



Trends by Sex



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[*] 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.
[‡] Based on sex at birth and includes transgender people.
[**] People who got HIV through perinatal transmission but aged 13 or older at the time of diagnosis.
[††] Includes blood transfusion, hemophilia, and risk factors not reported or not identified.
[‡‡] Does not include *perinatal* and *other* transmission categories.
[***] In 50 states and the District of Columbia.

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Division of HIV/AIDS Prevention

Hispanics/Latinos who don't know they have HIV can't get the care and treatment they need to stay healthy.

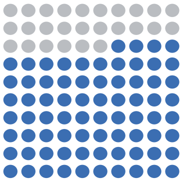
At the end of 2018, an estimated **1.2 MILLION AMERICANS** had HIV.*** Of those, 274,100 were Hispanics/Latinos.

5 in 6

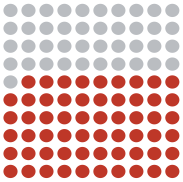
Hispanics/Latinos knew they had the virus.

It is important for Hispanics/Latinos 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. People who get and keep an undetectable viral load (or stay virally suppressed) can live a long and healthy life. They also have effectively no risk of transmitting HIV to HIV-negative sex partners.

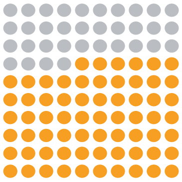
Compared to all people with HIV, Hispanics/Latinos have lower viral suppression rates. More work is needed to increase these rates. For every **100 Hispanics/Latinos with HIV**:



61 received some HIV care



49 were retained in care



53 were virally suppressed

For comparison, for every **100 people overall** with HIV, **65 received some HIV care**, **50 were retained in care**, and **56 were virally suppressed**.

There are several challenges that place some Hispanics/Latinos at higher risk for HIV.

Knowledge of HIV Status

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

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.

Racism, HIV Stigma, and Homophobia

Racism, HIV stigma, and homophobia can negatively impact risk-taking behaviors, knowledge of HIV status, HIV care, and other needed services for many Hispanics/Latinos.

Access to HIV Prevention and Treatment Services

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

How is CDC making a difference for Hispanics/Latinos?

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, 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 October 2020.

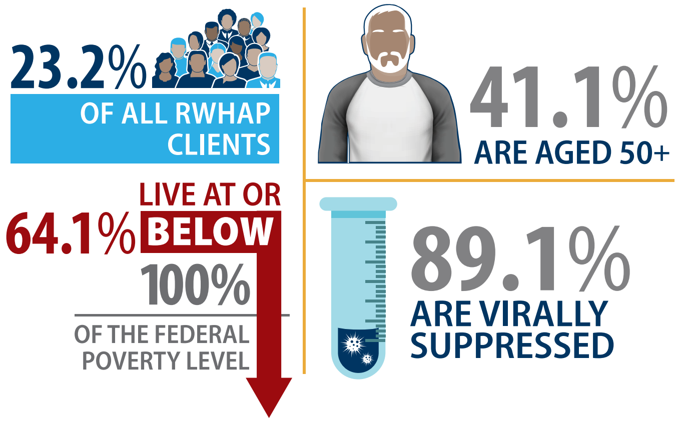
HRSA's Ryan White HIV/AIDS Program

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).

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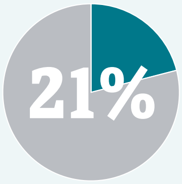
* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

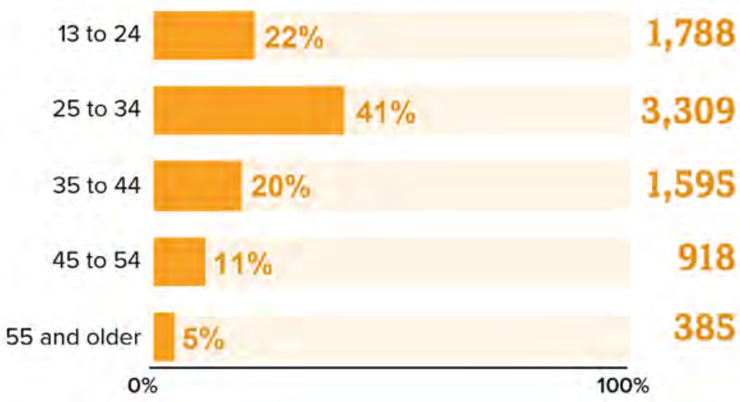
For more information on HRSA's Ryan White HIV/AIDS Program, please visit: hab.hrsa.gov.

HIV and Hispanic/Latino Gay and Bisexual Men



Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2018, 21% were among Hispanic/Latino[†] gay and bisexual men.[‡][**]

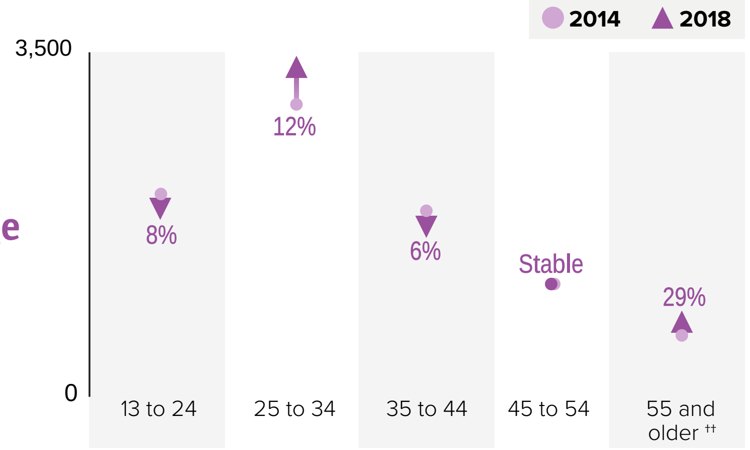
About 2 out of 3 Hispanic/Latino gay and bisexual men who received an HIV diagnosis were aged 13 to 34.



The numbers have been statistically adjusted to account for missing transmission categories. Values may not equal the subpopulation total.

Though HIV diagnoses remained stable among Hispanic/Latino gay and bisexual men overall from 2014 to 2018, trends varied by age.

Trends by Age



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[*] 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.

[‡] This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who reported male-to-male sexual contact aged 13 and older.

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

[††] Changes in subpopulations with fewer HIV diagnoses can lead to a large percentage increase or decrease.

[‡‡] In 50 states and the District of Columbia.

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Division of HIV/AIDS Prevention

Hispanic/Latino gay and bisexual men who don't know they have HIV can't get the care and treatment they need to stay healthy.

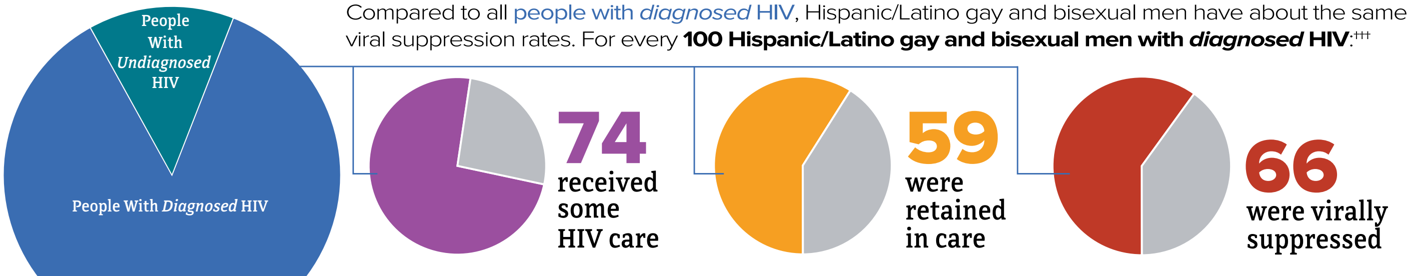
At the end of 2018, an estimated **1.2 MILLION AMERICANS** had HIV.[‡‡] Of those, 186,900 were Hispanic/Latino gay and bisexual men.

4 in 5

Hispanic/Latino gay and bisexual men knew they had the virus.[***]

It is important for Hispanic/Latino gay and bisexual men 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. People who get and keep an undetectable viral load (or stay virally suppressed) can live a long and healthy life. They also have effectively no risk of transmitting HIV to HIV-negative sex partners.

Compared to all people with *diagnosed* HIV, Hispanic/Latino gay and bisexual men have about the same viral suppression rates. For every **100 Hispanic/Latino gay and bisexual men with *diagnosed* HIV**:[†††]



For comparison, for every 100 people overall with *diagnosed* HIV, 76 received some HIV care, 58 were retained in care, and 65 were virally suppressed.[‡‡‡]

There are several challenges that place some Hispanic/Latino gay and bisexual men at higher risk for HIV.

Racism, HIV Stigma, and Homophobia

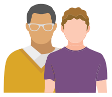
STIGMA

Racism, HIV stigma, and homophobia can negatively impact risk-taking behaviors, knowledge of HIV status, HIV care, and other needed services for many Hispanic/Latino gay and bisexual men.

Low PrEP Use

A small number of Hispanic/Latino gay and bisexual men reported using pre-exposure prophylaxis (PrEP). If taken as prescribed, 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 for Hispanic/Latino gay and bisexual men?

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.

LET'S STOP HIV TOGETHER

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

Ending the HIV Epidemic

Strengthening successful HIV prevention programs and supporting new efforts funded through the *Ending the HIV Epidemic* initiative.

[***] Includes infections attributed male-to-male sexual contact only. Among Hispanic/Latino men with HIV attributed to male-to-male sexual contact and injection drug use, 10 in 11 knew they had HIV.

[†††] In 41 states and the District of Columbia.

[‡‡‡] Learn more about CDC's different HIV care continuum approaches at www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf. 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 October 2020.

2020 Houston HIV Care Services Needs Assessment: Profile of Hispanic/Latino Men Who Have Sex with Men (MSM)

PROFILE OF HISPANIC/LATINO MSM

An analysis conducted by the Centers for Disease Control & Prevention (**CDC**) showed that among all new HIV diagnoses in 2018 within the U.S., 21% were among Hispanic/Latino men who have sex with men (**MSM**) (Center for Disease Control & Prevention, 2020). Though no single cause has been identified, intersections of high prevalence, racism, discrimination, stigma, homophobia, and fear of disclosing their immigration status likely contribute to increased transmission vulnerability among Hispanic/Latino MSM (Center for Disease Control & Prevention, 2020). A persistent challenge to designing HIV prevention and care services that meet the needs of Houston area people living with HIV (**PLWH**) is ensuing that services remain relevant and responsive to the needs of both the general population and groups with increased vulnerability to new transmissions and unmet need. Data about service needs and barriers Hispanic/Latino MSM PLWH in the Houston area encounter is of particular importance to local HIV planning, as this information equips communities to design prevention and care services that meet the unique needs of disproportionately affected groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment, as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include Hispanic/Latino MSM participants. This Profile highlights results *only* for participants who were Hispanic/Latino MSM, as well as comparisons to the entire needs assessment sample.

Notes: This analysis defines Hispanic/Latino MSM as PLWH who indicated they were cis-gender men with a primary race/ethnicity of Hispanic/Latino, and self-identified as gay, bisexual, pansexual, or undecided. Results for participants who are transgender or gender non-conforming were reported in a separate profile available on the Houston Ryan White Planning Council website.

Data presented in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile. (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check-all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 44 participants in the 2020 Houston HIV Care Services Needs Assessment were Hispanic/Latino MSM, comprising 8% of the entire sample.

Ninety-three percent (93%) of Hispanic/Latino MSM participants were residing in Houston/Harris County at the time of data collection. Compared to the total sample of the needs assessment participants, the majority of the respondents were between the ages of 35 to 64 (84%), have been a citizen of the U.S. for more than 5 years (48%), and primarily had health insurance through public health insurance programs (82%); Medicaid/Medicare (27%), the Harris Health System (23%), and Ryan White (32%). Among Hispanic/Latino MSM needs assessment participants, 71% had annual incomes that were 100% below the Federal Poverty Level (**FPL**). The average annual income reported by Hispanic/Latino MSM was $10,871.

-

Compared to all needs assessment participants, higher proportions of Hispanic/Latino MSM participants were between the ages of 55 to 64 (36% vs 28%), were U.S. citizens for more than 5 years (48% vs 10%), and were 100% below the FPL, and had higher occurrences of having health insurance (7% vs 2%). Hispanic/Latino MSM participants who reported income had a lower average annual income when compared to the total sample of the needs assessment ($10,871 vs $11,360).

Characteristics of African American MSM participants (as compared to all participants in general) can be summarized as follows:

- Residing in Houston/Harris County
- Adults between the ages of 35 and 64
- Lower average annual income
- Higher proportion of having no health insurance or utilizing public health insurance program.

TABLE 1-Select Characteristics among Hispanic/Latino MSM Participants, Houston Area HIV Needs Assessment, 2020

	No.	H/L MSM %	Total %		No.	H/L MSM %	Total %		No.	H/L MSM %	Total %
County of residence				**Age range** (median: 50-54)				**Sexual orientation** (self-reported)			
Harris	41	93%	95%	13-17	0	-	-	Heterosexual	39	93%	30%
Fort Bend	1	2%	2%	18-24	1	2%	3%	Gay	3	7%	9%
Montgomery	1	2%	1%	25-34	4	9%	9%	Bisexual / Pansexual	0	0%	1%
Other	1	2%	1.6%	35-49	13	30%	28%	Undecided	1	2%	2%
				50-54	8	18%	18%				
				55-64	16	36%	28%				
				≥65	2	5%	15%				
				Seniors (≥50)	26	29%	60%				
Immigration status				**Yearly income** (average: $10,871)				**Health insurance** (multiple response)			
Born in the U.S.	18	41%	88%	**Federal Poverty Level (FPL)**				Private insurance	6	10%	9%
Citizen > 5 years	21	48%	10%	Below 100%	12	71%	67%	Medicaid/Medicare	16	27%	67%
Citizen < 5 years	5	11%	1%	100%	3	18%	19%	Harris Health System	14	23%	29%
Visa (student, work, tourist, etc.)	0	-	0.2%	150%	2	12%	6%	Ryan White Only	19	32%	24%
Prefer not to answer	0	-	0.7%	200%	0	-	5%	VA	1	2%	3%
				250%	0	-	0.7%	None	4	7%	2%
				≥300%	0	-	2%				

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighed using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

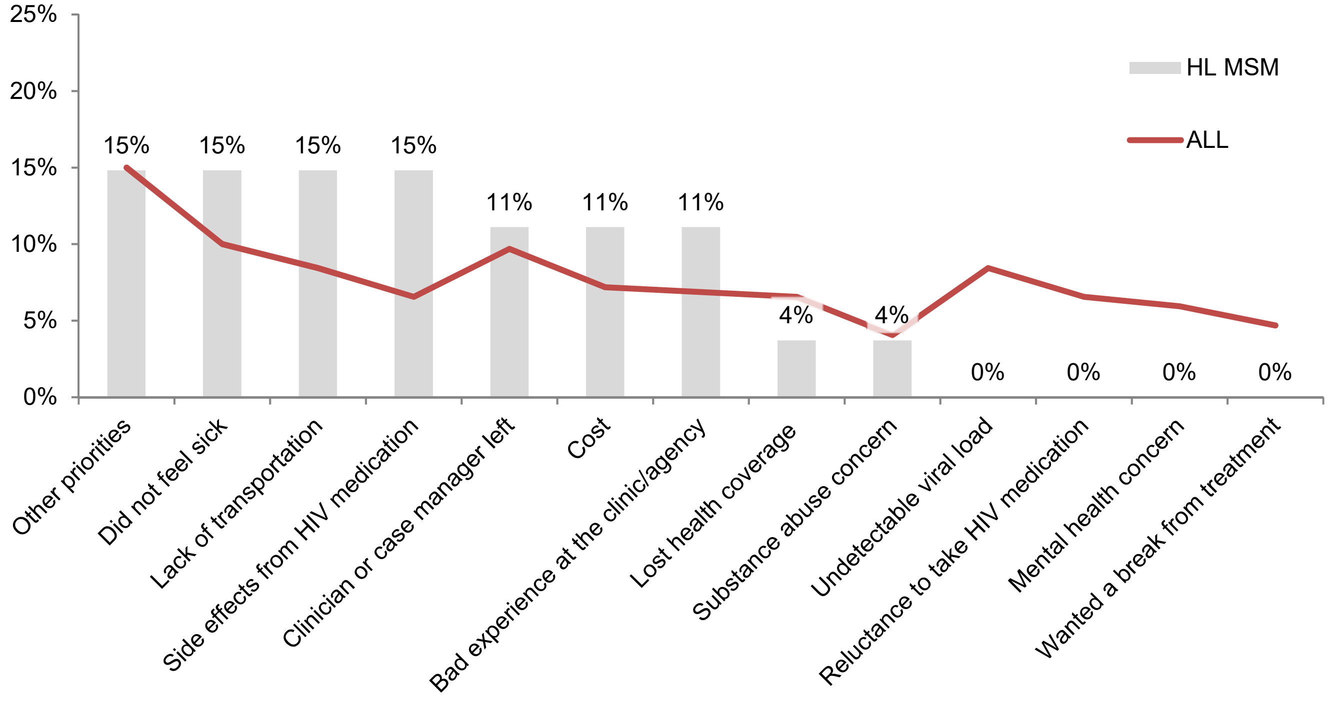
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months of more since their diagnosis, 81% of Hispanic/Latino MSM needs assessment participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey, and participants could provide multiple reasons. Participants could also write-in their reasons.

(**Graph 1**) Hispanic/Latino MSM needs assessment participants reported other priorities, not feeling sick, lack of transportation, and side effects from HIV medications (all 15%) as reasons for falling out of HIC medical care. Hispanic/Latino MSM also reported their clinician or case manager leaving, the cost of services, and bad experiences at the clinic/agency (all 11%) as reasons for falling out of HIV care.

Compared to the total sample, a higher proportion of Hispanic/Latino MSM participants reported having side effects from HIV medication (15% vs 7%), lack of transportation (15% vs 8%), and not feeling sick (15% vs 10%) as reasons for the lapse in HIV medical care. One write-in response was provided which reported "stupidity" as the reason for their lapse in HIV medical care.

GRAPH 1-Reasons for Falling Out of HIV Care among Hispanic/Latino MSM PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by Hispanic/Latino MSM needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



OVERALL RANKING OF FUNDED SERVICES, BY NEED

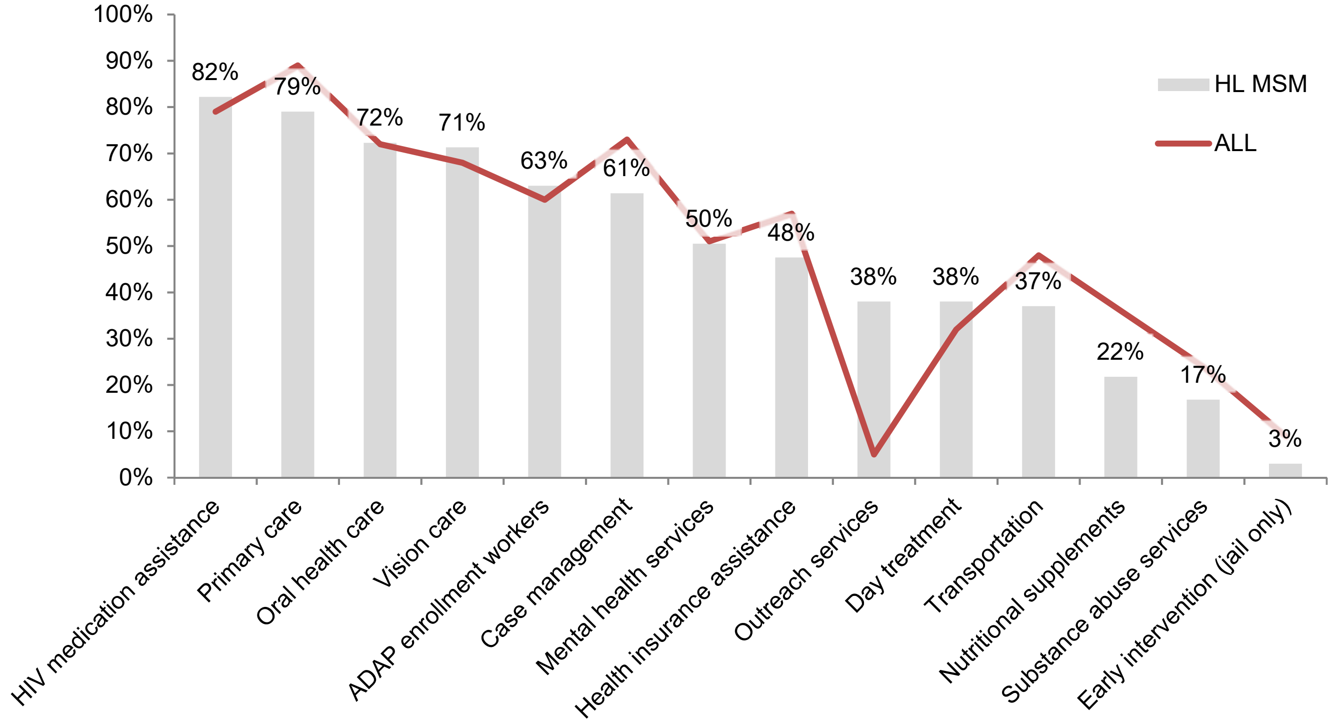
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Among Hispanic/Latino MSM participants, HIV medication assistance was the most needed funded service at 82% of Hispanic/Latino MSM participants reporting need. Hispanic/Latino MSM needs assessment participants also reported a need for primary care (79%), oral health care (72%) and vision care (71%).

Overall Hispanic/Latino MSM reported less need for funded services by the Houston Area Ryan White HIV/AIDS Program. However, Hispanic/Latino MSM did report a much greater need for outreach services when compared to the total sample (38% vs 5%). Lower proportions of Hispanic/Latino MSM reported needing nutritional supplements (22% vs 36%), case management (61% vs 73%), and transportation (37% vs 48%).

GRAPH 2-Ranking of HIV Services among Hispanic/Latino MSM PLWH in the Houston Area, By Need, 2020

Definition: Percent of Hispanic/Latino MSM needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



OTHER IDENTIFIED NEEDS

In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV-related services they needed in the past 12 months.

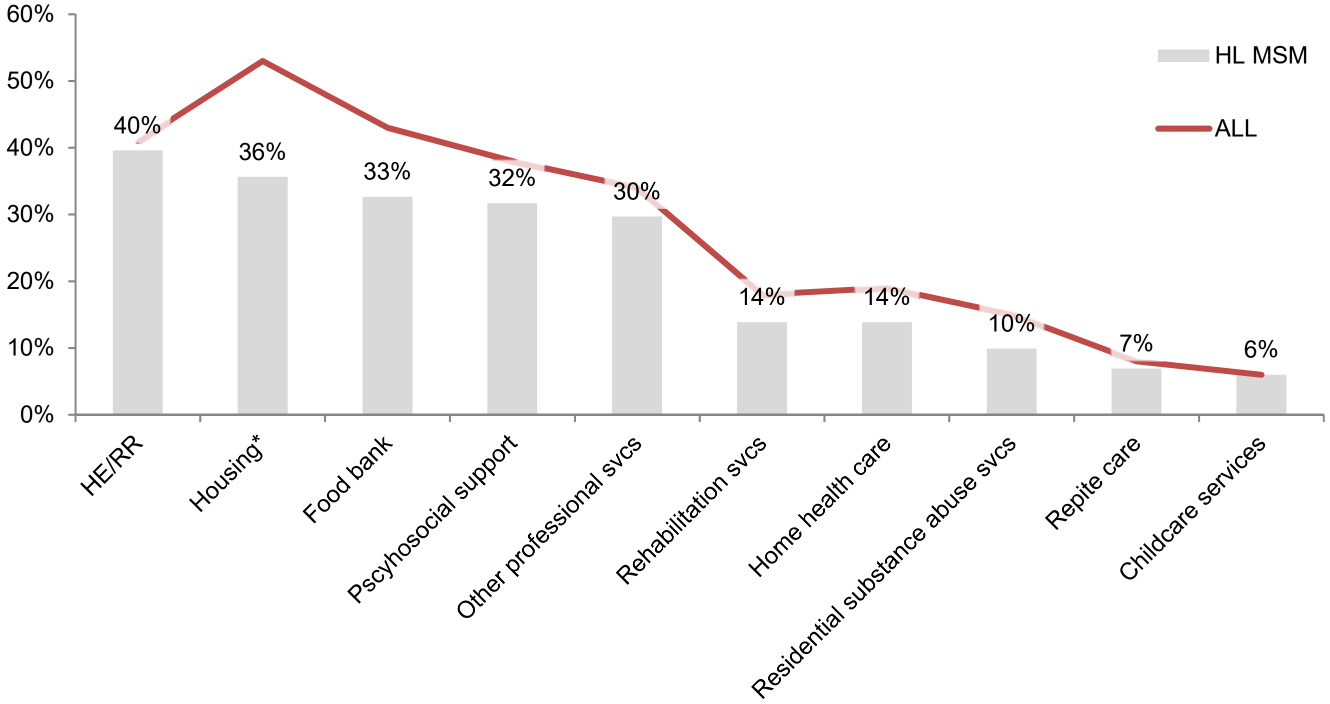
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, 40% of Hispanic/Latino MSM reported need for health education & risk reduction services as the most needed. Additionally, Hispanic/Latino MSM reported a need for housing (36%), food bank (33%), and psychosocial support services (32%).

Overall, Hispanic/Latino MSM reported a lower need for other/non-Ryan White Services in the 2020 Houston Care Services Needs Assessment. Compared to the total sample, lower proportions of Hispanic/Latino MSM reported need for housing (36% vs 53%), and food bank (33% vs 43%).

GRAPH 3-Other Needs for HIV Services among Hispanic/Latino MSM PLWH in the Houston Area, 2020

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

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



OVERALL BARRIERS TO HIV CARE

The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

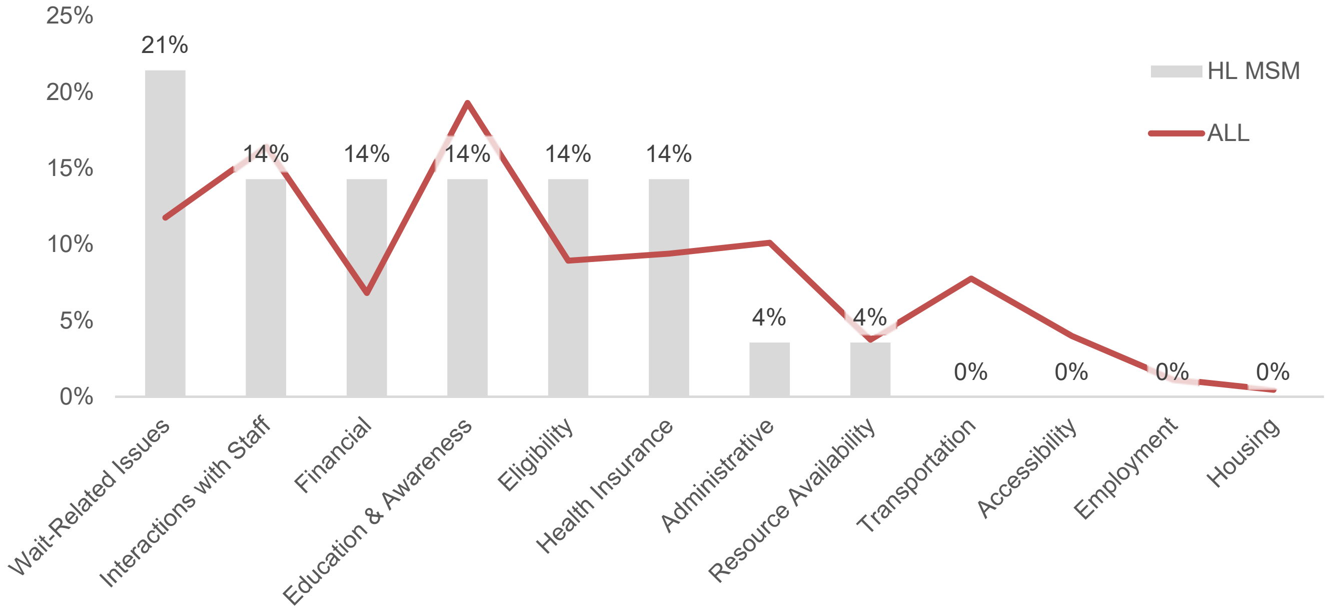
(**Graph 4**) Sixteen (16) Hispanic/Latino MSM participants cited barriers to Ryan White funded HIV care services. Hispanic/Latino MSM participants most often cited barriers related to wait issues (21%), interactions with staff at the agency or clinic, financial barriers, and education and awareness of services in the Houston area (all 14%).

Wait-related issues reported by Hispanic/Latino were related to being put on a waitlist, the service not being available due to a full waitlist, wait times at appointments, and approval of the application for the service. Issues related to interactions with staff reported by Hispanic/Latino MSM were that there was poor communication from staff, and providers not providing a referral for services. Barriers related to education and awareness of services were related to Hispanic/Latino MSM participants not knowing that a service was available.

Compared to the general sample, a greater proportion of Hispanic/Latino MSM participants reported encountering barriers that were wait-related (21% vs 12%), and related to finances or not being able to afford the service (14% vs 7%). Lower proportions of Hispanic/Latino MSM reported barriers related to transportation (0% vs 8%), and administrative issues (4% vs 10%) when compared to the total sample.

GRAPH 4-Ranking of Types of Barriers to HIV Services among Hispanic/Latino MSM PLWH in the Houston Area, 2020

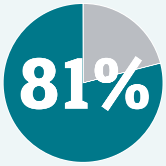
Definition: Percent of times each barrier type was reported by Hispanic/Latino MSM needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



Works Cited

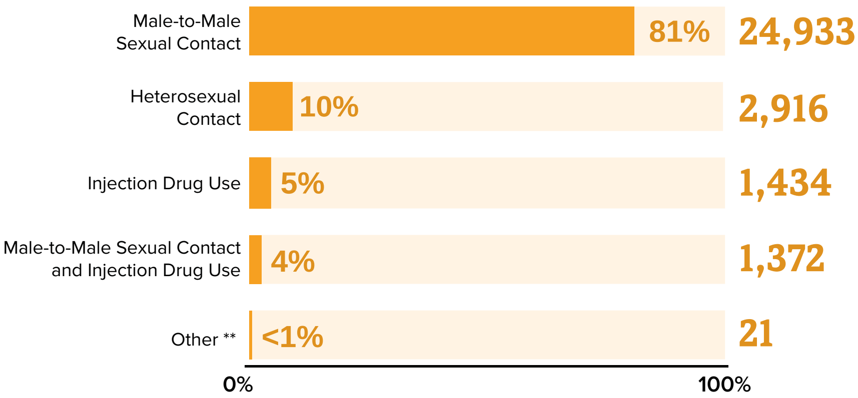
Centers for Disease Control and Prevention. (2020, May 7). *Diagnoses of HIV Infection in the United States and Dependent Areas, 2018*. Retrieved fromhttps://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-31/index.html.

HIV and Men



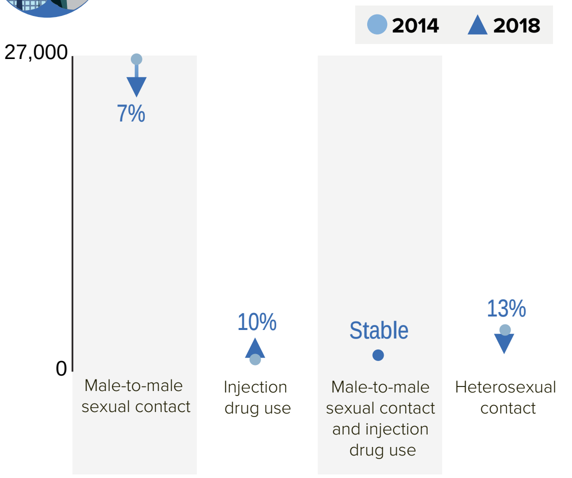
Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2018, 81% were among men.[†][‡]

Most new HIV diagnoses among men were attributed to male-to-male sexual contact.

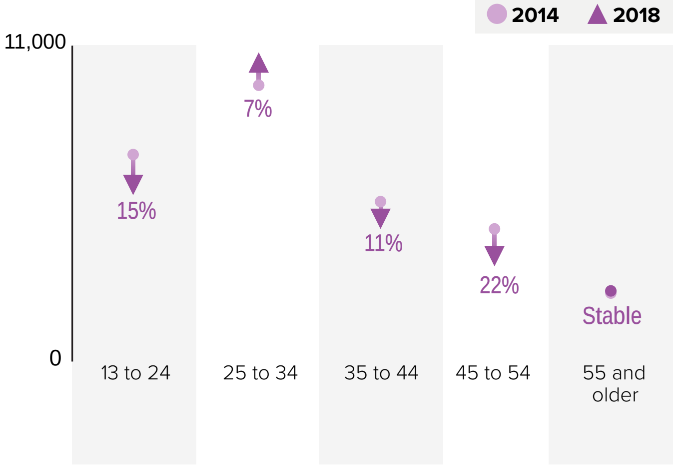


From 2014 to 2018, HIV diagnoses decreased 7% among men overall, but trends varied for different groups of men.

Trends by Transmission Category



Trends by Age



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[*] American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
[†] Adult and adolescent men aged 13 and older.
[‡] Based on sex at birth and includes transgender people.
[**] Includes hemophilia, blood transfusion, perinatal exposure, and risk factors not reported or not identified.
[††] In 50 states and the District of Columbia.

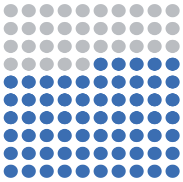
Men who don't know they have HIV cannot get the care and treatment they need to stay healthy.

At the end of 2018, an estimated **1.2 MILLION AMERICANS** had HIV.[††] Of those, 912,100 were men.

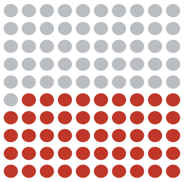
6 in 7 men knew they had the virus.

It is important for men 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. People who get and keep an undetectable viral load (or stay virally suppressed) can live a long and healthy life. They also have effectively no risk of transmitting HIV to HIV-negative sex partners.

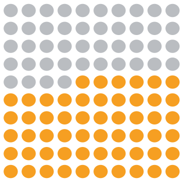
When compared to people overall with HIV, men have the same viral suppression rates. But more work is needed to increase these rates. In 2018, for every **100 men with HIV**:[††]



65 received some HIV care



49 were retained in care



56 were virally suppressed

For comparison, for every **100 people overall** with HIV, **65 received some HIV care**, **50 were retained in care**, and **56 were virally suppressed**.

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

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.

Sexually Transmitted Diseases (STDs)

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

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.

Access to HIV Prevention and Treatment Services

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

How is CDC making a difference for men?

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.

Strengthening successful HIV prevention programs and supporting new efforts funded through the *Ending the HIV Epidemic* initiative.

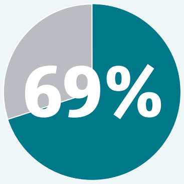
For more information about HIV surveillance data and how they are used, read the "Technical Notes" in the HIV surveillance reports at www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

For more information visit www.cdc.gov/hiv

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

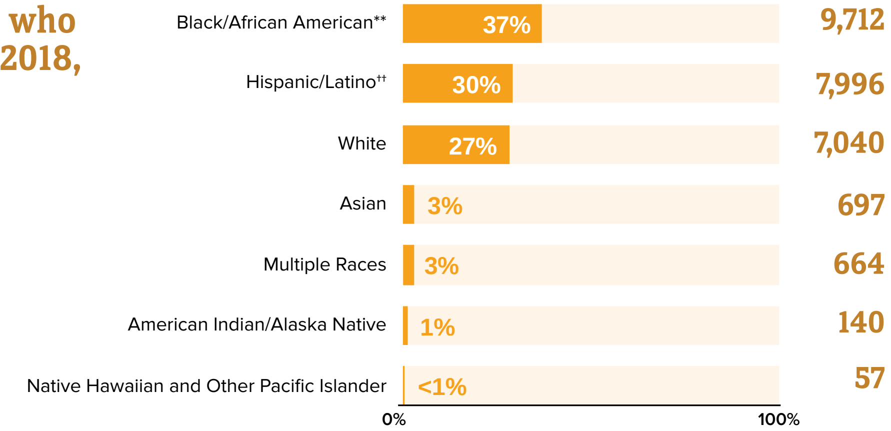
September 2020

HIV and Gay and Bisexual Men



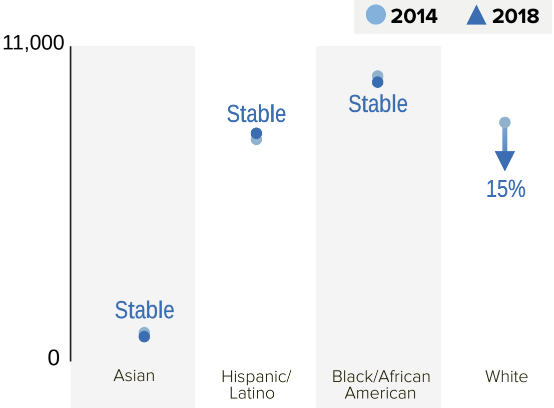
Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas* in 2018, 69% were among gay and bisexual men.†‡

Among gay and bisexual men who received an HIV diagnosis in 2018, racial and ethnic disparities continue to exist.

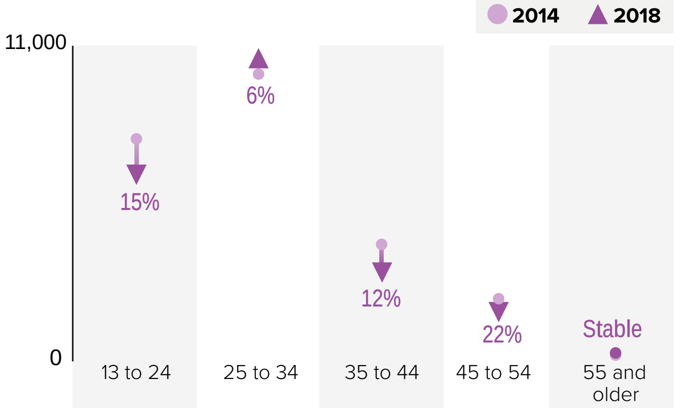


From 2014 to 2018, HIV diagnoses decreased 7% among gay and bisexual men overall.

Trends by Race and Ethnicity



Trends by Age



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

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

† This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who reported male-to-male sexual contact aged 13 and older.

‡ 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. *African American* is a term often used for Americans of African descent with ancestry in North America.

†† Hispanics/Latinos can be of any race.

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

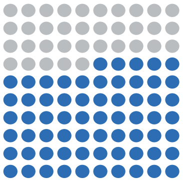
Gay and bisexual men who don't know they have HIV can't get the care and treatment they need to stay healthy.

At the end of 2018, an estimated **1.2 MILLION AMERICANS** had HIV.[‡‡] Of those, 740,400 were gay and bisexual men.

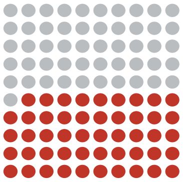
5 in 6 gay and bisexual men knew they had the virus.***

It is important for gay and bisexual men 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. People who get and keep an undetectable viral load (or stay virally suppressed) can live a long and healthy life. They also have effectively no risk of transmitting HIV to HIV-negative sex partners.

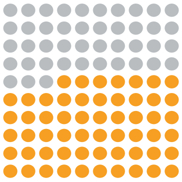
Compared to all people with HIV, gay and bisexual men have about the same viral suppression rates. For every **100 gay and bisexual men with HIV** in 2018:[‡‡]



65 received some HIV care



49 were retained in care



57 were virally suppressed

For comparison, for every **100 people overall** with HIV, **65 received some HIV care**, **50 were retained in care**, and **56 were virally suppressed**.

There are several challenges that place some gay and bisexual men at higher risk for HIV.

Lack of Awareness 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.

Increased Risk for Other STDs

Having another sexually transmitted disease (STD) can greatly increase the chance of getting or transmitting HIV.

Sexual Behaviors

Some factors put gay and bisexual men at higher risk for HIV, including having anal sex with someone who has HIV without using protection (like condoms or medicine to prevent or treat HIV).

Stigma, Homophobia, and Discrimination

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

How is CDC making a difference for gay and bisexual men?

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.

[‡‡] In 50 states and the District of Columbia.

*** 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, 12 in 13 knew they had HIV.

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 September 2020.

HRSA
Ryan White & Global HIV/AIDS Programs

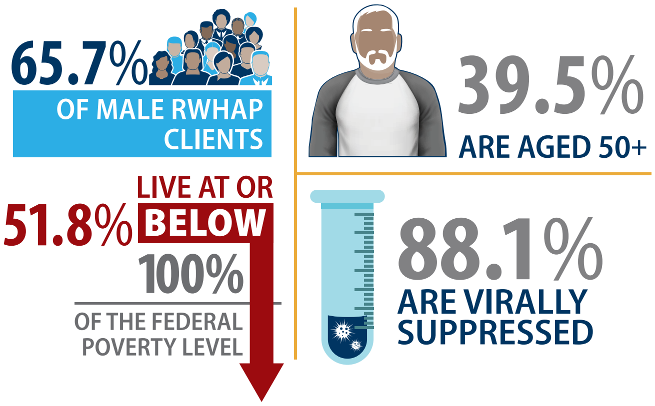
HRSA's Ryan White HIV/AIDS Program

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.

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* 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.

2020 Houston HIV Care Services Needs Assessment: Profile of Men Who Have Sex with Men (MSM)

PROFILE OF MSM

An analysis conducted by the Centers for Disease Prevention & Control (**CDC**) in 2018 determined that 69% of all new diagnoses among adolescents and adults within the U.S. were individuals who identified as men who have sex with men (**MSM**) (Center for Disease Control & Prevention, 2020). No one cause has been identified for the large impact of HIV on MSM, high prevalence, being unaware of their status, stigma, and discrimination likely contribute to the increased transmission vulnerability among MSM (Center for Disease Control & Prevention, 2020). A persistent challenge to designing HIV prevention and care services that meet the needs of Houston area people living with HIV (**PLWH**) is ensuring that services remain relevant and responsive to the needs of both the general population and groups with increased vulnerability to new transmissions and unmet need. Data about service needs and barriers MSM PLWH in the Houston area encounter is of particular importance to local HIV planning, as this information equips communities to design prevention and care services that meet the unique needs of disproportionately affected groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment, as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include all MSM participants. This Profile highlights results *only* for participants who identified as MSM, as well as comparisons to the entire needs assessment sample

Notes: This analysis defines MSM as PLWH who indicated that they were cis-gender men who identified as gay, bisexual, or pansexual regardless of race/ethnicity. Results for participants who are African American/Black, Hispanic/Latino, and transgender or gender non-conforming were reported in separate profiles available on the Houston Ryan White Planning Council website.

Data presented in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing values or "check all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 238 participants in the 2020 Houston HIV Care Services Needs Assessment were MSM, comprising 41% of the entire sample.

Ninety-two percent (92%) of MSM participants were residing in Houston/Harris County at the time of data collection. Compared to the total sample of the needs assessment participants, the majority of respondents were between the ages of 35 to 64 (79%), primarily African American/Black (45%), and born in the U.S. (80%). MSM participants mostly self-reported sexual orientation as gay (77%); however, MSM participants also reported being bisexual (16%), pansexual (4%), and being undecided about their sexual orientation (3%). The majority of MSM needs assessment participants reported using public health insurance – such as Medicaid, Medicare, Ryan White, and the Harris Health System - to pay for HIV medical care (83%). Fifty-four percent (54%) of MSM participants had reported annual incomes 100% below the Federal Poverty Level (**FPL**), with the average annual income among MSM needs assessment participants being $15,225.

Compared to all needs assessment participants, higher proportions of MSM participants were white (25% vs 14%), used Ryan White only to pay for their HIV medical care (26% vs 24%), and had higher occurrences of having no health insurance (5% vs 2%). The average annual income reported by MSM participants who reported income was larger than that of the total sample ($15,225 vs $11,360).

Characteristics of African American MSM participants (as compared to all participants in general) can be summarized as follows:

- Residing in Houston/Harris County
- Adults between the ages of 35 and 64
- Self-identified as gay or bisexual
- Higher average annual income
- Higher proportion of having no health insurance

TABLE 1-Select Characteristics among MSM Participants, Houston Area HIV Needs Assessment, 2020

	No.	MSM %	Total %		No.	MSM %	Total %		No.	MSM %	Total %
County of residence				**Age range** (median: 50-54)				**Primary race/ethnicity**			
Harris	197	92%	95%	13-17	0	-	0%	White	53	25%	14%
Fort Bend	5	2%	2%	18-24	11	5%	3%	African American / Black	96	45%	60%
Montgomery	3	1%	1%	25-34	22	11%	9%	Hispanic/Latino	45	21%	21%
Liberty	2	1%	1%	35-49	60	30%	28%	Asian American	4	2%	1%
Other	7	3%	2%	50-54	34	17%	18%	Other/Multiracial	16	7%	5%
				55-64	65	32%	28%				
				≥65	10	5%	14%				
				Seniors (≥50)	169	88%	60%				
Sexual orientation (self-reported)				**Yearly income** (average: $15,225)				**Health insurance** (multiple response)			
Gay	163	77%	30%	**Federal Poverty Level (FPL)**				Private insurance	27	10%	
Bisexual	34	16%	7%	Below 100%	56	54%	67%	Medicaid/Medicare	99	36%	
Pansexual	8	4%	2%	100%	20	19%	19%	Harris Health System	58	21%	
Undecided	7	3%	1%	150%	11	11%	6%	Ryan White Only	71	26%	
				200%	7	7%	5%	VA	6	2%	
				250%	0	0%	1%	None	13	5%	
				≥300%	9	9%	2%				
Immigration status											
Born in the U.S.	177	80%	88%								
Citizen > 5 years	30	14%	10%								
Citizen < 5 years	5	2%	1%								
Visa (student, work, tourist, etc.)	9	4%	0%								
Prefer not to answer	1	0%	1%								

BARRIERS TO RETENTION IN CARE

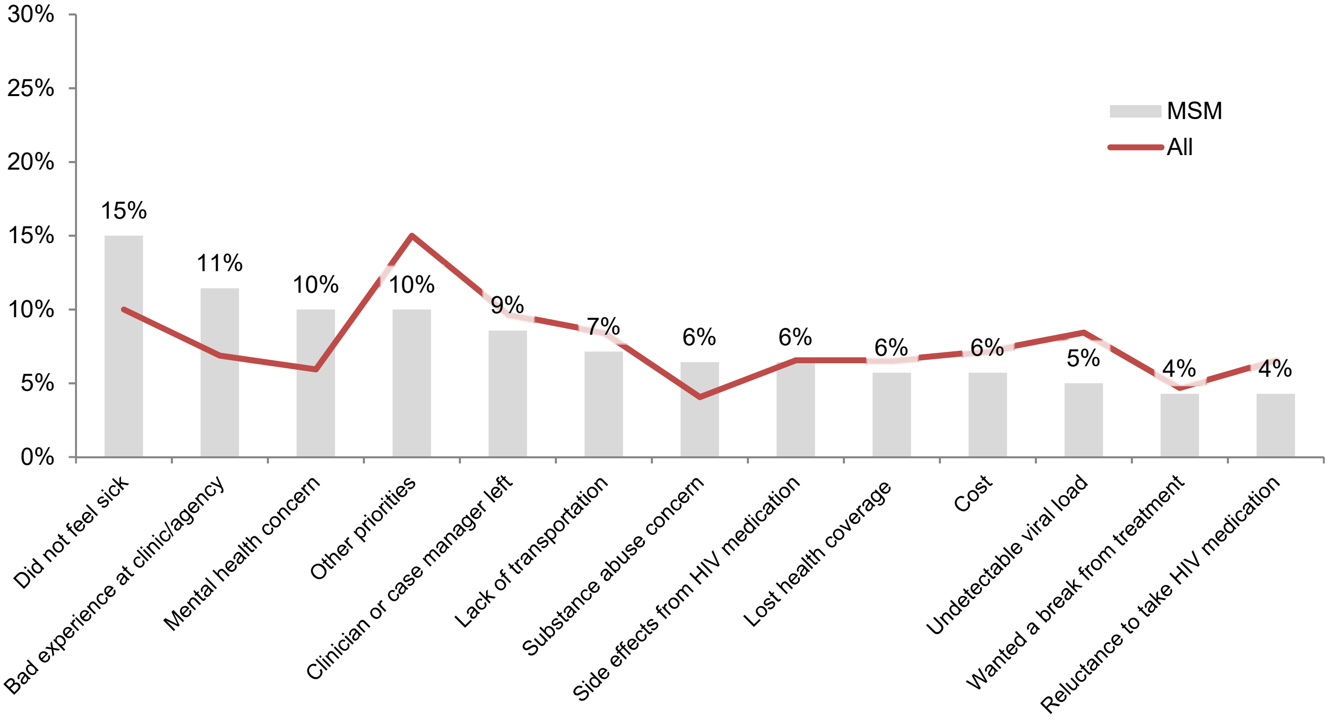
As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 70% of MSM participants reported no interruptions in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey, and participants could select multiple reasons and write in their reasons.

(**Graph 1**) Among MSM participants, not feeling sick was the most cited reason for interruption in HIV medical care (15%), followed by bad experiences at the clinic or agency (11%), mental health concerns (10%), and other priorities (10%). Compared to the total sample, a higher proportion of MSM participants reported not feeling sick (15% vs 10%), and bad experiences at the clinic or agency (11% vs 7%) as reasons for the lapse in care. Write in responses provided for this question varied with reasons reported by participants for lapses in HIV medical care being that they "didn't want to deal with it now", being homeless, not wanting family to know about their medications, being incarcerated, not knowing where to go to get care, and they weren't aware of the dates of their appointments.

GRAPH 1-Reasons for Falling Out of HIV Care among MSM PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by MSM needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



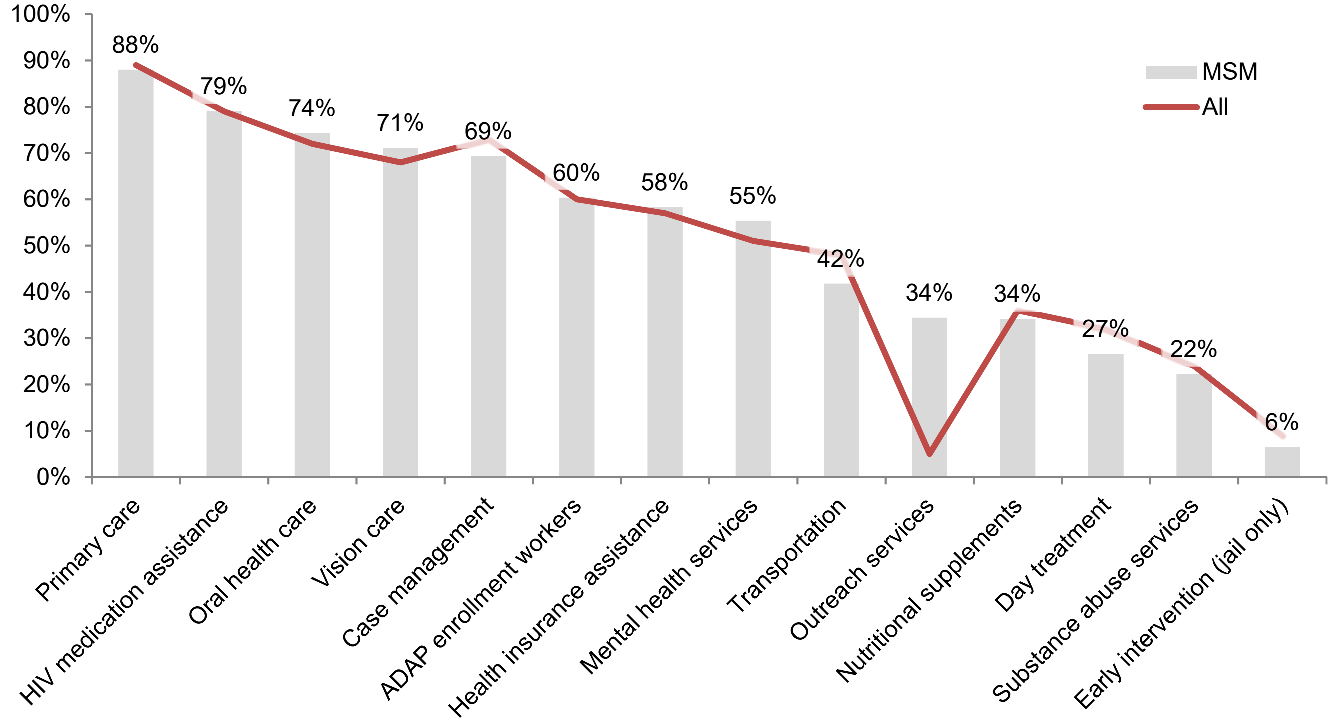
OVERALL RANKING OF FUNDED SERVICES, BY NEED

In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA Program. 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 2**) Among MSM participants, primary care was the most needed funded service at 88% of MSM participants reporting need, followed by HIV medication assistance (79%), oral health care (74%), and vision care (71%). When comparing need for HIV core medical and support services funded through the Houston Area Ryan White HIV/AIDS Program of MSM participants with the total sample, we see that the trends are similar, with the exception of one service. MSM participants reported a much higher proportion of need for outreach services when compared to the total sample (34% vs 5%).

GRAPH 2-Ranking of HIV Services among MSM PLWH in the Houston Area, By Need, 2020

Definition: Percent of MSM needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



OTHER IDENTIFIED NEEDS

In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV-related services they needed in the past 12 months.

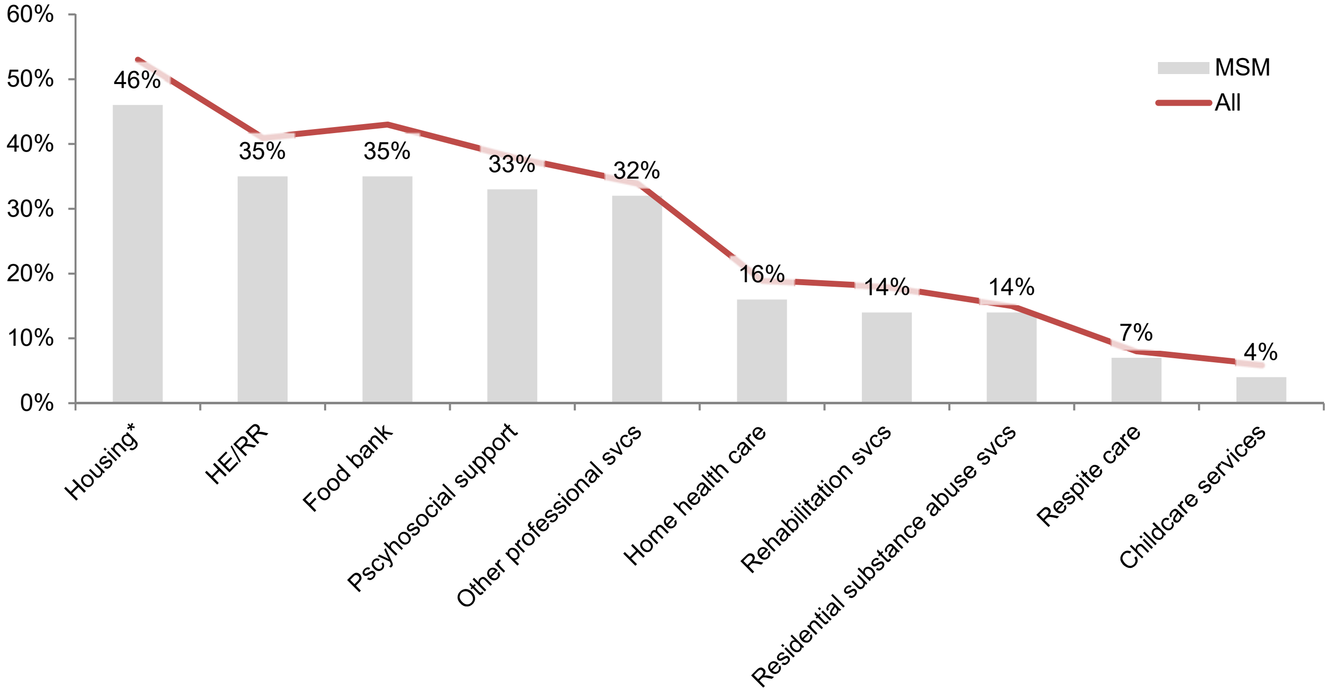
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, forty-six percent (46%) of MSM participants reported housing as the most needed. Additionally, MSM participants reported a need for health education & risk reduction (HE/RR) (35%), food bank (35%), and psychosocial support (33%).

Compared to the total sample, MSM participants reported lower need for all other/non-Ryan White funded HIV-related services. MSM participants reported lower proportions of need for food bank (35% vs 43%), housing (46% vs 53%), and health education & risk reduction (35% vs 41%).

GRAPH 3-Other Needs for HIV Services among MSM PLWH in the Houston Area, 2020

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

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



OVERALL BARRIERS TO HIV CARE

The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 district barriers. These barriers were then grouped together into 12 nodes, or barrier types.

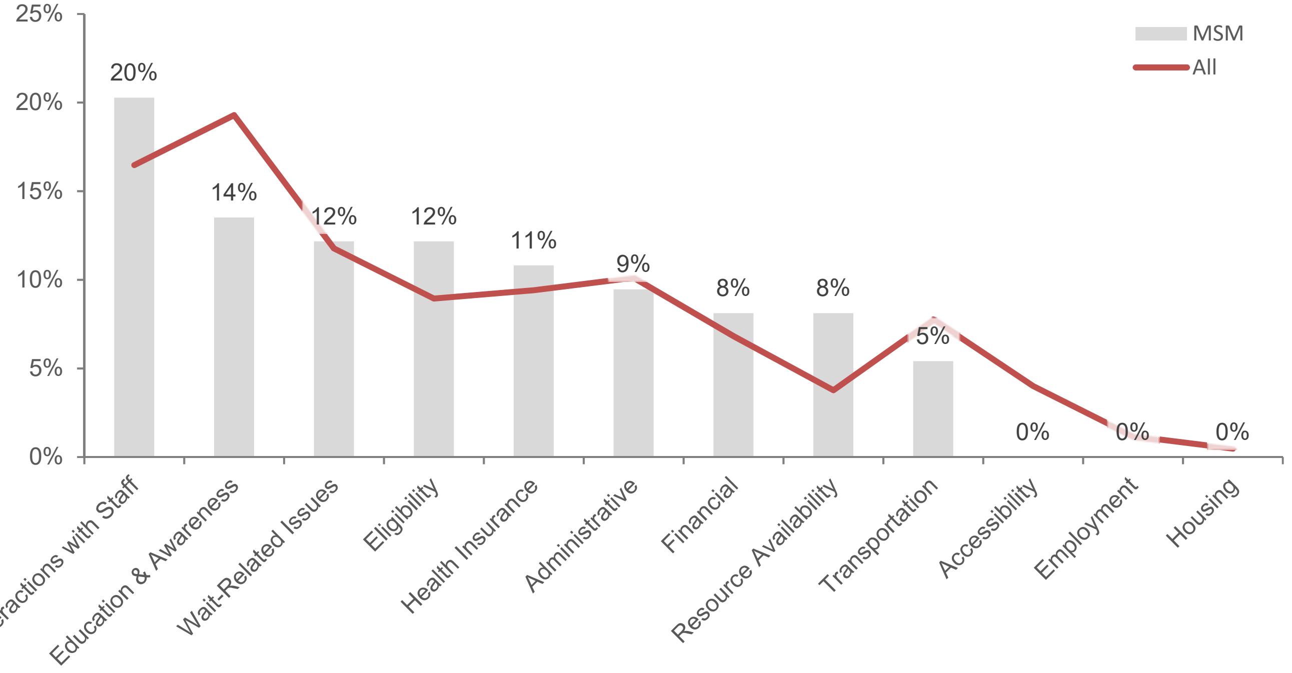
(**Graph 4**) Ninty (90) MSM participants cited barriers to Ryan White funded HIV care services. MSM participants most often cited interactions with staff (20%), service education & awareness (14%), as well as wait and eligibility related barriers (both 12%).

Poor treatment by staff, difficulty receiving a referral, and poor communication from staff were barriers related to interactions with staff reported by MSM participants. Not knowing a service was available, not knowing where to go, and not knowing who to contact for services were service education & awareness barriers reported by MSM participants. Being put on a waitlist, and redundant processes for service eligibility were the wait-related and eligibility related barriers reported by MSM participants.

Compared to the general sample, a greater proportion of MSM participants reported encountering barriers related to interactions with staff (20% vs 16%), and eligibility for services (12% vs 9%). Lower proportions of MSM participants reported barriers related to service education & awareness (14% vs 19%), and accessibility to services (0% vs 4%).

GRAPH 4-Ranking of Types of Barriers to HIV Services among MSM PLWH in the Houston Area, 2020

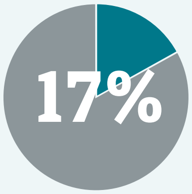
Definition: Percent of times each barrier type was reported by MSM needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



Works Cited

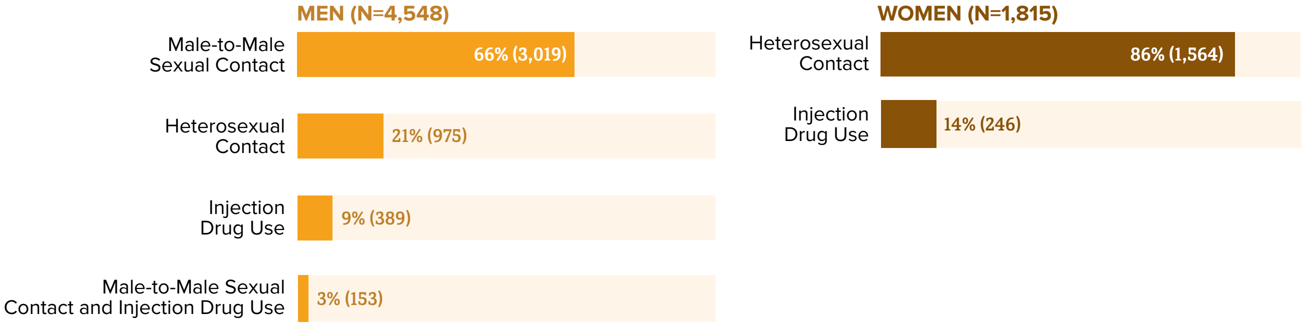
Centers for Disease Control and Prevention. (2020, May 7). *Diagnoses of HIV Infection in the United States and Dependent Areas, 2018*. Retrieved fromhttps://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-31/index.html.

HIV and Older Americans



Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas* in 2018, 17% were among people aged 50 and older.

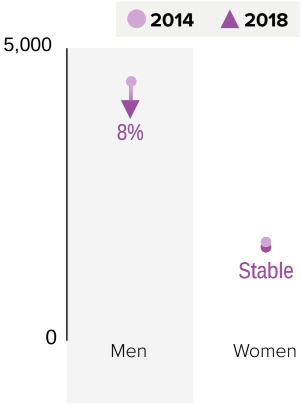
Among people aged 50 and older, most new HIV diagnoses were among men.[†]



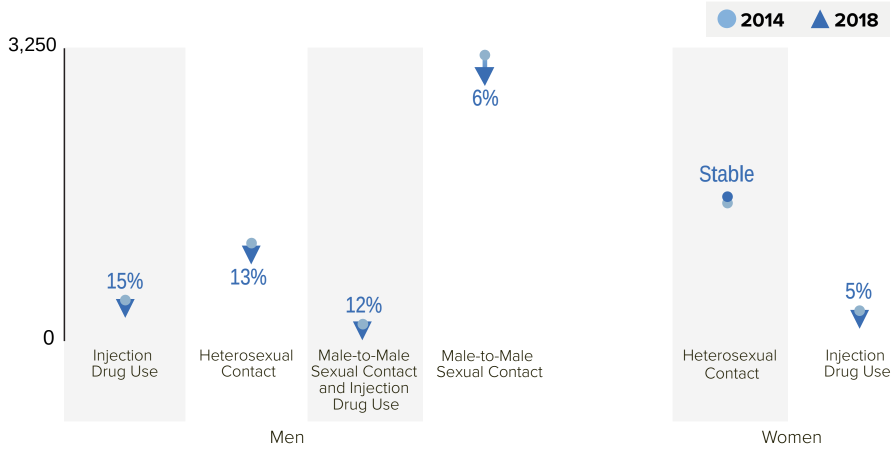
Totals may not equal 100% due to rounding.

HIV diagnoses decreased 6% overall among people aged 50 and older from 2014 to 2018.

Trends by Sex[†]



Trends by Transmission Category[†]



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

[†] Based on sex at birth and includes transgender people.

[‡] In 50 states and the District of Columbia.

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

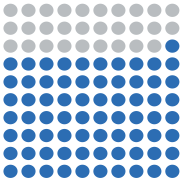
People aged 50 and older who don't know they have HIV can't get the care and treatment they need to stay healthy.

At the end of 2018, an estimated **1.2 MILLION AMERICANS** had HIV.‡ Of those, 379,000 were aged 55 and older.

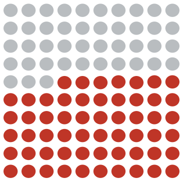
9 in 10 people aged 55 and older knew they had the virus.

It is important for people aged 50 and older 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. People who get and keep an undetectable viral load (or stay virally suppressed) can live a long and healthy life. They also have effectively no risk of transmitting HIV to HIV-negative sex partners.

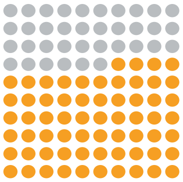
Compared to all people with HIV, people aged 55 and older have higher viral suppression rates. In 2018, for every **100 people aged 55 and older with HIV**: ‡



71 received some HIV care



57 were retained in care



64 were virally suppressed

For comparison, for every **100 people overall** with HIV, **65 received some HIV care**, **50 were retained in care**, and **56 were virally suppressed**.

There are several challenges that place some people aged 50 and older at higher risk for HIV.

Fewer Discussions with Doctors

Although they visit their doctors more frequently, older people and their health care providers are less likely to discuss HIV testing and sexual or drug use behaviors.

Knowledge of HIV Prevention

Older people may not be as knowledgeable about HIV prevention and sexual risk and may be less likely to use a condom or other prevention options.

Delayed Treatment

Older people are more likely to have late-stage HIV at the time of diagnosis, may start treatment late, and suffer more immune system damage.

Stigma

Older people may have additional challenges getting into care due to stigma, isolation, and loss of support from their family, friends, and community.

How is CDC making a difference for people aged 50 and older?

- 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 September 2020.

Ryan White & Global HIV/AIDS Programs

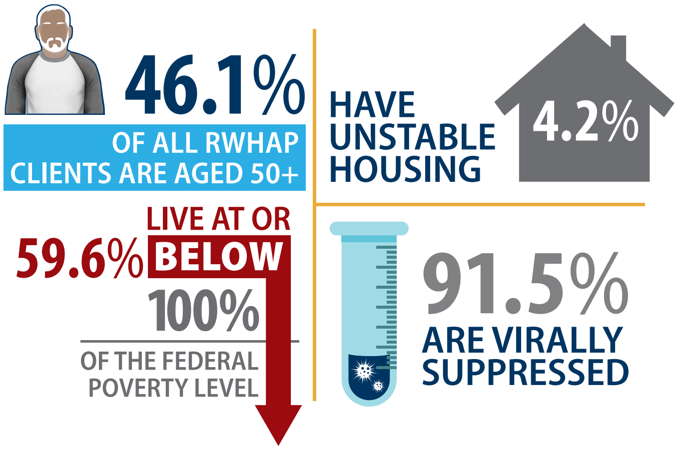
HRSA's Ryan White HIV/AIDS Program

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).

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* 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.

For more information on HRSA's Ryan White HIV/AIDS Program, please visit: hab.hrsa.gov.

2020 Houston HIV Care Services Needs Assessment: Profile of Youth and Aging PLWH

PROFILE OF YOUTH AND AGING WITH HIV

While HIV may affect people of all ages, the impact of HIV varies across age groups. The Centers for Disease Control and Prevention (**CDC**) report that youth aged 12 to 24 accounted for 21% of new HIV diagnoses in 2018 with 92% of youth new diagnoses occurring among young men who have sex with men (**MSM**).[1] Locally, the HIV diagnosis rate for youth aged 12 to 24 in the Houston Eligible Metropolitan Area (**EMA**) was 32.6 new diagnoses per 100,000 population, 20% higher than the population as a whole.[2]

People Living with HIV (**PLWH**) ages 45 to 54 within the Houston EMA in 2019 had a prevalence rate of 386.2 diagnosed cases per 100,000 population. Data about the needs and experiences of youth and those aging with HIV in the greater Houston area are of particular importance to local HIV planning as this information equips communities to tailor HIV prevention and care services to meet the markedly different yet equally critical needs of these age groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were recently released. This profile highlights results *only* for participants who were youth or aging at the time of survey, as well as comparisons to the entire needs assessment sample.

Notes: "Youth" and "aging" are defined in this analysis as PLWH who indicated at survey that they were between 18 and 24 years of age for youth, and age 50 or over for aging. Data presented in this in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check-all" responses.

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[1] https://www.cdc.gov/hiv/group/age/youth/index.html

[2] Texas Department of State Health Services

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 17 participants in the 2020 Houston HIV Care Services Needs Assessment were between the ages of 18 to 24 at the time of survey, while 353 were ages 50 and over. Youth comprised 3% of the total sample, while aging participants comprised 60%. This reflects the increasing number of aging PLLWH in the Houston area.

Eighty-nine percent (89%) of youth participants and 94% of aging participants were residing in Houston/Harris County at the time of data collection. As all needs assessment participants, the majority of youth and aging participants were male (84% and 66%) and African American/Black (53% and 62%). Among youth needs assessment participants, 19% reported not being retained in HIV care at the time of data collection. Among aging needs assessment participants, 13% reported not being retained in HIV medical care at the time of data collection.

Several differences were observed between these populations and the total sample. A greater proportion of youth participant's gender identities were reported as transgender/gender non-conforming (17% vs 4%), identified as multiracial (21% vs 4.7%), identified as gay/lesbian/bisexual/asexual (75% vs 39%). Compared to the total sample, a greater proportion of aging participants identified as heterosexual (61% vs 57%).

Several socio-economic characteristics of youth and aging participants were also different from all participants. No youth participants reported having private health insurance, and a smaller proportion reported utilizing Ryan White Program services to pay for medical care compared to the total sample (50% vs 24%). Youth needs assessment participants also showed a large proportion of having no insurance compared to the total sample (13% vs 2%). The average annual income among those reporting income for the total sample was $13,493, compared to $9,513 among youth participants and $12,011 among aging participants.

Characteristics of *youth* participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Gay/lesbian/bisexual/asexual
- Transgender/gender non-conforming
- With higher occurrences of no health insurance coverage, and lower average annual income.

Characteristics of *aging* participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Heterosexual
- With lower occurrences of no health insurance coverage, and slightly lower average annual income.

TABLE 1-Select Participant Characteristics among Youth (18-24) and Aging (50+) participants, Houston Area HIV Needs Assessment, 2016

County of residence	Youth %	Aging %	Total %
Harris	89%	94%	95%
Montgomery	5%	1%	1%
Walker	5%	0%	1%
Fort Bend	0%	2%	2%
Other	0%	3%	1.6%

Sex at birth	Youth %	Aging %	Total %
Male	84%	66%	66%
Female	16%	34%	34%
Intesex	0%	0%	0%
Other	0%	0%	0%
Transgender/Gender Non-Conforming	17%	2%	4%
Currently pregnant	0%	0%	2%

Primary race/ethnicity	Youth %	Aging %	Total %
White	11%	17%	14%
African American/Black	53%	62%	60%
Hispanic/Latino	5%	14%	21%
Asian American	5%	1%	1%
Native American or Native Alaskan	0%	1%	1%

Sexual orientation	Youth %	Aging %	Total %
Heterosexual	22%	61%	57%
Gay/Lesbian	44%	28%	30%
Bisexual/Pansexual	28%	9%	9%
Other	6%	2%	3.8%
MSM	77%	37%	43%

Health insurance (multiple response)	Youth %	Aging %	Total %
Private insurance	0%	7%	9%
Medicaid/Medicare	21%	56%	67%
Harris Health System	17%	21%	29%
Ryan White Only	50%	10%	24%
VA	0%	3%	3%

Immigration status	Youth %	Aging %	Total %
Born in the U.S.	100%	89%	88%
Citizen > 5 years	0%	10%	10%
Citizen < 5 years	0%	1%	1%
Visa (student, work, tourist, etc.)	0%	0%	0.2%
Prefer not to answer	0%	3%	0.7%

Yearly income (average: $9,380)
Yearly income – Youth (average: $12,017)
Yearly income – Aging (average: $9,581)

Federal Poverty Level (FPL)	Youth %	Aging %	Total %
Below 100%	100%	64%	67%
100%	0%	19%	19%
150%	0%	5%	6%
200%	0%	4%	5%
250%	0%	0%	0.7%
≥300%	0%	8%	2%

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighed using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (see: *Methodology*, full document).

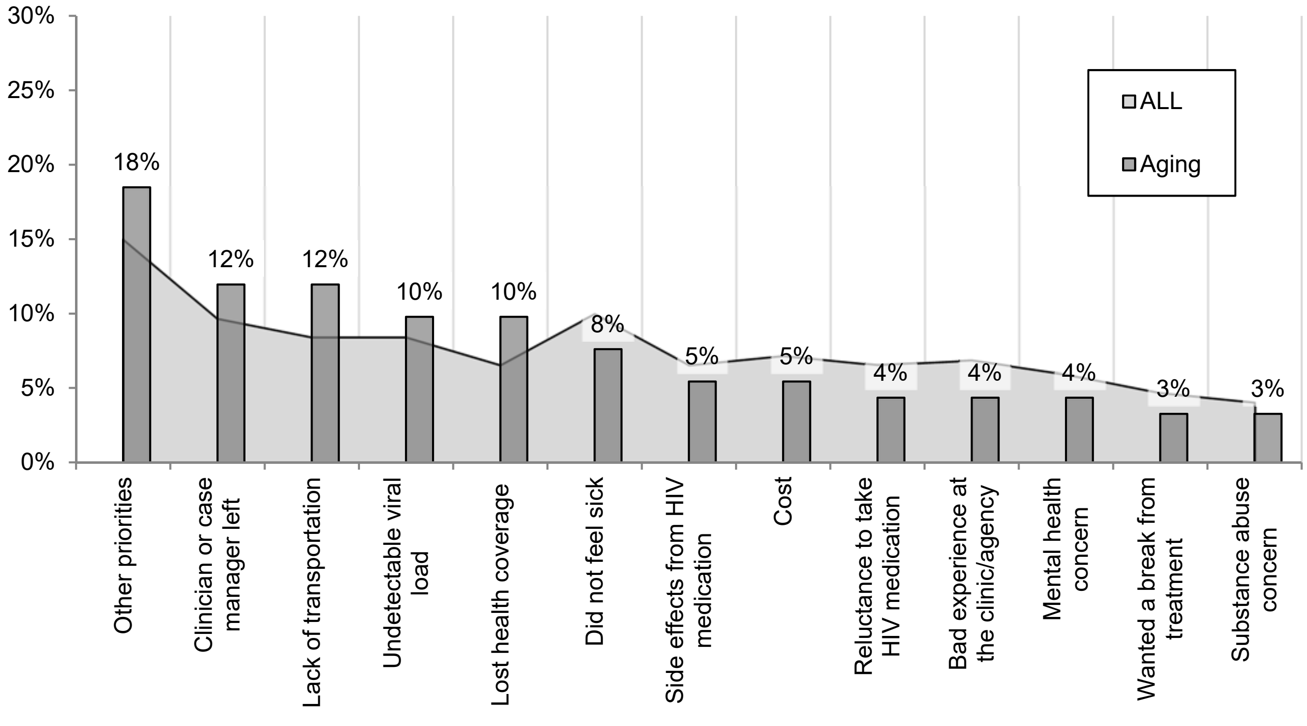
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 81% of youth and 70% of aging needs assessment participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey. Participants also had to the option to write in their reasons as well.

(**Graph 1**) The sample of youth participants with a history of interruption in care was too small to compare to the aging participants and the total sample and therefore are not reported on in this section. Among aging participants, other priorities were the most cited reason for a break in HIV medical care (18%). Other reasons for a break in HIV medical care were the clinician or case manager left the clinic/agency (12%), lack of transportation (12%), and having an undetectable viral load (10%).

Compared to the total sample, a greater proportion of aging needs assessment participants reported falling of care due to lack of transportation (12% vs 8%), other priorities (18% vs 15%), and loss of health coverage (10% vs 7%). Write-in responses that were provided by participants included being incarcerated, not wanting or being ready to start HIV medical care, it was hard to find a clinic or provider, and loss of loved ones as reported barriers to retention in HIV medical care.

GRAPH 1-Reasons for Falling Out of HIV Care among Aging PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by aging needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



OVERALL RANKING OF FUNDED SERVICES, BY NEED

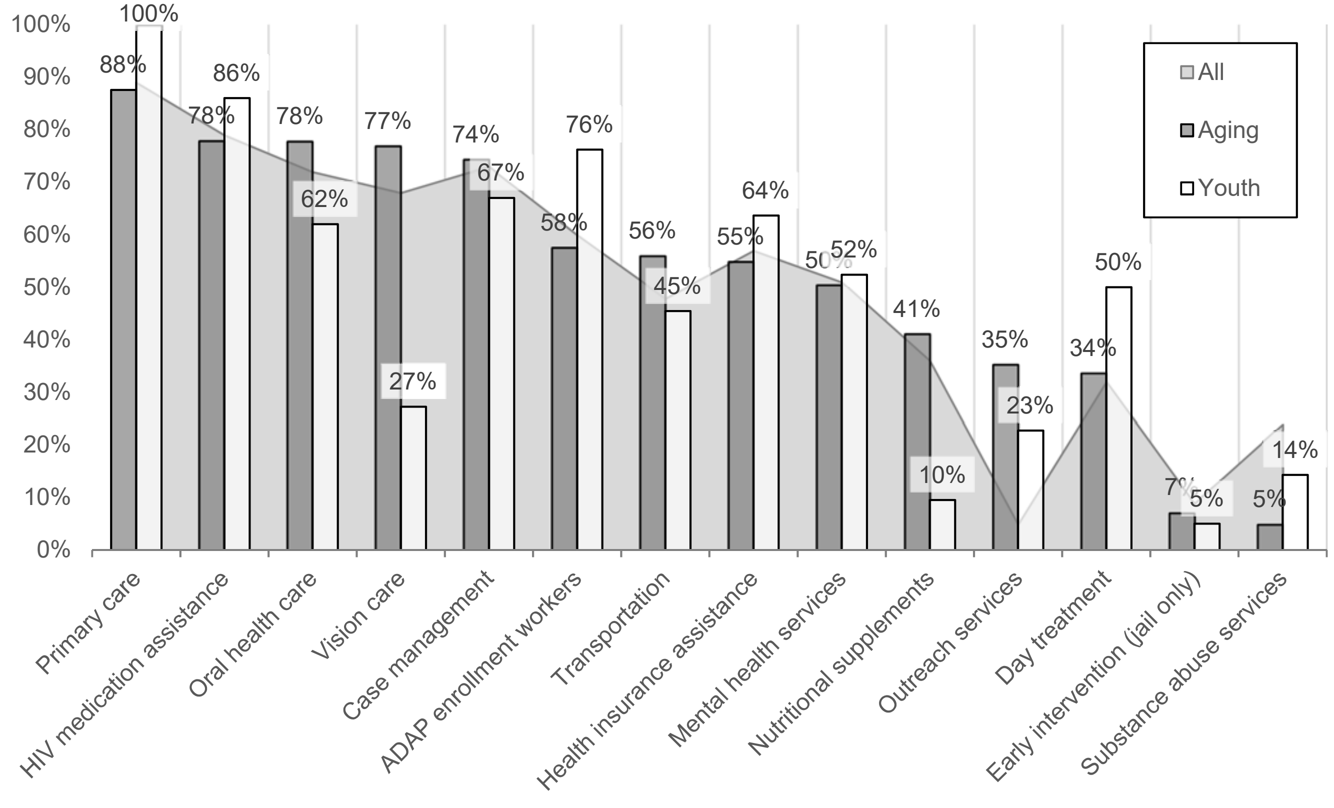
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Like the total sample, youth and aging needs assessment participants identified primary care as the most needed Ryan White funded service (100% of youth and 88% of aging participants). For youth, local HIV medication assistance (86%), ADAP enrollment workers (76%), and case management (67%) followed in ranking of need. For aging participants, local HIV medication assistance (78%), oral health care (78%), and vision care (78%) followed in ranking of need.

Compared to the total sample, higher proportions of youth participants indicated needing day treatment (50% vs 32%), outreach services (23% vs 5%), ADAP enrollment workers (76% vs 60%), primary care (100% vs 89%). Among aging needs assessment participants, a greater proportion indicated needing outreach services (35% vs 5%), vision care (77% vs 68%), and transportation (56% vs 48%).

GRAPH 2-Ranking of HIV Services among Youth (13-24) and Aging (60+) PLWH in the Houston Area, By Need, 2020

Definition: Percent of youth and aging needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

In 2020, 10 other/non-Ryan White funded HIV related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV related services they needed in the past 12 months.

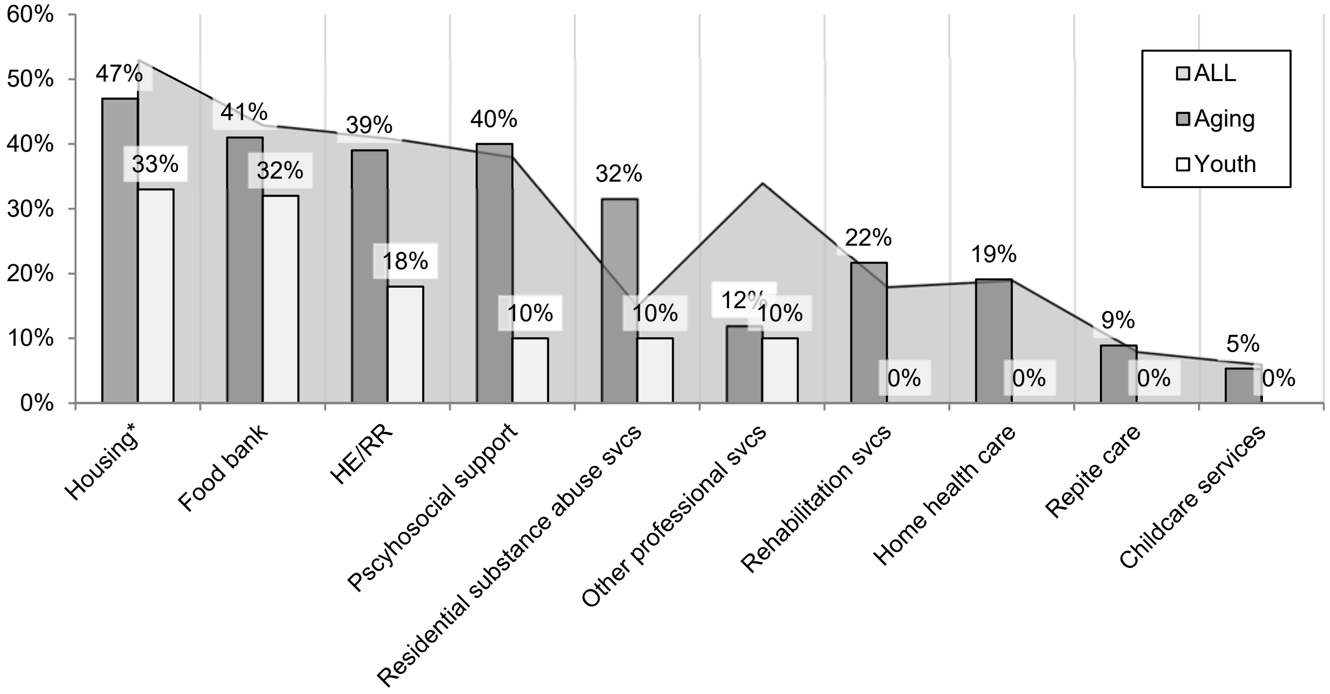
(**Graph 3**) From the 10 other/non-Ryan White funded HIV related services, the greatest proportion of youth participants reported needing housing (33%), food bank (32%), and health education and risk reduction services (18%). Among the aging needs assessment participants, the greatest reported non-Ryan White funded HIV related services were housing (47%), food bank (41%), and psychosocial support services (40%).

Aging participants reported comparable need for other services compared to the total sample, youth needs assessment participants expressed a lower need for other/non-Ryan White funded HIV-related services. Youth needs assessment participants reported a lower proportion of need for health education and risk reduction services (10% vs 41%), other professional services (10% vs 34%), and housing (33% vs 53%) when compared to the total sample.

GRAPH 3-Other Needs for HIV Services among Youth (13-24) and Aging (50+) PLWH in the Houston Area, 2020

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

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



OVERALL BARRIERS TO HIV CARE

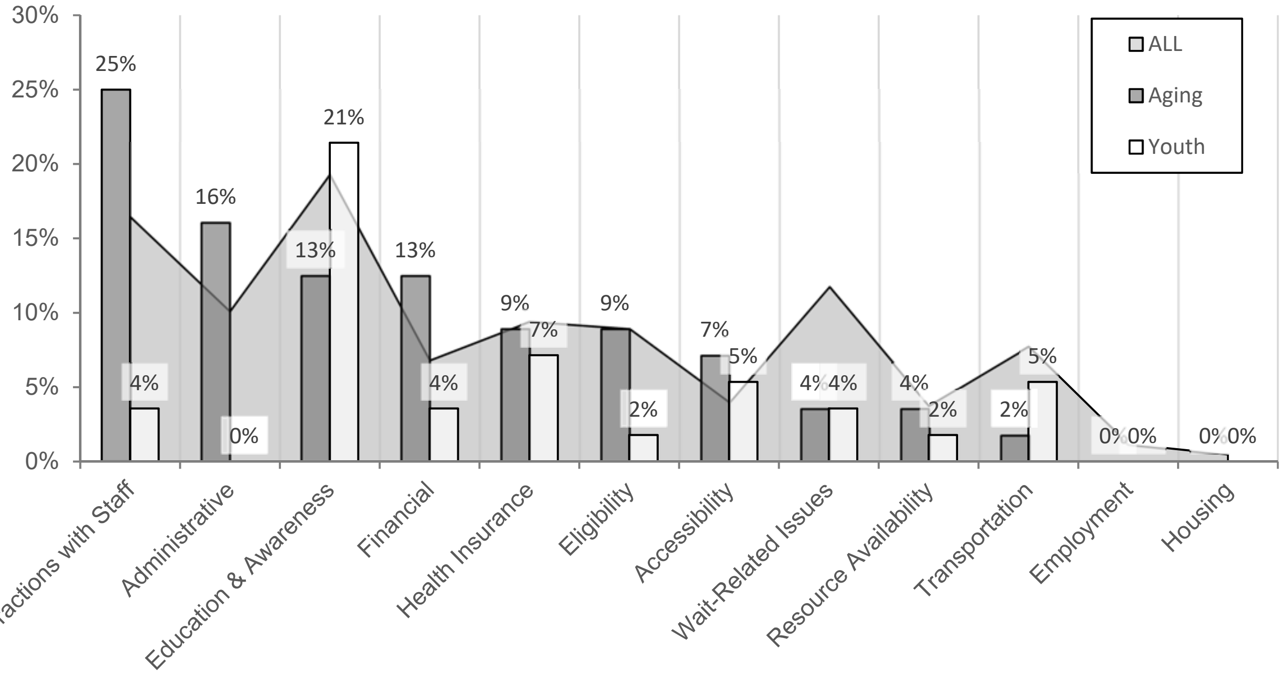
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 29 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

(**Graph 4**) Youth participants most often cited barriers related to service education and awareness issues (21%), and issues regarding health insurance (7%). Service education and awareness barriers among youth participants pertained mostly to not knowing who to contact for services, as well as not knowing that the service was available. While barriers related to health insurance among youth pertained mostly to health insurance gaps (certain services/medications not covered by the participants current health insurance) and being uninsured.

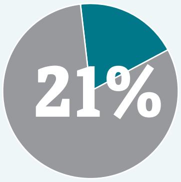
Aging needs assessment participants most often cited barriers related to interactions with staff (25%), administrative issues (16%), service education and awareness issues and issues related to finances (both 13%). Aging participants reported that issues relating to interactions with staff mainly pertained to poor treatment, staff having limited or no knowledge of services, and poor correspondence or follow-up from staff. Issues related to administrative issues reported by aging participants were complex processes at the clinic/agency, and understaffing. Education and awareness issues reported by aging participants were related to not knowing that a service was available.

GRAPH 4-Ranking of Types of Barriers to HIV Services among Youth (13-24) and Aging (50+) PLWH in the Houston Area, 2020

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

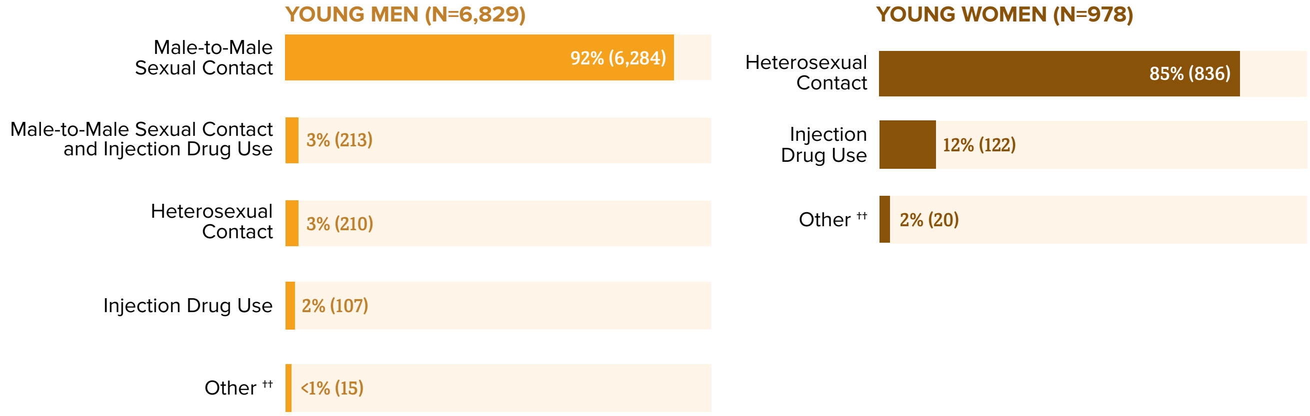


HIV and Youth



Of the **37,832 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2018, 21% were among youth.[†]

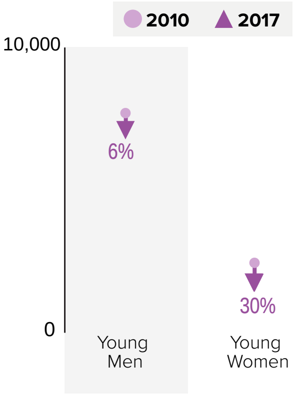
Most new HIV diagnoses among youth were among young gay and bisexual men.[‡] [**]



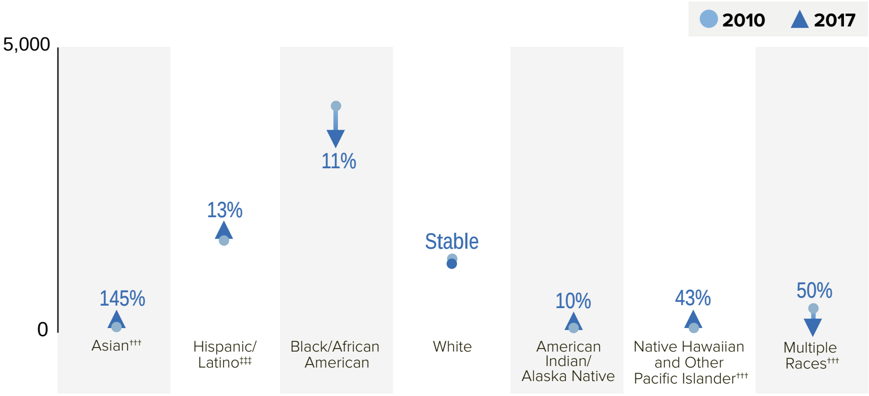
Totals may not equal 100% due to rounding.

HIV diagnoses declined 10% among youth overall from 2010 to 2017.[‡‡] Although trends varied for different groups of youth, HIV diagnoses declined for groups most affected by HIV, including young black/African American gay and bisexual men.[***]

Trends by Sex



Trends for Young Gay and Bisexual Men by Race and Ethnicity



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[*] American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
[†] Persons aged 13 to 24 are referred to as *youth* or *young* in this fact sheet.
[‡] 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).
[††] 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.
[‡‡‡] Hispanics/Latinos can be of any race.

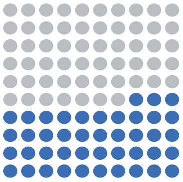
Youth who don't know they have HIV cannot get the care and treatment they need to stay healthy.

At the end of 2016, an estimated 1.1 MILLION PEOPLE had HIV.# Of those, 50,900 were young people.

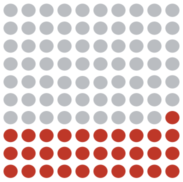
Nearly 4 in 7 youth knew they had the virus.

Youth were the least likely to be aware of their infection compared to any other age group. It is important for youth 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. Youth who get and keep an undetectable viral load (or stay virally suppressed) have effectively no risk of transmitting HIV to HIV-negative sex partners.

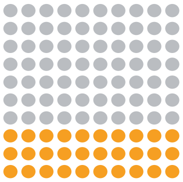
Compared to all people with HIV, youth have the lowest rates of viral suppression. **For every 100 youth with HIV:** ‡



43 received some HIV care



31 were retained in care



30 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**.

Several challenges make it difficult for youth to access the tools they need to reduce their risk or get treatment and care if they have HIV.

Low Rates of HIV Testing

HIV testing rates among high school students are low. People who do not know they have HIV cannot take advantage of HIV care and treatment and may unknowingly transmit HIV to others.

Low Rates of PrEP Use

Young people are less likely than adults to use medicine to prevent HIV. Barriers include cost, access, perceived stigma, and privacy concerns.

Socioeconomic Challenges

Among people with HIV, young people are more likely than older people to be living in households with low income levels, to have been recently homeless, recently incarcerated, or uninsured. These factors pose barriers to achieving viral suppression.

High Rates of Other STDs

Some of the highest STD rates are among youth aged 20 to 24. Having another STD can greatly increase the chance of getting or transmitting HIV.

How is CDC making a difference for youth?

- 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.
- 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 April 2020.

Ryan White & Global HIV/AIDS Programs

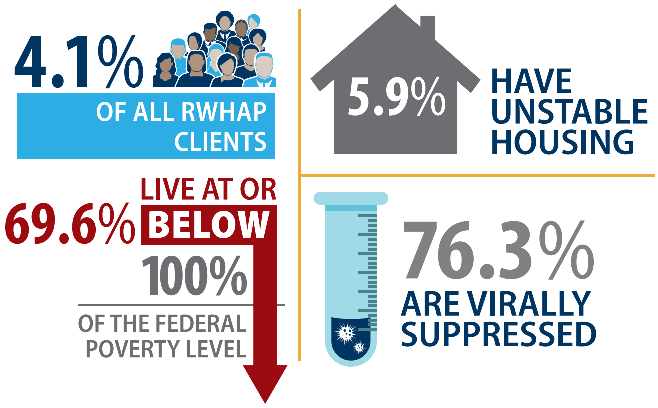
HRSA's Ryan White HIV/AIDS Program

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.

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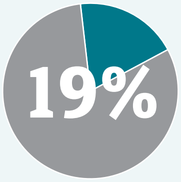
[*] Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

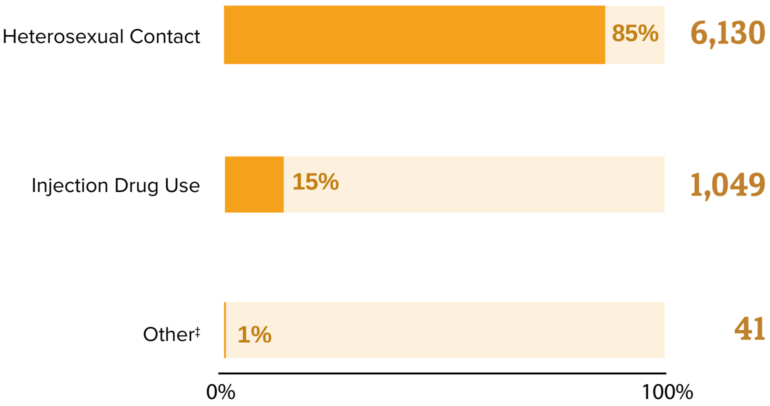
For more information on HRSA's Ryan White HIV/AIDS Program, please visit: hab.hrsa.gov.

HIV and Women



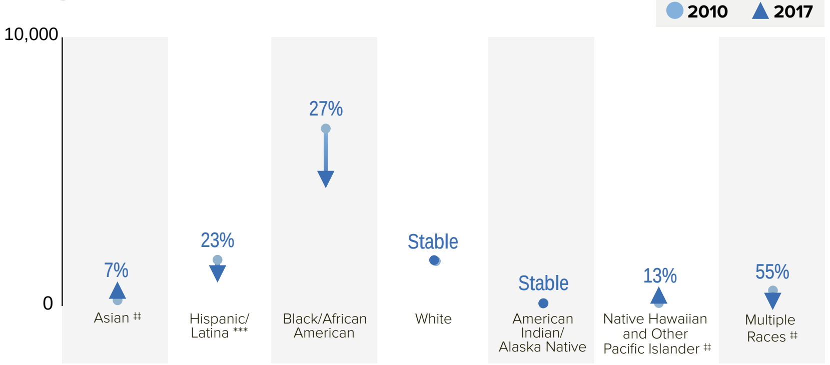
Of the **37,832 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2018, 19% were among women.[†]

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

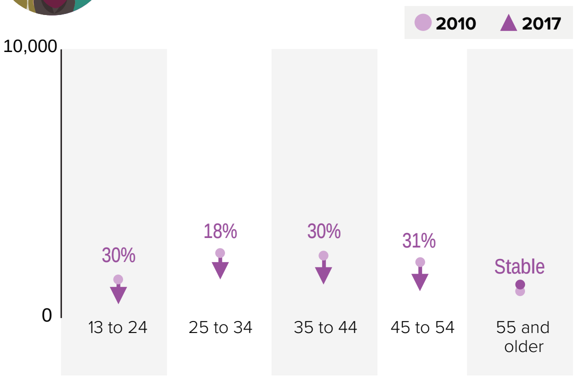


HIV diagnoses declined 23% among women overall from 2010 to 2017. ** Although trends varied for different groups of women, HIV diagnoses declined for groups most affected by HIV, including black/African American[††] women and women aged 25 to 34.

Trends by Race and Ethnicity



Trends by Age



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[*] 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.

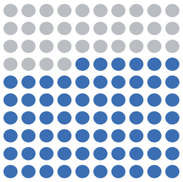
At the end of 2016, an estimated **1.1 MILLION PEOPLE** had HIV.** Of those, 258,000 were women.

8 in 9

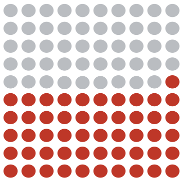
women knew they had the virus.

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.

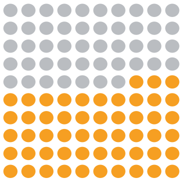
When compared to people overall with HIV, women have about the same viral suppression rates. But more work is needed to increase these rates. In 2016, for **every 100 women with HIV**: **



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.

LET'S STOP HIV TOGETHER

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.

Ending the HIV Epidemic

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

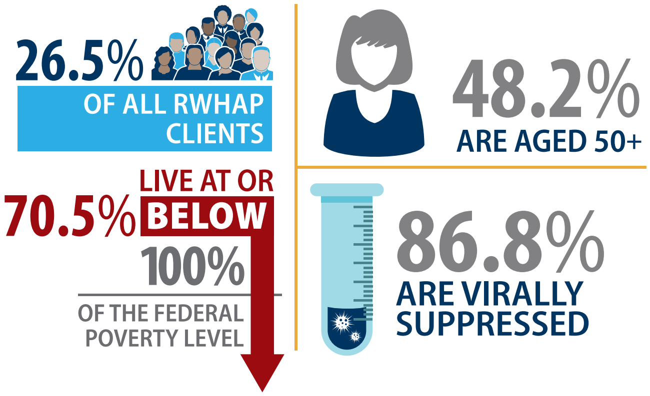
HRSA's Ryan White HIV/AIDS Program

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).

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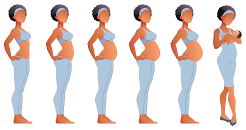
* Viral suppression is defined as a viral load result of less than 200 copies/mL at the most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

For more information on HRSA's Ryan White HIV/AIDS Program, please visit: hab.hrsa.gov.

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*.

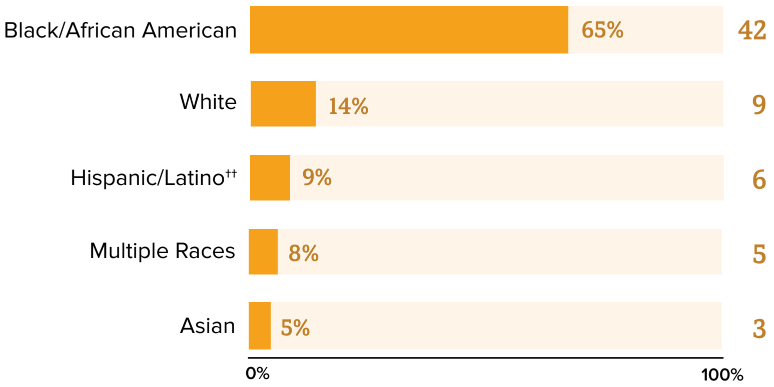
BUT THERE IS GOOD NEWS:

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

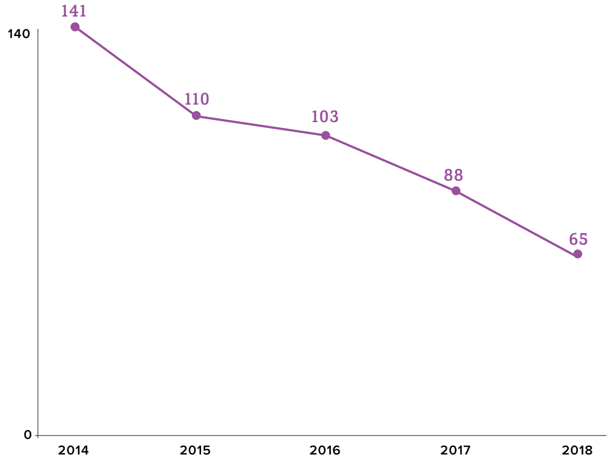
- Takes HIV medicine as prescribed throughout pregnancy, birth, and delivery.
- Gives HIV medicine to her baby for 4 to 6 weeks after giving birth.
- Does NOT breastfeed or pre-chew her baby's food.

Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2018, <1% (65) were due to perinatal transmission.

Most new perinatal HIV diagnoses were among Black/African American[†] children.[‡][**]



HIV diagnoses declined 54% among children overall from 2014 to 2018.



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[*] 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. *African American* is a term often used for Americans of African descent with ancestry in North America.

[‡] Children under the age of 13.

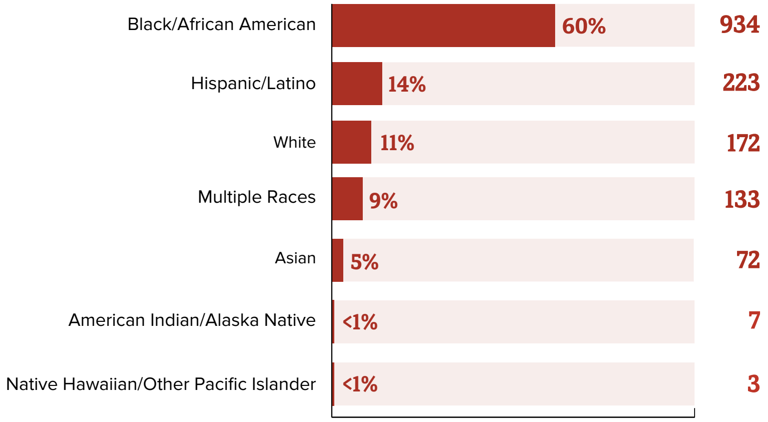
[**] In 2018, there were no cases of perinatal HIV among Native Hawaiians/Other Pacific Islanders and American Indians/Alaska Natives.

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

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

Of the **1,042,270 people with diagnosed HIV** at the end of 2018, <1% (1,544) were among children with diagnosed perinatal HIV.

Most children with diagnosed perinatal HIV are Black/African American.



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 sex partner. If you don't have HIV, but your partner does, ask your doctor about medicine to prevent getting HIV called pre-exposure prophylaxis (PrEP).

There are several challenges that place some babies at risk for HIV.

Unaware of HIV Status

Pregnant women with HIV may not know they have the virus. CDC recommends HIV testing for all women as part of routine prenatal care.

Unsure of the Care They Need

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.

Not Taking HIV Medicine as Prescribed

To get the full protective benefit of HIV medicine, the mother needs to take it as prescribed throughout pregnancy and childbirth and give HIV medicine to her baby after delivery.

Social and Economic Factors

Pregnant women with HIV may face more barriers to accessing medical care and staying on treatment.

How is CDC making a difference for pregnant women and their babies?

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.

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

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.

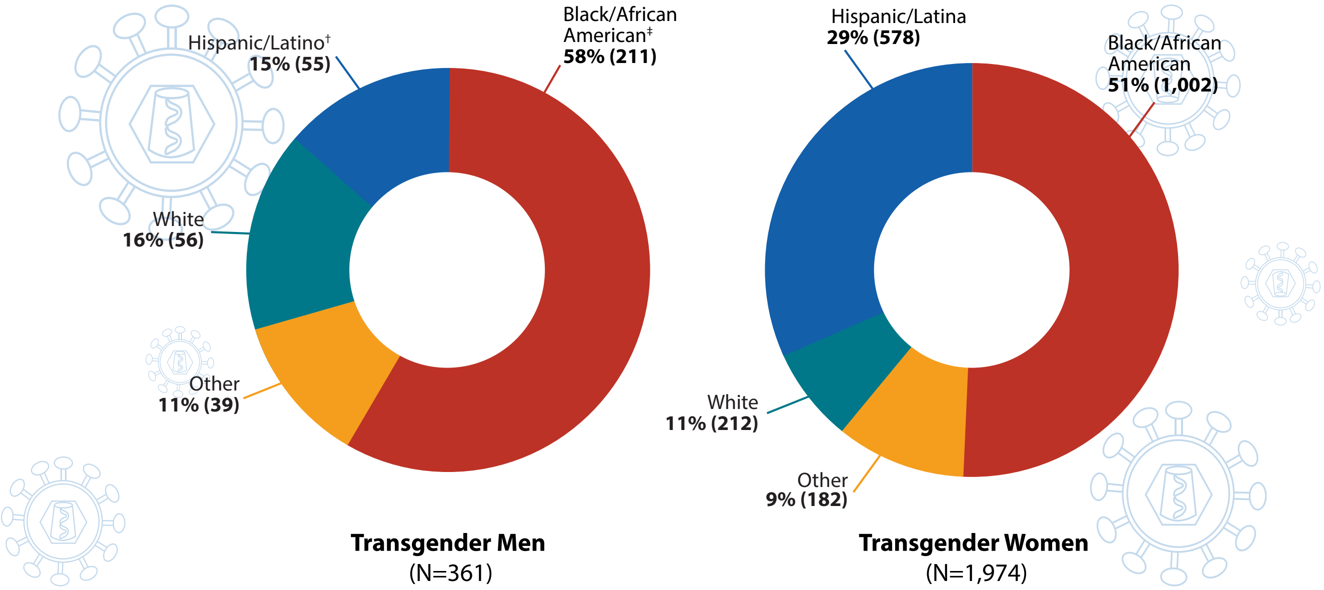
Gender identity: person's internal understanding of their own gender.

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



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* 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.

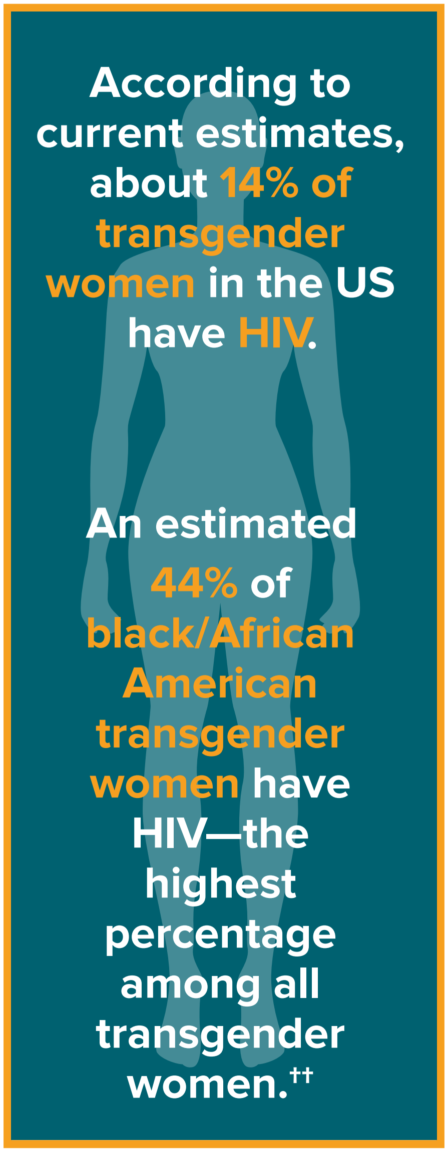
Why are transgender people at higher risk?

- 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.



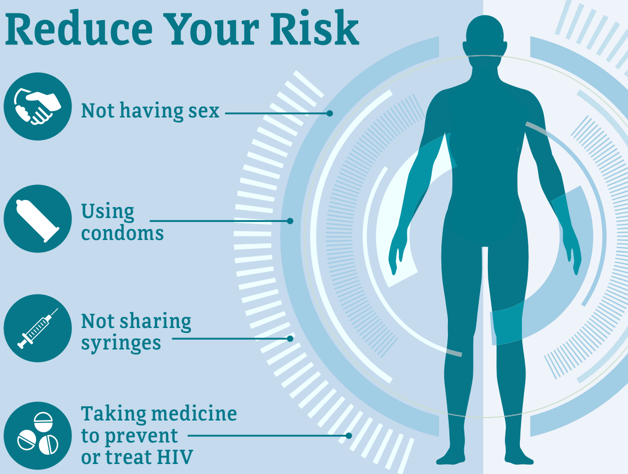
According to current estimates, about 14% of transgender women in the US have HIV.

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



- 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 April 2019.

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

1.9% OF ALL RWHAP CLIENTS

11.5% HAVE UNSTABLE HOUSING

75.6% LIVE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL

81.8% ARE VIRALLY SUPPRESSED

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).

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* 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.

2020 Houston HIV Care Services Needs Assessment: Profile of Transgender and Gender Non-conforming Individuals

PROFILE OF TRANSGENDER AND GENDER NON-CONFORMING INDIVIDUALS

A persistent challenge to designing HIV prevention and care services that meet the needs of all Houston area people living with HIV (**PLWH**) is the lack of epidemiological and surveillance data that accurately reflect the burden of HIV among transgender and gender non-conforming PLWH. A 2013 meta-analysis indicated a heavily disproportionate HIV burden among transgender women in the United States, estimating that 21.7% (1 in 5) of transgender women are living with HIV (Baral, et al., 2013). While included in most state and national surveillance datasets, transgender women living with HIV are categorized as male and men who have sex with men (**MSM**) by sex at birth and risk factor. Transgender MSM are often categorized as female with heterosexual risk factor. Gender non-conforming or non-binary individuals are included, but are only represented by sex at birth, not current gender identity. Data about service needs and barriers transgender and gender non-conforming PLWH in the Houston area encounter is of particular importance to local HIV planning as this information equips communities to provide prevention and care services that meet the unique needs of disproportionately affected gender minority groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were transgender or gender non-conforming.. This Profile highlights results *only* for participants who were transgender or gender non-conforming, as well as comparisons to the entire needs assessment sample.

Notes: "Transgender" and "gender non-conforming" are defined in this analysis as PLWH who indicated having a primary gender identity or gender expression at the time of survey that differed from the participant's reported sex they were assigned at birth, including an option for "intersex". As such, participants who self-identify as transgender or gender non-conforming but who did not meet this analysis criterion may be excluded. Care should be taken in applying the results presented in this profile to the Houston area transgender and gender non-conforming PLWH population as a whole due to small sample size. Data presented in this in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check-all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 22 participants in the 2020 Houston HIV Care Services Needs Assessment were identified as transgender or gender non-conforming, comprising 4% of the total sample.

At the time of data collection, 91% of transgender and gender non-conforming participants lived within Houston/Harris County, 48% identified as Black/African American, and 41% were between the ages of 35-49. The majority of transgender and gender non-conforming participants were assigned male at birth (91%). Among the transgender and gender non-conforming participants sampled, 50% identified as transgender female, 9% identified as transgender male, and 36% identified as other/non-conforming. Seven percent (93%) of transgender and gender non-conforming participants reported being in HIV medical care, and the majority of had public health insurance through Medicaid or Medicare (37%), the Harris Health System (Gold Card) (27%), and the Ryan White Program (23%).

Compared to all needs assessment participants, a greater proportion of transgender and gender non-conforming participants displayed a wider variety in sexual orientation with “other” or write-in responses including “transgender”, “human”, “queer” and “transsexual” when compared to the total needs assessment sample (38% vs 3.8%).

A lower proportion of transgender and gender non-conforming participants were below 100% of the Federal Poverty Line (**FPL**), identified as Black/African American (48% vs 60%), and were seniors (greater than fifty years old) (11% vs 60%) when compared to the total sample of the needs assessment.

Though representing a very small overall number, the proportion of transgender and gender non-conforming participants recently released from incarceration was the same as when compared to the total sample (both 11%). Similarities between the total sample and transgender and gender non-conforming participants and the total sample were also seen in the proportion of participants that were not currently retained in care (both 7%).

Characteristics of transgender and gender non-conforming participants (as compared to all participants in general) can be summarized as follows:
- Residing in Houston/Harris County
- Male at birth
- Transgender female
- African American/Black
- Adults between the ages of 35 and 49
- Self-identified as a wide variety of other sexual identities
- Similar occurrences of recent release from incarceration and not being retained in care when compared to the total sample

TABLE 1-Select Characteristics among Transgender and Gender Non-Conforming Participants, Houston Area HIV Needs Assessment, 2020

	No.	TG / GN %	Total %		No.	TG / GN %	Total %		No.	TG / GN %	Total %
County of residence				**Age range (median: 35-49)**				**Sex at birth**			
Harris	20	91%	95%	13 to 17	0	-	-	Male	20	91%	57%
Fort Bend	1	5%	2%	18 to 24	3	14%	3%	Female	2	9%	30%
Montgomery	1	5%	2%	25 to 34	2	9%	9%	Intersex	0	-	9%
				35 to 49	9	41%	28%	Other	0	-	4%
				50 to 54	3	14%	18%	**Gender Identity**			
				55 to 64	0	-	28%	Transgender Female	11	50.0%	
				≥65	5	23%	15%	Transgender Male	2	9%	
				Seniors (≥50)	8	11%	60%	Other/Non-conforming	8	36%	
Primary race/ethnicity				**Sexual orientation (self-reported)**				**Health insurance (multiple response)**			
White	3	14%	14%	Heterosexual	4	19%	57%	Private insurance	2	7%	9%
African American/Black	10	48%	60%	Gay/Lesbian	6	29%	30%	Medicaid/Medicare	11	37%	67%
Hispanic/Latino	5	24%	21%	Bisexual/Pansexual	3	14%	9%	Harris Health System	8	27%	29%
Asian American	1	5%	0.7%	Other	8	38%	3.8%	Ryan White Only	7	23%	24%
Other/Multiracial	2	10%	4.7%					None	2	7%	3%
Immigration status				Yearly income (average: $6,688)							
Born in the U.S.	17	77%	88%	**Federal Poverty Level (FPL)**							
Citizen > 5 years	4	18%	10%	Below 100%	8	53%	67%				
Citizen < 5 years	0	-	1%	100%	6	40%	19%				
Undocumented	0	-	0.2%	150%	0	-	6%				
Prefer not to answer	1	5%	0.7%	200%	0	-	5%				
Other			1.8%	250%	0	-	-				
				≥300%	1	7%	2%				

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of the Transgender and Gender Non-Conforming Needs Assessment Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

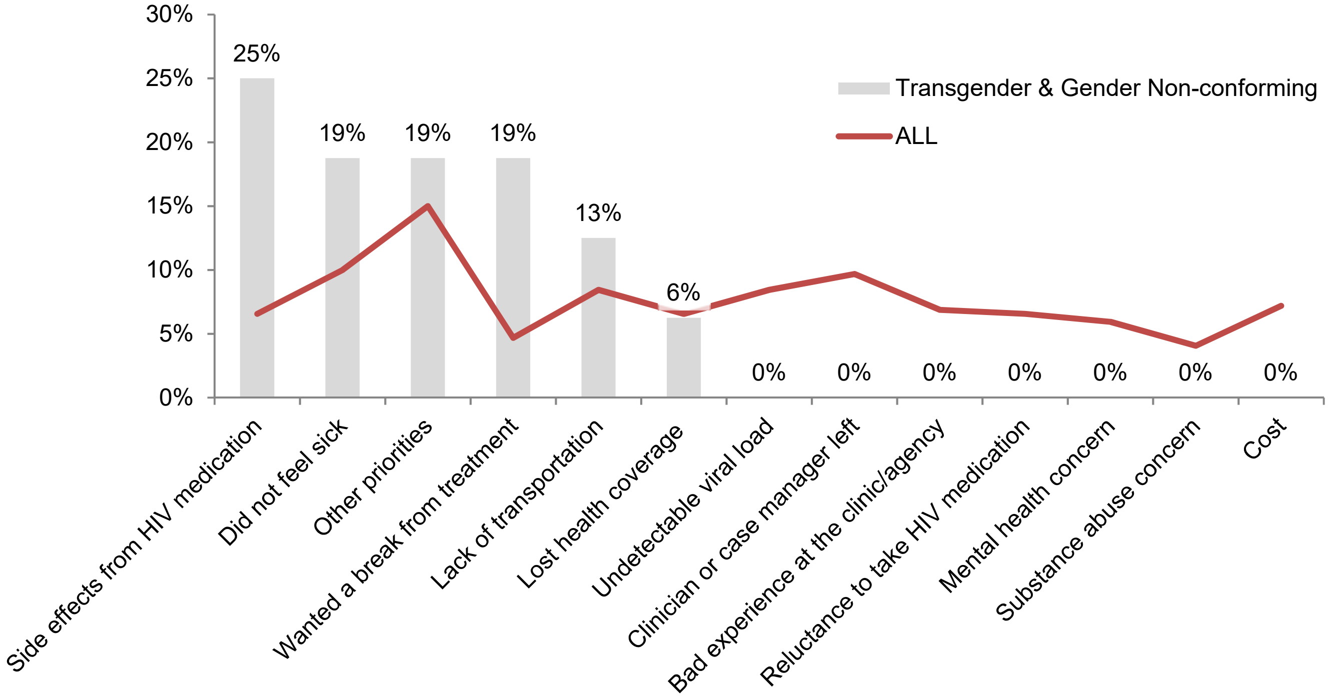
Though representing a very small overall number, the proportion of transgender and gender non-conforming participants reported a higher proportion of at least one interruption in their HIV medical care for 12 months or more since their diagnosis (42% vs 32%). Those who reported a break in HIV care for 12 month or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey, and participants could select multiple reasons. Participants could also write-in their reasons as well.

(**Graph 1**) Among transgender and gender non-conforming participants, side effects from HIV medication was cited most often as the reason for interruption in HIV medical care at 25% of reported reasons. Transgender and gender non-conforming participants also reported not feeling sick, other priorities, and wanting a break from treatment as common reasons for interruption in HIV medical care (all 19%).

The largest differences in reported barriers to retention in HIV medical care between transgender and gender non-conforming participants and the total sample were in the proportions of reports of side effects from HIV medication (25% vs 7%) and wanting a break from treatment (19% vs 5%). Transgender and gender non-conforming participants did not report undetectable viral load, clinician or case manager leaving, bad experiences at clinics/agencies, reluctance to take HIV medication, mental health concerns, substance abuse concerns, and cost as barriers to retention in HIV medical care. One of the write-in responses when asked to report barriers to retention in HIV medical care was the loss of a participant's child.

GRAPH 1-Reasons for Falling Out of HIV Care among Transgender and Gender Non-conforming PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by transgender and gender non-conforming needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



OVERALL RANKING OF FUNDED SERVICES, BY NEED

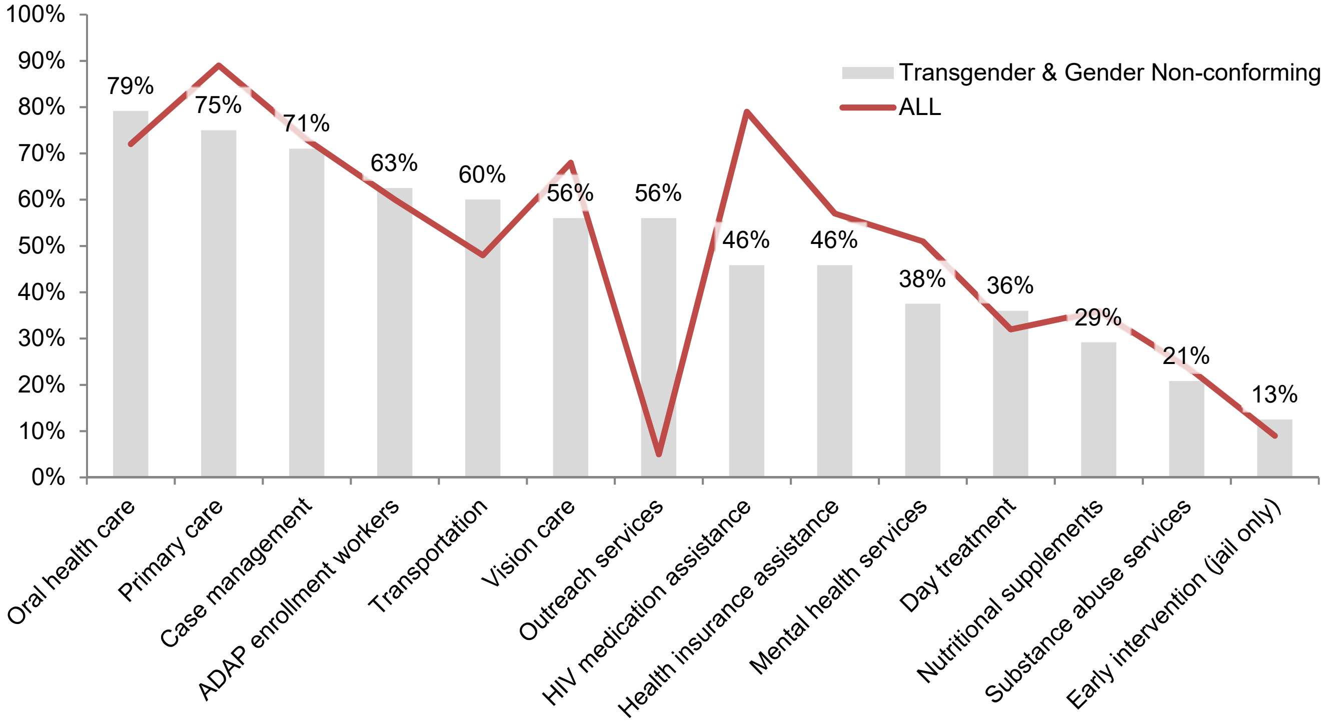
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Among transgender and gender non-conforming participants, oral health care was the most needed Ryan White funded service at 79% of transgender and gender non-conforming participants reporting need, followed by primary care (75%), and case management (71%).

The greatest difference between transgender and gender non-conforming participants and the total sample were in the proportions reporting need for outreach services (56% vs 5%), and transportation (60% vs 48%). Transgender and gender non-conforming participants reported lower proportions of need for HIV medication assistance (46% vs 79%), primary care (46% vs 79%), and mental health services (38% vs 51%).

GRAPH 2-Ranking of HIV Services among Transgender and Gender Non-conforming PLWH in the Houston Area, By Need, 2020

Definition: Percent of transgender and gender non-conforming needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

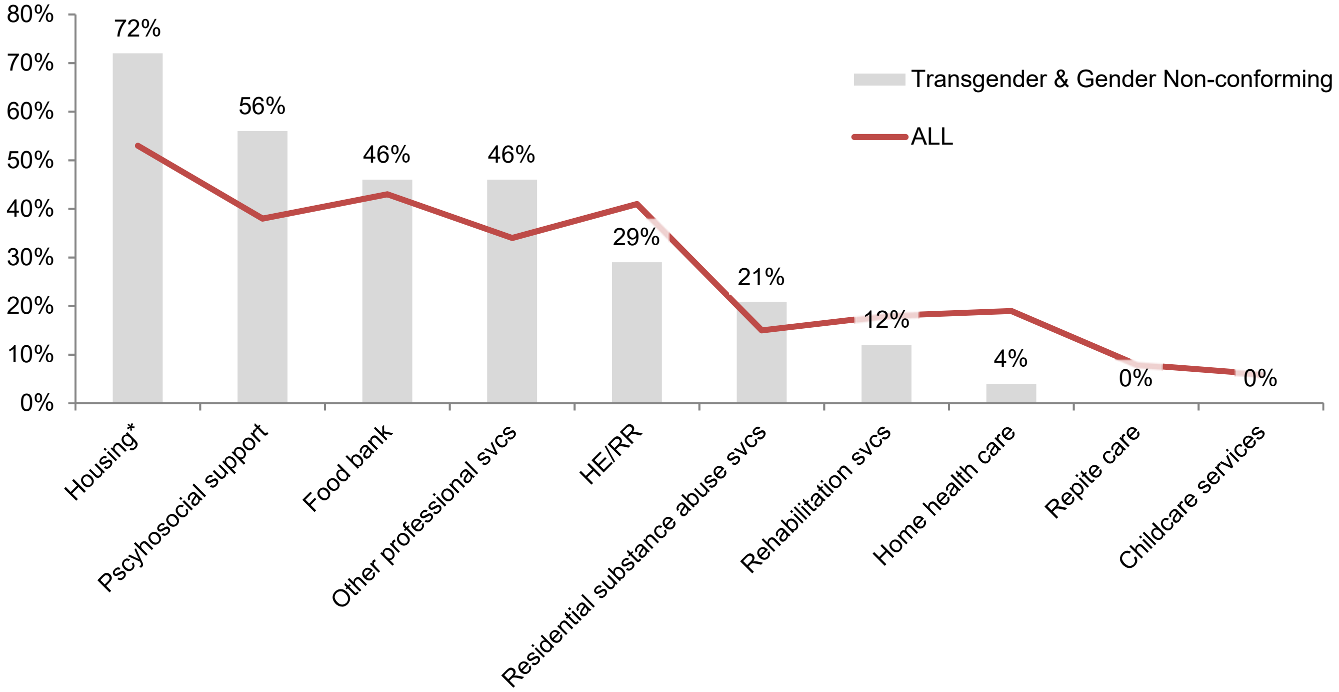
In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV-related services they needed in the past 12 months.

(**Graph 3**) In general, transgender and gender non-conforming participants reported a higher need for services skewed to meet psychological and safety needs like housing (72%), psychosocial support (56%), food bank (46%) and other professional services (46%). When compared to the reported other needs by the total sample, a greater proportion of transgender and gender non-conforming participants reported needing housing (72% vs 53%), psychosocial support (56% vs 28%), and other professional services (46% vs 34%). Lower proportions of transgender and gender non-conforming participants reported a need for home health care (4% vs 19%), and health education and risk reduction services (29% vs 41%).

GRAPH 3-Other Needs for HIV Services among Transgender and Gender Non-conforming PLWH in the Houston Area, 2020

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

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



OVERALL BARRIERS TO HIV CARE

The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 district barriers. These barriers were then grouped together into 12 nodes, or barrier types.

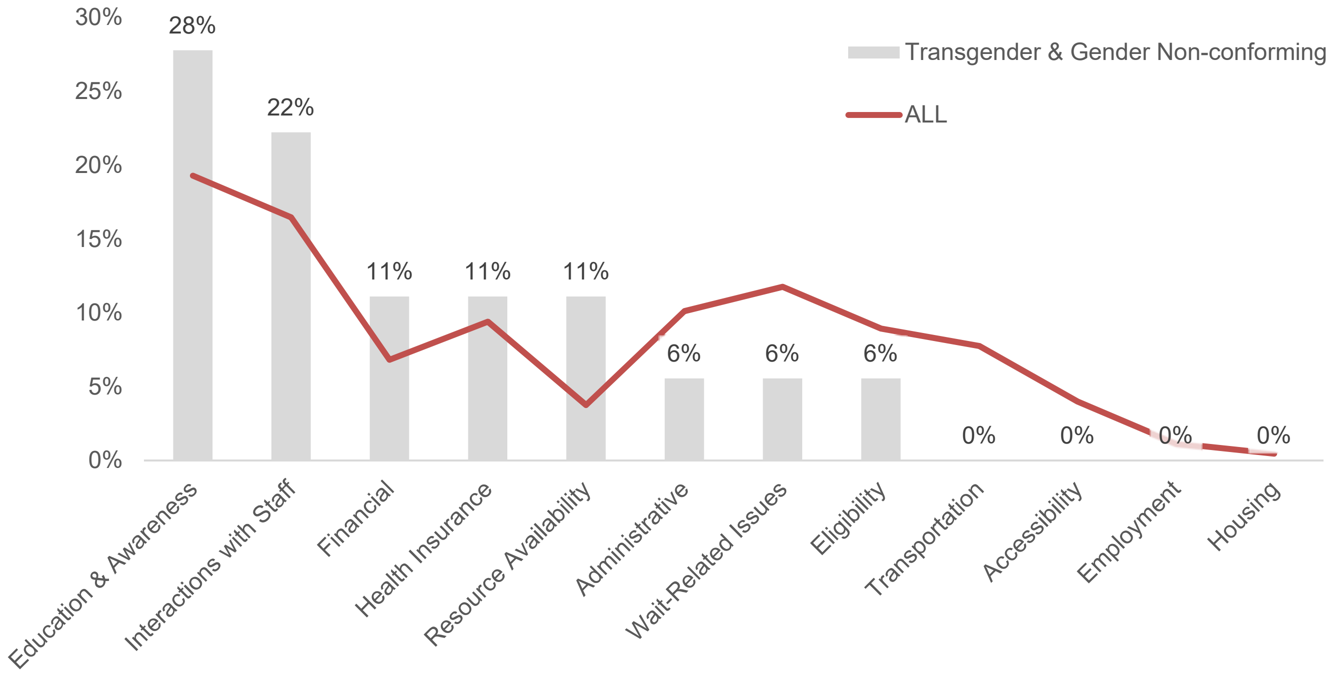
(**Graph 4**) Only 12 transgender and gender non-conforming participants cited barriers to HIV care services. As this group comprises only 50% of all transgender and gender non-conforming participants and 3.9% of the total sample, great care should be taken in applying data and conclusions from Graph 4 to the greater Houston area transgender and gender non-conforming PLWH populations.

Overall, the barrier types reported most often among transgender and gender non-conforming participants related to education and awareness (28%), and interactions with staff (22%). Transgender and gender non-conforming participants also reported interactions with staff, financial barriers, and health insurance (all 11%) as barriers to HIV medical care.

Due to the small number of transgender and gender non-conforming participants reporting barriers to HIV care services, comparison of barrier types between transgender and gender non-conforming participants and the total sample would not be generalizable and are not reported here.

GRAPH 4-Ranking of Types of Barriers to HIV Services among Transgender and Gender Non-conforming PLWH in the Houston Area, 2020

Definition: Percent of times each barrier type was reported by transgender and gender non-conforming needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



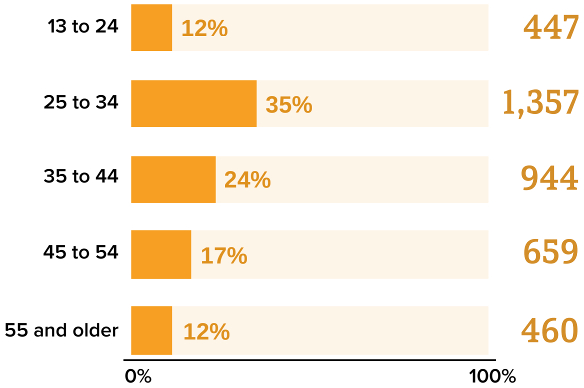
Works Cited

Baral, S. D., Poteat, T., Stromdahl, S., Wirtz, A. L., Guadamuz, T. E., & Beyrer, C. (2013). Worldwide Burden of HIV in Transgender Women: A Systematic Review and Meta-Analysis. *The Lancet Infections Diseases*, 214-222.

HIV and People Who Inject Drugs

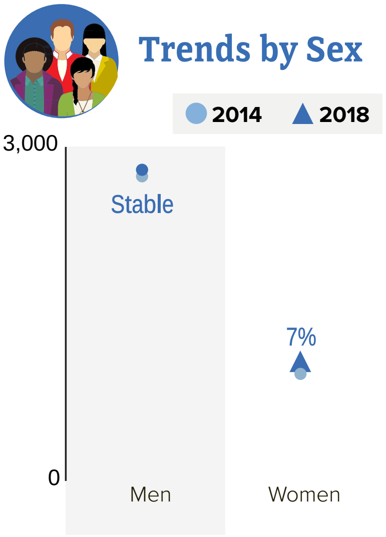
People who inject drugs (PWID)* made up 10% (3,864) of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas† in 2018.

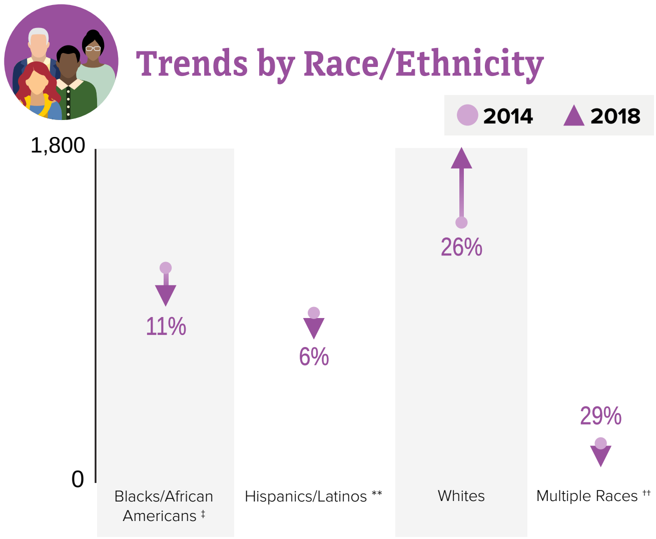
People aged 13 to 34 made up nearly half of all new HIV diagnoses among PWID.



The numbers have been statistically adjusted to account for missing transmission categories. Values may not equal the total number of PWID who received an HIV diagnosis in 2018.

From 2014 to 2018, HIV diagnoses remained stable among PWID overall. While progress has been made with reducing HIV diagnoses among some groups of PWID, efforts will continue to focus on lowering diagnoses among all PWID.


Trends by Sex


Trends by Race/Ethnicity

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

† 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. *African American* is a term often used for people of African descent with ancestry in North America.

** Hispanic/Latino people can be of any race.

†† Changes in subpopulations with fewer HIV diagnoses can lead to a large percentage increase or decrease.

‡‡ In 50 states and the District of Columbia.

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

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

At the end of 2018, an estimated **1.2 MILLION PEOPLE** had HIV. Of those, 186,500 were among people with HIV attributed to injection drug use.‡‡

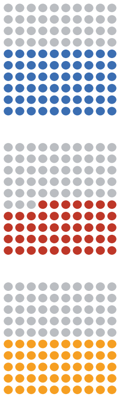
9 in 10

PWID knew they had the virus.

It is important for PWID 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. People who get and keep an undetectable viral load (or remain virally suppressed) can stay healthy for many years and have effectively no risk of transmitting HIV to their sex partners. Keeping an undetectable viral load also likely reduces the risk of transmitting HIV through shared needles, syringes, or other drug injection equipment, though we don't know by how much.

Compared to all people with HIV, male PWID have lower viral suppression rates, female PWID have about the same viral suppression rates, and gay and bisexual male PWID have higher viral suppression rates. More work is needed to increase these rates.

For every 100 male PWID with HIV: (not including gay and bisexual men)

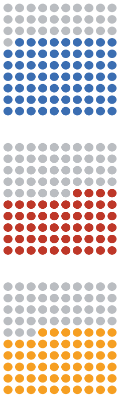


60 received some HIV care

47 were retained in care

50 were virally supressed

For every 100 female PWID with HIV:

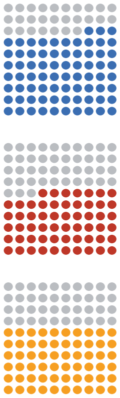


69 received some HIV care

54 were retained in care

57 were virally supressed

For every 100 gay and bisexual male PWID with HIV:



73 received some HIV care

57 were retained in care

60 were virally supressed

For comparison, for every **100 people overall** with HIV, **65 received some care**, **50 were retained in care**, and **56 were virally suppressed**.

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

Opioid Crisis

The prescription opioid and heroin crisis in nonurban areas has led to increased numbers of PWID and new populations being at risk. These areas have limited access to HIV services and substance use disorder treatment.

Other Diseases

PWID are at risk for getting blood-borne diseases such as viral hepatitis and other sexually transmitted diseases (STDs). Having another STD can greatly increase the likelihood of getting or transmitting HIV through sex.

Lack of Treatment

PWID may not have access to treatment, including medication-assisted treatment (MAT) and medication for opioid use disorder (MOUD). MAT and MOUD can lower HIV risk by reducing injection drug use.

Lack of Prevention Programs

Some PWID may not have access to effective syringe services programs (SSPs). SSPs provide access to sterile needles and syringes, facilitate safe disposal of used syringes, and most provide HIV testing and linkage to care.

How is CDC making a difference for PWID?

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, 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 February 2021.

Centers for Disease
Control and Prevention

HIV AND INJECTION DRUG USE

Sharing needles, syringes, or other drug injection equipment—for example, cookers—puts people at risk for getting or transmitting HIV and other infections.

LEARN ABOUT YOUR HIV RISK AND HOW TO LOWER IT

About 1 in 10 new HIV diagnoses in the United States are attributed to injection drug use or male-to-male sexual contact *and* injection drug use (men who report both risk factors).

Risk of HIV

The risk for getting or transmitting HIV is very high if an HIV-negative person uses injection equipment that someone with HIV has used. This is because the needles, syringes, or other injection equipment may have blood in them, and blood can carry HIV. HIV can survive in a used syringe for up to 42 days, depending on temperature and other factors.[a]

Substance use disorder can also increase the risk of getting HIV through sex. When people are under the influence of substances, they are more likely to engage in risky sexual behaviors, such as having anal or vaginal sex without protection (like a condom or medicine to prevent or treat HIV), having sex with multiple partners, or trading sex for money or drugs.

1/160 An HIV-negative person has a 1 in 160 chance of getting HIV every time they use a needle that has been used by someone with HIV.

#2 Sharing syringes is the second-riskiest behavior for getting HIV. Receptive anal sex is the riskiest.

Risk of Other Infections and Overdose

Sharing needles, syringes, or other injection equipment also puts people at risk for getting viral hepatitis. People who inject drugs should talk to a health care provider about getting a blood test for hepatitis B and C and getting vaccinated for hepatitis A and B.

In addition to being at risk for HIV and viral hepatitis, people who inject drugs can have other serious health problems, like skin infections and heart infections. People can also overdose and get very sick or even die from having too many drugs or too much of one drug in their body or from products that may be mixed with the drugs without their knowledge (for example, fentanyl).

[a] Abdala N, Reyes R, Carney JM, Heimer R. Survival of HIV-1 in syringes: effects of temperature during storage . *Subst Use Misuse* 2000;35(10):1369–83.

Page last reviewed: November 3, 2020

HRSA's Ryan White HIV/AIDS Program
Addressing the HIV Care Needs of People With HIV in State Prisons and Local Jails
Technical Expert Panel Executive Summary

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB), which oversees the Ryan White HIV/AIDS Program (RWHAP), convened a Technical Expert Panel (TEP) in March 2020 to explore the HIV care needs of people with HIV in state prisons and local jails and the role the RWHAP can play in addressing these needs. The purpose of this panel was to identify supports and barriers to HIV care and treatment in correctional facilities, as well as community re-entry and current approaches and guidance under HAB Policy Clarification Notice (PCN) 18-02, The Use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living With HIV Who Are Incarcerated and Justice Involved. The term "justice involved" is used by U.S. government agencies to refer to any person who is engaged at any point along the continuum of the criminal justice system as a defendant (including arrest, incarceration, and community supervision).

- **Federal and State Prison Systems.** RWHAP recipients may provide RWHAP core medical and support services to people with HIV who are incarcerated in federal or state prisons on a transitional basis where those services are not provided by the correctional facility. HRSA HAB defers to recipients/subrecipients to define the time limitation, which generally is up to 180 days. RWHAP recipients/subrecipients work with the correctional systems/facilities to define both the nature of the services based on identified HIV-related needs and the duration for which the services are offered.

- **Other Correctional Systems.** RWHAP recipients may provide RWHAP core medical and support services to people with HIV who are incarcerated in other correctional facilities on a short-term or transitional basis. RWHAP recipients/subrecipients work with the correctional systems/facilities to define both the nature of the services based on identified HIV-related needs and the duration for which the services are offered, which may be the duration of incarceration. If core medical and support services are being provided on a short-term basis, HAB recommends that RWHAP recipients also provide services on a transitional basis. For these systems, RWHAP cannot duplicate existing services.

The following TEP Executive Summary includes the following sections:

- Considerations for Improving HIV Treatment for People With HIV Who Are Justice Involved
- Issues Related to Providing HIV Care and Treatment in Correctional Settings
- Issues Related to HIV Care During Re-Entry
- Data Considerations

CONSIDERATIONS FOR IMPROVING HIV TREATMENT FOR PEOPLE WITH HIV WHO ARE JUSTICE INVOLVED

Over the course of the discussion, multiple themes and strategies emerged that relate to the provision of services to people with HIV who are involved in the justice system—either during incarceration, upon release, or under community supervision.

Policy Clarification Notice (PCN) 18-02 provides clarification to Ryan White HIV/AIDS Program (RWHAP) recipients and demonstrates the flexibility in the use of RWHAP funds to provide core medical services and support services (described in PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds) for people with HIV who are incarcerated or otherwise justice involved. There are differences between how an RWHAP recipient can collaborate with a federal or state facility versus a local correctional facility. These distinctions are based on the administrative entity (federal or state vs. local) relative to the payor of last resort statutory requirement for RWHAP recipients. The RWHAP statute specifies that payor of last resort applies to federal or state payers—like prisons operated by the Federal Bureau of Prisons or a state department of corrections. The provision does not mention local payors; as such, payor of last resort is not applicable. However, the RWHAP cannot duplicate existing services.

Specific Issues

- **HIV-Related Stigma and Incarceration.** The impact of HIV-related stigma can be exacerbated by incarceration. Breaches of confidentiality, particularly related to HIV status, can constitute a safety risk. To minimize these risks, some facilities have segregated units for people with HIV, or people with HIV may be placed in solitary confinement. These practices have been found in some instances to be discriminatory. The U.S. Department of Justice works to address discrimination complaints from people with HIV in correctional facilities. These often relate to housing, unequal access to services, and access to treatment. Stigma and discrimination also are associated with incarceration. People with HIV who have been incarcerated also may experience the effects of incarceration-related stigma and/or discrimination upon release.

- **Impact of Comorbidities.** People with HIV often have comorbidities, which can make HIV treatment more difficult and create barriers to linkage to and retention in care once the patient re-enters the community. Substance use disorder (SUD) presents a significant challenge, and panelists emphasized the importance of access to treatment, especially medication-assisted treatment (MAT) for opioid use disorder. Other comorbidities include mental illness, hepatitis C, sexually transmitted infections, and chronic conditions, such as cardiovascular disease.

- **Holistic Services—Treating the Whole Person.** To ensure optimal health outcomes, people with HIV need comprehensive services both within the correctional facility and upon release. This includes a wide range of support services, including support from peer specialists. In particular, panelists emphasized the need for SUD treatment, mental health services, care for aging individuals, and care that addresses health issues other than HIV.

  Services should address not only HIV-related needs but also the social determinants of health—conditions in a person's life and environment that affect a wide range of outcomes and risks related to health, functioning, and quality of life. Challenges confronting this population include lack of a social support network, domestic violence, low levels of educational attainment, history of trauma, low health literacy, limited access to employment (especially post-incarceration), unstable housing, and a history of debt. Any one of these factors constitutes a barrier to engaging in care; combined, they present a significant challenge. Many of these issues predate incarceration and may have contributed to the person's becoming justice involved.

- **Multidisciplinary Care Team/Patient-Centered Care.** Key members of the team include a physician, nurse, social worker (behavioral/mental health), and case worker (support services). Other disciplines can augment the team. The patient is also an important member of the team.

- **Value of Lived Experience.** Peer support services can enhance the quality of care and are an important component for ensuring linkage to care in the community. Peer specialists serve in various positions, including navigator, recovery coach, re-entry coach, and community health worker.

- **Creating a Bridge Between Incarceration and Community.** Many barriers exist between correctional facilities and community providers, which can affect the care and services incarcerated people receive while in the facility and during their re-entry process. In some service models—such as the Hampden County Model—clinicians are dually based in correctional facilities and community health centers to help ensure that essential linkages are made and treatment is not interrupted.

- **Challenge of Recidivism.** Although multiple factors are related to recidivism, many TEP members expressed that justice-involved individuals often face insurmountable challenges upon their release due to community corrections policies, judicial mandates, and the stigma related to incarceration. These individuals also face limited options, especially related to housing and employment, which can contribute to recidivism.

ISSUES RELATED TO PROVIDING HIV CARE AND TREATMENT IN CORRECTIONAL SETTINGS

Uninterrupted access to antiretroviral medications and adherence to clinical treatment guidelines must be ensured to achieve optimal health outcomes, including viral suppression. Clinical treatment guidelines (e.g., U.S. Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV) apply to correctional facilities. Panelists expressed concern that these guidelines may not always be followed, particularly in situations where facilities contract out for medical services.

Specific Issues

- **Access to Medication Upon Entry to the Facility.** Newly incarcerated individuals may experience delays in obtaining medications for multiple reasons. Not all HIV medications may be available—this depends on the formulary—so patients may be provided a different antiretroviral medication. If patients transfer to another facility, a delay in access also may occur if they run out of medication before they are provided more in the new facility.

- **Access to Medication During Incarceration.** Processes for dispensing medication in a facility may result in missed doses. These treatment interruptions, whether one dose or more, can impact health outcomes. Long lines (e.g., 1–2 hours) for directly observed therapy can result in patients missing doses, because they may opt to skip the line if they have work duty or a visitor or must appear in court. Sometimes after waiting in line, medications may not be available. In addition, other circumstances in a facility, such as solitary confinement or lock downs, can reduce access to medications.

- **Access to Specialty Care.** Correctional systems have multiple facilities with multiple buildings. Specialty care, including infectious disease specialists, may not be available in every clinic, and transfers to these specialists may not occur.

Strategies for Improving HIV Treatment and Care in Correctional Settings

- Ensure uninterrupted access to antiretroviral medication, including access on entry, a process to track that medications are received, and such strategies as keep-on-person [KOP] medication.
- Treat comorbidities, including substance use disorder, mental illness, and hepatitis.
- Provide a multidisciplinary team—at a minimum, a physician, a nurse, and a social worker/case manager, with the patient as a partner.
- Ensure dually based physicians and case managers (i.e., providers who serve the patient in both the facility and the community).
- Use telehealth to facilitate access to HIV care and specialists, and maintain a connection to the same clinicians as the patient moves to different facilities.
- Identify champions to advocate for the needs of patients with HIV, in the correctional system/facility, the community, or both.
- Introduce patients to harm reduction strategies; provide services in a harm reduction framework.
- Provide education/training for administration and correctional officers, including stigma reduction training.
- Train clinical staff to ensure adherence to treatment guidelines.
- Build connections with community-based organizations and community-based services and allow them access to the facility (e.g., Alcoholics Anonymous/Narcotics Anonymous).
- Ensure that contracts for the provision of health care within correctional facilities are aligned with HIV treatment guidelines.
- Develop standard language for requests for proposals for contracted health care services based on U.S. Department of Health and Human Services guidelines and tied to performance measures that correctional systems can use in their procurement process.
- Collect data on access to care within facilities (e.g., type of care provided, access to specialty care, viral suppression rates).
- Encourage representation of both the department of corrections and individual facilities on RWHAP planning bodies.

- **Training.** The lack of HIV-related information and training for administrators and staff in correctional systems/facilities can affect the care of people with HIV. County managers and correctional facility administrators (i.e., wardens) make decisions related to the resources available to facilities and the policies within facilities that may limit access to or the quality of treatment for people with HIV in those facilities. More training is necessary for clinical staff, corrections officers, and administrators to ensure an understanding of the needs of incarcerated individuals with HIV, with a particular focus on reducing stigma and discrimination in facilities. Panelists also noted the need to educate those in the corrections community about the RWHAP and the resources available to patients with HIV.

ISSUES RELATED TO HIV CARE DURING RE-ENTRY

Panelists noted that patients face multiple challenges to continuity of care during re-entry. Some of these relate to the release process, whereas others relate to disconnects between correctional facilities and services within the community.

Specific Issues

- **Unpredictable Release Dates.** Release dates may change, frustrating efforts to ensure a “warm handoff.” Sometimes release is scheduled for late at night, which can make coordination with community partners difficult. Unpredictable release also can result in a patient’s leaving the facility without their medications.

- **Connecting With a Community-Based Health Care Provider.** Many jurisdictions have processes in place to ensure continuity of care. However, even for systems/facilities where this is the intention, it may not take place. Patients (and staff) must navigate the system, which may include multiple payers, requirements, and processes. For example, enrolling a patient in Medicaid or the RWHAP AIDS Drug Assistance Program may or may not be possible within the facility. Some community-based providers will not make an appointment unless the patient has active insurance or Medicaid, so the patient leaves the correctional facility with no appointment. The patient must contact the provider and make an appointment after release. The Health Insurance Portability and Accountability Act (HIPAA) also plays a role. Many community-based providers will not engage with the patient’s clinician within the correctional facility until the patient is released, has accessed their organization, and has signed a HIPAA release. This policy makes advanced coordination impossible.

  Even if a community-based provider is selected prior to release, the process may not go smoothly. Many patients may not know where they will be living upon release and may select a provider and pharmacy that is not convenient to where they eventually live. Patients who are on Medicaid prior to release may be assigned to a provider who may not be the most appropriate to provide HIV-related care or be convenient to where the patient is living.

  Although the peer navigator is considered one of the most effective bridges to treatment, many community-based organizations (CBO) report challenges getting navigators into correctional facilities so they can facilitate a warm handoff. The issue is twofold: (1) Either the CBO or the facility may lack processes for CBO staff to enter the correctional facility; and (2) peer navigators, people with similar lived experience, may have a history of incarceration and have difficulty gaining approval to access the facility.

- **Access to Medications Upon Release.** Even if a patient is able to line up a community-based provider before release, ensuring ongoing access to medications can be a challenge. Patients may not have sufficient supply of medication upon release to last until their first appointment, and some retail pharmacies will not fill prescriptions from correctional facilities.

- **Followup.** Followup with patients is difficult. Often, patients leave facilities without a home address or telephone number. They are located only when and if they access care.

- **Exchange of Health Information.** Many systems/facilities do not have electronic health records (EHRs), which complicates the transfer of patient information; patients arrive at their new provider with paper records.

Strategies for Improving HIV Treatment and Care During Re-Entry

- Ensure a warm handoff (same clinician [dually based], clinician to clinician [face-to-face meeting before transfer], or establish a relationship with a new provider [via telephone]).
- Employ peer specialists to support re-entry (e.g., navigator, addiction coach, re-entry coach).
- Ensure that insurance/Medicaid/AIDS Drug Assistance Program is in place upon release.
- Ensure that the first appointment with a new clinic is in place on release.
- Follow up with patients to the extent possible, given challenges in tracking patients upon release.
- Connect patients with essential services, especially housing.
- Link patients to harm-reduction organizations, especially overdose prevention for the newly released.
- Help HIV-related community-based organizations connect with correctional facilities and organizations that serve incarcerated individuals (e.g., evangelical organizations).
- Educate correctional facilities about RWHAP.
- Engage formerly incarcerated people with HIV in the RWHAP planning process.

DATA CONSIDERATIONS

To improve the quality of patient care and data-driven decision-making, accurate data at the patient and facility levels need to be collected. At the patient level, health outcomes (e.g., viral suppression) need to be documented. At the facility level, quality indicators related to HIV testing, access to care, and access to antiretroviral treatment are needed. Sharable electronic health records and up-to-date data sets also are needed.

Providers also should collect data related to justice involvement, but these data need to be collected in a sensitive manner. Such information includes the date of release from most recent incarceration, length of most recent incarceration, number of previous incarcerations, and history of solitary confinement.

CONCLUSION

A knowledge gap remains on how RWHAP grant funds can be used to support people with HIV who are justice involved. Opportunities exist for RWHAP recipients and correctional facilities to collaborate and ensure that people with HIV who are justice involved receive needed care and treatment, both while incarcerated and upon release.

2020 Houston HIV Care Services Needs Assessment: Profile of the Recently Released

PROFILE OF THE RECENTLY RELEASED

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were recently released. This profile highlights results *only* for participants at the time of survey, as well as comparisons to the entire needs assessment sample.

Notes: "Recently released from incarcerations" and "recently released" are defined in this analysis as PLWH who indicated at survey that they were released from jail or prison within the past 12 months at the time of survey. Data presented in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or "check all" responses.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 65 participants in the 2020 Houston HIV Care Services Needs Assessment were recently released from jail or prison within the 12 months prior to survey comprising 12% of the total sample.

Ninety-five percent (95%) of recently released participants were residing in Houston/Harris County at the time of data collection. Like all needs assessment participants, the majority of recently released participants were male (80%), African American (67%), and identified as heterosexual (60%). Among the recently released participants that were surveyed, 14% reported being out of HIV medical care, and the majority of the recently released participants had public health insurance through Medicaid or Medicare (37%), the Harris Health System (31%), and the Ryan White Program (25%).

Several differences were observed when comparing the recently released participants with the total sample of the 2020 Houston HIV Care Services Needs Assessment. Recently released participants had a higher proportion of males (80% vs 66%), individuals between the ages of 35-49 (37% vs 28%), and participants who identified as African American/Black (67% vs 60%) when compared to the total sample. Recently released participants had a lower proportion of participants who were females (20% vs 34%), participants ages 55-64 (20% vs 28%), and people who had health insurance through Medicare or Medicaid (37% vs 67%). The average annual among recently released participants who reported income was one-third less than the total sample ($8,974 vs $13,493).

Characteristics of recently released participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Adults between the ages of 35 and 49
- Heterosexual
- With higher occurrences of no health insurance coverage, and lower average annual income.

TABLE 1-Select Participant Characteristics for Recently Released Participants, Houston Area HIV Needs Assessment, 2020

	No.	Released %	Total %		No.	Released %	Total %		No.	Released %	Total %
County of residence				**Age range (median: 50-54)**				**Sex at birth**			
Harris	58	95%	95%	13 to 17	0	-	-	Male	52	80%	66%
Montgomery	2	3%	1%	18 to 24	3	5%	3%	Female	13	20%	34%
Liberty	1	2%	1%	25 to 34	6	9%	9%	Intersex	0	-	0%
Other	4	7%	1.6%	35 to 49	24	37%	28%	Other	0	-	0%
				50 to 54	15	23%	18%	Transgender	3	4.6%	4%
				55 to 64	13	20%	28%	Currently pregnant	0	-	2%
				≥65	4	6%	15%				
				Seniors (≥50)	52	85%	3%				
Primary race/ethnicity				**Sexual orientation**				**Health insurance (multiple response)**			
White	13	20%	14%	Heterosexual	38	60%	57%	Private insurance	2	2%	9%
African American/Black	43	67%	60%	Gay/Lesbian	18	29%	30%	Medicaid/Medicare	35	37%	67%
Hispanic/Latino	3	5%	21%	Bisexual	6	10%	9%	Harris Health System	29	31%	29%
Asian American	1	2%	0.7%	Other	1	2%	3.8%	Ryan White Only	24	25%	24%
Other/Multiracial	4	6%	4.7%					None	1	1%	3%
				MSM	27	42%	40%				
Immigration status				Yearly income (average: $8,974)							
Born in the U.S.	2	2%	9%	**Federal Poverty Level (FPL)**							
Citizen > 5 years	35	37%	67%	Below 100%	19	76%	67%				
Citizen < 5 years	29	31%	29%	100%	3	12%	19%				
Undocumented	24	25%	24%	150%	3	12%	6%				
Prefer not to answer	1	1%	3%	200%	0	-	5%				
Other	4	4%	2%	250%	0	-	-				
				≥300%	0	-	2%				

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

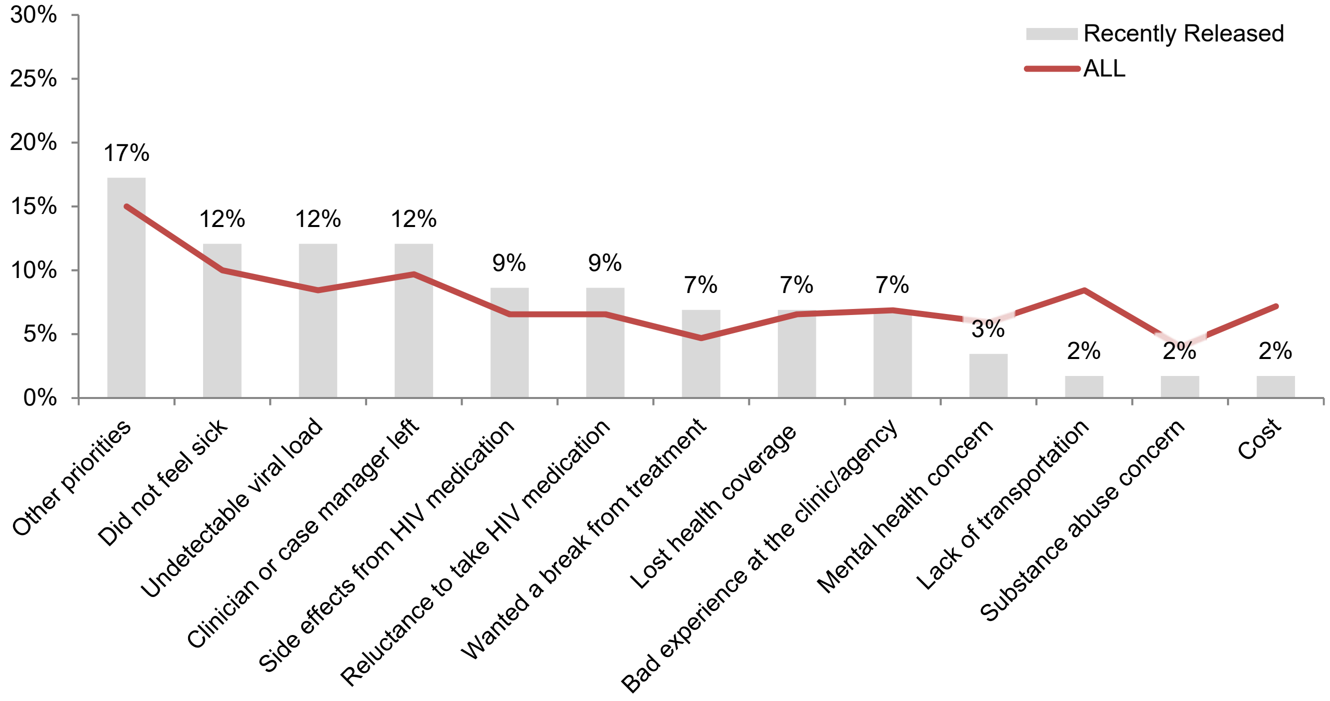
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 58% of recently released participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey. Participants could also write-in their reasons.

(**Graph 1**) Among recently released participants, other priorities was cited most often as the reason for interruption in HIV medical care at 17% of the reported reasons, followed by not feeling sick, undetectable viral load, and clinician or case manager leaving the clinic/agency (all 12%).

The greatest differences between recently released participants and the total sample were in the proportions reporting an undetectable viral load (12% vs 8%) as a reason for falling out of HIV medical care. Write-in responses for this question reported the following as reasons for falling out of HIV medical care – experiencing homelessness, being hospitalized, and the loss of family member.

GRAPH 1-Reasons for Falling Out of HIV Care among Recently Released PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by recently released needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



OVERALL RANKING OF FUNDED SERVICES, BY NEED

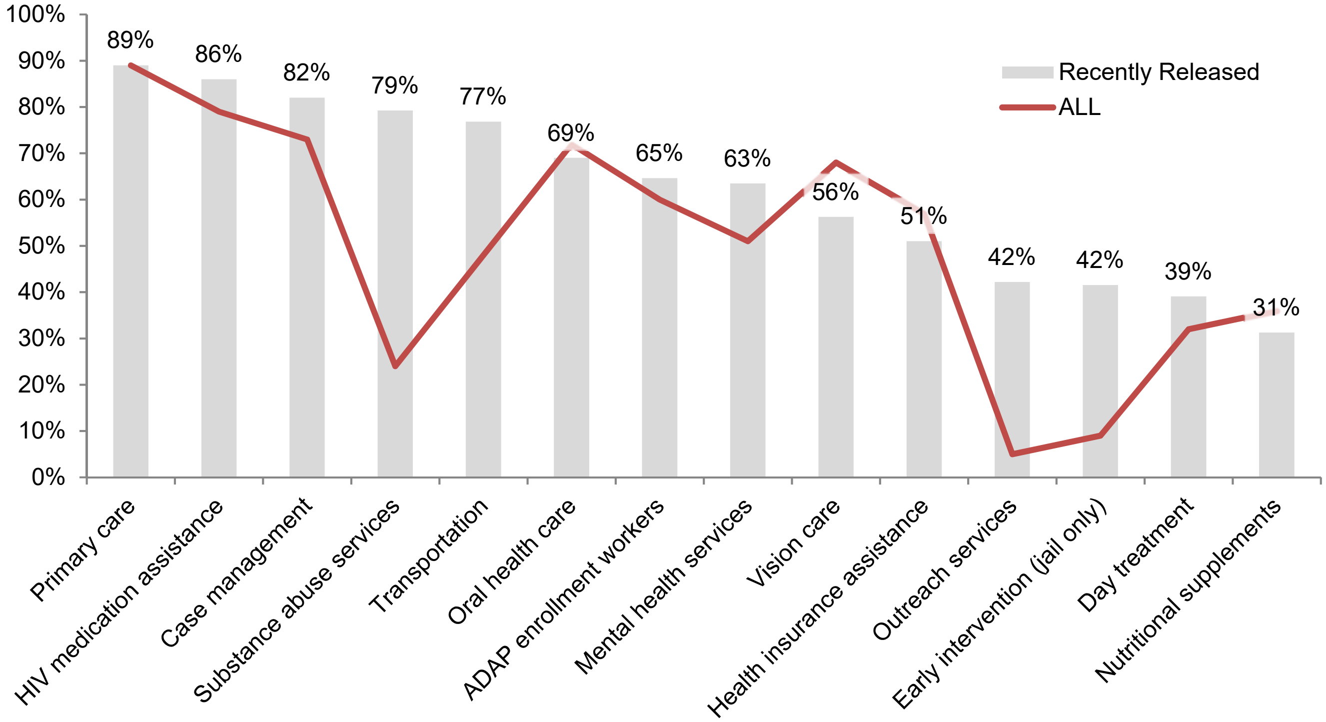
In 2020, 16 HIV care medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 2**) Among recently released participants, primary care was the most needed funded service at 89% of recently released participants reporting a need. Recently released participants also reported a need for HIV medication assistance (86%), case management (82%), and substance abuse services (79%).

The greatest differences between recently released participants and the total sample were in the proportions reporting need for outreach services (42% vs 5%), early intervention (jail only) services (42% vs 9%), transportation (66% vs 48%) and substance abuse services (79% vs 24%).

GRAPH 2-Ranking of HIV Services among Recently Released in the Houston Area, By Need, 2020

Definition: Percent of recently released needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants in the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other-non-Ryan White funded HIV-related services they needed in the past 12 months.

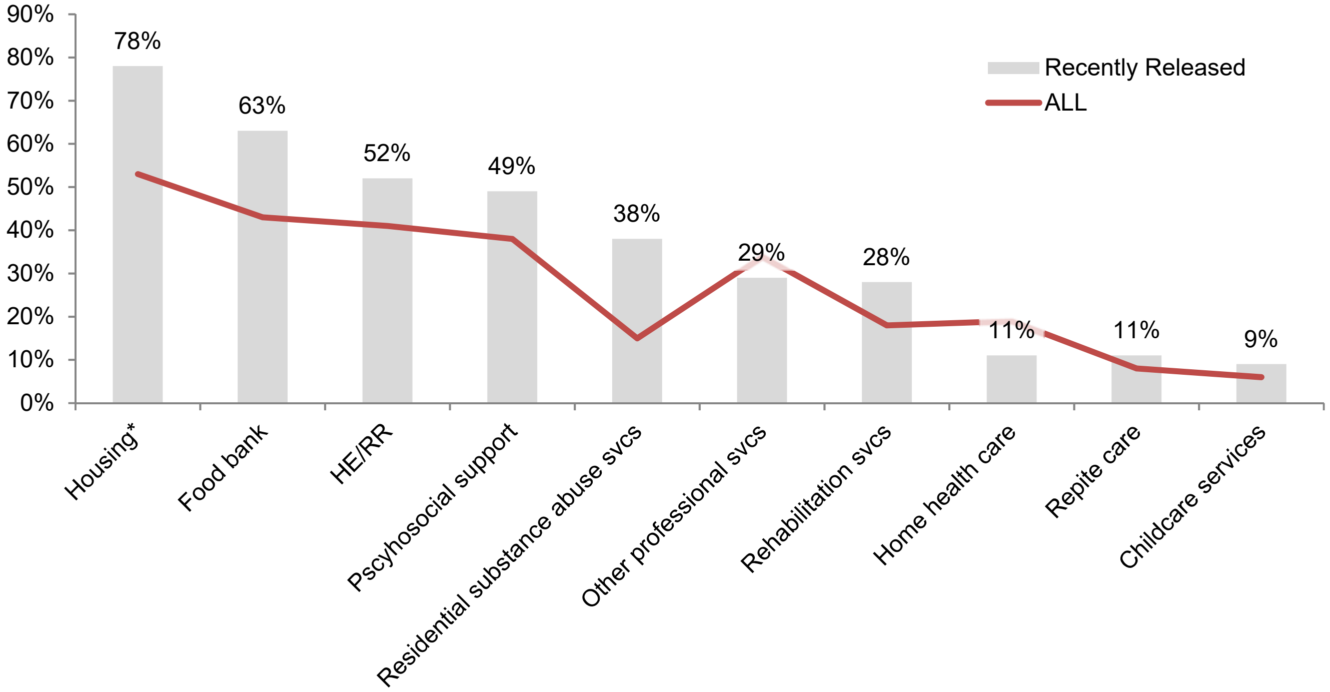
(**Graph 3**) From the 10 services options provided, the greatest proportion of recently released participants reported housing (78%) as the most needed service. This was followed by food bank (63%) and health education and risk reduction services (52%).

Compared to the total sample, a greater proportion of recently released participants reported needing housing services (78% vs 53%), food bank (63% vs 43%), and residential substance abuse services (38% vs 15%).

GRAPH 3-Other Needs for HIV Services among Recently Released PLWH in the Houston Area, 2020

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

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



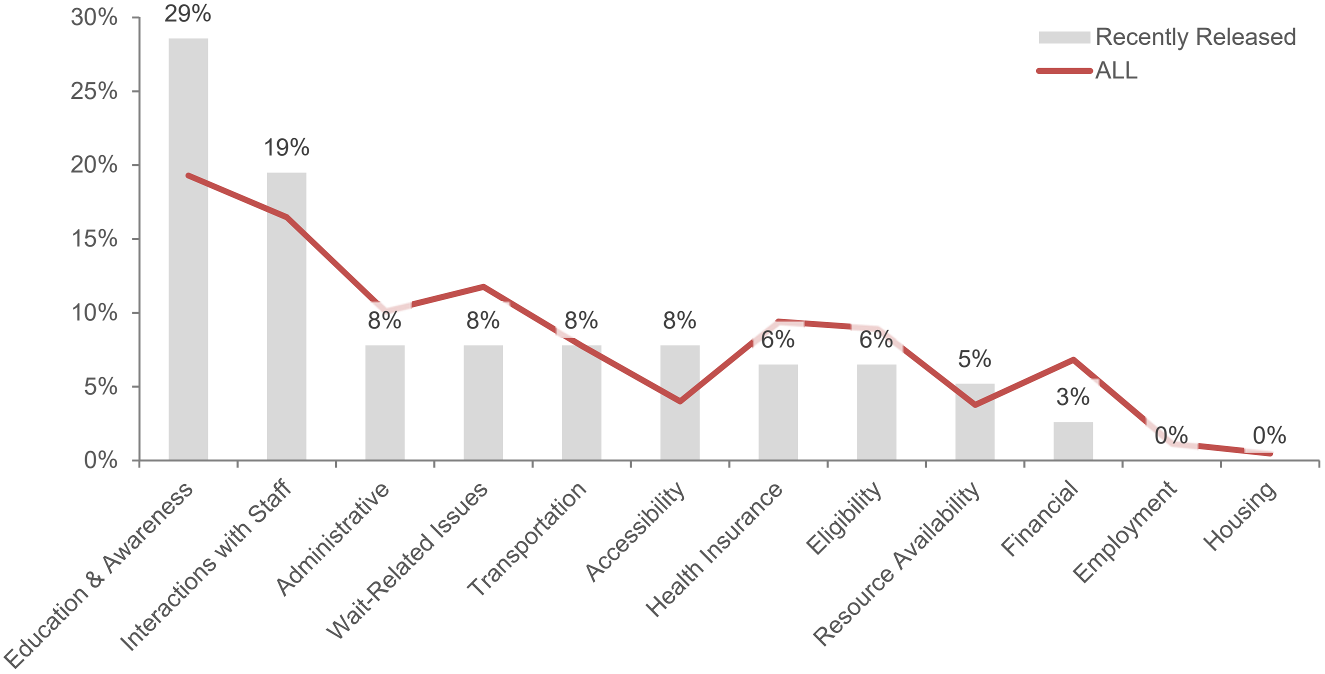
OVERALL BARRIERS TO HIV CARE

The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

(**Graph 4**) Thirty-one (31) recently released participants cited barriers to Ryan White funded HIV care services. Recently released participants most often cited barriers related to service education & awareness (29%), and interactions with staff at the clinic/agency (19%).

Compared to the total sample, recently released participants reported greater proportions of service education & awareness barriers (29% vs 19%), with specific barriers reported being related to not knowing a service was available and not knowing the location of the service/where the service was available in an agency as specific barriers. Recently released participants also reported a greater proportion of barriers related to accessibility (8% vs 4%), with specific barriers reported being related to the former incarceration status, i.e. being restricted from services due to probation, parole, or felon status.

GRAPH 4-Ranking of Types of Barriers to HIV Services among Recently Released PLWH in the Houston Area, 2020
Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



2020 Houston HIV Care Services Needs Assessment: Profile of Rural PLWH

PROFILE OF RURAL AREAS

People living with HIV (**PLWH**) in rural areas experience the impact of HIV disproportionately and have specific HIV prevention and care needs that are much different than those seen in urban areas. The CDC estimates that 24% of all new diagnoses in the United States are within rural areas, which is more than any other region (Center for Disease Control & Prevention, 2019).

Proactive efforts were made to gather a representative sample of all PLWH in the 2020 Houston HIV Care Services Needs Assessment as well as focus targeting sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were currently living in rural areas within the Houston EMA at the time of data collection.

Note: Rural participants are defined in this analysis as PLWH who indicated at survey that they were currently residing in a county within the Houston EMA that is not Harris County. Data presented in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for each variable due to missing or "check all" responses within the survey.

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(**Table 1**) In total, 29 participants in the 2020 Houston HIV Care Services Needs Assessment reported currently residing in a rural county at the time of data collection comprising 5% off the total sample.

The majority of rural needs assessment participants resided within Fort Bend County (31%) at the time of survey. Rural needs assessment participants also reported living within Montgomery County (22%), and Liberty County (9%). Like all needs assessment participants, the majority of rural needs assessment participants were male (70%), and were between the ages of 35 to 64 (70%). While most rural needs assessment participants primarily identified as Black/African American (45%) and heterosexual (45%), a high proportion of rural needs assessment participants identified as White (41%) and gay/lesbian (45%). Among rural needs assessment participants, 87% reported being retained in HIV medical care at the time of the survey, and primarily paid for medical care through Medicaid, Medicare, and the Ryan White Program.

Several differences were observed when comparing the rural needs assessment participants with the total sample of the 2020 Houston HIV Care Services Needs Assessment. Rural needs assessment participants had a higher proportion of individuals between the ages of 25 to 34 (13% vs 9%), who are seniors (78% vs 3%), who identified as transgender (7% vs 4%), individuals who identified as White (41% vs 14%), and individuals who have Ryan White to pay for their HIV medical care (24% vs 24%). Rural needs assessment participants were also more likely to have no health insurance compared to the total sample (7% vs 2%).

Rural needs assessment participants had a lower proportion of participants who had insurance through Medicare or Medicaid (37% vs 67%) or the Harris Health System (12% vs 29%). The average yearly income reported by rural needs assessment participants was $13,544, which is slightly more than that of the total sample ($13,544 vs $13,493).

Characteristics of recently released participants (as compared to all participants) can be summarized as follows:

- Residing in Fort Bend County
- Male
- African American/Black as well as White
- Adults between the ages of 35 and 64
- Heterosexual as well as Gay/Lesbian
- With higher occurrences of no health insurance coverage, and use of public health insurance.

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

	No.	Rural %	Total %		No.	Rural %	Total %		No.	Rural %	Total %
County of residence				**Age range (median: 50-54)**				**Sex at birth**			
Fort Bend	10	31%	2%	13-17	0	-	-	Male	21	70%	66%
Montgomery	7	22%	1%	18-24	2	7%	3%	Female	9	30%	34%
Liberty	3	9%	0.5%	25-34	4	13%	9%	Intersex	0	-	0%
Other*	12	38%	1.6%	35-49	8	27%	28%	Other	0	-	0%
*Other includes: Colorado, Walker and Waller County				50-54	4	13%	18%	Transgender	2	6.7%	4%
				55-64	9	30%	28%	Currently pregnant	0	0.0%	2%
				≥65	3	10%	15%				
				Seniors (≥50)	21	78%	3%				
Primary race/ethnicity				**Sexual orientation**				**Health insurance (multiple response)**			
White	12	41%	14%	Heterosexual	13	45%	57%	Private insurance	3	7%	9%
African American/Black	13	45%	60%	Gay/Lesbian	13	45%	30%	Medicaid/Medicare	15	37%	67%
Hispanic/Latino	3	10%	21%	Bisexual/Pansexual	3	10%	9%	Harris Health System	5	12%	29%
Asian American	0	-	0.7%	Other	0	-	3.8%	Ryan White Only	14	34%	24%
Other/Multiracial	1	3%	4.7%					VA	1	2%	3%
				MSM	`16	52%	41%				
Immigration status				Yearly income (average: $13,544)							
Born in the U.S.	27	90%	88%	**Federal Poverty Level (FPL)**							
Citizen > 5 years	2	7%	10%	Below 100%	4	33%	67%				
Citizen < 5 years	0	-	1%	100%	8	67%	19%				
Visa (student, work, tourist, etc.)	1	3%	0.2%	150%	0	-	6%				
Prefer not to answer	0	-	0.7%	200%	0	-	5%				
Born in the U.S.	27	90%	88%	250%	0	-	-				
				≥300%	0	-	2%				

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

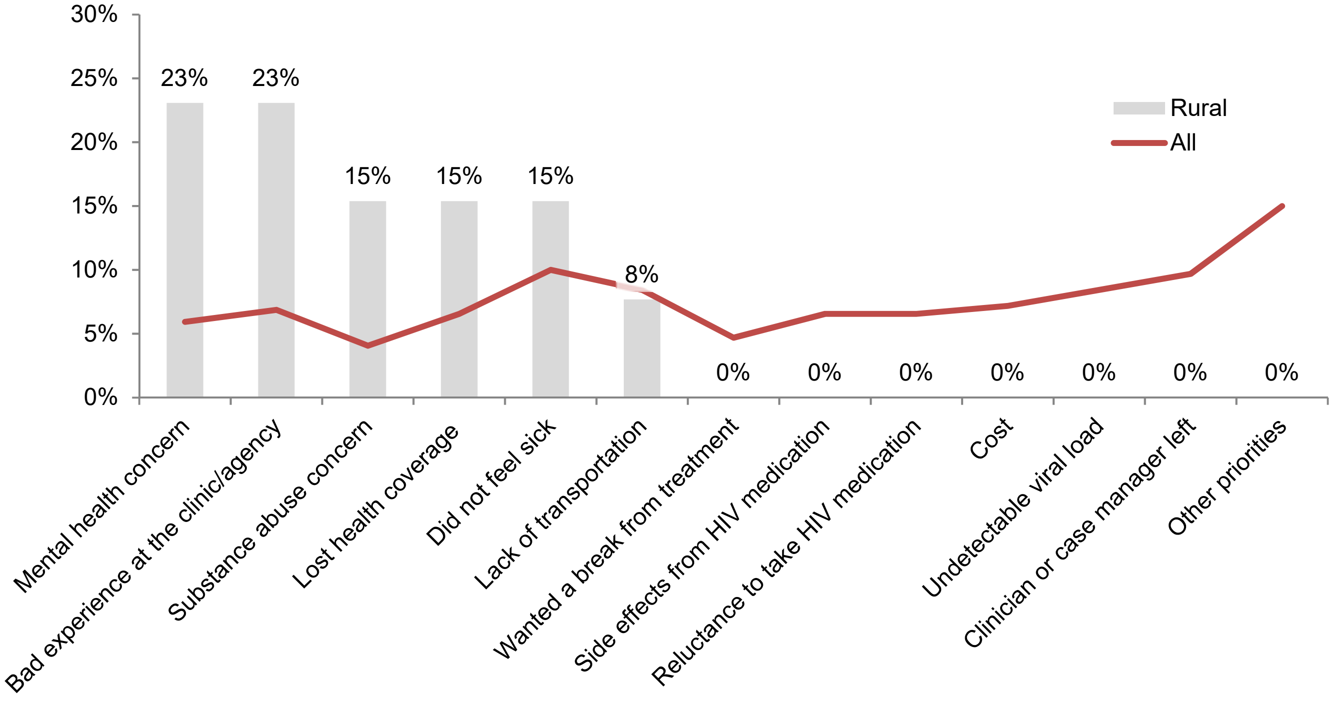
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 80% of rural participants reported no interruptions in their HIV care for 12 months or more since their diagnosis. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey. Participants could also write in their reasons.

(**Graph 1**) Among rural needs assessment participants, bad experiences at the clinic/agency and mental health concerns was the most cited most often as the reasons for interruption in HIV medical care both at 23% of the reported reasons. The next most cited reasons for interruptions in HIC medical care were not feeling sick, loss of health coverage, and substance abuse concerns (all 15%).

The greatest differences between rural needs assessment participants and the total sample were the proportions reporting mental health concerns (23% vs 6%), bad experiences at the clinic/agency (23% vs 7%), substance abuse concerns (15% vs 4%), loss of health care coverage (15% vs 7%), and not feeling sick (15% vs 10%) as reasons for interruption in HIV medical care. Rural needs assessment participants provided no write in responses.

GRAPH 1-Reasons for Falling Out of HIV Care among Rural PLWH in the Houston Area, 2020

Definition: Percent of times each item was reported by rural needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



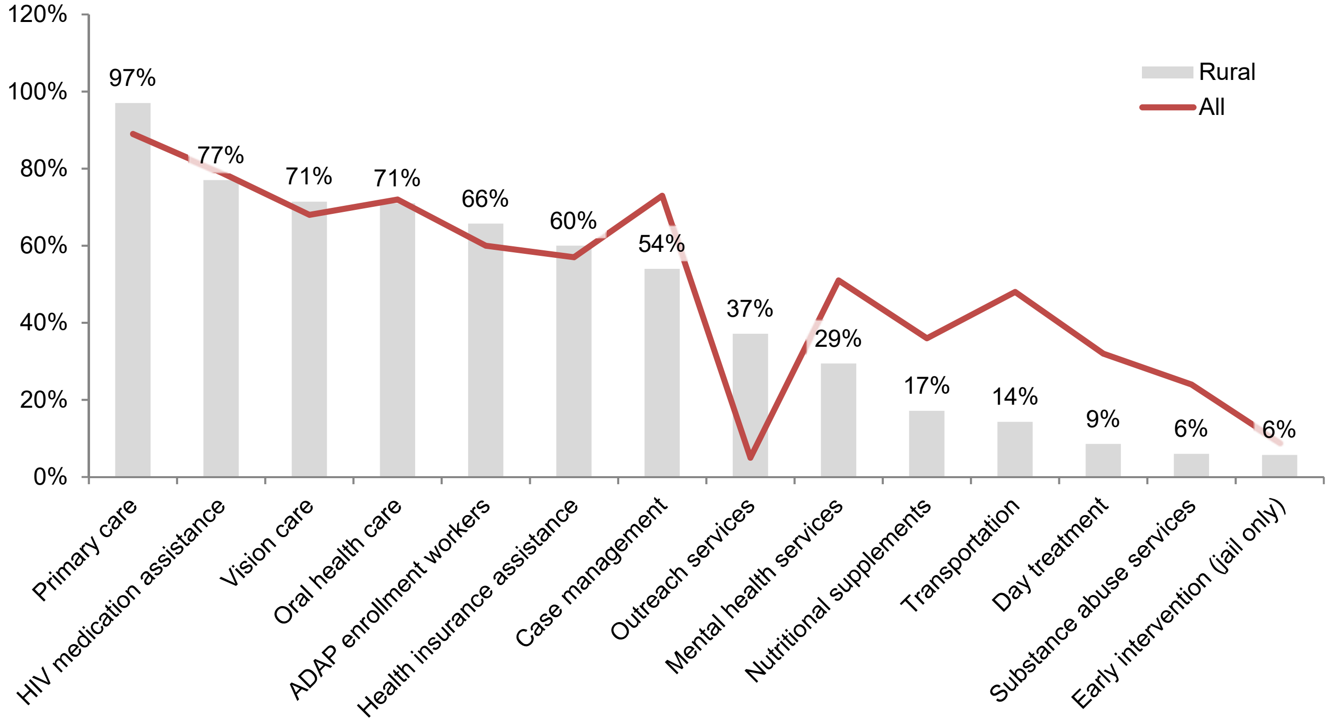
OVERALL RANKING OF FUNDED SERVICES, BY NEED

In 2020, 16 HIV care medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. 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 2**) Among rural participants, primary care was the most needed funded service at 97% of rural participants reporting a need. Rural participants also indicated needs for local HIV medication assistance (77%), vision care (71%), and oral health care (71%). The greatest differences between rural needs assessment participants and the total sample were in the proportions reporting need for outreach services (37% vs 5%), primary care (97% vs 89%), ADAP enrollment workers (66% vs 60%), and vision care (71% vs 68%).

GRAPH 2-Ranking of HIV Services among Rural PLWH, By Need, 2020

Definition: Percent of rural needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

In 2020, 10 other/non-Ryan White Funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants in the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded services they needed in the past 12 months.

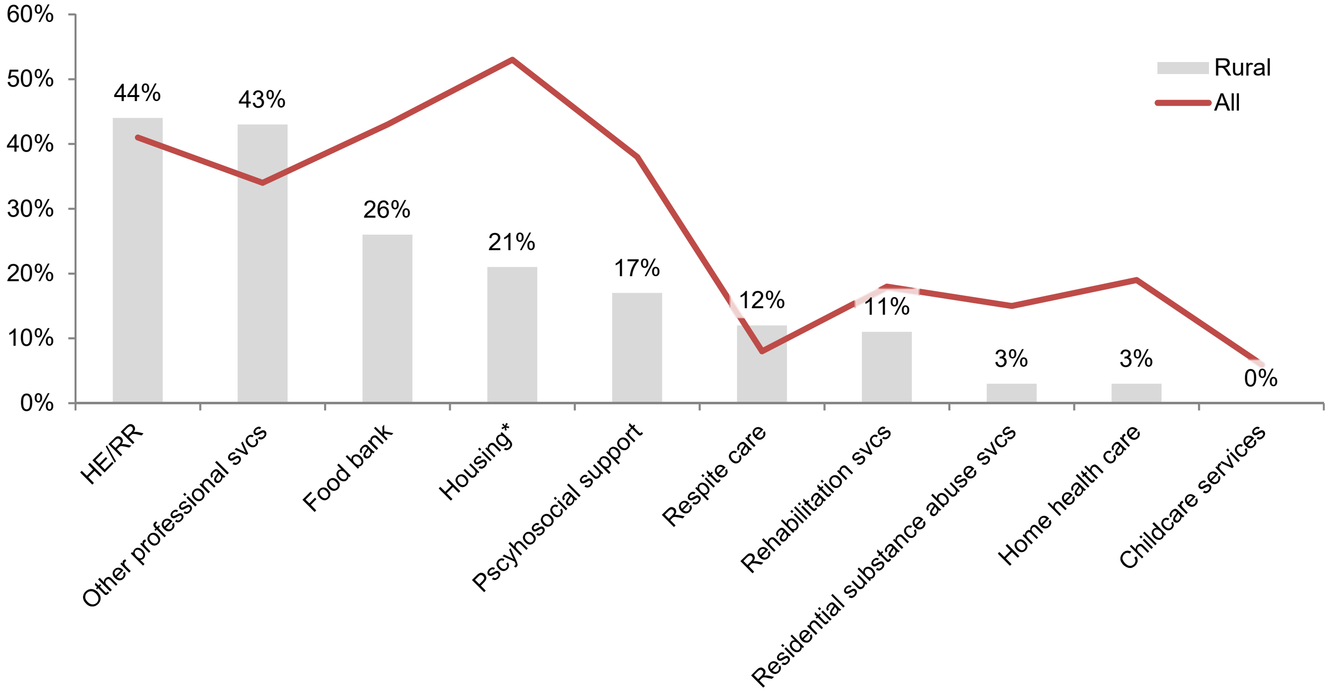
(**Graph 5**) From the 10 service options provided, rural needs assessment participants reported health education & risk reduction services (44%) as the most needed other/non-Ryan White Funded HIV-related service. Rural needs assessment participants also cited other professional services (43%), and food bank services (26%) as needed other/non-Ryan White Funded HIV-related services.

Overall when compared to the total sample rural needs assessment participants reported less need for other/non-Ryan White Funded HIV-related services; however, a greater proportion of rural needs assessment participants reported need for other professional services (43% vs 34%), respite care (12% vs 8%), and health education & risk reduction services (44% vs 41%).

GRAPH 3-Other Needs for HIV Services among Rural PLWH, 2020

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

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



OVERALL BARRIERS TO HIV CARE

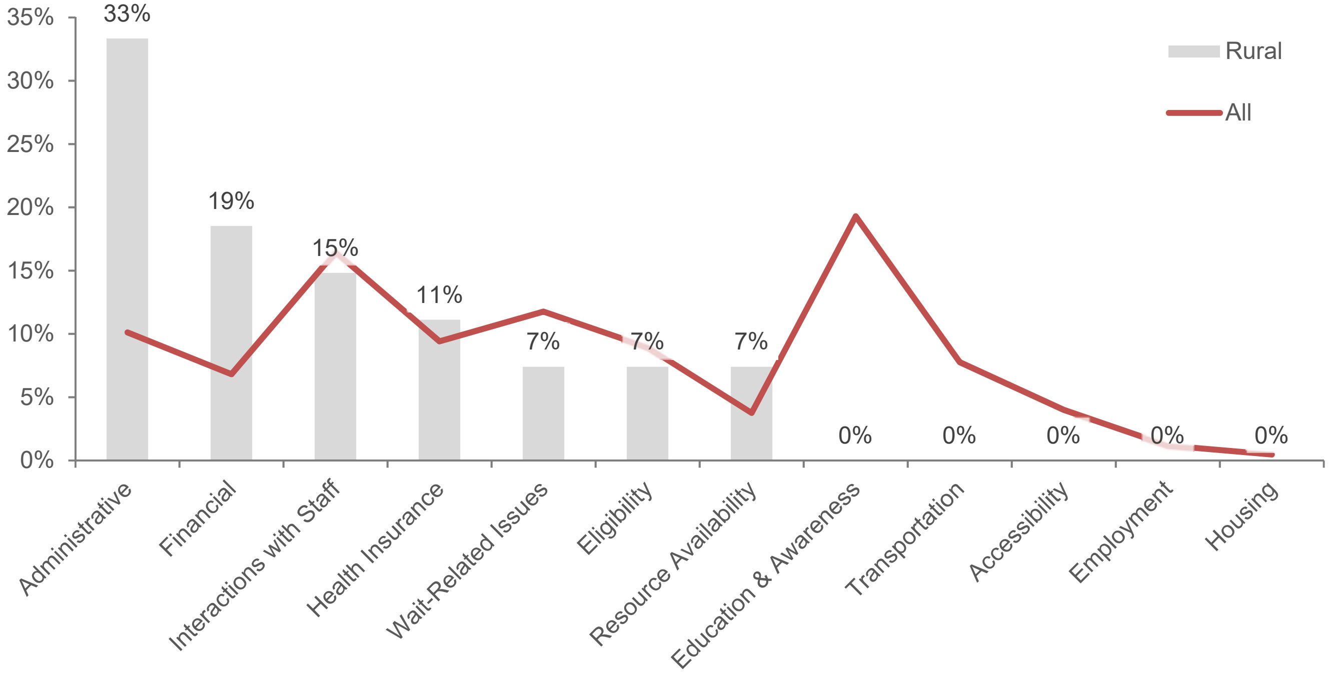
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers. These barriers were then groups together into 12 nodes, or barrier types.

(**Graph 4**) Thirteen (13) rural needs assessment participants cited barriers to Ryan White funded HIV care services. Rural needs assessment participants most cited barrier type was administrative related (33%); with complex processes, dismissal from the agency or clinic and understaffing being the barriers reported. Rural needs assessment participants also reported financial barriers (19%), not being able to pay for services, and interactions with staff (15%) as reported barrier types. Barriers related to interactions with staff reported by rural needs assessment participants were related to poor treatment by clinic or agency staff, and poor correspondence or follow from staff.

Compared to the total sample, rural needs assessment participants reported greater proportions of service administrative barriers (33% vs 10%), financial barriers (19% vs 7%), and barriers due to resource availability (7% vs 4%).

GRAPH 4-Ranking of Types of Barriers to HIV Services among Rural PLWH, 2020

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



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For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:

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