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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

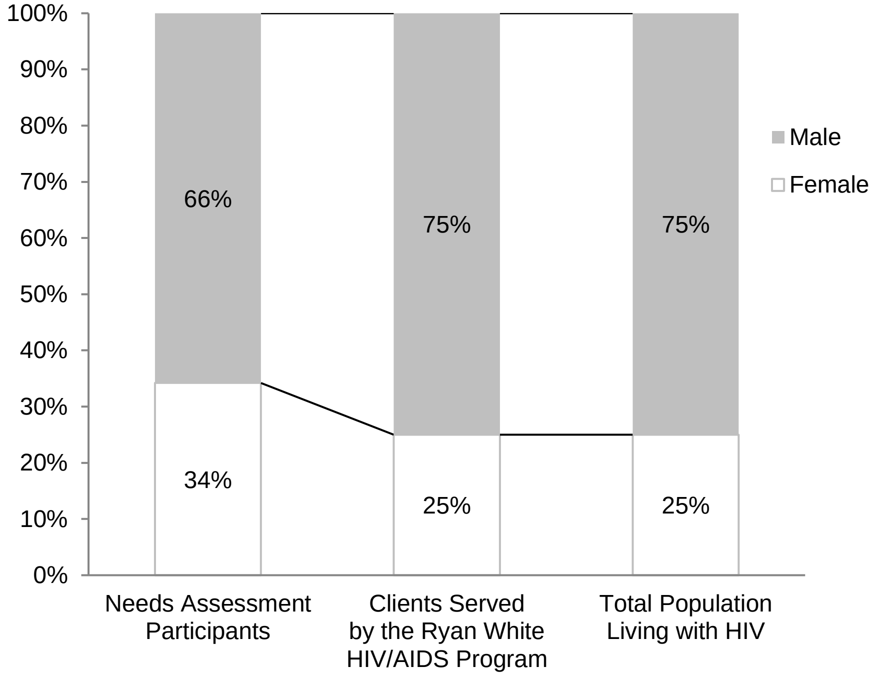
	No.	%
Young adult (18-24 years)	17	2.9%
Adult age 50+ years	353	59.9%
Homeless	65	11.1%
Unstably Housed	159	29.0%
People who inject drugs (PWID)*	47	8.2%
Male-male sexual contact (MSM)	238	40.5%
Out of care (last 12 months)	24	4.3%
Recently released from incarceration	65	11.6%
Rural (non-Harris County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

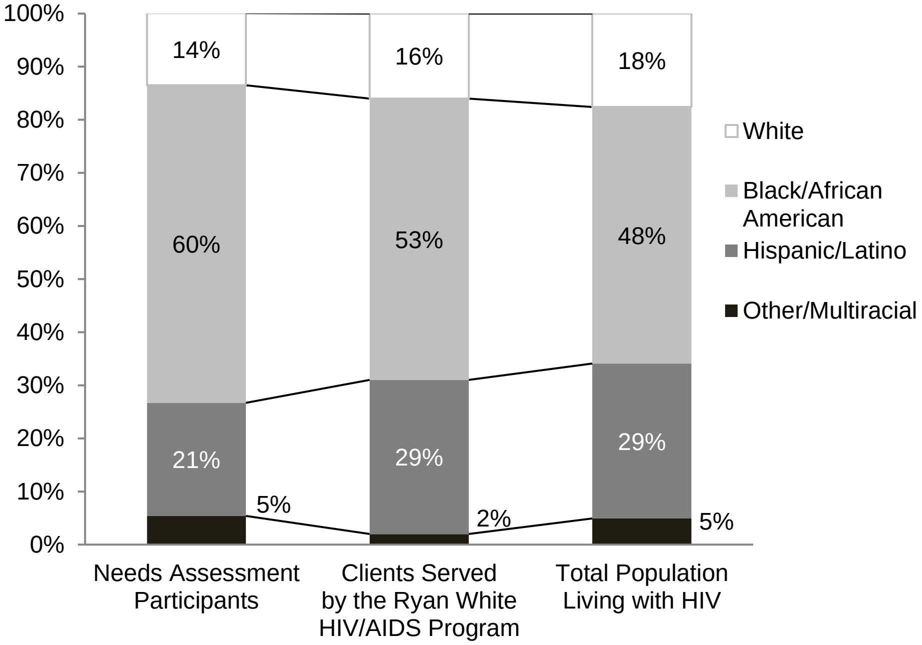


[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18.

(**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.

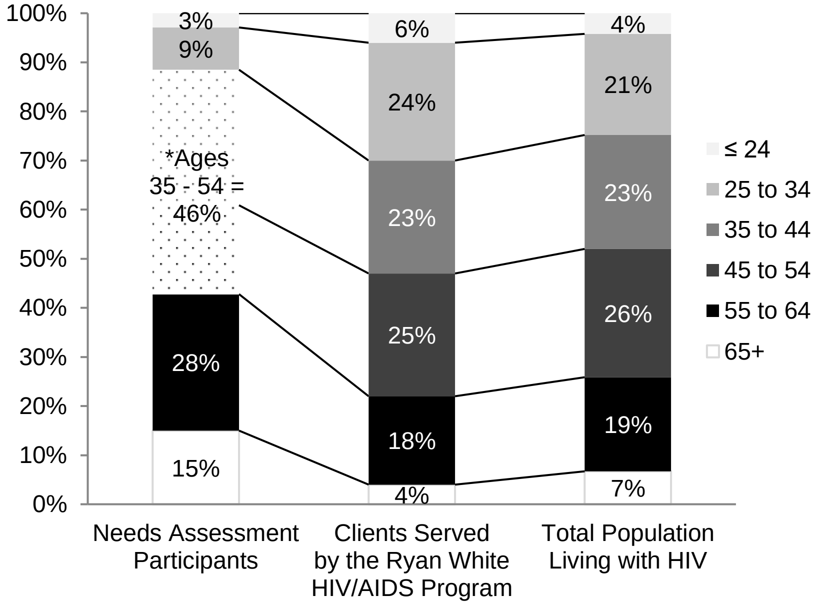
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Race/Ethnicity, 2018



[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.

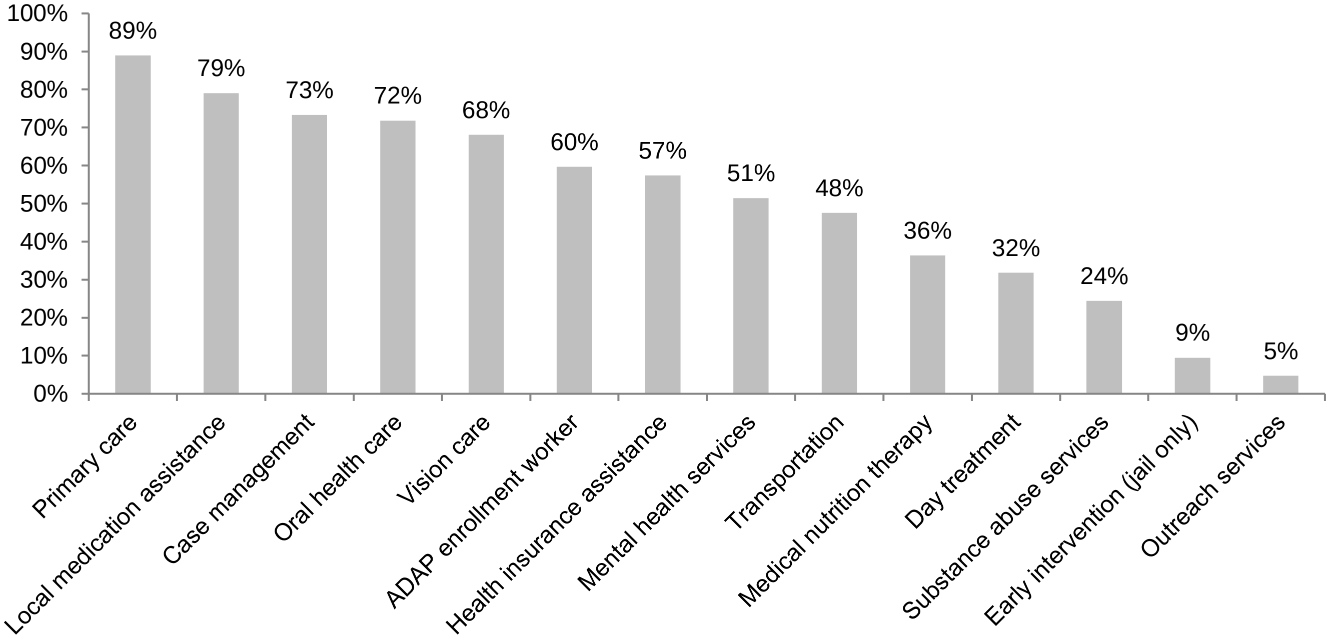
Overall Ranking of Funded Services, by Need

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

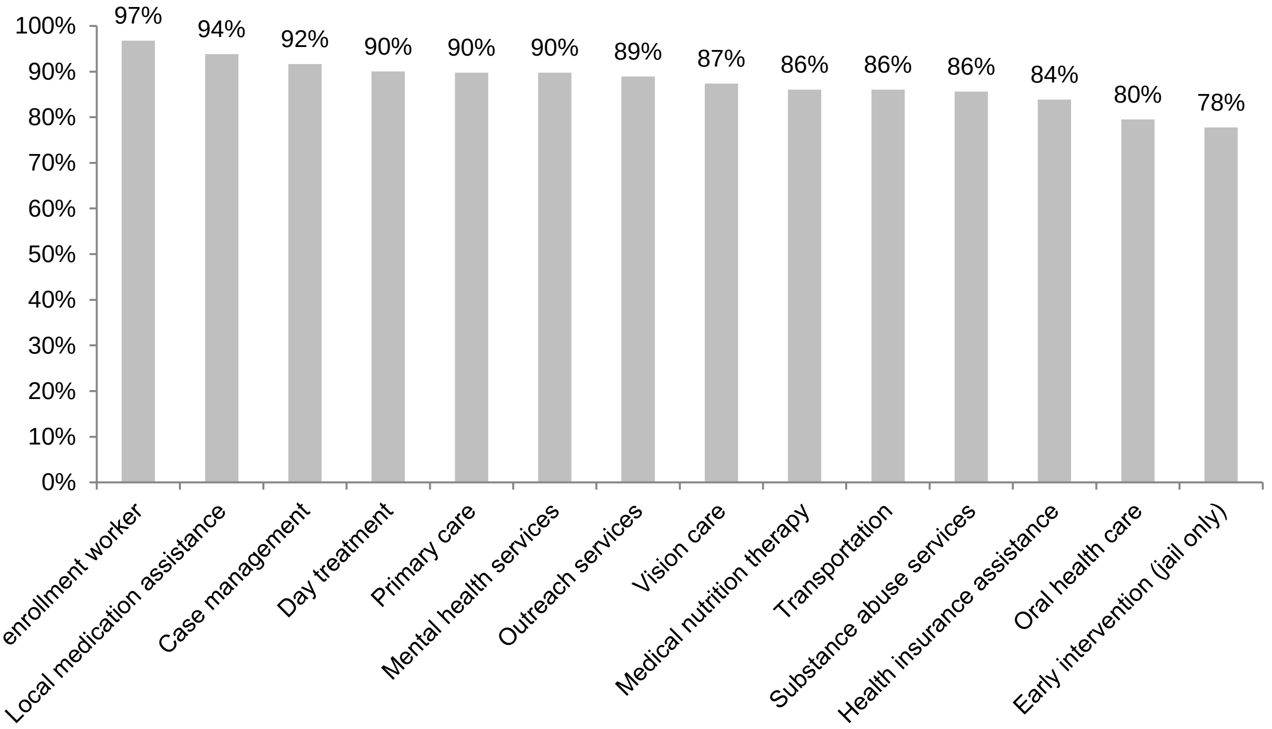
Participants were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both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

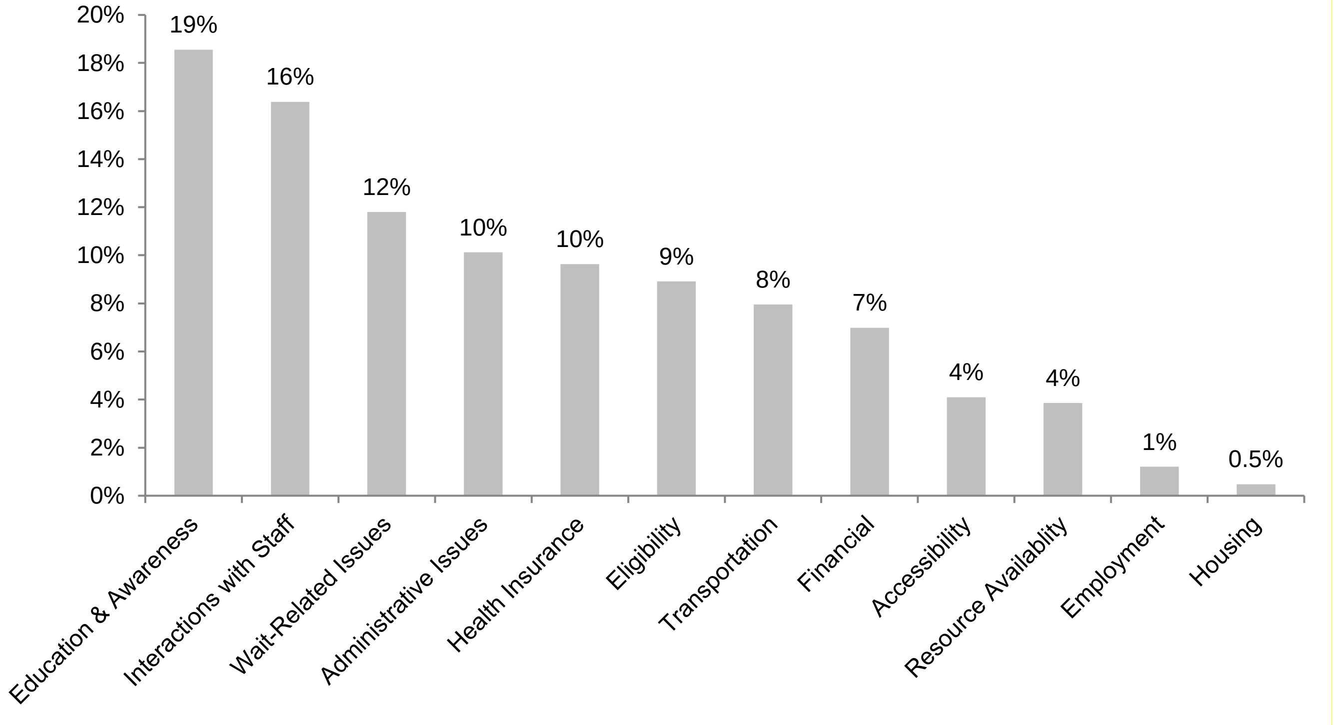
(**Graph 3**) Overall, fewer barriers were reported in 2020 (415 barrier reports) than in previous 2016 needs assessment (501 barrier reports), despite the increase in sample size in 2020. Across all funded services, the barrier types reported most often related to service education and awareness issues (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.

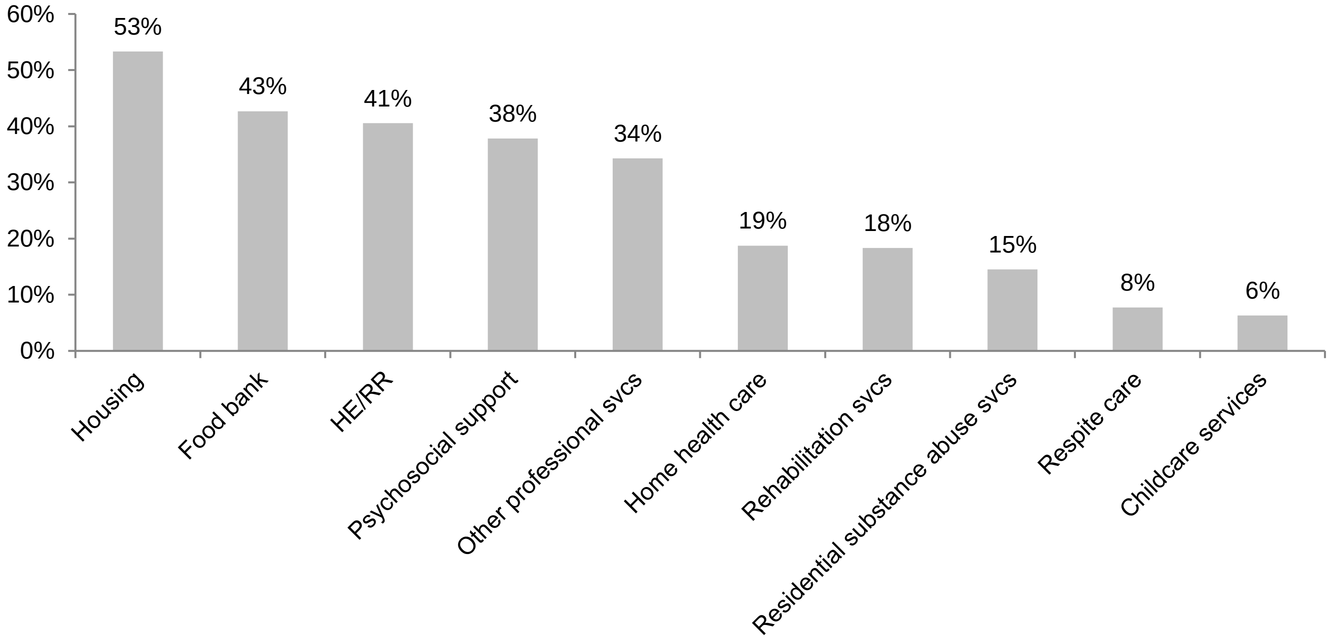
(**Graph 4**) At 53%, housing was the most needed unfunded service in the Houston Area, followed by food bank at 43%, health education/risk reduction at 41%, psychosocial support services at 38%, and other professional services at 34%. Of participants indicating a need for food bank, 69% reported needing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

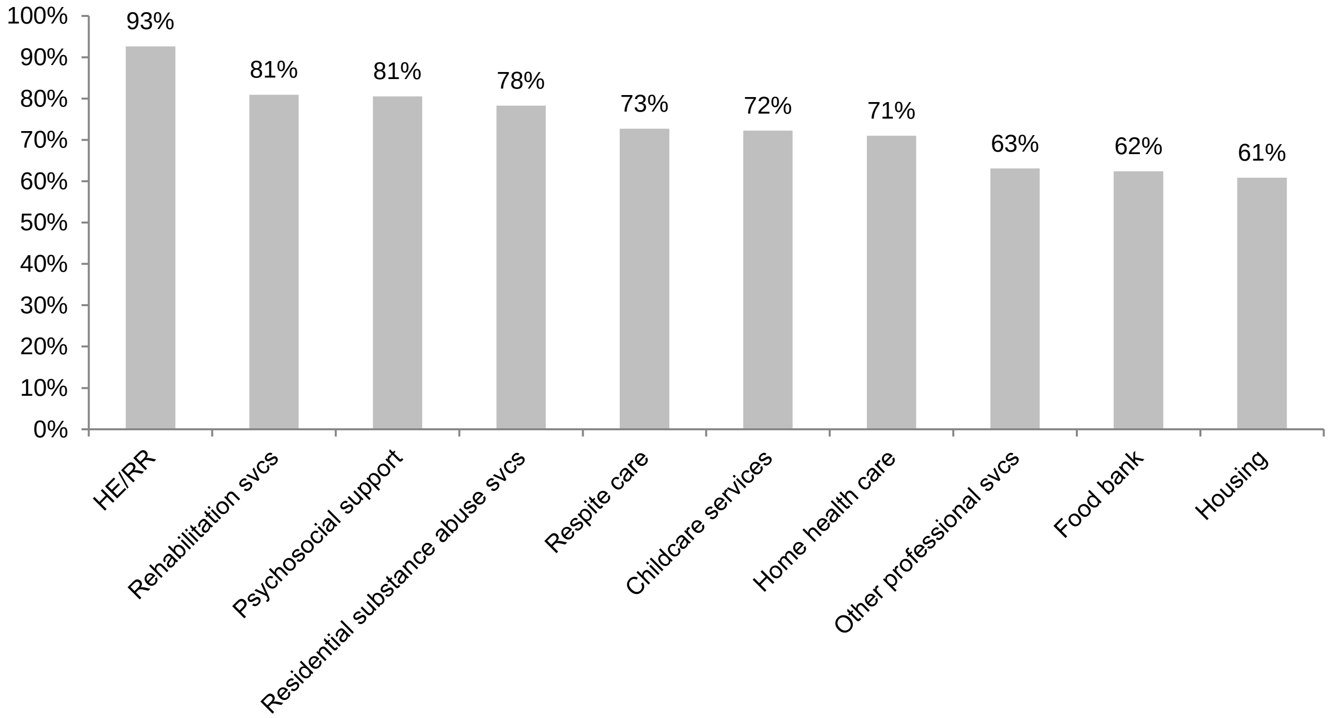
Participants were asked to indicate if each of the unfunded HIV services they needed in the past 12 months was easy or difficult for them to access.

(**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

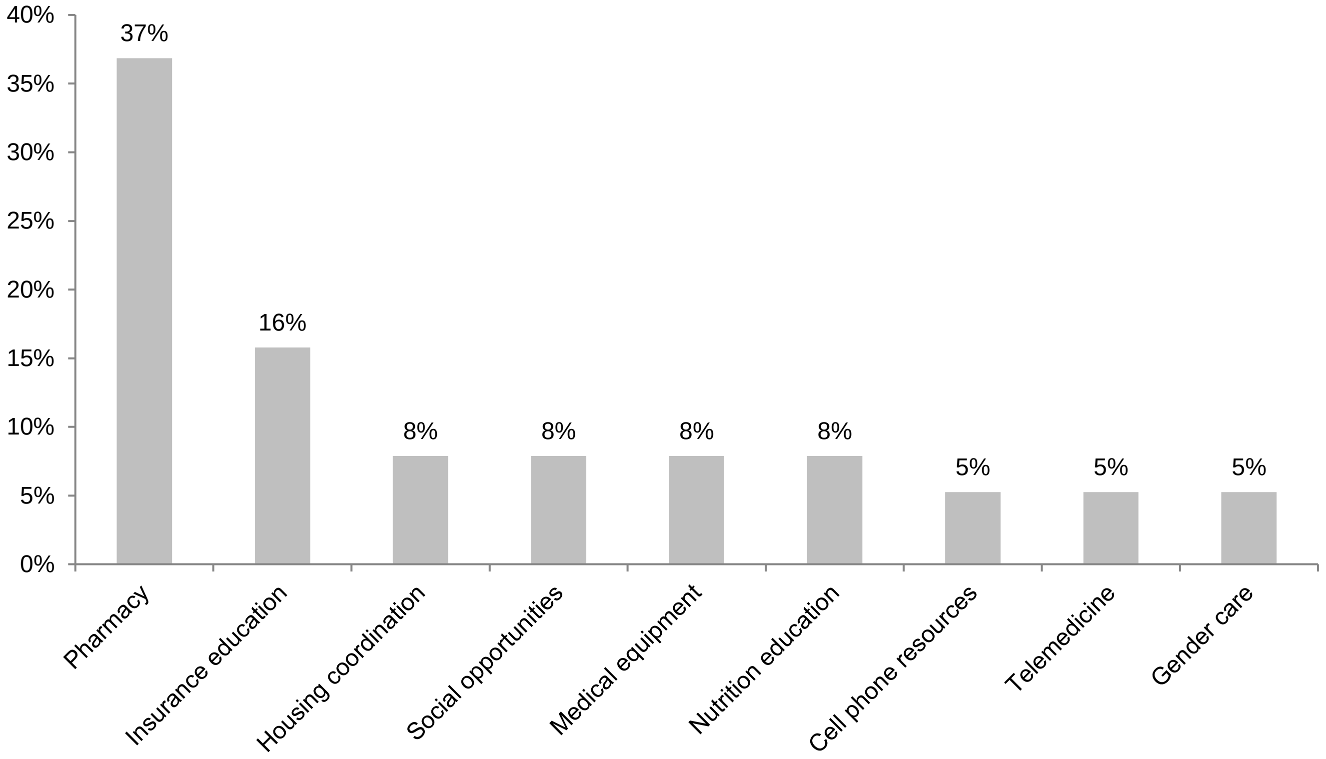
In addition to the allowable HIV services listed above, participants were also encouraged to write-in other types of needed services to gauge any new or emerging service needs in the community.

(**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.

GRAPH 1-ADAP Enrollment Worker, 2020

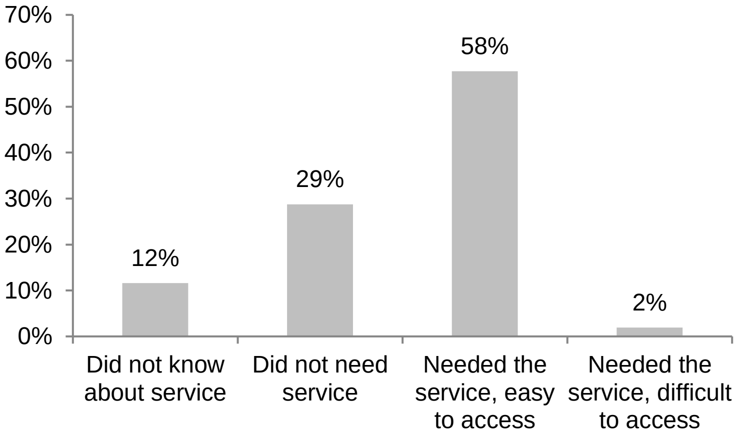


TABLE 1-Top 3 Reported Barrier Types for ADAP Enrollment Worker, 2020

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

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

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

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

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

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

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

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

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

CASE MANAGEMENT

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

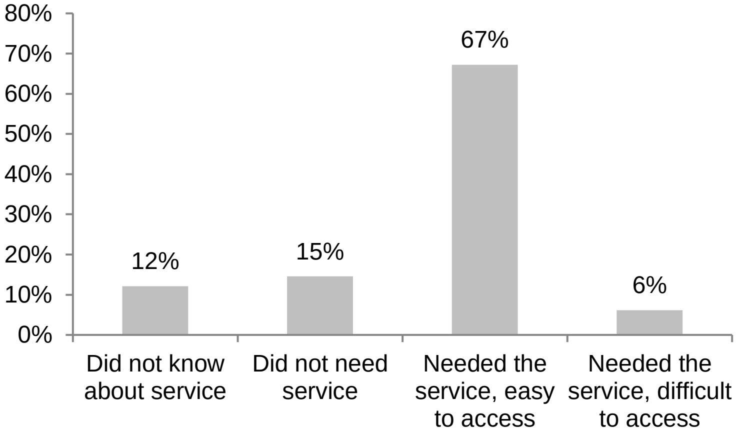
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 73% of participants indicated a need for *case management* in the past 12 months. 67% reported the service was easy to access, and 6% reported difficulty. 12% stated they did not know the service was available.

(**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%

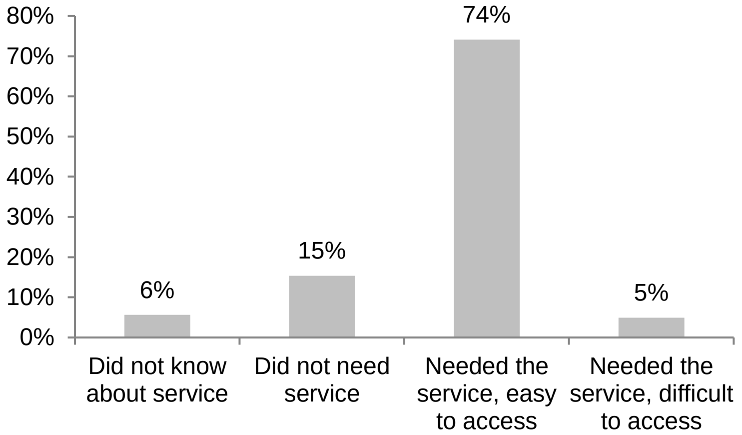
[a] Persons reporting current homelessness [b] Men who have sex with men [c] Persons with no evidence of HIV care for 12 mo.
[d] Persons released from incarceration in the past 12 mo. [e] Non-Houston/Harris County residents [f] Persons with discordant sex assigned at birth and current gender

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.

GRAPH 1-Local HIV Medication Assistance, 2020



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

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

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

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

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

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

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

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

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

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

OUTREACH SERVICES

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

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

(**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

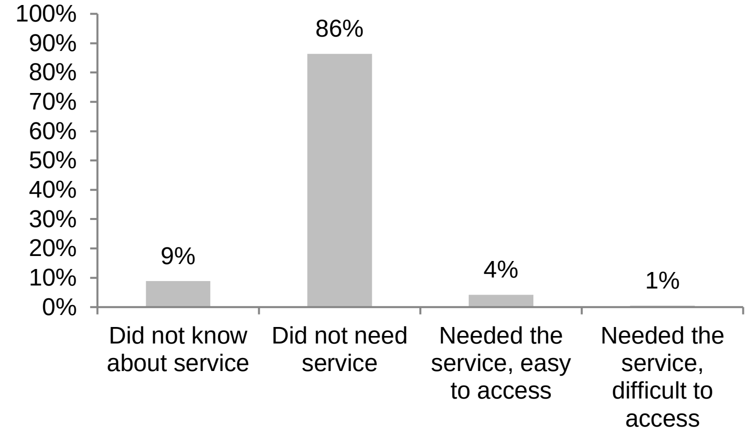


TABLE 1-Top Reported Barrier Type for Outreach Services, 2020

	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.

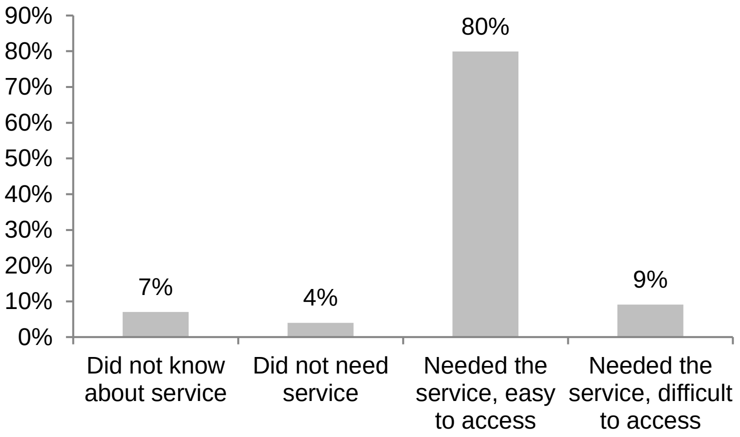
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 89% of participants indicated a need for *primary HIV medical care* in the past 12 months. 80% reported the service was easy to access, and 90% reported difficulty. 7% stated that they did not know the service was available.

(**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.

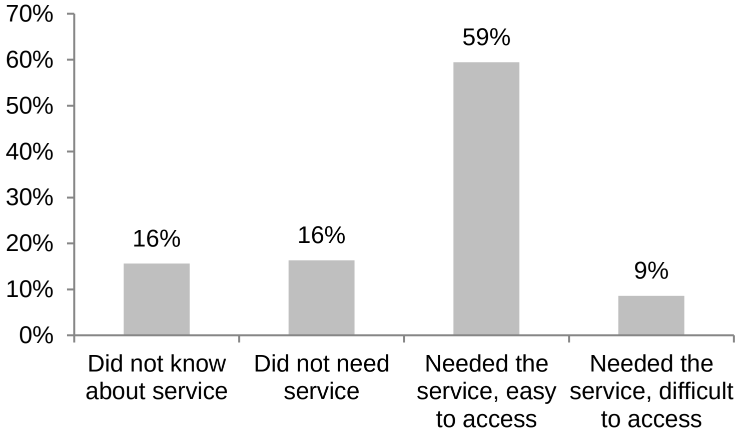
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 68% of participants indicated a need for *vision care* in the past 12 months. 59% reported the service was easy to access, and 9% reported difficulty. 16% stated they did not know the service was available.

(**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%

GRAPH 1-Vision 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 *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

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

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.

Recommendation 2: Improve cultural competency for better access to care

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

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

WE THE PEOPLE

A Black Strategy to End HIV

OUR PEOPLE • OUR PROBLEM • OUR SOLUTION •
BAI

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Ver. 1.1

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Download the full document We the People – A Black Strategy to End HIV here:
https://blackaids.org/wp-content/uploads/2021/02/Black-AIDS-Institute-We-The-People-Report-2020-Version-1.1.pdf 4

Introduction to a Black Strategy to End HIV

By RANIYAH COPELAND, M.P.H.
President and Chief Executive Officer
Black AIDS Institute

HIV is a disease that affects the most marginalized: Black and brown people, LGBTQ people, people living in poverty, people who don't have housing, people experiencing substance addiction, and so many others who aren't able to thrive simply because of who they are, who they love, or where they live. HIV is certainly not the only disease for which health disparities exist, but few health conditions match HIV in the degree to which it has affected those with the fewest resources to respond.

Scientifically, much has been revolutionized since the epidemic's early days. Extraordinarily effective medications have been developed to slow the progression of the disease and to prevent further HIV transmission. In the near future we are likely to have even more effective biomedical tools at our disposal—including long-acting, injectable antiretrovirals for both treatment and prevention and a plausible future of a cure and vaccine.

As optimism about available biomedical tools to fight HIV has increased, the HIV community has become more ambitious in its aspirations. Globally, in 2010 UNAIDS unveiled a vision of "getting to zero"—zero new HIV infections, zero discrimination, and zero AIDS-related deaths. That same year, the Obama administration unveiled the first National HIV/AIDS Strategy, which envisioned concerted action to reduce new infections and deaths.

These plans included important recommendations and helped unite diverse communities around a set of common goals. But, in the end, they ultimately haven't worked, as the number of new HIV cases in the U.S. has barely budged in recent years and Black people are the least likely to achieve and sustain viral suppression. While catalyzing important reforms in clinical settings, these plans failed to grapple with how HIV thrives on inhumanity, hatred and exclusion.

We cannot solely 'treat' our way out of this epidemic. It's been tried for the past 10 years and has failed. Our inability to effectively deliver these biomedical breakthroughs to those who need them most intersects with the oppressive systems and structures that the most marginalized live in. The treatments and preventive interventions we've developed are godsends for Black communities. But they have not and will not end HIV on their own. To end HIV, we must end the systems and practices that undermine, disempower, and harm Black individuals and communities. The individuals and communities who need these medications confront major obstacles for access, effective use, and receiving the support they need to prosper.

In recent years, New York State, San Francisco, and other state and local actors have put in place plans to end their HIV epidemics. And only last year, the current Administration unveiled a plan to end HIV in the United States by 2030—by allocating an additional $250 million to the FY2020 budget to intensify efforts in the 48 counties and seven states that account for most new HIV infections.

While these new initiatives are exciting and laudable, disappointment is assured if we fail yet again to address the root causes of Black America's heightened vulnerability to HIV.

Regular reports on the State of AIDS in Black America are the Black AIDS Institute's flagship publication. This is my first State of AIDS report since assuming the leadership of the Black AIDS Institute a little more than a year ago.

This *We the People* report takes up the challenge of envisioning a world without HIV, by examining the fight against HIV from an unapologetically Black perspective.

This report was developed by the Black communities and individuals impacted by HIV. We held three townhalls in the Southern U.S., surveyed Black communities, conducted over 20 informant interviews, and were guided by an advisory group of some of the most innovative Black leaders from the across the country leading efforts and organizations at the forefront of HIV and social justice issues. Their feedback and recommendations are the backbone of this report.

The reality is that the disproportionate impact of HIV in Black America cannot be separated from the long history of anti-Black racism in this country. The same forces that render Black Americans vulnerable to poverty, unemployment, limited educational opportunities, incarceration, voter suppression and housing instability are the same forces that have made HIV such a crisis in our communities. We can set all the lofty HIV goals we want, but we'll never reach them if we don't courageously tackle the dynamics that increase Black people's risk for HIV and reduce our ability to benefit from biomedical breakthroughs.

Over the next year BAI will be working with our Black Treatment Advocate Networks (BTAN) and other partners across the country to host more than 10 townhalls to develop jurisdictional recommendations to end HIV within their Black communities. BAI will then support concerted efforts to move key recommendations in local communities and states to support the uptake of biomedical tools for Black people. *We The People* is more than a theoretical document, it is the strategy we will use to make meaningful progress towards ending HIV in Black America.

As a mother of two Black boys, I know in the deepest part of my being that the well-being of Black people inevitably depends on true freedom—our freedom to choose our own destiny, to have an equal chance to succeed, freedom from discrimination and exclusion and freedom to live within our full dignity as humans. These are the values I was raised with and guide my life's work. It's why I'm so deeply committed to our community's health and wellness, and why I am so deeply honored to lead the Black AIDS Institute.

If we truly hope to end HIV, we'll need to approach this challenge in innovative and radical new ways. As Black Americans, we must own this fight and articulate and drive new ways of doing business. That is the vision set forth in *We the People*—a blueprint for ending HIV in our communities.

Raniyah M. Copeland

The Quest to End HIV in the United States

Since its founding in 1999, the Black AIDS Institute has been dedicated to a single, overarching goal—ending the HIV epidemic in Black communities. In its first decade of existence, the Institute focused on increasing awareness of the HIV crisis in Black America and mobilizing leading Black institutions to respond more vigorously and effectively to the epidemic. In its definitive history of the Black response to HIV in the U.S., the Black AIDS Institute declared that "30 years is enuf!"[32]

The following year, spurred by new research findings that antiretroviral therapy reduces by 96% or more the risk of HIV transmission[33], the Black AIDS Institute released a strategy for ending the HIV epidemic in Black communities, prioritizing early knowledge of HIV status, scale-up of HIV treatment, retention in care, and sustained viral suppression.[34] Since publication of its 2012 strategy, additional evidence of the powerful prevention benefits of PrEP has further buttressed hopes that the epidemic can be ended.[35]

Growing hopes for ending the HIV epidemic have galvanized action at the state and local level. Black organizations and stakeholders have played key roles in putting in place plans to end the HIV epidemic in many parts of the U.S., including New York State, Houston, Washington D.C. and Fulton County GA.[36 37 38 39]

In 2019, the Trump administration unveiled *Ending the HIV Epidemic: A Plan for America.*[40] With the goal of reducing new HIV infections by 75% by 2025 and by 90% by 2030, the strategy has four pillars: (1) Diagnose all individuals with HIV as early as possible; (2) Treat people with HIV rapidly and effectively to reach sustained viral suppression; (3) Prevent new transmission by using proven interventions, including PrEP and syringe services programs; and (4) Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them. The national initiative calls for intensified efforts in 48 counties, Washington DC., San Juan, Puerto Rico, and seven states with substantial rural epidemics (primarily in the South).

A Black Strategy to End HIV in America

Although the federal government's new initiative for ending the HIV epidemic is a welcome development, we have far to go to declare an end to HIV in the United States. While certain cities have seen encouraging declines in new HIV diagnoses, the country as a whole has made only minimal progress in reducing the number of new HIV diagnoses.[41]

Failure to effectively address the factors that increase HIV vulnerability in Black communities and the impediments to accelerated service uptake is a key reason why progress in the HIV fight remains so slow. In this regard, the federal plan is concerning. While the plan rightly prioritizes greater geographic focus in the national response, it does not openly grapple with the social and structural factors that contribute to racial and ethnic disparities in HIV outcomes.

As every advance in the HIV response has often been accompanied by an increase in HIV disparities, it is apparent that business as usual will not enable us to end HIV. And in an epidemic that most heavily affects Black communities, it is equally plain the national epidemic as a whole cannot be ended if it is not ended in Black America.

One of the most promising features of *Ending the HIV Epidemic: A Plan for America* (also known as EHE) is its emphasis on doing things differently and encouraging innovation in the HIV response. *We the People: A Black Strategy to End HIV in America* has been developed in the spirit of doing things differently. While the roles of biomedical tools for ending HIV are well understood, we will only obtain the results we seek from these tools if we operate in radically new ways. We must straightforwardly acknowledge the degree to which HIV disparities are grounded in racism and in anti-Black systems and institutions, and we must find innovative ways to meet the needs of Black communities, addressing each individual in their fullness and grounding service approaches in the lived reality of Black people. HIV in America is a racial and social justice issue, and addressing HIV as if it were solely a health issue is a sure recipe for failure.

This strategy is named *We the People* for several reasons. At the most basic, it aims to embrace and fully realize the inclusive vision rather than the exclusionary reality of our country's founding, by promoting equitable health and well-being in ways that recognize the dignity and worth of every person. *We the People* also emphasizes the centrality of communities in advancing health and well-being and the right of communities to lead and shape efforts to respond to the problems they face. Toward this end, *We the People* prioritizes the empowerment of Black communities.

Consistent with the name of the strategy, the Institute has pursued a people-centered approach to developing *We the People: A Black Strategy to End HIV in America.* Through extensive outreach and consultation, the Institute has sought the input of Black communities and stakeholders regarding what needs to change in order to end HIV in Black America. The Institute conducted more than 20 interviews with key informants from across the country, undertook surveys of HIV workers, solicited recommendations from the 14 chapters of the Black Treatment Advocates Network (BTAN), conducted town hall meetings in three Southern cities (Houston, Montgomery and Natchez) and hosted a community forum at the U.S. Conference on AIDS. In December 2019, 20 diverse stakeholders and experts gathered in Los Angeles to assist the Institute in finalizing the plan's recommendations and strategic directions.

The We the People strategy, outlined in the remainder of this report, rests on four pillars:

1 **Dismantle anti-Black practices, systems and institutions that endanger the health and well-being of Black people and undermine an effective, equitable response to HIV in Black America.**

2 **Provide resources and services that address the fullness, richness, potential and expertise of Black people and mitigate social and structural factors that worsen health outcomes in Black communities.**

3 **Ensure universal access to and robust utilization of high-quality, comprehensive, affordable and culturally- and gender-affirming healthcare to enable Black people to live healthy lives in our full dignity.**

4 **Build the capacity and motivation of Black communities to be the change agents for ending HIV.**

Under each pillar, the strategy includes specific recommendations. The Institute has established indicators and milestones for its recommendations as well as for overall

outcomes. The Black AIDS Institute will issue regular reports to enable transparent assessment of progress.

We the People is a strategy for America as a whole—and specifically for Black America. The Black AIDS Institute lacks the capacity to implement this strategy on its own, and it has no desire to, as the purpose of this strategy is to spur investment and engagement across the breadth of Black America. That being said, the Black AIDS Institute is orienting its work around the action blueprint outlined here, with the aim of accelerating and supporting the work of diverse partners and stakeholders. In particular, the Black AIDS Institute's work with its 14 BTAN chapters and 12 affiliates—most of them located in priority EHE jurisdictions—will use *We the People* as a framework for action at the local and state levels.

In addition to outlining an action plan to end HIV, this report also includes profiles of Black excellence, highlighting how Black activists and leaders are pioneering new, effective, intersectional ways to respond to HIV in their communities. These profiles are more than mere side notes, but instead reflect to the very core of *We the People.* Only if Black communities are empowered, supported and effectively resourced will it be possible to end this national epidemic. The profiles of excellence speak to the extraordinary potential in Black communities all across the country, which needs to be unleashed to lead the way toward ultimate victory in our long struggle against HIV.

DEMANDING BETTER:

An HIV Federal Policy Agenda by People Living with HIV

ACKNOWLEDGMENTS

This document was a collaborative effort informed by our relationships with thousands of people living with HIV throughout the United States, as well as our lived experience.

Authors contributed thought leadership as well as writing, research, reflection, and editing time. We are grateful to Martha Cameron, Barb Cardell, Marco Castro-Bojorquez, Cecilia Chung, Tami Haught, Vanessa Johnson, Ronald Johnson, Naina Khanna, Kamaria Laffrey, Lorenzo Lewis, Mark Misrok, Heather O'Connor, Venita Ray, Malcolm Reid, Bamby Salcedo, Linda Scruggs, Waheedah Shabazz-El, Andrew Spieldenner, Kiara St. James, Sean Strub, and Evany Turk for their contributions.

We are additionally especially indebted to Tyler Barbarin, Breanna Diaz, Kelly Flannery, Jennie Smith-Camejo, and Allie Watson for thought leadership, writing, editing, research, and communications support on this momentous project.

We dedicate this agenda to the many people living with HIV who paved the way for our understanding of HIV as an issue of justice, and on whose shoulders we stand. Some are still with us and too many have been lost along the way.

May this collective set of priorities, created jointly by U.S. based networks of people living with HIV for the first time ever, assure a better world for all of us.

For Mary. For Marco. For Deloris. For Loren. For Juanita.

GNP+ GLOBAL NETWORK OF PEOPLE LIVING WITH HIV

ICW North America

NATIONAL WORKING POSITIVE COALITION

Positively Trans

POSITIVE WOMEN'S NETWORK USA
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THE REUNION PROJECT

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Download the full document Demanding Better: An HIV Federal Policy Agenda by People Living with HIV here:

https://www.pwn-usa.org/wp-content/uploads/2021/07/Networks-Policy-Agenda-FINAL.pdf

DEMANDING BETTER:

An HIV Federal Policy Agenda by People Living with HIV

EXECUTIVE SUMMARY

Networks of people living with HIV in the United States have come together as the U.S. People Living with HIV Caucus (HIV Caucus) to outline our policy agenda for the federal response to the HIV epidemic. People living with HIV networks are organized formations created, led by, and accountable to the estimated 1.1 million people living with HIV in the United States. They are vehicles through which we, as people living with HIV, can define our own agenda, choose our own leaders, and speak with collective voices.

For stakeholders in the federal government, the HIV Caucus brings a unique lens, informed by lived experience, to the development of policies to ensure better care, treatment, and quality of life for people living with HIV. The networks which make up the HIV Caucus have been involved as service providers, have run programs that serve people living with HIV, and have built community-based organizations and advocacy initiatives from the ground up. We are in direct contact with tens of thousands of people living with HIV throughout the United States.

These unique abilities and access inform our work and led us to create this living policy agenda to collect our expertise into a road map for lawmakers and other key stakeholders to use in addressing the HIV epidemic at the federal level.

This policy agenda contains recommendations in 5 issues areas which must be centered in every aspect of the federal HIV response:

1. **Concretely elevating the meaningful involvement of people living with HIV and disproportionately impacted communities in the HIV response;**
2. **Proactively creating an affirming human rights environment for people living with HIV by addressing stigma, eliminating HIV criminalization, and halting molecular HIV surveillance;**
3. **Addressing inequities in the federal response by attending to racial and gender disparities;**
4. **Adding sex workers and immigrants living with HIV as priority populations throughout the federal response; and**
5. **Affirmatively committing to improving quality of life for people living with HIV.**

To address each of these issue areas, we have suggested concrete recommendations for the associated executive agencies, the HIV National Strategic Plan, and the Ending the HIV Epidemic Plan, which are broadly delineated on the pages that follow.

Concretely elevating the meaningful involvement of people living with HIV and disproportionately impacted communities in the HIV response
Staff federal bodies addressing the epidemic, such as the Office of National AIDS Policy, with people living with HIV from the communities most impacted by the epidemic and recharter the HIV advisory boards of the federal agencies to include a minimum of two seats for representatives of the HIV Caucus.
Develop a process to solicit input from, engage and consult with the HIV Caucus, and include meaningful involvement of people living with HIV indicators in the final version of the HIV National Strategic Plan and in updates to the Ending the HIV Epidemic Plan.

Proactively creating an affirming human rights environment for people living with HIV
Identify stigma-reduction activities that partners in the HIV response can engage in, require Ending the Epidemics jurisdictions to create plans that incorporate these activities, and resource people living with HIV networks to develop and implement stigma-reduction initiatives.
Utilize data collection tools and interventions that examine structural change.
Promote advocacy efforts to remove punitive laws and policies, like HIV criminalization, by acknowledging the federal government's role in creating them and making clear commitments in federal plans to end HIV criminalization.
Declare a moratorium on molecular HIV surveillance and partner with people living with HIV networks to develop standards for obtaining informed consent; privacy protections; and security, sharing, and storage protocols.
Implement community generated standards in all aspects of the federal HIV response and ensure funding is in place for training and compliance.

Addressing inequities in the federal response: attend to racial and gender disparities
Explicitly include racial and gender disparities as elements of the HIV epidemic to be addressed in all funding opportunities and create grant opportunities for and led by these populations.
Require Ending the Epidemic jurisdictions to target resources to Black, Indigenous, and other people of color, especially those who are also gay and bisexual men, people of trans experience, people who use drugs, sex workers, and immigrants.
Require jurisdictions and grantees to provide care services to dependents while people living with HIV receive services and to screen for intimate partner violence.

Adding sex workers and immigrants living with HIV as priority populations throughout the federal response
Push to prohibit the practice of using condom possession as evidence of sex work and eliminate federal policies conflating sex work and human trafficking.
Prioritize and require commitments to the decriminalization of sex work, including restrictions of individuals with sex work-related or drug-related convictions from accessing federal programs and services.
Ensure health care is accessible regardless of immigration status.
Add sex workers and immigrants as priority populations in the federal HIV response and fund programs led by and serving them accordingly.
Fund language services, particularly those that are in-person, and require certain grantees to staff certified medical interpreters or train staff on interpretation utilization.

Affirmatively commit to improve quality of life for people living with HIV
Create a minimum standard of care and quality of life for people living with HIV, promulgate regulations requiring those providing health care to people living with HIV to conform to those standards, and monitor and report how these standards are being upheld.

Establish access to online and in-person benefits counseling/advisement for people living with HIV; design system to improve portability of benefits between jurisdictions; and create programs to train, recruit, and hire people living with HIV into the HIV workforce and other employment opportunities.
Fully fund Housing Opportunities for People with AIDS and other federal housing programs and enforce the Fair Housing Act to address housing discrimination.
Require the federal HIV programs to track and address housing for people living with HIV.
Improve the Supplemental Nutrition Assistance Program to account for regional differences, increase overall benefits, continue extensions of work requirements, and reduce administrative burdens for people living with HIV.
Improve, expand, and fund access to sexual and reproductive health care for people living with HIV, including transition-related care, and monitor this progress with metrics in the federal HIV response.
Fund research and create accessible guidelines for birthing people living with HIV to breast/chest-feed their children that do not include criminalization.

NATIONAL HIV/AIDS STRATEGY

for the **United States**

2022–2025

THE WHITE HOUSE
WASHINGTON

Acknowledgments: The National HIV/AIDS Strategy (NHAS or Strategy) was developed by the White House Office of National AIDS Policy (ONAP) in collaboration with federal partners and with input from the HIV community across the country. Interested parties and organizations throughout the federal government and those engaged in work in many different communities have helped shape the goals, objectives, and strategies in the Strategy. ONAP extends the gratitude and appreciation of the White House to everyone who made thoughtful recommendations and recommitted to the Strategy's vision and goals. ONAP also offers thanks to the team at the Office of Infectious Disease and HIV/AIDS Policy in the U.S. Department of Health and Human Services for its many contributions to developing the Strategy.

Language used in the National HIV/AIDS Strategy: The Strategy honors the lived experiences and choices of all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance. To reflect this, authors made a concerted effort to use inclusive and person-first language throughout the strategy. Evidence-based, contemporary terminology is also used to convey respect and to reduce stigma faced by communities and populations disproportionately impacted by HIV. This approach is intended to reflect the administration's vision for a collective, inclusive, and respectful national response. Despite these efforts, in certain instances, for example to accurately convey scientific meaning, specific terminology or language may be unintentionally offensive or stigmatizing to some individuals or populations.

Additional information regarding the Strategy and associated activities may be accessed at the White House website.

Suggested citation: The White House. 2021. *National HIV/AIDS Strategy for the United States 2022–2025*. Washington, DC.

The National HIV/AIDS Strategy is not a budget document and does not imply approval for any specific action under Executive Order 12866 or the Paperwork Reduction Act. The Strategy will inform the Federal budget and regulatory development processes within the context of the goals articulated in the President's Budget. All activities included in the Strategy are subject to budgetary constraints and other approvals, including the weighing of priorities and available resources by the Administration in formulating its annual budget and by Congress in legislating appropriations.

VISION

The United States will be a place where new HIV infections are prevented, every person knows their status, and every person with HIV has high-quality care and treatment, lives free from stigma and discrimination, and can achieve their full potential for health and well-being across the lifespan.

This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.

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Download the full National HIV/AIDS Strategy 2022–2025 here:
https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf

EXECUTIVE SUMMARY

Building on lessons learned and progress made in the past 40 years, the United States now has the opportunity to end the HIV epidemic. This opportunity has been made possible by tireless advocacy, determined research, and dedicated delivery of diagnostic, prevention, care, treatment, and supportive services.

The nation's annual new HIV infections have declined from their peak in the mid-1980s, and people with HIV in care and treatment are living longer, healthier lives. In 2019, the estimated number of new HIV infections was 34,800 and 1.2 million people were living with HIV in the United States. However, not all groups have experienced decreases in HIV infections or improvements in health outcomes. Centers for Disease Control and Prevention data show that new HIV infections fell 8% from 2015 to 2019, after a period of general stability in new infections in the United States. This trend represents a hopeful sign of progress. But gains remain uneven, illuminating opportunities for geographic- and population-focused efforts to make more effective use of the powerful HIV prevention, care, and treatment tools now available.

This National HIV/AIDS Strategy (the Strategy), the nation's third national HIV strategy, updates the HIV National Strategic Plan (2021). The Strategy sets forth bold targets for ending the HIV epidemic in the United States by 2030, including a 75% reduction in new HIV infections by 2025 and a 90% reduction by 2030. For interested parties and organizations across the nation, the Strategy articulates goals, objectives, and strategies to prevent new infections, treat people with HIV to improve health outcomes, reduce HIV-related disparities, and better integrate and coordinate the efforts of all partners to achieve the bold targets for ending the epidemic. The Strategy also establishes evidence-based indicators to measure progress, with quantitative targets for each indicator, and designates priority populations.

The Strategy establishes the following vision:

The United States will be a place where new HIV infections are prevented, every person knows their status, and every person with HIV has high-quality care and treatment, lives free from stigma and discrimination, and can achieve their full potential for health and well-being across the lifespan.

This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.

The vision, goals, objectives, and other components of the Strategy were developed and approved by a dedicated Steering Committee, composed of subject matter experts from across the federal government, with input from numerous and varied interested parties and organizations in the field. The Strategy is designed to be accessible to and useful for a broad audience, including people working in public health, health care, government, community-based organizations, research, private industry, and academia. It serves as a roadmap for all sectors of society to guide development of policies, services, programs, initiatives, and other actions to achieve the nation's goal of ending the HIV epidemic by 2030.

The Strategy is designed to facilitate a whole-of-society national response to the HIV epidemic in the United States that accelerates efforts to end the HIV epidemic in the United States by 2030 while supporting people with HIV and reducing HIV-associated morbidity and mortality. While not every objective or strategy will speak to or be actionable by all readers, the intent is that individuals and organizations from all sectors of society can find opportunities where they can support necessary scale-up, expansion, and refinement efforts. All communities, regardless of HIV prevalence, are vital to ending the HIV epidemic in this country and private- and public-sector partners must work together with community-based, faith-focused, and advocacy organizations; governmental public health; mental health and substance use disorder treatment services; the criminal justice system; and providers of housing, food and nutrition, education, and employment services because we all have a role in reducing new HIV infections, improving outcomes and quality of life for people with HIV, and eliminating HIV disparities.

Interwoven throughout the Strategy are approaches to address the individual, community, and structural factors and inequities that contribute to the spread of HIV, such as stigma and social determinants of health. The Strategy highlights opportunities to integrate HIV prevention, care, and treatment into prevention and treatment for sexually transmitted infections, viral hepatitis, mental health and substance use disorders, and other public health efforts by leveraging capacity and infrastructure across the domains and breaking down operational and funding silos. A recurring theme is the need to bring to scale innovative solutions and data-driven approaches to address the ongoing and emerging challenges to HIV prevention, care, and treatment, including expanding the types of community and clinical sites that address HIV to help reach and engage people in need of services; supporting retention in HIV prevention and care services; continuing research into development of better prevention tools, therapeutics, and vaccines; and understanding how to make best use of available tools in real-world settings. Throughout this document, the term “care” is used as an umbrella term meant to encompass holistic services including treatment and supportive services.

To ensure implementation and accountability, a Federal Implementation Plan that documents the specific actions that federal partners will take to achieve the Strategy’s goals and objectives will be developed in early 2022. Progress toward meeting the Strategy’s goals will be monitored and reported annually.

The Strategy and the *Ending the HIV Epidemic in the U.S.* (EHE) initiative are closely aligned and complementary, with EHE serving as a leading component of the work by the U.S. Department of Health and Human Services (HHS), in collaboration with local, state, tribal, federal, and community partners, to achieve the Strategy’s goals. The EHE initiative focuses on scaling up four strategies in the communities most affected by HIV. The Strategy covers the entire country, has a broader focus across federal departments and agencies beyond HHS and all sectors of society, and addresses the integration of several key components that are vital to our collective work, including stigma, discrimination, and social determinants of health.

NHAS AT-A-GLANCE

This At-A-Glance section briefly summarizes the Goals, Objectives, and Strategies that are discussed in detail in the narrative that follows.

Goal 1: Prevent New HIV Infections

1.1 Increase awareness of HIV

1.1.1 Develop and implement campaigns, interventions, and resources to provide education about comprehensive sexual health; HIV risks; options for prevention, testing, care, and treatment; and HIV-related stigma reduction.

1.1.2 Increase knowledge of HIV among people, communities, and the health workforce in geographic areas disproportionately affected.

1.1.3 Integrate HIV messaging into existing campaigns and other activities pertaining to other parts of the syndemic, such as STIs, viral hepatitis, and substance use and mental health disorders, as well as in primary care and general wellness, and as part of annual reproductive health visits and wellness visits.

1.2 Increase knowledge of HIV status

1.2.1 Test all people for HIV according to the most current USPSTF recommendations and CDC guidelines.

1.2.2 Develop new and expand implementation of effective, evidence-based, or evidence-informed models for HIV testing that improve convenience and access.

1.2.3 Incorporate a status-neutral approach to HIV testing, offering linkage to prevention services for people who test negative and immediate linkage to HIV care and treatment for those who test positive.

1.2.4 Provide partner services to people diagnosed with HIV or other STIs and their sexual and/or syringe-sharing partners.

1.3 Expand and improve implementation of safe, effective prevention interventions, including treatment as prevention, PrEP, PEP, and SSPs, and develop new options

1.3.1 Engage people who experience risk for HIV in traditional public health and health care delivery systems, as well as in nontraditional community settings.

1.3.2 Scale up treatment as prevention (i.e., U=U) by diagnosing all people with HIV, as early as possible, and engaging them in care and treatment to achieve and maintain viral suppression.

1.3.3 Make HIV prevention services, including condoms, PrEP, PEP, and SSPs, easier to access and support continued use.

1.3.4 Implement culturally competent and linguistically appropriate models and other innovative approaches for delivering HIV prevention services.

1.3.5 Support research into the development and evaluation of new HIV prevention modalities and interventions for preventing HIV transmissions in priority populations.

1.3.6 Expand implementation research to successfully adapt evidence-based interventions to local environments to maximize potential for uptake and sustainability.

1.4 Increase the diversity and capacity of health care delivery systems, community health, public health, and the health workforce to prevent and diagnose HIV

1.4.1 Provide resources, incentives, training, and technical assistance to expand workforce and systems capacity to provide or link clients to culturally competent, linguistically appropriate, and accessible HIV testing, prevention, and supportive services especially in areas with shortages that are geographic, population, or facility based.

1.4.2 Increase the diversity of the workforce of providers who deliver HIV prevention, testing, and supportive services.

1.4.3 Increase the inclusion of paraprofessionals on prevention teams by advancing training, certification, supervision, financing, and team-based care service delivery.

1.4.4 Include comprehensive sexual health and substance use prevention and treatment information in curricula of medical and other health workforce education and training programs.

Goal 2: Improve HIV-Related Health Outcomes of People with HIV

2.1 Link people to care immediately after diagnosis and provide low-barrier access to HIV treatment

2.1.1 Provide same-day or rapid (within 7 days) start of antiretroviral therapy for persons who are able to take it; increase linkage to HIV health care within 30 days for all persons who test positive for HIV.

2.1.2 Increase the number of schools providing on-site sexual health services through school-based health centers and school nurses, and linkages to HIV testing and medical care through youth-friendly providers in the community.

2.2 Identify, engage, or reengage people with HIV who are not in care or not virally suppressed

2.2.1 Expand uptake of data-to-care models using data sharing agreements, integration and use of surveillance, clinical services, pharmacy, and social/support services data to identify and engage people not in care or not virally suppressed.

2.2.2 Identify and address barriers for people who have never engaged in care or who have fallen out of care.

2.3 Increase retention in care and adherence to HIV treatment to achieve and maintain long-term viral suppression and provide integrative HIV services for HIV-associated comorbidities, coinfections, and complications, including STIs

2.3.1 Support the transition of health care systems, organizations, and patients/clients to become more health literate in the provision of HIV prevention, care, and treatment services.

2.3.2 Develop and implement effective, evidence-based, or evidence-informed interventions and supportive services that improve retention in care.

2.3.3 Expand implementation research to successfully adapt effective evidence-based interventions, such as HIV telehealth, patient and peer navigators, accessible pharmacy services, community health workers, and others, to local environments to facilitate uptake and retention to priority populations.

2.3.4 Support ongoing clinical, behavioral, and other research to support retention in care, medication adherence, and durable viral suppression.

2.4 Increase the capacity of the public health, health care delivery systems, and health care workforce to effectively identify, diagnose, and provide holistic care and treatment for people with HIV

2.4.1 Provide resources, value-based and other incentives, training, and technical assistance to expand workforce and systems capacity to provide or link clients to culturally competent and linguistically appropriate care, treatment, and supportive services especially in areas with shortages that are geographic, population, or facility based.

2.4.2 Increase the diversity of the workforce of providers who deliver HIV care and supportive services.

2.4.3 Increase inclusion of paraprofessionals on teams by advancing training, certification, supervision, reimbursement, and team functioning to assist with screening/management of HIV, STIs, viral hepatitis, and mental and substance use disorders and other behavioral health conditions.

2.5 Expand capacity to provide whole-person care to older adults with HIV and long-term survivors

2.5.1 Identify, implement, and evaluate models of care that meet the needs of people with HIV who are aging and ensure quality of care across services.

2.5.2 Identify and implement best practices related to addressing psychosocial and behavioral health needs of older people with HIV and long-term survivors including substance use treatment, mental health treatment, and programs designed to decrease social isolation.

2.5.3 Increase HIV awareness, capability, and collaboration of service providers to support older people with HIV, including in settings such as aging services, housing for older adults, substance use treatment, and disability and other medical services.

2.5.4 Promote research, cross-agency collaborations, and sharing of research discoveries that address specific aging-related conditions in people with HIV, and other comorbidities and coinfections that can impact people with HIV of all ages.

2.5.5 Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing people living with HIV at various life stages to support healthy aging with HIV.

2.6 Advance the development of next-generation HIV therapies and accelerate research for HIV cure

2.6.1 Promote research and encourage public-private partnerships to accelerate new therapies to achieve sustained viral suppression and to address drug toxicity, viral resistance, adherence, and retention in care and stigma associated with ART use.

2.6.2 Increase investment in innovative basic and clinical research to inform and accelerate a research agenda to discover how to sustain viral suppression, achieve ART-free remission, reduce and eliminate viral reservoirs, and achieve HIV cure.

Goal 3: Reduce HIV-Related Disparities and Health Inequities

3.1 Reduce HIV-related stigma and discrimination

3.1.1 Strengthen enforcement of civil rights laws (including language access services and disability rights), promote reform of state HIV criminalization laws, and assist states in protecting people with HIV from violence, retaliation, and discrimination associated with HIV status, homophobia, transphobia, xenophobia, racism, substance use, and sexism.

3.1.2 Ensure that health care professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or who experience risk for HIV, including LGBTQI+ people, immigrants, people who use drugs, and people involved in sex work.

3.1.3 Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes.

3.1.4 Ensure resources are focused on the communities and populations where the need is greatest, especially Black, Latino, and American Indian/Alaska Native and other people of color, particularly those who are also gay and bisexual men, transgender people, people who use substances, sex workers, and immigrants.

3.1.5 Create funding opportunities that specifically address social and structural drivers of health as they relate to Black, Latino, and American Indian/Alaska Native and other people of color.

3.2 Reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum

3.2.1 Increase awareness of HIV-related disparities through data collection, analysis, and dissemination of findings.

3.2.2 Develop new and scale up effective, evidence-based or evidence-informed interventions to improve health outcomes among priority populations and other populations or geographic areas experiencing disparities.

3.3 Engage, employ, and provide public leadership opportunities at all levels for people with or who experience risk for HIV

3.3.1 Create and promote public leadership opportunities for people with or who experience risk for HIV.

3.3.2 Work with communities to reframe HIV services and HIV-related messaging so that they do not stigmatize people or behaviors.

3.4 Address social and structural determinants of health and co-occurring conditions that impede access to HIV services and exacerbate HIV-related disparities

3.4.1 Develop whole-person systems of care and wellness that address co-occurring conditions for people with or who experience risk for HIV.

3.4.2 Adopt policies that reduce cost, payment, coverage, and/or access barriers to improve the delivery and receipt of services for people with or who experience risk for HIV.

3.4.3 Improve screening and linkage to services for people with or who experience risk for HIV who are diagnosed with and/or are receiving services for co-occurring conditions.

3.4.4 Develop and implement effective, evidence-based and evidence-informed interventions that address social and structural determinants of health among people with or who experience risk for HIV including lack of continuous health care coverage, HIV-related stigma and discrimination in public health and health care systems, medical mistrust, inadequate housing and transportation, food insecurity, unemployment, low health literacy, and involvement with the justice system.

3.4.5 Increase the number of schools that have implemented LGBTQ-supportive policies and practices, including (1) having a Gay/Straight Alliance (GSA), Gender Sexuality Alliance, or similar clubs, (2) identifying safe spaces, (3) adopting policies expressly prohibiting discrimination and harassment based on sexual orientation or gender identity, (4) encouraging staff to attend professional development, (5) facilitating access to out-of-school health service providers, (6) facilitating access to out-of-school social and psychological service providers, and (7) providing LGBTQ-relevant curricula or supplementary materials.

3.4.6 Develop new and scale up effective, evidence-based or evidence-informed interventions that address intersecting factors of HIV, homelessness or housing instability, mental health and violence, substance use, and gender especially among cis- and transgender women and gay and bisexual men.

3.5 Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including health care workers, researchers, and community partners, particularly from underrepresented populations

3.5.1 Promote the expansion of existing programs and initiatives designed to increase the numbers of non-White research and health professionals.

3.5.2 Increase support for the implementation of mentoring programs for individuals from diverse cultural backgrounds to expand the pool of HIV research and health professionals.

3.5.3 Encourage the implementation of effective recruitment of community partners through community-based participatory research and social networking approaches.

3.6 Advance HIV-related communications to achieve improved messaging and uptake, as well as to address misinformation and health care mistrust

3.6.1 Develop and test strategies to promote accurate creation, dissemination, and uptake of information and to counter associated misinformation and disinformation.

3.6.2 Increase diversity and cultural competence in health communication research, training, and policy.

3.6.3 Expand community engagement in health communication initiatives and research.

3.6.4 Include critical analysis and health communication skills in HIV programs to provide participants with the tools to seek and identify accurate health information and to advocate for themselves and their communities.

3.6.5 Expand effective communication strategies between providers and consumers to build trust, optimize collaborative decision-making, and promote success of evidence-based prevention and treatment strategies.

Goal 4: Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties

4.1 Integrate programs to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence

4.1.1 Integrate HIV awareness and services into outreach and services for issues that intersect with HIV such as intimate partner violence, homelessness or housing instability, STIs, viral hepatitis, and substance use and mental health disorders.

4.1.2 Implement a no-wrong-door approach to screening and linkage to services for HIV, STIs, viral hepatitis, and substance use and mental health disorders across programs.

4.1.3 Identify and address funding, policy, data, workforce capacity, and programmatic barriers to effectively address the syndemic.

4.1.4 Coordinate and align strategic planning efforts on HIV, STIs, viral hepatitis, substance use disorders, and mental health care across national, state, and local partners.

4.1.5 Enhance the ability of the HIV workforce to provide naloxone and educate people on the existence of fentanyl in the drug supply to prevent overdose and deaths and facilitate linkage to substance use disorder treatment and harm reduction programs.

4.2 Increase coordination among and sharing of best practices from HIV programs across all levels of government (federal, state, tribal, local, and territorial) and with public and private health care payers, faith-based and community-based organizations, the private sector, academic partners, and the community

4.2.1 Focus resources including evidence-based and evidence-informed interventions in the geographic areas and priority populations disproportionately affected by HIV.

4.2.2 Enhance collaboration among local, state, tribal, territorial, national, and federal partners and the community to address policy and structural barriers that contribute to persistent HIV-related disparities and implement policies that foster improved health outcomes.

4.2.3 Coordinate across partners to quickly detect and respond to HIV outbreaks.

4.2.4 Support collaborations between community-based organizations, public health organizations, education agencies and schools, housing providers, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services.

4.3 Enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care continua data and social determinants of health data

4.3.1 Promote the collection, electronic sharing, and use of HIV risk, prevention, and care and treatment data using interoperable data standards, including data from electronic health records, in accordance with applicable law.

4.3.2 Use interoperable health information technology, including application programming interfaces (APIs), clinical decision support tools, electronic health records and health IT products certified by the Office of the National Coordinator's Health IT Certification Program, and health information exchange networks, to improve HIV prevention efforts and care outcomes.

4.3.3 Encourage and support patient access to and use of their individual health information, including use of their patient-generated health information and use of consumer health technologies in a secure and privacy supportive manner.

4.4 Foster private-public-community partnerships to identify and scale up best practices and accelerate HIV advances

4.4.1 Adopt approaches that incentivize the scale up of effective interventions among academic centers, health departments, community-based organizations, allied health professionals, people with HIV and their advocates, the private sector, and other partners.

4.4.2 Expand opportunities and mechanisms for information sharing and peer technical assistance within and across jurisdictions to move effective interventions into practice more swiftly.

4.4.3 Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing persons of all ages living with HIV.

4.5 Improve mechanisms to measure, monitor, evaluate, and use the information to report progress and course correct as needed in order to achieve the Strategy's goals

4.5.1 Streamline and harmonize reporting and data systems to reduce burden and improve the timeliness, availability, and usefulness of data.

4.5.2 Monitor, review, evaluate, and regularly communicate progress on the National HIV/AIDS Strategy.

4.5.3 Ensure that the National HIV/AIDS Strategy's goals and priorities are included in cross-sector federal funding requirements.

4.5.4 Strengthen monitoring and accountability for adherence to requirements, targets, and goals by funded partners.

4.5.5 Identify and address barriers and challenges that hinder achievement of goals by funded partners and other interested parties.

INDICATORS AT-A-GLANCE

Indicator 1: Increase knowledge of status to 95% from a 2017 baseline of 85.8%.

Indicator 2: Reduce new HIV infections by 75% from a 2017 baseline of 37,000.

Indicator 3: Reduce new HIV diagnoses by 75% from a 2017 baseline of 38,351.

Indicator 4: Increase PrEP coverage to 50% from a 2017 baseline of 13.2%.

Indicator 5: Increase linkage to care within 1 month of diagnosis to 95% from a 2017 baseline of 77.8%.

Indicator 6: Increase viral suppression among people with diagnosed HIV to 95% from a 2017 baseline of 63.1%.

Indicator 6a: Increase viral suppression among MSM diagnosed with HIV to 95% from a 2017 baseline of 66.1%.

Indicator 6b: Increase viral suppression among Black MSM diagnosed with HIV to 95% from a 2017 baseline of 58.4%.

Indicator 6c: Increase viral suppression among Latino MSM diagnosed with HIV to 95% from a 2017 baseline of 64.9%.

Indicator 6d: Increase viral suppression among American Indian/Alaska Native MSM diagnosed with HIV to 95% from a 2017 baseline of 67.3%.

Indicator 6e: Increase viral suppression among Black women diagnosed with HIV to 95% from a 2017 baseline of 59.3%.

Indicator 6f: Increase viral suppression among transgender women in HIV medical care to 95% from a 2017 baseline of 80.5%.

Indicator 6g: Increase viral suppression among people who inject drugs diagnosed with HIV to 95% from a 2017 baseline of 54.9%.

Indicator 6h: Increase viral suppression among youth aged 13-24 diagnosed with HIV to 95% from a 2017 baseline of 57.1%.

Indicator 7: Decrease stigma among people with diagnosed HIV by 50% from a 2018 baseline median score of 31.2 on a 10-item questionnaire.

Indicator 8: Reduce homelessness among people with diagnosed HIV by 50% from a 2017 baseline of 9.1%.

Indicator 9: Increase the median percentage of secondary schools that implement at least 4 out of 7 LGBTQ-supportive policies and practices to 65% from a 2018 baseline of 59.8%.

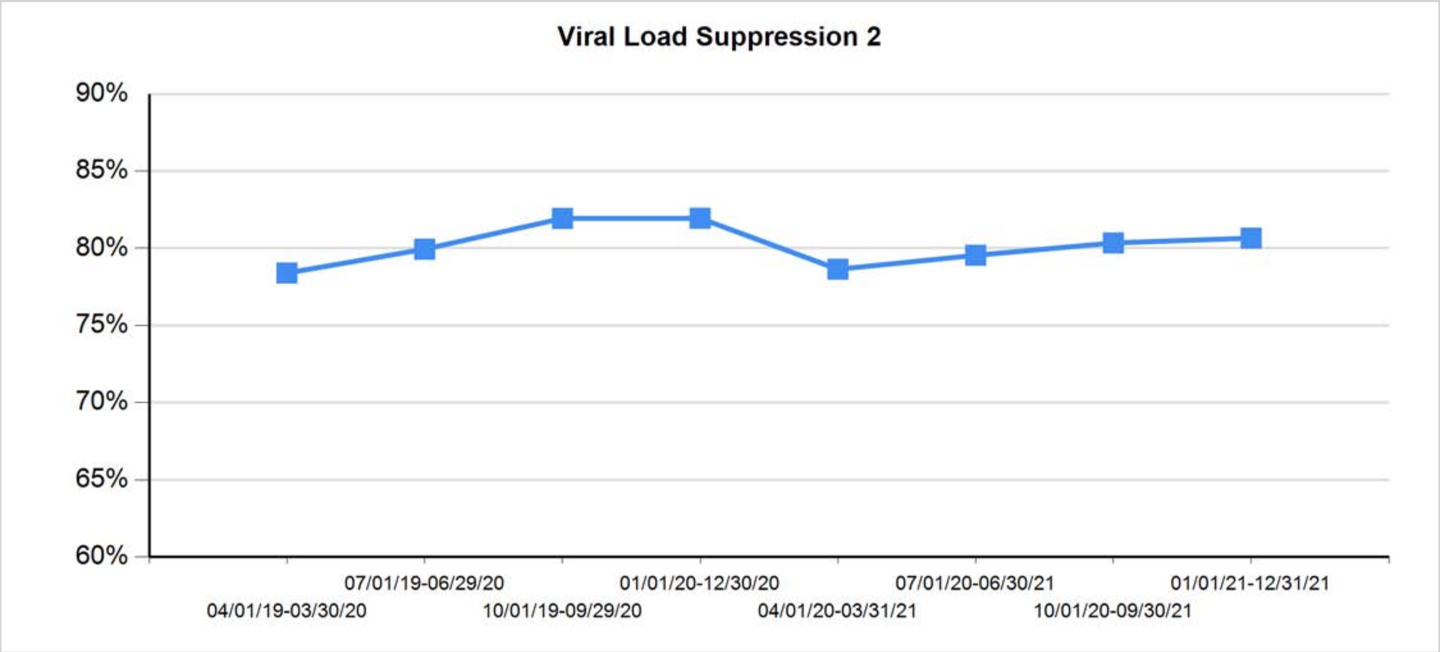
In addition, quality of life for people with HIV was designated as the subject for a developmental indicator, meaning that data sources, measures, and targets will be identified and progress monitored thereafter.

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

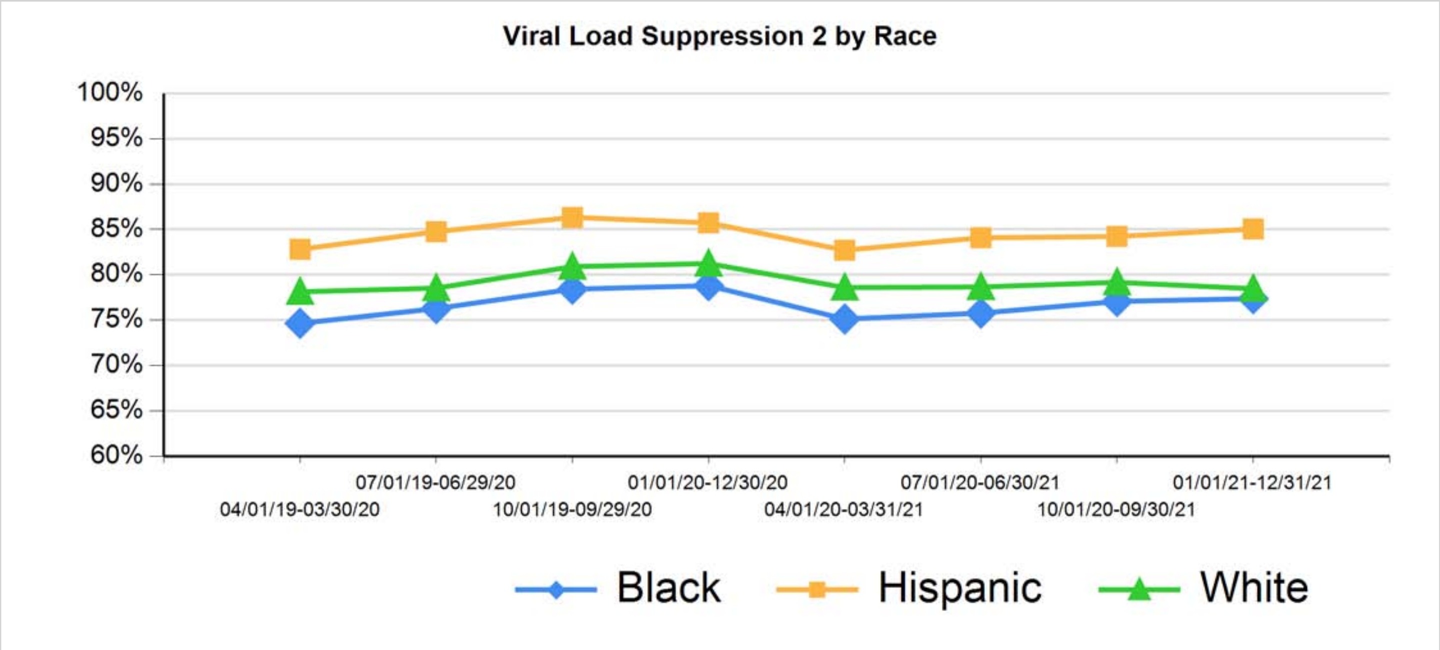
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **1/1/2021**

Viral Load Suppression 2- HAB Measure				
	04/01/20 - 03/31/21	07/01/20 - 06/30/21	10/01/20 - 09/30/21	01/01/21 - 12/31/21
Number of clients who have a viral load of <200 copies/ml during the measurement year	6,867	7,117	7,216	7,120
Number of clients who have had at least 1 medical visit with a provider with prescribing privileges	8,732	8,947	8,981	8,827
Percentage	78.6%	79.5%	80.3%	80.7%
Change from Previous Quarter Results	-3.3%	0.9%	0.8%	0.3%

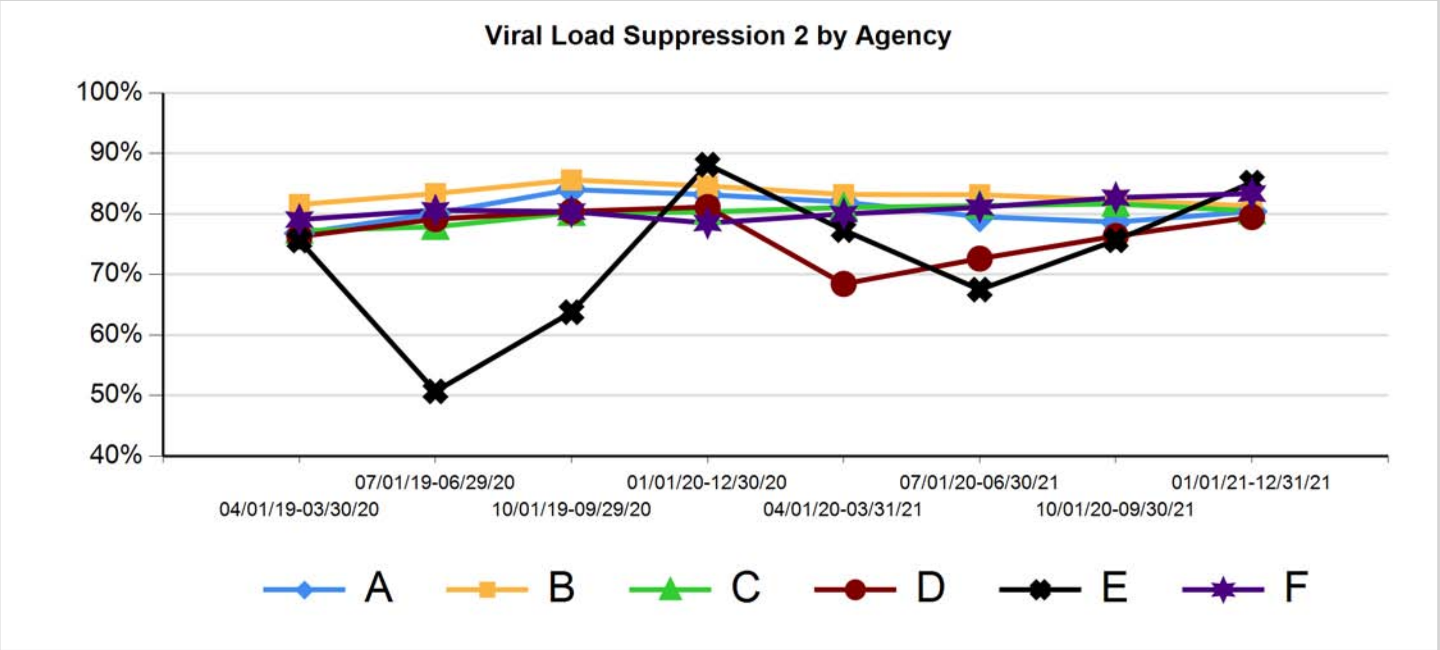


VL Suppression 2 by Race/Ethnicity									
	07/01/20 - 06/30/21			10/01/20 - 09/30/21			01/01/21 - 12/31/21		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	3,218	2,863	862	3,275	2,914	851	3,217	2,935	798
Number 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	4,247	3,405	1,096	4,250	3,460	1,075	4,158	3,451	1,017
Percentage	75.8%	84.1%	78.6%	77.1%	84.2%	79.2%	77.4%	85.0%	78.5%
Change from Previous Quarter Results	0.7%	1.4%	0.1%	1.3%	0.1%	0.5%	0.3%	0.8%	-0.7%

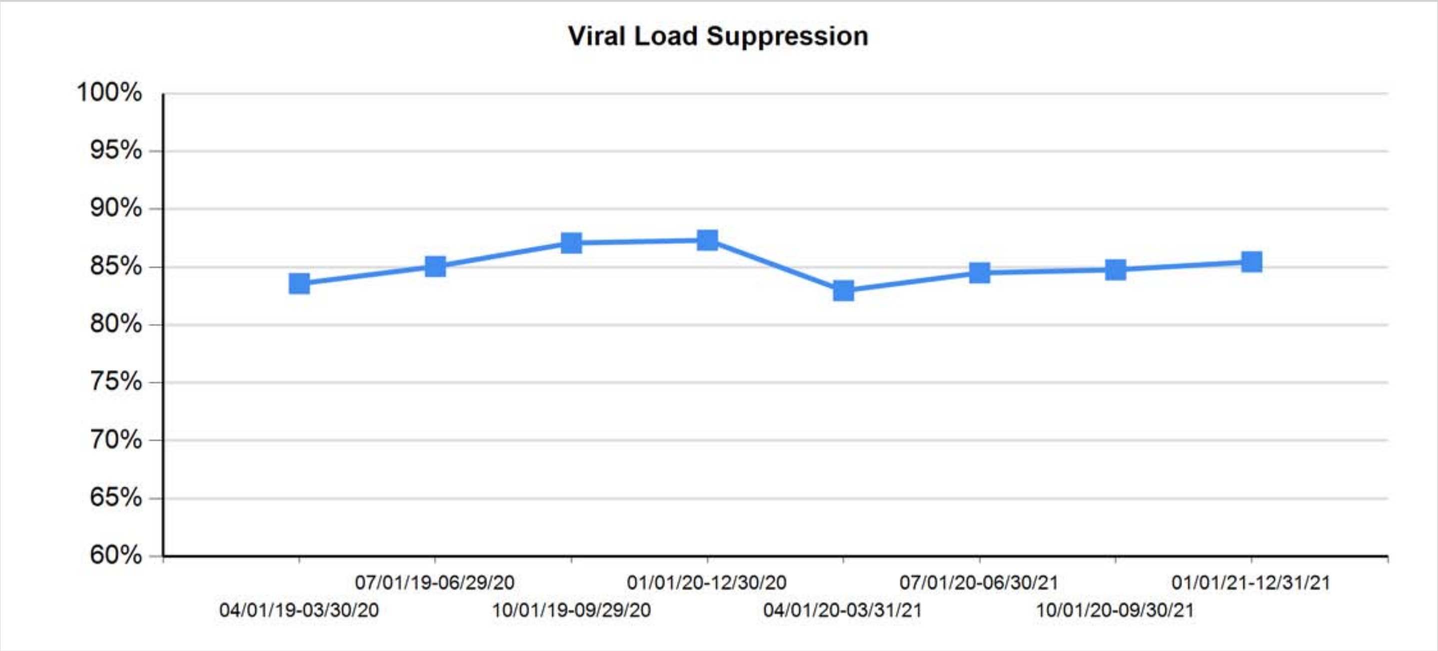


Viral Load 2 Suppression by Agency

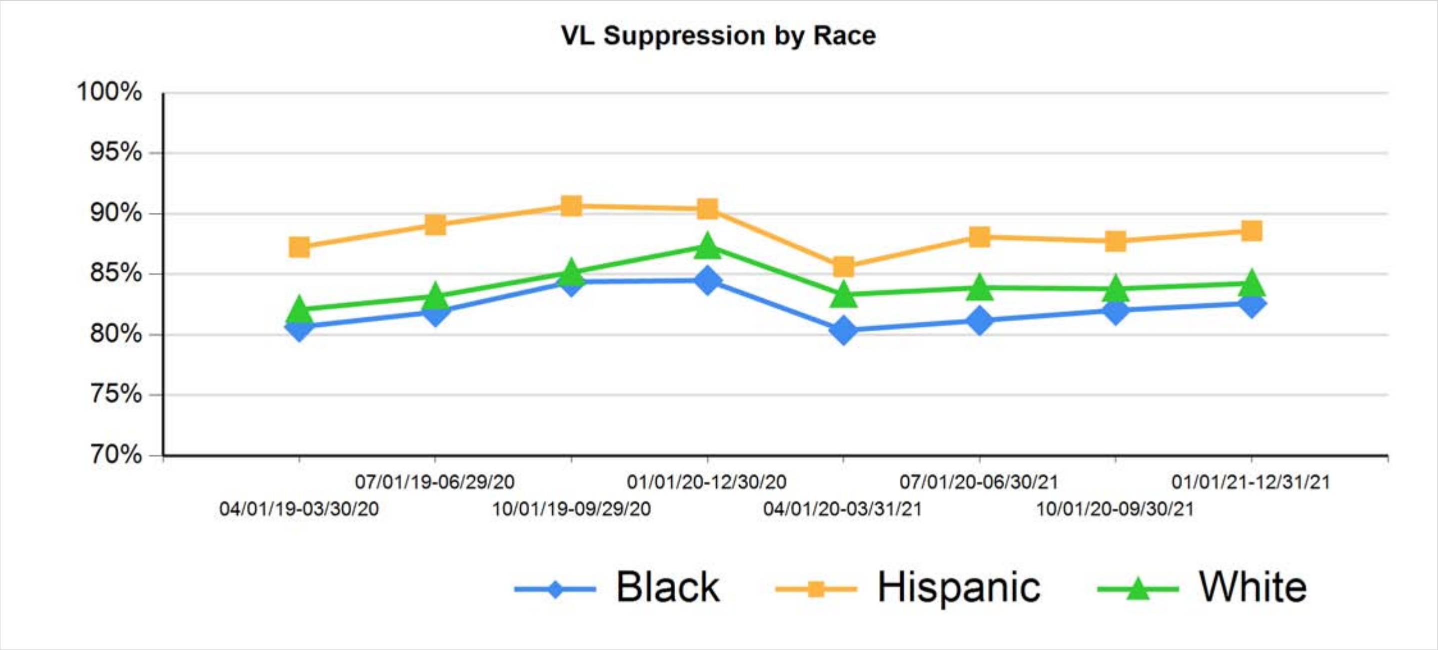
	10/01/20 - 09/30/21						01/01/21 - 12/31/21					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load of <200 copies/ml during the measurement year	542	2,112	2,308	1,693	59	621	558	1,979	2,234	1,747	69	647
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	689	2,566	2,826	2,217	78	751	694	2,434	2,776	2,198	81	776
Percentage	78.7%	82.3%	81.7%	76.4%	75.6%	82.7%	80.4%	81.3%	80.5%	79.5%	85.2%	83.4%
Change from Previous Quarter Results	-0.9%	-0.9%	0.3%	3.7%	8.1%	1.6%	1.7%	-1.0%	-1.2%	3.1%	9.5%	0.7%



Viral Load Suppression				
	04/01/20 - 03/31/21	07/01/20 - 06/30/21	10/01/20 - 09/30/21	01/01/21 - 12/31/21
Number of clients who have a viral load of <200 copies/ml during the measurement year	5,074	5,243	5,275	5,244
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	6,116	6,205	6,223	6,137
Percentage	83.0%	84.5%	84.8%	85.4%
Change from Previous Quarter Results	-4.4%	1.5%	0.3%	0.7%

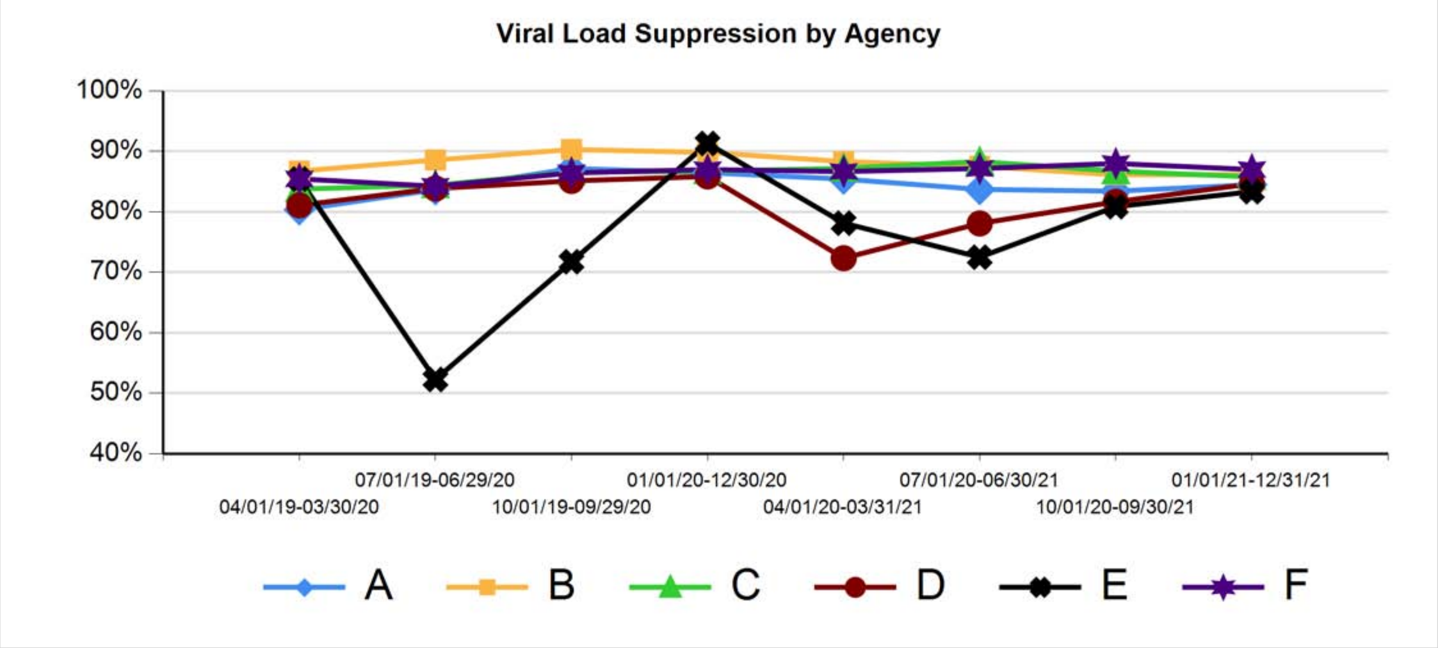


VL Suppression by Race/Ethnicity									
	07/01/20 - 06/30/21			10/01/20 - 09/30/21			01/01/21 - 12/31/21		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	2,311	2,205	604	2,335	2,203	605	2,288	2,244	583
Number 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	2,847	2,503	720	2,847	2,511	722	2,770	2,533	692
Percentage	81.2%	88.1%	83.9%	82.0%	87.7%	83.8%	82.6%	88.6%	84.2%
Change from Previous Quarter Results	0.8%	2.5%	0.6%	0.8%	-0.4%	-0.1%	0.6%	0.9%	0.5%

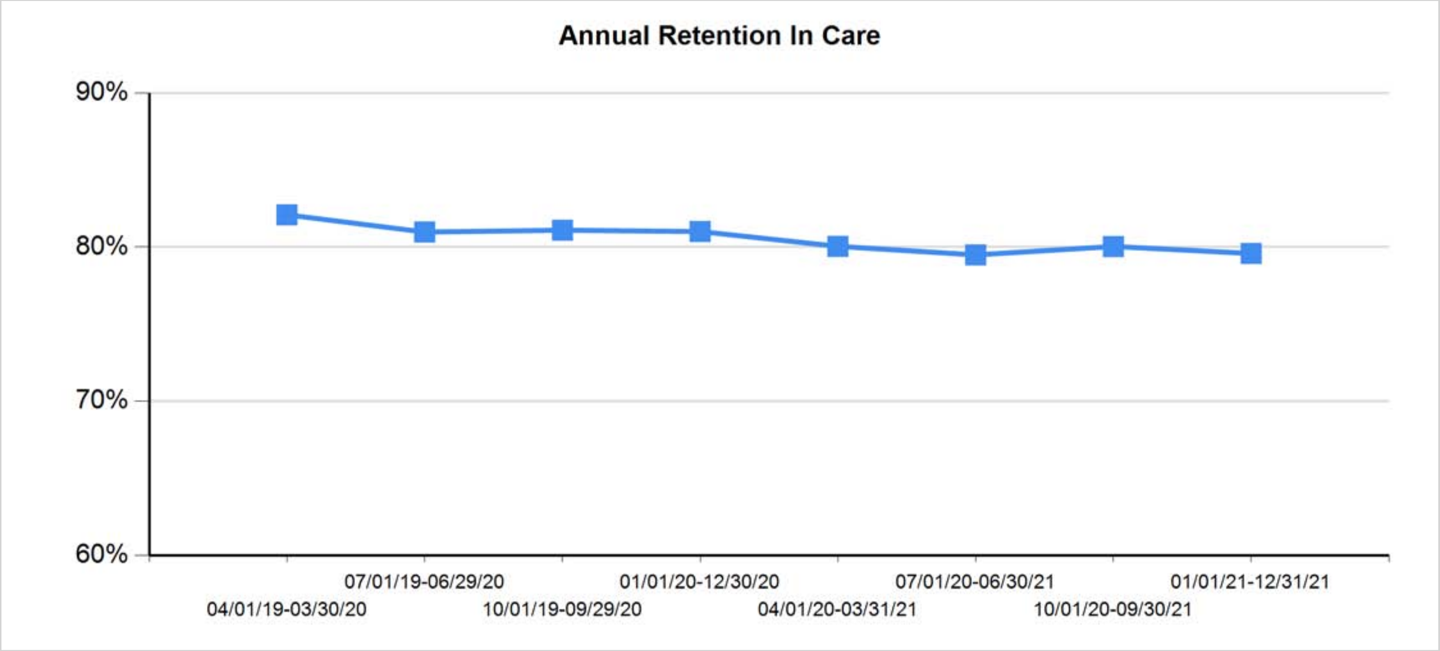


VL Suppression by Agency

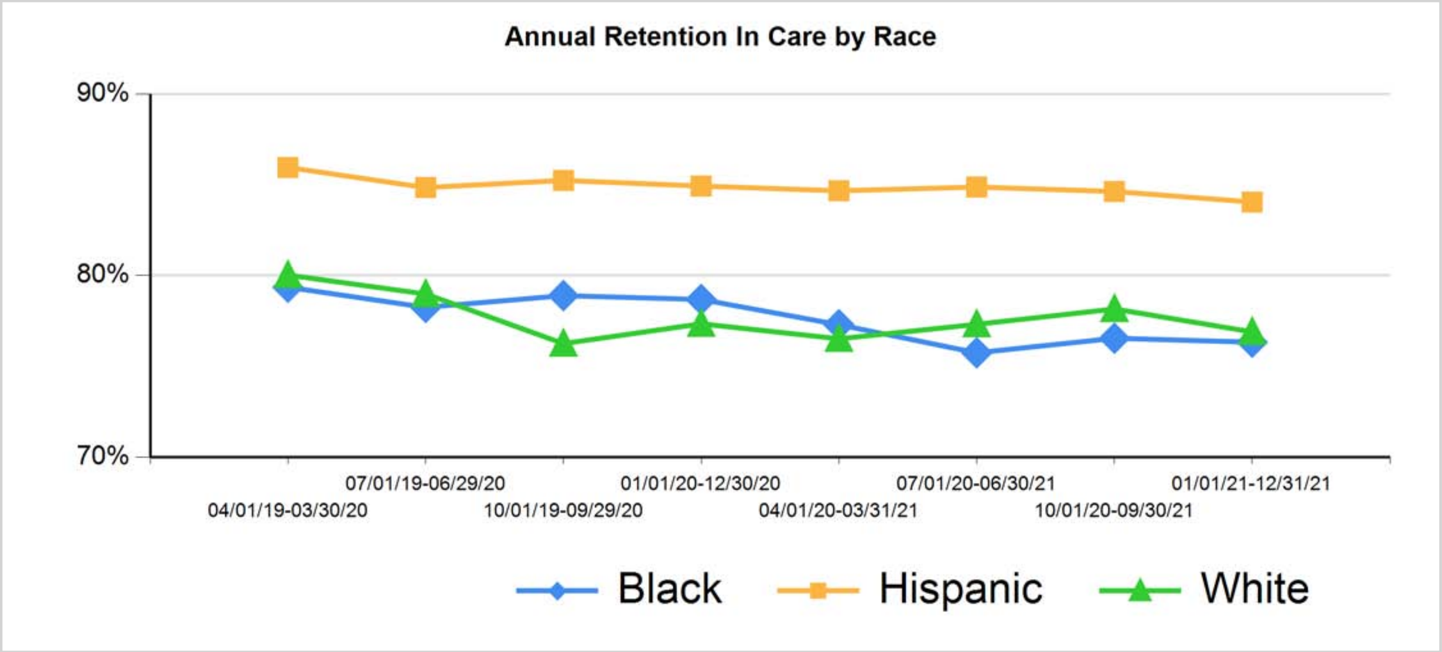
	10/01/20 - 09/30/21						01/01/21 - 12/31/21					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load of <200 copies/ml during the measurement year	478	1,501	1,378	1,491	38	425	479	1,450	1,381	1,504	35	428
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	573	1,743	1,589	1,826	47	483	567	1,683	1,610	1,777	42	492
Percentage	83.4%	86.1%	86.7%	81.7%	80.9%	88.0%	84.5%	86.2%	85.8%	84.6%	83.3%	87.0%
Change from Previous Quarter Results	-0.3%	-1.4%	-1.6%	3.6%	8.4%	0.8%	1.1%	0.0%	-0.9%	3.0%	2.5%	-1.0%



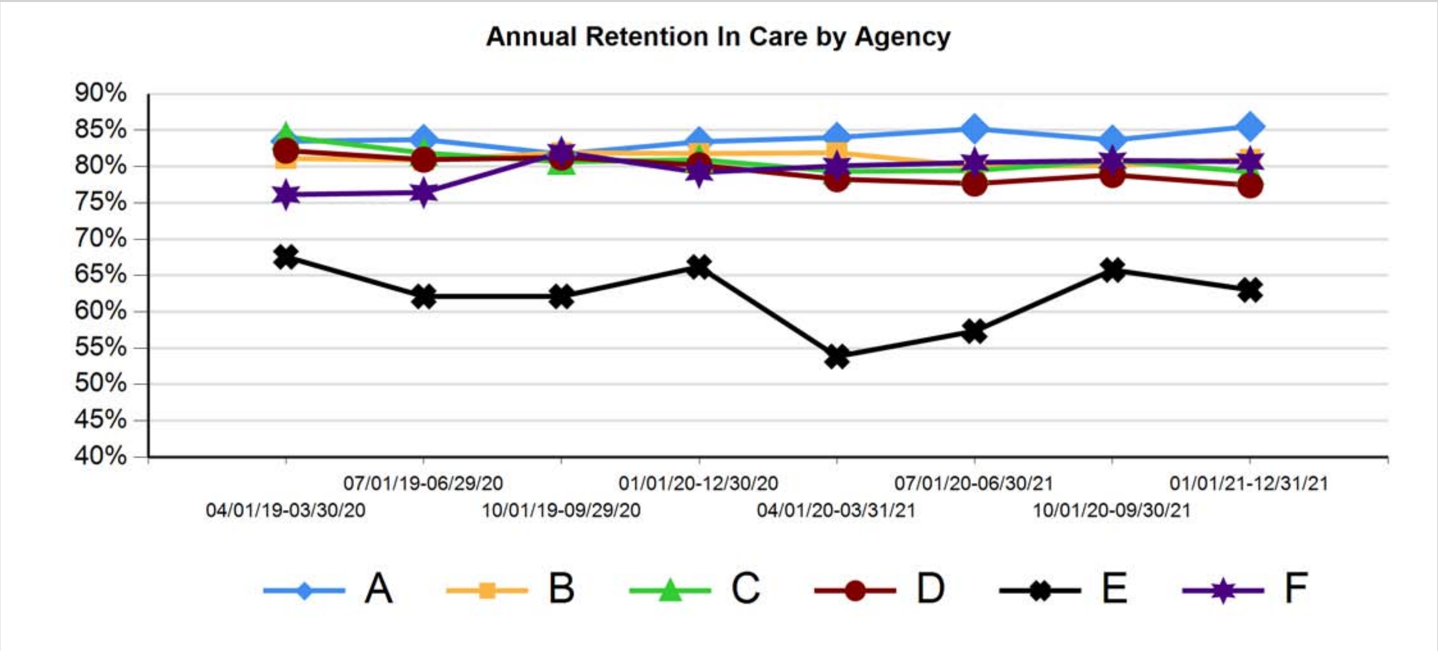
Annual Retention In Care				
Houston EMA Medical Visits Measure				
	04/01/20 - 03/31/21	07/01/20 - 06/30/21	10/01/20 - 09/30/21	01/01/21 - 12/31/21
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year*	6,379	6,474	6,536	6,421
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	7,969	8,144	8,166	8,068
Percentage	80.0%	79.5%	80.0%	79.6%
Change from Previous Quarter Results	-1.0%	-0.6%	0.5%	-0.5%
* Not newly enrolled in care				



Annual Retention In Care by Race/Ethnicity									
	07/01/20 - 06/30/21			10/01/20 - 09/30/21			01/01/21 - 12/31/21		
	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	2,916	2,648	770	2,953	2,670	762	2,892	2,655	722
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	3,850	3,120	996	3,858	3,155	975	3,789	3,159	939
Percentage	75.7%	84.9%	77.3%	76.5%	84.6%	78.2%	76.3%	84.0%	76.9%
Change from Previous Quarter Results	-1.5%	0.2%	0.8%	0.8%	-0.2%	0.8%	-0.2%	-0.6%	-1.3%


Annual Retention In Care by Race

Annual Retention In Care by Agency												
	10/01/20 - 09/30/21						01/01/21 - 12/31/21					
	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	542	1,908	2,054	1,625	48	468	555	1,834	2,011	1,587	46	489
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	648	2,381	2,541	2,061	73	579	649	2,264	2,537	2,050	73	606
Percentage	83.6%	80.1%	80.8%	78.8%	65.8%	80.8%	85.5%	81.0%	79.3%	77.4%	63.0%	80.7%
Change from Previous Quarter Results	-1.6%	0.1%	1.4%	1.2%	8.4%	0.3%	1.9%	0.9%	-1.6%	-1.4%	-2.7%	-0.1%



2022-2023 HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE CARE ACT PART A
STANDARDS OF CARE FOR HIV SERVICES
RYAN WHITE GRANT ADMINISTRATION SECTION
HARRIS COUNTY PUBLIC HEALTH (HCPH)

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Introduction

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

Purpose

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

Scope

The Houston EMA SOCs apply to Part A funded HRSA defined core and support services including the following services in FY 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 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.

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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

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://learn.sba.gov/learning-center-manage/understanding-your-customer	• Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure • Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.3	Staff Performance Evaluation Agency will perform annual staff performance evaluation.	• Completed annual performance evaluation kept in employee's file • Signed and dated by employee and supervisor (includes electronic signature)
1.4	Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers All staff tenured 0 – 5 year with their current employer must receive four (4) hours of cultural competency training to include information on working with people of all races, ethnicities, nationalities, gender identities, and sexual orientations and an	• Documentation of training is maintained by the agency in the personnel file

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

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

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

	• 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.	
3.5	<u>Grievance Procedure</u> Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to: • to whom complaints can be made • steps necessary to complain • form of grievance, if any • timelines and steps taken by the agency to resolve the grievance • documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client • all complaints or grievances initiated by clients are documented on the Agency's standardized form • resolution of each grievance/complaint is documented on the Standardized form and shared with client • confidentiality of grievance • addresses and phone numbers of licensing authorities and funding sources	• Signed receipt of agency Grievance Procedure, filed in client chart • Review of Agency's Policies and Procedures Manual indicates compliance • Review of Agency's Grievance file indicates compliance, • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2

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

	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 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 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. At a minimum, agency confirms an individual's income, residency and re-screens, as appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance.	• Client record contains documentation of re-certification of client residence, income and rescreening for third party payers at least every twelve (12) months • Review of Policies and Procedures indicates compliance

	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)	• 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 has a written substantiated annual plan to targeted populations • Zip code data show provider is reaching clients throughout service

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

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

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

	response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	
7.2	<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.C: Introduction to the Incident Command System, ICS 100 -IS-200.C: Basic Incident Command System for Initial Response -IS-700.B: An Introduction to the National Incident Management System -IS-800.D: National Response Framework, An Introduction 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 [Texas DSHS HIV/STD Program - Texas HIV Case Management](#) 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.	• 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 accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient interaction.	• Documentation of staff training

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 management referrals	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of follow-up tracking activities in clients' records • A current list of agencies that provide services including availability of the Blue Book

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

Clinical Case Management Services

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

1.0	**Staff Requirements**	
1.1	<u>Minimum Qualifications</u> All clinical case managers must have a current and in good standing State of Texas license (LCSW, LPC, LMFT). LMSW, LPC-I, and LMFT-A may provide Clinical Case Management services with clinical supervision under a waiver agreement. Staff providing Clinical Case Management services with LBSW licensure must have accompanying LCDC, CI, Substance Abuse Counselor, or Addictions Counselor certification. Other training experiences may be considered 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	<u>Scope of Services</u> 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	<u>Ongoing Education/Training for Clinical Case Managers</u> After the first year of employment in the case management system each clinical case manager will obtain the minimum number of hours of continuing education to maintain his or her licensure and four (4) hours of training in current Community Resources conducted by RWGA	• Certificates of completion are maintained by the agency • Current License on case manager's file

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

2. 3	Coordination with Primary Medical Care and Medical Case Management Provider Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White Part A funded Medical Case Management programs. 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.	• Review of Agency's Policies and Procedures Manual indicates compliance • Case conferences are documented in the client record
2.4	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. 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	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated

	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.	
2.6	<u>Service Plan</u> 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	<u>Clinical Supervision and Caseload Coverage</u> 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	<u>Minimum Qualifications</u> 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	<u>Client Eligibility – Service Linkage targeted to Not-in-Care and Newly Diagnosed (HHD Only)</u> 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

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

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

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

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

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

Emergency Financial Assistance Program

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

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

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

Local Pharmacy Assistance Program

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

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

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

Outreach Services

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

1.0	**Staff Training**	
1.1	**Minimum/Qualifications** Minimum Qualifications – High School Diploma or GED. Six months of working with or volunteering with PLWH.	• Documentation of credentials and job description in outreach worker's file • Documentation includes, but is not limited to high school diploma, GED and experience
1.2	Scope of Services The OW will generate EMR reports to determine eligibility for services. Monthly, during OW-RWGA meetings OW will provide client status updates on engagement activities. Outreach workers are expected to document client's immediate needs and barriers to service in order to relink and reengage them back in to care. Upon successfully re-engaging clients back in to care, outreach workers will provide a warm handoff to a service linkage worker or medical case manager for additional assistance of the client's needs as necessary.	• Review of reporting records indicates compliance • Monthly review of spreadsheet engagement activities • Documentation of assessment will be maintained in the client file
1.3	Ongoing Education/Training for Outreach Workers Staff who provide field-based services should receive at least two (2) hours of field safety training within their first six (6) months of employment. The Outreach Workers are required to attend a minimum of five (5) of the six (6) Outreach Worker meetings and four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA within the grant year, and one of the Joint Prevention and Care Collaborative Workshops presented by RGWA & HHD.	• Documentation of attendance will be 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	Case Reviews – Outreach Worker Supervisor reviews a random sample equal to 10% of unduplicated clients served by each Outreach Worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible and that services provided appropriately.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and Outreach Worker.

Primary Medical Care

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

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

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

	contractors must ensure that this requirement is met and must provide evidence at the annual program monitoring site visits. - Psychiatrists only: after the first biennium, psychiatrists must maintain a minimum of 10 hours of HIV-specific CME every two years in accordance with State licensure renewal dates - Physician extenders must obtain this experience within six months of hire - All staff receive professional supervision - Staff show training and/or experience with the medical care of adults living with HIV	
1.3	Peer Review Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e. MD, NP, PA).	- Provider will document peer review has occurred annually
1.4	**Standing Delegation Orders (SDO)** Standing delegation orders provide direction to RNs, LVNs and, when applicable, Medical Assistants in supporting management of patients seen by a physician. Standing Delegation Orders must adhere to Texas Administrative Code, Title 22, Part 9; Chapter 193; Rule §193.1 and must be congruent with the requirements specified by the Board of Nursing (BON) and Texas State Board of Medical Examiners (TSBME).	- Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider. - Standing Delegation Orders will be reviewed, updated as needed and signed by the physician annually. - Use of standing delegation orders will be documented in patient's primary record system.
1.5	Primary Care Guidelines Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (https://clinicalinfo.hiv.gov/en/overall-search?search=Clinical+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 A plan of care shall be developed for each identified problem and should address diagnostic, therapeutic and educational issues in accordance with the current U.S. HHS treatment guidelines.	• Plan of Care documented in client's record
1.9	Follow- Up Visits All patients shall have follow –up visits every three to six months or as clinically indicated for treatment monitoring and 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	Yearly Surveillance Monitoring and Vaccinations • 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 (https://hivinfo.nih.gov/understanding-hiv/fact-sheets/preventing-perinatal-transmission-hiv), 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 https://clinicalinfo.hiv.gov/en/guidelines-search?search=Obstetrical+Care+for+Pregnant+Women.	- 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 (https://clinicalinfo.hiv.gov/en/guidelines-search?search=Pediatric+Guidelines) 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.	- Documentation in client's record

	A multidisciplinary team approach must be utilized in meeting clients' need and team should consist of physicians, nurses, case managers, pharmacists, nutritionists, dentists, psychologists and outreach workers.	
1.15	Patient Medication Education All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed and then documented in the patient record: the names, actions and purposes of all medications in the patient's regimen; the dosage schedule; food requirements, if any; side effects; drug interactions; and adherence. Patients must be informed of the following: how to pick up medications; how to get refills; and what to do and who to call when having problems taking medications as prescribed. Medication education must also include patient's return demonstration of the most current prescribed medication regimen. The program must utilize an RN, LVN, PA, NP, CNS, pharmacist or MD licensed by the State of Texas, who has at least one year 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	• Review of Policies and Procedures Manual indicates compliance.

	agency's process for assessing clients' mental health and substance use; the treatment and referral of clients for mental illness and substance abuse; and care coordination with mental health and/or substance abuse providers for clients who have mental health and substance abuse issues.	
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 (The Federation of Texas Psychiatry (txpsych.org) and the American Psychiatric Association (HIV Psychiatry) 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	• Documentation of referrals out • Staff interviews indicate compliance • Established tracking systems

	identify clients who are out of care and/or need health screenings (e.g. Hepatitis b & c, cervical cancer screening, etc., for follow-up).	
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	Client Accommodation for Same Day Provider Cancellations Agency must have a policy in place that outlines a timeline for client notification of provider cancellations, and a protocol for how patients will be accommodated when they do not receive notification in advance of arriving to the clinic.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.7	Client Prescription Refill Policy Agency must have a policy in place that details short term prescription refill availability in when office visit is not feasible prior to patient depletion of medication.	• Review of Agency's Policies and Procedures Manual indicates compliance

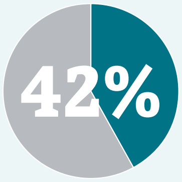
Vision Services

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

1.0	**Staff HIV knowledge is based on documented training.**	
1.1	Ongoing Training Four (4) hours of continuing education in vision-related or other specific topics is required annually.	• Documentation of all training in personnel file • Staff interviews indicate compliance
1.2	Staff Experience/Qualifications Minimum of one (1) year HIV work experience for paid staff (optometry interns exempt) is preferred. Provider must have a staff Doctor 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

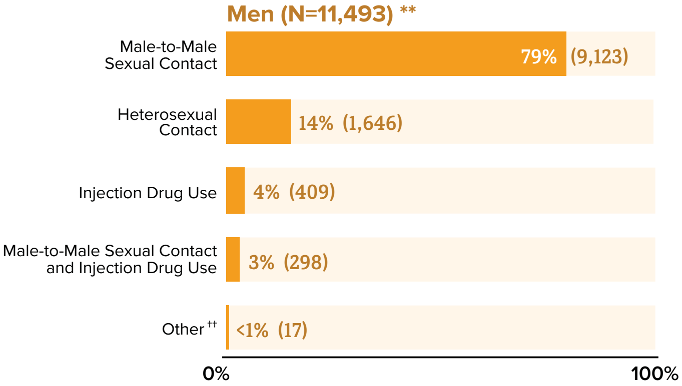
	- Current medications, - Allergies and drug sensitivities, - Reason for visit (chief complaint).	
2.3	CD4/Viral Loads When clinically indicated, current (within the last 6 months) CD4 and Viral Load laboratory test results for clients are obtained.	- Documentation in the client record
2.4	Comprehensive 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

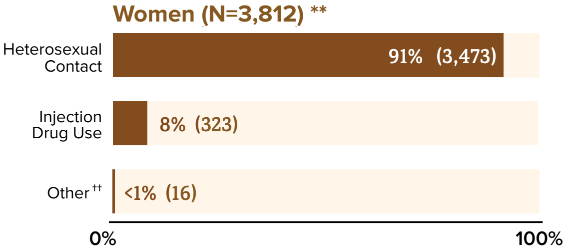
HIV and African American People



Black/African American[*] people made up 42% (15,305)[†] of the **36,801 new HIV diagnoses** in the US and dependent areas[‡] in 2019.

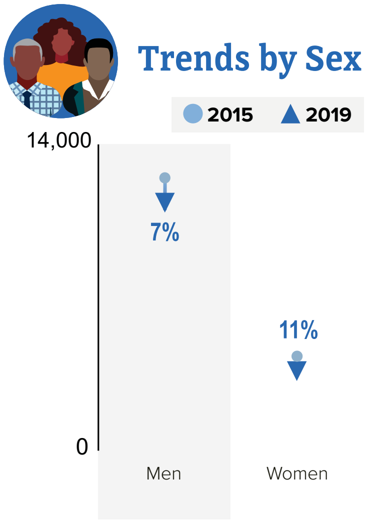
Among Black/African American people, most new HIV diagnoses were among men.



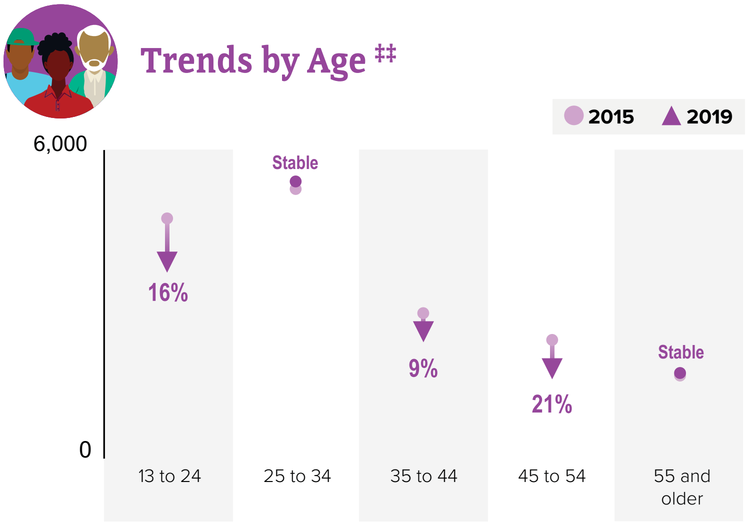


Progress has been made with reducing HIV diagnoses among most age groups, with HIV diagnoses decreasing 8% among Black/African American people overall from 2015 to 2019.

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.

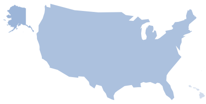
[‡] American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

[**] Based on sex assigned at birth and includes transgender people. For more information about transgender people, visit www.cdc.gov/hiv/group/gender/transgender.

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

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

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

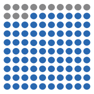


In 2019, an estimated **1.2 MILLION PEOPLE** had HIV. **Of those, 479,300 were Black/African American people.**[***]

For every 100 people with HIV

87 knew their HIV status.

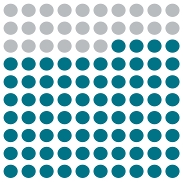
For every 100 Black/African American people with HIV



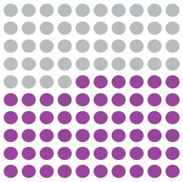
87 knew their HIV status.

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.

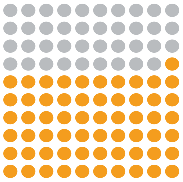
Compared to all people with diagnosed HIV, Black/African American people have lower viral suppression rates. More work is needed to increase these rates. For every **100 Black/African American people with diagnosed HIV** in 2019:[†††]



74 received some HIV care



56 were retained in care

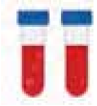


61 were virally suppressed

For comparison, for every **100 people overall** with diagnosed HIV, **76 received some HIV care**, **58 were retained in care**, and **66 were virally suppressed**.

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

Viral Supression



African American people have lower percentages of viral suppression compared to all people with HIV. Getting and keeping an undetectable viral load (or staying virally suppressed) can prevent transmission to others.

Sexually Transmitted Diseases (STDs)

African American people are disproportionately affected by some other 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, including among African American people.

Supporting community organizations that increase access to HIV testing and care for African American people.

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 in African American communities and supporting new efforts funded through the *Ending the HIV Epidemic in the U.S.* initiative.

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

[†††] In 44 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 data on HIV risk behaviors and barriers to HIV care, visit www.cdc.gov/hiv/group/racialethnic/africanamericans.

All content is based on the most recent data available in February 2022.

Black/African American Clients: HRSA's Ryan White HIV/AIDS Program, 2019

Population Fact Sheet | June 2021

HRSA
Ryan White HIV/AIDS Program

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—nearly 568,000 people in 2019—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care, treatment, and support services for people with HIV to improve health outcomes and reduce HIV transmission.

Of the more than half a million clients served by RWHAP, 73.4 percent are from racial/ethnic minority populations, with 46.6 percent of all RWHAP clients identifying as Black/African American.

Below are more details about this RWHAP client population:

- The majority of Black/African American clients served by RWHAP are male. Data show that 62.9 percent of clients are male, 34.5 percent of clients are female, and 2.6 percent of clients are transgender. The proportion of Black/African American male clients is lower than the national RWHAP average (72.0 percent), whereas the proportion of Black/African American female clients is higher than the national RWHAP average (26.1 percent).
- The majority of Black/African American clients served by RWHAP are low income. Data show that 65.9 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 (60.7 percent).
- One in seven Black/African American clients served by RWHAP has temporary or unstable housing. Among Black/African American clients served by RWHAP, 8.0 percent have temporary housing, and 6.1 percent have unstable housing.
- Black/African American RWHAP clients are aging. Data show 44.5 percent of Black/African American RWHAP clients are aged 50 years and older.
- Among Black/African American male RWHAP clients, 56.9 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 2019, 85.2 percent of Black/African American clients receiving RWHAP HIV medical care are virally suppressed,* which is slightly lower than the national RWHAP average (88.1 percent).

- 84.5 percent of Black/African American men receiving RWHAP HIV medical care are virally suppressed.
- 86.7 percent of Black/African American women receiving RWHAP HIV medical care are virally suppressed.

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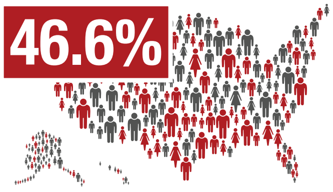
* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

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



46.6% of All RWHAP Clients

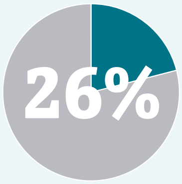
65.9% Live at or Below **100%** of the Federal Poverty Level

85.2% **2019** Are Virally Suppressed

44.5% Are Aged 50+

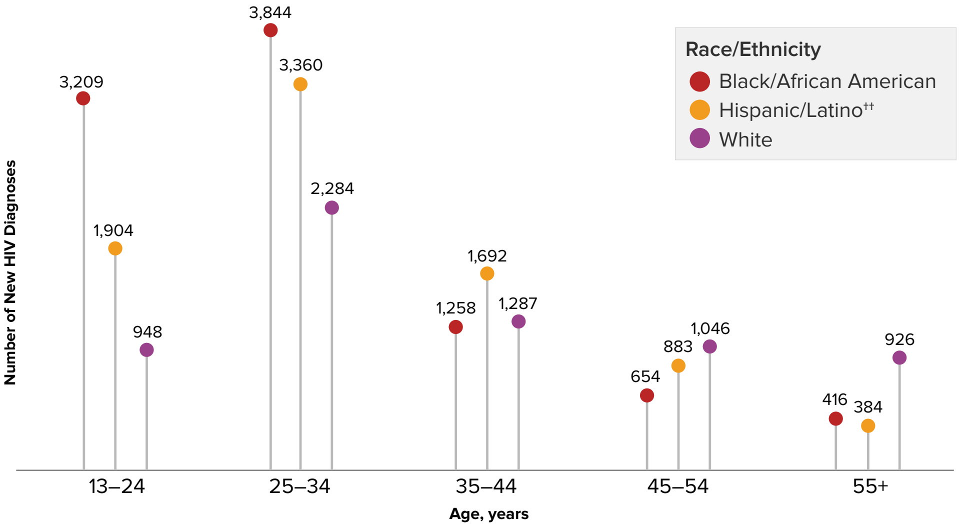
For more information on HRSA's Ryan White HIV/AIDS Program, visit: hab.hrsa.gov.

HIV and African American Gay and Bisexual Men



Of the **36,801 NEW HIV DIAGNOSES** in the US and dependent areas* in 2019, 26% (9,421) were among Black/African American† gay and bisexual men.‡ **

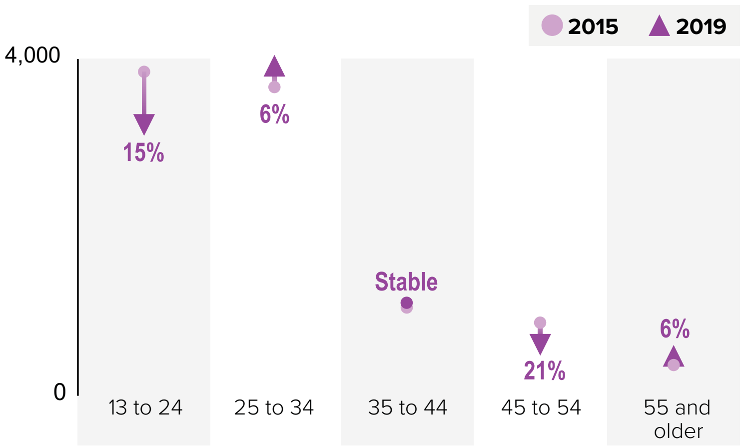
About 3 out of 4 Black/African American gay and bisexual men who received an HIV diagnosis were aged 13 to 34.



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

From 2015 to 2019, 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 people of African descent with ancestry in North America. This fact sheet uses *African American*, unless referencing surveillance data.

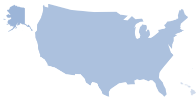
‡ This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who reported male-to-male sexual contact.

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

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

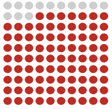
‡‡ In 50 states and the District of Columbia.

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.



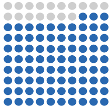
In 2019, an estimated **1.2 MILLION PEOPLE** had HIV. **Of those, 235,400 were Black/ African American gay and bisexual men.**

For every 100 people with HIV



87 knew their HIV status.

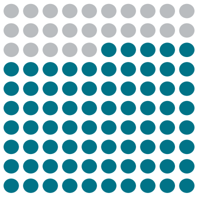
For every 100 Black/African American gay and bisexual men



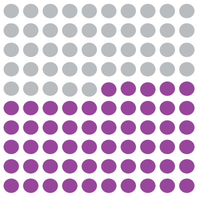
83 knew their HIV status.

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 remain virally suppressed) can stay healthy for many years and have effectively no risk of transmitting HIV to their sex partners.

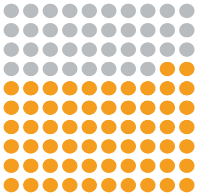
Compared to all people with diagnosed HIV, Black/African American gay and bisexual men have lower viral suppression rates. For every **100 Black/African American gay and bisexual man with diagnosed HIV in 2019:**[†††]



75 received some HIV care



55 were retained in care



62 were virally suppressed

For comparison, for every **100 people overall** with diagnosed HIV,
76 received some care, **58 were retained in care**, and **66 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 in the U.S.* initiative.

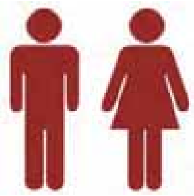
[***] Includes infections attributed male-to-male sexual contact only. Among Black/African American men with HIV attributed to male-to-male sexual contact andinjection drug use, 94% knew they had HIV.

[†††] In 44 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 data on HIV risk behaviors and barriers to HIV care, visit www.cdc.gov/hiv/group/msm/bmsm.html.

All content is based on the most recent data available in December 2021.



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

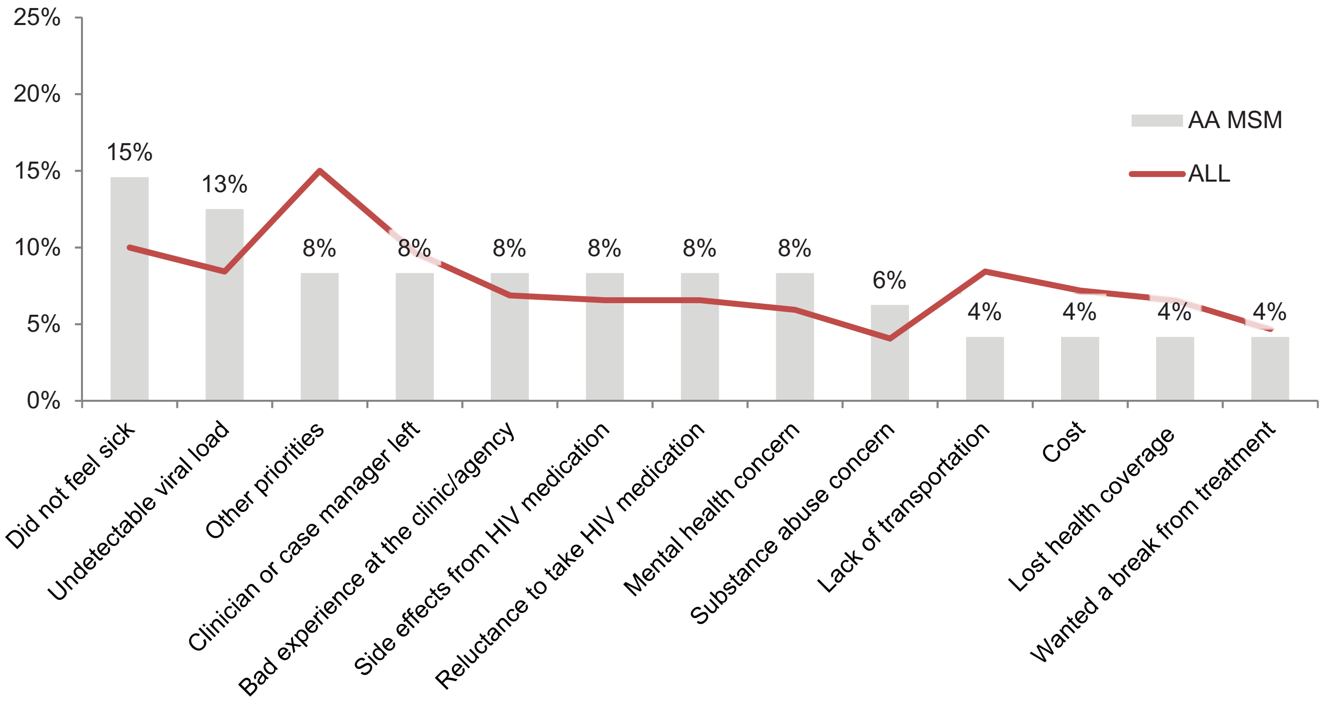
As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

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.



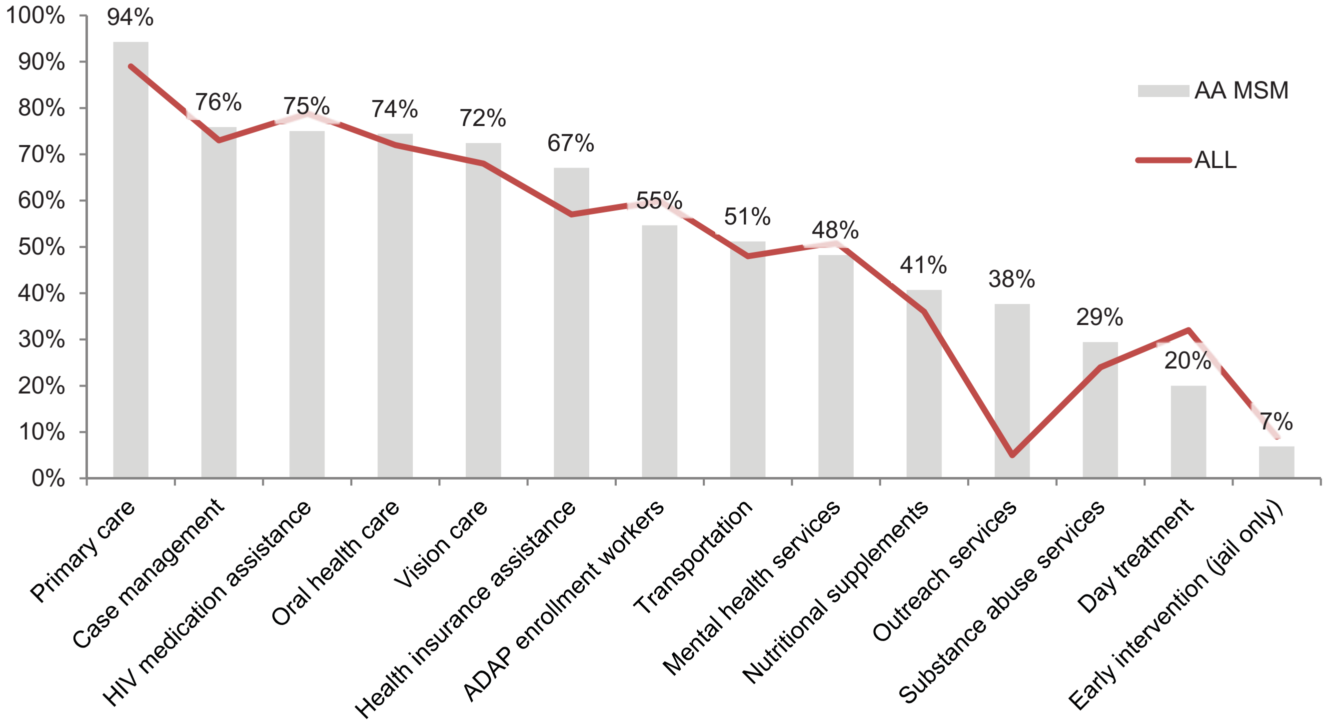
OVERALL RANKING OF FUNDED SERVICES, BY NEED

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.

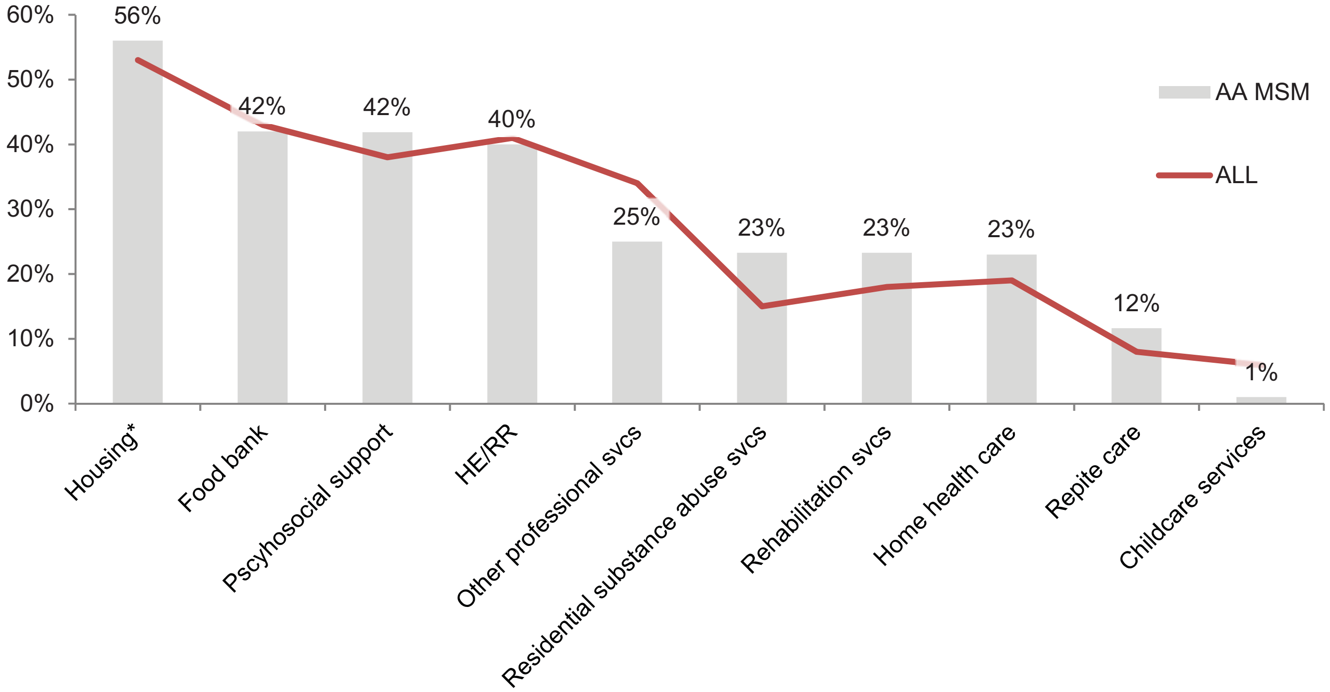
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, 56% of African American MSM reported housing as the most needed. Additionally, African American MSM participants reported a need for the following other/non-Ryan White funded HIV-related services: food bank (42%), psychosocial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

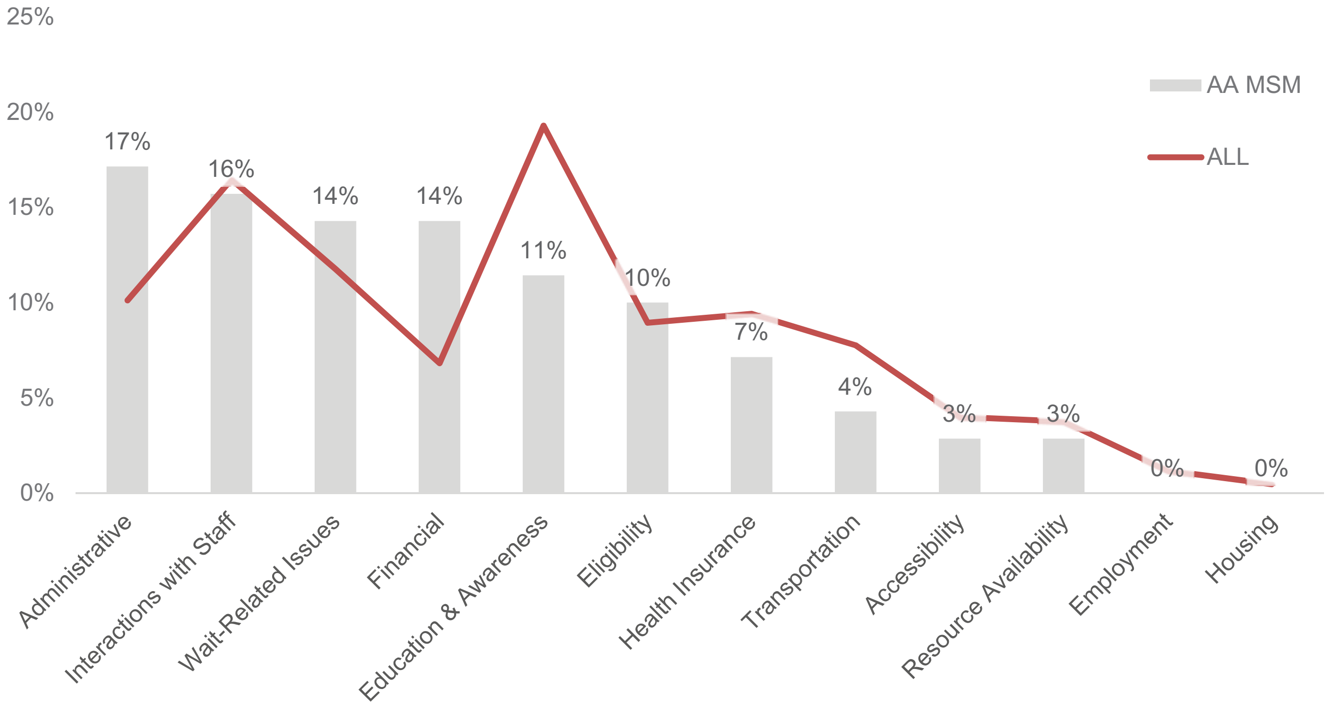
(**Graph 4**) Eighty-six (86) African American MSM participants cited barriers to Ryan White funded HIV care services. African American MSM participants most often cited barriers related to administrative issues (17%), interactions with staff (16%), wait related issues (14%), and financial barriers (14%).

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.

For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:

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Houston, TX 77027
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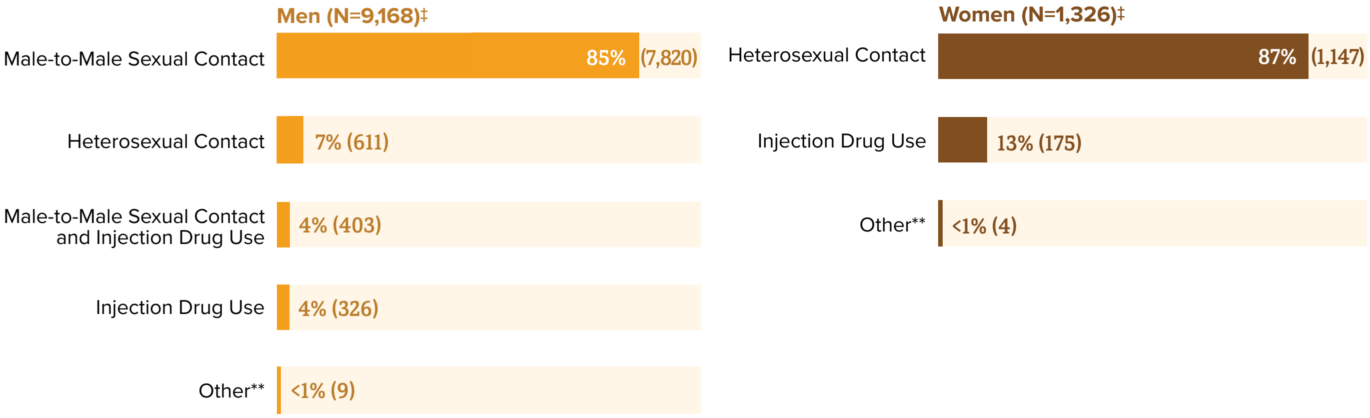
Fax: (713) 572-3740
Web: rwpchouston.org

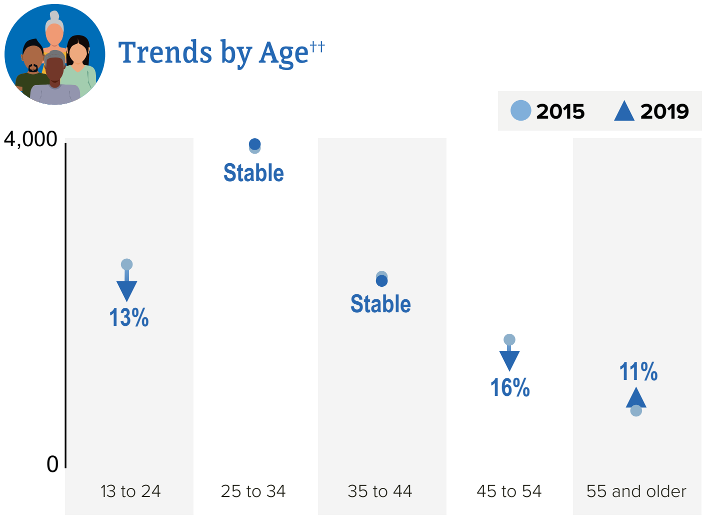
HIV and Hispanic/Latino People

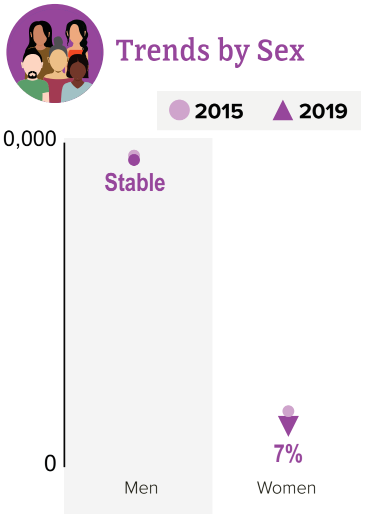
Of the **36,801 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2019, 29% (10,494) were among Hispanic/Latino people.[†]

Hispanic/Latino gay and bisexual men accounted for most new HIV diagnoses in 2019.



From 2015 to 2019, HIV diagnoses remained stable among Hispanic/Latino people overall. Although trends varied for different groups of Hispanic/Latino people, HIV diagnoses declined for some groups, including Hispanic/Latina women and Hispanic/Latino youth aged 13 to 24.


Trends by Age[††]


Trends by Sex

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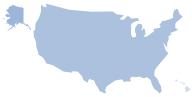
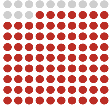
[*] American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
[†] Hispanic/Latino people can be of any race.
[‡] Based on sex assigned at birth and includes transgender people.
[**] Includes perinatal exposure, blood transfusion, hemophilia, and risk factors not reported or not identified.
[††] Does not include *perinatal* and *other* transmission categories.
[‡‡] In 50 states and the District of Columbia.
[***] In 44 states and the District of Columbia.

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



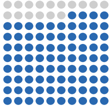
In 2019, an estimated **1.2 MILLION PEOPLE** had HIV.[#] **Of those, 294,200 were Hispanic/Latino people.**

For every 100 people with HIV



87 knew their HIV status.

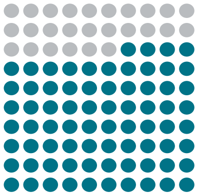
For every 100 Hispanic/Latino people with HIV



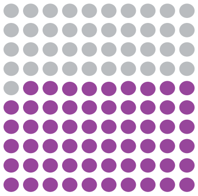
84 knew their HIV status.

It is important for Hispanic/Latino 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.

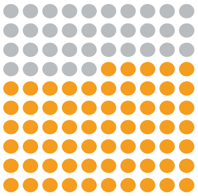
Compared to all people with diagnosed HIV, Hispanic/Latino people have about the same viral suppression rates. For every **100 Hispanic/Latino people with diagnosed HIV in 2019**:***



74 received some HIV care



59 were retained in care



65 were virally suppressed

For comparison, for every **100 people overall** with diagnosed HIV, **76 received some care**, **58 were retained in care**, and **66 were virally suppressed**.

There are several challenges that place some Hispanic/Latino people 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)

Hispanic/Latino people have higher rates of other 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 Hispanic/Latino people.

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 people to get HIV services.

How is CDC making a difference for Hispanic/Latino 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 in the U.S.* 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 data on HIV risk behaviors and barriers to HIV care, visit www.cdc.gov/hiv/group/racialethnic/hispaniclatinos.

All content is based on the most recent data available in October 2021.

Hispanic/Latino Clients: HRSA's Ryan White HIV/AIDS Program, 2019

Population Fact Sheet | June 2021

HRSA
Ryan White HIV/AIDS Program

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—nearly 568,000 people in 2019—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care, treatment, and support services for people with HIV to improve health outcomes and reduce HIV transmission.

Of the more than half a million clients served by RWHAP, 73.4 percent are from racial/ethnic minority populations, with 23.3 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 male.** Data show that 75.6 percent of clients are male, 21.7 percent are female, and 2.6 percent are transgender.
- **The majority of Hispanic/Latino clients served by RWHAP are low income.** Data show that 62.8 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 (60.7 percent).
- **Data show that 4.8 percent of Hispanic/Latino RWHAP clients have unstable housing.** This percentage is slightly lower than the national RWHAP average (5.5 percent).
- **The Hispanic/Latino RWHAP client population is aging.** Hispanic/Latino clients aged 50 years and older account for 42.0 percent of all Hispanic/Latino RWHAP clients, which is lower than the national RWHAP average (46.8 percent).
- **Among Hispanic/Latino male RWHAP clients, 66.2 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 2019, 90.1 percent of Hispanic/Latino RWHAP clients receiving HIV medical care were virally suppressed,* which is slightly higher than the national RWHAP average (88.1 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.

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

23.3% of All RWHAP Clients

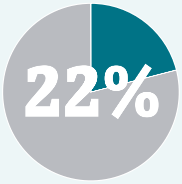
62.8% Live at or Below **100%** of the Federal Poverty Level

90.1% 2019 Are Virally Suppressed

42.0% Are Aged 50+

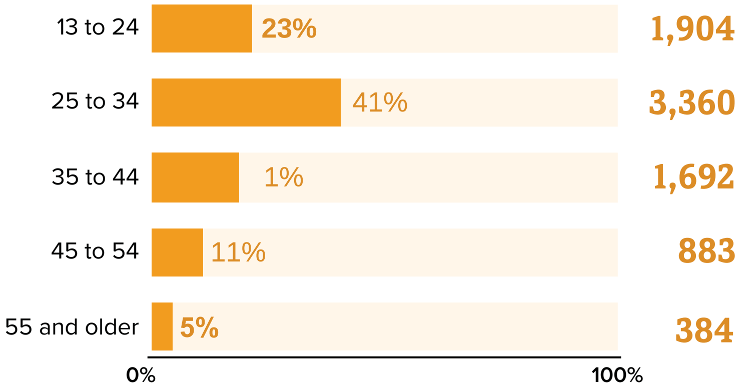
For more information on HRSA's Ryan White HIV/AIDS Program, visit: hab.hrsa.gov.

HIV and Hispanic/Latino Gay and Bisexual Men



Of the **36,801 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2019, 22% (8,223) were among Hispanic/Latino[†] gay and bisexual men.[‡][**]

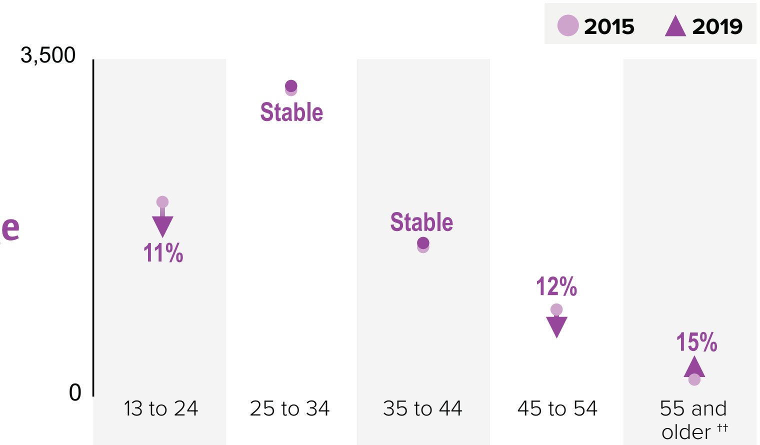
About 2 out of 3 Hispanic/Latino gay and bisexual men who received an HIV diagnosis were aged 13 to 34.



Total may not equal 100% due to rounding.

Though HIV diagnoses remained stable among Hispanic/Latino gay and bisexual men overall from 2015 to 2019, 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.

[†] Hispanic/Latino people can be of any race.

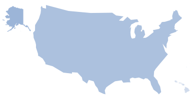
[‡] This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who reported male-to-male sexual contact aged 13 and older.

[**] 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.

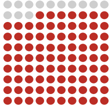
[‡‡] In 50 states and the District of Columbia.

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.



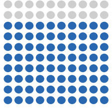
In 2019, an estimated **1.2 MILLION PEOPLE** had HIV.‡ **Of those, 202,000 were Hispanic/Latino gay and bisexual men.**

For every 100 people with HIV



87 knew their HIV status.

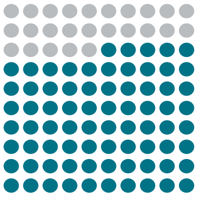
For every 100 Hispanic/Latino gay and bisexual men with HIV



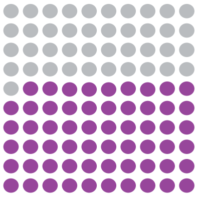
80 knew their HIV status.***

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 remain virally suppressed) can stay healthy for many years and have effectively no risk of transmitting HIV to their sex partners.

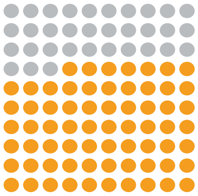
Compared to all people with diagnosed HIV, Hispanic/Latino gay and bisexual men have about the same viral suppression rates. For every **100 Hispanic/Latino gay and bisexual men with diagnosed HIV in 2019**:†††



75 received some HIV care



59 were retained in care



67 were virally suppressed

For comparison, for every **100 people overall** with diagnosed HIV, **76 received some care**, **58 were retained in care**, and **66 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

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.

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.

Low PrEP Use

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

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 in the U.S.* initiative.

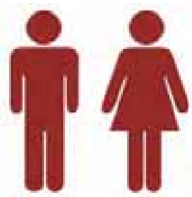
*** Includes infections attributed male-to-male sexual contact *only*. Among Hispanic/Latino men with HIV attributed to male-to-male sexual contact *and* injection drug use, 91% knew they had HIV.

††† In 44 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 data on HIV risk behaviors and barriers to HIV care, visit www.cdc.gov/hiv/group/msm/hispanic-latino.html.

All content is based on the most recent data available in October 2021.



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).

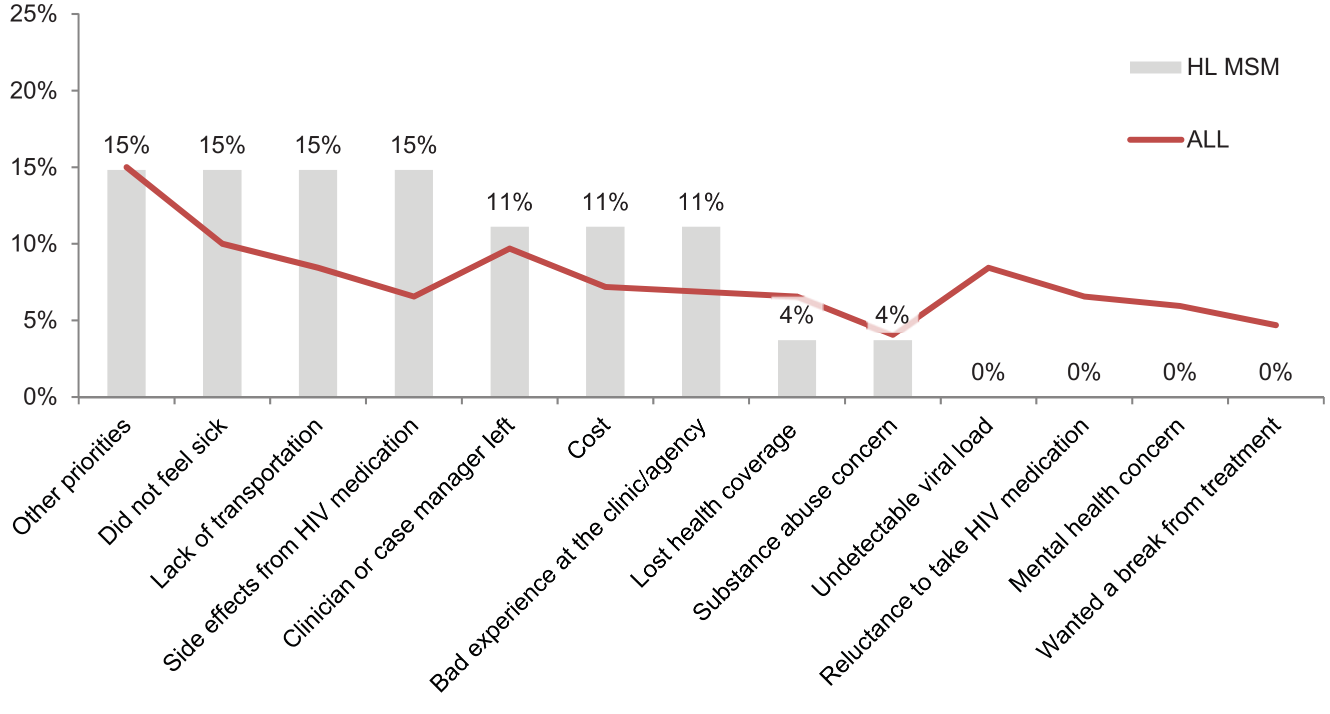
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months of more since their diagnosis, 81% of Hispanic/Latino MSM needs assessment participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering 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

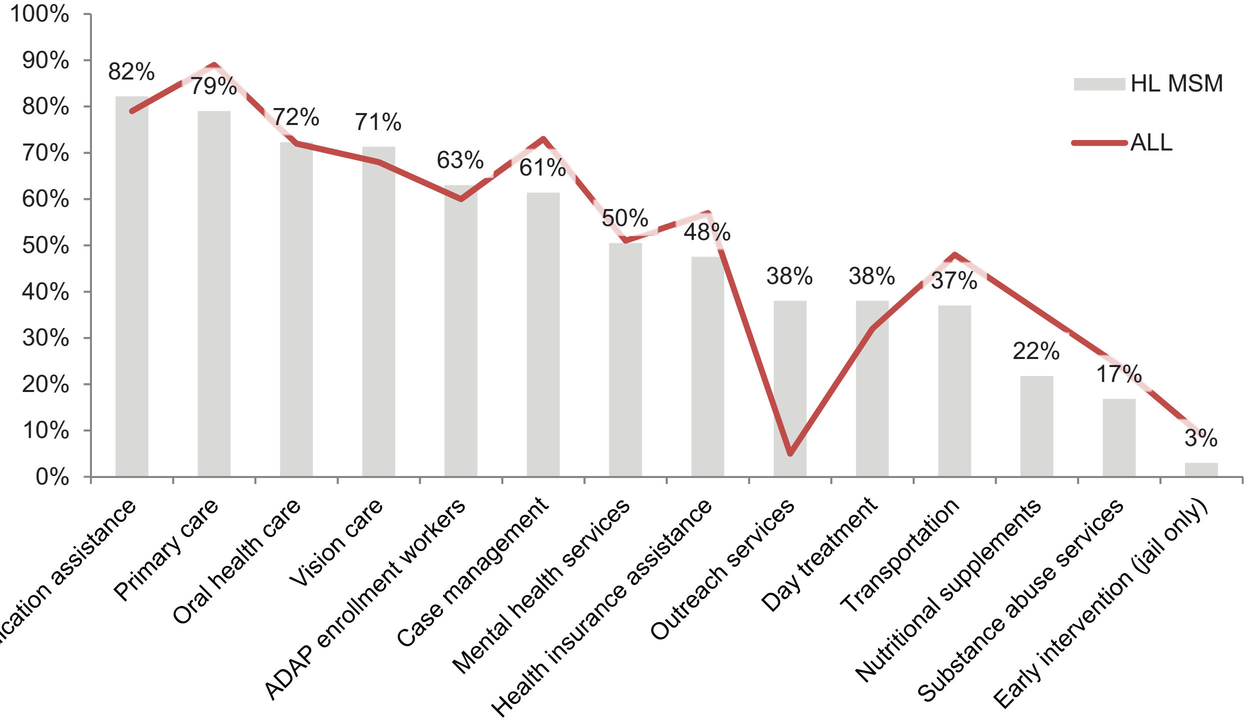
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services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

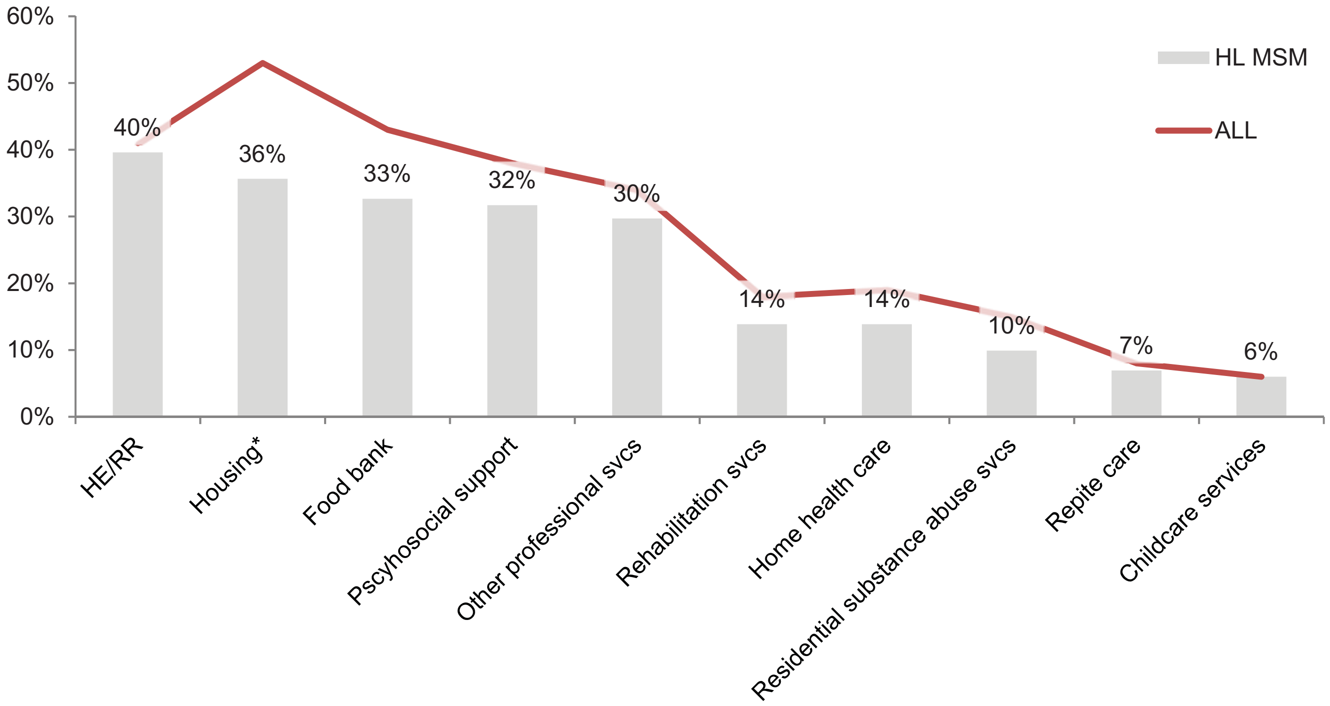
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, 40% of Hispanic/Latino MSM reported need for health education & risk reduction services as the most needed. Additionally, Hispanic/Latino MSM reported a need for housing (36%), food bank (33%), and psychosocial support services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

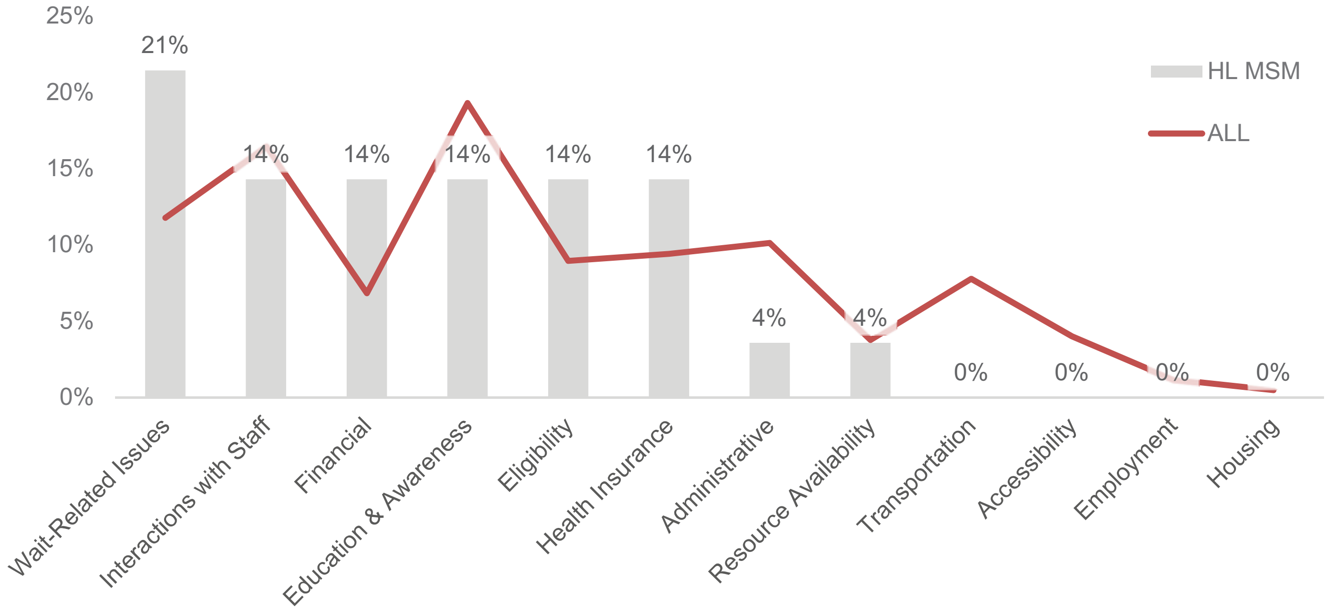
(**Graph 4**) Sixteen (16) Hispanic/Latino MSM participants cited barriers to Ryan White funded HIV care services. Hispanic/Latino MSM participants most often cited barriers related to wait issues (21%), interactions with staff at the agency or clinic, financial barriers, and education and awareness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

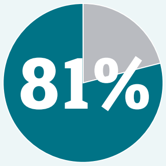


Works Cited

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.

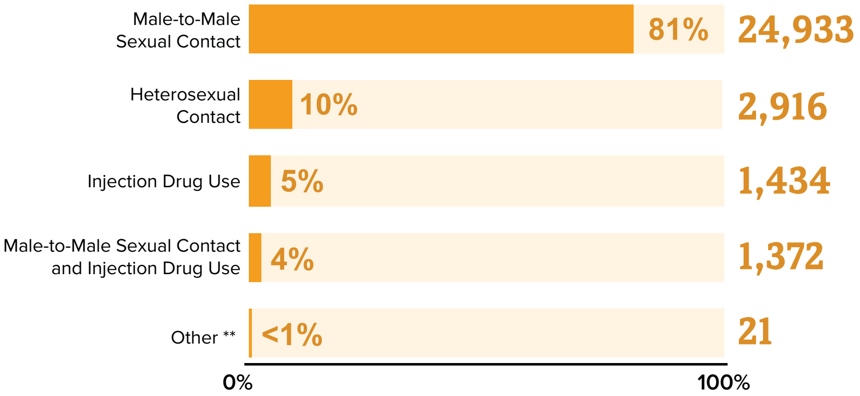
For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
Houston Area Ryan White Planning Council
2223 West Loop South #240
Houston, TX 77027
Tel: (832) 927-7926
Fax: (713) 572-3740
Web: rwpchouston.org

HIV and Men



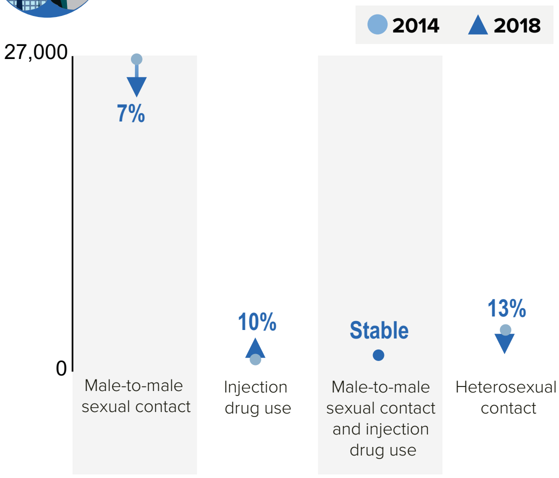
Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2018, 81% were among men.[†‡]

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

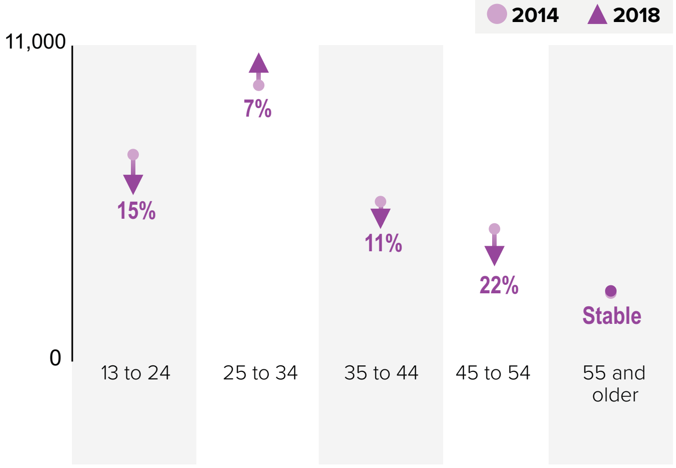


From 2014 to 2018, HIV diagnoses decreased 7% among men overall, but trends varied for different groups of men.

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.

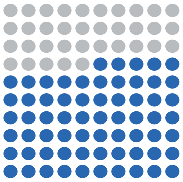
Men who don't know they have HIV cannot get the care and treatment they need to stay healthy.

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

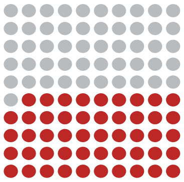
6 in 7
men knew they had the virus.

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.

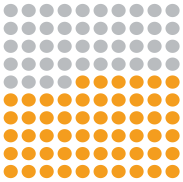
When compared to people overall with HIV, men have the same viral suppression rates. But more work is needed to increase these rates. In 2018, for every **100 men with HIV**:[††]



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.

Sexual Behaviors

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

Sexually Transmitted Diseases (STDs)

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

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.

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.

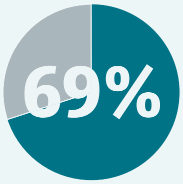
Ending the HIV Epidemic

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 they are used, read the "Technical Notes" in the HIV surveillance reports at www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

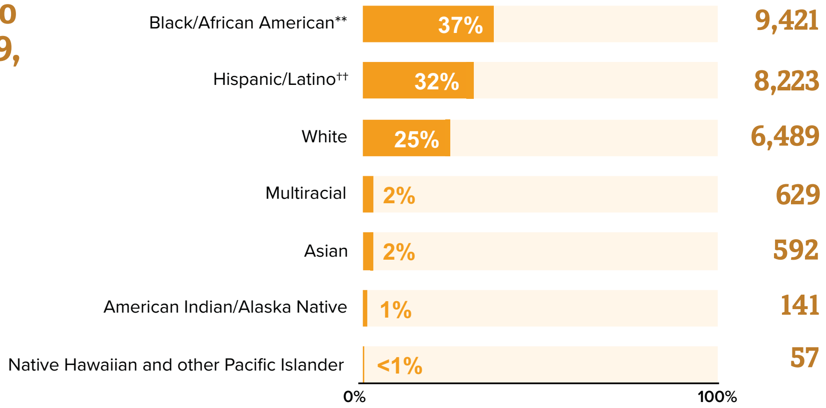
For more information visit www.cdc.gov/hiv

HIV and Gay and Bisexual Men



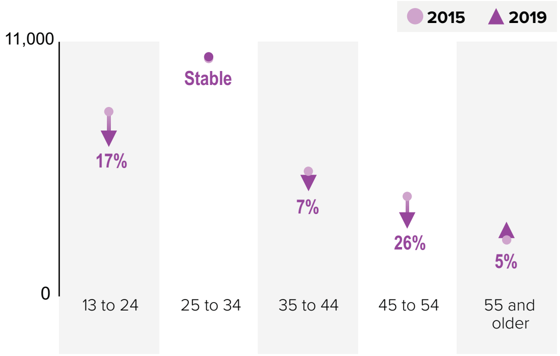
Of the **36,801 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2019, 69% (25,552) were among gay and bisexual men.[†‡]

Among gay and bisexual men who received an HIV diagnosis in 2019, racial and ethnic disparities continue to exist.

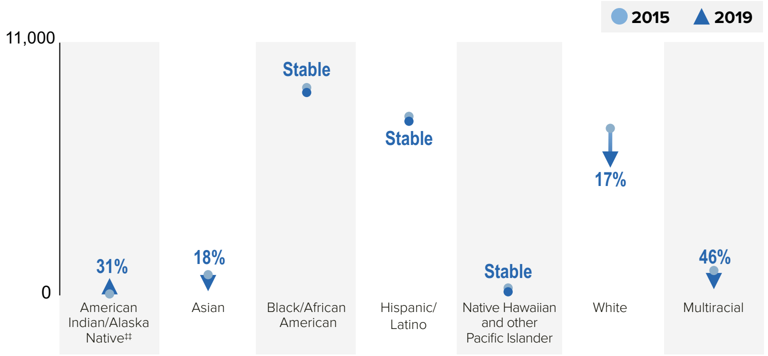


From 2015 to 2019, HIV diagnoses decreased 9% among gay and bisexual men overall.

Trends by Age



Trends 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.

[†] 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).

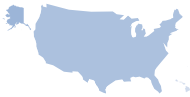
[**] *Black* refers to people having origins in any of the Black racial groups of Africa. *African American* is a term often used for people of African descent with ancestry in North America.

[††] Hispanic/Latino people can be of any race.

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

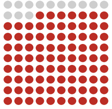
Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

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



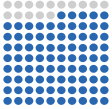
In 2019, an estimated **1.2 MILLION PEOPLE** had HIV.*** **Of those, 754,700 were gay and bisexual men.**

For every 100 people with HIV



87 knew their HIV status.

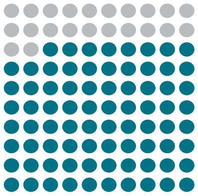
For every 100 gay and bisexual men with HIV



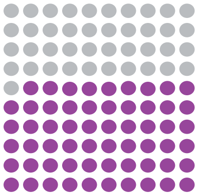
85 knew their HIV status.†††

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 remain virally suppressed) can stay healthy for many years and have effectively no risk of transmitting HIV to their sex partners.

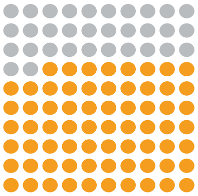
Compared to all people with diagnosed HIV, gay and bisexual men have higher viral suppression rates. For every **100 gay and bisexual men with diagnosed HIV in 2019:**‡‡‡



78 received some HIV care



59 were retained in care



68 were virally suppressed

For comparison, for every **100 people overall** with diagnosed HIV, **76 received some care**, **58 were retained in care**, and **66 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 medicines 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.

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 in the U.S.* initiative.

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

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

‡‡‡ In 44 states and the District of Columbia.

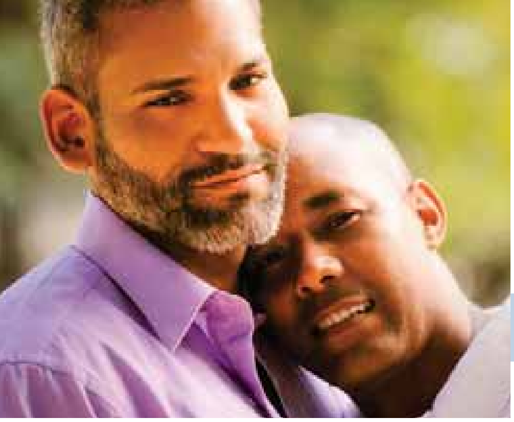
For more information about HIV surveillance data, read the "Technical Notes" in the HIV surveillance reports at www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

For data on HIV risk behaviors and barriers to HIV care, visit www.cdc.gov/hiv/group/msm.

All content is based on the most recent data available in September 2021.

Gay, Bisexual, and Other Men Who Have Sex with Men (MSM) Clients: HRSA's Ryan White HIV/AIDS Program, 2019

Population Fact Sheet | June 2021



HRSA
Ryan White HIV/AIDS Program

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—nearly 568,000 people in 2019—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care, treatment, and support services for people with HIV to improve health outcomes and reduce HIV transmission.

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, 47.2 percent are MSM. Of male clients served by RWHAP, 65.7 percent are MSM.

Below are more details about this RWHAP client population:

- The majority of MSM clients served by RWHAP are a diverse population. Data show that 64.6 percent of MSM RWHAP clients served are from racial/ethnic minority populations. Among MSM, 35.4 percent identify as white, 35.4 percent identify as Black/African American, and 25.6 percent identify as Hispanic/Latino.
- Approximately half of MSM clients served by RWHAP are low income. Of the MSM RWHAP clients served, 51.7 percent are living at or below 100 percent of the federal poverty level, which is lower than the national RWHAP average (60.7 percent).
- Among the MSM RWHAP clients, 4.8 percent have unstable housing. This percentage is slightly lower than the national RWHAP average (5.5 percent).
- The MSM RWHAP client population is aging. MSM clients aged 50 years and older account for 39.9 percent of all RWHAP MSM clients. This percentage is lower than the national RWHAP average (46.8 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 2019, 89.1 percent of MSM receiving RWHAP HIV medical care were virally suppressed,* which is slightly higher than the national RWHAP average (88.1 percent).

- 81.3 percent of young MSM (aged 13–24) receiving RWHAP HIV medical care are virally suppressed.
- 77.8 percent of young Black/African American MSM (aged 13–24) receiving RWHAP HIV medical care are virally suppressed.

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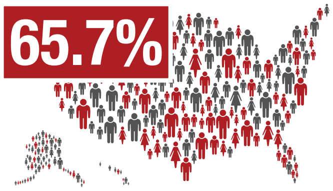
* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

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



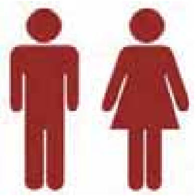
65.7% of All Male RWHAP Clients

51.7% Live at or Below **100%** of the Federal Poverty Level

89.1% 2019 Are Virally Suppressed

39.9% Are Aged 50+

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



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

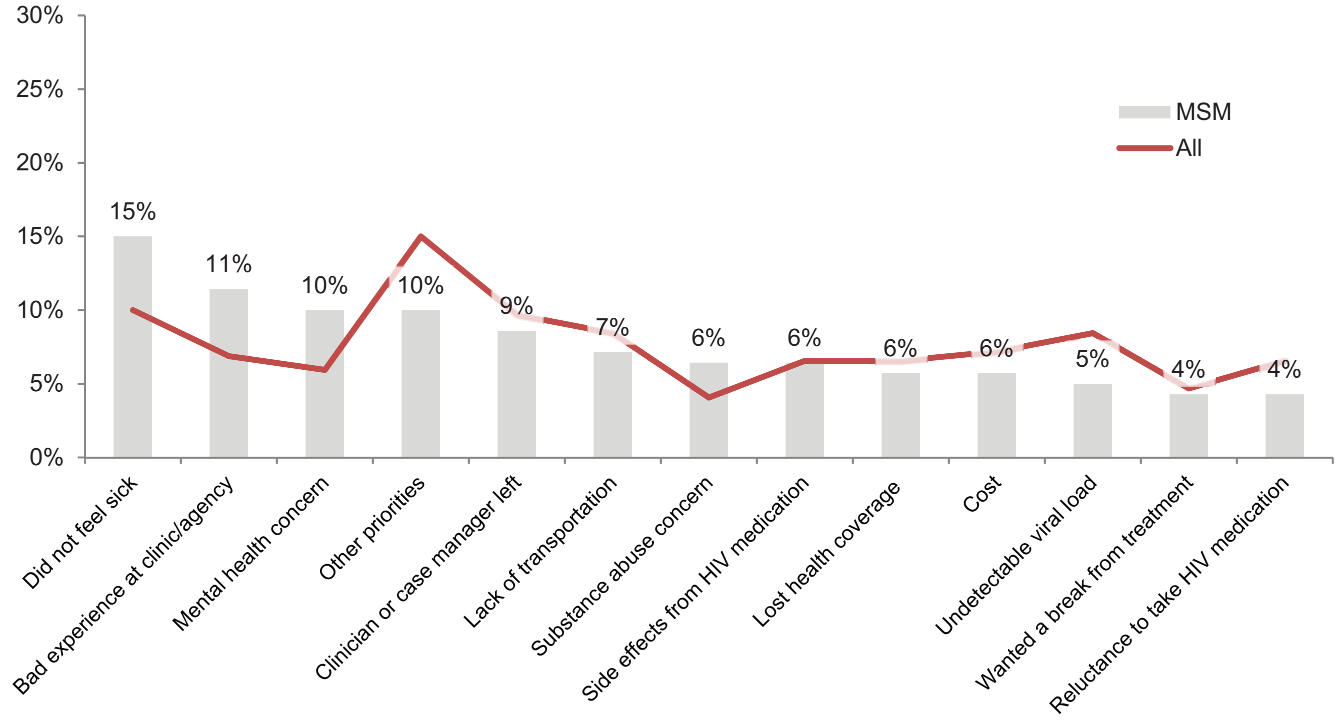
As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

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.



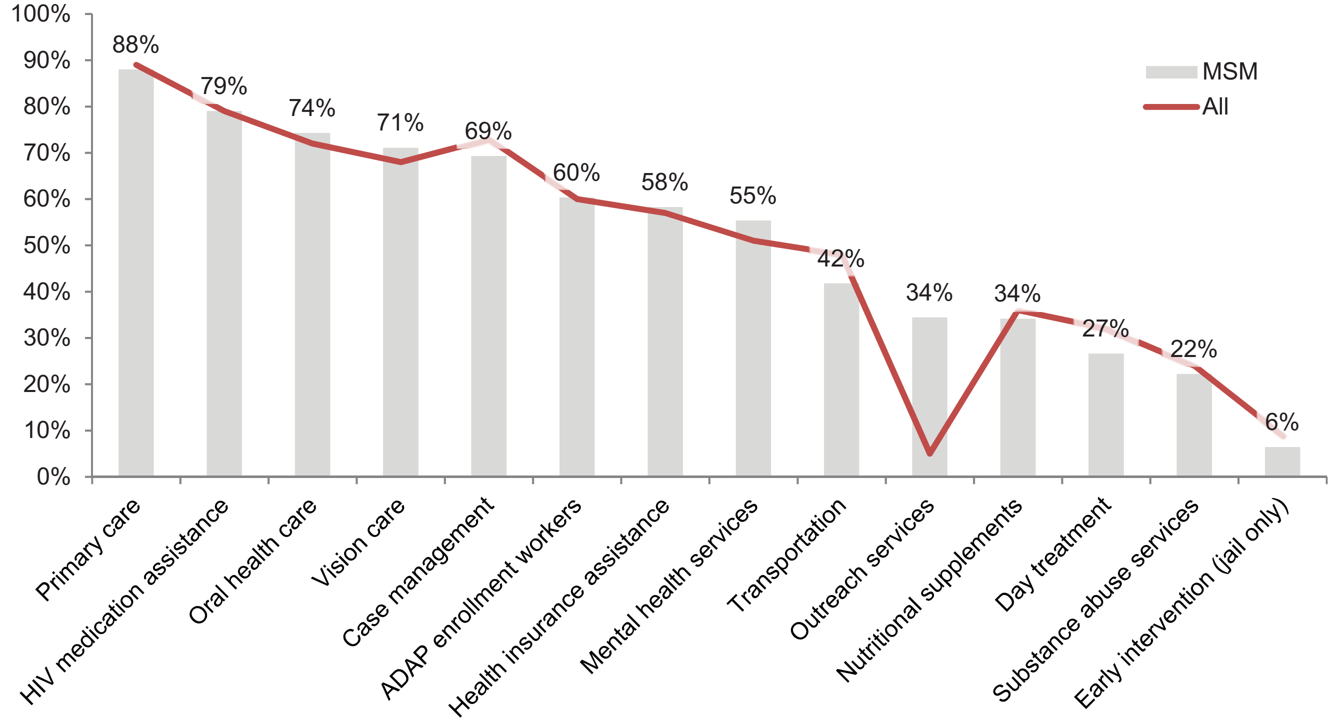
OVERALL RANKING OF FUNDED SERVICES, BY NEED

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.

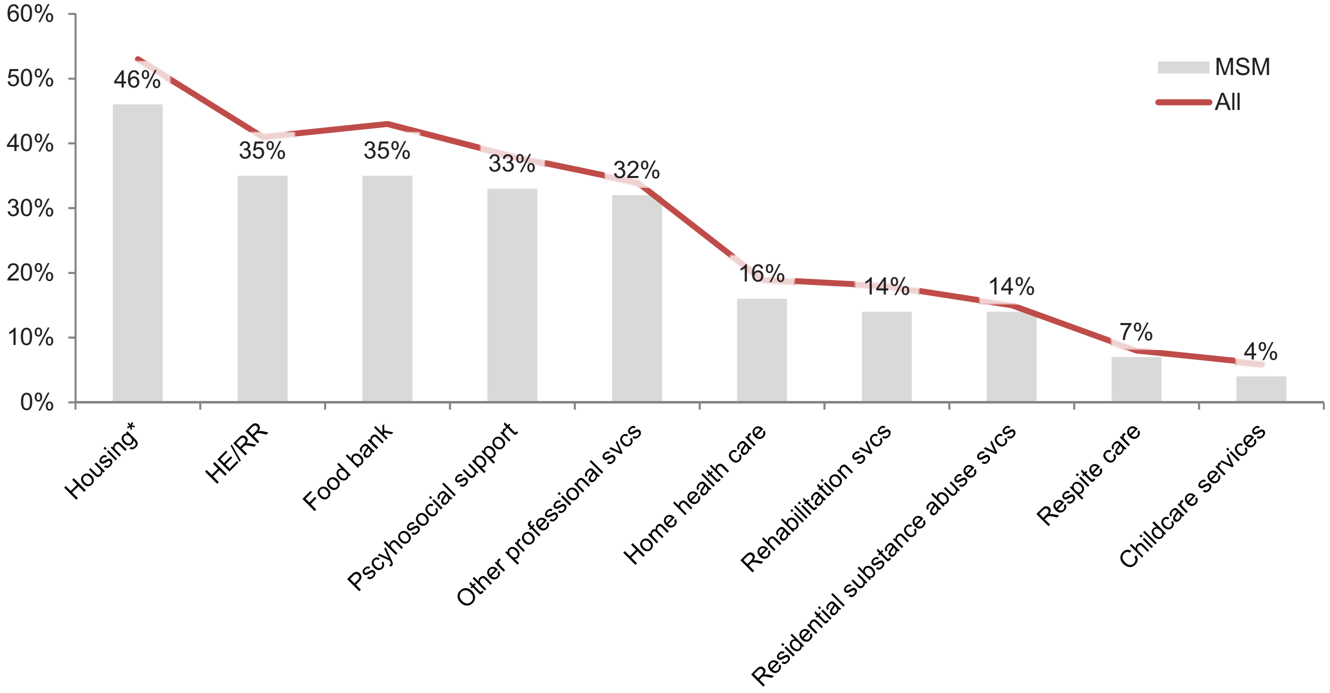
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, forty-six percent (46%) of MSM participants reported housing as the most needed. Additionally, MSM participants reported a need for health education & risk reduction (HE/RR) (35%), food bank (35%), and psychosocial support (33%).

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.

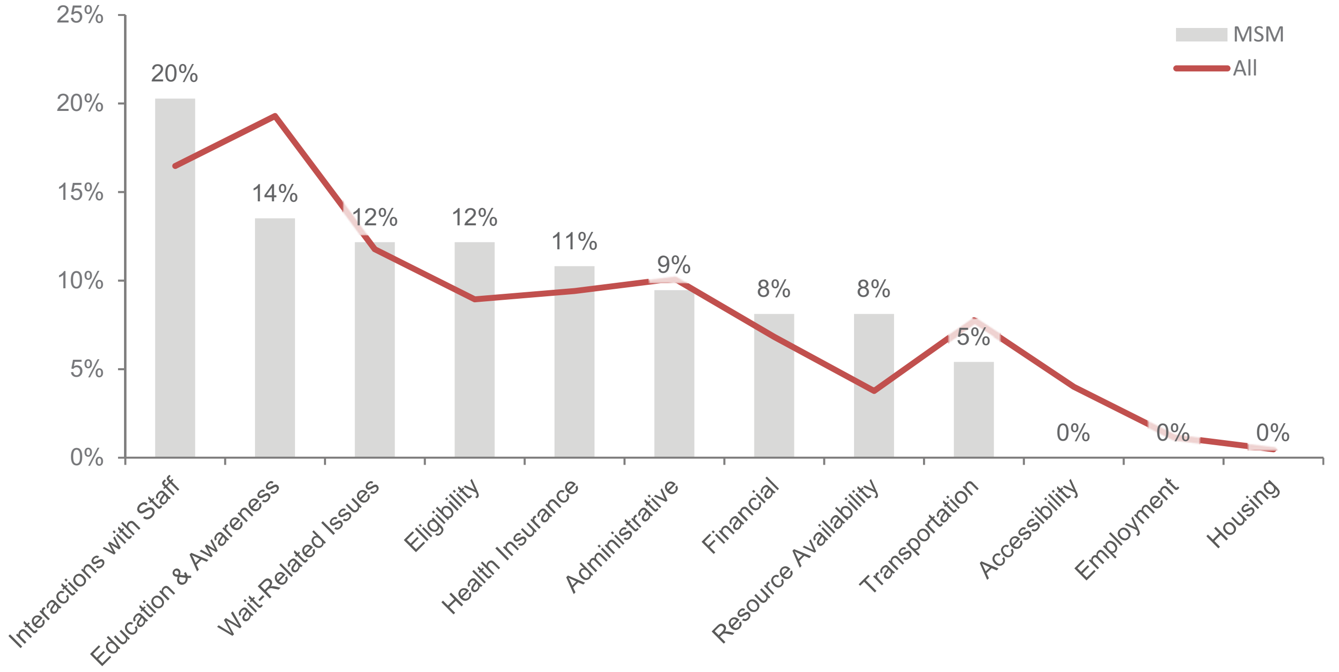
(**Graph 4**) Ninty (90) MSM participants cited barriers to Ryan White funded HIV care services. MSM participants most often cited interactions with staff (20%), service education & awareness (14%), as well as wait and eligibility related barriers (both 12%).

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.

For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
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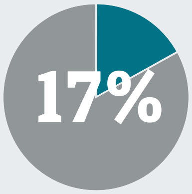
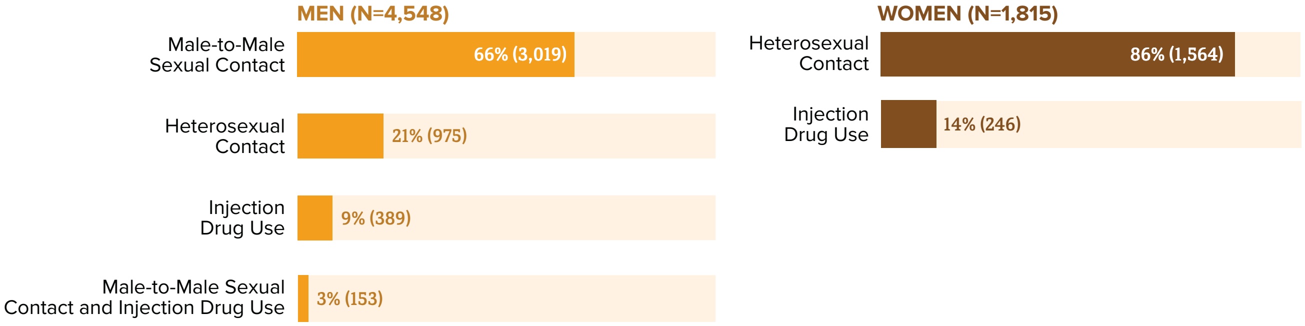
HIV and Older Americans



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

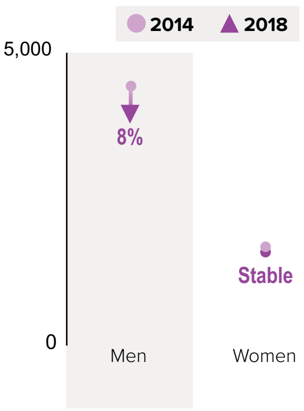
Among people aged 50 and older, most new HIV diagnoses were among men.†



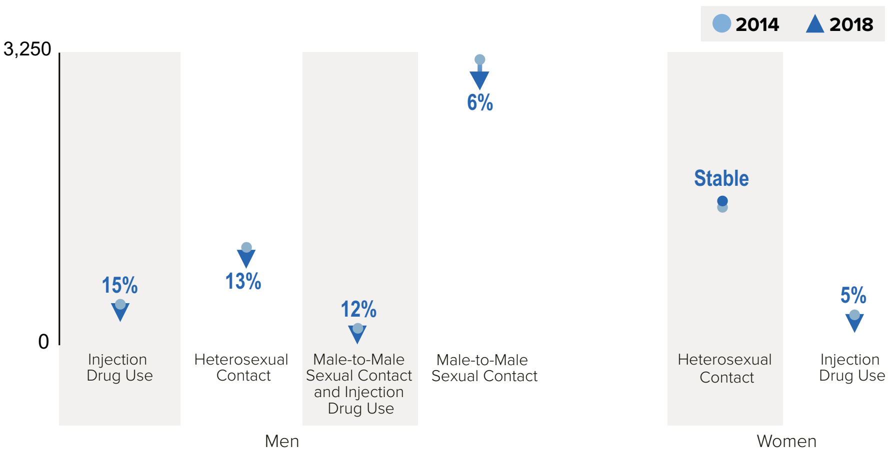
Totals may not equal 100% due to rounding.

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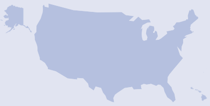
* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

† 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.

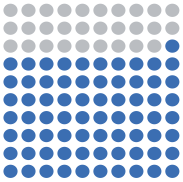


At the end of 2018, an estimated **1.2 MILLION AMERICANS** had HIV.‡ Of those, 379,000 were aged 55 and older.

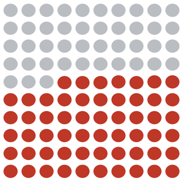
9 in 10 people aged 55 and older knew they had the virus.

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.

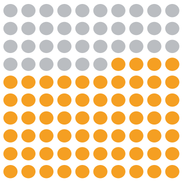
Compared to all people with HIV, people aged 55 and older have higher viral suppression rates. In 2018, for every **100 people aged 55 and older with HIV**: ‡



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

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

Older Adult Clients: HRSA's Ryan White HIV/AIDS Program, 2019

Population Fact Sheet | June 2021

Ryan White HIV/AIDS Program

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—nearly 568,000 people in 2019—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care, treatment, and support services for people with HIV to improve health outcomes and reduce HIV transmission.

The RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.8 percent are aged 50 years and older—an increase from 31.6 percent in 2010. Below are more details about this RWHAP client population:

- The majority of RWHAP clients aged 50 years and older are a diverse population. Among RWHAP clients aged 50 years and older, 67.9 percent are from racial/ethnic minority populations; 44.2 percent of RWHAP clients in this age group identify as Black/African American, which is slightly lower than the national RWHAP average (46.6 percent). Additionally, 20.9 percent of RWHAP clients in this age group identify as Hispanic/Latino, which is slightly lower than the national RWHAP average (23.3 percent).
- The majority of RWHAP clients aged 50 years and older are male. Data show 70.9 percent of clients aged 50 years and older are male, 27.8 percent are female, and 1.3 percent are transgender.
- The majority of RWHAP clients aged 50 years and older are low income. Among RWHAP clients aged 50 years and older, 59.1 percent are living at or below 100 percent of the federal poverty level, which is slightly lower than the national RWHAP average (60.7 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 (5.5 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 2019, 90.9 percent of clients aged 50 years and older receiving RWHAP HIV medical care are virally suppressed,* which is slightly higher than the national RWHAP average (88.1 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

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

46.8%

of All RWHAP Clients are Aged 50+

59.1% Live at or Below **100%** of the Federal Poverty Level

$

90.9% **2019** Are Virally Suppressed

4.2% Have Unstable Housing

For more information on HRSA's Ryan White HIV/AIDS Program, 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

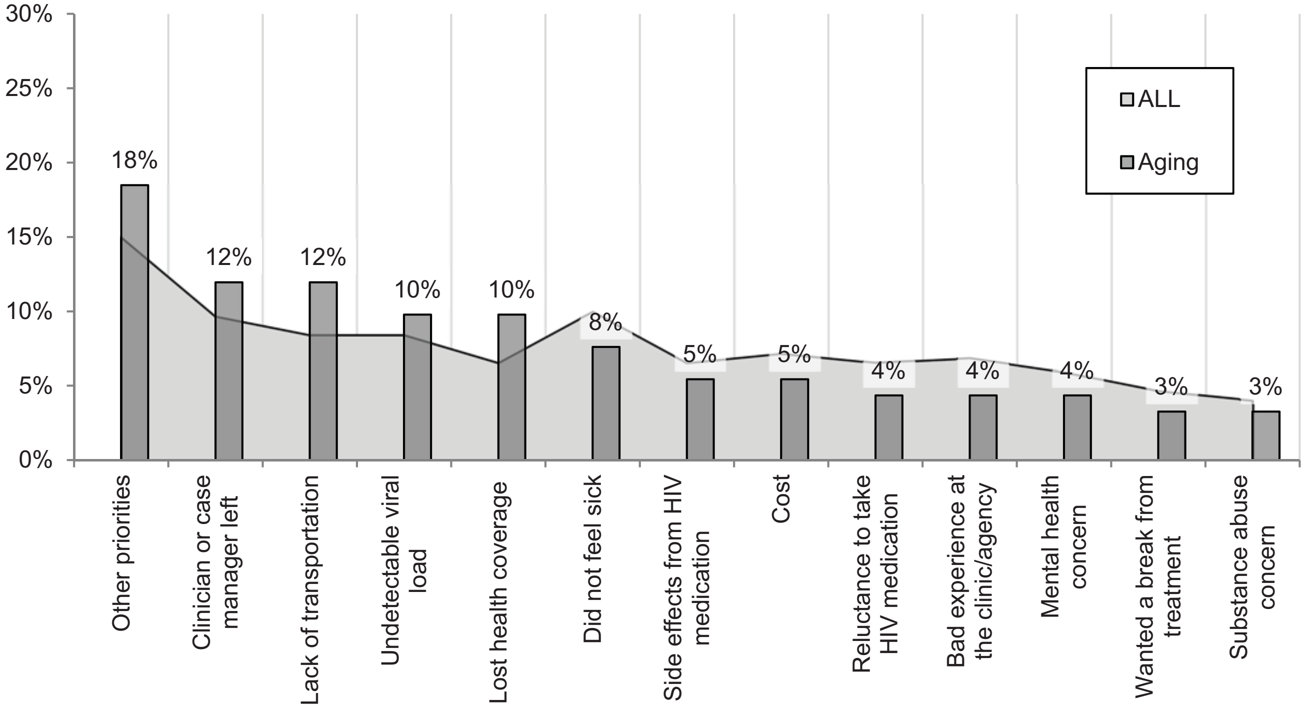
As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighed using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (see: *Methodology*, full document).

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

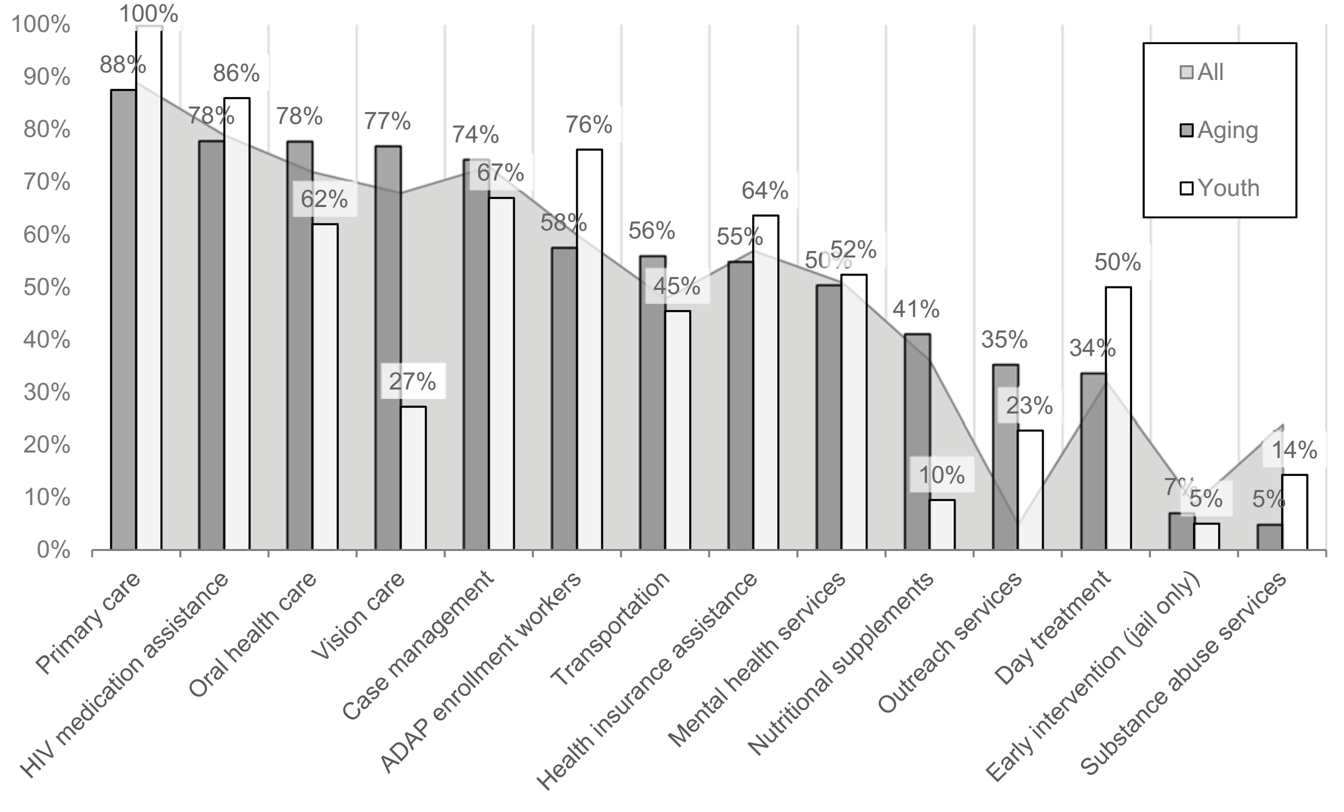
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services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

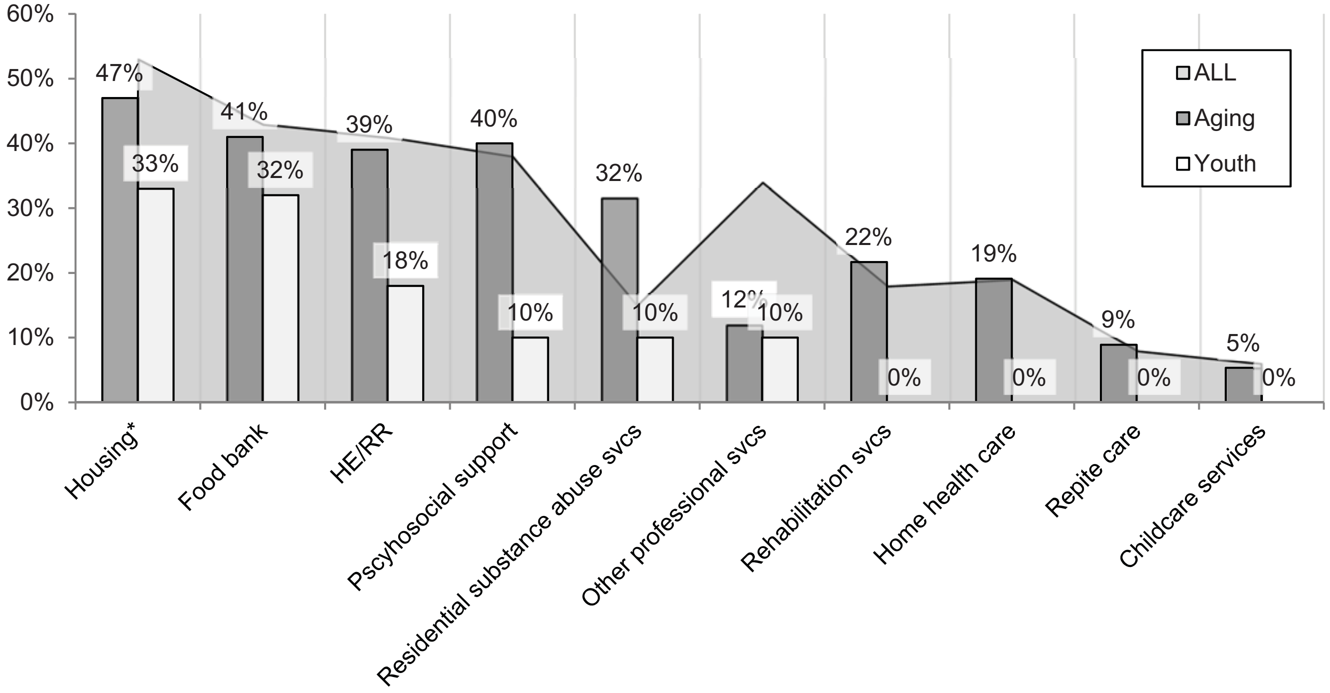
(**Graph 3**) From the 10 other/non-Ryan White funded HIV related services, the greatest proportion of youth participants reported needing housing (33%), food bank (32%), and health education and risk reduction services (18%). Among the aging needs assessment participants, the greatest reported non-Ryan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

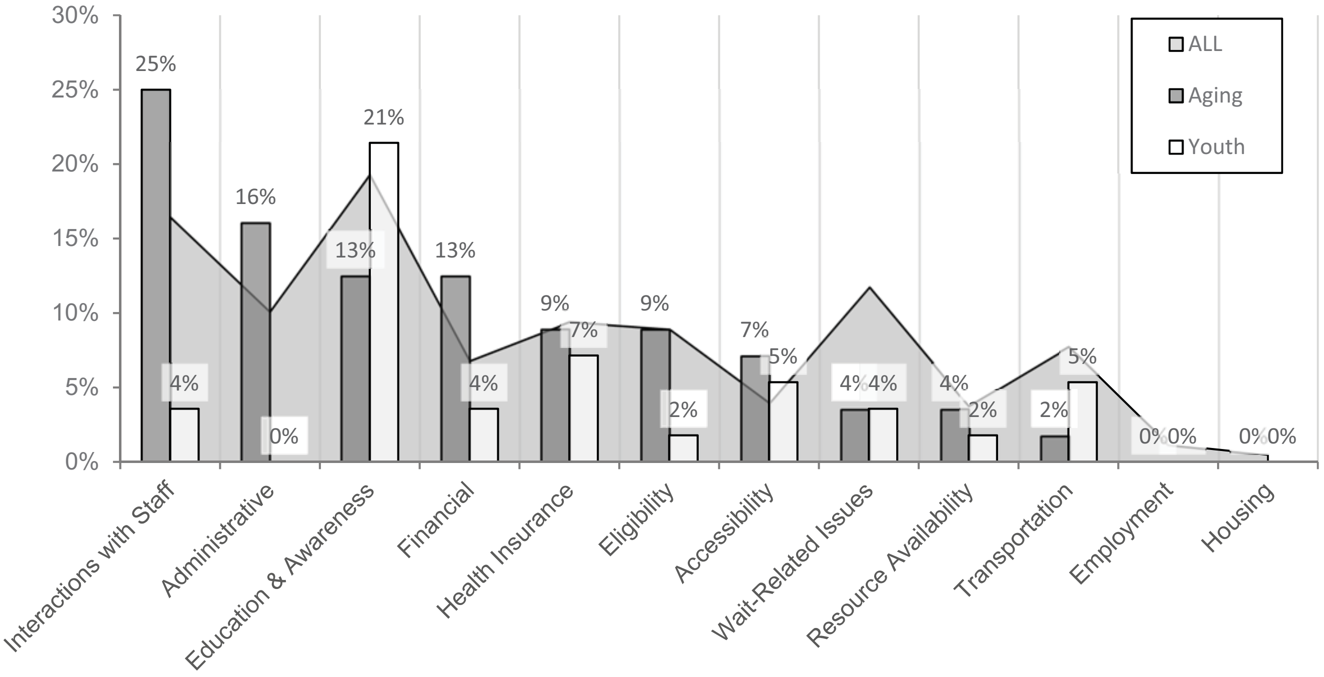
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant 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.



For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:

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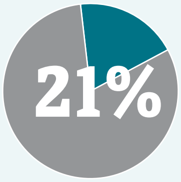
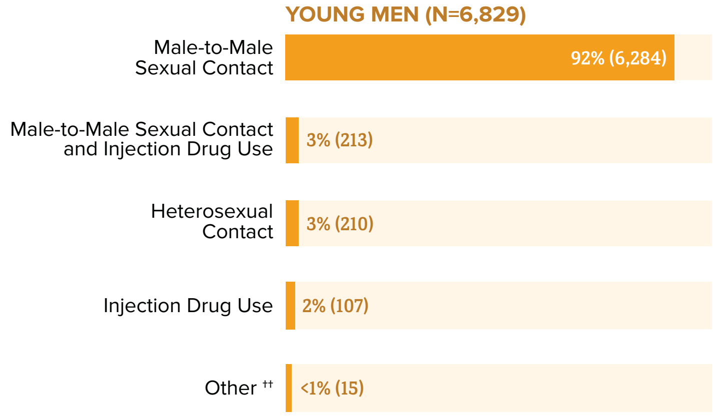
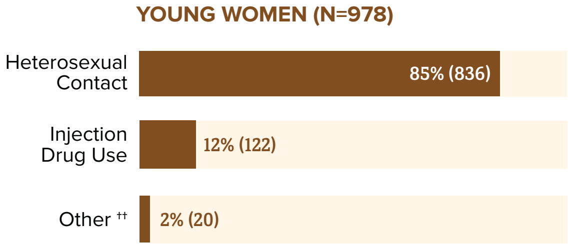
HIV and Youth



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. ‡ **

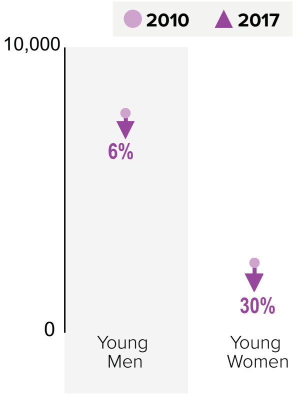




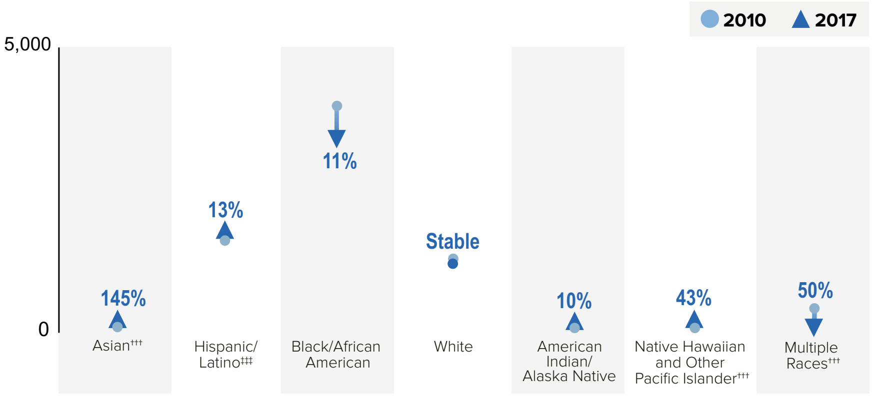
Totals may not equal 100% due to rounding.

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.

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

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

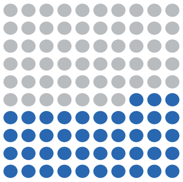
At the end of 2016, an estimated 1.1 MILLION PEOPLE had HIV.[#] Of those, 50,900 were young people.

Nearly 4 in 7

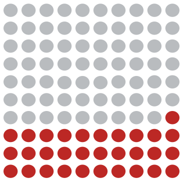
youth knew they had the virus.

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.

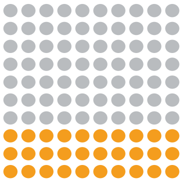
Compared to all people with HIV, youth have the lowest rates of viral suppression. **For every 100 youth with HIV:** [‡]



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.

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.

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.

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.

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 April 2020.

Youth and Young Adult Clients: HRSA's Ryan White HIV/AIDS Program, 2019

Population Fact Sheet | June 2021

HRSA
Ryan White HIV/AIDS Program

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—nearly 568,000 people in 2019—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care, treatment, and support services for people with HIV to improve health outcomes and reduce HIV transmission.

Youth and young adults aged 13–24 years represent 3.9 percent (more than 22,000 clients) of the more than half a million RWHAP clients. Below are more details about this RWHAP client population:

- The majority of youth and young adult RWHAP clients aged 13–24 years are a diverse population. Among RWHAP clients in this age group, 86.4 percent are from racial/ethnic minority populations. Data show 59.6 percent of youth and young adult RWHAP clients identify as Black/African American, which is higher than the national RWHAP average (46.6 percent). Hispanics/Latinos represent 22.7 percent of youth and young adult RWHAP clients, which is slightly lower than the national RWHAP average (23.3 percent).
- The majority of RWHAP clients aged 13–24 years are male. Data show that 73.7 percent of clients aged 13–24 years are male, 22.6 percent are female, and 3.7 percent are transgender.
- The majority of RWHAP clients aged 13–24 years are low income. Among youth and young adult RWHAP clients, 68.9 percent are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (60.7 percent).
- Data show that 5.8 percent of RWHAP clients aged 13–24 years have unstable housing. This percentage is slightly higher than the national RWHAP average (5.5 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 2019, 79.4 percent of clients aged 13–24 years receiving RWHAP HIV medical care are virally suppressed,* which is substantially lower than the national RWHAP average (88.1 percent).

- 81.3 percent of young men who have sex with men (MSM) receiving RWHAP HIV medical care are virally suppressed.
- 77.8 percent of young Black/African American MSM receiving RWHAP HIV medical care are virally suppressed.
- 74.0 percent of young Black/African American women receiving RWHAP HIV medical care are virally suppressed.
- 73.8 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.

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

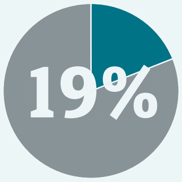
3.9%
of All RWHAP Clients

68.9%
Live at or Below
100%
of the Federal Poverty Level

79.4%
2019
Are Virally Suppressed

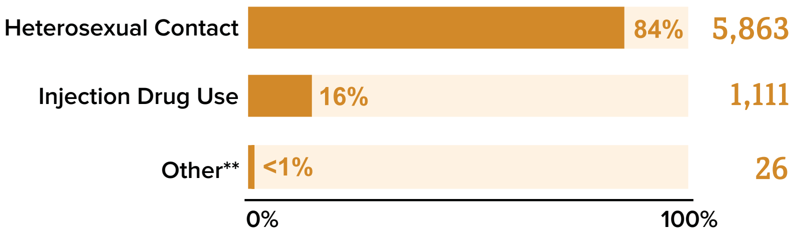
5.8% Have Unstable Housing

HIV and Women



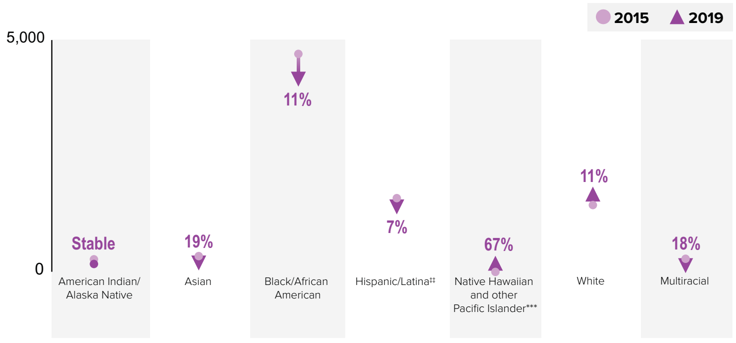
There were **36,801 new HIV diagnoses** in the US and dependent areas in 2019.[*] Of those, 19% (6,999) were among women.[†‡]

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

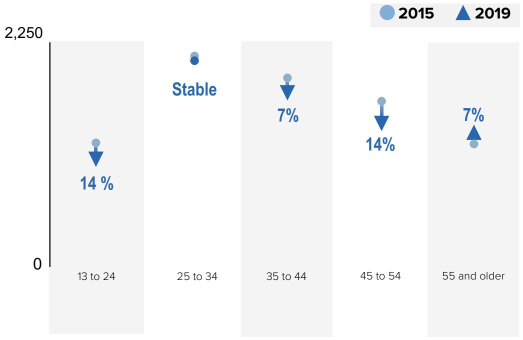


HIV diagnoses decreased 6% among women overall from 2015 to 2019. Although trends varied for different groups of women, HIV diagnoses declined for groups most affected by HIV, including Black/African American[††] women and women aged 13 to 24.

Trends by Race/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.

[‡] Based on sex assigned at birth and includes transgender people. For more information about transgender people, visit www.cdc.gov/hiv/group/gender/transgender.

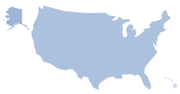
[**] Includes perinatal exposure, blood transfusion, hemophilia, and risk factors not reported or not identified.

[††] *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/Latina women can be of any race.

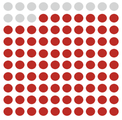
[***] Changes in subpopulations with fewer HIV diagnoses can lead to a large percentage increase or decrease.

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



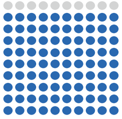
In 2019, an estimated **1.2 million PEOPLE** had HIV.[†††] **Of those, 263,900 were women.**[‡‡‡]

For every 100 people with HIV



87 knew their HIV status.

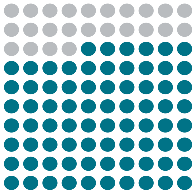
For every 100 women with HIV



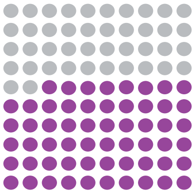
90 knew their HIV status.

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. 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.

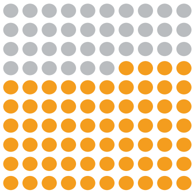
Compared to all people with diagnosed HIV, women have lower viral suppression rates. More work is needed to increase these rates. For every **100 women with diagnosed HIV** in 2019: [****]



76 received some HIV care



58 were retained in care



64 were virally suppressed

For comparison, for every **100 people overall** with diagnosed HIV, **76 received some care**, **58 were retained in care**, and **66 were virally suppressed**.

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

Racism, Discrimination, and HIV Stigma

Racism, discrimination, and stigma may affect whether some women seek or receive high-quality health services.

Risk of Exposure

Because receptive sex is riskier than insertive sex, women are more likely to get HIV during vaginal or anal sex than their sex partner.

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 a condom or medicine to prevent HIV.

Intimate Partner Violence (IPV)

Women who have been exposed to IPV may be more likely to engage in risky behaviors or be forced to have sex without a condom or medicines to prevent or treat HIV.

How is CDC making a difference for women?

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 in the U.S.* initiative.

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

[‡‡‡] Includes only people who were assigned female at birth.

[****] In 44 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 data on HIV risk behaviors and barriers to HIV care, visit www.cdc.gov/hiv/group/gender/women.

All content is based on the most recent data available in March 2022.

Female Clients: HRSA's Ryan White HIV/AIDS Program, 2019

Population Fact Sheet | June 2021

HRSA
Ryan White HIV/AIDS Program

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—nearly 568,000 people in 2019—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care, treatment, and support services for people with HIV to improve health outcomes and reduce HIV transmission.

Of the more than half a million clients served by RWHAP, 26.2 percent are female.

Below are more details about this RWHAP client population:

- **Female clients served by RWHAP are a diverse population.** Data show that 83.6 percent of female clients are from racial/ethnic minority populations. 61.3 percent of female clients identify as Black/African American, which is higher than the national RWHAP average (46.6 percent), and 19.4 percent of female clients identify as Hispanic/Latina, which is lower than the national RWHAP average (23.3 percent).
- **The majority of female clients served by RWHAP are low income.** Among female clients served, 69.8 percent are living at or below 100 percent of the federal poverty level, which is higher than the national RWHAP average (60.7 percent).
- **Data show that 4.2 percent of female RWHAP clients have unstable housing.** This percentage is lower than the national RWHAP average (5.5 percent).
- **The RWHAP female client population is aging.** Among female RWHAP clients served, 49.7 percent are aged 50 years and older, which is higher than the national average (46.8 percent). Only 3.4 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 2019, 87.9 percent of female clients receiving RWHAP HIV medical care are virally suppressed,* which is comparable to the national RWHAP average (88.1 percent).

- 86.7 percent of Black/African American women receiving RWHAP HIV medical care are virally suppressed.
- 90.1 percent of Hispanic/Latina women receiving HIV medical care are virally suppressed.

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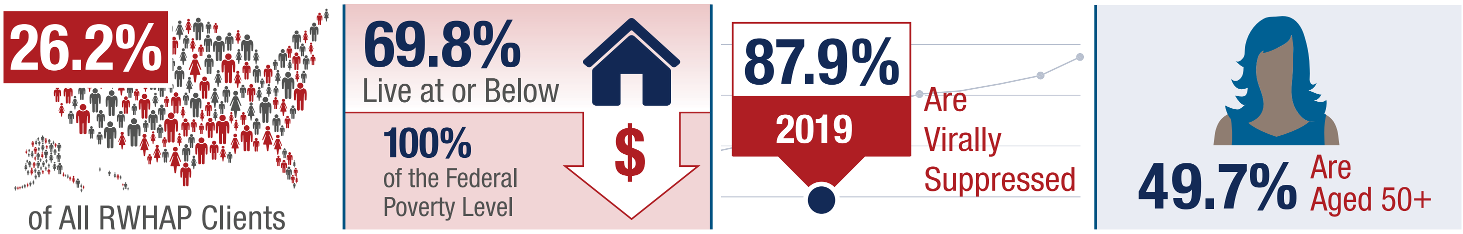
* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

Ryan White HIV/AIDS Program Fast Facts: Female Clients



26.2% of All RWHAP Clients

69.8% Live at or Below 100% of the Federal Poverty Level

87.9% 2019 Are Virally Suppressed

49.7% Are Aged 50+

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

HIV and Transgender People

Transgender: A person whose gender identity or expression is different from their sex assigned at birth.

Transgender man: A person assigned female at birth and identifies as a male.

Transgender woman: A person assigned male at birth and identifies as a female.

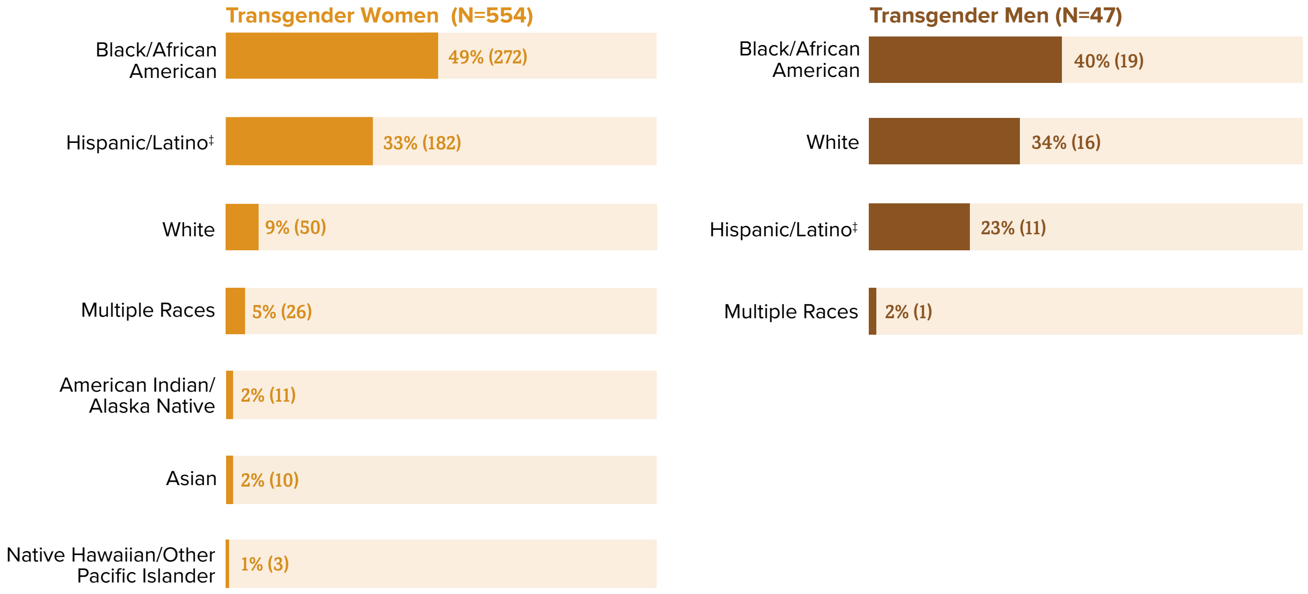
Cisgender: A person whose sex assigned at birth is the same as their gender identity or expression.

Gender expression: A person's outward presentation of their gender (for example, how they act or dress).

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

Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2018, 2% (601) were among transgender people.

Most new HIV diagnoses among transgender people were among Black/African American people.[†]



Total may not equal 100% due to rounding.

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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 people of African descent with ancestry in North America.

[‡] Hispanic/Latino people can be of any race.

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

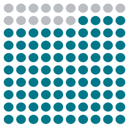
Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

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

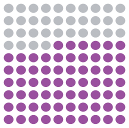
It is important for transgender people to know their HIV status so they can take medicine to treat HIV if they have the virus. Taking HIV medicine every day can make the viral load undetectable. People who get and keep an undetectable viral load (or remain virally suppressed) can stay healthy for many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

Compared to all people with *diagnosed* HIV in 2018, transgender women have about the same viral suppression rates, and transgender men have higher viral suppression rates. More work is needed to increase these rates.

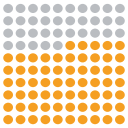
For every 100 transgender women with diagnosed HIV in 2018: **



84 received some HIV care

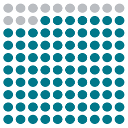


66 were retained in care

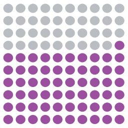


65 were virally supressed

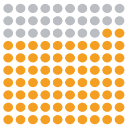
For every 100 transgender men with diagnosed HIV in 2018: **



87 received some HIV care



61 were retained in care



72 were virally supressed

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

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

Racism, HIV Stigma, and Transphobia

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

Lack of Knowledge

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.

Few Multilevel Interventions

Interventions that address the structural, biomedical, and behavioral risks for HIV among transgender women and men are needed to address HIV disparities.

Unmet Need for Gender Affirmation

When transgender people do not feel supported through medical gender affirmation, they are less likely to engage in HIV prevention and care services.

How is CDC making a difference for transgender 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.

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 2021.

Transgender Clients: HRSA's Ryan White HIV/AIDS Program, 2019

Population Fact Sheet | June 2021

HRSA
Ryan White HIV/AIDS Program

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—nearly 568,000 people in 2019—receive services through RWHAP each year. The RWHAP funds grants to states, cities, counties, and local community-based organizations to provide care, treatment, and support services for people with HIV to improve health outcomes and reduce HIV transmission.

Of the more than half a million clients served by RWHAP, 2.3 percent are transgender, representing approximately 12,800 clients. Below are more details about this RWHAP client population:

- The majority of transgender clients served by RWHAP are a diverse population. Among transgender clients served, 87.0 percent are from racial/ethnic minority populations; 55.1 percent of transgender clients identify as Black/African American and 27.4 percent identify as Hispanic/Latino, both of which are higher than the national RWHAP averages (46.6 percent and 23.3 percent, respectively).
- The majority of transgender clients served by RWHAP are low income. Among transgender RWHAP clients served, 74.1 percent live at or below 100 percent of the federal poverty level, which is substantially higher than the national RWHAP average (60.7 percent).
- Data show that 10.9 percent of transgender RWHAP clients have unstable housing. This percentage is substantially higher than the national RWHAP average (5.5 percent).
- The transgender client population is younger than the average for RWHAP clients. Approximately 27.4 percent of RWHAP transgender clients are aged 50 years and older, which is substantially lower than the national RWHAP average (46.8 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. Among the transgender clients receiving RWHAP HIV medical care in 2019, 83.2 percent are virally suppressed,* which is lower than the national RWHAP average (88.1 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.

Ryan White HIV/AIDS Program Fast Facts: Transgender Clients

2.3%

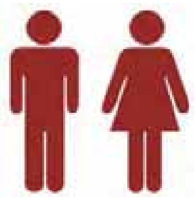
of All RWHAP Clients

74.1% Live at or Below **100%** of the Federal Poverty Level

83.2% **2019** Are Virally Suppressed

10.9% Have Unstable Housing

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



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).

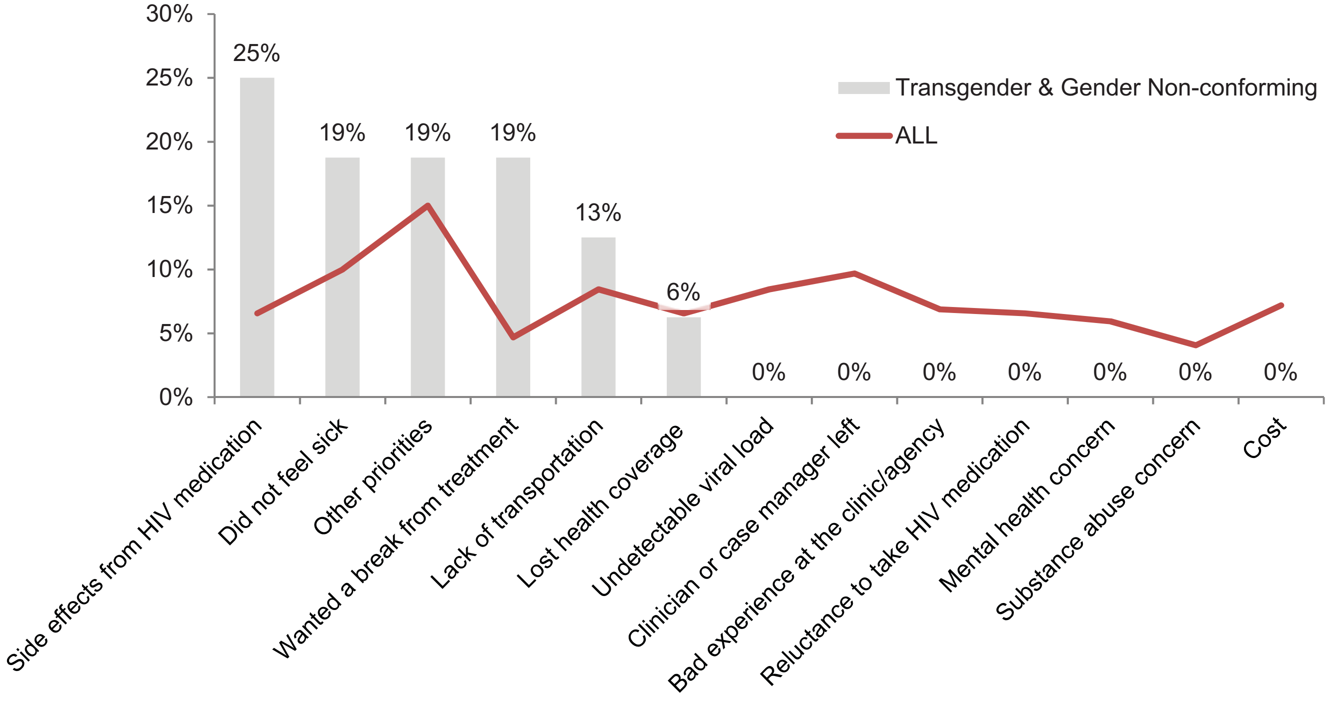
Though representing a very small overall number, the proportion of transgender and gender non-conforming participants reported a higher proportion of at least one interruption in their HIV medical care for 12 months or more since their diagnosis (42% vs 32%). Those who reported a break in HIV care for 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

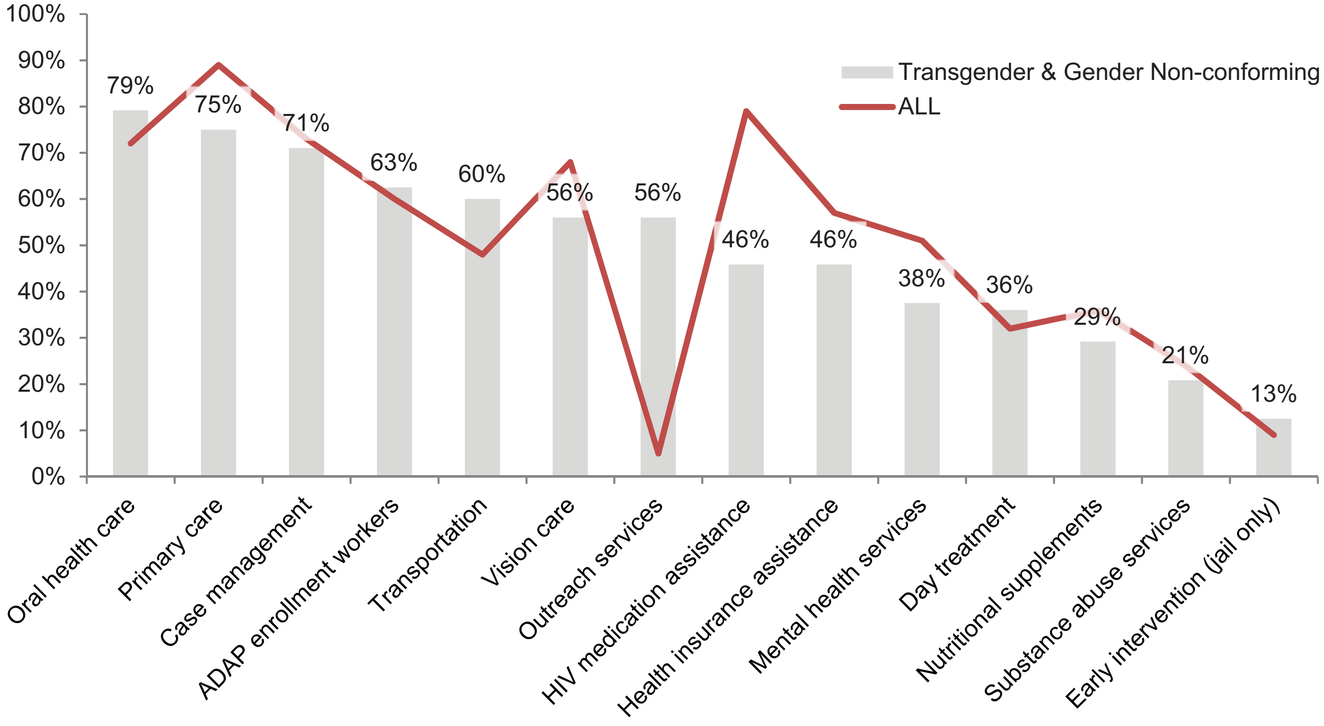
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services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

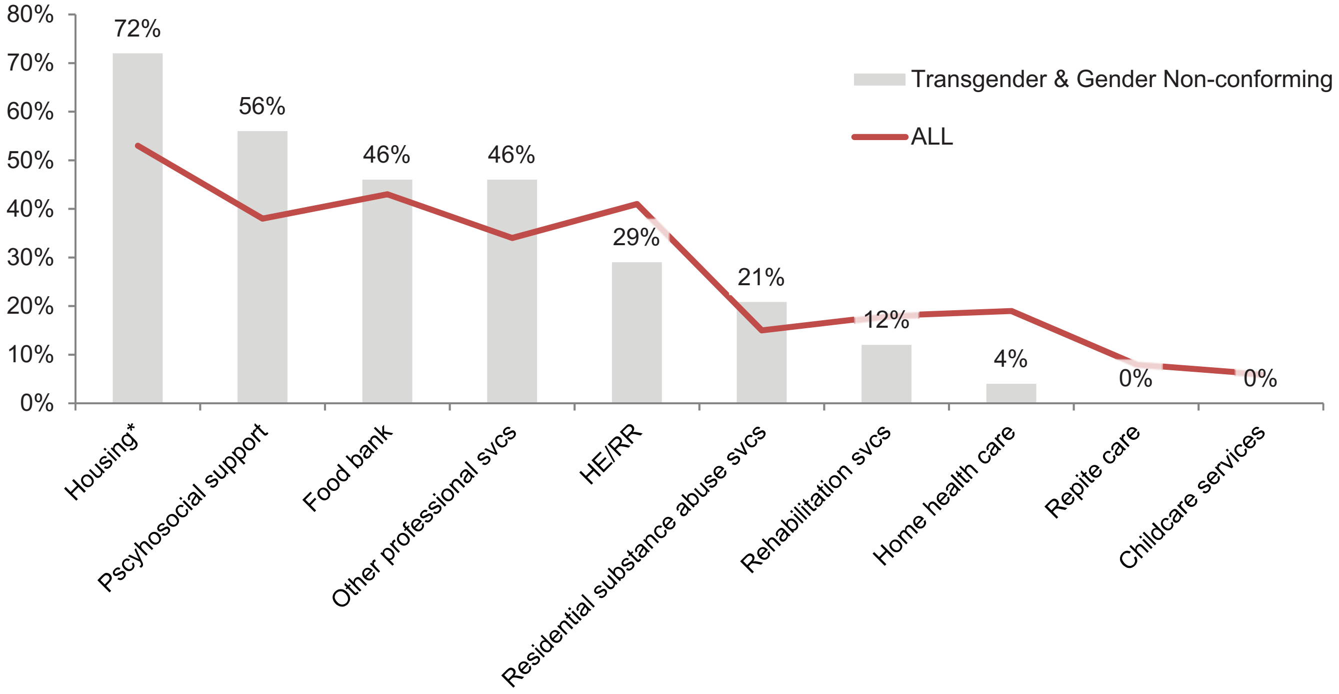
In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV-related services they needed in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

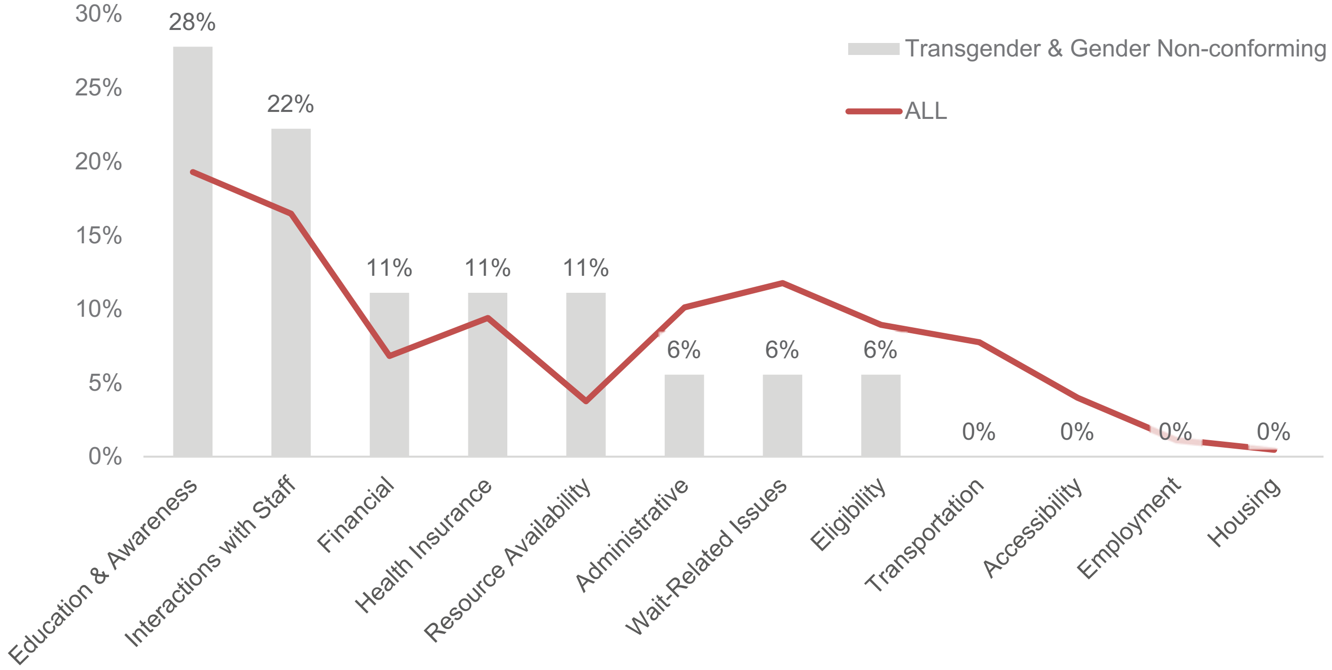
(**Graph 4**) Only 12 transgender and gender non-conforming participants cited barriers to HIV care services. As this group comprises only 50% of all transgender and gender non-conforming participants and 3.9% of the total sample, great care should be taken in applying data and conclusions from Graph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

For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:

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HIV and People Who Inject Drugs

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

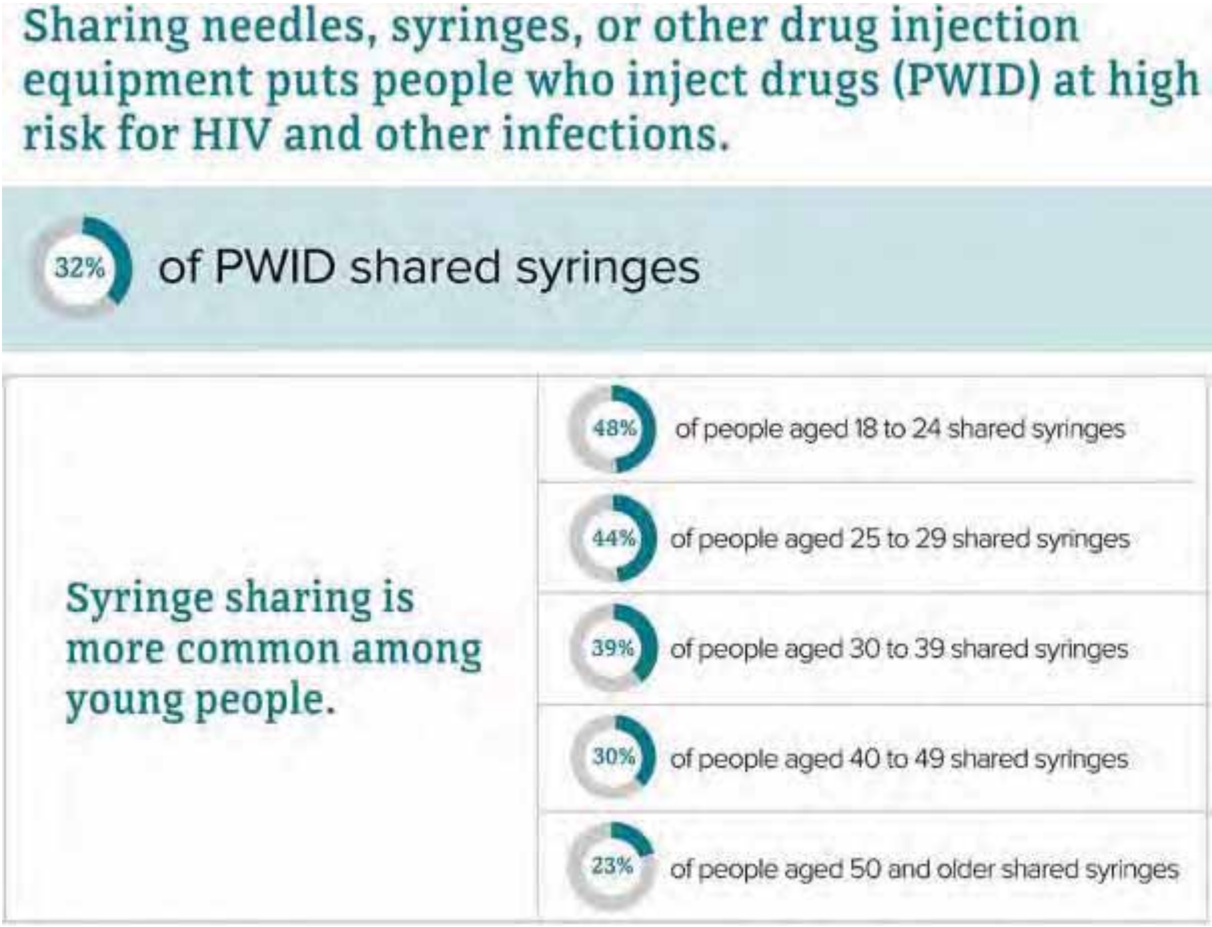
Although HIV diagnoses among PWID have remained stable in recent years, injection drug use in some areas of the United States have created prevention challenges and placed new populations at risk for HIV. This highlights the need for strengthened HIV prevention efforts for PWID, such as expanding coverage and support for comprehensive syringe services programs (SSPs).

HIV Risk Behaviors

The risk of getting or transmitting HIV varies widely depending on the type of exposure or behavior. Most commonly, people get or transmit HIV through anal or vaginal sex, or sharing needles, syringes, or other drug injection equipment—for example, cookers.

Syringe Sharing

Sharing needles, syringes, or other drug injection equipment means using a needle or syringe after someone else used it to inject drugs or medicine or for tattoos or piercings.



Sharing needles, syringes, or other drug injection equipment puts people who inject drugs (PWID) at high risk for HIV and other infections.

32% of PWID shared syringes

Syringe sharing is more common among young people.

48% of people aged 18 to 24 shared syringes

44% of people aged 25 to 29 shared syringes

39% of people aged 30 to 39 shared syringes

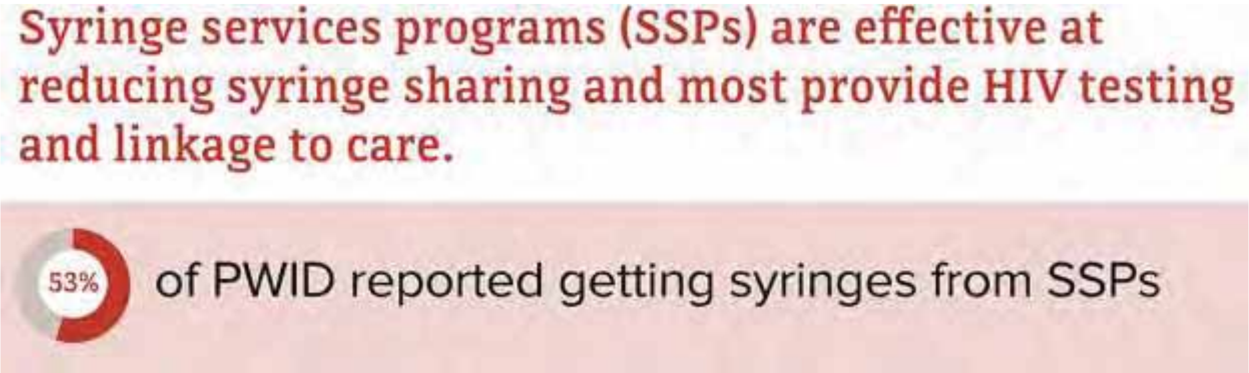
30% of people aged 40 to 49 shared syringes

23% of people aged 50 and older shared syringes

HIV Prevention

Syringe Services Programs

Syringe services programs (SSPs) are community-based prevention programs that provide a range of services, including access to sterile needles and syringes, facilitation of safe disposal of used syringes, and provide and link people to other important services and programs, such as substance use disorder treatment, vaccination, testing, and linkage to care and treatment for infectious diseases.

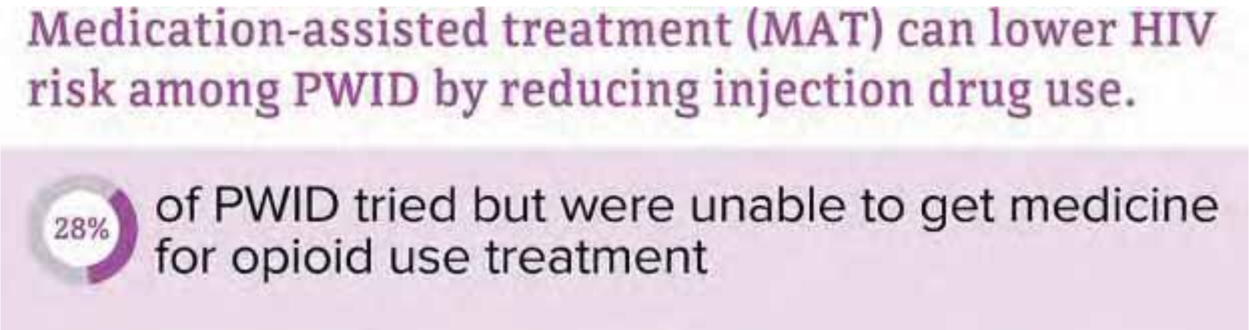


Syringe services programs (SSPs) are effective at reducing syringe sharing and most provide HIV testing and linkage to care.

of PWID reported getting syringes from SSPs

Medication-Assisted Treatment

Medication-assisted treatment (MAT) combines medications and behavioral therapy to treat substance use disorders and prevent overdose.

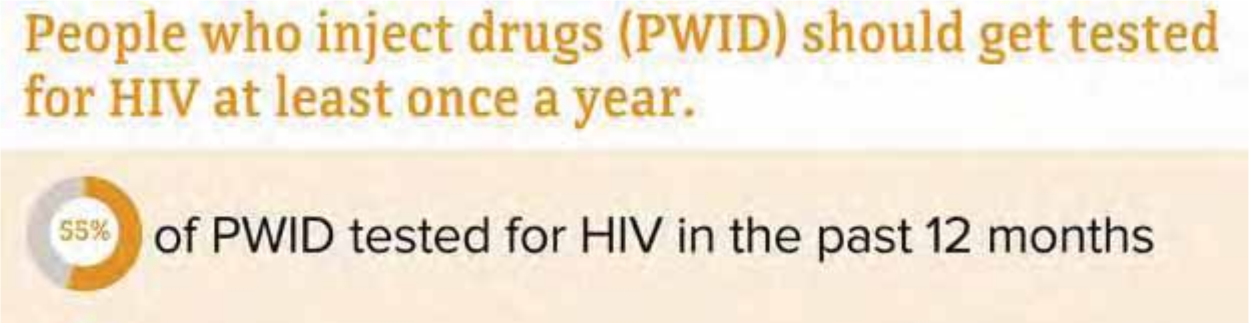


Medication-assisted treatment (MAT) can lower HIV risk among PWID by reducing injection drug use.

of PWID tried but were unable to get medicine for opioid use treatment

HIV Testing

HIV testing tells you whether or not you have HIV. CDC recommends that everyone between the ages of 13 and 64 get tested for HIV at least once as part of routine health care. People with certain risk factors should get tested at least once a year.



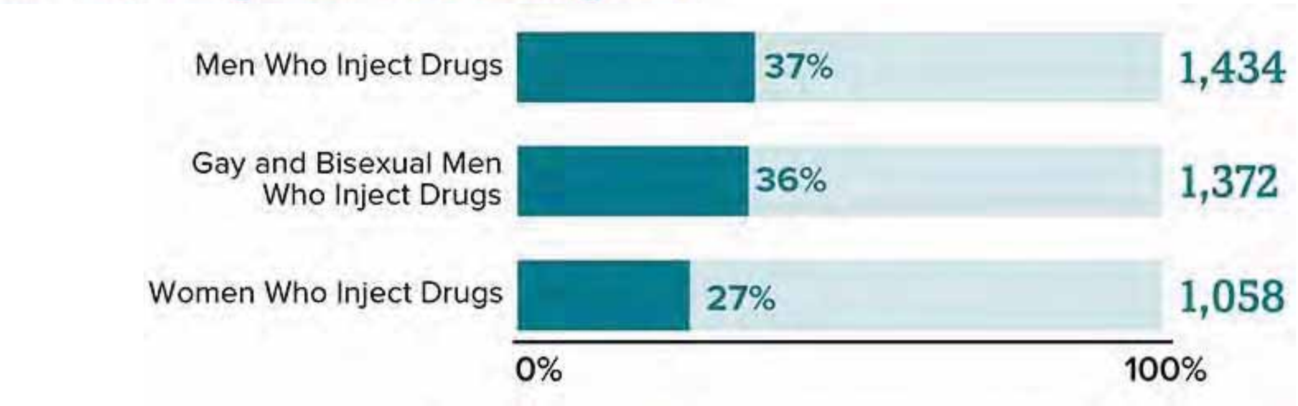
People who inject drugs (PWID) should get tested for HIV at least once a year.

of PWID tested for HIV in the past 12 months

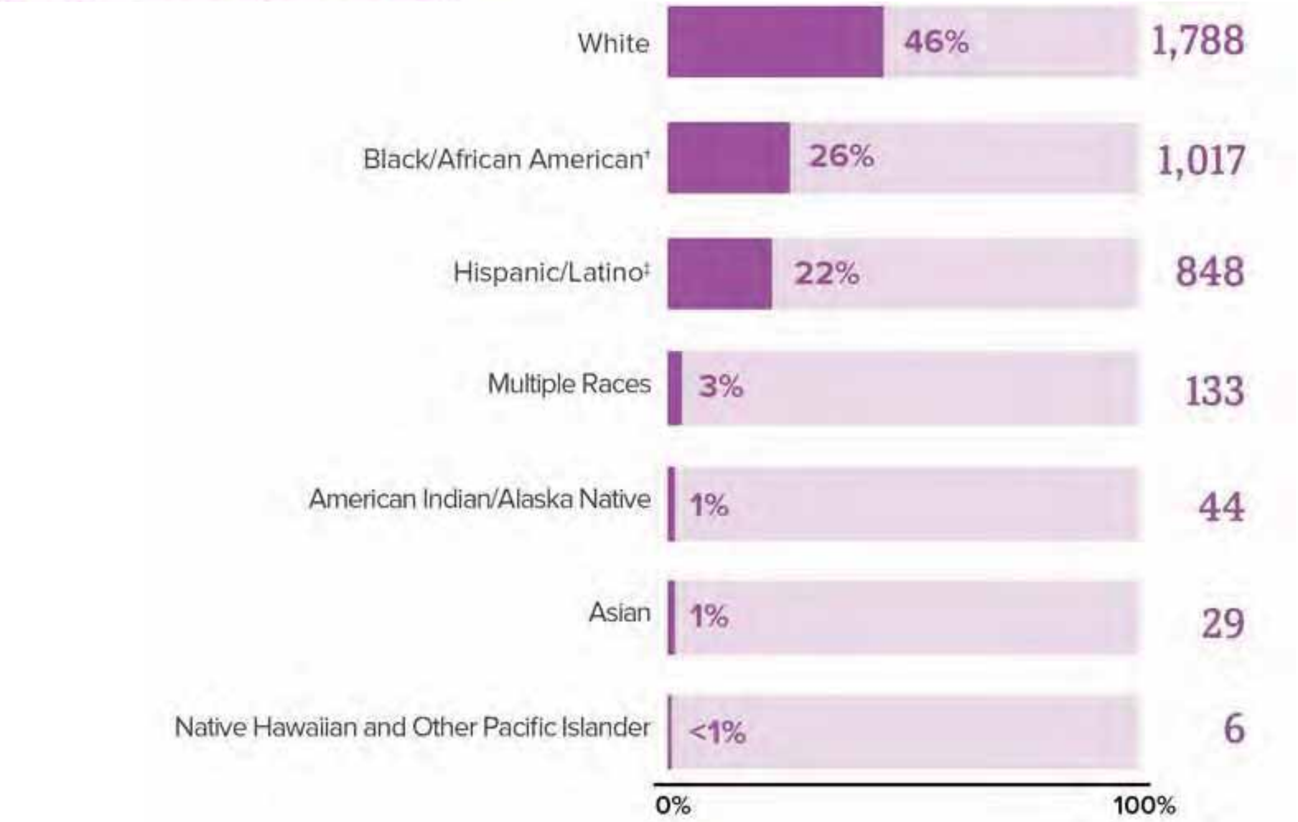
HIV Diagnoses

Diagnoses refers to the number of people who received an HIV diagnosis during a given year. Adult and adolescent PWID[a] accounted for 10% (3,864)[b] of the 37,968 new HIV diagnoses in the United States (US) and dependent areas[c] in 2018 (2,492 cases were attributed to injection drug use and 1,372 to male-to-male sexual contact[d] *and* injection drug use).

Among people who inject drugs, most new HIV diagnoses were among men.



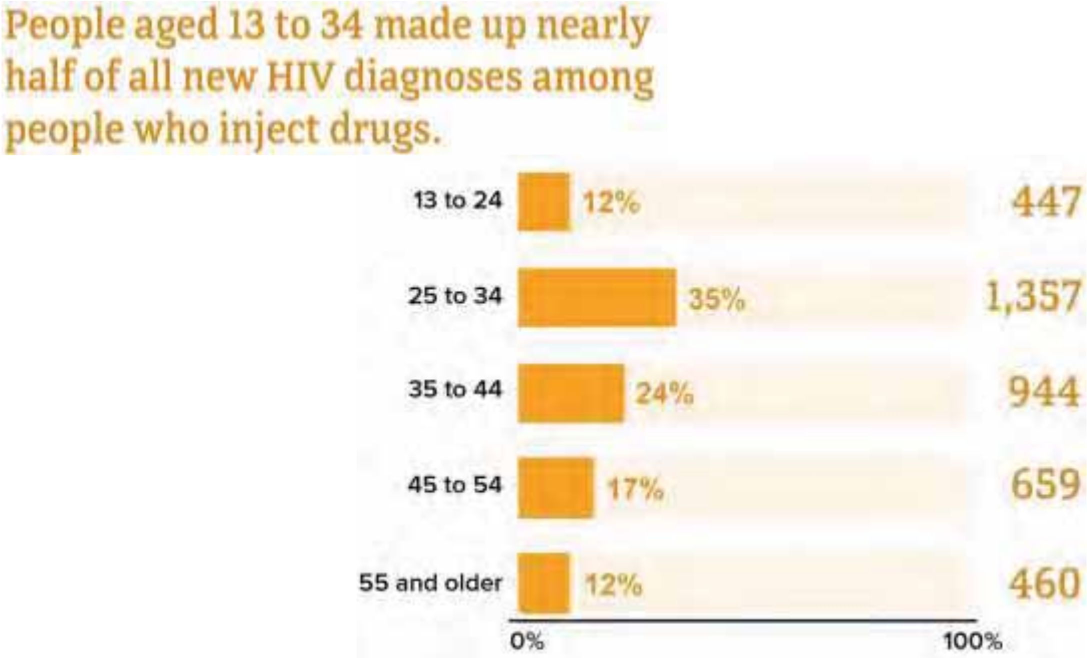
White people accounted for the highest number of new HIV diagnoses among people who inject drugs.



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

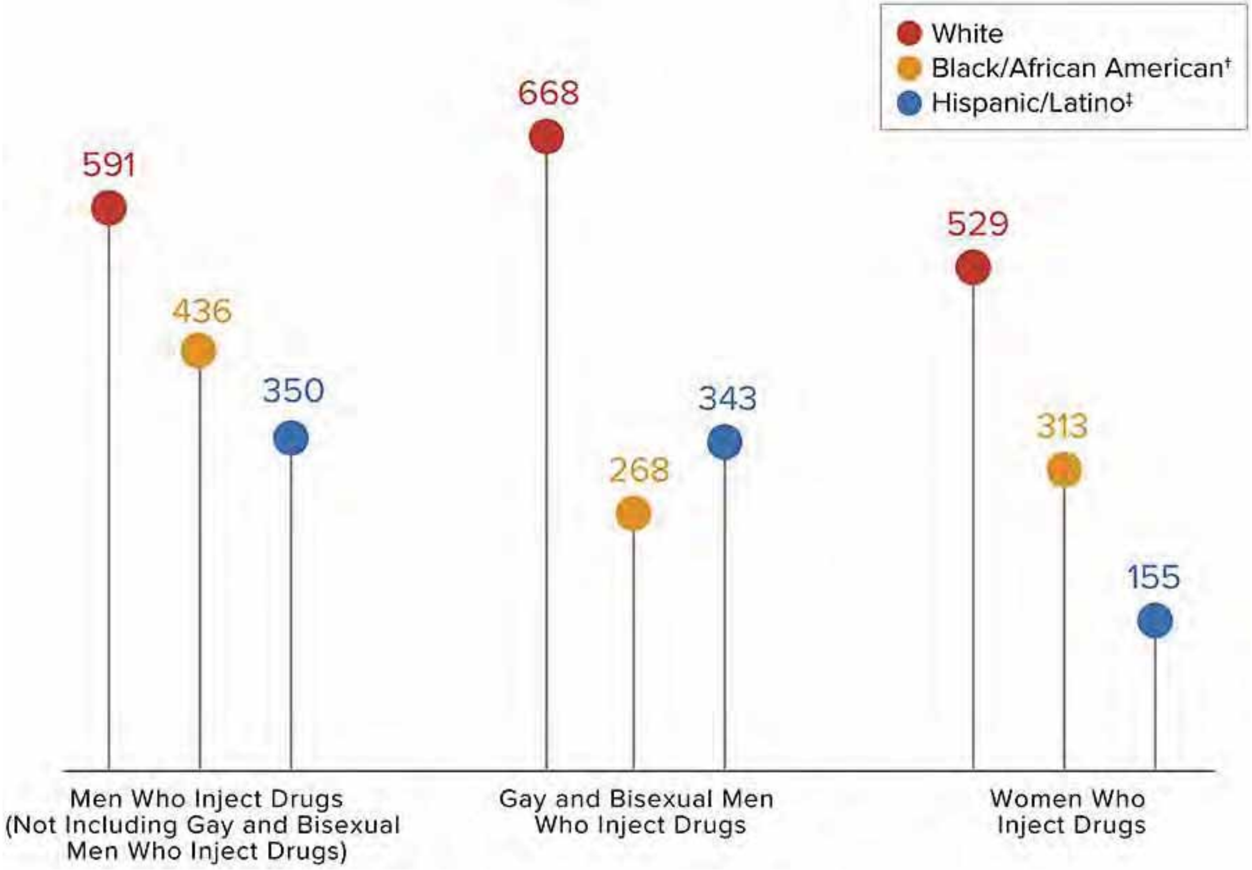
† *Black* refers to people having origins in any of the Black racial groups of Africa. *African American* is a term often used for people of African descent with ancestry in North America.

‡ Hispanic/Latino people can be of any race.



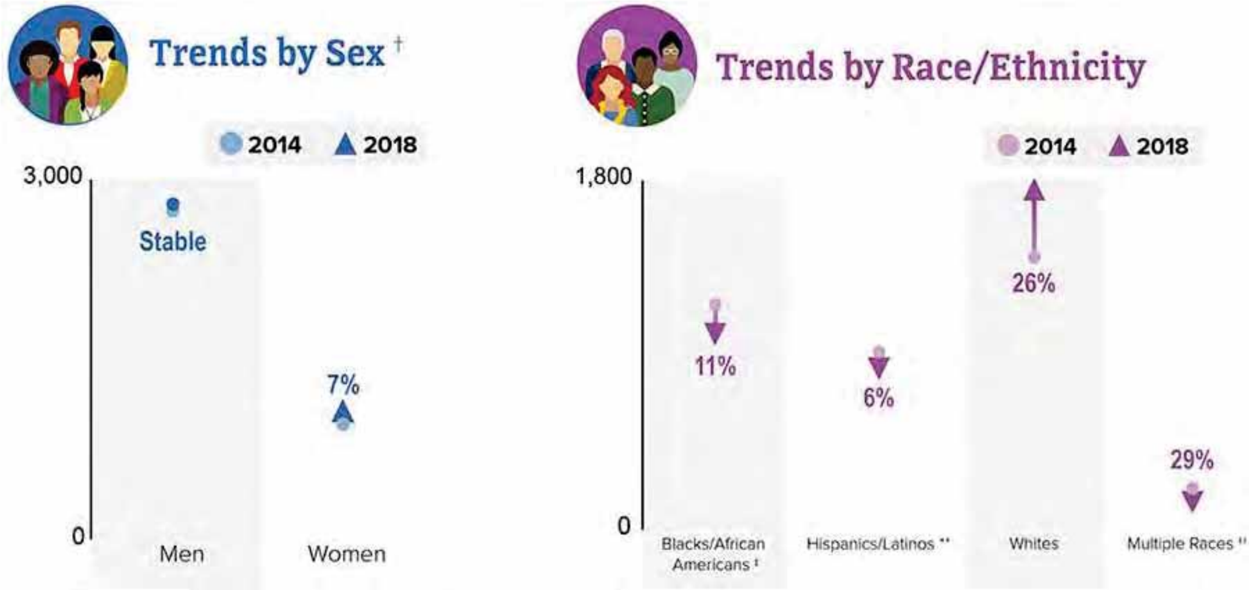
The numbers have been statistically adjusted to account for missing transmission categories. Values may not equal the total number of PWID who received an HIV diagnosis in 2018.
* Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).

New HIV Diagnoses Among People Who Inject Drugs in the US and Dependent Areas by Sex, Race/Ethnicity, and Transmission Category, 2018*



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

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.



This chart does not include subpopulations representing 2% or less of all PWID who received an HIV diagnosis in 2018.

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

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

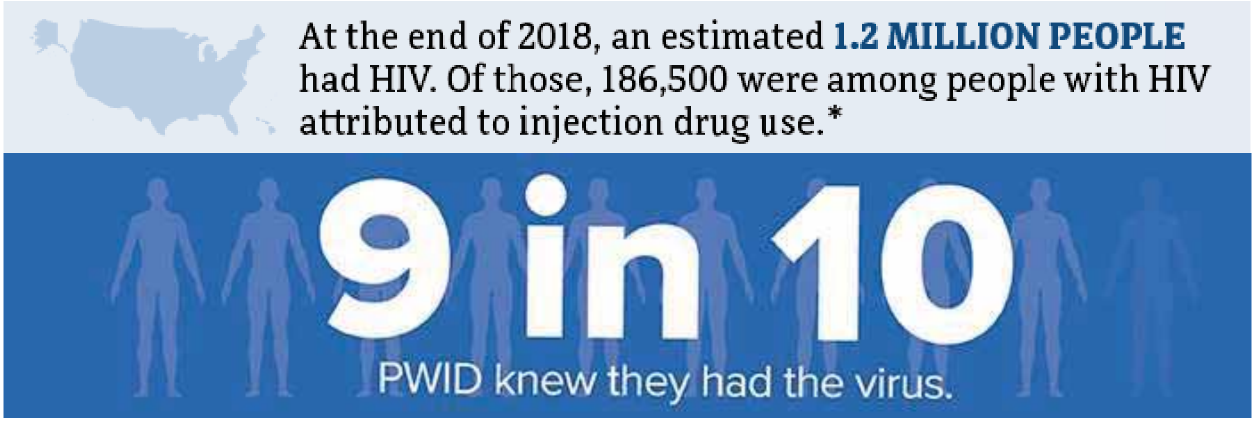
[‡] *Black* refers to people having origins in any of the Black racial groups of Africa. *African American* is a term often used for people of African descent with ancestry in North America.

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

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

PWID With HIV

People with HIV who take HIV medicine as prescribed can live long, healthy lives and help prevent HIV transmission.

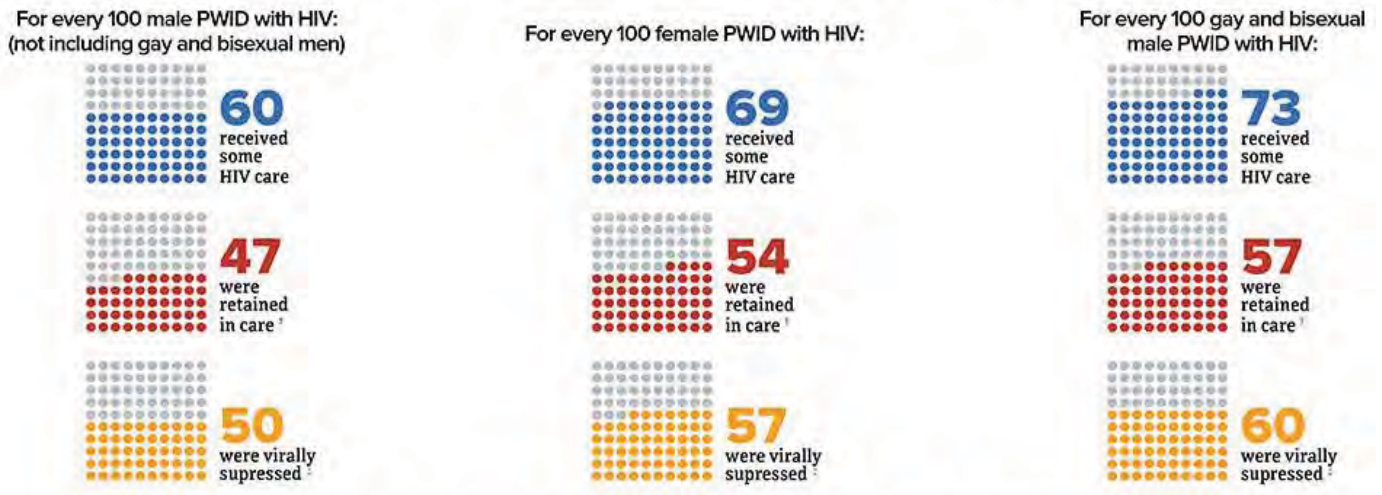


At the end of 2018, an estimated **1.2 MILLION PEOPLE** had HIV. Of those, 186,500 were among people with HIV attributed to injection drug use.*

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.

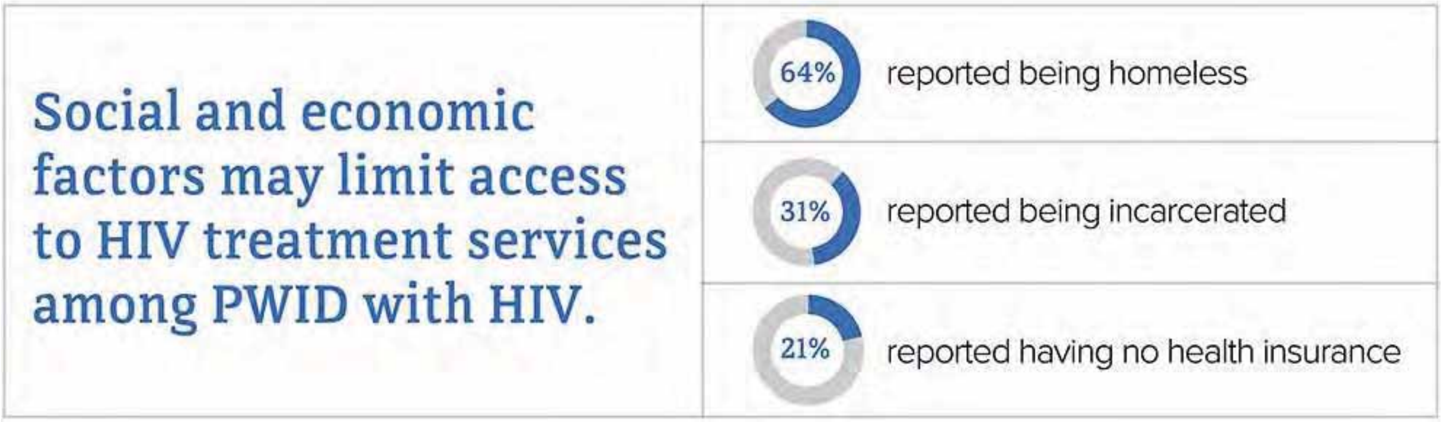


For comparison, for every **100 people overall** with HIV, **65 received some care**, **50 were retained in care**, and **56 were virally suppressed**.

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

† Had 2 viral load or CD4 tests at least 3 months apart in a year.

‡ Based on most recent viral load test.



Social and economic factors may limit access to HIV treatment services among PWID with HIV.

64% reported being homeless

31% reported being incarcerated

21% reported having no health insurance

Deaths

In 2018, there were 4,905 deaths among PWID with diagnosed HIV in the US and dependent areas. These deaths could be from any cause.

Prevention Challenges

Many communities do not have the resources or support to establish effective syringe services programs (SSPs). Barriers to SSPs include legal and regulatory issues, insufficient funding, and misunderstandings about the effectiveness and safety of SSPs.

The prescription opioid and heroin crisis has led to increased numbers of PWID, placing new populations at risk for HIV. The crisis has disproportionately affected nonurban areas, where HIV prevalence rates have been low historically. These areas have limited services for HIV prevention and treatment and substance use disorder treatment.

PWID may also engage in risky sexual behaviors, such as having sex without protection (like condoms or medicine to prevent or treat HIV), having sex with multiple partners, or trading sex for money or drugs. Studies have found that young PWID are more likely than older PWID to have sex without a condom, have more than one sex partner, and have sex partners who also inject drugs.

PWID may face stigma and discrimination. Although substance use disorder is a health issue that requires treatment, it is often viewed as a criminal activity. Stigma and mistrust of the health care system may prevent PWID from seeking HIV testing, care, and treatment.

PWID may not have access to substance use disorder treatment, including medication-assisted treatment (MAT) and medication for opioid use disorder (MOUD). MAT and MOUD can lower HIV risk among PWID by reducing injection drug use. Also, PWID who have HIV are more likely to take HIV medicine as prescribed if they are on MAT or MOUD. Barriers may include lack of prescribers, legal and regulatory issues, insurance coverage, and confusion about the use of MAT and MOUD.

PWID are also at risk for getting other sexually transmitted diseases (STDs), blood-borne diseases, and bacterial infections. Having another STD can greatly increase the likelihood of getting or transmitting HIV through sex. For people with HIV, getting hepatitis B or C can put them at increased risk for serious, life-threatening complications. PWID can also have other bacterial infections, such as endocarditis and methicillin-resistant staphylococcus aureus.

What CDC Is Doing

CDC is pursuing a high-impact HIV prevention approach to maximize the effectiveness of HIV prevention interventions and strategies. Funding state, territorial, and local health departments and community-based organizations (CBOs) to develop and implement tailored programs is CDC's largest investment in HIV prevention. This includes longstanding successful programs and new efforts funded through the *Ending the HIV Epidemic in the U.S.* initiative. In addition to funding health departments and CBOs, CDC is also strengthening the HIV prevention workforce and developing HIV communication resources for consumers and health care providers.

- Under the integrated HIV surveillance and prevention cooperative agreement, CDC awards around $400 million per year to health departments for HIV data collection and prevention efforts. This award directs resources to the populations and geographic areas of greatest need, while supporting core HIV surveillance and prevention efforts across the US.

- In 2019, CDC awarded $12 million to support the development of state and local *Ending the HIV Epidemic in the U.S.* plans in the nation's 57 priority areas. To further enhance capacity building efforts, CDC uses HIV prevention resources to fund the National Alliance of State and Territorial AIDS Directors (NASTAD) with $1.5 million per year to support strategic partnerships, community engagement, peer-to-peer technical assistance, and planning efforts.
- In 2020, CDC awarded$109 million to 32 state and local health departments that represent the 57 jurisdictions across the United States prioritized in the *Ending the HIV Epidemic in the U.S.* initiative. This award supports the implementation of state and local *Ending the HIV Epidemic in the U.S.* plans.
- Under the flagship community-based organization cooperative agreement, CDC awards about $42 million per year to community organizations. This award directs resources to support the delivery of effective HIV prevention strategies to key populations.
- In 2019, CDC awarded a cooperative agreement to strengthen the capacity and improve the performance of the nation's HIV prevention workforce. New elements include dedicated providers for web-based and classroom-based national training, and technical assistance tailored within four geographic regions.
- CDC supports intervention programs that deliver services to PWID such as *Community PROMISE*, a community-level HIV prevention program that uses role-model stories and peer advocates to distribute prevention materials within social networks.
- CDC provides guidance on SSP activities that can be supported with CDC funds and how CDC-funded programs may request to direct resources to support SSPs.
- CDC provides technical assistance on SSP implementation. SSPs are proven and effective community-based prevention programs that provide a range of services, including access to and disposal of sterile syringes and injection equipment, vaccination, testing, and linkage to infectious disease care and substance use treatment. SSPs play a key role in preventing HIV and other health problems among PWID.
- CDC uses cutting-edge technology to detect and respond to clusters of HIV transmission, and supports state and local responses to HIV outbreakspdf icon traced to injection drug use.
- CDC supports programs to deliver biomedical approaches to HIV prevention and treatment for PWID such as pre-exposure prophylaxis (PrEP) for people at risk, post-exposure prophylaxis (PEP) to lower the chances of getting HIV after an exposure, and antiretroviral therapy (ART) or medicines to treat HIV.
- CDC maintains the National HIV Behavioral Surveillance(NHBS) system among populations at risk for HIV. Every three years, NHBS collects information on HIV infection and behaviors from PWID in jurisdictions with high HIV prevalence, including drug use and sexual risk behaviors, testing behaviors, and use of HIV prevention services.
- Through its *Let's Stop HIV Together* campaign, CDC offers resources about HIV stigma, testing, prevention, and treatment. This campaign is part of the *Ending the HIV Epidemic in the U.S.* initiative.

[a] Adult and adolescent PWID aged 13 and older.

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

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

[d] The term *male-to-male sexual contact* is used in CDC surveillance systems. It indicates a behavior that transmits HIV infection, not how people self-identify in terms of their sexuality. This web content uses the term *gay and bisexual men* to represent gay, bisexual, and other men who reported male-to-male sexual contact.

Page last reviewed: March 16, 2022

Content source: Division of HIV Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention

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

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.

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.

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.

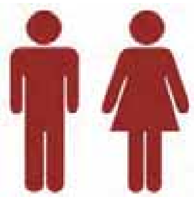
DATA CONSIDERATIONS

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).

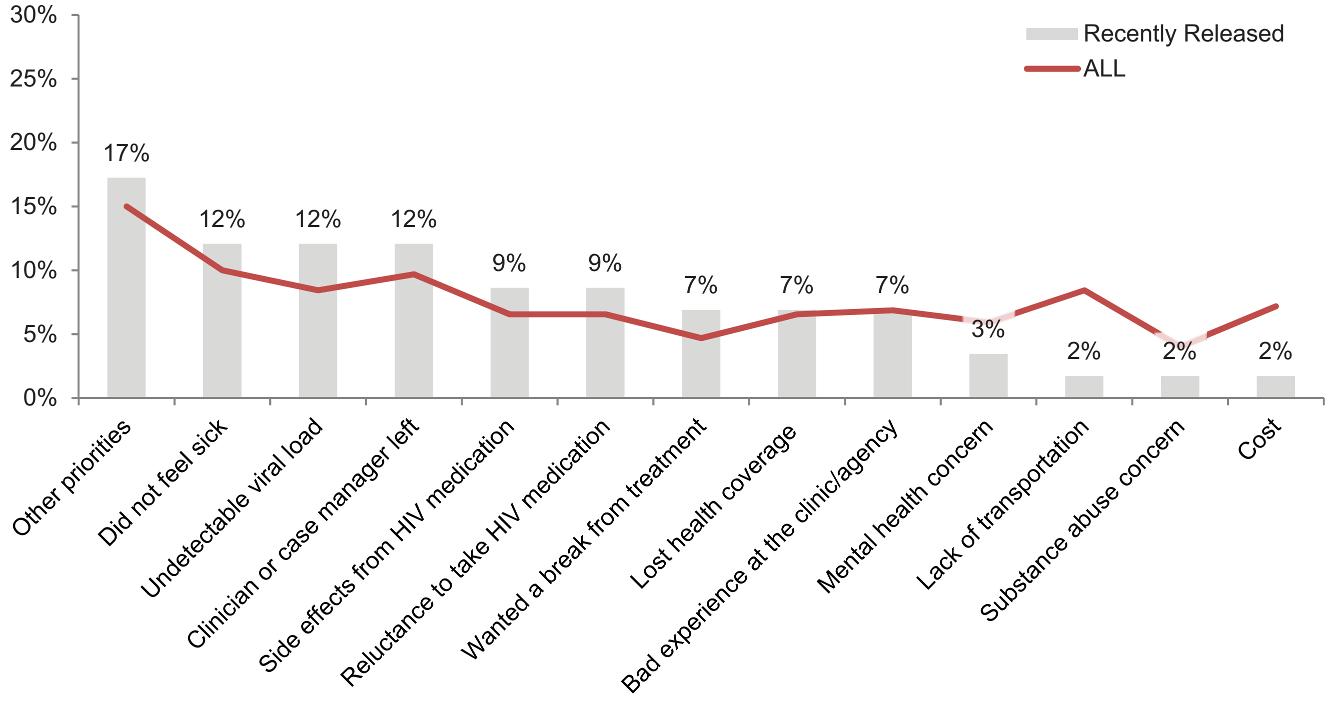
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 58% of recently released participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked 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

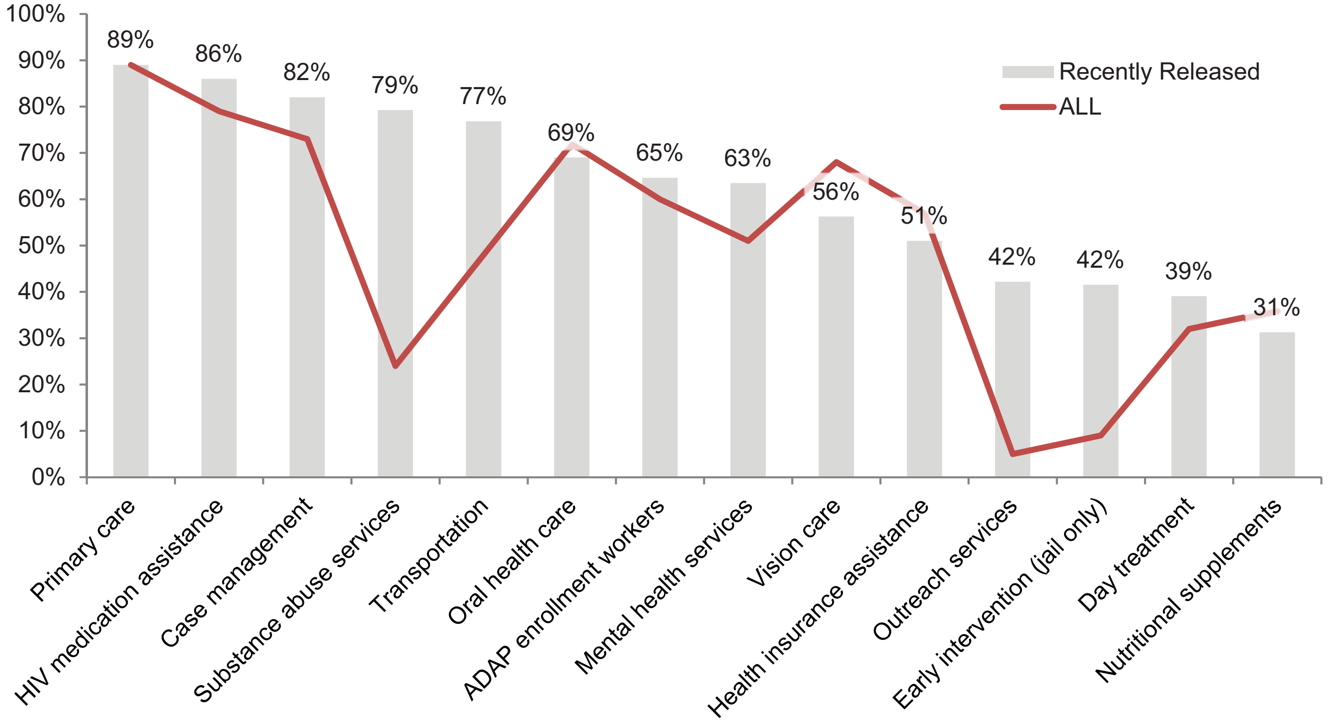
In 2020, 16 HIV care medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services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

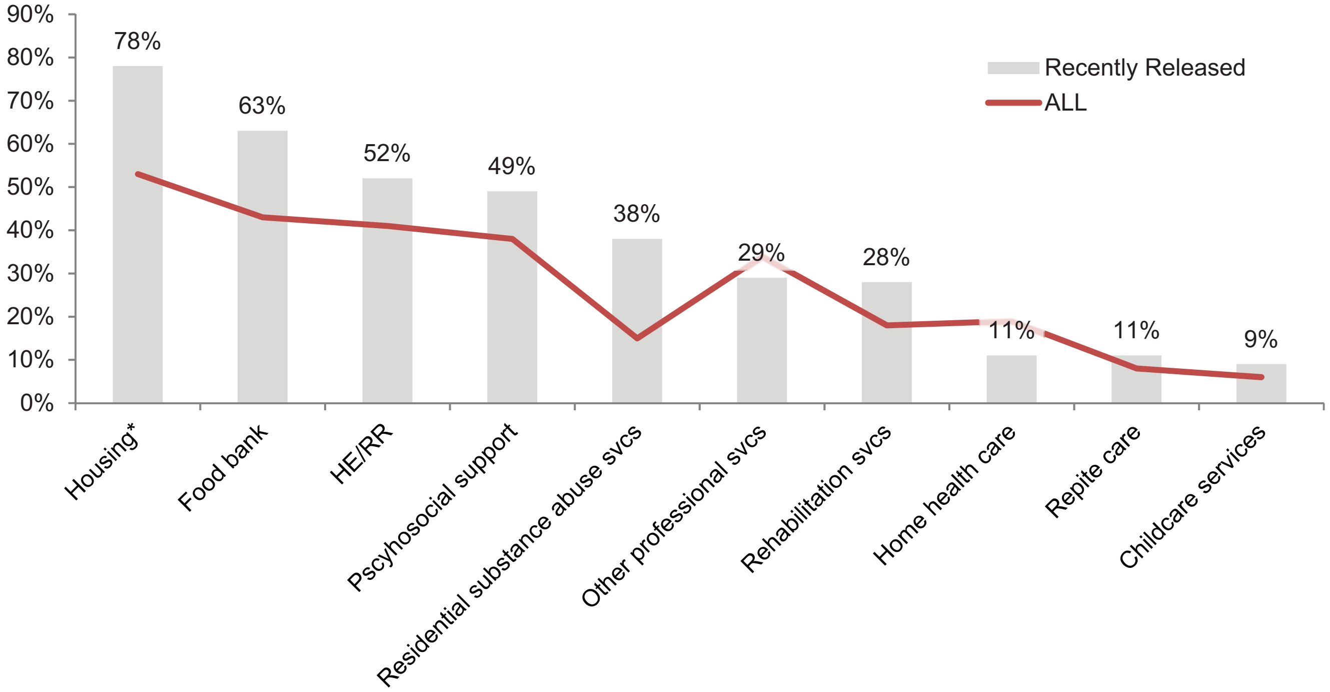
(**Graph 3**) From the 10 services options provided, the greatest proportion of recently released participants reported housing (78%) as the most needed service. This was followed by food bank (63%) and health education and risk reduction services (52%).

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

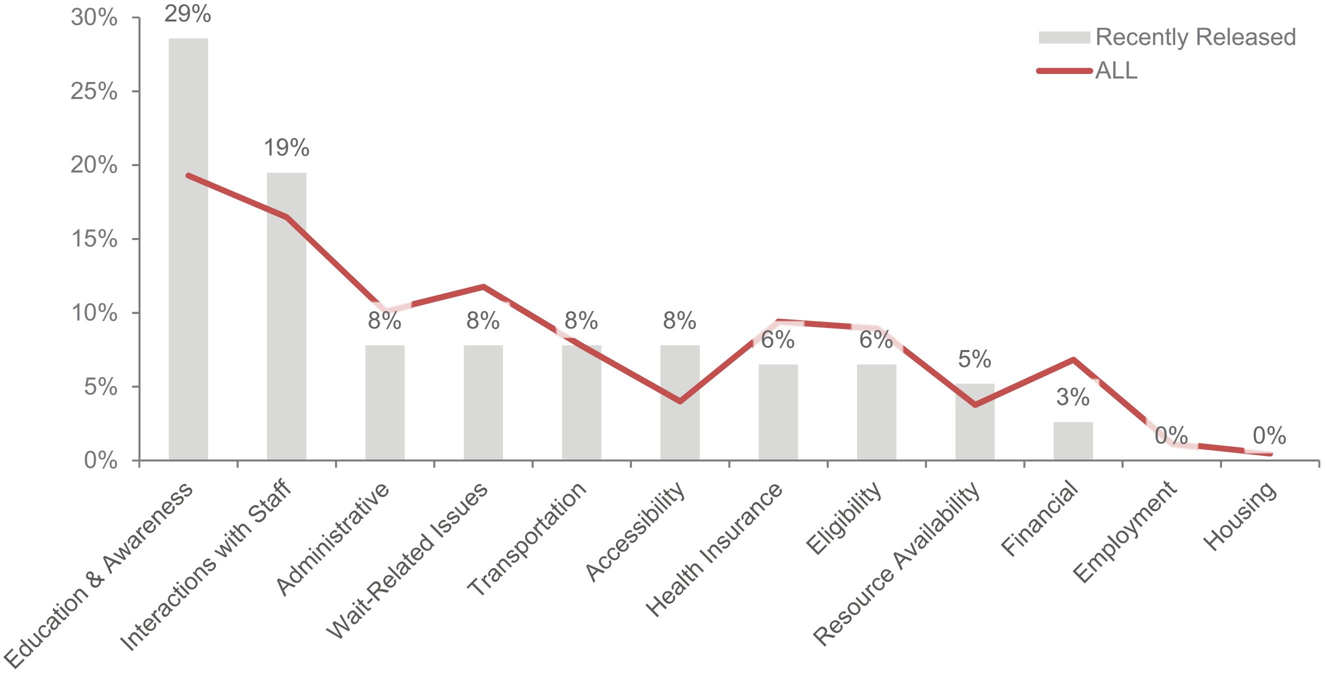
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant 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.



For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
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HRSA's Ryan White HIV/AIDS Program: HIV Care and Treatment in Rural Communities

Population Fact Sheet | September 2021

HRSA
Ryan White HIV/AIDS Program

The Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) provides support and resources to RWHAP grant recipients to assist in the delivery of optimal care and treatment for people with HIV, including those in rural communities.[a] Addressing health inequities and racial disparities in engagement in care and viral suppression is critical to ending the HIV epidemic in the United States.[b] The RWHAP encourages innovative practices to best meet the needs of people with HIV in rural communities. Although barriers remain, RWHAP service providers[c] in rural areas have demonstrated success in such areas as telemedicine, rapid antiretroviral therapy, transportation services, and the use of community health workers.

The Reach and Impact of the RWHAP in Rural Areas in 2019

- 7.9% of all RWHAP providers (n = 160/2,037) were located in rural areas.[1]
- 10.2% of all RWHAP outpatient medical care[2] providers (n = 91/894) were located in rural areas.

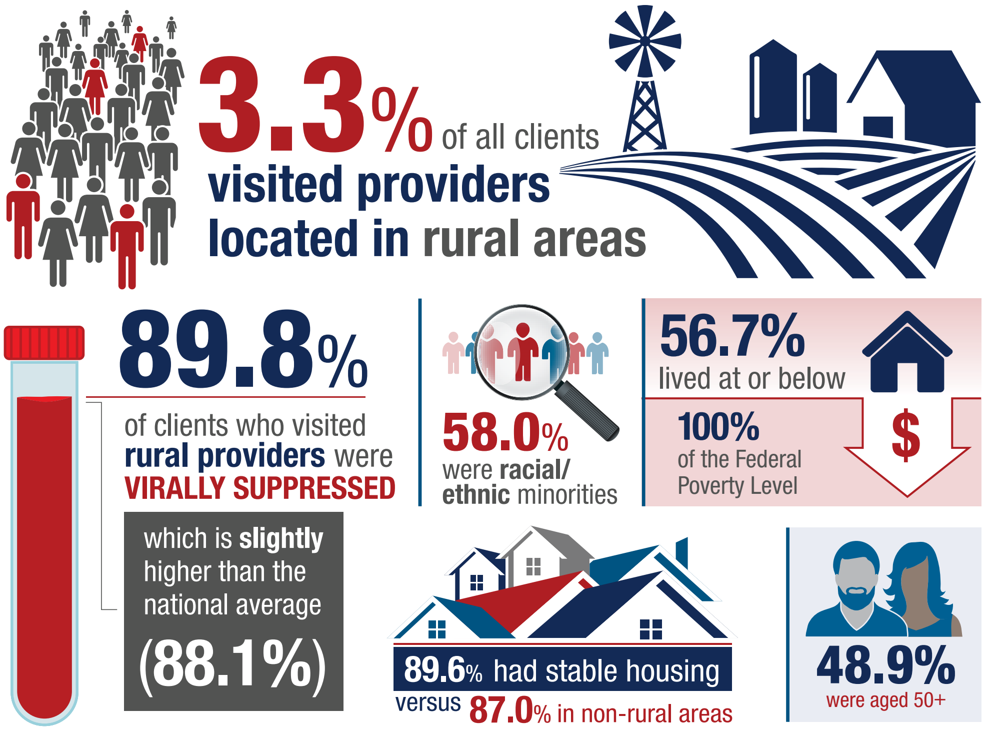
Among RWHAP providers in rural areas in 2019—

- Nearly 50% served more than 100 RWHAP clients.
- 42% were health departments.
- Approximately 87% received Public Health Service Act Section 330 funding, which supports HRSA-funded Community Health Centers.

In 2019, the top 10 most common services delivered by RWHAP providers in rural areas were—

- Medical case management – **57.5%**
- Outpatient/ambulatory health services – **56.9%**
- Oral health care – **48.1%**
- Medical transportation – **45.6%**
- Non-medical case management – **43.1%**
- Emergency financial assistance – **36.3%**
- Mental health services – **35.6%**
- Health insurance premium and cost-sharing assistance – **29.4%**
- Food bank/home-delivered meals – **21.3%**
- Outreach services – **21.3%**

RWHAP Clients Who Visited Rural Providers in 2019



3.3% of all clients **visited providers located in rural areas**

89.8% of clients who visited **rural providers** were **VIRALLY SUPPRESSED**

which is **slightly** higher than the national average **(88.1%)**

58.0% were **racial/ethnic** minorities

56.7% lived at or below **100%** of the Federal Poverty Level

89.6% had stable housing versus **87.0%** in non-rural areas

48.9% were aged 50+

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[a] Klein PW, Geiger T, Chavis NS, et al. The Health Resources and Services Administration's Ryan White HIV/AIDS Program in rural areas of the United States: Geographic distribution, provider characteristics, and clinical outcomes. *PLoS One.* 2020;15(3): e0230121

[b] HRSA. Ending the HIV Epidemic in the U.S. https://www.hrsa.gov/ending-hiv-epidemic

[c] "RWHAP service providers" refers to provider organizations that deliver direct care and support services to RWHAP clients

Ending the HIV Epidemic in the U.S.

The Ending the HIV Epidemic in the U.S. (EHE) federal initiative focuses on accelerating progress to end the HIV epidemic through four key strategies: diagnose, treat, prevent, and respond. EHE infuses priority jurisdictions with additional resources, technology, and expertise to expand HIV treatment and prevention activities. The first phase includes seven rural states with a disproportionate occurrence of HIV—Alabama, Arkansas, Kentucky, Mississippi, Missouri, Oklahoma, and South Carolina. The U.S. Department of Health and Human Services (HHS) leads the government-wide effort, and HRSA has a key role in leading the implementation of EHE.

Rural Health and HIV Resources

The following resources describe promising practices to meet rural barriers and challenges, address training and technology needs, and review research and policy recommendations.

RWHAP Part F AIDS Education and Training Centers (AETC) Program. The AETC Program builds the capacity to provide accessible, high-quality treatment and services throughout the United States and its territories; trains and provides technical assistance to health care professionals, inter-professional health teams, and health care organizations on the prevention, diagnosis, and treatment of HIV; and provides special training to minority providers and providers who are serving minority populations.

HIV Prevention and Treatment Challenges in Rural America: A Policy Brief and Recommendations to the Secretary. The National Advisory Committee on Rural Health and Human Services provides recommendations to the HHS Secretary on addressing HIV prevention and treatment challenges in rural communities.

National Rural Health Association (NRHA): Rural Health Resources and Best Practices. The NRHA provides free rural health resources covering telehealth, policy, and leadership for rural communities and rural health.

National Rural Health Resource Center (NRHRC): Rural Response to Coronavirus Disease 2019 (COVID-19). In response to the COVID-19 pandemic, the NRHRC provides up-to-date and relevant tools and resources for rural clinics, hospitals, and their communities from multiple federal partners.

Prevention and Treatment of HIV Among People Living With Substance Use and/or Mental Disorders. This publication of the HHS Substance Abuse and Mental Health Services Administration reviews interventions for people at risk for or with HIV who have substance use and mental disorders. Interventions are in alignment with the goals of EHE.

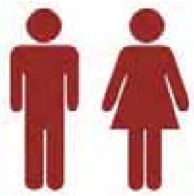
Rural HIV/AIDS Prevention and Treatment Toolkit. This toolkit contains modules that cover resources and information focused on developing, implementing, evaluating, and sustaining rural HIV/AIDS programs.

Telehealth Resource Centers (TRCs). This resource, developed by HRSA's Federal Office of Rural Health Policy, lists regional and national TRCs that provide technical assistance to states and territories concerning technology assessment and telehealth policy.

References

1. RWHAP providers were defined as being in a rural area if their main organizational address was in an area designated as rural by the HRSA Federal Office of Rural Health Policy (FORHP). FORHP classifies all non-Metro counties, as defined by the Office of Management and Budget, as rural. In addition, FORHP uses Rural-Urban Commuting Area (RUCA) codes to identify other rural areas. https://www.hrsa.gov/rural-health/about-us/definition/index.html
2. Outpatient medical care is classified as Outpatient/Ambulatory Health Services (OAHS) in HRSA HAB's Policy Clarification Notice (PCN) 16-02. OAHS provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

HRSA
Ryan White HIV/AIDS Program



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).

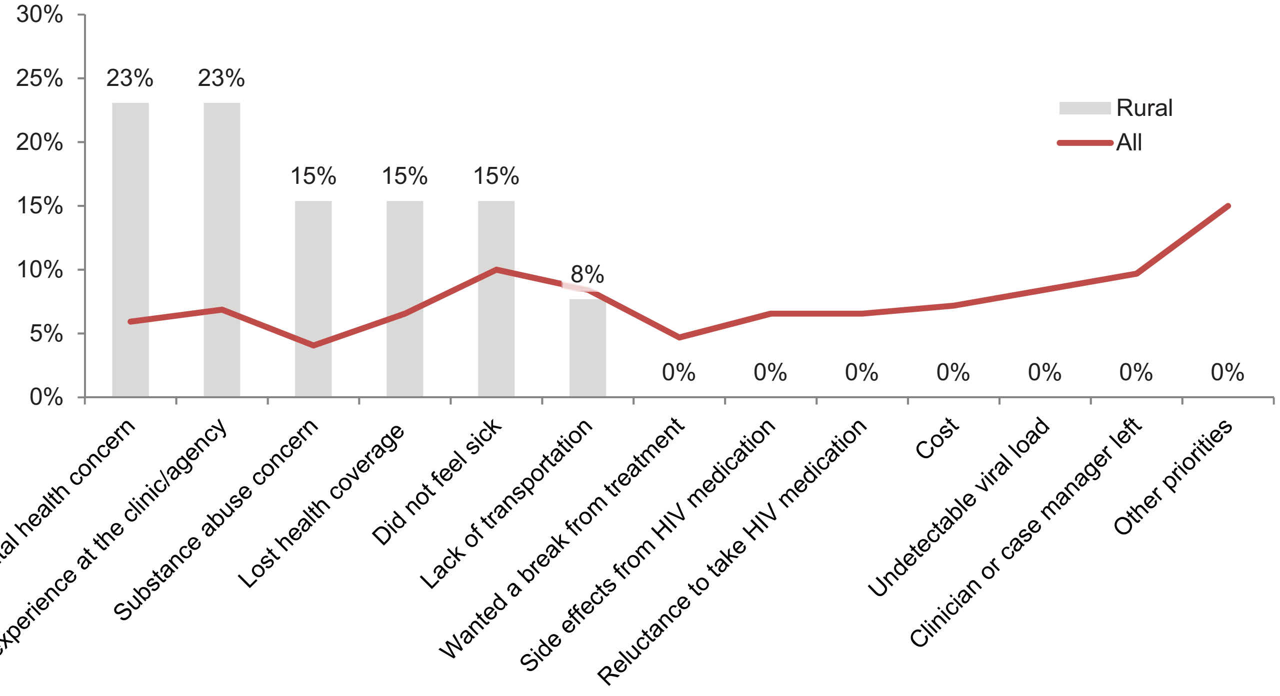
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 80% of rural participants reported no interruptions in their HIV care for 12 months or more since their diagnosis. Those who reported a break in HIV care for 12 months 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.



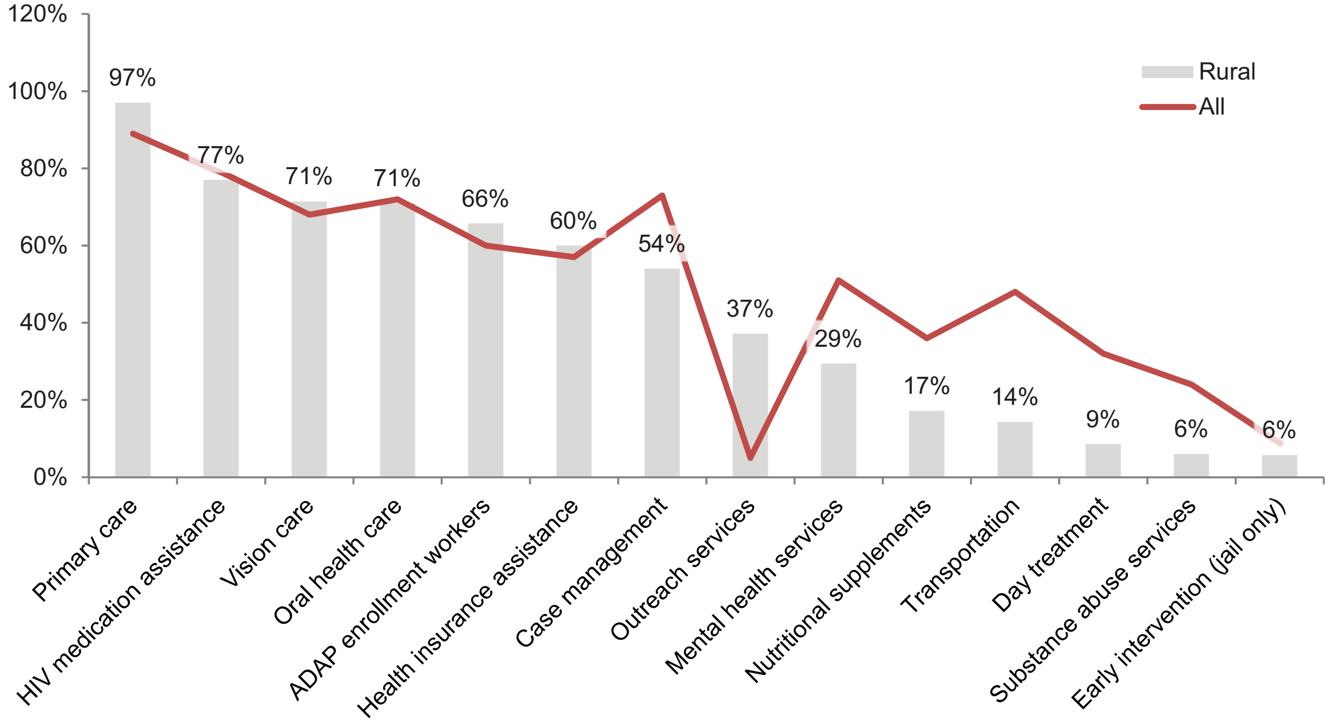
OVERALL RANKING OF FUNDED SERVICES, BY NEED

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.

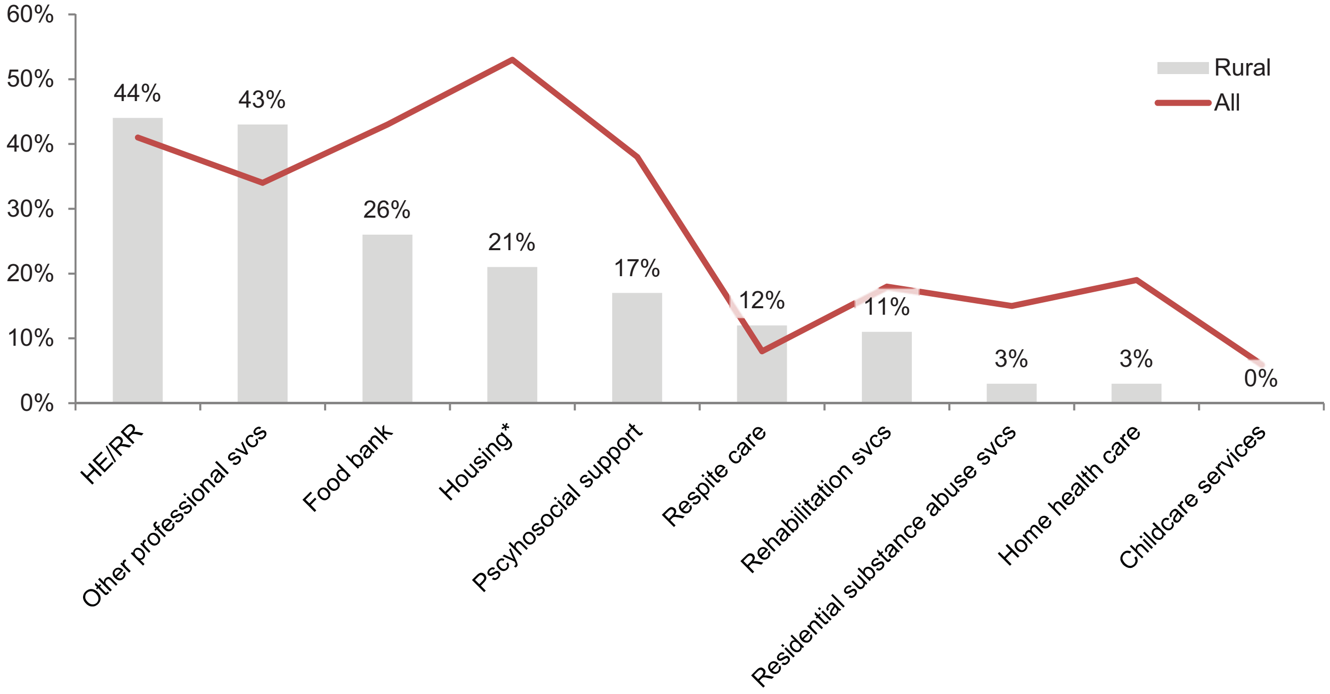
(**Graph 5**) From the 10 service options provided, rural needs assessment participants reported health education & risk reduction services (44%) as the most needed other/non-Ryan White Funded HIV-related service. Rural needs assessment participants also cited other professional services (43%), and food 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

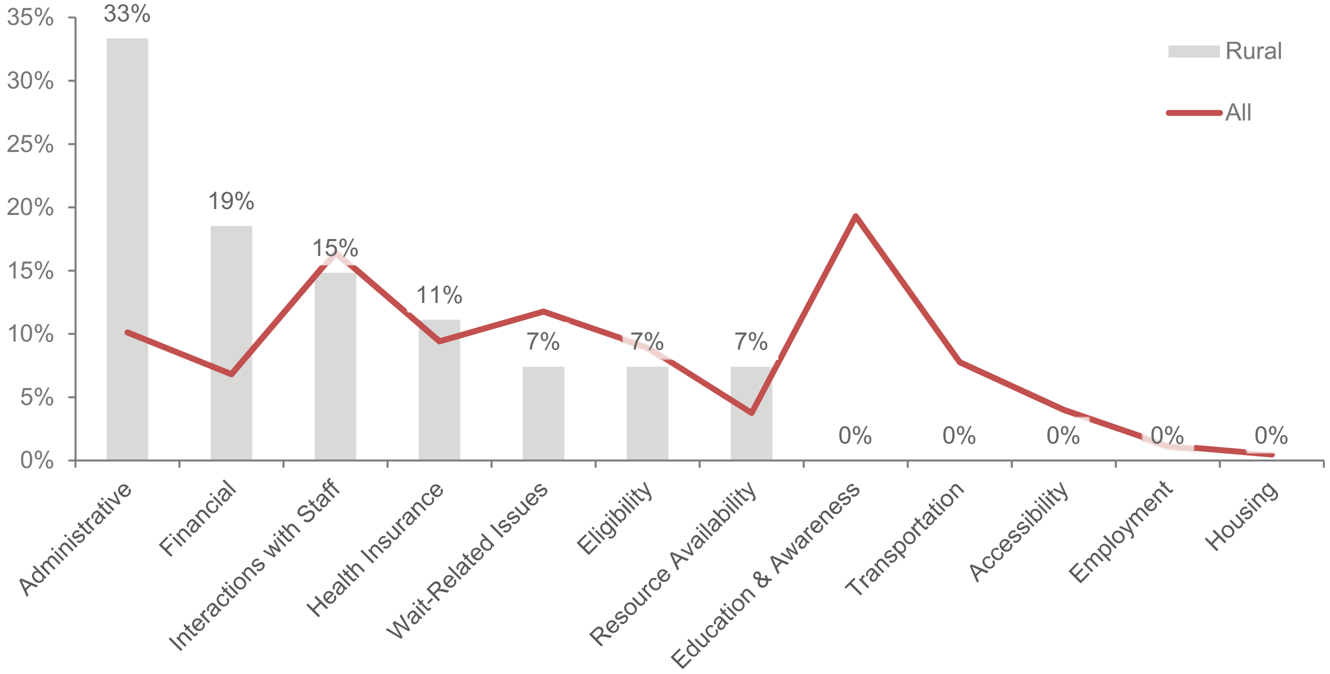
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant 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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